City and Hackney

Health and Wellbeing Profile

2011/12

Our Joint Strategic Needs Assessment
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Acknowledgements

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Introduction

The *City and Hackney Health and Wellbeing Profile 2011/12* is the Joint Strategic Needs Assessment of the London Borough of Hackney, the City of London Corporation, NHS East London and the City, City and Hackney Pathfinder Clinical Commissioning Group and partners in the voluntary and community sector, local economy and wider statutory sector. It is designed for everyone who has a professional, community or personal interest in promoting the health and wellbeing of the people of Hackney and the City of London.

The annual production of the Health and Wellbeing Profile is supported by a Stakeholder Involvement Advisory Group which includes representatives from the Local Involvement Networks, City and Hackney Health and Social Care Forum and other Voluntary and Community Sector organisations. This group has played an important role in shaping this year’s edition and bringing a rich seam of ‘community intelligence’ to the wider evidence in the document. Although this document is dominated by official statistics, the value of evidence from organisations working on a daily basis with people in need in Hackney and the City is also recognised.

**Maps and stories: understanding the determinants of health and wellbeing**

The Health and Wellbeing Profile takes a broad view of the factors that affect health and wellbeing, many of which lie well beyond the control of clinical and other health professionals. Figure 1 describes this diversity spatially, mapping everything from the factors which are close to the individual, and within the individual’s control, to the broader determinants of health which the individual may have little control over.

*Figure 1. The determinants of health and wellbeing*¹

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This spatial understanding of the determinants of health is widely shared by ordinary people in Hackney and the City. As part of the community engagement for this edition of the Health and Wellbeing Profile, three workshops were held with community groups at which the question was asked of participants: “What affects your health and wellbeing and the health and wellbeing of your family and friends?” The responses from the three groups – the Black and Ethnic Minority Working Group (BEMWG), City and Hackney Older People’s Reference Group (OPRG) and Patients’ Network are summarised on the three health and wellbeing maps below (Figure 2).

There were many issues that came up in all three groups, ranging from stress and isolation to housing and money. But there were also interesting differences between the groups. For the older participants in the OPRG workshop, the comfort, security and cleanliness of the home were stressed, as was the value of regular social interaction. They cared about the quality of human interaction at all levels, including the way in which they were treated by carers and professionals and the way in which people behaved in the public environment including on buses and on the streets. They wanted to be treated with dignity at all times.

Not surprisingly, members of the Patient’s Network also had a particular concern for the quality of health and social services though this went beyond the quality of the human interaction to all other aspects of the patient experience including waiting times, bureaucracy and the information they were given. This group was the most willing to talk about the reality of their immediate experience – of pain, depression, worry and low self-esteem – as defining their health and wellbeing, but they also saw the links between this experience and the wider world. They were concerned about safety and policing, the difficulties of getting around and the cost of transport, and the attitudes of strangers who were quick to make assumptions about them.
The participants in the BEMWG workshop took a particularly broad view of the factors that shaped their health and wellbeing. They were quick to identify the ‘big issues’ that define so much of everyday life – poverty, the cost of living, education and housing – but were also interested in the nature of human interaction and behaviour within this context. They were worried about bad parenting and the breakdown of family life, the lack of positive role models for children and young people, the challenge of achieving a good work-life balance, and the difficulty of eating well when fast food shops proliferate and advertising drowns out education about healthy eating. They also identified the particular issues that differences in language and culture can create for people trying to access services and get the support they need.

Maps are not the only way of describing the determinants of health and wellbeing. An alternative approach is temporal rather than spatial – i.e. telling stories rather than drawing maps. This is the approach taken by the Marmot Team in their 2010 report on health inequalities in England: *Fair Society, Healthy Lives*. This report takes the broadest view of the factors that affect health but describes these principally in terms of the life course, set in a context of sustainable communities and healthy standards of living (Figure 3). A particular emphasis is given to the beginning of this story: action to reduce health inequalities must start before birth and be followed through the life of the child. The top recommendation of the report is that every child should be given the best start in life. However the report also identifies the many opportunities through school and education, working life and older life to minimise adverse health impacts and maximise positive impacts.

The *City and Hackney Health and Wellbeing Profile* incorporates both a spatial view of health and wellbeing – beginning with population profile and socio-economic context – and a life-course view, moving from the needs of infants, children and young people to the needs of adults and older people. These two ways of describing health and wellbeing needs together provide a comprehensive view of the issues that need to be considered when planning for the protection and improvement of the health and wellbeing of the people of Hackney and the City of London. As the participants in the workshops made clear, no one organisation or
service can secure health and wellbeing for the local population – action is needed at all levels and at all times
of life. In Hackney and the City we are proud of our history of working in partnership to deliver this action and
we remain committed to tackling the broader determinants of health while also ensuring that patients and
clients receive high quality services that respect the individuality of their needs.

This document also follows the Marmot Report in taking a particular focus on inequalities. Previous editions
of the Profile have always drawn attention to the differences between Hackney, the City and London as a
whole. This edition also looks within Hackney and the City to identify, where possible, the inequalities in
health and wellbeing between different population subgroups, defined according to age, ethnicity,
deprivation, locality or social care need.

This new focus was one of the recommendations of the review of the last City and Hackney Health and
Wellbeing Profile. The other key recommendations were to provide better disaggregated data for the City, to
include more community intelligence and to improve the ‘What Works?’ sections. All of these
recommendations have been addressed in this document. Throughout the document there are small boxes
citing submission from our call to evidence to the local voluntary and community sector, facilitated by the City
and Hackney Health and Social Care Forum. We hope that this input will expand in future editions of the
Profile.

A ranking of local needs

This document contains a wealth of information about the needs of the people of Hackney and the City. As
there are so many needs, across so many communities, a new process was developed in 2012 to rank the
needs identified in the Profile. This ranking, undertaken separately for Hackney and the City of London, will
inform the development of the two new Health and Wellbeing Strategies for Hackney and the City
respectively.

The following is a summary of the methodology used to rank the needs:

- A set of key questions was developed to interrogate the identified needs, based on criteria first
developed for JSNA prioritisation in Leeds, with input from local institutional and community
stakeholders including members of the Health and Wellbeing Profile Management Group, the Public
Health Implementation Group, the Stakeholder Involvement Advisory Group and the shadow Health
and Wellbeing Boards;
- The draft Health and Wellbeing Profile was shared with local stakeholders to ensure there were no
important omissions;
- A summary of the needs for each locality (Hackney and the City) was prepared by officers on and
scored against the agreed questions (with clearly defined evidence-based scoring criteria for each
questions);
- The total scores for each need were ranked and a final ranked list prepared. The list and the ranking
process were shared with stakeholders, tested and amended where appropriate;
- The final rankings were discussed at the two shadow Health and Wellbeing Boards.

The questions against which the scoring was conducted were:

- Is this an issue which affects a significant proportion of the population (directly or indirectly)? 100%
- Is this an issue which significantly affects vulnerable groups? 75%
- Is this issue a significant contributor to inequalities in health and wellbeing? 75%
- Are there significant unmet needs? 150%
- Are needs amenable to intervention by local authority, NHS and partners? 100%
- Is this a national/London priority? 25%

The ranking of the needs of Hackney residents is shown in the Appendix, as are the priorities for residents in
the City of London. These rankings focus solely on specific needs, not on groups or communities affected by
these needs. Although this is taken account of within the prioritisation methodology, these groups are not
visible in the lists themselves (though acknowledged in the City priorities). For full details of how needs map
on to these groups and communities in Hackney, and of the scoring process, see the Appendix on page 294.
Chapter 1: The people of Hackney and the City

This chapter describes the size, structure, density and ethnic makeup of the population of Hackney and the City of London. This information is vital for the design and delivery of local services as changes in the size and profile of the local population change both the extent of local health need and the demand for services.

Hackney is a densely populated inner London borough with a remarkably diverse population. Over twenty thousand people come to live in Hackney every year and a similar number leave; one third of the population was born outside the UK. Although deprived, the borough has enormous assets in both its physical and community resources.

The City of London is unique. Although little more than one mile square in size, it is densely developed and provides employment for 360,000 people, most of whom use public transport to commute to the City from across London and the surrounding regions. Alongside its primary business function the City has many other roles including education, tourism and providing a home to 11,700 residents. These residents are concentrated into a relatively small number of areas, with the rest of the City consisting primarily of commercial property. There is both a day time and a night time economy, which reflect the different groups of people who enter the City at different times. This Profile focuses upon the health needs of residents in the City but the health and wellbeing needs of the City’s commuters and students are also a concern of the City of London Corporation.

Population size

2011 update

The new assessment of the size of the population of Hackney by Mayhew Associates, based on administrative data, is 8.4% higher than the official estimate.

Population data from the 2011 Census will not be available for at least another year. In the mean time, the official population estimates remain the ONS mid-year estimates\(^2\). The GLA’s estimates\(^3\) are significantly higher than the ONS estimates (Table 1.1).

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\(^2\) ONS: 2010 mid-year estimates

\(^3\) GLA: 2011 Round of Demographic Projections - (Strategic Housing Land Availability Assessment), 2011
There is, however, a further estimate available for Hackney. An investigation into the size of the population using local administrative data, undertaken at the same time as the Census, has concluded that the population of Hackney is even higher: a total of 237,646 people. This is 8.4% higher than the official estimate.

The Mayhew study was conducted, in part, because of concerns that the official estimate, based on the Census, is not robust because of poor response rates to the Census in the inner city. It also provides a more detailed picture of the profile of the local population. The GLA’s population estimates take account of housing supply and are therefore commonly used within spatial planning.

The City

The official resident population estimate for the City is 11,700 people (ONS). However the City of London Corporation uses the GLA’s estimates for planning purposes as these take account of the constraints of housing supply.

The City of London has a large daytime commuter population, whose significant needs must be addressed by local infrastructure and services. The ONS estimate of the size of the working population in 2010 was 360,000 people, up from 344,000 in 2008. The City attracts some of the highest paid individuals in the country, but they are supported by lower-paid administrative and support staff, as well as the caterers and cleaners who may not earn much above minimum wage. There is a commitment among local partners to understand the health needs of the City worker population better.

The City is also home to a number of academic and adult learning institutions, including universities, colleges, training providers and its own Adult Skills Service. Over 10,000 adult students attend courses in the City. The student population includes young people (16-18 year olds), adults in higher education, City workers studying at lunchtime and after work and City residents, families and older learners attending community classes.

Table 1.1 Resident population estimates for Hackney and the City (ONS, GLA, Mayhew Associates)

<table>
<thead>
<tr>
<th></th>
<th>Hackney</th>
<th>City</th>
<th>City and Hackney</th>
</tr>
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<tr>
<td>ONS 2010 population estimate</td>
<td>219,200</td>
<td>11,700</td>
<td>230,900</td>
</tr>
<tr>
<td>GLA 2011 population estimate</td>
<td>235,334</td>
<td>8,863</td>
<td>244,197</td>
</tr>
<tr>
<td>Mayhew Associates 2011</td>
<td>237,646</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

Population density

Population density describes the number of residents per square kilometre. Hackney has an area of 19.05 km² and a population density, based on the Mayhew Associates estimate, of 12,442 residents per km². If the ONS population estimate is used, the population density of Hackney is 11,476 residents per km².

By comparison, Greater London has a population density of 5,000 residents per km². Hackney’s high population density – the fourth highest in London – reflects the character of the housing in the inner city which is dominated by flats and terraces rather than the larger, detached houses that are more common in outer London boroughs.

The City

The City covers an area of only 2.9km² (‘the square mile’) and has a relatively small resident population. The population density of the City is 4,034 residents per km² (ONS population estimate) or 3358 residents per km² (GLA population estimate). The majority of the City’s land is in office use, with housing occupying a small

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5 ONS Business Register and Employment Survey 2010.
proportion of land. Residential densities in the City are very high as the majority of housing schemes are multi-storey with little or no outdoor space or car parking⁶.

**Age and sex profile**

Hackney has a young population with more than one in four (27%) of its residents aged under 20 years and 39% aged between 20 and 39 years (Mayhew data – see Figure 1.1 and Table 1.2 for comparison with GLA and ONS). The 0-4 age group in Figure 1.1 and Table 1.2 includes 1,960 infants under the age of one year. There are nearly 19,000 people aged 65 years or more, 8% of the total population.

The differences between the Mayhew population estimate and the official estimate are most prominent in the younger age groups and especially in the 10-14 and 15-19 age groups, both of which Mayhew Associates estimate to be over a fifth bigger than the official estimate.

Mayhew Associates agree with the ONS about the overall balance of the sexes in Hackney: 51% female and 49% male.

![Figure 1.1 Comparison of Mayhew 2011 and ONS 2010 estimated population age distributions for Hackney.](image)

<table>
<thead>
<tr>
<th></th>
<th>ONS 2010</th>
<th>GLA 2011</th>
<th>Mayhew 2011</th>
<th>Mayhew increase over ONS</th>
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<tbody>
<tr>
<td>0-4</td>
<td>19,642</td>
<td>20,003</td>
<td>21,337</td>
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<tr>
<td>5-9</td>
<td>14,459</td>
<td>16,215</td>
<td>16,053</td>
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<tr>
<td>10-14</td>
<td>11,740</td>
<td>13,883</td>
<td>14,129</td>
<td>20.3%</td>
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<tr>
<td>15-19</td>
<td>10,964</td>
<td>12,613</td>
<td>13,389</td>
<td>22.1%</td>
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<tr>
<td>20-24</td>
<td>16,356</td>
<td>19,859</td>
<td>19,367</td>
<td>18.4%</td>
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</table>

⁶ City of London Local Development Framework, Core Strategy: Delivering a World Class City, Affordable Housing Viability Study, May 2010
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<th>Age Group</th>
<th>ONS 2010</th>
<th>GLA 2011</th>
<th>Mayhew 2011</th>
<th>Mayhew increase over ONS</th>
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<tbody>
<tr>
<td>25-29</td>
<td>25,873</td>
<td>28,133</td>
<td>28,608</td>
<td>10.6%</td>
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<tr>
<td>30-34</td>
<td>24,352</td>
<td>24,501</td>
<td>25,365</td>
<td>4.2%</td>
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<tr>
<td>35-39</td>
<td>19,819</td>
<td>20,152</td>
<td>20,127</td>
<td>1.6%</td>
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<td>40-44</td>
<td>17,099</td>
<td>17,760</td>
<td>17,115</td>
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<tr>
<td>45-49</td>
<td>14,689</td>
<td>15,433</td>
<td>15,550</td>
<td>5.9%</td>
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<tr>
<td>50-54</td>
<td>10,715</td>
<td>11,638</td>
<td>11,777</td>
<td>9.9%</td>
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<tr>
<td>55-59</td>
<td>8,399</td>
<td>8,804</td>
<td>8,707</td>
<td>3.7%</td>
</tr>
<tr>
<td>60-64</td>
<td>6,906</td>
<td>7,293</td>
<td>7,155</td>
<td>3.6%</td>
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<tr>
<td>65-69</td>
<td>4,940</td>
<td>5,421</td>
<td>5,292</td>
<td>7.1%</td>
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<tr>
<td>70-74</td>
<td>4,562</td>
<td>4,707</td>
<td>4,602</td>
<td>0.9%</td>
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<tr>
<td>75-79</td>
<td>3,380</td>
<td>3,605</td>
<td>3,577</td>
<td>5.8%</td>
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<tr>
<td>80-84</td>
<td>2,608</td>
<td>2,630</td>
<td>2,668</td>
<td>2.3%</td>
</tr>
<tr>
<td>85-89</td>
<td>1,655</td>
<td>1,625</td>
<td>1,680</td>
<td>1.5%</td>
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<tr>
<td>90+</td>
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<td>1,059</td>
<td>1,110</td>
<td>3.7%</td>
</tr>
<tr>
<td>All ages</td>
<td>219,228</td>
<td>235,334</td>
<td>237,646</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

The City

The resident population of the City is predominantly working age: four fifths (80%) are aged between 20 and 64 years (ONS estimates). Ten per cent (1,200 people) of residents are aged under 20 years and the remaining 10% are aged 65 years or more (Figure 1.2). The City’s population is 55% male and 45% female.

Figure 1.2 Estimated age distribution of the population of the City in 2010 (ONS)
Population change and migration

2011 update

The population of Hackney has grown by 6.5% over the last four years. The increase has largely been in the young adult and young child age groups.

Over the last two years there has been a sharp rise in the number of people from overseas registering with GPs in Hackney.

Focus on inequalities:

Population data is based on official surveys and administrative data. Some of the most marginalised people in Hackney and the City, such as unregistered migrants, may not therefore appear in this data.

The recent analysis by Mayhew Associates found that from June 2007 to March 2011 the population of Hackney grew by 6.5% from 223,171 to 237,646. This growth was driven by an increase in the young adult and young child age groups, with particular growth in 25-34 year olds and under 5s. This growth did not have a single geographical pattern, but a mix of changes with the growth and relative decline in population in different parts of the borough. Particular growth has been seen in parts of Shoreditch, and certain areas around Dalston.

The Mayhew analysis of migration and population turnover found that inflows into the borough through birth or in-migration since 2007 totalled 72,000 persons, and outflows through death or moving out of the borough totalled 65,000 persons. Overall, people moving into Hackney tend to be younger than people leaving Hackney. Since 2007 it is also clear that the population has been boosted by a higher number of births. Population churn over this period (2007 to 2011) ranged from between 20%-45% depending on the part of the borough examined. Changes of this magnitude are not unusual.

The ONS mid-year population estimates are based on a similar analysis of natural change (births and deaths) and migration. Table 1.3 describes these components of change for Hackney. According to these estimates, net migration over the last year was negative but the population still grew due to the large number of births.

Hackney has a large migrant population. The needs of this population are diverse, reflecting not only the range of places and cultures that people come from but also their many different reasons for migration. Migrants include:

- Migrant workers
- Family migrants
- International students
- Refugees
- Asylum-seekers
- Refused asylum-seekers
- Trafficked persons
- Undocumented migrants

A range of indicators are available of the size of the local migrant population:

- The ONS Annual Population Survey distinguishes between residents born in the UK and residents born outside the UK and between those with and without British nationality. In 2010, an estimated 146,000 (66%) Hackney residents were born in the UK and 73,000 (33%) were born outside the UK. The number of residents born outside the UK has not changed significantly over the last six years.

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8 Rose N et al: Including migrant populations in Joint Strategic Needs Assessments, DH Health Inequalities and Local Improvement Team 2011
9 ONS: Local area migration indicators, 2011
• Overall, 40,000 residents (18%) do not have British nationality. This number has also been fairly stable for the last six years. Approximately half of these residents have EU nationality.

• There were 7,660 new registrations for National Insurance numbers made by international migrants resident in Hackney in 2010. This was a 5% increase on the previous year. This is a good indicator of the number of people from overseas arriving to work and includes refugees and family joiners but does not include illegal migrants. This figure includes adult overseas nationals allocated a National Insurance number for any reason, i.e. for benefit/tax credit recipients as well as workers (including the self employed). All adult overseas nationals allocated a National Insurance number are included, regardless of their length of stay in the UK.

• There were 6,890 new GP registrations in Hackney in 2010 for people previously living abroad. This was a 23% increase on the previous year. This indicator captures most migrants and their dependants but excludes those who do not register with a GP including short-term economic migrants. There has been a sharp rise in the number of new GP registrations of people previously living abroad over the last two years (Figure 1.3).

Most migrants are young, healthy adults who have chosen to come to the UK, mainly to work or study, and most arrive from countries with a low prevalence of infectious disease such as Western Europe and North America. However, some arrive from regions of the world with a high burden of infection, such as Africa and South Asia. Migrants from these areas may be at increased risk of infectious diseases such as HIV, hepatitis, malaria and tuberculosis. This increased risk may continue for a number of years after arrival as migrants often travel back to their country of origin to visit friends and relatives. They may also have close contact with other migrants living in the UK.

The City

Table 1.3 describes the ONS calculation for the 2010 mid-year population estimate for the City, based on natural change and internal and international migration.

The following indicators provide further detail on the size of the migrant population:

• The Annual Population Survey does not provide data on the country of birth or nationality of residents of the City of London due to the small population size.

• There were 690 new registrations for National Insurance numbers made by international migrants resident in the City in 2010. This was an 11% increase on the previous year.

• There were 266 new GP registrations in the City in 2010 for people previously living abroad. This was a 45% increase on the previous year. There has been a sharp rise in the number of new GP registrations of people previously living abroad over the last two years (Figure 1.3).

For more information on the health needs of international migrants, see the Health Protection Agency’s Migrant Health Guide (www.hpa.org.uk/migranthealthguide)
Table 1.3 Components of change in ONS mid-year estimates 2009-2010 (ONS)

<table>
<thead>
<tr>
<th></th>
<th>Hackney</th>
<th>The City</th>
<th>City and Hackney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-2009 population</td>
<td>216,000</td>
<td>11,500</td>
<td>227,500</td>
</tr>
<tr>
<td>Natural change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>live births (see page 147 for precise data)</td>
<td>4,600</td>
<td>100</td>
<td>4,700</td>
</tr>
<tr>
<td>Deaths (see page 198 for precise data)</td>
<td>1,100</td>
<td>&lt;100</td>
<td>1,100</td>
</tr>
<tr>
<td>net natural change</td>
<td>3,500</td>
<td>0</td>
<td>3,600</td>
</tr>
<tr>
<td>Migration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>international migration: in</td>
<td>3,900</td>
<td>700</td>
<td>4,600</td>
</tr>
<tr>
<td>international migration: out</td>
<td>3,700</td>
<td>700</td>
<td>4,400</td>
</tr>
<tr>
<td>UK internal migration: in</td>
<td>18,200</td>
<td>1,000</td>
<td>19,200</td>
</tr>
<tr>
<td>UK internal migration: out</td>
<td>18,700</td>
<td>800</td>
<td>19,500</td>
</tr>
<tr>
<td>net migration</td>
<td>-300</td>
<td>200</td>
<td>-100</td>
</tr>
<tr>
<td>Total change</td>
<td>3,200</td>
<td>200</td>
<td>3,400</td>
</tr>
<tr>
<td>Mid-2010 population estimate</td>
<td>219,200</td>
<td>11,700</td>
<td>230,900</td>
</tr>
</tbody>
</table>

Figure 1.3 New GP registrations of people previously living abroad per 1,000 population, 2001-2010 (ONS/Patient Register Data Service)
Asylum seekers and refugees

2011 update

Accurate data on the number of asylum seekers, failed asylum seekers and refugees living in Hackney and the City is difficult to obtain. Over the past five years, the number of asylum seekers supported by London Borough of Hackney under Section 95 of the Immigration and Asylum Act has reduced by 87%.

Refugees and asylum seekers may suffer from physical and mental health problems as a consequence of experiences in their country of origin. Their health can be made worse by poor access to health services and journeys to the UK. Many refugees arrive without any friends or family, leading to isolation, fear and low confidence. However, the average physical health status of refugees on arrival is not especially poor: most are young and fit. There is some evidence to suggest that the health status of new entrants may become relatively worse in the 2-3 years after arrival. Although overall their health is reasonable, there are significant numbers of refugees who exhibit particular health problems, including:

- Physical after-effects of war, torture, displacement and journey to the UK
- Communicable diseases, importantly, tuberculosis
- Mental health problems
- Psychological distress following trauma, the effects of coping with a new culture, and exposure to racism, associated loss of status, uncertainty relating to securing asylum can be significant

Refugees and migrants meet a number of obstacles in accessing good healthcare, including:

- Language and cultural differences
- Lack of awareness of the ways healthcare is delivered in the UK, different from home
- Racism
- Failure to prioritise their healthcare needs compared to other primary needs such as immigration issues, housing and employment. As a result they may delay seeking healthcare and have low uptake of prevention services
- Stigma and other barriers in seeking help for HIV and sexually transmitted infections, and other communicable diseases such as TB, which are common in Sub-Saharan African refugee and migrant communities

Local data is available on asylum seekers who are supported under Section 95 of the Immigration and Asylum Act 1999 and Section 21 of the National Assistance Act 1948. Section 95 provides for accommodation and/or subsistence payments while a person’s asylum claim is considered. This support is funded by the UK Borders Agency.

Section 21 says that a local authority has a duty to provide support for people aged eighteen or over who because of age, illness, disability or any other circumstances are in need of care and attention, which is not otherwise available to them.

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13 Unheard Voices - Listening to the Views of Asylum Seekers and Refugees, Commission for Patient and Public Involvement in Health, 2006
However, the Immigration and Asylum Act 1999 amended this in order to disqualify those who are destitute because of a failed asylum claim. This means that in order to be eligible for assistance a failed asylum seeker must have needs which are 'above and beyond' destitution, commonly known as 'destitute plus'. Such circumstances would typically be ill health, disability and old age but there may be others such as domestic violence and/or if an individual is an expectant or nursing mother.

In July-September 2011, 53 asylum seekers were in receipt of Section 95 support in Hackney, of whom 31 received subsistence support only and 22 also received accommodation. The number of asylum seekers receiving Section 95 support has declined dramatically in the last 5 years. In the same quarter of 2006, 418 asylum seekers received this support. The decline in London as a whole has not been as great – a 55% drop compared to 87% in Hackney.

In 2010, a survey of 40 community workers within migrant and refugee organisations in Hackney identified their top three perceived health priorities as mental health, access to health services and domestic violence.

The City
Fewer than five asylum seekers are supported under Section 95 in the City.

Future population growth

### 2011 update

The GLA estimates that Hackney’s population will exceed a quarter of a million in the next five years.

The primary drivers of population growth are the birth rate, death rate and net migration. Future trends in population growth are based on these drivers. However many other factors shape or constrain these drivers. The population projections from the GLA take account of the long-term prospects for housing availability in the area. The availability of housing is a core constraint on migration in an inner city area.

After decades of decline, Hackney’s population started to grow in the early 1990s when there were more births than deaths and young people started moving into the borough. Growth is expected to continue over the coming decades, with the GLA predicting that Hackney’s population will exceed a quarter of a million in the next five years. By 2031 the population of Hackney is projected to increase by 16%.

The GLA projections indicate growth in all age groups within Hackney though the biggest proportionate increase will be in the older, pensionable age group (Figure 1.4).

The City

The GLA projects a 38% increase in the City’s population over the next 20 years (Table 1.4). The largest growth in absolute numbers will be in the working age population but the largest proportionate growth will be in the older, pensionable age population (Figure 1.5). More detail can be found in the City of London’s Annual Monitoring Report.

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15 Refugee Quick Health Survey, HCVS & Hackney Refugee Forum 2010
## Table 1.4 Projected population in Hackney and the City to 2031 (GLA\textsuperscript{17})

<table>
<thead>
<tr>
<th>Year</th>
<th>Hackney Population</th>
<th>Increase on 2011</th>
<th>The City Population</th>
<th>Increase on 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>235,334</td>
<td></td>
<td>8,863</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>250,940</td>
<td>7%</td>
<td>9,680</td>
<td>9%</td>
</tr>
<tr>
<td>2021</td>
<td>261,084</td>
<td>11%</td>
<td>10,786</td>
<td>22%</td>
</tr>
<tr>
<td>2026</td>
<td>268,180</td>
<td>14%</td>
<td>11,527</td>
<td>30%</td>
</tr>
<tr>
<td>2031</td>
<td>273,496</td>
<td>16%</td>
<td>12,235</td>
<td>38%</td>
</tr>
</tbody>
</table>

\textsuperscript{17} GLA: 2011 Round of Demographic Projections - (Strategic Housing Land Availability Assessment), 2011
Ethnicity

2011 update

The Mayhew study has provided a more detailed picture of the ethnic profile of Hackney than that offered by the Census categories. Turkish, Nigerian, Ghananian, Somali, Kurdish and Vietnamese communities are all prominent alongside the established Census categories.

The GLA estimates that three fifths (60%) of Hackney residents are White and a quarter (25%) of the population is Black including 12% Black African, 8% Black Caribbean and 5% ‘Black other’ (Figure 1.6). Ten percent of the population is Asian including 7% who are south Asian. The ethnic profile varies across the ages with much larger Black and minority ethnic population in the young age group (Figure 1.7, see page 143 for more details).

The ONS also publishes estimates of the ethnic profile of the local population using the Census categories including ‘mixed’ ethnicity categories which do not appear in the GLA estimates. The 2009 estimate for Hackney was 62.7% White, 18.2% Black, 11.0% Asian, 4.2% Mixed ethnicity, 2.3% Chinese and 1.7% other ethnicities.

The ethnic categories used by the GLA and ONS do not show the complexity of the ethnic profile in Hackney. The recent Mayhew study describes the ethnicity of the population of Hackney in much greater detail. Here the Turkish community, invisible in the official statistics, appears as the third biggest ethnic group. Nigerian, Ghananian, Somali, Kurdish and Vietnamese communities are also prominent (Table 1.5). These data are, however, based principally on the name of the individual, so should be treated as broad indicators rather than accurate statistics.

The Mayhew study also estimated the size of the Orthodox Jewish (Charedi) population as 17,587 people or 7.4% of the population. This population has grown by 14% since the last Mayhew study in 2007.

The City

The GLA estimates that three quarters (76%) of City residents are White, 5% are Black and 12% are Asian (Figure 1.8). There is some variation across age groups with more ethnic diversity in younger age groups (Figure 1.9).
Figure 1.7 Ethnicity of Hackney residents by broad age group, 2011 projection (GLA)

Table 1.5 Ethnicity of population of Hackney (Mayhew analysis)

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>estimated number</th>
<th>%</th>
<th>Ethnic group</th>
<th>estimated number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>75,648</td>
<td>32%</td>
<td>Congolese</td>
<td>1,025</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>16,186</td>
<td>7%</td>
<td>Sierra Leone</td>
<td>609</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Turkish</td>
<td>11,497</td>
<td>5%</td>
<td>Greek</td>
<td>537</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Indian</td>
<td>7,687</td>
<td>3%</td>
<td>Afghan</td>
<td>414</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Nigerian</td>
<td>7,411</td>
<td>3%</td>
<td>Albanian</td>
<td>375</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>5,583</td>
<td>2%</td>
<td>Traveller of Irish heritage</td>
<td>370</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>3,384</td>
<td>1%</td>
<td>Portuguese</td>
<td>278</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Ghanaian</td>
<td>3,161</td>
<td>1%</td>
<td>Angolan</td>
<td>278</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Chinese</td>
<td>2,266</td>
<td>1%</td>
<td>Gypsy/Roma</td>
<td>243</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Somali</td>
<td>2,213</td>
<td>1%</td>
<td>Filipino</td>
<td>183</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>White Irish</td>
<td>1,778</td>
<td>1%</td>
<td>Kosovo</td>
<td>145</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Kurdish</td>
<td>1,741</td>
<td>1%</td>
<td>Sri Lanka</td>
<td>135</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>1,515</td>
<td>1%</td>
<td>Korean</td>
<td>115</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>
Travellers and Gypsies

In the United Kingdom, Gypsy Travellers consist of Welsh and English Romanichal or Romany Gypsies, Scottish and Irish Travellers and more recently, European Roma. Gypsies and Travellers have been described by the government as persons of nomadic habit of life whatever their race or origin, including such persons who, on grounds only of their own or their family’s or dependants’ educational or health needs or old age, have ceased to travel temporarily or permanently, and all other persons with a cultural tradition of nomadism and/or caravan dwelling. Despite the fact that many Gypsy Travellers have either chosen or been forced to live in houses for all or part of the time, they consider themselves to be Travellers, whether travelling or not.

In 2005 the size of the Gypsy Traveller population in Hackney was estimated through consultation with local stakeholders to be five hundred individuals. In 2007, data drawn from the London Gypsy and Traveller Unit and the Traveller Education Service indicated a larger population of 600 - 800 Irish Travellers. These figures are likely to be an underestimate of the size of the Gypsy Traveller community because they account only for individuals and families who are accessing or are known to those services. Although the majority of Gypsy Travellers in Hackney are Irish Travellers, there are also English Gypsies, Circus and Fairground Families, Barge Travellers, New Travellers and Roma from Eastern Europe residing in the borough, numbers of whom remain uncertain.

Within Hackney there are currently five official Traveller sites managed by the London Borough of Hackney, consisting of 27 plots, which are a mixture of traditional pitches for trailers and amenity blocks, and group housing. These sites are occupied solely by Travellers of Irish heritage. More invisible, and often harder to reach, are those families living in houses, making up the majority of the Gypsy Traveller community in Hackney.

18 All information in this section is drawn from Francis G: Traveller Health Needs Assessment Report, NHS City and Hackney, 2010
Nationally, Gypsy Travellers experience a high degree of marginalisation and social exclusion which contribute to poorer health outcomes. Gypsy Travellers have been found to have significantly poorer health and more self-reported ill-health symptoms than other English speaking ethnic minorities and economically disadvantaged white UK residents. The reasons for these disparities in health are generally attributed to poor access to health services, poor literacy, and poor accommodation and lifestyle choices. Other reasons may be a lack of understanding of the needs of Travellers and Gypsies by health professionals and racism, actual and perceived.

Adverse health outcomes include problems in the following areas:

- Maternal and child health, with high rates of maternal mortality, infant mortality, perinatal death, low birthweight, child accidents, dental caries and infectious disease; and low rates of immunisation and breast-feeding
- Mental health, with high rates of anxiety and depression
- Low uptake of services, reflecting both the experience of discrimination by service providers and a cultural preference for independence. However in Hackney the experiences of Travellers wanting to access GP services in Hackney is generally good, with very few not registered with a GP
- Long-term conditions: there is substantial ignorance about self-management of long-term conditions, partly related to poor literacy but also influenced by traditional health beliefs
- High levels of smoking and alcohol consumption
- Domestic violence (though prevalence is disputed)

**Religion**

**2011 update**

The Mayhew study has provided a new estimate of the size of the Orthodox Jewish (Charedi) population in north Hackney – 17,587 people or 7.4% of the population of Hackney.

Local data on religious affiliation is available from the 2001 Census (Table 1.6). This indicated that 47% of Hackney residents are Christian, 14% are Muslim and 5% are Jewish. This may under-represent the Jewish population, given the growth of the Orthodox Jewish (Charedi) population in north Hackney in the last ten years. The recent Mayhew study estimated the size of the Charedi population as 17,587 people or 7.4% of the population. This population has grown by 14% since the last Mayhew study in 2007.

Data on religious affiliation from the 2010/11 GP patient survey, distributed to households by Ipsos MORI using GP patient lists, are broadly consistent with the Census. In Hackney and the City, 46% of respondents identified as Christian, 12% as Muslim, 7% as Jewish, 2% as Buddhist, 1% as Hindu and 1% as Sikh. In the north of the borough, there are large populations of Jewish patients registered at the Cranwich Road surgery (78%), Stamford Hill practice (46%) and Allerton Road surgery (41%)\(^2\). As in the Census, there are many people who say they have no religion (24%) or who do not state their religion (5%).

**The City**

In the City, 55% of residents identified as Christian in the Census, 6% as Muslim and 3% as Jewish (Table 1.6). The profile of the patients at the Neaman practice, from the 2010/11 GP patient survey, is 50% Christian, 5% Jewish, 2% Muslim and 2% Hindu.

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\(^2\) Department of Health: 2010/11 GP Patient Survey.
Table 1.6 Religious affiliation in Hackney and the City (ONS 2001)

<table>
<thead>
<tr>
<th>Religious Denomination</th>
<th>Hackney</th>
<th>The City</th>
<th>London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>47%</td>
<td>55%</td>
<td>58%</td>
<td>72%</td>
</tr>
<tr>
<td>No religion</td>
<td>19%</td>
<td>25%</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Muslim</td>
<td>14%</td>
<td>6%</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Jewish</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Hindu</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Sikh</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Any other religion</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Religion not stated</td>
<td>12%</td>
<td>9%</td>
<td>9%</td>
<td>8%</td>
</tr>
</tbody>
</table>

The Orthodox Jewish (Charedi) community in Hackney

The roots of the Charedi community are in immigrants from Eastern Europe who arrived in East End of London in the late 19th Century and early 20th century, driven from their places of birth by persecution and economic hardship. The main flow of migrants came as a result of the Holocaust just before, during and after the Second World War, from Eastern and Central Europe. These communities were later joined by other refugees and migrants coming from a range of geographical locations including the Indian sub continent, North Africa, the former Soviet Union, Aden, France, Israel and more recently the Yemen.

The common denominator for Charedi people is strict adherence to the main tenets of Judaism. This includes observing the Shabbos (the Jewish Sabbath) and Jewish festivals; the laws of Kashrus (the special dietary laws); fixed daily times for prayer; and observance of many numerous other Judaic laws pertaining to many aspects of daily life. Outside of observance of ‘core’ Jewish laws, there are many variations in customs and culture according to people’s origin and affiliations.

Charedi life is centred on the family and the preservation of Jewish laws and values. Consequently the community has set up its own network of organisations, homes for the elderly and vulnerable, kosher food outlets, synagogues, social welfare organisations, special housing projects, places of study and perhaps most significantly its own independent faith schools.

Geographically, the Charedi community is clustered in the North East of Hackney mainly in the Springfield, New River, Lordship and Cazenove wards. They cluster not only because of people’s desire to live close to other members of their community and the feeling of security this provides (the community experience high levels of racist abuse and other crime), but because Charedi people are dependent on community infrastructure such as kosher shops, schools and synagogues. They are particularly constrained by the prohibition to use any vehicular mode of transport on the Shabbos (the Sabbath) and Jewish holidays, as this requires them to live within walking distance of synagogues.

Contrary to most other immigrant populations which eventually assimilate into society at large, through education, employment, etc., the Charedi community, although well established in the borough, is self contained. There is a strict gender separation from a young age. Children from nursery age through to adulthood are educated in Charedi schools, and out of school facilities are also separate. For many, Yiddish and sometimes other languages such as Hebrew and Arabic are a first language. The Jewish laws and cultural norms of ‘tznius’ - modesty and privacy in respect of male/female interactions - are central to Charedi life so, as well as the strict gender separation, there is limited access to mainstream media such as television, daily newspapers and the internet.

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21 Submission for Health and Wellbeing Profile from The Interlink Foundation, 2011
22 Holman: Baseline Indicators for the Charedi Community in Stamford Hill, 2002
Languages

2011 update

The most common languages other than English spoken in Hackney homes are Turkish, Yiddish and French. A minority (45%) of pupils in Hackney’s maintained schools speak English only, with 55% speaking English as an additional language. The three most common languages spoken by pupils are Turkish, Bengali and Yoruba.

Hackney’s 2004 household survey indicated that more than 100 languages are spoken in the borough. Two thirds (66%) of households stated that English was the only language spoken in their household and 22% said that English was the main language spoken at home, leaving 12% for whom English was not the main language spoken at home (if spoken at all).

Table 1.7 lists the languages other than English spoken within homes in Hackney. The most widely spoken languages are Turkish, Yiddish and French.

The 2011 Schools Census revealed that, among pupils in Hackney maintained schools, a minority (45%) speak English only, with 55% speaking English as an additional language\(^23\). The most common languages spoken are Turkish, Bengali, Yoruba, Gujarati and French (Figure 1.10). Yiddish does not appear on this chart because most Orthodox Jewish children are educated in independent schools.

Language differences can cause problems in many ways and in many settings. The VLC Community Centre, which provides support to Vietnamese and other Southeast Asian communities in Hackney, identified the language barrier as the primary problem affecting the health and wellbeing of its clients.

The Acton Estate Residents Association also identified language and literacy as the most common problems affecting wellbeing, alongside obesity and stroke.

The African Support and Project Centre, which supports French-speaking refugees, identified language as a key problem alongside unemployment, low income and lack of skills.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Language</th>
<th>Percentage of households</th>
<th>Rank</th>
<th>Language</th>
<th>Percentage of households</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Turkish</td>
<td>5.5%</td>
<td>11</td>
<td>Twi</td>
<td>0.8%</td>
</tr>
<tr>
<td>2</td>
<td>Yiddish</td>
<td>5.2%</td>
<td>12</td>
<td>Arabic</td>
<td>0.7%</td>
</tr>
<tr>
<td>3</td>
<td>French</td>
<td>2.2%</td>
<td>13</td>
<td>Italian</td>
<td>0.6%</td>
</tr>
<tr>
<td>4</td>
<td>Gujarati</td>
<td>1.8%</td>
<td>14</td>
<td>Kurdish</td>
<td>0.6%</td>
</tr>
<tr>
<td>5</td>
<td>Bengali</td>
<td>1.6%</td>
<td>15</td>
<td>Vietnamese</td>
<td>0.6%</td>
</tr>
<tr>
<td>6</td>
<td>Yoruba</td>
<td>1.3%</td>
<td>16</td>
<td>German</td>
<td>0.6%</td>
</tr>
<tr>
<td>7</td>
<td>Spanish</td>
<td>1.0%</td>
<td>17</td>
<td>Polish</td>
<td>0.6%</td>
</tr>
<tr>
<td>8</td>
<td>Panjabi</td>
<td>1.0%</td>
<td>18</td>
<td>Chinese</td>
<td>0.5%</td>
</tr>
<tr>
<td>9</td>
<td>Portuguese</td>
<td>0.9%</td>
<td>19</td>
<td>Hebrew</td>
<td>0.5%</td>
</tr>
<tr>
<td>10</td>
<td>Urdu</td>
<td>0.9%</td>
<td>20</td>
<td>Greek</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

\(^{23}\) Department for Education January 2011 School Census

The City

There is little data available on the languages spoken in City households. The only Schools Census data is from the Sir John Cass’s Foundation Primary School, the only maintained school in the City. Other than English, the following languages are spoken by pupils attending this school (not all of whom live in the City): Bengali (18%), Arabic (3%), Albanian (2%), Tagalog (2%) and several other languages at 1% prevalence or less.

Sexual identity

2011 update

The 2010/11 GP patient survey indicates that, in Hackney, there are comparatively high numbers of people who identify as gay or lesbian (4%) or bisexual (1%). These figures may under-represent the size of this population, given the problems involved in disclosure of sexuality.

Measuring the prevalence of different sexual identities within a population is fraught with difficulty, given the unwillingness of many people to disclose this information, especially if they are unconvinced that data about them will be treated confidentially. This is particularly a problem for gay men and lesbians, given the long history of discrimination against them, but heterosexual men and women may also feel that such questions about their private lives are inappropriate.

The ONS asked about sexual identity in the Integrated Household Survey\(^{25}\). The great majority of respondents identified as heterosexual with 1.0% identifying as lesbian or gay and 0.5% as bisexual (see Table 1.8). However other surveys have produced higher proportions of lesbian, gay and bisexual people. In 2006, the Treasury estimated that 6% of the population was lesbian or gay.

The only local data on sexual identity is from the GP Patient Survey\(^{26}\). This is a survey of patients registered at local GP practices and so excludes the population not registered with primary care. The most recent data is from the 2010/11 survey.

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\(^{26}\) Department of Health, 2011
In Hackney, 82% of respondents identified as heterosexual, 4% identified as gay or lesbian, 1% as bisexual and 2% as ‘Other’. However 10% answered that ‘they would prefer not to say’, so these rates are likely to be an underestimate. The GP patient survey is a national survey and the results for England as a whole tally with the ONS study.

### The City

There is no official data on the sexual identity of residents of the City.

#### Table 1.8 Population estimates of sexual identity (GP patient survey and ONS)

<table>
<thead>
<tr>
<th></th>
<th>Hackney</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All adults</td>
<td>All adults</td>
</tr>
<tr>
<td>Heterosexual/ straight</td>
<td>82%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Gay/ lesbian</td>
<td>4%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>1%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Don’t know/ refusal</td>
<td>10%</td>
<td>2.8%</td>
</tr>
<tr>
<td>No response</td>
<td>-</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

### Carers

#### 2011 update

In the last year, there has been an increase in the financial problems experienced by carers, in part because of the changes in welfare benefits.

Carers are people who look after a friend or relative who needs support because of a physical or learning disability, mental illness, addiction or impaired health due to sickness or old age. Carers save the economy approximately £87 billion per year.

The vision of the government’s Carers Strategy is that carers will be universally recognised and valued as being fundamental to strong families and stable communities. The four priority areas for the refresh of this strategy have been identified as:

- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages.
- Enabling those with caring responsibilities to fulfil their educational and employment potential.
- Personalised support both for carers and those they support, enabling them to have a family and community life.
- Supporting carers to remain mentally and physically well.

Carers fall broadly into three categories:

- Adult carers – an adult caring for an adult such as a spouse, partner, friend or relative. This group includes young adult carers who care for their parents.
- Parent carers – an adult who cares for an ill or disabled child.

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28 HM Government: Carers at the heart of 21st-century families and communities: A caring system on your side, a life of your own, 2008
29 HM Government: Recognised, valued and supported: Next steps for the Carers Strategy, 2010
Young carers – a child or young person who is carrying out significant caring tasks and assuming a level of responsibility for another person which would usually be taken on by an adult.

The 2001 Census recorded 15,347 carers in Hackney (7.6% of the population). This compares to an average for England of 10%. Although the population of carers in Hackney may be under-reported in the Census due to low response rates in the borough, we would expect the rate to be lower than the national rate, given the relatively young population in Hackney.

The Census question – “Do you look after, or give any help or support to family members, friends, neighbours or others because of: long term physical or mental ill health; or disability or problems relating to old age?” – is a wide definition of caring. However, a significant number of people with caring responsibilities do not readily identify themselves as carers. They understandably see themselves primarily as a parent, spouse, son, daughter, partner, friend or neighbour. The concept of caring is assumed but not recognised in some families in ethnic minority communities. Many carers do not identify themselves as such until they have been caring for a number of years. This is understandable when the caring role develops gradually, for example with the onset of dementia. And when a family member or friend is suddenly in need of support, such as after a stroke, it can be difficult to find the time and energy to think through what the future may hold in terms of a caring role.

In 2001, fifteen per cent of Hackney carers were in poor health and 4% were over 75 years old. The more time people spend every week caring, the more likely they are to be in poor health, across all age groups. Those providing care over a long period of time are at particular risk of poor health and both mental and physical health are likely to deteriorate the longer the carer has been caring. Analysis of the British Household Panel Survey has demonstrated that the health of carers is more likely to deteriorate over time than the health of non-carers and many of the detrimental changes can be attributed to the caring role. Spouse carers and mothers looking after a disabled child are most at risk of psychological distress and the period immediately after caring ends as a period where ill health is likely to increase.

City and Hackney Carer’s Centre identified the following as the most common problems affecting the health and wellbeing of their users:

- debt and poverty
- inadequate breaks from caring causing stress and distress
- inadequate community care
- housing/adaptations

In the last year, there have been increasing debt and money problems among clients, with some needing basic financial assistance for essential items. There has also been an increased need for advice in relation both to benefits, because of the current changes to benefits, and to personalised budgets.

Housing problems are dominated by the poor suitability of housing for the needs of disabled people. Transport problems have also increased in the past year. There has been a noticeable change in the number of carers with learning disabilities having to care for elderly parents. Many of these clients do not ask for support; those that do need much more time from the service and

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10 HM Government: Recognised, valued and supported: Next steps for the Carers Strategy, 2010
11 In Poor Health: the impact of caring on health, Carers UK, 2004.
Chapter 2: Society and environment

Our health and wellbeing are influenced by a wide variety of factors, many of which lie outside the direct influence of health and social services. These include economic and housing conditions, the quality of the local environment, crime levels and individual participation in society. This chapter explores some of these broad determinants of health.

It is important that all factors which affect health and wellbeing are taken into account when planning services, not least because of the links between social and economic inequality and health. We know from international evidence that the narrower the income inequality within a society, the more likely it is that everyone in that society will enjoy better health and wellbeing.

The quality of the local area

Community cohesion and neighbourhood attachment

2011 update

In Hackney, resident satisfaction with the local has increased since the 2008 Place Survey with four out of five people now saying they are satisfied. Neighbourhood attachment has also increased to 62%.

Focus on inequalities:

- Satisfaction with the local area is less common among men, young adults, the unemployed and council or housing association tenants.
- Only half of people with a limiting long-term illness are satisfied with their local area.

When people identify with the places they live, they are likely to be healthier. Evidence, particularly from the World Health Organisation, shows that people who suffer stress, fear of crime, repeat victimisation and

poverty experience long-term physical and psychological problems. By comparison, living in communities and neighbourhoods where there is strong social cohesion has positive effects\textsuperscript{34}. The Place Survey, conducted for the last time in 2008, sought to capture the views and perceptions of local people about the areas in which they live and their participation in civil society, including their sense of belonging to a neighbourhood and their involvement in volunteering. Key results for Hackney\textsuperscript{35} are summarised in Table 2.1. In 2008, the majority (72\%) of Hackney residents were satisfied with their local area. This was lower than the London average of 75\% but was a significant improvement on the 60\% satisfaction level recorded in 2006. The proportion of people who were actively dissatisfied with their local area also fell from 22\% in 2006 to 14\% in 2008. On all other indicators of satisfaction and participation in civil society in Table 2.1, Hackney scores higher than the London average.

Interim results from an e-panel survey conducted by London Borough of Hackney in 2011 indicate further improvements in the views of local people of the area they live in. Overall, 80\% of respondents said they were satisfied with their local area as a place to live with only 6\% actively dissatisfied. The following differences in satisfaction rates were found:

- More women were satisfied (85\%) than men (74\%)
- Younger adults were least likely to be satisfied (69\% in the 16-24 age group)
- More employed respondents were satisfied (85\%) than the unemployed (70\%)
- More owner occupiers were satisfied (85\%) than council or housing association tenants (72\%)
- A relatively low proportion of those living with a long-term illness were satisfied (53\%)

The survey also found that 62\% of respondents felt that they belonged to their immediate neighbourhood, up from 57\% in the 2008 Place Survey.

In a survey of knowledge and satisfaction with health services conducted in 2010, local people in Hackney and the City were asked about their involvement with community groups. Overall, nearly four in five (78\%) respondents said that they took part in at least one community group\textsuperscript{36}. This included 43\% who said they were involved in a sports or exercise group, 35\% of who were involved in a hobby or social club, 29\% involved with charitable organisations, 28\% involved with neighbourhood groups and 27\% involved with religious groups.

In 2010, Hackney Council undertook a detailed review of community cohesion, drawing on the Place Survey but also other local data. This review concluded that, on the whole, residents feel Hackney is cohesive; somewhere where they feel they belong, and where people from different backgrounds get on well\textsuperscript{37}. The review reported many reasons for this. Neighbourhoods in Hackney are very diverse, giving people the opportunity to meet and mix with people from different ethnic or religious backgrounds on a daily basis. Many people have personal or family experience of migration, and are generally positive about new arrivals. Residents struggling to make ends meet and improve their living conditions see that their neighbours face similar challenges, whatever their background.

Although Hackney is a cohesive place, the review did find that there are strains on community life. Meeting these challenges will help communities in Hackney become more cohesive and resilient:

- Younger and older residents don’t always see eye-to-eye, and this can lead to mistrust and isolation
- Some people face a range of issues which make it difficult for them to get involved in community life. Poverty, limited English language skills, mental health problems, physical barriers and discrimination or prejudice are some of the things which limit people’s opportunities
- Some parts of the community - such as refugees and migrants, Gypsies and Travellers, disabled adults and families with disabled children – can face many barriers at once.

\textsuperscript{34} The concept of ‘community cohesion’ entered public policy following the riots in the north of England in 2001. For an account of the ensuing reports and debate, see www.cohesioninstitute.org.uk.
\textsuperscript{36} Ipsos MORI: Residents’ views of health services 2010, NHS City and Hackney, 2010
Hackney can be a busy, noisy, and sometimes difficult place to live: tackling noise, crime and anti-social behaviour is an important element of cohesion. Many people told us that moving around safely and comfortably in Hackney and making full use of public spaces can be difficult or stressful. This is particularly true for young people affected by ‘postcode’ rivalry, but also for others, including the disabled and lesbian and gay residents we consulted during the review. People want welcoming places and events where they can get together.

Although residents generally get on well with people from different backgrounds, many people wanted more chances for people to get to know their neighbours and make friends with people from different backgrounds.

There are sometimes difficult decisions to be made about how local services and priorities can serve all communities whilst making sure specific needs are addressed. Women-only swimming sessions are a classic example of how local services work to meet the needs of all communities.

The City

In 2008, the Place survey found that 92% City residents were satisfied with their local area with almost half saying they were ‘very satisfied’ (Table 2.1).

A comparable survey conducted for the City in 2009 found that 95% of residents were satisfied with the City of London as a place to live including 67% who were very satisfied. This survey also found that 88% of City workers were satisfied with the City as a place to work.

The City scores well on all the indicators of satisfaction and participation in civil society, shown in Table 2.1. City residents see traffic congestion and pollution as in need of improvement, followed by road and pavement repairs, affordable decent housing, parks and open spaces and shopping facilities.

<table>
<thead>
<tr>
<th>Table 2.1. National indicators of strength of civic society and satisfaction with local area, 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hackney</td>
</tr>
<tr>
<td>People who believe people from different backgrounds get on well together</td>
</tr>
<tr>
<td>People who feel that they belong to their neighbourhood</td>
</tr>
<tr>
<td>Civic participation in the local area</td>
</tr>
<tr>
<td>People who feel they can influence decisions</td>
</tr>
<tr>
<td>Overall satisfaction with local area</td>
</tr>
<tr>
<td>Participation in regular volunteering</td>
</tr>
<tr>
<td>Environment for a thriving third sector</td>
</tr>
</tbody>
</table>

Transport

2011 update

Hackney is now better connected to the Underground via the Overground network. However, most trips taken by Hackney residents are likely to be on foot or by bus.

The City of London is a public transport hub serving tens of thousands of people every day. However most of the trips taken by residents of the City are on foot.

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Focus on inequalities

- Lower income groups take fewer trips and tend to use the bus more.
- Men are more likely to use cars and to cycle; women are more likely to use the bus or to walk.
- White British people have a high rate of car use, people of Black ethnicity use buses more and Bangladeshis have the highest rate of trips on foot.

Hackney is a relatively easy place to get around. The borough is well served by bus routes and is now better connected to the Underground via the expanded Overground network. Local parks and green spaces help to make routes for pedestrians and cyclists safer and more attractive. When it opens, the Olympic Park will improve pedestrian and cycle connections to the east.

The residents of Hackney take an average of 2 trips per day. The most common mode of transport is walking – 37% of all trips are on foot (Table 2.2). Buses are the second most common mode of transport. Although cars are used far more often than cycles, the rate of car use is relatively low in Hackney and the rate of cycle use is relatively high – one in twenty trips is by cycle compared to a London average of one in fifty.

Hackney’s inner London location means that in general access to public transport is good. However there are significant variations across the borough. Figure 2.1 illustrates these variations by mapping ‘public transport accessibility levels’. These reflect:

- Walking time from each location to public transport access points;
- The reliability of the transport modes available;
- The number of services available within the catchment; and
- The level of service at the public transport access points (i.e. average waiting time)

The areas of poor accessibility are mainly around green spaces like Hackney Downs, Hackney Marshes, London Fields, Clissold Park and Springfield Park, and neighbouring residential areas. Feedback from Elect Care Services also makes clear the significance of this issue for people isolated at home (see box).

There are some predictable variations in how transport is used within the population. In London as a whole, the number of trips taken increases with household income. The modes used also change as income increases, with lower income groups making more bus trips, and higher income groups making more car, rail and Underground trips.

Although the number of trips taken by men and women is similar, car and cycle trip rates are much higher among men, while women tend to use the bus and walk more. There are few clear differences between ethnic groups though White British people have a high rate of car use, Black people use buses more and Bangladeshis have the highest rate of trips on foot.

The City

The City of London is situated at the heart of London’s extensive public transport system. Seven of the 11 underground lines in London, and the DLR, serve the City via 13 underground stations. There are seven mainline rail stations, four of which are major rail termini. Fifty-two bus routes use the City’s streets as part of their itinerary and 19 of these terminate within the City’s boundaries. There are also various commuter coach services and river boat services which operate from piers at Blackfriars, London Bridge and Tower Hill.

The City of London has a public transportation accessibility level rating of 6b (the highest level, see Figure 2.1), indicating excellent accessibility. However, because most of the numerous visitors, students, workers and

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residents travel to and from the City by public transport, these services can be overcrowded and congested during weekdays.

Currently the City of London provides public cycle parking facilities for 6,761 cycles. There are an estimated 4,663 spaces within buildings in the City. This total provision of 11,424 spaces is 31% of the estimated demand of 37,000 spaces42.

Pedestrian flows are high at certain times during the week. With an estimated 360,000 workers, 16,000 students and about 8,000 residents walking in the City, pedestrian facilities can be inadequate at peak times. Additionally, local residents report that cyclists riding on pavements are a concern for pedestrians. The City of London is working to improve this, by facilitating the conversion of narrow lanes into footpaths and creating pedestrian zones which prohibit or restrict the entry of vehicles.

The residents of the City take an average of 3.4 trips per day of which the majority (56%) are on foot. However cycle use is very low (Table 2.2). Those who use public transport tend to use the Underground. However these TfL data have limited accuracy as City data is based on a small survey sample.

Table 2.2. Residents’ trips by mode of transport 2007/08 - 2009/10 (TfL)

<table>
<thead>
<tr>
<th></th>
<th>Walk</th>
<th>Cycle</th>
<th>Bus</th>
<th>Underground</th>
<th>Rail</th>
<th>Motor car/cycle</th>
<th>Taxi/other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hackney</td>
<td>2.0</td>
<td>37%</td>
<td>5%</td>
<td>30%</td>
<td>6%</td>
<td>3%</td>
<td>17%</td>
</tr>
<tr>
<td>City of London</td>
<td>3.4</td>
<td>56%</td>
<td>0%</td>
<td>5%</td>
<td>17%</td>
<td>5%</td>
<td>16%</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>2.3</td>
<td>42%</td>
<td>2%</td>
<td>17%</td>
<td>14%</td>
<td>2%</td>
<td>21%</td>
</tr>
<tr>
<td>Newham</td>
<td>2.4</td>
<td>39%</td>
<td>1%</td>
<td>15%</td>
<td>12%</td>
<td>2%</td>
<td>30%</td>
</tr>
<tr>
<td>London</td>
<td>2.5</td>
<td>31%</td>
<td>2%</td>
<td>15%</td>
<td>7%</td>
<td>4%</td>
<td>39%</td>
</tr>
</tbody>
</table>

Figure 2.1 Public transport accessibility levels in Hackney and the City (TfL/ ELC Health Intelligence)

42 City of London Planning and Transportation Committee: Cycle Parking Strategy.
Green spaces

2011 update

Two parks were awarded Green Flag status for the first time in Hackney in 2011, taking the total number of Hackney parks bearing this award to 13.

Focus on inequalities

- There is little or no evidence of inequalities in the use of parks and green spaces in Hackney and the City, though specific barriers to use such as concerns about safety are more prevalent in older age groups.

Hackney has exceptionally good provision of green open space for an inner city borough: 17% of the land is green open space compared to only 4% in Waltham Forest and 5% in Haringey. The average open space provision is 2.14 hectares per 1,000 population. There are 467 hectares of open space within Hackney, of which the Council manages 329 hectares, spread across 62 different sites. Table 2.3 identifies the range of types of open space in the borough.

The Green Flag scheme is the benchmark national standard for parks and green spaces in England and Wales. It is managed by Keep Britain Tidy, GreenSpace and BTCV. It was first launched in 1996 to recognise and reward the best green spaces in the country. A site must fulfil several criteria to gain a Green Flag award, namely that spaces should be welcoming, healthy, safe and secure, clean and well-maintained. Attention has to be paid to sustainability, conservation and heritage, site marketing and management and community involvement.

In 2011 two new parks in Hackney achieved the Green Flag award: Butterfield Green and Hackney Marshes. This took the total number of sites in Hackney awarded Green Flag status to 13. The following is the full list of parks in Hackney with Green Flag status:

- Butterfield Green, N16
- Cassland Road Gardens, E9
- Clapton Pond, E5
- Clapton Square, E5
- Clissold Park, N16
- De Beauvoir Square, N1
- Hackney Downs, E5
- Well Street Common, E9
- Hackney Marshes, E9
- Haggerston Park, E2
- London Fields, E8
- Shoreditch Park, N1
- Springfield Park, E5

Parks are very important to local people in Hackney and are used regularly, possibly in part because so many people live in flats with no access to private green space. Parks and open spaces are used by 57% of residents at least once a week and four in five residents use parks for physical activity. The extensive provision of parks and green spaces is especially important in a borough with such a high population density.

Research into the use of parks and green spaces in Hackney and the City found that levels of satisfaction with the quality of green spaces are high across all age groups. The study found no evidence of differences in the use of parks between different groups within the population. However a range of barriers to using parks was identified including personal circumstances – health, time, childcare, desire to exercise – and park conditions,

44 London Borough of Hackney: Sustainable borough, 2009
including irresponsible dog owners and perceived safety. Safety concerns were more prevalent among those of pension age.

Twenty four of the open spaces within Hackney are Sites of Metropolitan, Borough or Local Importance for Nature Conservation due to their importance for wildlife. A draft Biodiversity Action Plan for Hackney was produced in 2011, and is due to be adopted in 2012.

**The City**

Open spaces in the City of London are an important resource for residents, workers and visitors. A survey of the large daytime population found that 86% use the City’s public gardens regularly, with 50% visiting at least once per week. Almost all users (96%) rate these spaces as good or very good.46

Since 2007, there has been a small increase in the total amount of open space in the City, to 32.47 hectares (324,700 square metres)47. Unfortunately part of the City’s largest open space, Finsbury Circus, is temporarily closed due to the Crossrail project, but will be returned to open space upon completion in 2017.

Given the constraints on land in the City, the City of London Corporation focuses on improving the quality of the limited open space available48. However the City’s Open Space Strategy also seeks to identify opportunities to increase provision of green space where possible.

Eleven of the open spaces within the Square Mile are Sites of Metropolitan, Borough or Local Importance for Nature Conservation due to their importance for wildlife49. The Open Spaces Department works with residents, local schools and volunteers to maintain these important sustainable assets, as well as delivering a range of opportunities for education and healthy lifestyles.

In 2011, the City’s gardens won Gold and category winner in the London in Bloom competition, as well as gold awards in a number of individual disciplines. Bunhill Fields won both a Green Flag Award and a Green Heritage Award, and received Grade One status on the national Register of Parks and Gardens50.

**Table 2.3. Types and area of open space in Hackney**

<table>
<thead>
<tr>
<th>Type of open space</th>
<th>Number in Hackney</th>
<th>hectares</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Parks</td>
<td>13</td>
<td>182.7</td>
</tr>
<tr>
<td>District Parks</td>
<td>4</td>
<td>59.7</td>
</tr>
<tr>
<td>Neighbourhood Parks/Local Parks</td>
<td>4</td>
<td>21.5</td>
</tr>
<tr>
<td>Small Local Park/Open Spaces</td>
<td>19</td>
<td>21.1</td>
</tr>
<tr>
<td>Linear Open Spaces /Green Corridor (including waterways)</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Allotments/ Community Garden/ Urban Farms</td>
<td>8</td>
<td>0.5</td>
</tr>
<tr>
<td>Cemeteries and Churchyards</td>
<td>17</td>
<td>20.6</td>
</tr>
<tr>
<td>Civic Spaces/ Pedestrianised Areas</td>
<td>4</td>
<td>0.4</td>
</tr>
<tr>
<td>Green Spaces within grounds of institutions</td>
<td>5</td>
<td>2.2</td>
</tr>
<tr>
<td>Natural or semi-natural urban greenspaces</td>
<td>14</td>
<td>32.1</td>
</tr>
<tr>
<td>Outdoor sports facilities/ playing fields</td>
<td>17</td>
<td>8.33</td>
</tr>
<tr>
<td>Provision for children/teenagers</td>
<td>9</td>
<td>15.4</td>
</tr>
<tr>
<td>Amenity green space</td>
<td>138</td>
<td>86</td>
</tr>
<tr>
<td><strong>Total open spaces</strong></td>
<td><strong>255</strong></td>
<td><strong>467</strong></td>
</tr>
</tbody>
</table>

46 City Gardens Visitor Survey 2009
47 City of London Open Space Audit 2007 (March 2011 Update), 2011
49 City of London Sustainability Review 2009/10
50 English Heritage Register of Parks and Gardens of Special Historic Interest, 2011
Cultural services

2011 update

In 2010/11 use of Hackney libraries increased by 14% compared to the previous year.

Focus on inequalities

- There is no evidence of significant inequalities in access to libraries in Hackney. The ethnic profile of library users matches that of the local population.
- The profile of museum users is also comparable to the population profile except for lower use by people of Black African and some Asian ethnicities.

Libraries, museums, theatres and art galleries deliver many benefits for local communities, promoting education and learning, creativity and personal development, and greater identification and belonging for residents with their locality. They also offer an opportunity to communicate with users about health and wellbeing through embedded programmes and marketing and media opportunities.

Research into personalised budgets in adult social care has highlighted the likely increase in demand for cultural and leisure services from people receiving personal budgets. Such mainstream services are likely to play an important role in helping people socialise, meet new people, go out and engage in specific activities like art and music\footnote{Wood C: Personal Best, DEMOS, 2010}.

Libraries

There are eight council-run libraries in Hackney. In 2010/11, 37% of residents report having used a library service during the previous month, in line with the London average. In 2010/11 there were 1.6 million visits to libraries in Hackney, an increase of 14% on 2009/10\footnote{London Borough of Hackney performance data}.

Table 2.4 describes the ethnicity of active library users in Hackney. The sheer diversity of this ethnic profile suggests that the libraries are being used by all communities in Hackney. If the ethnic categories in Table 2.4 are collapsed to those used by in the GLA population projections, the ethnic profile of library users can be compared to that of the local population. Figure 2.2 reveals that this profile is remarkably similar to the population profile, though this comparison does not capture potential inequalities in communities not well represented by this summary classification.

Library users are, however, more likely to be women than men: 58% of users are women and 42% are men.

Figure 2.3 illustrates the age profile of Hackney library users against the age profile of the population. Libraries appear to be disproportionately used by young people (under 20 years) in Hackney. The profile across the other age groups follows the pattern for the population but is reduced because of the large number of young users.

The City

The City of London has five major libraries at the Barbican, the Guildhall, Shoe Lane, City Business Library and a mobile library temporarily replacing the site at Camomile Street which will be relocating to a new multi-use centre in White Kennet Street in 2012. Several of these libraries are designated as being of regional or national importance. For example, City Business Library provides its users with access to a wide range of financial and business data and runs a full programme of events to support business start-ups and sole traders; the Guildhall Library specialises in the history of London and the City, and holds significant collections including those of many Livery Companies, the Stock Exchange and Lloyd’s of London; and the Barbican Library houses a specialist music library which is a regional centre of excellence.
The libraries in the City also provide for local communities including community language collections, a toy library and an extensive programme of work with local schools, nurseries and children. The great majority of City residents (84%) use public libraries and 60% use local art galleries and museums. The Barbican and Guildhall libraries attribute 11% and 16% of their visitors to residents respectively.

Table 2.4 Ethnicity of active library users in Hackney (excludes users with unknown ethnicity)

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>number</th>
<th>%</th>
<th>Ethnic group</th>
<th>number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>10178</td>
<td>35%</td>
<td>Indian</td>
<td>796</td>
<td>3%</td>
</tr>
<tr>
<td>White Irish</td>
<td>646</td>
<td>2%</td>
<td>Pakistani</td>
<td>214</td>
<td>1%</td>
</tr>
<tr>
<td>White Jewish</td>
<td>1017</td>
<td>4%</td>
<td>Bangladeshi</td>
<td>494</td>
<td>2%</td>
</tr>
<tr>
<td>White Turkish</td>
<td>1009</td>
<td>4%</td>
<td>Chinese</td>
<td>326</td>
<td>1%</td>
</tr>
<tr>
<td>White Eastern European</td>
<td>565</td>
<td>2%</td>
<td>Vietnamese</td>
<td>151</td>
<td>1%</td>
</tr>
<tr>
<td>White Other</td>
<td>2707</td>
<td>9%</td>
<td>Kurdish</td>
<td>109</td>
<td>0%</td>
</tr>
<tr>
<td>Black British</td>
<td>1780</td>
<td>6%</td>
<td>Asian Other</td>
<td>587</td>
<td>2%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1806</td>
<td>6%</td>
<td>Mixed - White/Black Caribbean</td>
<td>295</td>
<td>1%</td>
</tr>
<tr>
<td>Black African</td>
<td>3577</td>
<td>12%</td>
<td>Mixed - White/Black African</td>
<td>246</td>
<td>1%</td>
</tr>
<tr>
<td>Black Other</td>
<td>197</td>
<td>1%</td>
<td>Mixed - White/Asian</td>
<td>166</td>
<td>1%</td>
</tr>
<tr>
<td>Asian British</td>
<td>133</td>
<td>0%</td>
<td>Mixed Other</td>
<td>271</td>
<td>1%</td>
</tr>
</tbody>
</table>

Figure 2.2 Ethnic profile of Hackney library users compared to population profile (GLA projection)
Museums and theatres

Museums in Hackney include:

- Hackney Museum, which collects, preserves and interprets the history of Hackney and the local and international roots of its people, and has a strong emphasis on community engagement;
- Geffrye Museum, which specialises in the history of the development of the English domestic interior;
- Sutton House, an Elizabethan house which is the oldest domestic residence in London’s East End;
- the Building Exploratory which helps people discover the secrets of their local area and gain a better understanding of the buildings and spaces that surround them;
- St Augustine’s Tower stands alone as the only medieval structure in the borough.

These organisations, together with Hackney Historic Buildings Trust, Hackney Historic Society and Hackney Archives, form Discover Hackney, the Hackney Heritage and Built Environment Cluster, which runs programmes with significant wellbeing and social cohesion outcomes.

In 2010/11 there were 36,000 visits to Hackney Museum. Figure 2.4 compares the age profile of visitors to Hackney Museum to that of Hackney’s population (under 16s are not recorded but visitor numbers in this age group are high as all state school pupils visit). There is no evidence of any inequalities in access to Hackney Museum across age groups. The ethnic profile of visitors is comparable to that of the population except for under-representation of Black Africans, Indians and other Asians. One in nine visitors has a physical, sensory or learning disability.

Visitor satisfaction with Hackney Museum is universal (99.3%) and the museum enjoys an international reputation for excellence in community engagement. The former Museum Libraries and Archives Council, now part of the Arts Council, advocates the use the measurement tools of Generic Learning Outcomes and Generic Social Outcomes which enable museums and libraries to measure the impacts programmes have on users’ social wellbeing. These help to record and quantify the harder to measure elements of cultural engagement and the positive impact it has on not only educational attainment but on self confidence, social skills and community cohesion.

A large number of independent arts and cultural organisations make their home in Hackney, with many keen to contribute to improving the quality of life of residents. Hackney Empire, Arcola Theatre and Immediate Theatre run programmes which contribute to the wellbeing agenda, including the Empire’s Community Choir with members aged from 9 to 90 years, Arcola’s 50+ theatre group and Immediate’s intergenerational work.

54 Lynch BT & Bienkowski. P: Museums and Community Engagement - Best Practice, Paul Hamlyn Foundation (in press)
with harder to reach groups on the Borough’s housing estates. Hackney is also home to Graeae, the leading national theatre company for deaf and disabled artists.

Hackney Picture House runs a range of community tailored events including autism friendly screenings and mother and baby screenings. The Rio Cinema undertakes a large number of programmes with older people. The Discover Young Hackney youth arts festival trains young people as accessibility ambassadors both for the festival itself and for other cultural venues in the borough.

**The City**

Museums in the City include the Museum of London, the Clockmakers’ Museum, the Bank of England Museum and Dr Johnson’s House. Galleries include the Guildhall Art Gallery and the two art galleries at the Barbican centre. The Barbican also houses a concert hall, two theatres and three cinemas, and presents a variety of world class calibre performing and visual arts.

Every year the City of London spends over £80m on its culture and leisure services, including everything from libraries, open spaces, and street scene to arts institutions, festivals, museums, galleries, ensembles and the Guildhall School, one of the UK’s leading conservatoires. City arts festivals and institutions regularly attract over 10 million visitors annually.55

Satisfaction is very high for libraries (93%), museums/galleries (87%), and theatres/concert halls (85% satisfied) in the City.56 In 2011, 94% of service users agreed that the City’s libraries, archives, and Guildhall Art Gallery offered appropriate and accessible learning opportunities both for citizens, and community groups, whilst 99% of parents, carers, and teachers agreed that the City’s libraries, archives, and Guildhall Art Gallery services and activities contributed to the enjoyment and achievement of children and young people through increased participation in a broad range of high-quality activities.

**Figure 2.4 Age profile of Hackney Museum visitors compared to population profile (GLA projection)**

Air quality

**2011 update**

Concentrations of nitrogen dioxide remain above their target maximum levels in both Hackney and the City. This is a significant problem, given the high rates of illness and hospital admissions due to respiratory problems in the area.

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55 City of London Cultural Strategy 2010-2014

56 Public Library Users Survey (PLUS) 2010
Air pollution can have serious consequences for both human health and the environment. Exhaust fumes from vehicles are the primary source of air-borne chemicals and particles affecting people living in London. Indoors the biggest source of air pollution is tobacco smoke.

There is growing evidence that high levels of air pollution can cause damage to the airways and lungs, cause heart attacks, and lead to premature death for people who are already ill. Long term exposure to air pollution (over many years) can also increase the risk of cancer. Air pollution can trigger asthma attacks for those who already suffer from the illness.

Hackney Council’s air pollution monitoring programme is focused on the pollutants nitrogen dioxide (NO2), fine particles (PM10 and PM2.5) and ozone. Previous monitoring has indicated that levels of sulphur dioxide, polycyclic aromatic hydrocarbons (PAH), carbon monoxide and benzene easily meet current National Air Quality Objectives and so no further monitoring of these pollutants was carried out during 2010.

In 2010 the main problem identified through local monitoring in Hackney is elevated levels of nitrogen dioxide. Most nitrogen dioxide is produced as a result of the high temperature combustion of fuels in, for example, cars, HGVs and other road vehicles. Nitrogen dioxide is a reddish brown non-inflammable gas with a detectable smell. Elevated levels of nitrogen dioxide gas in the atmosphere is an irritant, causes inflammation of the airways and enhances the response to allergens in sensitive individuals, for example those with asthma. Long term exposure may affect lung function and may lower an individual’s resistance to respiratory infections.

The annual mean concentration target level (40 μg/m³) was exceeded at both of the continuous monitoring sites in Hackney (62 μg/m³ at Old Street and 49 μg/m³ at Kenninghall Road) and the majority of the sites where diffusion tubes are used to record overall mean concentrations only:

- Millfields Road (56 μg/m³)
- Cardinal Poole School (41 μg/m³)
- St Dominic’s School (44 μg/m³)
- Gainsborough School (45 μg/m³)
- Victoria Park (42 μg/m³)
- Great Eastern Street (82 μg/m³)
- Shoreditch (77 μg/m³)
- Green Lanes (96 μg/m³).

The target level for any one hour period (200 μg/m³) was not exceeded at either continuous monitoring site.

Recent modelling of air quality in Hackney concluded that:

- The air quality standard of 40 μg/m³ for the annual average NO2 concentrations is predicted to be exceeded around major roads in Hackney for both 2011 and 2015.
- The air quality standard of 200 μg/m³ for the hourly average NO2 concentrations is predicted to be exceeded around the busiest roads and junctions in the borough for both 2011 and 2015.
- Neither the air quality standard of 40 μg/m³ for the annual average PM10 concentrations nor the air quality standard of 50 μg/m³ for the 24 hour average PM10 concentrations will be exceeded in 2011 or 2015.

**The City**

Nitrogen dioxide is also a problem in the City. In 2010, the annual average air quality objective for nitrogen dioxide was exceeded at nine of the ten monitoring locations. All air quality targets were met for sulphur dioxide but the air quality standard for ozone was breached on seven days. Levels of fine particulate matter (PM10) met the annual average objective. However the daily target was exceeded on 52 days along Upper Thames Street, 10 days at Sir John Cass’s Foundation Primary School and 29 days at Beech Street.

Air quality has long been a concern in the City due its role as a centre of commerce. In 1954 the City of London was the first local authority to introduce a smokeless zone, which preceded the Clean Air Act 1956, and it was

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the first authority to obtain powers to stop the burning of sulphurous fuel in 1971. In 2011, the City of London published a new air quality strategy outlining the steps that will be taken to improve air quality in the Square Mile. These include taking steps to reduce emissions from its buildings and fleet, and these have changed the way it deals with procurement to influence the amount of pollution being emitted in the Square Mile. The City of London has also been working with businesses to encourage them to do the same via the CityAir project. From January 2012, Fixed Penalty Notices will be issued to drivers of vehicles who refuse to turn their vehicle engines off when parked, in a bid to reduce emissions from idling vehicle engines. The City of London will also be looking at how it might be able to use parking policy to influence the type of vehicles that come into the Square Mile. The City of London runs two annual award schemes to encourage best practice in reducing air pollution. These are the Sustainable City Award for Air Quality and the Considerate Contractor’s Environment Award.

### Promoting health and wellbeing through spatial planning

The following framework for promoting health and wellbeing through effective planning and place-making was developed to inform the assessment of the development of the Olympic Site.

#### Housing quality and design

*Does the proposal encourage and promote housing quality? Consider:*

- Using design codes such as those advocated by CABE (now the Design Council) to ensure consistent design quality;
- Applying the principles of Lifetime Homes to ensure long-term adaptability for older and disabled people;
- Incorporating generous internal space standards including sufficient storage space and separate kitchen and living spaces;
- Employing modular housing design to allow for future changes in housing demand.

#### Access to public services

*Does the proposal encourage and promote access to good public services? Consider:*

- The provision of all forms of social infrastructure, including education, health and community facilities. Opportunities for the co-location of services should be explored;
- The medium- and long-term requirements of healthcare infrastructure, including floor space, accessible locations, the need for temporary facilities, and funding and delivery options. New health facilities should address the impact of the development proposal, the needs of the wider area, and the cumulative impact of development on the wider area.

#### Active design and access to open spaces

*Does the proposal enable people to be physically active in their immediate surroundings? Consider:*

- Ensuring that stairwells are attractive and welcoming;
- The provision of a range of different types of open spaces including informal and formal public spaces, play areas, and sports and games areas;
- Maximising the value of open spaces for all members of the community through the sensitive integration of different functions such as relaxation, games and play;
- The integration of open spaces with an attractive and welcoming streetscene.

#### Accessibility and active travel

*Is the proposal accessible and connected to the surrounding area by walking and cycling routes? Consider:*

- Ensuring that all dwellings are within walking distance of shops, key public services and public transport;
- Prioritising pedestrian and cycle routes over other modes of transport within the design of the public realm;
- The effective integration of the development with wider cycle and walking networks and the Green Grid;
- The use of traffic management and calming to minimise risks and obstacles to pedestrians, runners and cyclists;
- Incorporation of cycle parking in the public realm and cycle storage in dwellings.

#### Air quality, noise and neighbourhood amenity

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59 City of London Air Quality Strategy 2011-2015
60 Healthy Urban Planning in Practice for the Olympic Legacy Masterplan Framework, Report by the Supporting Healthier Lifestyles Strategic Regeneration Framework Steering Group, September 2011
Does the proposal manage and promote good air quality, protect occupiers from excessive noise and disturbance and provide an attractive environment for living and working? Consider:

- Designing settlements to minimise exposure of occupants to air, noise and light pollution;
- Reducing the impacts of motor vehicle traffic on residential areas through reduced car parking and effective traffic management, especially of larger vehicles;
- Incorporating trees to buffer noise and absorb pollution;
- Minimising adverse impacts on existing dwellings during construction.

Crime reduction and community safety

Does the proposal promote community safety and address the fear of crime? Consider:

- Ensuring natural surveillance and appropriate lighting of the entire public realm;
- Designing attractive, multi-use open spaces where people will mix and build trust;
- Employing the principles of ‘Secured by Design’, ‘Designing out Crime’ and ‘Safer Places’; but avoiding solutions which restrict access to open space and inhibit community interaction.

Access to healthy food

Does the proposal encourage and promote easy access to healthy and affordable food? Consider:

- Encouraging the provision of shops selling fresh food, including social enterprises;
- Restricting numbers of new A5 takeaway outlets;
- Allocating space for community gardens, allotments and micro-allotments;
- Generous provision of private gardens;
- Incorporating green roofs;
- Incorporating fruit trees within the design of the public realm.

Access to work

Does the proposal encourage and promote access to local employment opportunities? Consider:

- Maximising opportunities for local employment and training;
- Incorporating adequate provision of childcare facilities;
- Ensuring accessible routes to public transport for people with physical and sensory disabilities.

Social cohesion and social capital

Does the proposal encourage and promote social cohesion and social capital? Consider:

- Applying the principles of Lifetime Neighbourhoods;
- Incorporating appropriate provision of community facilities to enable communities to meet, interact and work together;
- Designing the public realm to maximise opportunities for social interaction, with clear social foci where people can meet informally, and minimise barriers created by transport routes;
- Including a range of housing types and sizes to provide for the diversity of local housing needs.

Climate change

Does the proposal seek to both mitigate and adapt to climate change? Consider:

- Designing houses with minimum energy loads including passive cooling strategies in the summer, taking account of the likely increase in summer temperatures of the lifetime of the development;
- Using water-efficient design principles to reduce water demand, including rainwater use where appropriate;
- Creating a public realm in which walking and cycling are safe, attractive and unobstructed;
- Reducing waste by ensuring that facilities for recycling and composting are integrated into dwelling and settlement design, and by employing waste minimisation strategies during construction.
- Reducing flood risk through effective management of surface water and the use of permeable surfaces;
- Reducing overheating risk at a development level by incorporating extensive vegetation in both the public and private realm and minimising the number of hard surfaces exposed to solar radiation.

Noise pollution

Noise can cause annoyance and fatigue, interfere with communication and sleep, reduce productivity and damage hearing. The World Health Organisation recommends a guideline average level of 30 dB for
undisturbed sleep, and a daytime level for outdoor sound levels of 50dB to prevent people from becoming ‘moderately annoyed’.  

Physiological effects of exposure to noise include constriction of blood vessels, tightening of muscles, increased heart rate and blood pressure and changes in stomach and abdomen movement. The effects of exposure to noise vary as hearing sensitivity varies. Exposure to constant or very loud noise, either occupational or leisure, can cause temporary or permanent damage to hearing.  

Local authorities have a duty to manage neighbourhood noise and nuisance under the Environmental Protection Act 1990.

In Hackney there were large increases in the number of noise and rowdy nuisance neighbour complaints made to police and other agencies in 2010/11 (noise up 126% and rowdy neighbours up 54%). Together they are responsible for 17% of all reported disorder. If Hackney Council noise figures are added this rises to 40%, with noise alone responsible for 35%.

The City

The City of London received 706 complaints about noise in 2010/11. These came from a range of sources, but were predominantly from construction sites, street works and entertainment venues.

The City is currently working on a Noise Strategy, which will aim to reduce the adverse impacts of noise on health, quality of life and business activity, and contribute to the health and quality of life of workers, residents and visitors. The strategy will cover environmental noise (e.g. transport), neighbourhood noise (construction sites/street works, licensed premises and events) and neighbour noise (domestic). A draft of the strategy is expected in early 2012.

Climate change

2011 update

Between 2008 and 2009 carbon emissions fell significantly in both Hackney and the City. Hackney now has the joint lowest per capita emissions in Britain.

Climate change is the greatest global challenge we face. Over-dependence on fossil fuels such as oil, coal and gas, and the widespread destruction and pollution of rainforest habitats has substantially increased emissions of greenhouse gases. Climate change poses a serious threat to health and wellbeing and the future security of resources and will result in a major ecological and humanitarian crisis if greenhouse gas emissions continue unchecked. Without urgent action climate change will inevitably have the greatest impact on people living in poverty, both in the UK and globally.

In Hackney, the biggest source of carbon dioxide emissions is homes (46%) with commercial buildings producing a third (32%) and road transport a fifth (21%). The overall level of carbon emission fell by 8.7% between 2008 and 2009 from 905,800 to 827,000 tonnes of CO2 (Figure 2.5). In 2009 per capita CO2 emissions in Hackney were 3.8 tonnes per person, the lowest rate in Britain (with Lewisham and Harrow). The average for the London is 5.4 tonnes.

The health benefits of tackling climate change are summarised below. In the current economic climate it is worthwhile highlighting the links between tackling climate change, promoting health and saving money. The table includes some of the key measures that will be needed to protect the population from the impacts of climate change. In London, these are likely to be dominated by winter flooding, summer heatwaves and drought, affecting health, biodiversity, the built environment, transport infrastructure, business and tourism.

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61 WHO Guidelines for Community Noise, 2000
62 WHO, Burden of disease from environmental noise, 2011
64 UK Climate Impacts Programme 2009 projections (www.ukcip.org.uk)
The City

In the City, carbon emissions overwhelmingly come from commercial buildings (Figure 2.6). The overall level of carbon emission fell by 12.5% between 2008 and 2009 from 1,674,200 to 1,465,600 tonnes CO₂.

Per capita CO₂ emissions are not relevant in the City due to the small resident population.

Figure 2.5 Sources of carbon dioxide emissions in Hackney, 2005-2009 (AEA)

Figure 2.6 Sources of carbon dioxide emissions in the City, 2005-2009 (AEA)

The health benefits of tackling climate change

More active travel

Reducing the use of cars, and shifting to more walking and cycling will:

- Lower carbon emissions
- Increase physical activity – which will help lower blood pressure and reduce obesity, heart disease, strokes, diabetes, osteoporosis (and associated injuries such as fractures) and cancer
- Reduce traffic-related injuries and deaths
- Result in less air pollution which can lead to less respiratory disease, such as asthma and chronic obstructive pulmonary disease

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65 Faculty of Public Health, 2008
- Reduce noise which will help protect from hearing loss and reduce stress
- Reduce depression and improve social cohesion

**Healthier, sustainable eating**
Eating less processed food will reduce intake of saturated fats, added sugar and salt, lowering the risk of obesity, heart disease, stroke, diabetes, and colon and breast cancers:

Eat more locally produced, fresh, seasonal food. It has been estimated that the environmental, social and economic costs of ‘food miles’ – including greenhouse gas emissions, air pollution, congestion and accidents – is over £9 billion. The UK is increasingly dependent on imported food. Our self-sufficiency has fallen by nearly 30 per cent since 1990, and by seven per cent since 2002.

Reducing consumption of animal products (meat and dairy foods), and eating more vegetables instead, will reduce CO₂ and methane emissions. Livestock farming is one of the biggest producers of methane due to the digestive processes of the animals. Reducing meat consumption would reduce emissions as there would be less farmed livestock. The World Health Organization suggests that industrialised countries need to reduce their meat consumption from the current 224g/person/day to 90g/ person/day which would have a positive effect on both carbon levels and health.

**Improved urban design**
Increasing green space in urban environments:
- Provides shade during heat waves
- Aids flood absorption
- Improves air quality and reduces CO₂
- Improves mental wellbeing
- Provides space for more physical activity, thus reducing obesity
- Reduces inequalities in health

Improving the built environment:
- Improves public transport infrastructure, pavements and paths, reducing the need to use the car and therefore reducing CO₂ emissions
- Increases social mobility and cohesion
- Improves public safety (eg. well-lit streets) which encourages more people to walk or cycle and improves accessibility (to facilities and amenities)

**Better insulation in homes**
Reduces CO₂ emissions through reduced energy requirements
Reduces fuel poverty and saves money in the long term
Improves resilience to both cold and hot weather
Reduces excess seasonal deaths and health inequalities
Promotes health and wellbeing

**Reduced material consumption**
Reduces waste (and therefore environmental impacts e.g. from landfill)
Saves money and reduces personal debt
Reduces emotional distress, dissatisfaction and alienation
Deprivation

The index of multiple deprivation

2011 update

Although Hackney is still one of the most deprived boroughs in England, the latest index of Multiple Deprivation shows improvements in deprivation rank of all but two wards.

Focus on inequalities:

- The most deprived wards in Hackney have seen relatively small improvements in their deprivation scores compared to the least deprived wards. Consequently, there is now a bigger difference in the deprivation scores of the least and most deprived (i.e. an increase in inequality)

The Index of Multiple Deprivation is a composite measure that attempts to combine a number of elements that contribute to deprivation. It aims to reflect the overall experience of individuals living in a small geographical area. Aspects of deprivation that are included in the measure are:

- Income
- Employment
- Health and disability
- Education
- Skills and training
- Housing
- Crime
- Living environment

The 2010 Index of Multiple Deprivation placed Hackney as the second most deprived borough in England, after Liverpool (ONS).

All of but one of Hackney’s wards (Clissold) are among the top 10% most deprived wards nationally and 11 are in the top 5% most deprived wards (Figure 2.7).

Deprivation rank has declined in all wards except Haggerston and Hackney Central since the Index was last calculated in 2007. However there has been a slight increase in the inequalities across the borough: improvements have been greater in the less deprived wards than in the most deprived wards. For example, Clissold has seen a decline in its percentage rank of 2.9 percentage points compared to Wick which has only improved by 0.2 percentage points.

The City

In 2010, the City of London was ranked 262 out of 326 boroughs, with 326 being least deprived. However, there is considerable variation between wards. Clear socio-economic differences remain between the Mansell Street and Middlesex Street estates in Portsoken and the wealthier Barbican estate in the northwest of the City.
Economic deprivation in the Orthodox Jewish (Charedi) community in Hackney

The Charedi community in Stamford Hill is economically mixed, with rich and poor living cheek by jowl. Wealthy members of this community choose to live alongside their poorer neighbours rather than move to more affluent areas because of the religious and cultural infrastructure they require. However the majority of the Charedi community are economically poor, with over 55% of households in receipt of a means tested benefit.

Living within the Charedi community carries extra costs. There are costs attached to religious observance and cultural practice, such as synagogue membership, Sabbath and holiday requirements, cultural dress and kosher food. But the highest additional cost of Charedi life is the cost of schooling, as children are educated in community schools which are not state maintained.

Although there are few Charedi households where no adults are in work, work is often part-time, generally low paid and usually within the Charedi community. Although Charedi people have undergone a high level of Jewish education, for most people this does not translate into traditional workplace skills and very few Charedim have vocational or professional education or a degree. Yiddish is the mother-tongue in the majority of Charedi households, and Charedi men in particular often have poor levels of spoken and written English. The most common route out of poverty for many of these men is entrepreneurship and there is a relatively high level of self-employment. But this is an inherently challenging path and is the pathway to economic success for only a minority of the community.

Lack of work in households inevitably increases poverty and very often child poverty in the Charedi community. The impacts of national welfare reform on this community may be severe as the caps on housing benefit and child benefit will be disproportionately felt by large households in the private rented sector.

Charedi men do not access mainstream careers advice and typically do not claim Jobseekers Allowance. Within the Charedi community there is a great stigma attached to being workless, which is sometimes hidden by participation in religious study programmes. Recently, Team Hackney has sought to address these issues by commissioning services targeted at this group but there is still a big gap in careers advice, guidance and counselling services to enable people in this group to participate more in the labour market.

66 Submission for Health and Well-being Profile by The Interlink Foundation, 2011.
67 Estimating and Profiling Hackney’s population, Mayhew, 2008; Holman: Baseline Indicators for the Charedi Community in Stamford Hill, 2002
68 Holman: Baseline Indicators for the Charedi Community in Stamford Hill, 2002; Gonen: Between Torah Learning and Wage Earning, 2006
Child poverty

2011 update

The proportion of children living in poverty in Hackney fell between 2008 and 2009 from 44% to 40%. However this remains almost twice the average for England of 21%. The proportion of pupils eligible for free school meals in Hackney’s secondary schools is the fourth highest rate in London and more than twice the national average.

In the City, the proportion of children living in poverty in Portsoken ward fell between 2008 and 2009 from 47% to 41%.

See page 144 for full details

Housing

People living in poor housing conditions are more likely to experience mental health problems, respiratory problems and long term illness. Nearly half of all social housing is now located in the most deprived fifth of neighbourhoods and people living in social housing experience, as well as poorer health outcomes, higher rates of unemployment and rates of poverty which are double that of the population as a whole.

Key challenges in Hackney and the City include:

- Affordability
- Overcrowding, particularly for households with children
- Housing quality and affordable warmth
- Housing related support for vulnerable adults, including people needing treatment for ill health (mental health, TB, substance misuse, HIV and hepatitis)

Housing stock and households

2011 update

A large proportion of the housing stock in Hackney remains in the ownership of the council or housing associations. However a majority of the stock (54%) is owner occupied or privately rented.

In 2010 there were 98,590 dwellings in Hackney, an annual increase in stock of 1,625 dwellings. Of these dwellings, 23% are owned by Hackney Council, 23% are owned by registered social landlords (RSLs) and 54% are owner occupied or privately rented69 (Table 2.5).

From 2006, all local authority owned housing within Hackney was managed by the arm’s length management organisation (ALMO) Hackney Homes. An ALMO is a company set up by a local authority to manage all or part of its housing stock. The housing stock remains in the ownership of the local authority but the ALMO takes responsibility for its day-to-day management including collecting council housing rent and repairing and maintaining council homes. There are over 60 RSLs providing social housing in Hackney.

69 ONS Neighbourhood statistics
The number of homes in Hackney has increased by about 12% since 2001 and is projected to increase by about 16% by 2031 (this is lower than the rate of projected growth for both London and England, 26% and 29% respectively).

In Hackney, the most common household types are single adults under pensionable age and multiple adult households with no children (Figure 2.6)\textsuperscript{70}. However one in every nine households is occupied by a single pensioner.

Approximately 17% of households in Hackney have one or more members with a support need\textsuperscript{71}. Table 2.7 describes these households according to type of need. Two fifths (41%) of these households include only people of pensionable age. These households represent 53% of the households in Hackney in this age range. The majority of households with support needs (77%) live in council or housing association property, compared to 41% of those without support needs.

In December 2011, 8,711 households in Hackney received Local Housing Allowance (LHA), a housing benefit to cover the cost of rented accommodation\textsuperscript{72}. Some of these households are vulnerable to current and future changes in welfare provision (see The impacts of welfare reform, below).

The City

As it is primarily a business district, the City has an unusual housing and household profile. There are four small areas that are predominantly residential and a number of other areas that are mixed use with some residential element (Figure 2.8). Over 90% of dwellings in the City have two bedrooms or fewer, with over 63% either studio or one-bedroom accommodation\textsuperscript{73}.

There were 5,900 dwellings in the City of London in 2010. There are three social housing estates, two of which are owned or managed by the City of London Corporation, with the majority of the rest of the residential accommodation either owner occupied or privately rented. The Barbican estate has 1,990 flats, of which 1,879 have been sold and the remaining 111 are rented. Overall, 81% of dwellings are owner occupied or private rented, 7% are owned by the City of London Corporation and 9% are owned by RSLs (Table 2.9).

In the City, 46% of households are single person households under pensionable age\textsuperscript{74}. Eighteen percent of households are occupied by pensioners including 14% living alone. The number of households with dependent children is very low: 10% of all households.

| Table 2.5. Dwellings in Hackney and the City, by tenure, 2010 (ONS) |
|-----------------------------|-----------------|-----------------|-----------------|
| Hackney                     | The City        | London          |
| Local authority owned       | 22,912 (23%)    | 430 (7%)        | 13%             |
| Registered social landlord  | 22,397 (23%)    | 549 (9%)        | 11%             |
| Other public sector         | 0               | 118 (2%)        | <1%             |
| Owner occupied and private rented | 53,280 (54%) | 4,800 (81%)   | 76%             |
| Total dwellings              | 98,590          | 5,900           |

\textsuperscript{70} London Borough of Hackney Housing Needs Assessment, 2009
\textsuperscript{71} London Borough of Hackney Housing Needs Assessment, 2009
\textsuperscript{72} London Borough of Hackney
\textsuperscript{73} City of London, Housing info, January 2010
\textsuperscript{74} ONS: Census 2001
Table 2.6. Households in Hackney, 2008 (LBH)

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Number of Households</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single non-pensioner</td>
<td>28,574</td>
<td>30.3%</td>
</tr>
<tr>
<td>Multiple adult</td>
<td>18,069</td>
<td>19.2%</td>
</tr>
<tr>
<td>Lone parent family</td>
<td>12,936</td>
<td>13.7%</td>
</tr>
<tr>
<td>Single pensioner</td>
<td>10,282</td>
<td>10.9%</td>
</tr>
<tr>
<td>Couple, no children</td>
<td>9,480</td>
<td>10.1%</td>
</tr>
<tr>
<td>2+ adults, 2+ children</td>
<td>8,100</td>
<td>8.6%</td>
</tr>
<tr>
<td>2+ adults, 1 child</td>
<td>4,872</td>
<td>5.2%</td>
</tr>
<tr>
<td>2+ pensioners</td>
<td>1,927</td>
<td>2.0%</td>
</tr>
<tr>
<td>Total</td>
<td>94,240</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2.7. Households with support needs in Hackney, 2008 (LBH)

<table>
<thead>
<tr>
<th>Support Need</th>
<th>Number of Households</th>
<th>% all households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical condition</td>
<td>7,728</td>
<td>8.2%</td>
</tr>
<tr>
<td>Physical disability</td>
<td>7,487</td>
<td>7.9%</td>
</tr>
<tr>
<td>Frail elderly</td>
<td>3,946</td>
<td>4.2%</td>
</tr>
<tr>
<td>Mental health problem</td>
<td>1,653</td>
<td>1.8%</td>
</tr>
<tr>
<td>Learning disability</td>
<td>1,018</td>
<td>1.1%</td>
</tr>
<tr>
<td>Sensory disability</td>
<td>844</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Figure 2.8 Dwellings in the City of London, April 2011
Housing standards

Poor housing conditions can affect health in a variety of ways. They are associated with increased incidence of infections, respiratory disease, asthma, heart disease and hypothermia. Poor housing conditions can also increase depression, stress and anxiety. The World Health Organisation identified the main significant hazards associated with poor housing conditions as poor air quality, poor temperature, radon, slips, trips and falls, noise, house dust mites, tobacco smoke and fires.

The Green Paper ‘Quality and Choice: A Decent Home for All’ in 2000, set targets to reduce the number of social housing properties not meeting the Decent Homes standards by 30% by 2004 and to have all social rented homes meeting the standard by 2010. A Decent Home is one which is ‘wind and weather tight, warm and has modern facilities’.

Since 2001, the number of homes in Hackney not meeting the Decent Homes standards has fallen from 95% to 35% in 2009. This large reduction is a result of prolonged local investment and has resulted in over 50,000 more homes being made ‘decent’.

The City

The City met its Decent Homes target by 2010, with the exception of Great Arthur House, a listed tower block on Golden Lane Estate where an extension was agreed by the then Government Office for London, until 2013.

Overcrowding

In 2009, 9.6% of households in Hackney were overcrowded (9,018 households). This is a high rate of overcrowding, reflecting the high population density, and compares to a London average of 7% and national average of 3%.

One in 20 (5%) households in Hackney has more than five people living in them and 4% of households have 1.5 persons per room (including kitchens and living rooms but not bathrooms and halls). The level of overcrowding in Hackney has increased from 2003 to 2008 by 7.2%, an increase of nearly 3,000 households. Overcrowding is particularly prevalent in the north of the borough (Figure 2.9).

Nationally, levels of overcrowding are known to vary between different ethnic groups, being most severe amongst Pakistani, Bangladeshi and Black African households. Black and minority ethnic households are over seven times more likely to be overcrowded than white households. In Hackney overcrowding is a particular issue for the Orthodox Jewish community in the north of the borough where the average household size is estimated to be 6.3 people and approximately 33% of households are overcrowded.

People living in subsidised housing (either social rented or private rented with support from the Local Housing Allowance) are more likely to be overcrowded. One parent families are also more likely to live in overcrowded housing. Overall, 45% of social renting one parent families in Hackney and 48% in the City are overcrowded.

The most frequently overcrowded households in Hackney are those with children. Half (49%) of overcrowded households in Hackney contain children. Of all the children living in Hackney,

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75 World Health Organisation, 4th ministerial conference on environment and health, 2004
76 London Borough of Hackney Housing Needs Assessment 2009
78 BME Housing needs and aspirations. Cambridge Centre for Housing and Planning Research, 2008
79 Ealing PCT: Overcrowded housing and its effects on London’s communities, 2004
80 Holman: Baseline Indicators for the Charedi Community in Stamford Hill, 2002
81 London Borough of Hackney Housing Needs Assessment 2009
46% live in homes which are overcrowded. Health impacts of overcrowding on children include higher risk of infectious diseases, meningitis, respiratory problems and emotional distress\(^82\).

**The City**

In the City, where over 60% of households are single person households, overcrowding is less of a problem. According to national statistics, only 1% of households have more than five people living in them and 2% have 1.5 persons per room. However, local survey data suggests a higher rate of overcrowding of 4%\(^83\) and 31% of households on the City of London’s registered housing list (i.e. who are waiting for social housing) are overcrowded. Of the people already resident within the City who are on the registered housing list, 22% are currently living in overcrowded conditions. Additionally, a number of properties in the City are rented out as Houses in Multiple Occupation (HMO), which means that they are rented with shared facilities (i.e. shared toilets, bathrooms or kitchens). In the City, most of these properties are bedsits. Currently, 20 buildings are registered as HMOs, each with over two households sharing facilities.

**Homelessness**

**2011 update**

The number of households accepted as homeless in Hackney has risen over the past two years following a five year decline.

**Focus on inequalities:**

- A disproportionately large number of homeless households in Hackney are of Black ethnicity.
- Homeless single adults face some of the highest health risks, and have some of the highest health needs, in Hackney
- The rough sleeper population in the City is predominantly white men: in 2009/10, 92% were male and 88% were White; 5% were Black and 2% were Asian. Many rough sleepers are from central and eastern Europe, especially Poland

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\(^82\) For full details, see NHS City and Hackney: Health and Housing in Hackney and the City, 2010.

\(^83\) East London Strategic Housing Market Assessment 2009/10, Report for the City of London Corporation, November 2010
Statutory homelessness

In 2010/11, 814 households in Hackney were accepted as being homeless and in priority need according to the law. This was a rate of nine households per 1,000 Hackney households (the highest rate in London). The number of households accepted as homeless has risen over the past two years following a five year decline (Figure 2.10). Figure 2.11 describes the ethnicity of these households. Compared to the population of Hackney as a whole, a disproportionately large number of homeless households are of Black ethnicity.

At March 31st 2011, there were 1,296 homeless households in temporary accommodation in Hackney. Figure 2.12 describes the type of accommodation they were housed in.

The City

In 2010/11, 18 households in the City were accepted as being homeless and in priority need according to the law. At March 31st 2011, there were fewer than five households in temporary accommodation in the City. This had risen to 11 households by October 2011.

Figure 2.10 Homeless households in Hackney, 2004-2011 (CLG, data for 2005-06 is not available)

Figure 2.11 Households accepted as statutory homeless in Hackney, 2010/11 by ethnicity

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84 CLG homelessness statistics
85 CLG homelessness statistics
86 City of London Housing database 2011
Single adults who are homeless

There are many single people in Hackney who are not deemed to be in priority need for housing (and so do not have a statutory right to housing) but who have nowhere stable to live. These single adults often have multiple, and sometimes complex, needs. They include people living in hostels, on the streets, in squats and others in impermanent accommodation at high risk of homelessness and street homelessness.

Single homeless people have significantly worse levels of ill health and early death than the general population:

- 8 in 10 single homeless people have one or more physical health condition. For over half this is a chronic problem
- 7 in 10 of single homeless people have one or more mental health condition and nearly half of those with a mental health problem self medicate with drugs or alcohol
- 77% single homeless people smoke

This population also has high prevalence of communicable diseases such as TB and hepatitis, particularly among those living in hostels or on the streets.

As a result of their complex needs, single homeless people are costly to the NHS. They disproportionately use acute local services at a cost four times more than the general population; inpatient costs average eight times higher than the comparison population.

Single adult homeless people are supported by Hackney Council through the Supporting People programme which funds shelters and other supported accommodation through agencies such as St Mungo’s.

A survey conducted by St Mungo’s in 2011 identified the following levels of need among its clients in Hackney:

- 73% were cigarette/tobacco smokers (5% unknown)
- 31% used alcohol problematically, and a further 6% had done so in the past. Of those, 34% had used alcohol problematically for more than 10 years
- 54% misused prescribed drugs or used illicit drugs, and a further 13% had done so in the past. Of those, 30% had done for more than 10 years
- 41% were identified as having a significant medical condition
- 50% required regular prescription medicine
- 35% generally accessed healthcare through A&E departments
- 41% were identified as having a mental health need
- 6% self harmed
- 12% were identified as being currently involved in sex work
- 14% were identified as current street drinkers

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87 Homeless Link/ St Mungo’s: Improving the health of the poorest, fastest: including single homeless people in your JSNA, 2011
88 Healthcare for Single Homeless People, Office of Chief Analyst; Department of Health, 2010
These findings reveal the severe level of health harms experienced by this client group.

In Hackney the Supporting People Programme provides 300 places in supported accommodation for single homeless adults and rough sleepers. In 2010/11 these services received 350 referrals from homeless people but were only able to house 177 of them\(^8^9\).

**Rough sleepers**

A rough sleeper is defined as a person who is sleeping or bedded down in the open air or in buildings and other places not designed for habitation\(^9^0\).

All forms of homelessness, including people housed in temporary accommodation, can lead to poor physical and mental health. However, rough sleepers are generally in much worse health than other homeless people\(^9^1\). There is an increased prevalence of a number of health issues including chronic chest problems, tuberculosis, skin complaints and mental health problems. A survey of health problems of rough sleepers throughout England in 1991 showed that rough sleepers are three times more likely to suffer from chest and breathing problems, three times as likely to have skin complaints and over four times as likely to have trouble seeing or hearing. Rough sleepers have higher rates of tuberculosis and hepatitis than the general population. Rough sleeping is linked with premature death, with rough sleepers having an average life expectancy of 43. These differences relate to both lack of protection from adverse weather conditions (such as cold, damp and heat/sun) and limited access to health care when ill.

Both Hackney and the City of London Corporation in conjunction with the East London Housing Partnership have developed a rough sleeper strategy with the aim of improving services for this group and better coordination across different agencies.

Compared to the City of London and other central London boroughs, Hackney does not have a large rough sleeper population. In 2010/11, 57 people were seen sleeping rough on the streets of Hackney, of whom 41 had not been seen in previous years\(^9^2\). This was a fall from 63 people in 2009/10.

A total of 110 rough sleepers in Hackney were contacted by outreach services or seen arriving or leaving accommodation in 2010/11 (including the 57 seen actually sleeping rough). They were predominantly male (85%) and White – 46% were White British, 7% were White Irish, 22% were White Other, 12% were Black and 6% were Asian. Most (84%) were aged between 26 and 55 years. A quarter (24%) had an alcohol-related support need, 22% had a drug-related support need and 10% had a mental health support need. An unusually high proportion – 28% – had a history of being in prison.

**The City**

The data on rough sleepers in the City is not characterised in quite the same way as the data for Hackney. A distinction is drawn between those who are seen sleeping rough and those who are contacted by outreach teams but not seen sleeping rough.

A total of 366 rough sleepers were known to services in the City in 2010/2011: 240 who were sleeping rough and 126 who were contacted by outreach services but not seen sleeping rough\(^9^3\). This represents a fall of 24% compared to 2009/2010 (there was a 14% rise in rough sleepers across London over the same period). Of the 240 people actually seen sleeping rough in the City in 2010/2011, 87 (36%) were new to the streets, 115 (48%) had been seen in the year before and 38 (16%) were ‘returners’ (people not seen in 2009/2010, but had been seen before that).

On average, approximately 20-25 people sleep on the streets of the City of London every night. Despite the recent decline in rough sleeping locally, the City still has the fifth highest number of rough sleepers in London after Westminster, Camden, Lambeth and Southwark.

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\(^8^9\) London Borough of Hackney
\(^9^3\) CHAIN Annual Report for City of London 1st April 2010 - 31st March 2011.
The rough sleeper population in the City is predominantly white men: in 2009/10, 92% were male and 88% were White; 5% were Black and 2% were Asian. Many rough sleepers are from central and eastern Europe, especially Poland (Figure 2.13).

Almost three quarters of rough sleepers in the City are aged 36 years or more and 18% are aged over 55 years (Figure 2.14). The rough sleeper population includes significant numbers of people who have been in the armed forces, been in care or been in prison.

Rough sleepers have high needs relating to alcohol, drugs and mental health. In 2010-11, 37% of rough sleepers in contact with services in the City had alcohol problems, 11% had drugs problems and 24% had mental health problems (with many having more than one of these problems).

In April 2011, the City of London became a pilot area for No Second Night Out, a new rapid response scheme that aims to help those who find themselves sleeping rough for the first time. Anyone new to the streets of London will be referred to an assessment hub, where they will be interviewed and either reconnected to their home location or directed to offered help through other services.

Additionally, the City has been working with St Mungo’s to develop a new type of hostel accommodation for older long-term rough sleepers, who have different needs to other types of rough sleeper. The Lodge, a new hotel-style of accommodation, has seen initial success in engaging with this group, and helping them to access services that they would not have otherwise approached. This accommodation won the Meeting the Needs of Older People award in the 2011 UK Housing Awards. It was also received a Housing Excellence award and was joint runner-up in the 2011 London Council’s Andy Ludlow Homelessness Awards.

Figure 2.13. Nationality of rough sleepers in City of London 2010/11 (Broadway)

Figure 2.14. Age of rough sleepers in City of London 2010/11 (Broadway)
Rough Sleepers on Personal Budgets

In 2010 the City of London piloted a new way of working with long term rough sleepers who were resistant to moving off the streets, focusing on personalised budgets. The project was delivered by Broadway, a London based homelessness charity. It was funded and supported by the City of London Corporation and the government’s Department of Communities and Local Government (CLG) as part of their strategy to end rough sleeping.

The pilot was successful and far exceeded the expectations of the project. Fifteen people who had been sleeping rough for between four and 45 years were offered a personalised budget. By the end of the project, the majority were in accommodation (seven) or making plans to move into accommodation (two). Those who had moved off the streets talked positively about their lives in accommodation. They had begun to make plans for the future, including taking courses, reconnecting with family and addressing physical, mental health and substance misuse problems.

In 2011, the City of London, in partnership with Broadway, received the Andy Ludlow award for this work. The awards are the country’s leading homelessness awards, with prize money awarded to the organisations that demonstrate innovative and creative solutions for tackling homelessness in the capital, as well as recognising good practice.

Housing: what works?

Information about housing should be clearly explained, non-stigmatising and easily accessible

It is crucial that agencies work together to ensure a good flow of information between services and clients

Housing design that includes features such as proximity to shared facilities such as community centres, restaurants, child care centres and leisure facilities, has a significant positive impact on quality of life and other health and social outcomes

Evidence supports the value of good quality ‘extra care’ housing that enables people to live independently in the community with support

The development of multi-service or ‘more than a roof’ responses to homelessness, involving joint working between health, housing and social care services is central to an effective response to housing need and homelessness

Specific groups of people such as ex-prisoners/ex-offenders, people who misuse substances, people with TB and refugees/asylum seekers benefit from an affirmative approach to meeting their housing needs

Preventative work and early intervention aimed groups particularly at risk of homelessness need to be prioritised - timely interventions can avert crisis

Existing disadvantages are compounded by social isolation, so identifying strong neighbourhood links is an important component of being adequately housed

Providing mixed housing options including different household income brackets is more effective than building large areas of housing aimed at only one group

Smoke alarms wake most adults as long as they are not under the influence of drugs, alcohol or sleep deprivation or are hearing impaired. Fitting interconnected smoke alarms, preferably with both high and low alarm frequency, improves warning effectiveness

Insulation reduces energy use which can have an impact on fuel poverty

Converting small properties into larger units or building larger units would reduce housing stress

Fuel poverty and cold homes

2011 update

The number of households in fuel poverty in Hackney doubled in the three years from 2006 to 2009. More than one in six households in Hackney is in fuel poverty.

Focus on inequalities:

- Fuel poverty and cold homes have adverse impacts on physical and mental health for all groups, though children, young people and older people are particularly vulnerable to such impacts.
As fuel poverty is a function of income, all low income households are at increased risk of fuel poverty. Among these households, single adult households and lone parent households are particularly likely to experience cold homes.

The health and wellbeing impacts of cold homes

The Marmot Review Team published a review of the health impacts of cold homes and fuel poverty in 2011\(^ {94}\). The following is a summary of their conclusions:

- There is a clear link between housing with low thermal efficiency and excess winter deaths. Excess winter deaths are almost three times higher in the coldest quarter of housing than in the warmest quarter.
- Around 40% of excess winter deaths are attributable to cardiovascular diseases and 33% are attributable to respiratory diseases. There is a strong relationship between cold temperatures and both cardiovascular and respiratory diseases.
- Mental health is negatively affected by fuel poverty and cold housing for any age group.
- Cold housing increases the level of minor illnesses such as colds and flu and exacerbates existing conditions such as arthritis and rheumatism.
- Fuel poverty negatively affects dietary opportunities and choices.
- Cold housing negatively affects dexterity and increases the risk of accidents and injuries in the home.

**Children**
- Significant negative effects of cold housing are evident in terms of infants’ weight gain, hospital admission rates, developmental status, and the severity and frequency of asthmatic symptoms.
- Children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems than children living in warm homes.
- Cold housing negatively affects children’s educational attainment, emotional well-being and resilience.

**Adolescents**
- There are clear negative effects of cold housing and fuel poverty on the mental health of adolescents.
- More than 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems compared to 1 in 20 adolescents who have always lived in warm housing.

**Adults**
- There are measurable effects of cold housing on adults’ physical health, well-being and self-assessed general health, in particular for vulnerable adults and those with existing health conditions.

**Older people**
- Effects of cold housing are evident in terms of higher mortality risk, and poorer physical and mental health.

The report concluded that improving the energy efficiency of the existing housing stock is a long-term, sustainable way of ensuring multiple gains, including environmental, health and social gains. Investing in the energy efficiency of housing can help stimulate the labour market and economy, as well as creating opportunities for skilling up the construction workforce.

There are, however, other ways of tackling fuel poverty other than improving thermal efficiency of dwellings. The experience of a cold home is also related to fuel prices and household income. There is a strong link between income poverty and cold homes: 47% of households in poverty (with an income less than half of the national median income) report being colder than they want to be in the winter, including 18% who are much colder than they want to be\(^ {95}\). Among these low income households, the following household types are especially likely to be cold:

- Single adult households under pension age (60%)
- Lone parent households (64%)

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\(^{94}\) The Marmot Review Team: The Health Impacts of Cold Homes and Fuel Poverty, Friends of the Earth 2011.

\(^{95}\) Anderson W, White V, Finney A: You just have to get by, Coping with low incomes and cold homes, Centre for Sustainable Energy, 2010.
Households on very low incomes – less than £6,000 per year (63%)
Couples with children (55%)
Tenants of private landlords (54%)
Households who use prepayment meters (62%) or budget schemes (63%) to pay for their electricity

Some households with very low incomes may go cold even when their fuel costs are less than 10% of their income simply because other priorities, such as having food on the table for children, may be a higher priority for the limited funds available. Conversely, some households cut their food budgets or other budgets in order to maintain domestic warmth.

Fuel poverty in Hackney and the City

By definition, a household is in fuel poverty if the amount of energy needed to heat the home to a comfortable standard costs more than 10% of the household income. This definition is currently under review by the government but is still used to determine the baseline data for local, regional and national fuel poverty levels.

Despite a government commitment to eradicate fuel poverty by 2016 (and by 2010 for vulnerable households, which has not been achieved), the number of households experiencing fuel poverty has increased dramatically in recent years due to rising fuel prices. In London, the proportion of households in fuel poverty has increased from 3.6% in 2003 to 13.3% in 200996 (Figure 2.15).

Estimated rates are only available for local authorities for 2006, 2008 and 2009. Over these three years, the proportion of households in fuel poverty in Hackney has doubled from 7.7% to 15.3%, the fourth highest rate in London (Figure 2.15)97. This puts more than one in six households in Hackney in fuel poverty.

The City

The level of fuel poverty in the City is relatively low and has been relatively stable over the last three years despite rising energy costs (Figure 2.15). In 2009 the estimated proportion of households in fuel poverty in the City was 6.4%, the lowest rate in London.

In recent years, the City of London has undertaken a programme of works to improve homes on housing estates as part of the Decent Homes programme. Measures undertaken include the installation of triple-glazed windows to the 220 properties at Middlesex Street Estate during 2010/11. It has not yet been possible to replace the original 1950s windows on the Golden Lane Estate, as these buildings are listed Grade II and Grade II*.

Figure 2.15 Proportion of households in fuel poverty 2003 - 2009

97 Department of Energy and Climate Change: Sub-regional fuel poverty levels, England 2009
Work and worklessness

Work and income are key determinants of health and wellbeing. The Waddle report lays out the evidence for improving health through work. Work is the generally the most effective way to earn enough resources in order to live in today’s society.

- Work meets important psychosocial needs in societies where employment is the norm
- Work is an essential part of someone’s identity, and social role and status in society
- Employment and socio-economic status are the main drivers of social gradients in physical and mental health and mortality

In addition there is a growing body of evidence that long term worklessness increases mortality, leads to poorer general and mental health and results in greater use of health services and higher rates of hospital admissions. Re-employment leads to improved self esteem and improved general and mental health. Where it is possible for sick or disabled people to work it should be encouraged because it is therapeutic, improves and promote recovery and reduces the risk of long term incapacity. Claimants who move off benefits and (re)-enter work generally experience improvements in income, socio-economic status, mental and general health, and wellbeing.

There are inequalities in access to the labour market, and patterns of employment reflect the social gradient. The highest rates of unemployment are found among those with few qualifications and skills, and also among those with disabilities and poor mental health. People in these groups who are in work are likely to be in jobs that are lower paid and of poorer quality.

Unemployed people often experience multiple health problems with higher rates of long term illness, mental illness and cardiovascular disease. Loss of work and long term unemployment are associated with worse health outcomes, increased rates of smoking and alcohol consumption and decreased physical exercise.

Resident employment

2011 update

The number of people in employment in Hackney fell for the first time in six years in 2010/11 but remains higher than the average for London.

Focus on inequalities:

- The employment rate in Hackney is higher among men than among women; men also earn more on average than women

Seven in ten Hackney residents (69.9%) are of working age. In 2010/11, 77.0% of the working age population of Hackney were economically active (82.9% of men and 71.4% of women). The economically active are people who are employed or actively seeking work. The economically inactive are people who are not actively seeking work and include carers, housewives/husbands, students and people unable to work due to sickness and disability.

In 2010/11, 69.0% of the working age population of Hackney (108,400 people) were in employment. This is a fall of one percentage point on the previous year – the first fall in the local employment rate for six years. The rate is still higher than the average for London (68.2%), which Hackney overtook for the first time in 2009/10 (Figure 2.16). The employment rate is higher among men (74.4%) than women (64.0%) though the

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100 All data in this section are from NOMIS (www.nomisweb.co.uk) except where indicated
difference between the two (10 percentage points) is smaller than the gap in London as a whole (15 percentage points).

Table 2.8 summarises the occupations of Hackney residents. The majority of residents (58.6%) are in managerial and professional jobs. In 2010, average gross weekly pay received by Hackney residents was £583, slightly below the London average of £607. The difference between the weekly pay received by men and women was relatively small in Hackney: average pay for men was £613 compared to £574 for women. In London as a whole the gap is larger: £645 for men and £574 for women.

The City

In the City, 82.6% of the resident population is of working age. The population is too small for reliable estimates of economic activity to be made.

Figure 2.16 proportion of Hackney’s working age population in employment 2004 - 2010 (NOMIS)

<table>
<thead>
<tr>
<th></th>
<th>Hackney</th>
<th>London</th>
<th>change on 2008/09</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers and senior officials</td>
<td>18,000</td>
<td>16.6%</td>
<td>+1,900</td>
<td>17.8%</td>
</tr>
<tr>
<td>Professional occupations</td>
<td>23,400</td>
<td>21.6%</td>
<td>+2,700</td>
<td>18.8%</td>
</tr>
<tr>
<td>Associate professional &amp; technical</td>
<td>21,800</td>
<td>20.1%</td>
<td>-2,900</td>
<td>18.6%</td>
</tr>
<tr>
<td>Administrative &amp; secretarial</td>
<td>11,000</td>
<td>10.1%</td>
<td>+1,400</td>
<td>10.3%</td>
</tr>
<tr>
<td>Skilled trades occupations</td>
<td>6,500</td>
<td>6.0%</td>
<td>-1,200</td>
<td>7.2%</td>
</tr>
<tr>
<td>Caring, leisure and personal services</td>
<td>5,100</td>
<td>4.7%</td>
<td>-2,000</td>
<td>7.0%</td>
</tr>
<tr>
<td>Sales and customer service occs</td>
<td>5,000</td>
<td>4.6%</td>
<td>-600</td>
<td>6.3%</td>
</tr>
<tr>
<td>Process plant &amp; machine operatives</td>
<td>4,400</td>
<td>4.0%</td>
<td>-100</td>
<td>4.1%</td>
</tr>
<tr>
<td>Elementary occupations$^{101}$</td>
<td>12,600</td>
<td>11.6%</td>
<td>+1,400</td>
<td>9.0%</td>
</tr>
<tr>
<td>Total</td>
<td>107,800</td>
<td>100%</td>
<td>+600</td>
<td>100%</td>
</tr>
</tbody>
</table>

101 Requiring a minimum general level of education. Some occupations at this level will also have short periods of work-related training in areas such as health and safety, food hygiene, and customer service requirements. (ONS)
Jobs within Hackney and the City

2011 update

The public sector remains the leading employer in Hackney. Finance is the leading employer in the City.

Focus on inequalities

- Men and women hold a similar range of occupations in Hackney
- In the City, managers and senior officials are far more likely to be men than women and administrative and personal services jobs are far more likely to be occupied by women than men

In 2010 there were 88,900 people employed in Hackney\(^{102}\). The Labour Force Survey provides an indication of the types of occupation and the industries of employment of these workers (Table 2.9, Figure 2.17). The occupation profile of the jobs within Hackney is similar to the profile of the jobs held by Hackney residents. The principal source of employment is the public sector, followed by distribution, hotels and restaurants and then banking and finance.

There is little difference between the male and female occupation profiles of jobs within Hackney (Figure 2.18).

In 2010 there were 590 new registrations of workers from the A8 countries in employers in Hackney. This was a 23% increase on the previous year\(^{103}\). The A8 countries are Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.

The City

In 2010 there were 359,700 people employed in the City\(^{104}\). The Labour Force Survey provides an indication of the types of occupation and the industries of employment of these workers (Table 2.9, Figure 2.19). Although banking and finance dominates the industries of the City, over 25% of those employed in the City are not in professional occupations.

There are distinct gender differences within the occupation profile of jobs within the City. Managers and senior officials are far more likely to be men. Administrative and personal services jobs are far more likely to be occupied by women (Figure 2.20).

In 2010 there were 860 new registrations of workers from the A8 countries in employers in the City. This was a 17% increase on the previous year. The A8 countries are Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.

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\(^{102}\) ONS Business Register and Employment Survey 2010.

\(^{103}\) ONS Local area migration statistics, 2011

\(^{104}\) ONS Business Register and Employment Survey 2010.
Table 2.9. Profile of people employed in Hackney and the City, 2010/11 (NOMIS - Labour Force Survey)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Hackney</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers and senior officials</td>
<td>16.1%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Professional occupations</td>
<td>19.9%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Associate professional &amp; technical</td>
<td>20.7%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Administrative &amp; secretarial</td>
<td>9.1%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Skilled trades occupations</td>
<td>7.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Personal service occupations</td>
<td>8.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Sales and customer service occs</td>
<td>8.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Process plant &amp; machine operatives</td>
<td>2.8%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Elementary occupations(^{105})</td>
<td>7.3%</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

Figure 2.17. Employment within Hackney: occupations (left) and industry (right), 2010/11 (Labour Force Survey)

Figure 2.18. Employment within Hackney: occupations by sex, 2010/11 (Labour Force Survey)

\(^{105}\) Requiring a minimum general level of education. Some occupations at this level will also have short periods of work-related training in areas such as health and safety, food hygiene, and customer service requirements. (ONS)
Unemployment and out-of-work benefits

2011 update

One fifth of the working age population in Hackney claims out of work benefits. The number of Incapacity Benefit/Employment Support Allowance claimants has been stable (though high) over the past five year but the number of Job Seekers Allowance claimants has risen.

Focus on inequalities:

- In Hackney, many more men claim Job Seekers Allowance than women but recent rises in the claimant rate have been much more pronounced among women than men
- The majority of people claiming Incapacity Benefit or Employment and Support Allowance in Hackney do so for reasons relating to mental health

In May 2011 there were 29,700 adults in Hackney claiming out-of-work benefits (including Job Seekers Allowance, Incapacity Benefit, Employment Support Allowance and lone parent benefits). This is nearly a fifth (19.4%) of the working age population, compared to an average for London of 12.5%. Of these, 10,500 people were claiming Job Seekers Allowance (JSA), 7.0% of the working age population. This was well above the average for London of 4.1%.
The number of people claiming Job Seekers Allowance in Hackney has been increasing steadily since mid-2008 (Figure 2.21). The rate is consistently higher among men (8.6%) than among women (5.2%). In the last year (May 2010-May 2011), there was an overall increase in claimants of 17% but a much bigger increase among women (36%) than among men (8%). This suggests that the economic downturn is having a more immediate effect on women than on men. The biggest rise was in the 45-54 age group.

Employment Support Allowance (ESA) was introduced for new claimants in 2008, replacing Incapacity Benefit for people unable to work due to ill health or disability, based on an independent assessment of work capability. As of May 2011 there were 13,260 people of working age in Hackney claiming Incapacity Benefit or ESA. This was 8.7% of the working age population in Hackney, a significantly higher rate than the average for London of 6.5%. Incapacity Benefit/ESA was the most common benefit claimed by people of working age in Hackney (Table 2.10).

The number of people claiming Incapacity Benefit/ESA in Hackney has been fairly stable for the last four years (Figure 2.22). The rate is higher among men than among women. However, in the last year (May 2010-May 2011), the number of Incapacity Benefit/ESA claimants has declined by 2%: 4% among men and 1% among women.

In May 2011, mental and behavioural disorders were the cause of 57% of Incapacity Benefit and Severe Disablement Allowance claims (Figure 2.23). The second most common cause was diseases of the musculoskeletal system (17%). There are no gender differences but there is a higher prevalence of mental and behavioural disorders compared to London as a whole.

Current and proposed changes to welfare policy introduced by the coalition government will affect up to 32,760 people claiming benefits in Hackney and their families, though not all reforms will affect everyone in the same way or with the same severity\(^\text{106}\) (see The impacts of welfare reform, below).

**The City**

In May 2010, only 1.5% of the working age residents of the City of London were claiming Job Seekers Allowance (120 people). The proportion of City residents claiming Incapacity Benefit is also relatively low at 1.7% (160 people).

It is likely, however, that there are distinct differences between people living in estates within the City. The family profiling project has indicated that 7% of households with children have no-one working, and that 10% of children live in a workless household. A survey of the tenants of Golden Lane and Middlesex Street estates found significant levels of unemployment among working age adults: 40% of respondents were either job seekers or not actively seeking work including 16% who were unable to work because of long-term sickness or disability\(^\text{107}\).

The City of London Corporation is currently concentrating efforts to tackle worklessness in the wards of Portsoken and Cripplegate, which have the highest levels of unemployment in the square mile. A new employability project, City STEP, aims to place 40 residents from these wards into stable employment.


\(^{107}\) City of London Corporation, 2011
Table 2.10. Key benefits claimed by residents of Hackney and City of London, May 2011. Percentages are of working age population (NOMIS/DWP)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Hackney number</th>
<th>Hackney %</th>
<th>The City number</th>
<th>The City %</th>
<th>London %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Seekers Allowance</td>
<td>10,660</td>
<td>7.0%</td>
<td>120</td>
<td>1.2%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Incapacity Benefit and ESA</td>
<td>13,260</td>
<td>8.7%</td>
<td>160</td>
<td>1.7%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Lone parents</td>
<td>4,620</td>
<td>3.0%</td>
<td>20</td>
<td>0.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Carers</td>
<td>1,640</td>
<td>1.1%</td>
<td>20</td>
<td>0.2%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Others on income related benefits</td>
<td>1,160</td>
<td>0.8%</td>
<td>10</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Disabled</td>
<td>1,220</td>
<td>0.8%</td>
<td>20</td>
<td>0.3%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Bereaved</td>
<td>160</td>
<td>0.1%</td>
<td>10</td>
<td>0.1%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Key out of work benefits</td>
<td>29,700</td>
<td>19.4%</td>
<td>380</td>
<td>3.2%</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

Figure 2.21 Job Seekers Allowance claimants in Hackney, 2007-2011, by sex (NOMIS/DWP)

Figure 2.22 Incapacity Benefit/ESA claimants in Hackney and the City 2007-2011 (NOMIS/DWP)

Figure 2.23 Conditions of those claiming Incapacity Benefit/ Severe Disablement Allowance, Hackney, May 2011 (NOMIS/DWP) (excludes ESA claimants)
What works? Employment and health

Managing long-term sickness, absence and incapacity for work

NICE produced guidance on the management of long-term sickness absence and incapacity for work in 2009. The guidance is for employers who have a direct or indirect role in – and responsibility for – the management of long-term sickness absence and incapacity. It outlines the following findings:

- Unemployment is linked to higher levels of mortality and psychological morbidity
- Being employed in some jobs may still have a worse impact on health than having no job at all. For example, poor quality, low paid and insecure employment
- The most common causes of long-term sickness absence among manual workers are acute medical conditions followed by back pain, musculoskeletal injuries, stress and mental health problems
- The most common causes of long-term sickness absence among non-manual workers (across all sectors) are stress, acute medical conditions, mental health problems (such as depression and anxiety), musculoskeletal injuries and back pain
- Individuals who are out of work for long periods of time due to sickness experience a drop in income which can result in poverty and social exclusion.

NICE reviewed the evidence for what works in order to maintain people in employment

- Intervening at an ‘early’ stage during sickness absence contributed to the success of the intervention
- There is some evidence that condition management, when combined with informal employment advice, can increase confidence levels about finding work and led to some increases in the number of people on Incapacity Benefit who returned to work. However further longer-term follow-up and evaluation was needed in order to strengthen the evidence base.
- The experience, training and competencies of those coordinating or delivering the intervention/s – and their access to supervision and consultation with more skilled and higher qualified professionals – may affect the long-term effectiveness and cost effectiveness of any intervention to support people back into work on maintain them in work
- There was little evidence of the effectiveness and cost effectiveness of interventions that focused on stress and mental illness or psychological interventions for specific population groups.

Vocational interventions for unemployed people

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108 NICE, Managing long-term sickness, absence and incapacity for work, 2009
A review\textsuperscript{109} conducted to assess the strength of evidence for the use of vocational interventions to increase work participation, and thereby reduce mental distress in unemployed individuals, concluded that there was weak evidence to support use of vocational interventions to improve work participation and limited evidence of reduced mental distress in unemployed individuals.

**Workplace interventions for people with common mental health problems**

This review\textsuperscript{110} focused on the evidence for the following areas:

- What is the evidence for preventative programmes at work and what are the conditions under which they are most effective?
- For those employees identified as at risk, what interventions most effectively enable them to remain at work?
- For those employees who have had periods of mental ill health related sickness, what interventions most effectively support their rehabilitation and return to work?

The review made the following recommendations:

- A range of stress management interventions can have a beneficial and practical impact on supporting employees but the extent to which any of these interventions prevent common mental health problems remains unclear.
- Limited evidence was found that focus on individuals rather than the organisation as a whole produced better results; although there was also limited evidence that changing the work environment can be effective in reducing common mental health problems.
- Amongst employees deemed to be at risk, either through their job role or who have been assessed as at risk, there was strong evidence that individual rather than organisational approaches to managing common mental health problems are most likely to be effective.
- The most effective programmes focused on personal support, individual social skills and coping skills training. The most long lasting effects were from multi-modal programmes.
- However it is imperative that those populations are identified accurately so that interventions can be correctly targeted and applied and the anticipated benefits of retaining key skills in organisations can be realised.
- For people already experiencing common mental health problems at work, there was strong evidence that, the most effective approach is brief (up to 8 weeks) of individual therapy, especially cognitive behavioural in nature (CBT).
- A stronger effect is associated with employees in high-control jobs.

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**The impacts of welfare reform**

**2011 update**

Current and proposed changes to the welfare system will have a significant impact on the income of a large number of Hackney residents claiming benefits.

From January 2012 significant impacts will be felt by people living in the private rented sector, particularly single people aged 25-35; families requiring five or more bedrooms; and households currently paying rents above the new Local Housing Allowance thresholds (30\textsuperscript{th} percentile).

Other households will be affected as further reforms are implemented, including changes for people renting from Hackney Homes or RSLs.


\textsuperscript{110} British Occupational Health Research Foundation. Workplace interventions for people with common mental health problems: Evidence review and recommendations, September 2005
Health and social care services are not routinely involved in work capability assessment or the Work Programme, but can play a key role in supporting people into work related activity and jobs.

**Focus on inequalities:**

- The number and percentage of people claiming Incapacity Benefit on the basis of a mental or behavioural disorder is high in Hackney. Our analysis suggests they may require advocacy and support through the reforms, particularly the work capability assessment, and to ensure they benefit from the opportunities of the work programme.
- The reforms are likely to have a disproportionate impact on households with children, particularly larger families. How they will respond to their shortfall in income, and the impact on child poverty, is not yet known.

There have been significant changes to welfare provision in the UK in recent years including the introduction of an independent ‘work capability assessment’ for people claiming benefits on the basis they are too ill or disabled to work, and the introduction of more stringent caps on housing related benefits. The recent White Paper, 21st Century Welfare, proposes more far reaching reform of the welfare system (in Parliament at time of writing) in order to address the current system’s complexity and limited incentives to work for some people. The reforms aim to get more people currently on benefits into work and out of poverty, and reduce the scope for fraud and error.

Welfare reform is a pertinent issue for Hackney given the large number of people claiming out of work and/or housing benefits, the relatively high cost of housing in London, and the high cost of child care (particularly for lone parents). Table 2.11 outlines the key changes to the welfare system (correct as of December 2011). Some of the reforms are already in place, and some are subject to passage of the Bill through Parliament. Locally we have started to try and identify, and put timescales to, the multiple impacts of welfare reforms on households in Hackney. Exact quantification of these impacts is difficult, given staggered introduction of the changes, the mobile nature of the population, and the dynamic nature of the economy and job markets currently. However it is possible to characterise households that are likely to experience a significant shortfall in their income.

A large number of people will be affected by reforms to the welfare system in Hackney, which has one of the highest rates of people claiming out of work benefits in the country (see Unemployment and out-of-work benefits, above). Here we report on the possible impact of three major changes: reassessment of people claiming Incapacity Benefit, changes to housing benefits, and the proposed introduction of a Universal Credit.

### Table 2.11 Timetable for welfare reforms (correct as of December 2011)

<table>
<thead>
<tr>
<th>Date of introduction</th>
<th>Change</th>
<th>Affects</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2011 - March 2014</td>
<td>Reassessment of all Incapacity Benefit claimants, to move onto either Job Seekers Allowance or Employment Support Allowance.</td>
<td>All tenure types.</td>
<td>9,300 claimants with London Borough of Hackney(^{111}).</td>
</tr>
<tr>
<td>April 2011</td>
<td>Removing the five bedroom local housing allowance rate so that the maximum level is for a four bedroom property.</td>
<td>Customers renting from the private rented sector receiving local Housing Allowance</td>
<td>Changes only affect new customers from April 2011 and existing tenants from the end of their 9 month period of transitional protection which starts from their LHA anniversary date. 169 customers affected by five bedroom restriction. 1,614 customers affected by caps.</td>
</tr>
</tbody>
</table>

\(^{111}\) All impact estimates are from the London Borough of Hackney
property, £340 for a three bedroom property and £400 for a four bedroom property.

Providing for local housing allowance rates to be set at the 30th percentile of rents in each broad rental market area rather than the median.

Removing the up to £15 per week excess benefit which some claimants can receive

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Tenure Types</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2011</td>
<td>Provide for an additional bedroom within the size criteria used to assess housing benefit claims in the private rented sector where a disabled person, or someone with a long term health condition, has a proven need for overnight care and it is provided by a non-resident carer who requires a bedroom</td>
<td>Customers renting from the private rented sector receiving Local Housing Allowance</td>
<td>Number of claims affected unidentified.</td>
</tr>
<tr>
<td>April 2011</td>
<td>Staged increases in the rates of non-dependant deductions</td>
<td>All tenure types</td>
<td>To bring deductions up to fully up rated level by 2014; affects approximately 2,754 customers.</td>
</tr>
<tr>
<td>April 2011</td>
<td>Removing baby premium</td>
<td>All tenure types</td>
<td>Currently applies to customers with a child under one; will affect 163 working customers.</td>
</tr>
<tr>
<td>April 2011</td>
<td>Reducing the percentage of childcare costs that parents can claim</td>
<td>All tenure types</td>
<td>406 customers affected.</td>
</tr>
<tr>
<td>April 2011</td>
<td>Freezing the basic and 30 hour elements of Working Tax Credit (WTC) for three years.</td>
<td>All tenure types</td>
<td>5,437 customers affected.</td>
</tr>
<tr>
<td>2011/12 – 2014/5</td>
<td>Freezing the maximum Savings Credit award in Pension Credit for four years.</td>
<td>All tenure types</td>
<td>902 customers affected.</td>
</tr>
<tr>
<td>2011/12 &amp; 2012/13</td>
<td>Increasing the WTC child element above Consumer Price Index (CPI)</td>
<td>All tenure types</td>
<td>7,128 customers affected.</td>
</tr>
<tr>
<td>December 2011</td>
<td>Transitional protection starts to end for those affected by the LHA caps.</td>
<td>Customers renting from the private rented sector receiving Local Housing Allowance</td>
<td>See above.</td>
</tr>
<tr>
<td>January 2012</td>
<td>End entitlement to income support for lone parents with a youngest child of age 5 or over. Currently stands at age 7.</td>
<td>All tenure types</td>
<td>1250 customers affected.</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
<td>Customers</td>
<td>Affected Customers</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>January 2012</td>
<td>Increasing the age threshold for the Shared Room Rate (SRR) in Housing Benefit from 25 to 35</td>
<td>Customers renting from the private rented sector receiving or applying for Local Housing Allowance</td>
<td>Up to 800 customers affected.</td>
</tr>
<tr>
<td>April 2012</td>
<td>working tax credit eligibility rules change so that couples with children must work 24 hours a week between them</td>
<td>All tenure types.</td>
<td>2,145 customers affected.</td>
</tr>
<tr>
<td>April 2012</td>
<td>Time limiting contributory Employment and Support Allowance (ESA)</td>
<td>All tenure types.</td>
<td>11 customers affected.</td>
</tr>
<tr>
<td>April 2012</td>
<td>Simplify existing Industrial Injuries Benefit scheme</td>
<td>All tenure types.</td>
<td>50 customers affected.</td>
</tr>
<tr>
<td>2011/12 &amp; 2012/13</td>
<td>Increasing the WTC child element above Consumer Price Index (CPI)</td>
<td>All tenure types.</td>
<td>7,128 customers affected.</td>
</tr>
<tr>
<td>January 2013</td>
<td>Withdrawing Child Benefit from families with a higher rate taxpayer</td>
<td>All tenure types.</td>
<td>Unidentified. Unlikely to be in receipt of Housing Benefit.</td>
</tr>
<tr>
<td>April 2013</td>
<td>LHA rates up rated on basis of Consumer Price Index</td>
<td>Customers renting from the private rented sector receiving local Housing Allowance</td>
<td>Currently CPI is approx. 0.4 % points below retail price index. Will affect whole LHA caseload of 8,645 customers.</td>
</tr>
<tr>
<td>April 2013</td>
<td>Size criteria rules will be introduced for working age claimants in social rented sector</td>
<td>Social rented sector customers only</td>
<td>Precise arrangements not yet subject to legislation. Rough analysis indicates at least 2,500 customers affected.</td>
</tr>
<tr>
<td>April 2013</td>
<td>Capping household benefit payments at £500 per week for couple and lone parent households and around £350 per week for single adult households</td>
<td>All tenure types.</td>
<td>Precise arrangements subject to legislation- could affect 1,550 customers</td>
</tr>
<tr>
<td>April 2013</td>
<td>Council Tax Benefit will be localised to Local Authorities. Total spending on Council Tax Benefit will be reduced by 10%.</td>
<td>All tenure types. with Council Tax liability.</td>
<td>Precise arrangements subject to legislation but if implemented could affect up to 38,972 customers.</td>
</tr>
<tr>
<td>April 2013</td>
<td>Disability Living Allowance (DLA) will be replaced with a new benefit, Personal Independence Payment (PIP)</td>
<td>All tenure types.</td>
<td>Precise arrangements subject to legislation but if implemented new customers from April, existing customers to be re-assessed. 11,000 residents in receipt of DLA, 5,372 HB customers with 1,770 of these pensioners.</td>
</tr>
<tr>
<td>October 2013</td>
<td>Introduction of Universal Credit.</td>
<td>All tenure types.</td>
<td>Precise arrangements not yet subject to legislation if implemented new customers affected.</td>
</tr>
<tr>
<td>October 2014-2017</td>
<td>Migration of existing Housing Benefit claims to Universal Credit</td>
<td>All tenure types.</td>
<td>Precise arrangements not yet subject to legislation but if implemented 34,000+ working age customers affected.</td>
</tr>
</tbody>
</table>

Social rented sector = tenants renting from Hackney Homes or a registered social landlord
Private rented sector = tenants renting from a private landlord
LHA = Local housing allowance (housing benefit) which claimants may receive whether they rent from the social or private sector.
Work capability assessment

Work capability assessments were introduced in 2008 for all people claiming they were unable to work on grounds of illness or disability. The assessment aims to assess individuals for their work capabilities, rather than measuring specific aspects of functioning or disability, focusing on the effects of a condition rather than the condition itself. It takes into account any aids or adaptations which an individual might successfully and reasonably use to mitigate the disabling impact of their condition, and looks at the following domains:

1. Physical disabilities:
2. Mental, intellectual and cognitive function
3. Eating and drinking
4. Maintaining personal hygiene

Employment Support Allowance (ESA) is a two tiered benefit for people unable to work due to ill health or disability being phased in to replace incapacity benefit. Introduced in 2008, all successful claimants are entitled to the ESA basic benefit which is paid at the same rates as Job Seekers Allowance. Those judged unable to work are referred to as being in the ‘Support’ group and will not be expected to take part in any work related activity, unless they choose to. Those who are judged ‘sick but able to work’ only receive additional benefits if they participate in employability initiatives, such as work focused interviews and the new Work Programme. They are referred to as being in the ‘Work Related Activity’ group and receive the additional ‘Work Related Activity’ benefit if conditional on participation. Those deemed fit to work and not eligible for ESA can claim Job Seekers Allowance.

From April 2011 to Spring 2014 all existing claimants of Incapacity Benefit, Severe Disability Allowance and Income Support paid on the grounds of illness or disability will be reassessed for ESA. This assessment is based on a self-completed form ESA50, and a medical assessment delivered by ATOS Healthcare, an independent medical advice service commissioned by the Department for Work and Pensions. For Hackney residents these assessments are undertaken at ATOS centres in Marylebone, Highgate or Romford.

Long-term claimants

A review of worklessness in Hackney\(^\text{112}\) included a review of Incapacity Benefit claimants to better understand their needs and service demand. For many long-term claimants, attitudes and fears about work remain a significant barrier to finding and maintaining employment. Local service providers suggest that long-term Incapacity Benefit claimants are likely to take a minimum of 18 months to 3 years to get into sustainable work, which may involve a range of local services including:

- Mental health
- Drug and alcohol treatment and rehabilitation
- Skills and training e.g. ESOL, literacy, financial literacy, debt advice

In the past 12 months, Social Action for Health has seen many new enquiries relating to work capability assessments and related appeals. They identify the following key problems with the process:

- Communication is poor between the agency carrying out the assessment and Hackney residents
- People are struggling to get in touch with the agency to rearrange appointments or to find out more information. We have had people that have not received their appointment letter and have had their benefits stopped for failing to attend. Others have had their benefits stopped after an assessment but have not received a letter informing them of the results or outcome of the assessments.
- People are telling us that the assessments are not appropriate for assessing their health conditions particularly in relation to mental health.
- Many people feel that the person conducting the assessments is not qualified to understand complex medical issues.
- Others felt that the reports from the assessments give incorrect information relating to what took place in the assessment

\(^{112}\) Team Hackney 2010
The City and Hackney Health and Wellbeing Profile: our joint strategic needs assessment, 2011/12

- Reintegration of ex-offenders
- Long term condition management
- Community sport and physical activity
- Small scale tailored cultural programmes
- Libraries- including small satellite centres at homeless hostels

The review concluded that service packages which include supported employment placements, training or education as part of an integrated offer are most effective with this population. Work-related activity is only likely to be successful when delivered in conjunction with other services. The review also suggested that long-term Incapacity Benefit claimants are likely to take a minimum of 18 months to 3 years to get into sustainable work.

Late compliance and non-compliance

Accurate initial assessment of an individual’s capacity to work is essential to avoid unnecessary, resource-intensive appeals. A report\textsuperscript{113} from the areas piloting Incapacity Benefit reassessment suggests that many Incapacity Benefit claimants cope well with the reassessment process. It also identifies reasons for late and non-compliance:

- Anxiety and fear of being disallowed ESA could spur prompt action for some customers, but could also have the opposite effect; customers who were worried or overwhelmed by having to complete a form or the idea of reassessment sometimes struggled to return it on time.
- Customers with chaotic lifestyles or whose condition or medication affected their memory sometimes struggled with day-to-day organisation including the completion and return of the ESA50. Similarly, some customers were unable to cope with the form unaided, and this could cause delays if help was difficult to find or not immediately available.
- In a minority of cases, late return of the ESA50 was driven by an active decision not to co-operate with the process or to ignore the form for a while. This was typically because they were in contact with a hospital or specialist and felt that it was obvious they couldn’t work at the moment.
- Where customers had failed to return the ESA50 or attend a work capacity assessment appointment it was usually explained by

\textsuperscript{113} Insert ref to report

Case study from \textit{Try Being in My Shoes} (Social Action for Health, 2011)

C is a 54 year old man originally from Jamaica living in Hackney for more than 20 years. He is divorced and lives on his own, and has 4 grown-up children. One of his children was murdered 5 years ago.

He was diagnosed with Fibromyalgia in November 2010. It causes extreme aching and constant pain in his joints including his knees, hips and shoulders. He finds it difficult to walk and it is even painful sitting and standing. He really feels the cold and even a gust of wind can make him wince in pain.

He used to work in construction and did very heavy manual work. He gave up working due to his condition. In November 2010 C went onto ESA because of his illness and because he could no longer work. He then received a letter telling him that he had to undergo a medical assessment.

He was asked to go for a medical assessment on March 18th 2011 in Marylebone. His assessment was undertaken by a Physiotherapist and took 30 minutes. C was shocked that he did not do any physical tests in order to assess his condition.

C scored 0 points and was deemed after the assessment as able to work. He does not know how the physiotherapist reached the conclusion that he was able to work and would have to go on Job Seekers Allowance. C said that the whole experience made him feel like a liar. It made him feel mad. He says that he is not able to work.

C is appealing the decision that was made. He is yet to get an appeal date. It was 5 months since his medical assessment. The whole process has made him feel defeated.
administrative error or issues on the part of Jobcentre Plus or ATOS Healthcare, or was due to the
customer being unable to cope with the process unaided.

- Some customers failed to attend because they felt unable to cope (physically or psychologically) with
  the interview or even with leaving the house. These customers had intended to go to the work
  capacity assessment and had generally planned for it; having a variable or unpredictable condition,
  they stressed that the appointment had simply caught them on a ‘bad day’. These customers
  expressed a clear intention to attend their next work capacity assessment appointment if at all
  possible.

The pilot areas were predominantly English speaking, so the report does not consider the impact of English as
a second language on the assessment process or outcomes. The Harrington Review\textsuperscript{114} made
recommendations to improve work capability assessment of people with fluctuating conditions, and mental
health problems. Mental and behavioural disorders are the predominant reason for IB claims in Hackney.

Health and social care services can play an important role in supporting people through the work capability
assessment process (e.g. helping the claimant to present an accurate case), in appeals, and, if appropriate, in
getting back into work. However the process is led by the claimant, and health and social care services will not
be involved in the assessment routinely. Ultimately, failure to engage in the reassessment process will result
in termination of benefits.

**Claimants judged fit to work**

It is estimated that around 15-25\% of claimants will be assessed as fit to work and moved on to Job Seekers
Allowance, with certain groups who were previously exempt being assessed for the first time (e.g. learning
disabilities, severe mental illness). A number of claimants may appeal the decision, and experience in the
pilot areas highlights the importance of making the initial assessment as robust as possible to avoid
unnecessary appeals.

People assessed as fit to work will be referred to the new Work Programme, commissioned by the
Department of Work and Pensions. Claimants in Hackney or the City will be referred (randomly) to one of
three new work programme providers operating across 16 boroughs in the East of London: Seetec, CDG or
A4E. The new Work Programme has been commissioned to reward sustained job outcomes and success in
enabling ‘harder to help’ claimants (including Incapacity Benefit claimants) back into work. Work Programme
providers can put in place whatever they deem an individual requires to support their return to work. The
aim is to provide claimants access to focused support over a longer period, up to 2 years, including in-work
support.

The Work Programme is new, and relationships with local service providers are not yet fully established. One
key challenge as it develops is to establish how Programme providers will interface with the other local
support services identified in the worklessness review as central to individuals’ return to work, including the
health and social care services that will be required to address any on-going needs. Another critical factor will
be the employment market, and whether suitable jobs are available that support improvements in their
health and well being.

**Changes to housing benefits**

In December 2011, 8,711 households in Hackney received Local Housing Allowance (LHA), a housing benefit to
cover the cost of rented accommodation\textsuperscript{115}. Some of these people work, for whom LHA supplements their
income. Some live in housing owned by the local authority or a housing association, whose rent may be paid
by the tenant (generally below the market rent) or paid in full through LHA. Others may rent a home from a
private landlord, with LHA in part or in full.

\textsuperscript{114} Harrington Review
\textsuperscript{115} London Borough of Hackney
Reform of housing related benefits will impact differently depending on whether the tenant rents from the Local Authority, a Social Registered Landlord, or a Private Sector Landlord. The following changes to Local Housing Allowance payable to claimants in the private rented sector are currently being introduced (see Table 2.11 for timescales):

- Reduce all Local Housing Allowance rates so that about 3 in 10 properties for rent in the area should be affordable to people on Housing Benefit rather than 5 in every 10 properties as now. This will result in a shortfall of on average £28 per week (range £0.02 – £220 per week).
- Introduce absolute caps on Local Housing Allowance weekly rates payable for tenants in the private rented accommodation—£250 (for a 1 bedroom property), £290 (2 bed), £340 (3 bed) or £400 (4 bed).
- Remove the five bedroom Local Housing Allowance rate so that the maximum level is for a four bedroom property.
- Increase the upper age limit for receipt of a shared room rate from 25 to 35 years—affecting about 800 people in Hackney, the majority male.

In addition, the rate by which deductions are made from Local Housing Allowance for non-dependents living in that household will increase; i.e. people of working age living in a household will be expected to contribute more towards the rent. The £15 maximum weekly Local Housing Allowance excess is also being withdrawn, affecting 830 households in Hackney.

These changes are expected to lead to a significant financial shortfall for a number of households if they remain in their current accommodation, particularly for larger households that are currently in accommodation with 5+ bedrooms. The changes will affect claimants on the anniversary of their claims, although some transitional protection is available for up to 9 months. This transitional protection ended for the first customers in January 2012.

National, regional and local analysis points to the potential for a significant reduction in household income for those claimants affected, particularly larger families with 3+ children in the private rented sector. Child poverty is of particular concern because of its effects on the physical and mental development of children affected. In London, only 48% of lone parent work compared to 59% nationally, and women are predicated to experience disproportionate impact from changes to welfare as more than 90% of lone parents are women.

A number of changes are proposed to tenancies in the social rented sector, including freedom for RSLs to charge new tenants up to 80% of the market rent, and a focus on reducing under occupation. We will report on these next year as further details emerge.

**Universal Credit**

The longer term objective of the Bill is to streamline the benefits system with the introduction of a single benefit, known as Universal Credit, which will replace many current benefit entitlements including Job Seeker’s Allowance, employment support allowance, housing benefit, child benefit, and child tax credit. The sum of these benefits is the total credit to which they are entitled, and this will be capped at a maximum benefit entitlement, which is currently expected to be based on UK median earnings (currently £350 a week for a single person household, and £500 for all others). The cap will not apply to working households in receipt of benefit.

The reform will introduce a working age credit that provides a basic allowance with additional elements for disability, children, housing and caring. Some key changes are summarised below.

- Making receipt of benefits for those able to work conditional on the willingness to work, and participation in work related activity. People on Jobseeker’s Allowance who refuse to join the Work Programme will lose the right to claim out-of-work benefits; people who refuse to accept ‘reasonable job offers’ could forfeit benefits for up to three years.
- Introducing work (for benefit) programmes for unemployed people.
- Reforming the administration of tax credits to reduce fraud and overpayments, and reduce penalties for couples.
Reforming Access to Work so disabled people can apply for jobs with funding already secured for adaptations and equipment needed.

100% withdrawal of benefit for unearned income, and earned income will be subject to a 65% withdrawal of benefit rate.

There is ongoing debate about the potential for Universal Credit to improve the welfare system. However, there are concerns about its potential to increase income inequality and child poverty, particularly in the South East given the high costs of housing and childcare.

The Institute for Fiscal Studies initial analysis of Universal Credit identified that a total of 2.5 million families will gain, and, in the long-run, 1.4 million families will lose and 2.5 million families will see no change in their disposable income because their entitlements to Universal Credit will match their current entitlements to means-tested benefits and tax credits. Overall, Universal Credit will benefit poorer families. The bottom six-tenths of the income distribution will gain on average, while the richest four-tenths will lose out slightly in the long-run. And on average, couples with children will gain more (in cash and as a percentage of income) than couples without children, who will in turn gain more than single adults without children. Lone parents will, on average, lose in the long-run.

More recent research, funded by the Joseph Rowntree Foundation, reviewed the ability of Universal Credit to impact on absolute and relative poverty. The report concludes that universal credit is not enough to prevent rising poverty. The key findings conclude:

- 2012 – 2013 is likely to see a decline in real income and absolute poverty is forecast to rise by about 600,000 children and 800,000 working age adults
- Longer term, Universal Credit will impact on absolute poverty reducing it by about 450,000 children and 600,000 working age adults in 2020-2021
- Other tax and benefit changes, such as the switch from the Retail Price Index to the Consumer Price Index as the measure of inflation, could counteract Universal Credit’s impact on poverty resulting in increases in both absolute and relative poverty.

What do these changes mean for people in Hackney and the City?

The scope and scale of the changes to the welfare system are likely to have profound effects on the households affected in Hackney and the City. We currently predict a shortfall in income for a large number of households during 2012, the largest shortfalls arising from reductions in LHA. How these households will respond is not predictable, and in part will depend on the degree of shortfall they face. Options include:

- Renegotiation of rents with landlords
- Redeployment of the household income to meet the shortfall in LHA- reducing spending on food, heating, travel, leisure.
- Supplementing this income: through financial support from friends/family, through the informal economy, or by additional non-dependents joining the household that contribute to household expenses.
- Increased personal debt- through personal loans, or rent arrears. These households may have a poor credit rating, and be vulnerable to loan sharks and pay day loan companies. This also carries the risk of repossession, or non-renewal of a tenancy.
- Finding employment-but in the short term this has implications for continued receipt of benefits. In the longer term Universal Credit may increase work incentives as the cap will not apply to working households.
- Moving house- either to a smaller/ lower rent property in the same area, or to a cheaper area. Larger households could split themselves between two properties.

A review by London Councils points to the potential consequences for local government services of the reforms. It highlights that the reforms will impact on workless households and on families, consequent migration leading to a redistribution of these households across or outside London, and hence of who is accountable for meeting the health needs and inequalities that these households face. Service planning (based on an understanding of needs and resources) will have to keep pace with this migration. Given the importance of housing and income as determinants of health, this should be a key consideration in the transfer of responsibility for public health outcomes from the NHS to local authorities planned for April 2013.

In terms of priorities to protect the health and well being of these households through these changes:

- People will need advice, advocacy and support through the reforms, given the phasing and complexity of the changes. We would anticipate an increase in demand for benefits advice and support services, and there is some evidence of this already locally.
- Prevent overcrowding and homelessness - these are already significant issue in Hackney (see section) and could be exacerbated.
- Identify and support people who do not engage in the changes or drop out, to prevent homelessness and/or destitution.
- Establish good links between the new Work Programme and local services to give people the best chance of good employment or enterprise.
- If people have to/decide to move, consider what support they will need and help them plan eg re-registering with school or GP, access to formal and informal support networks (including carers), and ensuring good safeguarding procedures for vulnerable children and adults are maintained through good communication and hand over.

### Crime and safety

Crime affects the health of individual victims and the communities within which they live and has an impact on local health services. Perceptions of the incidence of crime and feelings of personal safety can have widespread effects on the way we live. Fear of crime can be a debilitating experience for many people. In the 2008 Place Survey, Hackney residents identified the level of crime both as the most important factor in their...
assessments of whether somewhere was a good place to live\textsuperscript{117}. Residents were most likely to say that drugs are a problem in the borough, as well as public drunkenness and rowdy behaviour.

In 2008, almost all City residents said they felt safe when outside in the local area during the day, and over four in five felt safe after dark. Residents viewed drunkenness and rowdiness in public places as the biggest local anti-social behaviour issues, followed by noisy neighbours, teenagers hanging around on streets, and rubbish and litter\textsuperscript{118}.

### Crime and community safety in Hackney

#### 2011 update

The overall recorded crime rate continues to fall year-on-year in Hackney. Youth-related crime, gang-related crime and knife and gun offences have also decreased, though the impact of the summer riots on crime statistics has yet to be felt.

Reports of disorder such as rowdy inconsiderate behaviour, noise and nuisance neighbour complaints have all risen, though this may reflect increases in reporting.

#### Focus on inequalities:

- Areas with higher levels of deprivation are correlated with high levels of crime particularly in Central, South and South East Hackney. Just under a half of all disorder occurs in seven wards, with a quarter in Haggerston, Hackney Central and Chatham.

- Most of the victims of knife and gang related crime attending Homerton Hospital A&E Department are of Black or Turkish ethnicity.

- Most victims of domestic violence are females aged between 10 and 29, and many have been the victim of crime in the previous twelve months.

Policy on crime and community safety in Hackney is overseen by the Hackney Community Safety Partnership. The data in this section is a summary of the evidence in the Partnership’s most recent Strategic Assessment\textsuperscript{119}.

Since 2002/03 recorded crime in Hackney has fallen: in 2010/11 there were 11,250 fewer victims of crime than in 2002/03. In 2010/11, 28,032 crimes were recorded in Hackney by the Metropolitan Police, down from 29,715 crimes in 2008/09\textsuperscript{120}.

The rate at which crime is falling has slowed and crime levels are beginning to plateau. This is also reflected in national and regional crime statistics and in the findings of the British Crime Survey.

Between 2008/09 and 2010/11, Hackney’s performance was measured against the following indicators: most serious violence, serious acquisitive crime, drug related offending, number of drug users in effective treatment, repeat incidents of domestic violence, adult re-offending rates, and serious gun and knife crime rates. Against these indicators, performance in 2010/11 was very good. Targets were met or exceeded in all but one category: there was a 5% increase in knife crime. This was attributed to an increase in ‘knife not seen /intimated’ offences as there was a 3.5% reduction in crime where a knife was actually present.

Youth related crime rates have also improved: the number of people on youth justice orders has halved since 2007/08, and the number of first time entrants to the youth justice system has fallen by 57% since 2008/09. There were also reductions in the number of custodial sentences for young people.

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\textsuperscript{118} Assessing the City of London’s performance. Results of the Place Survey 2008/09 for the City of London Corporation and partners. Ipsos Mori/City of London Corporation, 2009.

\textsuperscript{119} All data from Team Hackney: Hackney Community Safety Partnership Strategic Assessment, Financial year 2011/12-13 except where indicated

\textsuperscript{120} Metropolitan Police Crime Mapping data tables, 2011
Incidents of hate crime are rare in Hackney: 1.2% of incidents reported to the Met Police are qualified as ‘hate’ (though these crimes are known to be under-reported). The Hackney Cohesion Review found that communities are both accepting and tolerant of people from different backgrounds, but research in Muslim communities found that some Muslims feel disengaged from the wider community mostly due to the perception of Islamaphobia. In 2010/11 both racial and homophobic crime reduced, but it is not clear if this represents a drop in incidence or a drop in reporting.

Although crime has fallen, disorder increased by 31% in 2010/11, particularly rowdy inconsiderate behaviour (up 25%), noise (up 126%), and nuisance neighbour complaints (up 54%). It is believed that this is largely due to service improvements resulting in increased reporting.

Areas with higher levels of deprivation are correlated with high levels of crime, particularly Central, Southern and South East Hackney. Crime is significantly higher in Haggerston than any other ward, and over half of all crime occurs in only seven wards; with a quarter in Haggerston and Dalston alone. Antisocial behaviour/disorder levels are also significantly higher in Haggerston than elsewhere. Just under half of all disorder occurs in seven wards with a quarter in Haggerston, Hackney Central and Chatham. The six wards with the most consistently high crime and disorder are: Haggerston, Dalston, Hackney Central, Chatham, Queensbridge and Hoxton.

Hackney’s Community Safety Partnership reports local crime and safety issues against six themes which locate crime statistics within a broader context of evidence and scope for action. These are

- youth crime, disorder and engagement;
- alcohol related crime / disorder and safer socialising;
- domestic violence, rape and sexual assault;
- nuisance neighbours and domestic noise
- drug and substance misuse

**Youth crime, gangs, perception of youth disorder and youth engagement**

Perception of youth crime and disorder remain an issue for Hackney’s residents, in particular youth related disorder, youths hanging around, gangs and youths on bikes.

From January to September 2011 there were no gang related murders in Hackney, and gang related violence, gun and knife crime have reduced since the initiation of Hackney’s Integrated Gangs Intervention Project. However 9% of attendances at Homerton A&E are for knife-related injuries consistent with gang related violence, and 2% of attendances are directly attributed to gangs. Gun injuries account for 1% of attendances. Most victims are of Black or Turkish ethnicity and in their 20s (although victims range between 15 and 49 years which means that gang related violence is not just a youth problem).

There is limited information available about the role of girls in gangs, and associated sexual assaults, but work is underway to address this gap. Youth related disorder is difficult to determine on the basis of available data, but analysis reveals that over half of all youth related ASB occurs in Victoria, Chatham, De Beauvoir, Queensbridge, Hackney Downs and King’s Park.

**Alcohol-related crime and disorder, licensing and safer socialising**

Alcohol related incidents are correlated with licensed premises in Haggerston, Dalston and Stoke Newington, and high volume areas in Hackney Central and Chatham (along Mare Street). Regeneration, improved transport connections, growth in night time economies and the Olympics will bring more visitors and with them increased opportunity for crime and disorder and environmental pollution (such as noise and waste).

Analysis of alcohol related violence attendances at Homerton A&E found that most admissions occur at weekends (Friday to Sunday) late at night (including early morning), in the vicinity of pubs, clubs, bars, and public places, and bottles are twice as prevalent as weapons at weekends. Most victims are male, aged between 18 and 35 years, and incidents often involve multiple unknown perpetrators. Alcohol related incidents during weekdays involve a higher proportion of women than at weekends, and often involve a
friend, family member or acquaintance with the incident occurring at home; this suggests a link to domestic violence.

**Domestic violence, rape and sexual assault**

Overall sexual offences fell in 2010/11 though the incidence of rape increased slightly. Dalston has significantly higher levels of rape and sexual assault, whilst Haggerston has much higher than average levels. Research into serious sexual assault found that domestic related sexual assaults are more likely to occur during the week, which is consistent with the findings of analysis of hospital admissions. Most victims are White or Black females aged between 10 and 29, and many have been the victim of crime (any crime) in the previous twelve months. Most offenders are also White or Black in ethnicity.

Research also found a link between sexual assault and areas highly concentrated with licensed premises and drugs; in this context young women and young gay men are at higher risk. Other groups at risk include sex workers and those with learning difficulties.

There were 1,558 incidents of domestic violence reported to the Metropolitan Police in 2010/11. This was a decrease of 18% on the previous year, moving Hackney from having the third highest rate in London to the fourth lowest. However these statistics do not reveal the extent of repeat victimisation and victims of domestic violence are the most likely of all crime victims to experience repeat victimisation.

Domestic violence attendances at Homerton A&E account for 13% of all attendances, but this might underestimate the extent of the problem since 16.5% of all attendances involve a perpetrator described as a partner or family member. Other issues of concern are female genital mutilation, forced marriage and honour based violence. There are gaps in our understanding of domestic violence, not least because of the estimated levels of under-reporting.

London Borough of Hackney’s Domestic Violence and Hate Crime Team received 707 reports of domestic violence in 2010/11, marginally lower than the 720 received in the previous year. Compared to the population profile, victims of domestic violence are more likely to be women, to have children and to be of Black ethnicity

**Nuisance neighbours and domestic noise**

There were large increases in the number of noise and rowdy nuisance neighbour complaints made to police and other agencies in 2010/11 (noise up 126% and rowdy neighbours up 54% from the previous year). Together they are responsible for 17% of all reported disorder. If council noise figures are added this rises to 40%, with noise alone responsible for 35%.

Noise complaints to the police have been growing since 2007/08 and noise complaints to the council’s environmental noise team increased 10% in 2010/11. Haggerston is the ward with most related complaints, many of which may be related to the night time economy. Of the complaints made to the council, half were from a unique source, so repeat calls are common. In the last year there has been a 13% increase in warning letters, an 11% increase in noise abatement notices and a 32% increase in number of breach-of-notice letters. In most cases a warning letter prevents further occurrences.

Rowdy and nuisance neighbour complaints may also involve domestic noise. It is possible that building design and poor sound insulation contribute to neighbour disputes, and the high density population may also be a contributory factor. Neighbour disputes do not appear to be focused in any specific location, but many of the wards reporting fewer issues are located in areas with lower levels of deprivation. Neighbour disputes rose by 30% in Haggerston, 77% in Hackney Central and 37% in Leabridge.

**Substance misuse, treatment and drug dealing**

The number of problematic drug users (PDUs) in Hackney has decreased in recent years, mostly due to changes in calculating methodology, but there is also evidence that drug use trends are changing in Hackney,
away from heroin to cocaine, cannabis, mephadrone and ‘legal highs’. Hackney’s drug using population has complex needs linked to higher than average levels of housing, mental and physical health needs. For more details, see page 115.

Street drinking reduced 66% in Hackney 2010/11. This is attributable to improved partnership working, targeted action and outreach and the continued enforcement of the Designated Public Place Order (DPPO) and dispersal zones.

**Hate crime**

Hate crime can include homophobic, transphobic, racist, disablist, sexist, ageist, anti-Semitic, Islamophobic or any other faith related hate crime. In the year to January 2012 there were 239 instances of racist and religious hate crime recorded by the Metropolitan Police in Hackney, a 27% decrease on the same period in the previous year. However homophobic crime increased: there were 68 reports in the same period compared to 45 the previous year.

Hackney Council’s Domestic Violence and Hate Crime Team managed and advocated for 29 hate crime instances in 2010/11 of which 18 were racial harassment cases.

**Crime and community safety in the City**

Policy on crime and community safety in the City is overseen by the Safer City Partnership. The priorities of this partnership are:

- Anti-social behaviour
- Domestic abuse
- Reducing re-offending
- Night-time economy issues
- Fraud and economic crime
- Counter-terrorism
- Vehicle crime

Although the City has a small resident population, policing encompasses over 340,000 daily commuters and visitors. The most common reported crime in the City is theft and handling which includes shop-lifting, cycle theft and theft from a person.

From 2009/2010 to 2010/11 there were reductions in the rates of reported crime for drugs offences, violence against the person, burglary and criminal damage. The only substantial increase was in fraud and forgery, in part due to changes in the way this is recorded (Table 2.12).

The City of London Police carried out 1,638 drug tests during 2010/11 and of these approximately 25% were positive for opiates, cocaine/crack or both.

The City’s night-time economy has grown over recent years, with a large number of people now visiting the City specifically to socialise in the evenings. There have been significant changes around the opening hours and licensing of venues, particularly with regards to alcohol licensing and smoking legislation. Whilst the night-time economy can be a source of income and employment in the City, it also has negative effects, in the form of violence, noise, and other anti-social behaviour.

In 2010/11 there were 157 domestic violence incidents reported in the City. Of these, 130 were reported to the City of London Police and 27 were reported to the Citizens Advice Bureau.

| Table 2.12. Recorded crimes in The City, 2009/10 and 2010/11[^122] |
|---------------------|----------------|----------------|
|                     | 2009/10 | 2010/11 | change |

[^122]: City of London Police Data
<table>
<thead>
<tr>
<th>Crime: what works?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer influence strategies offering young people advice on how to resist pressure from friends to engage in antisocial behaviour delivered by specially trained, high-status peers rather than by parents or teachers are effective.</td>
</tr>
<tr>
<td>Improving the ways police and health professionals respond to, and report, domestic violence can improve professional results for victims.</td>
</tr>
<tr>
<td>Women experiencing violence from their partner who go to professionals benefit if they are familiar with them, if abuse is acknowledged, respect given and appropriate referrals made.</td>
</tr>
<tr>
<td>Frequent home visiting by health or social professionals during pregnancy and infancy can lead to a reduction in child abuse by parents as well as a longer term reduction in behavioural problems for the children concerned.</td>
</tr>
<tr>
<td>Educating parents and high quality nursery education results in children being less likely to be arrested in later life and more likely to complete their secondary education, have reasonably well-paid jobs and own their homes.</td>
</tr>
<tr>
<td>‘Stop and think’ training can help children to as well as consider the consequences of antisocial behaviour, understand other people’s feelings and solve problems by negotiation rather than aggression.</td>
</tr>
<tr>
<td>Security precautions such as telling neighbours when everyone in the household is away, locking doors and having good lighting are effective burglar deterrents. Burglars are also likely to be deterred by dogs and other security devices.</td>
</tr>
</tbody>
</table>

**Dog bites**

Dogs cause significant injury every year in Hackney. Figure 2.24 shows the number of attendances at Homerton Hospital Accident and Emergency Department every quarter that are related to dog bites. There is considerable variation across the year in the incidence of harm and there is no obvious trend. In 2010/11, 201 people were hurt by dogs compared to 154 in 2009/10 and 307 in 2008/09.
Figure 2.24 Accident and Emergency attendances at Homerton Hospital related to dogs (SUS - local hospital data)
Chapter 3:  
Lifestyle and behaviour

This chapter explores the impact of lifestyle and behaviour on health and wellbeing. These are issues over which we may feel we have control but often find we do not have as much control as we want, to the detriment of our health and wellbeing: smoking, alcohol consumption, physical exercise, diet, drug misuse and sex.

Understanding the patterns and determinants of these behaviours enables us to predict levels of chronic diseases such as heart disease, cancer and diabetes, the major contributors to premature deaths in Hackney and the City. In addition, excessive alcohol consumption and long term drug use can also have economic and social impacts such as reduced employment opportunities, increased criminal activity and lower incomes.

Smoking

Tobacco is the only legal product which kills people when it is used as intended. Despite a long-term decline in smoking prevalence, millions of people remain addicted to nicotine: in England today, over a fifth of the adult population smokes: 22% of men and 21% of women, a total of 8.8 million people123.

Smoking remains the main cause of preventable disease and premature death in the UK. Nationally it accounts for 1 in 5 of all deaths, 1 in 3 cancer deaths and 15% of deaths due to coronary heart disease. Half of all regular smokers are killed by tobacco and 50% of these deaths will occur before the age of 70124. Stopping smoking is the most important way of reducing mortality and morbidity in Hackney and the City. It is also the primary means of tackling health inequalities locally.

In February 2010, The Department of Health published a new tobacco control strategy, A Smokefree Future, which outlined the approach for England for the next 10 years. In March 2011, an action plan was published including the following targets for reducing smoking prevalence by 2015125:

- From 21.2% to 18.5% or less among adults

• From 15% to 12% or less among 15yr olds
• From 14% to 11% or less among pregnant women

Tobacco control programmes are designed to include any strategies that will help lower the prevalence of smoking. These include: limiting the availability of tobacco; restricting promotion; preventing smoking uptake; eradicating sales of counterfeit and illegal products; enforcing underage sales legislation; educating the public about the dangers of tobacco use; motivating and helping smokers to quit; reducing exposure to secondhand smoke and potential dangers from fire; and regulating the tobacco industry. In order to achieve a reduction in smoking prevalence a combination of the above approaches need to be delivered. A reduction in smoking prevalence cannot be achieved by smoking cessation services alone.

The burden of tobacco in Hackney and the City is not a problem that can be tackled by one person, group or organisation alone. High impact changes will only be achieved if all agencies work in partnership and engage with each other to promote streamlined, multi-agency working. One of the top priorities for 2010/11 was to establish local Tobacco Control Alliances in Hackney and the City. A Tobacco Control Alliance is a collaboration of agencies working towards an agreed set of outcomes for tobacco control. The Alliances are responsible for overseeing a range of workstreams identified within the local tobacco control strategy.

Smoking and health inequalities

Focus on inequalities:
• Smoking is the single biggest determinant of the health inequalities between socioeconomic groups
• Smoking is increasingly concentrated in the poorest families who can least afford to smoke: 70% of households on income support spend an average 15% of their disposable income on tobacco
• The highest smoking prevalence rates are in the most marginalised groups including rough sleepers, people with severe mental health problems and substance misusers
• Smoking during pregnancy is three times more common among women in the lowest socioeconomic groups compared to the highest socioeconomic groups

Socioeconomic status

Smoking is a key contributory factor to health inequalities between socio-economic groups in the UK and accounts for a major part of the differences in life expectancy between manual and non-manual groups.126 People in lower social classes are more likely to die early due to a range of factors of which smoking is the dominant factor: smoking accounts for over half of the difference in risk of premature deaths between social classes.127 Premature deaths due to lung cancer are five times higher among men in unskilled manual work compared with those in professional work.128 It is estimated that smoking prevalence amongst professional and managerial groups is as low as 15% compared to 29% amongst routine and manual groups.129 Smoking is increasingly concentrated among the poorest families, who can least afford to smoke, and a higher rate of smoking in this group is matched with poorer health outcomes and higher rates of disease and illness. Lower socioeconomic groups spend a disproportionately larger proportion of their income on cigarettes with the poorest tenth of the population spending around 15% of their weekly income on tobacco compared to a

128 ASH. Facts at a glance: Smoking statistics.
population average of 2% of weekly income. It is estimated that over 70% of households on income support spend an average 15% of their disposable income on tobacco and 55% of lone mothers smoke on average 5 packets of cigarettes per week.

Smoking rates amongst the most disadvantaged socioeconomic groups have remained static for over a decade. Targeting quitting support in deprived areas is therefore an effective approach to reducing health inequalities. The reasons why greater numbers of people from lower socio-economic groups smoke include a history of smoking in the family (growing up with a parent smoking), a lack of financial security, a poor quality living environment, isolation, the stress of caring for others, poor health and low self esteem.

People in lower socio-economic groups are just as motivated to quit as smokers in professional groups but quit rates are lower and they are more likely to relapse due to higher levels of dependency. More disadvantaged smokers are more dependent on nicotine: they tend to smoke more cigarettes, smoke them more intensively and smoke them for longer.

**Homelessness, mental health and drug use**

In very deprived groups smoking prevalence is even higher. For example smoking prevalence among homeless people sleeping rough is estimated to be as high as 90% and smoking rates are significantly higher among those with mental disorders. Studies have shown smoking prevalence to be as high as 80% amongst people with schizophrenia, and people with depression are more likely to smoke and to have difficulty when trying to stop. Levels of nicotine dependence vary depending on the severity of mental illness but smokers with mental health problems are likely to smoke more heavily and therefore be more nicotine dependant than the general population. In addition, people with poor mental health are less likely to be offered smoking cessation support despite studies suggesting they are just as motivated to quit as the general population.

Smoking is strongly associated with substance misuse, with smoking prevalence as high as 80% among those attending methadone maintenance treatment clinics. More than two thirds of drug misusers are regular tobacco users; smoking at an early age is associated with substance misuse; and people who smoke tobacco are more likely to use cannabis and abuse alcohol.

**Ethnicity**

Smoking rates vary considerably amongst ethnic groups with high prevalence rates in certain groups including: Bangladeshi men (36%), Black Caribbean men (37%) and other White men (30%) men and Black Caribbean women (22%), Irish women (23%) and other White women (23%). Use of different tobacco products, including shisha and smokeless tobacco, is more common among minority ethnic groups, indicating the need for greater enforcement of regulations on labelling and packaging of smokeless tobacco products to protect minority ethnic communities from the health risks. In addition, studies show that ethnic minorities have

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132 Department of Health (2003). Tackling Health Inequalities – A programme for action
134 Kotz, D. and West, R. (2009) Explaining the social gradient in smoking cessation: it’s not the trying, it’s in the succeeding. Tobacco Control 18: 43 - 46
less knowledge of the dangers of cigarette smoking and disease and are less likely to cite smoking as a health risk\(^\text{143}\).

In Hackney, local research identified high rates of smoking in the Turkish and Kurdish communities and in the White British population\(^\text{144}\). The research also identified specific smoking behaviours and preferences in these and other local communities (see box on page 92).

**Children**

It is estimated that every year, nationally, around 200,000 children and young people start smoking regularly. Of these 67% start before the age of 18 and 27% of 11 - 15 year olds have smoked at least one cigarette\(^\text{145}\). Young people from deprived backgrounds are marginally more likely to take up smoking than those from affluent backgrounds but the difference is not significant. However by the time they are 30, 50% of those young people from affluent backgrounds will have given up smoking compared to just 25% in the lowest income group\(^\text{146}\). The younger the age of uptake of smoking, the greater the harm is likely to be plus it is associated with heavier smoking, higher dependency and lower chances of quitting\(^\text{147}\). Girls are more likely to smoke than boys and young people who truant from school are twice as likely to become regular smokers, however the proportion of young people who think it is acceptable to smoke has dropped from over 50% in 1999 to 35% in 2010.

**Pregnancy**

Smoking in pregnancy is the single most preventable risk factor for adverse outcomes in pregnancy. It is estimated that it contributes to 40% of all infant deaths, a 12.5% increased risk of a premature birth and a 26.3% increased risk of intra-uterine growth restriction\(^\text{148}\). The highest smoking rates are found among expectant mothers under the age of 20 and among women who left school at the minimum leaving age and with no educational qualifications\(^\text{149}\). Consistently smoking among pregnant women in the lowest social groups has been about three times that of pregnant women in the highest social groups\(^\text{150}\).

**Prevalence of smoking**

### 2011 update

Nationally, the most recent data suggest that the long-term decline in smoking has halted and prevalence rates remain stable for both men and women.

**Focus on inequalities**

In Hackney:

- The great majority of smokers are of working age.
- Prevalence is higher than average in the White population and lower than average in the Black and Asian populations in Hackney. There is very high prevalence of smoking in the Turkish and Kurdish communities.


\(^\text{144}\) Continental Research: Turkish and Kurdish smokers in the borough of Hackney, COI/City and Hackney Primary Care Trust, 2009.


Prevalence of smoking is high among people with mental illness but below average among people with learning disabilities and people who are housebound, deaf or blind.

In the City of London, there is a high prevalence of smoking in the working population.

Nationally, smoking prevalence has declined over the past decade though in the last two years of recorded data, 2007 to 2009, this decline has stopped, for both men and women (Figure 3.1). In 2009, 21.8% of men and 19.7% of women in England smoked.

Local data on smoking prevalence is available from two sources: a subsample of the national Integrated Household Survey conducted in 2009/10 and GP records of patients’ smoking behaviour. The former indicates a high prevalence of smoking in Hackney: over a quarter (27%) of all residents are current smokers (Figure 3.2). This is significantly higher than the average for London and the prevalence rates in the neighbouring boroughs. However, an earlier assessment of local prevalence in the Health Survey for England put smoking prevalence in Hackney and the City in 2006-08 at 32%. This suggests that efforts to reduce local prevalence are having an impact.

The prevalence of smoking recorded by GPs locally is much lower. In 2011, 19% of the GP-registered population reported that they were smokers. However, this may be an underestimate as smokers may not report their behaviour to their GP.

The variations in smoking prevalence within the GP-registered population of Hackney by age, ethnicity and care group are illustrated in Figures 3.3 to 3.5. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup. Rates of smoking decline in adults with increasing age – this will in part be due to higher mortality among smokers. The great majority of smokers are of working age. Prevalence is higher than average in the White population and lower than average in the Black and Asian populations in Hackney. Prevalence of smoking is particularly high among people with mental illness but below average among people with learning disabilities and people who are housebound, deaf or blind.

Local studies into Hackney’s population have found high smoking prevalence in specific communities: 68% in the Turkish and Kurdish communities and 43% in the white British population (see box below).

The City

Although data is not available on smoking prevalence among the residents of the City of London, a local study revealed that 54% of City workers smoked (170,000 people). This is an exceptionally high prevalence rate and indicates a major long-term burden of ill health in this workforce. City workers indicated that they would be most willing to attend drop-in stop smoking clinics as a route to quitting.

The study found that a key correlate of smoking is stress - 34% of respondents gave this as the reason for smoking. Forty-four percent of respondents said they smoked mainly at work and, of these respondents, 37% smoke because of stress and 22% to help with keeping alert. Only 15% of respondents smoke mainly because they enjoy it. A reduction in the number of smokers in the workforce would result in employees that are more motivated and free from the illnesses associated with smoking. This in turn would help to reduce unplanned absenteeism and increase productivity, morale and staff retention.

Despite the national decline in smoking prevalence, each year many young people take up smoking. For secondary school children aged 11 to 15, the prevalence of those who smoke regularly (at least 1 cigarette a week) goes up from 1% at age 11, to 15% at age 15. Girls are more likely to be regular smokers than boys (19% of girls, 12% of boys) smokers at age 15.

Figure 3.1. Smoking prevalence in England (NHS Information Centre)

151 Continental Research: Turkish and Kurdish smokers in the borough of Hackney, COI/City and Hackney Primary Care Trust, 2009.
Figure 3.2 Self-reported smoking prevalence, 2009 (Integrated Household Survey)

- **Current smoker**
  - Hackney: 52%
  - Tower Hamlets: 49%
  - Newham: 59%
  - London: 49%

- **Ex smoker**
  - Hackney: 22%
  - Tower Hamlets: 28%
  - Newham: 20%
  - London: 30%

- **Never smoked**
  - Hackney: 27%
  - Tower Hamlets: 22%
  - Newham: 20%
  - London: 20%

Figure 3.3 Prevalence of smoking in Hackney by age: overall numbers per age group and rate per age group, 2011 (CEG)
Communities affected by smoking: results from local research

Turkish and Kurdish smokers

Up to 68% of the local Turkish and Kurdish communities smoke. Around a third had attempted to quit within the last six months. Seven per cent had used a local stop smoking service. The community has a strong preference for one to one counselling services, and there is a strong preference for services to be located at a hospital. Seventy-six per cent started smoking under the age of 20. There is a strong preference for Turkish speaking services and there is significant demand for a Sunday afternoon service. A service to meet these needs has since been set up at the Homerton Hospital.

White British smokers

Research identified that 43% of Hackney’s white British population smoked. Around a third were trying to quit or had made a quit attempt in the past two years and 61% had managed to stop for over four weeks. Awareness of NHS Stop Smoking Services was strong with over two fifths (42%) of all respondents claiming they would be likely to use a local Stop Smoking Service in future, rising to three fifths among those who had used an NHS Stop Smoking Service in the past (59%). Attitudes towards smoking showed that the vast majority believed cigarette smoke is harmful to children, a majority smoked to reduce stress and give them something to do while a minority felt that smoking was part of their identity, helped them perform better at work, or improved social cohesion - giving them social confidence or acceptance from family and friends.

Somali smokers

Few can afford Western style cigarettes on a regular basis and often purchase individual cigarettes. The young aspire to emulate Western images and society - smoking is perceived as a sign of sophistication, being ‘cool’, showing off and a way of impressing others. Additionally, smoking is seen as a means of forgetting life’s challenges such as poverty and war.

Polish smokers
The local health impacts of smoking

2011 update

The rates of smoking-attributable deaths and hospital admissions are high in Hackney.

The impact of smoking on the health of local people is profound. The main indicators of smoking-related harm are deaths attributed to smoking and hospital admissions attributed to smoking. In Hackney:

- Among people aged 35 and over, between 2007 and 2009, there were 254 deaths per 100,000 residents every year that could be attributed to smoking. This is significantly higher than the averages for London (208 deaths per 100,000 per year) and England (216 deaths per 100,000 per year)
- Among people aged 35 and over, in 2009-10, there were 1,580 hospital admissions per 100,000 residents every year that can be attributed to smoking. This is also higher than the averages for London (1,342 admissions per 100,000 residents) and England (1,417 admissions per 100,000 residents)

The following indicators also reflect the harm of smoking in Hackney. Between 2007 and 2009:

- There were 46 smoking attributable deaths from heart disease per 100,000 residents every year
- There were 14 smoking attributable deaths from stroke per 100,000 residents every year
- There were 42 deaths from lung cancer per 100,000 residents every year
- There were 30 deaths from chronic obstructive pulmonary disease per 100,000 residents every year

These rates are all higher than London and England averages but only the first is significantly higher than the England average.

The City

Data is not available for City residents due to small numbers

Preventing young people from starting smoking: what works

There is increasing evidence that a comprehensive integrated approach to smoking prevention can reduce smoking rates amongst young people.

Recent reviews of prevention programmes found that the most effective campaigns were sustained for at least two years and were relatively intense. They used a variety of media with brief repeated messages that motivated young people to remain tobacco free.

The effective messages were designed to provoke emotional reactions among young people. They were of two types - exposing the strategies of the tobacco industry, and providing information and support to help young people to remain non-smokers.

Successful interventions and the messages should be based on initial market research or built on successful components of previous campaigns.

School based prevention programmes should have the following features in order to increase the likelihood of programme success:

- Programmes should be built upon the effective elements of existing campaigns
- Programmes need to be flexible to address variability between communities

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153 London Health Observatory Tobacco Control Profiles
Developmental work should be carried out with representative samples of the target audience to implement appropriate messages and activities.

Programme messages and activities should be guided by theoretical constructs.

Community activities need to reach the intended audience.

**Quitting services**

**2011 update**

The local smoking cessation target set by the DH for City and Hackney was exceeded in 2010/11 when over 2,200 people quit smoking for at least four weeks.

**Focus on inequalities:**

- In both Hackney and the City, quit rates are comparable across socio-economic groups among employed people, contradicting the national trend for greater quitting success in higher socio-economic groups.
- In Hackney, quit rates are lower in the younger age groups, among Irish and Asian smokers and among the unemployed.
- In the City, quit rates are lower among Black and Asian smokers and among those not working.

In 2010/11 a total of 6,733 people accessed the smoking cessation services in Hackney and the City and 2,216 (30%) went on to be successful four week quitters. This exceeded the Department of Health target for Hackney and the City of 2,020 four week quitters.

In Hackney, 4,768 people set a quit date in 2010/11 and 1,454 (30%) went on to be successful four week quitters. Table 3.1 describes the quit rates across different population subgroups. Quit rates are lower in the younger age groups, among Irish and Asian smokers and among the unemployed. However, among employed people, quit rates are comparable across socio-economic groups – an important achievement, given the typically greater nicotine dependence of smokers in lower socio-economic groups.

**Table 3.1 People not smoking four weeks after quitting: absolute number and percentage of those who set a quit date, by population subgroup in Hackney, 2010/11 (DH)**

<table>
<thead>
<tr>
<th>Population group</th>
<th>Number of four week quitters</th>
<th>% those who set a quit date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>687</td>
<td>30%</td>
</tr>
<tr>
<td>female</td>
<td>767</td>
<td>31%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>under 18</td>
<td>18</td>
<td>18%</td>
</tr>
<tr>
<td>18-34</td>
<td>377</td>
<td>25%</td>
</tr>
<tr>
<td>35-44</td>
<td>368</td>
<td>30%</td>
</tr>
<tr>
<td>45-59</td>
<td>448</td>
<td>33%</td>
</tr>
<tr>
<td>60+</td>
<td>243</td>
<td>39%</td>
</tr>
</tbody>
</table>
The City and Hackney Health and Wellbeing Profile: our joint strategic needs assessment, 2011/12

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>620</td>
<td>32%</td>
</tr>
<tr>
<td>Irish</td>
<td>35</td>
<td>26%</td>
</tr>
<tr>
<td>White other</td>
<td>353</td>
<td>32%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>88</td>
<td>36%</td>
</tr>
<tr>
<td>Black African</td>
<td>52</td>
<td>34%</td>
</tr>
<tr>
<td>Asian</td>
<td>56</td>
<td>25%</td>
</tr>
<tr>
<td>Mixed</td>
<td>115</td>
<td>35%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work/ socio-economic status</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>unemployed</td>
<td>230</td>
<td>26%</td>
</tr>
<tr>
<td>student</td>
<td>62</td>
<td>33%</td>
</tr>
<tr>
<td>retired</td>
<td>115</td>
<td>46%</td>
</tr>
<tr>
<td>sick/disabled</td>
<td>105</td>
<td>36%</td>
</tr>
<tr>
<td>carer</td>
<td>55</td>
<td>42%</td>
</tr>
<tr>
<td>employed: managerial/professional</td>
<td>171</td>
<td>35%</td>
</tr>
<tr>
<td>employed: intermediate professions</td>
<td>51</td>
<td>32%</td>
</tr>
<tr>
<td>employed: routine and manual</td>
<td>193</td>
<td>33%</td>
</tr>
</tbody>
</table>

The City

In the City, 1,971 people set a quit date in 2010/11 and 762 (39%) went on to be successful four week quitters. Table 3.2 describes the quit rates across different population subgroups. The majority of those accessing quitting services were City workers, rather than residents, of whom most were in managerial or professional roles. However quit rates were slightly higher among the smaller numbers of people in intermediate and routine and manual professions. Quit rates were lower among Black and Asian smokers and among those not working.

Table 3.2 People not smoking four weeks after quitting: absolute number and percentage of those who set a quit date, by population subgroup in the City, 2010/11 (DH)

<table>
<thead>
<tr>
<th>Population group</th>
<th>Number of four week quitters</th>
<th>% those who set a quit date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>477</td>
<td>41%</td>
</tr>
<tr>
<td>female</td>
<td>285</td>
<td>36%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-34</td>
<td>332</td>
<td>34%</td>
</tr>
<tr>
<td>35-44</td>
<td>243</td>
<td>41%</td>
</tr>
<tr>
<td>45-59</td>
<td>167</td>
<td>47%</td>
</tr>
<tr>
<td>60+</td>
<td>19</td>
<td>48%</td>
</tr>
</tbody>
</table>
Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British/Irish</td>
<td>594</td>
<td>40%</td>
</tr>
<tr>
<td>White other</td>
<td>71</td>
<td>40%</td>
</tr>
<tr>
<td>Black</td>
<td>&lt;10</td>
<td>30%</td>
</tr>
<tr>
<td>Asian</td>
<td>47</td>
<td>30%</td>
</tr>
<tr>
<td>Mixed</td>
<td>24</td>
<td>36%</td>
</tr>
</tbody>
</table>

Work/ socio-economic status

<table>
<thead>
<tr>
<th>Status</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>not employed</td>
<td>66</td>
<td>30%</td>
</tr>
<tr>
<td>employed: managerial/professional</td>
<td>644</td>
<td>39%</td>
</tr>
<tr>
<td>employed: intermediate professions</td>
<td>23</td>
<td>42%</td>
</tr>
<tr>
<td>employed: routine and manual</td>
<td>27</td>
<td>42%</td>
</tr>
</tbody>
</table>

Alternative approaches to quitting

Currently the majority of smokers are offered the abrupt model and though this is seen as the most effective method of stopping, for the majority of smokers, it is also evident that not all smokers feel they are able to stop this way and that an alternative, more flexible approach is required.\(^{155}\)

Recent research commissioned locally identified a substantial demand for a more flexible services\(^{156}\). Respondents were asked if they would prefer a service that encouraged them to just stop smoking straight away on a set date or a service that encouraged them to cut down. 46% of respondents, who had tried to quit before, expressed a preference for gradually cutting down. This was driven by concerns about the impact of smoking on health but recognition that quitting smoking was hard.

There is a growing body of evidence that the use of NRT while cutting down on cigarettes can be helpful for smokers who find stopping in one step too difficult.\(^{157}\) In addition to cutting down before quitting there is an increasing evidence base that using NRT for a short period before a quit attempt (preloading) results in higher cessation rates\(^{158}\). Systematic reviews found that using NRT while smoking significantly increases the likelihood of long-term abstinence\(^{159}\).

Quitting smoking: what works?

NHS Stop Smoking Services: Service and Monitoring Guidance 2010/11\(^{160}\)

Interventions aimed at supporting smokers to stop smoking should provide the following support:

- Reinforce the motivation to quit and support to set a quit date
- Inform client expectation regarding the structure and process of the intervention
- Assess nicotine dependence and offer appropriate feedback; provide information on tobacco withdrawal and advise on the management of withdrawal symptoms

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\(^{156}\) COI (2010) Understanding White British Smokers in Hackney


\(^{159}\) Stead, L. and Lancaster, T. (2007) Interventions to reduce harm from continued tobacco use. Cochrane database of Systematic Reviews Issue 3

- Provide comprehensive advice on pharmacotherapies, possible side effects and method of access. NRT, Champix and Zyban, combined with behavioural support, are offered as first line treatments. Ongoing monitoring of pharmacotherapies should be provided
- Support clients to build a repertoire of coping strategies and troubleshoot specific client problems
- Conduct regular CO checks, provide feedback on progress and CO verification of quit attempt
- Plan ongoing coping mechanisms, support and pharmacotherapy at end of treatment
- Assess client satisfaction with the intervention provided

**Evidence base for intervention type:**

- **Strong evidence of effectiveness:** Brief and very brief interventions, one to one support, closed group support, telephone support
- **Some evidence of effectiveness:** online support, rapid smoking, Cytisine
- **Insufficient evidence:** couple/family support, open (rolling) group support, drop in support, Allen Carr, Nicobrevin, NicoBloc, St John’s wort, glucose, Lobeline, exercise
- **Evidence of no effectiveness:** hypnosis, acupuncture, acupressure, laser therapy and electrostimulation, anxiolytics (i.e. diazepam), incentives / competitions

**Smoking cessation guidelines for health professionals; an update**¹⁶¹

- GPs, hospitals and community teams should record smoking status of patients on a regular basis
- Primary care, community and hospital teams should regularly provide brief interventions on the benefits of stopping smoking and support patients to access stop smoking services
- Smokers should have access to specialist stop smoking clinics
- Stop smoking services should offer group and individual treatment
- Smokers should be encouraged to use stop smoking medication to aid their quit attempt including, NRT, varenicline and bupropion

**NICE Guidance on smoking cessation services**¹⁶²

- PCTs or commissioners of publicly funded smoking cessation services should assess the need of the local smoking population
- Stop smoking services should target minority ethnic groups, pregnant women, young people and socioeconomically disadvantaged communities in the local population
- Realistic performance targets should be set that reflect the local population demographics, and stop smoking services should aim to treat a minimum of 5% of their population
- Services should aim to see a minimum success rate of 35% and 85% of four week quitters should be CO validated at 4 weeks
- Patients should be offered behaviour support and pharmacotherapy
- Patients should be offered NRT, varenicline and bupropion as appropriate. All pharmacotherapy should be available first line

**NICE Guidance on brief interventions**¹⁶³

- Everyone should be advised to quit, unless there are exceptional circumstances. People who are not ready to quit should be asked to consider the possibility and encouraged to seek help in the future
- GPs should advise patients on the benefits of quitting when they attend a consultation and offer a referral to stop smoking services to those who want to quit
- Nurses in primary and community care should advise everyone who smokes to stop and refer them to stop smoking services
- All other health professionals should refer people who smoke to stop smoking services
- If a smoker is unwilling or unable to accept a referral to the stop smoking service, health professionals, with suitable training, should offer pharmacotherapy and additional support
- Community workers should refer people who smoke to stop smoking services
- Smoking cessation advice and support should be available in community, primary and secondary care settings


¹⁶² NICE Guidance on smoking cessation services - PHI010 [http://www.nice.org.uk/PHI010](http://www.nice.org.uk/PHI010)

¹⁶³ NICE Guidance on brief interventions - PHI001 [http://www.nice.org.uk/PHI001](http://www.nice.org.uk/PHI001)
Monitoring systems should be set up so health professionals have access to information on current smoking status of their patients

**Evidence base for smoking cessation and mental illness**

- Treating tobacco dependence is effective in patients with serious mental illness
- Treatments that work in the general population work for those with serious mental illness and are equally as effective
- Treating patients with stable psychiatric conditions does not worsen state

**Evidence base for harm reduction programmes**

Cut down to quit programmes

- Reducing cigarettes smoked before quit day and quitting abruptly, with no prior reduction, produced comparable quit rates.
- Reduction to quit helps those who have tried to quit a number of times without success and are disillusioned with the abrupt quit method. Offering a reduction to quit also appeals to those who would otherwise not have sought behavioural support and pharmacotherapy because they want to pursue gradual cessation and this is not currently supported.
- Cut down to quit is highly cost-effective compared with no quit attempt and remains cost-effective if dilution from abrupt quitting forms a small proportion of cut down to quit attempts

NRT pre loading

- NRT pre loading improves efficacy by separating nicotine levels from smoking and therefore eliminating smoking reinforcement, or possibly by acclimatising smokers to NRT
- NRT pre loading can potentially increase the reach of NRT. With its demonstrated increased efficacy and potentially increased reach, pre loading represents a real alternative approach to abrupt quitting

**Long term NRT use**

- Only 5% of users take NRT long term
- Users who use NRT long term are more highly addicted, and more likely to smoke for withdrawal relief and weight control.
- It is likely that without long term NRT they would be smoking again
- No evidence of any risks of using NRT long term

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165 Lindson N, Aveyard P, Hughes JR. Reduction versus abrupt cessation in smokers who want to quit. Cochrane Database of Systematic Reviews 2010, Issue 3
Healthy weight, diet and exercise

Obesity

2011 update

After rising sharply, the prevalence of adult obesity in Hackney has fallen for two years in a row, against an ongoing rise in London as a whole. However, more than one in nine adults registered with a GP in Hackney is obese – the fifth highest rate in London.

The proportion of school pupils who are overweight or obese remains high in Hackney and the City but the rates are relatively stable.

Focus on inequalities:

- Prevalence of obesity is higher than average in the Black population in Hackney
- Obesity rates are high among people with mental illness and learning disability and among deaf and blind residents.
- Obesity is more common among women in Hackney than among men.
- There is a high rate of adult obesity in the local Charedi (Orthodox Jewish) population
- Black pupils are most likely to be obese and Asian pupils are least likely to be obese in Hackney
- Nationally, childhood obesity is strongly correlated with deprivation

Obesity is a major public health issue. Being overweight or obese can increase the risk of diabetes, cancer, heart and liver disease, resulting in huge costs to the individual and society. While it is difficult to estimate the wider impacts of people being overweight and obese at a local level, one estimate cites a cost to the NHS in Hackney and the City of £85.3 million in 2007, projected to increase to £94.6 million by 2015

The Government recently published a new obesity strategy, ‘Healthy Lives, Healthy People: A call to action on obesity in England’. This adopts a life-course approach to tackling obesity from pre-conception through pregnancy, infancy, early years, childhood and adolescence to adulthood and older years.

The London Health Improvement Board has prioritised child obesity and will be developing a pan-London strategy. The strategy will include a revitalised healthy schools programme and a focus on increasing sporting activities to harness an Olympic legacy.

Locally the Child Obesity Strategic Partnership and Adult Obesity Strategic Partnership bring together representatives of key organisations from the NHS, London Borough of Hackney, City of London Corporation and the voluntary sector to assess need and plan interventions for the local population. A refresh of the action plans accompanying the strategy ‘Achieving a Healthy Weight for All in Hackney and the City’ has been prioritised, including a review of the care pathways.

Prevalence of adult obesity

The prevalence of obesity in the UK has more than doubled in the last 25 years. In England, two thirds of adults and a third of children are obese or overweight. Unless we take effective action now it is predicted that by 2050 the prevalence of obesity alone (let alone overweight) may rise to 60% of adult men, 50% of adult women and 25% of children.

The Health Survey for England 2006-08 estimated that 21% of adults in Hackney are obese. Although high, this is below the national average of 24%\(^{175}\). The prevalence of adult obesity as recorded in general practice is lower: in 2010/11, 11.6% of adults in Hackney who were registered with a GP were recorded as obese. This prevalence rate is the fifth highest rate in London. In London as a whole, the obesity rate is 9.3%.

Over the past two years the GP-recorded obesity prevalence rate has fallen, following a rise in the two previous years (Figure 3.6). For technical reasons, Figure 3.7 shows the obesity rate in adults as a proportion of the whole population. The actual adult obesity rate, described above, is higher. However figure 3.7 is an accurate description of the trend which is currently moving in the opposite direction to the London average.

The variations in obesity prevalence within the GP-registered population of Hackney by age, ethnicity and care group (including mental illness and disability) are illustrated in Figures 3.7 to 3.9. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup. The main cohort of obese people in Hackney is in the working age population aged over 25. Prevalence is higher than average in the Black population. It is strongly associated with mental illness, learning disability and, as might be expected, the housebound population. Rates are also high among deaf and blind residents. There is also a marked difference in the prevalence of obesity between men and women: among men, the prevalence is 106 per 1,000 men; among women, the prevalence is 163 per 1,000 women.

A local health needs assessment of the Charedi (Orthodox Jewish) population in Hackney identified high rates of obesity: 55% of Charedi men and 64% of women were overweight or obese\(^{176}\).

There is a diverse range of healthy weight-related projects operating in City and Hackney which together target many of the key determinants of obesity identified in both research evidence and national strategy. However, there are some notable gaps such as projects which attempt to change the environment itself through for example, transport policy and working with the food industry.

A 2009 evaluation of local healthy weight projects recommended strengthening the following\(^{177}\):

- Interventions that target the whole population plus targeted interventions to those most in need represent the best strategy for promoting health and reducing inequalities.
- Ways of increasing publicity for projects and strengthening referral routes should be explored.
- There is a need to explore the potential for increasing the number of projects which rely less on fixed facilities and venues.
- Consideration should be given to investing in projects over a longer term.
- There is a need to expand the healthy weight programme in a number of areas which are currently not well served, especially in terms of projects that directly target the obesogenic environment.

### The City

Obesity data is not available for the residents of the City, except for those registered at the Neaman practice in the northwest of the City. Only 3.6% of these adults are obese and the prevalence rate has been falling for the last two years (Figure 3.7).

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\(^{175}\) Health Profile for Hackney, July 2010, APHO and Department of Health, Crown Copyright 2010.

\(^{176}\) NHS City and Hackney: Orthodox Jewish Needs Assessment (summary), 2011

\(^{177}\) Harden et al: Final Report: A Review of Effectiveness, including cost-effectiveness wherever possible, of Commissioned Healthy Weight-related projects in City and Hackney, Institute of Health and Human Development, University of East London, 2009
Figure 3.6 Obese adults as recorded in general practice in Hackney (QOF)

Figure 3.7 Prevalence of obesity in Hackney by age: overall numbers per age group and rate per age group, 2011 (CEG)

Figure 3.8 Prevalence of obesity in Hackney by ethnic group: overall numbers per ethnic group and rate per ethnic group, 2011 (CEG)

Figure 3.9 Prevalence of obesity in Hackney by care group: overall numbers per care group and rate per care group (CEG)
Prevalence of childhood obesity

Among children attending schools in Hackney and the City in 2010-11, 13.5% of children in Reception year were overweight and 14.6% were obese, giving a total of 28.1% who were overweight or obese. Among children in Year 6, 16.0% were overweight and 25.0% were obese, giving a total of 41.0% who were overweight or obese. These rates are little changed from the previous year and there is no obvious trend in either age group over the last five years.

Although childhood obesity for boys and girls are similar in Reception year, by year 6 boys have significantly higher rates of obesity than girls. In both year groups, the highest obesity rate is among Black pupils and the lowest rate is among Asian pupils.

Nationally, childhood obesity is more prevalent among Black, Asian and Mixed ethnicity children than among children of White ethnicity. Childhood obesity is also strongly correlated with deprivation178.

See page 176 for more details of childhood obesity.

The City

There is no disaggregated data available for childhood obesity in the City.

Preventing obesity: what works?

Interventions aimed at preventing weight gain in adults and children should be179:

- Multi-component: the most successful interventions appear to be those which bring together physical activity, dietary advice and psychological support.
- Not facility dependent: long term integration of exercise into daily life is more successful when opportunities for physical activity are not facility dependent: for example, walking.
- Ongoing: behaviour change and maintenance of healthier lifestyles is more likely to occur if people are engaged with a service over a period of time rather than given one-off, ad hoc advice on lifestyle change.
- Tailored: interventions should consider individuals’ preferences and circumstances, and as far as possible be adaptable to meet their individual needs.
- Targeted at risk groups: there are certain groups who are at greater risk of developing obesity. These include those in deprived communities and also people at certain times in life, for example when giving up smoking or after child birth.
- Engage local providers: work across local providers is essential to ensure consistent messages are provided and to create an environment in which the wider determinants of obesity can be tackled.

Managing obesity: what works?

Children:

- Drug treatment is not recommended in under 12s

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179 NICE: Obesity guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children, 2006
Surgical interventions are not generally recommended for children and young people
- Interventions for childhood overweight and obesity should address lifestyles within family and social settings
- Parents of overweight or obese children and young people should be encouraged to lose weight if they are also overweight or obese

**Adults:**
- Surgical intervention may be considered, provided appropriate criteria are fulfilled
- Individuals’ preferences and circumstances should be considered
- Lifestyle interventions should be multi-component, including behaviour change strategies
- Partners or spouses should be encouraged to support any weight management programme
- Adults should be encouraged to increase their physical activity even if they do not lose weight as a result, because of the other health benefits physical activity can bring
- Drug treatment should be considered only after dietary, exercise and behavioural approaches have been started and the impact evaluated

### Nutrition

#### 2011 update
The proportion of adults in Hackney who consume five or more portions of fruit and vegetables every day is estimated to be 34%, above the national average.

**Focus on inequalities:**
- The availability of affordable healthy food in London is affected by location, income and ethnicity
- Boys consume more portions of fruit and vegetable a day than girls
- Higher fruit and vegetable consumption has also been recorded locally among men

The Government recommends an intake of at least five portions of fruit or vegetables per person per day to help reduce the risk of some cancers, heart disease and many other chronic conditions. Increasing consumption of fruit and vegetables can significantly reduce the risk of many chronic diseases. It has been estimated that eating at least five portions of a variety of fruit and vegetables a day could reduce the risk of deaths from chronic diseases such as heart disease, stroke, and cancer by up to 20%.[180]

The Health Survey for England 2006-08 estimated that 34% of the adult population in Hackney consume five or more portions of fruit and vegetables daily (estimates are not available for the City). This compares favourably with the national figure of 29%.[181]

It is likely, however, that there are local inequalities in access to a healthy diet. The availability of affordable healthy food in London is affected by location, income and ethnicity. Barriers to healthy eating also include a lack of understanding about what is and what is not healthy food, a perception of the time demands of healthy cooking and eating, and a perception of the cost of healthy eating.[182] In terms of consumption, national data suggests that boys on average, consume more portions of fruit and vegetable a day compared to girls and that boys are twice as likely as girls to meet the recommended ‘5 a day’.[183]

A local survey commissioned by NHS City and Hackney in 2008 showed that the majority (63%) of residents believed that a ‘balanced diet’ meant eating fruit and vegetables and one in six (17%) mentioned ‘getting your five a day’. A third said that a balanced diet meant eating a wide variety of food (32%), limiting fat, sugar and

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180 Department of Health, Be Active Be Healthy: A Plan for Getting the Nation Moving, 2009, Gateway Reference 10818.
181 Health Profile for Hackney, 2011, APHO 2011 (estimate has been revised)
183 National diet and nutrition survey: Headline results from years 1 and 2 (combined) of the rolling programme 2008-09 - 2009-10, Department of Health, 2011.
salt intake (31%), and a quarter (25%) said it meant ‘everything in moderation’. Younger residents were more likely than those over 55 to believe that a wide range of food is necessary for a balanced diet. One in six (17%) felt it meant eating protein, while one in ten mentioned eating better quality food with more nutrients, vitamins or minerals (11%), eating freshly cooked food at home (10%) and drinking lots of water (10%)184.

A recent evaluation of a project combining delivery of fresh fruit and vegetables to older people living at home in Hackney with healthy cooking sessions found that participants enjoyed not only an increase in fruit and vegetable consumption but also improvements in health, wellbeing and independence. Outcomes reported by participants included more energy for daily activities (37%), better gastro-intestinal health (54%), better access to community services (55%), better social interaction (28%) and relief at not having to carry fruit and vegetables (94%)185. The study reported higher fruit and vegetable intake among men than among women at the outset of the project, possibly reflecting lower levels of disability and mobility problems among men.

### Somerford and Shacklewell TRA (Tenants and Residents Association) Growing Club

**Winner of Capital Growth Award for Edible Estate 2010**

Supported by funding from NHS City and Hackney’s Community Chest (2009/10 and 2010/11), the Growing Club runs weekly on the Somerford Grove Estate. The Community Chest provided grants of up to £7,500 encouraging grassroots initiatives aimed at promoting healthy weight and increased physical activity. At the STRA Growing club, over 200 residents of all ages have participated in the last year, planting fruit trees on unloved grass patches, filling disused raised beds with organic seedlings and distributing the produce. Next door neighbours who didn’t know each other’s names have nurtured the trees and plants. Outside of the Growing Club, residents have gone a step further and taken over plots of land for themselves; covering railings with sunflowers, beans and peas and letting rampant squash plants, nasturtiums and cabbages loose on the estate.

**What has the community achieved in the garden since it started?**

‘I have lived in the area for 10 years and I have never seen it so busy. Now that the play area is finished and the planting is done, it looks more like a place to hang out. Passers-by that once avoided the estate have asked how they could do the same thing in their own estate.’ Somerford Grove resident.

The Growing Club runs through the Tenants and Residents Association so it responds directly to what residents want, as well as building capacity on the estate. The children learn about growing, nature and biodiversity whilst playing outdoors, trying vegetables they have grown themselves and making new friends; the adults have become more active in community decisions, been granted funding and access to start securing allotment space, starting up new clubs, and organising events such as a community swap shop and carbon conversation evenings. Importantly, residents have shared their skills, knowledge and experience with each other across all ages, cultures and abilities. They continue to hold cooking evenings and together have created a book of photos, recipes, drawings and stories that record and reflect their involvement and experience of the Growing Club.

**How has the garden improved life on the estate?**

The garden and Growing Club has radically improved life on the estate, in many different ways. ‘The Estate’ is more like a community now; more people stop to look at flowers, sit and talk, and pick vegetables. A local resident said: “Now there is more smiling, it is good for the community.” Not only are residents tasting more local, seasonal, organically grown food, they are exercising and meeting their neighbours, beautifying the area, and there is a greater sense of security. Previously some of the children were not allowed to go to certain parts of the estate and now they play over the whole estate as they’ve invested in all the green spaces via the growing club.

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184 Ipsos MORI, Residents’ views of health and health services in Hackney and the City, 2009.

185 Salah M, Grimble G, Moore L: The effect of a fresh fruit and vegetable delivery programme combined with healthy cooking sessions on the health and independence of self-reliant over 50s. UCL/East London Food Access, 2011
Physical activity

2011 update

Despite having a young population, participation in sports and physical recreation among adults in Hackney is lower than average. Nearly half of all adults in Hackney do no sport or active recreation at all.

The proportion of school pupils who participate in regular physical education is below average in Hackney

Focus on inequalities:

- In Hackney, rates of participation in sports and physical recreation are higher in men than women and higher among Whites groups than other ethnic groups.
- The rate of participation in sports and physical recreation declines across socio-economic classification with the lowest rates in the lowest socio-economic classes.

Physical activity is crucial for both physical and mental health. Physical activity contributes to well-being and reduces the risk of diabetes, heart disease, depression, osteoporosis, high blood pressure and some cancers.

The Department of Health and Department for Transport’s joint Active Travel Strategy outlines plans to increase walking and cycling in the population. It is estimated that just 2% of trips in England are cycled, compared with 26% in the Netherlands. However, cycling in London has more than doubled in the past decade.

In 2011, new physical activity guidelines for the UK were released with recommendations for early years (under 5s), children and young people, adults and older adults:

- Children under 5 years: the guidelines focus on the importance of movement for babies and for toddlers being active for at least 180 minutes every day.
- Children over 5 years and young people: this group should take part in moderate to vigorous intensity physical activity for at least 60 minutes every day. Activities such as jumping, dancing and running, which strengthen muscle and bone, should be pursued at least three times a week.
- Adults: the recommendation is for adults to do 150 minutes of moderate intensity physical activity per week. However there are additional benefits in being active every day.
- Older adults: the recommendations are similar to that of adults, however there are some important differences, particularly as the ability of older adults to take part in activity is highly variable. With this in mind, the guidelines emphasise that some activity is better than none, as well as the importance of improving balance and co-ordination to reduce the risk of falls.

Sport and physical activity among adults

In Hackney:

- 20.3% of adults take part in sport and active recreation (a minimum of three 30 minute sessions of moderate intensity activity per week) compared to a London average of 20.9% and a national average of 22.0%
- 48.5% of adults do no sport or active recreation at all (47.3% in London, 47.8% in England)
- 62.2% of adult residents in Hackney want to start playing sport or do a bit more

These rates are not adjusted for the age profile of the population. The rate of participation in Hackney is lower than would be expected given its young population.

186 Department of Health, Be Active Be Healthy: A Plan for Getting the Nation Moving, 2009, Gateway Reference 10818.
187 Active Travel Strategy, Department for Transport and Department of Health, 2010.
188 Department of Health, Physical Activity, Health Improvement and Protection, Start Active, Stay Active: A report on physical activity from the four home countries’ Chief Medical Officers, July 2011.
189 All data from Sport for England Local Sports Profile (Hackney) 2010
There are distinct differences in participation in active recreation in Hackney:

- 23.3% of men participate regularly compared to 17.4% of women, and 43.2% of men do no sport or active recreation at all compared to 53.4% of women
- 24.0% of people of White ethnicity participate regularly compared to 16.4% of other ethnic groups
- 71.1% of those with limiting disability do no sport or active recreation at all
- 35.8% of those in the highest socioeconomic classes do no sport or active recreation at all compared to 65.9% in the lowest classes

A needs assessment of the local Charedi (Orthodox Jewish) population did not reveal major differences from the pattern for Hackney overall. Although the methodology used was different from the national surveys used to obtain the data above, a third of adults reported undertaking no physical activity in the previous seven days. Barriers to physical activity included insufficient leisure time, lack of local facilities, lack of money and caring responsibilities. Other barriers include the omission of physical activity from the curriculum in the local independent schools run by the community; lack of free time due to religious observance and the demands of large families; a cultural preference for intellectual and religious activity over physical activity; the requirement for gender-specific exercise opportunities; a reliance on services provided by and for the community; and a perception that living by the Torah has a greater value for health than a ‘healthy lifestyle’.

The City

In the City:

- 25.8% take part in sport and active recreation (a minimum of three 30 minute sessions of moderate intensity activity per week)
- 39.7% of adults do no sport or active recreation at all

Numbers are generally too low in the City to identify differences between groups. However 35.2% of men do no sport or active recreation at all compared to 44.8% of women.

A local survey conducted with both residents and non-residents in the City revealed that 23% of residents and 26% of non-residents do not currently participate in any form of sport or physical activity.

Physical education for children and young people

In Hackney, 43% of school pupils (in years 1 to 13) participated in at least three hours of high quality Physical Education and out of hours sport per week in 2009/10. This is significantly lower than the average for England of 55%. It is also lower than rates in Tower Hamlets (49%) and Newham (51%).

- Many more boys regularly participate in PE (50%) than girls (36%)
- The participation rate is highest in years 3-6 (58%) after which the rate declines with increasing age: 40% participate in years 7-9, 24% in years 10-11 and only 6% in years 12-13.

Children and young people in the Orthodox Jewish (Charedi) community face some specific obstacles to participation in physical activity. Most schools are private and offer little or no physical activity in the curriculum. The cultural requirement for single sex swimming sessions limits the opportunities available, which must be negotiated with local leisure centres or provided by the community itself (the Lubavitch Foundation). Demand therefore outstrips supply – in a local needs assessment, 69% of Charedi children reported participating in some form of physical activity but the majority said they would like to undertake more.

Nationally, participation in PE is higher in schools with fewer pupils entitled to free school meals and higher among boys than among girls.
The City
In the City’s one maintained school, 100% of school pupils participated in at least three hours of high quality Physical Education and out of hours sport per week in 2009/10.

Smarter Travel: Walking and Cycling
Hackney Council’s Smarter Travel Team is promoting a modal shift away from the private car by encouraging active travel - walking and cycling. The Smarter Travel programme consists of several programmes designed to target specific groups based on where they travel to or from (e.g. school, workplace, home) as well as a wider travel awareness programme designed for all residents.

The School Travel Programme has seen a 45% reduction in car use for the school-run. The flagship school walking promotion WoW (walk once a week) is ongoing. Initiatives to encourage cycling to school include Bikers’ Breakfast events and the launch of a cycling guide for secondary school students. In 2012/13 secondary school pupils will be targeted with a campaign encouraging them to walk to school instead of taking the bus for short journeys.

Hackney businesses are being encouraged through a range of initiatives to increase the number of residents cycling to work to 22% by 2031. The Council is partnering with the local NHS, the largest employer in the Borough, to introduce initiatives and infrastructure to reduce single occupancy car travel and encourage active travel.

Leisure facilities

2011 update
Use of leisure centres in Hackney continues to increase year on year. In the City, the Golden Lane Leisure Centre has reopened.

Focus on inequalities:
- Overall, there is little evidence of inequalities in access to leisure centres in Hackney, though they are underused by the 60+ age group

There are six main leisure centres in Hackney: Britannia, Clissold, Kings Hall, Queensbridge, The West Reservoir Centre and London Fields Lido. In 2010/11, there were 1,187,298 visits to these centres including 586,544 visits for swimming. These are small rises (3% and 2% respectively) on the previous year but continue a rising trend that has increased use by 58% since 2007/08.

The ethnic profile of leisure centre users is very similar to the ethnic profile of Hackney’s population overall, though there is considerable variation across the six centres (Figure 3.10). The age profile of leisure centre users is also comparable to the profile of the population overall, though the older age group (60 years or more) is under-represented, as might be expected (Figure 3.11).

A local survey of over 1,000 residents of Hackney and the City, conducted in 2009, revealed the value of the diverse range of leisure and sports facilities in the area. Parks are the most popular local resource (77% of respondents said they used them) but swimming pools, leisure centres, playgrounds, gyms and football pitches are all widely used (Figure 3.12). Only one in six (16%) said they did not use any of the facilities listed, with residents aged over 55 (31%), Black (22%) and disabled residents (21%) more likely to be non-users.

The City
The Golden Lane Leisure Centre reopened in January 2011 and features a 20m four lane pool, sports hall, studio, gym, two outdoor courts for tennis, netball, and short tennis for children. The leisure centre is now managed on behalf of the City of London Corporation by Fusion Lifestyle, a registered charity, which will work

196 London Borough of Hackney (data from GLL)
197 Ipsos MORI: Residents’ views of health and health services in Hackney and the City, May 2009.
with local schools, colleges, universities, clubs and businesses to encourage people to get involved and lead an active and healthy lifestyle.

The high land values and density of existing buildings in the City mean that space for new development of sports facilities is limited, and often comes at a significant premium. Therefore the Sports Development Team use the City’s landscape which provides an environment that is conducive to active travel, walking, jogging, cycling, running, and participating in activities such as Street Gym (where the landscape is the equipment). A number of sports programmes and activities have been held in unconventional City spaces, such as the dance floors in bars and on the streets, that aim to engage with city workers and residents who cannot afford to access the large number of private gyms in the City.

Figure 3.10 Ethnic profile of Hackney leisure centre users compared to population profile (local data/GLA)

Figure 3.11 Age profile of Hackney leisure centre users compared to population profile (local data/GLA)

Figure 3.12 Use of local sports/leisure facilities by residents of Hackney and the City, 2009 (Ipsos MORI)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Hackney Leisure Centre Users</th>
<th>Hackney Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local park</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>Local swimming pool</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>Community centre/leisure centre</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Local playground</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Gym</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Local football pitches</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Tennis courts</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Basketball courts</td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>
Young At Heart is a City-led programme offering opportunities to people over the age of 50 to improve their physical and mental health, fitness and wellbeing through physical activities, health seminars, wellness events and free quarterly health checks and advice. Now in its 7th year, the scheme has engaged over 600 individuals in activities including gentle exercise, line dancing, short mat bowls, swimming, gym workout, chair-based exercise, ballroom dancing, table tennis and guided walks. There is a ‘health checks’ page on the Young at Heart website which enables members to log-in, record their results and track them on a graph over time.

City Masters is a sister project to Young at Heart consisting of a series of new sports clubs for adults aged 45 and over, providing weekly training sessions with fully qualified coaches in squash, fencing, short mat bowls, table tennis and tennis. It offers 6 hours of quality coaching per week to increase participation in sport. The programme was awarded the Inspire Mark by the London Organising Committee of the Olympic Games.

Alcohol use

In England, yearly alcohol consumption per adult is equivalent, on average, to 120 bottles of wine. Alcohol consumption has fallen in many European countries but in England it has increased by 40% over the last 40 years. According to the National Audit Office, over 10 million adults in England drink more alcohol than the recommended daily limit, with the House of Commons Health Committee reporting that 2.6 million of them are drinking more than twice this. Excessive drinking is a major cause of disease and injury: alcohol liver disease has risen by 20% since 2001. Recent pan-European research has found that 10% of cancers in men and 3% of cancers in women are attributable to alcohol consumption. Alcohol misuse costs the NHS around £2.7 billion per year.

The Department of Health currently defines alcohol-related risk as follows:

- **Lower Risk**: Men who regularly drink no more than 3 to 4 units per day and women who regularly drink no more than 2 to 3 units per day. Weekly limits are no more than 21 units per week for a man and 14 units per week for a woman.
- **Increasing Risk**: Men who regularly drink over 3 to 4 units per day and women who regularly drink over 2 to 3 units per day. Weekly limits are more than 21 units to 50 units for a man and more than 14 units to 35 units for a woman.
- **Higher Risk**: Men who regularly drink over 8 units per day or over 50 units per week and women who regularly drink over 6 units per day and over 35 units per week.

Levels of alcohol consumption

### 2011 update

The estimated level of alcohol consumption among Hackney residents is lower than average at all levels of risk. However a substantial proportion of the population is exposed to significant risk from alcohol.

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Focus on inequalities:

In Hackney, the following residents have a higher risk of harm from alcohol:

- Those in work
- Those of White ethnicity
- 16 – 34 year olds
- Those in socio-economic grade C1

In 2009, 69% of men and 55% of women surveyed nationally had drunk alcohol in the last seven days and 19% of men and 11% of women had drunk alcohol on five or more days during this week. Forty-three per cent of men and 31% of women had drunk more than the recommended maximum on at least one day\textsuperscript{201}.

There is limited local data on alcohol consumption in Hackney but synthetic estimates based on the population profile indicate a relatively high prevalence of abstinence and lower than average rates of risk taking at all levels of risk (Table 3.3). Local rates of hazardous drinking and binge drinking are also low in comparison to the England average. Estimates of the number of adults who binge drink, based on the Health Survey for England, suggest that 14% of adults binge drink in Hackney compared to an average for England of 20%\textsuperscript{202}. This low level of alcohol use may be due in part to the high ethnic diversity within Hackney as rates of alcohol consumption are low in some ethnic groups.

The most recent local estimates of alcohol use\textsuperscript{203} identified the following prevalence of high risk drinkers in City and Hackney:

- 6,185 dependent drinkers (3.6% of the population)
- 9,107 harmful drinkers (5.3%)

In addition, it is estimated that significant sections of the local population are drinking more than the recommended health levels:

- 25,601 hazardous Drinkers (14.9%)
- 25,085 Binge Drinkers (14.6%)

In 2010, Ipsos Mori conducted telephone interviews with 1,009 City and Hackney residents\textsuperscript{204}. A range of questions on alcohol consumption were asked as a part of a wider interview on health and access to services. The survey found that:

- Residents in work and those in White ethnic groups are more likely to be at possible risk of harm from alcohol.
- The proportion of low risk drinkers is higher among residents with a Black ethnicity and people over 55 years of age.
- 16 – 34 year olds consume large amounts of alcohol at least once a month.
- Socio-economic grade C1 residents are more likely to be at possible risk of harm from alcohol than other socio-economic grades.

The City

Synthetic estimates of alcohol consumption by City residents suggest a slightly higher level of risk than the average for London (Table 3.3)

Table 3.3 Estimates of alcohol consumption by DH risk categories\textsuperscript{205}

<table>
<thead>
<tr>
<th>Abstain (%)</th>
<th>Lower (%)</th>
<th>Increasing (%)</th>
<th>Higher (%)</th>
</tr>
</thead>
</table>

\textsuperscript{201} NHS Information Centre, Statistics on Alcohol, England: 2011.


\textsuperscript{203} Quest Consultancy 2009

\textsuperscript{204} Ipsos Mori, Residents' views of health and health services in the City and Hackney, June 2010.

\textsuperscript{205} NWPHO Local Alcohol Profiles for England
The impacts of alcohol

**2011 update**

The alcohol attributable death rate in Hackney is higher than the average for London. The rate has risen after two years of decline. Alcohol attributable hospital admissions have also risen significantly.

The rate of alcohol attributable crime in Hackney is also higher than the London average.

25% of the crimes reported in the City have a link to alcohol.

**Focus on inequalities:**

- Alcohol attributable deaths in Hackney are far more common among men than among women

**Health impacts**

Despite the lower than average drinking levels estimated for the population of Hackney, local people suffer higher than average health impacts.\(^{206}\) The annual alcohol attributable death rate is 39.0 deaths per 100,000 men and 18.2 per 100,000 women (age-standardised rate). This compares to averages for London of 33.4 per 100,000 men and 12.5 per 100,000 women.

Table 3.4 describes the rate of alcohol attributable hospital admissions in Hackney. The rate among men is twice the rate among women and both rates have increased in 2009/10. For men, the rate has increased by 39% from 1,197 admissions per 100,000 men in 2008/09 to 1,659 admissions per 100,000 men in 2009/10, above the London average. For women, the rate has increased by 12% from 725 admissions per 100,000 women in 2008/09 to 810 admissions per 100,000 women in 2009/10, also above the London average.

Figure 3.13 and 3.14 show the trend in alcohol attributable hospital admissions in men and women. The rise in 2009/10 following two years of decline makes the rate in Hackney consistent with the long-term rising trend in London.

The most recent hospital admissions data, for 2010/11, is only available for persons, not independently for men and women. The rate of alcohol attributable hospital admissions in Hackney for all people in 2010/11 was 2,161 per 100,000 adults. This is an increase of 9% on 2009/10. Hence hospital admissions have risen for two successive years.

In England as a whole, the number of hospital admissions attributable to alcohol misuse has increased by 100% since 2002-03.

**The City**

The annual alcohol attributable death rate in the City’s resident population is 12.9 deaths per 100,000 men and 1.9 per 100,000 women (age-standardised rate). These are the second lowest rates in the country.

Alcohol-attributable hospital admissions are also very low in the City’s resident population (Table 3.4).

There were 31 individuals in the City in contact with alcohol treatment in 2010/11 of whom 17 were successful competitions.

\(^{206}\) NWPHO Local Alcohol Profiles for England
Research is currently underway to better understand the impacts of drinking in the working population of the City.

Table 3.4: Alcohol attributable hospital admissions for men and women in Hackney and the City in 2009/10, compared with London average, and national rank, where rank 1 is best.

<table>
<thead>
<tr>
<th></th>
<th>Hackney</th>
<th>The City</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate per 100,000 standardised</td>
<td>National rank (out of 354)</td>
<td>Rate per 100,000 standardised</td>
</tr>
<tr>
<td>Men</td>
<td>1,659</td>
<td>268</td>
<td>Men</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>810</td>
<td>219</td>
<td>Women</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3.13 Trend in alcohol-attributable hospital admissions among men 2004-2010 (NWPHO)

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207 North West Public Health Observatory, Local Alcohol Profiles, 2011.
Figure 3.14. Trend in alcohol-attributable hospital admissions among women 2004-2010 (NWPHO)

Treatment

Hackney had over 600 individuals in structured alcohol treatment during the 2010/11. Of these, 67% were male and 33% female. The largest age group was those aged 40-49 years (36%) with 6% aged over 60 years. A third (35%) were parents or carers for under 18s and 20% misused another substance as well as alcohol. The overall treatment figure is set to increase in 2011/12 to 650.

Of those accessing treatment, some of who will have had more than one intervention

- 21 entered Inpatient Detoxification
- 51 Residential Rehabilitation
- 184 Community Prescribing (many for community detox)
- 441 Psychosocial Intervention
- 91 Group Work Programme

Older people

The Royal College of Psychiatrists estimates that ‘a significant amount of older people consume alcohol at dangerous levels, while the over 40s cohort is the only age group that is currently seeing increases in drug use’208. The NTA divides over-50 drug/alcohol users into two groups: ‘survivors’ whose use predated their 50th birthday, and ‘initiators’ whose use began subsequently. There are important distinctions between the two groups: survivors are generally known to services and age is not a determinant of drug/alcohol use; initiators are less likely to be known to drug/alcohol treatment services and age is precipitating factor for alcohol/drug misuse.

Natural, physiological changes make older people more susceptible to adverse effects of alcohol and drug use including alcohol-related deaths, problems of alcohol misuse such as Wernicke's encephalopathy and Korsakoff Syndrome, severe and prolonged withdrawal from alcohol, increased risk of accidental injury, and interactions between prescribed or over-the-counter medicines and alcohol and/or drugs. There is emerging evidence from local professionals that a level of previously hidden need may exist for this group and Hackney DAAT is now undertaking a more comprehensive needs assessment in relation to this group.

Crime and anti-social behaviour

Nationally, alcohol misuse contributes to 1.2 million incidents of violent crime a year, 40% of domestic violence cases and 6% of all road casualties209.

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208 Drugscope 2011
The crude alcohol-related crime rate in Hackney in 2010/11 was 14.0 per 1,000 population. This includes 10.2 violent crimes and 0.3 sexual offences per 1,000 population. These rates are all higher than the London averages (11.7 alcohol-attributable crimes per 1,000 population; 7.9 violent crimes, 0.2 sexual offences).

Analysis of attendances at Homerton Accident and Emergency linked to alcohol-related violence found that most attendances occur on Friday and Saturday nights through to early the following the morning and occurred in the vicinity of licensed venues. Most victims of violence were male aged between 18 and 35 years. Alcohol related incidents on weekdays involved a higher proportion of women than at weekends and often involve a friend, family member or acquaintance with the incident occurring at home. This suggests a link to domestic violence.

The City

The crude alcohol-related crime rate in the City in 2010/11 was 27.2 per 1,000 population. This includes 22.7 violent crimes and 0.4 sexual offences per 1,000 population. These rates are much higher than the London averages due to the inclusion of all alcohol-related crimes in the area, not just those committed by residents.

During 2010/11, the City of London Police identified 1,602 crimes where there was some involvement of alcohol. This is equivalent to 25% of the total crimes reported in the City during the same period. Over 40% of these occurred in pubs or wine bars, 62% occurred between Thursday and Sunday and the vast majority were between 18:00 and 02:00.

The London Ambulance Service (LAS) dealt with 19 calls in the City regarding alcohol overdoses or accidents in the 2010/11 year, with six of these coming from the Bishopsgate area. This is an improvement on the previous year when there were 44 alcohol-related calls.

What works: preventing the development of hazardous drinking

NICE recommends the following to prevent the development of hazardous or harmful drinking:

- Review licensing policy in order to identify local areas saturated with licensed premises and to limit the number of new licenses being granted; ensure sufficient resources are available to prevent under-age sales.
- Provide resources for screening and brief advice.
- Support children and young people aged 10 – 15 years at risk from their use of alcohol.
- Screening and extended brief intervention of young people aged 16 – 17 years who are thought to be at risk from their use of alcohol.
- Brief advice and extended brief advice for adults who have been screened and identified as at risk of hazardous or harmful drinking.

What works: alcohol treatment

The overall outcome for alcohol treatment is a reduction in alcohol related harm and an improvement in the health and social functioning of the individual. Local interventions to reduce alcohol consumption and alcohol related harm can be delivered in a variety of settings and usually begin with an assessment of the patient using a standardised alcohol screening tool. Psychosocial therapies such as cognitive behavioural therapy, motivational therapy and social skills training are effective interventions. Brief interventions refer to simple and practical advice given by a health professional normally in primary care or A&E services, immediately following a screening assessment. Where moderate and severe alcohol dependence is identified through an assessment, referral to a specialist alcohol treatment service is made. Pharmacological therapies such as Acamprosate and Naltrexone are delivered as an adjunct to psychosocial therapies, not as a stand alone treatment.
A hierarchy of interventions, called Mesa Grande, was developed by Miller and colleagues in 2002, wherein interventions are ranked according to the strength of evidence from the published literature. In terms of the evidence, the following are the most effective interventions for the treatment of alcohol use disorders:

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Intervention (1 = best)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Brief intervention</td>
</tr>
<tr>
<td>2</td>
<td>Motivational enhancement</td>
</tr>
<tr>
<td>3</td>
<td>Acamprosate</td>
</tr>
<tr>
<td>4</td>
<td>Community reinforcement</td>
</tr>
<tr>
<td>4</td>
<td>Self-change manual</td>
</tr>
<tr>
<td>6</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>7</td>
<td>Behavioural self-control training</td>
</tr>
<tr>
<td>8</td>
<td>Behaviour contracting</td>
</tr>
<tr>
<td>9</td>
<td>Social skills training</td>
</tr>
</tbody>
</table>

The least supported interventions from the evidence were methods designed to educate, confront, shock or foster insight regarding the nature and causes of alcoholism.

Substance misuse

A new National Drug Strategy, launched in 2010, has two overarching aims:

- To reduce illicit and other harmful drug use
- To increase the number of people recovering from their dependence

While continuing to focus on harms caused by heroin and crack cocaine use, the strategy recognises that patterns of drug consumption are changing and therefore calls upon services to respond more flexibly to local need. There is a greater focus on supporting service users to achieve and sustain recovery from substance misuse and reintegrate into mainstream society.

Prevalence of drug use

2011 update

Over the last six years there have been significant declines in both opiate and crack use in Hackney but a small rise in injecting drug use. Nationally, the pattern of drug use is changing with a decline in cannabis use but increases in use of ketamine, mephedrone and other synthetic drugs.

In the City, cocaine is the primary illegal substance used by patrons of local bars.

Focus on inequalities:

- There is a high prevalence of drug use among marginalised groups such as homeless people and sex workers
- Infants and children are at raised risk of harm if their parents or carers are drug users
- There is high prevalence of drug use in LGBT communities


Estimates of the number of opiate and crack cocaine users by local authority area have been produced by the University of Glasgow. These are designed to inform local service provision and interventions aimed at drug users aged 15 to 64 years. Table 3.5 describes the estimates for Hackney from 2004 to 2010. Over this period there have been significant declines in both opiate and crack use and a small rise in injecting drug use.

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2006/07</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate and crack cocaine use</td>
<td>4,586</td>
<td>3,898</td>
<td>2,925</td>
<td>2,009</td>
</tr>
<tr>
<td>Opiate use</td>
<td>2,909</td>
<td>2,656</td>
<td>1,939</td>
<td>1,795</td>
</tr>
<tr>
<td>Crack use</td>
<td>3,969</td>
<td>2,982</td>
<td>1,932</td>
<td>1,926</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>378</td>
<td>680</td>
<td>N/A</td>
<td>435</td>
</tr>
</tbody>
</table>

The City

The 2008/09 University of Glasgow estimates of problem drug use indicate 45 individuals residing in the City of London who use opiates and/or cocaine. This is a decline from 65 people in 2004/05.

Project Eclipse, run by City of London Substance Misuse Partnership, aims to take a closer look at the night time economy and substance misuse within the Square Mile. As part of the project, amnesty bins were provided at 11 night time venues within the City so that patrons could dispose of any substances in their possession before entry. The contents of the bins were then analysed at St George’s hospital. Cocaine was the most common substance deposited (87% of the samples analysed). A questionnaire carried out with patrons on Thursday and Friday nights found that the majority of the respondents work in the City (57%) and that a further 40% of people had come into the City specifically to socialise.

Emerging trends in drug use

According to the 2010 British Crime Survey, the use of any illicit drug in the UK has fallen from 11.1% in 1996 to 8.8% in 2010, mainly due to a decline in the use of cannabis. Although the long-term trend shows relatively constant levels of Class A drug use overall, within this category there was an increase in powder cocaine use between 1996 and 2010. In the last four years, ketamine use has doubled from 0.3% to 0.6% nationally. Consumption of synthetic drugs such as mephedrone has also increased, especially among younger age groups (4.4% among 16-24 years compared with 1.4% among 16-59 year olds).

The level of illicit drug use among men (12.0%) is twice as high as the level among women (5.7%). Men are also more likely than women to have used a Class A drug in the last year (4.2% in men vs. 1.8% in women).

Evidence from 50 months of drug testing data (heroin and cocaine only) at Hackney Police stations from April 2007 to June 2011 have shown a downward trend from 100 positive tests per month in 2008 to 67 positive tests per month in 2011. Possible causes include a drop in the quality/purity of heroin, an ageing heroin using population and the increased use of new drugs as mentioned above. Presentations for problems with crack cocaine continue to be high. The three main routes into drug treatment in City and Hackney are Criminal Justice; GPs and self referral.

Children and families

An estimated one in three of the English drug treatment population has a child living with them at least some of the time. The Department for Education estimates that parental drug use is a factor for around a third of the 120,000 most troubled families in England. In Hackney 22% of those in treatment are adults who live with children and 23% are parents who do not normally live with their children. Substance misuse is thought to be

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217 Smith, K. and Flatley, J., as above.
a factor in up to 50% of local Safeguarding Children cases and is also known to contribute to 45-65% of domestic violence cases\textsuperscript{218}.

Substance misuse is identified in 1.6% of the pregnant population of Hackney. This can have serious impacts including infant mortality. Hackney DAAT funds a specialist substance misuse mid-wife service: in 2006/7, prior to this service being in place, 80-90% of infants born following exposure to opiates during pregnancy were admitted to a neonatal unit for an average of 12 weeks. In 2010/11 this had been reduced to under 35%.

**LGBT communities**

Little is known about the drug treatment needs of the LGBT (lesbian, gay, bisexual and transgender) communities living and working across City and Hackney. The 2007 Gay Men’s Sex Survey asked participants whether they were currently concerned about their use of a range of drugs. One in seven (14.6%) respondents from City and Hackney reported being concerned about their drug use; slightly higher than the average for London (11.0%)\textsuperscript{219}.

What is understood nationally however is that people from LGBT communities are more likely to have problematic drug (and alcohol) use\textsuperscript{220} but have few targeted support services to turn to locally.

From a national perspective, drug use by LGBT people is higher than among their heterosexual counterparts irrespective of age or gender. Gay men are using more drugs, more frequently than lesbians, especially stimulant drugs, with lesbians citing cannabis as their primary drug of choice\textsuperscript{221}. The range of recreational drugs used is wide and also includes the misuse of prescription drugs and steroids. LGBT people also have high levels of tobacco and alcohol use\textsuperscript{222}. Table 3.6 compares drug use among gay and bisexual men to drug use in the general population. In general, little is known about drug use among lesbian and bisexual women.

For gay and bisexual men, recreational drug use, particularly of methamphetamine has been associated with risky sexual behaviour that may contribute to HIV transmission\textsuperscript{223,224}.

**Table 3.6 Use of alcohol and recreational drugs: proportion using in a 12 month period**

<table>
<thead>
<tr>
<th>Drug</th>
<th>General population\textsuperscript{225}</th>
<th>Gay and bisexual men\textsuperscript{226}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>64.5%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>8.2%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Cocaine powder</td>
<td>2.6%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1.8%</td>
<td>20.7%</td>
</tr>
</tbody>
</table>

\textsuperscript{218} Stella Project 2011

\textsuperscript{219} Meads, C., Pennant, M., McManus, J. And Bayliss, S., A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research, Unit of Public Health, Epidemiology and Biostatistics, West Midlands Health Technology Assessment Group, The University of Birmingham, 2009.


\textsuperscript{221} Meads, C., Pennant, M., McManus, J. And Bayliss, S., A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research, Unit of Public Health, Epidemiology and Biostatistics, West Midlands Health Technology Assessment Group, The University of Birmingham, 2009.


### Health impacts of drug use

The health harms of drug use vary depending on the substance consumed and the route of administration. The most common health effects of drug use are mental illness, infectious diseases, liver disease, respiratory problems, cancer and heart disease.

There is no definitive method for calculating all drug related deaths nationally; some individuals may die from overdose while other from the effects associated with long term use. However in regard to overdose (poisoning) figures suggest that over half (58 per cent) of all deaths related to drug poisoning involve an opiate drug. In 2010, there were 791 deaths nationally involving heroin and morphine. In Hackney, there were 8 reported drug related deaths where overdose was indicated, suggesting a rate of around 30 deaths per million which is close to the national average.

### The City

In the City, there was a slight increase in the number of incidents attended by the London Ambulance Service for drug overdoses from 68 in 2009-10 to 74 in 2010-11. Bishopsgate was the area with the highest number of calls, although there was a slight decrease in this area from 53% of drug overdose calls in 2009-10 to 42% in 2010-11.

### Treatment and engagement

When engaged in treatment, people use fewer illegal drugs, commit less crime, improve their health, and manage their lives better, which also benefits the community. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue.

In 2010/11, 1,350 drug users were in structured treatment in Hackney. Of these:

- 72% were male and 28% were female
- 94% were aged over 25 years.
- 667 were new clients
- 85% were primary heroin or crack cocaine users
- 79% were retained in treatment for 12 weeks or more

There was an increasing number of cannabis, ketamine and GHB users accessing treatment. The number of people who successfully completed treatment drug free was 182.

Treatment outcomes improve significantly for those who remain in treatment for 6 months or more: 39% of heroin users report no use in previous 28 days and a further 28% report a significant reduction in use. The treatment gains for crack users were 38% achieving abstinence and 14% achieving a significant reduction.

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228 Treatment Outcome Profile data, Hackney DAAT, 2010-11.
number of people who successfully completed treatment drug free was 182, an increase of 55% from 2009/10.

Participation in treatment also has an impact on housing and general health: 35% of those with an acute housing need saw improvements in their housing after 6 months and over 40% reported improvements in their general health. However the impact of treatment on employment has been negligible, pointing to the need for additional support from external employment partners229.

Drug users need timely and prompt help if they are to recover from dependency. Local efforts to keep waiting times low mean that the waiting time is around one week or less. In 2010/11, 97% of drug users wait less than three weeks to get treatment.

Hackney now has a substantial network of peer support services and self help groups including Alcoholic Anonymous, Narcotics Anonymous, a non-religious recovery-based SMART programme and a self help weekend relapse prevention group. A specialist mutual aid post natal support group, ‘Star Bright’, has been running for two years in conjunction with the specialist midwife service described above.

The City

In 2010/11 the City of London Substance Misuse Partnership supported 28 individuals in treatment, eight of whom also had an alcohol problem. Thirteen individuals exited the treatment system during the year, of whom seven were recorded as a planned exit and six were unplanned exits.

Mental health problems

Individuals with a dual diagnosis of mental health problems and substance misuse have specific challenges in engaging well with treatment and other services. National statistics indicate substance misuse affects 33-50% of people with severe mental illness with higher rates within acute inpatient facilities. National data from community mental health teams indicate up to 30% of clients with this dual diagnosis. Assertive Outreach teams report over 70% of clients with both needs. Psychiatric intensive care units have rates of 80-90% with dual needs. Prevalence of dual diagnosis is high within drug services: rates are estimated up to 75% and as much as 85% in alcohol services230.

In Hackney, there are specialist dual diagnosis workers in each of the main community treatment services and an assertive outreach worker based in the community mental health team. However, although it is clear that these problems often occur simultaneously, there is limited data on referrals between mental health services and substance misuse treatment. There is scope for improving pathways between these two sectors.

Harm reduction

People who inject drugs can put themselves at increased risk of blood-borne viruses. Harm reduction for this population focuses on decreasing risk from these viruses including Hepatitis B (HBV), Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV). The Health Protection Agency estimates that in the UK, 1 in 2 injecting drug users has contracted HCV, 1 in 6 has HBV and 1 in 100 has HIV231. The Health Protection Agency estimates that 1,971 Hackney residents and 77 City residents are infected with HCV232.

There is a well established needle exchange programme in place in Hackney and the City to ensure injecting drug users (IDUs) have access to clean injecting equipment as well as information and support from health professionals. Other health care needs such as sexual health, flu vaccination and advice on care of veins and other sites used to inject drugs are also addressed. There are 15 needle exchange sites in Hackney where 9,450 contacts were made in 2010/11.

229 Treatment Outcome Profile data, Hackney DAAT, 2010-11.
230 National Mental Health Development Unit, National Conference 23/09/09
232 Health Protection Agency. Commissioning template for estimating HCV prevalence by PCT and numbers eligible for treatment. 2011
The community drug service includes a nurse-led general health service which offers blood-borne virus testing, vaccination and, where necessary, referral into treatment. In 2010/11, 33% of new presentations to community drug services with a history of injecting drug use in Hackney accepted a vaccination for Hepatitis B, close to the national average at 34% and slightly more than half of all those who were offered a vaccination (Figure 3.15).

Hepatitis C testing is also offered to new clients with a history of injecting drug use. In 2010/11, 44% of new presentations to community drug services in Hackney accepted a test for Hepatitis C (Figure 3.16). The proportion of all former or current injecting drug users in treatment locally who have been tested for HCV is 58%, compared with a national average of 60%233. Although uptake of testing is improving, reporting of diagnoses to the HPA remains low. This will improve with the introduction of regulations for mandatory laboratory reports. (see also hepatitis C, page126)

The number of new diagnoses of HIV among injecting drug users in the UK has remained fairly constant over the past nine years. In 2009, the Health Protection Agency recorded 170 people in the UK newly diagnosed with HIV who acquired the infection through sharing injecting equipment. This is about 2% of all new diagnoses in 2009234. Although the rate of infection with HIV among injecting drug users remains low in the UK, the prevalence of HIV among current injectors has doubled in the past decade from 0.7% in 1990 to 1.5% in 2009. Although uptake of testing is improving, it is estimated that more than a third of injecting drug users who have HIV remain undiagnosed235. In Hackney, approximately 5% of injecting drug users are known to have HIV.

There are nine pharmacies in Hackney participating in a dried blood spot testing pilot project which aims to:

- Identify people with previously undiagnosed HBV, HCV and HIV through targeted testing of the local population;
- Get patients who have tested positive to HBV, HCV and HIV in a community pharmacy setting into specialist services as quickly as possible.

The pilot has been running since April 2011 and 47 people have been tested so far (December 2011) with 6 positive diagnoses. These preliminary results indicate that pharmacies can be a suitable setting for testing and diagnosis of infectious diseases. Recommendations for future service provision will be made based on final results of the pilot when it concludes in March 2012.

Harm reduction for injecting drug users must continue to focus on regular screening for blood-borne viruses across a number of settings and to increase the number of patients who have been vaccinated against HBV. Reporting of new HCV diagnoses to the HPA also needs to improve.

**The City**

Ten people began their treatment journeys in the City of London during 2010/11. Of these, six individuals had already been immunised against hepatitis B and three people accepted the offer of a vaccination. Hepatitis C testing of former or current injecting drug users in treatment in the City is high with 12 of 14 people being tested in 2010/11.

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233 Hackney DAAT Drug Treatment report, October 2011.
Sex work

Street and off-street sex work

Focus on inequalities

Sex workers are among the most marginalised people in society. Many have multiple health needs including drug and alcohol dependence, sexually transmitted infections and mental disorders and suffer from the effects of violence against them.

There are numerous ‘hard to reach’ populations in Hackney and historically one of the most marginalised has been sex workers. Street sex workers typically work at night and usually also have problems with drug use whereas off street sex workers are likely to be migrant, undocumented individuals. The needs of the two groups are quite distinct, requiring tailored services. Open Doors delivers outreach, clinical and case
management services to women selling sex in both street and off street environments in Hackney and the City.\footnote{All data in this section provide by Open Doors}

In 2010/11 Open Doors worked with 254 street sex workers providing intensive case management support to 167. The minimum intervention is providing access to condoms, needle and syringe exchange if they require it, harm reduction and encouragement to use the crisis drop-in so that more complex problems can be addressed. On average Open Doors supports 50 women per month.

The most significant driver of the street sex work scene in Hackney is chronic addiction and its associated poverty, homelessness, criminality and mental health problems. Drug use trends in the borough are changing significantly. In 2010/11, opiate use decreased significantly among sex workers cohort with only 9% identifying themselves as primary heroin users and 24% as poly drug users (including heroin, crack and alcohol). Thirty eight percent of street sex workers identified as primary crack cocaine users (for which there is no medical substitute) and 25% as alcohol and crack cocaine users, a co-addiction that is complex because the combination of both creates a third compound (coca ethylene) that increases the likelihood of cardiovascular damage amongst users. Although very few women using the service do not identify any problematic drug use, these women present with complex social problems exacerbated by extreme poverty and the many consequences of selling sex.

The street sex workers of Hackney are virtually all British born (less than 5% are not) and most are local women who were born and brought up or resident for some time in the borough. Ethnically, they are mostly white, African Caribbean or mixed ethnicity. Street sex workers range in age from 18 years to late 40s with most aged from late 20s to early 40s.

Overall morbidity amongst street based sex workers is high. Women are likely to suffer from at least one sexually transmitted infection during the time they are in contact with Open Doors. Approximately 38% have had one or more sexually transmitted infections. Historically women have not been quick to seek treatment. During 2010/11, Open Doors supported 12 street-based sex workers to engage with HIV care and support. A small number of women diagnosed with TB were supported to access screening and treatment services. Street sex workers tend to be fearful of testing for HIV and TB and, once diagnosed, it is a challenge to maintain them on long term medication. Persistent drug use and poor oral hygiene means that dental decay is significant amongst the women.

Primary care needs, particularly amongst injecting drug users tend to be related to abscesses, cellulitis and general skin infections. Most of the street based sex workers smoke tobacco and those who use alcohol tend to drink high strength lager or cider. Those engaged in chronic drug use are generally underweight.

Nine per cent of case-managed clients have severe mental health problems such as schizophrenia, bi-polar and personality disorder. Female street sex workers report high incidences of violence against them either at the hands of customers, drug dealers, the wider street fraternity and partners. In 2010/11 The Open Doors ISVA (Independent Sexual Violence Advisor) worked with 12 Hackney street sex workers who reported sexual violence against them, supporting them to access clinical, forensic, criminal justice and social and emotional support.

**The City**

Almost all sex work in the City is off-street. Very little is known about these sex workers and their health needs.
The Male Partner Project (MPP) was set up in July 2008 as an additional initiative within Open Doors (a sexual health outreach and clinical service for sex workers), to provide support for the male partners of street based sex workers. These male partners are a hard to reach, vulnerable cohort of men. The majority are prolific offenders and drug and/or alcohol dependent. They share similar health needs and chaotic lifestyles with their female partners and due to their social exclusion rarely access or engage with health services. The needs of male partners are multiple and complex and, as they represent a high risk group for transmission and infection of communicable diseases, potentially have a substantial public health impact.

One of the main achievements of the project has been to provide a link, which did not exist before, between key service providers and this client group. Fast track access into health and social services, such as the Department of Sexual Health at the Homerton Hospital, Specialist Addiction Unit and Hackney Homeless Persons Unit have been established. Other achievements of the project include:

- Engagement with 66 male partners or associates of street sex workers, of whom 84% were substance dependent. Since July 2008, a total of 95 referrals for health or social services including housing, benefits and legal advice were made.

- As well as supporting men to stay engaged with borough-based drug treatment services, a small number of clients have successfully completed drug rehabilitation.

- The project co-ordinator has engaged with this high risk group of men, helped to bring them into contact with acute services as required and supported them to maintain contact with community-based services. In turn this has had a positive impact on overall retention rates, compliance with medication and improved treatment outcomes and has lessened the overall cost in managing the health care needs of these individuals.

- Early intervention to treatment and care for preventable conditions has not only resulted in the improved well being of individuals but has also been shown to be cost effective in preventing this subgroup needing hospitalisation for acute conditions. Engagement and retention in treatment reduces further transmission of blood-borne viruses and related co-infection as well as potential multi-drug resistance.

- Providing support to the male partners of street sex workers has assisted Open Doors by reducing attrition rates of the female clients.

- The project demonstrates that regular engagement and support of prolific and persistent offenders has an overall impact in reducing continued offending among this group.

Outcomes from the Project demonstrate the importance and wider benefits of health commissioners and service providers investing in and exploring innovative approaches that identify, engage with and retain this hard to reach group of men. The wider impact is that public health services are able to address the health and social exclusion issues faced by both sex workers and the men who inhabit their lives. The model also illustrates the potential for adapting this outreach model to other parts of the UK, as well as broadening the model to include men who are not necessarily the partners of sex workers, but who are closely linked to the street fraternity.

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Chapter 4: Infectious diseases

Infectious diseases were once the scourge of British society. Advances in public health, vaccines and treatment have dramatically reduced the harm they cause but they are still responsible for a large burden of illness and death every year. Great vigilance is needed to keep them under control.

Worldwide, infectious diseases, caused by bacteria, viruses, parasites or fungi, represent the largest cause of childhood and adolescent deaths. In developed countries like the UK the following issues are important in the control and treatment of infectious diseases:

- The re-emergence of disease like tuberculosis (TB)
- The resistance of micro organisms to antibiotics
- Novel infections like SARS
- The threat of pandemic influenza
- The risk of healthcare associated infections, for example, MRSA
- The burden of long term conditions like HIV/AIDS and hepatitis
- The burden of sexually transmitted infections

Outbreaks of infectious diseases can place a great strain on health and social care services and our workforce. They can also reflect changes in the population, such as the influx of new migrants, or increases in the prevalence of risk-taking behaviours such as unprotected sex and injecting drug use.

Notifiable diseases

Health care professionals must report certain infectious diseases, called notifiable diseases, such as measles, mumps and meningitis, to enable speedy detection of possible outbreaks and epidemics.

Vaccine-preventable diseases

2011 update

The incidence of all vaccine-preventable diseases fell in 2010 compared to the previous year. However the mumps outbreak in 2009 kept mumps infections well above average until the middle of 2010.
Every year in Hackney and the City there are many new cases of infectious diseases that are vaccine-preventable.

Table 4.1 describes the incidence of measles, mumps, pertussis, pneumococcal disease and rubella from 2008 to 2010. In 2010, the incidence of each of these infections was lower than in the previous year. Incidence of mumps was high as the major outbreak of mumps that began in April 2009 did not finally run its course until the middle of 2010 (Figure 4.1).

### Table 4.1 Incidence of key vaccine-preventable diseases in Hackney and the City 2008-2010 (HPA)

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>43</td>
<td>39</td>
<td>19</td>
</tr>
<tr>
<td>Mumps</td>
<td>32</td>
<td>237</td>
<td>87</td>
</tr>
<tr>
<td>Pertussis (whooping cough)</td>
<td>10</td>
<td>10</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Pneumococcal disease</td>
<td>24</td>
<td>7</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Rubella</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

**Figure 4.1. Incidence of mumps in Hackney and the City 2008 - 2010 (HPA)**

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### Gastro-intestinal diseases

The following diagnoses of gastro-intestinal infections were confirmed in Hackney and the City in 2010:

- Campylobacteriosis: 98 cases
- Salmonellosis: 35 cases
- Acute hepatitis A: 15 cases
- Shigellosis: 18 cases

There were also small numbers of cases (<5) of Cryptosporidiosis, E.Coli infection, Enterobiasis, food poisoning, foodborne Clostridium Perfringens intoxication, Listeriosis, Noroviral gastroenteritis and Typhoid fever.
Infections were more common among males than females: 10 of the confirmed hepatitis A cases were among males compared to 5 among females and 58 of the Campylobacteriosis cases were among males compared to 40 among females. However Salmonellosis cases were evenly divided 18 males and 17 females.

There were 10 probable hepatitis A cases as well as the 15 confirmed cases (predominantly males). Most of the hepatitis A cases were due to an outbreak in the Orthodox Jewish community.

**Hepatitis C**

### 2011 update

Modelling by the Health Protection Agency indicates that 1,971 Hackney residents and 77 City residents are infected with hepatitis C virus.

### Focus on inequalities:

- Most of those living with Hepatitis C in Hackney are current or previous injecting drug users
- Hepatitis C is also likely to be more prevalent locally in international migrant communities originating in areas where incidence is high such as south and south-east Asia

Hepatitis C is an infection caused by a blood-borne virus. Most people who become infected are not aware of it and 15-20% of infected people clear their infections naturally within the first 6 months of infection. In the 80-85% of individuals who fail to clear their infections naturally, the outcome of infection is extremely variable. Many people with chronic infection have no symptoms. Others feel unwell: symptoms include mild to severe fatigue, loss of appetite, depression or anxiety, poor memory or concentration and pain or discomfort in the liver. Chronic infection with HCV causes serious liver disease, including cirrhosis and liver cancer in some people.

The most common route of infection in London is through sharing contaminated needles or injecting equipment by injecting drug users (Figure 4.2). The prevalence of HCV among injecting drug users is estimated at 55% in London. HCV infection is higher in those who are born in, or who have lived in, countries with a higher HCV prevalence than the UK. Sexual transmission, particularly amongst men who have sex with men, is higher in those co-infected with HIV.

The Health Protection Agency has developed a tool for estimating prevalence, disease burden and treatment costs of HCV. The tool provides prevalence estimates at local level but draws heavily on national datasets, modelling and national projections and some small studies. The model estimates that there are 1,971 adults infected with hepatitis C virus in Hackney, of whom 88% are current or previous injecting drug users and 3% are from south Asia where the incidence of hepatitis C is high. Based on these prevalence estimates, work is underway locally to identify the gap between the number of people who could be referred for treatment and the number who are referred for treatment.

### The City

The Health Protection Agency estimates that there are 77 people infected with HCV in the City of London, of whom 64 are current or previous injecting drug users.

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239 Health Protection Agency. Commissioning template for estimating HCV prevalence by PCT and numbers eligible for treatment. 2011
Influenza (flu)

Seasonal flu

2011 update
In 2010/11, uptake of seasonal flu vaccine rose in Hackney and the City among both the 65+ age group and among at risk groups, such as people with chronic conditions. Rates are above average for London and England.

The rate of vaccine uptake among pregnant women who are in a clinical risk group is low in Hackney and the City.

Seasonal influenza is an acute viral infection caused by an influenza virus. It is characterized by a sudden onset of high fever, cough (usually dry), headache, muscle and joint pain, severe malaise (feeling unwell), sore throat and runny nose. Most people recover from fever and other symptoms within a week without requiring medical attention. But influenza can cause severe illness or death in people at high risk such as adults aged 65 or older and people of any age with certain medical conditions, such as chronic heart, lung, kidney, liver, blood or metabolic diseases (such as diabetes), or weakened immune systems. Pregnant women are at high risk of H1N1.

Influenza occurs most often in winter and usually peaks between December and March. New strains are constantly emerging and new vaccines are developed annually to target the three most common strains in circulation.

Seasonal flu vaccination is recommended for everyone aged 65 and over, for younger people who have chronic conditions such as diabetes, for pregnant women and for health and social care professionals. Uptake
of the flu vaccine in Hackney and the City in the older age group rose in 2010/11 to 73.7%, once again above the average rates for both London (71.4%) and England (72.8%)\(^{240}\) (Figure 4.3).

Uptake of flu vaccination among at risk individuals less than 65 years old also rose, from 56.8% in 2009/10 to 61.5% in 2010-11 (Figure 4.4). This rate is higher than those in neighbouring boroughs and higher than the average rates for London (48.9%) and England (50.4%).

Uptake among pregnant women is reported for women in a clinical risk group and for ‘healthy’ women who are not in a clinical risk group. In 2010-11, uptake among pregnant women in a clinical risk group in Hackney and the City was 20.4%, below the London average of 29.8%. Uptake among ‘healthy’ pregnant women was 55.2%, compared to an average for London of 51.8%.

**Figure 4.3 Proportion of people aged 65 years and over immunized against influenza 2006 to 2011**

**Figure 4.4 Proportion of at risk people under 65 years immunized against influenza 2006 to 2010**

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**What works: seasonal flu**

Prevention measures are focused on influenza vaccination, which is the most effective way to prevent the disease or severe outcomes from the illness. Safe and effective vaccines have been available and used for more than 60 years. Among healthy adults, influenza vaccine can prevent 70% to 90% of influenza-specific illness. Among the elderly, the vaccine reduces severe illnesses and complications by up to 60%, and deaths by 80%.\(^{241}\)

Vaccination is especially important for people at higher risk of serious influenza complications, and for people who live with or care for high risk individuals.

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\(^{240}\) Department of Health

\(^{241}\) WHO Influenza Vaccines (http://www.who.int/wer/2005/wer8033.pdf)
Immunising those at risk within the community

The purpose of the seasonal flu immunisation programme is to offer protection to those who are most at risk of serious illness or death should they develop flu. Increasing flu vaccine uptake in individuals in the clinical risk groups is important in reducing serious illness and death in these groups.

The seasonal flu vaccine should be offered to:

- People aged over 65
- All pregnant women (at any stage of pregnancy). There is good evidence that pregnant women are at increased risk from complications if they contract flu, particularly the H1N1v strain. All pregnant women were recommended to receive the seasonal flu vaccine irrespective of their stage of pregnancy in the 2011/12 flu season.
- People with a serious medical condition. This includes people with: chronic (long term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis; chronic heart disease, such as heart failure; chronic kidney disease; chronic neurological disease, such as Parkinson’s disease or motor neuron disease; diabetes; and those with a weakened immune system due to disease such as HIV/ AIDS or treatment that suppresses the immune system.
- People living in long stay residential care homes or other long stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity or mortality.
- Those who are the main carer of an older or disabled person.

WHO recommends immunising at least 75% of people aged 65 and over and at least 75% of people aged under 65 with clinical conditions which put them more at risk of the effects of flu, and pregnant women as recommended by the EU.

Work to increase uptake of vaccine in clinical risk groups should include:

- Multi agency seasonal flu immunisation preparations in place to deliver a localised annual immunisation campaign.
- Robust local plans in place to identify eligible patients in at risk groups and have robust call and reminder systems in place to contact at risk patients with the aim of maximising uptake. Providers should develop a proactive and preventative approach to offering influenza immunisations.
- Sufficient vaccine supply - timely orders and evidence based estimates of vaccine required by providers.
- Increasing access arrangements to cater for patients who require home visits, those who are in long term care and those not registered with a GP practice.
- Engaging with midwifery services to identify and immunise pregnant women.

Immunising front-line health and social care staff

Influenza outbreaks can arise in health and social care settings with both staff and their patients being affected when flu is circulating in the community. It is important that health and social care professionals protect themselves by having the flu vaccine and so also reduce the risk of spreading flu to their family members. Uptake of the seasonal flu vaccine in frontline healthcare workers is traditionally low; however during the flu pandemic of 2009 some PCTs and Acute Trusts achieved high coverage levels in excess of 70% showing that high levels can be reached.

Vaccination of healthcare workers against flu significantly lowers rates of flu-like illness, hospitalisation and mortality in the elderly in healthcare settings. Vaccination of staff in social care settings may provide similar benefits. Flu immunisation of frontline health and social care staff may reduce the transmission of infection to vulnerable patients, some of whom may have impaired immunity that may not respond well to immunisation. Vaccination of frontline health and social care staff should not be seen as a substitute for universal vaccination of the population.

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workers also helps reduce the level of sickness absences which will contribute to keeping the NHS and care services running. This is particularly important when responding to winter pressures. Increasing vaccination uptake in frontline health and social care workers is focused around four broad themes:

- Flexible and accessible delivery approaches: take the vaccination to staff; create a pool of vaccinators and adopt a peer-to-peer approach; involve individual wards, departments and sites
- Visible leadership: corporate, visible and active leadership; set out expectations of staff
- Effective communications: communications plan within strategy; myth busting
- Planning, governance and project management: develop a comprehensive implementation plan and start early; include targeted approaches where appropriate; good project management

Pandemic flu and swine flu

Unlike seasonal influenza that occurs every winter in the UK, pandemic flu can occur at any time of the year. An influenza pandemic is a global outbreak of influenza that occurs when a new strain emerges that is able to spread easily between people because individuals have little or no immunity to it.

This situation developed in 2009 when the swine flu influenza virus emerged in Mexico in April. Swine flu is a respiratory illness caused by the type A flu (H1N1)2009 virus. Transmission of the new virus occurs in the same way as seasonal flu. Worldwide, the overwhelming majority of cases experienced mild symptoms and recovered fully, without the need for medical care, though pregnant women and people with underlying medical conditions are at increased risk of serious infection and complications. There is little evidence on effective interventions against pandemic flu, however antiviral preparations, if administered within the initial 48 hours of onset, can reduce severity of symptoms, transmission and the need for hospitalisation.

Tuberculosis

2011 update

The rate of incidence of TB in Hackney and the City has fallen by half in the last four years, against the trend elsewhere in east London. The rate is now lower than the London average.

Focus on inequalities:

- TB is associated with poor housing and living conditions, overcrowding and poor nutrition.
- Higher rates of TB incidence are found within immigrant populations and among marginalised groups including prisoners, sex workers, people who are homeless, problem drug and alcohol users, people with mental ill health, people diagnosed with HIV and undocumented migrants.

Tuberculosis (TB) is an infectious bacterial disease that most commonly affects the lungs but can also affect other parts of the body. It is transmitted from person to person through coughing. TB is curable with a six month antibiotic treatment regime.

TB has been resurgent in Britain since the 1980s. London accounts for 38% of all cases, with a rate of 44.4 per 100,000. Higher rates of TB incidence are found within immigrant populations, particularly from sub-Saharan

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251 Department of Health: Seasonal Flu Immunisation Programme 2011/12
252 Department of Health (2010) Learning the lessons for the H1N1 vaccination campaign for Health Care Workers
Africa and India. Nearly three quarters (73%) of people with diagnosed TB are non-UK-born (most of whom - 79% - are diagnosed two or more years after arrival in the UK).

TB is strongly associated with deprivation including poor housing and living conditions, overcrowding and poor nutrition. Many of those who are socially marginalised are also at higher risk of TB, such as prisoners, sex workers, people who are homeless, problem drug and alcohol users, people with mental ill health, people diagnosed with HIV and undocumented migrants.\textsuperscript{253}

In 2010 there were 95 new diagnoses of TB among residents of Hackney and the City\textsuperscript{254}. This is an age-adjusted rate of 41 per 100,000 population, lower than the average for London (42 per 100,000 population) despite the fact that East London has long borne the greatest burden from TB in the capital. The local TB incidence rate has fallen by half over the last four years, against the trend in neighbouring east London boroughs (Figure 4.5).

\textbf{TB treatment completion}

\textbf{2011 update}

The TB treatment rate in Hackney and the City is now above the World Health Organisation target.

Completion of a full course of appropriate treatment is important not only for the individual concerned but also to reduce the risk of transmission of infection to others and prevent relapse and the development of drug-resistance. Drug-resistant TB must be controlled to ensure the full range of treatment options remains viable to people newly diagnosed with TB.

The World Health Organization recommends a treatment completion rate for cases of sputum smear positive pulmonary TB of 85%. Completion rates are measured using data from patients receiving treatment in the previous year as TB treatment can last longer than 6 months. The TB treatment completion rate in Hackney and the City in 2010/11 was 87%.

Those infected with TB include a disproportionately large number of homeless people and people with drugs and alcohol problems. These groups pose a challenge for TB control due to their chaotic lifestyles and lack of contact with services. Presentation may be delayed or not occur at all. These groups also tend to have poorer treatment completion rates with increased risk of drug resistance.

\textsuperscript{253} London TB Service Review and Health Needs Assessment 2010  
\textsuperscript{254} London TB register 2011
TB: what works?

Successful prevention, control and treatment of TB requires a well co-ordinated multidisciplinary approach including work on prevention, detection and treatment completion. Work is needed to increase awareness of TB and dispel myths, stigma and misconceptions about the disease amongst high prevalence communities promoting the message that TB is curable. Effective partnership working with health services, health protection, commissioners and local authorities housing teams is needed to ensure effective care pathways are developed and sustainable through strong leadership and commitment to reducing incidence of the disease.

The Department of Health’s national action plan Stopping Tuberculosis in England\(^{255}\) aims to reduce and ultimately eliminate TB in England. Its immediate aims are to:

- Reduce the risk of people being newly infected with TB in England
- Provide high quality treatment and care for all people with TB
- Maintain low levels of drug resistance, particularly multidrug resistant (MDR) TB

To do this we need to:

- Improve early detection of TB
- Improve effectiveness of treatment
- Reduce the risk of transmission

The following Department of Health\(^{256}\) and NICE\(^{257}\) guidance focus on the prevention and control of TB:

**TB Awareness**

- Increasing awareness of TB amongst health professionals and high risk groups and people who work with them, teachers and the public.
- Awareness should be focused on working with communities most at risk such as those from the Indian Sub Continent and Sub Saharan Africa, homeless people and those living with HIV/AIDS.
- Disseminating accurate information and working with communities to identify symptoms and seek early diagnosis is important. The use of multilingual and culturally appropriate public information and educational materials should be disseminated widely. World TB day (24\(^{th}\) March) should be used to increase awareness locally through an annual campaign.

**Immunisation**

- BCG increases a person’s immunity to TB and protect against the most severe forms of disease but is not entirely effective and therefore cannot, on its own, control the disease.
- All newborn children should be vaccinated within 6 weeks of birth in London as there are more than 40 cases per 100,000 people\(^{258}\).

**Diagnosing TB**

- TB can be controlled by promptly recognising and treating people with the disease and so work should be focused on identifying and treating people with early infection.
- Employ Active Case Finding amongst high risk groups, such as undocumented migrants and those with no recourse to public funds, people who are homeless, alcohol/ drug dependant and prisoners, as well as close contacts of TB cases. Utilising the London TB Find and Treat team provide an outreach x ray screening service for people whose lifestyles make it more difficult for them to access traditional services such as those in high risk groups such as homeless, substance misusers and prisoners\(^{259}\).
- New Entrant Screening New entrants from countries with a high incidence of TB are screened on arrival at Port of entry screening, where those individuals with symptoms or radiological changes compatible with TB are referred to the TB services.
- Contact Tracing and Screening of household/close contacts of cases diagnosed with TB should be based on a risk assessment working in close collaboration with the Health Protection Agency when schools and work places are identified.

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257 NICE: Tuberculosis: clinical diagnosis and management of tuberculosis, and measures for its prevention and control, CG117 (http://www.nice.org.uk/CG033)

258 NICE clinical guideline 117 - Tuberculosis

High quality laboratory services are essential for ensuring the rapid identification of TB, including drug resistant strains.

**Good consistent contact tracing practices can be supported by systematic cohort review practice.**

### Management of Active TB

- All patients with suspected pulmonary TB to be seen by a TB team within two weeks of first presentation to health care.
- At least 65% of patients with pulmonary TB to have the diagnosis confirmed by laboratory culture of the organism.
- All patients diagnosed with TB to have the outcome of their treatment recorded and at least 85% successfully complete their treatment.
- All cases of uncomplicated TB managed using a 6 month standard treatment regime.
- Enhanced case management is recommended to meet the needs of complex and challenging patients.
- Patient education and support should be tailored to the needs of individual patients (availability of advocacy services).

### TB Treatment Completion

- Completion of a full course of appropriate, anti-tuberculosis treatment is important to ensure cure of the disease, reduce associated morbidity and the risk of transmission of infection to others, and prevent relapse of TB and development of drug-resistance. The World Health Organization recommends a treatment completion rate for cases of sputum smear positive pulmonary TB of 85%.
- Treatment should be focused around patient-centred care taking into account patients’ needs and preferences. Those with, or at risk of contracting TB should have the opportunity to make informed decisions about their care and treatment.
- All patients should have a risk assessment for adherence to treatment, and Directly Observed Therapy (DOT) should be considered for patients who have adverse factors on their risk assessment, in particular: street- or shelter-dwelling homeless people with active TB; patients with likely poor adherence, in particular those who have a history of non-adherence.
- There is a strong economic case for effective management of TB: poor management can lead to the emergence of drug-resistant cases which are more expensive to treat. If TB is not treated promptly there is a risk that others may become infected.

### HIV Screening

- Almost a quarter of the world’s 2 million HIV related deaths each year are associated with TB.
- Early identification of HIV infection in those with tuberculosis is essential, given the overlapping risk groups, consequences of co-infection and the improved prognosis of tuberculosis in HIV positive individuals once antiretrovirals are begun.
- UNAIDS/WHO recommend two approaches to HIV testing: client-initiated HIV testing and counselling or voluntary counselling and testing, which relies on ‘opt in’ testing of people who come to a service to find out their HIV status; and provider-initiated HIV testing and counselling which is effectively an ‘opt out’ approach. The latter is recommended for all patients diagnosed with tuberculosis or attending tuberculosis services.

### Strong Commitment and Leadership

- There is a need for continued commitment to increase understanding of TB and its control, improving the evidence base to better develop tools for diagnosis, treatment and prevention and the consistency of application of public health interventions.
- Create and develop multidisciplinary TB networks with a designated coordinator in each area. Improving the TB pathway from signs and symptoms to diagnosis to treatment completion requires multi-agency co-operation between Primary and Secondary Health Services and Social Services.

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260 Evaluation of the implementation of Cohort Review by North Central London TB Service, 2010

261 WHO: The Stop TB Strategy: Building on and enhancing DOTS to meet the TB-related Millennium Development Goals, 2006

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


- Every PCT to have a TB lead who is responsible for coordinating the development of a multi agency TB plan engaging with a wide range of stakeholders and has the authority and influence to ensure that services are commissioned against the local plan.

- Appropriately skilled workforce. Physicians and nurses with expertise in TB continue to be recruited, trained and retained. Appointment of a lead clinician and a named key worker/ case manager and specialist TB nurses directly employed by Acute Trusts.

### High quality surveillance

- High quality surveillance is needed to identify outbreaks, monitor the BCG immunization programme, monitor trends, inform policy, service development and monitor the success of TB programmes. In London, surveillance has been possible through the Health Protection Agency London Tuberculosis Register (LTBR). The Enhanced TB surveillance system will include microbiological molecular typing helping to monitor TB outbreaks and emerging clusters helping to minimize further transmission.

### Adequate housing

- Providing stable, safe and fixed accommodation for the duration of treatment for homeless TB patients to improve treatment completion.

- Reducing overcrowding and homelessness through, increasing the overall supply of permanent social housing lettings, particularly larger properties, can limit disease transmission and improve treatment adherence rates.

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**Sexually transmitted infections and HIV**

Sexually transmitted infections (STIs) are infections that are spread primarily through sexual contact. However some STIs, such as HIV and syphilis, can also be transmitted from mother to child (during pregnancy or childbirth) and through blood products and tissue transfer. Infection with STIs can lead to acute symptoms, chronic infection and serious later consequences such as infertility, ectopic pregnancy, cervical cancer and the untimely death of infants and adults.

Access to genitourinary medicine (GUM) clinics in Hackney and the City is excellent with 98% to 100% of residents who contact the service seen within 48 hours.

### Incidence of sexually transmitted infections

#### 2011 update

The incidence of sexually transmitted infections (STIs) in Hackney and the City fell by 11% last year. This is consistent with a longer-term trend of decreasing incidence reported by the Homerton Hospital. However Hackney has the second highest rate of infections in England. The rate of infections in the City of London is low.

#### Focus on inequalities

- In Hackney, STI diagnoses are more common among men than women, disproportionately high among gay/bisexual men and more common among other ethnic groups than White ethnic groups

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• In the City, the great majority of STI diagnoses are among White men, split evenly between gay/bisexual men and heterosexual men

STI infections by place of residence

Data on sexually transmitted infections by place of residence is only available for the last two years (2009 and 2010). The 2009 data was only available for PCT of residence. The 2010 data includes analysis by local authority.

Between 2009 and 2010 the number of acute STIs diagnosed among residents of Hackney and the City (excluding Chlamydia infections among the under 25s, for whom there is a screening programme in place) fell from 2,335 to 2,068 infections per 100,000 population, a drop of 11%. Figure 4.6 illustrates the change for the major infections. There was no change in diagnoses of Chlamydia, the most common STI in Hackney and the City, but diagnoses of warts, herpes and gonorrhoea all fell.

Table 4.2 describes the incidence rates for the major acute STIs in Hackney, the City of London and neighbouring boroughs for 2010 (described per 100,000 population). Hackney has the second highest rate of STI infection in England.

There were 4,179 acute STIs diagnosed among Hackney residents in 2010. Of the individuals diagnosed:

• 35% were aged under 25 years, 43% were aged 25-34 and 23% were aged 35 or more
• 63% were men (50% heterosexual men, 13% gay/bisexual men) and 37% were women
• 46% were White and 54% were other ethnic groups

The City

The incidence of acute STI infection among residents of the City of London is low (table 4.2). Only the incidence of Syphilis is higher than average but this may not be significant due to small absolute numbers and a low population baseline.

There were 142 STIs diagnosed among City of London residents in 2010. Of the individuals diagnosed:

• 15% were aged under 25 years, 39% were aged 25-34 and 45% were aged 35 or more
• 85% were men (44% heterosexual men, 42% gay/bisexual men) and 15% were women
• 81% were White and 19% were non-White

Figure 4.6 Rate of STI incidence among City and Hackney residents, 2009-2010, excluding Chlamydia in the under 25s (HPA)
Table 4.2 Rate of STI incidence per 100,000 population by local authority of residence, 2010 (HPA)

<table>
<thead>
<tr>
<th></th>
<th>Hackney</th>
<th>The City</th>
<th>Tower Hamlets</th>
<th>Newham</th>
<th>London</th>
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</thead>
<tbody>
<tr>
<td>Chlamydia (25+ years)</td>
<td>759</td>
<td>85</td>
<td>342</td>
<td>268</td>
<td>189</td>
</tr>
<tr>
<td>Warts</td>
<td>241</td>
<td>70</td>
<td>260</td>
<td>173</td>
<td>165</td>
</tr>
<tr>
<td>Herpes</td>
<td>162</td>
<td>61</td>
<td>133</td>
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<tr>
<td>Gonorrhoea</td>
<td>151</td>
<td>43</td>
<td>131</td>
<td>120</td>
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<tr>
<td>Syphilis</td>
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<td>26</td>
<td>22</td>
<td>11</td>
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</tr>
<tr>
<td>All acute STIs</td>
<td>2135</td>
<td>618</td>
<td>1755</td>
<td>1646</td>
<td>1196</td>
</tr>
</tbody>
</table>

**STI infections by place of diagnosis**

Over the past three years there has been a steady decline in the number of people diagnosed with acute STIs at Homerton Hospital (Figure 4.7). This is consistent with the emerging trend data for Hackney and the City (Figure 4.X above).

The drop in diagnoses since 2007 has been significant for all STIs:

- 30% fewer diagnoses of Chlamydia
- 27% fewer diagnoses of Genital Warts
- 48% fewer diagnoses of Gonorrhoea
- 31% fewer diagnoses of Herpes
- 27% fewer diagnoses of Syphilis

**Figure 4.7 STI diagnoses at Homerton Hospital 2003-2010**

Controlling sexually transmitted infections: what works?267

Interventions are more likely to be effective if they:

- Use theoretical models in developing interventions
- Are multi-component, addressing a range of personal structural determinants of risk simultaneously.

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- Are targeted and tailored (in terms of age, gender, culture, etc), making use of needs assessment or formative research
- Provide basic, accurate information through clear, unambiguous messages
- Use behavioural skills training, including self-efficacy.
- Emphasise risk reduction rather than promoting abstinence
- Use peers and community opinion leaders.

Specific interventions that are shown to be effective include:
- Partner notification is an effective means of detecting new infection.
- Individual risk counselling.
- School-based sex and relationships education, particularly if it starts before the onset of sexual activity.

**SHO-me: sexual health online www.sho-me.nhs.uk**

- SHO-me is the sexual health website for North East London developed by NHS City and Hackney. This innovative and user-friendly website is designed to enable people of all ages and backgrounds to gain the knowledge, skills and resources they need to make positive sexual choices.
- The website provides detailed, up to date information on local sexual health services such as the nearest GUM clinic, GP or pharmacy. It also provides information on sexually transmitted infections, pregnancy, contraception, safer sex and relationships enabling users to make choices appropriate to their needs and circumstances, without risk to their health and well-being or the health and well-being of others. The ‘Ask Dr Sarah’ function provides users with an opportunity to ask questions related to sexual health through the website.

**Chlamydia screening**

**2011 update**

Chlamydia screening coverage in Hackney and the City continues to rise year-on-year, reaching 32% in 2010/11. The proportion of young people testing positive was the fourth highest in London, reflecting both high prevalence and effective targeting.

The National Chlamydia Screening Programme aims to identify and treat Chlamydia in sexually active young men and women under the age of 25. NHS City and Hackney has implemented the programme since 2007 in a variety of settings including community sexual health clinics, young people’s clinics, ante-natal clinics, GP clinics, pharmacies, A&E departments and walk-in centres. This wide range of outlets combined with outreach services has helped to make the test more accessible to the diverse local population.

London is the region with the highest Chlamydia screening uptake in England: 29% of 16 to 24 year olds were tested for Chlamydia in 2010/11. The coverage in Hackney and the City in 2010/11 was 32%, up from 28% in the previous year and 24% in 2008/09.

The City and Hackney screening programme has a high positive test rate: 6.7% of those tested were found to have Chlamydia. This compares to a London average of 4.7% and lower rates in other east London boroughs (3.5% in Tower Hamlets and 3.8% in Newham). This is the fourth highest rate in London and reflects not only a high prevalence of Chlamydia in the area but also effective targeting of the programme.

The Chlamydia screening programme in NHS City and Hackney has focussed on embedding Chlamydia screening into established community health services such as contraceptive and sexual health clinics, pharmacies, GP practices and termination of pregnancy services. Across London, this approach has been

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shown to the most effective way of reaching people most at risk, in contrast to remote testing (sending testing kits by post) and community outreach. It is also the most sustainable approach.  

**Human immunodeficiency virus (HIV)**

**2010 update**

Prevalence of HIV continues to rise among residents of Hackney and the City. In 2008 there was a 5% increase in the number of local people with HIV seen for care.

**Focus on inequalities:**

Locally, HIV principally affects two groups: gay and bisexual men and the Black African community. The majority of new cases of HIV are among gay and bisexual men. Nearly one in fifty Black African residents is living with diagnosed HIV.

Infection with the Human Immunodeficiency Virus (HIV) is a severe chronic condition which, without treatment, can lead to AIDS and death. The profile of HIV has now changed to a more stable and chronic condition thanks to effective treatment. Consequently, HIV prevalence has steadily increased, placing a significant burden on health services. Early diagnosis is essential to ensure effective treatment and management, reduce the risk of long term complications and ensure a near to normal life expectancy. In contrast, late diagnosis is associated with a greater risk of hospitalisation and AIDS-related illness, reduced life expectancy and increased cost to the NHS. There is still significant stigma attached to HIV, which can inhibit testing, prevention and treatment.

**New diagnoses and prevalence**

The rate of new diagnoses of HIV in London is higher than anywhere else in the UK. In 2010, 2,891 new HIV diagnoses were recorded, a rate of 40 diagnoses per 100,000 population. The annual number of new diagnoses in London has declined slightly year on year since 2003, when 3,247 new cases were diagnosed (45 per 100,000 population). This decrease is mainly due to a decrease in heterosexual infection acquired abroad. There is good evidence that incidence of HIV is still increasing among gay and bisexual men and other men who have sex with men (MSM).

The number of London residents accessing care for HIV has more than doubled in the last decade, from 14,652 in 2001 to 29,738 in 2010, which corresponds to an increase in prevalence from 2.1/1,000 to 4.4/1,000. These are conservative estimates, as recent analyses by the Health Protection Agency (HPA) suggest that more than a quarter of all HIV cases (26.4%) in London remain undiagnosed, with an overall prevalence among the 15-59 years old estimated at 7.7 per 1,000 population in London.

There has been a steady increase in the prevalence of HIV in City and Hackney in the last four years. In 2010, 1,352 residents of City and Hackney between the ages of 15 and 59 years accessed care for HIV, compared to 1,105 in 2006 – an increase in the rate over four years of 18% from 6.5 per 1,000 to 8.2 per 1,000. This is the fourth highest rate in London after Lambeth (13.8), Southwark (11.2) and Islington (9.0). The prevalence is well

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270 New HIV diagnosis. Health Protection Agency (HPA), London UK
271 HPA: SOPHID 9 Survey of Prevalent Diagnosed HIV Infection, 2011
above the threshold of 2 per 1,000 at which the HPA recommends expanding HIV testing beyond antenatal and STI clinic settings and offering an HIV test to all adults registering in general practice and all general medical admissions.273.

Of these individuals with diagnosed HIV, the probable route of infection was:

- sex between men: 44%
- sex between men and women 44%
- injecting drug use: 3%
- mother to child transmission: 1.5%
- blood products: <1%

In 2009, 53% of the new cases diagnosed in City and Hackney were acquired through sex between men compared to 43% acquired through sex between men and women.

In City and Hackney, as in other areas in London and the UK, HIV disproportionately affects gay and bisexual men and black Africans. The ethnic profile of people living with HIV infection in Hackney and the City is shown in Figure 4.8: 32% are Black African. Figure 4.9 illustrates the prevalence by ethnic group. This shows the high burden of HIV among Black African – nearly one in fifty Black African residents is living with diagnosed HIV. The HIV prevalence among men who have sex with men is difficult to capture due to a lack of precise data on the size of the population, but the majority of cases in the white ethnic group are men who have sex with men.

The prevalence of HIV varies by age group, with the highest prevalence found among the 35 – 44 year olds (overall prevalence 31.3 per 1,000). It is also higher in men (46.4 per 1,000) than in women (18.7 per 1,000). The higher prevalence in men is seen in all age groups above 24 years of age, and reflects the high incidence among men who have sex with men.

The City

In the City of London, 56 people were living with diagnosed HIV infection in 2010. This is a rate of 5.8 per 1,000 population.

Figure 4.8 Diagnosed HIV Infections in Hackney and the City by ethnic group (HPA)

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HIV disease progression

Fewer than half (43%) of the patients seeking care for HIV are currently asymptomatic, 28% are in pre-AIDS stage and nearly a quarter are in AIDS stage. As expected the proportion of individuals at AIDS stage is higher in older age groups, and the proportion of asymptomatic cases is higher in younger age groups (Table 4.3).

City and Hackney residents seek care for HIV not only in the locality but also across London. Less than a third (32%) seek care and treatment at the Homerton University Hospital, 22% seek care at Barts and The Royal London Hospital, 15% at Mortimer Market, 6% at the Royal Free Hospital, 5% at Imperial College Hospital and another 14% in other London hospitals.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Asymptomatic</th>
<th>pre-AIDS</th>
<th>AIDS</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 15</td>
<td>12 (75%)</td>
<td>0 (0%)</td>
<td>&lt; 5 (25%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>16 – 34</td>
<td>174 (54%)</td>
<td>79 (24%)</td>
<td>36 (11%)</td>
<td>35 (11%)</td>
</tr>
<tr>
<td>35 - 54</td>
<td>369 (40%)</td>
<td>275 (30%)</td>
<td>233 (25%)</td>
<td>42 (5%)</td>
</tr>
<tr>
<td>55+</td>
<td>38 (32%)</td>
<td>33 (28%)</td>
<td>42 (36%)</td>
<td>5 (4%)</td>
</tr>
<tr>
<td>ALL</td>
<td>593 (43%)</td>
<td>387 (28%)</td>
<td>315 (23%)</td>
<td>82 (6%)</td>
</tr>
</tbody>
</table>

Very late diagnoses of HIV

Earlier HIV diagnosis improves morbidity and mortality and ensures that newly diagnosed people with HIV can receive effective treatment and support to reduce onward transmission.

In 2010, 25% of HIV diagnoses in Hackney and the City residents were very late (when the CD4 cells concentration in the blood is below 200 per cubic millimetre). The rate has fallen from an average of 30% in 2004 and 2005. Although the 2010 rate is lower than the London average (27%), a quarter of people diagnosed HIV positive in Hackney and the City are losing out on the benefits of early treatment and support. There is little difference between the rate of late diagnoses among gay and bisexual men (22%) and the rate among heterosexuals (27%).
Chapter 5: Children, young people and families

This chapter explores the health and well-being of babies, children, young people and their families and the factors that affect maternal health. There are many local agencies who share common cause in protecting the health of vulnerable children and promoting the wellbeing of all young people.

Outcomes for children and adults are strongly influenced by factors that operate during pregnancy and the first years of life, making early intervention and prevention an imperative. This is particularly true for children who are born into disadvantaged circumstances. A number of services in Hackney and the City including healthcare, family support, childcare, social services and education services work in partnership to ensure that all children get the best possible start.

Context

Policy context

In September 2010, the Department of Health published the Kennedy Review: *Getting it right for Children and Young People, overcoming cultural barriers in the NHS so as to meet their needs*. The recommendations of this review for local practice focused on the need for strong, coherent partnerships with effective governance to ensure that local health and care services for children and young people are integrated and accountable. Recommendation 4 states:

- There should be a dedicated Local Partnership in every local authority which is responsible for the planning and delivery of children and young people’s health and healthcare at the local level and for integrating these services into all of the services provided.

Recommendation 10 states that the Local Partnership must operate according to the following principles:

- There should be a holistic focus on children and young people.
- There should be a duty to ensure that local organisations work together.
- There should be appropriate ways of ensuring accountability to the public.
There should be an emphasis on efficiency in the provision of services. Children and young people should be actively engaged and involved.

The new Shadow Health and Wellbeing Boards and the Children’s Health and Wellbeing Advisory Group for Hackney will ensure that health outcomes for children are championed.

In both Hackney and the City, the reorganisation of the NHS and the transfer of some responsibilities to local government will also have an impact on how children’s health services are governed and delivered. The transfer of public health responsibilities to local government will include the transfer of responsibility for ensuring appropriate access to sexual health services, the National Child Measurement programme, NHS Health Checks, tobacco control and substance misuse services, preventing birth defects and elements of the Healthy Child Programme.

Public health brings a particular focus on inequalities in population health and wellbeing. As the Marmot Review of health inequalities in England made clear, tackling inequalities must begin with infants, children and young people, specifically giving every child the best start in life and enabling all children, young people and adults to maximise their capabilities and have control over their lives.\(^{274}\)

**Population size**

The recent local assessment of the size of the population of Hackney by Mayhew Associates identified more people than the official ONS estimate in every age group. However the biggest differences were in the young age groups where the Mayhew estimates were up to 22% higher than the ONS mid-year estimates (Table 5.1).

The GLA’s 2011 population projection, which takes account of housing supply, is 61,237 people aged under 20. This is 26% of the total population of Hackney. The largest age group is the under 5s: 20,340 infants or 8.7% of the total population.

**The City**

The City of London has a small population of children and young people. The ONS 2010 mid-year estimate is 1,200 people aged under 20, evenly distributed across this age range. The GLA’s more detailed 2011 population projection for the City is 1,492 people in the following age groups:

- 0-4 years: 366
- 5-9 years: 433
- 10-14 years: 341
- 15-19 years: 352

The housing available in the City, where 90% of accommodation is two bed or smaller, is not particularly suited to family life, particularly for older children. Additionally, there is only one state school in the City, which is for primary aged children only. Despite this, there are many families in the City of London, with particular concentrations in the areas around Barbican, Golden Lane, Mansell Street and Middlesex Street.

At the age of 11, when children leave the state primary school, it becomes harder to track their whereabouts in terms of schooling. Although around 18 children per year register to attend state maintained schools outside the City, it is not known whether these children remain City residents as they grow into older teenagers. Additionally, it is not known whether other children, who do not register, are going on to attend private schools outside the City, or whether the whole family is moving out of the City, and becoming resident in another borough with more suitable housing for teenagers.

Table 5.1 Estimated population of Hackney by five year age group: ONS 2010 mid-year estimates, GLA 2011 population projections, Mayhew Associates 2011 estimate.

<table>
<thead>
<tr>
<th>age</th>
<th>ONS 2010</th>
<th>GLA 2011</th>
<th>Mayhew 2011</th>
<th>Mayhew increase over ONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>19,642</td>
<td>20,340</td>
<td>21,337</td>
<td>8.6%</td>
</tr>
<tr>
<td>5-9</td>
<td>14,459</td>
<td>15,971</td>
<td>16,053</td>
<td>11.0%</td>
</tr>
<tr>
<td>10-14</td>
<td>11,740</td>
<td>13,000</td>
<td>14,129</td>
<td>20.3%</td>
</tr>
<tr>
<td>15-19</td>
<td>10,964</td>
<td>11,926</td>
<td>13,389</td>
<td>22.1%</td>
</tr>
<tr>
<td>total 0-19</td>
<td>56,805</td>
<td>61,237</td>
<td>64,908</td>
<td>13.2%</td>
</tr>
</tbody>
</table>

Ethnicity

The greatest ethnic diversity in Hackney is in the younger age groups. Table 5.2 and Figure 5.1 describe the ethnic profile of each five year age group (GLA 2011 projections).

Data from the Schools Census suggests the GLA projections may underestimate the size of the Black and Asian young populations in Hackney. Figure 5.2 describes the ethnicity of all school pupils in Hackney in 2010. The Black population is here shown to be bigger than the White population.

Both of these data sources collapse several ethnic groups into the ‘White’ category including the Orthodox Jewish (Charedi) population. However the recent Mayhew study described the age profile of the local Charedi population, which is highly skewed toward the younger age groups. An estimated 9,418 Charedi people aged under 20 live in Hackney, 53.6% of the Charedi population. This under 20 population also comprises 15% of the Hackney population of this age.

The City

Three fifths (59%) of 0-19 year olds in the City are White, 10% are Black, 11% are South Asian, 9% are other Asian and 10% are of other ethnicities (GLA 2011 projections).

There is one maintained primary school in the City of London: Sir John Cass’s Foundation Primary School. Of the pupils attending this school, many of whom do not live in the City, 44% are south Asian, 28% are White, 25% are Black, 8% are mixed race and 10% are other ethnicities.

Table 5.2 Ethnic profile of children and young people in Hackney, 2011 (GLA)

<table>
<thead>
<tr>
<th>age</th>
<th>White</th>
<th>Black Caribbean</th>
<th>Black African</th>
<th>Black Other</th>
<th>South Asian</th>
<th>Other Asian</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>9,006 (44%)</td>
<td>1,249 (6%)</td>
<td>2,991 (15%)</td>
<td>2,283 (11%)</td>
<td>2,128 (10%)</td>
<td>887 (4%)</td>
<td>1,795 (9%)</td>
</tr>
<tr>
<td>5-9</td>
<td>6,428 (40%)</td>
<td>1,219 (8%)</td>
<td>2,731 (17%)</td>
<td>1,940 (12%)</td>
<td>1,686 (11%)</td>
<td>639 (4%)</td>
<td>1,329 (8%)</td>
</tr>
<tr>
<td>10-14</td>
<td>5,852 (45%)</td>
<td>1,138 (9%)</td>
<td>2,288 (18%)</td>
<td>1,354 (10%)</td>
<td>1,283 (10%)</td>
<td>387 (3%)</td>
<td>697 (5%)</td>
</tr>
<tr>
<td>15-19</td>
<td>5,464 (46%)</td>
<td>1,143 (10%)</td>
<td>2,147 (18%)</td>
<td>1,022 (9%)</td>
<td>1,204 (10%)</td>
<td>415 (3%)</td>
<td>532 (4%)</td>
</tr>
</tbody>
</table>
Poverty and deprivation

2011 update

The proportion of children living in poverty in Hackney fell between 2008 and 2009 from 44% to 40%. However this remains almost twice the average for England of 21%. The proportion of pupils eligible for free school meals in Hackney’s secondary schools is the fourth highest rate in London and more than twice the national average.

In the City, the proportion of children living in poverty in Portsoken ward fell between 2008 and 2009 from 47% to 41%.
Over 2.5 million children are living in poverty in England\textsuperscript{275}. Children from households with low income or lower socio-economic status are more likely than other children\textsuperscript{276}:

- To die in the first year of life
- To have pre-school conduct and behavioural problems
- To experience bullying and take part in risky behaviours as teenagers such as smoking
- To do less well at school
- To grow up to be poor themselves

Low income is both a driver and an indicator of the many factors which contribute to poor health and wellbeing outcomes for children living in poverty.

In 2009, 40\% of children in Hackney were living in poverty compared to a national average of 21\%\textsuperscript{277}. This was a decline from 44\% in 2008. However, Hackney has the third highest rate of child poverty in London after Tower Hamlets and Newham. The range within London is wide: from 11\% in Richmond to 53\% in Tower Hamlets. Within Hackney, the child poverty rate varies from 28\% in Clissold to 51\% in Haggerston (Figure 5.3).

Local needs assessment in Hackney has described in detail the links between child poverty and poor educational attainment, obesity and poor housing conditions\textsuperscript{278}. This needs assessment concluded that improving outcomes for children in these areas requires action to address the cause of child poverty – low parental income – as well as action to mitigate the effects of poverty on low educational attainment, obesity and poor housing. The most needy children, experiencing the greatest disadvantage, are those exposed to multiple risk factors. These risk factors include the following:

- No parent in the family is in work
- Family lives in poor-quality or overcrowded housing
- No parent has any qualifications
- Mother has mental health problems
- At least one parent has a long-standing limiting illness, disability or infirmity
- Family has low income
- Family cannot afford a number of food or clothing items.

The City

In the City, 17.5\% of children were living in poverty in 2009, according to HMRC data. However there are large differences between the three main residential wards: the rate is 41\% in Portsoken, 15\% in Cripplegate and 8\% in Farringdon Within. The rate in Portsoken has fallen significantly from 47\% in 2008.

The City of London Corporation recently conducted a project to profile the needs of families within the City of London. The project aimed to describe the overall makeup and needs of families within the City, the effectiveness of services in reaching these families and whether there are particular groups of people who are not accessing services. The City of London Corporation is using this to review the delivery and targeting of services to better meet families’ needs. Findings suggest that the rate of child poverty may be higher than previously thought, with 19\% of families classed as low income households, accounting for 27\% of the children in the City.

\textsuperscript{275} HMRC, 2009
\textsuperscript{276} Field F: The Foundation Years, preventing poor children becoming poor adults, HMG 2010
\textsuperscript{277} HMRC
\textsuperscript{278} London Borough of Hackney Strategic Policy and Research: Children and young people’s needs assessment - thematic summary, 2010
Figure 5.3 Children living in poverty by wards in Hackney, 2009 (HMRC)

Free school meals

The number of school pupils eligible for free school meals is an alternative indicator of the level of economic deprivation experienced by children and young people.

In Hackney’s primary schools, 36% of pupils are eligible for free school meals. This is twice the national average of 18%. The average for London is 25%, rising to 34% for inner London. Hackney has the sixth highest rate in London.

In Hackney’s secondary schools, 38% of pupils are eligible for free school meals. This is more than twice the national average of 15%. The average for London is 23%, rising to 36% for inner London. Hackney has the fourth highest rate in London after Tower Hamlets, Islington and Newham.

These data exclude children who are educated in private schools, including all Orthodox Jewish (Charedi) children. The high proportion of Charedi families dependent on benefits suggests that there is significant child poverty within this community.

The City

There is one maintained primary school in the City, Sir John Cass’s Foundation Primary School, and no maintained secondary schools. Seventy children who are City residents aged 3-11 attend Sir John Cass’s Foundation Primary School, of whom 21% are entitled to free school meals.

Young people’s views of health

A major consultation exercise was conducted with secondary school pupils in Hackney in 2010 to gain a better understanding of both their current and future health needs. The following are key findings from this research:

Positive influences on health: From a set list of 12 choices, having good friends and family was the top priority for good health amongst students. Respecting yourself and self-confidence were the next ranked priorities. Knowing when to ask for help was ranked bottom.

Sources of advice on health: The majority of students reported they gained advice and information on their health and wellbeing from family and friends (parents 75%, other family members 64%, friends 63%).

279 Department for Education: Schools Census 2011
Approximately half of all students gain access to information via either television or the internet and 40% identified both their teachers and visiting professionals as a source of health information.

**Things that make you feel good or happy that are healthy or unhealthy:** The majority of students of all year groups consistently identified healthy eating and exercise as activities that make them feel good. Similarly, a significant number of students were able to associate foods they enjoyed eating with being unhealthy, mainly junk food and takeaways and/or sweets and chocolate. Nearly 51% of students identified ‘screen time’ to be an enjoyable unhealthy activity.

**Negative influences on health:** From a set list of 12 choices, the death of a friend or family member and exam stress were identified as the top two things to have had a negative impact on the students’ health (by 67% and 63% respectively). Over a third (35%) identified bullying as having had a negative impact on them at some stage in their life.

**How healthy they feel:** One quarter of students ranked themselves in the middle of the scale, as ‘okay’. Half of students ranked themselves above ‘okay’ including 16% identifying their current health to be ‘brilliant’.

**Most important change they want to make to improve their health:** Over 65% of students expressed a desire to eat more healthily or to exercise more.

**Most important change their school could make to improve their health:** Over 55% of students asked for an improvement to enable them to eat more healthily or participate in additional physical activities at school.

### Pregnancy and birth

A maternity is a pregnancy resulting in the birth of one or more live or still born children. Antenatal and postnatal care and maternity services are key components of local health services as the impact they have on the health of a mother and her child is both immediate and long term. Low birth weight babies are more likely to suffer heart disease as adults and babies that are not breastfed are more likely to develop diabetes, asthma and eczema and more likely to become obese. Life experiences and care in pregnancy and early life affect the longer term educational, emotional and psychological wellbeing of mother and child. Maternity services also have a broader impact on the health and wellbeing of families and communities by helping to build the foundations of strong parent-child attachment and promoting positive parenting (Maternity Strategy, 2009).

### Fertility rates

**2011 update**

The fertility rate is high in Hackney and low in the City. In Hackney, there is a particularly high fertility rate in the Orthodox Jewish (Charedi) population.

In 2009, there were 4,500 live births in Hackney, an increase of 1.5% on the previous year. This can be expressed both as the general fertility rate (the number of births per 1,000 women of child-bearing age) and as the ‘total period fertility rate’, which is the average number of children borne by women, given this rate of births (Table 5.4). The fertility rate in Hackney is high compared to the average for London, with a total period fertility rate higher than two.

Fertility rates vary between ethnic groups in London with women from Bangladesi, Pakistani, Black African and Other Black and Other Asian groups having higher numbers of births than White women. The large young
population in the Charedi community (18.5% are aged under 5 years) reflects the particularly high birth rate in this community.\(^{281}\)

**The City**

In 2009, there were 74 live births in the City of London. This is unusually high for the City and is a 48% increase on the previous year (there were 50 births in 2008). However the official fertility rate has actually fallen from 27 to 23 live births per 1,000 women of child-bearing age due to the revision in the official population estimate which defines the denominator of the rate calculation. The total period fertility rate remains very low (Table 5.1)

<table>
<thead>
<tr>
<th></th>
<th>Hackney</th>
<th>The City</th>
<th>Tower Hamlets</th>
<th>Newham</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of live births</td>
<td>4,500</td>
<td>74</td>
<td>4,337</td>
<td>6,003</td>
<td>129,245</td>
</tr>
<tr>
<td>General fertility rate per 1,000 women aged 15-44 yrs</td>
<td>78</td>
<td>23</td>
<td>63</td>
<td>106</td>
<td>70</td>
</tr>
<tr>
<td>Total period fertility rate (average no. children per woman)</td>
<td>2.17</td>
<td>0.73</td>
<td>1.65</td>
<td>2.96</td>
<td>1.95</td>
</tr>
</tbody>
</table>

**Smoking and pregnancy**

**2011 update**

The overall rate of smoking during pregnancy remains low in Hackney.

**Focus on inequalities:**

- Smoking in pregnancy is more prevalent among English, Irish, Turkish and Black Caribbean women in Hackney
- Smoking in pregnancy is uncommon among South Asian and Vietnamese women and extremely rare among Jewish, African and Chinese women.

Smoking during pregnancy is harmful to the mother and baby. Babies born to mothers who smoke tend to be smaller and are around 40% more likely to die within the first four weeks of life than babies born to non-smokers.\(^{282}\) The adverse effects of smoking during pregnancy include an increased risk of miscarriage, preterm birth, low birth weight and stillbirth. It is associated with sudden infant death syndrome.

In 2010/11, 6.8% of women in Hackney and the City reported being smokers at the time of delivery, a slight rise on 6.3% in the previous year. This is less than half the national average and is significantly lower than the average for London.

There are pronounced differences in rates of smoking during pregnancy within ethnic groups in Hackney (Figure 5.5). Smoking in pregnancy is more prevalent among English, Irish, Turkish and Black Caribbean women, uncommon among South Asian and Vietnamese women and extremely rare among Jewish, African and Chinese women.

All expectant mothers are asked at the first opportunity if they smoke and those who do quit are referred to the Smoking Cessation Specialist Midwife for support and advice. In 2010/11, 136 pregnant women accessing

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\(^{282}\) Department of Health (2011) NHS Stop Smoking Services. Service and monitoring guidance 2011/12
the service, an increase of 9% on the previous year. Of these women, 65 went on to be four-week quitters (48%). The DH minimum standard for this group is 35%. Three quarters (74%) were CO validated. This is significantly higher than the national average for CO validation of this group (58%). DH guidance recommends that every effort should be made to CO validate and record smoking status in pregnancy as self-reporting has been found to be less reliable in this group than the general population due to the stigma of smoking during pregnancy.

The City

In 2010/11 none of the pregnant women resident in the City reported being smokers at the time of delivery.

Figure 5.5 Smoking in pregnancy: deliveries at Homerton Hospital, April 2010 to September 2011: rates per ethnic group

![Bar chart showing smoking rates per ethnic group.]

Antenatal care

2011 update

The rate of early booking for maternity services has continued to rise, reaching 71% in 2011. However this is still one of the lowest rates in London

Focus on inequalities:

- Locally there is a particularly low rate of early booking in the Orthodox Jewish community. There are also low rates among Black African, Irish and Vietnamese and Chinese women.

Healthy parents are more likely to have healthier babies. Lifestyle factors such as smoking, consumption of alcohol, substance misuse, poor nutrition and obesity before conception and early in pregnancy can lead to poor health for both mother and baby.

Women are encouraged to book for their care as early as possible in pregnancy (and ideally by end of week 12). The proportion of women in Hackney booking early rose from 60% in 2009/10 to 71% in April to September 2010\(^2\). However this is still one of the lowest rates in London.

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\(^2\) NHS East London and the City: local maternity data
Figure 5.6 illustrates the differences in early booking rates between ethnic groups in Hackney and the City. There are low rates among Black African, Irish and Vietnamese and Chinese women. However the lowest rate is in the Jewish community. Women in the Orthodox Jewish (Charedi) community are particularly resistant to booking early for antenatal care, preferring to wait until the pregnancy is visible.

**The City**

Over the six months from April to September 2011, 21 women from the City booked for maternity care. Three quarters had booked by the 12th week.

Figure 5.6 Rates of early booking (before week 13) for antenatal care in Hackney and the City, Q1 and Q2 2011, by ethnic group (local maternity data)

Antenatal screening programme at Homerton University Hospital

**2011 update**

The antenatal screening programme at the Homerton continues to provide vital early information about health risks to unborn children. The major identified risks are lack of immunity to rubella in the mother and exposure to syphilis, HIV and hepatitis B.

In 2010/11, 5,589 women booked at the Homerton and there were 5,025 babies born (live and still births). All women are offered scans to ascertain likely birth dates and abnormalities. Women are offered infectious disease screening by either their GP at referral or at their first antenatal appointment with a midwife. In 2010/11, the following cases were identified: 19 cases of syphilis, 31 cases of HIV (16 new cases), 73 cases of hepatitis B and 239 cases of no immunity to rubella.

All women are offered screening for sickle cell and thalassaemia at the earliest opportunity if the Haemoglobinopathy status is not already known. At risk couples (including couples who are carriers of a haemoglobin variant as well as pregnant carriers where the partner is not available for testing) are offered

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284 Egole, C: *NHS Antenatal Screening Programmes Annual Report 2010-11*, Homerton University Hospital Foundation Trust, 2011
prenatal diagnosis. In 2010/11 49 ‘at risk’ couples were identified and offered prenatal diagnosis, which was accepted by 13 couples. Fewer than five affected babies were identified by prenatal screening.

Slightly over 10% of deliveries at the Homerton in 2007/08 were from the Orthodox Jewish community. A number of genetic screening tests are generally carried out before young Orthodox Jews reach marriageable age including for Tay Sachs and Cystic Fibrosis as well as some other more rare diseases. A single blood test is taken from teenagers (usually at their place of study) and results stored on an international database by anonymous identification number. At a later date, when a potential suitor is suggested for marriage, each of the ID numbers are looked up on the database and the couple are advised whether or not they are a suitable match, before they ever meet one another. No further details are revealed to them. In this way, the Jewish community are working toward eliminating the risk of genetic disorders in their community.

A number of steps are being taken to improve the accuracy of the reported screening coverage. These include remote access, improvement in referrals and full completion of related paperwork, early bookings and the creation of a weekly antenatal screening report. For the first time, the data for the 2010/11 Antenatal Screening Programme Annual Report was generated from the maternity system data (instead of laboratory data). This will encourage capture of more accurate data on uptake of screening from booking assessments.

Place of birth and delivery method

<table>
<thead>
<tr>
<th>2011 update</th>
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<tbody>
<tr>
<td>In 2010-11, only 3% of deliveries took place at home in Hackney (slightly higher than the rate for London which is 1.9%). In the City, the rate was 1.3%.</td>
</tr>
<tr>
<td>At the Homerton Hospital, 17% of births were by emergency caesarean section in 2009/10, higher than the national average.</td>
</tr>
</tbody>
</table>

Women are able to choose the hospital they want for delivery and are offered a choice (dependent on risk assessment) of home birth, delivery in a midwife-led setting or in an obstetrician-led setting. Most deliveries in Hackney take place in hospitals: between January 2010 and October 2011, 97% of births to Hackney women took place in hospital. The majority (76%) were at the Homerton Hospital (Figure 5.7).

The proportion of births that take place in the home is used as a measure of the responsiveness of maternity services to patient choice since research has shown that many women desire a home birth. Between January 2010 and October 2011, 3% of Hackney deliveries took place at home. This is a small increase on the 2% rate in 2008-09.

In 2009/10, 70% of women delivering at Homerton Hospital experienced a spontaneous onset of labour (as opposed to onset by induction or planned (caesarean). This is comparable to the averages for London (70%) and England (68%)286.

The proportion of babies born by caesarean section at Homerton Hospital in 2009/10 was 23% and of these the majority (64%) were emergency procedures (17% of all deliveries). This is slightly higher than the national rate of emergency caesarean sections (14%). Caesarean section rates vary by ethnicity. In 2006 to 2008, the proportion of caesarean sections was highest among African women (37.6%) and lowest among Orthodox Jewish women (6.7%). Nationally, caesarean section rates demonstrate a similar pattern and the association between ethnicity and caesarean rate (with the highest rates among black African and Caribbean women) persists even after adjustment for clinical or other demographic differences287.

The City

Between January 2010 and October 2011, 98% of births to City residents took place in hospital, mainly at UCL and the Royal London (Figure 5.8).

285 Thompson A: NHS Antenatal Screening Programmes Annual Report 2008-09, Homerton University Hospital Foundation Trust, 2009
286 All data on method of delivery from the Health Social Care Information Centre, 2010
As part of the development of the City and Hackney Maternity strategy, NHS City and Hackney commissioned a consultation with women who had recent experience of maternity care locally. The consultation prioritised particularly vulnerable and marginalised women whose views may otherwise not be heard, such as women who do not speak English, with physical or sensory disabilities, who are very young, who misuse alcohol or other substances or who experience mental ill health as well as asylum seekers and refugees.

The key areas of concern were:
- Breastfeeding and the need for greater support
- Insufficient or poor quality of food provided in the hospital
- Poor levels of cleanliness in hospital
- Level of care (particularly postnatal care)
- Lack of continuity of carer
- Staff attitudes

Maternal mortality

Maternal deaths, including deaths up to six weeks post-partum, are very rare in Hackney and the City. There were fewer than five maternal deaths in the three years from 2007 to 2009 (NCHOD).

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288 Fabry N, Stanwick S: Consulting with women in City and Hackney on the future of maternity services. Enterprise for Communities, Eastbourne, 2009.
At a national level, we know that Black African women and newly arrived refugees have higher maternal mortality rates than the general population. Given the large population of refugees and asylum seekers in Hackney and the high deprivation within the borough, the extremely low rate of maternal mortality (1.7 per 100,000 women of child-bearing age) is potentially an indicator of the effectiveness of local services in identifying and addressing these needs.

**The City**

There is no disaggregated maternal mortality data for the City due to low numbers.

**Terminations**

<table>
<thead>
<tr>
<th>2011 update</th>
</tr>
</thead>
<tbody>
<tr>
<td>The pregnancy termination rate in Hackney and the City continues to decline in all age groups, year-on-year. Over the past decade the rate has fallen by over a third while the national rate has remained stable.</td>
</tr>
</tbody>
</table>

In 2010, there were 1,651 terminations in City and Hackney, a rate of 27.3 per 1,000 women aged 15-44 years. This is significantly higher than the national average of 17.6 per 1,000 women of this age. However, since 2003 the local termination rate has declined by 35% while the national rate has remained stable (Figure 5.9). The local rate is no longer one of the highest in the country.

The termination rate in City and Hackney is higher, but not significantly higher, than the rate in London as a whole (25.7 terminations per 1,000 women aged 15-44 years).

In 2010, the highest rate of terminations in Hackney and the City was among those aged 20-24 years. There are no major differences in distribution of terminations by age groups for City & Hackney compared to London and England. Overall:

- 12% of terminations occurred among those aged under 20
- 54% of terminations occurred among those women aged between 20 and 29 inclusive
- 35% of terminations occurred among those aged 30 and over

**The City**

There is no disaggregated terminations data for the City due to low numbers.

**Figure 5.9 Termination rate 2003-2010 (Department of Health)**

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289 Department of Health
Early years

Infant mortality

2011 update

Infant mortality has risen in Hackney for the third successive year. The long-term trend in infant mortality remains downwards but we will be keeping a close eye on the issue.

Focus on inequalities:

- Nationally, higher rates of infant mortality have been identified in lower socio-economic groups, black and ethnic minority populations, and among single mothers and young mothers
- Infant mortality is also associated with maternal smoking and obesity and reduced access to, and uptake of, maternity services during pregnancy
- Locally there is a high rate of infant mortality among babies of Black Caribbean and Black African women

The infant mortality rate is defined as the number of deaths under the age of one year per 1,000 live births. It is a measure of the health of a community and reflects a range of social factors such as housing, poverty and deprivation as well as the availability of neonatal intensive care to support premature or very sick babies.

The infant mortality rate in Hackney for the three year period from 2007 to 2009 period was 5.8 deaths in the first year of life per 1,000 live births (Figure 5.10) or an average of 26 deaths per year. This was marginally higher than the rate in 2006-2008 of 5.7 infant deaths per 1,000 live births and was the third rise in three years. The long-term downward trend is still evident in Figure 5.6 but we will be keeping a close eye on the issue.

The City

Infant deaths are extremely rare in the City of London and are too low to report, even as a three year average.

Figure 5.10 Trend in infant mortality rate 2000 to 2009 (NCHOD)
Inequalities

A 2002 national review of health inequalities\(^290\) identified higher infant mortality rates in routine and manual socio-economic groups, ‘other’ socio-economic groups including long-term unemployed fathers, and black and ethnic minority populations.

In 2009 the National Perinatal Epidemiology Unit (NPEU) undertook a programme of work for the Department of Health to strengthen the evidence base on reducing infant mortality\(^291\). They identified the following factors associated with increased infant mortality rates in the general population:

- Prematurity
- Congenital abnormality
- Socioeconomic position (lower SEC most at risk)
- Marital status (sole registrations most at risk)
- Maternal age (younger mothers most at risk)
- Maternal smoking
- Maternal overweight and obesity
- Access to and uptake of maternity services during pregnancy
- Infant sleeping arrangements

In 2007 the London Health Observatory published a report exploring the factors contributing to infant mortality in London\(^292\) and suggested that inequalities in infant mortality rates could be reduced by focusing on the following higher risk groups:

- Women living in deprived areas
- Ethnic minority populations (based on mother’s country of birth rather than ethnicity)
- Teenage mothers
- Women at risk of delivering low birth weight babies

Local research has indicated that some groups within the population are at greater risk of experiencing infant mortality, particularly women of Black African and Black Caribbean ethnicity\(^293\).

Local action

Reducing infant mortality is a key national and local priority and has been the focus of much local effort work including Sure Start and Children’s Centre midwifery and more recently the targeted Reducing Infant Mortality Programme. This programme involved a range of activities across the locality designed to improve outcomes for pregnant women, targeting those who are particularly vulnerable, including West African and Caribbean women who are known to have higher rates of pre-term birth, women who delay in making contact with maternity services and young pregnant women. Interventions were delivered by the Homerton Hospital, Shoreditch Trust, NHS City and Hackney and City University.

Programmes included:

- Maternity Telephone helpline staffed by experienced midwives
- ‘Bump Buddies’, a peer education programme focusing on black British/ African/ Caribbean and Turkish/ Kurdish women in two deprived areas of Hackney
- ‘Birth Buddies’, a labour support volunteer programme aimed at women of African/ Caribbean origin
- Bilingual maternity support workers to work alongside community midwives
- Additional outreach midwifery services in Children’s Centres and the Sanctuary Practice (aimed at refugees, asylum seekers and homeless women)

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● Research into pre-term birth among African and Caribbean women in Hackney and an update of the FIDEL study

Work which is planned or underway to improve the outcomes for women and babies includes;

● Further distribution of “pregnant – what to do now” leaflet by pharmacies alongside pregnancy testing kits
● Education sessions delivered to services working with pregnant women, particularly those from groups known to book later in pregnancy
● Targeted advertising in the Orthodox Jewish press, explaining the benefits or early booking and how to access maternity services
● Continued use of a freepost maternity feedback card distributed postnatally to all women delivering at Homerton
● Encouraging women to take up the Healthy Start programme and in particular to claim the free vitamins offered to both pregnant women and children
● Development of a “breastfeeding welcome” scheme to be implemented in health, local authority and business premises across the locality

What works: reducing infant mortality

Department of Health guidance

A 2007294 government review identified a number of interventions that may help both to reduce infant mortality as a whole and to reduce inequalities in infant mortality rates.

Interventions that will reduce infant mortality overall

Quality of healthcare. Infant mortality is influenced by the quality of healthcare provided. Interventions include:

● Preventing pre-term birth
● Providing good quality neonatal care for pre-term babies
● Developing maternity and neonatal networks
● Carrying out reviews of all child deaths
● Ensuring all women are offered antenatal screening

Immunisation. The number of infants who die due to vaccine-preventable disease is very small but the number of children who suffer illness and long term disabilities due to vaccine-preventable illness makes a considerable impact on families, the NHS and other local services.

Interventions found to have a demonstrable effect on inequalities in infant mortality:

Reducing teenage pregnancy. Infant mortality is 60% higher for teenage mothers than for mothers aged 20-39. Among the main contributory factors are that younger women are more likely to present late for antenatal care, more likely to smoke and have a poor diet during pregnancy and less likely to breastfeed.

Reducing sudden unexplained death in infancy (SUDI). SUDI occurs in all populations but is more common in disadvantaged groups. Interventions include:

● Ensuring babies sleep on their backs (‘Back to Sleep’) and with their heads uncovered
● Ensuring infants sleep in a separate cot in their parent’s room, and not in the parental bed, especially if parents smoke, have been drinking or have taken drugs
● Reducing parental smoking

Reducing smoking in pregnancy. Smoking in pregnancy increases the risk of infant mortality by around 40%. Smoking in pregnancy is 1.5 times higher in women in the routine and manual socioeconomic group and nearly three times higher among mothers under 20 than the general population. Interventions include:

● Offering all pregnant women and their partners tailored smoking cessation support
● Implementing clear referral pathways and accessible services for pregnant smokers
● Providing professionals with appropriate training to discuss smoking, to refer when necessary or to provide brief smoking cessation intervention

Optimising nutrition for mother and infant. Women in disadvantaged groups are more likely to be obese than more affluent women. Neonatal death is more common in babies born to women who are overweight, underweight or obese before they conceive. Interventions include:

- Promoting breastfeeding and supporting women to continue to breastfeed by implementing an externally evaluated, structured programme such as the UNICEF Baby Friendly Initiative\textsuperscript{295}.
- Reducing maternal obesity
- Promoting the Healthy Start programme, increasing access to healthy food and vitamin supplements
- Developing a 5 A DAY communications programme aimed at increasing awareness of the health benefits of fruit and vegetables
- Providing tailored weight loss support for women with BMI greater than 30

Improving housing quality and reducing overcrowding. Overcrowded living conditions are associated with health problems such as stress and depression. Reducing overcrowding may help to reduce the gap between infant mortality rates in the R&M explain group and the general population.

Decreasing the number of children living in poverty. Parents need to be supported to enter and remain in the workplace and families need to receive adequate financial support.

Interventions likely to impact on inequalities in infant mortality:

Improving access to maternity care. By accessing maternity care early in pregnancy (by the end of week 12) women can benefit from a full range of personalised care leading to improved outcomes for mother and baby. Interventions include:

- Delivering targeted outreach work aimed at vulnerable and socially excluded women
- Providing maternity services at convenient times and locations, including integration of maternity services within Children’s Centres

National Perinatal Epidemiology Unit

The NPEU has published detailed summaries of research evidence on the effectiveness of a range of interventions in the following areas:\textsuperscript{296,297}

- Pre-conception health
- Prevention of pre-term birth
- Prevention of lung disease, infections and necrotizing enterocolitis in neonates
- Resuscitation of neonates
- Nutritional supplementation for neonates/infants
- Other interventions targeting neonates/infants
- Smoking during pregnancy
- Risk factors for sudden infant death (SID)/sudden unexplained death in infancy (SUDI)
- Obesity/overweight during pregnancy and pre-conception

NICE guidance

NICE guidance for pregnant women with complex social factors\textsuperscript{298} was published in 2010, aiming to improve health outcomes by addressing the barriers that prevent some women from benefiting fully from antenatal care. The key recommendations for all women with complex social factors are:

- Tailoring services to meet the needs of the local population
- Involving women in their antenatal care by gathering and acting upon women’s feedback
- Providing training on multiagency needs assessment and information sharing
- Enhancing the delivery of care, by referring at first contact, reinforcing contact at booking, coordinating care with other agencies, communicating in a sensitive manner and ensuring handheld notes are up to date.

Child deaths

The panel is chaired by a Consultant in Public Health for NHS East London and the City (City and Hackney) and has representatives with expertise in the fields of public health, paediatrics, child health, neonatology,

\textsuperscript{296} \url{http://www.unicef.org.uk/babyfriendly/}
\textsuperscript{296} NPEU: The effectiveness of interventions targeting infant mortality: a user’s guide to the systematic review evidence. NPEU: 2009.
\textsuperscript{297} NPEU: The effectiveness of interventions targeting major potentially modifiable risk factors for infant mortality: a user’s guide to the systematic review evidence. NPEU: 2009.
\textsuperscript{298} NICE: Pregnancy and complex social factors. CG110. 2010.
paediatric pathology, mental health, children’s social care, child protection, nursing, midwifery, general practice, child safety (police), education and youth crime reduction.

The panel plays an important role in improving the health, safety and wellbeing of all children who are resident in Hackney and the City by reviewing all child deaths to assess the degree of preventability and identify trends, risks and factors that could be associated with child deaths locally, such as service issues and epidemiological, environmental, social and cultural factors. The panel makes recommendations to reduce risks and to improve the quality of frontline services for children and young people, with the goal of preventing future deaths.

There are two interrelated processes for reviewing child deaths:

- a rapid response process by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child when it happens;
- an overview by the panel of all deaths under age 18 years.

During the period 1 April 2010 to 31 March 2011, there were 28 deaths in children and young people who were normally resident in Hackney and the City. This represents a mortality rate of 0.43 per 1,000 people aged under 18 years. The panel completed reviews of 48 deaths during 2010/11 including outstanding cases from 2008-09 and 2009-10.

The Rapid Response group considered the unexpected deaths of 12 of the 28 deaths that occurred during 2010/11. The findings of all rapid response meetings are discussed at the monthly Serious Case Review subcommittee of the CHSCB. None of the sudden deaths considered by the rapid response group during 2010-11 were put forward for Serious Case Review, but one case was recommended for independent review and two cases were subject to Gold Group meetings.299

Fourteen of the 48 cases reviewed by the panel were deaths occurring within the first 28 days of life and 28 occurred within the first year. Eleven of the deaths occurring within the first year of life were classified as due to chromosomal, genetic and congenital anomalies. Twenty of the 48 cases reviewed by the panel were defined as unexpected deaths.

The cause of death in 22 of the 28 child deaths in 2010/11 was, in the language of the international classification (ICD-10) of diseases, ‘diseases/morbid conditions’. This category includes congenital abnormalities, perinatal conditions, cancer (glioma and ependymoma), sickle cell disease/subarachnoid, acute asthma attack, acute histiocytosis and bronchiolitis/adenovirus.

During 2010/11, the panel has sought to improve the wellbeing and safety of children and young people by:

- reviewing the Homerton University Hospital’s Maternity Clinical Practice Guidelines in relation to Mother and Baby Bed sharing and Co-sleeping; and the NHS City and Hackney Health Visitor pack in relation to its safe sleeping messages. The CDOP agreed that both the guidelines and the pack are up-to-date and appropriate;
- supporting the need for Great Ormond Street Hospital to join the Image Exchange Portal System as soon as it is possible;
- raising awareness to clinical staff of the importance of early identification of the signs and symptoms related to blocked cerebral shunts;
- working with Homerton University Hospital in ensuring all community midwives receive training in cardiopulmonary resuscitation of babies and have access at all relevant times to the portable equipment needed for homebirths;
- advising on a recommendation by the London Ambulance Service about defibrillators in school;
- supporting a literature review of the use of hypertonic nasal spray in infants and its potential link with cerebral oedema by the paediatric pathologist from the Royal London Hospital;

299 A Gold Group is the command centre during a critical incident. The Rapid Response process runs in parallel with a Gold Group and the chair of the Rapid Respond meeting will always be part of Gold Group. Gold Groups are usually coordinated by the Borough Police. The investigating officer of the Gold Group will attend the Rapid Response meeting to ensure information is shared across two parallel processes.
informing the Medicines and Healthcare Products Regulatory Agency and GPs of potential risks in the use of hypertonic nasal spray in infants;

supporting parents in a review of agencies policies and procedures in relation to homebirths and ensuring that the recommendations of such review were implemented;

awareness raising with Hackney Homes in relation to fall prevention strategies from buildings and windows;

recommending that the Homerton University Hospital’s Asthma leaflets are made available to children’s social care staff;

advising about the risks of omitting important vaccines when choosing an alternative immunisation provider, who does not follow national guidelines;

ensuring in relevant cases that parents are referred to genetic counselling.

As a first step in the process of improving outcomes for children and families in relation to infant mortality, the panel has organised a number of themed meetings, including a presentation on the Homerton University Hospital’s policy on premature and prolonged rupture of membranes and a presentation on subdural haemorrhages by the paediatric pathologist from the Royal London Hospital.

Recommendations made by the panel about required future actions to prevent child deaths include:

- awareness raising of safe sleeping messages by distributing the “sleep sound sleep safe” leaflet developed by the Foundation for the Study of Infant Deaths to the public;

- a review of Homerton University Hospital’s policy in relation to Accident and Emergency for the identification of fever in premature babies;

- an audit of premature and prolonged rupture of membranes cases at the Homerton University Hospital;

- supporting the development of a policy regarding Vitamin D supplementation and the raising of awareness of Vitamin D supplementation within City and Hackney.

**Low birth weight babies**

**2011 update**

There was a fall in the number of low birth weight babies born in Hackney in 2009. The rate is now average for London.

**Focus on inequalities:**

- Locally there is a high rate of preterm birth among Black Caribbean and Black African women

Low birth weight is strongly associated with increased risk of infant death and can also affect adult health. Factors that contribute to low birth weight include smoking during pregnancy and poor nutrition. In the UK, low birth weight varies by socioeconomic status and ethnicity. Local research in Hackney found a high rate of preterm birth among Black Caribbean and Black African women.

In 2009, 343 newborn babies in Hackney weighed less than 2,500g, the weight used to define low birthweight. This is equivalent to 7.8% of all births, a decline from 8.5% the previous year. The average for London as a whole was 7.9%. Rates in neighbouring boroughs are significantly higher (8.8% in Tower Hamlets and 9.7% in Newham).

**The City**

There were no low birth weight babies born in the City in 2009.

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Newborn screening

All babies undergo a physical examination by the time they are 72 hours old. The examination includes a general overall physical check and a specific examination of the baby’s eyes, heart, hips and (for boys) testes. These checks are carried out by a paediatrician or midwife or sometimes by a GP or community midwife. The examination is repeated at 6-8 weeks of age and additional information is recorded including whether the baby is breast fed. The 6-8 week review is carried out by the GP or community paediatrician.

Newborn bloodspot screening

Newborn bloodspot screening is provided to all babies in Hackney and the City. A blood sample is taken from the baby’s heel (at aged 5-8 days) and screened for Phenylketonuria (PKU), Congenital Hypothyroidism (CHT), Sickle Cell Disease, Cystic Fibrosis (CF) and Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD). Although these conditions are not curable, early detection and treatment improves outcomes.

In Hackney and the City, in the first quarter of 2010/11, 991 out of 1,001 babies were tested (99%). Sickle cell is the most common condition identified through screening locally. In 2010/11, 11 suspected cases were identified and 248 suspected carriers. Positive samples are referred urgently to specialist clinical teams who ensure that the baby’s treatment and care are appropriately managed.

Newborn hearing screening

Newborn Hearing Screening Programme (NHSP) allows for the early identification of deafness and hearing impairment. Steps can be taken to aid speech and language development at a very early stage increasing the likelihood higher educational achievement, improved communication skills and a better quality of life.

The NHSP in Hackney and the City was implemented from early 2006. The majority of screening takes place at Homerton hospital (60% of babies in 2010/11) and in most cases screening is completed prior to discharge. Those babies who cannot be screened at Homerton are offered an outpatient appointment at one of four family-friendly outpatient clinics (31% of all babies in 2010/11). The NHSP also offers outpatient appointments to babies born at home, in private hospitals, in out of area hospitals and those that move into the area within three months of age. The NHSP team is responsible for offering follow-up appointments at 7-9 months of age to all babies who have a direct family history or specific risk factors for hearing impairment.

For April - June 2011, 99.5% of babies in Hackney and the City (GP population) were offered a newborn hearing screen within 3 months of age (national target 99%). City and Hackney NHSP completed screening on 97.6% of babies within 4 weeks of age (national target 95%) and 98.4% within 12 weeks of age (national target 95%).

Breastfeeding

2011 update

Rates of breast-feeding continuation at 6-8 weeks remain exceptionally high in Hackney and the City and continue to show year-on-year improvement.

Breastfeeding is the best form of nutrition for infants to ensure a good start in life. Breast milk provides all the nutrients a baby needs, protects them against respiratory and gastrointestinal infection and promotes bonding between mother and child. Breastfeeding is also beneficial to mothers as it promotes maternal recovery after childbirth, reduces the risk of osteoporosis, breast cancer and ovarian cancer and aids a return to pre-pregnancy body weight. Exclusive breastfeeding is recommended for the first six months of an infant’s life and after this point continuation of breastfeeding is recommended alongside solid foods.
Nationally, there are variations in breastfeeding rates: younger mothers and mothers from lower socioeconomic groups are less likely to breastfeed than others.\(^{301}\) Despite being an area of high deprivation, breastfeeding rates are very high in Hackney and the City. In 2010/11, 92% of mothers initiated breastfeeding and 80% were still breastfeeding after 6-8 weeks. In the first half of 2011/12 this rate had risen further to 84%. Over half of those still being breastfed at 6-8 weeks were being exclusively breastfed (50% of all babies in 2010/11).

Over the past two and a half years, the proportion of women in Hackney and the City initiating breast-feeding has remained stable and the proportion of women sustaining breast-feeding at 6-8 weeks has risen (Figure 5.11)

In 2006/07, a local audit at the Homerton found that women from Eastern European, Orthodox Jewish and Turkish (including Turkish Cypriot) backgrounds were more likely than White English mothers to initiate breastfeeding. Irish women appear less likely to breastfeed than English women.\(^{302}\)

**The City**

In 2010/11 all babies born to City mothers were recorded as initiating breast-feeding and continuing breast-feeding at 6-8 weeks.

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\(^{301}\) National Statistics/ The Information Centre: *Infant Feeding Survey 2005*

\(^{302}\) NHS City and Hackney: *City and Hackney Maternity Health Equity Audit*, 2006
Immunisation

### 2011 update

Most childhood immunisation rates continue to improve year-on-year in Hackney and the City. In 2010/11 there were marked improvements in the immunisation rates for 5 year-olds. However all rates remain below the national target.

**Focus on inequalities:**

- In Hackney there is high uptake of vaccinations in the Turkish, Black African and Asian communities and lower uptake in White British and Black Caribbean communities.
- The lowest uptake is in the Orthodox Jewish (Charedi) community. This is due to a range of factors including concerns about the safety of the vaccines, lack of trust in the information provided by professionals and large family sizes.

Immunisation is a very effective means of protection against serious infectious diseases, some of which can be fatal or cause lasting damage to a child’s health. Vaccinations are given to prepare a child’s immune system to fight off infections when he or she comes into contact with them.

All babies and children in Hackney and the City are offered vaccinations in accordance with the Department of Health routine immunisation schedule^303^. The Green Book^304^ describes in detail the immunisation programme and the diseases against which it protects, summarised in Table 5.4. It also provides guidance on vaccinating in specific circumstances such as children who are very unwell, children with unknown immunisation history or children who require selective immunisation against diseases that are not part of the routine programme, such as Hepatitis B. The vaccines are delivered through GP surgeries, child health clinics, children centres, nurseries, schools and in some community settings.

The immunisation rates for children in Hackney and the City by their first, second and fifth birthdays are shown in Tables 5.5, 5.6 and 5.7 respectively. Compared to rates for London and England, coverage in Hackney and the City is relatively low. However, most immunisation rates continue to improve year-on-year with the biggest recent improvements seen in the immunisation rates for 5-year-olds, for whom immunisation rates for Diphtheria, Tetanus, Polio and Hib are now comparable to the London average.

In September 2008 a new vaccine was added to the UK childhood immunisation schedule to protect girls against Human Papilloma virus (HPV), a sexually transmitted infection that causes cervical cancer. The HPV vaccine is given in three doses over a period of six months and was rolled out through the school nursing service to all 12 to 13 year old girls in year 8. In 2010/11, 56% of all girls of this age were vaccinated in Hackney and the City, a fall from 63% in the previous two years and below target of 70%. In part, the low rate is due to resistance within the Charedi community to HPV vaccination because of its association with sexual relationships outside marriage.

**The City**

Immunisation data for babies born in the City is constrained by the small number of babies born. However, in the first two quarters of 2011/12, 96% of babies due the 5-in-1 vaccine by their first birthday had received it and 71% of babies due their first MMR vaccine by their second birthday had received it (local data).

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^303^ [http://www.nhs.uk/Planners/vaccinations/Pages/Vaccinationchecklist.aspx](http://www.nhs.uk/Planners/vaccinations/Pages/Vaccinationchecklist.aspx)

Table 5.4 Routine Childhood Immunisation Programme UK (2009)

<table>
<thead>
<tr>
<th>Primary Immunisation</th>
<th>Disease protected against</th>
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<tr>
<td>2 months</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio, <em>Haemophilus influenzae</em> type b (Hib), Pneumococcal infection</td>
</tr>
<tr>
<td>3 months</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio, <em>Haemophilus influenzae</em> type b (Hib), Meningitis C</td>
</tr>
<tr>
<td>4 months</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio, <em>Haemophilus influenzae</em> type b (Hib), Meningitis C, Pneumococcal infection</td>
</tr>
<tr>
<td>At birth/in the 1st year of life</td>
<td>Tuberculosis*</td>
</tr>
</tbody>
</table>

12 months to 5 years

<table>
<thead>
<tr>
<th>Disease protected against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between 12 and 13 months old – within a month of the first birthday</td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib)</td>
</tr>
<tr>
<td>Meningitis C</td>
</tr>
<tr>
<td>Pneumococcal infection</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella</td>
</tr>
<tr>
<td>3 years and 4 months</td>
</tr>
<tr>
<td>Diphtheria, tetanus, pertussis and polio</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella</td>
</tr>
</tbody>
</table>

Age 12 to 18 years

<table>
<thead>
<tr>
<th>Disease protected against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls aged 12 to 13</td>
</tr>
<tr>
<td>Cervical cancer caused by human papillomavirus types 16 and 18.</td>
</tr>
<tr>
<td>13 to 18 years</td>
</tr>
<tr>
<td>Diphtheria, tetanus, polio</td>
</tr>
</tbody>
</table>

* The BCG vaccine given to children to protect against tuberculosis is not part of the routine childhood immunisation programme but is recommended for children born in Hackney due to the high incidence of TB locally.

Table 5.5. Immunisation coverage by 1st birthday

<table>
<thead>
<tr>
<th></th>
<th>Diphtheria, Tetanus, Polio, Pertussis, Hib</th>
<th>Meningitis C</th>
<th>Pneumococcal disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hackney &amp; the City</td>
<td>76.0%</td>
<td>81.2%</td>
<td>82.5%</td>
</tr>
<tr>
<td>London</td>
<td>83.4%</td>
<td>88.7%</td>
<td>90.7%</td>
</tr>
<tr>
<td>England</td>
<td>92.0%</td>
<td>93.6%</td>
<td>94.2%</td>
</tr>
</tbody>
</table>
Table 5.6. Immunisation coverage by 2nd birthday

<table>
<thead>
<tr>
<th></th>
<th>Diphtheria, Tetanus, Polio, Pertussis, Hib</th>
<th>MMR 1st dose</th>
<th>MMR 2nd dose</th>
<th>Meningitis C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hackney &amp; the City</td>
<td>80.9% 85.3% 89.6%</td>
<td>70.0% 75.3% 75.4%</td>
<td>81.4% 82.4% 81.7%</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>86.5% 90.8% 92.9%</td>
<td>76.3% 81.9% 83.8%</td>
<td>79.7% 88.0% 89.8%</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>93.9% 95.3% 96.0%</td>
<td>84.9% 88.2% 89.1%</td>
<td>91.9% 94.2% 94.8%</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>57.3% 73.4% 74.1%</td>
<td>55.1% 71.8% 88.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>85.4% 90.0% 91.6%</td>
<td>81.5% 87.6% 89.3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5.7. Immunisation coverage by 5th birthday

<table>
<thead>
<tr>
<th></th>
<th>Diphtheria, Tetanus, Polio</th>
<th>Hib</th>
<th>Diphtheria, Tetanus, Polio, Pertussis (booster)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hackney &amp; the City</td>
<td>76.1% 82.6% 89.9%</td>
<td>77.2% 82.5% 89.9%</td>
<td>22.7% 42.7% 57.7%</td>
</tr>
<tr>
<td>London</td>
<td>82.6% 88.0% 90.0%</td>
<td>77.0% 87.6% 90.2%</td>
<td>58.2% 71.8% 74.7%</td>
</tr>
<tr>
<td>England</td>
<td>92.5% 94.0% 94.7%</td>
<td>90.9% 93.1% 94.2%</td>
<td>80.1% 84.8% 85.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>MMR 1st dose</th>
<th>MMR 2nd dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hackney &amp; the City</td>
<td>67.2% 78.6% 86.5%</td>
<td>36.6% 49.3% 64.8%</td>
</tr>
<tr>
<td>London</td>
<td>80.9% 85.8% 88.2%</td>
<td>63.0% 72.2% 76.6%</td>
</tr>
<tr>
<td>England</td>
<td>88.9% 91.0% 91.9%</td>
<td>78.0% 82.7% 84.2%</td>
</tr>
</tbody>
</table>

Inequalities

Table 5.8 describes the number and proportion of infants who received the full course of five-in-one vaccinations by their first birthday in the first quarter of 2010/11 by ethnic group. There is high coverage in Turkish, Black African and Asian communities and lower coverage in White British and Black Caribbean communities. The lowest coverage is in ‘White Other’ and ‘Other’ groups – the latter includes many babies from the Orthodox Jewish (Charedi) community. Some care is needed in interpreting these data as there is a large number of babies with ethnicity ‘not known’.

Figure 5.12 describes the rates for the same vaccination by ward. Rates are low in Springfield, Lordship, New River and Cazenove. The lowest rates are in the wards with the largest Charedi populations.
Local research has identified a number of factors which affect uptake of immunisation in the Charedi community in the north of Hackney:

- Informal social networks and word of mouth are key routes for circulation of information
- Parents are inclined to wait until their children are a little older before immunising
- Parents have some concerns about the safety of some immunisations
- Some parents report lack of access to or trust in information provided by health professionals
- Some parents believe that the community is at decreased risk from some diseases
- Difficulty accessing services due to time restrictions, mobility restrictions, long waiting times at clinics and large family size (not found by all papers)

Table 5.8 Five-in-one immunisation by first birthday, Q1 2011/12: numbers and rates by ethnicity (local COVER data)

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Number fully immunised</th>
<th>Total infants</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>141</td>
<td>161</td>
<td>88%</td>
</tr>
<tr>
<td>White Turkish</td>
<td>37</td>
<td>37</td>
<td>100%</td>
</tr>
<tr>
<td>White Other</td>
<td>86</td>
<td>110</td>
<td>78%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>48</td>
<td>54</td>
<td>89%</td>
</tr>
<tr>
<td>Black African</td>
<td>151</td>
<td>156</td>
<td>97%</td>
</tr>
<tr>
<td>Black Other</td>
<td>57</td>
<td>63</td>
<td>90%</td>
</tr>
<tr>
<td>Asian</td>
<td>65</td>
<td>68</td>
<td>96%</td>
</tr>
<tr>
<td>Mixed</td>
<td>36</td>
<td>37</td>
<td>97%</td>
</tr>
<tr>
<td>Other</td>
<td>150</td>
<td>225</td>
<td>67%</td>
</tr>
<tr>
<td>Not known</td>
<td>160</td>
<td>196</td>
<td>82%</td>
</tr>
</tbody>
</table>

Figure 5.12. 5 in 1 vaccination rates in Hackney: % who have received 3 doses by 1st birthday (Q1 & Q2, 2011/12) by ward (Local data)

Local action

In 2009/10 all PCTs in London were required to produce a comprehensive action plan to provide assurance that sufficient plans are in place to deliver national targets on immunisation uptake. An action plan remains the central guiding document regarding work to improve immunisation uptake in Hackney. Examples of the work that is underway include;

- Setting in place robust governance arrangements and responsibilities including re-vamping the Immunisations Steering Committee
- Review of the GP Local Enhanced Service which rewards practices for achieving high uptake of routine immunisations and continues the catch-up campaigns for MMR and HPV
- Publishing a quarterly immunisations bulletin including uptake of immunisations by GP practice
- Distribution of regular “target lists” of children due for immunisation to health visitors and GP practices
- Sharing of information between Child Health and GP practices to ensure accurate data available
- Ensuring practices are recording immunisations given using the correct READ codes
- Piloting in four GP practices the use of personalised reminder letters sent to parents from a central source when their child is approaching immunisation due dates
- Working with schools to ensure children are fully immunised at the time they start primary school
- Working with other partner agencies including the London Borough of Hackney to ensure consistent messages about immunisation are communicated to families at every opportunity
- Producing a disseminating new publicity materials
- Increased immunisation sessions including on Sundays
- Increasing support to practices with low uptake

The Orthodox Jewish Community Health Team continues to work closely with families from the Charedi (as before) community in order to promote healthy behaviours including identifying and overcoming barriers to immunisation. They offer flexible and accessible services in a range of locations tailored to meet the needs of this community.

What works: increasing uptake of childhood immunisation

In order to provide effective protection at population level, very high uptake of immunisation is required. NICE have issued guidelines to reduce inequalities in childhood immunisation uptake rates. The key recommendations are:

**Immunisation programmes**

- Disseminate and implement all Department of Health guidelines and updates
- Adopt as part of the local child health strategy a multifaceted coordinated programme across different settings to increase timely immunisation among groups with low or partial uptake. The programme should:
  - Monitor immunisation status as part of wider health assessments
  - Identify immunisation leads in each PCT and GP practice
  - Provide all staff with access to the Green Book; implement and monitor all updates
  - Improve access to clinics by extending opening hours, providing family-friendly settings and seeing patients promptly.
  - Provide sufficient capacity to enable all children to be immunised on time
  - Send tailored invitation letters, reminder letters and recall invitations and follow up by telephone or text message where appointments are not attended
  - Provide tailored information about the immunisation programme in appropriate formats such as community languages
  - Provide parents with the opportunity to discuss concerns about immunisation with a suitably qualified professional, either face-to-face or by telephone
  - Consider home visits to non-responding families, to both discuss and to immunise
  - Check the immunisation status at every contact with health services

**Immunisation systems**
Establish a structured, systematic method for recording, maintaining and transferring accurate information about the immunisation status of all children and young people

Ensure all providers of immunisation including private providers share with GPs and PCTs information about any immunisations given

Record any factors that make it less likely that a child will be up to date with immunisation, such as being in local authority care, having special needs or contraindications to immunisation

Regularly maintain and update systems e.g. when a child leaves the area

Use local data to provide coverage for service providers, to inform local needs assessments and equity audits and to assess capacity requirements

**Training**

Provide appropriately tailored training to all staff involved in immunisation service, compliant with national minimum standards for immunisation training (for staff delivering immunisation) and Health Protection Agency core curriculum for immunisation training (for all staff working with children and young people)

Ensure all staff are appropriately trained to document immunisation accurately and in the appropriate records

The contribution of education services

The immunisation record of each child aged up to five years old should be checked when starting nursery, playgroup school or other educational/early years setting. The check should be carried out by the Healthy Child team, led by a health visitor and in conjunction with childcare/education staff and parents

School nursing teams, working with GPs, should check the immunisation records of all children transferring to a new school

Where children have missed immunisations, school nursing teams should discuss the importance of immunisation and offer immunisations if required

Head teachers, school governors, children’s centre managers and PCT immunisation coordinators should work with parents to encourage schools to become venues for provision of immunisation, as part of their extended schools role

**Targeting groups at risk of being unimmunised/partially immunised**

Improve access to immunisation services for those with transport, language or communication difficulties, for example by providing services with longer appointment times, extended opening hours, walk-in services, mobile or outreach services or home visits

Provide accurate and up-to-date information about the benefits of immunisation which is tailored to meet the needs of the community

Consider using pharmacies, retail outlets, libraries and local community venues to promote and disseminate accurate and up-to-date information on immunisation

Check the immunisation history of all newly arrived migrants, including asylum seekers, discuss outstanding immunisations and if necessary offer immunisation

Prison health services should check the immunisation status of all young offenders, discuss outstanding immunisations and if necessary offer immunisation

Check the immunisation status of looked after children during their initial health assessment, the annual review health plan. Offer opportunities to have any missed vaccinations, as appropriate, in discussion with the child or young person and those with parental responsibility for them

**Hepatitis B immunisation for infants**

PCTs should have a responsible lead for Hepatitis B immunisation, who is also responsible for scheduling and follow up to ensure immunisations are carried out in full and at the correct time

A clear process for infant Hepatitis B vaccination should be developed and implemented, including stipulations for information sharing, administration of immunisations, recording of information and provision of advice, information and support.

In September 2009 the London Regional Immunisation Steering Group published a report describing good practice and associated costs in improving immunisation uptake in London\(^{309}\). The report identified the following key interventions for improving uptake in London:

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Dental health

2011 update

There is no new data for 2011 on prevalence of tooth decay in children.

There is a low but improving rate of uptake of dental services among children in City & Hackney.

Focus on inequalities:

- There is a very high rate of dental decay among Eastern European three year old children
- At all ages, the rate of dental decay among White British children is higher than among Black African and Asian children
- Dental decay in five year old children is not correlated with ward deprivation

In June 2011, 46% of children and young people in Hackney and the City had been seen by a dentist in the previous 24 months. This is below the average for London (67%) and for neighbouring east London boroughs (55% in Tower Hamlets, 66% in Newham). However attendance has improved over the last four years (Figure 5.13)

Three year old children

A survey of three year old children conducted in east London in 2010 found that, in Hackney and the City, a quarter (24%) of children this age had experience of tooth decay. This compares to rates of 33% in Tower Hamlets and 22% in Newham. The rate in Hackney and the City has risen significantly since the last survey of
Among three year old children there are significant differences in tooth decay between ethnic groups. A recent health equity audit for East London and the City found that 44% of Eastern European children and 14% Black African children have experienced tooth decay compared to 18% of White British children. Around 1.7% of three year old children in City and Hackney experienced traumatic dental injuries compared to 8.2% in Newham and 1.9% in Tower Hamlets. Boys experienced significantly greater numbers than girls but there were no differences between ethnic groups.

**Five year-old children**

The experience of dental decay among five year old children is moving in the opposite direction: over the past few years there has been steady improvement in the oral health of five year olds. The proportion of children experiencing dental decay declined from 49.6% in 2001/2 to 29.7% to 2007/08 (Figure 5.14). The rate recorded in 2007/08 was lower than the rates in both London (32.7%) and England (30.9%). The proportion of five year old children with dental abscesses in 2007/08 was 3.4%, comparable to the rate for London.

The health equity audit found no correlation between the experience of dental decay in five year old children and ward deprivation.

**Older children**

In 2009, a fifth (20.5%) of 12 year old children had experience of tooth decay in Hackney and the City. This compares to 21.3% in Tower Hamlets, 30.1% in Newham, 28.2% in London and 33.4% in England. This data relates to permanent teeth whereas the data for young children relates to primary (baby) teeth.

A survey of adolescents aged 15 and 16 years was carried out in inner north east London in 2005. In Hackney 33.7% had experienced dental decay compared to 43.3% in Tower Hamlets and Newham. As with younger children there were significant differences between ethnic groups with Black African (17%) and Indian (13%) having less decay experience than White British (20%) children.

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311 Wright D. Health equity audit of oral health and dental services in inner north east London, 2011 (unpublished)
313 British Association for the study of Community Dentistry (BASCD)- Results of Annual Surveys
The following interventions have been found to improve oral health in children.

- Children who brush their teeth twice a day with a toothpaste containing fluoride will tend to have less dental decay\(^{315}\)
- Fluoride varnishes applied professionally twice a year substantially reduces tooth decay in children\(^{316}\)
- Regular supervised use of fluoride mouth rinses by children with special needs or at high risk of dental caries reduces tooth decay\(^{317}\)
- Home visits that provide new mothers with advice about breastfeeding and weaning appear to help reduce early childhood caries in infants\(^{318}\)
- Children who have their molar teeth covered by a resin-based sealant are less likely to get dental decay in their molar teeth than children without a sealant\(^{319}\)
- Policies which reduce sugar consumption may be helpful in preventing tooth decay\(^{320}\)
- Regulating and encouraging the use of properly fitted mouth guards in field sports can reduce oral trauma\(^{321}\)

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\(^{316}\) Marinho VC, Higgins et al. (2007) Fluoride varnishes for preventing dental caries in children and adolescents Cochrane Database of Systematic Reviews CD 002279

\(^{317}\) Marinho VC, Higgins et al. (2003) Fluoride mouthwashes for preventing dental caries in children and adolescents Cochrane Database of Systematic Reviews CD 002284


Early years support

Health visiting

The needs of infants and young children are often identified through the local health visiting service. In line with national reforms, this is currently being re-modelled to ensure these needs are addressed effectively. City and Hackney is one of 20 Health Visitor Implementation pilot sites nationally, and one of three in London. Health visitors prioritise vulnerable families, large families and families facing challenging health and social issues. Teams are configured in line with the six children centre clusters and linked with GP practices.

Need is identified through contact with families while delivering new birth visits, health and developmental reviews and child protection health reviews. Health visitors have a key role in delivering public health initiatives, including opportunistic immunisations and targeted work with high need communities, such as the traveller community, the Orthodox Jewish community and homeless families. There are also specific health visitors who lead on safeguarding, obesity and disability.

Children’s centres

Hackney has 21 children’s centres which provide a range of services to pre-school children and their families. The core offer includes early education integrated with childcare, child and family health services, family support services, community outreach services and links with childminders. Children’s centres seek to be hubs where multi-agency teams can provide an integrated service to young children and their families. They work with GPs and other local service providers including schools. Some also have specialist staff such as social workers, nurses and speech therapists, and provide a range of health services including immunisation clinics and post natal drop ins.

The total number of children aged 0-4 years in 2011 is 21,116. This is larger than the estimated population because it also includes out-of-borough children. A total of 7,058 new children accessed the service in 2010/11.

A significant proportion of our children and families accessing children’s centres are vulnerable. In 2010/11:

- 25% of those registered with children’s centres were living in workless households;
- 223 children accessed disability/special needs services;
- 203 teenage parents accessed the service;
- 393 parents accessed ESOL classes.

The biggest ethnic groups accessing children’s centres are White (21%), Black (18%) and Orthodox Jewish (16%).

In 2010/11, 1,420 parents were supported into employment, training or volunteering schemes, more than double the number the previous year due to a concerted effort.

The City

There are over 100 users of the City’s children’s centre. Some City children are also registered with Islington children’s centres.

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323 Children’s Centres in Hackney: An Overview for Staff, Hackney Children and Young People’s Services, 2006.
324 Ibid.
325 LBH e-Start database
327 City of London Corporation: Family Profiling Project
Young people

The national agenda for children, set out in the *Every Child Matters: Change for Children* framework defined a new approach to promoting the wellbeing of children and young people from birth to the age of 19. The aim is for every child, whatever their background or circumstances, to have the support they need to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being

These outcomes are consistent with those set out in the 10-year Childcare Strategy and the National Service Framework (NSF) for Children. The Marmot Review is also highly relevant. The Hackney Children and Young People Plan 2008/11 is a high level, strategic document, which links national priorities, through the Community Strategy, to local priorities and business/service planning. It reflects the planned local change programme, setting out the principles behind the reconfiguration of services in line with Every Child Matters.

Effective prevention and health promotion in childhood is the foundation of a healthy community. Research suggests that many of the health and wellbeing outcomes experienced by adults today have their roots in pregnancy and childhood. The National Healthy Child Programme is the early intervention and prevention public health programme that lies at the heart of our universal service for children and families. It covers pregnancy and the first five years of life and provides preventative services tailored to the needs of children and families.

Families in Hackney are more likely to experience the problems that come with poverty or unemployment than in many other areas of London or England. Children growing up facing these disadvantages are more likely to be physically or mentally unhealthy, and to do less well at school than others. Young people from poorer backgrounds are often less likely to get involved in positive activities that help them and the community, and are more likely to be involved in anti-social behaviour or crime. Effective parenting is vital to ensure that children grow up to be happy, healthy adults.

Children’s services in Hackney are organized around six ‘clusters’. Each cluster is currently led by a steering group, which brings together professionals from children’s centres, extended schools, social care and health services. A Common Support Framework has been adopted that allows professionals from a range of services to work with families in assessing needs, and in putting together high quality packages of support from a number of sources. (HCYPSP, 2008)
Education and training

2011 update

Educational attainment has improved at all levels in Hackney. However 7.9% of 16-19 year olds in Hackney are not in education, employment or training.

Focus on inequalities:

- Educational attainment is lower among pupils from more deprived backgrounds (who are eligible for free school meals).

Education is vital to the current and future wellbeing of the community in Hackney and the City. It is vital not only for gaining learning and skills but also as a route to social interaction, employment and personal fulfilment.

Current policy changes which affect local education provision include:

- The national emphasis on development and growth of Academies
- The devolution of funding more directly to schools
- The transition of the Learning Trust into ‘Hackney Learning Trust’, and the transfer of responsibility for this to London Borough of Hackney (to be completed 2012)
- The end of funding for ‘Healthy Schools’ – with an emphasis on local schools taking responsibility for achieving and maintaining the kitemark

Early Years Foundation Stage

The early years (0-5) are crucial to a child’s chances of later success and children who flourish at this age are much more likely to be successful in future education and in later life. In 2011, 54% of children aged five in Hackney’s maintained schools achieved at least 78 points across the Early Years Foundation Stage with at least six points in each of the scales in personal, social and emotional development and communication, language and literacy. Although this result is still below the average for London, the proportion achieving this level has risen by 19 percentage points over the last two years (Figure 5.15).

Analysis of the 2010 Early Years Foundation Stage results for Hackney reveals some differences within the population:

- The percentage of girls achieving a good level of development was higher than boys across all scales, with the largest differences in Writing (20pts) and Creative Development (14pts). Generally the gender differences reflected were wider than the national differences.
- Children with English as an additional language tended to score between 5 and 10 points lower across all scales compared to children for whom English is their first language.
- Children with special educational needs scored lower (14 to 26 points) on all scales.
- Children from the most deprived 10% areas scored 4 to 10 points less than those in the other 90%.
- Children from the private, voluntary and independent sectors (96% of them are in Orthodox Jewish settings) scored much lower (40 points fewer) and the children in maintained primary schools and settings.

The City

In the City, 87% of children aged five achieved at least 78 points across the Early Years Foundation Stage with at least six points in each of the scales in personal, social and emotional development and communication, language and literacy. These results are the highest in the country and represent a 20 percentage point increase over two years (Figure 5.13). The City also has the narrowest gap between the attainment of the highest and the lowest achievers at this level.

The 2011 OFSTED inspection of the City of London Corporation children’s services found that all provision for early years and childcare was good or outstanding, and that for children under the age of five, provision for
early years education was outstanding. Achievement at age five was found to be well above average and continues to improve far more quickly than nationally. Sir John Cass’s Foundation Primary School’s most recent OFSTED inspection was on September 26th 2008, when it was deemed to be outstanding in all aspects.

![Figure 5.15. Pupils achieving at least 78 points across the Early Years Foundation Stage with at least six in each of the scales in Personal Social and Emotional Development and Communication, Language and Literacy (Department for Education)](image)

**Primary and secondary schools**

Currently, in Hackney’s maintained sector, there are 53 primary schools (of which 40 are community and 13 voluntary aided), 12 secondary schools (of which 3 are community, 5 are voluntary aided, and 4 are Academies), 4 special schools and 4 Pupil Referral Units (PRUs)328. According to the Hackney School Census 2011, pupil numbers were 33, 893 pupils in these schools divided as follows:

- Maintained primary 18,699
- Maintained secondary 9,367
- Special 274
- PRU 190
- Independent 6,798
- Academies 2,525

Educational achievement at both primary and secondary level has also been improving locally year on year.

At primary level, 76% of Hackney pupils achieved level 4 or above in both English and Maths at Key Stage 2 in 2011 (Figure 5.16). This is, for the first time, higher than both the London and England averages (75% and 74% respectively). The success rate was higher among girls (79%) than among boys (73%).

The proportion of pupils achieving level 4 or above in each of the four subjects was as follows: English, 82%; Reading, 83%; Writing, 74% and Mathematics, 81%.

At secondary level, 56.5% of Hackney pupils achieved five or more A*- C grades at GCSE or equivalent including English and Maths (Figure 5.17). This rate has continued to rise year on year but remain just below the averages for both London and England (61% and 58% respectively).

Analysis of educational outcomes with Hackney, especially in vulnerable groups, has revealed the following differences329:

- Children with no identified vulnerability outperform children in vulnerable groups at KS2 and GCSE

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328 *Schools, Pupils and their Characteristics.*

329 The Learning trust: Vulnerable Groups Report, 2009/10
At both KS2 and GCSE, special educational needs is the vulnerability factor which impacts most on attainment.

Of the vulnerable groups that do not include special education needs as a factor, the Free School Meals only group perform less well than the others at both KS2 and GCSE.

Other groups considered vulnerable to not achieving the best possible academic outcomes include those who are highly mobile (traveller children) and Looked After Children although these groups were too small to include in this analysis.

**Special educational needs**

In January 2011, 24% of pupils in Hackney’s primary schools and 28% of pupils in Hackney’s secondary schools were registered as having special educational needs\(^\text{330}\).

\(^{330}\) Department for Education January 2011 School Census
In the City, 33% of pupils at Sir John Cass’s Foundation Primary School were registered as having special educational needs in 2009/10.

**Healthy schools**

The Healthy Schools Programme was a national programme that worked with children and young people, parents, and school staff to build a solid foundation for development, improving the physical and social development of the whole school community.

In December 2010 the Coalition Government announced that central funding for the Healthy Schools Programme would cease from April 2011. However the programme has not been abolished as schools are still expected to pursue it locally. A new national health and wellbeing toolkit is promised for spring 2011.

By March 2011, 60 schools in Hackney had achieved healthy school status.

**Young people not in education, employment or training**

The proportion of young people aged 16 -19 who are not in education, employment or training is an important indicator of wellbeing as non-participation is linked to a host of other poor outcomes later in life, including health outcomes. It captures those who are not being prepared for work as well as those who are unemployed.

In 2009/10, 7.8% of young people aged 16 -19 in Hackney were not in education, employment or training. This is higher than both the London average (5.8%) and the average for England (7.0%).

**The City**

In the City, less than 1% of the young people known to local Connexions services were not in education, employment or training.

**Young Hackney**

Young Hackney integrates the youth offending team, universal youth service and targeted youth support to deliver a range of services including a comprehensive health offer in partnership with NHS ELC, the East London Foundation Trust and community health services at the Homerton Hospital.

Five new and refurbished youth centres will be up and running by June 2012 supporting young people aged 8-19 with access to services for emotional health and wellbeing, mental health, substance misuse and alcohol, sexual health, healthy weight and smoking. Three new primary units will work closely with schools, supporting young people from the age of 6, alongside four family units working with both parents and young people with complex issues together. Additionally, all Young Hackney staff will receive comprehensive training across a broad range of health issues as part of their induction.

**Healthy weight and exercise**

**2011 update**

The proportion of school pupils who are overweight or obese remains high in Hackney and the City but the rates are relatively stable.

The proportion of school pupils who participate in regular in physical education is below average in Hackney.

**Focus on inequalities:**

- Locally, Black pupils are most likely to be obese and Asian pupils are least likely to be obese
- Nationally, childhood obesity is strongly correlated with deprivation
Childhood obesity

Childhood obesity is a major problem in Hackney and the City. The prevalence of obesity, as recorded by the National Child Measurement Programme (NCMP), is among the highest in England.

The National Child Measurement Programme is an annual process of weighing and measuring children in Reception Year (4/5 years) and Year 6 (10/11 years). Participation in this survey is particularly good in Hackney and the City: in 2010/11, 95% of Reception Year children and 92% of Year 6 children were weighed and measured. However the programme does not cover private schools, including the many private Jewish schools in the north of Hackney. Physical activity is rarely part of the curriculum in these schools.

Among children attending maintained schools in Hackney and the City in 2010-11, 13.5% of children in Reception year were overweight and 14.6% were obese, giving a total of 28.0% who were overweight or obese. Among children in Year 6, 15.9% were overweight and 25.0% were obese, giving a total of 41.0% who were overweight or obese (differences in totals are due to rounding). These rates are little changed from the previous year and there is no obvious trend in either age group over the last five years (Figures 5.18 and 5.19).

The rates of both overweight children and obese children are both higher than the London and national averages. The rate of obesity is particularly high in both years in Hackney and the City. (Figures 5.20 and 5.21).

Although childhood obesity for boys and girls are similar in Reception year, by year 6 boys have significantly higher rates of obesity than girls. In both year groups, the highest obesity rate is among Black pupils and the lowest rate is among Asian pupils.

Nationally, childhood obesity is more prevalent among Black, Asian and Mixed ethnicity children than among children of White ethnicity. Childhood obesity is also strongly correlated with deprivation331.

The City

There is no disaggregated data available for childhood obesity in the City.

Figure 5.18 Rates of overweight and obesity among Reception year pupils in Hackney and the City, 2006 - 2010 (NCMP, 2010-11 data is provisional)

Figure 5.19 Rates of overweight and obesity among Year 6 pupils in Hackney and the City, 2006 - 2010 (NCMP, 2010-11 data is provisional)

Figure 5.20. Weight of Reception Year children, 2010/11 (NCMP)

Figure 5.21. Weight of Year 6 children, 2010/11 (NCMP)
Physical activity

In Hackney, 43% of school pupils (in years 1 to 13) participated in at least three hours of high quality Physical Education and out of hours sport per week in 2009/10. This is significantly lower than the average for England of 55%. It is also lower than rates in Tower Hamlets (49%) and Newham (51%).

- Many more boys regularly participate in PE (50%) than girls (36%)
- The participation rate is highest in years 3-6 (58%) after which the rate declines with increasing age: 40% participate in years 7-9, 24% in years 10-11 and only 6% in years 12-13.

Children and young people in the Orthodox Jewish (Charedi) community face some specific obstacles to participation in physical activity. Most schools are private and offer little or no physical activity in the curriculum. The cultural requirement for single sex swimming sessions limits the opportunities available, which must be negotiated with local leisure centres or provided by the community itself (the Lubavitch Foundation). Demand therefore outstrips supply – in a local needs assessment, 69% of Charedi children reported participating in some form of physical activity but the majority said they would like to undertake more.

Nationally, participation in PE is higher in schools with fewer pupils entitled to free school meals and higher among boys than among girls.

The City

In the City’s one maintained school, 100% of school pupils participated in at least three hours of high quality Physical Education and out of hours sport per week in 2009/10.

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**Children’s physical activity projects in Hackney**

**Healthy Lifestyles Programme** - A multi-faceted programme aimed at clinically obese and overweight children aged six to 13. The programme includes a combination of physical activity such as football, basketball, athletics, street dance, bowling, ice skating, rounders, boxing, circuits, gym and drama, psychological support and dietetic input.

**Fitness Fun Programme** - Low cost opportunities for physical activity provided to children and parents through local schools. Currently there are 45 sessions taking place in 35 venues with 660 participants in total. The sessions include a broad range of physical activity such as yoga, sportdance, street dance, capoeira, Aero - Circuit, salsa, Hip Hop, Bollywood dance, aerobics and boxercise. Some sessions are just for children and young people including two specific for children with special needs, one based in a community estate centre, one based at the gypsy and traveller unit and three based in Orthodox Jewish schools. About half of these sessions are directed at parents and carers and a small number are combined for parents and children to exercise together.

**SHEL Multi Sports Camp** - Five multi sports camps run for 6 weeks during the holiday periods with a capacity of 45 children per camp. These camps are aimed at children aged 8 - 12 years in the most deprived wards from the borough. 96% of children attending are from BME communities. Some referrals are from social services. The activities provided include football, basketball, street dance, martial arts, fencing and athletics and include a mini sports day engaging parents and carers. The programme combines key health messages on healthy eating, fitness, smoking, skills and education.

**Be Active Keep Healthy** Project for Orthodox Jewish children - Physical activity intervention programmes (including dietetic intervention) tailored for children and young people from the Orthodox Jewish community, started in January 2008. The programmes run for 10 weeks, with a session once a week and follow a split gender group format. So far the programme has reached 300 children and young people, aged 7 to 15 years.

**Healthy Lifestyles** Programme for Orthodox Jewish children: A 10 week programme physical activity programme aimed at clinically obese/overweight children aged 7 - 11 years within the Orthodox Jewish community. The programme includes a combination of physical activity, drama, psychological support and dietetic input and sessions are run separately for boys and girls.

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333 NHS City and Hackney: Orthodox Jewish Needs Assessment (summary), 2011
Hackney Council offers a range of free and subsidised physical activities through its leisure centres, sports development programme and youth offer.

**Children’s Physical Activity Projects within the City**

**Youth Community Sports Scheme.** Since 2008 the City of London Sports development team have been in partnership with West Ham Community Sports Trust to deliver a Community football project. Since March 2011, the programme has been organised directly by the City’s Sports Development team to deliver a more bespoke service and to create cost savings. The new programme is a youth community sports scheme aimed at young people in the City of London aged 19 and under. The project engages young people in weekly positive activities and is supplemented by free holiday courses and tournaments located centrally within the catchment areas. There are 12 hours of weekly coaching across 7 different City of London locations, with activities including Football, Dance, Table Tennis, Athletics and Basketball. In order to provide sustainability and a lasting legacy beyond the project a coach education and volunteering strand has been implemented. This scheme has engaged 182 young participants to date.

**City of London Police Community Boxing club.** The City of London Police boxing club was launched in September 2009. The young people are coached by the City of London Police officers, which means that they spend part of their social time with the police, learning about the essential work the police do in their area, how, when and why the police work. Alongside the already qualified police officers, some police community support officers (PCSO’s) have taken their level 1 coaching qualification and volunteer within the project. Two young people identified through the club have also completed the coaching education course. The club has engaged 131 participants through taster sessions and two weekly club nights to date.

**London Youth Games.** The Balfour Beatty London Youth Games (BBLYG) is a series of sports competitions where all 33 London Boroughs compete in over 30 different sports for the Jubilee Trophy. There are 26 sports coaching and training opportunities for the London Youth Games, as well as volunteering opportunities for young people and adults within this programme. In 2010/11, 12 out of the 20 main games sports were entered, giving 752 children experience of the games. Primary school children can participate in up to 7.5 hours of activity per week across 5 different sports. The City of London squad is made up from a variety of City of London residents and the City schools.

**Mini Marathon.** The City of London enters the mini marathon race: a squad of 48 runners aged between 11 and 17 competes against the other 32 London boroughs in the last 3 miles of the official Virgin London Marathon route. In 2012 all runners that are selected and complete the 2012 Mini London Marathon on Sunday 22 April will receive an Olympic 2012 ticket, which will enable participants to watch a worldwide athletic event in July 2012 hosted at Olympic Park.
Teenage pregnancy

**2011 update**

The teenage pregnancy rate in Hackney fell to its lowest ever rate in 2009. The decline since the 1998 baseline is one of the greatest in London: a 37% reduction compared to a London average of 20%.

**Focus on inequalities:**

- Teenage pregnancy is profoundly linked to poverty. The majority of teenage parents and their children live in deprived areas.
- Teenage pregnancy is also a driver of inequalities, creating further disadvantage for both mother and child. Most teenage mothers are not in education, training or employment.
- Locally, Black teenage women are more likely to become pregnant than White and Asian women of the same age.

Teenage pregnancy (under 18 conceptions) and early parenthood are widely recognised to be associated with poor health and social exclusion. Although young people can be competent parents, the evidence suggests that the mother’s age, disadvantaged socioeconomic background and limited uptake of antenatal care come together to contribute to poor outcomes overall.

The majority of teenage parents and their children live in deprived areas. Teenage pregnancy and poverty follow linked intergenerational cycles with children born into poverty at increased risk of teenage pregnancy, especially young women living in workless households when aged 11-15. Teenagers who become pregnant are more likely to drop out of school, leading to low educational attainment, worklessness or insecure jobs without training. Young mothers are more likely to be lone parents with their children raised in sub-standard housing or temporary accommodation.

The links between teenage pregnancy and poverty and social exclusion could not be clearer:

- Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties.
- Teenage mothers are 20% more likely to have no qualifications at age 30 than mothers giving birth aged 24 or over.
- About 70% of teenage mothers aged 16-19 are not in education, training or employment.
- 70% of mothers aged 16-19 claim Income Support.
- At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner.
- Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment.

The maternal and child outcomes associated with teenage parenthood include:

- premature birth and low birth weight
- infant mortality
- hospitalisation of infant
- smoking in pregnancy
- low breastfeeding rates

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336 2001 Census data
339 2001 Census data
 poor diet
- poor maternal health
- accidental injuries in childhood
- postnatal depression
- isolation and relationship breakdown
- repeat unplanned pregnancies
- no qualifications
- not in education, training or employment
- parenting difficulties
- mothers at risk of poverty and poor housing in later life
- children at risk of lower academic achievement, poverty and unemployment in later life

In 2009 there were 163 teenage conceptions reported in Hackney and the City. This is a rate of 48.6 per 1,000 females aged 15-17. This is a marked drop on the previous year (in 2008, there were 212 teenage pregnancies) and sustains the long-term decline in teenage pregnancies. The rate has fallen from a highpoint in 2000 of 79.5 conceptions per 1,000 females aged 15-17 (Figure 5.22).

Although the teenage pregnancy rate in Hackney and the City remains higher than the rates in London and in neighbouring boroughs, the decline over the past 10 years has been much greater than the average decline for the capital: 37% in Hackney compared to 20% in London as a whole.

In Hackney and the City, teenage conceptions are most common among Black women: over half (55%) of the young mothers who gave birth at the Homerton in 2010 were Black, a fifth were white, 10% were mixed race and 9% were Asian (Figure 5.23). This compares to an estimated ethnic profile in the population of 15-19 year-old girls in Hackney of 35% Black, 47% white and 13% Asian (GLA data).

The number of conceptions among girls aged under 16 has declined steadily over the past ten years (Figure 5.4). Although the rate is still high in Hackney and the City (an average of 33 conceptions per year in the 2007-2009), the gap with the London average and with rates in neighbouring boroughs has decreased.

The City

Teenage conceptions are too rare in the City (fewer than five per year) to be reported independently.
Figure 5.23 Ethnicity of teenage mothers giving birth at the Homerton Hospital in 2010 (Homerton data)

Figure 5.24 Trend of under 16 conceptions, 2001 - 2009 (ONS)

Contraception: what works?\textsuperscript{340}

Strong evidence of effectiveness:
- Advanced supply of emergency contraception
- Promotion of condoms
- School-based provision
- Community Outreach

Moderate evidence of effectiveness:
- Outreach from mainstream services
- Virtual world interventions
- Computer-based media

Weak evidence of effectiveness:
- Social marketing

Unclear evidence:
- Home visiting (repeat conceptions)
- Generic programmes for young mothers (repeat conceptions)
- Generic youth interventions

Cost effectiveness

Dispensing contraceptives in schools, particularly hormonal contraceptives, is shown to be cost effective. The advance supply of emergency hormonal contraceptive is also shown to be cost effective and remains so when it happens alongside the provision of wider hormonal contraceptives in schools settings.

Terminations

Over the past decade the proportion of teenage pregnancies ending in termination has risen: in 2009, 69% of teenage pregnancies in Hackney and the City ended in termination compared to 54% in 1998 (Figure 5.25). However, this percentage is highly dependent on the overall number of teenage pregnancies. The rate of terminations has actually fallen over this period from 77 per 1,000 women aged 15-17 in 1998 to 49 terminations per 1,000 women in 2009.

Similarly, the increase in the percentage of teenage pregnancies ending in termination from 2008 to 2009 is also partly due to the big drop in the overall number of teenage pregnancies. The rate fell from 61 to 49 terminations per 1,000 women aged 15-17.

The ethnic profile of teenagers having terminations locally is similar to the profile of the teenagers who chose to continue with their pregnancy (Figure 5.26).

Figure 5.25. Proportion of teenage pregnancies ending in termination 1998-2008 (ONS)

Figure 5.26 Ethnicity of teenage women having terminations at the Homerton Hospital in 2010 (Homerton data)
Mental health

2011 update

The most common focus of worry among Hackney pupils is school work but personal relationships – families and friendships – are also prominent.

Among older pupils (years 8 and 10), a key worry is what they will be doing when they leave school.

Two fifths (40%) of pupils in Hackney said they had been bullied at school.

The following national data provide some indication of the importance of protecting and promoting the mental health of young people:

- In 2004, among 11-15 year olds, 13.1% of males and 10.2% of females had some form of mental disorder (emotional, conduct or hyperkinetic); rates were higher among Black young people and lower among South Asian young people; rates were also highly correlated with the socio-economic status of parents.
- In 2007, among 14-17 year olds, 3.2% of males and 11.1% of females group reported self-harm behaviour in the last year. The number of young people who reported thinking about self-harm in the last year was much higher: 8.8% of males and nearly a quarter (23.8%) of females.
- In 2006, among 5-17 year olds looked after by local authorities, 45% had a psychiatric disorder, 12% had an emotional disorder, 38% had a conduct disorder and 8% had a hyperkinetic disorder.

The national TellUs survey of school pupils aged 10-15 provides some local insight into what young people of this age worry about (Table 5.9). The most common focus of worry among Hackney pupils is school work but personal relationships – families and friendships – are also prominent. Despite the extent of worry described in Table 5.6, 63% of Hackney pupils said they were happy about life at the moment and 89% said they had one or more good friends. Nearly two thirds (63%) said they could talk to their mum or dad if they are worried about something and 61% said they can talk to their friends.

Among older pupils (years 8 and 10), a key worry is what they will be doing when they leave school. This is consistent with the submission from Off Centre (see box) that the lack of opportunities for young people is an important determinant of poor mental health.

Two fifths (40%) of pupils in Hackney said they had been bullied at school, of whom 26% said they had been bullied in the last year.

In 2010, members of Hackney Youth Parliament CAHMS Peer Research Project conducted a review of mental health among their peers (aged 13-22 with a majority between 14 and 17). They found that:

- Approximately 31% of females and 29% of males had a family member who had experienced mental health issues

Off Centre, a local organisation providing mental health support to young people aged 11-25 reported the following as the four most common problems and issues facing their clients:

- Loss and bereavement
- Depression, anxiety and stress
- Family/relationship breakdown
- Emotional difficulties

In the last 12 months, Off Centre has seen both an increase in demand for their services and an increase in the complexity and severity of referrals (both self and directed). Off Centre identifies social exclusion and the lack of opportunities for young people in Hackney as key determinants of poor mental health among children and young people. The organisation believes that these problems, combined with the impacts of recession and cuts to public services, are having a disproportionately negative effect.
The City and Hackney Health and Wellbeing Profile: our joint strategic needs assessment, 2011/12

- 26% of females and 27% of males had friends who had experienced mental health issues
- 60% of females and 49% of males thought there was not enough information available to young people about mental health issues
- 28% of females and 26% of males responding that mental health should be discussed more in schools
- 36% of females and 35% of males knew of services to direct others to locally, who were in need of support

Respondents consistently highlighted exams as the top source of concern (‘stress’) for them, followed by family and relationships and money.

Table 5.9. Proportion of Hackney school pupils aged 10-15 worried about the identified issues, 2010 (TellUs4)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Hackney</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>School work and exams</td>
<td>59%</td>
<td>51%</td>
</tr>
<tr>
<td>What to do after year 11 (years 8 and 10)</td>
<td>47%</td>
<td>43%</td>
</tr>
<tr>
<td>My parents or family</td>
<td>33%</td>
<td>29%</td>
</tr>
<tr>
<td>Friendships</td>
<td>24%</td>
<td>31%</td>
</tr>
<tr>
<td>Being bullied</td>
<td>23%</td>
<td>25%</td>
</tr>
<tr>
<td>Being healthy</td>
<td>23%</td>
<td>26%</td>
</tr>
<tr>
<td>Money</td>
<td>21%</td>
<td>26%</td>
</tr>
<tr>
<td>Being a victim of crime</td>
<td>21%</td>
<td>16%</td>
</tr>
<tr>
<td>Relationships/girlfriends/boyfriends (years 8 and 10)</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>The way I look</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Sex (years 8 and 10)</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Nothing worries me</td>
<td>12%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Alcohol and drug misuse

The national Youth Alcohol Action Plan\textsuperscript{342} published in 2008 identified the particular risks associated with young people’s drinking. The report found that there is disturbing evidence from the UK of:

- A sharp increase in liver cirrhosis among people in their 20s – almost certainly linked to heavy alcohol consumption in the teenage years
- A strong association between alcohol consumption and accidents involving young people.
- Rising deaths among young people linked to alcohol – there was a 57% increase in alcohol-related deaths amongst young people aged 15-34 between 1991 and 2006.

Levels of alcohol and drug use among young people are relatively low in Hackney and the City. In 2009, 6% of children (sampled from years 6, 8 and 10) reported that they had been drunk one or more times in the last four weeks. This compares to a national average of 15%\textsuperscript{343}. Only 2% of children in years 8 and 10 reported that they have taken cannabis or skunk one or more times in the last four weeks, compared to 4% nationally.

In Hackney and the City, the rate of alcohol-specific hospital admissions among children aged under 18 years was an annual average of 35 per 100,000 children for the years 2006/07-2008/09. This compares to a national average of 64 alcohol-specific admissions per 100,000 children\textsuperscript{344}. The rate of hospital admissions for

\textsuperscript{342} Department for Children, Schools and Families, Home Office and Department of Health, Youth Alcohol Action Plan, 2008.
\textsuperscript{343} Department of Culture, Media and Sport: Tellus4 Survey, 2010.
\textsuperscript{344} Local Alcohol Profiles for England.
substance misuse among 15-24 year olds in Hackney and the City was 47 per 100,000 young people of this age, compared to a national average of 63 per 100,000 young people\textsuperscript{345}.

### Prevention of drug misuse by young people: What works?

Effective interventions to prevent drug misuse for young people include\textsuperscript{346}:

- Interactive learning
- Peer-led interventions
- Social influence interventions, such as the Life Skills Training programme
- Booster sessions which aim to reinforce the effects of a programme
- Programmes delivered in school settings to students aged between 11 – 14 years
- School prevention programmes that target at-risk students are more effective than targeting a general student population
- Drama and theatre workshops

As the evidence for the benefits of needle and syringe programmes (NSPs) in preventing the transmission of blood-borne viruses is so strong, needle exchange services are available for young people in England under the age of 18 years. However, access to NSPs is considered to be one element of treatment undertaken only after a risk assessment and a care package is opened. Research on young people attending NSPs also demonstrated participants were introduced to a broader range of harm reduction initiatives\textsuperscript{347}.

### Accidental injuries

#### 2011 update

More than one in 60 children and young people in Hackney and the City are admitted to hospital every year due to injury. However the number of children killed or seriously injured on the roads has declined by 73% over the last decade.

Accidental injury is a leading cause of death and is also responsible for considerable long-term illness or permanent disability. Accidents can affect all age groups but children and young people are a particularly vulnerable and at risk group. Injuries resulting from traffic collisions, drowning, poisoning, falls, burns and violence are a leading cause of hospital admissions. Accidental injuries to children are also closely linked to social deprivation. Children from unskilled families are five times more likely to die from accidental injury than those from professional families.

In the three years from 2006/07 to 2009/10, the rate of hospital admissions following any injury among children aged 0 - 17 years was 1,577 per 100,000 children of this age\textsuperscript{348}. This is 9% higher than the average for England of 1,443 admissions per 100,000 children.

The number of children killed or seriously injured on the roads in Hackney and the City has declined dramatically over the last decade. On average, there were 12 child casualties per year recently compared to an average of 41 casualties per year over 1994-1998\textsuperscript{349}. This is a decline of 72% and is comparable to the decline in London as a whole of 69%.

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\textsuperscript{345} Hospital Episode Statistics


\textsuperscript{347} National Treatment Agency for Substance Misuse, Exploring the evidence: Young people’s specialist substance misuse treatment, 2009.

\textsuperscript{348} Hospital Episode Statistics

\textsuperscript{349} Department for Transport statistics
Vulnerable children

It is vitally important that the most vulnerable children and young people in Hackney and the City receive maximum support and opportunities in order that they can be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing.

Children who come from families with multiple risk factors such as mental illness, substance misuse, debt, poor housing and domestic violence are more likely to experience a range of poor health and social outcomes. These might include developmental and behavioural problems, mental illness, substance misuse, teenage parenthood, low educational attainment and offending behaviour.

Safeguarding children: child protection

2011 update

The number of children subject to a child protection plan in Hackney has fallen by 47% in one year.

Focus on inequalities:

- There is a disproportionate number of child protection cases among children of Black or Mixed ethnicity

Abuse of children can have both short and long term effects on the health of children. The short term effects may be manifested in depression, learning problems in school and behavioural disorders. The long term consequences can affect a child’s development and psychosocial functioning. There is thought to be a strong link between abuse of women by a male partner and abuse of children350.

Working closely with families is key to supporting vulnerable children and young people who are in or on the edge of the care system. Factors that lead to children becoming vulnerable are a direct result of parenting skills and other factors, in particular mental illness, substance misuse, learning difficulties and domestic violence.

Increased investment in prevention and early intervention services is a key component of London Borough of Hackney’s innovative Reclaiming Social Work programme, and this investment has seen a reduction in the number of looked after children, and in the number of children who are the subject of child protection plans.

At 31st March 2011 there were 128 children in Hackney who were subject to a child protection plan. This was a substantial decrease (47%) on the previous year351. The types of abuse experienced by these children were as follows:

- Neglect (39%)
- Physical abuse (6%)
- Sexual abuse (5%)
- Emotional abuse (16%)
- Multiple reasons (34%)

Figure 5.28 illustrates the ethnicity of children in Hackney who were subject to a child protection plan at 31st March 2011

The City

Very few children (fewer than five) were subject to a child protection plan in the City of London in 2009/10352.

350 London health Observatory: Determinants of Health: lifestyle and behaviour, 2009
351 London Borough of Hackney
352 City of London Corporation
The immunisation rate for Hackney’s looked after children is well above average. Oral care and annual health assessments are also above the national average. Mental health scores and rates of criminal offences are average.

Children and young people come into the care of the local authority either on a voluntary basis with the agreement of parent(s) or through the family courts. This may be necessary to protect a child from harm, or because the family is in need of support due to a crisis. These children are described as ‘looked after’ children. Looked after children typically have complex needs which require a considered and individualized response from local service providers in every case.

In March 2011 there were 215 Hackney children who had been looked after for at least 12 months. The number of looked after children has fallen year-on-year from 354 in 2008. Figure 5.29 illustrates the ethnicity of looked after children in Hackney at 31st March 2011.

Hackney has a good record of caring for looked after children: looked after children have a high rate of stable placements and a low rate of multiple placements and placement breakdown. This stability supports improved emotional wellbeing. This is further supported through the involvement of clinicians (systemic family therapists and clinical practitioners) in their care planning under the Reclaiming Social Work model. The availability of clinicians within the social work units has made a significant difference to some of the most vulnerable looked after children and young people, with timely mental health assessments at times of crisis and holistic support to overcome barriers in their lives, such as contact with family, the effects of past abuse or labelling by professionals, carers or peers.

Table 5.10 describes key health performance indicators of Hackney’s looked after children. Hackney’s performance is above average for immunisations and oral care. The proportion of children who had received an annual health assessment is average nationally and below average for London. All rates in Hackney are improvements on performance in the previous year.

Looked after children are assessed against an emotional and behavioural questionnaire (SDQ). The scores of Hackney’s looked after children on this measure are average for London. Records are also kept of interventions for substance misuse among looked after children. None of Hackney’s looked after children received such an intervention in 2010/11. However 6.3% of children aged over 10 years were convicted of a criminal offence or subject to a final warning or reprimand, similar to rates in London (6.0%) and England (7.3%).
Table 5.10. Health indicators of looked after children, March 2011 (Department for Education)

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Hackney</th>
<th>London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisations up to date</td>
<td>93%</td>
<td>78%</td>
<td>79%</td>
</tr>
<tr>
<td>Teeth checked by dentist</td>
<td>88%</td>
<td>87%</td>
<td>82%</td>
</tr>
<tr>
<td>Had annual health assessment</td>
<td>84%</td>
<td>90%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Figure 5.29. Ethnicity of looked after children in Hackney (March 2011)

The City

The City has a good record of caring for looked after children. All looked after children in the City have stable placements and accommodation.

In March 2010, there were 14 looked after children in the City of London.

In the City, all the children who had been looked after for at least 12 months in September 2009 had up to date health checks, immunisations, dental checks and health assessments. This maintains the 100% record of the previous year.

Disabilities

2011 update

Learning disability, language difficulties and emotional and behavioural problems are the main problems of the children on the Hackney child disability register. The prevalence of severe forms of these disabilities and problems is also high.

A disability is defined as a physical or mental impairment that has a substantial and long term adverse effect on the child’s ability to carry out day to day activities. Children with disabilities require extra support to ensure that they prosper, stay healthy and have equal access to education and other local resources.

Hackney’s child disability register provides a valuable overview of the range of disabilities that children and families are coping with locally. At the beginning of 2011 there were 947 children and young people on the register353. Of these, 7% were aged under five years, 31% were aged between 5 and 10 years, 44% were aged between 11 and 16 years and 18% were aged 17-19 years.

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353 London Borough of Hackney
Figure 5.31 and Table 5.11 describe the prevalence of different disabilities and problems among the children and young people on the Hackney register. Some children and young people are coping with more than one problem, so the data on the prevalence of different conditions is not independent.

The most prevalent disabilities and problems are learning disability, language difficulties and emotional and behavioural problems. The prevalence of severe forms of these disabilities and problems is also high.

The City

There were fewer than ten children and young people with disabilities known to the City of London Corporation in 2011.

Hackney Independent Forum for Parents/Carers of Children with Disabilities identified the following as the most common problems or issues affecting the health and wellbeing of their members:
- Stress
- Poverty
- Parents’/carers’ own health problems
- Difficulties in accessing services/information

The prospect of services disappearing because of funding cuts is a particular current anxiety.

Table 5.11. Disabilities and problems among children and young people on Hackney child disability register by severity, March 2011 (London Borough of Hackney)

<table>
<thead>
<tr>
<th></th>
<th>severity</th>
<th>total</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>mild/moderate</td>
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<tr>
<td>physical disability</td>
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<tr>
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<tr>
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<tr>
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<td>121</td>
</tr>
<tr>
<td>language difficulty</td>
<td>72</td>
<td>243</td>
</tr>
</tbody>
</table>
Children Travellers’ Health Needs Assessment, Hackney 2009

Hackney Council, in partnership with the London Development Agency, has developed three new permanent Traveller sites for Traveller communities living in the area. Despite this, there is still a lack of culturally appropriate housing to meet the needs of the Traveller population in Hackney. Subsequently many children live in circumstances that are not conducive to supporting their educational needs at home.

Gypsy Traveller children are sometimes subject to racist bullying. Although this has declined to a greater extent in recent years, an occurrence can become a reason for parents to remove their children from a school if not dealt with robustly. Young Traveller boys are at high risk and suffer disproportionately from exclusion and dropout from school; subsequently they have much poorer educational outcomes than any other BME group.

Amongst some families, the need for consistent regular school attendance may not be prioritised and the value of education beyond the achievement of reading and writing skills may not be acknowledged. This is further compounded by the inability of some parents to act as reading role models because of their own poor literacy skills. Poor attendance also results in children missing out on access to health interventions.

Breastfeeding initiation amongst traveller mothers has been poor over the past two generations, despite health messages promoting its benefits.
Chapter 6: Adult health and illness

This chapter describes the impact of long-term conditions on adults in Hackney and the City. These conditions, which include heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are the leading causes of death and disability in the local population.

People with long-term conditions are intensive users of health and social care services. It is estimated that the treatment and care of those with long-term conditions accounts for 69% of the primary and acute health care spend in England. Long term conditions such as coronary heart disease stroke and cancer are among the leading causes of premature death locally and make a major contribution to the differences in life expectancy between Hackney, the City, and the average for England. Focusing on long term conditions makes economic sense and can transform lives, helping people achieve good health and wellbeing.

General health and life expectancy

Self-reported health

There are various ways of measuring or assessing the general health of the population, the simplest of which is self-assessment. How people rate their own health takes some account of how people feel about their health and illness and indicates how important health is to personal wellbeing.

In a 2010 local survey of residents of Hackney and the City residents\(^{354}\), three fifths (59%) of those interviewed stated that their health was ‘good’, 29% stated that their health was ‘fairly good’ and 12% said that their health was ‘not good’. Self-reported health has been improving locally: in 2006, only 55% said their health was good. However the proportion who say they health is not good has remained stable at around one in eight people (Figure 6.1).

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\(^{354}\) Ipsos MORI: Residents’ views of health and health services 2010. NHS City and Hackney, 2010
In 2009, 62% of White respondents said their health was good compared to 51% of Black respondents and 46% of Asian respondents. In 2010, the proportion of Black respondents reporting good health was much higher at 64%. This was similar to the proportion of White respondents who said their health was good (60%). The response among Asian respondents remained low at 42%.

The Place Survey conducted in both localities in 2008 found that, in Hackney, 78% of respondents felt their health was ‘good’ or ‘very good’. In the City, 89% of respondents said their health was ‘good’ or ‘very good’. This survey offered more choices than the local survey, including ‘fair’, so the total proportion reporting good or very good health is lower than the results for the local survey illustrated by Figure 6.1.

Age Well is a project of Age UK Hackney which works with people aged 50-65 years to promote healthier lifestyle choices. The project identified the following as the most common problems or issues affecting the health and wellbeing of its clients:
- social isolation
- diabetes
- hypertension
- mobility
- low grade depression
- financial worries

These clients, approaching pension age, are keen to plan for the future. They worry about loss of independence in older age and factors that would contribute towards this such as incontinence, loss of memory, loss of mobility.

### Life Expectancy

**2011 update**

Life expectancy in Hackney continues to rise year-on-year for both men and women. Female life expectancy is above the national average. Male life expectancy is below average but the decrease in the gap between life expectancy in Hackney and life expectancy in England has been sustained.

Life expectancy is a measure of the average number of years a person born in Hackney or the City can expect to live if the death rates currently experienced locally stayed the same throughout their lifetime. It may not be a realistic measure of how long someone will actually live, because death rates change over time, but it is a good indicator of current population health.
Life expectancy in Hackney is 77.4 years for males and 83.0 years for females. In the City, life expectancy is 82.2 years for men and 89.2 years for women. The City has the highest life expectancy in the country.

Life expectancy in Hackney has been increasing steadily over the past decade for both males and females (Figures 6.2, 6.3). Female life expectancy has increased at a faster rate and is now between the averages for London (83.3 years) and England (82.6 years). Male life expectancy remains lower than the averages for London (79.0 years) and England (78.6 years) but the gap between male life expectancy in Hackney and in England is just over a year – much smaller than its historical trend.

There are variations in life expectancy within Hackney and the City. Within Hackney, male life expectancy ranges from 71.1 years in Chatham to 79.4 years in New River (Figure 6.4) and female life expectancy ranges 78.7 years in Hackney Central to 86.1 years in Victoria (Figure 6.5).

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355 ONS. Based on data for 2008-2010.

The life expectancy gap for males in Hackney is an important issue with many causes. To address this, and in response to the priorities in the 2009 Health and Wellbeing Profile, a detailed assessment of male life expectancy in Hackney has been published\textsuperscript{357}. The following is taken from the Executive Summary:

**Causes of premature death among men in Hackney**

- The main causes of premature death of males in Hackney are: cancer, coronary heart disease, stroke, respiratory diseases, chronic liver disease, accidents, infectious diseases and suicide
- The London Health Observatory life expectancy inequalities tool calculates that the major contributors to the gap in life expectancy between Hackney and England to be (% contribution to the gap in brackets): circulatory diseases (32%), cancers (13%), respiratory diseases (9%), digestive diseases (9%), external causes (14%) and infectious diseases (12%)
- Mortality from coronary heart disease is much greater in Hackney than England, particularly in the 65-74 age group. Mortality from stroke is also higher in this age group.
- Mortality from lung cancer is much higher than nationally, especially in the 35-64 and over 75 age groups
- Mortality from stomach cancer is far in excess of national rates, in all age groups

\textsuperscript{357} Garner A, Rahman S, Hobart V, Schmocker F: Reducing the gap in male life expectancy in Hackney, NHS City and Hackney 2010
Mortality due to chronic liver disease and digestive ulcers is higher in Hackney than England. Chronic liver disease has higher mortality rates at age groups 35-74 in Hackney than England.

There is higher mortality from COPD locally than in England, with higher mortality at younger ages than nationally.

Mortality from infectious diseases is higher in Hackney across all age groups than England. The main contributors to deaths from infectious disease are: HIV, hepatitis and septicaemia.

Mortality from external causes is higher than nationally, the main contributors to which are: accidents, road accidents, suicide, drug poisoning and assault.

**What does this mean for men in Hackney?**

- Circulatory diseases and cancer contribute the highest number of YLL of any causes to men in Hackney. CHD contributes the majority of the YLL from circulatory diseases and lung cancer is the highest YLL of any cancer in males.
- YLL for circulatory diseases, all cancers, infectious diseases, accidents and suicides are higher in Hackney than in London and England.
- Accidents, suicides and infectious diseases have a higher number of YLL compared to what would be expected from their mortality rate (as they disproportionately affect younger people).
- The LHO tool confirms that nearly 40% of the gap in life expectancy is in men aged 60-69. 26% is in ages 50-59. Additionally, compared to other Spearhead areas deaths at younger ages (10-29) contribute more of the life expectancy gap in Hackney.
- Life expectancy in Hackney is inversely proportional to deprivation. The gap between the least and the most deprived in Hackney is five years.
- Analysis of the components of the IMD shows that life expectancy decreases with increasing scores only for income deprivation. This suggests that income deprivation is the main factor driving differences in life expectancy between the most and the least deprived in Hackney.

**Why does the gap exist for males and not females?**

- There are differences in life expectancy for males and females across the world which is consistent with all PCTs in England.
- The life expectancy gap between men and women is largest at younger ages and gets smaller with increasing age.
- Men have higher deaths rates for a number of causes and their premature death rate is significantly higher than women, both nationally and locally.
- This is likely to be a due to combination of factors including biological (genetic, hormonal and physiological), behavioural (lifestyle choices such as smoking, alcohol, risk-taking) and psychological (illness and health management, support systems, stress management).
- Increasing mortality rates seen with increasing deprivation is present for both sexes but the effect is stronger for males, particularly at ages under 65.
- Analysing cause-specific mortality rates in Hackney suggests there are distinct differences in mortality rates from different causes, which contribute to low life expectancy in men and not women.
- Males in Hackney have higher mortality from CHD, external causes (including accidents and suicides), infectious diseases and cancer than females in Hackney.
### Improving life expectancy: what works?[^358]

The following interventions have been shown to increase life expectancy:

- Improve basic skills and employment prospects
- Intensive support programmes for long term unemployed (particularly for those with mental illness)
- Interventions around providing information on appropriate health service, linked in with benefit reassessment intervention programmes
- Interventions to raise levels of physical activity, including creating better and safer local environments
- Interventions to reduce calorie intake in order to reduce obesity (including anti-obesity drugs, public education initiatives, workplace programmes, work with local food outlets to promote healthier choices, interventions in early years settings)
- Improve the nutrition of families and other groups by improving access to and consumption of fruit and vegetables
- Improve prescribing to people at high risk of CVD (anti-hypertensives, statins) and with diagnosed CVD
- Expand early intervention services for mental health issues
- Programmes to increase public awareness of cancer symptoms
- Work with GPs to increase timely referral of people with potential cancer symptoms
- Work with secondary care to ensure clinically effective diagnosis and treatment pathways are adhered to for all patients
- Provision of adequate capacity of smoking cessation services, including pharmacological therapy and counselling support, and advertising of these services
- Coordinated tobacco control programmes (smoke-free policies, banning advertising of tobacco products, reducing access to tobacco products)
- Combining smoking cessation and weight loss programmes
- Reducing the number of outlets selling alcohol and reducing licensing hours, imposing a minimum price per unit and reducing advertising
- Enabling GPs and healthcare professionals to screen people for harmful drinking/substance misuse and refer people into high quality treatment services
- Improve standards of local authority housing to meet Decent Homes standards
- Measures to reduce overcrowding in homes
- Implement coordinated accident prevention schemes, including delivering injury prevention advice in GPs and A&E departments, provision of home safety assessments, enforcing minimum safety standards in private and local authority housing, providing education to children and young people on accident prevention (regarding the water, fire/fireworks, road safety, cycle safety) and providing a safe environment by enforcing vehicle speed reduction.

### Deaths

#### 2011 update

Local death rates continue to decline. However the premature (<75 years) death rate in Hackney remains well above the London average.

#### Focus on inequalities:

- The premature death rate in Hackney is far higher among men than among women

In 2009 a total of 1,094 Hackney residents died, 522 women and 572 men. Adjusted for the age distribution within the borough, this is an annual death rate of 576 people per 100,000 residents. It was significantly higher among men (693 per 100,000 male residents) than among women (473 per 100,000 female residents).

The death rate in Hackney has fallen over the last 10 years at approximately the same rate as in London as a whole (Figure 6.6 and 6.7). The overall death rate has been consistently higher in men than in women but there has been a slight narrowing of the gap due to a steeper decline in the death rate in men. This decline is primarily associated with declining mortality from cardiovascular disease (see below).

[^358]: For a fuller account and references, see Garner A et al: Reducing the gap in male life expectancy in Hackney: The gap in 2006-8 and what we can learn from it. NHS City and Hackney, 2011 (available at [www.hackney.gov.uk/jsna](http://www.hackney.gov.uk/jsna))
The overall death rate gives a general indication of the health of the population. If it is declining, this is because people are living longer (hence the increase in life expectancy). A further indicator of population health is the premature death rate, i.e. the death rate among people aged under 75 years. These deaths are often preventable, so this is an important indicator of the potential to improve health outcomes in the local area.

In Hackney, 560 Hackney residents aged under 75 years died in 2009. This is an age adjusted rate of 357 per 100,000 people. There is a particularly pronounced difference between premature deaths among men (343 or a rate of 545 per 100,000 men) and women (217 or 267 deaths per 100,000 women). The premature death rate for both sexes has been declining over the last decade at a similar rate to the London average (Figure 6.8 and 6.9) but remains significantly above this average (351 per 100,000 men, 209 per 100,000 women), especially for men.

The City

In 2009, 41 residents of the City of London died: 19 females and 22 males. The age-adjusted rate was 309 deaths per 100,000 residents, though this figure is very variable year-on-year due to the small number of deaths and the small population (Figure 6.6 and 6.7).

The premature death rate in the City is low: in 2009, 13 City of London residents aged under 75 years died. The trend is erratic due to the small number of deaths but nonetheless demonstrates a long-term decline (Figure 6.8 and 6.9).

Figure 6.6. Age-adjusted death rate (males) per 100,000 population 2000-2009 (NCHOD)

Figure 6.7. Age-adjusted death rate (females) per 100,000 population 2000-2009 (NCHOD)
Figure 6.8. Age-adjusted premature (<75 years) death rate (males) per 100,000 population 2000-2009 (NCHOD)

Figure 6.9. Age-adjusted premature (<75 years) death rate (females) per 100,000 population 2000-2009 (NCHOD)

Road casualties

2011 update

The number of people killed or seriously injured on the roads fell in both Hackney and the City in 2009. This is consistent with the long term trend.

In 2009, 103 people were killed or seriously injured on Hackney’s roads\textsuperscript{359}. This was a sharp decline of 36% on 2008. There is considerable year-on-year variability in these data but the long-term trend is a 40% decline from an average of 211 deaths and serious injuries per year in 1994-98 to an average of 127 over 2006-2009. The decline over this period in London as a whole was 46%.

In the City, 46 people were killed or seriously injured on the roads in 2009, a fall of 10% on the previous year. With smaller numbers, there is even more year-on-year variability in these data in the City but the long term trend is also downwards: a fall of 21% from the 1994-98 average of 65 people killed or seriously injured to the 2006-09 average of 52 casualties per year.

\textsuperscript{359} Department for Transport: County and Unitary Authority Level Statistics, 2010
Cancer

More than one in three people in England will develop cancer at some stage in their lives and one in four will die from it. Over half of all cancers could be prevented if people adopted healthy behaviours such as360:

- Stopping smoking;
- Avoiding obesity;
- Eating a healthy diet;
- Not being sedentary, i.e. undertaking a moderate or more intense level of physical activity;
- Avoiding an excessive alcohol intake; and
- Avoiding excessive exposure to sunlight.

Vaccination against HPV and promotion of safer sex are also opportunities to prevent cervical cancer, which is linked to HPV infection.

The earlier a cancer can be diagnosed, the greater the prospect of survival. Evidence suggests that later diagnosis of cancer has been a major factor in the poorer survival rates in the UK compared with some other countries in Europe361.

Early diagnosis requires that individuals are aware of the symptoms of early cancer, that they have access to primary care professionals and seek advice from them if symptoms occur, that these symptoms are then identified as potential symptoms of cancer, and finally that appropriate investigations and referrals are initiated.

Public awareness of cancer and cancer symptoms

Focus on inequalities:

Nationally, awareness of the risk factors for cancer is low in deprived groups

Locally:

- Men are less likely than women to acknowledge dietary risk factors for cancer
- People from deprived areas and younger people are less likely to recognise warning signs for cancer
- Women are more likely than men to be put off seeking help about potential cancer warning signs

Public awareness of the main preventable risk factors for cancer is poor. Only five percent of the general population could, unprompted, name four of the six lifestyle factors linked to cancer listed above. Seventy-seven percent were only able to name up to two of these factors. Awareness of risk factors for cancer is particularly low in deprived groups362.

In 2010 a local study was conducted to identify levels of awareness of cancer risk factors, symptoms and screening programmes363. When asked to identify risk factors for cancer, 55% cited smoking. Awareness of other factors was much lower (Figure 6.10). Men were less likely than women to acknowledge risk factors relating to diet such as eating red processed meat once a day or eating fewer than 5 portions of fruit and vegetables per day.

363 STRC Research and Intelligence: Public awareness of cancer in City and Hackney. Report for North East Cancer London Network (NECLN), 2010
Awareness of the signs and symptoms of cancer is also limited. When respondents in the local study were asked if they could identify possible signs or symptoms of cancer, 57% of respondents cited a lump or swelling but other key signs or symptoms were mentioned far less often (Figure 6.11). The ‘Other’ category in Figure 6.9 includes fatigue, hair loss and skin problems.

There were no differences between men and women in their recognition of warning signs but people from more deprived areas were less likely to recognise warning signs than those from less deprived areas.

The main barriers to help-seeking described by respondents were difficulty in making an appointment, being too busy and being worried about wasting the doctor’s time. Women were more likely to report barriers such as being embarrassed and being scared as well as practical ones such as finding it difficult to make an appointment. Awareness of the breast and cervical cancer screening programme was high (>70%) but awareness of the most recent bowel cancer screening programme was much lower (40%).

New efforts are being made locally to increase awareness of cancer warning signs and risk factors, especially in more deprived areas and younger age groups. This is necessary both to reduce long-term incidence and to ensure that people with cancer present to front line medical services earlier.
Cancer screening

2011 update

The uptake of breast, cervical and bowel cancer screening all increased last year. However rates are still below national minimum standards in each programme.

Focus on inequalities:

- Breast screening: there are no significant differences by ethnic group in the uptake of breast screening in Hackney and the City
- Bowel screening: nationally, lower uptake of bowel screening has been identified among men, people from black and minority ethnic communities and in deprived communities.

Screening involves testing individuals in the apparently healthy population to identify those who have disease but do not yet have symptoms. The three national cancer screening programmes running in Hackney and the City are for breast, cervical and bowel cancer. These programmes aim to detect early stage cancer and improve the likelihood of survival.

Breast cancer screening

Breast cancer is the most common cancer in the UK, accounting for one in three of all cancer cases. In 2008, there were 94 new cases of breast cancer in Hackney.

The local breast screening service is provided by the Central and East London Breast Screening Service. All women between the ages of 50 and 70 are invited for a mammogram every 3 years. In 2010/11, 64% of the eligible women in Hackney and the City took up the offer of breast screening. The rate of uptake has been increasing year on year (Figure 6.12) but is still below the national minimum standard of 70% and national average of 75%.

Across GP practices in Hackney and the City coverage rates range from 46% to 78% in 2011. Only 11 practices (out of 45) are over the 70% coverage target. The lowest coverage is seen in the 50-52 year old age group (32.2%) and 65-70 year old age group (61.1%)\(^{364}\). However, coverage has increased between 2009/2010 and 2010/2011 by 3 to 4 percentage points in all age groups except the 50-52 year olds.

Some studies have suggested that black and minority ethnic women are less likely to participate in breast screening\(^ {365} \) but local research shows that all ethnic groups within Hackney and the City had a similar uptake. Research identified several key reasons why women do not attend, including lack of awareness/understanding of the screening process, fear of pain during the process, fear of cancer and misunderstandings about cancer, including not feeling at risk. These issues were similar across women of different ages and ethnic groups.

Women who have a family history of breast cancer are at a greater risk of being diagnosed with breast cancer. Those who are assessed by the family history clinic as high risk are offered regular screening from an earlier age than the rest of the population, including access to MRI scans.

The City

In the three years from 2006 to 2008, there were 14 new cases of breast cancer in the City. In 2010/11, breast cancer screening coverage at the Neaman practice was 62%.

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Cervical cancer screening

Five women were newly diagnosed with cervical cancer in 2008 in Hackney. Cervical cancer is almost entirely caused by infection with the human papilloma virus (HPV) which is sexually transmitted. More than half of all women who have sex will get infected with HPV at some time in their lives. A new vaccination programme has been introduced to tackle the problem (see childhood immunisation).

The purpose of cervical screening is to detect early changes in the cervix caused by the HPV virus which, if picked up early, can be treated and so prevent the development of cancer. Most HPV infections are harmless or cause genital warts but some types can cause cervical cancer.

The NHS Cervical Screening programme invites women aged 25 to 50 for screening every three years and those aged 50 to 64 (with previously normal smears) every five years. Deaths from cervical cancer in the UK occur mainly in women who have not participated in screening (IARC, 2007).

The evidence shows that if we are able to get 80% of eligible women to attend screening the death rates from cervical cancer will fall drastically by up to 95%. Nationally, the coverage of cervical screening has fallen from 82% in 1999/2000 to 79% 2009/2010 with the biggest decline seen in the 25-34 year age group, with only 62.8% of women in the age group having had cervical screening in the last five years.\(^{366}\)

In 2010/2011, cervical screening coverage in Hackney and the City was 72.7%.\(^{367}\) This is a small increase on the rate in the previous year (72.4%). There are wide variations in screening rates between GP practices ranging from 49% to 84%.\(^ {368}\) Only five of the 47 practices for which data are available achieved rates over the 80% national minimum standard. Both locally and nationally, the lowest coverage is in the 25-34 age group.

The City

In the three years from 2006 to 2008, there were fewer than 5 new cases of cervical cancer in the City. In 2010/11, cervical cancer screening coverage at the Neaman practice was 62% (the third lowest in Hackney and the City).

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Bowel cancer screening

About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second most common cause of cancer deaths, with over 16,000 people dying from it each year. In Hackney there were 75 new cases of bowel cancer in 2008.

Diagnosing bowel cancer early through population screening is anticipated to greatly improve health outcomes and reduce mortality from bowel cancer by up to 15%. In 2007 the NHS Bowel screening programme was rolled out across Hackney and the City. Men and women in their sixties are invited to be screened for bowel cancer every two years. In Hackney and the City, uptake of bowel cancer screening reached 38% in 2009/10, up from 35% in the previous year. However this rate is still well below the national target of 60% and the national average of 50%. Across GP practices in Hackney and the City, coverage ranges from 22% to 44% of the eligible population.

Evidence from the national bowel screening pilots has shown that uptake of the screening test varies significantly between different groups. Participation in bowel cancer screening is lower among men, people from black and minority ethnic communities, and those who live in areas of higher deprivation.

Local research in Newham found low levels of awareness of bowel cancer and the screening process, especially among Asian men and women. Men did not identify themselves at risk as they did not have symptoms. Among women there was a misperception that bowel cancer is largely a male cancer, and there was a mix of fear and apprehension of test results and colonoscopy.

The City

In the three years from 2006 to 2008, there were 13 new cases of bowel cancer in the City. In 2010/11, bowel cancer screening coverage at the Neaman practice was 46%.

Prostate cancer screening

The most common cancer in men in Hackney is prostate cancer. In 2008 there were 124 new cases in Hackney.

The incidence of this cancer increases with age and the average age at diagnosis is 70 to 74 years. Most cases of prostate cancer grow slowly and may not cause any symptoms or shorten life, however some cancers are more aggressive and progress more quickly.

The UK National Screening Committee does not recommend screening men for prostate cancer but in response to considerable demand for the Prostate Specific Antigen (PSA) test among men worried about the disease the government has introduced a PSA Informed Choice Programme, Prostate Cancer Risk Management (PCRMP). This was introduced in 2002 to help GPs and practice nurses in advising men who are worried about prostate cancer but have no symptoms on the implications of having a PSA test. The key elements are the provision of high quality information for men requesting the test. This should enable men to decide whether or not to have the test based on the available evidence about risks and benefits.

The City

In the three years from 2006 to 2008, there were 11 new cases of prostate cancer in the City.

369 Cancer Research UK, 2005
370 London Bowel Cancer Screening Hub 2010/2011
371 North East London Bowel Cancer Screening Centre, 2011
What works: cancer prevention, screening and timely diagnosis

Prevention

Primary prevention (preventing people getting cancer in the first place) is thought to be about seven times more effective than secondary prevention (detecting and treating cancer before it is symptomatic).

Effective cancer prevention includes interventions that reduce smoking, reducing alcohol consumption, increase fruit and vegetable consumption, reduce obesity and encourage physical activity. These interventions can also reduce the risk of recurrence of cancer.

Encouraging attendance at screening

Where screening is possible, it is an important method of detecting abnormalities at an early stage, enabling treatment when the cancer is most likely to be curable or, in some cases, even when it is in a pre-cancerous stage.

Lack of participation in screening is linked with a number of factors including: not feeling at risk of the disease, lack of knowledge of how screening works or the benefits of screening, unacceptability of the test and inability to access the service. Interventions that can overcome these barriers increase uptake of screening services.

Health professional endorsement of screening programmes has been shown repeatedly to increase uptake of screening. Sending people fixed appointments (relevant only for breast and cervical screening), and second time appointments can increase uptake.

Following up people who do not participate increases uptake and can reduce inequalities in screening participation, particularly if combined with provision of information in languages other than English.

Reducing delays in diagnosis

There is a clear link between delay in cancer diagnosis and survival, with patients delaying presentation at their GP for more than 3 months having significantly lower survival. Late diagnosis also contributes to cancer survival inequalities. Therefore, reducing delays in diagnosis can improve survival and reduce mortality from cancer and reduce inequalities.

Delays can arise from lack of patient awareness of symptoms, delayed presentation to primary care, delays within primary care prior to referral and delays within secondary care.

Several initiatives have been successful at raising awareness of cancer symptoms and encouraging early presentation including: utilising community volunteers and creating local partnerships, such as in the Health Communities Collaborative; individual level interventions such as letters and leaflets; one-to-one interventions delivered by health professionals; public communication campaigns and education sessions held in the community.

Ensuring GPs refer people presenting at their practice according to appropriate guidance and in a timely manner reduces delays in diagnosis. Peer review of referrals within practice has been shown to improve the quality of GP referrals.

Improving GPs’ knowledge of NICE or other guidance, or their knowledge of the PPV (positive predictive value) for cancer of various symptoms improves referrals.

382 Community Links (2011). Breast Screening take-up project Year One Report.
384 www.practicalcommissioning.net
Incidence of cancer

2011 update

Cancer incidence in Hackney and the City has risen by 8% over the last ten years and is now higher than the London average.

The proportion of cancers that present when the cancer has spread and is deemed incurable is extremely high in Hackney, particularly for cancers of the stomach, bowel, pancreas, lung and ovary.

Focus on inequalities:

- Lung cancer incidence is independently linked to smoking prevalence and deprivation, both of which are high in Hackney.
- The two cancers associated with affluence – breast and skin cancer – have relatively low prevalence in Hackney.

Every year, on average, between 600 and 700 people are diagnosed with cancer in Hackney and the City. This is equivalent to around 12 people receiving a cancer diagnosis every week.\(^{385}\)

Cancer incidence in Hackney and the City has risen by 8% over the past ten years (Figure 6.10). Over the five years from 2004 to 2008, an average of 391 people in every 100,000 were diagnosed with cancer every year. This compares to an average of 360 people per 100,000 a decade before. Cancer incidence is now higher than the rate for London of 373 diagnoses per 100,000 residents per year (all figures are age-standardised).

The most common cancers are breast, lung and prostate cancers (Figure 6.11). Every year, on average, 98 women are diagnosed with breast cancer, 92 people are diagnosed with lung cancer and 88 people are diagnosed with prostate cancer in Hackney and the City. Colorectal cancer is also common with an average of 73 people diagnosed every year in Hackney and the City. Over the past 10 years, prostate, colorectal and skin cancers have all become more common whereas incidence of stomach and bladder cancer has decreased.

City and Hackney has higher than average incidence of lung, prostate and stomach cancer, but lower incidence rates for breast and skin cancer. The biggest risk factor for lung cancer is smoking (around 90% of lung cancers in men and 83% in women are estimated to be caused by smoking\(^{386}\) and estimates of 10-15% of heavy smokers developing lung cancer\(^{387}\)) so the high incidence of lung cancer is likely to reflect the higher than average prevalence of smoking in Hackney. Deprivation is also independently linked with incidence of lung cancer.\(^{388}\)

Prostate cancer is three times more common in black men than other ethnic groups, which may account for the higher than average incidence of prostate cancer in Hackney. Breast and skin cancers are the only two cancers associated with affluence, therefore lower rates of these cancers in Hackney may be due to high levels of deprivation.

\(^{385}\) All data on incidence, survival and mortality is provided by the Thames Cancer Registry

\(^{386}\) Peto, R et al. Mortality from smoking in developed countries 1950-2000 2004


Stage of disease development at diagnosis

When cancers are diagnosed, their stage of disease development is recorded where possible:

- **Stage 1** indicates the disease is confined to the organ of origin
- **Stage 2** means the cancer has extended beyond the organ of origin into the area around it
- **Stage 3** indicates that the cancer has spread to the regional lymph nodes
- **Stage 4** means the cancer has metastasised – spread to distant parts of the body.

The proportion of cancers where the stage is not recorded or known is variable between cancer sites. In City and Hackney, this varies from around 20% for ovarian cancers to around 65% for melanoma. Figure 6.12 describes the stage of presentation for the main cancers, where the stage of presentation is known.

Late diagnosis of cancer leads to poorer prognosis, poorer survival and increased mortality.

The proportion of cancers that present at stage 4, when the cancer has spread and is deemed incurable, is extremely high for cancers of the stomach, colon/rectum, pancreas, lung and ovary. As colorectal and lung cancers are common, this late presentation contributes significantly to local cancer mortality.
Cancer deaths, survival and prevalence

2011 update

Cancer mortality in both Hackney and the City continues to decline at a rate comparable to that of London. The death rate in Hackney is slightly higher than the London average. The death rate in the City is significantly lower than the London average.

Focus on inequalities:

- Socio-economic deprivation is associated with later presentation of cancer and lower survival rates.
- Breast cancer survival is lower among Black women. Black women and minority ethnic women are less likely than other women to be aware of cancer symptoms, less likely to check their breasts and more likely to present late.
- Older women and women from more deprived areas are less likely to think they are at risk of breast cancer than other women, more likely to think that survival is rare and treatments are severe and more likely to delay presentation.
- Cancer prevalence is below average in the South Asian population.

Deaths and survival

The death rate from cancer in Hackney continues to decline year-on-year. Over the three years from 2007 to 2009, an average of 289 people died from cancer every year, 51% male and 49% female. This is an age-standardised rate of 168 deaths per 100,000 population per year. This is slightly higher than the average for London (164 per year) but considerably lower than the averages for Tower Hamlets (214 per year) and Newham (183 deaths per 100,000 population per year).

Figure 6.14 illustrates the long-term trend in cancer mortality, based on five year averages. Over the 16 year period illustrated, the annual age-standardised death rate from cancer fell by a quarter or 58 deaths per 100,000 population. The decline in the cancer death rate in Hackney follows the average for London very closely.

There is a more distinct difference between Hackney and London in the rate of premature (under 75 years) cancer mortality (Figure 6.15). Premature cancer mortality has also been falling steadily, at a similar rate to...
London, but remains higher than in London. In 2005-09, the age-standardised premature death rate in Hackney was 122 deaths per 100,000 people compared to 111 deaths per 100,000 people in London.

Survival rates are very different for different cancers (Figure 6.16). In north east London, nearly a quarter (72%) of people diagnosed with lung cancer and three fifths (60%) of people diagnosed with stomach cancer die within a year of diagnosis. In contrast, 77% of those diagnosed with breast cancer and 76% of those diagnosed with prostate cancer are still alive five years after diagnosis.

There are large variations in survival from cancer between socioeconomic groups, with deprivation associated with later stage at presentation and lower survival\(^{389,390,391,392}\). Survival from cancer in North East London is low, with late stage at presentation associated with this poor survival\(^ {393}\). The NAEDI pathway\(^ {394}\) shows that there are various sources of delay along the diagnosis pathway.

**Figure 6.13 The NAEDI pathway of cancer diagnosis**

![Diagram](image)

**Figure 6.17 illustrates the trend in breast cancer survival over the past 12 years. In Hackney and the City, the rate of improvement in breast cancer survival over the last eight years has been better than in neighbouring boroughs and in London as a whole, though the longer term trend is a comparable improvement.**

Breast cancer survival is lower in Black women than other ethnic groups\(^ {395}\). Black and minority ethnic groups are less likely to be aware of symptoms of breast cancer\(^ {396}\) and more likely to delay in presenting to a GP with breast symptoms\(^ {397}\). Black women are also more likely to get more aggressive cancer\(^ {398}\) and present with late.

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395 National Cancer Information Network (2009). Breast Cancer specific Cancer Awareness Measure. A validated population level survey carried out across INEL in January 2010, with over 1500 respondents. For more details see “Awareness of Breast Cancer in women living in Inner North East London, Kings College London Promoting Early Presentation Group, July 2010”
stage disease\textsuperscript{399}. Local research showed that around 25% of women check their breasts regularly (fewer in Black and minority ethnic groups) and only 50% of women felt confident that they would notice a change\textsuperscript{400}. Older women and women from more deprived areas are less likely to think they at risk, more likely to think that survival is rare and treatments are long and severe and more likely to delay presentation\textsuperscript{401,402}.

**The City**

In the City, the annual death rate from cancer over the three years from 2007 to 2009 was an average of 15 people (43% women, 57% men). This is an age standardised rate of 128 deaths per 100,000 population per year.

Figure 6.14 and 6.15 illustrate the long-term trends in deaths from all cancers and from premature cancer (under 75 years). Both rates in the City are well below the average for London and premature deaths have fallen markedly over the last 6 years.

**Figure 6.14. Long-term trend in deaths from all cancers, at all ages (Thames Cancer Registry)**

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure6.14.png}
\caption{Long-term trend in deaths from all cancers, at all ages (Thames Cancer Registry)}
\end{figure}

**Figure 6.15. Long-term trend in deaths from premature (<75) cancer (Thames Cancer Registry)**

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure6.15.png}
\caption{Long-term trend in deaths from premature (<75) cancer (Thames Cancer Registry)}
\end{figure}


\textsuperscript{400} Breast specific Cancer Awareness Measure carried out in inner North East London in 2010. See Final report “Awareness of breast cancer among women living in inner North East London” for more details.

\textsuperscript{401} Grunfield E, Ramirez A, Hunter M and Richards M (2002). Women’s knowledge and beliefs regarding breast cancer. BJC 86: 1373-1379

Prevalence

Figure 6.18 describes the crude prevalence of cancer in the GP-registered population in Hackney. In 2010/11, 0.9% of this population was living with cancer (90 per 1,000 population or 2,431 individuals). Cancer prevalence is rising year-on-year, reflecting the combination of improving survival, a declining death rate and stable incidence (Figure 6.18).

The variations in cancer prevalence within the GP-registered population of Hackney by age, ethnicity and care group (including mental illness and disability) are illustrated in Figures 6.19 to 6.21. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup.

As we would expect, the prevalence of cancer increases with age, though the number of people with cancer aged under 65 is actually greater than the number aged 65 or more. There are relatively small differences between ethnic groups with a below average prevalence in the South Asian population of Hackney. Cancer prevalence is high among residents who are deaf, blind or housebound. However this relationship is principally a function of the older age of these client groups – older people are more likely to be deaf, blind or housebound and more likely to have cancer than younger age groups. There is also a small difference in the prevalence of cancer between men and women: among men, the prevalence is 12.5 per 1,000 men; among women, the prevalence is 14.3 per 1,000 women.
The City

There is no data on cancer prevalence among residents of the City, except for those residents registered at the Neaman practice in the northwest of the City. In 2010/11, the crude prevalence of cancer recorded by the Neaman practice was 1.8% (160 individuals). This rate is relatively high due to the older population (the rates are not age-standardised) (Figure 6.18).

Figure 6.18 Crude prevalence of cancer in GP-registered population 2006-2011

Figure 6.19 Prevalence of cancer in Hackney by age: overall numbers per age group and rate per age group, 2011 (CEG)

Figure 6.20 Prevalence of cancer in Hackney by ethnic group: overall numbers per ethnic group and rate per ethnic group, 2011 (CEG)

Figure 6.21 Prevalence of cancer in Hackney by care group: overall numbers per care group and rate per care group (CEG)
Focus on inequalities

- There is a high rate of hospital admissions for cancer in the Black Caribbean population in Hackney, including both planned and emergency admissions.

In 2010/11 there were 5,951 hospital admissions for cancer in Hackney. The majority of these admissions (86%) were planned. The ethnic profile of these admissions, and the rates per ethnic group, are illustrated in Figures 6.22 for planned admissions and 6.23 for emergency admissions. In both cases there is a high rate of admissions in the Black Caribbean population.

The City

In 2010/11 there were 417 hospital admissions for cancer in the City of London, 83% of which were planned.

Figure 6.22. Planned hospital admissions for cancer in Hackney, 2008-11: overall ethnic profile of clients and rate per ethnic group (SUS/GLA)
Cardiovascular disease

Cardiovascular disease includes disorders of the heart and blood vessels such as coronary heart disease, stroke, raised blood pressure (hypertension), diabetes and kidney disease. It is the largest single cause of long-term ill health and disability, affecting the lives of over four million people in England and causing 36% of all deaths. The burden of vascular disease falls disproportionately on particular ethnic groups such as South Asians and on people living in deprived conditions, making it a big contributor to health inequalities in our society.

The major causes of vascular disease over which individuals have control are tobacco use, physical inactivity, alcohol consumption and an unhealthy diet.

Coronary heart disease

2011 update

Premature deaths from coronary heart disease continue to decline in Hackney and the City but remain higher than in London as a whole.

Focus on inequalities:

- There is a high rate of coronary heart disease in the South Asian population in Hackney
- There are very high rates of coronary heart disease among deaf, blind and housebound residents of Hackney, but not among those with mental illness or learning disability.
- Prevalence of coronary heart disease is much higher in men than women. The premature death rate is also much higher in men.

Coronary heart disease (CHD) includes angina (chest pain on exertion), heart attacks (myocardial infarction) and heart failure. Premature CHD is preventable yet CHD kills more people than any other disease, both nationally and in Hackney and the City.
Prevalence

In 2010/11, the crude prevalence of CHD recorded by GP practices within Hackney was 1.6% (16 per 1,000 population or 4,405 individuals in total)\(^{403}\). This is the fourth lowest rate in London though, as the data is not age-standardised, this partly reflects Hackney’s younger inner-city population. The crude prevalence of CHD has fallen slightly in Hackney over the past four years, in line with the trend in London as a whole (Figure 6.24).

Actual prevalence, including undiagnosed CHD, will be higher. National modelling suggests that age-adjusted CHD prevalence in Hackney and the City could be as high as 5.0%\(^{404}\). This suggests that there are many people within Hackney and the City living with CHD who are not aware of their condition. The difference between recorded and modelled prevalence is typical of all London PCTs.

The variations in CHD prevalence within the GP-registered population of Hackney by age, ethnicity and care group (including mental illness and disability) are illustrated in Figures 6.25 to 6.27. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup. As we would expect, the prevalence of CHD increases with age, though the number of people with CHD aged under 65 is substantial. CHD is particularly common in the South Asian population but not so common in the Black population – despite the fact that there is a high prevalence of hypertension and a high rate of hospital admissions for all cardiovascular disease in this ethnic group (see below). There are very high rates of CHD among deaf, blind and housebound residents of Hackney, but not among those with mental illness or learning disability. There is also a marked difference in the prevalence of CHD between men and women: among men, the prevalence is 20 per 1,000 men; among women, the prevalence is 12 per 1,000 women.

The City

There is no data on coronary heart disease among residents of the City, except for those residents registered at the Neaman practice in the northwest of the City. In 2010/11, the crude prevalence of CHD recorded by the Neaman practice was 2.1% (181 individuals)\(^{405}\). This crude rate is comparable to the average for London. Prevalence has fallen slightly in the past four years (Figure 6.24).

Figure 6.24. Prevalence of CHD in GP-registered population in Hackney 2006-2011 (QOF)

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403 QOF data
404 Eastern Region Public Health Observatory modelled estimates of prevalence of CHD for PCTs in England, 2008
405 QOF data
Deaths

Coronary heart disease accounted for 171 deaths among Hackney residents in 2009. This included 75 premature deaths (among people aged under 75 years). Over two-thirds (69%) of these premature deaths were men. The premature death rate has fallen fairly steadily over the last ten years (Figure 6.28) but remains higher than the London average. Almost all of the decline has been in the male premature death rate but this remains well above the female premature death rate (Figure 6.29).
The City

Over the three years from 2007 to 2009 there were 20 deaths from coronary heart disease in the City (12 men and 8 women). Six of these deaths were premature (under the age of 75 years). As there are so few deaths in the City, any trend is difficult to identify but Figure 6.17 suggests a long-term decline, in line with the pattern in London as a whole.

Figure 6.28. Premature deaths from CHD per 100,000 people aged under 75, age-standardised, 2000-2009 (NHS IC)

Hypertension

2011 update

Nearly one in ten adults in Hackney have hypertension, a major risk factor for cardiovascular and other diseases.

Focus on inequalities

- There is a high rate of hypertension in the Black population in Hackney
- There are very high rates of hypertension among blind and housebound residents of Hackney, and high rates among deaf people and those with mental illness
High blood pressure (hypertension) is one of the most common disorders in the UK and a major cause of coronary heart disease, stroke, kidney disease, aortic aneurysm and other diseases. Although it rarely causes symptoms on its own, the damage it does to arteries and organs can lead to considerable suffering and healthcare costs.

The main risk factors for developing hypertension, over which individuals have control, are excess salt intake, excess weight and obesity, physical inactivity and excess alcohol intake. Age, ethnicity and diabetes are also risk factors. Evidence has shown a strong association between salt intake and elevated blood pressure. In the UK, 65-70% of the salt we eat comes from processed foods such as bread, breakfast cereals and ready meals. Average adult daily intake is 9g of salt per day, three times the amount actually needed and 3g more than the recommended maximum intake. Obesity multiplies the risk of developing hypertension about fourfold in men and threefold in women. Blood pressure rises when we drink large amounts of alcohol, particularly when binge-drinking, and heavy alcohol use is a well-established risk factor for hypertension and stroke.

In 2010/11, the crude prevalence of hypertension recorded by GP practices within Hackney was 9.4% (94 per 1,000 population or 25,585 individuals in total)\(^{406}\). This is below the average for London but, as the data is not age-standardised, this partly reflects Hackney’s younger population. The crude prevalence of hypertension has risen slightly in Hackney over the past four years, in line with the trend in London as a whole (Figure 6.30).

This rise in hypertension prevalence could reflect wider blood pressure measurement, including NHS Health Checks, as many people have high blood pressure but do not seek help from their GPs. The modelled prevalence of hypertension is much higher than the recorded prevalence. The modelled prevalence for Hackney and the City in 2010 is 26%\(^{407}\). This is nearly three times the rate recorded in primary care and suggests that the majority of high blood pressure is undiagnosed and untreated. The modelled prevalence of hypertension in Hackney and the City is higher for men (29.1%) than for women (23.6%).

The variations in hypertension prevalence within the GP-registered population of Hackney by age, ethnicity and care group (including mental illness and disability) are illustrated in Figures 6.32 to 6.34. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup. As we would expect, the prevalence of hypertension increases with age, though the number of people with hypertension aged under 65 is substantial. Hypertension is particularly common in the Black population: no distinction is made in this data between Black Caribbean and Black African but data on hospital admissions suggests the problem may be greater in the Black Caribbean population (see below). There are very high rates of hypertension among blind and housebound residents of Hackney, and high rates among deaf people and those with mental illness. There is only a small difference in the prevalence of hypertension between men and women: among men, the prevalence is 84 per 1,000 men; among women, the prevalence is 99 per 1,000 women.

In 2010/11, 78.1% of patients in City and Hackney who have diagnosed and treated hypertension had their blood pressure controlled to at least 150/85. This improvement in blood pressure control means that the rate in City and Hackney is now average for London (Figure 6.31).

**The City**

There is no data on hypertension among residents of the City, except for those residents registered at the Neaman practice in the northwest of the City. In 2010/11, the crude prevalence of hypertension recorded by the Neaman practice was 8.2% (719 individuals)\(^{408}\). This rate has been stable for the last four years (Figure 6.30).

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406 QOF data
408 QOF data
Figure 6.30 Crude prevalence of hypertension in GP-registered population 2006-2011

Figure 6.31. Proportion of diagnosed and treated hypertension patients achieving good blood pressure control, 2004-2011 (QOF)

Figure 6.32 Prevalence of hypertension in Hackney by age: overall numbers per age group and rate per age group, 2011 (CEG)
Stroke

2011 update

The premature death rate from stroke in Hackney and the City is unchanged but is now above the London average.

Focus on inequalities:

- There is an above average rate of stroke in the Black population in Hackney
- Although the numbers are small, there are high rates of stroke among residents who are blind, deaf or have mental illness.

Stroke is the third biggest cause of death in the UK and the largest single cause of severe disability.

In 2010/11, the crude prevalence of stroke and transient ischaemic attack in the GP-registered population in Hackney was 0.8% (80 per 1,000 population or 2,300 individuals in total). The prevalence rate has been fairly stable over the past four years (Figure 6.35).

The variations in stroke prevalence within the GP-registered population of Hackney by age, ethnicity and care group (including

TLC Stroke Project works with people affected by stroke and people at raised risk of stroke in Hackney and the City. The most common problems or issues affecting its clients, other than the effects of stroke itself, are reported to be:

- isolation
- lack of physical activity combined with a high calorie diet
- motivation

In the last year, the project’s clients have sought increased support to enable their greater involvement in social care reviews and use of personal budgets. There has also been increased demand from people with long-term conditions and carers for in-depth preventative information about lifestyle and medication...
mental illness and disability) are illustrated in Figures 6.36 to 6.37. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup. As we would expect, the prevalence of stroke increases with age, though the number of people with hypertension aged under 65 is substantial. Prevalence of stroke is higher in the Black population; no distinction is made in this data between Black Caribbean and Black African but data on hospital admissions suggests the problem may be greater in the Black Caribbean population (see below). The absolute numbers are small for the care groups and we would expect a correlation between stroke and being housebound. Nonetheless there are the high rates among people who are deaf, blind or have mental illness. There is no difference in stroke prevalence between men and women.

In 2009, 81 people died from stroke in Hackney, of whom 46 were women and 35 were men. Of these deaths, 28 were premature (before the age of 75). This is an age standardised rate of 19 deaths per 100,000 people, significantly higher than the London average of 12 deaths per 100,000 population. However, there is significant year-on-year variability in the rate, due to the small absolute numbers, and the long-term trend is a decline (Figure 6.39).

The premature mortality rate from stroke is higher in City and Hackney than in London and is unchanged from last year. It is now above the average for London but the long-term decline in premature mortality from stroke follows the trend for London (Figure 6.20).

The City

There is no data on stroke prevalence among residents of the City, except for those residents registered at the Neaman practice in the northwest of the City. In 2010/11, the crude prevalence of stroke recorded by the Neaman practice was 1.0% (84 individuals).

Deaths from stroke are rare in the City: in the three years from 2007 to 2009 there were nine deaths from stroke among City residents.

Figure 6.35 Crude prevalence of stroke in GP-registered population 2006-2011
Figure 6.36 Prevalence of stroke in Hackney by age: overall numbers per age group and rate per age group, 2011 (CEG)

Figure 6.37 Prevalence of stroke in Hackney by ethnic group: overall numbers per ethnic group and rate per ethnic group, 2011 (CEG)

Figure 6.38 Prevalence of stroke in Hackney by care group: overall numbers per care group and rate per care group (CEG)
Focus on inequalities

- There is a high rate of hospital admissions for cardiovascular conditions in the Black Caribbean population in Hackney, especially planned admissions.

In 2010/11 there were 4,157 hospital admissions for cardiovascular conditions in Hackney, 38% of which were emergency admissions. The emergency admissions were dominated by heart failure, cerebral infarction (stroke), atrial fibrillation (abnormal heart rhythm), acute myocardial infarction (heart attack) and angina.

The ethnic profile of these admissions, and the rates per ethnic group, are illustrated in Figures 6.40 for planned admissions and 6.41 for emergency admissions. There is a high rate of admissions in the Black Caribbean population, especially for planned admissions.

The City

In 2010/11 there were 101 hospital admissions for cardiovascular conditions in the City of London, half of which were emergency admissions.
Cardiovascular disease: what works

The top priorities for primary prevention include:

- Smoking cessation
- Improve diet and physical activity
- BP control < 140/90 mmHg
- For people with a >20% 10-year CVD risk prescribe a statin (Simvastatin 40mg)
- Stopping smoking is the single most important change that can be achieved to reduce coronary heart disease.

The top priorities for secondary prevention include:

- Smoking cessation
- Improve diet and physical activity
- Optimal BP control < 130/80 mmHg
- Optimal cholesterol control < 4mmols/l or LDL < 2 mmols/l
- Specific advice related to people suffering from heart attack, angina, stroke or Type 2 diabetes

Diabetes

Diabetes is a long term condition which impacts on every aspect of life. It can affect people of all ages, and is becoming more common as the prevalence of obesity increases. Diabetes is the leading cause of blindness in people of working age in the UK.

There are two different types of diabetes. Type 1, affecting 10% of the population with diagnosed diabetes, usually starts at a young age and requires life-long treatment with insulin. Type 1 diabetes reduces life expectancy by up to 15 years. Type 2 diabetes is more common, affecting 90% of the population with diabetes, and usually starts later in life. It is associated with obesity and therefore is amenable to primary prevention. Type 2 diabetes reduces life expectancy by up to 10 years.
Diabetes prevalence and deaths

**2011 update**

The prevalence of diabetes continues to rise year on year in Hackney. However the local prevalence rate is average for London.

**Focus on inequalities:**

- There are high rates of diabetes in the South Asian and Black populations in Hackney.
- There are also high rates of diabetes among blind, deaf and housebound residents, and among people with learning disabilities and mental illness.

In Hackney, there were 11,032 people over the age of 16 living with diagnosed diabetes in 2010/11, as recorded in general practice (QOF data). This is equivalent to one in twenty adults (5.2%). This is slightly lower than the average for London (5.4%).

The prevalence of adult diabetes is rising in Hackney, in step with the trend in London as a whole (Figure 6.42). For technical reasons, Figure 6.42 shows the diabetes rate in adults as a proportion of the whole population. The actual adult prevalence rate, described above, is higher. However figure 6.42 is an accurate description of the trend.

The modelled age-adjusted prevalence of adult diabetes in Hackney and the City, which includes both diagnosed and undiagnosed disease, is 7.9%. Although care is needed in comparing this figure to the unadjusted crude prevalence data, it is clear from the difference between the two that there is a significant local population of people living with undiagnosed diabetes.

The variations in diabetes prevalence within the GP-registered population of Hackney by age, ethnicity and care group (including mental illness and disability) are illustrated in Figures 6.43 to 6.44. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup.

As we would expect, the prevalence of diabetes increases with age, though falls in the highest age group reflecting the lower life expectancy of people with diabetes. Diabetes is particularly common in the South Asian and Black populations in Hackney. There are high rates of diabetes in all the care groups, especially among blind and housebound residents (diabetes is the leading preventable cause of blindness and lack of exercise is a risk factor for diabetes). Prevalence of diabetes is the same among men and women.

Premature deaths (under 75 years) attributed to diabetes are relatively rare as most people living with diabetes die from other conditions which diabetes exacerbates, such as cardiovascular disease. Over the three years from 2007 to 2009 a total of 20 people died prematurely from diabetes in Hackney and the City, an average of seven people per year. This is an age-standardised annual death rate of 4.5 per 100,000 people under 75 years, significantly higher than the average for London of 3.0 per 100,000 per year.

**The City**

There is no data on diabetes prevalence among residents of the City, except for those residents registered at the Neaman practice in the northwest of the City. In 2010/11, the crude prevalence of diabetes recorded by the Neaman practice was 2.4% (192 individuals).

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410 National Centre for Health Outcomes Development (NCHOD)
Deaths from diabetes are rare in the City: in the three years from 2007 to 2009 there were no deaths from diabetes among City residents.

**Figure 6.42 Prevalence of diabetes, 2006-2011 (QOF)**

![Graph showing diabetes prevalence by year and location.]

**Figure 6.43 Prevalence of diabetes in Hackney by age: overall numbers per age group and rate per age group, 2011 (CEG)**

![Graph showing diabetes prevalence by age group and ethnicity.]

**Figure 6.44 Prevalence of diabetes in Hackney by ethnic group: overall numbers per ethnic group and rate per ethnic group, 2011 (CEG)**

![Graph showing diabetes prevalence by care group and location.]

**Figure 6.45 Prevalence of diabetes in Hackney by care group: overall numbers per care group and rate per care group (CEG)**
Control of diabetes in primary care

2011 update

There have been year-on-year improvements in all but one of the key indicators of control of diabetes in primary care in Hackney and the City. Results are all above the London average. Retinopathy screening coverage is now the third highest in London.

Focus on inequalities:

- People with diabetes of Black African/Caribbean and South Asian people ethnicity have a significantly higher mean blood sugar level than those of White ethnicity
- Younger people with diabetes are less likely to attend retinopathy screening

Good control and self-management of diabetes reduces the long-term health risks of living with the condition. The following three measures are used within primary care as indicators of good control:

- Glycated Haemoglobin (HbA1c) of 8 or less (blood sugar control)
- Blood pressure of 145/85 mm Hg or less
- Total cholesterol of 5 mmol/l or less

In 2010/11, 86.5% of patients with diabetes registered in general practice in Hackney and the City had a glycated Haemoglobin of 9 or less. This is an improvement of over three percentage points on the previous year and is above the London average (85.7%). In east London, people with diabetes of Black African/Caribbean and South Asian people ethnicity have a significantly higher mean HbA1c level than those of White ethnicity411.

In 2010/11, 82.2% of patients with diabetes registered in general practice in Hackney and the City had a blood pressure of 145/85 or less. This is an improvement of one percentage point over the previous year. The rate is above the average for London (80.9%) and has improved significantly over the last five years, up from 66.1% in 2004/05.

In 2010/11, 82.3% of patients with diabetes registered in general practice in Hackney and the City had a total cholesterol of 5 mmol/l or less. This is unchanged from the previous year but is above the average for London (80.9%).

Retinal screening is vital in preventing blindness. In Hackney and the City, coverage of retinal screening was 90.2%. This was an improvement of over four percentage points on the previous year and is well above the

national minimum threshold of 80% coverage. The coverage rate in Hackney and the City is now the third highest in London. However, in east London as a whole, younger patients are less likely to attend retinopathy screening than older adults.

**Diabetes: what works?**

Draft NICE guidance, *Preventing type 2 diabetes: risk identification and interventions for individuals at high risk* was published in 2011. It complements NICE guidance on behaviour change, cardiovascular disease, community engagement, obesity, physical activity and weight management before, during and after pregnancy.

The recommendations focus on two major activities:

- How to identify people at particular risk of developing type 2 diabetes (using risk assessment scores and blood testing)
- The provision of information, advice and tailored support to help those people make the long term lifestyle changes that have been shown to reduce the risk or delay the onset of diabetes

Detailed recommendations cover the following areas:

1. Risk assessment
2. Encouraging people to have a risk assessment
3. Communicating the risks of type 2 diabetes and the benefits of prevention
4. Reassessing risk
5. Matching interventions to risk
6. Quality assured intensive lifestyle change programmes
7. Dietary advice
8. Physical activity advice
9. Weight management advice
10. Diabetes prevention programmes for black, minority ethnic and vulnerable groups
11. Diabetes prevention programmes for people in long stay institutions and residential care
12. Evaluation of intensive lifestyle change programmes
13. Use of medication
14. Surgical intervention
15. Assessing and evaluating local need and capacity
16. Commissioning risk assessment programmes
17. Commissioning intensive lifestyle change programmes
18. National public health programmes
19. Training and professional development

Diabetes prevention programmes that use behaviour change strategies to support adults with impaired glucose tolerance have been shown to be effective in large-scale trials. The greater the number of lifestyle-change goals achieved, the greater the subsequent reduction in risk. The programmes set similar specific targets. For example:

- Sustained weight loss of between 5 and 7% (or more) of initial body weight
- An increase in fibre intake to at least 15 g per 1000 kcal consumed
- A reduction in total fat intake to less than 30% of the energy consumed
- A reduction in saturated fat intake to less than 10% of the energy consumed
- Physical activity of more than 4 hours a week

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Respiratory disease

Respiratory diseases are one of the most common forms of ill-health. They are also a leading cause of hospitalisation and death, especially in the elderly, and include pneumonia, bronchitis and emphysema.

Chronic obstructive pulmonary disease

2011 update

There has been a decline in the death rate from chronic obstructive pulmonary disease over the last 15 years, especially among men, but the rate has now stabilised.

Focus on inequalities:

- COPD prevalence is high in the White population of Hackney
- COPD is also common among people who are deaf, blind or mentally ill, though the absolute numbers are small

Prevalence

Chronic obstructive pulmonary disease (COPD) is a chronic progressive disorder that leads to narrowed, damaged airways, which makes it harder for air to get in and out of the lungs. The term covers a range of conditions including chronic bronchitis and emphysema. COPD can be highly debilitating and it can seriously undermine wellbeing and quality of life. The major risk factor for COPD is smoking making smoking cessation the most effective treatment. The majority of patients with COPD are managed through primary care and in the community with onward referral to secondary care when needed.

The recorded prevalence of COPD in GP practices in Hackney and the City was 0.9% (2,347 individuals) in 2009/10. This was below the average for London of 1.0% and well below the average for England of 1.6% (QOF data). However this is likely to be an underestimate of true prevalence which has been estimated at 4.5%413.

The variations in COPD prevalence within the GP-registered population of Hackney by age, ethnicity and care group (including mental illness and disability) are illustrated in Figures 6.46 to 6.47. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup.

As we would expect, the prevalence of COPD increases with age, though the number of people with COPD aged under 65 is substantial. COPD is particularly common in the White population and relatively uncommon in the Black population. The high rate of COPD in the housebound population reflects the debilitating impacts of the disease. Rates are also high among deaf and blind residents, and among those with mental illness, though absolute numbers are small. There are very high rates of COPD among deaf, blind and housebound residents of Hackney, but not among those with mental illness or learning disability. There is a small difference in the prevalence of COPD between men and women: among men, the prevalence is 10 per 1,000 men; among women, the prevalence is 8 per 1,000 women.

Figure 6.46 Prevalence of COPD in Hackney by age: overall numbers per age group and rate per age group, 2011 (CEG)

413 Association of Public Health Observatories
Deaths

The death rate from COPD in Hackney is high. Over the three years from 2006 to 2008, an average of 61 people died from COPD in Hackney every year. This is an age-standardised rate of 35 per 100,000 population and compares to a rate of 27 per 100,000 in London as a whole. The rates in Tower Hamlets and Newham are even higher: 48 and 39 per 100,000 respectively (NCHOD). Around 50% more men than women die from COPD in Hackney. The premature (under 75 years) death rate in Hackney is 18 per 100,000 population, compared to a rate in London of 12 deaths per 100,000 population.

There has been a decline in the death rate from COPD over the last 15 years (Figure 6.49) in Hackney and the City. This has been entirely due to the decline in COPD deaths among men. The death rate among women has been static (Figure 6.50). However there has been little change in the death rate for either sex over the last 8 years.
The City

In the City, there are very few deaths (fewer than five) per year from COPD.
Oral health

Dental hygiene and health

2011 update
There is a low but improving rate of uptake of dental services among adults in City & Hackney

Focus on inequalities
- In the local Asian population there is a relatively high rate of gum disease but a relatively low rate of dental decay
- The highest rate of dental decay is found in the White population
- Adults with learning disabilities report fear, limited mobility and lack of carer support as barriers to accessing dental services. However oral health in this group is better than average (Tower Hamlets data)

The possession of 21 or more natural teeth is used to define a minimum functional dentition to ensure good oral health. A survey conducted in 2008 found that, in City and Hackney residents, 88% of adults had a functional dentition compared to 91% in Newham, 92% in Tower Hamlets\(^{414}\) and 86% for England\(^{415}\). A high proportion of adults in Hackney and the City had poor mouth hygiene, 94% had visible debris and 80% had tartar on their teeth. Gum disease was present in 49% of adults. There were significant differences between ethnic groups: Asians were the most likely to have gum disease (65%) followed by White (50%) and Black (44%) respondents.

The survey also found that the 46% of adults in Hackney and the City have decayed teeth. This compares to 39% in Tower Hamlets, 58% in Newham and a national average of 28%. Again, there was marked variations between ethnic groups, though these were not consistent with the differences found for gum disease. Dental decay was most common in the White population (71%) followed by Black (54%) and Asian (45%) respondents.

In June 2011 two fifths (40%) of adults in Hackney and the City had been seen by a dentist in the previous 24 months. This is below the average for London (48%) and for neighbouring east London boroughs (45% in Tower Hamlets, 55% in Newham). However attendance has improved over the last four years (Figure 6.51)

Clinical indicators of dental problems may not directly reflect the problems people experience. Several measuring tools have been developed to provide insights into quality of life experiences of both patients and the public alike. In the survey, two thirds (66%) of adults who had teeth reported having experienced one or more oral problems that had an impact on some aspect of their life. The most frequently experienced problem was dental pain (32%) followed by psychological impacts such as self consciousness or embarrassment.

In a study of oral health in adults with learning disabilities in Tower Hamlets, 46% had decayed teeth\(^{416}\). Mouth hygiene was slightly better than the general adult population with 90% having visible debris on teeth. The main barriers to accessing dental services in the group of adults were fear, limited mobility and lack of a carer to accompany them to the clinics.

A study of Orthodox Jewish mothers in Hackney found that cultural influences, competing pressures and perceptions of hereditary influences, together with a lack of contemporary oral health knowledge, were the main factors affecting oral health knowledge and beliefs. This supported an overall perspective of

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\(^{415}\) NHS Information Centre Adult Dental Health Survey 2009

disempowerment or a perceived lack of control over oral health behaviours, both for mothers and their children. Community signposting pointed mothers to dental services, whilst family pressures together with inadequate capacity and generic barriers such as fear and cost acted as barriers. Mothers from this community welcomed community development initiatives from the NHS.

Figure 6.51 Proportion of adults seen by a dentist in previous 24 months

Oral cancer

People over 50 years are more at risk of developing mouth cancer. Mouth cancer is more common in men but rates in women are increasing. Alcohol consumption and smoking are both risk factors for mouth cancer and these risks are multiplied together when both behaviours are present. Chewing tobacco which is a social habit in parts of the Asian community is also known to lead to mouth cancer.

Between 2003 and 2008 the age standardised rate of new cases of mouth cancer in Hackney and the City was 8.9 per 100,000 population. This was higher than the average for London (7.9 per 100,000 population) but lower than the rates in Tower Hamlets (11.3 per 100,000) and Newham (9.2 per 100,000).

Oral health: what works?

Fluoride is effective in preventing dental decay in adults of all ages and in particular root decay in older people.

Behavioural interventions contribute to dental anxiety reduction and results in improved dental attendance in adults.

When compared to manual toothbrushes powered toothbrushes with a rotating oscillation action provides protection against gum inflammation and plaque control.

Older people can benefit from oral health promotion provided the appropriate support is given e.g. programmes providing oral health education should be combined with skills training for carers.

Programmes using more innovative approaches than the medical/behavioural model have more potential for achieving longer-term behaviour changes. Tailored approaches based on active participation and addressing social cultural and personal norms offer longer-term changes in behaviour compared with simple one-off interventions.

418 The Information Centre: NHS Dental Statistics for England: 2010/11
419 Yeung A (2007) Fluoride prevents caries among adults of all ages. Evidence Based Dentistry 8, 72-73
420 Ilana Eli. (2005) Behavioural Interventions and Dental attendance. Evidence Based Dentistry 6, 46
Sickle cell disease

Sickle cell disease is a group of genetic conditions affecting red blood cells. In sickle cell disease, red blood cells have a tendency to go out of shape and become sickle-shaped (like a crescent moon) instead of their normal disc shape. Sickle cells are stiff and sticky and tend to block blood flow in the blood vessels of the limbs and organs. Blocked blood flow can cause pain, serious infections, and organ damage.

Sickle cell disease affects 1 in every 2,400 live births in England and is now the most common genetic condition at birth. The highest prevalence occurs in people of African or African Caribbean origin. In these populations, 1 in every 200 people has sickle cell disease and 1 in every 10 people has sickle cell trait. As there are large Black African and Black Caribbean populations in Hackney, sickle cell is a significant cause of illness and hospital admissions.

In 2010/11 there were 1,798 hospital admissions for sickle cell disorder among patient registered in Hackney (SUS data). Of these, nearly half (49%) were emergency admissions. These admissions were overwhelmingly from the local Black population (Figure 6.52).

The City
There were no admissions for sickle cell disease in the City in 2010/11.

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422 DH. Choosing Better Oral health, 2005
423 Conway D (2006) To screen or not to screen? Evidence Based Dentistry 7 81-82
424 West et al. (2004) Smokeless cessation guidelines for health professionals Br Dent J 196 (10) 611-8
425 NHS Evidence: Clinical Knowledge Summaries
Chapter 7: Shared needs

This chapter explores those needs where traditionally services are jointly commissioned between the NHS and local authorities, particularly mental health, disability and the needs of older people. In all the sections we look at a range of needs and the services available to address them, focusing on approaches that help people to maintain their health and well-being, preventing or reducing longer term interventions and helping people to continue living and working in their community.

Mental health

2011 update

The recorded prevalence rates of severe mental health conditions and depression in general practice in Hackney remain among the highest in London. The rate of emergency mental health admissions is exceptionally high and is the highest in London.

Focus on inequalities

There are complex variations in the prevalence of mental health and mental illness depending on the severity and types of mental condition.

- Older people are least likely to have common mental disorders, but may suffer from dementia
- Women are more likely than men to have common mental disorders but men are more likely to have personality disorders
- The prevalence of psychotic disorders is significantly higher among Black men than men from other ethnic groups, but there is no significant variation by ethnicity among women
- Common mental disorders such as depression, anxiety and obsessive compulsive disorder are known to be more prevalent in deprived households

In Hackney:
- There is a high rate of serious mental illness in the Black population
- There is a very high rate of serious mental illness among people with learning disability. High rates are also seen among deaf, blind and housebound residents
There are above average rates of emergency mental health admissions among Black Caribbean and Black Other residents.

Although there is widespread agreement that mental health is more than just the absence of clinically defined mental illness, there is ongoing debate regarding what constitutes the necessary or sufficient components that make up positive mental health, wellbeing or flourishing. The World Health Organisation defines the concept of mental health as including subjective wellbeing, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realise one’s intellectual and emotional potential. It can also be understood as a state of wellbeing whereby individuals recognise their abilities, are able to cope with the normal stresses of life, work productively and fruitfully and make a contribution to their communities. Although definitions vary, mental health is generally seen to include emotion (affect/feeling), cognition (perception/thinking/resources), social functioning (relationships with others and with society) and coherence (sense of meaning and purpose in life).

There is growing evidence that promoting mental health results not only in lower rates of some mental disorders but also in improved physical health and better educational performance, greater workforce productivity, improved relationships within families and safer communities.

The data reported in this section focus principally on mental illness including depression, serious mental health and wellbeing encompassing the social, family and individual factors which contribute to personal wellbeing.

**Determinants of mental health**

The following is a summary of the determinants of mental health and mental illness:

**Age:** Rates of mental illness vary by age. Older people are least likely to have common mental disorders, but may suffer from dementia. A high proportion of mental health problems develop during ages 14–20. The prevalence of ‘anti-social’ personality disorder is most prevalent among 16-34 year olds.

**Gender:** Women are more likely than men to have common mental disorders; however, men are more likely to have personality disorders. Rates of psychotic disorders are slightly higher among women than among men across England.

**Ethnicity:** Rates of mental health admissions are higher for Black African, Black Caribbean and Black Other groups compared to White British, Indian and Chinese groups nationally. The prevalence of psychotic disorders is significantly higher among Black men than men from other ethnic groups, but there is no significant variation by ethnicity among women.

**Children and Young People:** One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood. Early interventions, particularly with vulnerable children and young people, can improve mental health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime.

**Births:** Around one in eight women are affected by moderate to severe post-natal depression following childbirth. This mental health condition has adverse consequences on the mother-

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426 Friedli L: Mental health, resilience and inequalities, WHO 2009
427 MHN NHS Confederation 2011, DH 2011
infant relationship, a woman’s quality of life, and the behavioural, emotional and intellectual development of children; it also increases the likelihood that fathers become depressed after birth

**Deprivation:** Common mental disorders such as depression, anxiety and obsessive compulsive disorder are known to be more prevalent in deprived households\(^{428}\).

**Education:** The majority of mental health problems affect people early, interrupting their education and limiting their life chances. People with mental health problems often have fewer qualifications.

**Employment:** Mental health conditions are the primary reason for claiming health-related benefits. Only 7.9% of adults in England with mental health conditions in contact with secondary mental health services are known to be employed. Attitudes towards employing those with a mental health condition are poor: just four in ten employers would hire someone with a mental health condition, compared with 62% of employers who would hire someone with a physical condition.

**Housing and homelessness:** People with mental health conditions are far less likely to be homeowners than those without these conditions: 38% of those with a mental health condition live in rented accommodation versus 24% of those without a condition. In addition, 43% of those accessing homelessness projects in England suffer from a mental health condition. An estimated 69 per cent of rough sleepers suffer from both mental ill health and a substance misuse problem.

**Physical health and life expectancy:** People who use mental health services, especially those with severe mental illness (SMI), are at increased risk for poor physical ill health, including: coronary heart disease, diabetes, infections, respiratory disease and obesity\(^{429}\). People with SMI die an average of 25 years earlier than the general population\(^{430}\).

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### Prevalence of mental illness

It is estimated that nationally, at any one time, one in six adults of working age experiences symptoms of mental illness that impair their ability to function. A further sixth of the population have symptoms, such as anxiety or depression that are severe enough to require health care treatment. Between 1% and 2% of the population are likely to have more severe mental illness which requires intensive and often continuing treatment and care during their lifetime, such as schizophrenia or bipolar affective disorder.

#### Depression

The crude prevalence of depression in GP practices in Hackney was 10.0% (20,898 individuals) in 2010/11. This was the third highest recorded prevalence of depression in London which had an average prevalence of 7.5%. The rate is unchanged from 2009/10.

**The City**

There is no data on depression among residents of the City, except for those residents registered at the Neaman practice in the northwest of the City. In 2010/11, the crude prevalence of depression recorded by the Neaman practice was 9.0% (696 individuals).

#### Severe mental illness

The crude prevalence of severe mental illness (SMI) – schizophrenia, bipolar disorder and other psychoses – in GP practices in Hackney was 1.2% (3,363 individuals) in 2010/11. This was the fifth highest recorded prevalence in London which had an average prevalence of 0.9%\(^{431}\). This rate has been stable over the last five years.

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\(^{428}\) National Psychiatric Morbidity Survey 2007


\(^{430}\) Parks et al 2006

\(^{431}\) NHS Information Centre: Quality Outcomes Framework
The variations in SMI prevalence within the GP-registered population of Hackney by age, ethnicity and care group (including mental illness and disability) are illustrated in Figures 7.1 to 7.3. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup. Although prevalence of SMI increases with age up to the age of 75, prevalence is high in all adults over 25, with the largest absolute numbers among those aged 25-50 years. There is a high rate SMI in the Black population and a very high rate among people with learning disability (though this may be complicated by definitional issues on the boundary of learning disability and mental illness). High rates are also seen among deaf, blind and housebound residents. There is also a small difference in the prevalence of SMI between men and women: among men, the prevalence is 10 per 1,000 men; among women, the prevalence is 8 per 1,000 women.

For data on dementia, see page 263.

**The City**

There is no data on severe mental health conditions among residents of the City, except for those residents registered at the Neaman practice in the northwest of the City. In 2010/11, the crude prevalence of severe mental health conditions recorded by the Neaman practice was 0.8% (69 individuals).

**Figure 7.1 Prevalence of serious mental illness in Hackney by age: overall numbers per age group and rate per age group, 2011 (CEG)**

**Figure 7.2 Prevalence of serious mental illness in Hackney by ethnic group: overall numbers per ethnic group and rate per ethnic group, 2011 (CEG)**
Hospital admissions

Following the major rise in emergency mental health hospital admissions among the population of City and Hackney in 2009/10, there has been a further small rise in 2010/11 – 936 people were admitted over the year (Figure 7.4). This is an age-standardised rate of 3.74 per 1,000 population, the highest in London by some way (the second highest is Camden with a rate of 2.67 per 1,000 population). The average for London is 1.67 admissions per 1,000 population.\footnote{NHS Comparators - standardised data is only available at PCT level}

In contrast, City and Hackney has one of the lowest rates of elective (planned) mental health admissions: 0.32 per 1,000 population or 154 individuals in 2010/11. This is the fifth lowest rate in London which has an average rate of 0.71 per 1,000 population.

In Hackney, emergency mental health admissions are dominated by schizophrenia (25%) and disorders due to alcohol (25%) followed by depressive episodes (7%) and bipolar disorder (7%).\footnote{Local admissions data (SUS) 433}

Figure 7.5 illustrates the ethnicity of all mental health admissions in Hackney in 2010/11 by each ethnic group, using the GLA estimates of the size of each population. This suggests that, although admissions are high in Hackney as a whole, there is a particularly high rate in Black Caribbean and Black Other groups and a relatively low rate in the Bangladeshi group.

The age distribution of the emergency mental health admissions in Hackney is illustrated in Figure 7.2. The majority of emergency admissions are among people in mid-life. Figure 7.6 illustrates the same data as rates within each age group, using the GLA estimates of the size of each population. This reveals that although there are fewer admissions among the older age groups, this is due to the smaller population size – the rates are highest in the older groups.

The City

There were 21 emergency admissions for mental health and behavioural disorders among City residents in 2010/11\footnote{Local admissions data (SUS)}.\footnote{Local admissions data (SUS) 434}
Figure 7.4. Mental health admissions in Hackney and the City, 2005-2011 (NHS Comparators)

Figure 7.5 Emergency mental health admissions in Hackney, 2008-11: overall ethnic profile of clients and rate per ethnic group (SUS/GLA)

Figure 7.6. Emergency mental health admissions in Hackney, 2008-11: overall age profile and rate per 15 year age group (SUS/GLA)
Social care for people with mental health problems

2011 update

There have been improvements in the number of people receiving mental health services who are in settled accommodation and in employment.

Focus on inequalities:

- There is a high level of mental health care support provided to the Black Caribbean population and, in the working age population, to the ‘Black Other’ population
- There is a relatively low level of support provided to the South Asian population

In 2010/11, Hackney Council provided social care services to 1,110 adults with mental health problems, of whom 37% were aged over 65. Four out of five of these clients (79%) received community-based services; 21% were supported in nursing or residential care. Over the past five years there has been a significant decline in the number of people with mental health problems receiving care packages from Hackney Council: a 32% drop in the rate per 100,000 population since 2005/06 (Figure 7.4).

At the same time, the proportion of adults receiving secondary mental health services who live in settled accommodation has more than doubled from 32.5% in 2008/09 to 67.5% in 2010/11. The number of adults receiving secondary mental health services in employment remains low but has also more than doubled over this period from 1.3% in 2009/09 to 3.7% in 2010/11.

Of the adults in contact with secondary mental health services in 2010/11, 5.2% were in paid employment.

There are pronounced differences in the mental health support provided to different ethnic groups within Hackney (Figure 7.7 and 7.8). In the working age client group there are high rates in the Black population, especially Black Caribbean and ‘Black Other’, though the latter may be an artefact of different approaches to coding between social care records and the GLA population estimates on which these rates are calculated. These differences are less pronounced in the older age group (pension age). The support provided to the South Asian population is low in both age groups.

The City

In 2010/11, the City of London Corporation provided services to 84 adults with mental health problems, of whom 38% were aged over 65. Over the past five years there has been a significant decline in the number of people with mental health problems receiving care packages from the City of London Corporation: a 32% drop in the rate per 100,000 population since 2005/06 (Figure 7.6). Over half (55%) of adults receiving secondary mental health services in the City lived in settled accommodation in 2010/11.

Talking Matters Wellbeing Centre provides support to people within the Orthodox Jewish community suffering mild to moderate mental health problems. They report seeing growing numbers of single isolated people who are depressed and overweight (approximately 50% of users are overweight or obese). There is also a changing demographic from predominantly clients of Eastern European origin to Middle Eastern clients. There are obstacles within the community to addressing mental health problems. There is a fear of “what the neighbours might say” and many older clients use physical/complementary therapies as a vehicle into talking therapies, e.g. reporting that “my back hurts” when the key issues are emotional/psychological. Problems beyond the community are felt to be ignorance of statutory officers and about the needs and culture of the community and insufficient funding for long-term therapy.

435 All data from National Adult Social Care Intelligence Service
Figure 7.6. Number of adults with mental health problems receiving care packages, per 100,000 population, 2005-2011 (National Adult Social Care Intelligence Service)

Figure 7.7 Working age clients with mental health problems receiving social care packages from Hackney Council 2010/11: overall ethnic profile of clients and rate per ethnic group (NASCIS/GLA)

Figure 7.8 Pension age clients with mental health problems receiving social care packages from Hackney Council 2010/11: overall ethnic profile of clients and rate per ethnic group (NASCIS/GLA)
Suicide

2011 update

The unusually high rate of suicide seen in Hackney in 2008 fell in 2009 but remains far higher than the long-term average for Hackney and for London. There were no suicides among City of London residents in 2009.

Focus on inequalities:

- Suicide is much more common among men than women in Hackney

Suicide is a devastating event. Its emotional and practical consequences are felt by both family and friends and health and social care professionals. Suicide is the commonest cause of death in men under 35 and the main cause of premature death in people with mental illness.\footnote{Department of Health, 2009}

Variations in suicide rates across the country, and within London, have been linked to a number of socio-economic factors. Deprivation is linked to mental health service use (particularly inpatient services), which in turn is a strong predictor of suicide risk. The National Suicide Prevention Strategy also identifies a number of high-risk occupation groups, namely nurses, medical practitioners and farmers/agricultural workers.

In 2009, there were 19 suicides in Hackney, a rate of eight people for every 100,000 population (Figure 7.9). This is the second year in a row that the suicide rate has been this high (there were 22 suicides in Hackney in 2008). The suicide rate in Hackney is nearly twice the rate in London as a whole. The majority of suicides are among men (14 male suicides compared to 5 female suicides).

The City

Suicides are rare among residents of the City of London. There were no suicides in the City in 2009.

Figure 7.9. Trend in suicides, rate per 100,000 population 2000-2009 (NCHOD)
Mental health: what works?

NICE guidance on mental health and well-being

For the promotion of social and emotional wellbeing in primary\(^\text{437}\) and secondary\(^\text{438}\) education:

- Schools should provide emotionally secure and safe environments that prevent bullying, provide help and support, and promote positive behaviour.
- Schools should have an integrated programme with well-trained staff to help develop emotional and social wellbeing.

Teachers and other staff should be well-trained to identify and manage anxiety or social and emotional problems with parents/carers and specialists where needed.

For the promotion of mental wellbeing at work\(^\text{439}\):

- Employers should promote a culture of participation, equality and fairness that is based on open communication and inclusion.
- Employers should tackle work-related stress and promote employee well-being.
- Employers should consider flexible working arrangements appropriate for the organisation.

For the promotion of mental wellbeing of older people\(^\text{440}\):

- Use regular sessions to encourage older people to construct daily routines to help maintain or improve their mental wellbeing and increase their knowledge on health issues, such as nutrition, how to stay active and personal care.
- Offer tailored, community-based physical activity programmes.
- Promote regular participation in local walking schemes.
- Involve occupational therapists in the design of training offered to practitioners.

For the treatment of common mental disorders\(^\text{441}\):

- Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways that promote access to services for people with common mental health disorders.

DH guidance No Health without Mental Health\(^\text{442}\)

The Department of Health has recently published a cross-government strategy and delivery plan to promote well-being and prevent mental ill health over the life course. They recommend the following:

Ensure that everyone has the best start in life

- Offer support to families and improve maternal mental health and physical health.

Ensure that children and young people are developing well

- Use a targeted approach for children and young people at risk of developing mental health problems. Early identification, stepped care approaches and programmes targeting at-risk children that use parent training or child social skills training are the most effective.
- Physical activity interventions, leisure activities, cleaner and safer environments, and sustainable, connected and capable communities all improve mental health and wellbeing.

Ensure that adults are living well

- Volunteering increases wellbeing for both the volunteer and the recipient of help.
- Support people with debt problems with locally available services.
- Facilitate social networks and social support groups, for example arts and leisure activities.

Ensure that adults are working well

- Intervene early with those who are out of work to help to prevent deterioration of mental health and support job-seeking.
- Encourage employers to create healthy workplaces by reducing stress and raising awareness of mental health issues. Benefits employers too by reducing absence and low productivity.

\(^\text{437}\)NICE: Social and emotional wellbeing in primary education, PH12, 2008 (http://guidance.nice.org.uk/PH12)

\(^\text{438}\) NICE: Social and emotional wellbeing in secondary education, PH20, 2009 (http://guidance.nice.org.uk/PH20)

\(^\text{439}\)NICE: Promoting mental wellbeing at work, PH22, 2009 (http://guidance.nice.org.uk/PH22)

\(^\text{440}\) NICE: Mental wellbeing and older people, PH16, 2008 (http://guidance.nice.org.uk/PH16)

\(^\text{441}\) NICE: Common mental disorders, CG123, 2011 (http://guidance.nice.org.uk.CG123)

\(^\text{442}\) DH: No health without mental health: delivering better mental health outcomes for people of all age, 2011, (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124057.pdf)
Ensure that adults are ageing well
- Improve the physical and mental health of older people by: reducing isolation, offering support during times of difficulty, increasing social networks and opportunities for community engagement, providing access to continued learning, supporting carers; warm homes initiatives; and promoting physical activity and physical health.

Ensure that people with mental health problems are recovering well
- Improve access to mental health care, especially for high risk groups, including some Black and minority ethnic groups, homeless people, people with low skills, asylum seekers and those in the criminal justice system.
- Ensure that primary and secondary care staff work together using a comprehensive approach to improve care for those with mental health problems.
- Parenting programmes and/or school-based programmes help to improve child behaviour, family relationships and educational outcomes, and also help to reduce antisocial behaviour and crime.
- Talking therapies, psychological approaches, vocational support and skills development services can help people to help themselves, improve their relationships, and improve opportunities for education and employment.
- Support employers to help people stay in, return to and perform well at work.
- Ensure that stable and appropriate housing is provided.

Ensure that more people with mental health problems have good physical health
- Improve primary care management of both mental health and physical health conditions.
- Intervene early to promote healthy lifestyles and reduce health risk behaviours.
- Promote the use of smoking cessation programmes.
- Prevent sexual health risk behaviour using sexual health education programmes.

Disability

Learning disabilities

2011 update
The long-standing estimate of the prevalence of learning disability in Hackney (3,943 adults) has been complemented by an estimate of moderate or severe learning disability of 842 adults. This is much closer to, though still higher than, the GP-recorded prevalence and local authority client base.

Focus on inequalities:
People with learning disabilities have a high burden of ill health and disease and reduced life expectancy. They experience high rates of obesity, coronary heart disease, respiratory disease, mental illness and physical and sensory disabilities.

In Hackney,
- There are no differences in prevalence of learning disability between ethnic groups
- Prevalence of learning disability is high in all care groups (those with mental illness; those who are deaf or blind) though absolute numbers are small.
People with learning disabilities have worse health than the general population and also have a reduced life expectancy, with life expectancy decreasing with increasing severity of impairment. Studies have estimated that people with learning disability are four times more likely to die of a preventable cause and 58 times more likely to die before the age of 50 than the general population. Predictors of early mortality include inability to walk, cerebral palsy, incontinence, residence in hospital and other health problems such as epilepsy.

There is widespread evidence of the burden of specific disease:

- around one person in three with learning disabilities is obese, compared with one in five of the general population (linked with use of psychotropic medication which can cause significant increases in weight and obesity is also more prevalent in a number of genetic syndromes commonly associated with learning disability. Additionally, studies have shown that people with a disability are less likely to engage in physical activity and more likely to have lower cardiovascular fitness levels). A local study into the level of obesity in people with learning disability showed that 38% of people with learning disabilities from GP registers were obese and a further 21% were overweight.
- coronary health disease (CHD) is the second most common cause of death in people with learning disabilities. This suggests that the potential health benefits of physical activity may be greater for those with disabilities.
- the incidence of respiratory disease is three time higher in people with learning difficulties than in the general population
- some 40% of people with learning disabilities have a hearing impairment and many have common visual impairments

According to POhWER, a local organisation that works with people with learning disabilities, the most common problems affecting the health and wellbeing of its clients are:

- ‘Hate and mate’ crime
- Individual budgets
- Transport problems
- Access to health screening
- East London Communication Enterprise (ELCE) also provides support to people with learning disabilities and sees the main issues for clients as follows:
  - Needing help to make healthy choices and to make needs known
  - Needing help to do healthy activities such as walks and swimming
- ELCE also reports problems with personal budgets holding up the provision of services (though these relate to Tower Hamlets).
- Pressure to engage with direct payments is also the single problem identified by Disability Back Up

446 World class commissioning for the health and wellbeing of people with learning disabilities. 2009. DH Commissioning and System Management Directorate
• the rate of dementia is four times higher and the rate of schizophrenia three times higher than in the general population
• people with learning disabilities tend to have substantially lower bone density and experience higher levels of osteoporosis
• epilepsy is over 20 times more common in people with learning disabilities than in the general population. Sudden unexplained death from epilepsy is five times more common in people with learning disabilities than in others with epilepsy.
• around 15% of people with learning disabilities have difficulty walking

These patterns of illness also have a significant impact on use of secondary care. Some 26% of people with learning disabilities are admitted to hospital each year, compared with 14% of the general population. Sir Jonathan Michael’s independent inquiry found that the inequalities in health between the general population and those with learning disability arise in part because:

• people with learning disabilities find it harder to access assessment and treatment
• health service staff have often very limited knowledge about learning disabilities
• healthcare providers make insufficient adjustments for communication problems, difficulty in understanding, or individual preferences
• carers struggle to be accepted as effective partners in care
• although there are examples of good practice, witnesses have also described appalling examples of discrimination, abuse and neglect.

The Michael inquiry identified a number of reasons for these failings. Those most relevant to commissioning are:

• the lack of data and information on people with learning disabilities and their journey through the general healthcare system
• lack of awareness in primary care of the health needs of people with learning disabilities (with limited training for healthcare staff about learning disabilities)
• a lack of priority given to learning disabilities
• no effective monitoring or performance management of providers’ compliance with the legislative framework

Prevalence of learning disability

There are an estimated 3,943 adults with learning disability in Hackney, a prevalence of about 2.2%. This baseline estimate has recently been qualified with a new estimate for the number of people living with moderate or severe learning disabilities. The estimate for Hackney is 842 adults or a prevalence of 0.47%. Figure 7.10 illustrates the likely age range of this population. The skew to the younger age groups is greater than in the general population due to the lower life expectancy of people with learning disabilities. The number of adults living with a moderate or severe learning disability in Hackney is expected to grow by 8% by 2020 and 17% by 2030.

In 2010/11 there were 747 adults with learning disabilities registered with general practices in Hackney, a prevalence of 0.4% (40 per 1,000 population).

454 Michael J: Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities, DH 2008
455 Projecting Adult Needs and Service Information System (PANSI), 2011
The variations in prevalence of learning disability within the GP-registered population of Hackney by age, ethnicity and care group are illustrated in Figures 7.11 to 7.13. Each pair of charts compares the absolute number of people in each population subgroup with the rate in each subgroup.

There are relatively small differences in prevalence by age group with the absolute numbers tailing off in the 65+ age group, as in the estimated population profile. There are no differences in prevalence across ethnic groups. Prevalence is high among deaf and blind residents, though absolute numbers are small, and among those with mental illness. Learning disability is more common among men (3.9 per 1,000 men) than among women (2.7 per 1,000 women).

The City

There are an estimated 271 people living with a learning disability in the City of London, including 57 with a moderate or severe learning disability. These estimates, based on national prevalence rates with some adjustment for local demographics, may not be reliable for the unusual profile of the City’s population.

The only general practice data in the City is of those residents registered at the Neaman practice in the northwest of the City. In 2010/11, the prevalence of learning disability recorded by the Neaman practice was 0.1% (fewer than 5 individuals).

Figure 7.10. Age distribution of people with moderate or severe learning disabilities in Hackney (estimated) (PANSI)

Figure 7.11 Prevalence of learning disability in Hackney by age: overall numbers per age group and rate per age group, 2011 (CEG)

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456 Projecting Adult Needs and Service Information System (PANSI), 2011
Autistic spectrum disorders

There is a wide range of Autism-like symptoms, referred to as Autistic Spectrum Disorders. These share the following behavioural criteria:

- Qualitative impairment in reciprocal social interaction
- Qualitative impairment in verbal and non-verbal communication
- Restricted repertoire of activities and interests

Autism is one of three recognized disorders in the autism spectrum, the other two being Asperger syndrome, which lacks cognitive development and language, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS), which is diagnosed when the full set of criteria for autism or Asperger syndrome are not met.

In Hackney, an estimated 1,437 working adults have an autistic spectrum disorder, of whom 90% are men and 10% are women\(^{457}\). The prevalence of autistic spectrum disorders in this age group is predicted to rise by 7% over the next 20 years. Estimates of prevalence among children are not available.

The City

In the City, an estimated 113 working age adult residents have an autistic spectrum disorder. However this estimate may not be sensitive to the unusual profile of the City’s population.

Down’s syndrome

Down’s syndrome is caused by a chromosomal abnormality (extra copies of chromosome 21, either in totality – trisomy 21, or translocations). The frequency of Down’s syndrome is strongly linked to maternal age: the risk

\(^{457}\) Projecting Adult Needs and Service Information System (PANSI), 2011
of having a child with Down’s syndrome at 1 in 2000 when aged 20 years, whereas this increases to 20 in 2000 (1 in 100) when aged 40 years.

People with Down’s syndrome have a higher incidence of medical problems, such as congenital heart abnormalities (around 30-45% of Down’s syndrome individuals have heart abnormalities), gastrointestinal problems (in 6% of individuals), hypothyroidism, and visual and hearing difficulties (50% and 70% respectively). The majority of people with Down’s syndrome will develop early onset dementia.

In Hackney, an estimated 93 people have Down’s syndrome, of whom 72% are aged under 45 years458.

The City

In the City, an estimated six adults have Down’s syndrome. However this estimate may not be sensitive to the unusual profile of the City’s population.

Social care for people with learning disabilities

In 2010/11, Hackney Council provided services to 595 clients with learning disabilities. The number of clients with a learning disability receiving care packages has remained fairly stable over the past three years (Figure 7.14).

Figure 7.15 describes the range of community services received by clients with learning disabilities in 2010/11. These services are predominantly home care and day care. Eighty-five clients received direct payments with which to purchase their own services.

Of the adults with learning disabilities known to Hackney Council in 2010/11, 64.8% were in settled accommodation and 4.8% were in paid employment459.

Figure 7.16 describes the ethnic profile of the adults with learning disabilities receiving care packages from Hackney Council including the rate per ethnic group. There appears to be a high level of need in the ‘Black Other’ population and a relatively low rate in the Black African population.

The City

In 2010/11, the City of London Corporation provided services to 16 clients with learning disabilities. This relatively low population rate has remained stable over the past five years (Figure 7.14). The majority of these clients (86%) were living in settled accommodation.

Figure 7.14. Adults with learning disabilities receiving care packages per 100,000 population, (National Adult Social Care Intelligence Service)

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458 Projecting Adult Needs and Service Information System (PANSI), 2011
459 LBH health and Community Services Digest, August 2011
Learning disabilities: what works?

The following recommendations are drawn principally from Department of Health guidance.\(^\text{460}\).

**Planning and commissioning of services**

- Establish effective Learning Disability Partnership Boards (and health sub-groups of these) to shape the design and delivery of local health services. Establish lead commissioner arrangements and appropriate governance to ensure a coordinated approach to the support provided by health, education, employment and social care.

- Share information: ensure that GP practices, PCTs, local authorities and local Learning Disability Partnership Boards work together to share information about the health and care needs of people with learning disabilities.

- Take a broad view of health needs and consider the range of factors associated with poorer health and other risks associated with social exclusion. For example, ensure that responses to health problems do not preclude options to achieving paid employment or independent housing.

- Ensure that the ‘voice’ of people and families is heard and there is evidence of appropriate representation, including independent advocacy

**Delivery of services**

- Establish a multidisciplinary Community Learning Disability Team with the skills to support people with LD in a range of settings, deliver health promotion and help to facilitate interactions with health professionals, social services and the voluntary sector. Ensure that staff involved in providing healthcare understand issues of confidentiality, consent and mental capacity legislation for adults with learning disabilities and have access, where necessary, to expert advice.

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\(^\text{460}\) World class commissioning for the health and wellbeing of people with learning disabilities. DH Commissioning and System Management Directorate. 2009

Commissioning Specialist Adult Learning Disability Health Services: Good Practice Guidance. DH, 2007
- Provide specialist learning disability health services that both support mainstream practice and directly serve those with the most complex needs.
- Intervene early through community based treatment and support.
- Develop care pathways that promote individualised services that are community based and, wherever possible, support people in their everyday surroundings (assertive outreach). Dedicated pathways for people with learning disabilities for common health needs such as visual impairment can improve access to services and improve health outcomes461.
- Avoid institutional responses to crisis where possible - prevent admission to hospital by providing 24hour community based treatment. Support people and families when needed through swift access to the services of specialist professionals including medical, nursing and allied health professionals.
- Invest in training and development not just for specialist professionals but also for families and for frontline support staff to enable them to better support people where they live.
- Take proactive steps to help people access general health services that meet the individual needs identified in annual health checks.
- Communicate effectively with service users, their families and carers to ensure that their needs, choices and preferences are understood and that services are available to reflect individual choices.
- Be aware of diagnostic overshadowing: address the risk that reports of physical ill health or unusual behaviours are viewed as part of learning disabilities and so are not investigated or treated.
- Provide support for pre-planning of appointments to reduce anxiety and improve satisfaction for all parties462.

**Primary Care**

Intensive work with GPs, including training, raising awareness of key issues and supporting practices to produce Practice Development Plans can improve access of people with LD to primary care services463.

A review of the Healthcare Commission metrics for people with learning disabilities464 recommends building the following into discussions with GP practices:

- coding all of the people with learning disabilities known to the GP using a locally agreed and appropriate READ code
- improving uptake of health checks
- increasing the number of people who have a health action plan465
- increasing the number of people who have been screened for dysphagia in the last three years

The green light toolkit466 provides a useful reference for improving mental health support services for people with learning disabilities. It describes what good mental health support services for people with learning disabilities look like and provides a way of assessing how well your local services measure up to this.

**Autism467**

Establish an Autism strategy group (with aims including auditing pathways, collecting data, raising awareness of training for relevant professionals and how to access diagnostic services).

Establish a multidisciplinary group to:

- take all referrals for possible autism assessments
- provide advice to professionals about whether to refer children and young people for autism diagnostic assessments
- decide on the assessment needs of those referred or when referral to another service will be needed

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461 Project by Sutton and Merton PCT, included as best practice in World class commissioning for the health and wellbeing of people with learning disabilities. DH Commissioning and System Management Directorate. 2009
462 Equal access? A practical guide for the NHS: Creating a Single Equality Scheme that includes improving access for people with learning disabilities. DH, 2009
464 http://www.cqc.org.uk/guidanceforprofessionals/healthcare/allhealthcarestaff/improvingclinicalquality/developingbettermetrics.cfm
466 www.learningdisabilities.org.uk/EasySiteWeb/getresource.axd?AssetID=14930&type=Full&servicetype=Attachment
467 Autism: recognition, referral and diagnosis of children and young people on the autism spectrum. NICE Clinical Guideline. September 2011
Physical disabilities

2011 update

Adults with physical disabilities present significant challenges for services in Hackney and the City, with most aged over 65.

Focus on inequalities:

- Among the physically disabled clients receiving care packages from Hackney Council, there is a high rate of Black Caribbean clients and a low rate of Asian clients.

People with physical disabilities are a disparate group with varied long-term conditions. However, they experience high levels of deprivation and exclusion. Nationally people with disabilities earn less than half the income of non-disabled people, and half of all physically disabled people are unemployed. They are more likely than the general population to have no educational qualifications, to experience hate crime and harassment, to live in inadequate and inappropriate housing and to experience problems with transport.

Prevalence of physical disability

Population prevalence estimates for physical disability are only for the working age population: in Hackney, an estimated 9,700 adults of working age are living with a moderate physical disability and an estimated 2,500 people have a serious physical disability[^468]. However the majority of adults living with physical disability are in the older age group (see below).

In February 2011 there were 149 adults on the City of London’s Physical Disability Register.

Social care for people with physical disabilities

In 2010/11, Hackney Council provided social care services to 3,535 clients with physical disabilities, of whom three quarters (2,600, 74%) were aged 65 or over; 935 were of working age. This includes people who are frail or who have a hearing or visual impairment.

Over the past five years there has been a steady decline in the number of people with physical disabilities receiving care packages from Hackney Council: a 15% drop in the rate per 100,000 population since 2005/06 (Figure 7.17). This is likely to reflect the greater emphasis within Adult Social Care on re-ablement, i.e. supporting people to return to independent living without the ongoing support of the Council.

[^468]: PANSI (Projecting Adult Needs Information Service)
The ethnicity of physically disabled clients is shown in Figures 7.18 and 7.19 for working age and pension age groups respectively. Each figure includes a comparison to the ethnic profile of Hackney’s population as a whole (ONS 2009 estimates). For both the working age population and the pension age population, there are relatively high caseloads of Black Caribbean clients and relatively low caseloads of Asian clients.

Nine out of ten of physically disabled clients received community-based services; only 10% were supported in residential or nursing homes. Figure 7.20 describes the range of community-based services provided and the number of clients receiving each service. These services are dominated by home care and the provision of equipment and adaptations. A total of 250 people received direct payments to purchase their own care.

**The City**

In 2010/11, the City of London Corporation provided services to 178 clients with physical disabilities, of whom 78% were aged over 65. Over 90% of these clients received community-based support. Home care was provided to 94 clients, equipment and adaptations to 74 clients and meals to 18 clients. Thirty clients received direct payments to purchase their own care.

The number of people receiving ongoing support from the City of London Corporation has fallen significantly since 2005/06: a 46% drop in the rate per 100,000 population (Figure 7.17).

**Figure 7.17. Adults with physical disabilities receiving care packages per 100,000 population (National Adult Social Care Intelligence Service)**

![Graph showing the rate of adults with physical disabilities receiving care packages per 100,000 population for Hackney, The City, Tower Hamlets, and London from 2005/06 to 2010/11. The overall trend shows a decrease in the rate of care packages, with a notable decline in The City.]
Physical disability consultation with service users, Hackney, June 2009

Service users acknowledged progress in the ways needs are being met, but indicated that more work is needed to improve people’s experience of the services they receive. Issues raised included:

a) lack of awareness of disabled people’s needs and understanding of their specific health conditions
b) need for attitudinal changes by people providing support across all agencies
c) environmental issues associated with housing, disabled parking (lack of and location) and access to adapted properties
In light of the changes to the national agenda, agencies in Hackney and the City recognised the need to update the Physical Disabilities Strategy, placing more emphasis on preventative services and approaches. For many the introduction of individual budgets has raised anxieties, and the need to have access to help manage money, apply for care-related benefits in order to maximise income, and increasingly support for managing debt and budgeting. Personalisation will also increase demand not only for more advocacy, but also better publicity and access to well-trained/skilled staff to deliver professional and independent advocacy in the borough.

The current drive to increase access to employment and to help people move into the world of work needs to be well managed and sensitive to the individual, to avoid creating undue and detrimental pressure. The key message is that it needs to be supported at the time that is right for the individual, to improve confidence and help people to apply for jobs in a very competitive job market.

Social inclusion and the need to maintain significant social contacts was also seen as an area for improvement and more work.

Access to healthcare where referral criteria sometimes act as a barrier, e.g. falls service, access to signing interpreter services for hearing impaired people (Sign Translate service is free to GPs but take-up is low).

**Identified service gaps for people with physical disabilities**

Step down facilities to help move people through rehabilitation services into short-term therapeutic placements. These facilities continue to help improve independence while awaiting suitable tenancies, aids and adaptation work to be completed. This includes facilities for people with acquired brain injury and neurological conditions.

End-of-life care pathway to improve the experience of people with neurological conditions at the stage when specialist support is often required.

Shortage of and access to affordable tenancies especially for young adults with dependent children: essential to reduce demand for long-stay residential care (although numbers not high - costs and choice important).

Vocational rehabilitation is a gap that needs to be addressed as part of the preparation for access to adult learning vocational courses. There are few examples of social enterprise models in the borough and plans are being developed to scope out the potential for this kind of approach to offer meaningful and supported employment opportunities for disabled people.

In terms of wellbeing, social interaction and befriending particularly for younger adults, users want a different model of the service with a change from the current setting to one where they can engage in life-enhancing experiences out in the community.

The needs of BME groups should be explored to ensure better access to support and advice including the use of interpreter services, and raising understanding/awareness in communities.

### Visual impairment

**Focus on inequalities:**

- Visual disorders including glaucoma and cataracts are a particular problem within the Black Caribbean population in Hackney

Sight loss affects about 2,000,000 people in the UK\(^{469}\). The vast majority are older people although an estimated 80,000 working age people and 25,000 children are affected by sight problems in the UK. Evidence suggests that over 50% of sight loss is due to preventable or treatable causes. This is most marked in the older population, where it is estimated to be between 50-70%\(^{470}\).

The leading causes of sight loss are age-related macular degeneration (AMD), glaucoma and diabetic retinopathy. In England and Wales, the age-specific incidence of all three has increased significantly since 1990-1991 – with changes in diabetic retinopathy being the most marked – particularly in the over 65s where

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\(^{469}\) Royal National Institute of Blind People, 2008

\(^{470}\) Tate R, Smeeth L, Evans J, Fletcher A: The prevalence of visual impairment in the UK, 2005
figures have more than doubled\textsuperscript{471}. As the population ages and the incidence and prevalence in key underlying causes of sight loss increases, so sight loss is expected to become even more prevalent in the future\textsuperscript{472}.

Sight loss has significant quality of life impacts, which are often under-recognised by health professionals. One study estimates that very severe age-related macular degeneration causes a 63\% decrease in quality of life\textsuperscript{473}. Adverse health impacts associated with sight loss include an increased risk of depression and falls and people with sight problems are likely to have additional disabilities and are likely to live alone. Consequently, people affected by sight loss are among the most vulnerable and isolated in the community\textsuperscript{474}.

in October 2008 a new National Eye Health Epidemiological Model (NEHEM) was launched, which for the first time made data on the prevalence of four common eye conditions (glaucoma, cataracts, age-related macular degeneration and low vision) available. The estimated prevalence of these eye conditions in Hackney and the City is described in Table 7.1. ‘Low vision’ is divided into three categories: impaired vision, low vision and severe sight impairment.

The estimated prevalence of glaucoma is higher than the London and national averages because of the large African and Caribbean populations in Hackney (who have higher risk of glaucoma). The prevalence range for cataracts reflects the range of ways in which the condition is defined. The lower than average prevalence of age-related macular degeneration and low vision in Hackney and the City reflects the relatively young population in the area.

In 2010 there were 1,082 patients on the Hackney visual impairment register. Of these, 463 were registered as partially sighted and 619 as severely sight impaired (blind).

The City

In the City there are 18 people on the local visual impairment register with 9 registered as partially sighted and 9 registered as blind.

<table>
<thead>
<tr>
<th></th>
<th>Hackney and the City</th>
<th>London</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>prevalence</td>
<td>prevalence</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>2,202</td>
<td>1.78%</td>
<td>1.52%</td>
</tr>
<tr>
<td>Cataracts</td>
<td>1,177 - 4,460</td>
<td>1.52% - 5.77%</td>
<td>1.75% - 6.37%</td>
</tr>
<tr>
<td>Age-related macular</td>
<td>1,050</td>
<td>2.17%</td>
<td>2.41%</td>
</tr>
<tr>
<td>degeneration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired vision</td>
<td>1,799</td>
<td>3.72%</td>
<td>4.01%</td>
</tr>
<tr>
<td>Low vision</td>
<td>1,542</td>
<td>3.19%</td>
<td>3.42%</td>
</tr>
<tr>
<td>Severe sight impairment</td>
<td>261</td>
<td>0.54%</td>
<td>0.59%</td>
</tr>
</tbody>
</table>

Hospital admissions

In 2010/11 there were 1,692 hospital admissions for eye disorders in Hackney, almost all of which (95\%) were planned. The ethnic profile of these planned admissions, and the rates per ethnic group, are illustrated in Figures 7.21. There is a particularly high rate in the Black Caribbean population. Of the 784 admissions for


\textsuperscript{474} For full references and a wider discussion of health and wellbeing impacts, see NHS City and Hackney: Eye Care Needs Assessment (draft), October 2010

\textsuperscript{475} NEHEM model data reported in NHS City and Hackney: Eye Care Needs Assessment (draft), October 2010
The City and Hackney Health and Wellbeing Profile: our joint strategic needs assessment, 2011/12

Cataracts, 21% were in this population. Figure 7.22 reveals the high burden of eye disorders in the older population.

The City

In 2010/11 there were 63 hospital admissions for eye disorders in the City of London, almost all of which (95%) were planned.

Figure 7.21. Planned hospital admissions for eye disorders in Hackney, 2008-11: overall ethnic profile of clients and rate per ethnic group (SUS/GLA)

Figure 7.22. Planned hospital admissions for eye disorders in Hackney, 2008-11: overall age profile of clients and rate per age group (SUS/GLA)

Older people

Promoting the health and wellbeing of older people is vital to maintaining independence and reducing the need for more substantial social care support. Over time, as needs increase and become more complex, much can be done to ensure that individuals remain at home as long as they can rather than resorting to residential nursing home admission.

Dignity in care is particularly important to older people. Dignity in care is the kind of care, in any setting, which supports and promotes, and does not undermine, a person’s self-respect regardless of any difference. Ensuring the dignity of older people is vital to maintaining their wellbeing. Research has shown that factors associated with the absence of dignity in care include bureaucracy, staff shortages, poor management and
lack of leadership, absence of appropriate training and induction and difficulties with recruitment and retention leading to overuse of temporary staff. There are also wider societal issues, including ageism, other forms of discrimination and abuse. Everyday details also matter: the City & Hackney Older People’s Reference Group noted that appropriate forms of address, respectable appearance when receiving care and stimulation and a sense of purpose when in a care home or when home alone are important aspects of dignity in care.

The health of older people

The prevalence of most non-communicable conditions increases with age so a large burden of these conditions is borne by older people. However, within the older age group, this pattern is more variable. Table 7.2 describes the number of people in Hackney in each of three age groups over 65 who are living with the dominant non-communicable conditions of the modern era: cardiovascular disease, diabetes, cancer and respiratory disease. Table 7.2 also identifies the rate within each group. This data is from GP practices in Hackney so excludes people who are not registered with a GP. Figures 7.24 and 7.25 illustrate the same data – the former as absolute numbers, the latter as rates.

It is clear from Figure 7.24 that the number of people affected by each condition falls consistently across these three age groups. This reflects the shrinking size of the population due to mortality. Changes in the prevalence of disease are not so consistent. There is a steady increase in the prevalence of coronary heart disease, stroke and cancer. The other conditions – hypertension, diabetes and COPD first rise then fall.

The one condition that falls consistently both in absolute numbers and as a rate across these age groups is obesity. In the GP-registered population in Hackney, 33% of people aged 65-74 are obese, as are 28% of those aged 75-84 and 17% of those aged 85 years or more.

Table 7.2 Prevalence of key non-communicable diseases in Hackney: absolute numbers and rates per age group (CEG)

<table>
<thead>
<tr>
<th>Condition</th>
<th>65-74 years</th>
<th></th>
<th>75-84 years</th>
<th></th>
<th>85+ years</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>rate per 1,000 pop.</td>
<td>number</td>
<td>rate per 1,000 pop.</td>
<td>number</td>
<td>rate per 1,000 pop.</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>1,140</td>
<td>120</td>
<td>1,057</td>
<td>190</td>
<td>364</td>
<td>201</td>
</tr>
<tr>
<td>Stroke</td>
<td>375</td>
<td>39</td>
<td>425</td>
<td>77</td>
<td>148</td>
<td>82</td>
</tr>
<tr>
<td>Hypertension</td>
<td>5,274</td>
<td>556</td>
<td>3,724</td>
<td>671</td>
<td>1,184</td>
<td>653</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2,318</td>
<td>244</td>
<td>1,479</td>
<td>266</td>
<td>337</td>
<td>186</td>
</tr>
<tr>
<td>Cancer</td>
<td>795</td>
<td>84</td>
<td>667</td>
<td>120</td>
<td>238</td>
<td>131</td>
</tr>
<tr>
<td>COPD</td>
<td>671</td>
<td>71</td>
<td>526</td>
<td>95</td>
<td>150</td>
<td>83</td>
</tr>
</tbody>
</table>

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Social Care Institute of Excellence: *Dignity in care*, 2009
Mobility and falls

Falls and fall-related injuries among older people can cause substantial morbidity and mortality and premature nursing home admission. Studies suggest that fall-related injuries are the fifth leading cause of mortality among people aged 65 years or more, after cardiovascular and cerebrovascular diseases, cancer and pulmonary disorders.

Fall-related injuries in older people are due to a combination of increased instability (e.g. due to weakness, unsteady gait or medication) and increased susceptibility to fracture and injury (e.g. due to underlying factors such as osteoporosis). Risk factors for falls include being a man, obesity, below average health, alcohol consumption, health problems requiring assistive devices and a history of stroke. In contrast, adults above 85 years of life in good health were not at higher risk for falls than 64-85 years old in good health.

Hip fractures are the most common injury related to such falls, and in elderly and frail people can lead to a loss of mobility and independence. For many it is an event that forces them to leave their homes and move to residential care. Mortality after hip fracture is high, around 30% per year.

In 2009/10, 91 residents of Hackney and the City were admitted to Accident and Emergency with a fractured femur. Of these, 81 were aged 60 or over.

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477 Rubenstein LZ et al. (2002) The Epidemiology of Falls and Syncope
478 Grundstrom AC et al. (2011). Risk factors for falls and fall-related injuries in adults 85 years of age and older. Arch Gerontol Geriatr, 19 Aug
Preventing falls: what works?

Effective approaches are multidimensional and should include a risk factor assessment, exercise programmes and environmental assessment and modification.

More specifically, fall prevention programmes often include a combination of the following interventions:

- Physical activity promoting muscle strengthening and dynamic balance
- Medication review such as not to increase the risk for falls with them (e.g. psychotropic drugs)
- Visual assessment
- Footwear assessment
- Hazard reduction through environmental and home modifications
- Cognitive and behavioural interventions
- Safety equipment and devices if needs be.

Long-term trends in ill health

Currently around 10,500 older people in Hackney are estimated to be living with a limiting long-term illness. This population is expected to increase by 33% over the next 20 years. Absolute prevalence of other problems common among older people will also increase (Figure 7.25). This includes a 35% increase in older people living with dementia in Hackney and the City from around 1,350 people in 2010 to 1,850 in 2030 (see below).

These projections must, however, be qualified by the results of the recent Mayhew study which recorded a significant fall in the older population in Hackney between 2007 and 2011.

Figure 7.25. Estimated change in prevalence of illness in over 65 age group in Hackney in six areas (POPPI)
Mental health of older people

2011 update
The prevalence of diagnosed dementia among older people in Hackney and the City, as recorded in primary care, remains well below the estimated prevalence for the area.

The mental health needs of older people are complex and often overlaid by loneliness and failing physical health. Different cultures also have different beliefs and understanding about mental ill health. Over a third of older people in the UK experience mental illness such as depression, anxiety, delirium (acute confusion), dementia, schizophrenia, bipolar disorder, and alcohol and drug (including prescription drug) misuse. In many cases older people suffer from multiple mental health problems, and dementia and depression often come together.

Figure 7.25 shows a high and rising prevalence of depression among older people in Hackney and the City. Age Concern research estimated that 20% of people aged 65–69 and 40% of people aged 85+ will suffer from depression. The prevalence is even higher for older people in hospitals or care homes. The impact of depression on the older person and their family includes increased risk of physical health problems, slower recovery from illness, and increase in the risk of readmission to hospital after discharge and also of premature death. Older people with depression are three times more likely to be abused. Depression is the leading cause of suicide in older people - those with the symptoms are 23 times more likely to take their own lives480.

Figure 7.13 also indicates a high prevalence of dementia among older people in Hackney and the City. The term ‘dementia’ is used to describe a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain as a result of physical diseases such as Alzheimer’s disease. Dementia can affect people of any age, but is most common in older people. One in six people over 80 has a form of dementia and one in 14 people over 65 has a form of dementia481.

The prevalence of both early onset and late onset dementia increases with age, doubling with every five-year increase across the entire age range from 30 to 95-and-over. Overall, 10% of deaths in men over 65 years, and 15% of deaths in women over 65 years are attributable to dementia.

These prevalence estimates, taken from the report Dementia UK, are based on a systematic review of the evidence base and underpin the estimates in Figure 7.25. The prevalence of dementia among the population aged 65 years and over in Hackney is estimated to be 1,292 in 2010, rising to 1,409 in 2020 and 1,707 in 2030. The prevalence of dementia among the population aged 65 years and over in the City is estimated to be 73 in 2010, rising to 91 in 2020 and 137 in 2030482.

However data from primary care suggest that 436 people in Hackney and the City have dementia, giving a prevalence of 0.2%. This is lower than the POPPI estimate and may reflect the fact that dementia is not always diagnosed.

480 Older People’s Mental Health Needs Assessment, 2008
481 Dementia UK, London School of Economics and the Institute of Psychiatry at King’s College London, for the Alzheimer’s Society, 2007.
482 Projecting Older People Population Information System, Department of Health 2010.
The number of adults with dementia receiving social care packages is lower still. In Hackney, only 40 people aged 65 and over with dementia were recorded as having received a care package in 2009/10. In the City of London, 14 people aged 65 and over with dementia received a care package in 2009/10 (NASCIS).

The Dementia Advisory Service has been set up with the aim of improving the early identification and diagnosis of older people living with the onset of dementia. The service provides patients and carers with information on how to recognise and manage the condition, and signposts clients to a range of voluntary sector support groups.

**Social care for older people**

**2011 update**

Over the last five years, the number of people aged over 65 years receiving social care packages has remained stable in Hackney but has declined slightly in the City.

**Focus on inequalities:**

- There is above average demand for social care in the Black Caribbean population in Hackney and relatively low demand in the Black African and South Asian populations.

In 2010/11, London Borough of Hackney provided social care packages to 3,090 people aged over 65, equivalent to just over one in six people in this age group. The great majority of these clients (84%, 2,600 older people) were coping with a physical disability. However 410 clients had mental health problems (13%) and 35 clients had a learning disability (1%).

Over the last five years, the number of people aged over 65 years receiving social care packages has remained stable in Hackney (Figure 7.26). Figure 7.27 describes the ethnic profile of these clients. There is a higher than average demand for services within the Black Caribbean population (aged 65+) and a relatively low demand within this age group in the Black African and South Asian populations.

Services provided in the community include home care, equipment and adaptations, meals, day care and short term residential care. Figure 7.28 shows the changing levels of demand for these services over the last five years in Hackney. Personalised budgets have also been used over this period by a minority of clients and in 2009/10 these became direct payments for 145 older people in Hackney. Support for older people is also provided by Voluntary and Community Sector organisations (see page 292) and by informal carers (see page 29).

**The City**

In 2010/11, the City of London Corporation provided services to 183 clients aged over 65, equivalent to just over one in six people in this age group. Of these clients, 139 (76%) had a physical disability, 32 (17%) had mental health problems and 4 (2%) had problems with alcohol or substance misuse.

Over the last five years, the number of people aged over 65 years receiving social care packages has declined in the City (Figure 7.26).
A recent survey of residents living on the Golden Lane and Middlesex Street estates found that people living on these estates have a slightly different age profile to the general profile for the City, with greater numbers of older people, as well as high disability rates in the oldest groups\(^\text{483}\) (Table 7.3).

Figure 7.26. Adults aged over 65 years receiving care packages per 100,000 population (National Adult Social Care Intelligence Service)

Figure 7.27 Adults aged over 65 years receiving social care packages from Hackney Council 2010/11: overall ethnic profile of clients and rate per ethnic group (65+ population) (NASCIS/GLA)

Figure 7.28 Community services used by older people in Hackney 2005-2010 (NASCIS)

\(^{483}\) City of London Housing tenants profiling, 2011
End-of-life care

2011 update

In 2010/11, the great majority of deaths in Hackney and the City (94%) required end-of-life care. A quarter (24%) of these deaths took place at home.

The terms ‘end-of-life care’ and ‘palliative care’ are used interchangeably and are defined as an approach that improves the quality of life of patients and their families facing a life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement⁴⁸⁴.

In an ageing population, people increasingly die from chronic illnesses such as cancer or chronic heart failure. End-of-life care has therefore become an important public health issue. It has also become more complex, as people living longer are more likely to have concomitant chronic conditions requiring multiple and complex health and social interventions⁴⁸⁵.

End-of-life care should include patient choice within the model of care, offering individuals the opportunity to consider the type of care that is offered to them and where they wish to be when they die⁴⁸⁶. Although every individual may have a different idea about what would, for them, constitute a ‘good death’, for many this would involve:

- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in familiar surroundings
- Being in the company of close family and/or friends

⁴⁸⁶ National End of Life Care Strategy DH 2008
How we care for the dying is an indicator of how we care for all sick and vulnerable people. The National Strategy for End of Life Care recommended that all statutory and voluntary partners work together to provide more integrated and coordinated support to enable people to die in a community setting. This can include care in individuals’ own homes, hospices and other local care and residential homes.

In 2010/11, 1,096 residents of Hackney and the City died. The great majority of these deaths (94%) involved the provision of end-of-life care (ONS). This high proportion has been stable over the last five years. Of the deaths requiring end-of-life care, 73% were among people aged 65 years or more (compared to 29% of the deaths without end-of-life care). A quarter (24%) of these deaths took place at home.

Figure 7.30 describes the place of death of all Hackney residents who died between 2008 and 2010. The proportion of people dying in hospital (60%) is above the national average of 54%. However the proportion of people dying in their own homes (21%) is also above average (20%). The biggest difference is in the proportion of people dying in care homes: 8% compared to a national figure of 18%. The proportion dying in a hospice (8%) is above the average of 5%.

The proportion of patients dying at home, in hospice and in hospital is approximately the same for all the major causes of death. In 2009, in east London, 66% of deaths from diseases of the circulatory system took place in hospital, as did 65% of deaths from cancer, 64% of deaths from disease of the respiratory system and 68% of deaths from diseases of the nervous system. However, in Hackney and the City, there has been a fall in the number of respiratory deaths taking place in hospital and an increase in the number of deaths taking place at home. This may reflect the efforts of the local specialist respiratory team which aims to provide more community focused care, reduce hospital admissions and provide care at the end of life.

A needs assessment carried out by St Joseph’s Hospice found that people from the Orthodox Jewish (Charedi) community often do not take up end-of-life palliative care services. St Josephs is working with Charedi community organisations to increase access487.

Figure 7.30 Place of death of hackney residents 2008-2010 (National End of Life Care Intelligence Network)

End of life care: what works?
The Department of Health’s End of Life Care strategy recommends a holistic approach, with a care pathway consisting of seven steps:
1. the identification of people approaching the end of life and initiation of discussion about preferences for end of life care;
2. care planning, including assessing needs and preferences, agreeing a care plan to reflect these and reviewing these regularly;

487 An Assessment of the Needs of the Charedi Orthodox Jewish Community in Stamford Hill for Specialist Palliative Care Services, Jennings, 2010
3. coordination of care;
4. delivery of high quality services in all locations;
5. management of the last days of life;
6. care after death; and
7. support for carers, both during a person’s illness and after their death.

There is good evidence that home care and dying at home is at least comparable to hospital care and dying at hospital in terms of quality of care and pain\textsuperscript{488}. Most people would prefer not to die in hospital, but a lack of social support often means that people will die in hospital when there is no clinical need for them to do so.

All End of Life care strategies recognise the need for individuals at the end of their life to be treated with dignity and respect, without pain or other symptoms, to be in the close company of family and/or friends and in familiar surroundings.

The following recommendations are recurrent themes within the DH Strategy, NICE guidance\textsuperscript{489}, and the Liverpool Care Pathway\textsuperscript{490}:

- Ensure 24/7 availability of nursing and community services
- Take into account patients’ needs using a holistic approach (physical, psychological, social and spiritual needs).
- Ensure effective communication between services and ensure continuity of care.
- Ensure that commissioners and providers of services inform patients about cancer and cancer services.
- Provide continuous psychological support throughout the follow up of patients.
- Train staff in health and social care appropriately: coordination between health and social care services is crucial to provide appropriate care to people in the community.
- Ensure appropriate resources and services are in place, i.e. at least one specialist palliative care in-patient facility available 24/7 as well as community teams providing support at patients’ homes, community hospitals and care homes.

It is also important to consider the quality of patients’ environment when dying in other settings than their homes. This should include a high quality natural environment (including gardens, bright and green views, good natural light), and building design which respects privacy, provides spaces for friends and relatives, and offers spiritual places\textsuperscript{491}.

**Carers**

**Support for carers**

Carers are people who provide help and support to a friend or family member who, due to illness, disability or frailty cannot manage without their help. Carers are unpaid although they may be in receipt of benefits relating to their caring role.

Performing a caring role can have major implications for someone’s life: young carers can suffer a loss of education and life chances; carers of working age can see their employment opportunities limited and suffer the consequences of poverty as a result; and older carers are particularly vulnerable to the impact on health and wellbeing that caring for someone else can have.


\textsuperscript{489} National Institute for Clinical Excellence (NICE). Guidance on Cancer Services. Improving Supportive and Palliative Care for Adults with Cancer The Manual. March 2004

\textsuperscript{490} What is the Liverpool Care Pathway (LCP)? Information for Healthcare professionals. The Marie Curie Palliative Care Institute Liverpool. March 2010.

\textsuperscript{491} The King’s Fund. Improving the patient experience. Environments for care at end of life Enhancing the Healing Environment Programme 2008-2010. The King’s Fund. 2011
Carers play a vital role in supporting family members or friends to live independently and maintain their wellbeing. However, many carers are also frail or in poor health and so may need support themselves. By law, carers have a right to request an assessment and subsequent review of their own needs. Carers can have a joint assessment or review with the person they care for, or they can request a separate assessment or review for themselves. The number of carers receiving services as a result of these assessments and reviews is an indication of the extent to which a council is working with and for carers.

Both the London Borough of Hackney and the City of London Corporation are committed to ensuring that carers are recognised, valued and supported both in continuing their essential caring role or, when appropriate, in returning to employment.

In 2010/11, London Borough of Hackney conducted 1,204 carer assessments or reviews (Figure 7.31). Of those 43% received support services including carers discount cards, residential respite, carers retreat, counselling and sitting services. Most of these carers (81%) were aged 18-64 but a significant number are in the older age group (19%, 299 individuals).

There are many other forms of support available to carers looking after Hackney and City residents. The City and Hackney Carers Centre provide advice on housing, community care and debt. Other services include

- the Hackney Carers (discount shopping and leisure) Card
- Hackney Carers Helpline
- Carers Direct Payments
- Emergency Home Respite Service
- Hackney Carers training
- an Access to Work and Education programme for carers
- Carers retreat breaks providing carers with a total break from the caring role
- the Homeshare Day Care scheme

**The City**

The City of London undertook assessments or reviews of 51 carers during 2010/11. The Carers register lists 60 known carers of clients over 18 years old. Of these, 15 are receiving additional support from a dedicated carers’ service.

The vast majority of carers are not known to local services, and will only get in touch if they experience a crisis or need additional help. In the City, this situation may be complicated by older people who are not eligible for local authority provision, but who still have health service needs.

Data collected within the City suggested that most carers in the City are supporting people who would otherwise be in residential or nursing home care, and do so by virtue of being ‘live-in’ carers, whether spouse, civil partner son/daughter or parent. Of the City carers surveyed, 85% were living with the patient and 54% of these were either husband/wife or civil partner. Women represented 59% of the carer population and 40% of the cared for and supported492.

The average duration of care amongst these City carers is 14 years but this figure is skewed by a small number who have only been carers for a short period of time. The average age of both carers and cared for is 64 years. However, these averages hide a more complex picture, where a significant number of carers are both very elderly and have been caring for decades: 31 % have been caring for over 20 years. Carers in the younger age groups have usually been supporting a long-term disabled son or daughter and have therefore been caring for a very long time.

Most carers in the City are sole carers with little other support. Almost everyone is wholly committed to the role and has adjusted to what this involves both physically, psychologically and in terms of limitations of life choices. It is estimated that, if the live-in carer were not available, 21 of the 35 cared for studied (60%) would require residential or nursing home care493.

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492 City of London Carers Assessment Project, 2011
493 City of London Carers Assessment Project, 2011
Figure 7.31. Annual carer assessments and reviews as rate per 100,000 population aged 18+, 2004-2009 (NASCIS)
Chapter 8:
Local services

Health services

Knowledge and use of health services

In 2006, 2009 and 2010, NHS City and Hackney commissioned surveys of the local population to assess their knowledge of, and satisfaction with, local services. In each year, respondents were asked how much they knew about the services provided by chemists, GPs, the Homerton Hospital, A&E departments and walk-in centres, opticians, dentists, mental health services and NHS Direct. These surveys were conducted with a representative sample from Hackney and the City but there are no disaggregated results for the two localities.

Figure 8.1 illustrates how many people in each year said they knew ‘a fair amount’ or ‘a great deal’ about the services offered by these providers. The other possible responses were ‘never heard of it’, ‘heard of only’ and ‘not very much’, all of which indicate a low likelihood to access a service because of a lack of knowledge about what is offered.

Figure 8.1 reveals that the four services that are most well known – the chemist, GP, hospital and A&E department – are also the four services for which familiarity increases over the four year period. Familiarity with NHS Direct also increased over this period. This may reflect wider use of these services and so growing familiarity with the range of services offered.

Knowledge of the services offered by the other providers, including opticians and dentists, is stable. Large numbers of local people say they know very little about the services offered by these key primary care providers.

Figure 8.2 illustrates the actual use of these services by respondents. As we would expect, the pattern is similar to Figure 8.1 – the more a service is used the better it is known and vice versa – though there are some differences. In particular, although a majority of people are familiar with the services provided by A&E departments, less than a third actually use one in any given 12 month period.

Levels of use of all services have remained fairly stable over the four year period, with walk-in centres showing a consistent year-on-year increase. However, the Liverpool Street walk-in centre has since closed.

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494 Ipsos MORI: *Residents’ views of health services 2010, NHS City and Hackney*, 2010
Figure 8.1. Familiarity with local health services among people in Hackney and the City

![Chart showing familiarity with local health services]

Figure 8.2. Use of local services in last 12 months by people in Hackney and the City

![Chart showing use of local services]

Health services and health promotion in the Orthodox Jewish (Charedi) community

A needs assessment of the Orthodox Jewish (Charedi) community in Hackney found high awareness of services such as dentists (98%), pharmacists (97%), GPs/health centres (97%), opticians (96%) and Accident and Emergency (93%). There was lower awareness of services such as dieticians (45%), mental health services (42%), learning disability services (37%) and patient advice and liaison services (19%).

Use of key local services was comparable to, or greater than, the general population. Over the previous 12 months, 84% of participants in the needs assessment had used a GP/health centre, 82% had used a pharmacist, 80% had used a dentist, 64% had used an optician and 41% had used Accident and Emergency services. Only 1% had used mental health services.

Most participants were aware of the established network of Jewish health community services in the area: 96% Hazola (emergency/ambulance), 91% Bikur Cholim D'Satmar (family and domestic support services), and 66% Chizuk (emotional/mental stress). In the past 12 months 44% had used Hazola, 16% Bikur Cholim and 5% Chizuk.

Local organizations working within the Charedi community also report high levels of use of primary care services. However, a distinction is drawn between reacting to health problems and preventing them. Charedi people are generally quick to react to health problems but are less good at prevention, and participate less in health promotion and prevention activities. This can be seen in:

- GP practices servicing the Charedi community report poorer levels of screening for breast, cervical and other cancers.

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495 The Charlotte Street Agency: Stamford Hill Charedi Community Health and Wellbeing Needs Assessment for NHS City and Hackney, 2011
496 Submission to Health and Wellbeing Profile by The Interlink Foundation, 2011
• Lower levels of physical activity (see page 105)
• Lower levels of childhood immunisations (resulting in outbreaks of measles and mumps in recent years)
• Poorer oral health.
• Poor participation in group-based re-ablement sessions targeting victims of stroke and heart attacks.

Primary care

2011 update
Recent evidence suggests that 13% of the population of Hackney is not registered with a GP.

Focus on inequalities:
Non-registration is more common among men and among younger age groups.

Primary care services include the many services provided at GP practices, dentists, pharmacists and optometrists. The geographical distribution of these services in Hackney and the City are show in Figures 8.3 and 8.4 respectively. In addition to these location-based services, optometry is also delivered in people’s homes, where necessary. GPs also offer home visits.

Figure 8.3 Primary care services in Hackney

Figure 8.4 Primary care services in the City
General practice

General practitioners (GPs) act as the gatekeepers to health services and are often the first point of contact for patients. Local GP surgeries offer a range of services including health advice and treatment, vaccinations and immunisations, contraception and maternity services.

In November 2011 there were 275,027 people registered in 46 GP practices in Hackney\(^{497}\). This is higher than the estimated resident population, in part because people who leave the area often stay on the GP register for some time.

The recent Mayhew study identified only 207,799 Hackney residents who are registered with GPs and a further 29,847 (13%) who are not\(^{498}\). This is likely to be a more accurate estimate of the GP registered population as it is based on cross-referencing of local administrative data including GP practice lists.

The Mayhew estimate of non-registered patients is significantly higher than the estimates gained from local surveys, which put the level of non-registration at 4-5\(^{499}\). However such surveys are more likely to miss non-registered patients than the more comprehensive approach taken by the Mayhew study.

Figure 8.5 illustrates the age distribution of the registered and unregistered population in Hackney, according to the Mayhew analysis, both as absolute numbers and as proportions of each age group. Although most of the unregistered population is in the younger and working age groups, the proportion

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\(^{497}\) NHS ELC Emisweb


\(^{499}\) Ipsos MORI: Residents’ views of health services 2010, NHS City and Hackney, 2010
unregistered is similar across all age groups after infancy.

**The City**

The Neaman practice in the City had 8,751 registered patients in November 2011. However some City residents are registered with practices located outside the City. Within the City, GP services are also provided by NHS Tower Hamlets at the Portsoken Health and Community Centre.

The Portsoken ward contains two social housing estates at Mansell Street and Middlesex Street. Some of this residential accommodation was originally in Tower Hamlets, but was transferred to the City under The City and London Borough Boundaries Order 1993. This relatively recent addition to the City means that the Portsoken area’s links to Tower Hamlets are still strong, and the area is not co-terminus with some services. The catchment area of the City’s only GP practice does not cover the Mansell Street and Middlesex Street estates. This means that residents of these two estates must register with GPs from Tower Hamlets. A Tower Hamlets GP practice currently provides services to Portsoken residents from the Green Box Community Centre, located on the Mansell Street Estate.

**Figure 8.5. Registration with GPs in Hackney by age band (Mayhew)**

**Dental services**

Primary care dental services in Hackney and the City are mainly provided by independent contractors within the general dental service. In addition a directly provided Trust Dental Service hosted by NHS Tower Hamlets is responsible for providing care for people with special needs and undertaking epidemiological surveys.

Dental services in Hackney comprise the following:

- 28 general dental practices
- two practices providing specialist orthodontic services in primary care
- Trust Dental Services working out of three fixed sites and a mobile dental unit
- urgent care services hosted by NHS Tower Hamlets and provided via a telephone triage, the Royal London Hospital and three general dental practices.
- hospital dental services mainly at Barts and the London and the Homerton provide specialist care for local residents

**The City**

There is one dental practice in the City, the Barbican Orthodontic Practice, which offers specialist orthodontic services. City residents also have access to the community services described above.

**Pharmacy and prescribing**

Community pharmacy has had an important role to play in reducing health inequalities through increasing access to health information, prevention and screening services as well as signposting patients to other
services and supporting them to take medications. There is a potential to expand services in pharmacy to meet local health needs.

There are 50 community pharmacies in Hackney providing essential, advanced and local enhanced services to cover the needs of the local population. There are a further 16 community pharmacies in the City.

Essential services include dispensing NHS prescriptions. Pharmacies in Hackney and the City dispensed an average of 3,794 prescription items per month\^500. This compares with a median of 6,340 in England. The low average rate of dispensing in Hackney and the City is due to the priority given to advice and retailing in the pharmacies in the City of London.

Advanced services include medicines use review which is particularly important for improving outcomes for patients with long-term conditions. Local enhanced services include the following:

- City and Hackney airways review and management service, which supports patients to better manage asthma and chronic obstructive pulmonary disease;
- Chlamydia screening and treatment services, targeting young people in particular;
- Minor ailments service;
- Weight management service, designed to improve access and choice to services that help people manage their diet and exercise and maintain a healthy weight;
- Emergency hormonal contraception service;
- Free-dom condom distribution service;
- Drug misuse services including needle exchange and supervised consumption;
- TB treatment supervision service, supporting people with TB to adhere to therapy;
- Seasonal flu vaccination service;
- Stop smoking service

There are 28 pharmacies per 100,000 population in Hackney and the City. This level of pharmacy provision is consistent with a primary care trust of this size and type\^501. Pharmacies are well distributed across Hackney, with all but one ward (Cazenove) having more than one pharmacy.

In a local survey of pharmacy use, almost all (94%) respondents said they found it easy to find a pharmacy with less than 1% finding this difficult\^502. Nine in 10 respondents (91%) said they were happy with the opening hours of their pharmacies but 9% had experienced problems in the last 12 months accessing pharmacy services. Three quarters (76%) of patients who had a prescription dispensed on their last visit to a pharmacy rated their experience as good, very good or excellent.

The survey revealed that many local people are not aware of the full range of services provided by pharmacies:

- 37% of respondents were aware that pharmacies could provide a medication review service and 20% had used this service in the past
- 11% of respondents were aware that pharmacies provide Chlamydia screening services
- 25% of respondents were aware that pharmacies provided an NHS minor ailments service and 11% had used this service in the past
- 31% of respondents were aware that pharmacies provided a weight management service and 5% had used the service in the past
- 41% of respondents were aware that pharmacies provided the emergency hormonal contraception service and 16% had used it in the past
- 13% of respondents were aware that pharmacies provided a condom supply service through the NHS and 2% had used it in the past
- 41% of respondents were aware that pharmacies provided seasonal flu vaccination and 10% had used it in the past.

\^500 NHS Information Centre, referenced in Pharmaceutical Needs Assessment, 2011
\^501 NHS City and Hackney: Pharmaceutical Needs Assessment (draft), January 2011
\^502 Local survey undertaken to inform Pharmaceutical Needs Assessment, 2011
In the 2010 survey of the use of all local health services in Hackney and the City, pharmacists were not only the most widely used local service (with GPs), they were also the provider whose services most people felt they knew a lot or a fair amount about (82% said this)\textsuperscript{503}. This suggests that most people are very familiar with the essential services provided by pharmacists, above all prescribing/dispensing, but may not be aware of the many other opportunities that pharmacists offer.

**Optometry**

In the City of London there are 28 high street providers offering NHS funded sight tests. In Hackney there are 22 high street providers. In addition, there are 22 providers who offer home-based NHS-funded sight tests to residents of Hackney and the City.

In 2009/10, 47,930 NHS sight tests were conducted by optometrists and Ophthalmic Medical Practitioners in Hackney and the City. This represents an increase of just over 6.2% compared to the previous year. There has been a year-on-year increase in the number of sight tests in Hackney and the City since 2005/06\textsuperscript{504}.

It is not possible to determine with any degree of accuracy the number of residents in Hackney and the City who are entitled to a NHS funded sight test. However, with an estimated 20% of the local population in 2009/10 taking a NHS sight test, this would appear to be quite a low take-up. The two groups of residents which can be analysed with some degree of accuracy, namely residents aged 60 and over, and those aged less than 16, both appear to have a low uptake of sight tests. For residents age 60 and over the uptake appears to be just over 56% with around 46% taking regular sight tests.

An eye care needs assessment for Hackney and the City has recently been conducted\textsuperscript{505}. Its primary recommendation is the development of an Eye Care Strategy to address the weaknesses in local eye care provision. These include the following issues:

- The number of community based eye care services available to local residents is limited with most eye care conditions being managed in a secondary care setting. Not only has this led to increasing demands on secondary care services with subsequent increases in waiting time, but it also means patients have limited choice in terms of provider.
- The regular monitoring of a number of the more stable eye conditions such as glaucoma and diabetic retinopathy is currently conducted in secondary care. With an increasing demand on secondary care services much of this work could be performed in a local primary care environment.
- Access to eye care services should be open to all sections of the population. However one group in particular, those with learning disabilities, have been identified as not having full access to eye care services.
- The distribution of sight test providers across Hackney is uneven, with many providers concentrated in certain small areas. This has resulted in some areas having either no or limited provision. The local public survey conducted into eye care services indicated the lack of access to a local provider as one of the reasons for residents not taking regular sight tests.
- No promotion of eye health is currently conducted in Hackney and the City.
- There is currently no regular public engagement exercises conducted around eye health in City and Hackney. Public engagement is vital to the understanding of local needs and also for the on-going evaluation of how well eye care services are performing.

**Secondary Care**

The Homerton Hospital sits at the heart of Hackney and provides a range of services to local people, complementing GPs, dentists and pharmacists. St. Bartholomew’s Hospital (Barts) is the hospital of the City of London and is the oldest hospital in England.

\textsuperscript{503} Ipsos MORI: Residents’ views of health services 2010, NHS City and Hackney, 2010
\textsuperscript{504} NHS City and Hackney: Eye Care Needs Assessment (draft), October 2010
\textsuperscript{505} NHS City and Hackney: Eye Care Needs Assessment (draft), October 2010
Although hospitals are often described as offering ‘secondary care’ - that is places you go after your first contact with a GP or other primary care professional - they also offer direct access through their Accident and Emergency (A&E) Departments.

**Hospital admissions and attendances**

**2011 update**

In 2010/11 emergency admissions among Hackney and the City residents rose by 6.0%. The rate of emergency admissions is above average for London. The rate of A&E attendances remains high, indicating an over use of A&E for conditions that could be addressed in primary care.

In 2010/11 there were 20,111 emergency hospital admissions among registered patients in Hackney and the City. This is a standardised rate of 88.1 emergency admissions per 1,000 population. This is above the average for London (82.2 admissions per 1,000 population). The number of emergency admissions has risen over the past two years (Figure 8.6)

The number of attendances at A&E is particularly high. In 2010/11 there were 114,909 attendances at A&E departments among registered patients in Hackney and the City. However the rate of 413 per 1,000 population is no longer the highest in London but is now the third highest. The average rate in London is 335 attendances per 1,000 population. Despite the change in the ranking within London, the absolute number of attendances is almost unchanged from the previous year.

Table 8.1 describes the range of conditions which residents of Hackney were admitted to hospital for in 2010/11, divided into planned admissions, emergency admissions and, for pregnancy and childbirth, maternity admissions. Figure 8.7 show the differences in admission for these conditions by ethnic group.

**The City**

Table 8.2 describes the range of conditions which residents of the City were admitted to hospital for in 2010/11. There were 523 emergency hospital admissions of City residents in 2010/11.

**Figure 8.6. Hospital admissions among patients registered in Hackney and the City 2005-2011 (NHS Comparators)**

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506 All age standardised admissions data from NHS Comparators. As NHS Comparators uses the GP registered population for calculating admission rates, reported rates are lower than would be obtained using the official population estimates.
Table 8.1. Hospital admissions in Hackney population, 2010/11 by condition (SUS)

<table>
<thead>
<tr>
<th>Condition classification</th>
<th>Total</th>
<th>% all admissions</th>
<th>planned</th>
<th>emergency</th>
<th>% emergency</th>
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<tbody>
<tr>
<td>Diseases of the digestive system</td>
<td>7,243</td>
<td>11%</td>
<td>5,405</td>
<td>1,838</td>
<td>25%</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>5,951</td>
<td>9%</td>
<td>5,147</td>
<td>804</td>
<td>14%</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>5,296</td>
<td>8%</td>
<td>4,085</td>
<td>1,211</td>
<td>23%</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>4,157</td>
<td>6%</td>
<td>2,355</td>
<td>1,802</td>
<td>43%</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>3,218</td>
<td>5%</td>
<td>2,478</td>
<td>740</td>
<td>23%</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>3,213</td>
<td>5%</td>
<td>705</td>
<td>2,508</td>
<td>78%</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>3,096</td>
<td>5%</td>
<td>486</td>
<td>2,610</td>
<td>84%</td>
</tr>
<tr>
<td>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism</td>
<td>2,876</td>
<td>4%</td>
<td>1,696</td>
<td>1,180</td>
<td>41%</td>
</tr>
<tr>
<td>Diseases of the eye and adnexa</td>
<td>1,692</td>
<td>2%</td>
<td>1,615</td>
<td>77</td>
<td>5%</td>
</tr>
<tr>
<td>Certain infectious and parasitic diseases</td>
<td>1,524</td>
<td>2%</td>
<td>796</td>
<td>728</td>
<td>48%</td>
</tr>
<tr>
<td>Mental and behavioural disorders</td>
<td>1,324</td>
<td>2%</td>
<td>149</td>
<td>1,174</td>
<td>89%</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>1,139</td>
<td>2%</td>
<td>710</td>
<td>429</td>
<td>38%</td>
</tr>
<tr>
<td>Certain conditions originating in the perinatal period</td>
<td>1,120</td>
<td>2%</td>
<td>17</td>
<td>1,103</td>
<td>98%</td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>1,083</td>
<td>2%</td>
<td>464</td>
<td>619</td>
<td>57%</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>873</td>
<td>1%</td>
<td>466</td>
<td>407</td>
<td>47%</td>
</tr>
<tr>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>485</td>
<td>1%</td>
<td>372</td>
<td>113</td>
<td>23%</td>
</tr>
<tr>
<td>Diseases of the ear and mastoid process</td>
<td>311</td>
<td>0%</td>
<td>217</td>
<td>94</td>
<td>30%</td>
</tr>
<tr>
<td>Other</td>
<td>13,546</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition classification</th>
<th>Total</th>
<th>% all admissions</th>
<th>planned</th>
<th>emergency</th>
<th>maternity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy and childbirth</td>
<td>9,603</td>
<td>14%</td>
<td>1,198</td>
<td>668</td>
<td>7,737</td>
</tr>
</tbody>
</table>
Figure 8.7 Hospital admissions in Hackney 2010/11, by ethnicity

Table 8.2. Hospital admissions in City of London population, 2010/11 by condition (SUS)

<table>
<thead>
<tr>
<th>Condition classification</th>
<th>Total</th>
<th>% all admissions</th>
<th>planned</th>
<th>emergency</th>
<th>% emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasms</td>
<td>417</td>
<td>22.2%</td>
<td>347</td>
<td>70</td>
<td>17%</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>187</td>
<td>9.9%</td>
<td>137</td>
<td>50</td>
<td>27%</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>134</td>
<td>7.1%</td>
<td>106</td>
<td>28</td>
<td>21%</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>127</td>
<td>6.8%</td>
<td>101</td>
<td>26</td>
<td>20%</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>101</td>
<td>5.4%</td>
<td>48</td>
<td>53</td>
<td>52%</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>83</td>
<td>4.4%</td>
<td>73</td>
<td>10</td>
<td>12%</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>81</td>
<td>4.3%</td>
<td>15</td>
<td>66</td>
<td>81%</td>
</tr>
<tr>
<td>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism</td>
<td>79</td>
<td>4.2%</td>
<td>73</td>
<td>6</td>
<td>8%</td>
</tr>
<tr>
<td>Diseases of the eye and adnexa</td>
<td>63</td>
<td>3.3%</td>
<td>60</td>
<td>&lt;5</td>
<td>5%</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>40</td>
<td>2.1%</td>
<td>12</td>
<td>28</td>
<td>70%</td>
</tr>
<tr>
<td>Mental and behavioural disorders</td>
<td>25</td>
<td>1.3%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>24</td>
<td>1.3%</td>
<td>12</td>
<td>12</td>
<td>50%</td>
</tr>
</tbody>
</table>
Endocrine, nutritional and metabolic diseases 24 1.3% 8 16 67%
Certain conditions originating in the perinatal period 20 1.1% 0 20 100%
Congenital malformations, deformations and chromosomal abnormalities 13 0.7% - - -
Certain infectious and parasitic diseases 12 0.6% 0 12 100%
Diseases of the ear and mastoid process 8 0.4% - - -
Other 320 17.0%

<table>
<thead>
<tr>
<th>Condition classification</th>
<th>Total</th>
<th>% all admissions</th>
<th>planned</th>
<th>emergency</th>
<th>maternity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy and childbirth</td>
<td>123</td>
<td>6.5%</td>
<td>13</td>
<td>12</td>
<td>98</td>
</tr>
</tbody>
</table>

**Healthcare associated infections**

All hospitals have to follow a code of practice to minimise the risk of infections spreading within the hospital. These are called healthcare associated infections.

One of the most problematic healthcare-associated infections is MRSA. Sometimes referred to as the super bug, MRSA stands for methicillin resistant *Staphylococcus aureus*, a drug resistant form of a relatively common infection which can be difficult to treat. Over the three years from 2008/09 to 2010/11 there were less than ten MRSA cases per year at the Homerton hospital. As the numbers are low, there is considerable variability in the rate of infection year-on year. However the rate has remained above the London and national averages, with an average over these three years of 5.2 cases per 100,000 bed days compared to three year averages of 4.0 for London and 2.9 for England507.

The most important cause of hospital-acquired diarrhoea infection is *Clostridium difficile*. When certain antibiotics disturb the balance of bacteria in the gut, *Clostridium difficile* can multiply rapidly and produce toxins which cause illness. The number of cases of *Clostridium difficile* at the Homerton Hospital has declined dramatically over the past four years from 58 in 2007/08 to 10 in 2010/11. The rate is well below the rates for both London and England (Figure 8.8).

**Figure 8.8 Clostridium difficile infections in patients aged 2 years + per 100,000 bed days 2007-2011 (HPA)**

507 Health Protection Agency Regional Epidemiology Unit
Adult social care

Adult social care services in Hackney and the City aim to support people who are frail, ill or disabled to live full and independent lives in the community. They aim not only to support people who have long-term needs but also to help people regain independence after difficult periods, such as hospitalisation, and to support people who are well to maintain and improve their health and wellbeing and avoid disabling illness.

This continuum of activity, from prevention through to ongoing care, is expressed in the following aims for people receiving social care services:

- Improve their health and wellbeing
- Maintain independence
- Be safe in vulnerable situations
- Choose and control their own care
- Be supported in their caring role

Social care services are provided in partnership with the NHS and other local partners in order that each individual receives an appropriate, tailored response. In Hackney, the service aims

- To meet the person, not just the need: ensuring the needs of the whole person are recognised so services are designed around them;
- To promote health and wellbeing: helping people to be safe, live healthily, make healthy choices; tackling inequalities and keeping communities safe through preventative and enforcement activities to increase the wellbeing of local communities;
- To provide wider choice: having access to a choice of, and control of, good quality services;
- To improve access to services: enabling people to access services which meet, and are responsive to, their individual and diverse needs;

Hackney Council seeks to provide something for everyone, a little extra for some and more for those who need it most. The model is designed to make sure that every citizen of the borough feels able to approach the Council and enquire about the help and advice that they require. It is envisaged that the majority of people will receive advice, information or be sign-posted to resources in the community. However a proportion of people may require some intensive, short term intervention to enable them to continue to live independently in the community. A smaller proportion, those living with long term conditions, will need on-going intervention which will be targeted to their specific need.

Personalisation of adult social care aims to ensure that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the way that support is delivered in all care settings.

For a full account of the adult social care services provided by the London Borough of Hackney see the Council’s Local Account: How we deliver adult social care services.

Services provided

London Borough of Hackney provides a range of services to people in their own homes including:

- Home care
- Day care
- Meals
- Professional support
- Equipment and home adaptations
- Intermediate care
- Direct payments
These services concentrate on enabling people to remain at home or return home after hospital treatment or time spent in residential care. Most people prefer to be cared for in their own homes so these services are crucial for helping people to live independent lives.

In 2010/11, London Borough of Hackney provided services to 5,389 people with a wide range of needs, both at home and in care homes. Four fifths (81%, 4,541 individuals) received services in the community. Table 8.3 describes the client groups receiving services by age and gender.

Table 8.4 and Figure 8.9 describe the split between community-based services and residential and nursing care, by ethnic group. This demonstrates the priority given to community services. Although there are differences between the ethnic groups, these do not suggest inequalities in access to either type of service.

Figure 8.10 describes the range of community services provided in 2010/11. These are dominated by home care, day care and equipment and adaptations. Equipment and adaptations are specialist items provided to service users following an assessment by an occupational therapist or physiotherapist. Equipment is prescribed to help service users experiencing difficulties with their functional mobility. They enable the service user and/or carer remain safe in their home and allow them to perform daily activities as independently as possible.

Further detailed information about the social care service provided to the main social care client groups is provided elsewhere in this document under mental health (page 236), learning disabilities (page 246), physical disabilities (page 254), older people (page 259) and carers (page 268).

### Table 8.3 People receiving social care services in Hackney by client group, age and gender, 2010/11 (LBH)

<table>
<thead>
<tr>
<th>Client Group</th>
<th>Total</th>
<th>%</th>
<th>18-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>female</td>
<td>male</td>
</tr>
<tr>
<td>People with physical disabilities</td>
<td>3,536</td>
<td>66%</td>
<td>566</td>
<td>370</td>
</tr>
<tr>
<td>People with learning disabilities</td>
<td>595</td>
<td>11%</td>
<td>229</td>
<td>329</td>
</tr>
<tr>
<td>People with mental health needs</td>
<td>1,111</td>
<td>20%</td>
<td>284</td>
<td>415</td>
</tr>
<tr>
<td>Other vulnerable people</td>
<td>147</td>
<td>3%</td>
<td>36</td>
<td>70</td>
</tr>
<tr>
<td>Total</td>
<td>5,389</td>
<td>100%</td>
<td>1,115</td>
<td>1,184</td>
</tr>
</tbody>
</table>

### Table 8.4 People receiving community-based services, residential or nursing care by ethnicity, 2010/11 (LBH)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Total</th>
<th>%</th>
<th>White</th>
<th>Black</th>
<th>South Asian</th>
<th>Chinese/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based services</td>
<td>4,541</td>
<td>81%</td>
<td>2,698</td>
<td>1,440</td>
<td>251</td>
<td>150</td>
</tr>
<tr>
<td>Residential or nursing care</td>
<td>1,036</td>
<td>19%</td>
<td>758</td>
<td>230</td>
<td>15</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>5,577*</td>
<td>100%</td>
<td>3,456 (61%)</td>
<td>1,670 (30%)</td>
<td>266 (5%)</td>
<td>183 (3%)</td>
</tr>
</tbody>
</table>

* Total includes some double counting due to service users moving into care homes from the community during the year
The City

In 2010/11, The City of London Corporation provided services to 296 people with a wide range of needs, both at home and in care homes. Approximately 79% of clients received services in the community. The majority of clients (62%) were older people, aged 65+ years. In this older age group, there were more women than men (52% vs. 48%). In the younger age group, under 65 years, there were fewer women than men (31% vs. 69%).

These clients were 91% White, 4% Asian, 3% Black and 3% of mixed or other ethnicities. Compared to the GLA ethnic profile for the City, White clients are over-represented and Asian clients under-represented in this social care client group, though the numbers are relatively small so variations do not necessarily reflect inequalities in access.

Figure 8.11 describes the range of social care services provided to City residents by the City of London Corporation in 2010/11. These services are dominated by home care and equipment and adaptations, with many clients also receiving direct payments (see below).
Direct payments

Direct payments and personal budgets are designed to give people control over their lives by providing an alternative to the community social care services provided by councils. They are an opportunity to enhance independence. However, they are better suited to some individuals rather than others. Hackney Council and the City of London Corporation have a duty to make direct payments where individuals consent and are able to manage them, with or without assistance. Some people may request a direct payment to organise and pay for care, in which case it is set up and delivered in the way they wish.

In 2010/11, 489 clients of adult social services in Hackney chose to receive direct payments, an increase of 16% on the previous year. Over two thirds of these clients (69%) were people with disabilities, similar to the overall profile of social care users. However, compared to this profile, a relatively high proportion of clients with learning disabilities are receiving direct payments or personal budgets (18% vs. 11% overall client profile) and a low proportion of clients with mental health needs are receiving direct payments or personal budgets (11% vs. 20% overall client profile).

The City

In 2010/11, the City had 70 clients in receipt of direct payments and individual budgets. Of this total 43% had a physical disability, 29% mental health needs and 16% learning disabilities.

Telecare

Telecare brings health and social care directly to service users in their own homes, supported by information and communication technology. It uses technology to support more people to live independently, thus making the best use of limited resources to support their safety and wellbeing.

Telecare includes community alarms which plug into a service user’s telephone line, enabling them to summon help from a central call handling and monitoring centre. Telecare equipment can also detect fire, smoke, extremes of temperature, carbon monoxide, natural gas and flooding. The more advanced sensors can also monitor the movements of a service user in their home to indicate if the person has stopped moving, had a fall, wandered outside or is in bed or sitting in a chair. Where relevant a mobile response team can rapidly visit the user’s home to render assistance as required.

Telecare and telehealth services:

- Increase choice and independence for service users
- Reduce the burden on carers and provide them with more personal freedom;
- Reduce the need for residential and nursing care;
- Unlock resources and redirect them elsewhere in the system;
- Reduce acute hospital admissions;
- Reduce accidents and falls in the home;
Outcomes for service users

The annual social care survey provides insight into the lives of users of social care services, including key aspects of health and wellbeing such as personal control over daily life and the experience of pain and anxiety. The following is a description of some of the key findings from the survey.

Social care-related quality of life

This measure provides an overall indication of the impact of social care service on health and wellbeing. It is a compound measure, based on eight questions about activities in daily life.

The overall score for Hackney was 76.6%. Initial benchmarking with six other London local authorities suggests that this is an above average result.

The following differences were identified within the population surveyed:

- Higher rates were reported by people with learning disabilities (84.9%) and substance misusers (83.3%). Below average rates were reported by people with physical disability/frailty/sensory impairment (71.4%) and people with mental health needs (67.0%).
- There were variations by ethnic group but the sample sizes of the smaller ethnic groups were too small to draw robust conclusions. However there is some evidence that lower social care-related quality of life was reported by people of South Asian ethnicity.
- The cost of the annual care package received by a client has almost no correlation with client-reported social care-related quality of life. This is not a negative result – the size and cost of a care package is based on the extent of the presenting need. If people with different levels of need achieve similar levels of quality of life, this is a good outcome.

Overall satisfaction with care and support

This measure provides an indication of the overall experience of services and service quality.

Levels of satisfaction are high in Hackney: 88.0% of survey respondents said they were satisfied including 62.3% who were very or extremely satisfied. The level of active dissatisfaction is very low (3.9%). Initial benchmarking with six other London local authorities suggests that this is an excellent result (the highest of the six).

- There is little difference in satisfaction rates between the over 65 client group (89.5% satisfied) and the working age client group (87.8%).
- Among the working age client group satisfaction is highest among people with learning disabilities (100%) and lowest among substance misusers (73.5%).

Control over daily life

Control over daily life is a key outcome of personalised services. This measure is one component of the overarching measure of social care-related quality of life.

Overall, 73.3% of respondents felt they had at least adequate control over their daily lives including 31.8% who said they had as much control over their daily lives as they wanted. Figure 8.12 illustrates the results for all respondents and for different client subgroups.
As with other indicators, there was little difference in response between older clients (72.2% had at least adequate control over their daily lives) and working age clients (74.8%) but the proportion of people who felt in control of their daily lives was higher among people with learning disabilities (93.3%) and lower among those with physical disabilities (66.7%) and those with mental health needs (58.3%).

Figure 8.12 Clients’ sense of control over their daily lives (LBH)

Pain and discomfort
Experience of pain and discomfort is a key component of quality of life. Overall, the majority of clients (68.7%) reported they were in some pain or discomfort including nearly a fifth (19.2%) who were in extreme pain or discomfort.

Clients with physical disabilities/frailty were most likely to report being in pain or discomfort: 81.8% were in some pain or discomfort including over a third (36.4%) who were in extreme pain or discomfort (Figure 8.13).

Figure 8.13 Clients’ experience of pain and discomfort (LBH)

Anxiety and depression
Survey respondents also reported whether or not they were anxious or depressed. Over half (54.3%) of all clients reported some degree of anxiety or depression including 9.0% who said that they were extremely anxious or depressed.

As might be expected, the highest rates of anxiety and depression were among clients with mental health needs (69.4%), though the rate among people with physical disability/frailty was also high (61.8%) and comparable at the level of extreme anxiety or depression (20.0% vs. 22.2% among mental health clients) (Figure 8.14).
Personal safety

Feeling safe is fundamental to quality of life, wellbeing and independence. It is also underpins the delivery of social care services. Overall, a majority of clients (56.8%) said they felt as safe as they want. A further third (34%) felt ‘adequately safe but not as safe as I would like’. However nearly one in ten (9.3%) felt either ‘less than adequately safe’ or not at all safe.

Figure 8.15 describes the differences between different client groups.

Primary, secondary and tertiary prevention: keeping vulnerable people well in Hackney

The implementation of the Transformation of Adult Social Care in Hackney centred on prevention - ensuring as many people as possible are enabled to stay healthy and remain actively involved in their communities for longer, thereby delaying or avoiding the need for targeted services. It also emphasises early intervention and reablement.

There are three potential areas of prevention action:

- **Primary prevention** - keeping people well, independent and healthy for as long as possible. This is where the greatest impact and the largest savings can be made and is crucial to building sustainable long term outcomes.

- **Secondary prevention** - helping people regain their wellbeing and independence after a period of service use resulting from heightened need, reducing the likelihood of people needing to access services again. Its scope is restricted to those who have already experienced avoidable episodes.
The following are examples of primary, secondary and tertiary prevention in Hackney:

**Primary prevention**

- **The New Age Games.** This is a fun sports activity programme which is open to all Hackney residents who are 50 years old or above. The aim of the games is to encourage older people to try out new sports such as archery, swimming, aerobics and darts. The activities will take place at different leisure centres across Hackney.
- **Healthy Walks.** Hackney’s Walking Together Programme is suitable for all ages, especially those who are beginners to exercise, feel unfit or are over 50. The walks take between 30 - 60 minutes and are led by a qualified Health Walks leader and First Aider.
- **Tea Dances.** Regular tea dances are held for Hackney’s over 50s at Stoke Newington Town Hall. They help older residents to lead healthy, active and independent lives.

**Secondary prevention**

- **3H project.** This project focuses on intervening with people who have approached social care but only have low needs. It provides short periods of work to bridge people into community and universal services so they can receive support.
- **Older People Floating Support.** While not a social care service, these schemes provide housing related support to up to 1,400 older people in the borough. They are advice, empowerment and support services working holistically.

**Tertiary prevention**

- **Healthy eating and physical activity projects in supported living schemes.** These projects prevent deterioration in the health and wellbeing of their residents.
- **Median Road Resource Centre (MRRC).** Median Road Resource Centre is a council run short-term residential resource facility and day centre for older people. The centre comprises four distinct but complementary services, all of which aim to promote independence and provide care based on individual need.
- **Formerly a standard residential home, in recent years the service has been developed to meet the increasing demand for transitory residential facilities. The 37 beds are divided into small units with 24-hour care provided by care support workers.**
- **Intermediate care in Hackney Short Stay Rehabilitation Unit.** This service provides up to six weeks intensive rehabilitation. The service is available to City and Hackney residents age 55 and over.
- **Interim placement.** Interim Placement provides short-term transitional placement to facilitate hospital discharge or prevent a hospital admission for non-medical reasons.
- **Residential respite.** This service provides a respite break for individuals who require assistance with all aspects of personal care as well as those with some characteristics of cognitive impairment.
- **Day centre.** A community day centre runs from Median Road Resource Centre on weekdays. The service provides a safe and supportive environment for service users with cognitive impairment to meet with others and take part in a range of activities.
- **Telecare.** Telecare (see above) provides remote care and reassurance, facilitated via telecommunication-based equipment. Telecare helps individuals of all ages and their carers to remain living safely and independently in their own homes.
Safeguarding adults

2011 update

The number of referrals in Hackney to the Safeguarding Adults Board rose by 40% in 2010/11. This is seen as a positive indication that the abuse of vulnerable adults is being recognised more widely in Hackney. The rate of referrals is average for London.

Adults at risk should be afforded the greatest protection possible from harm. In both Hackney and the City this protection is overseen by the multi-agency Safeguarding Adults Board. The Board brings together the two local authorities, police, NHS, voluntary sector and user groups to work together both to promote safer communities to prevent harm and abuse and to deal well with suspected or actual cases.

A consistent pan-London approach has recently been adopted for safeguarding adults. The policy, Protecting adults at risk: London multi-agency policy and procedures, sets out who an adult at risk may be, what sort of situations may give cause for concern about abuse or neglect, and what actions must be taken when someone has concerns. It recognises that our understanding of abuse has developed to encompass adults at risk who may:

- Be elderly and frail due to ill health, physical disability or cognitive impairment
- Have a learning disability
- Have a physical disability and/or sensory impairment
- Have mental health needs including dementia or a personality disorder
- Have a long term illness/condition
- Be misusing substances or alcohol
- Be a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse

Abuse is defined by the Department of Health as ‘a violation of an individual’s human and civil rights by any other person or persons which results in significant harm’. Abuse is the misuse of power and control that one person has over another. Where there is dependency, there is the possibility of abuse or neglect unless adequate safeguards are put in place.

The London policy identifies types of abuse of an adult at risk that may result in significant harm, including:

- Physical
- Sexual
- Psychological
- Financial and material
- Neglect and acts of omission
- Forced marriage and human trafficking
- Exploitation by radicalisers who promote violence
- Discrimination and hate crime
- Institutional or systemic abuse /neglect

The London policy and procedure describes a seven stage process for reporting, investigating and determining appropriate actions where there is concern that abuse or neglect may be taking place. The City and Hackney Safeguarding Board has published an additional protocol which sets out how this seven stage process operates within the City of London and the London Borough of Hackney. The protocol identifies the central role of Safeguarding Adults Managers, suitably qualified professionals in lead agencies responsible for coordinating action in response to referrals, and the importance of a graded response to handling abuse concerns so that resources can be effectively targeted towards the more serious safeguarding cases.

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The number of referrals to the Adult Safeguarding Board has risen over the last six years from 150 in 2005/06 to 416 in 2010/11. In the last year alone there was a 40% increase in referrals over the previous year. This rise is seen as a positive indication that the abuse of vulnerable adults is being recognised more widely in Hackney, and not as an indication that the abuse of adults itself has increased.

The rate of referrals is 240 per 100,000 population. This is average for London.

Of the 416 referrals in 2010/11, 238 (57%) were for those aged under 65, and 179 (43%) for those aged 65+ years. There were 375 adults in total referred to the safeguarding procedure, 40 of whom were the subject of referrals more than once during the year. Overall, 58% of referrals were from females, 42% from males.

The number of referrals of adults at risk is likely to increase over next few years due to increasing life expectancy, including for people with learning disability and profound and multiple learning disability; more cases of dementia; and the potential risks linked to personalisation. Furthermore, the new London-wide policy on safeguarding adults has resulted in a widening range of circumstances in which people may be considered vulnerable/at risk including homelessness. This policy also brings some health Serious Untoward Incidents under safeguarding.

Overall, therefore, there is likely to be greater demand for safeguarding investigations and for more (or different) support services following investigation.

The City

The number of referrals in the City is much smaller due to its population size. In 2009/10 there were nine referrals to the Safeguarding Adults Board. This includes referrals for City residents who are placed in residential or nursing homes outside the authority for whom the City still has a duty of care.

The Voluntary and Community Sector

The Voluntary and Community Sector in Hackney and the City includes registered charities, community groups and other nongovernmental organisations such as faith organisations, social enterprises, co-operatives, mutuals and housing associations.

Hackney has a large and diverse voluntary and community sector comprising almost 3,000 organisations. Over 70% of the organisations are very small, and a significant proportion of these are BME organisations. Three quarters (76%) of the organisations based in Hackney have a local area of operation. They receive 23% of the total income of Hackney based organisations.

Hackney Council, the local NHS and other partners have commissioned a broad range of voluntary organisations to provide services for vulnerable groups such as carers, young people, older people, people with disabilities and those with mental ill health. Local services commissioned in this way include:

- Lunch and day activity programmes, including healthy eating activities
- Generalist and specialist exercise classes, including for those who are housebound
- Bereavement services
- Carers services, including for those with mental ill health
- Advocacy services, including for those with mental ill health
- Home improvement and small repairs services
- Drugs and alcohol services

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509 Hackney Safeguarding Adults Board: The Safeguarding Vulnerable Adults Annual Report for 2010/11
510 Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board: Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse, 2011
511 Data from Guidestar research on third sector organisations.
Advice and information services

In addition to these commissioned services, there are many unfunded community groups who are working to improve the health and social care of local residents.

Research carried out in 2005 by South Bank University, in partnership with Social Action for Health, found that the Voluntary Sector contribution to the health and social care economy was £14-£16million pounds or 13% of the total adult social care budget at the time. In 2009, eleven local Hackney based groups who were funded to provide advocacy or carers’ services bought into the borough an additional £700,000 of grants and investment income between them.

The local voluntary sector also adds value to the local economy because these many organisations:

- Are known and used by local people
- Have expertise in reaching Hackney’s communities
- Are often set up and run by Hackney’s communities
- Employ local people and local volunteers
- Bring in external funding to provide additional services
- Work in partnership to shape commissioning as well as service delivery.

The Voluntary and Community Sector is close to Hackney’s diverse communities and enjoys a trust that has been built up over many years. This added value cannot be ‘scaled up’ and will not be easily replaced if it is lost.

Partnership working

Hackney’s Compact facilitates effective relationships between public agencies, the voluntary and community sector and wider ‘Third Sector’ organisations in the borough.

The Community Empowerment Network is the overarching mechanism through which the Voluntary and Community Sector can contribute to the strategic decision making locally. A number of community networks feed into the CEN. For health the main ones are the City & Hackney Health and Social Care Forum, with a membership of over 230 organisations, the Black and Ethnic Minority Working Group (BEMWG), and the Children and Young People’s Providers Network. Through these networks there is CEN representation on the Local Strategic Partnership and the Shadow Health and Wellbeing Board. This representation has meant that the Voluntary Sector has been involved in the reviews of adult social care services and helped to shape the new services that will be commissioned.

Challenges and opportunities

The Voluntary and Community Sector in Hackney has faced many challenges in 2011 including funding cuts, the reorganisation of the health service and new competitive local authority procurement processes. Reorganisation has resulted in the loss of many valued relationships with statutory sector and staff at a time when local organisations are seeking to manage change despite a lack of clarity in national social policy. Voluntary and community sector organisations are having to compete in new ways for contracts in a climate of less external funding and rising need as the economic climate and cuts affect Hackney residents.

To meet these challenges the local voluntary and community sector is working to develop consortia, groups of local organisations who can share good practice and tender for the new larger contracts. The personalisation of adult social care offers opportunities for specialist and culturally specific groups to provide personalised services to service users. There is also the opportunity for the voluntary and community sector to make new relationships with clinical commissioning groups and to work much more closely with GP practices.

In order to retain the diversity, reach and innovation of the local voluntary and community sector the Community Empowerment Network believes it is essential:

- to retain a grants programme that local groups can bid for that enables them to design their own projects based around community need
that all commissioning takes account of the Government guidance *Best Value Statutory Guidance*\(^{512}\)

that commissioning takes account of the Hackney voluntary and community sector strategy.

**The City**

The City of London's voluntary and community sector is coordinated and supported by the City's Council for Voluntary Service, CITY.COMM, a key partner in the planning and delivery of services. There are around 350 organisations operating or based in the City ranging from small neighbourhood groups and churches to large national charities and regional funders including the City Bridge Trust and the various Livery Companies.

The way the City commissions from the voluntary and community sector, including from organisations based in the City, Hackney, Islington and Tower Hamlets, is guided by Best Value principles and the Local Procurement Directive. City voluntary and community organisations are important stakeholders in this, mainly through the City of London’s local strategic partnership ‘The City Together’.

The City’s relatively small resident population and large daytime population of commuters and workers provide a unique environment for the voluntary and community sector. There are many opportunities for City workers to volunteer their time and resources to the voluntary and community sector, particularly in the City Fringe area, and several City organisations and others exist to support this.

\(^{512}\) Department for Communities and Local Government, 2011
Appendix: ranked needs

Ranked list of needs of Hackney residents

1= smoking
1= child obesity
1= mental health
4= cancer
5= antenatal care
5= cardiovascular disease
7= fuel poverty
7= worklessness
7= drug use
7= child poverty
11= adult obesity
12= teenage pregnancy
13= crime
13= infant mortality
13= childhood immunisations
13= young people's mental health
17= sexually transmitted infections
18= homelessness
18= oral health
20= alcohol
21= HIV
21= domestic violence
23= seasonal flu
23= breastfeeding
23= diabetes
26= sickle cell
27= child oral health
28= air quality
28= respiratory disease
30= hepatitis C
31= TB
31= smoking in pregnancy
31= low birthweight babies
31= young people's alcohol & drug use
35= terminations
36= maternal mortality
37= climate change
38= noise pollution

City of London priorities

The priorities for residents of the City are:
- mental health
- cancer prevention
- homelessness
- smoking
- social isolation
- air quality
- worklessness
- childhood poverty
- prevention of cardiovascular disease
- childhood immunisations
- alcohol
- fuel poverty
- welfare reform

The needs of vulnerable groups in the City, including carers, disabled people and rough sleepers are also acknowledged.
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<th>Category</th>
<th>In-life or near-term effects (to significant economic or social, health or wellbeing)</th>
<th>Who have a significant contribution to meeting needs and wellbeing?</th>
<th>Are there significant inter-related needs?</th>
<th>Can the needs be met in meeting local authority, NHS and partner outcomes?</th>
<th>Any other notes or further guidance needed?</th>
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