TOWER HAMLETS

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 18 October 2011 at 6.30 p.m.

A G E N D A

VENUE
M72 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

Members:	**Deputies (if any):**
Chair: Councillor Rachael Saunders **Vice-Chair:**	
Councillor Lesley Pavitt **Councillor Denise Jones** **Councillor David Edgar** **Councillor Dr. Emma Jones** **Councillor Helal Uddin** **Councillor Lutfa Begum**	Councillor Tim Archer, (Designated Deputy representing Councillor Dr. Emma Jones) Councillor Mizan Chaudhury, (Designated Deputy representing Councillors Rachael Saunders, Lesley Pavitt, Denise Jones, David Edgar and Helal Uddin) Councillor Anna Lynch, (Designated Deputy representing Councillors Rachael Saunders, Lesley Pavitt, Denise Jones, David Edgar and Helal Uddin)

[Note: The quorum for this body is 3 Members].

Co-opted Members:		
David Burbridge	–	(THINk)
Dr Amjad Rahi	–	(THINk)

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Zoe Folley, Democratic Services, Tel: 020 7364 4877, E-mail: zoe.folley@towerhamlets.gov.uk

LONDON BOROUGH OF TOWER HAMLETS

HEALTH SCRUTINY PANEL

Tuesday, 18 October 2011

6.30 p.m.

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Chief Executive.

		PAGE NUMBER	WARD(S) AFFECTED
3.	**UNRESTRICTED MINUTES** To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 26th July 2011.	**3 - 8**	
4.	**REPORTS FOR CONSIDERATION**		
4.1	**Joint Strategic Needs Assessment – Presentation by Public Health**	**9 - 110**	
4.2	**Child and Adolescent Mental Health Services**	**111 - 116**	
4.3	**Proposed merger of Barts and the London, Newham and Whipps Cross**	**117 - 142**	
5.	**ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT**		

DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

Declaration of interests for Members

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

(a) An interest that you must **register**

(b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

What constitutes a prejudicial interest? - Please refer to paragraph 6 of the adopted Code of Conduct.

Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-

(a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
(b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
(c) The matter affects your financial position or the financial interest of a body with which you are associated; or
(d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and

ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.

iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 26 JULY 2011

M72 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Rachael Saunders (Chair)

Dr Amjad Rahi
Councillor Denise Jones
Councillor David Edgar
Councillor Dr. Emma Jones

Councillor Anna Lynch

Other Councillors Present:
Nil

Co-opted Members Present:

Dr Amjad Rahi	–	(THINk)

Guests Present:

Paul James	–	(East London NHS Foundation Trust)
Dianne Barham	–	(THINk Director)
Jane Ray	–	(Quality Care Commission Team Leader)
James Pitts	–	(Quality Care Commission Inspector)
Peter Morris	–	Chief Executive, Barts & the London NHS Trust
Sariat Olatunji	–	(Care Quality Commission Inspector)
Steve Ryan	–	(Barts & The London NHS Trust)

Officers Present:

Sarah Barr	–	(Senior Strategy Policy and Performance Officer, Strategy Policy and Performance, Chief Executive's)
Deborah Cohen	–	(Service Head, Commissioning and Strategy, Adults Health and Wellbeing)
Mary Durkin	–	(Service Head, Youth and Community Learning)
Alan Ingram	–	(Democratic Services)

1. APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Councillor Abdul Asad and Councillor Lesley Pavitt, for whom Councillor Anna Lynch deputised.

2. DECLARATIONS OF INTEREST

Councillor Anna Lynch declared a personal interest in connection with agenda item 4.2 – "Presentation from Barts and The London NHS Trust". The declaration was made on the basis that Councillor Lynch was an employee of the Trust.

3. UNRESTRICTED MINUTES

Referring to discussions at the previous meeting relating to the composition of the Health and Wellbeing Board, the Chair reported that she had since asked a question at Council on the matter and would be requesting that the Chair of the Health Scrutiny Panel be appointed as a Board Member. She added that she had also met Ms Dianne Barham of THINk to agree joint working arrangements concerning the GP network.

RESOLVED

That the minutes of the meeting of the Panel held on 21 June 2011 be agreed as a correct record and signed by the Chair.

4. REPORTS FOR CONSIDERATION

4.1 Presentation from the Care Quality Commission

The Chair thanked the Care Quality Commission (CQC) for attending the meeting and invited them to make their presentation.

Ms Jane Ray, Team Leader, stated that the object of the presentation was to give an overview of the work of the CQC in Tower Hamlets. Two Inspectors who were members of her team (James Pitts and Sariat Olatunji) were also present and could answer detailed queries.

She commented that the CQC brought together the Healthcare Commission and Mental Health Act Commissioners and part of its remit was to inspect the Mental Health Trust service. They also dealt with regulation of private doctors, private ambulance services and, more recently, dentists but GP inspections had been deferred for a year. London comprised the busiest healthcare region in the country and so had more compliance inspectors. Her team covered five London Boroughs but all worked closely together as many cross-boundary issues arose. There were eight CMC teams in London and hers included eight inspectors, two more of whom were being recruited to reflect additional work arising from dental practice inspections. Ms Ray provided further details as follows:-

- The minimum inspection period for care facilities was once every two years and it was hoped to increase the number of visits to establishments. Visits were always unannounced and the number of inspectors involved varied according to the type of facility. An inspection of the East London Mental Health Foundation had involved seven inspectors, with 20 over a period of several days at the Royal London Hospital. Care Homes usually required an individual inspector but there could be more if a Court appearance was considered likely.
- Inspectors from other parts of the region could also help and inspections could be undertaken at all hours and at weekends, particularly when complaint-led. Other health professionals and experts could attend as required.
- Engagement was very important and CQC relied on links with other organisations and individuals for feedback on best use of resources. This presentation was aimed at encouraging people to contact CQC.
- Enforcement powers available to CQC were used carefully and with the focus on improving services. Care organisations were usually keen to improve so enforcement tended to be a last resort.
- Work was carried out in liaison with the General Medical Council and General dental Council to decide upon priority client groups, with emphasis on the elderly, especially in hospitals. Maternity and domiciliary care agencies were also areas to be examined and other NHS establishments would be inspected over the next few months.

The CQC representatives then responded to matters of detail put by the Panel members, including:-

- The use of experts by experience.
- Checks made on staff qualifications and recruitment practices, particularly in care homes.
- The use of feedback from patients.
- The educational role of CQC in encouraging people to monitor their own care.
- The implications for the service of local NHS changes and hospital mergers.
- CQC as an advisory service for individuals relating to care pathways, including the use of the Parliamentary Ombudsmen.
- The approach taken by CQC to avoid being seen as threatening or punitive when inspections were being made.
- The clarification of appropriate bodies to be responsible for addressing problems identified by CQC.

Ms Ray concluded by indicating that inspectorate reports were now published on the CQC website and invited Panel members to read them.

The Chair again thanked the representatives and expressed the hope that they would be able to work further with the Council in future.

4.2 Presentation from Barts and The London NHS Trust

The Chair commented that the Panel would like to hear from the Barts and the London NHS Trust about the huge organisational changes arising from the new hospital facilities; issues relating to outpatients' services; possible Government targets and what the Trust was choosing to measure.

Mr Steve Ryan then indicated that the Trust's Board was to receive next day a business case to ensure improved care around all areas of treatment, based around care pathways. This applied to all parts of a process, e.g. cancer treatment was linked to education and prevention as well as the medical care system. The Board would be testing whether it could improve on what individual organisations could give after the merger and was creating a medical community. He then indicated that merged services would allow the Trust to become a bigger hitter, increasing the footpath of research in East London with academic endeavour. Some £6m could be saved in informatics when software and systems were merged.

Mr Peter Morris, Chief Executive of the Trust, added that the Board was at the first stage of developing an outline business case, following which there would be a tight programme of engagement with other stakeholders and bodies. In response to a query from the Chair, Mr Morris stated that the present conversation related both to what should happen and what would happen. Mobilisation of services to East London as a whole was a substantial challenge and it was necessary to shape the design and pathways of the organisation to ensure it delivered on the promise of improvement and to enable people to have a platform to help do that.

Replying to queries from those present, the Trust representatives indicated that:-

- There was risk in determining how such a huge transaction could be delivered and the key challenge was to get the culture right. The initial decision to merge with Whipps Cross and Newham hospitals was now translating into 8 – 10 areas with a large number of clinicians becoming involved. There was a real momentum of clinical movement aimed at transforming how care was delivered.
- Holistic delivery bases were also required, to provide great medication and an informed access for the community. It was essential to find out what people felt about the whole care experience, not just the medication delivered. The organisation also needed people who understood public health and primary care issues to help provide answers, so that an impact could be made on the health of the community.
- The reorganisation was not just being led by doctors, although their contribution was very important. Leadership groups were being set up to ensure other professionals could contribute to the knowledge base.
- The Trust was concerned especially about addressing the overall quite poor public health in East London and do all it could to improve the new environment/infrastructure. As an employer of 7,000 staff – soon to be 13-14,000 – it could help provide career aspiration for local

children, especially in view of the population increase in Tower Hamlets.

- Details were given regarding the layout of the new hospital, floor by floor and the point was made that there would not be mixed sex accommodation. Infection control had been designed-in and resuscitation facilities were hugely advanced, with ensuite CT screening.
- Outpatient's services continued as work in progress and worthwhile improvements in bookings were being seen. Appointment misses were now running at 3%. Service plans were under review, e.g. the provision of notes to clinic; customer care in reception; and there was an annual survey of patients' opinions. It was also necessary to map out when patients were informed of their next stage of treatment.
- There would be large savings in informatics, with a big investment in new computer and printing equipment and these would be introduced next year when suitable training had been given. Security in the new building would be improved, with many less entrances, and enhanced security around babies and children.
- The hospital would be larger in terms of volume and floor area but the aim was that patients should not be kept in longer than necessary. If bed occupancy levels could be maintained at 93% there would be scope for emergency admissions. With 100% occupancy, people had to be moved around the building which was bad for patient experience and incurred costs. It was better for people to be looked after outside hospital, wherever possible.
- A compassionate care programme was being established, led by clinicians and nurses, aimed at enhancing the respect needs of patients. The Safety Express initiative would also have all patients visited by a nurse every two hours, which helped reducing potential harms to patients, e.g. from falls.

The Chair referred to the Quality Dimension document circulated from the Trust and expressed the view that there should be email conversation after the meeting, to ensure how to measure service improvements.

The Panel **agreed**

(1) That Mr Steve Ryan provide Ms Sarah Barr, Senior Strategy Policy & Performance Officer, with the monthly detailed performance report made to Barts and The London NHS Trust.
(2) That Ms Barr make arrangements for members of the Panel to visit the new hospital facility.

The Chair then thanked the NHS representatives for the information provided.

4.3 Progress update on Transforming Adult Social Care and Efficiency Programme – Adults, Health and Wellbeing Directorate.

At the request of the Chair, Ms Deborah Cohen, Service Head Commissioning and Strategy, introduced the circulated report providing an update on the transformation of adult social care in Tower Hamlets. She then responded to

questions put by the Panel with regard to: the need to empower people to ask for personal budgets and training up experts through experience to help with this; domiciliary care contracts; efforts for the provision of the London living wage to all employees of care service providers; the need to ensure home carers to have the skills to write cogent notes; home visits would be for a minimum of 30 minutes; the work of the brokerage team who would ensure that service users had the option of dipping in and out of having their budget managed by the local authority.

The Panel **agreed**

(1) That its thanks be recorded for the work undertaken by Helen Taylor, Acting Corporate Director, Adults' Health & Wellbeing.
(2) That the Panel's feeling be recorded that permanent appointments are preferable for such senior management positions.
(3) That the Panel be provided with the report submitted to the last Overview & Scrutiny Committee regarding with overspends in connection with domiciliary care contracts, together with details of the actual savings to be achieved.

The Chair thanked Ms Cohen for the report provided.

5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

There was no further business.

The meeting ended at 8.50 p.m.

Chair, Councillor Rachael Saunders
Health Scrutiny Panel

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**18 October 2011**	**Unrestricted**		**1**

Reports of:	**Title:**
NHS East London and the City London Borough of Tower Hamlets	Joint Strategic Needs Assessment – Summary Document and Factsheets
Presenting Officer:	**Ward(s) affected:**
Somen Banerjee Co-Director Public Health NHS East London and the City and LBTH	All

1. Summary

This document provides an overview of the Joint Strategic Needs Assessment (JSNA) 2010-11 for Tower Hamlets. It is still in draft format currently. It is underpinned by a series of factsheets which detail the supporting evidence and rationale for the recommendations provided. Sections 1-3 of this document set out the aims and methodology adopted by Tower Hamlets for this process. Sections 4 and 5 describe the key findings for the borough, including population, social determinants of health and health and wellbeing throughout the course of someone's life. Recommendations based on this evidence are reported in section 6, spanning all areas outlined in the previous sections. These recommendations are the key outcome of this process and will be audited in the following financial year in order to chart progress and improvement.

Accompanying the summary document are 5 examples of the JSNA Factsheets, and Child Health Locality Profiles.

2. Recommendations

The Health Scrutiny Panel is asked to consider the information in these documents and note the recommendations made in the JSNA.

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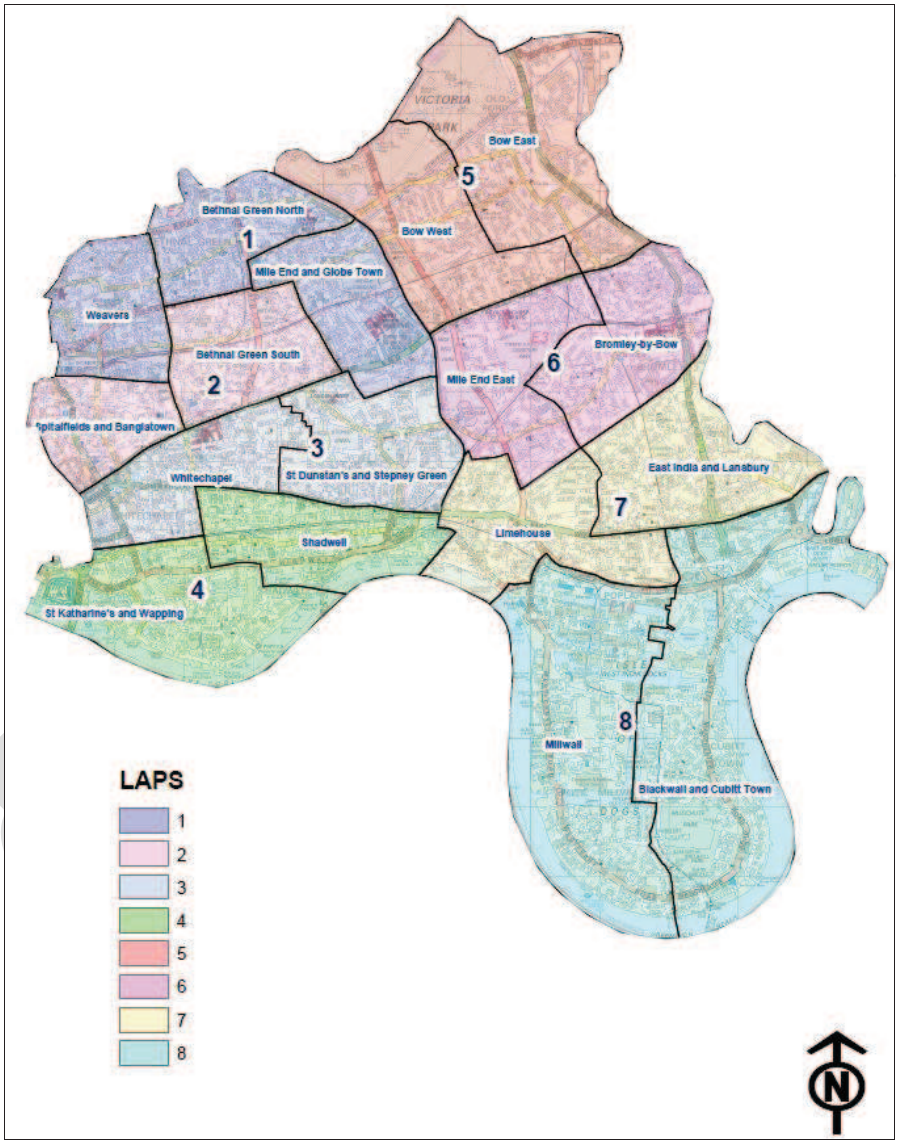
Health and Wellbeing in Tower Hamlets

Tower Hamlets Joint Strategic Needs Assessment 2010-2011



Map of Tower Hamlets showing the borough, LAP and ward boundaries. Source: ELCA HIU, 2010

Contents

This document provides an overview of the Joint Strategic Needs Assessment (JSNA) 2010-11 for Tower Hamlets. It is underpinned by a series of factsheets which detail the supporting evidence and rationale for the recommendations provided. Sections 1-3 of this document set out the aims and methodology adopted by Tower Hamlets for this process. Sections 4 and 5 describe the key findings for the borough, including population, social determinants of health, and health and wellbeing throughout the course of someone's life. Recommendations based on this evidence are reported in section 6, spanning all areas outlined in the previous sections. These recommendations are the key outcome of this process and will be audited in the following financial year in order to chart progress and improvement.

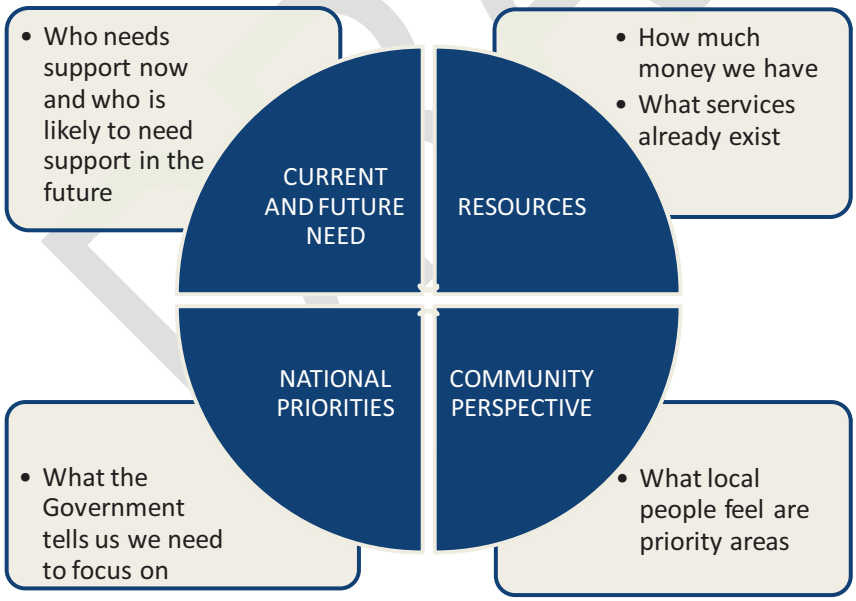
1. What is the Joint Strategic Needs Assessment?

- The Local Government and Public Involvement in Health Act 2007 stipulates that local authorities and Primary Care Trusts (PCTs) produce a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing of the local community:

> *"The JSNA is a process that identifies the current and projected health and wellbeing needs of the local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities"*

- The JSNA core dataset draws together data on population demographics, disease patterns, the wider determinants of health (such as housing, education, employment, benefits, etc), use of social care, use of primary care (i.e. GPs, pharmacists, dentists, etc.), planned and unplanned secondary care (i.e. hospitals, clinics, etc.), performance trends, spend, public perspectives and the views of professionals.
- Local data are analysed alongside regional and national figures to allow comparisons with other areas.
- Health and social care data analysis highlights the needs of the local population and any gaps in service provision.
- Conclusions are drawn and recommendations made to inform how money is spent by the local authority and the PCT.
- In the future, the JSNA will underpin the priorities of the new Health and Wellbeing Boards and of local GP commissioners and providers.

Figure 1 JSNA Considerations



2. Our approach to the JSNA

The overall picture that the JSNA provides of the borough should be rich and insightful. However, it is equally important that the JSNA is genuinely useful and accessible to its customers – including commissioners, providers, local councillors, community groups, and members of the public. Therefore, we asked key groups how to make the JSNA useful to them in the future, and they said that the JSNA should:

- Be equally accessible, and easy to use, for members of the public and commissioners and providers of services.
- Provide information about the needs of the population at a very local level, as well as in the borough as a whole.
- Include interpretation of information, helping people to understand the implications of particular patterns of need for service design in the future.
- Compare Tower Hamlets' local needs and issues with needs and experiences in other places, and examine examples of best practice from around the UK.
- Include community experience of services and reflect service users, patients and carers' views about local needs and priorities.
- Forecast future demand for services, to inform forward planning, and suggest priorities for future analysis where current knowledge gaps are identified.
- Be a rolling programme of work, with each year's contribution building on the previous year's output.
- Include shorter 'Factsheets' focusing on particular topics, alongside more in-depth reports, all available online.

Therefore, a brief but comprehensive overview document will be produced each year (of which this is the first) drawing readers' attention to key facts and figures, and highlighting priority issues for Tower Hamlets. Supporting this, topic-specific Factsheets as well as more in-depth reports will be produced and updated as new evidence or research is identified, containing links to supporting data, maps and further analysis for those who require more detail.

Figure 2 JSNA Process in Tower Hamlets

Figure 3 Structure of Each JSNA Factsheet

STRUCTURE OF TOPIC-SPECIFIC FACTSHEETS

What do we know?
What does this tell us?

What is the local picture for a particular issue (including trends and comparisons)?
What should we be doing: what are the effective interventions?
What are we doing locally to address this issue and how well are we doing?
How can we do things better?
What is the perspective of the public on need and services?
What do we need to know more about?
What should we prioritise?
What should we de-prioritise?

Evidence-Based Commissioning

This rolling programme will enable evidence-based commissioning and highlight gaps and areas for future work. It will also provide timely information to help providers shape their services. It will help inform the following local strategic plans/strategies:

- NHS Tower Hamlets' Commissioning Strategy Plan
- The Tower Hamlets Community Plan
- Transformation of Adult Social Care
- Strategic developments in Children's services
- Plans of specific groups (e.g. Learning Disabilities Partnership Board)

In the future, the JSNA will also help shape the priorities of the Health and Wellbeing Board, and of local GP commissioners and providers, who will require locality information in order to inform their planning.

As described in the government's White Paper 'Health Lives, Healthy People: Our strategy for public health in England', published in November 2010, the Health and Wellbeing Board will bring together key NHS, public health and social care leaders in Tower Hamlets to work in partnership to establish a shared local view on the needs of the local community and support joint commissioning of NHS, social care and public health services.

The Health and Wellbeing Board will develop joint Health and Wellbeing Strategies based on the assessment of need outlined in the Joint Strategic Needs Assessment. This joint approach to needs assessment will continue to enable an increasingly integrated approach to health and social care commissioning and provision, with many benefits to service users, patients and carers, not least a more seamless experience of health and social care services.

3. A Framework for the JSNA: thinking about the 'Life Course'

As detailed in the next section, which gives an overview of health and wellbeing in Tower Hamlets, there are evident inequalities when comparing Tower Hamlets with the rest of England, and also inequalities within Tower Hamlets itself.

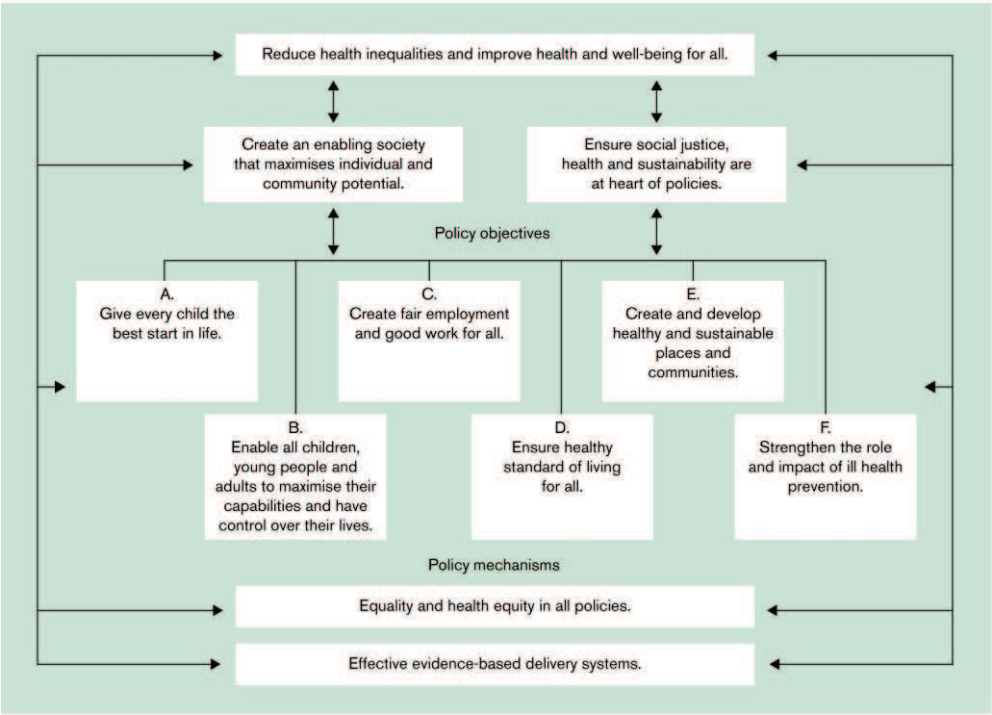
Since the JSNA process is designed to enable conclusions to be drawn and recommendations made to inform commissioning priorities for the local authority and the PCT, it is useful to think about what actions have the biggest impact on inequalities in health and wellbeing: how can we most effectively improve the health and wellbeing of our local population?

The recent Marmot Review 'Fair Society, Healthy Lives' – a Strategic Review of Health Inequalities in England post-2010 – gives a framework for how positive and negative effects on health and wellbeing accumulate over a person's life. This 'life course' approach says that disadvantage starts before birth and accumulates throughout life, leading to poorer health outcomes.
The Review demonstrates an evidence base that action on six policy objectives is key to improving health and wellbeing and reducing health inequalities. These are to:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives and life chances
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create sustainable communities and places that foster health and wellbeing
- Strengthen the role and impact of prevention

Figure 4 below shows how these objectives fit into a framework for reducing health inequalities.

Figure 4 The Marmot Review Conceptual Framework for Action across the Life Course (Source: Strategic Review of Health inequalities in England Post-2010)



Marmot's 'life course' approach has been identified in the new national strategy 'Health Lives, Healthy People: Our strategy for public health in England' published by the Department of Health in November 2010, which discusses health and wellbeing throughout life, from Starting well and Developing well through to Living well, Working well and Ageing well, and aiming to improve health at key stages in people's lives through implementing some of Marmot's policy actions.

The Life Course framework and associated policy objectives provide the cross-cutting policy framework which Tower Hamlets local authority and PCT are using to underpin the recommendations for action in each of the Tower Hamlets JSNA Factsheets, recognising that partnership working across health and social care and a focus on identifying, supporting and improving health and wellbeing particularly in the early years of life ensures the greatest impact on individual and population health.

Figure 5 Tower Hamlets JSNA Themes for 2010/2011, informed by the Marmot Review's Life Course Model

JSNA themes in 2010/11:
The People of Tower Hamlets
Environment and Health
Lifestyle, Health and Wellbeing
Infectious Diseases
Health and Wellbeing of Children, Young People and Families
Adult Health, Wellbeing and Disability
Local Health and Social Services

Putting this into practice in Tower Hamlets, the information pulled together in JSNA Factsheets must then inform the development of pathways and action plans to improve health and social care. Figure 6 shows the characteristics of effective pathways:

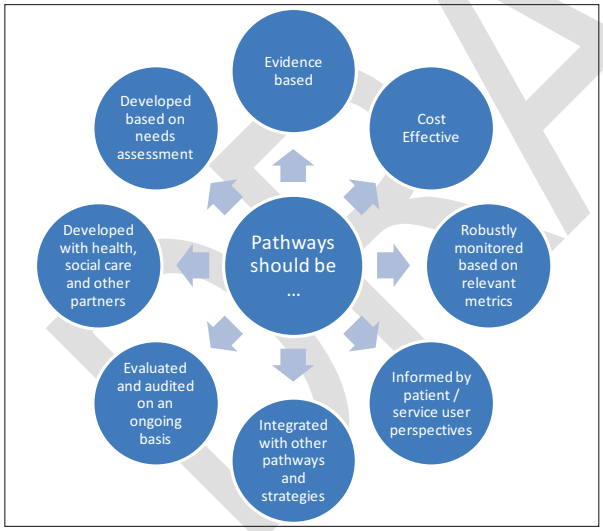


Figure 6 The Characteristics of Effective Pathways

These characteristics have underpinned the development of the factsheet model for this year's JSNA in that discrete factsheets can be updated on an ongoing basis as new needs assessments and audits are undertaken, and this approach has informed the specific content of each factsheet (e.g. inclusion of evidence base for interventions, and community perspectives).

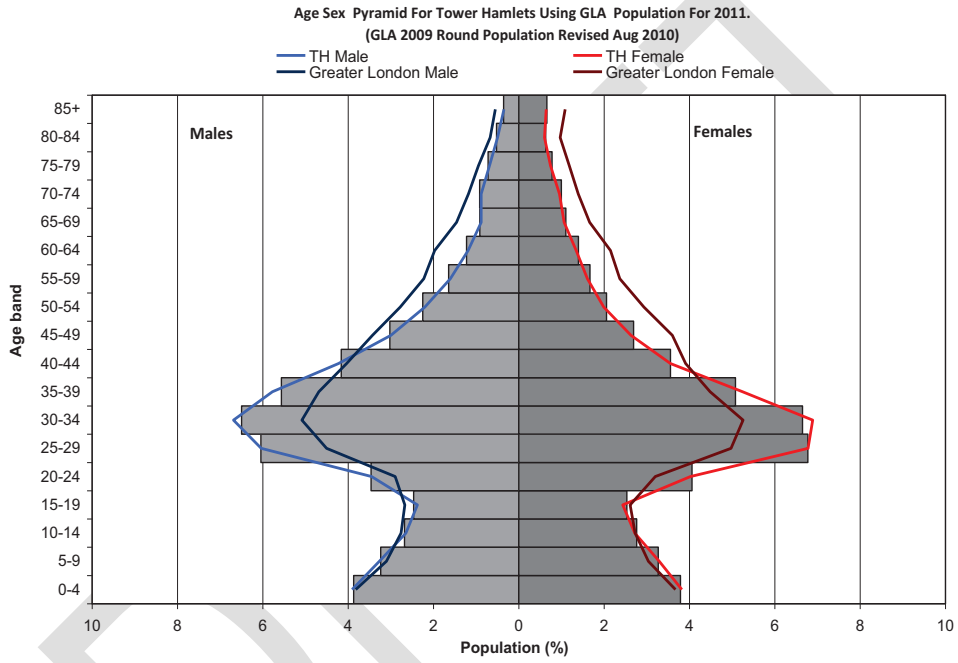
4. Key Headlines for Tower Hamlets

This section gives some of the headlines for the population in Tower Hamlets, and then goes into more detail structured around the Life Course approach. Much more detailed information is available in the accompanying JSNA Factsheets.

Population

There are around 242,000 people living in Tower Hamlets, with an unusually young age profile. Tower Hamlets has a larger than average proportion of the population aged under 10 years, or aged between 20 and 39 years, and a correspondingly smaller than average proportion aged 40 and above[1].

Figure 7 Age Sex Pyramid for the Tower Hamlets population, 2011[2]



People aged 65 and over make up a relatively small proportion of the Tower Hamlets population in comparison to London and England as a whole. In 2010 just 7.1% of the total Tower Hamlets population is thought to be aged 65 and over (between 15,000-18,000 people)[3] compared to 18.9% nationally.

There is currently estimated to be an approximately equal gender split in the borough, with a slightly larger female population overall (50.3%) and over the age of 65 (54.6%), and a marginally smaller female population aged 18-64 years (49.9%).

According to a recent minimum population count by Mayhew Harper Associates (2009) the largest proportion of the population lives in Local Area Partnerships (LAPs) 1 and 8[4]. LAPs 1 and 5 have the largest older population (aged 65 and over), whilst LAP 8 has a particularly large working age population, reflecting the presence of Canary Wharf.

[1] ONS Mid-Year Estimates, 2007.
[2] © GLA 2009 Round Population Projections.
[3] Mayhew Harper Associates, 2009.
[4] NB. The Mayhew Harper Associates Count should be considered a minimum dataset, as the count does not include those living in residential homes or halls of residence. Numbers may not sum due to numbers of people whose age is not identified.

Table 1 Population age profile by LAP[5]

Name	% aged under 18	% aged 18 - 64	% aged 65+
England[6]	21.3%	62.5%	18.9%
London[7]	22.2%	66.5%	13.8%
Tower Hamlets[8]	26.8%	66.1%	7.1%
LAP 1	25.6%	66.1%	8.3%
LAP 2	26.4%	67.2%	6.4%
LAP 3	29.0%	63.5%	7.6%
LAP 4	25.0%	68.0%	6.9%
LAP 5	23.4%	67.8%	8.7%
LAP 6	32.4%	61.1%	6.6%
LAP 7	30.7%	62.1%	7.2%
LAP 8	23.1%	72.7%	5.1%

According to the Tower Hamlets Planning for Population Change and Growth (PPCG) model, which takes into account housing development in the borough as well as migration, births and deaths, the population is expected to increase by over 23,000 people between 2010 and 2015, and increase of about 10%. The largest growth is expected in LAPs 6 and 8 (over 7,000 people in each, a 28% and 17% increase respectively).

Table 2 Population growth by LAP[9]

LAP	2010	2011	2012	2013	2014	2015	Population change 2010-2015
1	41,400	41,310	41,140	41,700	42,440	42,280	880
2	26,780	26,990	26,910	26,820	27,430	29,390	2,610
3	27,590	27,520	28,010	28,370	28,250	28,870	1,280
4	25,350	25,680	25,740	25,640	25,530	25,430	80
5	22,650	22,660	23,290	23,220	23,130	23,040	390
6	27,290	29,260	29,460	30,300	32,660	34,870	7,570
7	27,680	28,030	28,530	28,570	30,930	31,000	3,330
8	42,550	43,470	43,310	43,360	47,110	49,720	7,180
Total	**241,290**	**244,920**	**246,390**	**247,970**	**257,480**	**264,600**	**23,310**

Although numbers of people in all age groups are expected to increase substantially over the next 20 years, the *age structure* of the Tower Hamlets population is not expected to change dramatically. GLA (Greater London Assembly) estimates show that there will be a small decline in the population aged under 18 and a small growth of the population aged between 18 and 64. There will also be a marginal decrease in the population aged over 65 until 2020 (only in the 70-79 years population), followed by a gradual increase[10].

Analysis conducted at London level suggests a population churn (combined inflow and outflow) in Tower Hamlets of 189 per 1,000 residents, equating to nearly 19% of the population. If movement within the Borough is added, this equates to 24% of the population per year (the 11th highest population movement of the 33 Boroughs)[11].

[5] Numbers may not sum due to rounding
[6] Office for National Statistics (ONS) Mid Year Estimates, 2009.
[7] © GLA 2009 Round Population Projections.
[8] Mayhew Harper Associates, 2009.
[9] Tower Hamlets Planning for Population Change and Growth (PPCG) model. Numbers may not sum due to rounding.
[10] © GLA 2009 Round Population Projections
[11] London Borough Migration 2001-2006 - DMAG briefing 2008-10, Greater London Authority.

There are two sources of data on the ethnicity profile of the borough (GLA and Mayhew Harper Associates (NKM)). Whilst the NKM data is an accurate method of counting the population 13% of the population do not have an identified ethnicity. For this reason the GLA 2009 ethnic group projections will be used. Based on these projections, 50% of the population is classified as white and 33% Bangladeshi. This distribution varies substantially across different age groups. Although 59% of the 0-20 age range is Bangladeshi, this proportion decreases to 25% of the 20-64 age range (adult) population and just 22% of the 65 years and over population. In contrast, just 21% of the 0-20 age range population is white (all), rising to 60% of the 20-64 age range population and 65% of 65 years and over population. The Somali population although not separately identified in the GLA data has been recently estimated to be between 2.3%[12] and 3%[13].

There are no clear figures indicating how many gay, lesbian and bisexual residents there are in Tower Hamlets. National estimates indicate that between 5 – 7% of the population is gay, lesbian or bisexual, and that the proportions may be higher in London than elsewhere in the UK[14]. If applied to the Tower Hamlets population, this would suggest at least between 12,000 and 16,800 people identifying themselves as gay, lesbian or bisexual in the borough.

Health headlines

Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Male life expectancy is 75.3 years compared to 77.8 nationally and female life expectancy is 80.4 compared to 82.0 (2006-8). The Borough has the highest or second highest mortality in London for the three major killers: cardiovascular disease, cancer and chronic respiratory disease (COPD). Trends indicate year on year improvement but with limited reduction in the gap[15].

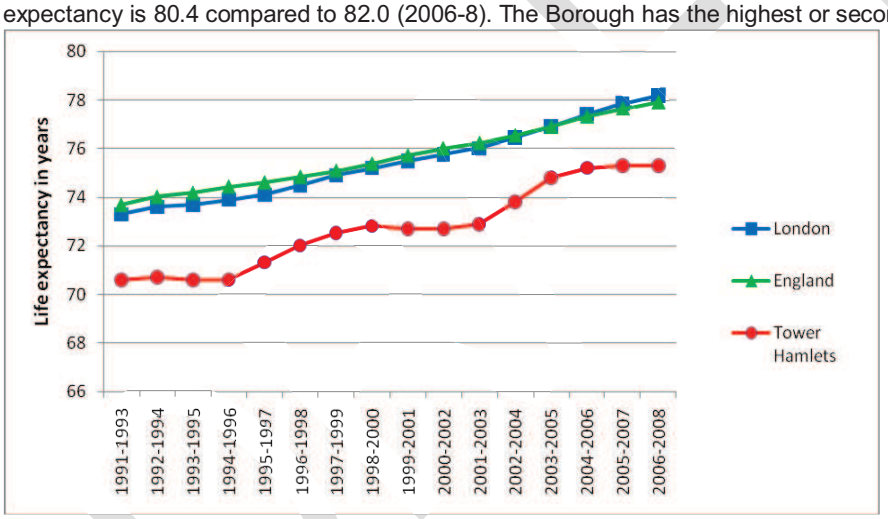


Figure 8 Trend of life expectancy at birth for males in Tower Hamlets, London and England. 1991-1993 to 2006- 2008[16]

There is variation in life expectancy within the borough. For example, St Katherine's and Wapping has the highest life expectancy in the borough for males (80.4 years) and Millwall has the highest for females (89.2 years). Conversely, average life expectancy for males is just 72.5 years in St Dunstan's and Stepney Green (the lowest in the borough) and for females is 77.9 years in Mile End East (the lowest in the borough).

Overall mortality in Tower Hamlets (known as All Age All Cause Mortality, AACM) for males and females combined is the highest in London and significantly higher than the national average

[12] NKM Population count, 2009
[13] Tower Hamlets Health and Lifestyle Survey 2009; NB Survey was of people aged 16 and over.
[14] Stonewall, 2009.
[15] National Statistics accessed at the NHS Information Centre for health and social care. © Crown Copyright.
[16] National Centre for Health Outcomes Development (NCHOD).

(Directly Standardised rates (DSR) are 717 per 100,000 in Tower Hamlets, compared to 582 per 100,000 in England).

For males, Tower Hamlets has the 2nd highest directly standardised AACM rate in London (859 per 100,000 compared to 677 in London and 692 in England) and for females the highest in London (579 per 100,000 compared to the London average of 463)[17]. Despite improvements over time, there has been only a marginal reduction in this inequality. Tower Hamlets has the highest directly standardised rate in London of mortality from all causes amenable to healthcare in under 75s (151 per 100,000 compared to a London average of 104)[18].

Cardiovascular disease (CVD) and cancer are the leading causes of death contributing to overall mortality. Cardiovascular disease mortality has particularly high inequalities across the Borough. Four wards (Mile End East, Whitechapel, Bethnal Green North and Shadwell) have mortality rates that are close to twice the national average. This contrasts with Millwall and St Katharine's and Wapping, where mortality is below the national average, reflecting a strong relationship between ward deprivation and mortality[19].

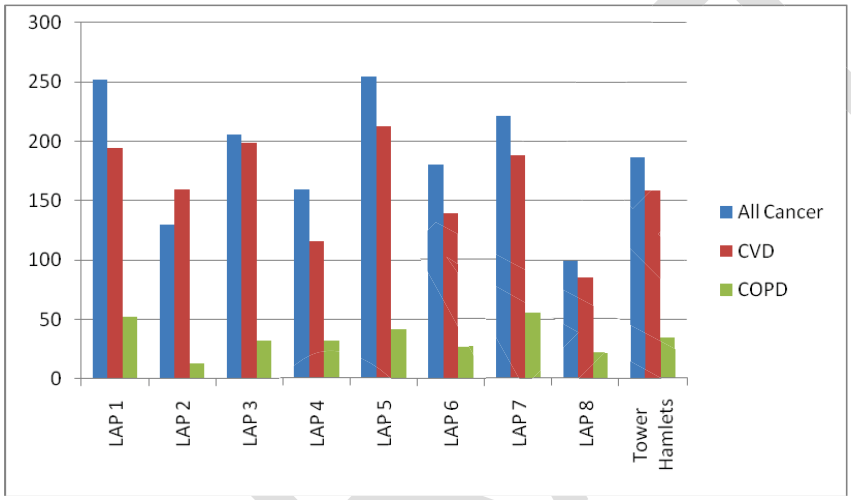


Figure 9 Crude Mortality Rate per 100,000 population for cancer, CVD and COPD[20]

Tower Hamlets has the highest cancer mortality in London. This is driven to a significant extent by high incidence and mortality from lung cancer, and reflects the high prevalence of smoking in the borough. However, one year survival from cancer is in the bottom 10% nationally and this is particularly poor for breast, colorectal and prostate cancer. Cancer screening uptake is lower than national averages (breast, cervical and bowel) Evidence indicates that late diagnosis is a significant contributor to poorer survival. Although there are also sharp inequalities in cancer mortality across the Borough, the pattern is different to cardiovascular disease. Bow East and West (and St Dunstan's and Stepney Green in the case of males) have by far the highest mortality (around 50% higher than national averages) with the remaining wards tending to be fairly similar except for Millwall and St Katharine's and Wapping, which have mortality rates 30% below the national average[21].

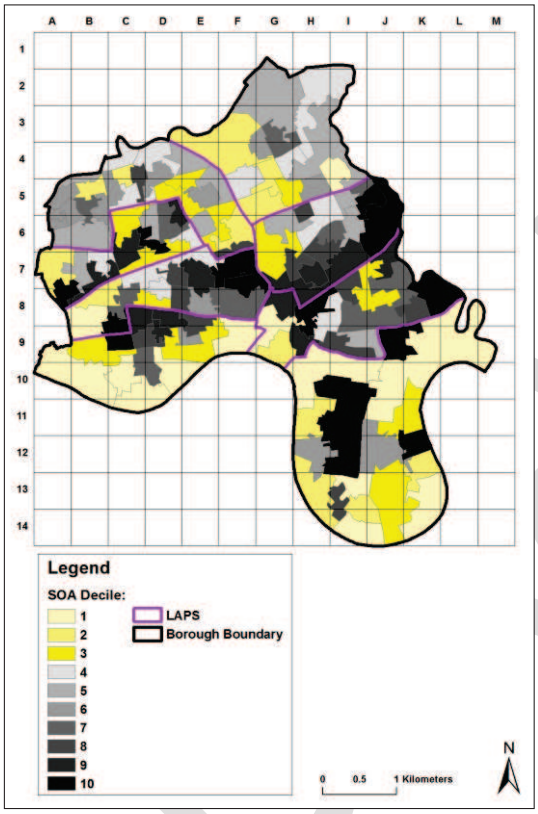
Chronic Obstructive Pulmonary Disease (COPD) is the third biggest driver of higher mortality in Inner East London (after CVD and Cancer). Tower Hamlets has by far the highest mortality from COPD in London (a standardised mortality ratio of 172 compared to a London average of 98)[22], which is likely due to levels of deprivation and other socioeconomic factors, and higher smoking rates in some population groups.

[17] Mortality from all causes in males, females and persons all ages in London boroughs and England. 2006-2008. Directly age-standardised rates (DSR) per 100,000 population, all ages. National Statistics.
[18] Mortality from causes considered amendable to health care in all persons in London boroughs and England. 2006-2008. Directly age-standardised rates (DSR) per 100,000 population (Various cause-specific ages). National Statistics.
[19] CVD mortality in under 75 Persons by Tower Hamlets Wards, 2003-07, London Health Observatory.
[20] Office for National Statistics (ONS) 2008.
[21] CVD mortality in under 75 Persons by Tower Hamlets Wards, 2003-07, London Health Observatory.
[22] Mortality from COPD, all persons, London boroughs and England. 2006-2008, National Statistics.

Age adjusted mortality rates are significantly higher in the white population compared to the Bangladeshi population for deaths from all causes, cardiovascular disease (under 75) and cancer (under 75). Health inequalities between men and women are frequently overlooked, however it is striking that the life expectancy gap between men and women in Tower Hamlets is 5 years, compared to 4 years nationally. This is consistent with a higher gap in areas of high deprivation.

Socioeconomic determinants of health and wellbeing

As the Marmot Review[23] restated, health is tightly linked to socioeconomic status. The 'wider determinants of health' such as income, education, poverty, quality of housing, physical environment and community cohesion are profoundly linked to people's health.



The most important factor accounting for poorer health outcomes in the sector is socioeconomic deprivation. Based on the Index of Multiple Deprivation (IMD), Tower Hamlets is the 3rd most deprived local authority area in the country[24].

In 2007, 16 out of 17 Tower Hamlets wards were ranked in the 20% most deprived in the country and 12 were ranked in the 5% most deprived. 78.5% of Tower Hamlets residents live in the 20% most deprived areas in England, compared to around 26% of London residents. Between 2004 and 2007 there were no substantial changes in deprivation scores by ward except for Millwall, which became less deprived, probably reflecting the impact of inward migration of more affluent populations into Canary Wharf and its surroundings.

Figure 10 Decile map based on IMD 2007 showing distribution of deprivation across the borough (1=least deprived; 10 = most deprived)[25]

According to the Office for National Statistics (ONS) Annual Population Survey, in 2009/10 Tower Hamlets had an unemployment rate of 14.5% (the highest in London) compared to 13.9% in Newham (2nd highest), 11.1% in Hackney (6th highest) and 9.1% in London[26].

London has a higher percentage of local authority homes not meeting the decent homes standard than other parts of the country (26% of homes in London are non-decent compared to 16% in England, 2009/10). Housing quality is noticeably poorer than average in East London. Fifty six percent of 'Tower Hamlets Homes' properties are classed as non-decent (the second highest proportion in the country)[27]. Overcrowding is also a problem across London and East London in particular. The overall over-occupation level (whereby a dwelling does not have sufficient bedrooms to meet the requirement according to age and gender of occupants) in Tower Hamlets is 16.4%, or 15,752 implied households, with the majority of overcrowding found in Black and Minority Ethnic (BME) households[28].

[23] Fair Society, Healthy Lives' – a Strategic Review of Health Inequalities in England post-2010
[24] Index of Multiple Deprivation (IMD) 2007.
[25] Mayhew Harper Associates, 2010
[26] ONS Annual Population Survey, 2009/10, extracted from Nomis. Percentage is a proportion of economically active.
[27] 'Business Plan Statistical Appendix (BPSA)- Annual Monitoring 2010, from www.communities.gov.uk.
[28] Tower Hamlets Overcrowding Reduction Strategy, 2009-12.

Homelessness has a significant negative impact on the health of people affected. In Tower Hamlets, in the quarter April – June 2010, 156 households were assessed as being homeless and in priority need. This represents 1.8 per 1,000 households being homeless and in priority need, compared with a London average of 0.7 households per 1,000 population. At the same time, 1,774 households were living in temporary accommodation, which represents 19.1 households per 1,000 population, compared with a London rate of 11.4 households per 1,000 population[29].

Violent crime impacts on health both directly and through its impact on the community. Rates of violent crime in Tower Hamlets (31.5 offences per 1,000 population) are considerably higher than the London average (23.0 per 1,000)[30]. Forty six percent of residents in Tower Hamlets perceive anti social behaviour to be a problem in the local area (the second highest percentage of all London boroughs)[31].

Tower Hamlets has a particularly high rate of people killed or seriously injured on the road (0.66 per 1,000 in Tower Hamlets compared to 0.46 in London). This rate increased by 4.5% in 2007-09 compared to 2006-08[32].

Health & Wellbeing Through the Life Course

Early Years

The birth rate in Tower Hamlets (67.1 live births per 1,000 female population) is higher than the England average (63.9) but lower than the London average (69.3)[33]. Forty five percent of births are to Bangladeshi mothers. Although a higher proportion of newborns have lower birth weight (<2500g), infant mortality is lower in Tower Hamlets (4.1 per 1,000 live births) than in Hackney (5.7) or Newham (5.8), and slightly lower than the London average (4.6)[34]. Breastfeeding initiation rates are higher than London.

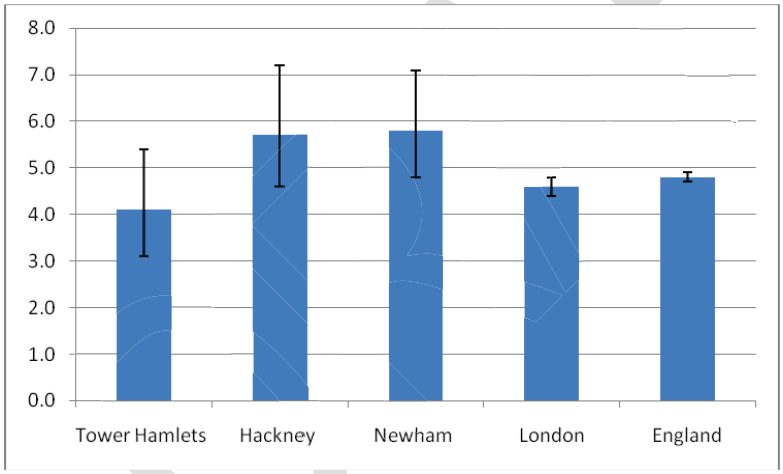


Figure 11 Infant mortality (rate per 1,000 births)[35]

Children & Young People

Two thirds (66%) of children under the age of 16 live in low income households (less than 60% of the national median income). This is the highest rate of child poverty in the country. 52% of school pupils are entitled to free school meals; this is again the highest rate in the country. 1 in 12 children in Tower Hamlets live in homeless households.

[29] CLG 2010, Supplementary Table: Local authorities' action under the homelessness provisions of the 1985 and 1996 Housing Acts: Apr - June Quarter 2010
[30] Violence against the person offences recorded rate in London boroughs and England, 2008/2009. APHO.
[31] Place Survey, 2008.
[32] Percentage change in the number of people killed or seriously injured during the latest 3 year averages (2007-09) compared to previous 3 year averages (2006-08). Figures are based on a 3 year rolling average, up to the current year. Department for Transport.
[33] Office for National Statistics.
[34] Infant mortality rate in London boroughs and England. 2006-2008 (Crude rates (all maternal ages) per 1,000 live births). National Statistics.
[35] National Statistics, 2006-09 pooled.

The number of children subject to a child protection plan has increased sharply over recent years (from 189 in 2006/07 to 316 in November 2010), primarily reflecting increases in ascertainment. There has been a particular rise in the number of children subject to a child protection plan due to neglect[36]. The rate of 'children in need' in Tower Hamlets (580.3 per 10,000 population) is higher than the national average (341.3 per 10,000) and one of the highest in London[37].

In Tower Hamlets, 3,052 children are registered as disabled or with learning needs, representing 5.54% of those under the age of 18[38]. The number of children with complex disabilities, including learning disabilities, physical disabilities and sensory impairment in Tower Hamlets is increasing and children with complex conditions and co-morbidities are living longer. Around 1,033 children were identified in schools as having a long term condition in 2009/2010[39].

Emergency admissions data for long term health conditions such as asthma, diabetes and epilepsy[40] suggests that improved management of long term conditions in children in the community could prevent emergency admissions and reduce longer than average stays in hospital. Admissions for unintentional and deliberate injuries in under 18s are particularly high in Tower Hamlets (123.4 admissions per 100,000 in Tower Hamlets compared to a London average of 94.8 per 100,000)[41].

Tooth decay rates in 5 year olds have been improving but remain higher than London. Tower Hamlets has the 5th highest prevalence of obesity in reception year children (13.4%) and the 2nd highest prevalence of obesity in year 6 (25.6%) in London.

Three in ten children under the age of 15 has tried a cigarette (similar to the national average)[42] and 4 out of 10 local retailers are selling cigarettes to under 18s[43]. Three in 10 children have ever had an alcoholic drink compared to 7 in 10 nationally (reflecting the large Muslim community in the borough)[44].

Childhood immunisation uptake is higher than London and Measles Mumps and Rubella (MMR) uptake at 24 months and 5 years has increased significantly over the past year (most recent data indicates over 92% uptake of second MMR). Prevalence of mental health disorders in children is similar to national averages (around 1 in 10).

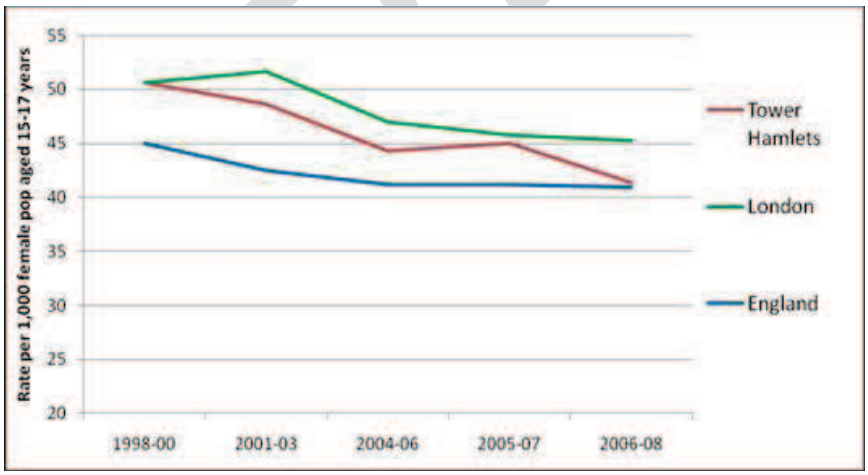


Figure 12 Trend of teenage pregnancy rates per 1,000 female population aged 15-17[45]

Teenage pregnancy rates in Tower Hamlets are in line with London

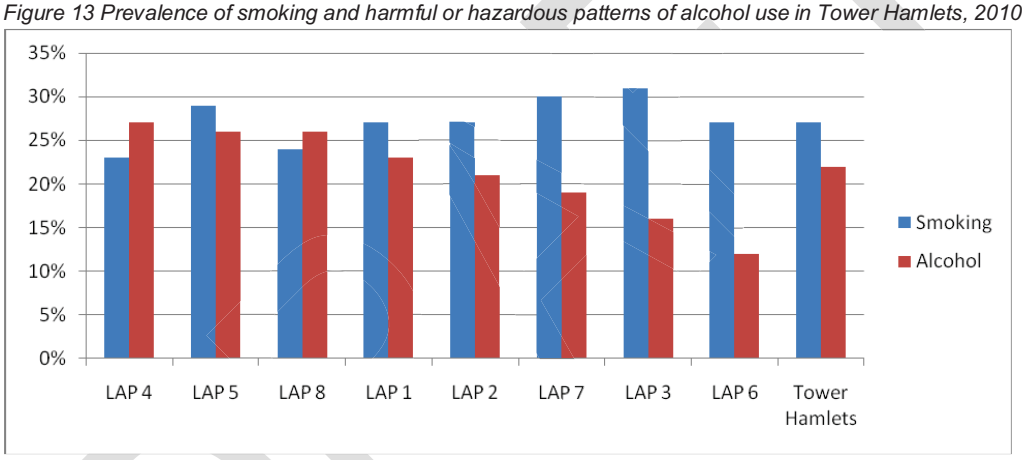
[36] LBTH Children, Schools and Families Social Care Data, November 2010.
[37] Children in Need Census, 2009-10, from www.education.gov.uk. A child in need is one who has been referred to children's social care services, and who has been assessed, usually through an initial assessment, to be in need of social care services. A child can have more than one episode of need throughout the year but episodes should not overlap. If a child has more than one episode, then each is counted in the figures.
[38] Child Poverty Needs Assessment, LBTH 2010
[39] School Health team, LBTH 2010
[40] CHIMAT Disease Management Information Toolkit - Paediatrics
[41] Admissions for unintentional/deliberate injuries CYP per 10,000. ONS.
[42] TellUs 3 Survey, 2008.
[43] London Borough of Tower Hamlets Trading Standards Performance Report.
[44] TellUs 3 Survey, 2008.
[45] Office for National Statistics and Teenage Pregnancy Unit, 1998-00 - 2006-08.

and slightly higher than the England averages (2009 figures). Since 1998, under-18 conceptions in Tower Hamlets have decreased 29.6% to 40.7 per 1,000 females aged 15-17 (compared to a London decrease of 20.3% and an England decrease of 18.1%). Data from 2008 shows that in Tower Hamlets, nearly two thirds of teenage conceptions led to an abortion, which was similar to London figures but is a higher proportion than the England average, suggesting that a significant number of teenage conceptions are unplanned. The data for 2009 is pending.

Staying Healthy: lifestyles that pose risks to wellbeing now and in future

Smoking prevalence is higher in Tower Hamlets than the national average, although this varies from 22.5% in Local Area Partnership (LAP) 4 to 31.8% in LAP 3 (with a borough average of 27.1%, compared to 21% nationally)[46]. In the Tower Hamlets Health and Lifestyle survey results, 34% of males were current smokers compared to 20% of females. However, there were important gender differences in smoking prevalence by ethnicity, with a particularly high smoking prevalence in Bangladeshi males. In the white population, the proportion of female smokers and male smokers was not significantly different. However, in the Asian and black populations a much higher proportion of males smoke than females. Smoking quit rates are relatively good in the borough however, with 323 four week self-reported quitters per 100,000 population in quarter 1 of 2009/10, compared to 160 in London and 192 in England[47].

Figure 13 Prevalence of smoking and harmful or hazardous patterns of alcohol use in Tower Hamlets, 2010



Although rates of alcohol consumption are relatively low in Tower Hamlets due to a large abstinent population, risky drinking amongst the population who do drink is high. 43% of people who drink in Tower Hamlets have harmful or hazardous drinking patterns, though this varies from 38% in LAPs 6 and 8 to 48% in LAPs 4 and 5. Of the total population, 21.7% have harmful or hazardous drinking patterns, and again this is particularly high in LAPs 4 and 5, where 27.5% and 26.1% of the population have harmful or hazardous drinking patterns[48]. There is evidence of harmful drinking in those over the age of 65 in Tower Hamlets, including an over-representation of older people attending A&E due to alcohol.

Recorded levels of substance misuse are considerably higher in Tower Hamlets than the London average. There are thought to be around 3,850 problem drug users in Tower Hamlets, with around 1,460 in effective treatment[49].

The national minimum recommended level of physical activity for a healthy life is thirty minutes of moderate activity on at least five days per week. 68% of Tower Hamlets residents (aged 16 and over) fail to meet this recommended level and are considered physically inactive. There is very little

[46] Tower Hamlets Ipsos Mori Health and Lifestyle Survey, 2010.
[47] www.go-london.gov.uk
[48] Tower Hamlets Ipsos Mori Health and Lifestyle Survey, 2010.
[49] Tower Hamlets Adult Substance Misuse Needs Assessment, 2010/11 (Draft).

variation across LAPs. Only 10% of Tower Hamlets residents (aged 16 and over) meet the recommended consumption of five fruit or vegetables per day, compared to 30% nationally.

Health Conditions and Disabilities in the adult population

Disabilities

There are thought to be around 11,000 adults (aged 18-64 years) with moderate physical disabilities in Tower Hamlets, and a further 2,700 with severe physical disabilities. Approximately 1,650 adults (mainly people aged 65 and over) in Tower Hamlets are thought to have moderate or severe visual impairments and over 11,500 moderate, severe or profound hearing impairments. There are approximately 6,000 adults with learning disabilities, a small percentage of whom are known to health and social care services. More than 29,000 adults are expected to have a common mental disorder in Tower Hamlets, with around 1,880 adults expected to have autistic spectrum disorder[50].

Long Term Conditions

Analysis of observed prevalence against expected for long term conditions indicates levels of under-diagnosis for most conditions, but particularly hypertension, Coronary Heart Disease (CHD), Chronic Kidney Disease (CKD) and Chronic Obstructive Pulmonary Disease (COPD). In primary care, quality and outcome indicators are generally relatively good compared to London. Management of blood pressure and cholesterol in CHD and diabetic patients is generally well above the London average. Conversely, HbA1C, an indicator of diabetes control, has been in the bottom quadrant in London. In the 45-64 age band, Tower Hamlets has the highest modelled prevalence of CHD in London (8.1% compared to an England average of 5.7%).

There are an increasing number of complex patients with co-morbidities, particularly in the 65 years and over age group, and the distribution of these patients varies across the borough. The highest percentages of patients with mulitple comorbidities are based in LAPs 1, 6 and 7. Analysis shows that people with vascular conditions and diabetes are most likely to have co-mobidities.

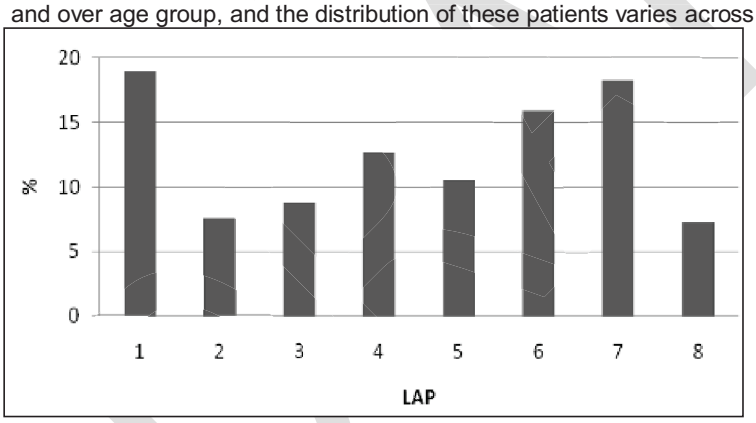


Figure 14 Percentage of patients in Tower Hamlets with two or more co-morbidities[51]

Prevalence of long term conditions varies across LAPs, with noticeably high prevalence for some conditions in LAPs 3, 4, 5 and 7. This is broadly consistent with where there are high proportions of the population aged 65 and over in the borough (particularly LAP 5)[52].

There are differences in observed prevalence of long term conditions across different ethnicities, age groups and genders in Tower Hamlets. Figures are available for the white and Bangladeshi population, and for the total population. Hypertension, depression and asthma are the most common conditions affecting the white population, whereas asthma, diabetes and hypertension are most common seen in the Bangladeshi population[53].

There are gender differentials in prevalence of long term conditions in Tower Hamlets. Male adults have higher prevalence of most conditions than females; in particular diabetes, Ischaemic Heart

[50] Projecting Adult Needs and Service Information System (PANSI), 2010. Prevalence rates have been applied to GLA population estimates for adults and will differ from figures quoted by PANSI, which are based on ONS population estimates.
[51] CEG Co-morbidities data extract, 2009.
[52] CEG SQUID Audit prevalence data (2008/09).
[53] CEG SQUID Audit prevalence data (2008/09).

Disease (IHD), stroke and asthma. Prevalence of depression, dementia, CKD and hypertension is higher in females however, with prevalence of depression substantially higher in females than males[54].

With improved treatment and outcomes, diseases such as HIV and cancer are increasingly becoming long term conditions. Survivorship issues can be a challenge, including physical, emotional, and financial hardships which can often persist for years after diagnosis and treatment.

Mental Health

Suicide is a high level indicator of mental health need in a population, and Tower Hamlets has the fourth highest rate in London. Schizophrenia prevalence is just under three times the national average, reflecting factors such as homelessness and substance misuse. Overall prevalence of dementia is lower than in London due to the younger population. However, 7% of over 65s are estimated to suffer from dementia and there is evidence of significant levels of under-reporting or under-diagnosis in primary care.

Carers

People with a long term condition or disability are often cared for by a family member or friend. There are thought to be around 21,000 carers in Tower Hamlets, of whom around 9,000 are providing 20 hours or more unpaid care per week, including around 6,000 people providing 50 hours or more unpaid care per week.

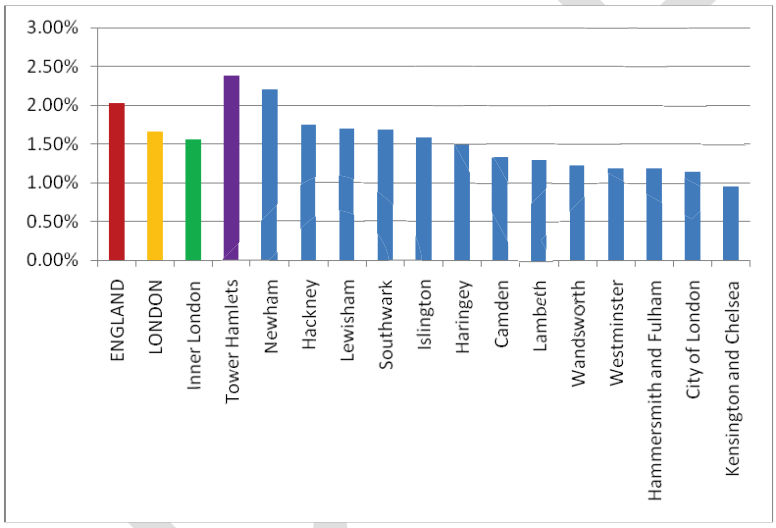


Figure 15 Percentage of the population providing 50 hours or more per week unpaid care[55]

A larger proportion of the population in Tower Hamlets provide 50 hours or more of unpaid care per week than in any other London borough, with substantial numbers of people providing 100 hours or more per week[56]. Around 3% of carers in Tower Hamlets are under the age of 18, which is higher than the national average (1.6%)[57].

Infectious Diseases

Tower Hamlets has the 8th highest rate of Sexually Transmitted Infections (STIs) per 100,000 population in the country (50% higher than the London rate). Gonorrhoea, Chlamydia and Genital Herpes diagnoses have risen, with higher numbers of new infections being seen in men compared with women. The number of STI diagnoses is disproportionately low in the Asian population and disproportionately high in the white, gay male population[58].

[54] CEG SQUID Audit prevalence data (2008/09).
[55] 2001 Census
[56] 2001 Census (applied to current population estimates).
[57] Tower Hamlets Young Carers Strategy, 2008-2011.
[58] Health Protection Weekly Report August 2010. Vol. 4 (34).

In 2009 there were over 1,000 people living with HIV in Tower Hamlets (3.9 per 1,000 population) – an increase of 34% since 2005[59]. Twenty three percent of HIV infections were diagnosed late in Tower Hamlets in 2009 compared to 31% in London.

Prevalence rates for tuberculosis have been slowly rising over the past few years and reached 65.3 cases per 100,000 population in 2009, significantly higher than the London average of 45.1 per 100,000.

Seasonal flu immunisation uptake is adequate in over 65s (76%) but lower in under 65s with long term conditions (55%) although this is above the national average (52%).

Older People: how many older people are there and what difficulties do they have?

There are thought to be around 18,000 people aged 65 and over living in Tower Hamlets (around 7% of the population)[60]. Although the largest numbers of older people live in LAP 1, LAP 5 has the largest proportion of its population aged 65 and over. There are thought to be over 5,500 people aged 65 and over living alone in Tower Hamlets in 2010, representing approximately 37% of the older population[61]. This varies geographically, from just 31.1% in LAP 8 to 40.2% in LAP 4.

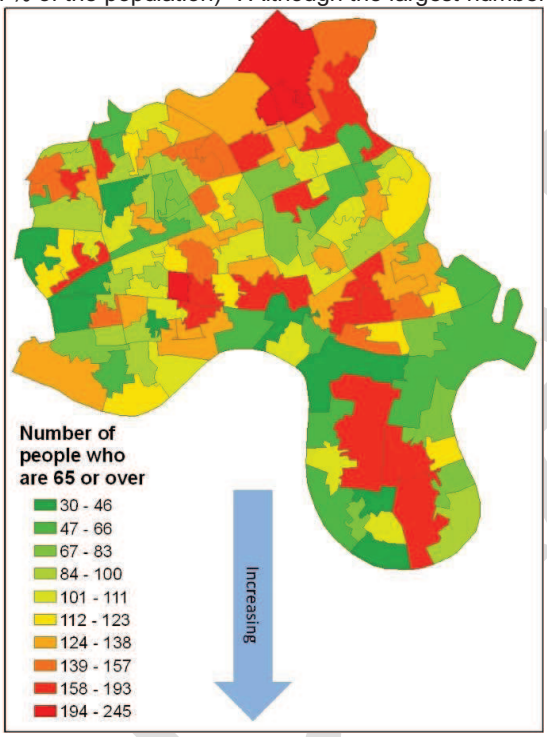


Figure 16 Number of people aged 65 and over living in Tower Hamlets, by Lower Super Output Area (LSOA)[62]

Around 9,500 people aged 65 and over are thought to have a limiting long term illness in Tower Hamlets. 1,500 people are thought to have moderate or severe visual impairment; 7,600 have a moderate or severe hearing impairment; 190 a profound hearing impairment; 50 people are thought to have a moderate or severe learning disability; 1,480 have depression; 470 have severe depression and 1,225 have dementia[63].

According to national estimates around 4,800 people aged 65 and over are expected to have a fall in Tower Hamlets (1,900 men and 2,900 women)[64]. Over 400 people aged 65 and over were admitted to hospital in Tower Hamlets in 2009 as a result of a fall[65].

A larger than average proportion of the older population are assessed as eligible (i.e. as having critical or substantial needs) for social services in Tower Hamlets, including homecare, residential care, day care and nursing services. Under 'Transforming Adult Social Care', these people are now eligible for Personal Budgets and may increasingly choose to meet their social care needs by purchasing a more diverse range of services. Twenty percent of the 65 and over population used

[59] Health Protection Agency, 2010.
[60] © GLA 2009 Round Population Projections.
[61] Mayhew Harper Associates, 2009.
[62] Mayhew Harper Associates, 2010.
[63] Projecting Older People Population Information System (POPPI), 2010.
[64] Projecting Older People Population Information System (POPPI), 2010.
[65] Hospital Episode Statistics.

social services in 2009/10, compared to 15% in London[66]. Around sixty percent of the Tower Hamlets population aged 85 and over use social services (over 1,400 people in 2009/10)[67].

The population aged 85 and over will steadily increase over the next 15 years, reaching almost 3,800 by 2025[68]. This is likely to contribute to an increase in the number of people using services for physical disability, sensory impairment, dementia and frailty (therefore potential increased demand for services, particularly home care).

Caring for People with a Terminal Illness

Around 1,140 Tower Hamlets residents will die per year. It is estimated that around 870 will need some form of palliative care. Although the majority of these people will be aged over 65, it is important to remember that terminal illness affects people of all ages, emphasising the importance of a personalised approach to end of life care. Based on national findings, most people, when asked, state a preference for dying at home. However, Tower Hamlets has a higher hospital death rate compared to national (68% compared to 58%) and a significantly lower home death rate (17% compared to 19%). The percentage of deaths in hospitals has been slowly falling with a corresponding increase in hospice deaths. The percentage of people who are dying at home has remained relatively static.

Local health & social services: demand for services

Elective (planned) hospital admission rates are lower than average across Inner North East London. In 2008/9, Tower Hamlets had the lowest rate of total elective admissions per 1,000 population (78.8) followed by Newham (93.1) and then City and Hackney (93.4). Rates in all localities were lower than the London rate of 102.6 (and the England rate of 109.3).

Mean length of stay of inpatient admissions is similar in Tower Hamlets (3.7 days) to the London average (3.4 days) and lower than Hackney or Newham.

Tower Hamlets has the lowest standardised rate of outpatient attendances in North East London and lower than London or England averages. Outpatient 'Did Not Attend' (DNA) rates are higher at Barts and the London (25.4%) than the London (18.4%) and England (14.2%) averages, meaning that a quarter of people do not attend their outpatient appointments at Barts and the London.

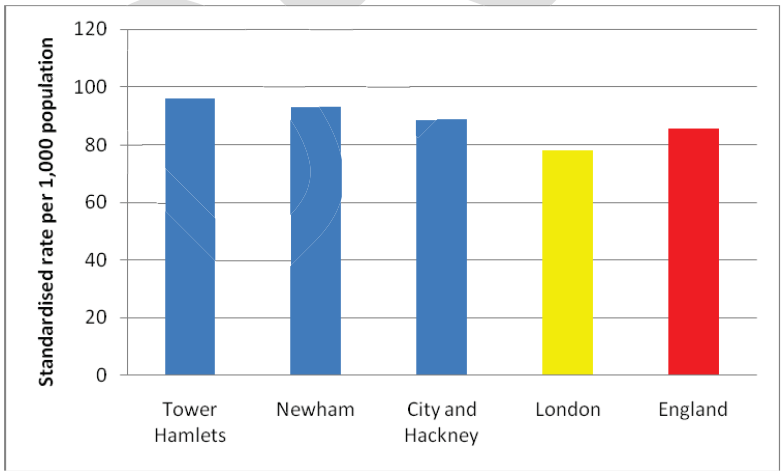


Figure 17 Standardised rates of emergency hospital admissions[69]

Accident and Emergency (A&E) attendance rates are higher in Tower Hamlets (347 per 1,000 population) than in London (306 per 1,000 population) though lower than in City and Hackney (414 per 1,000 population). These are higher particularly for heart attacks, stroke, falls, accidents and hip

[66] NHS Information Centre, NASCIS 2009/10
[67] AHWB SWIFT Data, 2009/10.
[68] © GLA 2009 Round Population Projections.
[69] NHS Comparators, 2009.

fractures. Tower Hamlets also has higher than average standardised rates of emergency admissions (95.8 per 1,000 population compared to a London average of 78.0 per 1,000). This suggests that the lower rates of planned admissions lead to a higher number of emergency admissions, and local analysis indicates a significant relationship between the ratio of elective to non-elective admissions and deprivation: the ratio of planned admissions to emergency admissions is substantially lower in high deprivation deciles.

In Tower Hamlets, 345 adults per 10,000 population used adult social services in 2009/10. This is the same as Newham but slightly higher than in Hackney (340 adults per 10,000). Use of adult social care is lower in Tower Hamlets and across Inner North East London than the London and England averages (350 per 10,000 and 415 per 10,000 respectively). Use of community based social care services is comparable with the London average (300 per 10,000 in Tower Hamlets and in London) but lower than the national average (360 per 10,000). These lower rates are likely to be explained by the younger than average age structure in London in general, and particularly in Tower Hamlets.

NHS Tower Hamlets is the biggest spender in the country on trauma services (per 100,000 unified weighted population) and 37th for maternity and reproductive health, but ranks relatively low on spending on cancers and tumours, problems of circulation and problems of the respiratory system. Spending on problems of the respiratory system decreased by over 10% from 2008/09 to 2009/10.

London Borough of Tower Hamlets spends one of the lowest proportions of its total budget on adult social care (excluding school funds) in London. In 2009/10 the Local Authority spent 24.0% of its total budget on adult social care, compared to a London average of 28.2%. London Borough of Tower Hamlets spends the lowest proportion of gross social care expenditure on residential and nursing care for older people out of all London boroughs. London Borough of Tower Hamlets also spends the second lowest proportion of gross social care expenditure on residential and nursing care for adults with learning disabilities of all London boroughs. This is likely to reflect the high proportion of people with learning disabilities in the borough who live with their families. For both older people and adults with learning disabilities, London Borough of Tower Hamlets spends a slightly higher than average proportion of gross social care expenditure on day care and home care services[70].

Key new findings

In 2009/10 there were **five in depth projects** conducted on areas identified as joint priorities for needs assessment. Key messages from each are outlined below.

- **Children with disabilities**
  - The number of children with complex disabilities, including learning disabilities, physical disabilities and sensory impairment in Tower Hamlets is increasing.
  - Children with complex conditions and co-morbidities are living longer.
  - Areas of unmet need include transport, access to continence services, assessment of children with Attention Deficit Hyperactivity Disorder (ADHD) and assessment of children with Autistic Spectrum Disorder.

- **Child and adolescent mental health**
  - There are estimated to be 3,600 children with a mental health condition in Tower Hamlets.
  - Prevalence of mental health conditions is higher in children from lone parent households, in social rented accommodation, and in areas of high deprivation. Prevalence is also associated with parental unemployment or lack of qualifications.
  - There are around 150 children looked after who are expected to have a mental health condition in Tower Hamlets.

[70] Use of Resources in Tower Hamlets, NASCIS, 2009.

- CAMHS teams in East London Foundation Trust have a caseload of around 620 children or young people from Tower Hamlets. Males represent 62% of the caseload. Bangladeshi children are thought to be under-represented in the CAMHS caseload (31%).
- Emotional disorders constitute the largest number of CAMHS diagnoses, compared to conduct disorders being most prevalent nationally.

- **Learning disabilities**
  - Around 1,000 people aged 14 and over are known to learning disability services in Tower Hamlets. Prevalence of learning disabilities is expected to be higher in Tower Hamlets than elsewhere due to high levels of social deprivation and a large Bangladeshi population. Research has shown that prevalence tends to be higher in South Asian populations in general and in migrant communities from developing countries, due to poorer anti-natal and neo-natal care or poor access to healthcare.
  - Prevalence is higher in males than females.
  - Female service users are more likely to live independently than males, while white service users are more likely to live out of borough (placed in residential settings) than Asian service users.
  - The learning disability population has higher rates of asthma, diabetes, depression, epilepsy and stroke than the general Tower Hamlets population. The rate of Severe Mental Illness is ten times higher in people with a learning disability in Tower Hamlets than in the general population.
  - People with learning disabilities are living longer, which will lead to an increasing prevalence above and beyond that due to population growth in the borough.

- **Carers**
  - Over 9,000 people provide 20 hours or more unpaid care per week in Tower Hamlets, and Tower Hamlets has the largest proportion of its population providing 50 hours or more unpaid care per week of all London boroughs. A larger proportion of the Asian population of Tower Hamlets provide unpaid care than any other ethnic group.
  - Around 1,500 people receive carers' assessments in Tower Hamlets each year.
  - The JSNA found evidence of poor recording of carers on GP registers, and generally there is a lack of information about the most vulnerable carers in the borough (such as older carers, people with learning disabilities who care for family members, and people caring for more than one person).
  - There is poor public knowledge of carers' assessments and services available for carers and the people they care for. Specifically, there should be a focus on the mental health of carers at assessment or review, or during carer health checks.
  - Carers must be involved and their own needs considered during any changes made to the social care package of the person they care for. Carers in Tower Hamlets particularly value One-Off Direct Payments and home based respite.

- **Older people and mental health**
  - There are over 2,000 people aged 65 and over on GP registers with depression in Tower Hamlets; around 415 are diagnosed with dementia and around 215 with Severe Mental Illness. These figures are lower than expected, but particularly for dementia.
  - Older people account for 9% of suicides in Tower Hamlets.
  - 33% of older people who use social services have suspected or diagnosed mental health conditions.
  - There is a lack of awareness about depression and dementia in older people amongst the general public and within health and social care services.
  - There is a lack of appropriate services for younger people with dementia.

Research on local deprivation and health inequalities

An extensive piece of work has been undertaken to examine inequalities within the borough, and the relationship between deprivation (the borough has been split into deprivation deciles), wider determinants of health (such as social housing), and the use (and associated cost) of secondary health care.

The gap in life expectancy between the least and most deprived deciles is 11.2 years in males and 6.5 years in females. In the five more deprived deciles, more than half the population receives means tested benefits, and more than half live in social tenure. In the six more deprived deciles around 10% of households are single parent households.

This work has highlighted that the secondary care costs (for instance the costs of a stay in hospital) of those living in the most deprived areas in Tower Hamlets are almost twice those living in the least deprived (£227 per head compared to £117 per head). Furthermore, the ratio between planned and emergency admissions is around three times higher in the least deprived areas compared to the most deprived. This suggests that that those living in the least deprived areas of the borough have good access to appropriate planned care, where as those in the most deprived do not have such good access and need to rely more heavily on emergency care, and often at a later stage which is likely to be worse for health outcomes and is also more costly.

The analysis has identified the importance of understanding health inequalities at small geographical area levels (e.g. lower super output area) to inform locality and LAP level clinical commissioning as well as service integration at a very local level (e.g. estate, neighbourhood). Further work is now underway to profile deprivation, demographics, wider determinants of health and use of health and social services by Super Output Area, to explore variation within LAPs.

5. Community Perspectives

Adults Health and Wellbeing, Children, Schools and Families, NHS Tower Hamlets and Tower Hamlets Involvement Network (THINk) have collected a wealth of customer feedback on a range of topics, including maternity, heart failure, learning disabilities, carers, dementia and social care in general.

The key messages are that:

- Ill health, the pressures of being a carer and difficulty in speaking English can all create barriers to people being able to navigate what is perceived as a complicated social care system.
- Clear information available at an early stage enables fairer access to services.
- Transport facilitates community participation, which in turn reduces social isolation.
- A lack of appropriate services can create social isolation, which in turn can contribute to ill health.
- Overcrowded and low-quality housing can contribute to ill health and anti-social behaviour.

- **Key issues regarding quality of life included:**
  - Overcrowding and inappropriate design of homes is an area of concern.
  - Concerns about personal safety can be addresses through telecare, increased security and anti-drugs campaigns.
  - Relationships and having a social life are felt to be important and services that facilitate this should be maintained or extended (especially for carers and older people).
  - Awareness of services available for carers is low.
  - Increased and more flexible Dial-a-ride services is recommended.
  - Young people with disabilities reported difficulties accessing public transport, and would 'like to get out more'.
  - Adults with physical disabilities would like more opportunities for leisure activities.

- **Key issues regarding healthy lifestyles included:**
  - Perceived competency and self-efficacy, inaccessible services, a dislike of sport, negative peer influences, time constraints and having other priorities are key barriers to participation in physical activity for young people in Tower Hamlets.
  - Young women felt that looks were a more important factor than health in adopting healthy lifestyles.
  - Peers and parents are most influential in encouraging children and young people to adopt healthy lifestyles.
  - Young people with disabilities expressed a strong interest in sporting activities although some said that travel implications prevented them from attending after-school clubs, particularly where they were dependent on Transport Services to get home.
  - Tobacco is often used to 'self-medicate' for stress and depression by people with COPD or mental health conditions and by routine and manual workers in Tower Hamlets.
  - Boredom, emotional factors, fear of withdrawal symptoms and influence of friends are considered major factors in smoking by people with mental health conditions.
  - Routine and manual construction workers identified habit and routine, opportunity (working outside) and social benefits as additional major factors in their smoking.
  - Health and family were felt to be the biggest motivating factors to stop smoking.
  - Escapism, pushing the limits, social function, to overcome boredom and have fun, and peer pressure were identified as primary reasons for alcohol consumption in young people. Drinking is also associated with sexual activity, and cost influences choice of drink.
  - Key factors in alcohol consumption in the older population were identified as boredom, loneliness, negative life events, socialising, tradition.
  - Bangladeshi women who chew paan reported mistrust of information about the dangers of paan,
  - Reasons for chewing paan were identified as pain relief, cultural expectation, availability and social isolation.
  - Healthy lifestyles promotion (particularly healthy eating) is a priority for residents
  - Residents would like increased public knowledge through campaigns and education
  - Healthy lifestyles can be promoted informally through socialising and good services

- To carry out these campaigns effectively, a trusted source of information (NHS) is needed along with a simple approach, a commitment to address taboo topics, and an inclusion of case studies and information on what people can do for themselves to prevent, identify and manage their health

- **Key issues regarding long term conditions included:**
  - White men aged 30-50 have fatalistic attitudes towards health (in particular cardiovascular disease) and are reluctant to trust or 'burden' GPs with health concerns.
  - People with COPD have low awareness and expectations of stop smoking and support services.
  - Young people with disabilities express the importance of having someone outside of their family to talk to about their difficulties.
  - The GP Survey highlighted that local services and organisations do not provide enough support to help with the management of long term conditions for around a quarter of patients in Tower Hamlets
  - Staff knowledge, skills and attitude have all been raised as issues for people across health services (especially in relation to dementia, learning disabilities and people who speak English as a second language)

- **Key issues regarding mental health included:**
  - Stigma around mental health conditions reduces willingness to access services.
  - Poor identification of dementia by GPs.
  - Addressing overcrowding and substance misuse can reduce mental ill health.
  - Social isolation and unsuitable services are felt to contribute to mental ill health.
  - Improved access to talking therapies and taking a holistic approach to mental health are priorities for residents.

- **Key issues regarding support at home included:**
  - Professionals sometimes appear rushed and spend less time with people than they are supposed to
  - Improved training for homecare staff on key issues (such as dementia) is a priority
  - Communication barriers and providing a low quality service (particularly raised in relation to agency staff) have been highlighted as issues for some customers
  - Carers express a preference for home based respite
  - Having continuity of homecare staff is important for customers
  - Having a system where people know who to contact if problems arise and having a monitoring system that people can trust to pick up on any issues are felt to be important aspects of good quality homecare
  - Social care staff are good at setting up and clearly demonstrating equipment to users
  - Satisfaction rates and the amount of people who said the equipment made their lives much better is slightly lower than the national average
  - Telecare is viewed positively and should be promoted more

- **Key issues regarding partnership working included:**
  - The need for health and social care professionals to work more effectively in partnership with each other and with other services has been highlighted as an issue
  - There is a preference for a single smooth pathway, with accessible information in place to support access to the pathway.
  - A lack of information about pathways can be stressful

- **Key issues regarding information and advice included:**
  - People outside the health and social care system don't know about it, and people "in the system" aren't always informed of new opportunities or changes
  - Having a single and accessible "one stop shop" with an outreach function to proactively communicate change would help with this
  - There is an issue with staff returning phone calls and responding to queries and questions
  - A need for more housing advice and support for people with learning disabilities

- There is some anxiety and confusion about personal budgets for adult social care
- Health and housing are highlighted as particular areas where people need advocacy services. Also needed for complaints, money and to navigate the system to get the right services

- **Key issues regarding health services included:**
  - Lack of GP awareness of carers
  - Language barriers to accessing health services for non-English speaking residents
  - Need to reduce drug and alcohol misuse and cheap unhealthy food
  - Issues around accessibility, consultation time and continuity of staff at GP surgeries
  - Issues around food and cleanliness at hospitals
  - Issues in dental care, including training, privatisation, and problems for people with support needs queuing for emergency treatment

How messages from consultation have been used

- Focus groups with people with learning disabilities and a survey of health and social care professionals have been used to inform the learning disabilities JSNA project, which supports the work plan of the Learning Disability Partnership Board to highlight the importance of focusing on employment, carers and feeling safe.
- Feedback from the Six Lives Panel resulted in the development of the Health Sub Group of the Learning Disabilities Partnership Board, which has been implementing an action plan to address health inequalities for people with learning disabilities in Tower Hamlets.
- Discovery interviews exploring people's experience of maternity services have been used to improve services at Barts and the London through work on staff attitude, communication and redesigning the provision of inpatient antenatal care.
- The results of discovery interviews with patients that had recently had a myocardial infarction (heart attack) were shared with all relevant care teams to raise awareness of patient anxiety and there has been a review of the information provided to patients prior to discharge. The work also provided support to ongoing changes to the cardiac rehabilitation programme, including the provision of rehab at home and counselling as part of the programme.
- Discovery interviews relating to access of A&E highlighted that patients reported positively about their experiences of the new streaming service, and commented that their perceptions of quality have improved. The interviews indicate that further improvements might be made by expanding the role of streaming and simplifying access points to urgent care.
- Feedback from carer forums and a Department of Health Carer Survey was used to inform the carers JSNA, which supports the work of the Carers' Strategy Implementation Group to highlight the importance of focusing on health, respite, information and advice and respect from health and social care professionals.
- Consultation with older people, people with dementia and carers was used to inform the development of a Dementia Strategy for Tower Hamlets, with a focus on awareness raising (both in the community and amongst health and social care professionals), early intervention, carer support and a clear pathway through services. This strategy is being implemented between 2010–2013.

6. Recommendations/Commissioning Priorities

Evidence from Factors Influencing Health and Wellbeing

Recommendation	Evidence
Success of community plan fundamental to improving health and wellbeing.	Evidence of the impact of wider (social) determinants on health and wellbeing is well documented.
Continued integration of benefits, unemployment, health and wellbeing services and health promotion services.	18% of working population are on benefits and this group has the highest health need. 14.5% of the Tower Hamlets population are unemployed, the highest rate in London.
Awareness of impacts of economic climate, including worklessness, on health and wellbeing.	Evidence base indicates mental health, alcohol problems, homelessness, impacts on carers and families.
Support for wider focus on improving quality housing options for health and wellbeing.	Evidence of high levels of overcrowding, poor housing design impacting on the health and wellbeing of all groups.
Continue to prioritise support for carers.	Evidence of largest % of population providing 50+ hrs unpaid care in London. The health and wellbeing of this group is poorer than average, and meeting the needs of many vulnerable people depends on the carers' ability to continue to care.
New residents to be targeted for health messages and GP registration.	Population churn within Tower Hamlets is 24% (the 11th highest in London) providing opportunity to target a notoriously hard-to-reach population.

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Evidence from Indicators of Health and Wellbeing

Recommendation	Evidence
Maintained focus on Cardio-Vascular Disease.	Tower Hamlets has the 2nd highest mortality rate in London.
Intensified focus on cancer.	Tower Hamlets has the highest mortality rate in London.. Cancer screening uptake is lower than national averages. Late diagnosis contributes to poor survival.
Maintained focus on Chronic Respiratory Disease	Tower Hamlets has the highest mortality rate in London
Maintained focus on integration of health services.	There are an increasing number of complex patients with co-morbidities, particularly in the 65 years and over age group.
Development of preventative approaches to support hospital discharge and prevent emergency admissions.	A&E attendance is higher than average in Tower Hamlets, with a lower rate of planned admissions than other London boroughs.
Exploration of further targeting of white population.	Mortality rates are higher than average in the white population.
Embedding of equality impact assessment to ensure programmes are not widening health and wellbeing inequalities.	There are already inequalities within the Tower Hamlets population, in prevalence of disease, life expectancy and mortality, and uptake of services.

Support for healthy, active lifestyles among all population groups, particularly those most affected by deprivation.	Healthy lifestyles are key in preventing long term conditions, improving wellbeing, and reducing the impacts of poor mobility in older people.
Move away from one-size fits all model of care to more tailored models of health service provision. Need should be considered in terms of differences due to gender and differences due to socio-economic status.	Considerable internal health inequalities exist in Tower Hamlets. Male life expectancy ranges from 72.5-80.4 years, and female life expectancy varies from 77.9-89.2 years. The life expectancy gap between men and women is 5 years. Proportional universalism is a concept which promotes intervention for all at a level that is proportionate to their need.
Maintain focus on early years support to most vulnerable families	Ascertainment of children subject to a child protection has improved but numbers are high.
Improve management of long term conditions in children in the community.	The number of children with complex disabilities is increasing and children with complex conditions and comorbidities are living longer. Management in the community could prevent emergency admissions and reduce longer than average stays in hospital.

Evidence from Service Data

Recommendation	Evidence
Targeting under-diagnosis and poor recording of long term conditions in primary care.	Numbers recorded are less than expected for hypertension, chronic kidney disease, heart failure, chronic obstructive pulmonary disease, and mental health conditions, including dementia.
Continued focus on community perspectives in shaping health and social care services.	Good progress has been made, but use of community perspectives needs to be more systematic.
Refocusing social marketing and development of a strategic approach to behavioural change.	There is evidence of the benefits of social marketing approaches in encouraging healthy behaviours and appropriate use of services.
Having an ambitious approach across all priority areas.	It is important to build on the success of immunisation in improving the health and wellbeing of the population.
Raising awareness among GPs and other health workers about the needs of people with dementia, learning disabilities, carers, and other vulnerable groups.	These groups have particular needs and there is evidence of poor access to health services, particularly for people with learning disabilities.
Continued development of whole-system approaches that promote independence and reduce social isolation.	This is emphasised by service user perspectives
Health services that are delivered at LAP level need to take into account the population size of each LAP to ensure they are resourced appropriately	In 2011 LAP populations ranged from 22,660 to 43,310 and it would be inappropriate to resource them to the same degree therefore. Projections indicated that these discrepancies will still exist in five years time.

7. What we are doing next – How the JSNA has been used, and next steps

- The JSNA has been used to inform the development of health and social care services, and how resources are prioritised; for example, it underpins the PCT's Commissioning Strategy Plans which have been produced annually until this year, and provides the evidence base which has underpinned recent improvements in dementia service provision in the borough.
- The JSNA aims to support partnerships with other agencies, to inform wider work across the borough to improve the social and spatial environment, and provides the evidence which is required to attract funding from central Government and other funders to support local needs.
- The JSNA also helps to enable the public and other stakeholders to hold health and social care commissioners to account for their decisions.[71]
- Consultation with commissioners across NHS Tower Hamlets, Children, Schools and Families and Adults Health and Wellbeing has led to a number of suggested improvements to the JSNA, including:
    - Development of factsheets
    - Better use of maps
    - Better availability and accessibility of data and key headlines
    - A more localised focus on need: examining the health and wellbeing of LAPs within Tower Hamlets as well as smaller areas where possible.
- The use of public perspectives can always be improved. It will be increasingly important to make effective use of consultations and surveys across the Partnership now that the Place Survey no longer exists.
- It is important, as the JSNA process develops and improves, that the findings are communicated more widely across the borough and beyond health and social care services, in order to inform policy and practice with regard to the wider determinants of health which are so significant – such as crime, education, unemployment, access to green spaces and other key issues.
- Continued improvement of JSNA research and analysis will be critical to the successful implementation of the Public Health White Paper, 'Health Lives, Healthy People: Our strategy for public health in England', in the Borough. The new Health and Wellbeing Board will develop joint Health and Wellbeing Strategies based on the assessment of need outlined in the Joint Strategic Need Assessment, highlighting the key role which the JSNA will play in these new arrangements.

- [71] The JSNA has been used to inform the work of various strategic groups, including:
    - Learning Disability Partnership Board
    - Health sub group of the Learning Disability Partnership Board
    - Carers Strategy Implementation Group
    - Autism Strategy Steering Group
    - Dementia Strategy
    - THINk
- The JSNA has also been used to inform various strategies and key documents in health and social care:
    - Commissioning Strategy Plan of NHS Tower Hamlets
    - Adults Health and Wellbeing Promoting Independence Strategy
    - Adults Health and Wellbeing Market Development Strategy
    - Commissioning Strategy for People with Dementia and their Carers
    - Annual Public Health Report
    - Transforming Adult Social Care workstreams

8. How to find out more

The JSNA will be available to all interested parties via an online interface:
http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx

This website will include a 'feedback' function in the future, enabling users to let the JSNA Programme Team know what was and was not useful about the website, make suggestions for future priorities for analysis, or alert the JSNA Programme Team to new pieces of research or sources of data which could be incorporated into the JSNA, or at least to which a link could be provided.

JSNA Programme Team members will undertake a programme of targeted visits to meet with key 'customer' groups, such as health and social care commissioners (including GPs), provider forums, and the THINk (Tower Hamlets Involvement Network, soon to become 'Healthwatch') Steering Group.

How you can get involved:

- Provide feedback on issues and priorities which we may have missed
- Volunteer to undertake 'discovery interviews' with people about their experience of services
- Work with Healthwatch, or with other local patient or service user involvement groups, using JSNA data and analysis to identify gaps or priorities in service provision in your own locality

For further information:

- Email questions or comments to: JSNA@towerhamlets.gov.uk
- Access all available factsheets and JSNA documents on our website:
  - http://www.towerhamlets.gov.uk/lgsl/701-750/732_jsna.aspx
- Find out more about Tower Hamlets Involvement Network to influence or change the way local NHS and social care services are delivered:
  - http://www.thinknetwork.org.uk/about/
  - **020 8223 8922**

Appendix 1: Abbreviations used in the JSNA Summary Document

A&E	Accident & Emergency
AACM	All Age All Cause Mortality (i.e. overall mortality)
ADHD	Attention Deficit Hyperactivity Disorder
AHWB	Adult Health & Wellbeing directorate of the local authority
BME	Black & Minority Ethnic
CAMHS	Child & Adolescent Mental Health Services
CEG	Clinical Effectiveness Group, Queen Mary, University of London
CEG SQUID	CEG's Sharing QUality In Data project
CLG	Government Department for Communities and Local Government
COPD	Chronic Obstructive Pulmonary Disease
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
CVD	Cardiovascular Disease (e.g. coronary heart disease, stroke etc)
CYP	Children & Young People
DMAG	GLA Data Management and Analysis Group
DNA	The number or rate of those who 'Did Not Attend' an appointment
DSR	Directly Age Standardised Rates (often used for mortality and morbidity figures)
ELCA	East London and the City Alliance
GLA	Greater London Authority
GP	General Practitioner (local primary care doctors)
HIU	Health Intelligence Unit
IHD	Ischaemic Heart Disease
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LAP	Local Area Partnership (8 of these geographic administrative areas in Tower Hamlets)
LBTH	London Borough of Tower Hamlets
MMR	Measles, Mumps & Rubella immunisation
NASCIS	National Adult Social Care Intelligence Service
NHS	National Health Service
ONS	Office for National Statistics
PANSI	Projecting Adult Needs and Service Information System
PCT	NHS Primary Care Trust
POPPI	Projecting Older People Population Information System
PPCG	'Planning for Population Change & Growth' (a local Tower Hamlets population model)
STI	Sexually Transmitted Infections
THINk	Tower Hamlets Local Involvement Network

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Adult Carers: Factsheet

Tower Hamlets Joint Strategic Needs Assessment 2010-2011

Executive Summary

A higher proportion of the Tower Hamlets population (1.32%) provides 20 -49 hours unpaid care per week to a family member, partner or friend than the London (1.01%) or England average (1.08%). The proportion providing 50 hours or more per week in Tower Hamlets is the highest in London (2.38% in Tower Hamlets compared to 1.66% in London and 2.03% in England). Nationally, carers have worse general health than the general population. In Tower Hamlets carers have worse general health than the national carers' average.

The Carers Strategy Implementation Group is a multi agency group that oversees implementation of the Carers Strategy in Tower Hamlets. Current priorities of the group include:

- Development of marketing plan to increase awareness of the support available to carers in Tower Hamlets, leading to greater uptake of services.
- Increased provision of training related to carers' assessments, including promotion of annual health checks.
- Commissioning of Dementia Advisor service as part of the Dementia Awareness Raising Strategy.
- Protocol for carer support during transition period of the person they care for (ages 15-25).
- Monitoring the completeness of Carers Registers in Primary Care through quarterly reports by GP Practices.
- Review of current breaks available for carers, with a view to increasing flexibility and use of carer one off direct payments.
- The interests of carers to be included in the updated Reablement Service Operational Policy.
- Partnership working with Job Centre Plus and Carers Centre to engage carers re Employment training programmes.

1. What is a carer?

A carer is defined as someone who spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems[1].

Within this group there is substantial variability. The carer-cared for relationship can be adult to adult, parent to child (young or adult) or young carers caring for others. Those cared for might be relatives, friends, or neighbours. The reasons someone might require care include frailty (older people), learning disabilities, physical disabilities, serious illness, mental health conditions, and substance abuse, or a combination of reasons. This variability results in complex and diverse carer needs. Some of the types of support that someone might need from a carer include:

- Moving around the house
- Washing and dressing
- Eating and preparing meals
- Shopping for groceries
- Making telephone calls or filling in forms
- Managing money, such as paying bills
- Taking medicines
- Attending appointments
- Work around the house or garden

[1] Department of Health (2008) Carers at the heart of 21st Century families and communities: "A caring system on your side. A life of your own".

- Having someone to talk to

Some people may need 24 hour care and cannot be left alone; others may require a daily reminder to take medicine, and a weekly food shop; others might be very independent, but need emotional support during times of crisis.

It is also important to consider the exacerbation of difficulties faced by carers for those who are engaged in complex multiple caring roles, caring for more than one person or caring for people with more than one condition or need.

Nationally, approximately **one in ten people is a carer**[2]. The number of people taking on a caring role is rising all the time, as more people live longer or develop long term conditions, and simultaneously aspire to maintain independence and control over their lives. The caring relationship is most frequently established within the family, often creating complex interdependencies across generations.

"It is estimated that there are more than 6 million adult carers in the UK providing unpaid care to the value of £87 billion. In 2006-7 the total cost of the entire National Health Service was £82 billion. Total spending on Social Services in 2005-6 was £19.3 billion thus demonstrating the huge contribution that unpaid carers contribute to the social care system of the UK"[3].

2. What is the local picture?

There are around 21,000 unpaid carers in Tower Hamlets in 2010, of whom at least 5,800 provide 50 hours or more of unpaid care per week. A higher proportion of the Tower Hamlets population (1.32%) provides 20 -49 hours unpaid care per week to a family member, partner or friend than the London (1.01%) or England average (1.08%). The proportion providing 50 hours or more per week in Tower Hamlets is the highest in London (2.38% in Tower Hamlets compared to 1.66% in London and 2.03% in England)[4].

- 63% of carers (providing 20 hours or more unpaid care per week) in Tower Hamlets are female.
- 18% of carers are of pensionable age.
- 3% of carers are under the age of 16.
- 44% of carers are Bangladeshi[5].
- 41% are white British.

The gender discrepancy is largest in the working age group, where 64% of carers are female. In the younger carer group 52% are female.

In the young carer group 64% of carers are Bangladeshi (almost 80% for female young carers) and just 18% white British. This varies across older age groups; 49% of working age carers are Bangladeshi and less than 16% of older carers are Bangladeshi. The Asian population is disproportionately represented as carers (compared to the general Tower Hamlets population) in the working age group in particular.

A survey of carers in Tower Hamlets found that health problems are commonly reported. Around two thirds of carers surveyed reported experiencing tiredness or disturbed sleep. Around one third of carers reported feelings of stress, depression and physical strain[6]. Carers in Tower Hamlets have worse general health than carers

[2] National Statistics (based on 2001 Census).
[3] Valuing Care, Carers UK & University of Leeds, 2007- from www.carerscentretowerhamlets.org.uk.
[4] 2001 Census percentages applied to current GLA population estimates.
[5] This is based on 2001 Census data and may have changed substantially since then.
[6] Tower Hamlets Carers Survey, NHS Information Centre, 2010.

surveyed nationally and than the general Tower Hamlets population. Forty one percent of carers surveyed reported their general health to be good or very good (49% England average[7]), compared to 77% of the Tower Hamlets population as a whole[8].

Carers in Tower Hamlets experience more financial difficulties as a result of caring than the national average. Fifty one percent of carers surveyed in Tower Hamlets reported some or a lot of financial difficulties, compared to 40% surveyed in England as a whole.

Seventeen percent of carers surveyed in Tower Hamlets reported their quality of life to be 'bad or worse', which is similar to the national average for carers. Eighteen percent of carers in Tower Hamlets reported not having time to do 'anything they value or enjoy' compared to 13% nationally.

Around 7% of carers surveyed look after more than one person, both in Tower Hamlets and nationally. However, carers in Tower Hamlets are more likely to live with the person they care for (84% in Tower Hamlets, compared to 73% England average). This is likely to result in a more time intensive caring role, which may explain the higher than average proportion of the Tower Hamlets population providing 20 hours or more care per week. Fifty one percent of carers surveyed in Tower Hamlets reported spending 100 hours or more per week caring, compared to 37% of carers nationally.

Carers in Tower Hamlets report feeling less supported by services than average. Only 76% of carers in Tower Hamlets report feeling 'always or usually' supported by their GP, compared to 81% nationally. Seventy five percent of carers in Tower Hamlets report feeling 'always or usually' involved in hospital discussions about the person they care for, compared to 82% nationally.

3. What are the effective interventions?

The national carers' strategy, *Carers at the heart of 21st Century Families and Communities* (2008)[9] was refreshed in 2010. *Recognised, Valued and Supported: next steps for the Carers' Strategy*[10] identifies six key priorities for supporting carers:

Identification and Recognition

Carers should be encouraged to identify themselves as carers at an early stage, facilitating access to information and advice. In November 2010, the Department of Health awarded almost £2 million in grants to Carers UK, Crossroads Care, The Princess Royal Trust for Carers, Partners in Policymaking, The Afiya Trust and The Children's Society to support their work with carers. In addition, it has launched the Reaching out to Carers Innovation Fund to encourage patient-led and condition-specific voluntary organisations to focus more on how they can support carers.

Health and social care professionals must recognise the value of carers' contributions and must involve them in the design of local services as well as in planning individual care packages. Carers should be routinely involved in the Joint Strategic Needs Assessment.

Realising and Releasing Potential

Young and adult carers should be enabled to fulfill their educational potential. Aspirations for education,

[7] 2009-10 Personal Social Services User Experience Survey of Carers. Copyright © 2010, The Health and Social Care Information Centre. All Rights Reserved.

[8] Tower Hamlets Carers Survey, NHS Information Centre, 2010 and Tower Hamlets Health and Lifestyle Survey, 2010.

[9] Department of Health (2008) Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own.

[10] Department of Health (2010) Recognised, valued and supported: next steps for the Carers Strategy.

training, work and leisure should be taken into account when assessing a carer's needs. Carers should also be enabled to fulfill their employment potential, which requires employers and colleagues to be understanding and flexible.

A life outside of Caring

Carers should be enabled to have a family and community life though personalized support for both themselves and the people they care for. No assumptions should be made about a carer's ability and willingness to care. As outlined in the *Vision for Adult Social Care*, personal budgets will be the norm, but carers should not have to manage financial arrangements or procure their own services unless they wish to – an anxiety particularly among older carers. ADASS and the Princess Royal trust for Carers have developed a carers support pathway and a self assessment audit tool: *Commissioning better outcomes for carers – and knowing if you have.*

Supporting Carers to stay Healthy

Studies show that people providing high levels of care are twice as likely to have poor health as those without caring responsibilities. Supporting carers is a key element of the prevention and public health agendas, as evidenced in the Public Health White Paper Healthy Lives, Healthy People (2010). Breaks are extremely important for maintaining good health, but mainstream provision tends to be still one-size-fits-all; the majority of carers who have experienced a good break have organised this themselves through direct payments.

Developing an Evidence base for Supporting Carers

Further evidence is required on the impact and effectiveness of carer specific services and interventions, in terms of outcomes such as carers being informed, having a break, accessing emotional support, maintaining their own health, and having a voice.

Supporting Local Delivery, Transparency and Local Accountability

Carers should be involved and able to contribute their knowledge and expertise to the Joint Strategic Needs Assessment (JSNA) and service planning. "Co-production with carers should be integral to the delivery of all care services"[11].

The Carers Equal Opportunities Act (2004) places a duty on social services departments to inform carers of their right to an assessment. The purpose of the assessment is to determine what types of support a carer may need to continue providing care, but should also include a discussion on any effects caring is having on the carer's health, relationships, ability to go out, as well as whether the person they care for is receiving enough support, whether the carer wishes to start paid work or continue to work, their wish for further education and their wish to engage in leisure pursuits.

4. What is being done locally to address this issue?

Approximately 9% of all people identifying themselves as a carer in Tower Hamlets (1,870 carers) received an assessment or review in 2009/10 (100 per 10,000 adult population; figures are not available for London, but were 75 per 10,000 population in London in 2008/09). The majority of these carers were aged 18-64 years, with 170 people aged 75 and over receiving carers' assessments or reviews. Fifty four percent of carers assessed in 2009/10 were caring for someone aged 65 or over, the majority of whom had either a physical disability or mental health condition. Most people who were caring for someone aged 18-64 were caring for someone with a mental health condition or physical disability, with a substantial minority having a learning disability.

One off direct payments for carers are available for people to spend in the way that is most useful for their individual situations. The majority of one off direct payments in Tower Hamlets are spent on washing machines, short breaks, computers, kitchen appliances, beds, home improvements and cars/ driving lessons.

[11] Cross Government Publication (2010) Recognised, Valued and Supported: next steps for the Carers' Strategy, p.35.

Carers' Allowance is available to those over the age of 16 who provide 35 hours or more care per week for someone who receives Attendance Allowance, Disability Living Allowance, or Constant Attendance Allowance. Those carers in full time education or earning over £100 per week are not entitled to the benefit. The amount received is not adjusted to take into account multiple caring responsibilities (i.e. caring for more than one person). Almost 3,000 people in Tower Hamlets receive Carers' Allowance[12]. It is not possible to estimate the number of people eligible who are not claiming Carers' Allowance.

A list of support services currently commissioned by London Borough of Tower Hamlets and NHS Tower Hamlets can be found at the end of this factsheet. It is planned to review services during 2011/12.

5. What evidence is there that we are making a difference?

The number of carers receiving carers' assessments or reviews in Tower Hamlets has increased from 945 in 2006/07 to 1,870 in 2009/10. As a rate, this represents an increase from 55 assessments or reviews per 10,000 adult population to 100 assessments or reviews per 10,000 adult population in 2009/10. This compares favourably to the London average of 75 assessments or reviews per 10,000 adult population (in 2008/09).

6. What is the perspective of the public on support available to them?

From forums or focus groups at the Carers Centre, St Hilda's and Alzheimer's Society, as well as a user experience survey sent to carers who received assessments or reviews in the past 12 months, the following issues were identified as important to carers locally:

- Respite (especially at the weekend when there is no day services provision)
- Time
- Awareness of services
- Respect
- Financial difficulties
- Control
- Social isolation
- Health issues (including stress)

Carers in Tower Hamlets highlight feeling a lack of respect shown towards them by services, demonstrated by the huge financial discrepancy between what professionals are paid to provide sitting services for the cared for, and the money carers receive for providing the same or greater level of care. Carers receive the equivalent of £1.50 per hour from Carers Allowance (£53.10 per week). They feel that this does not adequately reflect the extremely difficult job they do ('Undervalued, Underpaid, Overworked'), or the fact that they save the government a lot of money.

It is felt that the money professionals are paid to provide sitting services would be more effectively spent if flexibility was allowed to enable friends and family (other than the primary carer) to provide paid respite. This would allow minimum disruption for the cared-for, good continuity and trust in the quality of care provided, thus minimising the stress involved for the carer.

Carers often report being unaware of what respite services are available in the borough. Amongst those who do know of services, it is felt that there are not enough respite services, especially at the weekend when the person they care for does not attend school or day services[13].

Carers sometimes find the aftermath of respite chaotic and struggle to regain the previous routine for the person

[12] https://www.nomisweb.co.uk, 2009/10.
[13] St Hilda's Carer Focus Group November 2009.

they care for. Anecdotally there is widespread demand for home based respite in which the individual is able to remain in familiar surroundings.

"*I spent a week away and came back to so many issues, had to spend at least six weeks to resettle my dad in again, he was confused and short tempered*"[14].

The issue of time is central to carers' concerns: a lot of the time carers are invited to attend meetings, forums, user groups etc, and even if they want to go they are not able to because of time constraints[15].

Carers frequently report experiencing difficulty preparing for the transition of the person they care for from children's to adults' services. It is essential that the carer is adequately involved in the care planning for the person they care for, as specified in national guidance[16].

The Carers Centre was described as invaluable and having saved a lot of carers from 'going under', and carers feel that the Centre should be advertised more.

"*If you don't know about what's available, it's impossible to find out. No-one is putting information out there. It feels like a secret society. The services should advertise themselves more*"[17].

7. What more do we need to know?

GPs should hold more accurate registers of carers at each practice to enable better geographical targeting of services and information according to where carers live within the borough. This would also allow comparison of the health status of carers with the non-carer population, to evidence the effect of the caring role on health and wellbeing.

The 2011 Census should provide up to date data on the number of people providing unpaid care, the weekly hours they provide, and their characteristics. This information is unlikely to be available before 2013.

8. What are the priorities for improvement over the next 5 years?

Priorities highlighted in the 2010/11 work plan of the Carers' Strategy Implementation Group include:

- Development of marketing plan to increase awareness of the support available to carers in Tower Hamlets, leading to greater uptake of services.
- Increased provision of training related to carers' assessments, including promotion of annual health checks.
- Commissioning of Dementia Advisor service as part of the Dementia Awareness Raising Strategy.
- Protocol for carer support during transition period of the person they care for (ages 15-25).
- Monitoring the completeness of Carers Registers in Primary Care through quarterly reports by GP Practices.
- Review of current breaks available for carers, with a view to increasing flexibility and use of carer one off direct payments.
- The interests of carers to be included in the updated Reablement Service Operational Policy.
- Partnership working with Job Centre Plus and Carers Centre to engage carers re Employment training programmes.

[14] Carer of someone with dementia, Tower Hamlets. From Bari, R. (2010) 'Service User and Carer Views on Dementia Services.

[15] Carers Centre Forum October 2009.

[16] Department of Health (2010) Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care.

[17] Comment from Tower Hamlets Carer User Experience Survey 2010.

9. Key Contacts & Links to Further Information

The general contact email for JSNA queries is JSNA@towerhamlets.gov.uk

Penny Collier is the Commissioning Manager for Carers, London Borough of Tower Hamlets, penny.collier@towerhamlets.gov.uk

Local Services:

Tower Hamlets Carers Centre (Princess Royal Trust) | 21 Brayford Square, Off Commercial Road, Stepney Green E1 0SG | Tel. 0207 790 1765 | www.carerscentretowerhamlets.org.uk

Alzheimer's Society Tower Hamlets (for carers of people with dementia and memory problems) | Tel: 0207 392 9631 | www.alzheimers.org.uk

Family Welfare Association (for support to families of people with mental health conditions) | 22-28 Underwood Rd, E1 5AW | Tel: 0207 364 3406

Age Concern (for carers of older people) | 82 Russia Lane, E2 9LU | Tel: 0208 981 7124 | www.acth.org.uk

APASENTH Care Services (for Asian families caring for someone with a learning disability) | The Brady Centre, 192-6 Hanbury St, E1 5HU | www.apasenth.org.uk

St Hilda's East Community Centre | 18 Club Row, E2 7EY | Tel: 0207 739 8066 | www.sthildas.org.uk

Black Women's Health and Family Support (support for Somalian carers) | 82 Russia Lane, E2 | Tel: 0208 980 3503 | Email: bwhafs@btconnect.com

Jewish Care | Tel: 0208 922 2222 | www.jewishcare.org

London Buddhist Centre | 51 Roman Road, Bethnal Green, London, E2 0HU | Tel: 0845 458 4716

TLC Care Services | 3rd Floor, 77 East Road, London, N1 6AH | Tel:020 7017 2836 | Fax:020 7017 2837 | Email: towerhamletsrespite@tlccare.org.uk | www.tlccare.org.uk

Date updated:	08/04/11	**Updated by:**	Lizzy Gatrell	**Next Update Due:**	

Date signed off by Senior JSNA Leads:	08/04/11	**Signed off by (Public Health Lead):**	Somen Banerjee	**Date signed off by Strategic Group:**		**Sign off by Strategic Group:**	Carers Strategy Implementation Group
		Signed off by (LBTH Lead):	Deborah Cohen				

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Chronic Obstructive Pulmonary Disease (COPD): Factsheet

Tower Hamlets Joint Strategic Needs Assessment 2010-2011

Executive Summary

- Chronic Obstructive Pulmonary Disease (COPD) is predominately caused by smoking and leads to progressive airway obstruction. It is common and under-diagnosed.
- About 2900 people have COPD in Tower Hamlets. The age-standardised prevalence (1.9%) is higher than the London average.
- Last data from 2009/10 shows Tower Hamlets has the highest emergency admission rate for COPD in the country. Readmission rates and COPD mortality are also high.
- Since 2009, NHS Tower Hamlets has invested over £1m in primary care, community/outreach services and pulmonary rehabilitation to address these issues. There has also been significant investment in smoking cessation services in recognition of the particularly high smoking prevalence in the population.
- In April 2011, NHS Tower Hamlets implemented a COPD Care Package which aims to provide effective interventions to all COPD patient across the borough, decrease hospital admissions and readmissions and extend healthy life expectancy. It involves primary, secondary and community care services, and focuses on delivering care at a local level.
- Data is not yet available on the effectiveness of the care package.
- Our priorities are to embed the Care Package in the health service within the borough and to monitor its effectiveness, particularly with respect to the current high emergency admission and readmission rates.

What is COPD?

Chronic obstructive pulmonary disease (COPD) is characterised by airflow obstruction. The airflow obstruction is usually progressive, not fully reversible and does not change markedly over several months[1]. Chronic obstructive pulmonary disease (COPD) is a general term which includes the conditions chronic bronchitis and emphysema.

Prevalence

- COPD is common. An estimated three million people are affected by COPD in the UK, about 2-4% of the population. About 900,000 have been diagnosed with COPD (1.5% of the population) and an estimated two million people have COPD which remains undiagnosed, among whom it is considered that 5.5% will have COPD at the mild end of the spectrum[2].

Mortality

- COPD is the fifth leading cause of death in the UK, accounting for 30,000 deaths each year in the UK, with more than 90% occurring in the over 65 age group in 2004[3].

Risk factors

- Most COPD cases are caused by smoking. The lifetime risk of developing COPD as a smoker is 10-25%. COPD cases caused by other risk factors (such as air pollution, polluted working conditions and a genetic condition called alpha-1-antitripsin deficiency) are rarer in the UK. COPD is closely associated with levels of deprivation - rates of COPD are higher in more deprived communities.

- COPD mainly affects people over the age of 40 and becomes more common with increasing age. The average age of diagnosis is around 67 years. It is more common in men than women. Prevalence rates appear to be increasing steadily in women but have reached a plateau in men, reflecting historical patterns in smoking prevalence[4]. COPD is most common amongst the white population, also reflecting historically higher smoking rates.

Impact on the individual

- Symptoms include cough, shortness of breath and excessive sputum production. Chest infections are much more common. Exacerbations, which may be precipitated by infection, can result in hospital admissions. Breathlessness has a significant impact on quality of life.

Impact on business

- COPD accounts for more time off work than any other illness.

Impact on NHS

- Direct health care costs are an estimated £800 million, with over half related to hospital-based care. COPD is among the most costly inpatient conditions treated by the NHS.

What is the local picture?

Prevalence

COPD prevalence in Tower Hamlets is high, reflecting high levels of smoking and deprivation. About 2900 people have COPD in the borough[5].

The crude prevalence of COPD is higher than the London average, but not higher than the England average, which is likely to be due to the young age profile of the borough (and that COPD is more common in older age). The age-standardised prevalence, which takes this into account, shows that Tower Hamlets has a higher burden of COPD than nationally.

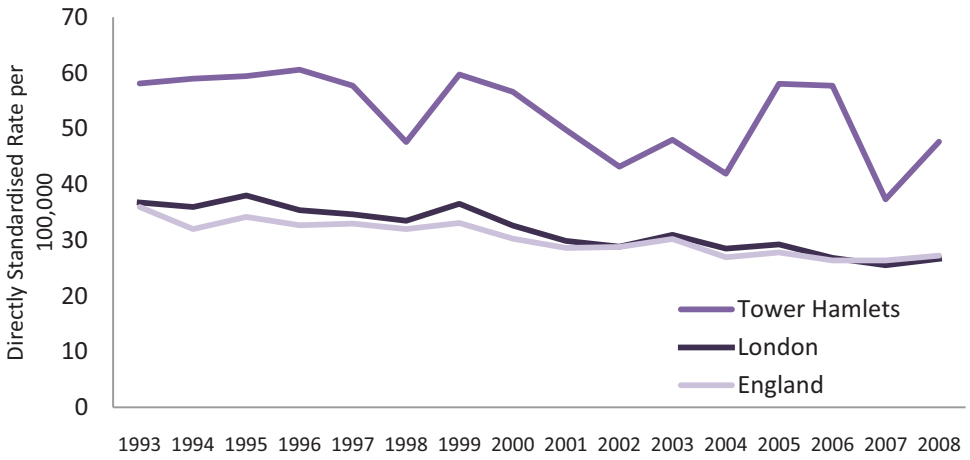
	Tower Hamlets		National (England)	
	COPD prevalence	Data source	COPD prevalence	Data source
Crude prevalence	1.1%	CEG SQUID Audit	1.5%	NICE
Age-standardised prevalence	1.9%	CEG SQUID Audit	N/A	N/A

There is likely to be an increase in COPD prevalence seen in the borough, both due to real increases in disease levels as a result of increases in overall population size and population ageing, and due to changes in diagnostic criteria which will label previously 'borderline' cases as 'mild COPD'.

Mortality

Mortality from COPD is significantly higher than the London and England average (Tower Hamlets SMR 172 (95% CI 151-195), compared to London 98, England 100) (Figure 1). Mortality rates (SMR) are the same in males and females. In 2006-08, there were 134 males deaths and 101 female deaths (235 deaths overall). The mortality rate of inpatients with COPD in Tower Hamlets is not significantly different from the national average (Dr Foster 09/10).

Figure 1: COPD Mortality trend (All Ages, all persons). Source: NCHOD



Health care services

Emergency admission rates are high level indicators of the overall function of a health service, particularly its

ability to prevent admissions through early intervention, effective primary and community services and appropriate hospital discharges. However, crude rates do not take into account the local characteristics, which in Tower Hamlets are quite unique – a young, diverse and deprived population. Therefore crude rates reflect both health service performance and high levels of need in a deprived population, but still reflect that this need is unmet.

The emergency admission rate for COPD amongst all registered patients is the highest in the country (4.9 per 1000 GP registered population, 2009/10). The emergency admission rate for COPD amongst COPD registered patients (those on the GP COPD register) is significantly higher than the England average, but not the worst. The difference in admission rates between all COPD patients and those on COPD registers may indicate that those on the COPD register receive better care, which may prevent admissions to hospital.

There have been similar figures over the past few years, which are being addressed through the design and implementation of the new COPD Care package, described. Furthermore, this data has not been adjusted for Tower Hamlets population characteristics and

Figure 2: Key health service performance indicators

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

England Key:

Domain	Indicator	Local Number	Local Value	Lon Avg	Eng Avg	Eng Worst	England Range	Eng Best
Secondary Care	19 Length of stay, emergency inpatient COPD admissions*	4,721	8.6	6.7	6.8	9.6		3.2
	20 Emergency admissions for COPD, overall*	563	4.9	1.9	1.8	4.9		0.9
	21 Emergency admissions for COPD, COPD registered patients*	465	15.8	13.6	12.5	17.9		9.6
	22 Emergency readmissions within 28 days, overall*	42	33.9	23.3	21.6	44.2		9.9
	23 Emergency readmissions within 90 days, COPD admitted patients	181	55.9	40.2	33.9	63.8		7.5
Mortality & End of Life Care	24 Deaths from COPD, all ages	210	41.3	25.4	26.2	48.7		11.9
	25 Deaths from COPD, <75yrs	63	18.4	11.4	11.8	27.5		3.4
	26 Years of life lost due to mortality from COPD	63	17.4	9.8	10.5	26.0		1.2
	27 Deaths with any mention of respiratory disease as cause	1,208	35.7	35.1	33.9	41.1		25.7
	28 Respiratory deaths at own residence	55	12.8	12.9	13.7	7.5		29.1

Figure 2 also shows that emergency readmission rates for COPD within both 28 days and 90 days of admission are significantly higher than the England average. The profile data is unadjusted, however Dr Foster data also shows Tower Hamlets had a significantly higher readmission rate (28 days) for COPD even after adjusting for the population characteristics – about 22% more readmissions than we would expect to see (2009/10).

However, for 2010/11, the available data for this period however shows that we have made progress – there is no evidence of a higher readmission rate in Tower Hamlets compared to England, after adjusting for our unique population characteristics.

The average length of stay for COPD emergency inpatient admissions is 8.6 days (London average 6.7 days, England worse 9.6 days). However, after adjusting for Tower Hamlets' unique population characteristics, using

Dr Foster data for both 09/10 and 10/11, the length of stay for Tower Hamlets COPD patients is no higher than would be expected for our population.

Inequalities

The majority of COPD cases occur in later life, reflecting the cumulative damage of smoking. The burden of COPD is predominately amongst the white population, although Bangladeshi males are expected to share an increase burden in coming decades due to very high smoking levels in this group. COPD cases are slightly higher amongst men, again reflecting a higher proportion of male smokers (Figure 3).

Figure 3: COPD cases in Tower Hamlets

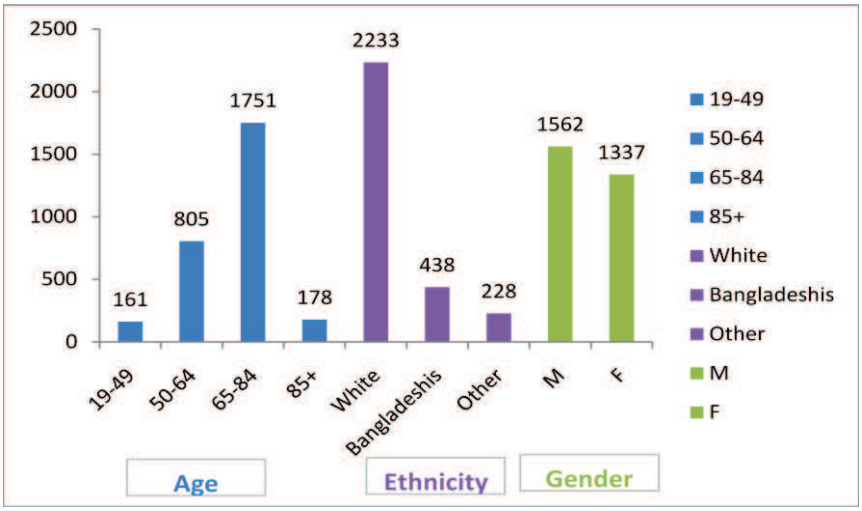
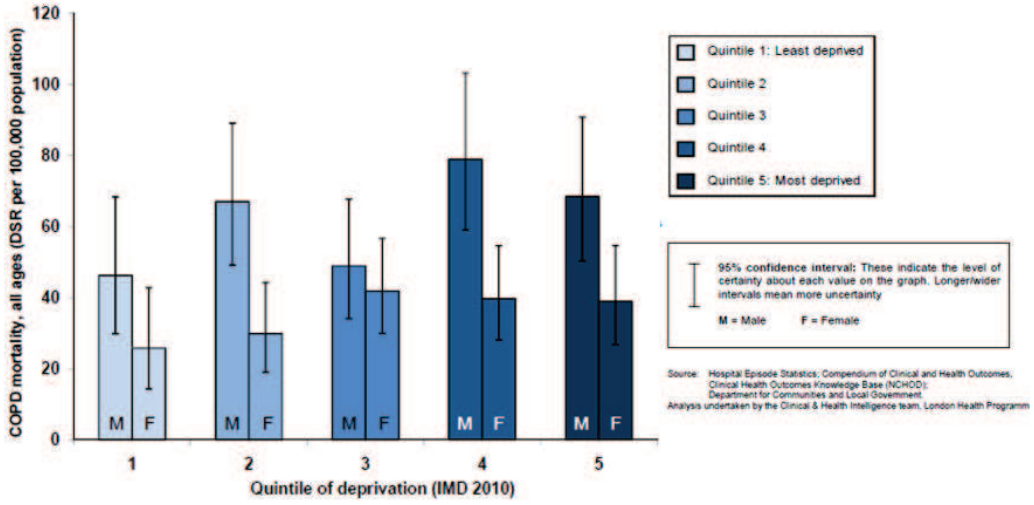


Figure 4 shows that there is no difference in mortality from COPD between the different levels of deprivation in Tower Hamlets, but that there is some evidence of a difference between genders in some of the deprivation categories. For example, COPD mortality amongst men is higher than women in groups 2 and 4, but not in 1, 3 and 5. This weak finding is likely to be due to small numbers – a strong pattern may arise if comparing data over a longer time period.

Figure 4: Mortality from COPD (2005-09) and level of deprivation (Source: LHP COPD profile 2011)



What are the effective interventions?

The NICE National Clinical Guidelines for COPD makes nearly 200 specific recommendations concerning the management of COPD. These deal with diagnosis and assessment, management of stable COPD and management of exacerbations, and include:

Pulmonary rehabilitation: This should be made available to all appropriate people, including those who consider themselves functionally disabled by COPD or those who have had a recent hospitalisation for an acute exacerbation. Programmes must meet clinical needs in terms of access, location and availability.

Non-invasive ventilation (NIV): This should be used as the treatment of choice for persistent hypercapnic ventilatory failure during exacerbations not responding to medical therapy.

Spirometry: The presence of airflow obstruction should be confirmed by performing post-bronchodilator spirometry. All health professionals involved in the care of people with COPD should have access to spirometry and be competent in the interpretation of the results.

Multidisciplinary teams: COPD care should be delivered by a multidisciplinary team.

To address under-diagnosis: A diagnosis of COPD should be considered in patients over the age of 35 who have a risk factor (generally smoking) and who present with exertional breathlessness, chronic cough, regular sputum production, frequent winter 'bronchitis' or wheeze.

NICE also performed a cost-effectiveness analysis for opportunistic COPD case finding and found that it was a relatively cost-effective strategy to identify patients early in their disease course such that smoking cessation interventions could have maximal benefit to delay progression.

Smoking cessation: Encouraging patients with COPD to stop smoking is one of the most important components of their management. All COPD patients still smoking, regardless of age should be encouraged to stop, and offered help to do so, at every opportunity.

Self-management: Patients at risk of having an exacerbation of COPD should be given self-management advice

that encourages them to respond promptly to the symptoms of an exacerbation and should be given a course of antibiotic and corticosteroid tablets to keep at home for use as part of a self-management strategy.

Palliative care: Patients with end-stage COPD and their family and carers should have access to the full range of services offered by multidisciplinary palliative care teams, including admission to hospices.

What are we doing locally to address this issue?

Since 2009, NHS Tower Hamlets has invested over £1m in primary care, community/outreach services and pulmonary rehabilitation to address the issues outlined in this JSNA factsheet. There has also been significant investment in smoking cessation services in recognition of the particularly high smoking prevalence in the population.

NHS Tower Hamlets has recently rolled out a COPD Care Package, effective from April 2011, which aims to provide effective interventions to all COPD patients across the borough, decrease hospital admissions and readmissions and extend healthy life expectancy. It involves primary secondary and community care services, and focuses on delivering care at a local level.

The Care Package has been developed in conjunction with local clinicians and service leads. There are eight streams within the COPD Care Package, which stratify COPD patients according to their severity and other needs. This aims to ensure all patients access the highest quality of care. Each stream has funding for a range of appropriate interventions for that patient group:

1. Case finding
2. First review
3. Mild/moderate/severe management
4. Very severe management
5. Housebound management
6. LTOT and NIV
7. (Re)admission avoidance
8. Enhanced care (2 or more COPD admissions in past 12 months)

The key services delivered for COPD patients are described below:

Prevention

Smoking cessation services are the cornerstone of COPD prevention. Please see the relevant JSNA for more detail on smoking cessation services.

Primary care

Primary care has a dominant role in the management of COPD. This includes initial diagnosis, referrals to specialists and COPD services (e.g. RDOT, CRT), administering seasonal flu jabs, annual reviews, self-management plans, inhaler checks etc.

Secondary care

- **Emergency Department:** COPD patients can be discharged to intermediate care or back home with appropriate acute follow-up, however, these services are not available out-of hours.
- **Integrated care pathway:** On admission with an exacerbation, a patient's care is defined with an integrated COPD pathway to ensure high quality care and that all appropriate interventions are addressed.

Community COPD Services

- **Community Respiratory Team (CRT)**
  - Started in 2008 with the intention to reduced emergency bed spells and readmission rates for patients under the CRT's care
  - Split into two arms, a case-management arm and a schedule/acute-care arm (which also provide spirometry assessment and training)
- **Respiratory Discharge Outreach Team**
  - Funded by BLT to provide inpatient education and supported discharge, including making evidence-based management recommendations and appropriate referrals to other services.
  - Depending on clinical need, such as newly prescribed long term oxygen therapy (LTOT), RDOT may facilitate a supported discharge; this involves visiting the patient in the community shortly after discharge to check progress, reinforce disease education, and to ensure that referrals and handovers are made to community teams such as CRT, the district nurse and the community matron.
- **Pulmonary Rehabilitation**
  - Pulmonary rehabilitation is funded by THPCT and delivered by Action East to provide community based self management programmes for people with COPD, heart failure, and intermittent claudication.

What evidence is there that we are making a difference?

It is too early to assess the effects of the new COPD Care Package, which represented a step change in COPD care delivered to patients in Tower Hamlets. However, we have a range of indicators of current performance in the care of COPD patients.

Prevention

97% of registered COPD patients have their smoking status recorded on practice records[6]. Recorded smoking prevalence amongst COPD patients is 42%[7]. Please see the relevant JSNA for more detail on smoking cessation services.

Primary care

Information collected as part of the monitoring for the Local Enhanced Service for COPD, prior to the implementation of the COPD Care Package has shown that, of all COPD patients registered with GPs in Tower Hamlets:

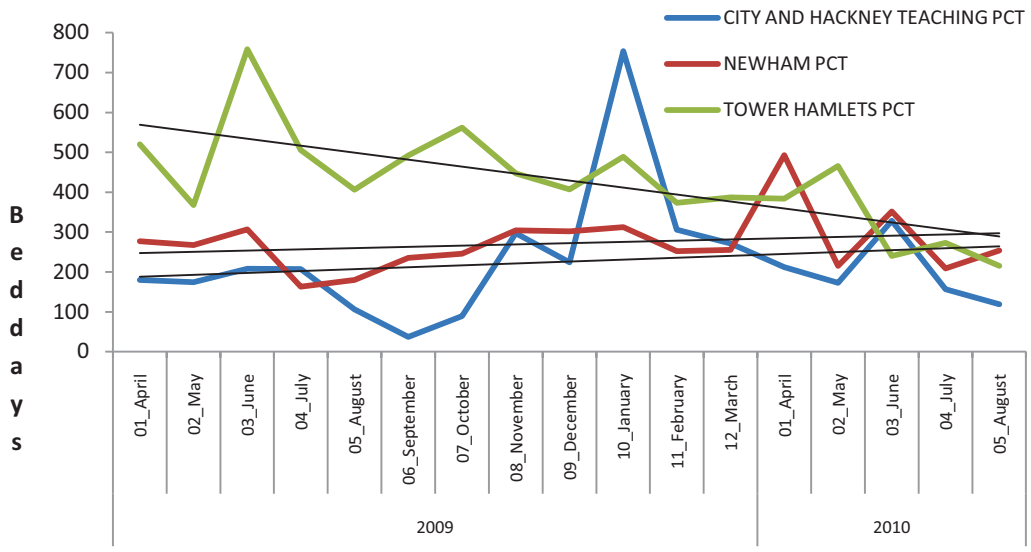
- 74% have had an annual review and their smoking status recorded
- 70% have had an annual review and received a flu vaccination

- 44% have had an annual review and have a self-management plan
- 10% have had an annual review and been referred to pulmonary rehabilitation
- 55% have been screened for depression
- 73% have had an annual review and had their body mass index (BMI) measured

Secondary care

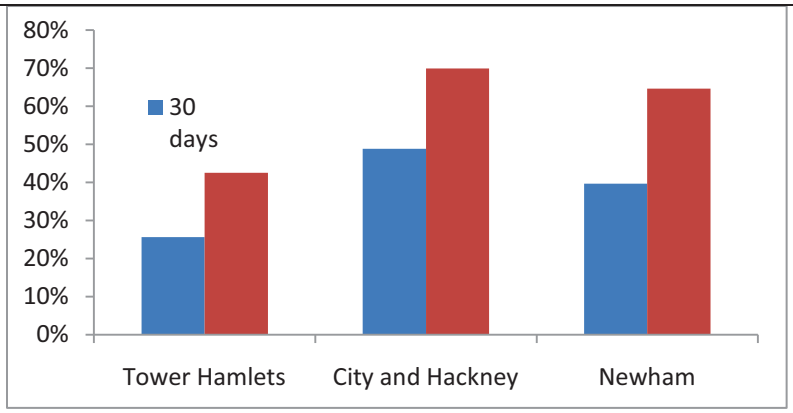
- **Unplanned admissions:** There appears to be a downward trend over the past year in unplanned admissions, measured by total bed-days, bed-days per 1000 population and total unplanned admissions.

Figure 5: Total bed-days for unplanned admissions



- Readmissions: There is some evidence that Tower Hamlets has a lower proportion of readmissions to admissions compared to Newham and City & Hackney as shown below.

Figure 6: Ratio of admissions to readmissions (Approximately: % of admissions that result in readmissions - April-Aug 2010)



Between April-August 2010, there were 70 readmissions at 30 days post-discharge and 166 readmissions at 90 days.

Community COPD Services

An evaluation of community COPD services in April 2010 had the following findings:

- Community Respiratory Team (CRT)
  - In April 2010, there were 60 case-managed patients and 36 patients under the schedule arm
  - Educational GP sessions are provided to each GP surgery approximately once every 3 years
  - There was a waiting time of 9 weeks before being seen by the schedule arm (April 2010)
  - Patient co-morbidities make it difficult to discharge patients
- Respiratory Discharge Outreach Team
  - COPD accounts for approximately 70% of caseload – 148 admissions between April 2009 and September 2009
  - 37% of patients were either referred to or already known to CRT
  - 26% of patients were either referred to or already known to pulmonary rehabilitation
  - In January 2010 RDOT introduced an early discharge scheme for COPD patients
- Pulmonary Rehabilitation
  - On average around 45 patients are referred for pulmonary rehabilitation a month
  - Between May 2009 and December 2009, 36% of patients referred completed pulmonary rehabilitation, this compares to 37% of patients in 2008
  - The main problems are with patients failing to attend initial assessment and with patients dropping out mid-course. Patients with worse breathlessness and more anxiety are less likely to complete pulmonary rehabilitation.

What is the perspective of the public on services?

Patient perspectives

The two CRT patients were interviewed as part of the COPD evaluation in 2009. Each was seen once a month by the CRT and from their perspective the role of the CRT in both patients appeared to be more in coordinating care rather than delivering it. Patient BR appeared very independent and despite his 3-4 weekly exacerbations and LTOT he hadn't been to hospital for a year and only needed to see the CRT once every month. When he gets a problem he will always phone the GP rather than the CRT and he is not sure of the role of CRT in his care aside from arranging his portable oxygen; in this type of well motivated and sensible patient there may be a potential for discharge with re-referral should he deteriorate.

What are the priorities for improvement over the next 5 years?

The priorities for improvement over the next 5 years have been incorporated into the COPD Care Package. The aims of the Care Package, and hence the priorities for improvement are:

1. To improve the diagnosis of COPD to enable primary care to provide targeted early interventions. Improved diagnosis will increase the observed prevalence in Tower Hamlets.
2. To provide best evidence, best practice primary care for all patients diagnosed with COPD
3. To incentivise a proactive response in the community for patient at risk of, or post non-elective acute attendance
4. To provide an equitable level of primary care management for housebound patients with COPD

The COPD Care Package has been designed to meet these priorities. Key performance metrics will be measured through regularly reporting and through a performance dashboard. These metrics will be regularly assessed to ensure that the Care Package is delivering on its objectives. In subsequent years, the Care Package will be revisited to ensure that it continues to address the needs of the population.

What more do we need to know?

Performance data for the new COPD Care Package will be very useful in assessing its effectiveness. More specifically, the following information would also be useful:

- Better patient perspectives on all services
- Age-standardised emergency admission rates
- Trends in smoking prevalence amongst COPD patients

Key Contacts & Links to Further Information

- For general JSNA queries email: JSNA@towerhamlets.gov.uk
- Factsheet contact Katie Cole, Respiratory Public Health Lead, Specialty Registrar in Public Health, Katie.cole@thpct.nhs.uk

Further Information

The COPD Patient Pathway – an evaluation.

Contact Katie Cole Katie.cole@thpct.nhs.uk for a copy

NICE 2010 - Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care

www.nice.org.uk

Date updated:	21/6/2010	**Updated by:**	Dr Katie Cole Specialty Registrar in Public Health	**Next Update Due:**	

[1] NICE 2010. COPD guidance – full version.
[2] NICE 2010. COPD guidance – full version.
[3] NICE 2010. COPD guidance – full version
[4] NICE 2010. COPD guidance – full version.
[5] CEG data 1/12/10 (COPD dashboard working 16 12 2010.doc file)
[6] CEG SQUID Audit April 2010
[7] CEG SQUID Audit April 2010

Diabetes: Factsheet

Tower Hamlets Joint Strategic Needs Assessment 2010-2011

Executive Summary

Diabetes is a long term condition that affects 11,859 people in Tower Hamlets, as a result of high levels of glucose in their blood. It is an important health issue as diabetes increases someone's risk of a heart attack or stroke, eye problems and limb problems. Prevalence is higher in Tower Hamlets than the nationally average, in part due to the large Bangladeshi community. Prevalence is also increasing at a faster rate here than elsewhere, and there are a sizeable number of people with diabetes in younger age groups.

A National Service Framework for diabetes was published in 2001, outlining twelve standards for high quality diabetes care. We have introduced the diabetes care package in primary care to support care planning and self-management. The Diabetes Specialist Nurse team has recently been reorganised to provide glycaemic control clinics within the community. Diabetes education services have been developed at a local level to increase uptake.

The proportion of people with controlled diabetes has steadily increased over the last 18 months. Blood pressure and cholesterol control has proved cost-effective though more work is required to improve blood glucose control. The Diabetes Retinal Screening Service has reached over 75% uptake. Patients have been responsive to repeated phone contact to ensure take up of service. Local services and promoting social contact and support within services were also valued. Success in these areas endorses the current strategy to continue with these programmes of care.

Another factsheet is available on gestational diabetes.

Recommendations

- The identification and management of people at risk of diabetes should be investigated for local implementation to combat the increasing prevalence within Tower Hamlets.
- A multi-level strategy is required to target the stabilised prevalence of smoking and obesity in the diabetes population. Reducing levels of these behaviours would reduce diabetes complications, even within one-five year timescales.
- The diabetes care package in primary care requires ongoing monitoring of its implementation to feedback to GP networks on progress and provide areas of key learning.
- The Care Planning Approach needs to consider diabetes and mental health as common comorbidities. The mental health Whole Systems Review should incorporate diabetes.
- Improving the quality of care for people with diabetes in secondary care should be prioritized. This would need to address the findings of the National Diabetes Inpatient Audit.
- Improve local understanding of type 1 diabetes in Tower Hamlets.

1. What is Diabetes?

Diabetes is a long term condition that affects around 2.8million people in the UK, and a predicted additional 850,000 people who have not yet been diagnosed. It is an important health issue as diabetes increases someone's risk of a heart attack or stroke, eye problems and limb problems. Diabetes is present when there are high levels of glucose in the blood, as a result of the body not being able to use it properly. There are two main types of diabetes: Type 1 diabetes and Type 2 diabetes.

Type 1 diabetes accounts for approximately 10% of all cases. Type 1 diabetes occurs when the body is unable to produce insulin, the hormone required for glucose to enter cells and be used for producing energy for the body. It is unknown why some people are unable to produce insulin, though we understand that this is usually detected early in life, and there is a likely genetic link. There is no preventative action that can be taken. Type 1 diabetes is treated by daily insulin injections, a healthy diet and regular physical activity.

Type 2 diabetes occurs when insufficient insulin is produced, or the insulin produced does not work properly, which has the same effect on the body as type 1 diabetes. Typically, this type of diabetes occurs later in life. It is treated with a healthy diet and regular physical exercise, and medication is often also required.

Type 2 diabetes is most common in people over 40 years of age, though there is an increasing trend in younger people. There is a high prevalence among south asian and black populations in whom it is more common to develop diabetes at a younger age. There is a familial link also, so people with a close family member with diabetes is at increased risk of developing it themselves.

Obesity is the primary risk factor for diabetes. Without the intervention of healthy diet and exercise, obesity can develop into diabetes in a relatively short period of time. The increasing prevalence of diabetes in younger people can be attributed to the obesity epidemic in these age groups. In addition to obesity, smoking and poor control of one's diabetes are risk factors for vascular complications in people with diabetes.

Other risk factors for type 2 diabetes include high blood pressure, having previously had a stroke or a heart attack, polycystic ovary syndrome and severe mental health problems.

Prediabetes occurs in people with raised levels of glucose in their blood, but they are not high enough for a diagnosis of diabetes. It puts the person at increased risk of developing type 2 diabetes and of heart disease so it is important to focus on the steps that can be taken to minimize this risk. A Finnish study found that an intensive lifestyle intervention produced long-term beneficial changes in diet, physical activity, and clinical and biochemical parameters and reduced diabetes risk[1].

Another factsheet is available on gestational diabetes.

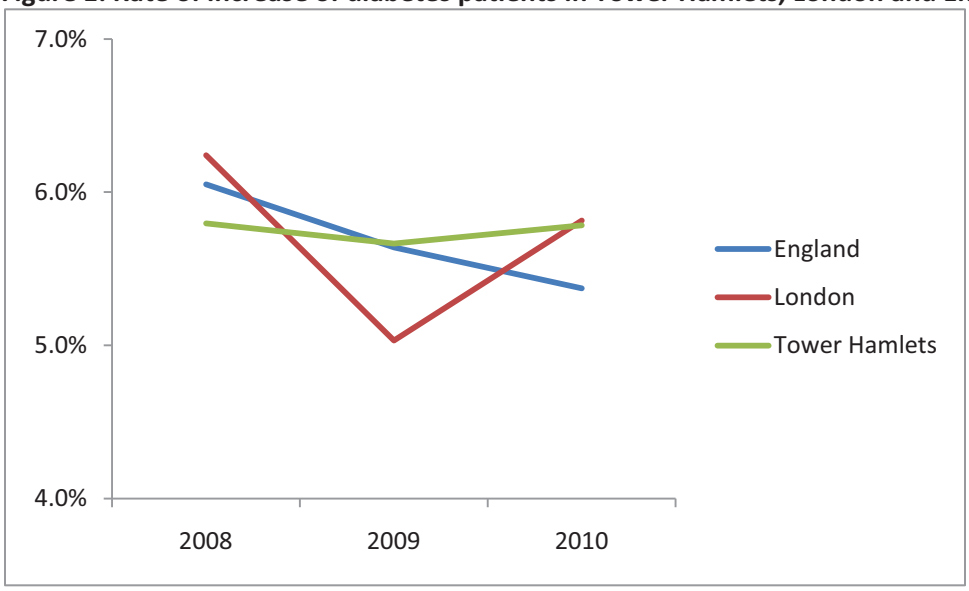
[1] Lindstrom, J. et al, (2003), *The Finnish Diabetes Prevention Study (DPS),* Diabetes Care December 2003 vol. 26 no. 12 3230-3236

2. What is the local picture?

In March 2010 this equated to 11,859 diagnosed cases of diabetes in Tower Hamlets. This equates to 6.1% of the population, which is significantly higher than the England and London averages of 5.4% and 5.3% respectively (QOF, 2009/10). 1,000 of the cases are attributable to type 1 diabetes and the rest have type 2. National predictive prevalence models do not work well with the outlier Tower Hamlets population and produce estimates that are less than the observed numbers. Based on our bespoke local predictive model, we estimate that at the end of 09/10 there were at least 1,815 people with undiagnosed diabetes in Tower Hamlets. The NHS Health Checks programme (a vascular risk assessment conducted in primary care in people aged 40-74) diagnosed 50 people with diabetes in 2010/11.

Year on year the diabetes register in Tower Hamlets has increased by just under 6%, meaning that over the last three years there has been an increase of between 611 and 686 cases of diabetes per year, taking into account new diagnoses, deaths and migration. This compares to numbers rising less fast across England as a whole. This means that the prevalence of diabetes in Tower Hamlets is increasing at a faster rate than elsewhere (figure 1).

Figure 1: Rate of increase of diabetes patients in Tower Hamlets, London and England 2008-2010 (QOF)



Diabetes prevalence is set to continue to increase dramatically over the next 20 years, according to the APHO Diabetes Prevalence model.

Table 1: Diabetes Prevalence Projections in Tower Hamlets 2010-2030, APHO Diabetes Prevalence Model, 2010

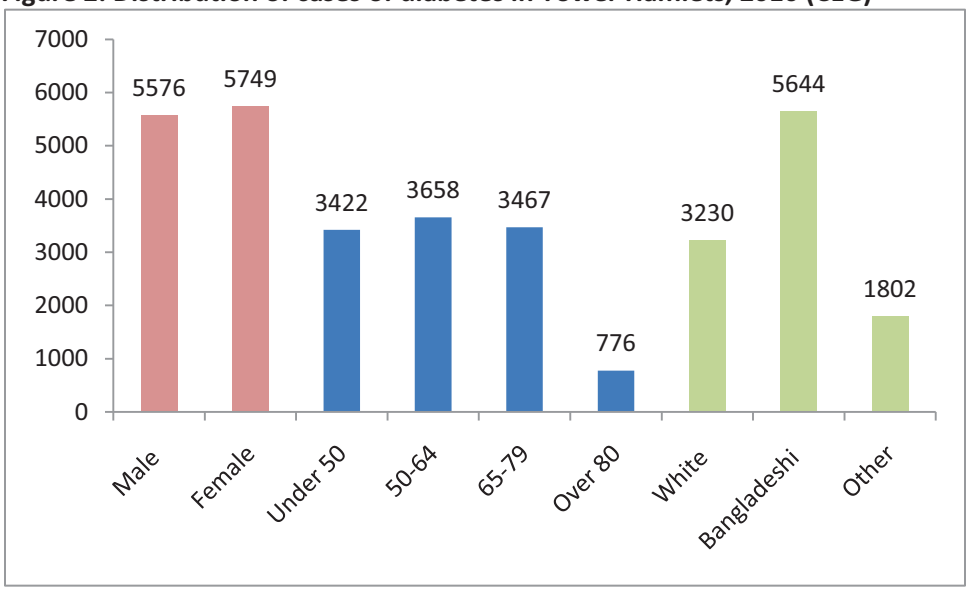
	2010	2015	2020	2025	2030
Number	13,674	14,987	16,871	18,968	21,314
Prevalence	7.8%	8.1%	8.7%	9.3%	10.1%

The numbers of deaths associated with diabetes is not easy to estimate as the primary cause of death is most likely to be circulatory disease. However, age-adjusted deaths directly attributable to diabetes in Tower Hamlets are 8.7 per 100,000, compared to 6.1 in London and 5.9 in England (2007-09, NCHOD).

A snapshot of the diabetes' register in 2010 found the following distribution of cases across three of the

inequalities strands (gender, age and ethnicity)

Figure 2: Distribution of cases of diabetes in Tower Hamlets, 2010 (CEG)



We further know that as of January 2011:

- 55.2% of people with diabetes have controlled blood glucose levels
- 64.8% have controlled blood pressure
- 71.2% have controlled cholesterol
- 15.3% have eye complications
- 28.2% have limb complications
- 20.8% smoke
- 35.7% are obese (BMI>30)

3. What are the effective interventions?

The Diabetes National Service Framework was published in 2001 and set out twelve standards for diabetes care. These are summarised below:

1) Develop and monitor local strategies to support prevention of type 2 diabetes and to address inequalities in risk.

2) Develop strategies to identify the undiagnosed population

3) Engage patients of all ages and their carers in the self-management of their conditions, adoption of healthy lifestyles and developing an agreed and shared care plan in a personalised format.

4) High quality care, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

5) All children and young people with diabetes and their carers will be supported to optimise their physical,

psychological, intellectual, educational and social development.

6) Smooth transition of care for adolescents moving into adult services, made in conjunction with the individual and all partnership care organisations.

7) Develop and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained health care professionals.

8) High quality care for all people with diabetes in hospital, regardless of cause of admission.

9) Develop and monitor policy to support women with pre-existing or gestational diabetes during pregnancy.

10) Regular surveillance for long-term complications

11) Timely, appropriate and effective investigation and treatment of long-term complications of diabetes

12) Multi-agency support of integrated health and social care for all people with diabetes.

NICE guidance is available for the management of type 1 diabetes (CG15), the management of type 2 diabetes (CG66), footcare (CG10, CG119), patient education models (TA60) and prevention (PH35). NICE guidance on the treatment of people with pre-diabetes is due to be published in 2012.

People living with diabetes can also benefit from social care input as part of an integrated approach, with health services and other partners. Social workers may facilitate care coordination and provide linkage to physical or psychological care across a range of health care settings. People may experience anxiety or depression as well as physical limitations, and may therefore be eligible for social care. People may also benefit from preventative services (some of which may be commissioned by social care) to address challenges relating to life disruption, social isolation and sometimes living with uncertainty around prognosis. Social care, working in partnership with health services, may also be appropriate to address any palliative care needs.

4. What are we doing locally to address this issue?

Secondary prevention in people with diabetes is a local priority to ensure that conditions are well-managed, complications are reduced and there is minimal impact on individuals' quality of life.

Prevention statement

The Tower Hamlets population has access to a range of healthy lifestyle services. Please refer specifically to the obesity factsheet, as this is the major risk factor for diabetes. The NHS Health Check programme identifies people at high risk of CVD and directs them to lifestyle services. The programme also facilitates the early diagnosis of diabetes - in the last year alone 50 new cases have been identified. Research is underway locally to determine whether a diabetes risk score could be cost-effectively applied locally for incorporation into the Health Checks programme.

Primary care statement

A diabetes care package has been in operation through general practices since September 2009. This approach supports care planning consultations in which each patient has a session to jointly plan their care for the following year and tailor it to their individual needs and circumstance. As of March 2011, 89.4% of people with diagnosed diabetes had received a care planning session in primary care.

At the end of the financial year 2009/10 83.2% of people with diabetes had their blood pressure controlled below 145/85 and 84.5% had a total cholesterol reading below 5mmol – the third and second highest proportions in London, respectively and eleventh and 32nd highest in England. 45.1% of patients had a HbA1c measure below 7, the third lowest proportion in London and fourth lowest in England.

Secondary care statement

Local clinical audits indicate that at any one time 25% of patients in Barts and the London NHS Trust who are residents of Tower Hamlets have diabetes. In the 2010 National Diabetes Inpatient audit the trust scored below average for a number of patient satisfaction measures including care planning, meal times, confidence in staff and reporting a positive experience. Glucose testing was higher than average and there was further work to be done around ensuring visits by specialist team members and prescription and management errors.

Community services statement

There are a number of services for people with diabetes provided by Community Health Services. The Diabetes Retinal Screening Service screens people on the diabetes register annually for retinopathy, and achieved 75% uptake in January 2011, in line with national standards. The Diabetes Specialist Nurse team provide a range of services including the glycaemic control clinic, education sessions and an insulin pump services. Specialist dietician and podiatrist services are also available.

5. What evidence is there that we are making a difference?

Through the NHS Health Checks 49 people have been diagnosed with diabetes in the last year, or 14% of the estimated undiagnosed population. The prevalence of people with diabetes under the age of 50 is increasing. A cross-sectional study in January 2010, indicated that there were 2993 of this age group, (or 27% of the diabetic population).

Since implementation of the diabetes care package in primary care in September 2009, all three clinical indicators (HbA1c<7.5, blood pressure<140/80, total cholesterol<5mmol) have improved. A composite measure, which requires that HbA1c, blood pressure and cholesterol to all be controlled below proscribed parameters, is incentivised through this locally enhanced service. Between August 2009 and January 2010, this improved from 24% to 28%. The register increased by 681 patients in this time. Levels of smoking and obesity have both remained stable in this time period.

Based on 2008/09 data, Tower Hamlets was average for emergency admissions for diabetes, an improvement from the previous two years when it scored in the top 20% nationally, and average in all three years for elective admissions. Yorkshire and Humber Public Health Observatory produced a tool comparing outcomes and expenditure for diabetes. It found that total expenditure on diabetes care was above average, but not significantly so, whilst outcomes were good for cholesterol and blood pressure control but among the lowest in the country for HbA1c control.

Diabetes Retinal Screening uptake has been improving over the last twelve months and is now above 75%, the national target. The local HAMLET programme was shown to improve blood glucose control in those who completed the course – to which fewer males and older people were referred. The glycaemic control clinic has undergone a restructure in 2010/11, for which an evaluation is planned in the coming financial year.

6. What is the perspective of the public on services?

THINk's 2009 consultation into Long Term Conditions found that some of the prominent views around diabetes care were around lack of education to avoid hypoglycaemic attacks, fear of diabetic retinopathy, turning blind, and a perceived lack of support following any problems being detected as well as considering condition-specific advocates for the Bangladeshi population to be advantageous.

A qualitative evaluation of the diabetes education programme contained findings that could be applied to more generic diabetes services:

- Repeated phoning, in a friendly and polite manner, to attend services was thought to be productive and encouraged people to attend and ensured maintenance
- Services provided locally also encouraged uptake
- People who attend courses generally consider themselves to be in good health
- HAMLET, followed by Key Short Messages, were the most memorable courses – other education materials such as DVDs were not recalled by the majority of people to whom they were provided
- The social aspect of attending classes was highlighted, particularly for those newly diagnosed
- It was considered helpful to have someone with experience of diabetes facilitating classes

7. What more do we need to know?

- There is research underway locally to determine the prevalence of pre-diabetes in Tower Hamlets. In preparation for the NICE guidelines for managing risk of diabetes being published in 2012, it will be important to consider how this could be implemented locally.
- It would be important to link primary care and secondary care outcomes to determine whether care planning is successfully reducing emergency admissions. An evaluation of the glycaemic control clinic should be prioritised.
- Follow-up and locally assessment of the national inpatient audit will need to be prioritised. Diabetes is no longer a specific CQUIN under the new quality arrangements so specific audits of the care of people with diabetes will need to be conducted to assess improvements.

8. What are the priorities for improvement over the next 5 years?

Key areas for improvement include the management of prediabetes, improving healthy lifestyles among those with diabetes and the care of people in hospital with diabetes. Services also need to be mindful of the predicted increase in diabetes prevalence over the next few years and the impact this is likely to have on local resources.

- The identification and management of people at risk of diabetes should be investigated for local implementation to combat the increasing prevalence within Tower Hamlets.
- A multi-level strategy is required to target the stabilised prevalence of smoking and obesity in the diabetes population. Reducing levels of these behaviours would reduce diabetes complications, even within one-five year timescales.
- The diabetes care package in primary care requires ongoing monitoring of its implementation to feedback to GP networks on progress and provide areas of key learning.
- The Care Planning Approach needs to consider diabetes and mental health as common comorbidities. The mental health Whole Systems Review should incorporate diabetes.
- Improving the quality of care for people with diabetes in secondary care should be prioritized. This would need to address the findings of the National Diabetes Inpatient Audit.
- Improve local understanding of type 1 diabetes in Tower Hamlets.

9. Key Contacts & Links to Further Information

- General JSNA queries email: JSNA@towerhamlets.gov.uk
- Abigail Knight, Senior Public Health Strategist, NHS Tower Hamlets: Abigail.knight@thpct.nhs.uk
- The Vascular Care Quality Group has oversight of the diabetes programme in Tower Hamlets. This is chaired by the Co-Director of Public Health.
- If you would like to know more about diabetes you can visit the following websites:
  Diabetes UK: www.diabetes.org.uk
  NHS Diabetes: www.diabetes.nhs.uk

Date updated:	June 2011	Updated by:	Abigail Knight	Next Update Due:	1st September 2011

Date signed off by Senior JSNA Leads:	*Date factsheet signed off by senior JSNA leads from Public Health and LBTH*	**Signed off by (Public Health Lead):**	*e.g. Director or Associate Director*	**Date signed off by Strategic Group:**	*Date factsheet signed off by Strategic Group*	**Sign off by Strategic Group:**	*Name the relevant Strategic Group*
		Signed off by (LBTH Lead):	*e.g. Director of Adults/CFS*				

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Learning Disabilities: Factsheet

Tower Hamlets Joint Strategic Needs Assessment 2010-2011

Executive Summary

There are approximately 1,000 people aged 14 and over with a learning disability known to services in Tower Hamlets, which is consistent with national estimates. Prevalence of learning disability is higher in the male, Asian and black populations. People with learning disabilities experience higher than average prevalence of a range of health conditions, most notably diabetes, asthma, epilepsy, stroke and all mental health conditions including depression and severe mental illness (SMI).

Local priorities of the Learning Disability Partnership Board include:

- Carers
- Challenging Behaviour
- Communication and engagement with service users
- Employment
- Health Inequalities
- Safeguarding and Community Safety
- Personalisation

1. What are learning disabilities?

Valuing People (2001) defines a learning disability as the presence of:
-A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence);
-A reduced ability to cope independently (impaired social functioning);
-Which started before adulthood (before the age of 18), with a lasting effect on development.

This definition is consistent with both International Classification of Diseases (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and encompasses people with a broad range of disabilities. The presence of a low intelligence quotient (IQ of 50-69 is usually classified as mild learning disability; 35-49 moderate; 20-34 severe; less than 20 profound) is not of itself a sufficient reason for deciding on a diagnosis of learning disability and whether an individual should be provided with associated health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining severity and support needs, and historical information also needs to be sought about childhood development.

2. What is the local picture?

Nationally and locally the true prevalence of learning disabilities and coexisting conditions is most likely underestimated. The percentage of the Tower Hamlets population with a learning disability *known to services* (health and social care) ranges from around 0.26%-0.86%, consistent with national estimates of people with moderate or severe learning disabilities. There are most likely to be many more people in the borough with learning disabilities who are not known to the Community Learning Disability Service (CLDS), and they are very difficult to identify. It is possible that people with learning disabilities are less likely to access services because of various communication, social or practical barriers, and therefore health and social care services are less likely to have data on the actual number of people with learning disabilities in the borough.

Table 1 Prevalence estimates of learning disability in the Tower Hamlets population, 2010 (different sources)

Data Source	Age Range Covered	Number of people in Tower Hamlets with a learning disability	Prevalence (percentage of the population)
Special Educational Needs (SEN)	2-17 years	406	0.86%
Community Learning Disability Service (CLDS)[1]	14 years and over	956	0.49%
Social Care (Adults Health and Wellbeing)	18 years and over	625	0.33%
EMIS Web[2]	18 years and over	711	0.29%
Quality Outcomes Framework (QOF)	18 years and over	636	0.26%
Expected overall prevalence (moderate or severe learning disabilities)	15 years and over	1,049	0.54%
Expected overall prevalence (all learning disabilities)	15 years and over	4,870	1.89% - 2.77%

Prevalence is expected to be higher in Tower Hamlets (particularly in the younger population) due to the large South Asian community and to high levels of deprivation.

Table 2 Prevalence by ethnicity and gender (CLDS clients aged 14 years and over)[3]

Ethnicity	Prevalence (14 years and over)		
	Males	Females	Total
Asian or Asian British	0.86%	0.49%	0.68%
Black or Black British	0.95%	0.62%	0.80%
Other	0.55%	0.25%	0.21%
White	0.41%	0.33%	0.37%
Total	0.58%	0.39%	0.49%

Prevalence of learning disabilities is higher in the male population of Tower Hamlets (and nationally). Around 0.58% of the male population aged 14 and over has a learning disability and is known to services, compared to 0.39% of the female age equivalent population.

Age specific prevalence rates are likely to increase nationally over the next twenty years, due to an increased proportion of the population being of South Asian origin, increased survival rates of young people with severe and complex disabilities, and reduced mortality in older people with learning disabilities. Although is difficult to predict actual figures of adults with learning disabilities in the future, we can assume minimum estimates if prevalence rates remain constant.

Assuming prevalence rates remain constant, the number of people requiring support from CLDS is expected to increase to over 1,040 over the next five years, and to around 1,235 by 2030.

[1] February 2010
[2] As at 1st April 2010
[3] Crude prevalence rates calculated using CLDS ethnicity data and GLA Population Estimates, 2010.

Table 3 Approximate number of CLDS clients, projected to 2030[4]

Year	2010	2011	2012	2013	2014	2015	2020	2025	2030
Expected numbers (rounded)	955	980	990	1010	1025	1040	1145	1210	1235

Learning Disabilities and Co-morbidities

Analysis of GP registered data by condition shows an inequality in the health conditions of people with learning disabilities compared to the general Tower Hamlets population (i.e. a relatively higher prevalence). Notable differences exist particularly with diabetes, asthma, epilepsy, stroke and all mental health conditions including depression and severe mental illness (SMI). There is a 10 times higher recorded prevalence of SMI in the population with learning disabilities compared to the general population.

3. What are the effective interventions?

Policy and service development in the area of learning disabilities is driven by the White Paper, *Valuing People* (2001) and subsequent strategies, *Valuing People Now* (2009) and *Valuing Employment Now* (2009). These strategies focus on promoting and delivering advocacy, employment support, person-centred planning and partnership working to improve the lives of people with learning disabilities. People with learning disabilities must be supported to live an ordinary life in the community in line with human rights legislation, the Disability Discrimination Act (2005) and the Equality Act (2010). Other policies such as *Aiming High for Disabled Children* focus on action for children.

National priorities for 2008-2011

Personalisation: to ensure that people have real choice and control over the services they receive and over their lives.

How people spend their time: to ensure that people are included in their communities (with a focus on increased independence and paid work).

Better health: to ensure that people have full and equal access to good quality healthcare for both physical and mental health needs.

Access to housing: to ensure that people have options for housing that they want and need (with a focus on home ownership and tenancies).

Making change happen: to ensure that partnership boards are more effective in delivering policy.

Mencap's paper *Death by Indifference* (2007) and the subsequent *Six Lives* (2009) report, published jointly by the Local Government and Parliamentary and Health Service Ombudsmen, highlighted serious failures in health and social care for people with learning disabilities, which all local authorities were required to investigate in their area.

Personalisation, outlined in *Putting People First* is changing the way services are commissioned and delivered. It emphasises independence, social inclusion, rights, employment, choice and control. As part of this, person-centred planning and self directed support are required to become mainstreamed. Personal budgets are to be made available to everyone eligible for publicly funded social care support other than in circumstances where people require emergency access to provision.

4. What is being done locally to address this issue?

Prevention

Preventative services for people with learning disabilities focus on providing information and advice, advocacy and other services to enable people to enjoy independent lives. Supporting family carers of people with learning

[4] Estimates calculated using crude prevalence rates and GLA Population Estimates, 2010.

disabilities is also designed to prevent people requiring long term social or secondary care.

In Tower Hamlets there are several preventative services available to people with learning disabilities. The Tower Project Jobs, Enterprise and Training team (JET) provides support and training for people with disabilities in Tower Hamlets and the City of London seeking employment.

Poetry in Wood is a social enterprise, training and employment scheme for people with learning disabilities. Individuals are trained in woodwork, art and design, developing skills in creativity, research, communication and peer tutorage. Members of the social enterprise project are supported in paid employment, working largely on commission.

MAP Squad offers advocacy support and day opportunities to people with learning disabilities who want to work on their own or in partnership on community projects.

People with disabilities in Tower Hamlets can access advocacy services through Disability Advocacy Network.

Supporting People commission 'housing-related support' to develop and maintain people's ability to live independently, either in their own home or in supported accommodation. Housing related support can include:

- Helping someone to get their correct benefits
- Helping someone to learn to budget properly for rent and bills
- Helping someone to access a GP or dentist
- Helping someone to get on a training or education course
- Helping someone to get a community alarm service
- Helping someone to improve their social network

Work is currently underway with existing providers to develop three community hubs in Tower Hamlets for people with learning disabilities to access information and advice without necessarily meeting FACS criteria. As part of the review of day opportunities there will be an increased focus on preventative and universal services, including advocacy and improved training and employment opportunities.

Health promotion literature produced nationally in easy read is to be made available to GP practices and day services across the borough.

Primary Care

Tower Hamlets organised a 'Six Lives Panel' in November 2009 to address gaps in meeting the health needs of people with learning disabilities. The Panel including senior staff from commissioning and services across health and social care, formed a steering group and commissioned a DVD of people's experiences of health services made by people with learning disabilities. This DVD posed a number of questions for the group which has influenced subsequent development, including the recruitment by Barts and the London Trust of a Learning Disabilities Liaison Office. There is work underway to try and increase the number of people with learning disabilities accessing annual GP health checks to which they are entitled.

Secondary Care

The Six Lives Panel highlighted some issues with secondary care, particularly regarding the involvement of carers during hospital stays. Barts and the London Trust have recruited a Learning Disabilities Liaison Officer to support people with learning disabilities and their carers during admissions to hospital.

Community Services

Tower Hamlets Community Learning Disabilities Service (CLDS) is an integrated health and social care service, comprising social workers, occupational therapists, community nurses, psychologists, psychiatrists, and a team

of Bangladeshi Parent and Carer Advisers. CLDS works with just under 1,000 people aged 14 and over with a range of health and social care needs. There is a dedicated transition team at CLDS, working with young people from the age of 14, going through transition from children's to adults' services.

Social Care

There are no residential facilities for people with learning disabilities in Tower Hamlets, but around 160 CLDS clients are placed in residential care out of borough and around 50 people in supported living (including in-borough).

Over 400 adults with learning disabilities receive either domestic or personal homecare services in Tower Hamlets.

There are several day opportunities accessed by around 250 people with learning disabilities in Tower Hamlets, including Coborn day centre, Apasenth, Blue Skies Project (Redbridge Community Housing Ltd.), the Camden Society, and Tower Project New Dawn. The Tower Project also provides a day service for adults with Autistic Spectrum Disorder, First Start.

Through the Transforming Adult Social Care Programme there is increased focus on choice and control and the use of personal budgets.

Learning Disabilities and the Criminal Justice System

There are no definitive numbers of the number of people with learning disabilities who are arrested and taken into custody, due to the inadequacy of identification, difficulty in diagnosis and the lack of local systematic data collection. However, estimates suggest that there are about 6,000 prisoners in the UK with a learning disability[5]. One study of over 9,000 custody records over a 3-year period in an inner-city police liaison service judged 8.7% of suspects to have a definite or possible learning disability. The Shoreditch ward at the John Howard Centre was opened in June 2009, providing a 14 bed specialist inpatient service for offenders with learning disabilities and complex mental health needs in Tower Hamlets, Hackney and Newham.

5. What evidence is there that we are making a difference?

There are two National Indicators relating to adults with learning disabilities:

- NI 145: The percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation at the time of their assessment or latest review.
- NI 146: All adults aged 18-69 with learning disabilities that are known to 'Councils with Adult Social Services Responsibilities' (CASSRs) employed as an employee or self employed for one or more hours per week.

In 2009/10 Tower Hamlets performed poorly on NI 145, reporting just 50% of adults with learning disabilities in settled accommodation (a decrease from 77% in 2008/09 and one of the lowest percentages in the country). This compares to a London average of 59% and an England average of 61%, and is lower than both Hackney (65%) and Newham (54%).

In 2009/10 there was a slight increase in the percentage of adults with learning disabilities in employment compared to the previous year (3.4% compared to 3.3% in 2008/09). This is lower than both the London and England averages (8.3% and 6.4% respectively), lower than Hackney (4.8%) and the same as Newham.

In Tower Hamlets only 20% of people registered on GP registers with a learning disability received a health check in 2009/10, compared to 41% nationally and a London average of 37%. This figure was the same in Tower

[5] Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board. Department of Health, 2009

Hamlets in 2008/09 and in 2009/10 despite most London PCTs achieving an increase. It is of some concern that more than 1,130 people were registered on GP registers with a learning disability in Tower Hamlets in 2008/09, but only 635 were in 2009/10. This suggests there are serious issues with data recording rather than an actual decrease in the number of people with learning disabilities.

6. What is the perspective of the public on support available to them?

The DVD produced for the Six Lives Panel highlighted some areas of concern within health services, where people had some negative experiences.

A CLDS service user survey conducted in 2008/09 indicated a lack of awareness of information leaflets and of health action plans amongst service users.

A focus group conducted with service users at Coborn Day Opportunities found that people were very positive about a range of activities they took part in, especially activities that involved going out and socializing. People also enjoyed creative activities in the centre and using the kitchen facilities to develop cooking and food preparation skills. People were also very positive about experiences at Poetry in Wood and using Makaton.

A focus group conducted with people at Poetry in Wood identified several people who were keen to move house and get a job. Some people also mentioned that they would like more time with or support from a social worker.

Suggestions from THINk Patient and User Comments include:

- Increased support for young adults with learning disabilities (who are not eligible or could not secure access to day care centres) for independent living as well as access to public places. Specifically, the need to increase the range of facilities available for physical activities and socialisation, and the need to increase support for securing employment were identified.
- More team advocates for young people with learning disabilities.
- More accessible easy-read documents.
- Improved co-ordination between different agencies involved in disabilities services.
- Increased public information on learning disabilities.
- Increased facilities and opportunities for respite care.
- Increased outreach for people with learning disabilities, especially for those at university or attending colleges in the borough.
- Increased support for independent and small community living for people with any disability, including a learning disability.

7. What more do we need to know?

There is no systematic recording in health or social care data of specific diagnosis or type of learning disability. It is currently difficult to estimate the number of people with learning disabilities in Tower Hamlets who have complex needs. This is important in order to predict future numbers for service planning and work is planned with CLDS to audit the number of clients with complex needs, including behavioural issues, mental health conditions and complex physical needs.

8. What are the priorities for improvement over the next 5 years?

- **Carers**
  - To develop a plan of support for carers of people with learning disabilities, to include how carers can be important in helping someone with a learning disability get a job, go to college or try new activities.
- **Challenging Behaviour**
  - To develop a strategy of how best to support people with challenging behaviour, with particular

focus on what services are available, people living out of borough because of their behaviour, and young people with challenging behaviour going through transition.

- **Communication and engagement with service users**
  - To improve service user involvement with the Partnership Board and ensure that people are able to contribute to discussions about important issues.
- **Employment**
  - To ensure that organisations in Tower Hamlets offer work experience and paid work to people with learning disabilities, with focus on monitoring progress of the JET scheme at Tower Project.
- **Health Inequalities**
  - The Health Sub Group of the Partnership Board to write an action plan with recommendations from the Six Lives Project and the Big Health Check Up Day.
- **Safeguarding and Community Safety**
  - To involve the Safeguarding Board in the Partnership Board and to work with the borough's Crime and Disorder Reduction Partnership
  - To work on reducing hate crime, improve support for people with learning disabilities in the criminal justice system, and to work on how to help people feel safer when using public transport.
- **Personalisation**
  - To help people with learning disabilities understand about personalisation and personal budgets, how they can spend them and what choice and control means for them. To ensure that Adults Health and Wellbeing have an understanding of the concerns voiced by people with learning disabilities regarding personalisation.

Longer term, it is hoped that the impact of personal budgets will be a shift away from use of long term social services such as day care and residential care for as many people as possible. It is intended that increased resources for preventative services such as employment support, information and advice, advocacy, leisure opportunities and adult education will promote wellbeing and independence for people with learning disabilities and reduce the need for long term services.

9. Key Contacts & Links to Further Information

The general contact email for JSNA queries is JSNA@towerhamlets.gov.uk

To contact the **Community Learning Disabilities Service**:
Telephone 020 8121 4444 or email learningdisabilities@thpct.nhs.uk

To find out more about **services available for people with learning disabilities and their carers** in Tower Hamlets:
http://www.lddirectory.org.uk/HomePage.asp?NodeID=89723

To access useful **national data and reports** on the health and wellbeing of people with learning disabilities:
www.improvinghealthandlives.org.uk

Date updated:	11/04/11	**Updated by:**	Lizzy Gatrell	**Next Update Due:**	

Date signed off by Senior JSNA Leads:	April 2011	**Signed off by (Public Health Lead):**	Dr Somen Banerjee	**Date signed off by Strategic Group:**	n/a	**Sign off by Strategic Group:**	Learning Disabilities Partnership Board
		Signed off by (LBTH Lead):	Deborah Cohen				

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Teenage pregnancy: Factsheet

Tower Hamlets Joint Strategic Needs Assessment 2010-2011

Executive Summary

- Teenage Pregnancy (TP) is a significant public health, inequality and social exclusion issue which is strongly associated with the most deprived and socially excluded young people. Difficulties in young people's lives such as poor family relationships, low self-esteem and dislike of school contribute to young people's risk.
- Teenage pregnancy is a complex issue that can have negative consequences on the mother and child as are more likely to suffer poor health outcomes, poor emotional health and economic well-being. TP places significant burdens on the NHS and wider public services.
- Reducing TP is central to improved outcomes for young men and women. It reduces health inequality, child poverty and the cost associated with addressing the poor outcomes for young parents and their children.
- The provisional 2009[1] under-18 conception rate for Tower Hamlets was 40.7 per 1000 females aged 15-17 – a decrease of 29.6% from the baseline (1998) compared with a national decrease of 18.1% and a London decrease of 20.3%. The under-18 conception increased by 12.5% from the 2008 rate. However, even with the increase Tower Hamlets rate is the same as London but slightly higher than England.
- In 2009, 66% of conceptions under the age of 18 led to an abortion. This is higher than the average for England (49%) and London (61%).
- There is clear evidence of what works in reducing TP. The three most important aspects are high quality Sex and Relationship Education (SRE), easy access to youth-centred sexual health services and early intervention to target young women at greatest risk of pregnancy[2].
- Locally the challenge is to maintain the current downward trend in teenage pregnancy during major re-organisation in the NHS/Local Authority (LA), the removal of targets and at a time of reduced public spending. It is essential that the effective measures currently in place to tackling child poverty and teenage pregnancy is reviewed and sustained to maintain downward trend.

Recommendations

- Local investment in teenage pregnancy prevention needs to continue. Disinvestment now will lead to increases in child poverty and widening of health and educational inequalities.
- Mainstream / integrate teenage pregnancy prevention and support for young parents within core services.
- Continue with early intervention programme to identify young people at risk of teenage pregnancy / other negative outcomes and provide targeted support.
- Review abortion and post-abortion support.
- Improve young people's access to and use of effective contraception when they need it. Maintain mystery

[1] ONS 2009 data, released in August 2011.
[2] Teenage Pregnancy: The evidence (February 2011) www.teenagepregancyassociates.co.uk

shoppers and You're Welcome programme

- Work collaboratively with LA on SRE in school and youth settings.

1. What is teenage pregnancy?

- Teen pregnancy is a pregnancy occurring in a young girl between the ages of 13 and 19.
- The data of conception is estimated using recorded gestation for abortions and stillbirths and assuming 38 weeks gestation for live births. A women's age at conception is calculated as the number of complete years between her date of birth and the date she conceived.
- A three year group (15-17) is used as the denominator population because the vast majority of conceptions to under 18 years old occur in this age group (95%). The 15-17 groups are effectively treated as the "population at risk". Miscarriages and illegal abortions are not included in the conception rates, resulting in rates that may be an under estimation.
- The key risk factors likely to increase the likelihood of teenage pregnancy can be broadly grouped into: risky behaviours (e.g. early onset of sexual activity, poor contraceptive use, mental health and conduct disorder, involvement in crime, alcohol and substance misuse etc); education-related factor ; and family and social circumstances. Low educational attainment, disengagement from school, being Not in Education, Employment or training (NEET) and living in care, put young people at greatly increased risk of early pregnancy[3].
- TP often leads to poor long-term outcomes for young parents and their children. Babies of teenage mothers face more health problems than those of older mothers.
- Reducing teenage pregnancy contributes to a wider strategy to reduce inequalities and social exclusion. For example, not addressing the underlying causes of teenage pregnancy will contribute to child poverty, infant mortality and the transfer of disadvantage between generations.

2. What is the local picture?

- The most recent figures released by ONS are for 2009 (There is a 14 months delay in the publication of national conception statistics).
- In 2009, there were 132 conceptions out of 3207 female aged 15-17 (ONS population estimate), a rate of 40.7/1000, which is a 29.6% decrease from 1998 baseline compared with a national decrease of 18.1% and London decrease of 20.3%. This still falls short of the national target of 50% (from the 1998 baseline)[4] and the local target[5] of 55% to be achieved by 2010.
- In 2009 the conception rate in Tower Hamlets 15-17 year olds was same as London (40.7) but higher than England (38.2) rates.
- In 2009, 66% (87) of conceptions under the age of 18 led to an abortion. This is higher than the average for England (49%) and for London (61%). Although the number and rate of 15-17 year olds conceiving decreased from the 2003-05 period to the 2006-08 period, the percentage of U18 conceptions leading to abortion has

[3] Teenage Pregnancy: Accelerating the Strategy to 2010 (2006) http://media.education.gov.uk/assets/files/pdf/t/teenage%20pregnancy%20%20%20accelerating%20the%20strategy%20to%202010.pdf

[4] As an original commitment in the Teenage Pregnancy Strategy (1999), reduction in the under-18 conception rate by 50% by 2010 has been a Public Service Agreement target since 2005.

[5] NHS Tower Hamlets (2007) Sexual Health Strategy, 2008-2013.

increased slightly.

- The percentages of abortions that are repeat have remained relatively stable, with higher averages than England, but lower than average for Inner London.
- Since the start of the strategy, increasing proportions of young women have opted for abortion, with most recent data showing over half (66%) of these under-18 conceptions are terminated.
- The birth rate arising from under-18 conceptions fell by 40% (1998-2008). Indicating that early childbearing has become less appealing.
- Local data suggest that in comparison to the demographic white females are more likely to conceive and also continue with the pregnancy. The Bangladeshi females conceiving are under-representing in comparison to the demographic, however high percentages tend to have abortion rather than continue with pregnancy.
- A review of the aggregated ward level data for 2006-2008 shows that efforts should be focused particularly on the east of the borough, LAP 5, 6 7 and 8. Lap 5 and 7 in particular has the highest Under 18 conception rate. The teenage pregnancy hotspots are located in: Spitalfields & Banglatown (Lap 2); Whitechapel (LAP 3); Bow East & Bow West (LAP 5); Mile End East & Bromley By Bow (Lap 6); East India, Lansbury & Limehouse (LAP 7); Blackwell and Cubitt Town (LAP 8).

3. What are the effective interventions?

The Department for Children, Schools and Families (DCSF) and Department of Health (DH) have published several documents [6] [7] [8] on effective interventions that reduce teenage pregnancy and have identified a range of factors that local areas need to put in place to successfully reduce teenage pregnancy rates. All areas have been asked to implement these factors, which are:

- Engagement of delivery partners
- Selection of senior champion(s)
- Effective sexual health advice service
- Focus on targeted interventions for young people at higher risk
- Prioritisation and effective delivery of Sex and Relationships Education (SRE)
- Training on SRE for partner organisations
- Well-resourced youth service

DCSF and DH highlighted the importance of having prevention programmes in place and providing support for teenage parents.

- National and international research suggest that giving young people knowledge about sex and relationships and helping them develop skills to mange relationships effectively, is protective. There is strong evidence that SRE programmes help to delay first sex and make it more likely that young people will use contraception when they become sexually active. Clear and consistent messages to young people through media campaigns can also impact positively on young people's attitudes and behavior. School-based SRE is a key source of information for young people.

- Improving young people's access to and use of effective contraception when they need it via provision of young people focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them.

- Early intervention programme with those most at risk by tackling the underlying factors that increases the risk of teenage pregnancy – such as poverty and low aspirations. These include young people with low educational attainment, dislike of school and poor attendance, in contact with the police, poor emotional and mental health and those living in and leaving care. Offering appropriate support to young people who experience these underlying risk factors will help to build their resilience and raise aspirations and so reduce the likelihood that they experience a range of poor outcomes, including teenage pregnancy.

- Workforce training on sex and relationship issues within mainstream partner agencies who work with the most vulnerable young people.

- Youth Service providing things to do and places to go for young people, with a clear focus on addressing key social issues affecting young people, such as sexual health.

- Improving outcomes for teenage parents and their children rest with a range of services working together across the NHS, Local Authority and the voluntary sector. The Teenage Parents Next Steps highlighted the importance of early identification and needs assessment in the antenatal period and dedicated, sustained dedicated one to one support from a lead professional providing co-ordinated package of care and drawing

[6] DfES Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies. 2006. (www.everychildmatetrs.gov.uk)
[7] DfES Teenage Pregnancy: Accelerating the Strategy to 2010. 2006. (www.everychildmatters.gov)
[8] DCSF Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trust. 2007. (www.everychildmatters.gov)

in specialist services as needed.

4. What is being done locally to address this issue?

Tower Hamlets Teenage Pregnancy strategy seeks to tackle unplanned teenage conceptions and support for teenage parents. Reducing local teenage conception is included within a broader strategy of improving Sexual Health and Children and Young People's Plan.

A number of local initiatives exist within Tower Hamlets to provide support and encouragement for young people to be sexually responsible, use contraception and to raise young people's aspirations. These initiatives works across the health, education, social care and youth support sector.

The local initiatives are based on evidence of best practice and successful factors highlighted by Department for Children, Schools and Families (DCSF) and Department of Health (DH). Below is a summary of the key local programmes in place to reduce unplanned pregnancy in Tower Hamlets:

- *Provision of young people focused contraception and sexual health services (CASH)* - There are three mainstream sexual health integrated hubs in the borough provided for all ages that young people can access. Young people contraception and sexual health service include:
    - A dedicated team 'Options' within THCASH provides sexual health/contraceptive advice and sexual health promotion to young people under 25.
    - Young people focused sexual health drop-in/clinic. In addition drop-in sessions are held for young people in leaving-care service and residential homes.
    - Free Emergency Hormonal Contraception (EHC) to all residents, 34 pharmacies out of 40 are taking part in the scheme.
    - Condom Distribution Scheme (CDS) in youth and community settings

- *Delivery of Sex and Relationships Education (SRE)* – SRE is being delivered in formal (school) & informal settings (youth and community venues). A number of programmes have been commissioned to support the delivery of SRE to promote positive, safe personal and sexual relationships. In addition, Sexual Health Peer Educators programmes have been developed in schools and the community.

- *Early intervention programme* to prevent unplanned pregnancy, targeted at young girls engaged in risky behaviour. The project offers one-to-one coaching, career aspiration sessions and sex relationship education. Building on the success of this programme, the project has been extended to young men engaged in risky behaviour.

- *Training on SRE for partner organisations* – There is a programme in place for workforce training on teenage pregnancy and sex and relationship issues in mainstream partner agencies. Key professionals for SRE workforce training include: Youth Workers, Personal Advisers and Social Workers etc.

- *Well-resourced youth service* - Local Authority developed initiatives including positive activities and volunteering opportunities for young people across the borough. This includes universal and targeted interventions for young people.

- *Media and communication initiatives* – A number of media and communication campaigns (events, posters, radio adverts) have been developed to give young people clear, consistent messages about early sex and its associated risks. Information about the local sexual health services, contraception, and STI prevention is provided. The main campaigns are in February (Valentine's Campaign), July/August (Summer Campaign) and December (festive season).

- *Support for teenage parent* – There are number of initiatives that are in place to support young parents from conception to birth and until the child is 1 year old (Under 18 Pregnancy Adviser, Children Centre and TP Re-integration Officer). Tower Hamlets also have Family Nurse Partnership programme that support first time

mother under 20 until child is 2 year old.

5. What evidence is there that we are making a difference?

- Over the past decade there has been significant progress in reducing teenage pregnancy.
- In 1998, there were 222 conceptions equating to at a rate of 57.8 per 1,000 female aged 15-17 living in Tower Hamlets.
- In 2009, there were 132 conceptions, a rate of 40.7/1000, which is a 29.6% decrease from 1998 baseline.
- In 2009 the conception rate in Tower Hamlets 15-17 years olds was same as London (40.7) but slightly higher than then England (38.2) rates.
- If under-18 conception rates had stayed at the 1998 level, there would have been a cumulative total of 598 additional conceptions by 2009.
- Since the start of the strategy, increasing proportions of young women have opted for abortion, with most recent data showing over half (66%) of these under-18 conceptions are terminated.
- The birth rate arising from under-18 conceptions fell by 40% (1998-2008). Indicating that early childbearing has become less appealing.

6. What is the perspective of the public on support available to them?

Sexual Health Needs Assessment and Equity Audit in Tower Hamlets with main focus on young people under 25 : In-depth engagement and mobile survey with 16-25 young people highlighted the following:

In-depth engagement

- SRE was mostly perceived as inadequate, yet was regarded as a primary area where Sexual and Reproductive Health (SRH) information should be learnt. A preference for outside speakers and not teachers for delivery was made.
- Young men had far less information than young women, were less inclined to seek out services and often perceived that contraception was the girl's responsibility.
- Confidentiality concerns are the main barrier for every group. Young people are actively seeking reassurance from services that they are indeed confidential and suggested it is included in advertising/promotional materials.
- White/black/mixed men had clear preference for youth services/community based organisation to provide sexual health services though it is suitable in general practice as well; White/black/mixed girls had a very clear preference for SRH services in general practice and they were probably most knowledgeable about services of all young people. Young Asian men and women had concerns about being judged by family GPs, particularly if they were also of Asian origin.
- Access to services for some young men, notably in E3, was hindered by postcode/territorial boundaries.

Mobile Survey

201 respondents participated in the mobile survey – 58% were women and 40% were men and diverse ethnicities were well represented.

- Young people felt that they were well informed about sexual health in Tower Hamlets, with 71% saying that they had enough information.
- There was a relatively low recognition of mainstream services, with Mile End Hospital (The Sylvia Pankhurst

centre) being most frequently recognised (by 19% of respondents).

- 28% of respondents said that they had never been to a sexual health clinic.
- There was a strong reliance on the condom as a form of contraception – 48% respondents cited it as their current method, with very low (2-5%) use of LARCs apparent.
- Shops and pharmacies were the preferred location for accessing condoms (cited by 30% of respondents).
- There was high awareness that EHC was available, but only half of respondents knew that it was free for those under 25 years old.
- Demand of EHC was high – nearly a third of respondents said that they had needed to access EHC in the last two years, most often (for 40% of respondents) through a local pharmacy. Self-reported problems accessing EHC were also high – 68% of those using EHC had reported a problem.
- There was a high rate of testing for STIs and HIV – 35% reported having tested for STIs and 30% for HIV in the past 5 years, mainly through GUM and GPs.
- There was a clear preference for being able to access SRH services through GPs in the future, including for general contraception, STI and HIV testing.
- There was strong support for current walk-in services, with 58% citing this as their preferred option.

7. What more do we need to know?

- Undertake an audit of abortion and post-abortion care in Tower Hamlets in order to understand the care pathway provided/available in Tower Hamlets.
- Analysis of live birth and abortion data via LAP area.
- Evaluate impact of early intervention programme.
- Strategic media and communication and social marketing strategy.

8. What are the priorities for improvement over the next 5 years?

- Mainstream / integrate teenage pregnancy prevention and support for young parents within core services.
- Refresh the Teenage Pregnancy strategy beyond 2010.
- Train up teachers, support staff and school nurses to deliver SRE.
- Improve quality and consistency of what is provided through SRE in schools.
- Improve young people's access to and use of effective contraception when they need it – service to be young people friendly via achieving the You're Welcome accreditation.
- Ensure health providers offering full range of contraception, including long acting reversible methods along with condoms to protect against STIs.
- Review abortion and post abortion care pathway.
- Review and further develop the early intervention programme, which has the potential to identify young people at risk of teenage pregnancy / other negative outcomes and provide targeted support.

- Ensure robust care pathways are in place for prevention and support
- Continue to deliver a comprehensive co-ordinated package of support for teenage parents through Children's Centre.

9. Key Contacts

- Reha Begum – Public Health Strategist: Tel 020 7092 5111 e-mail reha.begum@thpct.nhs.uk
- General JSNA queries email: JSNA@towerhamlets.gov.uk

Teenage Pregnancy Strategy / key national documents
http://webarchive.nationalarchives.gov.uk/tna/+/dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/teenagepregnancy/

Sexual Health Needs Assessment and Equity Audit in Tower Hamlets with main focus on Young People Under 25
http://www.towerhamlets.nhs.uk/publications/corporate-publications/?entryid4=37884&q=0%c2%acsexual+health%c2%ac

NICE guideline - Prevention of sexually transmitted infections and under 18 conceptions
http://www.nice.org.uk/PHI003

Under 18 conceptions statistics (Annual data released at the end of February)
http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15055

Date updated:	*April 2011*	**Updated by:**	*Reha Begum, Public Health Strategist*	**Next Update Due:**	*March 2012*

Date signed off by Senior JSNA Leads:	*Date factsheet signed off by senior JSNA leads from Public Health and LBTH*	**Signed off by (Public Health Lead):**	*e.g. Director or Associate Director*	**Date signed off by Strategic Group:**	*Date factsheet signed off by Strategic Group*	**Sign off by Strategic Group:**	*Name the relevant Strategic Group*
		Signed off by (LBTH Lead):	*e.g. Director of Adults/CFS*				

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North East Locality Maternity and Child Health Profile

Index **Page**

Health headlines for children and young people

In Tower Hamlets

- Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Male life expectancy is 75.3 years compared to 77.82 nationally and female life expectancy is 80.4 compared to 81.95 (2006-8).
- The most important factor accounting for health inequalities between Tower Hamlets and elsewhere is socioeconomic deprivation. The borough is ranked the third most deprived nationally with the most deprived Super Output Area in London. All wards in Tower Hamlets are in the 2% most deprived wards in the country for deprivation affecting children.

Early years

- The birth rate in Tower Hamlets is similar to the London average (64.8/1000 female population aged 15-44). 45% of births are to mothers of Bangladesh origin.
- Although a higher proportion of newborns have lower birth weight than London (9.9% <2500g), infant mortality rates are not significantly different to London, although rates increased markedly in 2009.
- High breastfeeding initiation and continuation rates in comparison to London and England averages.
- Tooth decay rates in five year olds have been improving but remain higher than London.
- Childhood obesity in 4-5 year olds is the 6th highest in London.
- Smoking at time of delivery is lower than London and England rates and has continued to reduce.
- High prevalence of maternal vitamin D insufficiency and deficiency

Children and young people

- 60% of under 19s are Bangladeshi.
- Two thirds of under 16s live in low income households (the highest levels of child poverty in the country).
- 1 in 5 children under 15 have tried a cigarette (similar to national averages) and 4 out 10 retailers are selling cigarettes to under 18s.
- Tower Hamlets has the 3rd highest prevalence of obesity in year 6 in the country.
- 3 in 10 children have ever had an alcoholic drink compared to 7 in 10 nationally (reflecting the large Muslim community in the borough).
- Teenage pregnancy rates are lower than England and London averages following a recent downward trend although recent data indicates that rates are expected to increase for 2009.

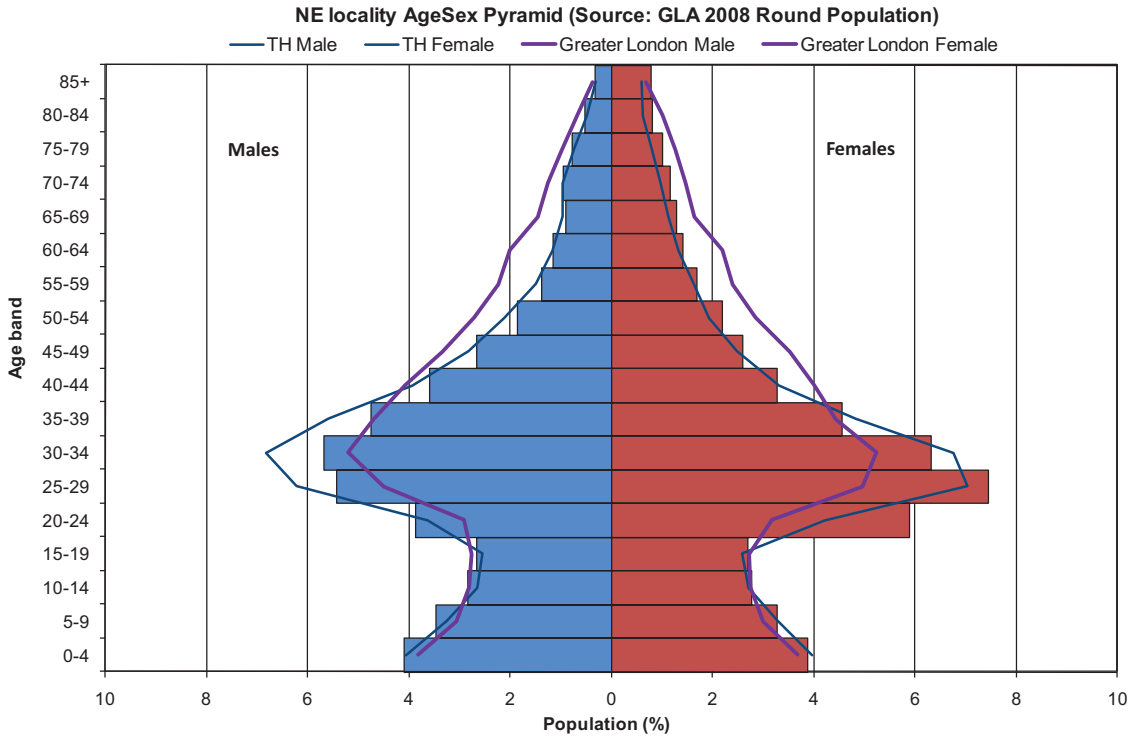
- Childhood immunisation uptake is higher than London and MMR uptake at 24 months and 5 years has increased significantly over the past year (most recent data indicates over 92% uptake of second MMR).
- The number of children on the Child Protection Register has increased sharply over recent years. This primarily reflects increases in ascertainment.
- Prevalence of mental health disorders in children is similar to national averages (around 1 in 10)

In the NE Locality

- Expected population growth in LAP 5 in the 0-19 age range is lower than across the borough as a whole, but higher in LAP 6;
- Male life expectancy in LAP 5 is two years lower than that for Tower Hamlets;
- Crude birth rates are lower than those for Tower Hamlets as a whole;
- Crude under 18 conception rates are higher in all wards than Tower Hamlets except Bromley by Bow, in which they are lower;
- Bromley by Bow and Bow West have significantly higher numbers of low birth weight births than Tower Hamlets as a whole;
- Levels of childhood immunisation are higher than Tower Hamlets levels;
- The NE Locality has lower rates of breast feeding at 6-8 weeks than Tower Hamlets as a whole;
- 5 year olds in LAP 5 have higher levels of dental caries than the Tower Hamlets average.

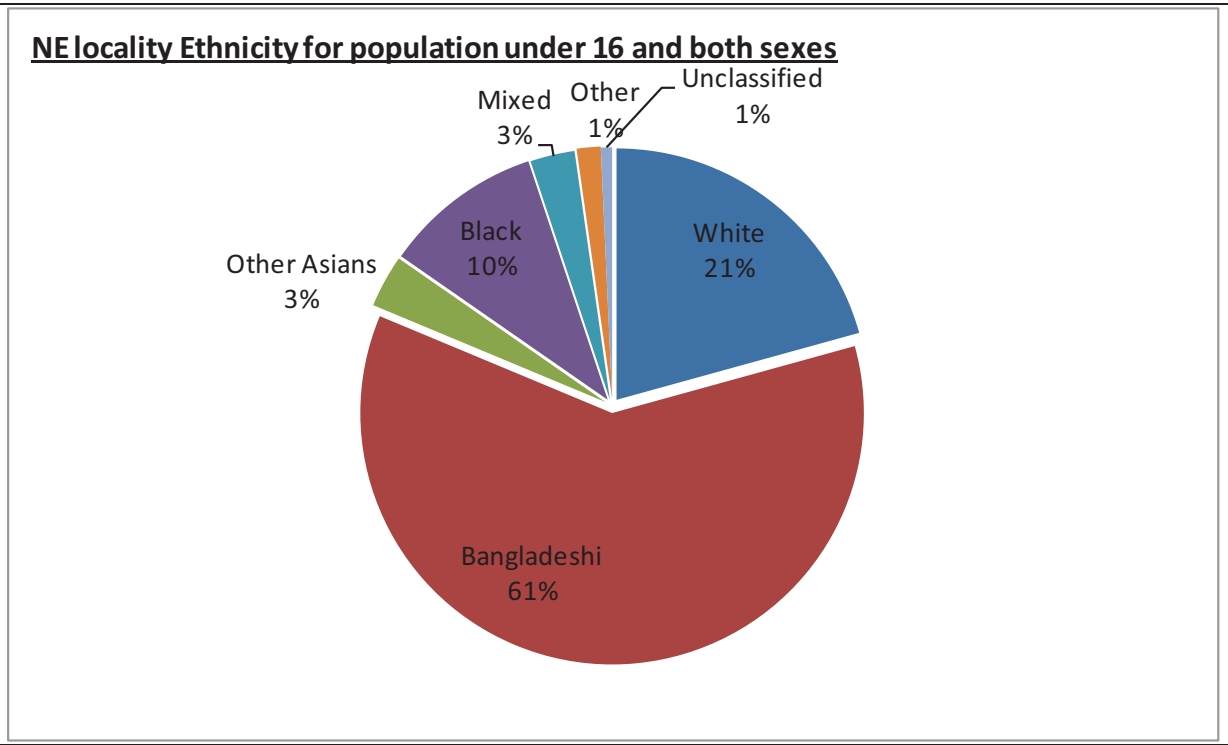
In the locality detail below the sign '*' denotes a proposed indicator in Healthy Lives, Healthy People: Transparency in Outcomes, Proposals for a Public Health Outcomes Framework, while '‡' denotes a proposed indicator in the NHS Outcomes Framework.

North East Locality Maternity and Child Health Headlines		
	LAP 5	**LAP 6**
1 Demographic Data		
1.1 Population 00-19 Source: GLA 2011 Round Ward Population Projections	Number / As % of LAP total 00-04: 1702 — 7.4% 05-09: 1323 — 5.8% 10-14: 1093 — 4.8% 15-19: 1049 — 4.6% 00-19: 5167 — 22.6%	Number / As % of LAP total 00-04: 2971 — 10.1% 05-09: 2524 — 8.6% 10-14: 2124 — 7.2% 15-19: 1853 — 6.3% 00-19: 9472 — 32.2%
Practice registered population 00-19 Source: BLT CEG SQUID Audit 2010	**LAP Total:** Male 13,994 Female 14,010 **00 – 05**: Male 1130 Female 1089	**LAP Total:** Male 15,710 Female 13,972 **00 – 05**: Male 1452 Female: 1477

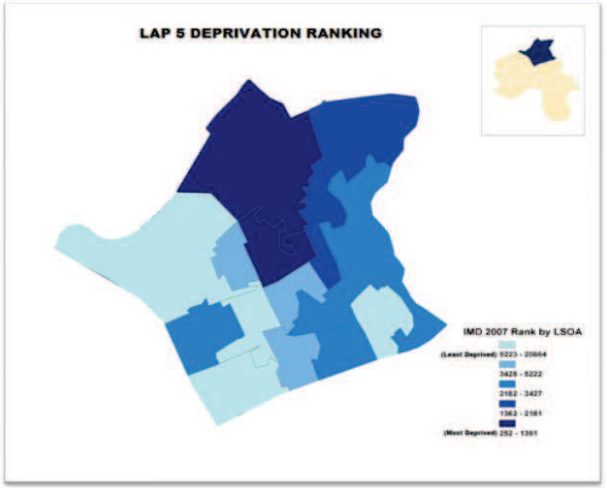
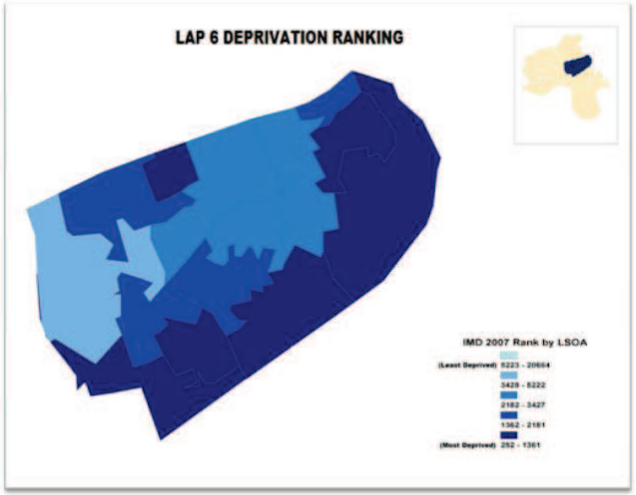
	00 – 16: Male 2647 Female 2567 **00 - 19**: Male 3219 Female 3161	**00 – 16**: Male 3783 Female: 3745 **00 - 19**: Male 4685 Female: 4491
Population – age/sex pyramid Source: GLA 2008 Round Population		
1.2 Expected Growth	The population of Tower Hamlets is expected to increase by 20,000 over the next five years, with the fastest growth rate between 2013 and 2014. The sharp rise is based on an assumption of resumption of housing development as the economic climate improves. The substantial growth in population will be spread unevenly across the Borough. 48% is expected to be in LAPs 7 and 8, 27% in LAPs 5 and 6, 21% in LAPs 1 and 2 and only 3% in LAPs 3 and 4. GLA and ONS MYE projections predict that the London population will increase by 5% and 4.3% respectively between 2010 and 2015.	

Source: NHS TH/LBTH Planning for Population Change and Growth model[1]	**Age** **2011-2012** **2015-2016** **Total:** 23,781 24,096 **00-03**: 1281 1323 **04-10:** 1872 1925 **11-15:** 1081 1149 **16-19:** 827 860 **00-19:** 5062 5258 **% change (00-19) 2011-12 to 2015-16: 3.8%**	**Age** **2011-2012** **2015-2016** **Total:** 30,266 34,993 **00-03:** 2505 2900 **04-10:** 3708 4154 **11-15:** 2071 2403 **16-19:** 1419 1542 **00-19:** 9704 10999 **% change (00-19) 2011-12 to 2015-16: 13.3%**
1.3 Ethnic breakdown total registered population <16, both sexes Source: GLA 2010 Round Project Ethnicity projections/ONS Population Estimates by Ethnic Group 2001-2007 (experimental) Source: BLT CEG SQUID 2009	The ethnic breakdown for Tower Hamlets (GLA 2008) suggests that 20.9% of the 00-19 age group are white (83.6%), 59.7% Bangladeshi (.7%), 3.9% Black African, 3% Black Other, 1.6% Black Caribbean (2.8% for all Black categories), 2.7% Other Asian (.7%), 2% Chinese (.8%), 1.7% Indian (2.6%), .9% Pakistani (1.8%) and 3.7% Other. The non-white 00-19 population is significantly larger at 79.1%than the non-white population across all age groups at 49.7% (numbers in parenthesis are ONS values for England).	

[1] A bespoke population model (PPCG) developed with Tower Hamlets Council that is based on the most recent housing development data and the current and anticipated impact of the recession.



1.4 Birth rate Source: NHS Information Centre (NCHOD) 2008	**Total period fertility rate** (average number of born/woman if she followed age-specific fertility rates) Maternal ages 11-49	**General fertility rate** (number of live births/number of women of childbearing age) per 1,000 female population aged 15-44) births
	England*:* 1.97 (1.96-1.97) London*:* 1.95 (1.94-1.96) **Tower Hamlets***:* **1.75 (1.70-1.81)**	England*:* 63.76 (63.62-64.03) London*:* 69.32 (68.95-69.69) **Tower Hamlets***:* **67.08 (65.15-69.06)**
	The **Tower Hamlets** crude birth rate per 1000 of women aged 15-44 in 2009 is **64.8**	
Source : Public Health Birth File (2009) Population from GLA 2009 round projections SHLAA variant	The **Lap 5** crude birth rate in 2009 was **63.2** per 1000 of women aged 15-44	The **LAP 6** crude birth rate in 2009 was **52.7** per 1000 of women aged 15-44
1.5 Birth rate projections	The numbers of births in **Tower Hamlets** are projected to remain fairly stable over the next 10 years - from	

Source: GLA 2008 demographic projections	4145 in 2010 to 4115 in 2020 but as suggested by the crude birth rate figures, this will be unequally distributed across the borough.
2 Socio-economic Data	
2.1 General deprivation	The borough is ranked the third most deprived nationally. 78.5% of Tower Hamlets residents live in the 20% most deprived areas in England compared to around 26% of London residents. This is reflected in statistics indicating the highest levels of child poverty in the country, amongst the highest unemployment rates in London, a high proportion of people with no qualifications, lower (but improving) educational attainment compared to the rest of the country, higher levels of overcrowding and significant levels of housing classified as 'non decent' (in 2008 52% council housing fell below the decent homes standard compared to 32% in London).
	 
2.2 Homelessness* Source: Communities and Local Government Statutory Homelessness returns 2009	Homelessness is a social determinant of health and an indicator of extreme poverty. Statutorily homeless households contain some of the most vulnerable members of society. In 2009 **Tower Hamlets** had the highest number of statutory homeless households in priority need of all London boroughs (8.3 per thousand households). In **Tower Hamlets** 2007 6.5 per thousand households were households with pregnant women or households with dependant children. One in twelve Tower Hamlets children live in homeless households.
2.3 Children living in poverty* Source: IDAC 2007	Growing up in poverty damages children's health and wellbeing adversely affecting their future health and life chances as adults. All wards in **Tower Hamlets** are in the 2% most deprived wards in the country for deprivation affecting children.

		Score	Rank	% rank (national)		Score	Rank	% rank (national)
	Bow East	.695	18	.2%	Mile End East	.706	14	.2%
	Bow West	.586	94	1.2%	Bromley by Bow	.709	11	.1%
2.4 Access to green space* Source: ONS Neighbourhood Statistics	There is strong evidence to suggest that there is a positive relationship between green space and the general health of the population. Studies indicate that better health is linked to green space provision, regardless of the socio-economic status of the people who use it. There is strong evidence to suggest that green spaces have a beneficial impact on mental wellbeing and cognitive function through both physical access and usage. Tower Hamlets has the 3rd lowest percentage of green space of all UK boroughs at 15.2%, although much of this is restricted access.							
3 Health Data								
General								
3.1 Life expectancy at birth* Source: LHO, 2009 (2003 – 2007 data)	*England life expectancy: Male: 77.3; Female: 81.5* *Tower Hamlets: Male 75.2; Female 80.8* **LAP 5** Male: 73.5 yrs (almost 2 yrs lower than Tower Hamlets) **LAP 5** Female: 80.3 yrs (similar to Tower Hamlets) **Bow East** Male 72.6 Female 80.9 **Bow West** Male 74.5 Female 79.7				*England life expectancy: Male: 77.3; Female: 81.5* *Tower Hamlets: Male 75.2; Female 80.8* **LAP 6** Male 73.9 yrs (1yr lower than Tower Hamlets) **LAP 6** Female 80.7 yrs (similar to Tower Hamlets) **Mile End East** Male 73.7 Female 77.9 **Bromley by Bow** Male 74.1 Female 83.6			
Maternity and Early Years								
3.2 Booked by 12 weeks 6 days Source: BLT Maternity Unit	Percentage of Tower Hamlets mothers booked 2009/10: 83.68% Percentage of Tower Hamlets mothers booked Q3 2010/11: 92.16%							
3.3 Smoking at booking and delivery* Source: BLT Maternity Unit; DH monitoring return (quarter 3 2009/10)	Smoking during pregnancy contributes to 6% of all infant deaths and accounts for about a third of the difference in infant deaths between the most and least deprived groups in the population. The proportion of mothers who smoked throughout their pregnancy is much higher in mothers under 20 years of age. England: 13.9% London: 7.1% **Tower Hamlets: 5.7%**							
3.4 Under 18 conception rates (per 1000 female population aged 15-17)*	Evidence shows that teenage parenthood leads to poorer health outcomes for both teenage parents and their children - babies born to teenage parents have a 60% higher risk of infant mortality and teenage mothers and							

<table>
<tr><td>Source: Teenage Pregnancy Unit 2006-08

Ward level: ONS <18 conception rate (2005-07)</td><td>three times more likely to suffer from post-natal depression.
Rate per 1000 of females aged 15-17:
England: 40.9
London: 45.3
Tower Hamlets: 41.4

Tower Hamlets: 45.0/1000
Bow West: 68.4/1000
Bow East: 61.0/1000

Tower Hamlets: 45.0/1000
Mile End East: 48.0/1000
Bromley by Bow: 41.9/1000</td></tr>
<tr><td>3.5 Gestational diabetes and diabetes in pregnancy
Source: 2008 Diabetes Audit BLT</td><td>Diabetes audit suggested that 10% of those reviewed had developed gestational Diabetes Mellitus; 81.7% were Bangladeshi, 7.9% Black African and 4.1% White.</td></tr>
<tr><td>3.6 Antenatal screening
Newborn bloodspot
Source: Q2 2010 Tower Hamlets sickle cell and thalassaemia service newborn bloodspot quarterly report</td><td>41 results received; 0 babies affected, 41 carrier results, 0 transfused results, 3 inconclusive results.</td></tr>
<tr><td>3.7 Vitamin D
Maternal Vitamin D status
Source: Antenatal vitamin D screening at Barts and the Royal London NHS Trust, April 2010 (N = 497)</td><td>Deficiency (≤50nmol/L): 74%
Insufficiency (50-75nmol/L): 11%
Normal (≥75nmol/L) 15%</td></tr>
<tr><td>Under 5’s treated for Vitamin D deficiency
Source: Antenatal vitamin D screening at Barts and the Royal London NHS Trust, April 2010 (N = 497)</td><td>
<table>
<tr><th>Network</th><th>Number</th><th>% of 5 pop</th><th>Under 5 population</th></tr>
<tr><td>NW1</td><td>137</td><td>8.03%</td><td>1706</td></tr>
<tr><td>NW</td><td>256</td><td>.14%</td><td>3144</td></tr>
<tr><td>NW3</td><td>257</td><td>11.30%</td><td>2274</td></tr>
<tr><td>NW4</td><td>420</td><td>18.13%</td><td>2317</td></tr>
<tr><td>NW5</td><td>138</td><td>7.01%</td><td>1969</td></tr>
<tr><td>NW6</td><td>104</td><td>5.90%</td><td>1763</td></tr>
<tr><td>NW7</td><td>335</td><td>10.08%</td><td>3324</td></tr>
</table>
</td></tr>
</table>

		NW8	102	3.99%	2555	
		Total	1749	9.2%	19052	

3.8 Caesarean section rates 2009-10 Source: HES 2011 Provider level analysis, 2009-10		Total births:	Elective Caesarean	Emergency Caesarean	Total
	England:	652,377	9.7%	14.4%	24.1%
	London:	129,264	10.2%	16.9%	27.1%
	Barts & The London NHS Trust:	4,428	7.5%	17.1%	24.6%

3.9 % Low birth weight births (<1,500 and <2,500 grams)* Source: NCHOD	Although a higher proportion of newborns have lower birth weight than London, infant mortality rates are not significantly different to London (3.1/1000 live births).			
		<1,500	<2,500	
	England:	1.4% (1.4-1.5)	7.5% (7.4-7.5)	
	London:	1.6% (1.5-1.7)	7.9% (7.8-8.1)	
	Tower Hamlets:	**1.5% (1.2-1.9)**	**9.9% (9.1-10.9)**	
Source: <2,500 grams 2004-06 ONS, analyses by LHO	**Bow West**	**Statistical significance**	**Mile End East**	**Statistical significance**
	10.6%	Yes - high	9.5%	No
	Bow East		**Bromley by Bow**	
	9.6%	No	11.0%	Yes - high

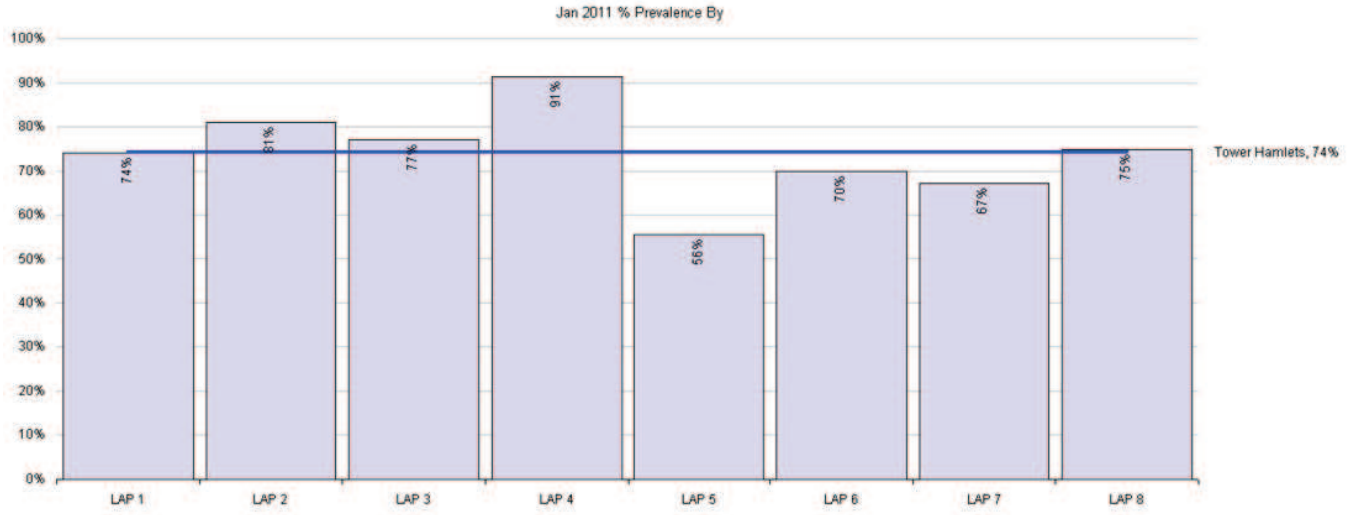
% Low birth weight births (<2,500 grams) by ethnic group Source: Births from Public Health Birth File (2009-10)	The following data breaks the 2009-10 **Tower Hamlets** low birth weight births down by ethnic group:			
	White:	6.4%	Not known/stated:	7.9%
	Mixed:	6.5%	Other:	8.4%
	Black:	7.3%	Asian:	9.0%

3.10 Infant mortality (2008 and 2009 crude rate – all maternal ages/1000 live births)*‡ Source: NCHOD	Infant mortality is a widely used indicator of the overall health of a population. It reflects a broad range of determinants including upstream determinants such as economic development, general living conditions and social and environmental factors. *Infant mortality* is defined as the number of deaths at ages under one year, per 1,000 live births. *Perinatal mortality* is defined as stillbirths plus deaths before 7 days of life, per 1,000 live and stillbirths. *Stillbirths* are defined as deaths in babies born after 24 or more weeks' completed gestation and which did not, at any time, breathe or show signs of life.							
		2009				**2008**		
		<1 yr	**<28 days**	**<7 days**		**<1 yr**	**<28 days**	**<7 days**
	Eng:	4.6 (4.5 – 4.8)	3.2 (3.0 – 3.3)	2.4 (2.3 – 2.5)	Eng:	4.7 (4.5 – 4.9)	3.2 (3.1 – 3.4)	2.5 (2.4 – 2.6)
	Lon:	4.5 (4.1 – 4.9)	3.1 (2.8 – 3.4)	2.4 (2.1 – 2.6)	Lon:	4.3 (3.9 – 4.6)	2.8 (2.6 – 3.1)	2.2 (1.9 – 2.4)
	TH:	**5.1 (3.3 – 7.7)**	**3.9 (2.4 – 6.3)**	**3.0 (1.7 – 5.2)**	**TH**:	**3.1 (1.8 – 5.3)**	**1.9 (.9 – 3.8)**	**1.7 (.8 – 3.5)**

3.11 Breastfeeding rates at 6-8 weeks* (Q3 2010-11)	There is evidence that breastfeeding has positive health benefits for both mother and baby in the short and longer term (beyond the period of breastfeeding).

Source: Department of Health Vital sign monitoring return

	England	*London*	**TH**
Overall prevalence (total plus partial)	44.9%	64%	74%
Infants totally breastfed:	31.1%	37.8%	35.7%
Infants partially breastfed:	13.8%	26.2%	38%
Infants not at all breastfed:	46.9%	26.2%	25.4%
Not known:	8.1%	9.9%	0.7 %



Breastfeeding initiation* 2010-11 Q3
Source: Department of Health, Vital Signs Monitoring Return

England:	73.5%
London:	86.9%
Tower Hamlets:	88.6%

3.12 Immunisation coverage (Q3 2010-11)*
Source: Extract from Exeter

	LAP 5	TH		**LAP 6**	TH
12 month DtaP/IPV/Hib:	94%	93%	12 month DtaP/IPV/Hib:	93%	93%
24 month MMR:	93%	88%	24 month MMR:	93%	88%
5 year DtaP/IPV (Booster):	91%	87%	5 year DtaP/IPV (Booster):	93%	87%
5 year MMR (2nd dose):	86%	87%	5 year MMR (2nd dose):	91%	87%

3.13 Prevalence of dental caries: decayed, missing or filled teeth (DMFT) average in children aged 5*

Dental disease is more common in deprived, compared with affluent, communities. This indicator is a good direct measure of dental health and an indirect, proxy measures for child health and diet. **Tower Hamlets** has historically had a higher proportion of < 5 year old children with tooth decay although this figure has fallen

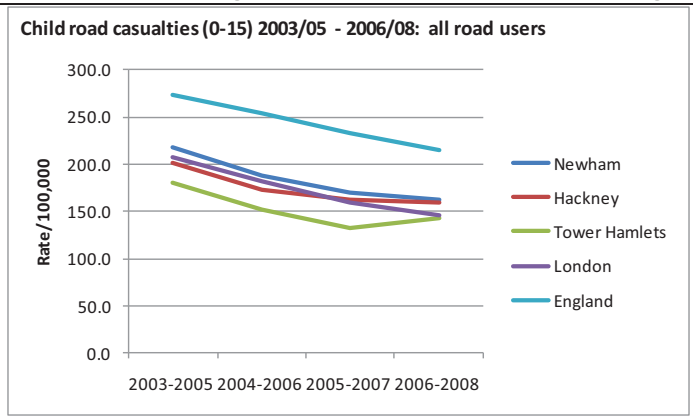
Source: BASCD, 2009	significantly over the past decade. The DMFT index quantifies dental health status based on the number of carious, missing and filled teeth.				
	England:	1.11		England:	1.11
	London:	1.31		London:	1.31
	Tower Hamlets:	**1.77**		**Tower Hamlets:**	**1.77**
	LAP 5:	**1.94**		**LAP 6**:	**1.47**
3.14 Childhood obesity in Reception year* Source: NHS Information Centre 2010, analysis by Public Health	Obese/overweight individuals cost the NHS approximately £4.2bn per annum. By 2015, it is estimated that 53,000 deaths each year will be due to excess weight. **Tower Hamlets** ranks 6th highest in London for childhood obesity measured at Reception. Levels have fallen by 1.3% since 2006-07. Childhood under weight in **Tower Hamlets** is 2% at Reception, 10th highest in London. Differences in prevalence in **LAPs 5** and **6** are not statistically significant from the Tower Hamlets levels.				
		Underweight	Overweight	Obese	
	England:	0.9%	13.3%	9.8%	
	London:	1.3%	12.7%	11.6%	
	Tower Hamlets:	**2.0%**	**11.3%**	**13.3%**	
	LAP 5 (2008-09)			**LAP 6 (2008-09)**	
	Reception underweight:	**1.7% (.7 – 3.4)**		Reception underweight:	**2.2 % (1.2 – 4.1)**
	Reception overweight:	**12.7% (9.0 – 14.1)**		Reception overweight:	**11.4% (8.7 – 14.9)**
	Reception obesity:	**9.6% (6.4 – 11.1)**		Reception obesity:	**14.6% (11.5 – 18.3)**
3.15 Hospital episodes: Serious accidental injury relating to hospital admissions 0-4 directly standardised rates per 100,000 (95% confidence intervals)* Source: NCHOD	Injuries are the leading cause of death in children and disproportionately affect children from lower socioeconomic groups.				
		2005-06	2006-07	2007-08	
	England:	84.3 (81.0-87.6)	85.2 (81.9-88.5)	85.99 (82.7-89.3)	
	London:	80.6 (72.8-88.5)	84.6 (76.7-92.6)	77.19 (69.7-84.6)	
	Tower Hamlets:	138.1 (81.6-194.7)	110.7 (60.9-160.6)	132.2 (78.1-186.4)	
Children and Young People					
Lifestyle factors					
3.16 Childhood obesity in school year 6* Source: NHS Information Centre 2010, analysis by Public Health	Obese/overweight individuals cost the NHS approximately £4.2bn per annum. By 2015, it is estimated that 53,000 deaths each year will be due to excess weight. **Tower Hamlets** ranks 3rd highest in London for prevalence of obesity at Year 6. Levels rose by 2.7% between 2006-07 and 2008-09 but remained static between 2008-09 and 2009-10.				

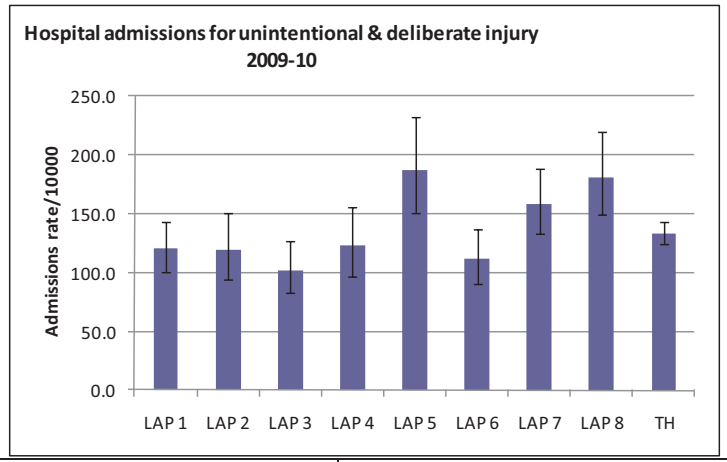
<table>
<tr><td></td><td>Childhood under weight in Tower Hamlets is 2.1% at Year 6, the 11th highest in London. Differences in prevalence in LAPs 5 and 6 are not statistically significant from the Tower Hamlets levels.

<table>
<tr><td></td><td>Underweight</td><td>Overweight</td><td>Obese</td></tr>
<tr><td>England:</td><td>1.3%</td><td>14.6%</td><td>18.7%</td></tr>
<tr><td>London:</td><td>1.5%</td><td>15.1%</td><td>21.8%</td></tr>
<tr><td>Tower Hamlets:</td><td>2.1%</td><td>15.6%</td><td>25.7%</td></tr>
</table>
<table>
<tr><td>LAP 5 (2008-09)</td><td></td><td>LAP 6 (2008-09)</td><td></td></tr>
<tr><td>Year 6 underweight:</td><td>1.9% (.7 – 3.7)</td><td>Year 6 underweight:</td><td>3.1% (1.7 – 5.4)</td></tr>
<tr><td>Year 6 overweight:</td><td>14.8% (10.7 – 16.4)</td><td>Year 6 overweight:</td><td>13.1% (10.0 – 16.9)</td></tr>
<tr><td>Year 6 obesity:</td><td>29.7% (23.9 – 30.9)</td><td>Year 6 obesity:</td><td>23.1% (19.0 – 27.7)</td></tr>
</table></td></tr>
<tr><td>3.17 Physical activity
Source: TellUs Survey, Ofsted (discontinued 2010)</td><td>More children in Tower Hamlets are doing less than the recommended amounts of physical activity per week, with 8% “not having spent at least 30 minutes doing sport or other active things on any day in the preceding week“(compared to 4% nationally).</td></tr>
<tr><td>% of pupils who participated in at least two hours of high quality PE in a typical week
Source: Communities and Local Government Places Database (http://www.communities.gov.uk)</td><td>
<table>
<tr><td></td><td>2005-06</td><td>2006-07</td><td>2007-08</td><td>2008-09</td></tr>
<tr><td>England:</td><td>59.5</td><td>69.3</td><td>76.6</td><td>81.0</td></tr>
<tr><td>London:</td><td>56.0</td><td>69.0</td><td>73.0</td><td>80.0</td></tr>
<tr><td>Tower Hamlets:</td><td>39.0</td><td>63.0</td><td>71.0</td><td>74.0</td></tr>
</table></td></tr>
<tr><td>% of children walking or cycling to school*
Source: Transport for London i-trace database 2010-11</td><td>The % of children walking to school in Tower Hamlets is higher than nationally; In England (2009) 50% of primary school children and 38% at secondary school walked to school.

<table>
<tr><td></td><td>2008-09</td><td>2009-10</td><td>2010-11</td></tr>
<tr><td>% of children walking to primary school:</td><td>77.4%</td><td>76.1%</td><td>75.0%</td></tr>
<tr><td>% of children walking to secondary school:</td><td>53.4%</td><td>53.4%</td><td>55.2%</td></tr>
<tr><td>% of children cycling to primary school:</td><td>0.7%</td><td>0.7%</td><td>0.7%</td></tr>
<tr><td>% of children cycling to secondary school:</td><td>2.1%</td><td>1.3%</td><td>0.9%</td></tr>
<tr><td>% travelling to school by car living < 7 minutes walk:</td><td></td><td></td><td>27%</td></tr>
<tr><td>% travelling to school by car living < 14 minutes walk:</td><td></td><td></td><td>50%</td></tr>
</table></td></tr>
<tr><td>3.18 Healthy diet
Source: TellUs Survey, Ofsted (discontinued 2010)</td><td>Higher numbers of Tower Hamlets children eat lower than the recommended amount of fruit and vegetables than children nationally (15% responding “none yesterday” compared to 9% nationally in 2009).</td></tr>
</table>

Uptake of school meals (% having lunch that is provided by local authority or school) Source: Communities and Local Government Places Database (http://www.communities.gov.uk)	The percentage of children taking up the school lunch offer has remained stable over the last 3 years in primary and secondary schools in **Tower Hamlets**. Uptake has increased rapidly in Newham (from 45.3% in 2007-08 to 60.3% in 2009-10 in primary school, and 32.5% to 41.3% in secondary schools). Uptake in Hackney is broadly similar to that in Tower Hamlets. **Primary** **Secondary** England: 41.4 England: 35.8 London: 49.2 London: 41.3 **Tower Hamlets**: 65.1 **Tower Hamlets**: 50.9
3.19 Smoking and young people Source: TellUs Survey, Ofsted (discontinued 2010)	The annual Ofsted 'Tell Us' survey for 2010 reports that 6% of respondents in **Tower Hamlets** smoke (the same as nationally). This is a slight fall from 2009 (7% locally and nationally). An ASSIST baseline survey of Year 8 pupils (12-13 years old) in 4 **Tower Hamlets** secondary schools in 2009 found that 4% smoked cigarettes at the time of the survey, while 80% had never smoked a cigarette.
3.20 Alcohol and young people Source: TellUs Survey, Ofsted (discontinued 2010)	The annual Ofsted 'Tell Us' survey for 2010 reports that 80% of young people report never having had an alcoholic drink (68% for England), with 3% saying that they had been drunk once (6% for England) , 2% twice (4% for England) and 4% three or more times (5% for England) in the past month. In 2009 62% reported never having had an alcoholic drink, with 1% reporting having been drunk once, twice or 3 or more times in the past month.
3.21 Substance misuse and young people Source: TellUs Survey, Ofsted (discontinued 2010)	The annual Ofsted 'Tell Us' survey for 2010 reports that 9% of young people asked in Years 8 and 10 reported that they had ever taken drugs, with 2% preferring not to say (compared to 9% and 3% nationally). In 2009 9% of young people asked in Years 8 and 10 reported that they had ever taken drugs, with 4% preferring not to say (compared to 11% and 4% nationally).
3.22 STIs Chlamydia diagnosis rates per 100,000 young adults aged 15-24* 2009 Source: Health Protection Agency STI Annual Data Tables	Nationally 29.9% of the population aged 15-24 was tested for chlamydia in 2009/10 and 7.2% tested positive. This indicates a high burden of infection in young people. Annual testing and testing at partner change in this age group is expected to reduce the transmission rate, leading to a fall in prevalence and a secondary reduction in the incidence of new infections. Early diagnosis and treatment will reduce the severe effects of chlamydia in women, such as pelvic inflammatory disease and infertility. England: 2180.6 London: 2428.5 **Tower Hamlets: 1692.7**
3.23 Killed and seriously injured (KSI) children and young people on England's roads*	Road user safety is a public health issue as incidents and collisions on the roads are a significant cause of death and injuries; disproportionately so among young age groups and in disadvantaged areas. They have a large affect on the resources of health and rescue services and there are strong synergies between active travel, road safety and health.
Road traffic injuries	**No. of Child KSIs in 2006-2008/billion vehicle-kms**: **% Reduction in Child KSIs ('94-'98/'06-'08)**:

Source: London Road Safety Unit for 2009 LIP1 data reports	Outer London: 10 62% Inner London: 13 65% **Tower Hamlets**: 9 (15th out of 33 boroughs) 66% (11th out of 33 boroughs)
Average annual rate of reported child (age 0-15) road traffic casualties in England per 100,000 population aged 0-15, by Local Authority Source: LHO Basket of Indicators - Accidents and Injury	 Average annual rate of reported child (age 0-15) road casualties in England per 100,000 population (2006-08) *England:* *214.8* *London:* *145.6* **Tower Hamlets:** **143.4** The number of reported child road casualties for all domains (pedestrian, pedal cycles and all other road users) is consistently lower in Tower Hamlets than regional and national figures and has fallen steadily between 2003-05 and 2005-07 from 79 to 58; the rise in 2006-08 is accounted for by a rise in 'all other road users' numbers from 18 in 2005-07 to 22 in 2006-08.
Hospital admissions	
3.24 Persons aged under 18 years admitted to hospital with alcohol specific conditions (rate/100,000 population)* Source: 2006-07 North West Public Health Observatory local alcohol profile data set	There are substantial differences in the health consequences of alcohol use between affluent and deprived communities. Deprived areas suffer higher levels of alcohol related mortality, hospital admission, crime, absence from school, school exclusions, teenage pregnancy and road traffic accidents linked to greater levels of alcohol consumption. While Tower Hamlets admissions are lower than those nationally, the majority of young people are from communities in which alcohol is proscribed and hence this rate is likely to conceal a relatively large number of admissions from a smaller population, and concealed (and hence riskier) consumption by members of those communities. England: 64.5 (63.6 – 65.4) London: 39.3 (37.6 – 41.1)

<table>
<tr><td></td><td>Tower Hamlets: 49.1 (38.4 – 61.8)</td></tr>
<tr><td>3.25 Hospital episodes: Serious accidental injury relating to hospital admissions 5-14 directly standardised rates per 100,000 (95% confidence intervals)
Source: NCHOD</td><td>Injuries are the leading cause of death in children and disproportionately affect children from lower socioeconomic groups.
<table>
<tr><td></td><td>2005-06</td><td>2006-07</td><td>2007-08</td></tr>
<tr><td>England:</td><td>71.9 (69.8-74.0)</td><td>65.2 (63.2-67.2)</td><td>64.9 (62.9-66.9)</td></tr>
<tr><td>London:</td><td>73.5 (67.7-79.2)</td><td>58.8 (53.6-63.9)</td><td>64.7 (59.3-70.2)</td></tr>
<tr><td>Tower Hamlets:</td><td>96.9 (58.1-135.7)</td><td>94.3 (55.7-132.8)</td><td>103.8 (63.0-144.5)</td></tr>
</table></td></tr>
<tr><td>3.26 Hospital admissions for intentional and unintentional injuries <18*
Source: HES 2010</td><td>Tower Hamlets rate/10,000 in 2009-10: 135.8. The HNA Toolkit CSL/LHO ranked Tower Hamlets 2nd highest in London in 2008-09.
 

<table>
<tr><td>LAP 5: 187.1/10000 (150.8 – 231.9)</td><td>LAP 6: 111.6/10000 (90.9 – 136.9)</td></tr>
</table></td></tr>
<tr><td>3.27 Rate of hospital admissions as a result of self-harm*</td><td>Currently unable to report; indicator will be developed if selected as part of Public Health Outcomes Framework.</td></tr>
<tr><td>3.28 Unplanned hospitalisation for asthma, epilepsy and diabetes in under 19s' ‡</td><td>There are three conditions (asthma, epilepsy and diabetes) which account for 94% of emergency admissions for children (under 19s) with long-term conditions.</td></tr>
<tr><td>Asthma:

Emergency Admissions per 100,000 0-18 population (2008-09)</td><td>Asthma is the most common chronic disease in children, with a prevalence of between 17% and 23% (NICE 2007). Better management of the condition in the community could reduce the number of emergency admissions for asthma. Asthma UK has estimated that 75% of hospital admissions for asthma are preventable.
<table>
<tr><td>England:</td><td>244</td><td rowspan="3">Tower Hamlets is ranked 70th lowest of 152 PCTs in terms of emergency admission rates.</td></tr>
<tr><td>London:</td><td>237</td></tr>
<tr><td>Tower Hamlets:</td><td>229</td></tr>
</table></td></tr>
</table>

Emergency bed days per 100,000 0-18 population (2008-09) Source: CHIMAT Disease Management Information Toolkit (Paediatrics)	England: London: **Tower Hamlets**:	293 320 316	Tower Hamlets is ranked 88th lowest of 152 PCTs in terms of emergency bed days.
Diabetes: **Emergency Admissions per 100,000 0-18 population (2008-09)** **Emergency bed days per 100,000 0-18 population (2008-09)** Source: CHIMAT Disease Management Information Toolkit (Paediatrics)	England: London: **Tower Hamlets**: England: London: **Tower Hamlets**:	64 50 33 132 130 96	Tower Hamlets is ranked 9th lowest of 152 PCTs in terms of emergency admission rates. Tower Hamlets is ranked 38th lowest of 152 PCTs in terms of emergency bed days.
Epilepsy: **Emergency Admissions per 100,000 0-18 population (2008-09)** **Emergency bed days per 100,000 0-18 population (2008-09)** Source: CHIMAT Disease Management Information Toolkit (Paediatrics)	England: London: **Tower Hamlets**: England: London: **Tower Hamlets**:	78 69 75 145 140 191	Tower Hamlets is ranked 76th lowest of 152 PCTs in terms of emergency admission rates. Tower Hamlets is ranked 116th lowest of 152 PCTs in terms of emergency bed days.
Emergency admissions for children with lower respiratory tract infections (LRTIs) 0-15‡ indirectly age and sex standardised rate/100,000 Source: NCHOD	LRTIs in children should not in general require hospital care, but are one of the top causes of hospitalisation. Rates of emergency admission in Tower Hamlets are significantly better (at the 99.8% level) than those for England. Improvement is also statistically significantly better. Rate England: 345.9 (342.3-349.5) London: 180.7 (174.6-186.9) Tower Hamlets: 97.6 (74.1-126.2 % improvement 2007/08-2008/09 -3.2 17.2 77.5		
Vulnerable Children and Young People			
3.29 Looked After Children (rate/10,000 <18) 2008/09	England: London:	55 65	

Source: The Places Database (http://www.communities.gov.uk)	**Tower Hamlets**: 71 *The **Tower Hamlets** rate equated to 345 children of whom 71% were in foster placements, 8.7% in secure units or children's homes and 7.2% in residential schools or other residential settings. Trends in rates of Looked After Children have fallen between 2004/5 and 2007/8, possibly reflecting improvements in prevention.*		
3.30 'Hidden harm' (children living with parents with alcohol and/or substance addiction) Source: Tower Hamlets DAAT	*DAAT data for 2008-09 suggests that across **Tower Hamlets** 1091 clients passed through the service, 640 (58.7%) of who were parents, 134 of whom (12.3%) had their children living with them or were pregnant. A further 283 (25.9%) had children who lived with a partner or other family member.*		
3.31 Young Offenders **Rate of proven re-offending by young offenders* (2008/09)** Source: The Places Database (http://www.communities.gov.uk)	The cohort includes all those receiving a pre-court disposal (reprimand or final warning) or a first-tier or community penalty or who are released from custody. A reoffence is counted if it occurs within the 12 month tracking period and leads to a pre-court disposal or a court conviction. England: 1.05 London: 1.06 **Tower Hamlets**: 1.01		
First time entrants to Youth Justice System* rate/100,000 10-17 year olds Source: DfE statistical release	First-time entrants are defined as young people (aged 10-17) who receive their first substantive outcome (relating to a reprimand, a final warning with our without an intervention, or a court disposal for those who go directly to court without a reprimand or final warning)		
		2005-06	**2006-07**	**2007-08**
	England:	1,965	2,031	1,840
	London:	1,630	1,890	1,760
	Tower Hamlets:	1,990	2,270	2,210
4 Service provision				
4.1 Location of children's centres	**Olga Children's Centre**, Lanfranc Road, E3 5DN Tel: 020 8981 7127 **Overland Children's Centre**, 60 Parnell Road, Bow, E3 2RU Tel: 020 7364 0538		**Bromley by Bow Centre**, St Leonard's Street, E3 3BT Tel: 020 8709 9716 **Lincoln Children's Centre**, 2 Belton Way, Bow, E3 4BB Tel: 020 7093 1442 **Mile End Children's Centre**, 38 Wager Street, E3 4JE Tel: 020 8880 7830
4.2 Locality staffing allocations for community midwives	The North East Locality is covered by Team 3; 7 WTE		

Date updated:	05/04/2011	**Updated by:**	Simon Twite	**Next Update Due:**	Six months

Date signed off by Senior JSNA Leads:	*Date factsheet signed off by senior JSNA leads from Public Health and LBTH*	**Signed off by (Public Health Lead):** **Signed off by (LBTH Lead):**	*e.g. Director or Associate Director* *e.g. Director of Adults/CFS*	**Date signed off by Strategic Group:**	*Date factsheet signed off by Strategic Group*	**Sign off by Strategic Group:**	*Name the relevant Strategic Group*

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**18 October 2011**	**Unrestricted**		**2**

Reports of:	Title:
Children and Adolescent Mental Health Service London Borough of Tower Hamlets **Presenting Officer:** Bill Williams General Manager Tower Hamlets CAMHS	Update on Children and Adolescent Mental Health Service **Ward(s) affected:** All

1. Summary

Tower Hamlets CAMHS is part of a wider network of statutory, non-statutory, universal and targeted services who regularly engage with children and young people who have mental health difficulties. It is funded by the Primary Care Trust and London Borough of Tower Hamlets.

The briefing and presentation provides a summary of the below issues related to the Children and Adolescent Mental Health Service in the London Borough of Tower Hamlets. These issues include:

- Demographics
- Partnership Working
- Demand and Capacity
- The referral system
- Accountability and governance

2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the information contained in the briefing and presentation.

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Health Scrutiny Panel

18th October 2011

CAMHS Briefing Paper

1. CAMHS – Children and Adolescent Mental Health Service

Tower Hamlets CAMHS is part of a wider network of statutory, non-statutory, universal and targeted services who regularly engage with children and young people who have mental health difficulties. We will accept referrals of children and young people up to the age of 18 years.

CAMHS is funded by the PCT and LBTH (ABG)

CAMHS is a specialist provision aiming to offer high quality mental health assessment and treatment services to children and young people who are experiencing serious risks to their emotional and psychological wellbeing and development. The threshold for referral to core CAMHS is that the suspected mental health difficulties must be urgent, or persistent, complex and severe. We will say more about this later in the paper.

CAMHS professionals include psychiatrists, psychologists, social workers, nurses, family therapists and psychotherapists.

CAMHS are delivered from 3 main community bases but CAMHS professionals also see young people in schools, children's centres and other community settings as well as undertaking home visits.

CAMHS provides 24 hour psychiatric cover 52 weeks of the year. Access to CAMHS is available to all children and young people regardless of their age, gender, race, religion, ability, class, culture, ethnicity or sexuality.

CAMHS offers a variety of assessments and treatments to children and young people and their families. All treatment options are explained and discussed with the children and families/carers.

2. The Demographics

Tower Hamlets has the fastest growing population in London, estimated to be 242,000 and projected to increase to 316,300 by 2026. The borough has a relatively young population with 37% of people aged 20-34, compared to 20% across England. Twenty four percent of the population in the borough are aged 0 to 19. Of these residents, 77% are from BME groups (55% Bangladeshi groups and 22% from other BME groups).

3. Partnership Working

Tower Hamlets CAMHS is committed to delivering a multi-disciplinary service to the community. This aspect is strengthened by a long history of partnership work between ELFT and LBTH. This partnership is in part evidenced by the

ongoing commitment of LBTH to embedding social workers within CAMHS provision.

4. Demand and Capacity

Referrals to the service have increased over the past 2 years. It is difficult to make direct comparisons with earlier years as methods of collecting data have changed.

In 2009/10 there were 1618 referrals made to the service and 1314 taken on. In 2010/11 these figures increased to 1807 referred and 1529 taken on by the service. In most cases those cases not accepted were signposted to other provision.

Year	Referrals Received	Referrals Accepted
2009/10	1618	1314
2010/11	1807	1529

Referrals are received from a number of sources including schools, CSC, primary care, GP's and the third sector.

2009/10 saw 61% of the referrals male and 39% female. These margins narrowed in 2010/11 with 54% male and 46% female.

The pattern of age in referrals has remained relatively consistent.

Age	0-4	5-11	11-17
2008/09	16%	32%	52%
2009/10	14%	35%	51%

The largest ethnic group referred is Bangladeshi followed by white British. There are 18 ethnic category groups of which 4 are highlighted below.

Ethnicity	2009/10	2010/11
Bangladeshi	782	606
White British	672	452
Black/Black British other	87	73
African	74	54

5. Presenting Condition

CAMHS take referral of clients who present with a wide range of problems. Severe and life threatening conditions can include psychosis, risk of suicide or severe self harm, a severe depressive episode or anorexia nervosa.

Some young people can display a severe impairment of functioning associated with mental health disorders such as severe obsessive-compulsive disorder (OCD), severe anxiety/phobic/panic disorders, ADHD, ASD, Learning Disabilities and Tourette's syndrome.

6. How do we decide who is an appropriate referral

CAMHS use 4 criteria to make decisions about whether or not to accept a referral.

(a) Severity of mental health disorder

Specialist CAMHS will accept referrals where there is a likelihood that the child or young person has a severe mental health disorder

(b) Severity of impairment

Specialist CAMHS will only accept referrals of children and young people whose symptoms, or distress, and degree of social and/or functional impairment are severe.

(c) Duration of difficulties

Usually, the duration of these difficulties should be not less than three months. For severe / urgent/ life-threatening conditions and for other conditions where there is severe impairment of functioning, the referral will be considered immediately.

(d) Case Complexity

Specialist CAMHS will accept referrals where there is a high level of case complexity, that is, where there are *significant* mental health problems, and in addition, multiple risk factors (co-morbidity), including complex family problems, child protection concerns, significant risk of harm to self or others, risks of violence, terminal illness, substance misuse, parental mental illness, seeking asylum, refugee status, or being the victims of torture, placing self or others at risk, being at the threshold of corporate care or being looked after, or being subject to child safeguarding procedures.

7. Accountability and Governance

A Commissioning Group made up of LBTH and the PCT meet quarterly to agree strategy and monitor service targets. Although the PCT are the major service funders the lead commissioning role is held by LBTH.

A separate quarterly meeting is held to monitor performance.

We look forward to developing this conversation with you on 18th October 2011.

Bill Williams and Dr Ruma Bose

October 2011

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Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**18 October 2011**	**Unrestricted**		**3**

Reports of:	Title:
Merger Team, NHS East London and the City **Presenting Officer:** TBC	Proposed Merger of Barts and The London, Newham and Whipps Cross Hospitals - Update **Ward(s) affected:** All

1. Summary

This presentation aims to update Tower Hamlets Health Scrutiny Panel on what has happened in the last few months in relation to the proposed merger and provide an overview of the planning process. The merger team will highlight the key areas emerging through the development of the Full Business Case, discuss the key challenges and risks and outline the journey ahead.

2. Recommendations

The Health Scrutiny Panel is asked to consider the information in this presentation, ask questions and raise concern on behalf of the residents of Tower Hamlets.

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Proposed merger of Barts and The London, Whipps Cross and Newham hospitals

Tower Hamlets Overview and Scrutiny Committee

18 October 2011

Purpose

- To update what has happened in the last few months and provide an overview of our planning process
- To highlight key areas emerging from our FBC development
- To ensure common understanding of the challenges and risks
- To outline the journey ahead

Progress to date

- 29 July Whipps Cross Board approved the Outline Business Case (OBC)
- 4 August NHS London Capital Investment Committee agreed that we could continue to develop our integration plans and to produce a Full Business Case (FBC)
- The FBC needs to build on the OBC and include the following:
  - Background and case for change
  - Vision and strategy
  - Long term financial planning detail
  - How we will want the organisation to work with local health and social care partners
  - Organisational design
  - Full integration plans and how these will be achieved
  - Developed risk and assurance processes
  - Transition timetable details

Key developments to September 2011

Significant progress in developing the FBC

- Benefits case in five exemplar areas developed
- Corporate governance arrangements agreed, including principle committee structure
- Organisational structures for both corporate and operational areas currently being considered
- Integration parameters and merger transitional arrangements agreed
- Ambition for day one agreed
- Performance management framework developed
- Significant work on cost improvement plans for the first years of operation

Key area: financial planning

Monitor (FT regulator): measures of financial viability

- A financial risk rating (FRR) of at least three every year for the first five years following authorisation as a foundation trust. This requires:
  - A rating of three or more on a scale of one to five. This must be achieved for at least four out of five metrics, which are:
    - Achievement of plan
    - Underlying performance
    - Financial efficiency: return on capital
    - Financial efficiency: income and expenditure surplus margin
    - Liquidity
  - To be no lower than a two on any individual metric
  - To be within a tier two Prudential Borrowing Limit, which assesses a trust's ability to cover interest, loan repayments and working capital facilities.
  - Enhanced scrutiny for cost improvement plans (CIP) targets in excess of 7% in a year

Summary

- The three individual trusts need to have cost improvement plans which equate to £237.6m over the next five years.
  - Barts and the London, £159.1M
  - Newham, £29.9
  - Whipps Cross, £48.6
- The historic deficits will also still need to be addressed, however some of this funding has been identified (Challenge Trust Board – if Whipps Cross changes organisational form) and we are discussing the balance with NHS London and the Department of Health
- As single organisations it is likely that two if not three of the trusts would enter the Department of Health failure regime and the future for our hospitals will be taken away from the local health and social care economy
- Merger would bring forward the necessary investment in the Whipps Cross estate by seizing the opportunities for capital investment that a larger organisation could offer

Merging closes the gap

- Merge benefits will reduce this gap through:
  - Corporate management pay savings; one executive management team and board
  - Back office staffing synergies; initial modeling suggests a conservative £26m in savings
  - Estates, procurement and IT non-pay savings; termination of property leases that will no longer be required
  - Surgical repatriation; BLT and WXHUT currently send patients to other parts of London, these services could be provided from the Surgical Gateway Centre at NUHT
  - Consolidation of, and improved productivity in, diagnostic and clinical support services; this is only behind the scenes support
  - Improved clinical productivity; standardising best practice through clinical service group working arrangements
- Analysis indicates with synergy benefits and conservative productivity benefits the residual CIP gap is reduced to less than 5% per year

Key area: clinical integration

BELH is a platform for the future

The Vision

To offer acute, specialist and community services that are tailored to meet the needs of its local communities

To be recognised locally, nationally and internationally for outstanding clinical services, research and education

Identifying and sharing best practice across the trusts

- Standardise services to best practice – reducing length of stay

Realising any efficiencies and economies of scale

- Combining the clinical workforce to raise quality of care in paediatrics
- Change the way we deliver pathology services to capture economies of scale

Developing clear clinical pathways to enable rapid access to the right care

- Integrate acute patient pathways in cancer care
- Integrate specialist, secondary and community patient pathways for diabetic patients

Financially resilient trust with no organisational barriers,
a single clinical vision and accountability
that is capable of becoming a foundation trust

A focus on medicine

- Take advantage of **new developments in healthcare and technology** e.g.
  - Providing locally-led services supported by better use of IT
  - Consolidating specialist services (as agreed for vascular surgery)*
  - Separating urgent and planned care*
  - Ensuring senior doctors are on site for longer. In England more people die because of short staffing in the evenings and at weekends than die in road accidents. By sharing rotas we could develop a truly 24/7 service
  - Pooling resources to make more impact e.g. the small c campaign
- **Invest** in technology, research and specialist services that would otherwise be uneconomic for one trust
- Remove organisational barriers:
  - bringing local **services closer to people's homes** e.g. we could make better use of the Gateway Surgical Centre. Each year 1,600 patients would be operated on closer to home and the trust would save £3.5m
  - bringing **specialist services closer to people's homes** e.g. the Barts chemotherapy service could be offered at Whipps Cross

***N.B. Some changes would require further public consultation but a merger would allow the Trusts to better understand the problems, quickly come up with solutions and work with councils, overview and scrutiny committees, patients and the public to agree a way forward in a collaborative way**

A focus on science

- There is clear international evidence that local patients benefit from local research
- By merging we could be more competitive when bidding for **research funding**
  - Charities/ governments want the best value for money. Funds are directed to organisations around the world with the brightest minds and the best facilities.
- Joining forces with other partners in an Academic Health Science Centre would mean that senior doctors would be better able to secure funds and find colleagues that could pool their talents to **develop new technology, techniques and treatments**

A focus on care

- We have taken great strides recently in **patient experience** and by joining together we can make further advances more quickly.
  - Whipps Cross patient experience revolution
  - East London Partnership for Compassionate care
- Patients would have **greater access to specialist nursing and allied health professionals** e.g. consultant HIV nurses.
- **Integrated patient safety programmes** would lead to improved patient outcomes and lower mortality as we standardise to the level of the best in trust.
- Standardisation to the best in trust would also see a reduction in **hospital acquired infections.**

A focus on care

- There is clear evidence that patient experience and outcomes are enhanced when staff see better opportunities for career development

  - there would be greater opportunity for career progression – we could **retain good staff** who would otherwise leave to gain promotion. We could also attract staff to posts which are **traditionally difficult to recruit** too.
  - becoming world-class would enable us to recruit some of the best doctors and researchers in the world – who could **share their knowledge and experience.**
  - We can build **stronger relationship with the community health** and social care colleagues by learning from the integration of Tower Hamlets services.
  - success breeds success. An organisation that is recognised as a world-leader will make it **easier to recruit more junior staff**, meaning we could reduce the number of persistent vacancies

Key area: risk management

Risk v opportunity

- Merger projects can be difficult and we are ensuring that we maintain operational performance in the current year whilst this is being considered
- Should the merger proceed we are alert to the challenge of delivering cost improvement plans whilst integrating organisations
- Risk is being mitigated by:
  - Reducing the CIP burden in the early years
  - Ensuring clinical leadership and accountability is at the heart of CIP delivery via the Clinical Service Group structure
- We don't believe that the scale of productivity improvements required at each of the organisations can be delivered wtihout organisational change

The scale of the challenge and key risks assuming approval of FBC

Based on others experience we are clear that the scale of the challenge and risks are of significant scale.

Key issues are:

- Financial and performance legacy 2011/12
- Business as usual agenda
- Leadership capacity and capability
- Timetable to achieve FT

The journey ahead

Building on engagement to date

- **26,000 copies** of our prospectus have been distributed throughout our hospitals, to community groups, libraries, trust membership lists and to local authority and commissioning colleagues. The prospectus is also available in a variety of languages and alternative formats including Easy Read & audio.
- A series of **roadshows for staff, patients and the public** have commenced throughout the three hospital trusts.
- Attendance by clinicians and senior managers at **local meetings** throughout north east London including overview and scrutiny, local involvement networks and clinical commissioning groups

- The merger is a regular feature in **local community publications** and features on the **hospital trust and partner websites** and intranets for staff.
- All the views expressed are being collated and provided to the appropriate. workstreams for consideration in our integration planning and will be shared as part of our full business case development and decision making.

Event: finance

The aim of this session will be to:

- To outline the national and local financial context for the NHS;
- To outline the current financial position of the three trusts;
- To describe the financial benefits of the three trusts merging together; and
- To raise any concerns and queries directly with the finance workstream leads.

Date: **Thursday 20 October 2011**
Time: **12.30pm – 3.00pm** (registrations and light lunch from 12.00pm)
Venue: **West Ham United Football Club**
Nearest tube**: Upton Park**

You can register your attendance by emailing merger@elca.nhs.uk or phone: 020 7092 5287. When registering, please state any special requirements you may have.

Event: workstream review

The aim of this session will be to:

- To meet, debate and inform our integration plans with colleagues from the CASG and corporate workstreams:

  Date: **Thursday 3 November 2011**
  Time for session with corporate workstreams: **2.30pm – 4.30pm** (registrations from 2.00pm)
  Time for session with CASGs: **5.30pm – 7.30pm** (registrations from 5.00pm)
  Venue: **West Ham United Football Club**
  Nearest tube**: Upton Park**

Register your attendance by emailing merger@elca.nhs.uk or phone:
020 7092 5287. When registering, please state which session(s) you would like to attend and any special requirements you may have.

The merger journey…

- Cooperation and Competition Panel assessment is underway and due to report in November
- Full Business Case (FBC) submission and decision making: November/December 2011
- Submission to NHS transaction board/Secretary of State: January 2012
- Proposed merger date: 1 April 2012
- Foundation trust application: 2013
- Foundation trust authorisation: 2014

We would like to hear from you

As we prepare the full business case we would like to hear your views…by the end of October

- Write: Aneurin Bevan House, 81 Commercial Rd, London E1 1RD
- Phone: 020 7092 5398
- Email: merger@elca.nhs.uk
- Ask: for further presentations/information

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