Widening the focus:

tackling health inequalities in Camden & Islington

Annual report 2013/14

Camden

ISLINGTON

Working in partnership

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Foreword

Welcome to my first Annual Public Health Report as Director of Public Health for the London Boroughs of Camden and Islington.

Reducing health inequalities, particularly inequalities in life expectancy, rightly remains a central goal for both Islington and Camden Councils and their partners on the Health and Wellbeing Boards, and is the major focus of my Public Health team.

There has already been lots of work locally on reducing health inequalities. However, my focus on health inequalities in this report is different, as it considers the impact of the social determinants of health — the 'causes of the causes', all of which fundamentally impact on people's health and wellbeing throughout their lives. This is a change in emphasis of work for me and my Department as, traditionally, Public Health has had more of a focus on a healthcare and lifestyles agenda while in the NHS. For the moment, therefore, I have chosen to focus on employment, housing, education and supporting people to have a healthy standard of living: all important determinants of health and wellbeing and the key corporate priorities for Camden and Islington Councils. This does not mean that other areas are not important, and we should be capitalising on opportunities to improve health and wellbeing in a range of other areas including the built environment, access and use of green space, air quality, and active travel.

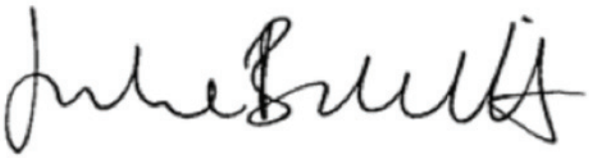
Considerable efforts have already been made locally to improve the health and wellbeing of Camden and Islington residents and to tackle health inequalities. The success of this work can be seen in the reductions in deaths from heart disease in both boroughs and the reduction in cancer deaths in Camden. However, there is still more we can do to reduce inequalities between the richest and poorest residents, which persist despite our best efforts both locally and nationally.

I am optimistic, however, that we can change this and reduce health inequalities in Camden and Islington. There are several reasons for this. Firstly, the transition of Public Health from the local NHS to Camden and Islington Councils provides us with many more opportunities to tackle the underlying causes of health

inequalities. Additionally, there is an already strong commitment from across both councils and local health services to reduce health inequalities and visible enthusiasm among councillors, council officers, GPs and other partners to do so. Finally, as this report demonstrates, there is plenty of good work happening locally: changing things is not about starting from scratch, it is about building upon what we have that already works.

This report sets the scene for our work to reduce health inequalities by tackling the 'causes of the causes'. I know that achieving change will not be easy, particularly against the backdrop of the biggest cuts to local government in recent history, and that it will take time. However, my team and I are committed to reducing health inequalities and improving the health and wellbeing of residents in Camden and Islington. I am confident that by us all working together, that we can make a real difference for local people and local communities.

Finally, I would like to thank all of those who have been involved in bringing this report together. As always, this has required a lot of hard work and dedication from everyone involved. I would particularly like to mention the leadership and hard work of Sarah Dougan and Alexandra Cronberg, and the knowledge and intelligence team that support them, in producing this annual report. Given the focus of this year's report, my team has also worked closely with officers from across Camden and Islington Councils. I would particularly like to thank these colleagues for their contributions, engagement, and insightful comments during this process, and I look forward to building upon this collaborative work going forward.



Julie Billett

Joint Director of Public Health, Camden & Islington

Executive Summary

Key messages of this report

1. The social determinants of health — including employment, housing, education and the ability to afford a healthy standard of living — all underpin the **stark inequalities in health in Camden and Islington**. Reducing these inequalities is a matter of fairness and social justice.

2. Building upon the existing work of Camden and Islington Councils and their partners, the recent transition of Public Health into local government provides an opportunity to consider what more can be done locally to reduce health inequalities by **tackling the social determinants of health**. This statutory, independent report of the Director of Public Health outlines some of those local opportunities and will hopefully be used by Public Health in collaboration with partners to strengthen and prioritise work in this area.

3. While around half of residents in both Camden and Islington experience comparatively poorer health than the national average, there are **differences in how patterns of health inequalities emerge locally**, requiring different responses. In Camden, there are clear geographical patterns with residents living in the most deprived wards experiencing poorer health. In Islington, levels of deprivation are more widely spread and a whole borough approach will be required to tackle health inequalities, targeting different groups of people. What is clear is that focussing efforts on only the most deprived and most vulnerable residents, or those experiencing the largest inequalities, will not be enough to tackle health inequalities in Camden and Islington, because so many residents experience poor health.

4. Helping people **find good jobs and stay in work** is important for their health and wellbeing and that of their family. There are stark inequalities in the health of employees by occupational group: two-fifths of Camden and Islington residents in routine and manual work report being in poor health compared to about 14% in higher managerial positions. Both Camden and Islington also have a large number of people who are out of work because of ill health, and particularly poor mental health. Supporting people to stay in work and helping people with health problems back to work should be central to reducing health inequalities.

5. **Housing** makes a very significant impact on people's health and wellbeing, and homelessness, overcrowding, and cold, damp homes all substantially contribute to health inequalities. People from ethnic minority groups and families with children are overrepresented among homeless and overcrowded households, leading to health inequalities. People living in older housing stock, mainly privately owned, tend to be more vulnerable to fuel poverty. There have already been substantial improvements in the quality of social housing stock and a number of successful initiatives to tackle homelessness, overcrowding and fuel poverty across Camden and Islington. Strengthening the work to identify people in need of housing support early, working with housing providers to promote better health, and better understanding the housing needs of people with complex health problems will all help to reduce health inequalities in the future.

6. A **good education** leads to better health outcomes in childhood and in later life. There have been significant strides in improving educational attainment in Camden and Islington in recent years, with very good standards of achievement in local schools. However, inequalities in educational attainment remain, particularly for children who have higher levels of absence (often associated with health problems or appointments with health services) or who are disadvantaged. A number of young people locally are also NEET (not in education, training or employment) with potentially negative impacts on their health and wellbeing, particularly their mental health. Continuing the work to improve educational attainment in disadvantaged groups, encouraging early years' settings and schools to promote positive health and wellbeing, and preventing young people from becoming NEET will all help to reduce health inequalities in Camden and Islington.

7. **Being able to afford a 'healthy lifestyle'** is becoming increasingly challenging for people, particularly those on lower incomes, as increases in the cost of living continue to outpace household incomes. To help reduce the level of in-work poverty and to be an exemplar of good practice, both councils have already adopted the London Living Wage and strongly promote it through the procurement of goods and services. Affordable housing is a particular issue for residents in Camden and Islington where house prices and rents are very high. Food poverty is also an area of concern, with a growing reliance on food banks and breakfast clubs for schoolchildren. While many of the levers to help residents be able to afford a 'healthy lifestyle' are outside of the control of local government, Camden and Islington Councils should continue with their efforts to mitigate the impact of poverty and income inequality by supporting the provision of breakfast clubs, helping people to quit smoking to save money, and by influencing statutory sector partners and local businesses to adopt the London Living Wage.

8. The next steps proposed for widening the focus on reducing health inequalities in Camden and Islington include:

NEXT STEPS

- **Doing more to address the social determinants of health, by embedding them into existing processes, strategies and policies, and making them everyone's business;**
- **Prioritising our children and young people, to break the cycle of intergenerational health inequalities;**
- **Focussing on prevention and early intervention to provide better outcomes for residents and increase the sustainability of public services;**
- **Targeting the right people and the right places at the right scale to ensure that interventions are successful in reducing health inequalities;**
- **Working better together to address multiple underlying problems – a defining feature of families and communities affected by poor health is that they are often challenged by multiple rather than single issues;**
- **Making best use of resources to ensure that services and interventions are evidence-based, cost-effective, and are being delivered to achieve maximum impact.**

Introduction

There are stark health inequalities in Camden and Islington. For the less affluent in our communities, these inequalities mean poorer physical and mental health, poorer quality of life and an earlier death. As well as the economic impact for individuals, families and society, reducing these inequalities is a matter of fairness and social justice.

What are health inequalities and what causes them?

"Inequalities in health arise because of inequalities in society — in the conditions in which people are born, grow, live, work and age"

Fair Society, Healthy Lives: The Marmot Review, 2010

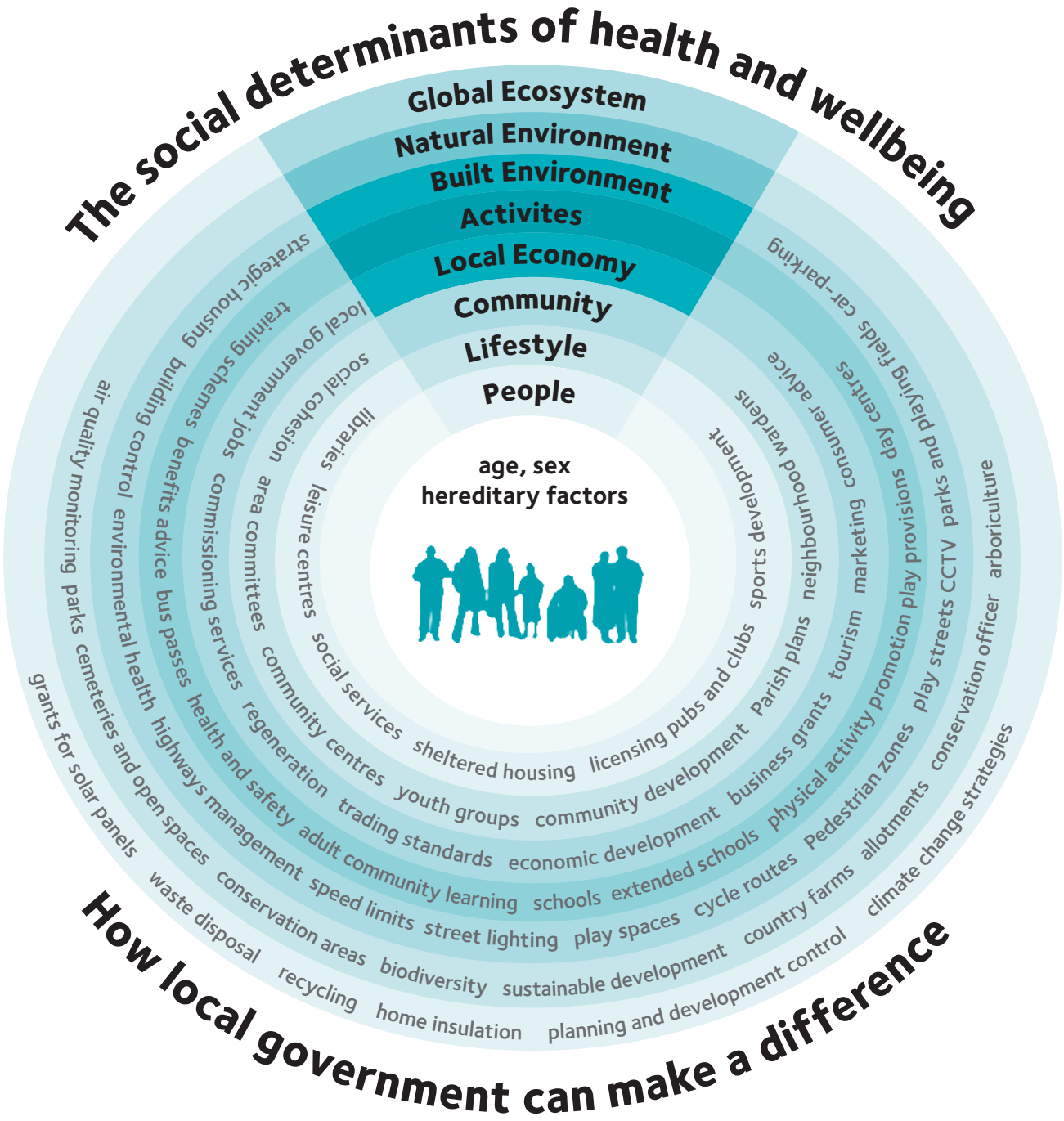
Health inequalities are differences in health experiences and outcomes between individuals or groups. Both Camden and Islington have large health inequalities. Islington has the lowest life expectancy for men in London. While life expectancy in Camden is higher than the England average, this masks large inequalities *within* the borough, where men in the most deprived areas live on average 11 years less than those in the most affluent areas. Recent data from the 2011 Census on people reporting not being in 'good health' also highlights the stark differences in health between those in routine jobs (e.g. labourers) and those in higher professional jobs (e.g. lawyers). Nationally, Islington has the largest 'health gap' between different types of workers, and Camden has the third largest 'health gap' for men, again highlighting the stark differences in health outcomes for different residents.

The fundamental drivers of health inequalities are inequities in power, money and resources. All of these things impact on the conditions of people's daily lives: their early years and educational attainment, employment prospects, housing conditions, living environment and the ability to afford a 'healthy lifestyle'. These are the 'social determinants of health' **(figure 1)**. The impacts of these accumulate throughout people's lives, from conception to old age, and are deeply entrenched within particular communities and areas. For example, a child's health is significantly influenced by the socioeconomic status of its parents, which will most likely determine their life chances in terms of education, employment, and housing, to name a few. Children in poorer families are more likely to be born prematurely, are at greater risk of dying in childhood, and in later life are at higher risk of developing long term conditions, such as heart disease, and of dying prematurely.

"Serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, 'bad', unhealthy behaviour, or differences in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society."

Fair Society, Healthy Lives: The Marmot Review, 2010

Figure 1: The social determinants of health and wellbeing



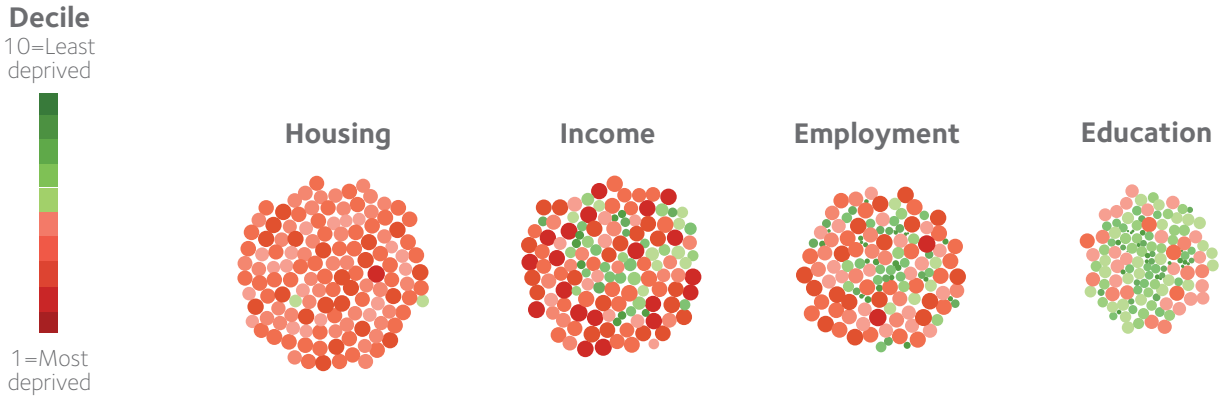
Source: Campbell F (2010). The Social Determinants of Health and the Role of Local Government. London: Improvement and Development Agency (IDeA). http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/3510830/ARTICLE

The Index of Multiple Deprivation (IMD) is a useful way of summarising deprivation across the different domains of the social determinants of health; However, the data used to construct the domains are getting old now (mainly from around 2008) which needs to be borne in mind when looking at this. As measured by the Index of Multiple Deprivation (IMD), Camden and Islington fare worse than the England average for most of the social determinants of health **(figure 2)**. The exception is education, where both boroughs are about average nationally. Strikingly, for nearly all of the social determinants, the variation in the levels of deprivation within both boroughs is large, highlighting the inequalities between different population groups and places.

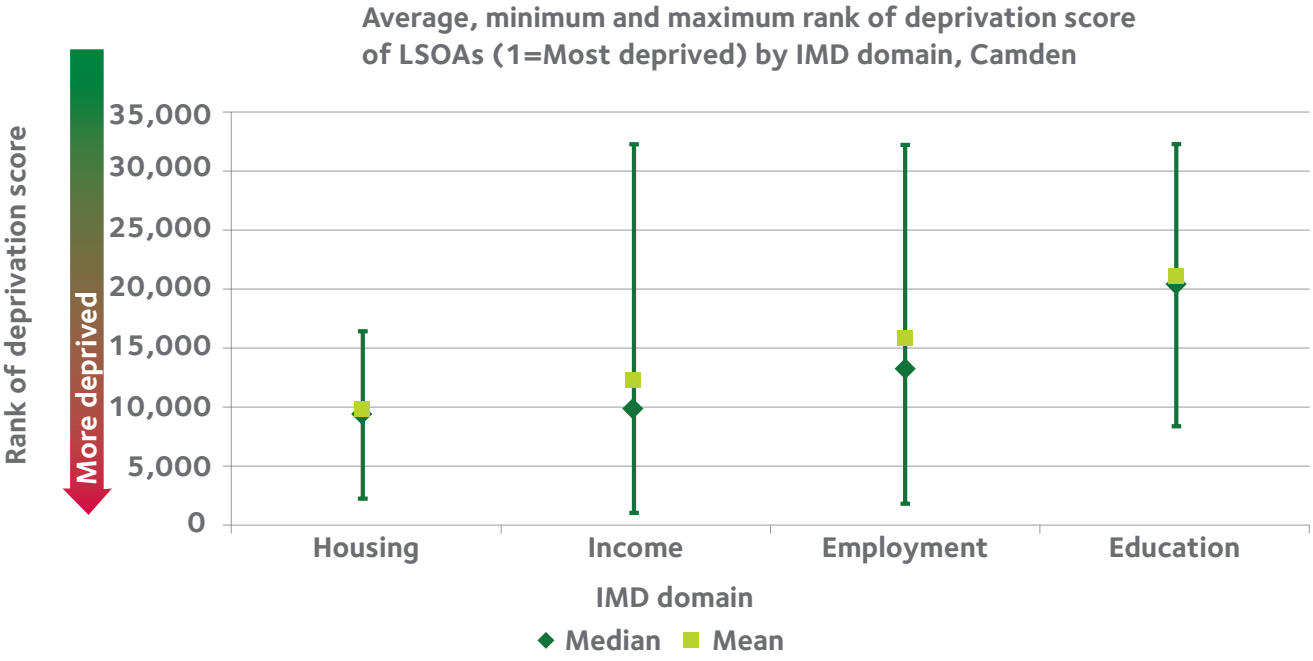
Figure 2: Social determinants of health in Camden and Islington: level of deprivation by domain

Camden

a) By small area (Lower Super Output Area)



b) Average rank



Source: Department for Communities and Local Government (2010), Index of Multiple Deprivation

How to interpret the bubble diagram:

The bubble diagram shows three things: a) the deprivation domains that form part of the councils' strategic priorities, b) the colour of the bubbles shows how small areas within each domain compare to England, and c) the size of the clusters show how deprivation domains compare within the borough.

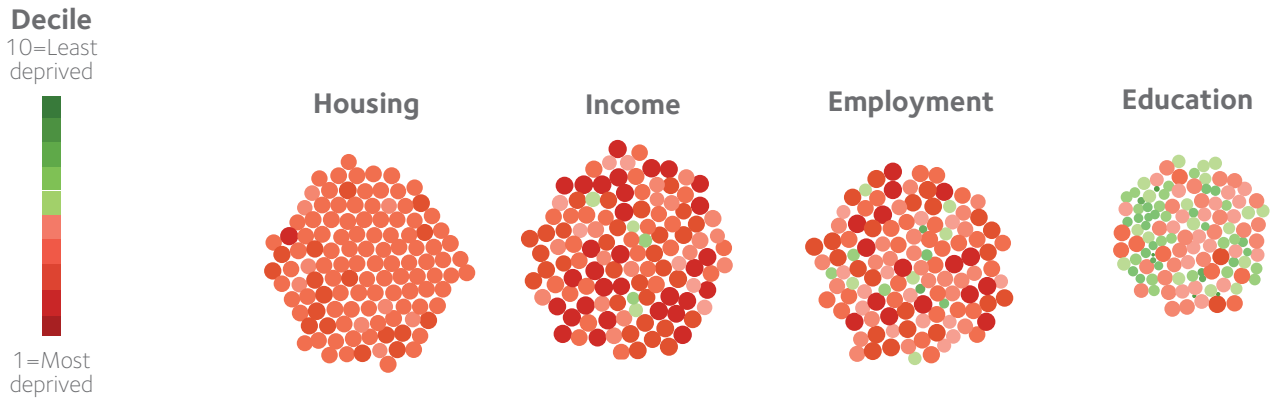
Specifically, each bubble represents a small area (Lower Super Output Area (LSOA), a geographical area of about 1,500 residents) within the borough. The colour represents the national decile of each LSOA for the respective deprivation domain, showing how LSOAs within the borough compare to England. The bubble size shows the rank of deprivation score: the larger the bubble, the more deprived the LSOA. This means a larger cluster of bubbles indicate the borough is more deprived for that domain than other domains.

For example, a large cluster with mostly red bubbles means that domain is worse than others and the borough is more deprived compared to England.

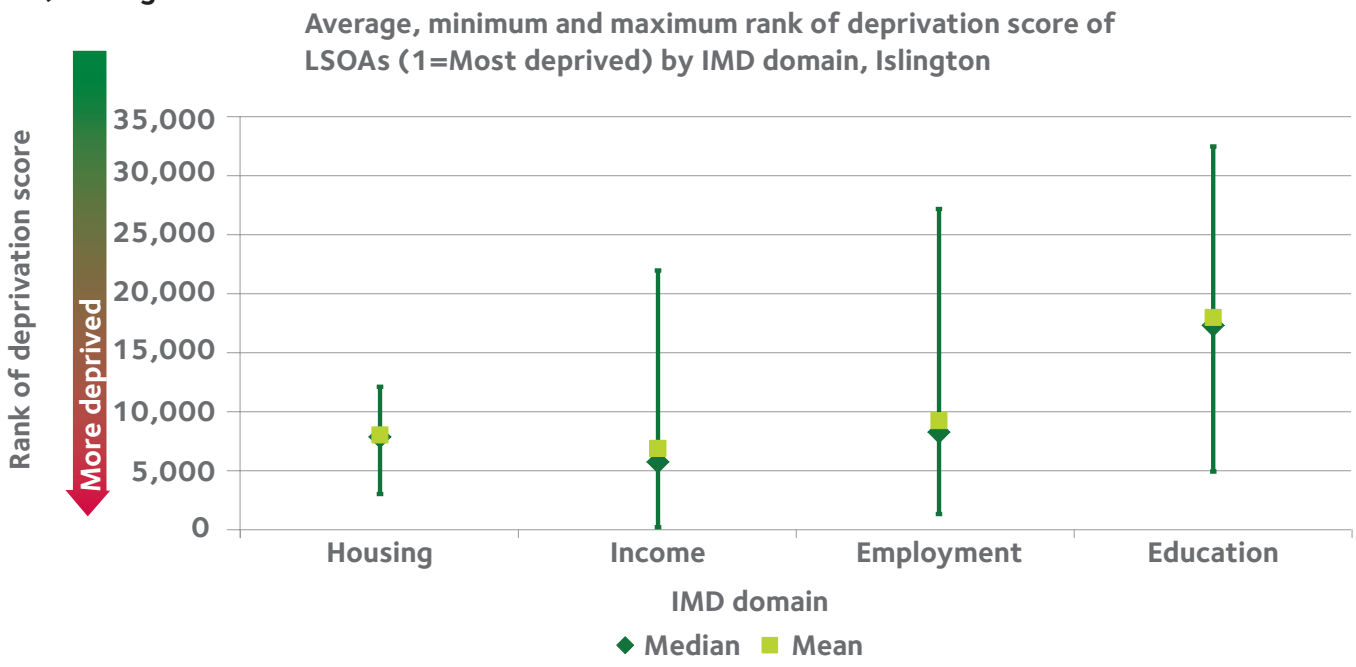
Figure 2: Social determinants of health in Camden and Islington: level of deprivation by domain

Islington

a) By small area (Lower Super Output Area)



b) Average rank



Source: Department for Communities and Local Government (2010), Index of Multiple Deprivation

Maintaining and strengthening the focus on health inequalities in Camden and Islington is timely, as the current prolonged period of economic austerity is likely to have widened inequalities locally. Based on national evidence from previous recessions, those worst affected are likely be people on low incomes, those vulnerable to unemployment (e.g. low-skilled workers), and those who do not have the material or psychosocial resilience to deal with problems. Against a background of existing high mental health need in both boroughs, the recent financial crisis is also likely to have had a significant impact on mental health and wellbeing, because of economic stressors caused by reduced income, debt, poverty, unemployment and job insecurity. Of particular concern is the impact on young people who are struggling to find work and the enduring impact this will have on their lives.

Approaches to tackling health inequalities

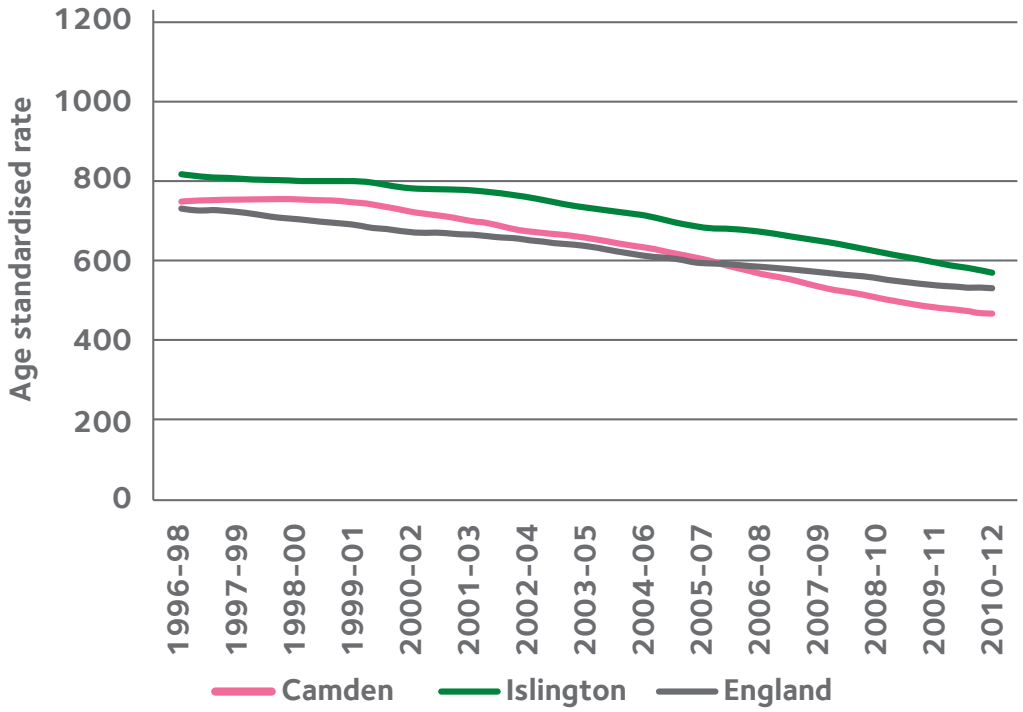
There have been a number of different strategic approaches taken by national Government to tackling the root causes of health inequalities. In 1998, the independent Acheson inquiry was commissioned to improve understanding of health inequalities, their causes and how to tackle them. This was followed by the Government setting national targets to narrow health inequalities between the richest and the poorest in society by 2010, as measured by life expectancy at birth and infant deaths. The NHS was at the forefront of delivering on these targets, tackling the key causes of early death through health interventions. These include: reducing smoking in routine and manual workers, preventing and managing other risk factors for heart disease (e.g. prescription of high blood pressure tablets), earlier diagnosis of cancer (e.g. screening), together with steps to improve the early diagnosis and management of long term conditions. The contribution of NHS services towards reducing health inequalities, particularly in terms of achieving an impact in the short to medium term, remains important.

Following the publication of the Department of Health's health inequalities strategy *A Programme for Action (2003)*, Camden and Islington Primary Care Trusts (PCTs) had to ensure that tackling health inequalities was central to their planning, and they were performance managed by the Department of Health on progress against targets. To help focus resource, the Department of Health identified 70 'spearhead' local authority areas — the group of areas with the highest levels of deprivation and poor health outcomes, which included Islington but not Camden. Targets were focussed towards closing the gap between these 'spearhead' areas and the rest of England. Unfortunately, although health outcomes improved across both groups of local authorities, the gap in life expectancy between the spearhead areas and the rest of England continued to widen. A National Audit Office report into why these targets were not met by 2010 concludes that it needed time to embed health inequalities into policy and planning frameworks within the NHS; that the evidence base for what PCTs should do to reduce health inequalities was not available for a few years; that interventions were not implemented at sufficient scale; and that performance management focussed on achievement of the overall targets, but not on whether key interventions were being implemented.

To develop a new post-2010 health inequalities strategy, the Department of Health commissioned an independent review by Professor Sir Michael Marmot. His report, Fair Society, Healthy Lives (2010), focussed on the impact of the social determinants of health including education, employment and housing on health inequalities. This was influential in the Coalition Government's decision to move public health functions back into local authorities, where they are closer to and have more influence over

Figure 3: Trends in deaths per 100,000 population, Camden, Islington, and England, all ages, 1996-98 to 2010-12

a) All causes



b) Heart disease

c) Cancer

Source: Health and Social Care Information Centre, 2013

social determinants of health. In addition to the stronger focus on the social determinants of health, the Coalition Government has also moved away from centralised targets and will rely on incentives and transparency in health outcomes supported by the new Public Health Outcomes Framework (PHOF) to drive improvement. There is also a new focus on *within* borough inequalities, which is particularly relevant for Camden.

National policy on health inequalities has until recently tended to focus on the NHS and indeed the Health and Social Care Act 2012 places specific legal duties on the Secretary of State for Health, for the first time, in relation to reducing health inequalities. But local government has also been working to reduce health inequalities for many years, particularly in areas like Camden and Islington, where poor health is a key issue and there have been strong partnerships between the local authority and the local NHS. There have been various policy initiatives setting out the role for local government intervention in health inequalities, with increasing emphasis on earlier intervention and prevention in social care. Sir Michael Lyon's report on local government as a 'place shaper' was also influential in setting out how local authorities could work towards reducing health inequalities by bringing together local stakeholders and developing a vision for their area.

Locally, reducing health inequalities has been a priority in both boroughs for many years, with Camden and Islington Councils working in partnership with the local NHS, and specifically the public health teams prior to April 2013. In Camden, previous annual public health reports have highlighted key health inequalities within the borough. Reducing health inequalities through

increasing life expectancy in the most deprived areas is central to delivering the council's vision of making Camden a better borough, as set out in the Camden Plan. Camden's Equality Taskforce in its final report published in May 2013, issued six recommendations focussed on addressing some of the critical, structural determinants of inequality in the borough, many of which should lead to reductions in health inequalities. In Islington, a health inequalities strategy was developed by the London Borough of Islington and Islington PCT in 2010, which outlined actions that would be taken to reduce inequalities within the short, medium, and longer terms. In 2010, Islington Council's Fairness Commission also made recommendations for what more should be done to reduce health inequalities locally. Camden's and Islington's Health and Wellbeing Boards now have the responsibility of overseeing efforts to tackle health inequalities locally, with democratic oversight by each council's existing health scrutiny committees. The transition of Public Health from the NHS into local government from April 2013, and the creation of Camden and Islington's joint Public Health Department, presents us with a good opportunity to renew and refocus efforts on reducing health inequalities in the two boroughs.

Principles for future action

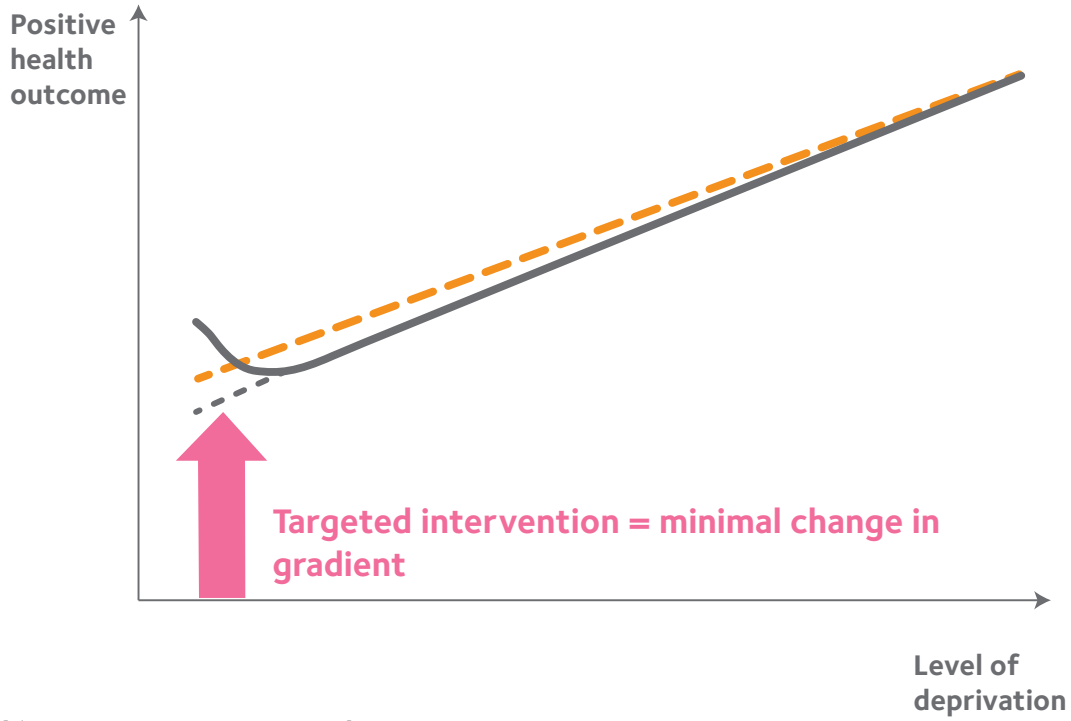
Given that previous approaches to tackling health inequalities have often had only a limited impact on reducing the gap between the most and least deprived, it is worth reflecting on the principles that should underlie future actions on health inequalities in Camden and Islington. These principles are based on national evidence from academic research, appraisals of "what works" from organisations like the National Institute for Health and Care Excellence (NICE), and evaluations of past strategies.

It is not just the most deprived in society who experience the effects of health inequalities. There is a '**social gradient in health**' whereby health status gets progressively worse as people's social position gets lower. While more intensive action is needed for the most socially and economically disadvantaged, focussing solely on them will only tackle a small part of the problem **(figure 4)**. This is because many more people are in poor health in Camden and Islington than just those who are most deprived. This means that actions must be universal but with a scale and intensity which is proportionate to the level of disadvantage. This is known as '**proportionate universalism**'. For Camden and Islington, this means understanding the social gradient in health for a specific need (e.g. which groups are impacted by unemployment and by how much) and making sure that any interventions to tackle health inequalities are specifically designed to address this gradient at the right level of intensity for different population groups or in specific places.

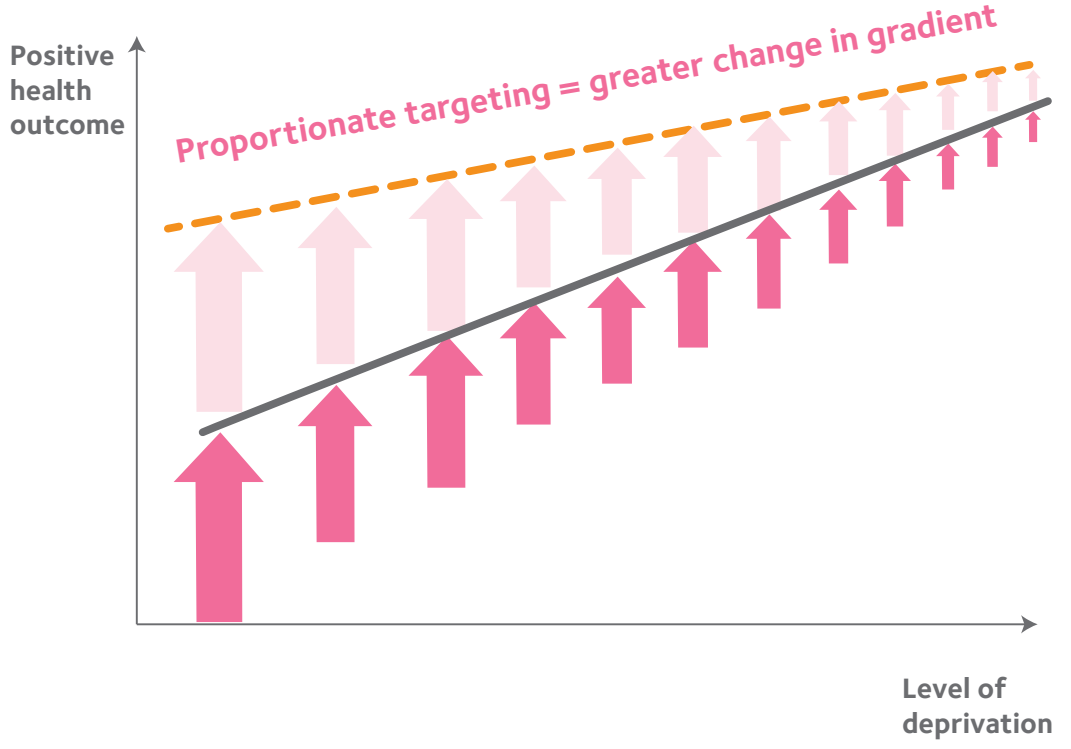
Disadvantage, which leads to poorer health outcomes, accumulates across the whole of people's lives, starting from conception **(figure 5)**. To tackle health inequalities therefore, disadvantage at every stage of a person's life needs to be addressed. This is known as a 'life course approach'. To break the inter-generational cycles of inequalities for example, the focus needs to be on improving the lives of children. Indeed, of the six priority objectives outlined in The Marmot Review: *Fair Society, Healthy Lives*, giving children the 'best start in life' was identified as the most important one to reduce health inequalities. Actions in pregnancy and the early years are particularly vital and effective in reducing long term inequalities and there is a strong and growing body of evidence to show a good return on investment in these early years. This approach is encapsulated in Camden's and Islington's focus on improving the life of children from the outset by improving access to high quality care and support in pregnancy, supporting mothers to breastfeed, providing support through Children's Centres, and encouraging

Figure 4: The theoretical effect of different strategies to tackle health inequalities

a) Targeted approach



b) Proportionate universalism



Source: Health Lives, Healthy people in Newcastle – presentation by Dr Khaw (2011). Available at: http://www.cvsnewcastle.org.uk/assets/files/healthy_lives_healthy_people_dr_khaw.pdf

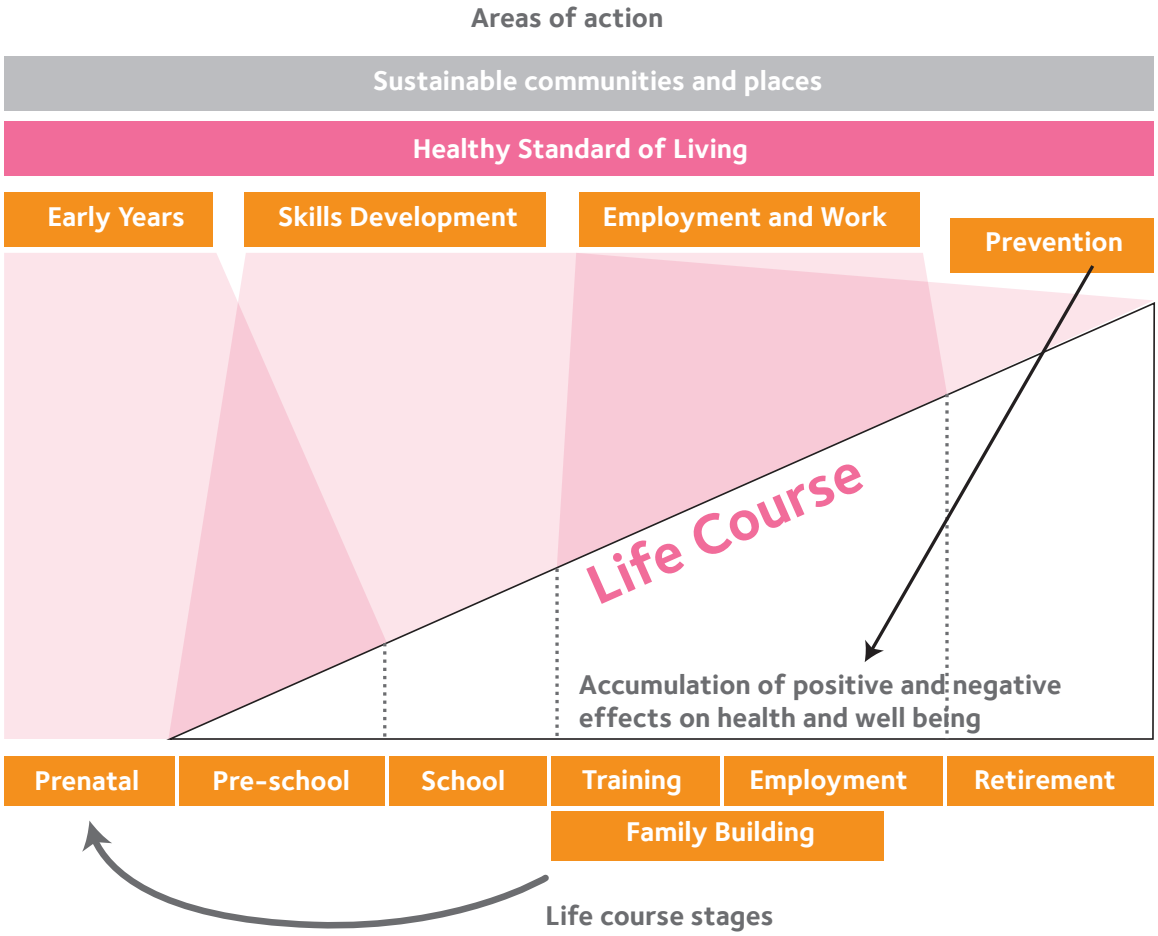
parents to get their children vaccinated. It also extends to ensuring that there is support for parents to find a 'good job' so that children are not being brought up in workless households, and that families are able to live in stable and good quality accommodation.

Given the projected increases in the number of children and young people over the coming years, particularly in Islington and to a lesser extent in Camden, maintaining this focus on children and young people will remain crucial in tackling health inequalities.

In contrast to supporting someone to quit smoking or to take high blood pressure tablets, many of the interventions tackling the social determinants of health will have an impact on health and wellbeing over a much longer time period **(table 1)**. Getting a family into stable accommodation may improve a child's absence record at school and exam results in the short term, but will only impact on their chances of maintaining good health over many years. This means **investing for the future**. While returns will not be realised immediately there is a lot of evidence to suggest that prevention and early intervention is more cost-effective than cure. In making prioritisation and investment decisions, therefore, a balance needs to be struck between interventions that will have a shorter term impact on health inequalities and ones that will improve outcomes over the longer term and for future generations.

Given the wide reaching, complex and intractable nature of health inequalities, tackling them requires a **whole systems approach** across the whole spectrum of work of local, regional and national governments, the NHS, the private sector, and the community and voluntary sectors.

Figure 5: Action across the life course



Source: Marmot M (2010). Fair Society, Healthy Lives: The Marmot Review. London: UCL The Institute of Health Equity
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

This can be achieved through strengthening partnership working as well as further collaboration between different service areas and commissioners (those who purchase services) within organisations. The **indirect impacts** of one social determinant on another means that most is to be gained by collaborating across the different determinants and designing pathways and services that address more than one determinant at once. In some instances it may require supporting a particular population group (e.g. Asian men) while in other cases it may require addressing health needs within a particular geographical area, through local regeneration, for example. Understanding how direct action on one social determinant of health will impact indirectly on other social determinants of health should also be an important factor in deciding where to intervene and to invest resource **(table 1)**.

Table 1: Impacts of actions on health outcomes
a) Direct impacts

Area	Scale of problem in relation to public health	Strength of evidence of actions	Impact on health	Speed of impact on health	Contribution to reducing inequalities
Best start in life	Highest	Highest	Highest	Longest	Highest
Healthy schools and pupils	Highest	Highest	Highest	Longer	Highest
Jobs and work	Highest	Highest	Highest	Quicker	Highest
Active and safe travel	High	High	High	Quicker	Lower
Warmer and safer homes	Highest	Highest	High	Longer	High
Access to green spaces and leisure services	High	Highest	High	Longer	Highest
Strong communities, wellbeing and resilience	Highest	High	Highest	Longer	High
Public protection	High	High	High	Quicker	High
Health and spatial planning	Highest	High	Highest	Longest	Highest

Source: Buck D & Gregory S (2013). Improving the public's health. A resource for local authorities. London: The King's Fund. http://www.kingsfund.org.uk/publications/improving-publics-health

Table 1: Impacts of actions on health outcomes
b) Indirect impacts

Impact from...	Impact on...							
	Best start in life	Healthy schools and pupils	Jobs and work	Active and safe travel	Warmer and safer homes	Access to green spaces and leisure services	Strong communities wellbeing and resilience	Public protection
Best start in life		Highest	Highest	Lower	Lower	Lower	Higher	Lower
Healthy schools and pupils	Lower		Highest	Lower	Lower	Lower	Higher	Lower
Jobs and work	Higher	Higher		Lower	Higher	Lower	Higher	Lower
Active and safe travel	Lower	Lower	Lower		Lower	Higher	Lower	Higher
Warmer and safer homes	Higher	Lower	Higher	Lower		Lower	Higher	Lower
Access to green spaces and leisure services	Lower	Lower	Lower	Highest	Lower		Higher	Higher
Strong communities, wellbeing and resilience	Lower	Lower	Higher	Lower	Lower	Lower		Lower
Public protection	Lower	Lower	Higher	Lower	Higher	Lower	Lower	
Health and spatial planning*	Lower	Lower	Higher	Highest	Highest	Highest	Highest	Highest

*NB Spatial planning is not represented as an area that is affected by the others, since it 'sits outside' those areas; its crucial impact is in terms of how objectives of activities in the other areas are planned and delivered through spatial planning.

Source: Buck D & Gregory S (2013). Improving the public's health. A resource for local authorities. London: The King's Fund. http://www.kingsfund.org.uk/publications/improving-publics-health

Finally, decisions about which social determinants of health to prioritise, which population groups or geographical areas to focus on, and which interventions to implement should all be based on **robust analysis of need** (as set out in the Camden and Islington Joint Strategic Needs Assessments (JSNAs)), what the **evidence** shows works and rigorous monitoring and **evaluation**. This also includes residents' views on what helps them to have 'good health and wellbeing' and where there are opportunities for improvement. This is particularly important given the current financial constraints in the public sector and local government in particular, and local areas need to be sure that they are making best use of more limited public funds to improve health and wellbeing and reduce health inequalities.

The rest of this report

Chapter 1 describes the current state of health inequalities in Camden and Islington, looking specifically at the life expectancy gap and health status between the richest and poorest in both boroughs. Focussing on key social determinants that align with the corporate priorities of both Camden and Islington Councils, **chapters 2 to 5** look at health inequalities in employment, housing, education and supporting people to have a healthy standard of living. This includes what the impacts of these social determinants are on health inequalities, a description of the local situation, what interventions have worked elsewhere, and examples of local projects and residents' views. Finally, **chapter 6** sets out an approach and recommendations for further action on health inequalities in Camden and Islington, with a focus on social determinants.

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1. Health inequalities in Camden and Islington

There are health inequalities in all local authorities in England. Camden and Islington are no exception. However, despite improvements in some health outcomes in both boroughs in recent years, Camden and Islington remain characterised by stark inequalities in health. This includes Islington having the largest health inequalities gap between occupational groups in England for both men and women, followed closely by Camden. The pattern of health inequalities is different in the two boroughs, however, requiring different approaches to tackling the problem.

Camden

Life expectancy in Camden has increased at a faster rate than England over the past ten years, and is now higher than the national average for both men (80.5 vs 79.2 years) and women (85.4 vs 83.0 years). The absolute improvement in life expectancy since 2000-02 was the largest of any local authority in England. This improvement in life expectancy has been driven by fewer deaths from heart disease, cancer, and chronic lung disease — the three main causes of death. The most common causes of cancer deaths, that is, lung, breast, prostate and bowel cancer, have all fallen over time.

Has the health inequalities gap widened or narrowed?

The life expectancy gap between the most and least deprived areas has shown no consistent trend in Camden, similar to England. However, deaths from heart disease may have fallen at a faster rate in the most deprived areas, but there is no clear pattern for cancer deaths. It is not clear whether the trend in Camden is the result of gentrification of more deprived areas, or successful interventions, such as smoking cessation or improvements to housing conditions.

Despite the fact that the gap in life expectancy has not widened, there is evidence to suggest that the poorest are being left behind: proportionately more people in the most deprived areas have reported poor health over the past 10 years. Furthermore, Camden has one of the largest health gaps in England in terms of people living in "not good health" across occupational groups: the third largest health gap for men and the seventh largest for women. This highlights the large health inequalities in the borough which are masked by good life expectancy overall.

What are the geographical patterns?

There are stark geographical health inequalities in Camden. People suffering from poor general health, mental ill health, and low life expectancy are generally concentrated in a few, deprived wards in the borough including St Pancras and Somers Town, Haverstock, and Kilburn. In contrast, residents in the most affluent parts of the borough have longer life expectancy, better general health, and fewer mental health problems than the England average. The stark inequalities at a geographical level in Camden demand an area-based, targeted approach to reduce health inequalities **(maps 1 & 2)**.

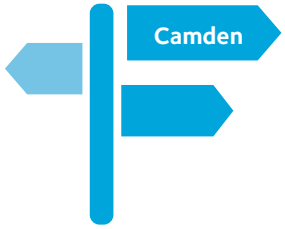
The most deprived people in the borough are not only more likely to suffer from ill health than the most affluent; they also tend to be sicker with multiple long term conditions. The

long term conditions most strongly associated with deprivation in Camden (adjusted for age) are diabetes, learning disabilities, chronic lung disease and chronic liver disease. At the level of individual Camden residents, it is not possible to say whether ill health follows deprivation or deprivation follows ill health, but we do know from national studies that there is a complex causal relationship between ill health and deprivation.

Who's living in poor health?

Although the prevalence of living in poor health increases with age, two-thirds of Camden people living in poor health are under 65 years of age. While people's health generally deteriorates as they get older, in Camden people start experiencing poor health earlier than in England, when residents are middle-aged. Almost half of people reporting poor health are White British, and more than one-in-six are Asian and one-in-eight are 'Other White' ethnic groups[1]. This largely reflects the ethnic profile of Camden's population. It is some of the smaller ethnic groups, however, that experience the starkest health inequalities. Notably, White Irish people are more than twice as likely to be living in poor health compared to the Camden average. Unusually in the Irish population the proportion of middle-aged people who report poor health is the same as in the older-age group[2]. In contrast, there is a clear relationship between age and poor health among Asian ethnic groups, with older Asians being almost twice as likely to be in poor health compared to the Camden average for over 65s.

Has the health inequalities gap widened or narrowed?



What are the geographical patterns?

Who's living in poor health?

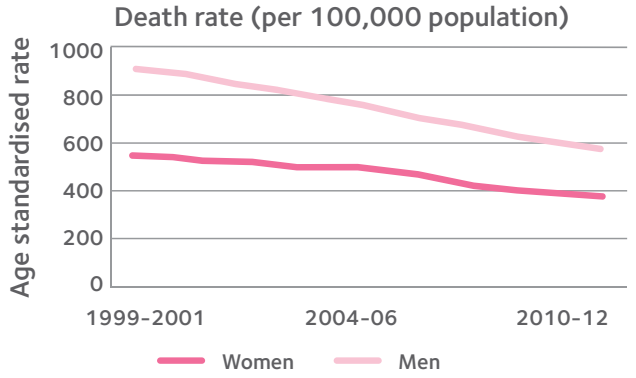
[1] This is based on people reporting "bad" or "very bad" health in the Census 2011. The difference between Camden and England is less clear for people reporting "not good health" (defined as "fair", "bad", or "very bad" health).

[2] Again, this is based on people reporting "bad" or "very bad" health in the Census 2011.

Health inequalities: the Camden story

Camden

The death rate is falling across Camden. [a]



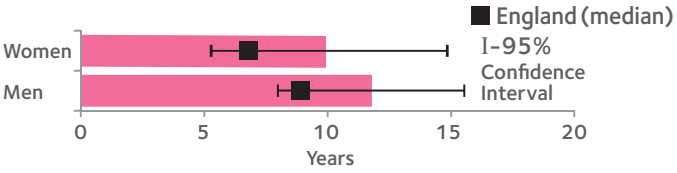
The slope index of inequality is a measure of the health gap, which accounts for inequality between all groups.

For example, a value of 12 years means the people who are worse off people can expect to live 12 years less than the people who are best off.

Life expectancy in Camden is **now higher than the England average**, for both men and women. b) 2010-12

However, there are large inequalities between the best and worst off within Camden: c) 2010-12

Slope index of inequality for life expectancy



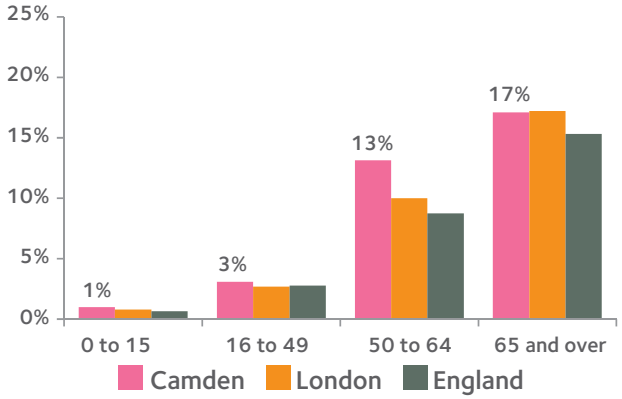
Deprivation

People who are worse off are 1.5-3 times more likely to suffer from health problems:

Age

Camden residents start to experience **poor health** at an earlier age. f) 2011

People reporting bad or very bad health



Ethnicity

f) 2011

The age-related pattern of bad or very bad health is even starker for some ethnic groups:

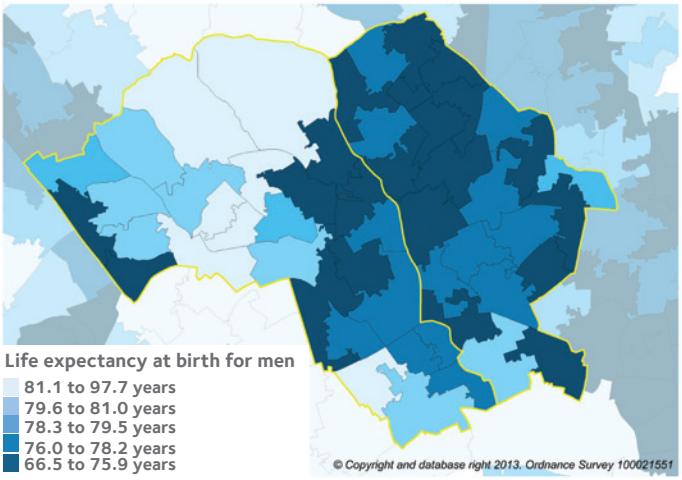
390
(23%) White Irish 50-64 year olds report bad or very bad health compared to the average of 13% for 50-64 year olds.

590
(30%) Asian/Asian British people aged 65+ in Camden report bad or very bad health compared to 17% of people aged 65+ overall.

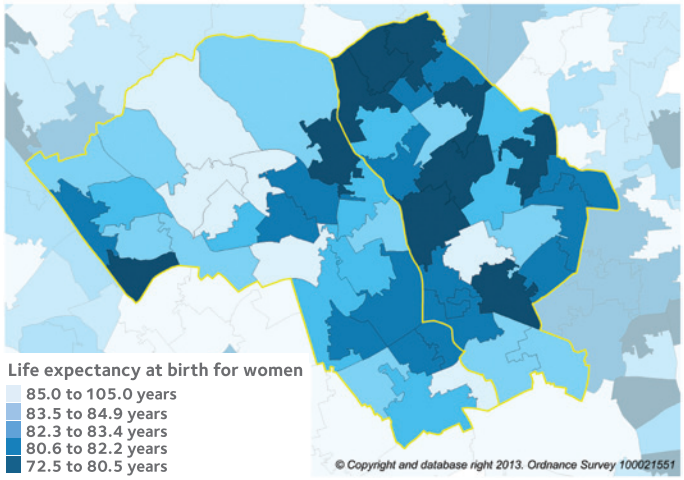
Sources: a) HSCIC Indicator Portal (2013); b) ONS, Life expectancy at birth in England and Wales (2013); c) Public Health England, Public Health Outcomes Framework (2014); d) Adapted from ONS, Health Gap in England and Wales (2013); e) Camden and Islington Public Health Intelligence (2013); f) ONS, Census 2011 (2013)

Map 1: Life expectancy for men and women by Middle Super Output Area (MSOA), Camden and Islington resident populations, 2006-10

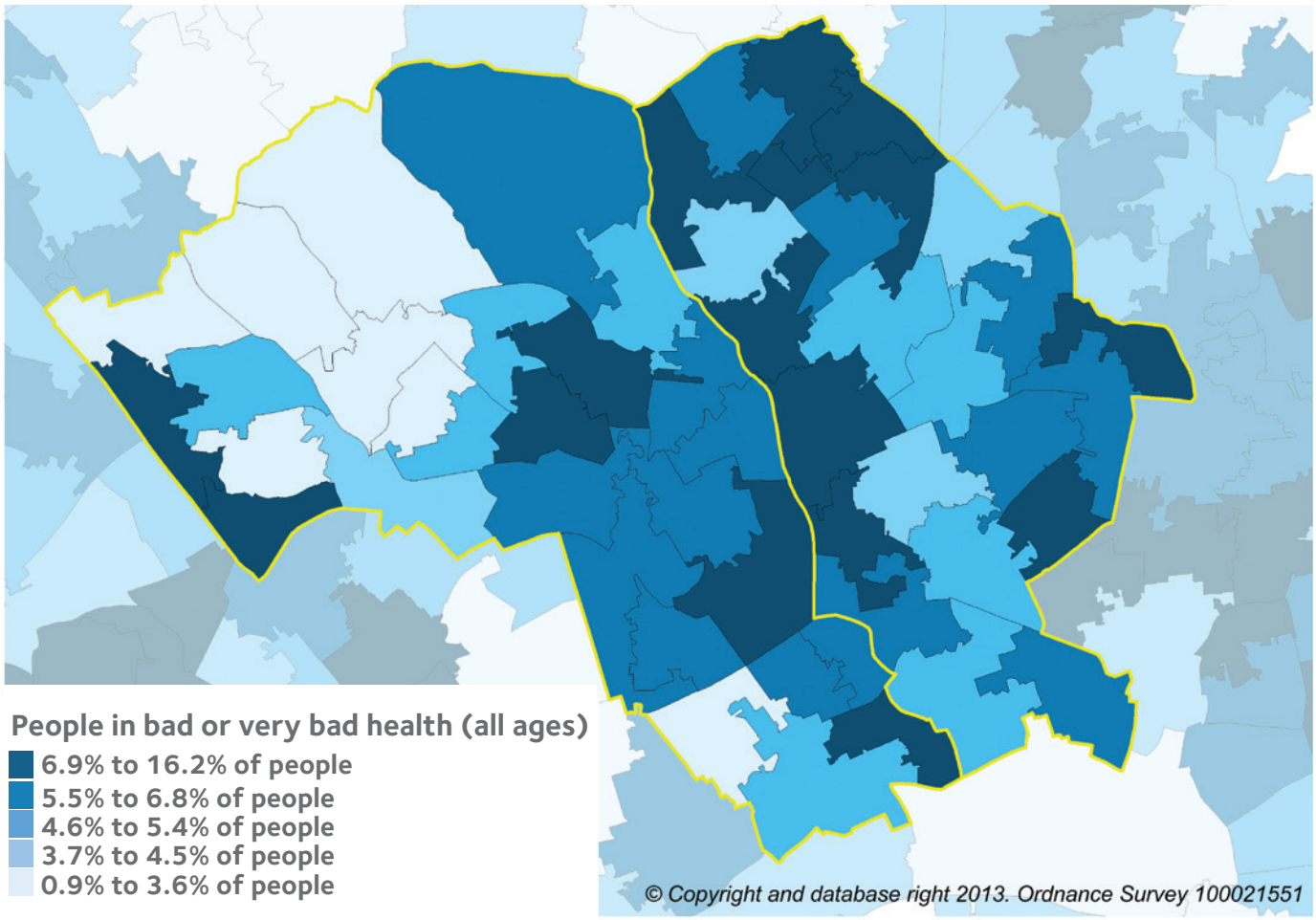
a) Men



b) Women



Map 2: Percentage of people reporting bad or very bad health by Middle Super Output Area (MSOA), Camden and Islington resident population, 2011



Mita's story, Camden

Mita is in her mid-thirties and arrived in Camden 16 years ago from Bangladesh. She lives with her husband and four children in a flat. She has a four-year-old daughter Chandra, and three boys aged between 10 and 14. Hasan, her 10-year-old son is disabled.

Hasan needs around-the-clock care. He sleeps in a bedroom with his two parents, which they lock at night time as he only sleeps for a few hours and then wants to run around the house. There is obvious love and affection in the family, but Mita describes it as "a very hard life". Often Mita's husband will look after Hasan in the night and she will look after him in the day.

The whole family suffers from a range of different health complications. Mita suffers from physical conditions including a trapped nerve in her brain, along with depression, which she partly attributes to the high levels of stress when Hasan was born and was very unwell. Mita's husband suffers from Type 2 diabetes. Hasan has complex health conditions, and requires five to six regular medications a day, along with regular hospital appointments. In addition her daughter has to have regular hospital appointments because of poor eating and persistent infections. During my visit, both Hasan and Chandra are off school unwell.

Mita visits her GP several times a week, for herself or her children, and the staff know her to say hello. She says that she has noticed her GP becoming less accommodating towards disabled children. Before they would be seen as soon as possible, whereas now they often have to wait which is hard as Hasan struggles to sit down. Recently she has had difficulty getting medication for Hasan. The hospital had no supplies of one of the medications and the staff told her to go to the GP. The GP in turn signposted them back to the hospital. They have now been waiting over a week which is worrying Mita.

Neither Mita nor her husband work. Mita's husband has been advised to work for no more than 16 hours a week, on account of his health. Previously he worked in a casino, but after the business folded he has not worked. The family receives income support, invalidity carers allowance, child benefits, housing and Council tax benefits, and child tax credits. They have noticed their benefits have not increased but the rent has gone up. Money is a struggle for them and "there is nothing left at the end". They have found it hard since Mita's husband lost his job to maintain the lifestyle they are used to.

Source: Aylott M, Norman W, Russell C, Sellick V. An insight into the impact of the cuts on some of the most vulnerable in Camden: A Young Foundation report for the London Borough of Camden. The Young Foundation; 2012. http://youngfoundation.org/publications/an-insight-into-the-impact-of-the-cuts-on-some-of-the-most-vulnerable-in-camden/url.

Islington

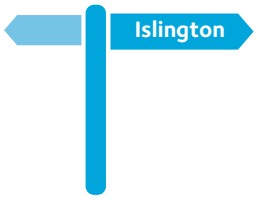
Life expectancy in Islington has increased for both women and men over the past ten years. It is now similar to England for women (83.2 vs 83.0 years) but it is still lower for men (77.8 vs 79.2 years). The improvement in life expectancy has mostly been driven by fewer deaths from heart disease, and to a lesser extent chronic lung disease and cancer. There is no clear spatial pattern in life expectancy. This is because the most and least deprived people live side-by-side.

Has the inequalities gap widened or narrowed?

The distribution of poverty and deprivation and the low life expectancy across Islington means that when measured, the life expectancy gap is narrow. However, this probably does not reflect the true scale of inequality in the borough: based on people reporting "not good health" across occupational groups, Islington has the largest estimated health gap in England for both men and women. The narrow life expectancy gap more likely shows the limitations of the methods used to measure inequalities using deprivation.

There has been no consistent trend in the life expectancy gap for Islington, similar to England. However, there is some evidence to suggest that improvements in life expectancy have not been shared equally across the population: deaths from heart disease may have fallen at a faster rate in less deprived areas. Heart disease is still the largest contributor to the life expectancy gap for men, whereas for women it is heart disease and cancers.

When looking at socioeconomic groups, as reported in Census data, the gap between the proportion of people reporting poor health has become starker in the past ten years, suggesting that Islington's population are become more polarised.



What are the geographical patterns?

Low life expectancy, poor general health, and mental ill health, including chronic depression and psychotic disorders, are problems affecting almost all areas in the borough rather than being localised to particular wards. Overall most areas are classed as deprived compared to England. There are pockets of affluence, however, but better off people tend to live side-by-side with the people who are worst off. This means the whole borough needs to be targeted for interventions aimed at improving both physical and mental health and wellbeing **(maps 1 & 2)**.

Similar to Camden, the most deprived people in Islington are more likely to be living with poor health compared to the most affluent people. Among people diagnosed with one or more long term conditions, more deprived people are living with multiple long term conditions than less deprived people. This is likely to reflect the complex relationship between deprivation and ill health, with deprivation following ill health and ill health following deprivation.

Who's living in poor health?

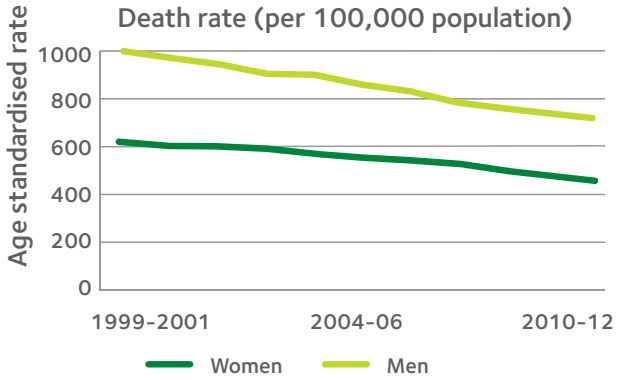
Two-thirds of people reporting poor health in Islington are aged less than 65 years[3]. Compared to England, both middle aged and older people in Islington have a notably high level of poor health. Almost half of people living in poor health are White British, one-in-six are White Other, and one-in-eight are Black. This largely reflects the ethnic profile of Islington's population. However, as with Camden, some of the smaller ethnic groups experience the starkest health inequalities. White Irish people have the highest level of poor health overall and 'Other' ethnic groups have the highest level of poor health in those aged under 65 years. More than a third of the 'Other' ethnic group are Arab, Iranian, and Kurdish, while Turkish/Turkish Cypriot people account for a fifth.

[3] This is based on people reporting "bad" or "very bad" health in the Census 2011.

Health inequalities: the Islington story

Islington

The death rate is falling across Islington.[a]



The slope index of inequality is a measure of the health gap, which accounts for inequality between all groups.

For example, a value of 12 years means the people who are worst off people can expect to live 12 years less than the people who are best off.

Life expectancy is **lower than England for men**, and **similar to England for women**.

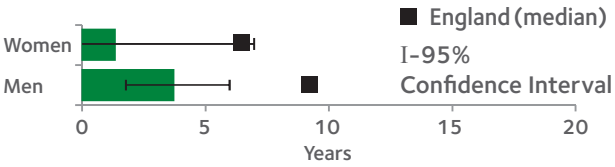
b) 2010-12

Islington: 77.8 years
England: 79.2 years

Islington: 83.2 years
England: 83.0 years

However, there are large inequalities between the best and worst off within Islington: c) 2010-12

Slope index of inequality for life expectancy



Deprivation

People who are worse off are 1.3 - 3 times more likely to suffer from health problems:

Not good health d) 2011 — **Social class 7** — **Social class 1**

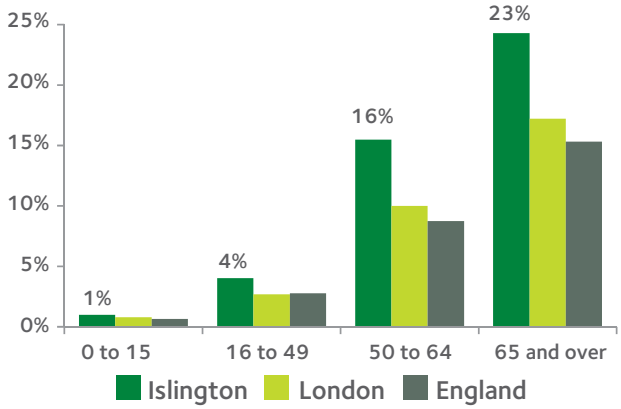
1+ conditions e) 2012 — **Most deprived** — **Least deprived**

3+ conditions e) 2012

Age

Islington residents start to experience poor health at an earlier age. f) 2011

People reporting bad or very bad health



Ethnicity

The level of bad or very bad health is particularly high for some ethnic groups: f) 2011

Islington average

6%
of all Islington residents rate their health as bad or very bad.

White Irish

12%
(1000) of White Irish residents in Islington rate their health as bad or very bad, double the Islington average.

'Other' ethnic groups

9%
(649) The equivalent figure for people from 'Other' ethnic groups, such as Arab, Iranian, Kurdish, and Turkish.

1/3
of people (120) in 'Other' ethnic groups aged 65+ report bad or very bad health.

Sources: a) HSCIC Indicator Portal (2013); b) ONS, Life expectancy at birth in England and Wales (2013); c) Public Health England, Public Health Outcomes Framework (2014); d) Adapted from ONS, Health Gap in England and Wales (2013); e) Camden and Islington Public Health Intelligence (2013); f) ONS, Census 2011 (2013)

Sam's story, Islington

Sam was born at the Royal Free Hospital and – just like her mother and grandmother – has lived in the Islington area all her life. She has a young son and lives with her husband, who is on Incapacity Benefit following a serious accident. Sam was recently diagnosed with type 1 diabetes. She has been trying to get her insulin dosage right but it has been an uphill struggle: "I was having hypos constantly (up to 3-4 times a day) and my life became very chaotic because these things were taking over my life.... The way you feel when it happens is very scary." It has made her life chaotic and left Sam feeling frightened about the impact of her condition on her life and on her future.

Sam's life now seems dominated by health appointments with weekly visits to the doctor, the diabetic nurse and a hospital dietician. She often forgets to fill out one of her many repeat prescriptions, and "it's always a last minute panic" because she's not used to it yet. She is also waiting for tests to show whether she has an underactive thyroid. Sam wants to get back into work but "it's because of the way I feel health-wise that I find it such a struggle".

Sam is still friendly with the people from her old job and has an open invitation to go back to work when she feels able. She was the co-chair of the PTA but has recently resigned as she felt poorly qualified for the role.

Source: Rocket Science. Invisible Islington: living in poverty in inner London. Cripplegate Foundation; 2008. http://www.cripplegate.org/wp-content/uploads/Invisible-Islington-Nov08.pdf

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2. Helping people find good jobs and stay in work

Being out of work is bad for people's health. Aside from a lack of money to afford a 'healthy' standard of living, the stress of unemployment causes depression and anxiety, and the loss of personal identity and social integration lowers wellbeing. However, not all employment is good. Being in a low paid, low quality job also detrimentally impacts on people's health as these jobs may be physically demanding and stressful.

The importance of 'good work'

People who are in low paid, low quality work are more likely to become unemployed or become dependent on benefits. These jobs are often more physically demanding and can lead to physical problems over time (e.g. back pain), potentially forcing people to leave work and move onto sickness benefits. They also tend to be more insecure, less rewarding jobs, so employees are more likely to develop depression or anxiety. In addition, this type of work can be inflexible, offering few contractual benefits (e.g. sick leave or carer's leave) or part-time working options. This makes it harder for people to deal with problems outside of work without losing their job and can trap them in a 'no-pay, low-pay' cycle.

What is 'good work'?

"Being without work is rarely good for one's health, but while '*good work*' is linked to positive health outcomes, jobs that are insecure, low-paid and that fail to protect employees from stress and danger make people ill." (Marmot, 2010)

Good work is:

- Secure and safe
- Enables the employee to have control over what they do and when
- Sufficiently demanding
- Pays a fair wage
- Offers opportunities for training and development
- Prevents social isolation, discrimination and violence
- Enables employees to participate in the organisation
- Promotes a good work-life balance
- Supports those who are disabled or returning from sick leave back into full time employment
- Contributes to employees feelings of self-efficacy, self-esteem, sense of belonging and meaningfulness

Adapted from Fair Society, Healthy Lives, The Marmot Review

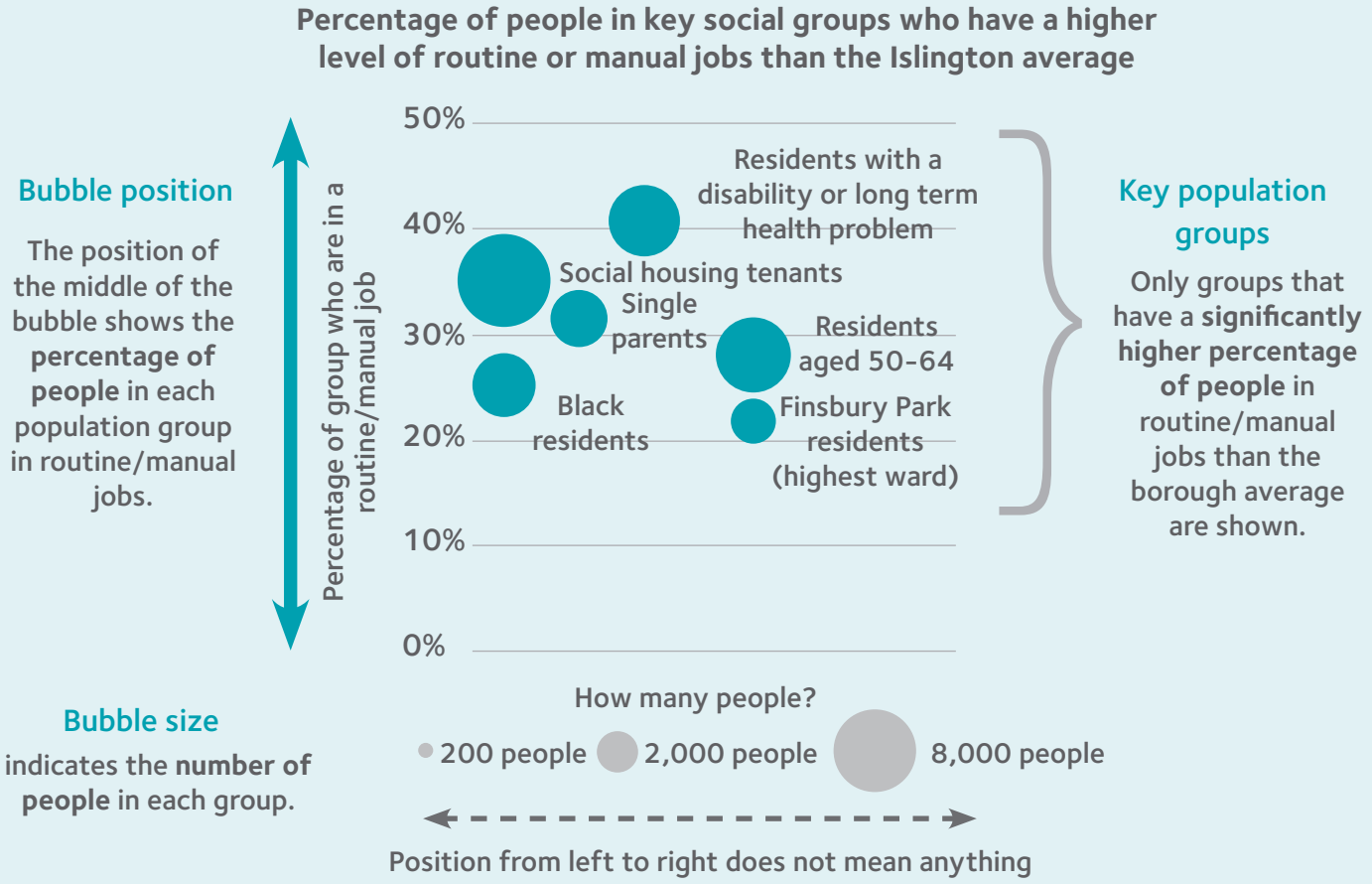
The importance of 'good work'

The impacts of being out-of-work

Key

Bubble charts: presenting three key points

These visualisations summarise three pieces of information in one place: **key population groups, percentages** and **numbers**. This visualisation looks at people in the working age population who are in routine or manual jobs.



Taking social housing tenants as an example, the visualisation shows:

- The percentage of working age social housing tenants who have routine/manual jobs is higher than the borough average.
- 35% of working age social housing tenants are in a routine/manual job.
- This is over 8,000 people.

Note: people can appear in more than one group, for example a social housing tenant who is also a single parent will be represented in two bubbles.

The local picture

What more can be done to reduce health inequalities?

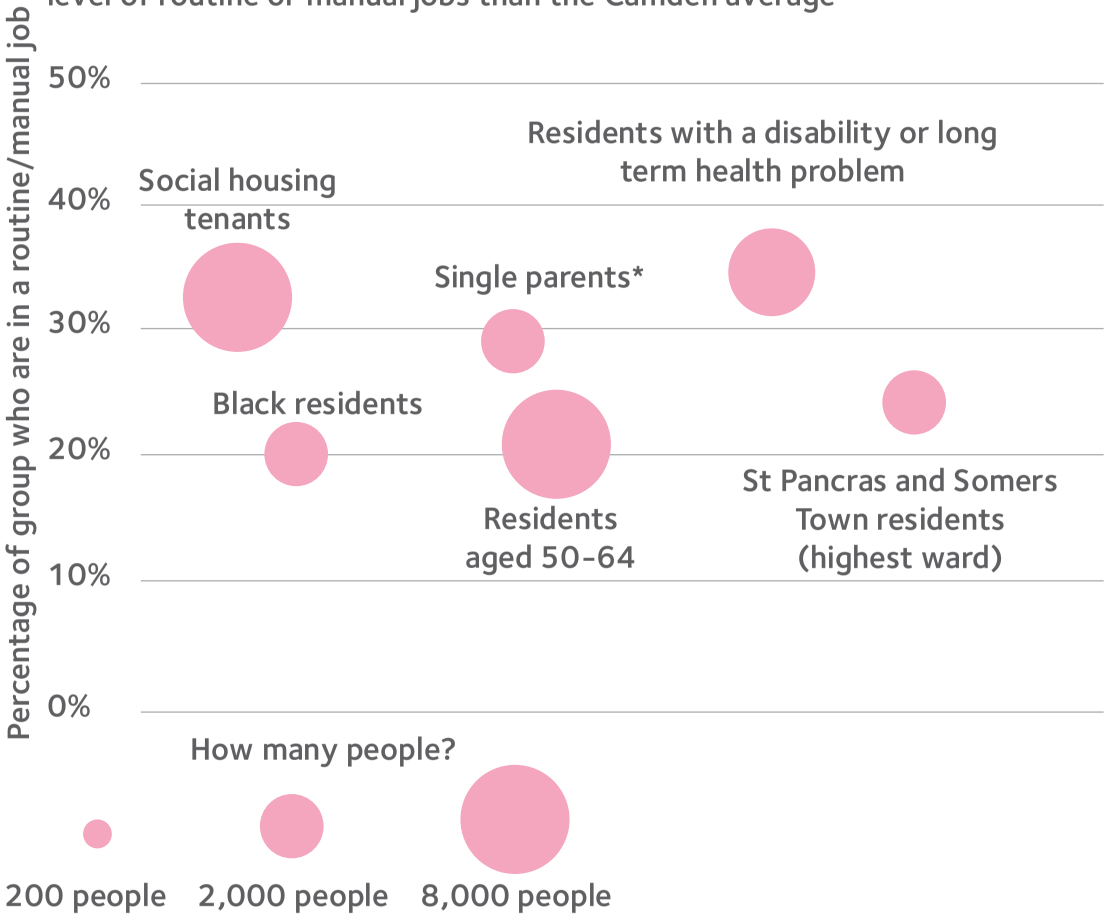
Employment: the Camden story

Routine and manual jobs a) 2011

23,400 people work in routine and manual jobs
15% of working age population

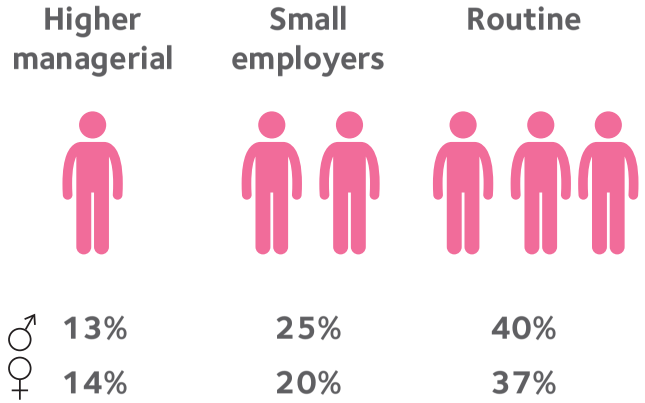
Camden lower than London

Percentage of people in key social groups who have a higher level of routine or manual jobs than the Camden average a) 2011



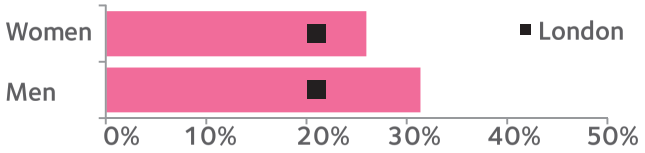
Employment and health b) 2011

For every person reporting 'Not good' health in higher managerial occupations, there are an estimated three people in not good health in routine jobs.



In Camden the health gap between the higher managerial and routine groups is among the widest in the country, for both men and women.

Gap in reporting 'Not good' health 2011



Notes *ages 16 years and over, as data for ages 16-64 were not available. People may appear more than once on the chart, as groups overlap (e.g. 16-24 year olds who live in social housing will appear twice).

Sources: a) ONS, Census 2011 (2013); b) Adapted from ONS, Health Gap in England and Wales (2013).

Toby's story, Islington

"When it first happens [being laid off] you feel just like, how can I explain it? Not worthy. Like the company doesn't want you, so who else will? You feel drained and you got no get up and go in you.

Me working in a warehouse on a forklift I'm not using my potential.... There's no way of showing your strengths and weaknesses in a job like that...It's not the field I want to be in, it's the money side. I've got bills and stuff to pay so I have to do it."

Toby is a young man in his mid-twenties, was brought up in Islington, went to school here, and got his first job in the area. Four-and-a-half years ago, when his first son was born, he moved into a council house on a local estate with his partner.

They now have two children under five. The last three years have been particularly difficult for their family because Toby was made redundant and then had a series of jobs with temporary contracts, from which he was repeatedly laid off. More recently he has been working night shifts as a forklift truck driver in a supermarket depot about 15 miles away.

During the last three years Toby has had five different jobs, interspersed with short but difficult periods of unemployment. He has found himself caught in a low-pay no-pay carousel. Job offers have been for casual employment, on temporary contracts, with little job security. Toby enjoys working but has found the constant possibility of losing his job a psychological and emotional strain.

Toby now feels a lack of control over his work life. A few months ago his employer changed his contract without notice, moving him from day work to nights and lengthening his shift time.

Toby wants rewarding work in which he can use the full range of his skills. He misses the emotional rewards of working directly with people. Toby's ideal job would be as an events organiser or running his own football coaching business. However his main aims are keeping his family afloat and finding more stable work.

Source: Penny J, Shaheen F, Lyall S. (2013). Distant neighbours: poverty and inequality in Islington. New Economics Foundation. http://www.cripplegate.org/reports-publications/distant-neighbours

In comparison to the rest of London and England, there are fewer people in routine and manual jobs in Camden and Islington. While not all of these people will be in low quality work, people in routine and manual jobs are three times as likely to be 'not in good health' than those in the highest professional positions. This is described as the 'health gap'. Nationally, Islington has the largest 'health gap' between different types of workers, with Camden not far behind. The levels of poor health among routine and manual workers are concerning, as evidence suggests that many will eventually end up on sickness benefits. Being out of work will have further negative impacts on their health and that of their families. This all highlights the important role for employers to support health and wellbeing in businesses with these types of jobs, through health promoting initiatives and occupational health schemes, and making them 'good jobs'.

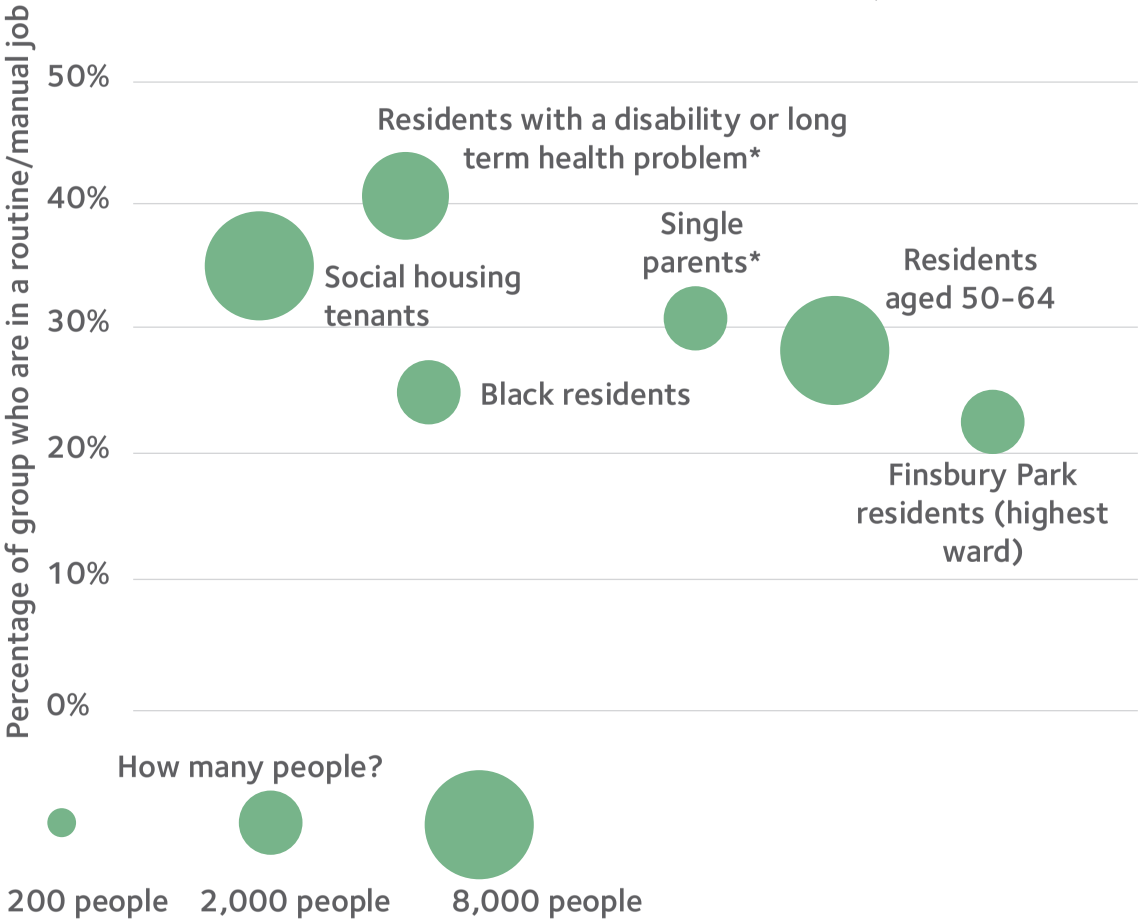
Employment: the Islington story

Routine and manual jobs a) 2011

26,900 people work in routine and manual jobs
17% of working age population

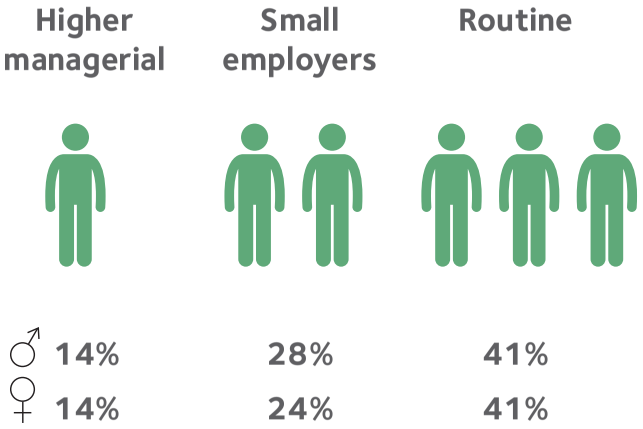
Islington **lower** than London

Percentage of people in key social groups who have a higher level of routine or manual jobs than the Islington average a) 2011



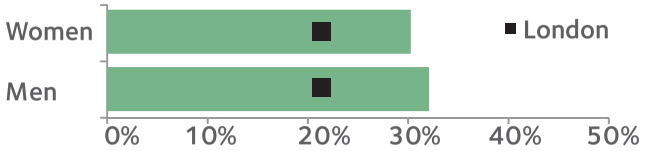
Employment and health b) 2011

For every person reporting 'Not good' health in higher managerial occupations, there are an estimated three people in not good health in routine jobs.



In Islington the gap between the higher managerial and routine groups is the widest in the country, for both men and women.

Gap in reporting 'Not good' health 2011



Notes *ages 16 years and over, as data for ages 16-64 were not available. People may appear more than once on the chart, as groups overlap (e.g. 16-24 year olds who live in social housing will appear twice).

Sources: a) ONS, Census 2011 (2013); b) Adapted from ONS, Health Gap in England and Wales (2013).

On average, 15-17% of Camden and Islington's working age population are in routine and manual jobs, but among certain groups this figure is much higher. For example, 34 - 41% of those with a disability or long term health problem have routine and manual jobs.[1] Black or Black British residents are more likely to be in routine and manual work, as are older residents and social housing tenants.[2] About 30% of single parents in Camden and Islington work in routine and manual jobs. Camden's Equalities Taskforce has already identified parental worklessness as a key issue within the borough and steps are being taken to support these parents, mainly women, back into high quality work. In Islington, the Working for Parents Service which was set up in response to high levels of child poverty in the borough provides intensive support to help parents back to work.

The impacts of being out-of-work

Losing a job causes financial problems for many people and their families, lowering living standards and making it harder to afford a healthy lifestyle. Being out of work is stressful and often results in anxiety, depression and the deterioration of existing physical health problems. Not having a job also removes a person's sense of identity, reduces their contact with other people and may also make people feel that they are no longer in control of their life, all of which will affect their health. Those who are out of work are also more likely to smoke, consume more alcohol and do less physical activity. Even people's recovery from illness is affected by being out of work: the long term unemployed are less likely to recover or see an improvement in their health than people in employment.

The distress, financial hardship and other knock-on effects that unemployment causes have a wide-reaching impact on families and the wider community. Following the recent financial crisis, worse outcomes are anticipated for many of today's children who are being brought up in households where one or more family member is unemployed. While the upward trend in youth unemployment pre-dates the recent financial crisis, this has still specifically impacted on young people who are struggling to enter the labour market, and many of these young people are likely to remain unemployed in the future. This will have a major impact on their mental health and wellbeing. Ultimately, the financial crisis is likely to result in a widening of health inequalities in Camden and Islington.

The local picture

Worklessness substantially contributes to health inequalities in both Camden and Islington. Compared to the London average, Camden and Islington have a lower percentage of people who are unemployed (actively seeking work), but this still equates to more than one-in-twenty people in both boroughs. While there has been progress in getting people back to work the numbers of people seeking work is still higher than before the start of the financial crisis. Young people (aged 16-24), Black or Black British residents and those in social housing are disproportionately affected by unemployment, as are those in the most deprived wards. Not only are all of these groups more vulnerable to unemployment, they are also less likely to have the money or emotional resilience to deal effectively with its negative effects.

A key challenge in Camden and Islington is the large number of people who are out of work because of sickness or disability. Islington has the highest percentage of working age residents claiming sickness benefits in London, and Camden

[1] It is not clear from the data whether these people are in routine and manual jobs because an existing health problem has limited their employment prospects or if being in a routine and manual job has caused their health problem.

[2] These groups are not mutually exclusive. An older, Black or Black British resident who lives in social housing will be counted three times, for example.

Hayley, Camden

Hayley is in her late-30s and lives in a one bedroom flat with her two-and-a-half year old son, Denzel. Hayley is not currently working. She was made redundant around three years ago. She likes being able to spend time with Denzel, but is very keen to find a job again. She would love to work again and is flexible about what she does. Much of her experience lies in sports and she is conscious that this is one of the areas where the council is cutting back.

Hayley is enrolled on a course to support her in looking for a job. She has been rated at 8-9 out of 10 in terms of her work readiness and once she's got childcare she thinks she is 'good to go'. However, she feels trapped. Hayley cannot afford childcare until she has the job, but looking after Denzel makes it very hard to job search. She recently attended a session on cold calling which she found useful. Hayley had planned to call GP surgeries speculatively asking for work. However, as she has no landline at home, the calls can be expensive. She does not have access to the internet at home and has to use the library, which can be difficult with Denzel.

She sometimes finds advice from the Job Centre unhelpful. At her last six-monthly review, after establishing Hayley had a CV and was looking for jobs, her advisor told her, "OK, I'll see you in six months". She says she was told to go back home and sit and do nothing until her son goes to school, as she would be better off this way.

Hayley found some volunteer work that was similar to the sports work she had done in the past. However, she was told that unless it was full-time paid work, they would be unable to provide any assistance with childcare. She feels there is nobody there to help her.

Source: Aylott M, Norman W, Russell C, Sellick V. (2012). An insight into the impact of the cuts on some of the most vulnerable in Camden: A Young Foundation report for the London Borough of Camden. The Young Foundation. http://youngfoundation.org/wp-content/uploads/2012/10/uts_on_some_of_the_most_vulnerable_in_Camden_2.pdf

the fifth highest. A substantial number of these people have serious mental health problems, with one-in-ten having musculoskeletal problems (e.g. back pain). Many have been out of work for several years. Those groups disproportionately affected by long term sickness or disability and unable to work in Camden and Islington include older residents aged 55-59 years and Black or Black British residents.

Looking after family is another key reason why people, and particularly women, are out-of-work. While the statistics do not distinguish between parents who are out-of-work because of a positive choice to look after children, local evidence suggests that many parents who do want to work struggle to access affordable and quality childcare, and there are not enough quality part-time or flexible jobs that fit with their childcare commitments. Again, this affects about one-in-twenty people of working age, mainly women, in Camden and Islington. Single parents, Asian residents, and those in middle-age are more likely to be looking after family.

NEETs and London Living Wage

Young people who are 'Not in Employment, Education or Training' (NEETs) are covered in chapter four on Education.

London Living Wage is covered in chapter five on supporting people to have a healthy standard of living.

Employment: the Camden story

Unemployed

9,300 people
6% of working age population

Camden lower than London

Long term sick/disabled

7,400 people
5% of working age population

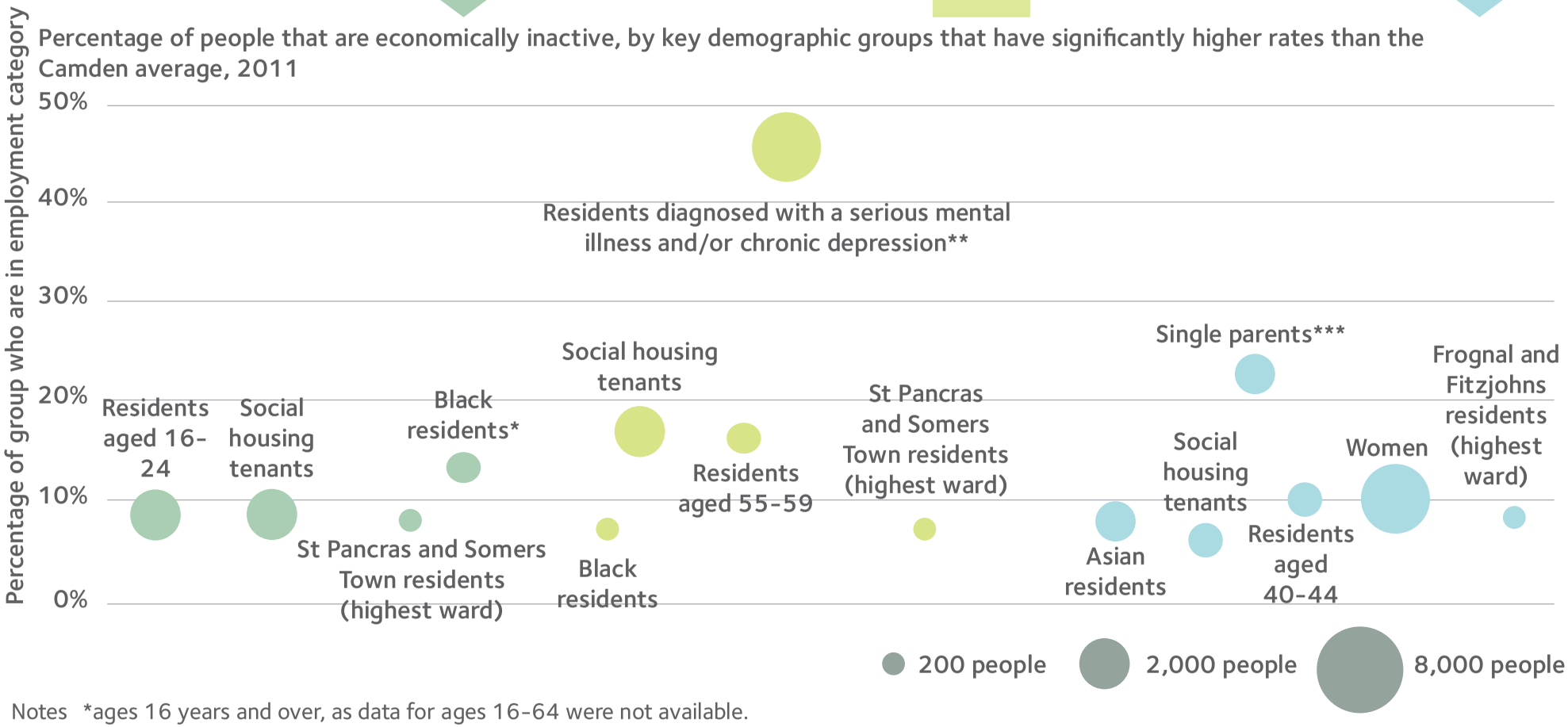
Camden higher than London

Looking after family

7,800 people
5% of working age population

Camden lower than London

Percentage of people that are economically inactive, by key demographic groups that have significantly higher rates than the Camden average, 2011



Notes *ages 16 years and over, as data for ages 16-64 were not available.
**proportion of residents on Incapacity Benefit, Severe Disablement Allowance, Employment and Support Allowance
***proportion of residents who have never worked or long term unemployed (NS-SEC).
People may appear more than once on the chart, as groups overlap (e.g. 16-24 year olds who live in social housing will appear twice in the unemployment chart).

Sources: All data based on the ONS Census 2011 (published 2013), except ** which is from Nomis Web, August 2013, and the Camden GP Dataset, 2012

Employment: the Islington story

Unemployed

10,700 people
7% of working age population

Islington lower than London

Long term sick/disabled

8,400 people
5% of working age population

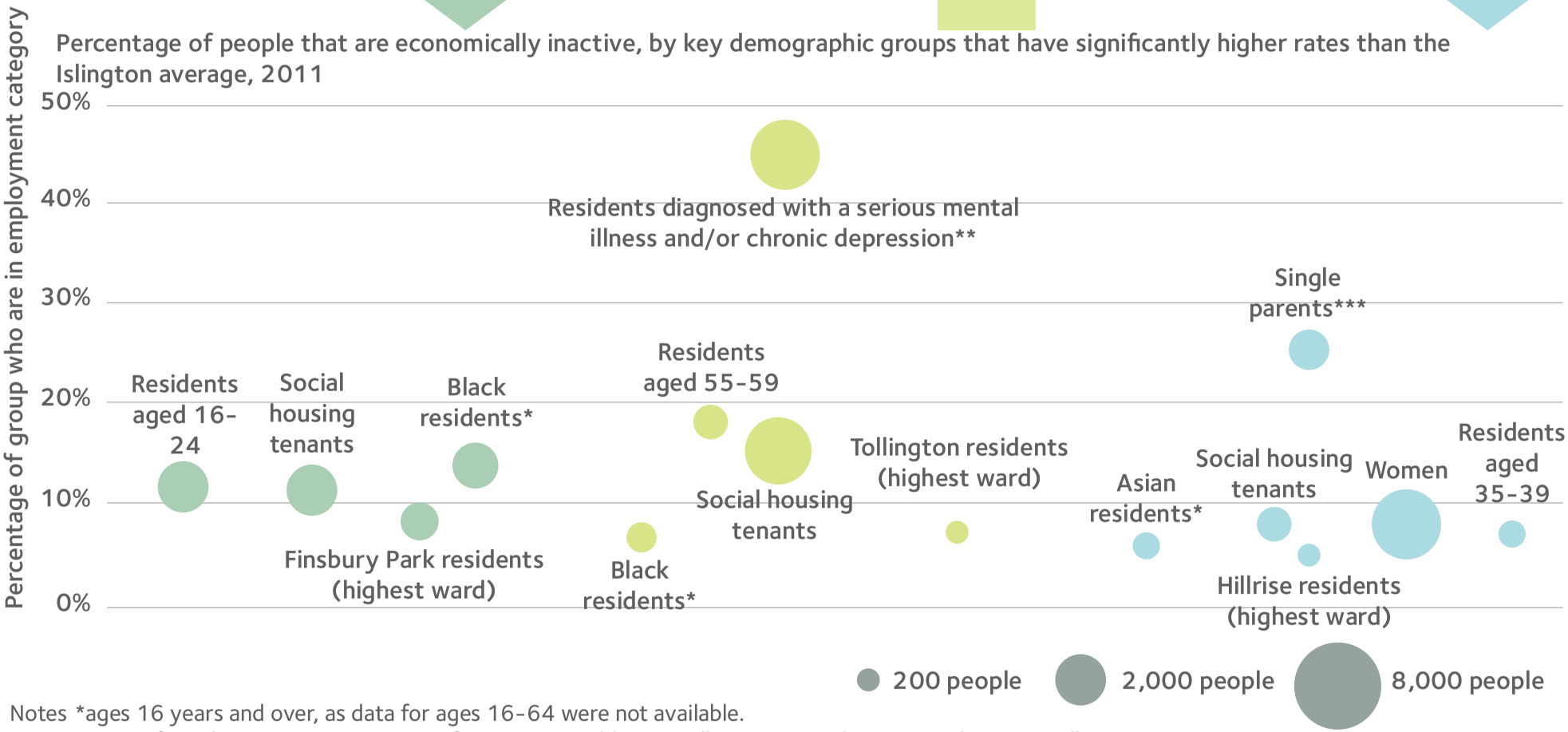
Islington higher than London

Looking after family

6,500 people
4% of working age population

Islington lower than London

Percentage of people that are economically inactive, by key demographic groups that have significantly higher rates than the Islington average, 2011



Notes *ages 16 years and over, as data for ages 16-64 were not available.
**proportion of residents on Incapacity Benefit, Severe Disablement Allowance, Employment and Support Allowance
***proportion of residents who have never worked or long term unemployed (NS-SEC).
People may appear more than once on the chart, as groups overlap (e.g. 16-24 year olds who live in social housing will appear twice in the unemployment chart).

Sources: All data based on the ONS Census 2011 (published 2013), except ** which is from Nomis Web, August 2013, and the Islington GP Dataset, 2012

What more can be done to reduce health inequalities?

Getting people back into work and improving work conditions are key corporate priorities for both Camden and Islington Councils, in collaboration with local partners. The Marmot Review, *Fair Society, Healthy Lives*, outlined three high-level policy recommendations for reducing health inequalities relating to employment:

1. Improve access to 'good jobs' and reduce long term unemployment
2. Make it easier for people who are disadvantaged within the labour market to obtain and keep work
3. Improve the quality of jobs

It is important to recognise that both councils already have existing programmes of work in these areas, much of which already impacts on health inequalities. These recommendations below would therefore build on the existing good work:

- The Camden and Islington **Health and Wellbeing Boards** should hold "Employment and Health" summits to understand the impact of employment on health in Camden and Islington and decide what more all partners could do to support residents and reduce health inequalities.
- Public Health will use its specialist expertise in understanding populations and the determinants of health and wellbeing, in finding 'what works', and in evaluation. This will support **Camden's Employment Strategy Group**, the **Employment and Skills Network**, **Islington's Employment Commission (box A)** and **Employment Services Board**, and will support the delivery of other corporate recommendations (e.g. from Camden's Equality Taskforce). This work would encourage locally provided accessible, effective services to support people with health problems into employment and to help them keep their jobs. Public Health will also work to strengthen the focus on employment in the **Joint Strategic Needs Assessments (JSNAs)** and **Joint Health and Wellbeing strategies (JHWSs)** as these are refreshed and renewed.
- There is good evidence that promoting health and wellbeing in the workplace can reduce sickness absences, reduce stress, support people to engage in healthy behaviours and keep people in work, bringing economic benefits for all involved. Encouraging Camden and Islington businesses to become **'health promoting workplaces'** by adopting practical, evidence-based interventions would support this, with a particular focus on mental health and emotional wellbeing given the high levels of need in the two boroughs. Importantly, to reduce health inequalities, any interventions of this nature need to be targeted at small and medium sized businesses which are less likely to already have employee wellbeing programmes in place and are more likely to be employing lower paid staff. Public Health will work with the relevant employment and environmental health teams to look at whether this type of intervention would be beneficial locally, and will draw support and expertise from Public Health England, for whom improving health in the workplace is a key priority.
- **Supporting people back to work after sick leave** or supporting people out of work with long term sickness and disability should increasingly become part of an integrated approach to meeting the health and care needs of Camden and Islington residents. This would include earlier identification by health and social

care professionals, including GPs, of people who would benefit from being proactively supported back to work after sick leave, with clear referral pathways into support services. Opportunities to integrate employment support into the multi-disciplinary approaches to management of people with long term conditions being developed by both Clinical Commissioning Groups should be explored. If more can be done to keep people in their existing jobs, then over time there will be fewer people who are unemployed. Additionally, some other areas have adopted a 'health first' approach to tackling worklessness, where health services focus on improving people's health first before addressing skills and employability. The merits of adopting a similar approach locally could be explored.

- **Mental health problems** make it difficult to get and to keep a 'good job'. Many of those out of work in Camden and Islington have mental health problems. Building on the employment support already available locally for people with mental health problems **(box B)**, the support for people with a mental health condition to gain employment should be reviewed alongside other commissioned employment support services to see if there is more that could be done. This may include, for example, encouraging greater mental health awareness and employment of people with mental health problems by organisations in the borough, particularly through the councils' and the local health services' own supply chains. It is also important that staff supporting people back to work, in HR roles for example, are specifically trained in recognising, understanding and dealing with mental health problems and disability discrimination legislation.
- Given the wide-reaching negative impacts of parental unemployment on **children's future chances**, employment should be a key strand of programmes focussed on giving children the 'Best Start in Life' which are underway in both boroughs. The Health and Wellbeing Boards should consider whether more can be done through board partners and other stakeholders to support parents to keep their jobs and particularly to support lone parents back into work **(boxes C & D)**.

BOX A: Supporting Islington's Employment Commission

The Islington Employment Commission has been established to look into the local challenges and barriers to becoming employed and staying in employment. Whilst local partners have some understanding of the challenges that people face in getting into work, such as health issues, the aim of the Commission is to develop a richer and more sophisticated understanding of people's everyday experiences of worklessness, especially the unique combinations of barriers they face in returning to employment, and new ideas for ways to work with residents to support them back into the labour market.

Public Health is supporting the Commission by engaging with residents and employers to gain qualitative insights into being out of work, undertaking analysis of the data on employment and looking at what the national evidence says about barriers to employment and 'what works' in getting people into jobs.

BOX B: Employment Support for Camden and Islington Mental Health Service Users

The opportunity for people with mental health problems to engage in meaningful employment activities is one important way of supporting a return to positive mental wellbeing.

Mental Health Working is an employment support service for people in Camden and Islington with mental health needs. Remploy, as the lead provider, delivers the service in partnership with Hillside Clubhouse and Twining Enterprise.

The service uses a pathway-based approach ranging from providing support for individuals to become job ready, to supporting someone already in employment to retain their job. Participants are supported to acquire the necessary skills to access employment, training, education and volunteering opportunities.

From August 2012, when the service commenced, to September 2013, over 448 Islington residents with mental health needs have enrolled in the service. Over this period, 58 people gained or retained paid employment or became self-employed; 67 were supported to undertake a mainstream education or training course; and 115 started a work experience or volunteering placement.

Over the same period in Camden, 421 people with mental health needs registered and enrolled with the service. Of those 41 people were helped to gain or retain paid employment, a further 41 people were supported to begin a mainstream education or training course and 98 people were helped to access work experience or volunteering opportunities.

The percentage of Islington mental health service users with a Care Programme Approach (CPA) support plan in paid employment is 12% as of November 2013, which is part of a rising trend starting in August 2013 when it was 7.7%. The Inner London average for 2012/13 was 5.2%.

In Camden the proportion of people with mental health needs on a CPA and in employment is above target at just over 5% and is in line with the inner London average. However, there are opportunities to improve this, and performance has been steadily improving since the beginning of the year.

BOX C: Camden's Equality Taskforce — helping parents to access quality work

Camden's Equality Taskforce has sought to deal with some of the most significant socioeconomic challenges affecting residents, including access to employment. The Taskforce's research identified that the labour market is particularly complicated and challenging for parents seeking work (predominantly a maternal employment issue), which can negatively affect their health but also the life chances of their children. Many parents struggle to access affordable and high quality childcare, and there are not enough quality part time or flexible jobs that fit with their childcare commitments. As a consequence of this more than a third of Camden mothers are out of work (37%) and rates of maternal worklessness are higher in Camden than both the London average and the UK average. There is also a strong correlation with child poverty, with approximately 35% (13,000) of children in Camden living in child poverty compared with 27% nationally.

The Equality Taskforce made a series of recommendations in response to these findings. Camden Council is now committed to becoming the first 'Timewise Council', by ensuring flexible working is

part of the council's policies and that they promote these positive recruitment practices to other local employers, helping mothers to find quality flexible employment. Two projects have been commissioned to provide bespoke employment advice and support to mothers, run by Women Like Us and Hopscotch Asian Women's Centre in partnership with the Somali Cultural Centre. Also, in response to childcare challenges, Camden is providing 25 hours free childcare through its maintained settings (e.g. nurseries and children's centres) until 2015. If these approaches support mothers into work it can help improve their health and wellbeing, as well as that of their children.

BOX D: Islington's Working for Parents Service

Islington Working for Parents (IWP) is a council service set up in response to high levels of child poverty in the borough. The team of five staff provide an intensive one-to-one support service for parents who are 6-12 months from the labour market. Parents need to have multiple barriers to employment to receive the service – e.g. childcare and a need to improve their English (ESOL) or childcare and no work experience. For those more than 12 months away from the labour market there is a universal offer via local parents – Parent Champions – supporting residents in adult learning centres, and then later referring to the Islington Working for Parents Service. The team works closely with, and is co-located in Jobcentre Plus, Children's Centres, Family Support team (called Families First), Stronger Families team (Troubled Families), and the local further education college. The team is exceeding its target of 200 parents into work each year. Key to its successes are:

- Clear, tailored individual action plans that progress parents through skills development and work experience to employment
- An easy-to-access, responsive bursary which can fund childcare for training and at the start of a job
- A team expert in local job opportunities with the flexibility and confidence to negotiate with employers
- A team with a detailed knowledge of local childcare providers who can match a parent with suitable childcare quickly

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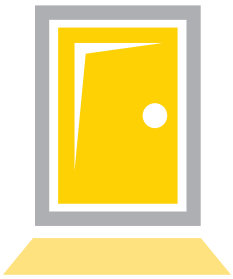
3. Healthier homes

Housing makes a very significant contribution to people's health and inequalities across Camden and Islington. This chapter focuses on three aspects of this connection: homelessness, overcrowding and poor and unsafe housing conditions. Adequate housing is becoming more difficult to afford in the current economic environment, particularly in inner London boroughs where housing costs are high and there is a shortage of affordable homes. Given the rising costs of living and the Government's welfare changes, there is a growing risk of more and more residents on low incomes being forced to live in conditions where there is a risk to health.



Homelessness

Homelessness is associated with severe poverty, and homeless households contain some of the most vulnerable residents. Reasons for becoming homeless include family breakdown, loss of private rented accommodation, domestic violence and harassment, leaving prison, and loss of asylum seeker accommodation.

Single homeless people are at greater risk of physical and mental health problems. Some will already have had underlying problems, such as substance misuse and mental health problems, which will have contributed to their homelessness. Those living on the streets, in squats or shared accommodation (e.g. hostels), have particularly poor health outcomes. This population has higher rates of alcohol and substance misuse, smoking and tuberculosis (TB), and are more likely to die from cancer or commit suicide, particularly in middle-age. According to a report by charity Crisis, their life expectancy is 47 years, 30 years below the general population. Homelessness also takes its toll on the health of those who are living in hostel (shared) accommodation, particularly on their mental health because of the stress and uncertainty in their lives.

The impact of the financial crisis is likely to have contributed to the rise in homelessness seen across London since 2009/10, and the Coalition Government's welfare changes are likely to continue to drive this increase. In Camden concerted efforts to keep homelessness rates stable have been successful, with proportionately fewer statutorily accepted homeless households in 2012/13 (125, 1.1 per 1,000 households) than in London (4.4 per 1,000) and England (2.4 per 1,000). This has been achieved by helping households facing homelessness to consider other options, including moving into the private rented sector, for example. In Islington, the rate of homelessness acceptances increased more quickly than for London as a whole between 2009/10 and 2011/12, partly due to increasing numbers of private sector evictions. The rate has now stabilised (4.6 per 1,000), with over 400 households accepted as homeless in 2012/13. Prior to the financial crisis, Islington had seen a sharp fall in homelessness, with rates below the London average due to the proactive steps the Council had taken.

There were over 650 statutorily accepted households living in temporary accommodation in Camden and more than 1,000 households in

Affordable housing is discussed in **chapter 5** - supporting people to have a healthy standard of living.

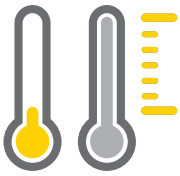
Homelessness

Overcrowding

The impact of welfare changes

Cold damp homes

What is fuel poverty?



What more can be done to reduce health inequalities?

Islington living in temporary accommodation in March 2013; however, in Islington not all of these will have had statutory homelessness duty determined. More recent local data show these figures fell during 2013, to about 560 in Camden (December 2013) and about 950 households in Islington (September 2013). The higher figure for Islington reflects a difference in services available for single homeless households across the boroughs.

The rate of households living in temporary accommodation fell in Camden between 2007/08 and 2009/10 and has remained stable since. In Islington the rate has remained largely unchanged since 2007/08. Both Councils have managed to keep the levels of households in temporary accommodation fairly stable through a combination of helping people to access other options. These include moving into the private rented sector, assisting more vulnerable people to move into supported housing, and providing housing related support through floating support services. Camden also provides support to single homeless people, through its Hostel Pathway support programme. As of November 2013, 610 people were being supported through this service. Similarly, Islington had 774 people in its short term supported housing services as of November 2013, funded through its Supporting People Programme.

The BME population is overrepresented among the homeless populations of Camden and Islington, despite targeted efforts to tackle this inequality. The actual numbers of people in temporary accommodation is decreasing, but a substantial proportion of them are families: more than half of homeless households in Islington have at least one child, and in Camden the figure is nearer 80%. This is particularly concerning given that homelessness impacts on children's educational attainment and development, with longer term consequences for their health. About 7% and 15% of homeless households in Camden and Islington respectively, have someone with a mental health condition. Being homeless is likely to further contribute to these people's existing mental health problems.

While there is some evidence that the numbers of rough sleepers, particularly those aged under 25, has been increasing in London recently, the 'No second night out' campaign is helping to support people to find shelter. As are local initiatives to support single homeless people. Between January and March 2014, 31 people in Camden were sleeping rough for five or more nights in a three week period. In Islington the equivalent figure was three people. While some sources suggest that these figures are underestimates, there has undoubtedly been a substantial reduction in the numbers sleeping rough compared to a decade or so ago particularly in Camden (54 in Camden and 12 in Islington in 2000).

Overcrowding

People in overcrowded households are more likely to suffer from higher rates of respiratory disease, TB, meningitis and gastric conditions. They are also more likely to be suffering from stress and anxiety, and to have disrupted sleep. Overcrowding can also negatively impact on children's education, family relationships, and lead to more accidents around the home.

Nearly a third of all households[1] in Camden are overcrowded, with insufficient numbers of rooms for the number of people within the household. This is higher than average for inner London, reflecting the larger share of privately rented accommodation in Camden which tends to be more overcrowded. Where it is not possible to move overcrowded households into larger accommodation, Camden Council has taken steps to mitigate against the impacts of overcrowding by reconfiguring rooms and providing financial support for things like bunk beds. In Islington, the level of overcrowding is slightly lower and similar to inner London (29%). This is due in part to the larger proportion of households living in social housing and the pro-active work undertaken by Islington to move under occupiers into smaller homes releasing more family-sized accommodation.

Overcrowding in households with children increases to nearly 40% in both Camden and Islington which is of concern, given the wide-ranging impacts that overcrowding will have on a child's life. This is a particular issue for lone parents and those families with children who may already have to share with others to afford housing costs. Disproportionately more people in BME groups live in overcrowded conditions (many larger households are BME), reaching almost 50% in some groups in Camden and more than 40% in Islington. This contributes to some of the poorer health outcomes experienced by BME communities. However, the majority of those living in overcrowded conditions are from a white background, reflecting the ethnic make-up of both populations.

Overcrowding: Joyeeta's story

Joyeeta lives in a two bedroom flat with her three sons. They live in very cramped conditions, and she feels like they have no hope of a move, as her children are all the same sex. She discusses the impact this will have on her boys, "as they grow up we want to be able to buy them books, a computer for their education... There is no space for any of this."

Source: Aylott M, Norman W, Russell C, Sellick V. (2012). An insight into the impact of the cuts on some of the most vulnerable in Camden: A Young Foundation report for the London Borough of Camden. The Young Foundation. http://youngfoundation.org/publications/an-insight-into-the-impact-of-the-cuts-on-some-of-the-most-vulnerable-in-camden/

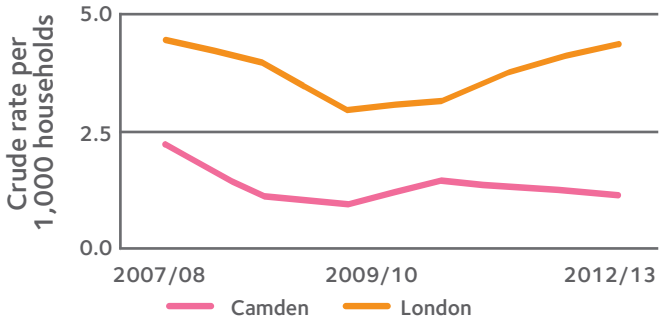
[1] Based on Census 2011 (ONS)

Housing: the Camden story

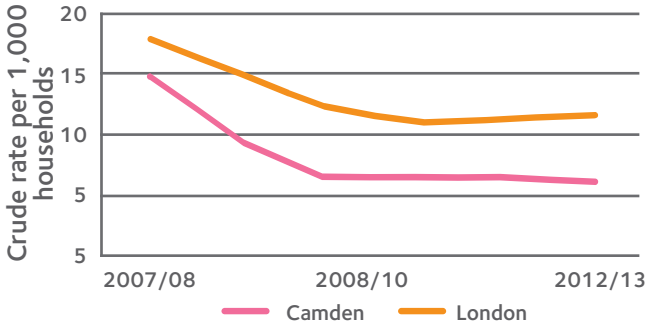
Camden

Homelessness [a]

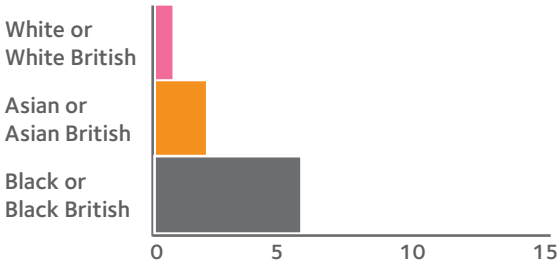
Crude rate of homelessness acceptances, 2007/08-2012/13



Crude rate of households in temporary accommodation, 2007/08-2012/13



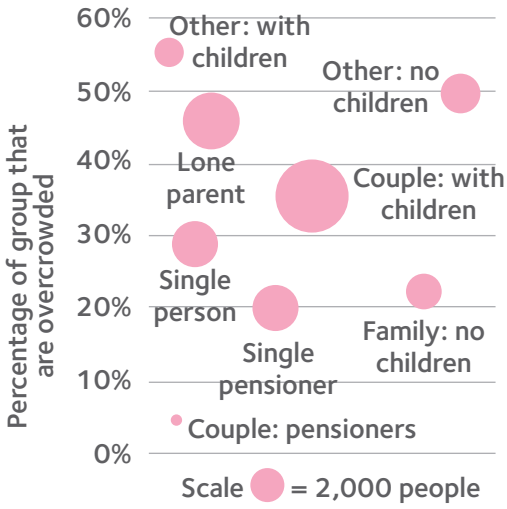
The rate of homelessness is eight times higher among Black and three times higher among Asian compared to White ethnic groups: 2012/13



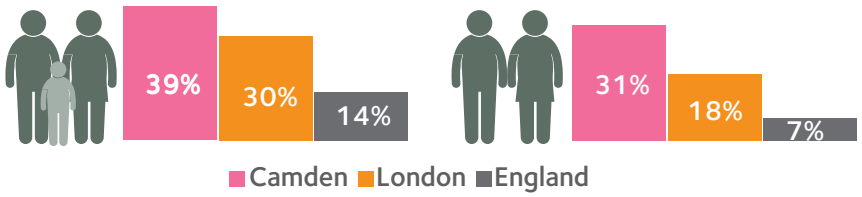
There are 50 White or White British households that are homeless, 36 Black or Black British, and 23 Asian or Asian British

31 people living on the streets March 2014

Overcrowding [c] 2011

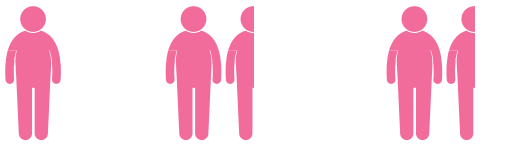


Households with children are more likely to be overcrowded:

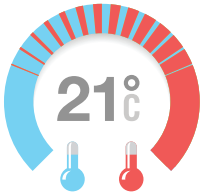


Note: 'Other: no children' includes students and professionals sharing privately rented accommodation

Black and Minority ethnic groups are about 1.5 times more likely to live in overcrowded housing:



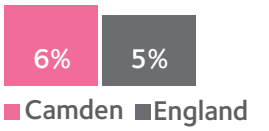
Fuel poverty [d] 2011



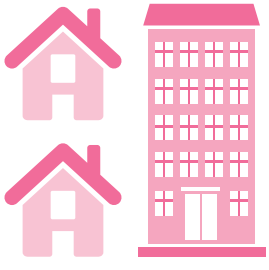
9%* (8,100) of all households live in fuel poverty.

This is lower than England (11%).

Heating [d] 2011

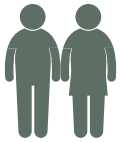


6% of all households in private rented accommodation have no central heating.



People living in private rented accommodation are **twice** as likely to lack central heating as other accommodation types.

Excess winter deaths [d] 2010/11



74 deaths (22%) more than expected in the winter months compared to non-winter months.

*note that these estimates do not take into account housing costs which are much higher in London. Therefore there may be a higher percentage of people living in fuel poverty locally.

Sources: a) Department for Communities and Local Government (2014); b) Living On The Streets (2014); c) ONS,Census 2011 (2013); d) Public Health England, Public Health Outcomes Framework 2012 (2013).

The impact of welfare changes for those living in social rented housing

The cumulative impact of welfare changes is likely to impact on the housing needs of low income households over the coming years, particularly given the already high costs of housing in Camden and Islington. Increasing private sector rents mean that people on benefits living in private rented accommodation are having to move to cheaper parts of the borough, move out of the borough or face significant shortfalls between rent payable and benefit entitlement. There is evidence that these changes have already pushed more families into poverty, have led to more overcrowding, and have forced people to move house.

In Camden and Islington, more than 700 households are facing shortfalls between their rent and their benefits as part of the cap on total benefits (£500 per week per household with children, £350 for couples/single people) that came into effect in August 2013. As many of these households live in social rented housing there is little scope for moving into cheaper accommodation in either borough. Since April 2013, a further significant number of social housing tenants have also had their benefits deducted (about 1,575 as of February 2014 in Camden; and about 2,500 in February 2014 in Islington) because they live in properties which are deemed to be larger than they need. While swaps can be done with households which are overcrowded, they are often hard to broker and complete, and many households are reluctant to move from what may have been their family home for a number of years.

BOX A: Reducing fuel poverty, Camden and Islington

WISH Plus (Warmth, Income, Safety and Health) in Camden

WISH+ works to improve health and wellbeing by offering packages of support and onward referral for a wide range of services such as health services, safety and security measures in the home and the take up of benefits for those in need.

Recently, the WISH+ referral hub has relocated to housing meaning closer integration with core teams who work within deprived communities and with vulnerable people. This will ensure that the health interventions generated by WISH+ are better targeted to the residents with the most need.

SHINE (Seasonal Health Interventions Network) in Islington

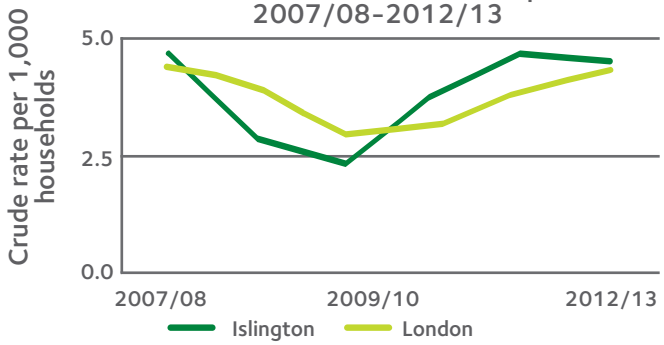
SHINE is a one-stop referral system for affordable warmth and seasonal health interventions. A single referral to SHINE leads to an assessment for more than twenty potential interventions. SHINE has recently expanded its offer to low income families and 2013/14 saw the start of the HomeSmart programme, offering training on home and budget management, and a bulk referral scheme for £135 fuel bill discounts. It is also increasing engagement with mental health and paediatric services to identify people most in need and is embarking on a campaign to educate on dampness and mould prevention.

Housing: the Islington story

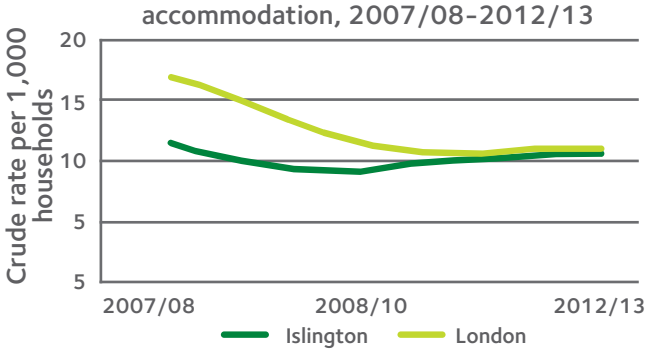
Islington

Homelessness [a]

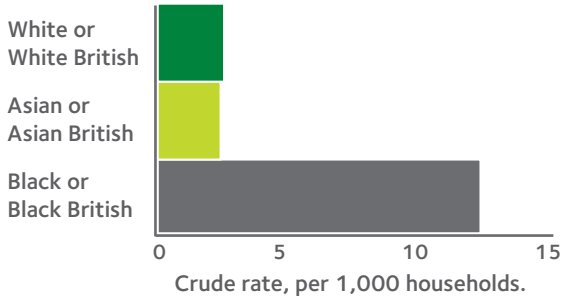
Crude rate of homelessness acceptances, 2007/08-2012/13



Crude rate of households in temporary accommodation, 2007/08-2012/13



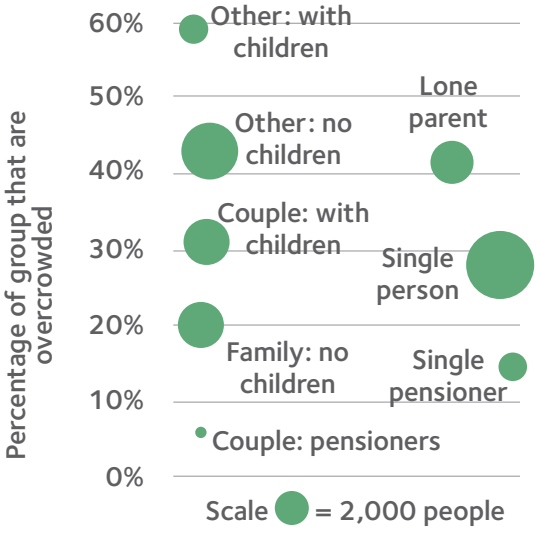
The rate of homelessness is five times higher among Black than White ethnic groups: 2012/13



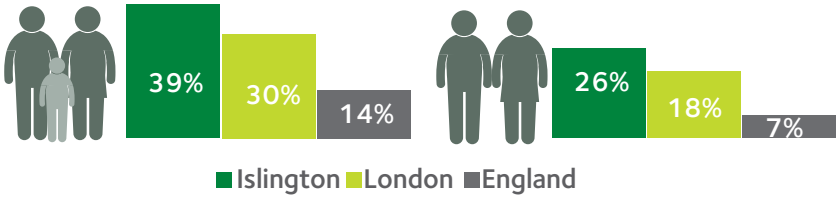
There are 179 White or White British households that are homeless, 134 Black or Black British, and 17 Asian or Asian British

3 people living on the streets [b] March 2014

Overcrowding [c] 2011



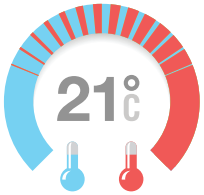
Households with children are more likely to be overcrowded:



Note: 'Other: no children' includes students and professionals sharing privately rented accommodation

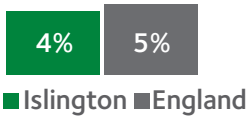
Black and Minority ethnic groups are about 1.5 times more likely to live in overcrowded housing:

Fuel poverty [d] 2011



7%* (6,100) of all households live in fuel poverty. This is lower than England (11%).

Heating [d] 2011



4% of all households in private rented accommodation have no central heating.

People living in private rented accommodation are **twice** as likely to lack central heating as other accommodation types.

Excess winter deaths [d] 2010/11

31 deaths (10%) more than expected in the winter months compared to non-winter months.

*note that these estimates do not take into account housing costs which are much higher in London. Therefore there may be a higher percentage of people living in fuel poverty locally.

Sources: a) Department for Communities and Local Government (2014); b) Living On The Streets (2014); c) ONS,Census 2011 (2013); d) Public Health England, Public Health Outcomes Framework 2012 (2013).

Cold damp homes

Cold damp homes lead to higher rates of heart and respiratory diseases and mental health problems. The risk of fuel poverty rises sharply as income falls — people have to choose to "eat or heat". Fuel poverty is a particular problem for low income families with children in Camden and Islington. As well as the direct health risks to children, particularly respiratory problems, living in a cold home also has an indirect effect on children's dexterity and educational attainment, and their mental health and wellbeing, which will have a lasting impact throughout their lives. Older people who live alone and those living with long term health conditions are also disproportionately affected by fuel poverty. Cold housing can exacerbate existing conditions such as arthritis and rheumatism, with increased risk of accidents because of reduced dexterity. They are also at increased risk of hospital admissions (from respiratory and heart diseases) and mental health problems, and an earlier death particularly during cold spells. In general, households living in private rented accommodation are more likely to be living in fuel poverty because the quality of housing stock in this sector tends to be lower, particularly in inner London as many of these houses are old.

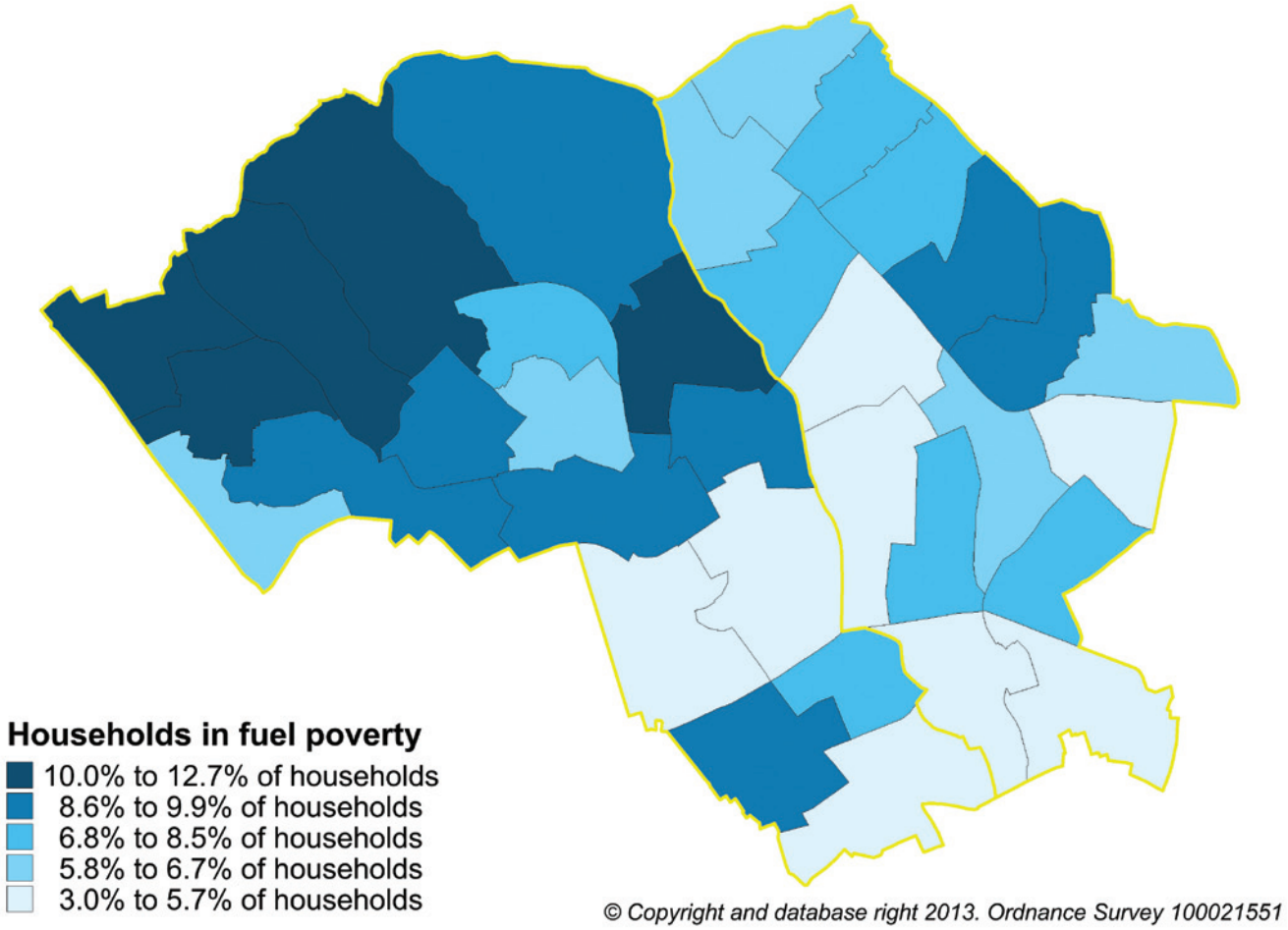
What is fuel poverty?

Fuel poverty is currently defined as the condition in which a household is required to spend more than 10% of their income on maintaining an adequate level of warmth in their home and on power. Adequate warmth is defined by the World Health Organisation as 21°C in living rooms and 18°C in other rooms. The Mayor of London, taking into account the high cost of accommodation in London, has adopted an enhanced definition which calculates 10% of income after housing costs.

National estimates suggest that in Camden, about 9% of households experience fuel poverty and in Islington it is slightly lower at 7%. Both figures are lower than England and London. However, these estimates are not adjusted for housing costs in London. Given the very high housing costs in Camden and Islington, these estimates are probably too low. People most vulnerable to fuel poverty tend to be on low incomes, including single pensioners, lone parents and unemployed people.

Within Camden, there is a three-fold difference in fuel poverty rates between wards **(map 1)**, with some of the most affluent wards experiencing the highest level of fuel poverty. In Islington, on the other hand, there is no apparent relationship between area deprivation and fuel poverty rates. This is because rich and poor people, living in all types of accommodation, live side-by-side. The pattern of fuel poverty in Camden is probably because these more affluent areas have a larger share of privately rented accommodation, which tends to have poorer insulation and makes it more costly to keep the property warm. About one-in-twenty households living in private rented accommodation in Camden and Islington do not have central heating, which is double the rate of those living in other accommodation types. Deprived, vulnerable and/or older people (who are more likely to be living in social housing) are entitled to winter fuel allowance and warm home discounts, which helps mitigate against fuel poverty.

Map 1: Fuel poverty in Camden and Islington, 2011



Source: Department of Energy and Climate Change

At a national level, it has been estimated that fuel poverty causes at least 10% of excess winter deaths[1]. In Camden there were an estimated 74 excess winter deaths in 2010/11 (22% higher than expected) with 31 excess deaths in Islington (10% higher than expected). Neither of these figures is statistically different to London and England. The most common causes of excess winter deaths are heart and respiratory disease. Emergency hospital admissions also tend to go up during the winter, although not as much as deaths. Respiratory problems are the most common cause of excess emergency admissions in winter.

[1] This means there were about 74 extra deaths in the winter months compared to the average rate of deaths during the non-winter months.

Living in a cold home: a family in Holly Park, Islington

David lives with his wife and two children in a flat in north Islington. They like the area and have lived there for six years. However, the flat is cold and his children's bedrooms in particular are very cold during the winter. He tries to tuck the curtains up on the windowsill but they still feel a very cold draught around the windows. Even with the heating on and with the doors between the rooms closed they still feel very cold. He has to wear extra jumpers and gives his son a double duvet and long johns to wear at night. They have to limit their heating because they cannot afford to pay for heating when it is not keeping the house warm. This is frustrating and stressful for the family.

There is damp and mould in most of the rooms in the house, including the living room and the bedrooms, where it is causing the wallpaper to peel off. It is worst in the bathroom. David has spent a lot of money on cleaning and anti-mould products but nothing really seems to work.

He thinks that the family gets more coughs and colds because of the coldness and damp in the flat. They tend to last for a long time and it is difficult to get better from them when you are constantly coming back to a cold house.

Also see **box E** which describes how Islington Council is improving insulation in Holly Park.

Source: London Borough of Islington (2013) Holly Park housing insulation evaluation.

What more can be done to reduce health inequalities?

Both Camden and Islington Councils have been working proactively to identify the housing needs of residents and to reduce homelessness, overcrowding, and fuel poverty and to mitigate the impact of welfare reforms. Given the close relationship between housing and health, these activities will help to improve the health and wellbeing of residents and reduce health inequalities. The following recommendations build upon the existing, good work that has already been done across Camden and Islington.

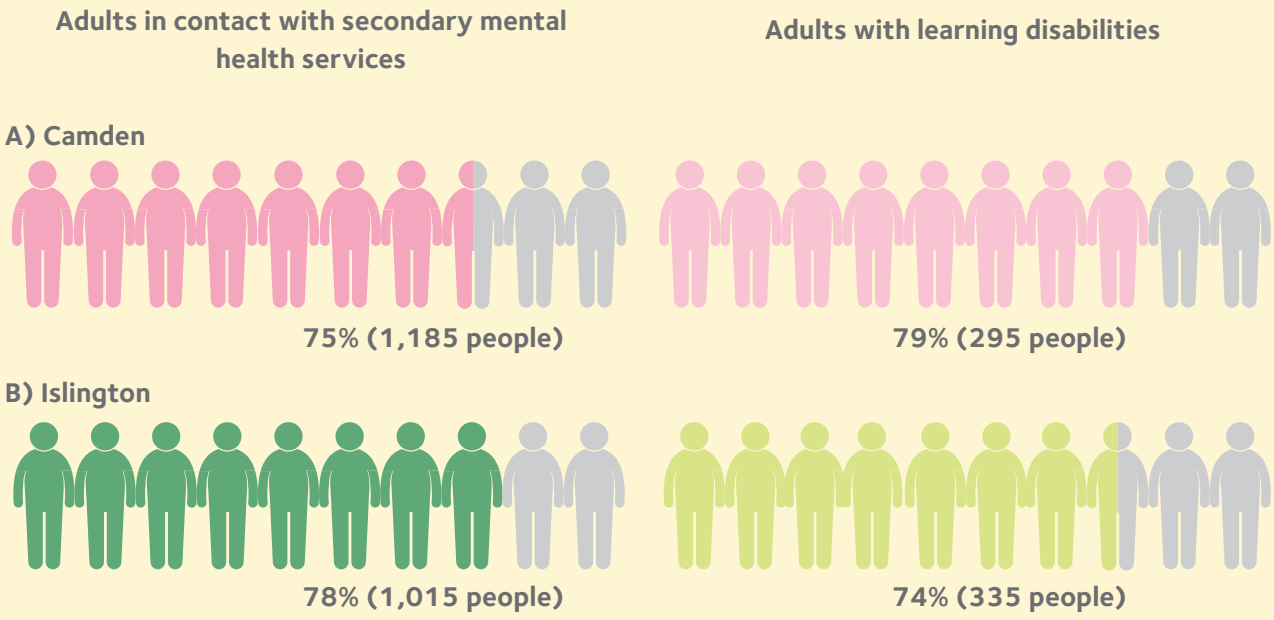
- The **Camden Health and Wellbeing Board** should hold a "Housing and Health" summit, linked into the work of Camden's Equalities Taskforce on ensuring the right housing for Camden's diverse communities. This will help all partners to understand the impact of housing on health, to understand what services are already available in Camden, and to decide what more all partners could do to support residents and reduce health inequalities. The **Islington Health and Wellbeing Board** should continue their work on housing and health following their summit in September 2013.
- Public Health will work with partners to strengthen the focus on housing throughout the **Joint Strategic Needs Assessments (JSNAs) and the Joint Health and Wellbeing strategies (JHWS)**, focussing particularly on the views of local residents (including vulnerable people with complex needs) on how their housing affects their health.
- Existing contacts with residents should be used to **identify people in need of early housing or health interventions**, taking a prevention and early intervention approach, building upon Camden's '**No wrong door**'

People with mental health problems or learning disabilities living in stable accommodation

It is important for people with mental health problems or learning disabilities to live in stable and appropriate accommodation so as to improve their safety and reduce the risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care, and ensures a positive experience of social care. Both Camden and Islington have high levels of mental health need due to their relatively young populations and inner city locations.

Seventy-five percent of adults aged 18-64 years who are in contact with specialist mental health services in Camden and 78% in Islington live in stable accommodation. This compares to 59% in England and 79% in London. The equivalent figure for adults with learning disabilities is 79% in Camden and 74% in Islington, compared to 74% in England and 68% in London. The numbers of people who may require this type of accommodation is expected to increase over the coming years, so it will be important that the supply of specialist accommodation keeps up with demand.

Proportion of adults aged under 65 in contact with secondary mental health services or learning disabilities living in stable accommodation, 2012/13



Source HSCIC, Adult Social Care Outcomes Framework (2013)

BOX B: NHS Health Checks Programme for Council Tenants

Since 2010, Camden's Housing Support Group has worked with the local NHS on delivering targeted sessions of NHS health checks for council tenants and leaseholders, in tenants' halls on estates and other local venues where there are high concentrations of social housing. These partnership projects target interventions to populations with the highest health inequalities where many do not access other health services.

The Housing Support Group is currently working with Solutions 4 Health to deliver drop-in health sessions on the Regent's Park Estate with a mobile health clinic. The team are offering NHS Health Checks, stop smoking clinics and brief advice. Staff discuss patients' needs, provide support, and refer patients into other services including:

- Apples & Pears - weight management service
- Camden Alcohol Service
- Give It A Go! - free leisure centre memberships
- WISH+ Referral Hub - access to fire safety advice, home energy efficiency improvements, child safety equipment and other support
- Smokefreelife Camden: help to stop smoking
- Camden Psychological Therapies Services

The Mobile Clinic will target various other housing estates, council tenants and leaseholders throughout Camden during 2014.

policy and '**Every contact counts**' in Islington. This will help to mitigate against the impacts of the financial crisis and welfare reforms, and to build resilience within local communities. This requires **better information sharing** between different services. At a recent Housing and Health summit in Islington a GP stated "There is already lots of great work going on. I have heard about some fantastic work going on today but no one knows about it". Public Health will work with partners to ensure that health professionals, especially GPs, know about key housing interventions like WISH+ in Camden and SHINE in Islington **(box A)**, and where to refer people for housing advice and support. With other colleagues, the team will also explore whether there are further opportunities to **provide advice in different settings** (e.g. GP practices, children's centres, and other key community settings), which would include housing advice.

- Given that people in social housing have poorer health, there are also opportunities to do more work with **housing associations** and on **housing estates to promote better health** among residents using a whole range of interventions **(boxes B & C)**. There are also opportunities to work with residents themselves to improve their own health, using **asset-based community development approaches** which focus on strengthening existing skills, networks and resources that can be used to promote good health. Public Health will continue to work with partners to further develop these types of interventions if the pilots show that these approaches have been successful.

BOX C: Health Begins at Home — Family Mosaic pilot, Islington

In 2013, Family Mosaic started a pilot programme to see if a new model of health and housing interventions can reduce NHS usage in social housing residents aged over 50. It is too early to draw any substantive conclusions from the pilot, but it is clear that there are high levels of unmet health need, that people want to improve their health, and that social housing providers are ideally placed to support residents to take the first steps to healthier living.

"Mr D is 51 years old, and has sickle cell anaemia, an illness that can cause extreme pain without regular monitoring and medication. When we first met him, he wasn't registered with a GP and would regularly go to A&E when he was in crisis because of his illness.

In addition, his flat was cold and poorly furnished: he wasn't working, and was often short of money. We supported him to get a passport, so he can register with his GP. We've helped him to understand information about sickle cell anaemia, so now he's able to manage his illness better.

The windows in his flat have been draught-proofed, and we've told him about local groups who can help him with grants and recycled furniture. And with budgeting support, Mr D is now managing his money better, and has started saving for a new carpet."

The pilot designed as a randomised control study is running over 18 months, and will be jointly evaluated with the London School of Economics.

BOX D: Camden Housing First – tackling chronic homelessness

Camden Housing First (CHF) provides secure self-contained housing with intensive floating support for people with complex needs who are finding it difficult to move on from services provided in the Camden Hostel Pathway. CHF service users will usually have substance misuse and/or mental health needs and a history over many years of moving from hostel to hostel within the borough, often interspersed with periods of rough sleeping.

A CHF pilot service run by specialist charity SHP (which provides Supported Housing for people with immediate and ongoing needs in Camden) has been in operation for two years and has been independently evaluated by the University of York. The evaluation report, published in September 2013, found that positive outcomes had been achieved with all service users, with only one of them not sustaining their tenancy. Many of the service users had started to engage with services to address their support needs, which was something they had rarely done while staying in hostels. Some had also re-established links with friends and family that had been broken during their stays in hostels. Given the success of the pilot, Camden Council is about to tender for an expanded service that will work with up to 20 service users. It also found that CHF was cost effective compared to hostel-based services.

- People with **complex health needs** including mental health problems are more at risk of becoming homeless. Better understanding of why these groups are at risk, the trigger points for housing crisis and what upstream interventions would prevent these vulnerable groups from becoming homeless is needed.
- Both Councils are already proactively trying to mitigate the **impact of welfare changes**. It will be important to understand the impact of these and future changes on the population, building on existing research, and what this means for health inequalities in Camden and Islington. Public Health will monitor this over the next few years and will use the results to inform further initiatives.
- All of Islington Council's social housing meets the Decent Homes standard. In Camden, the council is making good progress to meet the Decent Homes standard by 2017 for all its homes (under its Better Homes programme). However, while the standard of social housing is improving, available data on the quality of homes in the **private rented sector** suggests that it is falling behind. Given the importance of good quality housing on people's health, both Councils should prioritise their work with private landlords and identify effective interventions to improve the quality of local private sector housing **(box E).**

BOX E: External wall insulation in Holly Park, Islington

Islington Council is installing external wall insulation to 269 solid-walled brick built properties on the Holly Park estate and cavity wall insulation to 623 'hard to treat' properties on Girdlestone Estate. The work began in September 2013, is scheduled to take six months at an overall cost of £2.5m. Similar previous external wall insulation works in other parts of the borough delivered average annual heating cost savings of £185 per property and received an average 95% satisfaction rating from residents.

One hundred of the 269 properties being treated at Holly Park have reported damp problems. Insulating walls will help reduce instances of damp caused by condensation as well as helping to alleviate fuel poverty and its negative impacts on physical and mental health. These objectives are being measured as part of an evaluation of the work, looking at its impact on energy usage, thermal comfort, and physical health and mental wellbeing.

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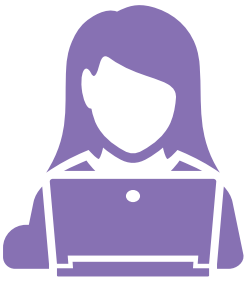
4. Education and health

Health and education are closely linked. A good education leads to better health outcomes in childhood and later life. The converse is also true: a child who is healthy is more likely to do well at school.



The importance of a good education

A child's level of physical activity, weight, sleep, mental wellbeing, use of drugs and tobacco, are all linked with educational attainment. The evidence also suggests that the long term influence of these factors exerts a similar impact on health, as on educational and career achievement. Therefore, many of the most common concerns about children's health are directly linked both with educational outcomes and the chances of a child living a healthy life.

These influences disproportionately affect children from disadvantaged backgrounds, perpetuating the links between inequalities in education and health. A wealth of evidence suggests that gaps in life expectancy between the most and least deprived communities in Camden and Islington are likely to be rooted in different experiences in childhood. Ensuring that children are healthy and able to learn should be considered a critical prerequisite of a successful schooling. Ensuring children receive a good quality education will likewise be a critical determinant of their health and wellbeing over the course of their lives.

Educational inequalities, influenced by family background, neighbourhood and relationships with peers, emerge early on in life. These are then compounded over time. The conditions that foster inequality early in life — demonstrated in cognitive tests even by the age of 22 months — are often maintained throughout childhood. The home-learning environment is the critical influence. Differences appear early on in the levels of stimulation provided to small babies, with research showing huge differences, for example, in the sheer numbers of words directed by parents to children and the nature of communication, from nurturing and encouraging to disciplining and authoritarian. The same factors that impact on educational inequalities shape these early interactions and will likely influence the support and encouragement given for school and homework later on in childhood. Children can overcome these disadvantages, however, with the right support, help, and opportunities.

Poor skills at school entry make it harder to catch up in a school environment. Once children come towards the end of their school lives, differences are stark. For children who achieve five good GCSEs, there are good opportunities to continue with their education, achieving A-levels or other qualifications, and to go on to further higher education or an apprenticeship. For those who do not achieve five good GCSEs whilst there remain options, they are more limited. Many will find a successful path forward but others will struggle to find a place on the 'good work' ladder associated with good health. The risk of being NEET — not in education, employment and training — rises considerably without good GCSE results.

Chapter 2 on employment considers the importance of parental employment and looks at what is being done locally to support parents back into work.

The importance of a good education

The local picture

What more can be done to reduce health inequalities?

"A large body of research in social science, psychology and neuroscience shows that skill begets skill; that learning begets learning. The earlier the seed is planted and watered, the faster and larger it grows....Once a child falls behind, he or she is likely to remain behind. Remediation for impoverished early environments becomes progressively more costly the later it is attempted in the life cycle of the child."

James Heckman, Nobel Prize winning economist

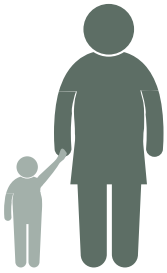
All across that childhood journey, health is one of the factors that influence positive educational experiences. Having their basic needs met, healthy nutrition, sufficient sleep and good mental health are critical to a child's ability to concentrate on schooling. Poor health causes children to miss school. Sixty four percent of all pupil absences in Islington and 68% in Camden are due to health reasons (including illness, medical and dental appointments). Absence from school, which is also associated with other factors such as bullying, is strongly associated with poorer educational outcomes. Early Help strategies in Camden and Islington are designed to ensure that individuals and families receive early intervention and, where necessary, targeted support as early as possible to reduce absence. For example, Islington's Families First programme works with some of the borough's most vulnerable families (e.g. low income, minority ethnic communities, single parents, sick/disabled parents). Families First has delivered a number of positive outcomes, including a 60% reduction in unauthorised absence within a group of 109 children where this was identified as an issue. In Camden, the complex families programme is being piloted to support a reduction in the number of families experiencing complex and multiple needs. This has led to the development of a new framework to enhance earlier identification of need, family engagement, assessment and integrated care planning. As of July 2013, two-thirds (167) of families supported as part of the year one cohort of the pilot met the nationally defined 'measures of success', of which reducing absence is a key indicator.

Family background such as poverty, parental education and the home environment, play a strong role in predicting educational attainment, but the system itself can play a hugely significant role in helping all children to realise their potential.

Education: children

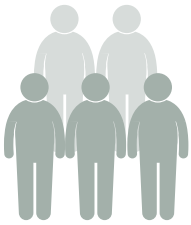
School readiness [a] 2012/13

'School readiness' is an assessment of a child's behaviour and understanding, and is an indicator of the child's development in the first years of their life.



47% of 5 year olds in Camden are reaching a 'good level of development'.

This is **lower** than the London (53%) and England (52%) averages.

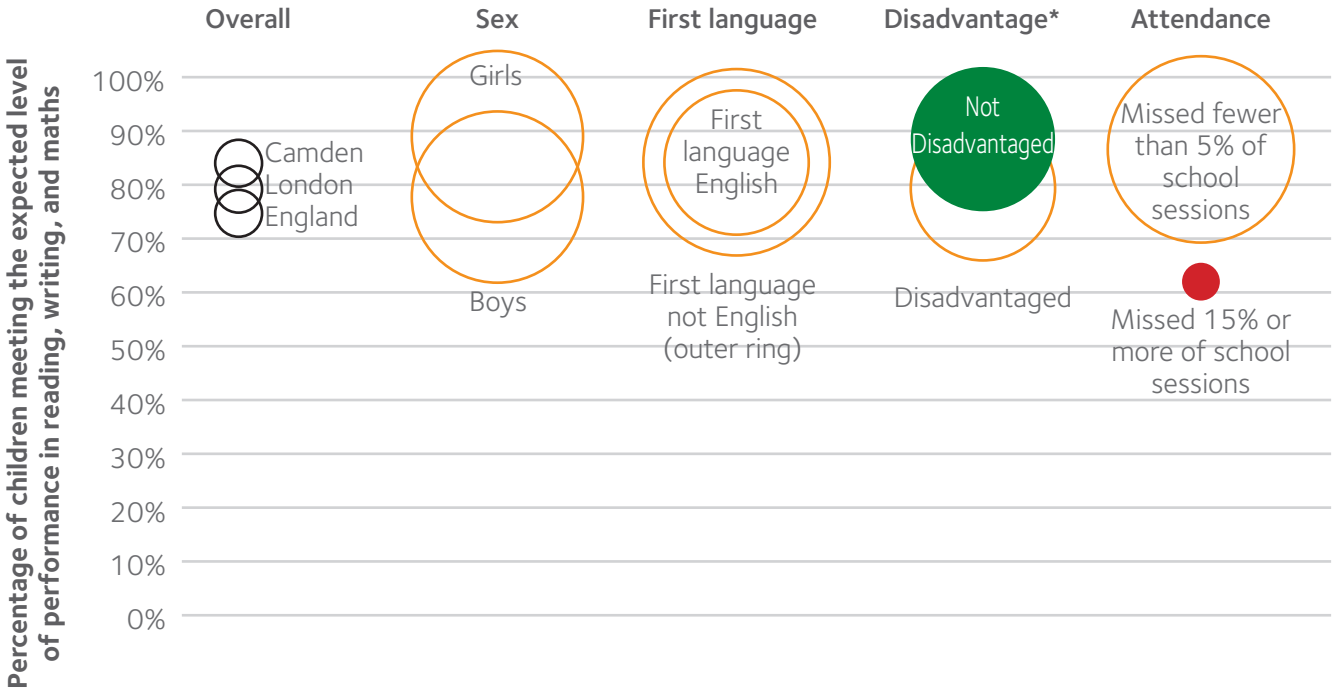


930 children in Camden are not reaching a good level of development by age 5.

About **110** (11%) of these children would need to reach a good level of development by age 5 to reach the current London average.

School readiness is lower in deprived areas - 43% of five year olds in deprived areas achieve a good level of development, compared to 53% of all other children.

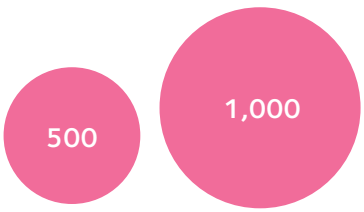
Attainment among primary school pupils (Key Stage 2) [b, c] 2012/13



What is the difference?

- Higher than the Camden average
- Not significantly different from the Camden average
- Lower than the Camden average

How many pupils?



* Disadvantage is defined here as being eligible for free school meals at any point in the past six years and children looked after.

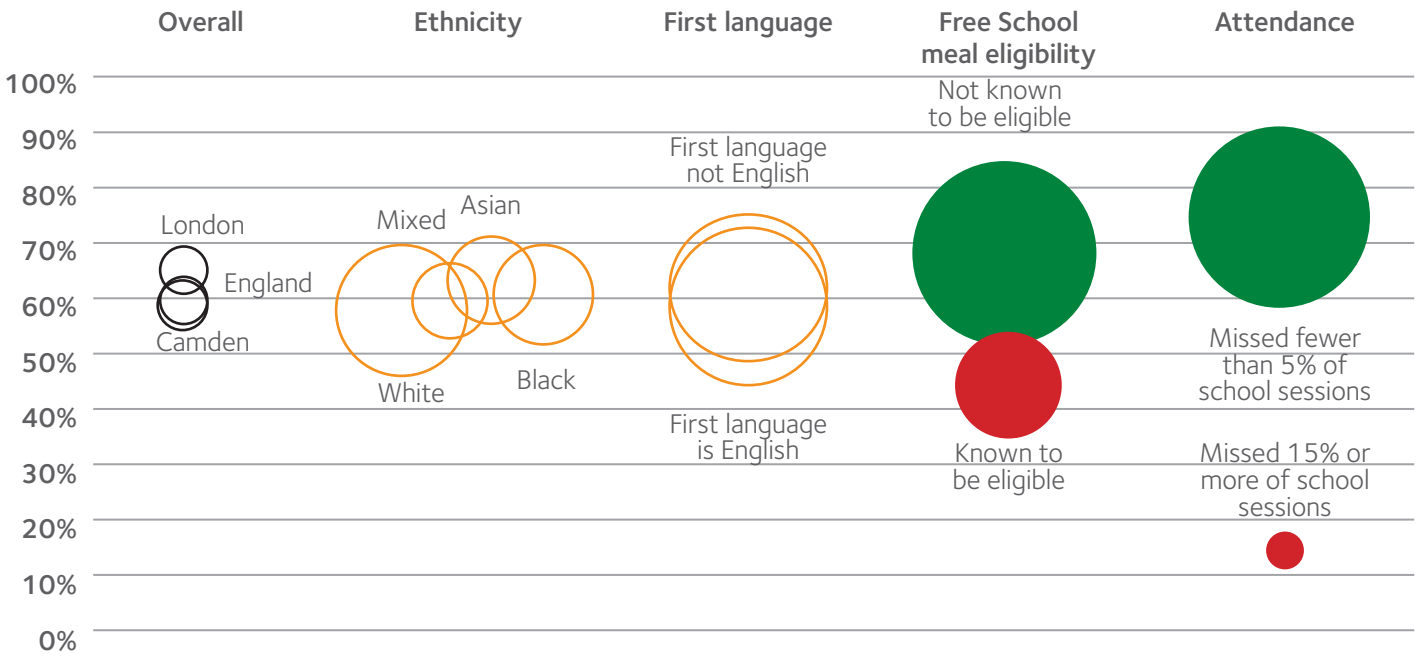
Note: 'Overall' bubbles are not to scale.

Sources: a) Department for Education (2013); b) Department for Education (2014); c) Camden Council (2014).

Education: young people

GCSE attainment [a, b) 2012/13

This shows the percentage of Camden students achieving 5 A*-C grade GCSEs, compared against the London and England averages, and by selected demographic and economic factors.

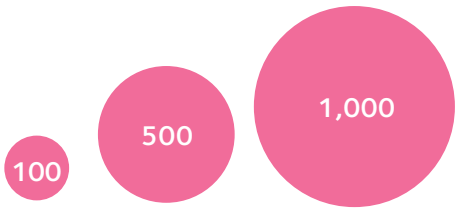


What is the difference?

- Higher than the Camden average
- Not significantly different from the Camden average
- Lower than the Camden average

Note: 'Overall' bubbles are not to scale.

How many pupils?

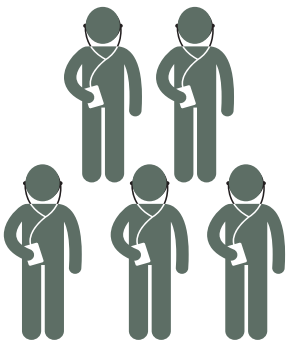


Young people not in education, employment or training (NEET) [c) 2013/14

4.0% of 16-18 year olds in Camden are not in education, employment, or training.

This is **higher** than the Central London average (3.7%).

Note: The percentage and number of NEETs may be underestimated due to the level of young people with unknown activity.



155
16-18 year olds in Camden are 'NEET'.

A-level attainment (Key Stage 5) [a) 2012/13

83% of students aged 16-18 in Camden achieved A Level qualification or equivalent (including two substantial Level 3 qualifications).

This is **lower** than the London (92%) and England (92%) averages.

8% of young people aged 16-18 year olds in Camden are achieving the best A level score (3 A*- A).

This is **lower** than the London (10%) and England (13%) averages.

Sources: a) Department for Education (2014); b) Camden Council (2014); c) Camden Council, February 2014.

The local picture

In recent years there have been significant strides in raising educational standards and attainment in both Camden and Islington, and both boroughs now have very good standards of educational achievement, particularly considering the levels of deprivation locally. This reflects the high quality teaching and leadership within local schools and early years settings. However, given the levels and patterns of socioeconomic deprivation locally, significant challenges remain in tackling inequalities in educational and health outcomes, a challenge which is also evident right across the country.

As of August 2013, 79% of children[1] in Camden and 81% in Islington attended early years providers rated as good or better by OFSTED, compared with 81% nationally. However, nationally, children from deprived backgrounds and low income families are less likely to access early years education due to affordability or flexibility of service provision. The work of local children's centres aims to engage with families and provide high quality, affordable childcare as well as informal stay and play sessions. To support better health outcomes during the first years of life in Camden and Islington, public health provision in children's centres and nurseries encourages breastfeeding and healthy eating, physical activity and promotes smoke-free homes, supporting families to give their children the best start in life. Camden and Islington's children's centres are continuing to increase the success they have at reaching local children and families. In 2012/13, Islington's children's centres reached 88% of children and families in the borough including 83% from low income families. In Camden, children's centres reached 75% of children under 5 in the borough. For children under 5 living in the top 5 most deprived wards (IDACI) the average reach was 85%. This highlights the importance of these settings for the delivery of these key early years' health and wellbeing interventions.

At the end of reception year, teachers rate children on what is known as the Early Years Foundation Stage Profile. This assesses children across a broad developmental spectrum and is taken as a measure of 'school readiness'. The areas assessed include: communication and language; physical development; personal, social and emotional development; literacy; mathematics; understanding the world; expressive arts and design. Children's school readiness will reflect strongly their home environment, but also the potential impact children's centres, childcare provision, libraries and the reception year itself will have had on children's development. In Camden and Islington, 47% and 44% of children respectively, are reaching a 'good level of development' at the end of reception year. This is below the London and England averages (53% and 52% respectively), highlighting potential opportunities to build upon the work in children's centres and other early years settings locally. Both locally and nationally, school readiness is lower among boys than girls; 38% of boys and 57% of girls in Camden are school ready, and 37% and 51% in Islington. Deprivation is also linked to school readiness; nationally, 44% of children who live in the most deprived areas[2] of the country are school ready, compared to 56% of all other children. There is a similar difference in school readiness linked to deprivation within Camden, but not in Islington. This is because the vast majority of Islington's five year olds live in the most deprived areas nationally.

In 2012/13, 94% of pupils[3] in Camden and 89% in Islington attended primary schools rated good or outstanding by OFSTED, compared with 77% nationally. By the end of primary school

[1] These are pupils attending Camden or Islington early years education. They are not necessarily all residents and some residents will attend early years education out-of-borough.

[2] The most deprived 30% of small areas (Lower Super Output Areas) in the England.

[3] These are pupils attending Camden or Islington schools. They are not necessarily all residents and some residents will attend schools out-of-borough.

(key stage 2), the proportion of pupils achieving the expected level of reading, writing and mathematics was higher in Camden than England and London (82% compared to 76% and 79% respectively). Attainment in Islington (77%) was similar to the England average but lower than London, which can probably be explained by higher levels of deprivation across the borough. Disadvantaged pupils (defined as children with any eligibility for free school meals in the past six years, and looked after children) in both Camden and Islington are less likely to achieve the expected standard at key stage 2 than other pupils.

In 2012/13, all pupils in Camden and Islington attended secondary schools rated as good or outstanding by OFSTED. The level of GCSE attainment has improved over the past five years in both boroughs. In Camden, the level of GCSE attainment has largely improved in line with England, and is now similar to the national average (60% vs. 61% nationally) but is lower than London (65%). In Islington, GCSE attainment has improved at a faster rate, starting from a lower point. The level of pupils achieving five good GCSEs A*-C (including English and Maths) was notably lower than England and London in previous years, but is now higher (64%) than England and similar to London. In both boroughs, those eligible for free school meals (a marker of deprivation) and those with high levels of absence are less likely to achieve good GCSE results. In Camden the gap between deprived/ disadvantaged students and students who are better off is much starker in secondary school compared to primary school, illustrating how the inequalities gap increases over time. In Islington the gap is smaller and remains unchanged.

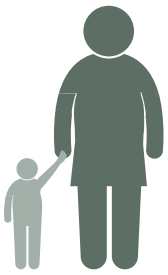
While many children from Camden and Islington achieve excellent results at school, too many continue to leave school without the requisite qualifications associated with good employment and healthy adult lives. In Camden and Islington in 2013/14 4.0% and 4.8% of 16-18 year olds were not in education, employment or training (NEET). This compares to 3.7% across Central London as a whole, although these figures should be interpreted with caution as there are issues with data quality in some areas and young people's outcomes are not universally recorded. Local data show that in both Camden and Islington over 60% of NEETs have attended secondary school within their home borough.

The majority of NEETs are of White ethnicity (55-60%), followed by Black, Mixed, and Asian ethnic groups (3-18%), Compared to the general population aged 16-19 in each borough, White young people are overrepresented among NEETs in Islington whereas the equivalent is true for Black young people in Camden. Asian young people are under represented in both boroughs. Of those who do stay in education after 16 years, the percentage of students who achieved a least two substantial A levels (level 3 qualifications) is lower in both Camden and Islington compared to London and England, as is the percentage achieving the best A level scores. This highlights opportunities to improve educational outcomes for young people post-GCSE in Camden and Islington, as well as continuing efforts to reduce the number of children who become NEET.

Education: children

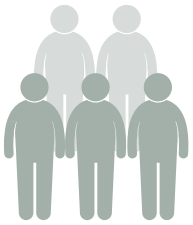
School readiness [a] 2012/13

'School readiness' is an assessment of a child's behaviour and understanding, and is an indicator of the child's development in the first years of their life.



44% of 5 year olds in Islington are reaching a 'good level of development'.

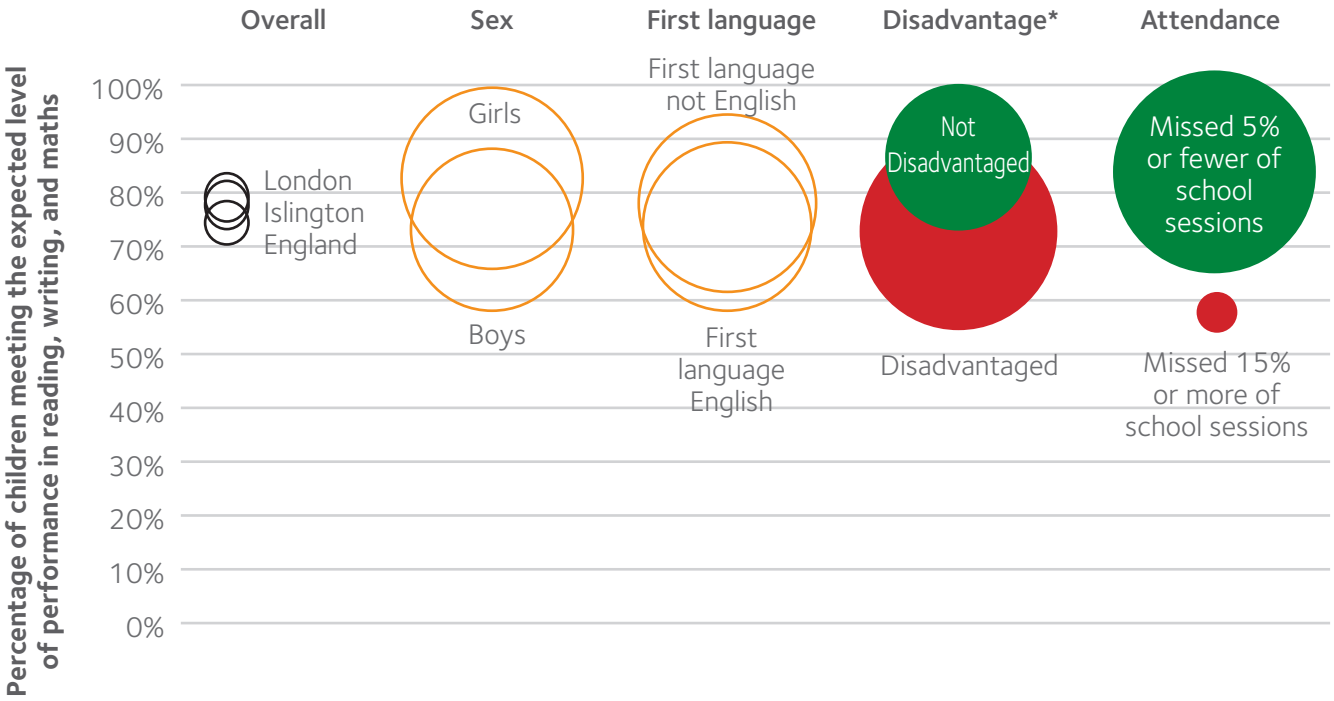
This is **lower** than the London (53%) and England (52%) averages.



1,140 children in Islington are not reaching a good level of development by age 5.

About **180** (16%) of these children would need to reach a good level of development by age 5 to reach the current London average.

Attainment among primary school pupils (Key Stage 2) [b, c] 2012/13



What is the difference?

- Higher than the Islington average
- Not significantly different from the Islington average
- Lower than the Islington average

How many pupils?

* Disadvantage is defined here as being eligible for free school meals at any point in the past six years and children looked after.

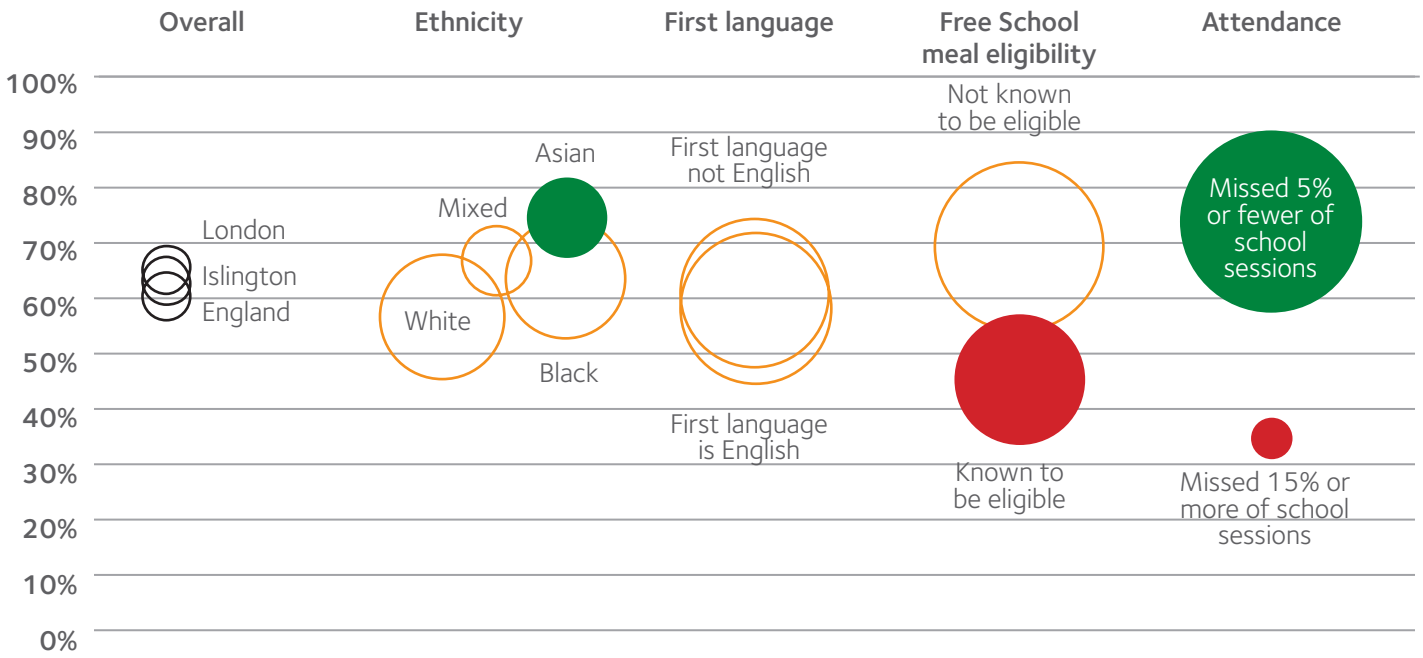
Note: 'Overall' bubbles are not to scale.

Sources: a) Department for Education (2013); b) Department for Education (2014); c) Islington Council (2014).

Education: young people

GCSE attainment [a, b) 2012/13

This shows the percentage of Islington students achieving 5 A*-C grade GCSEs, compared against the London and England averages, and by selected demographic and economic factors.



What is the difference?

- Higher than the Islington average
- Not significantly different from the Islington average
- Lower than the Islington average

How many pupils?

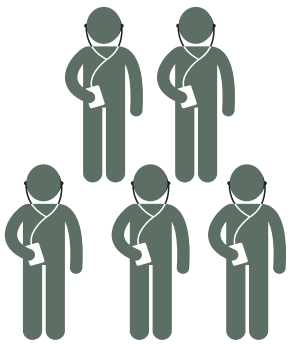
Note: 'Overall' bubbles are not to scale.

Young people not in education, employment or training (NEET) [c) 2013/14

4.8% of 16-18 year olds in Islington are not in education, employment, or training.

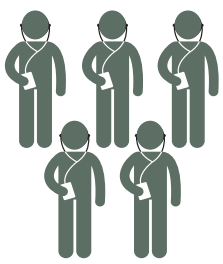
This is **higher** than the Central London average (3.7%).

Note: The percentage and number of NEETs may be underestimated due to the level of young people with unknown activity.



214
16-18 year olds in Islington are 'NEET'.

A-level attainment (Key Stage 5) [a) 2012/13



86% of students aged 16-18 in Islington achieved A level qualification or equivalent (including two substantial Level 3 qualifications).

This is **lower** than the London (92%) and England (92%) averages.

4% of young people aged 16-18 year olds in Islington are achieving the best A level score (3 A*- A).

This is **lower** than the London (10%) and England (13%) averages.

Sources: a) Department for Education (2014); b) Islington Council (2014); c) Islington Council, February 2014.

Conor: Young person not in education or employment, Camden

Conor is a 19 year old, white Irish male who had been out of work for nearly a year. Gaining an apprenticeship provided him with a step back into work and employment.

Before becoming an apprentice Conor was unemployed due to being made redundant from his previous job as an Office Administrator. He was unemployed for 10 months but had been actively looking for jobs in that time. It was not until the last 3 months of this period that he started applying for apprenticeships.

Conor was a looked after child and began to do voluntary work for the organisation that ran the children's home he was placed in. Working in this sector helped Conor develop an understanding of the way it works. He quickly became interested in learning more and wanted to help make the environments that young people lived in better. Conor did not expect to change it all but felt that even being able to make a small part of it better would have been a good outcome. He applied for an administration apprenticeship with Look Ahead but after speaking with the advisor interviewing for the post, it became clear that he was more interested in working with people than working in an office. He was invited to interview for the position of apprentice support worker instead of the administration role. He was very happy with this outcome, although a little bit sceptical about working with vulnerable adults because he had originally wanted to work with young people, however, he was happy to start somewhere.

Conor was placed in a High Support Complex Needs Service which dealt with alcoholism, substance misuse, mental health, homelessness and young people. At first he had little confidence in dealing with residents who were aggressive but he soon developed approaches to help him deal with the various behaviours. He also worked with external bodies including local Job Centres and housing departments. He undertook regular training to ensure he kept up to date with government legislation.

Six months into his apprenticeship Conor was offered the position of Assistant Support Worker. He is now a full time Support worker with a client base averaging 11-13 residents.

Conor's own experience and that of working with young people has led him to consider studying to become a social worker. He hopes that as a social worker he will have a better ability to help young people achieve their goals and hopefully get them set up with the life they want.

Source: National Apprenticeship Service (2013)

What more can be done to reduce health inequalities?

A recent report by the King's Fund on reducing health inequalities has highlighted a range of steps that local authorities can take to support schools to deliver better educational outcomes, with a particular focus on the most vulnerable children and young people. These actions focus on:

- reducing drop-out and exclusion rates, bullying and the prevalence and impact of conduct disorders
- developing children's life skills such as problem-solving, and building self-esteem and resilience to peer and media pressure
- incorporating more physical activity into the school curriculum and promoting healthy diets at school, focusing on 6–12 year olds
- developing targeted wellness services for children with multiple poor behaviours
- supporting the use of resources, such as those available through the 'Healthy Schools' programme.'

BOX A: Improving Packed Lunches at Edith Neville, Camden

Staff at Edith Neville contacted the Health Improvement Team (HIT) due to concerns over the content of pupils' packed lunches. The HIT undertook a packed lunch audit that showed that children were consuming low levels of vegetables and water and high levels of chocolate, sweets and sugary drinks. The majority of the children were having pre-packaged foods and a significant number were having crisps. The HIT also observed that many children were throwing away most of their lunch uneaten.

With support from the HIT, staff updated the healthy packed lunch policy and invited parents with children on packed lunches to a focus group to get their views on the policy. After hearing about the rising obesity levels in Camden and what would constitute a balanced diet, parents voted on key points in the policy with a resulting ban on sugary foods or drinks. Further support with implementing the new policy was offered through packed lunch workshops and fussy eating workshops attended by both parents and children.

After three months the packed lunch audit was repeated with very positive results. Fruit and vegetable intake had increased, while consumption of sugary drinks, crisps, salted snacks, chocolates and sweets had all fallen. In addition, food wastage fell as staff ensured uneaten food was taken back home in the children's lunchboxes.

Percentage change in packed lunch contents

Locally, it is important to recognise that both councils already have existing programmes of work focused on improving educational attainment. The following recommendations, therefore, build on this existing good work:

- Camden and Islington Councils already recognise the importance of ensuring every child has the best start in life and this includes a good education. Both **Camden's and Islington's Health and Wellbeing Boards** have prioritised improving the health and wellbeing of children and young people. In Camden this includes supporting the borough's most complex families and tackling childhood obesity. In Islington, the Board's 'Best Start in Life' priority has focussed attention and coordinated action on the First 21 Months, from conception to a child's first birthday. The boards should continue to maximise opportunities to deliver improvements in this important area, with a particular focus on continuing to improve educational attainment.
- Camden and Islington have both developed strategies on **Early Help**. These aim to ensure that individuals and families receive early intervention and, where necessary, targeted support as early as possible. Both boroughs will continue to develop and support action on Early Help and Early Intervention for children, young people and their families including throughout the education setting. Given the strong links between educational attainment and other social determinants of health such as housing and employment, as well as

BOX B: Use of the Pupil Premium Grant by Pakeman Primary School, Islington

The Pupil Premium Grant, which is additional to main school funding, is designed to address the underlying inequalities between children eligible for free school meals and their peers, by ensuring that funding to tackle disadvantage reaches the pupils who need it most.

The Pupil Premium Grant is allocated to schools to work directly with children who have been registered for free school meals at any point in the last six years. Pakeman Primary School has a higher percentage of children on free school meals, with Special Educational Needs and who are learning English as an additional language compared to the Islington average. The school views its diverse community as a strength, and is committed to mitigating some of the challenges pupils face so that they can reach their full potential. Pupil premium funding represents a significant proportion of the school's overall budget.

Pakeman Primary School is using the Pupil Premium Grant to narrow the gap between pupil groups, particularly those on free school meals, who often have lower levels of attainment. The primary focus for use of the grant has been on improving learning in the curriculum through initiatives such as introducing non-class based team leaders, assertive mentoring, developing children as leaders, providing additional reading and writing support, and enrichment activities including Shakespeare workshops and Puzzle days. Pakeman Primary School has also used the grant to support the wider school community and families through targeted work with parents in crisis and supporting parents to extend their own skills.

The school has seen improvements in the level of attainment of disadvantaged pupils at the end of key stage 2 across all areas, including: increases in the proportion achieving level 4 in reading from 57% (2011) to 88% (2013) and increases in those achieving level 4 in maths from 71% (2011) to 96% (2013). The school was recently awarded the National Primary School of the Year award for raising the attainment of disadvantaged pupils.

opportunities for health professionals to intervene early, it is important that these strategies are wide-reaching.

- The school nursing teams in Islington and Camden continue to deliver the **5-19 Healthy Child Programme**. The teams should continue to identify areas where delivery could be strengthened to meet the health and wellbeing needs of school-aged children and young people. These include; increasing uptake of childhood immunisations, supporting children to maintain a healthy weight, closer working with the healthy schools teams and promoting an understanding of their population, linking in with primary care and community services to support children with long term conditions and manage health-related absence.
- Through the **Healthy Schools Programme**, Camden and Islington Councils support and encourage primary, secondary and special schools and pupil referral units to implement policies and practices that will improve children's health and educational attainment. In Camden thirty schools are recognised as Healthy Schools and a further 10 are nearing completion of the process. Overall 93% of schools are engaged in the renewal process. In Islington thirty-two (55%) of the fifty eight schools are currently recognised as Healthy Schools with a further 14 (24%) working towards accreditation. With the support of school improvement teams in both councils, **all schools** should work towards becoming recognised as a Healthy School.

BOX C: Increasing physical education (PE) participation at Mount Carmel Catholic College for Girls, Islington

Low participation in PE lessons and extra-curricular clubs was a serious concern at the school in 2012.

As a first step, a whole school survey on PE and school sport was undertaken to explore students' attitudes and barriers to participation, as well as to understand what might encourage students to take part in PE and school sport. A range of changes were made as a result of the survey, including:

- Broadening the range of physical activities available to students in school to include swimming, dance, netball, table tennis, rounders and fitness, and expanding the range of extra-curricular activities to include yoga, cheerleading and football through building stronger relations with outside agencies.
- Running associated activities that students had requested including cycle training and Heart Start CPR.
- Renovating the PE facilities to make them more welcoming and inspiring.
- Sports Captains nominated in all forms, with a specific role in encouraging peers to engage in physical activity.
- A new PE policy was introduced which states that "Students must bring PE kit to every lesson. If they are ill or injured they must bring a note and kit in order to play an alternative active role in the lesson e.g. scorer, coach, official".

As a result of these changes, there has been a significant increase in participation in PE lessons, with attitudes, behaviour, physical competence, fitness and relationships all noticeably improved.

- Supporting young people aged 16-18 years who are **not in employment, education or training (NEET)** to get a job or get further education or training is vitally important for their life chances. This includes working with schools outside of Camden and Islington, as a substantial number of children who are NEET are schooled elsewhere. In addition to supporting existing initiatives to do this, there should be greater emphasis on the early identification of and support for **mental health problems** in this age group, which evidence suggests has increased in recent years.

BOX D: Skills for life programme in Brookfield Primary School, Camden

Brookfield Primary School has developed the Skills for Life programme — in collaboration with the Camden School Improvement service — as part of their wider programme to enhance learning for vulnerable children. Pupils from each year group were identified for this specific project, all with some 'barriers' to learning (e.g. resilience, behaviour, motivation). These pupils became known as the 'Skills for Life' cohort.

Camden School Improvement Service provided training to school staff to support the development of a model mentoring programme. Key features of the programme included:

- Adopting a problem solving approach tailored to Brookfield's context, based on research and effective practice.
- Staff commitment to weekly 15 minute mentoring sessions with an identified pupil
- Working with staff to establish achievable 'skills' with pupils
- Involving parents/carers in the process
- Identifying and celebrating success

A number of changes and differences were observed between the children attending the programme and the rest of the school:

- Academic progress: equal or better progress than other children in reading and writing
- Behaviour: 45% reduction in the number of serious incidents
- Attendance and punctuality: compared favourably with data for the school overall
- Relationships between staff and identified pupils had improved

In addition, staff reported feeling more empowered in their role, and also developed a greater range of approaches and creative strategies for supporting children facing particular challenges.

This highly inclusive programme enabled the school to reach out to some of the more vulnerable children, and the children engaged in the programme have acquired a range of new skills, leading to improved outcomes in behaviour, attendance, confidence, self-esteem and national curriculum attainment levels. The Skills for Life programme has also been much praised by parents and carers.

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Suhreke M, de Paz Nieves C (2011). The impact of health and health behaviours on educational outcomes in high-income countries: a review of evidence. Copenhagen, WHO Regional Office for Europe. Available from http://www.euro.who.int/__data/assets/pdf_file/0004/134671/e94805.pdf [accessed 13/6/11]

5. Supporting people to have a healthy standard of living

Transport, housing, energy and food costs have all risen in recent years making it increasingly challenging for people to afford a healthy standard of living, particularly if they are on lower incomes.

Being able to afford a healthy standard of living and income inequalities

Insufficient income can have a detrimental impact on health in a number of different ways. Firstly, people may be unable to afford to heat their homes, live in decent housing, or buy nutritious food. In addition, they may be forced to reduce their leisure time and cut back on their social life which may leave them feeling excluded from society, impacting on both their physical and mental health. Analysis by the Joseph Rowntree Foundation shows how the cost of living across the UK has been increasing over the past few years, and particularly so for families with children.

The rising cost of living does not just affect those who are on benefits —plenty of people are affected by 'in-work' poverty too, particularly given that rises in inflation have been outpacing wage increases over the past few years. 'In-work' poverty has been a key driver behind the creation of a 'living wage', which is calculated so that people can afford the basic cost of living **(box A)**. Local estimates suggest that one-in-ten working residents in Camden and Islington earn less than the London Living Wage per hour. These residents are likely to be struggling to afford the basics necessary for a healthy life if this is their only income. For example, a lone parent supporting one child and earning the national minimum wage would need to earn about £900 more each week to live in the private rented sector in Camden or Islington.

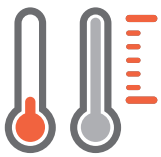
While the average income in London is higher than the national average, once regional price variations are considered, people's disposable income (or lack of it) is about the same for many, but less for those on the lowest incomes. The difference in London is that income inequality is far wider than the rest of country, and particularly so in inner London boroughs like Camden and Islington, where there are extreme levels of wealth and poverty. Evidence suggests that it is not just the poor whose health and wellbeing suffers from these large inequalities: the wider the inequality the worse the health and social outcomes are for everyone.

Fuel poverty

Rising energy prices are a key issue for many people with those on the lowest incomes having to decide whether to 'heat or eat'. Fuel poverty is covered in **chapter 3** on housing.

Being able to afford a healthy standard of living and income inequalities

Fuel poverty



Affordable housing

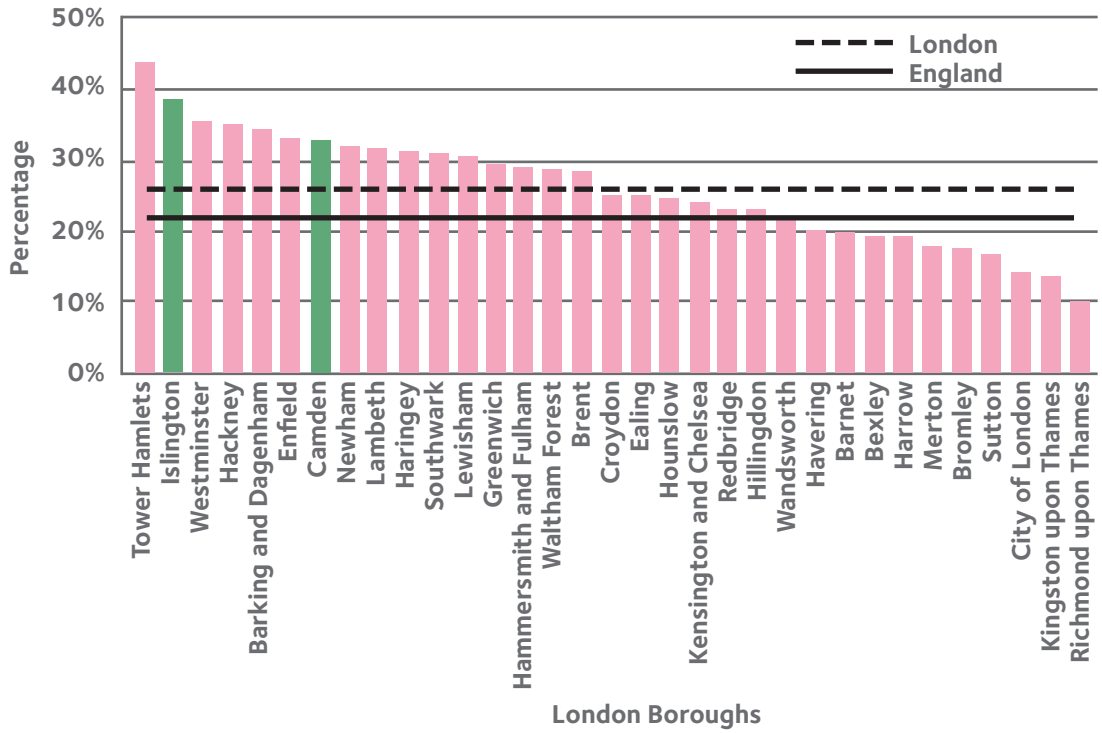
Food poverty

Debt

What more can be done to reduce health inequalities?

Children in poverty

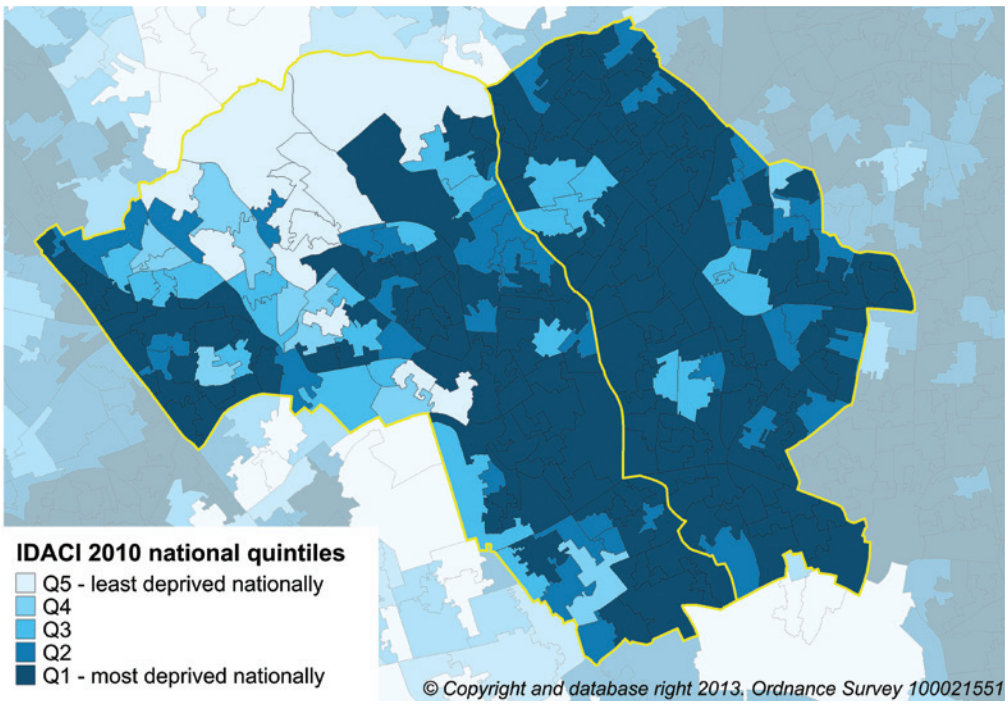
Percentage of children living in poverty (under 16s), 2011



Source: Child Poverty Statistics, (2011), Public Health Outcomes Framework (2013)

A key concern in both Camden and Islington is the high levels of child poverty, as there is evidence that childhood poverty leads to early deaths and poor health outcomes for adults, as well as an increased risk of developmental and social problems both in childhood and in the longer term. Therefore reducing child poverty is central to increasing life expectancy and reducing health inequalities. A third of children in Camden and 38% of children in Islington are living in poverty. These are children who are living in families in receipt of out-of-work benefits or tax credits where their reported income is less than 60% of median national income. The Income Deprivation Affecting Children Index (IDACI) highlights the geographical differences in deprivation affecting children in Camden and Islington. While children across most of Islington are deprived, there are geographical differences in Camden, with fewer children affected by income deprivation in the more affluent areas in the north of the borough.

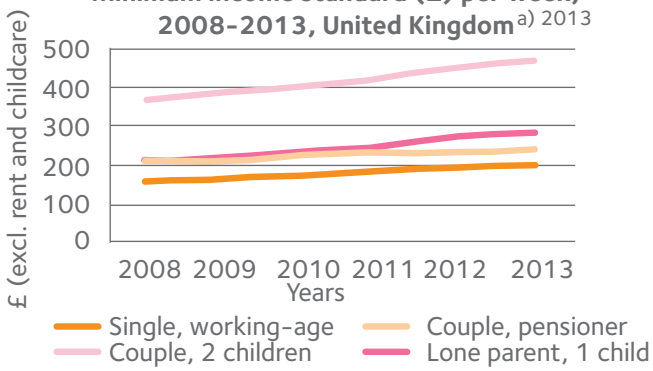
Income Deprivation Affecting Children Index (2010) by Lower Level Super Output Area, Camden and Islington



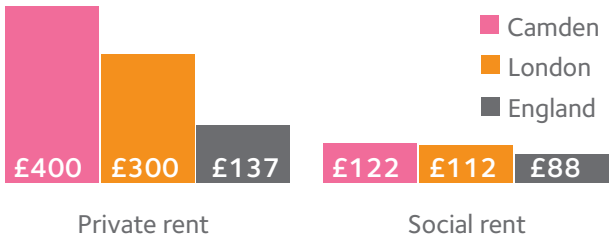
Being able to afford a healthy standard of living, and income inequalities

Expenditure

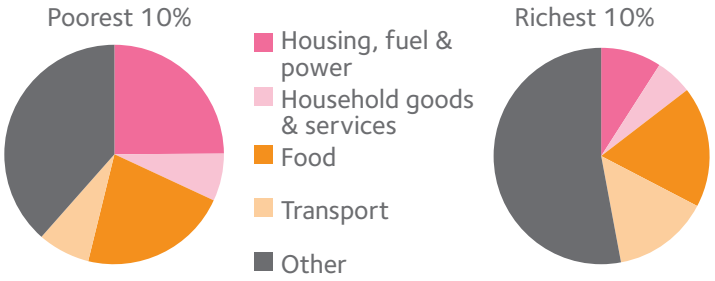
Minimum income standard (£) per week, 2008-2013, United Kingdom [a) 2013]



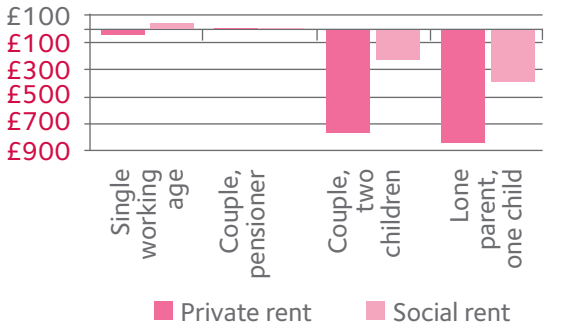
Weekly private and social rent (median) [b, c) 2013]



Weekly expenditure by income groups in UK [d) 2012]

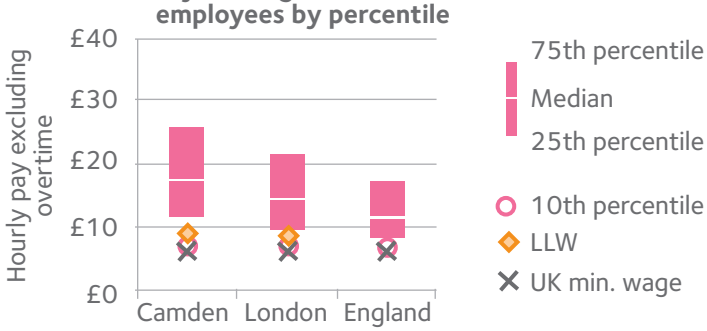


Indicative difference between weekly earnings based on London Living Wage and expenditure (Min. Income Standard) [a, b, c, g) 2013]

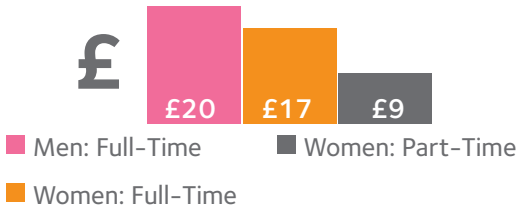


Earnings [d) 2012]

Hourly earnings for all resident employees by percentile



Median earnings, hourly rate excluding overtime, by gender

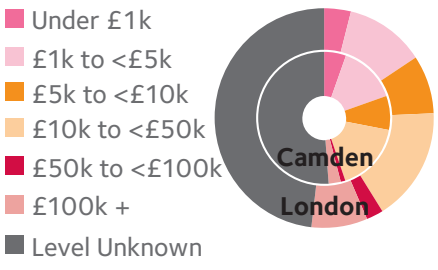


Note: Data not available for part-time men

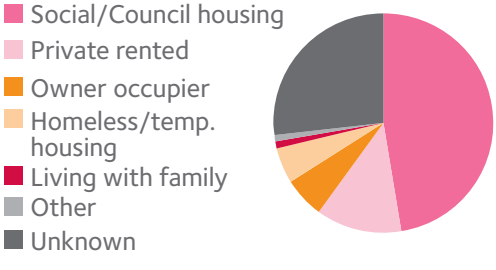
Debt and Individual insolvencies

1,639 people seeking advice from debt advice agencies (Citizens Advice Bureau, Capitalise, and CCCS) [f) 2011/12]

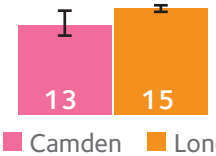
Debt level



Debt advice by tenure



Individual insolvencies rate per 10,000 adult population [e) 2012]



232 individual insolvencies

-4% since 2011

Sources: a) JFR report, MIS Budget (2013); b) Department for Communities and Local Government (2013); c) Valuation Office Agency (2013); d) Office for National Statistics, ONS (2013); e) The Insolvency Service (2013); f) Citizens Advice Database (2013); g) HMRC tax calculators

Affordable housing

Across the UK, the poorest in society spend disproportionately more of their income on housing and heating costs than the richest (25% vs. 9%), reducing their disposable income. Affordable housing is a particular problem in Camden and Islington, with average house prices of around £885,000 and £570,000[1] in each borough, respectively, and average market rents that are far higher than the London and national averages. Difficulty accessing suitable, affordable housing can be detrimental to health and wellbeing because households are at greater risk of debt, arrears, overcrowding, and potentially homelessness. High expenditure on housing, combined with other costs, like rising energy bills, also reduces people's disposable income to spend on healthy living, including nutritious food, leisure, and social activities.

Lack of affordable housing is a key concern for both Camden and Islington residents, and both councils have made addressing the challenge of affordable housing a top priority. In Camden the challenges faced by residents were clearly

BOX A: Raising incomes: paying the London Living Wage

Implementing a living wage has been identified as a way to have a direct impact on income inequality — a root cause of health inequalities. Paying a living wage helps to address 'in-work poverty' and provides an incentive to work and enhance health and wellbeing. It also has benefits for employers, with evidence that it improves work quality and productivity, reduces absenteeism, and has a positive impact on staff retention and recruitment. At a societal level, there is evidence that income inequalities are detrimental to everyone's health; both rich and poor, so reducing these inequalities through paying a living wage will benefit the whole population.

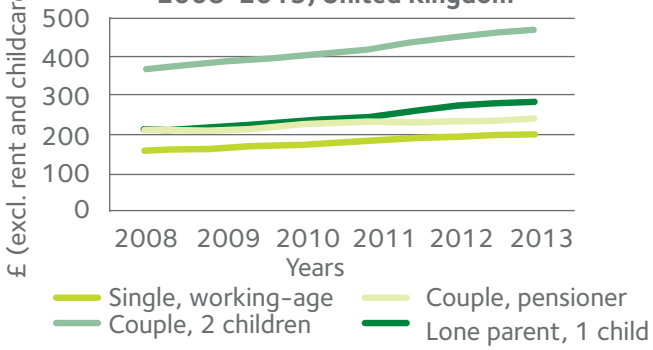
London has its own 'London Living Wage', which reflects the higher basic cost of living in the capital. Currently this stands at £8.80 per hour, compared to the national minimum wage which is £6.31. Looking at the hourly earnings of working age residents in Camden and Islington shows that one-in-ten (about 8,000 residents in Camden and 9,000 residents in Islington) earn less than the London Living Wage.

Both Camden and Islington Councils are fully committed to supporting and promoting the London Living Wage, acting as exemplar employers. Islington Council was the first local authority to adopt the London Living Wage and Islington CCG the first CCG to adopt the Living Wage. All employees of both councils are paid the London Living Wage and it is also strongly promoted through the procurement of goods and services from contracted providers. To date, 20 and 36 external organisations in Camden and Islington respectively, have publicly signed up to pay the London Living Wage. While this is a sizeable number compared to many other boroughs, there are still many opportunities for other organisations, including health partners, to sign up.

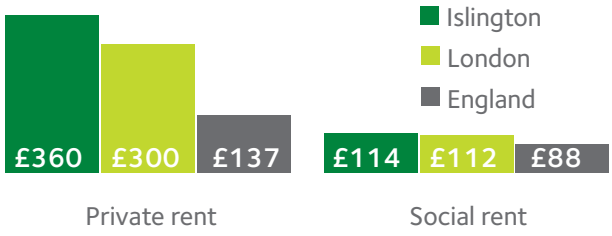
Being able to afford a healthy standard of living, and income inequalities

Expenditure

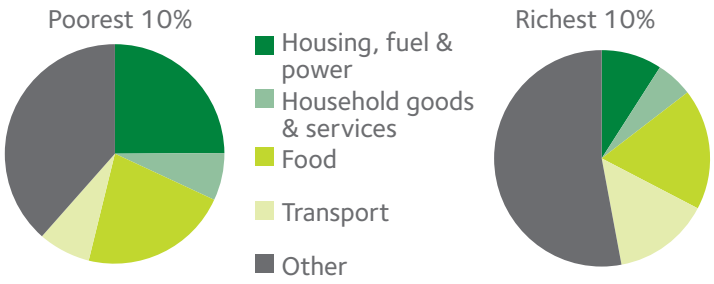
Minimum income standard (£) per week, 2008-2013, United Kingdom a) 2013



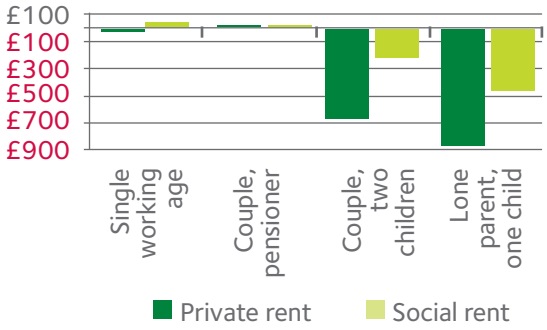
Weekly private and social rent (median) b, c) 2013



Weekly expenditure by income groups in UK d) 2012

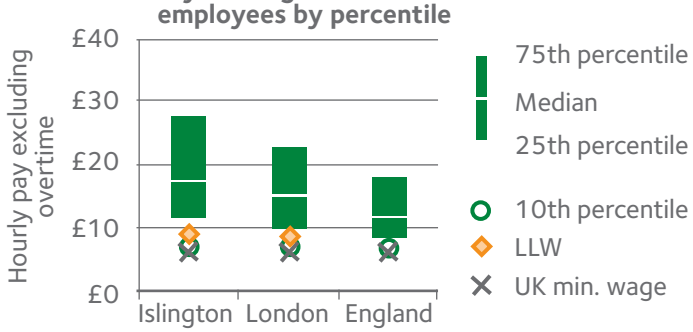


Indicative difference between weekly earnings based on London Living Wage and expenditure a, b, c, g) 2013

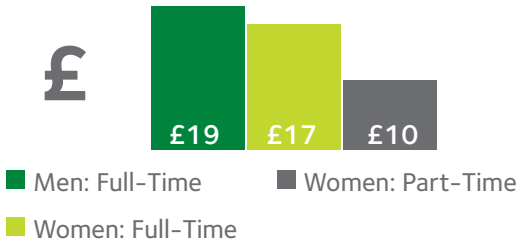


Earnings d) 2012

Hourly earnings for all resident employees by percentile



Median earnings, hourly rate excluding overtime, by gender

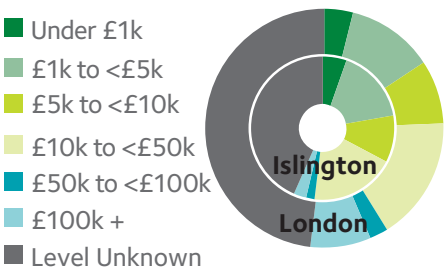


Note: Data not available for part-time men

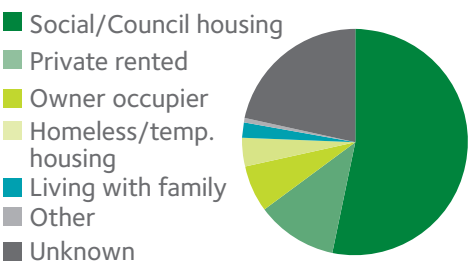
Debt and Individual insolvencies

1,177 people seeking advice from debt advice agencies (Citizens Advice Bureau, Capitalise, and CCCS) f) 2011/12

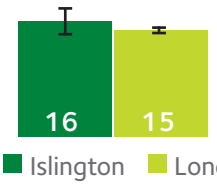
Debt level



Debt advice by tenure



Individual insolvencies rate per 10,000 adult population e) 2012



272 individual insolvencies

-3% since 2011

Sources: a) JFR report, MIS Budget (2013); b) Department for Communities and Local Government (2013); c) Valuation Office Agency (2013); d) Office for National Statistics, ONS (2013); e) The Insolvency Service (2013); f) Citizens Advice Database (2013); g) HMRC tax calculators

articulated as part of the Equalities Taskforce, with the Council committed to ensuring that the housing needs of Camden's diverse communities are met through increasing the supply of affordable housing. In Islington, one of the key housing-related recommendations from the 2011 Fairness Commission report "Closing the Gap" was to increase the supply of decent, genuinely affordable homes in the borough. There has been considerable investment and progress in both boroughs **(boxes B & C)**. However, Camden and Islington Councils both recognise there is a limit to how much can be achieved to support residents to access affordable housing, as demand for social housing is high and rising, outstripping supply in both boroughs. Over 27,000 households (not all residents) have made applications for social rented housing to Camden Council in January 2014, an increase of more than 55% over five years. In Islington, there were nearly 18,000 people on the housing register for social rented accommodation as of March 2012. In both boroughs, around half of all applicants do not meet current eligibility criteria for social housing, but will nevertheless struggle to afford market rents.

BOX B: Camden's Community Investment Programme

The council's Community Investment Programme is ensuring that there is continued investment in homes through redeveloping or selling buildings or land that are underused or expensive to maintain. The programme is seeking to raise £300 million for reinvestment in Camden over a fifteen year period.

As part of the Community Investment Programme, there will be 2,750 new homes built in Camden, made up of:

- 500 new council rented homes which will be offered to people on the council house waiting list. These are the first new council homes for rent in nearly 20 years.
- 200 new shared ownership homes, through working in partnership with private sector developers and housing associations.
- 400 existing council homes will be replaced to ensure that tenants are living in good quality accommodation.
- 1,650 new private homes are being built in Camden, which will be marketed to local people first.

[1] Land Registry, January 2014

BOX C: Affordable housing in Islington

The council has set a target of 2,000 affordable homes to be completed by 2015, including 500 new council rented homes as well as shared ownership accommodation. This will include new council homes and homes developed by partner housing associations. The housing team has also recently recovered 151 homes from illegal subletting and has brought back 139 empty properties into use.

The council is committed to ensuring rents for new affordable housing developments remain at rent levels which will make them genuinely affordable to local people, as with existing social rents. To this end, the council is working with housing associations to develop their tenancy policies, which include rental costs.

Food poverty

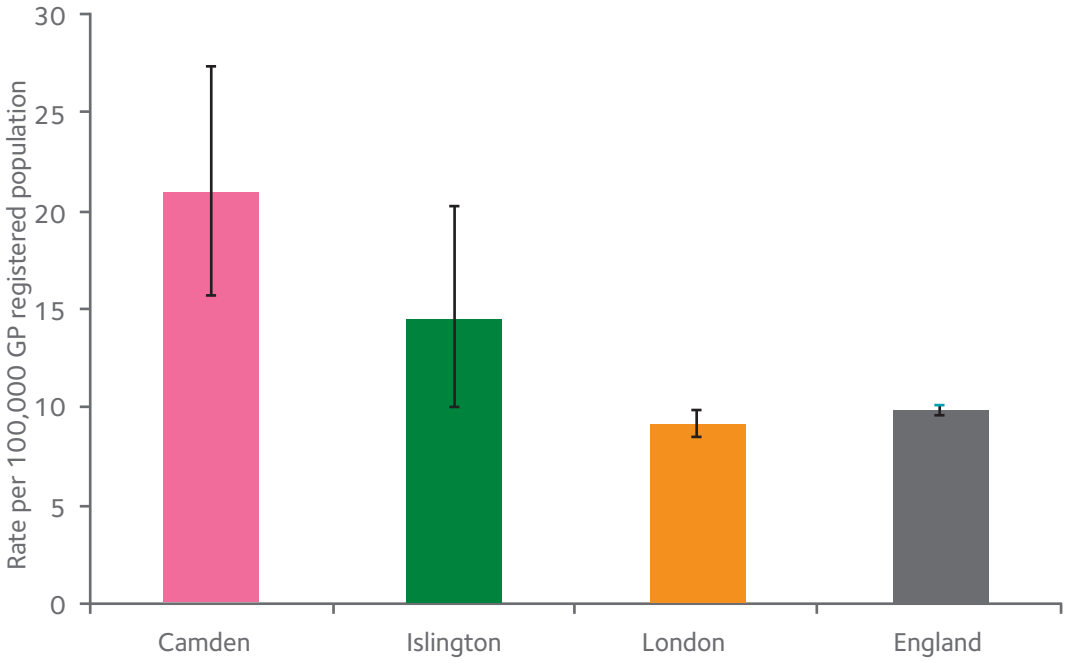
Food poverty is the inability to afford, or to have access to food to make up a healthy diet. Rising food and energy prices, changes to welfare benefits, low incomes and poor access to healthy food all contribute to food poverty. Cooking skills, knowledge about healthy diets, and household budgeting are also important in preventing food poverty in low income families.

Groups who are more likely to experience food poverty include those living on low incomes or benefits, households with dependent children, older people, people with disabilities, and members of black and minority ethnic (BME) communities.

Food poverty leads to malnutrition, which can result in people becoming either obese or underweight. During the previous five years, the number of hospital admissions for malnutrition has increased in Camden and Islington, with both boroughs now having some of the highest rates in London (second and third highest, respectively) **(figure 1)**. One-in-three children aged 10-11 years in England are overweight or obese, but in both Camden and Islington, the rate of overweight and obesity is significantly higher than the national average (37% and 38% of 10-11 year olds, respectively).

An increasing reliance on food banks in both boroughs is indicative of increasing levels of food poverty. Whilst food banks offer a short term solution for some households, the focus needs to be on maximising household income so that families can afford to buy nutritious food, and equipping people with the skills to cook healthy meals, on a budget.

Figure 1: Rate of hospital admissions for malnutrition in Camden and Islington, compared to the London and England averages



Note: this rate is not adjusted for the age structure of the population so needs to be interpreted with care. Camden and Islington have a larger population of younger people than the London and England averages.

Source: Number of hospital admissions, 2012/13, Hansard 2013 Nov 12: col 620W; Registered population size, QOF 2012/13

Debt

Debt is a key determinant of people's mental wellbeing, and those who already have a mental health problem are more likely to get into debt. Debt is commonly associated with increased stress, stigma, shame and relationship problems. Women seem to be particularly affected by the impacts of debt, possibly because they are often responsible for dealing with household finances, having caring responsibilities and are more likely to 'go without' to protect their children.

The rate of individual insolvencies in Camden and Islington is similar to the London average (15 insolvencies per 10,000 adults). While there has been a small decrease in the numbers of people seeking advice from debt advice agencies[2] in Camden and Islington over the past couple of years, in 2011/12, 1,639 Camden residents and 1,177 Islington residents sought advice. Whilst there is not a comprehensive picture of who is seeking debt advice, where it is reported, most of those seeking advice have debts of under £50,000, and many under £5,000. Where reported, most of those seeking advice live in social rented housing.

[2] Citizens Advice Bureau, Capitalise and CCCS.

What more can be done to reduce health inequalities?

The Marmot Review identified that having insufficient money was a substantial cause of health inequalities because people cannot afford to live a healthy life. It recommended that the UK government review and establish systems of taxation, benefits, pensions and tax credits to provide a minimum income for healthy living for people of all ages — actions that need to be taken by central government. In terms of local action to improve health and wellbeing, more recent publications have highlighted implementation of the London Living Wage, which Camden and Islington Councils are already signed up to, as a key action. While there are limits to what local government can do to raise people's incomes or to lower living costs, the following recommendations make suggestions for what more can be done locally to reduce health inequalities associated with poverty and income inequality, building upon the work that is already happening across Camden and Islington.

- Given the important impact of **child poverty** on health and wellbeing and health inequalities over the short and longer terms, Camden and Islington Councils should maintain their focus on tackling child poverty.
- Camden and Islington Councils are already working to integrate service delivery through their **Every Contact Counts** (Islington) or their '**No Wrong Door**' (Camden) approaches. The Health and Wellbeing Boards in both boroughs should use their influence to ensure **health professionals** are maximising opportunities to refer residents to services which can help them have a healthy standard of living, including fuel poverty initiatives, housing support, and debt advice **(box D & E)**.
- Both Camden and Islington Councils and their partners on the Health and Wellbeing Boards should continue to use their influence to encourage other statutory sector organisations, local businesses and the local voluntary and community sectors to pay the **London Living Wage**. Raising the wages of the lowest paid workers will help them afford to live a healthy life and will reduce health inequalities.

- To help mitigate the impacts of food poverty and to support children's learning and development, Camden and Islington Councils should promote a consistent approach to **breakfast clubs** by ensuring all schools where 40% or more of pupils are eligible for free school meals have a breakfast club.
- Camden and Islington Councils should use their planning powers to support the development of '**healthy high streets**'. This would include improving the quality of the food environment, particularly in areas identified as food deserts and by restricting the opening of additional fast food outlets in areas where there is already a high density. It would also look at taking action to reduce the number of betting shops and pay day loan establishments, to reduce debt.
- Camden and Islington Councils, and in conjunction with other health partners, should continue to strongly encourage and support residents to **quit smoking** not only to realise the direct health benefits but also because smoking is expensive, eating into household's disposable incomes.

BOX D: 'A helping hand with the cost of living', Islington

This new campaign in Islington promotes the range of practical support that the Council can offer in relation to energy, debt and employment. The first phase of the campaign launched in January 2014, and focuses on the various ways that Islington Council can help residents to reduce their energy bills. This includes the Energy Advice Service which provides lots of useful advice to help residents save energy at home; from how to switch energy suppliers to draught proofing and using heating controls correctly.

The service also signposts to a range of other support schemes designed to deliver energy efficiency and seasonal health improvements, including:

- SHINE, Islington's successful affordable warmth referral network, with almost 5,500 referrals made between December 2010 and December 2014, leading to around 24,600 interventions;
- Islington Fuel Switch, which helps residents to change energy suppliers and save around £150 a year;
- Grants such as the Warm Home Discount, which has saved almost 1,000 vulnerable households £135 on their energy bills between November 2013 and January 2014;
- The Energy Doctor in the Home, a service that provides a package of energy efficiency measures and advice, visited 3,364 vulnerable households between September 2009 and December 2013.

Since the 'helping hand' campaign launched earlier this month, visits to the energy advice pages on the Council's website have more than tripled in comparison to last January.

BOX E: Camden Advice Partnership

Camden's Equality Taskforce recognised that there is limited scope for direct intervention by local authorities to increase household incomes, particularly in the current financial climate. However the Council is strongly committed to funding advice services which equip residents to make informed choices, develop skills and where appropriate find employment. This has been particularly critical during this time of unprecedented change to the welfare system.

The Camden Advice Partnership (CAP) was established in April 2012, following a comprehensive review of advice provision in the borough. Through the partnership, the Council works with local organisations to ensure that there is a comprehensive understanding and a flexible, coordinated response to changing need in the borough.

Five organisations with contracts with the Council make up the partnership, with the Council as the sixth member. Together, they provide free, confidential, unbiased advice and information on a range of issues affecting people living in the borough such as welfare benefits, housing, employment and debt and money management.

Recent successes of the partnership include:

- Levering in additional funding to provide targeted and timely advice where the need emerges, for example: within GP surgeries; improving access by BME communities to mainstream services; and increasing capacity for disability advice during the period of benefit change.
- Launching a website that acts as a single hub for information on welfare advice in the borough: www.camdenadvice.org
- Developing and distributing a range of free factsheets to help people understand the key changes taking place in the benefits system.

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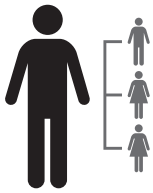
6. Widening the focus: next steps

The analysis in this report clearly articulates the stark health inequalities faced by the residents of Camden and Islington, which lead to high levels of sickness and early deaths in both boroughs particularly among the most deprived. It also shows the complex relationships between health outcomes and the social determinants of health — housing, employment, education and the cost of living. Focussing more attention on the 'causes of the causes' — the social determinants of health — will reduce health inequalities and improve the health and wellbeing of our communities over the longer term.

These are financially challenging times, particularly so for many of the poorest and most vulnerable in society, some of whom are already struggling to make ends meet given the slow growth in the economy, job insecurity, and ever-increasing costs of living. The Government's welfare changes are also making it more difficult for people to cope. It is also a difficult time for local government and this is especially true in inner city areas, including Camden and Islington, which have seen disproportionately large budget reductions since 2010/11. Taken in concert, this is all likely to result in a widening of health inequalities: the poor will get poorer, with some evidence that this has already happened locally. This makes it even more imperative that we redouble our efforts to reduce health inequalities, as otherwise the legacy of the recent financial crisis, and the response to it, will be felt for generations to come. Building upon the good work that is already being done across Camden and Islington, we need to be sure that we are prioritising and investing in cost-effective activities that will have the biggest impact on health inequalities. We also need to make sure that we are delivering these at sufficient scale so that they have a demonstrable impact.

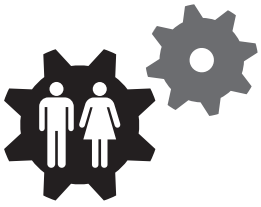
Doing more to address the social determinants of health and making this everyone's business

Prioritise our children and young people



Focus on prevention and early intervention

Targeting the right people and the right places at the right scale



Working better together

Making best use of resources

Throughout this report there are examples of innovative and effective work on the social determinants of health in Camden and Islington which will impact positively on health inequalities. The following recommendations build upon this work to further tackle health inequalities. Whilst these broad recommendations are made for both Camden and Islington, it is important to recognise the differences between the two boroughs both in terms of the patterns in health inequalities (as described in chapter 1) and the differing organisational approaches of each council, which will influence how these recommendations are taken forward locally.

Doing more to address the social determinants of health and making this everyone's business

We need to look at rebalancing the Joint Strategic Needs Assessments (JSNAs), the Health and Wellbeing strategies (JHWSs) and the work of the Health and Wellbeing Boards, to incorporate the social determinants of health. We know that having a Board meeting, writing a strategy, or doing a needs assessment will not change anything by itself but it will be this work that provides the strategic direction for what we and our partners do. Ensuring all partners are equally committed to reducing health inequalities by tackling issues such as employment, housing, education and cost of living, is an important first step, as well as understanding what each can do individually and together.

Until April 2013, the local public health function was based in the NHS. Owing to the recency of the transition of public health to both councils, the legacy of the past is still very much evident — many of the public health department's programmes are still more oriented towards healthcare interventions: preventing sickness through behaviour change and immunisations, diagnosing people with long term conditions earlier, and supporting people who are sick to live healthier lives. Whilst these programmes will undoubtedly have an important impact on health and health inequalities, particularly in the short and medium term, they will not fundamentally change the health inequalities that are being underpinned and driven by the social determinants of health. While continuing to deliver our existing high quality public health services, we need to look at expanding the work of public health to more fully encompass the social determinants of health.

However, the Health and Wellbeing Boards and the Camden and Islington Public Health team are not going to be able to reduce health inequalities alone: this is everyone's business. In their entirety, the social determinants of health incorporate just about all aspects of the work of local government. The Health and Wellbeing Boards and the Public Health team will need to work with others to look at how we can collectively improve health outcomes and reduce health inequalities. As well as local government colleagues, this also includes the local community and voluntary sectors and the local NHS. In practice, this means increasing understanding of health inequalities, their causes and impact, and getting everyone involved in thinking about how best to tackle health inequalities in their area of work on an ongoing, systematic basis.

RECOMMENDATIONS

1. Rebalance the work of the Health and Wellbeing Boards and the Public Health team to put a stronger emphasis on the social determinants of health, in conjunction with refocussing the JSNAs and JHWSs on the social determinants.
2. The Health and Wellbeing Board to sponsor summits on key topic areas, starting with the councils' key corporate priorities, to ensure a shared understanding of the impact of social determinants on health inequalities and identify the actions that need to be taken across all partners, collaborating together.
3. Reorienting both councils to become 'Public Health councils', so that improving health and wellbeing is everyone's business.

Prioritise our children and young people

Health inequalities are entrenched in communities and are intergenerational. To break the cycle of health inequalities, above all else, we need to prioritise and invest in our children and young people. This is because poor health outcomes and inequalities arise from cumulative negative impacts throughout life which begin before a child is even born. Investing in our children and young people is important as without a healthy start to life and a good education they will not be able to get a 'good job', afford a healthy lifestyle and good quality housing, and they may not have the emotional resilience to deal with things when something does go wrong. Addressing early inequalities in people's lives, through universal and targeted interventions, will reap large benefits over the longer term.

Improving the lives of children and young people is not just about focussing on the children and young people themselves. It also means investing in their families. To improve outcomes, our children and young people need to be growing up in stable accommodation, with a parent or parents in good quality work, with opportunities to develop, learn and play, and in a household which can afford to live 'healthily'. This investment will not yield quick results, however, but it will give us the best outcomes. Over the longer term it should provide value for money by decreasing reliance on local services, and through taxation if people are in work.

The impact of the social determinants of health on children and young people is a central theme throughout this report, and its importance is already clearly understood within different areas across both councils. For example, there is a focus on prioritising families for housing and supporting parents back into work, in addition to the work with schools to improve educational attainment. A key priority is getting young people (aged 16-18) into employment or training as this group has been particularly affected by the recent financial crisis. Being unemployed at such a young age has serious consequences for their future, including their health, and their mental health and wellbeing over the short and longer terms.

Prioritising children and young people does not mean that we ignore health inequalities and poor health in adults without families. It recognises that we will never reduce health inequalities if we do not tackle the root causes, and we do not start to do this before all of the negative impacts associated with poor housing, poor education and a lack of employment prospects start to accumulate.

RECOMMENDATIONS

4. The Health and Wellbeing Boards and their constituent member organisations should prioritise reducing health inequalities for children and young people above all else to break the cycle of inequalities in Camden and Islington. Both Boards and all statutory organisations already have a strong strategic focus on children and young people, and as work develops, this will be an excellent platform to further broaden and strengthen our approach to the social determinants of health and their impacts.
5. Building on existing work, we should map the current activities on the social determinants of health across Camden and Islington, and the work that others are doing that will impact directly on reducing health inequalities for children, young people and their families. This will help us to understand where there are gaps and opportunities, and to inform future priorities.
6. We need to better understand the multiple issues being faced by families which make it difficult to give children the best start in life, so that we can design more integrated and targeted services which focus on the whole picture. There are already examples of this type of multicomponent approach through universal, targeted and specialist interventions, from which we can learn and build on, such as the work around Complex

Families (Camden) and Stronger Families (Islington), and the work of the Family Nurse Partnerships with teenage parents.

7. Given the serious, potentially life-long implications of being NEET (not in employment, education and training) and the higher percentage of young residents that are NEET in Camden and Islington compared to the London average, both boroughs should continue with their efforts to support these young people back into education, or into training or employment. As part of these approaches, we need to ensure that there are measures in place to support positive mental health and wellbeing among this group as we know poor mental health can be both a determinant and outcome of being NEET. Work to prevent young people from becoming NEET in the first place, through addressing absenteeism and raising educational attainment, for example, should also continue to be prioritised.

Focus on prevention and early intervention

Both Camden and Islington Councils are already trying to extend their work on prevention and early intervention, in recognition that this will result in better outcomes for residents as well as ultimately increasing the sustainability of public services. There are numerous examples throughout this report which highlight the importance of prevention and early intervention on improving health outcomes and reducing health inequalities. For example, proactively supporting people to make choices about their housing options early on can prevent them from becoming homeless. Not only will this proactive approach have saved money, it will also have helped prevent all of the negative health outcomes associated with being homeless, including stress and anxiety. Similarly, both councils have signed up to pay the London Living Wage, which will help low income workers stay out of debt, keep their home, and afford a healthier lifestyle. Finally, both councils are proactively supporting parents back into work through championing flexible working and providing direct support with childcare and training. This work is pivotal to improving children's life chances as living in a workless household is a key driver of poor outcomes for children.

There are more opportunities for this type of work however. Our approach to tackling the very high levels of people out of work on sickness benefits in Camden and Islington, for example, is broadly focussed on supporting people back into work, rather than helping them keep a job in the first place. A good example of where we are taking action to help people keep their jobs is by supporting people with mental health problems to stay in work, through our mental health services. Given the large health inequalities between routine and manual workers (e.g. labourers) and those in higher professional jobs (e.g. lawyers), we should be considering what more can be done earlier on, through 'healthy workplace' initiatives, occupational health interventions, and other health services (e.g. physiotherapy) for people in routine and manual occupations. This would help to reduce the number of people on sickness benefits over time and would help to reduce health inequalities.

RECOMMENDATIONS

8. Both councils should continue to prioritise prevention and early intervention, in spite of more limited resources.

9. Working collaboratively with Camden and Islington Clinical Commissioning Groups (CCGs) (the GPs who are responsible for planning and buying health services for the community), other council departments and businesses, we should look to provide more support to help people with health problems stay in work, shifting the focus onto prevention of worklessness related to ill-health.

Targeting the right people and the right places at the right scale

Focussing our efforts only on the most deprived and most vulnerable residents, or those experiencing the largest inequalities, will not be enough to tackle health inequalities in Camden and Islington. For example, half of adults in Camden and Islington have worse health outcomes compared to the national average. Only those employed in managerial positions fare better. For the best outcomes therefore, we must make sure that interventions reach large numbers of residents but with a targeted approach to those communities and people with the greatest needs.

To be able to do this, we must first understand the size of the health inequality gaps related to different priority areas (e.g. housing, employment, education), and the differences experienced by different communities — defined either by groups of people or by place. Our approach will need to be flexible depending on what we find, and may not always be the same. For example, in Camden, we may need a more targeted approach focussed on specific areas, because of the clear geographical differences in health, whereas in Islington, the focus is almost always likely to be on different people because geographical differences are generally much less pronounced.

Importantly, whatever we do, we need to make sure that interventions to reduce health inequalities are being implemented with sufficient scale to have an impact. Nationally, a key reason why some NHS interventions have not had an impact on health inequalities (despite high quality, strong evidence that the interventions themselves do work) is because they did not reach sufficient numbers of people. Knowing what scale of intervention is required to have an impact on inequalities in terms of life expectancy or healthy life expectancy is very complex, but we should make more effort to try and understand this.

10. Be clear that tackling health inequalities in Camden and Islington will require different approaches for different communities, but that to have an impact at a population level, we need to be addressing the poor health of a large number of residents, not only focussing on small groups due to the extent of health inequalities across the borough.
11. Identify locally the scale of interventions that need to be delivered to have an impact on health inequalities, in order to inform service design and delivery.

Working better together

There is lots of work locally to better integrate services, with Camden aspiring to be a 'No Wrong Door' borough and Islington's 'Every Contact Counts' approach. This is important for health equalities, because a defining feature of the people, families and communities affected by poor health is that they normally have multiple underlying problems — not just one. To be effective in supporting them to improve their health, we need to understand what these problems are, how these problems interact and compound each other, and find their root causes.

This means taking an integrated, 'whole systems approach'. Importantly, this is not just about getting different parts of the same organisation to work better together, but also to integrate the work of different organisations. A central theme throughout the report has been the opportunities for greater collaboration between local authorities and health services, particularly on issues such as employment and housing, in identifying vulnerable residents earlier and making sure they have access to the right support. Similarly, we can learn from the innovative work being undertaken by some of our housing associations to improve people's health, and look to expand this for more residents.

12. Continue to work to reduce 'silo working' and integrate services so that our approach is more holistic, tackling root causes of problems not just those that are presented to one service.
13. Specifically identify key areas and services that should be promoted among Camden and Islington GPs and other relevant health services, so that health professionals can refer more people for help and support earlier on. This would include, for example, employment support services, housing support, and fuel poverty initiatives (WISH and SHINE). Make it as easy as possible for GPs and other health professionals to refer people to these services.
14. Systematically work with housing associations to maximise their resources and ability to improve residents' health, building on and learning from the work that is already happening in this area.

Making best use of resources

We should make best use of our data and available evidence to inform service design and delivery, making sure that our interventions are cost-effective and being delivered to achieve maximum impact. This includes ongoing monitoring and evaluation of existing services to ensure they are delivering the intended outcome and to see where improvements to delivery could be made.

A challenge going forward will be prioritising key interventions to reduce health inequalities across the social determinants of health at the same time as resources are becoming more limited. To do this, we would normally look at what the evidence tell us about the most effective interventions to reduce health inequalities. However, there is currently only limited evidence about 'what works' in relation to the social determinants of health and which areas should be prioritised specifically, just as when the NHS started tackling health inequalities. This means that to begin with, we will need to take a pragmatic approach — identifying locally the biggest impacts given population needs, corporate priorities and opportunities to make change. Importantly, 'population needs' includes the views of residents, which we need to understand better in relation to what supports them to have good health. We can also look at and learn from other areas on what they are doing on the social determinants of health, as they develop their approaches and interventions, as well as monitoring and rigorously evaluating the impact of local interventions.

RECOMMENDATIONS

15. Increase our understanding of residents' views on health and wellbeing and what supports people to have good health, to inform how we prioritise available resources. This would include for example, introducing a dedicated chapter in Camden's and Islington's JSNAs on residents' views about health and wellbeing.
16. Keep abreast of the evidence for 'what works' to address the social determinants of health from the published literature, statutory bodies, and other local authorities and ensure that, as the evidence-base develops, emerging findings are considered locally.
17. Make best of use of council data, combined with public health's specialist expertise in analysis, to profile the health inequalities gaps better, in relation to the social determinants of health and work with services to impact on those gaps.

Acronyms

BME	Black or Minority Ethnic
CCG	Clinical Commissioning Group
CHF	Camden Housing First
CPA	Care Programme Approach
CPR	Cardio Pulmonary Resuscitation
DH	Department of Health
ESOL	English for Speakers of Other Languages
GLA	Greater London Authority
GP	General Practice or General Practitioner
HIT	Health Improvement Team
IMD	Index of Multiple Deprivation
IWP	Islington Working for Parents
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LSOA	Lower Super Output Area
MSOA	Middle Super Output Area
NAO	National Audit Office
NEET	Not in Education, Employment, or Training
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NS-SEC	National Statistics Socio-economic Classification
OFSTED	Office for Standards in Education
ONS	Office for National Statistics
PCT	Primary Care Trust
PH	Public Health
PHOF	Public Health Outcomes Framework
SHINE	Seasonal Health Interventions Network
SHP	Supported Housing for People
TB	Tuberculosis
WISH	Warmth, Income, Safety and Health

Glossary

Commissioning	The processes local authorities and local NHS commissioners undertake to ensure that services funded by them meet the needs of their client group and offer best value for money.
Community	Group of people living or working in a geographically defined area (geographical community) or who have a characteristic, cause, need or experience in common (community of interest).
Deprivation	Poverty is lack of money, deprivation also encompasses lack of opportunities and resources.
Empowerment	A process through which individuals and/or groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs.
Ethnic group	A social group characterised by a distinctive social and cultural tradition, maintained within the group from generation to generation, a common history and origin; and a sense of identification with the group. Members of the group have distinctive features in their way of life, shared experiences, and often a common genetic heritage. These features may be reflected in their health and disease experience.
Health behaviour	The combination of knowledge, practices, and attitudes that together contribute to motivate the actions we take regarding health. Health behaviour may promote and preserve good health, or if the behaviour is harmful, eg. tobacco smoking, may be a determinant of disease.
Index of Multiple Deprivation (IMD)	Combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation.

Inequalities in health	The virtually universal phenomenon of variation in health indicators (infant and maternal mortality rates, mortality and incidence rates of many diseases, etc.) especially those associated with socioeconomic status and ethnicity.
Life course approach	Considering an individual's or a population's history for contributing factors to current patterns of health and disease, whilst acknowledging that life experience is affected by the wider social, economic and cultural context.
Life expectancy (at birth)	Average number of years that a newborn is expected to live if current mortality rates continue to apply.
Lifestyle	The set of habits and customs that is influenced, modified, encouraged, or constrained by the lifelong process of socialisation. These habits and customs include use of substances such as alcohol, tobacco, tea, coffee; dietary habits; exercise; etc. which have important implications for health and are often the subject of epidemiologic investigations.
Local deprivation quintile	Calculated by ranking small areas within each local authority based on how deprived they are and then grouping the areas in each local authority into five groups (quintiles) with approximately equal numbers of areas in each. Quintile 1 corresponds with the 20% most deprived small areas within that local authority, whereas quintile 5 represents the least deprived group.
Long term condition	An illness which cannot currently be cured but can be controlled and managed by medication, other therapies, and adoption of healthier behaviours.
Mental health	A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.
Morbidity	Any departure, subjective or objective, from a state of physiological or psychological well-being (ie. illness).

Mortality	Death.
Musculoskeletal conditions	Relating to the muscles and the skeleton, this group of conditions includes among others joint diseases, rheumatoid arthritis and osteoarthritis, osteoporosis, spinal disorders, low back pain and severe trauma.
Partnership	A partnership (for health) is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes.
Poverty	The most commonly used way to measure poverty is based on incomes. A person is considered poor if their income falls below the minimum level necessary to meet basic needs.
Premature mortality	Deaths occurring before the age of 75. Many of these deaths are preventable.
Prevalence	The number of events, eg. instances of a given disease or other condition, in a given population at a designated time.
Prevention	Actions aimed at eradicating, eliminating, or minimising the impact of disease and disability, or if none of these is feasible, retarding the progress of disease and disability.
Proportionate universalism	Universal actions to reduce inequalities in health that vary in level of intensity, allowing greater resource to go to the most disadvantaged.
Public Health	The science and art of preventing disease, prolonging life, and promoting health through organised efforts of society.
Quality of life	The degree to which persons perceive themselves able to function physically, emotionally, and socially.
Resident population	A population with a usual address within the geographical boundary (eg. in Islington).
Risk factor	An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic, that on the basis of epidemiologic evidence, is known to be associated with health-related condition(s) considered important to prevent.

Social determinants of health	The environment in which people grow up, live and work, and the systems put in place to deal with illness. This environment is influenced by a wider set of forces: economics, social policies, and politics.
Statutory homelessness	Where a household has been defined as homeless by a local authority – i.e. the household falls within the terms of the homelessness legislation. Where a household is in priority need and not intentionally homeless, it is the duty of the local authority to offer the household accommodation.
Systematic review	A detailed structural analysis of previously conducted research. A detailed synthesis of research evidence relevant to a specific question.
Wellbeing	A positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It requires that basic needs are met, that individuals have a sense of purpose, that they feel able to achieve important personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, strong and inclusive communities, good health, financial and personal security, rewarding employment, and a healthy and attractive environment.

Main sources

1. Department for Environment, Food and Rural Affairs
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6. Public Health Electronic Library
7. World Health Organisation
8. World Bank Organisation

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