Appendix 1: Equalities insights for the Health and Wellbeing Strategy

Source key:

C Consultation analysis

SC Specific consultation response

I Officer insight

D Data

E Engagement and consultation log

Overarching insights

- Implications of promoting choice and control for those from different equality strands (I);
- Impact of sexual orientation or gender identity on people's ability to make choices or take control when they don't feel that they have control of who they are (SC);
- Implications of promoting independence on carers and those that don't have appropriate support to do this (C);
- Building on community potential; the community needs to be given the means to fulfil its potential rather than relying on voluntary and community sectors to deliver services – how can we do this so that the impact is equitable? (C & I);
- Importance of public health messages; especially in community languages (C);
- Accessibility of leisure centres both financially and physically (for those with physical disabilities) (C);
- Consultation responses show that respondents think that class, how connected you are in your community and difference are important wider determinants that impact on their health and wellbeing (C);
- Plain english and and well-designed information was raised as important so that people can easily understand and act on the information (C);
- Concern was raised in the consultation that vulnerable groups who could benefit greatly from access to health services can easily be overlooked in the delivery of care and often face barriers to accessing health services (C);
- Importance of end of life care experiences about allowing people to die with dignity and shaping the grieving process of friends and family (C)

Gender:

- Male life expectancy is 76 years compared to 78.3 years nationally. (D)
- Female life expectancy is 80.9 years compared to 82.3 years nationally. (D)
- The life expectancy gap between least and most deprived people in Tower Hamlets is 12.0 years in males and 5.4 in females. (D)
- In males, ward life expectancy varies by ten years. It is 82 years in Millwall and 72 years in Stepney Green. In females it varies by 13 years. It is 92 years in Millwall and 79 years in Mile End East. These variations generally correlate with relative deprivation across the borough. (2004-2008, ONS) (D)
- Healthy life expectancy in men at age 65 is 17.1 years compared to 18.4 years in London (D)
- Healthy life expectancy in females at age 65 is 19.2 years in women compared to 21.2 yearsin London(D)
- Across East London and the City "analysis of selected chronic diseases[1] by gender shows that the main burden of chronic disease falls on the male population… with the exception of obesity, which is higher in women in all three PCT areas."[2]. When looking at Tower Hamlets only this pattern is shown except prevalence of cancer is slightly higher in females than males. Prevalence rates for Tower Hamlets amongst men are statistically significantly worse than the total population prevalence for the following conditions (D):

    - Chronic Obstructive Pulmonary Disease;
    - Coronary Heart Disease;
    - Diabetes;
    - Learning Disability;
    - Serious Mental Illness;
    - Smoking; and
    - Stroke.

[1] Asthma, cancer, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, learning disability, obesity, serious mental illness, smoking and stroke

[2] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4

- In summary the JSNA highlights that overall men have higher rates of chronic illnesses and diseases than women. Men also have lower life expectancy (D)
- Good blood sugar control is statistically significantly worse amongst men with diabetes than compared with the total diabetic population (D);
- A greater proportion of females have good blood sugar control compared to males. (D)
- From the healthy lives survey 2009 we found that 34% of males were current smokers compared to 20% of females. There were important gender differences in smoking prevalence by ethnicity. 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 smoked than females. (D)
- From the healthy lives survey 2009 we found that men were more likely to eat an inadequate amount of fruit and vegetables than women, which reflects a national trend (HSE 2008). In Tower Hamlets, 92% of men did not reach the 5-a-day target, and 83% of women. This is significantly worse than the national figures – 78% for men and 69% for women. (D)
- "Men in Tower Hamlets have the highest numbers of diagnoses for the key five STIs (Chlamydia, Gonorrhea, Syphilis, ano-genital Herpes, ano-genital Warts). Men who have sex with men (MSM) have disproportionately high levels of STI diagnoses (23% of all male diagnosis) and 74% of them were in white MSM. However, apart from syphilis and anogenital herpes, heterosexual men remain the group most commonly diagnosed with STIs. By age men aged between 20-44 year olds are those mostly affected by STIs."[3] (D)
- "A lower proportion of female deaths in Tower Hamlets occur at home than for males (12.4% for females compared to 19.6% for males) and the same is true nationally (15.9% for females compared to 22.2% for males)."[4] (D)

Age:

[3] Tower Hamlets, 2011, 2010-11 JSNA Factsheet on Sexual Health
[4] Tower Hamlets, 2011, 2010-11 JSNA Factsheet on End of Life Care

- Across East London and the City "analysis by age group shows increasing disease prevalence[5] with increasing age, highlighting the importance of early interventions to prevent disease risk-factors from accumulating."[6](D)
- "the proportion of patients with diabetes and stroke in whom disease management indicators are met is lower amongst young and middle aged patients, than amongst older patients, suggesting opportunities for early interventions to prevent secondary complications of disease are being missed."[7](D)
- In Tower Hamlets for those aged 40+ prevalence of the following conditions is statistically significantly worse than the total population with that condition: (D)

    - Asthma
    - Diabetes
    - Hypertension
    - Obesity
    - Serious Mental Illness
    - Smoking

  And, for those aged 50+ statistically significantly worse for:

    - Cancer
    - Chronic Obstructive Pulmonary Disease
    - Coronary Heart Disease.
- "There is a consistent pattern across the three PCTs, whereby disease management indicators (diabetes or stroke) are achieved for a higher proportion of older patients, than for young and middle-aged patients. This suggests that opportunities for early secondary prevention interventions are being missed, with the risk that young and middle-aged patients will go on to develop disease complications in later life."[8](D);
- Specifically, a disease management indicator for diabetes (blood glucose levels) for those aged 5-15, 19-24, 25-39 and 40-49 (NB. There is no data for 16-18)is shown to be statistically significantly worse than the total population with diabetes. (D)
- Attendance at eye screening[9] (a disease management indicator for diabetes) is statistically significantly worse for those aged 19-24 and 25-39than the total population with diabetes. (D)

[5] Asthma, cancer, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, learning disability, obesity, serious mental illness, smoking and stroke
[6] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4
[7] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4
[8] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 17
[9] Retinopathy screening

- The cholesterol disease management indicator for stroke is statistically significantly worse for those aged 25-39 than the total population who have suffered a stroke. (D)
- Use of the internet has been increasing in recent years: 15% of residents contacted the Council online over the last year, and 25% say they would prefer to use this method in the future[10] and there are concerns about how this form of service delivery may impact older people. When using websites was discussed by the Older People's Reference Group people supported the website and could see themselves using it provided there was sufficient help/teaching and support to learn or alternatively, someone available to access the information with them at home. The group thought there were benefits specifically for Housebound Older People (E);
- From the Healthy Lives Survey 2009 we drew the following insights:
    - Younger people aged 16 to 24 were the highest consumers of fast food. One in twenty members of this age group eat fast food at least once a day (D);
    - Smoking prevalence was highest in Asian and Black males and younger black residents (D);
    - Older people were more likely to be physically inactive than younger people (D);
    - alcohol use and harmful/hazardous use was more common amongst the white population. Young, white men were at particularly high risk.
- The 0 to 5 year old population in Tower Hamlets makes up 9.6% of the total population in the borough and 36.8% of the 0 to 19 population - the largest age group within the 0 to 19 population. The group is expected to grow at a greater rate than other age groups. (D)
- Childhood obesity in Year 6 has plateaued for the last three years, with the current rate at 25.6% for 2011/12, the 2nd highest in London. (D)
- Hospital admissions caused by unintentional and deliberate injuries in under 18s are higher than the London average with a crude rate of 122.5 per 10,000 population aged 0-17 years. (D)
- National evidence shows that 1/10 children aged between 5 and 16 has a clinically diagnosable mental health problem. About half of these have a conduct disorder, 3.7% an emotional disorder (anxiety, depression) and 1-2% has severe Attention Deficit Hyperactivity Disorder (ADHD). (D)
- Nationally, around 60% of Looked after Children and 72% of those in residential care have some level of emotional and mental health problem. (D)
- Smoking amongst young people is similar to the national average and may be increasing amongst girls (Tell Us). (D)
- Chlamydia rates in the borough are lower than average for the 15-24 age group, though women aged 16-19 are considered at risk. (D)

[10] Annual Residents Survey 2012

Ethnicity:

- New migrants and refugees face barriers in accessing healthcare (D);
- National Insurance Number (NINo) registrations are an indicator for economic immigration; data from 2000 onwards show higher levels of NINo registrations from Eastern European and Ascension 8 countries. (D)
- Out of all London NINo registrations, 5.4% registered in Tower Hamlets in 2009/10. 45% of the London NINo registrations by Bangladeshi nationals took place in Tower Hamlets (D)
- There is a lack of data about new migrant groups in the Borough e.g. Eastern European and how this impacts need (I);
- Key issues for migrants accessing are: information about how the 'system' works, how to access services, registering with a GP and then being able to make an appointment, finding and registering with an affordable dentist. (D)
- Teenage refugees and asylum seekers in find it difficult to access mental health services which adequately meet their needs. (I)
- Across North East London and the City "analysis by ethnicity shows that for many chronic diseases[11], particularly smoking associated diseases, prevalence is highest in the White population, with diabetes more prevalent in the Asian population, and hypertension, obesity and serious mental illness more prevalent in the Black population."[12](D)
- In Tower Hamlets the white population has a prevalence of disease higher than the total population for all conditions[13] except diabetes, learning disabilities and severe mental illness. (D)
- In Tower Hamlets prevalence rates for the black population are statistically significantly worse than the total population prevalence in asthma, diabetes, hypertension, obesity and stroke (D).
- "For the majority of disease management indicators, there are no statistically significant differences by ethnicity…However, in Newham and Tower Hamlets, the proportion of diabetic patients with good blood sugar control is higher in White patients than in the total diabetic population…and in all three

[11] Asthma, cancer, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, learning disability, obesity, serious mental illness, smoking and stroke

[12] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4

[13] Asthma, Cancer, COPD, Coronary Heart Disease, Hypertension, Obesity, Stroke

PCTs the proportion of diabetic patients with good blood pressure control is lower in Black patients that in the total diabetic population."[14] (D)

- There is a projected and disproportionate increase in learning disabilities for BME residents (D);
- From the Health and Wellbeing consultation one respondent raised the need for more access to nursing courses for BME women (C);
- From the Health and Wellbeing consultation a recommendation was raised to set a priority in dealing with Heart disease and Diabetes amongst Bangladeshis (C);
- One consultation respondent didn't feel there is enough support out there to help people from disadvantaged BME groups (C);
- The promotion of Mental Health in BME communities was raised as important in the Health and Wellbeing Strategy consultation (C);
- Language was raised by the CVS as an important factor for improving health and wellbeing in Tower Hamlets (E);
- The Bangladeshi community have a higher risk of children born at lower birth weight (D);
- There is a high percentage of Black/Black British mothers who smoke during pregnancy (D);
- Asian men/women have low STI diagnosis (D).
- The following insights are from the 2009 Healthy Lives Survey
    - only 2% of residents showed all four indicators of healthy behaviour (not currently smoking, consuming at least five portions of fruit or vegetables on an average day, abstaining from alcohol or moderate drinking,taking part in the recommended minimum 30 minutes of physical activity at least five times a week).White residents were more likely to display these behaviours than their Bangladeshi counterparts, though they are also far more likely to drink alcohol to excess (D);
    - while three in five (60%) of White smokers would like to quit, this proportion rises to four in five Asian smokers (80%) (D);
    - Bangladeshi men are the demographic group most likely to smoke, while Bangladeshi women are least likely. A small minority of residents,

[14] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 17

almost exclusively from Asian ethnic groups, use forms of tobacco other than cigarettes, including paan (4%) and sheesha (2%) (D);

- asian residents are slightly more likely to eat takeaway food at least three times a week compared to White residents. (D)
- alcohol use and harmful/hazardous use was more common amongst the white population. Young, white men were at particularly high risk.
- Abstention from alcohol is closely linked with ethnicity: while 96% of Asian residents say they do not drink alcohol, only 18% of White residents abstain. Likewise, while only 2% of Asian residents are harmful drinkers or at risk of harm, this figure rises to 38% among all Whites. (D)
- there were significant and substantial differences in patterns of fruit and vegetables consumption by ethnicity as shown in Figure 11. Only 2% of Asian men, 3% of Black men and 12% of White men reported eating five-a-day. The Asian population was the least likely to reach the 5-a-day target. (D)

- "Nationally "uptake of routine invitations for breast screening is lower amongst Muslim women than among women in the general population possibly due to fear of a male carrying out the mammogram; and in the first phase of the bowel screening programme overall population uptake was 62% but only 32% for Muslims." (D)
- 69.8% of all young people in drug and alcohol treatment are Asian or Asian British background -similar to the overall ethnic make-up of this age group. (D)

Sexual Orientation:

- Lack of data mapping sexual orientation against health outcomes/access. (D)
- It is difficult to estimate the size and profile of the lesbian, gay and bisexual (LGB) population in the borough as sexual orientation was not a specific category used in the last census, however:
  - A national survey indicates that LGB people make up around 10% of the population in London.
  - Although the census did not ask specific questions around sexual orientation, it did ask about those who were living in same sex couples. This revealed that the borough has the fifth largest reported number of cohabiting same sex couples nationally, and the fourth largest in London (D);

- Research conducted by the One Tower Hamlets Team shows that there is a danger of isolation for older LGBT individuals in Tower Hamlets (D);
- Feedback about the LGBT population (E):
    - That the LGBT community find it difficult to access some health services due to fear of admitting their sexual orientation.
    - Some sections of the LGBT community may not access services due to cultural/religious reasons.
    - The LGBT awareness of GPs has been questioned with a view that GPs see the issues in terms of sexual health.
    - LGBT communities are often not out to their GP's due to fear of discrimination, homophobia and fear that their family and/or wider community will find out as a result of this disclosure;
    - Suicide rates are higher in the LGBT population as are rates of depression, drug and smoking.
    - Tower hamlets has high rates of STI's and HIV, with HIV being more prevalent amongst men who have sex with men. Evidence from the HPA http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SexualHealthProfilesAndIndex/ has shown growth in HIV transmission and certain STI's amongst the late 30s and 40's
    - For elders in care homes there is the issue of homophobia. LGBT residents complain of poor mental health due to the isolation and discrimination felt due to a lack of recognition of their sexuality or a denial of their sexuality
- LGBT siblings in a family often have to take on caring responsibilities for older family members as they are less likely to have children and are thus expected to be the carer. This can be an isolating experience and not all LGBT carers feel able to access support that is available (E);
- Concern that talking about families is quite excluding to those who aren't part of a "traditional" family. A family-centred approach needs to acknowledge and recognise the wider social networks of people that include family and friends/significant others for some, there is a need to recognise family structures beyond the hetero-normative model to one of "families of choice". There needs to be better promotion of acceptance of alternative lifestyles all being valid ways of living (C);

- Comment made noting that mental health issues stem from people not accepting who they are, or not being able to disclose their personal status openly, which causes stress and tension. This is particularly true for those people who have non-standard sexual and social orientations. A consultation response suggests that as a result of a lack of pro-active promotion of all types of lifestyles as being natural and acceptable, people feel alienated and withdraw from society and the facilities provided. One respondent also noted that "providing a safe environment for people to accept and show their differences - e.g. Coming Out as gay; being open about 'hidden' disabilities; etc…" should be an outcome of the Mental Health Strategy(C);

- One consultation response suggests a need for the Health and WellbeingStrategy to consider LGBT issues holistically (SC);

- For the principle of intervening early and effectively amongst the LGBT community an issue is about preventing self-harm and suicide; *"there is at least twice the risk of suicide in LGB people compared to heterosexuals. This risk increased to four times in gay and bisexual men"*[15](SC);

- Concern raised that LGBT people are overlooked for the purposes of community engagement or consultation (SC);

- One consultation response reminds the partnership that LGBT people can be parents too and that ante-natal, delivery and post-natal services need to be welcoming of LGBT parents. (SC);

- There is some national evidence that LBG people are more likely to smoke and that the use of drugs and alcohol is more widespread among LGB people (SC);

- Implications group based therapy approach on LGBT people and their ability to disclose openly if they're not "safe" spaces from LGBT people (SC);

- One consultation response suggested that research is needed into newly diagnose cases of HIV/AIDS and other sexually transmitted infections to establish more conclusively why infection rates continue to grow (SC);

- National evidence to suggest that there are higher incidences of substance misuse, self-harm, anxiety, depression, suicidal ideation and attempted suicide amongst LGBT people[16]. There are also recurring issues associated with LGBT identity that lend themselves to stress, anxiety and depression(including "coming out", rejection from others post "coming out" and not feeling able to "come out")(SC);

[15] Reference from the draft Rainbow Hamlets response, original source: National Institute for Mental Health, 2007, Mental disorders, suicide and deliberate self harm in lesbian, gay and bisexual people;
[16] Ibid

- One consultation response noted that the development of virtual wards should offer significant benefits to gay men with HIV and aids (SC);
- Harrasment and discrination experienced by older LGBT men in residential homes and fear this could also be the case for transgender (SC);
- Poor data recording of equality strands across health and social care, suggested actions (E):
    - training for staff to know how to approach patients when asking this information;
    - ensuring that patients are aware of what this data will be used for;
    - displaying rainbow flags/targeted information in GP receptions to make LGBT patients more at ease.

Marriage/Civil Partnership:

- Lack of data mapping marriage/civil partnership against health outcomes/access. (D)
- Risk that service delivery is done in a way that's geared towards a particular social structure. Need to recognise non-traditional family types beyond the hetero-normative model to one of "families of choice"– e.g. young carers, informal carers, network of close friends etc. (C)
- One consultation response raises issues about healthcare professionals understanding that the partner of a LGB patient should not be treated differently from the partner of a heterosexual patient (SC);

Religion/Belief:

- Lack of data mapping religion/belief against health outcomes/access. (D)
- Certain social factors around religion can impact mental health i.e. unable to be openly LGB. (I)
- A suggestion made in the consultation for the Health and Wellbeing Strategywas to focus on "healthy faith", because religious faith is so important to such a lot of people in Tower Hamlets it could be a distinct priority as the religious leaders and community reverence to them could inspire healthy living (C);
- Tower Hamlets Interfaith forum expressed desire for more interaction between faith orgs/communities and health in delivering services/messages/outreach - especially in relation to people who may be otherwise hard to reach (E);

- Social factors around religion impacting on health, e.g. LGB people not being out and resultant impact on mental health, young people not accessing sexual health or other taboo services (e.g. alcohol, drugs) due to worries about confidentiality of family GPs. (I)

- Impact of religious belief on Sexual Realtionship Education and resultant impact on sexual health of young people (I)

- Religious taboos about certain disabilities.(I)

- Nationally, "uptake of routine invitations for breast screening is lower amongst Muslim women than among women in the general population…and in the first phase of the bowel screening programme overall population uptake was 62% but only 32% for Muslims."[17] (D)

Pregnancy:

- Strategy to have particular focus on maternity (I)

- Areas of higher fertility roughly correlate with the distribution of deprivation and child poverty across the borough. The higher birth rates occur across the centre of the borough, although higher absolute numbers of births occur in LAPs 1, 7 & 8. (D)

- Locally data on under-18 conception shows that white females are more likely to conceive and also continue with the pregnancy. The Bangladeshi females conceiving are under-represented in comparison to the demographic, but high percentages tend to have abortion rather than continue with pregnancy. (D)

- Anecdotally, domestic violence, mental health problems and drug and alcohol problems seem to be increasing for families of 0-5s.However, this could be a result of better reporting. (I)

- Gypsy and Irish Traveller mothers are 20 times more likely than mothers in the rest of the population to have experienced the death of a child - TH has a small traveller community based in Bow. (D)

- Domestic violence is associated with a raised incidence of miscarriage, low birth weight, prematurity, foetal injury and foetal death. (D)

- A 2005/06 audit found that 81.7% of women with gestational diabetes were Bangladeshi. (D)

- The estimated prevalence of vitamin D deficiency and insufficiency in pregnant women at booking is 74%. (D)

[17] DoH, 2011, Public Health Outcomes Framework: Equalities Analysis

Gender reassignment:

- Lack of data mapping gender reassignment against health outcomes/access. (D)
- Evidence suggests transgendered people suffer from higher levels of poor mental health (I);
- Over focus by practitioners on transgender identity to the exclusion of other aspects (SC);
- Physical activity: evidence to suggest a lack of transfriendly spaces i.e. gender appropriate changing facilities and trans gender perceptions around competitive advantage (SC);
- Interplay between mental health and gender reassignment surgery – mental ill health delaying surgery (SC);
- Issues surrounding appropriate intimate personal care – no evidence of this but suspicion from the community that this could be a source of concern (SC);
- GPs are gatekeepers to gender reassignment surgery (SC);
- Concern raised that LGBT people are overlooked for the purposes of community engagement or consultation (SC);

Disability

- The 2001 census revealed that there are estimated 1.4 million disabled people living in London with 35,000 living in Tower Hamlets:
    - The census also recorded that 17% of Tower Hamlets residents reported that they had a 'limiting long term illness' compared to 15.1% in London.
    - In 2009 over eleven thousand people in Tower Hamlets claimed Incapacity Benefit – 7% of the working age population.
- "Prevalence of the majority of chronic diseases[18] investigated is seen to be higher in those with learning disabilities; serious mental illness; those are deaf-affected, registered blind or housebound."[19](D)
- There is high prevalence of obesity and morbid obesity in those with learning disability or serious mental illness in Tower Hamlets – this is also seen across all 3 North East London Boroughs (D)

[18] Asthma, cancer, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, learning disability, obesity, serious mental illness, smoking and stroke

[19] NHS East London and the City, Health Equity in Primary Care in East London and the City, p 4

- In Tower Hamlets, the proportion of diabetic patients with serious mental illness who have attended diabetic retinopathy screening is lower than the proportion in the total diabetic population – this is one of the few statistically significant differences shown amongst care groups. (D)

- Local research has found that there are specific issues around the BME population and disabilities. The research showed that there is poor communication around sexual health and isolation for this group (I)

- There is a prevalence of 'informal care' in the borough which has been highlighted at a recent THESG workshop on carers. (I)

- High prevalence of learning disabilities for Bengali groups (D);

- The following insights are from the Healthy Lives Survey 2009:

    - we found that residents with long term conditions and poor mental health were less likely to achieve adequate levels of physical activity (D).

    - people with a long term condition, disability or infirmity were significantly more likely to be physically inactive than those without physical health problems. 47% reported that they were active less than once per week, compared to 20% of other residents (D).

    - poor mental well-being was significantly associated with low levels of physical activity, even after controlling for age, gender and ethnicity. Respondents who were physically inactive scored significantly lower on the mental well-being scale than those who were physically inactive (51.8 compared to 53.9).

- Nationally "there is low uptake of both breast and cervical cancer screening amongst disabled people:

    - Only 19% of women with a learning disability have cervical smears, compared to 77% inthe general population.

    - Access to mobile breast screening units is difficult for womenwith a physical impairment"[20] (D)

- Nationally "the lack of inclusion of disability in routine recording makes it difficult to measure equity of access and treatment for disabled people, and presence of a disability is not recorded ondeath certificates so it is not possible to break down ONS mortality data by disability."[21] (D)

[20] DoH, 2011, Public Health Outcomes Framework: Equalities Analysis
[21] DoH, 2011, Public Health Outcomes Framework: Equalities Analysis

- Research suggests that 80% of children with learning difficulties; 70% of children with autism; and 40% of children with speech and language difficulties are bullied and/or victimised. (D)

Socio economic status

- Tower Hamlets is one of the most deprived areas in the country,it is the seventh most deprived in the country based on most recent IMD 2010 data. Child poverty data for 2009 (released September 2011) shows that levels remain the highest nationally. (D)

- Poverty is high among primary aged children - 46.4% were eligible for Free School Meals in 2011, of which 39% took up FSM. (D)

- Mental health problems are very closely related to many forms of inequality - in the case of psychotic disorders the prevalence among the lowest quintile of household income is nine times higher than in the highest. (D)

- Lack of data mapping socio-economic status against health outcomes/access. (D)

- Disease prevalence for the majority of diseases is seen to be higher amongst those in the most deprived quintiles except for cancer where the reverse is trend is seen.

- There are few statistically significant differences in disease management targets by deprivation.

- The Healthy Lives survey found that residents from socioeconomically deprived groups tend to consume fewer portions of fruit and vegetables than their wealthier counterparts.

- The Healthy Lives survey found that residents living in social housing were more likely to be physically inactive than those living in the private housing sector (31% vs. 20% were active less thanonce per week).

- From the Healthy Lives Survey, residents who eat at least 5-a-day are more likely to live in a less deprived area, to have higher levels of educational qualification and to be employed.

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Apprendix 1: Lifecourse summary

Being Born	There were 4565 babies born to Tower Hamlets mothers in 2010. 45% of births were to Bangladeshi mothers 9% of babies born to Tower Hamlets mothers have a low birth weight compared to 7.5% in London
Early Years	• In 2011 50% of children in Tower Hamlets achieved a good level of development at age 5 compared to 60% in London and 59% in England. We have seen steady improvement in EYFS, improving by 7 percentage points since 2009. However, we have not succeeded in closing the gap with the national average, and remain 9 percentage points below the national figure. • 12.7% are obese (6th highest in the country) • 46.3% have experience of tooth decay compared to 40.1% nationally (although there is evidence that this inequality is declining) [2009] • Local evidence indicates particularly high levels of Vitamin D deficiency in both mothers and children
Children and Young People	• 25.6% 10-11 year olds in Tower Hamlet are obese (4th highest in the country) • the incidence of sexually transmitted infections in young people country is likely to be high (overall Tower Hamlets has the 8th highest rate in the country in all age groups) • 2nd highest rate of admissions of children due to injury at 0-17, 2010/11; statistically significantly higher than London but not England. • Around 1 in 10 children are estimated to have a mental health disorder (similar to national averages)
Adulthood	• Compared to London, Tower Hamlets has: the second highest premature death rate from circulatory disease (fig 8), the fourth highest death rate from cancer (fig 9) and the fifth highest death rate from chronic lung disease (these conditions typically constitute 75% of all premature deaths) • Cancer in Tower Hamlets is higher than elsewhere due to the high incidence of lung cancer reflecting the high prevalence of smoking in the borough
Growing Old	• 56% of 65-84 year olds report long term limiting illness compared to 48% nationally • 80% 65+ have at least one chronic condition of which 35% have at least 3 'comorbid' conditions • A larger proportion of 65+ used social services in 2009/10 compared to London (20% compared to 15%) • Although it is expected that around 7% of the 65+ population would have dementia only around 2% are on dementia registers indicating significant under diagnosis • Stroke is predominantly a condition of older age and Tower Hamlets has the second highest stroke mortality in London • Older people account for 70% of strokes and 90% of caseloads of community heart failure services in the borough

Source: JSNA Summary Document

Appendix 2: Healthy Lives Survey

Table 3 - The findings of the Adult Healthy and Lifestyles Survey emphasise the need to link healthy lifestyle services with services addressing wider determinants of health, integrate them into clinical and social care pathways and target by population segment

Associations	Smoking prevalence	Physical inactivity	Poor diet	Risky drinking
Gender	↑ in Males	No	↑ in Males	↑ in Males
Ethnicity	↑ in Asian males	No	↑ in Asian and Black populations	↑ in White population
Age	↑ in young Black population	↑ in older people	↑ in younger women vs. older women	↑ in young, especially young white men
Deprivation	↑ if more deprived	↑ if more deprived	↑ if more deprived	↑ if more deprived
Education	↑ if lower attainment	↑ if lower attainment	↑ if lower attainment	↑ if lower attainment
Employment	↑ if unemployed	↑ if unemployed	↑ if unemployed	↑ if unemployed
Poor English literacy	↑ if poorer English literacy	↑ if poorer English literacy	↑ if poorer English literacy	No
Housing	↑ if social housing	↑ if social housing	↑ if social housing	↑ if social housing
Long term conditions	↑ if LTC	↑ if LTC	No	↑ if LTC in White population
Mental health	↑ if poorer MH	↑ if poorer MH	↑ if poorer MH	No

Source: Tower Hamlets Adult Health & Lifestyle Survey 2009