Ealing

Joint Strategic Needs Assessment

DEC 2010

FINAL DRAFT

EALING JOINT STRATEGIC NEEDS ASSESSMENT

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Contents

Executive Summary	**2**
Section 1 Background to the JSNA	**6**
Section 2 Population Characteristics and Change	**9**
Understanding our population characteristics	10
Population Characteristics	10
Projected Future Populations	12
Young People	15
Older People	15
Births	21
Ethnicity	21
Migrant Population	28
Disability	29
Section 3 How do we compare with similar local authorities	**38**
Health Outcomes for Ealing compared to similar authorities	39
Life Expectancy	39
All Cause Mortality	40
Circulatory Disease	41
All Cancers	42
Lung Cancer	42
Breast Cancer	43
Chronic Obstructive Pulmonary Disease	43
Stroke	44
Coronary Heart Disease	45
Section 4 Socio-economic Factors	**46**
Understanding Socio-economic factors	47
Index of Multiple Deprivation	47
Overall Index of Multiple Deprivation	48
Overall Income Deprivation	49
Income Deprivation Affecting Older People	49
Income Deprivation Affecting Children	50
Employment Deprivation	50
Health and Disability Deprivation	51
Education, Skills and Training Deprivation	52
Barriers to Housing and Services	53
Crime Deprivation	53
Living Environment	54
Air Quality	54
Housing	55
Employment and Unemployment	57
Fuel Poverty	62
Community Health Profiles	65

Section 5 Life Expectancy **67**
Healthy Life Expectancy 70
Disability-Free Life Expectancy 72
All Cause Mortality 74
Main Causes of Death 75
Mortality From Causes Considered Amenable to Healthcare 77

Section 6 Burden of Ill-Health **80**
Income Inequality and Health Inequality 81
Circulatory Diseases 81
Cancers 85
Chronic Obstructive Pulmonary Disease 87
Stroke 89
Mental Health 92
Infant Mortality 96
Other Lifestyle Factors 99
Risk Taking Behaviours 105
Sexual Health 111

Section 7 Children and Young People **117**
Child Population 118
Birth 119
Infant Mortality 120
Low Birth Weights 120
Under 15 Mortality 122
Dental Health 123
Obesity 124
Mental Health 125
Additional Needs 128
Alcohol and Substance Misuse 130
Teenage Conceptions and Sexual Health 133
Safety 135
Education 142
Poverty 149
Employment and Training 150
Children and Young People Profile 151

Section 8 Social Marketing to Address Health Inequalities **152**

References **i**

Equalities and the JSNA **v**

Executive Summary

EALING JOINT STRATEGIC NEEDS ASSESSMENT

EXECUTIVE SUMMARY

Background

Joint Strategic Needs Assessment (JSNA) is a partnership process to identify and understand the current and future health and well being needs of the local population leading to improved outcomes and reductions in health inequalities. The Local Government and Public Involvement in Health Act placed a duty on upper-tier local authorities and PCTs to undertake JSNA and from 1st April 2008 this became a joint statutory duty for directors of Adult Social Services, Directors of Public Health and Directors of Children and Young People's Services.

Ealing JSNA

The of the JSNA is to provide clear intelligence on the current and future health and well-being needs of all sectors of the population to inform commissioning plans and strategies. The JSNA is provides an overview of population and health trends, both actual and predicted, and considers the effect these will have on the need for local services, for example maternity services, services for older people, school places, employment opportunities or housing.

Given the complexities of health inequalities, well-being and ill-health, a range of data was analysed to give a picture of Ealing's health needs. For the purposes of this summary they have been grouped together under the following titles;

1. Population Characteristics
2. Social Economic Factors
3. Comparisons with Similar Authorities
4. Early Years and Young People
5. Adulthood
6. Older People
7. Life Expectancy and Diseases

The first three cover topics that are most associated with what Ealing is like as a place and how that impacts on health, well-being and health need. 4 to 6 address the three main life stages and specific issues that impact on those cohorts and title 7 covers life expectancy, disease and main causes of death.

Population Characteristics

According to the ONS the population of Ealing is estimated to have risen from 286,400 in 1994 to approximately 316,600 in 2009.

ONS projections suggest that, by 2020, the population will reach 334,700, with most of the increase due to an anticipated 14.5% rise in the number of people between 0 and 14 years old, closely followed by a 12.0% rise in the numbers of over 65 years of age. The increase in over 85s is expected to be 30.6%. However Ealing Council's estimate show that the population is likely to be 336,308 by 2020.

Population (000s)					
Year	**0-14**	**15-24**	**25-64**	**65+**	**All Ages**
2008	55.8	38.7	182.7	34.9	312.1
2020	63.9	35.1	196.5	39.1	334.7

Source: Office of National Statistics (ONS) 2008-based Sub national population projections

Black and minority ethnic (BME) communities, including individuals of mixed ethnicity, make up approximately 41.1% of the Ealing's total population, this compares to approximately 11.8% of England's population.

Social and Economic Factors

Ealing's economically active population is just above the London percentage (76% compared to 75.8%). The percentage claiming Jobseekers Allowance in Ealing is very similar to the London percentage. Income inequalities in Ealing are significant, with median income ranging from £19,150 annually in Southall Broadway to more than double that in Southfield at £39,651.

The 2010 Community Health Profiles were used to compare 32 health indicators. Ealing scored significantly worse than the England average for indicators such as, Child Poverty, Child Obesity, Tooth Decay in the Under 5s, Alcohol related Hospital Admissions and new cases of Tuberculosis.

The Index of multiple deprivation shows significant areas of deprivation in Southall, Northolt, areas of Acton and small pockets throughout the Borough, particularly in areas of dense social housing.

Comparisons with similar areas

To explore how health outcomes for Ealing compare with other similar local authorities the Office for National Statistics (ONS) area classification was used. A low health outcome score should act as a prompt for organisations to explore the underlying factors more fully and so develop local strategies and action plans to address them.

Health outcomes assessed were life expectancy, all cause mortality, deaths from circulatory disease, cancers, chronic obstructive pulmonary disease, stroke and coronary heart disease. Results showed Ealing in the middle third for both male and female life expectancy and all cause mortality. Ealing has a higher mortality rate for circulatory diseases, breast cancer and coronary heart disease than comparator authorities. This suggests that improvements are possible in life expectancy and all cause mortality, while strategies to combat circulatory diseases, breast cancer and coronary heart disease could be further enhanced.

Early Years and Young People (Age 0 – 17)

Infant mortality has fallen in Ealing, in line with England and Europe as a whole. The rate in Ealing is lower than the average for England but still above than the lowest in London, suggesting that improvement is still possible.

The proportion of mothers who initiate breastfeeding in Ealing is higher than in London. This percentage has remained relatively stable in recent years at around 87%

There are high numbers of under fives with decayed, missing or filled teeth and high proportions of children and young people with active decay or who have experienced decay. Nearly a third of all five year olds surveyed had active decay in Ealing.

Levels of obesity in boys in Ealing are high, above the London and national rates in reception and Year 6. Ealing girls in Year 6 have an obesity rate that is higher than the national rate but just below the London rate.

Ealing's performance in all areas of the Key Stage 1 is better now than in 2006. While there has been improvement over recent years, Ealing's performance does remain below England and London levels. The proportion of pupils in Ealing attaining 5 or more GCSEs at grades A* to C rose in 2008/09 as did the proportion attaining 5 GCSEs at grades A* to G including English and Mathematics. For those achieving 5 or more grades at A* to C, Ealing is above the national average but below the London average.

Nearly a quarter of Ealing's secondary school pupils are eligible for free school meals, above the London percentage and nearly double the national rate.

Northolt West End, Northolt Mandeville, Acton Central and Elthorne have highest numbers of under 18 conception rates, with Northolt West End having one of the highest rates in the country. However under 18 conceptions in the borough as a whole are falling.

Adults aged 18 – 64

76% of Ealing working age population are economically active; the vast majority are employed while just over 11% are self-employed. The mean income in the borough £35,643, below the London mean, and the median income is £29,088, also below the London median. 4.4% are claiming Job Seeker Allowance.

Ealing has a lower percentage of Detached and Semi-detached houses than Outer London and England. Ealing has higher percentages of homeowners, both outright or with a mortgage, than Greater London but lower than the England percentages. Ealing has lower than West London, Greater London and England levels for Social Renting.

Ealing's rate for alcohol related admissions has been rising for several years and is the highest in London. It is now more than double the 2002/03 rate. The effect of excessive alcohol intake on males in Ealing is a loss of nearly 9 months of life. For females the effect is a loss of just over 3 months of life.

Smoking prevalence in Ealing is highest amongst the manual group. Chewing tobacco is more common among South Asians in Ealing than the rest of the general public. The effects of smokeless tobacco are not as well publicised as cigarettes. The number of smoking quitters in Ealing has fallen by over three quarters between 2005/06 and 2008/09

Over the coming years it is anticipated that the population of those aged 18-64 within Ealing suffering from a disability will grow, by between 7% and 12% between now and 2030 across common disabilities.

Older People (aged 65 and over)

Older people population projections show that the total number of people over 65 years will grow by 4,200 between 2008 and 2020. The greatest percentage rise is in the 85 and over age group with a predicted increase of 30.6% or 1,500 people.

The prevalence of dementia increases with age and between 2010 and 2030 there is predicted to be a 39% increase in the number of over 65s suffering from dementia.

There were 6,130 people aged 65 and over who received social care services in 2009/10. Projected population growth would lead to increased demand, potentially rising to 7,458 by 2030. A 29% increase to 4,928 is predicted between 2010 and 2030 in the number of over 65s providing unpaid care. While nearly 13,000 over 65s live alone, it is expected that number will increase to 16,784 by 2030.

Estimates predict that just over 10,700 households in Ealing will be in fuel poverty by 2011. 2006 figures show that the percentage of households in fuel poverty in the borough is slightly higher than the London percentage.

Life Expectancy and Disease

In Ealing, as nationally, there is a long term trend of rising life expectancy for both males and females. Life expectancy is a general measure of health across the life course. Currently male life expectancy is 77.6 years and female is 82.6 years. There are large inequalities, however: there is a 9 year gap between the lowest and highest wards for males And for females the gap is 7 years. Healthy life expectancy at birth for women is nearly three years long than for men in Ealing and at birth females can expected to live disability-free for 2.3 years longer than males.

The top three main causes of death (Circulatory Diseases, Cancers and Respiratory Diseases) are the same for men and women in the borough but the proportions are slightly different.

- Deaths from circulatory diseases are falling in most local authorities however the rate in Ealing remains higher than the national and London rates.

- There is a long term trend of declining mortality from cancers. Survival following diagnosis is worse in England than in most of Europe, however, and there is a need for improvements in detection and care.

- The mortality rate in Ealing for Chronic Obstructive Pulmonary Disease (COPD) which includes bronchitis and emphysema is currently lower than England and London,. There is a long term decline in mortality and this has been slightly higher in Ealing than in London and England as whole.

SECTION 1

Background to the JSNA

Background to Joint Strategic Needs Assessment

In 2006 the DH white paper 'Our Health, Our Care, Our Say – A new direction for community services'[1] set out guidance for improving the health and well-being of the population. Its aims were:

- Better prevention and early intervention for improved health, independence and well-being
- More choice and a stronger voice for individuals and communities
- Tackling inequalities and improving access to services
- More support for people with long term needs

Later that year the local government white paper, 'Strong and Prosperous Communities'[2], outlined a vision of responsive services and empowered communities. The Commissioning Framework for Health and Well-being DH 2007 built on the reforms and identified eight steps to effective commissioning for health and social care:

- Putting people at the centre of commissioning
- Understanding the needs of populations and individuals
- Sharing and using information more effectively
- Assuring high quality providers for all services
- Recognising the interdependence between work, health and well-being
- Developing incentives for commissioning for health and well-being
- Making it happen – local accountability
- Making it happen – capability and leadership

In 2007 the Local Government and Public Involvement in Health Act,[3] placed a duty on upper-tier local authorities and PCTs to undertake **Joint Strategic Needs Assessment (JSNA).**

JSNA is defined as a process to identify and understand the current and future health and well being needs of the local population leading to improved outcomes and reductions in health inequalities. It takes into account existing services and evidence of effectiveness, and informs the strategic direction of service commissioning and delivery. It is a partnership duty which involves a range of statutory and non-statutory partners, informing commissioning and the development of appropriate, sustainable and effective services.

From 1st April 2008 JSNA became a statutory duty for directors of Adult Social Services, Public Health and Children and Young People's Services.

The need for a JSNA is further illustrated in the 2010 DH white paper 'Equity and excellence: Liberating the NHS' as its aims is to put patients at the heart of the NHS, through an information revolution and greater choice and control and to achieve world-class healthcare outcomes through commissioning services that are focused on outcomes and the quality.

The Ealing JSNA

Representatives from London Borough of Ealing Council, NHS Ealing, Children and Families, Adult Social Care and Ealing's Voluntary Sector agreed an approach to the development of an Ealing-wide Strategic Needs Assessment. It was agreed that the Ealing JSNA would be a live document based on an agreed data set that would be detailed enough to be analysed at a ward or borough-wide level.

A JSNA for Ealing

The following chapters provide the JSNA for Ealing. In drawing the document together the aim has been to provide clear intelligence on the health and well-being needs of all sectors of the population, based on analysis of available data. In particular this JSNA will be used to inform: NHS Ealing's Strategy Plan, Children's Young People Plan, Adults Integrated Commissioning Strategy, Ealing Hospital Trust Commissioning Plan, Housing Strategy, Crime Prevention Strategy and Work and Skills Plan.

SECTION 2

Population Characteristics and Change

UNDERSTANDING OUR POPULATION CHARACTERISTICS

- Increases or decreases in the number of people living in an area, or changes in the age make-up of the population in an area, can impact on the need for specific services, for example maternity, children, or services for older peple.

- Particular sub-groups of the population have a higher prevalence of certain conditions and increases in these groups may lead to an increased need and demand for care and support.

- Changes in patterns of inward migration can lead to an increase in previously uncommon conditions. Services must to be ready and able to respond as required.

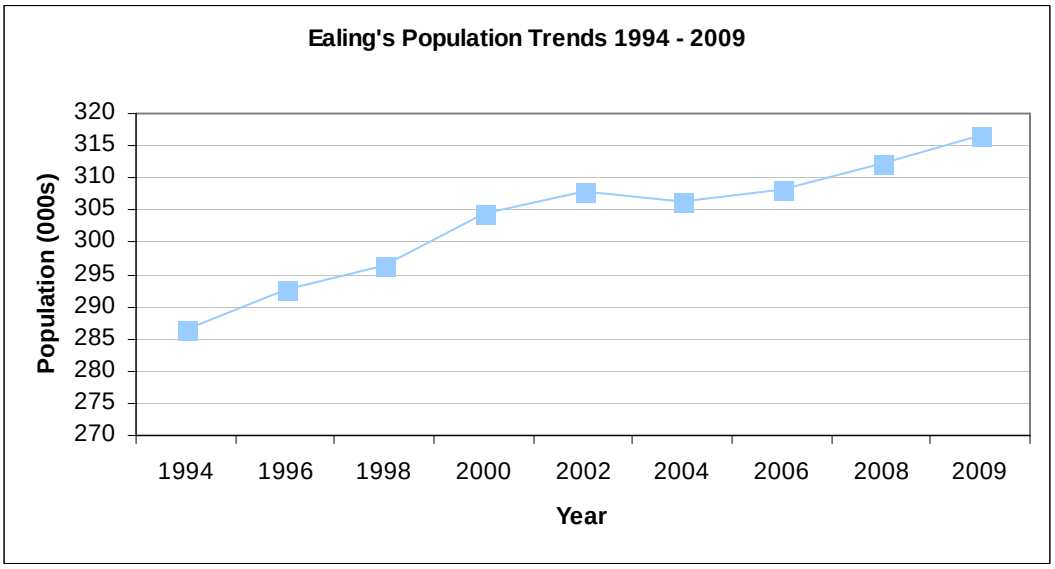
- Numbers of transient migrant workers from different countries can increase considerably with changes in legislation. The age profile of the workers will determine where the main impact will be on service demand.

- Expansion of higher education establishments can lead to a rapid increase in term-time student populations from within the UK and overseas. This can produce term-time surges in demand.

POPULATION CHARACTERISTICS

The population of Ealing has risen from 286,400 in 1994 to approximately 316,600 in 2009 according to Office of National Statistics (ONS) published mid year estimates (Figure 2.1)

Figure 2.1 Ealing Population Trends 1994 - 2009



Source: Office for National Statistics (ONS)

In line with the overall London picture, Ealing's under 15 population has increased slightly (1.0%) from 59,900 in 1994 to 60,500 in 2009 (Table 2.2). Nationally, however, the population this age group has fallen by 2.5% over the same period.

The working age population (males aged 16-64, females aged 16-59) in Ealing has risen by 16% to 214,300, this is broadly in line with increases seen in London and in the country. The increase between 1994 and 2009 is more marked in London overall (18.5%) than in the country (9.1%).

In England, the number of older people (males aged 65+, females aged 60+) rose by 13.1% from 1994 to 2009. During the same time, however, the number of older people fell in London by 2.3% and only rose in Ealing by 0.2% to 41,900.

Table 2.2 Trends in Population Estimates Mid 1994 – Mid 2009

Ealing

Population (000s)			
Year	**0-15**	**16-64M/16-59F**	**65+M/60+F**
1994	59.9	184.7	41.8
1996	61.2	190.2	41.4
1998	61.8	193.4	41.1
2000	60.7	202.8	40.9
2002	58.8	208.5	40.6
2004	57.7	208.3	40.4
2006	57.6	210.3	40.4
2008	59.1	211.8	41.3
2009	60.5	214.3	41.9
Change 1994 - 2009			
Number	0.6	29.6	0.1
Percentage	1.0	16.0	0.2

London

Population (000s)			
Year	**0-15**	**16-64M/16-59F**	**65+M/60+F**
1994	1405.0	4378.6	1090.0
1996	1439.5	4461.7	1073.3
1998	1465.4	4540.0	1060.1
2000	1462.9	4725.8	1048.0
2002	1445.6	4884.3	1038.9
2004	1436.1	4943.6	1033.3
2006	1444.2	5069.0	1033.3
2008	1472.8	5144.1	1051.5
2009	1498.7	5189.8	1065.0
Change 1994 - 2009			
Number	93.7	811.2	-25.0
Percentage	6.7	18.5	-2.3

England

Population (000s)			
Year	**0-15**	**16-64M/16-59F**	**65+M/60+F**
1994	9950.6	29418.1	8860.1
1996	9985.3	29638.7	8895.1
1998	10002.8	29868.1	8949.7
2000	9980.1	30242.7	9010.4
2002	9853.6	30685.3	9110.2
2004	9751.0	31085.3	9273.4
2006	9670.1	31631.2	9462.6
2008	9666.3	31956.2	9842.1
2009	9704.4	32083.3	10022.0
Change 1994 - 2009			
Number	-246.2	2665.2	1161.9
Percentage	-2.5	9.1	13.1

Source: Office for National Statistics 2010

The fertility rate measures the number of live births from women 11 and over in the calendar year divided by the population of women aged 15 to 44. The fertility rate in Ealing currently stands at 2.14 which is higher than London and England rates

Table 2.3 Fertility Rates in Ealing

	2004	**2005**	**2006**	**2007**	**2008**
Ealing	1.86	1.93	1.94	2.09	2.14
London	1.76	1.77	1.86	1.92	1.95
England	1.78	1.79	1.85	1.91	1.97

Source: National Centre for Health Outcomes Development 2009

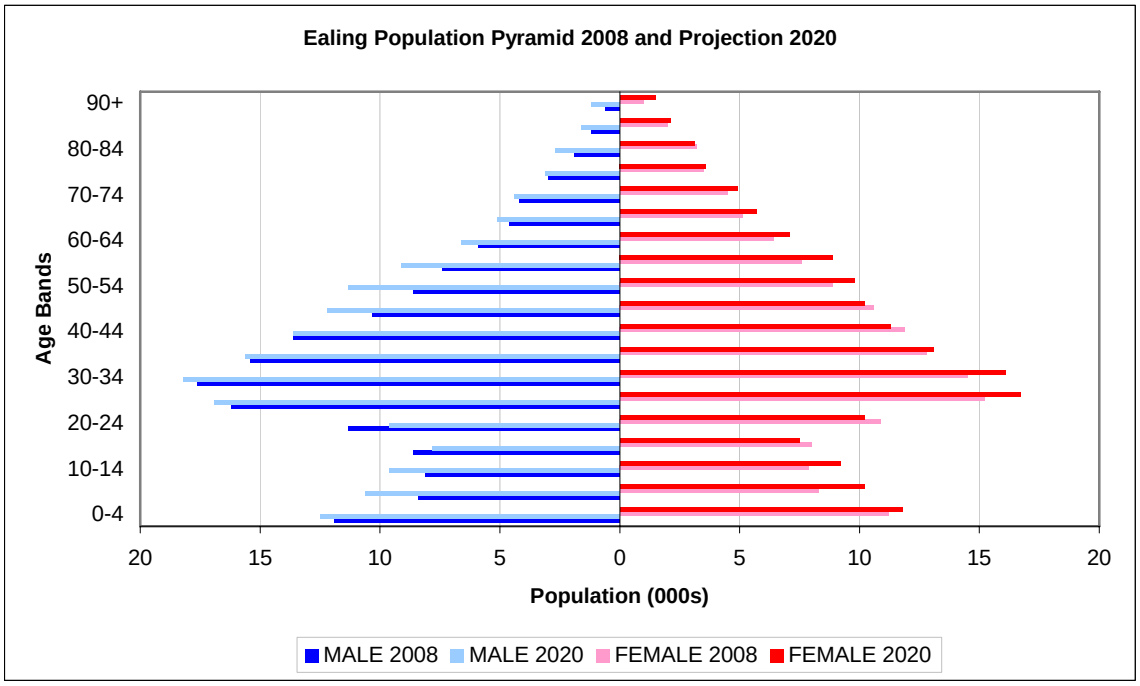
The fertility rate in Ealing is currently higher than the rate in England and London and has been rising since 2004. Ealing's rate is now 15% higher than in 2004, this compares with nearly 11% in London and England.

Official ONS population projections and estimates are based on births, deaths and estimates of migration. Estimations of migration are a recognised challenge for the ONS are known to be unreliable at local authority level. There are more households paying council tax than are estimated by ONS.

PROJECTED FUTURE POPULATIONS

Predicted population changes between 2008 and 2020 are shown in the table and population pyramid below (Figure 2.4 and Table 2.5). The pyramid shows actual numbers for 2008 and predicted numbers for 2020 by male and female five-year age bands. Predicted differences over time reflect past trends in birth rates, levels of inward and outward migration, household size in 2001 and the predicted impact of health and social change on life expectancy. They do not take account of local housing expansion plans that have not yet been implemented.

Figure 2.4 Ealing Population Pyramid 2008 and Projection to 2020



Source: Office for National Statistics (ONS) 2008 population estimates

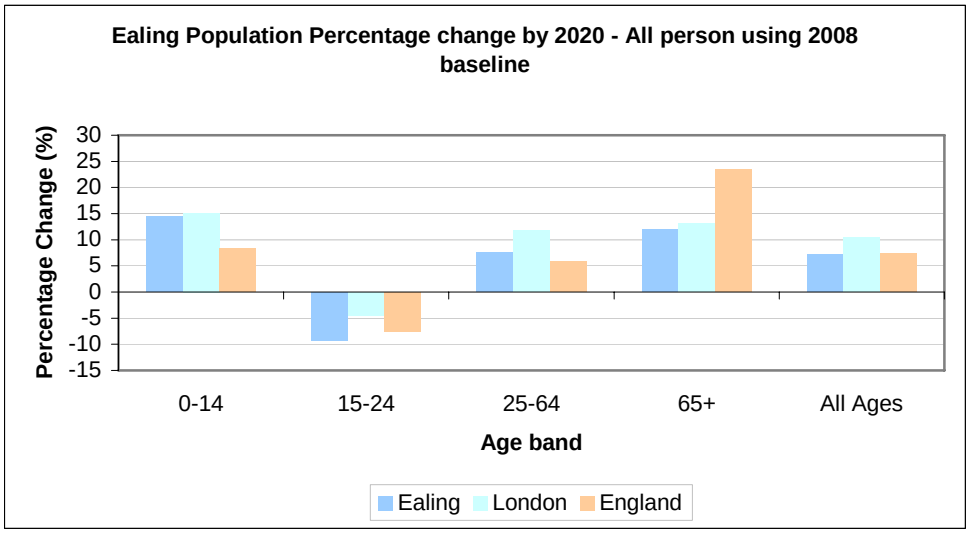
Table 2.5 Projected Population Change 2008 – 2020

Population (000s)					
Year	**0-14**	**15-24**	**25-64**	**65+**	**All Ages**
2008	55.8	38.7	182.7	34.9	312.1
2010	57.2	37.9	185.2	34.9	315.2
2012	58.5	37.2	187.8	35.6	319.1
2014	60.1	36.3	190.2	36.5	323.0
2016	61.7	35.2	192.6	37.2	326.7
2018	63.0	34.8	194.7	38.1	330.7
2020	63.9	35.1	196.5	39.1	334.7
Change 2008 - 2020					
Number	8.1	-3.6	13.8	4.2	22.6
Percentage	14.5%	-9.3%	7.6%	12.0%	7.2%

Source: Office of National Statistics (ONS) 2008-based Sub national population projections

Projections suggest that, by 2020, the population will reach 334,700, with most of the increase due to an anticipated 14.5% rise in the numbers of males and females between 0 and 14 years old, closely followed by 12.0% rise in the numbers of 65 years of age. (Figure 2.6).

Figure 2.6 Predicted Ealing Population change between 2008 - 2020



Source: 2008 based Office for National Statistics (ONS) population estimates

Administrative data held by Ealing Council shows the 2009 ONS mid year estimates to be an underestimate of Ealing's true resident population. Using council tax data and other sources it is estimated the borough's 2009 population to be in excess of 321,000.

GP registered population as at March 2010 was 379,572 but this is likely to include a number of people who live outside the borough's boundary, however is a further indication that ONS population underestimates Ealing's true population.

Ealing local population estimates are based on council tax records between 2001 and 2009, and projections factor in local housing development plans which were finalised with the GLA in early October 2009. Local estimates projections are still likely to underestimate Ealing's population. One reason for this is that houses in multiple occupation pay a collective council tax fee, meaning that they are here counted as one household.

Table 2.7 shows that Ealing population is likely to be 336,308 by 2020 which is higher than the 334,700 the ONS currently estimates for the same year. Working age population (Male 16-64, Female 16-59) is predicted to rise by 2%, while the number of young people and older people is predicted to rise by 10% and 15% respectively.

Table 2.7 Ealing Council population projections

Population				
Year	**0-15**	**16-59F/16-64M**	**60F/65M**	**All Ages**
2008	64,178	211,999	42,659	318,836
2010	65,554	213,270	43,214	322,125
2012	67,115	213,646	44,069	324,830
2014	68,230	214,459	45,336	328,025
2016	69,192	215,303	46,534	331,029
2018	70,148	215,745	47,798	333,691
2020	70,831	216,237	49,240	336,308

Change 2008-2020				
Number	6,653	4,238	6,581	17,472
Percentage	10.4%	2.0%	15.4%	5.5%

Source: Ealing Council, Research and Consultation 2009

YOUNG PEOPLE

ONS population projections show that the total number people aged 0 to 14 will grow by 14.5% between 2008 to 2020 to 63,900. The highest numerical rise is in the 5 to 9 years age band which will increase by 4,100 (25.6%). This increase in the 0 to 14 (Table 2.8) will require an expansion of health, children social care, school places and sport and leisure services.

Table 2.8 Population Projections 0 to 14 years 2008 – 2020

Ealing					
Age Band	**2008**	**2012**	**2016**	**2020**	**Percentage Rise**
0-4	23.1	24.3	23.9	24.3	5.2%
5-9	16.7	19.2	21.1	20.8	24.6%
10-14	16.0	15.0	16.7	18.8	17.5%
Total Population 0 -14	55.8	58.5	61.7	63.9	14.5%

Source: Office for National Statistics (ONS) sub national population projections based on 2008 mid year estimates

OLDER PEOPLE

ONS population projections show that the total number of people over 65 years will grow by 4,200 between 2008 and 2020. The greatest percentage rise is in the 85 and over age group with a predicted increase of 30.6% or 1,500 people. This increase in the number of people aged 85 and over (Table 2.9) may require an expansion in age appropriate health, housing and social care services as they are more likely than any other group to require extra support.

Table 2.9 Population Projections 65 years and over 2008 – 2020 (thousands)

Ealing					
Age Band	**2008**	**2012**	**2016**	**2020**	**Percentage Rise**
65-69	9.6	9.8	11.0	10.8	12.5%
70-74	8.7	8.4	8.0	9.3	6.9%
75-79	6.5	7.0	7.2	6.7	3.1%
80-84	5.2	4.9	5.3	5.9	13.5%
85+	4.9	5.5	5.7	6.4	30.6%
Total Population 65+	34.9	35.6	37.2	39.1	12.0%

Source: Office for National Statistics (ONS) sub national population projections based on 2008 mid year estimates

Older People Receiving Social Services

Table 2.10 Trend in People 65 years and over receiving social care services

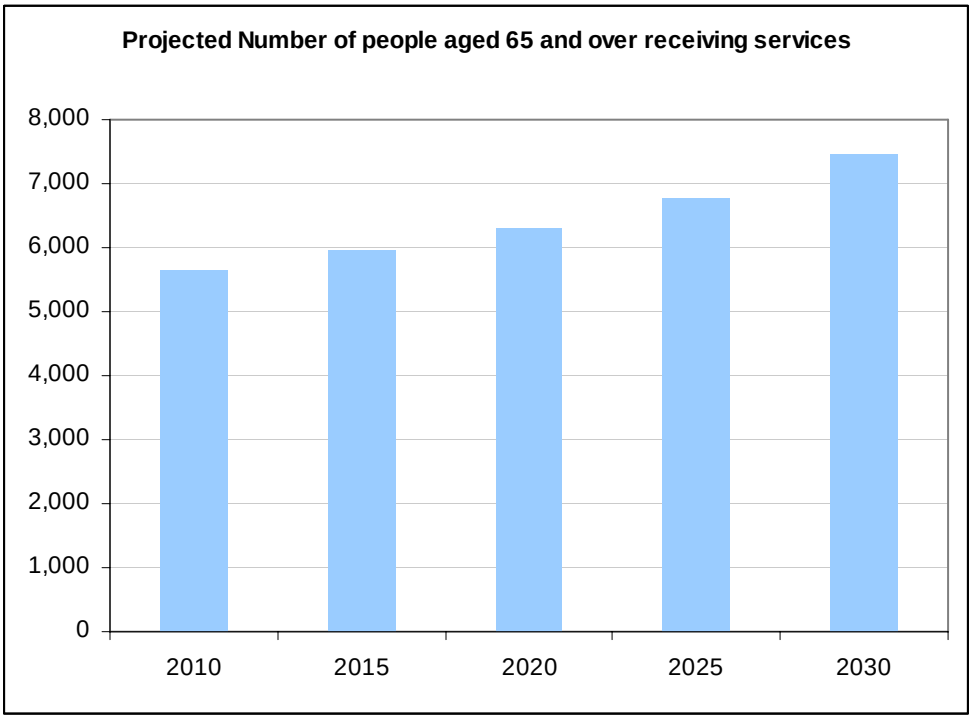
	2005/06	2006/07	2007/08	2008/09	2009/10
People with Learning Disabilities	51	68	54	68	54
People with Mental Health Problems	485	392	364	476	987
People with Physical Disabilities	5,357	5,313	4,875	5,564	4,854
Vulnerable People	28	7	17	21	21
Other	4	5	3	3	3
Total	**5,925**	**5,785**	**5,315**	**6,132**	**5,919**

Source: NASCIS, Information Centre, Department of Health 2010–

5,919 people received social care services in 2009/10. (Table 2.10) While this shows the number of people receiving services, it does not indicate all need. As receiving social care services is dependent on meeting an eligibility criteria, those with low-level or non-qualifying needs, will be met through means outside formal social care.

It is important to anticipate the demand on social services in Ealing over the coming years and to that end Figure 2.11 shows projected numbers who are anticipated to need social service interventions and support.

Figure 2.11 Projected number of people (aged 65 and over) receiving social services



Source: POPPI 2010

It is clear that these numbers are projected to increase and are likely to impact on the amount of funding required for these interventions. The number of over 65s supported is projected to increase by around 34% from 5,464 people this year to 7,458 people in 2030

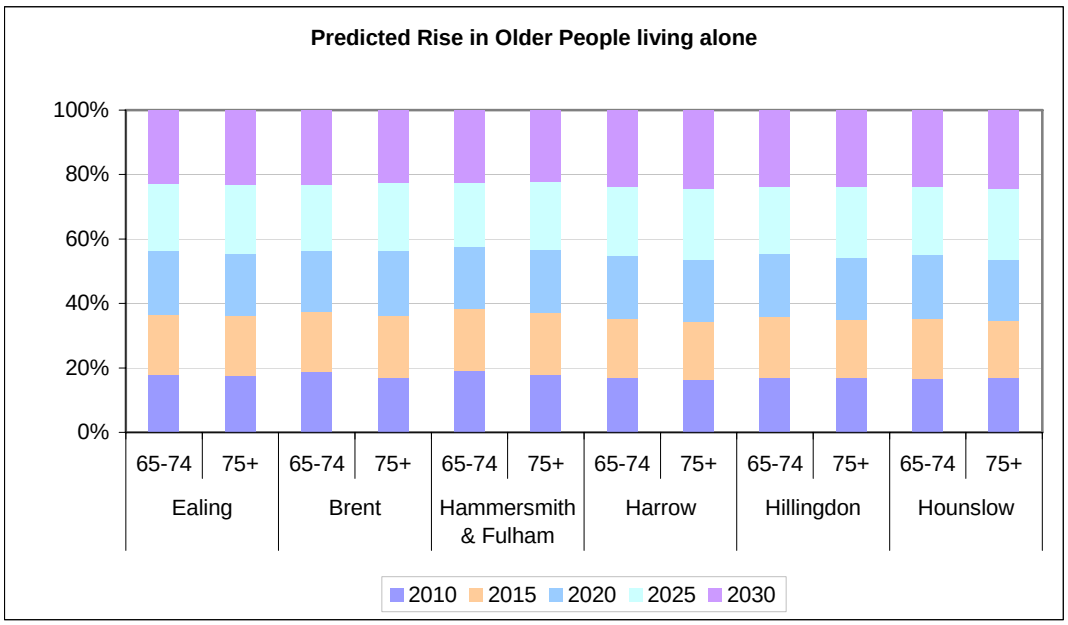
Older People Living Alone

At the present time nearly 13,000 people over 65 years of age are living alone in Ealing, a figure predicted to rise to 16,784 by 2030.

Table and Figure 2.12 Predicted rise in the number of Older People living alone

Numbers aged 65-74 and 75 and over predicted to be living alone by 2030 (West London)												
	Ealing		Brent		Hammersmith & Fulham		Harrow		Hillingdon		Hounslow	
	65-74	75+	65-74	75+	65-74	75+	65-74	75+	65-74	75+	65-74	75+
2010	4,600	8,297	4,280	7,490	2,250	4,206	4,180	7,788	4,440	8,439	3,310	5,529
2015	4,730	8,854	4,140	8,474	2,220	4,464	4,560	8,487	4,880	9,077	3,650	5,923
2020	5,080	9,207	4,270	8,881	2,250	4,586	4,950	9,308	5,190	9,620	3,950	6,303
2025	5,280	10,191	4,660	9,417	2,310	4,871	5,280	10,543	5,430	10,943	4,150	7,280
2030	5,860	10,924	5,210	9,980	2,640	5,217	5,940	11,554	6,220	11,893	4,710	8,006

Source: General Population Survey 2007 and POPPI



Source: General Population Survey 2007 and POPPI

Older People living in Care Homes

In addition to those 13,000 older people living alone, a further 1,040 aged 65 and over live in local authority and non-local authority care homes and, assuming demand for such places continues in line with current projections, there will be a need for a total of 1,507 care home places by 2030 (Table 2.13).

Table 2.13 Projected rise in the number of Older People living in Care Homes

Ealing					
	2010	**2015**	**2020**	**2025**	**2030**
People living in a Local Authority care home with or without nursing					
Aged 65-74	18	19	20	21	23
Aged 75-84	50	54	55	58	63
Aged 85 and over	50	54	62	74	81
People living in a non Local Authority care home with or without nursing					
Aged 65-74	115	118	127	132	147
Aged 75-84	283	307	310	330	357
Aged 85 and over	525	565	646	767	837
Total population aged 65 and over living in a care home with or without nursing	1,040	1,118	1,219	1,381	1,507
Total population aged 75 and over living in a care home with or without nursing	908	980	1,073	1,229	1,338

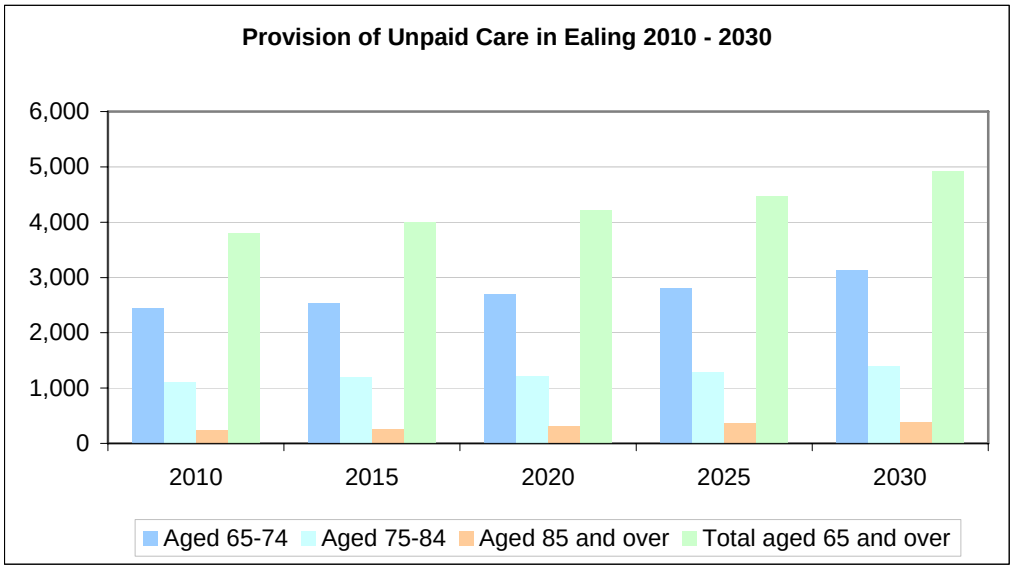
Source: Office for National Statistics (ONS) 2001 Census and POPPI

Provision of Unpaid Care

Many people over 65 years of age play a vital role within the community as important providers of unpaid care. The term 'unpaid care' covers any unpaid help provided towards looking after or supporting family members, friends, neighbours or others who have a long-term physical disability, or a mental illness, or problems related to old age. While the majority are between 65 and 74 years old (Figure 2.14), notable numbers of people over 75 years also provide unpaid care. This section of the population is important, given that the absence of the provision they are responsible for could have a significant impact on local services.

In 2009/10 Ealing took part in the new carers survey, of those that returned the survey 67% were satisfied with the support and services they received while 11% were dissatisfied. Only 22% of the carers surveyed had used the available support to take a break from caring for more than 24 hours. Of those that did not, 27% said that the support was not available. Overall 11% of carers survey said that their general health was bad or very bad with 51% saying that their caring role had caused some or a lot of financial difficulty.[23]

Figure 2.14 Provision of Unpaid Care in Ealing by People over 65 years



Source: Office for National Statistics (ONS) Census 2001 and POPPI

Self-care

Some of the un-paid care provided is to support other older people who are unable to manage at least one self-care activity on their own. Essential self-care activities include bathing, showering or washing all over, dressing and undressing, washing face and hands, feeding and cutting toenails.

It is estimated that nationally 22% of 65-74 year olds and nearly 47% of people over[4] 75 years are unable to manage at least one of the listed self-care activities on their own. Table 2.15 shows estimated numbers for Ealing.

Table 2.15 Predicted rise in the number of Older People unable to manage at least one self-care activity on their own

Ealing					
	2010	**2015**	**2020**	**2025**	**2030**
People unable to manage at least one self-care activity on their own					
Aged 65-74	4,021	4,087	4,421	4,577	5,079
Aged 75-84	4,467	4,740	4,837	5,093	5,556
Aged 85 and over	3,388	3,689	4,092	4,870	5,171
Total aged 65 and over	11,876	12,516	13,350	14,540	15,806

Source: Living in Britain Survey (2001) and POPPI

SPECIFIC HEALTH NEEDS ASSOCIATED WITH AGEING

Dementia

The prevalence of dementia increases with age, from 1.5% of males aged 65-69 years to 19.7% of males over the age of 85 years. Similarly among females the prevalence increases from 1% of females aged 65-69 years to 25.2% of females over 85 years. Applying prevalence rates to projected population figures gives an estimate of the numbers of people who will require dementia care by 2030 (Table 2.16).

Table 2.16 Projected Increase in the number of people with Dementia 2010 – 2030

Ealing					
Projected rise in the number of Males with Dementia by Age Group					
(%) shows estimated prevalence by age band	**2010**	**2015**	**2020**	**2025**	**2030**
Males aged 65-69 (1.5%)	65	77	77	83	98
Males aged 70-74 (3.1%)	133	115	136	136	149
Males aged 75-79 (5.1%)	158	179	158	189	189
Males aged 80-84 (10.2%)	194	235	275	245	306
Males aged 85 and over (19.7%)	394	453	552	709	768
Total Males aged 65 and over	944	1,057	1,198	1,362	1,509
Projected rise in the number of Females with Dementia by Age Group					
Females aged 65-69 (1.0%)	50	56	57	61	67
Females aged 70-74 (2.4%)	110	103	118	118	127
Females aged 75-79 (6.5%)	234	247	234	273	273
Females aged 80-84 (13.3%)	386	372	412	399	466
Females aged 85 and over (25.2%)	806	857	907	1,033	1,084
Total Females aged 65 and over	1,587	1,635	1,728	1,884	2,016
Total population aged 65 and over	**2,530**	**2,693**	**2,926**	**3,245**	**3,526**
Projected Percentage Increase		**6.4%**	**15.7%**	**28.3%**	**39.4%**

Source: Dementia UK, Personal Social Services Research Unit (LSE) 2007, Office for National Statistics (ONS) and POPPI

Using the same approach (Tables 2.17 and 2.18) show likely numbers of people who by 2030 will require care for long term health problems associated with a stroke and the number of hospital admissions due to falls in the older people population.

Table 2.17 Projected Increase in the number of people with Long-term Health problems due to a Stroke 2010 – 2030

Ealing					
People projected to have a longstanding health condition caused by a stroke					
(%) shows estimated prevalence by age band	**2010**	**2015**	**2020**	**2025**	**2030**
Males aged 65-74 (2.8%)	241	246	266	277	316
Males aged 75 and over (3.8%)	266	308	327	369	403
Females aged 65-74 (1.2%)	115	119	127	132	144
Females aged 75 and over (1.9%)	184	190	196	215	288
Total Population aged 65 and over	**807**	**863**	**916**	**993**	**1,091**
Projected Percentage Increase		**6.9%**	**13.5%**	**23.0%**	**35.2%**

Source: General Household Survey 2007, POPPI and Office for National Statistics (ONS)

Table 2.18 Projected Increase in the number of people with hospital admissions due to unintentional falls 2010 – 2030

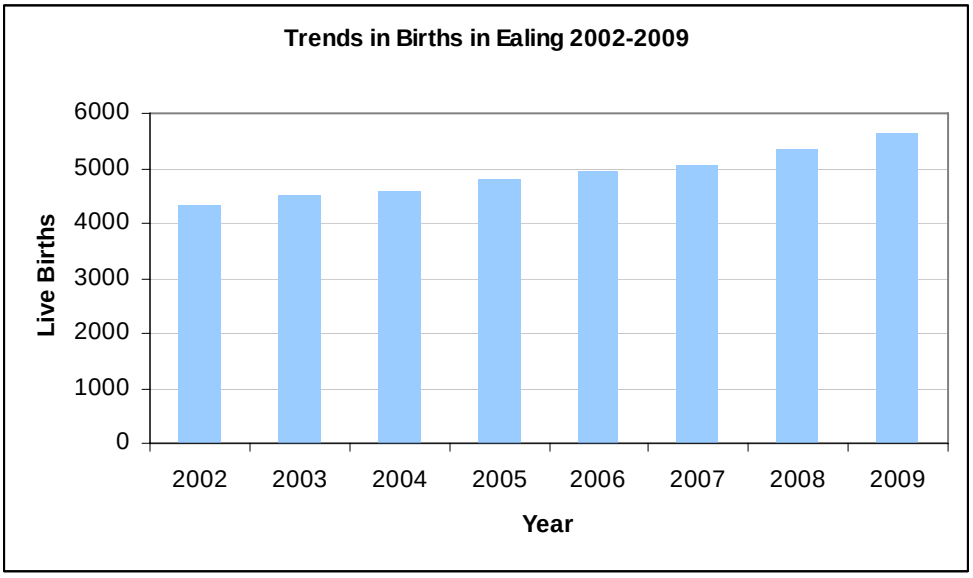
Ealing					
People aged 65 and over admitted to hospital as a result of falls					
(%) shows estimated prevalence by age band	**2010**	**2015**	**2020**	**2025**	**2030**
People aged 65-69 (0.52%)	48	56	56	60	69
People aged 70-74 (0.92%)	82	74	86	86	93
People aged 75 and over (3.68%)	615	666	669	773	839
Total population aged 65 and over	**745**	**796**	**841**	**919**	**1,001**
Projected Percentage Increase		**6.9%**	**12.9%**	**23.4%**	**34.4%**

Source: Scuffham, P. et al, Incidence and costs of unintentional falls in older people in the United Kingdom, Journal of Epidemiology and Community Health, Vol. 57, No.9, Sept. 2003, pp.740-744, Office for National Statistics (ONS) and POPPI

BIRTHS

The number of live Births in Ealing has increased steadily since 2002 (Figure 2.19) and is now 30.5% higher than 2002 levels. The highest single year increase of 5.6% was between 2007 and 2008, while lowest single year increase of 2.2% occurred the previous year (2006 to 2007).

Figure 2.19 Trends in Live Births in Ealing 2002-2009

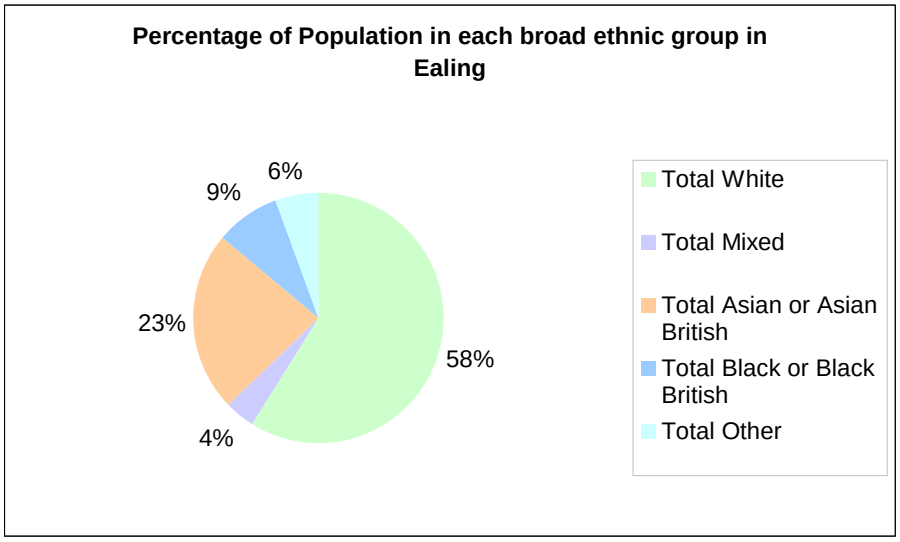


Source: Greater London Authority Data Management and Office for National Statistics (ONS) 2009

ETHNICITY

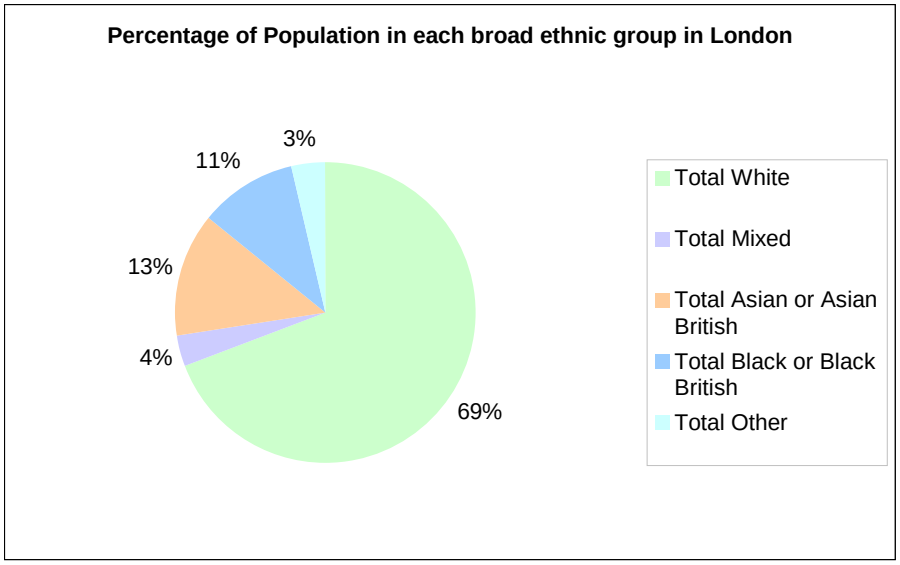
Black and minority ethnic (BME) communities, including individuals of mixed ethnicity, make up approximately 41.1% of the Ealing's total population, this compares to approximately 11.8% of England's population. Looking more closely regionally we can see that for London, the BME population is 31.0% of total population, for Inner London and Outer London this stands at 33.5% and 29.3% respectively. In Ealing individuals of Asian or Asian British community form the largest percentage of the BME communities.

Figure 2.20 Percentage of Population in broad ethnic groups in Ealing



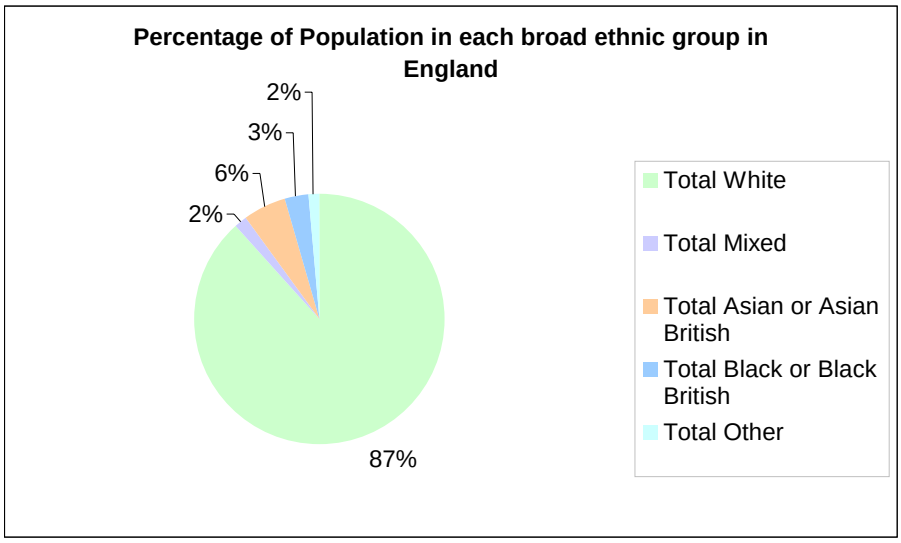
Source: Experimental Population Estimates by Ethnic Group for local authority districts 2007 Office for National Statistics

Figure 2.21 Percentage of Population in broad ethnic groups in London



Source: Experimental Population Estimates by Ethnic Group for local authority districts 2007 Office for National Statistics

Figure 2.22 Percentage of Population in broad ethnic groups in England



Source: Experimental Population Estimates by Ethnic Group for local authority districts 2007 Office for National Statistics

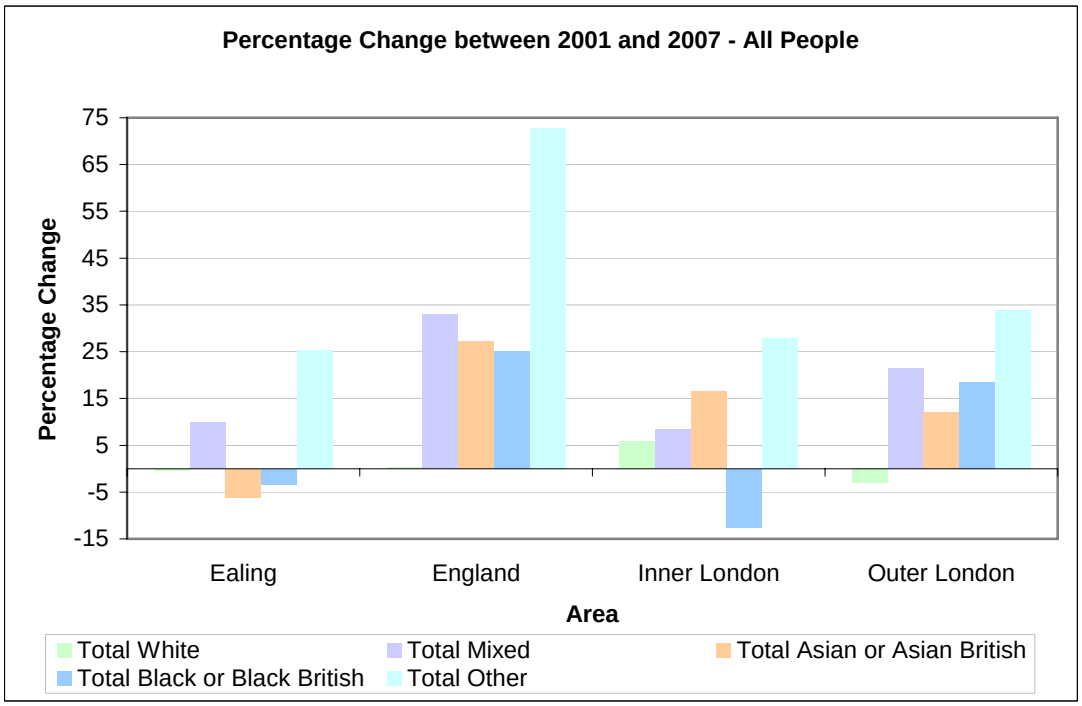
Table 2.23 shows how broad ethnic group population between 2001 and 2007, while the White and Black and Black British groups remain broadly the same, the Mixed and Other groups appear to have increased, with a decrease within the Asian or Asian British group.

Table 2.23 Trend in broad ethnic group population 2001 –2007

Ealing (000s)					
	Total White	**Total Mixed**	**Total Asian or Asian British**	**Total Black or Black British**	**Total Other**
2001	180.7	11.1	75.1	26.9	13.4
2002	181.1	11.3	73.5	27.0	14.5
2003	179.5	11.4	72.0	27.1	15.2
2004	179.0	11.5	71.2	26.9	15.5
2005	180.0	11.7	71.1	26.7	16.0
2006	180.6	12.0	70.8	26.3	16.5
2007	179.9	12.2	70.5	26.0	16.8

Source: Past and Current Population Mid Year Estimates by Ethnic group 2007

Figure 2.24 Percentage Change by broad ethnic group 2001 - 2007

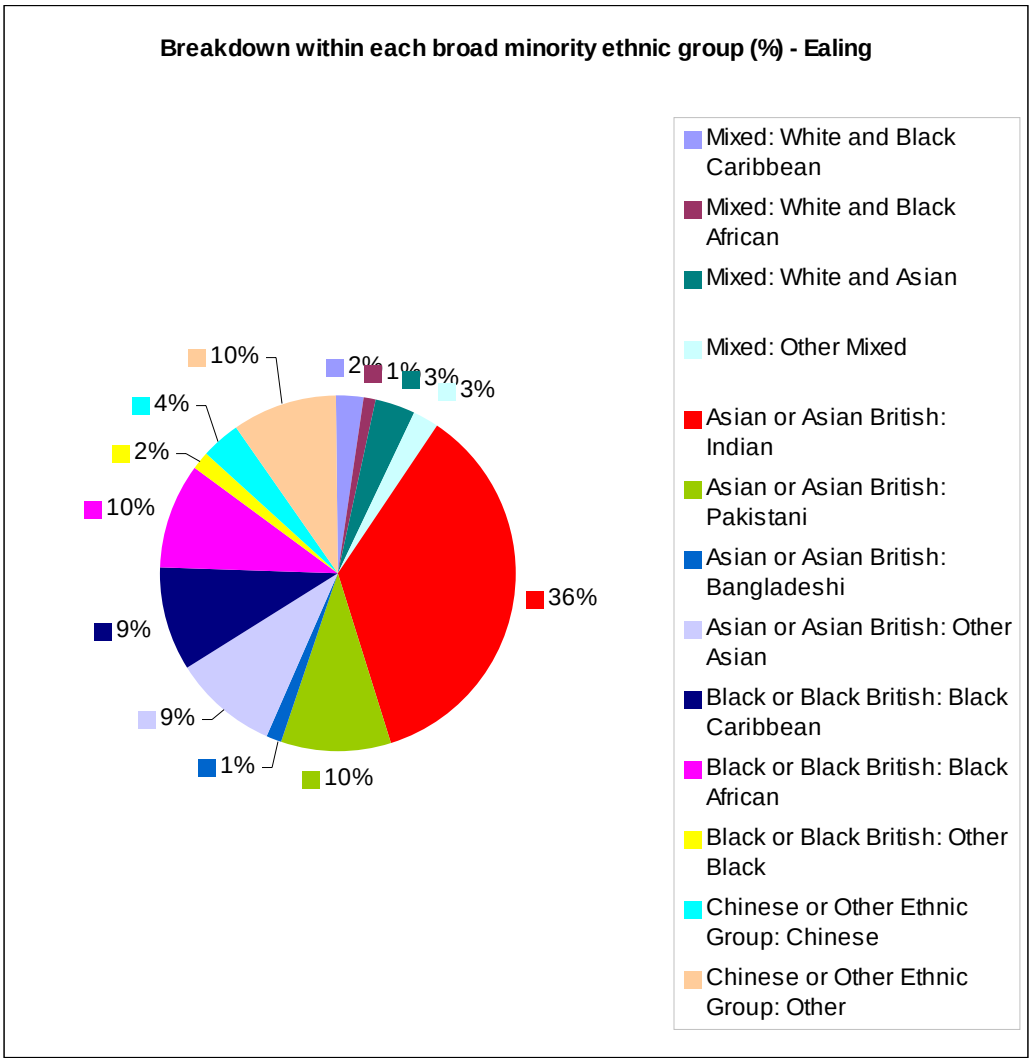


Source: Past and Current Population Mid Year Estimates by Ethnic group 2007

Compared with national and regional picture (Figure 2.24), Ealing's change in ethnicity is somewhat different. While like the national picture there is relatively little change to the White population, this is not in keeping with Inner or Outer London. However Ealing is similar to other areas when it comes to the change in Other population, increasing from 2001 to 2007. Ealing has seen a percentage fall in populations of Black or Black British and Asian or Asian British unlike England or Outer London. The fall in the Black and Black British population seems similar to Inner London borough although to a smaller extent.

It is worth noting that ethnicity numbers provided by ONS are experimental and are based on past patterns of migration and the 2001 census. Country of Mother's Birth and the ethnicity of school age children can give a better indication as to the ethnic diversity of the borough. These figures can be seen in Chapter 7 of the JSNA.

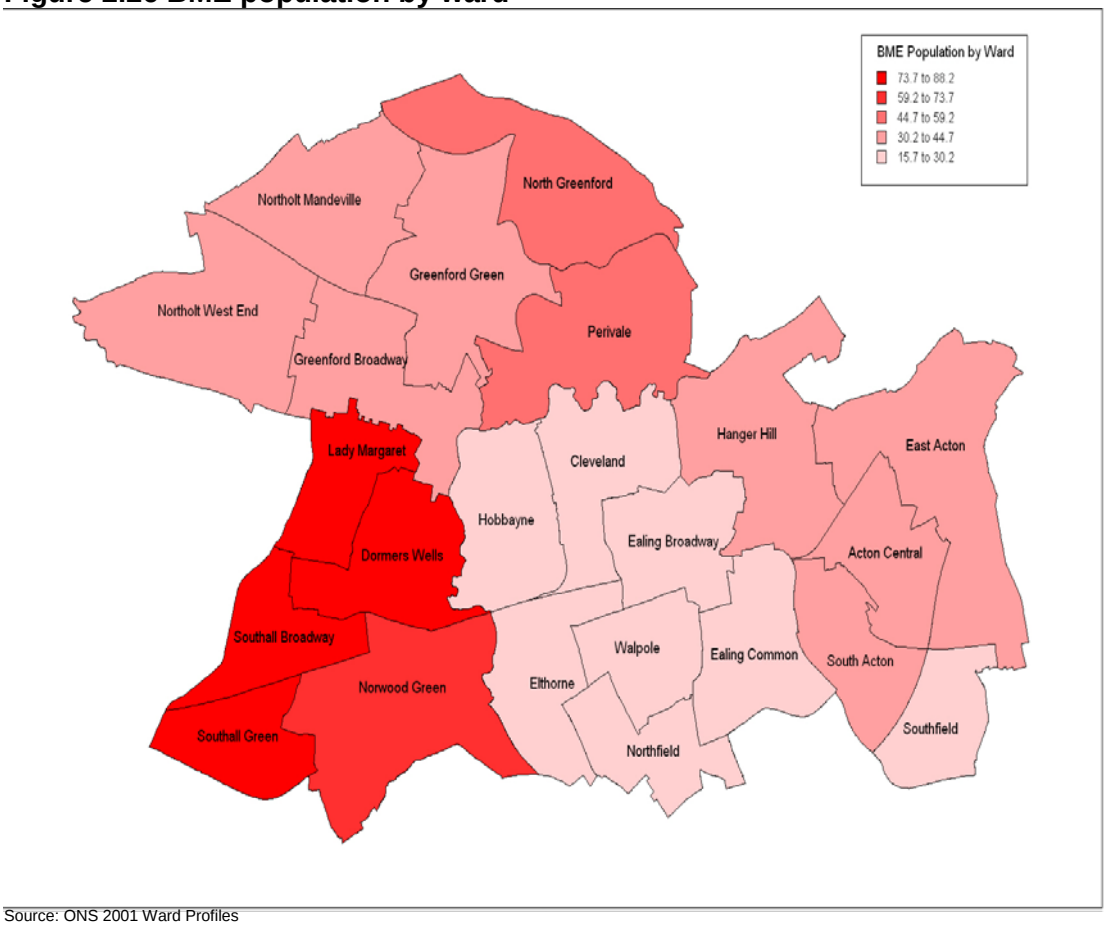
Figure 2.25 Break down of individual ethnic minority groups (%) in Ealing 2007



Source: Office for National Statistics (2007) Mid Year Estimates

Looking more specifically within the broad ethnic groups (Figure 2.25), we can see that Asian or Asian British Indian community dominate the ethnic population in Ealing, being over a third in number. Significantly Asian or Asian British Pakistani, Black or Black British African and Chinese or Other Ethnic Other are around 10% each, with a further 9% from Black Caribbean background.

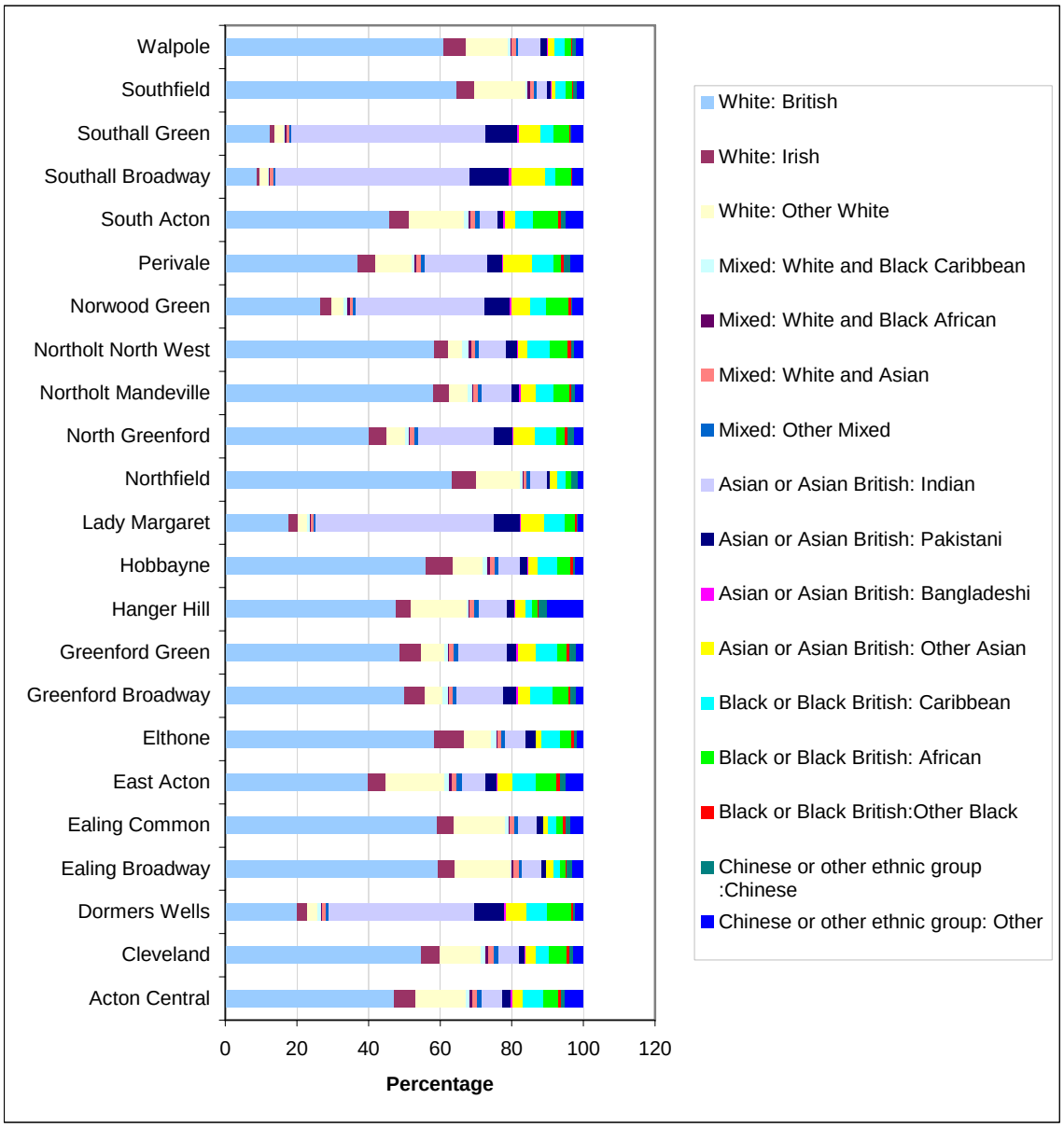
Figure 2.26 BME population by ward



Source: ONS 2001 Ward Profiles

Figure 2.26 clearly shows that Ealing BME population varies between wards, with areas like Southall Broadway, Lady Margaret, Dormers Wells, Southall Green and Norwood Green having higher concentration of ethnic minorities than Southfield, Northfield and Ealing Common.

Figure 2.27 Ethnic Profile of Wards in Ealing



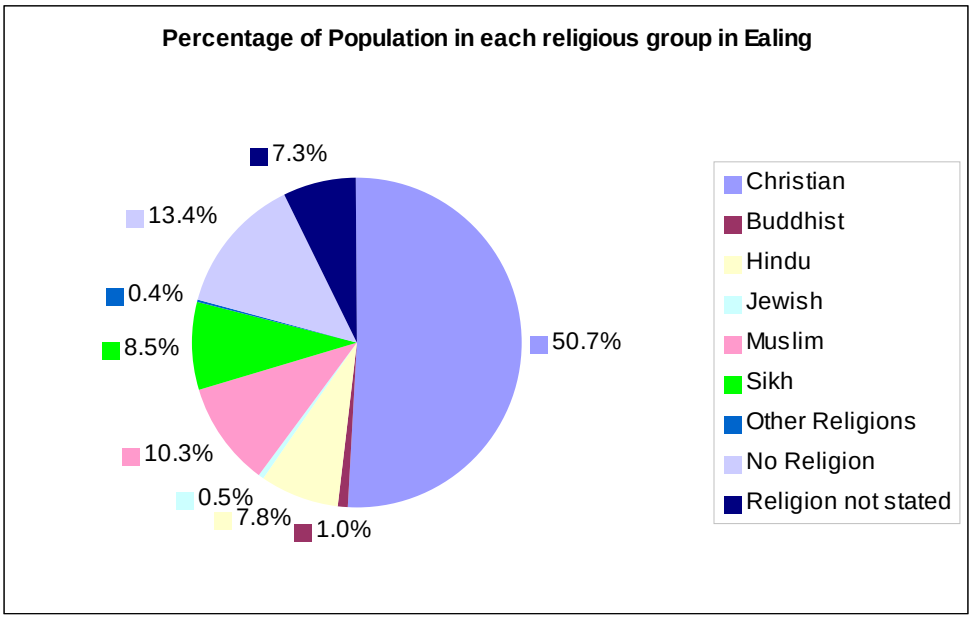
Source: Office for National Statistics 2001

As stated earlier, ethnic profile of the wards in Ealing vary significantly. Figure 2.27 shows that White British population can vary from just under 9% in Southall Broadway to 65% in Southfield. Similarly the Asian Indian population can vary from about 3% in Southfield to about 54% in Southall Broadway and Southall Green.

RELIGION

41.4% of the population of Ealing regard themselves as Christian, 13.4% as having no religion, 10.3% as Muslim, 8.5% as Sikh and 7.8% as Hindu. (Figure 2.28)

Figure 2.28 Percentage Population in each religious group in Ealing



Source: Office for National Statistics (ONS) 2001 Census

MIGRANT POPULATION

The number of people moving into and out of Ealing is dynamic and is likely to remain so for the foreseeable future. The movement of people is as important a factor as births and deaths in determining the size and structure of the population.

One way of estimating the number of foreign nationals settling in Ealing is to use data available from the Department for Work and Pensions on National Insurance Number (NINO) registrations. National insurance numbers are a necessary first step for employment, self-employment and for claiming benefits and tax credits. NINO registrations are recorded by place of residence rather than place of work (Table 2.29).

Table 2.29 NINO Registrations to adult overseas nationals entering the UK by year of registration

	Ealing						
	2002/03	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**
NINO Registrations (000s)	7.47	8.23	10.7	15.19	14.25	15.33	14.25
Yearly Percentage Change		10.2%	30.0%	42.0%	-6.2%	7.6%	-7.0%

Source: HMRC 2009

The number of NINO registrations has nearly doubled from 7,470 in 2002-03 to 14,250 in 2008-09. The highest single year percentage increase was between 2004-05 and 2005-06 of 42%. While registrations remain changeable, the increases or decreases in recent years are smaller in magnitude.

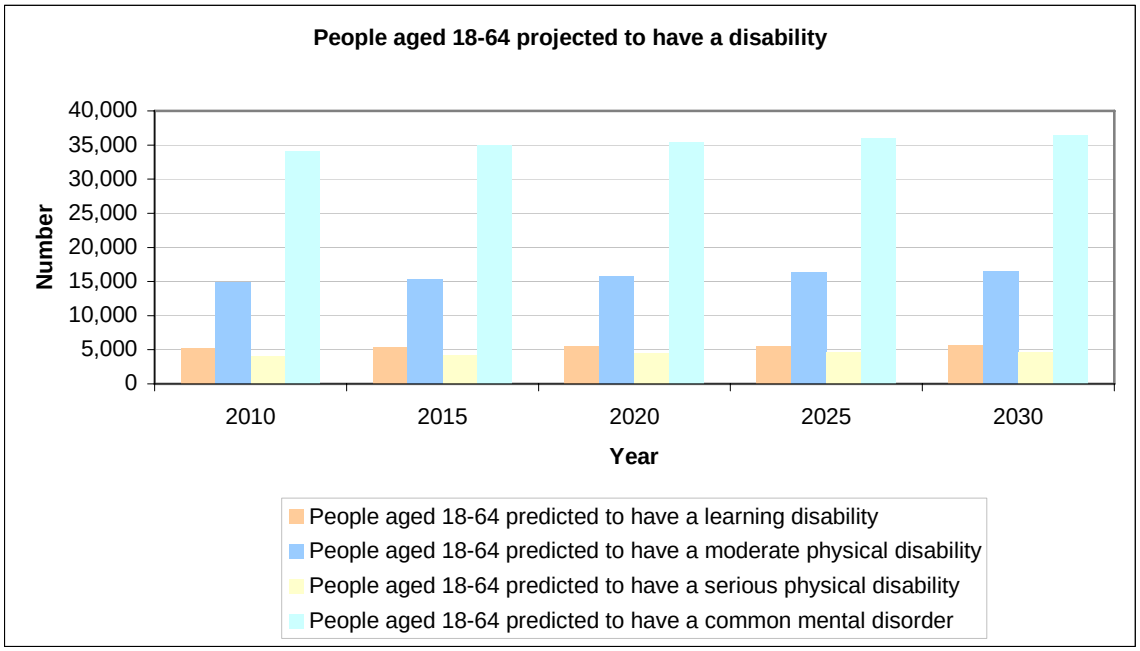
DISABILITY

Over the coming years it is anticipated that the population within Ealing with a disability will grow. Figure and table 2.30 show that across common disabilities the increases will range between 7% and 12%, from now until 2030.

Figure and Table 2.30 Projected number of people having a disability in Ealing

	2010	2015	2020	2025	2030
People aged 18-64 predicted to have a learning disability	5,226	5,350	5,435	5,536	5,627
People aged 18-64 predicted to have a moderate physical disability	14,855	15,355	15,813	16,285	16,502
People aged 18-64 predicted to have a serious physical disability	4,084	4,223	4,391	4,586	4,655
People aged 18-64 predicted to have a common mental disorder	34,075	34,871	35,402	35,965	36,451

Source: PANSI 2010



Source: PANSI 2010

People with learning disabilities have wide ranging health needs. Often co-existing conditions, including physical and developmental disabilities, mental and behavioural problems. Prevalence is underestimated, especially amongst people with uncomplicated, mild or borderline intellectual impairment. Males are more likely than females to have both mild and severe learning disabilities. Severe learning disabilities are more common amongst males, young people and people from South Asian Communities.[33]

Some people with disabilities will go on to receive social care. Over the last few years the number of people 18 to 64 receiving social services has increased (Figure 2.31). Between 2005/06 and 2009/10 there was a 35% increase in the number of people receiving social care services.

People with Learning Disabilities

Learning disability is defined as:

- A significantly reduced ability to understand new or complex information or to learn new skills
- A reduced ability to cope independently

The Government Strategy 'Valuing People Now' highlighted major shortcomings in services for people with learning disabilities. "Working Together To Make Better Lives (2006-11)" is Ealing's response, setting targets for mainstream and specialist services.

In 2008 Mencap produced a report entitled "Death by Indifference" that highlighted the inequalities and lack of support people with learning disabilities face across NHS Trusts nationally, and the government put the issue firmly on the agenda with its recent paper "Health Care for All". Better health for people with learning disabilities in Ealing is now a key priority.

944 adults with learning disabilities were known to services in 2009/10. 75% live in Ealing with the remaining 25% residing out of borough. National prevalence data estimates the local population of people with learning disabilities should be at least 1000. Just over 60% of the local population of adults with a learning disability is male.

People with learning disabilities have much greater health needs than the general population. They are more likely to have general health problems, sensory impairments, mental health problems, respiratory and heart disease, dementia, epilepsy and other physical disabilities. Uptake of regular health screening, disease prevention and health promotion activities is poor. Evidence shows that people with learning disabilities in Ealing still have a negative experience with local health services. The Treat Me Right project has been working with Ealing Hospital, NHS Ealing and WLMHT to make reasonable adjustments for patients with learning disabilities and improve access to acute, primary care and mental health services.

Adults with learning disabilities are more likely than the general adult population to develop bi-polar disorder, anxiety, ADHD and schizophrenia. In 2009/10,102 adults with learning disabilities in Ealing are known to have a diagnosed mental health need. The way mental health problems present in people with learning disabilities, together with problems with communication can make the assessment process difficult. National prevalence data estimates that 20 – 22% will have mental health needs, suggesting the local figure should be double. There is a comprehensive range of specialist learning disabilities services available to sustain and support people in their local community, avoiding unnecessary admissions or re-admissions to hospital. People with mild and moderate learning disabilities can use local mainstream inpatient mental health services. The demand for specialist inpatient mental health services is very low and as there is suitable provision in one of the neighboring boroughs, this is not considered an unmet need.

Just below 50% of adults with learning disabilities are from minority ethnic communities, with 23% from an Asian background. There are some services specifically for people with learning disabilities and their carers from minority ethnic communities for example, respite and information and advocacy services. It is recognised that adults with learning disabilities from minority ethnic communities have specific health needs arising from diet, prevalence to certain health conditions, and preferred treatment types. These issues are addressed as part of Health Action Plans and are being explored as part of the national project “Reaching Out” that Ealing is participating in.

There are 182 people with learning disabilities who have also been diagnosed as having autism. There are 149 people with profound and multiple learning disabilities and complex needs in Ealing and this number is likely to increase due to increased life expectancy. There are 128 people who exhibit behaviour that challenges services, including self-harm and anti-social behaviour. Around 40% of these individuals have autism.

Suitable accommodation is a particularly pressing need. Many people with learning disabilities do not choose where they live or with whom and are placed in residential care. People with learning disabilities have limited access to mainstream housing. Just over 50% of adults with learning disabilities in Ealing live with family carers.

Research conducted by Mencap has shown that almost 90% of people with learning disabilities have been subject to hate crime. People with learning disabilities are actively involved in campaigning against hate crime and are members of Ealing's Hate Crime Task Group.

Advances in medical and social care have led to a significant increase in the life expectancy of people with learning disabilities. There are 73 people with learning disabilities over the age of 65 in Ealing. The prevalence of dementia in people with learning disabilities, including early onset dementia is significantly higher than the general population (21.6% compared with 5.7%). A specialist memory clinic has been established in Ealing to provide a service for older people with learning disabilities who have dementia. There is limited provision of residential and nursing care for older people with learning disabilities who have dementia and nursing needs in Ealing and further work is needed to develop the local market.

29 people with learning disabilities are parents in Ealing. Services in Ealing to support parents with learning disabilities to develop parenting skills are limited.

Adults with Autism Spectrum Conditions (ASC)

Autism is a lifelong developmental disability that affects the way a person communicates and relates to people around them. People with autism have difficulties with everyday social interaction. Asperger’s syndrome is a form of autism.

The Government’s recent strategy “Fulfilling and Rewarding Lives” sets out their vision that all adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. Ealing is producing a local strategy and delivery plan in response to this that aims to build on current capacity and universal opportunities

to improve access to services and support and increase awareness amongst frontline public services. The strategy will focus on addressing the needs of adults with high functioning autism and Asperger's syndome who are not eligible for social care services

National prevalence rates indicate that every 1 in 100 people has autism which would be roughly 2241 adults with an ASC in Ealing. Prevalence rates also suggest that over 2000 of these adults in Ealing have high functioning autism and Asperger's syndrome. The vast majority of this group is not eligible for learning disability or mental health services but many will need support due to reduced ability to cope independently.

There are 182 people with learning disabilities who have also been diagnosed as having autism. National data suggests a prevalence of 115 adults with Autism Spectrum Conditions who have a severe learning disability in Ealing. Whilst there is adequate local provision of day opportunity and respite services, there is a shortage of specialist organisations operating locally who provide residential and supported living services for adults with ASC who have a learning disability and complex needs

Nationally, the diagnosis of children with ASC has increased ten-fold in the last 10 years which will place additional pressure on adult services in future years.

There are no diagnostic services available locally for adults who think they may have an ASC. A mapping exercise is being undertaken to determine local demand for diagnostic services for adults.

There are limited post diagnostic support services in Ealing for adults with high functioning ASC and Asperger's Syndrome who do not meet the eligibility criteria for learning disability or mental health services. The ASSIST service in Ealing provided by the National Autistic Society offers signposting, information and support to this group.

People with ASC face barriers when attempting to access mainstream services such as housing, employment, leisure, education and health and part of Ealing's local strategy will set out plans to increase awareness and understanding of autism amongst frontline workers and employers to enable them to make reasonable adjustments to their services.

Adults with ASC are especially vulnerable to abuse. Recent research conducted by the National Autistic Society suggests that all people with ASC will be victims of abuse at some point in their lives.

Without early diagnosis, intervention and support, adults with ASC are likely to develop other needs relating to eating disorders, obsessive compulsive disorders, extreme phobias, self harming, sexually inappropriate behaviour, forensic histories and substance misuse. National prevalence rates suggest that around 670 of the local adult population of people with ASC will experience mental health problems due to the lack of diagnosis and support. Common mental health difficulties experienced will include depression, anxiety and schizophrenia.

Only 15% of people with ASC are likely to be in paid employment, and consequently many people with ASC are financially deprived and live at home with their families. There is currently no support for carers of adults with ASC who fall below the eligibility threshold for learning disabilities and mental health services, and typically these carers

will not be known to Ealing social services. Information about services for people with autism will be included in Ealing's Service Directory.

Figure 2.31 Trend in People between 18 and 64 years receiving social care services

	2005/06	2006/07	2007/08	2008/09	2009/10
Alcohol/Drug Misusers	4	56	11	43	57
People with Learning Disabilities	590	702	666	740	656
People with Mental Health problems	1,031	922	1,167	1,831	2,075
People with Physical Disabilities	1,415	1,380	1,520	1,389	1,253
Vulnerable People	8	5	5	0	62
Total	**3,048**	**3,065**	**3,369**	**4,003**	**4,103**

Source: NASCIS, Information Centre 2010

Attendance Allowance and Disability Living Allowance provide a proxy indicator for the number of disabled people in the community. Attendance Allowance is focused on people aged 65 and over and an increase in claimants reflects the increasing number of elderly people in the population. Disability Living Allowance is available for those under 65 years of age.

Attendance Allowance

Attendance Allowance provides a non-contributory, non-means-tested and tax-free contribution towards the disability-related extra costs incurred by physically or mentally disabled people who are aged 65 years and over. To qualify, people must have needed help with personal care for at least 6 months. Table 2.27 shows the numbers of people in receipt of Attendance Allowance between November 2008 and November 2009.

Table 2.32 Numbers in receipt of Attendance Allowance November 2008 – November 2009

	2008			2009			
	Gender		Total	Gender		Total	
Ward Name	Male	Female		Male	Female		% Change
Acton Central	80	170	250	80	190	270	8.0%
Cleveland	100	190	290	100	180	280	-3.4%
Dormers Wells	105	190	295	105	190	295	0.0%
Ealing Broadway	80	205	285	90	205	295	3.5%
Ealing Common	90	185	275	90	195	285	3.6%
East Acton	85	150	235	85	170	255	8.5%
Elthorne	70	155	225	70	185	255	13.3%
Greenford Broadway	130	260	390	135	275	410	5.1%
Greenford Green	95	190	285	100	185	285	0.0%
Hanger Hill	85	185	270	90	190	280	3.7%
Hobbayne	95	180	275	95	195	290	5.5%
Lady Margaret	90	170	260	105	195	300	15.4%
Northfield	80	150	230	85	155	240	4.3%
North Greenford	80	140	220	85	150	235	6.8%
Northolt Mandeville	95	205	300	100	205	305	1.7%
Northolt West End	110	165	275	105	175	280	1.8%
Norwood Green	125	210	335	145	225	370	10.4%
Perivale	90	160	250	95	160	255	2.0%
South Acton	130	225	355	140	225	365	2.8%
Southall Broadway	115	170	285	120	190	310	8.8%
Southall Green	100	165	265	85	165	250	-5.7%
Southfield	55	120	175	55	135	190	8.6%
Walpole	85	165	250	80	170	250	0.0%

Source: Department of Work and Pension 2009

Only two wards, Cleveland and Southall Green saw a fall in the numbers in receipt of Attendance. Cleveland fell by 3.4% and Southall Green 5.7% from 2008 to 2009. Lady Margaret, Elthorne and Norwood Green at 15.4%, 13.3% and 10.4% respectively were the wards that saw the highest percentage increase since November 2008.

Disability Living Allowance

Disability Living Allowance (DLA) provides a contribution towards the disability related extra costs of severely disabled people who make a claim before the age of 65 years. DLA has both a care component and a mobility component.

Table 2.33 shows that the numbers claiming DLA remained unchanged in Ealing Common and Northfield since 2008. With the exception of Norwood Green (down 0.6%) and Perivale (down 1.0%) wards, the rest of Ealing's wards have seen the numbers claiming DLA rise between 2008 and 2009.

Table 2.33 Numbers in receipt of Disability Living Allowance November 2008 – November 2009

Ward Name	2008 Total	2009 Total	% Change
Acton Central	555	595	7.2
Cleveland	455	475	4.4
Dormers Wells	690	695	0.7
Ealing Broadway	315	340	7.9
Ealing Common	420	420	0.0
East Acton	615	660	7.3
Elthorne	565	575	1.8
Greenford Broadway	660	680	3.0
Greenford Green	395	415	5.1
Hanger Hill	270	300	11.1
Hobbayne	550	580	5.5
Lady Margaret	555	580	4.5
Northfield	275	275	0.0
North Greenford	420	435	3.6
Northolt Mandeville	525	560	6.7
Northolt West End	655	680	3.8
Norwood Green	865	860	-0.6
Perivale	490	485	-1.0
South Acton	585	600	2.6
Southall Broadway	700	705	0.7
Southall Green	635	645	1.6
Southfield	320	335	4.7
Walpole	325	340	4.6

Source: Department of Work and Pension 2009

Incapacity Benefit and Severe Disablement Allowance Claimants

Incapacity Benefit (IB) and Severe Disablement Allowance (SDA) are sickness and disability benefits that are claimed by a large proportion of working age people. People claiming these benefits are economically inactive i.e. not working or not actively seeking work so this is a useful additional indicator of joblessness among the working age population.

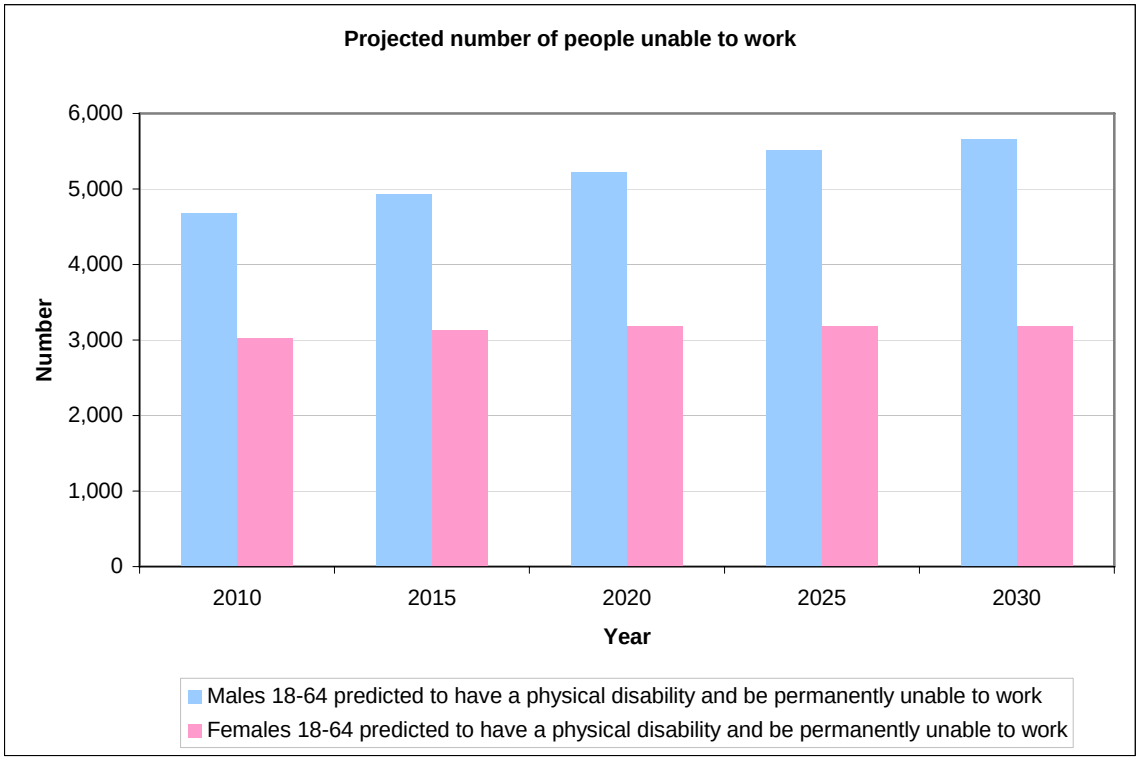
Table 2.34 Numbers in receipt of Incapacity Benefit and Severe Disablement Allowance November 2008 – November 2009

	2008	2009	
Ward Name	**Total**	**Total**	**% Change**
Acton Central	690	645	-6.5
Cleveland	530	450	-15.1
Dormers Wells	660	580	-12.1
Ealing Broadway	365	320	-12.3
Ealing Common	445	375	-15.7
East Acton	705	650	-7.8
Elthorne	635	560	-11.8
Greenford Broadway	670	600	-10.4
Greenford Green	400	350	-12.5
Hanger Hill	275	230	-16.4
Hobbayne	505	455	-9.9
Lady Margaret	495	430	-13.1
Northfield	230	220	-4.3
North Greenford	385	335	-13.0
Northolt Mandeville	550	485	-11.8
Northolt West End	735	645	-12.2
Norwood Green	990	880	-11.1
Perivale	450	385	-14.4
South Acton	730	650	-11.0
Southall Broadway	685	570	-16.8
Southall Green	645	555	-14.0
Southfield	325	295	-9.2
Walpole	325	290	-10.8

Source: Department of Work and Pension 2009

The numbers of people in receipt of Incapacity Benefit and Severe Disablement Allowance has decreased since 2008; every ward within the borough has seen an fall ranging from 4.3% in Northfield to 16.8% in Southall Broadway.

Figure 2.35 Projected number of people aged 18 to 64 predicted to have a physical disability and be permanently unable to work.



Source: PANSI 2010

It is projected that number of males unable to work because of a physical disability will rise between 2010 and 2030 by 21% to 5,664. The number of females not able to work is also anticipated to rise but more slowly to 3,189, a 5% rise over the same period.

SECTION 3

How do we compare with similar local authorities

HEALTH OUTCOMES FOR EALING COMPARED TO SIMILAR AUTHORITIES

To explore how health outcomes for Ealing compared with other similar local authorities we used the Office for National Statistics (ONS) area classification. ONS developed its area classification process using 42 census variables to place each local authority in a group with other most similar authorities. The variables used are age; ethnicity; country of birth; population density; living arrangements; household composition; housing tenure, type, size and overcrowding; education; socio-economic class; ownership/commuting; health and care; employment industry sector. Similar districts are grouped according to their particular combination of characteristics.

Since the local authorities in each group are socio-economically similar they provide a realistic benchmark against which to compare health outcomes. Where a district scores badly in comparison to others in its ONS group, this cannot be put down to the above socio-economic factors as they have already been taken into account. A low health outcome score can then act as a prompt for organisations to explore the underlying factors more fully and so develop local strategies and action plans to address them.

Using the ONS classification:

Ealing local authority is in the **"London Suburbs - A"** cluster of 8 similar authorities.

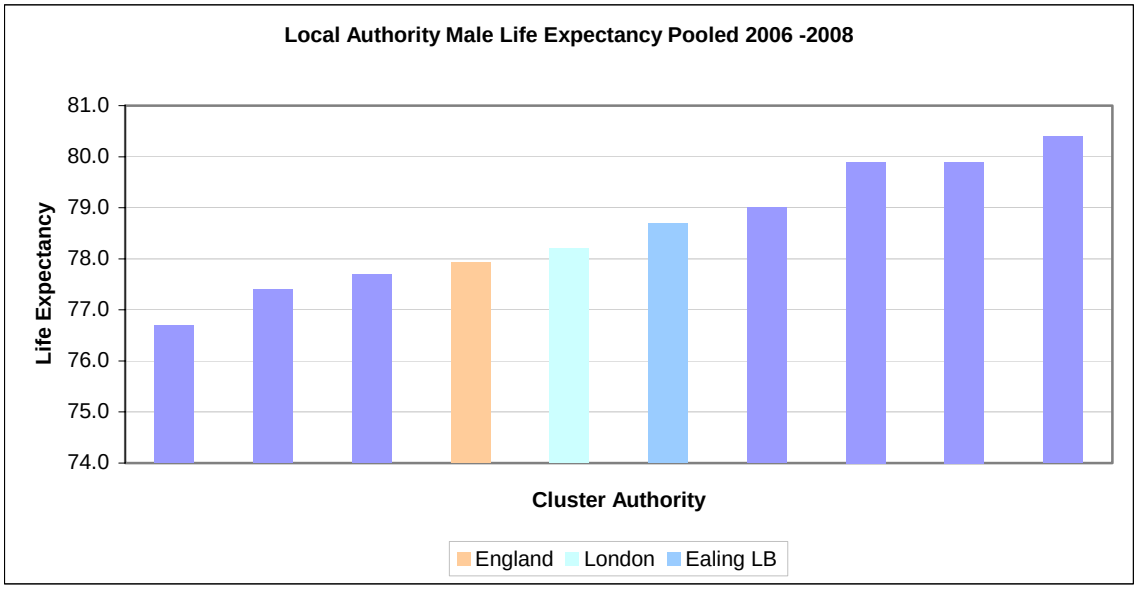
Table 3.1 Similar Local Authorities ONS Grouped

District	ONS Grouped similar local authorities
Ealing	Barnet, Ealing, Harrow, Hounslow, Luton, Merton, Redbridge, Slough

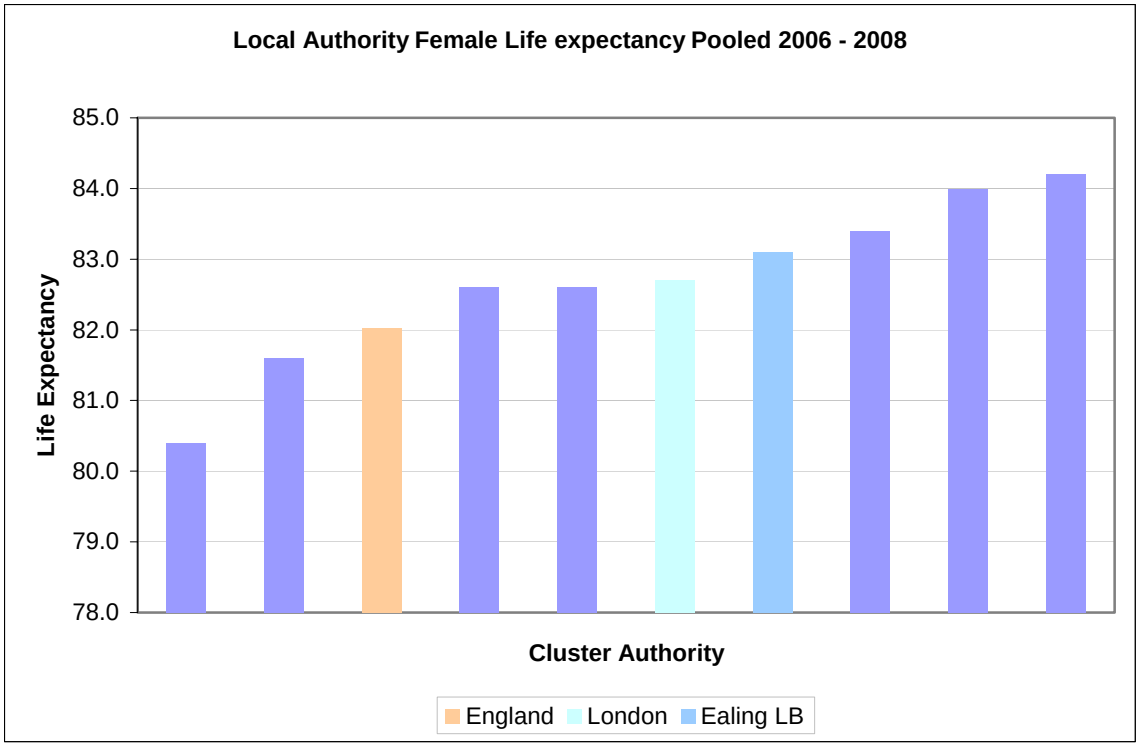
Source: Office for National Statistics (ONS) classification

LIFE EXPECTANCY

Figure 3.2 Life Expectancy by ONS Cluster Group 2006 - 2008



Source: National Centre for Health Outcomes Development 2009

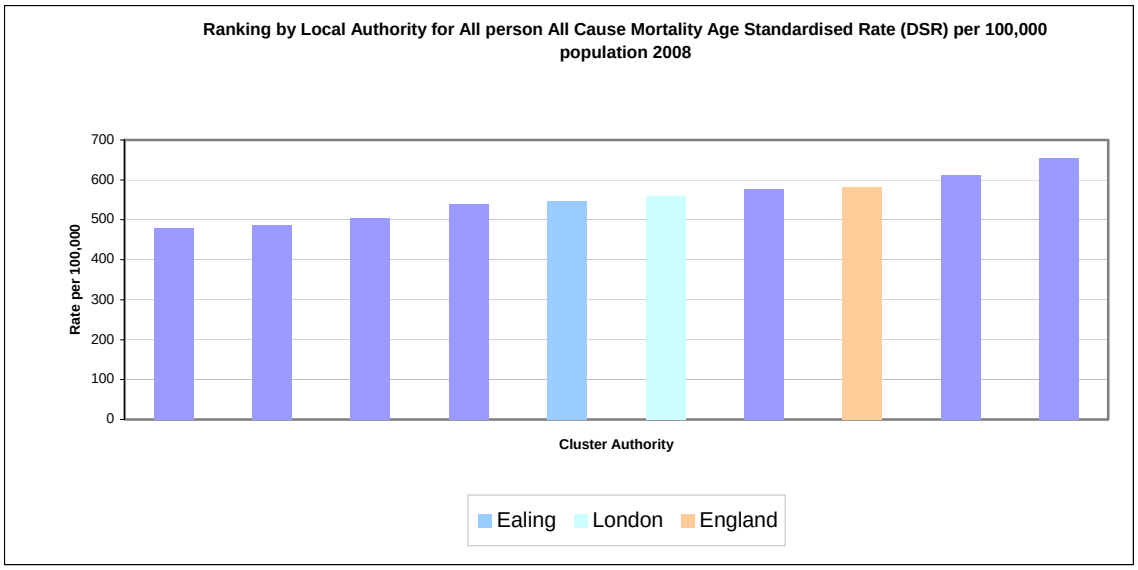


Source: National Centre for Health Outcomes Development 2009

In Ealing both male and female life expectancy rates are above the England and London rates. In comparison to its ONS cluster, Ealing's life expectancy for both genders sits in the middle third. For males in Ealing, there life expectancy is just under 79 years which is over 20 months shorter than the top authority in its cluster. For females in Ealing, life expectancy is just over 83 years and is just over 13 months shorter than the top authority.

ALL CAUSE MORTALITY

Figure 3.3 All Cause Mortality Ranking by ONS Cluster Group 2008



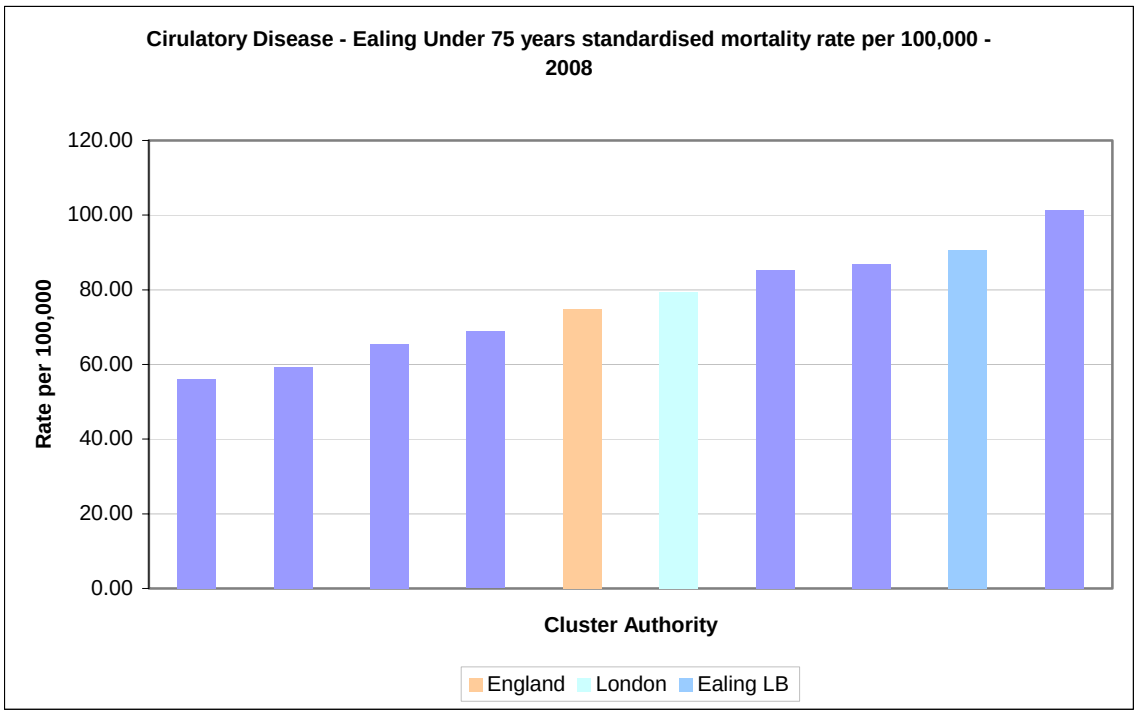
Source: National Centre for Health Outcomes Development (NCHOD) 2009

Ealing's all cause, all age mortality rate (number of deaths in a population in a given period of time) is lower than the London and England rate. Within the ONS cluster Ealing falls in the middle third for this rate. The difference between Ealing's rate and lowest rate within the cluster is 109 per 100,000.

CIRCULATORY DISEASE

Circulatory disease is one of the main causes of potentially avoidable deaths in Ealing. Although progress has been made in managing cardiovascular disease and reducing deaths, in 2008 the mortality rate for Ealing was above the London and England rates and is the second highest of its cluster group.

Figure 3.4 Circulatory Disease under 75 years standardised mortality ranking by ONS cluster group 2008

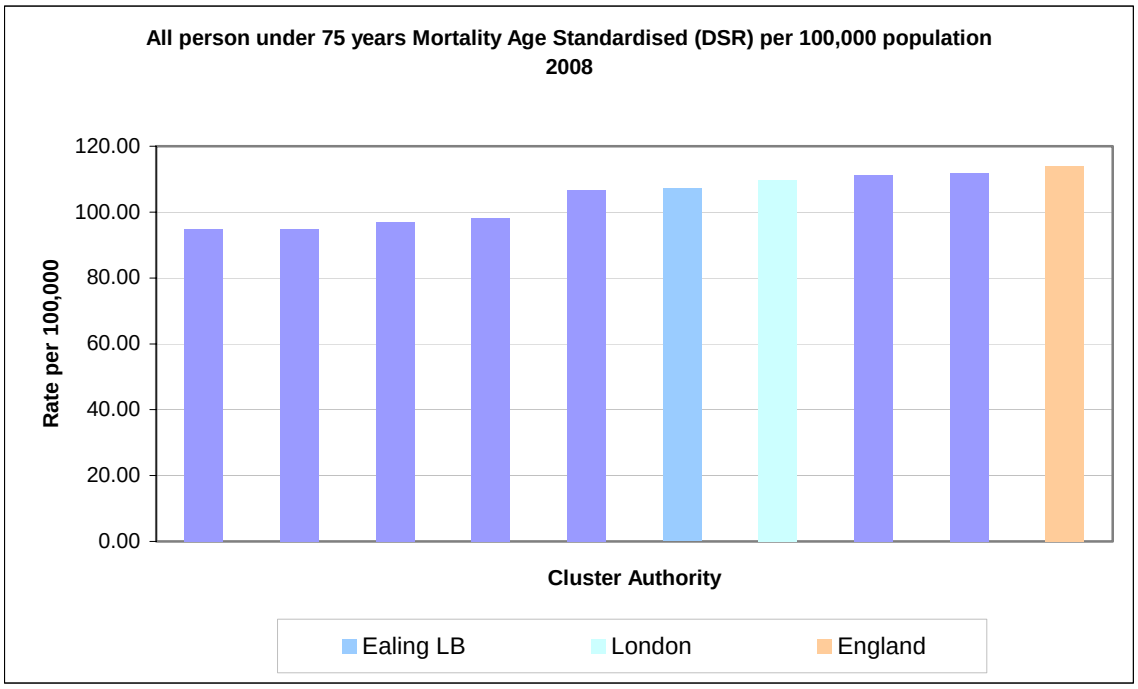


Source: National Centre for Health Outcomes Development (NCHOD) (2009)

ALL CANCERS

Mortality rates for all cancers in Ealing is below both the London and England rate. Similar to the all cause mortality rate, the all cancer mortality rate is in the middle third of its ONS cluster group. The lowest rate within Ealing's ONS cluster group is 94.9 compared to Ealing's rate of 107.2 which is nearly 13% higher.

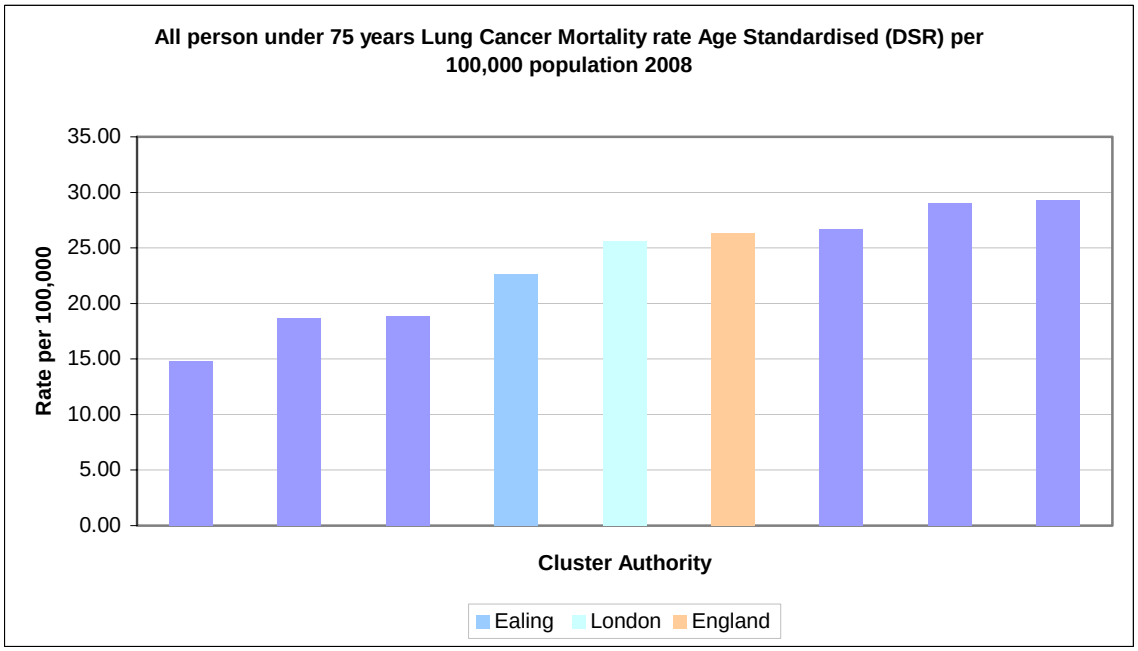
Figure 3.5 All cancer under 75 years standardised mortality ranking by ONS cluster group 2008



Source: National Centre for Health Outcomes Development (NCHOD) 2009

LUNG CANCER

Figure 3.6 Lung Cancer Mortality Rate for under 75s by ONS cluster group 2008

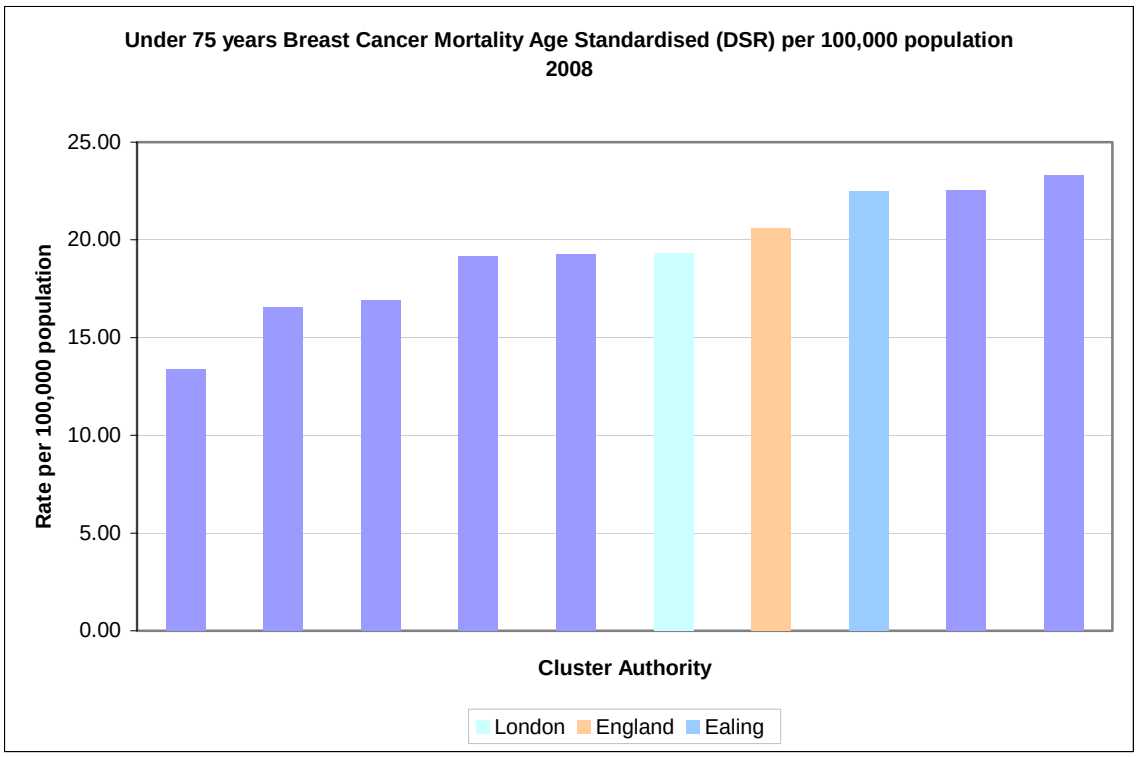


Source: National Centre for Health Outcomes Development (NCHOD), 2009

Ealing's lung cancer mortality rate is lower than the London and England rate. It is within the middle third of its ONS cluster group and 35% higher than the authority with the lowest lung cancer mortality rate in the ONS cluster group.

BREAST CANCER

Figure 3.7 Breast Cancer Mortality Rate for Females under 75s by ONS cluster group 2008



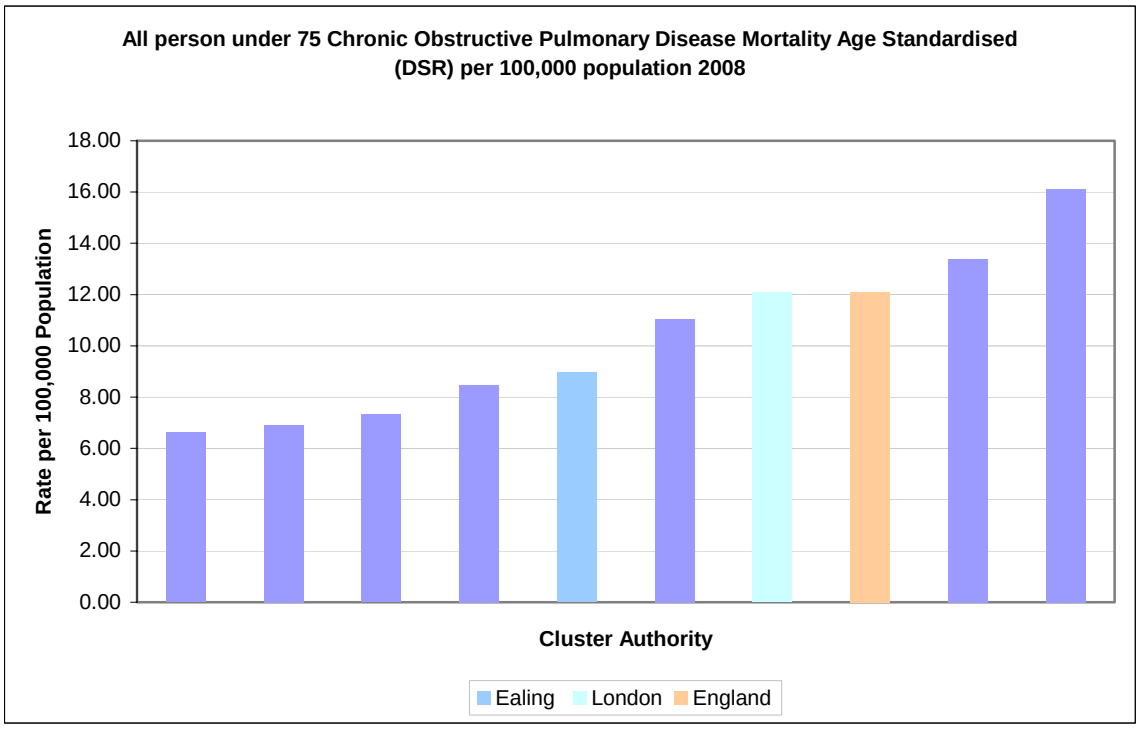
Source: National Centre for Health Outcomes Development (NCHOD), 2009

The breast cancer mortality rate in Ealing is higher than the London and England rates. Ealing's rate stands at 22.46 per 100,000 population while the authority with the lowest rate in its ONS cluster group is 13.38.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Figure 3.8 shows that Ealing has notably smaller mortality rate for Chronic Obstructive Pulmonary Disease than the London and England Rates. Ealing sits in the middle third of the ONS cluster group for this mortality rate. The lowest rate of the group being 6.63 compared with Ealing's 8.96 per 100,000 population.

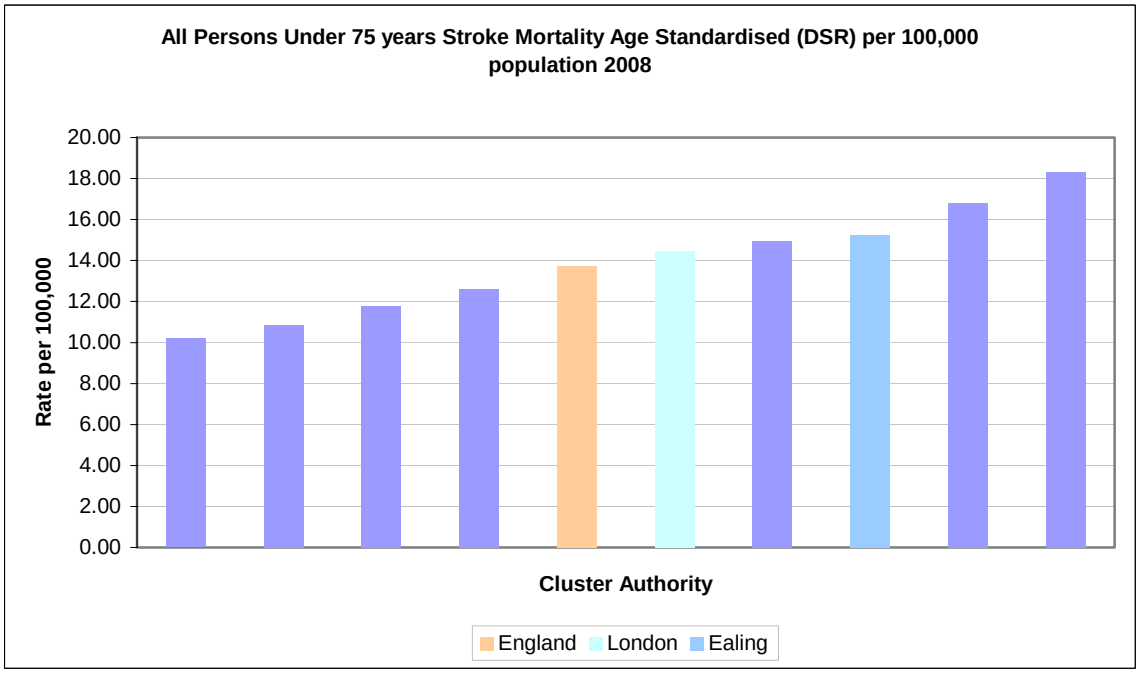
Figure 3.8 All persons under 75 years Chronic Obstructive Pulmonary Disease Mortality Rate by ONS cluster group 2008



Source: National Centre for Health Outcomes Development (NCHOD) 2009

STROKE

Figure 3.9 All persons under 75 years Stroke Mortality Rate by ONS cluster group 2008



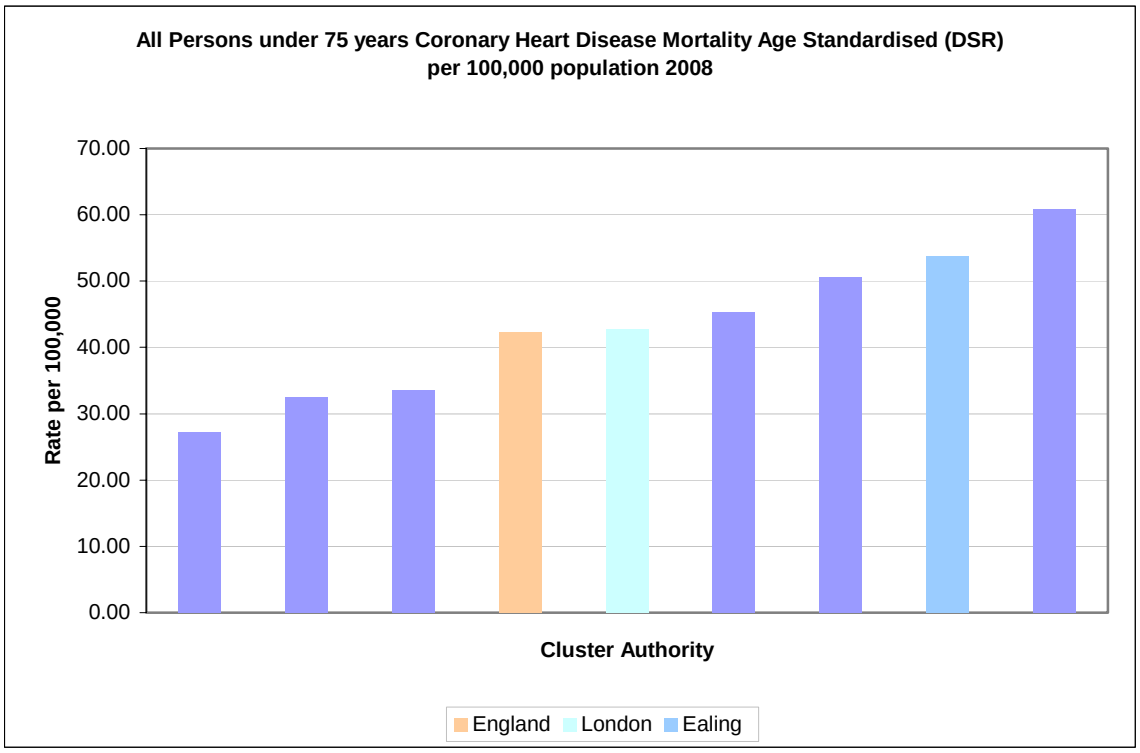
Source: National Centre for Health Outcomes Development (NCHOD) 2009

Ealing's stroke mortality rate is higher than both the London and England rate. Ealing's rate is 15.26 per 100,000 population, with London at 14.46. Within the ONS cluster group, the lowest rate is 10.19.

CORONARY HEART DISEASE

Ealing's mortality rate for coronary heart disease, 53.79, is second highest within its ONS cluster group. It is significantly higher than both the London and England rate. It is 97% higher than that of the authority with lowest rate within the cluster. (Figure 3.10)

Figure 3.10 All persons under 75 years Coronary Heart Disease Mortality Rate by ONS cluster group 2008



Source: National Centre for Health Outcomes Development (NCHOD) 2009

SECTION 4

Socio-economic factors

EALING SOCIO-ECONOMIC FACTORS

While it is important to benchmark the health status of primary care trusts and district authorities against similar authorities across the country, it is as important to understand the socio-economic and health inequalities that exist within the borough between its different wards and neighbourhoods.

UNDERSTANDING SOCIO-ECONOMIC FACTORS

People living in poorer socio-economic circumstances or in the more deprived areas of the borough tend to experience poorer health. They have higher levels of chronic disease and disability, higher deaths rates (under 75 years) and they experience the adverse effects of ageing at an earlier stage in their lives. They have difficulty accessing health and social care services and when contact is made it is often at a later stage in their condition. As a consequence they require more complex treatment and experience poorer health outcomes. They are less likely to engage with health promotion and disease prevention activities and tend to achieve poorer educational outcomes

In this section census-based **Indices of Deprivation 2007** have been used to provide comparative information by district, ward and lower level super-output area. There is also a summary of the information available in the annual **Community Profiles** from the Association of Public Health Observatories.

Super-output areas

Prior to 2004 the standard unit for presenting local statistical information was the electoral ward. However electoral wards can vary in size from under 100 residents to over 30,000 and so are not ideal for nationwide comparisons. Electoral wards are also subject to regular boundary changes which create continuity problems. Subdivisions of wards have now been created, of a consistent size and with fixed boundaries. They are based on groupings of census output areas and are termed Super Output Areas (SOAs). England & Wales have upper, middle and lower level SOAs. There are generally about four lower level SOAs in a ward, each with a minimum population of 1000 and an average population of 1500. There are over 32,000 SOAs in England compared to only 8005 wards.

INDEX OF MULTIPLE DEPRIVATION

The Indices of Deprivation 2007 cover seven different measures or domains of deprivation and are presented at lower level SOAs:

- Income
- Employment
- Health and disability
- Barriers to housing and services
- Living environment
- Crime
- Education skills and training

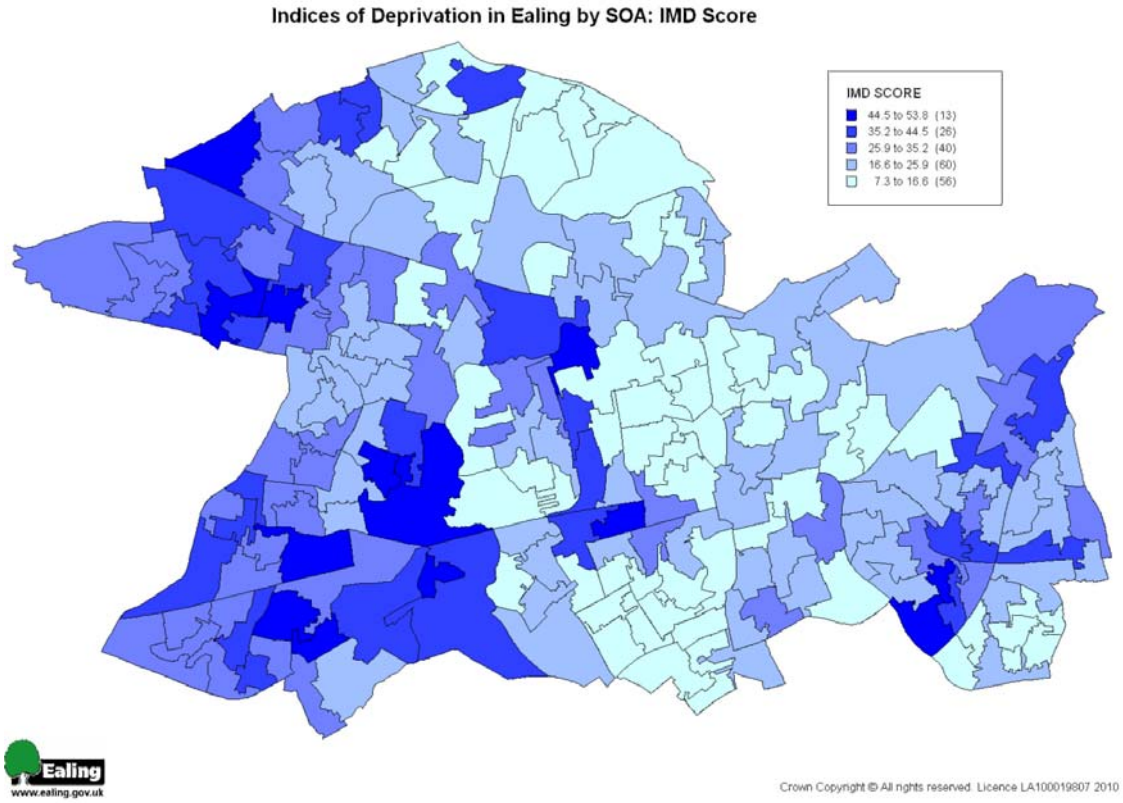
An overall Index of Multiple Deprivation (IMD) is produced by combining data from the seven domains. All indices are produced at local authority, ward and super output area level for the whole of England.

Using the Index of Multiple Deprivation ranking

Using the Index of Multiple Deprivation at local authority level shows that Ealing has an IMD rank of 62 out of 149, (where 1 = most deprived local authority and 149 = least deprived local authority). It is therefore in the least deprived 50% of local authority in the country.

The following maps use the IMD scores for lower level super-output areas and illustrate the spread of affluence and deprivation across the local authority areas.

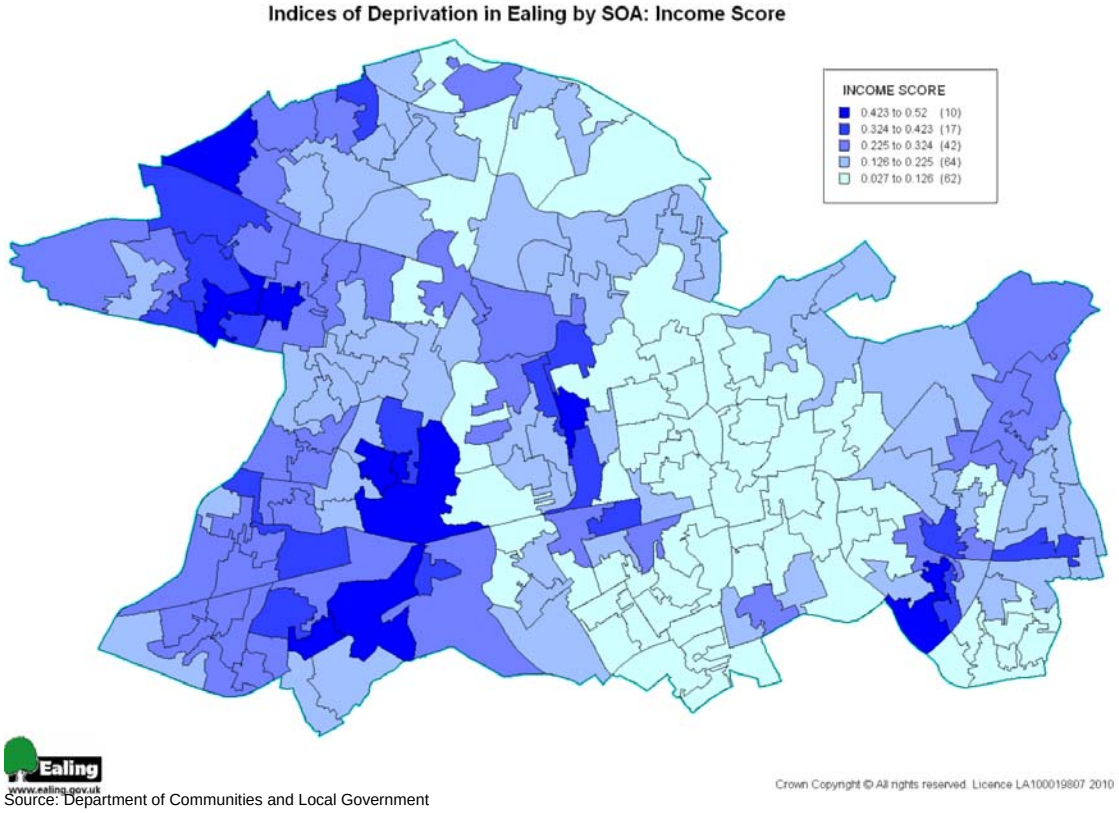
Figure 4.1 Overall Index of Multiple Deprivation



Source: Department of Communities and Local Government

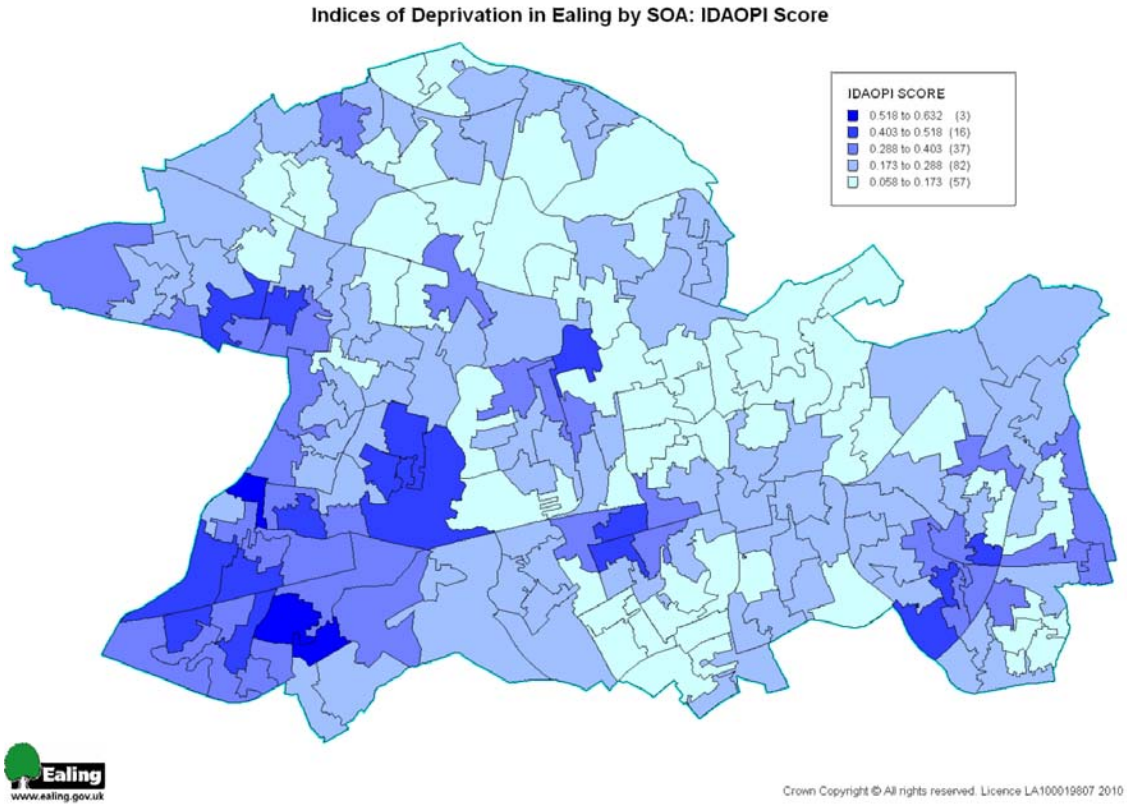
Figure 4.1 shows SOAs deprivation levels in Ealing. The most deprived areas concentrated Southall, Northolt, areas of Acton and small pockets throughout the Borough, particularly in areas of dense social housing.

Figure 4.2 Overall Income Deprivation



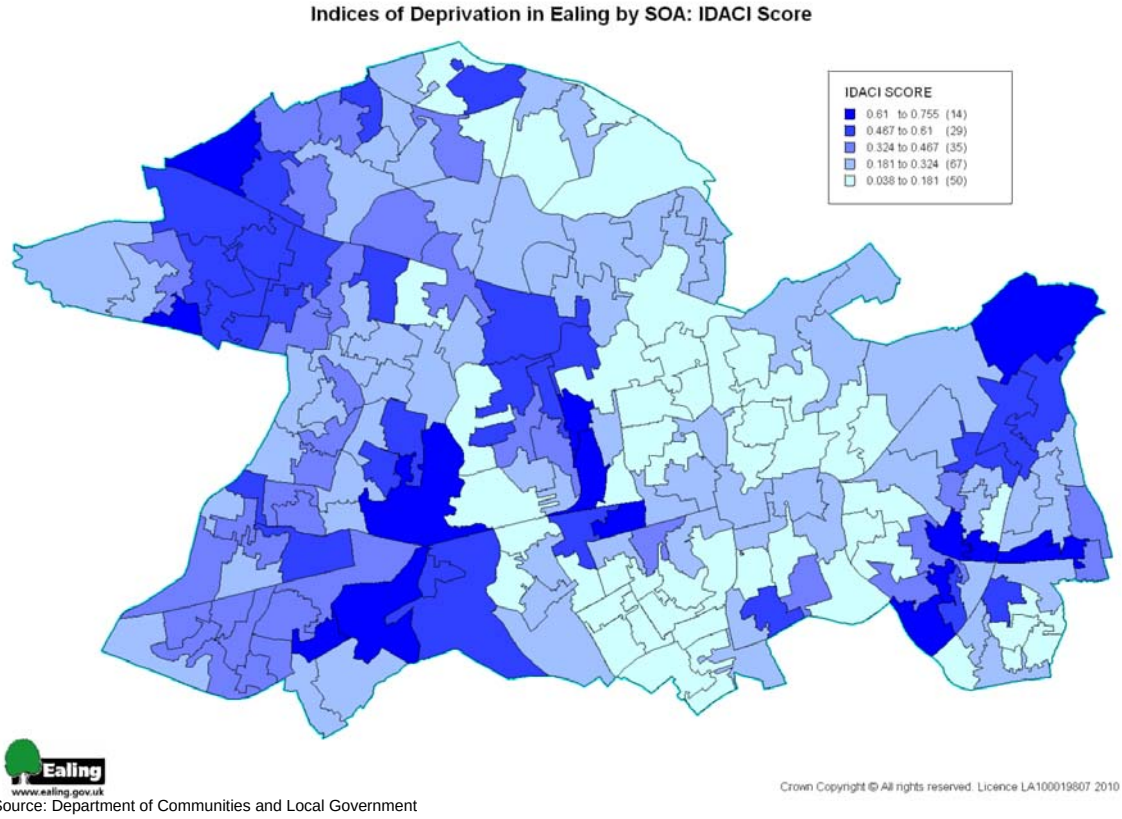
Source: Department of Communities and Local Government

Figure 4.3 Income Deprivation Affecting Older People



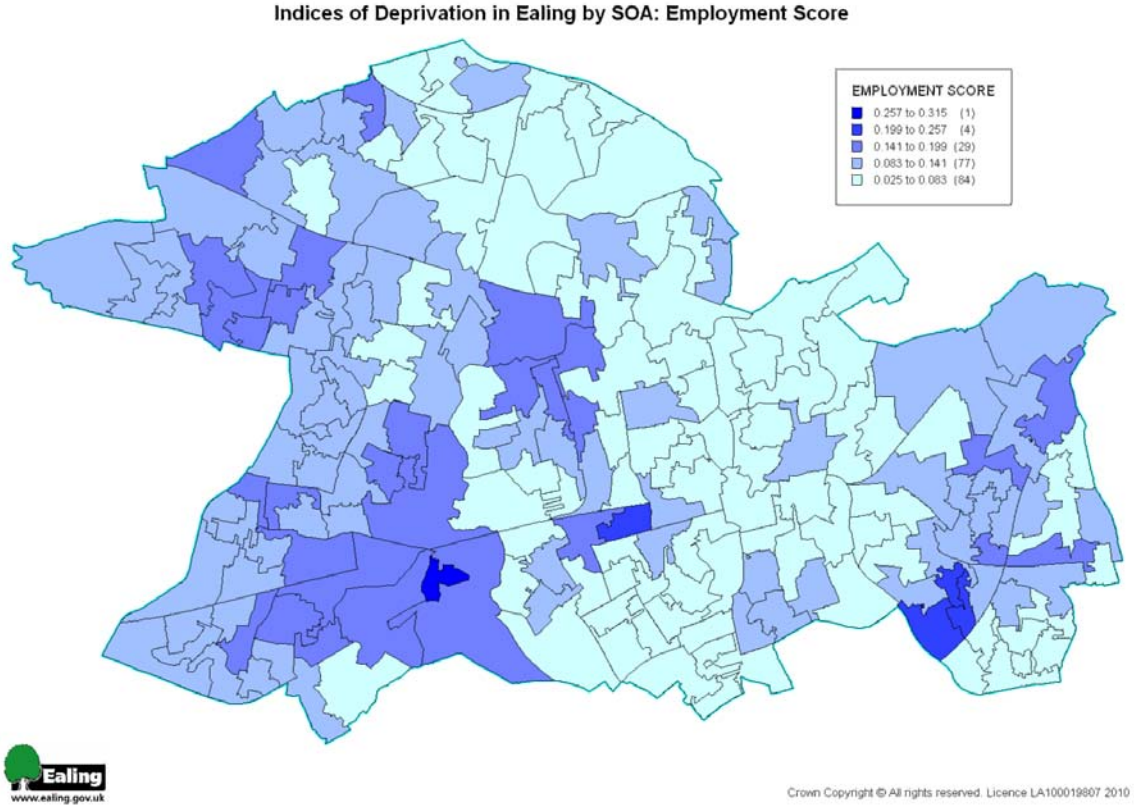
Source: Department of Communities and Local Government

Figure 4.4 Income Deprivation Affecting Children



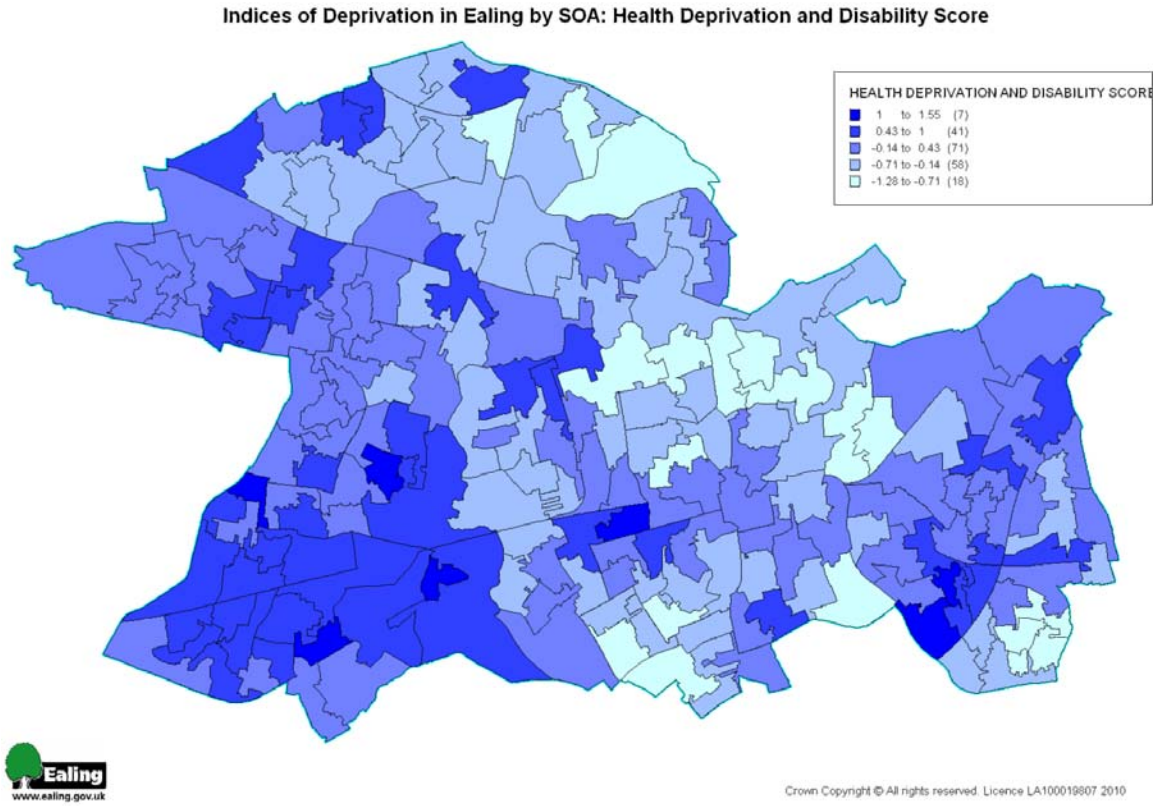
Source: Department of Communities and Local Government

Figure 4.5 Employment Deprivation



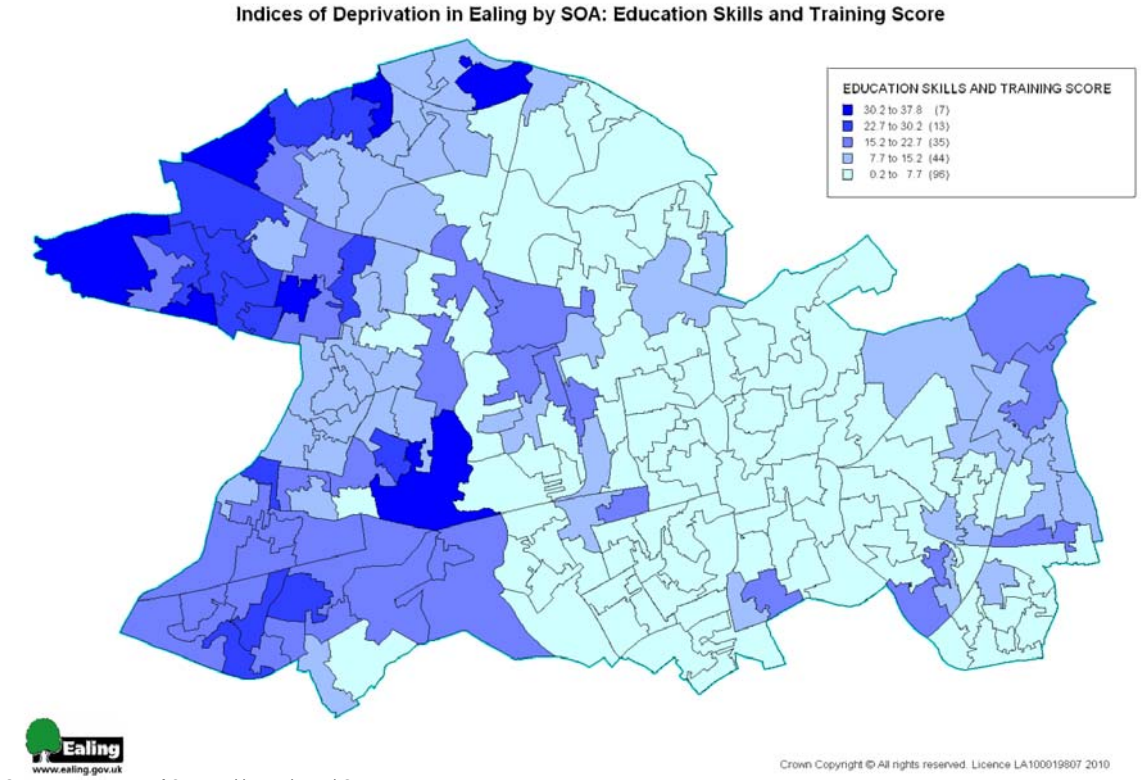
Source: Department of Communities and Local Government

Figure 4.6 Health and Disability Deprivation



Source: Department of Communities and Local Government

Figure 4.7 Education Skills and Training Deprivation

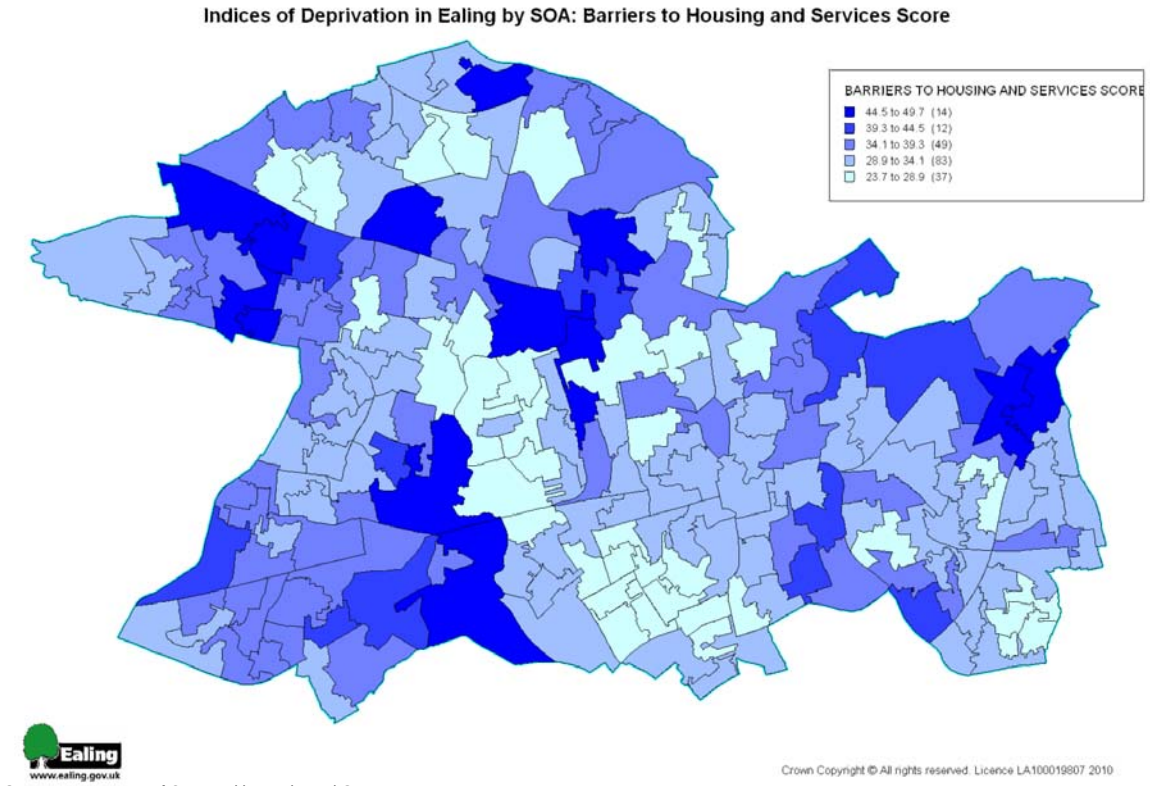


Source: Department of Communities and Local Government

Barriers to Housing and Services

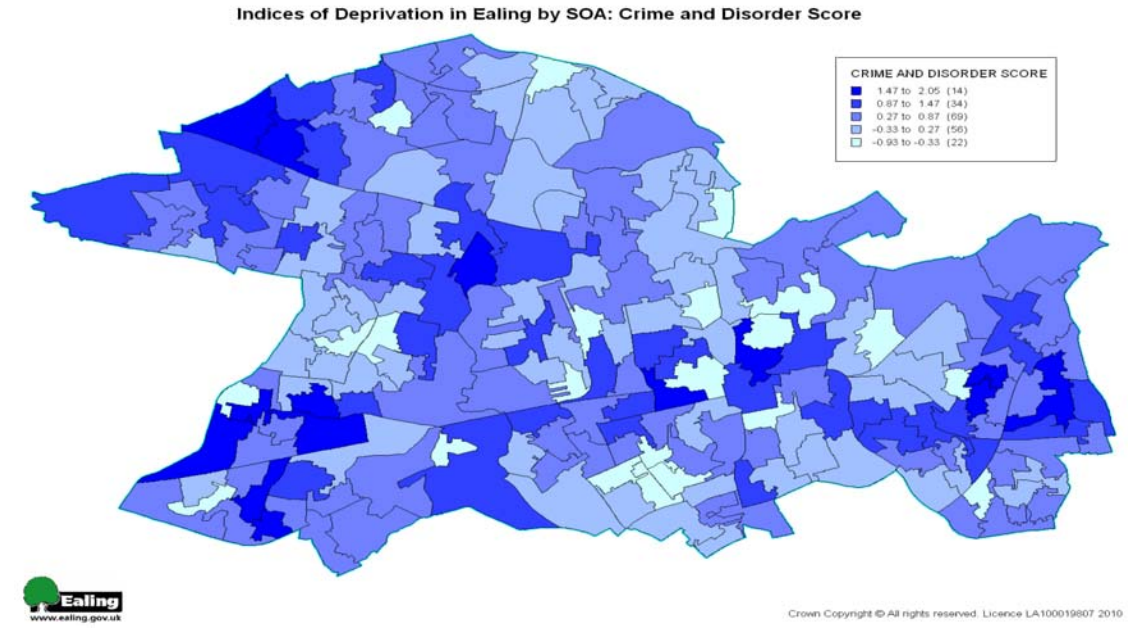
This domain takes into account overcrowding, access to owner occupation, road distance to GP surgeries, shops, primary schools and post offices.

Figure 4.8 Barriers to Housing and Services



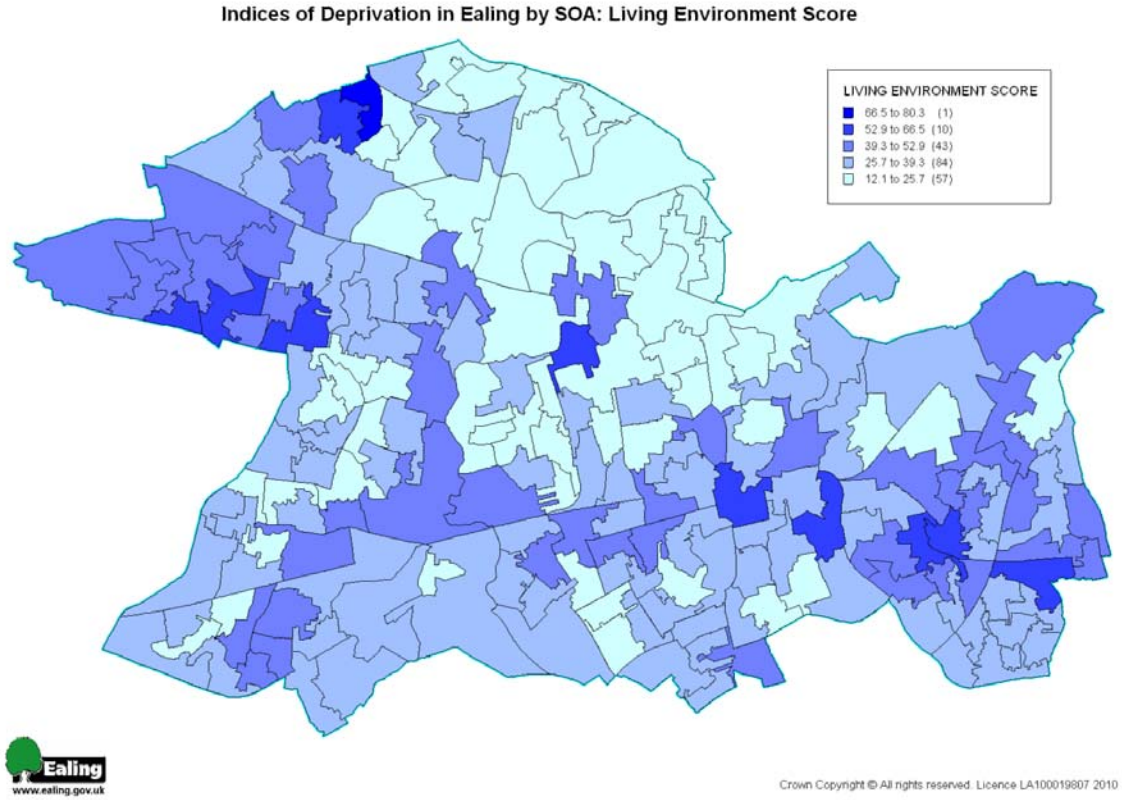
Source: Department of Communities and Local Government

Figure 4.9 Crime Deprivation



Source: Department of Communities and Local Government

Figure 4.10 Living Environment



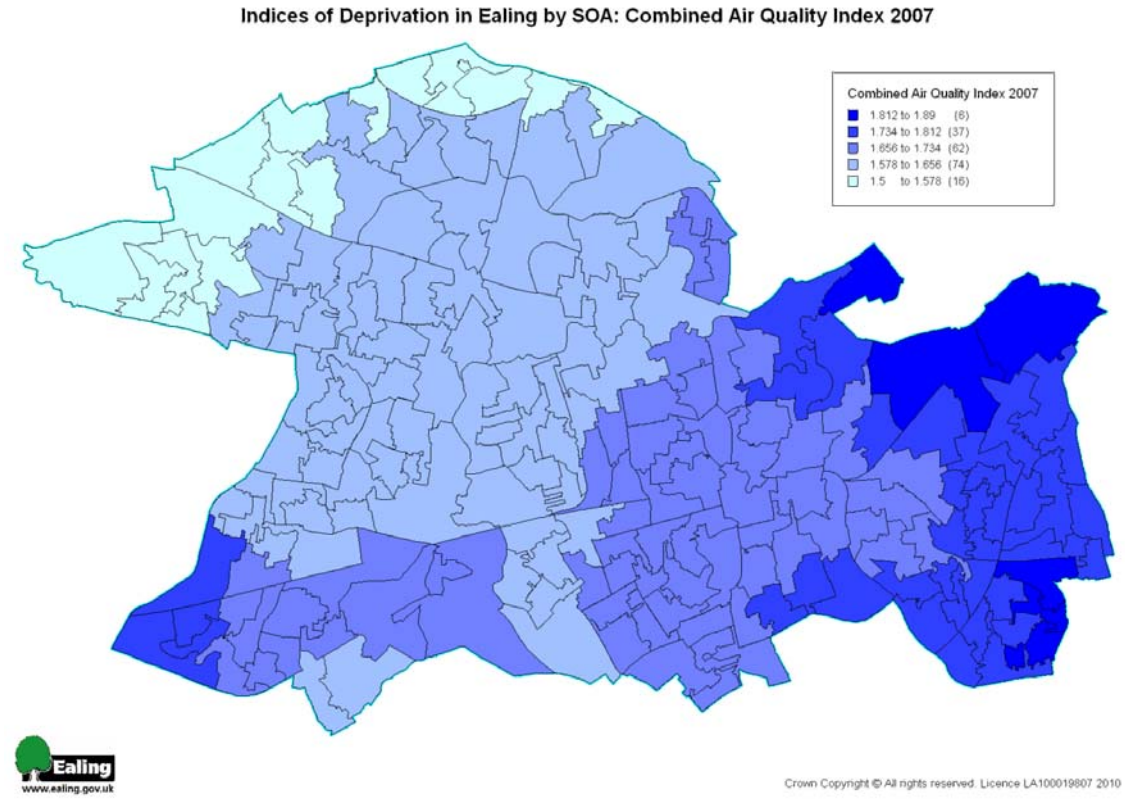
Source: Department of Communities and Local Government

AIR QUALITY

Across England the combined air quality scores for lower level SOAs vary from 0.52 (best) to 2.54 (poorest) – a difference of more than five-fold. The worst air quality is found in the centre of major conurbations and larger cities and the best air quality in more remote rural and peripheral locations.

The average Ealing SOA has an air quality indicator of 1.67. The worst air quality figures in Ealing are in a number of SOAs in Acton and Southall. The urbanised nature of much of this area, population density, the through traffic and the busy intersections appear to combine to produce a local concentration of poor air quality (Figure 4.11).

Figure 4.11 Combined Air Quality Index



Source: Department of Communities and Local Government and Department for Energy and Climate Change

HOUSING

Table 4.12 shows the number of household spaces and the spread of housing by type across Ealing at the time of the 2001 census. Ealing has a lower percentage of Detached and Semi-detached houses than Outer London and England but as expected higher than the Inner London percentage. It has higher percentages of purpose built flats and converted or shared house than Outer London and England but lower than the Inner London percentages. It has similar to Outer London Levels of flats in commercial buildings and Caravan or temporary structures.

Table 4.12 Housing by types in Ealing, Inner London, Outer London and England

		Percentage of Household spaces of accommodation type						
	Total Household Spaces	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Ealing	120,887	4.37	23.45	29.61	28.22	12.64	1.61	0.09
Outer London	1,841,954	8.81	28.24	29.27	23.98	7.94	1.63	0.11
Inner London	1,267,703	2.00	5.89	21.07	46.20	22.65	2.09	0.10
England	21,262,825	22.51	31.57	25.84	13.96	4.55	1.15	0.42

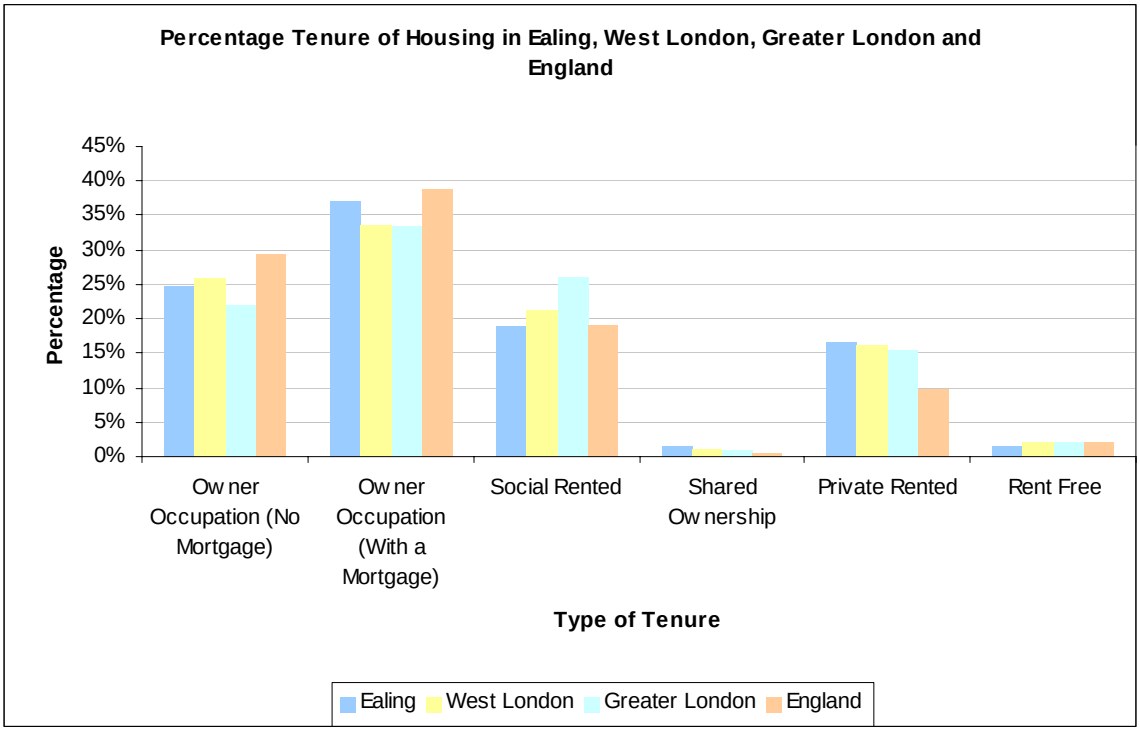
Source: Office for National Statistics (ONS) 2001 Census

A: Detached whole house or bungalow
B: Semi-detached whole house or bungalow
C: Terraced, including end terrace
D: Flat, maisonette or apartment: purpose-built block of flats or tenement
E: Flat, maisonette or apartment: part of a converted or shared house (including bedsits)
F: Flat, maisonette or apartment: In a commercial building
G: Caravan or other mobile or temporary structure

Tenure

Ealing has higher percentages of homeowners, both outright or with a mortgage, than Greater London but lower than the England percentages. However outright owners are very slightly below the West London percentage in Ealing but owners with a mortgage are higher than West London. Shared Ownerships and Private Renting are higher than West London, Greater London and England percentages. Ealing has lower than West London, Greater London and England levels for Social Renting. (Figure 4.13)

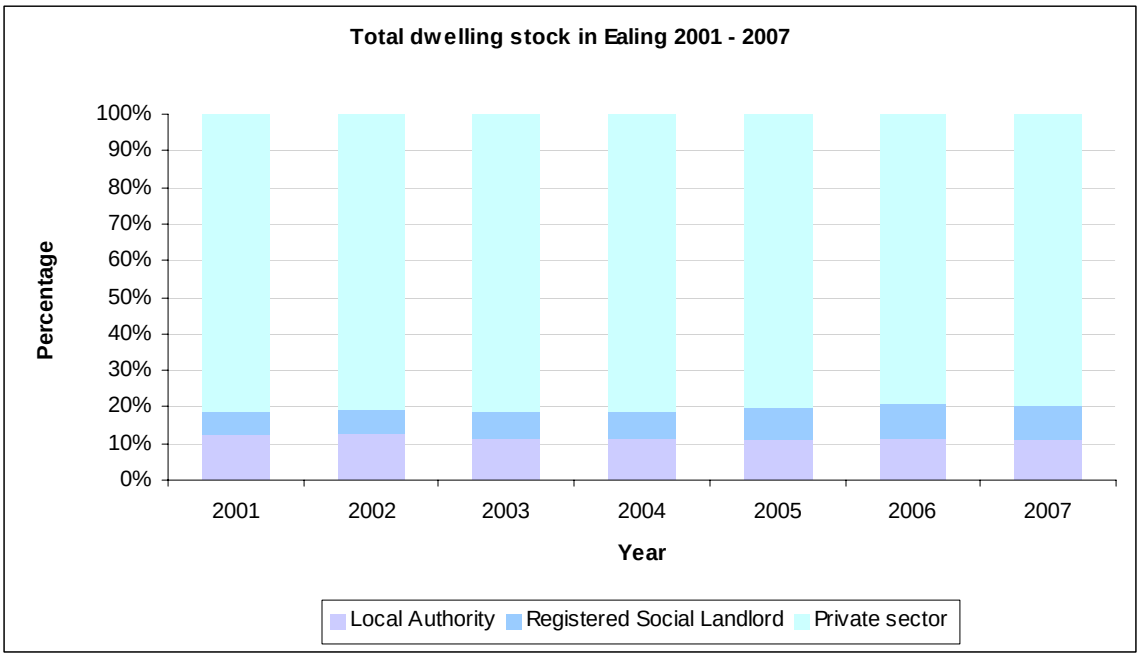
Figure 4.13 Percentage Housing Tenure types in Ealing, West London and Greater London



Source: Office for National Statistics (2001)

Dwelling Stock

Figure 4.14 Trends in Dwelling Stock in Ealing 2001 - 2007



Source: Department of Communities and Local Govt, HSSA, 2008

Figure 4.12 shows how Ealing's dwelling stock has changed over recent years. Registered Social Landlord dwellings have increased year on year between 2001 and 2007, the overall percentage increase between 2001 and 2007 stands at about 57%. Local Authority dwelling stock has fluctuated over the years but overall is 8% lower in 2007 than 2001. Similar fluctuations can be seen with Private sector dwellings but 2007 levels are currently about 3% higher than in 2001. Overall Ealing's dwelling stock remains relatively unchanged (5% increase) since 2001 in comparison to the increases seen in its population in general.

EMPLOYMENT & UNEMPLOYMENT

Table 4.15 Employment and Unemployment (Oct 2008 – Sep 2009)

	Economically Active*		In Employment*		Employees*		Self Employed*		Unemployed (model-based)**	
	Number	%	Number	%	Number	%	Number	%	Number	Percentage
Ealing	164800	76.0%	146500	67.3%	120700	56.1%	25500	11.2%	15100	9.3%
Brent	145300	77.1%	133700	70.8%	108100	57.4%	25200	13.2%	12500	8.6%
Hammersmith & Fulham	94300	74.3%	86500	68.1%	71000	56.3%	14900	11.3%	8400	8.8%
Harrow	113200	78.0%	103400	71.4%	87300	60.9%	15900	10.5%	8000	7.2%
Hillingdon	130800	77.5%	123900	73.2%	107700	63.9%	15300	9.0%	9000	6.8%
Hounslow	121400	77.1%	112500	71.2%	96400	61.2%	15700	9.6%	9000	7.4%
London		75.8%		69.3%		58.1%		10.8%		8.4%

*numbers are for those aged 16 and over, % are for those of working age (16-59/64)

**numbers and % are for those aged 16 and over. % is a proportion of economically active

Source: NOMIS

Ealing's economically active population is just above the London percentage (76% compared to 75.8%), however in comparison to its West London immediate neighbours, it is slightly below their percentages with the exception of Hammersmith and Fulham.

Jobseekers Allowance

The percentage of the male and female working age population claiming the Jobseekers Allowance unemployment-related benefit (April 2010) is shown in Table 4.16. The percentage claiming Jobseekers Allowance in Ealing is very similar to the London percentages. However compared to Ealing's immediate neighbours, the percentage of claimants is higher with the exception of Brent for males and Hammersmith and Fulham and Brent for females.

Table 4.16 Jobseekers Allowance unemployment-related benefit claimants April 2010

	Male		**Female**		**All Person**	
	Number	**%**	**Number**	**%**	**Number**	**%**
Ealing	6129	5.5%	3062	3.1%	9191	4.4%
Brent	6415	6.8%	3193	3.7%	9608	5.3%
Hammersmith & Fulham	3329	5.2%	1825	3.1%	5154	4.2%
Harrow	2873	4.0%	1559	2.4%	4432	3.2%
Hillingdon	3978	4.8%	2097	2.7%	6075	3.8%
Hounslow	3631	4.6%	1967	2.8%	5598	3.7%
London		5.6%		3.0%		4.4%

Source: NOMIS

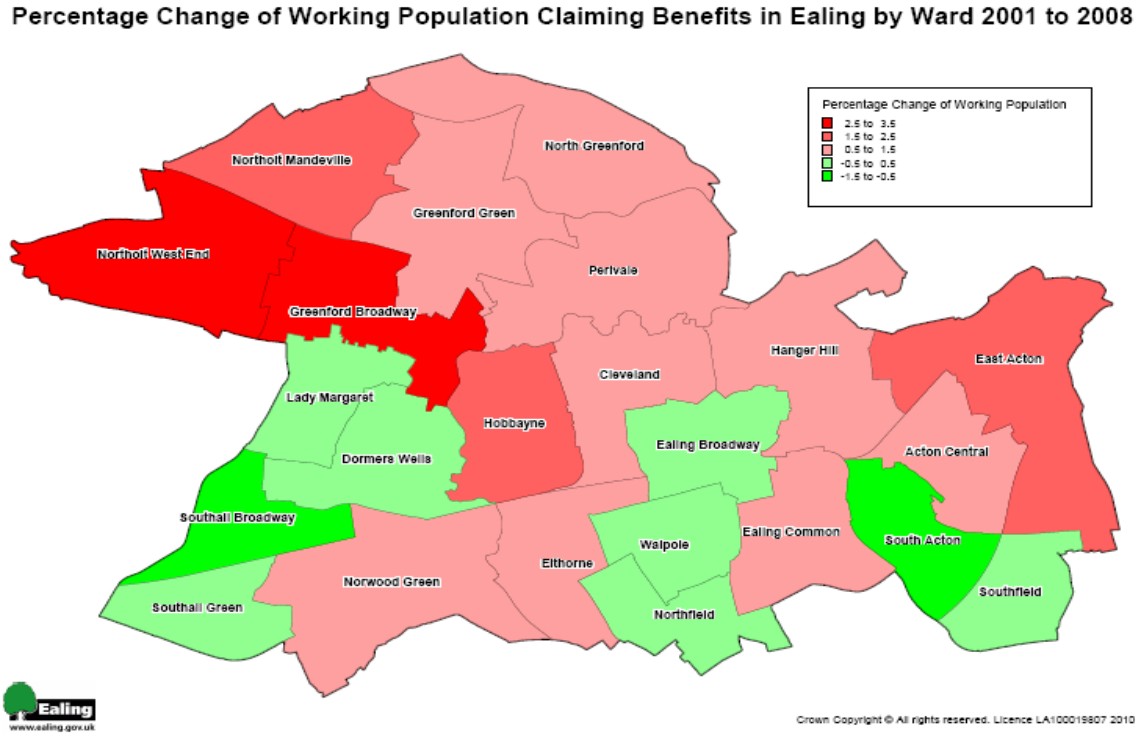
Population Claiming Key Benefits in Ealing

Table 4.17 Percentage of Working Age Population in Ealing Wards 2001 and 2008

	2001		2008		
	JSA (all), IB, SDA and IS Claimants		JSA (all), IB, SDA and IS Claimants		
Ward name	**Working Age Total**	**% of Working Age Population**	**Working Age Total**	**% of Working Age Population**	**% Change 2001 to 2008**
Acton Central	1,400	14.8%	1450	15.3%	0.5%
Cleveland	1,180	12.5%	1255	13.3%	0.8%
Dormers Wells	1,540	17.8%	1555	18.0%	0.2%
Ealing Broadway	720	7.7%	720	7.7%	0.0%
Ealing Common	900	9.5%	985	10.4%	0.9%
East Acton	1,400	13.9%	1620	16.1%	2.2%
Elthorne	1,240	14.0%	1320	14.9%	0.9%
Greenford Broadway	1,360	15.7%	1630	18.8%	3.1%
Greenford Green	800	9.4%	880	10.4%	0.9%
Hanger Hill	540	5.5%	650	6.7%	1.1%
Hobbayne	1,040	12.1%	1245	14.5%	2.4%
Lady Margaret	1,140	13.3%	1110	12.9%	-0.3%
Northfield	520	5.8%	530	5.9%	0.1%
North Greenford	860	9.8%	900	10.3%	0.5%
Northolt Mandeville	1,240	15.1%	1405	17.1%	2.0%
Northolt West End	1,620	19.2%	1850	21.9%	2.7%
Norwood Green	1,860	22.6%	1915	23.3%	0.7%
Perivale	900	9.8%	995	10.8%	1.0%
South Acton	1,660	17.9%	1570	16.9%	-1.0%
Southall Broadway	1,560	17.7%	1465	16.6%	-1.1%
Southall Green	1,580	18.1%	1545	17.7%	-0.4%
Southfield	700	7.5%	675	7.2%	-0.3%
Walpole	720	7.8%	695	7.6%	-0.3%

Source: London Public Health Observatory (2009)

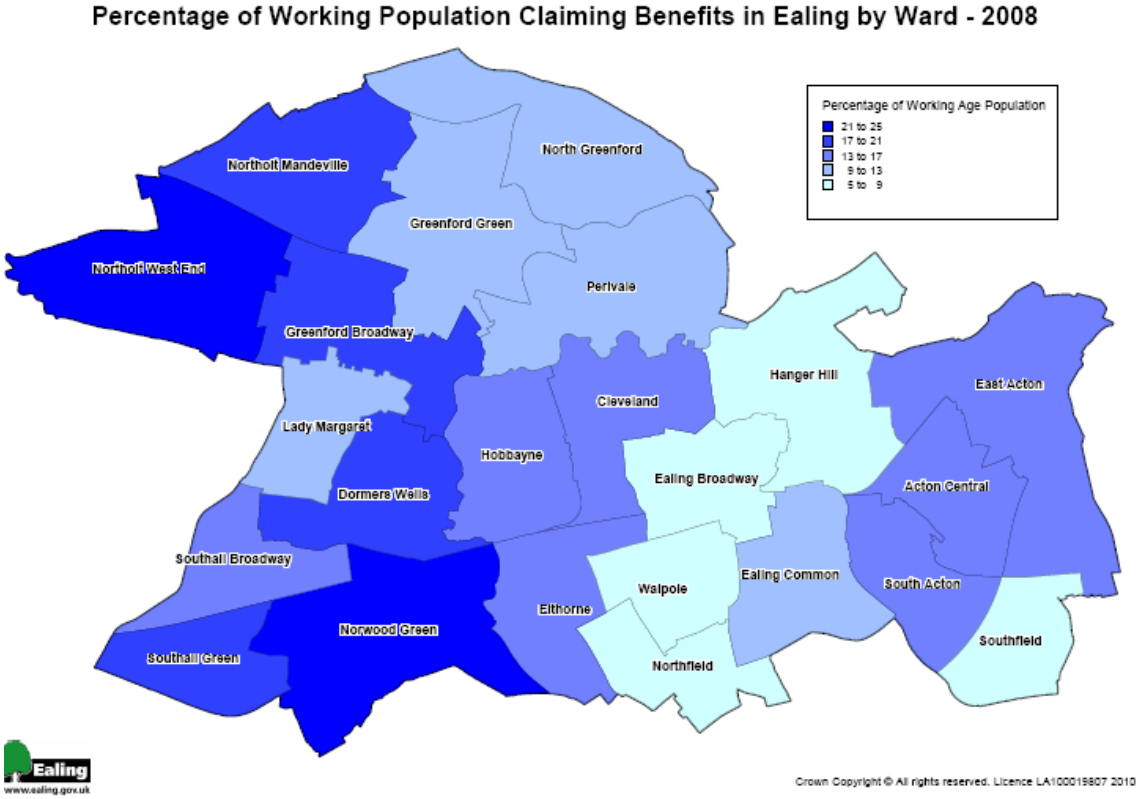
Figure 4.18 Percentage Change of Working Population Claiming Benefits in Ealing by Ward 2001 - 2008



Source: London Public Health Observatory (2009)

Table 4.17 and Figure 4.18 shows the change between 2001 and 2008 of percentage of working age population (males 16-64, females 16-59) at ward level in Ealing claiming key benefits. Key benefits being those receiving any one of the following: Jobseekers Allowance, Incapacity Benefit, Severe Disability Allowance or Income Support. Most of the wards within Ealing have seen small increases in the percentage of the population claiming key benefits. Two wards in Southall, Green and Broadway have seen falls in the percentage which is interesting but given how deprived Southall is compared to other areas in Ealing. This is more likely to indicate higher baselines for these wards than any significant improvement of the relative depravation of these wards. Greenford Broadway, Northolt West End and Hobbayne were the three wards that saw largest percentage increases in people claiming key benefits between 2001 and 2008. (Figure 4.18)

Figure 4.19 Percentage of Working Population Claiming Benefits in Ealing by Ward, 2008



Source: London Public Health Observatory (2009)

Income

Income inequalities in Ealing are significant, median income can range between £19,150 annually in Southall Broadway to more than double that in Southfield at £39,651.

Table 4.20 Median Income by Ward

Ward	Median Income
Southall Broadway	£19,150
Southall Green	£19,758
Dormers Wells	£21,998
Norwood Green	£22,503
Lady Margaret	£24,070
Northolt West End	£25,139
Northolt Mandeville	£25,755
East Acton	£26,166
Greenford Broadway	£26,534
Perivale	£26,732
North Greenford	£26,846
Hobbayne	£27,520
Greenford Green	£27,906
South Acton	£29,591
Acton Central	£30,817
Elthorne	£32,403
Cleveland	£33,440
Northfield	£34,533
Ealing Common	£35,004
Walpole	£37,584
Ealing Broadway	£38,212
Hanger Hill	£38,726
Southfield	£39,651

Source: CACI Paycheck 2009

FUEL POVERTY

At the end of 2008 approximately 3.6 million (2.4 million in England) households in the UK were suffering from fuel poverty, defined as a household which spends more than 10% of its income on all fuel use, including heating. Over 50% of people living in fuel poverty in the UK are over 60 years old, the majority of whom live on their own. Over two thirds of households in fuel poverty either live in private rented accommodation or own their home.[5]

The following table illustrates the health effects experienced by people living temperatures below the recommended 16°-21°C (18°C and over in living areas):

Table 4.21 Effect of Temperature on Health

Indoor Temperature	Effect
21°C	Recommended living room temperature
18°C	Minimum temperature with no health risk, though may feel cold
Under 16°C	Resistance to respiratory diseases may be diminished
9-12°C	Increases blood pressure and risk of cardiovascular disease
5°C	High risk of hypothermia

Source: Baker W. (In press.) *Fuel Poverty and Ill Health – A Review*. London: Centre for Sustainable Energy and Collins KJ. 1986. Low indoor temperatures and morbidity in the elderly. *Age and Aging*; 15: 212-20.

How the cold affects health

In older people, a one degree lowering of living room temperature is associated with a rise of 1.3 mmHg blood pressure, due to cold extremities and lowered core body temperature. Increases in blood pressure, along with increased blood viscosity, (caused by mild skin surface cooling), increases the risk of strokes and heart attacks.

Cold air affects the normal protective function of the respiratory tract, with increased broncho-constriction, mucus production and reduced mucus clearance. Cold, damp houses also promote mould growth, which increases the risk of respiratory infections.

Excess winter deaths

In the UK, there are over 60,000 excess deaths throughout the year related to the colder winter weather. Over 30,000 of these excess deaths are from cardiovascular disease and 20,000 from respiratory disease[6]. It is possible to predict when excess deaths will occur after a cold day: heart attacks after 2 days, strokes after 5 days and respiratory disease after 12 days.

Although cold weather is clearly a factor in excess deaths, most Scandinavian countries do not have the same pattern. The excess winter deaths in the UK are related to factors which affect how warm a house is, for example, energy efficiency and insulation, central heating and household income. There is a 20% difference in excess winter deaths between the coldest and warmest homes. Table 2.31 summarises the main health effects of fuel poverty in the UK:

Table 4.22 The Health effects of Fuel Poverty in the UK

Cardio-vascular disease:

- Can be attributed to over 30,000 excess winter deaths each year
- The cold increases blood pressure.
- A one degree lowering of living room temperature is associated with a rise of 1.3 mmHg blood pressure.
- A rise in blood pressure during the cold increases the risk of heart attacks and strokes.

Respiratory Illness:

- Can be attributed 20,000 excess winter deaths each year
- The cold lowers resistance to respiratory infections.
- Coldness impairs lung function and can trigger broncho-constriction in asthma and Chronic Obstructive Pulmonary Disease (COPD).
- Dampness is associated with cold houses; damp increases mould growths which can cause asthma and respiratory infections.
- Home energy improvements have decreased school sickness by 80% in children with asthma or recurrent respiratory infections.

Cold houses affect mobility and increase falls and non-intentional injuries:

- Symptoms of arthritis become worse in cold damp houses.
- Strength and dexterity decrease as temperatures drop, increasing the risk of non-intentional injuries.
- A cold house increases the risk of falls in the elderly.

Mental and social health:

- Damp, cold housing is associated with an increase in mental health problems.
- Some people become socially isolated as they are reluctant to invite friends round to a cold house.
- In cold homes where only one room is heated, it is difficult for children to do homework, affecting educational and long-term work and health opportunities.

Source: Press, V. (2003), "Fuel Poverty + Health Toolkit"

Estimates predict that just over 10,700 households in Ealing will be in fuel poverty by 2011. 2006 figures show that percentage of households in fuel poverty is slightly higher than the London percentage but below England (Table 4.23).

Table 4.23 Households in Fuel Poverty

	2006		2011 (Projected)	
	Number	**Percentage**	**Number**	**Percentage Change 2006 - 2011**
Ealing	10,397	8.8	10,736	3.3
London	254,249	8.3	277,137	9.0
England	2,431,691	11.5	2,604,290	7.1

Source: DECC- UK Fuel Poverty Annual Report 2009

COMMUNITY HEALTH PROFILES

In addition to the census based Index of Multiple Deprivation the local authority uses annual Community Health Profiles which are published by the Association of Public Health Observatories for all local authority areas in England. Each authority is assessed against 32 indicators and scored as either significantly better, significantly worse or not significantly different from the England average. Figure 4.24 shows Ealing's profile for 2009 and 2010, and provides a good insight into the variations in health outcomes that exist within the borough.

Table 4.24 Ealing Health Profile

Domain	Number	Indicator	Ealing 2010	Ealing 2009
Our Communities	1	Deprivation		
	2	Children in poverty		
	3	Statutory homelessness		
	4	GCSE achieved (5A*-C inc Eng & Maths)		
	5	Violent crime		
	6	Carbon emissions		
Children's and Young People's health	7	Smoking in pregnancy		
	8	Breast feeding initiation		
	9	Physically active children		
	10	Obese Children		
	11	Children's tooth decay (age 5)		
	12	Teenage pregnancy (under 18)		
Adults health and Lifestyle	13	Adults who smoke		
	14	Binge drinking adults		
	15	Health eating adults		
	16	Physically active adults		
	17	Obese adults		
Disease and poor health	18	Over 65s 'not in good health'		
	19	Incapacity benefits for mental illness		
	20	Hospital stays for alcohol related harm		
	21	Drug misuse		
	22	People diagnosed with diabetes		
	23	New cases tuberculosis		
	24	Hip fracture in over 65s		
Life expectancy and causes of death	25	Excess winter deaths		
	26	Life expectancy - male		
	27	Life expectancy - female		
	28	Infant death		
	29	Deaths from smoking		
	30	Early deaths: heart disease & stroke		
	31	Early deaths: cancer		
	32	Road injuries and deaths		

Source: APHO and Department of Health (Health Profiles) 2009 & 2010

Key	
	Significantly worse than England Average
	Not significantly different from England Average
	Significantly better than England Average

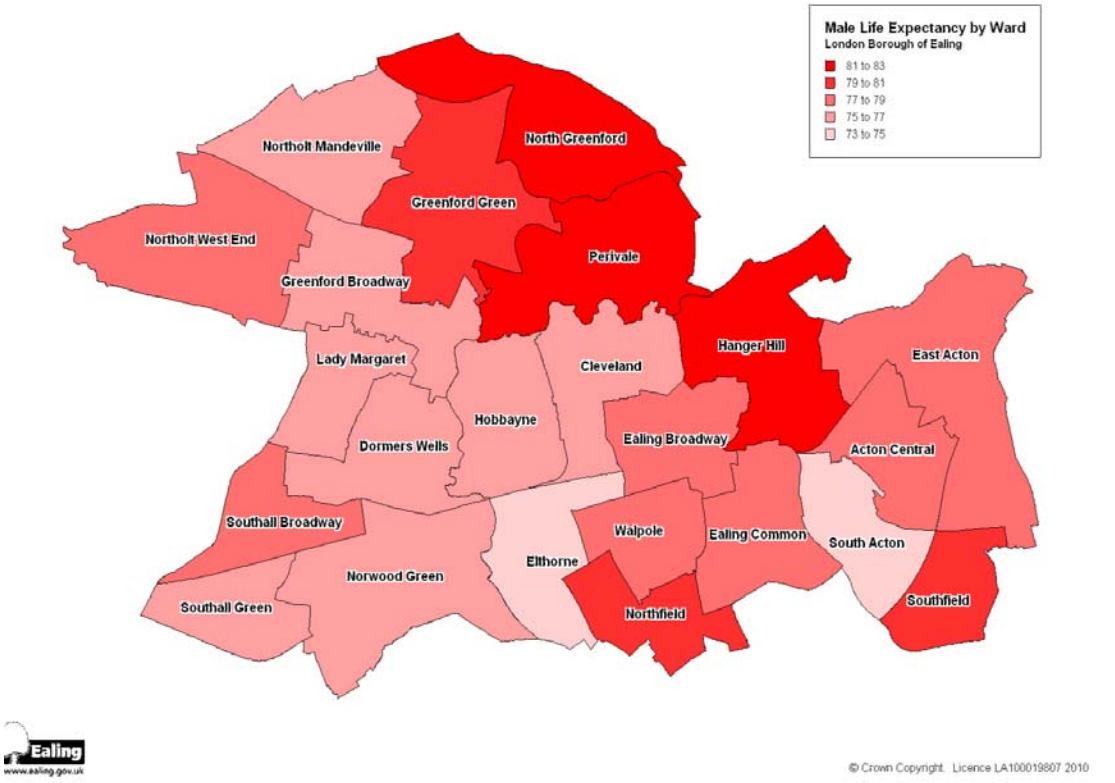
SECTION 5

Life Expectancy

LIFE EXPECTANCY

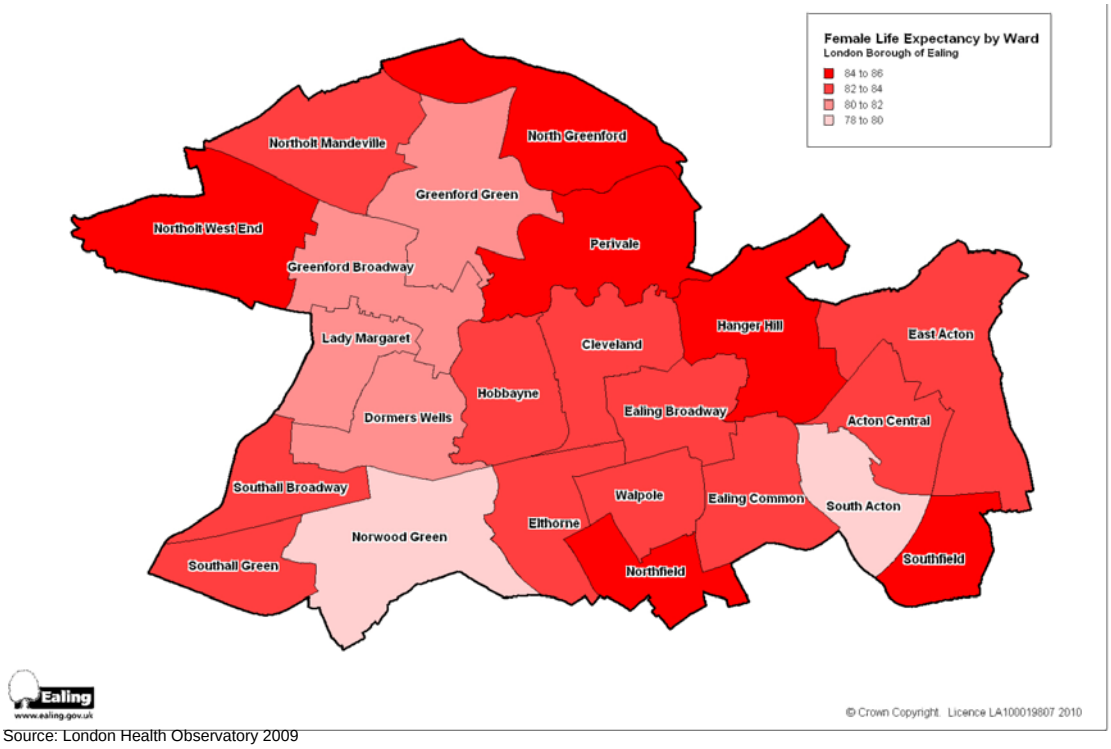
Life expectancy at birth reflects the overall mortality level of a population. It summarises the mortality pattern that prevails across all age groups - children and adolescents, adults and older people. Life expectancy at birth is a measure of general population health and health inequalities. In Ealing male life expectancy is 77.6 years and female is 82.6 years. There is a 9 year gap between the lowest and highest wards for males. For females the gap is 7 years. Life expectancy in Ealing is better than UK by about 1 year for both men and women. Life expectancy has increased nationally and locally, but there are persistent inequalities.

Figure 5.1 Life Expectancy for Males in Ealing by Ward 2003-07



Source: London Health Observatory 2009

Figure 5.2 Life Expectancy for Females in Ealing by Ward 2003-07

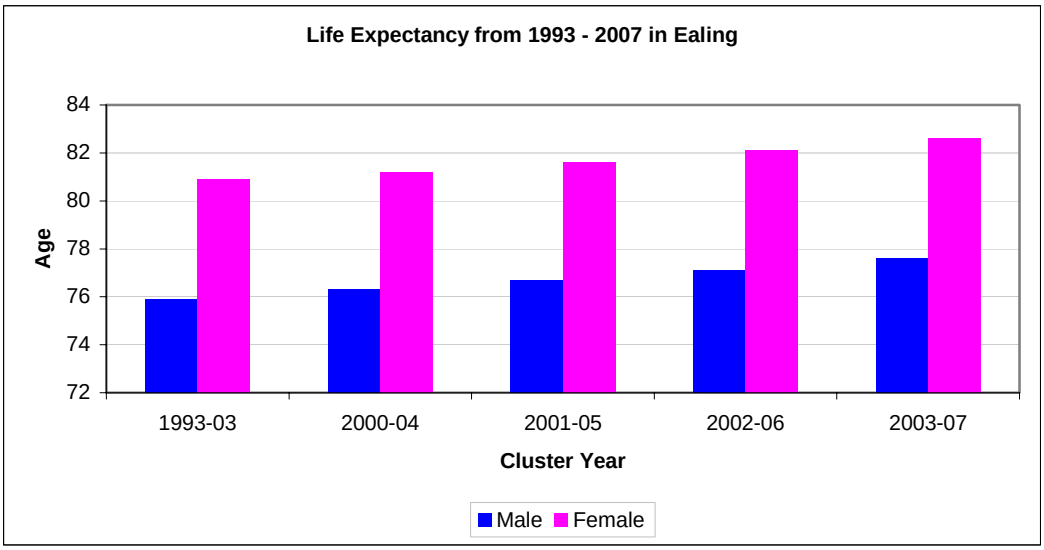


Source: London Health Observatory 2009

Life expectancy in Ealing varies from ward to ward for both men and women. For men, longer life expectancy occurs in North Greenford, Greenford Green, Perivale, Hanger Hill, Northfield and Southfield. Shorter life expectancy exist for men in Elthorne and South Acton.

The Norwood Green and South Acton wards have the lowest life expectancy for women in Ealing. Wards with the highest life expectancy for men tend to be the wards with higher expectancy for women with the exception of Greenford Green.

Figure 5.3 Life Expectancy from 1993 – 2007 in Ealing



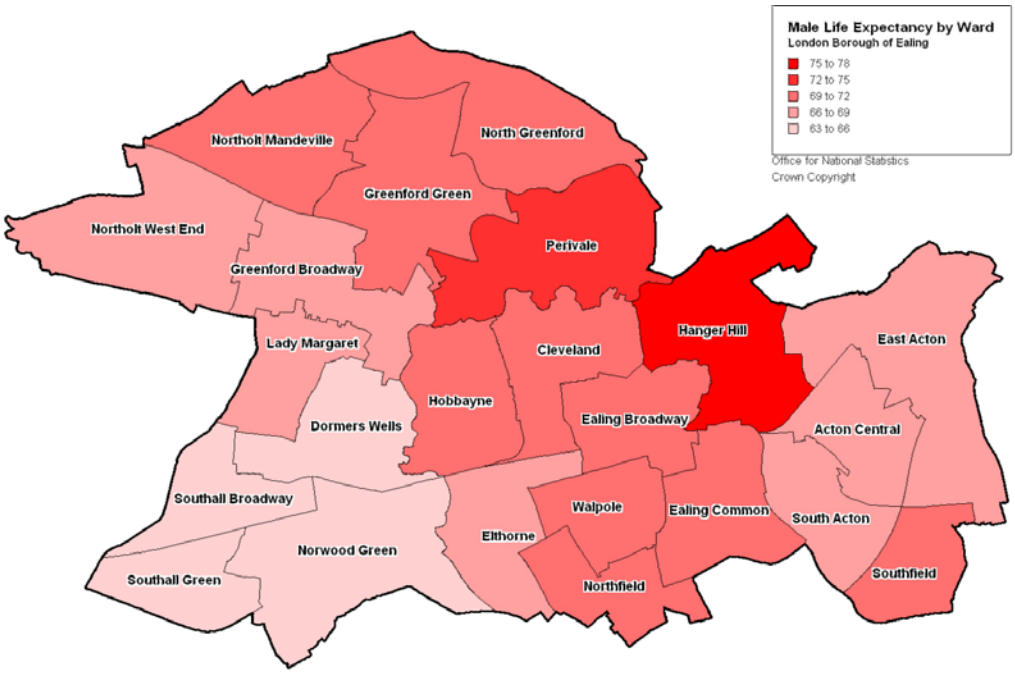
Source: London Health Observatory and Office for National Statistics 2009

Figure 5.3 shows the life expectancy trends between 1993 and 2007 for men and women in Ealing. Women's life expectancy is higher than men's in the borough, since 1993 both men and women rose by 1.7 years. The gap between men and women life expectancy has remained steady over the years.

Healthy Life Expectancy

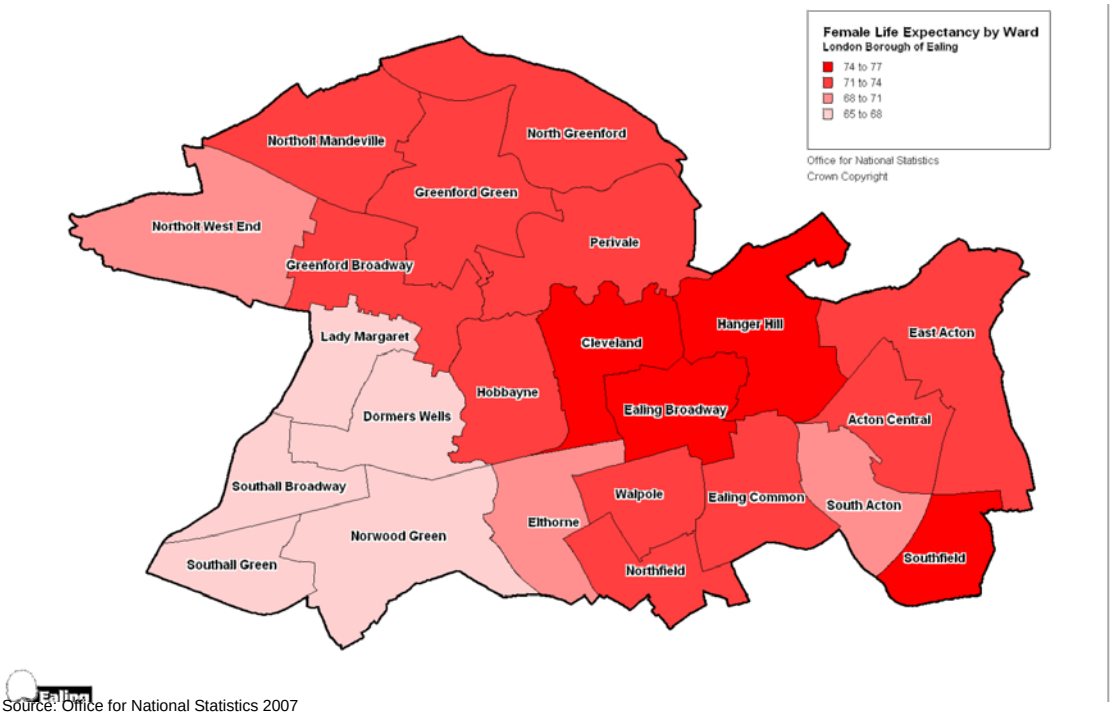
Substantial resources are devoted to reducing the incidence, duration and severity of major diseases that cause morbidity but not mortality and to reducing their impact on people's lives. It is important to capture both fatal and non-fatal health outcomes in a summary measure of average levels of population health. Healthy life expectancy (HLE) at birth adds up expectation of life for different health states, adjusted for severity distribution making it sensitive to changes over time or differences between countries in the severity distribution of health states.

Figure 5.4 Healthy Life Expectancy for Males at Birth by Ward



Source: Office for National Statistics 2007

Figure 5.5 Healthy Life Expectancy for Females at Birth by Ward



Source: Office for National Statistics 2007

As with life expectancy, healthy life expectancy also varies from ward to ward in Ealing. Healthy life expectancy is longer for men living in Perivale and Hanger Hill. Men in Southall Broadway, Dormers Wells, Southall Green and Norwood Green have a shorter healthy life expectancy.

Women generally have a longer healthy life expectancy than men in Ealing. On the whole the wards identified for men as having lower healthy life expectancy are the same for women with the addition of Lady Margaret. Ealing Broadway, Cleveland, Hanger Hill and Southfield are the wards where women have a longer healthy life expectancy.

Table 5.6 Healthy Life Expectancy in Ealing at Birth

	Male	Female
Ealing	68.7	71.6
London	68.7	72.0
England	69.1	72.3

Source: Office for National Statistics 2007

Table 5.7 Healthy Life Expectancy in Ealing at Age 65

	Male	Female
Ealing	12.6	14.2
London	12.5	14.6
England	12.5	14.5

Source: Office for National Statistics 2007

Healthy life expectancy at birth for women is nearly three years longer than for men in Ealing. However women in Ealing do have slightly lower healthy life expectancy at

birth than women in London and England. For men, the Ealing life expectancy is the same as that of London and slightly below that of the country. (Table 5.6)

Although still lower than healthy life expectancy of women, the healthy life expectancy of men at age 65 in Ealing is comparable to that on London and England. For women, healthy life expectancy at age 65 is 1.6 years longer than men's, however it is very slightly lower than the London and England figure (Table 5.7)

Disability-free life expectancy

Disability-free life expectancy measures disability by looking at reported limitations in day to day activities such as work, school and leisure activities. More severe disability and dependence can be measured by people's ability to carry out activities of daily living such as bathing, dressing, and shopping (which can be used to calculate dependency-free life expectancy). Such measures of functional ability are considered to be more independent of social factors than self-reported health.

Figure 5.8 Disability-free Life Expectancy at Birth

Source: Office for National Statistics 2007

Figure 5.9 Disability-free Life Expectancy at Age 65

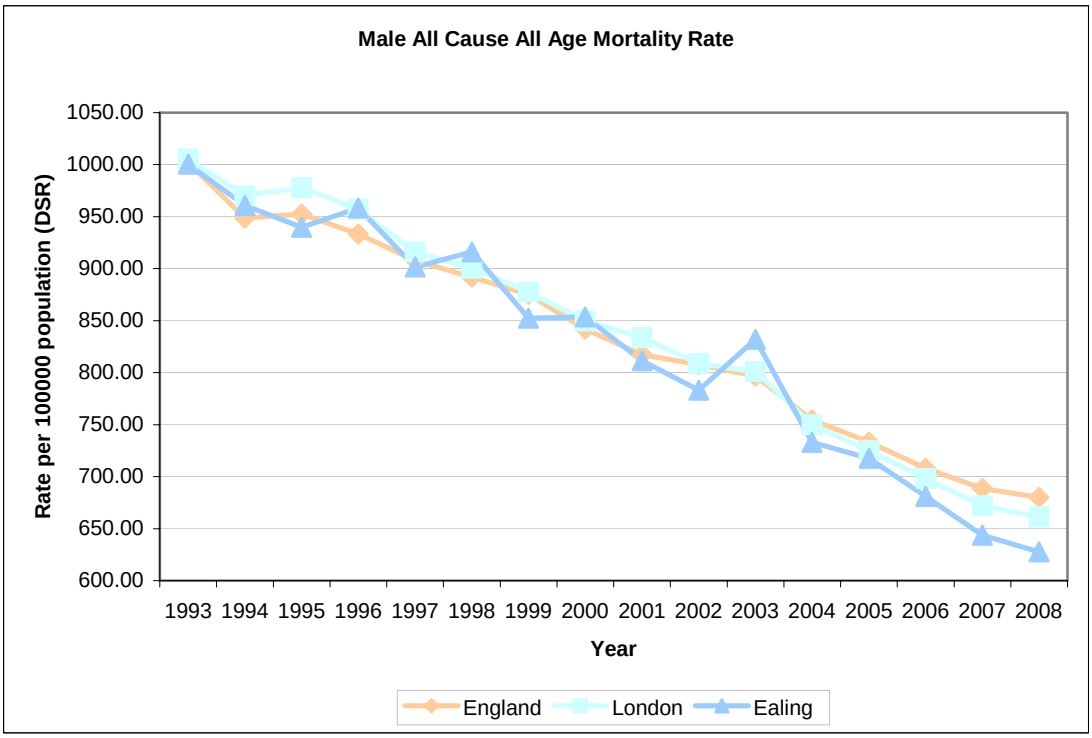
Source: Office for National Statistics 2007

Disability-free life expectancy is higher for females than males at birth and at age 65 in Ealing. At birth females can expected to live disability-free for 2.3 years longer than males. This is the same in London but slightly lower than the 2.5 years in England. Males and females are comparable with male and females in London and England with very little difference between the number of disability-free years.

At age 65 men in the borough have a very similar number of disability free years as men in England and London. For women, the number of years is slightly lower than the London years, 9.1 compared to 9.9.

ALL CAUSE MORTALITY

Figure 5.10 Male All Cause All Age Mortality



Source: National Centre for Health Outcomes Development 2009

Figure 5.11 Female All Cause All Age Mortality

Source: National Centre for Health Outcomes Development 2009

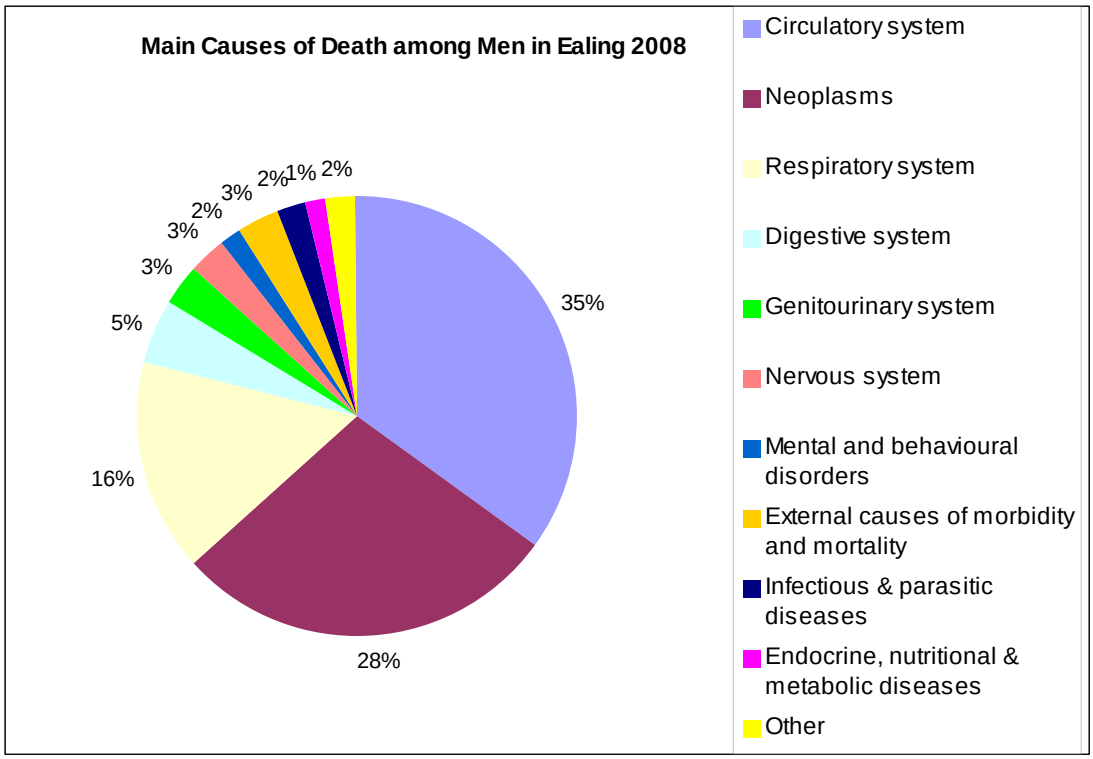
Figure 5.10 and 5.11 both show that the all cause all age mortality rate has been falling in Ealing for both men and women. This is in keeping with both the London and England picture. Female mortality rates in Ealing, as well as London and England, are much lower than male mortality rates. In 2008 male all cause mortality

rates in Ealing were 627.78 per 100,000 population while female rates were 474.44. In the same year female mortality rates were slightly higher than the London rate but lower than the England. Male rates are lower than the England and London rate. Overall female mortality rates have fallen by nearly 23% since 1993 however this London and England rates have fallen by about 28% and 24% respectively. For men the rate has fallen by 37% in Ealing since 1993 by 34% in London and by 32% in England.

MAIN CAUSES OF DEATH

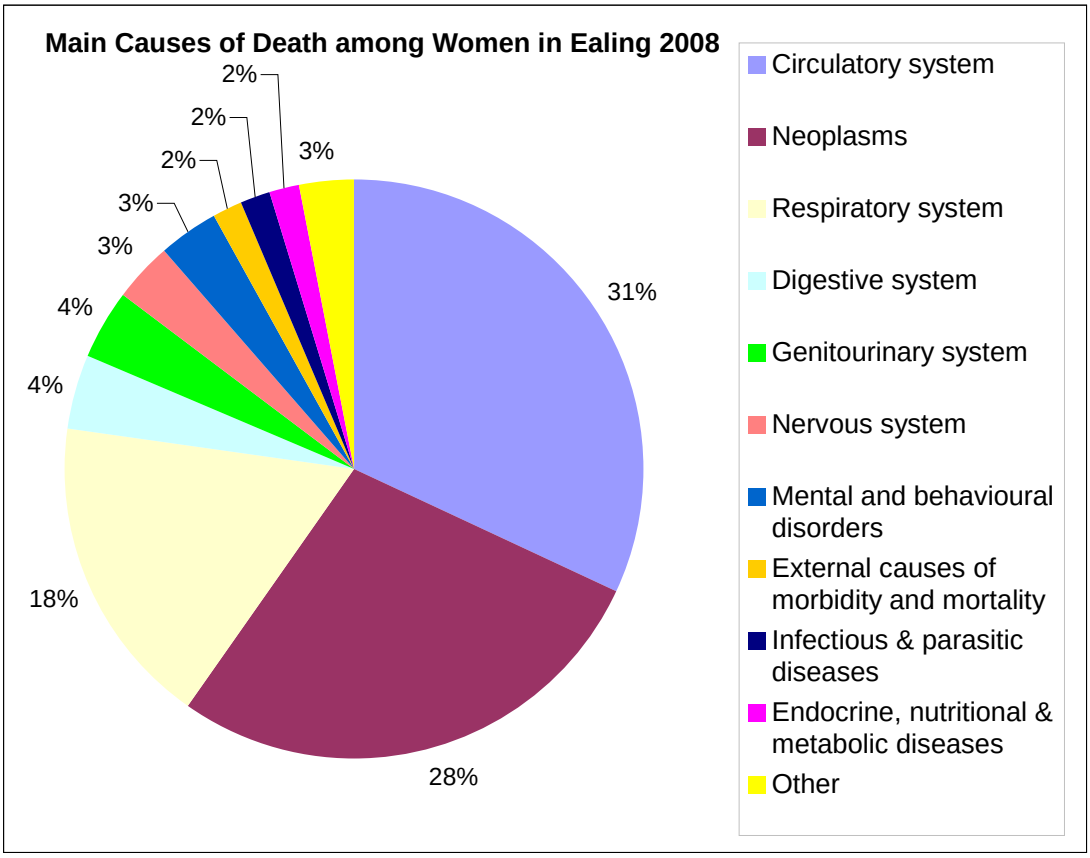
In 2008, the main causes of death in Ealing generally the same for men and women. The top three were diseases of circulatory system, neoplasms and diseases of the respiratory system. (see Table 5.14 for details)

Figure 5.12 Main Causes of Death among men in Ealing



Source: Ealing Primary Care Trust 2009

Figure 5.13 Main Causes of Death among women in Ealing



Source: Ealing Primary Care Trust 2009

While the top three main causes of death are the same for men and women in the borough the proportions are slightly different. Diseases of the circulatory system account for 31% of deaths in women but for 35% in men. Neoplasms (Cancers) account for the same percentage of deaths in men and women, 28%, while more women than men die from diseases of the respiratory system, 18% against 16%.

Cardiovascular disease includes coronary heart disease, strokes and high blood pressure. It is the main cause of death in the UK, being responsible for 38% of all deaths. (British Heart Foundation) Deaths from cancers of the lung, bowel, breast and prostate together account for 47% of all cancer deaths. (Cancer Research UK)
Respiratory diseases are a major cause of death, especially in older people. In 2001, approximately 8.3% of all deaths in London were from respiratory disease, mainly pneumonia, bronchitis and emphysema. (London Health Observatory)

Table 5.14 Disease included in Ealing Main Causes of death

Circulatory Disease	Neoplasms	Respiratory Disease
Acute Rheumatic Fever	Malignant neoplasms lip, oral, cavity and pharynx	Acute upper respiratory infections
Chronic Rheumatic Heart disease	Malignant neoplasms digestive organs	Influenza and Pneumonia
Hypetensive diseases	Malignant neoplasms respiratory system and intrathoracic	Other acute lower respiratory infections
Ischemic Heart disease	Malignant neoplasms bone and artcular cartilage	Other diseases of upper respiratory tract
Pulmonary Heart disease and diseases of pulmonary circulatory	Malignant neoplasms skin	Chronic lower respiratory diseases
Other forms of Heart disease	Malignant neoplasms connective and soft tissue	Lung diseases due to external agents
Cerebrovascular diseases	Malignant neoplasms breast and female genital organs	Suppurative and necrotic conditions of lower respiratory tract
Diseases of Arteries, arterioles and capillaries	Malignant neoplasms male genital organs	Other diseases of the respiratory system
Diseases of veins, lymphatic vessels and lymph nodes	Malignant neoplasms urinary organs	Other diseases of pleura
	Malignant neoplasms eye, brain and central nervous system	
	Malignant neoplasms endocrine and related structures	

Source: Department of Health 2009

MORTALITY FROM CAUSES CONSIDERED AMENABLE TO HEALTHCARE

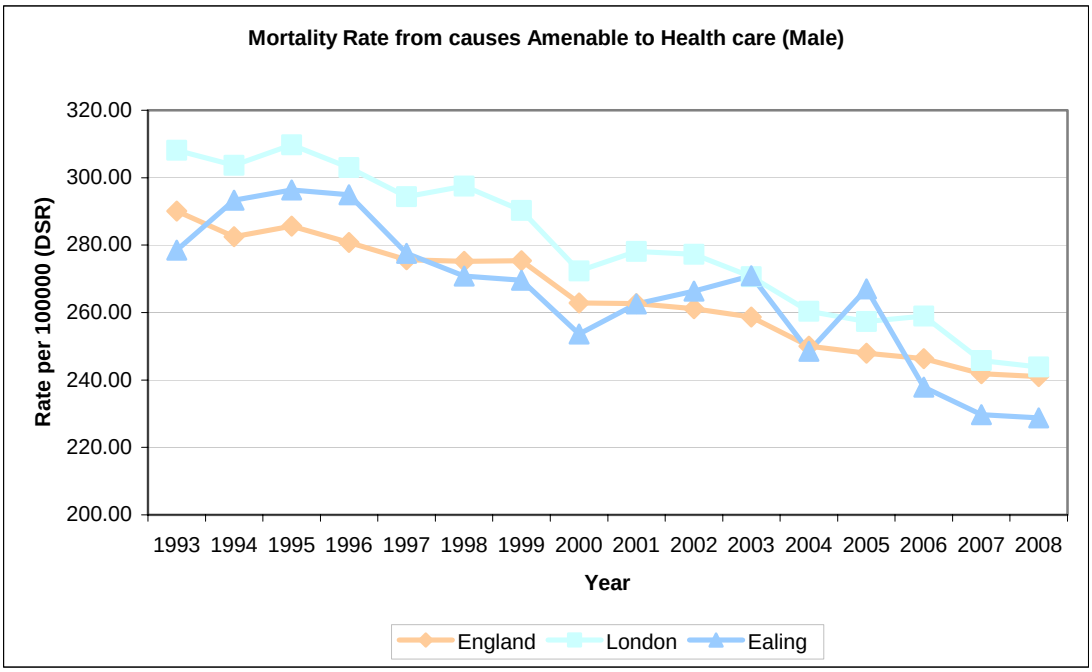
Amenable mortality can broadly be defined as deaths occurring before age 75 from causes that are considered amenable to medical intervention. Examples include breast cancer, cancer of colon and rectum, leukaemia, gastric and duodenal ulcer, and hypertensive diseases. Advances in medical care mean that diseases that are considered amenable to medical intervention keep changing over time.

Causes of death are included if there is evidence that they are amenable to healthcare interventions, including prevention, and that in the age groups specified, death rates should be low, given timely, appropriate, and high quality care.

Examples include

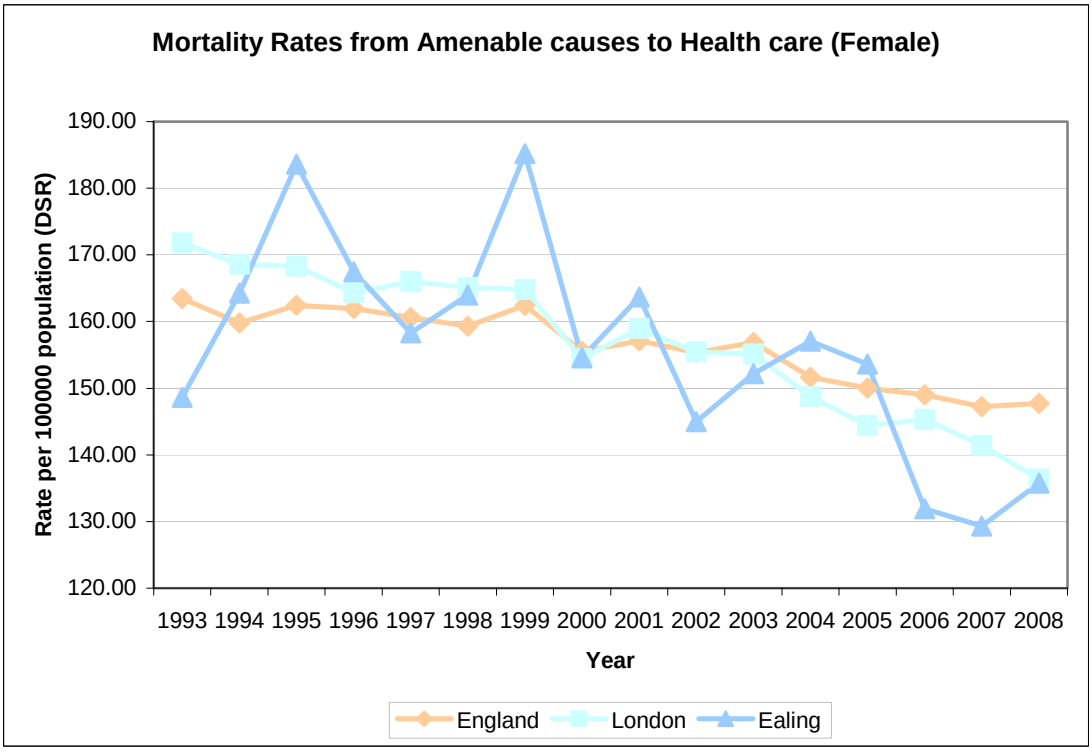
- Perinatal deaths, ages 0-6 days
- Whooping cough, measles, ages 0-14 years
- Asthma, ages 0-44 years
- Diabetes mellitus, ages 0-49 years
- Coronary heart disease, ages 0-74 years;
- Maternal deaths, all ages
- Misadventures to patients during surgical and medical care, all ages

Figure 5.15 Male Mortality from causes considered amenable to Health Care



Source: National Centre for Health Outcomes Development 2009

Figure 5.16 Female Mortality from causes considered amenable to Health Care



Source: National Centre for Health Outcomes Development 2009

Figure 5.15 and 5.16 show that mortality rates from causes considered amenable to health care are higher for men than women in Ealing which is similar to the London and England picture. In 2008 men and women mortality in Ealing was London and England rates. Overall this has been generally falling for both sexes since 1993. For

women rates were over 8% lower in 2008 than 1993, compared to a fall of nearly 21% for London and just over 9% for England.

Between 1993 and 2008 mortality rates for men in Ealing fell by nearly 18%, compared to nearly 21% for London and just under 17% for England over the same period. However, rates vary considerably from year to year, because of the relatively small numbers of these deaths.

SECTION 6

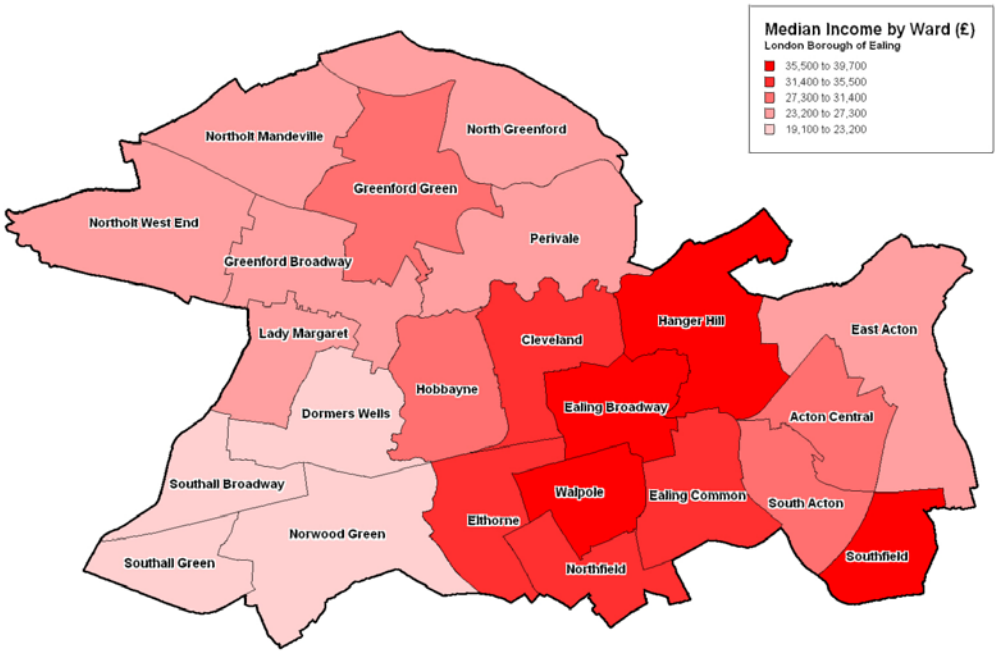
Burden of Ill-Health

INCOME INEQUALITY AND HEALTH INEQUALITY

Over recent times it has become clear that income inequality and the health outcomes of a population are correlated. Work by the Equalities Trust[7], Joseph Rowntree Foundation[8] and the BMJ[9] seem to confirm this correlation particularly in relation to life expectancy and infant mortality. Tackling income inequality is now seen as a component of improving health outcomes, for example it is one of the strategic objectives of the London Health Inequality Strategy 2010[10].

Figure 6.1 shows the median income by ward and this should be considered against prevalence of ill-health in a particular ward. Norwood Green, Southall Broadway, Southall Green and Dormers Wells have a median income of between £19,100 to £23,200 annually compared Ealing Broadway, Hanger Hill, Walpole and Southfield where incomes are between £35,500 and £39,700.

Figure 6.1 Median Income by Ward 2009



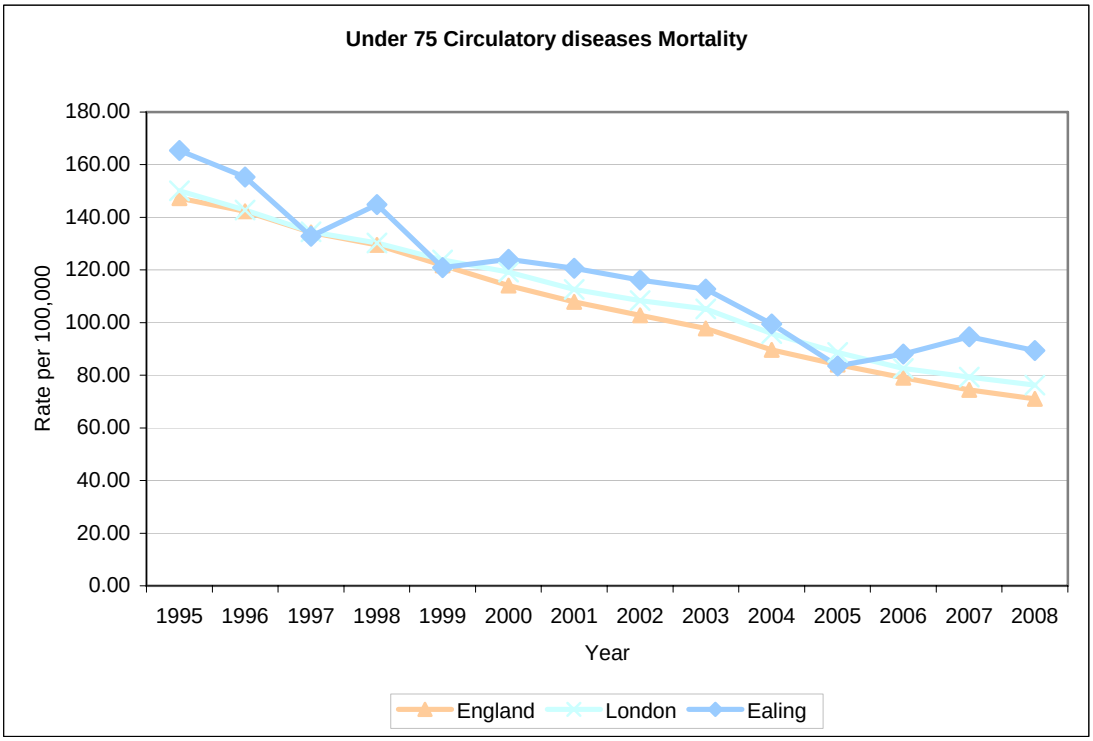
Source: CACI Paycheck 2009

CIRCULATORY DISEASES

Circulatory diseases are a significant cause of long term ill-health, disability, avoidable and premature death. They are strongly linked to large parts of the health inequalities that exist in Ealing with the highest mortality rates usually experienced within the most deprived communities.

Deaths from circulatory diseases are falling in most local authorities however the rate in Ealing remains higher than the national and London rates (Figure 6.2). It is documented that circulatory disease varies by socio-economic group (tending to be higher in manual social classes), geographic area and ethnic group.

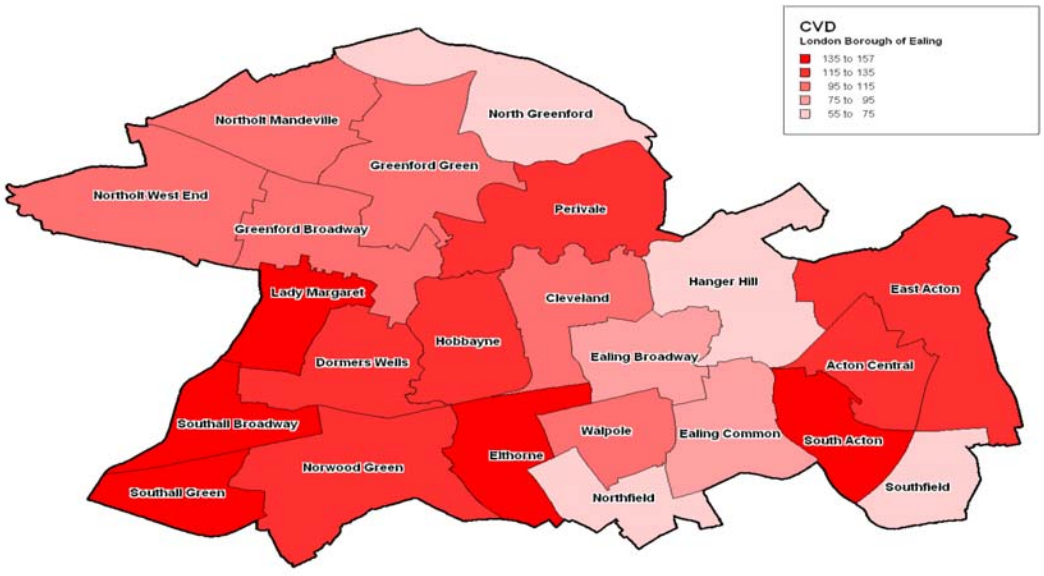
Figure 6.2 Trends of under 75 Mortality from circulatory diseases from 1995 to 2008



Source: National Centre for Health Outcomes Development (NCHOD) 2009

Risks of death and illness from circulatory disease can be reduced by lifestyle changes such as stopping smoking, eating well, being physically active, maintaining a healthy weight and drinking in moderation. Outcomes for circulatory diseases could be improved by identifying those at risk earlier and treating them through lifestyle interventions, management of blood pressure, management of cholesterol and management of blood sugar levels. Combining prevention with high quality primary care could have major benefits within the next 3 to 5 years.

Figure 6.3 Deaths from Cardiovascular Disease per ward (Under 75 years) 2003 – 2007 (standardised mortality ratio)



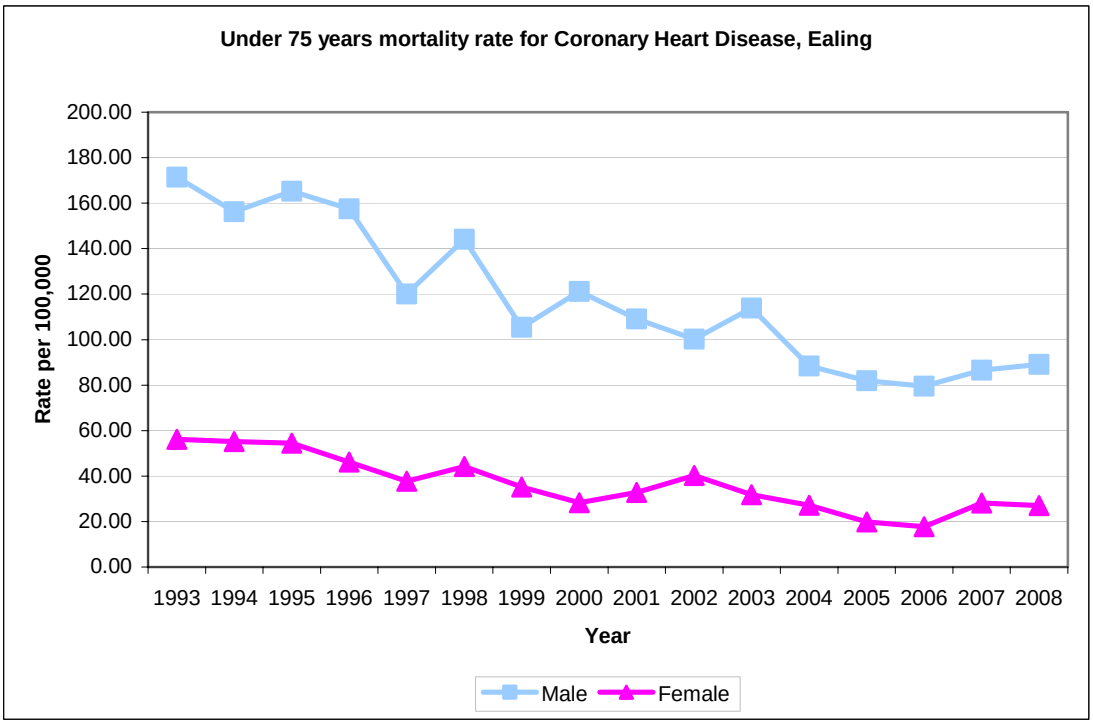
Source: London Health Observatory 2009

Figure 6.3 shows that there is significant variation between expected and observed mortality rates for cardiovascular disease within the wards of the borough. Higher than expected mortality rates can be seen in Southall Broadway and Southall Green and low rates in places like Hanger Hill and Southfield.

Coronary Heart Disease

Death rates from coronary heart disease for people in Ealing under 75 years old have halved since the early 1990s. Nationally, rates have fallen in the same period by nearly 60%, more than in Ealing. The rate for men is twice that for women, but the gap between men and women has narrowed, reducing the inequality.

Figure 6.4 Trends of under 75 Mortality from Coronary Heart Disease from 1995 to 2008



Source: National Centre for Health Outcomes Development (NCHOD) 2009

In 2007, 140 people under 75 years old died from coronary heart disease: 104 men and 36 women.

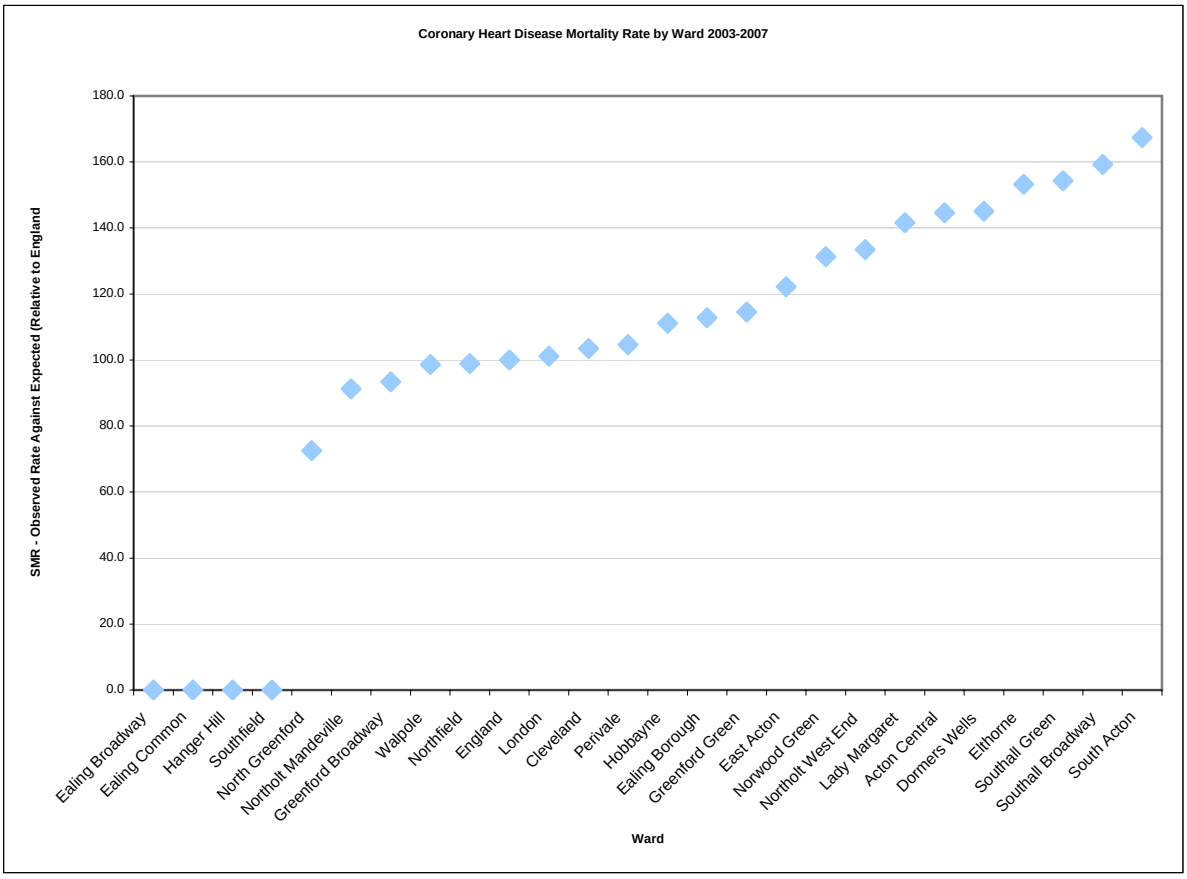
6.5 Predicted Prevalence of Coronary Heart Disease 2010 and 2020

	2010		2015		2020	
	Male	Female	Male	Female	Male	Female
Ealing	7502	4649	8223	4760	8955	4985
Change			721	111	732	225
Percentage Change			9.6%	2.4%	8.9%	4.7%

Eastern Region Public Health Observatory, 2008

Numbers of people with coronary heart disease are expected to rise over the next ten years. This will be due both to demographic change – a rising and ageing population – and some increasing risk factors, in particular obesity.

Figure 6.6 Coronary Heart Disease Mortality Rate by Ward 2003-2007



Source: London Health Observatory 2009

Figure 6.6 compares observed with 'expected' (relative to England) deaths in the four years 2003 – 2007. Death rates for Ealing as a whole were higher than in London and England. England standing at 100, London at 101.2 and Ealing at 112.8 confirming that higher than expected coronary heart disease deaths are observed in Ealing among the under 75s. Additionally there were large inequalities within Ealing, there were 67% more deaths than expected in South Acton. There were 27% fewer deaths than expected in North Greenford. Coronary heart disease mortality is strongly associated with social and economic deprivation.

In the UK the highest recorded rates of coronary heart disease (CHD) mortality are in people born in the Indian Sub-continent. South Asian men have an age standardised mortality rate about 40% higher than the whole population, and for women the figure is 51%. However, the many ethnic groups within South Asian are diverse in respect of social custom and risk factors.

The number of men with Coronary heart disease is anticipated to rise from 7,000 in 2008 to 9,000 in 2020 in Ealing. A smaller but significant rise is expected among women. From 2008 to 2020 prevalence of coronary heart disease is anticipated to rise from under 6% to nearly 7% for men and to nearly 4% for women. The rise in numbers will be due partly to population growth but also to increasing prevalence. The prevalence of CHD will increase in the near future because of increasing population, improved case finding, an ageing population as well as rising obesity. Between 2% and 3% of the population are recorded with Coronary heart disease. There appears to be undiagnosed Coronary heart disease in Ealing. Recorded prevalence has increased in the past four years, but there remains a gap of one percentage point.

There are large inequalities between different wards in Ealing. The standardised mortality ratio (SMR) for people under 75 years old is 157 in Southall Green, 155 in South Acton and 148 in Southall Broadway. Although mortality for all ages is slightly better than England as a whole, for under 75s it is about 10% higher than expected. This underlines the need to focus attention on the under 75s as this represents the group where the PCT population is likely to have maximum benefit from local interventions.

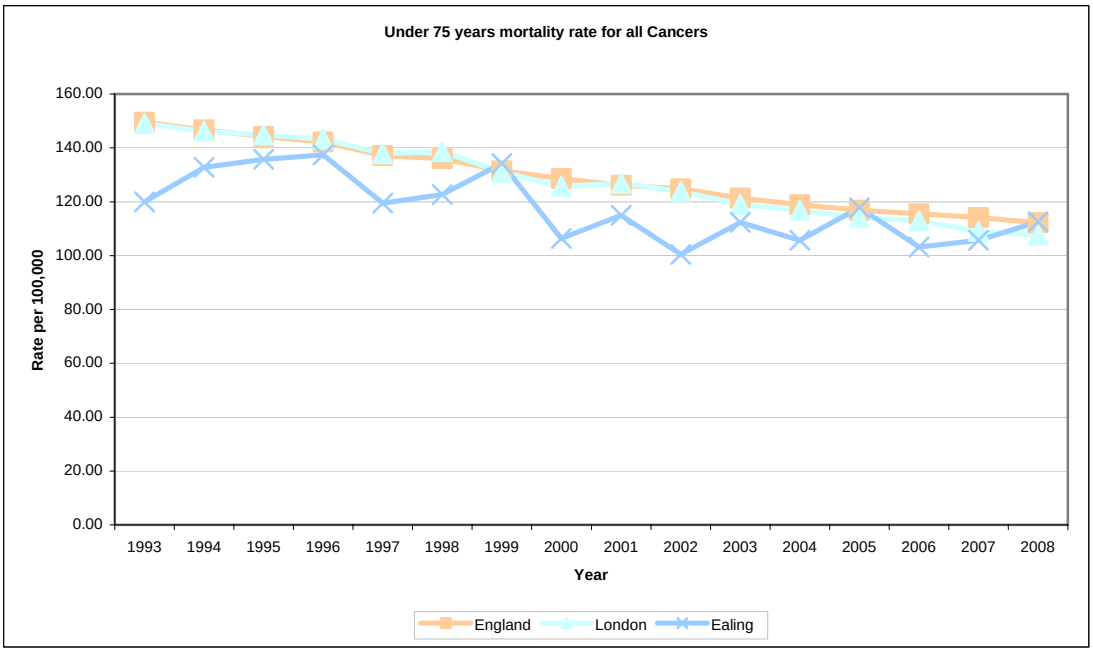
CANCERS

In Ealing, as nationally, there is a long term trend of reducing mortality and increasing survival rates from most cancers, due mainly to faster access to services and advances in treatment and care. England as a whole lags behind most of Europe in survival for many cancers, however, and there is a need for a continuing focus on early detection and service improvement.

Between 2006-08, 371 women and 442 men under 75 years died from cancer. Of these, 201 women and 224 men were under 65 years of age. The incidence of cancer rises with increasing age and given the anticipated ageing population, demand for specialist cancer services and end of life care will continue to rise.

Screening programmes effectively detect the pre-cancerous or early stages of cervical, breast and bowel cancer.

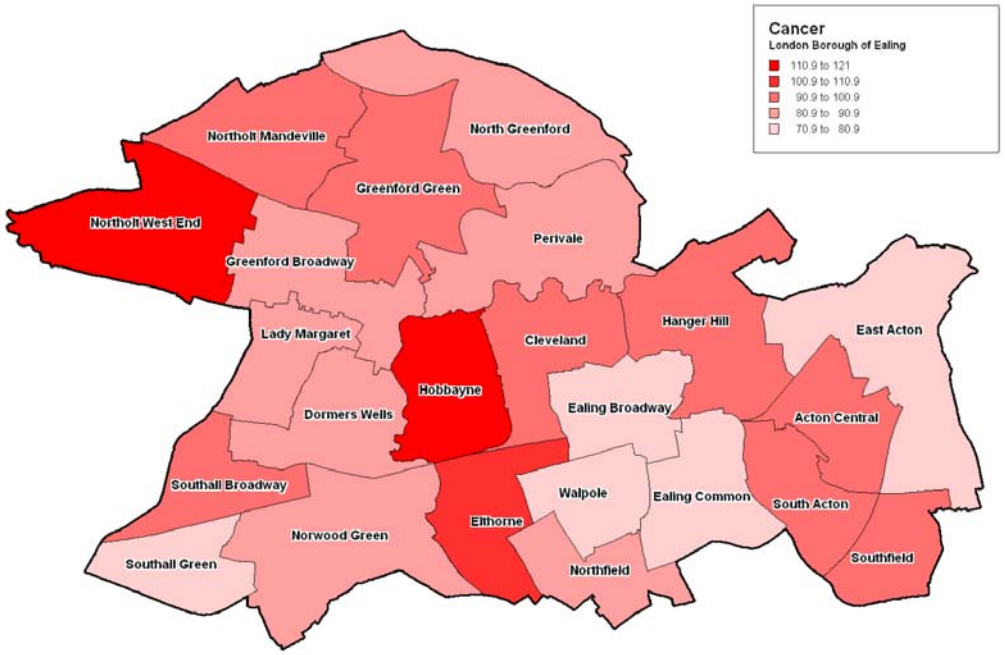
Figure 6.7 Under 75 years mortality rate for all cancers



Source: National Centre for Health Outcomes Development (NCHOD) 2009

The variation in the annual rate in Ealing is mainly due to relatively small numbers of deaths. The long term decline in mortality can be seen more clearly at regional and national levels.

Figure 6.8 Deaths from Cancer per ward (Under 75 years) 2003 – 2007 (standardised mortality ratio)

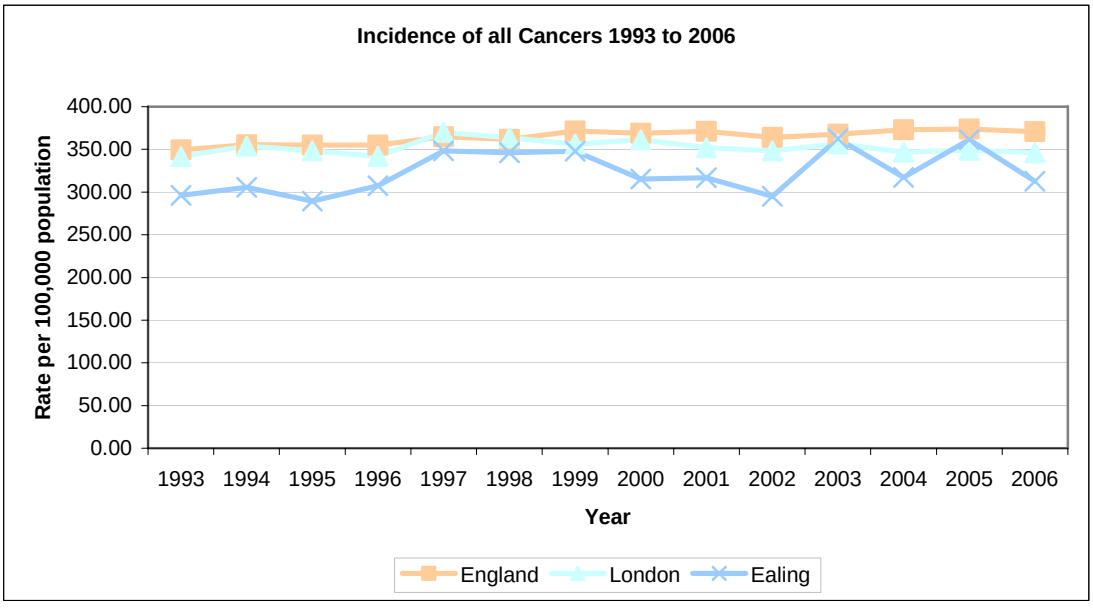


Source: London Health Observatory 2009

Mortality rates for Cancers are high for the wards of Northolt West End, Hobbayne and Elthorne and low for wards like Ealing Broadway, Walpole and East Acton.

Cancer Incidence

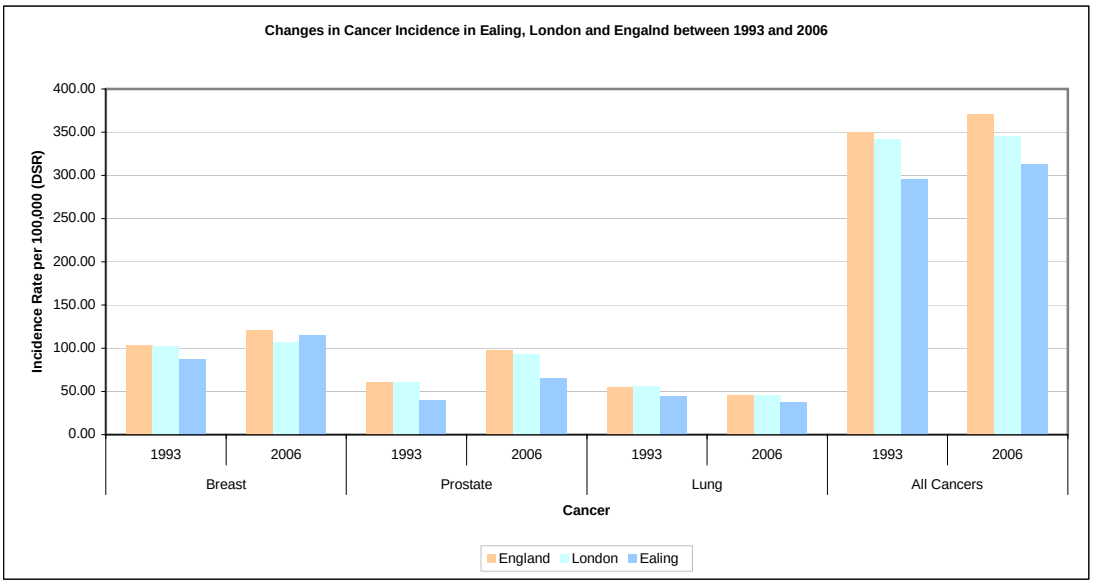
Figure 6.9 All age incidence for all cancer 1993 to 2006



Source: National Centre for Health Outcomes Development (NCHOD) 2009

Cancer incidence is the rate at which new cases occur in the population. This measure has been stable over the past fifteen years. The standardized rate seems to be somewhat lower than London or England.

Figure 6.10 Changes in Cancer Incidence in Ealing, London and England between 1993 and 2006



Source: National Centre for Health Outcomes Development (NCHOD) 2009

Figure 6.10 shows that incidence of most cancers in 2006 are higher than 1993 in Ealing. This is a similar pattern seen in London and England. Lung cancer incidence in Ealing, London and England were lower in 2006 than in 1993, with the 2006 rate being 15% lower than the 1993 rate in Ealing. As in 1993, the Ealing rate for lung cancer remains below the England and London rates.

Prostate cancer rates in Ealing remain lower than in England and London as it was in 1993. However, similar to the national and regional pattern, the incidence of cancer was higher in 2006 than in 1993.

In 1993 breast cancer rates in Ealing were below the London and England rates, however the Ealing rate was 33% higher in 2006, and is above the London rate. The incidence of lung cancer fell between 1993 and 2006, but the incidence of all cancers increased between 1993 and 2006.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Prevalence

Chronic Obstructive Pulmonary Disease (COPD) includes bronchitis and emphysema and is one of the most common respiratory diagnoses in the UK. The main cause is smoking. Although declining smoking rates will help to reduce COPD prevalence, the ageing of the population will have a contrary effect. It affects more men than women but a recent study by the British Thoracic Society suggested that the rate among women is also increasing. In 2009 an estimated 9,312 people in Ealing suffered from COPD.

Table 6.11 Predicted Prevalence of COPD 2010 and 2020

	2010		2015		2020	
	Male	Female	Male	Female	Male	Female
Ealing	5563	3844	5945	3911	6364	4034
Change			382	67	419	123
Percentage Change			6.9%	1.7%	7.0%	3.1%

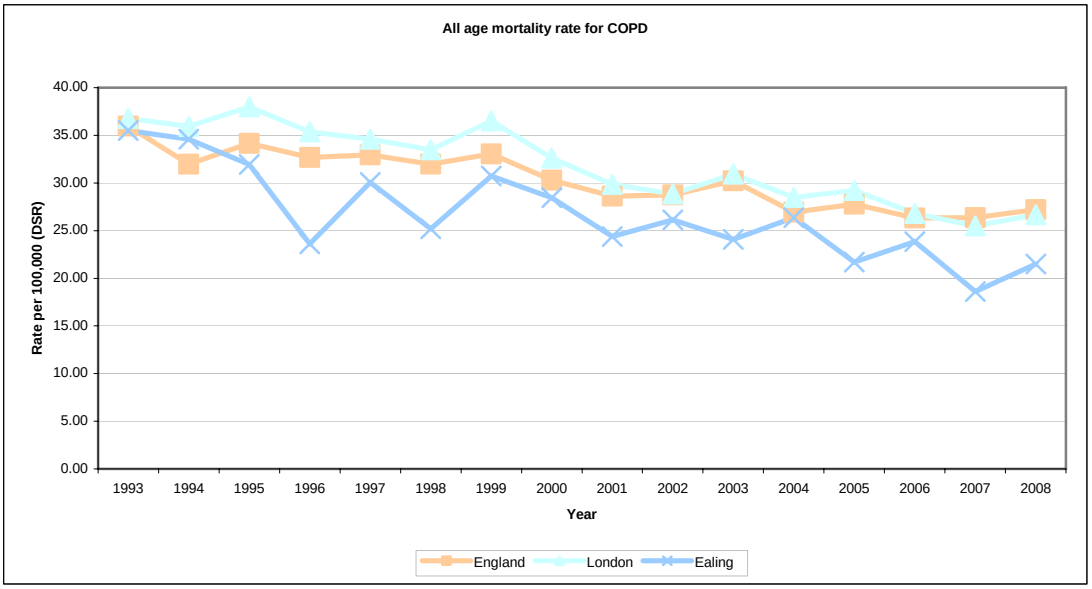
Eastern Region Public Health Observatory, 2008

While predicted prevalence shows that there will continue to be more male than female COPD patients we can see that the percentage changes between 2010 – 2015 and 2015 – 2020 goes from 1.7% to 3.1%. The male percentage is higher but it only changes from 6.9% to 7.0%. Overall we can see that in ten years prevalence of COPD will be just over 10% higher than the in 2010. (Table 6.11)

Looking broadly at ethnic groups in Ealing, the prevalence of COPD does vary. By ethnicity, prevalence among the Asian group is lowest at 2.8%, while the Black group is highest at 4.4%, while White group is at 3.9%.

Mortality

Figure 6.12 All age mortality rate for COPD



Source: National Centre for Health Outcomes Development (NCHOD) 2009

The mortality rate (Figure 6.12) for COPD in Ealing is currently lower than England and London, having started at similar rate in 1993. Although Ealing's rate in 2008 was higher than 2007, it is nearly 40% lower than 1993. In the same time, England and London's rates are 24% and 28% lower respectively.

Tuberculosis (TB)

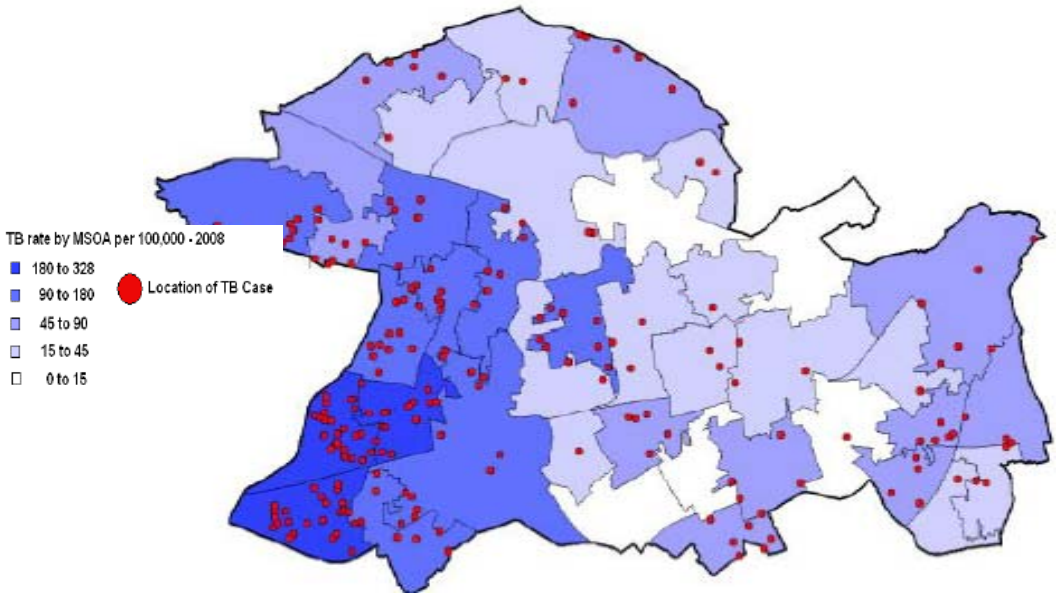
TB is a chronic infectious disease usually affecting the lungs, but any organ can be affected. TB is a cause of disability and can be fatal. The World Health Organisation recently called TB a 'global emergency', with 3 million people dying each year. Risk factors that increase the prevalence are: country of origin, poverty, overcrowding, co-

morbidity (renal disease, alcoholism, diabetes, malignancy, HIV) and close contact with people with infectious TB.

There was a 5.5% rise in TB cases in the UK from 2008 to 2009 and London accounted for 38% of the total new notifications in the UK with 3,476 in 2009. Ealing has the second highest rate of TB in North West London - although the rate has declined since 2005. TB in the local area affects men more than women, and younger age groups more than older.

In 2008 there were more TB notifications from Southall and Southall / Greenford borders than from other neighbourhoods of Ealing. (Figure 6.13)

Figure 6.13 TB notifications in Ealing



STROKE

Prevalence

A stroke can happen with no obvious cause, to people of any age, but there are factors known to increase the likelihood of it happening. Some of these factors are genetic so cannot be altered. Others may be reduced by lifestyle changes or medication. Among the manageable risks are:

- Excessive fat and salt in the diet
- Excessive alcohol intake
- Lack of exercise
- Smoking

Table 6.14 Predicted Prevalence of strokes 2010 and 2020

	2010		2015		2020	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Ealing	2612	2361	2883	2408	3126	2509
Change			271	47	243	101
Percentage Change			10.4%	2.0%	8.4%	4.2%

Eastern Region Public Health Observatory, 2008

More men than women have strokes, but it is expected that the gap between the sexes will narrow over the next fifteen years. The number of people who have had a stroke is expected to rise overall, mainly because of an ageing population and better survival following treatment.

Social inequalities in strokes are persistent and premature death rates in the most deprived areas are around three times higher than in the least deprived. People in socio-economic group V (unskilled manual workers) have a 60% higher chance of having a stroke than those in socio-economic group I (professionals), and the mortality rates from stroke are 50% higher in socio-economic group V than in socio-economic group I.

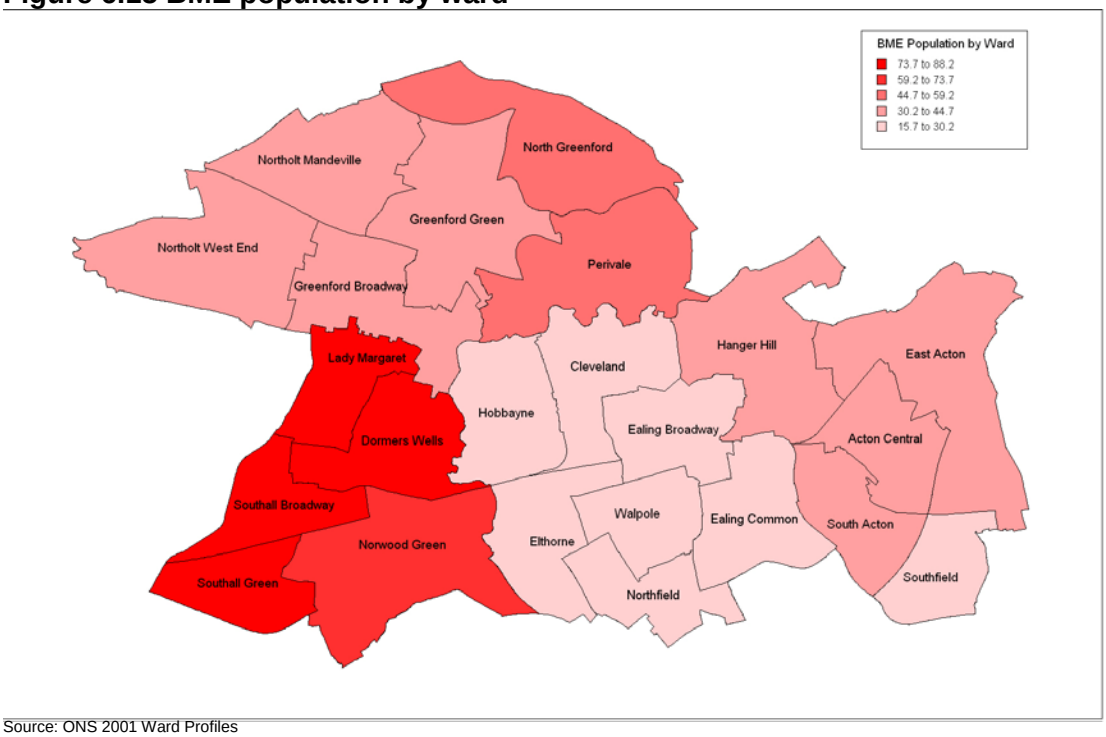
For people under 65 years old, mortality from stroke in the most deprived twentieth of England and Wales is over three and a half times higher for men and over two and a half times higher for women than in the least deprived.

More women who have strokes die from them by comparison with men. However, stroke is commoner in men by comparison to women by the age of 75.

The stroke mortality rate from men born in Bangaldesh is three times higher than those born in England and Wales and this gap has increased since the early 1980s. Data from the Health Survey for England show that among African-Caribbean and South Asian men the prevalence of stroke was between about 40% and 70% higher than that of the general population after adjusting for age.

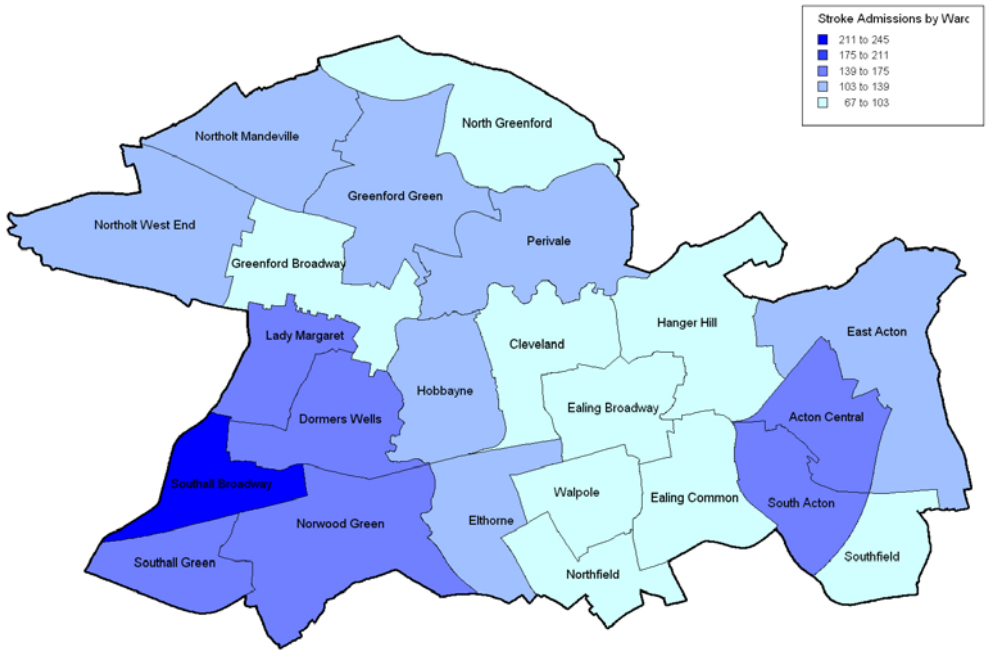
Strokes are the single most common cause of severe disability amongst adults. Improvement in the prevention, treatment and rehabilitation could significantly impact on disability. Some people who would have suffered disability as a result of a stroke may avoid having a stroke because of improvements in the effectiveness of prevention. Others who experience strokes may have the degree of disability they suffer as a result, reduced because of improvements in diagnosis, treatment and rehabilitation.

Figure 6.15 BME population by ward



Source: ONS 2001 Ward Profiles

Figure 6.16 Stroke hospital admissions by ward 2003-2008

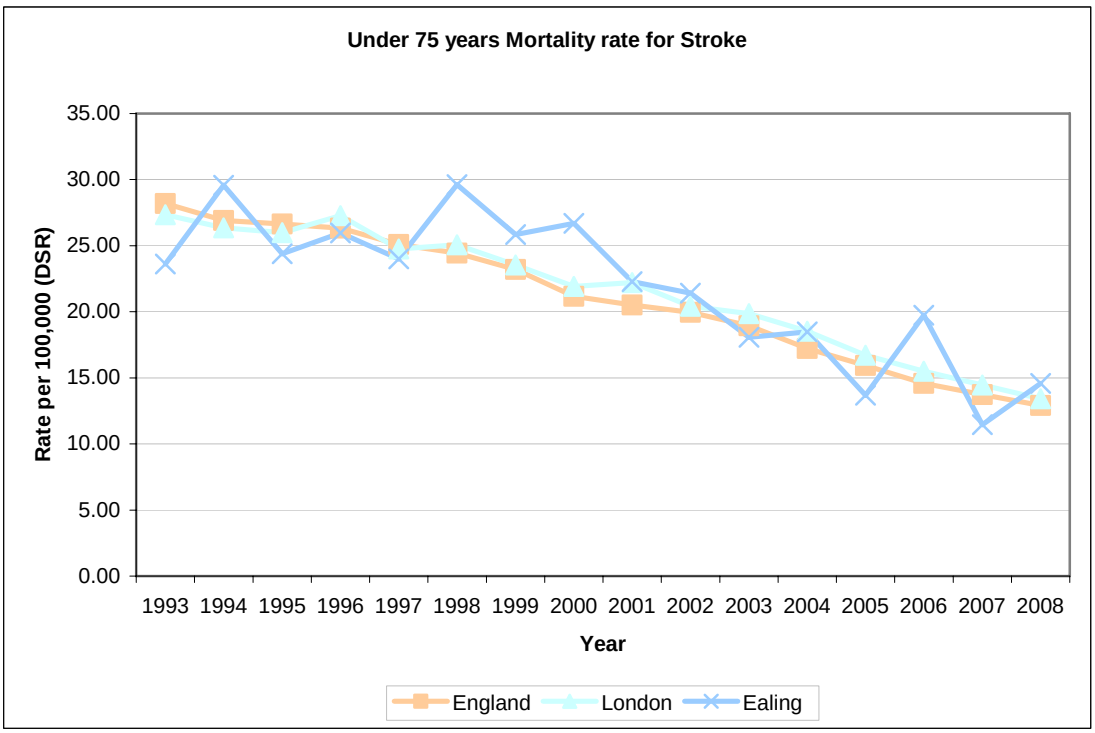


Source: London Health Observatory 2009

The highest rates of stroke admissions are in Southall and parts of Acton. This reflects patterns of deprivation and higher prevalence amongst some minority ethnic groups.

Mortality

Figure 6.17 Under 75 years mortality rate for stroke



Source: National Centre for Health Outcomes Development (NCHOD) 2009

The mortality rate for strokes has been falling generally, however Ealing's rate for 2008 is higher than the London and England rate. It stands at 14.57 against 13.41 for London and 12.90 for England. Since 1993 Ealing's mortality rate has usually been above the national and regional rate. Ealing's mortality rate for strokes is now 38% lower than in 1993.

MENTAL HEALTH

It is estimated that over 89,000[34] people in Ealing have a mental health problem. People with enduring mental health problems are among the most excluded and vulnerable social groups, and have a life expectancy of up to ten years less than the rest of the population.

Mental health problems can be classified as:

- Organic (identifiable brain malfunction) versus functional (not due to structural abnormalities of the brain).
- Neurosis (severe forms of normal experiences such a low mood, anxiety) versus psychosis (severe distortion of a person's perception of reality).
- Common mental health problems (anxiety, depression, phobias, obsessive compulsive and panic disorders), severe mental health problems (psychotic disorders and bipolar depression) and personality disorders.

People with mental health problems are more likely to be obese, to smoke and to be heavy drinkers. Unemployment, being homeless, or being a victim of violence can also increase the likelihood of mental ill-health.

Mental illness is more common in a wide range of vulnerable groups including the unemployed, people on low incomes and some black and minority ethnic communities.

Table 6.18 Estimated Prevalence of Common Mental Health Problems, 2006

Rates per 1000 population							
Area	**Any neurotic disorder**	**All phobias**	**Depressive episode**	**Generalised anxiety disorder**	**Mixed anxiety depression**	**Obsessive compulsive disorder**	**Panic disorder**
Brent	182.3	21.8	35.2	53.0	84.4	15.5	8.5
Ealing	174.4	20.8	34.0	51.7	80.0	14.7	8.2
Hammersmith and Fulham	205.7	24.7	39.2	59.6	95.9	17.4	9.6
Harrow	153.9	18.2	30.0	45.4	70.8	12.9	7.3
Hillingdon	160.1	19.1	31.2	46.5	74.1	13.7	7.4
Hounslow	168.9	20.1	33.0	49.8	77.6	14.4	8.0
London	182.1	21.8	35.2	53.2	84.4	15.5	8.5
England	165.7	18.0	25.0	45.0	89.1	11.0	6.5

Source: North East Public Health Observatory 2008

Table 6.18 shows that for common mental health problems, Ealing's rate per 1000 population is lower than the London rate for all conditions. However in comparison to the England rate they are higher for all conditions. Mixed anxiety depression and neurotic disorders are the most common condition in Ealing which is keeping with the national and regional picture.

The Adult Psychiatric Morbidity Survey, 2007, found the following, nationally:

- The proportion of people aged from 16 – 64 meeting the criteria for as least one common mental health problems has increased between 1997 (15.5%) – 2000 (17.5%) but remained the same between 2000 – 2007 (17.6%).

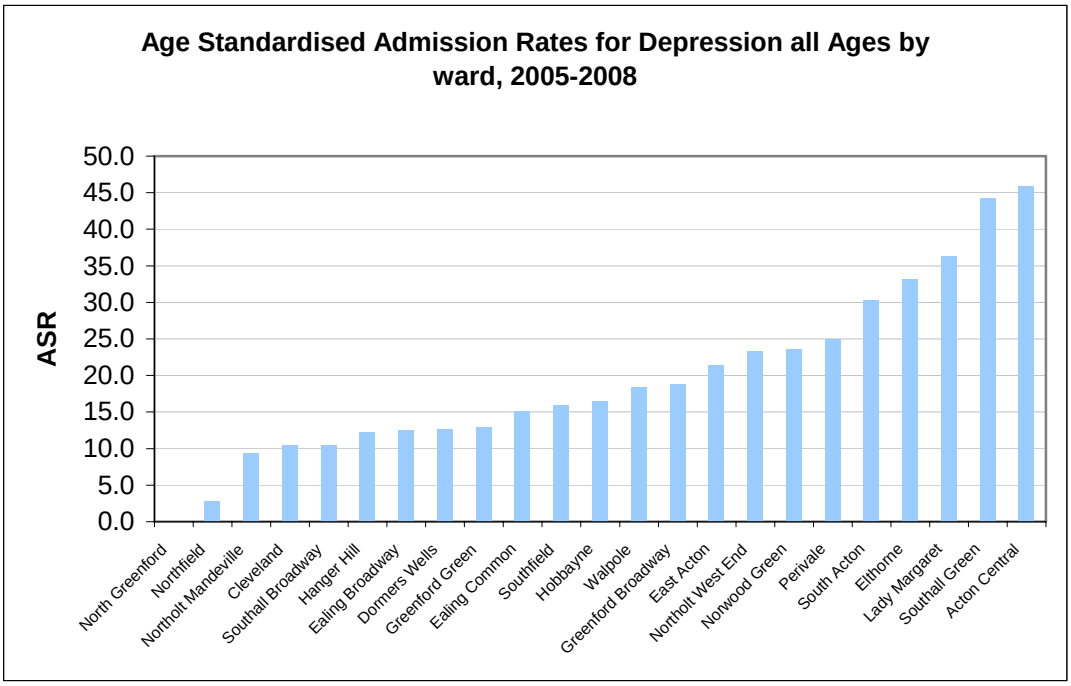
- The largest increase in rate of common mental health problems between 2000 – 2007 was seen in women aged 45 – 64; among whom the rate rose by a fifth.

- Women had a higher rate of common mental health disorders than men; 19.7% and 12.5% respectively.

- Rates of common mental health problems varied by age; in women the rate peaked among 45 – 54 years olds – 25.1%; in men the rate was the highest in 25 – 54 years olds – 15%.

- Only a quarter of people experiencing common mental health problems (24%) were receiving treatment, mostly in the form of medication.

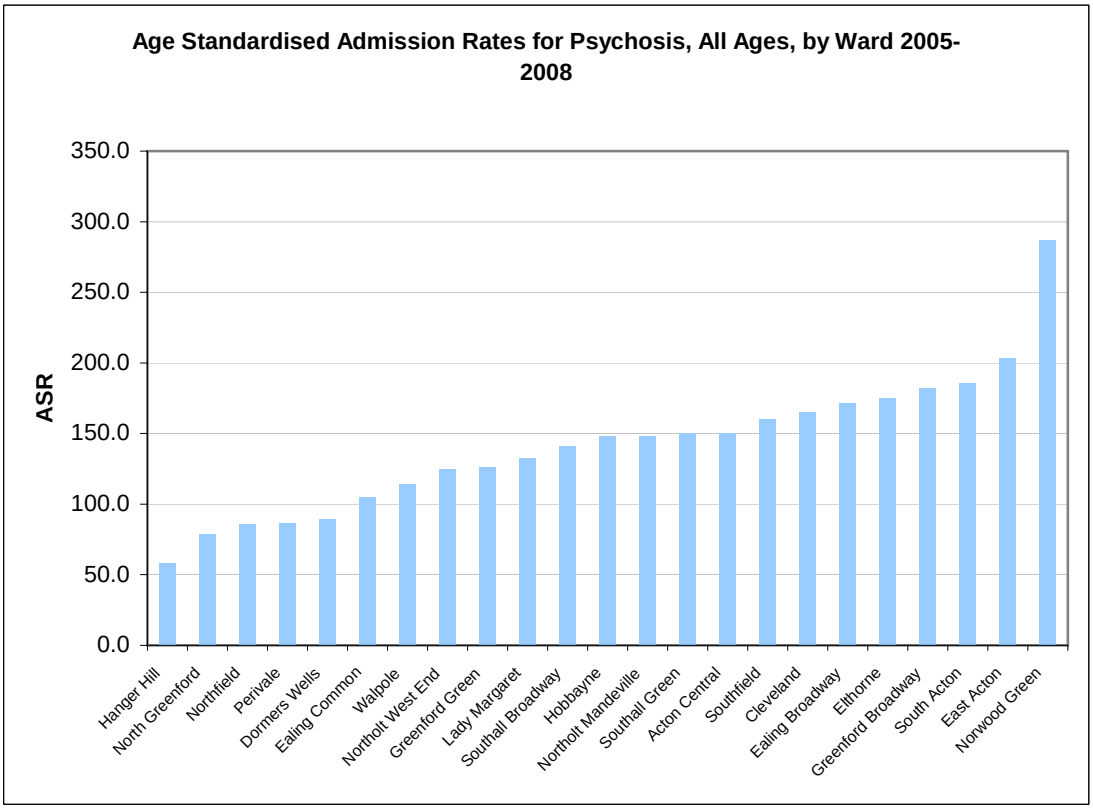
Figure 6.19 Admission Rates for Depression by Ward 2005-2008



Source: SUS, Hospital Inpatient Data, NHS Ealing Information Team 2009

Admission rates for depression show considerable variation between the wards of the borough. North Greenford and Northfield show an age standardised admission rate of 0 and 2.8 respectively compared to Southall Green and Acton Central which show a rate of 44.3 and 45.9.

Figure 6.20 Admission Rates for psychosis by Ward 2005-2008



Source: SUS, Hospital Inpatient Data, NHS Ealing Information Team 2009

Similarly to admission rates for depression, admission rates for psychosis varies between wards. In this instance Hanger Hill and North Greenford at 58.2 and 78.8 show lowest admission rates with East Acton and Norwood Green and 203.3 and 286.7 the highest.

Improving services and support for older people with mental health problems paper by Age Concern 2007 found the following:

- The range of mental health problems experienced in later life is very wide. It includes depression, anxiety, delirium (acute confusion), dementia, schizophrenia and other severe mental health problems, and alcohol and drug misuse.

- The levels of unmet mental health needs amongst older people are extremely high.

- One in four people aged 65 and over have symptoms of depression, much of which could be prevented.

- Depression is the leading risk factor for suicide. Older men and women have some of the highest suicide rates of all ages in the UK.

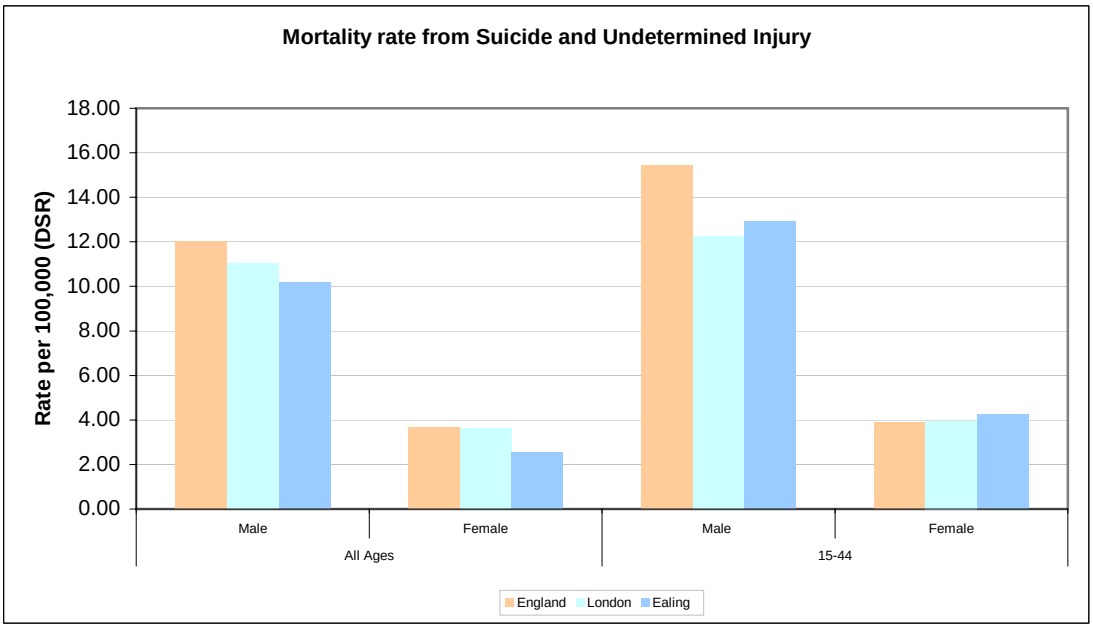
- The majority of older people with mental health problems do not receive services.

- Many mental health problems in later life can be prevented. The risk factors for depression, anxiety, suicide, delirium and some types of dementia are well known. Social isolation is a common risk factor across a range of problems.

Suicides

In 2008 there were 65 deaths (52 male, 13 female) from suicides or undetermined injury in Ealing.

Figure 6.21 Mortality rate from Suicide and Undetermined Injury



Source: National Centre for Health Outcomes Development 2009

Mortality rates for suicide are higher for 15-44 years than those for all ages and they are higher for males than females. For all ages, it is clear that for both male and female that Ealing's rate is lower than the London and England rates. However for females between 15 and 44 the Ealing rate is above the London and England and for males in the same age bracket the Ealing rate is above the London rate.

Suicide and Other Unexpected Deaths Review Project shows that following:

- 32% of individuals who committed suicide were in contact with psychiatric services at the time of death.
- 18% had been in contact with psychiatric services in the past.
- 28% of those in touch with psychiatric services at the time of death had been diagnosed with depression and a further third with schizophrenia.
- 26% of all individuals had been clinically diagnosed with depression.

INFANT MORTALITY

The infant mortality rate (deaths of infants under 1 year of age) is a strong indicator of the health of children and mothers and is linked to deprivation and wider determinants of health. In Ealing, the infant mortality rates are steadily decreasing (Table 6.22).

Table 6.22 Infant mortality rate trends in Ealing

INFANTS UNDER 1 YEAR (per 1000 live births)						
	2000-02	**2001-03**	**2002-04**	**2003-05**	**2004-06**	**2005-07**
Ealing	6.2	5.9	5.0	4.0	4.2	3.9
London	5.7	5.7	5.4	5.2	5.0	4.8

Source: National Centre for Health Outcomes Development and London Health Observatory 2009

The links between deprivation, smoking, high infant mortality and health inequalities are well described, as is the impact of infant mortality on life expectancy due to the loss of so many years of potential life.

Low birth weight (less than 2500g) and very low birth weight (less than 1500g) represent a significant risk for infant mortality and morbidity in the first year of life. Evidence suggests that babies who are born with low birth weight have increased risks later in life of developing of chronic diseases, including increased risk of becoming obese, insulin resistance syndrome and high blood pressure.

Figure 6.23 Infant Mortality – age under 1 year

Source: National Centre for Health Outcomes Development and London Health Observatory 2009

Immunisation Uptake

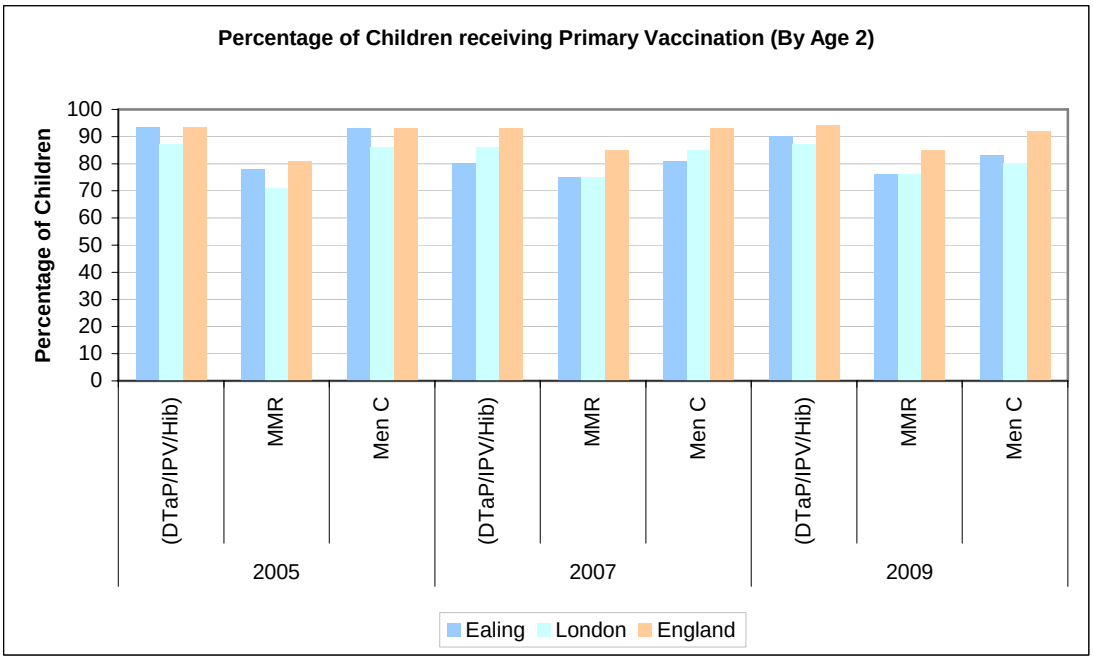
The primary aim of the national immunisation programme is the protection of the population from vaccine-preventable diseases. These include diphtheria, tetanus, whooping cough, polio, measles, mumps, rubella, some forms of meningitis and influenza.

As well as providing protection to immunised individuals, the programme also aims to protect those who have not been or cannot be immunised, by maintaining a high level of herd immunity. Herd[15] immunity is achieved when a sufficiently high percentage of the population are immunised, making it unlikely that un-immunised individuals will come into contact with the specific disease. Herd immunity is usually

dependant on maintaining an immunisation coverage rate of over 95% of the target population.

When herd immunity is maintained, infections may be virtually eliminated from a country (i.e. may no longer be endemic), as has occurred with Diphtheria in the United Kingdom. However, because the disease is still endemic in other countries, if high immunisation levels are not maintained, the likelihood of the disease returning is high.

Figure 6.24 Percentage of Children age 2 and under receiving Primary Vaccinations



Source: Department of Health, Information Centre, 2009

Figure 6.24 shows that currently immunisation take up in Ealing is lower than England take up, this is in common with London in general, usually the lowest uptake region. Highest take up is for Diphtheria, Tetanus, Polio Pertussis (Dtap/IPV/Hib) vaccine at 90% this is someway short of the 95% needed for heard immunity. Levels of take up for MMR (measles, mumps and rubella) and Men C (meningococcal C) vaccine stand at 76% and 83% respectively. Levels of MMR vaccine take up are low and are likely to have been affected by media coverage in recent years. It is likely that Ealing and London will be start follow the national trend of increasing take up for this vaccine.[30]

Musculoskeletal (MSK) Conditions

'MSK conditions' is a broad term, encompassing around 200 different problems affecting the muscles, joints and skeleton. Over 9.6 million adults, and around 12,000 children, have a musculoskeletal disorder in England today. MSK conditions are a major area of NHS expenditure, comprising a separate 'programme budget' which in 2008-09 consumed £4.2 billion (around £11 million a day).This represents a greater spend than on neurological conditions, blood disorders, and infectious diseases, and is an equivalent level of expenditure to that on respiratory conditions. Expenditure on MSK conditions has increased rapidly in recent years, and is now the fifth-highest area of NHS spending.[25]

There are 20 million people with back pain in the UK, this equates to one-third of the population. About 10% of the population consult their GP with back pain and 25% of these are referred to NHS. 8.5 million people have peripheral joint pain, 4.4 million have moderate/severe osteoarthritis and 650,000 have inflammatory arthritis. [26]

11.2 million working days per year are lost through MSK problems in the UK. The second largest group of patients in receipt of incapacity benefits after mental health, in Ealing it accounts for 16% of incapacity claims higher than London average (15%). Increasing longevity, obesity and lack of weight bearing exercise will increase the number of patients with MSK conditions.[27]

There are inequalities within Ealing in getting access to community MSK services. Southall with 625 referrals per 100,000 per month compared to the North's 758. The area with the highest deprivation and ethnic minority (Southall) has the lowest activity, converse to the expected position. Nationally evidence suggests that MSK pain prevalence is higher in ethnic groups 63%-89% than White groups (53%) in the 45-64 age group.

Given that MSK conditions tend to be long term and affect a significant number of people, how Ealing commissions services to tackle these conditions is vital and will have a significant impact on the number of people with long term conditions who are supported to be independent and in control of their condition throughout the borough.

Additionally a MSK strategy will need to be devised to cope with the increasing level of activity in this area, particularly elective joint replacement surgery.

OTHER LIFESTYLE FACTORS

Maintaining a Healthy weight

The number of people maintaining an unhealthy weight or obese has been rising for many years and has now reached significant proportions across the UK. The impact on general health and well-being is vast notable; unhealthy weight or obesity is a major risk factor for coronary heart disease, stroke, colon and breast cancer, type 2 diabetes (the first cases in obese children are now being seen in the UK), high blood pressure, degenerative joint disorders and back pain[11]. Obese children and adults also experience more psychological and mental health disorders than the rest of the population. They are likely to have a lowered self-esteem and to lack confidence. They may experience social discrimination and bullying in school and in the workplace, and have difficulty accessing services and getting involved in social activities.

Nationally two thirds of the adult population are overweight (body mass index (BMI) between 25 and 29) or obese (BMI 30 or above). In London it is estimated that approximately 22% of men and 24% of women are obese with a BMI of 30 or above. This equates to estimates of 1.4 million individuals who need support in managing weight problems actively in London[12].

As well as the impact on individual health, the cost to the NHS and the wider economy is immense. In 2001 the National Audit Office report estimated 'that obesity costs at least £½ billion a year in treatment costs to the NHS, and possibly in excess of £2 billion to the wider economy'[13].

Childhood Obesity

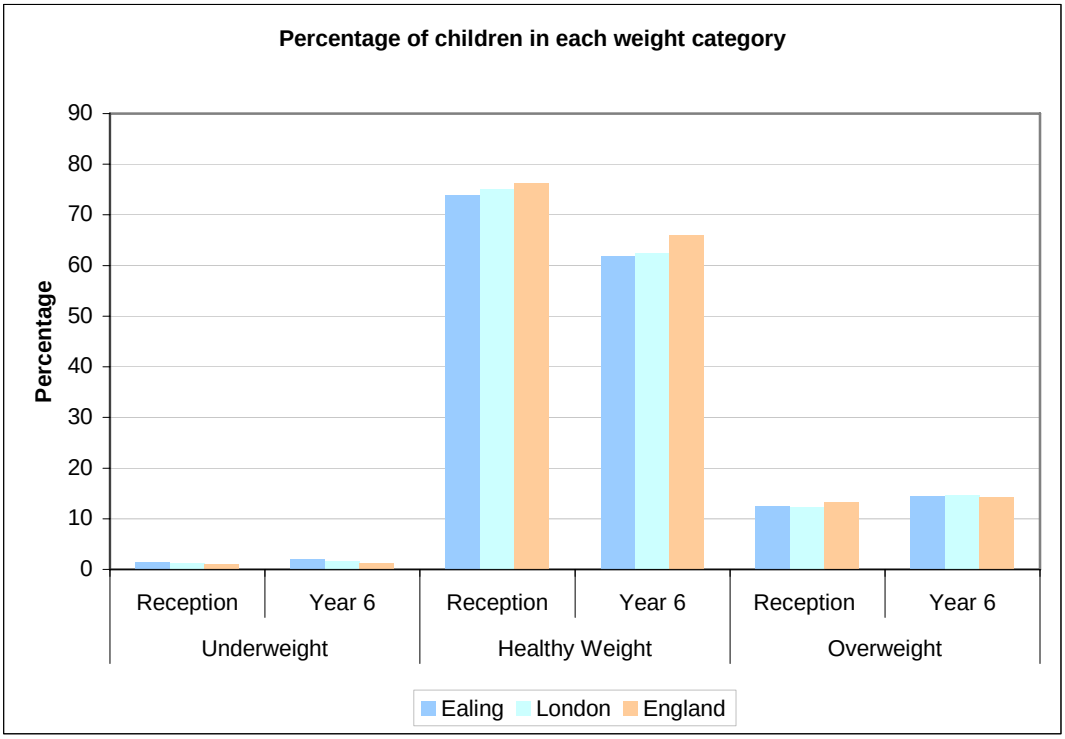
Table 6.25 Percentage of Obese

	Reception		Year 6	
	Boys	Girls	Boys	Girls
Ealing	13.2%	10.9%	24.9%	18.7%
London	12.1%	10.3%	23.3%	19.2%
England	10.2%	8.9%	20.0%	16.5%

Source: Department of Health, Information Centre 2010

- Between 2007/08 and 2008/09 'obese' category rose from 10.8% to 12.1% in reception; and 21.0% to 21.9% in year 6.
- Children in the borough have higher than average levels of obesity
- Underweight children made up 1.4% of reception year and 2% of year 6, above both London and national averages.
- The percentage of school children who participate in at least two hours of sport per week is higher than average.

Figure 6.26 Percentage of Children in each weight category



Source: Department of Health, Information Centre, 2010

In Ealing it is estimated that 19% of adults are obese according to the 2005 Health Survey. Levels of obesity in the borough do vary with particular high obesity wards shown in Table 6.27

Table 6.27 Wards with high levels of obesity

Ward	Percentage Adult Obesity
Dormers Wells	22.7%
Lady Margaret	22.4%
Northolt West End	22.8%
Southall Broadway	24.1%
Southall Green	23.7%

Source: London Health Observatory 2005

Eating Habits

Poor diet and nutrition are recognised as major risk factors contributing to poor health and premature mortality. The annual cost to the NHS of unhealthy eating habits has been estimated at £2 billion. The majority of people are still not eating the recommended daily consumption of at least five portions of fruit and vegetables a day, although consumption is steadily rising.

In Ealing, 30.8% of adults reported eating 5+ portions of fruit and vegetables on the day before the survey. This is significantly above the National average for England (26.30%). However in comparison to some of our neighbouring boroughs (Table 6.25), self-reported fruit and vegetable consumption is still lower than average. Caution needs to be exercised in interpreting self-reported behaviour. The Information Centre for Health and Social Care report: Statistics on obesity, physical activity and diet: England, found that 62% of men and 78% of women correctly stated that five portions of fruit and vegetables should be consumed a day, however, nationally, only 14% of men and 11% of women correctly identified what counts as a 'portion' of fruit or vegetables[14].

Table 6.28 Self-reported consumption of 5 a day fruit and vegetable.

Area	Consumption 5 a day
Brent	30.10%
Ealing	30.80%
Hammersmith & Fulham	35.70%
Harrow	34.50%
Hillingdon	29.30%
Hounslow	26.70%

Source: Office for National Statistics and Information Centre 2007

Physical Activity

Physical Activity is any force exerted by skeletal muscle that results in energy expenditure above resting level and includes the full range of human movement, from competitive sport and exercise to active hobbies, walking and cycling or activities of daily living[24]

The Chief Medical Officer recommends that Adults undertake 30 minutes a day on five or more days of the week of moderate intensity activity (one session or shorter bouts of 10 minutes or more), while Children should undertake 60 minutes of

moderate intensity activity every day of the week (one session or in shorter bouts of 10 minutes or more)

Health Impact of Physical Activity: People who are physically active reduce their risk of developing major chronic diseases – such as coronary heart disease, stroke and type II diabetes – by up to 50%, and the risk of premature death by about 20-30%[24]

Table 6.29 The percentage of the adult population participating in at least 30 minutes of sport and active recreation at least 3 days a week.

	2006/07	2007/08	2008/09
Brent	18.0%	19.5%	15.8%
Ealing	21.2%	20.0%	19.7%
Hammersmith & Fulham	25.4%	27.0%	28.8%
Harrow	18.6%	13.3%	15.9%
Hillingdon	20.6%	20.7%	18.9%
Hounslow	19.7%	15.1%	18.0%
London	21.3%	20.2%	21.2%
National	21.0%	21.3%	21.6%

Source: Active People Survey 2009

Ealing's participation level in 2009 is at 19.7% shows no statistically significant change from previous year. This is lower than the London average of 21.2%, and the National average of 21.6%

Table 6.30 The percentage of the adult population participating in at least 30 minutes of sport and active recreation at least 3 days a week by Age.

	16 to 34		35 to 54		55 and over	
	2007/08	2008/09	2007/08	2008/09	2007/08	2008/09
Brent	27.2%	16.8%	14.9%	16.9%	13.7%	12.9%
Ealing	23.9%	23.3%	20.1%	22.7%	13.7%	9.8%
Hammersmith & Fulham	31.7%	39.0%	27.7%	27.0%	15.5%	9.7%
Harrow	17.9%	20.7%	14.7%	14.4%	6.9%	12.5%
Hillingdon	30.0%	25.7%	24.1%	20.3%	5.8%	9.2%
Hounslow	15.7%	23.0%	16.8%	19.3%	11.7%	8.3%

Source: Active People Survey 2009

Table 6.30 shows that in Ealing participation rates declining with increasing age. A higher percentage of females (56.40%) reported undertaking zero days of participation in activity in comparison with males at 43.40%, and this has remained fairly constant for females across the three years. The older the age group the more likely they are to report undertaking zero days of activity with 66.90% of the 55s and over, in comparison to 47.70% of the 35 to 54 age group reporting zero days, and 40.70% of the 16 to 34 age group. Those reporting their ethnic group as non white report a greater percentage of zero days participation in activity at 54.40%, in comparison to those listed under white at 45.60%. Those reporting a limiting illness or disability also report a greater percentage of zero participation in activity at 72.30% in comparison to 46.60% of those with no limiting illness or disability.

58.9% of males and 63.90% of females would like to do more sport. The greatest number of people within an age group wishing to do more sport is from the 35 to 54 year olds age grouping at 76.70%, followed by 68.50% in the 16 to 34 year olds group, and then 34% of those aged 55 and over. There remains a significant amount of people within the non white grouping (72.80%) wishing to do more sport in comparison to the 52.50% in the white group. Whilst among those reporting a limiting

illness or disability the number wishing to do more sport has increased from 57.8% in 2007/08 to 65.80% in 2008/09.

Within the borough the following wards have the lowest levels of activity are Northolt Mandeville, Northolt West End, Greenford Broadway & Greenford Green, Southall Broadway, Dormers Wells, Norwood Green, South Acton, Ealing Common & Hobbayne. The most active are primarily around Central Ealing in Ealing Broadway.

Diabetes

Diabetes is a chronic condition characterised by a raised blood glucose level resulting from either a lack of or insensitivity to the hormone insulin. Unless it is diagnosed and effectively treated diabetes can put people at risk of complications such as heart and kidney disease, blindness, strokes and amputations. Deaths from diabetes are expected to rise by 25 per cent in the next 10 years (Diabetes UK).

Local Prevalence

The Quality and Outcomes Framework current data suggests that there are 18,679 people with diagnosed diabetes in Ealing making up nearly 5.4% of the registered population, which is higher than national average. This increase is likely to be due to the implementation of the NHS Health Checks by GP practices in Ealing. The expected diabetes prevalence in individual wards varies from 10.4% in Southall Broadway having a resident population of 80% Asian to 3.1% in Southfield, where 90% of the population is white. The estimated diabetes prevalence is 5.49% in the 30-59 years (1 in 20) and 18.30% in the over 60-age group (1 in 5). (Diabetes JSNA, 2009)

Diabetes prevalence is likely to increase to 7.5% by 2025. This increase is likely to be attributable to an upward trend in obesity, an aging population and the high prevalence of South Asian and African-Caribbean people who are more likely to develop diabetes compared to the white population.

Table and Figure 6.31 Modeled Prevalence of Diabetes 2005 to 2025

Year	2005	2010	2015	2020	2025
Numbers	15,994	17,731	19,589	21,536	23,522
Prevalence %	5.23	5.84	6.41	6.97	7.53

Source: PBS diabetes prevalence model

Differences are seen within PBC groups with the highest recorded prevalence in Southall (7.4%) and lowest in EACG (3.3%). Within PBC groups there is a considerable variation in the prevalence of diabetes ranging from 1.87% to 10.4%. (QMAS, 2008/09). This is possibly due to a combination of differences in case finding and recording on GP disease registers as well as real differences in practice prevalence due to demographic and risk factors between areas. The increased prevalence of diagnosed diabetes in 2008/09 compared to 2007/08 can be partly explained by detection through the vascular screening programme.

People who live in more deprived areas are more likely to suffer diabetes than those who live in less deprived areas. Half of the Ealing population live in the city's two most deprived quintiles, whereas only 14 percent reside in affluent quintiles. The high rates of type II diabetes (up to 11%) are expected in the wards having proportionately the largest Asian populations and where socio-economic deprivation is high. In contrast the highest prevalence of the much lower prevalent type I diabetes mellitus (26/10,000) does not appear to be related to ethnicity and socio-economic status.

Quality of Care in Primary Care

A good quality primary care reduces the occurrence of complications related to diabetes. These include control of blood glucose (HbAIc level<7.5), control of blood pressure (< 145/85), and screening for diabetic retinopathy.

HbA1c is the most important indicator for long term blood glucose control. The proportion of patients with diabetes who had HbA1c less than 7.5 is 60.54% in Ealing compared to 66.3% nationally in 2008/09. There is also a wide variation between the PBC groups. Southall Primary commissioning group has the lowest achievement of only 51% for HbA1c<7.5 with the highest exception rate of 24%. It is important to explore the reasons for these variations so that appropriate measures can be envisaged to address the problem.

Level of exception reporting for HbA1c< 7.5 is very variable and may mask the true picture of performance. In Southall PBC groups it is as high as 44%. This means in Southall PBC group when exceptions were excluded only 10 practices achieve the target higher than Ealing average. However, when exceptions were included only 2 practices achieve the target higher than Ealing average. This reflects an unmet need, as patients whose blood glucose is not well controlled are more at risk of developing complications.

There has been year-on-year increase in the number of emergency hospital admissions from 231 in 2003-04 to 397 in 2008/09, which represents a near 70% rise in the last 5 years. This rise is highest amongst age groups 10-14 years (onset of type 1 diabetes), followed by 40-44 years (onset of type 2 diabetes) and 80-84 years (co-morbidities affecting blood sugar).

Emergency admissions have risen by 95% from 2003/04 to 2008/09 with elective admissions only up 4%. Out of all hospital admissions related to diabetes in 2008/09 there were 85 percent emergency admissions compared to 14 percent elective admissions. Emergency admissions are a proxy indicator for the quality of diabetic care provided in primary care so identifying these patients and developing appropriate personalised care plans will reduce dependency on hospital outpatient services and reduce the high rate of emergency admissions.

The last 5 year trend suggests nearly all PBC groups have higher proportions of emergency admissions compared to elective admissions. West Ealing PBC group remains lowest in hospital admissions, however in this group elective admissions dropped 3 times and emergency admissions nearly doubled in 2008/09 from 2007/08.

In 2003/04-2008/09 58% men appear experienced a somewhat greater increase in hospital admissions than women (42%). The reasons for gender differences are not well established and may reflect differences in reporting and access to services.

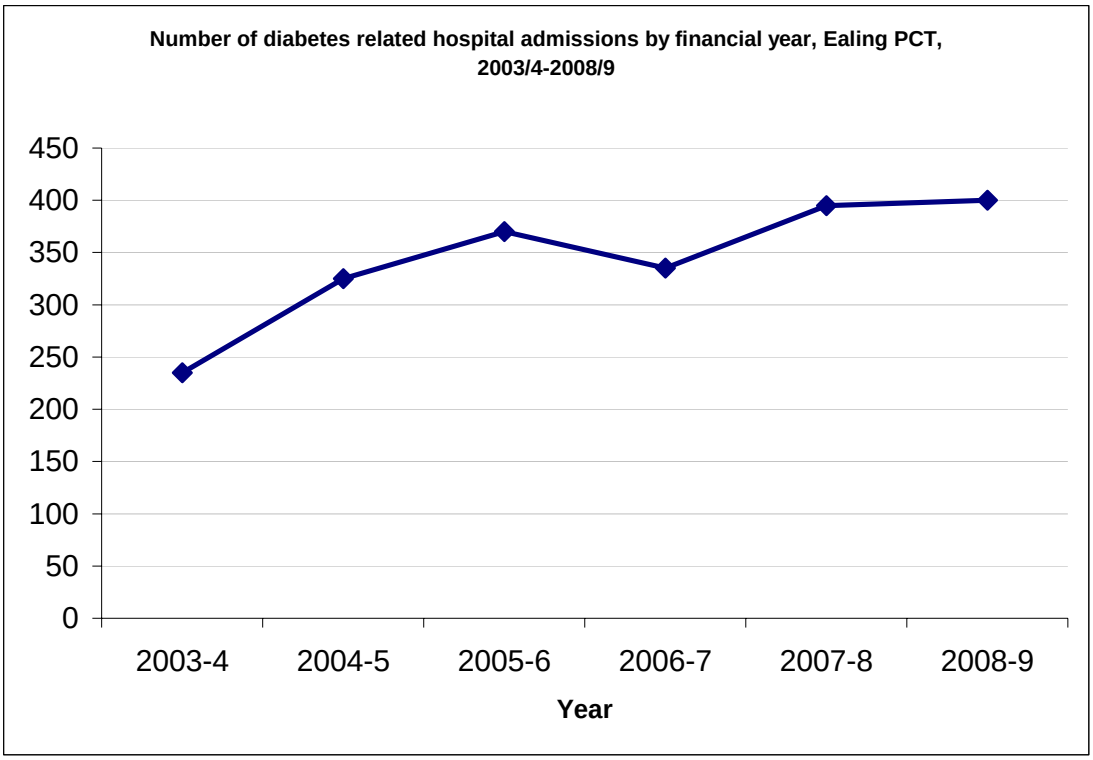
The number of diabetes related hospital admissions has increased from 2003/04 to 2008/09 in the ‘Asian/Asian British’, ‘Black/Black British’ and ‘White’ ethnic groups, by 84%, 140% and 61% respectively.

Within the Ealing wards, there exists a huge variation in admission rates Age adjusted diabetic admission rates in 2003/04-2008/09 shows significantly higher rates for men in Norwood Green and Lady Margaret followed by Dormers Wells and

Southall Broadway. Whereas, Ealing Broadway has the highest admission rates for women.

Age adjusted hospital admission rates for diabetes for people less than 75 shows significantly higher rates for Norwood Green followed by Dormer Wells and Southall Broadway.

Figure 6.32 Emergency Hospital admissions for Diabetes 2003/04 - 2008/09



RISK-TAKING BEHAVIOURS

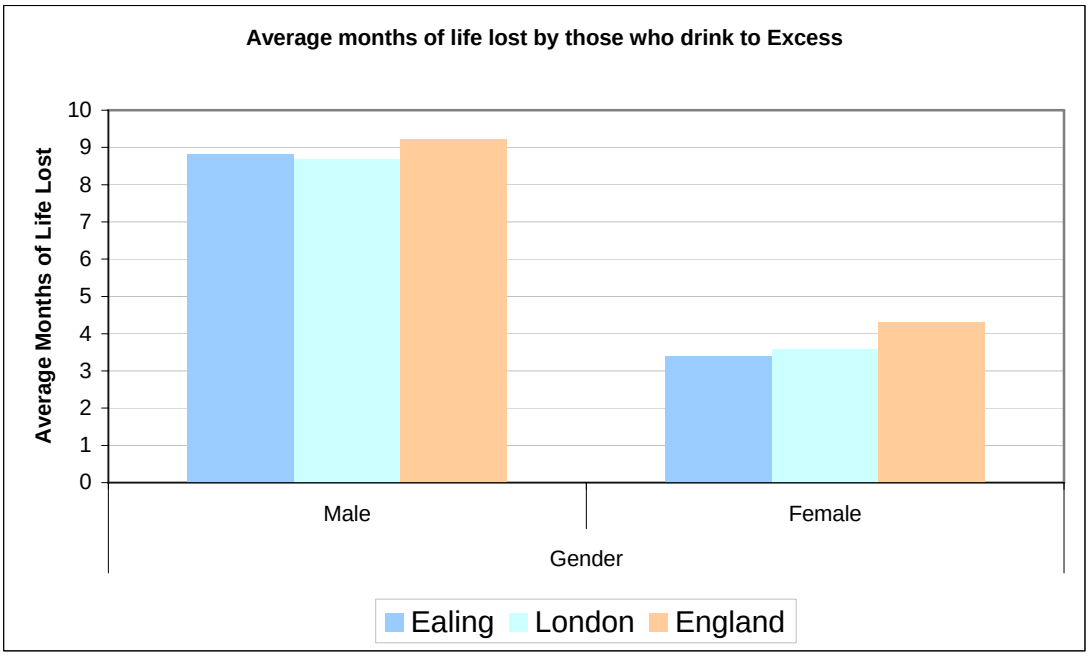
Risk taking behaviour is defined as any action that jeopardises an individual's health and well-being directly or indirectly. It is strongly associated with age with most such behaviour seen in young men and women between the ages of 14 and 25 years[20]. Risk taking behaviour, and its consequences, impact not only on the individual concerned but also on their family and the broader community.

Within Ealing the risk taking behaviours we think have most impact on health include unsafe sex, substance misuse (including tobacco and alcohol), violence and behaviours causing risk of injury.

Tobacco and alcohol use are major lifestyle factors that contribute not only to deaths from cardiovascular diseases and cancers, but also to deaths from cirrhosis, violence, transport accidents and poisoning.

The average months of life lost of excessive drinkers between 2005 and 2007 in Ealing are shown below. The effect of alcohol on males in Ealing is a loss of nearly 9 months of life. For females the effect is a loss of just over 3 months of life. It is important to be aware that relative few deaths directly as a result of excessive alcohol intake, however over a sustained period, excessive alcohol intake will lead to poorer health outcomes.

Figure 6.33 Average months of life lost in persons under 75 years who drink to excess (2005-2007)



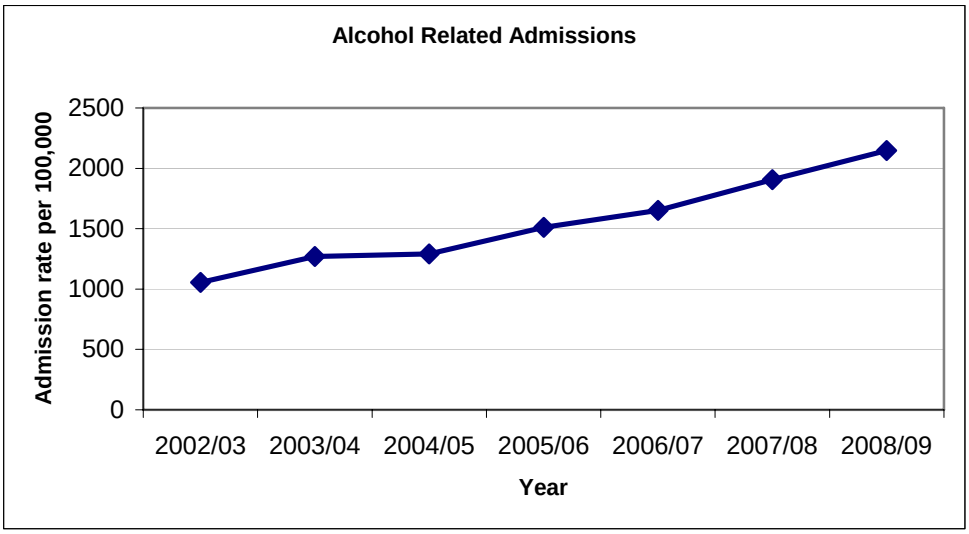
Source: North West Public Health Observatory 2009

Alcohol Misuse

Alcohol misuse is a major factor that often leads on to further risk taking behaviours. Alcohol misuse can lead to consequences that range from acute alcohol poisoning and longer term cirrhosis of the liver, to sexually transmitted infections, unwanted pregnancies and sexual assault, road accidents and crime, both within the home and in the community.

Alcohol Related Hospital Admissions

Figure 6.34 Alcohol related hospital admissions rate for Ealing



Source: Hospital Episode Statistics (HES) 2009

Figure 6.34 shows that Ealing's rate for alcohol related admissions has been rising for a few years. It is now more than double the 2002/03 rate. Within the Borough, excessive alcohol intake appears to be more prevalent in older age groups. This is reflected in a high level of hospital admission and Accident and Emergency attendances in the 30-50 years age group.

Binge Drinking

Binge drinking prevalence rates for England are estimated directly from the 2003-2005 Health Survey for England. They suggest that binge drinking prevalence in Ealing is 12.5%, below the England prevalence 18% and about the same as London, 12.7%. This appears to show that alcohol related admissions are for largely hazardous or harmful drinking or those surveyed underestimate their levels of alcohol consumption

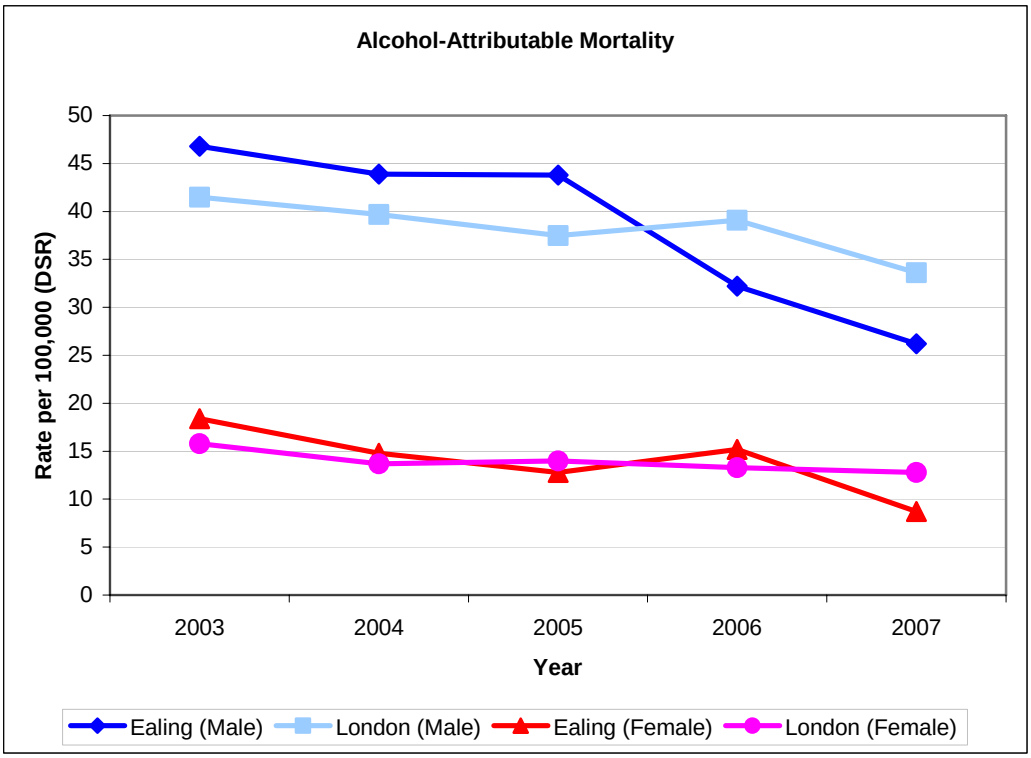
Table 6.35 Mortality from Chronic Liver Disease including Cirrhosis, rate per 100,000

	Mortality from Chronic Liver Disease	
	Male	**Female**
Ealing	12.96	3.67
London	14.84	5.99
England	13.79	7.13

Source: North West Public Health Observatory Pooled 2005-07

Deaths Attributable to Alcohol

Figure 6.36 Deaths Attributable to Alcohol



Source North West Public Health Observatory 2009

Deaths attributable to alcohol appear to have been falling in Ealing, the male rate falling quicker than the female rate (although the female rate falling from a lower rate). Both rates are now below the London rates. Deaths attributable to alcohol are small and can therefore be subject to variation. While the above figures appear to show a fall, time trends over 15 years indicate that this number is beginning to rise.

Overall the impact of alcohol misuse in Ealing is more common in men, in older age groups, in the western half of the Borough and in certain ethnic minority sub-groups. Seemingly chronic drinking is a greater issue for the borough than binge drinking.

Deaths Attributable to Smoking

The table shows the number of deaths attributable to smoking for the period 2003-07. During that period there were 3,125 smoking attributable deaths in Ealing.

Table 6.37 Death Attributable to Smoking

	2003-05		2004-06		2005-07	
Area	**Numbers**	**Rate***	**Numbers**	**Rate**	**Numbers**	**Rate**
Ealing	1,114	230.9	1,056	218.4	955	198.7
England	260,988	234.4	254,092	225.4	238,532	210.2

Source: London Health Observatory * Age standardized rate per 100,000

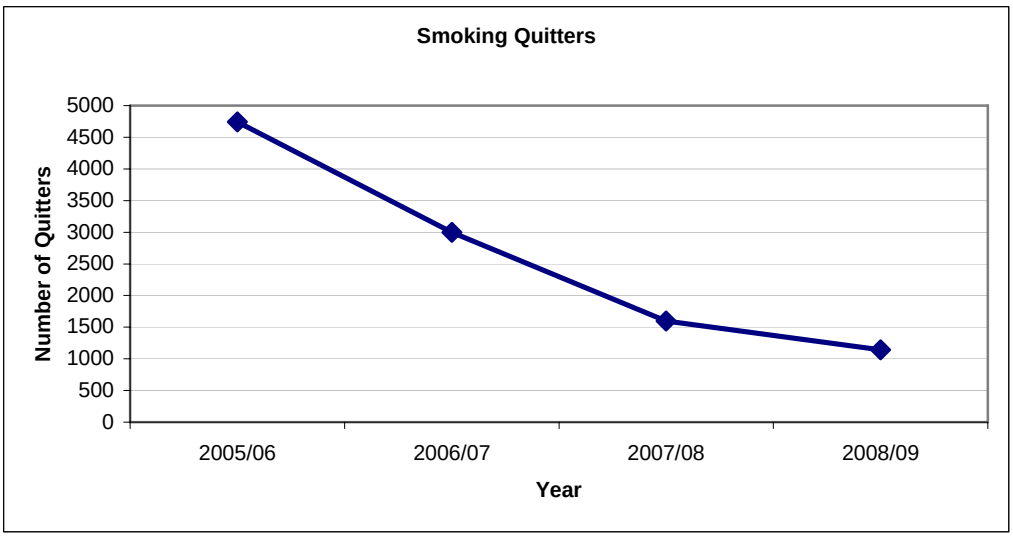
Smoking has been identified as the single greatest cause of preventable illness and premature death in the UK. A smoker's life span is shortened by about five minutes for each cigarette smoked. On average, those killed by smoking have lost 10-15 years of life.

Smoking prevalence among young people in Ealing is lower than national figures but there are still a significant number of regular secondary school smokers. Smoking prevalence in Ealing is highest among the routine manual group. Although smoking prevalence is low amongst Ealing's young population there is still a significant number of secondary pupils who have tried smoking, and are at risk of becoming smokers.

Chewing tobacco is more common among South Asians than the rest of the general public. The effects of smokeless tobacco are not as well publicised as cigarettes.

The number of Annual Smoking Quitters has fallen by over 75% between 2005/06 and 2008/09. This may be an indication that current smokers are entrenched in the habit and are more challenging to engage in quitting.

Figure 6.38 Annual Smoking Quitters

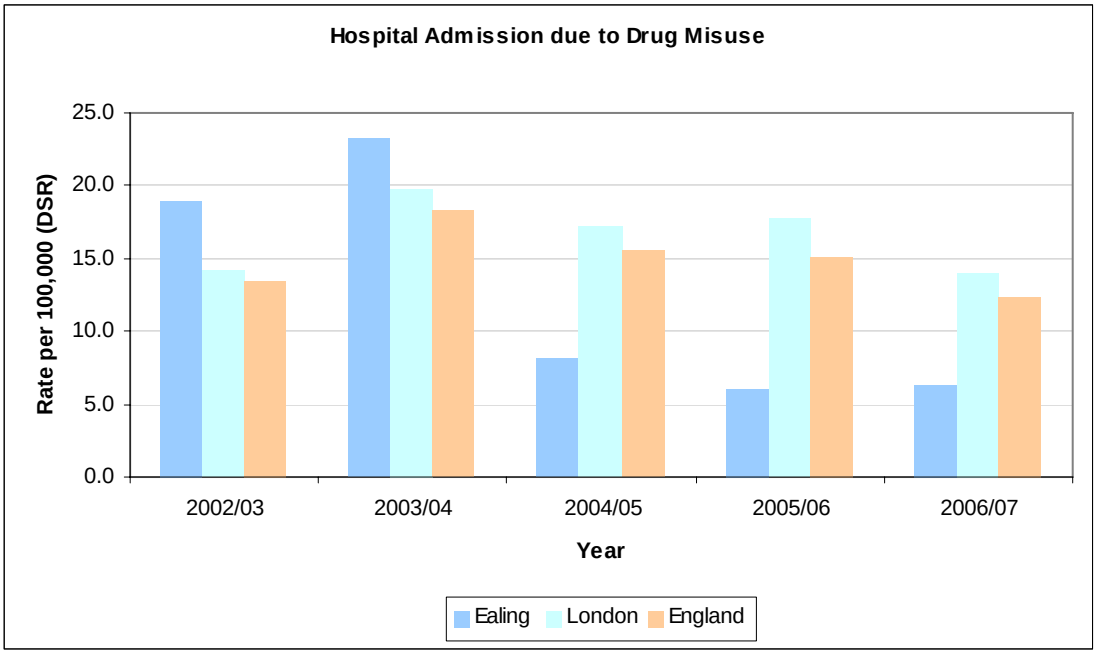


Source: London Health Observatory

Drug Misuse

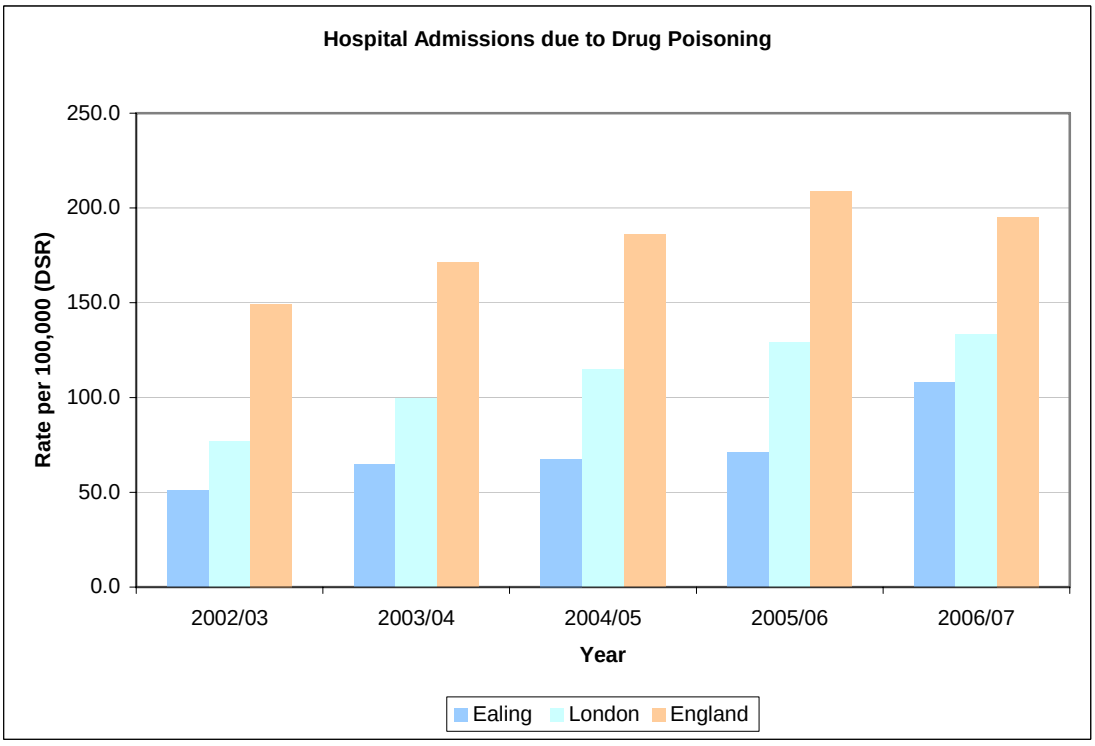
There are often higher rates of drug misuse within more deprived neighbourhoods. Young people who experience homelessness, exclusion from school or crime are more likely to be exposed to drugs at an earlier age and so have higher rates of frequent drug use.

Figure 6.39 Hospital Admission due to Drug Misuse



Source: London Health Observatory

Figure 6.40 Hospital Admissions due to Drug Poisoning



Source: London Health Observatory

Unplanned pregnancy, especially among teenagers, and sexually transmitted infections also have strong links to substance misuse. Hospital admissions for drug poisoning appear to be rising (figure 6.38) in Ealing, still below London and England levels but may reflect increased levels of drug use. Hospital admissions for drug misuse in Ealing were above London and England rates but these have fallen in recent times.

SEXUAL HEALTH

Human immunodeficiency virus (HIV)

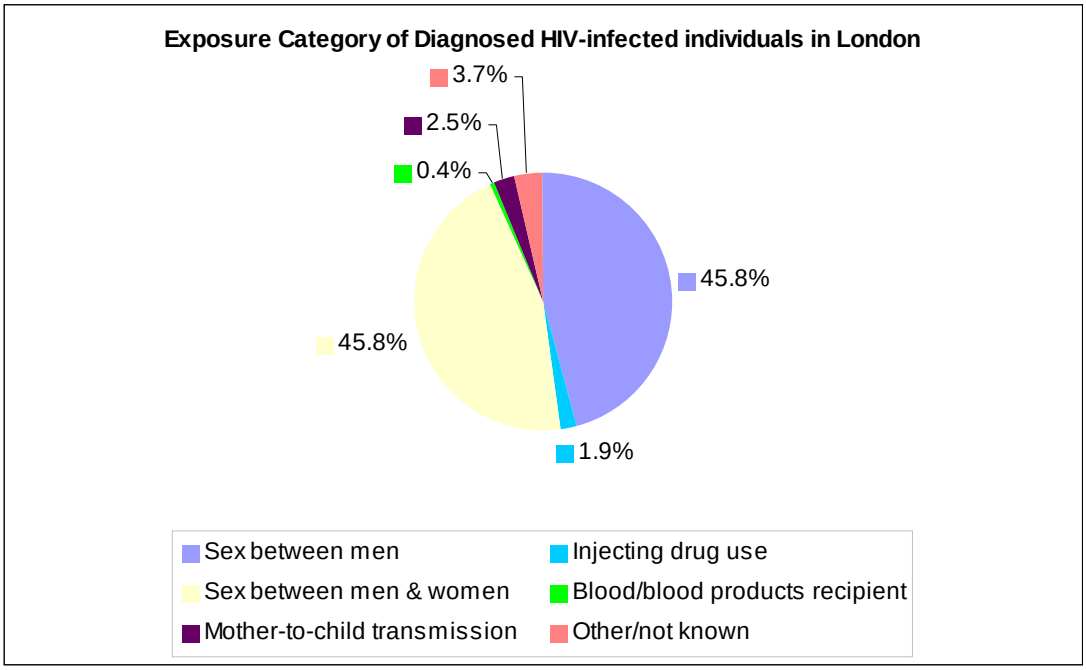
Table 6.41 HIV prevalence by borough 2008

Borough	Residents Accessing HIV Related Care	Diagnosed per 1000 15-59 population
Brent	723	4.03
Ealing	596	2.89
Hammersmith & Fulham	928	7.61
Harrow	249	1.85
Hillingdon	366	2.31
Hounslow	540	3.65

Source: Health Protection Agency, 2009

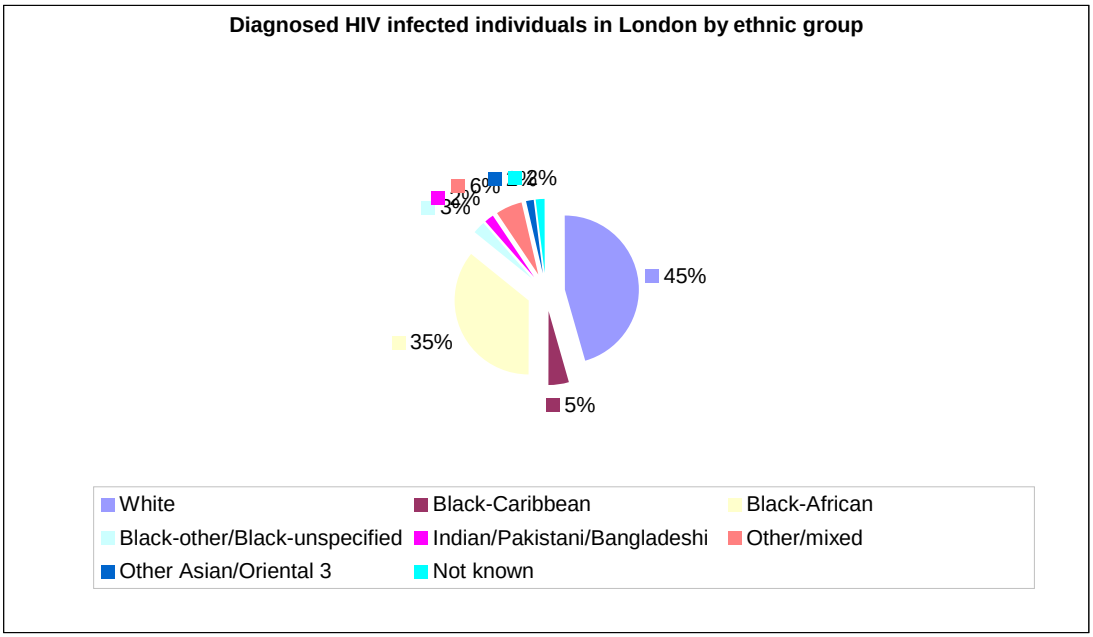
596 people in Ealing accessed HIV related care in 2008. In comparison to it West London neighbours, Ealing's diagnosed rate falls in the middle. It is significantly lower than highest rate in London, 12.85. In the majority of cases (91.6%), exposure occurs through sex between men and sex between men and women. Infection numbers vary with ethnicity in London, with the White and Black African ethnic groups accounting for the highest numbers of infected individuals. Infections are most prominent among males aged 40 to 44

Figure 6.42 Exposure Category of Diagnosed HIV-infected individuals in London, 2008



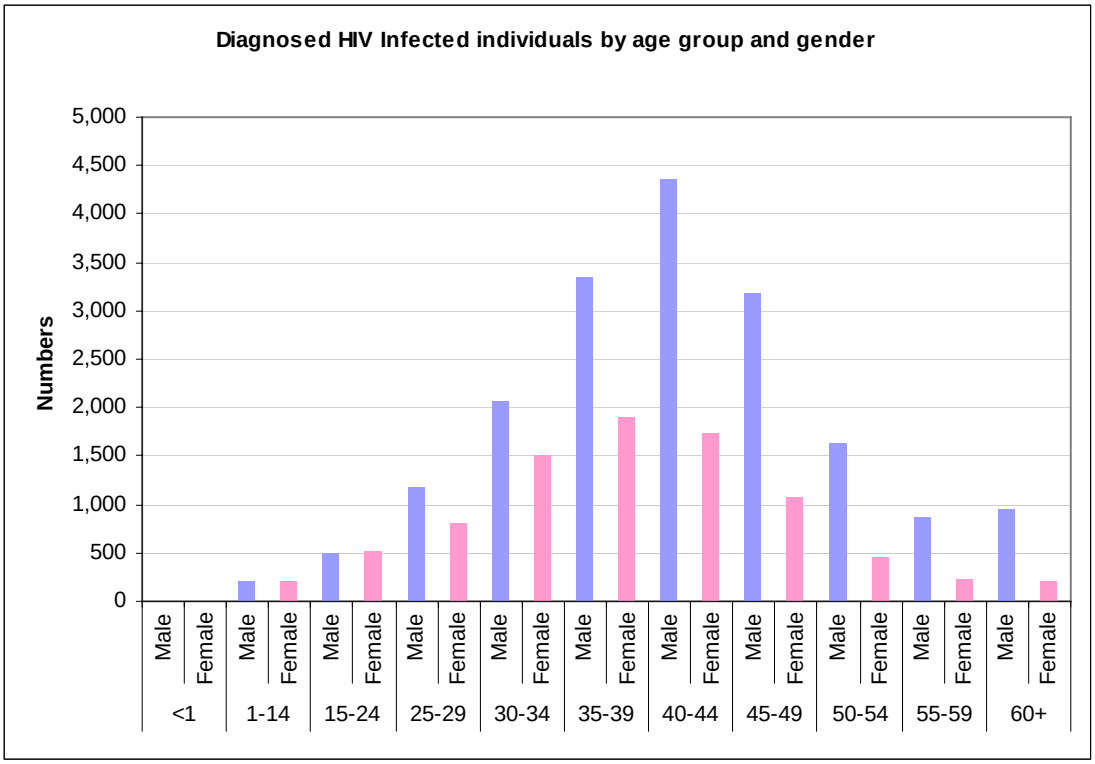
Source: Health Protection Agency, 2009

Figure 6.43 Diagnosed HIV infected individuals by ethnic group, 2008



Source: Health Protection Agency 2009

Figure 6.44 Diagnosed HIV infected individuals by gender and age in London, 2008



Source: Health Protection Agency 2009

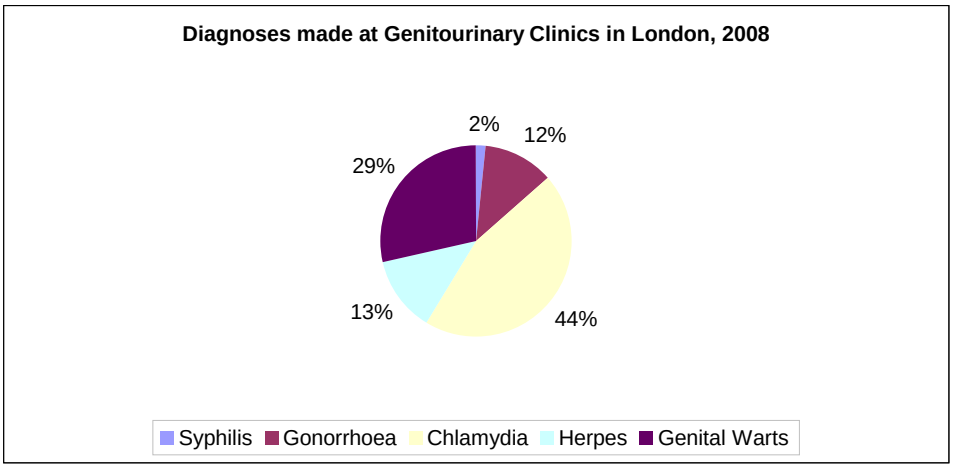
Sexually Transmitted Disease

According to the Health Protection Agency, the top five most diagnosed sexually transmitted disease are:

- Syphilis
- Gonorrhoea
- Chlamydia

- Herpes
- Genital Warts

Figure 6.45 Sexually Transmitted Disease diagnoses made at genitounrinary clinics



Source: Health Protection Agency, 2009

Chlamydia

Chlamydia is the most common bacterial sexually transmitted infection (STI) in the UK; affecting both men and women. Most people with chlamydia have no symptoms, but left untreated, chlamydia, can lead, in women, to infertility, ectopic pregnancy and chronic pelvic pain. In men it may cause urethritis and epididymitis. In both sexes it can cause arthritis.

National Screening Strategy

- The National Chlamydia Screening Programme (NCSP) is a control and prevention programme targeted at sexually active young people under 25.
- The NCSP facilitates the provision of screening in core sexual health services (community contraceptive services, general practice, abortion services and community pharmacies). This work is supported by outreach that aims to introduce young people to local sexual health services.
- The NCSP has found that approximately one in 14 young people under 25 years who are tested carry chlamydia. Chlamydia is often asymptomatic so a large proportion of cases remain undiagnosed, but infection can be diagnosed easily (young people can do the test themselves), and treated effectively.
- For 2009/2010 The target for the National Chlamydia Screening Programme was to test 25% of sexually active young people under 25.

Local Screening Strategy

- The local screening strategy is based on reaching out to venues where young people congregate rather than expecting them to attend health centres. Much of this outreach takes place in local educational settings and youth and community centres. Access can be further extended by sending letters with a link to a website that offers a screening kit through the post or by sending kits directly to young people aged 15-24
- Targets set by the Department of Health are as follows:
  2009/10: 25% of the relevant population = 9, 675 screens

2010/11: 35% of the relevant population =13,370 screens

Local Achievements

- In Ealing the 2009/10 target of 25% was exceeded, with the kit mail out producing the final numbers needed.
- A high positivity rate is an indicator of need for screening and appropriate targeting of a screening programme. Positivity rates remained below 4% overall; however 14% positivity was detected in certain groups.

- 4,271 young men and 5,461 women were screened. Women tend to make greater use of health services than men, including sexual health and contraceptive services, and so there are more opportunities to offer a screen. The screened population included all Ealing post-codes and ethnic groups.

Areas for development

As far as resources allow we aim to:

- Increase capacity and develop skills within core NHS services to offer screening, with the aim of offering 60% of screens from local services.

- Establish the 'Text for a test' service in 2010-11.

- Sustain regular sessions in educational establishments which offer screens, condom distribution and sign posting to other services

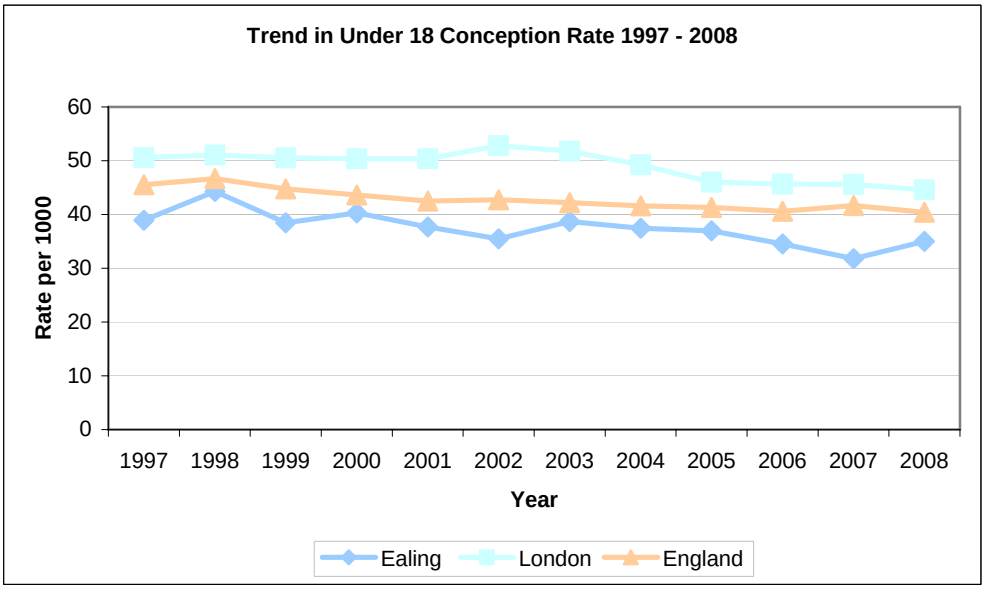
Teenage Pregnancy

Health outcomes for babies born to young mothers are worse than for babies born to older mothers. The main contributing factors are that younger mothers are less likely to attend for antenatal care, more likely to smoke, less likely to breast feed and have poorer diets during pregnancy.

Teenage mothers are 22% more likely to be living in poverty at 30, and much less likely to be employed or living with a partner. They are 20% more likely to have no qualifications at age 30. They have three times the rate of post-natal depression and a higher risk of poor mental health for 3 years after the birth of the child. There is an increased chance (three times more likely) of smoking throughout their pregnancy, and 50% less likely to breastfeed, with negative health consequences for the child.

Children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems. The infant mortality rate for babies born to teenage mothers is 60% higher than other mothers. The majority of teen pregnancies are unplanned and half end in abortion.

Figure 6.47 Trend in Under 18 Conception Rates 1997 - 2008

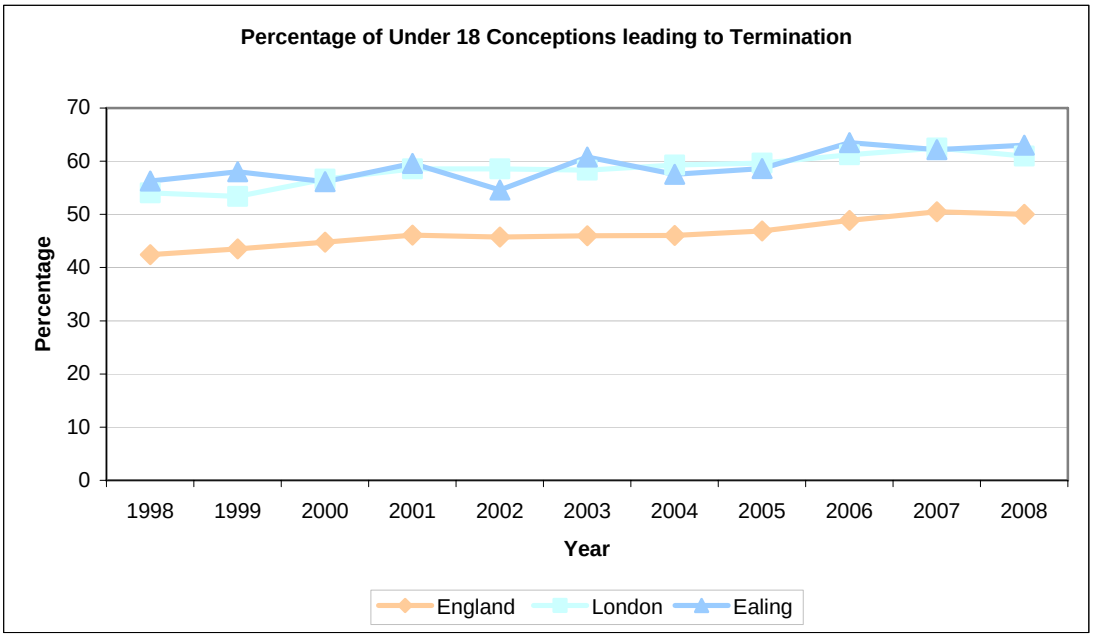


Source: Teenage Pregnancy Unit, Department of Health, 2009

In Ealing between 1997 and 2008 the percentage change in rate is a reduction of 10%. Within the borough there are some clearly identified areas of under 18 conceptions, namely Northolt and Acton; Greenford Broadway appears to be an emerging area for high under 18 conceptions. The highest under 18 conception rate is concentrated in Northolt which overlaps with patches of high deprivation.

Termination of Pregnancy

Figure 6.48 Percentage of Under 18 conceptions leading to termination



Source: Teenage Pregnancy Unit, Depart of Health, 2009

In England, 50% of under 18 conceptions end in the pregnancy being terminated while in Ealing this stands at 63%, slightly higher the London percentage of 61%. Ealing's termination percentage has been higher than the England percentage since 1998 but fairly close to the London percentage.

SECTION 7

Children and Young People

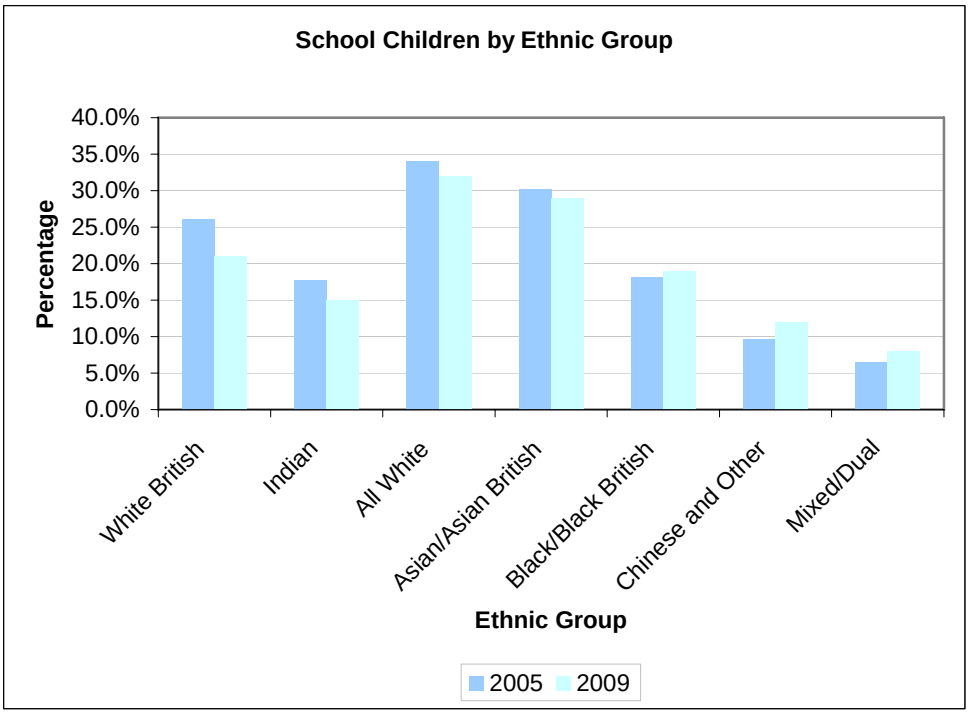
CHILD POPULATION

There were 5,346 Live Births in 2007 in Ealing and there are currently 21,781 children aged between 0 and 4 years which is around 8% of the borough's population. There are 71,661 children aged between 0 and 19 yrs, making up over 23% of the population. By 2020 it is predicted that the number of children between 0 and 19 will be 75,700.

It is estimated that about a third of children in Ealing aged between 0 and 15 are living in poverty. There are 28,334 school children from Black/Ethnic minority backgrounds which is about just under 77% of the school age population.

Ethnicity Profile

Figure 7.1 School Children by Ethnic Group

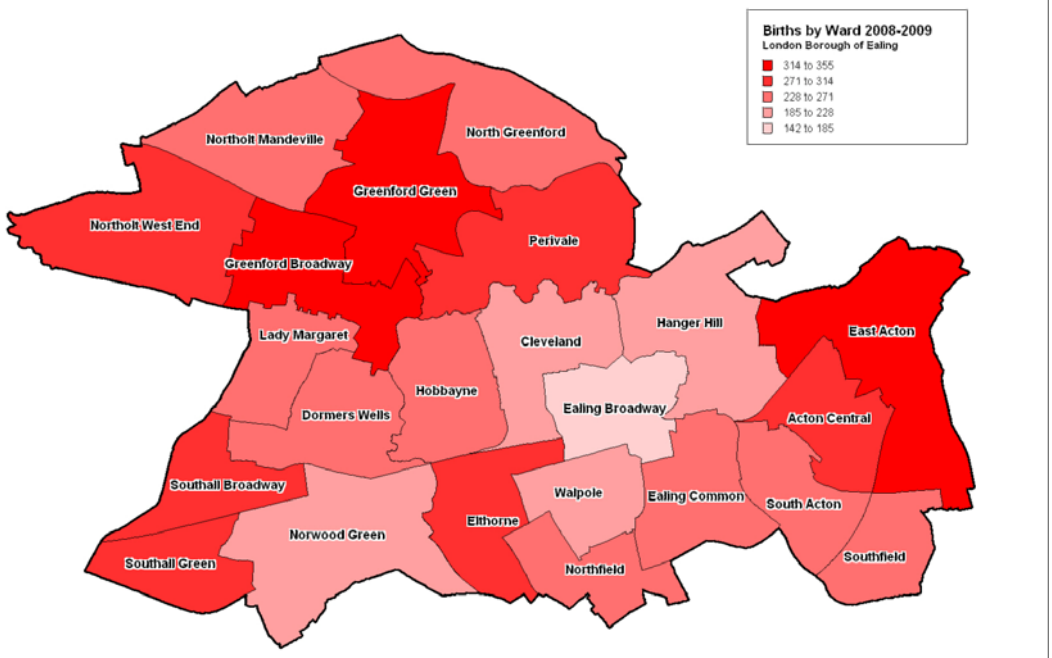


Source: Ealing School Census 2005 and 2009

Ealing has seen changes in the ethnic make up of its school children largely becoming more diverse between 2005 and 2009. The white British and all white school population has fallen. However this is similar to the Indian and Asian/Asian British population. Black/Black British, Chinese and other and Mixed or Dual ethnic groups have increased in Ealing's school population.

BIRTHS

Figure 7.2 Births By Ward 2008/09

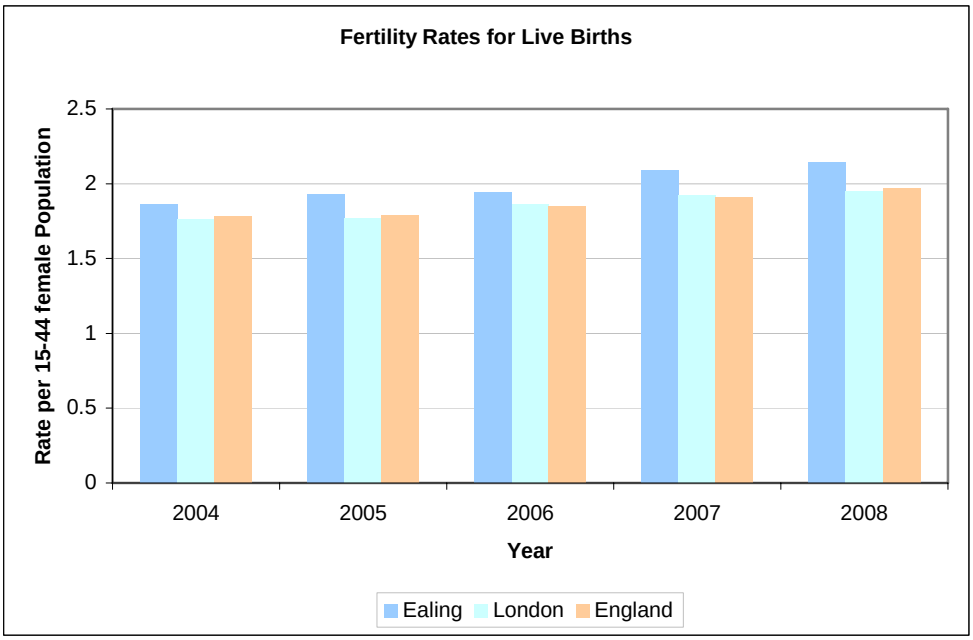


Source: Ealing PCT 2009

Greenford Broadway, Greenford Green, Acton, East Acton and Southall Broadway had the highest number of births in 2008/09. They were usually between 314 and 355 births in each of these wards.

Fertility Rate

Figure 7.3 Fertility Rate for Live Births



Source: National Centre for Health Outcomes Development 2009

Fertility rates in Ealing are higher than the rates for England and London and have been rising since 2004. There are now 2.14 live births per female population (15-44) compared to 1.86 in 2004

Country of Birth of Mother

Table 7.4 Country of Birth of Mother – Top Ten in Ealing

	2007	2008	Percentage Change
England	1760	1807	2.7
Poland	482	648	34.4
India	420	425	1.2
Somalia	362	399	10.2
Sri Lanka	254	231	-9.1
Afghanistan	233	218	-6.4
Pakistan	223	212	-4.9
Iraq	99	106	7.1
Ireland	73	60	-17.8
South Africa	52	57	9.6

Source: NHS Ealing 2010

Women giving birth in Ealing could have been born in any one of 144 countries. Table 7.4 shows the top ten countries according to number of births. These were in the same order for both 2007 and 2008. The top four countries, England, Poland, India and Somalia all saw increases between 2007 and 2008. This suggests that that Ealing diversity is likely to continue increasing over the medium term.

INFANT MORTALITY

The infant mortality rate (IMR) is defined as the number of deaths of infants aged less than 1 year per 1,000 live births. Infant mortality has fallen in Ealing, in line with England and Europe as a whole. The rate in Ealing is lower than the average for England but still highest than the lowest in London, suggesting that improvement is still possible.

Table 7.5 Infant Mortality Rates (2000-02 to 2005-07)

INFANTS UNDER 1 YEAR (per 1000 live births)						
	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
Ealing	6.2	5.9	5.0	4.0	4.2	3.9
London	5.7	5.7	5.4	5.2	5.0	4.8

Source: National Centre for Health Outcomes Development and London Health Observatory 2009

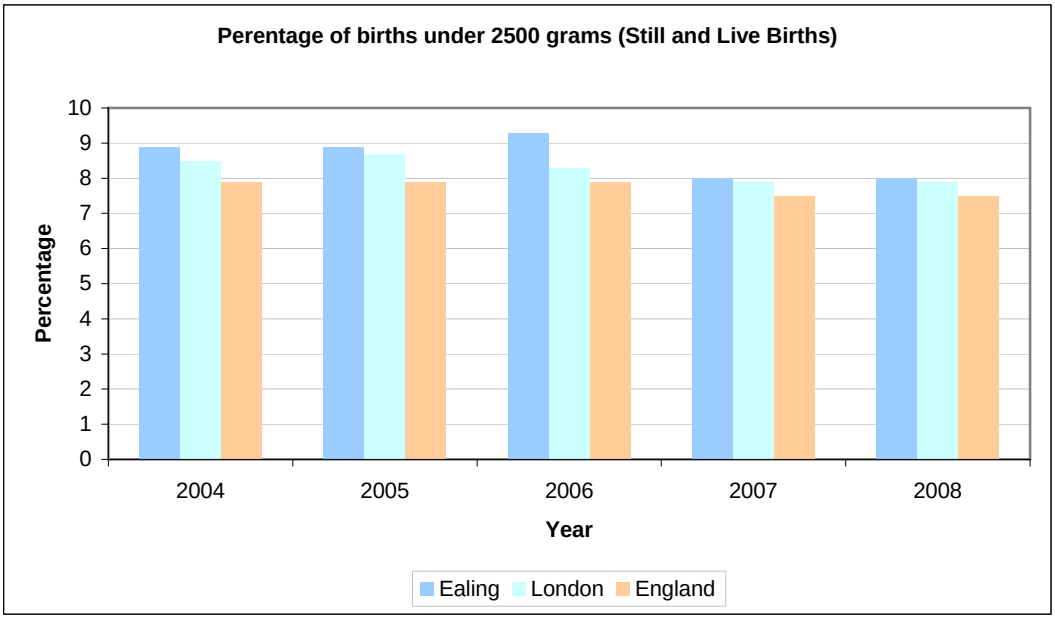
LOW BIRTH WEIGHTS

The low birth weight rate of a population is caused by a combination of babies being born too early or too small or both. Low birth weight is a predictor of poorer infant and child health. Optimal for a growing fetus or newborn may vary to some extent by mother's ethnicity. Babies gain most of their weight during the latter part of pregnancy therefore prematurity (<37 weeks gestation) is the primary reason for low birthweight. Babies born after 37 weeks may also have a low birthweight for any of the following reasons:

- poor placental function

- poor maternal health (poor nutrition, inadequate antenatal care)
- maternal substance use (smoking, alcohol, drug use)
- multiple birth (i.e. one of twins, triplets etc)
- birth defect
- maternal age – especially teenage mothers
- maternal low socio-economic status
- maternal ethnicity

Figure 7.6 Low Birthweights data



Source: Office for National Statistics 2009

Figure 7.6 shows that Ealing percentage of low birthweights is higher than England and London's. Although in 2007 and 2008 the gap between the London and Ealing rate appeared to be narrowing.

Smoking in Pregnancy

Maternal smoking in pregnancy is an important cause of low birth weight. Rates in Ealing have decreased between 2005 and 2008, have always been below the London rate. Currently less than 1 in 20 mothers smoke during pregnancy.

Table 7.7 Smoking during pregnancy

Percentage of Expectant Mothers smoking during pregnancy			
	2005/06	**2006/07**	**2007/08**
Ealing	7.9%	6.1%	4.5%
London	9.4%	8.3%	6.7%

Source: London Health Observatory

Breastfeeding

There is clear evidence that breastfeeding has positive health benefits for both mother and baby in the short and longer-term (beyond the period of breastfeeding). Breast milk is the best form of nutrition for infants and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life[16]. For infants, it reduces the incidence of gastrointestinal and respiratory infections, otitis media and recurrent otitis media and reduces the risk of allergies. There is also some evidence that it protects against neonatal necrotizing enterocolitis, respiratory and urinary tract infection, and that it reduces the risk of auto-immune disease, such as diabetes mellitus type I, and of adiposity later in childhood. For mothers, it promotes maternal recovery from childbirth, reduces the risk of pre-menopausal breast cancer and possibly of ovarian cancer, accelerates weight loss and a return to pre-pregnancy body weight and prolongs the period of postpartum infertility (World Health Organisation Regional Publications, European Series, No.87).

There is evidence indicating that the longer the duration of breastfeeding, the greater the health benefits in later life. Breastfeeding initiation rates have been improving over the last 10 years and, in 2005, 78% of mothers in England initiated breastfeeding. However, only 50% of all mothers who initiated breastfeeding were continuing to breastfeed at 6 weeks and 26% continued some breastfeeding at six months. There is clear evidence that adequate support to breastfeeding mothers in the first few weeks is likely to increase the duration of breastfeeding. Breastfeeding has an important contribution to make towards reducing infant mortality, childhood obesity and health inequalities[17].

Table 7.8 Percentage initiating breastfeeding

	2006/07	2007/08	2008/09
Ealing	87.01%	86.19%	87.97%
London	79.20%	84.20%	83.70%

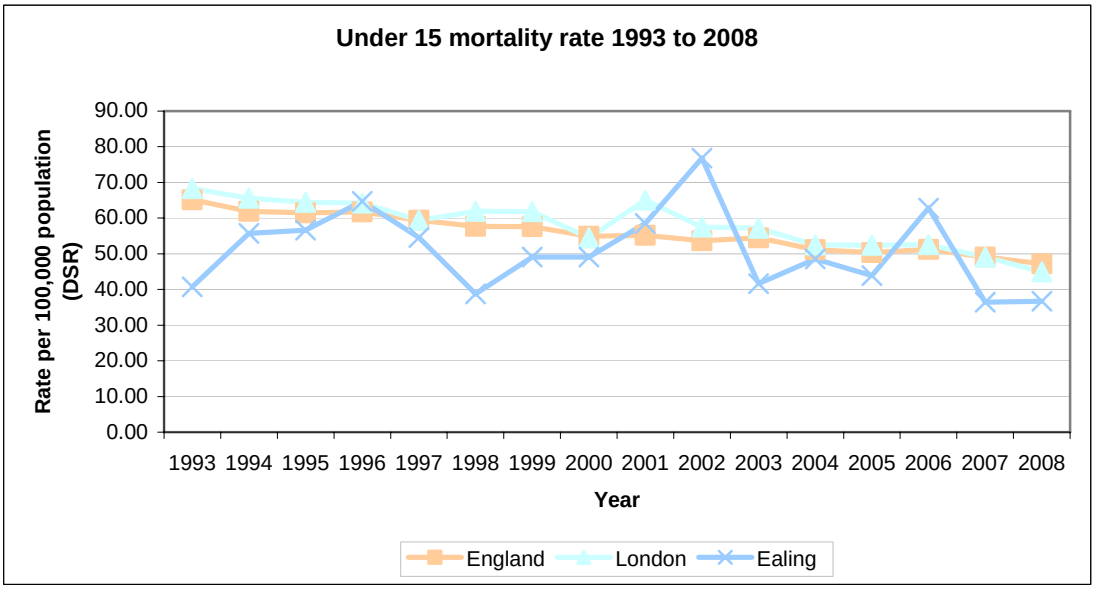
Source: Department of Health 2009

Table 7.8 indicates that on the whole mother initiate breastfeeding in Ealing more than in London. The percentage has remained relatively stable in recent years. However it is worth noting that they represent the percentage of women about data are collected.

UNDER 15 MORTALITY

Table 7.9 compares the number of deaths of under-15s per 100,000 population in Ealing with London and England between 1993 and 2008. The national and regional mortality rates have declined by over a third over the period. The pattern in Ealing is consistent with this decline, although absolute numbers are too small to show a clear trend. In 2008, 26 people aged under 15 died in Ealing which higher than the previous year (23) but notably lower than 43 in 2002.

Table 7.9 Under 15 Mortality rate 1993 to 2008



Source: National Centre for Health Outcomes Development 2009

DENTAL HEALTH

Dental caries and periodontal disease are almost entirely preventable, and oral cancers are strongly related to behaviours such as smoking or oral tobacco use and alcohol consumption. The other main causes of poor oral health are increased consumption of sugary food and drinks, poor oral hygiene and lack of exposure to fluorides.

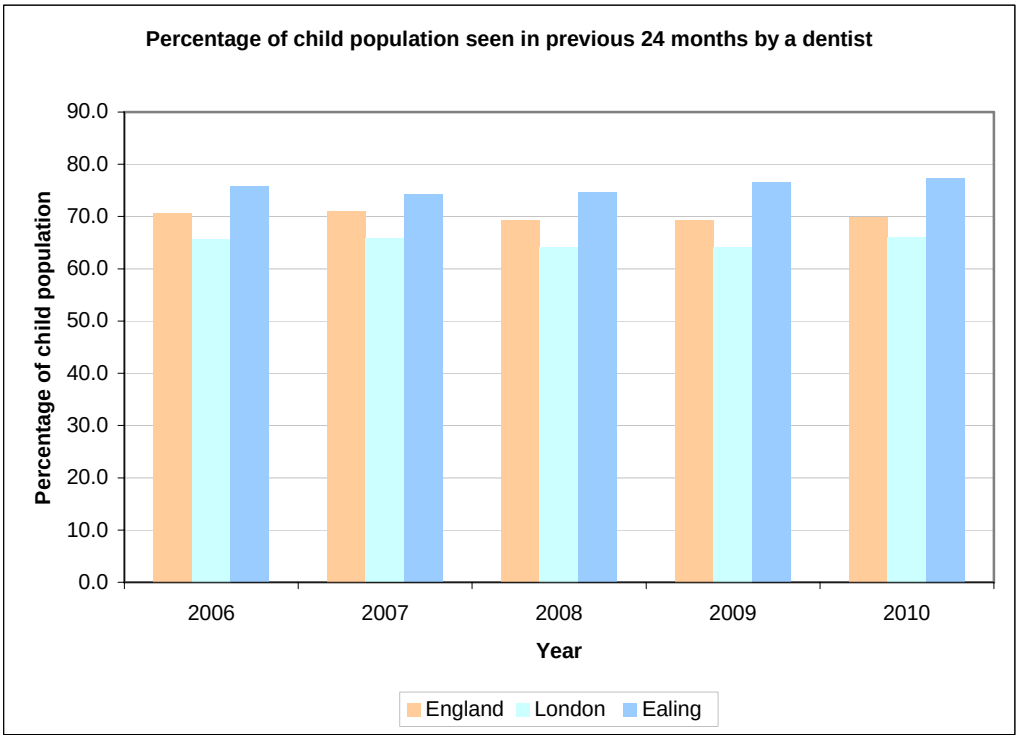
The dental health of young people in Ealing is worse than the national and London average. Data on under five year olds (Table 7.10) reveals high numbers of decayed, missing or filled teeth and high proportions of children and young people with active decay or experience of decay. Decayed, missing or filled teeth in the under fives is strongly linked to deprivation and may indicate sizeable health inequalities in Ealing. Nearly a third of all five year olds surveyed had active decay in Ealing.

Table 7.10 Under 5 Dental Health 2007 – 08

	Average no. of decayed teeth	Average no. decayed, missing/filled	Percentage with experience of decay	Percentage with active decay
Ealing	1.30	1.52	36.3%	32.8%
London	1.00	1.31	32.7%	29.0%
England	0.87	1.11	30.9%	27.5%

Source: NHS Dental Epidemiology Programme (NHS DEP) for England 2009

Figure 7.11 Percentage of the child population seen in the previous 24 months by a dentist 2006 -2010



Source: The Information Centre, Department of Health 2010

The percentage of children (17 years or younger) who have seen a dentist in the last 24 months is higher than the London and national rate. Given the rates of decay in younger children, it is not possible to say if the high percentages are due to active dental care or necessary dental care.

In Ealing 85% of primary and 82% of secondary pupils brush their teeth two or more times on the day before pupils were survey. Only 1% in primary and secondary did not clean them at all.[31]

The questions about dental health continue to raise concerns. 30% of primary pupils and 13% of secondary pupils had a filling on their last visit to the dentist compared to 21% primary pupils and 7% secondary pupils nationally. 12% of primary pupils and 15% of secondary school pupils had not visited the dentist in the past year and further still 21% had not been in the last 6 months.[31]

OBESITY

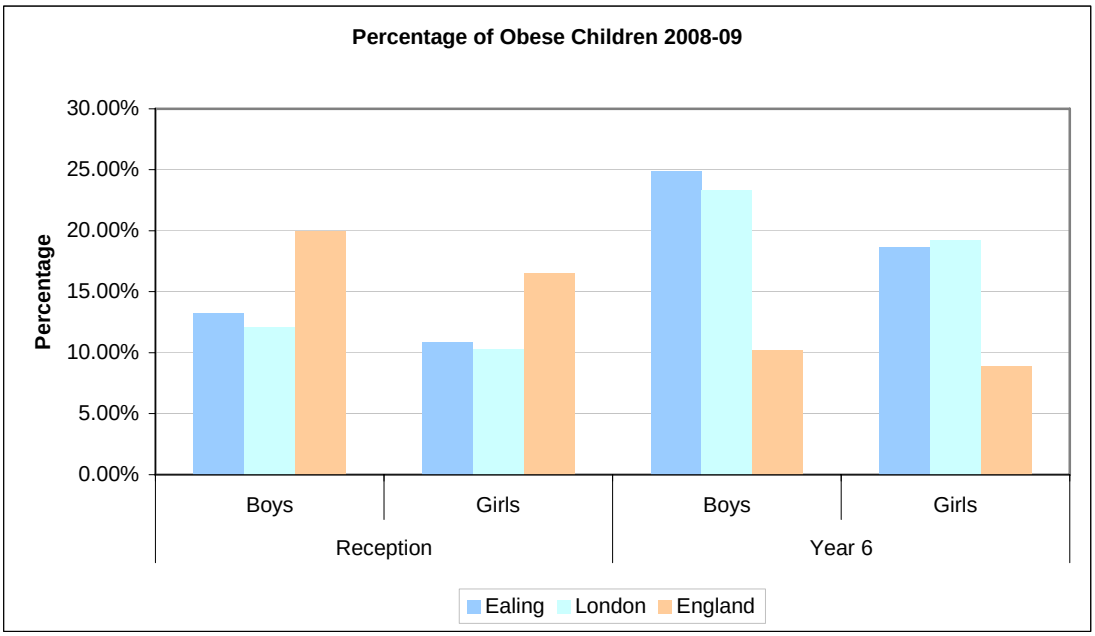
In the UK there are around 1 million obese children under 16 years of age.

Increasing rates of obesity have led to an increase in childhood type II diabetes and is likely to lead to a higher incidence of heart disease, osteoarthritis and some cancers in future. Estimates indicate that, if current trends continue, at least one fifth of boys and one third of girls will be obese by 2020 nationally.

Recognising this problem, the Government set a national target to halt the year on year rise in obesity among children under 11 by 2010.

In Figure 7.12 data for 2008/09 from the National Child Measurement Programme (NCMP) is shown. The NCMP weighs and measures children in Reception year (age 4-5 years) and Year 6 (aged 10-11 years) to assess overweight and obese levels.

Figure 7.12 Prevalence of Obesity in children in Ealing



Source: Information Centre, Department of Health 2010

Levels of obesity in boys in Ealing are high, it is above the London rate in reception and is higher than London and national levels by Year 6. While in Year 6 Ealing rates in boys are only slightly higher than London levels, it is more than double the national figure. Ealing girls in Reception have a slightly higher obese rate than London but significantly lower than the national rate. However by Year 6 Ealing girls' obesity is nearly double the national rate and only just below the London rate.

In Ealing, 19% of the secondary pupils and 14% of the primary pupils thought that they were too heavy, where as 11% of the secondary and 15% of primary pupils thought they were too light.[31]

40% of the primary school pupils said that they had tried to loose weight once or twice and 18% said lots of time. 57% of secondary pupils exercise sometimes or quite often to lose weight, while 13% said that they were always exercising to lose weight.[31]

MENTAL HEALTH

The effectiveness of child and adolescent mental health services (CAMHS) is measured and based on a self-assessment of how effectively mental health services meet children's mental health needs. This is an aggregated score of 1 to 4 for each of the four questions, where a total of 4 is the lowest possible score and 16 is the highest.

Table 7.13 Effectiveness of Child and Adolescent Mental Health Services (CAMHS)

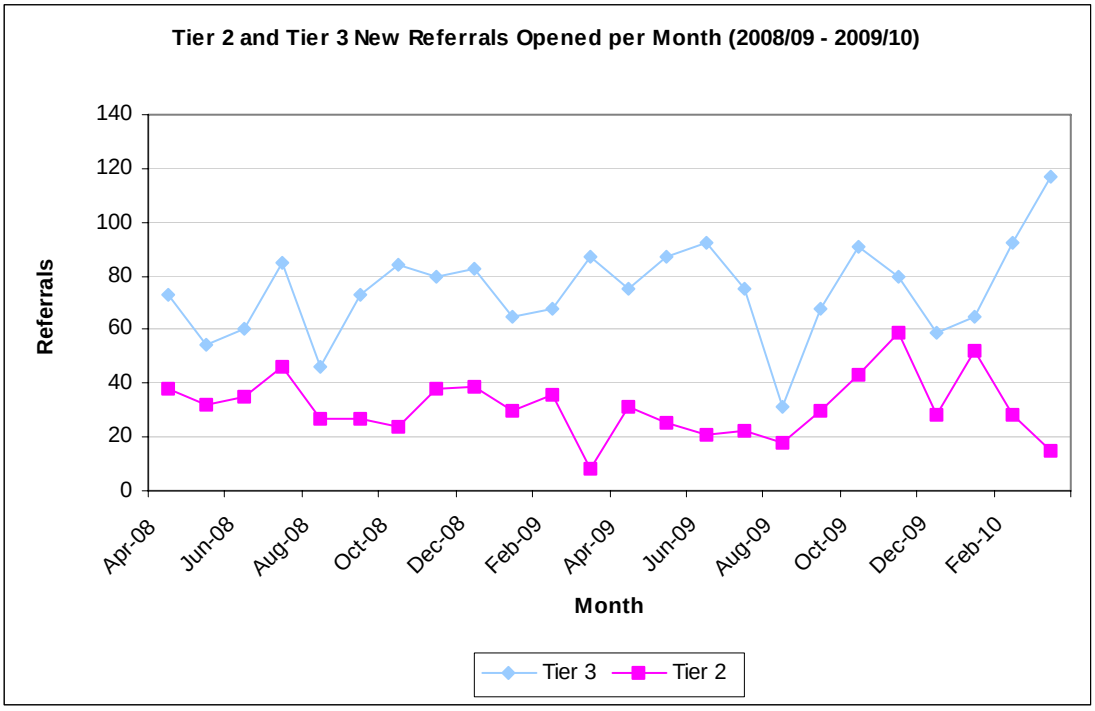
	2008	2009
Ealing	16.0	16.0
London	14.9	15.5
England	13.8	14.7

Source: Department for Education 2009

Child and Adolescent Mental Health Services in the UK are described in terms of Tiers. The description below comes from the National Service Framework for Children, Young People and Maternity Services - The Mental Health and Psychological Well-being of Children and Young People (DH 2004)

- Tier 1: Provision is centred on promotion of emotional and mental well being or early identification of children and young people who require referral to more specialised services
- Tier 2: A service provided by specialist individual professionals in community based/setting and may be part of a multi agency team working with the child or family.
- Tier 3: A specialised multi-disciplinary service for more severe, complex or persistent disorders.
- Tier 4: A highly specialised multi professional care approach, usually inpatient care but occasionally outpatient care at a specialist unit. Admission is and should be considered a last option where the child or young person cannot be safely managed in the community even with extensive support.

Table 7.14 Tier 2 and Tier 3 Referrals per month

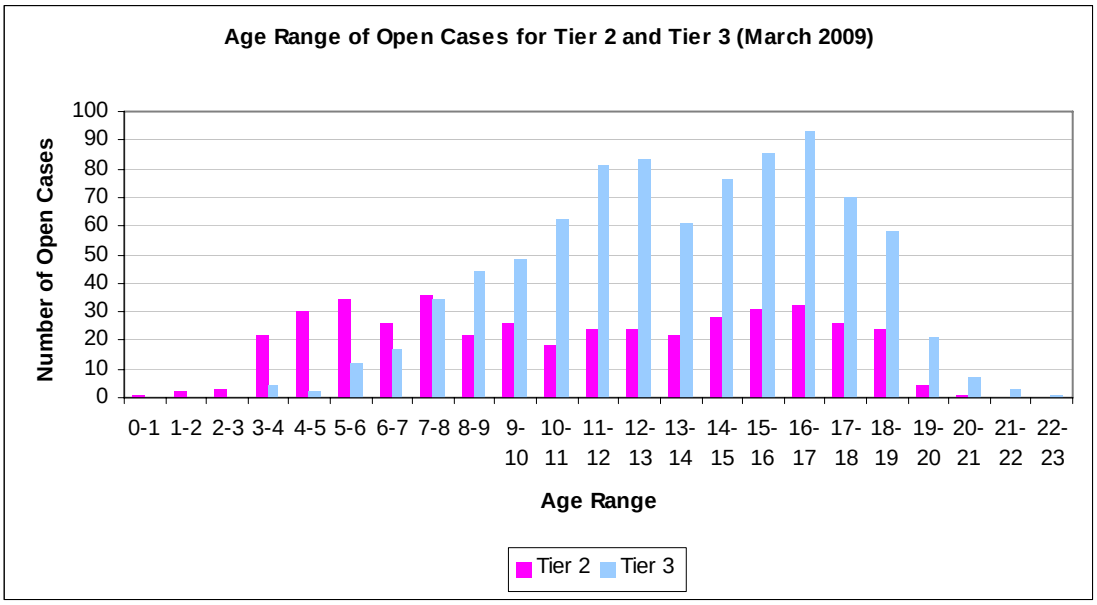


Source: Ealing CAHMS 2010

Over the period it is clear that there are more Tier 3 referrals than Tier 2, however since January 2010 it would seem that Tier 2 referrals have fallen while Tier 3

referrals seem to be increasing. It would normally be expected that as the severity of the health need increases it would be matched by a reduction in the number of cases.

Table 7.15 Age Range of Open Cases for Tier 2 and Tier 3 as at March 2009



Source: Ealing CAHMS 2010

During 2009/10 there were a total of 19 Tier 4 admissions, 10 female, 9 male. Over the past 18 months Ealing has had 29 admissions to tier 4 units. Data available from The Priory Group indicates that Ealing, despite a larger population, has a lower number of bed occupancy days and number of admissions than other neighbouring such as Brent, Hounslow. Westminster, Hammersmith & Fulham.

The rates of mental disorder in Great Britain vary by sex and age. Overall, boys were more likely to have a mental disorder than girls, and this was evident in both the 5 to 10 year age group (10 per cent of boys compared with six per cent of girls) and the 11 to 15 year age group (13 per cent of boys compared with 10 per cent of girls). More specifically, the prevalence of conduct and hyperkinetic disorders were greater among boys than girls.[28]

Table 7.16 Prevalence of mental disorders by gender in children (5 to 15) in Great Britain

	Male	Female
Anxiety Disorders	3.5%	4.0%
Depression	0.9%	1.0%
Conduct Disorders	7.4%	3.2%
Hyperkinetic Disorders	2.4%	0.4%
Pervasive Development Disorder	0.7%	0.4%
Tic Disorder	0.1%	0.0%
Eating Disorder	0.0%	0.2%

Source: The mental health of children and adolescents in Great Britain 1999

ADDITIONAL NEEDS

Table 7.17 Prevalence of longstanding illness in Great Britain

	Male		Female	
Year	**0 to 4**	**5 to 15**	**0 to 4**	**5 to 15**
1998	15%	21%	15%	19%
2000	14%	23%	13%	18%
2001	17%	20%	12%	16%
2002	17%	21%	12%	19%
2003	14%	18%	10%	17%
2004	15%	19%	11%	15%
2005	14%	19%	10%	16%
2006	11%	17%	10%	15%
2007	8%	17%	11%	14%
2008	9%	15%	7%	10%

Source: General Lifestyle Survey 2009

Table 7.18 Prevalence of limiting longstanding illness in Great Britain

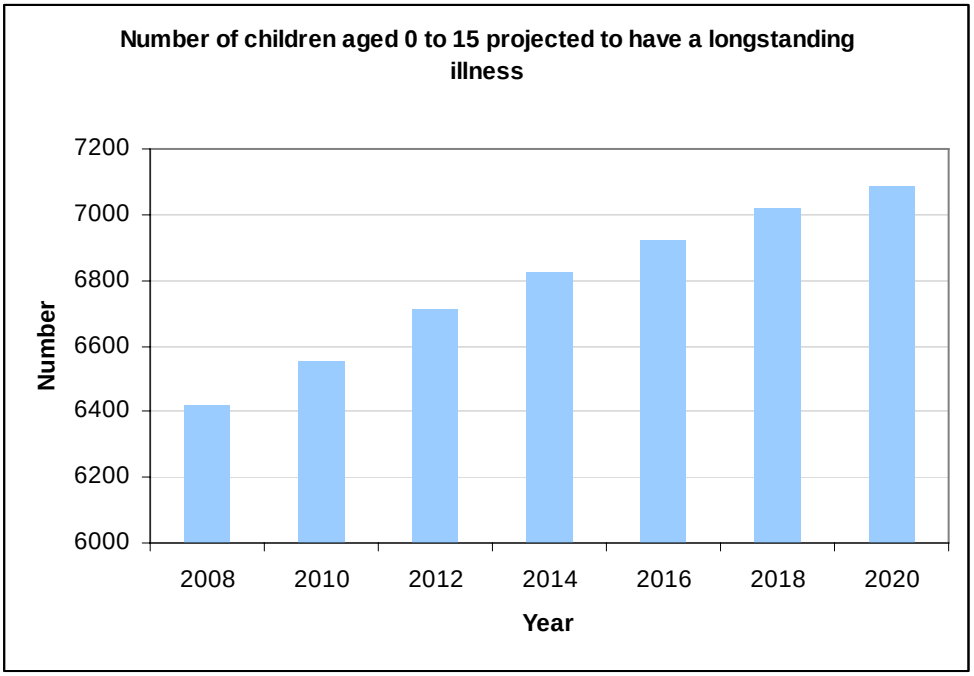
	Male		Female	
Year	**0 to 4**	**5 to 15**	**0 to 4**	**5 to 15**
1998	4%	8%	5%	8%
2000	4%	9%	4%	8%
2001	5%	9%	4%	8%
2002	5%	8%	3%	9%
2003	4%	7%	4%	7%
2004	4%	8%	4%	7%
2005	5%	7%	3%	7%
2006	3%	7%	3%	6%
2007	2%	6%	3%	5%
2008	2%	7%	3%	4%

Source: General Lifestyle Survey 2009

There appears to be no significant difference between the prevalence of longstanding and limiting longstanding illness among the 15 years and younger male and female population. Longstanding prevalence for males aged 0 to 4 ranges from 8% to 17% and for females between 7% and 15%. Limiting longstanding illness prevalence ranges from 6% to 9% for males aged 5 to 15, for females in the same age group the range is 4% to 9%.

Using this prevalence for 2008, an estimate of predicted prevalence has been calculated using Ealing Council's population estimates.

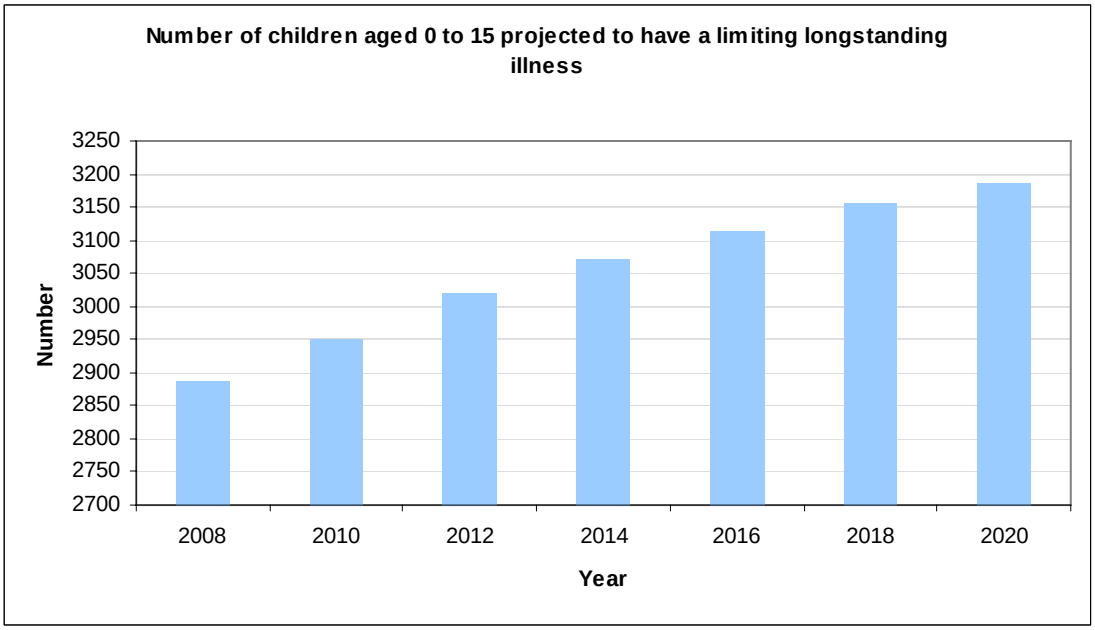
Figure 7.19 Projected numbers of children (0 to 15) with a longstanding illness



Source: General Lifestyle Survey 2009 and Ealing Council, Research and Consultation 2009

It is anticipated that the number of children with a longstanding illness in the borough will have risen by about 10% by 2020 to 7083. The numbers with a limiting longstanding illness is also set to increase to around 3187.

Figure 7.20 Projected numbers of children (0 to 15) with a limiting longstanding illness



Source: General Lifestyle Survey 2009 and Ealing Council, Research and Consultation 2009

Table 7.21 Estimated number of 0-19 year old with a disability in Ealing, 2010

Estimated number 0-19 year olds disability in Ealing	Boys	Girls	All	Percentage of total
Mental disorders	310	270	580	4%
Learning difficulties	150	140	290	2%
Nervous System Disorders not elsewhere specified	310	270	580	4%
Blindness or vision defects	310	270	580	4%
Deafness or ear defects	460	410	870	6%
Heart disease	230	200	430	3%
Lung or respiratory disease	460	410	870	6%
Asthma	3,210	2,850	6,060	42%
Digestive disorders	310	270	580	4%
Urogenitary disorders	230	200	430	3%
Musculoskeletal disorders	380	340	720	5%
Skin conditions	610	540	1,150	8%
All	6,970	6,170	13,140	
Total population	40,203	39,952	80,155	

Source: The Health of Children and Young People, ONS 2004, Chap 10, Tables 10.5 and 10.1; Special Population Projections, GLA/LBE, 2009

There appears to be around 16% (Table 7.21) of Ealing's 0-19 year old population with a disability, the most common being Asthma.

Table 7.22 Congenital Abnormalities admission data for Ealing registered patients (2007 – 2010)

All Outcomes	2007/2008	2008/2009	2009/2010
Others (Low needs/remedied in early childhood)	214	195	221
Atrioventricular septal defect	1	2	4
Tetralogy of Fallot	3	1	1
Deafness	2		
Atresia or stenosis of other parts of the small intestine	1	2	
Renal Dysplasia	1		
Craniosynostosis			1
Valproate syndrome		1	2
Down Syndrome	4	1	5
Wolff-Hirschorn syndrome		1	
Limb reductions	1		
Grand Total	**227**	**203**	**234**

Source: NHS Ealing 2010

Table 7.22 shows under 16s with congenital abnormalities registered in Ealing. While the majority are registered with low level needs or those remedied in childhood, small numbers are registered with serious conditions which require high intensity interventions.

ALCOHOL AND SUBSTANCE MISUSE

Evidence suggests that the life expectancy of males in Ealing is reduced by about 9 months on average due to excessive alcohol consumption. The life expectancy of females is reduced by just over 3 months.

Limited information is currently available on alcohol consumption by young people. However, a study carried out by National Centre for Social Research (NatCen) and the National Foundation for Educational Research (NFER) (2006-2008) found that

within the 11-15 age group, the proportions who have had at least one alcoholic drink varied between 55% in 2006 and 52% in 2008. Over the same period, there was a similar decline in the proportions who had drunk alcohol in the last week from 21% to 18%. Nationally boys and girls are equally likely to drink alcohol[18].

In London, young people in this age group (11-15) are much less likely to have ever drunk alcohol than those living elsewhere. In London, 39% had ever drunk alcohol; this proportion varies between regions from 51% in the East Midlands to 63% in the North East.

As perhaps expected, young people in London are less likely to have had an alcoholic drink during the past week at the time the survey the was carried out; this was 12% in London compared, for example, with 19% in the East Midlands and South East and 26% in the North East.

The mean consumption (units of alcohol) of those who drank in the last week, shows London as the lowest (11.3 units) and highest in the North East (17.7 units).

Hospital Admissions due to alcohol

Table 7.23 Under 18s hospital admissions due to alcohol specific conditions 2008-09

Area	Rate per 100,000 under 18
Brent	26.89
Ealing	56.21
Hammersmith & Fulham	58.83
Harrow	22.05
Hillingdon	56.69
Hounslow	40.30

Source: North West Public Health Observatory 2009

As Table 7.23 shows that hospital admissions for alcohol specific conditions in Ealing is comparable to Hammersmith and Fulham, and Hillingdon, but is significantly higher than our other near neighbours such as Brent and Harrow. All the above London boroughs except Hammersmith and Fulham have a lower hospital admissions rate than the national rate.

331 primary pupils, 6% of those surveyed had at least one alcoholic drink in the week before the survey, although for more than half it was just on one day. 8% of secondary pupils had at least one alcoholic drink in the previous week; with 1% of all pupils drinking on 3 or more days.[31]

Drug Use

NatCen and NFER study (2006-2008) asks about awareness, availability and use of 15 named drugs (see table 7.24). The prevalence of drug use has declined since 2001. The proportion of 11 to 15 year olds who reported having taken any drugs in the last year was 17% in 2006 and 2007 and 15% in 2008. Similar proportions of boys and girls had taken drugs in the last year.

The proportion of 11 to 15 year olds who have taken drugs at least once varies from 15% in the South West to 20% in the North West. In London this stands at 16%. Prevalence is similar among boys and girls in all regions.

Table 7.24 Named drugs used in the NatCen and NFER study

Amphetamines
Ecstasy
Cocaine
Crack
Heroin
LSD
Magic mushrooms
Methadone
Tranquillisers
Anabolic steroids
Ketamine
Cannabis
Poppers
Glue
Gas

Source: The Information Centre, Department of Health 2009

The most commonly taken drug in this age group is cannabis. In 2006, 10% of 11 to 15 year olds had taken cannabis in the last year; in both 2007 and 2008 9% reported this. Boys are more likely than girls to have taken cannabis. The prevalence of cannabis use in the last year varies by region from 8% in the North East to 12% in the North West. In London the prevalence is 9%.

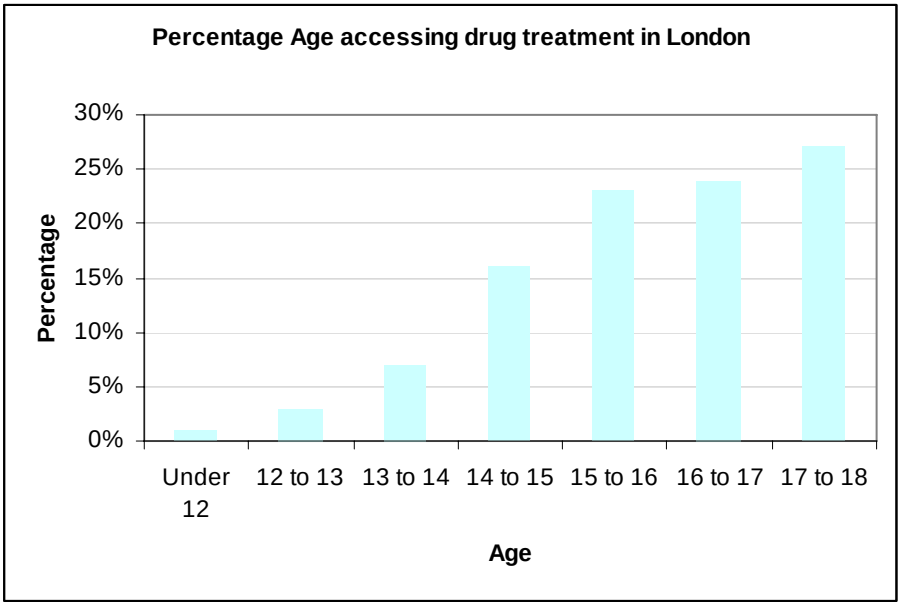
Recently the use of 'legal' drugs such as mephedrone were widely reported as increasing and were linked to a number of deaths. Data for the use of this drug is limited given that its legal status has only recently changed. A survey of 2000 people for dance magazine Mixmag showed that nearly 42% reported that they had tried mephedrone in the last month.[21] Equally, although mephedrone has been implicated in the deaths of 34 people in the UK it has only ever been established in the case of one person.[22]

13% of secondary pupils and 22% of year 10s have been offered drugs. The most common type of drugs offered were cannabis, cannabis resin and cocaine. 6% of secondary pupils had taken drugs. This was much higher among year 10 pupils, where 10% had taken drugs, compared to 2% of year 8 pupils.[31]

Drug Treatment

According to the National Treatment Agency (NTA), drug addiction is rare among young people, trends in interventions offered to under-18s over the last four years shows a steady decline in the reported incidence of problems with hard drugs.

Figure 7.25 Percentage by Age Group accessing drug treatment 2008-09



Source: National Treatment Agency 2010

The vast majority of young people who receive help do so for problems associated with the misuse of cannabis and/or alcohol.

Figure 7.26 shows that the percentage of children accessing treatment increases with age. Nationally, the number of under-18s treated for problem drug use associated with heroin and crack has fallen more than a third since 2005-06, from 1,081 to 657 in 2008-09. This represents 3% (2% in London) of the total number of young people receiving help. Although the numbers involved are much smaller, the pattern echoes a similar generational shift away from heroin and crack use among young adults (aged 18-24) in drug treatment. The analysis also shows the number of young people accessing services for ecstasy has fallen by a third to 210, while the numbers accessing services for cocaine has increased by more than half to 745. Cocaine users now represent 3% (2% in London) of all those young people receiving help.

Table 7.26 Young people (Under 18) accessing drug treatment in London 2008-09

Male	2218
Female	1273
Total	**3491**

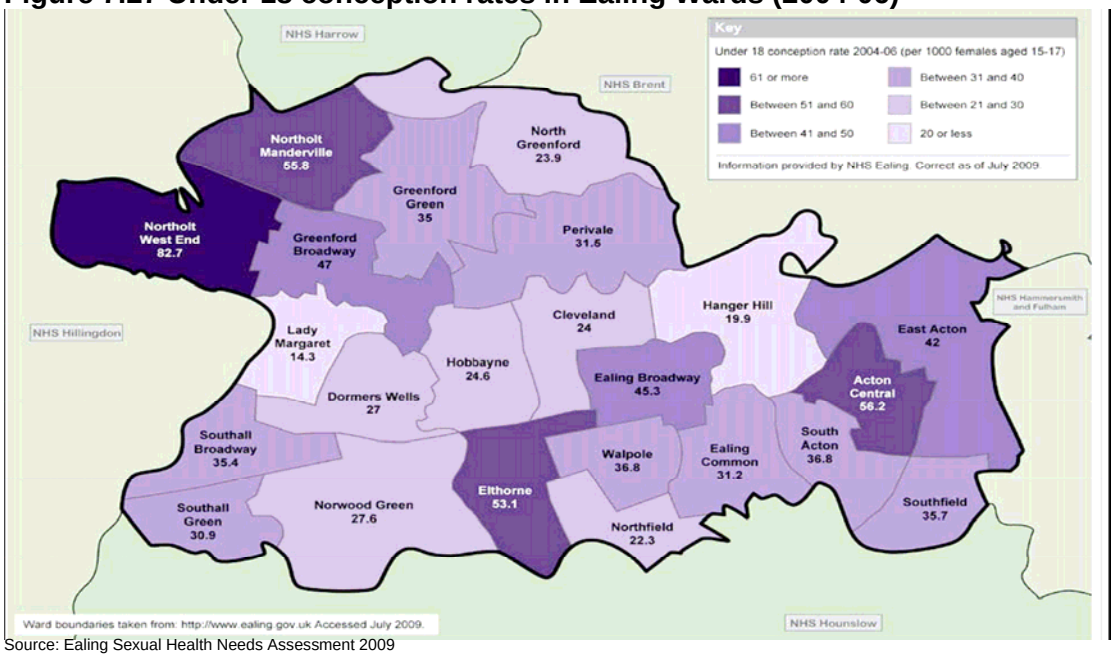
Source: National Treatment Agency, 2010

TEENAGE CONCEPTIONS AND SEXUAL HEALTH

Teenage Conceptions

The life chances of teenage parents and their children are worse than those of older parents and their children. Teenage mothers are likely to experience a poorer standard of living and poorer mental health. The children of teenage mothers are also likely to do less well in formal education, are more likely to become economically inactive and more likely to become teenage mothers themselves.

Figure 7.27 Under 18 conception rates in Ealing Wards (2004-06)



Source: Ealing Sexual Health Needs Assessment 2009

Looking at ward level data, Northolt West End, Northolt Mandeville, Acton Central and Elthorne have high under 18 conception rates**.** Northolt West End has 26.5 per 1,000 more conceptions annually than any other wards and is the one ward in Ealing with a conception rate amongst the highest in England. Greenford Broadway has seen the greatest increase in conception rates between the 2002 to 2006 periods (29.1 to 47 per 1,000) and Ealing Common has seen the greatest decrease during the same period (47.3 per thousand to 31.2 per 1,000).

Table 7.28 Under 18 conceptions 1998 –2008, rate per 1000 15-17 female population

	1998-00	2001-03	2004-06	2005-07	2006-08
England	45.0	42.5	41.2	41.2	40.9
London	50.6	51.7	47.0	45.8	45.3
Ealing	41.0	37.3	36.4	34.5	33.8

Source: Teenage Pregnancy Unit, Department of Health 2010

Table 7.29 Under 16 conceptions 2001-2007, rate per 1000 13-15 female population

	2001-03	2002-04	2003-05	2004-06	2005-07
England	7.9	7.8	7.7	7.7	7.9
London	9.9	9.5	9.1	8.8	8.7
Ealing	5.9	6.2	6.1	6.0	5.6

Source: Teenage Pregnancy Unit, Department of Health 2009

Tables 7.28 and 7.29 show under 16 and 18 conceptions in the borough; under 18 conceptions are falling. Under 16 conceptions are fewer but have only more recently appear to be falling.

Sexual Health

Below are the number of STIs reported from the selected four GUM clinics most utilised by Ealing residents (Level 8 Clinic, West London Centre for Sexual Health (WLCSH), Patrick Clements Clinic (PCC) and West Middlesex Sexual Health Clinic (W Middx) for those aged 19 and under. These figures represent the STI diagnoses for all clinic attendances and not for Ealing residents only.

Table 7.30 Under 19s STIs diagnosed for selected GUM clinics, 2008

		Male	Female	Total
Syphilis	Under 15	0	Less Than 5	Less Than 5
	15-19	Less Than 5	Less Than 5	5
Gonorrhoea	Under 15	0	Less Than 5	Less Than 5
	15-19	43	71	114
Genital Warts	Under 15	0	Less Than 5	Less Than 5
	15-19	51	104	155
Genital Herpes	Under 15	0	0	0
	15-19	9	63	72
Chlamydia	Under 15	0	10	10
	15-19	169	387	556

Source: Ealing Sexual Health Needs Assessment 2009

Chlamydia is the most prevalent diagnosed STI among the under 19s with Gential Warts and Gonorrhoea also high. Generally, it seems that STIs are more prevalent among females than males but it may also indicate that Girls are more likely to seek treatment.

According to the Ealing's Health Related Behaviour Survey, 2009, 68% of secondary pupils did not know where to get condoms free of charge. 13% of secondary pupils had never heard of HIV and AIDS. 18% have heard of it but know nothing about it, while a further 11% think it can be treated and cured. 24% of secondary pupils did not know of a contraception and advice service for young people locally.

SAFETY

There is relatively little local information on crime and fear of crime among children and young people. According to Social Trends report (2009) those living in London experienced the highest rate of personal crime in the UK, with 81% in the 12 months prior. Personal crime includes assault, sexual offences and all forms of theft.

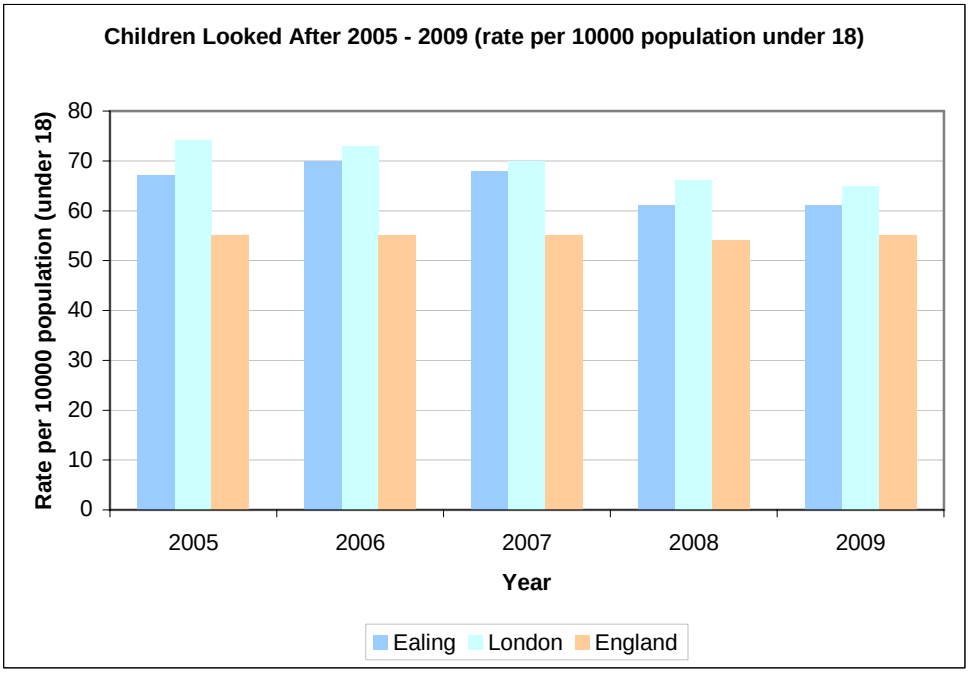
The incidence of personal crime continues to be high among young people aged under 26. The 2006 Offending, Crime and Justice Survey (OCJS) reported that 12 per cent of 10 to 25-year-olds had experienced at least one incident of personal theft in England and Wales in the 12 months prior to interview. More than one-quarter (26%) were victims of some kind of personal crime over the same period, including robbery, personal theft and assault (either with or without injury). Young males were more likely than young females to be victims of a personal crime within the last 12 months (31 per cent compared with 21 per cent). The difference was most pronounced among ten to 15-year-olds; nearly two-fifths (38 per cent) of boys of this age group were victims compared with around one-fifth (22 per cent) of girls.

Ealing's Health Related Behaviour Survey 2009 shows that 29% of primary pupils had been approached by an adult who scared or upset them up 2% (in 53% of cases someone they knew). 7% kept the incident to themselves. Attitudes towards the police change dramatically as pupils get older. 82% of primary pupils feel that they can trust the police. By secondary school, only 57% feel that they can trust the police. 27% of primary pupils and 17% of secondary pupils worry about crime. 25% of secondary pupils rate the area they live in as poor or very poor for safety after dark and 6% rate it as poor or very poor for safety during the day. 6% of secondary pupils have had something stolen from them by force or the threat of violence in the last month down 2%, most commonly on the way to or from school. Only 17% of these reported the incident to the police and 26% did not tell anyone down 9%.

Looked After Children

Nationally, there is a significant and widening gap between the outcomes achieved by Looked After Children and those achieved by other children. Looked After Children have been over-represented in a number of vulnerable groups including those who are not in employment, education or training post 16, teenage parents, young offenders, drug-users and prisoners. Stability is a key factor that can make a positive difference to the lives of Looked After Children. It provides the opportunity to form strong attachments with carers and friends, maximising their resilience, and improving their chances of achieving positive outcomes.

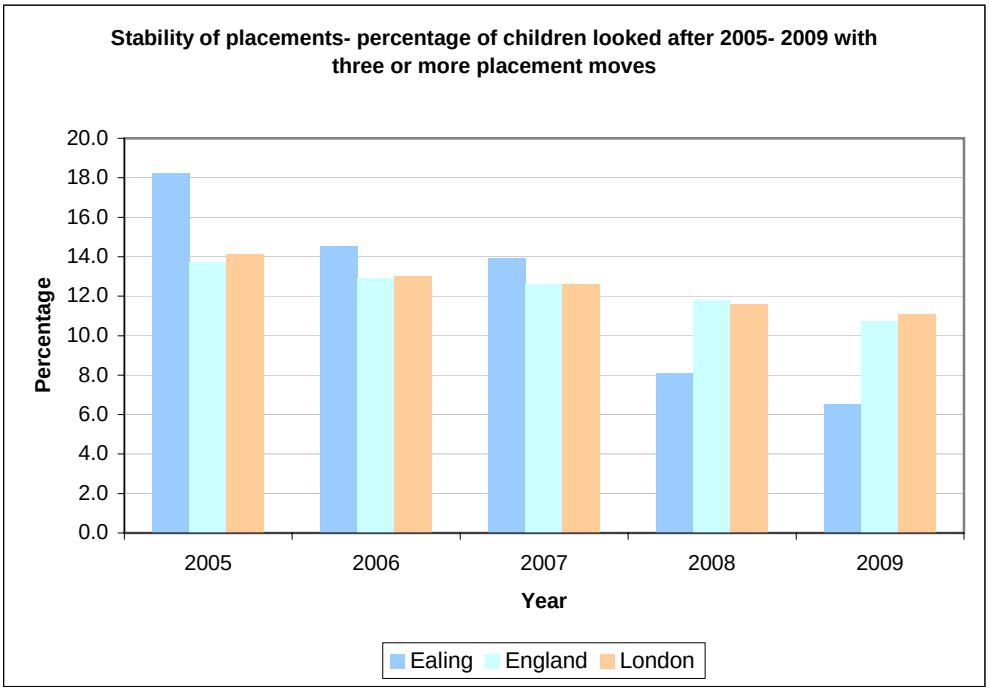
Figure 7.31 Children Looked After rate per 10000 under 18 population



Source: Department for Education 2010

The number of children looked after in Ealing seems to be falling in general and mirrors the London trend. Over the same period the national trend has remained consistent and lower than the London and Ealing rate. The Ealing rate is nearly 9% lower in 2009 than in 2005 while the London rate is just over 12% lower over the period.

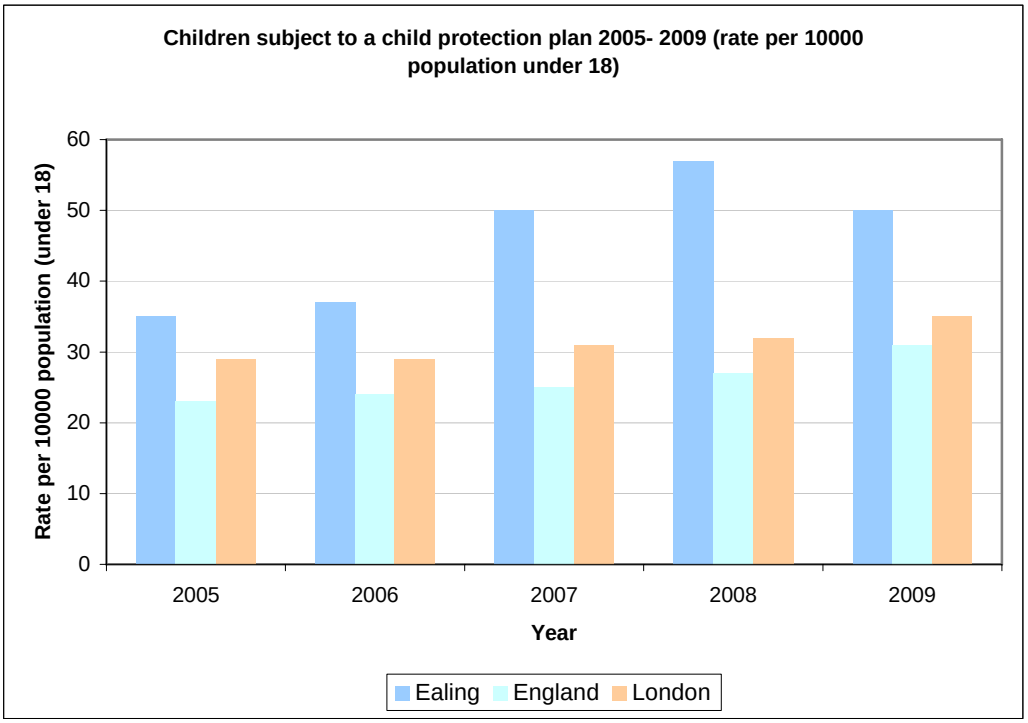
Table 7.32 Stability of placements- percentage of children looked after with three or more placements in a year



Source: Department for Education 2009

Stability as a whole leads to better outcomes for the child. A low percentage represents good performance and Ealing's performance has decreased year on year from a high of over 18% in 2005 to 6.5% in 2009. The trend both nationally and in London also shows a decrease in performance from 2005 to 2009. However the performance for both national and London closely mirrors one another and the drop in performance is not as significant as seen in Ealing.

Figure 7.33 Children who were the subject of a child protection plan at the end of year per 10,000 under 18 population

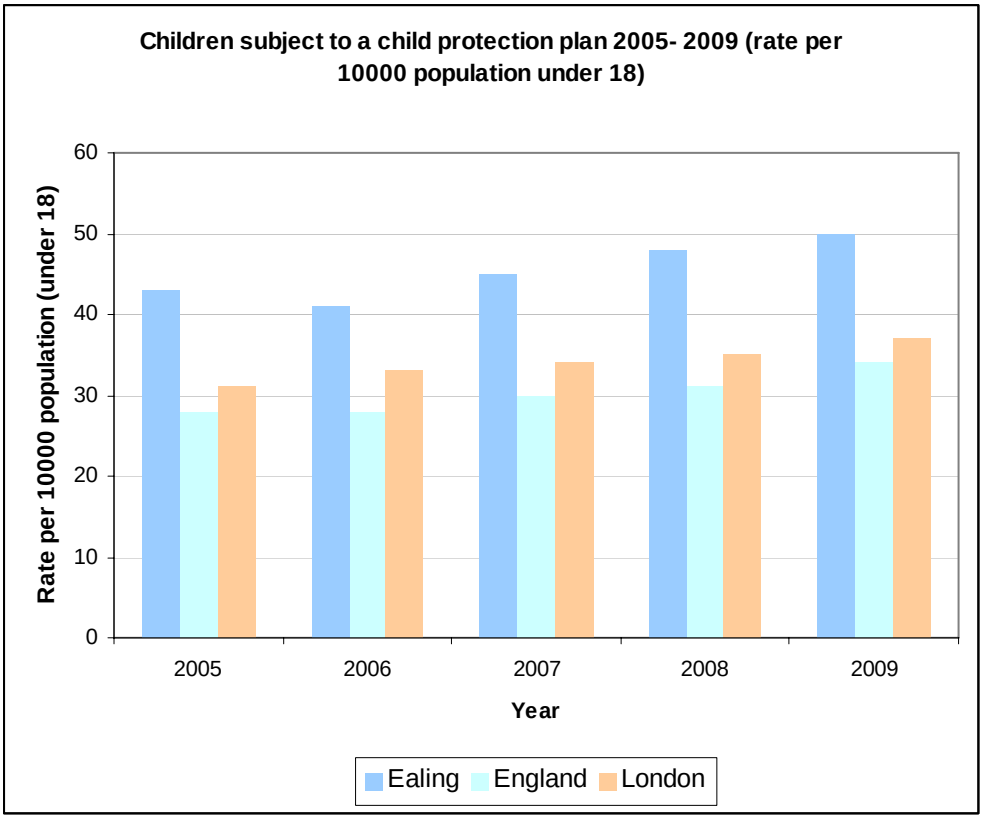


Source: Department for Education 2009

The number of children subject to a child protection (CP) plan has increased both in London and nationally. Ealing's rate per 10,000 children subject to a child protection plan is significantly higher than both the London and national picture. This reflects Ealing's diverse population, which has a high degree of vulnerability, with significant new arrivals and transient communities

Ealing has seen a year on year increase in numbers from 2005 to 2008. At the end of year 2009, the rate was 43% higher then it was in 2005. The national and London picture has shown a similar increase of 35% and 21% respectively when comparing 2009 figures against 2005. The rate in Ealing for 2009 dropped 12% compared to 2008 whereas the London and national trend showed an increase in the same period.

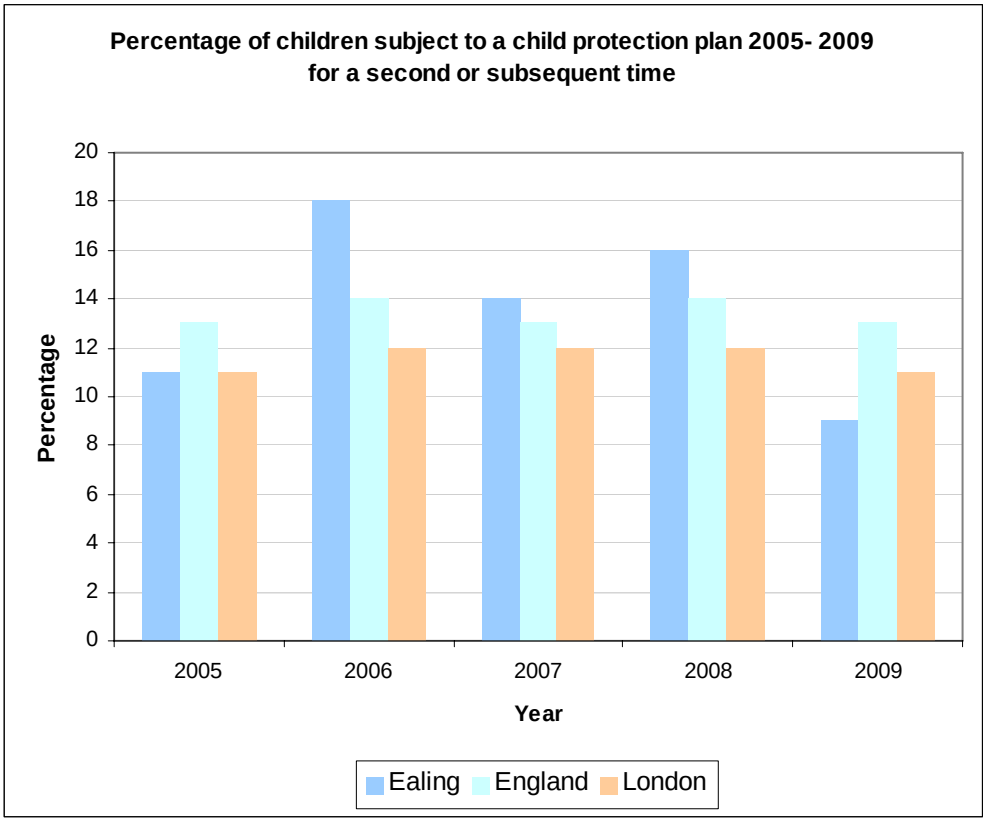
Figure 7.34 Children who became the subject of a child protection plan per 10,000 under 18 population



Source: Department for Education 2009

The number of children who became the subject of a child protection plan has increased in Ealing and this mirrors the London and national picture. The percentage increase in 2009 over 2005 for Ealing was 16%. This is lower then the national (21%) and London (19%) increases seen over the same period.

Figure 7.35 Percentage of children who became the subject of a child protection plan for a second or subsequent time



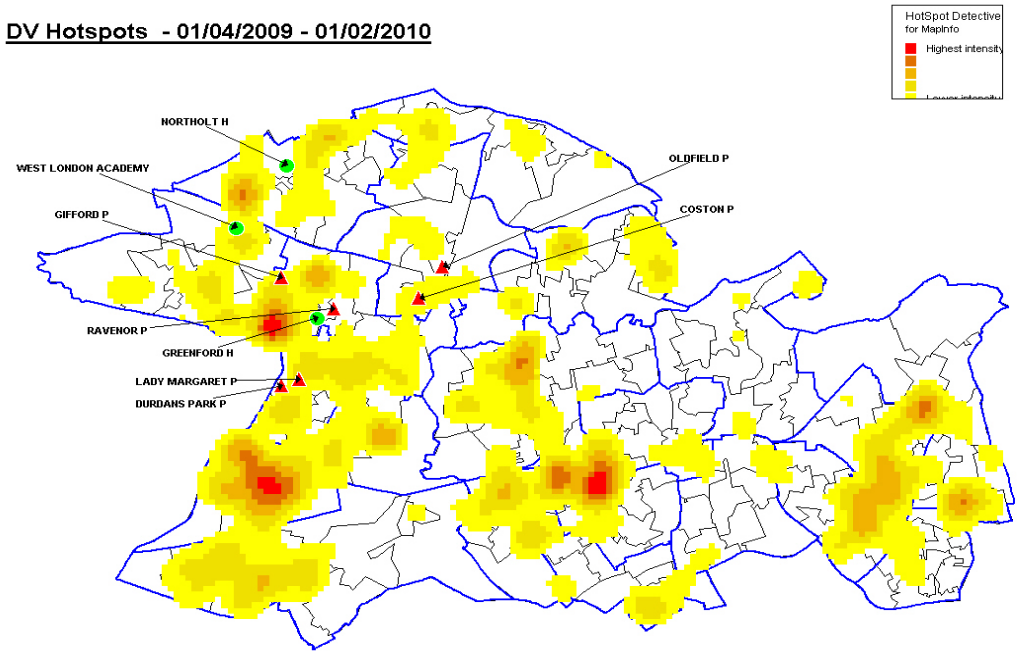
Source: Department for Education 2009

The percentage of re-registrations of children/young people subject to a child protection plan is generally represented by a low percentage, however, some re-registrations are essential in responding to any changes in circumstances in a young person's life. However, high levels of re-registrations will suggest that interventions by the professionals for the child's welfare is not effective enough to bring about the required changes in the child's family situation.

The Ealing trend generally matches the picture seen nationally whilst the London trend has more or less remained the same in 2006, 2007 and 2008. In 2009, Ealing's performance improved from 16% in 2008 to 9%. This was significantly lower than both the national and London average.

Domestic Violence

Figure 7.36 Domestic Violence Hotspot in Ealing, April 2009 to February 2010



Source: Ealing Community Safety Team 2010

There were a total of 1,644 incidents of domestic violence reported during this time frame. Northolt, Ealing Broadway and Southall Broadway are the three main hotspot areas for domestic violence within the borough. Levels of offending are lowest on a Thursday following a steady decline that starts on Monday. Increases begin again from Thursday before peaking on Saturdays/Sundays. Incidents after midnight on Saturday are counted within Sunday figures. There is an initial increase between 12-13hrs with a Secondary increase noted at 1800hrs at which point levels then steadily increase throughout the evening and correlate with the night time economy with a peak at 2300 hours.

Table 7.37 Reports of Violence in the home by children in Year 4 and 6

C: Which year group are you in? * 25: Has there been any violence between adults (e.g. hitting, punching, slapping) at home in the last month? Crosstabulation

			25: Has there been any violence between adults (e.g. hitting, punching, slapping) at home in the last month?	
			Once a week	Every day/almost every day
C: Which year group are you in?	Year 4	Count	6	12
		% within C: Which year group are you in?	2.3%	4.5%
		% of Total	1.2%	2.4%
	Year 6	Count	4	1
		% within C: Which year group are you in?	1.8%	.4%
		% of Total	.8%	.2%
	Total	Count	10	13
		% within C: Which year group are you in?	2.0%	2.6%
		% of Total	2.0%	2.6%

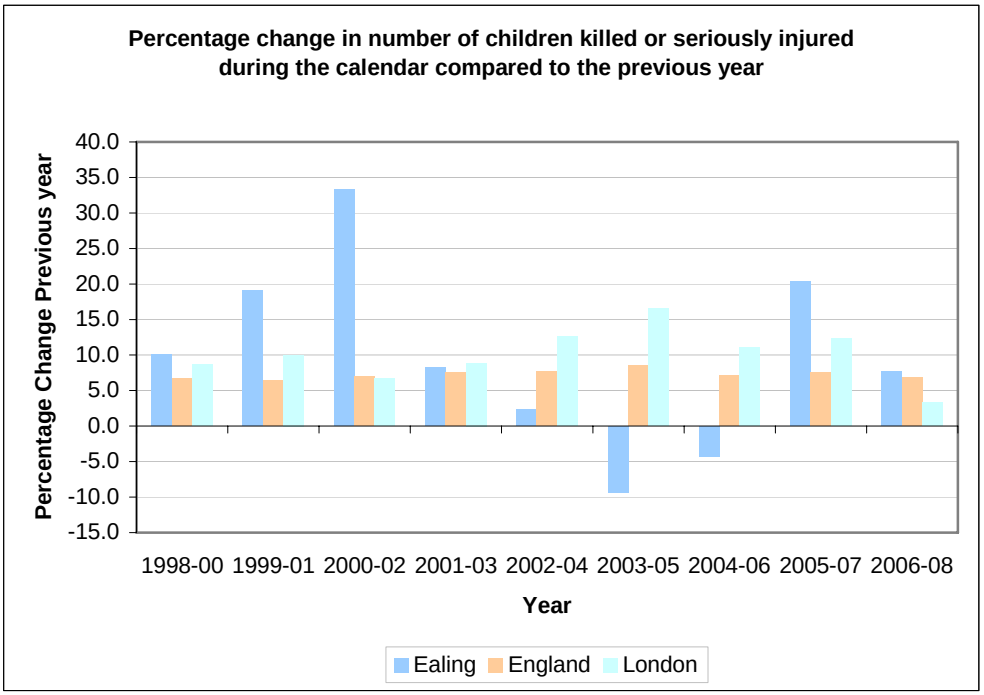
Source: Ealing Community Safety Team 2010

In responding to how frequent has there been violence between adults, 1.2% of those in year 4 stated once a week and 2.4% every day or almost every day and 0.8% of those in year 6 stated once a week and 0.2% every day or almost every day. Overall 2.0% in both years witnessed such occurrence once a week and 2.6% every day or almost every day.

Road Safety

The number of children and young people (under 16) killed or seriously injured in road traffic collisions in Ealing is currently increasing faster than in London or England. Factors contributing to this may be the relatively large number of children and young people in the borough, the volume of traffic and the size of the road network (Figure 7.38).

Figure 7.38 Percentage change in number of children killed or seriously injured during the calendar year compared to the previous year 1998 -2008



Source: Government Office for London, Department of Transport 2009

Ealing's levels of children killed or injured on the borough's road are lower than in 2000-02, they have been increasing since 2005 albeit slowing last year. Only 2003-05 and 2004-06 saw actual percentage falls in the number of children injured or killed.

EDUCATION

Special Needs Education

The numbers of pupils with Special Education Needs (SEN) in Ealing has risen significantly over the last few years which has increased demand for special needs provision for pupils with Statements of SEN.

This rise is set to continue and it is important that sufficient numbers of places and types of SEN provision is available to meet the full range of special educational needs.

As at January 2010 the numbers of pupils attending Ealing schools or early years settings or with a statement managed by Ealing was 1,627, a rise of 3.7% since 2007.

Looking on projections based on either rolling forward the current numbers in nursery (Method 1) or taking the average of the last five years (Method 2) indicate that numbers will continue to rise steadily over the next five years.

Table 7.39 Projected Number of Pupils with Special Education Needs 2011 to 2015

	Method 1	Method 2
2011	1,774	1,748
2012	1,941	1,849
2013	2,109	1,927
2014	2,295	2,002
2015	2,494	2,076

Key Stage One

Ealing's performance in all areas of the Key Stage 1 is better now than in 2006. While there has been improvement over recent years, Ealing's performance does remain below England and London levels. While the gap is generally between 2% and 3%, in science Ealing is currently behind London by 4% and England by 6%.

There is a correlation between educational attainment and levels of deprivation with more deprived areas tending to report lower levels of attainment. Improving attainment across the board and particularly in the borough's most deprived wards would pay dividends in future years.

Table 7.40 Percentage of pupils achieving Key Stage 1 Teacher Assessment level 2+ in Reading

Area	2006	2007	2008	2009
Ealing	79%	79%	81%	81%
London	82%	82%	83%	83%
England	84%	84%	84%	84%

Source: Department for Education 2010

Table 7.41 Percentage of pupils achieving Key Stage 1 Teacher Assessment level 2+ in Writing

Area	2006	2007	2008	2009
Ealing	72%	73%	73%	76%
London	79%	78%	78%	79%
England	81%	80%	80%	81%

Source: Department for Education 2010

Table 7.42 Percentage of pupils achieving Key Stage 1 Teacher Assessment level 2+ in Mathematics

Area	2006	2007	2008	2009
Ealing	84%	86%	87%	86%
London	89%	89%	89%	88%
England	90%	90%	90%	89%

Source: Department for Education 2010

Table 7.43 - Percentage of pupils achieving Key Stage 1 Teacher Assessment level 2+ in Science

Area	2006	2007	2008	2009
Ealing	81%	80%	81%	83%
London	87%	86%	86%	87%
England	89%	89%	89%	89%

Source: Department for Education 2010

Key Stage Four

The proportion of pupils in Ealing attaining 5 or more GCSEs at grades A* to C rose in 2008/09 as did the proportion attaining 5 GCSEs at grades A* to G including English and Mathematics but were below the London average. They are higher than the England average however. Table 7.41 shows that nearly 99% of Ealing's young people achieved at least one pass at GCSE in 2008/09, similar rates to England and London.

Table 7.44 Percentage of pupils achieving 5 or more GCSEs grades A*-C

Area	2007/08	2008/09
Ealing	68.4%	70.8%
London	62.5%	71.2%
England		70.0%

Source: Department for Education 2010

Table 7.45 Percentage of pupils achieving 5 or more GCSEs A*- G including English and Mathematics

Area	2007/08	2008/09
Ealing	52.1%	54.0%
London	47.5%	53.9%
England		49.8%

Source: Department for Education 2010

Table 7.46 Percentage of pupils achieving any passes at GCSE

Area	2007/08	2008/09
Ealing	99.4%	98.7%
London	98.3%	98.8%
England		98.9%

Source: Department for Education 2010

Attainment by Gender

There is a gap in attainment between boys and girls at Key Stage four the proportion of girls achieving 5 or more GCSEs at grades A*-C is significantly higher than the proportion of boys.

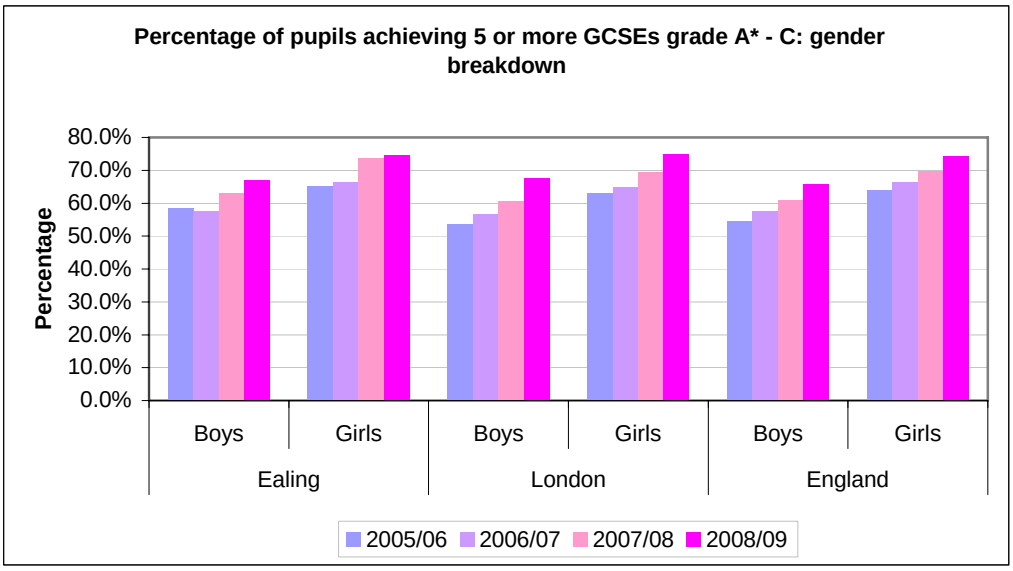
Table 7.47 Percentage of pupils achieving 5 or more GCSEs grades A*-C: Gender breakdown

		2005/06	2006/07	2007/08	2008/09
Ealing	**Boys**	58.5%	57.6%	63.2%	67.2%
	Girls	65.1%	66.4%	73.7%	74.6%
London	**Boys**	53.6%	56.7%	60.6%	67.5%
	Girls	63.0%	65.0%	69.4%	75.0%
England	**Boys**	54.6%	57.7%	60.9%	65.8%
	Girls	64.0%	66.4%	69.9%	74.4%

Source: Department for Education 2010

Attainment for boys and girls in Ealing is higher now than in 2005/06. However the attainment gap between genders is also higher, while in 2005/06, girls were out performing boys by 6.6% it now stands at 7.4%. Compared to London and England boys and girls attainment at this level is broadly similar. In terms of the attainment gender gap, the London gap is 7.5% and the national gap 8.6%, however unlike Ealing, these gaps are narrower now than in 2005/06.

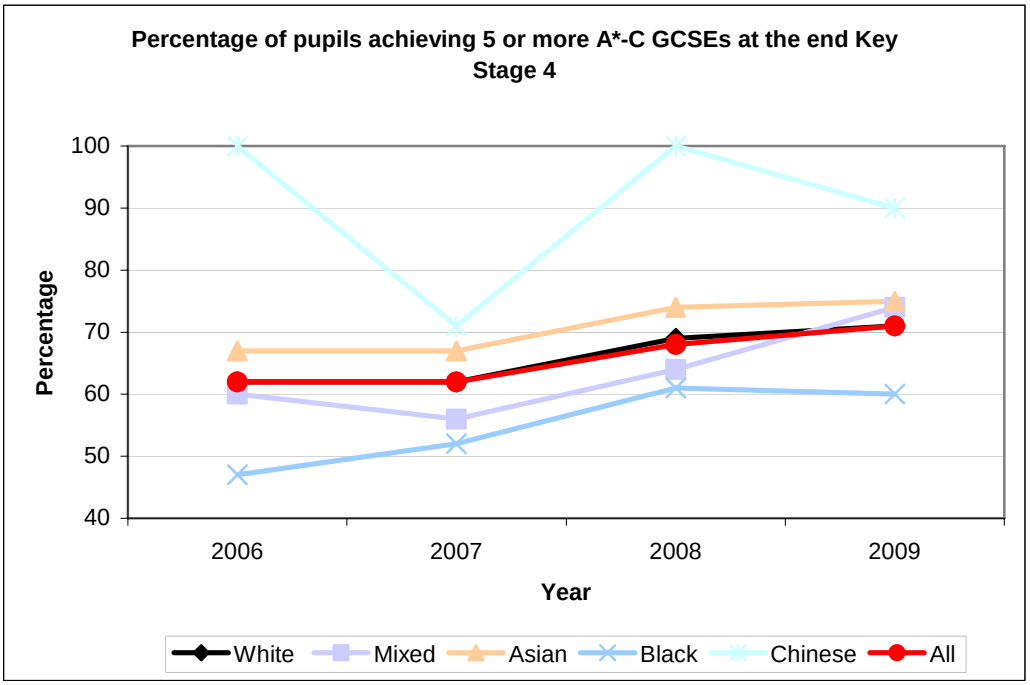
Figure 7.48 Percentage of pupils achieving 5 or more GCSEs grades A* -C: Gender breakdown



Source: Department for Education 2010

Attainment by Pupils from Minority Ethnic Groups

Figure 7.49 Percentage of pupils achieving 5 or more A*-C GCSEs by ethnic group



Source: Department for Education 2010

The average levels of educational attainment by different ethnic groups show considerable variation. Pupils from Chinese and Asian background do much better than white pupils. The attainment level of black pupils is the lowest and, until recently, mixed background pupils was lower than that of white pupils and of all pupils.

Class Sizes

Table 7.50 Average Class Size taught by one teacher 2008

	Primary	Secondary
Ealing	27.5	21.7
London	26.8	20.8
England	26.2	20.9

Source: Department for Education 2009

At both primary and secondary school, Ealing average class size is slightly larger that the average class size in London and England.

Absence in Secondary Schools

Table 7.51 Percentage of Absences from Schools in Ealing

	Authorised Absence		Unauthorised Absence		Total Absence	
	2007/08	2008/09	2007/08	2008/09	2007/08	2008/09
Ealing	6.05%	5.54%	1.07%	1.16%	7.13%	6.70%
London	5.50%	5.44%	1.54%	1.52%	7.04%	6.96%
England	5.86%	5.79%	1.41%	1.44%	7.27%	7.24%

Source: Department for Education 2009

Absences are measured by the number of half days missed as a percentage of total school days. The total absences for Ealing in 2008/09 is below London and England levels. Broken down, in the same year we can see that unauthorised absences in Ealing fit this pattern but authorised absences are higher than the London average but lower than the national average. Overall total absences in Ealing are lower than in 2007/08.

Exclusions

Research has suggested that there is a direct link between being excluded from school and becoming involved in crime. A Youth Justice Board survey showed that excluded pupils were more than twice as likely to become involved in crime as other school children[19]. Therefore intervening early to tackle truancy and exclusion is vital to preventing youth crime.

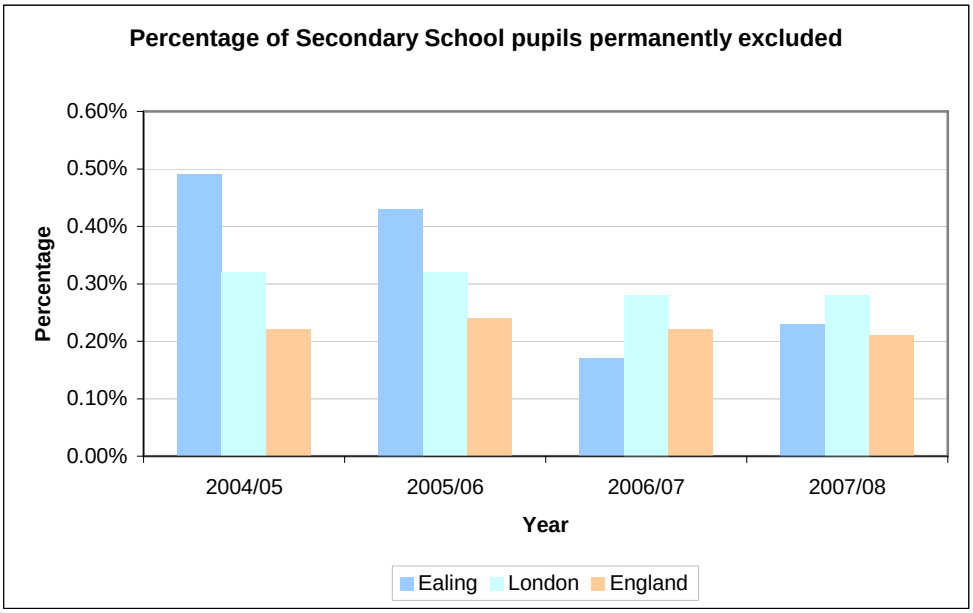
There were 40 permanent exclusions in Ealing in 2007/08, more than in 2006/07 (26) but less than the 74 seen in 2004/05.

Table 7.52 Number of Permanent Exclusions in Secondary Schools

	2004/05	2005/06	2006/07	2007/08
Ealing	74	65	26	40

Source: Department for Education 2010

Figure 7.53 Percentage of Secondary school pupils permanently excluded



Source: Department for Education 2010

In previous years (2004/05 and 2005/06) Ealing's permanent exclusion rate was significantly higher than that of London and England. Currently it stands at 0.23%, a fall of more than 50% on the 2004/05 figure. It is slightly above the England figure but lower than London figure.

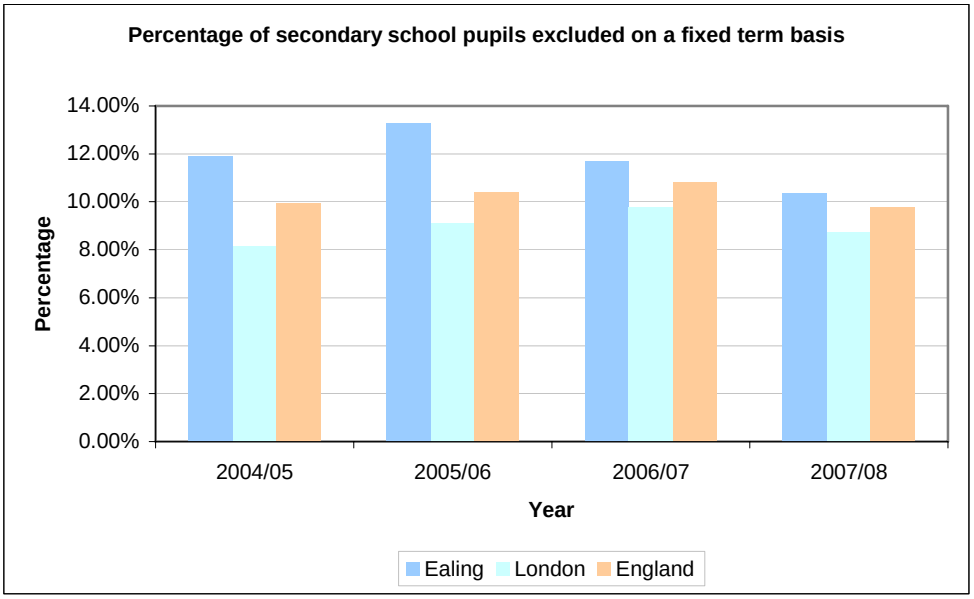
Table 7.54 Number of Fixed term Exclusions in Secondary Schools

	2004/05	2005/06	2006/07	2007/08
Ealing	1,785	2,020	1,794	1,620

Source: Department for Education 2010

1,620 secondary school pupils were excluded on a fixed term basis in 2007/08. Comparing Ealing against London and England shows that Ealing excludes more pupils.

Figure 7.55 Percentage of Secondary school pupils excluded on a fixed term basis



Source: Department for Education 2010

Since 2005/06 Ealing's percentage of fixed term exclusions has been falling but remains higher than London and England averages.

Bullying

Ealing's Health Related Behaviour Survey 2009 found that fear of bullying has increased among secondary pupils but decreased among primary pupils. 35% of primary, down 1% and 17% of secondary pupils up 3% feel afraid of going to school at least sometimes because of bulling; with 8% of primary and 3% of secondary pupils feeling afraid often or very often.

65% of primary, up 1% and 83% of secondary pupils down 3% were never afraid to go to school because of bullying.

Profile of Bullied Pupils

In primary school, girls were more likely to be often or very often afraid to go to school because of bullying (8.9%) than boys (6.6%). Northolt (8.8%) had the highest proportion of children who were afraid to go to school because of bullying, while "Other Black" and "Arab" children were the most likely to feel afraid.[32]

Racism

55% of primary and 51% of secondary pupils, according to Ealing's Health Related Behaviour survey, felt that people with different background were valued in their school. 68% of secondary pupils thought their school was a place where people from different backgrounds got on well.

Overall, 13% of primary and 7% of secondary pupils thought they were being bullied or picked on because of their race, colour or religion. 2% of secondary pupils thought they were being picked on because of their sexuality, while 5% of primary and 2% of secondary pupils thought they were being picked on for having a disability.[32]

POVERTY

Table 7.56 Eligibility for Free School Meals

	2006	2007	2008	2009
Ealing	25.3%	25.6%	26.3%	24.4%
London	23.2%	22.4%	22.5%	22.6%
England	13.6%	13.1%	13.1%	13.4%

Source: Department for Education 2010

Nearly a quarter of Ealing's secondary school pupils are eligible for free school meals. This is higher than the London percentage and nearly double that of the national. Currently there are 4,221 secondary school pupils eligible for free school meals.

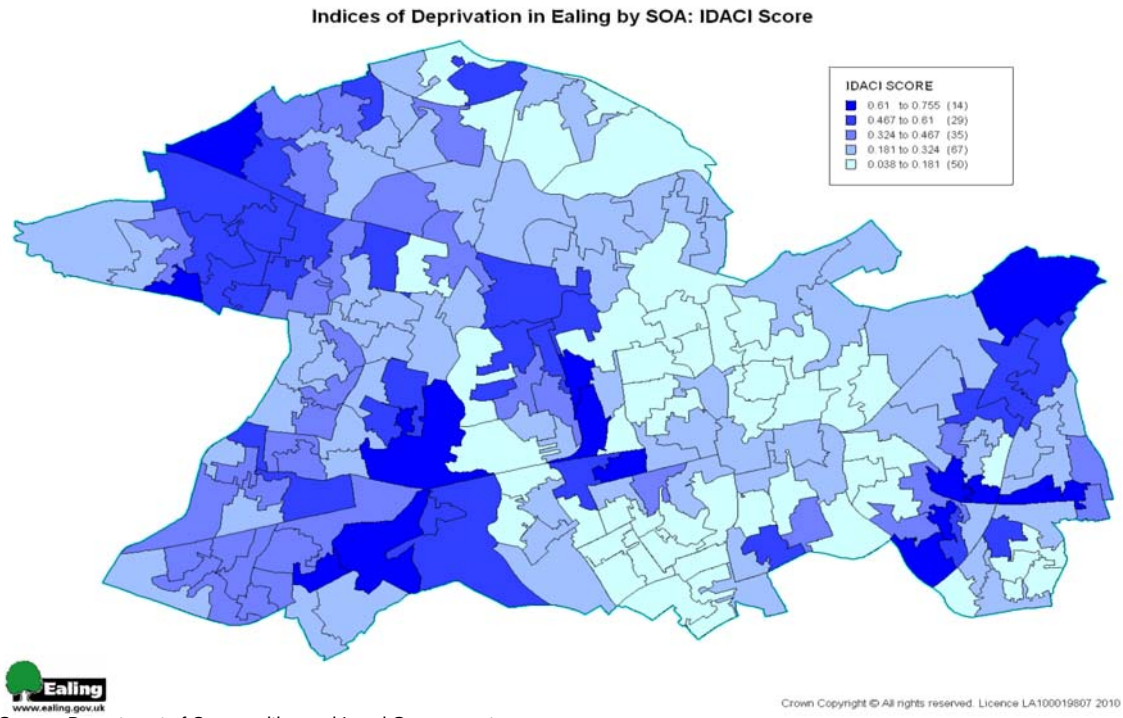
Table 7.57 Number of Secondary School Pupils Eligible for Free School Meal

	2006	2007	2008	2009
Ealing	3,848	3,930	4,460	4,221

Source: Department for Education 2010

Figure 7.58 Income Deprivation Affecting Children Index 2007

This index, illustrated in the map below, shows the distribution of Income Deprivation affecting children within Ealing, there are pockets in Ealing which are amongst the 20% most deprived nationally.



Source: Department of Communities and Local Government

EMPLOYMENT & TRAINING

Nationally the proportion of 16 to 18 year olds not in employment, education or training (NEET) remained broadly level over the last decade. The government target is for a 2% reduction between 2004 and 2010.

The proportion of young people who are not in employment, education or training (NEET) varies during the year. The level usually peaks in the summer, when the figures are swelled by young people leaving school and college, and reduces thereafter.

Ealing's rate has been falling since 2005/06 and now stands at 4.9%.

Table 7.59 Percentage of young people NEET in Ealing

	2005/06	2006/07	2007/08	2008/09	2009/10
Ealing	7.1%	7%	5.9%	5.4%	4.9%

Source: Ealing Connexions Service 2010

CHILDREN AND YOUNG PEOPLE PROFILE

Table 7.60 Children and Young People Profile, Ealing

Domain	Number	Indicator	Ealing
Be Healthy	1	Infant Deaths	
	2	All Cause mortality (age 1-17)	
	3	Breastfeeding initiation	
	4	Obese children (age 4-5)	
	5	Obese children (age 10-11)	
	6	Participation in at least 2 hours per week of sport	
	7	Tooth Decay (age 5)	
	8	Under 18 conceptions	
	9	Under 18 conceptions ending abortion	
Stay Safe	10	Children who have been Bullied	
	11	Hospital stay following injury (under 18)	
	12	MMR Immunisation (2 years)	
	13	Children in care immunisations	
	14	Road traffic accidents	
Enjoy and Achieve	15	Primary school exclusions	
	16	Secondary school exclusions	
Make a Positive Contribution	17	Alcohol specific hospital stays (under 18)	
	18	Hospital stays for drug misuse (age 15-24)	
	19	First time entrants to YJS	
	20	Reoffending rates	
	21	NEET	
Achieving Economic Well Being	22	Homeless families	
	23	Children living in poverty	

Source: London Health Observatory 2010

Key	
	Significantly worse than England Average
	Not significantly different England Average
	Significantly better than England Average
	Not Comparable

SECTION 8

Social Marketing to Address Health Inequalities

SOCIAL MARKETING TO ADDRESS HEALTH INEQUALITIES

The Council, NHS Ealing and its partners are committed to targeting resources efficiently and effectively to increase the health status across the gradient inequality. This will involve understanding and addressing the causes of ill-health affecting smaller neighbourhoods and communities. This can be done by using a population segmentation approach which helps in the targeting of services and interventions.

Different groups (or segments) of the population respond in different ways to a variety of approaches and influences when making decisions about their health or lifestyle. The retail industry has been aware of this for many years and has used a social marketing (lifestyle segmentation) approach to try to better understand the buying habits of consumers.

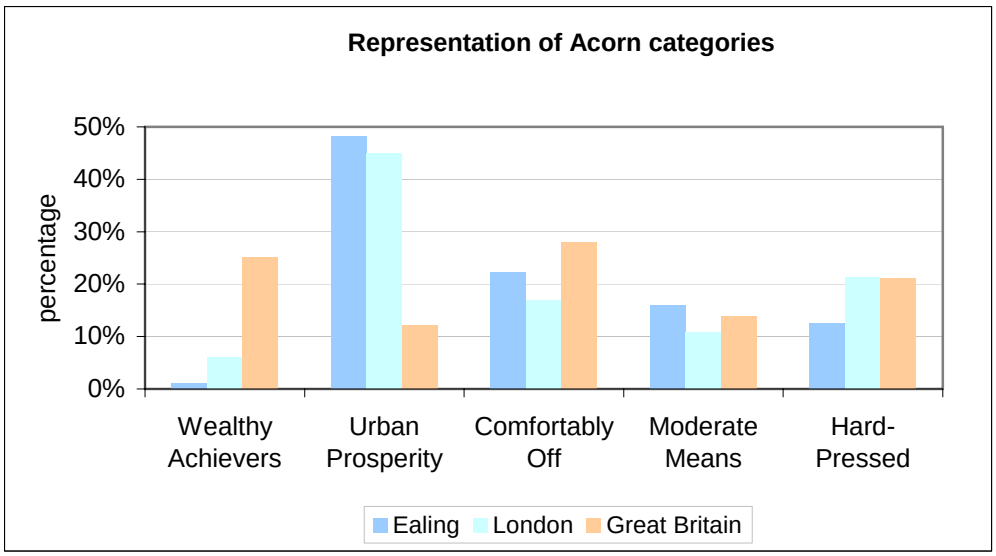
Newer tools make use of data from a range of public and private sources to complete a comprehensive citizen analysis to postcode level. They provide insight into socio-demographic factors, lifestyle, culture and behaviour and provides a 'common perspective' to support partnership working. ACORN is one such public sector tool which allocates a social marketing characteristic to each postcode to allow the effective targeting of products to the right consumer. Further information on the key characteristics of each group and the most appropriate communication method are provided later in this section.

ACORN can be used to map the distribution of different lifestyle groups across the borough to allow the better targeting of appropriate interventions to achieve the desired health outcomes.

Figure 8.1 shows representation of Acorn categories in Ealing, London and Great Britain. The groups with the worst health outcomes (Moderate Means, and Hard Pressed) are also the groups most likely to be found within the 20% most deprived super output areas of Ealing.

The maps are used to plot the location of these lifestyle groups, often as small neighbourhoods within more prosperous wards, allowing the better targeting of services.

Figure 8.1 Representation of Acorn categories and Groups

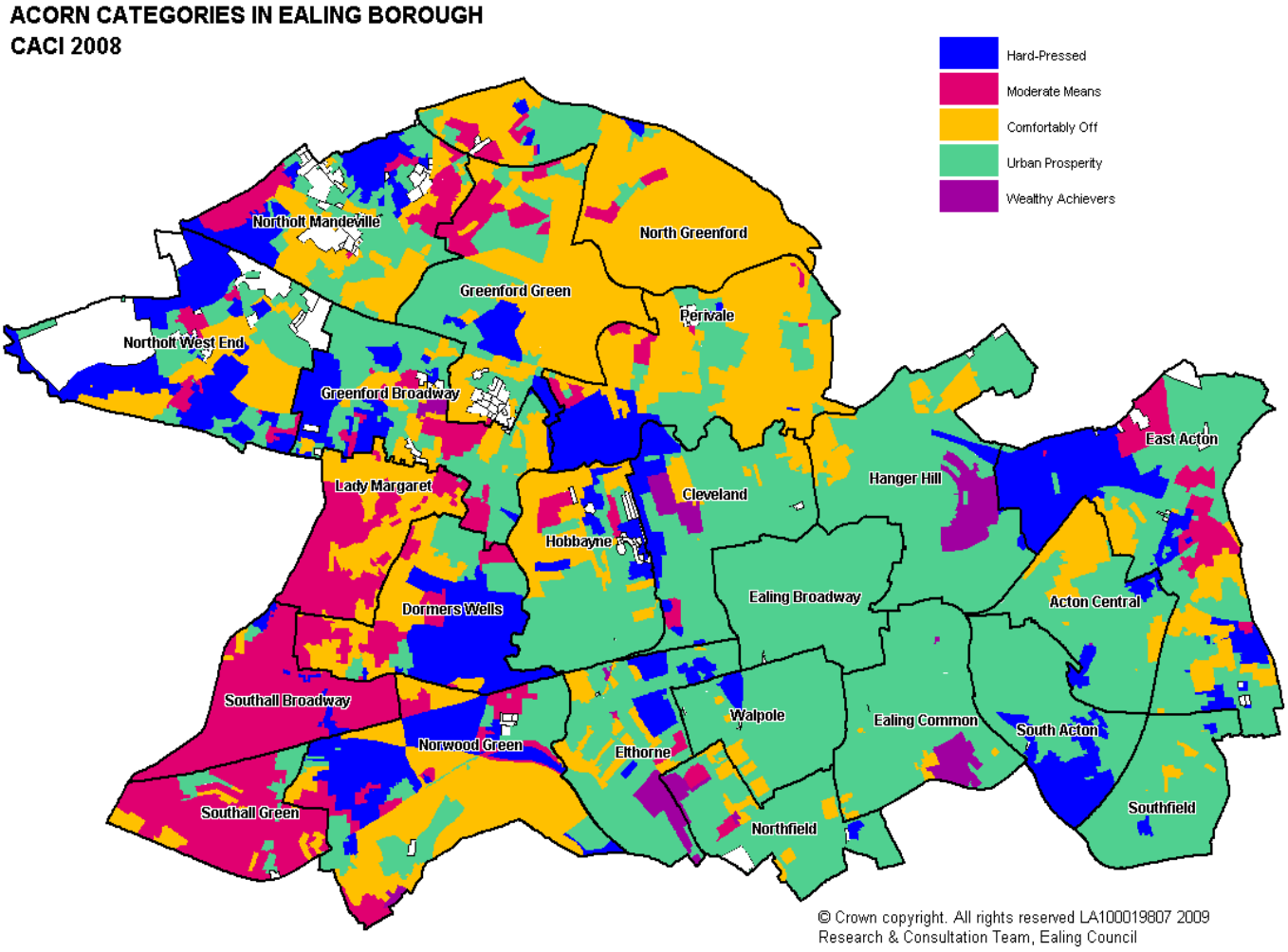


Source: ACORN 2009

Wealthy Achievers	Wealthy Executive Affluent Greys Flourishing Families
Urban Prosperity	Prosperous Professionals Educated Urbanities Aspiring Singles
Comfortably Off	Starting Out Secure Families Settled Suburbia Prudent Pensioners
Moderate Means	Asian Communities Post-Industrial Families Blue Collar Roots
Hard Pressed	Struggling Families Burdened Singles High Rise Hardships Inner City Adversity

Source: ACORN 2009

Figure 8.2 Acorn Categories in Ealing



Source: Ealing Council, Research and Consultation, 2009

Wealthy Achievers

Make up 1.09% of the borough population
This group enjoy all the advantages of being healthy, wealthy and confident consumers.

- These are some of the most successful and affluent people in the Borough
- Middle age and older people predominate
- These people tend to live in large houses, usually detached with 4+ bedrooms
- Almost 90% of homes are owner occupied
- This group is very well educated and most are employed in managerial and professional occupations
- Incomes are high as are levels of savings and investments
- Car ownership is high among this group
- They mainly read the Financial Times, Telegraph and the Sunday Times

- On average they take 2+ holidays a year – often skiing/snow holidays

Preferred Communication Channel; Email, Broadsheet Newspapers

Urban prosperity

Make up 48.2% of the borough population
This group have a cosmopolitan outlook and enjoy urban lifestyles.

- This group includes older wealthy people living in the most exclusive areas and highly educated younger professionals
- The wealthier people in this group live in large terraced or detached houses with 4+ bedrooms.
- Younger professionals may be renting or buying flats
- They like to eat out, go to the theatre and cinema and make the most of the culture and nightlife of the big city
- They are likely to take snow/skiing holidays
- They read the Guardian and the Financial Times

Preferred Communication Channel; Emails, Text Messages, Broadsheet Newspapers

Comfortably off

Make up 22.2% of the borough population
This group are 'middle-of-the-road'.

- All life stages are represented in this category
- They may not be wealthy, but have few financial worries
- Most own their own home - owner occupation exceeding 80%
- Most houses are semi-detached or detached
- Educational qualifications are in line with national average
- Employment is a mix of professional and managerial, clerical and skilled occupations

Preferred Communication Channel; Mail, Telephone, Mid-market tabloids

Moderate means

Make up 15.9% of the borough population
Overall people in this category live modest lifestyles but are able to get by

- Used to be the industrial heartlands
- People are still employed in traditional blue collar occupations
- In some areas incomes can fall below the national average
- In the better off areas, incomes are in line with the national average

- There are isolated pockets of unemployment and long term sick
- Some neighbourhoods have high concentrations of Asian families on low incomes
- Most housing is terraced, with 2 or 3 bedrooms

Preferred Communication Channel; Visits, Text Messages, Red top newspapers

Hard pressed

Make up 12.5% of the borough population
These people are experiencing the most difficult social and economic conditions

- These are some of the poorest areas in the borough
- Unemployment levels are well above national average
- People are employed in routine jobs
- Incomes are low
- There are pockets of unemployment and long term sick
- Qualification levels are low
- Housing is a mixture of low rise estates and high rise blocks
- Over 50% of housing is rented from the council or registered social landlords
- Single pensioners and lone parents dominate this group

Preferred Communication Channel; Visits, Text Messages, Red top newspapers

Patients Views

Patients' views on health care in Ealing are collected from various sources. National data are collected by agencies including the Department of Health, the Care Quality Commission and the Patient Environment Action Team (PEAT). Some national surveys may be applicable but are not analysed at a local level, e.g. maternity services. Local routine data include Patient Advice and Liaison Service reports; Ealing Residents' Survey; and complaints and compliments that are received by health care providers or commissioners. Non-routine data include reports from the Local Involvement Network and Overview and Scrutiny Committee; and feedback from patient groups and community organisations. NHS Trusts and independent contractors, such as GPs, involve patients and seek feedback, although the results may not be published.

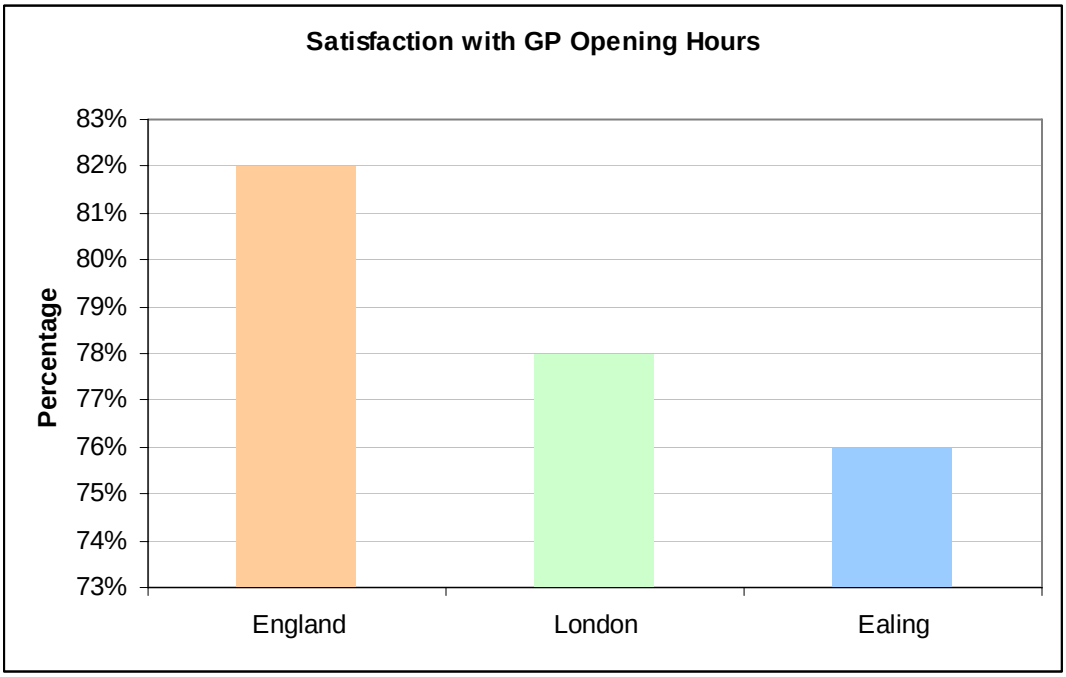
Table 8.3 Overall Satisfaction with GP Surgeries

	Very Satisfied	Fairly Satisfied	Neither satisfied nor dissatisfied	Fairly dissatisfied	Very dissatisfied	Satisfied (Total)
England	55%	35%	6%	3%	1%	90%
London	45%	40%	8%	4%	2%	86%
Ealing	39%	43%	10%	5%	2%	82%

Source: GP Survey 2009/10

The overall satisfaction with care received at GP surgeries was lower than London and England as a whole.

Figure 8.4 Satisfaction with GP opening hours



Source: GP Survey 2009/10

Satisfaction with GP practice opening hours was also lower in comparison with London and England.

In acute hospital care there are some results from inspections suggesting good environment, food, privacy and dignity. The Patient Environment Action Team rated Ealing Hospital's environment as 'Good' and food as 'Excellent' for the last four years. However, surveys of patients suggest that dignity and respect are rated lower than average across West London. Ealing was low for care and staff not working well together. The Care Quality Commission in-patient survey rated Ealing Hospital in the worst performing 20% of Trusts for dignity and respect, care, staff working together and wishing to complain; but in the intermediate 60% for being given information about how to complain.

Ealing Hospital undertook local surveys about involving patients and carers and found the following:

- 67% of patients and carers were definitely involved in decision making in August 2009 dropping to 55% in March 2010, with those being involved to some extent increasing from 32% to 48% for the same period.
- 91-92% of patients were nursed on a single sex ward or within single room accommodation for February and March 2010. However, patients were not regularly informed of the possibility that they may be nursed on a mixed sex ward.

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Equalities and the JSNA

Age	The health and well-being needs of individuals change throughout their life dependent on their age, the JSNA has differential impact in terms of informing different services to meet varying needs. We know that Ealing has a relatively young population however, around 34,900 people over 65 years of age live in Ealing, and this number is projected to increase. The population as a whole is growing and dependency – the proportion of non-working-age to working age residents – at both ends of the age range is also increasing. An increasing birth rate is creating demand for maternity, childcare and school places – with subsequent impacts on the need for childhood immunisation, treatment for typically childhood illnesses, and other healthcare services, such as those for mental health, specifically targeted at the needs of young people. As Ealing has a higher proportion of babies born with low birth weight than the average for London and for England, we also know there are specific needs and issues that need to be tackled in relation to the well-being of mothers and their babies. At the same time, the prevalence of common diseases of old age will rise with the ageing population. Rising numbers of people overall will create increased demand for health and social services, as well as potential workforce implications. The JSNA delivers an effective response to this by enabling needs-based services to be delivered to all, taking note of age-varying health needs. What we must assure against is any adverse impact through poor understanding or stereotyping of age-based need, and ensuring that sufficient and accurate information is gathered and used to ensure a full and accurate understanding of those needs. *Specific Sections: Population Characteristics and Change, Children and Young People Socio-Economic Factors*
Having dependants/Caring responsibility	The JSNA ensures that services are delivered according to people's needs, and will take account of caring responsibilities and the potential effect these may have on access to and use of healthcare services. Currently in Ealing there are 47 dependent people to every 100 people of working age (16-60/64 years). This is expected to increase to 55 per 100 working age people in 2020, taking Ealing higher than the London average, expected to be at 49 per 100. This will mean that the number of people with caring responsibilities will also increase,

	along with the additional pressures this may create on health and well-being needs. We know that there are estimated to be approximately 26,000 carers within the borough of Ealing, of whom only about a third have undergone assessments of their own needs in this position. It is estimated that 1 in 3 have trouble paying utility bills, and have no savings due to financial difficulties; this is considered particularly true for BME carers, who constitute almost half of all carers in Ealing and who are more likely to face difficulties in accessing mainstream public services, such as adequate housing. Where caring responsibilities are combined with other challenges, their needs and issues may increase even further. For example, people with learning disabilities have limited access to mainstream housing, meaning that about half of all adults with learning disabilities in Ealing live with family carers. Almost a fifth of these carers have been identified as being over the age of 65 – and therefore at greater risk of age-related health conditions themselves. We also know that carers are twice as likely to have mental health problems if they provide substantial care. However, the information on carers' needs specifically may be less well-developed than ideal; while there is much data and information on the needs of individuals receiving health and well-being care or obviously in great need of it, carers may remain hidden. It will therefore be important to consider the information available on this group specifically with a view to assessing its completeness and usefulness in informing genuinely targeted information; action may need to be taken to then collect further information about this group. *Specific Section: Population Characteristics and Change*
Disability	People with many disabilities will have specific health and well-being needs that will be sought to be met by the JSNA. There is also evidence to suggest that many people with disabilities experience greater health inequalities than those who do not have a disability, particularly where other factors, such as deprivation or being a member of a minority ethnic group are also present. The JSNA will include data and information collected on disability within both the adult and child population, with a view to enabling better joint health and social care provision for people with disabilities. POPPI estimates that there are about 58,240 people suffering from a disability in Ealing aged 18 – 64 years. The more common conditions reported are mobility and musculo-skeletal, neurological and limiting long-term illnesses (10%). The proportion of younger disabled people is the second highest in London, although overall prevalence is somewhat below average.

	Previous user consultations with people with disabilities including hearing impairments, neurological conditions, HIV, and wheelchair users, highlighted areas of need and improvement around increased access to deaf communicators, how to book them and use them, awareness of a range of disabilities for front line staff, the need for a comprehensive health and social care service directory, and better information, advice, signposting of opportunities for independent living. Such needs will need to be investigated and taken account of in the year's JSNA and the commissioning strategies that result. In 2009-10 a total of 656 people with learning disabilities were known to Ealing social services. National prevalence data estimates the local population of people with learning disabilities should be at least 1000 – indicating that there may be hidden need and greater understanding required of this area. Around 20% of adults with learning disabilities in Ealing have been diagnosed with a mental health need. We understand that people with learning disabilities have much greater health needs than the general population as a whole - they are more likely to have general health problems, sensory impairments, epilepsy and other physical disabilities, and uptake of regular screening is poor. A Disability Rights Commission (DRC) formal investigation found that people with learning disabilities and / or mental health problems were more likely than other citizens to experience most killer diseases and risk factors, including heart disease, stroke, respiratory illness, diabetes, some cancers, smoking and obesity. They became ill younger and died faster. Potentially avoidable ill health creates additional barriers to achieving independence and to participation. Such evidence shows that it is of utmost importance that the JSNA considers the specific needs of people with disabilities and tackles them directly to target these additional health needs that may be present. In doing so, it is again almost inevitable that people with disabilities will be impacted differentially by the work undertaken as a result of the JSNA – but this will be because of their differential health needs as a whole and the importance of tackling these to contribute to reduced inequalities in health as a whole. We understand that there may be limited information available about children with disabilities in some areas – the JSNA will therefore need to target this area. At present, we also understand that there may be limited information available about health outcomes broken down by types of impairment or health conditions considered disabilities, or the interventions people with disabilities receive – creating an area for focus and improvement in future data collection and analysis.

	Specific Sections: Population Characteristics and Change, Burden of Ill-Health, Children and Young People
Gender	At a very basic level many of the health needs of men and women are different, because of their different physiological make-up and life experiences. Therefore, again, the JSNA is intended to have a differential impact as it will be seeking to meet the specific needs of individuals in order to improve outcomes, and targeting men and women's needs will require differential approaches. However, what it must seek to ensure is that gender is not a cause for differential outcomes at the end of the work in terms of the quantifiable *improvements* different genders experience – therefore it will be important to ensure that sufficient information is collected and analysed, and actions taken to ensure that both genders are treated fairly in meeting their varying needs. The average life expectancy at birth of males living in Ealing, is 77.6 years. The average life expectancy at birth of females in Ealing is 82.6 years. There is therefore a distinct difference in the outcomes for men and women in terms of extending and improving life expectancy. The Census pattern of people reporting their health as 'not good' is higher in women than men. However, men are more likely to be permanently sick or disabled. Men have considerably higher rates of admission to hospital for coronary heart disease, particularly in more deprived areas of the borough. A smaller proportion of women carers were likely to be in full time employment compared to men, but female carers were more likely to be economically inactive because they were looking after a home or family. This suggests that male carers may be more prone to the difficulties expressed above in relation to caring for members of their family with disabilities or other health issues. The ratio between male and female suicides in Ealing is slightly higher at 3.2:1 than the national ratio of 3:1. Over one fifth of all suicides in Ealing (53 of 244 deaths) were committed by men between the ages of 25 and 34 years. Women are most likely to commit suicide in the age range 35-44 years (67% of the 58 female suicides), but women still only account for 29% of all suicides in that age range. Mental health service use varies considerably across the genders and indicates that there is a real need to ensure equality of access and use of services. It is estimated that 18.6% of people in Ealing are smokers, compared with 23.3% in London and 24.1% nationally. There are large ethnic and gender inequalities in smoking rates, however. It is estimated that 25.1% of Indian men are smokers, and this community represents a very large proportion of the population in some wards 29.4% of Black

	Caribbean men are estimated to be smokers. Ealing has the highest alcohol-related hospital admissions in London. The rate is 500 alcohol-related hospital admissions per 100,000 population. Men and middle aged to older people account for high admission levels, women's and younger age admissions are lower. Such difference in the prevalence of illnesses and the use of services indicates that the JSNA must collect and use as accurate and broad-ranging data as possible around the variations associated with gender; commissioners must then ensure that action is taken as far as possible to reduce the inequalities of access and outcomes currently seen. *Specific Sections: Population Characteristics and Change, Burden of Ill-Health, Life Expectancy, Socio-Economic Factors Children and Young People*
Race/ethnicity	Different ethnic groups in Ealing experience considerably different health outcomes and use of services. As such the JSNA will be targeting the use of information to ensure that inequalities are reduced as far as possible by understanding the specific needs of different ethnic groups. This is likely to mean that the impact of the JSNA may well vary dependent on people's ethnic group, but should always be for improving and positive outcomes for all, rather than adversely affecting any group. Over 40% of Ealing residents come from ethnic minorities, making Ealing the fourth most ethnically diverse borough in the country. This rate varies considerably across the borough; e.g. more than 75% of Southall's population is of minority ethnic origin; the proportion of Ealing school pupils from minority ethnic origin ranges from just under 50% to more than 99%. More than half of all Ealing school pupils do not speak English as a first language. We have already seen that it is estimated that 25.1% of Indian men are smokers, with this community representing a very large proportion of the population in some wards, and 29.4% of Black Caribbean men are estimated to be smokers. Over 50% of adults with learning disabilities are from minority ethnic communities. There are wards, particularly in Southall, in which over 40% of households have one or more members living with a long term limiting illness. Southall is a neighbourhood that generally ranks high in all deprivation scores as well as being affected by a number of chronic diseases compared to Ealing as a whole. There are exceptions, with lower levels of child poverty than other

	neighbourhoods; but mental health, diabetes and tuberculosis are particular problems. The poor health of Southall is reflected in the different mortality ratios in which Southall generally has a higher then expected mortality. Minority ethnic groups are far more likely to be affected by TB; particularly Black-Africans and Indians who were born in countries where this disease is prevalent. CHD is more common in lower socio-economic groups and certain ethnic minorities, particular South Asian population. For people born in the Indian sub-continent the death rate from heart disease is 46% higher for men and 51% higher for women compared to the average for England and Wales. People of South Asian origin are up to six times more likely, and Black African-Caribbean origin up to five times more likely, to develop diabetes compared to white people. Such conditions create particular challenges for healthcare in Ealing which is very focussed around some specific ethnic groups, and which will be targeted through effective data collection and subsequent planning as a result of the JSNA. There are also particular more hidden issues that may arise for minority groups within minorities; e.g. those with mental health issues within particular cultural groups where openness about this sort of challenge may not have traditionally been acceptable. Ealing has higher age-standardised admission ratios for Black minority groups to psychiatric inpatient services than the London average, but lower ratios for other BME groups. (Count me In Census (2006/07). Analysis of young people in specialist treatment for substance misuse, suggests that young people from Asian and other BME groups are under-represented in treatment. This is in contrast to the number of Asian adults in treatment, which reflects the large Asian population in Ealing. A recent needs assessment on dementia, conducted in 2008, identified that awareness about dementia and mental health in general amongst the local public was low, particularly among BME communities. Such indicators, statistics and attitudes suggest that there are real challenges to overcome in perceptions and access to services across BME communities; again it will be essential that the JSNA undertakes a full and accurate assessment of the information available on this and that service providers use this information to provide tailored and targeted services to meet needs in the future. *Specific Sections: Population Characteristics and Change, How do we compare to similar authorities, Burden of Ill-*

	Health, Life Expectancy, Socio-Economic Factors Children and Young People
Religion/belief	The JSNA will need to take into account the needs of all religious groups and consider whether specific information needs to be collected on the health and well-being needs affecting people of specific religions and beliefs in different ways. Services need to be sensitive and responsive to the cultural and religious needs of different communities, their attitudes and reactions to disease, types of treatment, prognosis, care-giving and death. For example, some religious groups are unable to take certain medications because of their ingredients. For others, access to a GP of the same sex may be essential for a visit to the doctors, and a same-sex ward be essential in a hospital. Others have varying perspectives on birth and reproduction, on the use of prayer in aiding recovery from illnesses, or on the approach to long term illness and palliative care. Some mental health conditions are viewed with considerable stigma in some communities, and their interpretation of the causes and treatments may vary from a purely clinical understanding. A holistic approach to the patient, which takes account of their physical, cultural, social, mental and spiritual needs, is essential. Such conditions mean that the JSNA needs to ensure accurate information is gathered on how religion might currently be affecting health inequalities in Ealing. While it seems that the above conditions may have an impact on how comfortable people are in accessing services and how well they respond to treatment, there appears to be little evidence at present about how religion may be affecting health needs in Ealing. We therefore need to ensure that JSNA collects and analyses as much of this information as possible and informs commissioners and service deliverers of the lessons learned, in order to ensure that services can be targeted and tailored in a way that effectively delivers to those with faiths of all kinds. *Specific Section*: *Population Characteristics and Change*
Sexual Orientation	Again, it is likely that LGBT groups in Ealing may on occasion have different needs from other members of the community. While this will of course not always be the case, there is evidence to suggest some greater and differing needs amongst the community taken as a whole, and sensitive approaches to specific issues affecting the LGBT community, will need to be understood and effectively met in the provision secured as a result of the JSNA.

	There is very little Ealing specific data available about this equalities strand at present, an area to consider rectifying in future consultation and data collection as a part of the JSNA's production. However, national data and surveys suggest that 5% to 7% of the population may be LGBT. While the lack of routinely collected information on this section of the population constrains analysis of the impact of sexual orientation on access to services, health status and outcomes, there is evidence to suggest that LGBT individuals experience significant problems related to both their mental and physical health. Research shows that more than 40% of gay men have not disclosed their sexuality to their GP. There are still concerns about the discrimination some LGBT people face when accessing NHS services; there are a number of accounts from research conducted by Stonewall that suggest many health workers are not dealing professionally with their sexuality. Also, many feel that they can't receive healthcare relevant to their sexuality because they don't feel comfortable discussing it with health workers. There is a real need to ensure professional and sensitive approaches and understanding amongst healthcare professionals, for example in dealing with next of kin information and support for people in same-sex relationships. Providing the right services and health promotion information to LGBT people is an ongoing challenge for sexual health services. Men from BME communities are more likely not to disclose their sexual orientation, causing further challenges in meeting needs. Health inequalities are likely to exist between gay men and adult men in rates of alcohol and drug use, smoking and psychological morbidity. Nationally, it appears the use of alcohol, tobacco and illegal drugs is higher among LGB people. Social exclusion, low self-esteem, anxiety and depression are common experiences for many young LGB people. Young homeless gay people can have specific emotional and psychological needs relating to the difficulties they have faced coming to terms with their sexuality in unsupportive environments. Sex between men is a notable route of HIV transmission in the UK; gay and bisexual men are disproportionately affected by sexually transmitted infections, and some viral infections, such as herpes simplex virus, can be relatively high in lesbian women. In Ealing sex between men has continued to be the highest probable route of HIV infection in diagnosed Ealing residents. In 2007 42% of the 607 people living with HIV in Ealing were infected via sex with men (HPA SOPHID 2007). Gonorrhoea is the second most common bacterial STI in the UK. In 2003, 70% of gonorrhoea

	diagnoses were in men, of which 30% had sex with men (HPA Briefing on SH in London 2005). LGBT people can face domestic abuse from partners, parents, siblings and other family members, an issue traditionally often more hidden than the DV experienced by women in relationships with men. One of the biggest obstacles for LGB people wanting to flee domestic abuse is the lack of emergency accommodation for LGB people, especially for men. Consultation suggests that lesbians feel that healthcare for gay people is overly targeted at gay men, without specific provision for them when they have a number of specific health needs. Research has shown that lesbians are more likely to smoke and drink compared to all women, yet there are few messages targeted at this group. The JSNA will need to ensure that as much information on LGBT people in Ealing is captured as possible and considered alongside the other healthcare needs information to meet the range of the communities' needs as bets as possible, If the JSNA is successful, its picture of the needs of the community will mean that targeted services at LGBT communities help to reduce health inequalities in this group, thus resulting in a positive differential impact – care must be taken to ensure that sufficient information is collected and used to inform equitable services so that sexuality does not remain a cause for worse access or use of appropriate healthcare services.