



Time for health

The annual report of the
joint director of public health

2008–09





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The purpose of the annual report of the director of public health is to review some of the main risks to health in the population and make recommendations on actions to address them. In previous years, the annual reports have been web-based and they provided detailed data on health within the borough. This report does not duplicate the version updated in 2008, which is available on our public health website.¹ We have included a summary of health issues in Tower Hamlets in chapter 1.

For 2008–09, I have chosen to focus on three of the main risks to health in the borough: tobacco, obesity and alcohol. There are good reasons for focusing on these three areas and each is different. The health risks of tobacco are widely understood and we have a well-developed strategy and joint work programme with the borough. However, despite this good work, tobacco is a heavily promoted and highly addictive drug, therefore, making progress difficult. Use of tobacco remains the major cause of health inequalities between Tower Hamlets and the rest of the country, and it is important to continue to remind ourselves of its impact and to maintain the momentum of our work.

Foreword

The scale of the problem being caused by obesity is increasingly being understood, including its impacts on diabetes (often in the relatively young), heart disease, cancer and strokes. But it is also clear that unless we reverse the current trends, then it will cast a very long shadow over future health in Tower Hamlets. The prevalence of obesity is the fifth highest in the country at reception year and sixth highest in year 6. The joint strategy for Healthy weight, healthy lives in Tower Hamlets was recently launched and work in this area is at an earlier stage than tobacco. We present some recently collected data on ease of access to unhealthy food, including some shocking data on its content. We are also fortunate in being one of only eight boroughs in the country to be awarded the status of a 'Healthy Town' on the basis of our plans to address this problem.

The third area I have chosen to focus on is alcohol. This has received less attention of late, but it is a significant problem in the borough, all the more surprising, perhaps, given that many do not drink at all. I believe this is a health problem where we need to significantly develop the existing work to deal with the scale of the issue. The section on alcohol outlines the impact it has on health in Tower Hamlets and what steps we can take.

All three of these problems are major issues within the Time for health initiative, so I have taken the

opportunity of calling this report Time for health and I hope it will provide background information and a resource for this campaign. Unless we take action now, future health in Tower Hamlets will fail to improve in line with the rest of the country. Everyone can take action; it is important for us to make time for ourselves to look after our health. There are some simple steps each of us can take:

- Stop smoking
- Eat healthier
- Drink sensibly
- Be active
- Get screened
- Get immunised
- Recognise symptoms
- Avoid/manage stress

One of the reasons that health inequalities remain so stubbornly embedded is that not only are the risks to health highest amongst those who are most deprived, it is often more difficult to give up smoking or eat healthily when you have a stressful life. It therefore remains vital that everything we do on health is supported by joint work to increase regeneration, healthy employment and general well-being within the borough. This will be more of a challenge in the current economic climate.

Finally, whilst we face challenges within Tower Hamlets, there is a lot of good news. As I hope you can see from this report, the partnership between the borough, PCT and others has invested substantially in improving health and, as a result, we have been successful in attracting resources from elsewhere. However, the problems I describe are long-standing and difficult to shift quickly. There remains much more to do and we need to invest even more over time.



Ian Basnett

Joint director of public health



Health and well-being

“One Tower Hamlets is about reducing the inequalities and poverty that we see around us, strengthening cohesion and making sure our communities continue to live well together. Most of all, One Tower Hamlets is about recognising that we all have a part to play in making this a reality.”

Tower Hamlets Community Plan, 2020 Vision.²

Snapshot of health and well-being in Tower Hamlets

People and place

- Tower Hamlets has the third highest level of multiple deprivation in the country and this is a major factor in explaining inequalities in health between Tower Hamlets and England.
- Based on London wide projections, the population is estimated at 232,000 and is expected to increase by 30,000 over the next five years (amongst the fastest growth rate in London).
- Tower Hamlets has one of youngest populations of all London boroughs with 45% aged 20-39 compared to 36% in London.
- 49% of the population is non white (compared to 29% in London) and 34% is Bangladeshi, 6% is black and 3% Chinese.

Life expectancy and main causes of death

- In 2005, life expectancy in Tower Hamlets was 75.2 in males and 80.2 in females. This was 2.1 years shorter in males and 1.3 years shorter in females compared to England and ranked

Tower Hamlets in the bottom 20% of all local authority areas.

- In 2006, the probability of survival to age 75 for a man in Tower Hamlets was 54% compared to 66% nationally.
- Higher death rates from circulatory disease, cancer and respiratory disease (highest or second highest in London) are the biggest contributors to inequalities in life expectancy between Tower Hamlets and England.
- Although life expectancy is increasing and death rates are falling steadily from year to year, there is little evidence of a reduction in the gap between Tower Hamlets and the rest of the country.
- The life expectancy of a boy born in Bethnal Green North is 8.5 years less than that for a boy born in Millwall and that of a girl born in Limehouse is 5.7 years less than for a girl born in Bromley-by-Bow.

Lifestyle and health

- Tower Hamlets has amongst the highest prevalence of risk factors for cancer, cardiovascular disease and respiratory disease in London.
- It is estimated that three out of ten adults smoke, seven out of ten eat less than five fruit and vegetables a day and a lower proportion participate in sport or recreational activity.
- Although alcohol consumption rates are lower overall, indicators of alcohol-related harm are above average for London suggesting high rates of consumption in some segments of the population.

Self reported health

- Based on the 2001 census, 10% of Tower Hamlets residents considered their health was poor compared to 8% in London and 17% reported a long term limiting illness compared to 15% in London.
- Breaking this data down by age groups highlights a wider gap in middle-aged and older populations with 36% of residents aged between 35 and 64 reporting a long term illness compared to 22% in London.

Disease prevalence

- Recent modelling data (taking account of deprivation and ethnicity) suggests that there are approximately 33,000 local residents with high blood pressure, 12,000 with diabetes, 11,000 with asthma, 7,000 with coronary heart disease and 3,000 with heart failure.
- Comparison of estimated numbers with these conditions (and other long term conditions) with those recorded on primary care disease registers suggests varying levels of under recording.
- Tower Hamlets has a higher prevalence of diabetes than elsewhere and this is associated with a higher prevalence in South Asians. There are currently approximately 11,000 people known to have diabetes in the borough and it is estimated that there are an additional 1,000 to 2,000 undiagnosed. As elsewhere, prevalence is rising.
- Recent data has highlighted the extent to which people live with a number of long term conditions. For example, 53% of people with diabetes have high blood pressure, 17% have diagnosed heart disease and 14% suffer from depression.

- There were 614 new cases of cancer in 2006. Tower Hamlets has higher rates of new diagnoses of lung, cervical, bowel and stomach cancers and lower rates of breast and prostate cancers compared to London. There is a consistent pattern of poorer survival which may be linked in part to later diagnosis.
- It is estimated that around 9,000 local residents have a level of depression that would benefit from mental health services, 1,500 have dementia and 1,200 have schizophrenia (around three times the national average). There is evidence of significant underdiagnosis or underrecording of depression and dementia in primary care
- Following the sharp rise in sexually transmitted diseases in the first half of the decade, numbers are beginning to decline nationally and regionally. The main diseases are chlamydia, genital warts and gonorrhoea.
- Following the introduction of the national chlamydia screening programme in Tower Hamlets, 5,195 screens were performed in young women aged 15-24 in 2007-08 of which 3% were positive.

Health and well-being

- In 2007 there were 869 diagnosed cases of HIV in Tower Hamlets (the third highest in North East London). As survival from HIV increases, the total prevalence has been rising and there have been an additional 60-70 new cases per year.
- Based on national surveys, around 30% of people with HIV are unaware of their diagnosis and late diagnosis accounts for 35% of HIV related deaths.

The health of children and young people

- Tower Hamlets has a young population with a high birth rate with around 60% of deliveries to Bangladeshi mothers.
- In 2006 there were 4,152 births to women resident in Tower Hamlets and this is projected to increase to 4,570 by 2010.
- Despite high deprivation in the borough, infant mortality rates are lower than London and England (4.5 per 1000 live births compared to 4.8 in London and 4.9 in England based on pooled 2005-07 data).

- Although smoking rates in pregnancy are significantly lower than London averages (3.6% in 2007), rates are high in young white pregnant women (16.2%).
- Breast feeding initiation rates are relatively high (83.8% in 2007–08), but there remains scope for further improvement.
- In 2005–06 there were 42% of 5 year old children with tooth decay in Tower Hamlets compared to 36% in London. The rate has been reducing rapidly over the past decade and there has been a reduction in the gap.
- Childhood immunisation rates in Tower Hamlets are improving but remain below the 95% level needed to achieve herd immunity (the rate needed to prevent outbreaks). At the end of 2007–08, 80% of children received the first dose of MMR vaccine at 2 years old and 76% received the booster at age 5.
- Tower Hamlets has lower teenage pregnancy rates (under 18 conception rates) than London. However, the fall in rates has plateaued and there is recent evidence of a rise in both conception and abortion rates.

The health of older people

- There are around 20,000 local residents over the age of 65. Although older people in Tower Hamlets constitute a lower proportion of the population than London as a whole, a higher proportion rate their health as poor and over half suffer from some form of long term limiting disease.

Chapter 1

Introduction

Improving health and well-being needs concerted action at a number of levels. Amongst the most important factors influencing the health of a population are the 'wider-determinants of health' such as income, education, poverty, housing, physical environment and community cohesion. These in turn have powerful impacts on people's lifestyles. It is well-established that social deprivation is strongly associated with higher smoking rates, poorer diets, lower levels of physical activity and higher rates of alcohol/substance misuse. In addition, areas of high deprivation, where high quality health and social care services are most needed, paradoxically tend to have worse quality services.

Understanding health and well-being in Tower Hamlets, therefore, needs to begin with an appreciation of the levels of deprivation in the borough compared to elsewhere. Based on national indicators, Tower Hamlets is the third most deprived local authority in England. The health impacts associated with this are reflected in amongst the highest death rates from cardiovascular disease, cancer and respiratory disease both in London and nationally. These are the biggest contributors to the significantly lower life expectancy in Tower Hamlets, in both males and females, compared to England.

The purpose of this chapter is to set out an overview of the health and well-being of the residents of Tower Hamlets. The chapter is divided into three sections. The first section describes the social, environmental and population characteristics of the borough that powerfully influence the health and pattern of illness in Tower Hamlets. The second section describes health trends in terms of illness in the population and what people die of. In particular, it focuses on health inequalities both within the borough and compared to England as a whole. The third section briefly looks at some of the insights from the community that we have gathered from the social marketing research we have commissioned over the past year.

Finally, if you are interested in finding out more around anything in this chapter, there is further detail in the PCT Health Needs Assessment 2008–09³ and the Tower Hamlets Joint Strategic Needs Assessment Core Dataset document. The JSNA has been produced jointly by the primary care trust and local authority.

Tower Hamlets people and place

This section is about those who live in Tower Hamlets and the wider factors that affect their health. It begins by describing the population in terms of characteristics relevant to health such as age, gender, ethnicity, migration and economic deprivation. It then outlines some of the important

factors about Tower Hamlets that impact on people's health and well-being such as housing, crime and the physical environment.

The Tower Hamlets population

The population in Tower Hamlets is growing rapidly. One of the smallest boroughs in London, it is also amongst the most densely populated. There are currently an estimated 232,000 people living in Tower Hamlets and, as part of the Thames Gateway Regeneration Zone, this is expected to rise by 30,000 over the next five years (figure 1). This is one of the fastest expected growth rates in London and has important implications for the pattern of health in the population and for service development. In particular, population growth is expected to be uneven across the borough with the biggest increases in the east of the borough (particularly the Isle of Dogs and Bromley by Bow).

Tower Hamlets has one of the youngest populations of all London boroughs; 45% are aged between 20-39 compared to 36% in London. Only 22% are over 40 compared to 39% in London. This composition will not change much over the next five years although the combination of ageing of the existing population and inward migration means that there are expected to be an additional 11,000 women of childbearing age, 1,500 under 5's and 500 over 80's.

Health and well-being

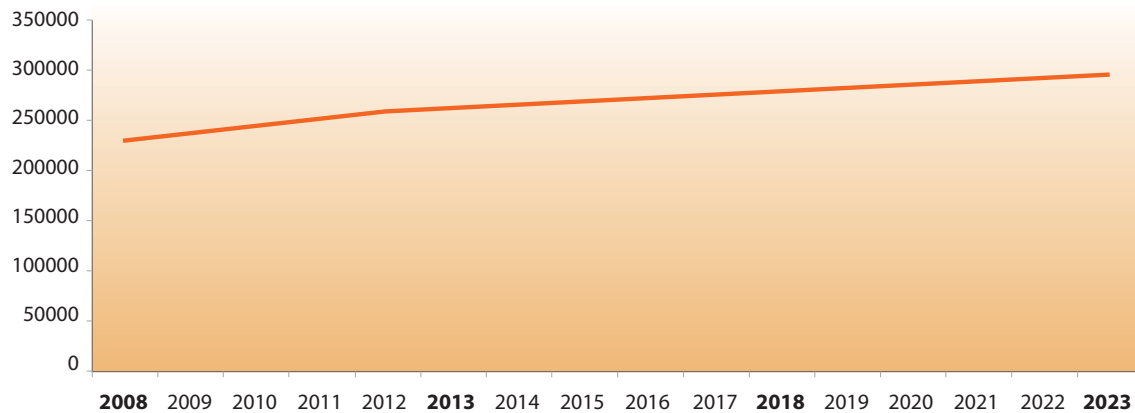


Figure 1: Population projections for 2008-2023 (GLA 2007 projections PLP Low)

Source: Greater London Authority, 2008

Ethnicity is a major factor in understanding the pattern of health and well-being in Tower Hamlets. Men born in South Asia are 50% more likely to have a heart attack or angina than men in the general population and Bangladeshis have the highest rates of diabetes. Men born in the Caribbean are 50% more likely to die of stroke than the general population. Studies show up to seven times higher rates of new diagnosis of psychosis among black Caribbean people than among white British.

An estimated 49% of the Tower Hamlets population is non-white compared to 29% in London and 9% nationally. 33% of the population is Bangladeshi, 6% is Black and 3% Chinese. Recent data suggests that around 3% of the population is eastern European. The ethnic composition of the population varies considerably by age. 60% of under 20's are Bangladeshi, 60-70% of over 20's are white (80% of over 80's).

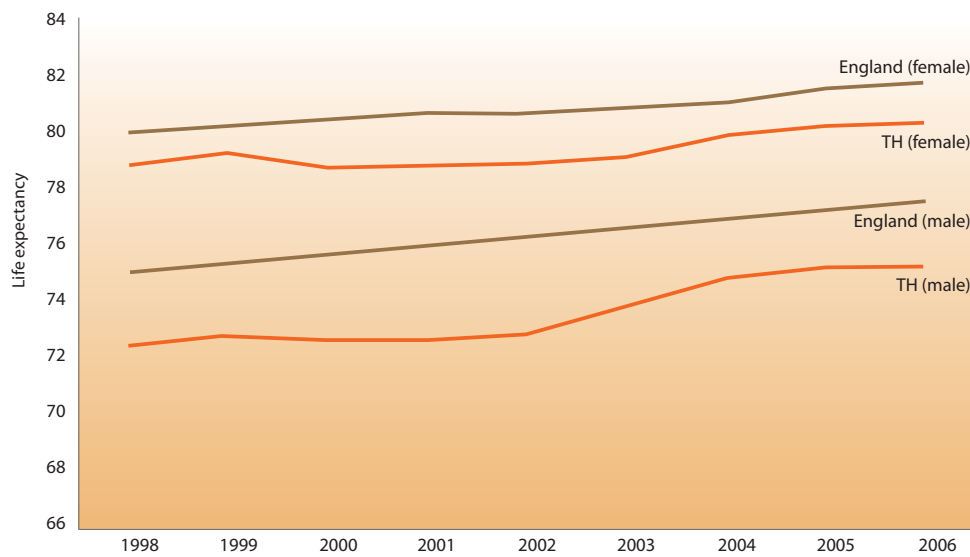
The wider determinants of health

Tower Hamlets is the third most deprived local authority in England and the health impacts of this cannot be underestimated. Income, employment, education, housing quality, overcrowding and crime are powerfully associated with both physical and mental health. The socio-economic characteristics of Tower Hamlets are major factors explaining poorer health in the borough. Tower Hamlets has amongst the highest rates of child poverty and unemployment in the country. Although children achieve results in line with national figures at Key stage 2, results lag behind the rest of the country by Key stage 3. It is encouraging, however, that Tower Hamlets is the fastest improving local authority in the country for GCSE results. Tower Hamlets has the highest rates of overcrowding in London and 45% of the population live in socially-rented housing. Crime

rates are generally higher than the rest of the country and there are a particularly high number of domestic offences and drug-related arrests.

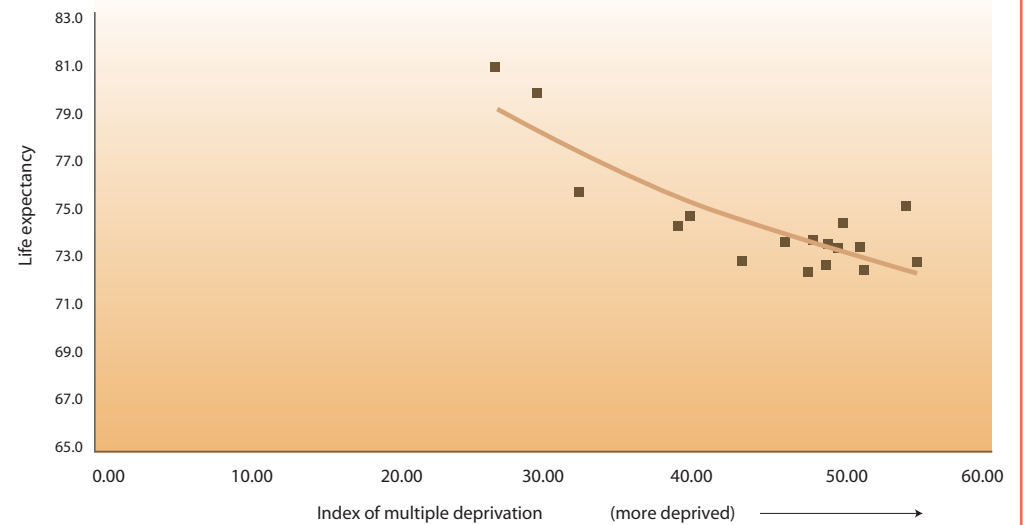
The recently refreshed Community Plan² is the major vehicle for transforming this picture over the next decade and is therefore at the heart of improving health and well-being in the borough in the longer term. Through its four themes (A great place to live, Prosperous communities, Safe and supportive communities, and Healthy communities), it sets out how the local authority, primary care trust and other local partners will work together in partnership to create the opportunities and environment in Tower Hamlets that will address the social, cultural and economic factors that underpin the health and well-being of local residents.

Figure 2: Male and female life expectancy trends in Tower Hamlets



ONS 3 year rolling averages

Figure 3: Male life expectancy and deprivation (index of multiple deprivation)



ONS Index of Multiple Deprivation (IMD) 2007

Health and well-being

Health and well-being in Tower Hamlets

This section is about the health and well-being of people in Tower Hamlets. It begins by looking at life expectancy in Tower Hamlets and exploring the factors that explain why it is lower than elsewhere. It then describes the burden of disease in the population and also how local residents assess their own health.

Life expectancy in Tower Hamlets

Life expectancy reflects how the broad range of interrelated factors influencing health interact to determine the average age of death in the population. Male life expectancy in Tower Hamlets was 75.2 years compared to 77.3 years nationally in 2005. In females, it was 80.2 years compared to 81.5 years. For both males and females, Tower Hamlets is ranked in the bottom 20% for life expectancy out of all local authority areas.

Looking at trends over time, it is encouraging that life expectancy is steadily increasing from year to year. However, it is also the case that there is little reduction in the gap in life expectancy between Tower Hamlets and the rest of the country (figure 2).

Exploring this further indicates that the main reasons for the gap are higher death rates from cardiovascular disease (mainly heart disease

and stroke), cancer, and lung diseases such as emphysema and bronchitis. Tower Hamlets has the second highest death rate from cardiovascular disease in London and the highest death rates from cancer and chronic lung disease. Deaths from these conditions account for 60-70% of all deaths in Tower Hamlets.

It is also important to be aware of the significant inequalities in life expectancy within the borough. It is remarkable that in an area of only approximately 15 square miles, the life expectancy of a boy born in Bethnal Green North ward is 8.5 years less than that for a boy born in Millwall ward; a difference of over 10%. That of a girl born in Limehouse is 5.7 years, or 7.3% less than for a girl born in Bromley-by-Bow.

Particularly striking is the correlation between variations in life expectancy and deprivation at ward level. This reflects the discussion in the previous section highlighting the strong link between deprivation and health. Figure 3 demonstrates this relationship for male life expectancy.

Risk factors for diseases

As outlined above, the major causes of lower life expectancy in Tower Hamlets are higher death rates from cardiovascular disease, cancer and respiratory disease. These are all conditions that

can be delayed or prevented to a significant extent through lifestyle change and medical intervention.

The risk of cardiovascular disease can be substantially reduced by stopping smoking, losing weight, eating healthier, being more active, drinking sensibly and using medical intervention to control blood pressure and cholesterol.

Most cancers are similarly linked to lifestyle. Lung cancer is not the only form of cancer linked to smoking; other forms include pancreatic, renal, bladder, mouth, stomach, liver and cervical cancer. Breast cancer and bowel cancer are also strongly linked to diet and stomach cancer is linked to alcohol. Bronchitis and emphysema are almost entirely linked to smoking.

It is therefore worrying that Tower Hamlets has some of the highest rates of risk factors for these diseases in London. It is estimated that at least three out of ten adults smoke, seven out of ten eat less than five fruit and vegetables a day and a lower proportion participate in sport or recreational activity compared to both London and England.

Although alcohol consumption rates are lower overall, alcohol-related harm is above average for London suggesting that lower rates of consumption in some groups are more than compensated for by above average consumption in others. It is a major source of concern that

Chapter 1

Tower Hamlets has amongst the highest rates of childhood obesity in the country and that one in five of Tower Hamlets' children have tried a cigarette by the age of 15.

Our strategies for tackling these issues are discussed more in-depth in the following chapters. Central to our approach is the understanding that achieving sustained behaviour change is not easy and that this is particularly the case in an area of high deprivation such as Tower Hamlets.

Our vision is to make Tower Hamlets a place where it is easy to be healthy. This requires action at a number of levels. It is important that all Tower Hamlets residents are aware of how making healthier choices will improve their health and well-being. However, this needs to be in the context of a social and physical environment that supports healthy lifestyles and easy access to high quality and appropriate support to make long-term changes.

Achieving this vision requires strong partnership work to bring about the changes needed to transform the environment in Tower Hamlets. It also requires an integrated approach to promoting healthy lifestyles to ensure that consistent and reliable advice and support is always available and people know how to access it.

Easy access means both increasing the supply of services and expanding further the range of settings where these are delivered (eg healthcare, social care, community and workplace). Effective services require us to work systematically in partnership with the community in order to develop interventions that are built around their needs and that respond to what will work at a grassroots level.

These are the principles that drive the Time for health programme and underpin the three strategies outlined in the next three chapters on tobacco, obesity and alcohol.



Health and well-being

Health and ill-health in Tower Hamlets

This section describes the extent of health and ill-health in Tower Hamlets. There are a number of approaches to looking at the health of a population. The most direct way is to ask people about their health using surveys. Another approach is to look at the conditions that are diagnosed through health and social care services, although this usually underestimates the total number as not everyone will access services for their conditions. Finally, deaths and death rates give an indication of the number of people suffering from diseases in the population. These data are particularly helpful as they are collected nationally so it becomes possible to make comparisons with London and England and therefore highlight inequalities. All three approaches are addressed in the following section. Further detail is available in the PCT Health Needs Assessment 2008–09.³

How do Tower Hamlets residents rate their health?

The 2001 census, which will be repeated in 2011, remains the most complete information source on how people in Tower Hamlets rate their own health. This indicated that 10% of Tower Hamlets residents considered that their health was poor compared to 8% in London and 9% in England. 17% reported a 'long-term limiting illness' compared to 15% in London and 17% in England. In understanding this data, it is important to bear in mind that Tower Hamlets has a significantly younger population than both London and England. Breaking this data down by age reveals a picture that illustrates substantially poorer health experience of middle-aged and older Tower Hamlets residents. For example, 36% of residents aged between 35 and 64 reported a long-term limiting illness compared to 22% in London. In addition, 23% reported that they were 'not in good health' compared to 8%. There was a similar picture in the over 65's.

These differences are not surprising given the high levels of deprivation within Tower Hamlets compared to elsewhere and the strong association of deprivation with poorer self-rated health. Although it is now eight years since the national census, it is likely that these inequalities persist as Tower Hamlets remains amongst the most deprived local authority areas in the country.

This has important implications for informing the relative scale of services needed to meet the health needs of the Tower Hamlets population.

What is the extent of ill-health in the Tower Hamlets population?

The World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. It is therefore important to bear in mind that description of the number or proportion of people in a population with a disease only provides a partial picture of health and ill-health in the population. However, such descriptions do at least provide some indication of the size of health problems in the population and this is important in planning local services.

Estimating the number of people in a population with particular diseases is not an exact science. People may suffer from serious diseases and not present them to local services for a range of reasons. If they are not known to services then they are not included in local databases and therefore the known number of people with a particular disease may be a significant underestimate. In recent years, there has been a focus on comparing the estimated numbers with disease to observed number. This is important from an inequalities perspective as those not known to services are likely to have the greatest need.

Chapter 1

Long-term conditions

As Tower Hamlets has a very different population structure to elsewhere (a young population, high ethnicity and high deprivation), national models to estimate the prevalence of diseases in the population do not work very well. This is particularly the case with diseases that have a strong link with ethnicity. For example, prevalence of diabetes is higher in south Asians and national models have predicted a prevalence that is below the observed number on registers.

For this reason, we have had to develop local estimation models taking into account both ethnicity and deprivation. Although these models cannot provide estimates to a high degree of accuracy, they do provide a broad indication of the burden of illness in the population. In terms of the conditions that have a substantial impact on people's health, our best estimates are that there are around:

- 33,000 people with high blood pressure,
- 12,000 with diabetes
- 11,000 with asthma
- 10,000 with chronic obstructive pulmonary disease (COPD)
- 9,000 with chronic kidney disease
- 7,000 with coronary heart disease

- 5,000 with long-term neurological disease (excluding epilepsy)
- 3,000 with heart failure

It is important to bear in mind that a substantial number of people will be living with at least two significant conditions. For example, recent data has shown that 53% of people with diabetes have high blood pressure, 17% have diagnosed heart disease and 14% suffer from clinically significant depression.⁴ This means that we need to work hard to ensure that our services are properly integrated from the perspective of those using them.

If we compare the above estimates to the numbers known to services, there is strong evidence of under diagnosis for some important conditions. For example, we think that there are around 1,500 to 2,000 undiagnosed diabetics currently in the population and a similar number of people with heart disease. This is important as early intervention in these groups can improve long-term survival. There are other important conditions where there is evidence of under diagnosis including high blood pressure, heart failure and lung disease that we are exploring.

Cancer

In 2006, there were 614 new cases of cancer. Rates of new diagnoses for some cancers were higher than England (lung, cervical and stomach) and lower for others (breast, bowel and prostate).

These reflect differences in factors such as smoking rates (smoking is an important risk factor for lung, cervical and stomach cancer), deprivation (breast cancer has a higher incidence in more affluent areas) and age of onset (prostate cancer tends to manifest in later life and incidence may therefore be lower in areas of lower life expectancy).

However, death rates from all main cancers apart from breast cancer are higher. This means that Tower Hamlets residents have a poorer chance of survival once diagnosed. There is evidence that one important factor explaining this is late diagnosis and it is therefore a major priority for us to put in place measures to ensure that the signs and symptoms of cancer are diagnosed as early as possible.

Health and well-being

Mental health

Estimating the burden of mental health problems is complex. We know that around one in four people will suffer from some form of mental disease during their lifetime. This amounts to around 65,000 Tower Hamlets residents.

It is estimated that currently around 9,000 local residents have a level of depression that would benefit from intervention from mental health services, 1,500 have dementia and 1,200 have schizophrenia (around three times the national average).

Comparison of estimated numbers with those known to services indicates significant levels of under diagnosis or under recording in primary care of depression and dementia.

Sexual health

Because sexual health data is anonymised, it is difficult to get a clear picture of the number of Tower Hamlets residents diagnosed with a sexually-transmitted disease over a year. We know that following the sharp increase in the number of sexually-transmitted diseases in the first half of the last decade, numbers are now beginning to decline, slightly based on data across North East London (NEL).

Based on NEL figures, we would estimate chlamydia accounts for 40% of diagnoses, genital warts 25% and gonorrhoea 15%. Numbers of syphilis cases are small but are not declining. It remains a source of concern that based on national surveys, one in six people would not use a condom. This is likely to be even higher in Tower Hamlets due to the younger population.

Chlamydia has been an important priority over the past few years in relation to sexual health. This is because 70% of women and 50% of men are unaware of their infection. Left untreated, it can have serious health consequences and may lead to infertility. Following the introduction of the national screening programme in Tower Hamlets, 5,195 screens were performed among young women aged 15-24 in 2007-08 of which 3% were positive.

HIV

In 2005 data from the Health Protection Agency showed that Tower Hamlets had a high prevalence of HIV compared to both London and England (365 per 100,000 compared to 290 per 100,000). The most recent data indicates that there are 869 diagnosed cases in Tower Hamlets residents.

The main routes of transmission were sex between men (72%) and sex between men and women (19%). The remainder of cases were through intravenous drug use and transmission between mother and infant. People of black African origin account for 14% of HIV cases, even though they only account for 3% of the population.

The total number of cases has been steadily rising and there have been around 60-70 new cases a year (with no clear trend up or down). Based on national surveys, we know that at least 30% of people with HIV are unaware of their diagnosis. Most people who are infected with HIV remain asymptomatic for seven to ten years. Late diagnosis accounts for at least 35% of HIV-related deaths and can limit treatment options resulting in premature death. Promotion of HIV testing and increased HIV awareness, therefore, remains a major priority.

Teenage pregnancy

Having children at a young age has health impacts for both the mother and child. These include social and economic impacts that can adversely affect health, higher rates of post-natal depression, poorer mental health, higher infant mortality rates and lower breastfeeding rates.

Tower Hamlets has lower teenage pregnancy rates (under-18 conception rates) compared to London. In 2007, there were 45.8 under-18 conceptions per 1,000 girls aged 15-17 compared to 45.6 in London. However, despite a fall in the first half of the last decade, rates have plateaued and the most recent data indicates that both conception and abortion rates are starting to rise; this is a source of concern. In 2007, 74% of teenage conceptions resulted in termination.

The Tower Hamlets Teenage Pregnancy Strategy provides the basis for the strong partnership work needed to both prevent teenage pregnancy and support teenage parents. Sex and relationship education is a key component of our prevention strategy.

The health of children and young people

Tower Hamlets has a young population with a high birth rate; around 60% of deliveries are to Bangladeshi mothers. Infant mortality rates are lower than London. The reasons for this are unclear as they might be expected to be higher in the context of the high levels of deprivation in the borough and a higher proportion of babies with low birth weight. Possible factors might include the low prevalence of smoking in pregnancy (particularly in Bangladeshi women) and relatively high breastfeeding rates.

Although smoking rates in pregnancy (3.6% in 2007) are significantly lower than the England average of 17%, there are high smoking rates in young white pregnant women. Late booking rates for ante-natal care have been historically high but there has been a marked improvement in the proportion of women booking for ante-natal care by 12 weeks from 49.7% (2006-07) to 62.2% (2007-08). Despite good clinical outcomes, the recent maternity review and Health Care Commission audit found poor experience amongst users of the local maternity services at the Royal London Hospital.

Although breastfeeding initiation rates are relatively high (83.8% in 2007-08), there remains scope for further improvement. Poor weaning practices may be one factor contributing to poor



oral health in infants and high rates of obesity by the age of five. While there has been a reduction in the gap between Tower Hamlets and London, recent local evidence of vitamin D deficiency in children (and adults) and other micronutrient deficiencies remains a concern.

Childhood immunisation rates in Tower Hamlets are improving but remain below the 95% level needed to achieve herd immunity (the rate needed to prevent outbreaks). Only 76% of 5 year olds were fully immunised in 2007-08, and this explains recent clusters of measles in children in the borough.

Smoking in early life is an important predictor of future use and increases the risk of smoking-related death in later life. 22% of Tower Hamlets

Health and well-being

children under 15 have tried a cigarette. Tower Hamlets reception year children have the fourth highest obesity rate in London (fifth highest in the country) at 13.7% and the fifth highest in year 6 children (sixth highest nationally) at 24.4%. Based on the TellUs3 survey by Ofsted, a higher proportion of year 8 and 10 children have a desire for more and better information/advice on alcohol compared to the national average (29% vs. 25%).

Referrals to 'child subject to protection plans' (previously the child protection register) have been rising although numbers of referrals are relatively low. Finally, unlike elsewhere, admission rates to hospital for child accidents are not falling.

The health of older people

There are estimated to be around 20,000 people over 65 in Tower Hamlets. Older people in Tower Hamlets constitute a smaller proportion of the population than for London as a whole. They are predominantly white (over 70%) and unevenly distributed across the borough.

We know from the census that compared to London and England, a higher proportion of older people rate their health as poor and over half suffer from some form of long-term limiting illness.

Furthermore, recent data indicates a high proportion of those living with a long-term condition suffer from more than one condition

(particularly combinations of cardiovascular disease, diabetes, mental ill-health and chronic respiratory disease). We estimate that each year around 35% to 40% of older people experience a fall. There is strong evidence of significant under diagnosis of depression and dementia. Based on national models, we expect around 1,500 Tower Hamlets residents to have dementia. However, only 413 are recorded on primary care databases (CEG data 2008).

Taking all these factors together, alongside issues such as social isolation and high levels of income deprivation, an integrated approach to meeting the needs of older people in the borough through strong partnership working across social and health care is vital; and it is of particular importance that this has been established as a priority for joint commissioning.



Table 1: Tower Hamlets - causes of death in 2006

Disease area	Number of deaths	%
Diseases of the circulatory system	389	33.2%
Cancer	326	27.8%
Diseases of the respiratory system	173	14.8%
Diseases of the digestive system	65	5.5%
External causes of morbidity & mortality*	64	5.5%
Infectious and parasitic diseases	39	3.3%
Mental and behavioural disorders	32	2.7%
Others **	84	7.2%
Total	1172	100.0%

Source: Office of National Statistics

* E.g. accidents

** Includes musculoskeletal, nervous system, genitourinary, endocrine, nutritional and metabolic diseases

What are the main causes of death in Tower Hamlets?

As elsewhere, the main causes of death in Tower Hamlets are heart disease, stroke, cancer and chronic lung disease (table 1). In 2006, 888 out of 1,172 deaths were due to these conditions (76%). Comparing the pattern of causes of death in Tower Hamlets residents with those in London and England highlights again the impact of the higher prevalence of risk factors in the population (particularly smoking). 18% of deaths were due to coronary heart disease compared to 16% in London. 8% were due to lung cancer compared to 6% in London.

When adjusted for age, Tower Hamlets has amongst the highest death rates from cardiovascular disease, cancer and chronic respiratory disease in the country. Although it is encouraging that these rates are falling every year, there is no evidence that the gap is reducing (see figures 4 and 5). In order for this to happen, rates would need to fall faster than elsewhere. In the short term, this requires focussed effort on interventions that are likely to have high impact on death rates from cardiovascular disease and cancer.

These include:

- Identification and management of people at high risk of vascular disease.
- Effective management of those with existing vascular disease.
- Identification of undiagnosed vascular disease.
- Stopping people smoking.
- Early identification and management of cancer.

Health and well-being

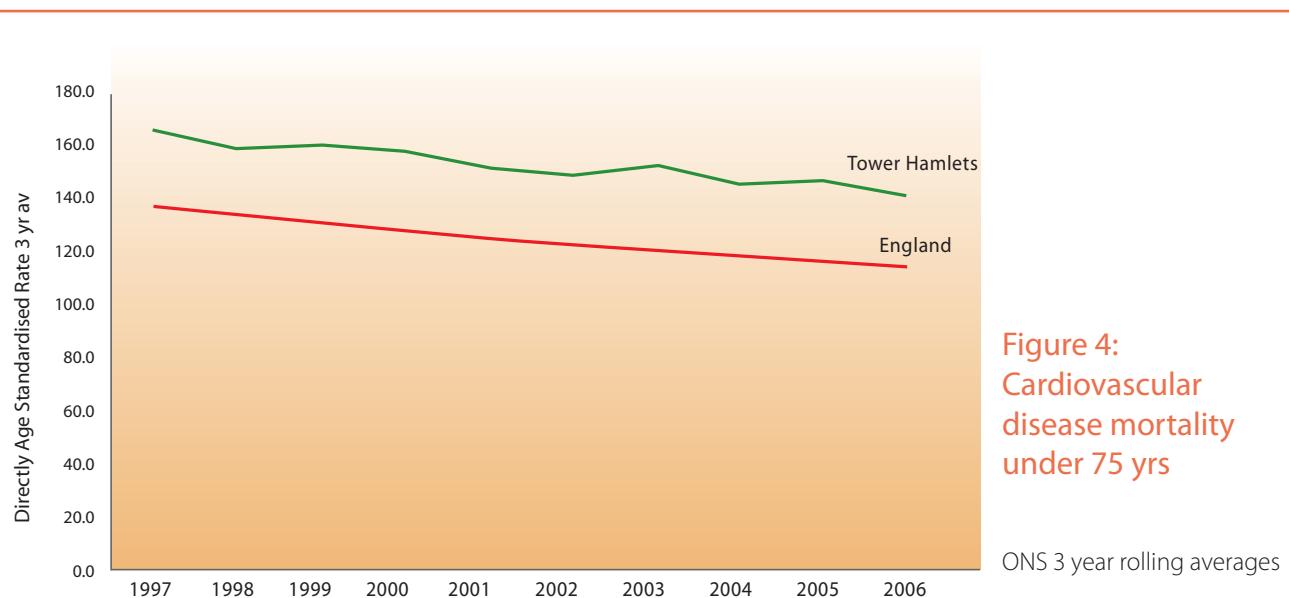


Figure 4:
Cardiovascular
disease mortality
under 75 yrs

ONS 3 year rolling averages

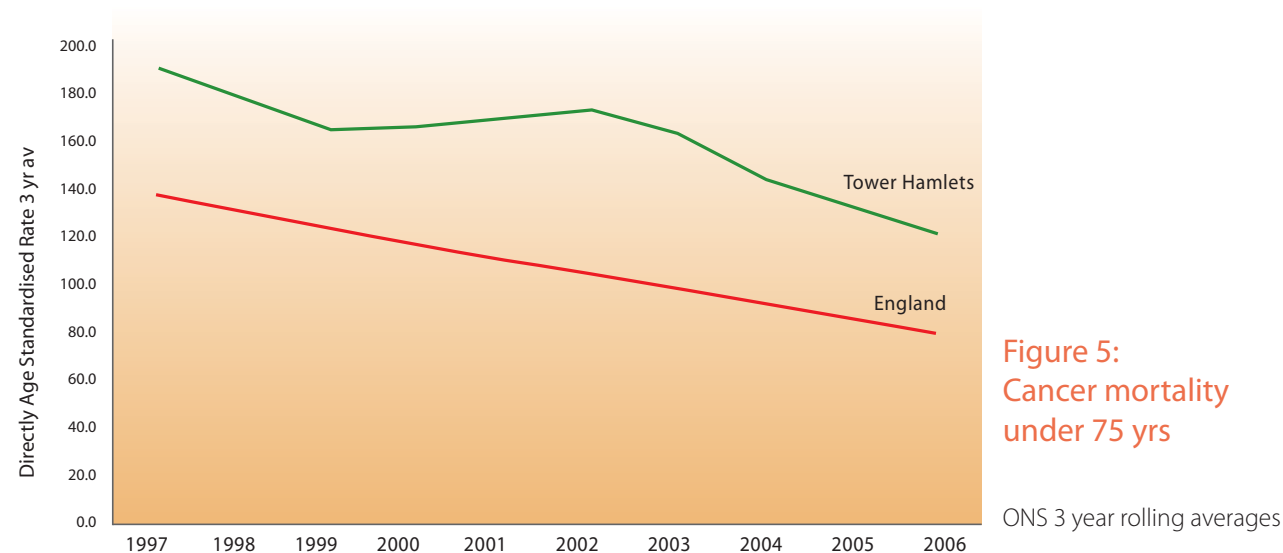


Figure 5:
Cancer mortality
under 75 yrs

ONS 3 year rolling averages

Death rates vary significantly by ward across the borough. Those from cardiovascular disease range from 81 to 148 per 100,000 and from 54.8 to 180.6 for cancer (table 2, page 20).

Years of life lost data gives an indication of how many years are lost due to premature death for a disease (dying before 75). This brings home the devastating impact of higher death rates from coronary heart disease and lung cancer in Tower Hamlets. For a population of 100,000, 94 years are lost from coronary heart disease in Tower Hamlets compared to 55 in England. For lung cancer, the figures are 46 and 30 respectively. These differences give an indication of the potential for health improvement that could be achieved through a concerted effort to address preventable risk factors for disease in Tower Hamlets.

Chapter 1

Table 2: Life expectancy, CVD mortality, cancer mortality and index of multiple deprivation (IMD) by ward (pooled 2002-06)

Ward	Male life expectancy	Female life expectancy	CVD mortality rate	Cancer mortality rate	IMD 2007
Bethnal Green North	72.2	79.0	128.3	120.2	47.71
St Dunstan's & Stepney Green	72.3	78.1	143.2	54.8	51.41
Limehouse	72.5	77.6	147.7	74.7	48.96
Whitechapel	72.7	79.7	138.4	120.5	43.30
East India and Lansbury	72.7	78.4	122.0	97.8	54.99
Weavers	73.3	81.2	109.5	78.3	49.69
Mile End East	73.3	79.2	146.7	129.9	51.20
Spitalfields and Banglatown	73.4	84.2	122.8	177.8	49.08
Bow East	73.5	77.9	123.4	122.8	46.18
Bethnal Green South	73.6	81.3	125.8	148.5	48.06
Mile End and Globe Town	74.1	80.2	106.6	106.5	39.08
Shadwell	74.3	79.9	115.8	114.6	50.09
Bow West	74.6	80.1	108.8	120.9	39.82
Bromley-by-Bow	75.0	83.3	113.2	147.4	54.33
Blackwall and Cubitt Town	75.5	81.6	102.6	97.6	32.44
St Katharine's and Wapping	79.6	81.2	84.4	160.8	29.65
Millwall	80.7	82.2	81.4	180.6	26.81

Source: Office of National Statistics

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Time for Health

Stay under the cancer prevention umbrella

Health and well-being



Social marketing

The Department of Health has described social marketing as being about 'putting people at the heart of policy, communications and delivery to encourage behaviour change'.⁵ This strongly reflects the approach we have taken to develop social marketing locally over the past few years.

Since 2007, we have commissioned a number of social marketing projects in a range of health areas including cancer screening, childhood obesity, smoking, immunisation, sexual health, mental health stigma and physical activity.

Our approach has been typically to break these projects into two components. The first component involves what we call the formative research phase. This involves developing a rich understanding of the segment of the population we are working with by bringing together quantitative data about the population and qualitative data gathered directly from the population, e.g. through focus groups and interviews. The insights that emerge out of this process are then used to shape how we develop policies, services or communications around supporting behaviour change (phase two).

The findings from the research have provided us with an appreciation of the need to be sensitive to the differences and similarities in knowledge,

attitudes and behaviours of different segments of the population around age, gender and ethnicity. They have also challenged our assumptions. People's awareness of services or health issues has sometimes been more and sometimes less than expected. Often there has been a willingness to make lifestyle changes that has been blocked by the way our services are designed. The insights generated have already been successful in informing services changes in a range of areas and have contributed towards increasing uptake of breast cancer screening and smoking cessation in specific segments of the population.

We have learnt a great deal from this research about how to work with people to develop services together. However, the most important lesson has been the realisation that social marketing is a way of working that needs to be embedded in all our work rather than being seen as a set of discrete projects.

Summary

This chapter has provided a brief overview of the population of Tower Hamlets and current health trends. It has highlighted the significant health inequalities within the borough compared to national trends providing strong evidence of unmet needs in the population.

This is because, where other factors are equal, they imply a set of interventions or conditions in which the health experience of those with poorer outcomes could be improved towards the level of those with better outcomes.

We know that lifestyle change can have a major impact on improving these outcomes, and in the following chapters we explore what we know, what we are doing and what more we need to do around three important risk factors for health: tobacco, obesity and alcohol.

Chapter 2: Tobacco



“The aims of the tobacco control strategy are simple: to make it hard to start smoking in Tower Hamlets, to make it easy to stop, and to ensure that no one is exposed to the harmful effects of second-hand smoke.”

Tower Hamlets Tobacco Control Strategy, 2008-11.⁶

Snapshot of tobacco use in Tower Hamlets

- It is estimated that there are 60-70,000 adult smokers in Tower Hamlets.
- Smoking is the biggest avoidable cause of death in Tower Hamlets and, despite recent successes in getting people to quit, it remains a major challenge.
- The Smoking Epidemic in England report in 2004 estimated that 37% of the Tower Hamlets adult population (16+) were smokers compared to an average of 27% in England.
- The smoking rate for men in Tower Hamlets was amongst the highest for all PCTs in England (43%). The highest prevalence of smoking was amongst men aged 25-44 years, and in particular, Bangladeshi men.
- 22% of Tower Hamlets children under 15 report that they have tried a cigarette, and 2% report that they smoke every day (compared to 4% nationally).
- Smoking is not the only form of tobacco used by the south Asian population. It has been reported that 19% of Bangladeshi men and 26% of Bangladeshi women have used some form of oral tobacco (one report put the figure in women at 49%). Chewing tobacco is associated with severe gum recession and bone loss, oral cancer.
- Hospital episode data from 2005-06 shows that standardised admission rates for COPD (468) were far higher than London (179) and England. This is explained, in large part, by the high incidence of smoking in the borough.
- 42% of all deaths in Tower Hamlets were estimated to be due to smoking, with almost half of all men over the age of 35 dying from smoking-related causes.
- Deaths from bronchitis, emphysema and other COPD for people of all ages in Tower Hamlets increased between 2001-06 from 49 to 57 per 100,000.

Chapter 2

Introduction

Although it is a message that has long been understood by the public, it is not possible to understate the importance of continuing and strengthening our concerted efforts to stop people starting smoking and helping smokers to stop. Over the past few years, there has also been an increasing recognition of the harmful effects of second-hand smoke and this has culminated in the national implementation of the smoking ban in June 2007. In Tower Hamlets, we have seen this as a major opportunity to link the ban to tobacco cessation activities, and this has resulted in the development of a strong Tobacco Control Alliance across the PCT and local authority that oversees the implementation of the Tower Hamlets Tobacco Control Strategy that was launched in 2008. This chapter sets out the reasons why tobacco cessation is important, what we know about tobacco use in Tower Hamlets, what we are doing and what more needs to be done.

Why is tobacco use a problem?

Regular tobacco use reduces life expectancy and quality of life. On average, a smoker who begins smoking in young adult life and continues to smoke has at least a 50% chance of dying from a tobacco-related illness in middle or old age. Looking at what underlies this figure unmasks the damage inflicted by regular smoking on health. Smokers have 20 times the death rate from lung cancer than non-smokers, 10 to 20 times the death rate for chronic lung disease (mainly bronchitis and emphysema) and twice the risk of death from vascular disease. Because vascular disease is so common, this means that much of the harm

caused by smoking is through increased rates of vascular disease. This is particularly the case in Tower Hamlets which has some of the highest rates of cardiovascular disease in the country.

Smoking in pregnancy also has adverse effects on child health. Birth weight is reduced by on average 200g although much of the weight loss can be prevented with successful smoking cessation in the third trimester. Smoking also increases rates of complications in pregnancy and triples the risk of sudden infant death.

Age of starting smoking is linked to smoking-related health damage in two main ways.



Tobacco

Firstly, early experimentation with smoking is an important predictor of future use. Secondly, someone who starts smoking at 15 is three times more likely to die of tobacco-related cancer than someone starting in their mid-20's.

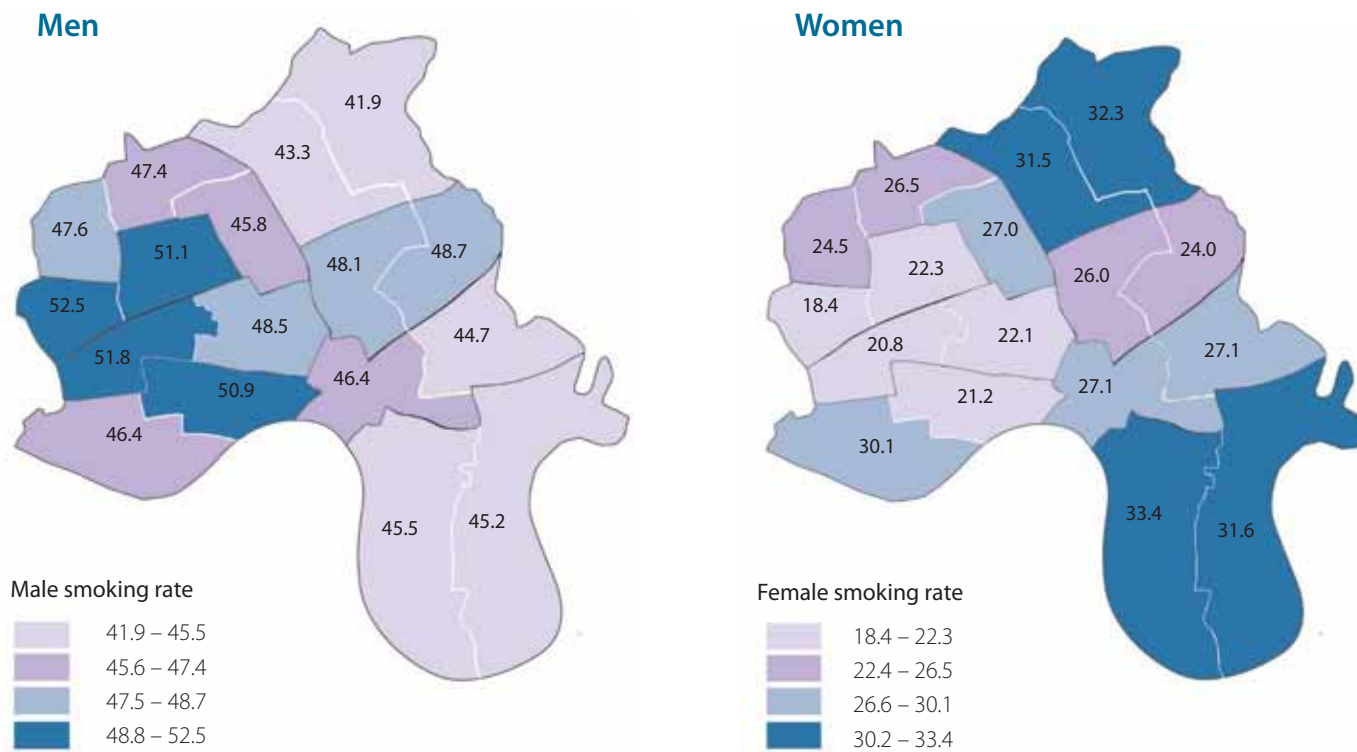
Chewing tobacco in paan, a common practice in Bangladeshis, is associated with severe gum recession, bone loss and oral cancer.

Evidence has accumulated around the adverse health impacts of passive smoking. Exposure to second-hand smoke in infants and children increases the risk of respiratory infections, middle ear disease and reduces the rate of lung function growth in children. There is also some evidence that exposure to pregnant women can reduce birth weight. In adults, exposure has been linked with higher risks of lung cancer, coronary heart disease, stroke and exacerbation of asthma.

Smoking is also a problem as it has broader social and economic impacts. It is estimated that 50% of accidental fires in London are caused by smoking material. In the absence of effective workplace smoking policies, productivity can be lost not only through sickness but also time lost for smoking breaks. Smoking is also linked with crime as it is estimated that one in six and almost half of rolling tobacco is contraband.



Figure 6: Estimated smoking prevalence in Tower Hamlets by ward (percentage of ward population)



Source: Smoking epidemic in England, 2004

What do we know about tobacco use in Tower Hamlets?

Our best estimates suggest that there are 60-70,000 regular smokers in Tower Hamlets. This is based on an estimate from The Smoking Epidemic in England, 2004 report, that 37% of the adult population (16+) were smokers compared to an average of 27% in England. Since then, rates have fallen nationally but it is unknown whether they have fallen in Tower Hamlets. In order to establish a more precise estimate, we have commissioned a healthy lifestyles survey that will be completed later this year.

We know that the higher rates of smoking in Tower Hamlets are linked to higher levels of deprivation and also to ethnicity. This also explains the variations in prevalence across the borough (see figure 6). National surveys have reported that Bangladeshi men have amongst the highest smoking rates of all ethnic groups (around 40%) although Bangladeshi women have the lowest (2%). This would explain the lower rates of smoking in pregnancy (4% of pregnant women in Tower Hamlets compared to 17% nationally) as 51% of deliveries are to Bangladeshi mothers. It is important to be aware that the low rate masks significant differences in smoking rates by ethnicity. The smoking rate in the white population is 16%.

Although precise figures are lacking, it is estimated that at least 19% of Bangladeshi men and 26% of Bangladeshi women have used some form of oral tobacco in paan (one report put the figure in women at 49%).⁷

Take up of smoking in children and young people is an area of particular concern in view of the significant health impacts of starting smoking early described in the previous section. The 2008 Ofsted TellUs3 survey (a survey of children and young people across England carried out in 2008 in year 6, 8 and 10 children) suggested that 22% of children aged 15 have ever smoked a cigarette.⁸ This is similar to national averages. Based on national data there is a sharp increase in smoking prevalence at around 12 to 13 years old which emphasises the importance of intervention prior to this age.

In order to find out more about attitudes to tobacco use in Tower Hamlets and barriers to stopping, we have commissioned social marketing research to explore these issues further. The two areas we have focussed on so far have been smoking in young people and smoking cessation in Bangladeshi men; these have involved in-depth focus groups.

The work on smoking in young people involved groups of children, parents and teachers. This highlighted the reasons that children start

smoking such as peer pressure, poor role models, easy access to cigarettes and smoking as a symbol of independence. In supporting young people to not start or to stop, it was clear that messages around the long-term health benefits were not necessarily a motivation. Factors that may support prevention or cessation included parental involvement, ensuring that schools are smoke-free zones, denormalisation of smoking and making it more difficult to get hold of tobacco.

Insight from social marketing research with Bangladeshi male smokers highlighted motivations to stop that went beyond fear of the health impacts and included factors such as setting good examples for children and saving money. Exploration of perceptions of local services raised issues around lack of understanding of what the services were about, the need for culturally-tailored services, accessibility and treatment. These are considerations that have critically informed both the design of our services and how we promote the stop smoking message in this segment of the population.

We are aware that there is a growing trend to use sheesha (water pipe smoking) in the borough and we need to know more about this. In addition, we estimate that one in six and almost half of rolling tobacco in this country is illicit.

What are we doing?

“Effective implementation of the smoking ban, promotion of stop tobacco messages and services, and provision of effective NHS accredited stop tobacco services are some of the key interventions we are employing to reduce the prevalence of tobacco use in Tower Hamlets.”

The Tower Hamlets Tobacco Control Alliance is at the heart of local efforts to reduce tobacco use in Tower Hamlets. The alliance is a strong partnership between the local authority, PCT and other partners that was developed around the time of the implementation of the smoking ban when it was recognised that there was a major opportunity to work together to link initiatives around tobacco cessation with enforcement of the ban. In 2008, the alliance launched the Tower Hamlets Tobacco Control Strategy that sets out a three-year plan to reduce the prevalence of tobacco use in the borough as well as the harm from second-hand smoke. The strategy has three objectives: to stop people from starting to use tobacco, to help people to stop and to protect people from the effects of second-hand smoke.

It is not planned to discuss the strategy in detail here as it is fully described in the strategy document. However, this section describes some of the main activities that are currently underway around the three main workstreams of the strategy.

Stopping people starting

Stopping children and young people from starting smoking is a challenge. As described in the previous section, we know that there are powerful drivers that influence them to start and that they have relatively easy access to tobacco. However, we also know that teachers, peers and parents can play a role in preventing children from starting or helping them to stop as soon as possible. In addition, enforcement of underage sales and measures to reduce the availability of cheap contraband tobacco can at least make it harder for them to take up or continue the habit.

These considerations inform the areas we have focussed on this year.

We have commissioned an innovative peer education programme in schools based on an evidence-based approach that has recently been implemented across Wales. The ASSIST programme (A Stop Smoking in Schools Trial) is targeted at schoolchildren aged 12-13, as this is the age at which smoking prevalence increases sharply, and has been demonstrated to reduce that rate of increase in smoking.^{9,10} Following an initial pilot in four schools, this is now being rolled out across all schools in the borough (see page 29).

ASSIST (A Stop Smoking in Schools Trial)

Researchers in Cardiff and Bristol developed the ASSIST (A Stop Smoking In Schools Trial) programme. It is one of the few interventions that have been shown to be effective in preventing young people from taking up smoking. The original trial involved over 10,000 students aged 12-13 years in 59 schools in England and Wales and demonstrated a 22% less chance of being a smoker with sustained effect at two years.

The project is a peer support initiative that targets students in year 8 (aged 12-13). It is not classroom-based or teacher-delivered; rather students are recruited as peer supporters and are given intensive training off the school premises by health promotion trainers. The peer supporters are trained to intervene effectively with their year 8 peers in everyday situations to discourage them from smoking.

As part of our broader strategy to reduce uptake, Tower Hamlets became one of the first areas to apply this model in its own schools. For the past year we have, through the local authority, piloted ASSIST in seven secondary schools.

The project involved the following steps:

- Peer education tutors (staff from local voluntary youth organisations with strong youth community work backgrounds) trained by the ASSIST team to deliver the training.
- Engaging with schools to deliver the project.
- Recruitment of peer supporters in each school.
- Training of 25-30 peer supporters per school (two days training).
- Four follow up sessions (40-50 minutes each) per school to monitor progress and provide support to peer supporters.
- Regular quality assurance visits from the developers of the project to ensure that implementation remains true to the original design.

Altogether, 188 peer supporters have been trained and intervention has been delivered to 1,730 12-13 year old students. The next phase is to roll the project out to all 15 secondary schools in the borough.



Recognising the importance of ensuring that all children and young people in Tower Hamlets are aware of the harm caused by tobacco in all its forms, we have worked with primary and secondary schools to ensure that the Personal Health and Social Education (PHSE) curriculum is effectively delivered and relevant locally.

We have also made it a priority to ensure that children and adolescents who have started smoking have access to stop smoking services by developing cessation services through working with school nursing teams. We are looking to expand capacity around this next year.

In addition, we have strengthened our work on no-smoking policies in schools. This has involved extending no-smoking zones outside school perimeters and promoting the provision of cessation support to both pupils and teachers.

The raising of the legal age of tobacco sales from 16 to 18 has been a catalyst for strengthening our partnership working with Trading Standards to make it harder for young people to access tobacco. Enforcement of legislation has been linked with raising the profile of the issue in schools. In addition, we have intensified our efforts to address the issue of contraband and counterfeit tobacco although we recognise that this also needs to be accompanied by concerted action at London and national levels to be fully effective.

Helping people stop

In 2007-08, 2,025 people successfully quit smoking using local NHS-accredited stop smoking services. This exceeded our target of 1,874.

This year, we have strengthened our efforts to drive people into services, improve the performance of existing services and expand provision to meet the needs of specific segments of the population more effectively.

We have developed a 12-month programme of marketing our services (see communications) and have also worked with dentists and ophthalmologists to ensure that they routinely signpost patients to cessation services.

We have also worked hard to embed smoking cessation into primary care through the implementation of a locally enhanced service that aims to improve promotion of local services and develop more cessation services within the practice. In addition, we have worked with community pharmacists to support them to increase their activity and have also implemented web-based data returns to streamline recording of activity.

Building on successful work with community organisations around tobacco cessation, we have strengthened the work of existing providers and commissioned new community providers to provide targeted support to a range of population

subgroups including Bangladeshi people (see page 31), Somali people, young people, people accessing community mental health services and staff in small businesses.

Finally, we have developed successful outreach programmes for the NHS Specialist Smoking Service (which was previously provided mainly in Barts and the London) in both community and primary care settings. These have demonstrated the potential for taking our specialist services into the community and bringing them closer to where people live or work.

Smoke-free Tower Hamlets

We know from experience of implementation of smoking bans in other countries that compliance begins to worsen a year or so after the introduction of the ban. It has therefore been a major priority to maintain the momentum of the successful initial implementation of the smoking ban in 2007 and to further develop the linkage with smoking cessation services.

The partnership between the local authority and PCT has developed and strengthened over the past year. Compliance with the ban remains good and this has been successfully linked with efforts to promote cessation in the workplace, coupled with messages around the impact of smoking on productivity and long-term sickness.

Developing tobacco cessation services for the Bangladeshi community

Tobacco use in the Bangladeshi community is high and is a major reason for poor health outcomes and health inequalities. Moreover, access to mainstream services is low. In response to this, we commissioned a social marketing intervention to address the problem. By gaining insight into tobacco use in the community, we have begun to address it through several approaches:

- Intelligence: Better health intelligence including social marketing research. Examples of insight include things such as smoking being very much the norm and part of quitting beliefs is that one should do it without Nicotine Replacement Therapy.
- Commissioning: The PCT has now commissioned a bespoke linguistically and culturally sensitive service to provide cessation services to men and women who use tobacco. Models of working focus on flexibility and providing services where community members are. Examples of this include the mosque, local markets and community centres.
- Community partnership: The community needs information that tobacco use is a problem and needs to be empowered to make and sustain change. Successful partnership working has begun with local business forums, local media outlets and faith-based organisations.

- Communication and media: The Bengali-speaking press has been very supportive in addressing this issue. Tobacco use is featured in most local press on a weekly basis.



To further strengthen this work, we have developed a Tower Hamlets Smoke-free Award that sets out criteria around going beyond mere compliance and proactively extending smoke-free zones and promoting cessation. Best practice is recognised as the development of a working environment that promotes a smoke-free environment and supports staff to seek and receive help if they smoke by accessing free NHS Stop Smoking services. An example of this is with Royal Mail whereby employees are fast-tracked to get free NHS help to stop smoking from local pharmacists. Seven businesses are currently being considered for this award and we are looking to expand this initiative next year.

Finally, it is critical to our strategy that the PCT and local authority are seen as exemplars around the smoke-free agenda and we have developed a joint policy that is currently being signed off.

Communications

The principle underpinning our communication strategy is to ensure that there is continual promotion of our services and the benefits of quitting throughout the year. This means that we have had to be creative to ensure that the messages remain fresh and engaging.

We have also used findings from social marketing research to inform us on how to communicate

messages around tobacco use. The work around Bangladeshi men has led to developing our engagement with community media and this has proven to be a highly successful partnership. We have also commissioned social marketing work with pregnant women to explore how we can use incentives to increase uptake of services and increase cessation. We are currently working with the National Social Marketing Centre to further develop our approach to social marketing.

What more do we need to do?

Our vision is for Tower Hamlets to be a place where it is hard to start smoking or to use tobacco, easy to give up and where no one is exposed to the harmful effects of second-hand smoke. We have made good progress this year, but it remains the case that we still have a long way to go to realise the potential health benefits in the population that could be achieved through a substantial reduction in the prevalence of tobacco use. Areas where further action is needed include the following;

- Although we have made progress around stopping children and young people from starting to use tobacco, we feel our efforts remain marginal in their impact. Efforts need to be intensified to ensure schools get the basics right in terms of school policies and working with enforcement officers around underage sales.

- We have had success meeting our smoking cessation targets. However, as commissioners we need to continue to ensure the effectiveness of existing services in term of delivery of long term quits and equity of use.
- We also need to extend our services to new settings and target groups. This year we are making further investments to increase the provision of stop tobacco services in workplace settings and to people with mental health problems.
- Smoking cessation needs to be systematically embedded into acute, primary care and social care settings to ensure that frontline providers take every opportunity to promote awareness of the health impacts of smoking and signpost people to services. We will be working closely with providers to make significant progress in these settings this year.
- If they are to be effective, stop tobacco services need to be developed in partnership with the community. Although we have done some work on engaging with the public and community groups, we need to do this more systematically in order to understand what will work locally and how we can improve our services.
- Evaluation and monitoring of progress of the strategy against its objectives needs to be strengthened. In addition, we need to bring in

Tobacco

research expertise from local academic units to address some of the knowledge gaps we have identified in implementation of the strategy. We have therefore added an intelligence, research and evaluation workstream to the strategy.

- There are some areas where we need to know more in order to develop effective action plans. These include contraband/counterfeit tobacco, sheesha (water pipe smoking) and the use of oral tobacco in paan and we will be taking forward work to find out more around these issues and identify actions that will have an impact locally.
- Finally, the Tobacco Control Alliance has become a powerful coalition for concerted action to reduce the prevalence of tobacco use in the borough. We need to continue to expand and strengthen the alliance in order to harness the evident commitment within the borough to help people to stop smoking and to improve health for the next generation.



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“One phone call got me the help I needed to stop smoking”

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Tower Hamlets
Time for Health

SMOKEFREE
TOWER HAMLETS

NHS/TH/2015



Healthy weight, healthy lives

“Our long-term vision for the future is that Tower Hamlets will be a place that promotes and supports health and well-being, providing opportunities for people from all sections of the community to be physically active, eat well and maintain a healthy weight throughout their lives.”

Healthy weight, healthy lives in Tower Hamlets, 2008–12¹¹

Snapshot of healthy eating, physical activity and obesity in Tower Hamlets

- There are estimated to be around 35-40,000 adults in Tower Hamlets who are obese.
- In 2007-08, 13.7% of Tower Hamlets children aged 4-5 (fourth highest in London) and 24.4% of those aged 10-11 (fifth highest in London) were obese. This compared to 10.9% and 21.6% respectively in London.
- In 2008, a significantly lower proportion of children in Tower Hamlets (55%) reported participating in sports or other physically active events on three or more days a week compared to the country as a whole (71%).
- In 2008, 7% of Tower Hamlets children in years 6, 8 and 10 reported eating no daily portions of fruit and vegetables compared to 4% nationally and only 15% ate five or more portions a day compared to 23% nationally.
- A recent mapping study of fast food outlets in Tower Hamlets identified that there were 42 fast food outlets per school in Tower Hamlets compared to 25 in Inner London. Analysis of the dietary content of a range of fast foods indicated not only high levels of saturated fats, but also salt and trans fats in most meals.
- The National Active People Survey 2008 found that 17.7% of adults resident in the borough reported participation in sport/active recreation for a minimum of 30 minutes three times per week compared to 21% nationally (London rates varied from 29.8% to 14.5%).
- It is estimated that seven out of ten adults in Tower Hamlets eat less than five fruit and vegetables a day.
- Assessment of the prevalence of lifestyles factors is limited by the lack of direct survey data and so we have commissioned an adult healthy lifestyles survey for 2009 to gather data on the prevalence of lifestyles factors.



Introduction

Over the past year, there has been increasing urgency at the national policy level on tackling obesity. Prevalence of obesity has been increasing alarmingly over the past decade in both children and adults and there are no signs of a decrease. The Wanless Report in 2004¹² warned of the impacts of this trend, both in terms of health and the cost to the NHS. It is worrying that based on current trends, today's children could have a shorter life expectancy than their parents.

In this context, two national documents are very welcome. The Foresight report *Tackling Obesity: Future Choices* published in 2007,¹³ provided evidence that only a comprehensive long-term strategy will have an impact on the rising trends of obesity and overweight. It challenged the previous policy emphasis on individual responsibility and choice and argued that the only scenario in which current trends can be slowed is through a strong emphasis on prevention and 'building in' health to everyday life.

Reflecting this approach, the government launched *Healthy weight, healthy lives: A cross-government strategy for England* in January 2008.¹⁴ This national strategy acknowledges that the causes of obesity lie both within the wider

environment and people's lifestyles. Tackling obesity therefore requires cross-cutting changes to our society, from increasing everyday activity through the design of the built environment and transport systems, to shifting the drivers of the food chain and consumer purchasing patterns to favour healthier choices.

In Tower Hamlets, we fully endorse this approach and have developed our own *Healthy weight, healthy lives* strategy based on the national strategy as well as local considerations. This chapter sets out why obesity is a problem, what we know about obesity in Tower Hamlets, what we are doing and what more needs to be done.

Healthy weight, healthy lives

Why is obesity a problem?

Obesity is associated with lower life expectancy and is estimated to be responsible for more than 9,000 premature deaths each year in England. It is a major risk factor for cardiovascular disease and is associated with high blood pressure, high cholesterol and diabetes. An increase of one unit of body mass index (BMI) has been associated with a 12 per cent increase in the risk of hypertension. The increasing prevalence of diabetes in the population has been linked directly with the rise in obesity.

Obesity has also been linked with some common cancers including breast and colon cancer. Low physical activity has also been associated with colon cancer and possibly lung and breast cancer. It has therefore been recommended that physical activity should be part of any comprehensive cancer prevention strategy. Poor diet (low fruit and vegetable intake, high saturated fat) is thought to be responsible for about a third of cancers.

Obesity is also associated with osteoarthritis (particularly knee arthritis). In pregnancy, obesity is associated with increased risks for both mother and baby. Obese people are also more likely to suffer from social and psychological problems such as low self esteem, depression, discrimination and stigmatisation. Severe obesity is a risk factor for reduced life expectancy in itself as well as through its association with other diseases.

The economic impacts of obesity are considerable. It is estimated that the cost of obesity to the NHS is approximately £1 billion per year with an additional £2.3 - £2.6 billion per year to the economy as a whole. By 2010 it is estimated that the cost to the economy could rise to £3.6 billion per year.

What do we know about obesity in Tower Hamlets?

We know that obesity in children is particularly high in Tower Hamlets than elsewhere. Results from the National Child Measurement Programme in the academic year 2007-08 showed that 13.7% of Tower Hamlets children in reception year (ages 4-5) and 24.5% in year 6 (ages 10-11) were obese. This is higher than the comparative rates for London (10.9% and 21.6%) and England (9.6% and 18.3%). Tower Hamlets had the fourth highest reception year rate and the fifth highest year 6 rate in London. Compared to 2006-07, the prevalence of obesity had dropped slightly in reception year (by 0.9%) but increased in year 6 (by 1.5%).

Results from the 2008 Ofsted TellUs 3 survey are consistent with high levels of obesity. In the 2007-08, 14% of Tower Hamlets children in years 6, 8 and 10 reported eating five or more daily portions of fruit and vegetables compared to 23% nationally.⁸ The picture with physical activity was similar. A lower proportion of children in the borough reported being active for 30 minutes per day for 6-7 days in the last week (27%) compared to the England average (36%).

Table 3: Obesity by ethnicity - reception year and year 6

Ethnicity	Reception year (% obese)	Year 6 (% obese)
Bangladeshi	13%	23%
White	14%	25%
Black African	18%	30%
Black Caribbean	27%	29%

Source: National Child Measurement Programme 2007–08

The data also showed some differences in levels of obesity by ethnic group (table 3). In general, obesity rates tended to be lowest in Bangladeshi groups and highest in Black African and Black Caribbean groups in both reception year and year 6.

Our data on obesity in adults is more limited although we will know more on completion of our healthy lifestyles survey later this year. Currently our best source of data is that collected on GP databases although in 2007–08 only 43% of adults have had their body mass index recorded in the last 15 months and 15,000 were identified as clinically obese. Estimates based on the demographic and socio-economic characteristics of the population suggest that around 20% of the Tower Hamlets population are likely to be obese which equates to about 40,000 obese adults, suggesting significant under diagnosis. Similar methods estimate that seven out of ten adults eat less than the recommended five fruit and vegetables a day.

The National Active People Survey 2008 found that 17.7% of adults resident in the borough reported participation in sport/active recreation for a minimum of 30 minutes three times per week compared to 21% nationally (London rates varied from 29.8% to 14.5%).¹⁵ Within the borough, participation rates are influenced by gender, ethnicity and deprivation. Rates are particularly low among women and those described as ‘non-white’ (figures 7 and 8), but are higher in the more affluent areas along the border with the river Thames and in the north east of the borough.

Healthy weight, healthy lives

Figure 7: Proportion of adults reporting participation in any sporting activity for a minimum of 30 minutes three times per week, comparison by ethnicity

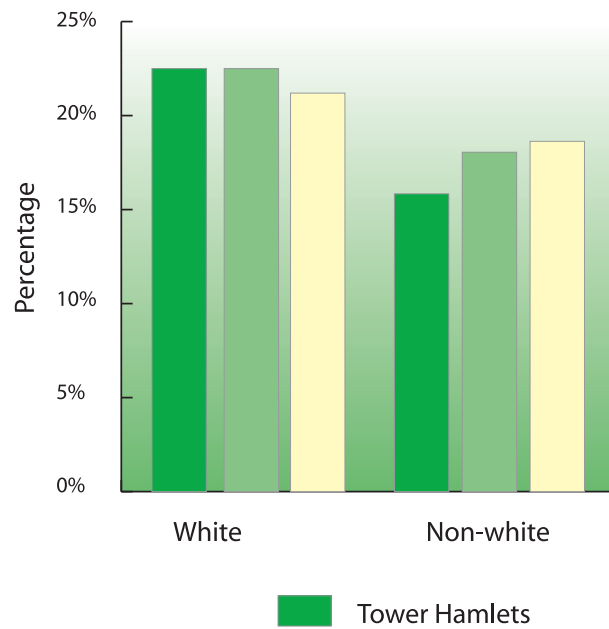
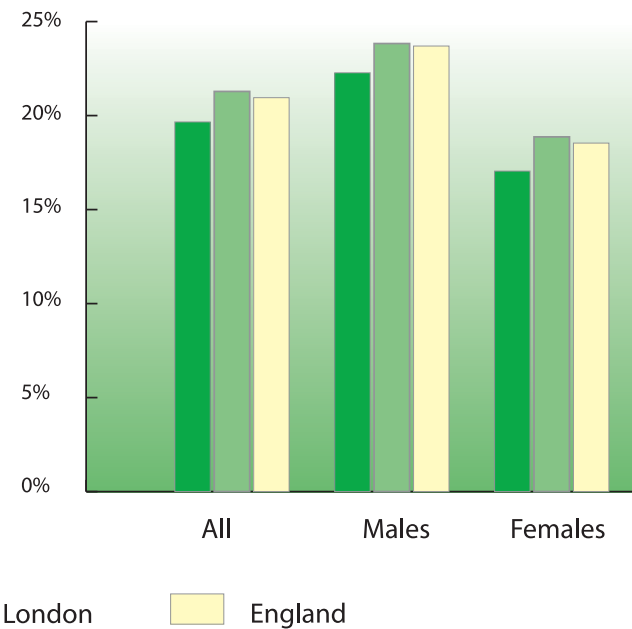


Figure 8: Proportion of adults reporting participation in any sporting activity for a minimum of 30 minutes three times per week, comparison by gender



Source: National Active People Survey, 2008

Chapter 3

Food mapping

One of the striking aspects of Tower Hamlets that is apparent to any visitor is the volume of fast food outlets in the borough. This has been a recurrent source of concern as it is intuitively apparent that the easy availability of cheap food that is high in fat content and low in nutritional content is a risk factor for obesity (particularly in young people). In order to begin to understand this issue further, we have conducted a systematic mapping of local fast food outlets. This study has two main strands: the first mapped fast food outlets in relation to their proximity to schools and their impact on children's food choices and dietary health. The second strand examined the wider influences of fast food outlets on food choice and the family.

The study confirmed the particularly high density of fast food outlets in the borough with a ratio of 42 fast food outlets per school in Tower Hamlets compared to 25 in inner London. The mapping also showed that the outlets tended to be located in areas of higher deprivation. Not unexpectedly, many lacked healthy options and nutrition information. The study also revealed that 97% of households are within a ten minute walk of a fast food outlet. However, 98% of households are also within a ten minute walk of a food retailer of some description. This makes the case for working

more closely with local businesses to increase the availability of healthy food options.

Part of the study involved an analysis of the calorie content of the fast food eaten by children. It indicated that a single meal from a fast food outlet contributed between 400-700 calories of that day's caloric intake. Many of the children ate fast food two or three times a week. For a typical 14 year old girl with an estimated average daily energy requirement of 1,845 calories, this would mean that between 22% and 38% of her daily requirement came from fast food. Table 4 provides further detail on the composition of different types of fast food sampled and highlights not only the high fat content of fast food meals but also the high levels of salt and trans fats in some of the meals. Trans fats are man-made fats that have been particularly implicated in raising cholesterol and therefore increasing the risk of cardiovascular disease.

What emerged from the study was a deeper understanding of the environmental context in which our obesity rates are set, and a sense of the enormity of the work that we need to do to meet our childhood obesity targets.

Based on the findings of the mapping study of fast food outlets, we are taking a number of steps including working with Environmental Health

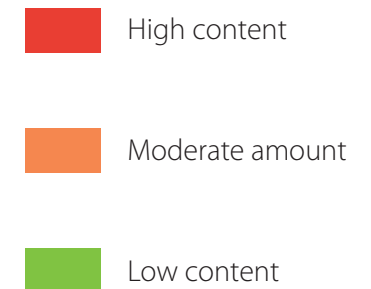
Officers to incorporate assessment, advice and referral on offering healthier food options and business advice for doing this; an award scheme for healthy food outlets; and working with an existing business advisory service to increase provision of healthy food outlets e.g. through support for social enterprise such as food co-ops.



Healthy weight, healthy lives

Table 4: Composition of different types of fast food

Type of takeaway	Samples taken	Signposts			
		Fat	Saturated Fat	Salt	Trans fats
Pizza bar	1. A small pizza with meat topping	Moderate amount	High content	Moderate amount	present
Fish and chip bar	2. A portion of chips from the fish and chip shop	High content	High content	Low content	present
	3. A portion of chicken	Moderate amount	Moderate amount	High content	present
	4. A small portion of fried fish	High content	High content	Low content	present
	5. A pie (medium)	High content	High content	Moderate amount	present
	6. A vegetable chow mein	Moderate amount	Low content	High content	present
Chinese takeaway and fish and chip shop	7. A chicken chow mein	High content	Low content	High content	present
	8. A portion of egg fried rice	High content	Low content	High content	present
	9. A portion of boiled rice	Low content	Low content	Low content	absent
Kebab house	10. A small shish kebab	Moderate amount	Moderate amount	Moderate amount	present
	11. A small doner kebab	High content	High content	High content	present
	12. Chicken curry	High content	Low content	High content	absent
	13. Meat curry	High content	High content	High content	present
	14. A portion of boiled rice	Low content	Low content	Low content	absent
Fried chicken takeaway	15. A portion of chips	High content	High content	Low content	present
	16. A 2 wing portion of fried chicken	Moderate amount	Moderate amount	Moderate amount	present
	17. A small burger	Moderate amount	Moderate amount	Moderate amount	present
	18. A small cheese burger	Moderate amount	Moderate amount	Moderate amount	present
	19. A vegetable burger	Moderate amount	Moderate amount	Moderate amount	present



What are we doing?

“The primary focus of our local strategy is on the prevention of overweight and obesity and promoting the maintenance of a healthy body weight. It is only by prioritising prevention that we stand any chance of reversing the current rise in obesity in the long term.”

Launched in 2008, the Healthy weight, healthy lives in Tower Hamlets strategy provides the foundation for our work across the partnership to tackle overweight and obesity in the borough.¹¹ The strategy mirrors the approach of the national strategy through its primary focus on prevention of overweight and obesity and prioritisation of children and early identification of families at high risk.

The overarching objective of the strategy is to contribute to the national target to reduce the rate of increase in obesity in children under 11 (for Tower Hamlets this means preventing the prevalence of obesity rising above 15.3% in reception year and 23.7% in year 6 by 2010) and it sets seven strategic objectives around:

- securing high level commitment from the partnership
- involving the community in developing and implementing the strategy
- creating the social, cultural and physical environments to support active lives

- promotion of healthy eating through increasing access to healthy food choices and reducing the availability of unhealthy foods
- creating healthy organisations
- providing evidence-based education and advice to maintain a healthy weight
- providing support for people who are overweight or obese.

Underpinning the delivery of the strategy is the recognition that it only stands a chance of success with the active involvement and commitment of all members of the Tower Hamlets partnership.

The strategy is in its second year of implementation. However, there has been considerable investment this year in initiatives and some of these are outlined below. Further information is available in the strategy document.

Healthy weight, healthy lives



“Fruit juice is one of our 5 A Day”

Call the Health Hotline on 020 7364 5016 for more information on healthy lifestyles

change 4life
Great. Realistic. Lifelong.

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NHS
Tower Hamlets

Chapter 3

Early years

The factors linked with high obesity prevalence in Tower Hamlets in 4-5 year olds are likely to be obesity in parents, lack of breastfeeding, poor weaning, poor diet and low physical activity. A set of new and existing initiatives has been developed or strengthened this year to address these issues.

The Baby Friendly Initiative (BFI) is a WHO framework around changing the culture and environment across PCT providers, children's centres and acute trusts to ensure that breastfeeding is the norm. We have implemented this locally and it is progressing well. Currently 80% of community staff are trained in this approach.

Cook 4 Life provides cook and eat sessions to increase the knowledge, skills and confidence of parents with children aged 0-4 years to provide a healthy diet for their families. The courses are delivered in community settings and particularly target children and families at greater risk of exclusion and poor outcomes. The programme is currently running and we expect at least 140 parents to access the sessions over the next year.

Active play and healthy eating courses enable families with children to build regular active play and healthy eating into their lives. They take a holistic approach that includes active play and resources to enable parents to provide active play

for their children at home; supported access to local venues where families can enjoy active play; and parent and carer training to enable families to eat healthy diets. We aim to engage 50 families a year in structured programmes as well as 1,000 families through outreach work.

One new element of the Activ8 programme described in further detail below is to intervene before birth. A programme of work has been

developed between the Active8 team and maternity services to identify overweight or obese parents and intervene in the ante-natal and post-natal period to address obesity in parents and prevent obesity in the infant. This has been scoped and an action plan has been developed.



Healthy weight, healthy lives

Children and young people

There is a wide range of work that is being taken forward to increase physical activity and to support healthy eating in children and young people. This ranges from environmental interventions to promote cycling and walking, schools-based activities, work in community settings such as youth clubs, work with parents and families and specific treatment services for children and young people who are obese.

The National Healthy Schools Programme is an important driver for increasing physical activity and promoting healthy eating in school settings. This year, priorities have included implementation of physical activity policies in line with curriculum guidance and also to improve school meal environment through training in schools.

Another focus this year has been to build physical activity into children and young people's lives through cycling. The Bike It programme is delivered with Sustrans to encourage children and young people to cycle to school through a range of cycling promotion, training and cycle storage initiatives. It is currently being rolled out to three secondary schools and nine primary schools.

Another exciting initiative this year has been the commissioning of 11 community-based organisations to prevent and tackle obesity

in families and children. This has provided the foundation for a diverse range of innovative projects. Hoops 4 Health encourages participation in basketball for young people and aims to access 1,000 participants over six months. Row East London project aims to involve over 4,000 young people in indoor rowing. Other projects have addressed healthy eating and food availability e.g. through expansion of food co-ops.

Finally, services for children and young people who are obese have been strengthened and developed this year.

The Activ8 programme is a service based in Barts and the London that incorporates physiotherapy, nutrition and dietetic services that provides one-to-one and group treatment in 0-19 year olds and their families who are overweight and obese. It also provides training on obesity for frontline staff. 312 children and young people were seen in 2007-08 and a recent audit of a sample of these demonstrated a reduction of body mass index in 79% of participants. This is an unusually high success rate for such a programme.

BEST (Better Eating, Self-Esteem and Total Health) is another weight management programme that delivers an integrated, holistic ten week intensive weight management programme comprising weekly sports sessions and workshops for children

and their parents. Participants gain skills to manage eating behaviours and knowledge about healthy eating. After the programme children and their families are offered a weekly activity club, monthly newsletter, awards, events and trips, and support.



Chapter 3

Adults

“We should never underestimate the value of what the health trainers are achieving. Stopping people smoking, helping people eat more healthily, getting people started on doing more exercise – these are the things that save lives.”

We know that there is a great deal more that we need to do around prevention and management of obesity in adults. There are 15,000 people who are classified as obese on primary care registers and only 43% adults have had their BMI recorded. As discussed previously, the focus of the strategy is on prevention and addressing the ‘obesogenic environment’. However, there is also a need to develop services that maintain healthy weights and support those who are overweight and obese.

Priorities this year have been to develop and expand the work of our community-based health trainers programme, develop an adult obesity care pathway to implement NICE guidelines and commission locality-based, weight management programmes.

It has been a great boost to the Health trainers programme to be provided with mainstream PCT funding (it was previously on Neighbourhood Renewal Funding). Health trainers work with all people in the community to help them make healthier choices and also to signpost them to local services.

Although health trainers is a national programme, the NHS Tower Hamlets health trainers programme is distinctive because it has adopted an innovative community development model commissioned through the voluntary sector. In line with the Tower Hamlets locality structure, four voluntary

sector organisations (one per locality) have been commissioned to employ four full-time equivalent health trainers and a team leader. We have recently commissioned a further organisation to develop health trainers to work with people with mental health problems.

The strength of the community development model means that health trainers employed from the local community have been able to make full use of local networks and partnerships in innovative and creative way to support local people in making healthier choices. This year, the programme will have worked with and supported nearly 3,000 people in different capacities: 400 individuals will have been supported to quit smoking, 2,200 will have been encouraged and supported to participate in healthy lifestyle sessions (healthy eating, physical activity); and 480 people will have had one-to-one sessions with a health trainer, allowing them to set goals and increase their levels of motivation to effect behaviour changes.

For people aged 50 and over, Linkage Plus is another programme delivered through community organisations that provides support and activities around healthy eating and physical activity.

Healthy weight, healthy lives

An important development this year in relation to increasing demand for weight management services has been the introduction of the national vascular check programme which assesses the risk of vascular disease in all 40-74 year olds and provides medical and lifestyle advice for those with a greater than 20% risk of vascular disease over the next ten years. The programme is currently being piloted in four practices in primary care and will be rolled out across all practices from April 2009. The implementation of the programme has highlighted the need for streamlined pathways around referrals to local healthy lifestyles as well as the need for more capacity around weight management programmes.

We have therefore commissioned four weight management programmes (one per locality). In view of the limited evidence base for long-term weight loss for such programmes, we are commissioning them for one year alongside an evaluation assessing and comparing their effectiveness. We expect 1,000 people to access these services in a year.

The workplace is an important setting for providing support for and promoting healthy lifestyle messages around physical activity and healthy eating. We have strengthened existing work this year. The LBTH/THPCT Healthy Workplace initiative has implemented a health and well-being

policy that covers diet, physical activity, mental health and travel plans. In collaboration with East London Business Alliance (ELBA), this scheme will be adapted for implementation in small and medium enterprises.





Healthy environments, healthy organisations, healthy communities – becoming a healthy borough

Our efforts to implement the strategy have received a considerable boost recently following our successful bid to become a 'Healthy Town', one of only nine areas in the country. This builds on and enhances elements of the healthy weight, healthy lives in Tower Hamlets strategy.

Healthy Tower Hamlets is a programme that tackles the environmental conditions that promote obesity in our communities. It takes a whole systems approach, working across three themes: healthy environments, healthy organisations and healthy communities with a specific focus on children and families. The programme is managed by a team based in the Tower Hamlets Partnership that coordinates a broad programme of work across the local authority, PCT, voluntary and private sector. Healthy Tower Hamlets will be at the core of our push to transform Tower Hamlets into a place that promotes and supports health and well-being and makes it easier for children, families and the wider community to be more physically active, eat well and maintain a healthy weight throughout their lives.

Healthy weight, healthy lives

What more do we need to do?

Our long-term vision is that Tower Hamlets is a place that promotes and supports health and wellbeing, providing opportunities for people from all sections of the community to be physically active, eat well and maintain a healthy weight throughout their lives

We are in a time of unprecedented opportunity to make progress on this vision. There is national support for action to address overweight and obesity. We have a robust strategy underpinned by a strong partnership and the Healthy Towns programme has provided us with the opportunity to embed our partnership working even further through concerted action to focus on prevention and to tackle the environmental barriers to maintaining a healthy weight.

However, we have a long way to go. The food mapping study has highlighted the extent of the challenge in trying to make it harder to access unhealthy food in the borough. We recognise that further action is needed in the following areas:

- As a partnership, we need to do everything to explore avenues to make healthy options more available locally and to increase labelling of nutritional content of unhealthy foods.
 - There remains much to do in designing the built environment to support everyday physical activity. NICE guidelines have been developed around physical activity and the environment. We need to work with partners in the local authority to ensure that these are embedded as part of the regeneration work in Tower Hamlets.
 - We have initiated much work this year and we need to take stock of what has been effective. It is important that we evaluate the wider range of interventions we have commissioned using common metrics to enable robust comparison.
 - There is a great deal of work going on in the community and health services around promoting healthy lifestyles. This is encouraging. However, as services are developed at a locality level, it is important that they are integrated into local networks and clinical pathways.
- Primary care and PCT services should link with these resources as they are developed, to provide those at highest risk with opportunities to improve their diet and take more exercise.
 - As pointed out in the tobacco chapter, in order to be effective services need to be developed in partnership with the community. We need to build on the effective work already begun with community groups and the voluntary sector to develop initiatives appropriate to people's lives and delivered in effective ways.
 - Finally, the London 2012 Olympic and Paralympic Games is a major opportunity to inspire more people in Tower Hamlets across all age groups to build regular exercise and healthy eating into their daily lives. Furthermore, it is vital that it leaves a legacy that provides the east London population with affordable access to world-class sports and leisure facilities. We need to ensure that we make the most this opportunity.

Chapter 4: Alcohol



“Our overarching goal is to reduce alcohol-related problems through partnership working to improve the quality of life for the residents of Tower Hamlets, its workers, businesses and visitors.”

Snapshot of drinking in Tower Hamlets

Consumption patterns

Alcohol consumption rates are lower overall in Tower Hamlets than nationally, reflecting the high proportion of people in the population, particularly Muslims, who do not drink.

However, on most borough level measures, alcohol-related harm is above the average for London suggesting particularly high rates of consumption in those groups within the local population who do drink.

Best estimates indicate that there are 27,900 hazardous drinkers and 6,600 dependent drinkers in the 16-64 age groups.

Consumption rates in children and young people are lower than elsewhere: 62% reported never having had an alcoholic drink compared to the national average of 25%.

In 2003-05, the proportion of people in Tower Hamlets who drank above recommended levels (binge drinking and harmful drinking) was higher than the London average.

Alcohol-related hospital admissions

In 2006-07, hospital admissions attributed to alcohol in both men and women in Tower Hamlets were higher than the average for London and England. The rates rose steadily in both groups between 2002 and 2007.

Alcohol-related offences

Although rates of offending fell between 2003 and 2008, the rates of alcohol-related recorded crime and violent crime in 2007-08 were higher than the rates for London and England.

Alcohol-related deaths

In 2006, deaths related to alcohol in Tower Hamlets were higher in men but lower in women compared to London and England.

Introduction

Many people drink alcohol sensibly or within the recommended limit of no more than three to four units per day for men, and no more than two to three units per day for women without problems. But for a growing number of people in England, alcohol consumption is a major cause of ill-health. More than 10 million people (31% of men and 20% of women) now regularly drink above the guidelines set by government.¹⁶

Drinking above sensible levels can be categorised into four levels:

- Binge drinking: eight or more units of alcohol for men, and six or more units of alcohol for women in a single session.
- Hazardous/risky drinking: drinking above recognised 'sensible' levels but not yet experiencing harm (22-50 units per week for men and 15-35 for women)
- Harmful drinking: drinking above 'sensible' levels and experiencing harm to physical and mental health (over 50 units per week for men and over 35 for women).
- Alcohol dependence: drinking above 'sensible' levels and experiencing harm and symptoms of dependence.

These are categories identified by the World Health Organisation and reflected in the Department of Health's alcohol strategies and guidance. They are useful in assessing the level of need in the population and the gap between need and the services provided. Different categories of drinkers will need different types of services or interventions.

Since 2004, there has been a National Alcohol Strategy in place aimed at encouraging a more sensible drinking culture and reducing the burden of alcohol harm.¹⁷ The strategy was updated in 2007 and laid down clear goals and actions to promote sensible drinking and reduce the harm that alcohol can cause.¹⁸ It specifically focused on those who are most affected (young people under 18 who drink, 18-24 year old binge drinkers, and harmful drinkers) and emphasised the effectiveness of early interventions such as 'brief advice' for hazardous and harmful drinkers.

The Tower Hamlets Alcohol Harm Reduction Strategy¹⁹ sets out the direction we intend to take over the next three years and is linked to a number of other partnership plans and strategies including the Improving Health and Well-being Strategy, Regeneration Strategy, Young People's Substance Misuse Plan, Children and Young People's Plan, Adult Drug Treatment Plan and Local Area Partnership (LAP) action plans.

Why is drinking a problem?

When people drink above sensible levels they can cause harm to themselves, their families and communities. The health impacts range from immediate harm from alcohol-related violence, traffic accidents and suicides to longer term impacts such as cirrhosis, mental ill-health, and a greater risk of many cancers and stroke which manifest many years later. Up to 22,000 premature deaths per annum are linked to alcohol misuse. There are other consequences in domestic violence, anti-social behaviour, crime and social exclusion.

Dealing with alcohol-related problems can stretch the resources of the health, social care and criminal justice systems. Alcohol misuse costs the NHS £2.7 billion annually while in the wider economy, an estimated 17 million working days are lost per annum through alcohol-related absence. The cost of lost productivity is £6.4 billion per annum.^{17,20}

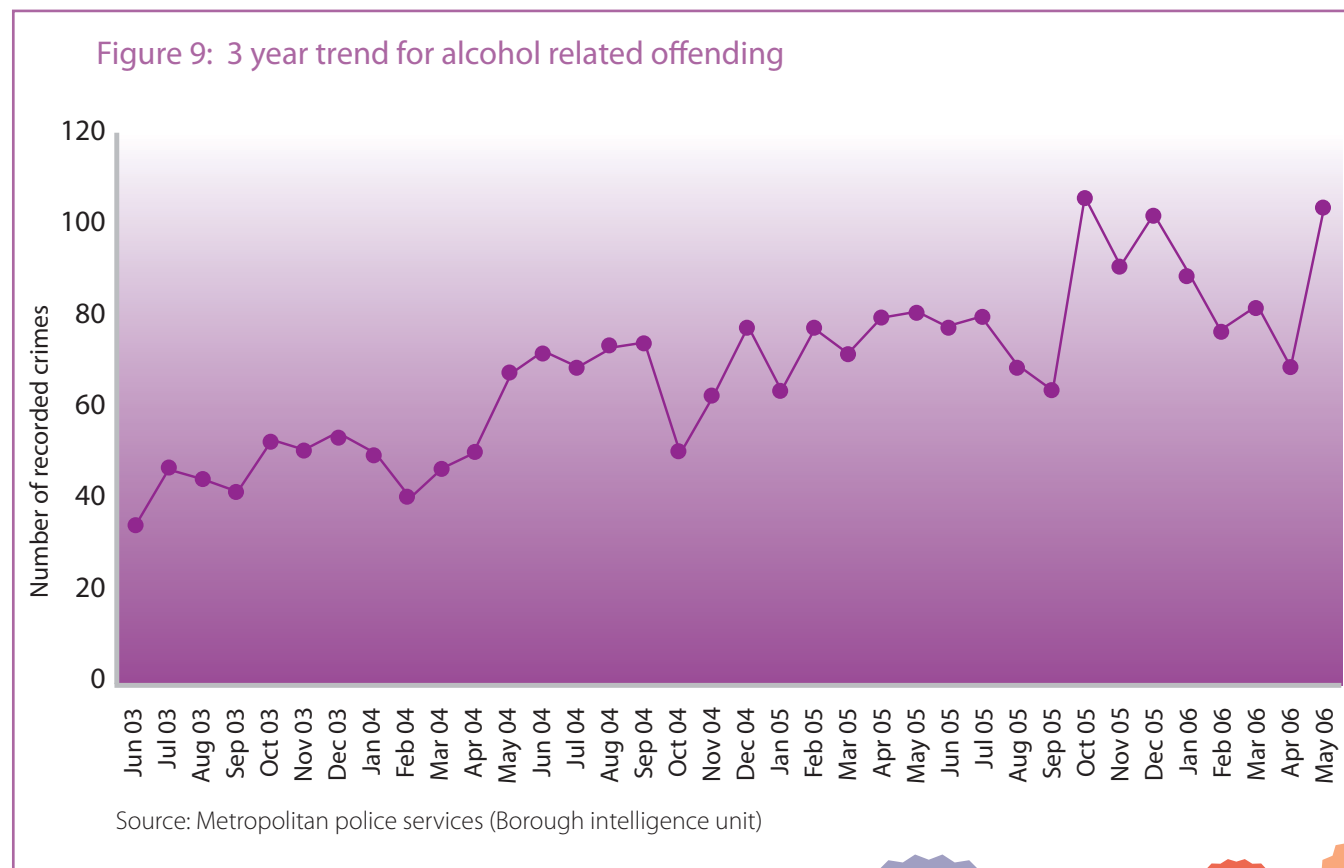
Alcohol

What do we know about alcohol use in Tower Hamlets?

The picture of alcohol use in Tower Hamlets is incomplete because local information is lacking and much of what we know is based on estimates derived from regional or national data. Data from the 2004 Health Survey for England estimated that over a third of the Tower Hamlets population (37%) identified themselves as non-drinkers compared to the national average of 32%.²¹ This is significantly higher than the proportion of non-drinkers in London as a whole and is not unexpected given the demography of Tower Hamlets, notably the high number of Muslims who abstain from alcohol altogether. However, it is worth noting that self-reported alcohol consumption is widely known to underestimate the true level of consumption.

The data indicates that alcohol consumption in the borough varies greatly across the ethnic groups; for instance consumption is significantly below the average for England in Bangladeshi women and significantly higher in east European men. But overall, on most borough level measures of alcohol-related harm such as alcohol-attributable hospital admissions and alcohol-related crime, the rates for Tower Hamlets are significantly worse than London.

The trend over three years between 2003 and 2006 showed that alcohol related offences had risen dramatically (figure 9).



Binge drinking

Binge drinking is usually associated with medium- or long-term harm but its health effects can also be more immediate. The General Household Survey suggests that 12% of men and 5% of women in London reported that they had binged on alcohol in the last week. Binge drinking may also be especially prevalent amongst young people with research suggesting that more than a quarter of 15-16 year olds had binged on alcohol three or more times in the last month.

Hazardous/risky and harmful drinking

The Alcohol Needs Assessment Research Project (ANARP) put the regional prevalence of hazardous/risky drinking at 21%, and the prevalence of alcohol dependency at 5% for adults aged 16-64. Applying these percentages to population figures for Tower Hamlets suggests the borough has 27,900 adult hazardous/risky drinkers and 6,600 adult dependent drinkers in the 16-64 age group.²² This is the best available evidence but is at best an approximation of the true picture in Tower Hamlets.

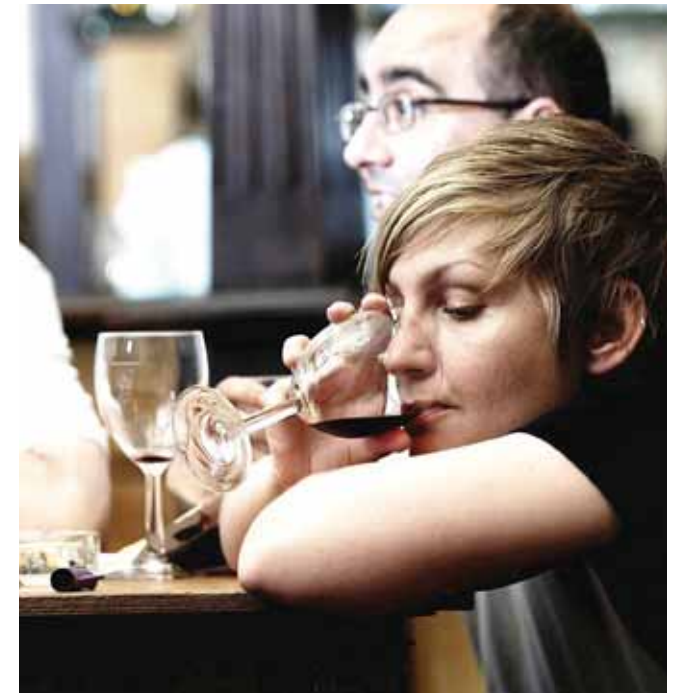
Health impact of alcohol

Of the 1,186 ambulance alcohol-related call-outs in 2006 in Tower Hamlets, the majority were concentrated in Bethnal Green South ward, followed by East India and Lansbury, Whitechapel, Bethnal Green North, Spitalfield and Banglatown and Mile End (figure 10). The highest call-out areas correlate with the hotspot areas for alcohol-related violence identified by police data analysis and represent 3% of total ambulance call-outs.

In 2006–07, hospital admissions attributed to alcohol for men in Tower Hamlets was well above the average for London and England. The rate for women was at par with the regional and national averages (figure 11, page 56). Nevertheless, it is worrying that admission rates for both men and women have risen steadily between 2002–03 and 2006–07.

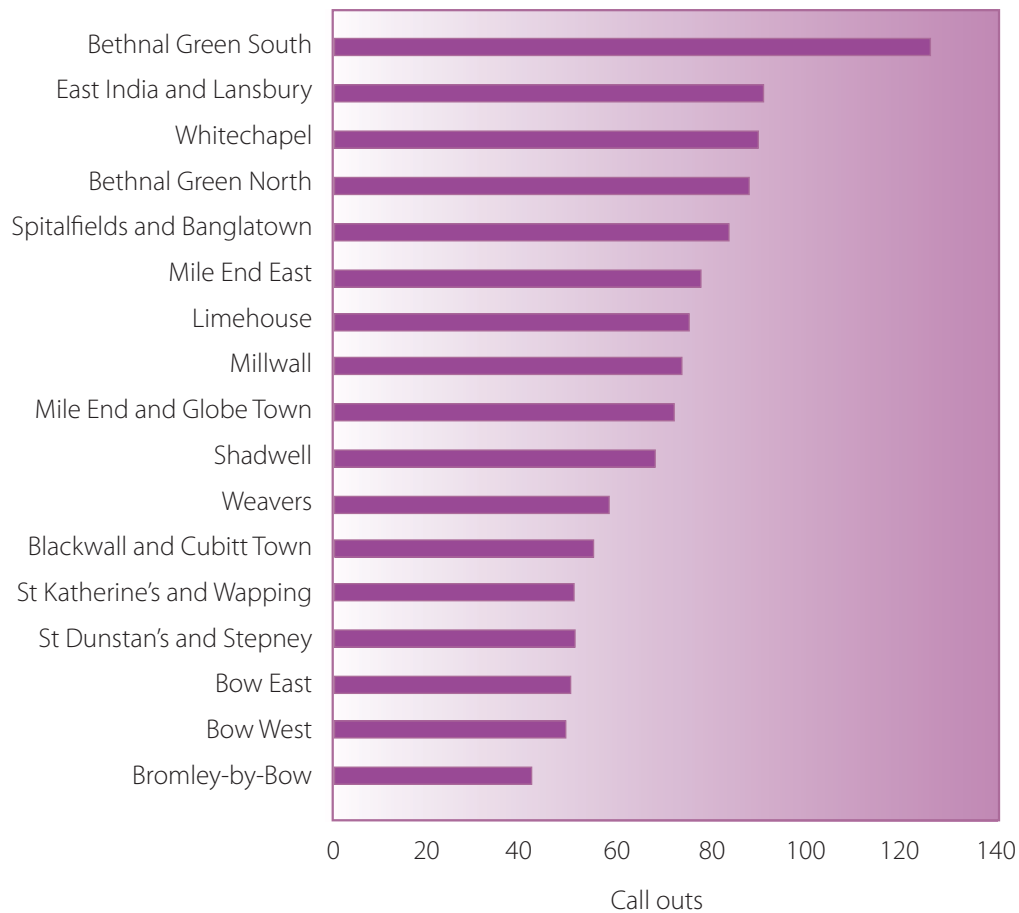
On the national indicator (NI 39) which measures hospital admissions for alcohol-related harm, the rate in Tower Hamlets (1,670.1 per 100,000) was higher than the average for London (1319.6) and England (1384.0).

‘Hidden harm’ is a term coined for those children of parents who misuse alcohol or drugs. These children are more vulnerable to substance misuse, social exclusion and low educational attainment.



Alcohol

Figure 10: Alcohol-related ambulance call outs by ward (Jan 06 to Jan 07)



Source: London Ambulance Service

NHS
Tower Hamlets

“I see more alcohol related attendances in A&E at weekends”

If you would like advice on alcohol speak to your GP, Health Trainer or call the Health Hotline on 020 7364 5016

Tower Hamlets
TIME FOR HEALTH

Alcohol-related offences are another area where the health impact of alcohol can be felt. While it is encouraging to see that between 2003–04 and 2007–08 the rates of alcohol-related offending have steadily fallen, the data for 2007–08 shows that Tower Hamlets still has significantly higher rates of alcohol-related recorded crimes, violent crimes and sexual offences compared to London and England.

Over the period 2003–06, alcohol-related deaths in the borough fell year-on-year in men (but with a rise in 2006). The most recent data for 2006 shows that men in Tower Hamlets have higher rates of alcohol-related deaths than the average for London and England. In women the rate has remained fairly stable over the same period, and in 2006 was lower than the average for London but higher than the England average (figure 12).

Figure 11: Alcohol-related admissions in men and women, 2006–07

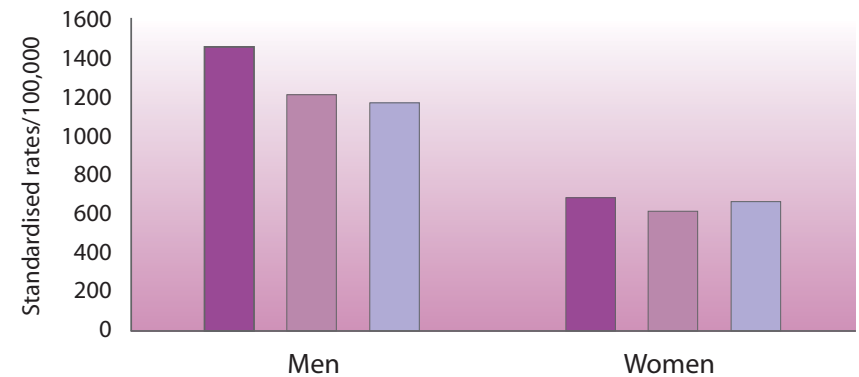


Figure 12: Alcohol-related deaths in men and women, 2006



Source: North West Public Health Observatory (NWPHO).

Alcohol

Homeless and hostels

Alcohol use is often a causal factor in homelessness with two-thirds of people reporting alcohol or drug use as the reason for first becoming homeless.²³ Rates of harmful and dependent use of alcohol, and consumption of alcohol-based products such as alcohol disinfecting hand gels, are also reportedly high amongst the homeless, with 37% of respondents being classed as dependent. The high prevalence of hepatitis and other blood borne viruses within this community exacerbates the damage caused by alcohol.

Alcohol in children

The 2008 TellUs3 survey in Tower Hamlets schools reported significantly lower levels of alcohol use in young people in years 6, 8, 10-11 and 12-13. Only 32% of children reported ever having had an alcoholic drink; less than half the national average of 67%. It is likely that the lower rates reflect the large Muslim population in the borough, but this may at the same time mask higher rates of drinking in other groups. It appears that patterns of alcohol consumption can also change very quickly: in the 2007 TellUs2 survey, the proportion of children who reported ever having an alcoholic drink was 19%,²⁴ representing an increase of 13 percentage points from 2007 to 2008. However, this may partly be due to the different ways in which the questions were asked.

The TellUs3 survey also tells us that there is a need for alcohol education in schools. Compared to the England average of 67%, only 55% of Tower Hamlets children in year 8 and 10 thought that the information and advice they received on alcohol was good enough. The difference is significant and has informed the redesign and restructure of alcohol education delivery in schools.

Community concerns about alcohol use in children are further highlighted by a recent review by the council's Overview and Scrutiny Committee which looked at circumstances that led young people to drink. Recommendations from the review included holding a consultation exercise with young people and using this to inform research to determine true extent of alcohol consumption amongst young people, and alcohol related training and support for staff in mainstream youth services.

Future impact of alcohol in Tower Hamlets

Nationally, alcohol-related harm is expected to increase as alcohol has become comparatively cheaper, consumption has increased in younger age groups especially amongst women, and the impact of long-term elevated consumption in more affluent groups begins to manifest. The current economic downturn is likely to see more people drinking.

An issue specific to Tower Hamlets is cultural adaptation, affecting especially second or third generation young people, born in UK to parents originally from abroad. This may lead to large increases in alcohol-related harm in Tower Hamlets as a population with hitherto low rates of alcohol consumption change their drinking patterns.

The 10,000 strong transient workforce employed on Olympics sites is also likely to contribute to increased alcohol related harm. A proportion of the male workforce will be accommodated in Tower Hamlets with high numbers from eastern European countries. Although it is unlikely that this transient workforce will remain in Tower Hamlets so the long-term health effects may present elsewhere, the health and crime effects of binge drinking will manifest in Tower Hamlets.

What are we doing?

The Tower Hamlets Alcohol Harm Reduction Strategy is patterned on the Models of Care for Alcohol Misuse (MoCAM) framework which is based on guidance and evidence from the Department of Health.²⁵ MoCAM recommends the provision of screening and brief interventions in primary care settings, assessment and referral pathways and the provision of aftercare services for people leaving treatment. Table 5 illustrates what interventions are most appropriate to various levels of problematic drinking.

The framework also emphasises the need for a stepped care approach to treatment with mainstream services (such as GPs and A&E staff) being key to early intervention, screening and onward journey through treatment where necessary. Mainstream services encounter problem drinkers in their day-to-day work and are expected to provide formal and informal screening and subsequent brief interventions to address harmful drinking behaviour.

While a detailed description of all our alcohol services and their activity levels is contained in the strategy document, this report touches on some of the work we are doing, especially around screening and brief interventions, which the evidence base has shown to be among the most effective actions to take for hazardous and harmful drinkers.²⁶

Table 5: Treatment interventions by category of alcohol misuse

Category of misuse	Intervention
Hazardous and harmful drinkers	<ul style="list-style-type: none"> • Brief intervention in primary care settings and custody suites. • Screening in generic setting and treatment services.
Moderately dependent and dependent drinkers	<ul style="list-style-type: none"> • Referral pathways across agencies and tiers of care. • Cognitive behaviour therapy (counselling; one to one and group sessions). • Community detoxification. • Structured day programme. • Care plans. • Aftercare: self help and mutual aid. • Alcoholics Anonymous
Severely dependent drinkers	<ul style="list-style-type: none"> • Residential rehabilitation. • Aftercare.

Alcohol



Screening and brief interventions

People drinking at hazardous or harmful levels can be screened using well-established tools and offered brief interventions to reduce their alcohol consumption, or where appropriate, referred to treatment services. Screening takes place within primary care mainly by GPs, A&E, homelessness services and mental health services.

There are plans to set up a dedicated team of alcohol nurse specialists within the acute hospital sector who will receive referrals from a range of departments, including A&E, for brief advice and support for patients whose attendance or admission is deemed to be related to alcohol. Patients will be managed in the longer term by the community alcohol service.

For children and young people, LBTH provides support for generic services which work with a wide range of clients including alcohol misusers and support alcohol education within primary and/or secondary schools. Ad hoc screening and diagnosis of children with alcohol problems is undertaken by Youth Offending Teams, schools and youth workers. Treatment is undertaken mainly through the LifeLine agency and CAMHS Specialist Substance Misuse Service (CSSS).

Treatment and rehabilitation

A range of treatment and rehabilitation services are currently being delivered including specialist units within homeless hostels and the Drug and Alcohol Service for London (DASL) which provides both advice on reducing drinking and treatment plans. The Specialist Addiction Unit (SAU) provides specialist secondary care to people in Tower Hamlets with complex drug-related problems and those requiring specialist interventions; such as multiple or chaotic drug users, pregnant drug users, those with complex physical health needs and users with mental health problems. The last group are categorised as dual diagnosis (a term that describes people who have both a mental disorder and an alcohol or drug problem).

The SAU provides a range of services including tailored care packages that offer one to one support and advice, counselling, opiate substitute therapy in maintenance and community detoxification, relapse prevention, harm minimisation, occupational therapy assessment and psychological therapies.



NHS
Tower Hamlets

“As a GP I see problems from heavy drinking affecting everyone, not just the person who drinks”

If you would like advice on alcohol speak to your GP, Health Trainer or call the Health Hotline on 020 7364 5016



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What more do we need to do?

The prevention and treatment of alcohol related harm in Tower Hamlets not only assists in reducing health inequalities but is also highly cost-effective. The prioritisation and implementation of the alcohol strategy will require new investment to ensure provision of new services e.g. primary prevention, but also expansion and re-provision of existing services. Action to address wider issues also has an important role to play in reducing alcohol-related harm.

Our commissioning intentions are aimed at strengthening current services and addressing the main gaps in provision. As with our tobacco and obesity services, we recognise that effective action will depend on strong partnership working. Over the next year our priorities are:

- To develop an extensive social marketing campaign on alcohol which will have a main focus on adults and a minor focus on young people. It will aim at reducing A&E alcohol related attendances, underage purchases of alcohol and problem drinking in older people.
- To improve alcohol education for all children as part of the Personal, Social and Health Education (PSHE), Sex and Relationship Education (SRE), Science and Citizenship requirements of the national curriculum. A dedicated alcohol worker

in schools will take a strategic focus in driving this.

- There will be coordinated multi-agency working to deliver more interventions to targeted groups at known hotspots within the borough based on police data analysis of ambulance call-outs.
- To expand the range of settings in which alcohol screening and brief interventions are delivered.
- To organise training for workers in alcohol treatment agencies.
- To run coordinated awareness campaigns during specific celebration periods such as Eid, Christmas, and summer festivals.
- Alongside these, we will work to further develop an alcohol licensing policy.
- There is huge potential in primary care to identify unhealthy use of alcohol and undertake brief interventions, and we will drive this through the planned locally enhanced service (LES).

Some of the anticipated outcomes from these services will include reducing admittances and re-attendances at A&E; increasing engagement with community alcohol services; and identifying alternative treatment pathways for alcohol-related emergency admissions.

Details of some of these services are contained in strategic documents such as the Alcohol Harm Reduction Strategy and the Alcohol-related Violence 2009-10 Action Plan which is presently being finalised. While keeping screening and brief interventions at the heart of our strategy, and building on current services, we intend to continue to work hard to address alcohol availability, illegal alcohol sales, street drinking, crime, violence and disorder associated with alcohol as part of the implementation of the joint strategy through partnership work with licensing and criminal justice.

Conclusion



Conclusion

In summary, this report has focussed on the impacts of three major risk factors for health. We have been tackling tobacco use for many years now in Tower Hamlets and have made some progress. However, it is clear that our efforts to address this need to be as strong and focussed as ever. In relation to obesity, our work is at an earlier stage and this is in part due to the complexity of the issue. Finally, alcohol is an increasing problem which has hitherto received less attention but has both personal and societal health impacts. In all three areas, we have clear strategic vision and strong alliances. It is a time of unprecedented opportunity to make progress on our ambition to make Tower Hamlets a place where it is easy to be healthy.



Acronyms and abbreviations

A&E	Accident and Emergency	LES	Locally enhanced service
ANARP	Alcohol Needs Assessment Research Project	MMR	Measles, Mumps and Rubella
ASSIST	A Stop Smoking in Schools Trial	NEL	North East London
BFI	Baby Friendly Initiative	NHS	National Health Service
BLT	Barts and the London Trust	NICE	National Institute for Health and Clinical Excellence
BMI	Body Mass Index	OFSTED	Office for Standards in Education, Children's Services and Skills
CAMHS	Child and Adolescent Mental Health Service	ONS	Office of National Statistics
CEG	Clinical Effectiveness Group	PCT	Primary care trust
COPD	Chronic Obstructive Pulmonary Disease	PLP	Post London Plan
CSSS	CAMHS Specialist Substance Misuse Service	PSHE	Personal, Social and Health Education
CVD	Cardiovascular disease	SAU	Specialist Addiction Unit
DASL	Drug and Alcohol Service for London	SRE	Sex and Relationship Education
GLA	Greater London Authority	Spearhead PCTs	A group of primary care trusts across the country with the worst health and deprivation indicators
GP	General practitioner	TellUs2	2007 Ofsted survey of children and young people in England
HIV	Human Immunodeficiency Virus	TellUs3	2008 Ofsted survey of children and young people in England
JSNA	Joint strategic needs assessment	THPCT	Tower Hamlets Primary Care Trust (NHS Tower Hamlets)
LAPs	Local Area Partnerships	WHO	World Health Organisation
LBTH	London Borough of Tower Hamlets		

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