LONDON BOROUGH OF HAVERING

Havering Health and Social Care Needs

2018

An overview

Joint Strategic Needs Assessment

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(with contributions from:
Learning and Achievement;
Children Social Care;
Adult Social Care; and
Business & Performance Services)

HAVERING
J S N A

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Executive Summary

1. Introduction

This report, developed as part of the Joint Strategic Needs Assessment (JSNA), is an overview of Havering's health and social care needs. It provides a high-level description of population growth, prevalence and pattern of risk factors for ill health, status of health and wellbeing, and the patterns of demand for health and social care services in Havering.

From the above understanding, all local stakeholders will be aware of the following changes that need to be made:

- **Prevention needs** to be prioritised in order to reduce the prevalence of risk factors in the population particularly in the more deprived parts of the borough.
- **A reduction in risk factors** will mean a reduction in the number of people who develop long term conditions; less people with multiple co-morbidities; reduced demand for more expensive and complex packages of care; and longer lives free of disability.
- **Targeting high-risk population groups** will ensure efficient use of limited resources and in the longer term reduce health inequalities.

2. What will happen to the Havering population?

- Based on the Greater London Authority (GLA) population projection, the population of Havering is projected to increase from 257,514 in 2018 to 303,769 in 2033 – 18% increase.
- The population aged 25-64 will remain the largest age group up to 2033 but from 2018 to 2033, the largest increases will be seen in children (5-10 year olds: 19%; 11-17 year olds: 43%), and older people (65-84 year olds: 26%; 85+ year olds: 54%).

3. Deprivation in Havering

- Havering is a relatively affluent borough. Based on IMD (Index of Multiple Deprivation) 2015[1], Havering is ranked 166th overall out of 326 local authorities in England for deprivation (1st being most deprived, 326th being least deprived).

[1] *In September 2015, the Department for Communities and Local Government (CLG) published the English Indices of Multiple Deprivation 2015 (IMD 2015). This includes county and district summary measures, and a series of separate domains and other measures at the level of Lower Super Output Area (LSOA).*

4. Life expectancy in Havering

- The life expectancy at birth for people living in Havering is 80.1 years for males and 84.2 years for females. This is higher than the England average but similar to London; it has been on the increase over the last decade.

- The life expectancy at age 65 years in Havering is 19 years for males and 21.7 years for females.
- The latest figures show that Havering males have a higher healthy life expectancy compared to London and national average for males; whereas the equivalent for females is in line with the London and England average.

5. What are the risk factors for ill health in Havering

- The results from the national childhood measurement programme (NCMP) show that the proportion of overweight and obese children in Havering is high. On average, one in four children in Reception Year and one in three children in Year 6 in Havering schools are overweight or obese. In addition, the proportion of Year 6 children in Havering that are overweight or obese continues for the third year in a row to be significantly higher than the England average.

- About half of the population in Havering eat the recommended five portions of fruit and vegetables a day at age 15. The consumption of both fruit and vegetables at age 15 in Havering is among the lowest in London and lower than the national average.

- Just above 12% of 15 year olds in Havering were physically active for at least 1 hour according to the 2014/15 WAY survey; however this was similar to both London and England averages. Many schools already offer an average of two hours of PE or other physical activities per week. However, more needs to be done to encourage children to be active every day.

- In Havering, the proportion of mothers who breastfed at birth is significantly worse than the England average and the gap between Havering and the England average is widening. Havering has the lowest breastfeeding initiation rate in the London region. Implementation of the Healthy Child Programme is important for sustained breastfeeding, good infant feeding and nutrition.

- Maternal depression and stress related disorders are the most common maternal mental health conditions in Havering. Maternity especially links to maternal mental health, so antenatal care is important. Early booking, services to support healthy pregnancy (smoking, nutrition, drugs and alcohol, mental health) should be accessible in Havering.

- Teenage (under-18) conception rate in Havering has substantially decreased from the rate in 1998. However, Havering's rate in 2016 was worse than that of Bexley, London and England.

- The number of deaths attributable to smoking is on the decline, but based on the most recent data this is still higher than Bexley, London and England.

6. What is the current status of health in Havering?

- There is an increasing number of Havering residents living with long term conditions (LTCs). Patients with LTCs are more likely to attend A&E, more likely to be admitted for an emergency, have longer inpatient bed days compared to patients with no LTC.

- Patients with five or more LTCs also have higher needs for outpatient stay for treatment or care than patients with no LTC. There is also a significant effect on cost in patients with more LTCs than in those with no LTC. This has a significant impact on daily lives including the use of urgent and emergency health and social care services.

- The proportion of people who feel supported to manage their long-term conditions in Havering is worse than the Bexley, London and England average.

- Dementia is more common in Havering than London but similar to England; and it will be an increasing problem for Havering because of its ageing population.

- The prevalence of patients with long-term conditions such as CHD, cancer, COPD and hypertension, in Havering is significantly higher than London and many London boroughs, but similar to the England average. This could be a reflection of the higher proportion of ageing population in Havering, which is in line with England average population structure that has higher proportion of people aged 65 and above

- Children and adults with a learning disability are at increased risk of having or developing physical and mental health problems. In addition, they are 10 times more likely to have serious sight problems.

- There is increasing demand for specialist help and schooling for children with autism (ASD) and for those with behavioural, emotional and social difficulties (BESD), including those with mental health issues.

7. Mortality

- The top 5 (underlying) causes of death in Havering (from 2013 to 2017) were: cancers, circulatory diseases, respiratory diseases, dementia & Parkinson's disease, and diseases of digestive system.

- Unspecified dementia comprises the biggest single underlying cause of death. Lung cancers comprise the largest proportion of deaths from Cancer.

- About 620 (28%) deaths each year occur prematurely (deaths that occur before a person reaches the age of 75 years). Cancer, heart disease and stroke are the main causes of premature deaths.

- Havering generally ranks well in comparison to the 150 local authorities (LAs) in England for premature mortality. Compared to the England average, Havering ranks among the best for all causes premature deaths, heart disease and stroke (combined), and injuries; better than average for heart disease, stroke, lung disease and lung cancer. However, it ranks among the worst for breast cancer; worse than average for liver disease, cancer and colorectal cancer.

- Compared to local authorities with similar deprivation levels, Havering ranks among the best for premature deaths from injuries; better than average for stroke, heart disease and stroke (combined). In addition, Havering ranks worst for liver disease, cancer and breast cancer; worse than average for all cause premature deaths, heart disease, lung cancer, and colorectal cancer related premature mortality.

8. How do local people use social care services?

- There was a decrease in the number of contacts progressing to an early help assessment by the end of financial year 2016/17.

9. How do local people use health services?

- Outcomes for indicators in the stroke profile for Havering are mixed. The proportion of people who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital is lower in Havering compared to Bexley, London, and England. The proportion of people in Havering with stroke, who are discharged from hospital and have a joint health and social care plan is significantly worse than London and England.

- However, the proportion of patients who have had an acute stroke who receive thrombolysis in Havering is higher than the Bexley, London, and England average.

- The proportion of patients who have a follow-up assessment between 4 and 8 months after initial admission for stroke in Havering is higher than the Bexley and London average, but lower than the England average.

- The proportion of patients in Havering who have an acute stroke and spend 90% or more of their stay on a stroke unit is higher than in Bexley, but lower than the London and England average.

- The proportion of patients with hip fracture in Havering recovering to their previous levels of mobility/walking ability at 30 days is higher than the Bexley and London average, but similar to the England average.

- Most recent data shows that the proportion of Havering's patients in the National Hip Fracture Database who received collaborative orthogeriatric care from admission was higher than the Bexley, London and England average; however the percentage of Havering's patients who received timely surgery was lower than the London and England average.
- Compared to Bexley and England, Havering has a lower rate of admission for children with mental health disorders aged 0-17 years.

1. Introduction

This document forms part of the Joint Strategic Needs Assessment (JSNA). The JSNA is a systematic method for reviewing the issues facing a population, leading to agreed priorities and resource allocation that will improve health and wellbeing of the population and reduce inequalities within the population. The production of a JSNA is a statutory requirement for Health and Wellbeing Board.

1.1 What is the purpose of this report?

This document is one of a suite of reports, developed as part of the Joint Strategic Needs Assessment (JSNA), which aims to give readers a high level understanding of the population of Havering. This report is an overview of Havering's health and social care needs. It is updated with new information, evidence and intelligence as it becomes available and as new issues and gaps are identified. Using routinely collected data, it describes the pattern of risk factors for ill health, the status of health and wellbeing and how people use local services.

From this understanding (of population growth, prevalence of risk factors for ill health across Havering, and the patterns of demand for health and social care services), all local stakeholders will understand the following changes that need to be made:

- Prevention needs to be prioritised in order to reduce the prevalence of risk factors in the population particularly in the more deprived areas of the borough.
- A reduction in risk factors will mean a reduction in the number of people who develop long-term conditions; less people with multiple co-morbidities; reduced demand for more expensive and complex packages of care; and longer lives free of disability.
- Targeting high-risk population groups will ensure efficient use of limited resources and in the longer term reduce health inequalities.

1.2 What is Health?

In 1948, the World Health Organisation (WHO) defined health as a state of complete physical and mental wellbeing and not merely the absence of disease and infirmity. This enduring definition has not been changed by the WHO since then, though there are many other definitions of health and wellbeing in existence.

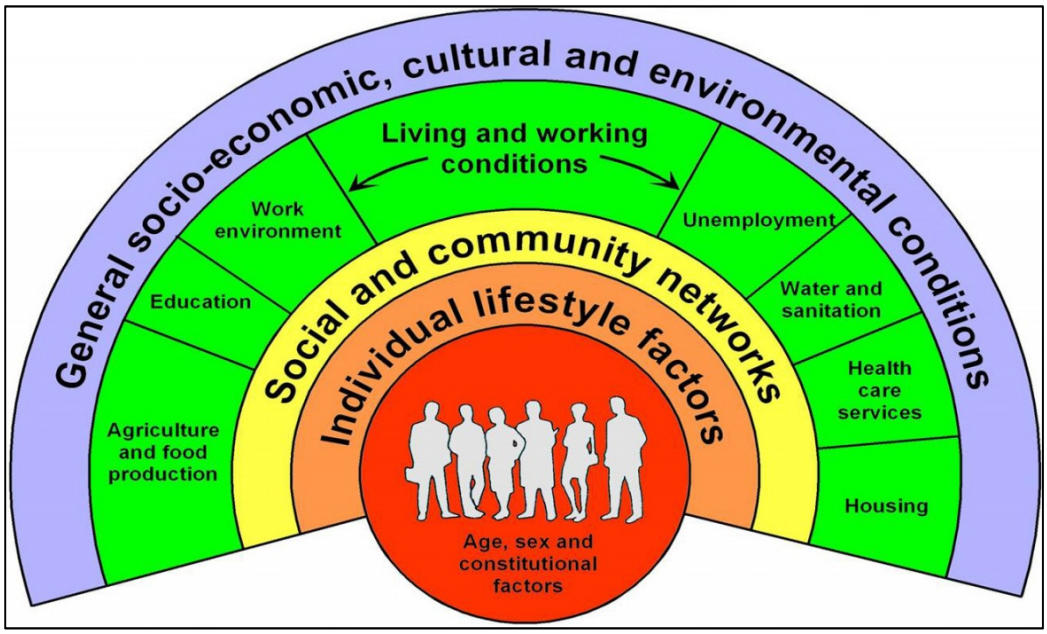
The factors that determine the health of a population are, broadly speaking, divided as follows:

- Socio-economic factors e.g. employment, income, education, housing, environment, etc.

- Lifestyle choices e.g. smoking, diet, exercise, alcohol, uptake of preventive services, etc.
- Health service provision (the contribution of health services to health differs by population subgroup).
- Genetics (although a relatively small contribution, its importance is increasing).

Dahlgren and Whitehead[2] have mapped the complex relationship between the factors that impact on the health of individuals and communities (see Figure 1).

Figure 1: Dahlgren and Whitehead's model of the determinants of health.



Source: Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Copenhagen: World Health Organization, 1992.

Individually and collectively, we can influence some of these factors in Havering to improve the quality of our lives.

1.3 What are health inequalities?

Health inequalities are differences or variations in health status between social groups. They exist in all countries – whether low, middle or high-income. Lower socioeconomic position and measures of social deprivation are associated with greater morbidity and mortality. Such health disparities are considered avoidable and modifiable and, therefore, unjust. There are health inequalities within Havering and between Havering and other local authorities.

Reducing health inequalities has been a longstanding national and local priority. There has been an increasing realisation (articulated in many Government

[2] *Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Copenhagen: World Health Organization, 1992.*

documents over the past 30 years), that more effort needs to be put into preventing individuals and families from getting into situations where they require health or social care interventions. This would help to reduce health inequalities. There is also amble evidence that it is possible to prevent such situations from occurring. Therefore, there has been a strong national and local policy drive to shift more resources into prevention and early intervention and away from more expensive services that are required once problems have occurred.

This understanding informs the selection of our prevention priorities and shapes the things we could do in Havering to deliver these priorities. It allows us to engage all the resources at our collective disposal to create a more resilient economic and social environment in which individuals can make fully informed decisions about how to live their lives. It guides us to develop the circumstances in which it is easier for individuals to make healthier choices and to make best use of the services that are available to them to promote and protect their health and that of their family.

2. What will happen to the Havering population?

Based on the Office for National Statistics (ONS) 2016 mid-year population estimates, the London Borough of Havering has a population of 252,783[3] - an increase of 13% from 223,641 in 1998[4]. Havering has the oldest population in London and is also one of the most ethnically homogenous boroughs with 83% of its residents recorded as White British in the 2011 census (London 43%, and England 80%).

Based on the Greater London Authority (GLA) population projections, the population of Havering is projected to increase from 257,514 in 2018 to:
276,645 in 2023 – a 7% increase from 2018
294,665 in 2028 – a 14% increase from 2018
303,769 in 2033 – a 18% increase from 2018; please see full details in Table 1.

The population aged 25-64 will remain the largest age group up to 2033 but the largest increases will be seen in children (5-10 year olds: 19%; 11-17 year olds: 43%), and older people (65-84 year olds: 26%; 85+ year olds: 54%) from 2018 to 2033 (see Table 2). Therefore, if the population continues to be affected by ill health at the current rate then the demand for health and social care services will grow (particularly services for frailty and dementia; long term conditions and child & adolescent mental health). However, as the population aged 25-64 will remain the largest age group up to 2033, access to affordable housing and good quality local employment opportunities will be important.

Table 1: Projected population change by age group, from 2018 to 2023, 2028 and 2033[5]

	Percentage change from 2018 to:		
Age group	**2023**	**2028**	**2033**
0-4	18,700	19,100	18,500
5-10	22,800	24,300	24,100
11-17	24,900	28,200	29,500
18-24	19,900	22,200	24,200
25-64	140,000	145,100	146,100
65-84	41,900	46,500	49,700
85+	8,400	9,300	11,700
Total	276,600	294,700	303,800

[3] *Mid-Year Population Estimates 2016 (published June 2017), Office for National Statistics*
[4] *Mid-Year Population Estimates 1998, Office for National Statistics*
[5] *2016 Round Strategic Housing Land Availability Assessment (SHLAA)-Based Projections (October 2017), Greater London Authority*

Data source: GLA 2016-based Demographic Projections – Local Authority population projection Housing-led Model; Greater London Authority (GLA); Produced by Public Health Intelligence

Table 2: Projected percentage population change by age group, from 2018 to 2023, 2028 and 2033

	Percentage change from 2018 to:		
Age group	**2023**	**2028**	**2033**
0-4	6%	9%	5%
5-10	12%	20%	19%
11-17	21%	37%	43%
18-24	1%	12%	22%
25-64	6%	10%	10%
65-84	7%	18%	26%
85+	11%	22%	54%

Data source: GLA 2016-based Demographic Projections – Local Authority population projection Housing-led Model; Greater London Authority (GLA); Produced by Public Health Intelligence

3. Deprivation in Havering

Detailed information on the key geographic, demographic and socio-economic facts and figures for the London Borough of Havering, can be accessed via the JSNA products prefixed *"This is Havering: a demographic and socioeconomic profile"* at the following website: https://www.haveringdata.net/wp-content/uploads/2018/04/Published-version-201718_Havering-Demographic-Profile-v3-4-1.pdf. However, please find below a summary of the deprivation in Havering.

People who live in the most deprived areas have the poorest health and well-being outcomes. On average people living in deprived areas, lower socio-economic groups and marginalised groups have poorer health and poorer access to health care than people resident in affluent areas and people from higher socio-economic groups.

Havering is a relatively affluent borough. Based on IMD (Index of Multiple Deprivation) 2015[6], Havering is ranked 166th overall out of 326 local authorities in England for deprivation (1st being most deprived, 326th being least deprived). Although this suggests a relative slight increase in deprivation compared to the IMD 2010[7] ranking (177th out of 326 local authorities), Havering remains within the third deprivation quintile[8] when compared to all local authorities.

In this report, we used Havering to compare with London, England, and Bexley in general. There are some occasions where no data is available for those areas or regions. For more information regarding how to choose comparators for Havering, and key public health statistics, e.g. standardisation and comparing non-standardised data, please see appendix 1 and 2.

[6] *In September 2015, the Department for Communities and Local Government (CLG) published the English Indices of Multiple Deprivation 2015 (IMD 2015). This includes county and district summary measures, and a series of separate domains and other measures at the level of Lower Super Output Area (LSOA).*

[7] *The Department for Communities and Local Government (CLG) published the English Indices of Multiple Deprivation 2010 (IMD 2010) in March 2011.*

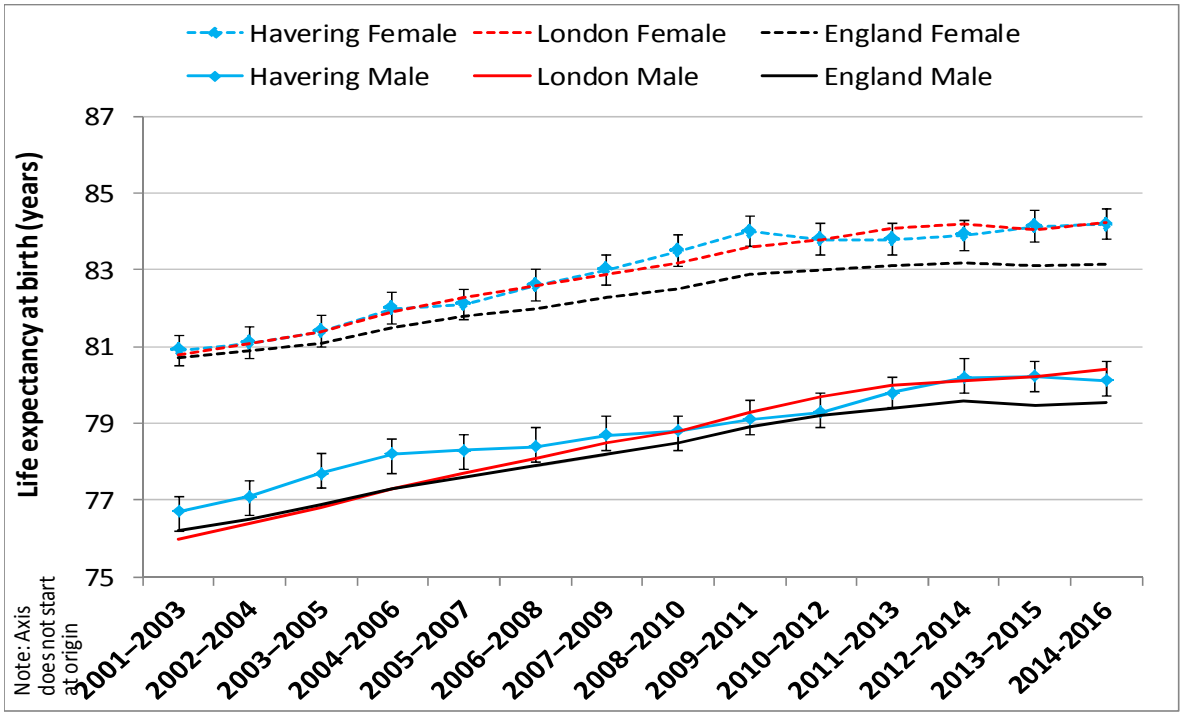
[8] *Deprivation quintile: A 'quintile' basically represents 20% (or one-fifth) of a given population. Deprivation quintiles are derived when a population is ranked in order of deprivation and split into 5 groups – from the most deprived to the least deprived quintile.*

4. Life expectancy in Havering

4.1 Life expectancy at birth in Havering

The life expectancy at birth[9] for people living in Havering is 80.1 years for males and 84.2 years for females. Life expectancy in Havering for both males and females has been mostly higher than the England average but similar to London; it has been on the increase over the last decade (see Figure 2).

Figure 2: Life expectancy at birth (years), by gender, Havering compared to London and England, 3-year rolling periods, 2001-03 to 2014-16



Data source: Life expectancy at birth, 2001-2003 to 2014-16; Public Health Outcomes Framework (PHOF); Produced by Public Health Intelligence

Within Havering, there are inequalities in life expectancy at birth by local deprivation decile[10] (Figure 3);

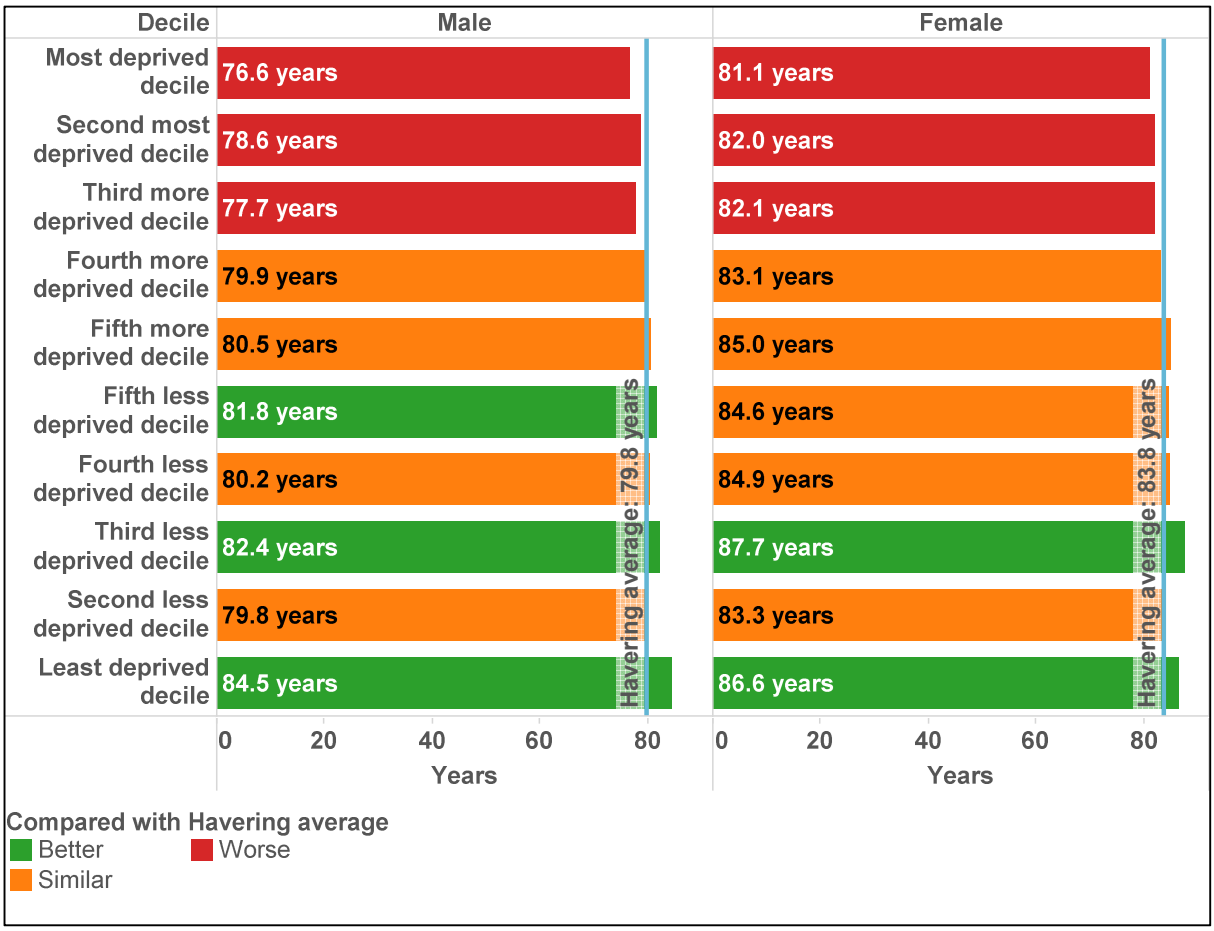
The most deprived deciles of the population have significantly shorter life expectancies than the Havering average.

[9] *Life expectancy is a frequently used indicator of the overall health of a population: a longer life expectancy is generally a reflection of better health. Reducing the differences in life expectancy is a key part of reducing health inequalities. Life expectancy at birth for an area is an estimate of how long, on average, babies born today may live if she or he experienced that area's age-specific mortality rates for that time period throughout her or his life.*

[10] *Deprivation decile: Population ranked in order of deprivation and split into 10 groups (from most to least deprived)*

- For males, life expectancy at birth ranges from 76.6 years in the most deprived decile to 84.5 years in the least deprived decile (difference of 7.9 years). This is greater than the gap seen across London (difference of 6.7 years).
- For females, life expectancy at birth ranges from 81.1 years in the most deprived decile to 86.6 years in the least deprived decile (difference of 5.5 years). This is greater than the gap seen across London (difference of 4.4 years).

Figure 3: Life expectancy at birth by local deprivation decile compared with Havering average, by gender, 2013-15



Data source: Public Health Outcomes Framework (PHOF - 0.1ii. Life expectancy at birth); Public Health England (PHE); Produced by Public Health Intelligence. Published on February 2017

The life expectancy at birth[11] for people living in Havering is 80.1 years for males and 84.2 years for females. Life expectancy in Havering for both males and females has been mostly higher than the England average but similar to London; it has been on the increase over the last decade

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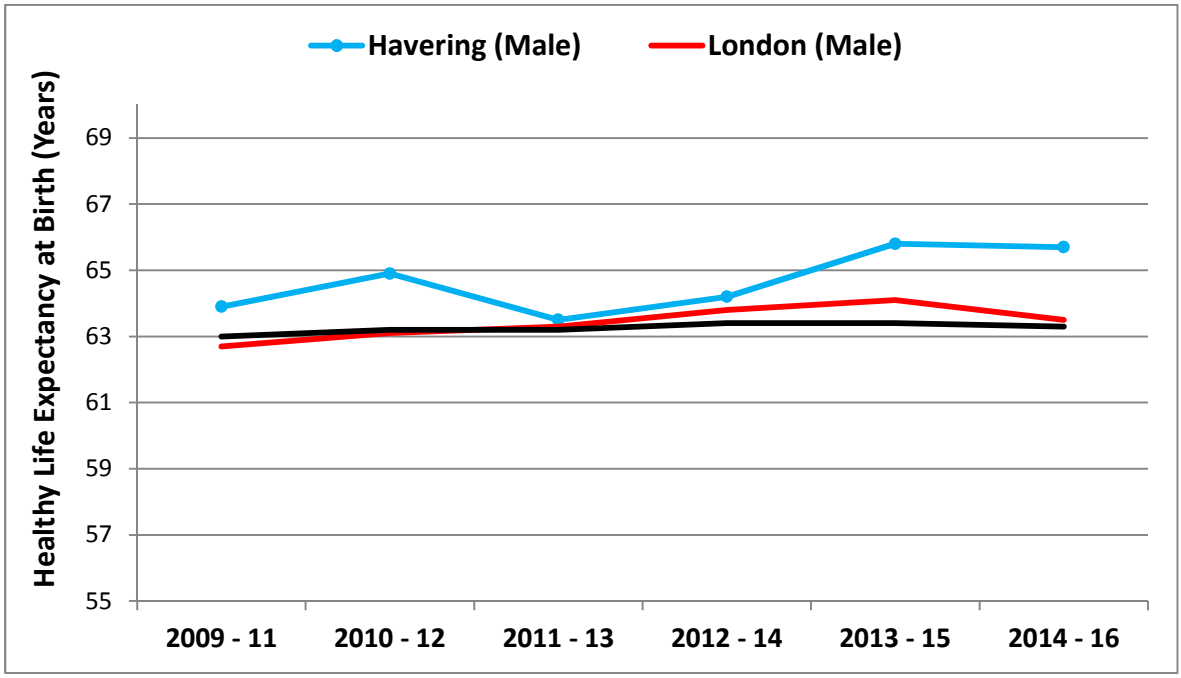
4.2 Healthy life expectancy at birth in Havering

There is much less disparity among male and females when it comes to healthy life expectancy within Havering, London and England. The latest figures based on a 3 year rolling period from 2014 to 2016 showed that Havering males had a higher healthy life expectancy compared to London and national average for males (Figure 3).

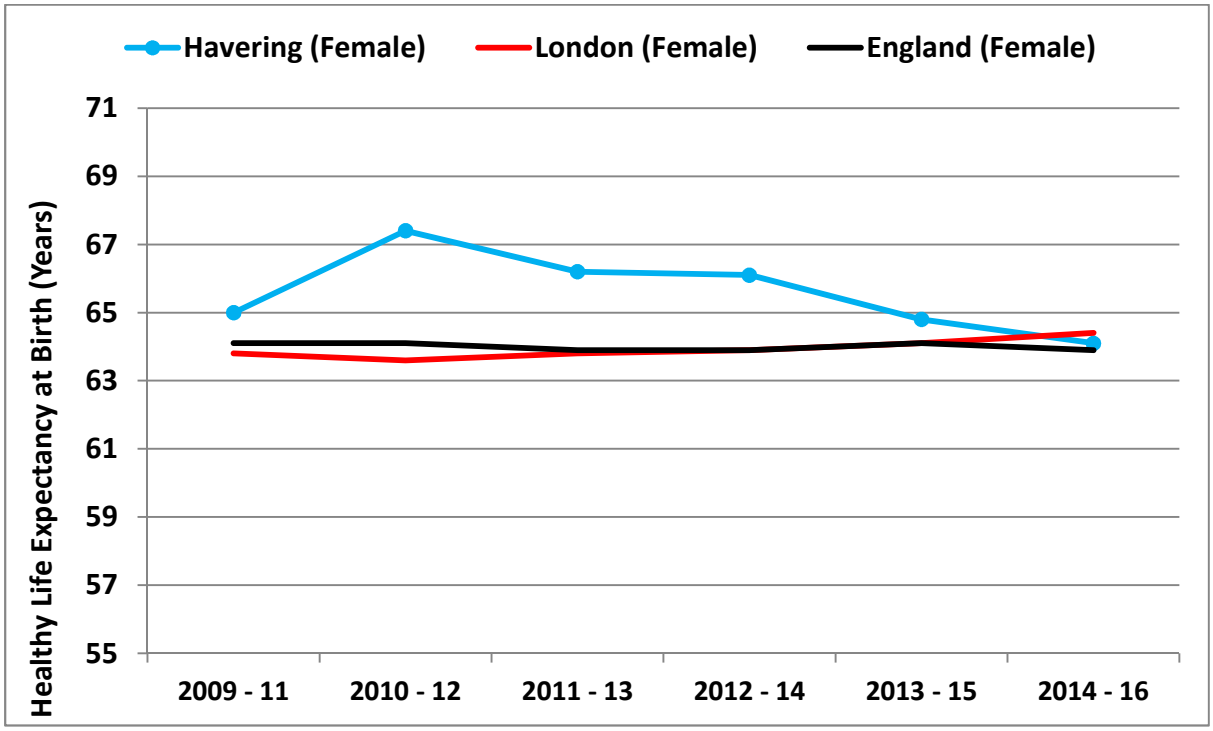
Figure 3: Healthy life expectancy at birth (years) among males, Havering compared to London and England, 3-year rolling periods, 2009-11 to 2014-16



Data source: Life expectancy at birth, 2001-2003 to 2014-16; Public Health Outcomes Framework (PHOF); Produced by Public Health Intelligence

The equivalent latest data for females showed that Havering females have a similar healthy life expectancy when compared with the London and England average (Figure 4)

Figure 4: Healthy life expectancy at birth (years) among females, Havering compared to London and England, 3-year rolling periods, 2009-11 to 2014-16



Data source: Life expectancy at birth, 2001-2003 to 2014-16; Public Health Outcomes Framework (PHOF); Produced by Public Health Intelligence

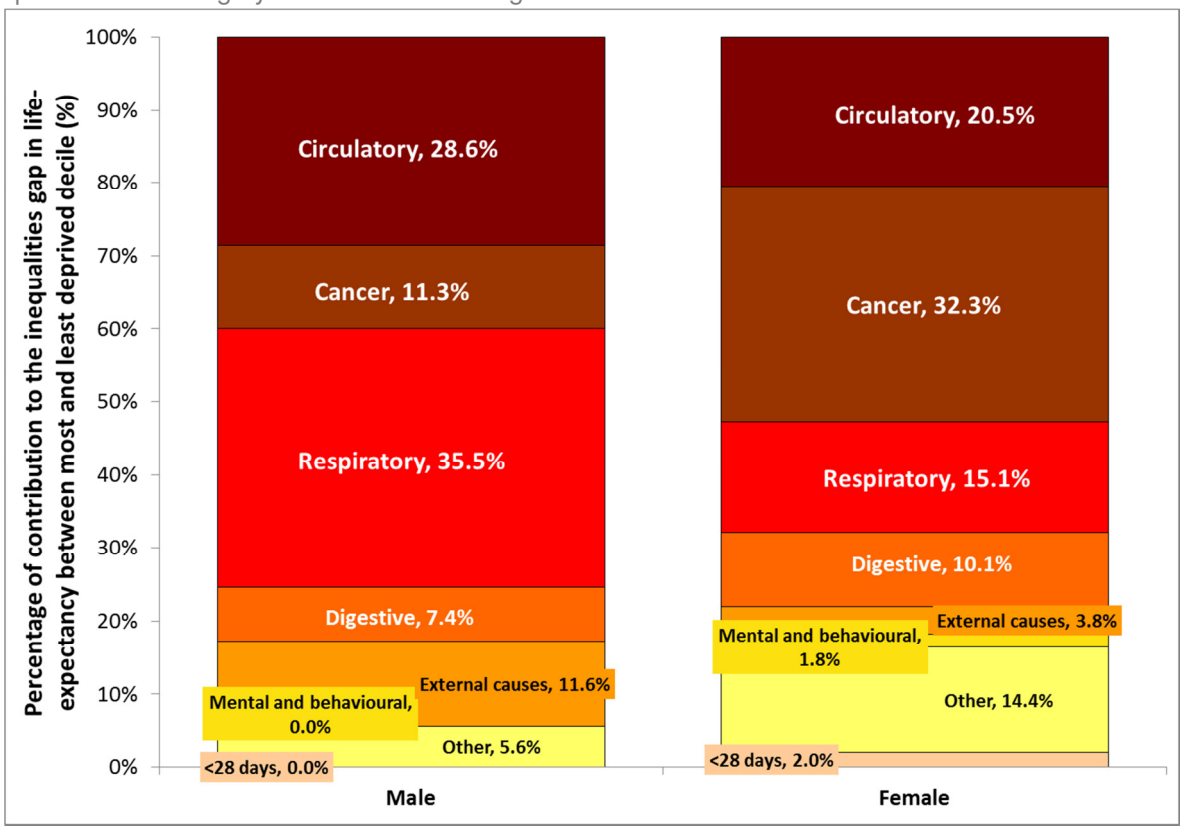
4.3 Life expectancy gap in Havering

People living in the most deprived parts of the borough are more likely to die early compared to those living in the least deprived parts of the borough (See Figure 4)

Main causes of death:

- Cancer: The main causes are lung, bowel, breast and prostate. The single most important risk factor for cancers is smoking. Men from the most deprived parts of the borough are more likely to die early from cancer.
- Heart disease and Stroke: Women from the most deprived parts of the borough are more likely to die early from heart disease.
- Lung disease: The main type of lung disease responsible for deaths is Chronic Obstructive Pulmonary Disease (COPD); the single most important risk factor is smoking. Men from the most deprived parts of the borough are more likely to die early from lung problems.

Figure 4: Breakdown of life expectancy gap between the most deprived quintile and the least deprived quintile in Havering by cause of death and gender



"<28 days" means neonatal deaths (i.e. deaths under 28 days).

Data source: Life Expectancy Segment Tool 2012-2014 (Published May 2016), Public Health England; Produced by Public Health Intelligence

5. What are the risk factors for ill health in Havering

5.1 Risk factors contributing to deaths by cause in the UK and Greater London

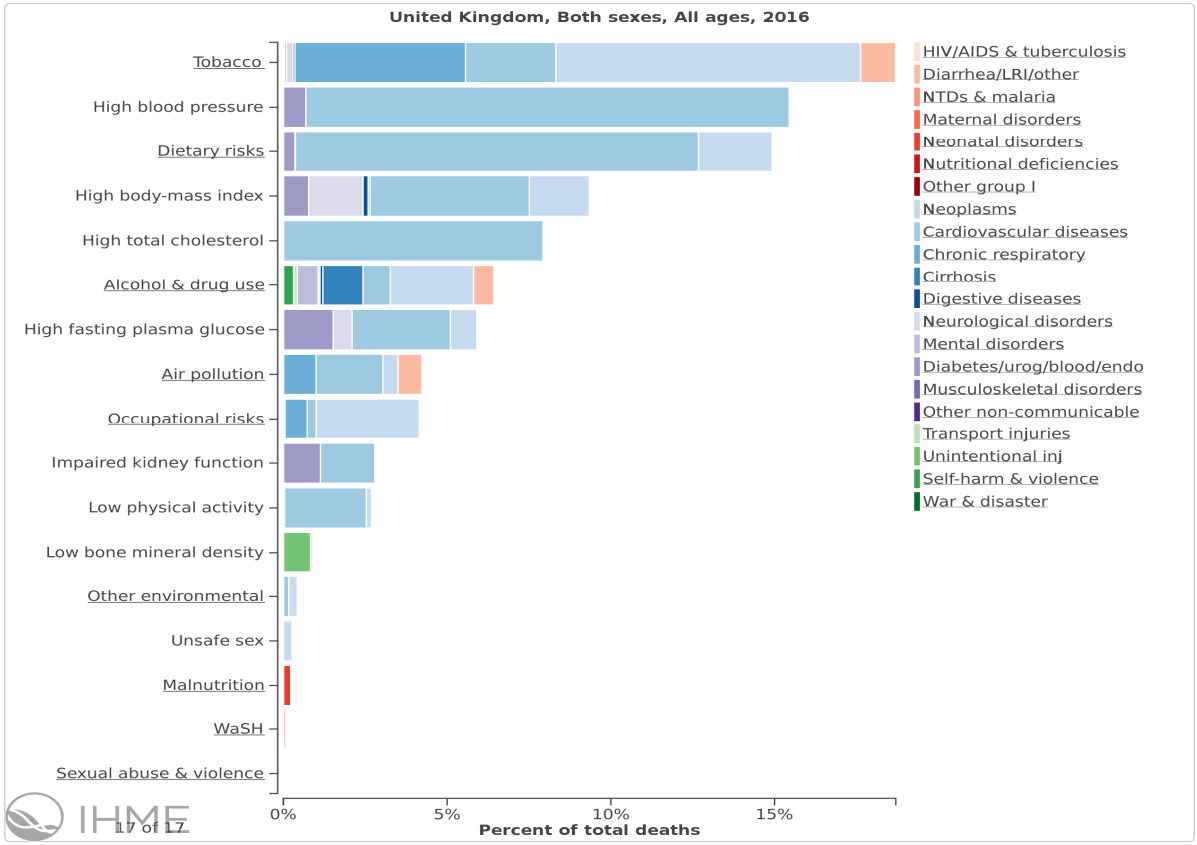
The trends and causes of death in the population are influenced by a broad range of factors. Using the Global Burden of Disease (GBD) model, certain risk factors for disease can be ranked based on the proportion of deaths they are associated with. The GBD divides risk factors into three main groups: behavioural, metabolic and environmental. Metabolic risk factors include high body mass index (BMI) and high cholesterol.

Behavioural risks include smoking, alcohol, and unsafe sex, while environmental and occupational risks include air pollution, unclean water and other risks due to the working or living environment.

The behavioural risk factors estimated to account for the highest proportion of deaths in the UK and Greater London in 2016 were tobacco smoke and diet (Figure 5 and Figure 6). Breaking dietary risk factors down into the causes of death they are associated with, it can be seen that they contribute to deaths from cardiovascular disease (heart disease and stroke), cancers and diabetes.

The smoking of tobacco is associated with deaths from cancer, chronic respiratory diseases, cardiovascular diseases, and other common infections, especially lower respiratory conditions.

Figure 5: Attribution of deaths to risk factors and broken down by broad causes of death in the United Kingdom, 2016

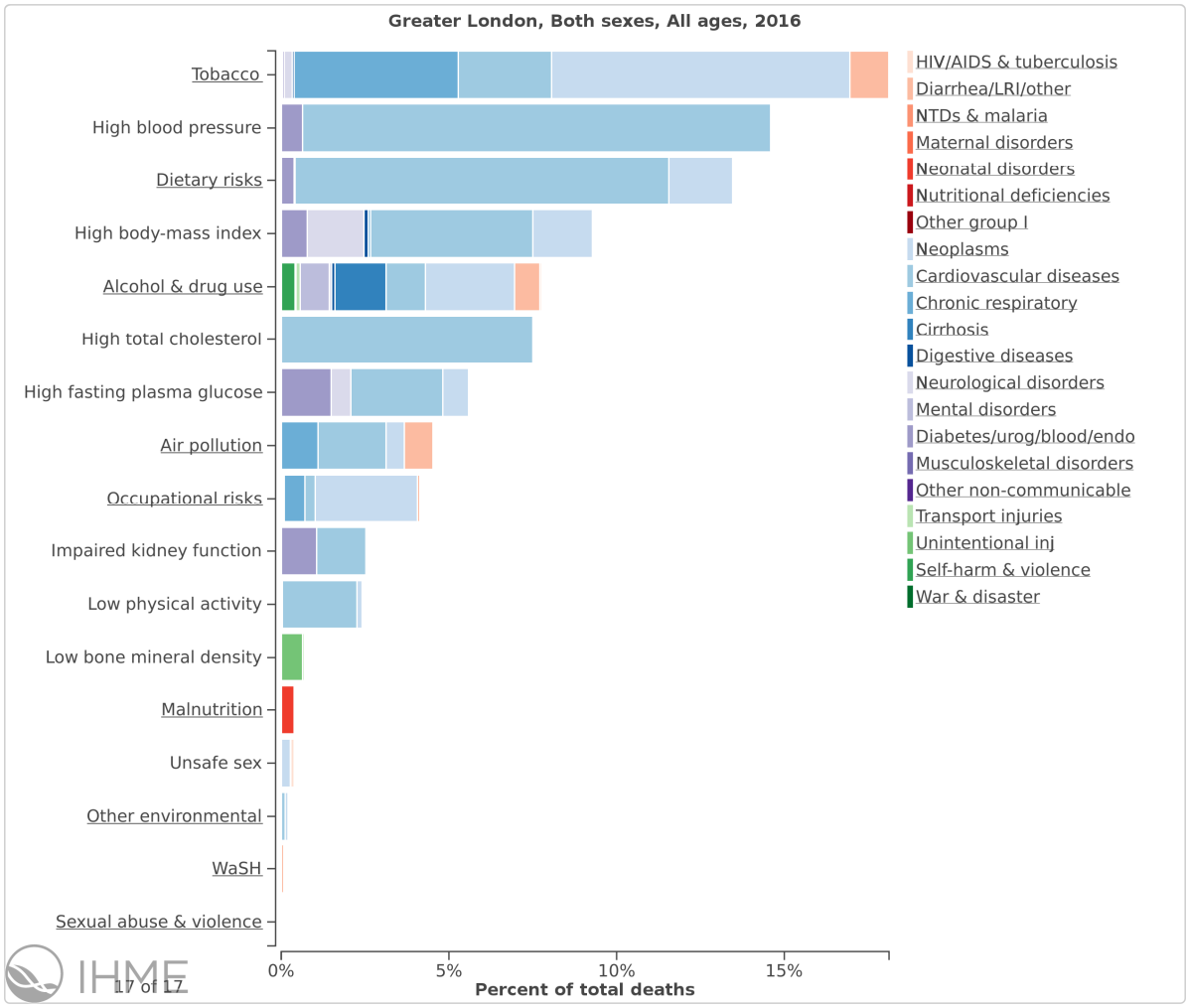


Data source: Global Burden of Disease 2016

This shows:

- among those risk factors included in the GBD UK analysis, tobacco smoke and high blood pressure accounted for the most deaths
- for dietary risks, the majority of deaths were due to cardiovascular diseases (heart disease and stroke)
- tobacco smoke accounted for deaths from four major causes, cardiovascular diseases (heart disease and stroke), neoplasms (cancers), chronic respiratory diseases, and common infectious diseases
- London had a similar risk profile with the UK (Figure 6)

Figure 6: Attribution of deaths to risk factors and broken down by broad causes of death in Greater London, 2016



Data source: Global Burden of Disease 2016

5.2 Risk factors for ill health in Havering: *Children and Young People*

The key risk factors for ill health in Havering include low levels of breastfeeding, childhood obesity, insufficient physical activity and teenage pregnancy.[12] The risk factors for health are organised along the life course (children and adolescent, and adult) as an organising principle.

Childhood obesity

On average, one in four children (25.1%) in Reception Year (Figure 7) and two in five children (38.9%) Year 6 (Figure 8) in Havering schools are overweight or obese.

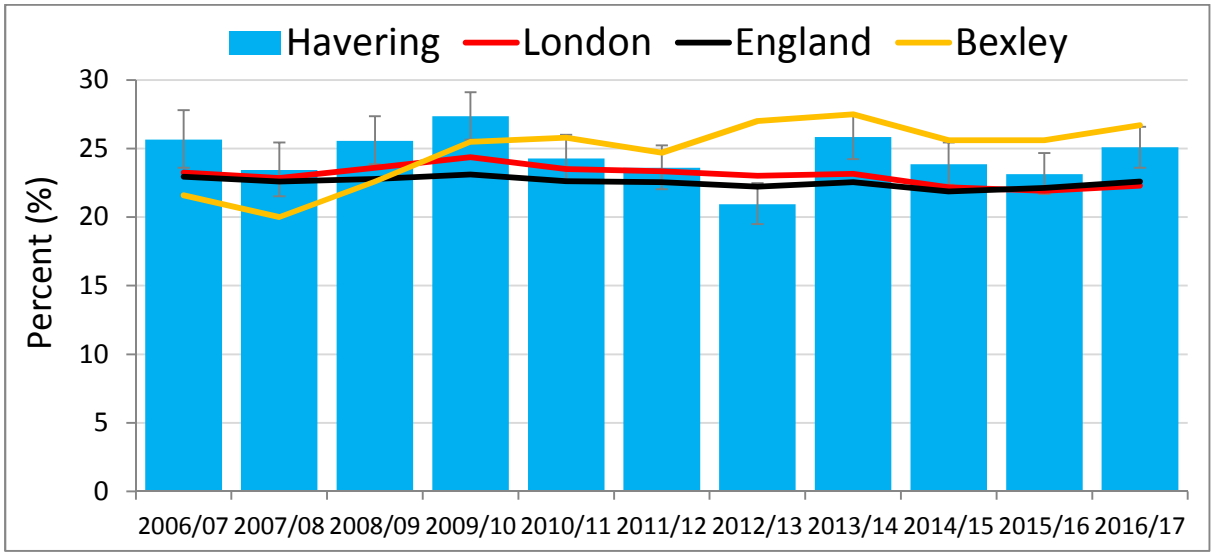
[12] *Public Health Outcomes Framework (PHOF – Health Improvement Domain), Public Health England*

Figure 7 shows that (in 2016/17) the proportion of Year 6 children in Havering that are overweight or obese continues for the third consecutive year to be significantly higher than the England average (34.2%).[13]

Health risks associated with being overweight in childhood are significant. Obese children are more likely to be obese in adulthood. Obese adults are more likely to die early (e.g. from cancer and circulatory diseases), develop limiting long-term illness (e.g. type 2 diabetes and osteoarthritis) and experience mental ill-health. As a result of the physical and mental health problems associated with childhood obesity, obese and overweight adolescents have a third more sick days than their healthy weight peers. The total cost of obesity to the UK economy is estimated at £27 billion per year.[14] The implications of Havering's high levels of obesity are therefore clear in terms of the demand placed on health and social care services and budgets.

A sustained, system wide approach is needed to reduce levels of obesity overall and narrow inequalities associated with deprivation. Actions to address obesity that are within the gift of local government and partners are detailed in Havering's *Prevention of Obesity Strategy* including a number of actions that focus on encouraging physical activity and healthy eating amongst low income families, for example introduction of the Kitchen Social programme and promotion of the Healthy Start scheme.

Figure 7: Proportion of children in Reception Year (aged 4-5 years) classified as overweight or obese, Havering compared to London, England and Bexley, 2006/07 to 2016/17

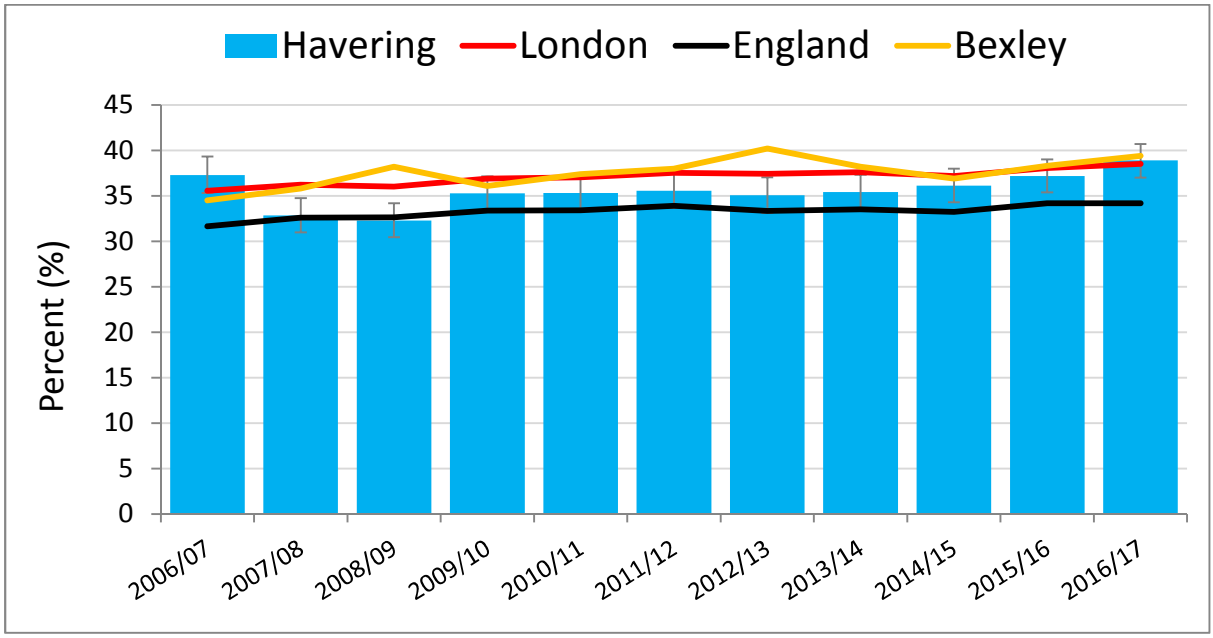


Data source: National Child Measurement Programme (published November 2017), Health and Social Care Information Centre; Produced by Public Health Intelligence

[13] *National child Measurement programme, Health and Social Care Information Centre*

[14] London Borough of Havering (2016) Prevention of Obesity Needs Assessment

Figure 8: Proportion of children in Year 6 (aged 10-11 years) classified as overweight or obese, Havering compared to London, England and Bexley, 2006/07 to 2016/17

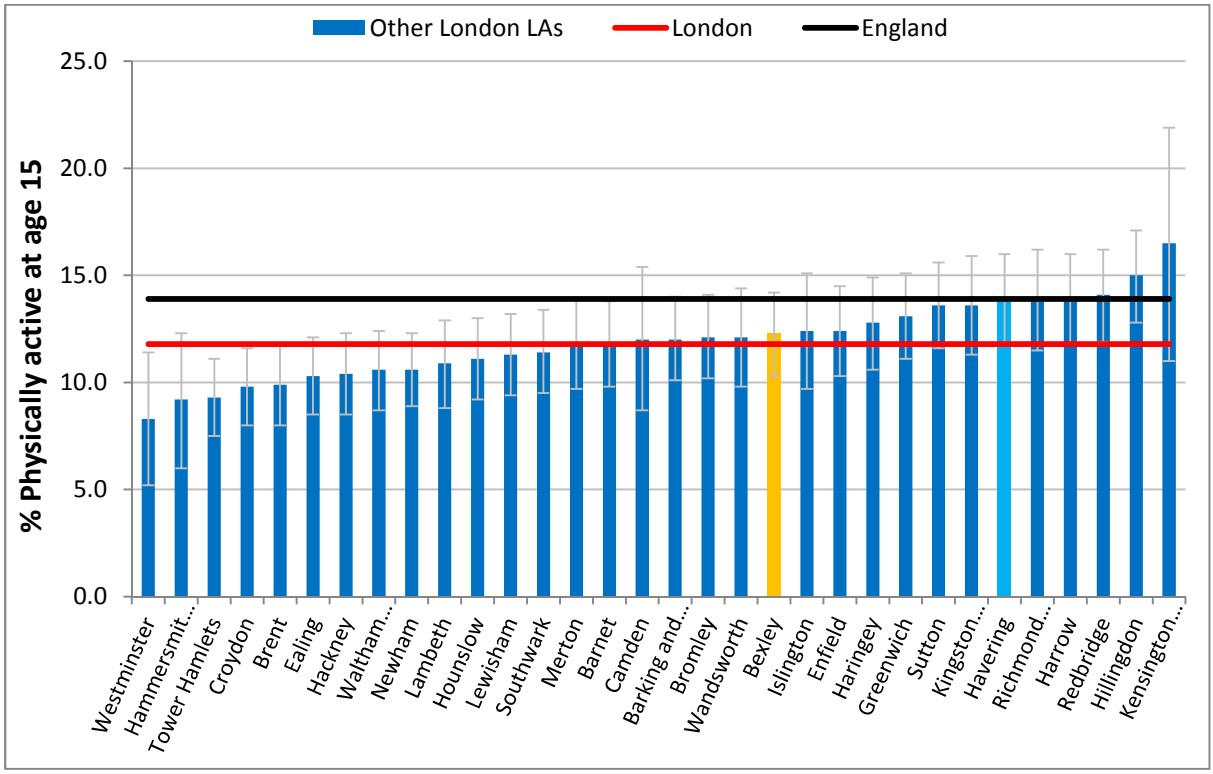


Data source: National Child Measurement Programme (published November 2017), Health and Social Care Information Centre; Produced by Public Health Intelligence

Physical activity

Just above 12% of 15 year olds in Havering were physically active for at least 1 hour according to the 2014/15 WAY survey; however this was similar to both London and England averages (Figure 9)

Figure 9: % of 15 year olds physically active for atleast one hour per day, seven days a week, 2014/15



Data source: Public Health Outcomes Framework 2.11iv (accessed April 2018); Produced by Public Health Intelligence

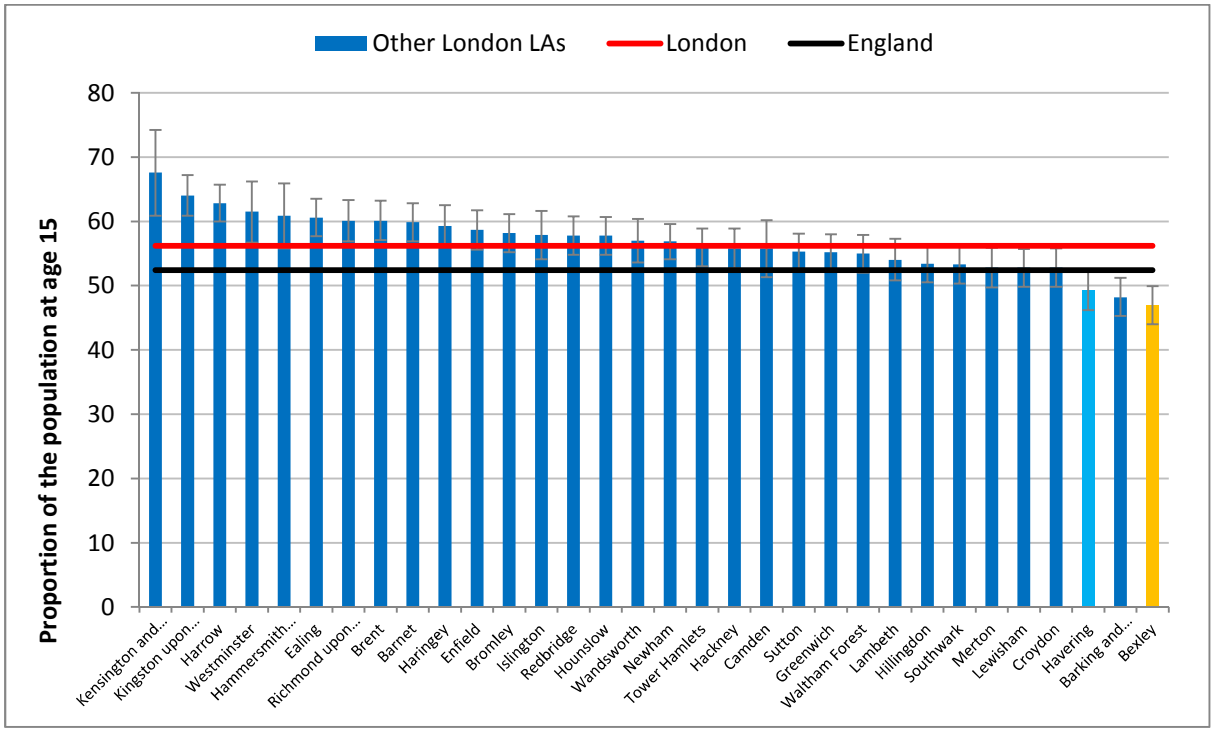
The implications for Havering of low levels of physical activity and high levels of sedentary behaviour are numerous. Increasing physical activity levels would reduce the risk of preventable diseases including cancer and diabetes, and conditions like obesity and depression[15], which would in turn reduce demand on health and social care services and budgets.

Diet and nutrition

Unhealthy diets contribute to obesity and poor oral health. Fruit and vegetable consumption is used as an indicator of dietary health. When comparing regional and national data collected as part of the What About YOUth (WAY) survey for 2014/15, about half of the population (49.2%) in Havering were eating the recommended five portions of fruit and vegetables a day at age 15. Comparisons with other London local authorities showed that Havering had a lower rate than many of the other local authorities. It was better than in Bexley (46.9%), but it was statistically significantly worse than the national figure of 52.4% and London average of 56.2% (Figure 10).

[15] PHE (2016) Everyboy Active Everyday

Figure 10: Proportion of the population meeting the recommended '5-a-day' at age 15 in Havering, compared to London, England and other London LAs in 2014/15

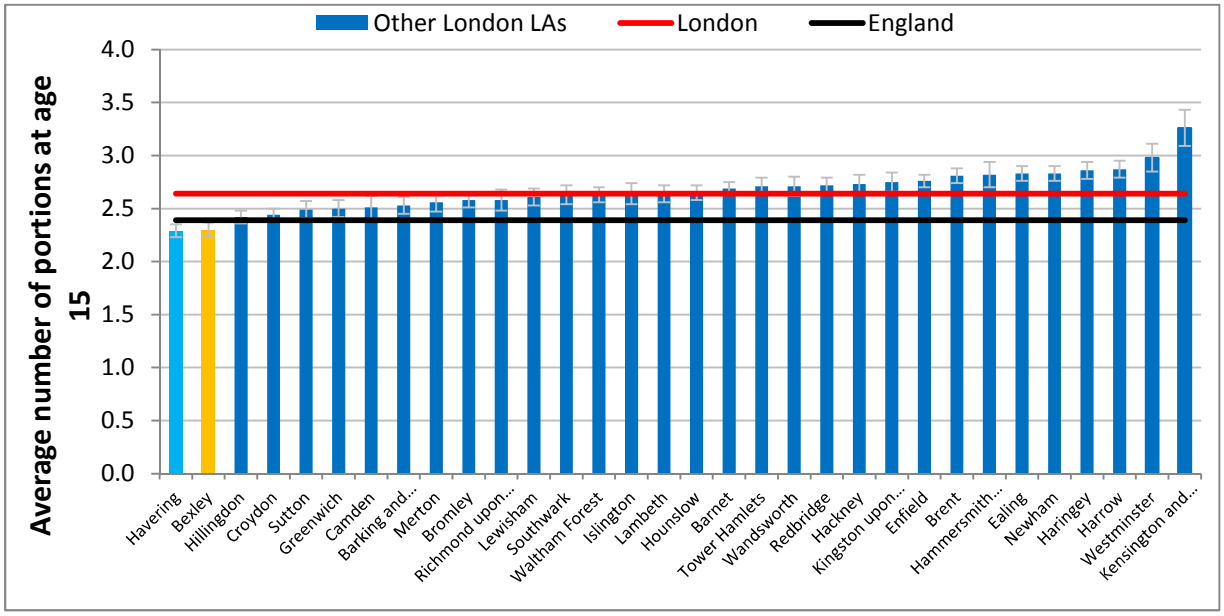


Data source: Public Health Outcomes Framework 2.11iv (accessed April 2018); Produced by Public Health Intelligence

The average number of portions of fruit eaten per day in Havering (2.29) was similar to Bexley (2.30), but was statistically significantly lower than the national (2.39) and London (2.64) average (Figure 11)

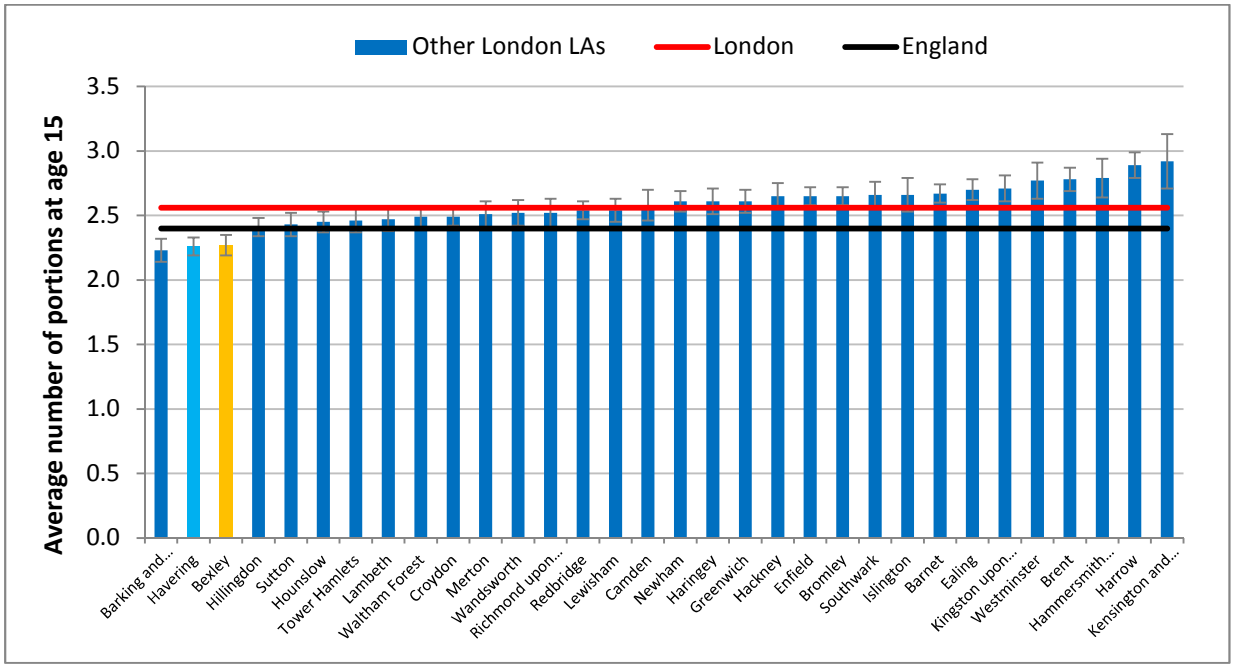
In terms of vegetables, a similar pattern is seen. The average number of portions of vegetables eaten per day in Havering (2.26) was similar to Bexley (2.27), but was statistically significantly lower than the national (2.40) and London (2.56) average (Figure 12).

Figure 11: Average numbers of portions of fruit consumed per day at age 15 in Havering, compared to London, England and other London LAs in 2014/15



Data source: Public Health Outcomes Framework 2.11v (accessed April 2018); Produced by Public Health Intelligence

Figure 12: Average numbers of portions of vegetables consumed per day at age 15 in Havering, compared to London, England and other London LAs in 2014/15



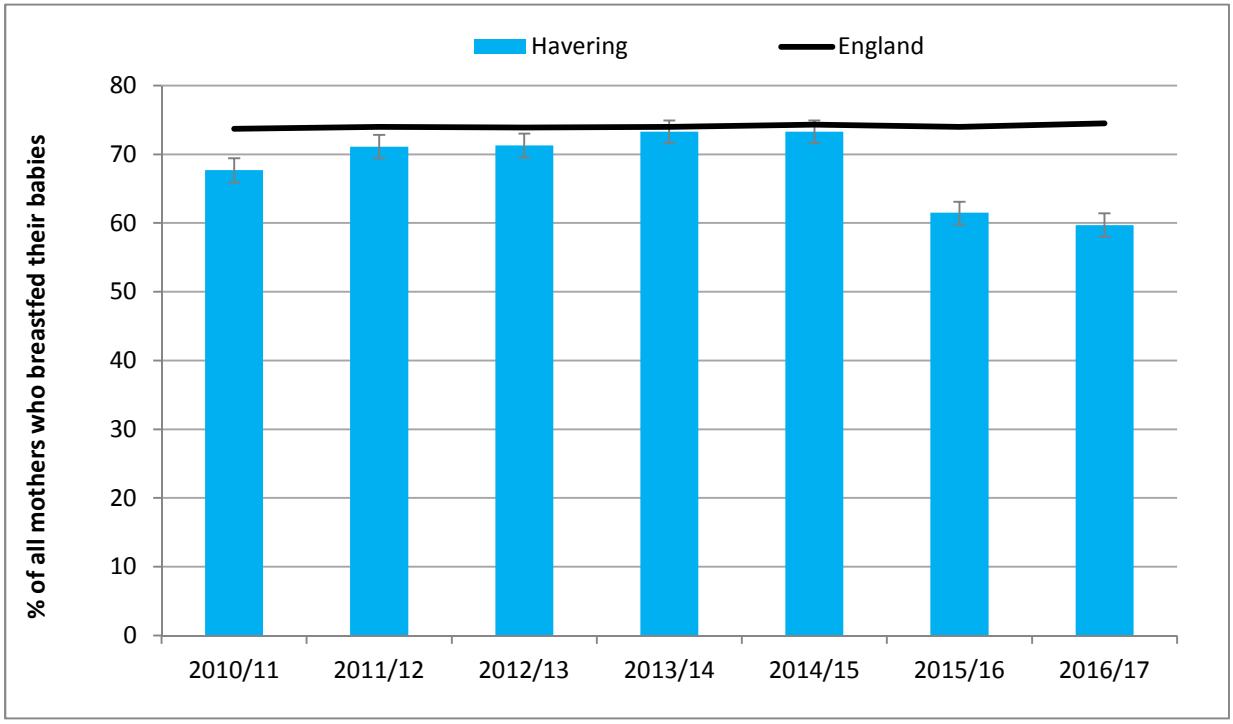
Data source: Public Health Outcomes Framework 2.11vi (accessed April 2018); Produced by Public Health Intelligence

Breastfeeding

Breastfeeding benefits both baby and mother. It protects against cancer, obesity, diabetes, infections and sudden infant death, and supports loving relationships and brain development.[16]Breastfeeding rates in the UK are among the lowest in Western Europe, with young mothers, women of lower socioeconomic status or those who left full-time education at an early age being least likely either to start breastfeeding or to continue breastfeeding beyond six to eight weeks.[17]

In Havering, 60% of mothers breastfed at birth in 2016/17. This is significantly worse than England average (74.5%) and the gap between Havering and England average has increased since 2014. In 2016/17 Havering had the lowest breastfeeding initiation rate in London region (Figure 13 and Figure 14).[18]

Figure 13: Percentage of all mothers who breastfed their babies in the first 48 hours after delivery in Havering, England, 2010/11 – 2016/17



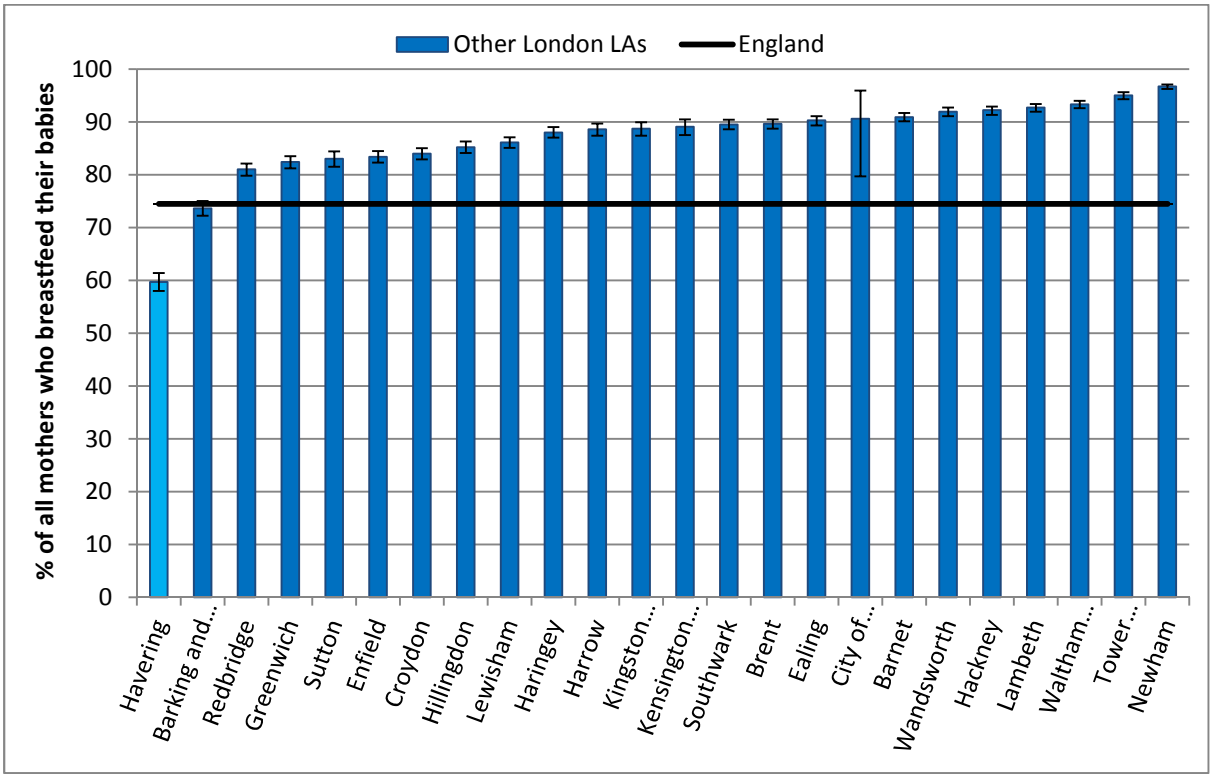
Data source: Public Health Outcomes Framework 2.02i (accessed April 2018); Produced by Public Health Intelligence

[16] *Victora, et al (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet, 387: 475–90*

[17] *Guide to the UNICEF UK Baby Friendly Initiative Standards*

[18] *Public Health Outcomes Framework 2.02i (2016/17) Breastfeeding Initiation*

Figure 14: Percentage of all mothers who breastfeed their babies in the first 48 hours after delivery, Havering, England, and other London Local Authorities in 2016/17



Data source: Public Health Outcomes Framework 2.02i (accessed April 2018); Produced by Public Health Intelligence

Data on continuation of breastfeeding at 6-8 weeks was not available at the time of writing. A new process for capturing and reporting this is being developed and will provide a valuable indication of the impact of breastfeeding promotion interventions once available.

Available data demonstrates a need to improve breastfeeding rates in Havering in order for mothers and babies to benefit from the protective factors and health benefits it provides. Research suggests that a flexible, family-centred approach is most successful, and that services should work towards empowering women to overcome potential barriers to breastfeeding, rather than simply focusing on the end goal of increasing breastfeeding rates.[19]

Early Help and Health Visiting services in Havering should aim to build on the approach taken by maternity and neonatal services in achieving Unicef Baby Friendly Initiative (BFI) Stage 2, mapping actions they are taking to align with the BFI framework relative to their services. Continuing to build communication across acute, community and voluntary sector organisations is also key.

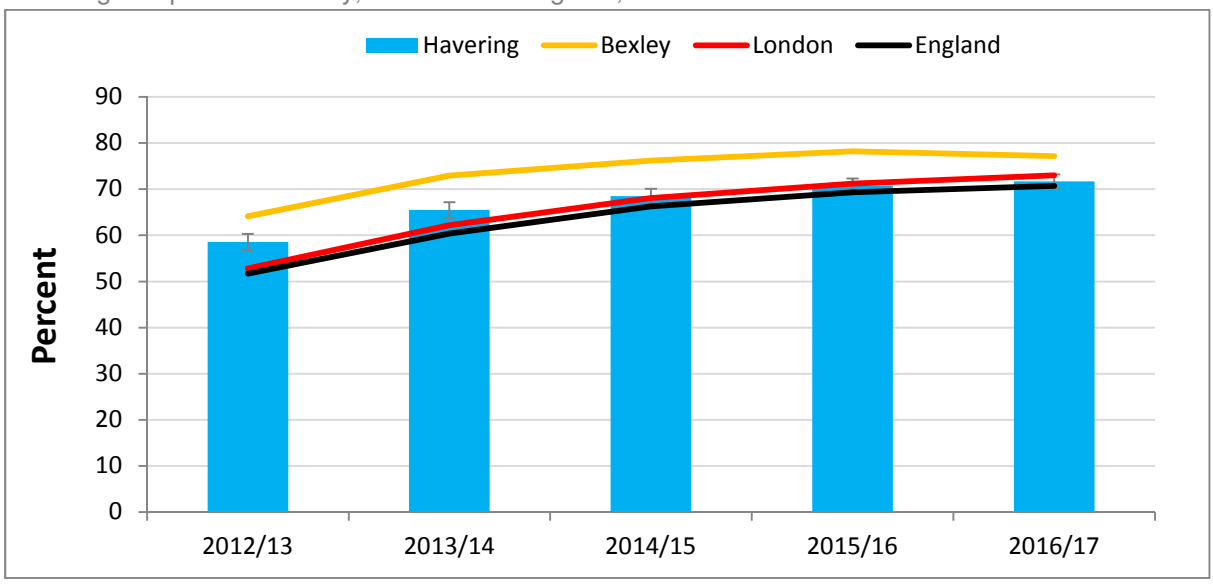
[19] Groleau (2017) Empowering women to breastfeed: Does the Baby Friendly Initiative make a difference?

Early Years

Achieving the very best outcomes in the early years is fundamental to shifting the long-term health and wellbeing of the residents of Havering. Evidence-based interventions[20] that have been shown to be highly cost effective include preschool early childhood education for 2, 3 and 4 year olds in families with low incomes.

There was an increase in the proportion of children achieving a good level of development during early years from over 50% to above 70% between 2012-13 and 2016-17. The proportion of children achieving a good level of development at the early years foundation stage in Havering is similar to London (73.0%) and England (70.7%) average in 2016-17 (Figure 15).

Figure 15: Percentage of children achieving a good level of development at the end of reception in Havering compared to Bexley, London and England, 2012/13 to 2016/17



Data source: Public Health Outcomes Framework 1.02i (accessed April 2018); Produced by Public Health Intelligence

Development at 2-2½ years old is also monitored by Health Visitors using the Ages and Stages Questionnaire. This tool measures child development across communication, gross motor skills, fine motor skills, problem solving and personal-social development. Data generated will create a public health outcome measure that will be of value in observing changes in population health from year to year and potentially tracking children's outcomes as they grow up.

Oral Health

Dental health in children is a good indicator of diet and overall health. Tooth decay is predominantly preventable. For 2014/15, in Havering, proportion of five year olds

[20] *Healthy child programme: rapid review to update evidence 2015*

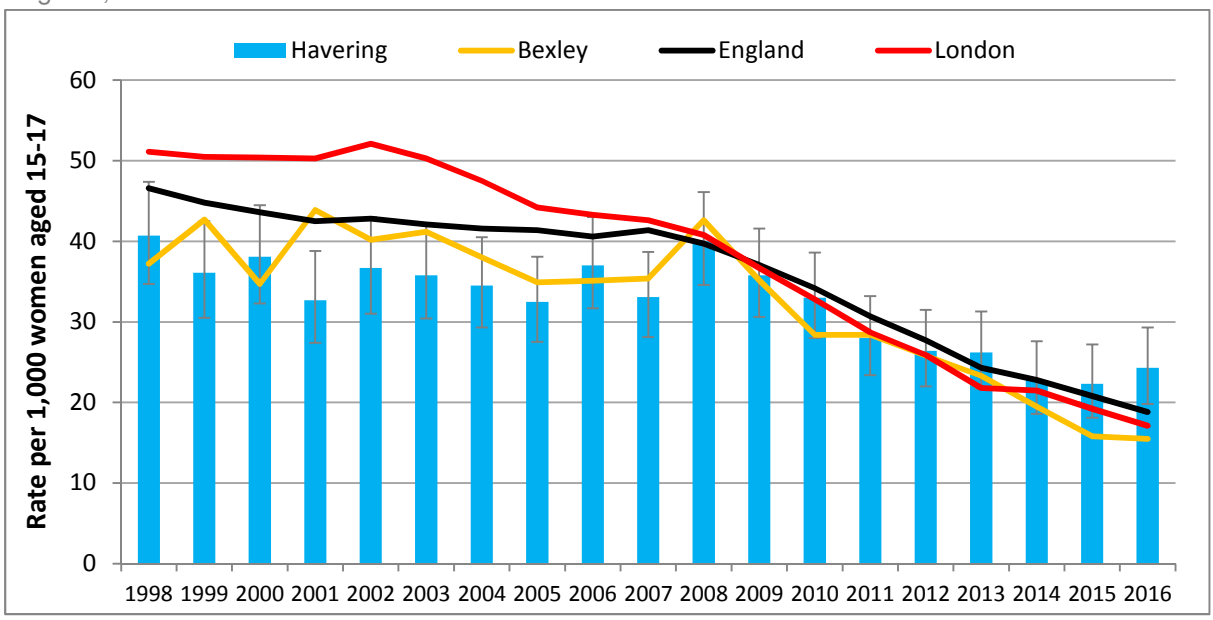
free from dental decay is 80.0%[21]. This is better than England (75.2%) and substantially better than London (72.6%), but worse than in Bexley (82.6%). Dental decay can result in pain, sleep loss, time off school and, in some cases, treatment under general anaesthetic.

Although data shows children in Havering have better oral health than average, intervention is needed to prevent inequality and to improve the oral health of children who do experience dental decay. Local services should continue to build close working relationships with the NHS England-commissioned dental outreach service, making use of available specialist training and support and facilitating links with priority groups (e.g. travelling communities and children in alternative provision) and schools in targeted areas of deprivation.

Teenage pregnancies

Teenage (under-18) conception rate in Havering has substantially decreased from the rate in 1998. However, the rate (24.3 per 1,000 women under the age of 18) in 2016 in Havering is worse than Bexley (15.5 per 1,000), London (17.1 per 1,000) and England (18.8 per 1,000) (Figure 16). For the conception rate under 16, the rate (3.2 per 1,000) in Havering is worse than England (3.0 per 1,000) and London (2.4 per 1,000), but better than Bexley (3.5 per 1,000).[22]

Figure 16: Under 18-conception rate per 1,000 women aged 15-17, Havering, Bexley, London and England, 1998-2016



Data source: Conception Statistics 2016 (published March 2018), Office for National Statistics; Produced by Public Health Intelligence

[21] *Dental Health Profile, Public Health England published October 2014 v2 % decay experience refers to the proportion of children affected by dental decay (source: Local authority dental profiles 5yr 2012)*

[22] *Conception Statistics 2016 (Published 27 March 2018), Office for National Statistics, Under 16 conceptions (numbers and rates) and outcome.*

Evidence shows that children born to teenage mothers are more likely to experience a range of negative outcomes in later life and are more likely, in time, to become teenage parents themselves – perpetuating the disadvantage that young parenthood brings from one generation to the next.[23]

Teenage pregnancy is both a contributory factor as well as an outcome of child poverty. However, with the right level of support, the life chances of young parents can be significantly improved.

A whole system preventative approach is key to reducing teenage pregnancy.[24] Relationships and Sex Education will become a mandatory subject within school curriculums from September 2019. This provides a good opportunity to develop a template borough policy for schools, ensure education and health professionals are appropriately trained to deliver support in this area, and ensure strong working relationships between schools, school nurses and sexual health services. There is an opportunity to update Havering's Teenage Pregnancy Prevention Strategy in line with the new PHE framework.

[23] *Department of Health. The Family Nurse Partnership in England – Third Year Report, published on January 5, 2011.*

[24] PHE (2018) Teenage Pregnancy Prevention Framework: Supporting young people to prevent unplanned pregnancy and develop healthy relationships.

5.3 Risk factors for ill health in Havering: Adults

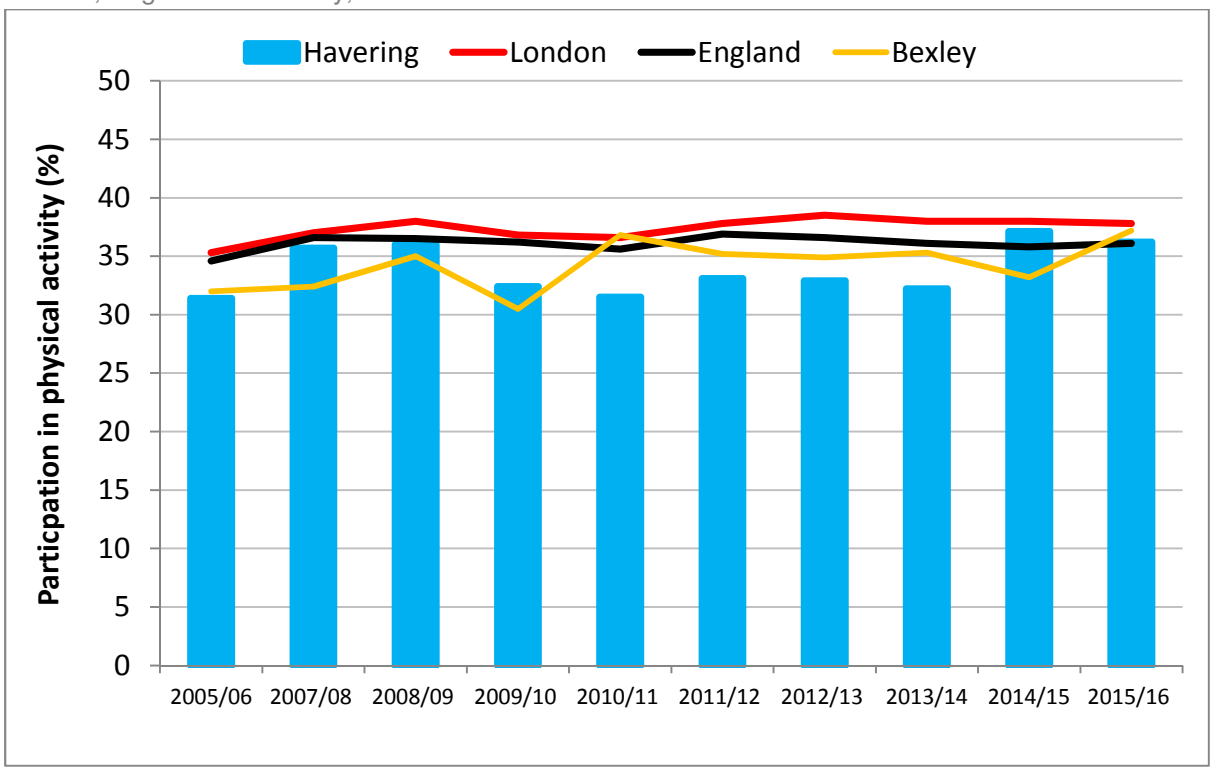
5.3.1 Excess weight

Among adults, around one in two (54%) of those registered with a General Practice (GP) in the Havering Clinical Commissioning Group (CCG) is overweight or obese.[25]

5.3.2 Physical inactivity

Physical inactivity increases the risk of being overweight and obese and developing diabetes, heart disease, cancers and mental ill health. Figure 17 below presents data from the Active People Survey which was carried out between 2005/06 and 2015/16 on behalf of Sport England. Estimates show that 36.2% of adults aged 19 years and above in Havering participated in at least once a week moderate intensity participation in physical activity in 2015/16; this was similar to the level in Bexley (37%), London (37.8%) and England (36.1%).

Figure 17: Percentage of adults participating in physical activity at least once a week in Havering, London, England and Bexley, 2005/06-2015/16



Data source: Active People Survey (APS) Interactive Tool, Sports England (accessed February 2017); Produced by Public Health Intelligence

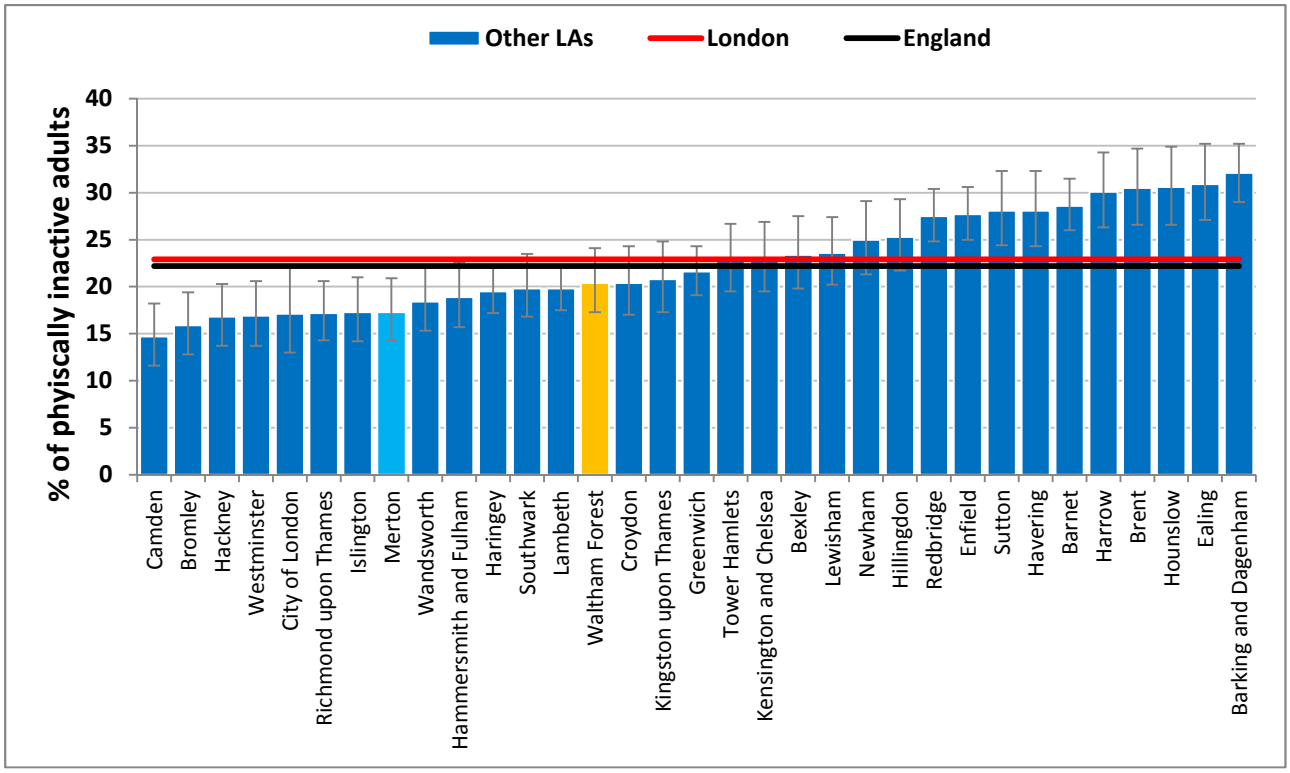
In 2016/17, 59% of adults aged 19 years and above in Havering met the guideline of 150 minutes physical activity per week in order to maintain or improve their health;

[25] *Health Analytics, (accessed March 2018); Produced by Public Health Intelligence*

this was lower compared to London (64.6%) and England (66%) but similar to Bexley (61.5%).[26]

In 2016/17, about 28% of adults in Havering aged 19 years and above were classified as physically inactive; this was significantly worse than Bexley (23.4%), London (23%) and England (22.2%) (Figure 18).[27]

Figure 18: Percentage of phyiscally inactive adults in Havering, London, England and other London LAs in 2016/17



Data source: Active Lives Adults Survey (ALAS), Sports England (accessed March 2018); Produced by Public Health Intelligence

5.3.3 Smoking

In Havering, approximately 15% of persons aged 18 years and above were smokers in 2016.[28] This is similar to both London (15.2%) and England (15.5%), but higher than the level in Bexley (12.5%). Smoking prevalence was highest in Gooshays (20.3%) and Heaton (19.6%), two of the most deprived wards in Havering; and lowest in Emerson Park (17.2%) and Upminster (16.6%) – Figure 19.[29]

Smoking increases risk of various diseases including lung cancer, throat cancer, heart disease and chronic obstructive lung disease (COPD). Since the 1980s there

[26] *Public Health Outcomes Framework 2.13i (2016/17) Percentage of physically active adults – current method*
[27] *Public Health Outcomes Framework 2.13ii (2016/17) Percentage of physically inactive adults – current method*
[28] *Local Tobacco Control Profiles, Public Health England*
[29] *Action on Smoking and Health Ready Reckoner (Published December 2015 and accessed March 2018)*

has been a fall in deaths from heart disease thought to be due mainly to a reduction in smoking. This trend has continued along with a fall in other respiratory conditions following the introduction of the smoking ban in 2007.[30]

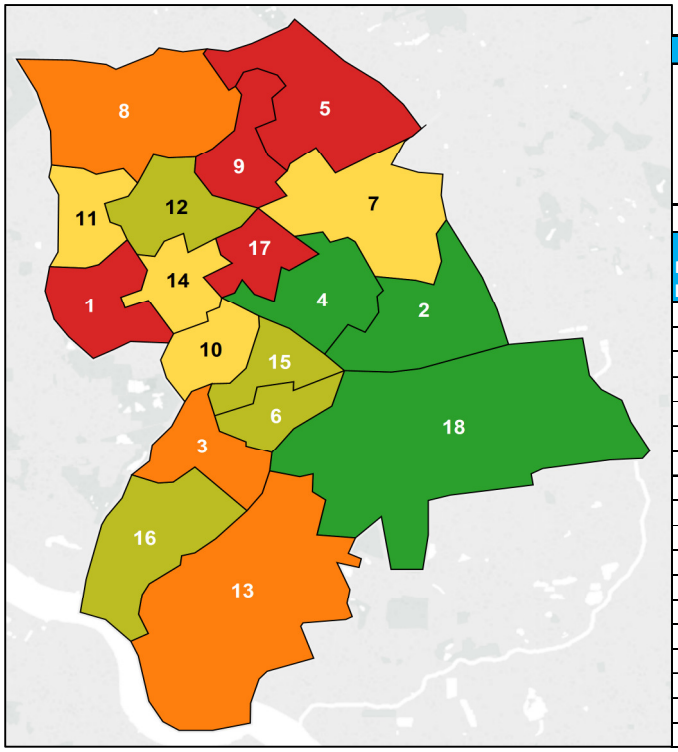
The number of deaths attributable to smoking in Havering has been on the decline since 2007-09. Between 2007-09 and 2014-16 the rate dropped from 319 to 283 per 100,000 populations aged 35 years and over.

[30] *Smoke Free England*

Figure 20 shows smoking attributable mortality in Havering, London, and Bexley between 2007-9 and 2014-16. The most recent data (2014-16) shows smoking attributable mortality in Havering is higher than the London (246.7 per 100,000 populations), England (272 per 100,000 populations), and Bexley (258.9 per 100,000) average.[31]

There has been a decreasing trend in the percentage of women in smoking status at time of delivery (Figure 21); In 2016/17 the Havering rate (7.6%) was significantly higher than the London average (4.9%) but similar to the statistical neighbour and fellow London borough, Bexley (7.5%) and lower than the national average (10.7%).

Figure 19: Smoking Prevalence (% of adult population) across Havering Wards by Quintile[32] (where Quintiles 1 and 5 refer to the lowest and highest prevalence wards respectively)



Legend

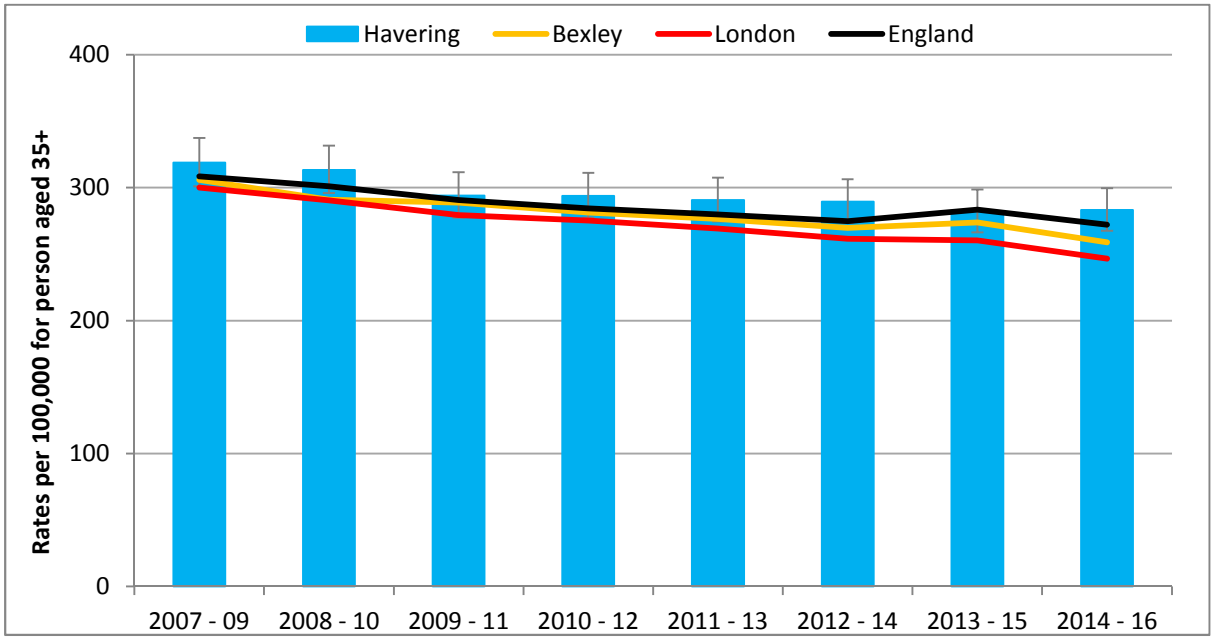
Quintile	Low(>=)	(<)High	Occurrences
1	16.6	17.6	3
2	17.6	18.3	4
3	18.3	18.8	4
4	18.8	19.1	3
5	19.1	20.5	4

Map key	Ward	Smoking prevalence (% of population aged 16+)	Quintile
1	Brooklands	19.1	5
2	Cranham	17.1	1
3	Elm Park	18.8	4
4	Emerson Park	17.2	1
5	Gooshays	20.3	5
6	Hacton	18.1	2
7	Harold Wood	18.3	3
8	Havering Park	19	4
9	Heaton	19.6	5
10	Hylands	18.3	3
11	Mawneys	18.6	3
12	Pettits	17.6	2
13	Rainham and Wennington	19	4
14	Romford Town	18.3	3
15	St Andrew's	18	2
16	South Hornchurch	19.4	5
17	Squirrel's Heath	17.6	2
18	Upminster	16.6	1

Data source: Action on Smoking and Health (ASH) Ready Reckoner Tool (published December 2015); Produced by Public Health Intelligence

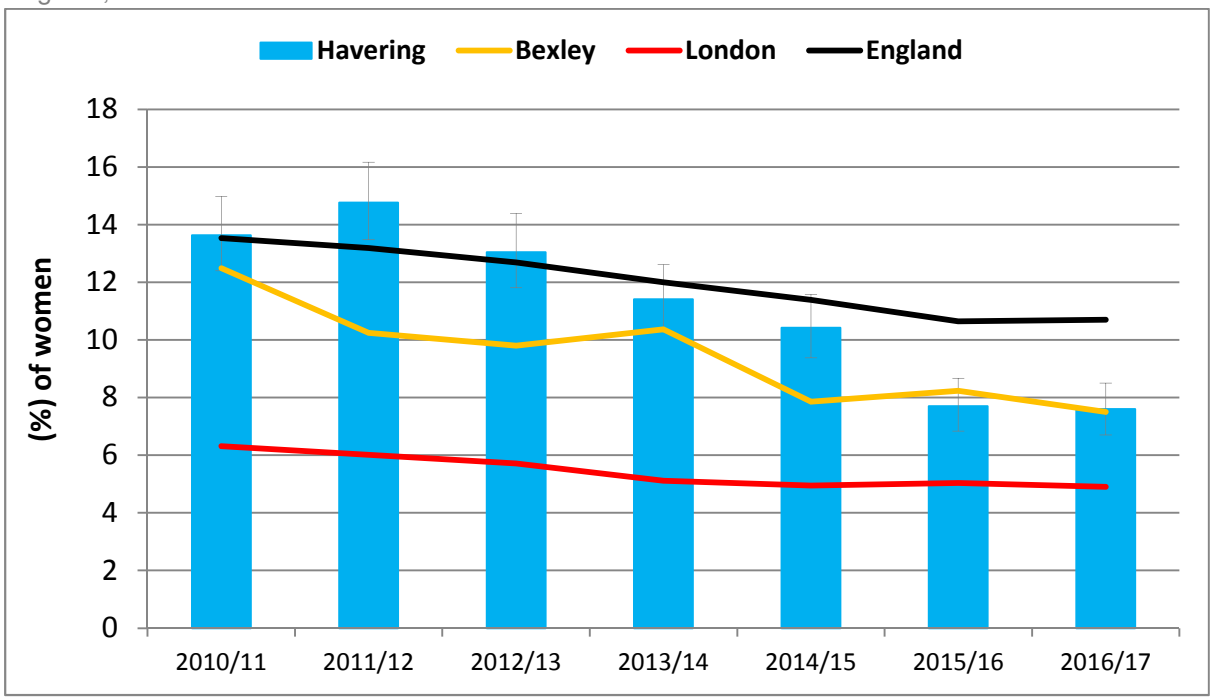
[31] *Local Tobacco Control Profile (accessed March 2018) latest available data 2014-2016, Public Health England*
[32] *Quintile is a statistical term to divide a sample or population into fifths*

Figure 20: Smoking attributable mortality in Havering, London, England, and Bexley (statistical comparator), 2007-9 and 2013-15



Data source: Local Tobacco Control Profile, accessed April 2018; produced by Public Health Intelligence

Figure 21: % of women in smoking status at the time of delivery in Havering, Bexley, London and England, 2010/11 to 2016/17



Data source: Local Tobacco Control Profile (accessed March 2017); Produced by Public Health Intelligence

5.3.4 Alcohol Misuse

Drinking alcohol above recommended limits (14 units per week for women and 21 units per week for men) increases the risk of cancers, liver and heart diseases. This is also associated with anti-social behaviour, domestic violence and other criminal offences. However, the majority of drinkers (73%) in Havering do so safely[33].

Havering had significantly better alcohol related admissions to hospital (435 per 100,000 hospital admissions for alcohol-related conditions) in comparison to London (529 per 100,000) and England (636 per 100,000) in 2016/17[34]. But alcohol as a behaviour risk factor, it implicated in 4% of ambulance call outs[35]; 16% of road fatalities[36] and over 70% of cases of domestic violence[37].

5.3.5 Maternal mental health

Women are at increased risk of suffering from mental health problems following childbirth, and women with pre-existing psychiatric disorders may also face a relapse or recurrence of their condition following childbirth.[38]

Mental illness occurring at this time may have an adverse effect on the woman herself, and also on her marriage, family and, in particular, on the future development of her infant. Maternal depression and stress related disorders are the most common maternal mental health conditions in Havering (Table 3).

[33] *Alcohol Harm Map by Alcohol Concern accessed March 2018*
[34] *Indicator 10.01: Admission episodes for alcohol-related conditions (Narrow) Local Alcohol Profile for England (accessed March 2018), Public Health England*
[35] *Drug and Alcohol Misuse in Havering JSNA (p78) via SafeStats, 2012-13*
[36] *Drug and Alcohol Misuse in Havering JSNA (p78) via Reported Road Casualties in Great Britain: 2012 Annual Report by Department of Transport*
[37] *Gilchrist, E., Johnson, R., Takriti, R., Weston, S., Beech, A. and Kebbell, M. (2003) Domestic violence offenders: characteristics and offending related needs, Findings, 217, London, Home Office*
[38] *Antenatal and postnatal mental health: clinical management and service guidance (source: NICE, published August 2014)*

Table 3: Expected prevalence of mental health among the maternal population in Havering based on National figures.

MENTAL HEALTH CONDITION	NUMBERS	PREVALENCE (per thousand maternities)
All Maternities	3,447	
Postpartum psychosis	7	2 in 1000
Chronic serious mental illness	7	2 in 1000
Severe depressive illness	103	30 in 1000
Mild-moderate depressive illness and anxiety states	345-517	100-150 in 1000
Post-traumatic stress disorder	103	30 in 1000
Adjustment disorders and stress	517-1034	150-300 in 1000

Data source: Guidance for commissioners of perinatal mental health services, Joint Commissioning Panel for Mental Health 2012 (Births based on ONS Mid-Year Population Estimates 2016); Produced by Public Health Intelligence

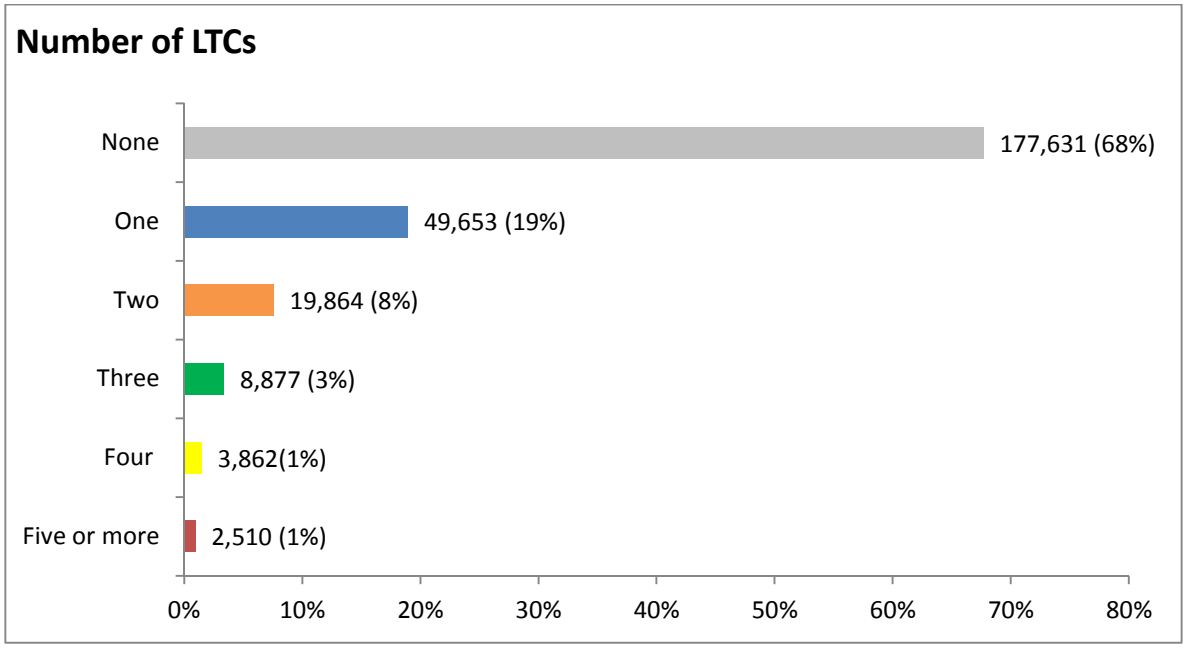
In January 2018, Havering's Early Help Service introduced 'Butterflies', a perinatal mental health support group at Collier Row Children's Centre. The group links closely to the Health Visiting Service and when additional support needs are identified refers to the Talking Therapies and Perinatal Infant Mental Health Services. This group is now running at capacity and steps should be taken to extend provision to other parts of the borough.

6. What is the current status of population health in Havering?

6.1 Long-Term Conditions

Long-term conditions (LTC) have a significant impact on daily lives including the use of urgent and emergency health and social care services. The current distribution of Havering CCG registered population by LTC count is presented in Figure 22 and the impact the LTCs have on hospital usage (compared to those with no LTC) is shown in Figure 23.

Figure 22: Number and proportion of registered people with long-term conditions count, Havering CCG, 2016/17



Data source: Health Analytics; Produced by Public Health Intelligence

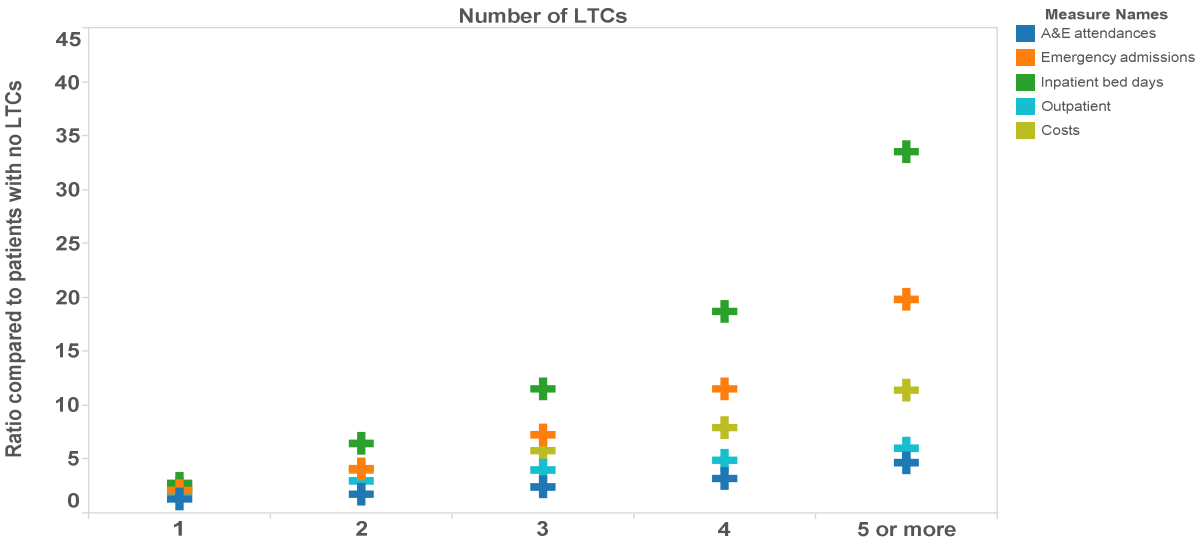
Patients with one LTC are 1.3 times more likely to attend A&E, twice as likely to be admitted for an emergency, the average number of inpatient bed days will be about 3 times greater compared to patients with no LTCs. They also have higher needs for outpatients stay for treatment or care, which is twice as likely as patients with no LTC. The healthcare cost is about 2.3 times higher in patients with one LTC than those with no LTC.

Patients with two LTCs are 1.7 times more likely to attend A&E, about 4 times more likely to be admitted for an emergency, the average number of inpatient bed days will be about 6.5 times greater compared to patients with no LTC. They also have higher needs for outpatients stay for treatment or care, which is 3 times greater than patients with no LTC. It also cost about 4 times more than those with no LTC.

Patients with five or more LTCs are about 5 times more likely to attend A&E, approximately 20 times more likely to be admitted for an emergency, the average

number of inpatient bed days will be 34 times greater compared to patients with no LTC. Patients with five or more LTCs also have higher needs for outpatient stay for treatment or care, which is 6 times greater than patients with no LTC. There is also a significant effect on cost, which is 11 times higher in patients with five or more LTCs than in those with no LTC.

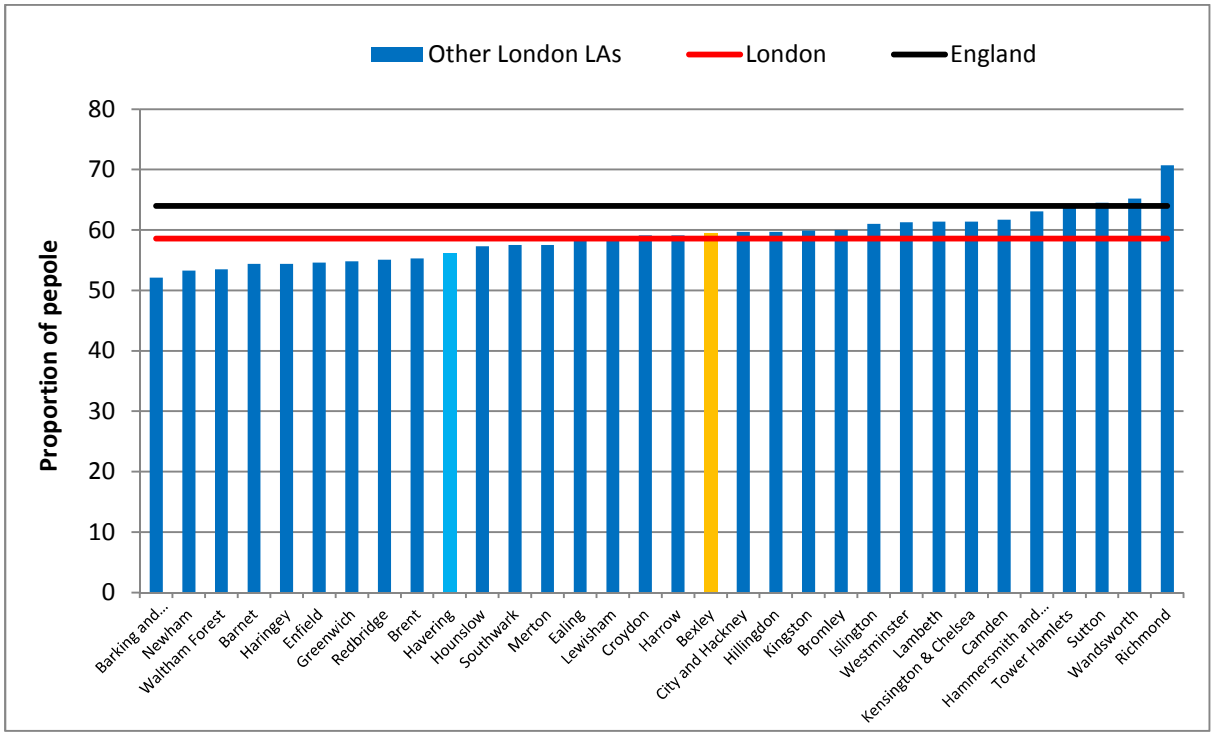
Figure 23: Ratio of patients with long-term conditions (LTCs) compared to patients with no long-term conditions (LTCs) for A&E attendances, Emergency Admissions, Inpatient Bed Days, Outpatient and Cost in 2016/17



Data source: Health Analytics; Produced by Public Health Intelligence

In 2016/17, the proportion of people who felt supported to manage their long-term conditions in Havering was about 56.2%. This was lower than the Bexley (59.5%), London (58.6%) and England (64%) average (Figure 24).

Figure 24: Proportion of people who feel supported to manage their long-term conditions, 2016/17



Data source: NHS CCG Outcomes Atlas – indicator 2.2 (http://tools.england.nhs.uk/ccgoutcomes/html/atlas.html)

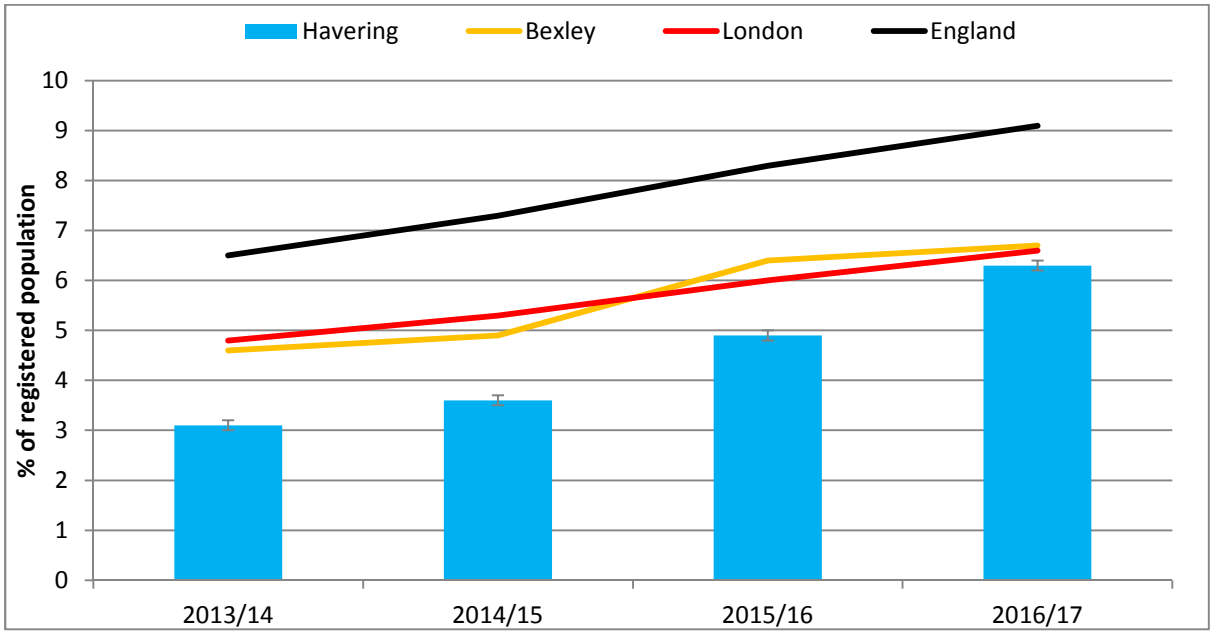
6.1.1 Mental Illness

Mental illness encompasses a range of conditions such as depression, anxiety, psychoses and schizophrenia. Risk factors for the development of mental illness are multifactorial. However, physical illness, stress and alcohol and substance misuse are important risk factors.[39]

The prevalence of depression in people aged 18 years and over in Havering has doubled over the past 4 years, from 3.1% in 2013/14 to 6.3% in 2016/17; however, Havering has shown consistently lower rates than Bexley, London and England (see Figure 25 and Figure 26).

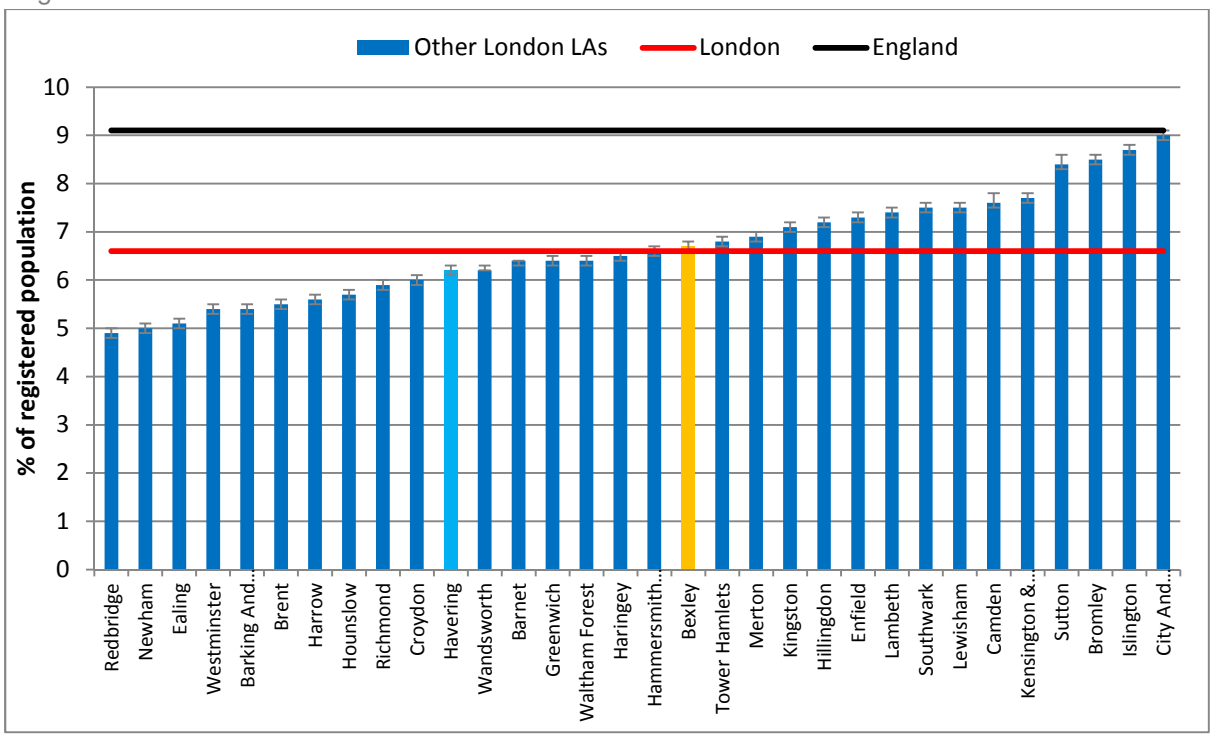
[39] *Improving the physical health of people with mental health problems: Actions for mental health nurses. Department for Health, Public Health England and NHS England, 2016.* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/532253/JRA_Physical_Health_revised.pdf*

Figure 25: Pecentage of adults aged 18+ registered as having depression in Havering, compared to Bexley, London and England, 2013/14 to 2016/17



Data source: Common Mental Health Disorders; Produced by Public Health Intelligence

Figure 26: Pecentage of adults aged 18+ registered as having depression in Havering, London, England and other London LAs in 2016/17



Data source: Common Mental Health Disorders; Produced by Public Health Intelligence

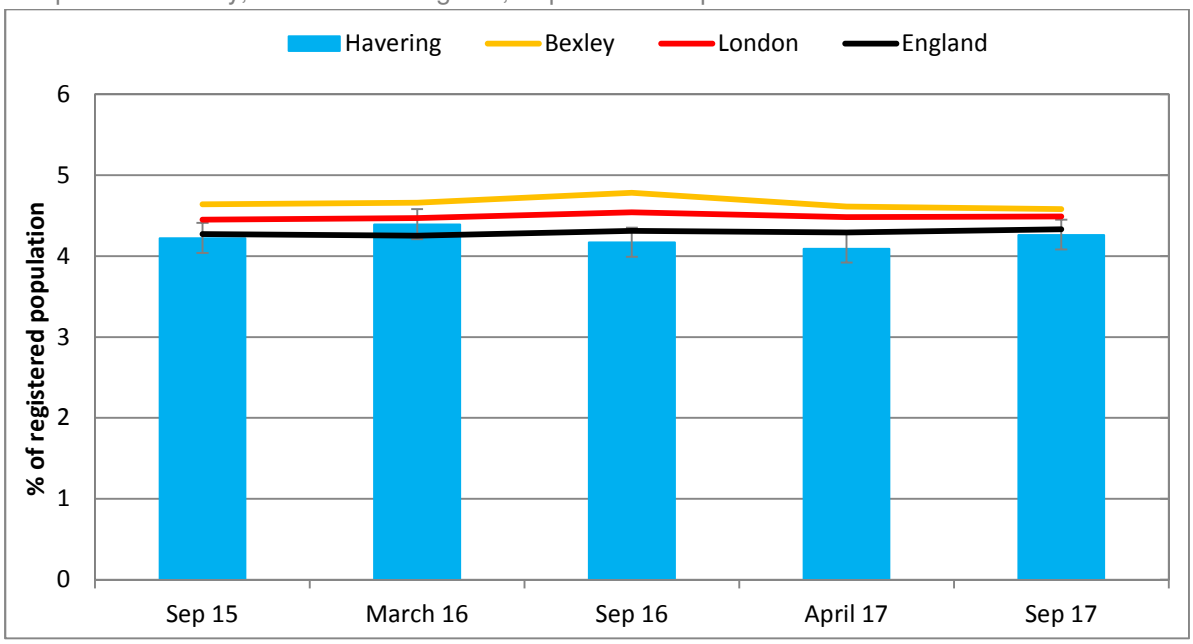
For more information on depression and mental health in Havering, see the mental health JSNA at http://www.haveringdata.net/research/jsna.htm.

6.1.2 Dementia

Dementia is a clinical syndrome of deterioration in mental function which interferes with activities of daily living (ADLs). It affects more than one cognitive domain (for example memory, language, orientation, or judgement) and social behaviour (for example, emotional control or motivation). Early (or young) onset dementia is generally defined as dementia that develops before 65 years of age. Modification of specific risk factors (in particular, cardiovascular risk factors such as smoking, diabetes and lack of physical activity) can delay or prevent the onset of dementia.[40]

In Havering, the prevalence of dementia has been around 4% in people aged 65 and above in the past 3 years. The trend is similar to England's, but lower than Bexley's and London's (see Figure 27). Figure 28 shows a much older age structure for the population of Havering compared to London but similar to England. Dementia could become an increasing problem for Havering because of its ageing population (see Figure 29). The care that people need is quite complex and expensive.

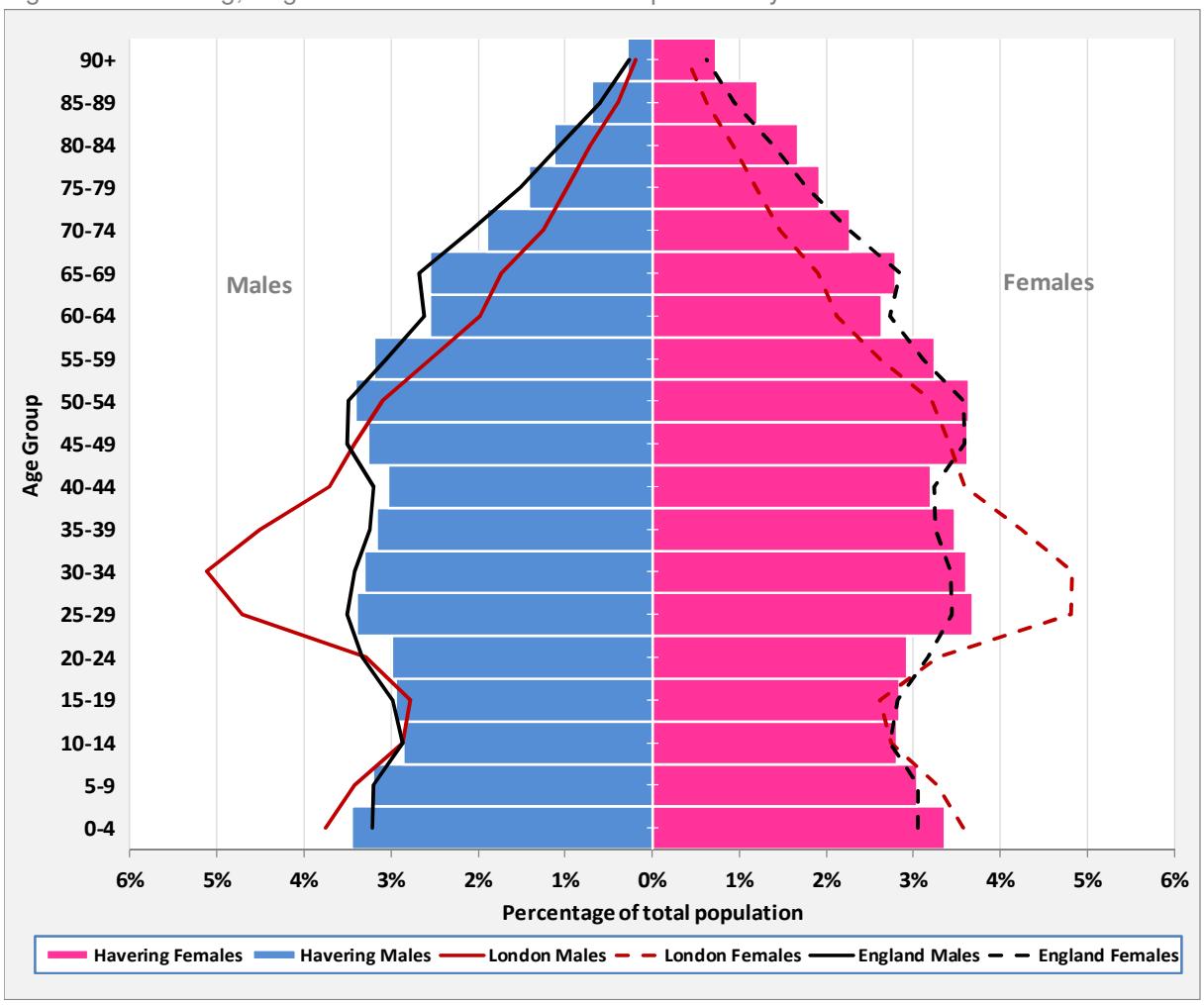
Figure 27: Percentage of patients aged 65+ with a recorded diagnosis of dementia in Havering, compared to Bexley, London and England, Sep 2015 to Sep 2017



Data source: Dementia Profile – Public Health Profiles; Produced by Public Health Intelligence

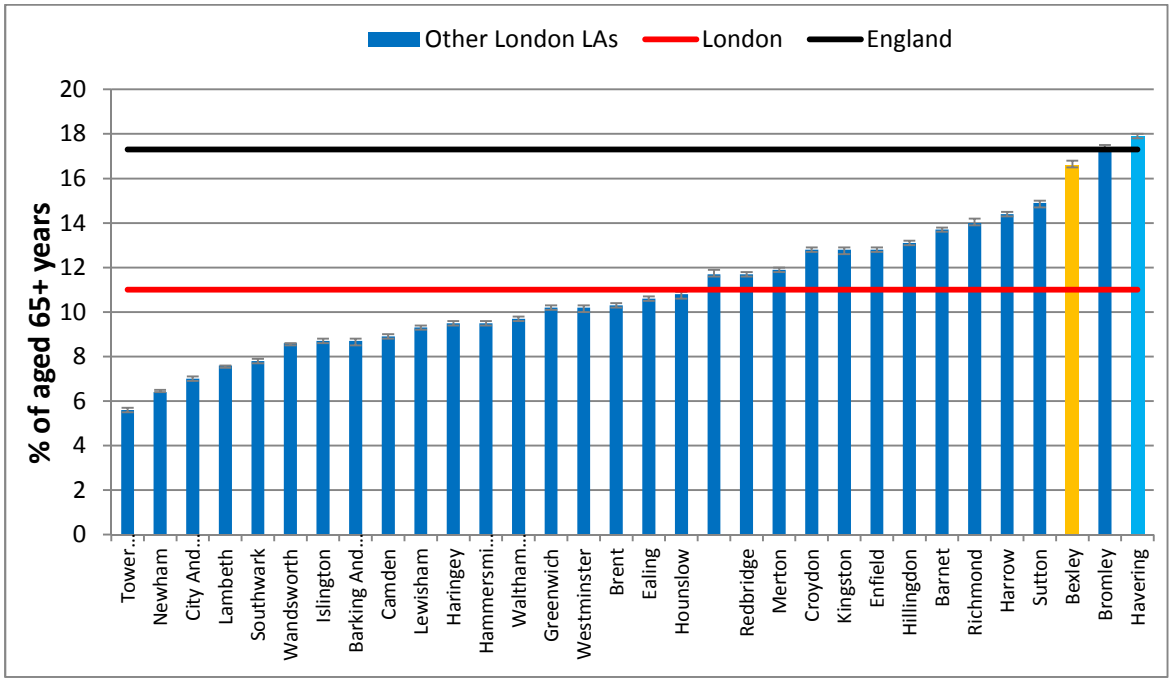
[40] *Dementia: Summary. Clinical Knowledge Summaries, NICE.* https://cks.nice.org.uk/dementia#!topicsummary

Figure 28: Havering, England and London Mid-2016 Population Pyramid



Data source: Mid-year population estimates 2016, Office for National Statistics (ONS); Produced by Public Health Intelligence

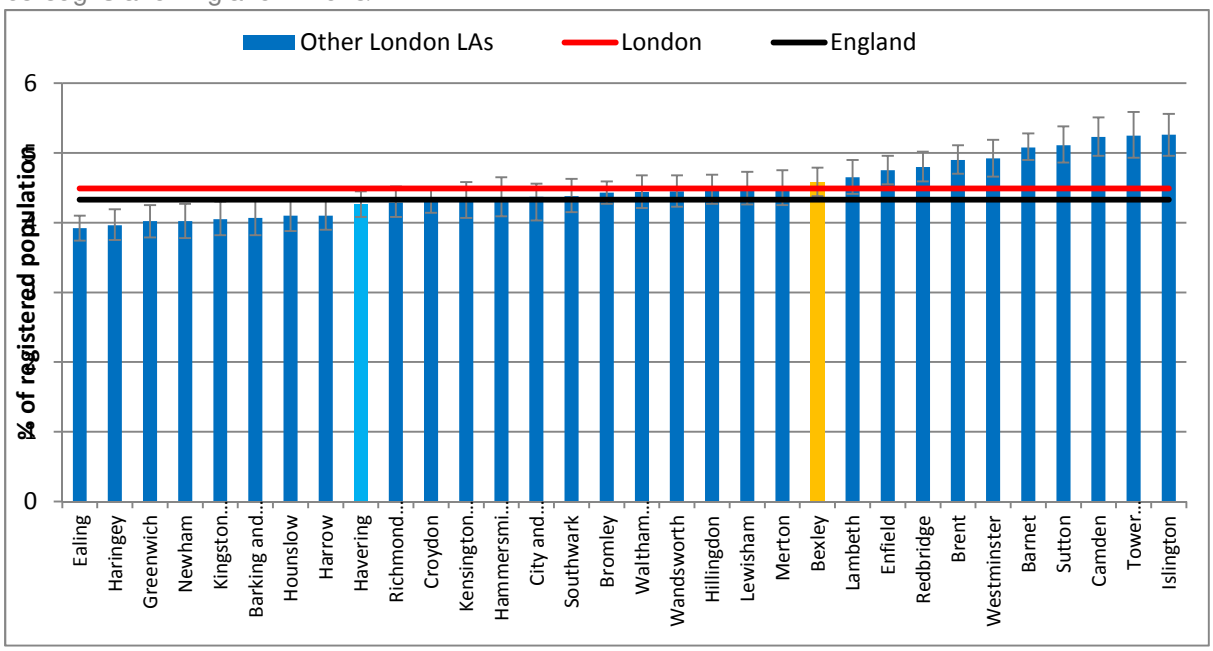
Figure 29: Percentage of population aged 65 years and above in Havering, compared to London, England and other London boroughs in 2017



Data source: Cancer Services – Public Health Profiles; Produced by Public Health Intelligence

In 2016/17, the prevalence of dementia in people aged 65 and above with a recorded diagnosis was 4.26%. This was similar to the England (4.33%) and London (4.49%) average (Figure 30).

Figure 30: Percentage of patients aged 65+ with a recorded diagnosis of dementia in London boroughs and England in 2016/17



Data source: Dementia Profile – Public Health Profiles; Produced by Public Health Intelligence

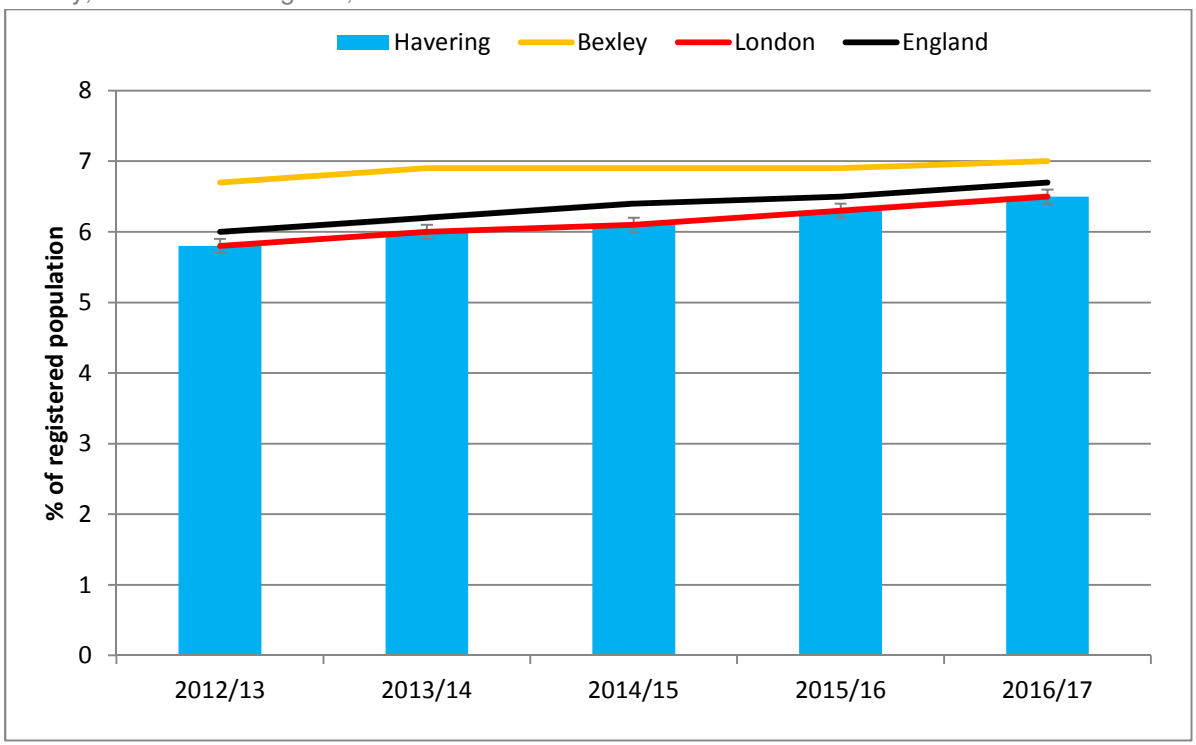
Many people with dementia will also be living with other long-term conditions, as the risk factors for the main types of dementia are similar to those that result in conditions such as cardiovascular diseases (CVD) and diabetes.

6.1.3 Diabetes

About 10% of the NHS budget is spent on patients with diabetes, 90% of whom have Type 2 or adult onset diabetes.[41] The main risk factors are a diet rich in unrefined sugars, physical inactivity and being overweight or obese. The risk is increased in people from certain Black, Asian, and minority ethnic (BAME) groups – South Asian and Afro-Caribbean backgrounds.[42]

In Havering, the number of people living with diabetes aged 17 years and above has been on the increase, from 5.8% to 6.5% over the past 5 years. However, the trend is similar to the London average, but significantly lower than Bexley and the national average (Figure 31).

Figure 31: Percentage of patients aged 17 years and over with diabetes in Havering compared to Bexley, London and England, 2012/13 to 2016/17.



Data source: Diabetes – Public Health Profiles; Produced by Public Health Intelligence

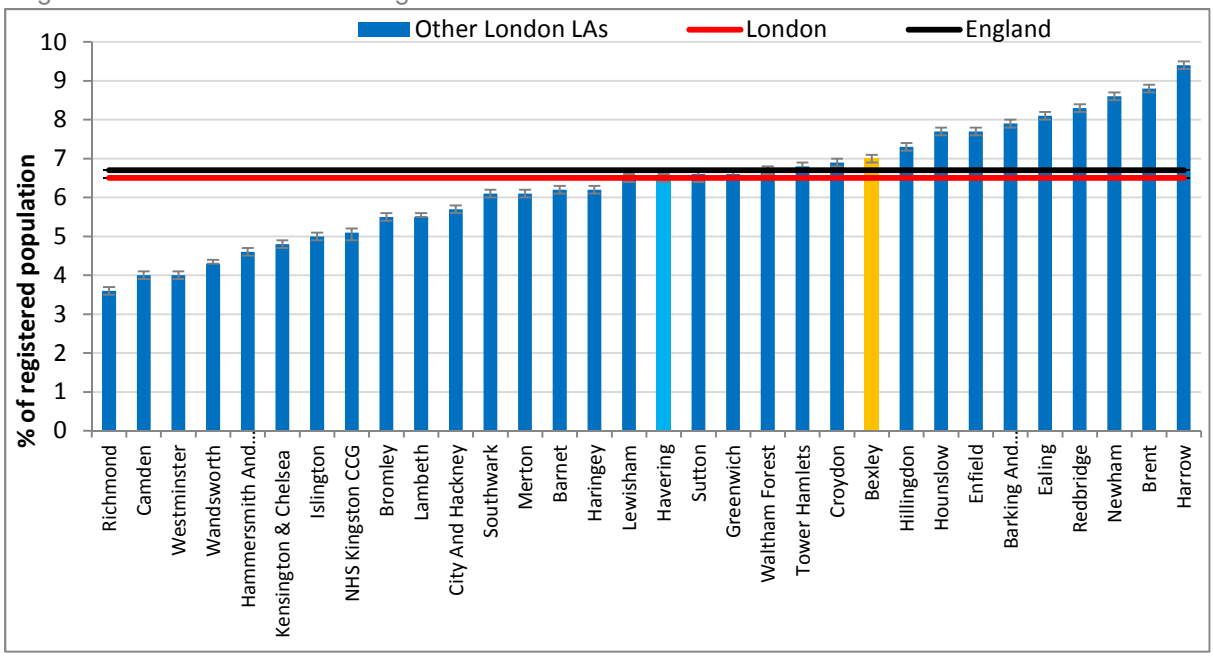
In 2016/17, the prevalence of patients aged 17 years and over with diabetes in Havering was about 6.5%. This was similar to England (6.7%) and London (6.5%) average (Figure 32).

[41] *Diabetes UK – Diabetes Facts and Stats; Version 4. Revised: May 2015*

[42] *Diabetes and ethnicity, Diabetes UK. https://www.diabetes.org.uk/about_us/what-we-do/communities*

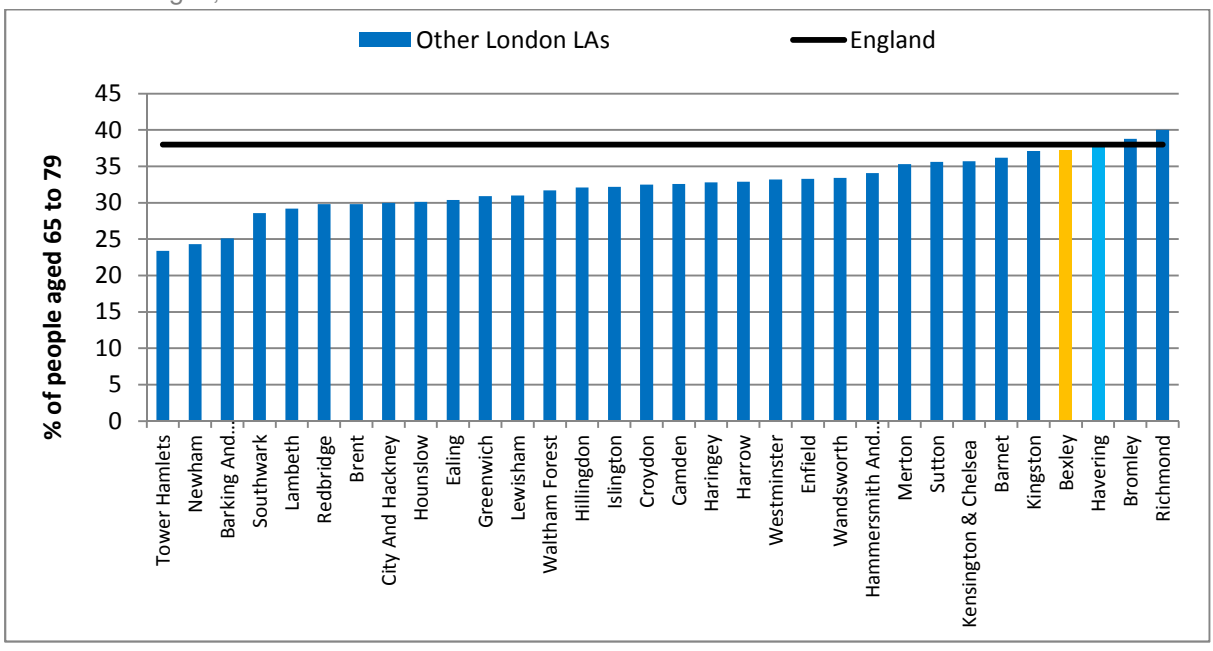
In Havering, the percentage of people with type 2 diabetes aged 65 and 79 was similar to the England and London averages (38%) in 2016/17, although higher than many London boroughs (see Figure 33). This could be a reflection of the higher proportion of ageing population in Havering (see Figure 29), which is in line with England average population structure that has a higher proportion of people aged 65 and above.

Figure 32: Percentage of patients aged 17 years and over with diabetes in Havering, London, England and other London boroughs in 2016/17



Data source: Diabetes – Public Health Profiles; Produced by Public Health Intelligence

Figure 33: Percentage with type 2 diabetes aged 65 and 79 years old in Havering, England and London boroughs, 2016/17



Data source: Diabetes – Public Health Profiles; Produced by Public Health Intelligence

6.1.4. Cancer

In Havering, the number of patients living with cancer has been on the increase, from 1.8% to 2.5% over the past 5 years. The trend has significantly been higher than the London average, but similar to the national average (see Figure 34). In 2016/17, the prevalence of patients with cancer in Havering was about 2.5%. This was significantly higher than London (1.8%), but similar to England (2.6%) average (see figure 10).This could be a reflection of the higher proportion of ageing population in Havering (see Figure 29), which is in line with the England average population structure that has higher proportion of people aged 65 and above (Figure 35).

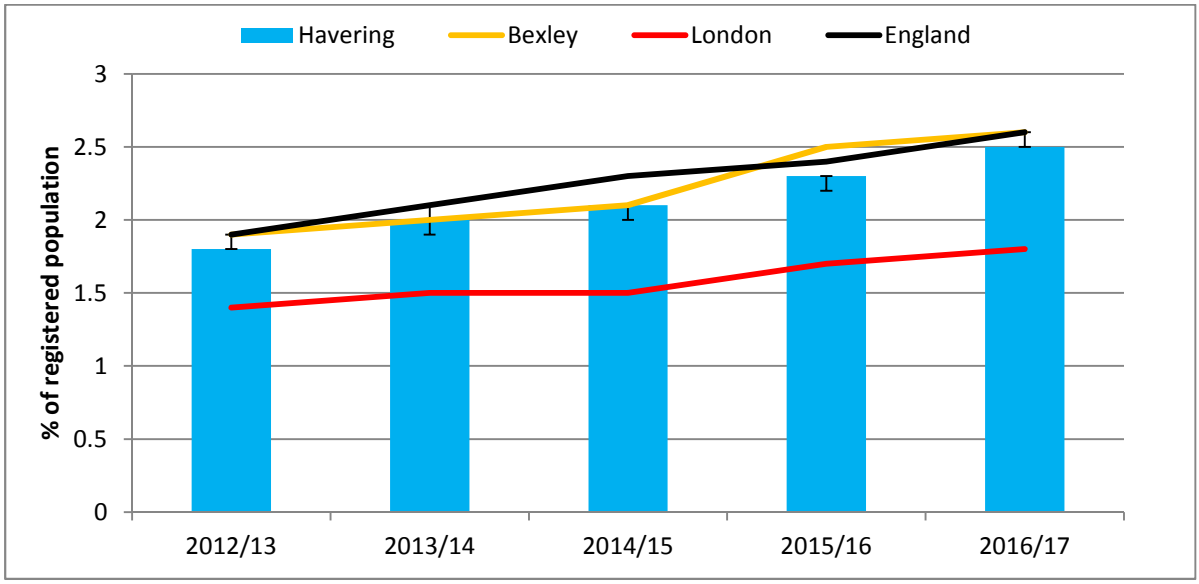
In Havering there are 41.9 people per 1000 persons living with cancer. The prevalence of cancer is lowest in Gooshays (26.7 per 1000 persons) and highest in Upminster (60.0 per 1000 persons) – see Figure 36; this can predominantly be explained by the variation in age structure between wards with Gooshays ward having a younger population and Upminster among the oldest.

Cancer is one of the major causes of death in the over 65's in England. Half of all cancer cases are diagnosed in people over 70 years old (2011-2013). More than half (53%) of cancer deaths are in people aged 75 years and over (2012-2014). Since the early 1970s, mortality rates for all cancers combined have decreased in most of the broad age groups in the UK, but have increased in people aged 75+.[43]

In 2014-16, directly age-standardised rate of deaths from cancer in Havering was 1105.2 per 100,000 among people aged 65 years and over. This was higher than London average (1031.7 per 100,000), but similar to England average (1115.2 per 100,000) (see Figure 37).

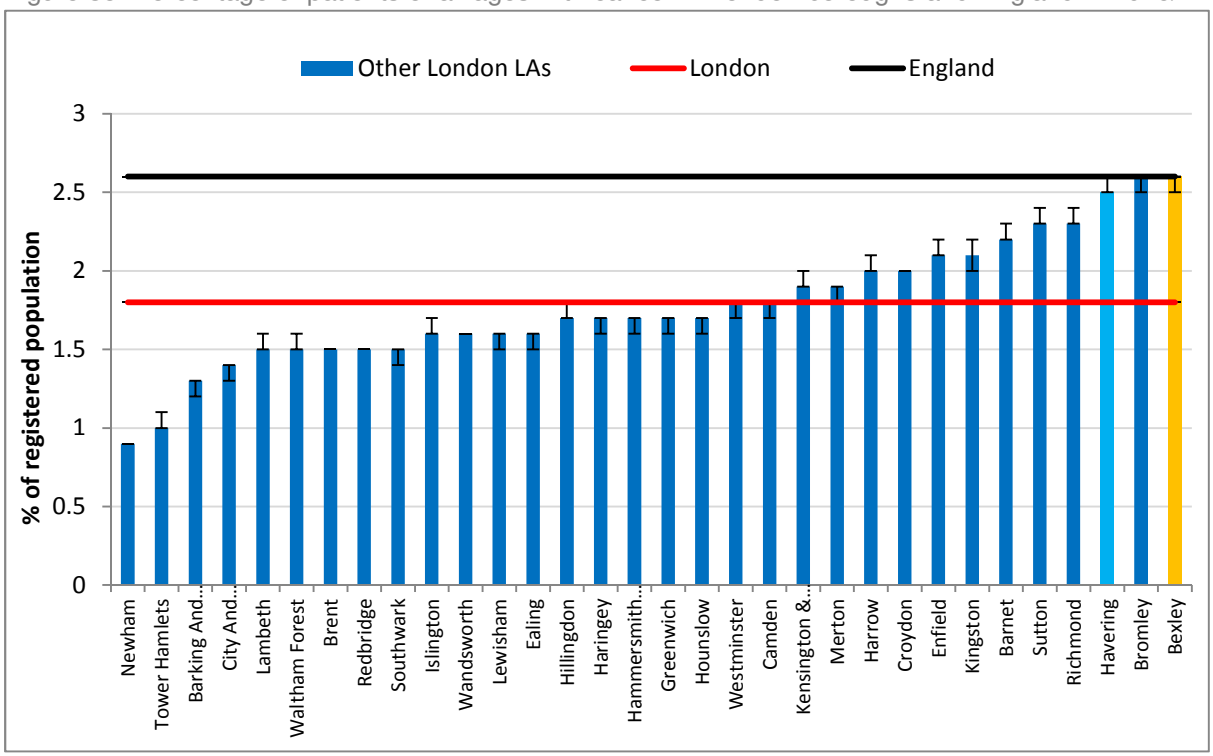
[43] *Older People's Health and Wellbeing, Public Health Profiles.*

Figure 34: Percentage of patients of all ages with cancer in Havering, compared to Bexley (statistical neighbour), London and England, 2012/13 to 2016/17



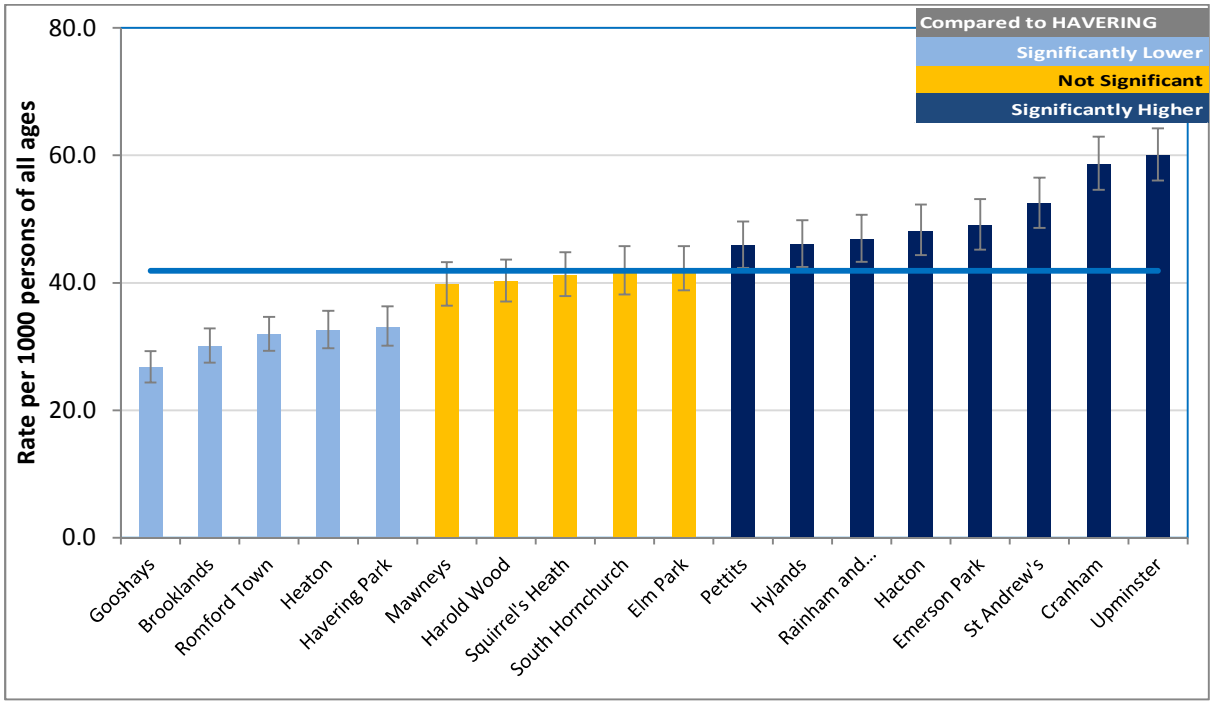
Data source: Cancer Services – Public Health Profiles; Produced by Public Health Intelligence

Figure 35: Percentage of patients of all ages with cancer in London boroughs and England in 2016/17



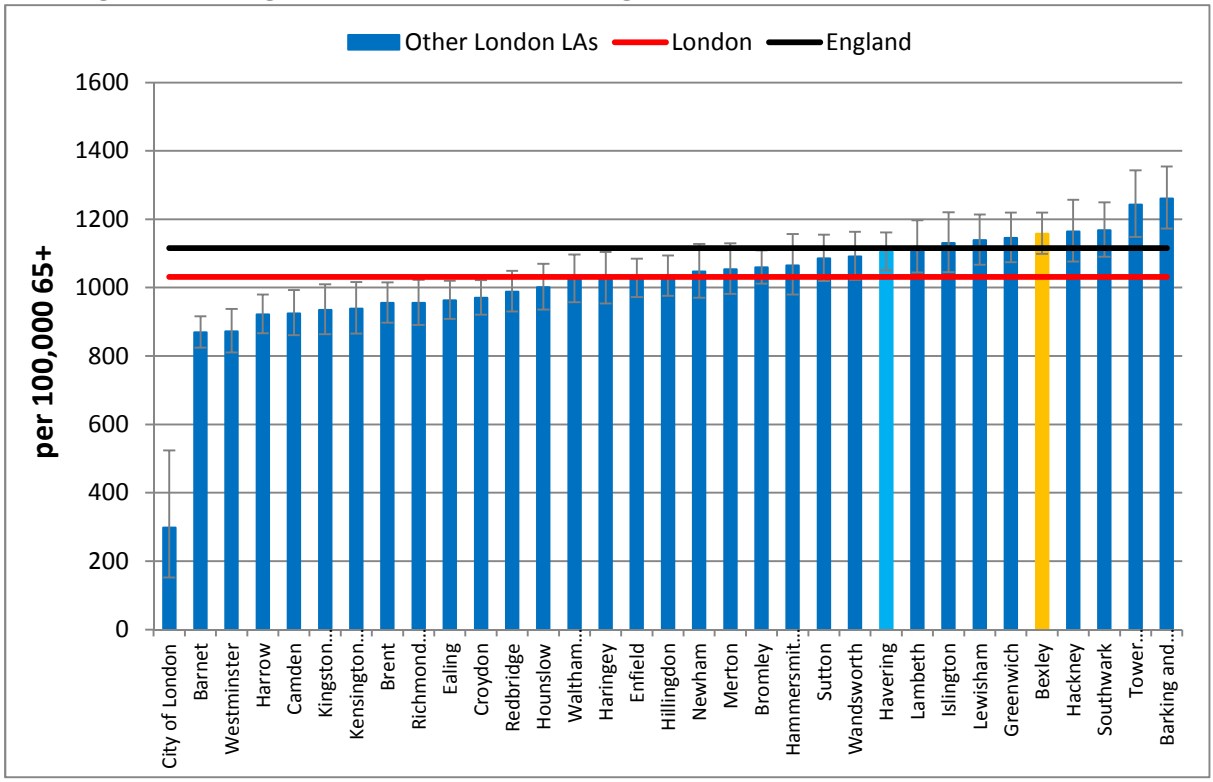
Data source: Cancer Services – Public Health Profiles; Produced by Public Health Intelligence

Figure 36: Prevalence of Cancer in patients registered with GP in Havering CCG per 1000 persons of all ages, Census wards, as of January 2018



Data source: Health Analytics (accessed January 2018); Produced by Public Health Intelligence

Figure 37: Directly standardised rate of deaths from cancer among people aged 65 years and over in Havering, London, England and other London boroughs, 2014-16



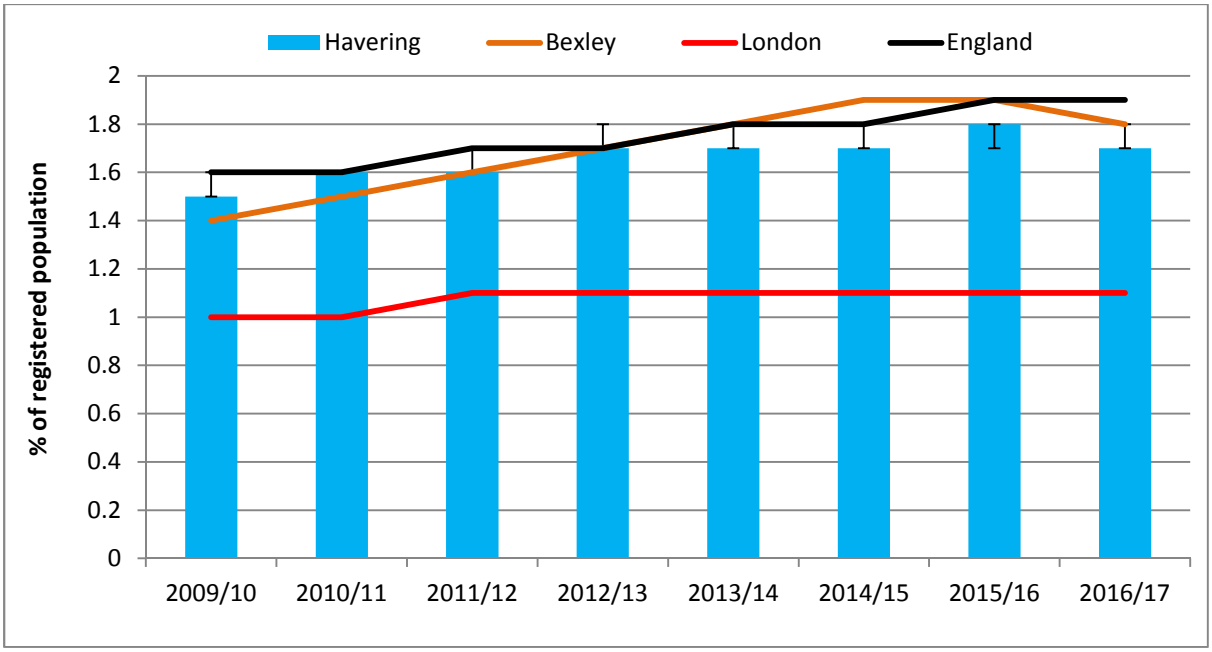
Data source: Older People's Health and Wellbeing Profile, PHE analysis of Office for National Statistics Mortality data; Produced by Public Health Intelligence

6.1.5 Chronic Obstructive Pulmonary Disease (COPD)

In Havering, the number of patients living with COPD has been on the increase, from 1.5% to 1.7% for the past 9 years. The trend has been significantly higher than London average, but lower than Bexley's and the national average (see Figure 38). In 2016/17, the prevalence of patients with COPD in Havering was about 1.7%. This was significantly higher than the London average (1.1%), but lower than the England average (1.9%). This could be a reflection of the higher proportion of ageing population in Havering (see Figure 29), which is in line with England average population structure that has higher proportion of people aged 65 and above.
In Havering, there were 19.4 people per 1000 persons living with COPD in 2018. The prevalence of COPD is lowest in Squirrel's Heath (14.1 per 1000 persons) and highest in Heaton (28 per 1000 persons) – see Figure 39; this may be as a result of Heaton being among the wards with the highest smoking prevalence and among the most deprived in Havering.

Respiratory disease is one of the major causes of death in the over 65's in England and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases.[44] In 2014-16, directly age-standardise rate of deaths from respiratory diseases in Havering was 684.9 per 100,000 among people aged 65 years and over. This was higher than the London (587.8 per 100,000), and England (629.1 per 100,000) average (see Figure 40).

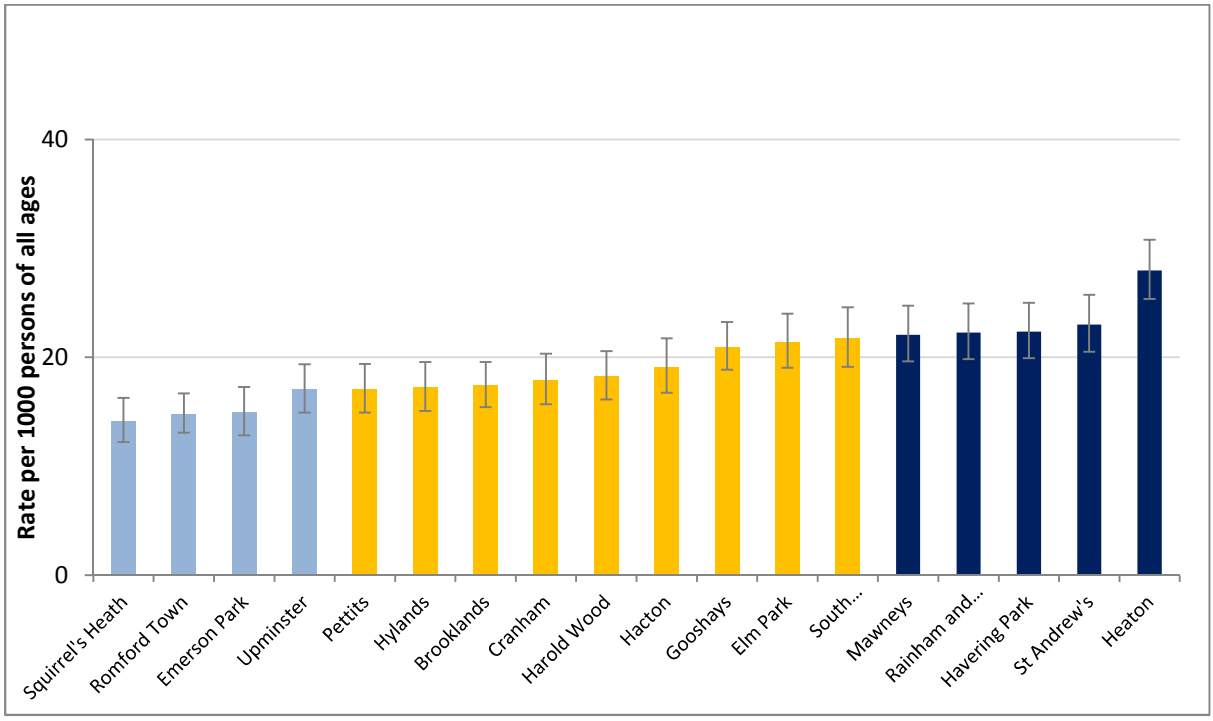
Figure 38: Percentage of patients of all ages with COPD in Havering, compared to Bexley (statistical neighbour), London and England, 2009/10 to 2016/17



Data source: Interactive Health Atlas of Lung conditions in England (Inhale) – Public Health Profile; Produced by Public Health Intelligence

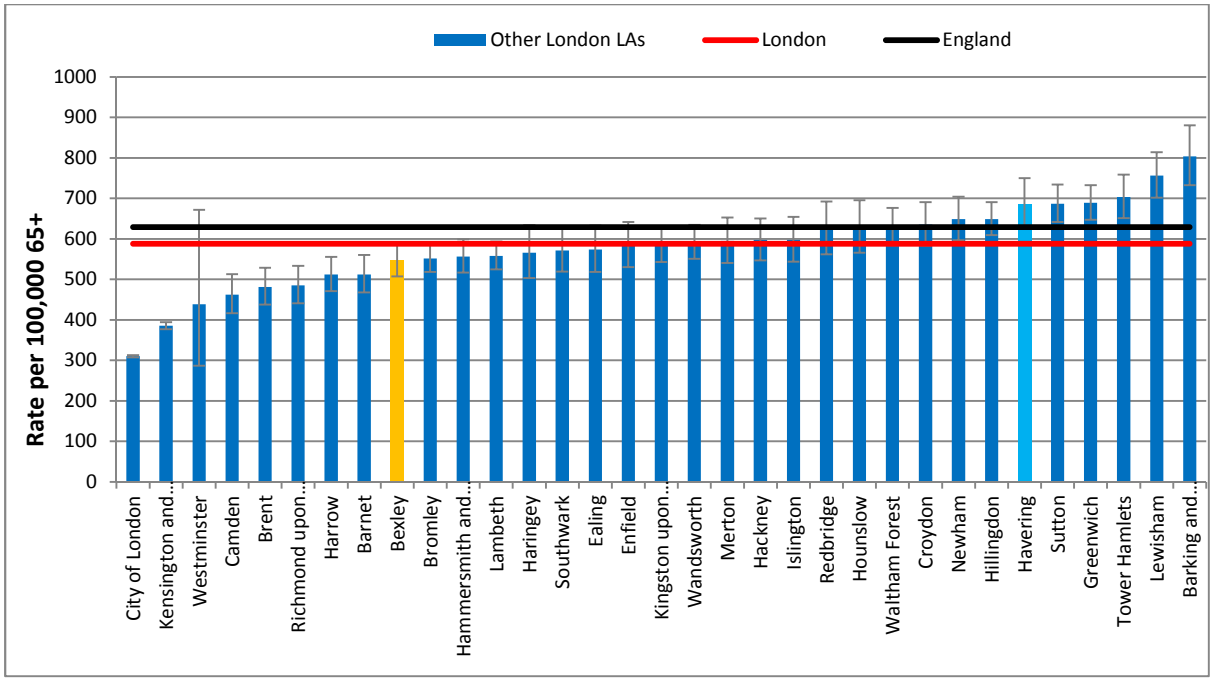
[44] *Older People's Health and Wellbeing, Public Health Profiles.*

Figure 39: Prevalence of COPD in patients registered with GP in Havering CCG per 1000 persons of all ages, Census wards, as of January 2018



Data source: Health Analytics (accessed January 2018); Produced by Public Health Intelligence

Figure 40: Directly standardised rate of deaths from Respiratory Disease among people aged 65 years and over in Havering, London, England and other London boroughs, 2014-16

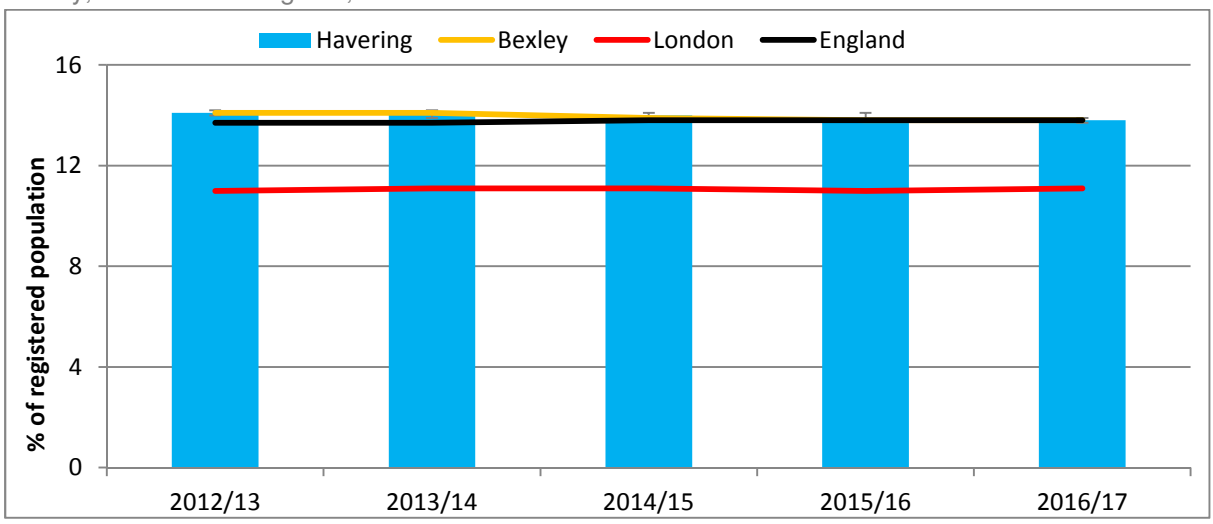


Data source: Older People's Health and Wellbeing Profile, PHE analysis of Office for National Statistics Mortality data; Produced by Public Health Intelligence

6.1.6 Hypertension

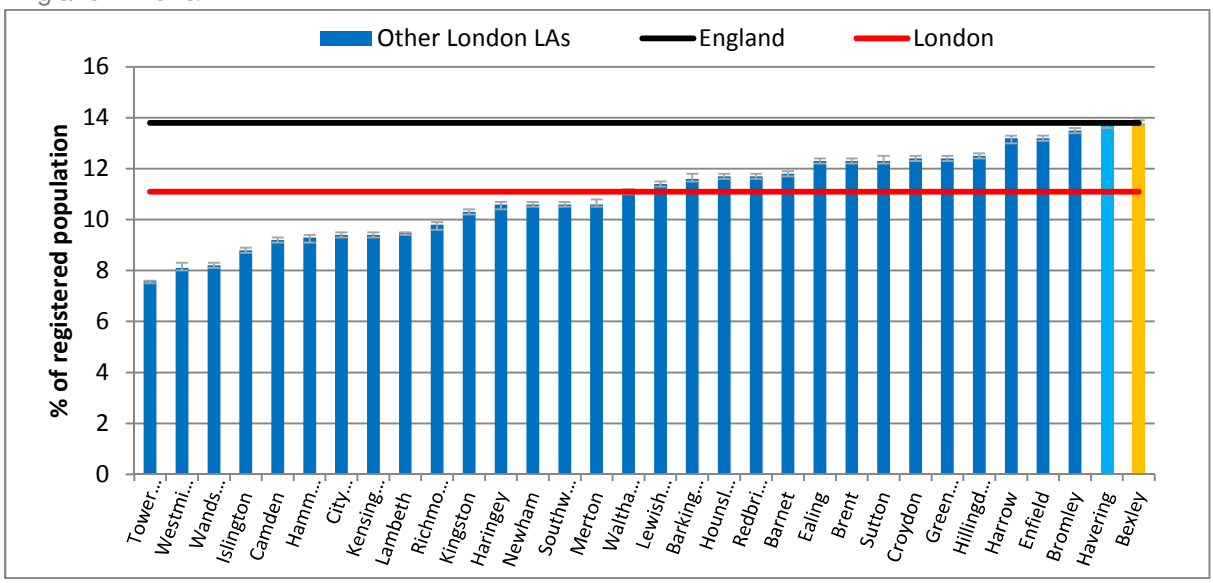
The prevalence of hypertension in Havering was about 14% in the past 5 years. It was similar to the Bexley and England average, but significantly higher than the London average (see Figure 41). In 2016/17, the prevalence of patients with hypertension in Havering was 13.8%. This was significantly higher than London (11.1%), but similar to England average (13.8%) (See Figure 42). Age is a non-modifiable risk factor of hypertension, and this could be a reflection of the higher proportion of ageing population in Havering (see Figure 29), which is in line with England average population structure that has higher proportion of people aged 65 and above.

Figure 41: Percentage of patients of all ages with established hypertension in Havering, compared to Bexley, London and England, 2012/13 to 2016/17



Data source: Hypertension – Public Health Profiles; Produced by Public Health Intelligence

Figure 42: Percentage of patients of all ages with established hypertension in London boroughs and England in 2016/17



Data source: Hypertension – Public Health Profiles; Produced by Public Health Intelligence

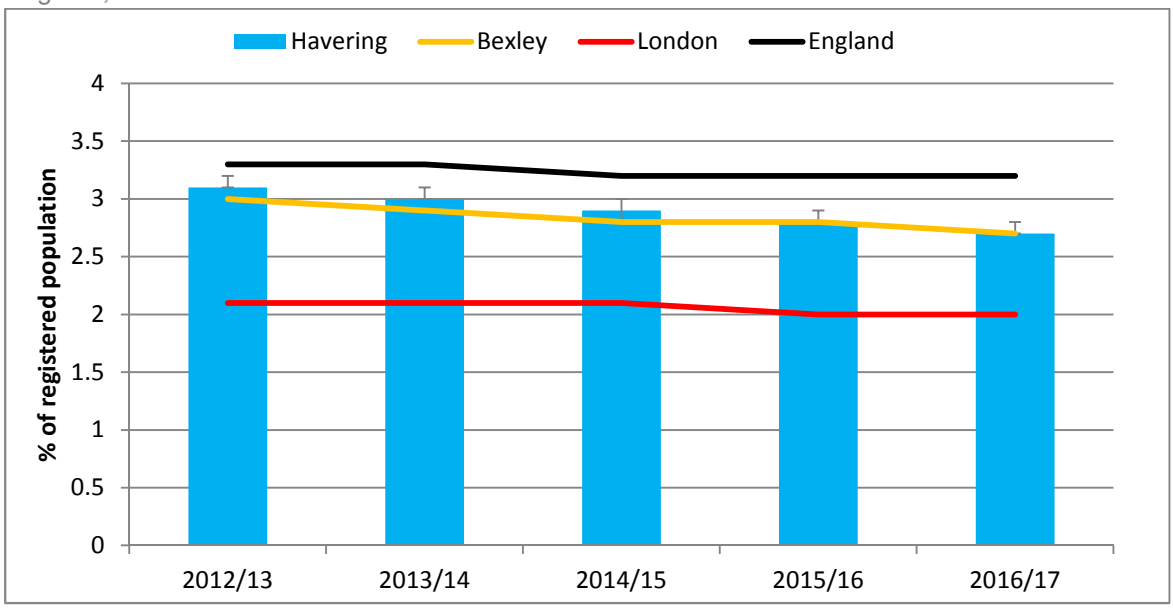
6.1.7 Coronary heart disease (CHD)

In Havering, the number of patients living with CHD has been on the decline, from 3.1% to 2.7% in the past 5 years. Havering's overall trend has significantly remained higher than that of London, similar to Bexley's, but lower than England's (see Figure 43). In 2016/17, the prevalence of patients with CHD in Havering was about 2.7%. This was significantly higher than the London average (2.0%), but lower than the England (3.2%) average (see Figure 44).

Cardiovascular disease (CVD) is one of the major causes of death in the over 65's in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but there needs to be concerted action in both prevention and treatment.[45]

In 2014-16, directly age-standardised rate of deaths from cardiovascular disease in Havering was 1008.8 per 100,000 among people aged 65 years and over. This was significantly lower than London (1115.9 per 100,000) and England average (1149.2 per 100,000) (see Figure 45).

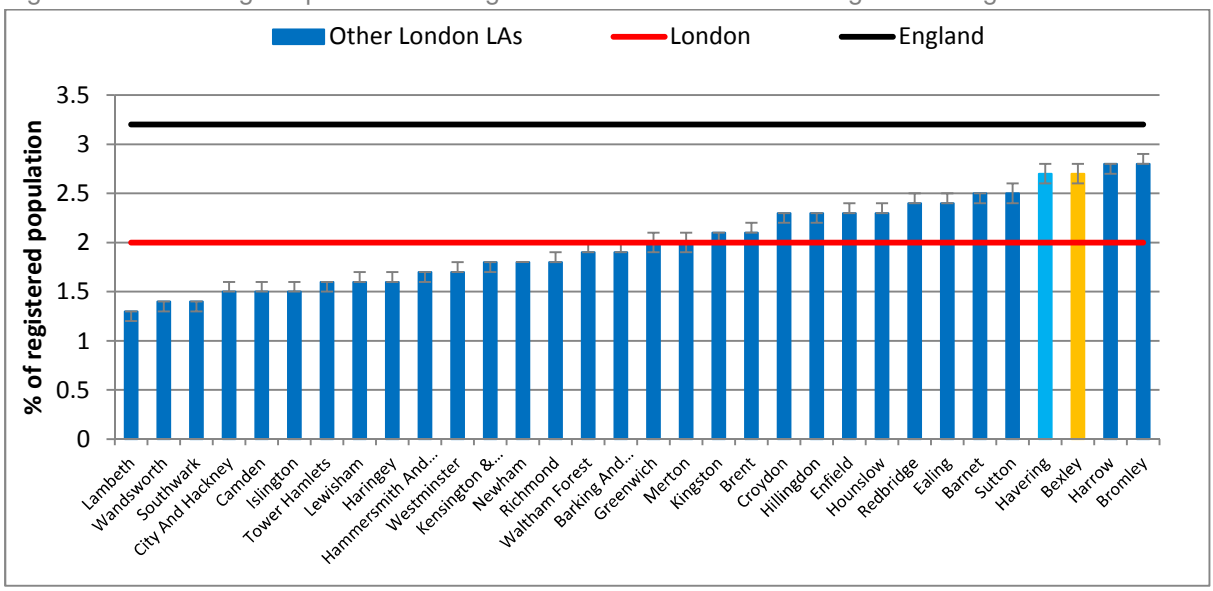
Figure 43: Percentage of patients of all ages with CHD in Havering, compared to Bexley, London and England, 2012/13 to 2016/17



Data source: Cardiovascular Disease – Public Health Profiles; Produced by Public Health Intelligence

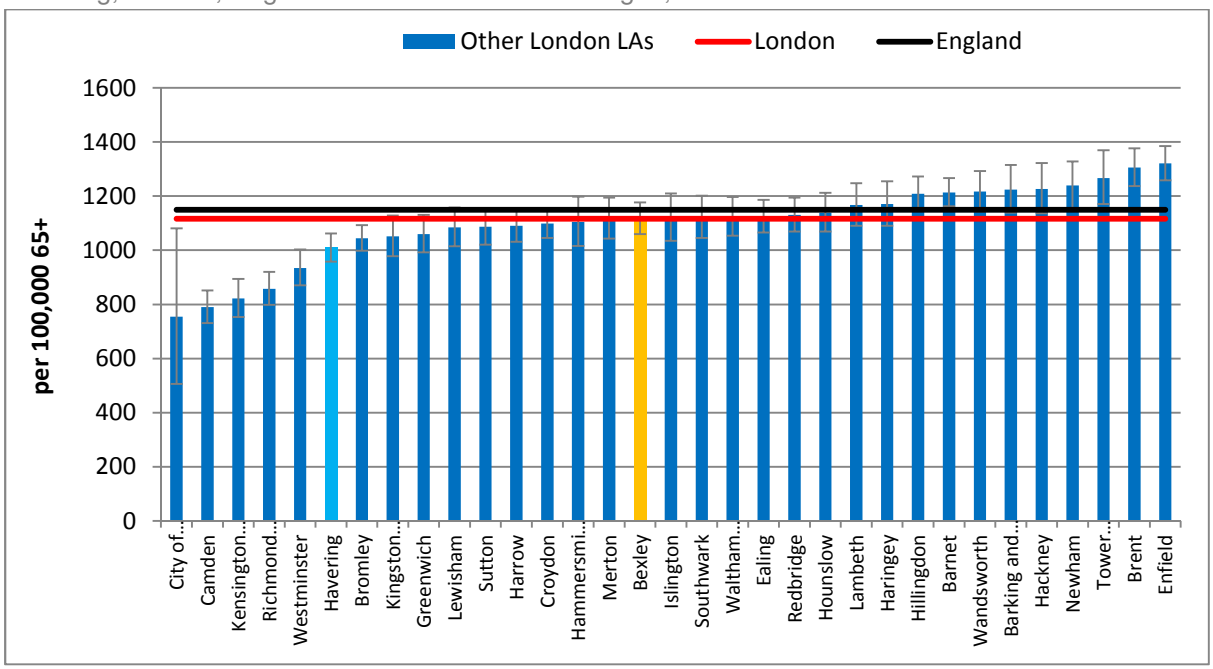
[45] *Older People's Health and Wellbeing, Public Health Profiles.*

Figure 44: Percentage of patients of all ages with CHD in London boroughs and England in 2016/17



Data source: Cardiovascular Disease – Public Health Profiles; Produced by Public Health Intelligence

Figure 45: Directly standardised rate of deaths from CVD among people aged 65 years and over in Havering, London, England and other London boroughs, 2014-16



Data source: Older People's Health and Wellbeing Profile, PHE analysis of Office for National Statistics Mortality data; Produced by Public Health Intelligence

6.2 Disability

Children and adults with a learning disability are at increased risk of having or developing physical and mental health problems. In addition, they are 10 times more likely to have serious sight problems.

Havering was estimated to have 970 adults with moderate or severe learning disability in 2017, of which 312 were estimated to be living with a parent (see Table 4). Additionally, about 1,900 people were estimated to have autistic spectrum disorders. Havering has a similar rate of people registered blind (449 per 100,000) compared to London (446 per 100,000), but lower than England (526 per 100,000)[46].

Table 4: Number of adults with learning disability in Havering, 2017

2017	Age groups (years)							
	18-24	25-34	35-44	45-54	55-64	65-74	75+	Total
People predicted to have a moderate or severe learning disability	127	185	198	182	147	85	46	970
People predicted to have a severe learning disability	42	52	54	40	34	Not calculated	Not Calculated	222
People predicted to have autistic spectrum disorders	205	335	309	335	296	229	190	1,900
People with learning disability predicted to be living with a parent	84	95	77	41	14	Not calculated	Not Calculated	312

Data source: Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information (POPPI), 2017; Produced by Public Health Intelligence

For more information on the key facts and figures on adult disabilities in Havering, see the JSNA products prefixed *"This is Havering: a demographic and socioeconomic profile"* at http://www.haveringdata.net/research/jsna.htm.

The number of children with special educational needs and disabilities increased at an average of between 40% and 60% in all groups between 2012 and 2015. These are particularly marked in respect of children with the most severe and complex needs where there are disproportionate growths, leading to pressures and shortfalls in relation to both mainstream and special school places[47].

There is increasing demand for specialist help and schooling for children with autism (ASD) and for those with behavioural, emotional and social difficulties (BESD), including those with mental health issues. Whilst respective increases of 40% and 62% were seen in these two groups between 2012 and 2015, numbers for ASD in the primary school population are expected to double over a 5-year period (from 2015 to 2020). Numbers for the BESD primary school group are also expected to treble during this period, and these will add to the increases already in secondary schools. There are also increases in children with moderate learning difficulties and

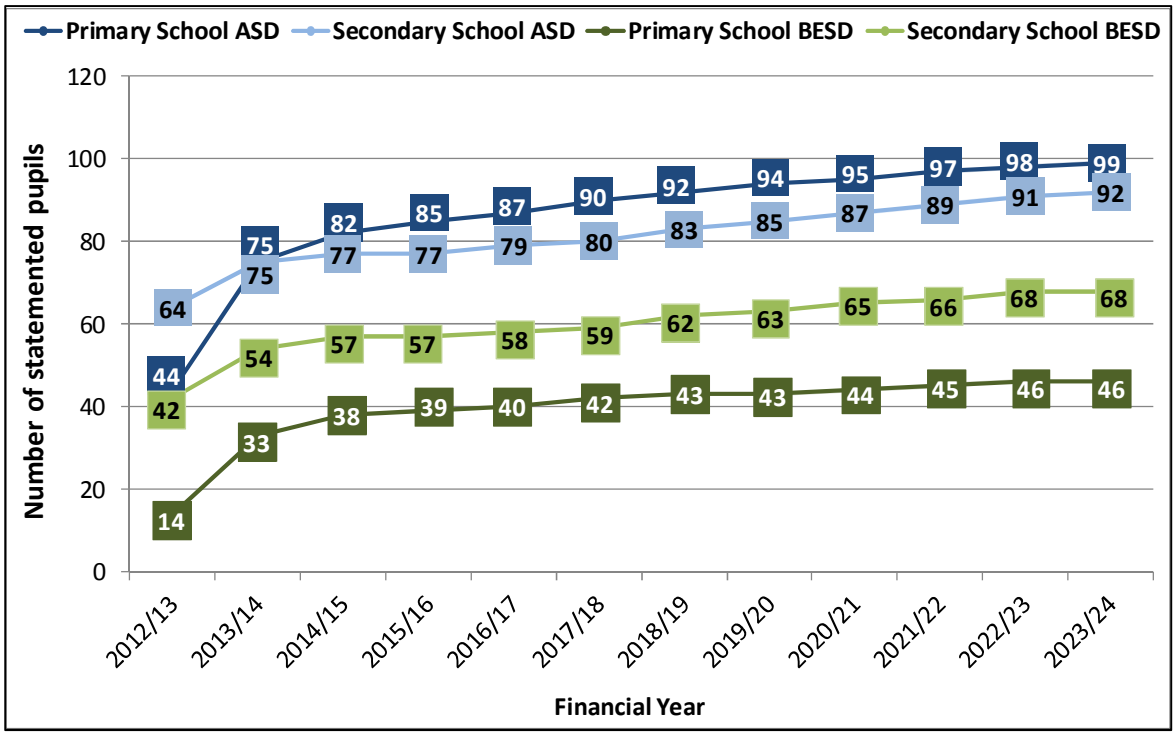
[46] *Data source: Registered Blind and Partially Sighted People - Year Ending 31 March 2017 (published December 2017), Health and Social Care Information Centre*

[47] *Strategy for Children and Young People with Special Educational Needs and Disabilities 2015-20 (published September 2015)*

those with speech, language and communication needs. However, mainstream schools are increasingly making successful provision for these two categories. Autism and behaviour difficulties remain major issues, requiring significant help and resources for schools to meet these needs.

Figure 46 shows predicted growths in ASD and BESD growths by type of need and school over a 10 year period. For more information, see the "*Strategy for Children and Young People with Special Educational Needs and Disabilities 2015-20"*

Figure 46: Projected numbers of children with statements of special educational needs by type and school in Havering, 2013/14 to 2023/24



Data source: Strategy for Children and Young People with Special Educational Needs and Disabilities 2015-20; Produced by Public Health Intelligence

6.3 Specific population groups who have additional needs

6.3.1 Children

- Overweight and obesity is an issue for children in Havering. They are likely to develop Type 2 Diabetes requiring long-term medical care. There are also mental health issues associated with being overweight and obese and living from an early age with a chronic medical condition.
- Havering has the lowest number of children going into care. Looked after children generally have greater mental and physical health care needs. In 2012/2013, screening test results for 95 children in care aged 5 to 16 showed that (56%) were at a high or borderline risk of clinically significant mental health problems.
- For more information, see the Children and Young People JSNA at http://www.haveringdata.net/research/jsna.htm.

6.3.2 Older People

- Older people are at increased risk of living with multiple long-term conditions; dementia; and experiencing falls.
- About 32% (13,449) of the population aged 65 years and above are living in one-person households. Almost half (48%) of all one person households in Havering are occupied by persons aged 65 years and over, which is the highest proportion in London[48]. Older people living alone can be an indicator of social isolation and may require more support from health and social care services.
- Havering has one of the largest proportions of the population in the country with dementia and it is estimated that around half of people living with dementia are as yet undiagnosed[49].
- Refractive error and cataracts cause two thirds of sight loss in older people[50]. However diabetes, smoking and hypertension increase the risk of developing sight loss due to macular degeneration.

6.3.3 Working Age Adults

- This is the largest age group in Havering. This age group is more likely to experience serious mental health problems such as depression, schizophrenia and psychoses.
- The majority of people who misuse drugs and alcohol also fall into this age group.

6.3.4 Ethnic Minority groups

- A small proportion of the Havering population is from a BAME group (17% compared to 55% of London and 20% of England). Certain health problems are more common in BAME groups because of various reasons including diet and

[48] *Census 2011 (Household Composition by Age), Office for National Statistics (ONS)*
[49] *Primary Care Web Tool https://www.primarycare.nhs.uk/default.aspx*
[50] *Royal National Institute of Blind People (accessed January 2016)*

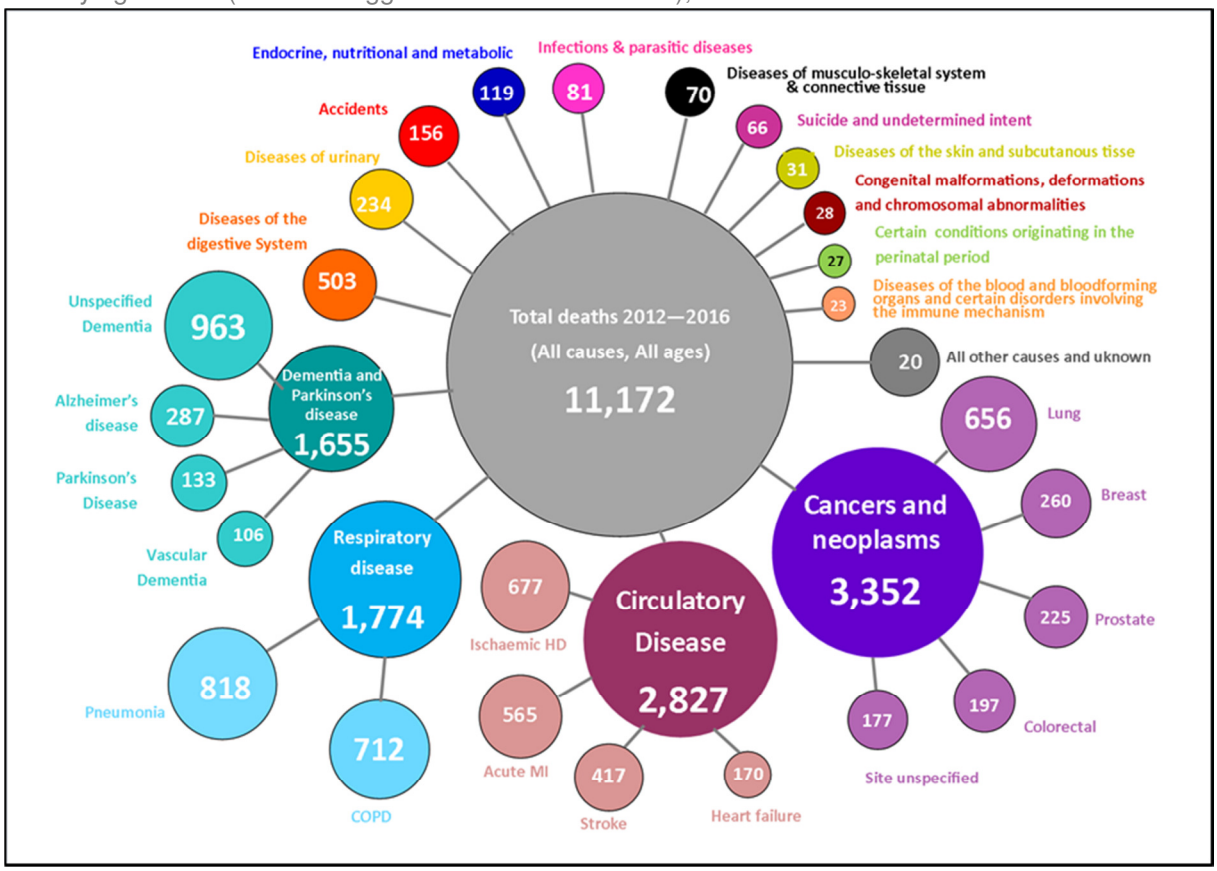
other lifestyle factors e.g. diabetes in South Asians; and sickle cell disease in Black Africans.

- For more information on the key facts and figures on ethnic minorities in Havering, see the JSNA products prefixed *"This is Havering: a demographic and socioeconomic profile" at* http://www.haveringdata.net/research/jsna.htm.

7. Mortality

Approximately 1% of the population of Havering die each year (on average 2,234 people)[51]. The top 5 (underlying) causes of death in Havering (from 2013 to 2017) are: cancers, circulatory diseases, respiratory diseases, dementia & Parkinson's disease, and diseases of the digestive system. Unspecified dementia comprises the biggest single underlying cause of death. Lung cancers comprise the largest proportion of deaths from Cancer (see Figure 47).

Figure 47: Distribution of number of deaths amongst Havering residents of all ages by broad underlying causes (with four biggest broken down further), in 2013-2017



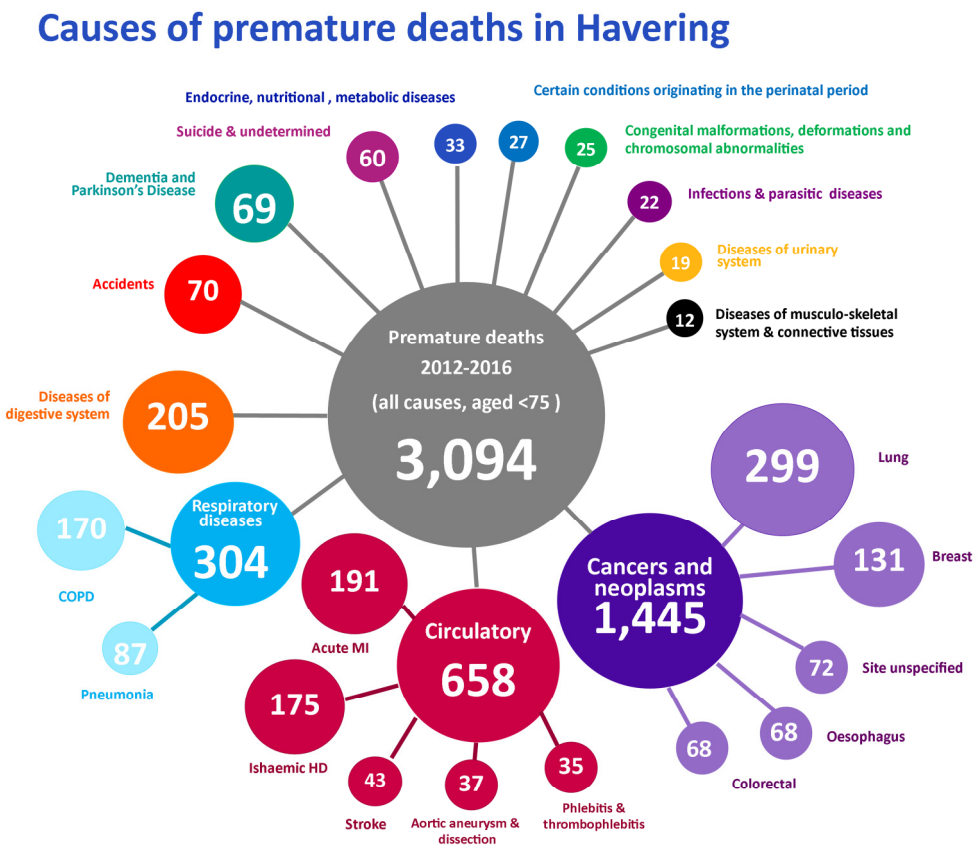
Data source: Primary Care Mortality Database (Office for National Statistics); Produced by Public Health Intelligence

In Havering, about 620 deaths (28%) each year[52] occur prematurely (deaths that occur before a person reaches the age of 75 years). Cancer, heart disease and stroke are the main causes of premature deaths (see Figure 48). This reflects the national picture.

[51] *Based on the number of deaths over 5-year period (2012-2016) – 11,172 (Data source: ONS PCMD)*

[52] *Based on the number of premature deaths over 5-year period (2012-2016) – 3,094 (Data source: ONS PCMD)*

Figure 48: Distribution of number of deaths amongst Havering residents of those aged under 75 by broad underlying causes, in 2013-2017



Data source: Primary Care Mortality Database (Office for National Statistics); Produced by Public Health Intelligence

Premature mortality data throughout Longer Lives tool is based on directly age-standardised rates. This measure of mortality makes allowances for the fact that death rates are higher in older populations and adjusts for differences in the age make up of different areas, enabling a more accurate comparison between local authorities.

A red, orange, yellow and green colour key indicates how the individual premature mortality rates in local authorities compare. Comparisons are by disease, with the national average, or with local authorities of similar socioeconomic status. Green denotes rates that are significantly better than the average and red denotes rates that are significantly worse. Yellow denotes rates that are within expected limits but better than average, and orange denotes rates within expected limits but worse than average.

Havering generally ranks well in comparison to 150 local authorities (LAs) in England for premature mortality. Compared to the England average, Havering ranks among the best for all causes premature deaths, heart disease and stroke (combined), and injuries; better than average for heart disease, stroke, lung disease and lung cancer.

However, it ranks among the worst for breast cancer; worse than average for liver disease, cancer and colorectal cancer. Compared to similar local authorities with similar deprivation levels, Havering ranks among the best for premature deaths from injuries; better than average for stroke, heart disease and stroke (combined). In addition, Havering ranks worst for liver disease, cancer and breast cancer; worse than average for all cause premature deaths, heart disease, lung cancer, and colorectal cancer related premature mortality (see Figure 49).

Figure 49: Premature mortality, Havering compared to all local authorities (LAs) in England and similar LAs average, 2014-16

Premature Mortality, 2014-2016

Cause of Premature deaths	Age standardised rate – per 100,000 (*In parenthesis: Lowest – Highest*)	Rank	Compared to England average	Compared to similar LAs average
All causes	306 *(293 – 321)*	150th (out of 324 LAs)	Best	Worse
Heart disease	35.8 *(31 – 41)*	157th (out of 324 LAs)	Better	Worse
Stroke	11.2 *(9 – 14)*	103th (out of 323 LAs)	Better	Better
Heart disease and stroke	63.6 *(57 – 70)*	133th (out of 324 LAs)	Best	Better
Lung disease	31.1 *(27 – 36)*	167th (out of 324 LAs)	Better	Worse
Liver disease	19.4 *(16 – 23)*	221th (out of 323 LAs)	Worse	Worst
Cancer	144 *(135 – 154)*	224th (out of 324 LAs)	Worse	Worst
Lung Cancer	55 *(50 – 61)*	179th (out of 324 LAs)	Better	Worse
Breast Cancer	26.9 *(22 – 33)*	308th (out of 324 LAs)	Worst	Worst
Colorectal Cancer	13 *(10 – 16)*	226th (out of 324 LAs)	Worse	Worse
Injuries	7.5 *(5 – 10)*	18th (out of 322 LAs)	Best	Best

Data source: Longer Lives tool (accessed March 2018), Public Health England; Produced by Public Health Intelligence

8. How do local people use social care services?

This section provides information on the use of health and care services by Havering residents.

8.1 Children Social Care

As discussed in the section of this document (and *"This is Havering: a demographic and socioeconomic profile"*[53]), the population of those aged 0-17 years in Havering is set to see huge increases in the coming years. Demand pressures have already been noticed across the Children Social Care Service, from Early Help and the front

[53] *Can be found at the following website:* http://www.haveringdata.net/research/jsna.htm.

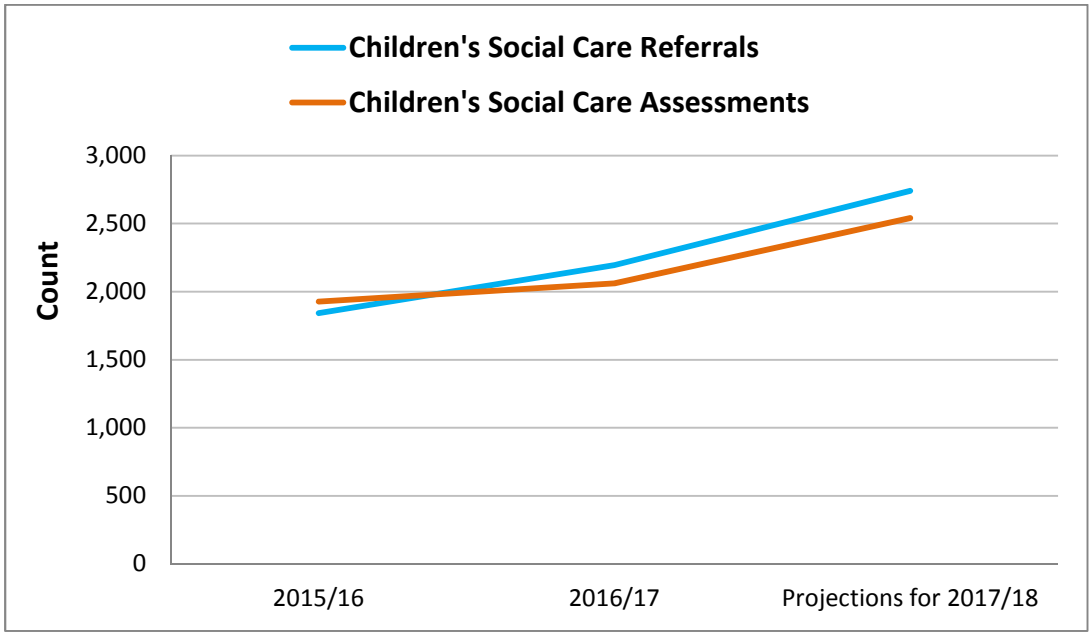
door – Multi Agency Safeguarding Hub (MASH) – through to the numbers of looked after children. Using data as at December 2015, the end of 2015/16 financial year activity figures for the service have been projected to show increased demand across board.

Havering saw a 12.4% increase in the number of people attending children's centres between 2016/17 and 2017/18 (14,558 to 16,359). There has been an 11% decrease in the total number of people accessing the children centres in March 2018 (5,699) compared to March 2017 (6,406), with a 20% increase compared to last month, February 2018 (4,753). There were 2,230 contacts received by the service in 2016/17. This is continued throughout the service when looking at the number of Contacts progressing to an Early Help assessment which was also set to decrease by 26% by the end of 2016/17 financial year (from 484 to 360)[54].

8.1.1 Referrals and Assessments

In 2015/16, Havering's Children Social Care received 1,842 referrals to the service. In 2016/17, this had increased by 50% to 2,194. Projections for 2017/18 are in the region of 2,741 which would indicate a further 25% increase from the previous year. Linked to the increase seen in referrals to the service, the number of assessments completed has also seen an increase. Between the years 2015/16 and 2016/17, a 7% (1,927 to 2,061) increase was seen with projections for 2017/18 set at 23% more than the previous year (2,541)[55] – see Figure 50.

Figure 50: Count of children's social care referrals and assessments in Havering, 2015/16 to 2017/18



Data source: Children's Social Care Case Management System

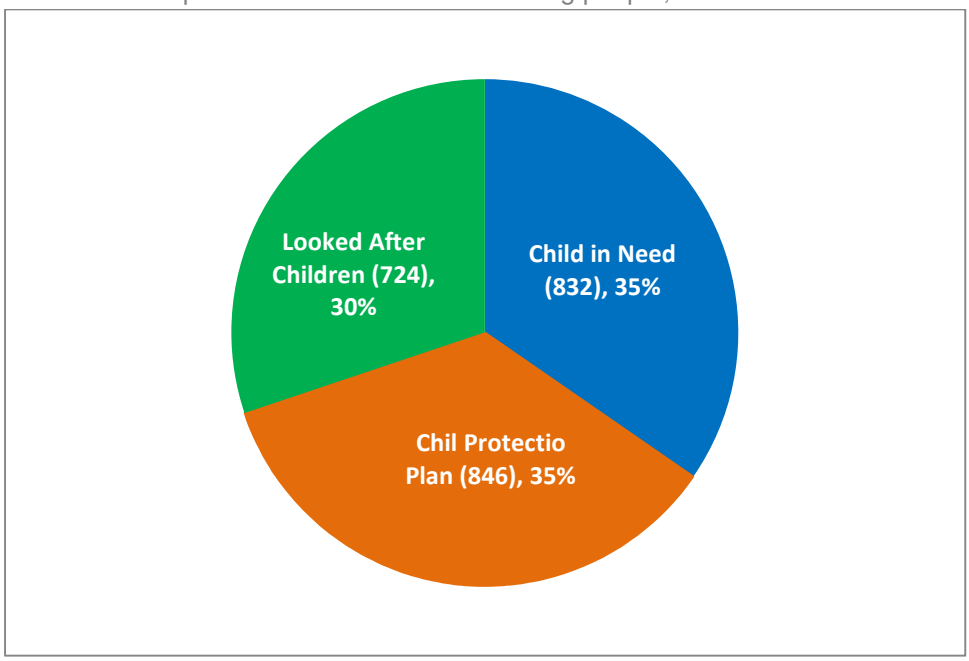
[54] *Early Help Monthly Performance Pack, March 2018, London Borough of Havering*

[55] *Children's Social Care Performance Monitoring, October 2017, London Borough of Havering*

8.2 Child and Young People on Plans

Between 2015 and 2018, there were 2402 plans in total across Children in Need, Child Protection Plan, Looked After Children. The spread of activity is shown in Figure 51

Figure 51: Distribution of plans across Children and Young people, 2015-2018



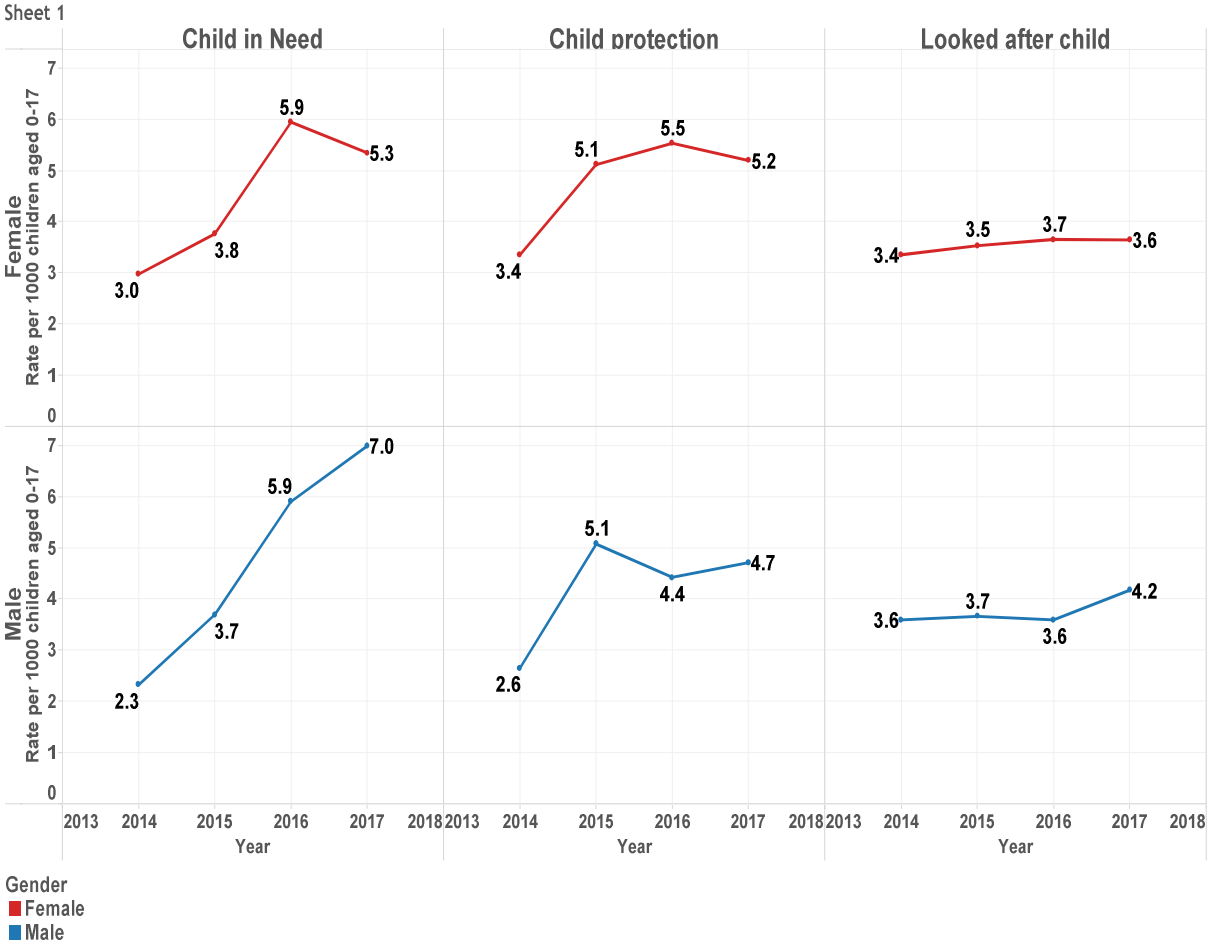
Data source: Children's Social Care Case Management System; Produced by Public Health Intelligence

Table 5: Rate of children's social care activity by type of plan per 1000 children aged under-18 years in Havering, Oct 2017

Measure	Children in Need	Child Protection Plan	Looked After Child
Rate per 1000 children	6.2	5	3.9
Count	335	268	212

Data source: Children's Social Care Case Management System; Produced by Public Health Intelligence

Figure 52: Rate of children's social care activity by type of plan and Gender per 1000 children aged under 18 years, Havering 2014-2016



Data source: Children's Social Care Case Management System; Produced by Public Health Intelligence

8.2.1 Children in Need

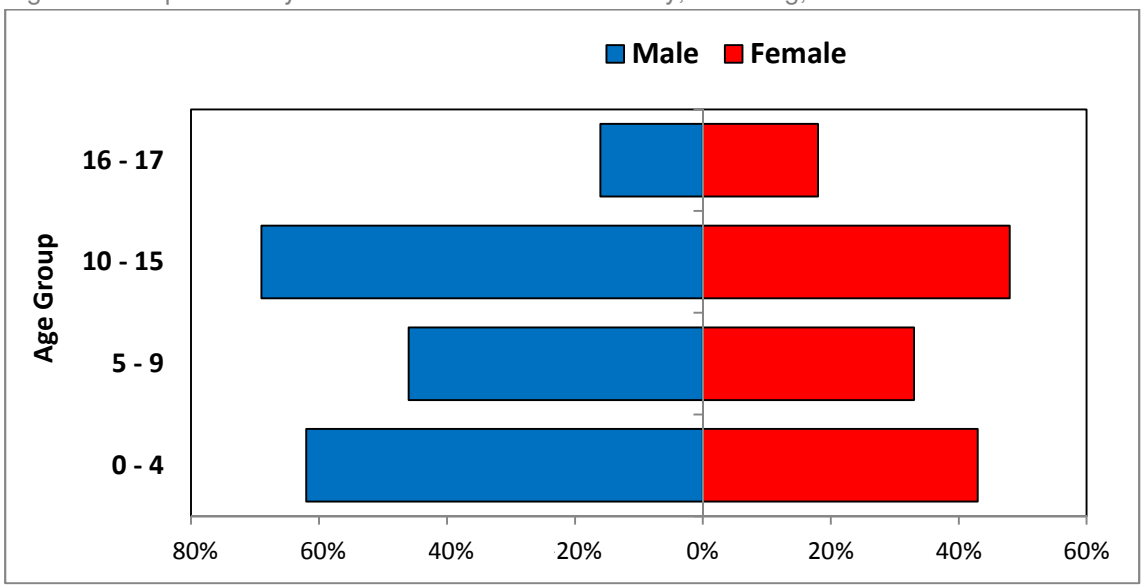
There were 335 children in need care plans as end of October 2017 (see Table 6, Figure 53). This is a rate of 6.2 per 1000 children aged under-18. This has been on the increase from 2014 to 2017.

Table 6: Count of children in need activity in Havering, Oct 2017

AGEBAND	GENDER	
	M	F
October 2017	**193**	**142**
0 - 4	62	43
5 - 9	46	33
10 - 15	69	48
16 - 17	16	18

Data source: Children's Social Care Case Management System; Produced by Public Health Intelligence

Figure 53: Population Pyramid of children in need activity, Havering, Oct 2017



Data source: Children's Social Care Case Management System; Produced by Public Health Intelligence

8.2.2 Child Protection

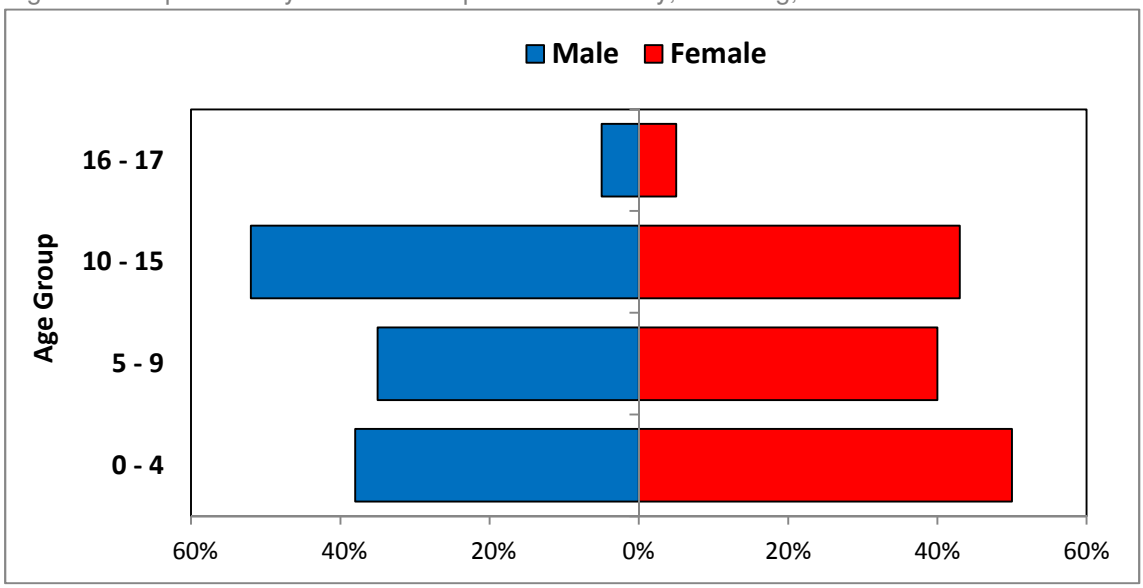
There were 268 plans for Section 47's (S47's) – Child Protection Investigations as end of October 2017. This is a rate of 5.0 per 1000 children aged under-18. This has been an increase since 2014 (3.1 per 1000 children aged under 18) but a drop from the previous year (6.0 per 1000 children aged under-18).

Table 7: Count of child protection activity in Havering, Oct 2017

AGEBAND	GENDER	
	M	F
October 2017	**130**	**138**
0 - 4	38	50
5 - 9	35	40
10 - 15	52	43
16 - 17	5	5

Data source: Children's Social Care Case Management System; Produced by Public Health Intelligence

Figure 54: Population Pyramid of child protection activity, Havering, Oct 2017



Data source: Children's Social Care Case Management System; Produced by Public Health Intelligence

8.2.3 Looked After Children

There were 212 plans for Looked After Children as at the end of October 2017 (see Table 8). This is equivalent to a rate of 3.9 per 1,000 children aged under-18. The rate of activity for Looked After Children (LAC) remained fairly consistent between 2014 and 2017. The consistency indicates that cases are being dealt with at an earlier stage (before crisis), which is better for families (see

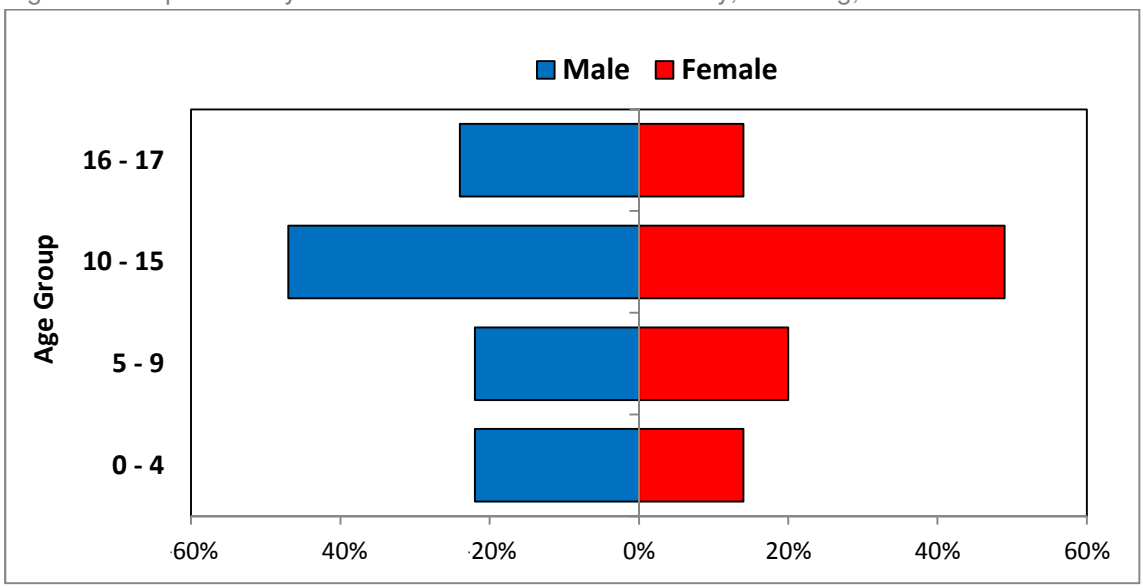
Figure 55).

Table 8: Count of looked after children activity, Havering, Oct 2017

AGEBAND	GENDER	
	M	F
October 2017	**115**	**97**
0 - 4	22	14
5 - 9	22	20
10 - 15	47	49
16 - 17	24	14

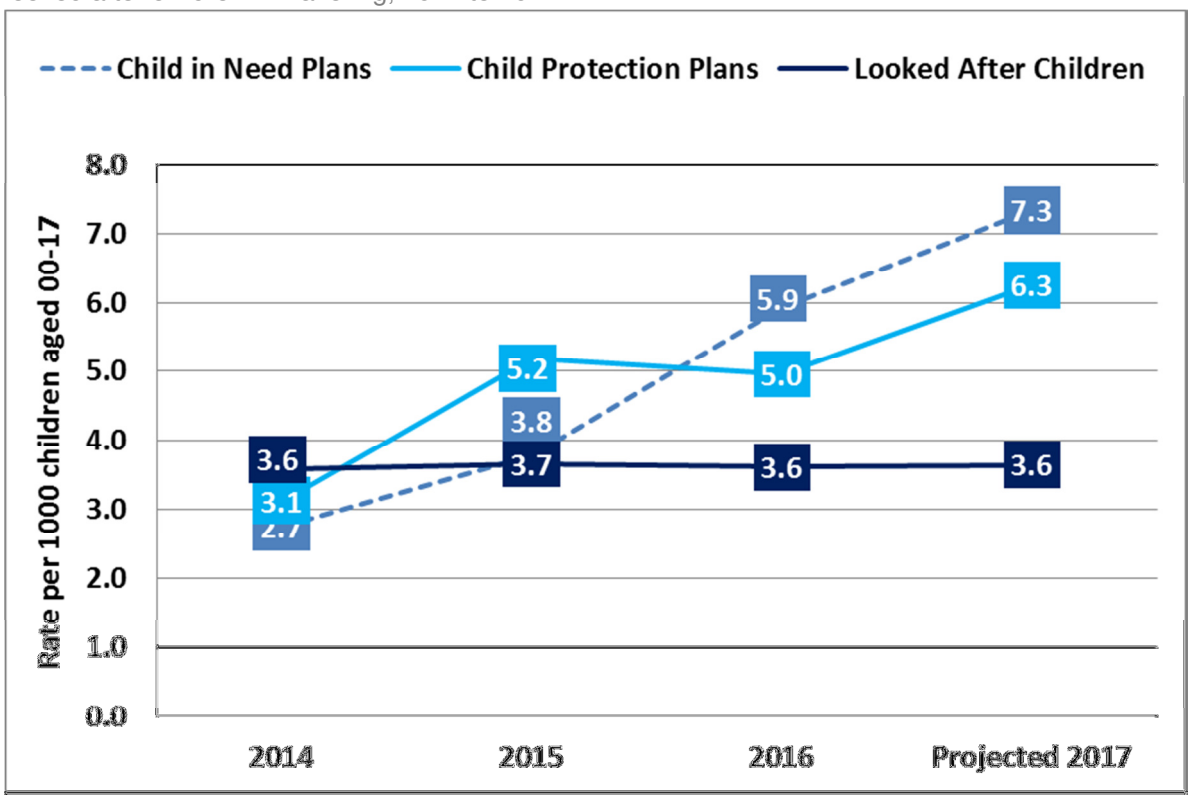
Data source: Children's Social Care Case Management System; Produced by Public Health Intelligence

Figure 55: Population Pyramid of looked after children activity, Havering, Oct 2017



Data source: Children's Social Care Case Management System; Produced by Public Health Intelligence

Figure 56: Rate per 1000 children aged under 18 for Child in need plans, child protection plans and looked after children in Havering, 2014 to 2017



Data source: Children's Social Care Case Management System

8.3 Adult Social Care

Residents require care and support for numerous reasons including age, disability, poor health or social isolation. The introduction of the Care Act 2014, which puts people and their carers in control of their care and support has changed the pattern of use.

- As end of 2016, 7224 clients received adult social care support in Havering.
- Three quarters of cases were those aged 65 and over.
- The majority of the demand (98%) was driven by the following: physical disability (78%), learning disability (12%) and mental health (8%).

8.3.1 Residential and Nursing Care

In Havering, the rate of adults aged 18-64 years admitted to residential and nursing homes was 8.6 per 100,000 in 2016/17. This was similar to London (8.6 per 100,000), but lower than England (12.8 per 100,000). The rate of adults aged 65 and over admitted to residential and nursing homes (694.2 per 100,000 adults aged 65 and over) in Havering was higher compared to London (438.71) and England (610.7)[56].

There are 39 care homes (21 residential and 18 nursing) in Havering with a total of 1,611 beds. Of these, Havering currently place a third of clients, the rest being self-funders, health placements, out of borough placements and vacancies. On average, adults with care needs were able to self-fund for 25 months before presenting to social care. [57]

Between April 2014 and March 2015, there were a total of 286 (including self-funders) new admissions into care homes with around 88% being over the age of 75. Over a third of these new admissions came directly from the local acute hospitals (Queens and King George's), the remainder were admitted from the community. Analysis last done in 2013-14 indicated that around 45% of care homes admissions from hospital were admitted as a result of a fall.

From April 2014 to March 2015 there were, on average, 602 adults over the age of 65 (known to Adult Social Care) in a long stay placement at the end of each month, with a general increase in the number of adults with dementia, rather than physical frailty.

[56] *Adult Social Care Outcomes Framework (ASCOF) 2014/15 published October 2015, Health and Social Care Information Centre*
[57] *Adult Social Care Market Position Statement 2016*

The majority of clients that have physical and sensory disabilities (PSD) are unable to access local placements with the right level of specialist support; and as a result are placed outside of the borough.

8.3.2 Home Care

Over a 1,101 adults receive support in their homes[58]; equating to about 11.3 hours per person per week; an increase from 10.7 in 13/14.

8.3.3 Respite Care

For 2014/15, 266 clients used respite services totalling 638 separate episodes[59]. There were:

- 600 respite placements:
  - 452 as planned respite (for 155 clients)
  - 148 as emergency placements (for 105 clients)
- 38 short stays (for 14 clients) which can sometimes be respite with no fixed end dates.

8.3.4 Day Care Services

The use of day care services in Havering decreased from 232 per 100,000 people aged 18 and over in 2010/11 to 203 per 100,000 people aged 18 and over in 2013/14. This is lower when compared to London (268 per 100,000 population) and England (301 per 100,000 population). [60]

In 2014/15, there were on average 140 clients over the age of 65, using day services each week[61].

8.3.5 Reablement

The aim of reablement is to support people after they have had a crisis, in order for them to remain as independent as possible. The majority of the demand for reablement, 80%, arises from the Joint Assessment and Discharge (JAD) team at the local acute trust; the remaining 20% from the community[62].

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[58] *Ibid*
[59] *Ibid*
[60] Adult Health Profiles, Public Health England: Adults who attended day care during the year per 100,000 population aged 18+ (RAP P2F)
[61] *Adult Social Care Market Position Statement 2016*
[62] *Ibid*

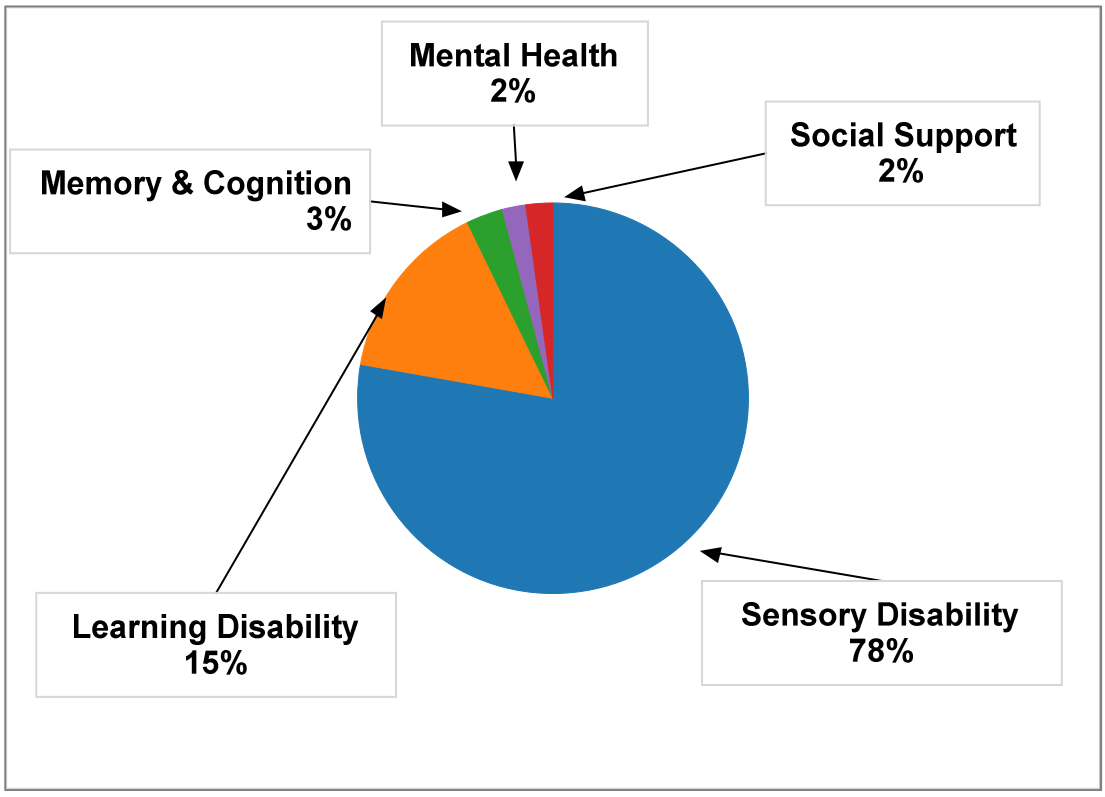
8.3.6 Carers and Carers Allowance

According to the 2011 Census, 25,214 people, 11% of Havering's residents identified themselves as carers, an increase by 8% from 23,253 in 2001. Twenty-three per cent (5,835) said they provided more than 50 hours of care per week.

There are 2,330 claimants of Carers Allowance in the borough and in the past year, 1,936 carers had an assessment of their needs carried out by Adult Social Care. This represents 9% and 8%, respectively, of the number of carers identified in the 2011 census.

Figure 57 shows that in 2014-15 the majority of Havering carers supported a loved one with a physical or learning disability.

Figure 57: Carers - Primary support reason of 'Cared For' person 2014-15



Source: ASC Market Position Statement 2016; Produced by Public Health Intelligence

For more information on adult social care in Havering, see the Adult Social Care Market Position Statement 2016 (https://www.havering.gov.uk/download/downloads/id/29/market_position_statement.pdf).

9. How do local people use health services?

9.1 Primary Care

The average number of patients registered with a Havering CCG practice per GP (Full Time Equivalent) is 2,186, which is similar to London (2,198), but higher than the England average (1,993).

The workload per GP will vary not only because of the number of registered patients but also the level of ill health amongst registered patients. GPs based in areas with higher levels of deprivation are also more likely to have increased demand for services.

80% of patients in Havering stated their overall experience with their GP was very good or good, but the proportion is lower than the England average (85%).[63]

9.2 Accident and Emergency (A&E) Attendances

In 2017/18, there were 87,430 A&E attendances by people registered with a Havering CCG and resident in Havering[64]. This equates to a rate of about 327 A&E attendances per 1,000 people[65].

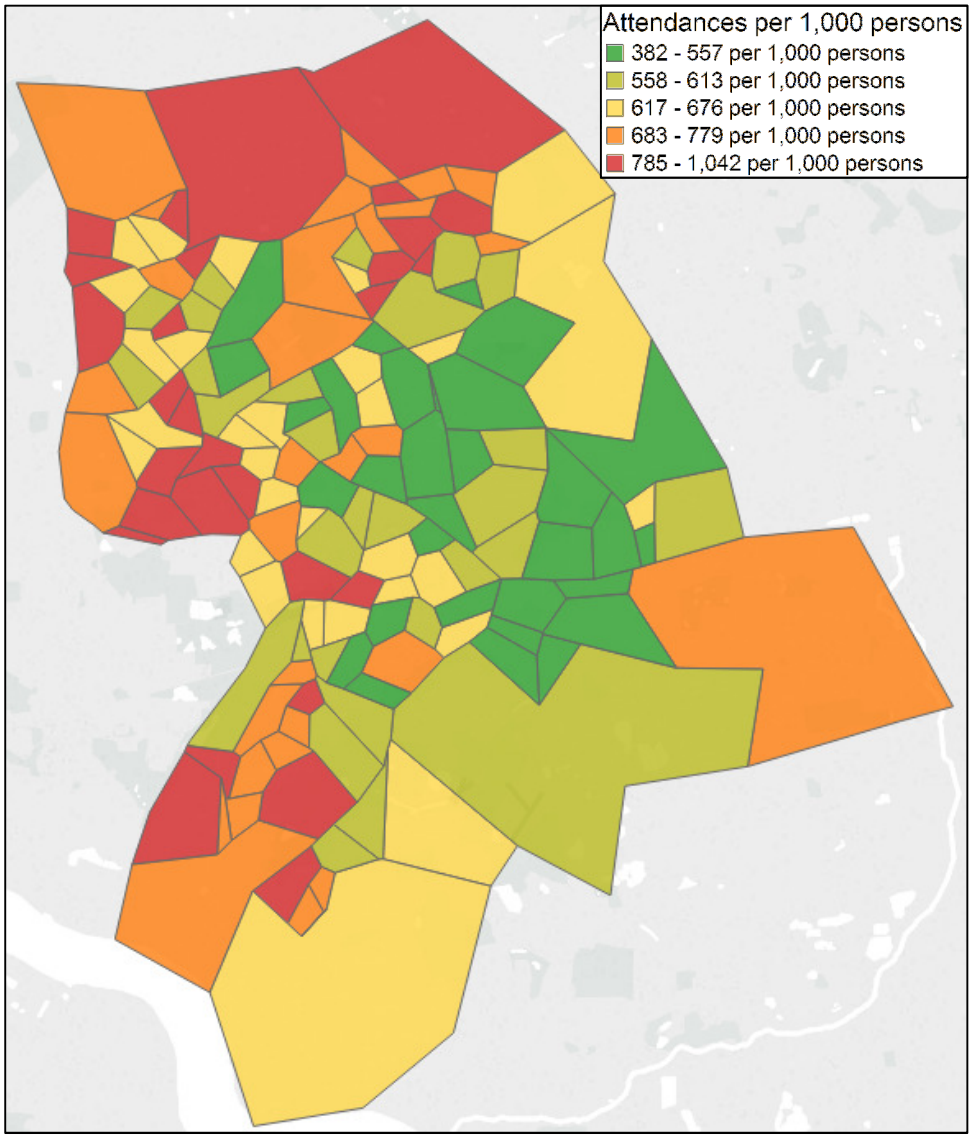
On the basis of 2015/16 data, a breakdown of the rate of A&E attendances per 1,000 people (presented in Figure 58) suggests that people living in the more deprived parts of the borough are more likely to use A&E services than those from least deprived areas in Havering.

[63] *GP Patient Survey July 2017*

[64] *Secondary Uses Services (SUS)*

[65] *The denominator used is 267755. Data source: Health Analytics*

Figure 58: Rate of A&E attendances per 1,000 population registered with Havering CCG GP and resident in Havering, by LSOA, 2015/16



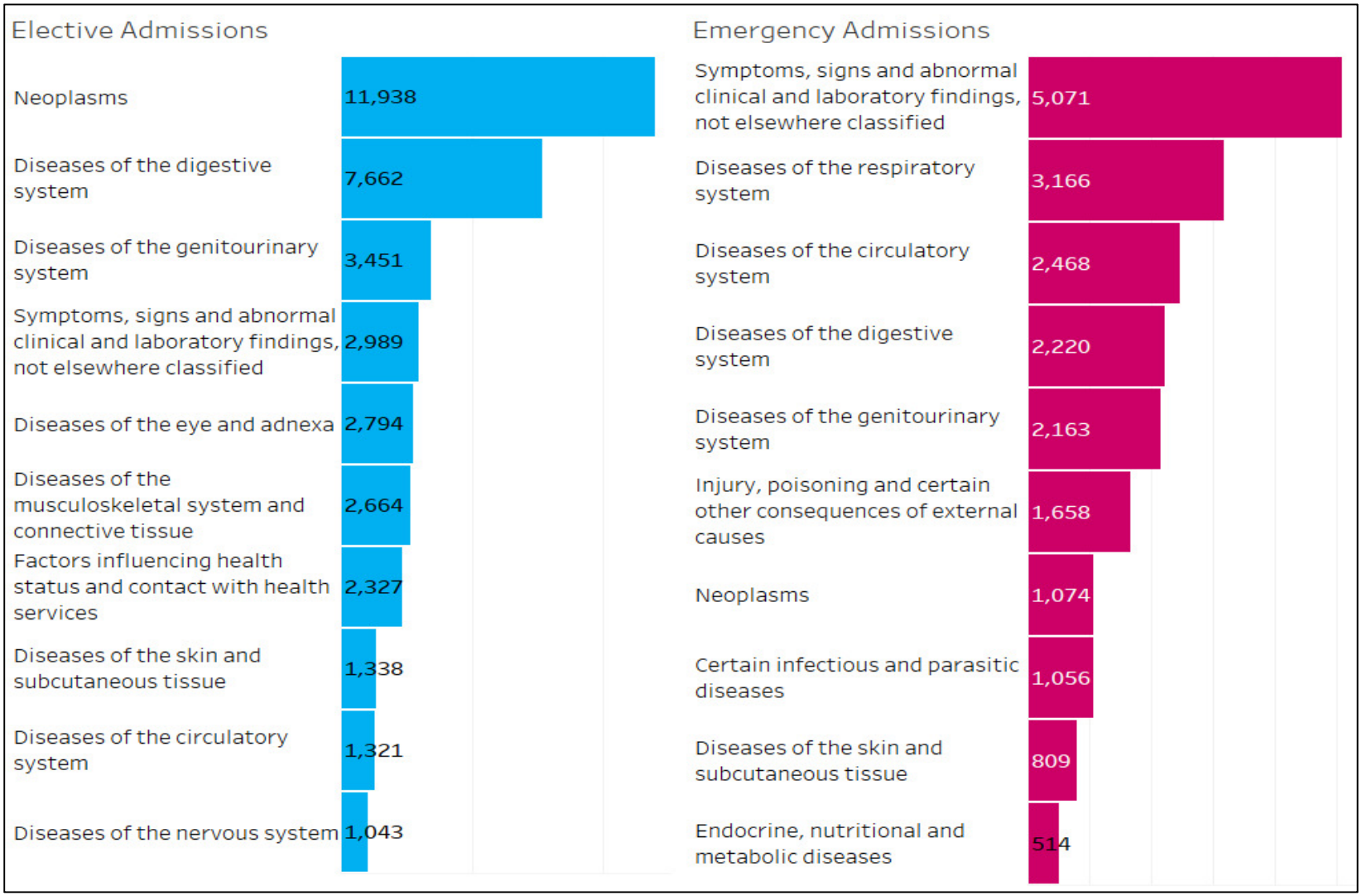
Data source: Secondary Uses Services (SUS)

9.3 Hospital Admissions

In 2017/18, there were 42,947 elective and 22,165 emergency hospital admissions (spells) for Havering CCG-registered patients[66]. The top 10 causes of elective and emergency admissions are displayed in Figure 59, Only the top 5 causes of Elective Admissions and Emergency Admissions account for 63% and 64% respectively.

[66] *Secondary Uses Services (SUS)*

Figure 59: Top 10 causes of admissions, by primary ICD-10 chapter, Havering CCG registered population, 2015/16



Data source: Secondary Uses Services (SUS)

9.4 Unplanned hospitalisation

In 2016/17, there were approximately 2,142 emergency admissions for chronic ambulatory care sensitive conditions in Havering. The rate (858 per 100,000 registered patients) in Havering was higher than the Bexley (612 per 100,000), London (706 per 100,000) and England (813 per 100,000) average. This could be a reflection of the higher proportion of ageing population in Havering (see Figure 29), which is in line with the England average population structure that has higher proportion of people aged 65 and above.

In 2016/17, there were 108 emergency admissions for asthma, diabetes and epilepsy in under 19s in Havering. Havering's rate (175 per 100,000 registered patients) was significantly lower than the Bexley (202 per 100,000), London (238 per 100,000) and England (295 per 100,000) average.

9.5 Health-related quality of life

In 2016/17, the index score of health-related quality of life for people with long-term conditions (measured by EuroQol-5D [EQ-5D]: an instrument for measuring quality of life) for Havering was 0.75. This was similar to the Bexley (0.74), London (0.75), and England (0.74) average.

However, the index score of health-related quality of life for carers aged 18 years and above in Havering (0.82) was higher than the Bexley (0.79), London (0.50) and England (0.52) average. In terms of health-related quality of life for people with a long-term mental health conditions, the index score in Havering was 0.56. This score was higher than Bexley's (0.44), but lower than the London (0.80) and England (0.80) average.

9.6 Emergency admissions

There were approximately 3633 emergency admissions for acute conditions that should not usually require hospital admission in Havering between October 2016 and September 2017. Havering's rate (1,241 per 100,000 registered patients) was higher than the Bexley (1,122 per 100,000) and London (706 per 100,000) average, but lower than the England average (1,295 per 100,000).

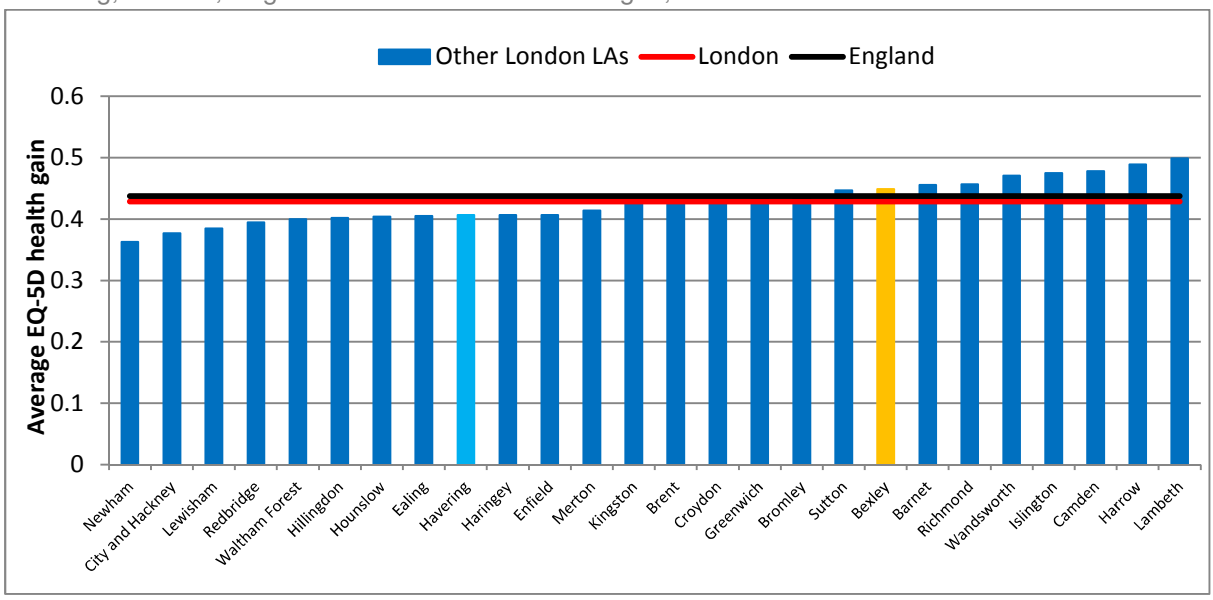
In 2011/12, there were approximately 3025 emergency readmissions within 30 days of discharge from hospital in Havering. Havering's rate (12.1 per 100,000 registered patients) was higher than the Bexley (11.6 per 100,000) and England (11.9 per 100,000) average, but lower than the London average (12.2 per 100,000).

There were approximately 133 emergency admissions for children with lower respiratory tract infections in Havering between October 2016 and September 2017. Havering's rate (224 per 100,000 registered patients) was lower than the Bexley (517 per 100,000), London (289 per 100,000), and England (449 per 100,000) average.

9.7 Patient-reported outcomes measures

In 2015/16, the average change in EQ-5D scores[67] for elective hip replacement procedures was 0.41 in Havering. This was worse than the London (0.43) and England (0.44) average (Figure 60).

Figure 60: Average change in EQ-5D scores before and after elective hip replacement procedures in Havering, London, England and other London boroughs, 2015/16



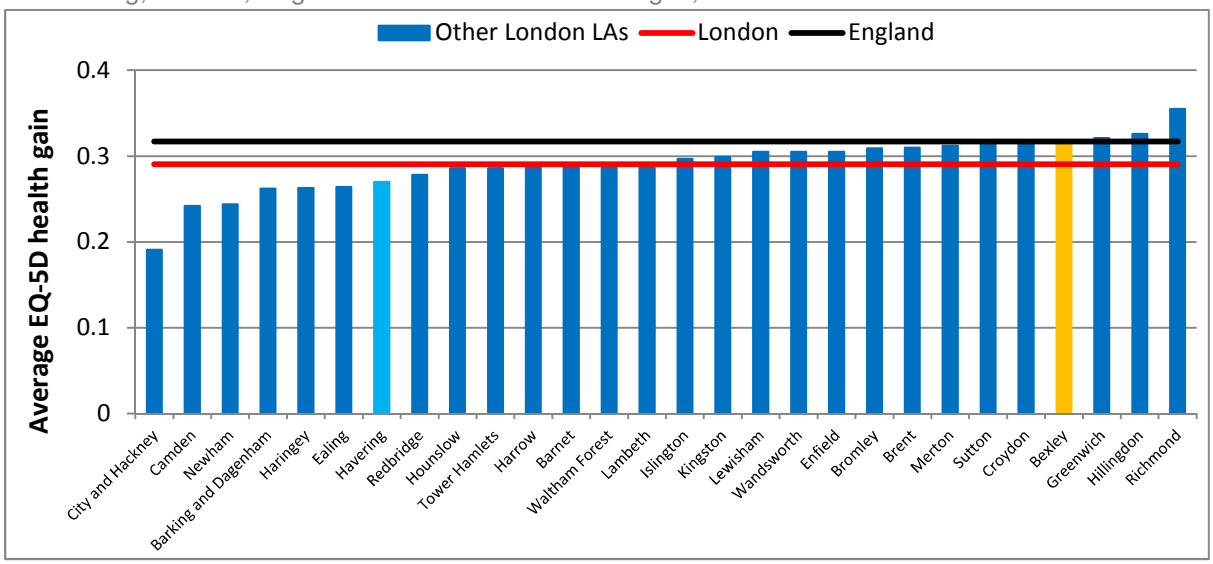
Data source: NHS CCG Outcomes Atlas – indicator 3.3 (http://tools.england.nhs.uk/ccgoutcomes/html/atlas.html)

In 2016/17 the average change in EQ-5D scores for elective knee replacement procedures was 0.27 in Havering. This was worse than the London (0.29) and England (0.32) average (

[67] *EQ-5D is a standardized instrument developed by the EuroQol Group as a measure of health-related quality of life that can be used in a wide range of health conditions and treatments. (https://euroqol.org/eq-5d-instruments/)*

Figure 61).

Figure 61: Average change in EQ-5D scores before and after elective knee replacement procedures in Havering, London, England and other London boroughs, 2015/16



Data source: NHS CCG Outcomes Atlas – indicator 3.3 (http://tools.england.nhs.uk/ccgoutcomes/html/atlas.html)

In 2015/16, the average change in EQ-5D scores of elective groin hernia replacement procedures was 0.14 in Havering. This was higher than the London (0.08) and England (0.10) average.

9.8 Stroke

In 2016/17, about 51% of patients who had a stroke were admitted to an acute stroke unit within 4 hours of arrival to hospital in Havering. This proportion was lower than the Bexley (55%), London (57%), and England (58.7%) average.

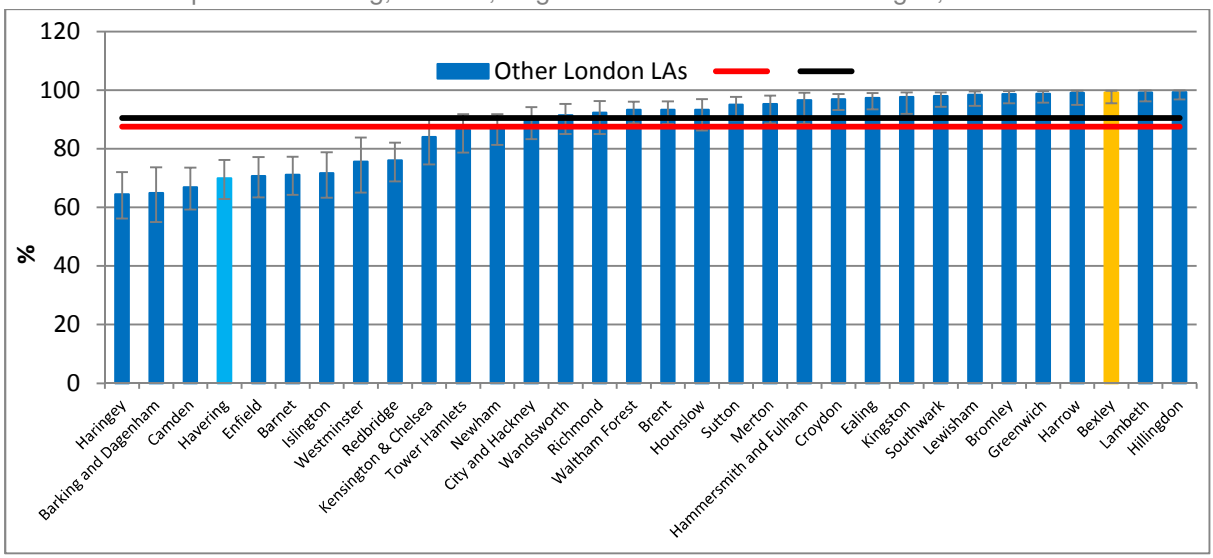
The proportion of patients who had an acute stroke and received thrombolysis in Havering were about 17.4% in 2016/17. This was better than the Bexley (13.6%), London (13.4%), and England (11.5%) average.

The proportion of patients who had a follow-up assessment between 4 and 8 months after initial admission for stroke in Havering was about 28.3% in 2016/17.

This was higher than the Bexley (0.9%) and London (23%) average, but lower than the England (31.6%) average.

In 2016, about 70% of patients in Havering with stroke who were discharged from hospital had a joint health and social care plan. This was significantly worse than the London (87.6%), and England (90.5%) average (see Figure 62).

Figure 62: Percentage of patients with stroke who were discharged from hospital with a joint health and social care plan in Havering, London, England and other London boroughs, 2016



Data source: NHS CCG Outcomes Atlas – indicator 3.7 (http://tools.england.nhs.uk/ccgoutcomes/html/atlas.html)

In 2016/17, patients in Havering who had an acute stroke and spent 90% or more of their stay on a stroke unit were about 82.4%. This was higher than in Bexley (80.2%), but lower than the London (85.3%) and England (84.3%) average.

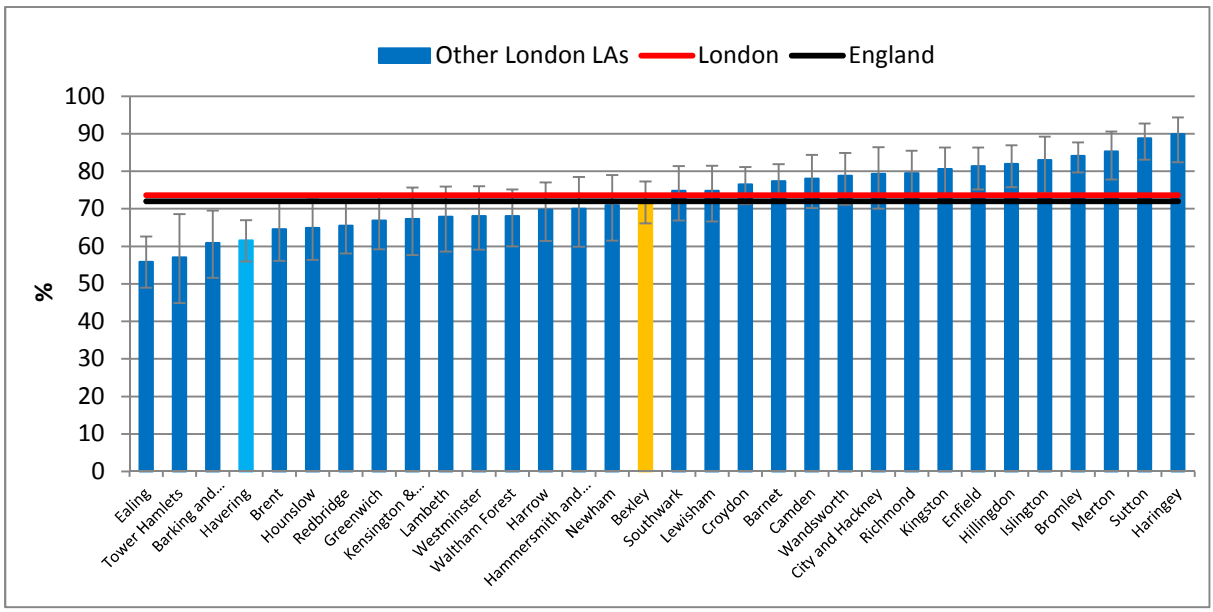
9.9 Hip fracture

The proportion of patients in Havering with hip fractures recovering to their previous levels of mobility/walking ability at 30 days was about 37.5% in 2015. This was higher than the Bexley (21.1%) and London (35.6%) average, but similar to the England average (37.6%).

In 2016, about 99% of Havering's patients in the National Hip Fracture Database received collaborative orthogeriatric care from admission. This was higher than the Bexley (98.4%), London (96.7%), and England (96.4%) average. But in the same year, the percentage of Havering's patients in the National Hip Fracture Database who received timely surgery was about 61.6%. This was lower than the London (73.2%) and England (72%) average (see Figure 63).

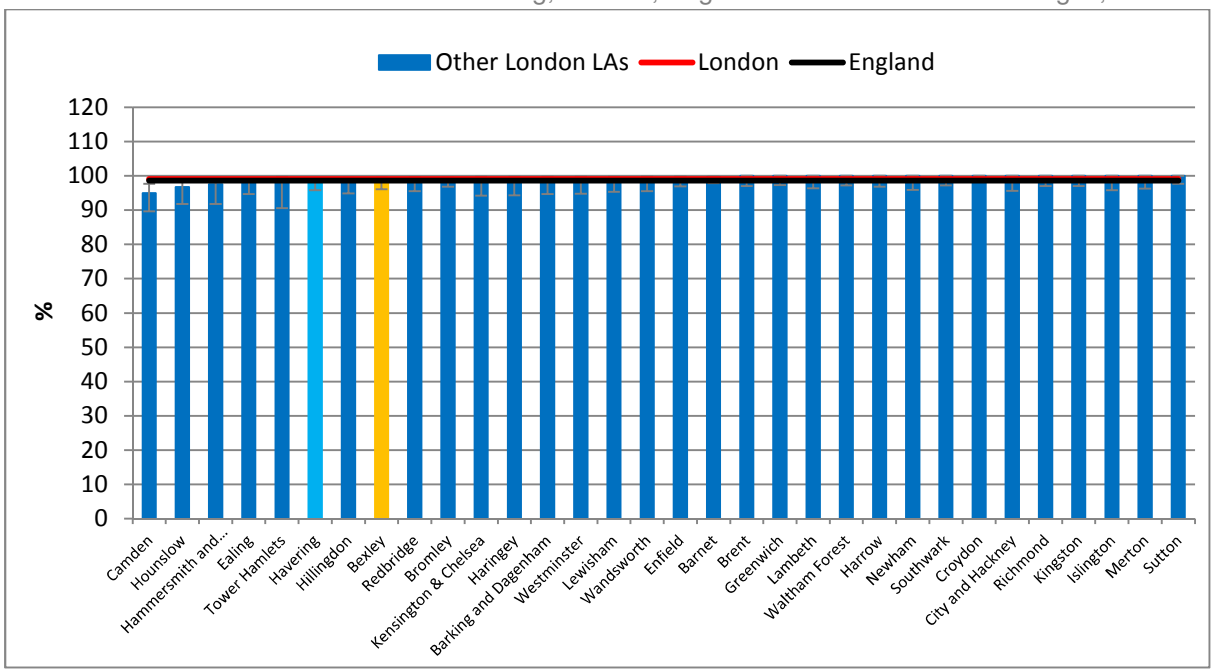
Also, in 2016, the percentage of Havering's patients in the National Hip Fracture Database who received a multifactorial risk assessment of future falls risk was about 98.2%. This was lower than the London (99.1%), and England (98.6%) average (see Figure 64).

Figure 63: Percentage of patients in the National Hip Fracture Database who received surgery on the same day, or the day after, admissions in Havering, London, England and other London boroughs, 2016



Data source: NHS CCG Outcomes Atlas – indicator 3.12
(http://tools.england.nhs.uk/ccgoutcomes/html/atlas.html)

Figure 64: Percentage of patients in the National Hip Fracture Database who received a multifactorial risk assessment of future falls risk in Havering, London, England and other London boroughs, 2016



Data source: NHS CCG Outcomes Atlas – indicator 3.13
(http://tools.england.nhs.uk/ccgoutcomes/html/atlas.html)

9.10 Alcohol-specific hospital admissions

There were approximately 130 hospital admission episodes in Havering where the primary or secondary diagnosis was an alcohol-specific condition between October 2016 and September 2017. The Havering rate (47.2 per 100,000 registered patients) was lower than the Bexley (64 per 100,000), London (73.6 per 100,000), and England (106.8 per 100,000) average.

Between October 2014 and September 2017, there were about 46 emergency readmissions to hospital within 30 days of the previous discharge date in Havering where the first episode was associated with a primary or secondary diagnosis of an alcohol-specific condition,. The ratio (expected readmissions/observed readmissions) was 79.5 which indicates that there were about 20% fewer alcohol-specific emergency readmissions than expected.

9.11 Mental Health

Estimates suggest that about 3,275 children aged 0-16 years and resident in Havering have a mental health disorder sufficient to cause distress to the child or have a considerable impact on the child's day-to-day life. Children and Mental Health Services (CAMHS) in Havering are provided by North East London Foundation Trust (NELFT). Over 2,000 children received care in 2012/13 - the majority of whom had emotional problems. Of these children over 64% were between 11 and 17 years of age. Compared to both Havering's statistical neighbour Bexley, and England, Havering has a lower rate of admission for children with mental health disorders aged 0-17 years.[68]

There were about 15 unplanned readmissions to a mental health service within 30 days of the discharge date in people aged 17 in Havering in 2014/15. The ratio (expected readmissions/observed readmissions) was 45.2 which indicates that there were about 55% fewer unplanned readmissions to mental health services than expected.

About 8% of adults aged 18 to 69 in Havering had received secondary mental health services at some point during the year recorded as being in employment at their most recent assessment, formal review, or other multi-disciplinary care planning meeting between Oct 2016 and Sep 2017. This was higher than the Bexley (6%), London (6.59%) and England (6%) average.

See the mental health JSNA (at http://www.haveringdata.net/research/jsna.htm) for information on service use by adults.

[68] *Havering Children and Young People JSNA*

10. Key documents for further information

Below is a list of useful documents and resources for further information. Except otherwise stated, these are locally produced documents which can provide more detailed information on various sections of this document. Any of the documents noted as being in draft will be available online when published.

- This is Havering: a Demographic and Socioeconomic Profile (updated quarterly)
- Health and Wellbeing Strategy 2015-2018
- Obesity JSNA 2016 *(currently in draft)*
- Obesity Strategy 2016 *(currently in draft)*
- Adult Social Care Market Position Statement 2016 *(currently in draft)*
- Strategy for Children and Young people with Special Educational Needs and Disabilities, 2015-2020 *(currently in draft)*
- Public Health Outcomes Framework – Havering profile *(nationally produced)*
- Adult Social Care Outcomes for Havering *(nationally produced)*
- NHS England and PHE's Commissioning for Value document for NHS Havering CCG *(nationally produced)*
- Pharmaceutical Needs Assessment 2015
- Mental Health JSNA 2015
- Sexual Health JSNA 2015
- Drug and Alcohol JSNA 2014
- Children and Young People JSNA 2014

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What is a comparator?

Comparators provide context to help interpret indicators. In public health, the state of an area for diseases and conditions are often measured by indicators. Without context it is difficult to interpret whether the value of these indicators is high or low, hence whether its outcomes are 'good' or 'bad', taking into account expected natural variation, and therefore whether actions should be taken to address the situation. When the value of an indicator is viewed side by side with a comparator, be it a target value or one based on values for other areas, it adds perspective to the information and provides the opportunity to decide how that indicator is performing. A benchmark is a comparator which represents good or best practice. Comparator groups can be defined, collecting together areas or organisations which are in some way similar (for example, demographically) and represent appropriate comparators for each other.

Commonly used comparators

Many ways of comparing outcomes or performance exist in different industries, and even within a single industry there can be many comparators. The number of comparators available can make it confusing when attempting to interpret information. Some commonly used comparators are:

- **Geographical hierarchies**. For example, a local authority (LA) can be compared to the region within which the LA falls, or the national value
- **Target-based**, as some indicators have a defined target for achievement. For example, Public Health England (PHE) recommends that LAs should work towards achieving a chlamydia detection rate of at least 2,300 per 100,000 population of 15-24 year olds
- **Chartered Institute of Public Finance and Accounting (CIPFA)** nearest neighbours.[69] This attempts to relate LAs by their traits by using descriptive features of the area each authority administers such as population, socioeconomic, household and mortality characteristics, rather than the services it provides
- **Office for National Statistics (ONS) area classifications**. These use socioeconomic and demographic data from each census to identify areas of the country with similar characteristics. They have been produced at different geographies including super output areas, LAs and health areas

[69] *Chartered Institute of Public Finance and Accounting. NNM 2015 - England Authorities [Internet]. Available from: http://www.cipfastats.net/download.asp?filename=http://www.cipfastats.net/uploads/NNM2015 - England Authorities.xlsx*

- The English Indices of Deprivation (ID),[70] which provide a set of relative measures of deprivation for small areas (lower layer super output areas, LSOAs) across England, based on seven domains of deprivation: income, employment, education, skills and training, health and disability, crime, barriers to housing, and living environment, as well supplementary indices and the overall Index of Multiple Deprivation (IMD). These scores are often divided into deciles in order to group areas for comparative purposes. ID can also be used at LA level to group areas with similar levels of deprivation

Examples of methodology for creating comparators

CIPFA nearest neighbours

The values for the indicators that are included in the calculation are collated. For each area, the nearest neighbour is derived by calculating the 'Euclidean distance' to all the other areas' data once they have been standardised to a normal distribution. A simple example of Euclidean distance for two areas with two indicators is the distance of the straight line between those two indicators for the two areas plotted on a graph. This method can be extended to multiple indicators. Each area is then sorted by this distance, where the shortest distance is the nearest neighbour.

Index of Multiple Deprivation

The initial stages to the calculation identify the domains and the indicators within those domains that will be used in the calculation. In the latest IMD calculation, seven domains were used and between one and seven indicators in each domain existed. 'Shrinkage' is then applied to impute values for indicators for small areas (as values for small areas are affected significantly by small changes in numerators). Domain scores are then calculated for each area using a variety of methods depending on the domain. Where all the indicators are the same units, they are summed to produce a domain score. Otherwise, the indicators are ranked and standardised before being summed with a defined weighting for each indicator to produce a domain score. Domain scores are then ranked and standardised to an exponential distribution (the exponential distribution is used to emphasise deprivation rather than give deprivation and affluence equal weighting). The domain scores are then combined, using a pre-defined weighting, to form the overall IMD for the LSOAs. These scores can then be summarised up to larger geographies. The scores can also be grouped into deciles to create benchmarks within the groups. Note, aggregating scores to different geographies may result in the decile for an area

[70] *Smith T, Noble M, Noble S, Wright G, McLennan D, Plunkett E. The English Indices of Deprivation 2015: Technical Report [Internet]. 2015. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464485/English_Indices_of_Deprivation_2015_-_Technical-Report.pdf*

changing, For example, a unitary authority can be in different deciles among upper tier LAs and among lower tier LAs.

Considerations when selecting a comparator

When selecting a comparator there are a number of factors to consider:

- comparing with areas that have similar characteristics. Areas can be categorised by a number of metrics related to their make-up. Comparing indicators with similar areas can be a good way of understanding how an area is performing compared to other areas that have the same challenges. Note that if the selected comparator includes the factor being compared, the comparison becomes less meaningful. For example, comparing employment indicators with other areas that have a similar Index of Multiple Deprivation (IMD) will not provide full context as employment indicators make up 22.5% of the IMD calculation
- aspirational versus realistic. Comparators such as targets, regional values and national values generally do not contain any situational context. As a result, comparing areas to other areas within the same region or to a national value may not indicate performance. Alternatively, comparing an area to other areas that have advantageous circumstances can inform aspirational goals and identify steps to achieve an improved score.
- level of geography. Comparators are not always published at the same levels of geography. Some organisations have standard operating procedures that estimate comparators from one geography level to another. Care should be taken when comparing areas of one geography level to another due to other influences such as political, administrative and financial.

Comparators to Havering:

Geographically, Havering is part of London, but population structure is more similar to England. Bexley is used as a comparator.

Key public health measures:

Counts, proportions, percentages and rates

The most basic measure used in public health is the count. This may be a count of events such as deaths or admissions to hospital, or a count of people with a particular attribute such as people who smoke. This count itself is essential information for planning the health services for prevention and/or treatment. However, to properly investigate the distribution of disease and risk factors and to make comparisons between different populations, the denominator population or population-years at risk in which the count was observed must also be taken into

consideration. The simplest way of doing this is to divide the numerator count by the denominator population to give a proportion, percentage or rate.

At this point it is worth distinguishing between these terms. The term ‘rate’ in particular tends to be rather loosely applied to describe many public health statistics, some of which would be better described as proportions. The distinction is not important to the calculation of the statistic itself but is necessary to best determine the confidence interval.

Proportions are statistics where the denominator is the count of a ‘closed’ population, and the numerator is the count of members of this population that have a specified characteristic. Common examples in public health occur where a population is evaluated at a finite time point for a certain characteristic, e.g. survey prevalence of smoking or obesity, day cases as a proportion of elective admissions, discharge to usual place of residence, or stillbirths as a proportion of all live and still births.

For other statistics the population is an ‘open’ one evaluated over a period of time. Individuals may enter or leave the population during this period (through ageing, migration, birth, death, loss to follow-up etc), each contributing different periods at risk. The denominator is the sum of the population-periods at risk experienced by the individuals (or an approximation to this, such as a mid-year population estimate). The numerator is usually a count of events that occurred in the population over the period. We shall refer to such statistics as ‘rates’ and examples include mortality rates and cancer incidence rates.

Both proportions and rates are frequently multiplied by a scaling factor for presentation purposes, e.g. per 100,000. When this factor is 100 the statistic is usually described as a percentage. In most, but not all, cases percentages are proportions.

Means

Some public health indicators are reported as the mean of the individual values observed in a sample or population. For example, the mean number of decayed, missing or filled teeth in children, or the mean length of stay in hospital.

Age-standardised ratios, rates and proportions

Disease and mortality rates may vary widely by age. Such variation complicates any comparisons made between two populations that have different age structures. For example, consider two areas A and B with equal-sized populations and identical crude all-age death rates. At first glance they appear to have a similar mortality experience. Suppose, however, that area A has a younger age structure than area B. Given that mortality rates increase with age, one would expect the older

population in area B to experience more deaths. The fact that the two have identical rates means that the younger population in area A must have a relatively worse mortality experience.

The most comprehensive way of comparing the disease experience of two populations is to present and compare their age-specific rates. However, when the number of populations being compared increases, the volume of data that needs to be considered quickly becomes unmanageable. What is needed is a single, easily interpreted, summary figure for each population that is adjusted to take into account its age structure. Such summary figures are calculated using age standardisation methods. It may also be desirable to standardise for other variables, such as sex or level of deprivation, which may also potentially confound any comparisons.

Confidence intervals

A confidence interval is a range of values that is used to quantify the imprecision in the estimate of a particular value. Specifically it quantifies the imprecision that results from random variation in the estimation of the value; it does not include imprecision resulting from systematic error (bias); for a given level of confidence, the wider the confidence interval, the greater the uncertainty in the estimate.

In many studies the source of this random variation is sampling. Even in the best designed studies there will be random differences between the particular sample group selected and the overall target population of inference. Any measurement taken from the sample group therefore provides an imprecise estimate of the true population value.

In public health many indicators are based on what can be considered to be complete data sets and not samples, e.g. mortality rates based on death registers. In these instances the imprecision arises not as a result of sampling variation but of ‘natural’ variation. The indicator is considered to be the outcome of a stochastic process, i.e. one which can be influenced by the random occurrences that are inherent in the world around us. In such instances the value actually observed is only one of the set that could occur under the same circumstances. Generally in public health, it is the underlying circumstances or process that is of interest and the actual value observed gives only an imprecise estimate of this ‘underlying risk’.