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Foreword

Once in a generation there comes an opportunity to transform radically the way a service is provided. In 1974, responsibility for public health was removed from local government control. Next year, local government is back in charge of public health. Public health has changed its focus considerably since its foundation. No longer is the emphasis on combating the major epidemic diseases spread by poor sanitation. Rather, its task is to tackle the diseases and consequences of modern day living, as well as striving to reduce health inequalities.

The difference in life expectancy between the most and least deprived London neighbourhoods is a good measure of these inequalities. On average, a man in Lewisham Central ward lives for 70.8 years. In the Queen's Gate ward, in the affluent borough of Kensington and Chelsea, this figure is 88.3 years, almost 17.5 years more.

Now, we see innovations in acute care. The redesign of patient pathways focussing on prevention, on keeping people out of hospital & encouraging people to manage their own health. The challenge for public health is also to innovate, offering a local approach different to traditional medical models, whilst operating under the most extreme financial stricture.

Public health, under local government control, is in a position to consider our community assets, those who deliver and benefit from services, looking beyond needs and treatments. Lewisham’s Health and Wellbeing Board, currently in shadow status, goes live in April 2013. It will be the foundation for developing a cogent and coherent system for public health, providing leadership and engagement along with local accountability.

Supporting wellness rather than treating illness is not a quick fix solution. Changes in policies will encourage genuine engagement and participation in the health and recovery of our residents, rather than being passive patients to be treated. Then will we start to create radical ways to deliver better health outcomes within a collaborative culture.

As this report shows, the financial crisis has already had an impact on our residents’ health and wellbeing, and will continue to do so. The effects will be felt most by some of our most vulnerable groups. This makes it even more important that we all work together, and we work differently to deliver public health in Lewisham.

We welcome the annual report of the Director of Public Health and commend it to our readers.

Sir Steve Bullock
Elected Mayor and Chair, Health and Wellbeing Board

John Muldoon
Chair, Healthier Communities Select Committee
As I write this report (in June 2012), I am conscious that it will be published at an extraordinary moment in the history of health care and public health in England. It is extraordinary for two reasons: first, because we are about to feel the full health impact of the financial crisis here in the UK; and second, because we are about to implement the biggest reform of the NHS in England since its formation in 1948. I have decided therefore not to make the main focus of my report achievements and health challenges in the past year, as is the tradition with public health annual reports, but to look instead at what these two momentous changes could mean for health and wellbeing in Lewisham in the months and years to come.

Assessing the impact of the financial crisis on health and wellbeing in Lewisham

We in the UK are now starting to feel the socio-economic consequences of a financial crisis that many economists believe to be worse for the economy than the great depression of the 1930s. The main section of this report (pages 11 to 37) attempts to assess the likely impact of the financial crisis on health and wellbeing in Lewisham. In that section I will review the available evidence linking the two most significant socio-economic consequences of the financial crisis – unemployment, and the reduction in ‘discretionary’ income available to households after taxes and bills are paid - with reductions in health. Having identified the many different ways in which these two factors impact on health, I then use locally available data to assess what this might mean for health and wellbeing in Lewisham over the next few years. Finally, I suggest actions that might be taken by the newly constituted Lewisham Health and Wellbeing Board, and other partners in the borough, to mitigate some of the negative health effects of the financial crisis on our residents.

Some key messages resonate loudly from this analysis:

- The impact of the financial crisis on the mental health of Lewisham residents is predicted to be particularly large as income, employment and housing all have significant associations with mental health. Approximately 500 additional people are predicted to develop mental illness in Lewisham as a result of unemployment alone. The suicide rate could increase significantly.

- Some groups of Lewisham residents will be disproportionately affected by the changes. The health of children, for example, is likely to be particularly severely affected because of the associations with income, employment and housing changes. Young men, in particular young black men, are disproportionately affected by unemployment, which is likely to be associated with significant mental health problems, and increased suicides.

- Certain groups of vulnerable people in Lewisham will be less resilient to the changes than others. This is likely to include over 1,000 people likely to experience a shortfall in their local housing allowance, and almost 14,000 households in fuel poverty.
What the Health and Social Care Act 2012 means for Lewisham

The government’s Health and Social Care Bill has now received Royal Assent. When the Act is implemented from the 1st April next year (and many of the changes it proposes are already being implemented), it will herald the most radical reform of the NHS in England in its history. The new 2012 Act is a ‘game changer’ for the way in which health care and public health will be commissioned and provided in England, and has generated much controversy across all areas of public life. For this reason I want to describe briefly here what I consider to be the key policy reforms contained within the Act. I want to highlight the potential opportunities for improving health and wellbeing in Lewisham, and for mitigating, in part at least, some of the effects of the financial crisis.

Four ‘game changing’ policy reforms

I think it is important to emphasise what will not change with the introduction of the Health and Social Care Act 2012. It will not change the way in which health care is financed. Unlike most of mainland Europe, health care will continue to be financed primarily from income tax and national insurance contributions, and will continue to be largely free at the point of delivery, with access to care determined by need rather than ability to pay. That said, four radical policy changes lie at the heart of the reforms. They are designed to fundamentally alter the way in which resources are deployed, such that the distribution of finite available NHS funding and the delivery of services better meet the health needs of the population.

The current pattern of NHS resource allocation and service delivery is shaped more by the suppliers of care than by patient/population need or demand, and the supplier exerting the most influence in the system is the acute hospital.

Each key policy change is designed to alter the existing power balance and flow of resources for health care in a different way:

- Minimizing political interference from ministers, particularly around hospital closures and bed reductions, through the establishment of an independent NHS Commissioning Board;
- Shifting the balance of power from acute hospitals to GPs, patients and local communities through the establishment of GP led clinical commissioning groups, and local Health and Wellbeing Boards;
- Shifting the balance of emphasis and expenditure on treatment/care of illness over prevention of illness by transferring around 4% of the funds raised in taxation from the NHS to a new National Public Health Service called Public Health England, and allocating a significant portion of that funding to local authorities through a ring-fenced public health budget;
- De-regulating the market for provision of NHS funded health care by allowing ‘any qualified provider’ to bid to provide health services.

The underlying rationale for these four policy reforms is that together they will make the health care system more efficient, more equitable, and better able to meet the health needs of local populations.

A ‘health warning’ for the new Health and Social Care Act 2012

There are two major potential risks to undertaking these radical, untested reforms. The first is that they may lead to a more fragmented, less co-ordinated, and more inequitable health care system. Significant financial responsibilities are transferring to GPs, and both financial and health responsibilities are transferring to local authorities, both of whom have little recent experience of discharging such duties.

The second risk is that an inadequately regulated, inherently uncompetitive NHS market (for example due to natural monopolies and imperfect information) may actually lead to poorer quality care at greater cost. Experience from health systems around the world, particularly the USA, suggests that health care markets are prone to imperfect competition and market failure.

Opportunities offered by the ‘amended’ bill

Many of the amendments made to the bill in its passage through parliament are intended to minimise the risks described above. They include amendments designed to promote co-operation, curtail competition, and encourage integration of health services and of health and social care. The amended bill offers exciting ‘health improving’ opportunities for the local health economy in Lewisham.

In an article in the BMJ a few years ago, I argued that “delivering efficient and equitable health care requires doctors to take responsibility for resources and to consider the needs of populations, while managers need to become more outcome and patient centred” (Ruta et al. 2005). A Lewisham clinical commissioning group (CCG), led by GPs working in close partnership with patients, hospital doctors, hospital and community nurses, and NHS managers, has the potential to achieve this. Working in this way, a local CCG could completely re-design local services and clinical pathways to improve quality of care, improve population health, reduce inequalities and reduce costs.

The amended Act places a new duty on commissioners and providers to collaborate to deliver integrated care. This could allow Lewisham Healthcare Trust, GP practices (both as commissioners and providers) and local authority adult services to operate as a single, integrated health and social care system. Such an integrated system could deliver enormous benefits in terms of more efficient, equitable, patient- and client-centred care. It would require the local health economy to set ‘competition’ to one side, thereby allowing a pooling of available resources and re-investment of efficiency savings from acute hospital care into community care and preventive services. This would serve to stop people becoming ill or dependent in the first place, which in turn would deliver even more efficiencies, in a virtuous circle of quality improvement.
If local commissioners and providers also set national NHS tariffs and ‘payment by results’ to one side, they can then move to a capitation model, and commission pathways of care rather than individual treatment episodes. In this way all parts of the system become financially incentivised to keep patients healthy and out of hospital. Seamless local clinical pathways between GP, local community and hospital services, local mental health services, and local social and children’s services would become a real possibility. The quality of the patient experience would be dramatically improved, and patients would only be referred for more specialist hospital care out of Lewisham when absolutely necessary. At any time, it should be pointed out, Lewisham patients can choose to be referred to any provider. The hope is that they would hardly ever want or need to be seen elsewhere, since Lewisham’s health and social care would be the best in the country.

The amended Act also gives increased powers to the new statutory Health and Wellbeing Boards. Lewisham’s Health and Wellbeing Board brings together the key partners for health, social and children’s services in Lewisham. It is chaired by our elected Mayor, and has a clear remit to promote and improve health and wellbeing in the borough. The board has the potential to provide a clear vision of what health and wellbeing in Lewisham could look like in ten years’ time. It also has the potential, using the best available evidence provided by our joint strategic needs assessment (JSNA), to forge an agreed set of shared priority health and wellbeing outcomes amongst all partners in the borough.

In the first section of this report (page 10), I describe our new JSNA process, and introduce our exciting new interactive web-based JSNA resource (www.lewishamjsna.org.uk). Based on the evidence produced by our JSNA process, I then go on to describe how Lewisham’s shadow Health and Wellbeing Board has identified nine draft priority health and wellbeing outcomes it wants to achieve by 2022. They are:

- Increase the uptake of childhood immunizations
- Prevent the uptake of smoking among children and young people and reduce the numbers of people smoking
- Reduce the harm caused by alcohol misuse
- Promote healthy weight
- Improve mental health and wellbeing
- Improve sexual health
- Delay and reduce the need for long term care and support
- Reduce the number of emergency admissions for people with chronic long term conditions
- Increase the number of people who survive colorectal, breast and lung cancer for 1 and 5 years.

The board aims to consult on these priorities in the next few months with a view to publishing a Lewisham Health and Wellbeing Strategy in the summer of 2012.

**Bringing public health back to its civic roots**

The amended Act brings public health back to its civic roots; where it was born, and where it resided for a hundred years. From the appointment of the first Medical Officers of Health in the 1870s, to the transfer of public health and other personal health services to the NHS in 1974, preventing disease, promoting health, and indeed a major part of health care in Britain was the responsibility of local government. If there is one overwhelming lesson to be learnt from this period, it is that the biggest impact on life expectancy came from preventive interventions targeted at the ‘causes of the causes’ of disease and illness.

These were: first, the sanitary reforms of the late nineteenth century; then, health promotion, particularly to mothers by health visitors in the first three decades of the twentieth century; followed by housing improvements in the mid-twentieth century, through enforcement of the public health acts (more than the housing acts) of the time; and finally, by the control of infectious diseases through mass immunization campaigns.

There is an increasing acknowledgement that until the full potential of gene therapies and other advanced technologies are realized, exactly the same interventions offer the greatest promise for the biggest improvements in health in the near future as they did in the past. A recent example of this was the implementation of the smokefree legislation in 2006, which was very effective at reducing smoking prevalence. I would argue that local authorities now, as they were then, are best placed to provide strategic leadership for health through their health and wellbeing boards, and indeed to commission or deliver many of these interventions directly. The challenge for a Lewisham local authority-based public health function will be to shift the balance of focus back to prevention and health improvement whilst still adding value to commissioning of health services and integration of care.

**Taking Lewisham’s ‘pulse’**

In the final section of this report (pages 39 to 57) I attempt to take the borough’s ‘pulse’ by looking at how well Lewisham is performing across key areas of public health. For each area, I have tried to measure performance using a dashboard of indicators. I have also tried to benchmark Lewisham wherever possible against other London boroughs, and against the English average.

These public health dashboards clearly show that collectively we have worked extremely hard in 2001-12 to improve health in the borough. Considering the socio-economic challenges that Lewisham faces as the 31st most deprived borough in England, I think we have been able to ‘punch above our weight’ in many areas. For example:

- We have almost halved our teenage pregnancy rate over the last few years, achieving one of the largest reductions seen anywhere in the country;
We screen more of our young people for Chlamydia than all but two other boroughs in England;

Almost 7,000 people aged 40-74 have undergone a health check in the past year;

We are now in the top ten boroughs in the country for breastfeeding and are well on the way to achieving the prestigious UNICEF/WHO baby friendly award;

In the last year, our immunization rate for children at 2 years of age for mumps, measles and rubella has increased significantly, taking us from the bottom of the league table of London boroughs to just above the middle;

The percentage of reception year children who are overweight and obese has fallen slightly in the last year;

We have been proactive in creating the first South East London Tobacco Alliance that aims to tackle illegal tobacco activity and prevent our children from accessing cheap cigarettes.

The dashboards, and the findings of our JSNA, also show how far we need to go in addressing the draft health and wellbeing strategy priorities, and realising our vision for what Lewisham could look like in 2022. For example:

- By the time our children reach year 6, almost 40% of them are overweight and obese;
- Around 700 11-15 year olds started smoking last year;
- The percentage of Lewisham children receiving their pre-school booster is amongst the lowest in London;
- 40% of deaths in Lewisham are premature, i.e. deaths below the age of 75 years;
- Over 30,000 Lewisham residents are estimated to have undiagnosed, and therefore untreated, high blood pressure, and even in those patients with a diagnosis, almost a third do not have their blood pressure adequately controlled;
- 40% of diabetic patients in Lewisham do not have adequately controlled blood sugar levels;
- Death rates from respiratory disease are significantly higher than the London average;
- Almost 40,000 people a year in Lewisham experience depression, anxiety, panic attacks and phobias;
- 1 in 4 HIV infections in Lewisham is diagnosed very late, when treatment is less effective.

In this report I show how the changes we are already starting to experience in Lewisham, in terms of unemployment, reduced household income, homelessness and fuel poverty will have an impact on the health and wellbeing of our residents. I’ve also given an indication of the size of that health impact, and for some health effects I’ve been able to predict how many people may be affected. My hope is that collectively we can use this information to better plan and prepare to meet these health challenges in the next few years.

I also highlight the key risks posed to our local health care system by the introduction of the health and social care bill next year. More importantly however, I’ve identified some of the exciting opportunities the amended bill offers our local health economy. These include opportunities for much more collaborative working to re-design local services across primary, community, secondary and social care, and the promise of a fully integrated health care system. The ‘glue’ that could hold it all together is our new Health and Wellbeing Board. That board has already started to set out a shared vision of what health and wellbeing in Lewisham could look like in 2022.

The last section of my report shows the progress we’ve made so far in Lewisham, but also how far we have still to go. I am confident that if we make that journey together, and make improving health and wellbeing everybody’s business, we will get there. To those who continue to work tirelessly to improve health and wellbeing in this proud borough, and who have contributed to the successes described in this report (and there are many), or helped to produce the report itself, I extend my grateful thanks.

Dr Danny Ruta
Director of Public Health for Lewisham
1 New duties to produce a ‘JSNA’ and a ‘Health and Wellbeing Strategy’ for Lewisham

The production of a joint strategic needs assessment of the health and social care needs of the local population (including the needs of children and young people), otherwise known as a ‘JSNA’, has been a statutory duty on PCTs and upper tier local authorities since 2007. The new Health and Social Care Act 2012 now places a statutory duty on Clinical Commissioning Groups, the Local Authority and the NHS Commissioning Board, to jointly produce and publish a JSNA. The new legislation also places a duty on the local authority and clinical commissioning groups to produce and publish a Health and Wellbeing Strategy for meeting the needs identified in their JSNA.

The new act goes further still: it requires the local authority, clinical commissioning groups, and NHS Commissioning Board, when exercising ‘any of its functions’, to have regard to the JSNA findings and the Health and Wellbeing Strategy. Not only that, but these bodies are also required to ‘sign off’ any commissioning plans, and have a duty to give their opinion to the NHS commissioning Board, and ultimately to the Secretary of State, on how well they think those plans align with their local Health and Wellbeing Strategy.

In each local authority it is the Health and Wellbeing Board that will be responsible for overseeing both the JSNA process and the Health and Wellbeing Strategy.

Lewisham’s Health and Wellbeing Board

In 2011 the Lewisham shadow Health and Wellbeing Board was established, chaired by Sir Steve Bullock, Mayor of Lewisham. Membership includes the Director of Adult Social Services, Director of Children’s Services, Director of Public Health, cabinet member for health and social care, Chair of the Lewisham Clinical Commissioning Group, Director of Voluntary Action Lewisham, Chief Executive of Lewisham Healthcare Trust, Managing Director of NHS South East London’s Lewisham Business Support Unit, and representation from Lewisham LINk and South London and the Maudsley Mental Health Trust. Representatives from other parts of the local authority, and from other agencies, may also be invited to work with or join the board where necessary, for example in relation to housing, unemployment, crime, and other factors impacting on health and wellbeing.

The shadow Board has overseen the development of a new Lewisham JSNA process (see below). It has used the evidence from the JSNA to identify three overarching aims, and nine draft priority outcome areas for action that will form the basis of Lewisham’s 10 year Health and Wellbeing Strategy (see Table 1). Following a period of consultation, the board intends to publish a final strategy in Summer 2012.
**Table 1**

**Lewisham's Draft Health and Wellbeing Strategy Outline**

<table>
<thead>
<tr>
<th><strong>Our vision</strong>*</th>
<th>People in Lewisham are able to maintain the best possible health and wellbeing, receive the best possible care within the resources available and maintain their independence for as long as possible.</th>
</tr>
</thead>
</table>
| **Three key aims*** | **Improve Health**  
Provide a wide range of support and opportunities to help adults and children keep fit and healthy and reduce preventable ill health.  
**Improve Care**  
Ensure that services and support are available to all those who need them so that they can regain their best health and wellbeing and maintain their independence for as long as possible.  
**Reduce Cost**  
Improve access and delivery, streamline pathways and ensure services provide good quality and value for money. |
| **Underpinning principles** | **In everything we do we will:**  
Address inequalities, involve patients and the community in the design and delivery of services, listen to feedback, deliver value for money, share information and treat people with respect and dignity at all times. |
| **Priority areas for action*** |  
1. Increase the uptake of immunisation  
2. Prevent the uptake of smoking among children and young people and reduce the numbers of people smoking  
3. Reduce the harm caused by alcohol misuse  
4. Promote healthy weight  
5. Improve mental health and wellbeing  
6. Improve sexual health  
7. Delay and reduce the need for long term care and support  
8. Reduce the number of emergency admissions for people with chronic long term conditions  
9. Increase the number of people who survive colorectal, breast and lung cancer for 1 and 5 years |
| **Coordinating Group** | Prevention and wellbeing  
Maintaining and improving health  
Specialist care and whole systems |

* Still to be agreed following consultation

Early in 2012 the board reviewed these nine draft priority areas and agreed that in the next year it will focus its work on three priority areas that are all underpinned by the need for behaviour change. These are smoking, obesity and alcohol. The Board intends to review all the available evidence on effective interventions for behaviour change, review existing multi-agency delivery plans, benchmark Lewisham against successes elsewhere, and then identify how the collective resources and activities of partner organisations can add value to existing plans through more cost-effective interventions targeted at behaviour change.

During 2011-12, Lewisham's Healthier Communities Select Committee has taken evidence on current and planned initiatives to tackle premature mortality in Lewisham. Conscious of the emerging priorities in the draft Health and Wellbeing Strategy, the Committee has focused on smoking, diet, physical activity and managing CVD risk in primary care, drawing heavily on the JSNA and on the last Director of Public Health annual report. The Committee has now published its report and recommendations, which the Health and Wellbeing Board will consider as part of its consultation on its Health and Wellbeing Strategy.

**Lewisham's Healthier Communities Select Committee**

Local Overview and Scrutiny committees have an important role in assessing the work of Health and Wellbeing Boards. They can also scrutinise what has been done to meet the needs and priorities identified in the JSNA and Health and Wellbeing Strategy, and monitor progress in achieving outcomes.

**The Lewisham JSNA process and website**

Draft guidance on JSNAs and joint Health and Wellbeing strategies was published in January 2012. The following key recommendations were made:

- They should be **strategic** and must take account of the current and future health and social care needs of the entire population;
Real gains can be made if health and wellbeing boards look beyond needs to examine how local assets including the local community itself can be used to meet identified needs;

JSNAs and joint Health and Wellbeing strategies are key to understanding inequalities in the local area and the factors that influence them such as poor housing, worklessness or crime;

There should be a focus on the things that can be done together;

Joint Health and Wellbeing strategies should prioritise the issues requiring the greatest attention, they will focus on key issues that make the biggest difference.

A new JSNA process was implemented in 2011 to support the work of the Council and health partners. This included a standardised process for prioritising the topics on which needs assessments should be undertaken, completion of the assessments and ensuring that these are translated, where appropriate, into planning and commissioning activity. The completed assessments are available to all interested parties via an interactive website (www.lewishamjsna.org.uk). Readers are urged to visit the website (see figure 1 for sample screen shots from the website). In addition to needs assessments on specific topics such as childhood obesity, the website also contains a wealth of concise and accessible socio-demographic information, and a comprehensive public health information portal containing public health data from a wide range of trusted sources. These data can be freely downloaded.

The JSNA process will continue on an ongoing basis to prioritise topics for needs assessment, and publish the findings and recommendations of these assessments to the JSNA website, where they can be accessed by everybody.
Section 2: The Likely Impact of the Financial Crisis on Health and Wellbeing in Lewisham

2.1 Introduction

While some of the world’s leading economists and bankers still debate whether the financial crisis of the late 2000s was worse than the great depression of the 1930s, the consequences of the ‘Great Recession’ for the UK economy are indisputable. The UK government has responded by instituting what the Prime Minister has called an ‘Age of Austerity’. This has, and may continue to have for several years to come, far reaching socio-economic consequences for the country. This section of my annual report attempts to assess the likely impact of the financial crisis and its socio-economic consequences in the UK on health and wellbeing in Lewisham, and then to identify actions that might be taken to mitigate this impact on the health and wellbeing of our residents in the coming years.

It begins by describing the methods we used to review the available evidence on the effect of selected social determinants on health outcomes, and briefly summarising the causes of the financial crisis and the current state of the UK economy.

Using the findings of the evidence review, it then goes on to describe the two most significant socio-economic consequences of the financial crisis and the government’s response for UK citizens: their impact on unemployment; and their effects on the ‘discretionary’ income available to households, after taxes and bills are paid. These income effects are summarised in relation to benefit changes, wage freezes, pension changes and increasing fuel prices.

The findings of the evidence review are then used to identify the impact of unemployment, income inequalities (and the resulting homelessness and poor accommodation) on health and wellbeing. The review findings also identify factors that might mitigate the worst health effects. These relationships are illustrated in a diagrammatic representation of the research evidence.

Drawing on the diagrammatic representation and using locally available socio-economic data, we then attempt to assess the likely negative health and wellbeing impact of the financial crisis and its UK socio-economic consequences in Lewisham. Finally, we identify from the evidence review actions that might be taken by the Lewisham Health and Wellbeing Board, and other partners in the borough, to mitigate this impact on the health and wellbeing of Lewisham residents.
2.2 Methods of Data Collection and Analysis

In this section we describe the methods we employed throughout the report to locate and appraise our evidence sources, model our predictions and come to our conclusions.

Our first task was to document the socio-economic changes that have occurred in the UK since 2007, and chart the effects that these changes have had on employment, housing and household income. To collect this type of information, it was essential to rely on trustworthy sources of current data. On the whole we used reports from the BBC, along with government-based statistics from the Office for National Statistics (ONS).

The evidence base suggesting a link between material circumstances and health is vast and varied. We decided to undertake a review that did not select evidence solely based on the scientific design of a study (Siegrist et al. 2010). Our first step was to conduct a broad scan of the literature available online and in print, using largely publicly-available means of searching and sources. At this stage the search criteria were not specific; we looked at all information that referred to the potential health effects of material changes. This produced a large base from which we created a map of the literature.

The second step was to try to strengthen the reliability and validity of our evidence base. We started the search again, using search terms developed from the collected literature, including ‘recession and health’, ‘unemployment and health’, ‘job insecurity and depression’ and ‘unemployment and mortality’. These were entered into the following databases: Medline, British Nursing Index, CINAHL, Health Business Elite, PsychInfo and HMIC (Health Management Information Consortium). Only literature from 1990 onwards and available in English was searched.

As well as undertaking a search of various databases using defined search terms, we also examined literature such as published reports authored by independent academics for national organisations such as charities and ‘think tanks’. Additionally, we drew upon the report ‘Fair Society, Health Lives’ by Professor Michael Marmot, as well as the associated task group reports that fed into it, to identify other reliable evidence.

Once we had reached saturation through our searches, we were able to develop inclusion criteria. We recognised that systematic review techniques, in which randomised controlled trials (RCTs) are regarded as the ‘best’ evidence, were not appropriate for this project, as RCTs are relatively rare in the field of social determinants of health (Bonnefoy et al. 2007). Following discussion, we included papers that described empirical qualitative or quantitative research or presented a review of empirically-based studies, and reports that were authored by independent academics that analysed publically-available or specially collected population data.

At the end of this process we were able to form a consensus based on the best currently available knowledge, and were confident that our emerging model was grounded in evidence that was the most reliable and valid available for our purpose. Having developed an evidence based model linking the financial crisis and its socio-economic consequences to health, we then applied that model to Lewisham in order to estimate the impact on our population. It draws on data from Nomis, a service provided by the ONS that provides access to the most detailed and up-to-date UK labour market statistics from official sources, (including data on population, employment, unemployment, qualifications, earnings, benefits claimants and businesses) and a database compiled by Lewisham Council.

References

2.3 The Socio-Economic Consequences of the Financial Crisis for the UK1

From Financial Crisis to Deep Recession

The causes of the financial crisis in the USA and much of Northern Europe are still debated, although most would agree they are complex and multifactorial. The way in which these factors played out across the world, interacting with each other, and how the effects were felt in the UK, can be charted as a timeline. It begins with the 1998 amendments to the Maastricht Treaty, continues through the banking crisis from 2007 to 2009, to the current sovereign debt crisis in Europe. The timeline can be found in Appendix 4 of this annual report. The recession in the UK is continuing for longer than the 1930s because of the depth of indebtedness in the household, corporate and government sectors. The UK economy is still producing 4.3% less output than it did prior to the recession. If growth is 1% per year it will take another four years to get back to 2007 levels. This deep “balance sheet” recession will take at least a decade to recover from as households and businesses attempt to pay down debt rather than spend/invest and because public sector debt is high. It is this depth of recession that justifies the detailed analysis that follows.

Current state of the UK economy

Intervention by the British Government to rescue failing banks led it to publish its accounts in two versions: with and without the effects of temporary financial interventions. Figure 2 shows UK national debt as a percentage of GDP from 1920 to 20112, excluding the effect of financial interventions.
Historically, it is clear that the current levels of national debt are much lower than they were for much of the 20th century. Only by the end of 2011 had the overall level of debt risen above the Eurozone’s 60% threshold (accumulated debt). However, from 2009 there has been a steep rise, probably as a consequence of the “temporary” financial interventions, and the 2011 current account deficit (the gap between government spending and revenue) at 11.7% of GDP is far higher than the 3% Eurozone threshold. When the effects of the financial interventions are included the position is very different. Figure 3 shows the equivalent data from 1993 onwards\(^1\). The cost of the intervention in 2008 more than trebled the overall debt, and at the end of 2011 was more than double the remainder of the debt.

### Figure 3

**Public Net Debt as percentage of GDP 1993 - 2011**

With and without financial interventions

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**Consequences for employment**

The British Government’s programme to deal with its debt and annual deficit has hinged on cutting national and local government spending, particularly spending on staffing. While reductions in the armed forces and the police service have been announced, they have yet to be implemented. By contrast, reductions in civil service, public corporations (including the newly nationalised banks) and local government staffing have begun to take effect. From 2007 (immediately before the banking crisis) to 2011 there was a reduction of 53,000 Civil Servants, equivalent to 10.5%.

### Figure 4

**Government job losses (FTEs) Quarterly Q3 2010 - Q3 2011**

Cumulative (000s)

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### Figure 5

**Public and Private Sector Employment 2005 - 2011 Headcount (millions)**

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\(^1\) Unless otherwise stated, sources for this section are the BBC (http://news.bbc.co.uk/1/hi/7527250.stm), and the Council for Foreign Relations (http://www.cfr.org/economics/timeline-global-economy-crisis/p18709)

\(^2\) Source: http://www.economicshelp.org/blog/334/uk-economy/uk-national-debt/ using data from ONS & HM Treasury. 1993 onward uses revised ONS calculations

\(^3\) http://www.ukpublicspending.co.uk/uk_national_debt using data from ONS & HM Treasury.
In the period Q2 2008 (the point before the failing banks were taken into public ownership) to 2011 Q3 there was a net reduction of 32,000 posts in the public sector and of 369,000 in the private sector.

Taken all in all, these figures suggest that the hope expressed by the coalition government that staff who lose their jobs in the public sector will be taken up by the private sector seems not to be coming true, at least at this stage of the economy. The picture that emerges is one of rising economic insecurity, lower real wages and rising unemployment.

Consequences for household discretionary income

Discretionary household income is defined as the income available to a household after taxes and bills are paid, including rent and mortgage bills. The financial recession and the consequent response by the UK government has impacted or is predicted to impact on household discretionary income through:

- benefit changes, including tax credits, child benefit, pregnancy and maternity grants, and housing benefit and an overall cap on total benefits received;
- wage freezes, particularly compounded in the public sector by increases in pension contributions;
- fuel price increases leading to fuel poverty.

What households are able to buy with their discretionary income will be affected by inflation. According to the Bank of England Consumer Price Index, inflation fell to 4.2% in December 2011, down from 5.2% in September, but still well above the 2% target set by the bank. Inflation is predicted to continue to fall sharply during 2012 as the impact of past rises in VAT and petrol prices drop out of the twelve-month comparison. Inflation is likely to decline further thereafter.

Benefits changes as they affect families with children

Health in Pregnancy Grant
Before 1 January 2011 a woman who was at least 25 weeks’ pregnant could receive a one-off tax-free payment of £190. This has now been abolished. The change affects all pregnant women/mothers.

Sure Start Maternity Grant
Parents (or expectant parents) receiving Income Support, Income-based Jobseeker’s Allowance, Income-related Employment and Support Allowance, Pension Credit, Child Tax Credit at a rate higher than the family element or Working Tax Credit where a disability or severe disability element is included in the award could receive a one-off payment of £500. From April 2011 this has been restricted to households with no other dependent children under 16. It affects parents on this range of benefits who already have at least one child under 16.

Child Tax Credit
Child Tax Credit is an income-related benefit to families which are responsible for one or more children, whether or not anyone in the family is in work. It comprises several elements: family (the basic payment), a child element (for up to three children), and additional elements for disabled and seriously disabled children. The child element increased by £180 pa above CPI in 2011-12. An additional baby element, paid to families with babies under the age of 1, was withdrawn from April 2011, resulting in a cut of £10.50 per week (£545 pa) for affected workplace families. The child element of Child Tax Credit was due to be increased by £110 above CPI in April 2012, but this will not now happen.

Above certain income thresholds, which have been reduced, the child element is now withdrawn at a rate of 41p in the pound (before April 2011 the withdrawal rate was 39p in the pound). From April 2012, the family element will be withdrawn immediately after the child element.

For both Child Tax Credit and Working Tax Credit, disregarded increases in income during a tax year were reduced from £25,000 to £10,000 in April 2011. The period for which a Tax Credits claim and certain changes of circumstances can be backdated will be reduced from three months to one month from April 2012.

All these changes affect families on quite modest incomes (below the national average).

Child Benefit
Child benefit has been frozen for three years. The effect of this will depend on future inflation, but at 2011 rates it is expected to mean an effective loss of £10.76 per week (£559 pa) for the first child, and £0.70 per week (£36 pa) for each subsequent child. It is proposed that child benefit be withdrawn from higher rate tax payers from January 2013, though this is still subject to debate.

Working Tax Credit
Working Tax Credit (WTC) is based on hours worked for pay (unpaid work such as volunteering does not count; payment in kind does count). Families with children need to work at least 16 hours per week to qualify. From April 2012 this will rise to 24 hours per week for couples, of which at least 16 must be worked by one person, but will remain at 16 hours for single parents. From April 2011 the childcare element of WTC was reduced from 80% to 70% of costs up to a maximum of £175 per week for one child and £300 per week for two or more children. The basic and 30 hour elements of Working Tax Credit were frozen in April 2011 for 3 years.

As with Child Tax Credit, the income-related withdrawal rate for WTC rose from 39% to 41% in the Pound.

Income Disregard
In the event of a loss of income caused, for example, by a reduction in working hours, Tax Credits have been recalculated immediately to reflect the new circumstances. From April 2012 Tax Credit entitlement will not be recalculated until the following tax year unless earnings have fallen by more than £2500.
Educational Maintenance Allowance

Educational Maintenance Allowance was a payment of up to £30 a week to 16 to 19 year olds from low income families in education. This was abolished in September 2011.

Marginal Tax Rate

It should be noted that Housing Benefit and Council Tax Benefit are also withdrawn at set percentages above certain income thresholds. Combined with National Insurance contributions and Income Tax, the overall effect is that the move from benefits to work can result in the highest effective marginal rate of tax of any group in the UK population. A report from the think tank Policy Exchange\(^4\) considered typical benefits claims, and compared them with what a person would earn working for between one and forty hours at the national minimum wage, allowing for the costs of getting a job (transport to work, suitable clothing etc). A Jobseeker’s Allowance couple with one or two children gain only £8.80 for 16 hours of work, and £29.30 for 40 hours, an effective rate of £0.73 per hour for 40 hours. An Income Support claimant with one or two children stands to gain £29.30 for 16 hours of work, and £55.13 for 40 hours, an effective hourly rate of £1.38 per hour for 40 hours. Families on benefits therefore have little incentive to move into work.

Housing Benefit Council Tax benefit

From 1 April 2011 the rates for Local Housing Allowance, which is used to assess Housing Benefit for private rented tenants, were reduced across the country. The maximum £15 weekly excess that some customers could get was removed. Limits were introduced so that Local Housing Allowance (LHA) does not exceed:

- £250 a week for a one bedroom property (including shared accommodation)
- £290 a week for a two bedroom property
- £340 a week for a three bedroom property
- £400 a week for a four bedroom property

The maximum rate of Housing Benefit in the private rented sector has been limited to the rate for a four bedroom property. These rates apply to all new claimants from 1 April 2011. Existing claimants whose circumstances have remained the same receive nine months at their pre-April 2011 LHA rate from their first Housing Benefit annual review after April 2011. This means that some existing claimants will not experience the full effect of these reductions until December 2012.

Housing Benefit claimants in the private rented and social housing sector with non-dependant adults in their household (eg parents, adult children) are experiencing reductions in their benefit as a result of significant increases in the rates of non-dependant deductions from both Housing and Council Tax Benefit in April 2011 and April 2012. In addition, the entitlement to claim shared room rate benefits only for single people under 25 years old, living alone, renting from a private landlord has been extended to those under 35 years of age, meaning that those between 25 and 35 on higher rate housing benefits will find their entitlement cut to the shared room rate from the single room rate.

Housing Benefit no longer covers the full cost of specialist accommodation. This may result in a restricted supply of supported accommodation, increased care costs, and more people being unable to maintain independent living.

Local authorities can award Discretionary Housing Payments to Housing Benefit and Council Tax Benefit claimants on grounds of hardship. Local authority budgets for these payments have been increased.

Expected effect on child poverty

A major study\(^5\) published in October 2011 by the Institute for Fiscal Studies, supported by the Joseph Rowntree Foundation, forecasts that 400,000 children will fall into relative poverty in the course of this parliament as a result of the benefit changes, and by 2015 there will be over three million children in absolute poverty. This means the government will miss the legally binding targets of reducing child poverty by about 450,000 children in 2020–21.

In the longer term, the introduction of Universal Credit to replace Tax Credits will act to reduce both absolute and relative poverty. The long term effect of Universal Credit is expected to be to reduce relative poverty by about 450,000 children in 2020–21.

The net direct effect of the coalition government’s tax and benefit changes is to increase both absolute and relative poverty. This is because other changes, such as the switch from RPI- to CPI-indexation of means-tested benefits, more than offset the impact on poverty of Universal Credit. Absolute and relative child poverty are forecast to be 23% and 24% in 2020–21 respectively. These compare to the targets of 5% and 10%, set out in the Child Poverty Act (2010), and would represent the highest rate of absolute child poverty since 2001–02 and the highest rate of relative child poverty since 1999–2000.

Effects on wage freezes and increased public sector pension contributions

Public Sector Pay Freeze

From 2010-11 and 2011-12 the public sector was subject to a pay freeze. With RPI inflation running at about 5% pa this amounts to an effective pay cut of about 10%. The government has announced that public sector pay increases will be limited to 1% until 2015. Even if the government’s inflation target of 2% is met, (which it has not been since the start of the financial crisis), this implies further reductions in pay for all public sector workers.

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Public Sector Pensions
Most of the public sector cuts and benefit changes have been designed so as not to impact on pensions. However, the move from indexing pensions by Retail Price Index (RPI) to the generally lower Consumer Price Index (CPI) will in the longer term reduce the discretionary income of pensioners, as will the Hutton Committee’s proposals to re-base the level of pensions by career average salary rather than final salary for public sector pension schemes if these proposals are implemented.

Additionally, increased pension contributions have resulted in a loss of discretionary income for those in public sector employment and contributing to occupational pension schemes.

Effects on Fuel Poverty
A household is officially defined as being in fuel poverty if it spends more than 10% of its income on fuel use whilst maintaining an adequate standard of warmth\(^6\). This definition is not entirely satisfactory as it ignores the absolute level of income\(^7\). There are two main components that determine fuel poverty: household income and the price of fuel.

For the purpose of this definition the measure of income used (“Fuel Poverty Full Income”, FPFI) is defined as

\[
FPFI = \text{Income from private sources and savings + benefits and tax credits} - \text{Income Tax, National Insurance, Council Tax}
\]

summed over all adult members of the household.

The “Fuel poverty ratio” is calculated as ratio of fuel costs to income:

\[
\text{Fuel Poverty Ratio} = \frac{\text{fuel costs (modelled usage x price)}}{\text{FPFI}}
\]

Fuel costs are modelled to take account of variation in prices from different suppliers and methods of payment.

In England in 2009 (the most recent data available) 18.4% of all households were fuel poor\(^8\). This is more than three times higher than the level in 2003, when the level was the lowest since the indicator was formulated. Fuel poverty in 2009 was the highest since 1996. In 2008 the national figure was 15.6%.

Figure 6 shows the percentage of households in fuel poverty and the Retail Price Index (RPI) component of fuel and light, from 2003 to 2009. The relation between RPI and percentage of households living in fuel poverty can be seen clearly. Important influences on fuel prices at present include:

- Warm weather reducing demand in Europe;
- Possible Israeli-American action against Iran over the oil producer’s nuclear programme;
- Disruption of supplies from unstable oil producer Nigeria;
- The threat to the economy - and therefore oil demand - from the debt crisis in Western countries.

\(^7\) At the time of writing, the Office of National Statistics is known to be reworking the definition and calculation of fuel poverty, but the outcome has not been published.
Figure 7
Socio-economic consequences of the financial crisis in the UK

- **2007 Financial Crisis**
  - Unemployment Increase
  - Job losses in finance sector
  - Credit squeeze
  - Job losses in private sector
  - Unemployment Increase

- **2010 General Election**
  - Public spending reductions
  - Job losses in local government
  - Job losses in central government
  - Inflation
  - Benefit changes
    - Children
    - Parents
    - Housing
    - Incapacity
    - Pensions
    - Public Sector pay freeze
  - Loss of discretionary income
  - Increased fuel poverty
  - Unstable fuel prices
  - Increased fuel poverty
2.4 The Impact of Income Inequalities and Reduced Income, Unemployment, Fuel Poverty and Housing Issues on Health and Wellbeing

Having examined in the last section the changes brought about by economic and social policies in response to the financial crisis, we now turn to the potential health effects of these changes, focusing on those affected by three main areas: reduced income; unemployment; and housing, homelessness and fuel poverty.

There is a plethora of studies examining how material and social circumstances affect people’s physical and mental health, and mortality. The evidence for each of the three main areas is extensive but also overlapping, as the relationships between material states and population health are not discrete. To elucidate the relationships within and between the variables, this section looks at evidence about each material area separately.

At the end of this section we summarise the evidence in a diagrammatic representation that indicates how the three main areas of reduced income, unemployment, and housing, homelessness and fuel poverty are associated with health and wellbeing.

Income inequalities and reduced income

The measurement of the relationship between income and health can be complex, as it has many dimensions and potential pathways (Burgess et al. 2004). However, there are many published studies from around the world linking poor physical and mental health to income inequality. For example, homicide rates were found to increase with income inequality in Rio de Janeiro (Szwarzwald et al. 1999), while there was a strong association between income inequality and suicide rates in Eastern Europe in the post-communist transition period (De Vogli and Gimeno, 2009). Suicide attempts and depression in South Korea rose as income-related inequalities widened over the ten years following economic crisis (Hong et al. 2011). The South Korean study found that people with higher incomes were less likely to suffer depression or to attempt suicide over the preceding decade, during which income inequalities had doubled.

A large, register-based study of over 1.6 million people in Norway concluded that, in addition to the general socioeconomic influences, a higher level of income inequality adds independently to higher mortality levels (Elstad, 2011). A distinct independent effect of income inequality on mortality remained after adjustment for regional-level social and economic characteristics. Overall, it appears that, when looking at income inequalities rather than absolute income levels, small differences in income distribution can have a large effect (Quick and Wilkinson 1991).

While income inequality has recognised implications for health, so too does a reduction in income that results in loss of discretionary income, debt and poverty. Indeed, a longitudinal study in the United States concluded that income affects health more than health affects income (Muennig, 2008).

Benzeval et al. (2000) reported that studies have shown that people whose income falls over time have poorer health outcomes than those whose income remains stable or increases. Similarly, a large US longitudinal study that compared two time points, three years apart, found that a decrease in household income during the two time points was associated with an increased risk of incident mood, anxiety, or substance use disorders in comparison with respondents with no change in income. Baseline presence of mental disorders did not increase the risk of change in personal or household income in the follow-up period (Sareen et al. 2011).

An American study (Sell et al. 2010) found significant evidence establishing a link between poverty and poor child health status, as well as research indicating that even temporary spells of poverty may have lifelong health implications for children. Controlling for confounding variables, food insecurity was strongly related to adverse outcomes for children of all ages. This is of concern if, as Fenton (2010) estimates, cuts to Local Housing Allowance (LHA) will move up to 27,000 additional households that include dependent children below the minimum income standard, as long as their housing situation remains unchanged.

Personal indebtedness, or the fear of becoming indebted, is a likely consequence of reduced income. Welch et al. (2008) examined the results of the General Health Questionnaire (GHQ-12), part of the British Household Panel Survey, for over 7700 participants. Using a three-category, subjective scale of financial stress (‘comfortable’, ‘just about getting by’ and ‘difficult or very difficult’), there was a significant positive association between both onset and duration of episodes of common mental disorders as levels of financial stress increased from ‘comfortable’ to ‘just about getting by’ to ‘difficult or very difficult’.

Analysis of work by the Department of Health, the NHS and the Mental Health Foundation found that approximately three in five clients of debt advice services reported having received treatment, medication or counselling as a result of debt-related health problems, and that the proportion (49%) of survey participants with anxieties about money, finances or debt was twice that of participants with anxieties about unemployment, despite the links between the two (London Health Forum, 2010). In another British study, being in debt was associated with depression independently of job insecurity (Meltzer et al. 2010). Suffolk County Council (2008) found that 91% of people with personal debt reported deterioration in their mental health, notably through stress and depression.

Unemployment

Unemployment is not evenly distributed in society, but is more likely to affect those from the lower end of the socioeconomic scale (Bartley 2011). This effect contributes to more pronounced inequality because analysis shows that, while the standardised
mortality rate (SMR) is highest for those at the bottom of the social class hierarchy and inversely follows the social gradient, the SMR for the unemployed is considerably higher in every social class (Bethune 1997 cited in Marmot Review Team 2010).

Giuntoli (2011) found that the risk of death by suicide was by two to three times higher for unemployed people, compared to those with jobs. Analysis of EU–wide data between 1970 and 2007 (Stuckler et al. 2009) found that every 1% increase in unemployment was associated with a 0.79% rise in suicides at ages younger than 65, and with a 0.79% rise in homicides. A more than 3% increase in unemployment had a greater effect on suicides at ages younger than 65 years, and also on deaths from alcohol abuse. In Greece, where adult unemployment almost trebled (to 17%) and youth unemployment more than doubled (to 40%) between 2007 and 2011, analysis of EU statistics on Income and Living Conditions in Greece found that there was a 17% increase in suicides between 2007 and 2009, a 25% increase in suicides from 2009 to 2010, and a 40% rise in suicides in the first half of 2011 compared with the equivalent period in 2010 (Kentikelas et al. 2011).

Waddell and Burton’s (2006) review of the health effects of not working found increased rates of suicide, para-suicide, psychological distress and minor psychiatric morbidity, as well as worse self-reported health. They also found strong evidence for a positive association between unemployment and increased rates of overall mortality, and mortality from CVD and lung cancer. They suggest that these health outcomes are likely to be attributable to relative socioeconomic status, poverty and financial anxiety, all of which are frequently outcomes of unemployment (Waddell and Burton 2006).

Financial stress associated with unemployment is a recurrent factor, and some studies have attempted to separate financial stress from other aspects of unemployment. Bartley (1994) asserts that there are several ways in which unemployment can affect mental health other than the financial effects, including social status, self esteem, physical and mental activity, application and maintenance of skills. In addition, there can be differences in mental health effects between onset of unemployment, duration of finite term unemployment, and long term (or permanent) unemployment.

A study of 4500 people in Spain (Artazcoz et al. 2004) found that unemployment had more effect on the mental health of men than of women, but employed women had higher base rates of poor mental health. The study excluded persons having a limiting long-term illness in the previous 12 months, those who had never been employed, and those not actively seeking work, to avoid possible confounding by reverse causation (mental illness leading to unemployment rather than the reverse) or where the onset of unemployment could not be a contributing factor to poor mental health. Combining the figures for both sexes, 13.9% of employed people reported poor mental health, compared to 26.4% of unemployed people.

The risk of domestic violence also appears to be affected by the victim’s employment status. Evidence from a large research study in the United States (Macmillan et al. 2005) discovered that, among unemployed women responding to the survey, 10.6% reported serious domestic abuse (physical assault or systematic abuse), compared with 5.2% of those in full time employment, and 5.8% of those in part-time employment.

Redundancy has its own effects on health, further to those attributed to unemployment. Involuntary redundancy is associated with higher levels of depression than voluntary redundancy, and with continued depression three months later, even if new employment had been secured (Waters 2007). A qualitative study of the effects of involuntary job loss in Bradford during the current economic downturn found that financial strain due to income loss, loss of daily structure and social role, and feelings of frustration and stigma, had major impacts on people’s mental well-being (Giuntoli 2011).

In a study of people made redundant when a factory closed, GPs found that increases in both major and minor illnesses among their patients dated from when redundancies were first announced - before people actually became unemployed (Quick and Wilkinson 1991). A US study linking administrative data on employment and earnings matched to death records to estimate the effects of job displacement (redundancy) on mortality over 15 years found that job displacement leads to a 15-20% increase in death rates during the following 20 years. If such increases were sustained beyond this period, they would imply a loss in life expectancy of about 1.5 years for a worker made redundant at age 40 (Sullivan and von Wachter, 2007).

While being in employment is generally agreed to be beneficial for the health of the working-age population and their families (Black 2008), the advantages may not accrue to those in poor-quality work. Even when employed, those in insecure and low-paid jobs are more at risk of suffering from stress and other common mental disorders (Marmot 2010). Job insecurity has been strongly associated with depression, even when age, sex, personal debt and type and level of work have been controlled for (Meltzer et al. 2010). Older employees, and those with longer tenures, appear more likely to suffer the negative health effects of job insecurity than younger workers or those with shorter tenure, respectively (Cheng and Chan 2008). Low income and job insecurity are likely to be found together (Bartley 2011), meaning that the problems associated with lower incomes and low socioeconomic status may exert a negative influence on top of that created by job insecurity.

Perception of job insecurity and the risk of unemployment can in themselves have an adverse effect on mental health. Analysis of a random sample from the national survey of psychiatric morbidity in Great Britain (Meltzer et al. 2010), found an increased likelihood of depression among those agreeing that their job security was poor. Job insecurity has a strong association with feelings of depression even after controlling for biographic characteristics (age and sex), economic factors (personal debt) and work characteristics (type of work and level of responsibility).

Siegrist et al. (2009) observed that job insecurity is often a function of downsizing, restructuring and outsourcing, all of which are more likely during an economic downturn (Meltzer
et al. 2010). There is recurring evidence of a relationship of job insecurity to minor psychiatric morbidity and to poor somatic health, including the incident of coronary heart disease and poor self-rated health (Laszlo et al. 2010).

**Housing, fuel poverty, and homelessness**

For the purposes of this report, the issue of housing and health comprises four issues: the health effects of living in unaffordable housing; the health effects of having to move to more affordable housing because of reduced housing-related income; the health effects of living in poor quality or insecure housing (including those associated with fuel poverty); and the relationship between health and homelessness.

As the Local Housing Allowance changes come in, many tenants are likely to find that their rent is now unaffordable. This is significant because unaffordable housing is a critical element of poverty, and can be a precursor of poor health outcomes, especially when households spend more than half of their incomes on housing (Guzman et al. 2005).

Unaffordable housing also contributes to poorer health by limiting the amount of money households have to spend on food to provide adequate nutrition, especially for children. A recent survey of American cities found that low paying jobs and high housing costs are the most frequently cited reasons for hunger (SFDPH 2004).

Using the British Household Panel Survey 1991-2003 and the 12-item General Health Questionnaire, Taylor et al. (2007) looked at the psychological effects of unsustainable housing commitments in Britain. They concluded that mental well-being of male heads of households is significantly damaged through having housing payment problems, while female heads of households’ mental well-being suffers from longer-term housing payment problems and arrears, independently of general financial hardship (Taylor et al. 2007).

As well as creating financial difficulties, many people, including families, will be likely to have to move areas to find affordable housing. Relocation results in people leaving valuable supportive family and community relationships which can protect health through the provision of material as well as emotional support. For example, support can buffer stressful situations, prevent feelings of isolation, and contribute to a sense of self-esteem and value. A study in Alameda County in the US found that those with fewer social contacts (e.g. marriage, family, friends, and group membership) had twice the risk of early death, even accounting for income, race, smoking, obesity, and exercise (Berkman and Syme 1979 cited in Guzman et al. 2005, p.2).

Children can also suffer negative health effects from displacement. Gilman et al. (2003) found that increased mobility in childhood (moving 3 or more times by the age of 7) resulted in a 36% increased risk of developing depression.

The lack of availability and inadequate quality of housing, including housing insecurity, plays a critical role in poor physical and mental health, mediated by the housing itself and the material deprivation that accompanies it (Marmot 2010). Children living in bad housing are at greater risk of suffering anxiety and depression, respiratory and other long-term health problems, and poor mental and physical development than other children (Harker 2006).

Cold housing, which is the ideal environment for damp, is a risk factor for the development of asthma in children (Barnes et al. 2008). A report for the Scottish Office (Wilkinson, 1999) found that there is ample evidence, from different studies, to suggest that cold, dampness and mould in housing are linked with illness in children, particularly respiratory symptoms. This link has been acknowledged by the British courts, which have awarded compensation for asthma aggravated by mould and damp.

Poor mental health has also been linked with poor, especially cold housing. Both children and adults are at increased risk of anxiety and depression. Children, particularly, can suffer from reduced motivation and increased psychological symptoms, independently of household income, if they live in poor quality housing (Evans et al. 2001, cited in Marmot Review Team 2011, p. 31).

While there is considerable evidence that living in cold homes affects illness and mental health, the most serious effect is its contribution to Britain’s unusually high rates of excess winter deaths (EWD) (Hills 2011). The occurrence of EWD is increased in colder homes, and studies have found a negative association between EWD and domestic heating (MRT 2011). EWD are caused primarily by respiratory (40%) and circulatory diseases (33%) due to cold homes in cold weather (Power et al. 2009; DH 2007).

People over 75 years old are most likely to suffer excess winter deaths for physiological reasons (El-Ansari and El-Simily 2008; Woodhouse et al. 1993). And, because they are more likely to need to heat their home for most of the day, rather than just at either end, they are also more likely to experience fuel poverty, as are children and those who are ill or disabled (Power et al. 2009; DH 2007). People in these groups may also be more likely than others to be living on a fixed income, and therefore to be more affected by changes to pensions and benefits.

As well as EWD, cold housing can cause circulatory, respiratory and mental illnesses, although these are more difficult to measure. The evidence for increased respiratory disorders during winter is based primarily on an increase in people’s contacts with their GP or admissions to hospital. However, a study in Newham was able to link excess winter mortality with a fuel poverty index for people over 65 years old, suggesting that factors such as energy inefficient accommodation and low income can lead to respiratory disease in the elderly during the winter months (Rudge and Gilchrist 2005).

As housing becomes less affordable, the risk of homelessness increases, as some people find it more difficult to find and sustain a tenancy. Homelessness contributes to a number of physical, behavioural and mental health problems in adults...
and children. Firstly, as individuals and families are moved into temporary accommodation, overcrowding becomes more likely. This has been found to contribute to morbidity from respiratory infections and activation of tuberculosis. If such accommodation is substandard and lacking efficient heating, adequate hot water supply, and adequate facilities for food storage and waste disposal, then the risk of the spread of infectious diseases is increased. Homeless people living in shelters have significantly higher age-adjusted death rates than the general population. Additionally, a 1994 study of children living in homeless shelters in the Los Angeles area found that 78% of the children interviewed suffered from depression, a behavioural problem, or severe academic delay (Guzman 2005).

Homeless people who do not live in temporary accommodation have especially poor health outcomes. The average life expectancy for a rough sleeper is only 42, compared with the national average of 76 for men and 79 for women. However, staying in hostels, overcrowded, temporary or substandard accommodation can lead to common health problems include respiratory conditions, foot conditions and dental problems, as well as mental health problems, which can be both a cause and consequence of homelessness (Crisis 2011).

Limitations of the evidence

Studies linking health with income gradient use a range of methods for representing and calculating the income component. Few published studies express their results in sufficient numeric detail to enable them to be used for estimating future effects in other populations.

Some categorisations (e.g. quintiles) may disguise the effects of financial austerity. If, as with the case of most of the benefits changes, cuts are concentrated mainly on those already in the most deprived income quintile, then while the people in this group are becoming poorer this will not necessarily result in transition from one quintile to another and there will be no change in the category.

Where adverse health-related behaviours are differentially associated with socio-economic or income categories (for example, smoking rates) then when people move between categories the extent to which they subsequently comply with the norms of the new category are unclear.

Evidence of association is not in itself proof of causation. For example, a rise in homicides that follows a rise in unemployment does not necessarily prove that being unemployed causes a person to murder or be murdered. It is possible that some other factor is both the cause of unemployment and of homicides. What can be concluded, however, is that the changes in income, employment and housing issues appear to predict with some confidence, a number of important impacts on health and wellbeing. Attempting to predict these impacts for people in Lewisham, not to prove causation, is the aim of this analysis.

Constructing a diagrammatic representation of the evidence for the relationship between social determinants and health

The studies presented in this section constitute good evidence of an association between reduced income and income inequality, unemployment, fuel poverty and poor housing and homelessness and many different aspects of health and wellbeing. The diagrammatic model on page 23 attempts to summarise these associations.

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Figure 8
Diagrammatic representation of the association between income inequality and the loss of discretionary income, poor housing, homelessness and fuel poverty and reduced health and wellbeing.

Unemployment → Loss of Discretionary income → Dependent income

Job Insecurity
- Greater income inequality
  - Increased homicide
  - Higher mortality
  - Depression
  - Increased suicide

Unaffordable housing
- Increased CVD mortality
- Higher SMR
- Increased lung cancer mortality
- Poor self-reported health
- Increased homicide
- Domestic Violence
- Increased suicide
- Psychological distress
- Alcohol abuse
- Poor mental health

Poor housing
- Depression
- Anxiety
- Stress
- Increased CVD mortality
- Increased respiratory disease
- Increased suicide
- Childhood asthma
- Excess winter deaths
- Heart attacks
- Strokes
- Poor mental health
- Increased substance abuse
- Poor health outcomes
- Increased mood and anxiety disorders
- Food insecurity
- Poor child health

Fuel poverty
- Poor mental health
- Increased CVD mortality
- Increased respiratory disease
- Increased suicide
- Childhood asthma
- Excess winter deaths
- Heart attacks
- Strokes
- Poor mental health
- Increased substance abuse
- Poor health outcomes
- Increased mood and anxiety disorders
- Food insecurity
- Poor child health

Reduced income
- Increased CHD
- Redundancy
- Job insecurity
- Increased CHD
- Depression
- Stress

Fuel poverty
- Social isolation
- Early death
- Childhood depression

Homelessness
- Childhood depression and behavioural problems
- Increased respiratory disease
- Spread of infectious disease
- Lower life expectancy
- Tuberculosis
- Mental health problems
- Foot conditions
- Dental problems
2.5 Assessing the Likely Impact of the Financial Crisis on Health and Wellbeing in Lewisham

In the previous section we identified a considerable body of evidence for the negative relationship between loss of income, income inequalities, unemployment, fuel poverty and housing issues and health and wellbeing. Independent analyses suggest that these socio-economic consequences of the financial crisis will disproportionately affect London due to demographics, higher living costs and the nature of its housing and employment markets (London Health Inequalities Network 2011). For example, the following commentators have said:

- **London Councils** - London will contribute 68% of Local Housing Allowance (LHA) savings, despite accounting for only 16.9% of the sector nationally; 82,000 London households are at risk; 10;

- **Greater London Authority** - Number of homeless households and households placed in temporary accommodation across London could increase by 4,865 by March 2012 11;

- **National Housing Federation** - 114,000 London households (71%) may be forced to seek cheaper accommodation elsewhere 12;

- **Institute of Fiscal Studies / New Policy Institute** - Tax and benefit changes on Londoners, amounting to 5.7% of net income for poorest fifth and 1.7% for richest fifth 13;

- **Job Centre Plus** - 175,000 Londoners are likely to be re-assessed as ‘fit to work’, with 135,00 moving to Employment Support Allowance and 40,000 to Job Seekers Allowance 14;

- **Work Foundation** - Migration of unemployed young people to London is predicted from areas of the UK more dependent on public sector employment 15; and

- **London Voluntary Services Council** - More people are in debt arrears in London than any other region and youth unemployment is higher in London than the rest of the UK. 81% of London voluntary services are reporting increased demand on their services at the same time as 54% expect to have to close services 16.

This section builds on the evidence from the previous section and summarises the health impact that the financial crisis has had and is likely to have in Lewisham through:

a) Describing the changes that have already happened in Lewisham and those that are likely to result in the areas of employment, income, and housing;

b) Understanding the extent of the health impact on the general population of Lewisham in relation to those areas, including identifying which population groups are likely to be most affected and the scale of the risk (a cumulative impact is expected for some groups);

c) Identifying a number of baseline measures to enable us to track the impact over the next few years;

d) Providing an analysis which can be used to inform strategic planning for mitigation of the impact.

### Loss of discretionary income in Lewisham

There has been and will continue to be a reduction in discretionary income for many Lewisham residents, including:

- those already receiving benefits, where entitlement has been reduced or restricted
- those who have lost employment and are new benefits claimants
- those still in employment who have had their wages frozen or pensions cost increased.

The average earnings for Lewisham residents are lower than those for London and have reduced since 2009. In 2011, average resident annual earnings in Lewisham were £29,476 compared with £31,935 for London 17. Lewisham average resident earnings were £400 less in 2011 than in 2010 (£29,880) and the same as in 2009 (£29,477). The impact of this reduction will be greater due to the increased cost of living during that period. The average resident earnings in some London boroughs have increased during that time (e.g. Croydon, Ealing and Hackney), although overall there has been a reduction in London average resident earnings.

The number of benefits claimants has risen since August 2008. The following figure 9 shows total claimants in Lewisham, by quarter. The total number was fairly steady (allowing for natural variation) in the period to November 2006. It was lower in the period February 2007 to August 2008, then rose sharply, before stabilising from February 2009 – May 2011 at a level 8% higher than the average for period to August 2008 (see Appendix 2 for more detail).

![Figure 9](http://www.nomisweb.co.uk/). All data has been rounded to the nearest 5 at the source
There was a substantial drop in the number of people receiving out-of-work benefits from August 2006 to August 2008, followed by a very steep rise from August 2008 to August 2009 after which the position apparently stabilised. The steep rise from August 2008 is seen in every ward.

The number of people in Lewisham receiving Carer’s Allowance has risen steadily throughout the ten-year period.

Data for disabled people is only available from May 2002. Numbers in Lewisham increased steadily over the period.

The number of carers and people with disabilities claiming benefits has steadily increased in Lewisham during the last ten years. This increase does not appear to be related to the crisis. The increase could reflect an increase in the number of people eligible for benefits, but is more likely to reflect a sustained effort to increase benefit take up. This is yet another indicator of the number of people living in Lewisham on low income.

Despite the fact that the number of people on benefits has increased due to increased levels of unemployment and for other reasons, there is also likely to be a decrease in the numbers claiming some benefits on account of the policy direction of encouraging people off benefits and into work. Government policy is heralding a new relationship between the state and individual with respect to employment, housing and income; in particular, reassessment of incapacity benefit recipients, and changes to housing and welfare benefits. Two such examples are Incapacity Benefit and the Lone Parent Allowance.

There was a steady increase in the number of ESA and Incapacity Benefit claimants in the period to February 2005. From then the position is unclear. It is consistent with a slower steady rate of increase over the whole of the rest of the period, and also with an even slower rate of increase to February 2009, a rapid rise from February 2009 to August 2009, and no underlying increase thereafter.

Job Centre Plus is in the process of reassessing most people on Incapacity Benefit to assess their capability for work. Those assessed as fully capable of work will be invited to make a claim for Jobseeker’s Allowance or will move off benefit into work. Those who cannot work or have limited capacity to work will move to Employment Support Allowance. The reassessments in Lewisham began in April 2011, when there were 10,040 people claiming Incapacity Benefit (the 7th highest in London). A large proportion of the Lewisham Incapacity Benefit claimants have mental and behavioural disorders (4,840).

---

19 Carer’s Allowance is payable to those who are aged 16 or over and spend at least 35 hours a week caring for a person who is receiving one of the following benefits: Attendance Allowance; Disability Living Allowance (at the middle or highest rate for personal care); Constant Attendance Allowance at or above the normal maximum rate with an Industrial Injuries Disablement Benefit; Constant Attendance Allowance at the basic (full day) rate with a War Disablement Pension. Recipients must not be in full time education or earn more than £100 per week after deductions.
The general and accelerating fall in the numbers of people claiming lone parents’ benefits needs to be seen against a background of a series of restrictions in eligibility for these benefits. From 24 November 2008, if a lone parent’s youngest child was aged 12 or over, or would have been 12 in the next year, their Income Support may have stopped during that year. From 26 October 2009, if a lone parent’s youngest child was aged 10 or over, or would have been 10 in the next year, their Income Support may have stopped during that year. From 25 October 2010, if a lone parent’s youngest child is aged 7 or over, or turned 7 in the next year, their Income Support may stop during that year. Income Support is only one of a range of benefits payable to lone parents (others include In Work Credit, Jobseeker’s Allowance, and some childcare costs).

In addition, it has been estimated that there will be around 900 households claiming benefit in Lewisham affected by the benefit cap of £500 per household to be introduced in April 2013.

About a third of employed Lewisham residents work within the borough. As most employment within the borough is in the public sector, this means that a higher proportion of employed residents, compared with other boroughs, will have reduced discretionary income due to pay freezes and increased pension costs.

Table 2
Incapacity Benefit claimants by health condition in Lewisham 2011

<table>
<thead>
<tr>
<th>Health condition</th>
<th>Claimants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Behavioural disorders</td>
<td>48%</td>
<td>4,840</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>5%</td>
<td>500</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>4%</td>
<td>400</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>14%</td>
<td>1,400</td>
</tr>
<tr>
<td>Other conditions</td>
<td>29%</td>
<td>2,900</td>
</tr>
<tr>
<td>All Conditions</td>
<td>100%</td>
<td>10,040</td>
</tr>
</tbody>
</table>

Figure 14
Lone parent benefits claimants in Lewisham, by quarter

Health impact predicted by reduced income and income inequalities

As stated in section 2.4, there is a wealth of published studies from around the world linking poor physical and mental health to income inequality and reduced income.

The increasing gap between Lewisham residents with stable incomes and those affected by the crisis predicts increased mortality levels (Elstad, 2011, Quick and Wilkinson 1991).

The reduced discretionary income for many people in Lewisham predicts poorer health outcomes (Muennig, 2008, Benzeval et al. 2000), including an increased risk of anxiety, mood or substance use disorders (Sareen et al. 2011).

A consequence of increased numbers of people with reduced discretionary income in Lewisham will inevitably mean more people in debt or in fear of debt, which in turn is likely to be associated with depression independently of job insecurity (Meltzer et al. 2010). Additionally, there is likely to be an increase in both onset and duration of episodes of common mental disorders as levels of financial stress increase (Welch et al. 2008).

Three in five people seeking debt advice reported having received treatment, medication or counselling as a result of debt related health problems (London Health Forum). Others found that 91% of people with personal debt reported deterioration in their mental health, notably through stress and depression (Meltzer et al. 2010). The numbers of people seeking debt advice has increased in Lewisham over the past few years. In the period January-March 2012, 254 people received debt advice from services in Lewisham (LB Lewisham local data). If the rate of people seeking debt advice remains constant throughout the year, and if the Suffolk percentage applies to Lewisham, then we can expect an additional 925 people in Lewisham to experience deteriorated mental health from financial stress in 2012.

It is clear that the health status of children living in Lewisham will deteriorate, given the increasing numbers of children living in poverty. There is a strong link between poverty and poor health status, even temporary poverty (Sell et al. 2010).

There is a strong negative correlation between healthy lifestyles and deprivation. As a result of the changes to income described above we can therefore expect to see increasing levels of alcohol misuse and smoking, and decreasing levels of physical activity.

Employment in Lewisham

Until the economic recession, employment levels in Lewisham have been buoyant and have risen in line with London. Seven in 10 of those residents in work, work outside the borough, principally in central London. However this means that almost a third of employed, Lewisham residents work within
the borough. As most employment within the borough is in the public sector\textsuperscript{25}, this means that a higher proportion of employed residents than other boroughs will have been made redundant, or are at risk of redundancy.

There are rising levels of unemployment in Lewisham, with an increasing proportion that are long term unemployed. Historically, Lewisham has had higher unemployment rates than London, and London than England and Great Britain. This has been true throughout the current financial crisis. Figure 15 shows unemployment rates for Lewisham, London, and Great Britain for rolling quarterly 12 month periods from January to December 2009 to July 2010 to June 2011\textsuperscript{26} (the most recent data available at the time of writing).

![Figure 15](image-url)

Figure 15
Unemployment Rate (%) January 2008 - June 2011
Rolling 12 months periods

Unemployment rates for Lewisham, London and Great Britain rose steadily over the period 2008 to 2011, but the underlying trend for Lewisham is steeper than for London and Great Britain. The number unemployed at the end of the period (15,000) represents a 38% increase from the start of the financial crisis.

Lewisham now has an unemployment rate of 10.2%, which is the same as the overall rate for Inner London. This is based on modelled data, which combines survey results with Jobseeker’s Allowance (JSA) claimant rates.\textsuperscript{27}

This picture is confirmed when examining data about JSA claimants. Figure 17 shows JSA claimants in Lewisham, by quarter, 2000 - 2010.

![Figure 17](image-url)

Figure 17
JSA claimants in Lewisham, by quarter, 2000 - 2010

Allowing for fluctuations, there was a general decline in the JSA claimant rate in the period to May 2008 (Figure 17). It then rose sharply and has continued to rise steadily in Lewisham since the initial sharp rise of 2009/10, with 10,567 JSA claimants in November 2011.

![Figure 18](image-url)

Figure 18
JSA Claimant Rate Jan 07-Nov 11 for Lewisham, of persons aged 16 - 65, Lewisham, London & Great Britain

The claimant rate in Lewisham has long been above the national and London average, but after narrowing slightly in 2008/09, the gap has increased again more recently. In November 2011 the JSA claimant rate in Lewisham was 5.6% (Figure 18).

Lewisham has the lowest proportion of JSA claimants who have been claiming for more than 12 months (16.9%) in Inner London. This is well below the overall Inner London rate of 23.9%. One possible explanation for this is that Lewisham residents tend to do low-paid, often short-term work, leading to a high ‘churn’ of JSA claimants. However, the number of long-term claimants has recently overtaken the number of short term claimants, suggesting that the increase in unemployment is becoming structural (Figure 19).

In October 2011, the number of people in Lewisham claiming JSA for more than 6 months overtook those claiming for less than 13 weeks. This is potentially significant for an area like Lewisham, where there has always been a high rate of ‘churn’ of JSA claimants.

\textsuperscript{25} Lewisham Strategic Partnership

\textsuperscript{26} Model-based data from ONS’s Annual Population Survey, sourced at [http://www.nomisweb.co.uk/reports/lmp/la/2038431868/subreports/ea_time_series/report.aspx](http://www.nomisweb.co.uk/reports/lmp/la/2038431868/subreports/ea_time_series/report.aspx)

\textsuperscript{27} Model-based data from ONS’s Annual Population Survey, sourced at [http://www.nomisweb.co.uk/reports/lmp/la/2038431868/subreports/ea_time_series/report.aspx](http://www.nomisweb.co.uk/reports/lmp/la/2038431868/subreports/ea_time_series/report.aspx)
One in four JSA claimants is aged 18–24 years (2,490), which is broadly similar to other inner London boroughs. However, Lewisham has one of the highest claimant rates among young males (Figure 20).

In particular, the traditional churn of young JSA claimants in Lewisham has started to slow down. The historically low number of long-term JSA claimants in Lewisham has risen since the recession, with a particularly dramatic rise in the last six months of 2011. This is illustrated in (Figure 21), which shows that the number of long-term JSA claimants aged 18-24 in December 2011 was nearly five times as high as it was in June 2011. Figure 22 places the rise in long-term 18-24 year old claimants within the wider context of overall young claimants.

Compared with other age groups, young people have been particularly vulnerable to the economic recession.

Health impact predicted by unemployment

It has already been established that unemployment is closely associated with a variety of detrimental health events and effects.

The impact on health associated with unemployment is likely to be high in Lewisham, due to the high and rising levels of unemployment. Particularly worrying is the apparent move to structural unemployment in Lewisham. Although the impact will be on the general population, some groups will be affected more than others. Young people in Lewisham, aged 18 to 24 will be particularly affected. The impact will be even greater on young black men, who are already overrepresented among the unemployed.
Overall, mortality is predicted to increase in Lewisham and, as unemployment is more likely to affect those from the lower end of the socioeconomic scale, this group will be affected more. There will be an increase in premature mortality from CVD and lung cancer, associated with relative socioeconomic status, poverty and financial anxiety, all of which are frequent outcomes of unemployment.

Redundancy predicts an impact on life expectancy rates for Lewisham. It has been found that job displacement is associated with a 15-20% increase in death rates during the following 20 years and if such increases were sustained beyond this period, they would imply a loss in life expectancy of about 1.5 years for a worker made redundant at age 40 (Sullivan and von Wachter, 2007).

As stated earlier, various studies have found that increased levels of unemployment are associated with increased suicide rates (Giuntoli 2011, Stuckler et al. 2009, Kentikelas et al. 2011). The association has been confirmed in Lewisham, with the suicide rate appearing to have increased in line with rising unemployment since 2007. By mid 2011 there had been a 38% increase in unemployment over the position at the start of the financial crisis. We can therefore expect an increase of 30-54% over the suicide rate for 2007.

**Figure 23**

Suicide rates in Lewisham29 (Directly Age Standardised Rates/100,000 Standard European Population) from 2007-2010 and percentage of the population aged 16-64 claiming JSA29 from at the end of years 1997 to 2010, together with the correlation statistics30.

While unemployment was falling, to year 2007, suicide rates also declined. However, unemployment has risen steadily since 2007, and suicide rates appear to have increased also (as absolute numbers are quite small there is some variability between years). Suicide rates for 2011 are not yet available, but JSA claimant rates at December 2011 were 5.6%, higher than any year since 1998. It seems likely that the effects of the financial crisis will include suicide rates between 3.6 and 4.5 per 100,000, and an equivalent increase in the actual number of suicides31. The effect may be even higher than this in the future, given the disproportionate effect of unemployment on young men, which is also the population group with the highest suicide rate.

The suicide rate is not the only indicator of mental health problems. Research has suggested that 26.4% of unemployed people report poor mental health, compared with 13.6% of employed people (Artazcoz et al. 2004). When applying this to Lewisham, (where we have seen that by mid 2011 there had been a increase in unemployment over the position at the start of the financial crisis of approximately 4000 persons), we can estimate 500 more mentally ill people in Lewisham as a result of the financial crisis32. This number will increase if the unemployment figures continue to rise.

Twice as many unemployed people are at risk of domestic violence compared with employed people (Macmillan et al. 2005). The Lewisham Jobseeker’s Allowance rate (as a proxy for unemployment) was 2.2% at the start of 2007/8 and 4.4% at the end of 2011-12. Applying these rates to the GLA’s population projection for working age women (aged 16-59) for 2007 (89992) and 2011 (95653), we get derived numbers of JSA claimants of 180 at the start of the period and 2077 at the end. Applying the US study’s (Macmillan et al. 2005) rate of 10.6% for unemployed women we estimate that there were 210 victims of serious domestic violence in 2007-8 and 432 in 2011-2.

Involuntary redundancies in Lewisham are likely to lead to high levels of depression even three months following the redundancy, when employment has been secured (Waters 2007). Major impacts on mental well-being are likely, including financial strain due to income loss, loss of daily structure and social role, and feelings of frustration and stigma (Giuntoli 2011).

Anecdotaly, Lewisham GPs have already noticed an increasing number of consultations, which reflect study findings of increases in both major and minor illnesses among patients dated from when redundancies were first announced, before people actually became unemployed (Quick and Wilkinson 1991).

It is likely that there will be an increase in the numbers of Lewisham residents in insecure or low paid jobs as a result of the economic downturn (Siegrist et al. 2009, Meltzer et al. 2010), leading to increased risk of suffering from stress and other common mental disorders (Marmot 2010), depression (Meltzer et al. 2010) and minor psychiatric morbidity (Laszlo et al. 2010). The impact is likely to be greater on older employees (Cheng and Chan 2008).

**Poor housing, fuel poverty and homelessness**

There are 117,340 households in Lewisham. Most of these are within the private sector (82,663), including owner occupied and privately rented33. A steep rise has been identified in the private rented sector in Lewisham in period 2001-2010. The size of the privately rented sector has doubled from 14.3%
of households in 2001 to 28% in 2010\textsuperscript{34}. There are currently 57 registered social landlords in Lewisham together with the ALMO\textsuperscript{35}. Overall there are nearly 35,000 social housing properties, which include supported housing for the elderly and adapted accommodation for disabled people.

Figure 24
Tenure of dwellings in Lewisham 2007 (household survey)

Towards the end of 2011 there were 28,168 households in Lewisham claiming housing benefit (excluding those aged 65 and over who are not affected by the changes)\textsuperscript{36}. More than 50% of these were also claiming income support (17,353) and about 50% were households with children (14,613). New young tenants aged between 16-24 represented over 1,500 of the housing benefit claimants.

Larger households are more likely to find that their rent is unaffordable. Most households claiming housing benefit in Lewisham are between 1 and 3 people, however, there are more than 2,000 households with 5 or more people and about 100 with more than 7 people.

Table: 3
Household size of housing benefit claimants in Lewisham\textsuperscript{37}

<table>
<thead>
<tr>
<th>Persons in household</th>
<th>Number of households</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13112</td>
</tr>
<tr>
<td>2</td>
<td>7277</td>
</tr>
<tr>
<td>3</td>
<td>5107</td>
</tr>
<tr>
<td>4</td>
<td>2985</td>
</tr>
<tr>
<td>5</td>
<td>1310</td>
</tr>
<tr>
<td>6</td>
<td>441</td>
</tr>
<tr>
<td>7</td>
<td>180</td>
</tr>
<tr>
<td>8</td>
<td>66</td>
</tr>
<tr>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30515</strong></td>
</tr>
</tbody>
</table>

It is likely that there will be an increase in Lewisham of people living in poor housing or homeless due to the increasing costs of housing and reduced discretionary income, including changes in entitlement to benefits. Recent statistics from Trading Standards show that of those people who have resorted to illegal loans, 35% of the loans were to cover housing costs.

As the Local Housing Allowance changes come in, many Lewisham residents are likely to find that their rent is unaffordable. This may be due to rising rents and reduced income. One group, which will be particularly affected by the changes, are people on housing benefit living alone aged over 25 and under 35 years old, whose entitlement will change to shared room only.

From data held by Lewisham Council\textsuperscript{38} at November 2011, within Lewisham there are almost 2,300 people aged between 25 and 35 who will be affected by this change. More than 60% of the total are male. More than 6% of the total are classified for benefits purposes as disabled. These people will be disproportionately affected, as their income will also be reduced as a result of the changes in disability benefits. Detailed figures are shown in Table 4.

Table: 4
Numbers of people on Housing Benefit, living alone aged 25-35 November 2011

<table>
<thead>
<tr>
<th></th>
<th>Not disabled</th>
<th>Blind</th>
<th>Disabled</th>
<th>Total potentially affected</th>
<th>Severely Disabled</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td>1328</td>
<td>1</td>
<td>91</td>
<td>1420</td>
<td>113</td>
<td>1533</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>806</td>
<td>55</td>
<td>861</td>
<td>939</td>
<td>78</td>
<td><strong>939</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>2134</td>
<td>1</td>
<td>146</td>
<td>2281</td>
<td>191</td>
<td><strong>2472</strong></td>
</tr>
</tbody>
</table>

Local Housing Allowance (LHA), the housing benefit applicable to those who rent in the private sector, is not constant, but varies by area (known as Broad Rental Market Areas, or BRMAs), and from month to month. BRMAs are decided by the Valuation Office Agency (VOA) of HMRC. Lewisham includes parts of two BRMAs, Inner South East London and Outer South East London\textsuperscript{31}. The boundaries of these are not coterminous with local authority or ward boundaries. Visual inspection of VOA’s maps suggest that most of Lewisham is within the Inner South East London BRMA, but Bellingham, Downham, Grove Park and substantial parts of Whitefoot and Lee Green wards are in Outer South East London BRMA. LHA rates are higher in Inner South East London BRMA. In February 2012, the shared room rate for Inner SEL BRMA is £85.38 per week, and that for Outer SEL BRMA is £76.15.
On a best-fit with wards estimate, of the 146 disabled people affected by this benefit change, 76 are currently receiving higher LHA than they will be entitled to after the reforms, and thus face a shortfall. Of these, 24 face a loss of between £50 and £100 per week, six face a loss of between £100 and £200 per week, and three face a shortfall of over £200 per week. Of the 2134 non-disabled people affected by this change, 1173 are currently receiving higher LHA than they will be entitled to after the reforms, and thus face a shortfall. Of these, 415 face a loss of between £50 and £100 per week, 244 face a loss of between £100 and £200 per week, seven face a shortfall of over £200 per week.

This change will impact on 76 people with disabilities and more than a thousand non-disabled people. The impact will take various forms including worse quality housing, mobility and increase in homelessness. It is likely that many of these Lewisham residents are vulnerable, have less resilience to cope with these changes and therefore the impact will be even greater.

The greatest concentration of non-disabled people who stand to lose from this change is in Lewisham Central and New Cross wards, with areas of high concentration in Brockley, Rushey Green and Forest Hill wards. The wards with the greatest concentration of disabled people who stand to lose from this change are Lewisham Central, Rushey Green, Crofton Park and Sydenham. The smallest number is in Ladywell.

The number of households living in fuel poverty in Lewisham has almost doubled since 2006, when there were 8,153 households. In 2009 there were 14,882 households (14%) in fuel poverty.

Official figures at borough level are less up to date, but when the topic was discussed in Parliament in November 2011 the following figures were referred to for South East London:

<table>
<thead>
<tr>
<th>Region</th>
<th>2006</th>
<th>2008</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>8,074</td>
<td>8,193</td>
<td>1.5%</td>
</tr>
<tr>
<td>Bromley</td>
<td>9,939</td>
<td>11,182</td>
<td>12.5%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>7,778</td>
<td>10,901</td>
<td>40.2%</td>
</tr>
<tr>
<td>Lambeth</td>
<td>8,385</td>
<td>11,649</td>
<td>38.9%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>8,153</td>
<td>13,704</td>
<td>68.1%</td>
</tr>
<tr>
<td>Southwark</td>
<td>7,840</td>
<td>12,309</td>
<td>57.0%</td>
</tr>
<tr>
<td>SE London</td>
<td>50,169</td>
<td>67,938</td>
<td>35.4%</td>
</tr>
</tbody>
</table>

Thus we see that Lewisham experienced the greatest increase in the percentage of households in fuel poverty over this period and the greatest increase in absolute numbers, and by 2008 had the highest number of households living in fuel poverty in South East London.

The latest data available at sub-borough relates to the position in 2008. The Lower Super Output Area (LSOA) with the highest proportion of households in fuel poverty was in the north of Brockley ward. There were LSOA in New Cross, Telegraph Hill and Lewisham Central ward with high rates also. Bellingham and Downham wards had area with higher proportions than the borough average. In most of the borough the proportion of households in fuel poverty was between 9% and 13%.

Health impact predicted by poor housing, fuel poverty and homelessness

Poor health outcomes and inadequate nutrition, particularly for children, are predicted in Lewisham, on account of the increase in the number of households living in unaffordable housing, especially when they spend more than half of their incomes on housing (Guzman et al. 2005).

Lewisham men and women, who are heads of households, will have poorer mental well being associated with unsustainable housing commitments (Taylor et al. 2007).

Some Lewisham residents will be forced to move within Lewisham to find affordable housing and it is also likely that people will move into Lewisham from other parts of London where house values are greater and housing even more unaffordable. This predicts an increased risk of early death with the loss of social support networks (Berkman and Syme 1979). Moreover those children having to move three times before they are seven years old will be at increased risk of depression (Gilman et al. 2003).

Poor physical and mental health is predicted from more Lewisham residents living in inadequate quality and insecure housing (Marmot 2010). Children, people with physical disabilities and those aged over 75 are more likely to be affected (Power et al. 2009; DH 2007).

The number of children living in bad housing will increase and therefore more of Lewisham’s children will be at greater risk of suffering anxiety and depression, respiratory and other long-term health problems, and poor mental and physical development (Harker 2006).

There is likely to be an increase in asthma and respiratory problems among Lewisham children associated with increasing numbers living in cold, damp housing (Barnes et al. 2008, Wilkinson 1999).
Poor mental health will increase in Lewisham. More children and adults will be at increased risk of anxiety and depression and children, particularly, are likely to suffer from reduced motivation and increased psychological symptoms, independently of household income (Evans et al. 2001).

There is likely to be an increase in excess winter deaths (EWD) in Lewisham (Hills 2011), caused primarily by respiratory (40%) and circulatory diseases (33%) due to cold homes in cold weather (Power et al. 2009; DH 2007), especially among people over 75 years old (El-Ansari and El-Simily 2008; Woodhouse et al. 1993).

There is likely to be an increase in the spread of infectious diseases, in Lewisham, e.g. tuberculosis. This will be on account of increasing numbers of people living in substandard accommodation (lacking efficient heating, adequate hot water supply, and adequate facilities for food storage and waste disposal) and temporary and overcrowded accommodation.

Poorer health outcomes will also result in Lewisham as a result of increases in homelessness. There will be increasing numbers of children with physical and mental health problems, including, depression, behavioural problems and severe academic delay (Guzman 2005). Homeless adults living in Lewisham will be more likely to die, especially those living rough (who already have a very low life expectancy of 42 years). Staying in hostels, overcrowded, temporary or substandard accommodation will lead to common health problems include respiratory conditions, foot conditions and dental problems, as well as mental health problems.

Key messages and other considerations

Some health impacts only arise in association with one social determinant and others are linked to several determinants, which may themselves be interlinked. This means that the impact on the mental health of Lewisham residents is predicted to be particularly large as income, employment and housing all have a significant association with mental health. Approximately 500 additional people are predicted to develop mental illness in Lewisham as a result of unemployment alone.

Moreover, some groups of Lewisham residents will be disproportionately affected by the changes. The health of children, for example, is likely to be particularly severely affected because of the associations with income, employment and housing changes. Young men, in particular young black men, are disproportionately affected by unemployment, which is likely to be associated with significant mental health problems, including increased suicides.

Some groups of people will be less resilient to the changes and reductions in income than others if they have fewer social support networks or are more vulnerable and are less able to cope with change.

Monitoring the changes in Lewisham over the next few years

Lewisham Council and health service commissioners need to monitor changes in housing, employment, income and demographics in the coming years, as well as their known health effects, in order to:

- Plan services (e.g. education, primary care);
- Maintain public health programmes (e.g. child immunisation, cancer screening);
- Maintain delivery of statutory duties (e.g. child and adult safeguarding);
- Identify groups or individuals that may be adversely affected by the changes (e.g. homeless);
- Support statutory health and equalities impact assessments of service reconfiguration; and
- Facilitate collaboration and negotiation between boroughs and with national Government (including supporting bids for ‘discretionary funding’).

Whilst data are available at a local level, the anticipated movement of households between different boroughs, and differential impact of change at a local level, suggests that a pan-London view of these impacts is required.

Changes in housing, employment and income are inherently linked, and compound each other to affect health and social outcomes in the short, medium and long term. For example, children and young people in households suffering housing, employment and/or income instability are at greater risk of poor mental health, domestic violence, substance misuse, truancy, undertaking anti-social behaviour, etc. Cost for all these consequences are borne across services and sectors (e.g. local authorities, police, schools, etc.), hence there is a need for coordinated monitoring and preventative actions.

A challenge persists as the consequences of the recession, welfare reform and changes to public services take effect. It is therefore imperative to monitor if predicted local housing, employment, income and health outcomes become reality and whether sufficient preventative services are in place.
This section identifies routinely measured key indicators, which could be used to monitor the changes currently occurring or predicted to take place in Lewisham as a result of the financial crisis. A range of criteria was used in the selection of the indicators, including:

- Indicators relating to factors for which there is an evidence base of impact;
- Availability and ease of collection;
- Comparability;
- Statistically meaningful when used to monitor changes at a local population level;
- Consistent with the new national public health outcomes framework

The recommended indicators are as follows:

**Socio-economic indicators**

Average earnings

Number of Jobseeker’s Allowance claimants

% Jobseeker’s Allowance claims for more than 6 months

Number of young people (18-24) claiming JSA

Number of people claiming ESA (incapacity benefit)

Number of people seeking debt advice

Number of children receiving free school meals, eligibility and uptake

School readiness measure

Number of people claiming housing benefit

Number of people moving in and out of borough and total population

Broad Rental Market Area values for Lewisham (Inner and Outer SE London)

The % of children who worry a lot about money\(^42\)

The % of children who usually get spending money

The % of those who got £5 or less when they were last given spending money

The % of children who have a regular job outside school term-time.

The % of children who worked for money in the week before the survey

**Health & Wellbeing Indicators**

Life expectancy

Mortality rates

Premature mortality for cancer

Premature mortality for CVD

Suicide rate

Incidence of tuberculosis

Alcohol related admissions to hospital

Asthma admissions to hospital of children

Reported cases of domestic abuse

Hospital admissions for severe and enduring depression

Prescriptions for anti-depressants

Physical activity levels

Diagnosed prevalence of long term conditions e.g. hypertension, asthma, chronic obstructive pulmonary disease

National Child Measurement Programme (NCMP) in Reception and Year 6 (identifies underweight, overweight and obese)

**Actions that may be taken to mitigate the health impact of the financial crisis**

There have been many actions taken within Lewisham since the crisis to mitigate the negative health effects on the population. This section seeks to suggest which of these actions should be prioritised and to identify new potential actions. All of these actions are:

- drawn from the evidence base regarding the effectiveness of interventions;
- informed by knowledge about which populations within Lewisham are most affected;
- focused on the most affected health outcomes.

This report can only flag up priorities for action where there is evidence of cost-effectiveness and where possible indicate the necessary scale of intervention required to achieve a significant effect in Lewisham. It is for those responsible for the commissioning and delivery of public services to identify the priorities for action within the finite resources available to them and to determine how and when these interventions might be developed and delivered.

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\(^{42}\) School Health Education Unit, Supporting the Health of Young People in Lewisham, A Summary Report of the Health Related Behaviour Survey
Suggested priority actions known to be cost-effective in mitigating the socio-economic consequences of the financial crisis

Maximise benefit take up in borough

Encourage local employers to advertise vacancies through Job Centre Plus, in local papers and on local websites

Encourage local employers to provide apprentice schemes

Invest in early years provision

Continue to prioritise and also increase the scale of the range of programmes provided by Lewisham Council that tackle fuel poverty:

Public health priority actions, identified in the emerging Health and Wellbeing Strategy for Lewisham that are known to be cost-effective in mitigating the negative health effects associated with reduced income, unemployment and housing issues

Increase the uptake of childhood immunizations

Prevent the uptake of smoking among children and young people and reduce the numbers of people smoking

Reduce the harm caused by alcohol misuse

Promote healthy weight

Improve mental health and wellbeing

Improve sexual health

Increase the number of people who survive colorectal, breast and lung cancer for 1 and 5 years

The Lewisham Health and Wellbeing Board, together with the wider Lewisham Strategic Partnership, will play a key role in agreeing and then implementing these and other priorities for action over the coming years.

The findings in this section are summarised in Table 6:
Table 6  
Assessing the likely impact of the financial crisis on health and wellbeing in Lewisham

<table>
<thead>
<tr>
<th>Socio-economic consequences of crisis</th>
<th>Current and expected socio economic changes in Lewisham</th>
<th>Estimated numbers or % affected</th>
<th>Health impacts predicted for Lewisham</th>
<th>Populations most affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of discretionary income</td>
<td>Average earnings have decreased to £29,476 and more than £2k lower than London</td>
<td>32-33,000 in total</td>
<td>Higher mortality rates</td>
<td>People with mental health problems</td>
</tr>
<tr>
<td></td>
<td>Number of benefit recipients has increased by 8% from 2008/11</td>
<td>1,600 receive disability benefits</td>
<td>Increase in suicide rate</td>
<td>Lone parents</td>
</tr>
<tr>
<td></td>
<td>Some benefit recipients lost income (lone parents, people on incapacity benefit)</td>
<td>1,600 receive carer’s allowance</td>
<td>Poorer health outcomes and self related health</td>
<td>People with physical disabilities/long term conditions</td>
</tr>
<tr>
<td>Reduced income among public sector employees – higher proportion than elsewhere</td>
<td>10,040 receive incapacity benefit, 4840 with mental health problems</td>
<td>2,500 lone parents lost benefit</td>
<td>Increased incidence of coronary heart disease</td>
<td>Pregnant women</td>
</tr>
<tr>
<td></td>
<td>Estimated 900 households affected by £500 benefit cap April 2013</td>
<td>Estimated 900 households</td>
<td>Increases in both major and minor illnesses among primary care patients</td>
<td>Young people aged 18 to 24</td>
</tr>
<tr>
<td></td>
<td>925 more people with deteriorating mental health</td>
<td>2,500 lone parents lost benefit</td>
<td>Major impact on people’s mental well-being</td>
<td>Young men aged 18 to 24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>925 more people with deteriorating mental health</td>
<td>Increased depression</td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>91% of those in debt had deteriorating mental health and stress</td>
<td>Increased common mental health disorders, including, depression &amp; mood and anxiety disorders</td>
<td>Adults in debt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 of 5 having debt advice receive treatment for depression</td>
<td>Increased substance misuse</td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Socio-economic consequences of crisis</th>
<th>Current and expected socio economic changes in Lewisham</th>
<th>Estimated numbers or % affected</th>
<th>Health impacts predicted for Lewisham</th>
<th>Populations most affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Unemployment is consistently higher than London and England</td>
<td>15,000 (10.2%) unemployed people 2,490 aged 18-24</td>
<td>Increased mortality</td>
<td>People with lower socio-economic status</td>
</tr>
<tr>
<td></td>
<td>Unemployment continues to rise (by 38% since 2008) and more steeply than London and England</td>
<td></td>
<td>Increased mortality from CVD</td>
<td>Young people aged 18 to 24</td>
</tr>
<tr>
<td></td>
<td>Moving from position of predominantly short term unemployment to structural unemployment</td>
<td></td>
<td>Increased mortality from lung cancer</td>
<td>Young men aged 18 to 24, especially young black men</td>
</tr>
<tr>
<td></td>
<td>Increased risk of redundancy among public sector employees – higher proportion than elsewhere</td>
<td></td>
<td>Reduced life expectancy</td>
<td>Men recently unemployed</td>
</tr>
<tr>
<td></td>
<td>Increased no. in insecure employment</td>
<td></td>
<td>Increased suicide rate – 7 - 9 more per annum</td>
<td>Older employed people</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Worse mental health, more people with mental health problems 500 more (2007/11)</td>
<td>People made involuntarily redundant in last 3 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increased of risk of people suffering from stress and other common mental disorders, depression and minor psychiatric morbidity.</td>
<td>Unemployed women</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increase in both major and minor illnesses presented to GPs</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Higher levels of depression</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Major impact on people’s mental well-being</td>
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<td></td>
<td></td>
<td></td>
<td>Increase in smoking prevalence</td>
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<td></td>
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<td></td>
<td>Increase in alcohol related harm</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Increased risk of domestic violence 222 more 2007/11</td>
<td></td>
</tr>
<tr>
<td>Socio-economic consequences of crisis</td>
<td>Current and expected socio economic changes in Lewisham</td>
<td>Estimated numbers or % affected</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>Housing, homelessness and fuel poverty</td>
<td>No. of households Private rented sector doubled since 2001 Social housing providers No. of under 65s claiming housing benefit Housing benefit claimants aged between 25 and 35 affected by shared room people 14% households in fuel poverty</td>
<td>117,340 14% - 28% 57 28,168 2,300 14,882</td>
<td>Increased risk of early death Poorer health outcomes Poorer nutrition Poorer mental well being Increased risk of depression Greater risk of suffering anxiety and depression Greater risk of respiratory and other long-term health problems Greater risk of poor mental and physical development Increase in asthma and respiratory problems Poorer physical and mental health Increase in CVD Increase in excess winter deaths Increase in infectious disease including tuberculosis</td>
<td>Single men aged 25 to 35 private sector tenants Children Heads of households (men &amp; women), adults, children Children who have moved more than 3 times under 7 years Children Children Children, people with physical disabilities and those aged over 75 Those aged over 75 People with disabilities</td>
</tr>
</tbody>
</table>
Section 3: Public Health Outcomes and Performance in Lewisham

Introduction

In January 2012 the Department of Health published “A Public Health Outcomes Framework”, which itemised a number of outcomes that it wished to see progressed from 2013 onwards. Many of these outcomes were known as “Vital signs” in the previous government’s arrangements. Lewisham Public Health in collaboration with colleagues in a range of agencies have been working on many of these outcomes for some years.

This section provides information on key public health outcomes and their indicators that have been tracked by Lewisham Public Health. Performance in these areas is important to the current and future wellbeing of the residents of Lewisham. Information is provided for each outcome on:

- performance in 2011-12
- benchmark data against England, London and other appropriate boroughs/ PCTs where available
- key actions identified for 2012-2013.
Increase Immunisation Rates

Performance

Uptake of immunisation has been a problem in Lewisham for some time. As a result, significant numbers of children in Lewisham are not protected against potentially serious infections. Due to the low uptake of MMR\(^43\) vaccine, there was an outbreak of measles in Lewisham in 2008 with a total of 275 confirmed or suspected cases. Action over recent years has resulted in considerable improvement in uptake but significant challenges remain. The most recent data (for the third quarter of 2011-2012) show that uptake of almost all vaccines continues to improve, including uptake of the preschool booster\(^44\) and of the second dose of MMR by the age of five (Figure 25). There is good news also on the Human Papilloma Virus (HPV) immunisation programme; the uptake of the first dose of HPV vaccine in Lewisham schoolgirls targeted in the 2011-2012 campaign is 83\%, a really significant improvement on the previous year when uptake was about 70\%. The final piece of good news this year is that for the first time in the 2011-2012 season, Lewisham has exceeded 70\% uptake of Influenza vaccine amongst the over 65s; even more impressively, uptake of the vaccine amongst frontline staff has increased almost five-fold.

A concern is that for the last three quarters the uptake of the third dose of diphtheria vaccine\(^45\) at the age of one has been about five percentage points lower than our best past performance. Immunising these children is particularly important because they are so vulnerable and because we are currently in the middle of a major national increase in the numbers of cases of whooping cough.

![Figure 25: Percentage uptake of vaccines in children under 5 in Lewisham](source: NHS London COVER data)

Benchmarking

In terms of uptake of vaccines, in the past Lewisham has not compared well with London, or with England as a whole (Figures 26,27,28 and 29). Implementation of the Lewisham Immunisation Action Plan has achieved much, especially in relation to the uptake of the first dose of MMR at the age of two (Figure 26). For the past year, NHS Lewisham Clinical Commissioning Group has adopted this indicator as a priority, and have been supported by Lewisham Public Health giving feedback to GP practices on their performance on this indicator and ensuring practical help for practices where improvement might have the greatest impact on the population as a whole. The result has been an increase in this indicator at a much higher rate than has occurred in London as a whole.

![Figure 26: Uptake of MMR1 in Lewisham children aged 2 years](source: NHS London COVER data)

Unfortunately, this level of improvement has not occurred in relation to other vaccines, especially the third dose of diphtheria vaccine at the age of 1 (Figure 27). For three quarters now, Lewisham’s performance has diverged from the upward trend for London and the rest of the country.

Uptake of the preschool booster and of the second dose of MMR also remains unacceptably lower than that for London and England as a whole (Figures 28 and 29), even though (in contrast with the story about D3 at 1), there has been a very encouraging improvement on both of these indicators.

![Figure 27: Uptake of DTaP/IPV/Hib in Lewisham children aged 1 year](source: NHS London COVER data)

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\(^{43}\) MMR aims to protect children against measles, mumps and rubella. Two doses are required: MMR 1 at 12 months and MMR 2 at any time after three months have elapsed since MMR 1, but before five years of age.

\(^{44}\) D4 is the fourth dose of diphtheria vaccine. This is a key component of the preschool booster, which should be given at any time from the age of three years and four months but before the child starts school.

\(^{45}\) Uptake of the third dose of Diphtheria vaccine (D3) is an indicator of completion of the primary course of immunisation of children under 12 months that aims to protect children against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae b and Group C Meningococcus.
Tackle Tobacco

Performance

Reduce smoking prevalence:
Reduce the prevalence of smoking in Lewisham among adults aged 16+ from 19.6% (Integrated Household Survey estimate) in 2010 to 15% by 2015. The target for 2011-12 is to reduce this to 17.3%. Prevalence data for 2010-11 will not be available until September 2012.

Stop the promotion of tobacco:
Reduce the smoking prevalence of young people aged 11-15 by 1% each year. The prevalence for 11-15s in 2010-11 is 4% of boys and 5% of girls. The target for 2011-12 is to reduce the prevalence to 3% of boys and 4% of girls. The percentage of 11-15s recorded as smoking will be reported in the bi-annual Schools Health Education Unit (SHEU) survey in 2012.

Regulate tobacco products effectively:
Target 2011-12: 100% follow up and compliance of any illegal sales. Measure: No of illegal sales reported by Trading Standards at a second test purchase after a breach. This target was achieved.

Reduce exposure to secondhand smoke:
Target: to reduce the number of children who are exposed to secondhand smoke in their home from 43% in 2010 to 35% in 2012. Measure: Number of children reporting someone smokes most days in their home in SHEU survey.

Motivate everyone who smokes to quit and help them to do so:
The Stop Smoking Service achieved 1080 quits at end Quarter 3 2011-12, including 28 pregnant women. Quarter 4 data will be available in June 2012.

The target for the Stop Smoking Service in 2011-12 was to achieve 1728 4 week quits. The predicted achievement is 1550 quits. Issues that were identified as contributing to the expected underachievement were problems with data recording and reporting from GP practices and lack of referrals from primary and secondary care.

Benchmarking:
Lewisham’s Stop Smoking Service performance ranks 17th out of the 32 boroughs (including London). However it should be noted that investment in the services across London is variable.

Key actions for 2012-2013

Over the next year, the following actions to improve uptake of immunisation will take priority:

- Further development of immunisation care pathways. The first of these (the MMR Pathway) was launched in July 2010. A pre-school booster pathway will come on line during 2012.

- Action to improve recorded uptake of vaccines in children who are not registered with a GP.

- Engaging with primary schools and early years providers to implement standardised collection of information on the immunisation of children, and to ensure parents are given the right advice on immunising their children.

- A survey of parents in order to understand barriers to immunisation and incorporation of actions to address these into the action plan.
Source: NHS Information Centre

Key actions for 2012-2013

■ **Stop the promotion of tobacco:**
The Director of the Children and Young Persons’ Directorate endorsed tackling tobacco as a 2012-13 priority. All schools have been asked to take action to prevent take up of smoking by young people and exposure to secondhand smoke. A peer education programme was tested in 3 schools Sept 2011- Mar 2012 and will be run in a minimum of 5 schools in 2012-13. Selected students are trained to influence their peers not to start smoking.

■ **Motivate everyone to quit and help them do so:**
Increase referrals from GP practices which do not offer a LES stop smoking service: online training module on very brief advice to be completed by all GPs and practice nurses and referral system to be improved. A CQUIN on smoking is to be implemented in 2012-13 by Lewisham Healthcare Trust to train all staff on brief intervention, to improve the referral system and to increase referrals and the number of quits.

■ **Reduce exposure to secondhand smoke:**
Training on smoke free homes to be provided for child minders. The pregnancy stop smoking advisors to promote smoke-free homes, including training peer educators. The national campaign for smoke-free homes and cars and an online training module on smoke-free homes and cars, will be promoted locally.

■ **Regulate tobacco products effectively:**
A SE London Tobacco Alliance was formed in 2012 to research the scale of illegal and niche tobacco products in Lewisham and across SE London and to develop an action plan to respond to the findings. This will reduce access to cheap tobacco, which undermines policies to reduce prevalence.

■ **Communicate effectively for tobacco control:**
All campaigns e.g. No Smoking Day, Smoke-free homes and cars are actively promoted. In 2012-13 SE London Tobacco Alliance will develop a joint communication strategy for SE London to increase the impact and reduce costs.

Promote Healthy Weight

**Performance**

Lewisham’s prevalence of childhood obesity is determined from participation in the annual National Child Measurement Programme (NCMP). This provides the prevalence of overweight and obese children in Reception Year (aged 4-5 years) and Year 6 (aged 10-11 years). The local target is to achieve a trend in the reduction of childhood obesity for Reception and Year 6 children by 2015.

For 2011-12 the target was to reduce obesity in Reception year children to 12% and Year 6 children to 24.3% and achieve a participation rate in the NCMP above 87% in Reception and 89% in Year 6. The target for participation rates were exceeded for both Reception (91%) and Year 6 (91.6%). The target for obesity prevalence for Reception was achieved with actual prevalence of 11.1%, and for Year 6 was 0.1% above the target with actual prevalence of 24.4%.

Please note the NCMP data are collected during the academic year 2010-11 but are fully reported in 2011-12.

There is no precise measure of adult obesity prevalence in Lewisham; a modelled estimate based on the Health Survey for England is currently used. The national ambition is a downward trend in the level of excess weight averaged across all adults by 2020; no target was set for Lewisham in 2011-12.

Lewisham has a high proportion of children identified at risk of obesity. Data from 2007-08 to 2010-11 of the NCMP for Lewisham reveal there is no consistent trend in the prevalence of obesity in Reception (Figure 31) or Year 6 (Figure 32).
Benchmarking

In 2010-11 the prevalence of obesity in Reception (Figure 33) and Year 6 (Figure 34) was significantly higher than the England average and for Year 6 also significantly higher than the London average. Lewisham has a similar prevalence of obesity to the majority of its children's services statistical neighbours.

Adult obesity

The modelled estimate of adult obesity prevalence in Lewisham was 23.7% which is not significantly different to the England average. However we know that maternal obesity rates in Lewisham (24%) in 2010 were higher than that of England (17%).

Key actions for 2012-2013

- Continue to build on local capabilities of our workforce by providing training on weaning, healthy eating and childhood weight management so that everyone is aware of their role in promoting healthy weight.

Figure 31
Percentage (with 95% confidence intervals) of school children in Reception who are obese. Year on year comparison of Lewisham with London and England


Figure 33
Reception year: Annual percentages with 95% confidence intervals of obese children 2010-11


Figure 32
Percentage (with 95% confidence intervals) of school children in Year 6 who are obese. Year on year comparison of Lewisham with London and England


Figure 34
Year 6: Annual percentages with 95% confidence intervals of obese children 2010-11

Work with families in children’s centres and schools to promote healthy eating and physical activity to include increase uptake of free school meals and school meals and provide opportunities for families and residents to improve cooking skills.

Deliver a healthy and active lifestyles programme for school children through the delivery of Hoops for Health in up to ten secondary schools and the Millwall programme in up to sixteen primary schools in 2012-13.

Promote national campaigns such as Change4life to Lewisham residents.

Provide a care pathway for children/young people and adults with weight management issues and commission specific specialist and targeted weight management programmes that support sustainable lifestyle changes.

Collect information on lifestyles of school children through the SHEU survey in schools.

Work with fast food outlets to increase range of healthy options available (Run a pilot project in Bellingham in 2012).

Work with Lewisham midwives to develop a maternal obesity care pathway.

Increase Physical Activity

The UK Chief Medical Officers’ recommendation for adults aged 19 - 64 is that they should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week. Regular physical activity can reduce the risk of many chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions. It also has economic and environmental benefits.

Physical activity for adults is measured as part of the Active People Survey (APS). The APS is a national sport participation survey (age 16 years and over) and is carried out by Ipsos MORI for Sport England.

The Public Health Outcome Framework 2013 includes the 5x30 minutes as an indicator for physical activity.

Benchmarking

Lewisham’s percentage of total adult participation in at least 3 days (in the last 12 days in the last 4 weeks) 3x30 minutes in sport and active recreation, including recreational walking and cycling has decreased from 20% in 2005-06 to 18.7% in 2009-11. In comparison this is lower than Southwark 19% and the London average of 21% but significantly higher than Greenwich (Figure 36).

Performance

Lewisham has seen a decrease in the total adult participation in the 5x30 minutes of sport and active recreation from 11% in 2005-06 to 9.5% in 2008-10 (Figure 35). This is similar to London and England which also show a decrease in physical activity.
**Key actions for 2012-2013**

- Agree local targets for Lewisham, based on the Active People Survey data and deliver a yearly physical activity action plan working with the Lewisham Physical Activity Partnership.

- Focus on raising the profile of swimming, cycling, walking and dance in Lewisham and work with the borough and NHS communications to promote these activities.

- Focus on supporting people move from inactivity to low or moderate activity through the effective delivery of schemes such as the Exercise on Referral Scheme, Active Heart programme and outdoor activities with Nature’s Gym.

- Continue to commission physical activity initiatives to support behaviour change through the NHS Health Check programme, Health Trainer Scheme and Healthy Walks programme.

- Encourage local promotion of the key message of the benefits of physical activity in the Change4Life campaign for adults and families and support the engagement by individuals, families, schools and local providers.

- Continue to train frontline health professionals in the implementation of the Let’s Get Moving Physical Activity Care Pathway.

**Improve Sexual Health**

**Teenage pregnancy – Performance and Benchmarking**

Teenage pregnancy rates have continued to fall in Lewisham from the 1998 baseline. The rate of the fall has increased over the last 3 years for which data is available. In 2010 the teenage conception rate was 48.6 per 1,000 females 15-17 years. This was a 39% reduction from the 1998 baseline of 80 per 1,000. The national target was to reduce the rate by 50% over 10 years. Whilst this target has not been achieved and Lewisham still has a high teenage conception rate, Lewisham has outperformed the England and Wales reduction of 24.6% and the London reduction of 27.6% (Figure 37).

**Figure 37**


Source: Department for Education

**Key Actions for 2012-2013**

- Ensure the pan-London condom distribution scheme (Come Correct) is well established in the borough.

- Review sex and relationships education in schools.

- Ensure access to contraception including emergency contraception and long acting reversible contraception (LARC) is made as easy as possible for young women.

**Chlamydia Screening – Performance and Benchmarking**

Lewisham continues to achieve some of the highest Chlamydia screening coverage nationally (Figure 38). At the 3rd quarter of 2011-12, 32% of 15-24 year olds had been screened. It is estimated that by the end of the financial year screening coverage would be around 40% in this age group. Nine percent of screens are positive for Chlamydia, indicating that those most at risk are being screened. There has been an increase in the number of screens being done in primary care over the last few years. From 2012 the new Public Health Outcomes Framework has a target to achieve a diagnosed prevalence of Chlamydia of at least 2,400 per 100,000 15-24 year olds. In Lewisham at quarter 3 2011-12 diagnosed prevalence was 3770 per 100,000 (Figure 39). This indicates high levels of infection and that current testing and screening activity is well targeted.

**Figure 38**


Source: National Chlamydia Screening Programme (http://www.chlamydiascreening.nhs.uk/ps/data/data_tables.html)
Figure 39
Chlamydia: diagnosis rate per 100,000 resident population aged 15-24 by South East London PCTs, London and England 2011 Q1-3

Source: National Chlamydia Screening Programme (http://www.chlamydiascreening.nhs.uk/ps/data/data_tables.html)

Key Actions for 2012-2013
- Maintain high levels of Chlamydia screening.
- Increase the number of males accessing screening.
- Ensure the number of screens from primary care continues to increase.

HIV prevalence – Performance and Benchmarking

HIV prevalence is increasing in Lewisham. In 2010 there were 1360 people known to be living with HIV. The prevalence of HIV infection in Lewisham remains amongst the highest in London (Figure 40).

Figure 40
HIV prevalence rate in persons aged 15 - 59 by LA of residence London 2010

Almost 60% of Lewisham residents who accessed HIV-related care in 2010 probably contracted the disease via heterosexual transmission. This is a phenomenon that also exists in some other SE London Boroughs (Figure 41). Despite this picture, HIV remains an issue for men who have sex with men and for intravenous drug users in Lewisham. As is the case in the UK as a whole, up to a third of those living with the virus do not know that they have been infected, despite perhaps knowing that they are at risk of infection.

Figure 41
Percentage of people accessing HIV-related care, by probable route of infection and PCT of residence, SE London 2010

A target was set for London to reduce ‘very late’ diagnosis of HIV (CD4 count of less than 200) to 15% by 2010-11. The proportion of patients diagnosed ‘very late’ in Lewisham increased to 33% in 2010 from 26% in 2009 (Figure 42). Early diagnosis of HIV infection dramatically improves outcomes for people living with HIV. HIV treatment can significantly reduce the spread of HIV infection, so early diagnosis and treatment can have a major public health impact in controlling spread of HIV infection. This is particularly important in couples were only one partner is HIV positive as it can prevent infection in the unaffected partner.

In Lewisham there are 16 GP practices routinely offering HIV testing to newly registering patients in primary care in line with national BHIVA guidance. In addition to this the community contraception and sexual health service offers rapid HIV testing to all patients. Already this has been successful in identifying patients who were unknowingly infected and can now benefit from treatment. In addition to treatment benefiting those infected with HIV it also has an important role to play in preventing onward transmission of HIV by reducing the amount of circulating virus and therefore preventing new infections. It is anticipated that all practices will offer HIV testing to newly registering patients in the future.

Source: Health Protection Agency

Sixty-three percent of patients were diagnosed late (with a CD4 count of less than 350, Figure 43).

Figure 43 Percentages of very late and late HIV diagnosis by PCT and London (CD4<200 and CD4<350 cells/mm3) 2010

Source: Health Protection Agency, Appendix 2.2

Other Sexually Transmitted Infections

Other sexually transmitted infections also remain a challenge in Lewisham (Table 7), though rates of syphilis are lower than in some other SE London boroughs, the rate is still far greater than the rate of this infection occurring in other parts of London and in the UK as a whole. Gonorrhoea rates appear low, however most gonorrhoea infection in Lewisham is diagnosed in community sexual health clinics and so may not appear in these figures. Amongst 15-24-year olds screened as part of the Chlamydia screening programme around 2% have gonorrhoea infection.

Table 7: Rate of new diagnoses by STI and PCT of residence per 100,000, SE London 2010

Source: Health Protection Agency

Abortion - Performance and Benchmarking

Abortion rates in Lewisham are high in women of all ages (29.9 per 1,000 females aged 15-44, Figure 44), although they are similar to the neighbouring boroughs of Lambeth and Southwark. The rate for London is 25.7 per 1,000 females.

Figure 44 Legal abortion rates (ASR with 95% confidence intervals) per 1000 women aged 15-44 by LSL, London and England 2010

Source: Department of Health

Key Actions for 2012-2013

- Increase HIV testing in all settings.
- Increase HIV awareness amongst professionals and the general population.
- Implement the recommendations of the service review of HIV care and support services to ensure all people living with HIV can access mainstream health services to promote normalisation of HIV as a long term condition.
Forty-six percent of abortions in 2010 were repeat abortions compared to 41% across London and 34% nationally (Figure 45). Overall rates of abortion appeared to be declining but based on activity in 2011-12 there appears to have been a 5% increase, which will need to be validated when the national data are released for 2011.

Figure 45
Repeat abortion percentages for women under 18 by quarter, LSL, London and England

Source: Department of Health

Key Actions for 2012-2013

- Work with GPs to support women pre and post termination to try and reduce the number of repeat abortions.
- Develop a local early medical abortion service in Lewisham so women do not have to travel out of borough.
- Increase the number of women leaving abortion services with a reliable form of contraception.

Reduce Premature CVD mortality

Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades as a result of reduced smoking prevalence and better treatment, especially the use of statins. To ensure that the reduction continues there needs to be concerted action in both prevention and treatment.

Performance

Premature mortality from cardiovascular disease has reduced, both in England and in Lewisham, over the period 1996-2010 (Figure 46). The rate of decline in Lewisham has been slightly faster than England and in some of Lewisham’s neighbours. Lewisham (84.4 per 100,000) is currently above the target (82 per 100,000) and based on current trends this is likely to continue.
Table 8: Recorded and expected prevalence for key QOF indicators 2008-09 to 2010-11

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Key Action for 2012-2013

- Undertake modelling of impact on atrial fibrillation and hypertension to identify priority for primary care.
- Redesign heart failure and cardiac rehabilitation pathways.
- Training programme for primary care on CVD diagnosis and management and brief interventions on alcohol, smoking, weight management and physical activity.
- Deliver NHS Health Check programme (see below).
- Deliver tobacco control, alcohol, physical activity, and obesity plans.

Lewisham NHS Health Check Programme

The first year of the Lewisham NHS Health Check programme was 2011-12. The call/recall programme started in March 2011 and offers health checks to all eligible people, aged 40-74 years who are registered with a Lewisham GP by invitation every 5 years.

Performance

The target for 2011-12 was to offer health checks to 18% eligible population and to complete 7100 health checks. Lewisham exceeded the 2011-12 performance target by offering health checks to 21% of the eligible population and 7224 health checks were received. These were delivered by 44 GP surgeries, 11 community pharmacists and a community outreach team.

The community pharmacists continue to increase the numbers of health checks they undertake. A new community outreach team is now in place. They have begun to target the “hard to reach” groups, for example people living in hostels and temporary accommodation and the Vietnamese community.

GP practices have undertaken the majority of health checks in 2011-12 but the community pharmacists and community outreach teams are recording higher numbers of patients with a high or very high risk of developing CVD. This illustrates that they are reaching the more “at risk” sections of the Lewisham population.

The majority of those receiving a health check are aged 55 years and younger. This reflects the fact that older people are more likely to be on a disease register already and will not receive an invitation for a health check.

Referrals to all healthy lifestyle services were initially very low but have steadily increased. One reason for this is that the referral process is too complicated for providers of health checks to use.

Benchmarking

Across South East London Lewisham ranks 3rd in performance for health checks offered, health checks received and percentage uptake ranks 12th in England (Figure 48).

The Community Pharmacy Health Check programme has been particularly successful and has been recognised as an example of excellent health check provision nationally. Many other areas are now modelling their pharmacy service on the Lewisham model.

Figure 48

Number of NHS Health Checks offered to persons aged under 75 compared with those completed, by South East London borough of residence 2011-12, Q1-3

Source: Department of Health
Key actions for 2012-2013

- Plans in place to commission services to provide support to GP practices in IT, template use and accurate clinical coding. This will result in more accurate data.

- 7 new community pharmacies will offer NHS Health Checks from June 2012.

- Plans in place to set up “NHS Health Check Catch Up Clinics” for patients who do not respond to the invitation letter.

- The Healthy Lifestyle services referral pathway will be redesigned to streamline the referral process.

- Develop guidelines for the management of high risk patients.

- Further analysis of data on outcomes of those who have received NHS Health Checks.

Reduce premature mortality from cancer

Cancer is the highest cause of death in England in under 75s. To ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and treatment.

Performance

Figure 49 shows directly age standardised mortality rates from cancer for Lewisham compared to London and England for persons 1993 to 2010 (the most recent data available).

While the rate fluctuates considerably from year to year because the absolute numbers are fairly small, it is clear that there has been a steady reduction in cancer mortality rates across the period. Lewisham’s rates have been consistently higher than London and England.

Benchmarking

Compared to other deprived London boroughs Lewisham’s premature cancer mortality rate is not statistically significantly different (Figure 50).

Cancer Screening

Cancer screening remains an important way to detect cancer early and, in some cases, such as cervical screening, prevent cancers. Over 5% of all cancers are currently diagnosed via screening, but this is set to rise as the extensions to the breast and bowel screening programmes progress. Around a third of breast cancers are now diagnosed through screening.
Meeting the coverage targets for cancer screening programmes in Lewisham remains a challenge as it does not meet any of the national targets. However Lewisham does perform better that most of other similarly deprived boroughs in London (Figure 52, 54 and 55).

Breast Screening

**Figure 51**
Breast Screening: trends in coverage of women aged 53-64 years 2005-06 to 2010-11

![Breast Screening Graph](image)

Source: NHS Information Centre

**Figure 52**
Breast Screening: coverage of women aged 53-64 years by ONS London Metropolitan Cluster and England 2010-11

![Breast Screening Coverage by ONS](image)

Source: NHS Information Centre

Cervical Screening

**Figure 53**
Cervical Screening: annual trends in coverage of women aged 25-64 years 2004-05 to 2010-11

![Cervical Screening Graph](image)

Source: NHS Information Centre

**Figure 54**
Cervical Screening: Coverage of women aged 15-64 years by ONS London Metropolitan Cluster and England 2010-11

![Cervical Screening Coverage by ONS](image)

Source: NHS Information Centre

Bowel Screening

**Figure 55**
Bowel Screening in persons aged 60-75. Percentage uptake by South East London PCT of residence 2010 Q1-3

![Bowel Screening Graph](image)

Source: NHS South East London Bowel Cancer Screening Centre
Key Issues that contribute to underperformance are the following:

High population mobility - An annually estimated population turnover (‘churn’) of 25% makes keeping current patient details up to date a challenge. The Women’s Health Survey\(^{46}\) indicated that 17% of women aged 53-64 in Lambeth, Southwark and Lewisham had changed address in the last three years. This is higher than in other areas of the country.

List inflation - It is generally accepted that the figures held on the NHAIS (Exeter) system for persons registered with a GP may not be accurate as patients die, move house or emigrate and their details are not removed in a timely fashion. At an England level “list inflation” has been estimated to be approximately 7%\(^{47}\). In 2009 “list inflation” for Lewisham was estimated to be approximately 14%\(^{48}\). As these lists are the source data for the screening programmes any inaccuracy in the lists has an impact in the calculations of the success, i.e. coverage of these programmes.

Programme structure - The breast screening and bowel programmes are not embedded in primary care. Thus GPs may not know when their patients will be called and there is no financial incentive in primary care for increasing uptake of the service.

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**Key actions for 2012-2013**

- There will be a London-wide implementation of a list validation exercise (Once 4 London) programme to begin in 2012.

- Production of a primary care resource pack to offer advice on key actions to improve uptake in screening.

- Deliver a programme of visits to GPs practices to introduce them to the resource and support them in promoting cancer screening programmes.

- Deliver a programme of visits to targeted community groups to promote cancer screening programmes and promotion of screening at general events.

- Undertake cancer specific JSNA summaries (breast and bowel) to provide more detailed understanding of need.

- Support the roll out of national early awareness and early diagnosis campaigns for Lung and Bowel cancer.

- Submit funding bids and support implementation if successful for local NAEDI initiatives.

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**Cervical cancer:** Early in the financial year 2012-13, there will be a national roll-out of HPV triage programme. In the new pathway, an HPV test will be carried out on the residual material in the LBC pot when low grade abnormalities are detected – borderline or mild dyskaryosis, borderline high grade or borderline endocervical cells. If the HPV test is positive for high risk strains of HPV, the woman will be referred to colposcopy without repeat cytology. If the HPV test is negative, the woman will be returned to normal recall. It is anticipated that this pathway will lead to increased activity in the first two years after implementation in colposcopy.

**Bowel cancer:** Expected that the age extension (to aged 75) for Bowel cancer screening in Lewisham will take place in 2012-13.

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**Mental Health**

**Suicide—Performance and benchmarking**

Suicide rates in Lewisham are lower than England and London. In 2010, the Lewisham rate was 3.4 per 100,000 compared with 5.7 per 100,000 in England and 4.8 in London (Figure 56).

**Figure 56**

Suicide rates per 100,000 population. Lewisham compared with London and England Annual trends, 1993-2010

![Suicide rates graph](image)

*Source: NHS Indicator Portal*

**Increasing Access to Psychological Therapies (IAPT)—Performance and benchmarking**

Since the introduction of the IAPT service in 2009, Lewisham has consistently performed well against the national targets and ranked amongst the best performers in London. At the end of 2011-12 it is estimated that across London 6.5% of those with anxiety and depression will have had their needs met through IAPT services. For Lewisham the figure is 9.22% (Figure 57).

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Source: South London and Maudsley NHS Trust (SLAM)

The average recovery rate following IAPT for the first 3 quarters of 2011-12 was 44% for Lewisham compared to 42.7% across London. At quarter 3 Lewisham ranked 7th in London (of 31 PCTs) for moving people off sick pay and benefits following IAPT intervention or support.

Dementia - Performance

NHS Lewisham (PCT) and London Borough of Lewisham have jointly commissioned a new pathway for Dementia. One of the aims of the new memory service is to diagnose people earlier so they can access a range of support. The previous annual public health report 2009 identified that just over a third of all patients expected to have dementia were recorded on practice dementia registers. This has now improved, and the number of patients recorded as having dementia have gone up by 22% since 2009 (Figure 58). There is still some way to go but the response to the new service by GPs has been very positive and as a result of this more patients should be referred for assessment and get an early diagnosis enabling them to get better support with their disease in the early and latter stages.

Mentally ill offenders – Performance

Lewisham has adopted a triage for all forensic patients (mentally ill offenders). Lewisham’s aim is to ensure that everyone is treated at the right place at the right time. The new model ensures that all prison transfers have a three month intensive assessment before the most clinically appropriate placement is made, subject to Ministry of Justice restrictions, rather than an automatic transfer to medium secure services. In the first 6 months of this new triage model over 60% of the patients initially highlighted as requiring admission to a medium secure unit were subsequently diverted away from a medium secure unit after triage. This has a positive impact on these patients enabling them to get the care they need in a more appropriate setting.

Key Actions for 2012-2013

- Ensuring a stepped care pathway and treatment model is adopted in order that such service users are treated in the most appropriate care setting. This includes a review of all specialist and secondary care provision and reviewing thresholds to services.
- Ensuring appropriate placements are made in order that service users are treated in the least restrictive environment. This includes a review of all forensic and residential provision.
- Maximising support in Primary Care including discharge of secondary care caseloads where clinically appropriate.
- Investing in the voluntary sector to deliver current provision that does not require a secondary care provider.
- Ensuring services are delivered in line with local needs assessment considering borough demographics.

Improve Maternal and Infant Health

Infant mortality - Performance and Benchmarking

Reducing the risk of infant mortality will improve the life chances, health and wellbeing of both the mother and the baby.

The following charts show infant mortality rates for 2007-9 (three-year average, Figure 59) and 2010 (single year’s data, Figure 60), for boroughs in South East London, London and England, with 95% confidence intervals.

In 2007-2009 Lewisham’s infant mortality rate was significantly higher than Bromley’s, but not significantly different from those of any other borough in South East London, London and England. In 2010 Lewisham’s rate was not significantly different from any of the comparators.
A low birth weight baby is defined as a baby who weighs less than 2.500kg (5lbs 8oz). Low birth weight is a major determinant of perinatal illness, disability and death and adversely affects babies born into families from a lower socio-economic background.

Smoking is the major modifiable risk factor contributing to low birth weight. Babies born to women who smoke weigh on average 200gms less than babies born to non-smokers. The incidence of low birth weight is twice as high among smokers as non-smokers. Smoking cessation in pregnancy is strongly affected by socio-economic status, with women of lower education, income and employment status far more likely to continue smoking than women from higher SES groups.

The relationship between pregnancy, nutrition and foetal growth has been described as deceptively complex. However, there is now retrospective and prospective evidence that poor maternal nutritional status at conception and inadequate maternal nutrition during pregnancy can result in low birth weight.

In order to ensure the effectiveness of any action taken in pregnancy to prevent low birth weight, it is essential that women access antenatal care as early as possible and that they are assessed for risk of a low birth weight baby and managed appropriately.

**Performance**

In Lewisham in the past, the percentage of babies born of low birth-weight was amongst the highest in London. Because of this, in May 2007 Lewisham Primary Care Trust (PCT) commissioned a project to assist in meeting two Local Public Service Agreement (LPSA) targets. The purpose of the Low Birth-Weight and Early Access to Maternity Care Project was to meet the following targets:

- To reduce the numbers of babies born in Lewisham who weigh less than 2.500kg expressed as a percentage of all live births in the borough from 8.8% to 8% by the end of March 2008.
- Increase by 20% the numbers of women having a first antenatal contact with a midwife before 10 weeks of pregnancy by March 2008.

A number of service changes, such as the provision of direct access to midwifery services by women themselves, and a range of actions aimed at ensuring early access to antenatal care, and opt-out referral of pregnant women who smoke to stop smoking services, were established. New antenatal care notes were also introduced, using validated means of identifying women whose pregnancies might be at risk of outcomes like low birthweight, and adherence to new London-wide care pathways instituted.

By 2008, the number of babies born in Lewisham who weighed less than 2.500kg had reduced to less than 8.0%, continuing a clear downward trend in this indicator. There is no significant difference now in this indicator for Lewisham in comparison with either London or England and Wales (Figure 61).

Over the same time period, the proportion of women accessing antenatal care early has increased dramatically and by the end of 2010, the target of 90% of pregnant women in Lewisham accessing antenatal care by 12 weeks of pregnancy had been reached and has been sustained since.

Smoking at time of delivery, which had decreased significantly, has increased recently. Further enquiry has revealed that the opt out referral scheme instituted in 2007-8 may not be operating as effectively as before.
Key Actions for 2012-2013

Early access to antenatal care, identification and effective management of pregnancies at risk, particularly in relation to smoking and nutrition of mothers, remain the mainstay of addressing this issue. Although early access to antenatal care now seems to have been secured, the identification and management of risk need to be reviewed again, including in particular the opt out system of referral of smokers to the smoking cessation team. Action will focus on the following:

- Continued steps to improve access to maternity services to ensure that all women are encouraged to consult a midwife as early as possible, certainly before the end of the twelfth week of pregnancy and before the end of the tenth week if possible.
- Review of the current opt-out programme that aims to help those pregnant women and members of their families who smoke to stop.
- Continued efforts to identify those women who may otherwise be at risk of having a low birthweight baby and to ensure that they receive appropriate care to minimize that risk.

Increase Breastfeeding Rates

The Department of Health has been collecting Breastfeeding Initiation data since 2002-03 Q1.

Each quarter, each PCT is required to submit 3 data items: number of maternities; number of mothers initiating breastfeeding; number of mothers not initiating breastfeeding. In addition since 2008-09 Q1 to assess breast feeding prevalence the following data items are collected; number of infants due a 6-8 week check; number of infants being ‘totally’ breastfed; number of infants being ‘partially’ breastfed; number of infants being ‘not at all’ breastfed. PCTs must meet the 95% coverage criteria on the number of infants due a 6-8 week check for all four quarters.

Performance

Quarterly trend in 6-8 week prevalence shows that the target set for 2011-12 of 75.5% is on course to be achieved (Figure 62).

Benchmarking

Breastfeeding prevalence at 6-8 weeks has been benchmarked against the England average and 8 London boroughs (Figure 63).
Key Actions 2012-2013

- Provide mandatory training in breastfeeding management to all health visiting team staff in preparation for the Stage 2 assessment.
- Provide UNICEF approved training to GPs within Lewisham on issues pertaining to prescribing and management of common conditions in breastfeeding mothers.
- Roll out of the national breastfeeding welcome scheme among local businesses to help women breastfeed when out and about.
- Provide support to breastfeeding groups being established along with a breastfeeding peer support programme.
- Achieve the stage 2 Baby Friendly award before October 2013.

Reduce Alcohol-related harm

Alcohol misuse is the third-greatest overall contributor to ill health, after smoking and raised blood pressure. Alcohol related harm is significant and increasing in Lewisham, exacerbated by the recession. In addition alcohol use has a major impact on anti-social behavior, crime and other important social issues, including the well-being and development of children.

Performance

The key performance indicator has been the rate of alcohol attributable admissions per 100,000 of the population (NI 39). The new Public Health Outcomes Framework has indicated that this indicator will be reviewed and is likely to be replaced.

The Lewisham target, set by the Alcohol Delivery Group and agreed by the Drugs and Alcohol Treatment Board, is to reduce the rate of increase - a 20% per annum reduction in the increase in the rate of alcohol attributable admissions. The target was exceeded in 2009-10 (1731 admissions per 100,000, compared with the target of 1835) and in 2010-11 (1930 compared with a target of 1951).

The rate of NI 39 admissions is high in both England and Lewisham. Since 2002 alcohol-related admissions (NI 39) in Lewisham have been increasing in line with patterns for England (Figure 64). However, since 2006-07 the rate of increase in alcohol-attributable admissions in Lewisham has been declining. In other words, although alcohol-attributable admissions continue to rise, the rate at which they do so has now slowed down and the gap between Lewisham and England has closed.

Figure 64
Hospital admissions for Alcohol related harm Directly age-standardised (DSR), Lewisham London and England 2002-03 to 2010-11

Source: Local Area Profiles for England (http://www.lape.org.uk/natind.html)

Benchmarking

As with the trend in England, hospital admissions for alcohol related harm is rising in all the South East London Boroughs. From 2007-08 Lewisham had the highest rates in South East London. However, the rates in Greenwich were higher in 2010-11.

Figure 65
Hospital admissions for alcohol related harm. Directly age-standardised rates (DSR) by SE London PCT of residence 2002-03 to 2010-11

Source: Local Area Profiles for England (http://www.lape.org.uk/natind.html)

Key actions for 2012-2013

- Focus on prevention of uptake by young women through: use of social marketing; involving families; school programmes.
- Ensure alcohol is supplied responsibly through: promoting the use of existing licensing powers and good practice; working with alcohol sellers to ensure all staff are properly trained and complying with licensing regulations; A&E data sharing to ensure a targeted approach to tackling alcohol related violence.
- Improve referral pathways and expand interventions to support those most at risk through: identification; early intervention and brief advice by key professionals; interventions through the criminal justice system; primary care helping people onto treatment pathways; accessible levels of treatment.

Health Protection in Lewisham

Sexually transmitted infections, including HIV, are arguably the most important health protection issue for Lewisham. These are dealt with elsewhere in this chapter. Other issues of importance include vaccine preventable diseases such as measles and pertussis (whooping cough) and tuberculosis (TB). There have been important changes in the incidence of measles, pertussis and tuberculosis in 2011.

Measles

In 2008, about 25% of cases of measles in England occurred in SE London. A high proportion of those cases occurred in Lewisham residents (Figure 66), mainly in children and young adults. Numbers have since declined, but in 2011 increasing numbers of cases were again seen in Lewisham. Although there have been improvements in uptake of the Measles Mumps and Rubella (MMR) vaccine since 2008, continued improvement in uptake is needed to reach levels of herd immunity that will ensure Lewisham is no longer at risk of major outbreaks of this disease.

Whooping cough (pertussis)

Compared to 2010, in 2011 there was a 68% rise in the numbers of confirmed and suspected cases of whooping cough reported in SE London. This mirrored a rise across the whole of England. In SE London, Lewisham was the borough most affected by this rise in cases (Figure 68). Pertussis typically displays three to four yearly cyclical peaks in activity with the last peak year in England recorded in 2008. The recent local fall in the uptake of the third dose of pertussis vaccine at one year of age is of particular concern, given this national and local rise in the number of cases. The decline in the uptake of this vaccine in infants (a decline of the order of five percentage points since March 2011, sustained over the past 10 to twelve months) will be investigated, and action taken to restore and exceed previously good levels of uptake of this vaccine.
**Tuberculosis**

Provisional data for the year 2011 suggest that after some years of declining rates of TB in Lewisham there was a considerable rise in incidence in that year (Figure 69). It is not clear why this rise occurred. Further analysis of these data is still underway, but there does not seem to be an increase in any single age, sex or ethnic group.

**Figure 69**
Rate per 100,000 population of new TB notifications in London residents by PCT of residence and year of notification 2006-2011

Source: Health Protection Agency

A key London target is to ensure that 85% of cases of TB have completed treatment within a year of diagnosis. Although there has been some variation in local performance on this, Lewisham is currently on target, and comparable to the rest of SE London and London as a whole (Figure 70).

**Figure 70**
Proportions of new TB notifications in London residents completing treatment within 1 year of notification by South East London PCT of residence and London 2006-2010

Source: Health Protection Agency

**Key Actions for 2012-2013**

- To ensure implementation of the Lewisham Immunisation Action Plan for 2012-2013. This includes actions to address problems with Measles and Pertussis.
- To ensure the development of a Health Protection Plan for Lewisham that addresses these and all other relevant health protection issues.
- To ensure the completion of a review of local TB services. This will be led by the SE London Health Protection Unit.
Appendices
Appendix 1

Jobseeker’s Allowance Claimants in Lewisham

The following charts show these changes over the same period by ward, in alphabetical order of ward name. While the pattern during the period when the number of job seekers was in decline varies from ward to ward the step change is clearly visible for each ward.
Appendix 2

Lewisham Benefit Claimants\textsuperscript{42} August 2000 – August 2010 by ward

In general, the step-change in February 2009 is seen throughout the borough, but previously underlying trends appear to have been maintained. Thus, the slow decline in claimants in Blackheath and Ladywell ward recurred after the step change, the rise in Catford South and Downham recurred, and the ward where the numbers were generally stable continued so after the step change. An exception is Rushey Green, where there has been a step increase following the step change.

\textsuperscript{42} Source: http://www.nomisweb.co.uk/. All data has been rounded to the nearest 5 at the source.
Appendix 3:

People on housing benefit living alone aged over 25 and under 35 years old, whose entitlement will change to shared room only.

The maps 1 and 2 show the numbers of people affected by the change, mapped at Lower Super Output Area\textsuperscript{43} level for the non-disabled and at local authority ward level for the disabled (because of restrictions on reporting small cell data) respectively.

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\textsuperscript{43} Lower Super Output Area is geographical level generated for the 2001 Census. They contain approximately 1500 people. There are 166 in Lewisham.
### Appendix 4

**A timeline for the financial crisis: 1998-2012**

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<tr>
<td>1998</td>
<td>Amendments to 1992 Maastricht Treaty set out monetary convergence criteria to be met before European nations permitted to join the Euro. Annual government deficit should not exceed 3% of gross domestic product (GDP), and that the gross (i.e., cumulative) government debt should not exceed 60% of GDP. In practice these criteria are not rigorously enforced, and criteria for accession not maintained across Eurozone following creation of Euro. Although UK is not part of Eurozone, its economy is intimately entangled with it.</td>
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<tr>
<td>2004-2006</td>
<td>US interest rates rise from 1% to 5.35%. Boom in U.S. housing prices abruptly reverses course.</td>
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<tr>
<td>2007</td>
<td>Housing price declines accelerate. Default rates on sub-prime loans - high risk loans rise to record levels. Homeowners default on their mortgages. Twenty-five subprime lending firms declare bankruptcy. Impact of defaults felt across financial system as many mortgages bundled up and sold on as ‘derivatives’.</td>
</tr>
<tr>
<td>July</td>
<td>Bear Stearns, one of largest US investment banks files for bankruptcy. Federal Reserve chairman Ben Bernanke warns US sub-prime crisis could cost up to $100bn (£50bn).</td>
</tr>
<tr>
<td>August</td>
<td>French investment bank BNP Paribas announces it cannot value assets held by three of its hedge funds. Other EU banks follow with similar announcements. The European Central Bank pumps 200 billion Euros into banking market to improve liquidity. Other central banks, including the US Federal Reserve, the Bank of Canada, Bank of Australia and the Bank of Japan also begin to intervene.</td>
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<tr>
<td>September</td>
<td>Northern Rock is subject to biggest run on a British bank for more than a century. Granted emergency financial support from Bank of England.</td>
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<tr>
<td>October</td>
<td>Swiss bank UBS becomes world’s first top-flight bank to announce losses - $3.4bn - from sub-prime related investments. Citigroup unveils losses of $9bn; within six months these have risen to $40bn.</td>
</tr>
<tr>
<td>December</td>
<td>US Federal Reserve co-ordinates five leading central banks around the world to offer billions of dollars in loans to banks.</td>
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<tr>
<td>2008</td>
<td>January</td>
</tr>
<tr>
<td>February</td>
<td>Northern Rock is taken into public ownership.</td>
</tr>
<tr>
<td>April</td>
<td>Royal Bank of Scotland writes off of almost £6bn on the value of investments, and seeks £12bn in a rights issue.</td>
</tr>
<tr>
<td>July</td>
<td>Financial authorities step in to assist America’s two largest lenders, Fannie Mae and Freddie Mac. These own or guarantee $5 trillion worth of home loans.</td>
</tr>
<tr>
<td>August</td>
<td>Bradford and Bingley posts losses of almost £27m for the first half of 2008, and is subsequently nationalised.</td>
</tr>
</tbody>
</table>

45 For convenience, the term billion will be used in this document in the American sense, to mean 10^9, for which the English term would normally be gillion or milliard. The term trillion will refer to 10^12, rather than the British billion.
A recession is officially defined as the economy shrinking in two successive quarters. Impact of changes in the National Accounts and Economic Commentary for 2011 quarter 2, ONS November 2011

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2009

January
Barack Obama succeeds George W Bush as US President. German Chancellor Angela Merkel unveils an economic stimulus package worth about 50bn Euros. Irish government nationalises Anglo Irish Bank. The UK officially enters recession. The International Labour Organization forecasts that as many as 51 million jobs worldwide could be lost in 2009 because of the economic crisis.

February
President Obama signs a $787bn economic stimulus plan into law, aimed at saving or creating 3.5 million jobs and boosting consumer spending and rebuilding infrastructure.

March
US Federal Reserve buys almost $1.2 trillion worth of debt to help boost lending and promote economic recovery. Leaders of the world's largest economies reach an agreement at the G20 summit in London to tackle the financial crisis with measures worth $1.1 trillion. U.S. unemployment reaches 8.5 percent, its highest level in over twenty-five years.

April
IMF raises its forecast of total financial sector write-downs to $4 trillion. UK Chancellor forecasts UK economy will shrink by 3.5% in 2009 and predicts a £175bn budget deficit amounting to more than 10% of GDP.

May
One of “big three” US carmakers, Chrysler, enters bankruptcy protection. The European Commission forecasts EU economies will shrink by 4% and unemployment rise to 10.9% in 2009. David Cameron, leading a Conservative / Liberal Democrat coalition government, succeeds Gordon Brown as UK Prime Minister.

June
World’s largest carmaker, GM, enters bankruptcy protection. UK unemployment rate reported a rise to 7.1% with 2.22 million people out of work in the first three months of 2009. Japan’s economy contracts at an annualised rate of 14.2% in first three months of 2009.

July
UK unemployment rises by a record 281,000 to 2.38 million in three months to May, and the jobless rate increases to 7.6%, the highest in more than 10 years. UK economy contracts 0.8% between April and June, more than double the figure economists had expected. The latest figures take the annual rate of decline to 5.6%, the biggest fall since records began in 1955.

September
UK officially comes out of recession. The total shrinkage in the British economy over the period of recession is estimated to be 7.1%.

October
Greece’s new government vows to overhaul its finances after announcing its 2009 budget deficit will be 12.7 percent of GDP, far in excess of the EU’s 3 percent limit.

November
Government-owned conglomerate Dubai World requests a six-month standstill on $26 billion in loan repayments, amid rising sovereign debt fears in Europe. Nearly three weeks later, fellow emirate Abu Dhabi offers Dubai a $10 billion bailout.

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46 A recession is officially defined as the economy shrinking in two successive quarters.
47 Impact of changes in the National Accounts and Economic Commentary for 2011 quarter 2, ONS November 2011
2010

April
Standard & Poor downgrades Greece’s credit rating to junk, making the country the first Eurozone member to lose investment-grade status. It also downgrades Spain’s rating.

May
EU and IMF announce a $146 billion financial rescue package for Greece to address its sovereign debt crisis in exchange for the country enacting strict austerity measures. Less than two weeks later, the EU and IMF creates a temporary Eurozone stability mechanism, the European Financial Stability Facility, worth $1 trillion.

June
At G20 meeting in Toronto, a disagreement appears over economic recovery strategies. French President Nicolas Sarkozy and German Chancellor Angela Merkel send a letter to summit host Canadian Prime Minister Stephen Harper urging his support for fiscal tightening among G20 countries. U.S. President Barack Obama stresses the need for continued spending to support growth and warns that excessive government spending cuts could lead to “renewed hardships and recession.” In their closing statement, member countries agree to halve their annual deficits within three years and stabilize their overall debt by 2016.

November
EU and IMF agree to provide Ireland with a $114 billion rescue package. The fund helps Ireland manage its sovereign debt and recapitalize its insolvent banking sector, having been forced into debt as a result of insuring its banks against all losses at the peak of the crisis in 2008.

2011

May
EU and IMF agree to provide Portugal with a $116 billion rescue package, whose current account deficit in 2009 had been in excess of 10% of GDP. Credit rating agencies predict Portugal’s exposure to the debt crisis will become unsustainable.

July
Mounting fears over sovereign debt contagion to Italy and Spain leads to an emergency Eurozone summit, where EU and IMF officials agree to provide Greece with a further financial rescue package worth $156 billion.

November
Elected Greek Prime Minister George Papandreou resigns, succeeded by Lucas Papademos, a former vice president of the European Central Bank, to head a government of national unity, and Italian Prime Minister Silvio Berlusconi resigns, succeeded by Mario Monti, a former member of the European Commission. This has political implications for other nations, including the UK, as it implies that those who control the money markets are in a position to have democratically elected heads of government replaced by their choice of unelected nominee.

2012

January
Standard & Poor downgrades credit status of France and eight other Eurozone countries from their previous AAA ratings.

At the time of writing (March 2012), the Greek government negotiates with its creditors to accept a substantial write-off of the country’s debts, and there is doubt that the country will be able to service debt that becomes due in March 2012.

March
Greece receives 130bn Euros bailout, 105bn Euros of Greek debt written off.

April
UK economy returns to recession (“double dip recession”).

May
Spain nationalises Bankia, which holds 10% of the county's bank deposits. Greece holds general election, with inconclusive results.

June
Eurozone finance ministers agree to lend 100bn Euros to Spain. Greece holds general election, with narrow victory for parties supporting the bailout. Cyprus requests EU bailout. Spain formally requests financial assistance. Barclays Bank fined £290m for misconduct in interbank lending (Libor-fixing). Several other banks, including RBS, are reported to be under investigation.

July
RBS announces it has dismissed several staff for involvement in Libor-fixing. IMF, European Central Bank and European Commission official visit Greece to assess implementation of second bailout. UK disposable income reported as 0.9% down in the previous quarter, and GDP 0.3% down.