A Health Needs Assessment for 5-19 Year Old Residents of the London Borough of Hackney and the City of London

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2 Executive Summary

2.1 Introduction

This report presents the findings of a health needs assessment – it identifies need across the wider determinants of health in the 5-19 age group for the Borough of Hackney and the City of London, and delivers recommendations to guide future areas of work and inform commissioning of services for these children and their families.

2.2 Key Findings

2.2.1 The Population

2.2.1.1 Hackney

Hackney is a densely populated inner London borough with 263,200 residents and a relatively young population with 44,700 children and young people aged 5-19. The number of children and young people is forecast to rise by 7% over the next five years.

The highest proportion of the population aged 5-19 is found in the north east of the borough and is likely due to the high birth rate in the Charedi (Orthodox Jewish) community where more than half of the population are under 16 years of age. Local calculations suggest that one in five of Hackney's young people belong to the Charedi community.

Hackney is ethnically diverse with fewer than 40% of 5-19 year olds identifying as White. After White British (27%), the next most common specific ethnic group in Hackney's children and young people is Black African (16%). One in five of Hackney's children and young people (aged 3-15) report that English is an additional language to them, and Turkish is the most

common first language in people who have English as an additional language. However, three quarters of children who have English as an additional language are still reported to speak English well or very well.

The male life expectancy at birth in Hackney is significantly lower than London and national averages. The female life expectancy at birth is similar to the national average, but significantly lower than the London average.

2.2.1.2 City of London

In contrast, the City of London has a far smaller resident population of only 8,100 people within one square mile, but this is dwarfed by the workday population which is over 50-fold greater. The City of London currently has relatively few children and young people with only 700 aged 5-19. However, this is forecast to rise to 800 by 2020. As a result of these small numbers data presented for the City of London must be viewed with some caution.

The City of London is less ethnically diverse than Hackney, but this is changing in the younger generation with less than 60% of children and young people identifying as White, compared to 80% of the City's whole population. One in ten children and young people do not count English as their first language which is half the rate in Hackney, but still twice the national rate.

The life expectancy at birth is significantly higher for each gender than London or England averages.

2.2.2 Wider Determinants

2.2.2.1 Hackney

Hackney is the eleventh most deprived local authority[1] in England (of 326 local authorities). However, five years ago Hackney was rated the most deprived local authority in England, and it has seen the largest decrease in the proportion of its neighbourhoods classified as highly deprived from 42% in 2010 to 17% in 2015.

One quarter of all Hackney residents live in houses classified as overcrowded which is greater than the London average. Over half of households containing dependent children are socially rented, which is higher than London and national averages. The highest proportion of social housing by ethnicity is found in the Black community where over 70% of households are socially rented. Three quarters of household homelessness applications that are deemed eligible, unintentionally homeless and in priority need involve dependent children, and three quarters of these are lone female parent households. The rate of family homelessness is increasing faster in Hackney than across London or England and now stands at 6.5 homeless families per 1,000 households.

[1] Note – using the rank of the extent summary measure of deprivation

While the proportion of children living in poverty has fallen from 49% in 2007 to 30% in 2012, this is still above the London average of 24% and the national rate of 19%. This places Hackney tenth in the ranking of local authorities with the highest proportion of children living in income deprivation. One third of Hackney's pupils attending state-funded primary and secondary schools are eligible for and claiming free school meals. While this proportion is higher than the London and national averages, the gap is closing.

The Child Wellbeing Index covers a range of domains, including deprivation. The index was last produced in 2009 (drawing on data from 2005) and it ranked Hackney as 352nd with only two local authorities scoring lower. While Hackney fared better in education, the environment and health and disability, it performed worst at material wellbeing, housing, crime and children in need.

2.2.2.2 City of London

Overall the City of London is ranked jointly with 24 other local authorities as the least deprived in the 2015 ranking of extent measure of deprivation. The total proportion of children living in poverty is only 12% (2012) which places it 277th when ranking local authorities by the proportion of children living in income deprivation (i.e. only 49 local authorities have a lower proportion of children living in poverty). However, significant pockets of deprivation persist with 2009 data revealing that 41% of children live in poverty in Portsoken ward but only 8% in Farringdon Within. Although the total proportion of households being overcrowded is lower than the London average, some ethnic groups are heavily overrepresented with over two-thirds of Bangladeshi people living in overcrowded housing in the City of London. The total proportion of housing that is socially rented in the City of London is relatively low, but over one third of households that contain dependent children are socially rented – higher than both the London and national averages.

Despite the relatively low level of deprivation, the City of London is ranked 284th in the Child Wellbeing Index, placing it in the lower half of local authorities nationally. It performs well on crime (having the best score nationally), health and disability, education and children in need; and performs less well on material wellbeing, housing and environment (for which it is ranked last). This dichotomy of having the best ranking for one domain (crime) and the worst for another (environment) is rare, and is likely to be a feature of the unusually small geographical area that the City occupies.

2.2.2.3 Education

There are 111 schools in Hackney serving 42,656 pupils – 86 schools are state-funded and 34 are independent which is approximately three times higher than the national proportion of independent schools[2]. In comparison, the City of London has only 2,107 pupils across one state-funded and four independent primary schools and there are no secondary schools. All further information relates to the 86 state-funded Hackney schools which are managed by Hackney Learning Trust, which, since 2013, is the responsibility of Hackney Council.

The performance of pupils at key stage 4 (GCSEs) can be broken down into 'non-disadvantaged' pupils and 'disadvantaged' pupils[3]. The proportion of disadvantaged pupils in Hackney is double the national rate (54% compared to 27%). Although non-disadvantaged pupils continue to outperform disadvantaged pupils in Hackney, the gap is narrower than national figures and Hackney outperforms the national average for both groups of pupils. When analysing the performance of pupils who receive free school meals (as a crude indicator for pupils from lower socioeconomic groups), over half of these pupils in Hackney obtain five A*-C grades at GCSE which is in the top quartile of results nationally.

Compared to national levels Hackney has a higher proportion of pupils with English as an additional language, higher proportion of pupils with special educational needs and at both key stage 2 and 4 has a higher proportion of pupils that start below the expected level.

The percentage of half-day school absences by Hackney pupils is significantly lower than the national average; the proportion of children receiving a fixed period or permanent exclusion is significantly higher than nationally.

In 2014, 3% of Hackney's 16-18 year olds were not in education, employment or training (NEET) – significantly lower than both the London and national average. However, the proportion of 19 year olds classed as NEET is higher, raising the total proportion of 16-19 year olds who are NEET to 6.7% in Hackney (2013). Those who are parents, carers or are currently pregnant have the highest rates of being NEET in Hackney. Although the proportion of 16-18 year olds classed as NEET in the City of London has been consistently lower than across London and England over the past four years, this is not statistically significant due to the low number of young people living in the City.

2.2.3 Vulnerable Children

The proportion of initial contacts with the first access and screening team (FAST) in Hackney that lead to an assessment has increased to 35% in 2014/15. The proportion of re-referrals within 12 months is significantly lower than the national average (14% compared to 23%). The number and rate of child protection plans in Hackney has seen a marginal year on year

[2] Note – this is predominantly due to the presence of Charedi (Orthodox Jewish) schools which are independent and conform to Orthodox Jewish culture

[3] Note – in this context 'disadvantaged' refers to pupils who have been eligible for free school meals within the last six years, have been adopted from care, or have been looked after for one day or more

decrease over the past three years and stood at 214 plans as at 31st March 2015. Over the past two years the proportion of children remaining on a plan for a very short time (less than three months) or long time (over two years) has increased.

Approximately 3,000 girls attending school in Hackney are recorded as being from an ethnic group associated with a country that practices female genital mutilation (FGM). 60 referrals were made to children's social care over a 10 month period in 2014/15 with concerns about a risk of FGM, but in no cases had the girl had FGM performed. Across all ages, the rate of newly recorded FGM within City & Hackney Clinical Commissioning Group (CCG) was 9.8 per 100,000 in July-September 2015 which was almost double the national average, but half the London average.

Across all adults Hackney has a higher estimated prevalence of opiate and/or crack cocaine use than nationally. However, Hackney has a similar rate of parents in drug treatment compared to national levels. The rate of higher risk drinking across all of Hackney's adults is lower than the national average and, similarly, significantly fewer parents are in alcohol treatment in Hackney than across England.

The rate of looked after children across Hackney and the City of London (56 per 10,000) is similar to the national rate. A measure of emotional wellbeing in looked after children places Hackney at the same level as the national average. However, Hackney performs significantly better in educational performance, with 25% of local looked after children gaining five GCSEs at grades A*-C (including English and Maths), compared to 15% across London or 12% nationally.

The proportion of those aged under 16 in Hackney and in the City of London who provide unpaid care is similar to the national rate of 1%. However, at 0.25% the proportion who provide at least 20 hours of unpaid care per week is higher in Hackney than the London or national averages. The proportion of young people providing unpaid care rises to 6.3% in Hackney by the age of 16-24, placing it second highest out of its ten statistical neighbours and higher than the London and national averages.

The number of 10-18 year olds who are supervised by a youth offending team has fallen faster in Hackney than nationally so that in 2013/14, at 6.9 per 1,000 population, Hackney has a lower rate than regionally and nationally and a lower rate than nine of Hackney's ten statistical neighbours.

The child mortality rate (covering ages 1-17 years) in Hackney has fallen from 27 per 100,000 in 2008-2010 to 12.8 per 100,000 in 2011-13 which is similar to Hackney's statistical neighbours, but still above the England average of 11.9 per 100,000.

2.2.4 Medical

2.2.4.1 Primary Care

GP data across City & Hackney CCG regarding consultations and diagnoses have been obtained for three age groups – 5-9 year olds, 10-14 year olds and 15-19 year olds. Overall, 5-19 year olds visit primary care 1.6 times per year. However, this varies between 0.9 and 2.4 between local GP practices, with the national average being between two and three. The number of primary care consultations per year decreases with increasing age groups in males, but in females the 15-19 year olds have the greatest number of consultations per year. In 5-9 year olds the highest rate of consultations is in Asian children, whereas in 15-19 year olds the highest rate is in White British or Mixed British young people.

2.2.4.2 Long term conditions

In total, 6% of 5-19 year olds have a recorded long term medical condition in City & Hackney with this figure increasing with age. At younger age groups the proportion is higher in boys than girls, but the genders equalise by 15-19 years of age.

2,334 City and Hackney 5-19 year olds have a current diagnosis of active asthma (a rate of 459 per 10,000). Within this age range, more boys are affected than girls. Active asthma peaks at 10-14 years of age in boys, and at 15-19 years of age in girls.

213 City and Hackney 5-19 year olds have a diagnosis of learning disability on their primary care record (a rate of 41.9 per 10,000). The rate peaks in 15-19 year olds, at which point boys have a rate over twice that in girls.

140 City and Hackney 5-19 year olds have a diagnosis of epilepsy (a rate of 27.5 per 10,000). In a similar fashion to learning disabilities, the rate peaks in 15-19 year olds and boys are affected more often than girls.

101 City and Hackney 5-19 year olds have a diagnosis of diabetes mellitus (a rate of 19.9 per 10,000). The rates are similar in boys and girls. However, while there is a steadily increasing rate with age in boys, girls show a trough in 15-19 year olds before the rate rises again from 20-24 year olds which is likely due to a slightly later onset of type 2 diabetes in girls.

2.2.4.3 Vaccine-preventable diseases

The proportion of girls who have received all three doses of the human papillomavirus (HPV) vaccine has increased year-on-year in Hackney for the past three years; however at 68% in 2013/14 it is still significantly lower than the national average of 87%. The uptake of the first dose of HPV vaccine alone is 85% on average in Hackney – however the uptake varies across state-maintained schools between 55% and 93%. The uptake of all three doses in the City of London is much closer to national uptake at 85%.

The uptake of the Meningitis C (MenC) booster used in adolescents in 2014/15 in Hackney varied by school between 35% and 88%[4]. This has been replaced by the MenACWY vaccine for the 2015/16 academic year. The uptake of the tetanus, diphtheria and polio (Td/IPV) booster was similar to the uptake of MenC in all of Hackney's schools.

The influenza vaccination programme is being rolled out to cover all children aged between two and 17 years in a phased manner. For 2015/16 the programme was delivered to school years one and two. Hackney had a coverage of 37% – similar to its statistical neighbours.

Hackney and the City of London have been affected by three measles outbreaks in the past ten years (2006, 2007 and 2012). In the 2012 outbreak, Hackney saw the greatest number of confirmed cases of any London borough with a local rate of 18.2 per 100,000 (more than ten-fold greater than the London rate). However, between 2008/09 to 2013/14 the rate of uptake of both doses of the measles, mumps and rubella (MMR) vaccine by age five has more than doubled from below 40% to over 80% and now surpasses the London average.

2.2.5 Public Health Key Priorities

2.2.5.1 Sexual Health

Nationally, between 2000 and 2010 there has been a three-fold rise in the proportion of men aged 16-24 who report having attended sexual health services and a four-fold rise in women aged 16-24. Of 16-24 year olds, women are more likely to report seeking help or advice for their sex life than men.

2.2.5.1.1 Contraception and Conceptions

The two most common types of contraception provided by sexual and reproductive health (SRH) services in under 25s in Hackney are oral contraception (42%) and male condoms (29%). Long acting reversible contraception (LARC) forms 15% of SRH service contraception prescriptions to under 25s.

Across all ages, SRH services provide one third of contraception prescriptions in Hackney, with two thirds being provided by primary care. However, LARC is provided more frequently by SRH services (26% of contraception) than by GPs (8% of contraception). The prescribing of LARC through GPs is lower in Hackney than London and national averages, and lower than six of Hackney's ten statistical neighbours. Registrations for free condoms occur most often in SRH clinics, whereas the majority of repeat condom collections occur in pharmacies.

Hackney and the City have a higher rate of prescribing emergency contraception to women of all ages than the London and national averages and seven of Hackney's ten statistical neighbours. A similar number of prescriptions are provided through GPs as SRH services.

[4] Note – national figures are not routinely collected for England but the uptake of MenC was 82% in Scotland in 2013/14 and PHE estimate the uptake of Td/IPV is approximately 70% in England

The rate of conceptions in those aged 15-17 has been falling in Hackney and the City for the past 15 years from 80 per 1,000 females in 1999 (which was almost twice the national rate), to 24 per 1,000 in 2013 (which was lower than the national rate). The rate of conceptions in those aged 13-15 is significantly lower and has also been declining, albeit at a slower rate.

Hackney and the City are ranked lower compared to Hackney's statistical neighbours for teenage births than for teenage conceptions. The rate of teenage births has been consistently lower than the national average for the past five years. 16-19 year old Asian women are significantly less likely to give birth than other ethnicities in Hackney.

In line with the relatively fewer teenage births than teenage pregnancies, Hackney has a higher rate of abortions than seven of Hackney's ten statistical neighbours. Furthermore, 37% of abortions in women under 25 years of age in Hackney and the City are repeat abortions which is higher than all ten of Hackney's statistical neighbours and ten percentage points higher than the national average.

2.2.5.1.2 Sexually Transmitted Infections

Nationally, the proportion of women with *Chlamydia trachomatis* detected in their urine peaks in 16-19 year olds, whereas it peaks in 20-24 year olds in men. For both men and women, chlamydia detection is significantly greater in the two most deprived quintiles (Hackney is in the most deprived quintile) than the two least deprived quintiles.

In 2014, 49% of 15-24 year olds were screened for chlamydia in Hackney which is statistically significantly higher than all ten of its statistical neighbours, the London average and the national average. This comprises of 35% of 15-19 year olds and 59% of 20-24 year olds being screened. The City of London also had a higher rate than seven of its nine statistical neighbours with 37% of 15-24 year olds being screened.

Locally and nationally chlamydia screening is more commonly performed in females than males – this difference is particularly marked in 20-24 year olds in Hackney who account for much of the increased level of testing in Hackney. Similarly, young females are more engaged with services linked to sexual health in general, with an approximately nine times higher rate of attendance at City and Hackney Young People's Service Plus (a young people's health clinic) in 2014/15 than their male counterparts.

With regards to detection of chlamydia, Hackney had a higher rate than all ten of its statistical neighbours for 15-24 year olds, and a higher rate than nine of its statistical neighbours when considering 15-19 year olds specifically, in 2014. Conversely, the City of London had a lower detection rate than all of nine its statistical neighbours in 2012[5].

[5] Note – the most recent data available

2.2.5.2 Mental Health

Despite having relatively high levels of many risk factors for poor mental health and wellbeing in Hackney, the What About YOUth survey of 15 year olds revealed that Hackney and the City outperform all of Hackney's ten statistical neighbours, along with the London and national averages, in a score of mental wellbeing. Nationally, those who are Asian, Black or of an Other ethnicity scored significantly more highly than those who are White or of Mixed ethnicity and therefore Hackney's diversity may partly explain its high results.

348 of City and Hackney's 5-19 year olds have been diagnosed with a mental health disorder (a rate of 77 per 10,000). 243 of these diagnoses are in 15-19 year olds. In 5-19 year olds there are more diagnoses in boys than girls, but this equalises by 20-24 years of age.

The proportion of pupils with autism has risen year-on-year for five years in Hackney to 8.7 per 1,000 school-age pupils, however this is in line with the national figures and they are not significantly different.

At 75 per 100,000 in 2013/14, Hackney and the City have a lower rate of inpatient hospital (including psychiatric hospital) admissions for a primary diagnosis of a mental health or behavioural disorder in 0-17 year olds than eight of Hackney's ten statistical neighbours and the London and England averages. This rate has also been falling over the previous three years – widening the gap with the London average which rose over the two previous years.

Self-harm related hospital admissions in 10-24 year olds in Hackney are lower than seven of Hackney's ten statistical neighbours and significantly lower than the London and England averages. Furthermore, this rate has been falling in Hackney over the past four years despite it increasing nationally.

2.2.5.3 Smoking

The proportion of 15 year olds in Hackney and the City who regard themselves as current smokers is 5.8%, which is lower than the London and national averages. However, a relatively high proportion (24%) of Hackney and the City's 15 year olds have tried tobacco other than in cigarettes.

Primary care data reveal that there is a higher rate of smoking in females aged 5-19 than males aged 5-19 in City and Hackney CCG – this is predominantly due to the difference in smoking in 15-19 year olds (5.4% compared to 4.5%). However, by 20-24 years of age the rate of smoking in men overtakes that in women (24% compared to 22%).

2.2.5.4 Substance Misuse

The proportion of children and young people (in school years 6, 8 and 10) who report using drugs in Hackney is half that reported nationally (2% compared to 4%). In addition, Hackney has a lower proportion of children and young people saying that they drink alcohol (6%) than the London average (10%) and the national average (15%).

Similar to nationally, none of Hackney's young substance misuse clients report injecting substances. The three most common substances reported by young service users locally are cannabis, alcohol and nicotine – this is the same as nationally. Cannabis use is reported in 96% of Hackney's substance misuse clients.

Hackney has a lower proportion of young substance misuse clients being female (17%) than nationally (35%); and a greater proportion (40%) are at the older end of the age-range (17 years of age) than nationally (26%). In general, the ethnicities of Hackney's clients are in line with local demographics, apart from a relative underrepresentation of those from White Other ethnicities. The proportion of Hackney's clients who are NEET is over three times the national proportion (44% compared to 14%).

Hackney has a significantly lower rate of alcohol-related hospital admissions (22 per 100,000 under 18 year olds) and substance misuse-related hospital admissions (55 per 100,000 15-24 year olds) than nationally.

2.2.5.5 Obesity

It is important to note that the National Child Measurement Programme (NCMP) is only mandated in state-maintained schools and therefore does not include data from Hackney's independent schools which predominantly serve the Charedi Orthodox Jewish community (who form 22% of all local 5-19 year olds).

In reception, 73% of children in Hackney and the City are of a healthy weight, with half of the remaining children overweight and half obese, with only 1% being underweight. This is in comparison to 77% of reception children being of a healthy weight nationally.

By Year 6 only 58% of Hackney's children are of a healthy weight, with most of this change being seen as a rise in the proportion of obese children. The proportion of obese Year 6 pupils places Hackney significantly worse than the London and national averages and eight of Hackney's ten statistical neighbours.

While these rates have been quite stable from the start of the NCMP in 2008/09 until 2014/15, there was a decrease in the proportion of reception aged children in Hackney and the City being obese in the most recent data (albeit not significantly).

Within Hackney and the City, children are significantly less likely to be obese if they are in the least deprived quartile and White children are significantly less likely to be obese than Black children. The highest rates of obesity are primarily found on the edges of the borough – in Brownswood in the north west, Victoria in the south east and Hoxton in the south west.

A pilot school reception health check performed in 22 of the 23 independent Charedi primary schools in Hackney in 2015 revealed that 84% of pupils were of a healthy weight, with 9% overweight, 5% obese and 2% underweight. Adding these results to the formal NCMP results brings the overall healthy weight rate to 75% in reception in Hackney.

127 children and young people attended one or more appointments with the young people's weight management service LEAP (Lifestyle Eat-Well Activity Positivity) in 2014. Of these, the genders were evenly balanced and the greatest number of referrals were for 10-14 year olds. The largest ethnic group served by LEAP is Black (40%) – while this is more than the proportion of Hackney's young population who are Black (30%), this is in keeping with NCMP obesity prevalence data. Three quarters of the White Other referrals were either Turkish or Turkish Cypriot.

At 10%, a significantly lower proportion of Hackney's 15 year olds report being physically active for at least one hour every day than nationally, and this is also lower than eight of Hackney's ten statistical neighbours.

There is no significant difference in the proportion of Hackney's 15 year olds who report consuming five portions of fruit and vegetables per day in comparison to Hackney's ten statistical neighbours or the London or national averages.

2.2.5.6 Dental Health

On average, 40% of Hackney's 0-17 year olds visit a dentist in the two year period to 2014/15, which is lower than all ten of Hackney's statistical neighbours. Conversely, City of London's 0-17 year olds visit a dentist on average more than once over two years. Hackney also has a higher population to dentist ratio than nine of its ten statistical neighbours. A lower proportion of 0-17 year olds had received a fluoride varnish application than all ten of its statistical neighbours.

Yet when considering output Hackney has a similar proportion of five year olds who have experienced tooth decay (approximately one third) and a similar average number of decayed/missing/filled teeth (approximately one) compared to London and national averages. However, the proportion of five to nine year olds who underwent an inpatient tooth extraction in 2013/14 in Hackney was twice the national rate.

Rates of decay vary markedly within Hackney, with a recent local pilot in 302 Charedi children (four to seven years of age) showing that half have evidence of tooth decay and the average number of decayed/missing/filled teeth is over two.

2.3 Key Recommendations

2.3.1 Medical

- Examine the types of presenting complaint that constitute the high rates of primary care consultations in Asian 5-9 year olds and White British 15-19 year olds
- Liaise with the Latimer Health Centre and Hoxton Surgery to try to understand why consultation rates with young people are high and low, respectively
- Ensure promotion and reassurance around the HPV vaccination is provided in a culturally-sensitive manner

2.3.2 Sexual Health

- Future sexual health service design in Hackney and the City should take into account the nationally-rising demand for sexual health services amongst young people, particularly given the open access nature of sexual health services
- The reasons why long-acting reversible contraceptives (LARC) account for a low proportion of contraceptive prescribing in local primary care should be explored. For instance, it is unknown whether the low prescription rate is due to low demand from young people (more education required), low promotion by GPs and practice nurses to young people (more health professional training required), or low availability of LARC in primary care (more practitioners trained to insert implants or coils required). As per NICE guidance (PH51), the use of 'commissioning for quality and innovation' (CQUIN) indicators could be explored as a route to increasing LARC prescribing
- The relatively high rate of teenage abortions, and in particular repeat abortions in young women, should be investigated further. The role of sexual health education in schools should be strengthened, with a view to reducing the abortion rate without seeing an increase in the rate of births to teenage mothers
- Future efforts to increase chlamydia screening should focus on 15-19 year olds and males, with an aim to match the excellent screening coverage in 20-24 year old females locally
- The importance of offering, and recording the offer of, chlamydia screening to those in young person's substance misuse services should be emphasised to staff

2.3.3 Mental Health

- Aim to ensure that the relatively low rate of inpatient hospital admissions for a primary diagnosis of a mental health or behavioural disorder are due to a low need, and not due to barriers to diagnosis or admission
- Encourage partnership work to improve the prevention offer around acute mental health needs as early as possible
- Work to increase the accessibility of mental health support for young men, who may be a harder to reach group, and who are known to be more likely to complete suicide or suffer from psychoses as young adults
- Consider a school health review at the transition to secondary school to identify mental health issues, in particular eating disorders, in line with the Child and Adolescent Mental Health Services (CAMHS) transformation plan and following the HCP suggested recommendation

2.3.4 Smoking

- Utilise social media to convey anti-smoking messages to local young people
- Provide increased education both in schools and through wider campaigns to highlight the harms of smoking non-cigarette tobacco products, such as shisha
- Concentrate efforts to reduce cigarette smoking in White and Mixed ethnicity young people particularly, and focus on girls at younger age groups, and on boys when approaching the legal age of 18
- Use a whole-family approach to reducing smoking, as smoking in parents and siblings is a risk factor for young people smoking

2.3.5 Substance Misuse

- Utilise social media to convey substance misuse messages to local young people
- Increase young people's awareness of the harms of smoking cannabis, particularly if smoked regularly
- Focus on girls when working to reduce alcohol consumption in local young people
- Investigate whether there are barriers preventing young women from accessing substance misuse services, given that they form a low proportion of service users despite having greater alcohol consumption on average
- Aim to increase referrals to the young people's substance misuse service through prevention work in local education services
- Ensure that the relative lack of an evidence base regarding the emerging issue of new psychoactive substances does not cause them to be overlooked when providing substance misuse related education or when commissioning substance misuse services for young people

2.3.6 Obesity

- Extend the local measurement scheme in Charedi schools to cover ten year old pupils to provide a more detailed picture of local childhood obesity rates in line with NCMP-published data
- Use a whole-family approach, not only in obesity management, but also in mainstream healthy weight maintenance education
- Aim to increase the proportion of young people being active every day – particularly in black and minority ethnic and LGBTQ groups. As the most common reason for young people not exercising outside of school is because they are not motivated to do so ("happy as I am"), rather than due to barriers in accessing facilities, it is important to increase young people's awareness of the importance of exercise – both for healthy weight maintenance and wider physical and mental health benefits
- Continue work to redress the balance in favour of more accessible healthy food near schools, and less accessible takeaway unhealthy food near schools
- Promote the LEAP service and its referral pathway to accident and emergency departments and to the 20 GP practices that did not refer any children during 2014

2.3.7 Dental Health

- Increase community awareness among children themselves, and their parents or guardians, of the need for children and young people to visit a dentist regularly
- Investigate the levers that could be used to increase the number of dentists practicing in both Hackney and the City
- Work with the Charedi community to ensure that any cultural-specific barriers to dental health are identified and addressed
- Explore the feasibility of extending the oral health promotion project ("Happy Smiles") to Hackney's special schools and re-engagement unit and facilitate partnership working with the Community Dental Service
- Ascertain what the obstacles are to the Community Dental Service operating in the re-engagement unit in Hackney, and work to remove them
- Expand the fluoride varnish programme to operate in all primary schools and nurseries in Hackney and the City, and work to increase the proportion of parents who consent to their children receiving the varnish – through warning of the harms associated with tooth decay and raising awareness of the benefits of varnishing
- Within the local authority consider the introduction of a water fluoridation scheme and discuss this with neighbouring local authorities that share the local water supply, in line with guidance from PHE

3 Contents

4 Introduction

4.1 Objectives

This report has five main aims:

1. Identify national and local policy and guidance relevant to the health of 5-19 year olds in the Borough of Hackney and the City of London

2. Assess epidemiological need by summarising the incidence and prevalence of key conditions and significant wider determinants of health in the local 5-19 year old population. Examine the six key public health priorities of sexual health, mental health, smoking, substance misuse, obesity, and dental health in greater depth

3. Gain the insight of local 5-19 year olds regarding the six key priorities

4. Outline current service provision

5. Identify areas for development by comparing the epidemiological need and consultation-identified need with the current level of service provision

4.2 Scope and Purpose

This needs assessment will highlight areas of need relating to health for children and young people aged between five and 19 years who are resident in the London Borough of Hackney and the City of London. It will inform the children's section of the local Joint Strategic Needs Assessment (JSNA) and guide the development of services targeted at the six priority areas for 5-19 year olds in the borough of Hackney and the City of London.

5 Background

Hackney is a diverse, densely populated inner London borough of 263,200 people (mid-2014 estimate) [1]. Of this, 44,700 are 5-19 years of age. The borough has an area of seven square miles (19 km^2), making it the fifth smallest London borough [2]. Hackney consists of 21 wards (detailed in Appendix 15.1, Figure 188). Both the highest proportion of the population being aged 5-19 and the highest household density of the population can be found in the north of the borough, in particular in the Stamford Hill area (Figure 1) [3].

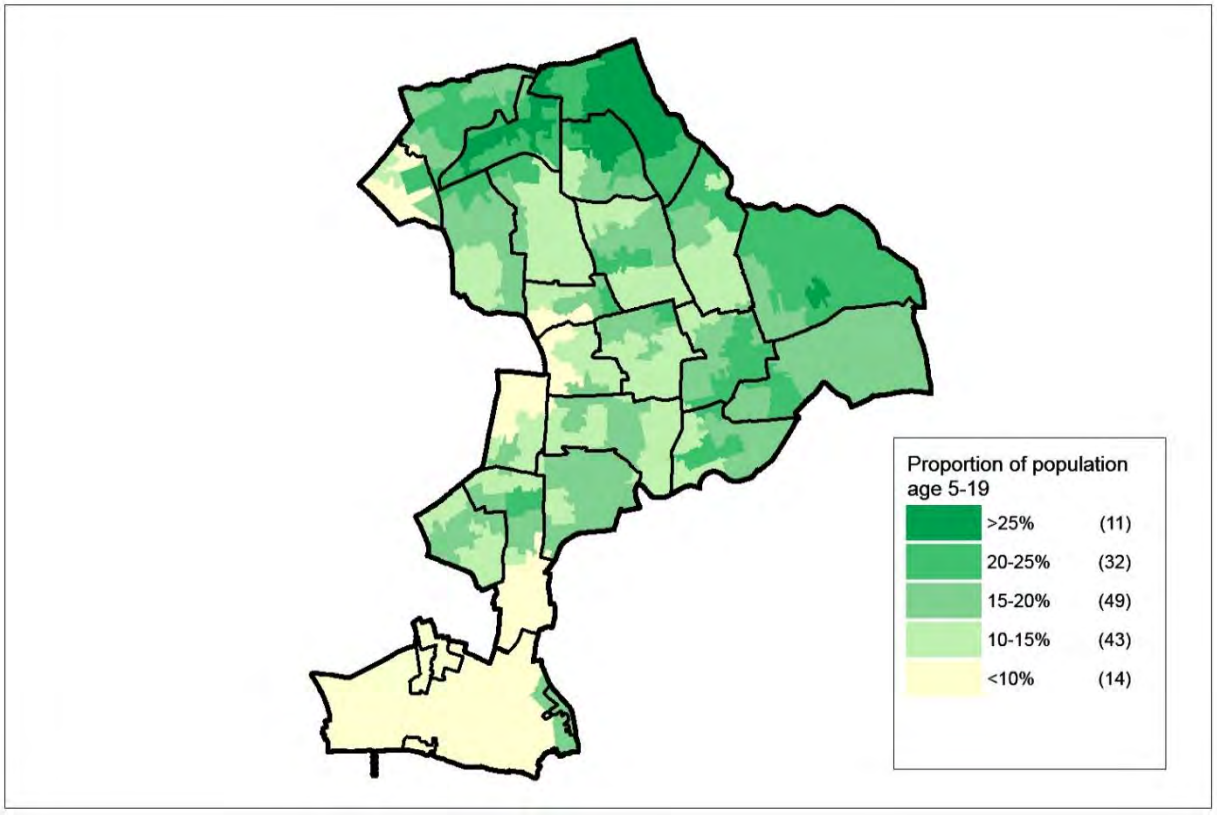

Figure 1: Proportion of the population aged 5-19 in Hackney and the City of London, mid-2012 estimate [3][6]

The life expectancy at birth in Hackney is lower than the London and national averages for both males and females (shown by dark green lines in Figure 2) [1]. In males, this difference is statistically significant as the error bars to not overlap with the other trend lines[7].

Throughout this document, the statistical neighbours that have been used to compare Hackney to similar boroughs are taken from the local authority interactive tool as at July 2016, as these boroughs have been compared on features that specifically relate to children and young people. Hackney's statistical neighbours are Haringey, Islington, Lambeth, Enfield, Southwark, Waltham Forest, Greenwich, Brent, Lewisham and Hammersmith & Fulham [4].

[6] Note – based on ONS data. Includes mapping data licensed from Ordinance Survey
[7] Note – the error bars (vertical lines) denote the range in which one can be 95% certain that the true value lies

The City of London is only one square mile (2.6 km^2) in size. It has a resident population of 8,100 people (mid-2014 estimate) [1], but the workday population is over 50-fold greater[8]. Of the resident population, 700 are aged 5-19 years. The City consists of 25 wards (detailed in Appendix 15.1, Figure 189), but each contains very few, or in some cases no, residents.

The life expectancy at birth in the City is higher than London and national averages for both males and females (shown by light green lines in Figure 2) [1]. However, these differences are no longer statistically significant, as the error bars are wide because of the small size of the City of London's population – causing them to overlap with other trend lines.

Like for Hackney, the City's statistical neighbours have been taken from the local authority interactive tool and are specific for children and young people. They are the London Boroughs of Richmond upon Thames, Wandsworth, Kingston upon Thames, Westminster, Barnet, Camden, Hammersmith and Fulham, Islington, Kensington and Chelsea and a non-London local authority of Brighton and Hove [4].

[8] Note – total workday population 360,000 in 2011 Census [1]

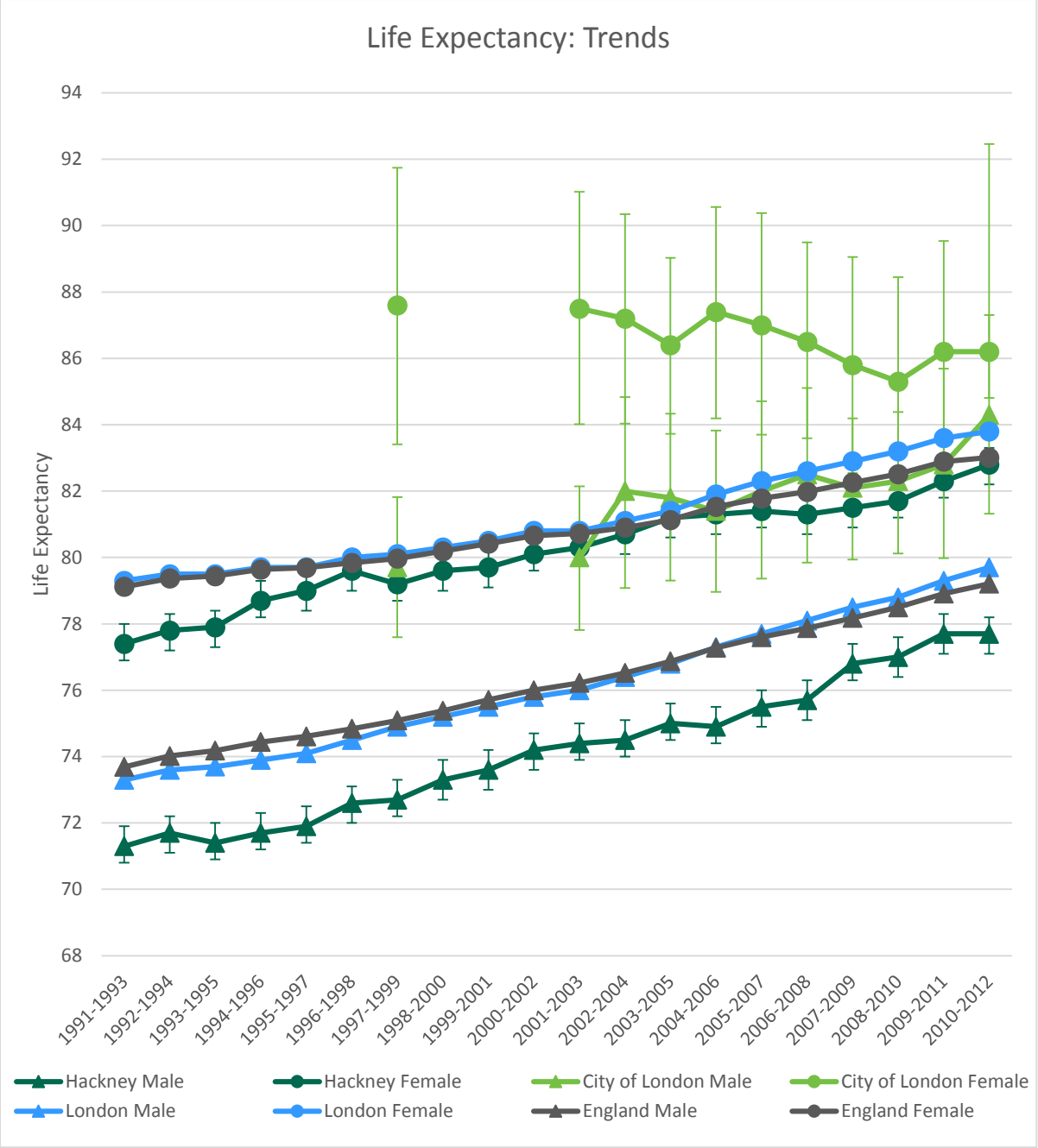

Figure 2: Trends in life expectancy at birth over 20 years [1][9]

6 Methods

Key governmental policies relating to the health and wellbeing of children and young people, whether solely focussing on young people or not, were searched for using the gov.uk website and the national archives relating to governmental documents. Major policies and reports produced by national organisations were identified either through

[9] Note – City of London data contain a ten-year average for 1993-2003. Unlike the three-year averages for Hackney, London and England, the data for the City of London post 2003 are averaged over five years due to the small numbers involved

reviewing the references of previously identified reports, or through a search of the grey literature[10] via Google in relation to the six public health priorities covered in this needs assessment. Current strategies produced by the Hackney and City public health team and associated Council colleagues have also been included following local discussion.

To accurately map current levels of prevalence, the most recent local data relating to priority areas have been sought primarily from nationally published Public Health England toolkits, the Office for National Statistics and the 2011 Census (via the Nomis online tool). Further local data have been provided by the local acute NHS trust (Homerton University Hospital NHS Foundation Trust), the Clinical Effectiveness Group and previous local public health team research. Where relevant data have not been available from these sources, a search of the grey literature for further information via Google has been performed.

Relevant National Institute for Health and Care excellence guidance regarding best practice has been identified through searching via the NHS Evidence website.

Information regarding current service provision has been obtained through local discussion with colleagues within the Council and with wider stakeholders, including the CCG and Hackney Learning Trust. Consultation with children and young people themselves has also been conducted by the London Borough of Hackney and City of London public health team and thematic analyses of these qualitative data have been performed and used to inform recommendations.

6.1 Caveats

The following five caveats must be borne in mind while interpreting the presented data.

Firstly, many of the data regarding demographics and the wider determinants of health are based on the results of the 2011 Census. While the Census is usually the most reliable source of data for these domains when considering small geographical areas, it must be remembered that the Census is not infallible. For example, the 2001 Census is estimated to have had an undercount of 6.1% [5]. This undercounting does not occur uniformly across populations (either geographically or demographically) and tends to occur more in those groups that attract higher levels of funding [5]. The Census Coverage Survey following the 2011 Census found that inner London had both the lowest household response rate and lowest person response rate [5].

Secondly, Hackney is a very ethnically and culturally diverse local authority and, as such, contains many sub-populations that may be significant in size locally, but are very small in size in a national context. As the Census includes the same response options nationwide,

[10] Note – 'grey literature' are those materials and research which are not controlled by commercial or academic publishing channels – for instance, reports of non-governmental organisation

some of these sub-populations may not be specifically elucidated and, therefore, the Census may not portray a full picture of the make-up of Hackney.

Thirdly, the 5-19 population is much smaller in the City of London than in Hackney. This means that some data that are available for Hackney are not available for the City of London as the low numbers involved may make the data unreliable and/or identifiable to individual children. For instance, while some data are presented at ward level in Hackney, this is not possible for the City of London as each of the City's 25 wards contain few, and in some cases no, residents. Furthermore, this small size means that there are no secondary schools based within the City of London. Instead these children attend schools in a number of different neighbouring local authorities which creates fragmented data.

Fourthly, while Hackney may be compared against its statistical neighbours to assess performance against other areas with a similar profile, the statistical neighbours for the City of London must be used with caution. The City of London has far fewer residents than its statistical neighbours, who have 21 to 46 times as many residents. These small numbers mean that data are less statistically robust with normal fluctuations appearing greater than in larger local authorities. Furthermore, the population demographics differ, with the City of London having a higher proportion of working aged males and a lower proportion of children than most of its neighbours.

Finally, Hackney and the City of London contain independent schools that cater for a large number of local children. Many of these independent schools are outside of data collection systems for state-maintained schools, and do not necessarily provide data for national programmes such as the National Child Measurement Programme (NCMP). This means that the data for some topics, such as obesity, may not cover all local children. As those who attend independent schools (for instance, those in the Charedi community) may differ in their health needs from other local children, these data may be skewed.

6.2 Statistical Significance

Throughout this report, statistical significance has been calculated at a 95% confidence level. That is, there is a 95% certainty that data which are deemed statistically significantly different represent a true underlying difference between two groups. In line with this, all of the error bars on graphs in this report represent the 95% confidence intervals – i.e. the range within which one can be 95% certain that the true value lies.

Data in tables have been colour-coded to match statistical significance, where the original data contain significance indicators. Number appearing in **red** are significantly worse than the national average or target value, numbers in **grey** are not statistically different and numbers in **green** are significantly better. Numbers appearing in **black** have not been statistically tested.

7 Policy

7.1 Governmental

There is no one governmental strategy that directs how children and young people should be supported – instead included below are a series of reports and legislature (Figure 3). These reports often build on strategies that have gone before them, but it must be remembered that they have been commissioned by a series of different governments.

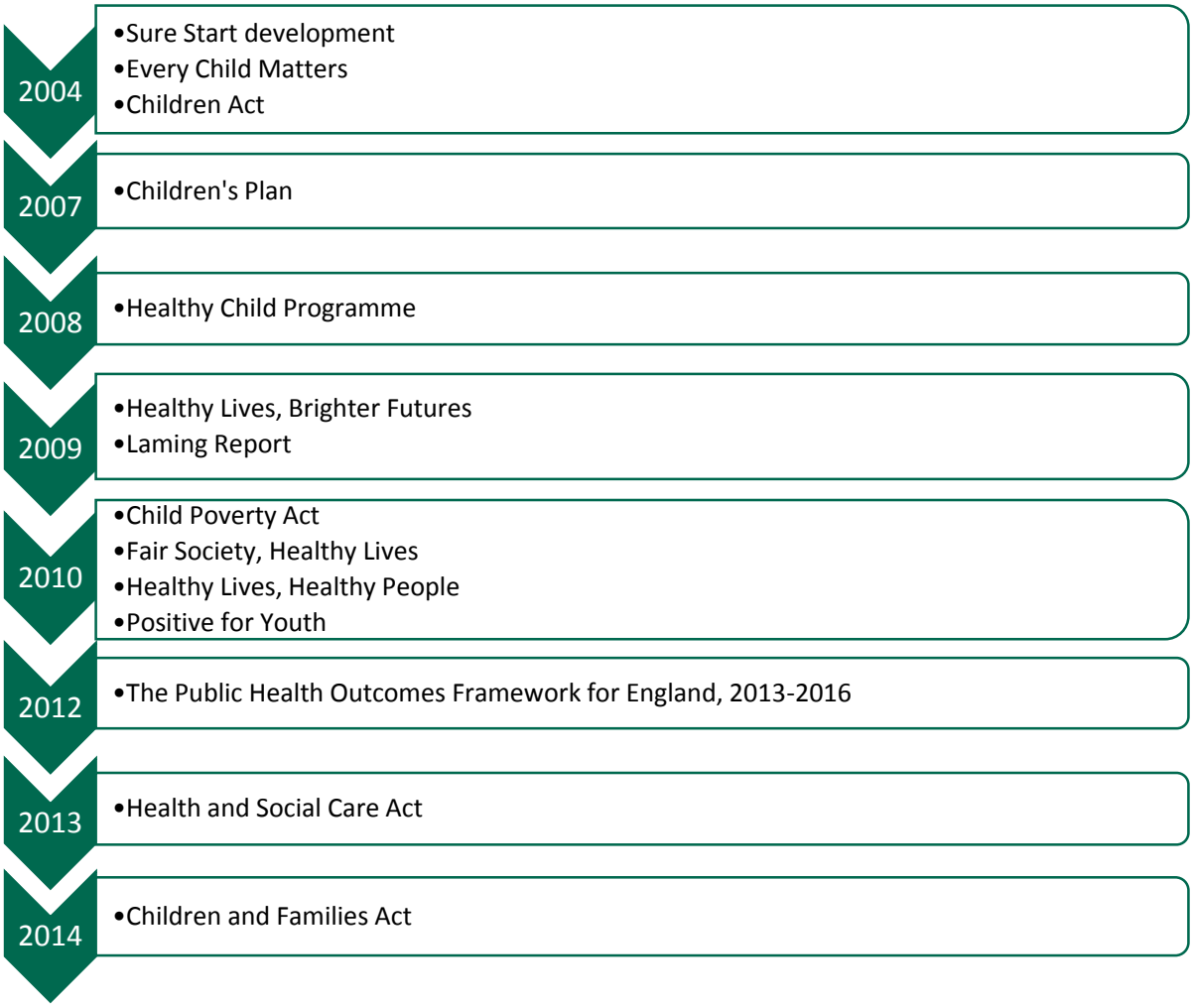

Figure 3: Timeline of governmental strategies and legislature, 2004-2014

The most pertinent of these strategies are discussed below in more detail.

7.1.1 Whole Population

'Fair Society, Healthy Lives' was commissioned in 2008 by the then Secretary of State for Health to identify and evidence the health inequalities facing England [6]. Chaired by Professor Sir Michael Marmot, and otherwise known as The Marmot Review, the key theme of the report was that the more favoured people are, socially and economically, the better their health. To counter this, the report proposed the use of "proportionate universalism", that is universal action with an intensity that is proportionate to the level of disadvantage.

Using a 'life course' perspective was a central focus of the Review, with the proposition that disadvantage starts before birth and accumulates throughout life; it is because of this that 'give every child the best start in life' is their highest priority recommendation. The six policy objectives produced by the Review are shown in Figure 4.

A. Give every child the best start in life
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives
C. Create fair employment and good work for all
D. Ensure healthy standard of living for all
E. Create and develop healthy and sustainable places and communities
F. Strengthen the role and impact of ill-health prevention

Figure 4: Key policy objectives in 'Fair Society, Healthy Lives' [6]

Policy objective B is the most relevant with regards to this needs assessment. This objective is based on evidence that the graded relationship between socioeconomic position and educational outcome has significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health. The report advises that not only are the early years crucial, but that commitment must be maintained throughout education to reduce the inequality gradient. The policy recommendations to meet objective B include extending the role of schools in supporting families and communities and taking a 'whole child' approach to education; developing the school-based workforce to build their skills in working across school-home boundaries and addressing social and emotional development, physical and mental health and wellbeing; providing easily accessible support and advice for 16-25 year olds on life skills, training and employment opportunities; and increasing availability of non-vocational lifelong learning across the life course [6].

*"Britain is now the most **obese** nation in Europe. We have among the worst rates of **sexually transmitted infections** recorded, a relatively large population of problem **drug users** and rising levels of harm from **alcohol**. **Smoking** alone claims over 80,000 lives every year. Experts estimate that tackling poor **mental health** could reduce our overall disease burden by nearly a quarter."*

Figure 5: 'Healthy Lives, Healthy People' [7]

'Healthy Lives, Healthy People' is the previous government's public health strategy for England [7] and is a response to *'Fair Society, Healthy Lives'*.

This paper highlights the lifestyle-driven health problems that are affecting Britain (see Figure 5). It outlines five key public health challenges, which form five of the six key priorities discussed in this document (with the addition of dental health – a specific health concern for children and young people).

To follow on from *'Healthy Lives, Healthy People'*, the previous government developed *'The Public Health Outcomes Framework for England, 2013-2016'* to help to understand any subsequent progress [8]. This new framework was designed to measure high level outcomes for the population, not process targets. The two outcomes focussed on were increased healthy life expectancy, and reduced differences in life expectancy and healthy life expectancy between communities. Four domains are described as part of the framework – improving the wider determinants of health, health improvement, health protection, and healthcare public health and preventing premature mortality. Within the framework, many of the collected data pertain to children and young people, as these early indicators and influencers will shape the health outcomes of the next adult generation, and are used during the discussions in this document.

7.1.2 Children

The most recent governmental health strategy to target all children and young people was *'Healthy Lives, Brighter Futures'* published in 2009 [9]. The four key aims of this strategy were (1) mothers and fathers are provided with the information they need to help their children lead healthy lives; (2) public sector settings provide healthy environments and encourage children and young people to make healthy choices; (3) the right services are in place to meet the specific health needs and expectations of children and their families; and (4) extra support is provided for those from the most disadvantaged backgrounds. This report raised childhood obesity, sexually transmitted infections, and the volume of alcohol consumed by young people who drink as areas of concern. Furthermore, the report highlighted the variation in the quality and experience of health services as areas for improvement.

With regards to school-age children specifically, *'Healthy Lives, Brighter Futures'* proposed an improvement to the healthy child programme (HCP), strengthening of the healthy schools programme, provision of five hours of physical education and sport per week, building the evidence to extend free school meal criteria and improvements to the quality and consistency of personal, social, health and economic (PSHE) education [9].

However, a more recent policy *('Positive for Youth'*) exists for young people aged 13-19 in England, albeit still produced by the previous government [10]. This report had six key messages which are shown in Figure 6.

SOCIETY: Strengthening communities and the voluntary sector / Stronger local partnership
"Strong communities which take responsibility for their young people will help them to feel a strong sense of belonging. Youth work has a key role to play". The National Citizen Service will be piloted to bring together 16 year olds from all backgrounds with opportunity for social action. 18 voluntary sector programmes will be funded at national level. A small number of youth innovation zones will test new approaches involving all local partners in supporting young people
FAMILIES: Putting families first
"Services for young people need to support families while respecting and nurturing young people's growing sense of independence and personal responsibility." National helplines and websites will support and advise parents of teenagers and a programme will support the most troubled families.
EDUCATION: Helping young people succeed
"Driving up participation and attainment in learning is the best way to help young people realise their potential". By 2015 young people must participate in education or training to 18.
EMPOWERMENT: Promoting youth voice
"Young people have a right to have their views taken into account in all decisions that affect their lives". Young people will be able to inspect and report on local youth services and government policy. Local HealthWatch to ensure young people have a voice in shaping local health services.
SERVICES: The valuable role of services for young people
Services should be "supporting young people's personal and social development […]; making sure all young people are able to participate and achieve in education or training; and raising young people's aspirations and thereby reducing teenage pregnancy, substance misuse and crime" The 63 Myplace youth centres will be completed to act as service hubs in disadvantaged areas.
SUPPORT: The importance of early help
"Young people who are particularly disadvantaged or vulnerable need effective additional early help […] to prevent issues escalating and causing further harm."

Figure 6: Key messages and commitments of 'Positive for Youth' [10]

7.1.3 Legislature

The Child Poverty Act (2010) [11] places a requirement on local authorities in England to reduce and mitigate the effects of child poverty through the local production of a child poverty needs assessment and strategy.

The Children and Families Act (2014) [12] lays out a range of new regulations. Of particular interest to 5-19 year olds the Act includes laws regarding children and young people with special educational needs or a disability, aims to improve circumstances for looked after children and young carers and aims to protect children from becoming addicted to nicotine or harmed by tobacco [13].

7.2 National Organisations

> *"Early interventions and preventive measures such as immunisation, health checks and education do make a difference to outcomes. If we can* ***act early we can prevent harm****."*
>
> *Prof Dame Sally Davies, Chief Medical Officer*

Figure 7: 'Our Children Deserve Better: Prevention Pays' [14]

The Chief Medical Officer (CMO) for England produces an annual report examining a specific health area in detail. In 2012 this report was entitled *'Our Children Deserve Better: Prevention Pays'*, and focussed on children's public health [14]. The key themes of this report were early action, proportionate universalism, engagement with children and young people and mental health. Attention was also paid to professional responsibility in the safeguarding of children and young people. A key message was for everyone in public services to 'think family and children and young people' at every interaction [14].

To address some of these themes, a list of recommendations was produced. The recommendations salient to this needs assessment are shown in Figure 8.

1. PHE should work with local authorities, schools and relevant agencies to build on current efforts to increase participation in physical activity and promote evidence based innovative solutions that lead to improved access to existing sports facilities
2. The Social Mobility and Child Poverty Commission and PHE should work together to ensure that efforts to narrow attainment gaps in education complement efforts being made to narrow health inequalities
3. PHE should work with NHS England, the Department for Communities and Local Government and the Department of Health to identify how the health needs of families are met through the Troubled Families Programme
4. The Department of Health, NHS England and PHE, alongside representatives of children and young people, should build on the You're Welcome programme
5. Children with long-term conditions, as vulnerable people, should have a named GP who co-ordinates their disease management
6. PHE should develop and enact a youth social marketing programme, "Rise Above" to engage young people around exploratory behaviours through multiple platforms
7. Regulators, including the Care Quality Commission and Ofsted, should annually review the effectiveness of inspection frameworks and the extent to which they evaluate the contribution of all partners to services for children and young people. This includes the contribution of statutory partners, local safeguarding boards and health and wellbeing boards to the health and protection needs of children and young people

Figure 8: Salient recommendations of 'Our Children Deserve Better: Prevention Pays' [14]

'*Better Health Outcomes for Children and Young People*' is a pledge from governmental, national and local organisations who work with children [15]. This 2013 pledge aims to reduce child deaths; prevent ill health for children and young people and improve their opportunities for better long-term health; improve the mental health of children and young people; support and protect the most vulnerable by focussing on the social determinants of health; and provide better care for children and young people with long term conditions or disability. The shared ambitions for working to achieve these aims are shown in Figure 9.

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people

Figure 9: Shared Ambitions in 'Better health outcomes for children and young people' [15]

The Children and Young People's Health Outcomes Forum is an independent body. Its annual report in 2013/2014 [16] stated that many of the top ten risk factors for the total adult disease burden are initiated in adolescence – alcohol consumption, smoking, obesity and mental illness. The key themes of the Forum's work plan for 2014 are engagement, workforce development, prevention, progress against indicators, data sharing and accountability. These are shown in Figure 10.

ENGAGEMENT
Effectively seek and act on the views of children and young people
WORKFORCE
Ensure that the children and young people's workforce across professions is fit for purpose (in terms of numbers, skills and cultures)
PREVENTION
Ensure that incentives for service development incentivise prevention, early intervention and safe and sustainable services
PROGRESS
Ensure that the appropriate children and young people's health outcome indicators are in place and that progress against these indicators, including regional variations, is reviewed
DATA SHARING
There is a lack of coherent data or a system that links outcomes of children enabling them to be tracked – work should be done to rectify this
ACCOUNTABLE
Ensure that children and young people's services are accountable at national and local levels and knowing this is working on the ground

Figure 10: Children and Young People's Health Outcomes Forum work plan 2014 [16]

7.3 Local Policy

The JSNA for Hackney and the City of London was last fully produced in 2012 [17], with a supplement produced in 2014 to update the included data (particularly as the 2011 Census had been published by that time) [3]. Within that document a ranked lists of needs was drawn up, based on weighted scoring of criteria developed in Leeds, with input from local stakeholders (see Figure 11 and Figure 12).

1=	Smoking
1=	Child Obesity
1=	Mental Health
4	Cancer
5=	Antenatal Care
5=	Cardiovascular Disease
7=	Fuel Poverty
7=	Worklessness
7=	Drug Use
7=	Childhood Poverty

Figure 11: Top 10 priorities identified for Hackney [17]

Mental Health
Cancer Prevention
Homelessness
Smoking
Social Isolation
Air Quality
Worklessness
Childhood Poverty
Prevention of Cardiovascular Disease
Childhood Immunisations

Figure 12: Top 10 priorities identified for the City of London [17]

The London Health Commission published '*Better Health for All*' in 2014 [18]. This report stated the aim of becoming the world's healthiest major global city, from its current standing of seventh place in a ranking of 14 comparable global cities. To achieve this aim, the report laid out ten aspirations which are shown in Figure 13.

	Aspirations for London	Ambitions for London
1	Give all London's children a healthy, happy start to life	Ensure all of London's children are school ready at age five Halve the number of children who are obese by the time they leave primary school and reverse the trend in those who are overweight
2	Get London fitter with better food, more exercise and healthier living	Boost the number of active Londoners to 80% by supporting them to walk, jog, run or cycle to school or work
3	Make work a healthy place to be in London	Gain 1.5 million working days a year by improving employee health and wellbeing in London
4	Help Londoners to kick unhealthy habits	Have the lowest smoking rate of any city over five million inhabitants
5	Care for the most mentally ill in London so they live longer, healthier lives	Reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 10%
6	Enable Londoners to do more to look after themselves	Increase the proportion of people who feel supported to manage their long-term condition to top quartile nationally
7	Ensure that every Londoner is able to see a GP when they need to and at a time that suits them	General practice in London to be open 8am to 8pm and delivered in modern purpose-built/designed facilities
8	Create the best health and care services of any world city, throughout London and on every day	Have the lowest death rates in the world for the top three killers: cancer, heart disease and respiratory illness: and close the gap in death rates between those admitted to hospital on weekdays and those admitted at the weekends
9	Fully engage and involve Londoners in the future health of their city	Year on year improvements in inpatient experience for trusts outside the top quintile nationally
10	Put London at the centre of the global revolution in digital health	Create 50,000 new jobs in the digital health sector

Figure 13: Top ten aspirations for London in 'Better Health for All' [18]

8 Programmes and Structures

While understanding services, both as part of national programmes and local initiatives, the *'You're Welcome'* quality criteria for young people friendly health services should be borne in mind [19]. These criteria are based on examples of effective local working for young people under 20 years of age and are cited in the white paper *'Healthy Lives, Healthy People'*. The ten areas of quality are access; publicity; confidentiality and consent; environment; staff training, skills, attitudes and values; joined-up working; involvement in monitoring and evaluation of patient experience; health issues; sexual and reproductive health services; and specialist and targeted CAMHS (Child and Adolescent Mental Health Services). Some criteria are relevant to the whole population (for instance, privacy and dignity should be maintained during discussion, examination, treatment and care); whereas some criteria are young person-specific (for instance, staff should be trained on the issues of confidentiality and consent relating to young people being seen without a parent/carer present).

8.1 National Programmes

8.1.1 Healthy Child Programme

The HCP is a national evidence-based framework for prevention and early intervention services by health, education and other partners in a range of settings to enhance children's and young people's lives [20]. The framework recommends service outputs, but allows delivery flexibility based on local needs and infrastructure. The routes for provision of the HCP are shown in Figure 14.

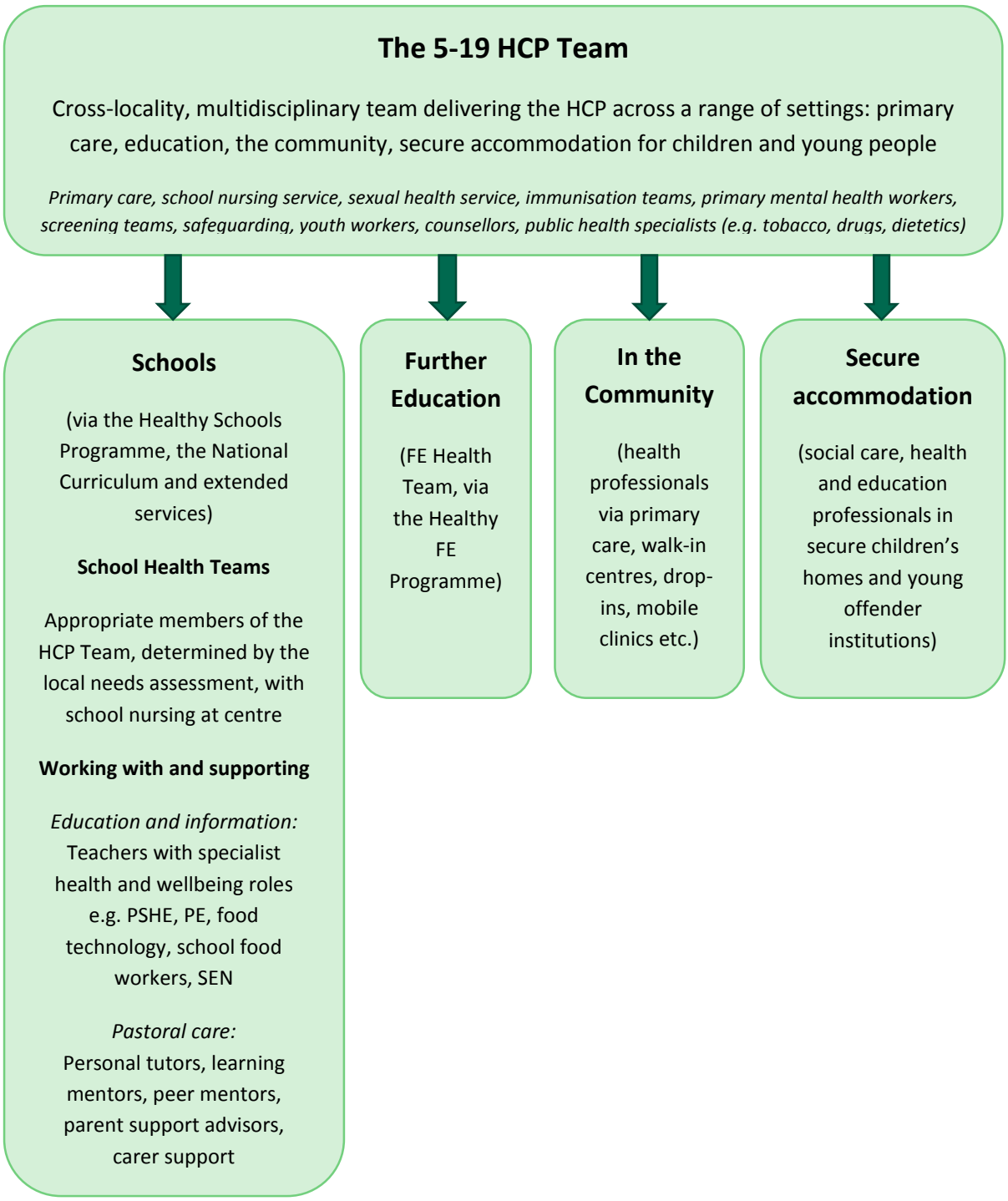

Figure 14: Routes of delivery for the 5-19 HCP [20]

The HCP involves a two-tiered approach (universal and progressive) and this is shown in Figure 15. This is split into three broad age categories of 5-11, 11-16 and 16-19; however, most care domains are present across the whole 5-19 age-span.

UNIVERSAL	PROGRESSIVE
•Transition • Sharing information about pre-school • Health assessment at school entry in YR • Health review at school transition in Y6/7 •Emotional health, psychological wellbeing and mental health •Promoting healthy weight / physical activity •Immunisations (11+) •Sexual health (11+) •Ongoing support •Support for parents and carers	•Immunisations for at-risk children •Overweight and obese children •Drug and alcohol misuse and smoking cessation (11+) •Specific groups of at-risk children and families • Complex welfare needs • Special educational needs • Complex health needs • Young carers • In contact with youth justice system (11+) •Support for parents and carers who: • Have alcohol or drug misuse problems • Have mental health or learning difficulties • Smoke • Are young • May be involved with domestic abuse

Figure 15: HCP universal and progressive pathways [20]

While the Department of Health guidance does not specify exactly how the support outlined in Figure 15 should be provided, it does give a range of examples of programmes and interventions that can contribute to delivery of the HCP.

'Getting it right for children, young people and families' is a 2012 national report that aims to set out a model for the school nursing system, within the context of the HCP, based on both the best evidence and the views of professionals, parents, children and young people [21]. The school nursing service co-ordinates health reviews at school entry and key transitions, manages pupils' wellbeing, medical and long-term condition needs, develops schools as health-promoting environments and plays a key role in the safeguarding of children and young people [7].

*"School nurses or Specialist Community Public Health Nurses (SCPHN) are **qualified nurses or midwives** with **specialist** graduate level education in community health and the health needs of school aged children and young people."*

Figure 16: 'Getting it right for children, young people and families' [21]

The model includes provision to support the transition from the health visiting to school nursing services, emotional health and wellbeing, safeguarding, children with complex needs and those in the youth justice system. Schools nurses work in a range of settings including mainstream education, faith schools, special schools, alternative education provision and services for looked after children. The new model for school nursing uses a four tiered approach to address the needs of all children, with more in-depth support for those who need it, alongside a stream of safeguarding at all levels (shown in Figure 17).

COMMUNITY
All communities have a range of health services (including GP and community services) for children and young people and their families. School nurses develop and provide these and make sure children and young people know about them.
UNIVERSAL SERVICES
Co-ordinate and provide the HCP to 5-19s to ensure a healthy start for every child (e.g. immunisations, advice on healthy eating and weight management, health checks).
UNIVERSAL PLUS
Ensure children, young people and families get extra support when needed (e.g. with sexual health, mental health and learning disabilities, and long-term conditions such as asthma or diabetes) by providing care and/or referring to other services.
UNIVERSAL PARTNERSHIP PLUS
Provide ongoing support together with a range of local services to deal with more complex issues including mental health, young carers and looked after children. School nurses also form part of high intensity multi-agency services where there are child protection or safeguarding concerns.

Figure 17: Four tiered school nursing team services [21]

In conjunction with the Department of Health, the British Youth Council consulted with 1599 young people aged 11-18 years across England to find out what they wanted from the school nursing service. Their report, *'Our School Nurse'*, highlighted that young people nationally want school nurses to be visible, accessible and confidential [22]. Their research found that 49% of young people were unsure about who their school nurse is, 69% did not have information about how they could access their school nurse for help and 39% said it wasn't clear to them that they could receive a confidential service when visiting their school nurse. The report produced eight key recommendations which are shown in Figure 18.

INDUCTION
When entering secondary school, all young people should receive an induction about the role of the school nurse, the service on offer, and information on how to access the service.
The Department of Health should involve young people to develop materials to support this induction. These materials could be piloted across a selection of schools in England.
ACCESS
School nursing teams and school staff should make sure that all young people know how to access the school nurse without involving a teacher or other school staff member.
All school nursing teams should consider what technology they can use to assist young people to access their service more readily – for example a text or email service. At a minimum, all young people should have a telephone number that they can call the school nurse about their problem.
SCHOOL NURSE CHAMPIONS
Young people should be supported to become 'school nurse champions' and work with school staff and their school nurse to promote the school nurse amongst their peers.
EARLY HELP
All school nursing teams should assess how they can offer early help and advice on key issues for children and young people, from an early age before health issues reach 'crisis point'.
CHOICE
All school nursing teams should assess how they can offer, wherever possible, young people a choice over where they access their school nurse, whether the school nurse they see is male or female, and whether they want a friend to accompany them.
FEEDBACK
All young people should be able to, and know how to, feedback on their experience of the school nursing service and whether they feel school nurses are visible, accessible and confidential. School councils or other pupil voice initiatives should work with school staff, youth workers, and community groups to create a youth-led evaluation process

Figure 18: Recommendations in 'Our School Nurse: Young people's views on the role of the school nurse' [22]

8.1.2 National Child Measurement Programme

The NCMP is a national, annual programme led by PHE and delivered by local authorities. The programme was established in 2005 after evidence revealed that the prevalence of obesity had more than quadrupled over the prior three decades from 1.5% in 1974 to 6.3% in 2003 [23]. Children have their height and weight measured in Reception (four to five years old) and Year 6 (ten to eleven years old) and then their Body Mass Index (BMI) is calculated[11]. There are two key purposes – to provide robust childhood obesity prevalence data; and to provide parents with feedback on their child's weight to help to support and encourage behaviour change when necessary [24]. The programme is mandated in every state-maintained primary and secondary school (including academy and free schools), and encouraged in non-state-maintained and special schools where possible. More than one million children across 99.5% of eligible schools are measured annually [24].

Further information on childhood obesity can be found in Chapter 11.5.

[11] Note - children's BMI cannot be interpreted using adult thresholds as a healthy BMI is age and sex dependent with normal growth. The BMI should be calculated and compared to the reference population (32,000 children measured between 1978 and 1994). The UK 1990 reference defines underweight as below the 2nd centile, overweight as above the 85th centile (population monitoring) or 91st centile (clinical assessment) and obese as above the 95th centile (population monitoring) or 98th centile (clinical assessment) [192]

8.1.3 National Curriculum

The national curriculum sets out the programmes of study and attainment targets for all subjects at all key stages to be taught in all local authority-maintained schools across England. PSHE education is not a statutory subject [25], but the national curriculum states that all schools should make provision for PSHE education, drawing on good practice [26]. However, sex and relationship education (SRE) *is* mandated in pupils in secondary education in state-maintained schools [26].

The previous government's public health strategy highlighted that good schools actively promote childhood and adolescent health, because "healthy children with high self-esteem learn and behave better at school" [7]. They advise that PHSE teaching should include relationships and sexual health, substance misuse, diet, physical activity and some mental health issues.

The PSHE Association has developed ten principles of good PSHE education to guide delivery in schools [27] and these are shown in Figure 19.

1. Start where children and young people are: find out what they already know, understand, are able to do and are able to say
2. Plan a 'spiral programme' which introduces new and more challenging learning, while building on what has gone before
3. Take a positive approach which does not attempt to induce shock or guilt but focuses on what children and young people can do to keep themselves and others healthy and safe and to lead happy and fulfilling lives
4. Offer a wide variety of teaching and learning styles within PSHE education, with an emphasis on interactive learning and the teacher as facilitator
5. Provide information which is realistic and relevant and reinforces positive social norms
6. Encourage young people to reflect on their learning and the progress they have made, and to transfer what they have learned to say and to do from one school subject to another, and from school to their lives in the wider community
7. Recognise that the PSHE education programme is just one part of what a school can do to help a child to develop the knowledge, skills, attitudes and understanding they need to fulfil their potential
8. Embed PSHE education within other efforts to ensure children and young people have positive relationships with adults, feel valued and where those who are most vulnerable are identified and supported
9. Provide opportunities for children and young people to make real decisions about their lives, to take part in activities which simulate adult choices and where they can demonstrate their ability to take responsibility for their decisions
10. Provide a safe and supportive learning environment where children and young people can develop the confidence to ask questions, challenge the information they are offered, draw on their own experience, express their views and put what they have learned into practice in their own lives

Figure 19: Ten principles of PSHE education [27]

8.2 Local Structures

8.2.1 Hackney

8.2.1.1 Education

In 1990 the Inner London Education Authority (ILEA) was abolished and the responsibility for education moved to Hackney Council. At this time GCSE results were among the lowest in the country with only 14% of students achieving at least five A-C grades, compared to the national average of 34.5% [28], and 42% of lessons in Hackney primary schools deemed unsatisfactory by inspectors compared to 30% nationally [28]. In 2002, responsibility passed to a not-for-profit company – Hackney Learning Trust (HLT), then known as The Learning Trust. This involved a ten year contract for HLT to take over the Council's entire educational function – the first such move in the UK. By this point, 31% of students were achieving five or more GCSEs at A*-C grade, but this was over 20% lower than the England average. During the ten year contract Hackney's performance increased and in 2009 Hackney's GCSE results surpassed the national average for the first time (see Figure 20) [28]. By 2010, Hackney's results at Key Stage 4 were the most improved in the country. Following this improvement, HLT have become a department in Hackney Council's Children and Young People's service.

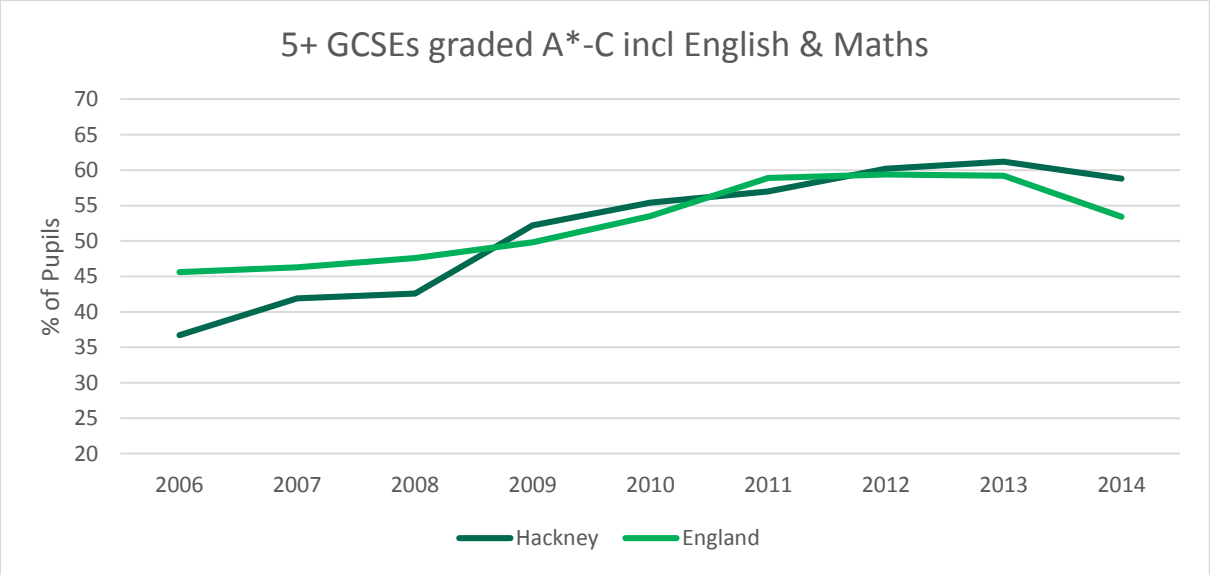

Figure 20: Percentage of pupils achieving at least five A*-C (incl English and maths) in Hackney and England [29]

There are 111 schools in Hackney – 34 independent and 86 state-funded (see Figure 21). The proportion of schools being independent (31%) and the proportion of pupils attending independent schools (21%) are both approximately three-fold greater than the national averages (11% and 7%, respectively) [30].

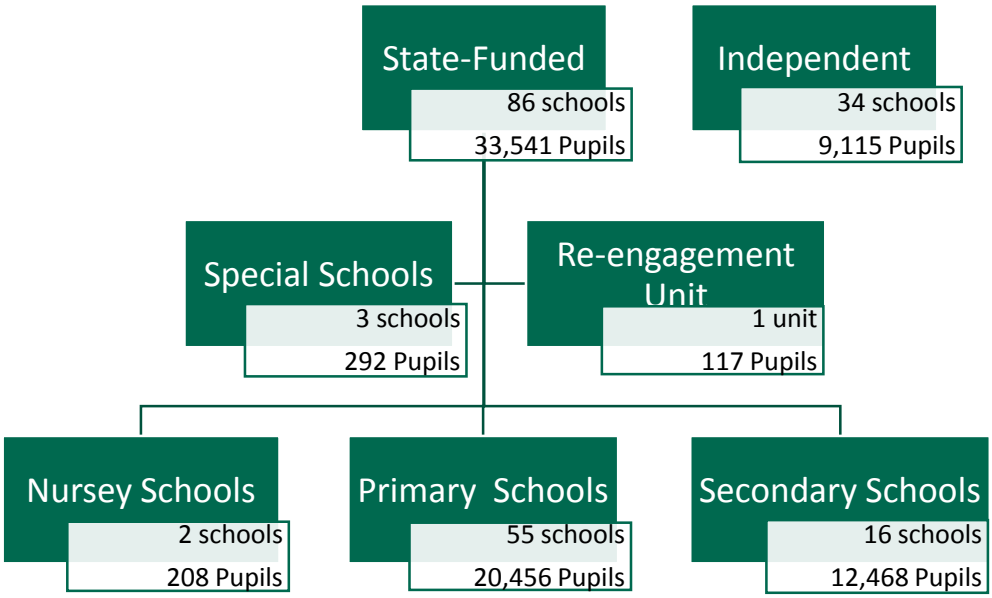

Figure 21: Hackney Schools, 2015 [30]

8.2.1.2 Other Young People's Services

In order to deliver the HCP (see section 8.1.1 above), Hackney has a wide range of universal and progressive services, centred around school and community based health provision, delivering statutory and additional health support (including a comprehensive school nursing offer, Family Nurse Partnership and services for the health of looked after children).

Young Hackney is provided by Hackney Council and is a single integrated youth service for all young people aged 8-19 with Young Hackney workers able to provide continuity of support across the range of services for individual young people. Young Hackney provides support for young people through a variety of mechanisms:

- Running youth clubs, centres and projects that provide sports, arts and multimedia and accredited programmes such as Arts Awards or the Duke of Edinburgh's Award;
- Providing opportunities, support and guidance for young people around employment and training, housing, substance misuse and mental health;
- Helping young people get involved in their communities;
- Working with young people who have been arrested or convicted of a criminal offence through the youth offending and youth justice team.

City and Hackney Young People's Health Service Plus (CHYPS+) provides holistic health services for young people in Hackney aged 11-19. It is a universal free open-access service with targeting towards those who are most vulnerable to poor health. CHYPS+ provides contraception and sexual health services alongside an SRE offer delivered through a multi-agency partnership approach, interventions around smoking cessation, emotional health and wellbeing and obesity and nutritionally-related services.

CHYPS+ currently operates in a variety of youth settings including:

- Two dedicated drop-in clinics – The House (Lower Clapton) and the Defoe building (Hackney Community College)
- Schools and alternative education providers
- Four Young Hackney Youth Hubs – Edge, Concorde, Stoke Newington, Forest Road

In 2014/15 CHYPS Plus saw 1,852 young people of which 500 were new to the service. The service is currently provided by Homerton University Hospital. A new service is being commissioned to be delivered from August 2016 at which point the education and prevention functions will be taken back into the Council and delivered by Young Hackney to maximise the existing reach, networks and reputation of the Council in working with vulnerable young people. The clinical and treatment functions will form a new service that will continue to deliver a high quality, evidence-based, youth friendly sexual health and emotional wellbeing service and include swift referral into partner agencies for specialist services around healthy weight and mental health.

Examples of local services for children and young people are listed within this needs assessment to highlight the range of support that is available and outline the demand placed on these services, where data are available and appropriate. However, this needs assessment does not intend to be a comprehensive directory of all local services. To search for further services, please consult with the Children and Young People's Resource Guide which has recently been updated (July2016) by Hackney Children and Young People's Services. This guide was produced in order to assist professionals working within the borough of Hackney in navigating the diverse range of services for children and families with support needs. The guide can be accessed at:

http://www.hackney.gov.uk/media/3989/CYPS-resource-guide-for-professionals/pdf/CYPS-resource-guide

8.2.1.3 Health Hubs

While Health Hubs in Hackney are not specific to young people, they provide estate-based services in the heart of some of Hackney's most disadvantaged communities. The Health Hubs are venues for community Health Coaches with services to prevent and manage obesity, advise on sexual health, and support smoking cessation and alcohol reduction.

8.2.2 City of London

The City of London has one state-funded primary school serving 240 pupils and four independent schools serving 2,107 pupils with no state-funded nursery schools, secondary schools, special schools or pupil re-engagement units.

With regards to community health support (in comparison to Hackney's Health Hubs), the Community Health Engagement Programme is commissioned to engage with the residents of Portsoken ward's housing estates to encourage healthy lifestyles.

9 Wider Determinants of Health

9.1 Core Demographics

9.1.1 Age and Gender

There are over 60 times as many children and young people aged 5-19 years (inclusive) in Hackney (44,700) than in the City of London (700) [31]. Across Hackney and the City of London, the genders are balanced with 50.1% female and 49.9% male [31].

Hackney has a relatively young population compared to national figures, with a greater proportion of people under 40 years of age, and a lower proportion of people at each age category after 40 years of age (Figure 22) [31].

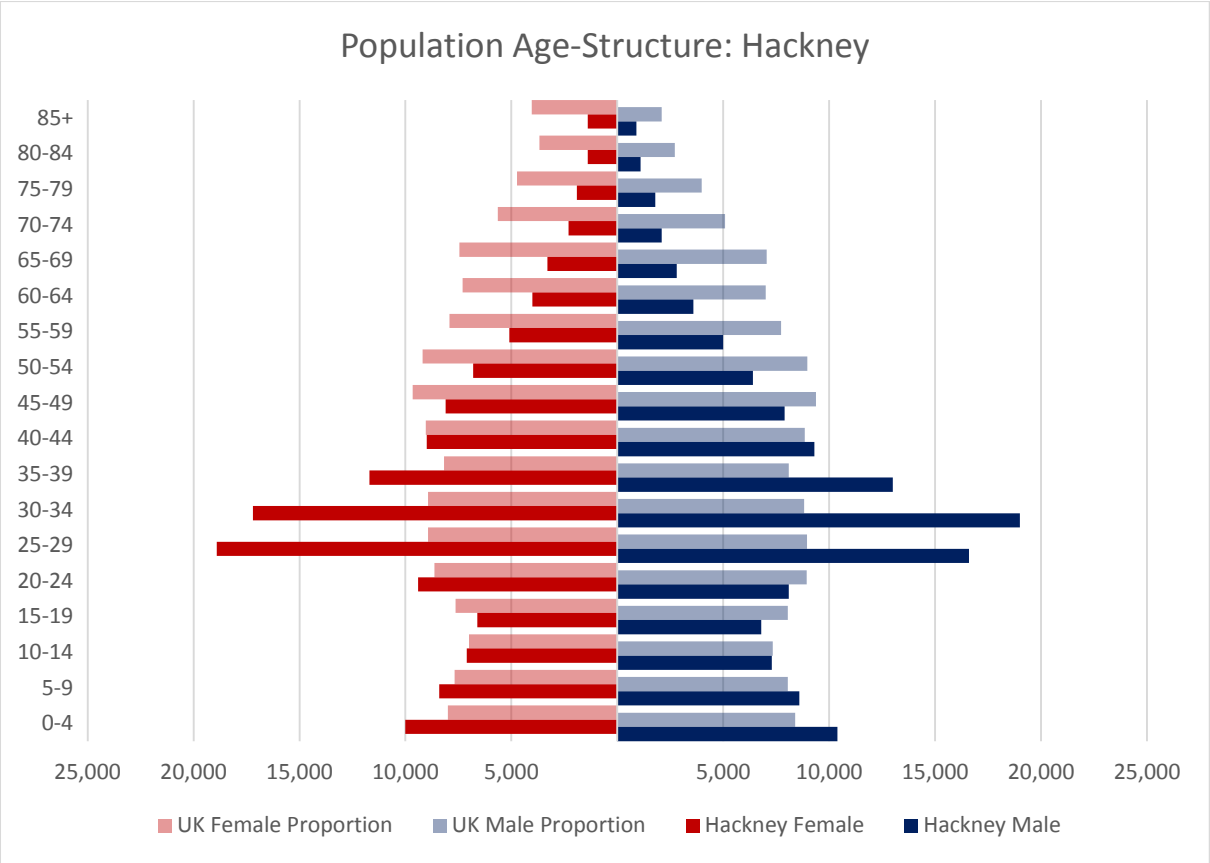

Figure 22: Hackney population age-structure, mid-2014 estimate [31]

The City of London also has a greater proportion of 25-39 year olds, particularly in males. However, this difference is predominantly shouldered by the City of London having a lower proportion of children and young people under 19 years of age (see Figure 23) [31].

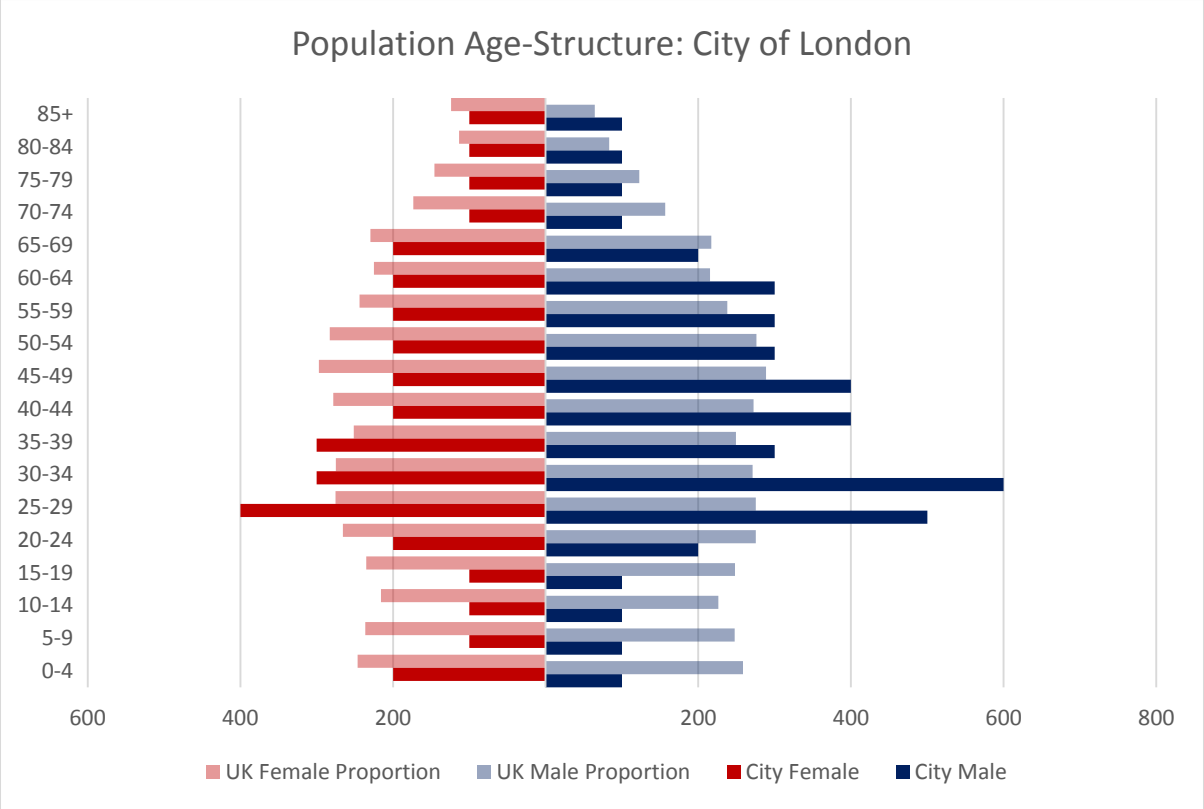

Figure 23: City of London population age-structure, mid-2014 estimate [31]

As shown in Figure 24, the 5-19 population is projected to increase across both Hackney and the City of London over the coming years to 2020.

	Hackney		City of London	
	Mid-2014	2020 Projection	Mid-2014	2020 Projection
Aged 5 - 9 years	17,000	18,350	300	350
Aged 10 - 14 years	14,300	16,100	200	200
Aged 15 - 19 years	13,400	13,600	200	250
Total	44,700	48,050	700	800

Figure 24: Residents aged 5-19 (inclusive) rounded to nearest 100, mid-2014 estimate [31] and 2020 forecast [32] [12]

However, as shown in Figure 25, these increases are not uniform. Within Hackney, the projected changes in 5-19 year olds vary from 100 fewer young people in Haggerston, Hackney Downs and Brownswood wards to 1,000 more young people in New River ward [32][13]. This correlates to an 8% reduction in the 5-19 population of Brownswood ward, but a 33% increase in New River. Four of the five wards with the highest forecast population increases are located in the Stamford Hill area of the borough – where the majority of the Charedi community are based (see Section 9.1.5.1).

[12] Note – the mid-2014 figures quoted here are according to ONS estimates as these are used throughout this report, however the 2020 projections are according to the GLA and therefore not directly comparable

[13] Note – population changes have been calculated here using GLA estimations for both 2014 and 2020 to allow comparability

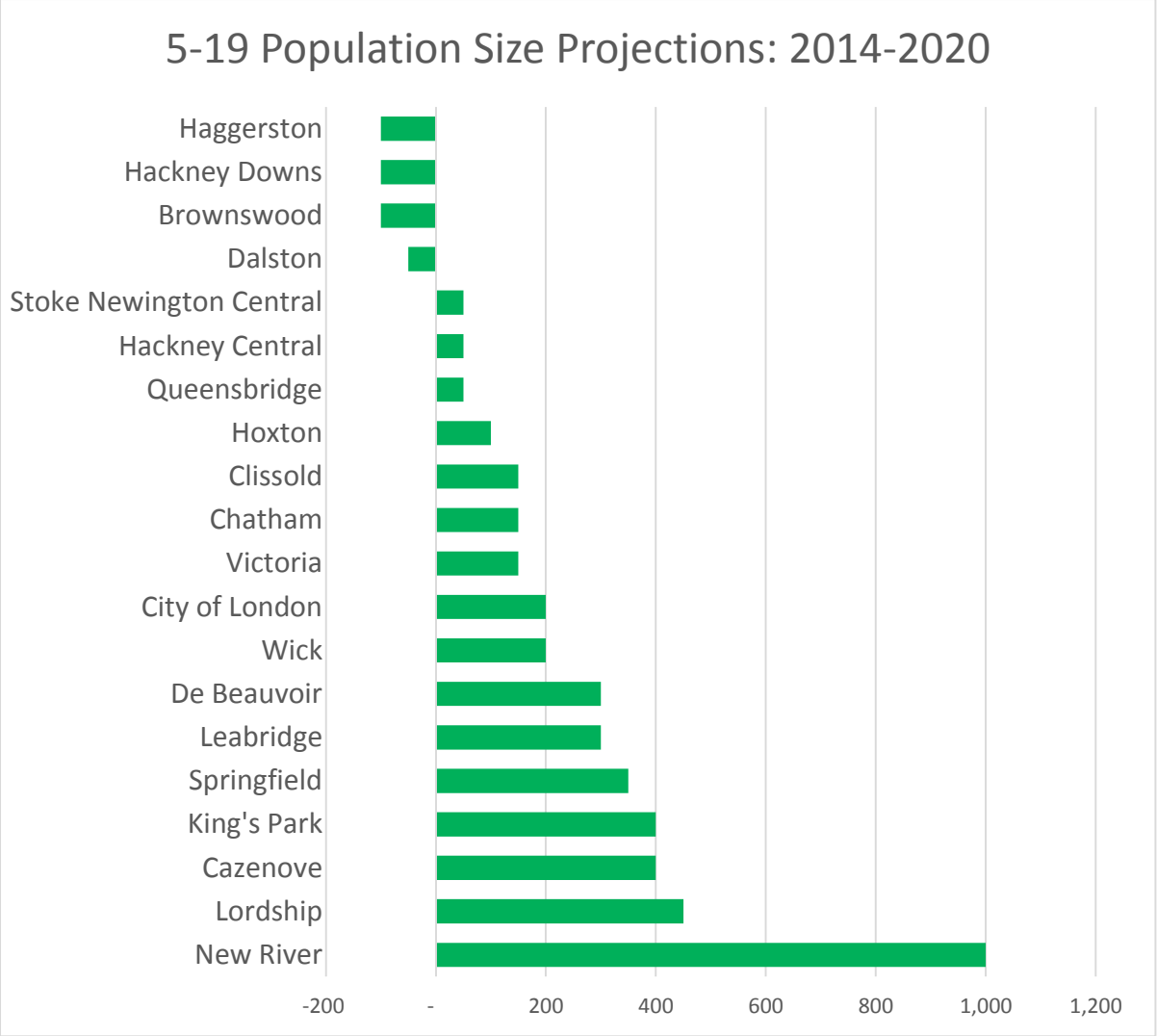

Figure 25: Projected change in 5-19 population 2014-2020 by ward [32]

9.1.2 Ethnicity

The single largest ethnic group in Hackney is White British at 36.2%, and the largest broad category is White at 54.7% (including White Irish, White Irish Traveller and Other White). This is in keeping with the London average of 59.8% identifying as White [33]. However, this is markedly more ethnically diverse than both the City of London (78.6% White) and nationally (85.4% White) [33] (see Appendix 15.3.1.1, Figure 191). Examining the 5-19 population specifically demonstrates that the younger generation is more ethnically diverse. This shift is occurring across the country, but is greater in Hackney, the City of London, and London overall [33] (see Figure 26).

Figure 26: Population identifying as White by age category, 2011 [33]

The main differences in the ethnicity composition of the 5-19 populations are the larger proportion of people identifying as White British and the lower proportion of people identifying as Black in the City of London compared to Hackney [33] (see Figure 27).

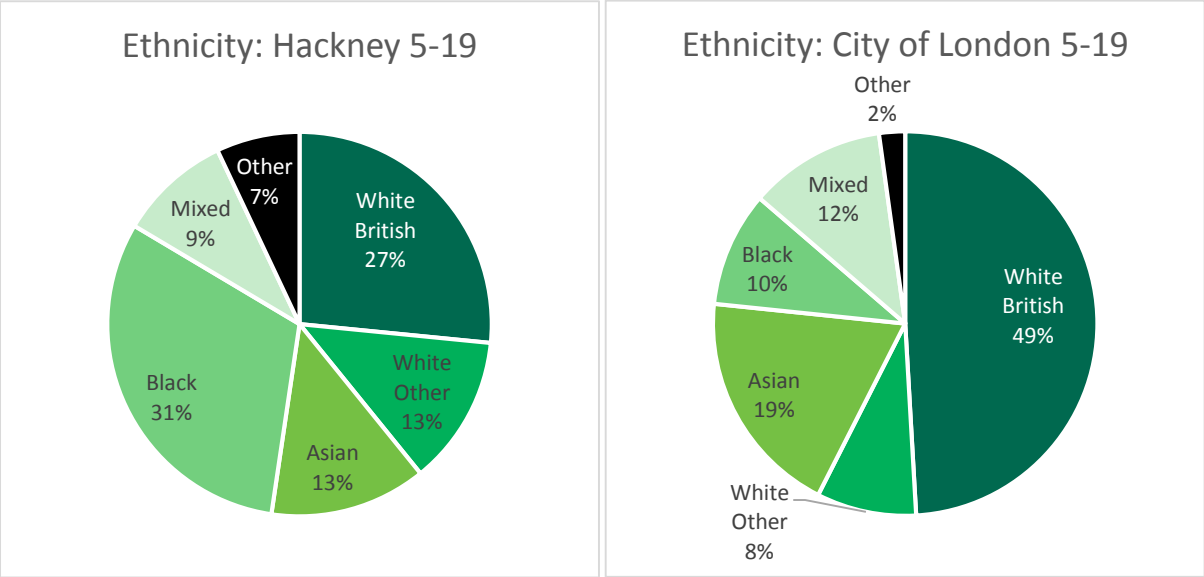

Figure 27: 2011 Ethnicity by area, 2011 [33]

In Hackney, 84.1% of pupils attending state-funded nursery, primary or secondary schools are of an ethnic minority, compared to only 27.0% of such pupils nationally.

There is a concern that census data are not robust locally, as there are poor response rates in inner London – in the 2001 Census it was estimated that the response rate in inner London was 78% compared to 94% nationally [34]. Furthermore, there are concerns that a number of distinct communities found in Hackney are not revealed by the Census due to their small numbers nationally. Mayhew et al investigated the population of Hackney in 2011 and found a range of other distinct communities with many numbering over 1,000 residents including Chinese, Somali, Kurdish and Vietnamese [35].

9.1.3 Migration

Overall, 61% of Hackney residents and 63% of residents of the City of London were born in the UK, which are both in line with the London average of 63%. However, these figures are all lower than the national average of 86% (see Appendix 15.3.1.2, Figure 192). The most common countries of birth outside of the UK for Hackney are Turkey, Nigeria, Jamaica, Poland and Ireland. Since EU changes, the Polish community is the fastest growing international community in Hackney. Conversely, the most common countries of birth outside of the UK for the City of London are the United States, France, Australia, Germany and Ireland.[14]

When examining the young population specifically, a far greater proportion were born in the UK, at 91% of 0-15 year olds in Hackney and 90% of 0-15 year olds in the City of London (see Figure 28).

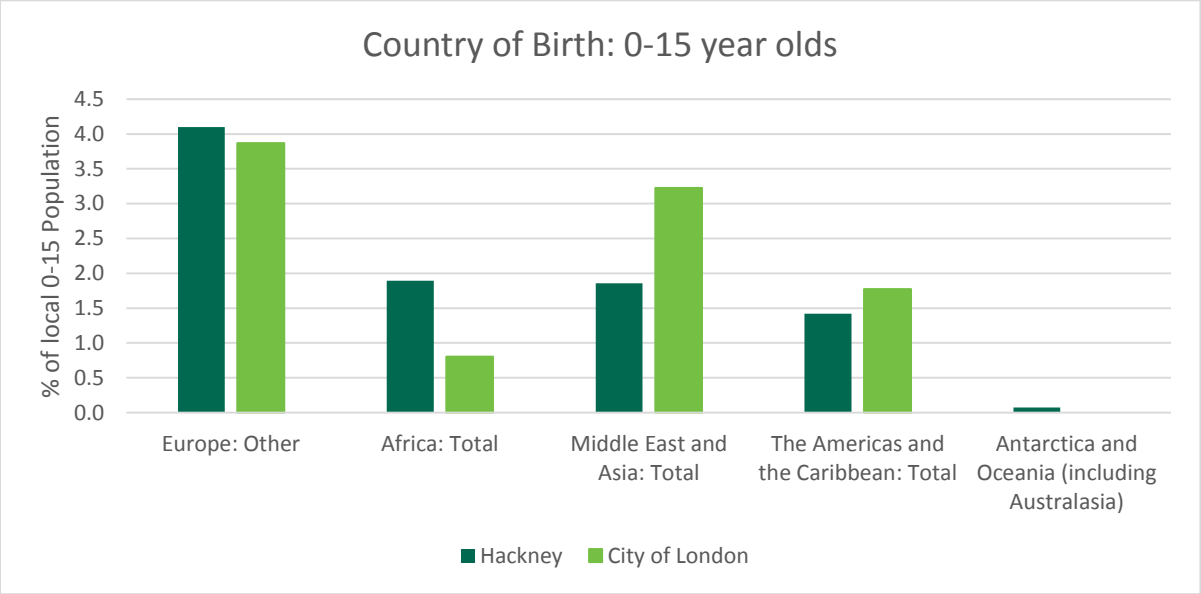

Figure 28: Country of birth if not UK for 0-15 year olds, 2011 [33]

At the 2011 Census, of those born outside of the UK, almost half (45%) had arrived within the previous ten years, and a further quarter within the past 20 years [33]. 78% of those born outside the UK were less than 30 years old on their arrival [33].

Of the 44,700 people aged 5-19 in Hackney at the 2011 Census, 475 people (1%) had moved to Hackney from outside the UK in the one year prior to the Census. Of the 700 people aged 5-19 in the City of London at the 2011 Census, 25 people (4%) had moved to Hackney from outside the UK in the one year prior to the Census.

Migration may be associated with an increased risk of poor physical and mental wellbeing due to their pre-migration experience (different background rates of wellbeing in their country of origin, as well as the circumstances that prompted their migration), the migration

[14] Note – the top 20 countries of birth for Hackney and the City are listed in Appendix 15.3.1.2, Figure 193

experience itself and the post-migration experience in the UK (which includes access to employment and good quality housing, isolation due to language barriers and fear of discrimination or deportation). These risks are likely to be especially high in asylum seekers and trafficked persons, particularly in children [36].

9.1.3.1 Asylum Seekers

The factors that are associated with an increased risk of poor physical and mental wellbeing described for migration above are likely to be more pronounced in those seeking asylum [37]. However, the average physical health status of refugees on arrival is not especially poor with most being young and fit. There is some evidence to suggest that the health status of new entrants may become relatively worse in the two to three years after arrival [38]. As outlined in Hackney's JSNA [17], particular health problems include trauma, communicable diseases (importantly tuberculosis), and mental health problems.

One measure of the number of people currently applying for asylum is through the uptake of Section 95 provision, which provides accommodation and/or subsistence payments while a person's application is considered (funded by the UK Borders Agency). At the end of the second quarter of 2015 there were 38 asylum seekers in receipt of this support in Hackney, and none in the City of London. These numbers have now plateaued, but follow a previous steep decline from the levels seen ten years ago – there were 13,680 recipients in Hackney at the end of the second quarter of 2005 (Figure 29). While the numbers across London have also been decreasing (54,522 to 30,457 over the same period), the decline in Hackney has been more rapid, so that now only 1.4% of those in receipt of support in London live in Hackney.

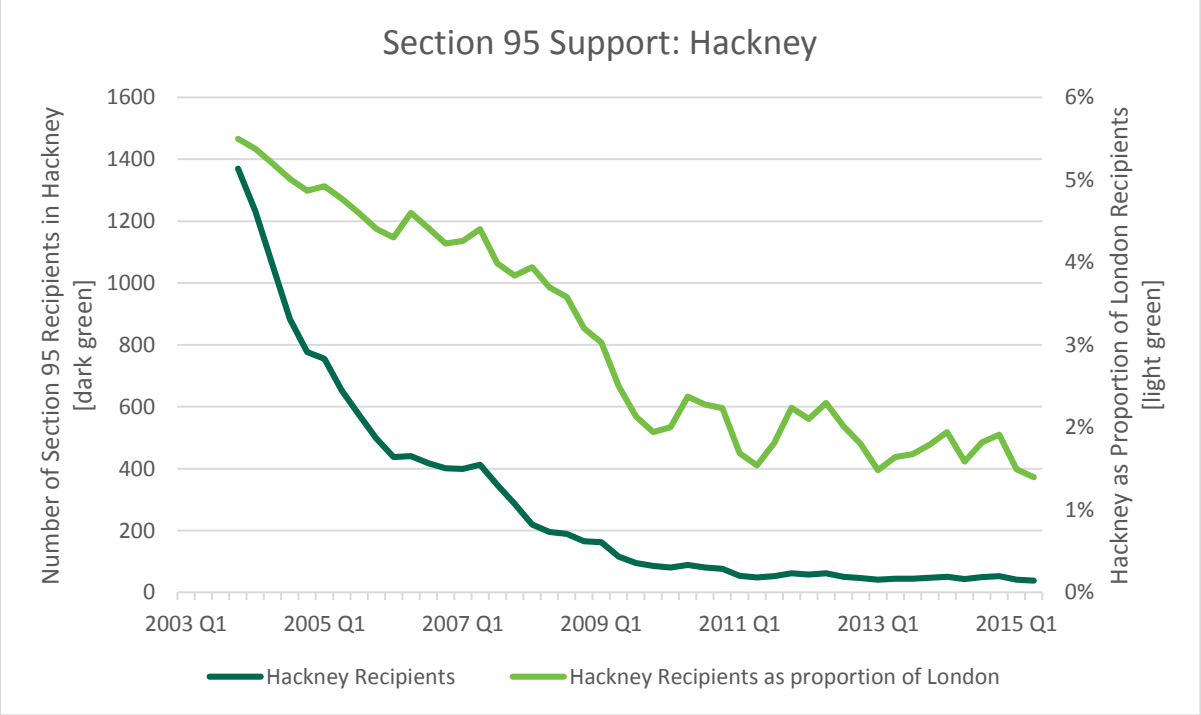

Figure 29: Section 95 support recipients, 2003 to 2015 [39]

Those who are in the process of claiming asylum, those who have been refused asylum and those with a visa subject to immigration control (for instance for five years after receiving indefinite leave to remain as the adult dependent of a person with settled status) have no recourse to public funds (NRPF). Hackney has formed a unit to assess the needs of families with NRPF. In 2012/13 this unit supported 190 people (61 principle adults with 42 dependent adults and 87 dependent children). However, by 2013/14 this had more than trebled to 614 people being assessed (165 principle adults with 154 dependent adults and 295 dependent children). This appears to be increasing further with the first half of 2014/15 seeing 180 children being assessed [40].

Of the 1,970 looked after children who were unaccompanied asylum-seekers in England in 2014, approximately half were in London (950) [41]. However, with only 15 such young people, Hackney had a lower number than eight of Hackney's statistical neighbours (with figures varying between 10 and 35). The number was too low to be reportable for the City.

9.1.3.2 Romany Gypsies, Irish Travellers and other Travelling Communities

Romany Gypsies and Irish Travellers are small, but significant, legally recognised distinct ethnic groups [36]. The Secretary of State for Communities and Local Government defined the term "Gypsies and Travellers" in 2006 [42] as:

a) Persons with a cultural tradition of nomadism or of living in a caravan; and
b) All other persons of a nomadic habit of life, whatever their race or origin, including—
    i. Such persons who, on grounds only of their own or their family's or dependent's educational or health needs or old age, have ceased to travel temporarily or permanently; and
    ii. Members of an organised group of travelling showpeople or circus people (whether or not travelling together as such).

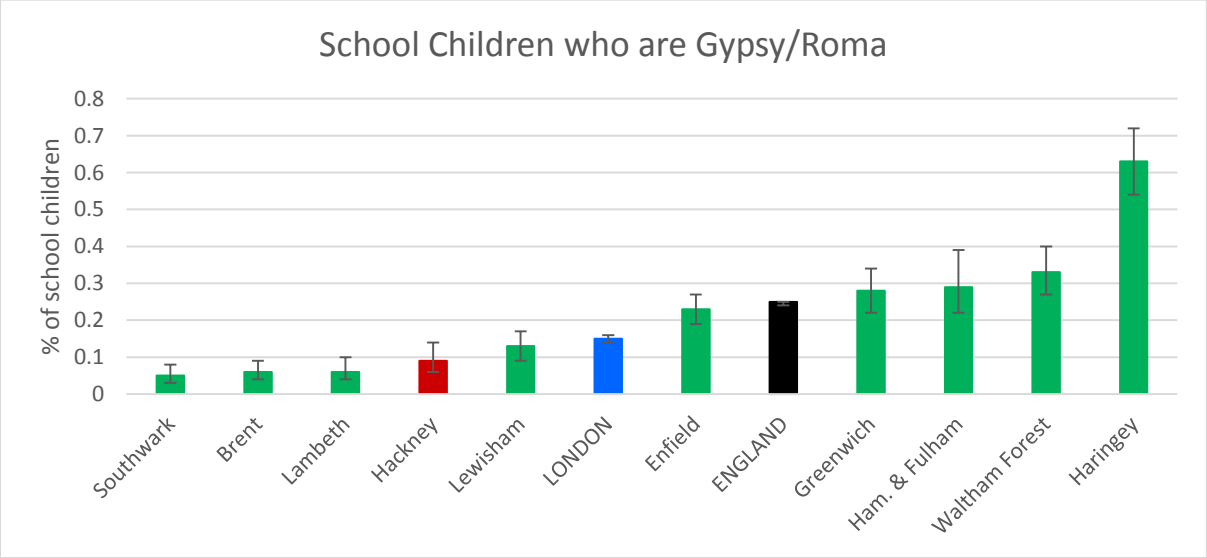

Figure 30: Percentage of school children who are Gypsy/Roma, 2013/14 [41]

An estimation of 600-800 Travellers in Hackney has been made by the Traveller Education Service, but this is felt likely to be an underestimate [17]. The majority of Gypsy Travellers in Hackney are Irish Travellers, however many other Traveller groups also live in Hackney. Data analysis is difficult for the Travelling community, as many ethnic monitoring forms do not include appropriate options. Only 183 patients registered with GPs in October 2014 in Hackney and the City of London have a Traveller ethnicity recorded – of these 107 are White Traveller, 55 are White Irish Traveller and 21 are White Gypsy Traveller. A higher proportion of these patients were under 40 years of age than in the wider community, and 40 patients were under 18 years old.

The peak season for travelling is May-August. Travellers predominantly live in the east of Hackney Borough (King's Park and Hackney Wick), where four of Hackney's five Traveller Sites are situated. These sites are managed by Hackney Homes and, as at January 2015, there were 27 residential pitches, no transit pitches and a caravan capacity of 39 (Appendix 15.3.1.2, Figure 194). Gypsy and Traveller caravans are counted biannually in January and July [43]. For at least the last five caravan counts, all caravans in Hackney have been socially rented (i.e. no private caravans and, therefore, no use of unauthorised sites), whereas only 34% of caravans were socially rented nationally at the most recent count. The number of caravans has been stable in Hackney at between 34 and 38. No caravans have been counted in the City of London.

Travellers are one of the most deprived communities in England, and fare poorly in the wider determinants of health with low levels of education, lack of good quality housing, lack of knowledge of mainstream services (including access to primary care) and a mistrust of authority [36]. With regards to education, Gypsy, Roma and Traveller pupils have lower levels of achievement than other ethnic groups at all key stages; have the highest level of special educational needs (SEN) of all ethnic minority groups; and have significantly higher levels of absence from school [44]. The Traveller Education Service is a team of advisory teachers who provide a multi-agency approach to supporting families with school access, attendance, special educational needs and tracing children who are missing education.

Members of the Travelling community have a shorter life expectancy [45], are more likely to have a long term illness or disability [46] and are more likely to suffer the premature death of offspring [46]. National reports of a higher prevalence of smoking [47] are mirrored with data from the clinical effectiveness group (CEG), with 32.9% of the 143 adult Traveller patients registered with a local GP currently smoking, compared to 23.3% in the wider community. Not only is deprivation likely to be a factor in these poor health outcomes, but there is also a greater prevalence of congenital anomalies such as metabolic conditions [48].

Obesity is viewed as a significant issue in this population nationally [49], and while local adult CEG data did show a higher rate of obesity in the Traveller population (18.9% versus 17.6%), this difference was not statistically significant. Similarly, data from the NCMP for 67 reception children across 2006-2013 showed that the rate of obesity is eight percentage

points higher than the general population, but again this difference is not statistically significant (Figure 31). However, the rate of obesity was not found to be higher for Travellers of Irish Heritage in Year 6 pupils across 2006-2013, but fewer children were measured at this age (50 children)[15].

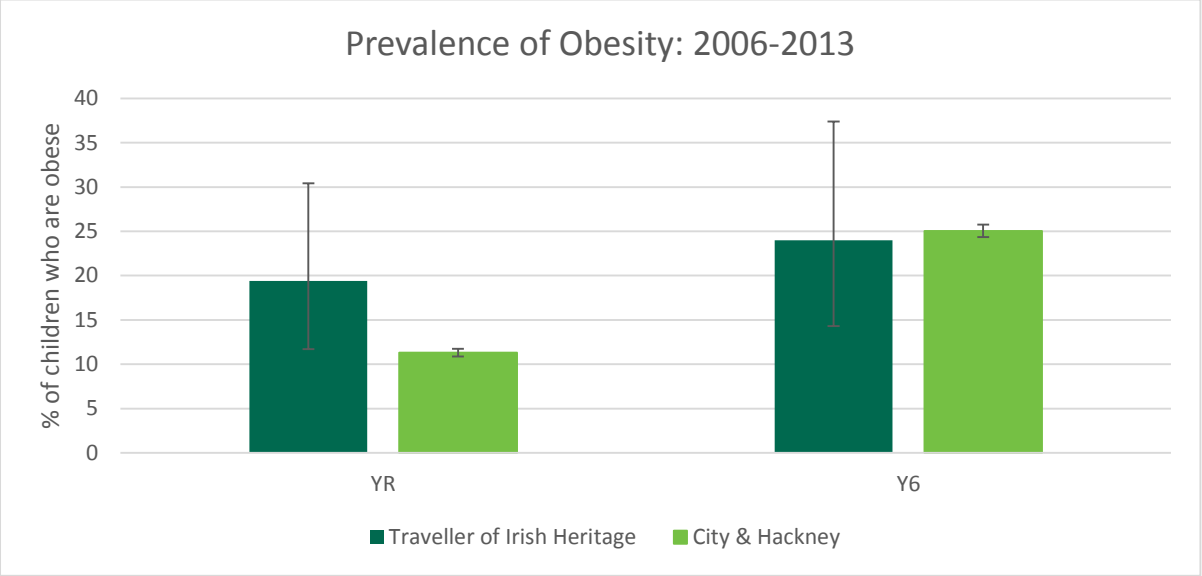

Figure 31: Prevalence of obesity in Irish Travellers and all NCMP results, 2006-2013 [50]

While child immunisation rates are commonly reported to be low in Travelling communities [51], these appear to be improving in Hackney with 79% of Traveller children having been immunised with the five-in-one (DTaP/IPV/Hib) vaccine by one year of age in 2013/14 (in comparison to a rate of 87% across Hackney).

As well as Romany Gypsy and Irish Traveller population, boat dwellers based on the Regents Canal and the river Lee form a significant travelling community in Hackney. This community is formed by boats which are 'continuously cruising', i.e. they do not have a home mooring. A boat is required to have a home mooring unless it is used to navigate continuously [52]. The default maximum stay period in the same place along the towpath for a short term mooring is 14 days [52]. However, marina and moorings operators may offer short term agreements, usually by the month. These short term permits are popular with continuous cruisers in the winter, as they may prefer not to move so much during bad weather, or may be prevented from moving because of waterway repair works.

The number of individual 'continuous cruisers' (CC) sighted in Hackney stretches of water per calendar year has been rising [52]. 874 individual CCs were sighted in 2014, and 288 were sighted on a single day in March (Figure 32). Between December 2013 and December 2014, 81.7% of boats sighted on Hackney stretches did not have a declared home mooring.

[15] Note – the rates of obesity for Hackney and the City of London are amongst the highest rates nationally, which may be masking the increased weight shown by Traveller children.

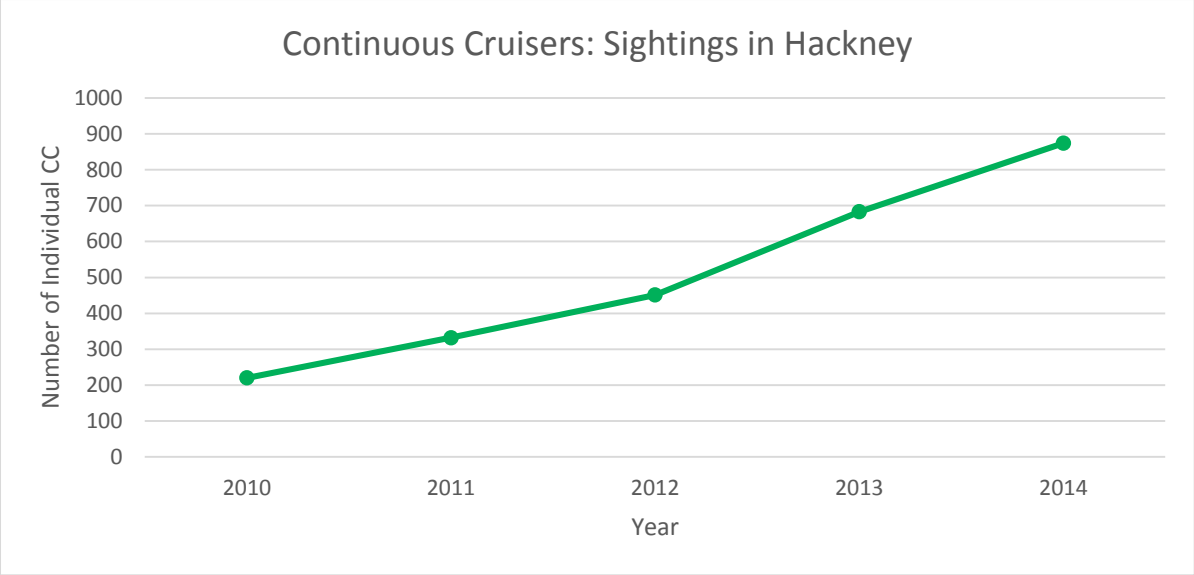

Figure 32: Continuous cruisers in Hackney, 2010-2014 [52]

9.1.4 Language

76% of Hackney residents and 83% of City residents cite English as their main spoken language, both of which are significantly lower than the national average of 91% [33]. The most common languages outside of English spoken in Hackney are Turkish, Polish, Spanish, French and Bengali; whereas in the City of London they are French, Spanish, Bengali, German and Italian (Appendix 15.3.1.3, Figure 195). While Yiddish is listed as the sixth most common language outside of English in Hackney at 1.3% of the population, this is likely to be an underestimate given the large Orthodox Jewish community and the known underreporting of this community in the Census (see Section 9.1.5.1).

In both Hackney and the City of London, young people are more likely to cite English as their main language than the rest of the community [33] (Figure 33). This may be a reflection of the fact that a greater proportion of young people were born in the UK. Many people who do not cite English as their main language still report being able to speak English well or very well, and taking this into account the overall rates of speaking English well are 94% in Hackney and 98.6% in the City of London. These rates of being able to speak English well rise to 98% and 99% when assessing young people (Appendix 15.3.1.3, Figure 196).

	Hackney		City of London	
	All ages	Aged 3-15	All Ages	Aged 3-15
Main Language is English (%)	75.9	80.1	82.9	90.6
Can Speak English Well or Very Well (%)	94.0	95.3	98.6	98.7

Figure 33: Main language and proficiency in English by age group [33]

9.1.5 Religion

Based on the 2011 Census, the most commonly reported religion in Hackney is Christianity at 39%, with 28% reporting that they have no religion and 10% not completing an answer. This is mirrored in the City, where 45% list Christianity, 34% state they have no religion and 9% did not complete an answer. In national data the reporting of Christianity is greater (59%), with most of this difference being borne by lower reported Judaism and Islam [33].

The results for Hackney and the City are broadly similar when focussing on the 5-19 population specifically. However, there are fewer people listed as being of no religion and more people listed as Jewish or Muslim in Hackney (Figure 34).

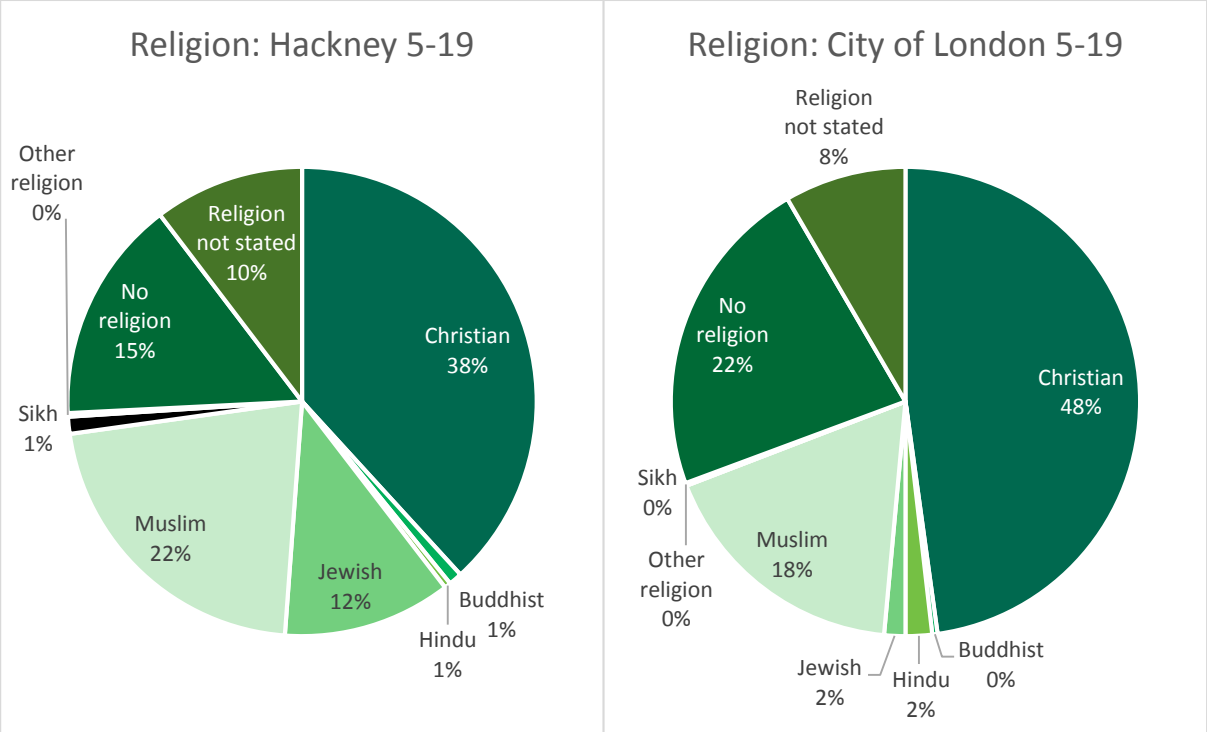

Figure 34: Religion in 5-19 year olds

Of the religions followed in Hackney, Judaism has the largest proportion of its followers being young, with 49.5% of Census responders listed as Jewish being aged 0-19 [33]. This may be a reflection of the high birth rate in Jewish communities in Hackney (see Section 9.1.5.1) and it could imply that the number of people identifying as Jewish is set to rise. Hinduism has the lowest proportion of its followers being young in Hackney, with only 15.7% being aged 0-19.

Conversely, Judaism has one of the smallest proportions of followers being young in the City of London at only 4.8%, with the largest proportion being found in Muslim residents at 29.6% (Appendix 15.3.1.4, Figure 197).

9.1.5.1 Orthodox Judaism

Research from the Institute for Jewish Policy Research has suggested that, nationally, 18% of people who identify as Jewish describe themselves as Orthodox [53] – which includes both Modern Orthodox Judaism and Strict Orthodox Judaism. For over 75 years there has been a Strict Orthodox Jewish community based in the Stamford Hill area (Figure 35), and this community often prefers the description 'Charedi'. 85% of the Charedi community is based in north Hackney and 16% in south Haringey. However, most Charedi infrastructure (including the entire educational infrastructure) is based in Hackney.

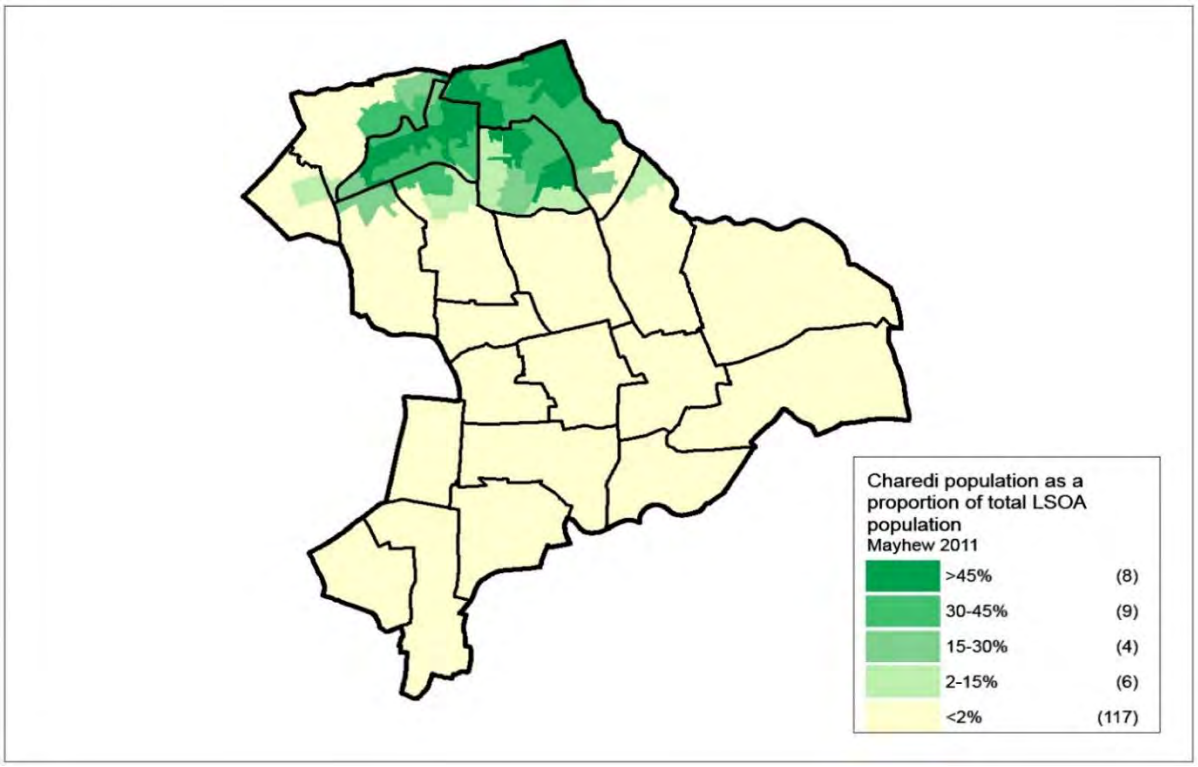

Figure 35: Charedi concentrations in Hackney by LSOA, 2011 [35]

9.1.5.1.1 Population

The size of the Charedi population was estimated in July 2015 by Interlink – a UK charity with 200 Charedi and Orthodox Jewish member charities [54]. Based on the number of households listed by the Shomer Shabbos telephone directory (SSTD)[16] and an average household size of 6.3 [35], Interlink estimates that there are over 25,000 Charedim living in Hackney, which corresponds to 9.5% of the total population of Hackney. This is slightly more than Mayhew et al [35], who calculated that the Charedi community consists of 17,587 persons in 2011, which is the equivalent of 21,620 in 2015[17]. By the same method, there are a further 4,775 Charedim are estimated to be living in Haringey. Therefore, the total Stamford Hill Charedi population is estimated at almost 30,000.

[16] Note – the SSTD lists Stamford Hill Charedi households and, by assuming an undercount of 5% and applying a growth rate of 5.3%, the estimated number of Hackney Charedi households in July 2015 is 3,985

[17] Note – assuming an annual growth rate of 5.3%

In 2011, it was calculated that 53.5% of the Stamford Hill Charedi population are under 19 years of age [35], and therefore there are 13,400 Charedi children and young people living in Hackney (equivalent to 22% of the total Hackney population), and a further 2,600 in Haringey. However, a study by Holman & Holman found the SSTD may have an undercount of more than 10%, particularly for young couples yet to secure permanent accommodation, and therefore the number of young children may be an underestimate [55].

The Institute for Jewish Policy Research analysed 2011 Census data and estimated the number of Charedim. The resulting population pyramid (Figure 36) demonstrates the skew towards young people in the community compared to the overall Hackney population.

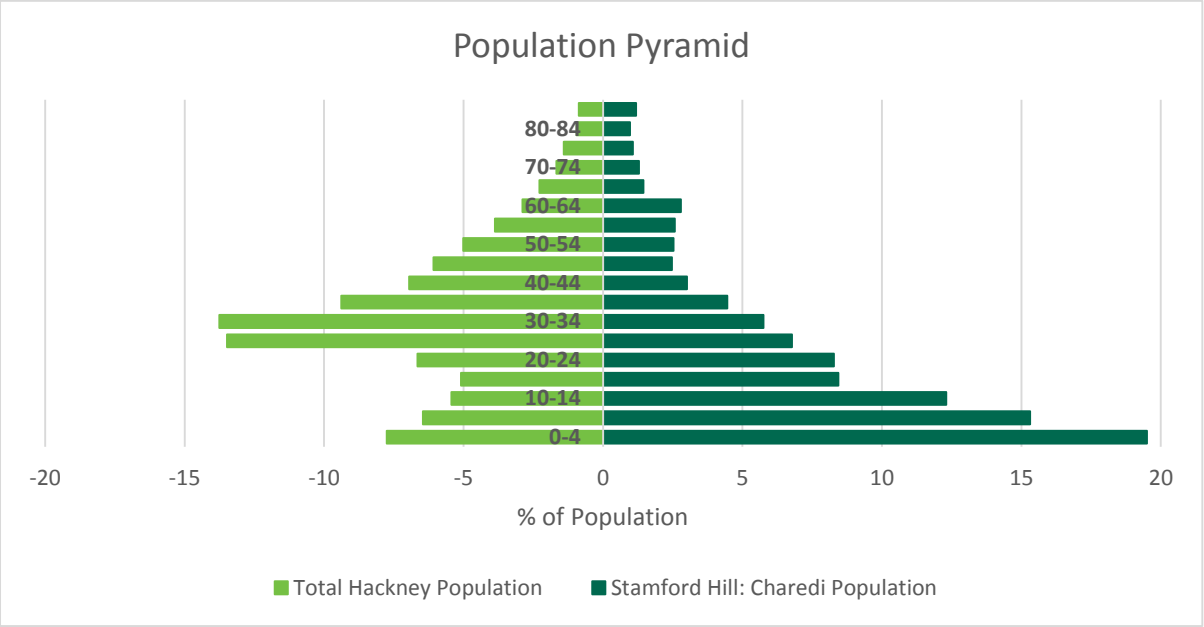

Figure 36: Population structure of Charedi Jews in Stamford Hill [54] compared to the total Hackney population [31]

This predominance of young people is a consequence of the high birth rate and which in turn causes a high growth rate for the community. Growth in the number of entries in the SSTD gives an annual household growth of 5.3%. Birth records published in the Kol Mevaser[18] estimate an annual growth rate of over 4%, but this is estimated to be underreported by 10-15% [54]. If the Charedi population grows at 4.5%, consistent with similar Charedi communities in the USA, the population will double every 18-20 years [54].

With regards to the whole Jewish population nationally, approximately 15% of parents of school-age children report that their child has SEN [53], which is in line with the national average of pupils with moderate learning difficulties (see Chapter 9.4.2). However, children with mild to moderate developmental delays may not be identified as such in more orthodox groups likely to attend independent educational provision due to a lack of capability in Charedi early years providers and schools; for instance at least one third of independent Charedi schools do not have a special educational needs co-ordinator (SENCO)

[18] Note – Kol Mevaser records births of the Stamford Hill Charedi community weekly

[56]. Furthermore, concerns have been raised around the effectiveness of referral pathways between Charedi schools and NHS provision for children with developmental delays[56].

Community leaders state that almost all 16,700 children attend local Charedi schools [55]. With the exception of four schools (Lubavitch Boys Primary School, Lubavitch Ruth Lunzer Girls' Primary School, Yesodey Hatorah Secondary School for Girls and Lubavitch Senior Girls' School), most of these educational settings exist in the independent sector. These independent schools can be costly for parents due to school fees and an associated lack of eligibility for school-based means-tested benefits such as free school meals [55].

Children are educated in single-sex primary schools, followed by yeshiva for males after their bar mitzvah (approximately aged 13) and seminaries for young women (usually from 16 years of age). Boys receive most tuition in Yiddish and Hebrew instead of English, and their study is based on religious scriptures [57]. Boys receive far fewer formal qualifications than girls: in a survey of adults, 35% of Charedi women had five GCSEs at grades A*-C, compared to only 11% of Charedi men [55].

9.1.5.1.2 Deprivation

21.3% of Jewish children in Hackney live in a household where no adult is in employment [57], and of the 44% of adults who are working, half work part time [55]. Being workless is stigmatised within the Charedi community and it has been reported that participation in religious study programmes sometimes hides unemployment rates [17]. A survey in 2002 found that over one third of men and almost two thirds of women earned less than £7,500 per year[19] [55] and a higher proportion of Charedi adults are receiving benefits than the wider population [35]. Furthermore, Charedi households are far larger with an average of 6.3 persons per household (compared to 2.1 across Hackney), with one in eight households having ten or more people [55]. In a study in 2002, over 40% of households had borrowed money in the previous year to meet living costs, and 70% of households found it 'difficult' or 'very difficult' to fund the gap between housing benefit and rent levels [55].

9.1.5.1.3 Health

In a Charedi household survey (predominantly completed by adult women), 80% of children's health was rated as 'Good' and 19% as 'Fairly good', with only 2% rated as 'Not good'. However, 15% of children were reported to have a long-standing illness or disability. 78% of children were reported not to have attended an outpatient appointment or Accident and Emergency in the previous three months, with 17% having attended once in that time and 5% attending on two or more occasions. 12% of Charedi households reportedly contain a cigarette-smoker (less than half the national rate). Less than 1% of husbands, wives or children had reportedly participated in a sports activity over the past two months, compared to 81% of men having attended a religious talk in that period. [55]

[19] Note – percentage of those who gave an amount with 'Don't know' or 'Prefer not to say' responses excluded

9.1.6 Sexual Orientation

National data from the Integrated Household Survey of 2011 [58] showed that the 16-24 age group had the lowest proportion identifying as heterosexual/straight with most of this difference seen in an accompanying greater rate of 'don't know / refusal' or no response (Figure 37). While a slightly greater proportion of people identified as bisexual in the 16-24 age group compared to older age groups, slightly fewer people identified as gay/lesbian.

	16-24	25-34	35-49	50-64	65+
Heterosexual / straight	91.4	93.6	94.0	95.2	94.7
Gay / lesbian	1.1	1.4	1.4	0.7	0.3
Bisexual	1.0	0.6	0.4	0.3	0.3
Other	0.3	0.3	0.3	0.3	0.5
Don't know / refusal	4.9	3.4	3.2	2.9	3.9
No response	1.3	0.7	0.7	0.6	0.3

Figure 37: Sexual identity by age group, national data, 2010/11 [58]

9.2 Child Wellbeing Index

The Child Wellbeing Index (CWI) was produced in 2009 [59]. It provides a measure of a number of child wellbeing-relevant domains. Much of the CWI was based on data from 2005 indicators, or from the 2001 Census [59], and therefore the results must be interpreted with caution as many changes have occurred over the past ten to fifteen years. The scores for each domain have been ranked out of 354 local authorities, and the rankings for Hackney and the City of London are shown in Figure 38.

Indicators		Rank	
		Hackney	City of London
Health and Disability	0-18 emergency hospital admissions & outpatient attendances; 0-16 receiving Disabled Living Allowance	312	73
Education	Key Stage 2, 3 & 4 scores; secondary school absences; leaving education at 16; not entering higher education under 21	265	98
Children in Need	Children (at risk of being) in need	346	174
Environment	Air quality; % of green space; number of bird species; road safety 0-16; sports/leisure facilities; distance to school	270	354
Housing	Occupancy rating; shared accommodation; homelessness; lack of central heating	352	321
Crime	Burglary, theft, criminal damage and violence rates	351	1
Material Wellbeing	0-15 in households claiming Income Support, JSA or Pension Credit; or claiming Working Tax or Child Tax Credit and income < 60% of median	353	219

Figure 38: Child Wellbeing Index 2009, rank out of 354 district counties [1 = best] [59]

When averaging the ranks for each domain, Hackney is given an overall ranking of 352nd, with only two local authorities ranked lower. Hackney fared best at education, the

environment and health and disability; and performed worst at material wellbeing, housing, crime and children in need.

The City of London fairs better with an overall ranking of 284th. However, this still places the City of London in the lower half of local authorities nationally. The City of London performs well on crime (having the best score nationally), health and disability, education and children in need; and performs less well on material wellbeing, housing and environment (for which it is ranked last). This dichotomy of having the best ranking for one domain (crime) and the worst for another (environment) is rare, and is likely to be a feature of the unusually small geographical area that the City occupies.

9.3 Social Factors

"People living in the poorest areas will, on average, die seven years earlier than people living in richer areas and spend up to 17 more years living with poor health. They have higher rates of mental illness; of harm from alcohol, drugs and smoking; and of childhood emotional and behavioural problems."

Figure 39: 'Healthy Lives, Healthy People', 2010 [7]

9.3.1 Deprivation

The Index of Multiple Deprivation (IMD) is a composite measure that combines 38 separate indicators to rank relative deprivation in Lower Super Output Areas (LSOAs; small areas each containing approximately 1,500 people). There are 32,482 LSOAs in England – 144 in Hackney and six in the City of London. The IMD aims to reflect the overall experience of individuals living in an area and indicators include income, employment, health and disability, education, skills and training, housing, crime, and living environment[20]. The rank of extent of deprivation is based on the proportion of the population being in the 30% most deprived, whereas the rank of average score is an average measure across the full range of deprivation. Local rankings are shown in Figure 40.

	Extent Rank 2010	Average Score Rank 2010	Extent Rank 2015	Average Score Rank 2015
Hackney	1	2	11	11
City of London	294	262	302	231

Figure 40: Indices of multiple deprivation, where 1 = most deprived [60] [61]

[20] Note – as these scores are generalised geographically at LSOA level, they will not fully portray the extremes of wealth affecting only a few individuals in each area

Hackney is the eleventh most deprived local authority in England in the rank of extent [61] – an improvement from being the most deprived local authority in 2010 [60]. Hackney has seen the largest percentage point decrease in the proportion of neighbourhoods classified as highly deprived of any local authority in England, from 42% (2010) to 17% (2015). When examining the deprivation at a ward level, it is broadly distributed throughout the borough (Figure 41). The most deprived LSOA in Hackney falls within Hackney Wick ward. Only two LSOAs are not in the 50% most deprived areas – one falls within De Beauvoir ward, and the other within Stoke Newington ward.

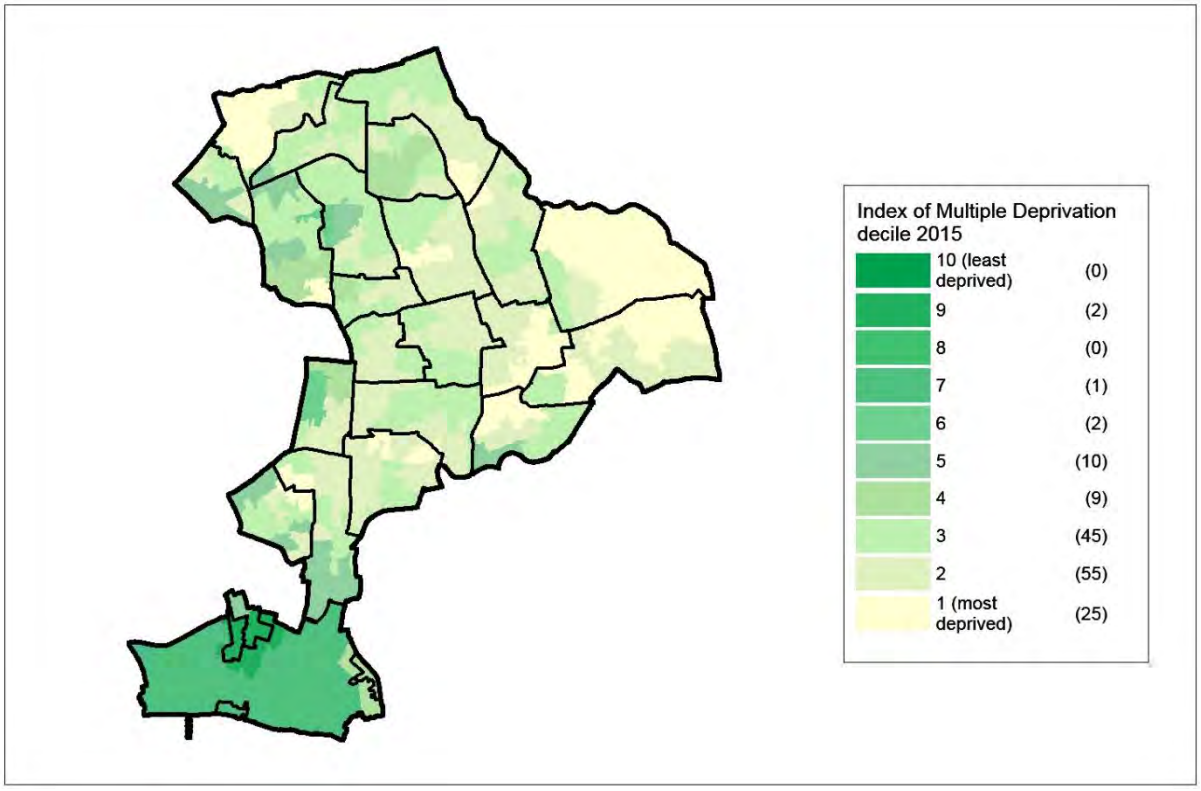

Figure 41: Deprivation by decile in Hackney, 2015 [62]

The City of London was ranked as the joint least deprived local authority by the rank of extent in England in both 2010 and 2015 as no residents live in an area classified to be within the 30% most deprived areas of the country. However, using the rank of average score, the City of London has fallen from being the 65th to the 96th least deprived local authority in England. The City of London's six LSOAs vary between being in the 40% most deprived (Portsoken) to the 20% least deprived (Aldersgate and Bassishaw wards).

9.3.1.1 Child Poverty

Children from households with low income or lower socio-economic status are more likely than other children to die in the first year of life, have pre-school conduct and behavioural problems, experience bullying, take part in risky behaviours (such as smoking), do less well at school and grow up to be poor themselves [63].

Hackney has a statistically significantly higher rate of 0-19 year old dependent children living in poverty than nine of its ten statistical neighbours and the London and national averages (Figure 42).

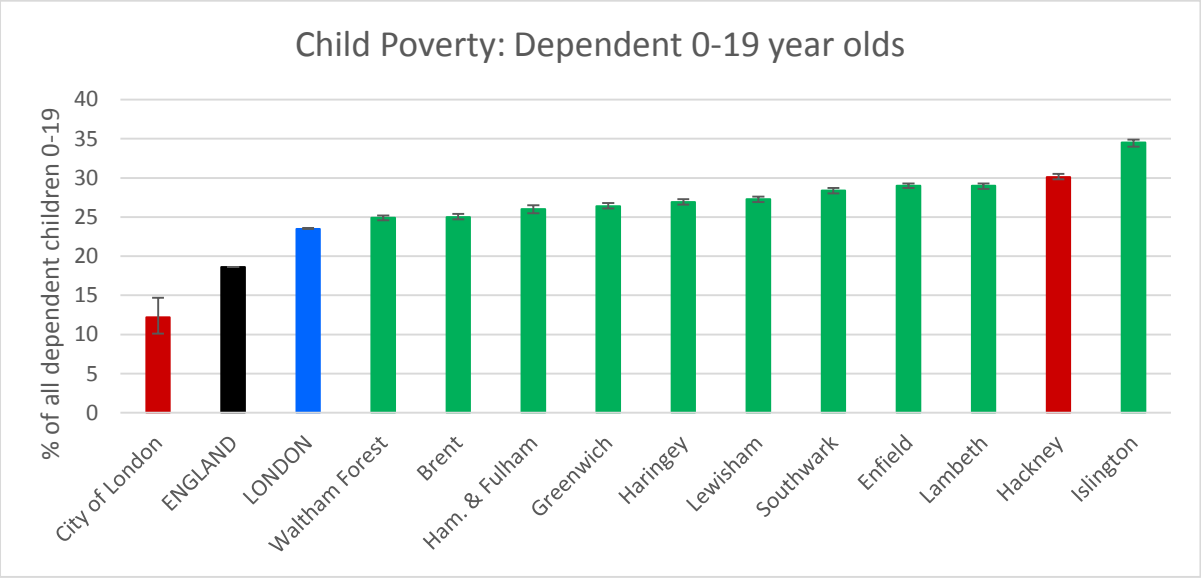

Figure 42: 0-19 year old dependent children living in poverty, 2012 [41]

The proportion of children living in low-income families[21] has remained relatively constant across England at approximately 21% since 2007 [64]. However, the proportion has been falling year-on-year across London from 33% in 2007 to 24% in 2012. This reduction has been particularly marked in Hackney, where the rate has fallen sharply from 49% in 2007 to 30% in 2012 (Appendix 15.3.2.1, Figure 198). However, Hackney remains tenth in the ranking of English local authorities by the highest proportion of children in income deprivation. The four wards with the greatest reduction in child poverty in Hackney (Springfield, Cazenove, Lordship and New River[22]) are all found in the north of the borough in the Stamford Hill area (Appendix 15.3.2.1, Figure 199). In general, the greatest prevalence of child poverty can now be found along the southern border of the borough (Figure 43).

[21] Note – the proportion of children living in families in receipt of out-of-work (means-tested) benefits or in families in receipt of tax credits whose reported income is less than 60% of median income

[22] Note – to allow comparison, these data refer to previous ward boundaries

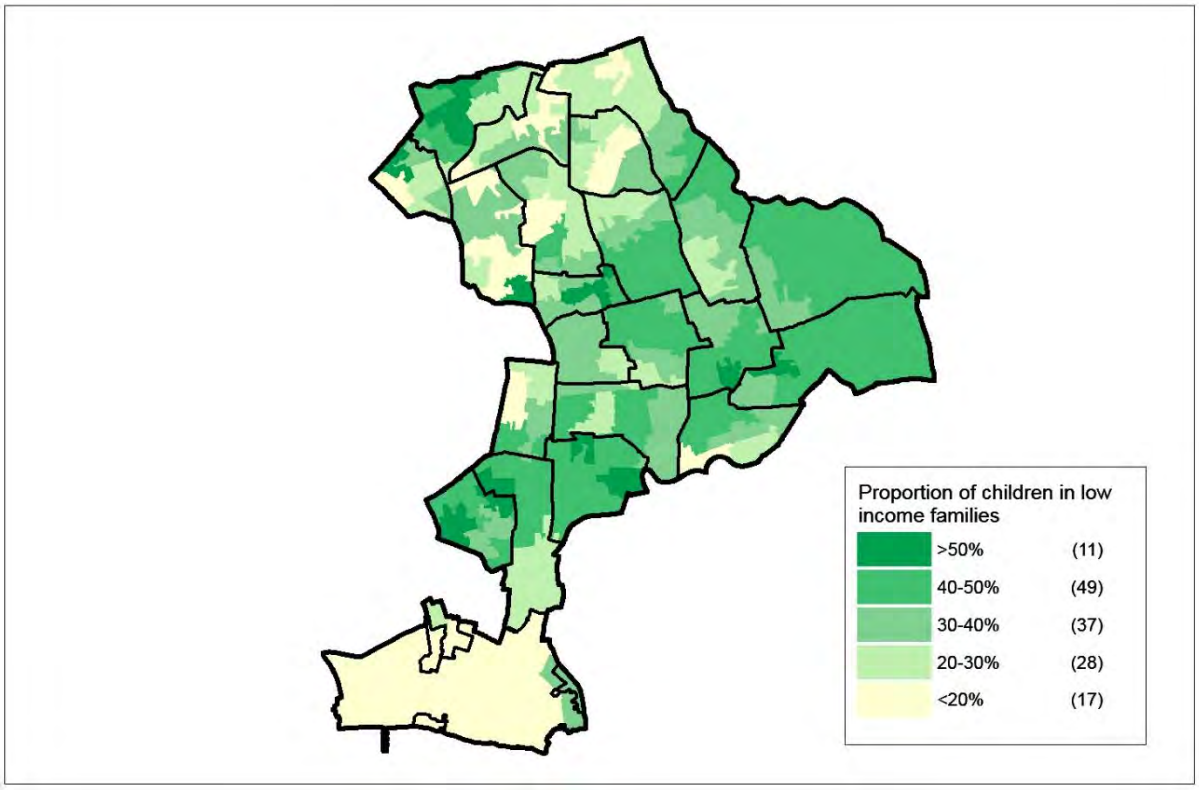

Figure 43: Proportion of Children Living in Poverty by LSOA, 2011 [65]

While average rates of child poverty are important, it must be understood that some groups may be disproportionately affected. For instance, work undertaken by Hackney Council has suggested that the biggest impact of reducing welfare incomes may fall on those families who have a disabled child [66]. Not only does raising a disabled children cost, on average, an additional £99 per week [67], but families supporting a disabled child are 2.5 times more likely to have no parent working for more than sixteen hours per week [68].

The City of London has also seen a reduction in the proportion of children living in poverty, from 21% in 2007 to 12% in 2012, so that it now outperforms the national average as well as the London average. This places it 225th out of 325 local authorities when ranking local authorities by the proportion of children living in income deprivation. However, this low rate in the City of London masks the variability of poverty in the region – in 2009 the rate was as high as 41% in Portsoken, but only 8% in Farringdon Within [17]. The City of London outperforms 323 local authorities when ranked according to education, skills and training in the IMD, with only two local authorities performing better[23].

[23] Note – however, given the very few schools in the City of London and that most children will attend some of their schooling outside of the borough, these data must be viewed with caution

9.3.1.2 Free School Meals

Free School Meals (FSM) are a national scheme to provide a cooked two course lunch to pupils from low income families, however the eligibility criteria vary across local authorities. In Hackney, children are eligible if they have a full-time place at a maintained school or academy and their parents are in receipt of one of a number of benefits, or support from the National Asylum Support Service. In the City the criteria are the same, but additionally all children in Reception, Year 1 and Year 2 are eligible.

Given that FSM are generally given to children from low income families, they are often used as a marker of deprivation in educational data. However, the varying criteria mean that there is not a consistent national relationship between FSM and deprivation. Furthermore, a relatively large number of Hackney's children attend Orthodox Jewish schools which are independent, and therefore the pupils are ineligible for FSM, but it cannot be assumed that these children are not from low income families.

Figure 44 shows that Hackney has a higher proportion of nursery and primary school pupils who are eligible for and claiming FSM but that, until 2014, the number has been slowly falling in Hackney, London and England. However, the most recent data show that the number has started to rise for Hackney and the gap between Hackney and London is widening[24]. The trend for Hackney's secondary schools mirrors that found in nursery and primary schools (Appendix 15.3.2.1, Figure 200).

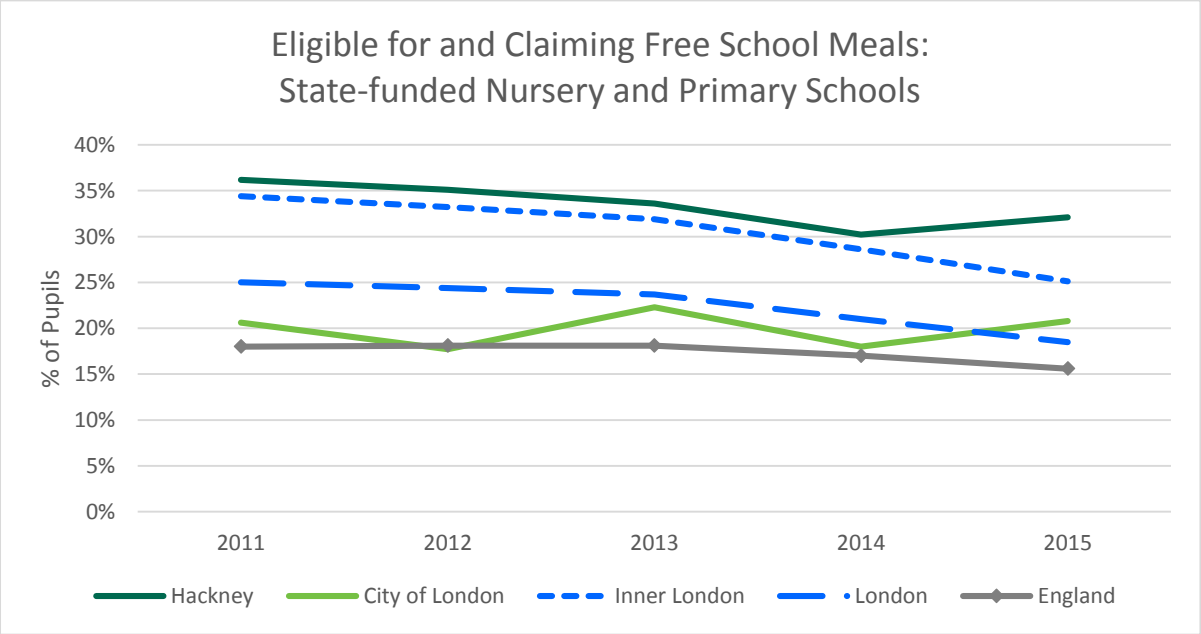

Figure 44: Nursery and primary pupils eligible for and claiming FSM, 2011-15 [30]

[24] Note – the value for the City also rose in 2014/15, however the universal coverage for Reception, Year 1 and Year 2 in the City was introduced in September 2014 which may account for this

9.3.2 Parental Employment and Income

The employment rate of 16-64 year olds in Hackney (68.1%) is not significantly different from that of London (71.2%) [69]. However, both of these rates are significantly lower than the England average (72.5%), but only by a small margin. Data are not available for the City of London as sample sizes are too small.

The breakdown of employment according to the Standard Occupation Classification (SOC) 2010 is shown in Figure 45 covering a range of employment from managerial (1) to elementary (9). This demonstrates that Hackney has a significantly higher proportion of professional and associate professional/technical occupations than nationally; with a significantly lower proportion of skilled trades, caring and leisure services, sales, and plant and machine operatives [69].

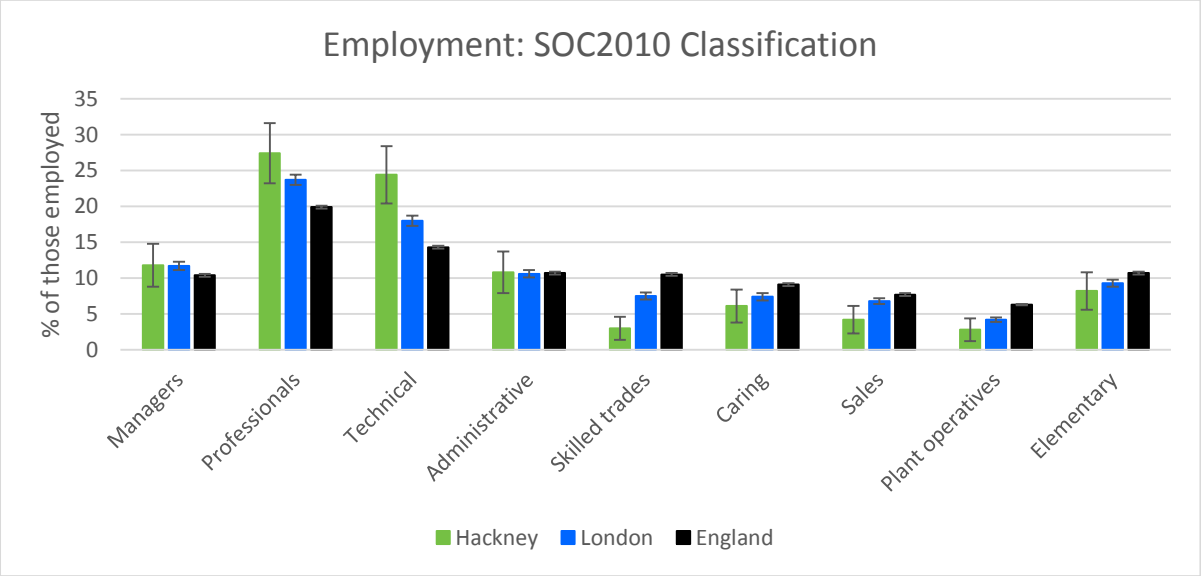

Figure 45: Employment according to Standard Occupation Classification, 2014 [69]

With regards to qualifications, Hackney has approximately the same proportion of working age adults without qualifications compared to the national average [69]. However, in Hackney, in line with London overall, a significantly higher proportion of adults have achieved higher qualifications of NVQ3+ (national vocational qualification) and NVQ4+ levels than nationally (Figure 46).

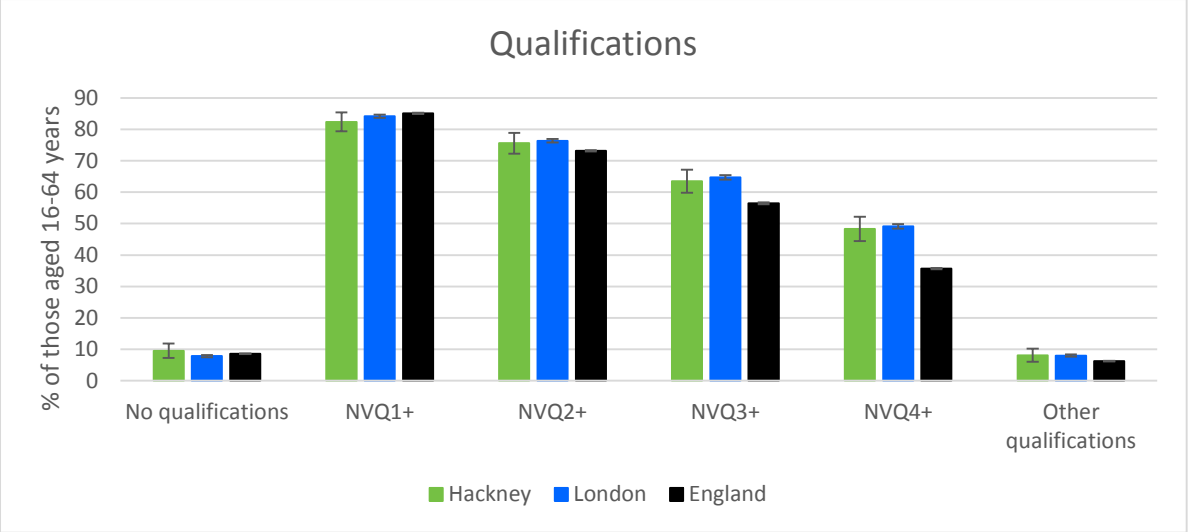

Figure 46: Level of qualification achievement in working adult population, 2014 [69]

While the employment rate in Hackney is not significantly different from London, Hackney does have a higher proportion of the population claiming one or more benefits at 15.7% compared to 11.8% regionally and 12.6% nationally. Conversely, the City of London has a lower proportion of people claiming a benefit, at only 5.1% [70]. Hackney's higher rates of claim appear to be predominantly shouldered by a higher rate of Employment and Support Allowance, and Job Seekers Allowance (JSA) (Figure 47). The City of London's lower rate of benefits claims appears to be spread across the range of benefits.

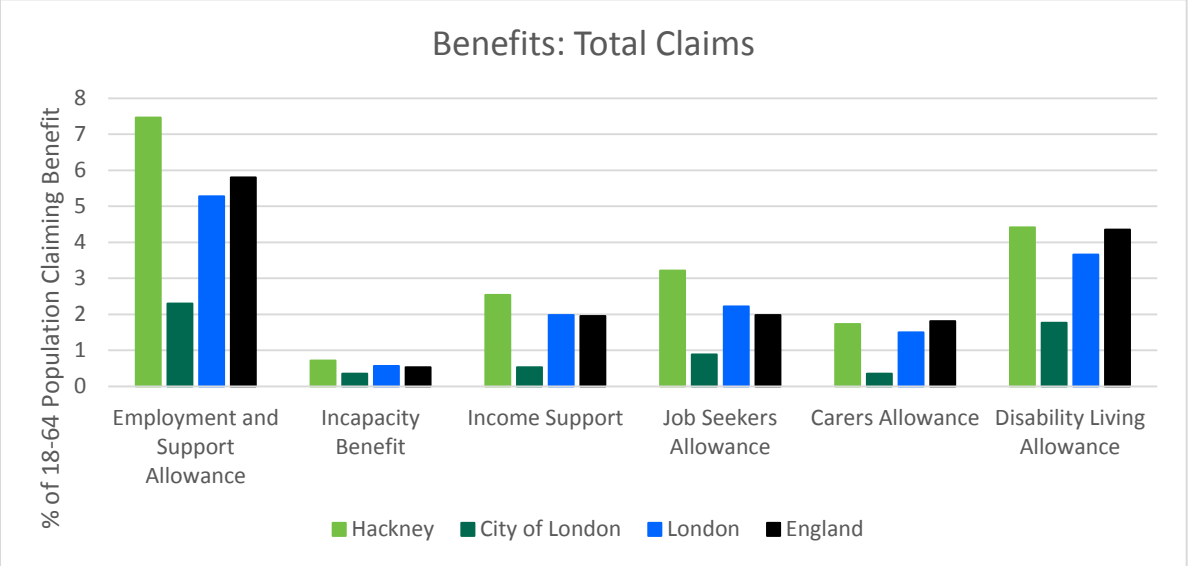

Figure 47: Proportion of working age adults claiming each benefit, 2015 [70][25]

In Hackney, similar to London and England as a whole, 96% of those claiming JSA are not known to have dependent children [70] (Appendix 15.3.2.2, Figure 201).

[25] Note – some people claim more than one benefit, and therefore the total number of claims is greater than the total number of people making claims

9.3.3 Housing

9.3.3.1 Household Composition

Overall, 28.6% of Hackney households contain dependent children, compared to only 9.8% in the City of London [33]. In households containing dependent children, the average number of all children (dependent and non-dependent) is 2.1 in Hackney, compared to 1.5 in the City of London (Appendix 15.3.2.3, Figure 202). When analysing by ethnicity, the highest number of people per household is found in Asian households in Hackney, at an average of 3.2, compared to the lowest value of 1.6 per household of White British households in the City of London (Appendix 15.3.2.3, Figure 203).

Occupancy rating provides a measure of whether a household's accommodation is overcrowded or under occupied based on the ages of the household members and their relationships to one another. An occupancy rating of -1 implies that a household has one fewer room/bedroom than required, whereas +1 implies that they have one more room/bedroom than the standard requirement. Overall, 25% of people in Hackney live in an overcrowded house, compared to 19% across London, and 8% across England [33]. The City of London, at 11%, fares better than the London average, but again worse than the England average.

Figure 48 shows that people of Asian and Black ethnicities are most likely to be overcrowded in Hackney at 36% and 35%, respectively. Within these groups, the most overcrowded ethnicities are Bangladeshi (48%) and African (42%).

The City of London similarly shows that people of Asian and Black ethnicities are most likely to be overcrowded at 27% and 35%, respectively. Within these groups, Bangladeshi is again the most overcrowded (67%), and 'Other Black' is also very high (52%).

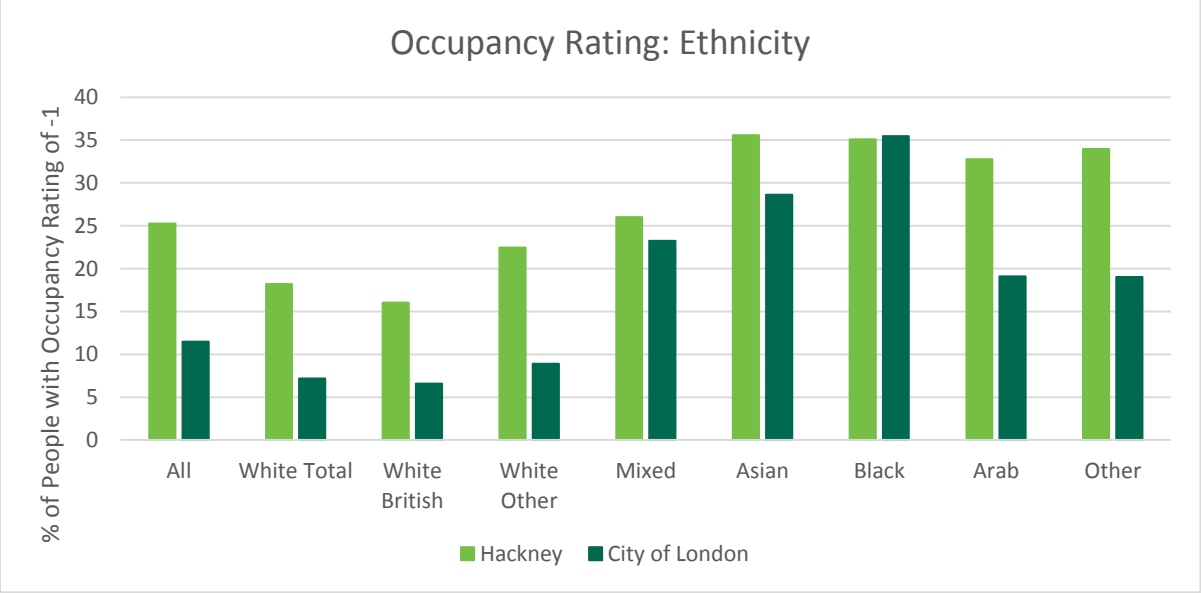

Figure 48: Proportion of people living in an overcrowded house by ethnicity, 2011 [33]

9.3.3.2 Tenure

The total proportion of households that are socially rented (as opposed to privately rented or owned) is higher in Hackney than regionally or nationally, yet it is lower in the City of London than regionally or nationally [33]. However, Figure 49 demonstrates that, in all of these areas, the proportion of households being socially rented is greater in households that contain dependent children. This effect is particularly large in the City of London, with twice as many households being socially rented if dependent children are present.

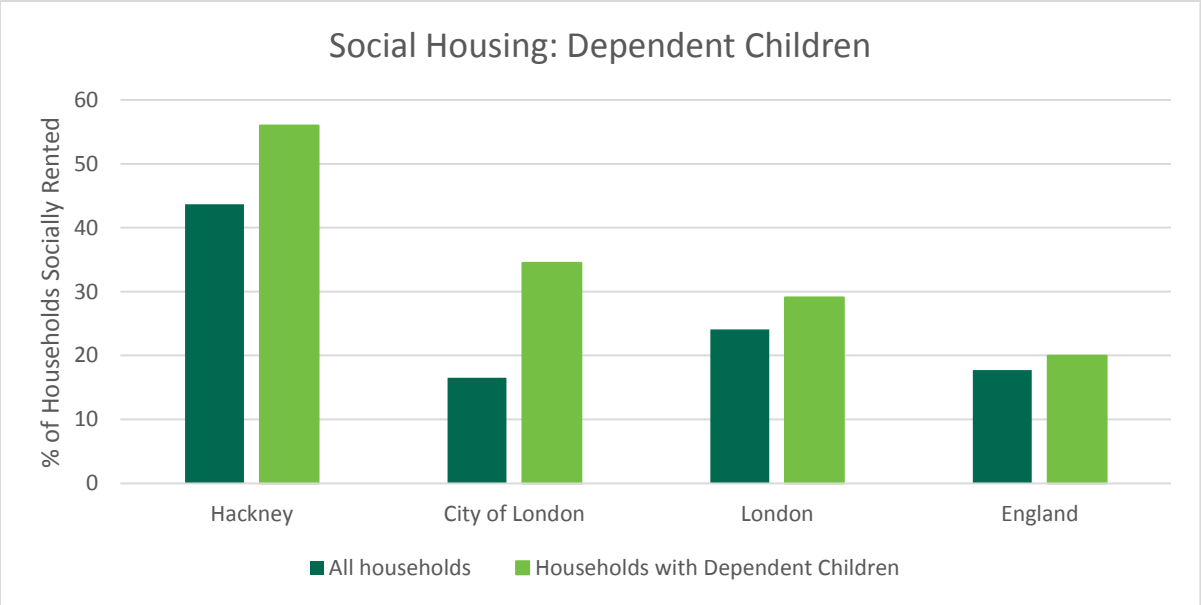

Figure 49: Proportion of households socially rented by children status, 2011 [33]

In Hackney and the City of London, the overall proportion of households being socially rented increases with the age of the 'Household Reference Person' (Appendix 15.3.2.3, Figure 204). 70% of households lived in by the over 85s in Hackney are socially rented. This effect is opposite to the England average, where the highest proportion of social housing is in the youngest age group (24 and under).

The highest proportion of social housing is found in people of Black ethnicity, at over 70% [33]. In Hackney, the rate of social housing in people of Arabic ethnicity is high at over 60% (Figure 50), but given that they constitute less than 0.5% of the Hackney population, this equates to a very low proportion of all of Hackney's social housing (0.9%).

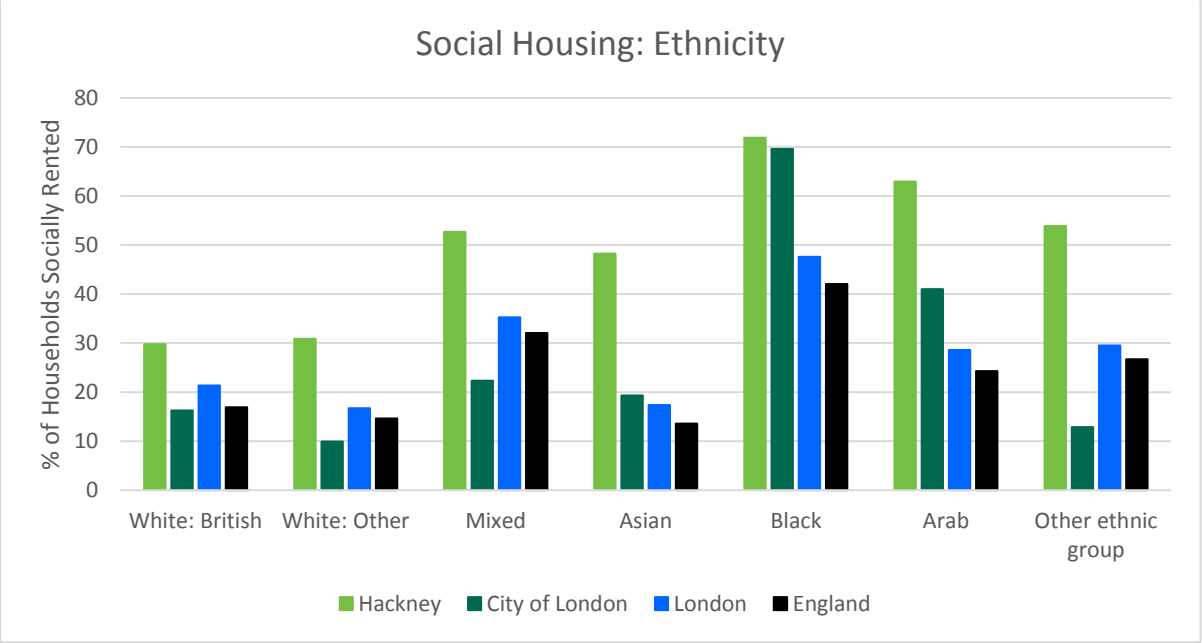

Figure 50: Proportion of households socially rented by ethnicity, 2011 [33]

9.3.3.3 Homelessness

The term 'homeless' is a broad definition that includes rough sleepers, those living in temporary accommodation (such as bed and breakfast accommodation) and those who are defined as statutorily homeless (those who do not have accommodation that they have a legal right to occupy which is accessible and physically available to them and in which it would be reasonable for them to continue to live) [36] [71]. The latter of these three categories are most applicable to 5-19 year olds.

If an applicant is in priority need and has become homeless through no fault of their own, the household will be an 'acceptance' and the authority has a duty to secure settled accommodation [71]. Priority need groups include households with dependent children, a pregnant women or a 'vulnerable' individual. 'Vulnerable' individuals include those with mental illness or a physical disability, or who have become vulnerable due to previously being in care, being in custody, being in HM Forces or forced to flee their home due to violence or the threat of violence. 67% of acceptances stated dependent children as the reason for their priority need, with a further 7% stating pregnancy [72]. 25% of acceptances occur in those aged 16-24 years [72].

Health problems (such as mental health problems or substance misuse) may contribute to becoming homeless, and being homeless may exacerbate existing or contribute to new health problems, such as the contraction of an infectious disease. Health outcomes are far worse for homeless people, with the life expectancy cut by 30 years in men from 77 to 47 years of age [36]. These poor health outcomes are not only caused directly by poor living conditions, but are also influenced by chaotic lifestyles, perception of social stigma and barriers to accessing primary and other health care [36].

The rate of family homelessness in Hackney and the City of London combined is higher than nine of Hackney's ten statistical neighbours with this being a statistically significant difference in eight of these boroughs (Figure 51).

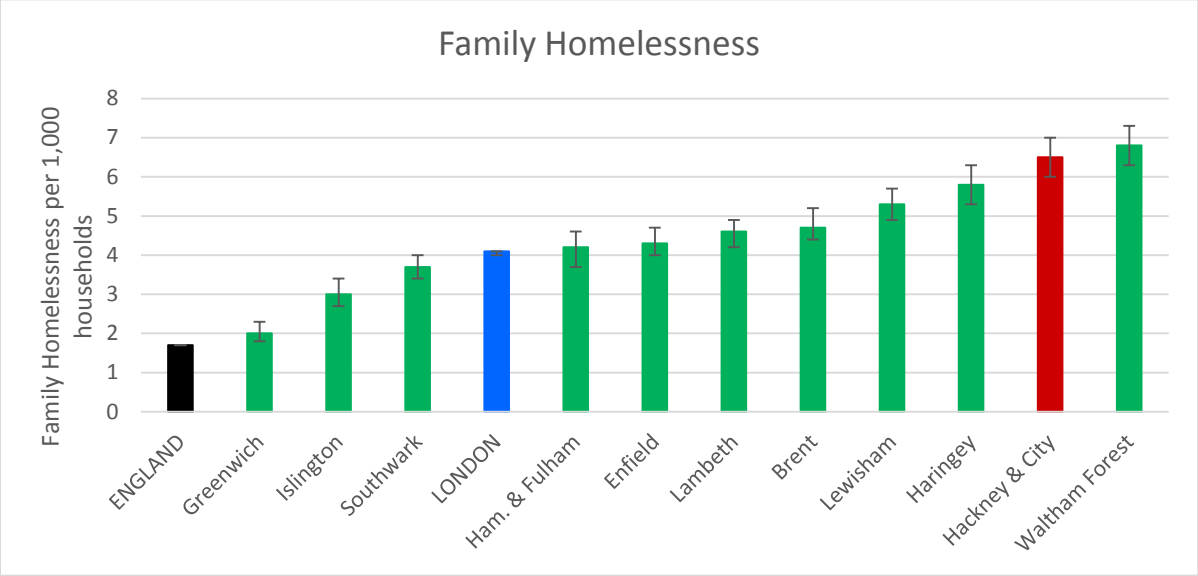

Figure 51: Family homelessness crude rate, 2013/14

The rate of family homelessness has been increasing in annual data, with this rate of increase higher locally – widening the gap as shown in Figure 52. As at quarter one of 2015, the rate of increase of eligible homelessness applications that include dependent children has been accelerating both locally and nationally with 14% more applications in Hackney and 13% more nationally compared to quarter one of 2014 [72].

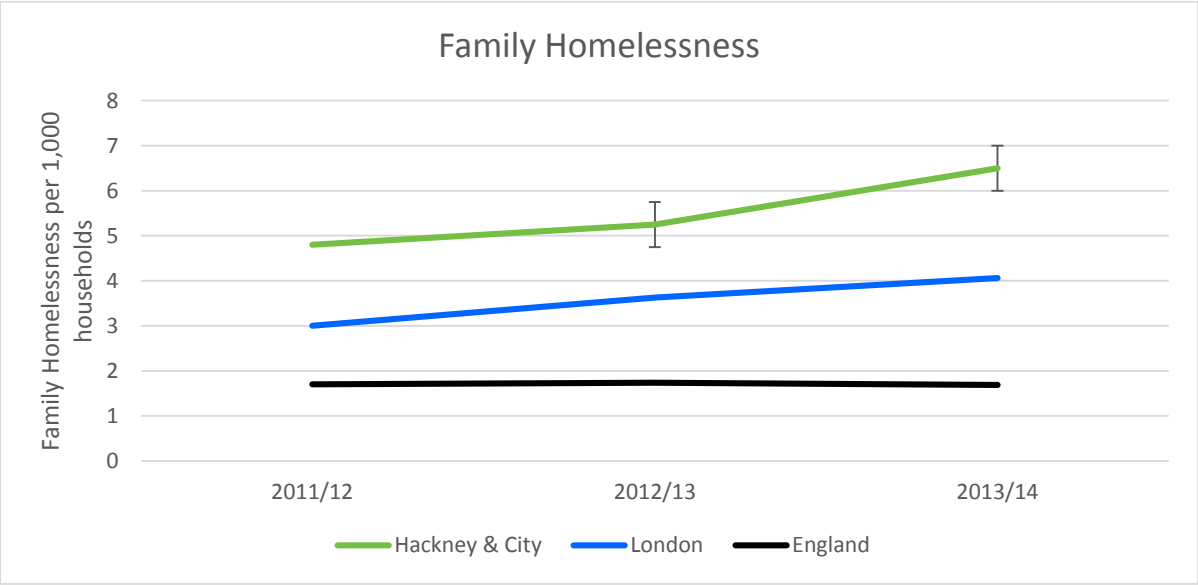

Figure 52: Family homelessness, 2011/12-2013/14 [41][26]

[26] Note – confidence interval information not available for 2011/12

For quarter one of 2015 there were 288 household homelessness applications in Hackney that were eligible, unintentionally homeless and in priority need in Hackney, compared to seven in the City of London[27]. 218 of Hackney's applications included dependent children, of which 72% were lone female parent households. While breakdown by ethnicity is not available specifically for those applications that involve dependent children, almost half of all applications (49%) were of Black ethnicity [72].

When analysing homelessness in 16 and 17 year olds, 43 homelessness assessments were undertaken in 2014/15, following which nine young people were provided with accommodation by the Council and the remaining 34 were either returned home or were supported to live with wider family members [73].

9.3.4 Environment

The Marmot Indicators for Local Authorities include a measure of residents' utilisation of outdoor space (including parks or the countryside and including holidays within England, but not residents' own gardens) for exercise/health reasons. Hackney had a proportion of 15.9% which, although being lower than the national average of 17.1%, is within the national interquartile range and is higher than the London average of 11.8% [74]. However, Hackney and the City of London have high rates of air pollution-attributable mortality, at 7.3% and 8.4% of deaths, respectively. These are both higher than the London average of 6.7%. This places Hackney as higher than eight of its ten statistical neighbours, and the City of London higher than all ten of Hackney's statistical neighbours (Figure 53).

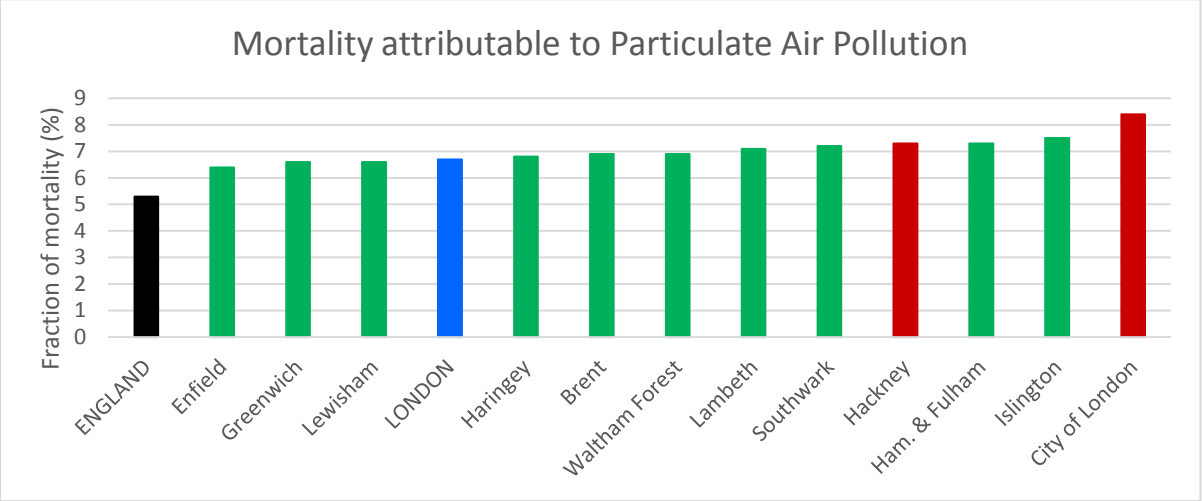

Figure 53: Fraction of mortality (in those aged 30 and over) attributable to particulate air pollution, 2013 [41]

Figure 54 shows that high proportions of the Hackney and City populations are exposed to high daytime noise, with 17.5% of Hackney's population being exposed to more than 55dB noise from road, rail or air transport during the daytime, and 14.3% being exposed to more than 65dB. This places Hackney above the national and London averages, and higher than

[27] Note – further breakdown for the City of London is not available due to the low numbers involved

eight of Hackney's ten statistical neighbours. The City of London fares worse, with 28.9% of the population being exposed to more than 55dB of transport noise, and almost all of these people being exposed to over 65dB. This places the City of London higher than all ten of Hackney's statistical neighbours, with the proportion of the population being exposed to over 65dB being 70% higher than the next highest comparator borough (Islington).

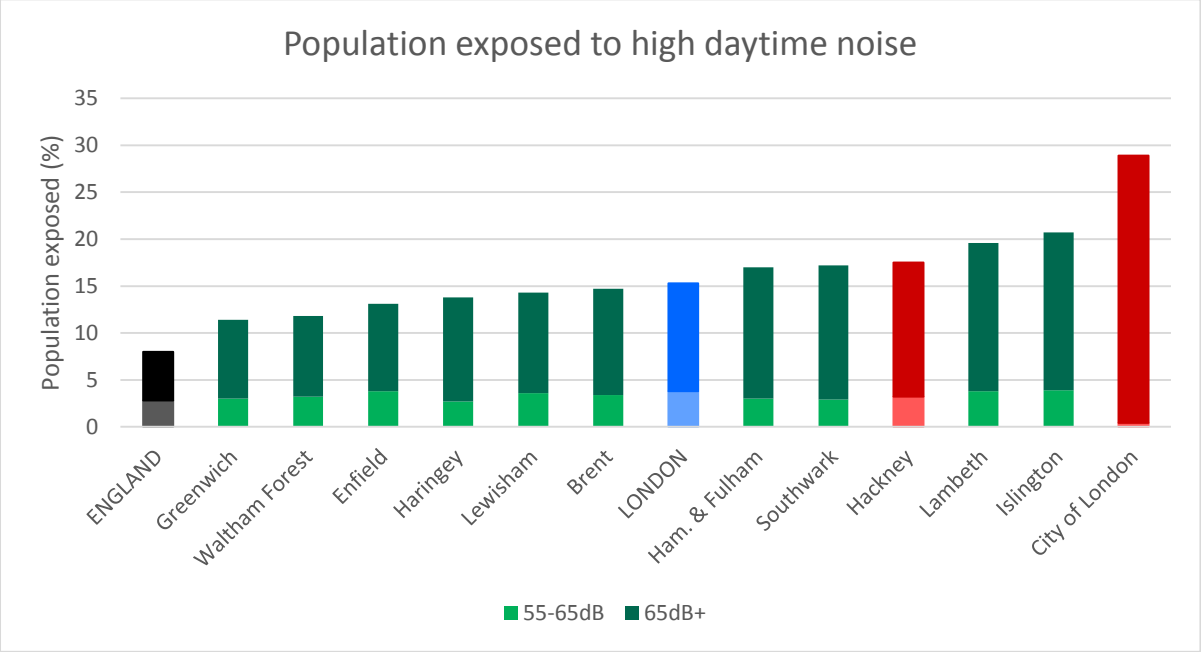

Figure 54: Proportion of population exposed to road, rail and air transport noise during the daytime, 2011 [41]

While the rate of children who are killed or seriously injured in road traffic accidents in Hackney and the City of London is not statistically significantly different from the national average at 17.6 per 100,000, it is higher than the average rate across London (Figure 55).

	Hackney and City of London	London	England
Children killed/seriously injured in road traffic accidents per 100,000 2011-2013	17.6	13.7	19.1

Figure 55: Road traffic accidents [41]

The overall crime rate in Hackney is higher than six of Hackney's ten statistical neighbours (Appendix 15.3.2.4, Figure 205). However, the number of offences in Hackney is falling with an 8% reduction over two years (2012/13 to 2014/15) [75]. Within Hackney, the highest crime rates[28] are found in areas where the night-time economy is centred (Hoxton East & Shoreditch 26.8, Dalston 17.7, Homerton 12.4), whereas the lowest crime rates are found in the north east of the borough (Cazenove 3.3, Stamford Hill West 4.8, Springfield 5.4).

Crime in the City of London is not comparable as these rates are based on resident population, which does not reflect the much larger workday population.

[28] Note – rates provided are the number of people per 1,000 population per month

9.4 Education

9.4.1 Demographics

	KS2		KS4	
	Hackney	England	Hackney	England
% pupils started below expected level	21	18	21	16
% with English as an Additional Language (EAL)	58	18	43	14
% with Special Educational Needs	15	11	12	9
% disadvantaged pupils	-	-	54	27
% mobile pupils	6	8	-	-

Figure 56: Demographics of pupils, 2014 [76]

9.4.2 Special Educational Needs

According to the Children and Families Act [12], "a child or young person has special educational needs if he or she has a learning difficulty or disability which calls for special educational provision to be made for him or her". A learning difficulty or disability is present in a child of school age if they have "a significantly greater difficulty in learning than the majority of others of the same age" or "a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions".

The Act goes on to state that local authorities must identify all children and young people in its area who have or may have SEN or a disability and ensure the integration of educational provision with health care provision and social care provision if it would promote the well-being of these children and improve the quality of special education provision. For the purposes of this Act, the well-being of children and young people relates to:

- Physical and mental health and emotional well-being
- Protection from abuse and neglect
- Control by them over their day-to-day lives
- Participation in education, training or recreation
- Social and economic well-being
- Domestic, family and personal relationships
- The contribution made to them by society

Previously, children received a Statement of Special Educational Needs from their local authority if they required additional educational provision. Children with a Statement accounted for 11% of all school pupils identified as having SEN in Hackney in 2013. However, under the Children and Families Act these Statements have been replaced by Educational Health and Care (EHC) plans which aim to address broader health and social care needs. As of September 2014, only EHC plans are issued and children who already have an SEN statement will be transferred to an EHC plan within three and a half years [77].

Comparing the proportions of pupils who have moderate learning difficulties known to schools (at school action plus or statement level) reveals that, while Hackney has a significantly greater proportion than London, at 15.5% it is in line with the England average and sits in the middle of Hackney's ten statistical neighbours (Appendix 15.3.3.1, Figure 206). Furthermore, this proportion is falling in line with the England average (Figure 57).

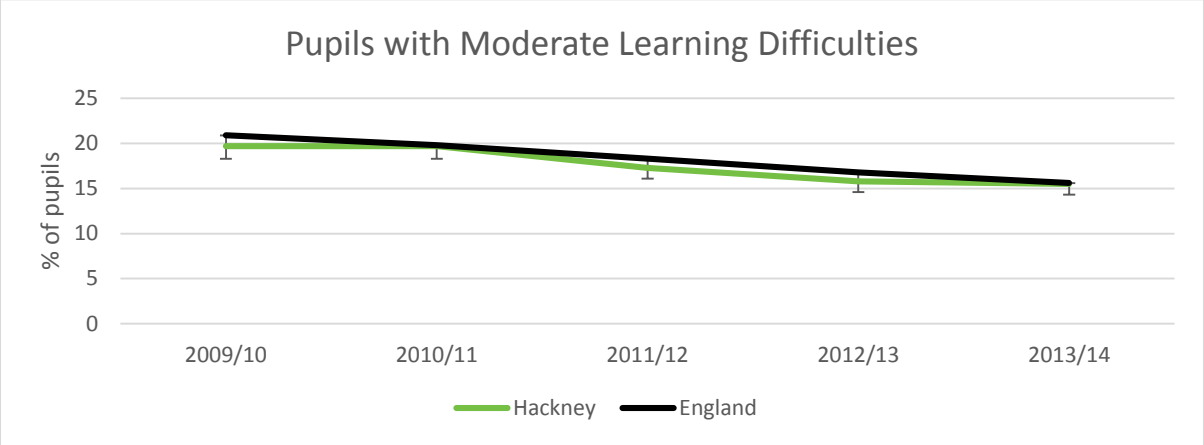

Figure 57: Pupils known by schools to have moderate learning difficulties, 2009-2014 [41]

Hackney has relatively fewer pupils known to have severe learning difficulties, the rate of 2.6 per 1,000 pupils being lower than eight of Hackney's ten statistical neighbours and significantly lower than the national average (Appendix 15.3.3.1, Figure 207). Like moderate learning difficulties, the proportion with severe learning difficulties is falling in Hackney, but this is widening the gap with the national average which is instead remaining static (Figure 58).

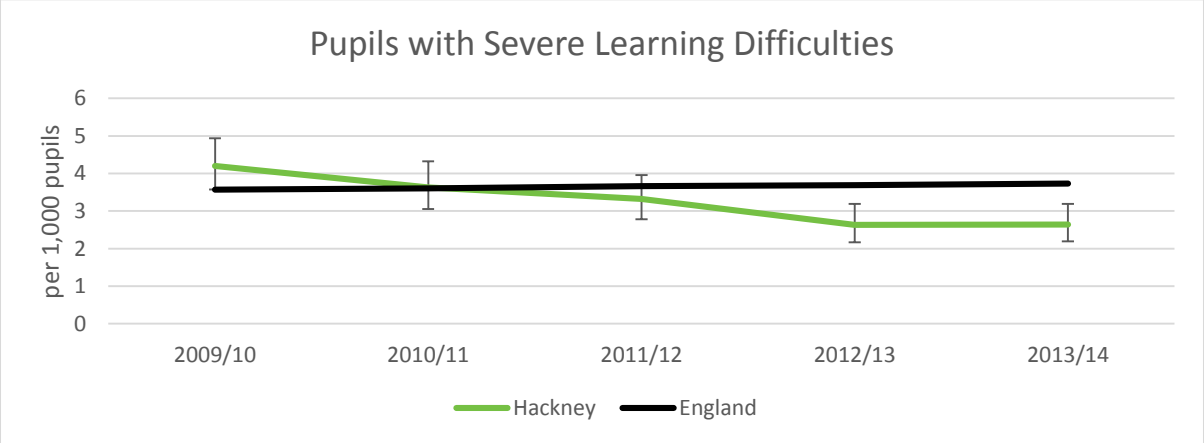

Figure 58: Pupils known by schools to have severe learning difficulties, 2009-2014 [41]

Children with SEN require greater support to reach their potential than non-affected children, not only because of the disabilities they have, but also because they are more likely to have other risk factors which are associated with poorer education outcomes, such as deprivation. Not only does raising a disabled children cost, on average, an additional £99 per week [67], but families supporting a disabled child are 2.5 times more likely to have no

parent working for more than sixteen hours per week [68]. In 2011, The Children's Society reported that 40% of disabled children were living in poverty, compared to a national average of 30%. Furthermore, 14% of disabled children were living in severe income poverty (where household income is less than 40% of the median income) in 2011, in comparison to 11% of all children [78].

9.4.2.1 Local Services

Since 2008, Hackney Ark has been a hub for health, education and social care services for children and young people living with disability or SEN in Hackney. The Ark provides a single point of entry referral assessment meeting, in order to provide a holistic co-ordinated package of care with the child's needs being addressed by the relevant clinical teams.

Further local services include those run by HLT (such as the educational psychologist service), disabled children's social care and local health services (for instance, the multi-agency referral service and services by speech and language therapy).

9.4.3 Attendance

Based on school census data, in 2013/14 children in the City of London had the lowest rate of half day absences in London and Hackney the tenth lowest, which put Hackney at significantly fewer absences than the England average. However, a significantly higher proportion of children in Hackney received exclusions from school in 2012/13 compared to the England average and Hackney had the highest rate of children receiving a fixed period exclusion from secondary school in London. No children were excluded in the City of London in 2012/13.

	Hackney	City of London	London	England
% of half days missed by pupils (authorised & unauthorised) 2013/14	4.22	3.47	4.33	4.51
% children receiving a fixed period exclusion from primary school 2012/13	1.3	0.0	0.7	0.9
% children receiving a fixed period exclusion from secondary school 2012/13	12.8	-	6.5	6.8
% children receiving permanent exclusion from secondary school 2012/13	0.26	-	0.16	0.12

Figure 59: Pupil absence and exclusion [41]

9.4.4 Performance

Pupils whose first language is not English and who were admitted to the school from particular countries outside the United Kingdom in the year before or the year of the key stage tests are not included in the calculations as it is understood that it will take time for their English language skills and familiarity with the curriculum to develop. Furthermore, as there are no state-funded secondary schools within the City of London, education data are only presented for Hackney.

9.4.4.1 Key Stage 2

Nationally collated results are only available for state-funded schools in England. Independent schools are not included as there is no requirement for them to enter their pupils for national curriculum tests. Key stage 2 (KS2) tests are used to assess mainstream state-funded primary schools against 'floor standards'. According to Department for Education guidance [79], a mainstream state-funded school is seen as underperforming if:

- Fewer than 65% of pupils achieve a level four or above in all of reading, writing and maths by the end of KS2; AND
- Below the average percentage of pupils at the end of KS2 made expected progress in reading (national median 94%); AND in writing (national median 96%); AND in maths (national median 93%).

Of the 51 Hackney primary schools with available data in 2015, two had fewer than 65% of pupils achieving a level four or above in all of reading, writing and maths and only one of these exhibited all four of the above features and could therefore be counted as underperforming (but has since improved and is no longer underperforming).

9.4.4.2 Key Stage 4

The coverage of schools at key stage 4 (KS4) includes state funded schools (excluding hospital schools, pupil re-engagement units and alternative provision) and all independent schools in England. As of 2013, only the first result a pupil achieves in a subject will count in performance measures in the English Baccalaureate and this will be expanded to all subjects in 2014/15.

For the academic year 2013/14, 58.8% of Hackney pupils achieved five A*-C grades at GCSE which was higher than the national average (56.8%), but lower than the London average (61.4%). When analysing the performance of pupils who receive FSM (as a crude indicator for pupils from lower socioeconomic groups), a similar proportion (50.6%) achieved five A*-C grades. In this measure Hackney outperforms the London average (46.5%), the national average (33.7%), and in fact falls in the top quartile of results nationally [74].

Instead of using FSM alone as an indicator, the Department for Education classifies pupils as 'disadvantaged' if they have been eligible for FSM within the last six years, they have been adopted from care or they have been looked after for one day or more. The proportion of pupils being classified as 'disadvantaged' in Hackney (54%) is twice the national figure (27%) and this could present a challenge to local education provision and achievement. However, while 'other' pupils continue to outperform 'disadvantaged' pupils in Hackney, this gap is narrower than national figures. Hackney outperforms the national average in both groups of pupils (Figure 60).

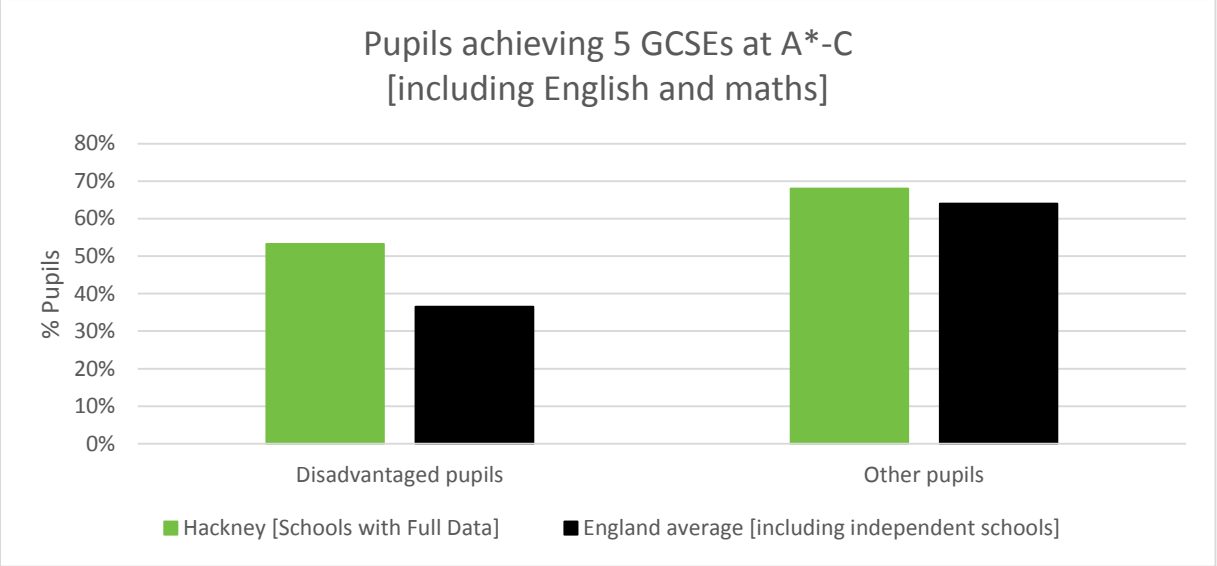

Figure 60: Proportion of pupils achieving 5 GCSEs at A*-C, 2014 [76]

Another predictor of achievement at KS4 is previous achievement (at KS2 level). When the average point score per pupil is broken down according to pupils' previous performance, the data available for Hackney (covering 14 schools) reveal a higher average point score in all categories (Figure 61).

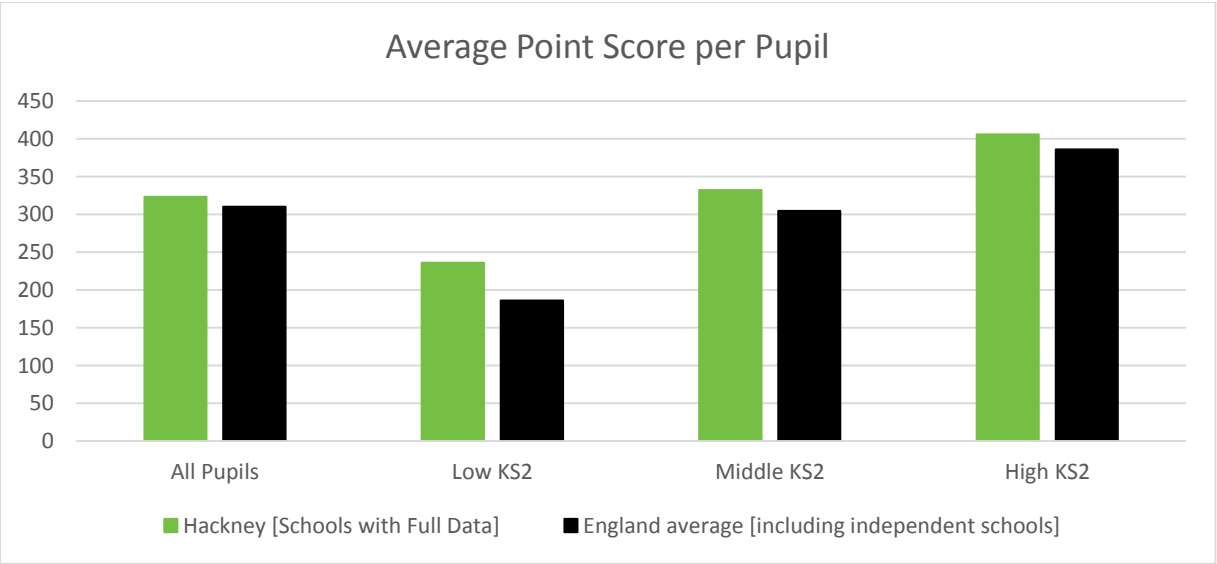

Figure 61: Average point score, 2014 [76]

According to Department for Education guidance [80], a mainstream state-funded school is seen as underperforming if:

- Fewer than 40% of pupils achieve five or more GCSEs at grade A*-C including English and maths
- The school has a below median score for the percentage of pupils making expected progress between KS2 and KS4 in English (national median 74%); AND in maths (national median 67%)

Of the 12 schools with available data in 2015, two had fewer than 40% of pupils achieving five A*-C GCSEs including English and maths, and only one of these exhibited below median scores for expected progress in both English and maths.

9.4.4.3 Key Stage 5 and higher qualifications

All schools and colleges are included in the key stage 5 (KS5) performance tables apart from special schools, although they may choose to be included [81]. Students are only included if they are aged 16, 17 or 18 at the start of the 2013/14 academic year. Results based on a cohort of five or fewer students are suppressed to reduce the risk of individual identification.

When assessing the average point scores of KS5 pupils, the achievements per entry in Hackney (be that A-level or vocational) are approximately the same as national scores (Appendix 15.3.3.2, Figure 208). While the proportion of students achieving at least two A*-E and at least three A*-E is the same in Hackney as nationally, the proportion receiving the top grades (AAB or higher) is lower (Appendix 15.3.3.2, Figure 209). Conversely, the proportion of students doing vocational subjects who achieve more than one substantial qualification is higher in Hackney than nationally, with the gap widening for the achievement of at least three qualifications (Appendix 15.3.3.2, Figure 210).

Breakdown is available by ethnicity for Hackney's adults with regards to whether they achieved any qualifications and the level of qualifications. Level four qualifications and above include Certificates and Diplomas of Higher Education, NVQ levels four and five, Higher or Degree apprenticeships, Foundation Degrees, Honours or Ordinary Degrees, and higher degrees. In Hackney, White British adults have the highest proportion gaining higher qualifications and the lowest proportion gaining no qualifications (Figure 62). Conversely, those of 'Other' ethnicity have the highest proportion gaining no qualifications and the lowest proportion gained higher qualifications, with having no qualifications being more common than having higher qualifications.

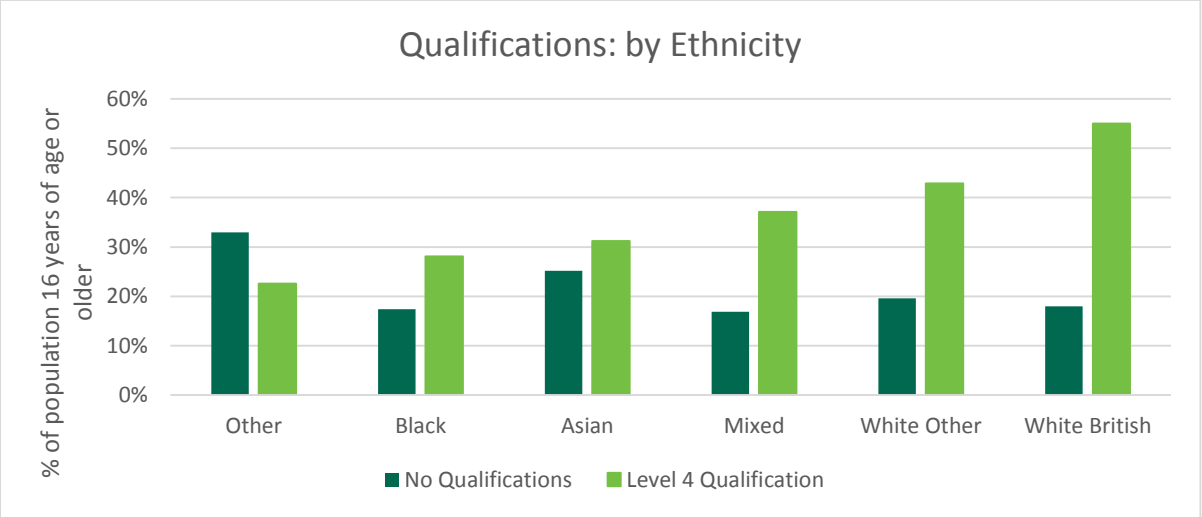

Figure 62: Highest level of qualifications gained by adults in Hackney, 2011 [33]

9.4.5 NEET

Being not in education, employment or training (NEET) is linked to a range of poor outcomes later in life, including poor health outcomes. Figure 63 shows that the proportion of 16-18 year olds NEET has been significantly lower than both the London and national averages for three of the past four years (but significantly higher in 2012) with the value currently standing at 3% (2014). While the rate in the City of London has been lower than across London and England for all of the past four years, this has not been statistically significant in the past two years due to wide confidence intervals.

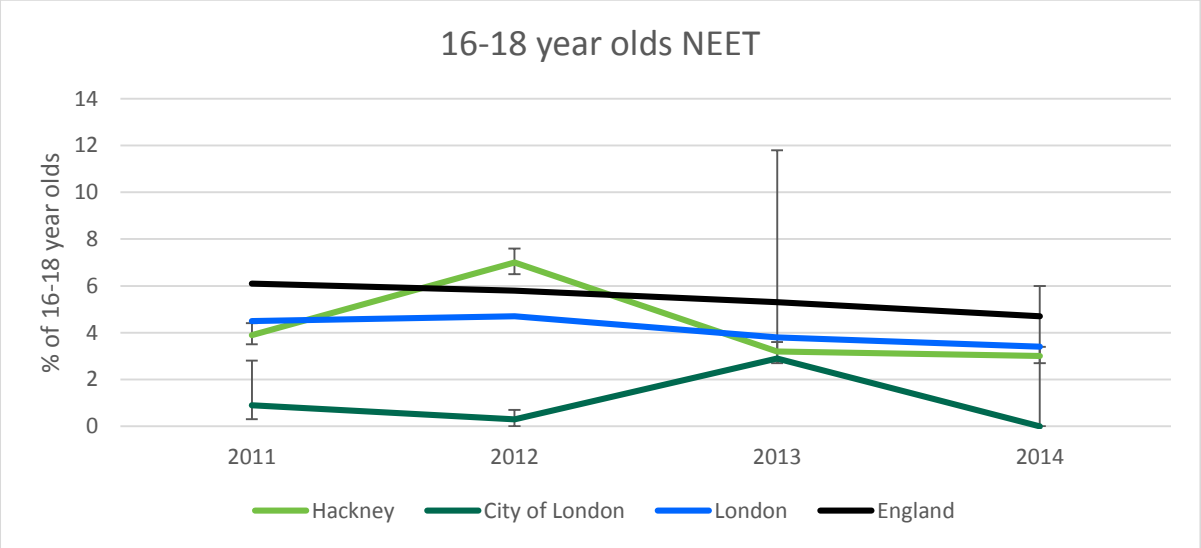

Figure 63: 16-18 year olds NEET, 2011-2014 [41]

The proportion of 19 year olds classed as NEET is higher, raising the proportion of 16-19 year olds NEET to 6.7% in Hackney in 2013 [82]. Further analysis of NEET data by ethnicity and vulnerability in 16-19 year olds in Hackney was conducted in 2013. This revealed that the highest rate of NEET was in the Mixed ethnicity population (9.5%), followed by the White British (9.3%) and Caribbean (8.0%) populations. The lowest rate of NEET was in the African (3.4%) and Bangladeshi (4.0%) communities. Many vulnerable groups have a high proportion of young people NEET. The 2013 breakdown found that 16-19 year olds who were parents, carers or currently pregnant had the highest rates of NEET (Figure 64).

	16-19 year olds NEET (2013)
Whole 16-19 year old population	6.7%
Parent (caring for own child)	54%
Parent (not caring for own child)	20%
Carer (not own child)	50%
Pregnant	44%
Supervised by Youth Offending	25%
Looked after child	16%
Care leaver	0%
Learning Disability	11%
Refugee / asylum seeker	0%

Figure 64: 16-19 year olds NEET across Hackney by vulnerable group, 2013 [82]

9.5 Safeguarding

9.5.1 Background

The HCP states that the safety of a child ultimately depends on staff having the time, knowledge and skill to understand the child or young person and their family circumstances, and this responsibility lies with the whole team. The Laming Report [83], commissioned following the case of 'Baby P', emphasised the importance of translating policy, legislation and guidance into day-to-day practice and the importance of the necessary specialist knowledge and skills in social workers.

"Safeguarding issues are just as important for older children and young people as they are for young children and babies."

Figure 65: Healthy Child Programme 5-19, 2009 [20]

'*Working Together to Safeguard Children*' was initially published in 2013 and revised in 2015 [84] – it outlines how organisations and individuals should work together in the assessment of children. It states that "Whilst local authorities play a lead role, safeguarding children and protecting them from harm is everyone's responsibility. Everyone who comes into contact with children and families has a role to play". Furthermore, it demonstrates that safeguarding children should not be something that only happens in the most extreme cases, but it is more far-reaching as it should include "taking action to enable all children to have the best outcomes".

The Single Inspection Framework (SIF) was introduced by Ofsted for the inspection of services for children in need of help and protection, looked after children and care leavers. As of July 2016 fewer than 25% of local authorities inspected under the SIF have been judged as 'good'. In the most recent inspection, Hackney's Children's Services received positive feedback about the services provided to children and young people in Hackney. The final Ofsted inspection report will be published in September 2016.

9.5.2 Children's Social Care Services in Hackney

The key principles and beliefs of children's social care in Hackney are described in their bi-annual report [73] and outlined in Figure 66.

Children are best cared for within their families wherever this can be safely achieved
Investing in providing services that are able to promote change within families is frequently more effective and efficient than removing children and placing them in alternative care
In most cases decisions about interventions should be made by those who understand the child and their family/carers best, which will normally be the practitioners working with them. However, responsibility for decisions that have life-long implications for the child should be carried out by senior managers
Social work is a skilled and highly responsible task and that to perform well, practitioners need to feel well supported within their work setting and to have opportunities to reflect on their interventions with others
Having more than one person's perspective on a situation enhances assessments and helps to mitigate risk by ensuring that alternative viewpoints are explored

Figure 66: Key principles of Hackney children's social care, 2015 [73]

9.5.2.1 First Access & Screening Team

The First Access & Screening Team (FAST) was formed from the merger of the First Response Team and Partnership Triage in 2014/15 and acts as a single point of contact for referrals to Children's Social Care. FAST provides responsive screening activities including a 'go look' visit when necessary to better understand a child's situation. FAST works as a part of a Multi-Agency Safeguarding Hub (MASH) alongside the police, probation and health services. FAST also signposts access to the Children's Centre Multi-Agency Team (MAT) meetings and the Children and Young People's Partnership Panel.

All contacts with FAST are immediately progressed as a referral to Children's Social Care if the threshold for a statutory assessment is met [73]. Figure 67 shows that the proportion of contacts that led to an assessment rose in 2014/15 to 35% from 25% the year before. The percentage of re-referrals within 12 months in 2013/14 was 15.7% which was significantly lower than the England rate of 23.4%. The rate in Hackney has now fallen to 13.6% in 2014/15 (national data for comparison are not yet available), and this may indicate an improved assessment process.

	2012/13	2013/14	2014/15
Contacts	12,688	10,942	9,875
Assessments	2,658	2,769	3,534
Percentage of contacts assessed	21%	25%	35%
Percentage of re-referrals within 12 months	13.1%	15.7%	13.6%

Figure 67: Children's Social Care contacts and assessments, 2012/13 – 2014/15 [73]

The out of hours social work service, or emergency duty team, receives 500-700 calls per month. The service provides advice in both simple and complex situations and also initiates child protection investigations and protective services including admission into care.

9.5.2.2 Family Support Services

In Hackney, 'Family Support Services' is an umbrella term for a range of services including contact services, the parenting assessment and support service, the targeted family support service, troubled families, family network meetings and clinical services. Some of the programmes reaching a larger number of local children are described in more detail below.

The Social Work in Schools Project provides family interventions to families at the earliest signs of difficulty to prevent children from becoming subject to child projection plans. The project was launched in eight of Hackney's schools in November 2014 and had worked with 93 children by 31st March 2015, with only six children requiring transfer to a social work unit due to a deterioration of their circumstances.

The Expanded Troubled Families Programme was launched nationally in April 2015 to reach children living through domestic violence or their own or parental health needs in addition to the existing criteria involving anti-social behaviour, school attendance or being out of work. Hackney will be required to work with 3,720 families who meet two of the six inclusion criteria over the next five years [73].

The inclusion criteria are:

- Parents and children involved in anti-social behaviour
- Adults out of work or at risk of financial exclusion or young people at risk of worklessness
- Children who are not attending school regularly
- Children of all ages identified as in need or subject to a Child Protection Plan
- Families affected by domestic violence and abuse
- Parents and children with a range of health problems

The Parenting Assessment and Support Service (PASS) supports families who are receiving statutory social work interventions and where parenting and other environmental factors have been assessed as compromising the welfare of children in the household. During 2014/15 PASS worked with 229 children and completed interventions with 160 children, of which 43% were subject to a Child Protection Plan at the start of the intervention, reducing to 28% at the end of the intervention.

Family Network Meetings (FNM) aim to mobilise existing support networks in families to enable children to remain living with their family through a flexible and swift response that maximises family engagement and reduces homelessness. For the year ending March 2015 there were 157 referrals to FNM, resulting in 61 children remaining in their family home, 30 children remaining in placements, 18 cases remaining open and the other cases pending.

9.5.3 Child Protection Plans and Children in Need

The Munro review of Child Protection [85] made a number of recommendations in order to attempt to shift the focus of the child protection system away from bureaucracy towards the valuing of professional expertise with the safety and welfare of children and young people at its heart. Within this report, it was recommended that local authorities and their partners use a combination of nationally collected and locally published performance information to help benchmark performance, facilitate improvement and promote accountability, but not to treat this information as an unambiguous measure of good or bad performance.

The decision to introduce a Child Protection Plan is made if a multi-agency child protection conference deems a child to be at a continuing risk of significant harm or impairment of their health and development. The number, and rate, of Child Protection Plans in Hackney has seen a marginal decrease over the past three years (Figure 68).

	2013	2014	2015
Number of Child Protection Plans	225	221	214
Rate of Child Protection Plans per 10,000	39.3	37.9	36.8

Figure 68: Child protection plans in Hackney as at 31st March 2015 [73]

The initial reasons for the introduction of the Child Protection Plans that existed in Hackney as at 31st March 2015 were categorised as:

- Emotional abuse (47%)
- Neglect (36%)
- Physical abuse (10%)
- Sexual abuse (4%)
- Multiple reasons (3%)

The most recent rates of Child Protection Plans averaged across Hackney's statistical neighbours is 40.9 per 10,000 (2014) which was broadly similar to Hackney's 37.9 per 10,000 that year.

Over the past two years the proportion of children remaining on a Child Protection Plan for either a very short (under three months) or long (over two years) period of time has increased, with fewer children remaining on a Plan for an intermediate period of time (Figure 69). It has been proposed that the increase in the percentage of children subject to a Plan for under three months may be due to an increase in the number of children becoming subject to a Plan in the three months prior to the collection of these data (i.e. between January and March 2015). Statistical neighbour and national data are not yet available for 2015 to compare whether this effect has been observed elsewhere.

	2013	2014	2015
Under 3 months	19%	27%	34%
3-6 months	35%	15%	19%
6-12 months	31%	25%	25%
1-2 years	12%	31%	13%
Over 2 years	3%	2%	8%

Figure 69: Duration of child protection plans, as at 31st March 2015 [73]

The proportion of Child Protection Plans that were placed on children who had previously been subject to one decreased from 17% in 2012/13, to 14% in 2013/14 to 11% in 2014/15.

The number of children requiring a statutory social care intervention in the City of London is low compared to other local authorities. Fewer than ten children were subject to a Child Protection Plan in the City of London in 2012/13.

9.5.4 Looked After Children

The Hackney Children and Young People's Service Social Care Sufficiency Strategy [86] lists their six strategic objectives are to:

1. Safely manage the number of children coming into care, ensuring that the needs of children and young people are met through the continued delivery, review and development of preventative family support services and ensuring that children only come into care where this is in their best interests
2. Ensure that looked after children are progressed through the care system without unnecessary delay and can achieve timely and appropriate reunification with their families, or permanent alternative placements (for example, through adoption, long-term fostering or special guardianship), wherever this is possible
3. Provide and commission the right mix of high quality placements (including through the development of existing partnerships and increased use of in-house provision) to meet identified needs of looked after children and care leavers as cost effectively as possible
4. Secure placement stability and improve outcomes for children and young people through strengthening: matching processes; placement planning; quality assurance processes; support available for carers (including foster carers, special guardians, adopters); and professional development opportunities for foster carers
5. Support children and young people to make a successful transition into adulthood through the provision of high quality leaving care services which support care leavers to find and maintain suitable accommodation arrangements that meet their needs and provide them with independent living skills
6. Strengthen the involvement of children, young people, families, carers and professionals in the design, delivery and evaluation of placement provision

Hackney's proportion of children being 'looked after' is not different from the London or national averages (56 per 10,000 compared to 54 and 60 per 10,000), but is lower than the average of Hackney's statistical neighbours [41]. The number of looked after children (LAC) has increased both locally and nationally over the last five years (Figure 70). However, the increase is faster locally, with a 22% increase between 2011 and 2014 in Hackney, compared to a 5% increase nationally and a 9% decrease amongst Hackney's statistical neighbours. This increase is predominantly in those aged ten and over, both locally and nationally [87].

	Hackney	Stat. Neighbour Average	National
2011	270	447	65,510
2012	315	438	67,070
2013	320	425	68,060
2014	330	405	68,800
2015	345	-	69,540

Figure 70: Number of looked after children on 31st March [86] [29]

The Children and Families Act of 2014 laid out new 'Staying Put' arrangements (Clause 98). In this scenario, a child who was looked after by a foster parent may continue to live with that same foster parent with the maintained advice, assistance and support of the local authority until the child reaches the age of 21. Therefore, the financial demands placed on Children's Social Care locally can be expected to rise further.

19% of Hackney's LAC are placed within Hackney, with 24% in a neighbouring local authority and 57% in a non-neighbouring local authority (predominantly in London, Essex, Kent or Hertfordshire). According to the Sufficiency Strategy this is consistent with other London boroughs. Due to a conscious decision to focus on providing family setting placements, only 3% of children are placed in children's homes, which is lower than the national average.

The emotional wellbeing of LAC and the proportion of LAC whose vaccinations are up-to-date is similar to nationally, despite Hackney as a whole having lower immunisation uptake than nationally. Of note, the proportion of LAC who achieve five GCSEs (including English and maths) at grades A*-C is twice the London and national averages. (Figure 71)

	Hackney	City of London	London	England
Looked after children per 10,000 2014	56		54	60
Emotional wellbeing of looked after children[30] 2014	13.9	-	-	13.9
Looked after children with up-to-date immunisations (%) 2014	89.1		84.3	87.1
Looked after children who gain 5 GCSEs at A*-C including English & maths (%) 2014	25.0		15.0	12.0

Figure 71: Looked after children, 2014 [41]

[29] Note – 2015 data are not yet available for Hackney's statistical neighbours

[30] Note – average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March for 2013/14

Data outlined in the Sufficiency Strategy demonstrate that, in 2015, 3.5% of LAC locally have a disability with the most common needs being autistic disorder and children with mobility issues. Data for the past four years reveal that these needs have remained stable.

As the number of LAC in the City of London is low the rate is subject to relatively wide year-on-year variation. During 2014/15 the City of London looked after 11 children. However, this is not comparable to the data provided for Hackney which relate to how many are looked after on one specific day (31st March). Unaccompanied asylum seeking children account for almost all of the LAC in the City of London, and this higher proportion than in Hackney results in different health needs.

9.5.5 Specific Causes of Vulnerability

9.5.5.1 Domestic Violence

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality."*

Figure 72: Cross-government definition of domestic violence, 2016 [193]

One quarter of women experience domestic violence in their lifetime and over half of all violent crime experienced by women is domestic violence. Approximately 250,000 children in Britain witness domestic violence every year, and in over half of cases children are also directly abused [88]. 25% of children who witness domestic violence will go on to develop serious social and behavioural problems [89].

The Home Office Ready Reckoner Tool, based on the findings of the British Crime Survey, estimated that 5,245 women and girls aged 15-69 in Hackney were the victim of domestic violence in 2010, but there were only 4,665 reports of domestic violence incidents to the police in Hackney in 2009/10 [90]. In approximately 70% of domestic violence incidents in Hackney children are in the same or next room [90].

A freedom of information request to the Metropolitan Police Service reported the rate of domestic violence incidents (that is, Crime Report Information System records where there is an allegation of domestic violence, regardless of whether the allegation was confirmed or not) and domestic violence offences (where a Confirmed Crime has been added to the Crime Report Information System record) for each of London's local authorities. These data have revealed that, for 2012, Hackney had a higher rate of domestic violence incidents than six of Hackney's ten statistical neighbours (Figure 73).

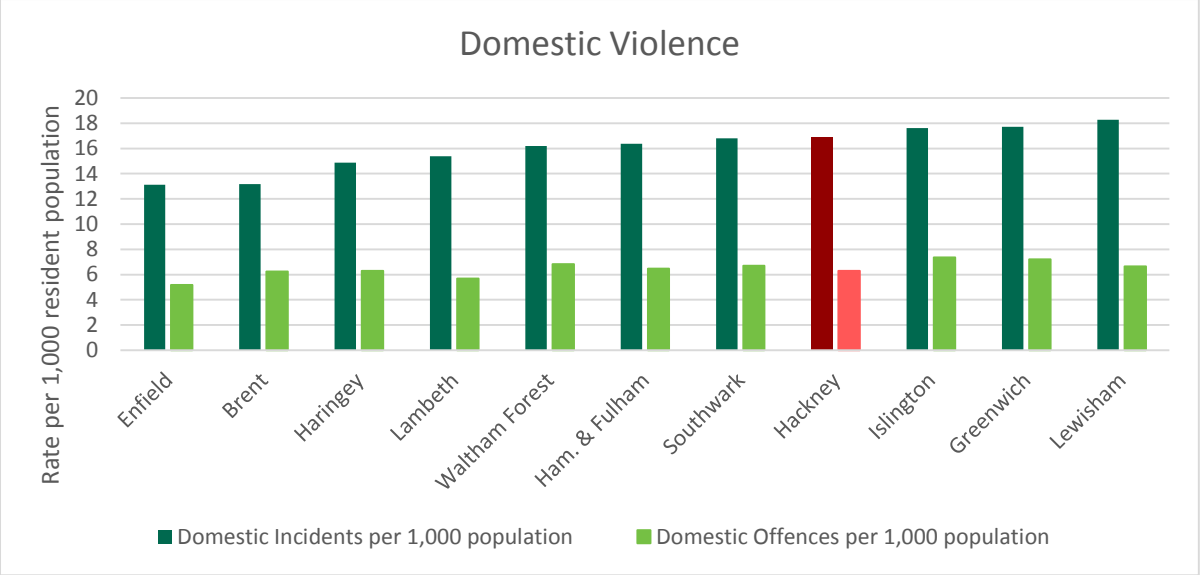

Figure 73: Domestic violence incidents and offences (2012) per 1,000 resident population (mid-2014 ONS estimate) [91]

In order to improve the identification of domestic violence, all City and Hackney GPs have joined the Identification and Referral to Improve Safety programme, which is delivered by the voluntary sector organisation Nia. This programme gives primary care training and provides a route for referral to specialist services. In 2013/14 there were 103 referrals by local GPs, 15 of which were deemed to be high risk and therefore referred to the Multi-Agency Risk Assessment Conference (MARAC). The MARAC provides a setting for information regarding high risk cases to be shared between different statutory and voluntary sector agencies to provide a co-ordinated response to meet the complex and wide-ranging needs of victims of domestic abuse.

Once domestic violence has been identified, the Domestic Violence Intervention Project (DVIP) works with Hackney's Children and Young People's Services to help strengthen the assessment of families and reduce the number of repeat incidents in those families [73]. During 2014/15 the DVIP received 61 referrals relating to adult perpetrators and completed 34 risk assessments. In order to support the children and young people who have been exposed to domestic violence in Hackney, Play Therapy (delivered by Nia) helps them to understand and deal with their feelings.

The Council also funds two refuges – one is a generic service and the other service is specialised for South and South East Asian and Muslim women. In total, up to 48 women can be provided with shelter and support at any one time. Refuge provision accounts for 40% of Hackney Council's £1.09 million spend on domestic violence support services.

In the City of London there were 145 domestic abuse incidents reported to the Domestic Abuse Forum in 2013/14 (including both crime and non-crime incidents) with over three quarters of these being female victims. 80% of child protection investigations in the City of London between January and October 2014 included domestic abuse as a risk factor [92].

9.5.5.2 Child Sexual Exploitation

There is not a definitive published numerical estimate of the number of children who are sexually exploited in Hackney due to a range of factors – from issues regarding the reporting of exploitation to statutory authorities, to concerns that data may be identifiable when the numbers involved are low. However, despite this, the local authority is aware that a number of young people have experienced or are at risk of experiencing sexual exploitation in Hackney and, as across London, indicators predominantly point to young women being exploited by male peers or those slightly older than them [73]. It has been identified that one could consider it a continuum from harmful sexual behaviour (HSB) to child sexual exploitation (CSE), and therefore Hackney Council have established a working group to address HSB to promote early intervention that may divert behaviours away from CSE, in addition to ongoing action regarding CSE itself.

9.5.5.3 Female Genital Mutilation

Female Genital Mutilation (FGM) includes any procedure involving the partial or total removal of the external female genitalia or any other injury to the female genitalia for non-medical reasons [93]. In line with the areas of high prevalence of FGM internationally shown in Figure 74, the UK communities that are most at risk of FGM include Kenyan, Somali, Sudanese, Sierra Leonean, Egyptian, Nigerian and Eritrean.

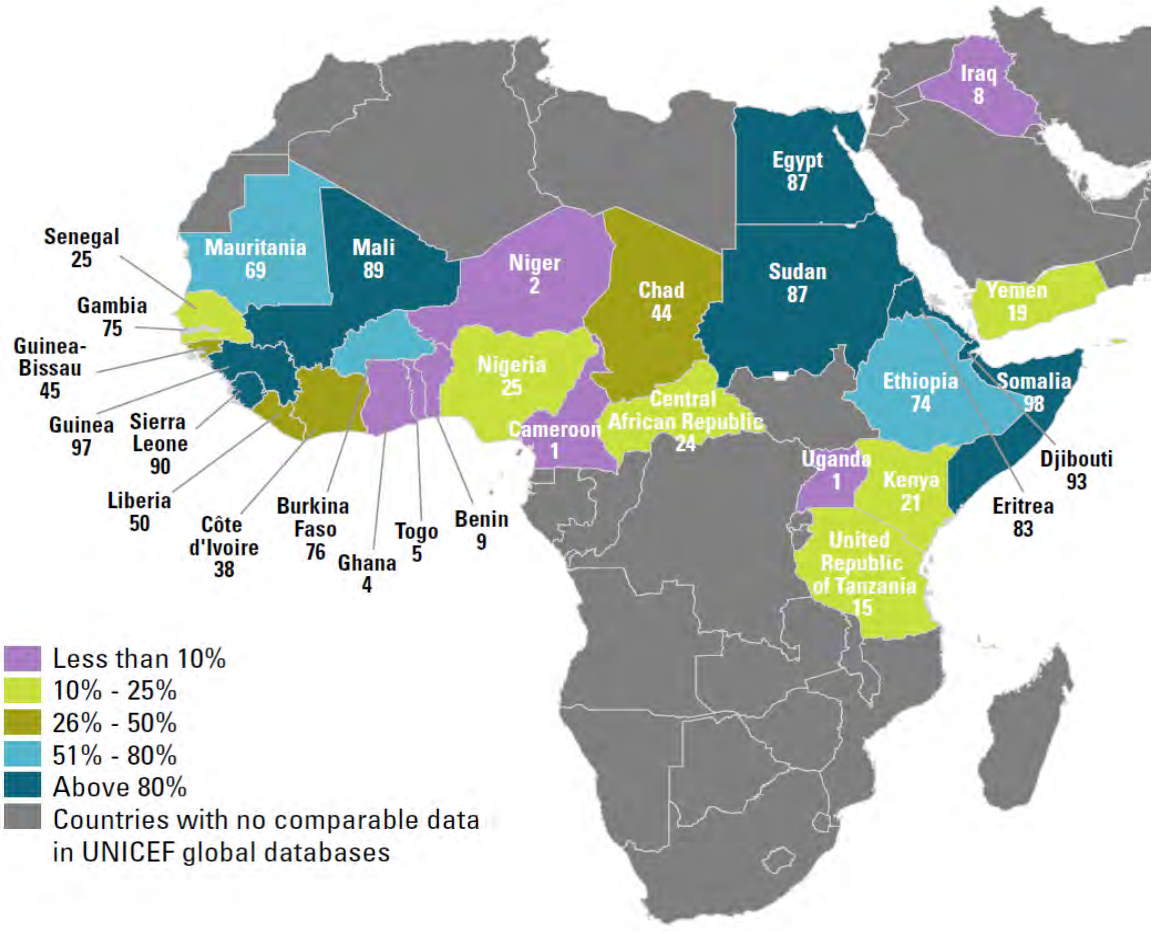

Figure 74: Prevalence of FGM among women aged 15-49 years in Africa and the Middle-East, 2004-2015 [94]

It has been estimated that, of 144,000 girls born in England and Wales to mothers from FGM practising countries between 1996 and 2010, 60,000 of these mothers had undergone FGM [95]. London has the highest prevalence of FGM in the UK at 21 per 1,000 population [96]. Data from the annual school census have revealed that approximately 3,000 girls each year in Hackney are from an ethnic group that is associated with a country that practices FGM.

In order to improve the awareness of, provision of services for, and safeguarding of girls at risk, the Department of Health introduced the FGM Prevalence Dataset in April 2014. This dataset required NHS healthcare settings to record and collect information about the prevalence of FGM within the patient population. In April 2015 the FGM Enhanced Dataset was introduced to replace the initial Prevalence Dataset, and includes 30 data items (however, only 'FGM Activity Identified' is mandatory). Homerton University Hospital has been recording FGM data in antenatal services prior to the introduction of mandatory recording. Women disclosed a history of FGM in 245 births over a six year period (2008-2014) out of approximately 36,000 births – equating to a prevalence of 0.7%. Data available from the Health and Social Care Information Centre reveal that City and Hackney CCG's rate of newly recorded FGM per 100,000 females is approximately twice the national average but, half the London average (Figure 75).

	City & Hackney CCG	London	England
Newly recorded FGM (cases)	13	758	1,385
Newly recorded FGM (rate per 100,000 females)	9.8	17.6	5.0
Pregnant at attendance (cases)	9	374	687
Pregnant at attendance (rate per 100,000 females aged 15-44)	12.4	18.6	6.5

Figure 75: Female genital mutilation experimental statistics, July-September 2015 [97]

There were 13 attendances in City and Hackney Clinical Commissioning Group (CCG) where FGM was newly identified in July-September 2015. In ten of these cases the type of FGM (type one, two, three or four) was unknown or not reported. In nine of the 13 cases the woman was pregnant, and a baby girl was born in fewer than five of these attendances[31]. Hackney Children's Social Care received 60 referrals for children being at risk of FGM over a ten month period in 2014/15, but in no cases had the girl had FGM performed.

There are no girls aged 0-15 in the City of London who were born in countries where FGM is prevalent [98].

In order to try to tackle FGM locally, a strategy has been drawn up for 2016-19 [98] which brings partners together to promote the welfare of girls and women by reducing the risk of FGM through local education and leadership and prevention initiatives, and protection and support for those who have undergone FGM.

[31] Note – numbers fewer than five are suppressed so that data are not identifiable

The Female Genital Mutilation Act (2003), as amended by the Serious Crime Act 2015, now includes a mandatory reporting duty which came into force on 31st October 2015 for health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18s to the police [93].

9.5.5.4 Parents with Substance Misuse Issues

Hackney has a higher estimated prevalence of opiate and/or crack cocaine use across all adults than nationally. While there is not an estimate for the prevalence of substance misuse in parents specifically, the rate of parents receiving drug treatment is the same in Hackney as nationally (Figure 76). It is not known whether this relatively lower rate of treatment in parents locally is due to a lower prevalence of substance misuse issues in parents, or under-treatment of parents. In 2014/15, 115 people who began treatment with substance misuse services in Hackney were living with children, accounting for 11% of all new service users.

For alcohol use, higher risk drinking across all adults is 15% more common nationally than it is in Hackney. The rate of parents receiving alcohol treatment is 39% higher nationally than in Hackney. Again it is unknown whether this relatively lower rate of treatment in parents locally is due to a lower prevalence of high risk drinking in parents, or an under-treatment of parents.

	Hackney	England
Prevalence of opiate and/or crack cocaine use per 1,000 (all adults)	14.4	8.4
Parents in drug treatment per 1,000 children aged 0-15	1.11	1.10
Prevalence of higher risk drinking per 1,000 (all adults)	194	223
Parents in alcohol treatment per 1,000 children aged 0-15	1.06	1.47

Figure 76: Rate of parents in substance misuse treatment, 2011/12 [41]

There are three main services that are relevant to parental substance misusers locally. Firstly, the new Hackney Recovery Service, which was launched in October 2015, provides free support to all Hackney residents aged over 18 as well as their families and carers and includes a parenting programme and wider work to improve relationships within families. Secondly, the Young Hackney Substance Misuse Service includes experienced treatment workers who can work with the children of parents who misuse substances. Thirdly, in September 2015 the second Hackney Real Time Family programme was delivered which provided a ten week group counselling programme for the most complex families.

9.5.5.5 Criminal Justice System

Hackney's Youth Justice work is delivered under the umbrella of Young Hackney, provided by Hackney Council. Hackney's Youth Justice Plan (2015/16) outlines four key priorities:

1. Preventing youth crime – through partnership working, early interventions to reduce gang involvement, improving health outcomes, reducing the involvement of Hackney's looked after children in the criminal justice system and improving outcomes for young Black men
2. Reducing re-offending – through partnership working, working with young people at risk of being NEET, improving the mental health of young offenders, dealing with substance misuse, working on the resettlement of young offenders, providing a seamless transition to adult services, and updating the real time tracker of young people re-offending
3. Safeguarding young people from harm – through tackling serious youth violence, dealing with substance misuse, working to reduce peer-to-peer child sexual exploitation, providing cross-agency working for missing children and improving support and protection for the victims of domestic violence
4. Protecting the public from harm – through identifying risk and managing it effectively, in particular by reducing incidents of knife crime

The proportion of 10-17 year olds who have received their first reprimand, warning or conviction in Hackney in 2014 has fallen to less than half its value in 2010 (Figure 77). Although the proportion is higher than the London and national averages this is not a statistically significant difference, and the proportion is lower than eight of Hackney's ten statistical neighbours (Appendix 15.3.4.1, Figure 211).

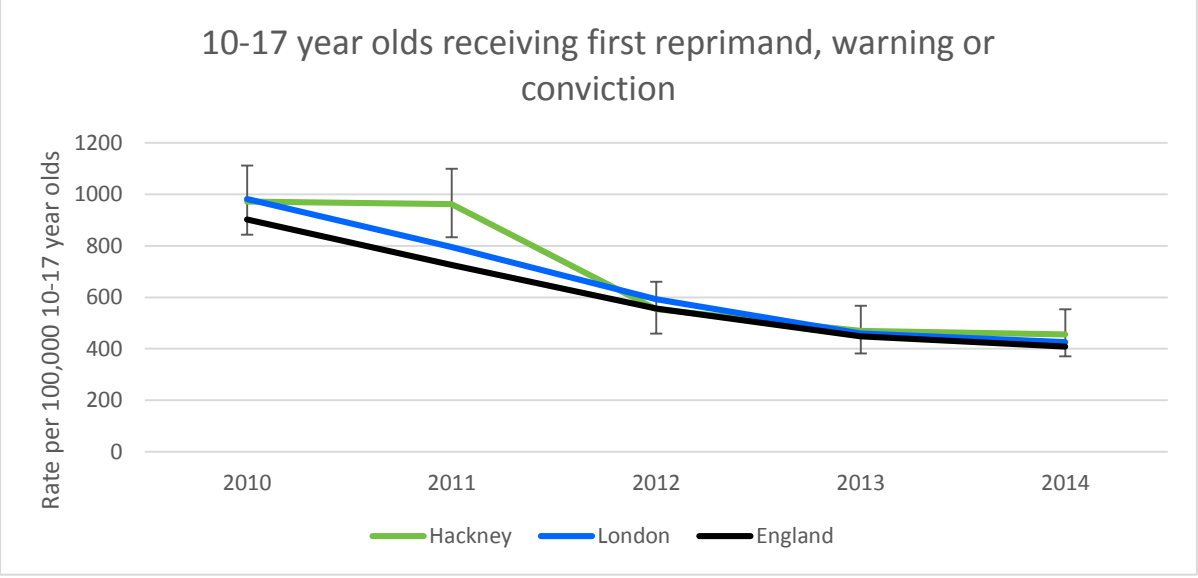

Figure 77: First entrants to the youth justice system, 2010-2014 [41]

Similarly, when considering young people who are formally in the youth justice system, Hackney's rate of 10-18 year olds being supervised by a youth offending team is falling (Figure 78). It is now lower than the London and national averages (albeit not statistically significantly) and lower than nine of Hackney's ten statistical neighbours (Appendix 15.3.4.1, Figure 212).

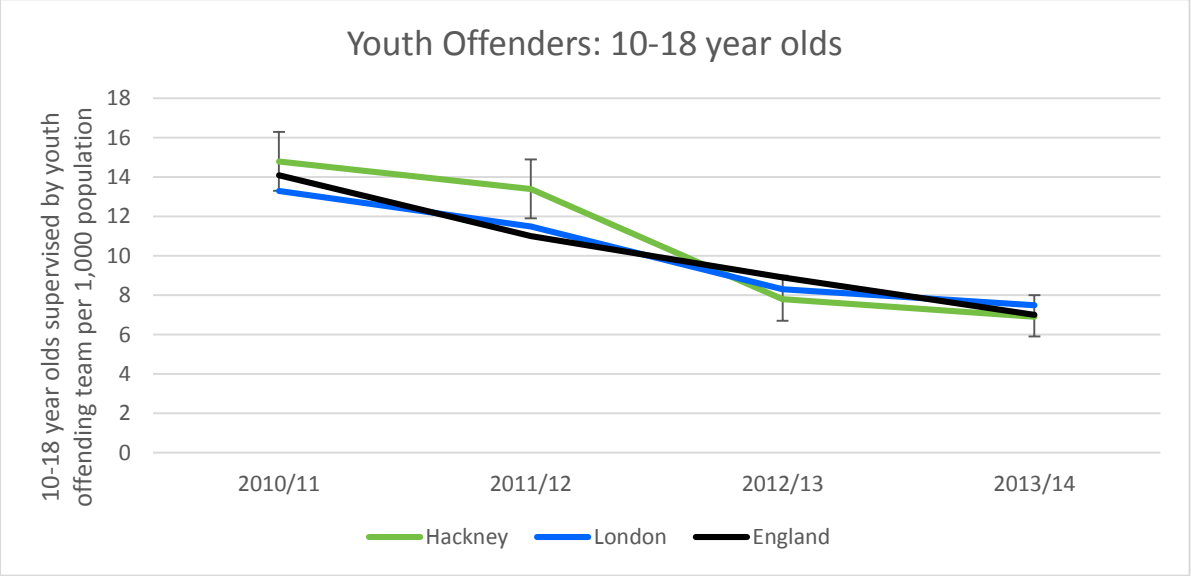

Figure 78: Proportion of 10-18 year olds supervised by youth offending team, 2010/11-2013/14 [41][32]

Hackney's Youth Justice Plan notes that, not only has the falling number of first time entrants to the youth justice system contributed to the falling number supervised by the youth offending team, the number of young people who re-offend has also substantially reduced from 157 in 2012/13 to 54 in 2014/15. The Safer Young Hackney Board is now focussing on working with those young people who do remain in the youth offending system who tend to have the most complex problems both at home, at school and in the community.

9.5.5.6 Children as Carers

A joint report on young carers entitled '*Working together to support young carers and their families*' was produced by the Association of Directors of Adult Social Services in England, the Association of Directors of Children's Services and The Children's Society in 2012 [99]. The report defined the term 'young carer' as children and young people under 18 who provide regular and ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances. Young carers provide caring responsibilities that are important and relied upon within the family in maintaining the health, safety or day to day well-being of the person receiving support or care and/or the wider family.

[32] Note – trend data are unavailable for the City of London

"A young carer becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical well-being or educational achievement and life chances."

Figure 79: 'Working together to support young carers and their families', 2012 [99]

According to census data, the number of young carers known about is rising – from 139,000 in 2001 to 166,000 in 2011 – however this is likely to be an underestimate [100]. The Longitudinal Survey of Young People in England (LSYPE) ran between 2004 and 2010 and included a question to identify young carers:

'Some people your age may have to look after other people. This could be a brother or sister, a relative or someone else who is disabled or sick. Is there anyone like this who lives here with you that you have to look after on a regular basis?'

According to the LSYPE, in comparison to their peers, young carers are 1.5 times more likely to have a special educational need or disability themselves, 1.5 times more likely to be from a black or minority ethnic (BME) community and twice as likely to not have English as their first language. Furthermore, data from the LSYPE reveal that, on average, young carers achieve the equivalent of nine grades lower overall than their peers[33] and data from the Audit Commission demonstrate that young carers are more likely to be NEET when 16-19 years of age (75% at least once, compared to 25% across all young people).

The time that young carers spend performing their caring responsibilities varies widely, with most caring for up to five hours per week (Figure 80). Around 5% of young carers report missing school, with a third of these missing school at least once per month.

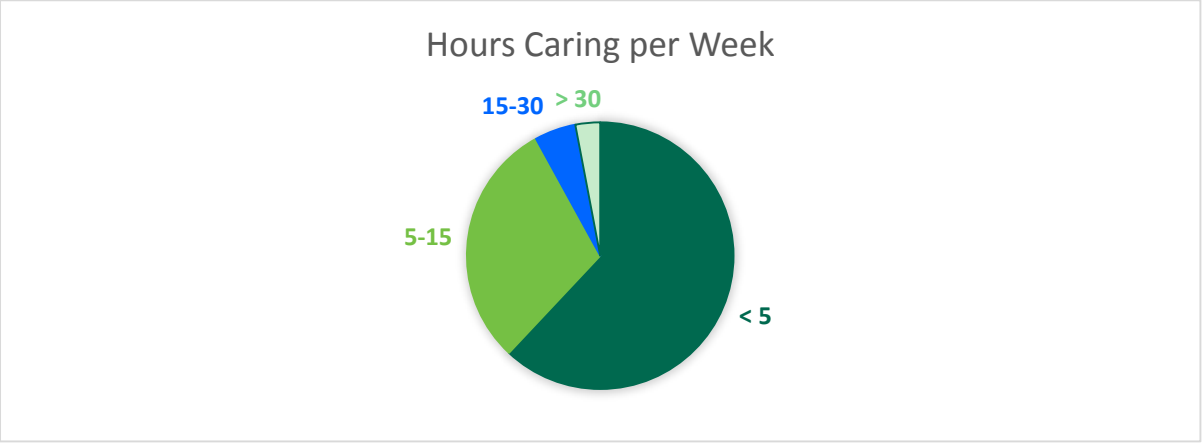

Figure 80: Hours spent caring per week by young carers nationally [100]

[33] Note – for instance receiving nine C grades rather than nine B grades

Clause 96 of the Children and Families Act [12] states that "a local authority in England must take reasonable steps to identify the extent to which there are young carers within their area who have needs for support".

	Hackney		City of London	
	Provide any unpaid care	Provide 20+ hrs of unpaid care	Provide any unpaid care	Provide 20+ hrs of unpaid care
0-15 year olds	618	130	9	<5
16-24 year olds	2,039	609	24	6

Figure 81: Number of children/young people providing unpaid care, 2011 [33]

The proportion of 0-15 year olds who provide any unpaid care is 1.2% in Hackney and 1.45% in the City of London, compared to a national average of 1.1%. Hackney's statistical neighbours fall into the range 0.9% (Hammersmith and Fulham) to 1.3% (Lewisham). The proportion of 16-24 year olds who provide any unpaid care is higher at 6.3% in Hackney and 3.4% in the City, this places Hackney second out of its ten statistical neighbours (Figure 82).

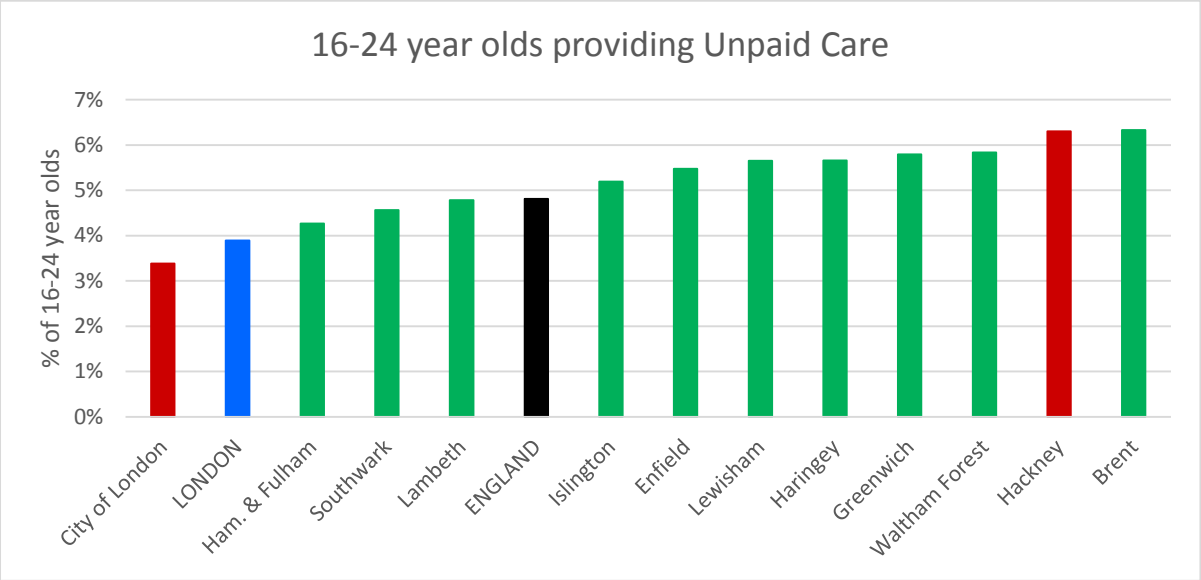

Figure 82: 16-24 year olds providing any unpaid care, 2011 [33]

When considering the provision of considerable care (over 20 hours per week), Hackney has the fourth highest rate in those under 16 compared to its ten statistical neighbours at 0.25% (Figure 83). However, this is not significantly greater than London or national averages.

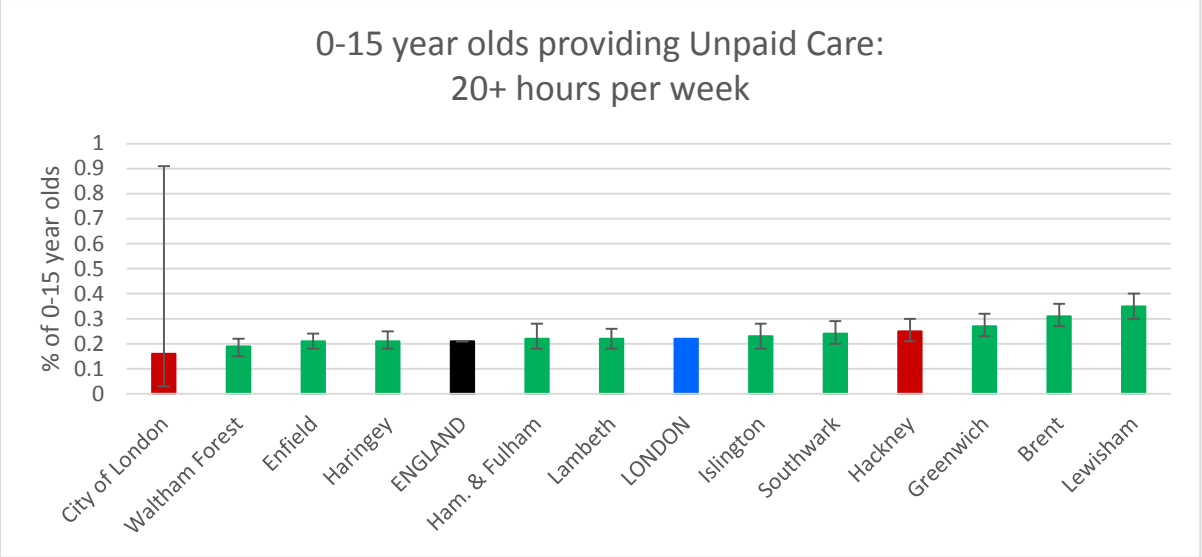

Figure 83: 0-15 year olds providing considerable unpaid care, 2011 [41]

At 15 years of age, young carers within City and Hackney CCG have been providing unpaid care for significantly fewer years than the England average (Appendix 15.3.4.1, Figure 213). This ranks City and Hackney as 204th (females) / 205th (males) out of 211 local authorities for most years of unpaid care in 15 year olds.

The Report of the Children and Young People Scrutiny Commission in Hackney [101] admitted that "there is no accurate figure for the number of young carers in Hackney and this makes it difficult to assess the true scale of the problem". The review highlighted the need to raise awareness of young carers amongst staff in all organisations (schools, healthcare providers, adult social care, children's social care and drug and alcohol services) and clarify what action should be taken when staff suspect a child is taking on caring responsibilities within a family. It also identified that "Schools need to work to raise awareness amongst pupils […] to promote better understanding amongst their peers, as well as helping young carers to self-identify themselves and realise there is support available for them and they are not alone in their situation". The report proposed an increased consideration for young carers' health needs, and suggested an annual invite for a GP health and wellbeing check for young carers.

Hackney Children and Young People's Service commissions the Hackney Young Carers Project as well as leading the Young Carers Steering Group. Hackney Young Carers Project service supports young carers aged 8-18. The services provides young carers needs assessment, personal support and guidance, individual and group support, trips and activities during school holidays, help to access specialist services and help to access universal services such as leisure and youth services. In January 2012 the project was supporting 171 young carers in Hackney.

9.6 Child Deaths

The child mortality rate (CMR) includes all children aged 1-17 and is measured using data aggregated over three years to reduce year on year variability due to the small numbers involved. The CMR in Hackney has fallen from 27 per 100,000 in 2008-2010 to 12.8 per 100,000 in 2011-13 [41]. It lies within the range of its statistical neighbours from 10.0 (Lewisham) to 17.3 (Brent) per 100,000. However, it remains above the England average of 11.9 per 100,000. The Child Death Overview Panel (CDOP) is an independent multidisciplinary panel that provides a review of all deaths of children who are under 18 and resident in Hackney or the City of London. The CDOP reviewed 34 of the 35 cases of child death in Hackney between 1st April 2014 and 31st March 2015 and found that over two-thirds (68%) were in infants (less than one year of age).

In the City of London there have been fewer than five child deaths in the last five years.

10 Key Medical Data

10.1 Primary Care

10.1.1 Registrations

In total, there were 297,085 people registered with GPs in City and Hackney CCG as at November 2015. As the ONS mid-2014 population estimate (the most recently available) for the population of Hackney and the City of London is 271,222 this is equivalent to more than 100% of the resident population being registered with a GP in City and Hackney (110%). This result holds true for each of the five-year age bands by gender between birth and 24 years of age – varying between 101% and 114%. This is largely linked to the high levels of population moving into and out of Hackney and the City as some people remain on a local GP register after having moved out of the area for a period of time. However, at the same time it is estimated that approximately 4-5% of Hackney's residents are not registered with a GP [102].

10.1.2 Patient Attendance

Each child and young person has, on average, 1.6 appointments with a GP per year (Figure 84). As a comparator, it has been quoted that school children visit the GP between two and three times a year [103] and therefore, on average, children and young people visit primary care less often in Hackney than nationally. It should be remembered that the average GP consultation costs £43 [104].

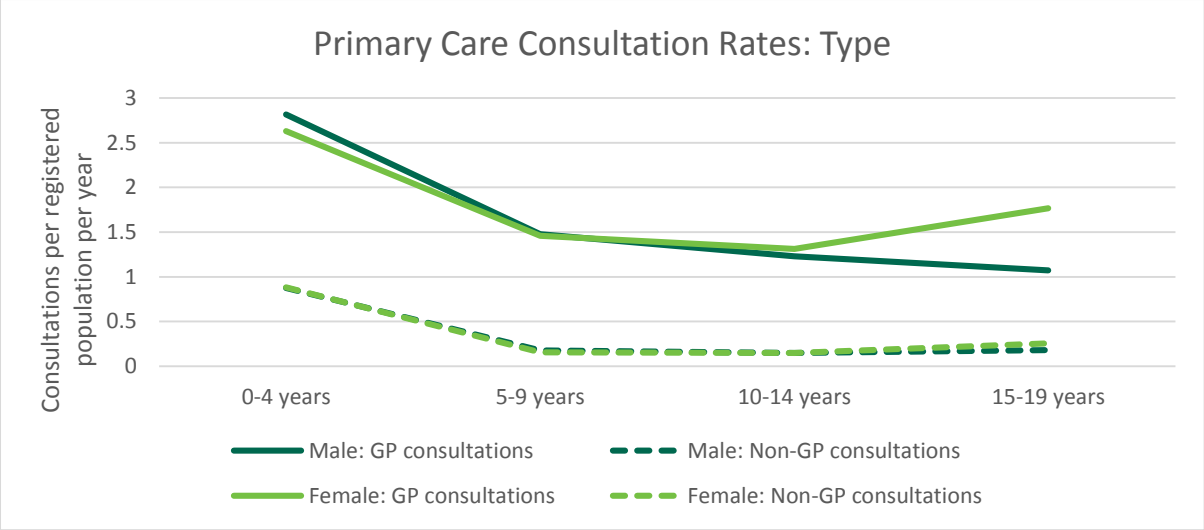

Figure 84: Rates of primary care consultations by age group, gender and type of consultation, Dec 2014-Dec 2015 [105]

Figure 85 shows that most ethnicities have the highest rate of consultation in 5-9 and 15-19 year olds. However, 15-19 year olds dominate for the British or Mixed British group, whereas the rate decreases with increasing age in the Asian group. Overall, Asian children and young people have the highest rate of GP consultations in City & Hackney.

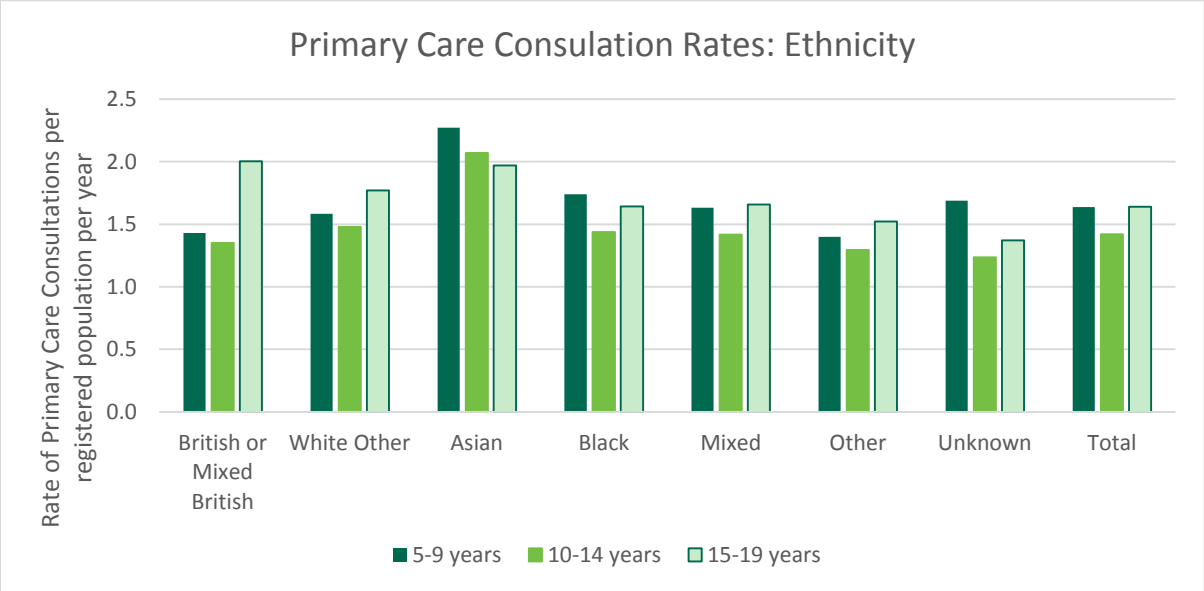

Figure 85: Rates of primary care consultations by age group and ethnicity, Dec 2014-Dec 2015 [105]

Comparing the overall rate of primary care consultations in children and young people by GP practice reveals a spread of results (Figure 86). The Dalston Practice has been excluded as the results are unreliable[34], as has the Greenhouse Health Centre as there are fewer than ten patients aged 19 or under which is not a sufficient size for comparison.

[34] Note – the Dalston Practice has switched from a different information system to EMIS during this period and it is likely that compatibility issues have affected the recording of consultations prior to the system change

The practice with the highest rates (indicated by purple) is the Latimer Health Centre, with an average of 2.6 appointments per year in 5-9 year olds, 2.1 in 10-14 year olds and 2.4 in 15-19 year olds. The lowest rates belong to Hoxton Surgery (indicated by orange) with an average of 1.1 appointments per year in 5-9 year olds, 0.9 appointments in 10-14 year olds and 1.0 appointments in 15-19 year olds. Therefore, there is a greater than two-fold difference in primary care consultation rates when comparing the furthest outlying practices. However, examining the distribution further does not reveal a clear geographical pattern to explain this variation. A full list of GP practices and their attendance rates is included in Appendix 15.4.1, Figure 214.

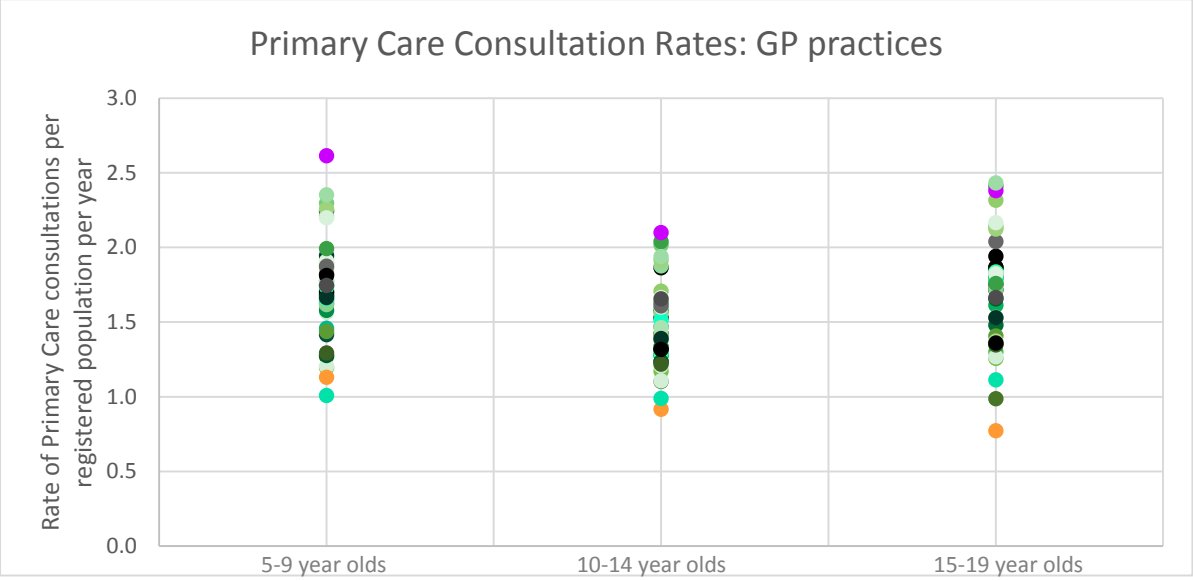

Figure 86: Rates of primary care consultations by age group and GP practices, Dec 2014-Dec 2015 [105]

10.2 Secondary Care

Nationally, those aged under 25 have been shown to use community pharmacists the least when seeking medical advice [106]. Children, young people and young adults are most likely to present to accident and emergency (A&E) departments for self-treatable conditions (STC) [107]. In total, over one quarter of all emergency presentations for those aged 6-20 are for STC – this peaks in those aged 11 to 15 where one third of presentations are for STC. The most common STC in A&E department presentations for young people is sprains – constituting 40% of STCs in those aged 6-20, and 65% of STCs in those aged 11-15. This poses a significant financial burden on the NHS – with the average A&E department presentation costing £112 [104].

Figure 87 shows that the rate of hospital admissions in children and young people for unintentional and deliberate injuries is significantly lower in City and Hackney than the national average. Furthermore, the emergency admission rate for lower respiratory tract infections in City and Hackney is less than a quarter of the national rate. In line with the national picture, the rate of emergency admissions for lower respiratory tract infections is lower in girls (72.9 per 100,000) than boys (87.6 per 100,000).

	Hackney and City of London	London	England
Hospital admission rate per 10,000 0-14 year olds for unintentional and deliberate injuries 2013/14	97.1	86.8	112.2
Hospital admission rate per 10,000 15-24 year olds for unintentional and deliberate injuries 2013/14	101.1	101.5	136.7
Emergency admission rate per 100,000 children with lower respiratory tract infections 2013/14	80.4	-	372.9

Figure 87: Secondary care, 2013/14 [41]

10.3 Long Term Conditions

Using data from the GP database, 6% of 5-19 year olds in Hackney and the City of London (3,113 people) are registered to have a long term condition. The full list of conditions included under the term "long term conditions" is included in Appendix 15.4.2, but the most relevant to 5-19 year olds are active asthma, depression, diabetes, epilepsy and learning disability and these are discussed in more detail below. In comparison, the 2014 Health Behaviour in School-aged Children survey for England found that 23% of young people (aged 11, 13 and 15 years) reported having a long term condition that had been diagnosed by a doctor [108]. The prevalence of having a long term condition in City and Hackney is higher in boys at younger age groups but becomes similar across genders by 20-24 years of age (Figure 88).

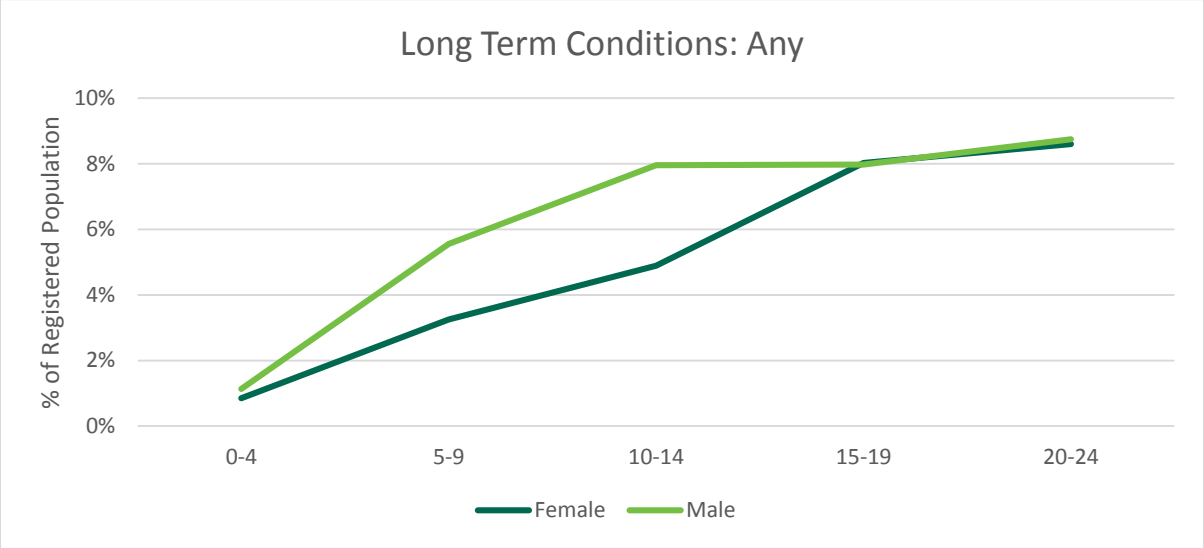

Figure 88: Percentage of population with any long term condition, City & Hackney CCG, April 2015

The number of 5-19 year olds in Hackney and the City of London who have more than one long term condition is 121, equating to 0.24% of the population.

In line with Hackney's rate of emergency attendances, the rate of unplanned hospital admissions for the main long term conditions (asthma, diabetes and epilepsy) in City and Hackney is less than a quarter of the national rate (Figure 89). The rate in girls in City and Hackney is almost half that in boys.

	Hackney and City of London	London	England
Total rate	70	-	311
- Boys	90	-	343
- Girls	50	-	278

Figure 89: Unplanned hospitalisation rate per 100,000 under 19s for asthma, diabetes and epilepsy, 2013/14 [41]

Data from the Department of Work and Pensions reveal that the age profile of disability living allowance claimants in Hackney is similar to the London and national profiles (Appendix 15.4.2, Figure 215) – therefore there can be some confidence that national estimates of disability can be scaled to Hackney figures.

From national estimates of the prevalence of disability in children by the Office for National Statistics (ONS) based on the General Household Survey and the Family Fund Trust register of applicants, the estimated numbers of children in Hackney with longstanding illness or disability are demonstrated in Figure 90. When considering those with severe disability, applying the same estimation techniques gives an estimated number of 32 affected boys and 16 affected girls aged between 0-19 in Hackney. Such estimations of severe disability are not appropriate for the City of London given the small numbers involved.

	Hackney	City of London
Boys 0-19	5909	77
Girls 0-19	5017	66

Figure 90: ONS estimations of childhood disability, 2011 [109]

10.3.1 Asthma & Respiratory Conditions

2,334 City and Hackney 5-19 year olds have a GP record of active asthma – a rate of 459 per 10,000. When considering all ages the rate of active asthma is higher in women (539 per 10,000) than men (437 per 10,000); however, in the 5-19 age group the rate of asthma is higher in boys (541 per 10,000) than girls (376 per 10,000). Nationally, across children and young people the prevalence of current asthma has been estimated at 1,100 per 10,000 in boys and 800 per 10,000 in girls [110] and therefore Hackney's rates show the same gender balance, but are lower overall. This is perhaps surprising, as the mortality attributable to particulate air pollution is high in City and Hackney (Figure 53). The rate in City and Hackney peaks in 10-14 year old boys at 645 per 10,000 (Figure 91).

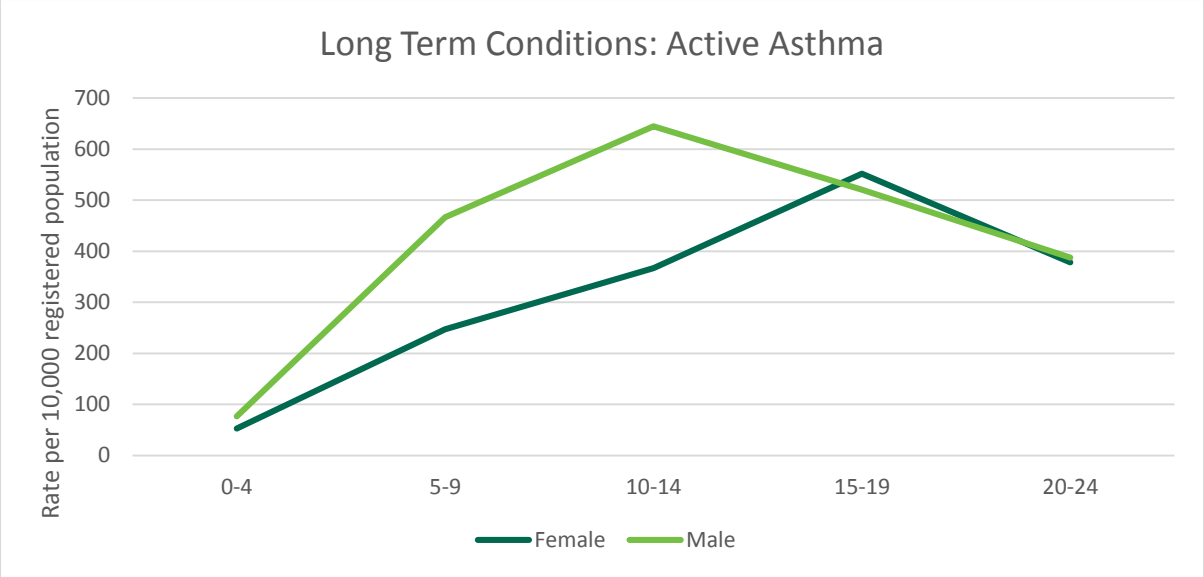

Figure 91: Active asthma per 10,000 population, City & Hackney CCG, April 2015

10.3.2 Learning Disability

213 City and Hackney 5-19 year olds have a GP record of learning disability – a rate of 41.9 per 10,000. Learning disabilities are more prevalent in men than women across all age groups (46.4 compared to 30.4 per 10,000) and this difference is more pronounced in the 5-19 age group (58.3 versus 25.1 per 10,000). Figure 92 shows that the prevalence peaks in young men aged 15-19 at a rate of 110 per 10,000).

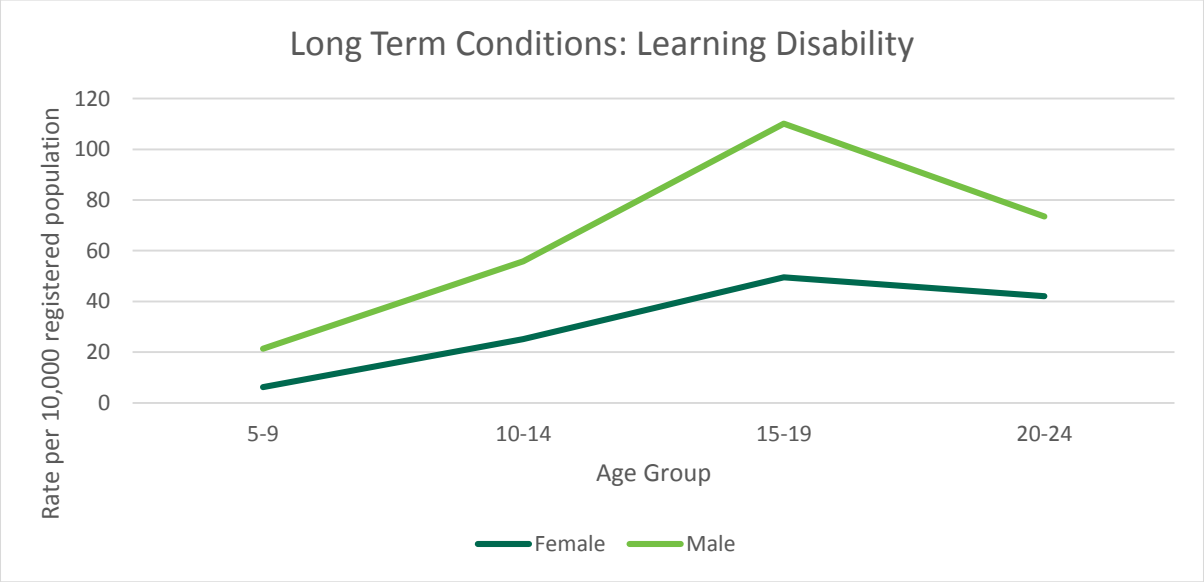

Figure 92: Learning disabilities per 10,000 population, City & Hackney CCG, April 2015

Stakeholders consulted for the 2014 City and Hackney Mental Health Needs Assessment suggested that the increase in children with mild learning impairments coming into contact with the police may indicate that mild learning disabilities are being under-diagnosed [111].

10.3.3 Epilepsy

140 City and Hackney 5-19 year olds have a GP record of epilepsy – a rate of 27.5 per 10,000. However, the prevalence of epilepsy in under 19s in the UK is estimated as 45.4 per 10,000 by the Joint Epilepsy Council [112]. The profile of epilepsy prevalence in children and young people in City and Hackney follows that of learning disabilities, albeit at lower rates, as the condition is more common in boys – in whom it peaks in 15-19 year olds (Figure 93).

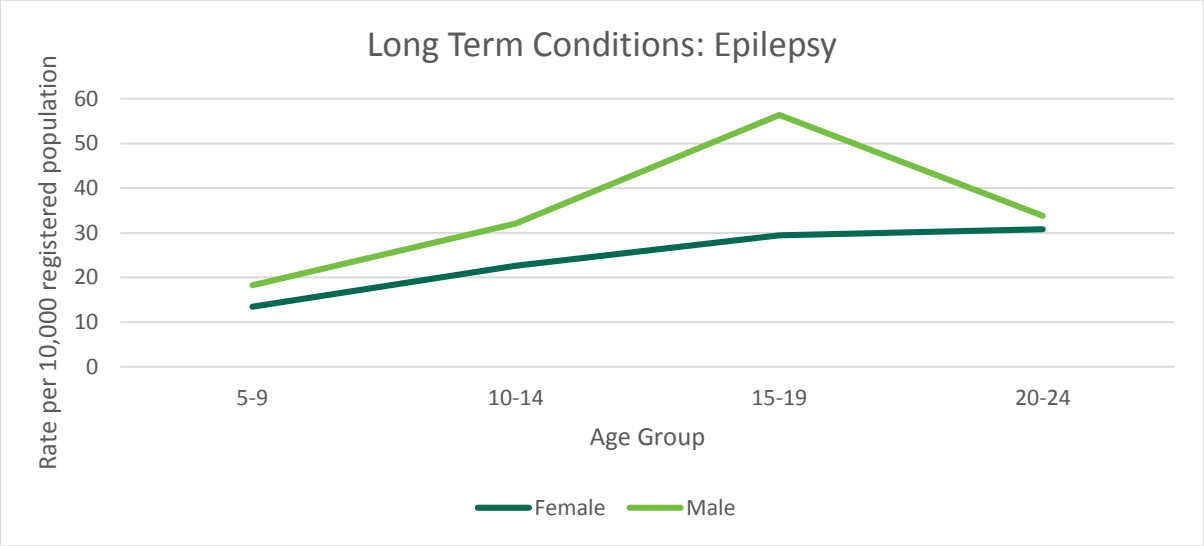

Figure 93: Epilepsy per 10,000 population, City & Hackney CCG, April 2015

10.3.4 Diabetes

101 City and Hackney 5-19 year olds have a GP record of diabetes – a rate of 19.9 per 10,000. This is similar to the UK rate of 25.1 per 10,000 [113]. Diabetes is slightly more prevalent in males than females both across all age groups (464 compared to 424 per 10,000) and in the 5-19 age group specifically (21.0 versus 18.7 per 10,000).

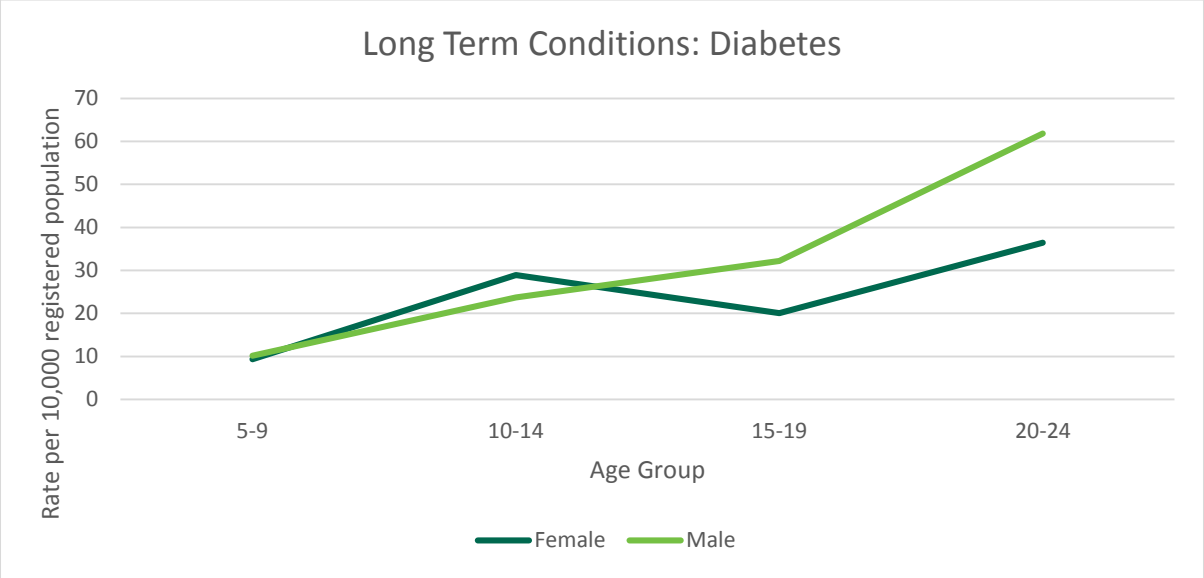

Figure 94: Diabetes per 10,000 population, City & Hackney CCG, April 2015

Across the whole population, separate aetiologies are at play with the majority of diabetes affecting 5-19 year olds being type 1, but the majority of diabetes affecting the whole population being type 2. Figure 95 shows that when the prevalence of diabetes is plotted across all age groups there is a bimodal distribution in that there appears to be a peak in the 10-24 age group (corresponding to type 1 diabetes) superimposed on an exponential rise until 80 years of age (corresponding to type 2 diabetes)[35].

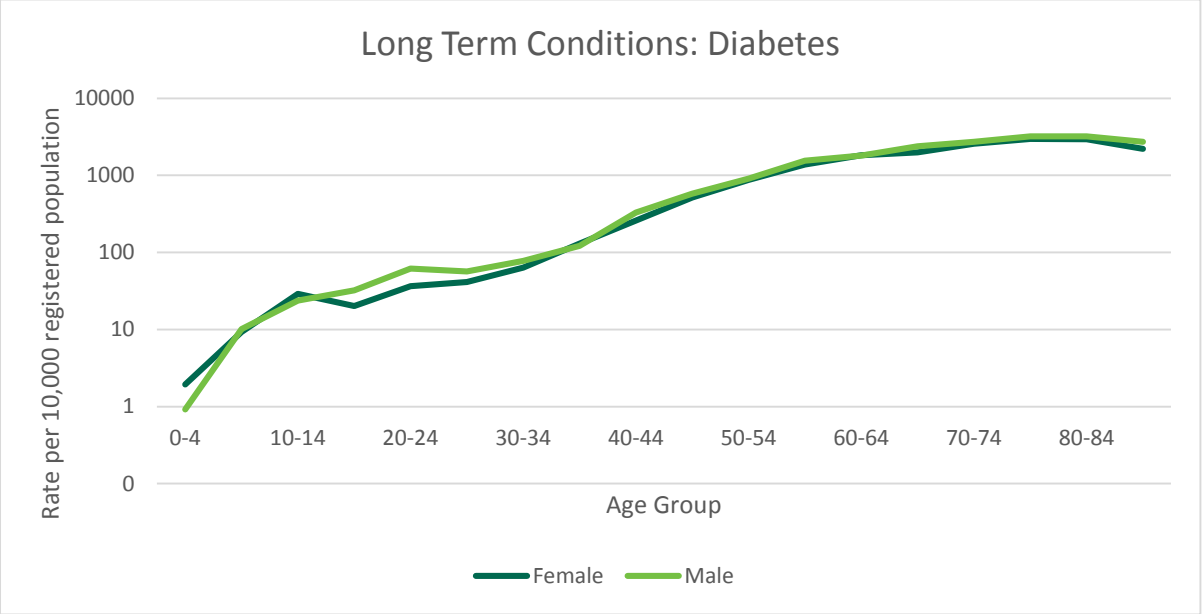

Figure 95: Rate of diabetes per 10,000 population [plotted on logarithmic scale], City & Hackney CCG, April 2015

10.4 Infectious Diseases

10.4.1 Immunisations

Previously, local GPs have been commissioned by NHS England to deliver all immunisations. The transfer of commissioning responsibility for 0-5 Public Health services to the local authority has not included the responsibility for, nor funding of, immunisations which have remained the responsibility of NHS England. Responsibility for the delivery of immunisations has remained with local GPs. Hackney local authority is working with partners to ensure there is no adverse impact on families and children during and after the transition.

When	Diseases protected against	Vaccine given
2, 3 and 4 year olds and in school years 1 and 2	Influenza	Fluenz Tetra (nasal spray)
Girls 12 - 13 years old	Human papillomavirus (HPV) 16 & 18 (cervical cancer) and 6 & 11 (genital warts)	Gardasil
Around 14 years old	Tetanus, diphtheria and polio	Revaxis (Td/IPV) and check MMR
	Meningococci C and W	Nimenrix or Menveo (MenACWY)

Figure 96: Vaccines for the routine immunisation schedule for 5-19 year olds from summer 2015 [114]

[35] Note – plotted logarithmically given the far higher prevalence of type 2 diabetes than type 1 diabetes

In 2012 the Joint Committee on Vaccination and Immunisation recommended that the influenza (flu) vaccination programme should cover all children aged between two and 17 years. The childhood flu vaccination programme is being extended in a phased manner – 2015/16 saw the programme being offered to all two, three and four year olds as well as children in school years one and two for the first time. Data for the school provision of the Fluenz vaccine are presented in Figure 97. However, data for the uptake of Fluenz in pre-school children covering the whole winter period have not yet been published.

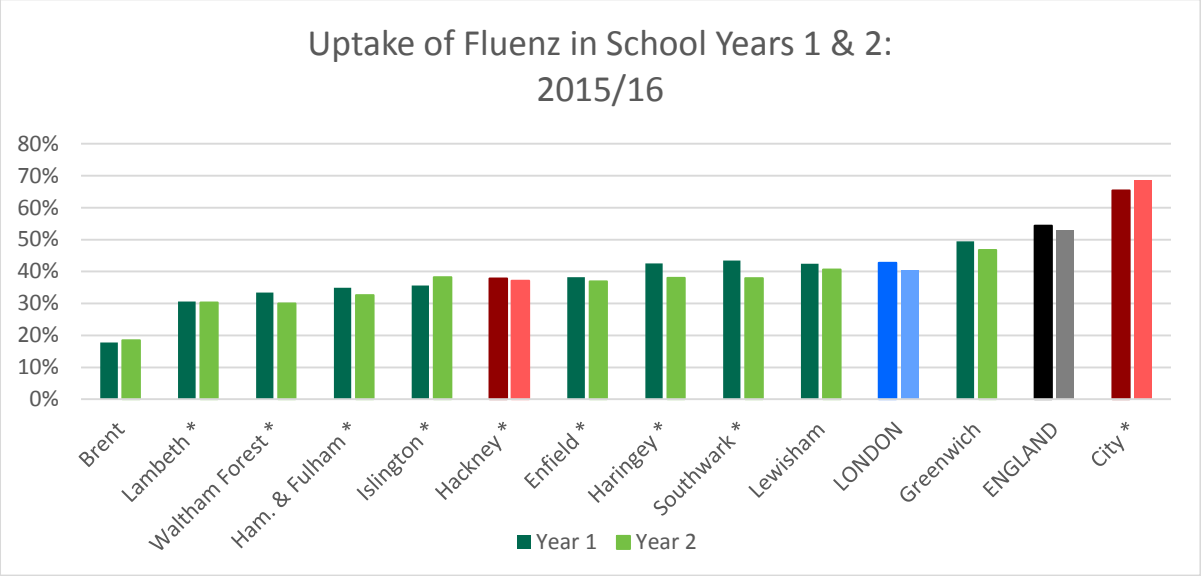

Figure 97: Proportion of eligible children receiving at least one dose of Fluenz, 1st Sep 2015 - 31st Jan 2016[36] [115]

On average, Hackney had a 37% coverage of Fluenz across school years one and two – which was higher than five and lower than five of Hackney's statistical neighbours. The City achieved a coverage of 67%, higher than the London and England averages; however, it should be noted that there were only 52 eligible children in year one and 52 in year two.

Human papillomavirus (HPV) vaccination was introduced for girls into the UK schedule in 2008 – initially with Cervarix and later being replaced by Gardasil due to its added protection against some genital warts. While the uptake of all three doses by 12-13 years of age has increased each year in Hackney from 56.4% in 2010/11 (Appendix 15.4.3, Figure 216), at 68.2% uptake still remains significantly below the London and national averages and lower than all ten of Hackney's statistical neighbours (Figure 98). Trend data are not available for the City of London; however the most recent value of 85.4% in 2013/14 is an increase on the only previous datum of 63.3% in 2009/2010. It has been suggested that the low rate in Hackney may be linked to the high proportion of faith schools locally, as internationally there have been links between religious education and low uptake of the vaccine due to concerns that it will promote sexual promiscuity [116].

[36] Note – local authorities marked by a * only provided coverage data for vaccinations provided through schools and children who may have received a vaccine through GPs or other settings were excluded

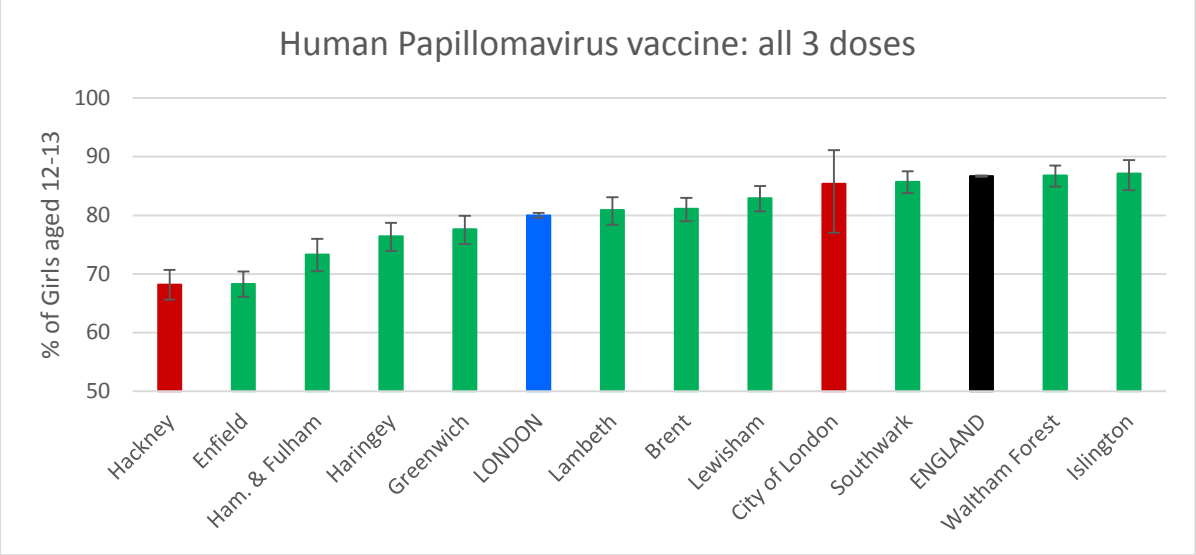

Figure 98: Uptake of all three doses of HPV vaccine by 12-13 years of age, 2013/14 [41]

The uptake for the first dose of HPV vaccine was 85% for Hackney and the City during the 2014-15 academic year [117]. Results reported by school varied between approximately 55% (Tayyibah Girls' School) and 93% (Cardinal Pole Catholic School). The uptake was reported as 98% for children being home-schooled. At every school the uptake of the second dose was lower than the first dose, by between 1% and 18% of the whole cohort.

The MenACWY vaccine in the routine schedule was newly introduced for the 2015-16 academic year. For the Men C booster used previously, the uptake varied between 35% (Upper Regents College) and 88% (Stormont House School) in Hackney in 2014-15 [117]. The uptake of the Td/IPV booster was similar to the uptake of Men C in all local schools (within 5%). Again, home-schooled children had the highest uptake of the vaccine at approximately 97% for both the MenC and Td/IPV vaccines. In England, the coverage of these booster immunisations is not routinely measured. However, PHE estimated that coverage of the teenage Td/IPV booster is around 70%. The uptake in Scotland in 2013/14 was 82% [118].

Some advice regarding immunisations is outlined in the HCP and shown below in Figure 99.

Immunisations should be offered to all children and young people in accordance with the routine immunisation schedule. Local planning should aim to target excluded or vulnerable families
BCG
The universal BCG vaccination programme delivered through schools was replaced in 2005 with an improved programme of targeted vaccination for those individuals who are at greatest risk
Hepatitis B
Children and young people at increased risk of contracting hepatitis B should be immunised – including those who live with someone infected with hepatitis B, those who regularly receive blood transfusions and those who travel to countries where hepatitis B is common
Influenza
Children and young people who are more likely to develop complications should be immunised with the seasonal influenza vaccine. These include those with chronic lung diseases, diabetes, a suppressed immune system, or serious liver/heart/kidney disease

Figure 99: Information relating to immunisations in the Healthy Child Programme [20]

10.4.2 Outbreaks

Hackney saw 11 outbreaks and the City of London four in 2015 – as outlined in Figure 100.[37]

Outbreak	Community	Food outlet	Workplace	Nursery	School	Hospital
Bordetella spp	1 H					
Corynebacterium spp	1 H					
Food poisoning		1 H + 2 C	1 C	1 H		1 C
Norovirus		1 H			1 H	2 H
Shigella spp	1 H					
Varicella-zoster virus				2 H		

Figure 100: North East North Central London Health Protection Team data for Hackney and the City in 2015
H = Outbreak(s) in Hackney; C = Outbreak(s) in the City of London

Hackney and the City of London have been affected by three measles outbreaks in the past ten years. In 2006 there were 739 confirmed cases of measles in England & Wales of which 271 were in London. The outbreak at that time was prominent in the Traveller community. Following this Hackney and the City of London introduced targeted interventions in the Traveller community to try to minimise the risk of future outbreaks. In 2007 Hackney and the City of London suffered another serious outbreak of measles with 336 cases. That outbreak was prominent in pre-school and primary school children in Charedi areas.

2012 saw almost 2,000 measles cases in England which was a record annual high. Nationally, this was attributed to unprotected 10-16 year olds who had not been vaccinated in the late 1990s and early 2000s following concern around the now discredited link between autism and the measles, mumps and rubella (MMR) vaccination. Of the 139 cases in London, Hackney saw by far the greatest number of confirmed cases at 45, equating to a local rate of 18.2 per 100,000 (the London average was 1.69 per 100,000) [119] – and of note the Charedi community were again affected [120]. In comparison, the second most affected local authority was Barnet with 14 confirmed cases at a rate of 3.92 per 100,000.

Discussions have been held with the Charedi community to further explore any population-specific barriers to immunisation. It was made clear that parents did not hold religious or cultural objections to the MMR vaccine, as had been previously suggested, but some parents had made a personal choice not to immunise or to delay immunisation and there were problems around access to services (for instance logistics with large families) and the provision of consistent, culturally-appropriate information. The critical importance of using all opportunities to capture the details and healthcare requirements of new arrivals to the Borough was recognised during the review of the outbreak [121].

Figure 101 demonstrates that Hackney has increased the population vaccination coverage of MMR from just below 40% in 2008 to above 80% in 2013 – surpassing the London average. However, this remains below the 95% coverage required to achieve herd immunity.

[37] Note – sexually transmitted infectious diseases are discussed in Chapter 11.1.2.4

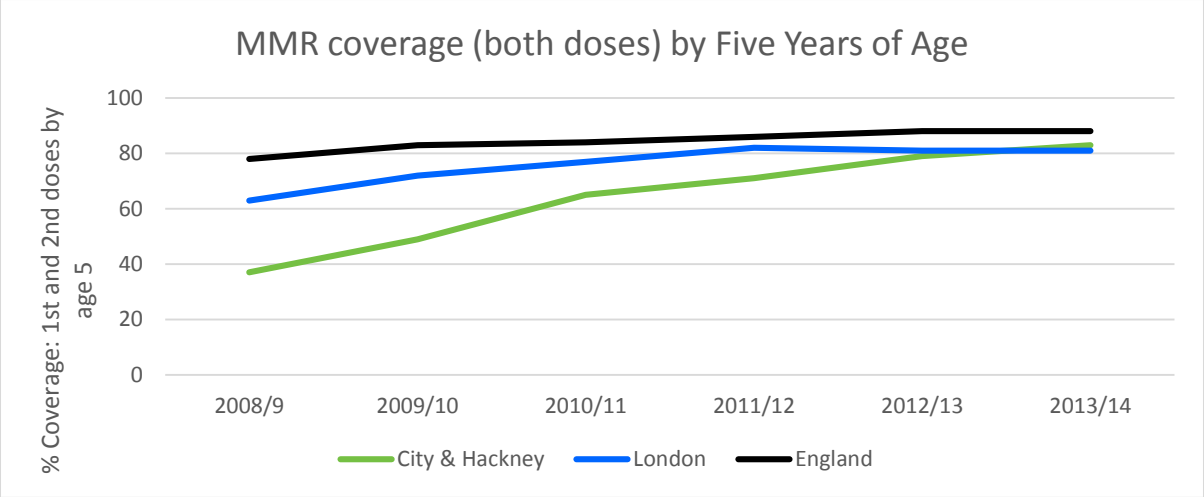

Figure 101: MMR coverage by five years of age, 2008/09-2013/14 [122]

10.5 Screening

The three main areas of screening outlined in the HCP are outlined in Figure 102. Of these, height and weight are discussed in Chapter 11.5.2.1 on obesity, and chlamydia screening in Chapter 11.1.2.4 on sexual health.

Vision and Hearing
• At or around the time of primary school entry every child should have a vision and hearing test performed. Colour vision screening should not be done • There is no evidence for or against a further universal vision test when starting secondary school but opinion suggests that this should be undertaken in schools with very high levels of deprivation
Height and Weight
• Height and weight should be measured and plotted on a chart to identify children with growth disorders which can also be used as part of the NCMP
Chlamydia
• Men and women aged under 25 years who have ever been sexually active are offered, or may request, a chlamydia screen under the National Chlamydia Screening Programme

Figure 102: Information relating to screening in the Healthy Child Programme [20]

10.6 Recommendations

- Examine the types of presenting complaint that constitute the high rates of primary care consultations in Asian 5-9 year olds and White British 15-19 year olds
- Liaise with the Latimer Health Centre and Hoxton Surgery to try to understand why consultation rates with young people are high and low, respectively
- Ensure promotion and reassurance around the HPV vaccination is provided in a culturally-sensitive manner

11 Key Priorities

11.1 Sexual Health

*"Sexual health is a state of **physical, emotional, mental and social well-being in relation to sexuality**; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."*

Figure 103: WHO working definition of sexual health, 2006 [196]

11.1.1 Introduction

The British National Survey of Sexual Attitudes and Lifestyles (Natsal) has been conducted three times – Natsal-1 in 1990-1991, Natsal-2 in 1999-2001 and Natsal-3 in 2010-2012. The Natsal is one of the largest studies of sexual behaviour undertaken in a single country in the world, with Natsal-3 involving over 15,000 adults aged 16-74.

The self-reported attendance at a sexual health clinic[38] over the previous five years has risen significantly for women and for men between each successive survey for each of the three age groups analysed (16-24, 25-34 and 35-44). This effect has been most pronounced for the 16-24 age group, where a three- to four-fold increase has been observed between Natsal-2 and Natsal-3 (Figure 104) [123].

[38] Note – question wording has changed from *"Have you ever attended a sexually transmitted disease (STD) clinic or special (VD) clinic?"* to *"Have you ever attended a sexual health clinic (GUM clinic)?"* for Natsal-3

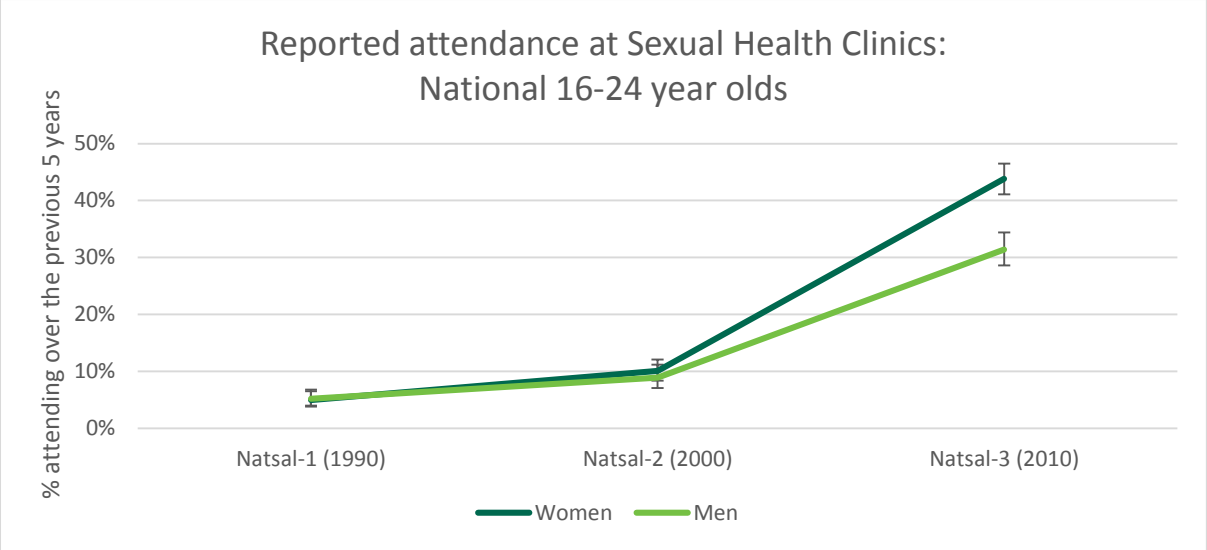

Figure 104: Self-reported attendance at sexual health clinics in 16-24 year olds [123]

11.1.2 Hackney and City of London

11.1.2.1 Sexual Attitudes

The Natsal-3 enquired about self-appraised sexual function [124]. Of those who had ever had sex, 16-24 year olds were more likely to be distressed or worried about their sex life if they were currently sexually inactive, with this effect being larger in men than in women[39] (Appendix 15.5.1.1, Figure 217).

Respondents were more likely to have sought help or advice about their sex life in the past year if they were aged 16-24 rather than in an older age group. Of 16-24 year olds, women were more likely to have sought help or advice (Figure 105).

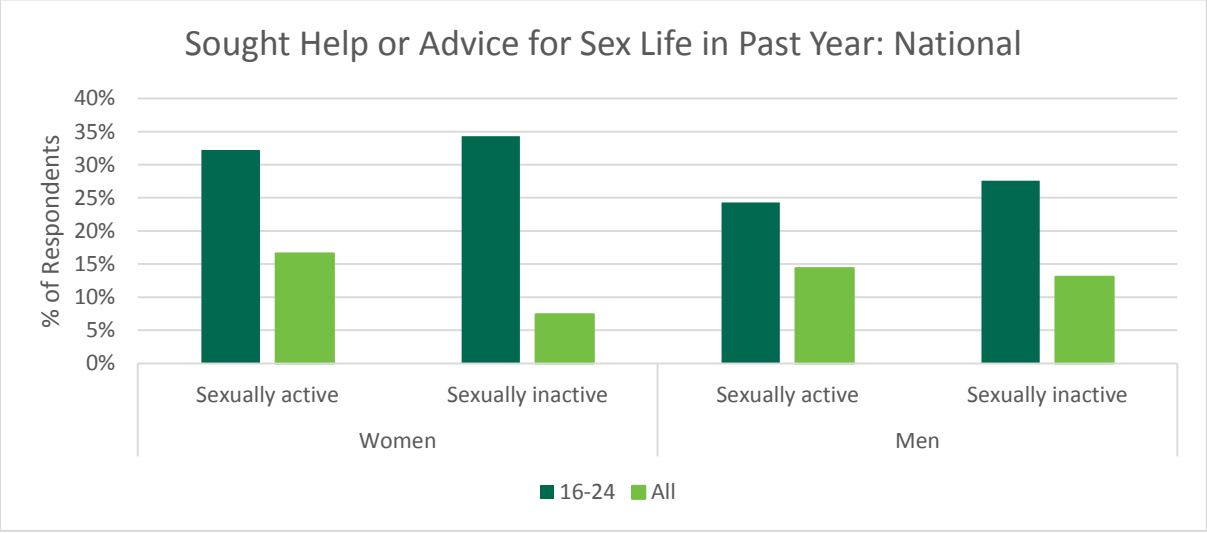

Figure 105: Sex life self-appraisal by age, gender and whether sexually active, 2013 [124]

[39] Note – sexually active participants are regarded as individuals who reported at least one sexual partner (opposite sex or same sex) in the past year

11.1.2.2 Contraception

Contraception is one of the mainstays of sexual health provision. Methods of contraception can be classified into five types – barrier, short acting, intermediate acting, long acting reversible contraception (LARC) and permanent (sterilisation)[40]. These five types can be categorised into either user dependent (barrier, short acting and some intermediate acting) or user independent (some intermediate acting, LARC and sterilisation).

The two most commonly prescribed types of contraception from sexual and reproductive health (SRH) services in under-25s in Hackney are oral contraception and male condoms (Figure 106). However, it should be noted that this does not necessarily reflect the number of individuals using each type of contraception as they have different lengths of action – for instance, one prescription for a LARC may last three to five years, whereas oral contraception must be collected more frequently, and condoms more frequently still.

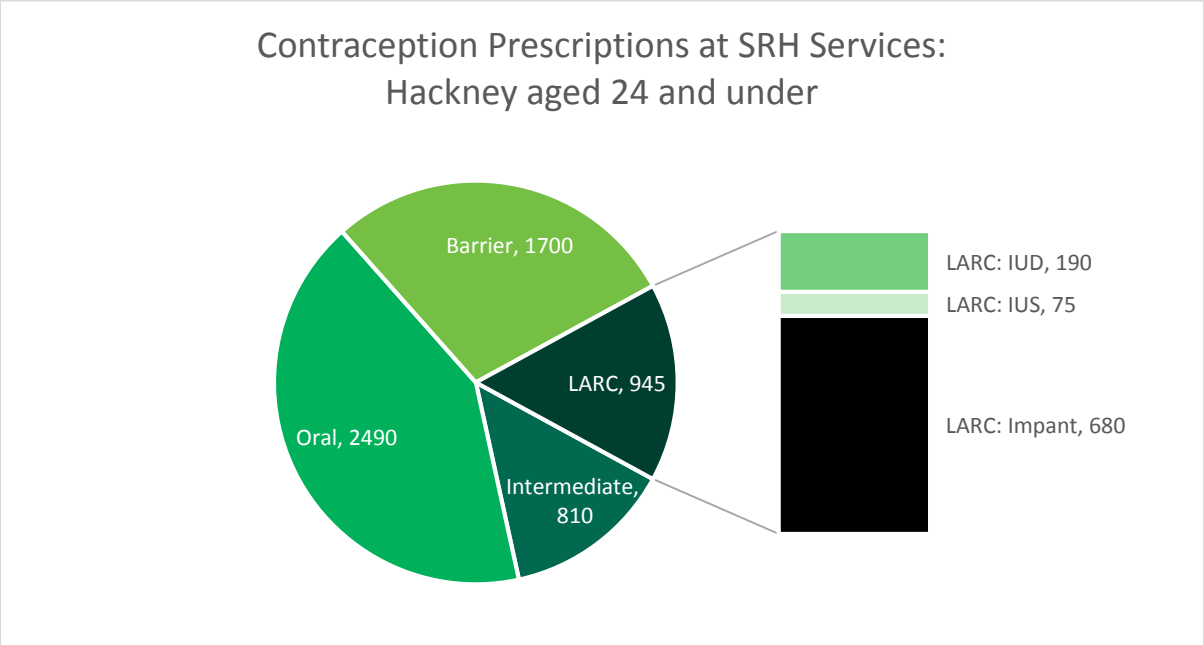

Figure 106: Contraception prescriptions at SRH Services in those aged 24 and under, 2014 [125]

Across all ages, SRH services provide one third of contraception prescriptions in Hackney, with two thirds being provided by primary care. However, SRH services prescribe LARC more frequently (26% of prescriptions) than GPs (8% of prescriptions) (Figure 107).

Contraceptive	SRH Services	General Practice
User Dependent	11,190	32,783
User Independent	4,590	3,065
Emergency Contraception[41]	1,570	1,035

Figure 107: Contraception type by source across all age groups, 2014 [125]

[40] Note – sterilisation will not be discussed further as it would very rarely be performed in young people
[41] Note – emergency contraception includes oral and IUD methods but does not include over the counter purchases

The number of contraception prescriptions increases with age in Hackney residents under the age of 25, with the take-off being most marked with oral contraceptives (Figure 108).

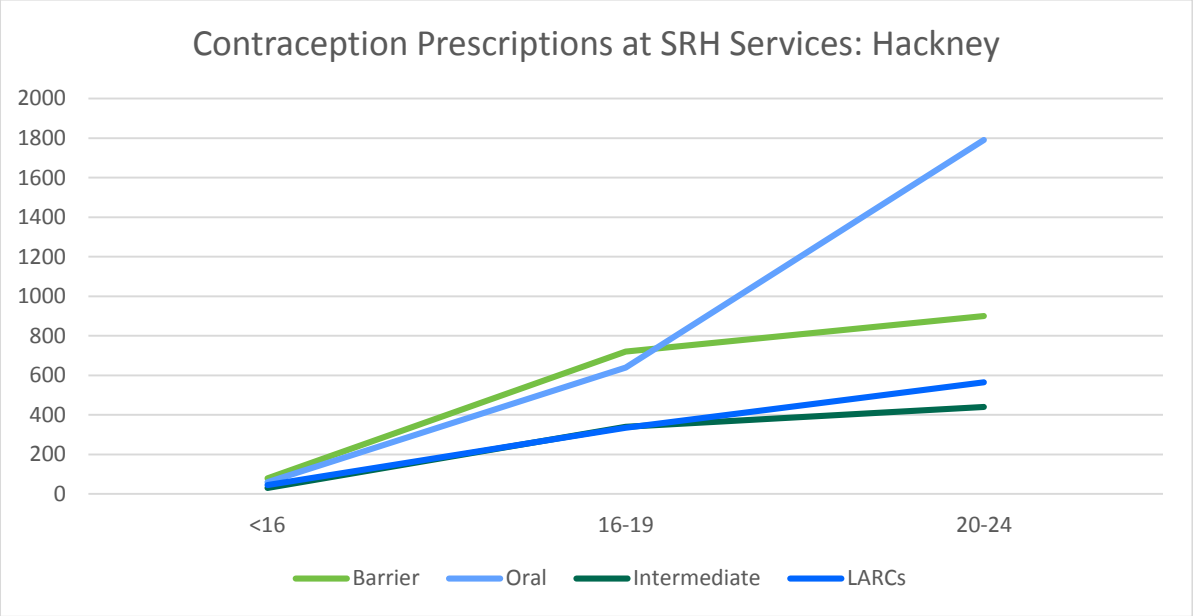

Figure 108: Contraception prescriptions at SRH Services in those aged 24 and under, 2014 [125]

11.1.2.2.1 Barrier

Nationally, male condoms are the most popular form of barrier contraception with 60% of men and women reporting that they always use a male condom, compared to less than 1% of women using a female condom and less than 1% of women using a diaphragm [126]. In Hackney there were 1,695 male condom distributions through SRH services in 2014, compared to only five female condom distributions.

Male condoms are available both commercially and through sexual health service provision. The average price for a pack of ten Durex Pleasuremax condoms in London was £6.62 in London in 2009 – marginally cheaper than the global average of £6.69 [127]. In Hackney and the City of London, free condoms are available for those 24 years of age and under through the Come Correct scheme in 76 locations that include youth centres, pharmacies and clinics [128].

Given the wide commercial availability of condoms, the total number distributed locally cannot be known. However, the number of condoms distributed for free to under-25s is known and this may be a better reflection of condom use in young people given the costs involved and the locations of distribution points. In Hackney and the City registration for free condoms occurs most often through SRH clinics. However, the majority of repeat visits for condom collection occur in pharmacies (Figure 109).

There were 1,695 episodes of condom distribution for under-25s in Hackney through SRH services in 2014.

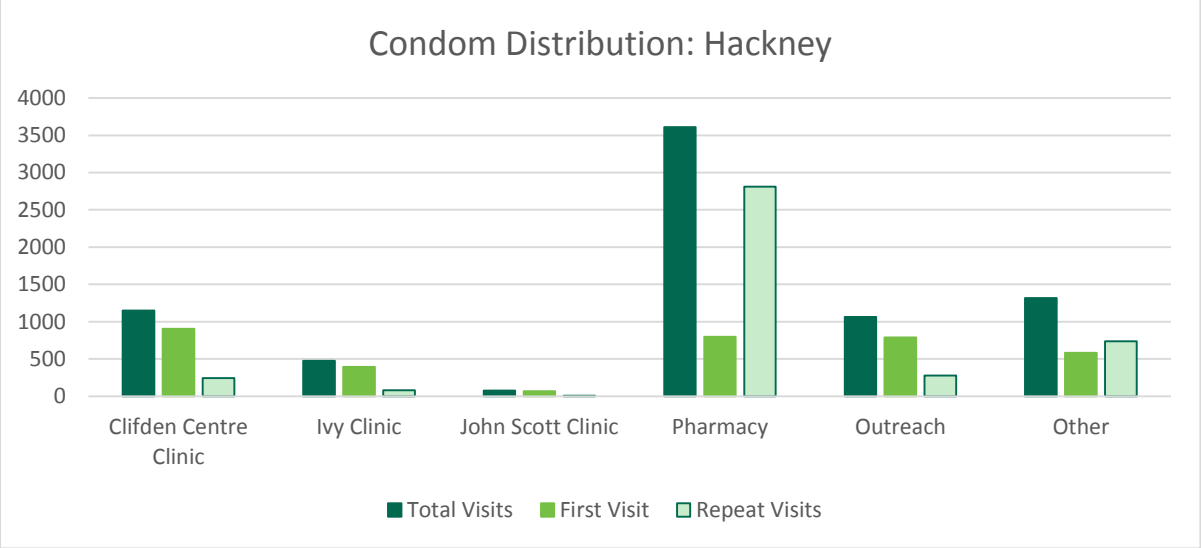

Figure 109: Condom distribution in Hackney, 2014/15 [125]

11.1.2.2.2 Short acting contraception

The mainstay of short acting contraception is the oral contraceptive pill (OCP). There are two forms – the combined OCP which contains oestrogen and progesterone known colloquially as "the pill", and the progestogen only pill (also known as the "mini-pill").

Oral contraceptives are available free of charge on prescription from GPs and sexual health services. Oral contraceptives are not purely indicated for prevention of pregnancy, but also for menorrhagia (heavy menstrual bleeding) and dysmenorrhoea (painful menstrual bleeding), for instance.

There were 2,490 oral contraceptive prescriptions for under-25s in Hackney through SRH services in 2014.

11.1.2.2.3 Intermediate acting contraception

Progestogen injections are available that provide intermediate-term, user independent contraception usually lasting two or three months. As the hormone is injected into the body without being in a device, unlike LARC the contraception is not reversible as the woman cannot regain her fertility more quickly than planned should her circumstances change. There were 515 prescriptions for contraceptive injections for under-25s in Hackney in 2014.

Intermediate-duration contraception can also be provided through the contraceptive patch. However, this contraception is classed as user dependent as the individual is required to check that the patch has remained in place and it must be changed by the user every week. There were 295 prescriptions for the contraceptive patch for under-25s in Hackney through SRH services in 2014.

11.1.2.2.4 Long acting reversible contraception

LARC includes the hormonal implant Nexplanon, the intra-uterine system (IUS) Mirena, and the intra-uterine device (IUD – also known as the "copper coil"). Contraception lasts for three to ten years (depending on the type of LARC used) and fertility should return to normal following removal of the device. Given that there is no user dependence and that contraception is maintained for a long time, the National Institute for Health and Care Excellence (NICE) advise that increasing the uptake of LARC methods will reduce the number of unintended pregnancies [129]

LARC is available through some GP practices and also through SRH services. Data show that across London the rate of GP prescriptions for LARC in women aged 15-44 years is less than half the rate in England. Hackney and the City have a rate that is significantly below the London average, with six of Hackney's ten statistical neighbours having higher GP prescription rates (Figure 110). Furthermore, while the rate of GP LARC prescriptions in England has risen by 10% over the past three years, the rate has remained stable in London and has decreased by over 20% in Hackney and the City of London during this time (Appendix 15.5.1.2, Figure 218). The number of LARC prescriptions through SRH services is 3.5 times greater than through GP practices in City and Hackney[42].

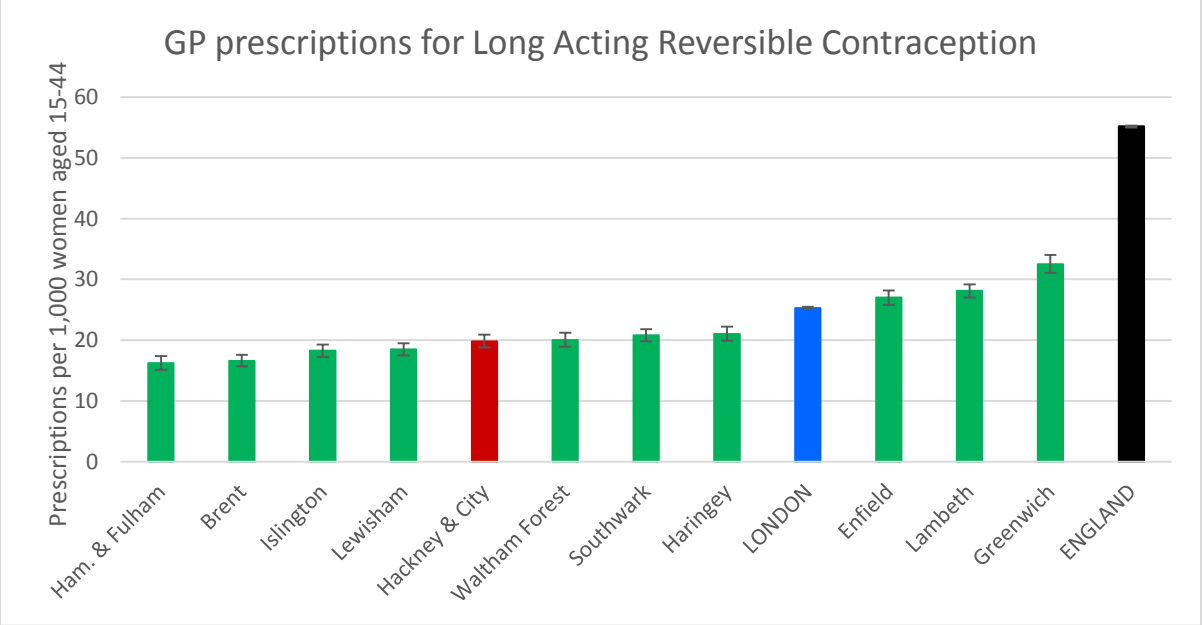

Figure 110: GP prescriptions for long acting reversible contraception, 2014 [41]

11.1.2.3 Teenage Pregnancy

Teenage pregnancies have a 44% higher risk of infant mortality, a 25% higher risk of low birth weight babies at term, a 63% higher risk of child poverty, a six-fold higher rate of maternal smoking and a one third lower rate of breastfeeding initiation [130]. Teenage

[42] Note – comparable SRH service data are not available for other boroughs and therefore it may be that Hackney's low GP LARC prescription rate reflects a differing use of services, rather than lower uptake per se

mothers are three times more likely than older mothers to suffer postnatal depression and have mental health problems in the first three years of their baby's life. The children of teenage mothers are also at an increased risk of low educational attainment and having poor housing, poor health and lower rates of economic activity in adult life [131].

11.1.2.3.1 Teenage Conceptions

The rate of teenage conceptions has been falling in Hackney and the City for the past 15 years at a rate faster than the England average. From a rate of 80 conceptions per 1,000 females aged 15-17 in Hackney in 1999 (almost twice the England rate of 45 per 1,000), the rate in 2013 had fallen to 24 per 1,000 in Hackney (marginally lower than the England rate of 24.3 per 1,000) [41]. The rate of conceptions in females aged 13-15 is significantly lower than in 15-17 year olds but, while there has been a decline in this rate, the decline is less marked (Figure 111).

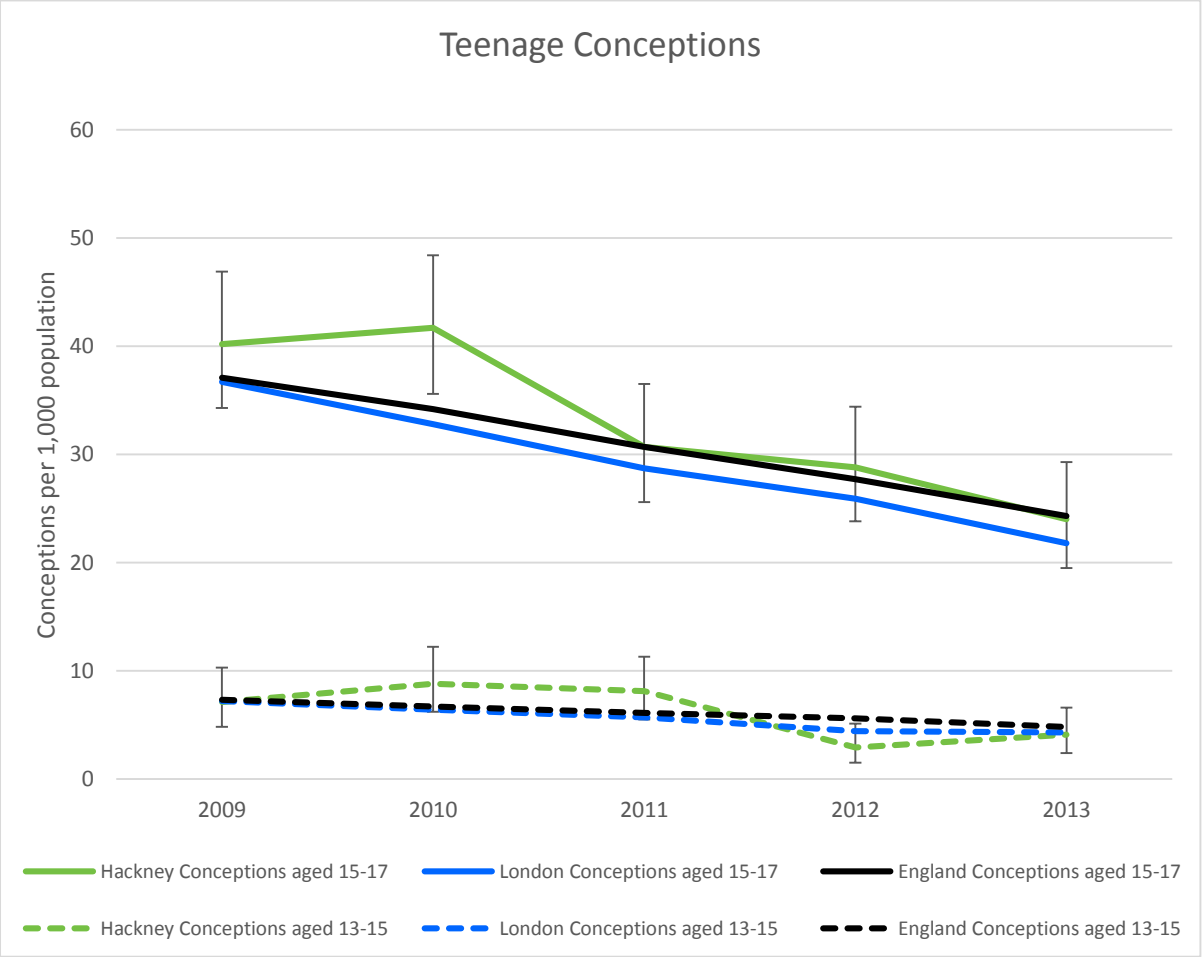

Figure 111: Teenage conceptions (Hackney and the City combined), 2009-13 [41]

Examining the 2013 teenage conception data reveal that four of Hackney's ten statistical neighbours have higher rates of conceptions in 15-17 year olds, and six have lower rates. Hackney and the City of London have a rate that is lower than England's but higher than London's, although neither of these differences are statistically significant (Appendix 15.5.1.3, Figure 219).

11.1.2.3.2 Emergency Contraception and Abortions

Hackney and the City of London have a lower rate of births to mothers aged 15-17 than seven of Hackney's ten statistical neighbours, which is a better ranking than for conceptions. This is likely due to a higher rate of emergency contraception use and abortions in this age group locally.

Emergency contraception can either be provided orally through a single dose of levonorgestrel (ideally within 12 hours, but can be taken up to 72 hours after unprotected intercourse) or through the insertion of an IUD (if the time window for levonorgestrel has lapsed but it is still within five days of unprotected intercourse).

Across women aged 13-54, the proportion given emergency contraception is higher in Hackney and the City than averages for London and England and seven of Hackney's ten statistical neighbours (Figure 112). A similar number of emergency contraception prescriptions are provided through GPs (1,035) as through SRH services (1,570).

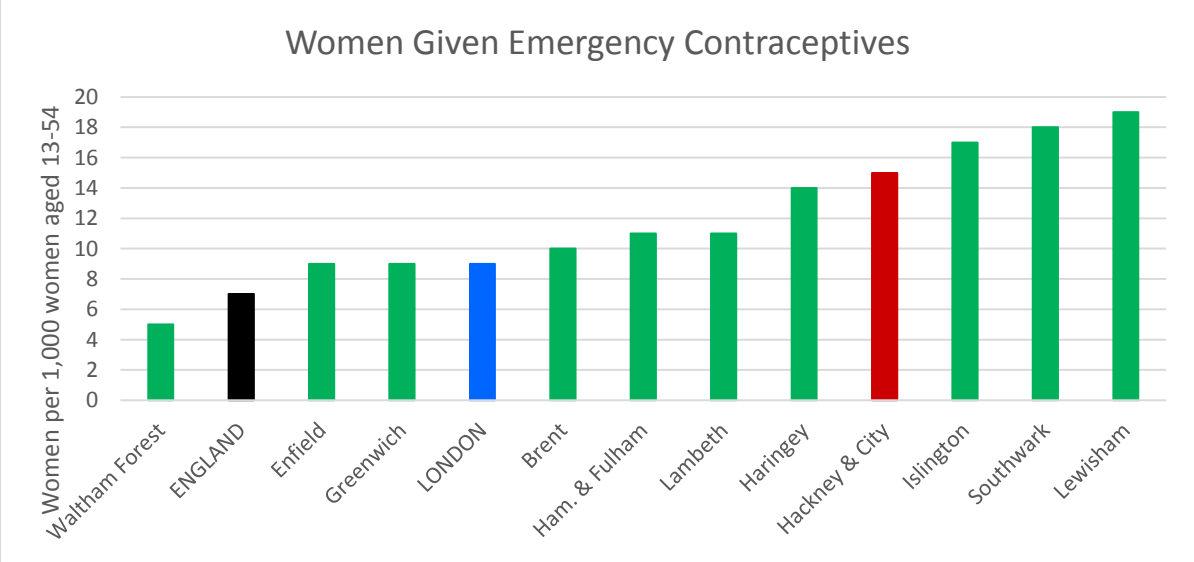

Figure 112: Proportion of women aged 13-54 given emergency contraception, 2014/15 [125][43]

The number emergency contraception prescriptions increases with age, and the majority of young women only receive emergency contraception once under the age of 25 (Figure 113).

[43] Note – emergency contraception includes prescribed oral and IUD methods but does not include over the counter purchases

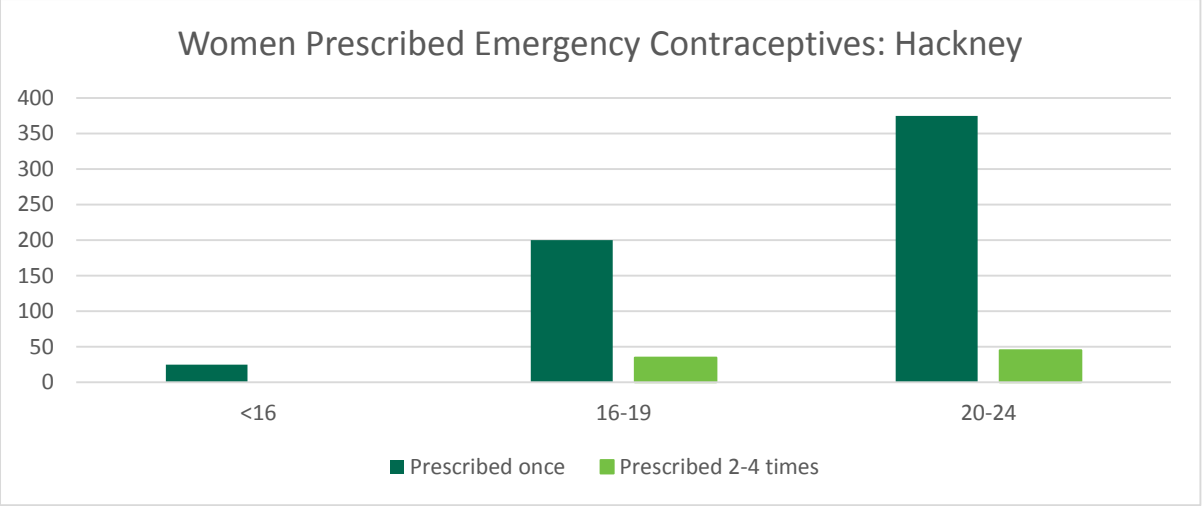

Figure 113: Emergency contraception prescriptions by age and frequency, 2014 [125]

Women aged 15-17 in Hackney have a higher rate of abortions than seven of Hackney's ten statistical neighbours (Figure 114).

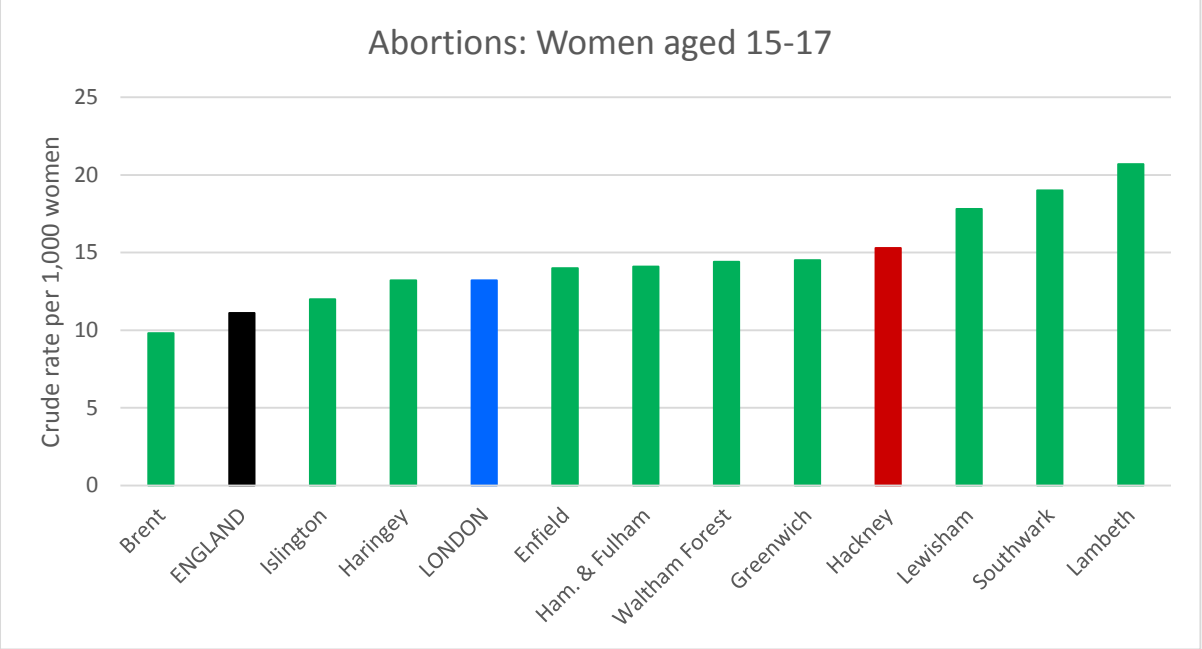

Figure 114: Rate of abortions in women aged 15-17, 2014 [41]

In addition, the proportion of abortions in women aged 24 and under in Hackney and the City that are a repeat abortion is high – higher than any of Hackney's ten statistical neighbours and significantly higher than the London and national averages (Figure 115).

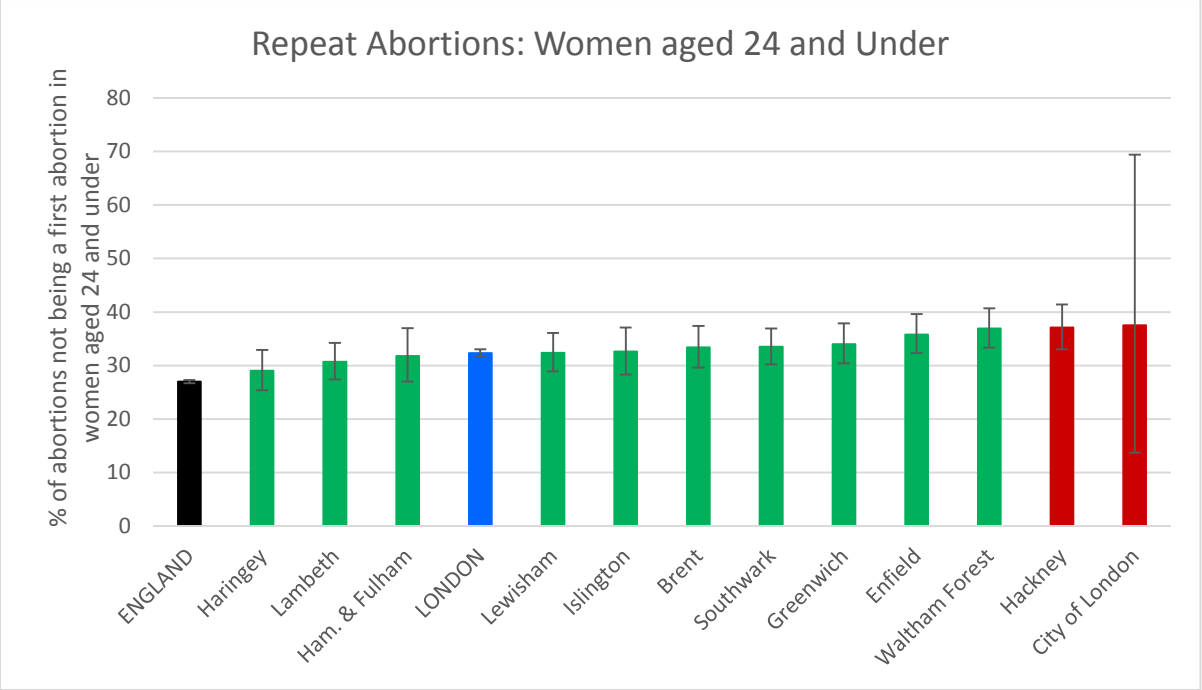

Figure 115: Repeat abortions in women aged 24 and under, 2014 [41]

11.1.2.3.3 Teenage Births

The rate of births to females aged 15-17 in Hackney and the City of London is lower than seven of Hackney's ten statistical neighbours (although these are not significant differences) (Appendix 15.5.1.3, Figure 221). The rate is falling in Hackney in line with the fall observed across London and across England (Figure 116). Locally collected data have shown that the number of births has continued to fall since the most recent nationally published data (2013), with the number of births to females under 19 years of age at Homerton University Hospital falling from 58 births in 2013/14 to 42 in 2014/15.

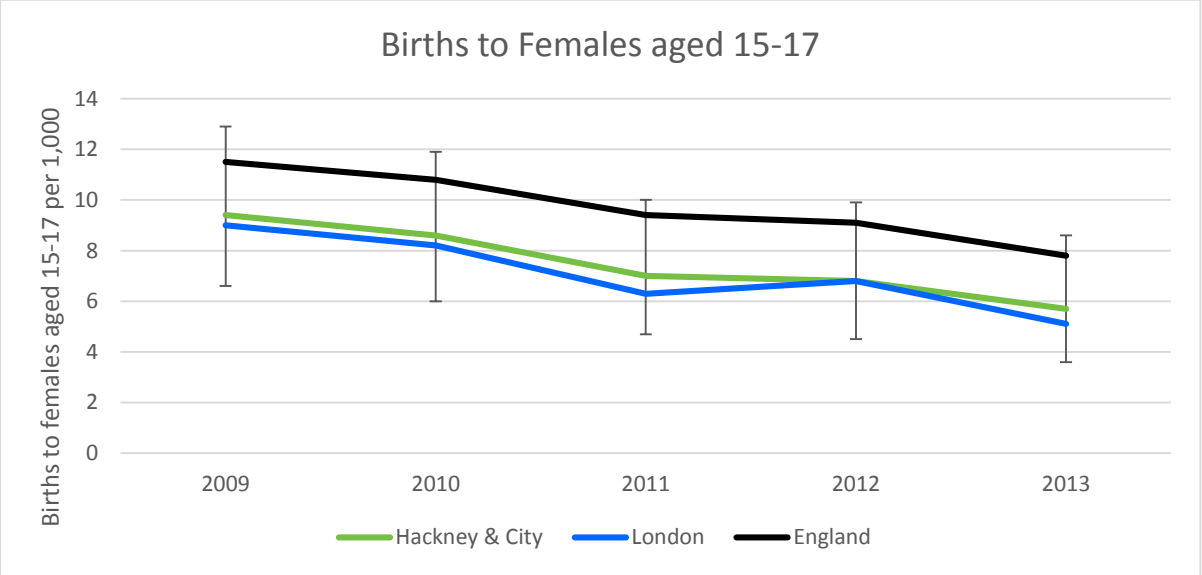

Figure 116: Births to females aged 15-17, 2009-2013 [41]

Homerton University Hospital data for 2013/14-2014/15 reveals that births to women aged 14-19 as a proportion of 14-19 year olds was significantly lower in Asian women than the other broad ethnic groups that had similar higher rates[44] (Figure 117).

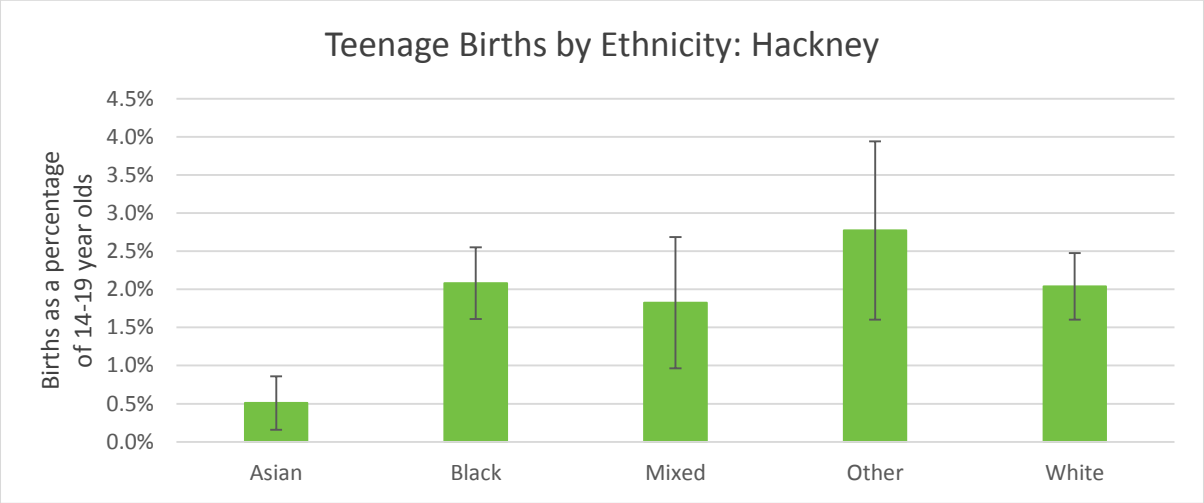

Figure 117: Births in 14-19 year olds by ethnicity, 2013-15, Homerton University Hospital

There are no statistically significant differences in the proportion of births being to mothers aged 14-19 out of all births by Children's Centre area. However, there are differences in the proportion of 14-19 year olds giving birth out of all 14-19 year olds by area, due to different age profiles across the areas. 14-19 year olds in Children's Centre areas B and D are significantly more likely to give birth than 14-19 year olds in area E (Appendix 15.5.1.3, Figure 223).

There have been no births to women aged 19 or under in the City in the past five years.

11.1.2.4 Sexually Transmitted Infections

11.1.2.4.1 Chlamydia

Chlamydia is a common infection caused by the bacterium *Chlamydia trachomatis* and is frequently asymptomatic. It is the most commonly diagnosed sexually transmitted infection (STI) in the UK [132]. It is estimated that 16% of untreated chlamydia infections result in the development of clinical pelvic inflammatory disease [133]. Other complications of chlamydia include ectopic pregnancy and infertility in women; epididymitis in men; and conjunctivitis and pneumonia in babies born to infected mothers [134].

The National Chlamydia Screening Programme (NCSP) in England was established in 2003 with the vision of offering chlamydia testing as a routine part of primary care and sexual health consultation and through opportunistic screening to all sexually active young adults.

[44] Note – 77% of Hackney mothers delivered at Homerton University Hospital over this time

The NCSP aims to:

1. Prevent and control chlamydia through early detection and treatment of infection
2. Reduce onward transmission to sexual partners
3. Prevent the consequences of untreated infection
4. Ensure all sexually active under 25 year olds are informed about chlamydia, and have access to sexual health services that can reduce risk of infection or transmission
5. Normalise the idea of regular chlamydia screening among young adults so they expect to be screened annually or when they change partner

As part of Natsal-3, 4,550 participants provided urine samples that were analysed for the presence of *Chlamydia trachomatis* [123]. In women detection was highest in the youngest age group assessed (16-19 years) and fell for every subsequent age group, whereas the rate peaked at a slightly older age in men (20-24 years). When only comparing 16-19 year olds, women had a significantly higher detection rate (3.8%) than men (0.3%) (Figure 118).

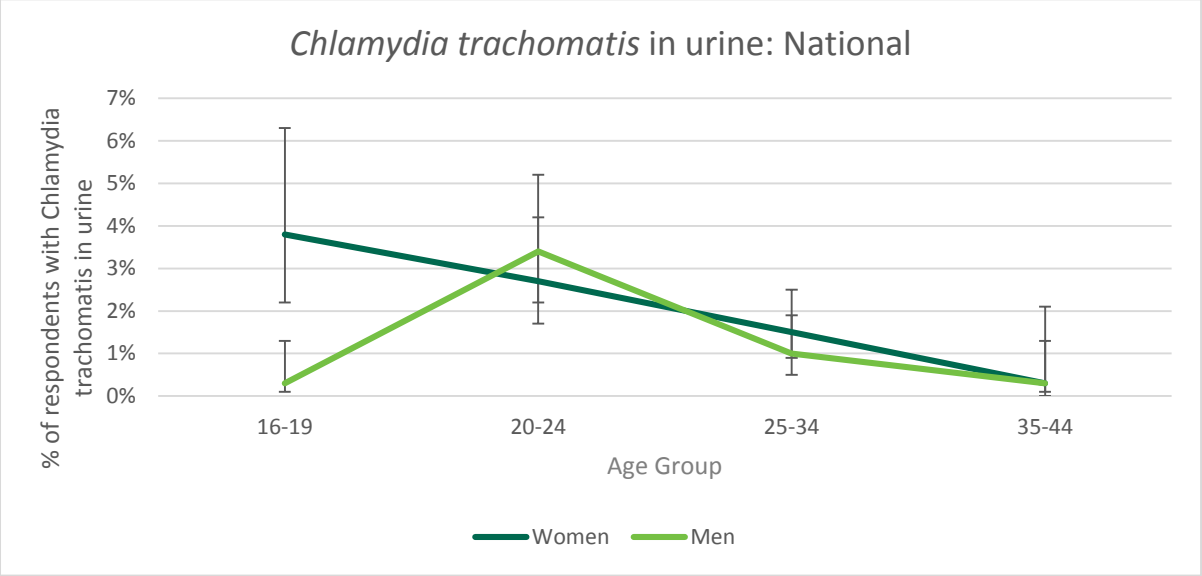

Figure 118: *Chlamydia trachomatis* urinary detection by age and gender, 2013 [123]

Urinary detection of *Chlamydia trachomatis* was also analysed by deprivation quintile (Figure 119). This showed that, for both men and women, detection rates were significantly higher in IMD groups 4-5 (most deprived) than IMD groups 1-2 (least deprived).

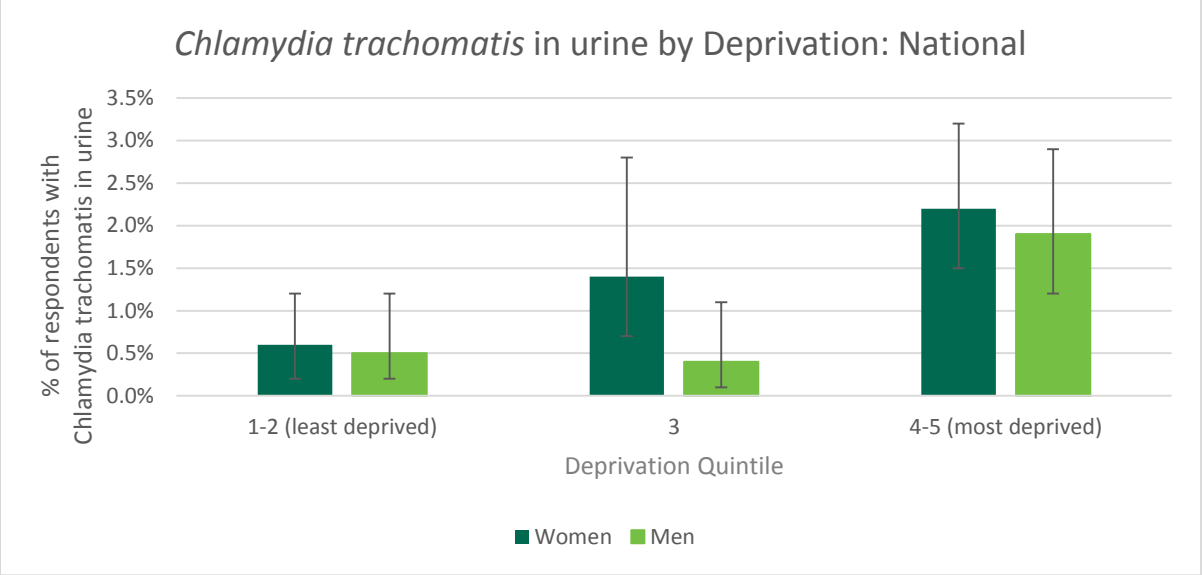

Figure 119: *Chlamydia trachomatis* urinary detection by deprivation and gender, 2013 [123]

Overall, Hackney performs very well in its level of chlamydia screening, with 49% of 15-24 year olds being tested in 2014 – statistically significantly higher than all ten of its statistical neighbours, the London average and the England average (Appendix 15.5.1.4, Figure 225). Broken down, this equates to 35% of 15-19 year olds (also higher than all ten of Hackney's statistical neighbours – see Figure 120) and 59% of 20-24 year olds being screened in Hackney.

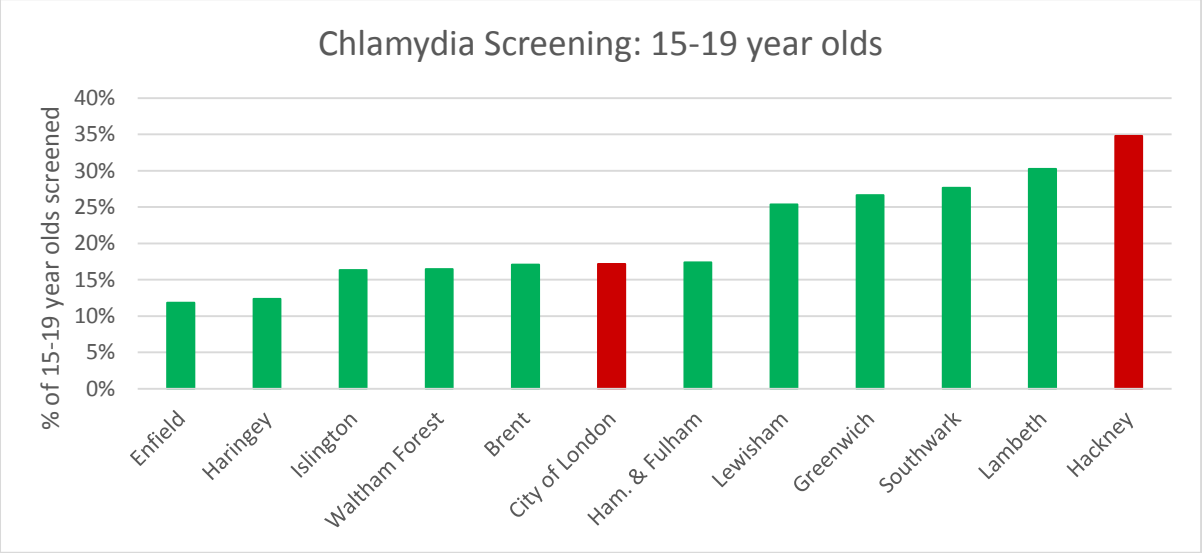

Figure 120: Chlamydia testing in 15-19 year olds, 2014 [135]

While the rate of screening in Hackney rose between 2012 and 2013, it plateaued in 2014. However, the rate has been slightly decreasing across London and England over the same period (Appendix 15.5.1.4, Figure 226).

Across 15-24 year olds the City of London also surpasses seven of its nine London statistical neighbours (only Wandsworth and Camden perform better) as 37% were screened – a significantly higher rate than the London and England averages. The proportion screened has increased year-on-year for the past three years in the City of London.

Chlamydia testing is more commonly performed in females than males in Hackney and the City, as well as across London and England (Figure 121). This is particularly marked in 20-24 year olds in Hackney, who account for much of Hackney's increased level of testing.

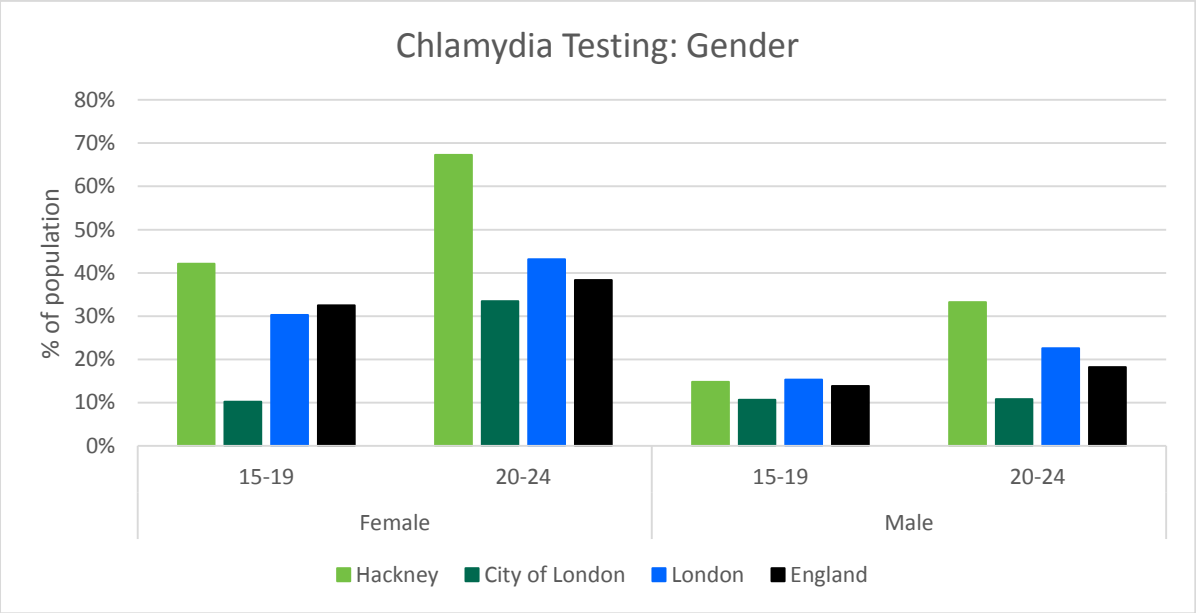

Figure 121: Chlamydia testing by gender, 2012 [136]

Young females are more engaged than young males in the wider context of SRH services, with a nine fold higher rate of CHYPS+ attendance in Hackney (2567 versus 290) in 2014/15.

Due to shared risk factors, brief screening assessments involving sexual health and viral hepatidites are often performed with substance misuse clients. The proportion of clients in young persons' substance misuse services who are offered and accept a chlamydia screen is low locally and nationally (Figure 122). However, the rate of non-documentation or of screening not being offered without explanation is higher in Hackney than nationally.

	Chlamydia Screen (%)		Hep B Vaccine (%)		Hep C Vaccine (%)	
	Hackney	England	Hackney	England	Hackney	England
Offered & accepted	5	12	0	6	0	5
Offered & refused	20	39	17	36	15	33
Assessed as not appropriate	7	31	22	44	17	47
Other	49	6	61	14	68	15

Figure 122: Screening and immunisation rates in clients, 2014/15 [137][45]

[45] Note – national data relate to first quarter 2015/16 but Hackney data relate to whole year 2014/15 so that samples are larger to reduce uncertainty or identification

The national goal is to detect 2,300 cases of chlamydia per 100,000 people aged 15-24 as, given the high prevalence of infection, a lower rate is likely to represent underdiagnosis, rather than a lower prevalence. Hackney achieves a significantly higher rate at 4,270 per 100,000 aged 15-24 in 2014 – higher than all ten of its statistical neighbours, and statistically significantly higher than nine of these boroughs (Appendix 15.5.1.4, Figure 227).

For 15-19 year olds specifically Hackney has a higher detection rate than nine of its ten statistical neighbours (Figure 123) and the trend for Hackney's detection rate mirrors that seen in Hackney's screening rate (Appendix 15.5.1.4, Figure 228).

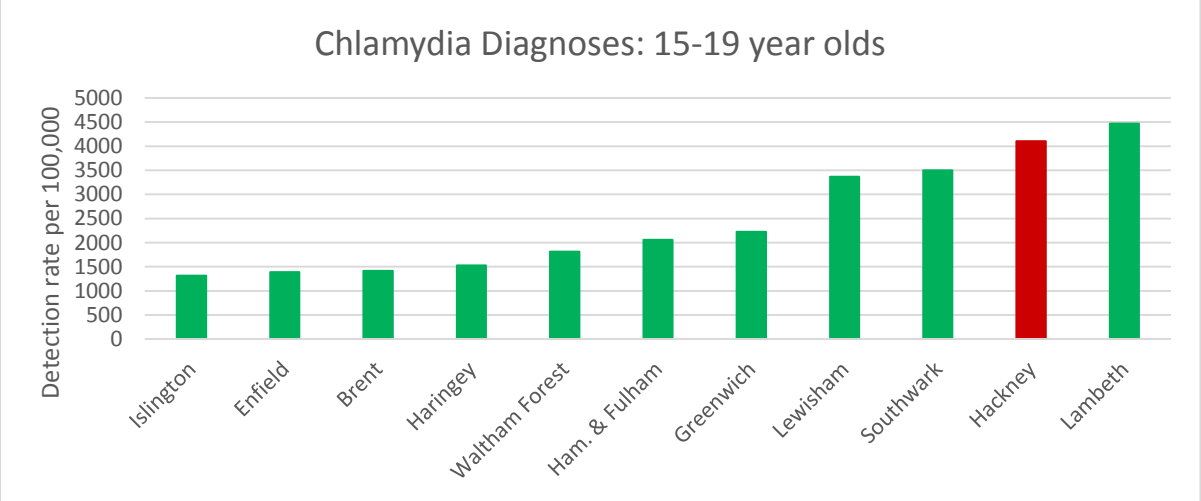

Figure 123: Chlamydia detection in 15-19 year olds, 2014 [135]

Investigating the chlamydia detection rate by gender again reveals a higher rate in females (2,664 per 100,000 in England) than males (1,355 per 100,000 in England). This effect is mirrored in Hackney, with each gender having a rate over twice that found in England [41].

Data published on the NCSP website by PHE [138] reveal that the City of London had a lower detection rate than all of its statistical neighbours in 2012[46].

There are many settings in which chlamydia screening can occur, with the most common being genito-urinary medicine (GUM) clinics where 123,235 tests were performed across London in 2012 (Figure 124). GUM clinics also have a relatively high positivity rate at 9.4%.

Setting	Total Tests	Positive Tests	% Positive
GUM clinics	123,235	11,527	9.4%
'Other'	72,719	3,843	5.3%
GP	53,772	2,741	5.1%
Contraception & Sexual Health Services	49,286	4,794	9.7%
Pharmacy	4,780	382	8.0%
Termination of Pregnancy clinic	3,632	257	7.1%

Figure 124: Chlamydia testing in London by setting, 2012 [136]

[46] Note – trend data are not available as City data are suppressed on the PHE Public Health Profiles tool [41]

11.1.2.4.2 HIV

HIV (human immunodeficiency virus) was first cultured in 1983. By 2014 an estimated 36.9 million people were living with HIV worldwide and 1.2 million people died from acquired immune deficiency syndrome (AIDS) related illnesses in 2014 alone [139]. Across adults in the UK, HIV is most prevalent in London, with the ten highest local authority rates in England all being in London [140]. The City of London has the third highest adult prevalence in England, but it should be noted that this relates to only 57 people in 2013, and therefore these low numbers create a rate that is more susceptible to variation and uncertainty. 91% of adult HIV diagnoses in the City of London are in men who have sex with men (MSM). Hackney has the ninth highest adult prevalence in England, with four of its statistical neighbours having higher rates and six having lower rates (Figure 125).

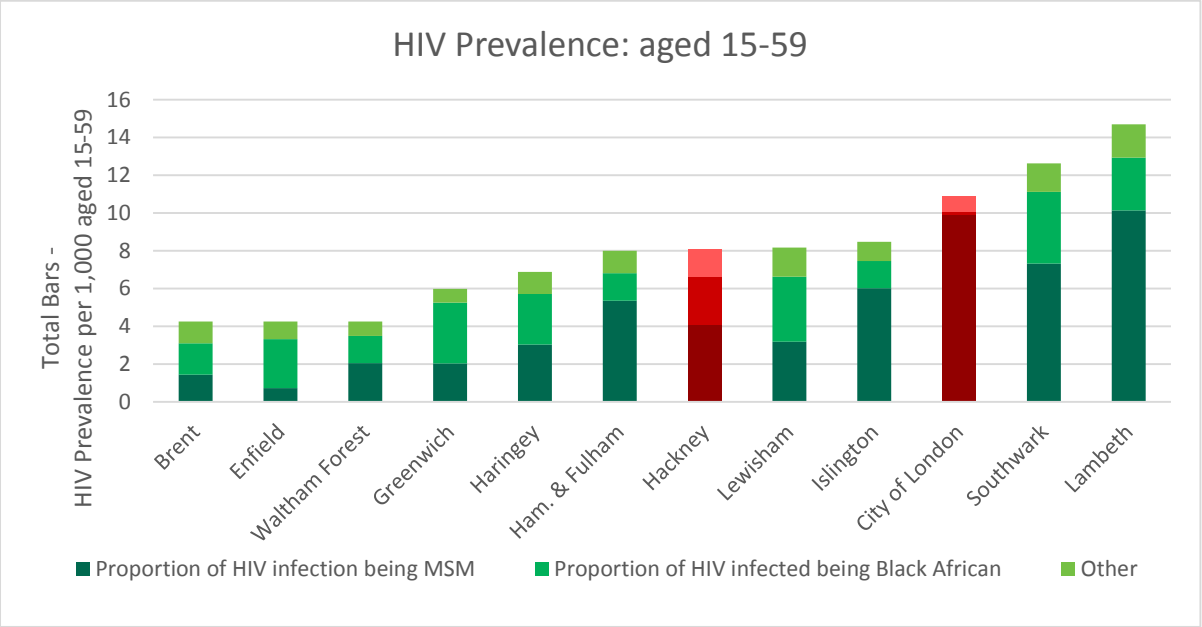

Figure 125: HIV prevalence by borough with proportion of diagnoses being in Black Africans or MSM indicated, 2013 [140]

It is recommended that routine HIV testing should be offered to all medical admissions in areas with a high diagnosed prevalence – this level is set at over 2 per 1,000 15-59 year olds and therefore testing would be recommended for all admissions in London [141].

In Hackney, HIV tests are accepted in 69% of eligible[47] new GUM attendees which is lower than nine of Hackney's statistical neighbours and statistically significantly lower than seven of these nine boroughs (Figure 126).

[47] Note – patients were ineligible if they were already known to be HIV positive or where an HIV test was deemed inappropriate

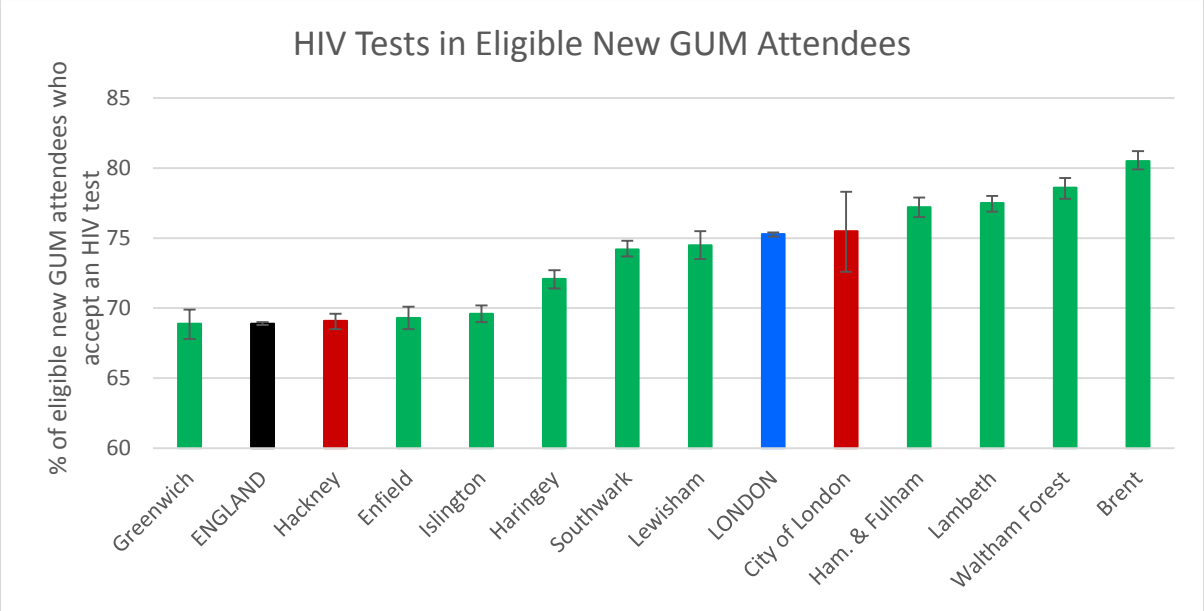

Figure 126: HIV test uptake in eligible new GUM attendees, 2014 [41]

With regards to 16-24 year olds, the national proportion who report having been tested for HIV over the preceding five years has risen significantly between 2000 and 2010 with a trebling in women and a doubling in men (Figure 127).

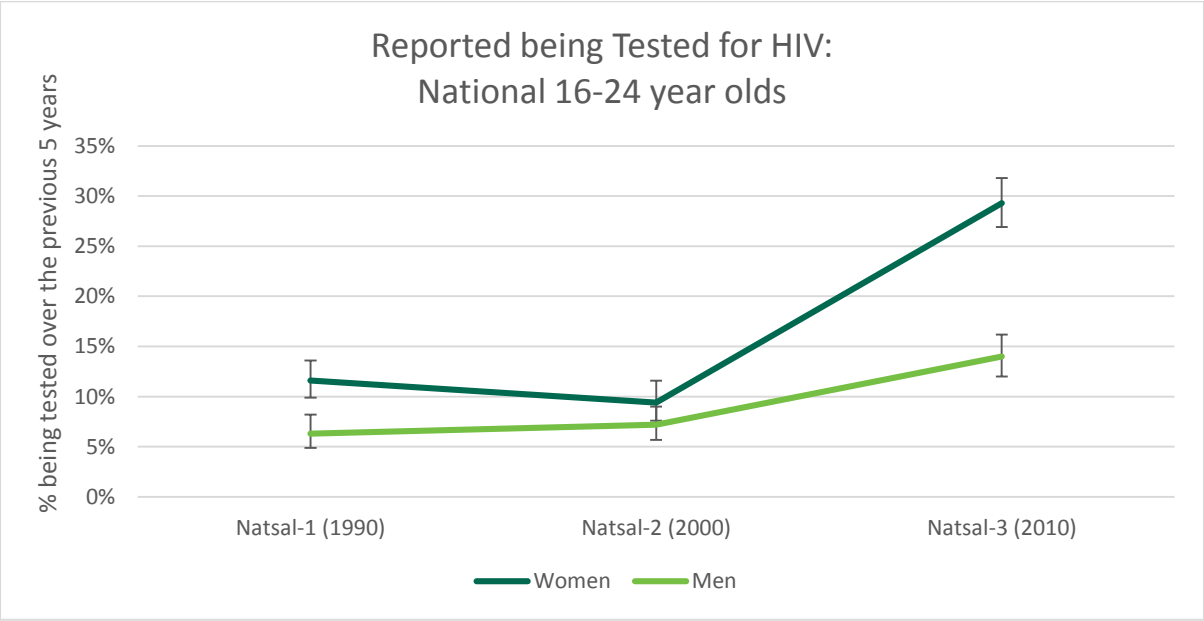

Figure 127: HIV testing in the preceding 5 years, 16-24 year olds [124]

11.1.3 Guidance

Those at high risk of STIs include MSM, those who have visited areas of high HIV prevalence, those who misuse substances (including alcohol) and those engaged in risky sexual behaviour (early onset of sexual activity, unprotected sex and frequent change of sexual partner).

The term 'health professionals' includes those working in general practice, genito-urinary medicine, community health services (including community contraceptive services), voluntary organisations and school clinics.

'Vulnerable' people under 18 include those from disadvantaged backgrounds, those leaving care or those with low educational attainment (PH3).

For the purposes of this guidance 'socially disadvantaged young people' may include those who are living in a deprived area, from a minority ethnic group (including traveller communities), refugees, asylum seekers or recently arrived in the UK, teenage parents or the children of teenage parents, looked after or leaving care, excluded from school, have poor attendance or poor educational attainment, NEET, homeless, living with mental health problems, living with physical or learning disabilities, living with HIV/AIDS, substance misuser or criminal offenders (PH51).

11.1.3.1 NICE PH3: Prevention of sexually transmitted infections and under-18 conceptions

1. Identification
• Health professionals should identify those at high risk of STIs in routine care or at new registration; during consultations on contraception, pregnancy or abortion; or when performing a cervical smear test, STI test or providing travel immunisation
2. Behaviour modification
• Those at high risk of STIs should receive one-to-one structured discussions each lasting 15-20 minutes to address factors that can help reduce risk-taking and improve self-efficacy and motivation
3. Confirmed STIs
• Patients with an STI should be provided with infection-specific information including advice about re-infection and, if chlamydia, consider providing a home sampling kit • Health professionals should give tailored help to patients with an STI to get their partners tested and treated when necessary
4.Service provision
• Commissioners should ensure sexual health services (including contraceptive and abortion services) meet local needs and include arrangements for notification, testing, treatment and follow-up of partners of those with an STI with defined referral pathways
5. Vulnerable young people
• GPs, nurses and other clinicians in healthcare should provide one-to-one sexual health advice on how to prevent/get tested for STIs, how to prevent unwanted pregnancies, methods of reversible contraception, how to get and use emergency contraception and other reproductive issues to vulnerable young people under 18
6. Vulnerable women who are pregnant or are already mothers
• Midwives and health visitors should regularly visit vulnerable women under 18 who are pregnant or are already mothers, discuss with them (and their partner where appropriate) how to prevent or get tested for STIs, how to prevent unwanted pregnancies and, refer the woman to relevant agencies (such as for reintegration into education and work)

11.1.3.2 NICE PH51: Contraceptive services for under 25s

1. Assessing local need
• Collect and analyse anonymised regional and local demographic data and information on local contraception and sexual health inequalities to inform local needs assessments • Map the current range of services, service activity and capacity across providers • Involve young men and women, including those who are socially disadvantaged, in planning, monitoring and regularly evaluating services
2. Commissioning coordinated and comprehensive services
• Use CQUIN indicators to improve the uptake of effective contraceptive methods • Include all relevant health, social care and children's services in comprehensive referral pathways and establish collaborative commissioning across localities to ensure comprehensive, open-access services in convenient locations • Ensure all contraceptive services meet the 'You're Welcome' quality criteria and the service standards for sexual and reproductive healthcare • Ensure all organisations provide a consistent service
3. Providing contraception for young people
• Ensure swift access to flexible, confidential and dedicated young people's contraceptive services – for example that provide out-of-hours services, drop-in appointments, waiting times under an hour and open to those under 16 without a parent / carer • Offer culturally appropriate, confidential, non-judgemental, empathic advice • Encourage young people to make an informed decision according to their needs • Inform about the full range of contraceptives with benefits and side effects • If possible provide contraceptive (including LARC), condoms and emergency contraception • Provide free same-day pregnancy test results and offer counselling (or signpost) • Work with PSHE and head teachers to encourage young people to use services
4. Tailoring services for socially disadvantaged young people
• Provide additional support for socially disadvantaged young people including access to trained interpreters, one-to-one sessions and special facilities for those with disabilities • Use outreach services that offer information, advice and the full range of options • Encourage and help young mothers to use contraceptive services • Offer support and referral to specialist services
5. Seeking consent and ensuring confidentiality
• Ensure staff are trained to understand the duty of confidentiality, are familiar with best practice guidance for those under 16 years and can assess competence • Ensure young people understand that their information is confidential, even if a young person is not mature enough to consent to contraceptive advice and treatment • Explain that sharing information with another professional might be necessary if there are concerns about harm but the young person is told who needs to be informed and why • Ensure young people are asked in private whether they wish anyone else to be present • Prominently display the confidentiality and complaints policy in waiting areas
6. Providing contraceptive services after a pregnancy to women aged up to 25
• Midwives should discuss what contraception they intend to use after their pregnancy, provide information on how and where to obtain it and after pregnancy check they have chosen a method and provide contraception before they are discharged from midwifery • Health visitors and health professionals working with new mothers should check women have been advised on contraception and do have contraceptives
7. Providing contraceptive services after an abortion
• Discuss contraception before and after an abortion, explain fertility returns immediately following an abortion, provide contraception and, if appropriate, offer counselling

8. Providing school and education-based contraceptive services
• Involve young people in the design, implementation, promotion and review of on-site and outreach contraceptive services in and near schools, colleges and other education sites • Ensure advice, free and confidential pregnancy testing and the full range of contraceptive methods are easily available or offer prompt and easy referral to local services • Ensure continuity, by explaining when and where services are available during holidays
9. Providing emergency contraception
• Establish patient group directions (PGDs) and local arrangements to ensure all young women can easily obtain free oral emergency contraception or have timely access to emergency contraception using an intrauterine device • Ensure women are advised where they can obtain a free pregnancy test with same-day results and encouraged to choose a suitable form of contraception for their future needs
10. Providing condoms in addition to other methods of contraception
• Advise all young people to use condoms consistently and correctly in addition to other contraception and ensure they are free and readily accessible
11. Communicating with young people
• Use a range of methods to provide young people, especially socially disadvantaged young people, with advice on sexual health and contraception including websites, social network sites, telephone helplines, text messaging and emails • Ensure information is available in a range of formats including other languages, large text and text relay for those who are hard of hearing • Involve young people in the design of any media and distribution strategies
12. Training and continuing professional development
• Ensure health professionals in contraceptive services have received the required post-registration training and have evidence to show they are maintaining their competencies • Staff should be experienced working with young people, especially those who are socially disadvantaged • Ensure all staff, including administrative staff, know about the duty of confidentiality and child protection processes and legislation

11.1.3.3 Healthy Child Programme

11-16: Universal
• Easy access to confidential contraceptive and sexual health services, including prompt access to emergency hormonal contraception, choice of effective contraception including LARC, treatment for STIs, swift referral to antenatal care or NHS-funded abortion services • Provide information about local services to all young people within PSHE • Remind of continuing risk of STIs including HIV and promote access to condoms • All sexually active under 25s should be encouraged to be screened for chlamydia annually or if there is a change of sexual partner
11-16: Progressive
• Health reviews for LAC to include addressing any risky sexual behaviour
16-19: Universal
• Consider FE on-site sexual health services to promote contraception and condoms
16-19: Progressive
• Offer one-to-one sexual health advice, if appropriate, to at risk, vulnerable under 18s

11.1.4 Local Services

There is universal access to free contraception and sexual health services through CHYPS+ which Homerton University Hospital is currently commissioned to provide. This service includes GUM clinics, a community sexual health liaison nurse, a sexual health screening service in primary care and a sexual health pharmacy service. The greatest number of sexual health service attendances across all ages in Hackney is seen in the Clifden Centre with 29,113 attendances in 2014/15, followed by Ivy (16,354) and John Scott (2,554) [142]. In addition to the universal offer, there are also targeted services such as community HIV checks for those at risk of contracting HIV.

The service is being reconfigured to allow the educational component of CHYPS+ to be taken back into the youth arm of Hackney Council, while a new clinical and treatment service will continue to deliver high quality, evidence based, youth-friendly sexual health services alongside wider health and wellbeing services.

Alongside this, the Come Correct (C-Card) scheme is delivered by Brook and provides free condoms to those up to the age of 25 across London, as well as providing a safe, non-judgemental and confidential space for young people to discuss, and seek advice about, their relationships and sexuality. Hackney and the City of London have the largest C-Card scheme in London, distributing 80,000 condoms per year with 3,000 new registrations and 4,000 repeat visits through over 80 locations. Of the 80 locations, 41 are pharmacies, five are sexual health clinics and the others consist of educational settings, and statutory and voluntary sector youth groups.

11.1.5 Stakeholder Consultation

Stakeholder consultation has been undertaken with a variety of groups to try to understand common opinions as well as the thoughts of hard to reach groups or those with protected characteristics.

CHYPS+ Voices is a youth forum that has been created locally as a platform for young people's opinions to be inputted into CHYPS+. This forum agreed that safe sex and sexually transmitted infections should be priorities for CHYPS+. The young people expressed a need for more sexual health education – both through PSHE in the school curriculum and through social media campaigns (for example Facebook, Twitter and Instagram). A group of parents at Young Hackney's largest youth hub (Forest Road) described their difficulties in knowing when and how much to talk about sexual health at home with their children and expressed a lack of awareness about what sexual health teaching was delivered through PSHE curricula.

In a workshop at New Regent's College (a re-engagement unit), students described "sexual intercourse safely", contraception and having regular check-ups as examples of the behaviour of a healthy young person, whereas "unprotected sex", sexually transmitted

infections and “keep hav[ing] abortions” were recognised as examples of an unhealthy young person.

Consultation with an LGBTQ (lesbian, gay, bisexual, transgender and queer) group for young people emphasised that “sexual health [is] important for young people, particularly for LGBT young people”. Some believed that “schools [are] not very good in this area – messages are all heterosexual”. There was a feeling that LGBT issues should be more mainstreamed and that viewing LGBT as a spectrum is important. The group raised the idea that services should be available after school (4-7pm) as that would be “good for anonymity” and also available at the weekend.

11.1.6 Recommendations

- Future sexual health service design in Hackney and the City should take into account the nationally-rising demand for sexual health services amongst young people, particularly given the open access nature of sexual health services
- The reasons why long-acting reversible contraceptives (LARC) account for a low proportion of contraceptive prescribing in local primary care should be explored. For instance, it is unknown whether the low prescription rate is due to low demand from young people (more education required), low promotion by GPs and practice nurses to young people (more health professional training required), or low availability of LARC in primary care (more practitioners trained to insert implants or coils required). As per NICE guidance (PH51), the use of ‘commissioning for quality and innovation’ (CQUIN) indicators could be explored as a route to increasing LARC prescribing
- The relatively high rate of teenage abortions, and in particular repeat abortions in young women, should be investigated further. The role of sexual health education in schools should be strengthened, with a view to reducing the abortion rate without seeing an increase in the rate of births to teenage mothers
- Future efforts to increase chlamydia screening should focus on 15-19 year olds and males, with an aim to match the excellent screening coverage in 20-24 year old females locally
- The importance of offering, and recording the offer of, chlamydia screening to those in young person’s substance misuse services should be emphasised to staff

11.2 Mental Health

11.2.1 Introduction

"Half of lifetime cases [of mental illness] start by age 14 years and three fourths by age 24 years."

Figure 128: Kessler et al, 2005 [197]

Childhood and adolescence is a period of crucial development for the mind. As such, it is a time when symptoms of mental ill-health may surface in many young people, but also a time when efforts to promote good mental health can have significant impacts on preventing mental illness. The most commonly diagnosed mental health conditions affecting children and young people are conduct disorder, anxiety, depression and attention deficit hyperactivity disorder (ADHD) [143]. A variety of demographic and social factors can make mental health problems in children more likely, and many of these risk factors are found to a greater extent in Hackney than other areas (Figure 129).

		Lower prevalence	Higher prevalence
Demographics	Gender	Girls (8%)	Boys (11%)
	Ethnicity	Indian (4%)	Black (12%)
Family structure	Parents	Married/cohabiting (8%)	Lone parent (16%)
	Nº. children	2 children (8%)	5 children (13%)
Social factors	Social Class	Class I (5%) – least deprived	Class V (14%) – most deprived
	Housing	Owner/occupier (6%)	Socially rented (17%)

Figure 129: Risk factors for mental health problems in childhood and adolescence [144]

No Health Without Mental Health is a strategy published in 2011 under the previous government that laid out six high level objectives for mental health in England:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people to suffer avoidable harm
6. Fewer people will experience stigma and discrimination

"By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does."

Figure 130: No Health Without Mental Health, 2011 [198]

11.2.2 Hackney and City of London

The What About YOUth survey, which was conducted nationally in 15 year olds, included 14 questions to calculate an overall mental wellbeing score using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[48]. Using this scale, mental wellbeing was rated better in Hackney and the City than any of Hackney's ten statistical neighbours (statistically significant in two cases) and significantly better than the London and national averages (Figure 131). Nationally, heterosexual 15 year olds, and those of Asian, Black and Other ethnicities scored significantly more highly than average, and those who are gay/lesbian, bisexual or of White or Mixed ethnicities scored significantly below average.

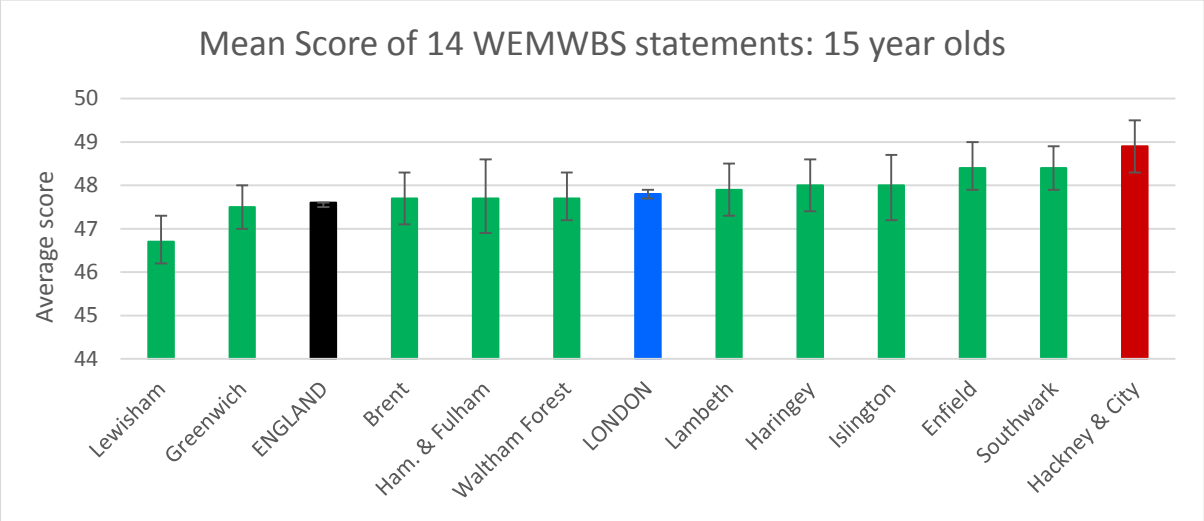

Figure 131: Mean score of 14 statements using WEMWBS in 15 year olds, 2015 [145]

An estimated 10.2% of Hackney's 5-16 year olds suffer from a mental health disorder[49] – which is higher than the London and England average of 9.3% [41]. However, this estimation is based on an ONS survey performed in 2004 [146]. While the data have been refreshed to reflect Hackney's changing population up to 2014, the underlying mental health disorder prevalence is over ten years out of date.

With regards to children and young people who have presented to primary care, CCG data reveal that 348 of City and Hackney's 5-19 year olds have a recorded diagnosis of a mental health disorder[50] which is a rate of 77 per 10,000. Most of these diagnoses are at the older end of this range with 243 of the 348 diagnoses in 15-19 year olds. More 5-19 year old boys (191) than girls (157) have been diagnosed, due to an increased rate in boys aged 10-14. However, by 20-24 years of age the rate is higher in females than males and this is true across the whole population at rate of 555 per 10,000 in women and 447 per 10,000 in men.

[48] Note – each question is rated between one and five to give a minimum of 14 and a maximum of 70
[49] Note – the term mental health disorder is used as defined by the ICD-10 (International Classification of Diseases, tenth revision) to "imply a clinically recognisable set of symptoms or behaviours associated in most cases with considerable distress and substantial interference with personal functions" [146]
[50] Note – mental health disorders included: depression, severe mental illness, dementia

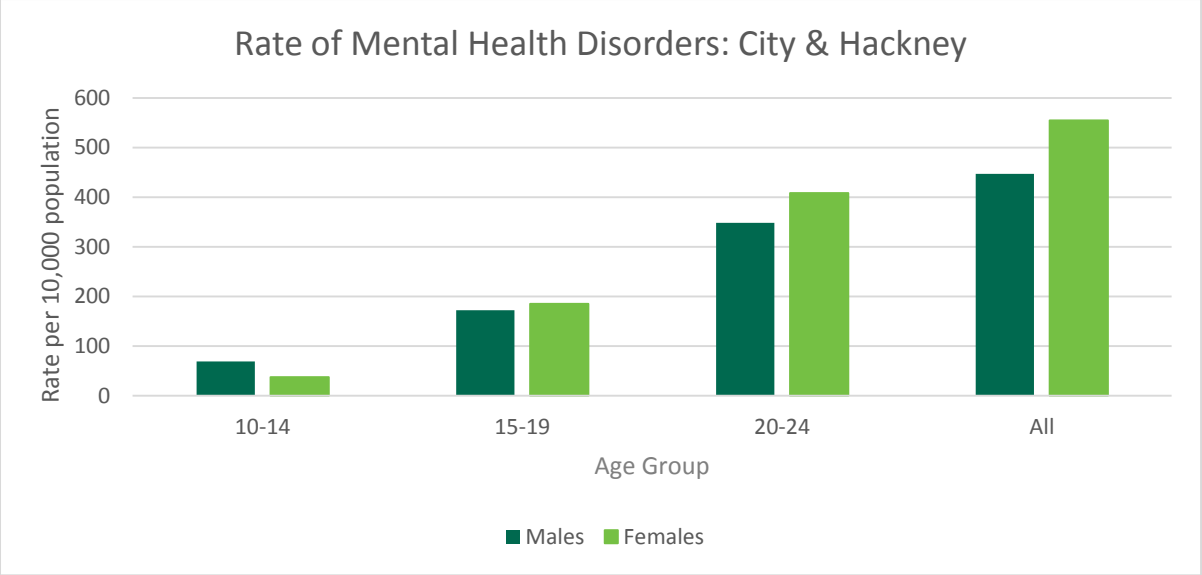

Figure 132: Rate of mental health disorders by age & gender, City & Hackney CCG, 2015

Despite having relatively high levels of the risk factors described above in Figure 129, there is a lower rate of inpatient hospital (including psychiatric hospital) admissions for a primary diagnosis of a mental health or behavioural disorder in 0-17 year olds in Hackney and the City than eight of Hackney's ten statistical neighbours and the London and England averages (with the difference being statistically significant in comparison to London and two of the eight boroughs) (Figure 133). However, of those cases that are admitted, local consultation with clinicians reports an increase in the complexity of cases being seen, especially with regards to their social factors [111].

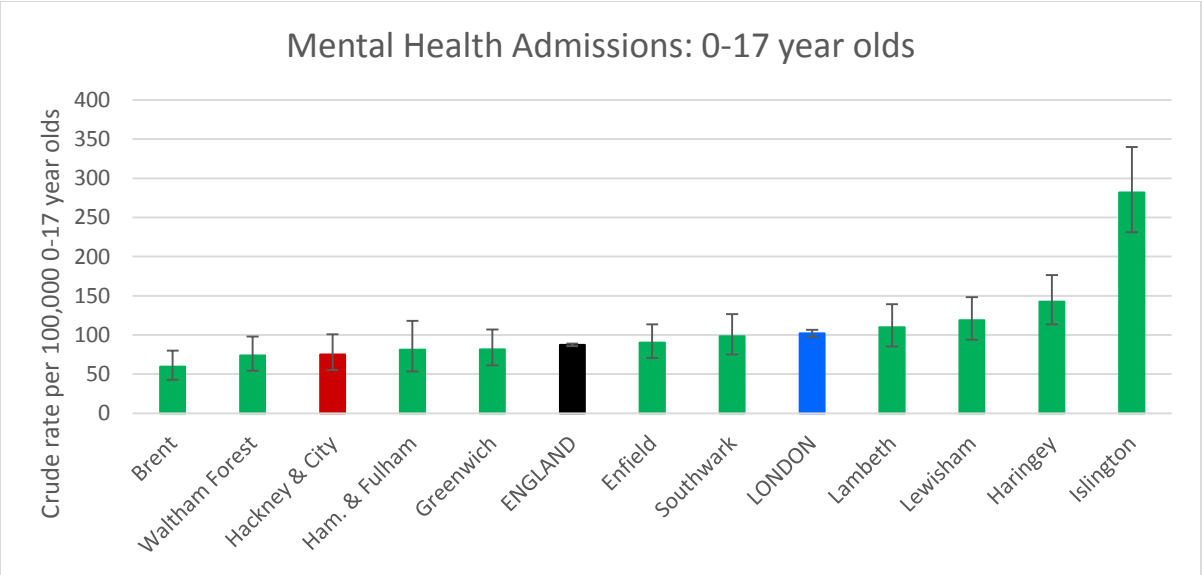

Figure 133: Mental health admissions per 100,000 under 18 years of age, 2013/14 [41]

The rate of mental health admissions in Hackney and the City is also falling – while the gap is remaining relatively constant compared to the national average, it is widening in comparison to the London average as the London rate is increasing (Figure 134).

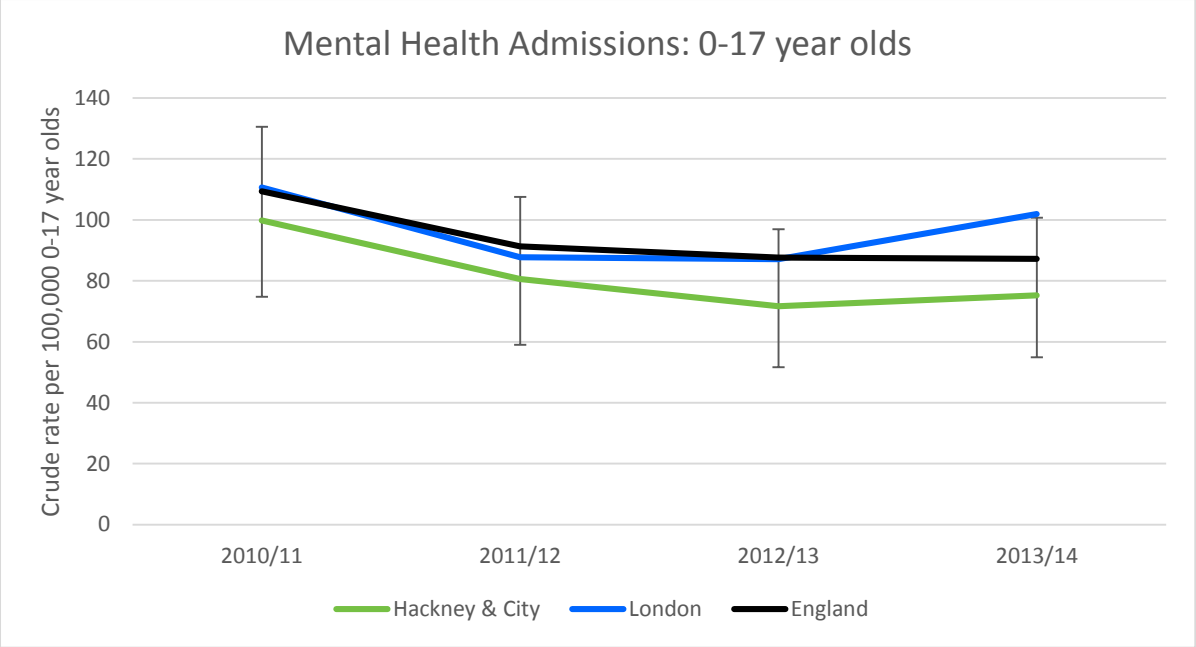

Figure 134: Mental health admissions per 100,000 under 18 years of age, 2010/11 - 2013/14 [41]

11.2.2.1 Common Mental Disorders

While a wide range of biological, psychological and social factors can contribute to common mental disorders, one factor that can be particularly pertinent to young people is bullying. In the What About YOUth (WAY) survey conducted nationally, 15 year olds were asked both whether they had been subject to bullying and whether they had bullied anyone else over the past few months. Hackney and the City's reported level of being bullied was lower than seven of Hackney's ten statistical neighbours, as well as being lower than the London and (significantly) the national average. However, in Hackney and the City a higher proportion reported bullying others than six of Hackney's statistical neighbours, and higher than the London and (significantly) the national average (Figure 135).

Nationally, the most deprived areas have significantly lower levels of 15 year olds being bullied and this is in line with Hackney and the City, although there is no difference in the reported rate of bullying others by level of deprivation nationally. Those of gay/lesbian and bisexual sexualities have significantly higher levels of being bullied as well as significantly higher levels of bullying others. White 15 year olds have significantly higher reported levels of being bullied and significantly lower levels of bullying others; whereas Asian and Black ethnicities have significantly lower levels of being bullied but higher reported levels of bullying others.

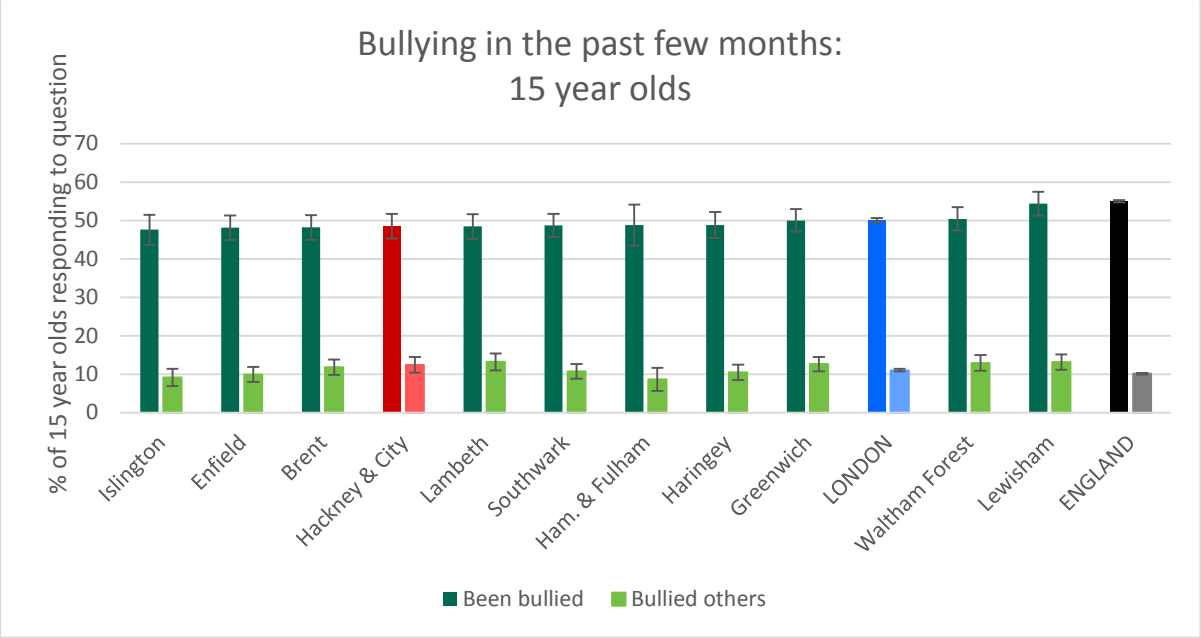

Figure 135: Self-reported levels of bullying in 15 year olds, 2015 [145]

In line with Meltzer et al's national findings [144], the estimated prevalence of mental health disorders in Hackney is 1.5-fold greater in boys than girls, with this difference being more marked in the 5-10 year old age group where the difference is over two-fold (Figure 136). For each age group boys in Hackney have a higher rate of conduct disorder and hyperkinetic disorder, whereas girls have a higher rate of emotional disorder[51]. Overall, the estimated prevalence of conduct disorders is higher in Hackney (6.3%) than London (5.7%) or England (5.6%) and similarly the estimated prevalence of emotional disorders is higher in Hackney (4.0%) than London or England (both 3.6%) [41].

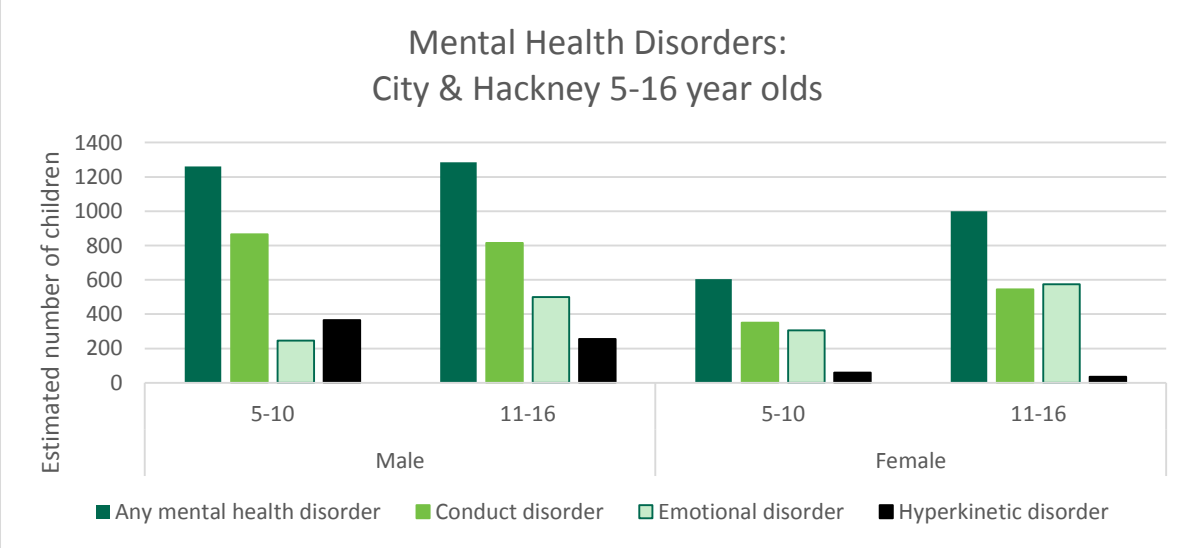

Figure 136: Estimated number of children affected by a mental health disorder in City & Hackney CCG, 2004 survey data [146] with 2014 data refresh [109]

[51] Note – emotional disorders include neuroses such as anxiety disorders, depression and phobias [146]

Conduct disorders in children are associated with the development of personality disorders in adulthood [147]. The rates of antisocial and borderline personality disorders in adults are higher in Hackney and the City than Hackney's statistical neighbours [111].

On average, neuroses have a later age of onset than conduct or hyperkinetic disorders (partly accounting for the relatively low prevalence of mental disorders in girls compared to the relatively high prevalence in adult females). Within Hackney and the City's 16-19 year olds, over twice as many females are estimated to have a neurotic disorder than males (Figure 137). The greatest gender difference is seen in phobias and depressive episodes, where approximately three times as many females are affected. In contrast, more males are estimated to be affected by generalised anxiety disorder than females.

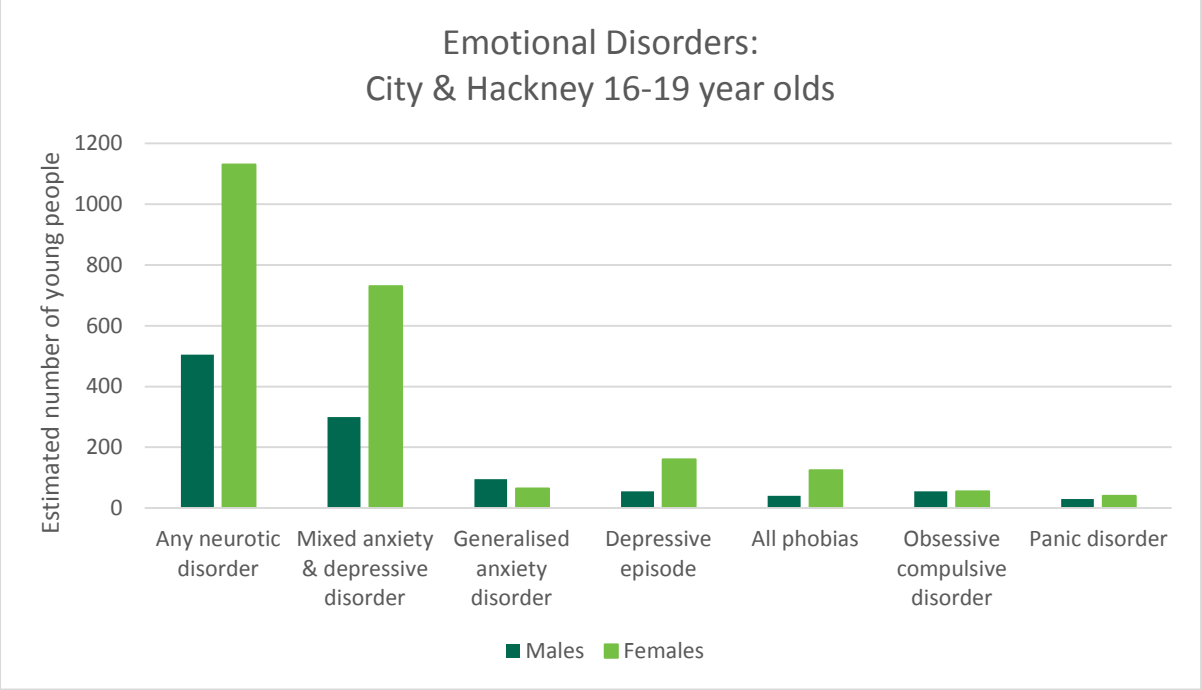

Figure 137: Estimated number of 16-19 year olds affected by a neurotic disorder in City & Hackney CCG, 2004 survey data with 2014 data refresh [109]

It is these neurotic disorders (in particular mixed anxiety and depression, generalised anxiety disorder, and depression) that are the most common mental health problems affecting adults in Hackney and the City. While a further breakdown of the prevalence of these neurotic disorders by ward would be difficult in young people due to the relatively small numbers involved, an investigation into adult cases has been performed and it is likely that the findings for young people would be similar. It was found that high levels of depression are seen in Wick, Lordship, Stoke Newington Central and Hoxton wards in Hackney, and in Cripplegate and Portsoken wards in the City of London [111].

Autism is classified as a 'less common mental disorder' that does not fall into the conduct/emotional/hyperkinetic categories [146]. Hackney has a lower proportion of school-age pupils recorded as having autism than eight of its ten statistical neighbours

(Figure 138). However, the prevalence of autism in Hackney has been increasing slightly faster than the national rate over the last five years so there is no longer a statistically significant difference between Hackney's and England's prevalence of autism (Appendix 15.5.2, Figure 229).

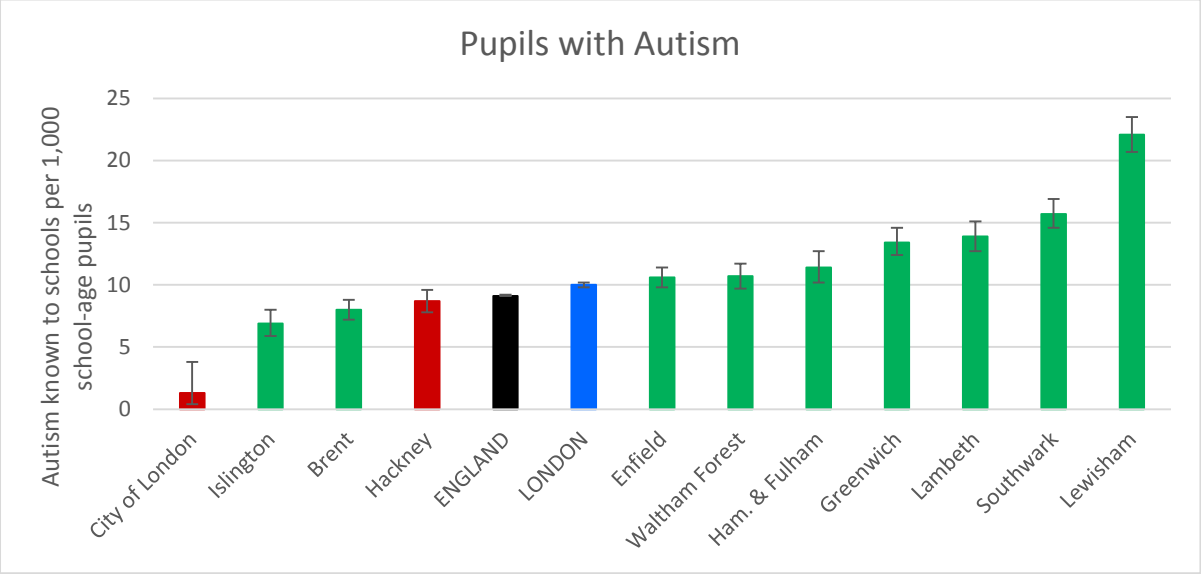

Figure 138: Pupils known by schools to have autism per 1,000, 2013/14 [41]

11.2.2.2 Severe Mental Illness

Severe mental illnesses (SMI) are enduring mental health problems that create a significant disability. Most SMIs are psychoses, such as schizophrenia, but severe and enduring depression and bipolar disorder are also included.

SMIs are less prevalent in children and adolescents than adults. Most men develop schizophrenia between 18 and 25 years of age, with the average onset being later in women at 25-35 years of age [148]. Numbers are therefore too small to assess in the 5-19 age group in Hackney, however SMIs should not be overlooked in young people as Hackney has the highest estimated[52] rate of new cases of psychosis in working age adults of any London borough at 71.9 per 100,000 [41]. Furthermore, the rate of schizophrenia-related emergency admissions in Hackney is the highest in the country and five times the national rate [111]. Black ethnicities [149] and deprivation [150] are risk factors for schizophrenia which may account for Hackney's increased prevalence.

While clinicians have reported an increase in the caseload for eating disorders, trend data are not available to support this [111]. Furthermore, a literature review conducted within the recent local mental health needs assessment [111] did not find evidence demonstrating effective prevention programmes aimed at those under 15 years of age.

[52] Note – the value is a 2011 estimate based on a modelling approach

11.2.2.3 Self-harm and Suicide

Self-harm related admissions in 10-24 year olds are lower in Hackney than seven of Hackney's ten statistical neighbours (significantly so in four of these), as well as being significantly lower than the London and national averages (Figure 139).

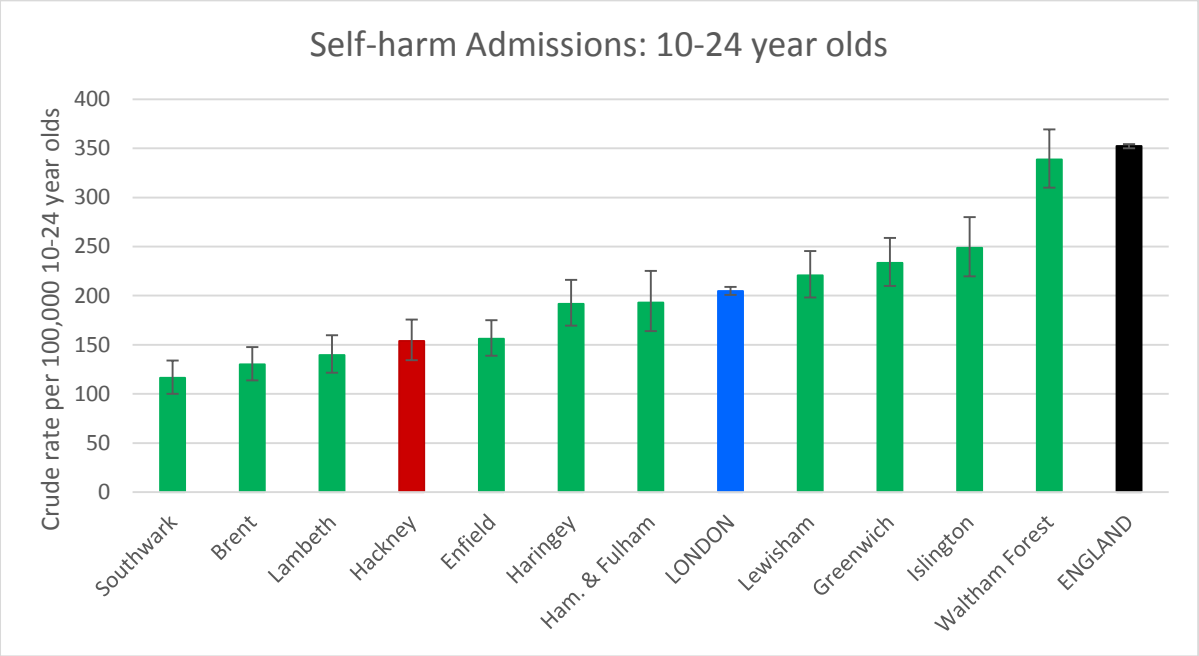

Figure 139: Self-harm admissions in 10-24 year olds, 2010/11-2012/13 [41]

Furthermore, Hackney's rate of self-harm related admissions has fallen slightly over the past four years in 10-24 year olds (although not significantly) – widening the gap with the London and national averages (Appendix 15.5.2, Figure 230).

However, despite this fall in admissions, local clinicians have reported an overall (across both young people and adults) increase in the number of self-harm cases presenting to services [111]. This may suggest that the incidence of mild to moderate self-harm is increasing, while the incidence of severe cases (thus requiring admission) is decreasing.

When considering suicide, the youngest age bracket for available data is 15-34 year olds. This is because, along with the numbers of suicides in those aged under 15 being very low, coroners are unable to give a verdict of suicide for those under 10 years of age and giving a verdict of suicide for those aged 10-15 years can be highly subjective [151].

Nationally, the rate of suicide in men aged 15-34 is almost four times higher than the rate in women aged 15-34. Given the low rate in women, no local authority-level breakdown is provided by PHE for this group. Hackney's rate of completed suicides in males aged 15-34 is higher than seven of its ten statistical neighbours and higher than the average rate in London, but lower than England's average (Figure 140). However, given the low numbers involved, the rates are subject to a wide degree of uncertainty and none of these ten boroughs have statistically significantly different rates.

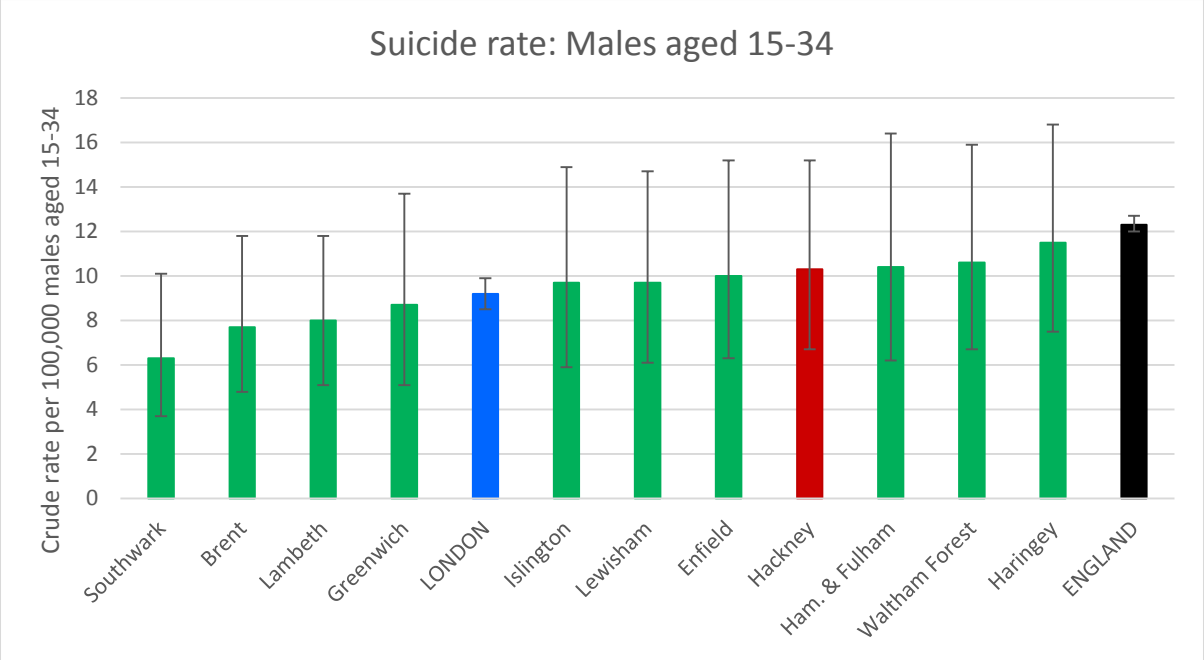

Figure 140: 5 year average crude suicide mortality rate, 2009-13 [41]

11.2.3 Guidance

11.2.3.1 NICE PH20: Social and emotional wellbeing in young people

Strategic framework
• Secondary education establishments to adopt organisation-wide promotion of social and emotional wellbeing of young people encompassing organisation and management issues as well as the curriculum and extra-curriculum provision • Ensure they have access to the specialist skills, advice and support required • Encourage the local authority scrutiny committee to assess their progress
Key principles and conditions
• Head teachers, governors and teachers should lead to ensure social and emotional wellbeing features within improvements plans, policies, systems and activities • Create a culture of mutual respect, inclusiveness, communication and learning • Provide a safe environment which nurtures sense of self-worth and self-efficacy, reduces the threat of bullying and violence and promotes positive behaviours • Systematically measure and assess young people's social and emotional wellbeing • Ensure young people have access to pastoral care as well as specialist services so emotional, social and behavioural problems can be dealt with as soon as they occur
Curriculum approaches
• Promote positive behaviours and reduce disruption / bullying by integrating social and emotional skills development (motivation, self-awareness, problem-solving, conflict management, collaborative working, relationship management) in all curriculum areas • Build on learning in primary education and sustain it throughout their education • Tailor social and emotional skills education to the developmental needs of young people

Working with parents and families
• Develop parents' / carers' parenting skills through small group-based programmes run by trained practitioners to help reinforce young people's learning from the curriculum • Ensure family members in disadvantaged circumstances are given the support needed to fully participate in activities to promote social and emotional wellbeing e.g. range of times, help with transport or childcare. May involve liaison with family support agencies
Working in partnership with young people
• Develop partnerships through a variety of mechanisms between young people and staff to formulate, implement and evaluate organisation-wide approaches and activities to promote social and emotional wellbeing • Provide opportunities for young people to build relationships e.g. peer education / mediation. Note young people acting as peer supporters need training and support • Provide clear and consistent information about opportunities to discuss personal issues and emotional concerns and make young people aware of their confidentiality rights
Training and continuing professional development
• Integrate social and emotional wellbeing within training and continuing professional development of practitioners and governors involved in secondary education • Training may cover non-judgemental listening and facilitating skills, how to effectively manage behaviours, identifying and responding to young people's emotional and behavioural needs, how to access pastoral care in education or specialist services, ensuring those with medical conditions are not inappropriately excluded and provide opportunities to reflect on and develop their own social and emotional skills

11.2.3.2 Healthy Child Programme

5-11	Universal
• Children and their families should have access to emotional health and wellbeing support through universal services. All pupils to have appropriate support e.g. through the primary SEAL (Social and Emotional Aspects of Learning) programme • Healthy Schools have a whole-school focus on promotion of positive emotional health and wellbeing. Enhanced Healthy Schools may develop targeted mental health outcomes • Schools participating in TaMHS (Targeted Mental Health in Schools) provide access to a range of support with a focus on building resilience and preventing the development of significant problems • Schools have a legal duty to have measures in place to prevent and tackle bullying • There should be agreed access for professionals to specialist CAMHS • Teachers and colleagues should use the Common Assessment Framework (CAF) to raise concerns such as emerging developmental, emotional adjustment, educational or behavioural difficulties in an accessible and speedy way and to alert and access support from the School Health Team and provide an opportunity for parents and carers to discuss family concerns and receive advice on matters relating to school progress	
5-11 Progressive	
• Professional consultation should be available and easily accessible from referral to primary, targeted and specialist CAMHS support for young people at risk of / experiencing poor mental health where there is an identified need • Schools using TaMHS provide access to additional support for those children who need it most and their families. Interventions include parent training/education programmes, therapeutic support for depression or family therapy. They also link with specialist CAMHS • Recommended that all looked after children have access to assessment, treatment and support through specialist CAMHS	

• Where there is significant concern regarding mental or physical health in children with special educational needs, early involvement of health professionals may be advisable • Protocols should allow School Health Teams to alert and access early support from the HCP team about emerging behavioural difficulties to provide an opportunity for parents to discuss family concerns and receive advice
11-16 Universal
In addition to the 5-11 Universal recommendations: • Health review at school transition in year 6/7 could include identifying incipient mental health problems including eating disorders
11-16 Progressive
In addition to the 5-11 Progressive recommendations: • The HCP team should be fully conversant with the role they can play in managing early symptoms in universal settings without the need for onward referral, but should also be conversant with referral protocols when these become necessary • Young people involved with the youth justice system should receive tailored co-ordinated multi-faceted care to meet their individual needs including communication and language needs, learning disabilities and mental health problems
16-19 Universal
• Young people and their families should have access to emotional health, psychological wellbeing and mental health support through universal services • HCP teams should contribute, as appropriate, paying particular attention to young people's needs at transition between CAMHS and AMH services
16-19 Progressive
• CAMHS is available for young people aged up to 18

11.2.4 Local Services

Universal provision is delivered under the existing CHYPS+ and universal services. The 'plus' denotes that, in addition to sexual health services, it also offers interventions around smoking cessation, emotional health and wellbeing, and obesity and nutritionally-related services. However, this service is currently being recommissioned, with the education element being taken back into Hackney Council, and the clinical service (predominantly sexual health) being delivered separately. This new service is being designed to support the delivery of the Council's key priorities which includes emotional wellbeing and mental health. Furthermore, the service includes the specific aim to "promote good mental health and wellbeing". This service will be universal for children and young people aged 5-19, with additional support available for vulnerable young people up to the age of 25.

Specialist child and adolescent mental health services (CAMHS) are delivered by a range of providers, and overseen through a partnership between the CCG and the local authority. Providers include Homerton University Hospital NHS Foundation Trust (First Steps and Disability CAMHS), East London NHS Foundation Trust (ELFT – more specialist CAMHS), and local authority clinicians (who deliver CAMHS for children known to Children's Social Care).

Across ELFT CAMHS, 243 referrals were received in quarter two of 2015/16, of which 193 were accepted and 160 were seen within the target of five weeks. In total, 640 different patients were seen during this period, of which 54% were male and 63% were aged 12-18 years. Of 239 follow up outcome questionnaires, 96% of clients showed an improvement in comparison to their initial questionnaire; and of 62 completed satisfaction questionnaires 100% reported being happy with the service.

The CAMHS Alliance was created in April 2015 to allow a single point of referral and joined up working across a range of tier two and tier three services and therapies in Hackney and the City of London. The CAMHS Alliance includes First Steps, Off Centre and specialist CAMHS. First Steps is an early intervention service providing brief psychological support for young people under 18 who have a mild to moderate mental health problem. Off Centre provides information, counselling and outreach services to 11 to 25 year olds. Core specialist services are provided for children or young people with a severe mental health disorder and the adolescent mental health team provides early intervention and appropriate treatment for psychosis. The Coborn Centre delivers mental health support (usually for six to eight weeks) in a residential setting for 12-18 year olds with complex and severe mental illnesses from Hackney, the City of London and other ELFT boroughs. CAMHS work is also integrated into children's social care with assessments and interventions through clinical, counselling and forensic psychologists, family therapists and an occupational therapist being undertaken collaboratively with social work assessments and planning.

A disability team provides support for young people who have a mental health issue in addition to a disability (including autism). Furthermore, the City commissions a scheme for all LAC and care leavers to receive a CAMHS assessment in their placement, which includes an assessment of their relationships with foster carers, siblings and peers. For some cases this scheme also provides crisis management support to foster parents and carers. For further information on CAMH services, please refer to the CAMHS framework[53].

However, the recent mental health needs assessment conducted in Hackney and the City [111] revealed that some clinical pathways that are relevant to children and young people are unclear amongst stakeholders. For instance, the management of conduct disorder and self-harm were highlighted as areas where referrals pathways could be clarified and communicated. Furthermore, the transition from adolescent to adult services has been identified as an area for development. Work to map mental health service provision is currently being undertaken by the City and Hackney public health team to allow pathways to be more easily recognised.

53 http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjmvtyvsfrOAhVGnRoKHbQ9CSMQFgglMAA&url=http%3A%2F%2Fwww.hackney.gov.uk%2Fmedia%2F4002%2Fchild-and-adolescent-mental-health-services-framework-for-Hackney%2Fpdf%2FCAMHS-framework-2013-15&usg=AFQjCNGZUFMYVVuwhJupHVb7SU0cQJKpTw

City and Hackney CCG have recently received funding to support their CAMHS transformation plan. The priorities that have been identified for this funding will be:

- Building reach and resilience through delivering training and supervision in third sector organisations
- Developing the reporting of outcome measures through more user friendly and standardised data collection and integrated information systems
- Creating integrated early years pathways involving improved liaison between the Mother and Baby service, the neonatal intensive care unit and First Steps
- Improving autistic spectrum disorder management in mainstream schools through increasing educational psychology capacity
- Developing crisis support with greater integration between mental and physical health for example through improved paediatric mental health liaison in A&E
- Improving eating disorder management in the community through the development of a single integrated service across City and Hackney, Newham and Tower Hamlets
- Redesigning mental health support for youth offenders alongside the Liaison Diversion Service

11.2.5 Stakeholder Consultation

Stakeholder consultation has been undertaken with a variety of young people-related groups to try to understand common opinions and also the thoughts of hard to reach groups and those with protected characteristics.

CHYPS+ Voices is a youth forum for 11-19 year olds that has been created locally as a platform for young people's opinions to be inputted into CHYPS+. This forum suggested that social media (such as Twitter, Facebook and Instagram) could be used to promote mental health issues such as depression. It was also raised that specific support around male health issues would be useful as it was felt that men are harder to reach. A workshop was also held with pupils at a local primary school and a list of perceived 'healthy' attributes was created that included "learning", "activities" and "a bit of everything" and things that made the children happy included their families, friends and pets, sport and exercise, and activities and hobbies. This falls in line with some of the five ways to wellbeing of connect, be active, take notice, keep learning and give [152]; Hackney has now adopted these five ways to wellbeing under the name of "five to thrive". Further examples of what made the children happy included attending church or mosque, and "a teacher being nice to [them]". Conversely, the children perceived stress as unhealthy, and reported that seeing others unhappy, being angry or rude, fighting, bullying, and having no one to play with would make them unhappy. A group of parents at Young Hackney's largest youth hub (Forest Road) suggested that exploring emotional wellbeing in a group setting at school may encourage children to talk about their issues and help them to feel that they're not alone.

Consultation with an LGBTQ group for young people emphasised that mental health is viewed as important – socialising outside of school was viewed as particularly valuable and it was felt that there should be a range of options to facilitate this (not just through sport, for instance). In line with the comments raised by the CHYPS+ Voices group, work with young men was identified as an area for development with the particular example of eating disorders in young men being highlighted as requiring acknowledgement. The group suggested that it is good to have a specific person to talk to in schools and who can direct young people towards resources, but that this person does not need to be a professional as long as they were interested in the individual. They also expressed concern that doctors can sometimes be "too clinical". The Childline website was raised as a good example of a source of support and information as it is online and anonymous.

In a workshop at New Regent's College (a re-engagement unit) students described being depressed, anxious and tired as examples of being unhealthy and that being "always with technology", "not socialising" and "sleeping a lot" might be behaviours that could contribute to this. Conversely, "having plans [for the] future", being "out and about" and being sociable were reported as healthy attributes for young people.

Stakeholders involved in Hackney and the City of London's mental health needs assessment [111] identified refugees as a specific group who would benefit from targeted preventative work in relation to suicide. However, this consultation was not specific to children and young people.

11.2.6 Recommendations

- Aim to ensure that the relatively low rate of inpatient hospital admissions for a primary diagnosis of a mental health or behavioural disorder are due to a low need, and not due to barriers to diagnosis or admission
- Encourage partnership work to improve the prevention offer around acute mental health needs as early as possible
- Work to increase the accessibility of mental health support for young men, who may be a harder to reach group, and who are known to be more likely to complete suicide or suffer from psychoses as young adults
- Consider a school health review at the transition to secondary school to identify mental health issues, in particular eating disorders, in line with the Child and Adolescent Mental Health Services (CAMHS) transformation plan and following the HCP suggested recommendation

11.3 Smoking

11.3.1 Introduction

"More than eight out of ten adults who have ever smoked regularly started before age 19."

Figure 141: Children and Young People's Health Outcomes Forum, 2014 [16]

The sale of tobacco or cigarettes to anyone aged 18 or under is prohibited under clause 92 of the Children and Families Act 2014, and the buying of tobacco or cigarettes on behalf of someone aged under 18 is prohibited under clause 91. Recent legislation, as an amendment to the Health Act of 2006, has also prohibited smoking in private vehicles when there is someone under the age of 18 present in the vehicle.

11.3.2 Hackney and City of London

In the What About YOUth survey of 15 year olds, 76% in Hackney and the City reported never having smoked, with 5.8% being current smokers, 4% being ex-smokers and 14% having tried smoking (Figure 142). This is in line with a survey of young Hackney residents aged between 11 and 19 done by Rockpool Research Associates [153], which found that, of 844 responses, 77% had never smoked and 4% were ex-smokers. However, the Rockpool survey revealed a higher proportion of current smokers (13%) and a correspondingly lower proportion of those who had tried smoking (6%).

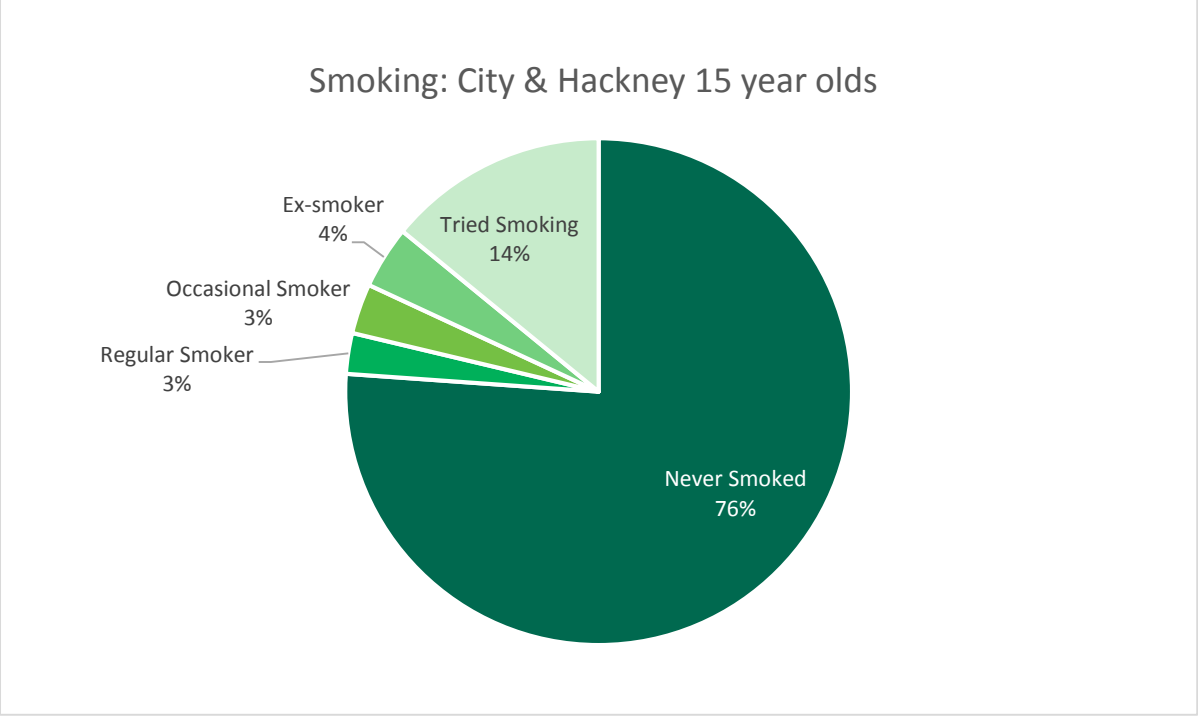

Figure 142: Smoking prevalence in 15 year olds in Hackney and the City, 2015 [145]

This proportion of current smokers in Hackney and City's 15 year olds is higher than six of Hackney's statistical neighbours, but lower than the London average and significantly lower than the national average (Figure 143). Nationally, White and Mixed ethnicity and gay/lesbian or bisexual 15 year olds have a significantly higher rate of reporting to be a current smoker, whereas Asian, Black, Other ethnicities and heterosexual 15 year olds have significantly lower reported rates of being a current smoker.

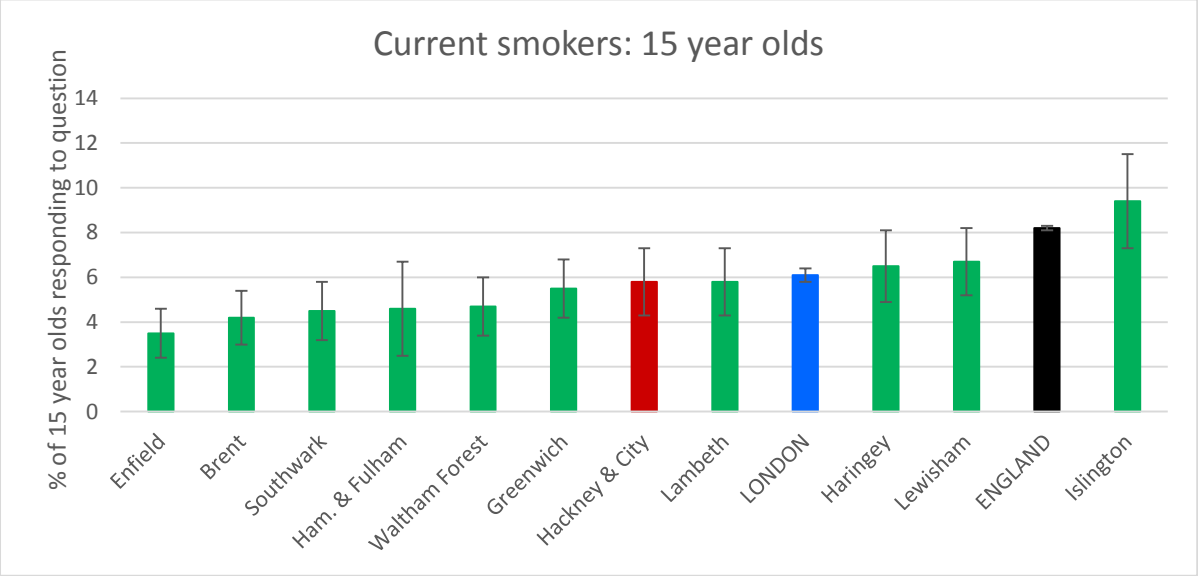

Figure 143: Self-reporting of being a current smoker in 15 year olds, 2015 [145]

The prevalence of smoking recorded in primary care (City and Hackney CCG) is negligible in those aged 14 and under, but in 15-19 year olds reveals a higher rate in girls (5.4%) than boys (4.5%). This gender imbalance is reflected in the national What About YOUth figures, with the rate of current smoking being 10% in girls and 7% in boys (similarly ex-smoking and tried smoking are also higher in girls than boys). However, the primary care figures increase sharply, and men overtake women, at 20-24 years of age (24% in men versus 22% in women).

Exploration of the social factors at play in smoking in young people was investigated by the Rockpool survey in Hackney. This showed that 51% whose parents smoke also smoke themselves, and 35% whose siblings smoke also smoke themselves. The most common reasons provided for trying smoking were "too see what it was like" (60%), followed by because their "friends are smoking" (35%).

According to the WAY survey, 24% of 15 year olds in Hackney and the City report to have tried tobacco other than in cigarettes. This is likely to predominantly relate to shisha tobacco, as the question asked in the survey gave the following examples to help participants answer the question: "shisha pipe, hookah, hubble-bubble and water pipe" (all being words to describe the instrument through which shisha tobacco is smoked). This places Hackney and the City's rate higher than six of Hackney's statistical neighbours

(significantly so for one local authority), higher than the London average, and significantly higher than the national average (Figure 144). However, as there are relatively few official shisha bars in Hackney in comparison to other neighbouring boroughs, it is unclear how or where young people are accessing shisha locally. With regards to sexuality nationally, the pattern is the same as for cigarette smokers with those who are gay/lesbian or bisexual being more likely to smoke. However, with regards to ethnicity nationally the pattern is the opposite of that seen with cigarette smoking, with a significantly higher rate of non-cigarette tobacco smoking in those of Mixed, Asian, Black and Other ethnicities and a significantly lower rate in White 15 year olds.

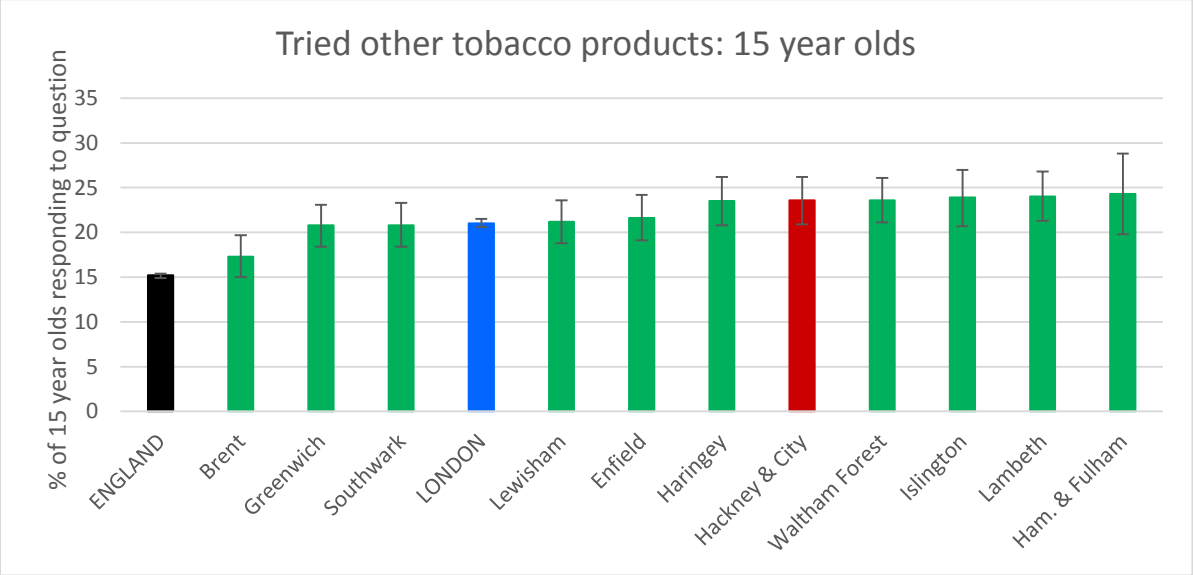

Figure 144: Self-reporting of trying tobacco products other than cigarettes in 15 year olds, 2015 [145]

The Hackney Rockpool survey revealed that, of opinions about smoking, the largest uncertainty was around the health impact of smoking shisha. For the statement "shisha isn't as harmful as smoking cigarettes" 26% agreed, 33% disagreed and 40% didn't know. The American Centres for disease control and prevention (CDC) states that shisha smoking has many of the same health risks as cigarette smoking as it delivers nicotine, and the heat from burning charcoal means that the smoke is at least as toxic as cigarette smoke [154]. Furthermore, due to the way in which shisha is usually smoked, an hour-long shisha-smoking session typically involves 200 puffs, whereas an average cigarette involves 20 puffs. This means that shisha smokers are at risk of cancers of the oral cavity, lung, stomach or oesophagus as well as reduced lung function and decreased fertility [154]. However, there may be some confusion in local respondents to both the Rockpool and WAY surveys as 'shisha pens' are now available (a similar concept to e-cigarettes), which may carry fewer health risks.

11.3.3 Guidance

11.3.3.1 NICE PH14: Preventing the uptake of smoking in children and young people

Campaign development
• Identify and understand the target audience (young people under 18) and consider groups with higher than average or rising rates of smoking • National/local government, NHS, media professionals, public relations agencies and local anti-tobacco activists should develop national, regional or local mass-media campaigns • Campaign(s) should not be developed in conjunction with the tobacco industry
Campaign messages
• Base messages on strategic research and perform qualitative testing with target audience • Portray tobacco as deadly and elicit strong, negative emotional reaction • Include graphic images of detrimental effects on health and appearance • Use testimonials and celebrities relatable to children and young people • Empower children and young people to refuse offers of cigarettes • Repeat messages in a number of ways and provide sources of further information/support
Campaign strategies
• Use a range of strategies (generate news, use posters/brochures, use new media) • Regional/local campaigns should build on and be integrated with national communications strategy using local press and radio to reach specific audiences • Campaigns should run for 3-5 years and use process and outcome measures to ensure campaigns are being delivered correctly and effectively • Campaign(s) should not be delivered in conjunction with the tobacco industry
Illegal sales
• Campaigns should publicise legislation prohibiting under-age tobacco sales • Local authorities and trading standards should provide training to retailers and encourage them to request proof of age for anyone who appears younger than 18 and complete 'Age restricted products refusal register' for each sale refused on grounds of age • Test purchases based on local data should detect breaches in the law, practice across local authorities should be audited and prosecute retailers who persistently break the law • Actively discourage tobacco industry developed enforcement and related campaigns

11.3.3.2 NICE PH23: Smoking prevention in schools

Organisation-wide or 'whole-school' approaches
• Develop whole-school smokefree policy in consultation with young people taking account of cultural, special educational or physical needs as part of wider PSHE/SRE strategy • Apply smokefree policy to everyone on site (do not allow any smoking areas except caretakers' homes) and publicise to everyone on site (including written material) • Support cessation as well as prevention by publicising local NHS Stop Smoking Services
Adult-led interventions
• Integrate health, legal, economic and social effects of smoking into curriculum • Deliver entertaining, factual, interactive, age-appropriate and ethnically and culturally sensitive interventions through credible teachers and working with local partners • Develop decision-making skills and enhance self-esteem through active learning • Provide additional 'booster' tobacco education activities until school leaving age • Encourage parents/carers to be involved

Peer-led interventions
• Consider offering evidence-based, peer-led interventions to young people aged 11-16 such as the ASSIST (A Stop Smoking In School Trial) programme • Ensure peer leaders (same age or older) are trained outside school by adults with expertise and receive support from them during programme • Encourage young people to consider and, if necessary challenge, peer and family norms
Training and development
• Provide training for all staff involved in smoking prevention work in schools • Design, deliver, monitor and evaluate prevention training and interventions with partners e.g. local authorities, school nursing, training agencies and voluntary sector
Coordinated approach
• Ensure school prevention interventions are evidence-based, part of the local tobacco control strategy and consistent with regional and national strategies • Ensure interventions are integrated into the curriculum, PSHE education and related to activities for Healthy Schools status

11.3.3.3 Healthy Child Programme

11-19 Progressive
• Provide Very Brief Advice using the '3As' to supporting young people who smoke to quit: • **A**sk if they smoke; • **A**dvise them about stopping and the efficacy of local NHS Stop Smoking services (the most effective evidence-based opportunity to stop smoking); and • **A**ct by offering a referral to the local service

It is recommended that all healthcare professionals also use the '3A' approach outlined above to supporting parents who smoke to quit.

11.3.4 Local Services

Smoking cessation support is currently offered through CHYPS+.

The new Children and Young People's Health and Wellbeing Service, to be delivered from August 2016, will also address both smoking prevention and cessation with the aim of reducing the smoking prevalence in 15 year olds (public health outcomes framework indicator 2.9). In order to achieve this, the service will provide age-appropriate, impartial and non-judgemental outreach sessions to children and young people in primary and secondary schools and other youth settings. Furthermore, the service will be responsible for leading on the development of locally-led health promotion campaigns including smoking prevention to be developed in partnership with the Council. Substance misuse prevention workers from young Hackney's substance misuse service will also be trained to deliver smoking prevention sessions in primary and secondary schools, either as a stand-alone activity or as one element in a wide-ranging session covering different types of substance misuse and addiction.

Since 2009, Hackney Council has worked with Cut Films – a film and social media project designed to educate and engage with young people about the harms caused by smoking. In 2015 a total of 134 films were created by young people across Hackney making it the most successful year so far.

The Healthy Hackney Fund awarded grants to four projects for smoking prevention for 2015/16. These projects are currently ongoing and learning, outcomes and evaluations will be available at the end of the grant in May 2016. The projects are:

- Clapton boys club Breathe Life – working with boys in the Jewish community
- Chinese Community Centre – working in the Vietnamese and Chinese community with families and young people
- Chain Reaction – delivering a theatre production and workshops to young people in six schools
- Youth of Haggerston – working with children and young people associated with gangs, particularly in the Kurdish and Turkish communities

11.3.5 Stakeholder Consultation

Stakeholder consultation has been undertaken with a variety of young people's groups to try to understand common opinions about health. A workshop was held with pupils at a local primary school and, even at this young age, smoking was given as an example of unhealthy behaviour. CHYPS+ Voices is a youth forum for 11-19 year olds that has been created locally as a platform for young people's opinions to be inputted into CHYPS+. This forum proposed that some young people were unaware of how addictive smoking is, or if they were they often did not wish to admit that it is a problem. In addition, they warned that the use of gruesome images does not always work as a deterrent as many young people are already desensitised to those images. However, they did recognise that the pictures might have different meanings for those who currently smoke, in comparison to those who have never tried smoking. Across two workshops held at New Regent's College (a vocational college and pupil re-engagement unit) smoking or smoking-related illnesses were given as examples of being unhealthy in seven of the ten sets of feedback.

11.3.6 Recommendations

- Utilise social media to convey anti-smoking messages to local young people
- Provide increased education both in schools and through wider campaigns to highlight the harms of smoking non-cigarette tobacco products, such as shisha
- Concentrate efforts to reduce cigarette smoking in White and Mixed ethnicity young people particularly, and focus on girls at younger age groups, and on boys when approaching the legal age of 18
- Use a whole-family approach to reducing smoking, as smoking in parents and siblings is a risk factor for young people smoking

11.4 Substance Misuse

[Alcohol and drug use] "affects their health and wellbeing, their education, their family life, their security, their future. It is also often a symptom of wider issues in their lives."

Figure 145: Substance misuse among young people 2011-12 [155]

11.4.1 Introduction

Alcohol use in young people is widespread, with more than half of 15-16 year olds consuming at least five alcoholic drinks in the previous month [16]. However, the prevalence of high risk drinking is far lower, with only 0.1% of the 5.5 million 9-17 year olds nationally accessing specialist services for alcohol abuse in 2011 [155].

The most common substance for which specialist services are accessed is cannabis [155]. It must be remembered that, in general, data exist for the use of alcohol, nicotine and commonly used illegal substances such as cannabis. However, there is an increasing concern over the use of new psychoactive substances (NPS), or 'legal highs', of which some can cause life-threatening symptoms. Often data are limited for NPS, which may be due in part to their relative ease of availability, the misconception that they are not harmful, and the difficulty in identifying them due to their wide ranging and often unknown chemical content. The Crime Survey for England and Wales found that, in 2013/14, 1.9% of young people aged 16-24 had taken mephedrone and 1.8% had taken salvia (a plant that can produce hallucinations when chewed or smoked) [156].

11.4.2 Hackney and City of London

11.4.2.1 Alcohol

The WAY survey found that fewer 15 year olds report being a current drinker in Hackney and the City (29%) than in London (35%) or England (57%). Furthermore, the proportion of 15 year olds currently drinking locally is lower than eight of Hackney's ten statistical neighbours. When looking at frequent drinking (at least once a week or once a fortnight), again the rate is lower in Hackney and the City (5.5%) than across London (7%) or England (13.9%) and lower than six of Hackney's ten statistical neighbours (Figure 146).

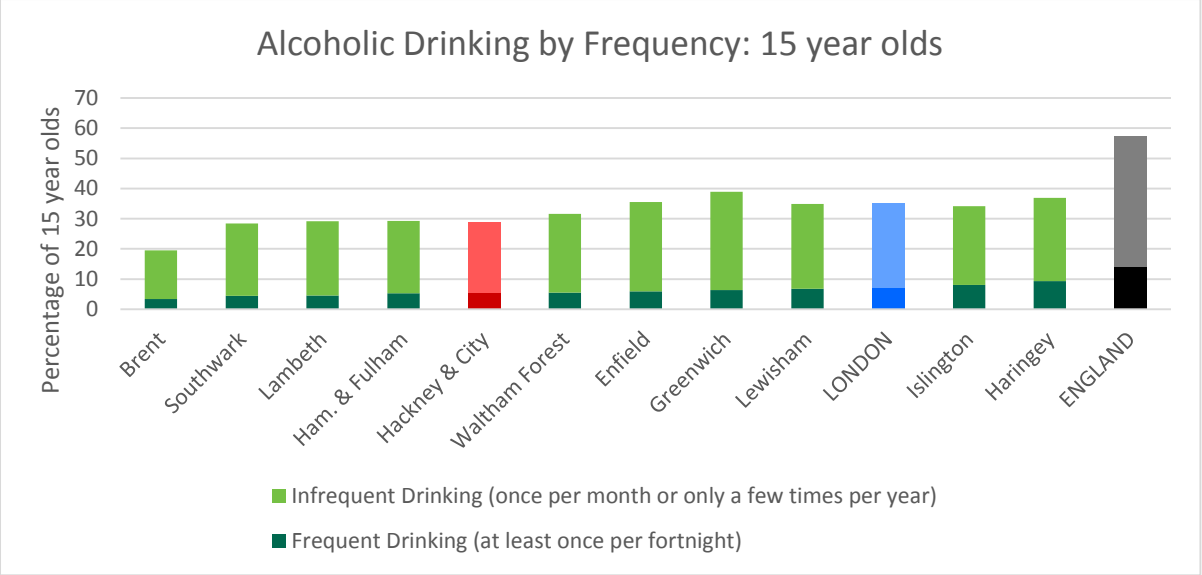

Figure 146: Frequent and infrequent alcoholic drinking in 15 year olds, 2015 [145]

National data reveal that frequent drinking is most common in 15 year olds of White ethnicity, and therefore Hackney's ethnic diversity may partially explain the relatively low rates locally (Figure 147).

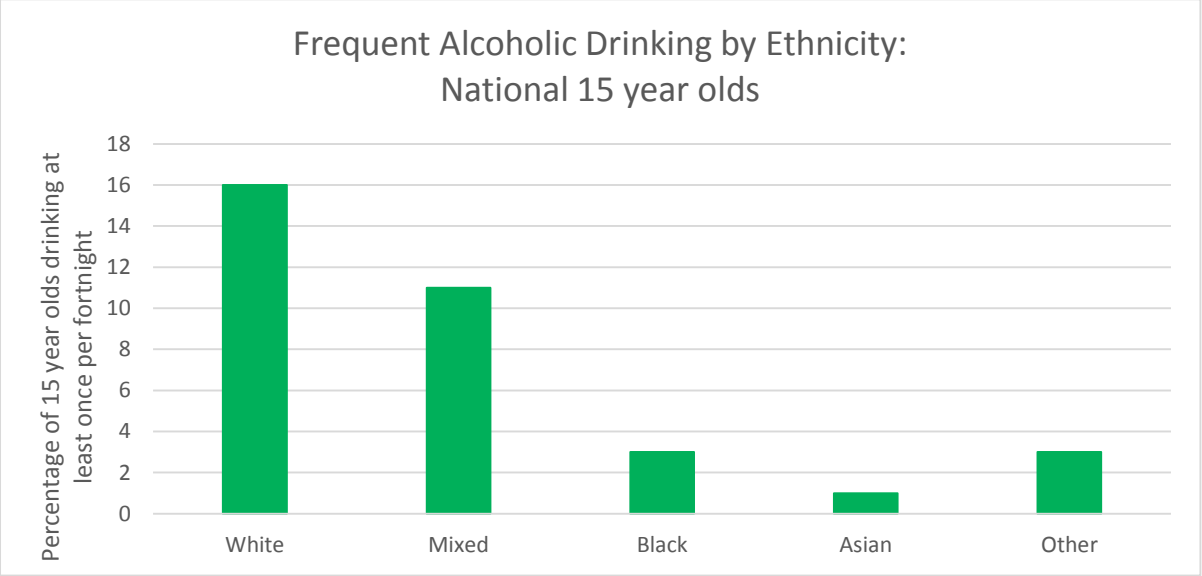

Figure 147: Frequent alcoholic drinking in 15 year olds nationally by ethnicity, 2015 [145]

Furthermore, in line with Hackney being in the most deprived quintile, nationally the proportion of 15 year olds who report frequent drinking increases as deprivation decreases. However, Hackney and the City have a lower proportion of 15 year olds frequently drinking (5.5%) than even the most deprived quintile (8%) (Appendix 15.5.3, Figure 231).

Unlike national data which show similar rates of frequent drinking between boys and girls, the rate of frequent drinking in Hackney and the City in girls is over twice that in boys (7.1% versus 3.2%).

Examining the rates of alcohol-related hospital admissions, as an approximate measure of harmful drinking, reveals that, at 22 per 100,000 under 18, Hackney has a rate that is again lower than the London average, and significantly lower than the national average (Figure 148). On this measure, Hackney fares typically for its statistical neighbours, being both better than and worse than five comparator boroughs. However, while the rate is continuing to fall in Hackney, the gap is closing as the rate nationally is falling more steeply (Appendix 15.5.3, Figure 232).

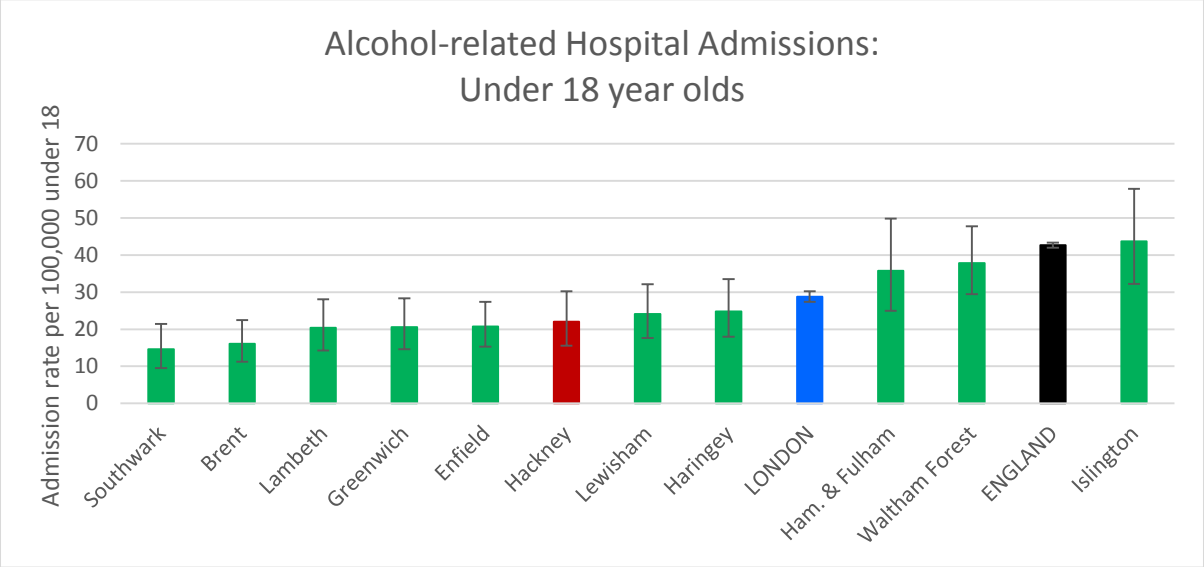

Figure 148: Alcohol-related hospital admissions in under 18s, 2010/11-2012/13 [41]

11.4.2.2 Other Substances

As cannabis is the most misused substance, the WAY survey collected data on the proportion of 15 year olds who had ever tried cannabis as well as how many had ever tried any other drug. In Hackney and the City 14% of 15 year olds have ever tried cannabis, whereas 2.9% have ever tried any other drugs. This places Hackney and the City as higher than six of Hackney's ten statistical neighbours for both ever having tried cannabis or ever having tried any other drug. However, other surveys have not ranked Hackney's rate of drug-taking in young people as highly; a survey by the Health and Social Care Information Centre across school years 6, 8 and 10 (and therefore covering younger age groups) in 2014 reported 2% taking drugs in Hackney compared to 3.3% in London and 4% in England.

Further breakdown of the WAY survey data are available by how recently cannabis was tried. On this measure, a higher proportion of Hackney and the City's 15 year olds had tried cannabis in the past month than nine of Hackney's ten statistical neighbours, as well as the London and national averages (Figure 149).

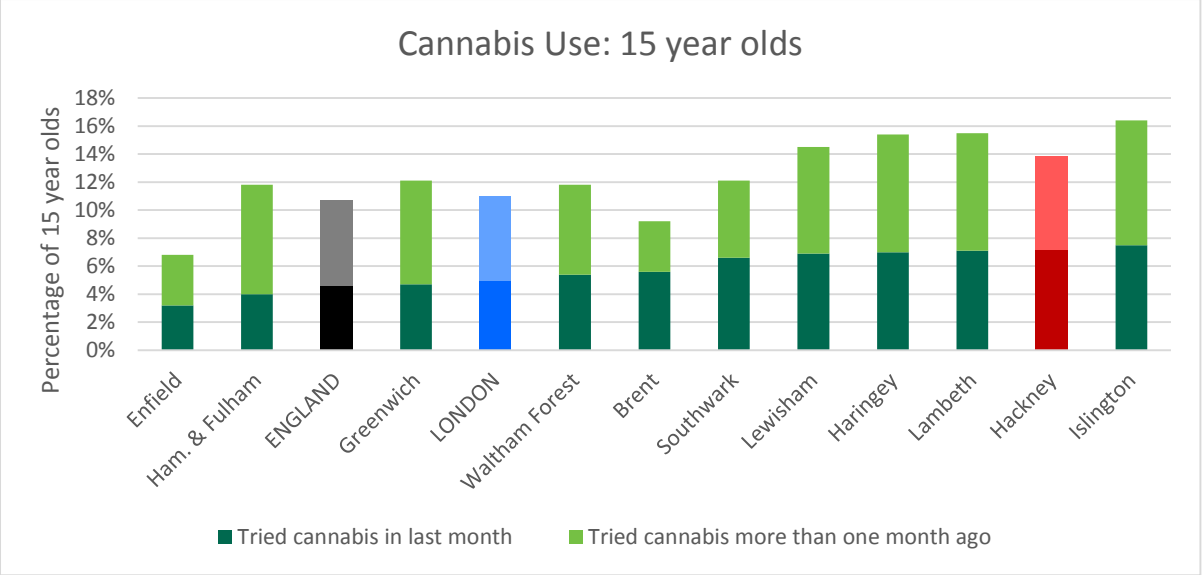

Figure 149: Cannabis use in 15 year olds by time of most recent use, 2015 [145]

Examining the breakdown of national figures reveals that there is not as clear a distinction between White and non-White ethnicities in reporting drug use as there is for alcohol use (Figure 150) and therefore Hackney's diversity would not necessarily lend it to having low rates as it does with alcohol.

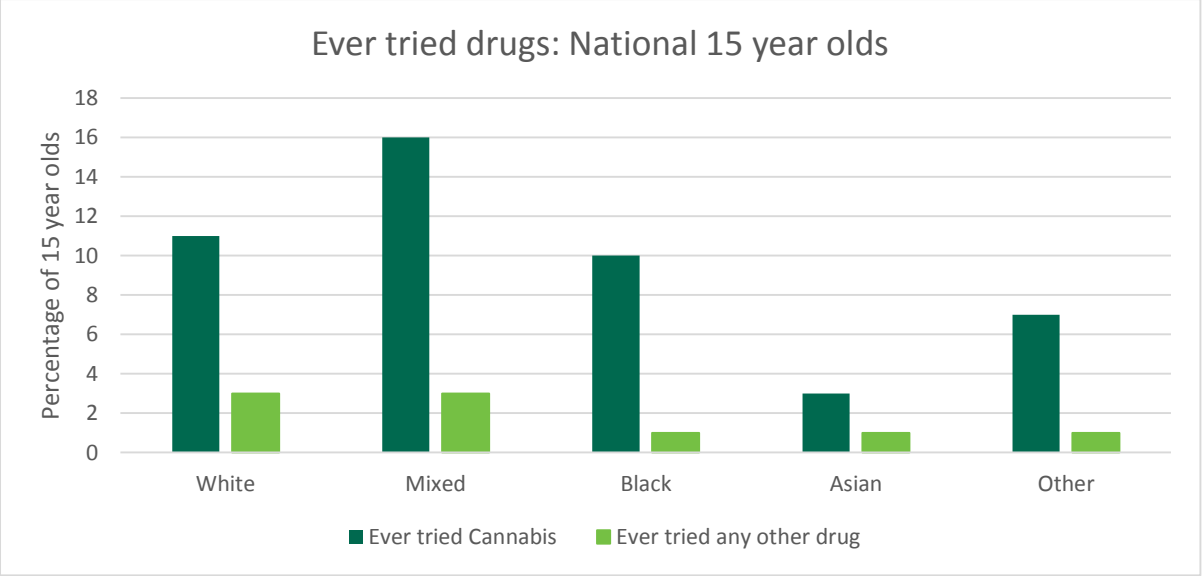

Figure 150: Ever trying cannabis or other drugs in 15 year olds, 2015 [145]

Also unlike alcohol use, reporting having taken cannabis appears to be lower in the two least deprived quintiles. However, there is not a large difference in proportions by deprivation quintile and it is unknown whether this is a statistically significant difference. Furthermore, there is not a clear relationship between ever having tried drugs other than cannabis and deprivation quintile (Appendix 15.5.3, Figure 233).

Despite Hackney and the City having a relatively high proportion of 15 year olds having taken cannabis in the last month according to the WAY survey, Hackney and the City has a relatively low rate of hospital admissions in 15 to 24 year olds due to substance misuse – lower than the London and national averages and seven of Hackney's ten statistical neighbours (Figure 151). Furthermore, while the proportion of substance misuse related hospital admissions is rising both in London and nationally, the rate has plateaued in Hackney and the City (Appendix 15.5.3, Figure 234).

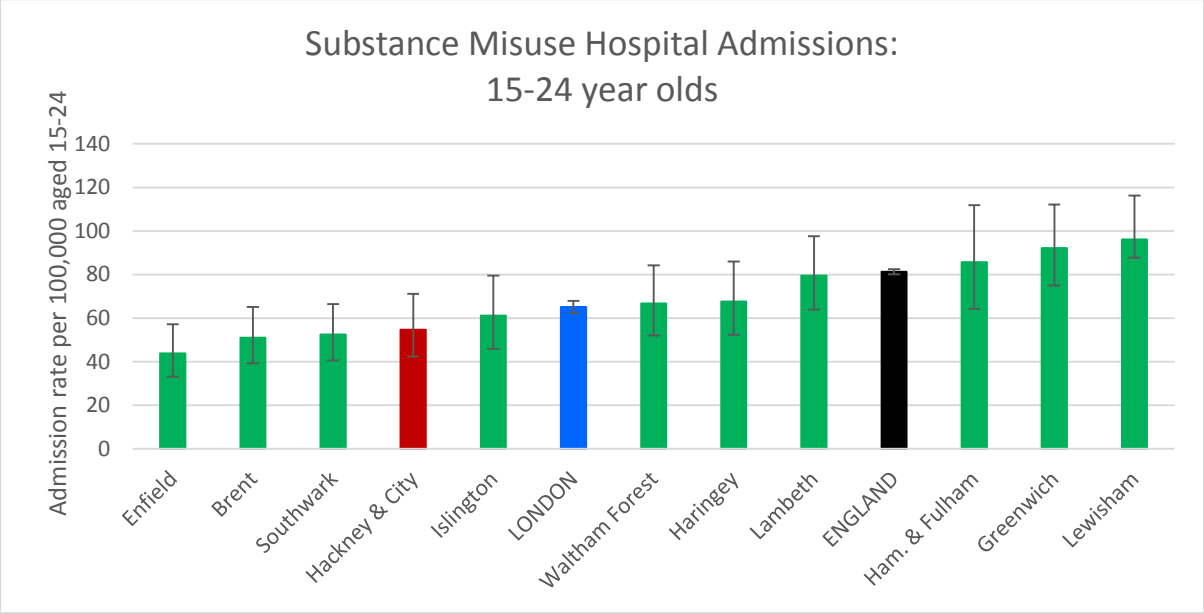

Figure 151: Substance misuse related hospital admissions in 15-24 year olds, 2011/12-2013/14 [41]

11.4.2.3 Alcohol and Substance Specialist Interventions

The National Drug Treatment Monitoring Service (NDTMS) summarises local and national data regarding young people receiving tier three specialist substance misuse interventions [137]. Tier two interventions are not reported by NDTMS, and no young people in Hackney receive tier four (residential) services. Currently published national data relate to the first quarter of 2015-16 (up to 30/06/2015). However, to reduce uncertainty and bias due to small numbers, the figures quoted below for Hackney relate to 2014/15 annual data.

While the number of recipients of tier three support has fallen by 10% nationally over the last two years, the number in Hackney has more than doubled (Appendix 15.5.3, Figure 235). It has been suggested that this may have been due to a recording issue prior to April 2014, as this doubling occurred sharply over the period of only a few months.

The main disparities between the sources of referral locally and nationally are in the relatively low rates of referral from education locally, and high rates of referral from youth justice services locally (Figure 152).

	Hackney (%)	England (%)
Children & family services	20	19
Education	8	27
Health & Mental Health	3	8
Substance misuse services	0	4
Youth justice services	63	27
Self, family & friends	8	12
Other (inc. blank)	0	4

Figure 152: Sources of referral to young people's substance misuse interventions, 2014/15 [137]

A lower proportion of those receiving treatment are girls in Hackney (17%) than nationally (35%). A greater proportion (40%) of clients are at the older end of the age-range (17 years of age) than nationally (26%).

The proportion of clients accessing services in Hackney who are White British is approximately half of the national proportion and the proportion who are of Black ethnicity is seven-fold greater (Appendix 15.5.3, Figure 237); however both of these would be expected given the underlying ethnicity proportions seen in Hackney's general population. The main discrepancy is that there are fewer young people of White Other ethnicities receiving substance misuse services in Hackney, despite the population being three-fold larger in Hackney than nationally. Of note, 27% of Hackney's clients do not have their ethnicity recorded (or it is inconsistent), compared to only 1% nationally.

Fewer of Hackney's clients are in education than national rates (44% versus 74%), with a correspondingly larger proportion of clients being classed as NEET (44% versus 14%) (Appendix 15.5.3, Figure 238).

Figure 153 shows the rates of 'wider vulnerabilities' in young substance misuse clients. While Hackney's clients have twice the rate of antisocial behaviour and of clients being a parent or pregnant than nationally, Hackney's clients are less likely to have a history of mental illness or self-harm or be a child in need compared to national tier three treatment.

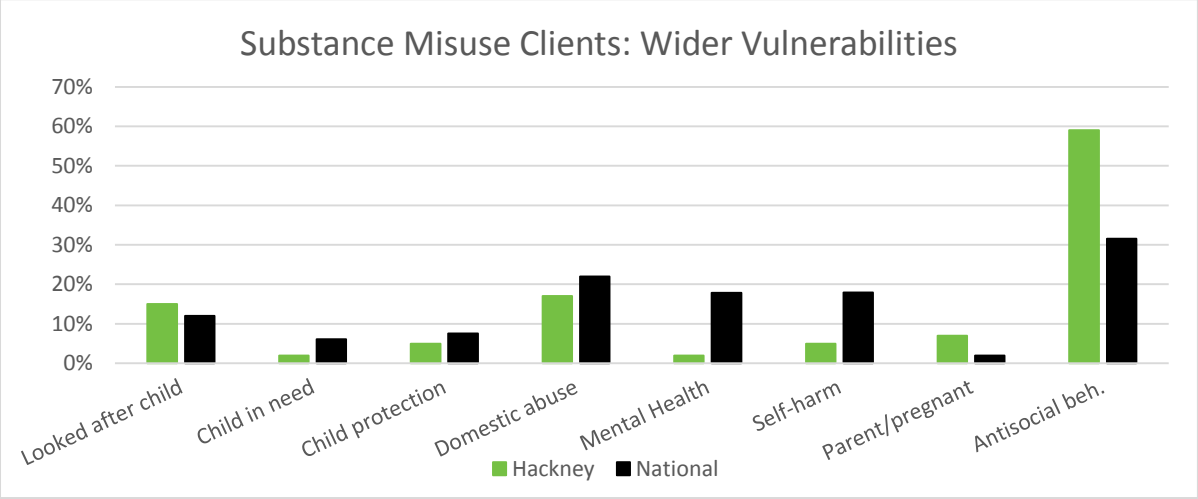

Figure 153: Vulnerabilities in young person substance misuse clients, 2014/15 [137]

Similar to nationally, none of Hackney's clients report injecting substances (1% nationally). Figure 154 shows that the three most common substances reported locally are cannabis, alcohol and nicotine and these are the same as those reported nationally. Cannabis use is reported in almost all local clients (96%).

	Hackney (%)	England (%)
Cannabis	96	88
Alcohol	38	48
Nicotine	17	14
Ecstasy	6	9
Cocaine	4	8
Amphetamines	0	9
New Psychoactive Substances	0	7

Figure 154: Substances reported by clients (only those above 5% nationally/locally shown), 2014/15 [137]

Analysing the trends of the two most common substances, cannabis and alcohol, over time reveals that cannabis use among tier three clients has remained stable over the past two years, but a rise was observed in alcohol use locally which peaked in May 2014 before falling back to 2013 levels (Appendix 15.5.3, Figure 236).

Hackney achieved a wait time of less than three weeks to starting treatment in all of its cases in 2014/15, and national figures were similar at 97%. The profile of the duration that young people remain in services is very similar between local and national averages (Appendix 15.5.3, Figure 239).

In 2014/15, 68% of Hackney's clients had a planned exit. In the first quarter of 2015/16 this has risen to 75% and is therefore approaching the 80% national average. Of the two clients who had an unplanned exit in the most recent quarter, one was due to the young person dropping out, and the other due to the client transferring. Hackney's services offered wider needs support to 61% in planned exits, more than the national rate of 34%. However, in one third of planned exits (both locally and nationally) information was not recorded as to whether wider needs support was required or offered.

11.4.3 Guidance

11.4.3.1 NICE PH4: Substance Misuse Interventions for Vulnerable under 25s

Strategy
• Produce local profile of target population (including age and vulnerable factors) • Develop and implement strategy to reduce substance misuse among vulnerable and disadvantaged people aged under 25 • Local service model should define roles, referral criteria and referral pathways

Identification
• Use existing screening and assessment tools (e.g. CAF) to identify vulnerable / disadvantaged young people who are, or are at risk of, misusing substances • Work with parents/carers, education welfare services, children's trusts, CAMHS, school drug advisors and other specialists to provide support • Refer as appropriate to other services (e.g. social care, housing, employment)
Family support
• Offer a family-based programme of structured support over two+ years (even if the young person moves school) drawn up with parents/carers of the young person • Include 3+ brief motivational interviews each year aimed at parents/carers, assess family interaction, offer parental skills training, encourage parents to monitor children's behaviour and academic performance, include feedback • Offer more intensive support to families who need it
School transition in aggressive / disruptive children
• Offer an hour of group-based behavioural therapy once/twice per month to children aged 10-12 who are persistently aggressive / disruptive and at high risk of substance misuse for one-two years before and during transition to secondary school • Focus on coping mechanisms, organisational and problem-solving skills and goal setting • Offer parents/carers monthly group-based parental skills training focussing on stress management, communication skills, and advise how to establish age-related rules
Problematic substance misusers
• Offer 1+ motivational interviews to problematic substance misusers aged under 25 • Encourage discussion of both legal and illegal substances, reflect on associated physical, psychological, social, educational and legal issues and set goals to reduce / stop misuse

11.4.3.2 Healthy Child Programme

11-19 Progressive
• Refer young people with substance misuse problems to local specialist services as part of a multi-agency strategy • Ensure that local substance misuse services are meeting the needs of young people in the youth justice system via input into the young person's substance misuse treatment plan • Healthcare screening of looked after children should be undertaken as soon as possible after a young person's arrival to a secure estate • Young people entering a secure estate should receive a substance misuse assessment to identify those who have not used substances or have only used on an occasional basis / those who use substances and have no immediate or significant problems but could benefit from targeted interventions / those who use substances and are experiencing current harm and who would benefit from specialist treatment • Every young person who is assessed as needing targeted services or specialist treatment should have a substance misuse plan developed by their substance misuse worker • Local substance misuse services should pay particular attention to the needs of looked after children in their treatment planning, and ensure that services are accessible to this group with clear, effective referral routes in place

Parents with alcohol or drug misuse should be referred to local specialist services as part of a multi-agency strategy. The HCP team should be aware of, and contribute to, the care package led by the specialist service, including identification of any safeguarding concerns and links to appropriate children's services. Local safeguarding children boards must ensure that clear protocols are in place between adult treatment services and children's services.

11.4.4 Local Services

In addition to the tier three service for which the usage has been analysed above, prevention and outreach services are also present in Hackney. Young Hackney provides a prevention service as well as an outreach service for young people affected by substance misuse – either directly or because a family member is using drugs. There is also a dedicated officer who provides support and interventions for young people in contact with youth justice. With the new children and young people's clinical service that will replace the existing CHYPS+ from August 2016, there will be a requirement for the service to provide holistic health and risk assessments for all young people seen as part of their core offer. These assessments are for early identification, referral and safeguarding and are based on the HEADSS assessment (Home and environment, Education and employment, Activities, Drugs, Sexuality and Suicide and depression).

11.4.5 Stakeholder Consultation

Stakeholder consultation has been undertaken with a variety of young people's groups to try to understand common opinions about health. However, unlike sexual health, mental health, diet and exercise, substance misuse was not raised in discussions about health and wellbeing priorities by the CHYPS+ Voices group (a youth forum for 11-19 year olds), by younger children in a workshop about what is healthy or unhealthy in a primary school, or by a parents' group based around a local youth hub. However, across two workshops held at New Regent's College (a vocational college and re-engagement unit) drugs or alcohol were provided as examples of being unhealthy in five out of ten sets of feedback. In this feedback, the only drug other than alcohol that was specifically mentioned was cannabis.

11.4.6 Recommendations

- Utilise social media to convey substance misuse messages to local young people
- Increase young people's awareness of the harms of smoking cannabis, particularly if smoked regularly
- Focus on girls when working to reduce alcohol consumption in local young people
- Investigate whether there are barriers preventing young women from accessing substance misuse services, given that they form a low proportion of service users despite having greater alcohol consumption on average
- Aim to increase referrals to the young people's substance misuse service through prevention work in local education services
- Ensure that the relative lack of an evidence base regarding the emerging issue of new psychoactive substances does not cause them to be overlooked when providing substance misuse related education or when commissioning substance misuse services for young people

11.5 Obesity

11.5.1 Introduction

"8 out of 10 obese teenagers go on to be obese adults."

Figure 155: Children and Young People's Health Outcomes Forum, 2013/14 [16]

While the underlying principle governing obesity may appear simple, that it occurs when an individual consumes more energy than they expend [157], the factors that influence energy consumption and physical activity are complex [158]. Current societal factors predominantly favour weight increases (commonly termed the 'obesogenic' environment) with the abundance of, and often relatively low cost of, energy dense food, alongside reduced physical activity with the ease and speed of motorised transport. As well as biological features, social contexts have been shown to influence the vulnerability of individuals to the obesogenic environment; deprivation, low educational achievement and ethnicity have all been shown to have relationships with the prevalence of obesity [159].

Childhood obesity can have a range of impacts during childhood, for example with mental health issues such as stigmatisation, bullying and low self-esteem, and through increased school absence which may affect educational attainment [160]. Furthermore, childhood obesity is a significant risk factor for adult obesity with eight out of ten obese teenagers becoming obese adults [16]. Therefore, it increases the risk of obesity-related morbidities later in life such as cardiovascular disease (such as coronary heart disease and stroke), type 2 diabetes, obstructive sleep apnoea, obesity-attributable cancers and osteoarthritis [158]. The health consequences of being an overweight or obese adult are shown in Figure 156. Unless effective action is taken now, it is predicted that by 2050 the prevalence of obesity alone (not including overweight) may rise to 60% in adult men, 50% in adult women and 25% in all children under 16. The NHS costs attributable to being overweight or obese are projected to double by 2050 to £10 billion each year [158].

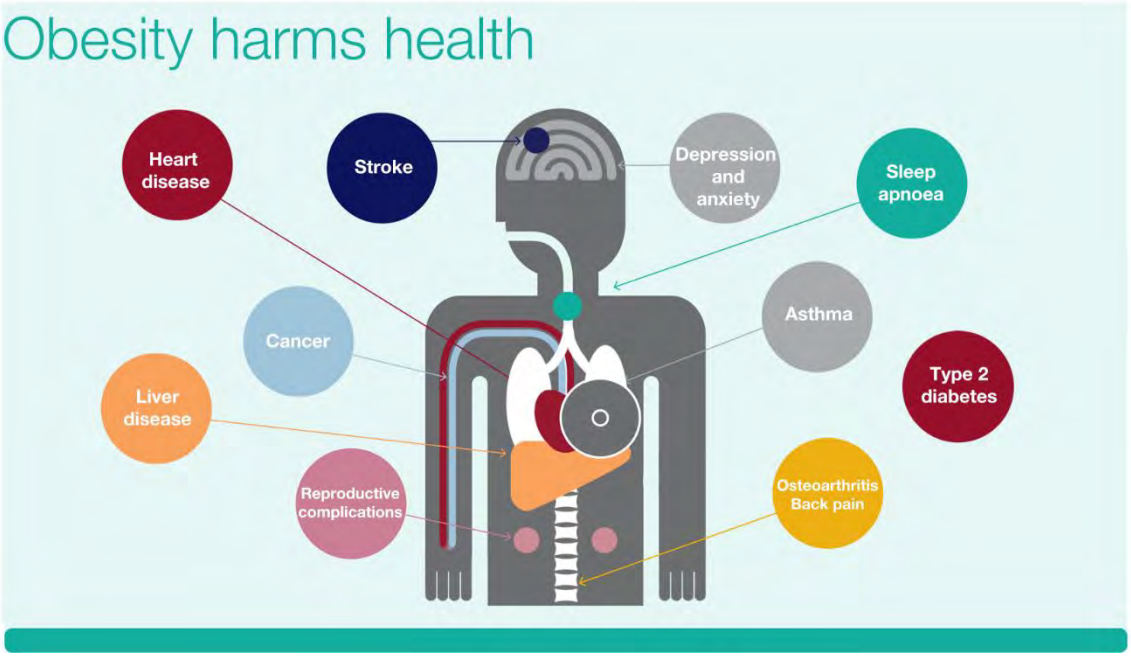

Figure 156: Health risks of obesity [160]

Given the high prevalence, and the range and complexity of influencing factors, tackling obesity is not straight-forward. The Foresight report highlighted that "a bold whole system approach is critical" to tackle unhealthy diets and the built environment, and to foster a change in cultural attitudes around weight [158].

The NCMP is a national, annual programme led by PHE and delivered by local authorities. The programme involves the measurement of height and weight of children in Reception (four to five years old) and Year 6 (ten to eleven years old) and the subsequent calculation of the child's BMI[54]. There are two key purposes – to provide robust public health surveillance data on child weight status to understand obesity prevalence and trends both locally and nationally; and to provide parents with feedback on their child's weight status to help to support and encourage behaviour change when necessary [24].

The programme is mandated in every state-maintained primary and middle school (including academy and free schools), and encouraged in non-state-maintained and special schools where possible. While parents should have the opportunity to withdraw their child from participating, prior explicit parental consent for participation is not required under the Local Authority Regulations [161].

[54] Note – the BMI of a child cannot be interpreted using the same thresholds as in adults as normal growth patterns mean that a healthy BMI is age and sex dependent. The child's BMI centile should be calculated, which compares to a reference population of over 32,000 children measured between 1978 and 1994. The British 1990 growth reference (UK90) defines underweight as below the 2nd centile, overweight as above the 85th centile (population monitoring) or 91st centile (clinical assessment) and obese as above the 95th centile (population monitoring) or 98th centile (clinical assessment) [192]

11.5.2 Hackney and City of London

Due to there being only one state school in the City of London, NCMP data have been combined between Hackney and the City to maintain school anonymity, but ensure that all data are represented. In-depth analysis is not yet available in all domains using 2014/15 data, and in these areas 2013/14 data are shown.

11.5.2.1 Participation in the NCMP

As shown in Figure 157, of those pupils who attend mandated schools (i.e. not including independent schools), Hackney's rate of participation has consistently been higher than the London and national averages since the NCMP began, varying between 96% and 98%.

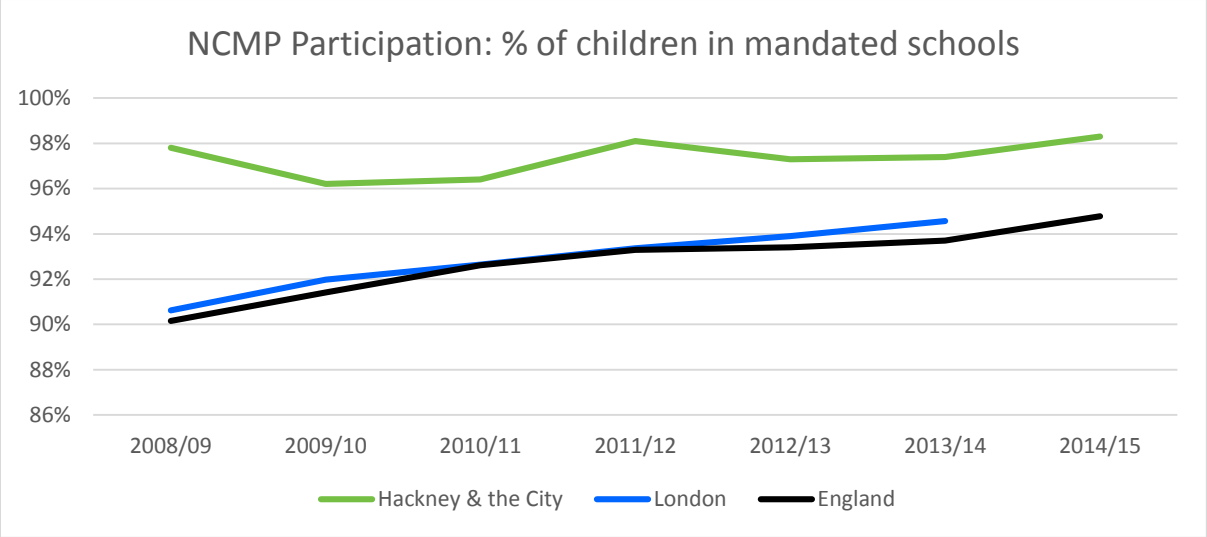

Figure 157: Participation within mandated schools, 2008/09-2014/15 [50]

It must be remembered that these NCMP data are based on children attending state-maintained schools within Hackney and the City, regardless of the borough in which they reside. Therefore, children who live locally but are educated elsewhere will not be included, and those who are educated locally will be included even if they reside elsewhere.

It is important to note that the NCMP is only mandated in state-maintained schools. City and Hackney has a higher proportion of five and ten year old pupils being educated in independent schools (24.5%), than across London (10.1%) or nationally (5.7%) [162]. Therefore, despite high participation in mandated schools, local NCMP data represent a lower proportion of the children of Hackney and the City of London.

Approximately 22% of local 5-19 year olds belong to the Charedi community – the majority of whom are educated in independent Charedi schools. It was hypothesised that the results of these Charedi children may differ from the results captured in the NCMP. Therefore, a school entry health check in Reception, including height and weight measurements, was piloted in these independent Charedi schools for the academic year 2014/15 to provide a more accurate assessment of the overall level of obesity locally *[detailed below].*

11.5.2.2 NCMP Findings

In Reception, 73% of local children are of a healthy weight, with approximately half of the other children being overweight and half being obese with only 1% underweight (Figure 158). However, by Year 6 only 58% of Hackney and the City's children are of a healthy weight, with most of this difference being accounted for by a more than two-fold increase in the proportion of obese children.

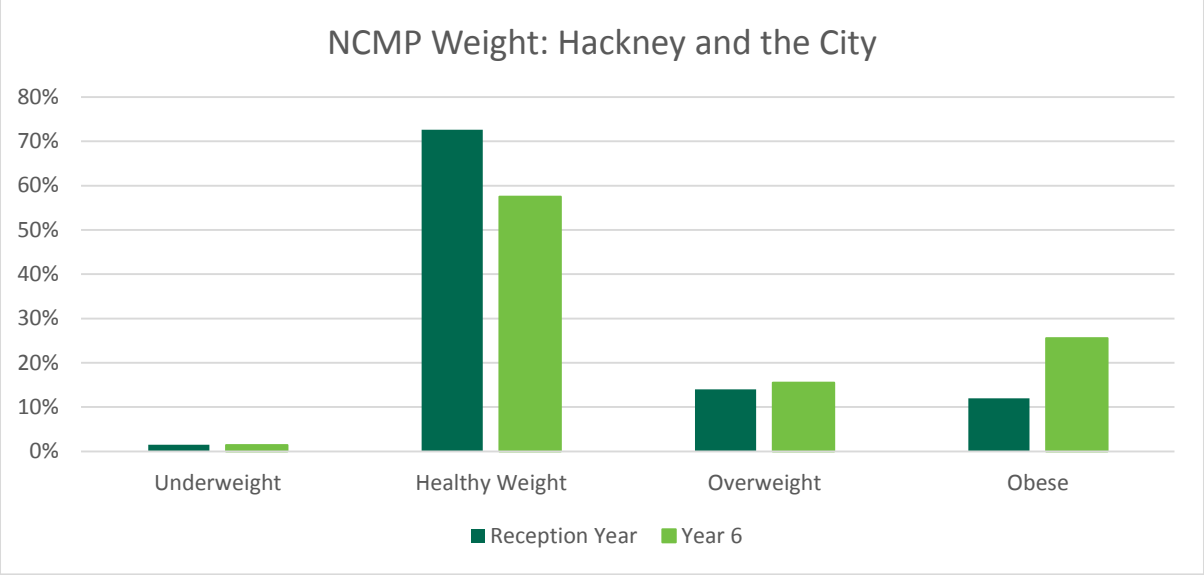

Figure 158: NCMP weight categories in Hackney and the City, 2014/15 [50]

Figure 159 shows that the approximate doubling of obesity prevalence between Reception Year and Year 6 holds true for London and national data, as well as locally in Hackney and the City of London. However, the prevalence in Hackney and the City is consistently significantly higher than across London or England – and this relationship holds in both age groups. For Reception Year Hackney and the City have the seventh highest level of obesity as recorded by the NCMP out of 150 local authorities nationally.

Figure 159 also shows that the prevalence of obesity locally, regionally and nationally has remained relatively stable since the first data were collected in 2008/09. However, while not being a sufficiently large decrease to be statistically significant, 2014/15 did see the lowest prevalence of obesity in Reception Year in Hackney and the City since the NCMP began.

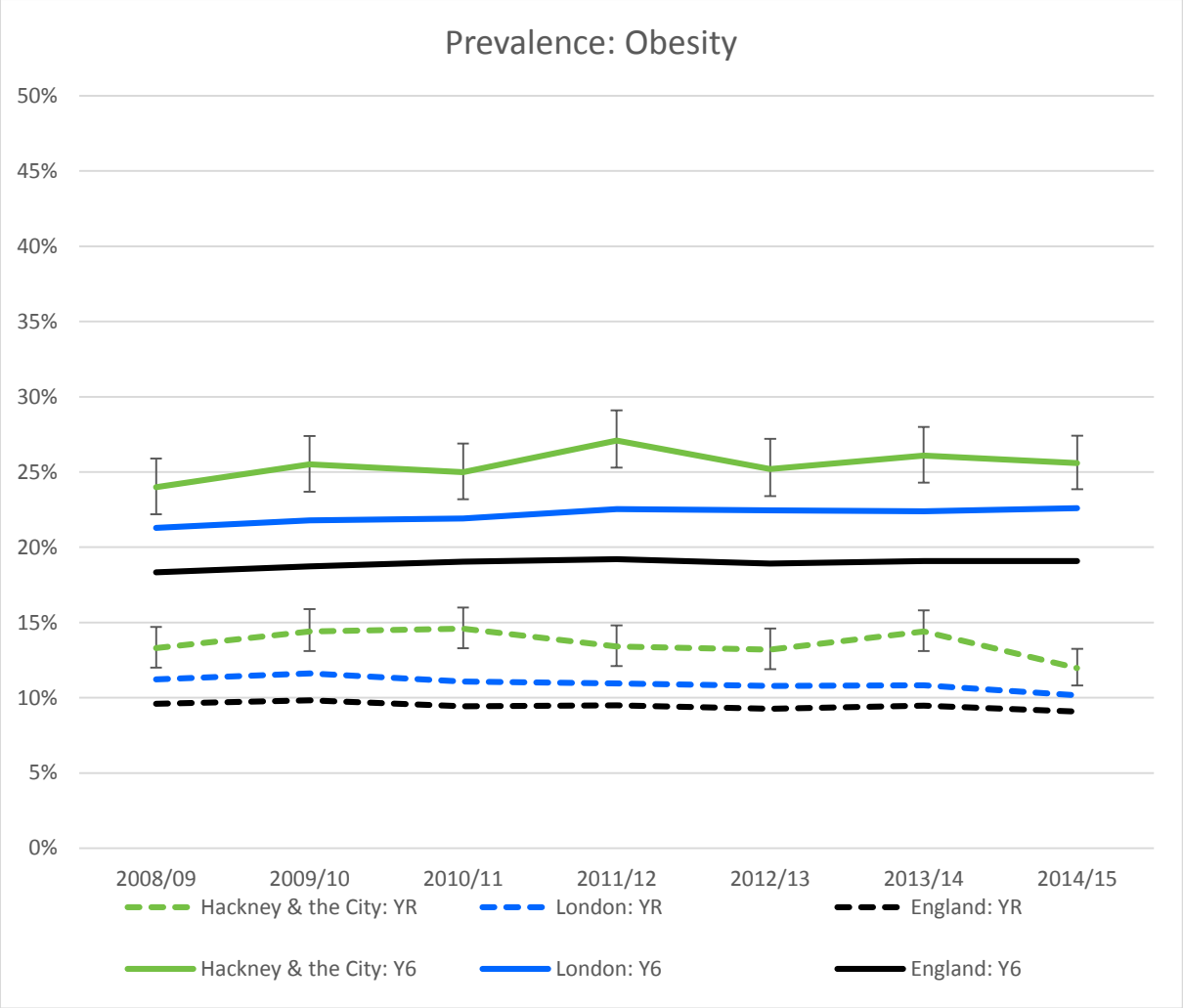

Figure 159: Trend in prevalence of obesity, 2008/09-2014/15 [50]

A number of key demographic factors influence the rates of obesity nationally. Figure 160 demonstrates that children of Black ethnicity are significantly more likely to be obese than other ethnicities, and children of White ethnicity are significantly less likely to be obese than other ethnicities. When analysing the results for Hackney and the City of London, in Reception the only significant difference is children of Black ethnicity being more likely to be obese than children of White ethnicity. In Year 6, children of Black ethnicity are significantly more likely to be obese than all other groups other than those of Mixed ethnicity. However, questions have been raised as to whether the current method of calculating BMI in children is valid in all ethnicities. As the relationship between BMI and fatness varies with age and sex in children, children's BMI results are generated through comparison to a growth reference chart. The NCMP BMI data are based on the British 1990 (UK90) growth reference [163], but the cohort who were measured in 1990 did not include any ethnic/cultural variation [164].

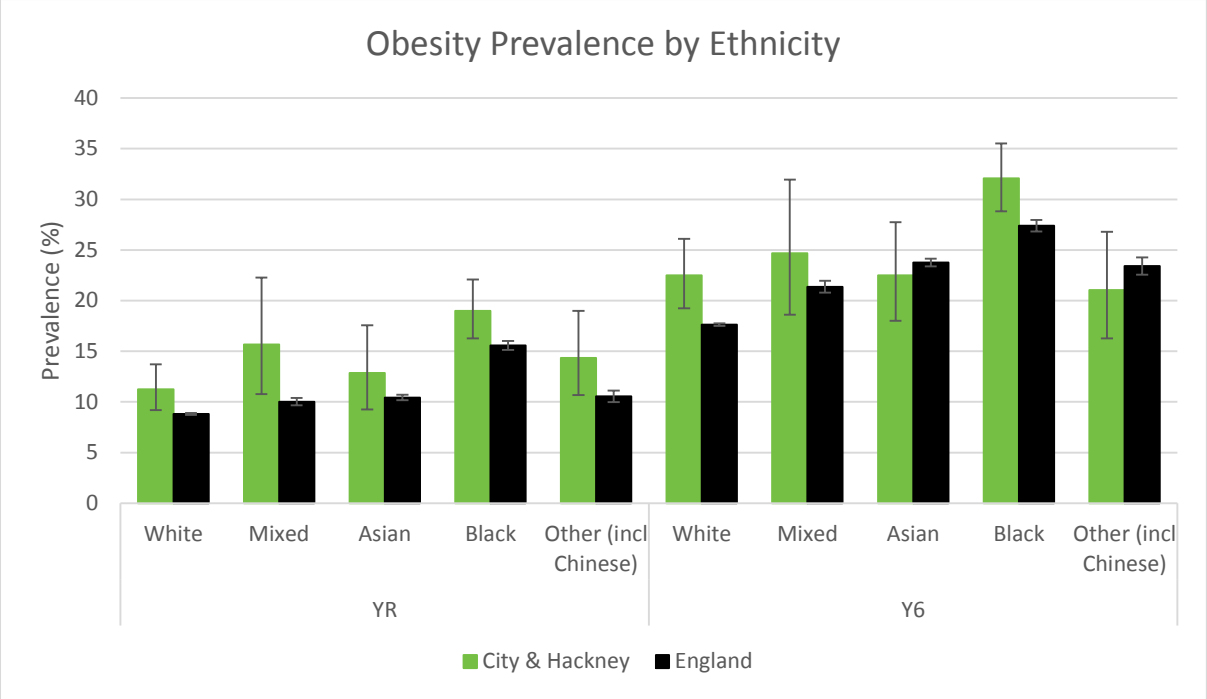

Figure 160: Prevalence of obesity by ethnicity, 2013/14 [50]

Another key factor for obesity is socioeconomic status. Nationally, obesity is more likely in communities that are deprived – 25% of ten year olds in the most deprived communities are obese, compared to 11% of ten year olds being obese in the least deprived communities (Figure 161). However, the proportions of children who are underweight and who are overweight are not affected by deprivation.

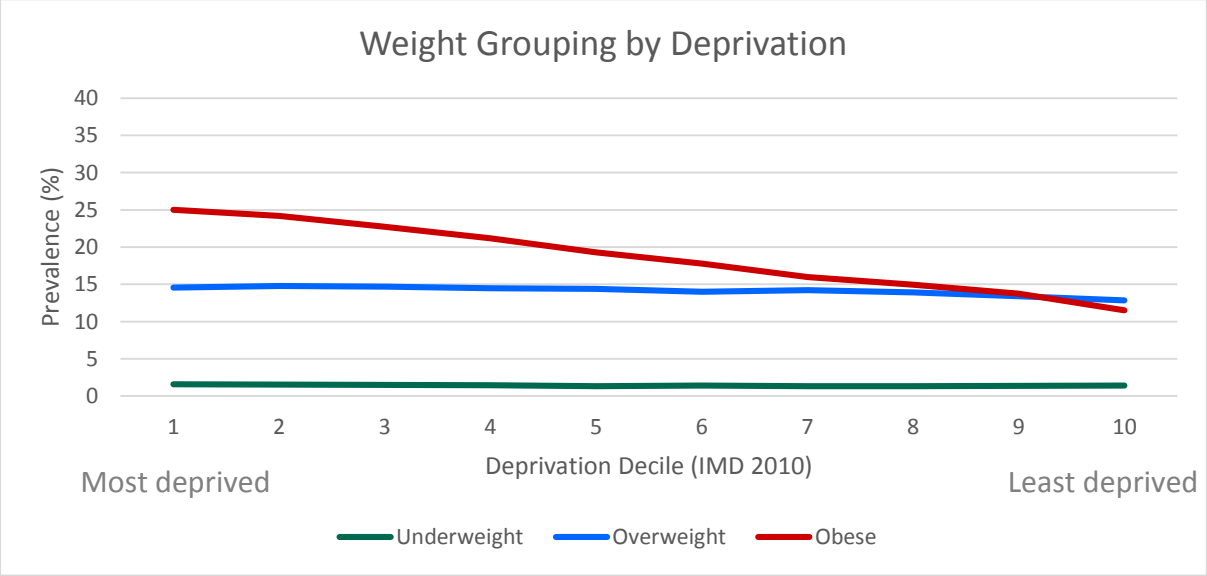

Figure 161: National weight groupings in ten year old children according to local extent of deprivation, 2014/15, [50]

While most pupils in Hackney are at the more deprived end of the deprivation spectrum, analysis by deprivation within Hackney and the City is possible, albeit with relatively wide confidence intervals. While those in deprivation quintiles two to five (the most deprived)

have statistically similar higher rates of obesity within Hackney and the City, the least deprived quintile locally has a significantly lower prevalence of obesity at both YR and Y6 (Appendix 15.5.4, Figure 240).

Given that the prevalence of obesity is associated with deprivation, Figure 162 compares obesity in Year 6 children across Hackney's statistical neighbours. While Hackney ranks poorly amongst its neighbours, the differences are small in comparison to the degree of uncertainty, and Waltham Forest is the only statistical neighbour to be statistically significantly better than Hackney.

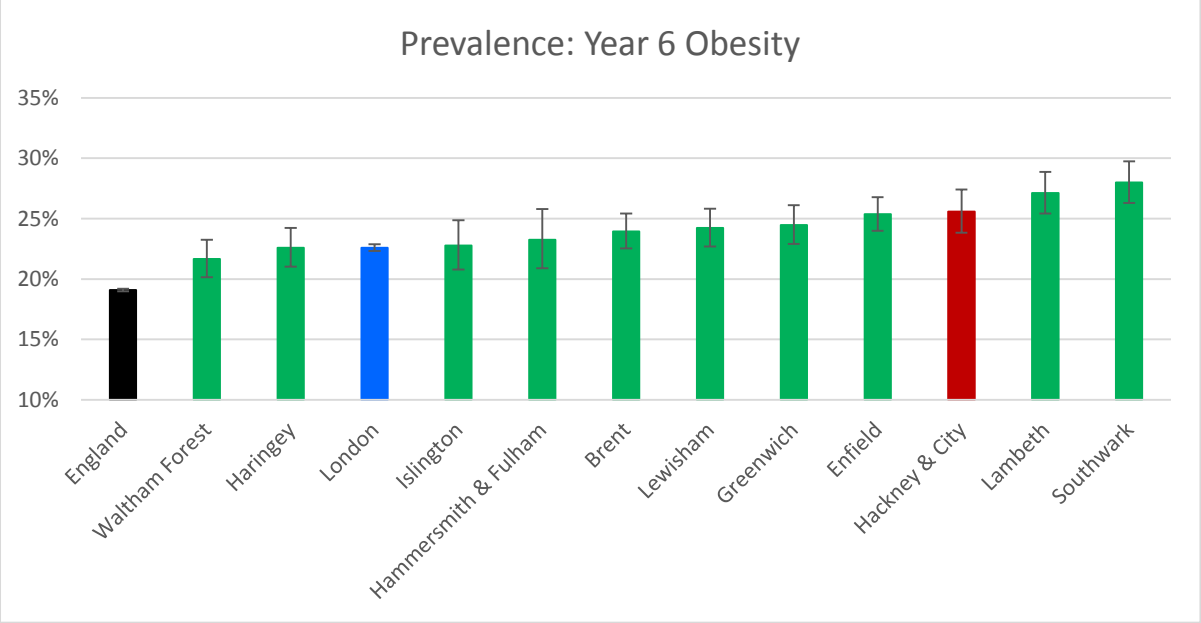

Figure 162: Prevalence of obesity in Year 6 pupils in Hackney's statistical neighbours, 2014/15 [50]

Figure 163 demonstrates that the wards of residence with the highest rates of obesity in Year 6 primarily lie on the edges of the Borough – Brownswood in the north west, Victoria in the south east and Hoxton in the south west. A broadly similar pattern is seen in Reception-aged children (albeit with lower rates), but with Springfield, Homerton and Shacklewell ranked relatively higher. It must be remembered that the rates in the north east of the Borough will be less representative as the majority of Charedi children (who are not measured as part of the NCMP as they predominantly attend independent schools) live in the Stamford Hill area.

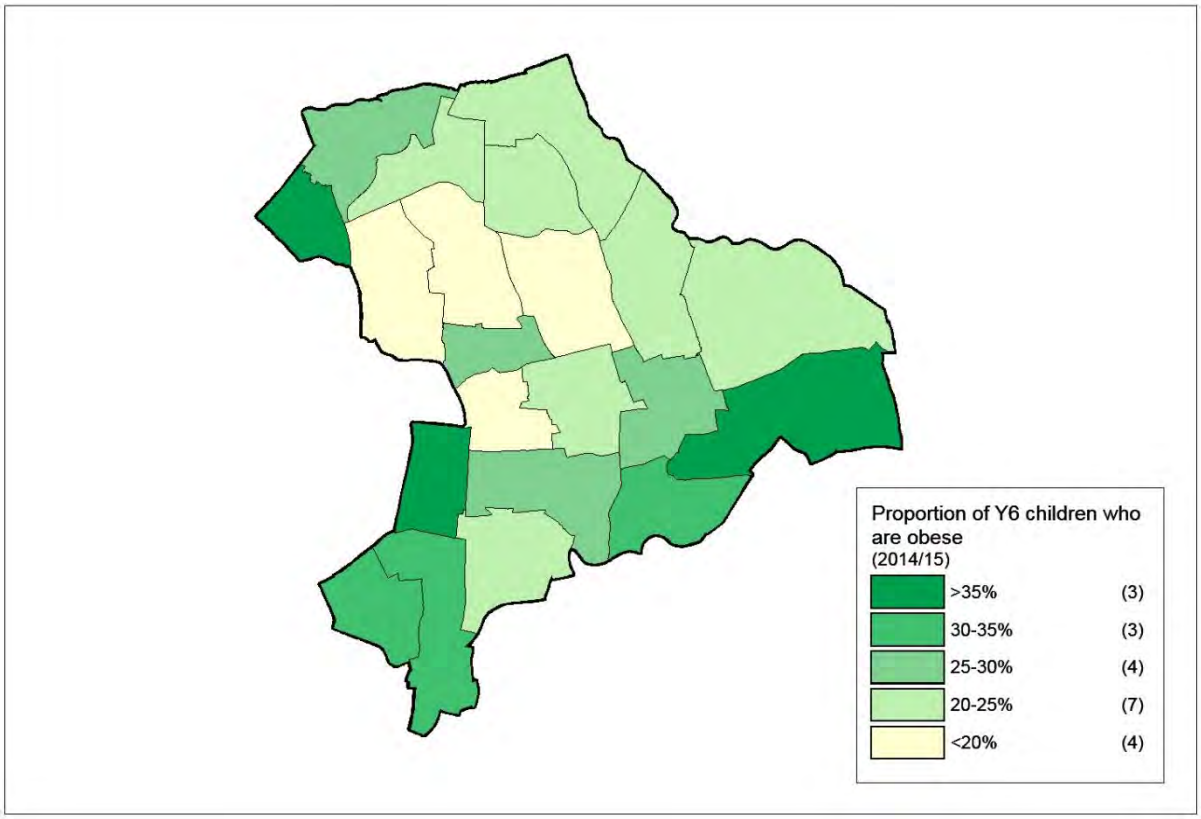

Figure 163: Prevalence of obesity by ward of residence of Year 6 children, 2014/15 [50]

11.5.2.3 Orthodox Jewish School Measurement Pilot

A pilot school reception health check was performed in 22 of the 23 independent Charedi primary schools in Hackney between January and July 2015. This pilot scheme included height and weight measurement (as collected in the NCMP), hearing and vision checks and a dental assessment. Of the 793 reception children attending Hackney's Charedi independent schools, complete height and weight measurements were collected for 689 children. Of the 104 children for whom data were not collected, 70 belonged to the girls' primary school that did not participate. Therefore the participation in the 22 involved schools was 95% which is similar to the national participation in the NCMP. Of the 664 children with a valid post code, 531 (80%) were Hackney residents.

The measurement pilot found that 84% of Charedi Reception Year children are of a healthy weight, with 9% being overweight, 5% obese and 2% underweight (Figure 164).

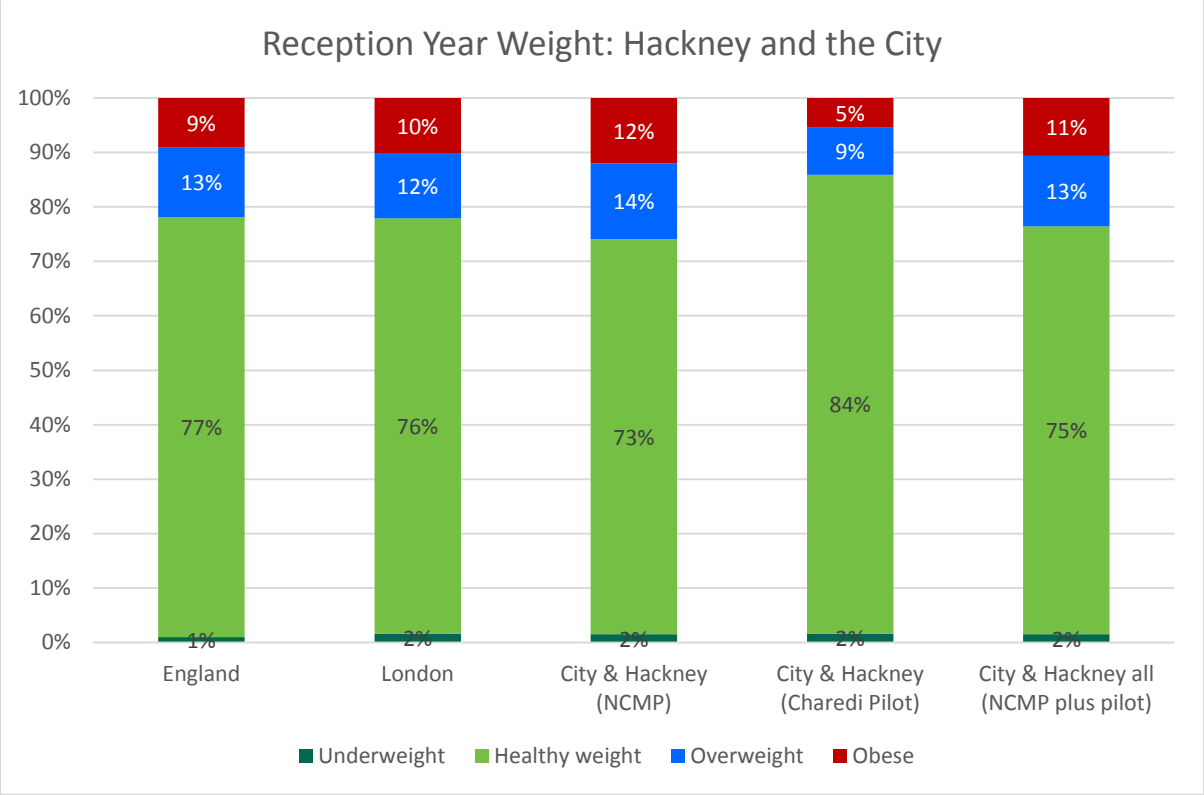

Figure 164: Proportion of Reception children in each weight category, 2014/15, based on the NCMP and local pilot data

These results show that being overweight or obese is less prevalent in Charedi reception children than in the rest of Hackney and the City, or than the London or national averages. When the results of the Charedi measurement pilot are collated with those of the NCMP to provide a more complete picture of weight across all of Hackney and the City, it reveals that 13% are overweight and 11% are obese. While this is still higher than the London and national averages this changes the ranking from being the 7th most obese local authority in the country at reception age to being the 27th most obese.

However, a local Charedi health needs assessment identified a high prevalence of obesity in Charedi adults with 55% of Charedi men and 64% of women being overweight or obese [165] – but these data were not collected as robustly as the pilot in five year olds outlined above. It is therefore unclear how including Charedi children who are ten to eleven years old (Year 6 equivalent) will affect local rates of overweight and obesity as it is unclear to what extent these young children will grow up to be adults of a healthy weight. In order to address this, the public health team are looking to fund a further measurement pilot to also measure ten to eleven year olds in the Charedi community in the 2015/16 academic year.

11.5.2.4 Physical Exercise

Guidance from the CMO recommends that children aged 5-18 should undertake the following physical activity[55] [166]:

1. All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day
2. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week
3. All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods

The Health Survey for England in 2008 [167] not only performed a survey of physical activity, but also collected objective measures of physical activity in children aged 4-15 nationally through accelerometers. The accelerometer study found that more boys were meeting the government's recommendation of 60 minutes of at least moderate intensity physical activity each day (33%) than girls (21%). This was in agreement with the self-reported survey, where 32% of boys aged 2-15 and 24% of girls met the recommendations. However, unlike the self-reported study only finding that physical activity decreased with age in girls, the accelerometer study found that the proportion meeting the recommendation fell in both genders with increasing age (Figure 165).

	Boys (%)	Girls (%)
Aged 4-10	51%	34%
Aged 11-15	7%	0%
Total (4-15)	33%	21%

Figure 165: Percentage of children meeting national physical activity guidelines – accelerometer study, 2008 [167]

When the Health Survey for England was conducted in 2012, the self-reported achievement of the recommended physical activity levels had fallen to 21% of boys aged 5-15 and 16% of girls aged 5-15 [168]. However, the decrease in physical activity with age observed in the 2008 objective data was not as steep in the subjective data of 2012 with the proportion achieving the recommended levels falling from 24% in boys aged 5-7 to 14% in boys aged 13-15; while in girls the rate fell from 23% in 5-7 year olds to 8% in 13-15 year olds.

The most recent Health Survey for England to have assessed children's knowledge about and attitudes towards physical activity was performed in 2007 [169]. This survey found that only 10% of children aged 11-15 knew that they are advised to be physically active for 60 minutes or more each day (however a further 8% of boys and 3% of girls overestimated the minimum recommendations). Most children surveyed (90% of boys and 84% of girls) perceived themselves as being either very or fairly physically active in comparison with other children their own age.

[55] Note – "Individual physical and mental capabilities should be considered when interpreting the guidelines"

'*Taking Part*' is a national annual child report based on a household survey concerning participation in culture and sport. The most recent report, for 2014/15, shows that participation in sport amongst 5-15 year olds has remained static over the past five years with 77-80% participating in the last week and 87-90% in the last four weeks (Appendix 15.5.4, Figure 241). In line with the Health Survey for England physical activity data these survey results reveal that boys are more likely to have participated in sport over the preceding four weeks than girls. However, this survey found that older children are more likely to have participated in sport than younger children (Figure 166). This does not mean that older children are necessarily more physically active than younger children and therefore does not necessarily contradict the Health Survey for England data, but suggests that younger children are physically active through routes other than organised sport.

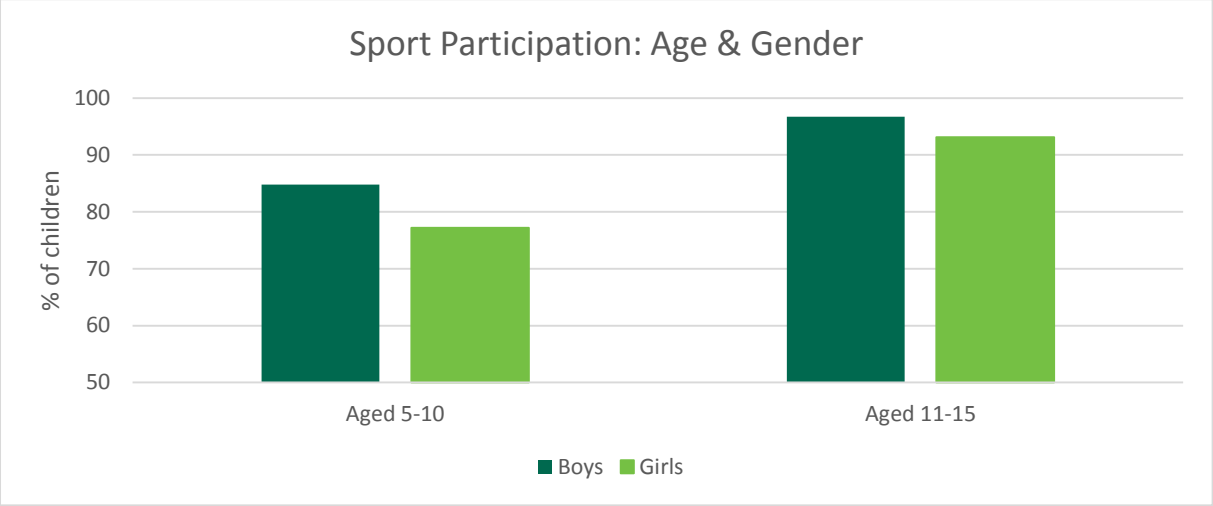

Figure 166: Participation in sport over the preceding four weeks across England by age & gender, 2015 [170]

The WAY survey found that the proportion of 15 year olds reporting being physically active for at least an hour every day for a week varies between 9% and 13% across Hackney's ten statistical neighbours. At 10.4%, Hackney and the City have a lower proportion than seven of Hackney's statistical neighbours, the London average and (significantly) the national average (Appendix 15.5.4, Figure 242). Across the country, the most deprived deciles scored significantly below average on this measure; as did Asian, Other and Black ethnicities, and those of gay/lesbian, bisexual and other sexualities. Given the high level of deprivation, and the relatively high proportion of these ethnicities, Hackney's result is therefore likely to be in keeping with its demographics.

In comparison, when considering sedentary behaviour the proportion of 15 year olds reporting a mean weekday daily sedentary time of greater than seven hours varies between 65% and 76% in Hackney's ten statistical neighbours. At 71%, Hackney and the City are typical for Hackney's statistical neighbours, however the rate is lower than the London and national averages (albeit not significantly) (Appendix 15.5.4, Figure 243). Nationally, the four most deprived deciles have rates significantly above average, as do White and Black ethnicities and gay/lesbian and bisexual sexualities.

The Rockpool survey provided an evaluation of the attitudes to sport from 814 of Hackney's young people. The survey found that 70% played sports or did an activity to keep fit outside of school [153]. Figure 167 shows the motivations given to keeping fit with the most common, at 63%, being because "it feels good".

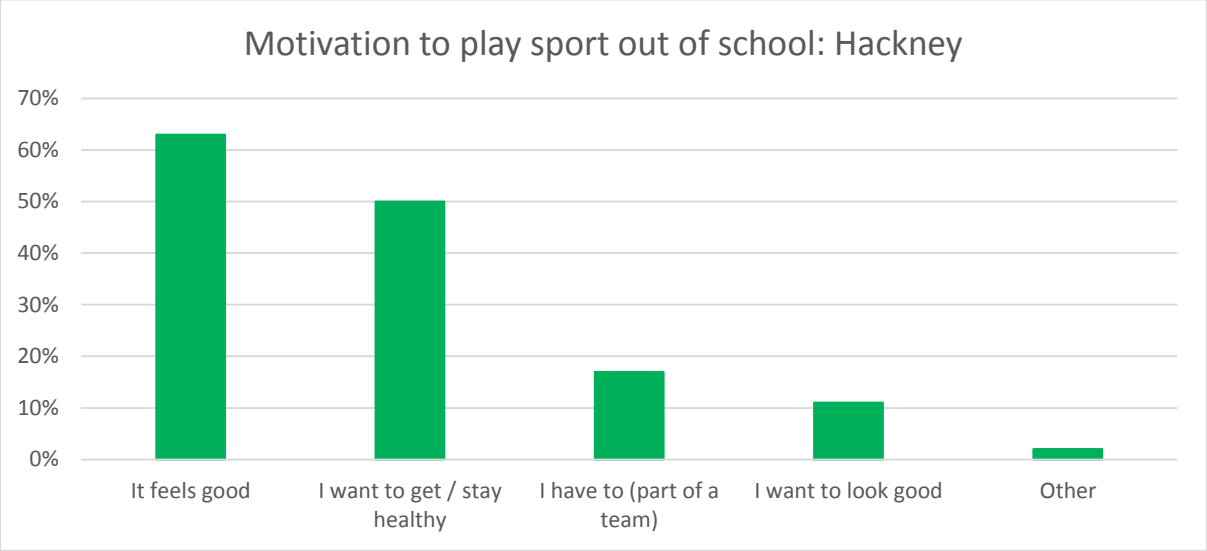

Figure 167: Motivation to play sport outside of school, 2012 [153]

85% of the survey respondents reported having visited or intending to visit a sports facility. Of the 15% who had not visited or did not intend to visit a sports facility, the most common reason given (45%) was because they were "happy as I am" (Figure 168).

Figure 168: Reasons why young people have not / do not intend to visit a sports facility, 2012 [153]

11.5.2.5 Diet

There are many recommendations regarding healthy diets, not all of which are relevant to obesity. While there are many scientific recommendations regarding the relative quantities of ingestion of dietary components or resultant blood concentrations of nutrients, the Eatwell Guide provides practical dietary recommendations aimed at the public (Figure 169).

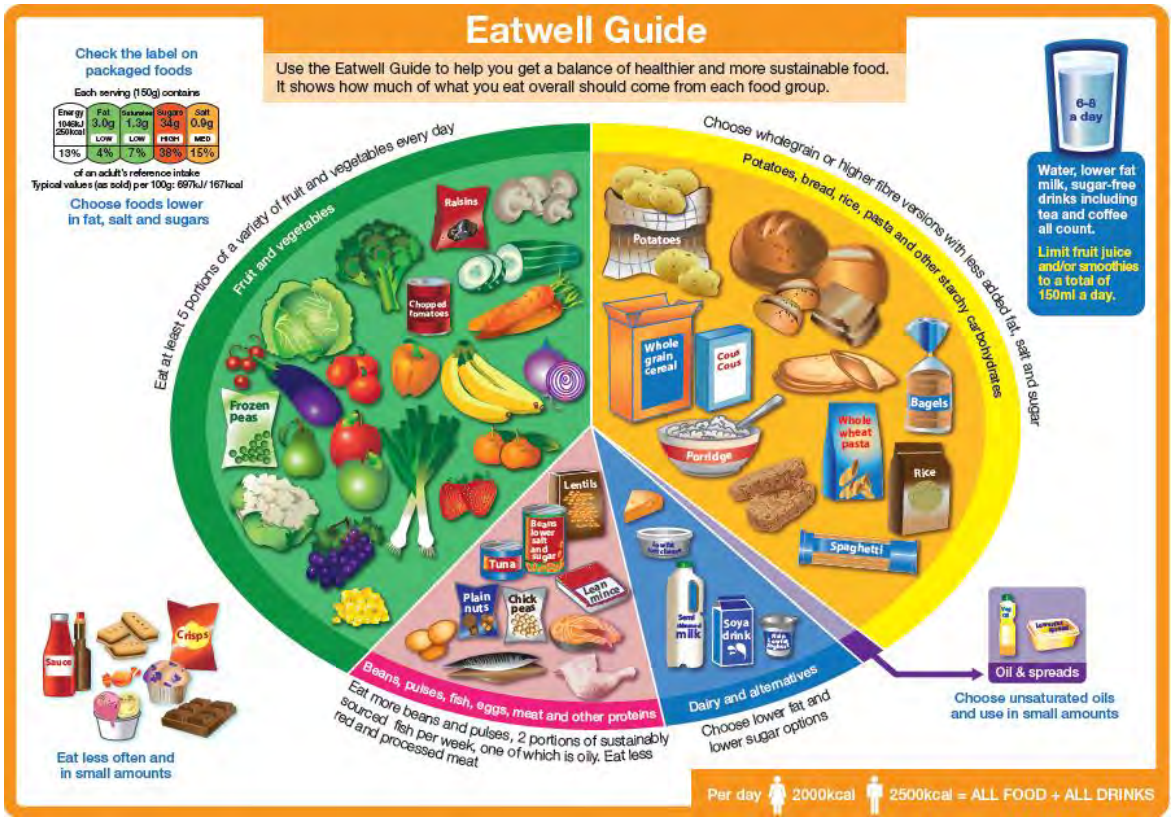

Figure 169: Eatwell Guide, produced by PHE in association with the Welsh government, Food Standards Scotland and the Food Standards Agency in Northern Ireland [171]

The six main recommendations contained in Eatwell include:

1. **Eat at least five portions of a variety of fruit and vegetables a day**

Nationally across young people, 11-12 year olds consume the lowest number of portions of fruit and vegetables per day. Analysis by gender reveals that at younger ages girls consume a greater number of portions of fruit and vegetables per day than boys, although this difference is not statistically significant. However, in older young people boys consume more portions than girls. Furthermore, when analysing what proportion consume five portions of fruit and vegetables per day, more boys achieve this recommendation than girls at 10.1% versus 7.5% [172].

Analysing the consumption of fruit and vegetables by household income reveals that the highest mean intake is found in the highest quintile of household income, however the trend plateaus for the second to fifth quintiles where there are no statistically significant differences [172].

Locally, the WAY survey has revealed that 56% of Hackney and the City's 15 year olds report consuming at least five portions of fruit and vegetables per day which is typical among Hackney's statistical neighbours (better than five and worse than five comparator boroughs), worse than the London average, but better than the national average – however none of these differences are statistically significant (Appendix 15.5.4, Figure 244).

The Rockpool survey collated 796 responses about eating fruit and vegetables across 11-19 year olds in Hackney and found that the most common response to how often five portions of fruit and vegetables are eaten was three-four days per week (34%) (Figure 170).

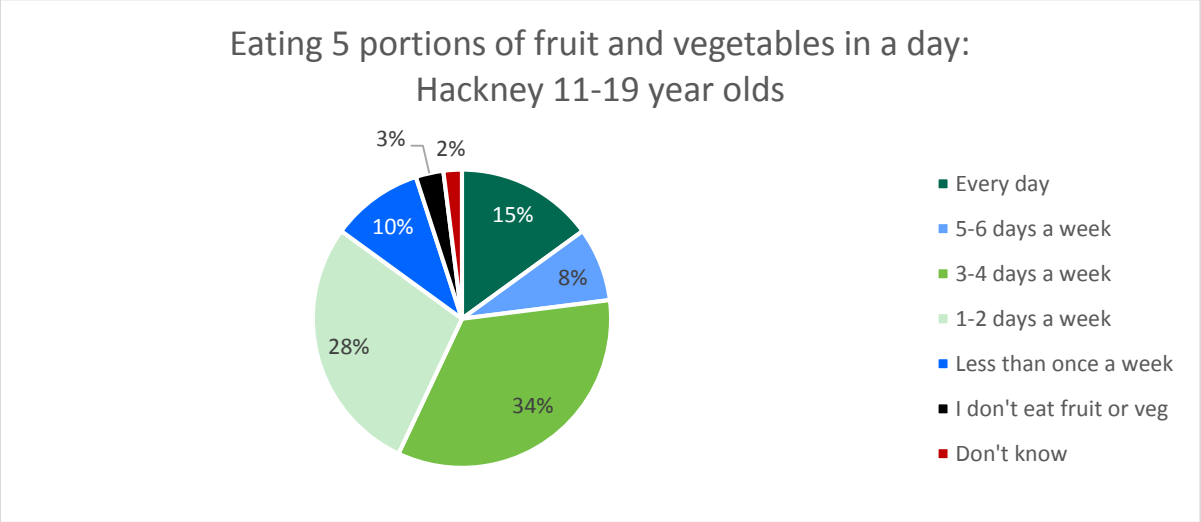

Figure 170: Consumption of five portions of fruit and vegetables in 11-19 year olds in Hackney, 2012 [153]

2. **Base meals on starchy carbohydrates (which are wholegrain where possible)**

3. **Include some dairy or dairy alternatives (that are lower-fat and lower-sugar where possible)**

4. **Eat beans/pulses/fish/eggs/meat as sources of protein and aim for two portions of fish every week (one of which should be oily)**

Children are recommended to consume at least one portion of oily fish (140g) per week [173]. However, national results show that, even in boys aged four-ten who have the highest intake at 15.7g per week, this is far less than the recommended level [172].

5. **Choose unsaturated oils and spreads and eat foods high in fat, salt and sugar less often and in small amounts**

The Rockpool survey collected data on the local consumption of takeaways and found that 54% of 11-19 year olds eat out or eat a takeaway at least once during the school week on average and 28% eat out or eat a takeaway at least once every weekend on average [153].

Children aged five and over are recommended to obtain no more than 35% of their food energy from fat [174]. On average nationally, 34% of food energy intake is in the form of fat in 4-18 year olds, and therefore this recommendation is currently being met [172]. However, 13% of food energy in children aged five and over is being obtained from saturated fat [172], and is above the national recommended limit of 11% [174].

Nationally the maximum salt intake is recommended to be 3 g/day in four-six year olds, 5 g/day in seven-ten year olds and the adult recommendation of 6 g/day from age eleven [175]. However, apart from girls aged between seven and ten years of age, this recommended maximum is exceeded in children nationally (Figure 171).

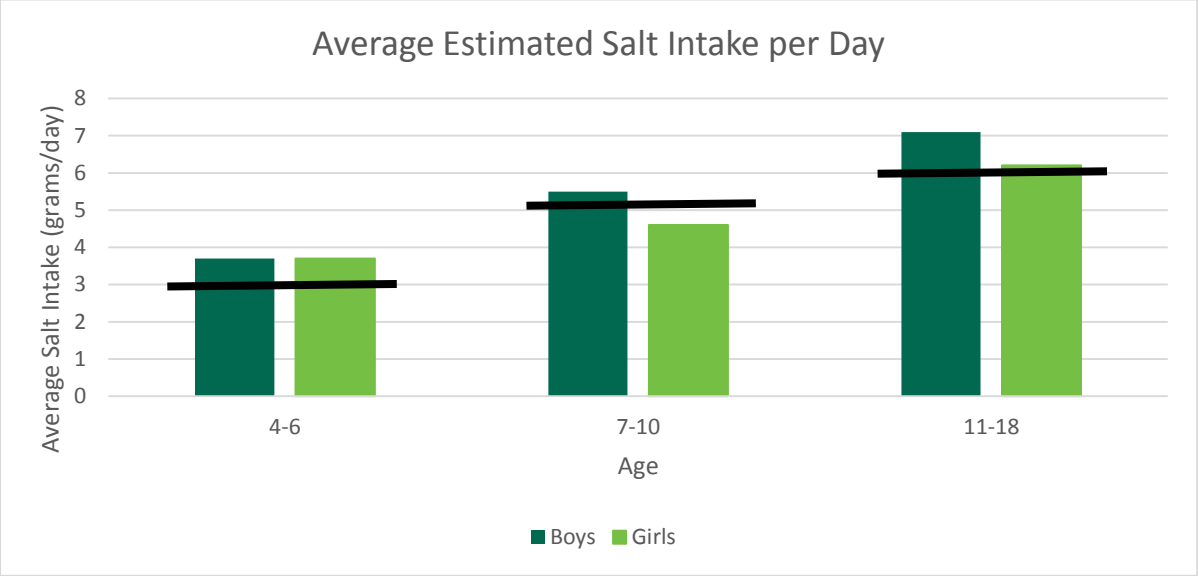

Figure 171: Average estimated salt intake per day with recommended maximum levels by age, 2015 [172]

Sugar intake far exceeds the recommended percentage of food energy intake, however this will be discussed in more detail in Chapter 11.6.

6. Drink plenty of fluids (aim for 6-8 glasses a day)

11.5.3 Guidance

11.5.3.1 NICE PH42: Obesity: working with local communities

Developing a sustainable, community-wide approach to obesity
Health and wellbeing boards should ensure a coherent, community-wide, multi-agency approach to address obesity prevention and management. Activities should be integrated within the joint health and wellbeing strategy and broader regeneration and environmental strategies. Action should be aligned with other disease-specific prevention (e.g. type 2 diabetes, cancers and cardiovascular disease), as well as broader initiatives (e.g. maternal health promotion, child nutrition, and alcohol reduction). JSNAs should address prevention and management of obesity and consider the full range of influencing factors including social determinants.
Strategic leadership
Public health teams, health and wellbeing boards, LA directors, Council members, leaders of community organisations, CCGs and local education boards should provide visible, strategic leadership to tackle obesity at all levels and ensure an effective team is in place. Directors of public health should seek high-level commitment to long-term, integrated action on obesity, ensure performance management focuses on partnership working as well as measuring outcomes, and ensure the obesity strategy is reviewed regularly based on needs identified in JSNAs. Marginalised groups at particular risk of obesity should be fully engaged and inequalities in obesity addressed.

Supporting leadership at all levels
Public health teams should identify and work with 'champions' who have a particular interest/role in preventing obesity across partner organisations to build and support a network of leaders. Directors of public health should provide regular opportunities for partners to meet, address fragmented/competing agendas between partners, fund small-scale community projects and foster a 'learning culture' supporting monitoring and evaluation.
Coordinating local action
The public health team should have a director or lead consultant, senior coordinator and community 'health champions' (working directly with the community) to develop a coordinated approach to obesity prevention. Frontline staff (e.g. health visitors, environmental health officers) should be engaged and receive training to improve their understanding of the needs of the local community and improve their implementation skills. A map of local people and assets that can support obesity prevention should be developed.
Communication
Directors of public health and LA communication leads should ensure elected members and staff are aware of the importance of preventing and managing obesity through highly visible and easily recognisable programmes.
Involving the community
Local people should be engaged in identifying their priorities in relation to weight loss and in deciding how to tackle obesity. Community engagement networks should include trusted community members, those who represent the needs of subgroups/marginalised groups, local champions, people with a link to local business, advocates with a strong voice in the community and patient/carer groups. CCGs should make GPs aware of local prevention and treatment services.
Integrated commissioning
Local commissioning should be integrated and support a long-term (5+ year) system-wide health and wellbeing strategy with an understanding of local demographics, characteristics and motivations. Commissioners should create an environment that allow the local system to take a truly community-wide approach that includes raising awareness of the health problems, training staff and volunteers, influencing the wider determinants of health and providing services. Both targeted and universal services should be funded based on local needs and interventions that are known to be effective should be included. Some funding should be used for innovative approaches and establishing and sustaining local community engagement activities. Contracts should require regular monitoring or evaluation, but with some flexibility, and encourage partnership working to reduce duplication. Decommissioning/redesigning ineffective programmes should be considered.
Involving businesses and social enterprises operating in the local area
Caterers, leisure providers, weight management groups, local chamber of commerce, food retailers and workplaces should be involved in obesity strategy implementation and mechanisms of governance for working with these groups developed. Businesses should be encouraged to recognise their corporate social responsibilities in relation to employees (supporting a healthy diet or active travel), products (ensuring overeating I not incentivised) and wider social interests (such as supporting wider community initiatives).
Local authorities and the NHS as exemplars of good practice
Internal policies to help staff, service users and the wider community achieve and maintain a healthy weight should be developed. Healthier food and drink choices should be encourage in onsite vendors. Staff should be encouraged and supported to be physically active. Lifestyle weight management service(s) should be offered for overweight staff who would like support.

Planning systems for monitoring and evaluation
Sufficient LA/NHS/other commissioner resources should be set aside for planning, monitoring and evaluation of strategies, policies and activities that may impact on the obesity agenda (whether intended or not) and a reflective learning approach should be encouraged.
Implementing monitoring and evaluation functions
PHE is encouraged to develop a framework for monitoring and evaluating integrated community-wide approaches to obesity to ensure consistency and comparability across areas. Public health teams should capture changes in the knowledge of, and benefits of, healthy weight. Academic institutions should establish local links and identify partnership working at a low cost. All partners should be encouraged to measure a broad range of outcomes to capture the full benefits of a sustainable, integrated health and wellbeing strategy.
Cost effectiveness
Simple tests should be used to assess value for money of local action such as measuring whether benefits in one sector are sufficient to offset costs incurred in another. Evaluation frameworks should assess value for money of partnership working in comparison to work as separate entities.
Organisational development and training
Health and wellbeing boards should ensure partners have opportunities to increase their awareness (around obesity, local challenges and local systems) and develop their skills. Health promotion, chronic disease prevention and early intervention should be part of the basic education and training for the public health workforce. Training for health and other relevant professionals should include the wider determinants of obesity, the local key players, community engagement, appropriate language use, strategies to address weight concerns, local services and understanding why it can be difficult for some people to avoid weight gain or achieve weight loss. Barriers to initiating conversations about weight issues (e.g. being overweight themselves or fear of damaging relationships) should be addressed.
Scrutiny and accountability
Health overview and scrutiny committees should assess local action on preventing obesity and ensure that commissioning meets the breadth of the joint health and wellbeing strategy, ensure the views of the community are reflected in the local approach to obesity, scrutinise the priority given to obesity prevention by local health and wellbeing boards and include plans of action to prevent obesity in their rolling programme of service reviews.

11.5.3.2 NICE PH47: Managing overweight and obesity among children and young people: lifestyle weight management services

Planning lifestyle weight management services for children and young people
Lifestyle weight management services should be family-based, multi-component, multi-agency and community-wide as part of a locally agreed obesity care or weight management pathway. Data from the JSNA and NCMP should identify local need. The development, implementation, delivery, promotion, monitoring and evaluation of services should occur over the long term.
Commissioning lifestyle weight management programmes for children and young people
Use community engagement to identify facilitators and barriers to uptake. Include professionals who specialise in children, young people and weight management. Consider how best to support children and young people with SEN or disabilities or those in at-risk groups including BME communities or low income families. Ensure there are clearly defined programme objectives, outcomes and monitoring requirements in specifications and contracts. Ensure specifications require height and weight are measured and BMI and BMI z scores are calculated for all children at recruitment, completion, 6 months post-completion and 1 year post-completion.

Lifestyle weight management programmes: core components
The following components should be included in a tailored plan to meet individual needs – behaviour-change techniques, positive parenting skills training, encouraging all family members to eat healthily and be physically active, how to become less sedentary. Ongoing support and follow up should be available for those who have completed the programme.
Developing a tailored plan to meet individual needs
Asses each person for obesity-related co-morbidities – refer to their GP if concerned. Identify whether mental wellbeing has affected or is affected by their weight and refer to CAMHS if appropriate. Discover whether the family recognises their child is overweight/obese, understand the benefits of managing their weight, and whether they have attempted to manage it previously. Offer to weigh, measure and calculate the BMI for family members also. Aim to gradually increase the amount of moderate to vigorous physical activity – focus on enjoyable and easily accessible activities. Agree age-appropriate, affordable and culturally sensitive dietary changes. Manage expectations of what is realistically achievable, monitor progress and provide feedback.
Encouraging adherence to lifestyle weight management programmes
Offer a range of programmes to groups of children or young people and their families at different ages and stages of development, but where necessary to individual families if this better meets their needs. Emphasise the importance of parental/carer support (but understand that adolescents may respond better separately) and that commitment should extend beyond the programme. Offer programmes in easily accessible venues with necessary facilities where clients feel comfortable at a range of convenient times. Adopt a flexible approach, for instance through a rolling programme, but maintain regular contact with participants and try to retain the same team of staff throughout each cycle to maintain continuity.
Raising awareness of lifestyle weight management programmes
LAs to maintain an up-to-date list of local lifestyle weight management programmes for children and young people that is accessible and regularly disseminated. Commissioners should use a range of organisations working with children and young people to raise awareness of programmes (Children's Centres, libraries, health professionals, voluntary organisations and local media). Health professionals should tell parents/carers of those identified as overweight/obese about local programmes. Schools, colleges, Children's Centres, LAC teams and other professionals should raise awareness of programmes and how to enrol onto them.
Formal referrals to lifestyle weight management programmes
[For health professionals] Where there are concerns about a young person's weight, weigh them in light clothing and, if older than two years, measure their height. Use UK growth charts for children aged four and over to determine their BMI or the UK-WHO 0-4 growth chart if younger. Note comorbidities, family medical history and psychosocial considerations. Discover whether the young person/family accept that the young person is overweight or obese, whether they have fears/concerns and whether they are willing to be referred. As appropriate refer the young person, address any concerns and give the family information about the programme. If unwilling to attend give enrolment details for the future, offer a follow up appointment and provide advice. Refer to CAMHS if concerned about their mental wellbeing. Refer to specialist obesity / paediatric services if appropriate.
Providing ongoing support
Health professionals should acknowledge that avoiding weight gain is a realistic short-term aim for children growing taller, but if not growing they need to lose weight; however improvements in diet and physical activity can have health benefits independent of BMI. The young person's BMI should be monitored at six months and one year after programme completion. With the client's consent, providers should send feedback to their referring health professional, offer ongoing support after completion for at least the first year, and tell clients about local services to further support them to manage their weight.

Lifestyle weight management programme staff
Ensure staff training has been developed with a multi-disciplinary team and that training needs are regularly reviewed and addressed. Ensure staff treat clients and their families with empathy, deliver feedback constructively and are culturally appropriate. Train staff to measure height and weight, use BMI charts, deliver behaviour-change techniques, use a locally approved comorbidities assessment tool and identify concerns about mental wellbeing (and how to refer to their GP for CAMHS referral). Ensure training is compliant with statutory and local policies regarding safeguarding and information governance. Ensure staff are available who can provide parenting skills training. Ensure there are staff trained in practical food preparation.
Training in how to make referrals to a lifestyle weight management programme
Employers are to ensure health professionals understand why some young people may have difficulty managing their weight, are aware of how obesity is viewed by different cultures, are able to measure height and weight and use charts, can raise the issue of weight management confidently and sensitively and are aware of local pathways.
Monitoring and evaluating programmes
Commissioners, health and wellbeing boards and providers should ensure monitoring focuses on sustaining longer term changes. Data should include – route of referral, demographics, numbers recruited, BMI and BMIz score at recruitment/completion/at follow up, percentage completing, percentage followed up at six months and one year, views of participants and views of staff. Ensure data collection tools are validated for the population group in the programme and are feasible and affordable. Monitor variations in recorded data and use it to amend and improve.

11.5.3.3 NICE PH17: Promoting physical activity for children and young people

Raising awareness of the importance of physical activity
• Ensure children and young people's plans, JSNAs, local development and planning frameworks and sustainable community plans and strategies are coordinated and explicitly address the need for children and young people to be physically active • Physical activity initiatives should be regularly evaluated and monitored • A senior Council member should be a champion for children and young people's physical activity to promote its importance in all Council portfolios, ensure it is a key priority when developing programmes and targets, promote partnership working with Council member leads and explain the local authority's role in promoting physical activity to the public • The strategy should ensure individuals responsible for increasing physical activity are aware of national and local government strategies
Developing physical activity plans
• Identify local groups of children and young people unlikely to participate in 1+ hour of moderate to vigorous physical activity a day and involve them in the design, planning and delivery of physical activity opportunities • Consult with children, young people and their families across different socioeconomic groups, ethnicities and abilities regularly to understand the factors that help/prevent them being physically active and act upon them
Planning the provision of spaces and facilities
• Ensure activity facilities meet safety standards for design, installation and maintenance and are suitable for different needs and cultural sensitivities • Provide places both indoors and outdoors where they feel safe – local authorities should coordinate the availability of facilities, where appropriate, and ensure all groups have access to them, including those with disabilities • Town planners should make provision for physical activity in an urban setting and ensure facilities are located close to walking and cycling routes

- Promote public parks and non-traditional spaces (e.g. car parks outside working hours)
- Make school facilities available before, during and after the school day, at weekends and during school holidays and to public, voluntary, community and private sector groups offering physical activity programmes for children and young people
- Assess all proposals for signs restricting physical activity in public spaces

Local transport plans

- Ensure local transport plans aim to increase the number of children and young people who regularly walk, cycle and use other modes of physically active travel and make provision for the additional needs of children, young people and their parents / carers with a disability or impaired mobility
- Develop, implement and promote school travel plans
- Identify aspects of transport policies which discourage children and young people from using physically active travel

Responding to children and young people

- Find out what physical activities children and young people enjoy
- Any dress policy should be practical, affordable and acceptable to participants without compromising their safety or restricting participation
- Ensure physical activity programmes are run by people with relevant training / experience

Multi-component school and community programmes

- Provide education and advice to increase awareness of the benefits of activity
- Use policy and environmental changes to create a more supportive school environment
- Provide homework activities which children and their parents / carers can do together
- Use the community e.g. by setting up family fun days

Supporting girls and young women

- Consult with girls and young women to find out what activities they prefer and actively involve them in the provision of a range of options in response
- Provide advice on self-monitoring and individually tailored feedback and advice
- Address any psychological, social and environmental barriers to physical activity

Helping children to be active

- Provide opportunities for unstructured, spontaneous play
- Tailor activities according to the child's developmental age and physical ability
- Help children identify activities they can enjoy by themselves or with friends and families

Helping girls and young women be active

- Emphasise the opportunities for participation, enjoyment and personal development, rather than focussing on the evaluation of performance
- Encourage those who initially choose not to participate to be involved with physical activities in other ways – help them move gradually towards full participation
- Provide appropriate role models

Helping families to be active

- Ensure parents / carers are aware of advice that young people should undertake at least 60 minutes of moderate to vigorous physical activity a day and that, at least twice a week, this should include activities to improve bone health, muscle strength and flexibility
- Provide information on the benefits of activity, emphasising how enjoyable it is, and provide examples of local opportunities
- Encourage parents/carers to complete at least some local journeys with young children using a physically active mode of travel on most days of the week
- Promote physically active travel as an option for all of the family

11.5.3.4 Healthy Child Programme

5-11 Universal
• School health team member measures height and weight for the NCMP at the health assessment at school entry in reception / Year 1 and in year 6 • NCMP results are fed back to parents and general advice / information provided to parents if requested • Every school is required to deliver the National Curriculum on PE. While there is no statutory minimum PE lesson time per week, there is an aspiration for all 5-16 year olds to access two hours of PE in the curriculum, plus an additional three hours of sport per week in and beyond the school (set out in the PE and Sport Strategy for young people in 2008) • All schools should have a school travel plan in place that encourages pupils to walk or cycle as the first choice mode of travel • Schools should consider how they can provide opportunities for children to partake in unstructured play opportunities during the school day • Nutrition: see Dental Health Chapter (11.6)
5-11 Progressive
• Parents of overweight / obese children should receive appropriate information and signposting to further sources of advice and support and referral to appropriate weight management services to enable the child to move towards and maintain a healthier weight, with an assessment of underlying health issues / co-morbidities as appropriate
11-16 Universal
• Health review at school transition in year 6/7 could include interpreting the BMI score as part of the NCMP and explaining the implications for diet and lifestyle • There is an aspiration for all 5-16 year olds to access two hours of PE in the curriculum, plus an additional three hours of sport per week in and beyond the school
16-19 Universal
• There is an aspiration for all 16-19 year olds to have access to three hours of college and community sport per week (set out in the PE and Sport Strategy for young people in 2008) • Organisations and institutions should strive to encourage and facilitate physical activity • The FE sports co-ordinator programme will increase opportunities for young people aged 16-19 and in education to participate, perform, lead and volunteer in sport

11.5.4 Local Services

In order to provide a strategic approach to tackle childhood obesity and associated health inequalities in Hackney, a new Obesity Strategic Partnership (OSP) was launched in February 2016 and is chaired by the Chief Executive of the London Borough of Hackney. The OSP will support the implementation of a 'whole systems' approach to obesity, taking into account the role of the food environment, physical activity environment, social influences, as well as individual psychology, physical activity and food consumption.

With regards to specific services, the local obesity pathway is based on a stepped care approach where the least resource intensive treatment is delivered first and clients move up from universal services, through tier two to tiers three and four if required.

Universal provision for 5-18 year olds is funded by the local authority and includes a number of programmes delivered through a range of stakeholders and access points including schools, Young Hackney and the wider Council. 'Get Hackney Healthy' is the overarching

borough-wide work programme, established alongside the transition of public health into the Council in 2013, with the aim of improving the health of children and young people by reducing obesity, with a particular focus on families. The programme is based on evidence in the Marmot report which highlighted the influence of wider social determinants on health, and the need to work with these to prevent an intergenerational cycle of health inequalities [6]. 'Get Hackney Healthy' includes a training programme for key professionals working with children and young people, a communications campaign, and a grants scheme (the 'Get Hackney Healthy Challenge Fund') which funds community and voluntary sector projects that increase physical activity and/or improve access to, or the knowledge of, healthy food.

One of the principle programmes of 'Get Hackney Healthy' is 'Health Heroes' in primary schools – seven schools participated between 2013 and 2015 and interventions focussed on physical activity, increasing children's knowledge of healthy eating, and school catering reviews. Other programmes include 'Play Streets', in which 2,000 children took part in safely playing on closed roads during 2014/15, and 'Hackney Wild Walks' with maps of walking routes around three locations being distributed to all Hackney residents in July 2014. Other local authority funded universal services contribute to the tackling of childhood obesity, for instance Hackney's 'Cook and Eat' community kitchen programme invites residents to learn how to cook health, nutritious and tasty meals while keeping to a budget in nine of Hackney's estates, with some courses being aimed at local families with children.

Tier two provision is also funded by the local authority and includes a 12 week group-based healthy lifestyle family-focussed programme working in partnership with the NCMP. One-to-one provision is only provided in tier two if needed.

Tier three provision covers all children aged 2-18 with a BMI >99.6th centile or those with problems engaging in group-based interventions. Interventions in tier three include LEAP (Lifestyle Eat-well Activity Positivity) – a service based at Homerton University Hospital providing holistic support through a multi-disciplinary approach that includes a paediatrician, dietician, nutritionist, physiotherapist and clinical psychologist. Intervention length varies but is generally up to six months with further follow up at three and six months post-intervention to assess progress and support the maintenance of weight loss. Based on the 2013/14 NCMP data, 106 Reception children and 156 Year 6 children would satisfy the criterion of being above the 99.6th BMI centile locally.

Tier four provision covers children aged 12-18 and involves the bariatric service.

11.5.4.1 Service Use

Over 12 months (January-December 2014) LEAP received 178 referrals, of which 127 clients attended one or more appointments [176]. These referrals were split evenly by gender (90 boys and 88 girls). Figure 172 shows that all except six of the 178 referrals were for children and young people aged 5-19, with 10-14 year olds having the greatest number of referrals.

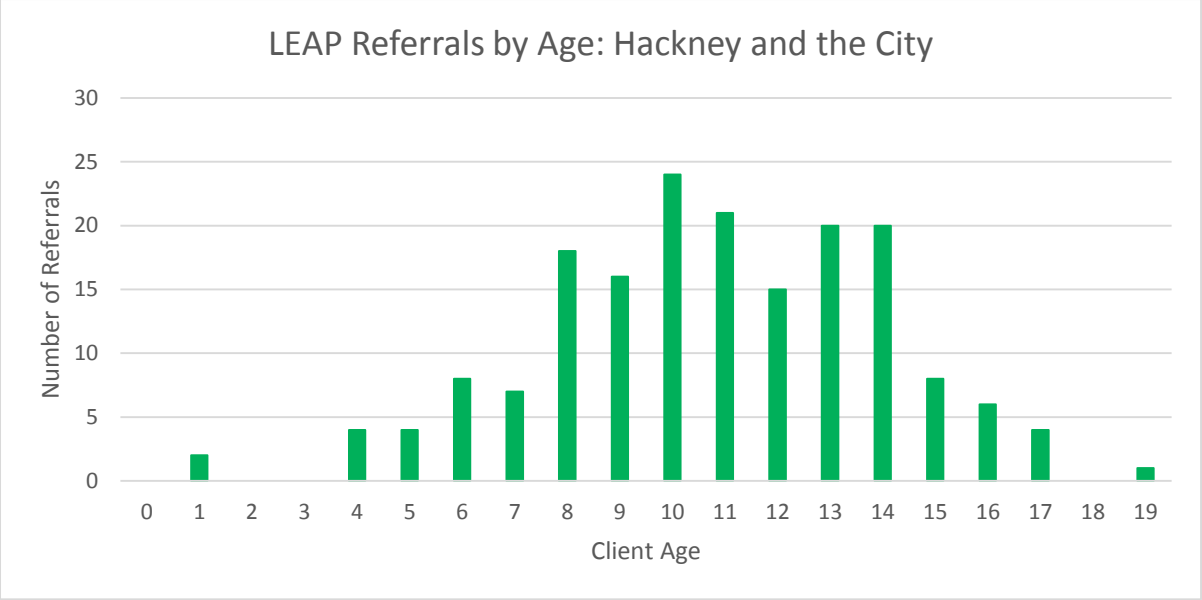

Figure 172: LEAP referrals by client's age, 2014 [176]

Children of Black ethnicity constituted 40% of all referrals to LEAP that had a documented ethnicity (Appendix 15.5.4, Figure 245) – this is higher than their proportion of Hackney's 5-19 population (31%) but in keeping with the NCMP findings that children of Black ethnicity have higher rates of obesity. 'White Other' children formed 23% of the referrals to LEAP and, of these, 75% of referrals were for Turkish or Turkish Cypriot children. At the other end of the spectrum, only 6% of referrals were for White British children, despite forming 27% of the local 5-19 population – again this is in keeping with NCMP findings that children of White ethnicity have lower rates of obesity.

LEAP received referrals from a wide range of sources and these are listed in Figure 173. The largest number of referrals came from GPs, but the number per practice varied widely – in 2014 19 practices did not submit any referrals, 18 practices sent one referral, 17 practices sent between two and four referrals and 14 sent between five and ten referrals (for the list of practices sending no or five or more referrals see Appendix 15.5.4 (Figure 246).

Source of Referral	Number of Referrals
Accident & Emergency department	5
CAMHS	5
Community Paediatric Service	15
GP	47
Health Visiting Service	<5
Looked After Children Service	<5
Nutrition & Dietetic Service	30
Physiotherapy	15
Psychology	<5
School Nursing Service	30
Other Source of Referral	27

Figure 173: Sources of referral to LEAP, 2014 [176]

Of the 76 clients who completed their treatment by the end of 2014, over half attended one, two or three appointments (Figure 174). The mean number of appointments attended was 3.9 per client (or 3.7 if the outlier who attended 18 appointments is excluded).

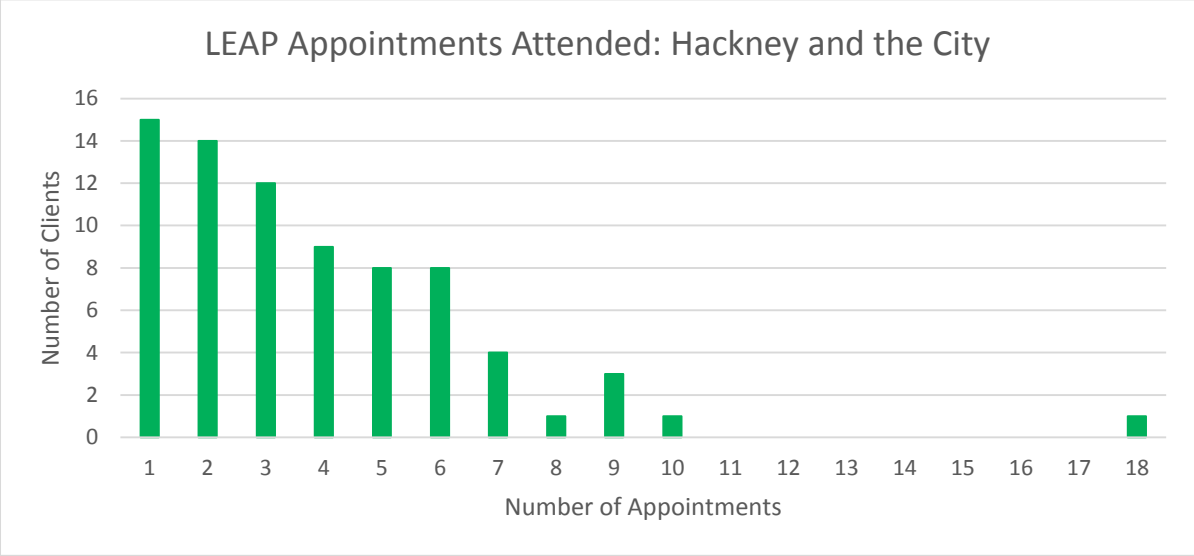

Figure 174: Number of LEAP appointments attended, 2014 [176]

11.5.5 Stakeholder Consultation

Consultation has been undertaken with a variety of groups to learn more about common opinions as well as those of hard to reach groups or those with protected characteristics.

At a consultation in a local primary school, of 71 responses about what is "healthy", 31 were food or drink related and 26 were sport or activity related. Of the 31 food responses, 18 were fruit or vegetables or the comment of "5 a day", three gave the response of "water" and two gave the response "balanced diet". When the children were asked about what is "unhealthy", out of 46 responses 16 regarded diet (sugary foods, fast food and salt intake), three related to not exercising and two mentioned being overweight (one response even recognising the poor health of animals being overweight – "dogs [*sic*] too fat").

CHYPS+ Voices is a youth forum for 11-19 year olds that has been created locally as a platform for young people's opinions to be inputted into CHYPS+. This forum agreed that exercise and healthy eating should be health and wellbeing priorities. However, the group expressed concern that, while there are opportunities to exercise at school, there are barriers to exercising outside of school; for instance, exercise classes do not always fit around the school schedule and students are not always comfortable enough to exercise with other people. Similarly, there was a feeling within the group that when students leave school at the end of the day it becomes harder to eat healthily, and this was partly blamed on the expense that the group associated with healthy food.

In six out of ten groups of pupils participating in a workshop at New Regent's College (a vocational college and re-engagement unit) "overweight", "fat" or "obese" were given as

examples of being unhealthy. Eating healthily and exercising were given in four out of ten responses as examples of being healthy.

Consultation with an LGBTQ group for young people acknowledged that "nutrition is important", however the group felt there was not as much emphasis on this as on other areas of the PSHE curriculum. Furthermore, the group felt that less stress should be placed on calorie intake, and more information should be shared about the components of nutrition, such as salt and sugar intake.

Discussion with parents revealed that cooking classes and education about nutrition for children were viewed as important. Other parents felt that it should be the role of parents to cook and show children how to eat healthily – however, there was appetite for healthy eating support to be extended to parents to facilitate this. There were mixed feelings about free school dinners with some parents worrying that catering did not always meet their children's needs, but parents would welcome the opportunity to input into the menu.

11.5.6 Recommendations

- Extend the local measurement scheme in Charedi schools to cover ten year old pupils to provide a more detailed picture of local childhood obesity rates in line with NCMP-published data
- Use a whole-family approach, not only in obesity management, but also in mainstream healthy weight maintenance education
- Aim to increase the proportion of young people being active every day – particularly in black and minority ethnic and LGBTQ groups. As the most common reason for young people not exercising outside of school is because they are not motivated to do so ("happy as I am"), rather than due to barriers in accessing facilities, it is important to increase young people's awareness of the importance of exercise – both for healthy weight maintenance and wider physical and mental health benefits
- Continue work to redress the balance in favour of more accessible healthy food near schools, and less accessible takeaway unhealthy food near schools
- Promote the LEAP service and its referral pathway to accident and emergency departments and to the 20 GP practices that did not refer any children during 2014

11.6 Dental Health

11.6.1 Introduction

"Oral health should be for life. The two common dental diseases – dental decay and gum disease – are chronic and the damage they cause is cumulative and costly."

Figure 175: 'An independent review of NHS Dental Services in England' [194]

Poor oral health can have a significant impact on quality of life by causing pain, affecting the ability to eat a healthy diet, affecting appearance, and occasionally resulting in sepsis. These factors may also cause sickness absence from school. Across England, almost a third of five year olds are suffering from tooth decay [177].

One of the key challenges in dental health is reducing health inequalities. The average number of decayed, missing or filled teeth in five year old children increases with increasing deprivation of lower tier local authorities [178]. Figure 176 also shows that the prevalence of severe or extensive dental decay is greater in more deprived areas, both in five and fifteen year olds.

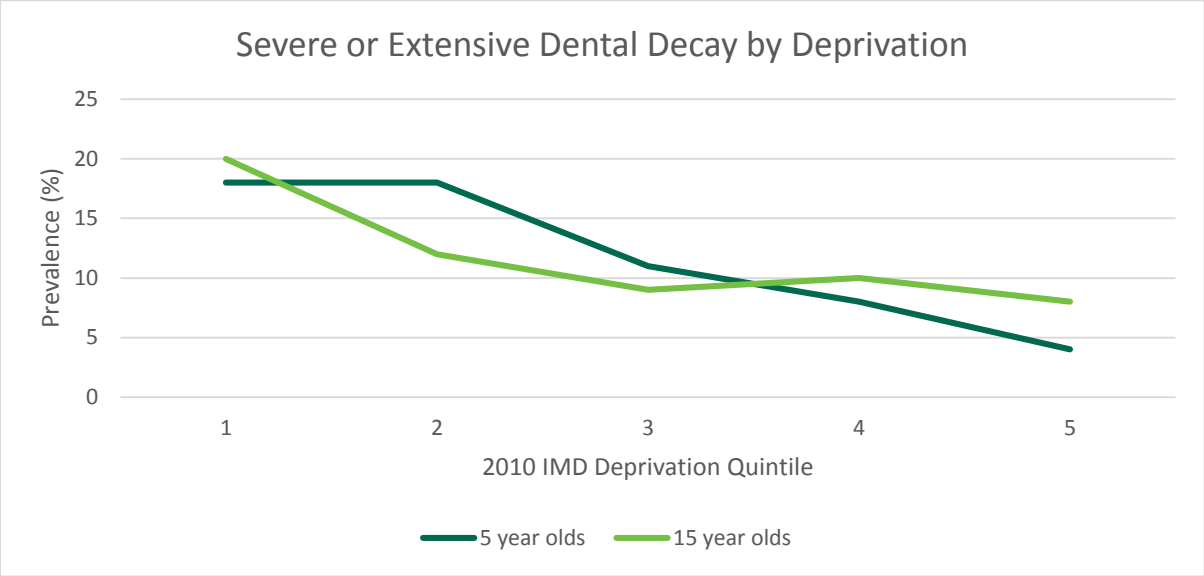

Figure 176: Severe or extensive dental decay by deprivation (IMD 2010), 2013

Sugar consumption is a major risk factor for tooth decay (also referred to as dental caries). Research has shown that there is a log-linear relationship of dental caries to sugar intake between no sugar consumption and sugar consumption accounting for 10% of energy intake [179]. The scientific advisory committee on nutrition (SACN) recommends that the average

population intake of free sugars[56] should not exceed 5% of total dietary energy from two years of age [180]. However, current estimates of UK sugar intake from the National Diet and Nutrition Survey (2008/09 to 2011/12) for school-aged children (aged four to 18) are 14.7-15.6% of energy intake – three-fold greater than the maximum recommended level [181]. National research reveals that soft drinks (excluding fruit juice) are the largest single source of sugar for children 11 to 18 years old – providing 29% of daily sugar intake [182].

PHE have estimated how many cases of dental caries could be avoided per year, and over the next 25 years, if the target of limiting sugar intake to 5% of energy intake is achieved within the next five years, ten years or fifteen years (Figure 177). For instance, over six million cases of dental caries could be avoided over the next 25 years if the target is achieved within the next five years.

Years to achieve target	Caries cases avoided over 25 years
5	6,030,000
10	5,101,000
15	4,310,000

Figure 177: Potential cases of dental caries avoided with adherence to SACN limit of 5% of energy intake from sugar [182]

In line with the finding that increasing deprivation is linked to increased dental decay, there is evidence that high sugar intake is associated with increased deprivation [182].

One method of trying to prevent dental decay is through the use of fluoride – a naturally occurring mineral that is found in tea, fish and some water supplies[57] – that can be added to a range of products to strengthen tooth enamel. Most toothpastes have added fluoride (to varying extents) – children aged up to six years old are advised to brush their teeth at least twice daily with a toothpaste containing more than 1000ppm fluoride, and adults are advised to brush their teeth at least twice daily with a toothpaste containing 1350-1500ppm fluoride [183]. According to a report on oral health produced by PHE, one of the best options for increasing the availability of topical fluoride, regardless of the levels of fluoride in the water supply, is fluoride varnish [184]. Fluoride varnish is applied to baby or adult teeth by a dentist or a trained dental nurse and is considered to be safe and well accepted. It is recommended that children should be offered fluoride varnish treatment at least twice a year from three years of age (and younger children may also be offered this treatment if deemed necessary by a dentist); it has been shown that two or more applications per year

[56] Note – free sugars comprises all monosaccharides and disaccharides added to foods by the manufacturer, cook or consumer, plus sugars naturally present in honey, syrups and unsweetened fruit juices. Under this definition lactose when naturally present in milk and milk products is excluded [180]

[57] Note – approximately 10% of England's population benefit from a water supply where the fluoride content (natural or artificial) is at the optimum level for dental health – these are predominantly in the West Midlands and the North East of England [184]

produces a mean reduction in caries increment of 37% in the primary dentition and 43% in the permanent [184].

The Faculty of Dental Surgery at the Royal College of Surgeons of England is "seriously concerned" about the state of children's oral health in England, and it highlights the following recommendations:

- Improve children's access to NHS dental services so they can visit a dentist regularly for preventive advice and receive early diagnosis for any problems so that appropriate treatment can be instigated promptly
- Address the relative shortage of specialist paediatric dentistry services in some parts of the country to ensure all children with advanced tooth decay have timely access to specialists with appropriate skills and facilities
- Ensure that NHS England and the profession work together to ensure that preventive care in primary care dentistry is adequately resourced and delivered
- Dental statistics should measure whether children have accessed an NHS dentist in the previous 12 months, rather than 24 months, in line with NICE guidance on dental recall. Public Health England should also consider a public campaign to stress the importance of children seeing a dentist
- Parents and children should be educated about the risks of tooth decay and the importance of good oral health and prevention. The government is urged to invest in a national oral health programme to drive improvements in children's oral health in England, as these have proved successful in Scotland and Wales
- Efforts should be made to raise awareness of the impact of sugar on tooth decay and explore ways to reduce sugar consumption
- Local authorities without water fluoridation should be encouraged to introduce schemes to tackle the significant inequalities in children's oral health across the country

11.6.2 Hackney and City of London

Children in Hackney visit their dentist less commonly than all of Hackney's statistical neighbours, with an average of 42% of 0-17 year olds visiting their dentist once over a two year period (Figure 178). In contrast, children of the City of London made more than one visit to the dentist over two years on average, which is more than all of Hackney's statistical neighbours and more than all of the City of London's statistical neighbours (which varied between 45% and 71% making one visit to the dentist).

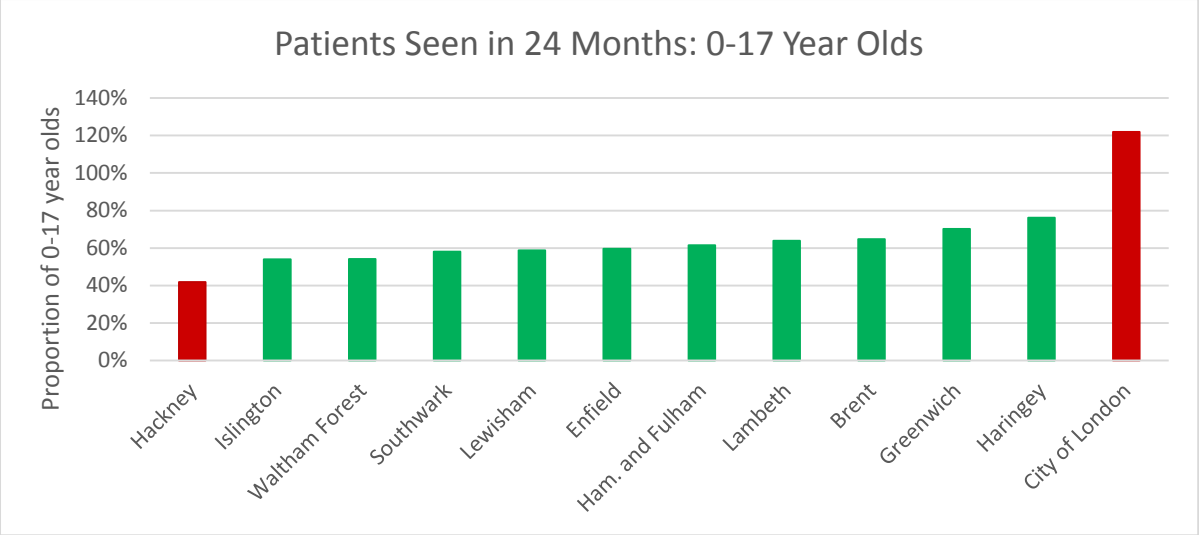

Figure 178: Dental visits in 0-17 year olds over 24 months, to 2014/15 [185]

When assessing the number of dentists available to the whole population, City and Hackney CCG has the second greatest size of population per dentist (i.e. the second fewest number of dentists per head of population) in comparison to the CCGs corresponding to Hackney's statistical neighbours (Figure 179). While this figure had improved during 2012/13 and 2013/14, it worsened again in 2014/15.

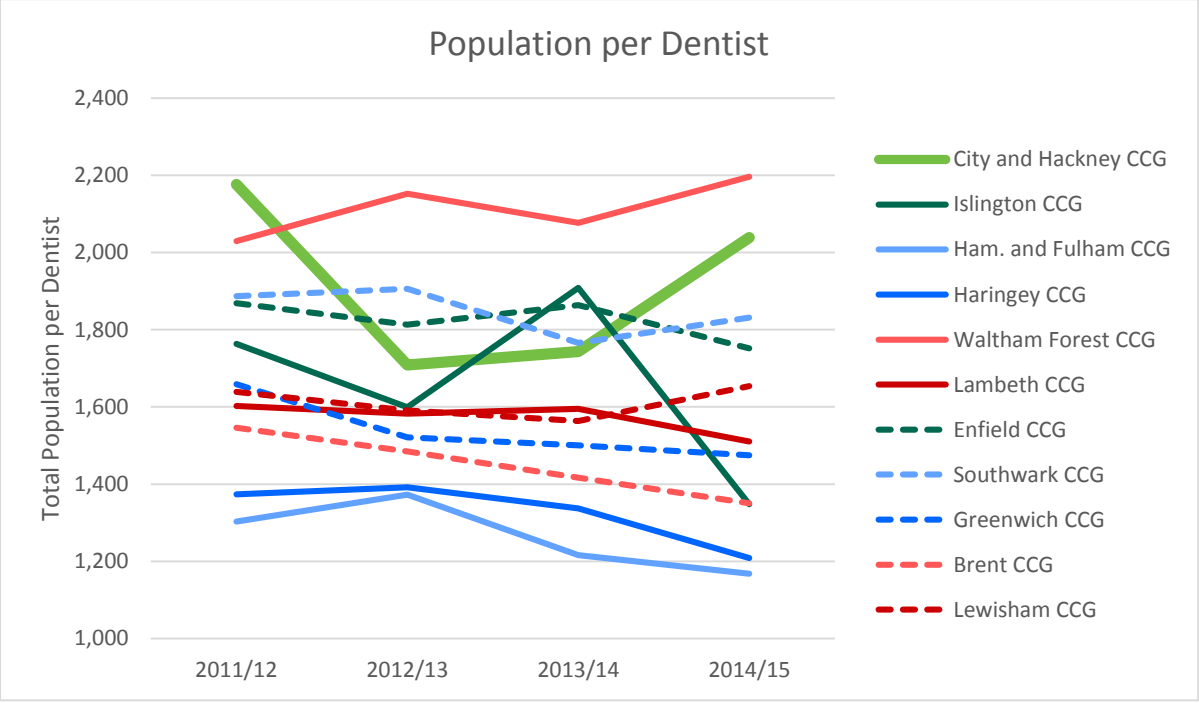

Figure 179: Population per dentist, 2014/15 [185]

Hackney has the lowest proportion of children who have had a fluoride varnish application (10% of 0-17 year olds) compared to its statistical neighbours (Figure 180). The City of London's rate is twice that of Hackney, at 20% of 0-17 year olds, but this is still lower than seven of Hackney's statistical neighbours.

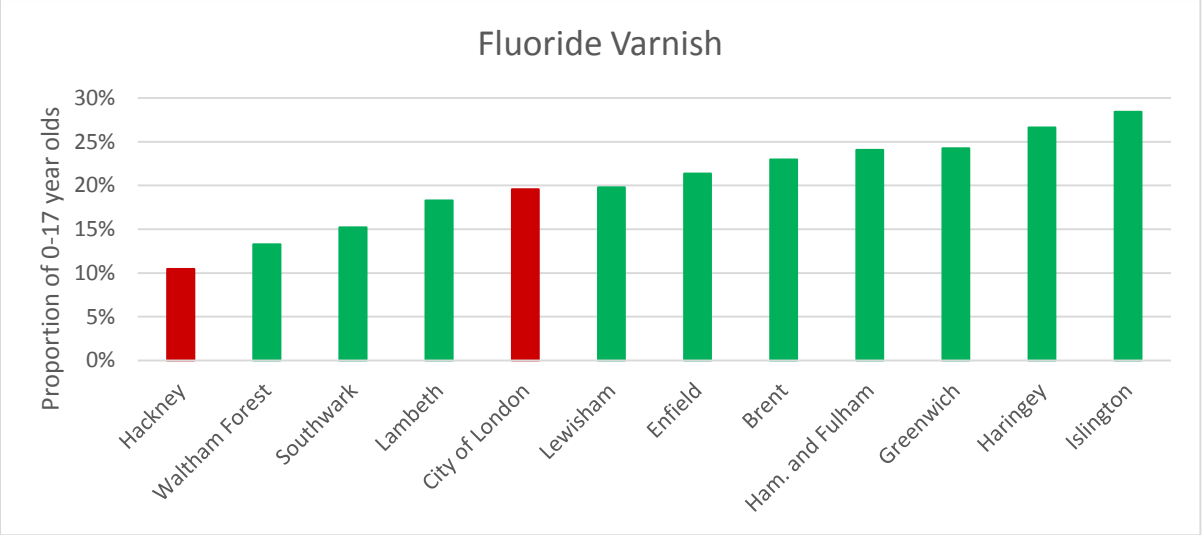

Figure 180: Child fluoride varnish applications, 2014/15 [185]

The picture with regards to dental decay and tooth extractions is not straightforward in Hackney. The national dental epidemiology programme in England surveyed five year old children in 2012; these data show that, at an average of 1.17 decayed, filled or extracted teeth per child, Hackney has a rate of tooth decay that fares on average for Hackney's statistical neighbours and lies between the London and national averages (Figure 181).

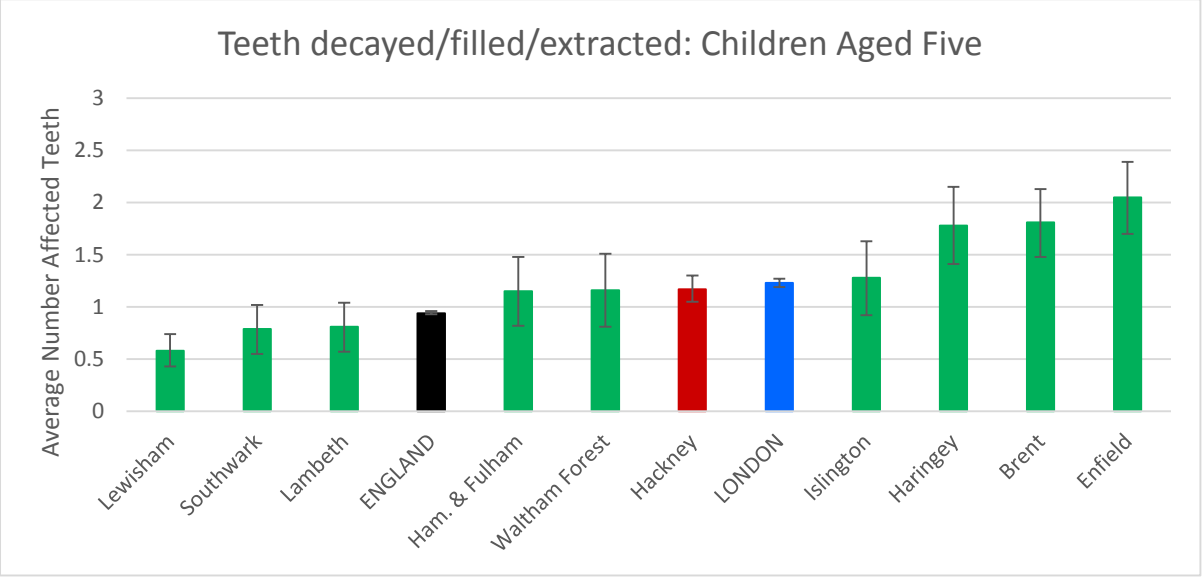

Figure 181: Tooth decay in five year old children, 2011/12 [41][58]

However, when tooth extractions are assessed separately (i.e. decayed but not extracted teeth are not included), Hackney has a lower rate than all ten of its statistical neighbours, at only 3% of 0-17 year olds[59]. This implies that Hackney has relatively more children who have tooth decay, but have not had their teeth extracted.

[58] Note – data for Greenwich are not available
[59] Note – these data refer to 0-17 year olds, whereas the previous figure related to children aged five only

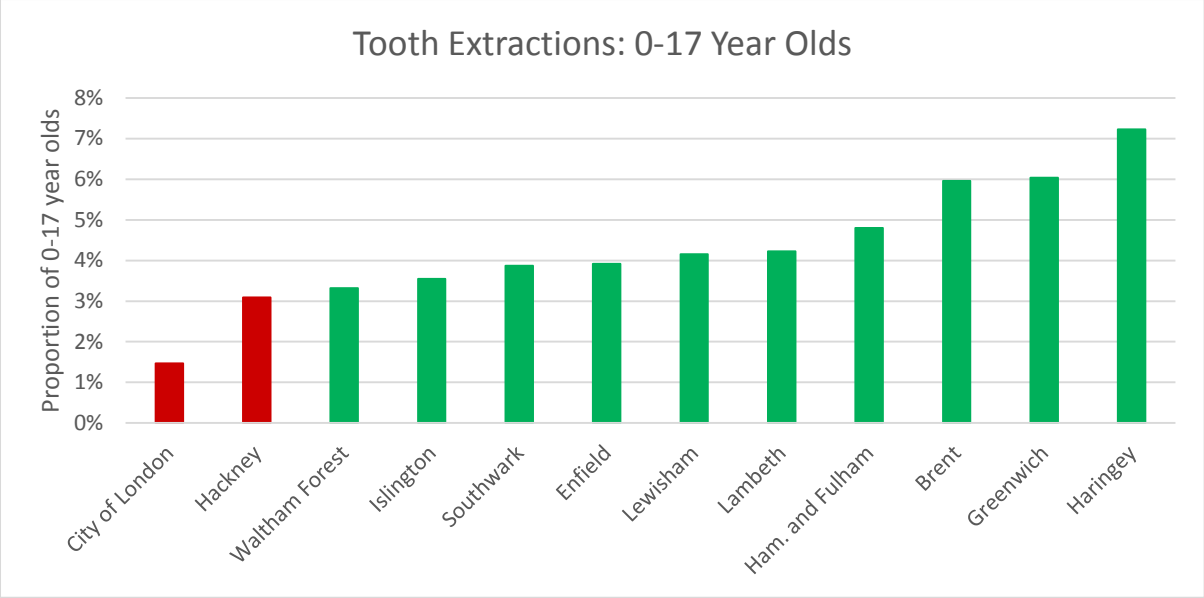

Figure 182: Child NHS dental extractions, 2014/15 [185]

The picture is complicated further when considering the location of tooth extractions. Ideally children with tooth decay are treated by primary care dentists in the community, however, children may be referred to hospital for specialist dental care if the teeth are badly damaged. General anaesthetic, which is only available in the hospital setting, is often given to children undergoing multiple tooth extractions to reduce pain and anxiety [177].

When considering tooth extractions in hospital, across all children Hackney has a higher rate

"The need for tooth extraction continues to be the number one reason why 5-9 year olds children are admitted to hospital."

Figure 183: Professor Nigel Hunt, Dean of the Faculty of Dental Surgery, 2016 [195]

than the London or national averages – with this difference being particularly marked in five to nine year old children (Figure 184). Trend data for inpatient dental extractions over the past three years reveal a relatively static picture across Hackney, London and England [186].

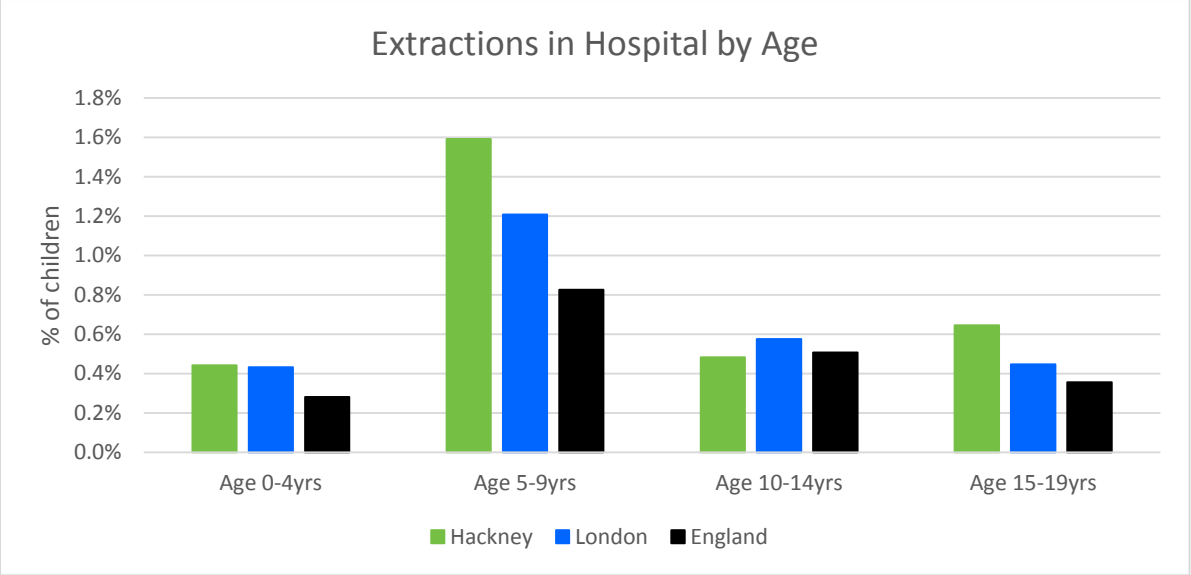

Figure 184: Hospital Tooth Extractions, 2013/14 [186]

Therefore, Hackney has relatively fewer teeth extracted for the rate of decay than other boroughs, but Hackney's children have a relatively high proportion of tooth extractions being in hospital. Therefore, it could be implied that there is an under-detection of tooth decay in children, and an underuse of community dental practices to extract children's teeth. Whether this is due to poor access to dentists, given the high population size per dentist in Hackney, or due to poor awareness leading to low demand for community dentists locally (and fewer dentists following low demand) is as yet unclear.

As concerns had been raised about the extent of tooth decay in Hackney's Charedi children, and the national dental surveys only include children attending state-maintained primary schools, during the local measurement pilot a dental survey and dental examinations in Charedi children were performed in Hackney in 2015. The dental examinations revealed that half of Charedi children had evidence of decayed teeth, in comparison to one third of Hackney children being quoted to have decayed teeth (Figure 185). Furthermore, the number of decayed/missing/filled teeth was higher in Charedi children at an average of 2.2 teeth per child, in comparison to 1.2 teeth per child in the wider Hackney community. The participation rate was broadly similar in the Charedi children (50% of children) as in the wider community (41% of eligible children).[60]

[60] Note – 302 of 604 Charedi children participated. 1,461 of the children of Hackney's wider community were examined out of a drawn sample of 2,478 from 3,532 eligible five year olds

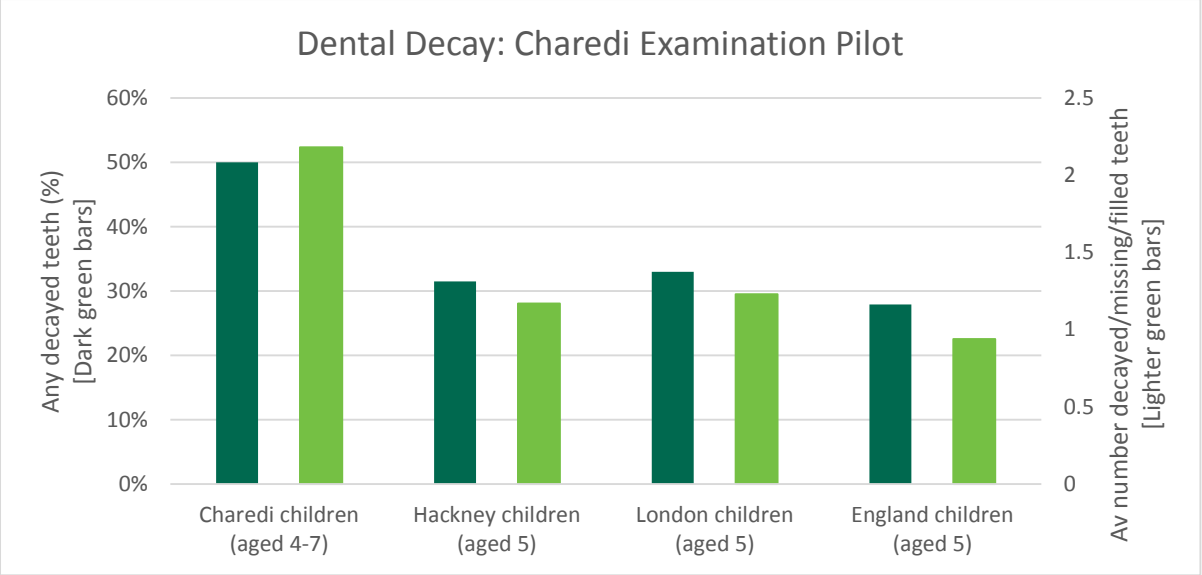

Figure 185: Tooth decay in Reception-aged children: national dental epidemiology (2012) and local Charedi pilot (2015)

A survey of parental attitudes was conducted in conjunction with the dental examinations of Charedi children. Of the 67 responses, 77% of parents declared that they took their child for 'regular dental care' (however frequency for this was not defined), 10% answered that they took their child to the dentist only if they were in pain, and 13% of parents revealed that they had never taken their child to a dentist (Figure 186).

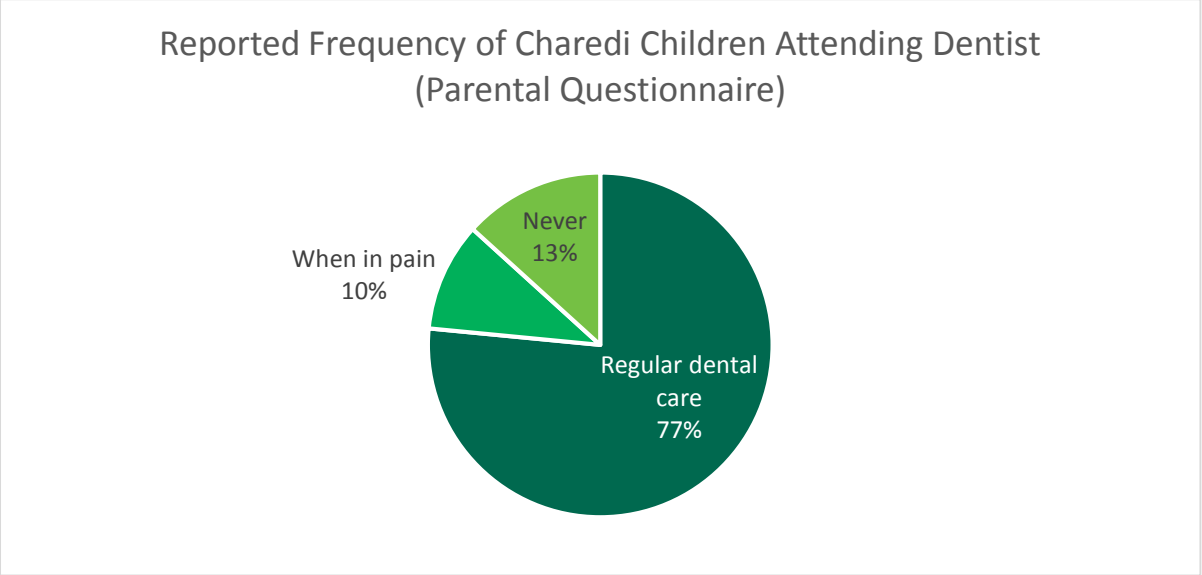

Figure 186: Local survey of Charedi parental attitudes to taking child to a dentist, 2015

Data for the City of London are not available for all of the above domains. However, data do show that the City has a high rate of 0-17 year olds attending a dentist in the past two years and a low rate of tooth extractions. While this may mask variability within the City (as is the case for data for any local authority), it is unlikely that the low rate of extractions is due to under-detection of decay, given the high number of visits to the dentist. It is therefore likely that this is a reflection of good dental health, on average, in the City.

11.6.3 Guidance

11.6.3.1 NICE PH55: Oral health: local authorities and partners

1. Ensure oral health is a key health and wellbeing priority
• Make oral health a core component of the JSNA and health and wellbeing strategy
2. Carry out an oral health needs assessment
• Include a consultant in dental public health, an NHS England commissioner of local dental services, and representatives from local authority public health, local professional dental network/committee, social care services, Healthwatch, and community groups • Have a senior local government representative to lead on, and advocate for, oral health • Ensure the needs assessment is an integral part of the JSNA and clearly linked to strategies on general health and wellbeing • Conduct the needs assessment as part of a cyclical planning process geared towards improving oral health and reduces health inequalities
4. Develop an oral health strategy
• Develop a strategy based on a needs assessment for universal and targeted approaches • Identify and work with groups able to improve oral health and their frontline staff e.g. children and young people's services, education, health services and community groups • Ensure easy access to services to help prevent oral disease occurring in the first place • Set out additional support that those working with high risk groups will be given, including training or resources • Evaluate what works and monitor the effect of the local strategy as a whole
5. Ensure public service environments promote oral health
• Ensure drinking water is available for free, provide a choice of sugar-free food, drinks and snacks in any vending machines and encourage breastfeeding in premises wholly or partly owned, hired or funded by the public sector e.g. community centres and schools • Review other 'levers' that local authorities can use e.g. planning for fast food outlets • Explore the possibility of linking with other sectors to promote oral health e.g. local shops
6. Include information and advice on oral health in all local health and wellbeing policies
• Ensure nutrition, looked after children, obesity, food, childcare services, education, safeguarding and other disease prevention policies cover oral health • Include information based on the advice for patients in 'Delivering better oral health'
8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health
• Ensure service specifications include a requirement to promote and assess oral health (with a referral if required) in the context of overall health e.g. substance misuse • Make oral health care (including regular dental checks) an integral part of care planning
9. Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health
• Commission regular training for frontline health and social care staff working with high risk groups to include causes, symptoms and prevention of tooth decay, basic assessment, care planning, local pathways and the consequences of poor oral health

17 and 21. Raise awareness of the importance of oral health as part of a whole-school approach in all primary and secondary schools
• Ensure school policies and procedures promote and protect oral health • Teach the importance of maintaining good oral health in the curriculum • Make plain drinking water available for free, encourage children to bring refillable water bottles to school and provide a choice of sugar-free food, drinks and snacks • Display and promote evidence-based, age-appropriate oral health information for parents / carers and children relevant to local needs and services • Ensure school nursing services encourage good oral health in secondary schools • Ensure all school leavers know where to get advice and help about oral health including dental treatment and help with costs
18. Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health
• Identify areas where children are at high risk of poor oral health • Train staff to give age-appropriate information and know where to get routine and emergency dental treatment (including advice about costs) • Provide opportunities for staff to talk with parents / carers about children's oral health
19 and 20. Consider supervised tooth brushing schemes and fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health
• Consider commissioning a supervised daily tooth brushing scheme (if resources are limited prioritise reception and year 1) or if this is not feasible consider commissioning a community-based fluoride varnish programme providing 2 applications per year • If resources are available consider commissioning both programmes • Work with parents / carers to gain consent for as many children as possible • Monitor uptake and seek parental feedback on the programmes

11.6.3.2 Healthy Child Programme

5-11 Universal:
• At school entry a school health team member reviews access to dental care • All schools should follow statutory nutritional standards and schools should be providing good-quality healthy food that children want to eat • Breakfast clubs provide an important opportunity to promote healthy eating among children, young people and their families
11-16 Universal:
• Recommended that pupils attending secondary school or special schools are offered a curriculum that includes the importance of a healthy, balanced diet, and the necessary skills for food preparation and making healthy food choices

11.6.4 Local Services

The local oral health promotion programme is called "Happy Smiles". As part of this programme, the importance of good oral hygiene, a healthy diet, and regular dental visits is promoted in the PSHE curricula of primary and secondary schools, and is also delivered in some Children's Centres. In 2013, nine primary schools were visited and 224 participants were involved. In the first half of 2014, six primary schools and one Children's Centre had been visited and 356 participants had been involved. However, no supervised toothbrushing currently exists in Hackney through the oral health promotion work in primary schools.

"Healthy Teeth" is the local fluoride varnish programme, which commenced in October 2012. The programme includes varnish awareness sessions for parents and guardians, and fluoride varnish is applied to children aged three to six years old – initially this programme was based in primary schools, but was since extended to delivery through nurseries as well. In 2013, 70 parents/guardians across seven nursery/school settings participated. 2709 children received fluoride varnish in the first year of the programme, and 2162 children did in the second year (in both cases accounting for just under half of the total eligible population) (Figure 187).

	Year 1 (2012/13)		Year 2 (2013/14)	
	Performed	% of eligible	Performed	% of eligible
Participating nurseries/schools	58	45%	49	38%
Children Screened	3385	56.5%	2468	50%
Children Requiring Treatment	598	17.7%	463	18.6%
Fluoride varnish: 1st application	2709	Total pop[n]: 45% With consent: 94%	2162	Total pop[n]: 43% With consent: 95%
Fluoride varnish: 2nd application	2709	Total pop[n]: 45% With consent: 94%	Not available	

Figure 187: Healthy Teeth Service Use, 2012/13-2013/14 [187]

The Community Dental Service provides dental care through their mobile dental clinic to four special schools in Hackney. The main aim of this service is to provide screening and treatment. While not mandated in their contract, fluoride varnish applications are also provided as the service has recognised the need for them. However, oral health promotion, including supervised toothbrushing, is not currently provided by the Community Dental Service. Unfortunately, the Community Dental Service's efforts to engage with the pupil re-engagement unit have been unsuccessful so far.

11.6.5 Stakeholder Consultation

Stakeholder consultation has been undertaken with a variety of groups to try to understand common opinions as well as the thoughts of hard to reach groups or those with protected characteristics.

At a consultation in a local primary school, of 46 responses about what is "unhealthy", 16 regarded diet and nine of these were related to sugar consumption – three mentioned sugar directly, four described chocolate or sweets, and two gave 'fizzy drinks' as their answer.

While obesity was referenced in six out of ten groups participating in a workshop at New Regent's College (a vocational college and re-engagement unit) when asked to give examples of being unhealthy, sugar consumption or dental decay were only mentioned in two responses.

Consultation with an LGBTQ group for young people acknowledged that “nutrition is important”, however the group felt there was not as much emphasis on this as on other areas of the PSHE curriculum. Furthermore, the group felt that less stress should be placed on calorie intake, and more information should be shared about the components of nutrition, such as salt and sugar intake.

Discussion with parents revealed that education about nutrition for children were viewed as important. Other parents felt that it should be the role of parents to cook and show children how to eat healthily – however, there was some appetite for healthy eating support to be extended to parents to facilitate this. There were mixed feelings about free school dinners with some parents worrying that catering did not always meet their children’s needs, but parents would welcome the opportunity to input into the menu.

11.6.6 Recommendations

- Increase community awareness among children themselves, and their parents or guardians, of the need for children and young people to visit a dentist regularly
- Investigate the levers that could be used to increase the number of dentists practicing in both Hackney and the City
- Work with the Charedi community to ensure that any cultural-specific barriers to dental health are identified and addressed
- Explore the feasibility of extending the oral health promotion project (“Happy Smiles”) to Hackney’s special schools and re-engagement unit and facilitate partnership working with the Community Dental Service
- Ascertain what the obstacles are to the Community Dental Service operating in the re-engagement unit in Hackney, and work to remove them
- Expand the fluoride varnish programme to operate in all primary schools and nurseries in Hackney and the City, and work to increase the proportion of parents who consent to their children receiving the varnish – through warning of the harms associated with tooth decay and raising awareness of the benefits of varnishing
- Within the local authority consider the introduction of a water fluoridation scheme and discuss this with neighbouring local authorities that share the local water supply, in line with guidance from PHE

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13 Table of Figures

14 Abbreviations

A&E	Accident and Emergency
ADHD	Attention deficit hyperactivity disorder
AIDS	Acquired immune deficiency syndrome
BCG	Bacillus Calmette-Guerin [vaccine]
BME	Black and minority ethnic
BMI	Body mass index
CAF	Common assessment framework
CAMHS	Child and adolescent mental health service
CC	Continuous cruisers
CCG	Clinical commissioning group
CDC	Centres for disease control and prevention
CDOP	Child death overview panel
CEG	Clinical effectiveness group
CHYPS+	City and Hackney young people's health service plus
CMO	Chief Medical Officer
CMR	Child mortality rate
CQUIN	Commissioning for quality and innovation
CSE	Child sexual exploitation
CWI	Child wellbeing index
DTaP/IPV/Hib	Diphtheria, tetanus, pertussis, inactivated polio and Haemophilus influenzae type b
DVIP	Domestic violence intervention project
EHC	Educational health and care
ELFT	East London NHS Foundation Trust
FAST	First access and screening team
FE	Further education
FGM	Female genital mutilation
FNM	Family network meetings
FSM	Free school meals
GCSE	General certificate of secondary education
GP	General Practitioner
GUM	Genito-urinary medicine
HCP	Healthy child programme
HIV	Human immunodeficiency virus
HLT	Hackney Learning Trust
HPV	Human papillomavirus
HSB	Harmful sexual behaviour
ICD-10	International classification of diseases, tenth revision
ILEA	Inner London education authority
IMD	Index of multiple deprivation
IUD	Intra-uterine device e.g. copper coil
IUS	Intra-uterine system e.g. Mirena coil
JSA	Job seekers allowance
JSNA	Joint strategic needs assessment
KS2/KS4/KS5	Key stage two/four/five
LA	Local authority
LAC	Looked after children
LARC	Long acting reversible contraception

LEAP	Lifestyle eat-well activity positivity
LGBTQ	Lesbian, gay, bisexual, transgender and queer
LSOA	Lower super output area
LSYPE	Longitudinal survey of young people in England
MARAC	Multi-agency risk assessment conference
MASH	Multi-agency safeguarding hub
MAT	Multi-agency team
MMR	Measles, mumps and rubella
MSM	Men who have sex with men
Natsal	[British] National survey of sexual attitudes and lifestyles
NCMP	National child measurement programme
NCSP	National chlamydia screening programme
NDTMS	National drug treatment monitoring service
NEET	Not in education, employment or training
NHS	National health service
NICE	National institute for health and care excellence
NPS	New psychoactive substances
NRPF	No recourse to public funds
OCP	Oral contraceptive pill
ONS	Office for national statistics
OSP	Obesity strategic partnership
PASS	Parenting assessment and support service
PE	Physical education
PHE	Public Health England
PHOF	Public health outcomes framework
PSHE	Personal, social, health and economic [education]
QOF	Quality outcomes framework
SACN	Scientific advisory committee on nutrition
SCPHN	Specialist community public health nurses
SEAL	Social and emotional aspects of learning
SEN	Special educational needs
SENCO	Special educational needs co-ordinator
SIF	Single inspection framework
SMI	Severe mental illness
SOC	Standard occupation classification
SRE	Sex and relationship education
SRH	Sexual and reproductive health
SSTD	Shomer Shabbos telephone directory
STC	Self-treatable conditions
STD	Sexually transmitted disease
STI	Sexually transmitted infection
Td/IPV	Tetanus, diphtheria, inactivated polio
VD	Venereal disease
VNQ	National vocational qualification
WAY	What About YOUth? [survey]
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale

15 Appendix

15.1 Background

Hackney's 21 constituent wards [65]:

- Brownswood
- Cazenove
- Clissold
- Dalston
- De Beauvoir
- Hackney Central
- Hackney Downs
- Hackney Wick
- Haggerston
- Homerton
- Hoxton East & Shoreditch
- Hoxton West
- King's Park
- Lea Bridge
- London Fields
- Shacklewell
- Springfield
- Stamford Hill West
- Stoke Newington
- Victoria
- Woodberry Down

Figure 188: Hackney's 21 constituent wards [65]

City of London's 25 constituent wards [189]:

- Aldersgate
- Aldgate
- Bassishaw
- Billingsgate
- Bishopsgate
- Bread Street
- Bridge and Bridge Without
- Broad Street
- Candlewick
- Castle Bavnard
- Cheap
- Coleman Street
- Cordwainer
- Cornhill
- Cripplegate
- Dowgate
- Farringdon Within
- Farringdon Without
- Langbourn
- Lime Street
- Portsoken
- Queenhithe
- Tower
- Vintry
- Walbrook

As the number of daytime workers far outnumbers the resident population in the City of London, unlike elsewhere in the UK, businesses, as well as residents, can register to vote in local elections [189].

Figure 189: City of London's 25 constituent wards [189]

15.2 Policy

1. Cabinet Office supported by PHE, and the Children's Commissioner, should consider initiating an annual National Children's Week
2. PHE in collaboration with the Early Intervention Foundation should assess the progress on early intervention and prevention, continue to develop and disseminate the evidence base for why this matters and build advice on how health agencies can be part of local efforts to move from a reactive to a proactive approach
3. PHE, working with Directors of Public Health and Health and Wellbeing Boards, should support the work of the Big Lottery Fund programmes and ensure that the lessons learnt are disseminated
4. PHE should undertake a Healthy Child Programme evidence refresh, starting with the early years
5. PHE should work with local authorities, schools and relevant agencies to build on current efforts to increase participation in physical activity and promote evidence based innovative solutions that lead to improved access to existing sports facilities
6. NICE should examine the cost-effectiveness of moving the Healthy Start vitamin programme from a targeted to a universal offering. The Department of Health should set out next steps in light of evidence from the Scientific Advisory Committee on Nutrition (SACN) about folic acid. Action should be taken if required on iodine following recommendations by SACN
7. The Social Mobility and Child Poverty Commission and PHE should work together to ensure that efforts to narrow attainment gaps in education complement efforts being made to narrow health inequalities
8. PHE should work with NHS England, the Department for Communities and Local Government and the Department of Health to identify how the health needs of families are met through the Troubled Families Programme
9. The Department of Health, NHS England and PHE, alongside representatives of children and young people, should build on the You're Welcome programme and the vision outlined in the recent pledge for better health outcomes for children and young people to create a 'health deal' which outlines the compact between children and young people and health providers, and creates a mechanism for assessing the implementation of this
10. Children with long-term conditions, as vulnerable people, should have a named GP who co-ordinates their disease management
11. As plans are made to extend GP training, paediatrics and child health should be part of the core component of extended training
12. Health Education England should commission education to ensure that the workforce is trained to deliver care that is appropriate for children and young people, in the same manner as is being currently carried out for age-appropriate care for older people
13. Health Education England, the Department of Health and PHE should work to ensure that commissioned education of health professionals stresses the important role of school nurses

14. PHE should develop and enact a youth social marketing programme, “Rise Above” to engage young people around exploratory behaviours through multiple platforms
15. PHE and other leading organisations working in the field should work together to strengthen the evidence base for programmes that develop resilience in young people
16. PHE should develop an adolescent health and wellbeing framework which includes the inter-relationships of exploratory behaviours. As part of their public-facing work. PHE should model engagement with young people on multiple health and wellbeing issues through a variety of platforms
17. PHE, the PSHE Association and other leading organisations in the field should review the evidence linking health and wellbeing with educational attainment, and from that promote models of good practice for educational establishments to use
18. The Children and Young People’s Health Outcomes Forum annual summit should provide an opportunity for the review of health outcomes that are relevant to children, and to examine regional variation
19. Regulators, including the Care Quality Commission and Ofsted, should annually review the effectiveness of inspection frameworks and the extent to which they evaluate the contribution of all partners to services for children and young people. This includes the contribution of statutory partners, local safeguarding boards and health and wellbeing boards to the health and protection needs of children and young people
20. The review of ‘Safeguarding Children and Young people: roles and competences for health care staff – intercollegiate document’ should embed the professional responsibility to the whole family, and professional bodies should develop the necessary innovative tools to support this
21. The Department of Health should work with ONS, PHE and relevant third sector organisations to investigate opportunities to commission a regular survey to identify the current prevalence of mental health problems among children and young people, with particular reference to those with underlying neurodevelopmental issues, those aged under 5, ethnic minorities and those in the youth justice system. This data collection should include international comparisons and be linked to the Child and Adolescent Mental Health Services data set, providing key data for developing local services to meet clinical need. An annual audit of services and expenditure in the area should be undertaken
22. The National Institute for Health Research should develop a research call to provide the evidence base to improve health outcomes for long-term conditions in childhood, to match the best worldwide
23. The National Institute for Health Research Clinical Research Network, including the Medicines for Children Network, should work with children and young people to input to the design of clinical studies in order to facilitate increased participation of children and young people in drug and other trials
24. The four UK Chief Medical Officers have agreed that the Chief Medical Officer in Northern Ireland will lead a group with the four public health agencies and The Royal Society for the Prevention of Accidents to develop strategies to combat blind cord deaths

Figure 190: Recommendations of 'Our Children Deserve Better: Prevention Pays' [14]

15.3 Wider Determinants of Health

15.3.1 Core Demographics

15.3.1.1 Ethnicity

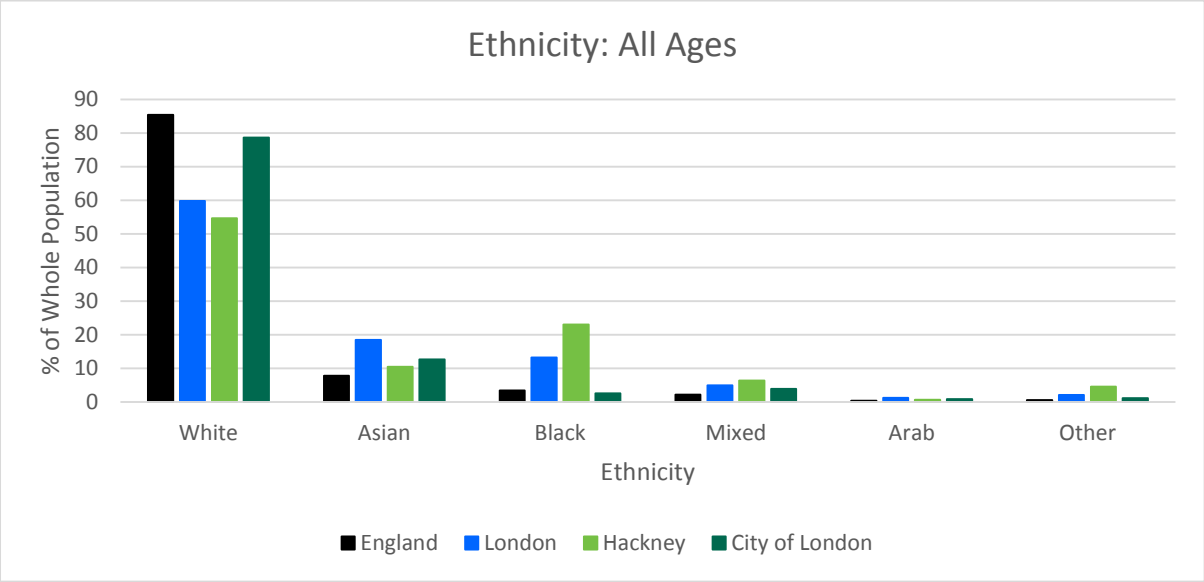

Figure 191: 2011 Ethnicity by location [33]

15.3.1.2 Migration

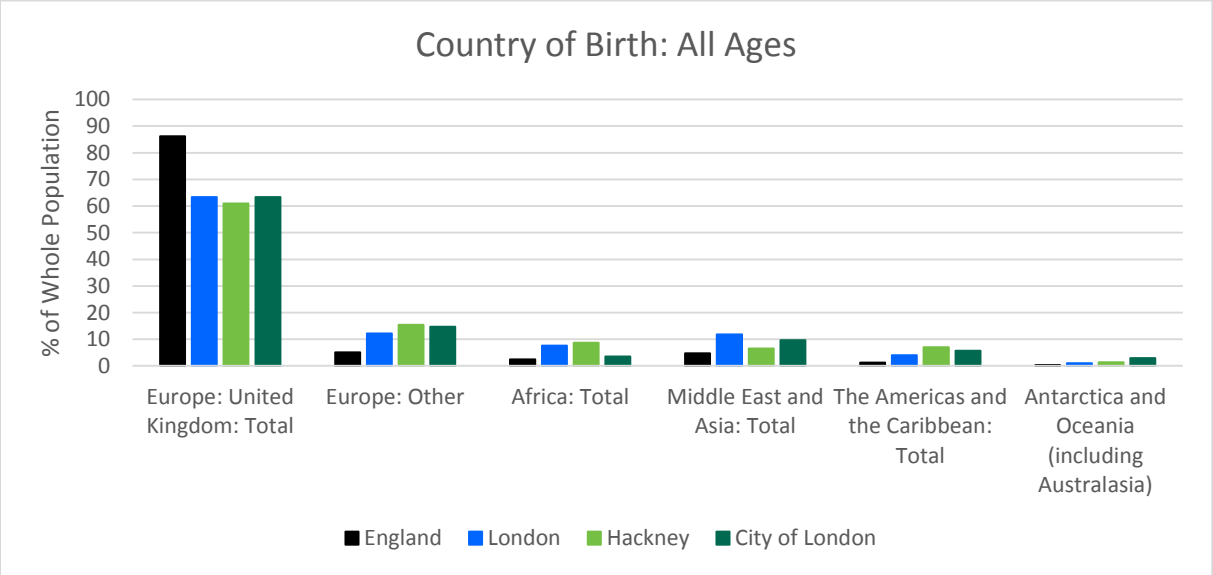

Figure 192: Country of Birth [33]

Hackney		City of London	
Country of Birth	% of Population	Country of Birth	% of Population
Turkey	3.6	United States	2.8
Nigeria	2.7	France	2.0
Jamaica	1.8	Australia	1.9
Poland	1.7	Germany	1.6
Ireland	1.6	Ireland	1.5
Ghana	1.5	India	1.4
India	1.2	Italy	1.4
United States	1.1	Bangladesh	1.3
Bangladesh	1.1	China	1.3
France	1.0	New Zealand	1.1
Italy	1.0	Hong Kong	1.0
Australia	1.0	South Africa	1.0
Germany	0.9	Spain	1.0
Spain	0.7	Canada	0.9
Cyprus	0.7	Japan	0.7
Israel	0.7	Greece	0.7
Vietnam	0.6	Malaysia	0.7
Somalia	0.6	Russia	0.7
Brazil	0.6	Colombia	0.7
Portugal	0.5	Poland	0.6

Figure 193: Top 20 Countries of birth for those born outside the UK [33]

	Residential Pitches	Caravan Capacity
Abbey Close, E5 8AQ	7	8
Ruby Close, E5 0AF	8	10
St Theresas Close, E9 5EF	7	14
Palace Close, E9 5DW	4	6
St Anthony's Close, E9 5ET	1	1

Figure 194: Pitches in Hackney (Local Authority and Private Providers), Jan 2015 [43]

15.3.1.3 Language

Language	% Hackney population	% City of London population
English	75.9	82.9
Turkish	4.5	0.2
Polish	1.7	0.4
Spanish	1.5	1.8
French	1.4	2.2
Bengali	1.3	1.6
Yiddish	1.3	-
Portuguese	1.2	0.7
Italian	0.9	1.1
German	0.7	1.2

Figure 195: Most common main languages [33]

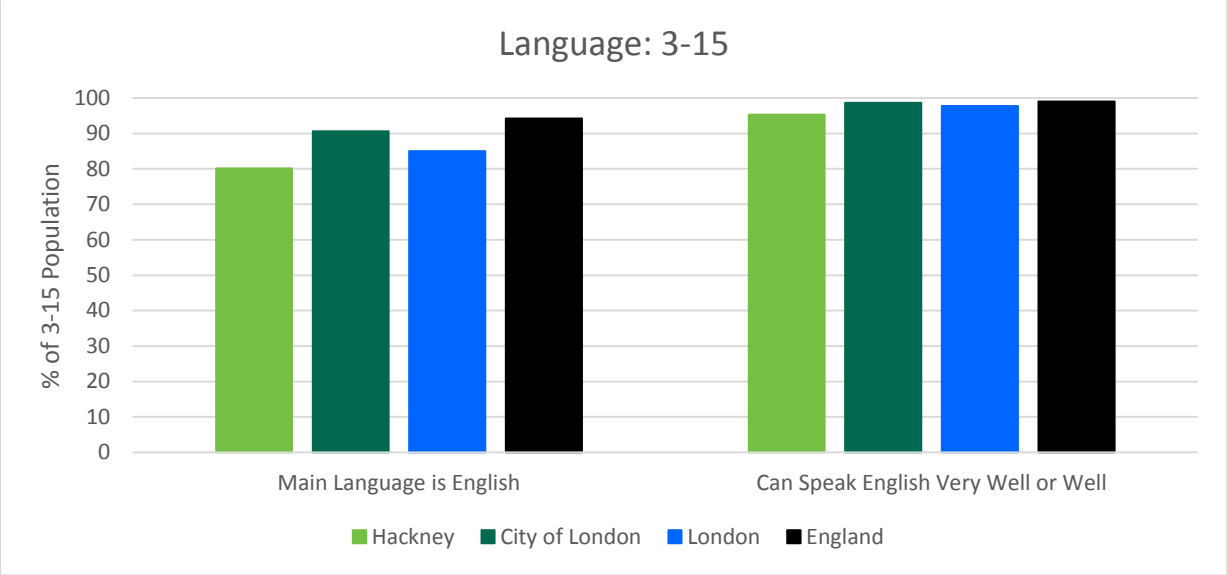

Figure 196: Main Language and Proficiency in English in 3-15 year olds [33]

15.3.1.4 Religion

	% of each religion in Hackney	% of each religion in the City
All religions	25.1	10.6
Christian	23.7	10.2
Buddhist	17.6	4.3
Hindu	15.7	11.0
Jewish	49.5	4.8
Muslim	36.4	29.6
Sikh	35.5	0.0
Other religion	10.4	3.6
No religion	14.9	8.0
Religion not stated	29.6	14.0

Figure 197: Proportion of responders for each religion being aged 0-19 years [33]

15.3.2 Social Factors

15.3.2.1 Deprivation

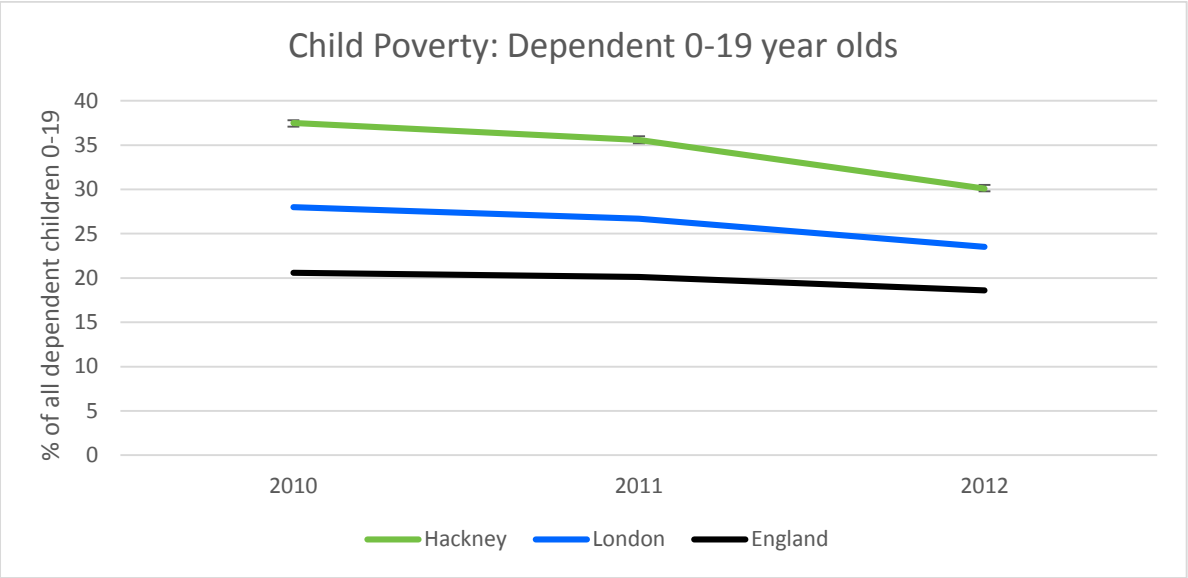

Figure 198: 0-19 year old dependent children living in poverty, 2012 [41]

Ward	Child Poverty % 2011	Decrease in percentage points from 2007
Leabridge	39.9	1.3
Wick	47.7	4.9
De Beauvoir	39.8	5.6
Clissold	27.0	7.0
Queensbridge	43.1	7.1
Dalston	41.5	7.2
Kings Park	45.4	7.5
Haggerston	47.4	7.6
Chatham	43.6	7.7
Hackney Central	42.6	7.9
Victoria	40.3	8.1
Stoke Newington Central	29.3	8.4
Hoxton	46.8	10.1
Brownswood	35.9	10.4
Hackney Downs	38.5	13.6
Springfield	31.6	15.9
Cazenove	27.4	19.5
Lordship	28.8	21.8
New River	29.0	22.2

Figure 199: Child Poverty by Ward in Hackney 2011 [190]

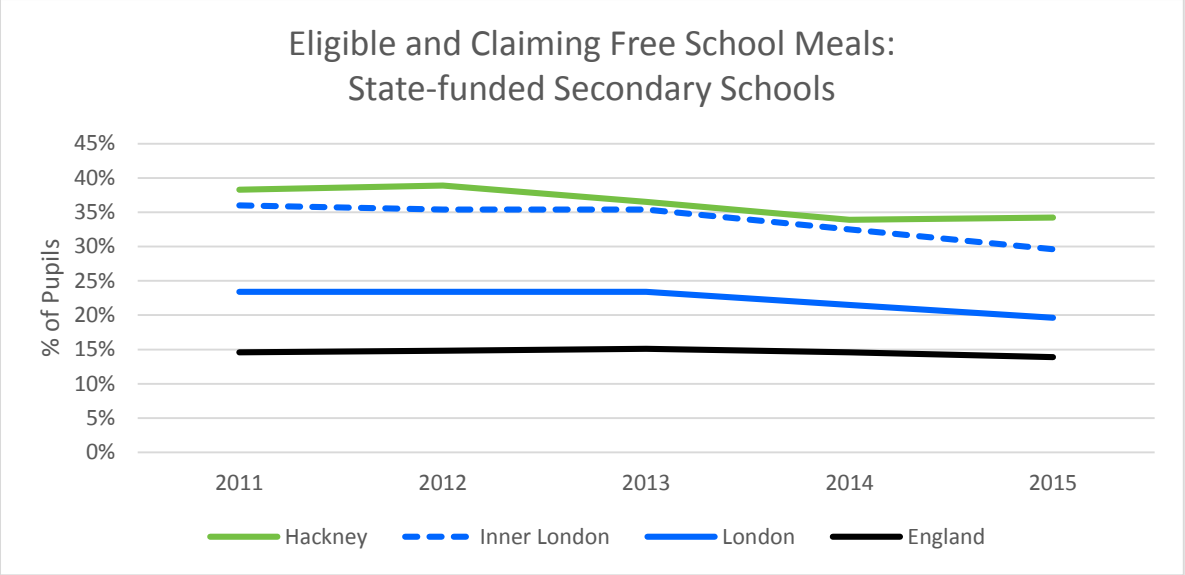

Figure 200: Secondary Pupils Eligible for and Claiming Free School Meals [30]

15.3.2.2 Parental Employment and Income

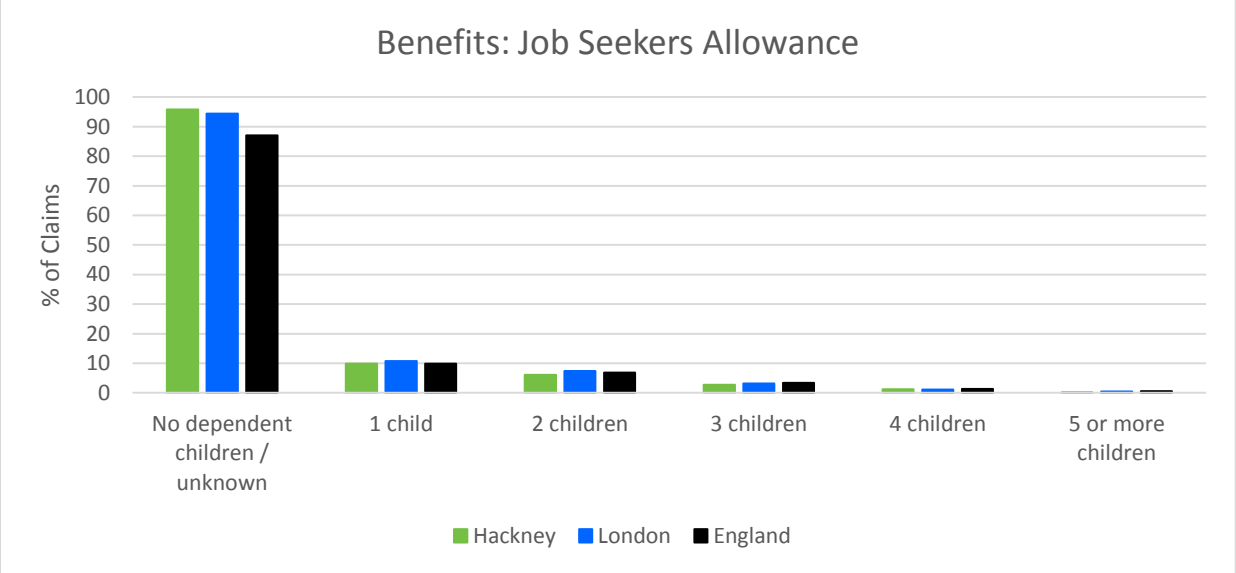

Figure 201: Proportion of JSA claims by number of dependent children [70]

15.3.2.3 Housing

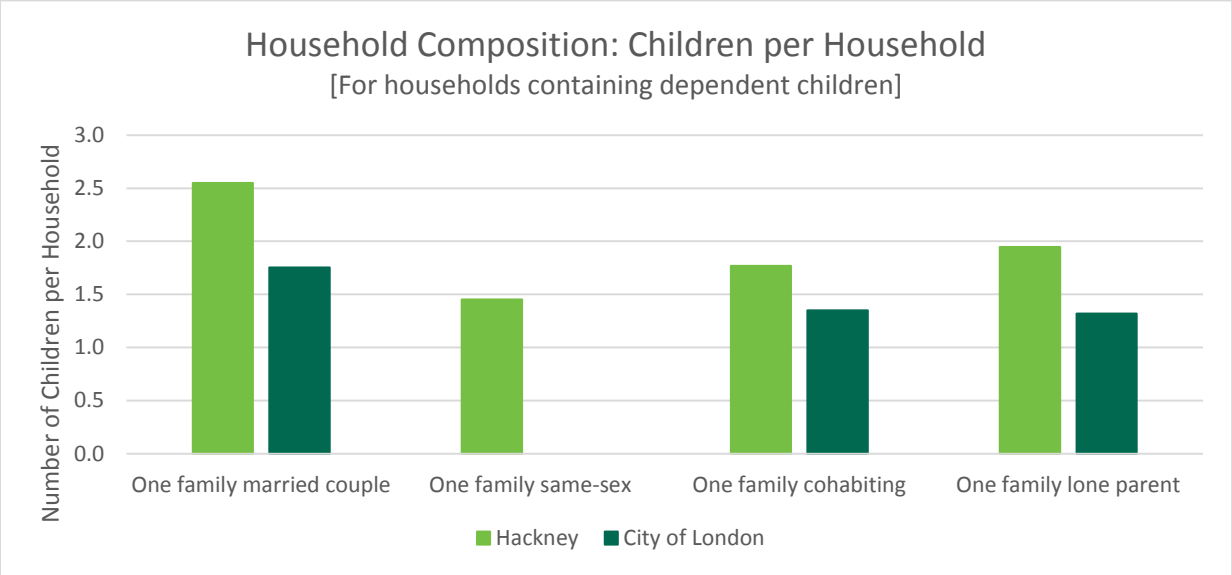

Figure 202: Number of children per household (for households containing dependent children) by family structure [33]

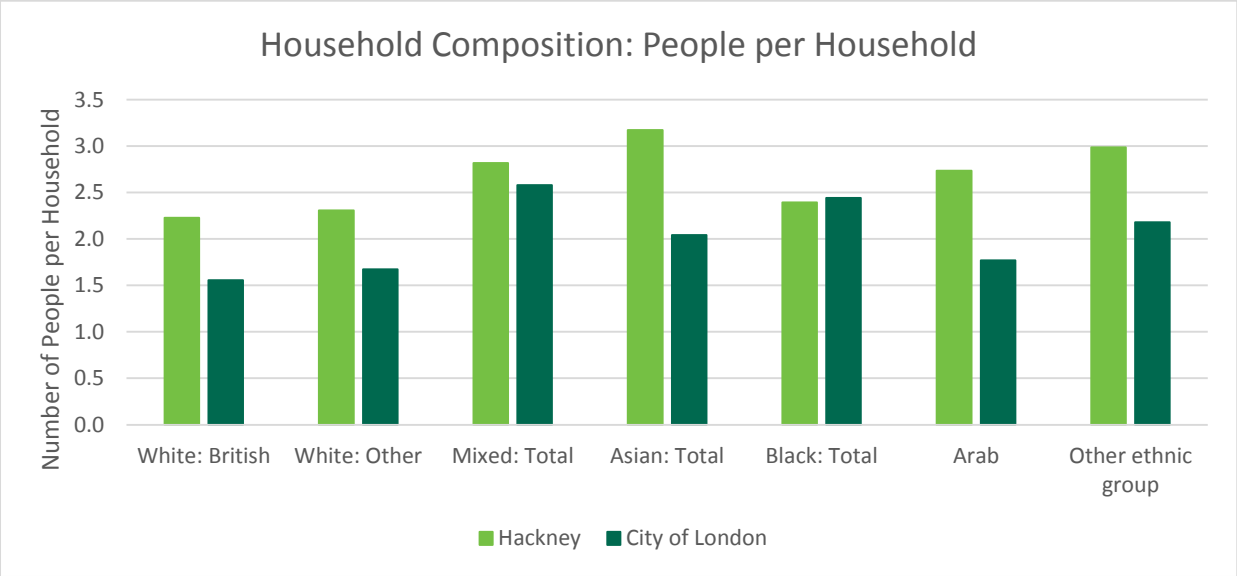

Figure 203: Number of people per household (all households) by ethnicity [33]

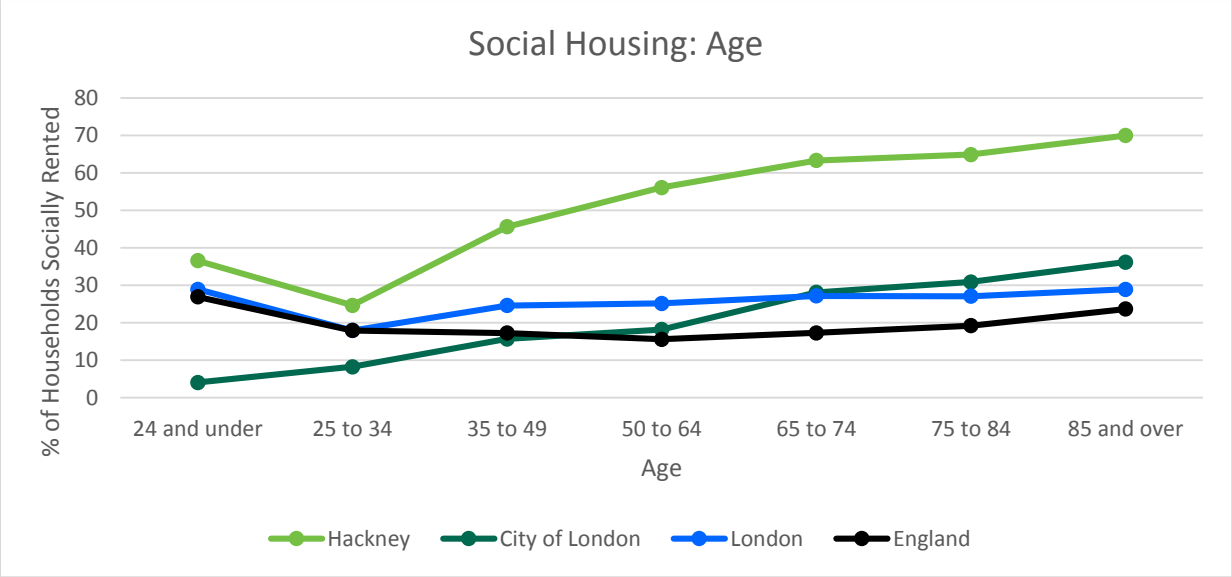

Figure 204: Proportion of households socially rented by age [33]

15.3.2.4 Environment

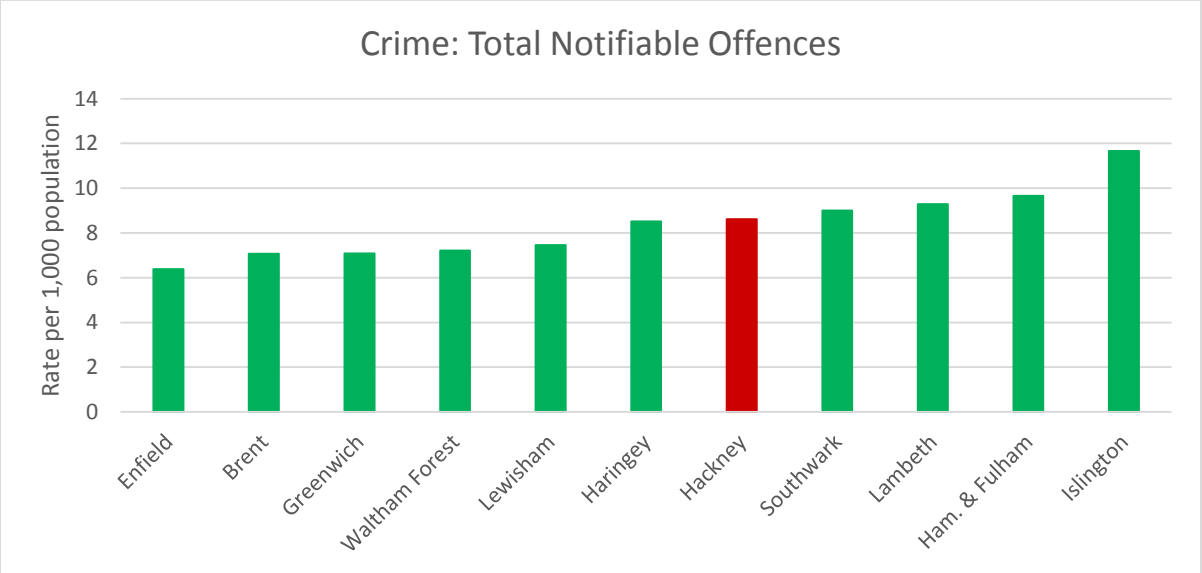

Figure 205: Crime rate per 1,000 resident population 2014/15 [75]

15.3.3 Education

15.3.3.1 Special Educational Needs

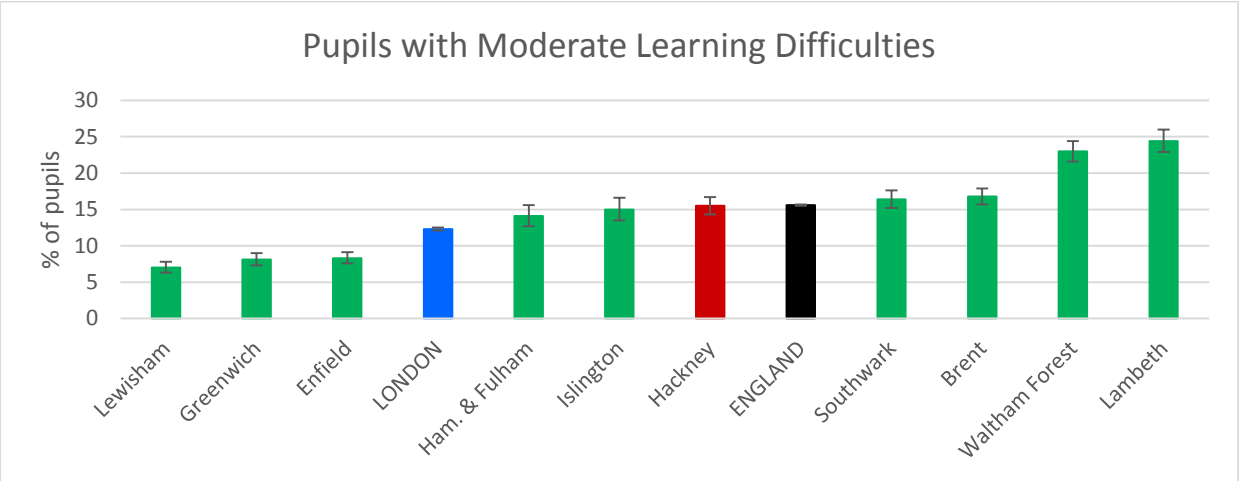

Figure 206: Pupils known by schools to have moderate learning difficulties, Spring 2013/14 [41]

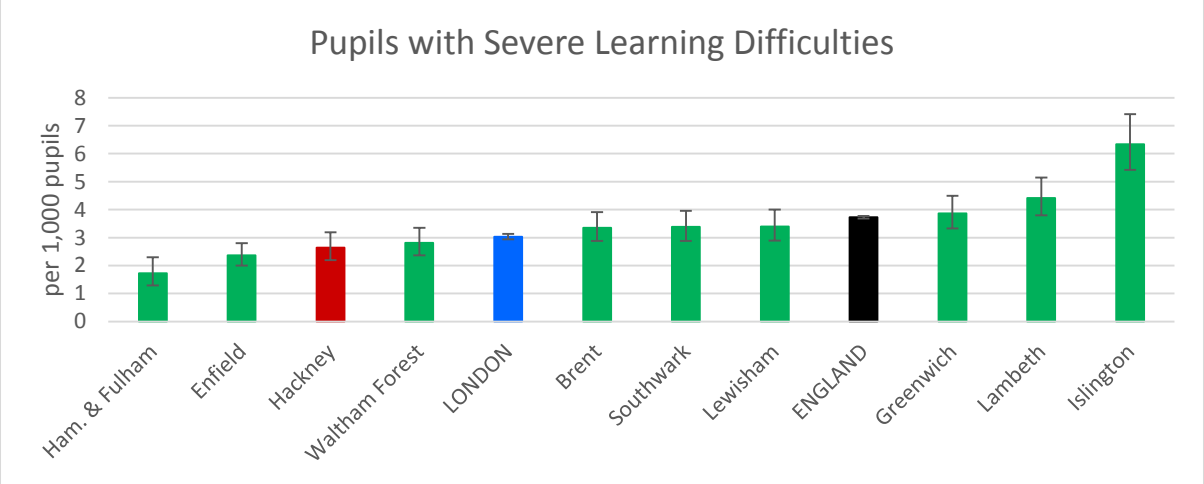

Figure 207: Pupils known by schools to have severe learning difficulties, Spring 2013/14 [41]

15.3.3.2 Performance

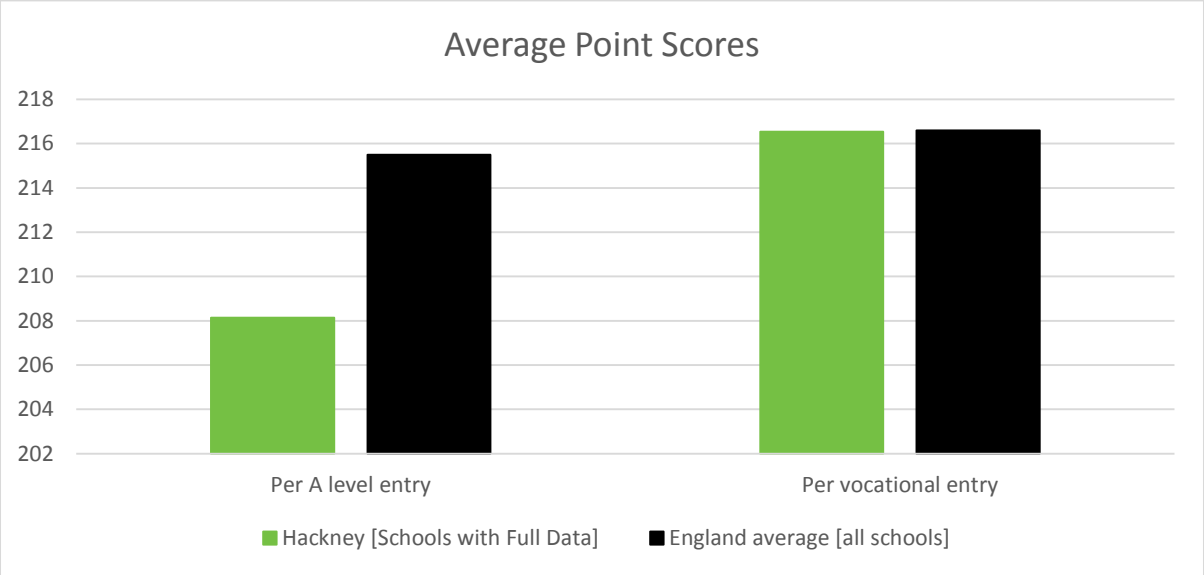

Figure 208: Average Point Scores per entry [76]

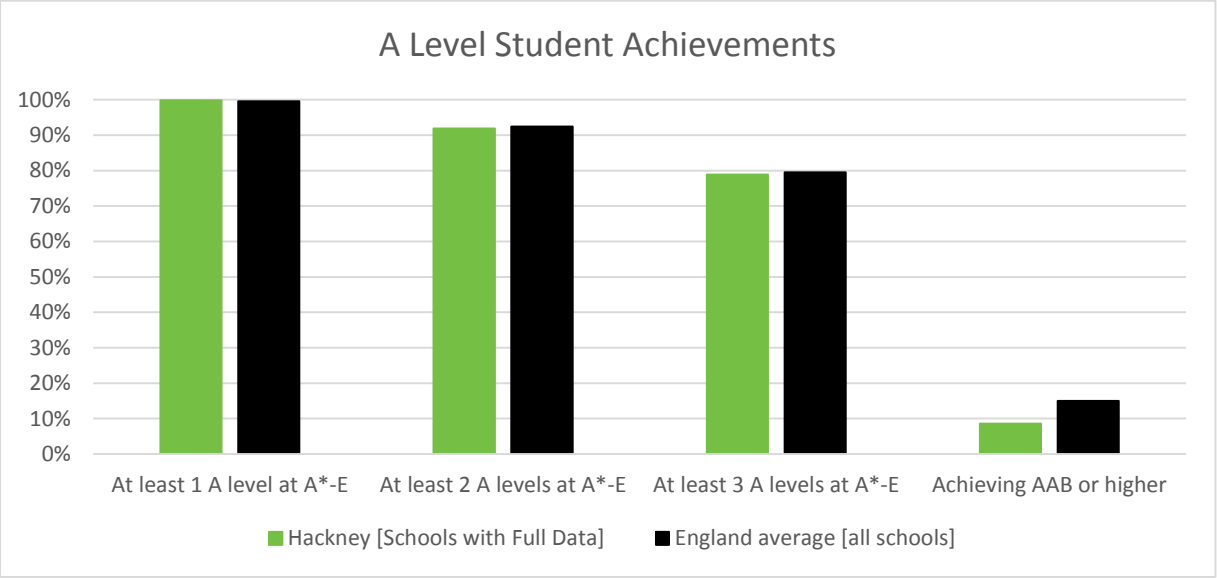

Figure 209: A-level achievement, 2014 [76]

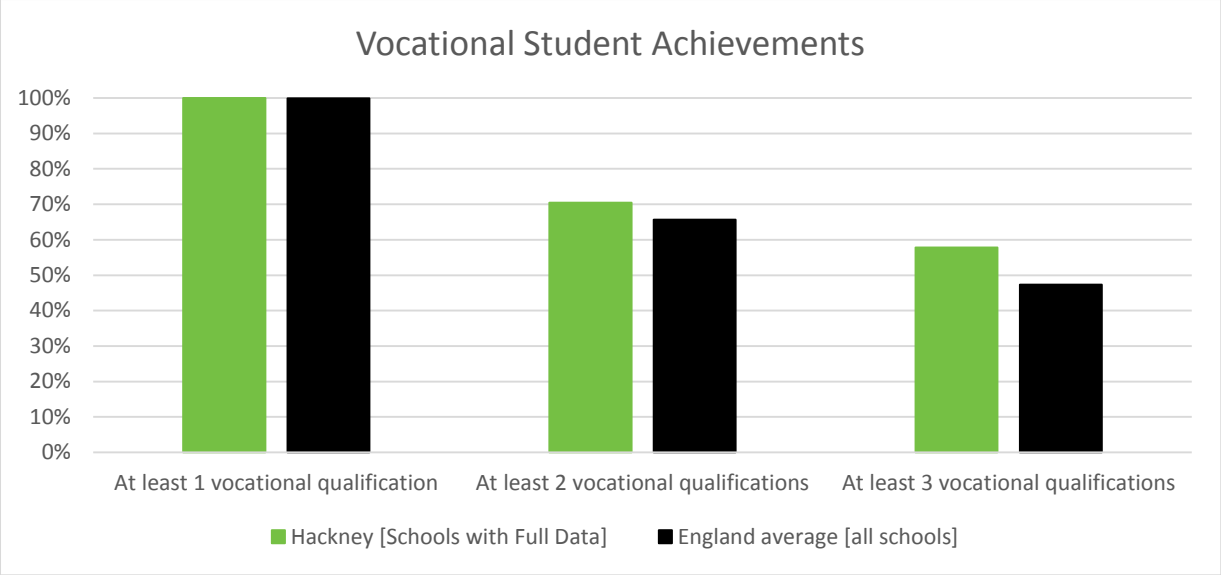

Figure 210: Substantial vocational qualification achievement, 2014 [76]

15.3.4 Safeguarding

15.3.4.1 Specific Causes of Vulnerability

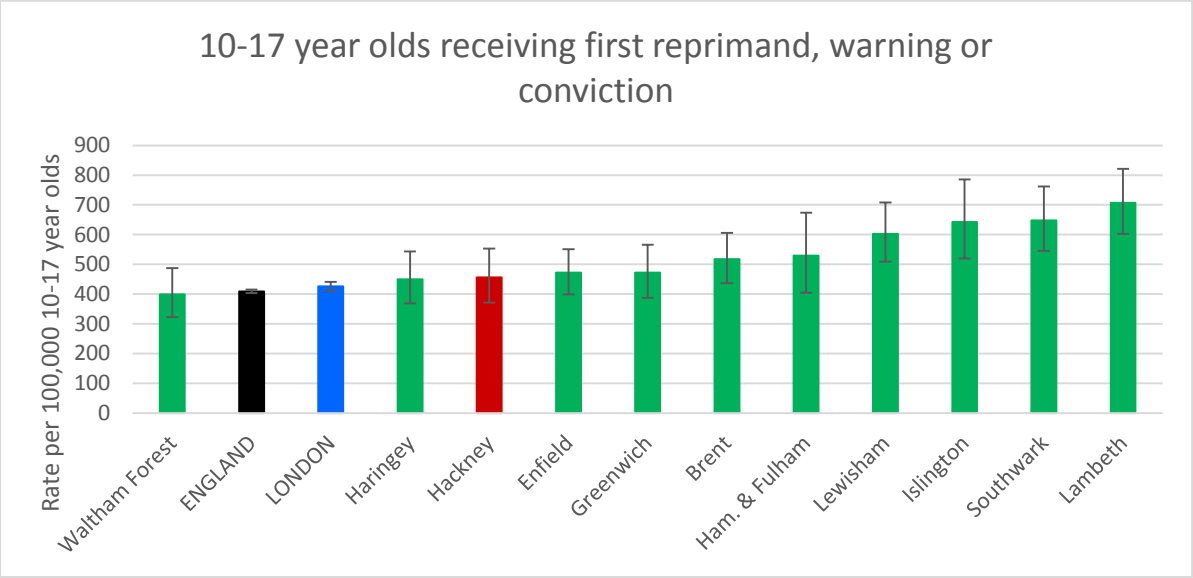

Figure 211: First entrants to the youth justice system, 2014 [41]

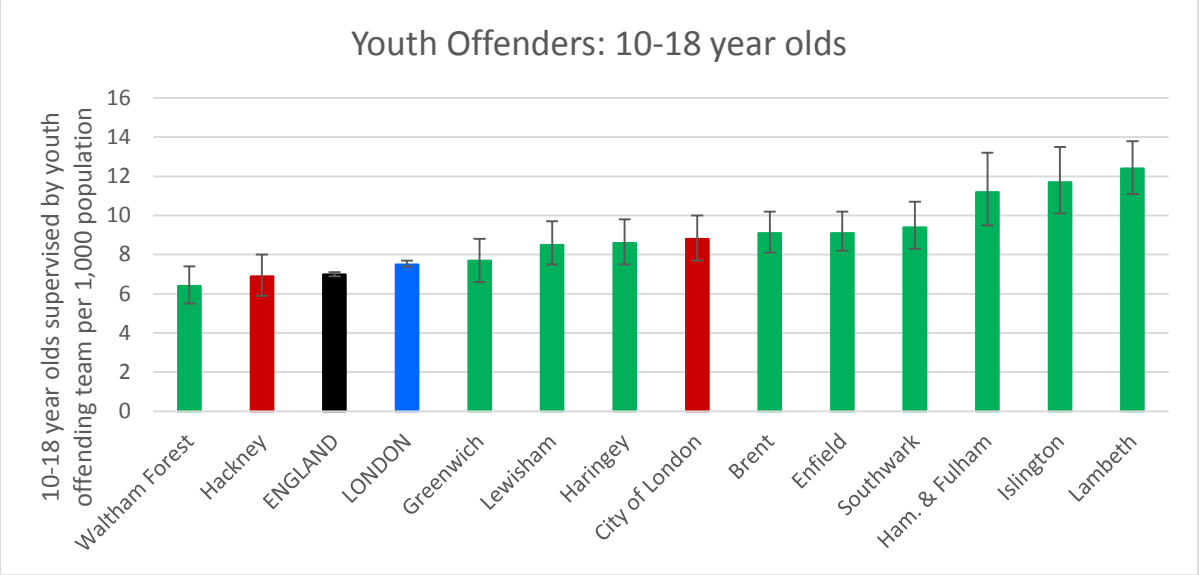

Figure 212: 10-18 year olds supervised by youth offending team, 2013/14 [41][61]

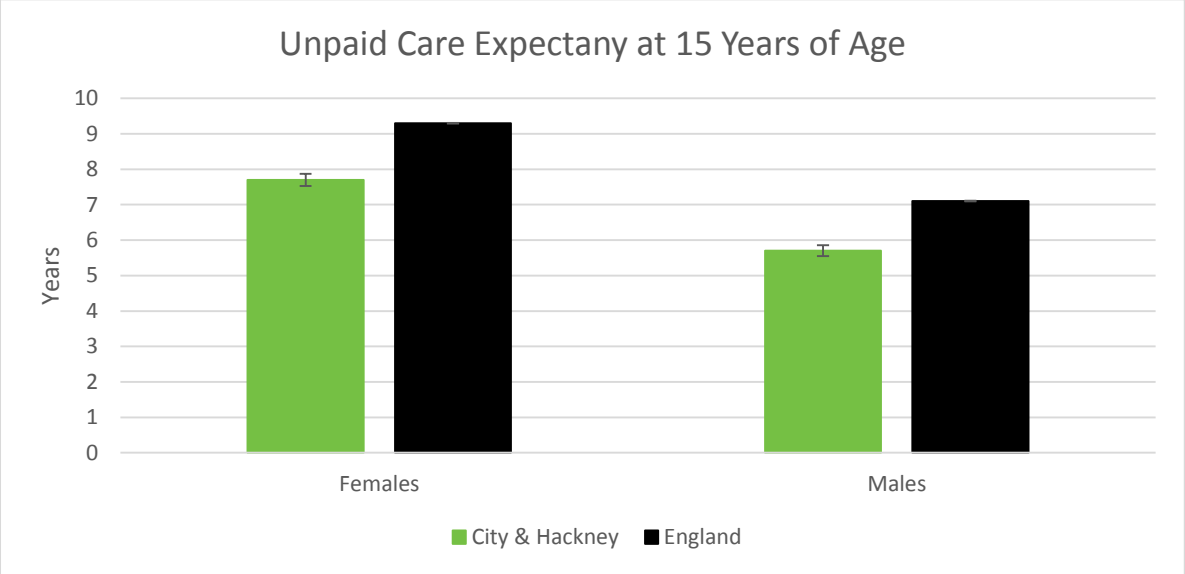

Figure 213: Unpaid Care Expectancy for 15 year olds, 2011 [33]

[61] Note – due to area boundaries some City of London data includes young people from Tower Hamlets

15.4 Key Medical Data

15.4.1 Primary Care

	5-9 years	10-14 years	15-19 years	5-19 average
Hoxton Surgery	1.1	0.9	0.8	0.9
Allerton Road Surgery	1.0	1.0	1.1	1.0
Cedar Practice, John Scott HC	1.3	1.1	1.0	1.1
Drs Gadhvi & Pathan	1.2	1.1	1.3	1.2
Stamford Hill Group Practice	1.2	1.2	1.3	1.2
Cranwich Road (Spitzer & Partners)	1.3	1.2	1.3	1.3
Lea Surgery	1.4	1.2	1.4	1.3
Elm Practice	1.3	1.2	1.7	1.4
Queensbridge Group Practice	1.4	1.4	1.4	1.4
Nightingale Practice	1.6	1.2	1.5	1.4
Southgate Rd & Whiston Rd MC	1.7	1.4	1.3	1.5
Rosewood Practice	1.8	1.3	1.4	1.5
Barton House Health Centre	1.6	1.3	1.6	1.5
Athena Medical Centre	1.5	1.3	1.8	1.5
Richmond Road MC	1.7	1.3	1.5	1.5
Clapton Surgery	1.7	1.4	1.5	1.5
Lower Clapton Health Centre	1.6	1.3	1.8	1.6
Riverside Practice	1.7	1.3	1.9	1.6
Shoreditch Park Surgery	1.8	1.5	1.5	1.6
Sandringham Road	1.7	1.3	1.8	1.6
Statham Grove Surgery	1.6	1.5	1.9	1.6
Abney House	1.9	1.4	1.4	1.6
Elsdale Street	1.6	1.6	1.7	1.6
Wick Health Centre	1.7	1.5	1.8	1.6
Sorsby Health Centre	1.7	1.5	1.7	1.7
The Lawson Practice	1.8	1.4	1.8	1.7
Springfield Medical Centre	1.7	1.7	1.7	1.7
The Heron Practice, John Scott HC	1.8	1.6	1.8	1.7
Dr Gangola, Barretts Grove	1.9	1.6	1.8	1.8
Somerford Grove Health Centre	1.9	1.6	1.9	1.8
Neaman Practice (Long Lane)	1.9	1.6	2.0	1.9
Beechwood Road	1.7	1.6	2.4	1.9
Dr SN Prasad (Brooke Road)	2.0	2.0	1.8	1.9
Well Street Surgery	1.9	1.7	2.3	1.9
De Beauvoir	2.2	1.9	1.8	2.0
Tollgate Lodge	2.2	1.7	2.2	2.0
London Fields Medical Centre	2.2	1.9	1.9	2.0
Healy Medical Centre	2.3	1.9	2.1	2.1
Kingsmead Healthcare	2.3	2.0	2.1	2.2
Trowbridge Practice	2.4	1.9	2.4	2.2
Latimer Health Centre	2.6	2.1	2.4	2.4

Figure 214: Rates of Primary Care Consultations by age group and GP practices, Dec 2014-Dec 2015 [105][62]

[62] Note – Greenhouse Health Centre is excluded from this chart as no 5-14 year olds are registered with the practice and only three 15-19 year olds are registered – this sample size is too small for reliable inclusion

15.4.2 Long Term Conditions

The term “long term conditions” as searched for on the GP database includes:

- Atrial fibrillation
- Active asthma
- Cancer
- Chronic heart disease
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Dementia
- Depression
- Diabetes
- Epilepsy
- Heart failure
- HIV
- Hypertension
- Learning disability
- Motor neurone disease
- Multiple sclerosis
- Muscular dystrophy
- Osteoporosis
- Parkinsons
- Rheumatoid arthritis
- Sickle cell
- Senile macular degeneration
- Severe mental illness
- Spinal cord injury
- Stroke

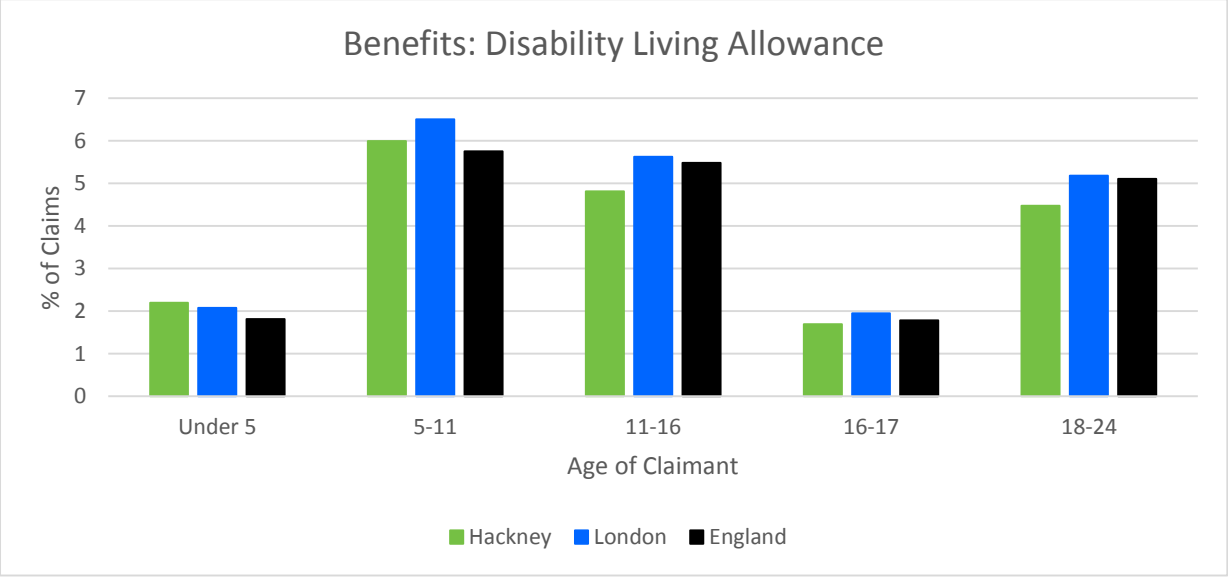

Figure 215: Proportion of disability living allowance claims by age, February 2015 [191]

15.4.3 Infectious Diseases

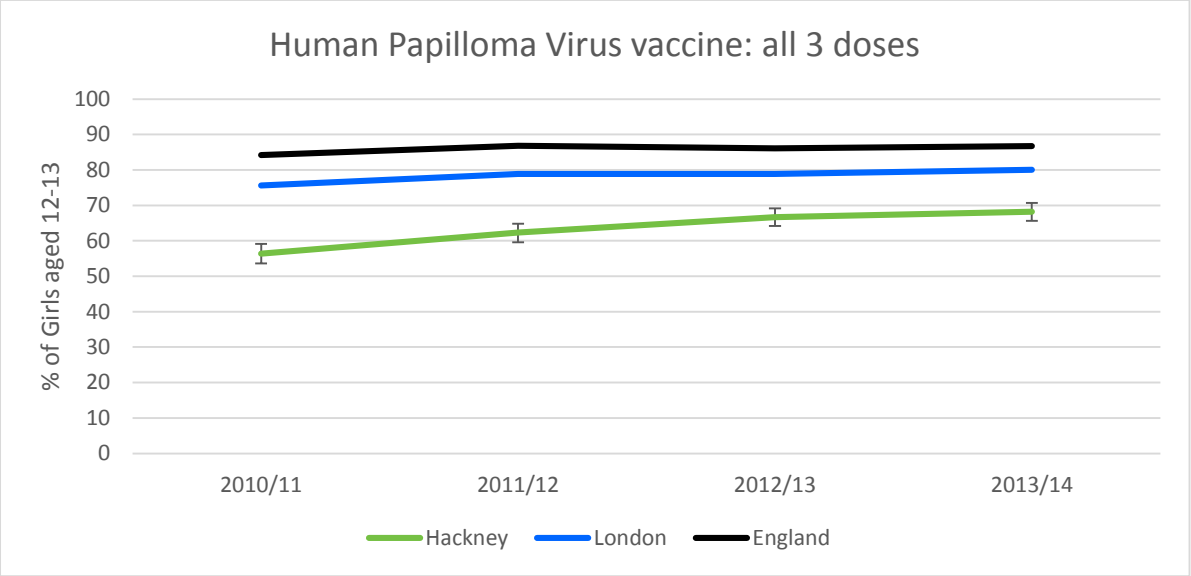

Figure 216: Uptake of all three doses of HPV vaccine by 12-13 years of age [41][63]

15.5 Key Priorities

15.5.1 Sexual Health

15.5.1.1 Sexual Attitudes

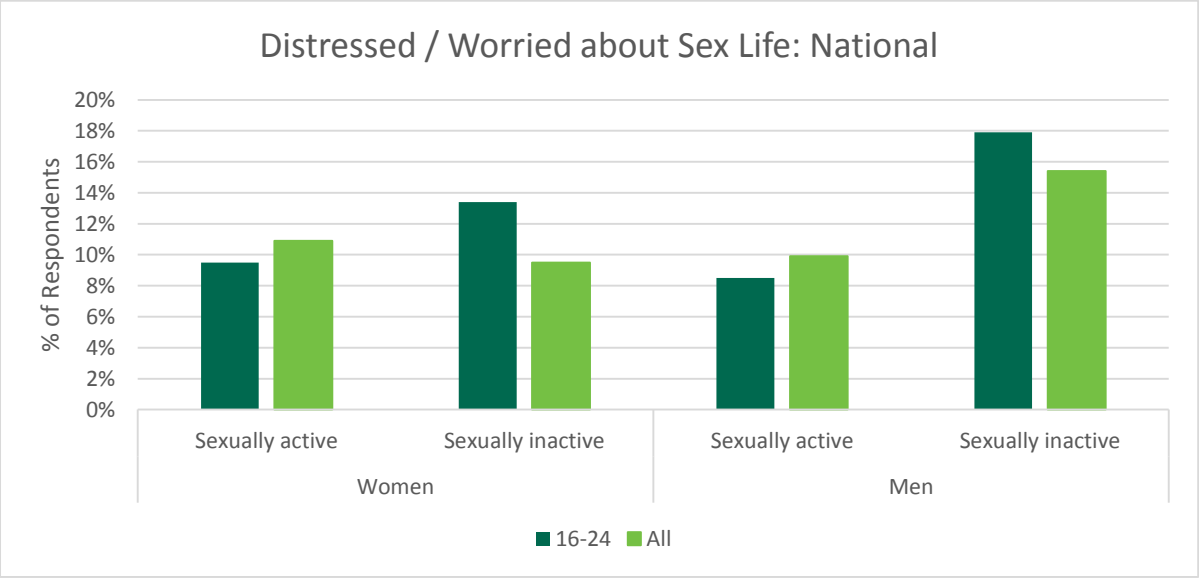

Figure 217: Sex life self-appraisal by age, gender and whether sexually active, 2013 [124]

[63] Note – for 2010/11, 2011/12 and 2012/13 local data is based on City and Hackney CCG, but for 2013/14 data is for Hackney alone

15.5.1.2 Contraception

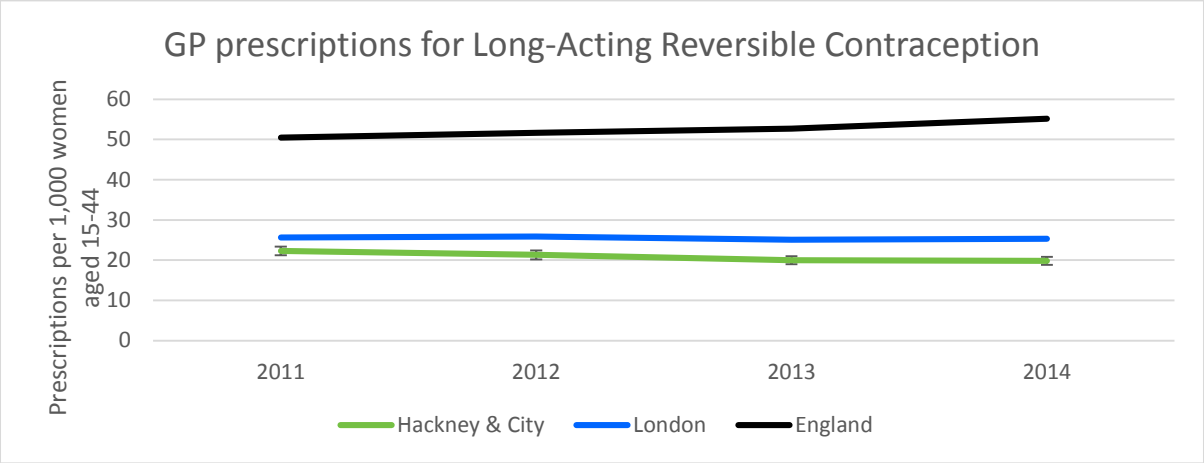

Figure 218: GP prescriptions for long acting reversible contraception, 2011-2014 [41]

15.5.1.3 Teenage pregnancy

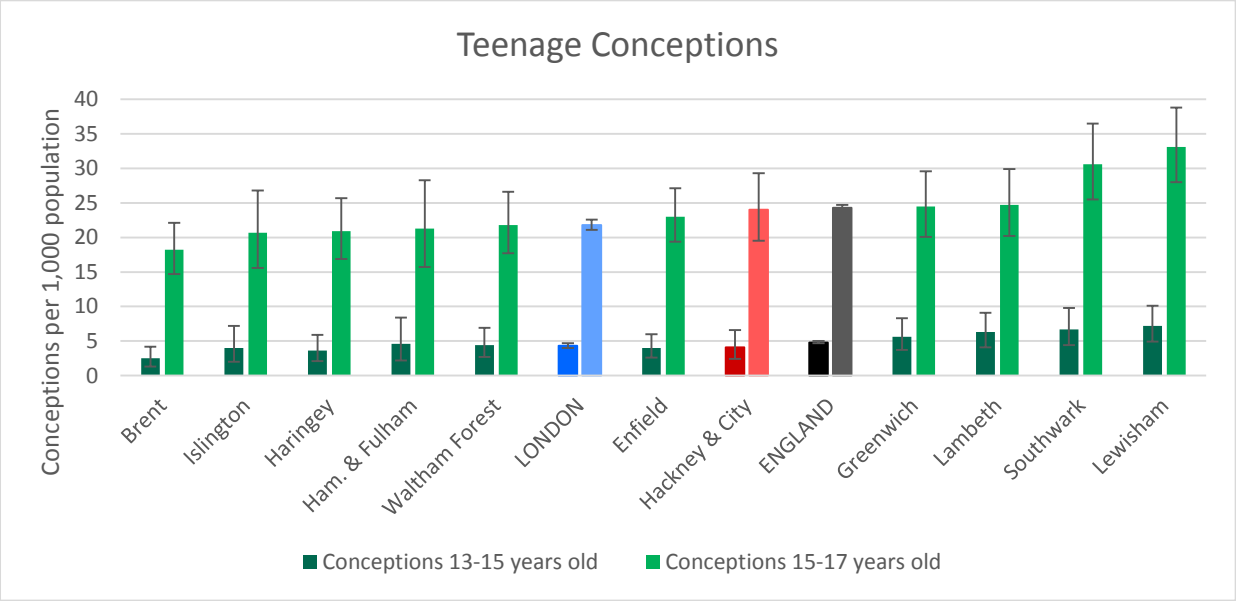

Figure 219: Teenage conceptions, 2013 [41]

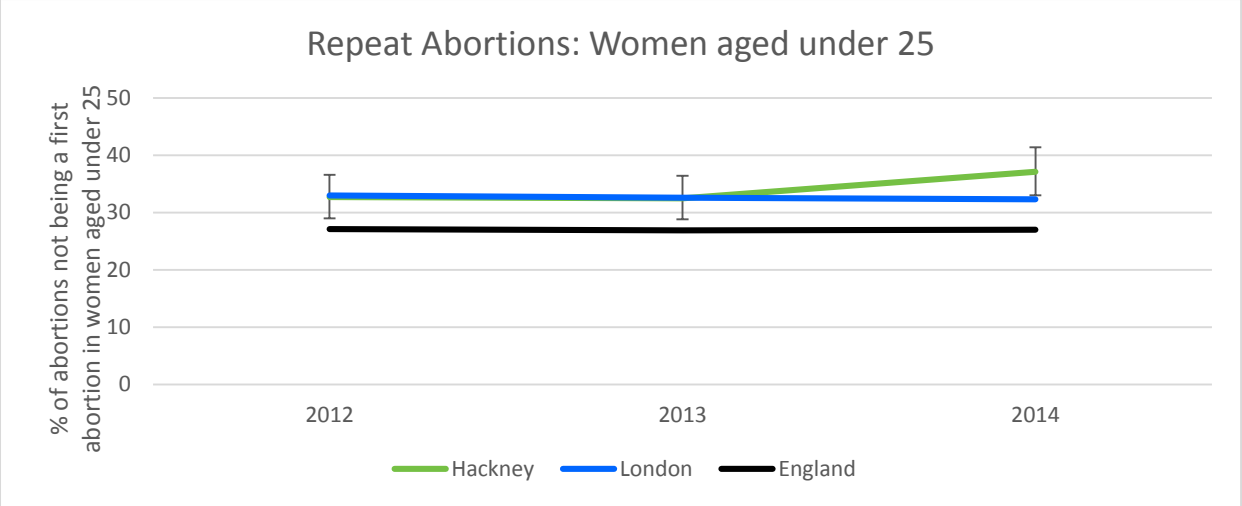

Figure 220: Repeat abortions in women under 25 years of age, 2012-2014 [41]

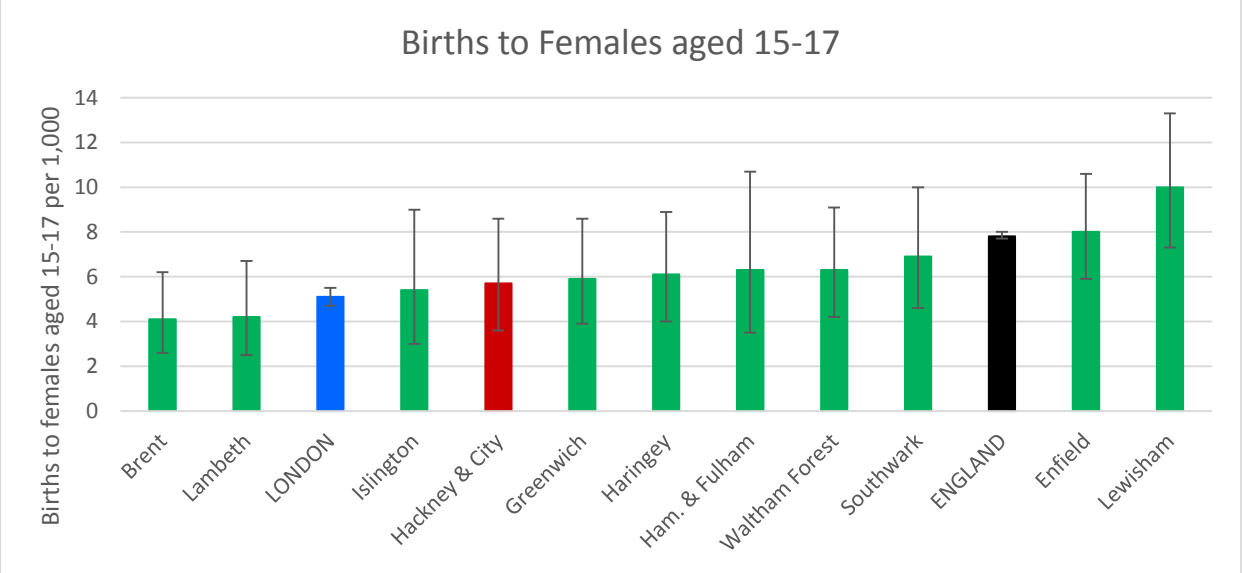

Figure 221: Births to females aged 15-17, 2013 [41]

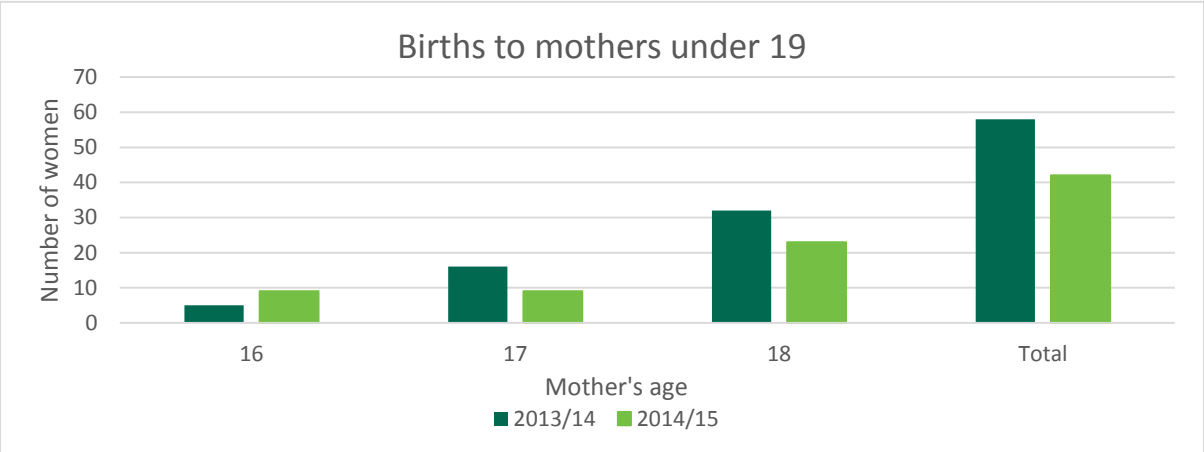

Figure 222: Number of births to mothers under 19 in HUH in 2013/14 and 2014/15

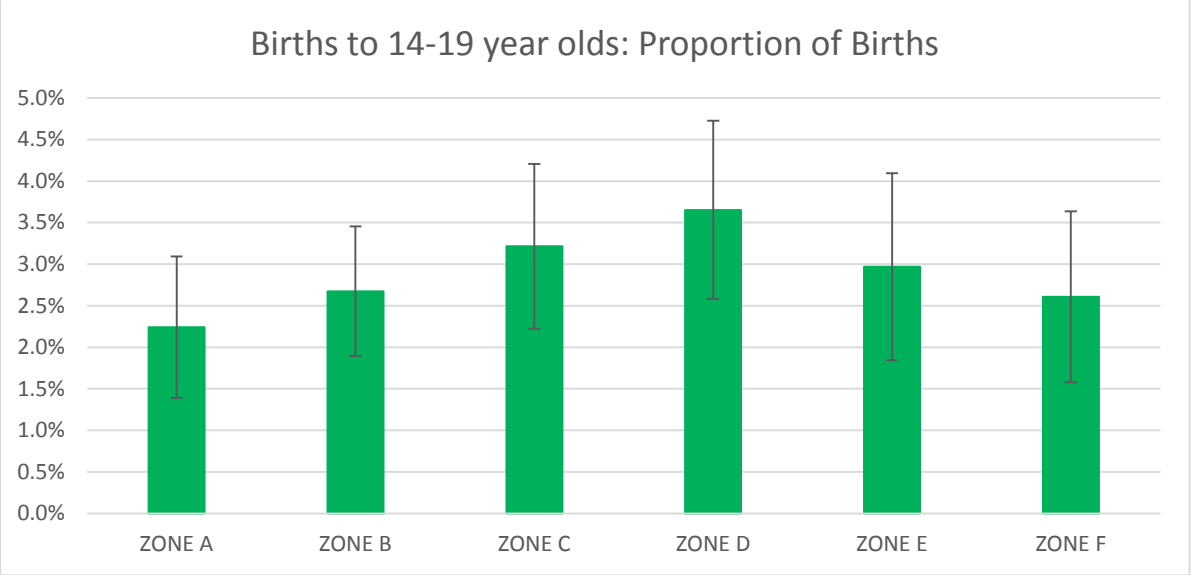

Figure 223: Births to 14-19 year olds as a proportion of births by Children's Centre area, HUH, 2013-15

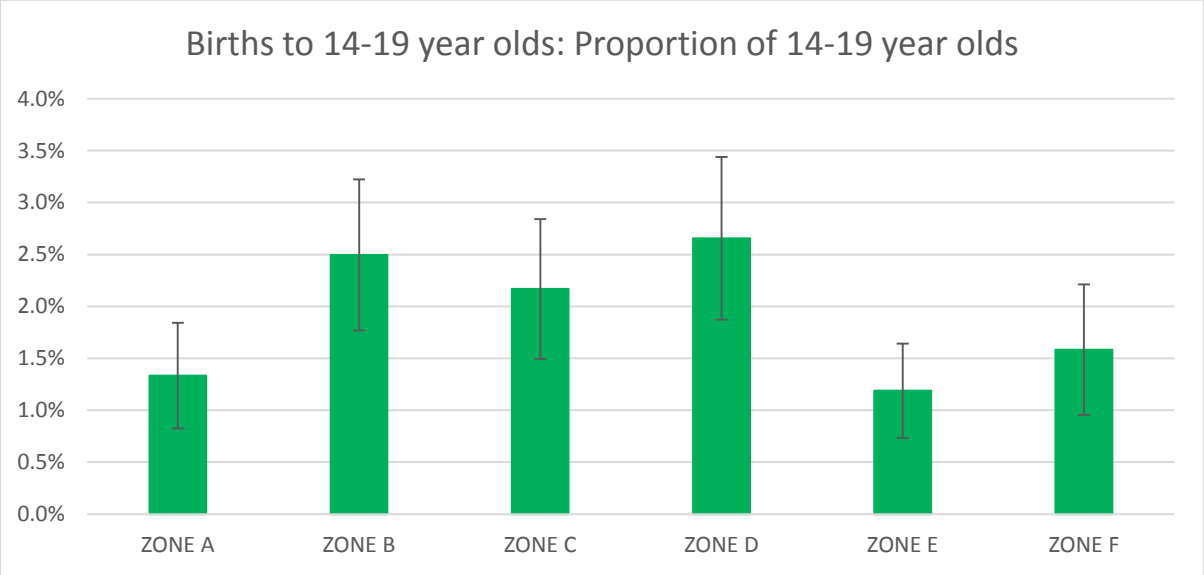

Figure 224: Births to 14-19 year olds as a proportion of 14-19 year olds by Children's Centre area, HUH, 2013-15

15.5.1.4 Sexually Transmitted Infections

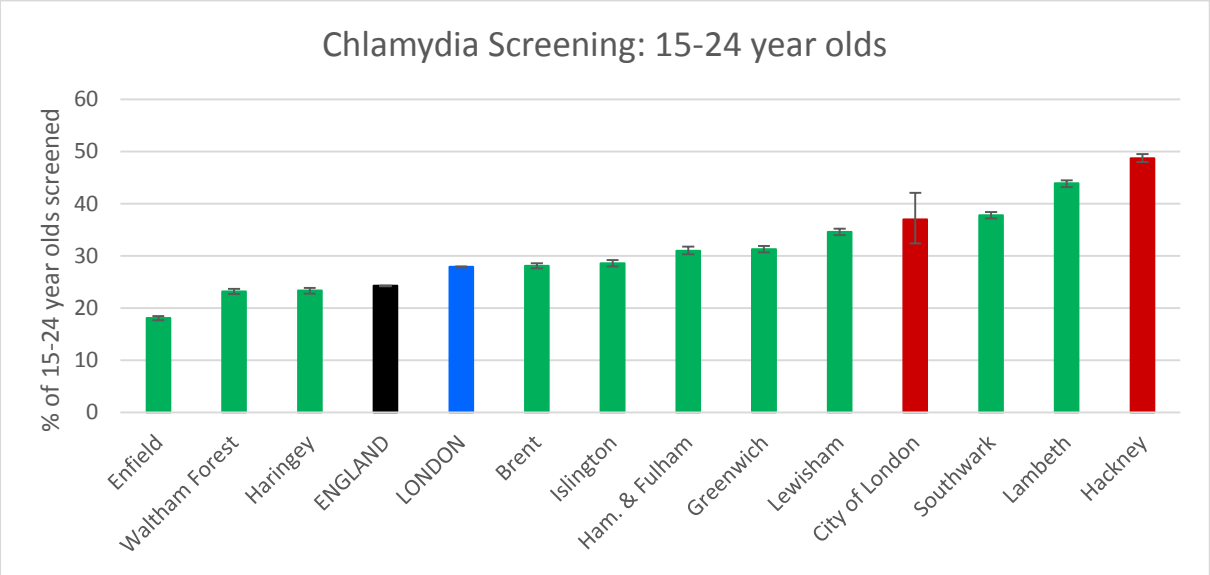

Figure 225: Chlamydia testing in 15-24 year olds, 2014 [136]

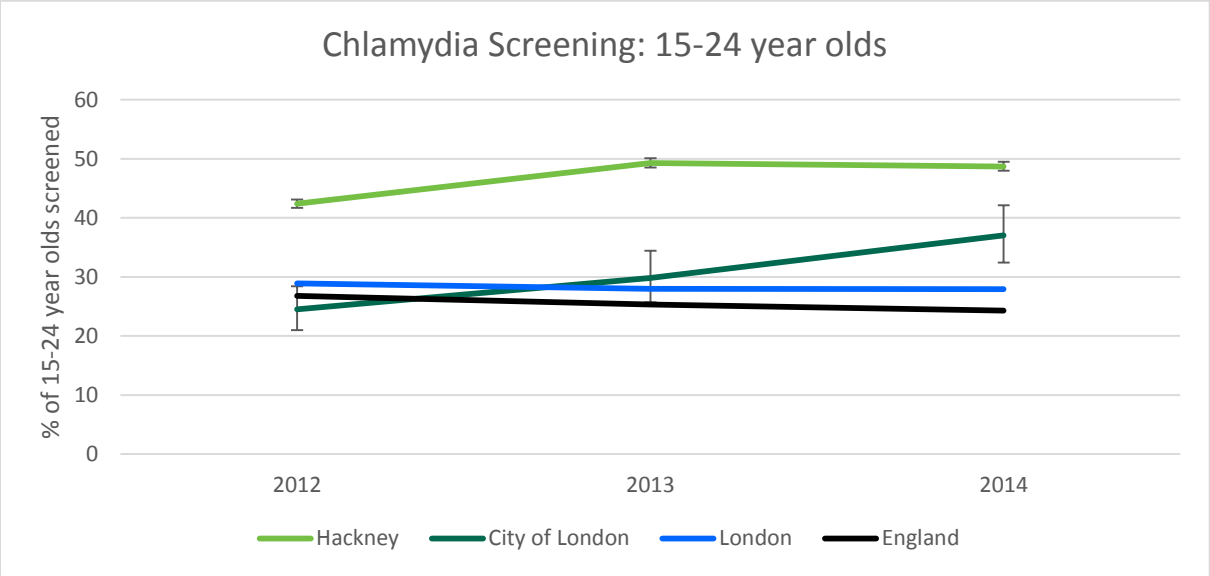

Figure 226: Chlamydia testing in 15-24 year olds, 2012-2014 [41]

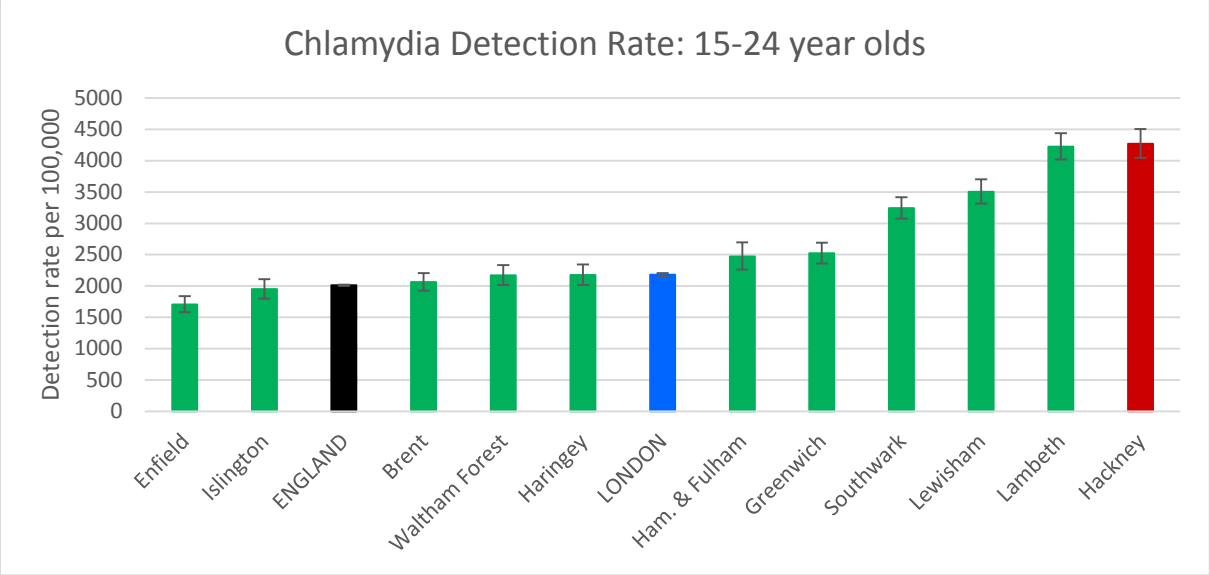

Figure 227: Chlamydia detection in 15-24 year olds, 2014 [41]

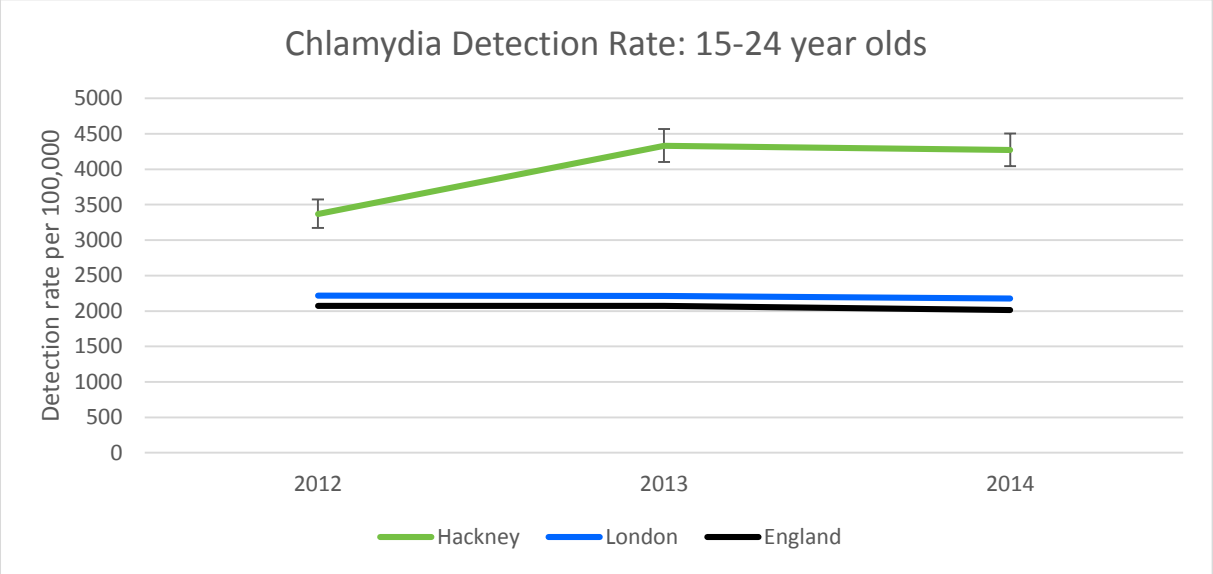

Figure 228: Chlamydia detection in 15-24 year olds, 2012-2014 [41]

15.5.2 Mental Health

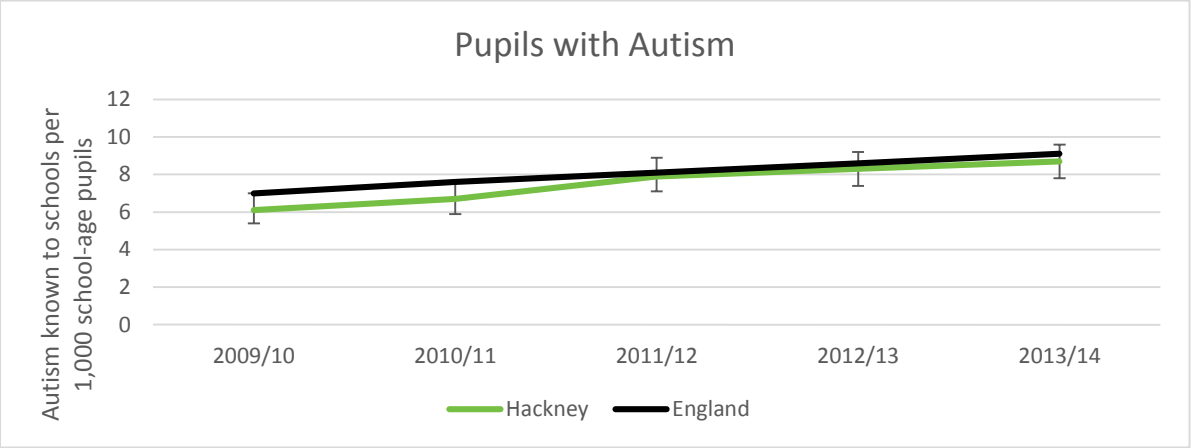

Figure 229: Pupils known by schools to have autism per 1,000 school-age pupils, 2009/10-2013/14 [41]

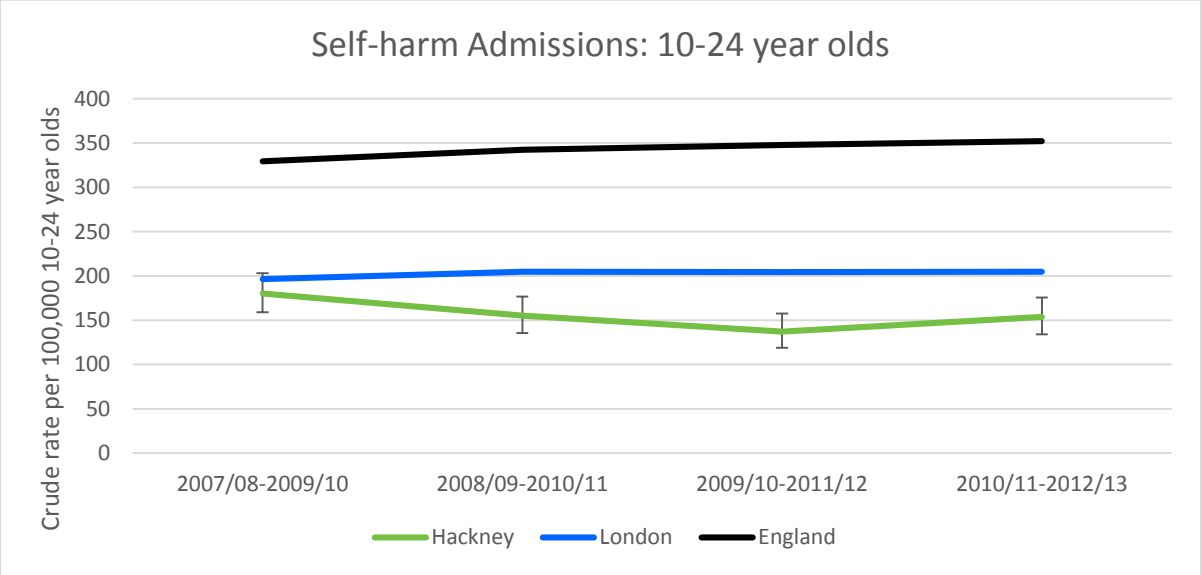

Figure 230: Self-harm admissions as a proportion of 10-24 year olds [41]

15.5.3 Substance Misuse

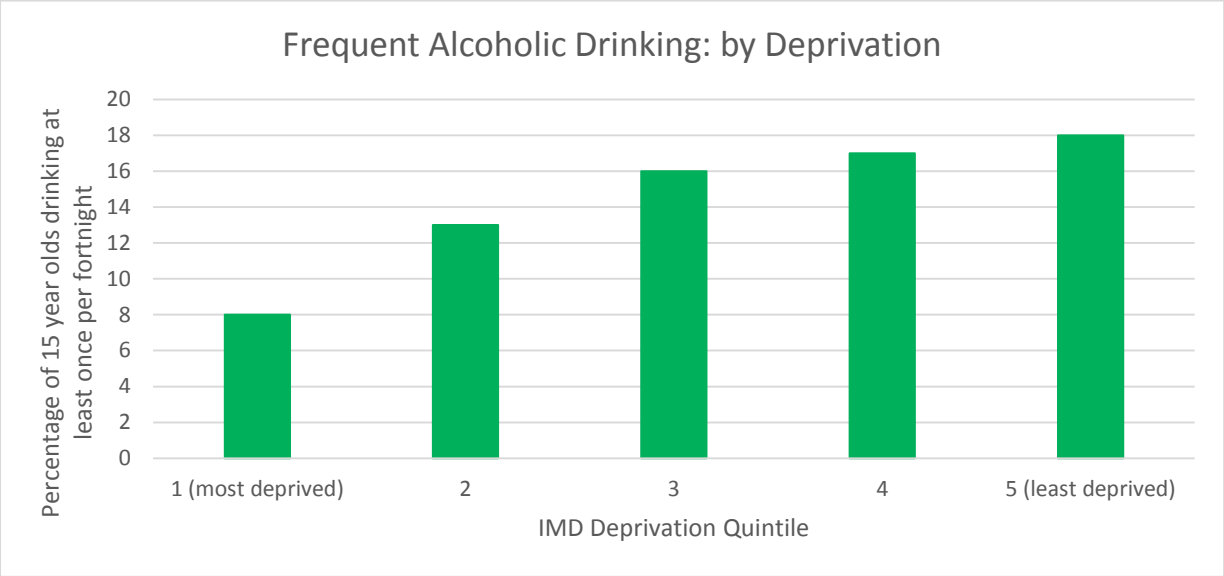

Figure 231: Frequent alcoholic drinking in 15 year olds nationally by deprivation quintile [145]

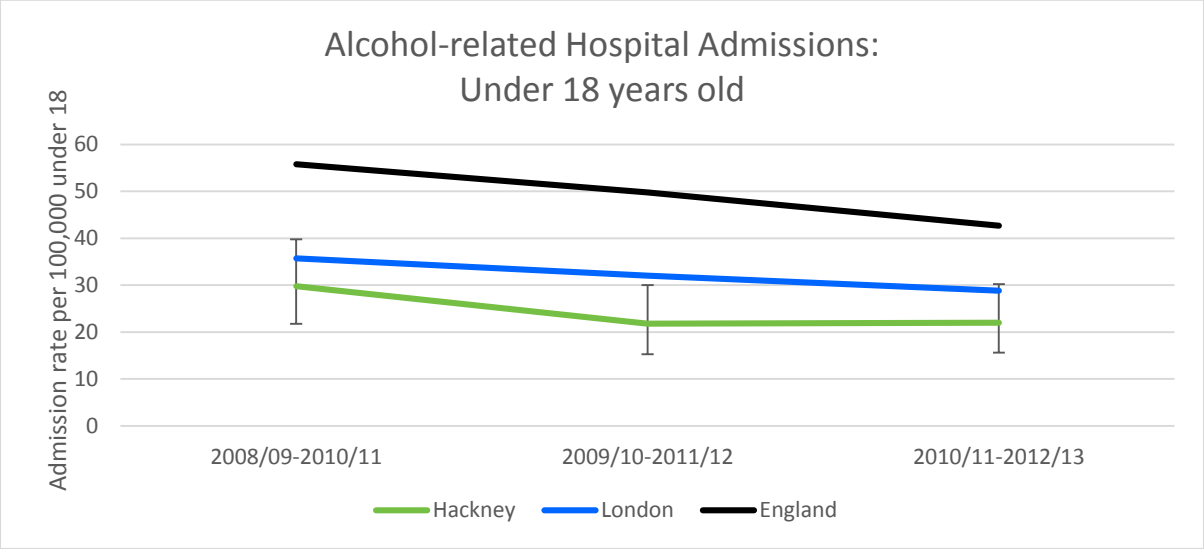

Figure 232: Alcohol-related hospital admissions in under 18s [41]

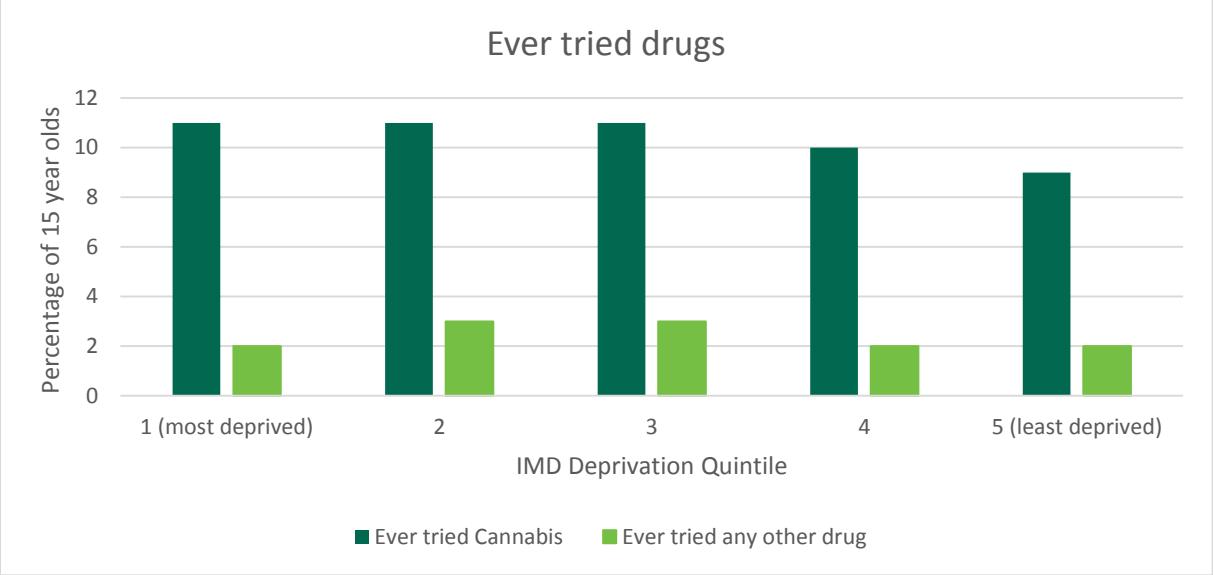

Figure 233: 15 year olds ever having tried drugs nationally by deprivation quintile [145]

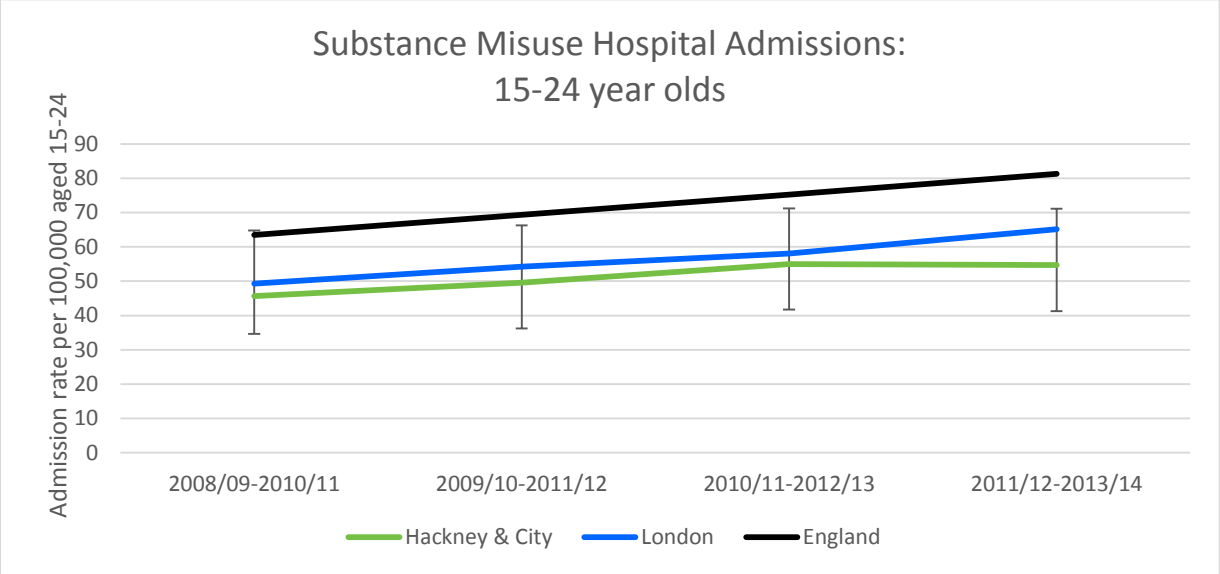

Figure 234: Substance misuse related hospital admissions in 15-24 year olds [41]

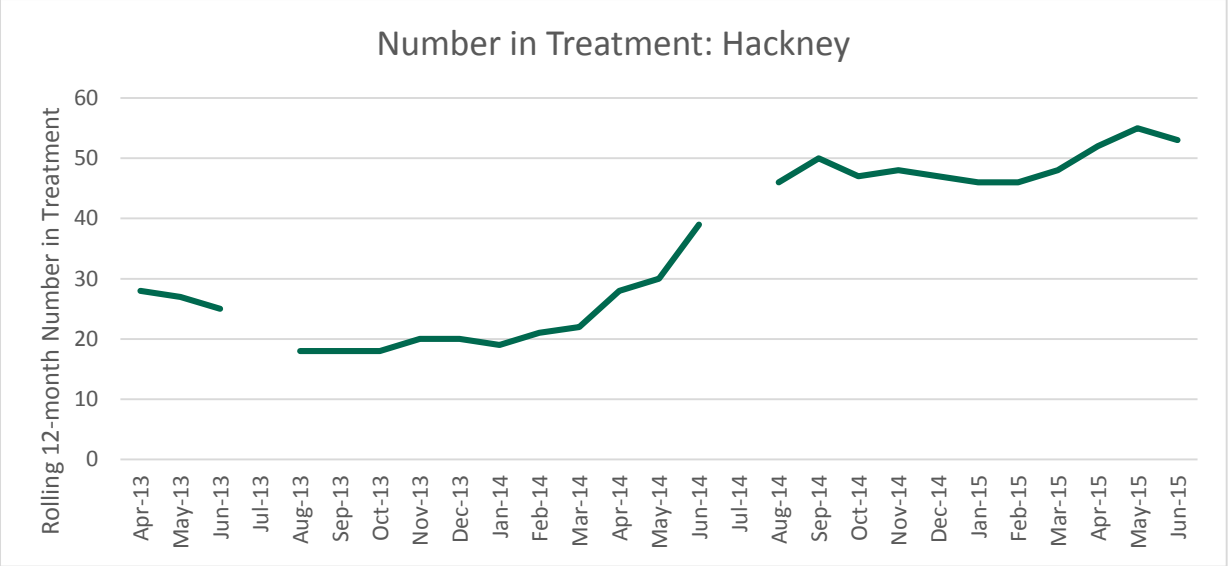

Figure 235: Rolling 12 month number in specialist young person's substance misuse treatment [137]

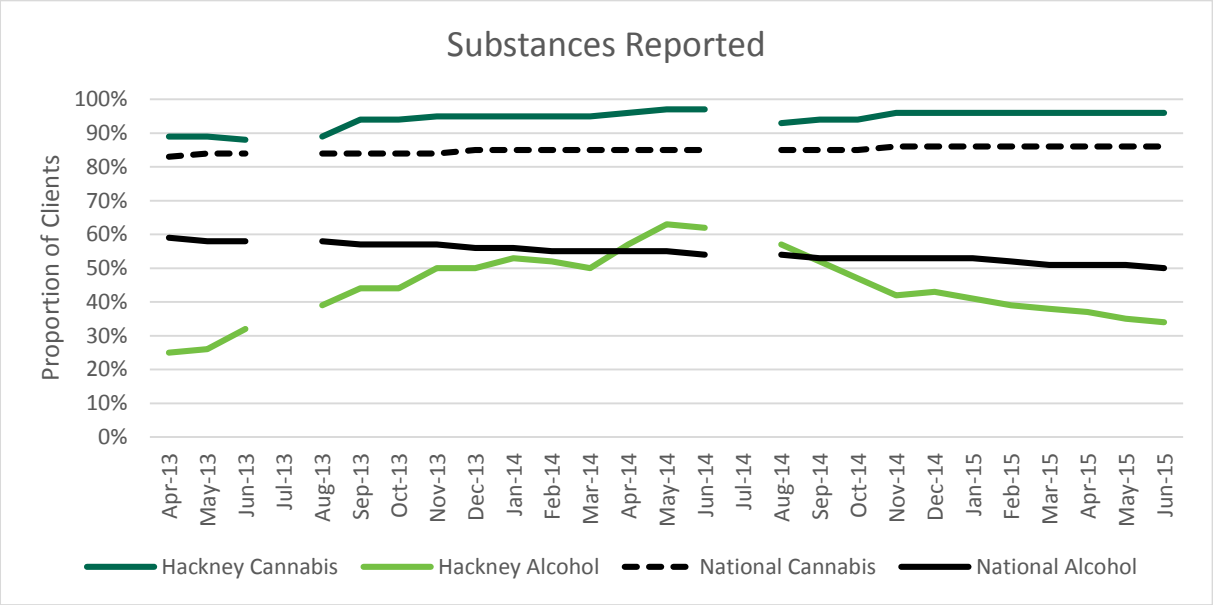

Figure 236: Proportion of clients reporting cannabis or alcohol misuse [137]

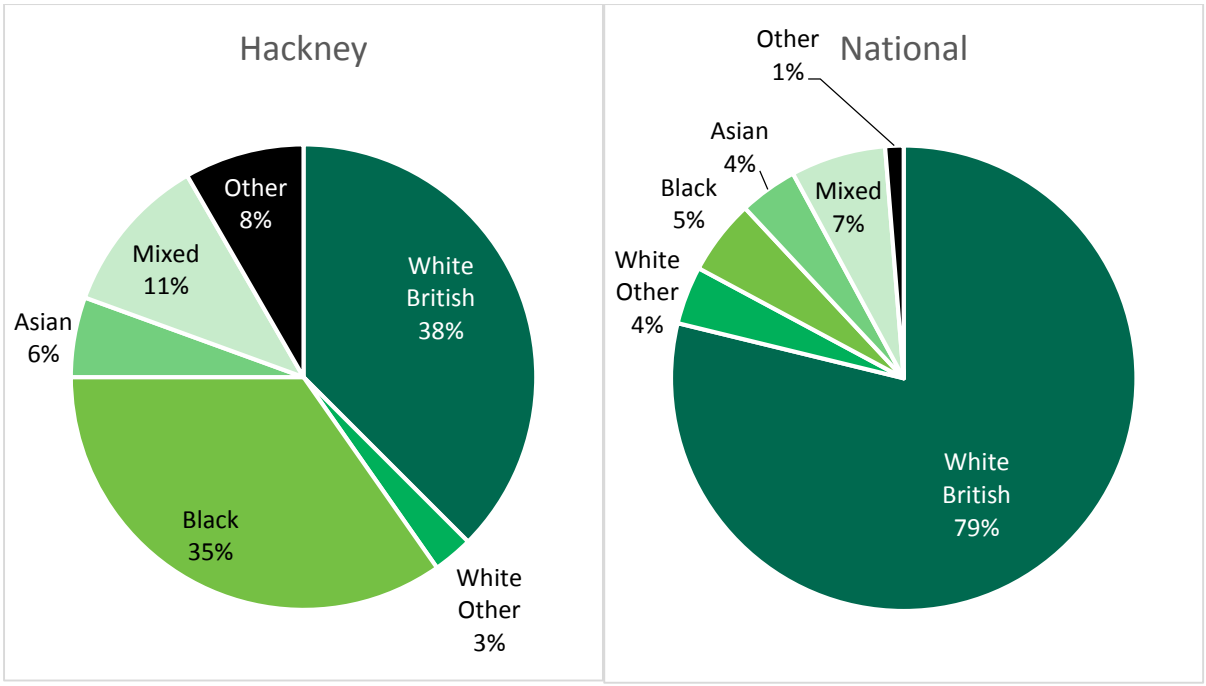

Figure 237: Ethnicity of young people receiving substance misuse interventions [137]

	Hackney (%)	England (%)
Education	44	74
Apprenticeship	8	4
Employed	4	2
NEET	44	14
Inconsistent/other	0	7

Figure 238: Education / Employment of young people in substance misuse services [137]

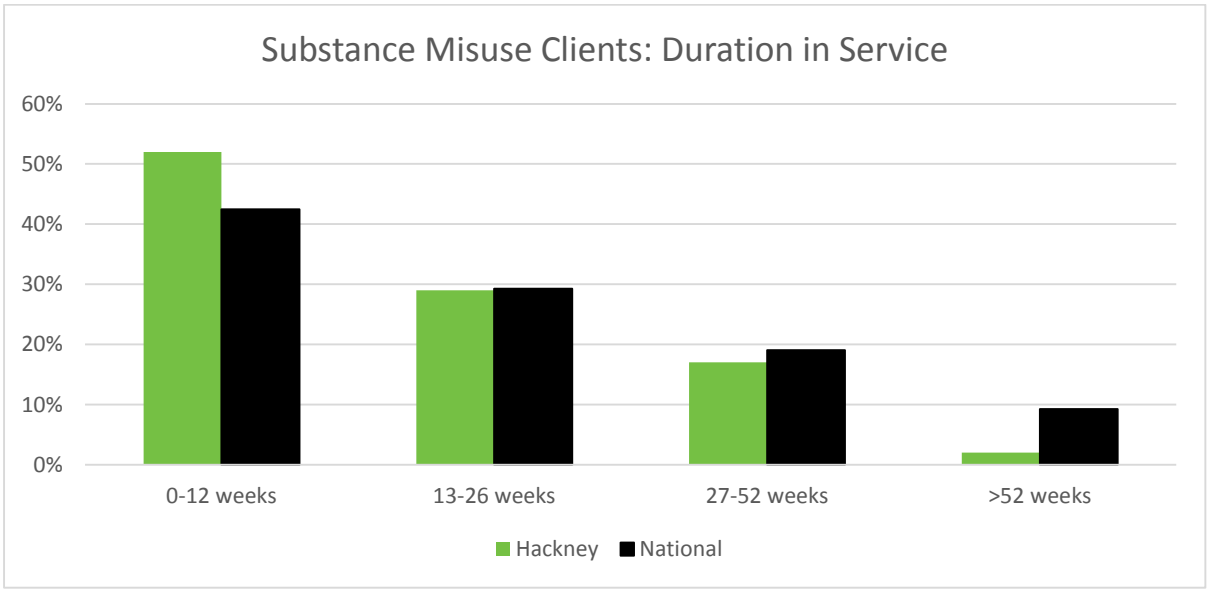

Figure 239: Duration of treatment for substance misuse in young people [137]

15.5.4 Obesity

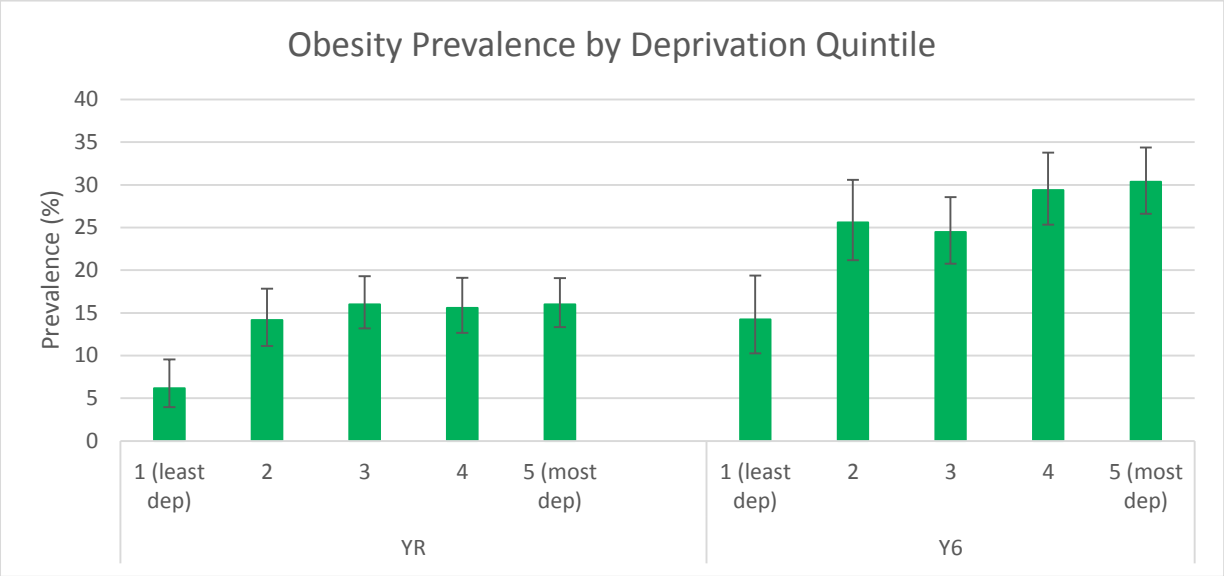

Figure 240: Prevalence of obesity in City & Hackney by deprivation quintile (IMD 2010), 2013/14 [50]

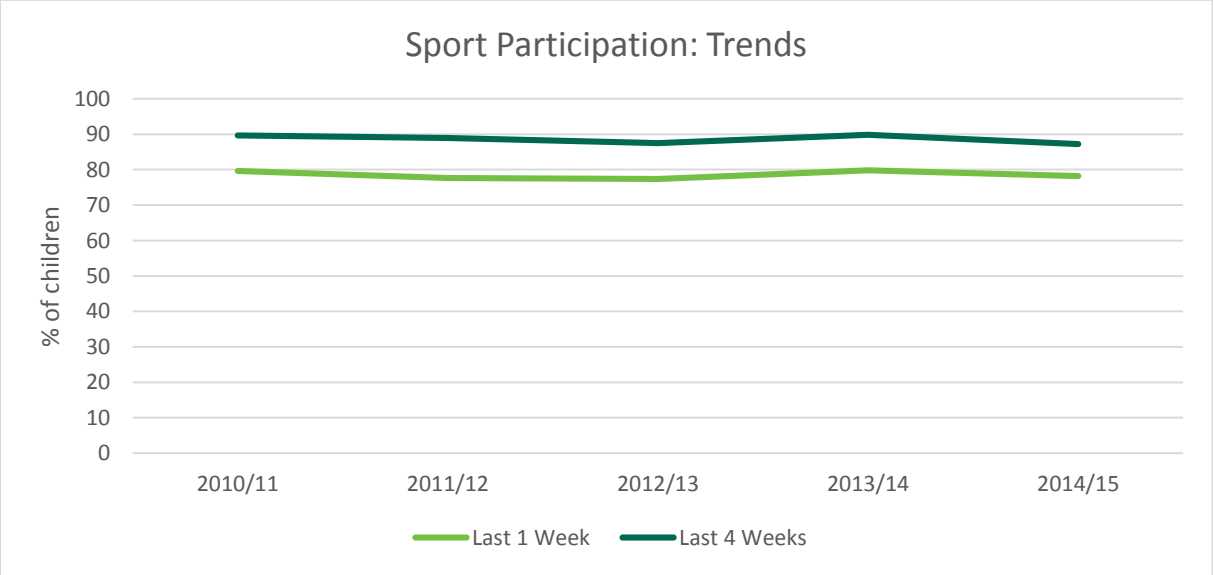

Figure 241: Participation in sport by children aged 5-15 across England [170]

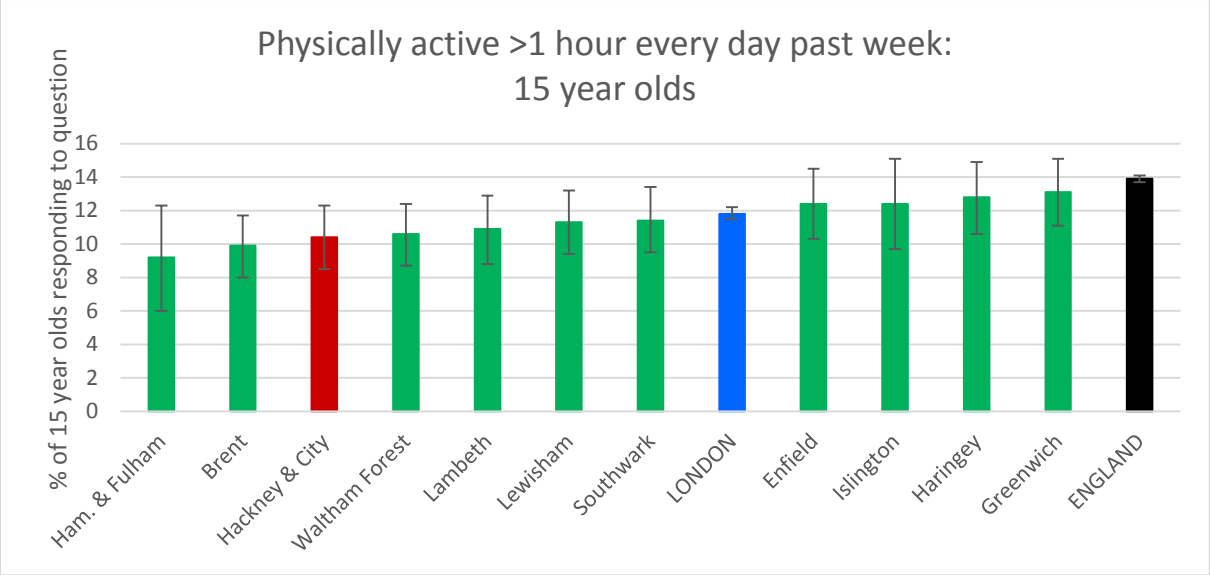

Figure 242: Self-reported physical activity of at least one hour per day every day of the last week in 15 year olds, 2015 [145]

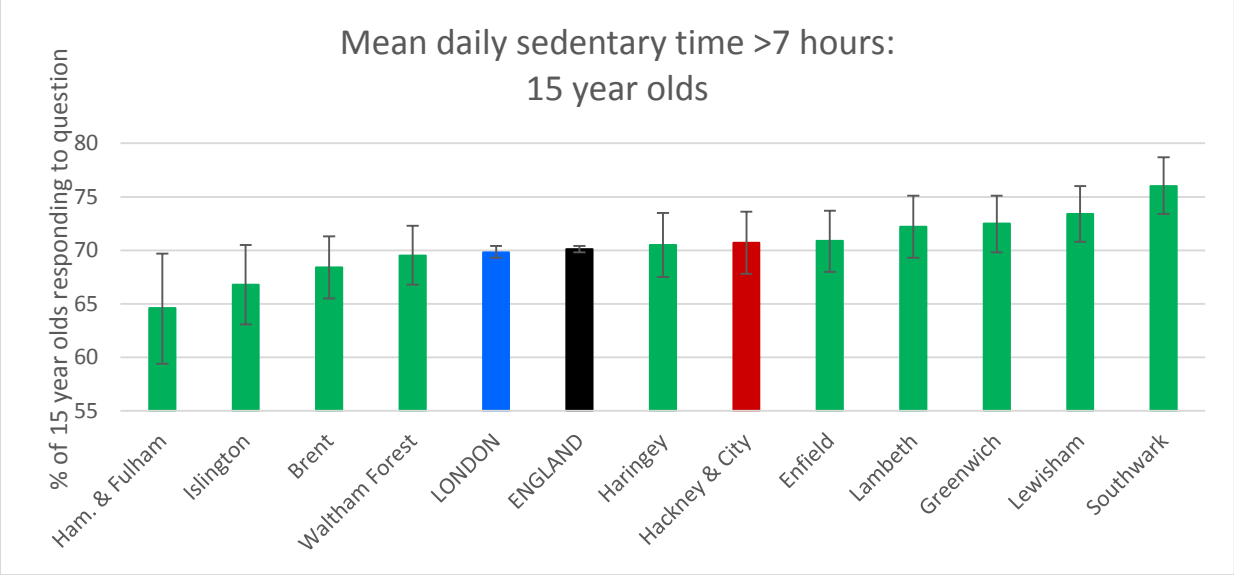

Figure 243: Self-reported mean sedentary time of greater than 7 hours per day each weekday in 15 year olds, 2015 [145]

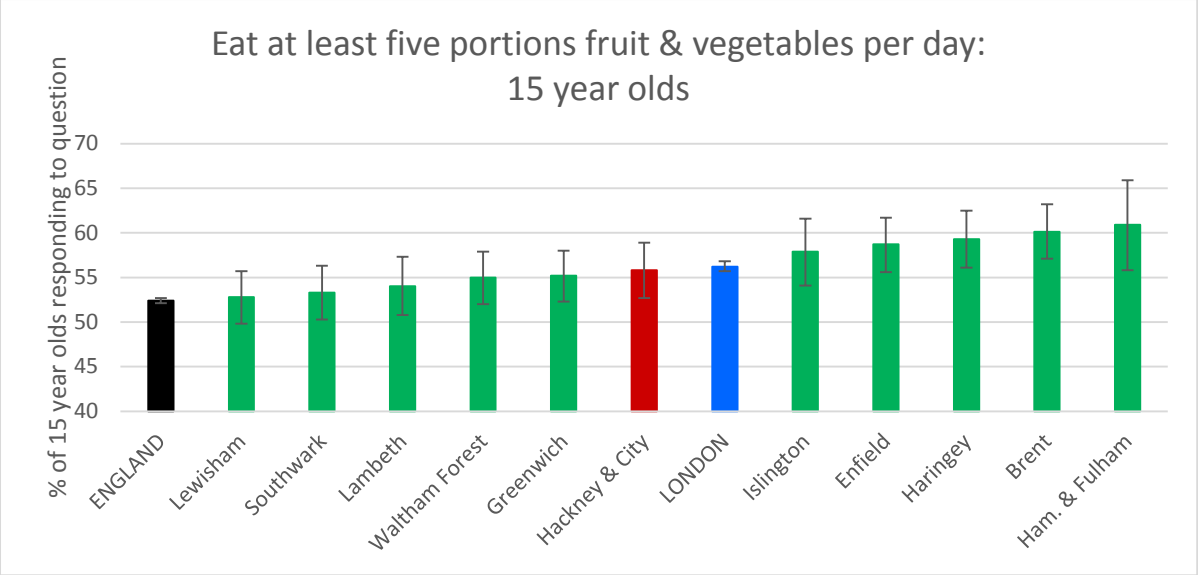

Figure 244: Self-reported consumption of five portions of fruit and vegetables per day in 15 year olds, 2015 [145]

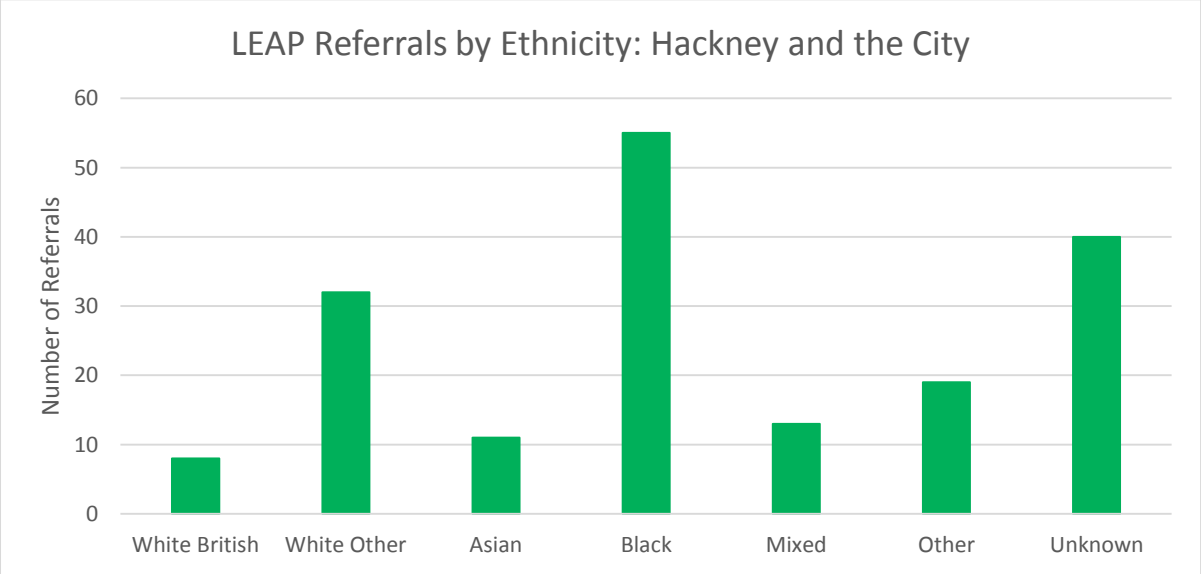

Figure 245: LEAP referrals by client's ethnicity, 2014 [176]

GP Practices sending no referrals to LEAP	GP Practices sending 5+ referrals to LEAP
Arcadian Gardens Surgery	Barton House Group Practice
City Road Medical Centre	London Fields Medical Centre
Connaught Square Practice	Lower Clapton Group Practice
Dr S Phillips and Dr M Patel Practice	Queensbridge Group Practice
Drs Bowry & Bowry's Practice	Shoreditch Park Surgery
Elizabeth Avenue Group Practice	Somerford Grove Practice
Grove Surgery	Stamford Hill Group Practice
Holborn Medical Centre	The Dalston Practice
John Tasker House Surgery	The Heron Practice
St Peter's Street Medical Practice	The Lawson Practice
Stratford Health Centre	The Sorsby Health Centre
Strouts Place Medical Centre	The Statham Grove Surgery
The 157 Medical Practice (Ramnani)	The Wick Health Centre
The Allerton Road Surgery	Well Street Surgery
The Bridge House Surgery	
The Mission Practice	
The Surgery (Barretts Grove)	
Tynemouth Medical Practice	
Woodlands Health Centre	

Figure 246: GP referrals to LEAP, 2014 [176]

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