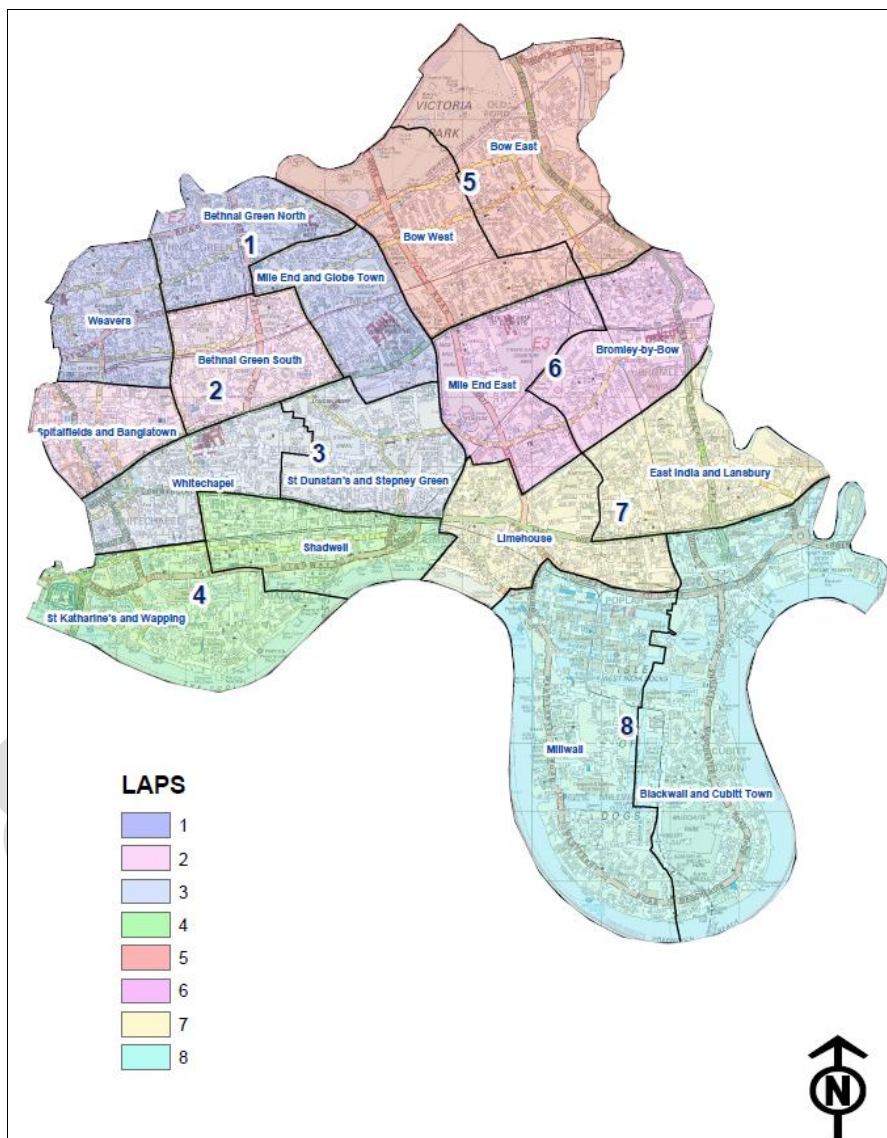


Health and Wellbeing in Tower Hamlets

Tower Hamlets Joint Strategic Needs Assessment 2010-2011



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

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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.

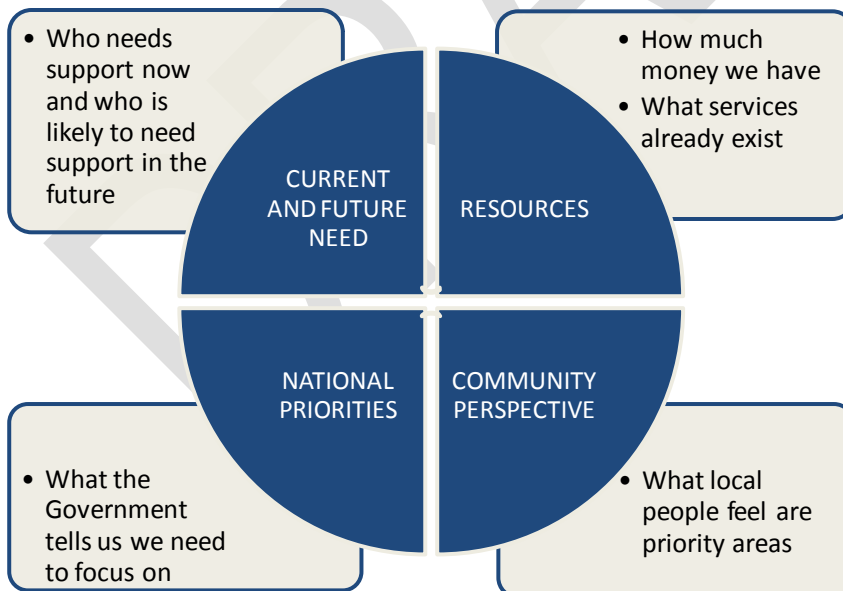
1. What is the Joint Strategic Needs Assessment?

- 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

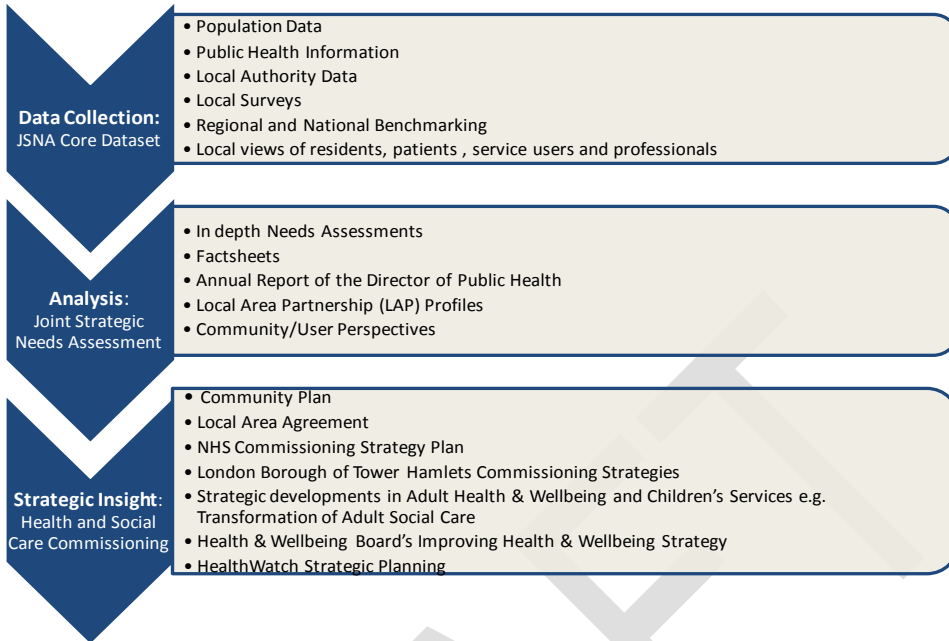
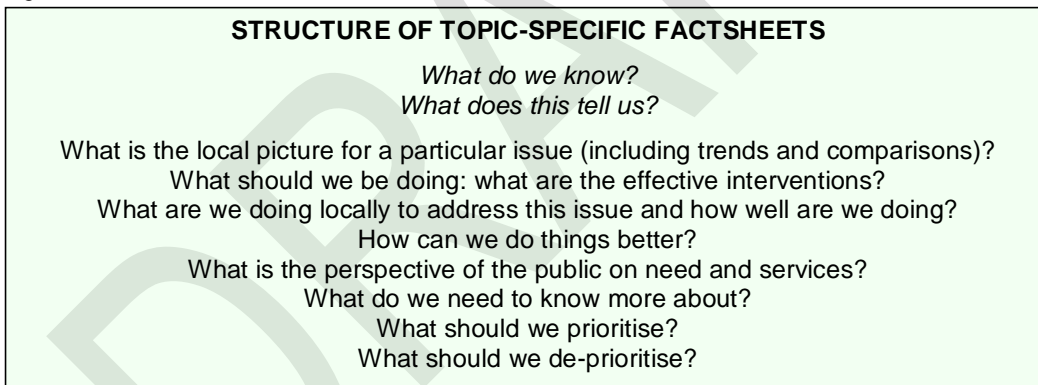


Figure 3 Structure of Each JSNA Factsheet



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.

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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.

DRAFT

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?

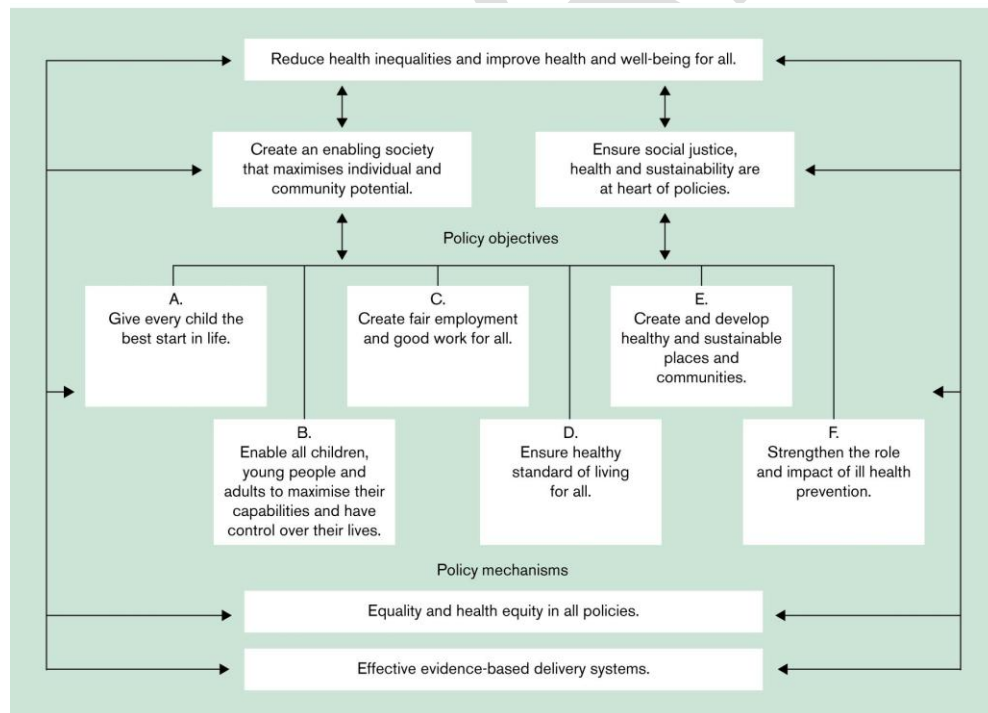
The recent Marmot Review 'Fair Society, Healthy Lives' – a Strategic Review of Health Inequalities in England post-2010 – gives a framework for how positive and negative effects on health and wellbeing accumulate over a person's life. This 'life course' approach says that disadvantage starts before birth 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:

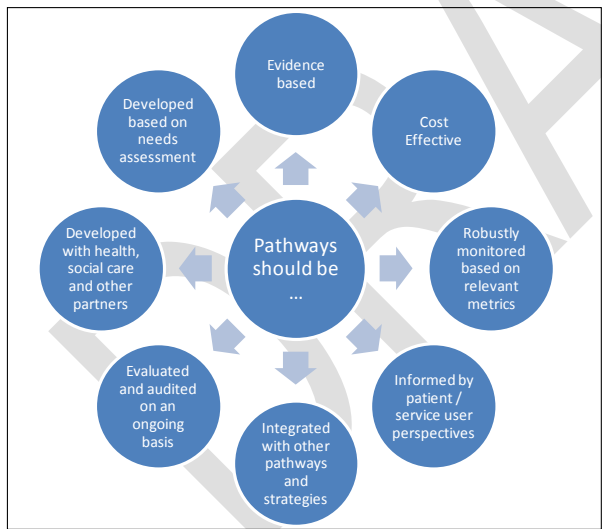


Figure 6 The Characteristics of Effective Pathways

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).

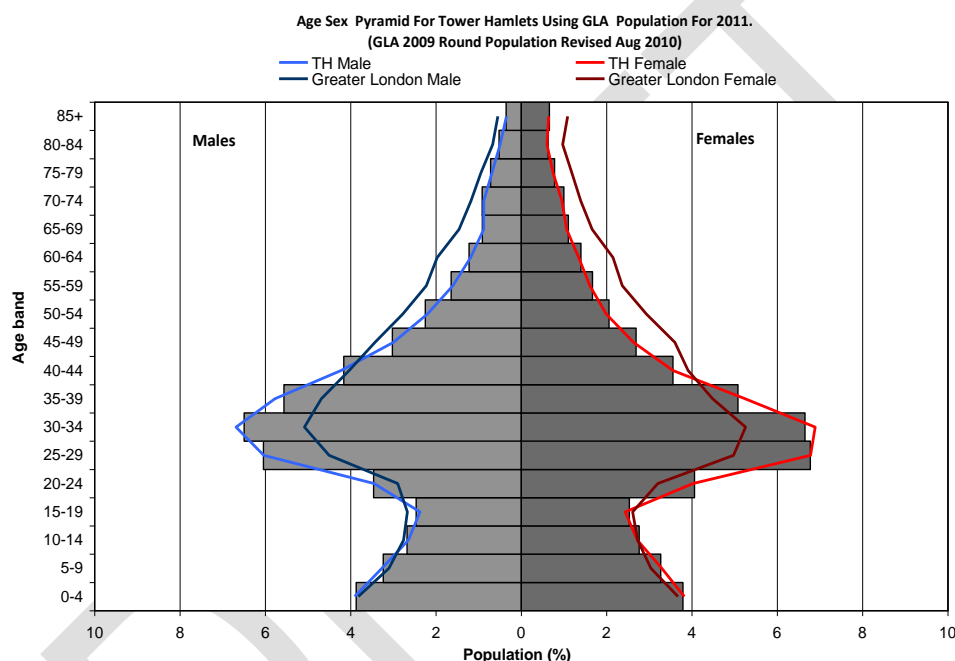
4. Key Headlines for Tower Hamlets

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 above¹.

Figure 7 Age Sex Pyramid for the Tower Hamlets population, 2011²



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 8⁴. 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 LAP⁵

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 Hamlets⁸	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 LAP⁹

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 increase¹⁰.

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 UK¹⁴. 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

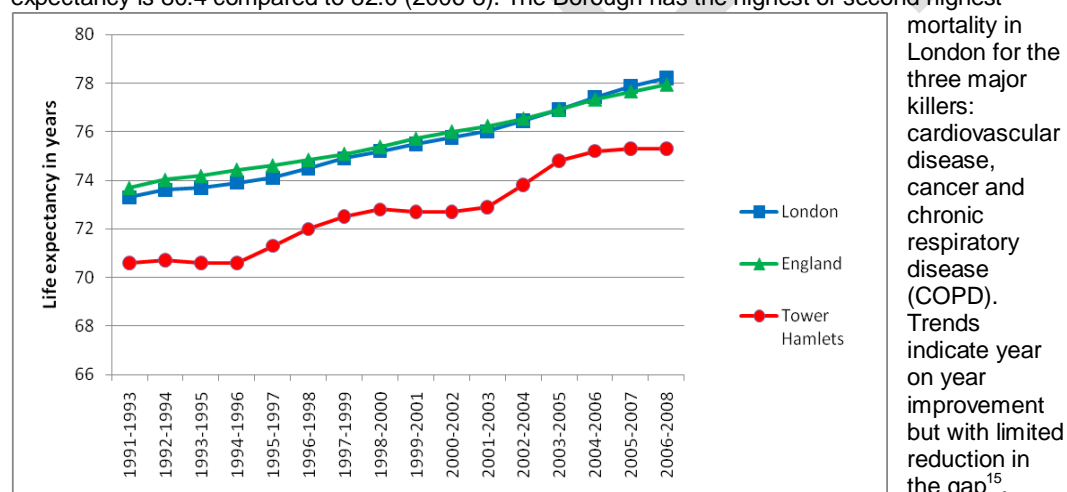


Figure 8 Trend of life expectancy at birth for males in Tower Hamlets, London and England. 1991-1993 to 2006-2008¹⁶

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 mortality¹⁹.

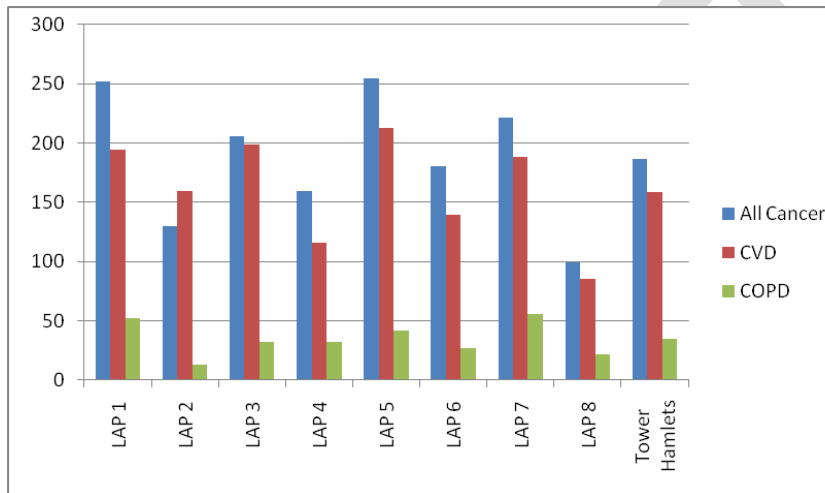


Figure 9 Crude Mortality Rate per 100,000 population for cancer, CVD and COPD²⁰

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 average²¹.

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 amenable 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.

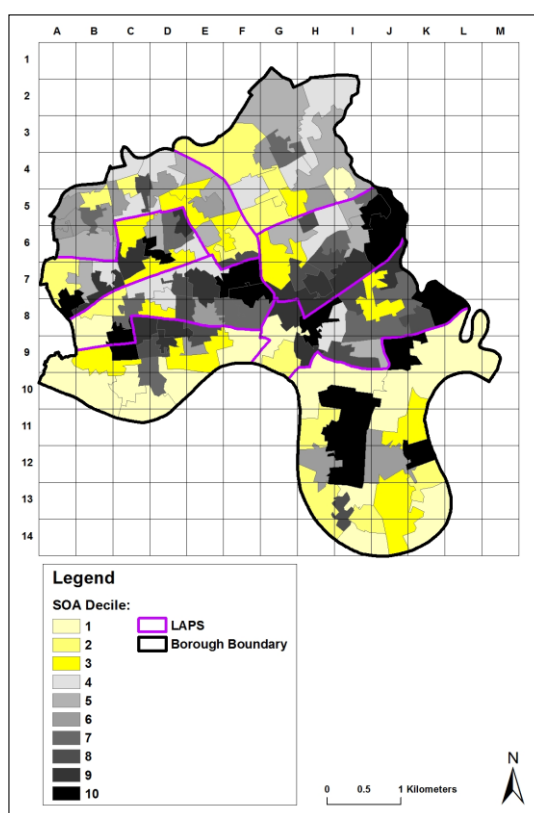
²¹ CVD mortality in under 75 Persons by Tower Hamlets Wards, 2003-07, London Health Observatory.

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 Review²³ 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 country²⁴.

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 London²⁶.

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) households²⁸.

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 population²⁹.

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 2006-08³².

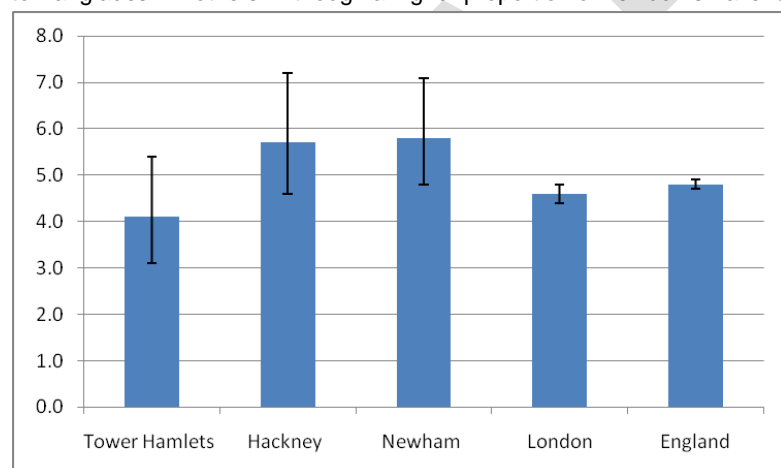
Health & Wellbeing Through the Life Course

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 neglect³⁶. 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 London³⁷.

In Tower Hamlets, 3,052 children are registered as disabled or with learning needs, representing 5.54% of those under the age of 18³⁸. 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 2009/2010³⁹.

Emergency admissions data for long term health conditions such as asthma, diabetes and epilepsy⁴⁰ 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.

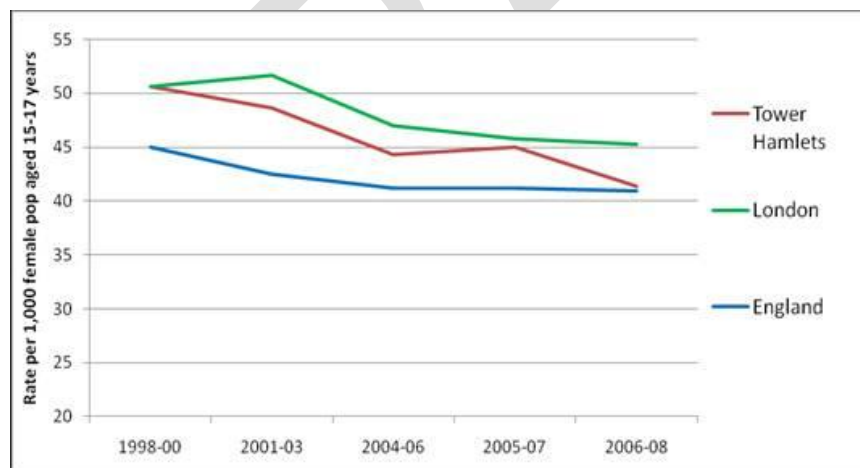
Three in ten children under the age of 15 has tried a cigarette (similar to the national average)⁴² and 4 out of 10 local retailers are selling cigarettes to under 18s⁴³. Three in 10 children have ever had an alcoholic drink compared to 7 in 10 nationally (reflecting the large Muslim community in the 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 15-17⁴⁵

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.

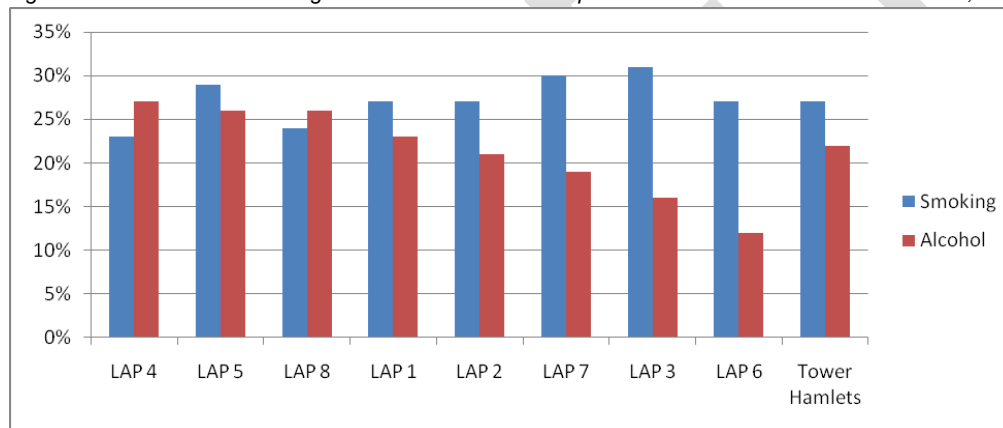
⁴⁵ Office for National Statistics and Teenage Pregnancy Unit, 1998-00 - 2006-08.

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 England⁴⁷.

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 patterns⁴⁸. 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 treatment⁴⁹.

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

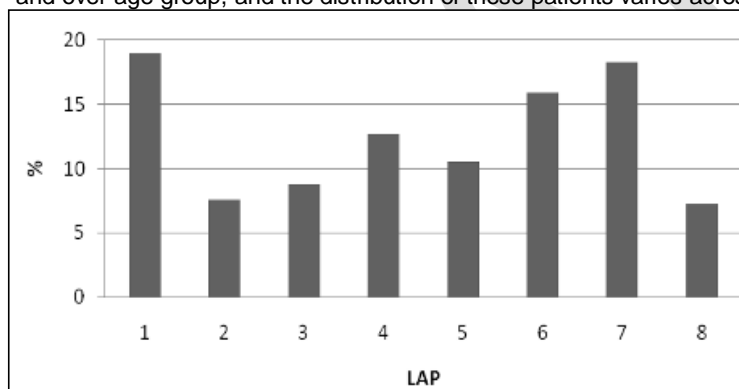
Disabilities

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 disorder⁵⁰.

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 multiple comorbidities are based in LAPs 1, 6 and 7. Analysis shows that people with vascular conditions and diabetes are most likely to have co-morbidities.

Figure 14 Percentage of patients in Tower Hamlets with two or more co-morbidities⁵¹

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 population⁵³.

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 males⁵⁴.

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.

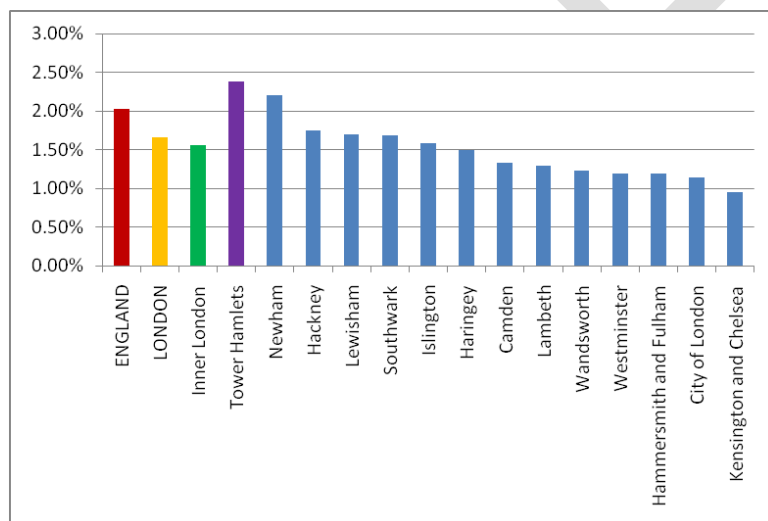


Figure 15 Percentage of the population providing 50 hours or more per week unpaid care⁵⁵

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 week⁵⁶. 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 population⁵⁸.

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).

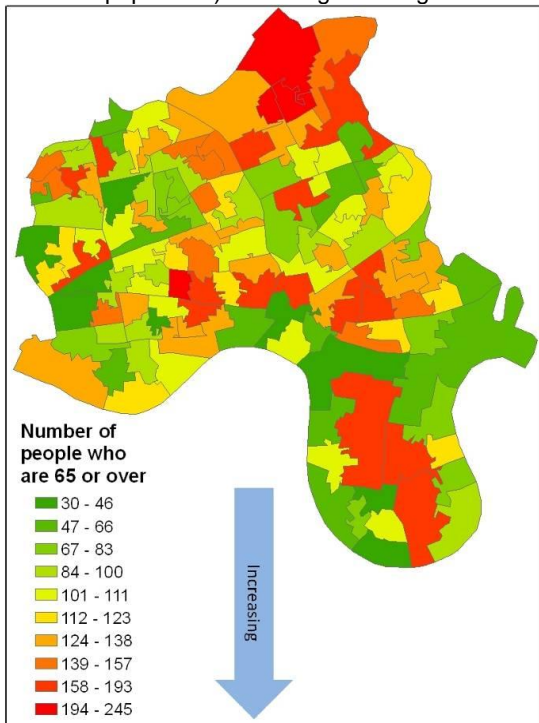
In 2009 there were over 1,000 people living with HIV in Tower Hamlets (3.9 per 1,000 population) – an increase of 34% since 2005⁵⁹. Twenty three percent of HIV infections were diagnosed late in Tower Hamlets in 2009 compared to 31% in London.

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 population⁶¹. 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 dementia⁶³.

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 fall⁶⁵.

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 (POPP), 2010.

⁶⁴ Projecting Older People Population Information System (POPP), 2010.

⁶⁵ Hospital Episode Statistics.

social services in 2009/10, compared to 15% in London⁶⁶. 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 2025⁶⁸. 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.

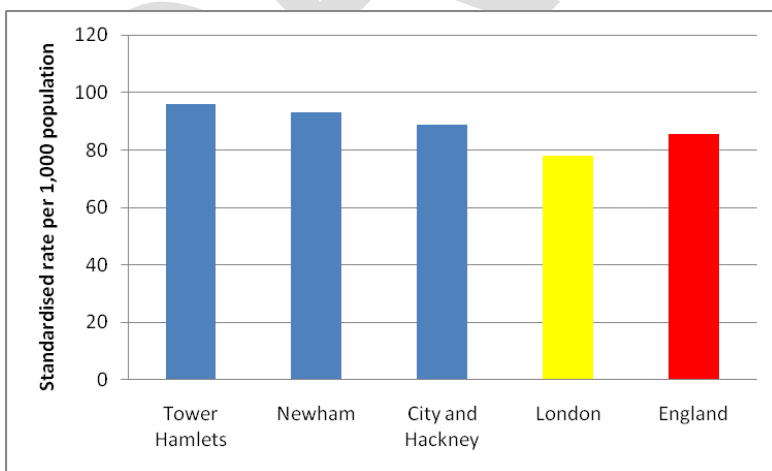


Figure 17 Standardised rates of emergency hospital admissions⁶⁹

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 services⁷⁰.

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 those living in the least deprived areas of the borough have good access to appropriate planned care, whereas 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 addressed 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 2 nd 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/lgs/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/lgs/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
AHWP	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