Camden's joint strategic needs assessment 2010

EXECUTIVE SUMMARY AND FOREWORD 3

1. OVERVIEW OF CAMDEN 5

2. POPULATION AND NEIGHBOURHOODS 10

CURRENT POPULATION 10
POPULATION CHANGE 11
BIRTHS 11
MIGRATION 11
MOBILE POPULATION 12
GEOGRAPHICAL GROWTH 12
ETHNICITY 13
LANGUAGE 15
RELIGION 15
MOSAIC CLASSIFICATIONS OF CAMDEN RESIDENT POPULATION 15
DISABILITY 17

3. SOCIAL, ECONOMIC AND ENVIRONMENTAL FACTORS 22

INDEX OF MULTIPLE DEPRIVATION 2007 (IMD) 22
CHILD POVERTY 23
OLDER PEOPLE POVERTY 24
ECONOMIC PROSPERITY 26
EDUCATION 29
HOUSING 31
COMMUNITY SAFETY 35
LIVING ENVIRONMENT 37

SOCIAL, ECONOMIC AND ENVIRONMENTAL FACTORS: KEY EVIDENCE BASED RECOMMENDATIONS 38

4. HEALTH IN CAMDEN 39

LIFE EXPECTANCY 39
LEADING CAUSES OF MORTALITY 41
LONG TERM CONDITIONS 46
MENTAL HEALTH AND WELL-BEING 48
COMMUNICABLE DISEASE 52
ORAL HEALTH 53

HEALTH IN CAMDEN: EVIDENCE BASED RECOMMENDATIONS 55

5. ADULT LIFESTYLES 58

SMOKING 58
ALCOHOL 59
SUBSTANCE MISUSE 61
SEXUAL HEALTH 63
ADULT OBESITY 65
HEALTHY EATING 66
PHYSICAL ACTIVITY 66

ADULT LIFESTYLES: KEY EVIDENCE BASED RECOMMENDATIONS 67

6. CHILDREN AND YOUNG PEOPLE LIFESTYLES 70

SMOKING 70
ALCOHOL 70
SUBSTANCE MISUSE 70
SEXUAL HEALTH 70
CHILDHOOD OBESITY 70
PHYSICAL EXERCISE AND HEALTHY EATING 71

CHILDREN AND YOUNG PEOPLE LIFESTYLES: KEY EVIDENCE BASED RECOMMENDATIONS .. 72

Executive summary and foreword

Camden has a distinctive population. It is young, it is diverse, it is always changing and it is marked by significant differences in health experience and outcomes between its richest and poorest communities. Health inequalities define the health needs of people living in Camden and our strategic response.

The joint strategic needs assessment (JSNA) helps public authorities make sense of the complexity of the many influences on the health of the population of Camden and enables them to agree strategic priorities to address the key challenges. The JSNA does not concern itself only with health and personal social care services, that is, the traditional NHS and local authority contributions to health and health improvement, or even public health services including interventions such as screening, prevention, health education and health promotion; it is also about the wider determinants of health including poverty, employment, education, public safety, housing and the environment.

NHS Camden and London Borough of Camden Council published its first JSNA in 2008. In common with many other places it provided only a partial picture of the health and social care needs of the population resident in the borough. This year we hope that we are able to fill in some of the gaps in our understanding of the local population and we set out some of our principal findings at the end of this summary. However, this is a dynamic and continuous process and our hope remains that it comes to be recognised for what it was always intended – as a living resource to inform the development and direction of key policies for the public authorities that answer to the people of Camden.

Production of the JSNA is led by a small technical group with representatives from the three statutory directorates responsible for its delivery – public health, adult social care and children and family services. The group is accountable to the Health and Well-Being Board, which is a sub-group of the Camden Local Strategic Partnership.

Whenever possible the JSNA reports trends and comparisons with other relevant PCT populations, regional and national benchmarks. Work has already begun to incorporate intelligence gathered from the people of Camden themselves through public surveys, opinion polls and other public engagement processes, as well as social marketing. Over time this will enrich our understanding of the health and social care needs locally and enable us to refine our response.

NHS Camden is already making use of the information provided by the JSNA to inform its strategic commissioning plan. Applying programme budgeting analysis and using prioritisation tools, including a local adaptation of the modified Portsmouth scorecard[1], the NHS will ensure that the public funds available to the population of Camden address the principal health needs of the population. Over time this process will become more sophisticated and the JSNA will continue to provide strategic partners with the intelligence required to ensure that limited public resources are used wisely.

A detailed joint needs assessment of the health and social care of children and young people is completed every year and translated into the Camden's children and young people's plan. The factors drawn out more generally in this JSNA as having an influence on health outcomes (deprivation, crime, alcohol and drugs, housing conditions, and

pollution) will impact on children, and will influence their likely outcomes from the early stages of childhood, through the teenage years, and subsequently as they progress to adulthood. The 2009-12 plan sets out the ten outcomes that the Children's Trust aims to achieve for children and young people.

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December 2009

1. Overview of Camden

Population and neighbourhoods

- Camden has a younger population compared to England and London with most of the population (over 40%) aged between 25-44 years. Over the next five to ten years the largest increase in absolute numbers is expected in the 45-64 year old age group and in the under 16s.
- Ethnic minorities make up over 30% of Camden's population. The younger population are more diverse than the older population (50% of children are from a black and minority ethnic background, compared to 15% of those aged 65 plus).
- Camden has higher proportions of people from the Irish and Bangladeshi communities compared to the rest of London.

Deprivation

- Camden is the 13th most deprived borough in London according to the Index of Multiple Deprivation 2007 (IMD 2007). Over a third (34%) of Camden's Lower Super output areas were in the 20% most deprived in the country; none were amongst the 20% least deprived.
- St Pancras and Somers Town and Kilburn are two wards that consistently show unfavourable outcomes across all the different domains of the IMD.

Population mobility

- An analysis of General Practice Lists in March 2008 and March 2009 showed that 15% of the patients on the lists in March 2009 were not on the lists a year earlier. This percentage differs by age band with the highest mobility in the younger age bands (ages 15-39), possibly due to the large student population resident in Camden.
- 1,500 households surveyed for Camden's 2004 Housing Needs Survey shows that households renting in the private rented sector are more mobile than those living in council or a housing association accommodation.

Income and employment

- According to Greater London Authority (GLA) projections 72% of Camden's population is of working age, slightly higher to the national and London figures but the employment rate is 69%, increasing consistently but below the rates for the UK and London.
- There are some key groups that are underrepresented in employment figures. 1% of Camden residents in secondary mental health services were in employment in 2008/09 and 4.4% of adults in Camden with a learning disability known to the council were in employment compared to 7.5% in England and 12.5% in London.
- Nearly half of benefit claimants are claiming due to incapacity to work, compared to 40% for London as a whole.
- Camden's 2008 housing needs update established that household incomes among those in social housing are, on average, much lower.

Housing

- Older people with support needs formed by far the largest group of those in need of accommodation-based support, with people with mental health issues forming the second largest group in need.
- The commonest need amongst households on Camden's housing needs register is overcrowding. 2001 Census found that 30% of Camden's households were overcrowded compared to 17% of households in London and 6% of households in England and Wales.

Community safety

- Camden is in the top ten of London local authorities for offences per 1,000 residents. 2007/08 data shows that there were 81 recorded offences per 1,000 population, compared to 65 in London and 54 in England and Wales.
- Camden has seen the greatest reduction in Total Notifiable Offences (TNO) and Serious Acquisitive Crime (SAC) between 2006/07 and 2008/09 compared to all London Boroughs.
- Crime remains the biggest concern amongst Camden residents, although this has fallen by 6% between the 2003/04 survey and 2006/07 survey.

Life expectancy and mortality

- There is an eight year gap in male life expectancy between Hampstead and St Pancras and Somers Town wards, and a seven year gap in female life expectancy between Hampstead and Kentish Town.
- Camden has the second highest male life expectancy inequality gap in London as described by the slope of inequality index (see Figure 20 on page 42).
- Circulatory disease (32% of all deaths) and cancer (28% of all deaths) are the biggest killers in Camden.
- 30% of all 'early years of life lost' (deaths under the age of 75) in the borough occur in the four wards of St Pancras and Somers Town, Kilburn, Gospel Oak and Kentish Town (which have 23% of the under 75 population).

Mental health

- There are currently over 3,000 adults registered with a Camden general practitioner who have severe mental health illness. This is a crude prevalence of 1.4% and is one of the highest in England.
- The London Health Observatory Mental Health and Wellbeing Scorecard (2008) shows that Camden has higher inpatient admission rates for schizophrenia and delusional disorders and common mental health problems compared to London.
- Camden's suicide and injury undetermined rate in 2005-07 was 13.18 deaths per 100,000 population. It is one of the highest suicide rates amongst all London boroughs and is higher than England (7.89 deaths per 100,000) and London (7.49 deaths per 100,000).
- Other risk factors prevalent in Camden associated with mental illness include high incidence of drug and alcohol misuse.

Morbidity

- Camden's recorded prevalence of selected long term conditions is often much less than the expected prevalence, particularly for vascular conditions, indicating that

some groups may have an existing condition that has not yet been diagnosed and is not being treated.

- There are currently 12,859 (6.8%) adults recorded as obese on General Practice registers; model-based synthetic estimates suggest up to 13% of Camden's adult population may be obese.
- Prevalence of obesity in children in Year 6 is above the national average.

Adults' lifestyle

- About a quarter of Camden adults smoke, with higher rates in lower socio-economic groups and those living in social housing.
- The Active People Survey (2007/08) suggests that 23.9% of people across the borough are regularly participating in 30 minutes moderate intensity of physical activity, which is higher than the national average.
- Camden has higher expected prevalence of hazardous and harmful drinking than London and England.
- Alcohol related and specific admissions in Camden are significantly higher in Camden compared to London and England.
- Camden has an estimated population of 4,328 problem drug users, i.e. users of opiates and / or crack cocaine. According to these estimates, Camden's prevalence of crack and / or opiate use is the fifth highest in London.

Education

- Camden residents are highly qualified, being in the top ten local authorities with people qualified to degree level or above (52.4%), compared to 38.6% in London and 29% nationally, according to the ONS Annual Population Survey Jan-Dec 2008. However, 7.4% of working-aged residents are without any qualifications at all, compared to 12% in London and 12.4% nationally.

Health of children and young people

- The current performance indicator for breastfeeding is defined as the percentage of babies who are full or partially breastfed at 6-8 weeks. In quarter one of 2009/10 breastfeeding rates in Camden was 74% which is higher than the national median of 42%.
- 4.3% of mothers were smoking during time of delivery in Camden in 2008/09 which is lower than the national median of 15%.
- Immunisation against measles, mumps and rubella (MMR) for Camden children has shown a marked improvement over the last three years, although it still remains lower than the national median. The proportion of children who completed their first dose of MMR immunisation by their 2nd birthday in Camden in 2008/09 was 71.6% - increasing from 63% in 2007/08. This is lower than the national median of 86.2%. The proportion of children who completed their MMR immunisation (first and second dose) by their fifth birthday in 2008/09 was 50.5%, which is lower than the national average of 80.8%.
- Despite most recent data (for the calendar year 2008) showing an increasing rate for under 18 conceptions, Camden remains as having the fourth lowest rate in Inner London.
- By the age of five 11.6% of Camden school children are obese and this rises to 20% by the age of eleven. Current rates are higher than England for both reception year and year 6.

Children and young people's lifestyles

- 33% of Camden pupils in the 2008 TellUs Survey stated that they regularly ate five or more portions of fruit and vegetables day – higher than the national average of 23%. 52% stated that they do 30 minutes or more of sport/exercise at least six days a week. This is up from 33% the previous year and above the national average of 36%.
- In both Reception Year and Year 6 obesity is more prevalent in males than females consistent with the national findings.
- 54% of those responding to the 2008 TellUs survey indicated that they had never had an alcoholic drink. Of those who said they had, 15% stated they had been drunk on at least one occasion compared to 33% nationally. In addition the 2008 Health Related Behavioural Questionnaire showed that fewer Year 10 boys in 2006 said that they had at least one unit of alcohol in the last week (16%) compared with 24% in 2002. 16% of Year 8 girls in 2004 compared with 5% in 2006.
- Perceptions captured through TellUs (2008) showed that 88% of respondents said they had never taken drugs, compared with 74% in 2007. These results are similar to the national picture. Where drug usage had occurred, cannabis is the most prevalent.
- 86% of respondents to the 2008 Survey said they never smoked compared to 75% nationally. The overall prevalence of adult smoking in Camden is 24%.

Vulnerable children

- Children in need (CIN) are those who may be eligible for assistance from the local authority. As at 31 March there were 2,700 children in need, a rate of 684 per 10,000 under 18 population. This was higher than both the England rate of 276 and inner London rate of 488.
- The number of children becoming subject to a child protection plan has increased over period 2005-2009 from 56.7 to 68.2. This high rate is particularly evident amongst the under one year old population which includes unborn children.
- Over the last five years the main reason for children becoming subject to a protection plan has been neglect. In the last two years domestic violence has been the main factor. Children in households where there is one or multiple issues of domestic violence, substance misuse and mental health are more likely to be referred and become subjects of initial and repeat child protection plans. The number of children made subject to repeat child protection plans is increasing and is higher than national and inner London averages.
- Nationally, looked after children are over four times more likely to experience significantly worse mental health[2].
- As of 31 of March 2009, there were 272 looked after children. The rate per 10,000 under 18 year olds looked after children has successfully been reduced in Camden over the year from 89 per 10,000 in 2005 to 69 per 10,000 in 2009 (as at 31 March 2009). However this rate is still higher than London (65, per 10,000) and England (55 per 10,000) but lower than our statistical neighbours (88 per 10,000) in 2008/9.
- The largest age group amongst looked after children over the past five years in Camden was teenagers in the 10-15 age group (42%). The next largest group is the 16-17 age group (26%).
- An examination of young offenders known to Camden's integrated youth support service by ethnicity since 2002 highlights the over-representation of young black males within the youth justice system compared to the overall 10-17 year old

population. Data from 2008/9 shows that the proportion of offenders who are black continues to remain constant around 25%.

Children and young people with special educational needs and/or disabilities (SEND)

- In January 2009, there were about 7,400 children and young people with SEND resident in Camden of whom three quarters are educated within the borough.
- The prevalence of SEND in Camden schools is 20% higher than the picture nationally. For social, emotional and behaviour difficulty (SLCN) the rate is twice the national picture while speech, language and communication needs (SEBD) is 60% higher. In the past five years the number with speech, language and communication needs in secondary schools has more than doubled.

Not in education, employment or training (NEET)

- Being 'not in education employment or training' (NEET) between the ages of 16-18 is a key risk to young people not gaining the skills and experience they need to maximise their future economic wellbeing. The proportion of 16-18 year olds in Camden who are NEET has been decreasing over recent years and there has been a decrease of 2.4% over three years compared to a 2.1% reduction in London and 1.5% in England.
- However there are disparities in the proportion of young people who are NEET by key vulnerable groups: Young people from a mixed race background are overrepresented in NEET group, a slightly higher proportion of young people with Learning Difficulties/Disability in Camden are NEET compared to England and London, and a similar picture can be seen for teenage mothers.

2. Population and neighbourhoods

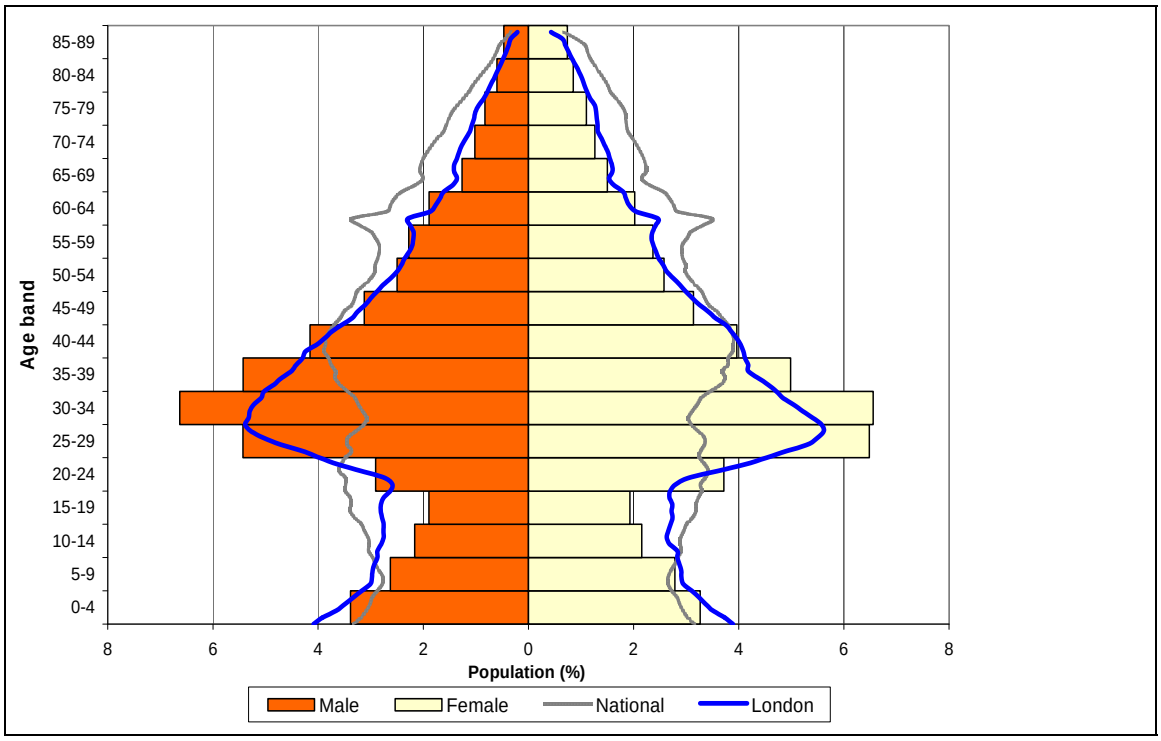
Current population

The number of people living in Camden is expected to increase and the makeup of the population will change over the next 10 years. The current resident population is predicted to be about 210,000 people in 2010. Camden's population is young and diverse with many people moving in and out of the borough every year.

Camden is not only a place for residents; almost a quarter of a million non-resident people work here every day and the borough attracts a large number of visitors each year. Camden has the largest proportion of students in London, and over 5,000 international students arrive each year.

Figure 1 shows that relative to England and London, Camden's population is younger with higher proportions of 25-44 year olds.

Figure 1: Camden resident population age distribution in comparison with London and England in 2008



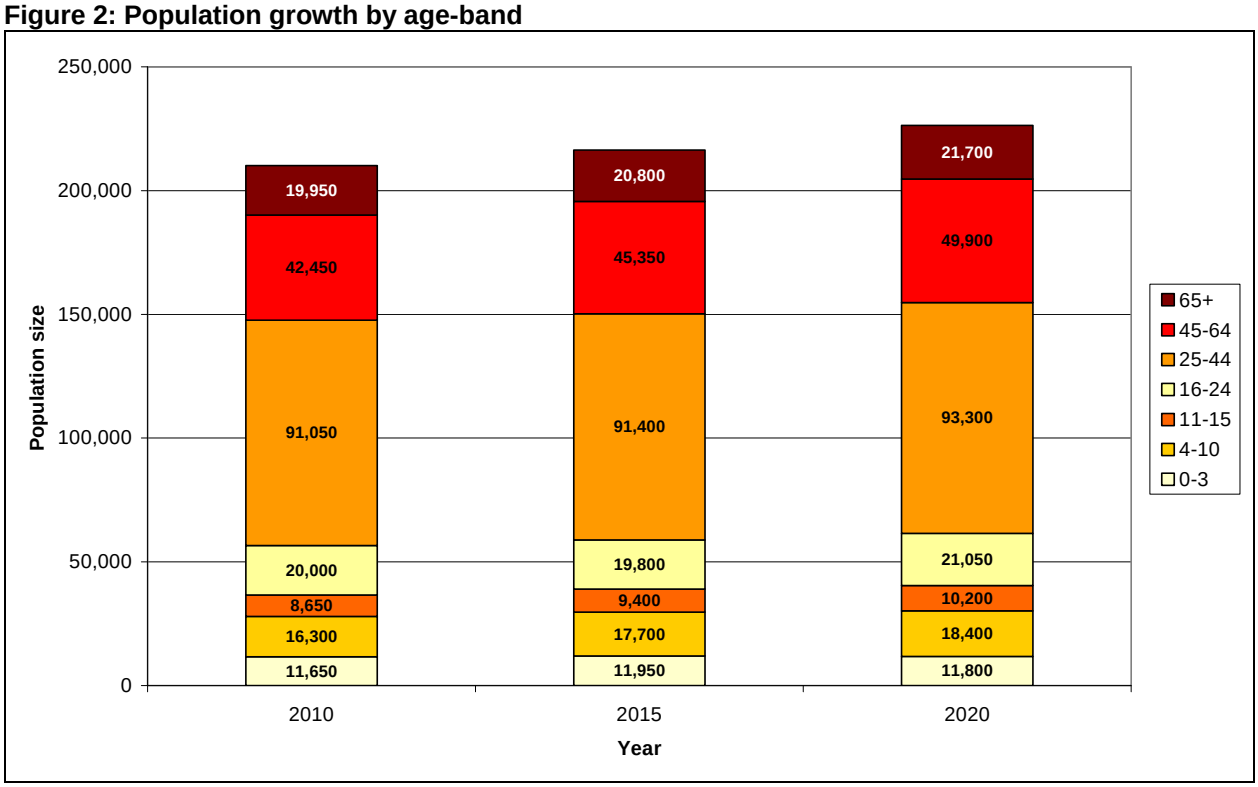
Source: **Camden and London, Greater London Authority (GLA) 2008 Round High, © GLA, 2009 England, Office for National Statistics (ONS) mid year estimate 2008.**

Population change

According to Greater London Authority (GLA) projections, Camden's population is expected to grow by about 6,300 over the next 5 years, with an additional 9,950 in the five years after that. The biggest increase in absolute numbers will be in the 45-64 and the under 16 age groups.

Figure 2 shows that whilst we see increases in these age groups, Camden's overall population will remain relatively young with the bulk of the population (over 40%) aged between 25-44 years.

Figure 2: Population growth by age-band



Source: Greater London Authority (GLA) 2008 Round High; © GLA, 2009

Births

According to the Office for National Statistics' (ONS) Annual Population Survey (APS), there were 3,147 live births in Camden in 2007. 62% of births in 2007 were born to mothers whose country of birth was outside of the UK. This compares to 24% for England as a whole and 53.9% in London.

Migration

Indicators from the ONS show that Camden is amongst the top ten authorities nationally for individual moves in and out of the borough both, national and international, confirming the high mobility of the population. During 2007-08 there were an estimated 27,000 people entering the borough, and 25,000 leaving it. This resulted in a net internal migration of minus 3,000 (meaning 3,000 more left for another part of the UK than arrived) and a net international migration of more than 5,000 people.

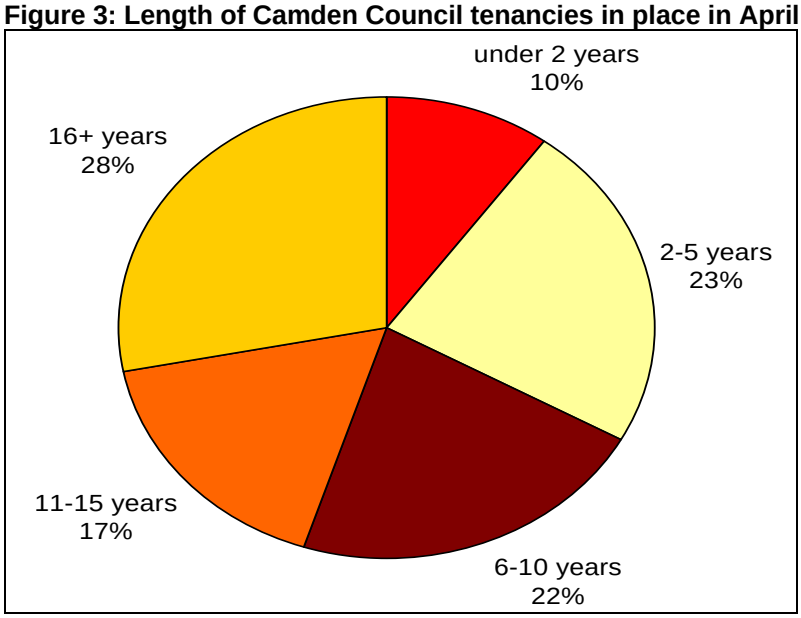
Mobile population

An analysis of General Practice Lists as of March 2008 and March 2009 showed that 15% of the patients on the lists in March 2009 were not on the lists a year earlier. This percentage differs by age band with the highest mobility in the younger age bands (ages 15-39), possibly due to the large student population resident in Camden.

A survey of 1,500 households surveyed for Camden's 2004 Housing Needs Survey shows that households who rent from the council or a Housing Association are much less mobile than those renting in the private rented sector. It showed that 51.3% of households had moved within the last 10 years. Of the households who had moved, 41.3% had moved from a home in the private rented sector, 19.1% from a home rented from either the Council or a Housing Association, and 16.4% from a home they had owned.[3]

Council tenants are relatively immobile; of the tenancies held in April 2009, 28% had lived in their homes for 16 years or longer and 67% for six years or longer (Figure 3).

Figure 3: Length of Camden Council tenancies in place in April 2009

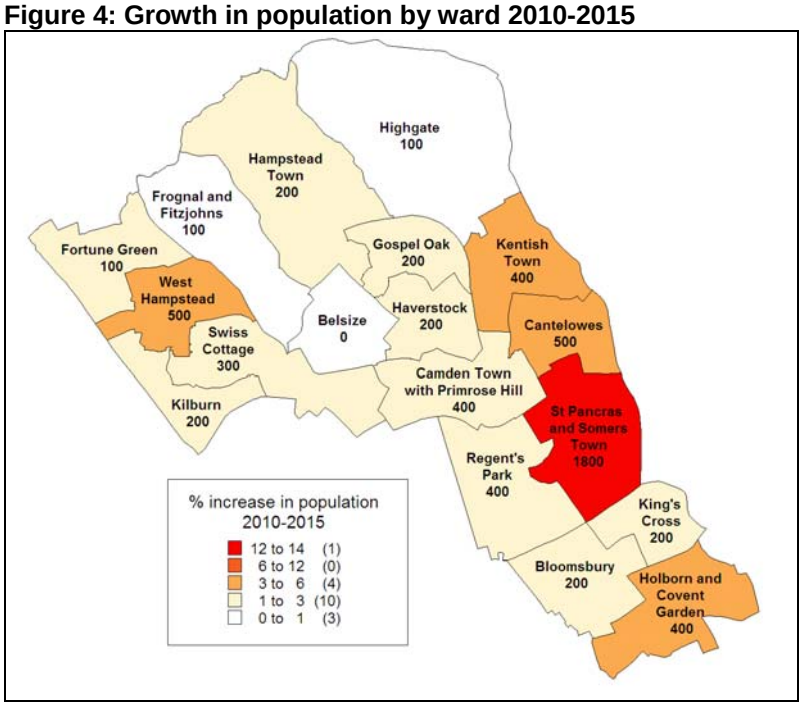


Source: Camden draft housing strategy evidence base, June 2009

Geographical growth

Figure 4 shows increase in population by ward, according to Greater London Authority (GLA) population projections, over the next five years. St Pancras and Somers Town, one of Camden's most deprived wards, will see the largest growth in the next 5 years, mostly due to the King's Cross redevelopment. Further areas of growth in infrastructure and population over the next 10 years have been identified by Camden's Local Development Framework (LDF) as King's Cross, Euston, Tottenham Court Road, Holborn and West Hampstead.

Figure 4: Growth in population by ward 2010-2015



Source: Greater London Authority (GLA) 2008 Round High; © GLA, 2009

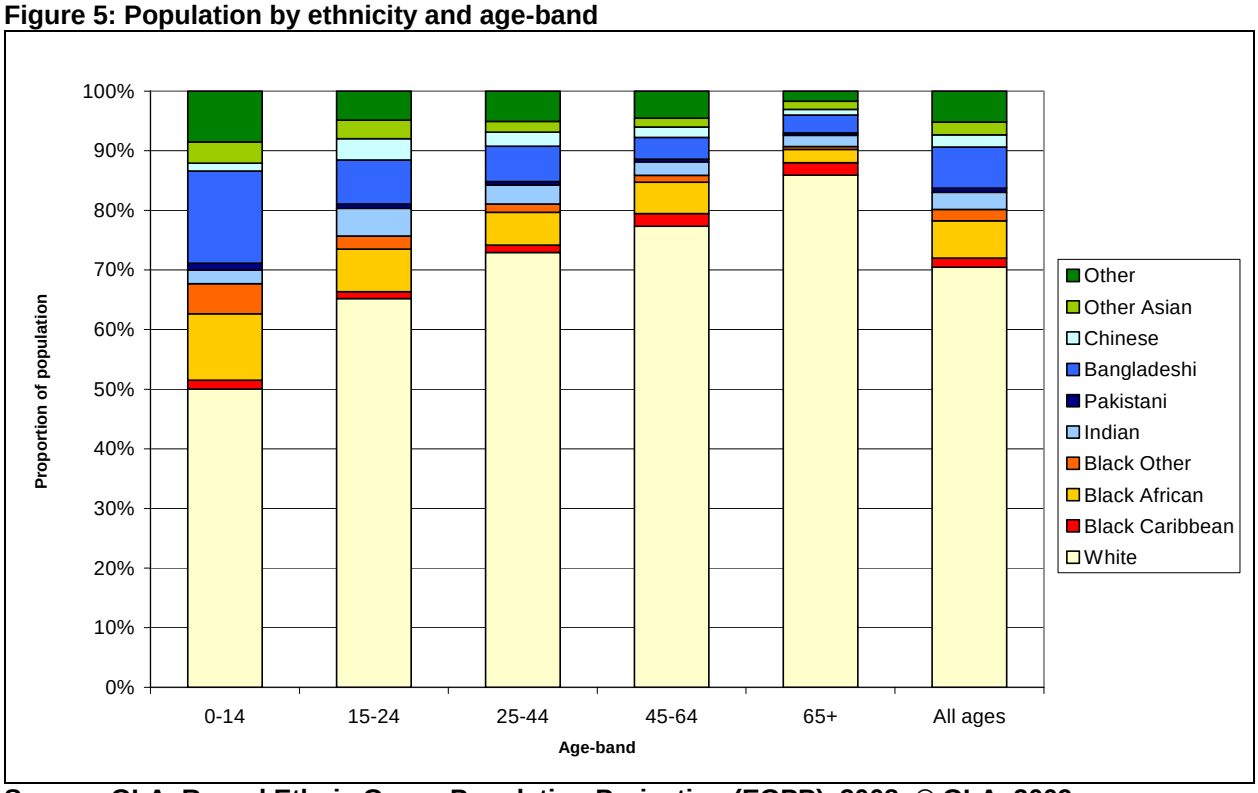
Ethnicity

Ethnicity refers to a common group identity based on language, culture, religion or other social characteristics. According to the GLA ethnicity estimates, 30% of the population are estimated to be from a black and minority ethnic background (excluding White Irish and White Other).

The Office of National Statistics' experimental ethnicity statistics estimate that up to 47% of the Camden population could be from a black and minority ethnic group if White Other and White Irish are included. Relative to the rest of London, Camden has high numbers of people from White Irish, Bangladeshi and White Other backgrounds. It is also of note that 6% of the population are from a Black African background, including a large Somali population. At least 3,000 people (1.5% of the population), were born in Somalia, and numbers from a Somali ethnic background are likely to be even higher.

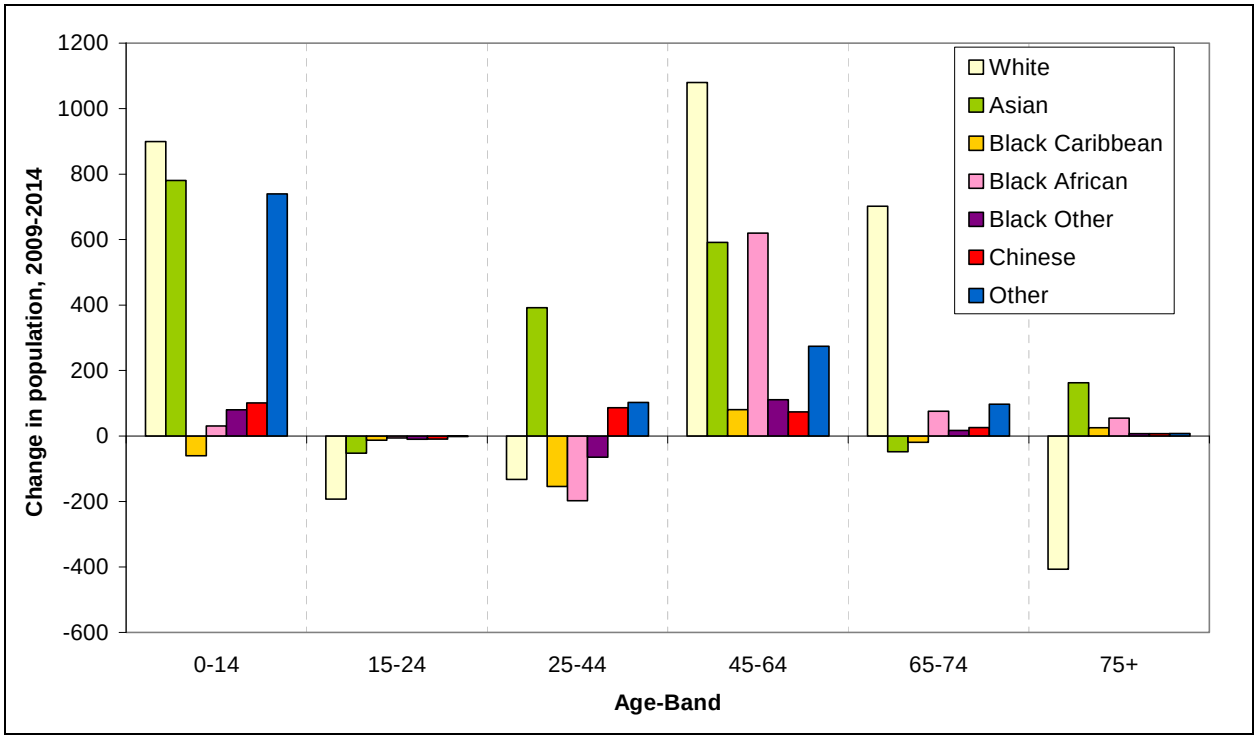
The ethnicity of the population varies by age (Figure 5). The younger population are more diverse than the older population (50% of children are from a black and minority ethnic background, compared to 15% of those aged 65+), although over the next five years there is expected to be an increase in ethnic minorities in the population aged 45-64 (Figure 6).

Figure 5: Population by ethnicity and age-band



Source: GLA, Round Ethnic Group Population Projection (EGPP), 2008; © GLA, 2009

Figure 6: Changes in population by ethnicity and age-band, 2009-2014



Source: GLA, Round Ethnic Group Population Projection (EGPP), 2008; © GLA, 2009

Language

Children in Camden schools speak more than 100 languages. In addition to English, the most widely spoken languages are Bengali/Sylheti, Somali, Albanian, Arabic, Spanish, Portuguese, French, Yoruba, Farsi and Lingala.

Religion

Camden has a diverse religious population, with a significantly higher proportion of people of Muslim, Jewish and Buddhist faith than either London or England. In the Census 2001, 47% of Camden people described themselves as Christian, 12% Muslim and 6% Jewish. 22% recorded themselves as having no religion.

MOSAIC classifications of Camden resident population

The MOSAIC classification system classifies each of the 1.7 million residential postcodes in England into 11 socio-economic groups, which are further broken down into 61 sub-groups, of which 20 are represented in Camden. However, the vast majority of residents come from just four of those:

a) Type A1 (Global Connections) - Very affluent childless older people or rich people from abroad living in extremely expensive housing. 22% of the Camden population live in such areas

b) Type E28 (Counter Cultural Mix) - A mixture of young professionals in rented flats, ethnic minorities sharing large old houses and poor tenants in council flats, that characterizes many of the less well off areas surrounding the centre of London. 25% of the Camden population lives in these areas.

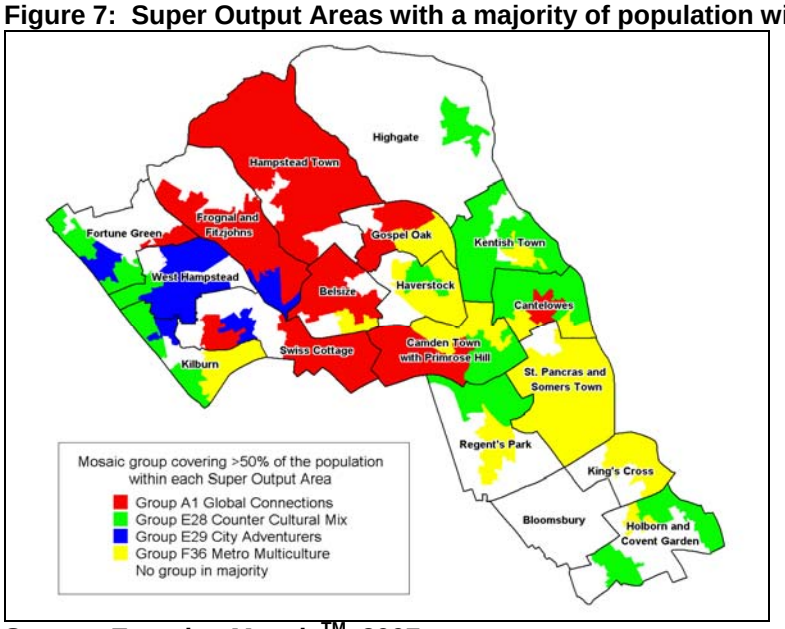
c) Type E29 (City Adventurers) - High-salaried, twenty-something singles in smart flats in inner urban areas. 12% of Camden's population live in these areas.

d) Type F36 (Metro Multi-culture) - Tenants of public housing in inner city areas, with a high proportion belonging to black and minority ethnic communities. 27% of Camden's population live in these areas.

Overall, the population from these four groups makes up 86% of the population of Camden. Type A1 are concentrated in the more affluent areas of Camden such as Hampstead Town and Belsize, whilst Type F36 are located in the areas of greater deprivation like St Pancras, as would be expected given the definitions of the groups.[4]

Figure 7 shows the super output areas where the majority of the populations comes from one of the MOSAIC groups.

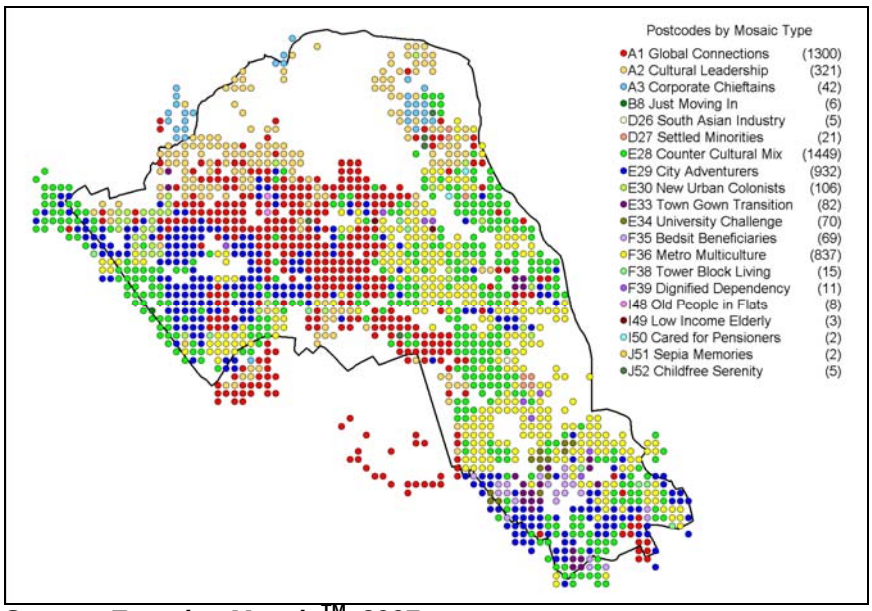
Figure 7: Super Output Areas with a majority of population within one MOSAIC Group, in Camden



Source: Experian Mosaic™, 2007

However, it should be noted that even in areas with a large proportion from one MOSAIC type, pockets of population from other types may also be present, as shown on the map below, which displays the MOSAIC type of each individual postcode. Large gaps on the map either represent commercial or industrial areas, or green spaces like Hampstead Heath and Regent's Park.

Figure 8: Camden residential postcodes by MOSAIC type



Source: Experian Mosaic™, 2007

Disability

Adults with learning disabilities

People with learning disabilities are amongst the most vulnerable and socially excluded in our society, and there is evidence that they have greater need for healthcare than other people, yet have worse access to the care that they need and poorer health outcomes[5].

A 'learning disability includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning); which started before adulthood, with lasting effect on development'[6]. This definition includes adults with autism who also have learning disabilities, but not those with a higher level autistic spectrum disorder who may be of average or even above average intelligence, such as some people with Asperger's syndrome.

Many people with a learning disability need some support from health and care services. People with learning disabilities will often have physical health and care needs and a lower life expectancy. Several recent reports have highlighted the magnitude of health inequalities faced by people with learning disabilities across the UK, in particular the 06/07 reports by the Disability Rights Commission and one widely quoted study in South London found that people with learning disabilities were 58 times more likely to die before the age of 50 than members of the general population (Hollins et al (1998)). This has been noted by Department of Health (DH) as an area for further work.

DH estimates suggest that between three and four people per thousand of the general population will have significant learning disabilities

In keeping with national trends, the learning disabilities population is increasing due in part to the rising numbers of young people with complex needs surviving into adulthood, and also to the increased life expectancy of the learning disabled population generally. The rate of increase is estimated to be 1.1% per year (Emerson and Hatton 2004).

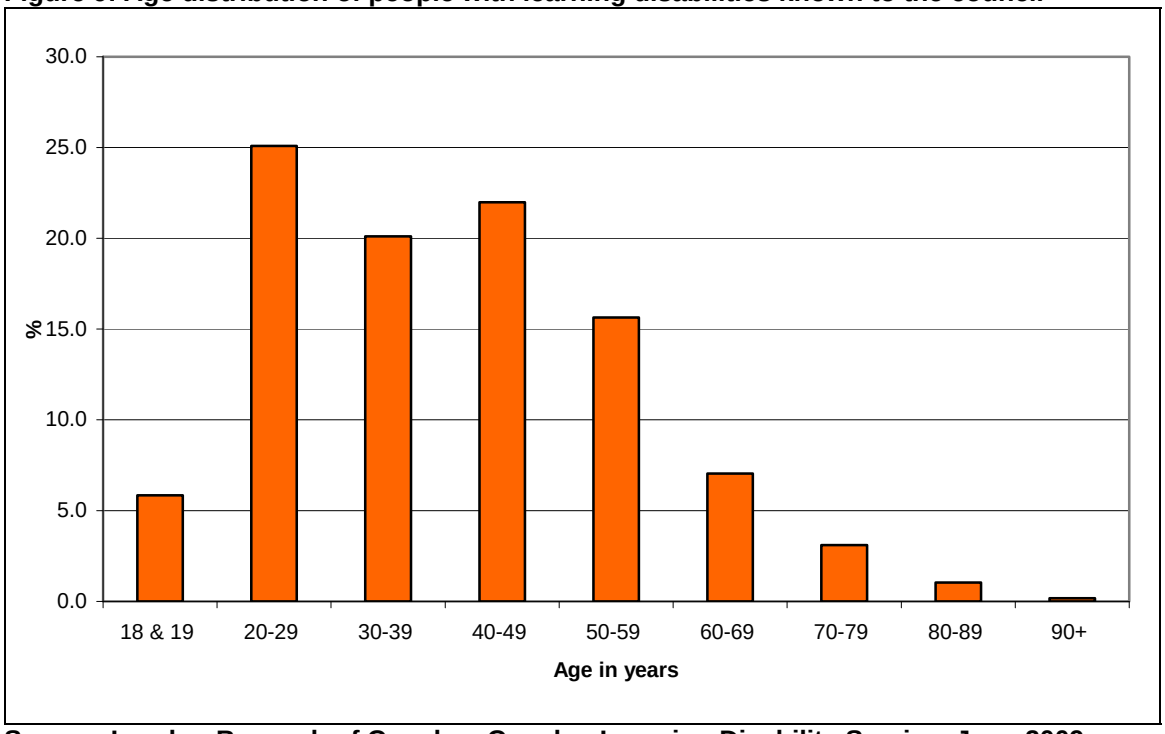
As of June 2009 there were 586 people known to Camden learning disabilities service of which 14% are classified as having a severe learning disability and 29% as a moderate.

Figure 9 shows that the majority of people with learning disability known to the council are aged between 20 -59. There are more males with learning disabilities known to the council than females (59% versus 41%).

Approximately 50% of the local learning disabled population live in the five most deprived wards in the borough.

Less than 10% of people known to local learning disabilities services are in paid employment.

Figure 9: Age distribution of people with learning disabilities known to the council



Source: London Borough of Camden, Camden Learning Disability Service, June 2009

The majority of people with learning disabilities have additional needs – most commonly in relation to communication and mental health, but also in relation to mobility and sensory impairments, and a significant proportion of this population will have specific health conditions such as epilepsy and diabetes. In Camden the top three additional needs of the learning disability population are mental health, challenging behaviour and general health.

The Department of Health (2001) Valuing People A New Strategy for Learning Disability indicates that numbers of people with learning disabilities may increase by 1% per annum over the next 15 years. The predicted increase in the number of young people in transition to adult services in Camden, is estimated to be between 10 -20 people per year for the next three years.

The tendency for people with learning disabilities to live longer means that many are now experiencing the range of age related health problems experienced by the general population as well as particular considerations that apply to this population for example, in the case of dementia, there is a pattern of earlier onset experienced by people who have Down's Syndrome.

The projecting adult needs and service information (PANSI) provides information on prevalence trends for learning disability by using Health Survey for England 2001 data and applying this to population projections. Using this information it is predicted that for the age group 18-64 there will be a 10% increase in people with severe learning disability from 2010 to 2015 and 17% from 2010 to 2020.

The projecting older people information system (POPPI) provides information on prevalence trends for people with learning disability for the older population. For the age group 65+ it is estimated in Camden that there will be a 10% increase in numbers with a moderate to serve learning disability from 2010 to 2015 and a 17% increase from 2010 to 2020.

Adults with sensory needs

In 2009 there were 743 registered sensory needs service users. While it is mandatory for the council to keep a register it is not compulsory for service users to register so the figures are likely to be an under-representation of the number of people with sensory needs in Camden. This assumption is supported by the national prevalence figures.

Table 1: Registered sensory needs users

Impairment	Camden Registered	National prevalence	Predicted actual
Deaf	97 People	1 in 68	2912
Hard of Hearing	161 People	1 in 12	16500
Blind	156 People	1 in 257	770
Visual Impairment	320 People		
Dual Sensory/Deaf/Blind	9 People		

Source: London Borough of Camden, Housing and Adult Social Care, 2009

Children and young people with special educational needs and/or disabilities (SEND)

In January 2009, there were about 7,400 children and young people with SEND resident in Camden of whom three quarters are educated within the borough.
Across Camden primary, secondary and special schools, the most common types of SEND are:

- Social, emotional and behaviour difficulty (SEBD)
- Speech, language and communication needs (SLCN)
- Learning difficulties (LD)

In many cases children have multiple needs and require a wide range of interventions.

In the general population around one in seven children have SEND however:

- More than a third of children in need also have SEND, for which abuse or neglect is the main reason for inclusion. As this data relates to just six months of children in need, the prevalence may be even higher.
- Four out of every ten children looked after by Camden have been identified with SEND. For nearly half, SEBD was the primary need with a further 10% having SEBD as an additional need.
- A disproportionately high number of children with SEND live in areas of high deprivation – 57% of SEND children live in areas considered the 20% most deprived nationally.
- There are twice as many boys with SEND than girls though this ratio differs for particular types of need – for Autistic Spectrum Disorders (ASD) the ratio is five boys for every one girl.
- Prevalence of SEND by type differs across black and minority ethnic communities:
  - SEBD is most common need for white British and black Caribbean children
  - SLCN is most common need for Bangladeshi and black African children
  - LD is more prevalent for Bangladeshi and white Irish children than for other black and minority ethnic communities

Carers

Carers provide unpaid care by looking after an ill, frail or disabled family member, friend or partner. Carers give so much to society yet as a consequence of caring, they may experience ill health, poverty and discrimination. However, substantial evidence exists, to show that there is a strong link between providing high levels of care and ill health. The evidence shows that this is due to the lack of appropriate support, isolation, financial stress and lack of information[7]

In Camden there are approximately 15,000 adult carers, of which 2,600 (14%) report poor health. Carers in Camden providing more than 50 hours care per week are twice as likely to report that they are not in good health compared to the non carer population. 555 carers in Camden provide more than 50 hours care per week[8].

Carers are more at risk of psychological distress if they are caring for more than 20 hours per week. 4,500 people in Camden care for more than 20 hours per week[9].

There is recognition that carers are a group at disproportionate risk of experiencing health inequalities.[10]

The wards with greatest percentage of carers caring for more than 50 hours per week are St Pancras/Somers Town, Gospel Oak, Regents Park, Haverstock and Kentish Town[11].

In the 15 to 64 age group, carers make up 8% of the Camden population (Census 2001) which is comparable to other inner city London boroughs. In 65 plus age group, 11% of population have caring responsibilities. The numbers of carers aged 65+ is expected to increase, see table 2.

The care that carers in Camden provide is estimated to be equivalent to £207 million a year .[12]

With the rise in older population the numbers of carers will increase. It is estimated that the number of carers could rise from 5.7 million in 2001 to 9.1 million in 2037 (It could be you: A report on the chances of becoming a carer, Carers UK 2001). Also 65% of long term care in 2000 was provided by unpaid care, compared to 25% state funded care and 10% private care.

Table 2: Projection of the numbers of carers

POPPI Data for: Camden carers

People aged 65 and over providing unpaid care to a partner, family member or other person, by age (65-74, 75-84, 85 and over), projected to 2025

	2008	2010	2015	2020	2025
People aged 65-74 providing unpaid care to a partner, family member or other person	1,370	1,406	1,590	1,651	1,724
People aged 75-84 providing unpaid care to a partner, family member or other person	643	634	661	714	821
People aged 85 and over providing unpaid care to a partner, family member or other person	104	108	116	128	143
Total population aged 65 and over providing unpaid care to a partner, family member or other person	2,116	2,148	2,366	2,492	2,689

Source: Projecting older people population information system (POPPI). Figures may not sum due to rounding. Crown copyright 2007

Adult carers

Most carers are women (59% of carers are women) which is comparable to national figures. People aged between 50 and 64 are most likely to provide unpaid care and people aged between 65 and 84 provide the most hours per week.

In 15-64 age group the ethnic background of carers is 17% Bangladeshi, 11% Caribbean, 13% African, 11.5% Pakistani, a higher representation than in the general population. In the65age group, 14% are Bengali, 18% African, higher than in the general population whereas other black and minority ethnic groups are similar to general population figure of 11%.

For most black and minority ethnic groups, females provide slightly more intensive unpaid care than males. There are exceptions however; proportionally far more females of White Irish, Pakistani and Bangladeshi backgrounds provide more than 50 hours per week than males. Males from these groups do provide care but it tends to be low level (under 20 hours per week).

Providing care can have a substantial impact on a carer's current and future quality of life. Carers providing high levels of care, unpaid, are twice as likely to suffer long term limiting illness compared to a person with no caring responsibilities (Census 2001).

Young carers

Young carers are children and young people under 18 who provide some care or support for a parent or other family member. There are approximately 630 young carers in Camden[13] . The intensity of the care they provide may vary, however it is often inappropriate for the young person's age.

3. Social, economic and environmental factors – the wider determinants of health

There are many factors that come together to determine the state of our health or our risk of future ill health. These are known as the determinants of health. Some of the determinants of health we cannot change; for example, our age or genetic makeup. Other determinants, often described as the "causes of the causes" of our health include our living and working conditions and environmental conditions.

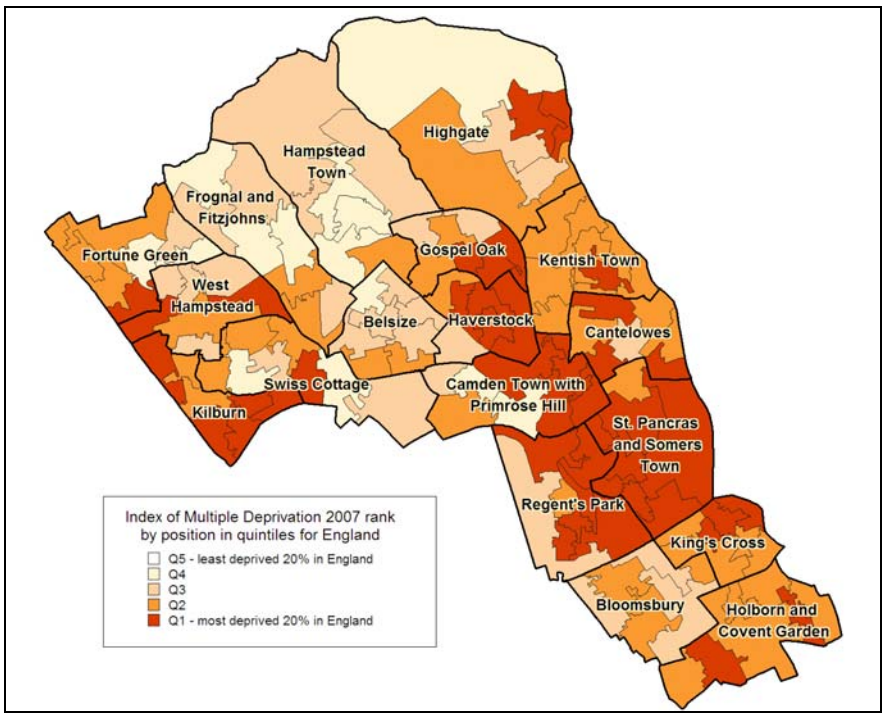
Index of Multiple Deprivation 2007 (IMD)

The Index of Multiple Deprivation (IMD) is a measure calculated by central government, that takes into account: income, employment, health and disability, education, skills and training, barriers to housing and other key local services, the living environment and crime. The latest IMD figures are for 2007.

Camden is the 13th most deprived borough in London. Of Camden's 133 Lower Level Super Output Areas (LSOA), each with approximately 1,500 residents, over a third (34%) were in the 20% most deprived in the country; none were amongst the 20% least deprived.

Figure 10 maps deprivation by LSOA across Camden to show those areas that are the most deprived.

Figure 10: Deprivation in Camden by LSOA, IMD 2007



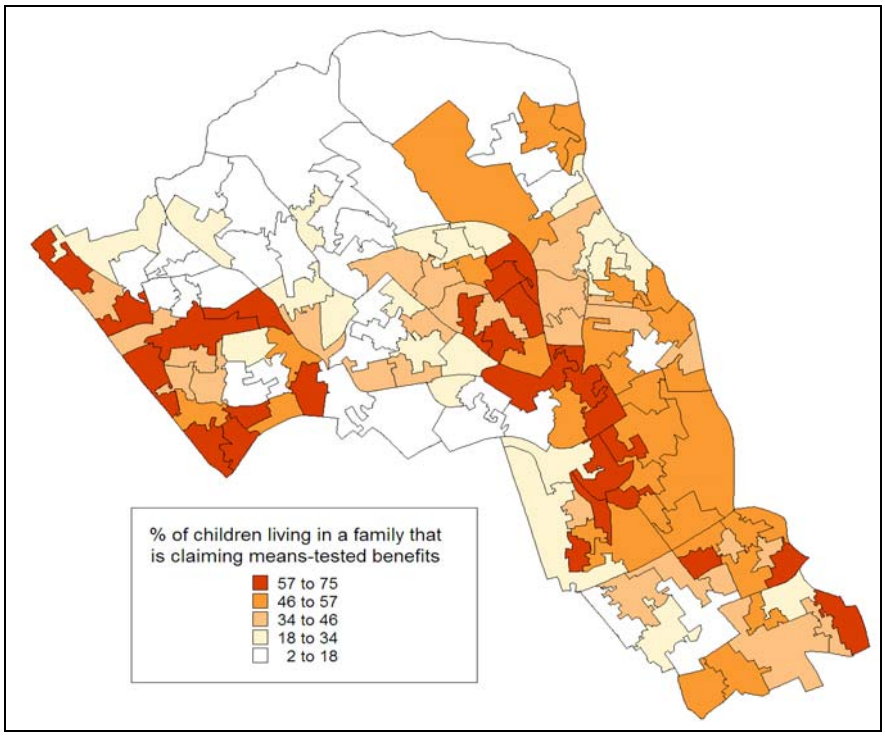
Source: Department of Communities and Local Government, Indices of Multiple Deprivation (IMD), 2007

Child poverty

The Income Deprivation Affecting Children Index (IDACI) measures the proportion of children under 16 years of age who were living in families receiving specific financial support, such as Income Support or Job Seeker's Allowance.

According to the IDACI approximately 40% of children aged under 16 in Camden live in families with a low income compared to 22.4% in England. Figure 11 shows the geographical distribution of children living in low income families, highlighting high levels of child poverty in the Kilburn area, as well as in central Camden.

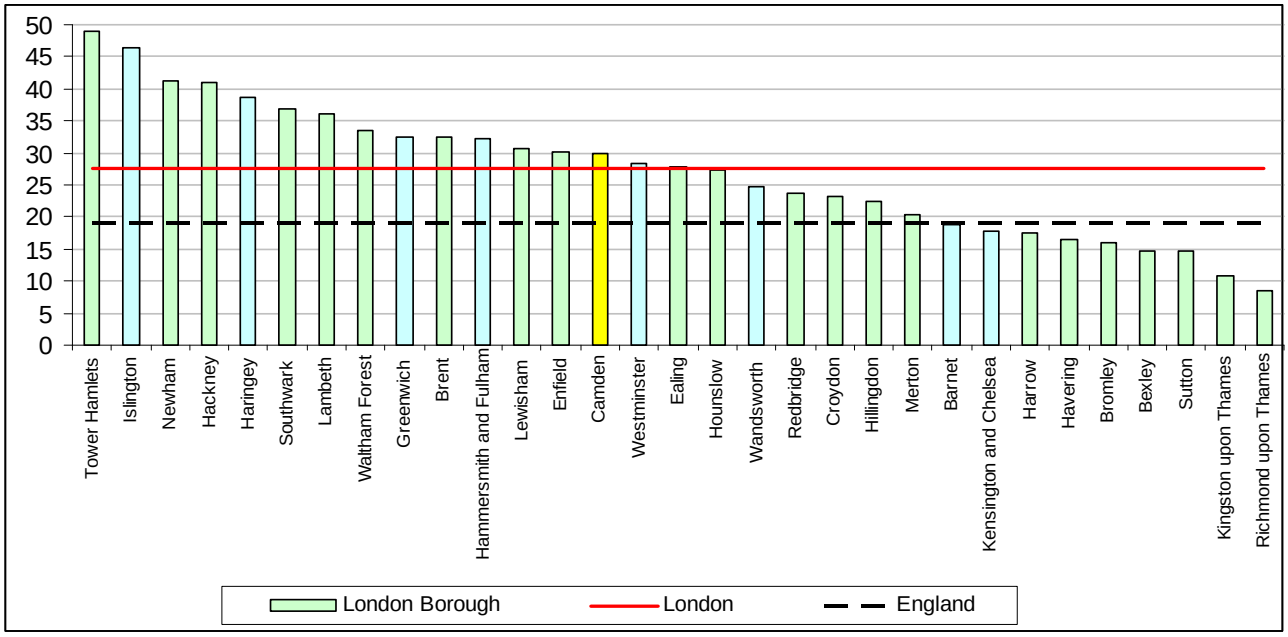
Figure 11: Proportion of children living in low income families by LSOA



Source: Department of Communities and Local Government, Indices of Multiple Deprivation (IMD), 2007

Data published by the Department for Work and Pensions (DWP) shows that in November 2007, 30.9% of children (12,900 children aged 0 – 18) in Camden were living in households in receipt of key benefits (Figure 12).

Figure 12: Proportion of children in families claiming key benefits, November 2007



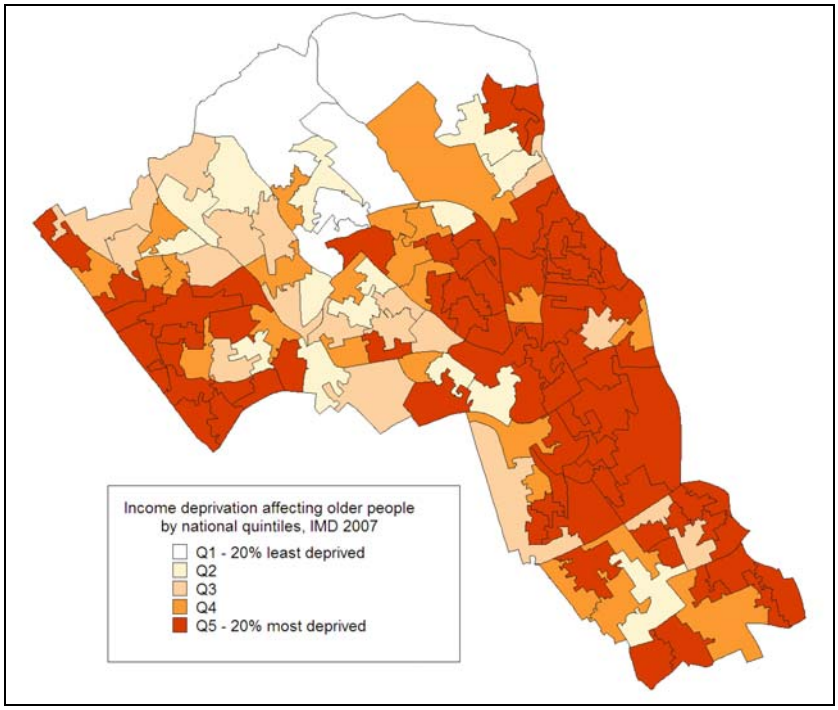
Source: Department of Work and Pensions data, November 2007

Free school meal entitlement is used as a proxy indicator for poverty. The proportion of pupils in Camden's primary schools eligible for free school meals is high (42%), compared to London (24%) and England (16%). The pattern is similar, though reduced in secondary schools, Camden 33%, London 23% and England 13%.

Older people poverty

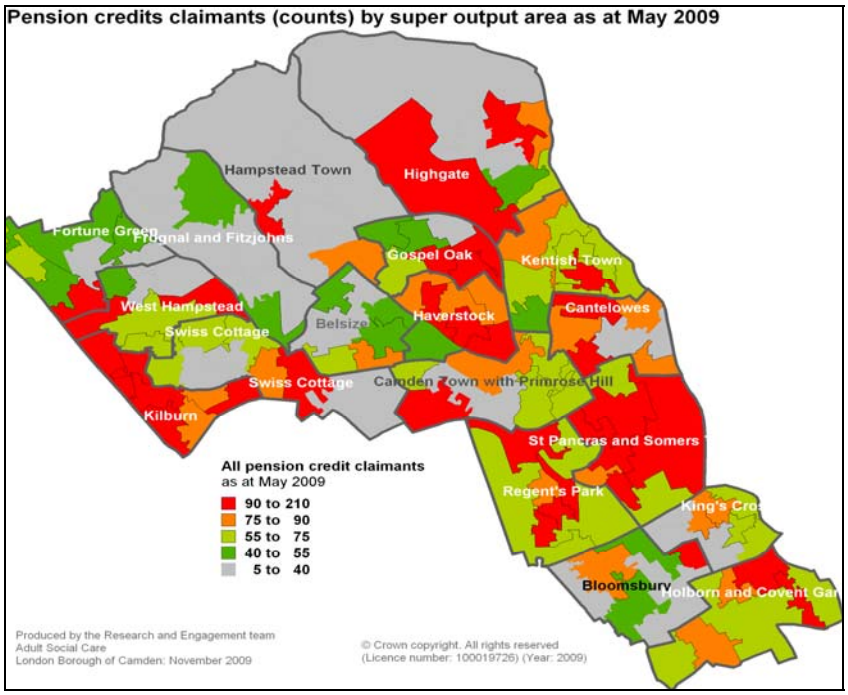
The income domain affecting older people (aged 60 and over) describes the proportion of older people affected by poverty. Figure 13 shows that compared to nationally, 53% of super output areas in Camden are within the 20% most deprived areas in England, whilst just 4% are in the 20% least deprived (just five LSOAs). Figure 14 shows the pension credit claimant counts by LSOA.

Figure 13: Income deprivation affecting older people by LSOA



Source: Department of Communities and Local Government, Indices of Multiple Deprivation (IMD), income deprivation affecting older people domain, 2007

Figure 14: Pension credit claimant counts



Source: Department for Work and Pensions, May 2009

Economic prosperity

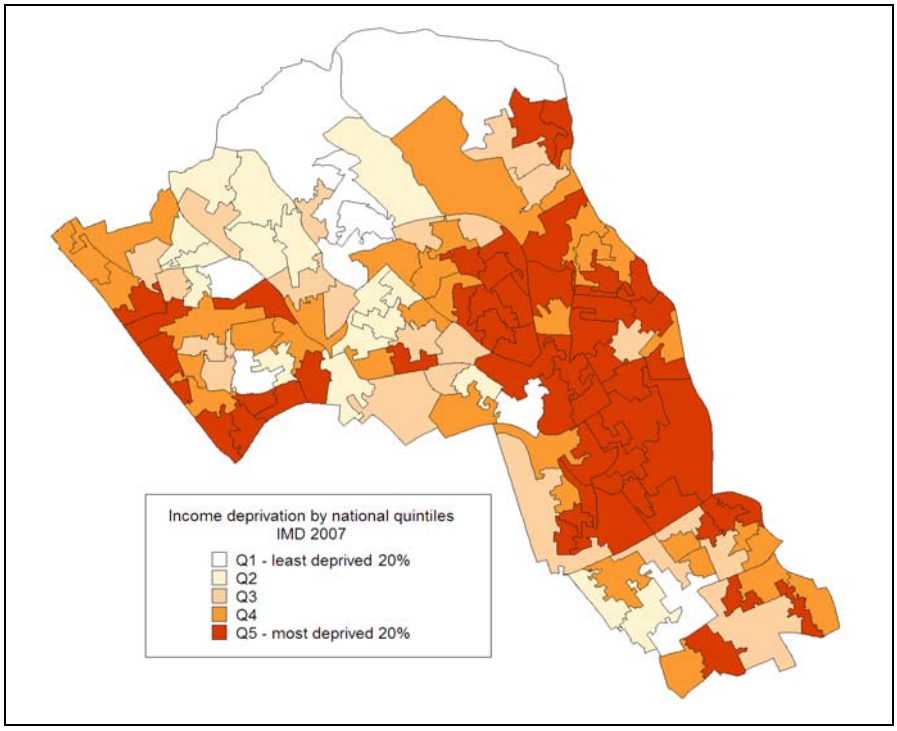
Income and employment are recognised as not only key determinants of overall health but also as important factors underlying health inequalities. The Solid Facts – Social Determinants of Health (2003) notes that "unemployment puts health at risk" and goes on to underline that "unemployed people and their families suffer a substantially increased risk of premature death" and that "the health effects of unemployment are linked to both its psychological consequences and financial problems, especially debt".

Evidence suggests that those in routine and manual occupation suffer poorer health. Job quality is also an important factor and fears over job security, a growing issue due to global changes in the economies and labour markets, can lead to anxiety and greater self reported ill-health.

Income deprivation

Figure 15 shows, 52 of Camden's LSOA's are amongst the 20% most income deprived in the country (39% of the total), whilst just nine are amongst the 20% least deprived (7%).

Figure 15: Income deprivation by LSOA



Source: Department of Communities and Local Government, Indices of Multiple Deprivation (IMD), income domain, 2007

Camden's local economy

There are a total of 296,000 jobs in Camden, 166,000 jobs (63%) are located in the area to the south of the Euston Road. The majority of Camden's jobs (84%) are taken by non-residents, while 60% of Camden residents work outside the borough, emphasising the inter-connectedness of the economy.

There are a broad mix of sectors in Camden with a bias to high skilled professional; 23% of jobs in public sector and around 33% of Camden jobs are in financial services, but just 2% in construction and 2% in real estate. 64% of jobs in Camden are professional/managerial/technical, 18% routine/ manual service, 15% intermediate.

75% of Camden's 23,300 businesses employ fewer than 5 people. However, the largest 1% of employers provide 40% of the jobs.

Employment

According to the GLA projections, 72% of Camden's population is of working age compared with 68% in Greater London and 62% in the UK. The working age population is set to increase over the next five and ten years requiring a corresponding availability of jobs to avoid economic deprivation and unemployment.

In between censuses the employment rate is measured by the Annual Population Survey, and calculated as the proportion of the resident population of working age who are in full or part-time employment. The employment rate in Camden is currently 69%, increasing but consistently below the rates for London (70%) and England (74%).[14] More men than women are in employment (76% vs. 62%) and 49% of people from black and minority ethnic communities are in employment.

Employment for vulnerable people

Supporting vulnerable people into (or to remain in) employment is integral to improving the quality of life and economic wellbeing of Camden residents. In 2008/09 4.4% of adults in Camden with a learning disability known to the council were in employment compared to 7.5% in England and 12.5% in London. 1% of Camden residents in secondary mental health services were in employment in 2008/09.

Out of work benefits claimants

Camden's economy is strong, contributing as much as 1%of the national economy, but many local people, particularly those living in our social housing and those disadvantaged by disability or illness, are without work.[15]

Working age benefits include the main out-of-work client group categories (unemployed people on Jobseekers Allowance, lone parents on Income Support, Incapacity Benefits customers and others on income related benefits). As of May 2009, 13.3% of working age people were on out of work benefits (just over 23,000 people), this compares to 15.7% in England and 15.2% in London.

Working age people claiming out of work benefits in the worst performing neighbourhoods is shown below for Camden in May 2009. The worst performing neighbourhoods are defined by this national indicator as Lower Super Output Areas

(LSOAs) with a benefit claim rate of 25% or more based on a four quarter average between May 2006 and February 2007. The working age population is defined as the sum of females aged 16-59 plus males aged 16-64, based on the 2008 ONS mid-year population estimate

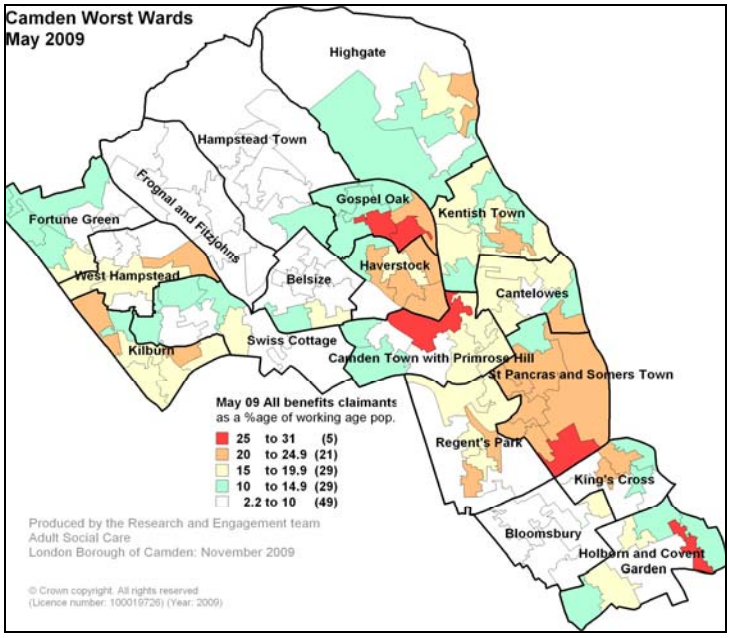
These data show the four worst wards in Camden as at May 2009 (in table 3 below) and the LSOAs where claimant rates are highest (in figure 16).

Table 3: Wards with the highest claimant rates in Camden

Ward Name	Claim rates where 25% or more by LSOA	Total claimant population by ward
Gospel Oak	29.3%	1,550
St Pancras & Somers Town	27.0%	2,220
Holborn & Covent Garden	26.2%	1,575
Camden Town with Primrose Hill	25.1%	1,460

Source: Department for Work and Pensions, 2009

Figure 16: Claimant rates by LSOA, May 2009



Source: Department for Work and Pensions, May 2009

Long term unemployment: the proportion of job seekers who have been claiming the benefit for more than a year has fallen sharply since 2007. In Camden, at January 2001, 29% of people claiming JSA had been claiming for more than 12 months; by January 2009 that proportion had dropped to 14% compared to 11% in London and 8% nationally.

Ill health and disability has an impact upon Camden's working age population. Table 4 below shows that nearly half of claimants are claiming due to incapacity to work, compared to 40% for London as a whole.

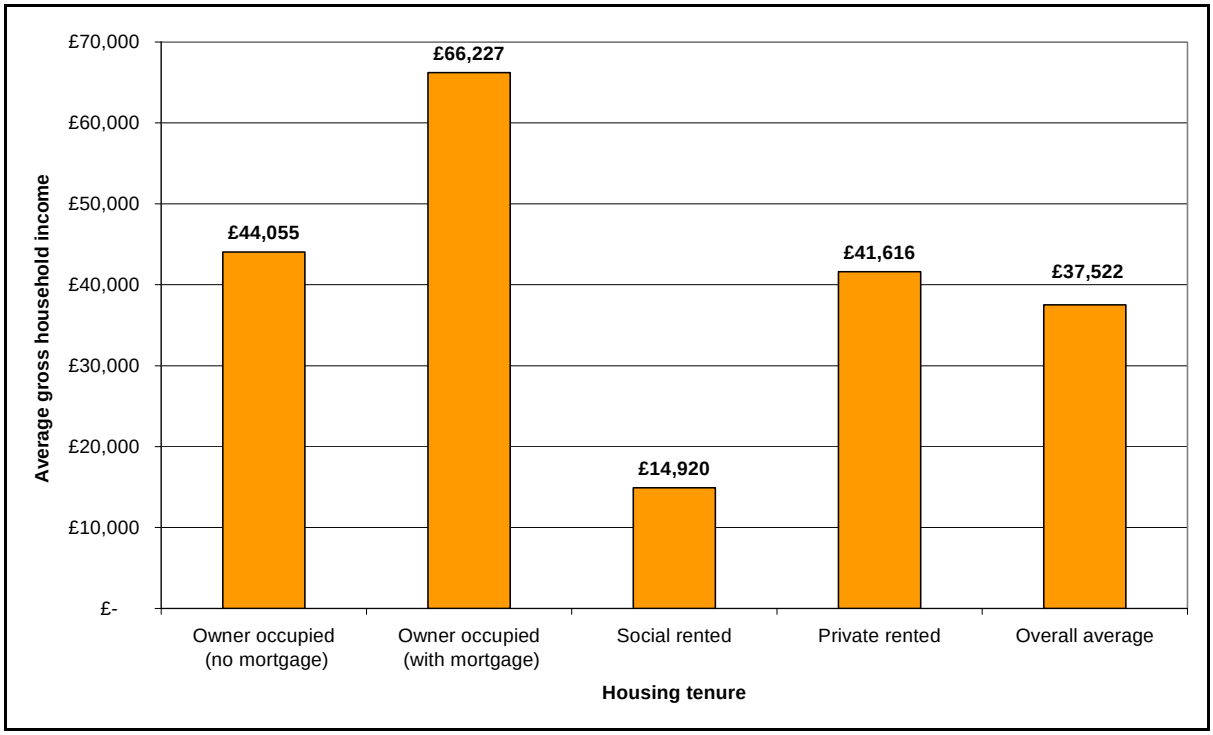
Table 4: Benefit claimants by category, May 2009

Category of benefit claimant	Camden claimants	Camden %	London %
Job Seekers Allowance	5,240	22.6%	26.3%
Employment Support Allowance and incapacity benefits	11,060	47.7%	40.1%
Lone parent	3,570	15.4%	18.4%
Carer	1,150	5.0%	5.3%
Other income related benefit	1,060	4.6%	3.9%
Disabled	940	4.1%	4.6%
Bereaved	170	0.7%	1.3%

Source: NOMIS, 2009

Camden's 2008 Housing Needs Update established that household incomes among those in social housing are, on average, much lower, than other types of tenures.

Figure 17: Mean gross household income by housing tenure



Source: Camden Housing Needs Update, 2008

Education

Education is viewed by many as a resource that, apart from providing qualifications, can potentially have a much broader beneficial impact on health and well-being in terms of developing values, emotional intelligence, self esteem and social functioning skills. A good education is therefore one of the important foundations in life; facilitating future employment and providing access to a fulfilling adult life. Education is recognised as a determinant of health and is recognised as having an important role in shaping lifelong health.

Camden residents are highly qualified, being in the top ten local authorities with people qualified to degree level or above (48%), compared to 35% in London and 27%

nationally, according to the ONS Annual Population Survey Jan-Dec 2006. However, 15% of working-aged residents are without any qualifications at all.

Primary and secondary school education

There is a complex pattern of attainment for different groups of children and young people in Camden. Camden's Children's Trust Partnership Board has made a commitment to narrow the gap in educational achievement for vulnerable children whilst raising standards for all as set out in the Children and Young People's Plan (CYP) 2009-12. Camden's CYP profile describes educational attainment for all children in Camden schools. Tables 5 and 6 show performance of Camden school children at key academic stages.

Table 5: Key stage 1 – 3 results 2008

	Percentage of pupils attaining level 2+ at Key Stage 1			Percentage of pupils attaining level 4+ at Key Stage 2			Percentage of pupils attaining level 5+ at Key Stage 3		
	Reading	**Writing**	**Maths**	**English**	**Maths**	**Science**	**English**	**Maths**	**Science**
Camden	77	76	86	83	80	89	77	74	69
London	83	78	89	80	78	86	N/A	N/A	N/A
England	84	80	90	81	78	88	73	77	71

Source: London Borough of Camden (LBC), Children Schools and Families, 2008

Table 6: GCSE Key stage 4 results, 2004 and 2008

	5 or more A* to G GCSEs or equivalent examinations including Maths and English		5 or more A* to C GCSEs or equivalent examinations including Maths and English	
	2004	**2008**	**2004**	**2008**
Camden	87	92	43	46
London	88	92	Not available	51
England	87	87	43	48

Source: London Borough of Camden (LBC), Children Schools and Families, 2008

However there is a complex pattern of attainment for different groups of children. The Children and Young People plan has highlighted key groups that achieve at a lower level than other groups in Camden. These are:

- Pupils entitled to free school meals achieve at a lower level than other groups in Camden at GCSE.
- Boys achieve at a lower level than girls at all of the key stages and the gap does not appear to be reducing.
- Pupils with Special Education Needs (SEN) achieve at a lower level than those without special needs, although the gap has narrowed.
- Outcomes for some ethnic groups remain below the borough average, although there is evidence of narrowing the gap in some areas.
- Persistent absence is higher for some groups including boys, those entitled to free school meals, those on the SEN register, White British pupils eligible for free school meals and known travellers.

Not in education, employment or training (NEET)

Being NEET between the ages of 16-18 is a key risk to young people not gaining the skills and experience they need to maximise their future economic wellbeing. The proportion of 16-18 year olds in Camden who are NEET has been decreasing over recent years and there has been a decrease of 2.4% over three years compared to a 2.1% reduction in London and 1.5% in England.

In 2007 6.5% of 16-18 year olds were NEET compared to 6.4% in London and 9.4% in England.

However there are disparities in the proportion of young people who are NEET by key vulnerable groups: young people from a mixed race background are overrepresented in the NEET group, a slightly higher proportion of young people with Learning Difficulties/ Disability in Camden are NEET compared to England and London, and a similar picture can be seen for teenage mothers.

Housing

Housing is a basic requirement for everyone. Homes that are warm, free from damp and have adequate space for the numbers occupying them are important for health and well-being. The quality of housing is especially crucial for the young and old who can be particularly vulnerable. For example, children living in temporary accommodation have been found to be at increased risk of behavioural problems, stress, infections, and poor sleep.

Housing tenure in Camden

According to 2001 Census there are 91,603 households in Camden. Camden has lower levels of owner occupation and larger social housing and private rented sectors than in London or England. 65.1% of households in Camden rent their homes; more than double the equivalent figure of 31.1% of households in England and Wales.

Table 7: Housing tenure in Camden

Housing tenure	Camden households	Camden %	London %
Renting from council	23,784	26.0%	13.2%
Renting from a Registered Social Landlord (RSL) /Housing association (HA)	10,457	11.4%	9.1%
Private renting	21,489	23.5%	14.3%
Owner occupied	31,967	34.9%	56.5%
Other	3,906	4.3%	2.9%
Total	**91,603**	**100%**	**100%**

Source: Census 2001

46% of Camden households consist of just one person living alone, the fourth highest proportion in England. A third of those living alone are pensioners. Projections made by the GLA indicates that the increasing trend in single person households will continue, so that single person households will account for 48.9% of households by 2016. They anticipate that the proportion of lone parent households will also increase, though by much less, while a corresponding decrease occurs among couple households, some of whom have children, and other multi-person households.

Who lives in council housing?

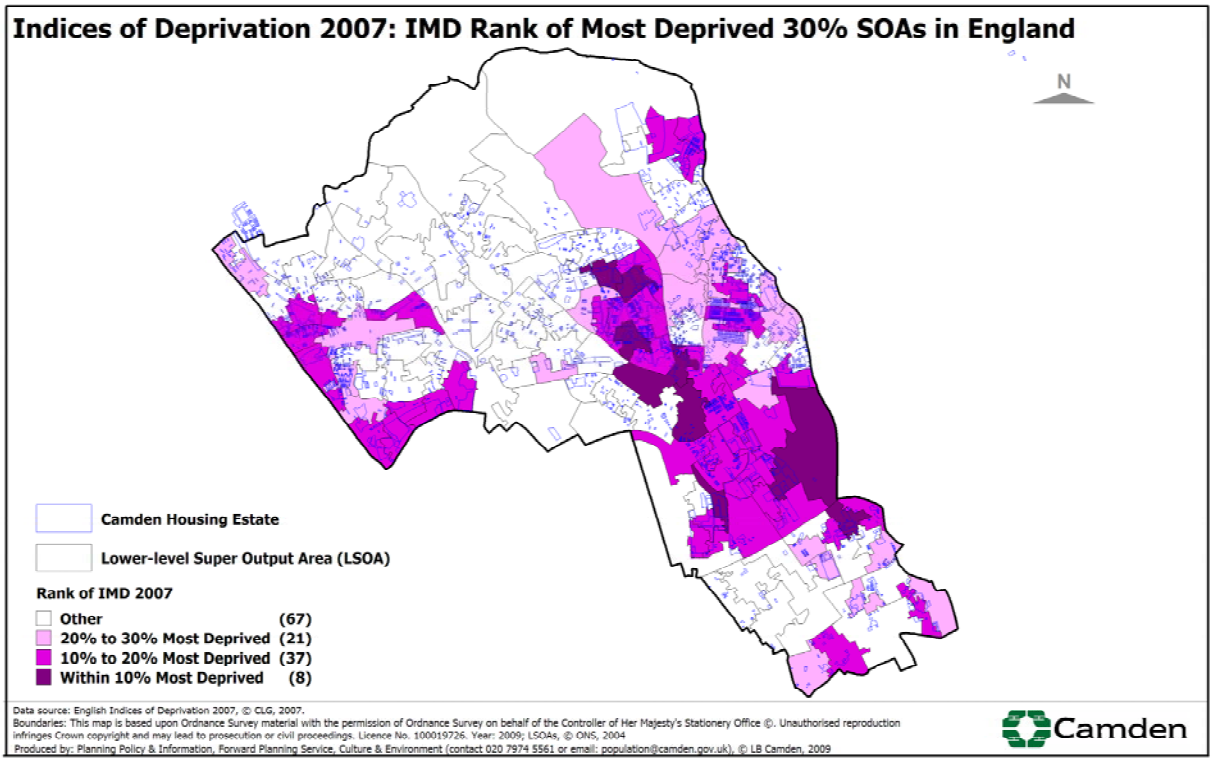
People in council housing have either qualified by being homeless and in 'priority need' or have been on the housing register and been in sufficient 'housing need'[16].

Households in council housing include higher numbers of lone parents, more female-"headed" households, more people from black and minority ethnic groups, more under 16s and over 64s, and more retired people than all households in Camden.

The 2001 Census found significantly higher levels of unemployment and long-term sickness or disability among social housing tenants than among owner occupiers and those renting privately.

Many of the most deprived areas of Camden, as measured by the Index of Multiple Deprivation, are those where social housing is concentrated. Figure 18 shows the locations of housing estates in Camden, superimposed over a map of deprivation. It shows the areas with the highest concentration of housing estates tend to be the more deprived areas of Camden.

Figure18: Deprivation in Camden and housing estates



Housing quality

Decent homes are important for the health and well-being of those living in them. In order to meet central government's Decent Homes Standard, a home must:

- Be free from any of the hazards categorised as most serious under the Housing Health and Safety Rating System
- Be in a reasonable state of repair
- Have reasonable modern facilities and services
- Provide a reasonable degree of thermal comfort

Some of Camden's homes are hazardous and significant numbers do not meet the Decent Homes Standard.[17]

Many of Camden's homes are old. Almost two thirds of owner occupied, privately rented and Housing Association properties were built before 1919 and only just over a sixth were built after 1964. Older homes are generally harder to maintain in a good state of repair and to keep warm. The age of homes in Camden is a significant factor in the failure of relatively high numbers of properties in all tenures to meet the Decent Homes standard set out by the Department for Communities and Local Government (CLG); and in falling short of statutory standards used to assess the fitness of homes.

A 2004 survey of 1,000 owner occupied, privately rented and Housing Association properties found:

- 25.6% of homes in these sectors failed to meet the Decent Homes standard (less than the national figure of 32%)[18]
- 9.3% of homes fell short of the fitness standard then used to assess a home's suitability for habitation (more than double 4.2% of homes nationally).[19]

Whilst a lower proportion of homes are in poor condition than is the case nationally, where poor housing conditions occur they are more likely to be severe.

A larger proportion of Council homes fell short of the Decent Homes standard: 42% at the end of 2008/09[20]. However, only 0.4% fell short of the statutory minimum standard. This indicates that poor conditions are more widespread in Council homes than in homes of other tenures, but it is far less common for Council homes to fall short of minimum statutory standards. Table 8 below shows the number of houses not meeting each of the criteria for being a decent home – it is possible for a house to fail to meet more than one of these.

Table 8: Non-decent council homes at 31 March 2009

Criteria for being a decent home	Number
Dwellings not meeting the statutory minimum standard	94
Dwellings not in a reasonable state of repair	8,190
Dwellings without reasonably modern amenities and services	4,173
Dwellings without a reasonable degree of thermal comfort	2,812
Total number of non-decent homes	**10,222**

Source: Housing Revenue Account Business Plan, Statistical Appendix Annual Monitoring, 2008/09

Overcrowding

The 2001 Census found that 30% of Camden's households were overcrowded, compared to 17% of households in London and 6% of households in England and Wales. The 2001 Census definition of overcrowding assumes that any household, including a single person household, requires two rooms in addition to bathrooms and bedrooms, which may regarding as a very generous benchmark.

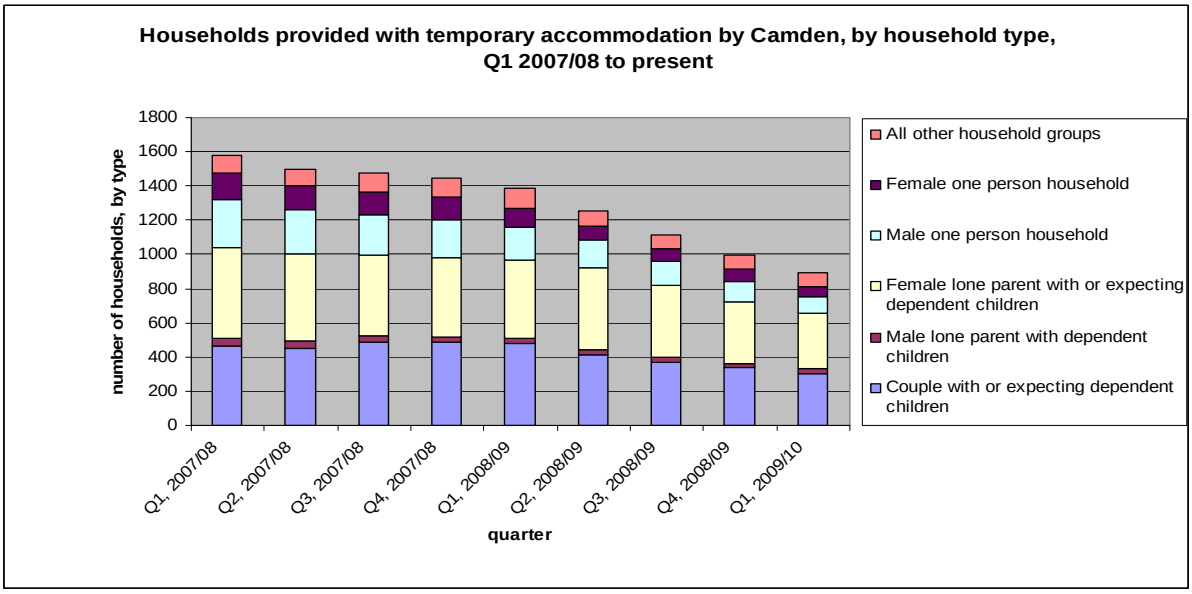
However, other measures and sources of data also indicate that overcrowding is a significant problem in Camden. Among households on Camden's Housing Needs Register (HNR), overcrowding (defined more strictly than in the 2001 Census) is the commonest cause of housing need. In March 2010, 3,865 households, almost 20% of those on the HNR, were overcrowded according to Camden's definition of overcrowding[21]. Similarly, the 2008 Housing Needs Survey Update, which adopts a more generous definition of overcrowding than the HNR, assessed that there were 5,549 household living in overcrowded conditions.

Temporary accommodation

Between March 2005 and June 2009, the number of households in temporary accommodation in London decreased by 8.7%. By contrast, as shown on Figure 19 below, the number of households in temporary accommodation in Camden has fallen by almost 53.6% in this period.

Having reduced the number of households in temporary accommodation at a rate far in advance of the London-wide trend, Camden met the Government's 2010 target for local authorities to halve the number of homeless households provided with temporary accommodation by April 2009. However, 967 households remained in temporary accommodation on that date. Figure 19 shows that the majority of households in temporary accommodation contained dependent children, frequently with just one parent.

Figure 19: Composition of households in temporary accommodation



Source: Camden draft housing strategy evidence base, June 2009

The Homeless Households Support Service (HHSS) monitors the percentage of members of households in temporary accommodation who are registered with health services. In 2007/08, 85.6% of household members were registered with a GP, rising to 87.2% in 2008/09[22]. At the end of the third quarter of 2009/10, 93% of children in temporary accommodation were registered with a GP and dentist[23]

Community safety

Crime can affect health in a number of ways. The most obvious impact is on the physical and mental health of victims, their friends and relatives. However, crime can also impact on the health of those who are not direct victims of it. This can come in the form of stress and fear of living in high crime areas and the health problems generated by coping mechanisms such as excessive drinking, smoking and self imposed isolation, such as not going out alone after dark. If people believe the locality to be a 'problem area' this can also result in low aspirations.

Camden experiences the crime that affects many inner-city areas. It is in the top four of London local authorities for offences per 1,000 residents. 2007/08 data shows that there were 81 recorded offences per 1,000 population, compared to 65 in London and 54 in England and Wales.

However recorded crime has been falling. Camden has seen the greatest reduction in Total Notifiable Offences (TNOs) and Serious Acquisitive Crime (SAC) between 2006/07 and 2008/09 compared to all London Boroughs. There was an 18% reduction in TNOs between 2006/07 and 2008/09 compared to 7% in London. SAC, which is made up of four offence types, robbery, residential burglary, theft of motor vehicles and theft from motor vehicles, has fallen 35% between 2006/07 and 2008/09 compared to 14% in London.

Violent crime

Violent crime and the impact it has on individuals and communities is a concern of Camden residents.

Violence against the person (VAP) is a complicated issue made up of a number of strands contributing on average 6,150 offences per year, around 15% of Camden's total level of reported crime, 37% of which resulted in an injury, with 6% defined as serious.

The volume of recorded violent crimes continues to fall in Camden, as it does throughout London. There was a 3.3% reduction in Camden and a 0.3% reduction in London between September 2008 and September 2009. From April 2009 to December 2009, a 28% reduction in Most Serious Violence was recorded for Camden when comparing figures from the same period of time in the previous year.

Latest crime figures

Table 9 shows the latest recorded crime figures from the metropolitan police and the percentage increase/decrease in recorded crime between the two years for selected offences. Camden is in the top 10 of London local authorities for offences per 1,000 residents.

Table 9: Crime figures for London Borough of Camden

Offence	12 months to Oct 09		12 months to Oct 08	
	Camden	Met	Camden	Met
Homicide	1	128	2	155
Violence Against the Person	5,771	174,086	5,975	173,787
Rape	50	2,498	37	2,108
Other Sexual	196	6,747	179	6,789
Robbery (Total)	1,039	32,954	998	33,750
Robbery (Person)	*951*	*29,589*	*911*	*30,052*
Robbery (Business)	*88*	*3,365*	*87*	*3,248*
Burglary (Total)	3,410	96,666	3,618	92,113
Burglary (Residential)	*1,800*	*62,398*	*2,061*	*58,511*
Burglary (Non-Residential)	*1,610*	*34,268*	*1,557*	*33,602*
Gun Enabled Crime	85	3,315	32	1,731
Motor Vehicle Crime	3,200	101,840	3,805	113,740
Domestic Crime	966	53,503	1,060	52,119
Racist Crime	407	9,811	336	9,193
Homophobic Crime	83	1,267	68	1,037
Total Crimes	**33,959**	**837,839**	**33,984**	**851,988**

Source: Metropolitan Police, latest crime figures, year ending October 2009 **Metropolitan Police Crime Figures**

Offenders

Health and mental health has been identified as one of the pathways to reducing re-offending. Many prisoners suffer from mental and physical health problems. Untreated, such problems can deteriorate and can be made worse by imprisonment. In the community offenders are also disproportionately without GPs and access to psychiatric or psychological services. Mental health can also undermine the chances of successful rehabilitation. Without support, the likelihood of an offender going on to offend again is high.

Alcohol and drugs

Alcohol and illegal drugs are key factors in antisocial behaviour and crime, which undermines the quality of life of residents. A recent survey (British Best Value Performance Indicator Survey 2006/7) showed that 40% of Camden residents perceive that people being drunk or rowdy is a problem in their area. The same survey found that 55% of residents felt drug use or dealing was a problem. Being effective in tackling crime and antisocial behaviour and its causes requires understanding the drivers of crime – drugs, alcohol abuse and poor environmental design.

Camden has higher expected prevalence of binge drinking, hazardous drinking and harmful drinking than both London and England. There are strong links between alcohol and violent crime and with the borough's night time economy in Camden Town and the areas bordering Covent Garden, Holborn and the north end of Tottenham Court Road with peaks in the early hours of the weekend. Alcohol related crime is also higher in Camden (9.58 per 1,000) compared to London (8.56) and England (6.09).

Rates of alcohol related admissions in Camden are significantly higher in Camden compared to London and England, as are alcohol specific admissions for men and women, as well as alcohol specific mortality amongst men (see also 'healthy lifestyles, alcohol')

Domestic violence

Four out of every five victims of domestic violence are female and 58% of these are classified as 'white'. Afro-Caribbean female victims are over represented when compared to the demographic profile of Camden[24]**.** Over the past three years, 16% of all violent offences in Camden were flagged as being domestic violence and alcohol can be linked to 44% of domestic violence offences.

Living environment

Open spaces

Green spaces contribute immeasurably to the quality of life for people living, working and visiting Camden. The largest amount of publically available space is in Highgate and Hampstead because of Hampstead Heath, followed by Regent's Park and Primrose Hill. Somers Town has the least amount of public open space. Overall, Camden currently has 19 square metres (sqm) of park provision per person. In comparison to some other inner London boroughs, Camden fairs better than Hackney which has only 15 sqm of park provision per person but has less than Wandsworth, which is particularly well served by large public parks, and has 24 sqm per person.

As the population increases over the next five and ten years, Camden will see the level of public open space provision fall to 17 sqm per person and the level of parks provision fall to 15 sqm per person, if no new open spaces are established.

Air quality

Poor air quality causes many early deaths, hospital admissions and loss of healthy days of life. In London, road traffic contributes 60% of air pollutants, and Camden as a borough has been designated an Air Quality Management Area due to the fact that two pollutants are likely to exceed the Government's air quality objectives, nitrogen oxides (NOx) and fine particulate matter (PM_{10}) emissions. Road transport has been identified as the main source of these pollutants.

Social, economic and environmental factors: key evidence based recommendations

The Marmot Review 'Fair Societies, Healthy Lives' points out that the most important determinants of health and health inequalities are the wider, 'upstream' determinants, including housing, education, transport and employment which offer real opportunities to improve health and reduce the health gap.

The Camden Local Strategic Partnership (LSP) aims to bring together the public, private, voluntary and community sectors to work together to improve the quality of life for all who live in, work in and visit Camden. In partnership, LSP members have set a shared strategic vision to shape Camden's future. This is set out in the Sustainable Community Strategy. The partnerships need to continue to recognise the links between health and wellbeing in all strategic plans.

Issue	**Recommendations based on evidence**
General	• Integrate planning, transport, housing, environmental and health systems to address social/wider determinants of health • Prioritise investment in ill health prevention and health promotion[25]
Economic prosperity income and employment	• Improve access to and promote good quality jobs • Reduce long term unemployment • Improve quality of jobs (decent pay, flexibility, security) • Promote well-being and physical and mental health at work.[26] • Develop an organisation-wide plan and introduce and monitor an organisation-wide, multi-component programme to encourage and support employees to be more physically active. (This could be part of a broader programme to improve health.) • Encourage employees to walk, cycle or use another mode of transport involving physical activity to travel part or all of the way to and from work (for example, by developing a travel plan). • Help employees to be physically active during the working day, for example, by encouraging them to take the stairs or walk to external meetings[27]
Education	• Support families to achieve progressive improvements in early child development • Provide good quality early years education and child care • Reduce inequalities in life skills • Reduce inequalities in educational outcome • Increase access and use of lifelong learning and work based learning and apprenticeships.[28]
Housing	• Improve energy efficiency of housing • Reduce overcrowding and numbers of people living in temporary accommodation • Reduce homelessness[29]
Community safety	• Reduce crime and the fear of crime • Promote social cohesion [30]
Living environment	• Ensure planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically

	active as a routine part of their daily life. • Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads. • Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity. • Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity. [31] • Prioritise policies and interventions that reduce both health inequalities and mitigate climate change (active travel, good quality open spaces, improving food environment) • Removing barriers to community participation • Reducing social isolation.[32]

4. Health in Camden

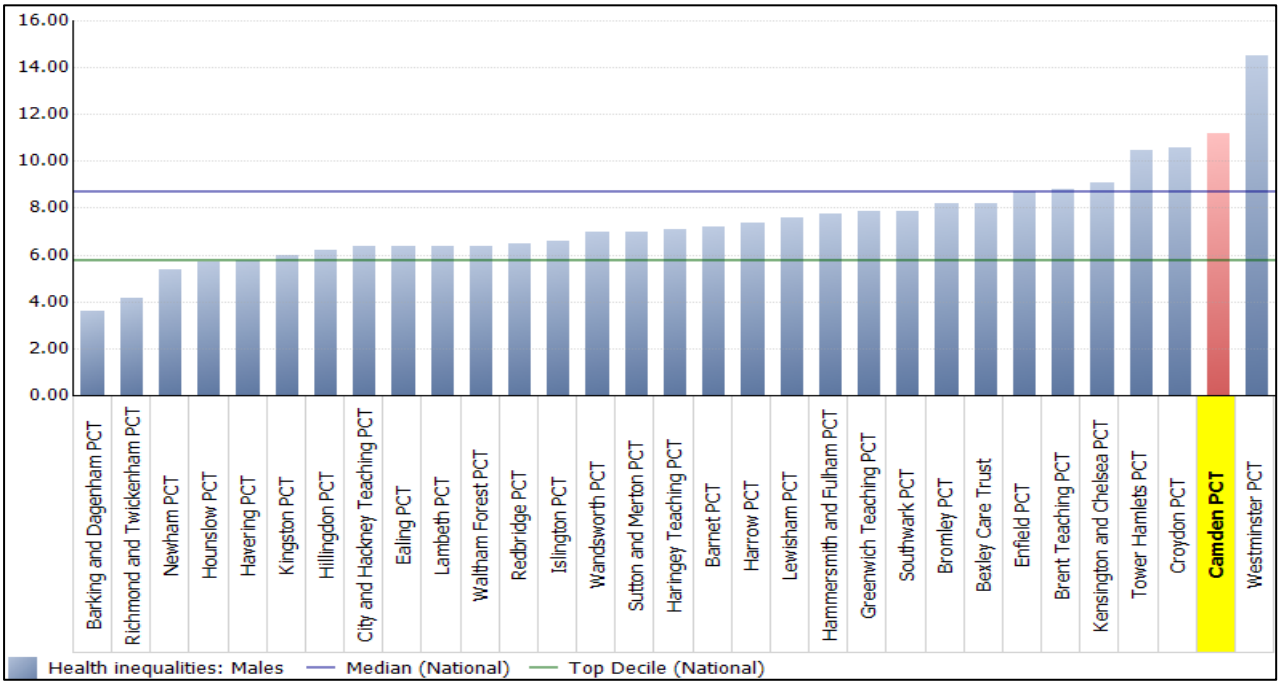
Life expectancy

Life expectancy is a general marker of good health. Overall, the life expectancy for men and women in Camden has improved at a faster rate over the past ten years than nationally. Latest figures (2006-08) show that life expectancy for Camden is not significantly different from England for men (77.8 vs. 77.8) and for women has exceeded the national average (82.6 vs. 82.0).

Although outcomes in terms of life expectancy are generally improving for most people in Camden, they are not improving fast enough for the poorest sections of the borough. For example, male life expectancy of those living in the 10% most deprived area of Camden is 71.5 years, whilst for those living in the 10% most affluent areas it is 80.9 years. These inequalities exist for both men and women but are more profound for men, with Camden having the second highest life expectancy inequality gap in London (figure 20).

Reducing health inequality amongst men in terms of life expectancy requires focus on reducing deaths from coronary heart disease (CHD), lung cancer and liver disease in the most deprived areas of Camden. For women, CHD, chronic obstructive pulmonary disease (COPD) and lung cancer need to be the focus.

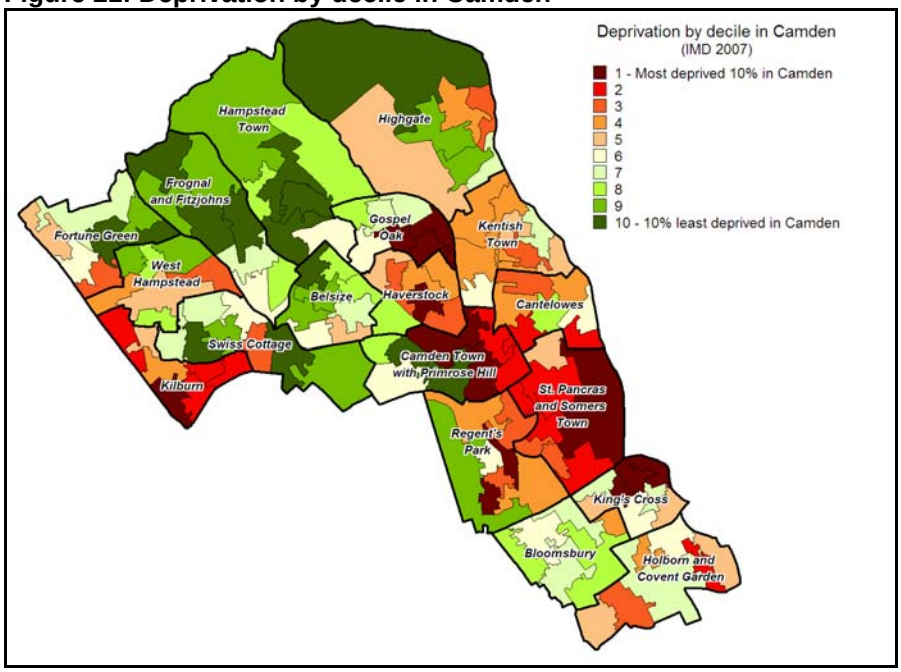
Figure 20: Slope of inequalities index – Male Life Expectancy



Source: Published by NHS Information Centre, www.ic.nhs.uk, produced by www.Apho.org.uk

Figure 21 shows the areas in Camden fitting in to each decile of deprivation. The 10% most deprived areas in Camden are mostly found in Gospel Oak, St Pancras and Somers Town and Kilburn wards.

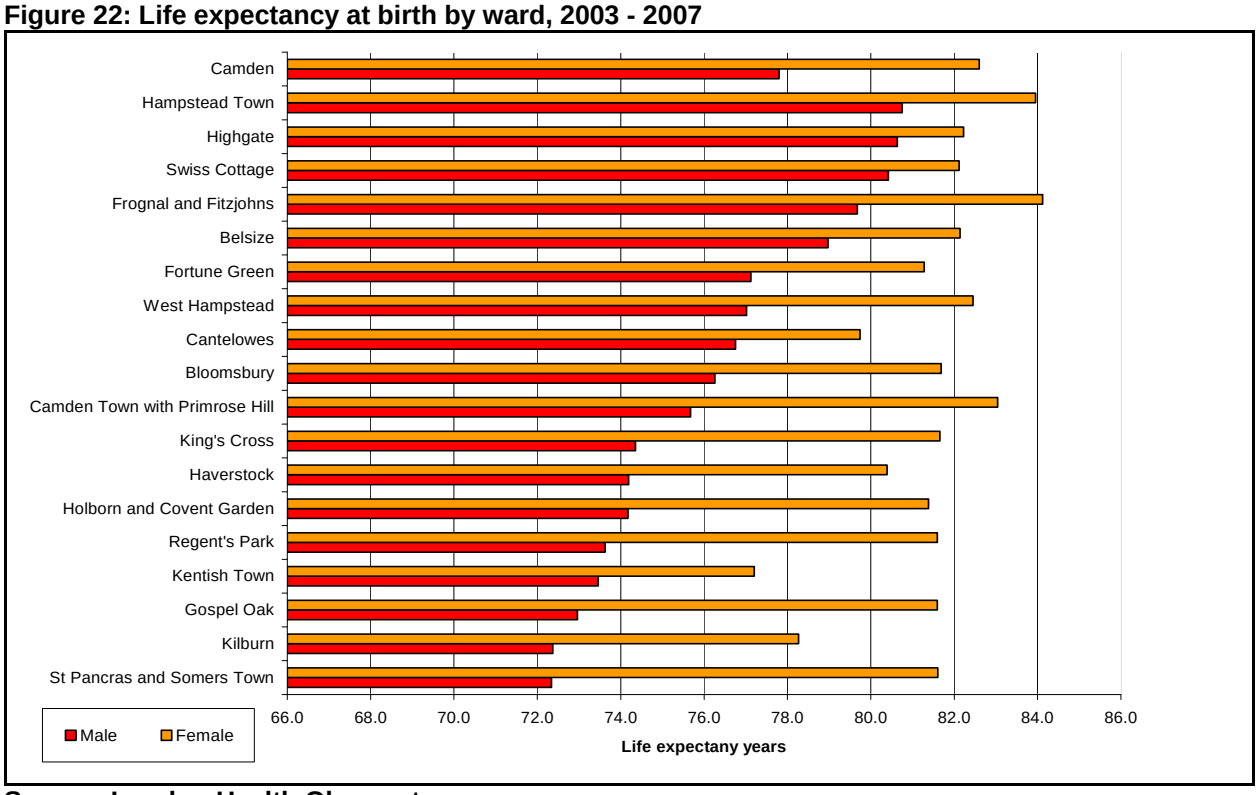
Figure 21: Deprivation by decile in Camden



Source: Department of Communities and Local Government, Indices of Multiple Deprivation (IMD), 2007

Figure 22 shows life expectancy for men and women by ward. There is an eight year difference in life expectancy for men by ward. St Pancras and Somers town, Kilburn, Gospel Oak and Kentish Town are the four wards with the lowest life expectancy for men.

Figure 22: Life expectancy at birth by ward, 2003 - 2007

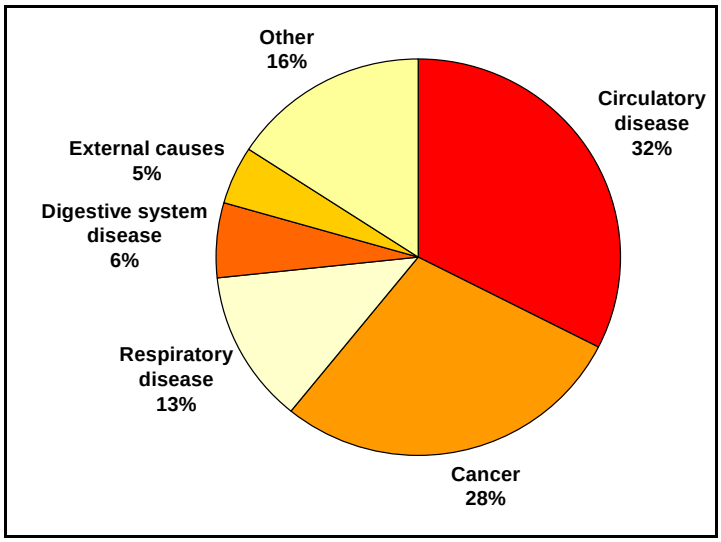


Source: London Health Observatory

Leading causes of mortality

There are on average 1,260 deaths a year in Camden. Figure 23 shows the leading causes of mortality for Camden residents for all ages are circulatory disease (400 deaths a year), cancer (340 deaths a year) and respiratory disease (60 deaths a year). These causes are also the top three for people aged 75 and under and those aged 65 and over.

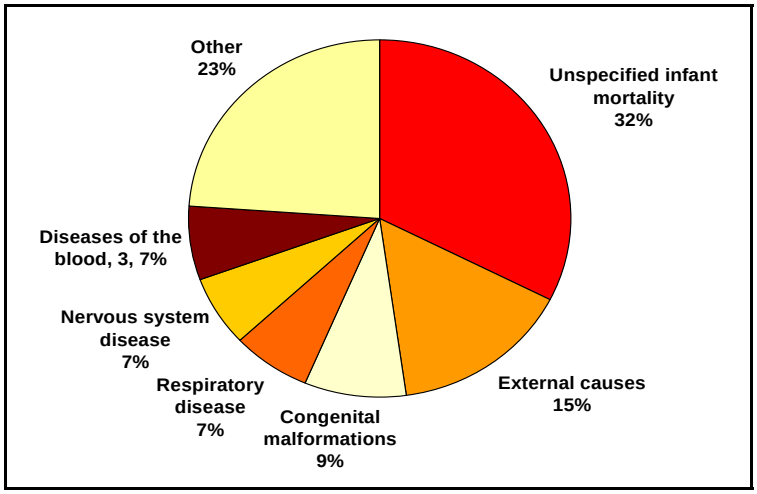
Figure 23: Leading causes of mortality, all ages, 2006-08



Source: Office for National Statistics (ONS), Public Health Mortality File, 2006-08

During the three year period 2006-08 there were just over 40 deaths for those aged 0-19. The majority of these were due to unspecified infant mortality and external causes, as shown in figure 24.

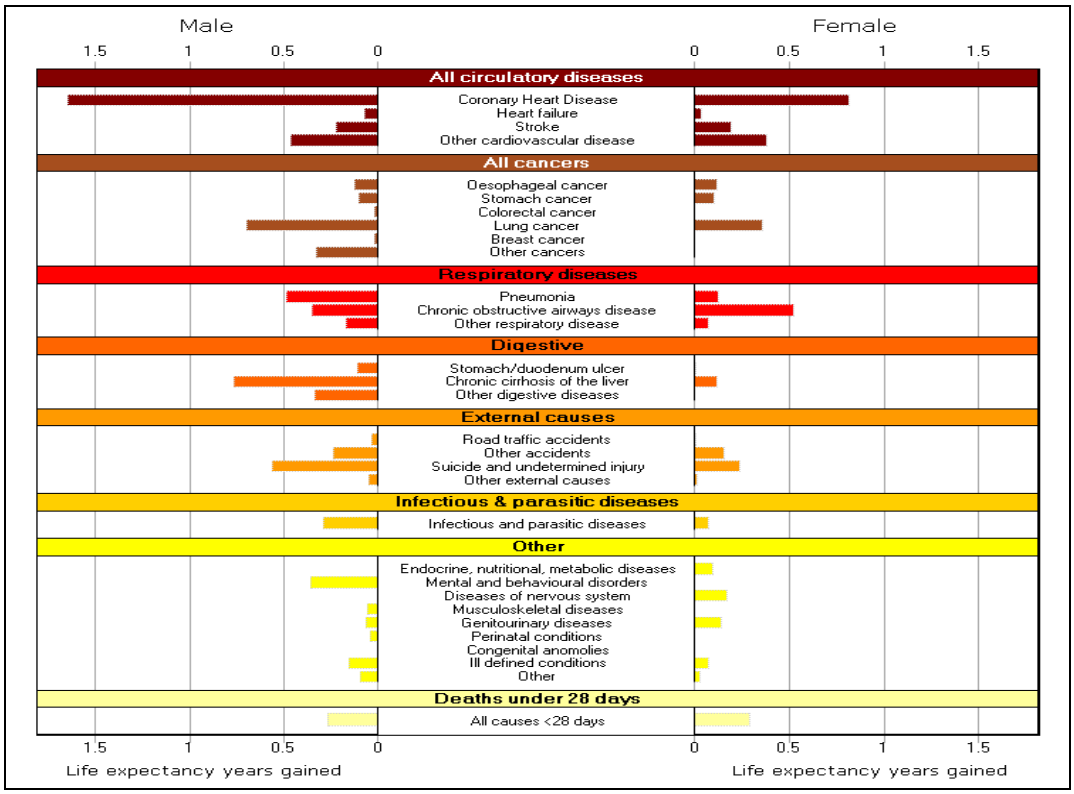
Figure 24: Leading causes of mortality, ages 0-19, 2006- 08



Source: Office for National Statistics (ONS), Public Health Mortality File, 2006-08

Figure 25 below shows that for reducing health inequality amongst men in terms of life expectancy, addressing deaths from coronary heart disease (CHD), lung cancer and liver disease in the most deprived areas of Camden will have the biggest gain. For women, CHD, chronic obstructive pulmonary disease (COPD) and lung cancer should be addressed.

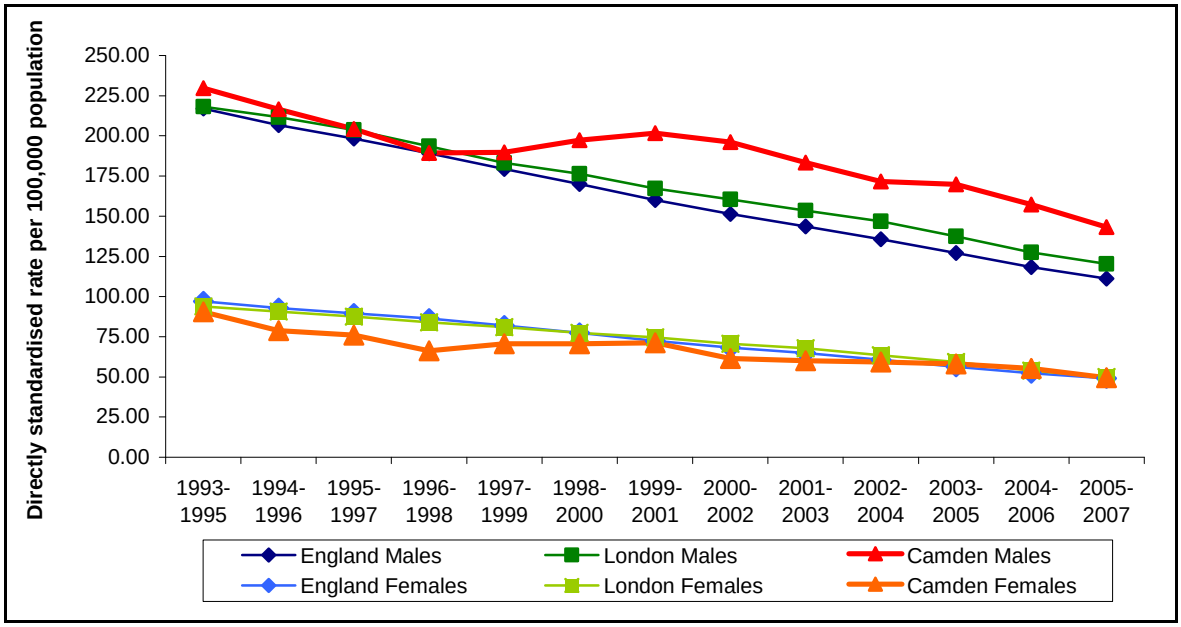
Figure 25: Life expectancy gained if the Most Deprived Quintile (MDQ) of Camden LB had the same mortality rate as the least deprived quintile in the local authority for each cause of death



Source: London Health Observatory – Health Inequalities Intervention Tool 2008, based on 2001-05 data

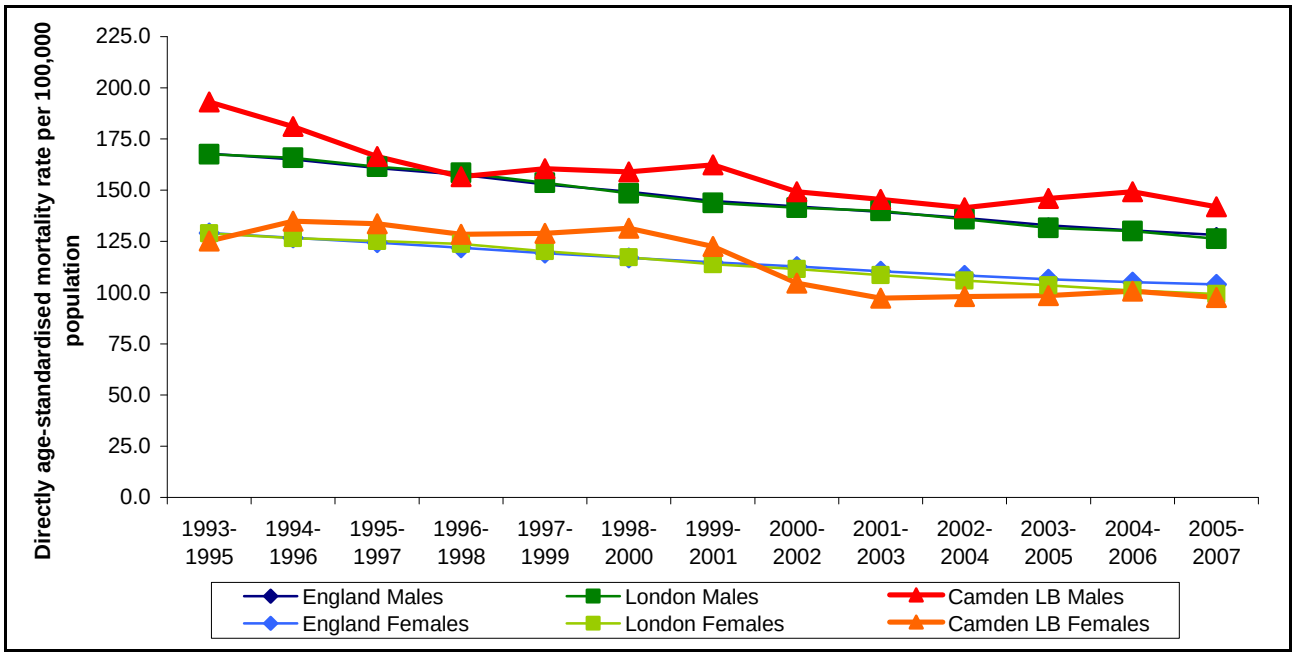
Figure 26, 27 and 28 show that deaths from the top three killers in Camden are declining., Although between 2003-7 deaths from respiratory disease have increased. Mortality for all three conditions is higher in men. For women mortality rates from these conditions are not significantly different from England and London.

Figure 26: Premature mortality from Cardiovascular disease



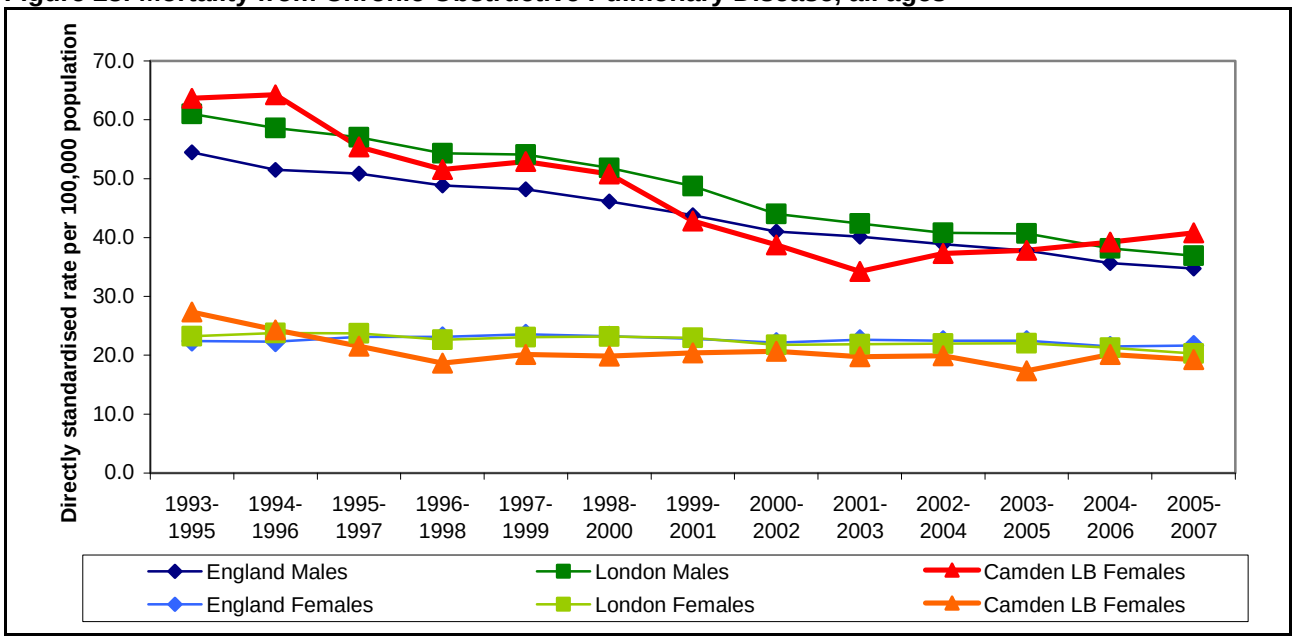
Source: Office for National Statistics (ONS) published by National Compendium of Health Outcomes (www.nchod.nhs.uk)

Figure 27: Premature mortality from Cancer



Source: Source: Office for National Statistics (ONS) published by National Compendium of Health Outcomes (www.nchod.nhs.uk)

Figure 28: Mortality from Chronic Obstructive Pulmonary Disease, all ages



Source: Source: Office for National Statistics (ONS) published by National Compendium of Health Outcomes (www.nchod.nhs.uk)

Table 10 shows that compared to the boroughs most similar to Camden, as identified by the Office for National Statistics, Camden has the fourth highest mortality rate for both cancer and cardiovascular disease and the third lowest for COPD mortality rate.

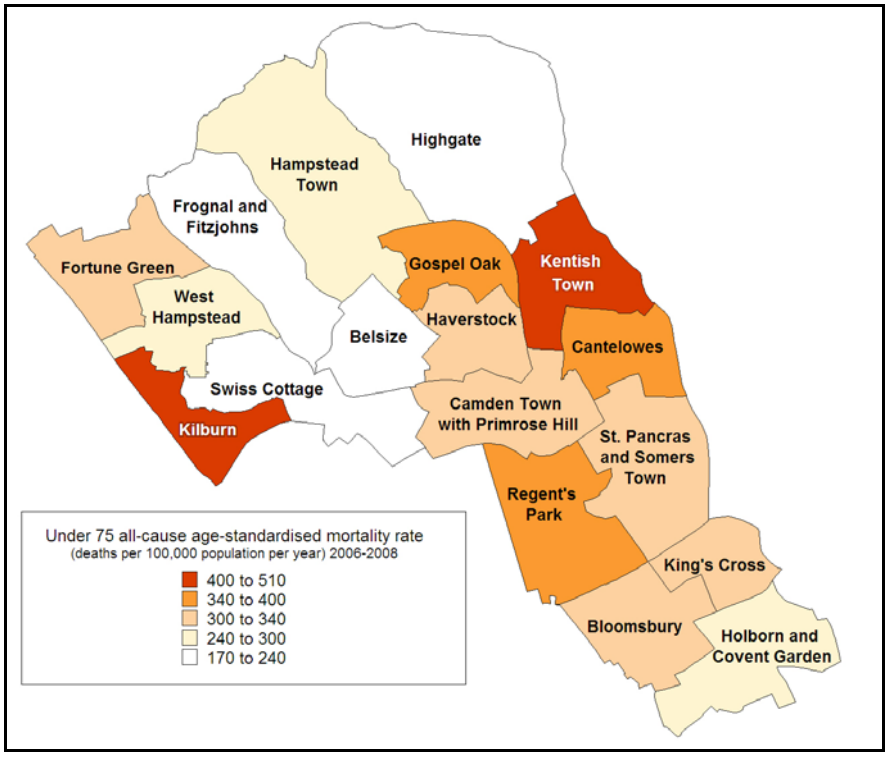
Table 10: Directly standardised mortality rate for selected conditions, persons, 2005-07

	Premature mortality from Cardiovascular disease	Premature mortality from respiratory disease	Premature mortality from Cancer
Kensington and Chelsea	51.04	18.69	75.74
Westminster	69.68	21.38	89.62
Hammersmith & Fulham	91.83	31.48	111.07
Camden	93.66	29.08	117.96
Wandsworth	98.09	29.66	122.63
Islington	119.81	32.84	133.96
Tower Hamlets	119.91	51.02	141.74

Source: Source: Office for National Statistics (ONS) published by National Compendium of Health Outcomes (www.nchod.nhs.uk)

An analysis of premature mortality from all causes by ward shows that Kilburn and Kentish Town are the two wards with the highest mortality rates, followed by Gospel oak, Regents Park and Cantelowes.

Figure 29: Premature all-cause mortality rates by ward, 2006-2008



Source: Office for National Statistics (ONS) Public Health Mortality Files, 2006-08

Reducing health inequality amongst men in terms of life expectancy requires focus on reducing deaths from coronary heart disease (CHD), lung cancer and liver disease in the most deprived areas of Camden. For women, CHD, chronic obstructive pulmonary disease (COPD) and lung cancer need to be the focus.

Long term conditions

The World Health Organisation (WHO) defines long term conditions (also called chronic conditions) as health problems that require ongoing management over a period of years or decades. This includes a wide range of health conditions including non-communicable diseases (e.g. cancer and cardiovascular disease), communicable diseases (e.g. HIV/AIDS) and certain mental disorders (e.g. schizophrenia, depression). The major burden of disease in Camden is associated with the prevalence of long term conditions.

Data from the quality and outcomes framework (QOF) of the new General Medical Services contract is the main source for routinely recorded prevalence of selected long term conditions for patients registered with a GP in a borough. For each patient on a disease register various process and outcome clinical indicators, such as recording and control of cholesterol, blood pressure etc. need to be achieved to qualify for extra incentive payments.

Table 11 lists selected long-term conditions, the recorded crude prevalence, and expected prevalence for the financial year 2008/09. Expected prevalence is predicted using models developed by various of the Public Health Observatories or by Doncaster PCT, though the models do make certain assumptions that may cause them to overestimate expected prevalence.

As can be seen, Camden's recorded prevalence is often much less than the expected prevalence, particularly for vascular conditions, indicating that some groups may have an existing condition that has not yet been diagnosed and is not being treated.

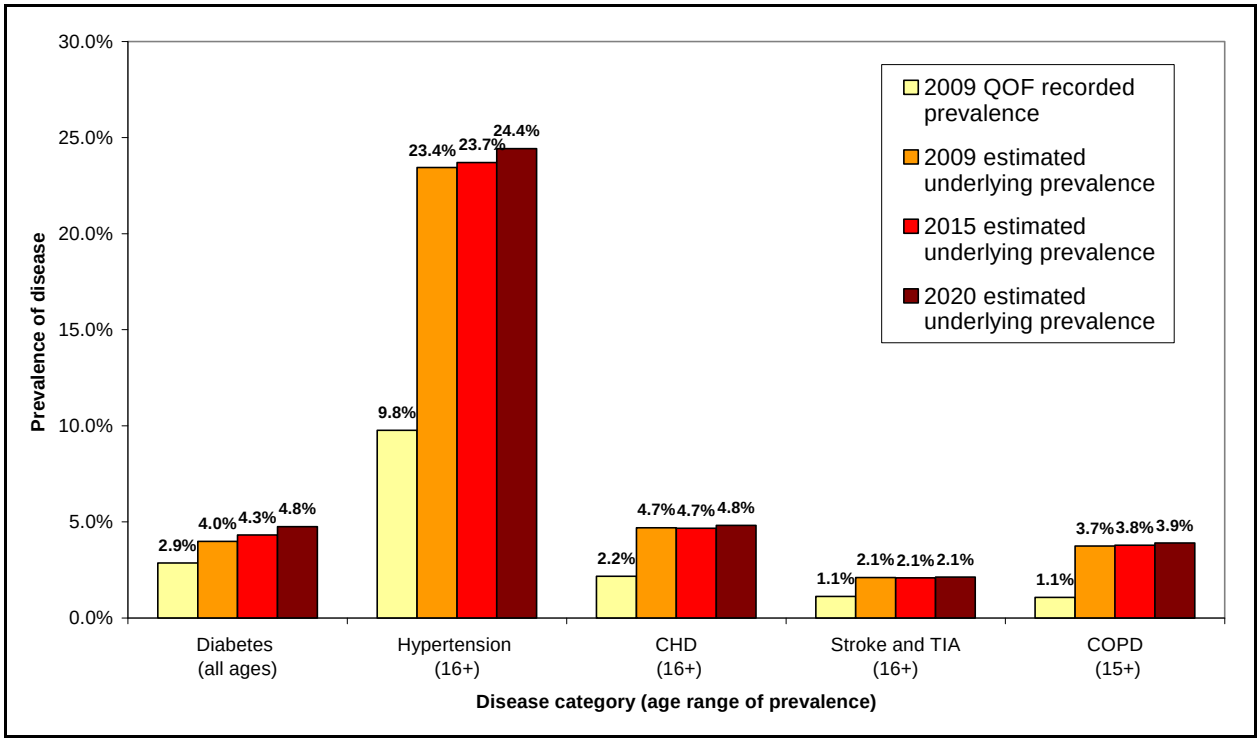
Table 11: Recorded and expected prevalence of selected conditions as of 2008/09

Disease Register	Camden Recorded Prevalence 2008/09 (numbers)	Camden Expected prevalence
CHD	1.85% (4,394)	4.80%
Heart Failure	0.51 % (1,207)	0.85%
Stroke or TIA	0.96% (2,276)	2.20%
Chronic Kidney Disease	1.58% (3,747)	2.72%
Hypertension	8.35% (19,784)	6.80%
Diabetes Mellitus	2.85% (6,765)	3.99%
COPD	0.92% (2,187)	3.90%
Cancer	0.97% (2,288)	0.66%
Severe Mental Illness	1.31%(3,107)	0.43%
Dementia	0.27% (641)	0.73%
Asthma	4.10% (9,728)	8.93%

Source: www.ic.nhs.uk/qof, local calculations of expected prevalence

Figure 30 shows the increase in prevalence of selected long term conditions given the population growth and for diabetes also includes the expected rise in obesity.

Figure 30: Estimated changes in prevalence 2009-2015-2020



Source: Eastern Region Public Health Observatory, Disease prevalence models, estimates and projections.

In the short term, the management of these conditions through controlled blood pressure and cholesterol levels (as well as controlled blood sugar levels in diabetes) will prevent premature mortality and unnecessary hospital admissions.

Table 12 shows the overall percentage of Camden's registered population that have these clinical risk factors controlled compared to London and England, and also shows the ranges of achievement by Camden practices. Although Camden's overall achievement on these indicators is similar to England and London, the variation in practice achievement suggest that parts of the registered population do not have these clinical risk factors controlled. The Quality and Outcome Framework only gives us aggregate information so we do not know the demographics of the populations which do not have control of clinical risk factors.

Table 12: QOF achievement on selected indicators 2008/09

QOF indicator	Camden	Practice range	London	England
CHD Cholesterol is 5mmol or less	77.8%	47.6% -100%	89.2%	82.1%
CHD Blood pressure control is 150/90 or less	87%	76.7%- 100%	79.8%	89.7%
Diabetes HbA1c control <7.5	67.7%	42.9%-87.6%	63.6%	66.3%
Hypertension blood pressure control 150/90	74.9%	60.8%- 87.7%	77.8%	78.6%

Source: NHS Information Centre, www.ic.nhs.uk/QOF

Mental health and well-being

Mental health is composed of two dimensions: a negative dimension (mental health problems) and a positive dimension (mental well being).

Mental wellbeing is more than the absence of mental health problems; features of mental wellbeing include high life satisfaction, mastery and a sense of control, having a purpose in life, a sense of belonging and positive relationships with others.

Mental health problems span from common conditions such as depression and anxiety to severe and enduring mental health problems such as schizophrenia, and are a major source of disability and impairment in the population. Mental and physical health is closely linked and each can affect the outcome of the other.

Recorded mental ill health prevalence

As part of the Quality Outcomes Framework all General Practices keep a register of people with severe mental health problems, depression and dementia. Table 13 below shows that Camden has a high crude prevalence of mental health compared to England and London. Camden also has a high crude prevalence of depression compared to London and England.

Table 13: Crude prevalence for Severe Mental Health Illness, Depression and Dementia, 2008/09

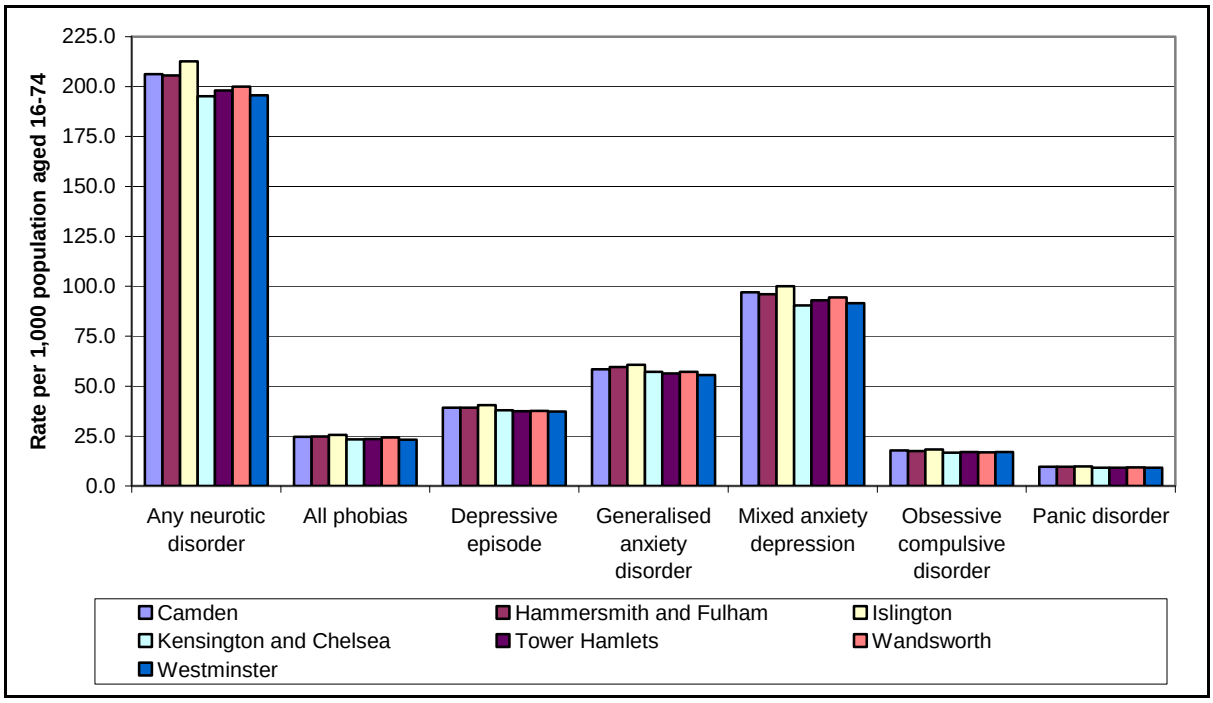
	Severe Mental Health Illness (numbers)	Depression (numbers)	Dementia (numbers)
Camden	1.4% (3,107)	7.6% (17,159)	0.3% (641)
Islington	1.4%	10.0%	0.3%
Tower Hamlets	1.1%	8%	0%
Hammersmith & Fulham	1.1%	4.5%	0.2%
Westminster	1.0%	4.3%	0.2%
Wandsworth	0.8%	6%	0%
Kensington & Chelsea	1.2%	6.9%	0.8%
London	0.9%	6%	0.3%
England	0.7%	8.1%	0.4%

Source: NHS Information Centre, www.ic.nhs.uk/QOF

Common mental health illness

Figure 31 shows the estimated prevalence of common mental health illnesses across boroughs similar to Camden, expressed as a rate per 1000 population. Camden has one of the highest estimated prevalence's for any neurotic disorder.

Figure 31: Estimated prevalence of mental health problems



Source: North East Public Health Observatory – Mental Health brief 4

Predicted mental ill health need

Table 14 shows the number of people predicted to be suffering from a mental illness over the next five and ten years. These figures are base on prevalence for mental conditions in national studies and applied to future population projections.

Table 14: Estimated projections of numbers with selected mental health problems

Mental Health Problem	2009	2015	2020
Neurotic disorder (18-64)	**30,162**	**33,997**	**36,252**
Psychotic disorder (18-64)	**1008**	**1139**	**1216**
Dementia (65+)	**1404**	**1500**	**1633**

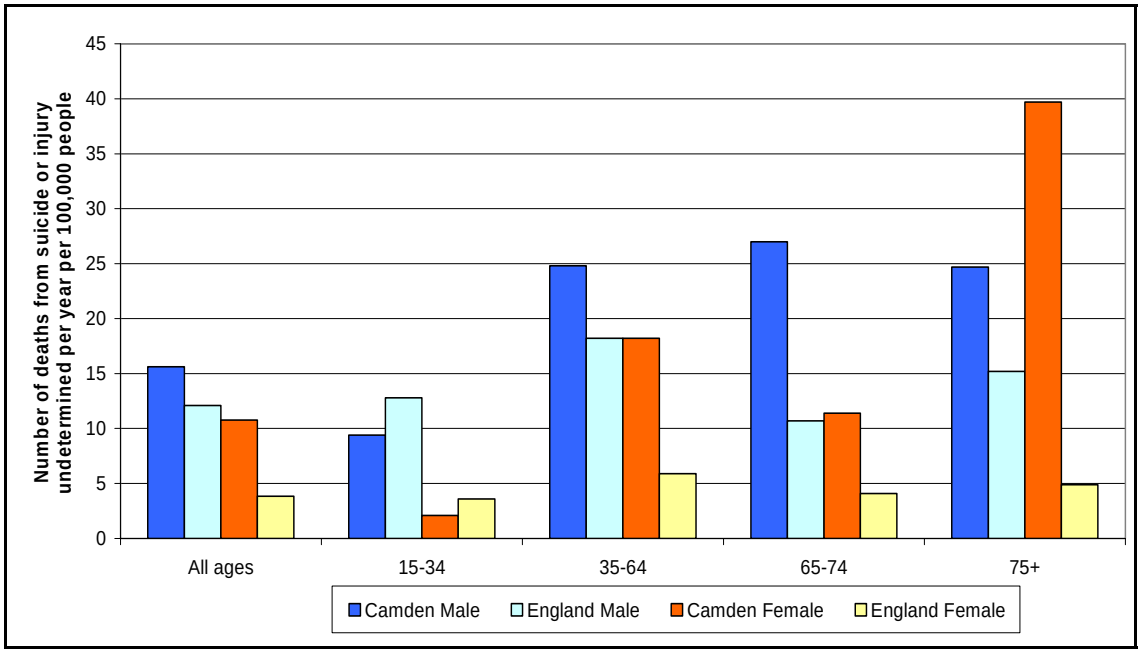
Source: POPPI and PANSI

Suicide and undetermined injury

There are approximately 25-30 deaths amongst Camden residents every year. Figure 32 shows that the suicide rates are above the national average, especially amongst women where the Camden rate is nearly three times that of England (and the highest of any borough). However, this higher rate is not seen amongst those living in Camden aged 15-34, whose rates are slightly lower than those found nationally. Whilst Camden's women have a very high rate amongst those aged 75+, it should be remembered that numbers are very small.

Camden's suicide and injury undetermined rate in 2005-07 was 13.18 deaths per 100,000 population. It is one of the highest suicide rates amongst all London boroughs and is higher than England (7.89 deaths per 100,000) and London (7.49 deaths per 100,000).

Figure 32: Suicide rates by age for Camden and England, 2005-2007



Source: **Office for National Statistics (ONS) published by National Compendium of Health Outcomes (www.nchod.nhs.uk)**

Mental illness

The Mental Index of Need (MINI2K) estimates the need for inpatient services for mental health based on socio-economic data and previous admission levels. The England figure is one so if a borough has a score of over one, for example 1.5, it means that the population in that borough have 50% more need for inpatient services than the England Average. The MINI2k score for Camden is 3.6, indicating that the Camden population is over three times more likely to need inpatient services for schizophrenia.

The London Health Observatory scorecard shows that Camden has higher inpatient admission rates for schizophrenia and delusional disorders and common mental health problems compared to London.

A review of existing evidence in 2009[33] highlighted a measure called the Local Index of Need which was initially developed from work commissioned by the King's fund to analyse expenditure on mental services in London. This measure distinguishes between areas according to the social demographic profile, which does not depend on service utilisation (such as admissions) as a proxy for need, since service utilisation may not reflect real need.

Four factors are used to generate the index and on one of the factors described as 'densely populated areas with high levels of recorded crime, a high proportion of people who are not married/co-habiting, large numbers of people living alone, large numbers of households with no car, high unemployment, relatively few school leavers with five or more GCSEs, a relatively large student population, a high level of occupational inequality, and a high rate of population turnover', Camden was the second highest scoring borough in England (after Westminster). The Local Index of Need places Camden in the group of London authorities with the highest mental health need.

Other risk factors prevalent in Camden associated with mental illness include drug and alcohol misuse. Long term illnesses are also established risk factors for depression with people with diabetes or CHD being more likely to develop depression than those without.

Children and young people and mental health

Rates of mental ill health are increasing among young people nationally. Research from the GLA's The State of London's Children report (2007) has suggested that rates are higher in inner London than in other areas (particularly for boys aged 11-15),

Based on national estimates of a prevalence of 9.6% children with any disorder (including conduct disorder, hyperkinetic disorder and emotional disorder), Camden is estimated to have approximately 2,500 5-16 year olds with a mental health disorder.

Looked after children, children on the child protection register and young offenders are more at risk of suffering from mental health problems.

Communicable disease

HIV

Camden has the highest rate of HIV amongst adults per 100,000 population in North Central London and has the third highest prevalence in London. However, it has seen the lowest percentage increase in prevalence since 2002 compared to the North Central London boroughs.

Table 14: Percentage increase in prevalence of diagnosed HIV adults (per 100,000 population)

BOROUGH	2002	2006	% INCREASE IN PREVALENCE
Barnet	145.9	191.0	30.9
Camden	605.5	713.8	17.9
Enfield	150.8	260.2	72.6
Haringey	424.0	558.9	31.8
Islington	529.4	693.2	31.0

Source: London Health Observatory, London Sexual Health Indicators: a data driven needs assessment, 2008

Late HIV diagnosis

Overall for the period 2005-06, there were 152 people in Camden identified as newly diagnosed, resident in Camden PCT and with a reported CD4 cell count. 34% (51) of newly diagnosed HIV cases for Camden residence were diagnosed late, similar to the London rate of 33%.

Table 15: Late HIV Diagnosis (CD4 <200 cells per mm) of HIV infection by PCT of residence, 2005-06

BOROUGH	CD4 COUNT <200	CD4 COUNT >=200	TOTAL	% WITH CD4 COUNT <200
Barnet	31	61	92	34
Camden	51	101	152	34
Enfield	50	80	130	38
Haringey	58	110	168	35
Islington	36	118	154	23

Source: Source: London Health Observatory, London Sexual Health Indicators: a data driven needs assessment, 2008

It should be noted that PCT of residence is not calculated for new diagnoses. These figures are based on experimental data obtained by cross-linking the new diagnosis database to the Survey of Prevalent HIV Infections Diagnosed (SOPHID).

HIV testing

The guidelines of the British Association for Sexual Health and HIV state that all patients attending a Genito-Urniary Medicine clinic should be offered a HIV test irrespective of risk factors or symptoms. The National Strategy for Sexual Health and HIV set a target of 60% uptake by 2007. In 2006, uptake of testing in North Central London was the highest in London at 84%.

Table 16: Uptake of HIV testing in North Central London GUM Clinics

	2003			2006		
	Offered	**Tested**	**Uptake**	**Offered**	**Tested**	**Uptake**
NCL	32832	26127	79.5%	40661	34158	84%

Source: Source: London Health Observatory, London Sexual Health Indicators: a data driven needs assessment, 2008

Oral health

Oral diseases are among the most commonly found chronic diseases in the UK. They reduce quality of life and have multiple impacts on physical and psychological well-being. Despite improvements in recent years, oral diseases can still have serious consequences. Many adults and children still suffer from oral pain and discomfort and poor self-esteem.

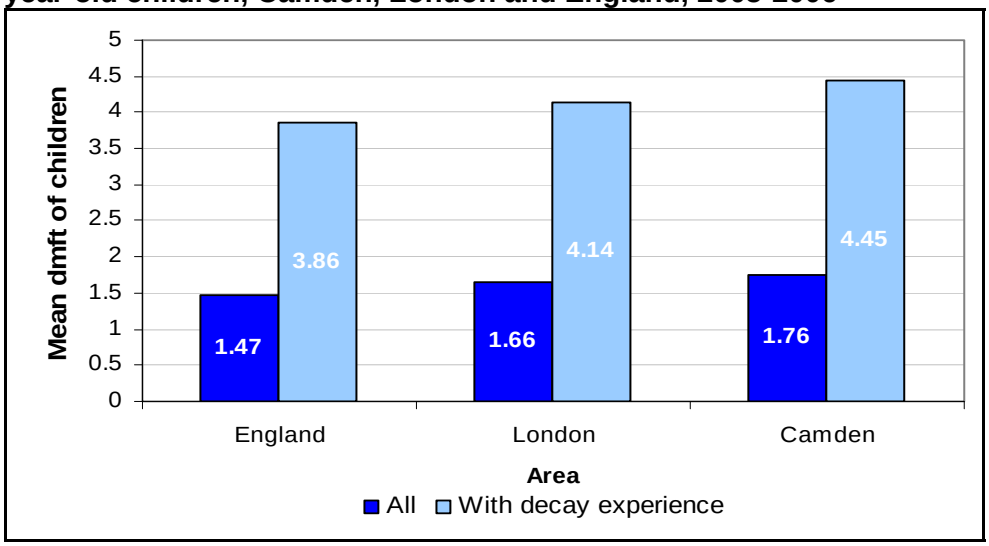
Epidemiology of oral diseases in Camden

The dental health of adults and children in the UK has improved significantly in recent years[34]. However, population averages mask oral health inequalities. Oral health in Camden is poor: cross London comparisons[35] show that there is still much improvement to be made if oral health in Camden is to match Enfield or Haringey, which show the lowest levels of disease in North Central London.

Oral diseases in children

Dental health of young children in Camden is among the poorest in North Central London, with 45% of five-year-olds experiencing tooth decay[36]. Children with decay have around four to five decayed, missing or filled teeth (dmft) compared to a population average of just under two decayed teeth per child (see Figure 33[37]. The majority of decayed teeth in this age group are untreated.

Figure 33: Comparison of average dmft for 5-year-olds with decay experience versus all 5-year-old children, Camden, London and England, 2005-2006



Source: BASCD co-ordinated NHS Dental Epidemiology Programme survey, 2005/2006

Oral diseases in adults in Camden

Epidemiological data on adult oral health are not routinely collected at a local level. However, it is an accepted orthodoxy to use data collected from five-year-olds as a proxy for population oral health. It is therefore likely that adults in Camden also experience poor oral health in comparison to the rest of London.

At risk groups

Demographic groups that are likely to be at particular risk of oral diseases include: people from deprived areas (e.g. St Pancras & Somers Town, Gospel Oak, Haverstock and Kilburn), black and minority ethnic groups (particularly Black African and Bangladeshi), homeless people, drug misusers, smokers, people with mental health problems, people with learning disabilities and elderly people[38].

Inequalities in oral diseases

Significant oral health inequalities exist in Camden even though oral diseases are largely preventable. Camden residents suffer from both inequalities in oral health and inequalities in access to oral health services. Oral health varies by gender, age, socioeconomic status and ethnic group and there is a well-established association between poor dental health and socio-economic deprivation[39].
While oral health has improved overall in recent years, disease is now increasingly concentrated in lower income groups. Socially deprived groups are doubly burdened with poor oral health and reduced access to care.

Causes of poor oral health and oral health inequalities

Oral diseases are widely considered to be caused by lifestyle and biological risk factors and there is little doubt that certain behaviours, such as frequent sugar consumption, will increase risk. However a persuasive body of evidence has emerged to suggest that the main causes of oral health inequalities are social and environmental. As with general health, oral health is determined by social, economic and environmental factors as well as lifestyle factors[40].

Health in Camden: evidence based recommendations

People who already have established disease, if not managed effectively in primary care become intense users of secondary care.

Issue	Recommendations based on evidence
Cardiovascular conditions	• Ensure optimal control of cholesterol as evidence suggests that in the short term control of cholesterol levels will have the biggest impact on mortality from CVD[7] • Actions focussed on preventing people from developing heart disease, including management of adults at high risk of developing CVD, which focuses on encouraging healthy lifestyles, in particular smoking cessation, and appropriate use of stains.[41] • Improve the completeness of primary care cardiovascular disease registers
Diabetes	• Control of blood sugar levels (HbA1c) • Improve the completeness of primary care diabetes registers • Improve self management of patients • Promoting healthy lifestyles in patients with diabetes
Cancer	• Work with the North London Cancer Network to support smoking cessation, health promotion and work with primary care to facilitate early diagnosis and referral[42]
COPD	• The overall approach to managing stable COPD should be individualized to address symptoms and improve quality of life. The statements below summarise the evidence.[8] • For patients with COPD, health education plays an important role in smoking cessation and can also play a role in improving skills, ability to cope with illness and health status. [8] • influenza vaccines can reduce serious illness[8]
Mental Health[43]	• Interventions promoting the best possible mental health to start as early as possible. High priority should be given to addressing maternal stress, diet and smoking and avoidance of alcohol during pre-natal development[44] [45]. • Enable the best possible family, social and physical environments in which children are nurtured. Parents should be offered coaching in life skills, particularly those who have not experienced effective parenting in their own upbringing[46]. • Ensure good quality housing – a proxy indicator for a supportive encouraging learning environment. • Early identification and prompt treatment of learning disabilities in children. Teachers and frontline professionals should be given scientifically accredited training. • Increase the priority and nature of the support for looked-after children • Address substance misuse in adolescents and within an overall strategy to reduce availability. • Address the risk factors associated with mental disorders; debt is a stronger risk factor than low income • Diagnose early and treat promptly[47] [48]. • Considerable scope for primary care setting to play a pivotal role in

	providing more integrated access to appropriate sources of help[49]. • Improve access to treatments. • Address important mediating factors e.g. addressing stigma associated with mental health, well designed work placements, support and intervention programmes to help those with mental health problems[50]. • Target high risk groups, looked after children, drug users and prisoners. • Prioritise learning in adult life, stimulating the demand for skills, empowering individuals to learn, addressing gap in basic skills, and realising potential of new technologies[51 52]. • Expand activities to improve access to work for those with mental health problems • Ensure positive mental health in the workplace. • Address cognitive decline in particular due to dementia, strategies should include strategies to address risk factors early in life. • Promoting environments enabling older people to flourish. • Ensure that services (e.g. crisis intervention, substance misuse) do not discriminate (directly or indirectly) by age (Healthcare Commission). • Identify depression and anxiety in older people in primary care, especially where exacerbated by physical ill health, caring responsibilities, bereavement etc; • Ensure promotion of services is tailored to older people's needs and wishes; • Commission "upstream" services in the community to prevent care homes and hospital admissions, and reduce isolation (un-befriended men are at particular risk of suicide)[53] **Dementia[54 55]** • Develop and use new methods for early diagnosis and assessment of cognitive decline and dementia. • People with dementia should be appropriately supported with co-ordinated services to maintain social lives, pursue interests and passions, and remain independent. • As well as appropriate medication people with dementia should be able to access non-pharmacological therapies, such as psychological therapies and Cognitive Stimulation Therapy • Hospital admission should, where possible, be avoided; people should be discharged appropriately when medically fit to leave hospital, and receive re-ablement and rehab to help them return home. Practitioners should understand the individual preferences of the patient, and pay particular attention to pain relief. • Health and social care professionals should discuss with the person with dementia, while he or she still has capacity, and his or her carer the use of advance statements, advance decisions to refuse treatment, Lasting Power of Attorney and a Preferred Place of Care Plan • Support should be offered to carers soon after the person they care for has been diagnosed. • Health and social care managers should ensure that all staff working

	with older people in the health, social care and voluntary sectors have access to dementia-care training (skill development) that is consistent with their roles and responsibilities. Staff working with people with dementia should also receive Safeguarding training. • Younger people with dementia have special requirements, and specialist multidisciplinary services should be developed, allied to existing dementia services, to meet their needs for assessment, diagnosis and care. • People with dementia at the end of life should receive appropriate palliative care, including pain relief.
Communicable Disease	• All HIV service providers should be able to provide ready access to staff trained in taking a sexual history and who can make an appropriate sexual health assessment. • Sexual health assessments and sexual history should be documented at first presentation and a 6 monthly intervals for all HIV + and people receiving long-term care • There should be documented local care pathways for diagnosis, treatment and partner work for sexually transmitted infections in people with HIV[56]
Oral Health	• Increase access to dental services for young children and vulnerable adults by designing services around the preferences of these groups and encouraging preventive attendance[57]. • Maximise fluoride delivery at a community level for young children and vulnerable adults[58]. • Integrate oral health priorities, where appropriate, into all health promoting strategy documents and general health policies, e.g. food strategy, healthy eating policy, alcohol strategy[59].

5. Adult lifestyles

There is significant evidence that suggests changing behaviours such as smoking, physical inactivity, diet, excessive alcohol intake will have a positive impact on the largest causes of mortality. This section gives an overview of the key lifestyle risks in Camden.

Lifestyle survey

In 2009 NHS Camden commissioned a local lifestyle survey. The survey was conducted over the in March 2009. There were 3009 interviews completed from Camden residents aged 16 and over. The questionnaires covered key lifestyle issues such as smoking, exercise, diet and alcohol consumption. Key results from the survey are presented below. The figures below present prevalence according to the lifestyle survey and model based synthetic estimates produced by National Centre for Social Research, 2003-05.

Smoking

Smoking is the single largest preventable cause of death and one of the leading causes of health inequalities. The Health Development Agency has estimated that smoking is responsible for 87% of all lung cancer deaths and 86% of all chronic obstructive pulmonary disease deaths, as well as 58% of deaths from Coronary Heart Disease amongst those aged 35-54. Smoking during pregnancy can result in babies with a low birth weight and premature delivery.

There were 143 male deaths and 81 female deaths attributable to smoking amongst Camden residents in 2008, representing 23% of all male deaths that year and 15% of female ones. Additionally, in 2008/09, there were 950 male hospital admissions, and 598 female hospital admissions that were attributable to smoking (3.6% of total male admissions, 2.0% of female admissions).

About a quarter of cases of circulatory disease below the age of 65 are linked to smoking. Further estimated costs attributable to smoking are 57% of cases of bronchitis and emphysema, 20% of other respiratory disease, 15% of all cancer diagnoses, 17% of stomach ulcers, 35% of people with a low lung function level, 9% of total GP consultations and 10% of GP prescriptions.

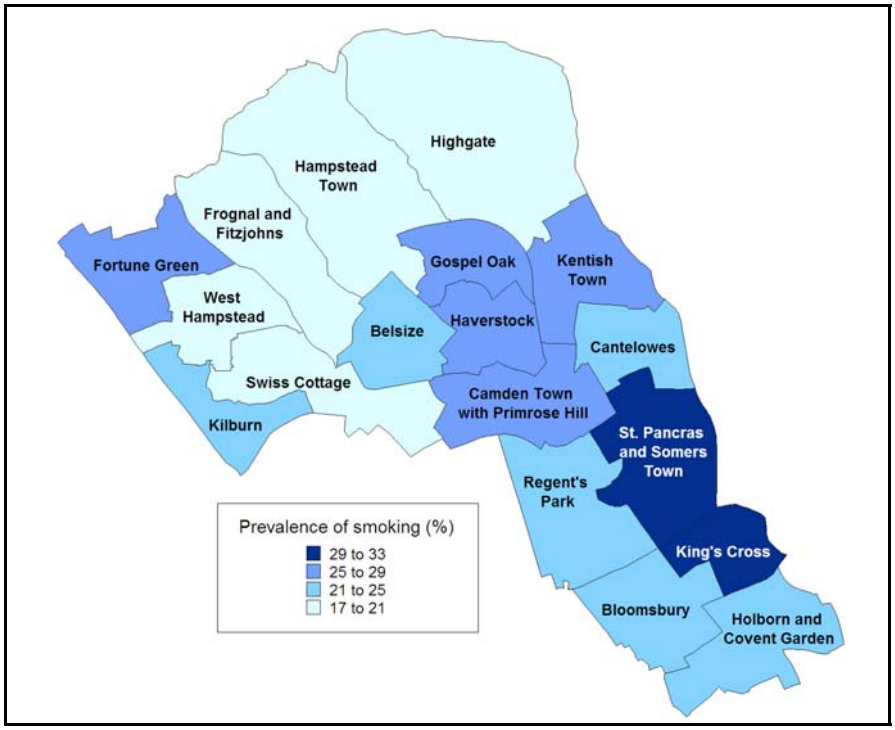
Nationally, there has been a consistent decline in numbers of people smoking over at least the last twenty years. The most recent results from the Health Survey for England suggest 24% of the adult population smoke, whilst results from the General Household Survey put the figure at around 21%.

The estimated smoking prevalence for Camden overall does not differ from national estimates. The local lifestyle survey suggests that 24% of the adult population smoke and this concurs with model based estimates of 23.5%. However, smoking prevalence varies in different socio-economic groups.

In Camden:

- Adult smoking prevalence is estimated to be 24%, very similar to national estimates
- Men have a higher smoking prevalence than women (27% vs. 21%)
- Smoking prevalence rises as social grade falls, with the highest prevalence being amongst groups C2 (28%) and D/E (33%), semi/unskilled manual workers and those dependent on the state. This means smoking levels will be higher in areas of deprivation.
- People from lower social grades are more likely to be living in social housing. So unsurprisingly prevalence of smoking differs greatly by housing tenure, with those living in owner occupied properties much less likely to smoke than the average, whilst those living in social housing (properties rented from the council or housing associations) were significantly more likely to smoke (31%).
- Prevalence of smoking does not differ significantly by age, with the exception that prevalence falls after the age of 65, and is especially low amongst those aged 75+.
- Smoking prevalence shows no significant differences by ethnicity within Camden.

Figure 33: Prevalence of smoking in Camden by ward



Source: NHS Camden Lifestyle Survey, 2009

Alcohol

Alcohol misuse is a major contributor to a range of harms and is a major preventable cause of ill health. Harms from alcohol misuse include crime, anti-social behaviour, domestic violence, drink driving and its impact on victims, loss of productivity by causing absenteeism from work and social harms such as problems with families. Health harms from alcohol include alcohol poisoning, liver disease and hypertension.

Amongst Camden resident's alcohol was estimated to be responsible for about 2650 hospital admissions in 2008/09, 6% of all ordinary and day case admissions. Alcohol-related admissions have been rising over the last few years, both in Camden and

nationally. There about 62 male deaths attributed to alcohol in 2008 (10% of all male deaths that year), and 21 female deaths (4% of all female deaths).

Sensible drinking is defined for women as not drinking more than 2-3 units of alcohol a day and for men not regularly drinking more than 3-4 alcohol units a day. Camden's lifestyle showed that only a third of men and half of women were able to correctly state their recommended daily alcohol limit.

Table 17: Percentage with knowledge of recommended daily alcohol limit by age (2009)

Age-band	Male	Female
16-24	34%	44%
25-34	31%	47%
35-44	40%	53%
45-54	41%	59%
55-64	36%	54%
65-74	21%	54%
75+	34%	26%
Total	**35%**	**50%**

Source: NHS Camden lifestyle survey, 2009

The North West Public Health observatory produces local authority alcohol health profiles for all local authorities every year. Table 18 below shows selected indicators relating to alcohol. Alcohol specific admissions and mortality refers to cases where alcohol is directly linked to the incident (for instance, a person admitted to hospital whilst intoxicated), whilst attributable refers to cases where it is assumed a certain proportion of incidents will be linked to alcohol (for instance, victims of traffic accidents).

Camden has higher expected prevalence of hazardous drinking and harmful drinking compared to both London and England.

Rates of alcohol related admissions in Camden are significantly higher in Camden compared to London and England, as are alcohol specific admissions for both men and women, as well as alcohol specific mortality amongst men (indicators where Camden is significantly above both London and England are highlighted in red).

Table 18: Selected alcohol-related indicators

Alcohol indicator	Camden	London	England
Binge drinking*	15.30%	12.70%	18.00%
Harmful drinking**	5.80%	5.10%	5.00%
Hazardous drinking***	22.80%	18.80%	20.10%
Alcohol specific admissions, rate per 100,000: Male	597	365	374
Alcohol specific admissions, rate per 100,000 population: Female	227	139	190
Alcohol related admissions, rate per 100,000 population	1602	1386	1472
Alcohol specific mortality, rate per 100,000 population: Male	20.8	11.3	12.7
Alcohol specific mortality, rate per 100,000 population: Female	2.63	3.77	5.92
Alcohol attributable mortality, rate per 100,000	49.2	33.6	36.1

population: Male			
Alcohol attributable mortality, rate per 100,000 population: Female	14.3	12.8	15.2
Alcohol related violent crime, crude rate per 1,000	9.58	8.56	6.09

Source: Northwest Public Health Observatory alcohol profiles - 2009
*consuming at least twice the maximum recommended daily units in a single drinking session
**Over 50 units of alcohol per week for men, over 35 units for alcohol for women
***22-50 unit of alcohol per week for men and 15-35 units of alcohol for women

Substance misuse

Camden has an estimated population of 4,328 problem drug users (PDUs), i.e. users of opiates and / or crack cocaine. This translates to a rate of 26 PDUs per 1,000 Camden residents aged between 15-64. According to these estimates, Camden's prevalence of crack and / or opiate use is the fifth highest in London.

3,699 (86%) are estimated to be opiate users, and 3,084 (71%) crack users. 2,455 (57%) of Camden's estimated PDUs are using both opiates and crack.

1,872 (43%) of Camden's PDUs are thought to be injecting. Camden has the highest number of injecting drug users in London, and has the highest prevalence per 1000 residents.

The prevalence of opiate and / or crack use increases with age. The prevalence amongst the 25-34 year-olds is nearly five times greater that amongst those aged 15-24, and the prevalence of those aged 35-64 is even higher.

The estimate accounts for Camden residents only and does not include the large transient population which is known to frequent Camden's open drug markets, and which is also behind a considerable proportion of the drug related harm in Camden.

Hospital admissions

Drug related hospital admissions increased slightly in 2008/09 from the previous year. Whereas prior to this drug related hospital admissions had decreased since 2006/07.

212 individuals had a drug related hospital admissions in 2008/09. Data shows that:

- 54% of the admissions were for complications caused by drug dependence.
- 80% of the admissions were amongst people from a white ethnic background who comprise 70% of the population.
- 50% of the admissions were for opiates, and 23% for multiple drug use.
- 73% of the admissions were from non-hostel residents.
- Drug related hospital admissions amongst 45-54 year olds have increased in the past two years, whereas admissions for people aged 25 and younger have decreased.
- 23% had more than one admission in 2008/09. Looking at data for 2006/07 – 2008/09 shows that around 25% of all drug related hospital admissions were of people being readmitted within the monitoring time period.

Drug related deaths

Drug related deaths in Camden have decreased since 2006

Overall 55 drug related deaths occurred between 2006 and 2008. Further analysis shows that:

- The majority of deaths (43%) were due to accidental overdose.
- 33% of the deaths were attributable to Hepatitis C.
- 67% of those who had a drug related death were male.
- Opiates were involved in 85% of the deaths.
- 76% of people that died between 2006 and 2008 were non-hostel residents.

Drug related crime

During the period August 2008 and July 2009, 3,555 drug arrests were made in Camden, this is a 7.5% increase on previous year's figures. This increase is mainly due to an increase in possession offences which increased from 3,055 to 3,283 (mainly for cannabis) due to a change in local charging policy. Drugs enforcement over the last 12 months has been considerable and attributed with the 7.5% increase in arrests compared to the previous 12 months and the reduced levels of CCTV incidents recorded concerning drugs.

- Just 30% (1,132) of those arrested were Camden residents.

Trafficking (possession with an intent to supply) offences in regards to all drugs have decreased by 17% from previous year (from 288 to 238).

- 58% (138) of those arrested for drug dealing in Camden travelled to Camden to deal in drugs.

The majority (33.6%) of all drug arrests happened in Camden Town however, there has been a 2.2% decrease from the overall three year trend of drug arrests in Camden Town suggesting a more spread out Police operation.

Drug arrests – Class A

Class A drugs made up 9.9% of all possession offences (329 out of 3,283) in the reporting year.

- Class A offences decreased by 0.8% from the previous year, including a decrease in the possession offences for crack and heroin.

Trafficking of heroin as a proportion of all trafficking offences has increased from 9.9% and 10% in the previous two years to 23.5% in the reporting year.
There has been almost no chance in trafficking offences for crack cocaine, which made up 9.2% of all trafficking offences.

- 67% (87) of those arrested for Class A trafficking had travelled to Camden to deal in drugs.

- Camden Town is the main hotspot for Class A arrests 30.3% of all class A took place there.

Two secondary hotspots were identified in areas around Kings Cross and St.Giles Street in Covent Garden and Holborn where 9.8% of Class A arrests were made. Although the secondary hotspots are small compared to Camden Town, these two areas were hotspots for Class A offences alone.

Sexual health

Sexual ill health affects all age groups and sections of society but harms disproportionately vulnerable groups such as young people, black and minority ethnic groups, and those affected by poverty and exclusion.

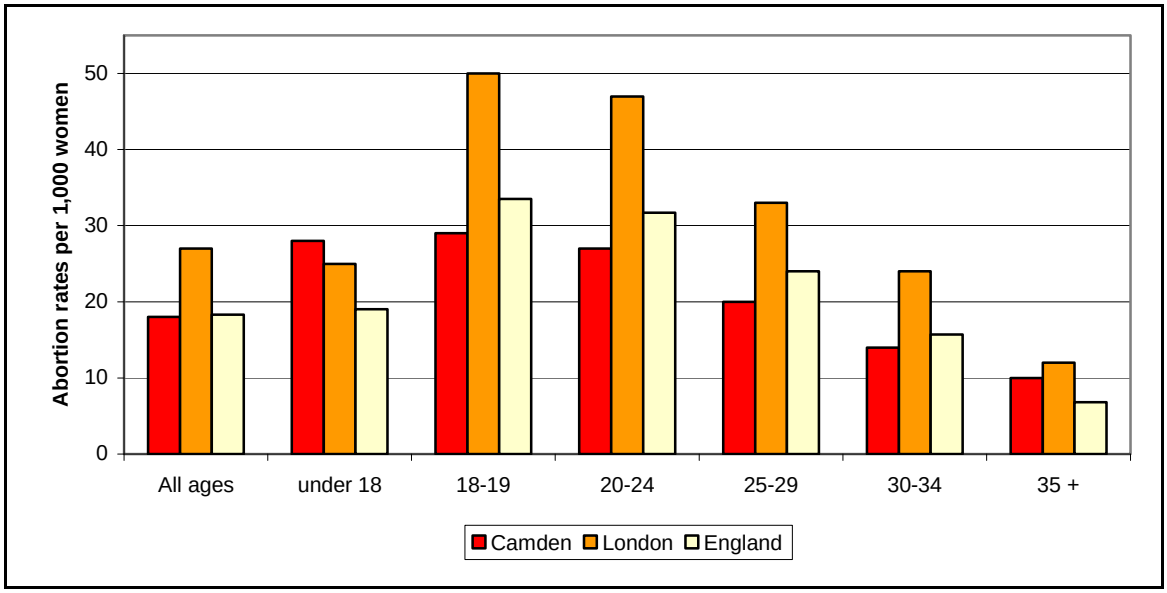
Sexually transmitted infections are one of the greatest infectious disease problems in the UK today. The consequences of poor sexual health have important implications for individuals and society, for instance from unintended pregnancies. Sexually transmitted infections are also associated with serious maternal and neonatal morbidity, preventable infertility, anogenital cancers, and transmission of HIV.

Termination of pregnancies

Unintended pregnancies can be associated with poor sexual health outcomes. They are a reflection of poor access to effective contraception and are associated with the consequences of unprotected sex including sexually transmitted infections.

Figure 34 shows that overall legal abortion rates in Camden are lower than London and similar to England. Across the different age groups Camden has higher abortion rates compared to England and London for those aged under 18 and higher rates than England for those aged 35 and over.

Figure 34: Abortion rates, 2008



Source: Office for National Statistics, Department of Health

Sexually Transmitted infections (STIs)

A recent report by the London Health Observatory highlights that London has the highest number of STIs in England compared with any other region.

STI data are not available by resident of each borough, but by Genito-Urinary Medicine (GUM) clinics. GUM clinics are open access clinics and therefore not restricted to patients residing in the area.

Table 19: Number of new diagnoses for common STIS in North Central London

STI	2004	2008
Genital Chlamydia	3,812	1,843
Gonorrhea	1,470	430
Infectious syphilis	193	82
Genital herpes	837	508
Genital Warts	2,091	1,086

Source:KC60, 2008

The London Health Observatory sexual health data driven needs assessment shows:

Syphilis – The largest absolute increase was seen in North Central London GUM clinics, the majority of primary and secondary syphilis was seen in men and two thirds of men diagnosed at clinics were men who had sex with men (MSM).

Uncomplicated Gonorrhoea – Overall, there has been a decrease in the number of diagnoses of uncomplicated gonorrhoea between 2002 and 2006, although an increase was seen amongst MSM.

Genital Herpes –Diagnoses of genital herpes in GUM clinics are much higher amongst women than men. In North Central London there has been a decrease from 2002 to 2006, despite the overall trend in London being an increase.

Genital Warts – Annual number of diagnoses of genital warts has declined in North Central London from 2002 to 2006. In London overall the numbers were higher among men. However diagnosis by age and gender showed higher diagnosis among women aged 16-19 compared to men in the same group.

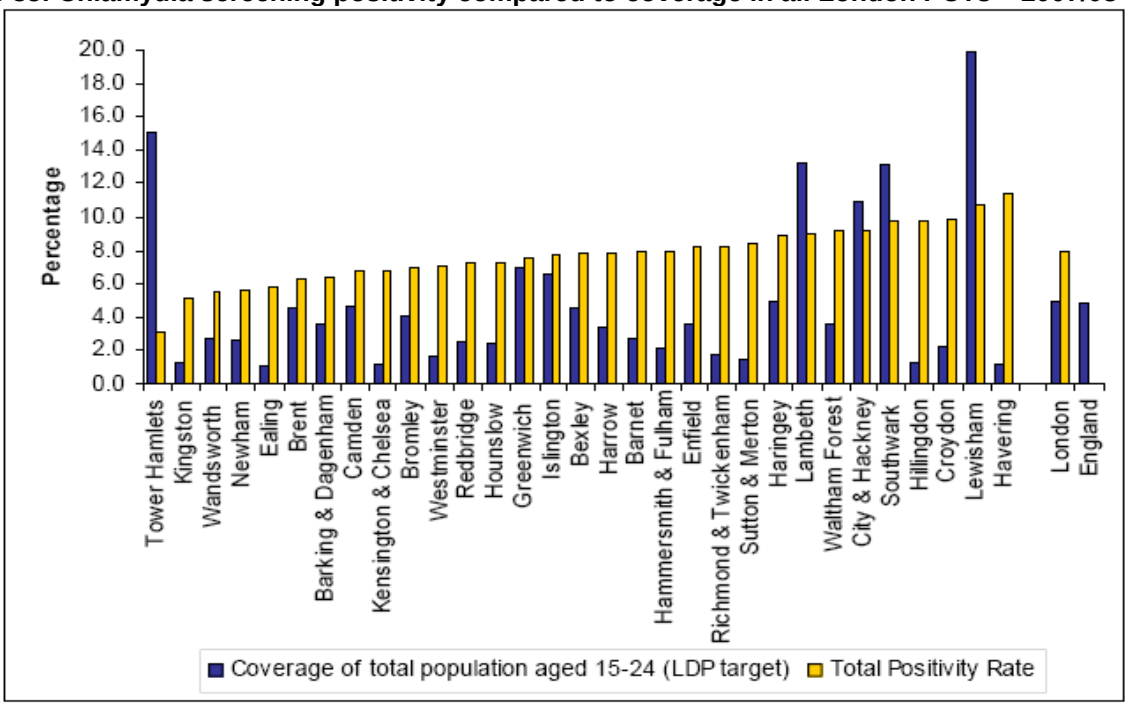
Chlamydia – the number of genital Chlamydia diagnoses in GUM clinics has reached a plateau over the past four years. This may be due to screening outside of GUM clinics, fewer referrals to GUM clinics from primary care and GUM clinics reaching capacity.

In 2008/09 the Department of Health set the Chlamydia vital sign indicator for Camden, which includes a target for Chlamydia screening and testing of 17% of young persons aged 15-24.

The latest complete financial year of data available is 2007/08 which showed that a total of 1,691 people aged 15-24 had been screened. This is a coverage of 4.7%. Amongst these 6.7% of screens were positive for Chlamydia (known as the positivity rate), slightly below the London average of 7.0% for men and 8.3% for women.

Figure 35 shows the coverage and positivity rate for all London PCTs.

Figure 35: Chlamydia screening positivity compared to coverage in all London PCTs – 2007/08



Source: Source: London Health Observatory, London Sexual Health Indicators: a data driven needs assessment, 2008

Adult obesity

Being overweight or obese (defined as having a Body Mass Index (BMI) above 25 and 30 respectively) shortens life expectancy and substantially increases the risk of type 2 diabetes, heart disease, some cancers, gall bladder disease and other conditions.

As part of the Quality and Outcomes Framework (QOF)GPs are required to keep a register of adults with a BMI over 30 and thus classified as obese. There are 12,859 (6.8% of the total population) adults recorded as being obese by Camden GPs as of March 2009. This is a prospective register, with not everyone having had their BMI measured, so this number can be expected to increase over time. Model based synthetic estimates suggest that up to 13% of the Camden adult population maybe obese.

The main behavioural factors known to influence the top causes of mortality in Camden are alcohol, smoking, diet and exercise. It is important to remember that many of these factors are both interlinked and closely related to other health determinants such as poverty, living environment, income and employment status.

Data on prevalence of lifestyle factors for both adults and children and young people is limited. Most data for both adults and children and young people relies on applying national estimates from large surveys to the local population, using Model based synthetic estimates. Prevalence of unhealthy lifestyles can often be underestimated in surveys.

Healthy eating

Model based synthetic estimates suggest that 34% (95% CI: 31%-37%) of the adult population consume the recommended 5 fruit and vegetables a day. This puts Camden in the top quartile of London local authorities who eat the recommended amount of fruit and vegetables. These estimates concur with results from the NHS Camden's Lifestyle Survey which show that 32% of the adult population reported that they ate the daily recommended amount of fruit and vegetables. This is above the national average of 26%.

However, the survey shows that fruit and vegetable consumption in Camden varies across different population groups. The recommended level of fruit and vegetable consumption is achieved:

- More frequently by women than men (38% vs. 25%)
- More frequently by those in the older age groups, with consumption amongst those aged 55-64 nearly double that of the 16-24 age group (45% vs. 23%)
- More frequently by those not from a black and minority ethnic group
- More frequently by those from the higher socio-economic groups (41% amongst group A vs. 21% amongst groups D/E)

More frequently by those living in owner-occupied homes than those from social housing (43% vs. 23%)

Physical activity

The consequences of low levels of physical activity are well known. Physically active adults have a 20-30% reduced risk of premature death and are up to 50% less likely to be at risk of major chronic disease such as CHD, stroke, diabetes and cancer, according to the Department of Health.

The recommended level of physical activity for adults to gain health benefit is 30 minutes of moderate intensity physical activity on at least five days each week. The Active People Survey (2007/08) suggests that 23.9% of people across the borough are regularly participating in 30 minutes moderate intensity of physical activity, which is higher than the national average.

An extensive needs assessment was carried out by NHS Camden and Pro-active Camden in 2008. The aim of this needs assessment was to provide an understanding of current provision for sport and physical activity in the borough and identifying interventions that would increase participation amongst residents. The needs assessment covered the borough as a whole but had a particular focus on residents of the wards with the worst health outcomes.

The main barriers to physical activity were time and cost. The needs assessment identified the following groups where there was a gap in physical activity provision;

- Girls
- Over 60's
- Disabled people
- Lone parents

Adult lifestyles: key evidence based recommendations

Issue	Evidence based recommendations
Smoking	• Primary care trusts (PCTs), strategic health authorities (SHAs) and commissioners should set achievable targets for their local populations, aiming to treat approximately five per cent of the population who smoke each year – a smoking cessation rate of 35 per cent at the four week mark should be the aim. • Black and minority ethnic and socio-economically disadvantaged communities within the local population should be targeted by NHS stop smoking services. • Personalised information, advice and support should be available to pregnant women on smoking cessation.[60]
Alcohol	• NICE is developing three pieces of guidance relating to alcohol use disorders over the next two years. Each piece of guidance will focus on a different element of the care pathway, from the prevention and early identification of alcohol use disorders through to the clinical management of acute alcohol withdrawal and alcohol related liver disease and pancreatitis. The third piece of guidance will focus on the management of alcohol dependency and psychological interventions. • Camden's proposed Alcohol Harm Reduction Strategy 2010-13 is consulting on priorities based on evidence from different sources including an Adults Alcohol Needs Assessment.
Substance misuse	• Local partnerships (and clinicians) working together to ensure local drug treatment systems are commissioned and provided to meet the changing needs of local drug misusing populations. • Joint working between partners, a key feature of effective treatment as many drug misusers have many health and social problems which require interventions from a range of providers. • Having a cohort of doctors providing treatment for drug misusers ranging from general medical services to specialist competencies in treating drug dependencies. • Good clinical governance within and between providers • Involving patients as active partners in their drug treatment • Involving families and carers whenever possible and agreed by the patient, without overlooking their needs. • Assessing needs of all drug misusers across the four domains of drug and alcohol misuse, health, social functioning and criminal involvement. • Assessing risks to dependent children for all drug-using parents. • Regularly reviewing the care or treatment plan of all drug misusers entering structured treatment • Drug misuse treatment should involve a range of interventions, not just prescribing. • A named individual should manage and deliver aspects of the patient's care or treatment plan. • Drug testing can be a useful tool in assessment and in monitoring compliance and outcomes of treatment. [61]
Sexual Health	• Health professionals should identify individuals at high risk of sexually transmitted infections(STIs) using their sexual history

	• Have one to one structured discussions with individuals at high risk of STIs or arrange for these discussions to take place • Help patients with STIs get their partners tested and treated. • PCTs should ensure that sexual health services, including contraception and abortion services are in place to meet local need.[62]
Obesity	• Interventions to increase physical activity should focus on activities that fit easily into people's everyday life (such as walking), should be tailored to people's individual preferences and circumstances and should aim to improve people's belief in their ability to change (for example, by verbal persuasion, modelling exercise behaviour and discussing positive effects). Ongoing support (including appropriate written materials) should be given in person or by phone, mail or internet. • Interventions to improve diet (and reduce energy intake) should be multi-component (for example, including dietary modification, targeted advice, family involvement and goal setting), be tailored to the individual and provide ongoing support. • Interventions may include promotional, awareness-raising activities, but these should be part of a long-term, multi-component intervention rather than one-off activities (and should be accompanied by targeted follow-up with different population groups). • Health professionals should discuss weight, diet and activity with people at times when weight gain is more likely, such as during and after pregnancy, the menopause and while stopping smoking. • All actions aimed at preventing excess weight gain and improving diet (including reducing energy intake) and activity levels in children and young people should actively involve parents and carers. [63]
Healthy eating	• Health eating interventions in workplaces, primary care, schools and the community should incorporate effective models of communication and behaviour change and should adopt a behaviourally based approach which includes active involvement of individuals. Inventions should be conducted mainly with individuals or in small groups and take into account personal characteristics such as needs, motivation and knowledge as well as behaviour and risk factors. • Interventions should include feedback on changes in behaviour and risk factor levels in person or by individualised printed material. • Consideration should be given to long term maintenance of change and to the social and physical environment of the intervention, in order to include influential people, elicit social support, and provide a consistent message. • School based healthy eating interventions should integrate long-term behaviour orientated programmes into the curriculum and support dietary change by modifications in the school environment, including the schools meals service. • In supermarket and catering settings, healthy eating information should be introduced at the point of choice and supported by more detailed printed guides and promotion within the outlet or local media.

	[64] • Develop healthy eating environment in school, develop healthy lunch box policies and arrangements conducive to healthy eating. • Local authorities to use existing planning powers to control more carefully the number and location of fast food outlets in their local areas[65]
Physical Activity	• 30 minutes a day of physical activity of at least moderate intensity 5 times a week • Brief interventions in primary care • Exercise referral schemes • Pedometers and community-based walking and cycling programmes[66]

6. Children and young people lifestyles

The Children and Young People Plan Profile draws on the TellUs survey to estimate prevalence of lifestyle issues. This is a survey of children and young people across England, asking their views about their local area, and including questions which covered the five Every Child Matters outcomes. The survey was carried out in Spring 2008. All Camden schools are invited to participate in the survey and it focuses on year groups 6, 8 and 10.

Smoking

Children who live in families where one or more adults smoke are also at risk from the ill health of passive smoking such as wheezing/asthma and more likely to take it up. 86% of respondents to the 2008 survey said they never smoked compared to 75% nationally. The overall prevalence of adult smoking in Camden is 24%.

Alcohol

54% of those responding to the 2008 TellUs survey indicated that they had never had an alcoholic drink. Of those who said they had, 15% stated they had been drunk on at least one occasion compared to 33% nationally. In addition the 2008 Health Related Behavioural Questionnaire showed that fewer Year 10 boys in 2006 said that they had at least one unit of alcohol in the last week (16%) compared with 24% in 2002. 16% of year 8 girls in 2004 compared with 5% in 2006.

Substance misuse

Perceptions captured through TellUs 3 (2008) showed that 88% of respondents said they had never taken drugs, compared with 74% in 2007. These results are similar to the national picture. Where drug usage had occurred, cannabis is the most prevalent.

Sexual health

Teenage conception rate

Most recent data (for the calendar year 2008) shows an increasing rate for under 18 conceptions in Camden. The rate has increased 0.5 to stand at 38.8 per 1,000. Despite this rise Camden remains the 4th lowest rate in inner London. In real terms this rate reflects 107 conceptions, just 3 higher than the previous year. There are however marked differences across wards with Belsize ward the highest number at 76.5 and Holborn and Covent Garden, the lowest at 27.2 (based on 2005-2007 rolling averages). Repeat abortion figures rose in 2008 to be the highest in inner London at 74%, 12% points higher than the previous year.

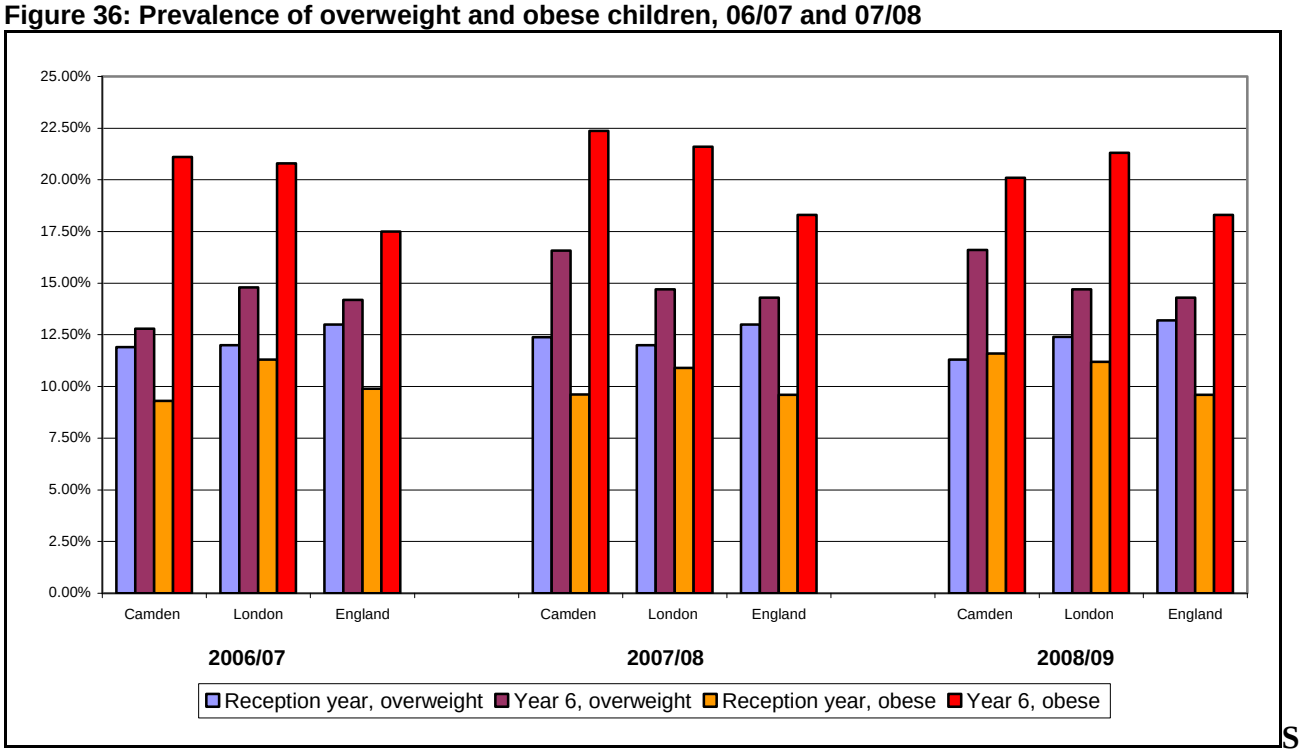
Childhood obesity

The observed rise in childhood obesity nationally has given rise to a Public Service Agreement: to return the proportion of overweight and obese children to the 2000 levels by 2020. Evidence suggests that obesity in children can continue into adulthood where it is associated with significant morbidity. There is evidence to suggest that diabetes in children is increasing due to rising levels of obesity.

Figure 36 shows the prevalence of obese and overweight children compared to London and England over the past two years. The graph shows that the prevalence of obesity in

Camden amongst those in Year 6 is above the national average despite a decrease in the last year. Obesity prevalence in reception year has risen in the past year and is now also above the national average.

Figure 36: Prevalence of overweight and obese children, 06/07 and 07/08



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Source: NHS Information Centre, www.ncmp.ic.nhs.uk

In both Reception Year and Year 6, obesity is more prevalent in males than females which is consistent with the national findings.

Table 20: Obesity prevalence in boys and girls

	Reception Year (aged 4/5)	Year 6 (aged 10/11)
Camden boys	12.1%	25.6%
Camden girls	10.7%	18.9%
England boys	10.2%	20.0%
England girls	8.9%	16.5%

Source: National Child Measurement Programme results, 2008/09

Physical exercise and healthy eating

Physical exercise and healthy eating are key factors in reducing and preventing childhood obesity. These behaviours themselves are interrelated with the socio-economic circumstance of a person and their environment.

33% of Camden pupils that responded to the Ofsted Tellus survey in 2008 stated that they regularly ate 5 or more portions of fruit and vegetables day – higher than the national average of 23%.

52% of those responding to the Tellus survey stated they do 30 minutes or more of sport/exercise at least 6 days a week. This is up from 33% the previous year and above the national average of 36%.

Children and young people lifestyles: key evidence based recommendations

Issue	Evidence based recommendations
Smoking	Young people aged between 12 and 17 should be offered information, advice and support on how to stop smoking – nicotine replacement therapy (NRT) could be used, especially for young people over 12 who show signs of nicotine dependence. The five recommendations include the following advice: • The smoking policy should support both prevention and stop smoking activities and should apply to everyone using the premises (including the grounds). • Information on smoking should be integrated into the curriculum. For example, classroom discussions could be relevant when teaching biology, chemistry, citizenship and maths. • Anti-smoking activities should be delivered as part of personal, social, health and economic (PHSE) and other activities related to Healthy Schools or Healthy Further Education status. • Anti-smoking activities should aim to develop decision-making skills and include strategies for enhancing self-esteem. Parents and carers should be encouraged to get involved and students could be trained to lead some of these programmes. • All staff involved in smoking prevention should be trained to do so. • Educational establishments should work in partnership with outside agencies to design, deliver, monitor and evaluate smoking prevention activities.[67]
Alcohol	• Alcohol education should be an integral part of the school curriculum and should be tailored for different age groups and different learning needs • A 'whole school' approach should be adopted, covering everything from policy development and the school environment to staff training and parents and pupils should be involved in developing and supporting this • Where appropriate, children and young people who are thought to be drinking harmful amounts should be offered one-to-one advice or should be referred to an external service • Schools should work with a range of local partners to support alcohol education in schools, ensure school interventions are integrated with community activities and to find ways to consult with families about initiatives to reduce alcohol use.[68]
Substance misuse	• Develop a local strategy • Use existing tools to identify children and young people who are misusing, or at risk of misusing, substances. • Work with parents and carers and other organisations involved with children and young people to provide support and, where necessary, to refer them to other services.

	• Offer motivational interviews to those who are misusing substances. • Offer group-based behavioral therapy to children aged 10–12 years who are persistently aggressive or disruptive – and deemed at high risk of misusing substances. Offer their parents or carers group-based parent skills training. • Offer a family-based programme of structured support to children aged 11–16 years who are disadvantaged and deemed at high risk of substance misuse[69]
Sexual Health	• For vulnerable people under 18 provide one to one sexual health advice on how to prevent and/or get tested for sexually transmitted infections and prevent unwanted pregnancies, all methods of reversible contraception, how to get and use emergency contraception and provide supporting information in appropriate formats. • Regularly visit vulnerable females under 18 who are pregnant or already mothers.[25]
Obesity	• Assess whole school environment and ensure ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active. Including; • Promoting the benefits of physical activity and encourage participation • Planning and providing spaces, facilities and opportunities • Training people to run programmes and activities • Promoting physically active travel such as cycling and walking. • Implementing policies relating to national healthy schools programme[70]
Healthy Eating and Physical Activity	Any programme to prevent obesity in preschool, childcare or family settings should incorporate a range of components (rather than focusing on parental education alone), such as: • diet – interactive cookery demonstrations, videos and group discussions on practical issues such as meal planning and shopping for food and drink • Physical activity – interactive demonstrations, videos and group discussions on practical issues such as ideas for activities, opportunities for active play, safety and local facilities. Family programmes to prevent obesity, improve diet (and reduce energy intake) and/or increase physical activity levels should provide ongoing, tailored support and incorporate a range of behaviour change techniques. • Programmes should have a clear aim to improve weight management.

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