Joint Strategic Needs Assessment (2017-19)

Newham London

NHS
Newham
Clinical Commissioning Group

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1.0 FOREW0RD

Foreword by the Chair

The 2016-2018 Joint Strategic Needs Assessment (JSNA) celebrates the population health gains made by Strategic Partners in Newham over the past five to ten years and provides areas where joint effort by Partners could accelerate improvements in population health over the next five to ten years.

Newham has seen many changes from the run up to the Olympics 2012 and beyond. The legacy of the physical infrastructure from the regeneration and the social impact on jobs, skills development and social connections are profound.

Work and income are key determinants of health and Newham Council's innovative workplace programme is more successful than the national programme with 80% of people finding jobs and keeping them for over six months. The increase in employment and income, as well as improvements in the NHS has seen Newham move from second last borough on the deprivation scale to 25th.

The positive trends in life expectancy, a measure of population health status, has seen the gap between Newham and England reduce over the same time. Male life expectancy in Newham is comparable with the national life expectancy.

Whilst there is much to celebrate, the financial challenges, the constant change to the NHS, the welfare reforms and the cuts to the public health grant means we need to increase our joint efforts to accelerate the improvements across all communities and mitigate where possible any negative impacts of national policies.

At the same time, we are publishing the children and young people Joint Strategic Needs Assessment. The evidence presented by Sir Michael Marmot and the approach taken by the Mayor, Sir Robin Wales, in his resilience plan for Newham are both clear that a life course approach is the best option to realise long-term population health gains.

Cllr Clive Furness
Chair, Health and Wellbeing Board

Dr Prakash Chandra
Chair, clinical commissioning group

Foreword by the Director of Public Health

The 2016-2018 JSNA analyses the trends in the adult population health in Newham using public health outcomes framework and relevant elements from the adult social care outcomes framework and the NHS outcomes framework.

Health is not just about the presence or absence of a disease but includes how we experience our lives and our ability to live our lives to the fullest potential. Health is influenced by where we live, work, play and study. All these factors can either promote, protect our health or increase our vulnerability to poor health. Many of these factors are therefore captured through the national outcomes frameworks for public health, social care and NHS.

Healthy life expectancy is an indicator within the public health outcomes framework. It provides a quality of life dimension to life expectancy. This along with other quality of life indicators from adult social care and NHS outcomes are described in this JSNA.

One of the underlying causes of poor quality of life is poor mental health. We are therefore also publishing a mental health needs assessment that provides a focus for CCG and LBN commissioners.

From an asset based health promotion model, women in any society have much to offer in improving the health of their families. My 2016 annual report to be published in 2017 focuses on women's health. It recognises women as assets in improving the health of their family, friends and neighbours.

Lastly, I recognise that data and health information is only part of the story. The real stories about health happen in our neighbourhoods. I am extremely pleased to say the Mayor and Cllr Clark's vision for Community Neighbourhoods is such a good basis for health promotion. The Health and Wellbeing board will be considering *Integrated Prevention: Neighbourhoods First,* a prevention framework for Newham in 2017.

All these documents provide a good basis for the Health and Wellbeing Board to develop a Health and Wellbeing Strategy for Newham. I thank my team for the tremendous efforts that have gone in producing these documents.

Meradin Peachey
Director of Public Health, London Borough of Newham

2.0 EXECUTIVE SUMMARY

Introduction

The Newham adult JSNA (2016-2018) fulfils the statutory responsibility of the Newham Health and Wellbeing Board as required by the Health and Social Care Act, 2012. The document is owned by the Newham Health and Wellbeing Board.

This report adopts the evidence based Dahlgren and Whitehead model of Health to describe the current health of Newham residents. This model was adopted over a medical model of disease because research has estimated that the wider determinants described in the model can have up to 50% of influence on health and life-style and behavioural factors upto 30% of influence. For example, babies born in higher socio economic environments are on average, more likely to live longer and healthier lives compared with babies born in poorer socioeconomic environments. Interventions to improve these factors – such as income, employment, education, community safety and build environment will have the greatest impact on population health. These wider determinants are described as 'upstream' or causes of causes' whilst the life style factors are described as 'midstream" factors. This model allows the Health and Wellbeing board to set priorities for a system wide integrated approach to prevention for the borough which brings together the resilience agenda of the Mayor of Newham, Sir Robin Wales and the prevention agenda in the NHS Five Year Forward View.

Population

Newham with an estimated resident population of 340,700 is the 18th largest borough in the country and fourth largest in London. The population served by Newham clinical commissioning group (NCCG) is estimated to be 332,800. The adult population is 75% of the total population at 256,100 for resident population and 249,000 for registered population. It is the fifth youngest borough in the country with a median age of 30.8 years and second youngest in London. It is the most diverse community with 75% of the population from Black and Asian communities (BAME) which is the highest in the country. For the adult population BAME communities form 70% of the population. The rest of the population is White British (15%) and White other 14%). The estimated projections based on natural change (births and deaths) and internal and international migration suggest an increase of 15% for adult population from 2016 to 2026. The greatest percentage increase is expected in the 65 -74 years age group (27%) and lowest in the 18-49 years group (8%). The greatest increase is expected to occur in the other ethnicities, (28%) British Asian (20%) with other White (15%) and all mixed (14%) and British Black (6%). The British White are estimated to decrease by 14%. The expected housing developments in parts of the borough will have a great impact on the population size and structure and this information will be under review.

Wider determinants of health

Newham has moved its ranking from being the second most deprived borough in England in 2010 to the 25th most deprived in 2015, which now places it in the second most deprived decile (20% most deprived) compared with most deprived decile (10% most deprived) as measured by the Index of multiple deprivation (IMD). As these measures are relative and not suitable for time trends, it cannot be said for certain how much of it is absolute change. Based on the 2015 IMD, Newham is performing well on education similar to other London boroughs, and falls in the middle range for employment and health based on proportion of

small areas in Newham falling in the 10% most deprived decile in the country. It ranks lower in the income and ranks the worst for crime and barriers to goods and services.

About 20% of all adults and 25% of all older people were income poor. The median annual household income in Newham was £28,780 (2012/13) which was £10,000 lower than the London average but comparable to that of North West England. Historically, Newham has had very low median income and even with the 60% increase in income from 2002/3, it remains comparatively low. The low income combined with higher house prices in London results in poor housing affordability for most of the residents. Newham ranked 4th worst in the country for housing deprivation. Newham along with its neighbouring Tower Hamlets and the City of London had the highest proportion of households living in overcrowded conditions. About half of all the households living in private housing live in overcrowded conditions and 20% in social housing.

Council's interventions to tackle the wider determinants

The Council has implemented a number of local policies and programmes to tackle the wider determinants of health.

Improving opportunities for employment is key to the Mayor's resilience agenda. In 2007, the Council launched it's flagship employment service, Workplace. The Workplace offers tailor made training packages to residents to skill them to fulfil the required needs of employers, thus supporting them for real jobs. The scheme has helped 30,000 residents find employment which has contributed to a greater increase in employment rates in Newham compared to rest of London.

MoneyWorks, a financial service for residents was launched in March 2016. It works with London Community Credit Union (LCCU) to support residents access fair low cost loans, offers money management and budgeting skills and exclusive saving deals from local business. A Life Changing Fund was introduced as part of Moneyworks providing loans upto £1,000 at 0% interest for things that could make a significant permanent difference to the recipient's life.

In 2006, the Council established a local housing Association, Local Space to provide 1,800 units with an additional 800 new units agreed. The Council provides 17,000 homes for social rent and works with Housing Associations to nominate residents for 11,000 units provided for social rent. In 2013, a borough wide landlord licensing scheme was introduced by the Council, which is the first such scheme in the Country. Under this scheme, the council has made 1,000 prosecutions, 120 rent repayment orders and banned landlords relating to more than 230 properties. Around 60,000 Newham residents are now protected under this scheme. In May 2016, the Mayor of Newham announced a New Deal for Housing aimed at more closely linking rents to tenant's income. To deliver this programme the Council has established an affordable housing vehicle to purchase properties for offer to residents under this scheme guaranteeing quality, security of tenure and affordability.

The Council has called for powers to intervene in minimum wage enforcement as about 20% of residents are paid less than the National Living Wage.

Whilst there is improvement in some of these indicators as shown by the performance on public health outcomes framework (PHOF), there is still much to make further improvements

and mitigate the fallout from the current financial environment and welfare changes. Statutory homelessness and violent crime (including sexual violence) are on the increase.

High level health and wellbeing outcomes

Babies born in Newham between 2013 and 2015 can expect to have higher life expectancies (79.0 years for men and 82.5 years for women) compared with those born a decade ago (74.8 years for men and 78.8 years for women). The health inequality gap between Newham and England as measured by life expectancy has narrowed from 2.1 to 0.2 years for men and 2.2 to 0.6 for women in the last decade with Newham having figures comparable to England. However, the gap between Newham and London has remained significant in 2013-2015 (1.2 for men and 1.6 for women), although it has reduced from 2.0 and 2.5 years for men and women in 2003 -2005.

However, the gains in life expectancy are not realised in gains in health as measured by health-status adjusted life expectancy (HLE) or disability free life expectancy (DFLE). Male babies born in Newham between 2013 and 2015 can expect, on average, to live in good health to 60.5 years and free from disability for 57.2 years. The corresponding figures for female babies born in Newham during the same period is 60.5 years and 58.5 years, respectively. The gap between Newham and England and Newham and London on these measures is higher (range 3 to 7 years) indicating that although Newham residents can expect to live comparable years of life with their counterparts on average in England and London, they will spend a higher proportion of that life not in good health and with disability

The residents of Newham reported on average better personal wellbeing compared with London. About 81.2% reporting very high to high satisfaction with life, 83.6% reporting that the things they do in their lives were worthwhile, 77.6% were happy and 32.5% were anxious the day before they participated in the survey.

People with long term conditions (LTC) living in Newham reported better health related quality of life (HRQoL) compared with that reported on average in England or London. People with multi-morbidity reported lower HRQoL. Carers in Newham reported similar HRQoL compared with London or England. About 54% of people with LTC felt that they were supported to manage their condition compared with 64% in England.

Social care service users in Newham reported social care quality of life that was comparable to that for London and England. However, the proportion of service users that reported control over daily life was lower in Newham compared with England, particularly in women. The gap was highest for older service users in Newham with only 57% reporting they had control over daily life compared with 75.1% in England and 69,2% in London. The gap between the 16-64 years age group and 65 years age group was highest in Newham. About 47% of male service users and 40% of women service users reported having as much social contact as they would like. For men, this was comparable with England, but the figures for women in Newham were lower than the 45% for England.

Health Improvement

The proportion of Newham residents that have lifestyle behaviours that protect against the risk of chronic conditions such as diabetes and heart disease is lower compared with England or London. About 42% of adults in Newham meet the 5 A day fruit and vegetable

recommendations compared with 52% in England and 56% in London. About 60% of Newham adults were estimated to meet the Chief Medical Officers 's guidelines for physical activity. For the England and London 65% were estimated to meet the CMO's guidelines. Newham.

A higher proportion of Newham residents that have behaviours that increase the risk of chronic conditions compared with England. About 20% of Newham residents smoke compared with 17% in England and 16% in London. A higher proportion of residents in Newham work in occupations which have higher smoking rates such as routine and manual occupations. About 29% of people in these occupations in Newham smoke which is comparable with England but higher than London. The rates for male alcohol specific hospital admissions were higher for Newham compared with London, although similar to England.

The proportion of people with clinical risk such as excess body weight, non-diabetic hyperglycemia and hypertension is high in Newham with 63% adults with excess weight and 10% clinically obese, 11% pre-diabetic and 10.6% have hypertension. These figures are comparable to England.

Burden of disease

The burden of disease measures years of life lost (YLL) due to a disease and the number of years lived with a disability as a result of a disease (YLD). These two measures are combined to give an overall measure of burden of disease, namely the disability adjusted life years (DALYS). DALYs provide an estimate of the gap between the current health status and an ideal health situation where the population lives to advanced age free of disease and disability. Based on the data from the Global Burden of Disease Study, Public Health England and Institute of Health Metrics have estimated that heart disease, lower back and neck pain, lung cancer, stroke, chronic obstructive lung disease, sight and hearing impairments, dementia and depression were the leading causes of DALYs for England in 2015. The World Health Organisation (WHO) has predicted that for Europe, the leading causes of DALYS in 2030 will be heart disease and stroke, cancers- lung, liver, colon and rectal cancers, chronic obstructive lung disease (COPD), dementia, hypertensive heart disease and diabetes. Applying the age specific data on DALYS for UK to Newham indicates that mental health and behavioural disorders, malignant neoplasms contribute to the greatest burden of disease followed by cardiovascular disease, musculoskeletal diseases, chronic obstructive lung diseases and dementia.

Trends in mortality indicate that the gap between all age all cause mortality between Newham and England as measured by standardised mortality ratios (SMR) has reduced although it is significantly higher for Newham males. Newham has also seen a greater improvement in potential years of life lost (PYLL), which is a measure of life lost due to premature deaths (before age 75 years) which has resulted in reduction in the gap between Newham and England. Coronary heart disease (CHD) is still the leading cause of years life lost (YLL), contributing to 34% followed by cancers, (21%) and stroke (11%) and pneumonia (8%).

The data on prevalence of CHD, COPD, diabetes and hypertension on the GP registers suggest that about 78% of estimated number of people expected to have diabetes have been diagnosed. The corresponding figures for CHD were 54% and COPD 39%. For hypertension, arterial fibrillation and heart failure the figures were 55%, 43% and 49% respectively. The incidence of all cancers was lower for Newham compared with London.

3.0 KEY MESSAGES

Principles

The Health and Wellbeing board approach to the social model of health using the Dahlgren and Whitehead framework allows a strategic overview of all the influences of health for prioritising health gains from commissioned services.

This approach should be applied for developing the Newham Health and Wellbeing Strategy and the Newham integrated prevention framework: Neighbourhoods First.

Population

The current population of Newham is young and diverse as defined by ethnicity and religion. As the current population ages, the demand for both social care and health can be expected to increase. It therefore would be prudent to use the current opportunity to promote and maintain healthy behaviours. Supporting local employers to implement the evidence based workplace health promotion charter workplace through workplace health network as implemented in some counties could be considered. This would align with the health and economic resilience agenda.

Wider determinants of health

The population of Newham face multiple challenges. The most pressing challenge is related to low income and housing affordability. One of the consequence is people living in overcrowded and poor housing conditions.

Newham Council is tackling these issues through local policies such as borough wide licensing for private landlords and New Deal for Housing aimed at closely linking people's rent with their income. Moneyworks, the flagship employment service offers training and support to meet demand for real jobs. Poverty in older people may need to be considered alongside these policies.

Crime is a concern for many residents and reducing crime and fear of crime and this should be one of the areas for further improvement.

Whilst local policies are in place, regional and national policies should be more supportive of improving the income, housing affordability and crime in historically poor areas such as Newham.

High Level health and Wellbeing outcomes

The focus for improvement may need to be more on prevention of disability at younger age and better health for longer period. Some of the key areas are reducing onset of diabetes at younger age, increasing awareness of the disabilities associated with early onset chronic conditions, and improving social contacts for people that are service users.

Health Improvement

Newham residents generally have a poorer life style profile on key risk factors that are known to influence the burden of disease related to the major killer diseases- coronary heart disease, stroke, cancer. Less than half the population meet the evidence based guidelines on fruit and vegetable consumption and 30% of the population is physically inactive. In addition, smoking and alcohol profile indicates many of the communities may have a cluster of risky life style factors that interact to increase risk of major long term conditions at younger age as witnessed by the incidence of type 2 diabetes in children.

The combination of lower socio-economic occupations, ethnic predisposition and life-style risk factors predicts a rising cost to health and social care unless interventions to support the population to adopt healthier life styles are implemented now.

Burden of disease

The healthcare improvements in Newham have contributed to the reduction in inequalities in health outcomes as measured by mortality between Newham and England, there is yet a high burden of disease across the age span that can be prevented. The five key areas are mental health, cancers, cardiovascular disease, musculoskeletal diseases and respiratory diseases. In the younger age groups the burden from mental health and musculoskeletal diseases is higher whilst in the older age, the burden from cancer and cardiovascular disease is higher. Newham Health and Wellbeing Strategy and Integrated Prevention Framework may need to consider prevention, variation in care and health literacy, and community empowerment for self-care.

4.0 INTRODUCTION

KEY PRINCIPLES

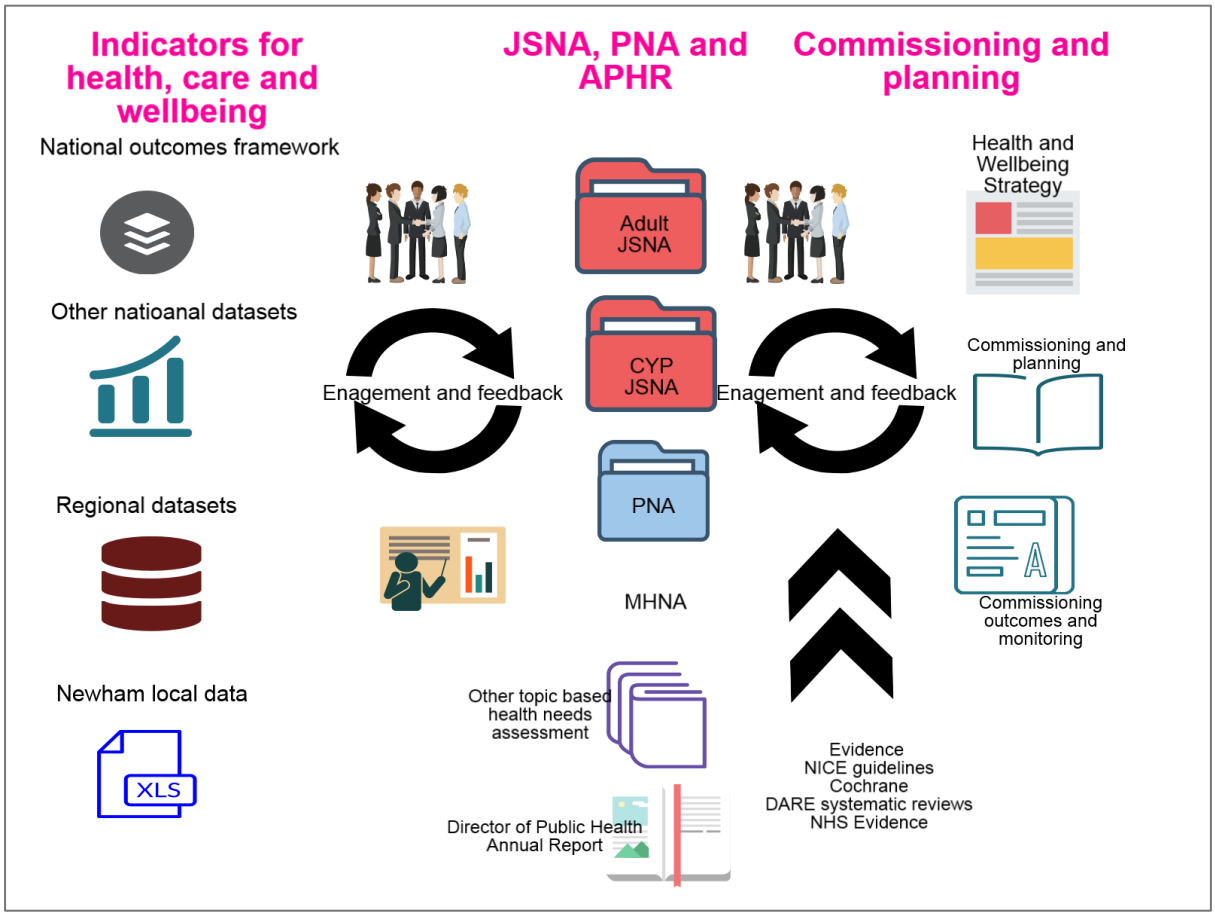
Purpose of Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) fulfils the statutory responsibility of the Health and Wellbeing Board. The JSNA identifies the key health priorities in Newham. This supports and informs the health and wellbeing strategy and the planning and commissioning decisions for improving and protecting the health of the population. The JSNA is owned by the Health and Wellbeing Board.

Process for Joint Strategic Needs Assessment

The JSNA is not a single document but a process that supports commissioning and planning and can be a series of documents and engagement processes with a wide number of stakeholders using evidence based practice [1,2]. Pharmacy Needs Assessment (PNA) is another statutory requirement of the HWB. Topic based health needs assessment (HNA) such as the mental health needs assessment (MHNA) provide further insights

Figure 1: An illustration of JSNA Process



Scope of JSNA

The scope of the JSNA is wider than a description of disease and illness. Figure 2 illustrates the scope of the JSNA.

The Dahlgren and Whitehead model [3] shown in Figure 2 is the most used model for health determinants as it provides an evidence based framework for explaining the diverse influences on population health.

These are factors that influence health positively or negatively [4]. The determinants of health can be,

- Positive health factors: contribute to the positive maintenance of health
- Protective factors: reduce risk of ill health
- Risk factors: can cause health problems that are preventative

Figure 2: Pictorial presentation of Dahlgren and Whitehead model[3] of determinants of health

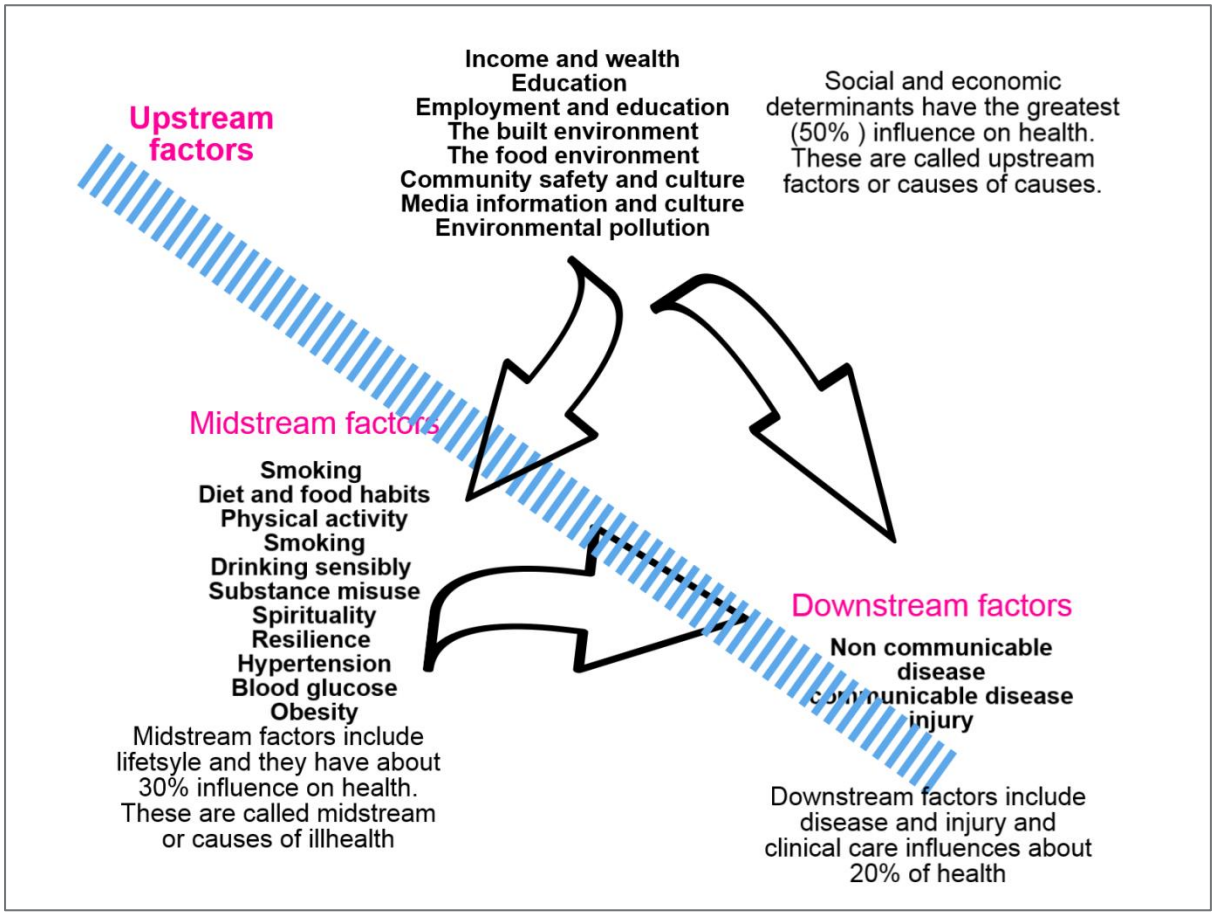
An approach for describing the determinants of health

There is strong evidence [5] that social and economic determinants together with environmental factors which are also called the 'upstream factors' have the greatest influence on health. They are called upstream as they are 'causes of the causes' of health of the population as shown in Figure 3.

For example, babies born in higher socio-economic environments are more likely to live longer and healthier lives compared on average to babies born in poorer socioeconomic environments. Interventions to improve the causes of causes such as income, employment, education, community safety, built environment will have the greatest impact on population health, as studies indicate that upto 50% of the health can be influenced by these upstream factors [6,7].

These upstream factors influence the prevalence of midstream causes of health in a population. Midstream causes include lifestyle factors such as smoking, diet and food habits, physical activity, drinking, and physiological states such as obesity, higher blood pressure and blood glucose. Midstream factors influence about 30% of population health. The population prevalence of disease and injury downstream is influenced both by upstream and midstream determinants of health

Figure 3: Upstream and downstream determinants of health



Approaches for Prevention

The NHS five year forward view emphasises the role of prevention. Particularly in the current financial climate, each pound spent needs to maximise the prevention gains across the health and care economy so we can make more sustainable savings while improving health outcomes and reducing inequalities. Figure 4A below on costs of the upstream and midstream determinants of health to the NHS shows the significant savings that can be made if prevention is targeted at these levels. Figure 4B is an illustration of prevention strategies. By focusing interventions at the upstream level, the demand at the lower levels reduce. The Newham prevention framework, Neighbourhoods First is based on this approach.

Figure 4a: Costs of determinants of health to NHS in England [8]

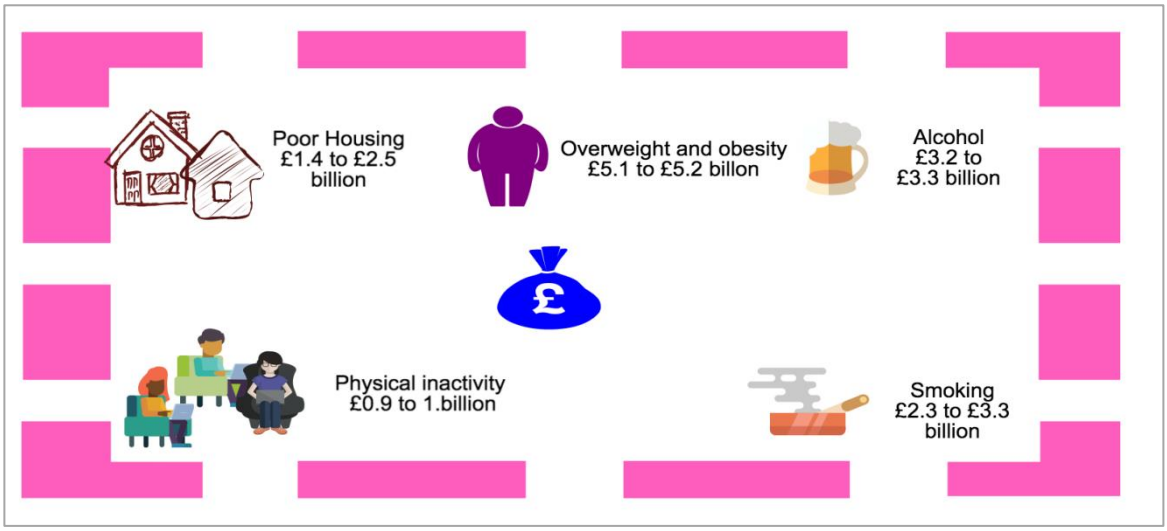
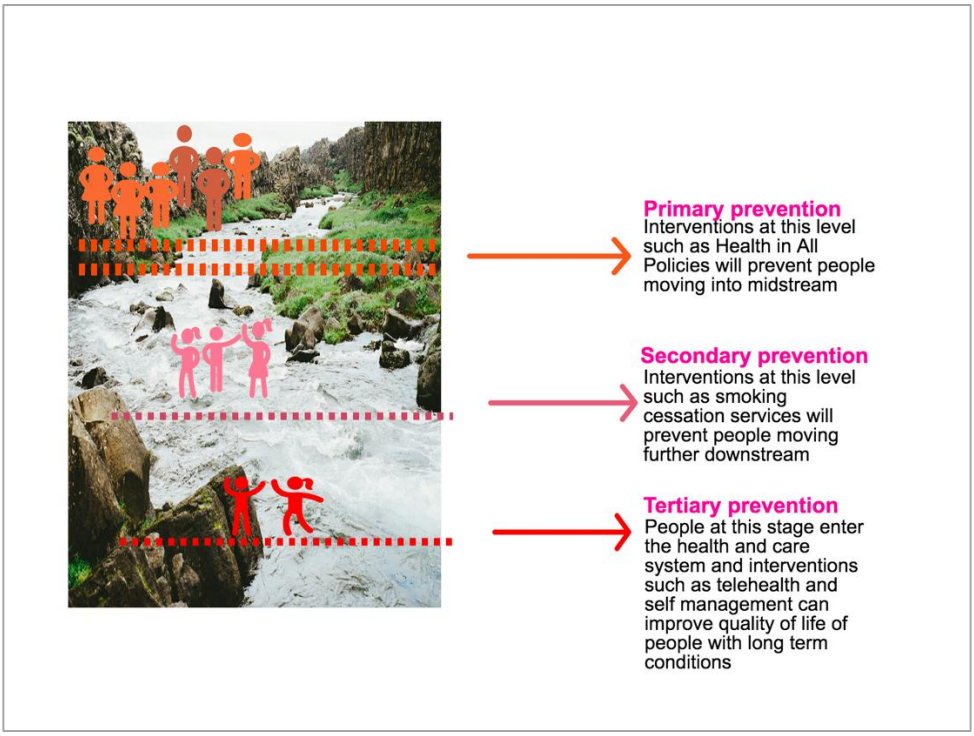


Figure 4b: An illustration of upstream and downstream prevention



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5.0 POPULATION

KEY STATISTICS ON NEWHAM ADULT POPULATION

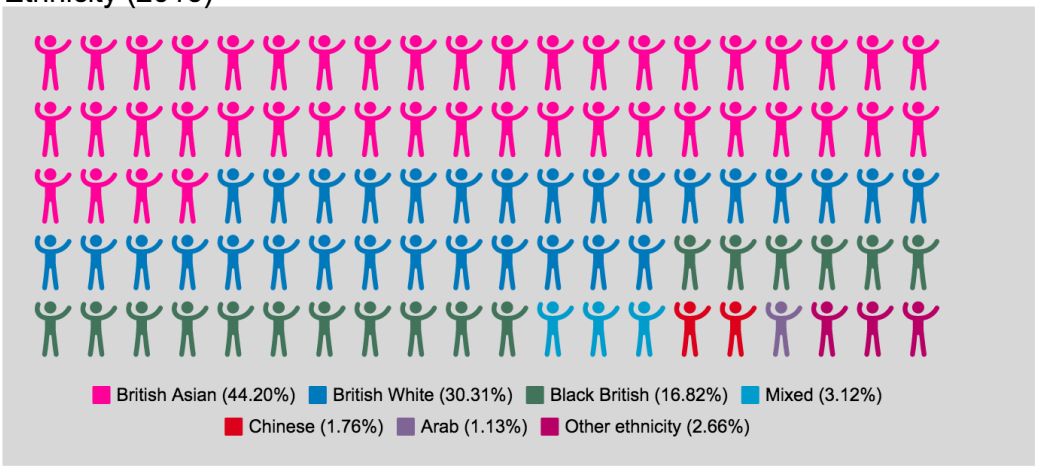
Size of adult population (2016)

In 2016, the adult population (aged 18+ years) was about 256,100 = 75% of total population

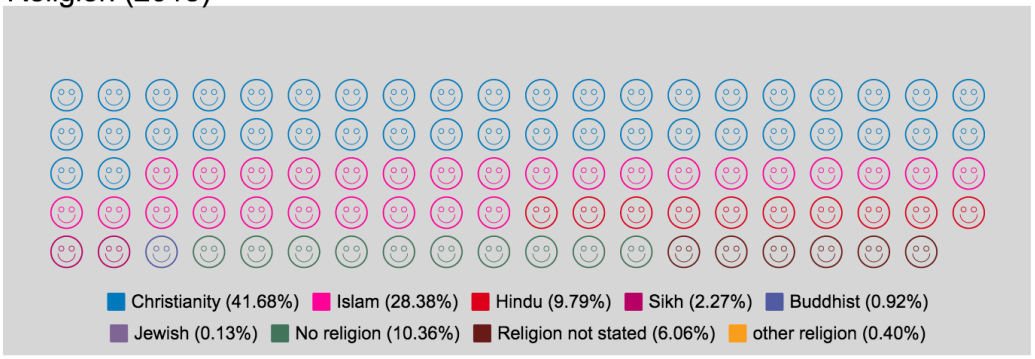
Gender (2016)

47% 53%

Ethnicity (2016)



Religion (2015)

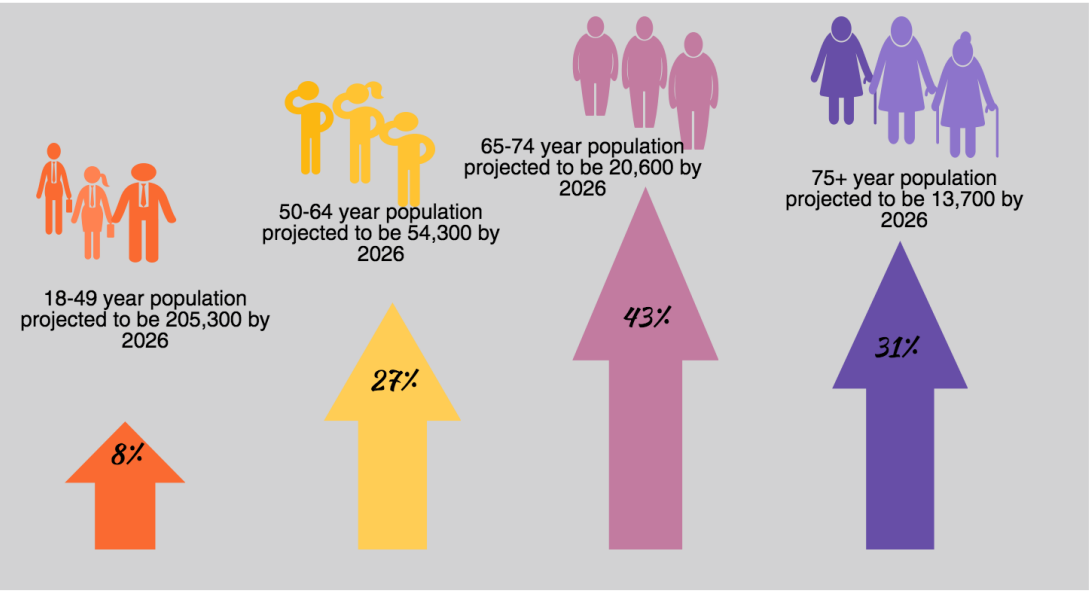


Key changes projected for the adult population in Newham in the next ten years (2016-2026)

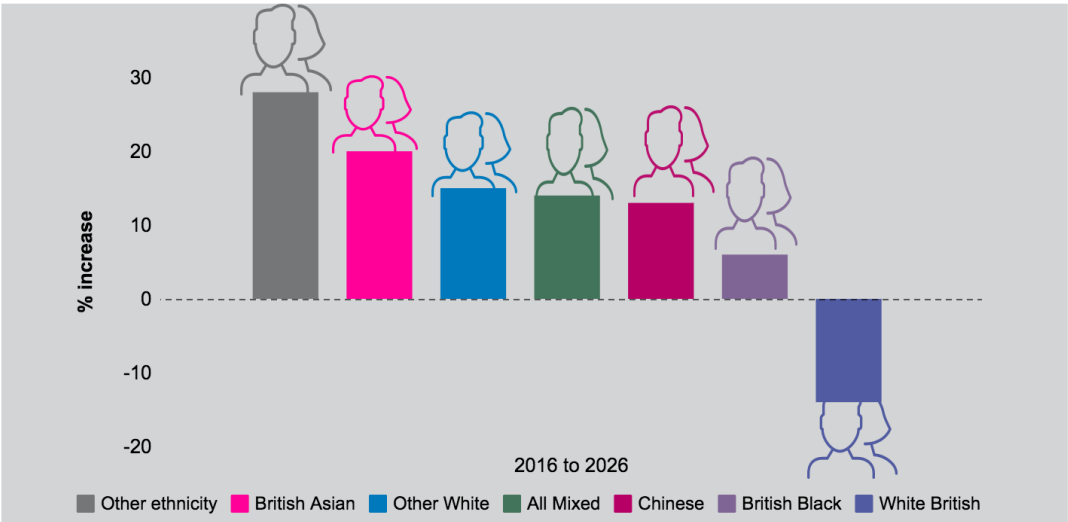
Size

The adult population is projected to increase by 15% from 256,100 to 293,800

Age



Ethncity



BACKGROUND

The size and structure of the population in an area are important determinants that influence need for health and care services. In the adult population, the costs for general and acute healthcare costs rise with age. The costs in the 75+ age group are nearly ten times more than that for 20 to 24 year age group. Funding for health and care generally reflects the need by age and gender.

Ethnicity is an established determinant of health equity and health inequality. Studies done in the UK, report that Black British people are 30% more likely than white people to describe their health as fair, poor or very poor, while Pakistani and Bangladeshi people, who generally have worse health than all other ethnic groups, are 50% more likely than White British to report fair, poor or very poor health [1,2].

Similar health inequalities have been found for other health outcomes, including limiting long-standing illness. Diabetes amongst people of Pakistani and Bangladeshi origin is over five times that of white people.

Despite repeated documentation of ethnic health inequalities, their causal mechanisms are still largely unexplained, although racism and discrimination have been identified as crucial determinants [1].

Religion, culture and health beliefs are other important determinants of health.

It is important to note that these determinants do not act singularly but interact with other factors such as poverty and deprivation [4,3]. There are also differences within the first generation that migrated and the second and third generation born in this country. Acclimatisation to the new environments is another factor that needs to be considered.

CURRENT POPULATION IN NEWHAM

Age

Newham is the 18th largest borough in the country and fourth largest in London with an estimated population of 340,700 in 2016. Using the adult population (*ONS Population projections - local authority based by single year of age, extracted from NOMIS Dec 2016*) , Using the adult population only, Newham is 28th largest in England and seventh largest in London, with a population of 247,000. The population served by the Newham clinical commissioning group is estimated to be about 332,800 (ONS, 2015 based MYE estimates), of which 75% is adult population at 249,000

Figure 1 shows the population pyramid for Newham, London and England by gender. Newham is the fifth youngest borough in the country with a median age of 30.8 years. Within London it is the second youngest borough. London has a median population age of 34.6 years which is lower than the median age of 39.8 years for England.

Ethnicity

Figure 2 shows the population by broad ethnic group for adult population. In 2016, the proportion of adult population from Black and Asian ethnic community (BAME) was about 70% with White British (15%) and White Other about 14%. forms about 75% of the total

population (*GLA 2015, Round Ethnic populations*). BAME form 75% of the total population (all ages) which is the highest BAME population in the Country.

Figure 3 provides population breakdown by more detailed ethnic classification. Newham is very diverse with communities from across all 17ethnic classification residing in the borough. Indian population (17%) is the largest followed by White British (15%) and other White (14%). Bangladeshi (11%), Black African (10% and Pakistani (10%) also make up substantial proportion of the adult population.

Figure 1: Age structure of Newham compared with London and England

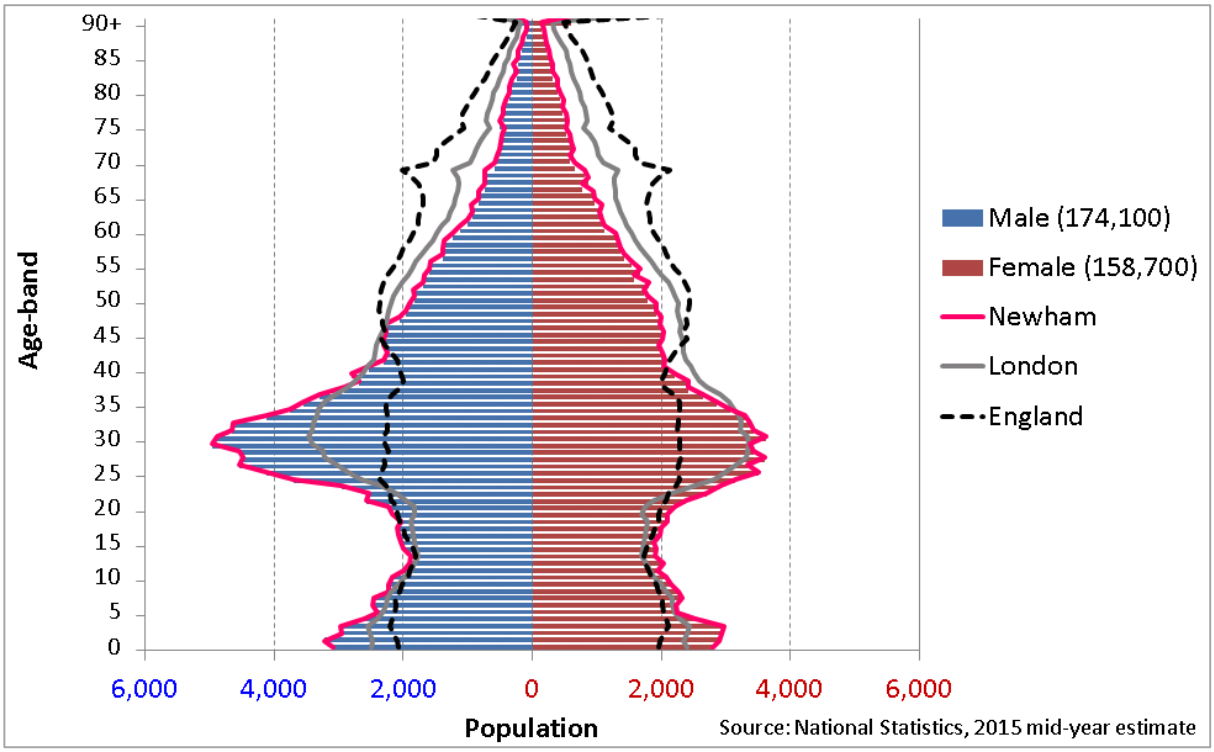
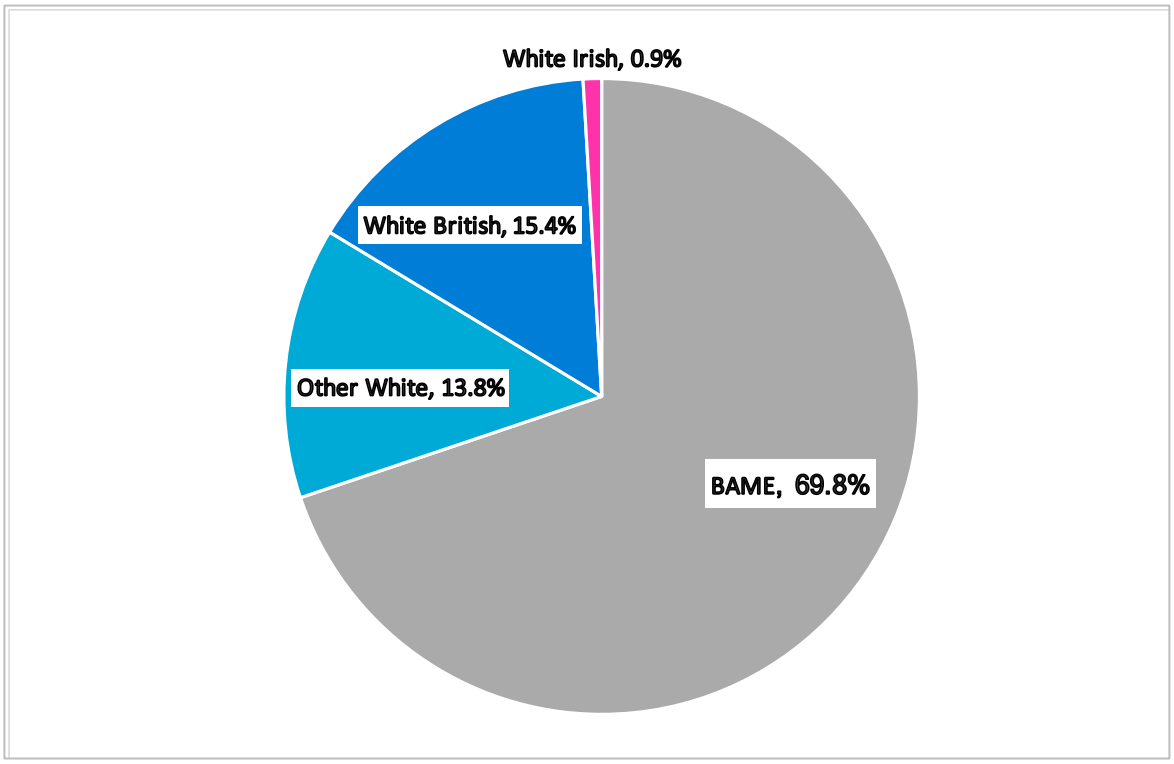
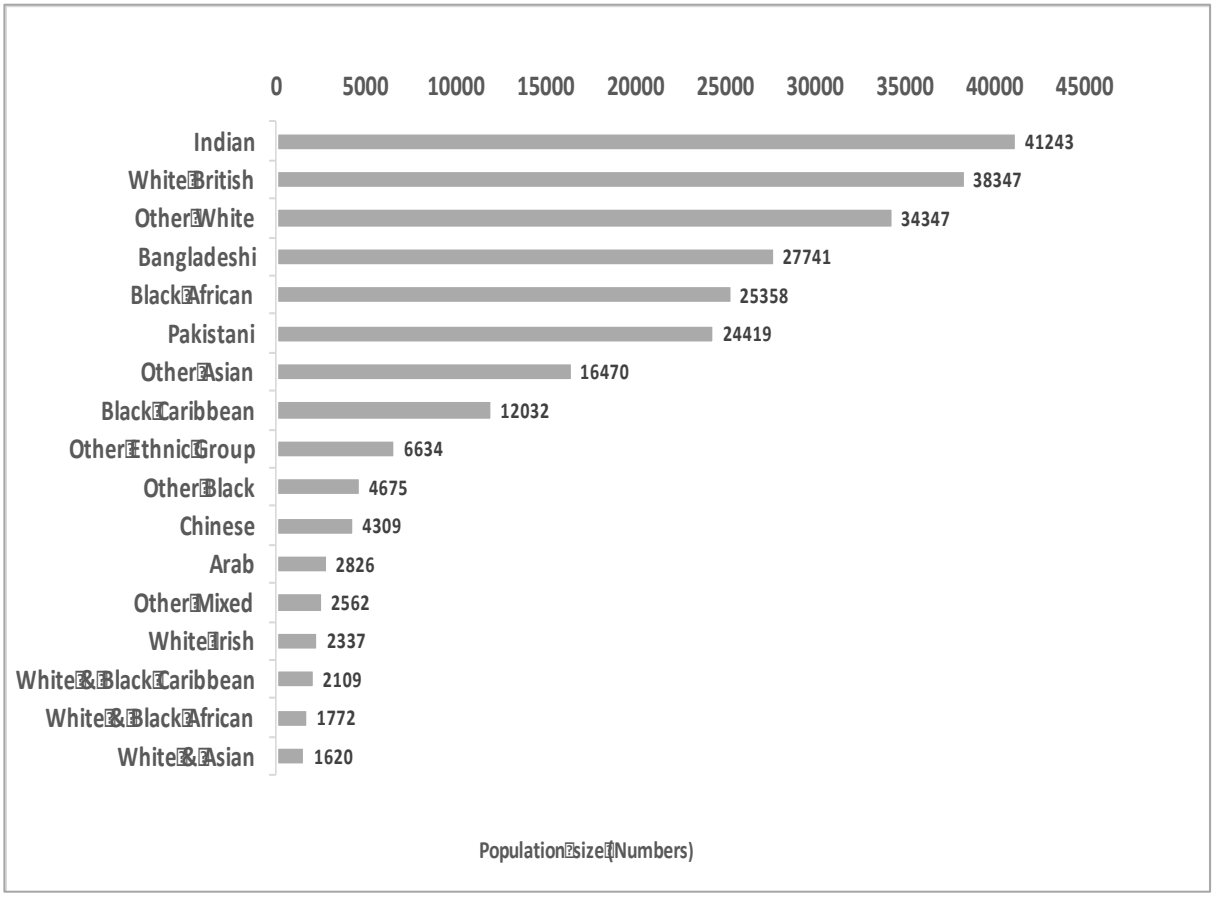


Figure 2: Adult population composition by broad ethnic group



Data Source: GLA 2015 Roundtable Ethnic population projections

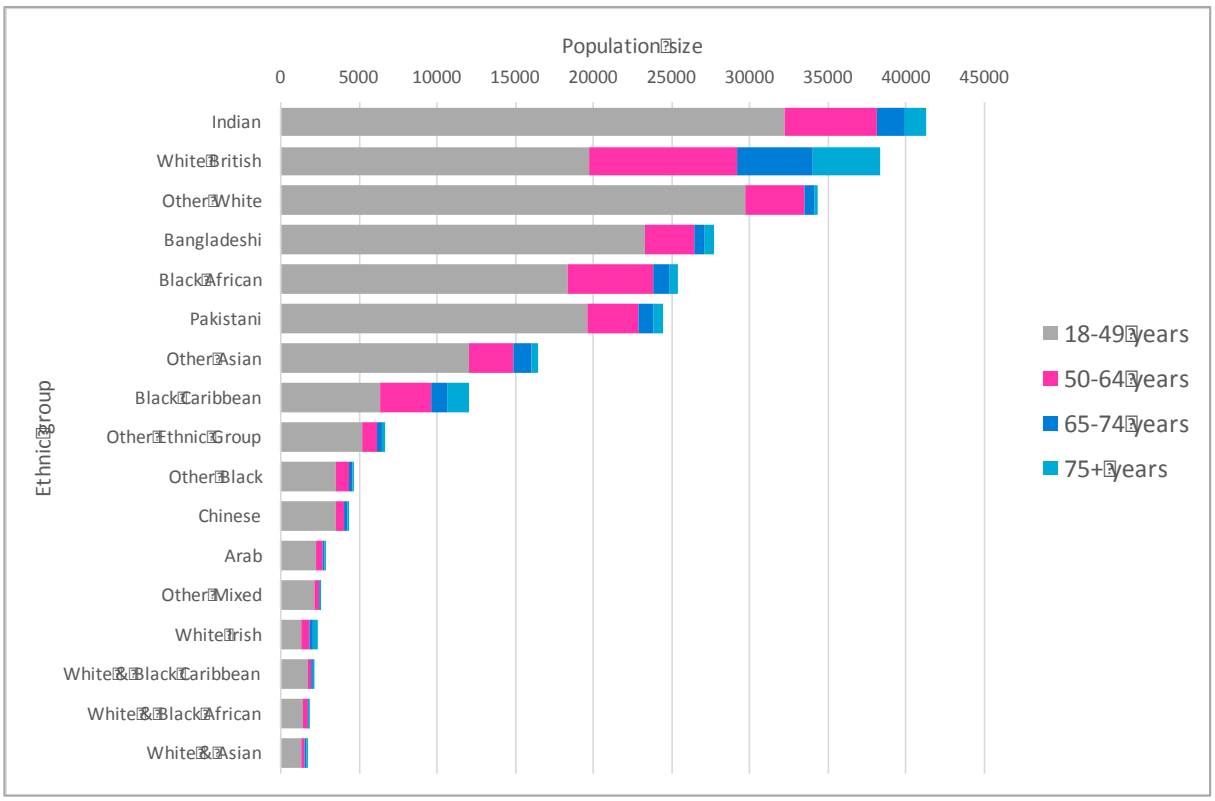
Figure 3: Adult population composition by detailed ethnic group



Data Source: GLA 2015 Roundtable Ethnic population projections

Figure 4 shows population breakdown by ethnicity and broad age groups. The proportion of people aged 65+ years in the White British population whilst the mixed ethnic population is mainly 18 to 49 years of age.

Figure 4: Age structure of adult ethnic population

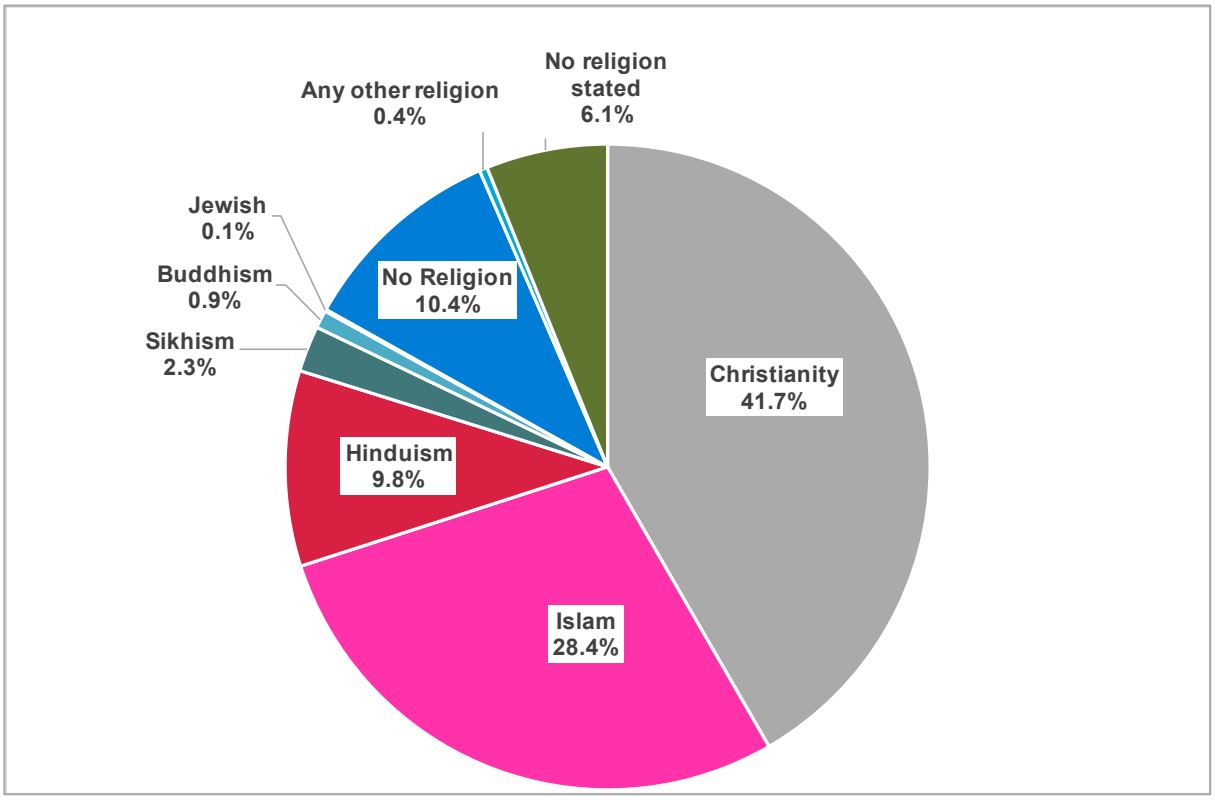


Data source: GLA 2015 Roundtable Ethnic population projections

Religion

Figure 5 provides the breakdown of the population by religion. The largest religious group is Christian (42%) followed by Muslim (28%). About 10% of population did not associate themselves with any religion.

Figure 5: Adult (18 + years) population by religion



Data Source: Census 2011, Religion by age for Newham extracted from Nomis

FUTURE POPULATION PROJECTIONS

Components of change

Future changes to population can be estimated from the trends in natural changes, namely births and deaths in a population and net migration in and out of the area. Figure 6 shows how natural change (births minus deaths) and net migration (domestic and international migration in minus domestic and international migration out) is projected for Newham.

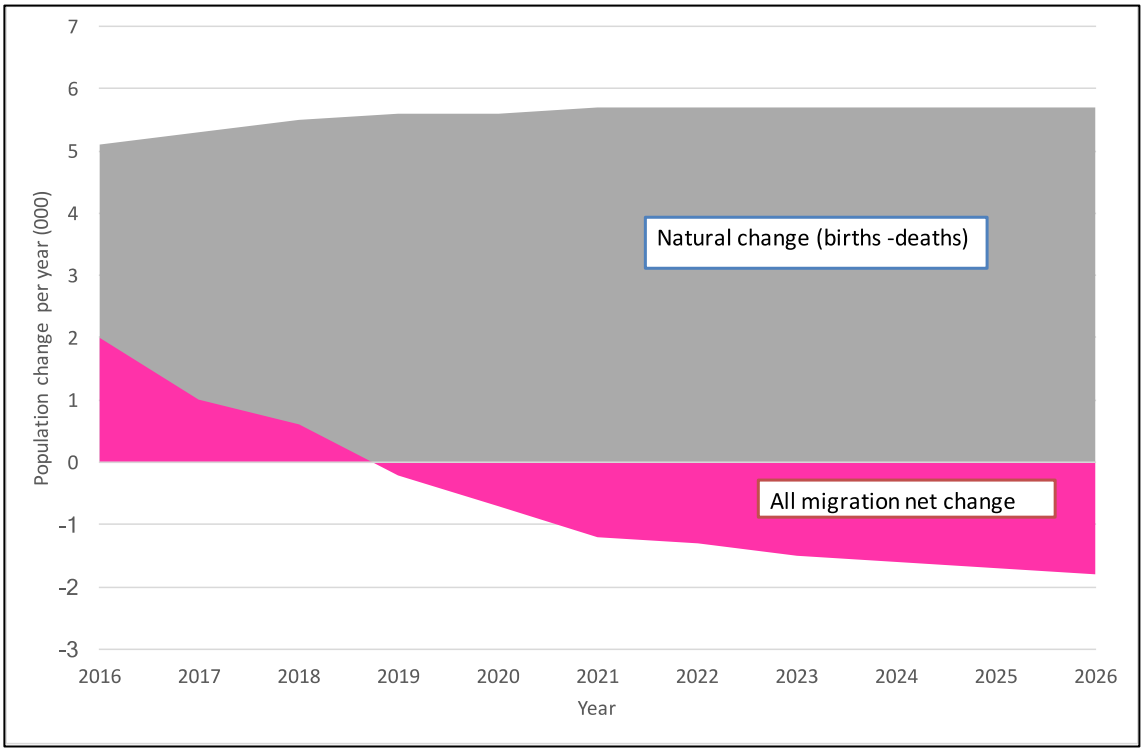
Projections by Age

The Newham adult population is projected to increase by 15% from a baseline of 256,200 in 2016 to 294,000 in 2026. The CCG adult population is projected to increase by 13% from 255,200 in 2016 to 288,100 in 2026.The graph below shows the proportion increase by broad age groups for both the borough and the CCG population.

Projections for Ethnicity

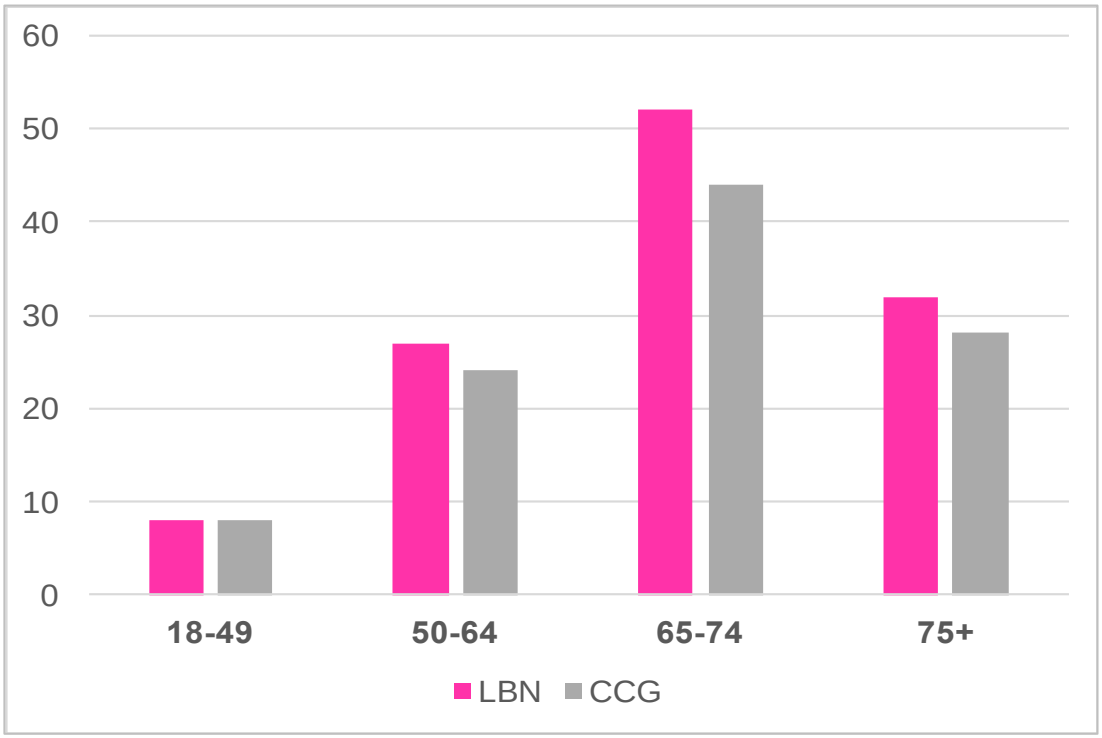
The adult BAME population is expected to increase by 16% and the other White by 15%. The White British is expected to decrease by 16%. Figure 8 shows the proportion increase in ethnic population by broad age groups. The BAME and other White population in 65+ years age group is projected to show higher increase which will have an impact on the services required.

Figure 6: Projected component of population changes in Newham by 2026



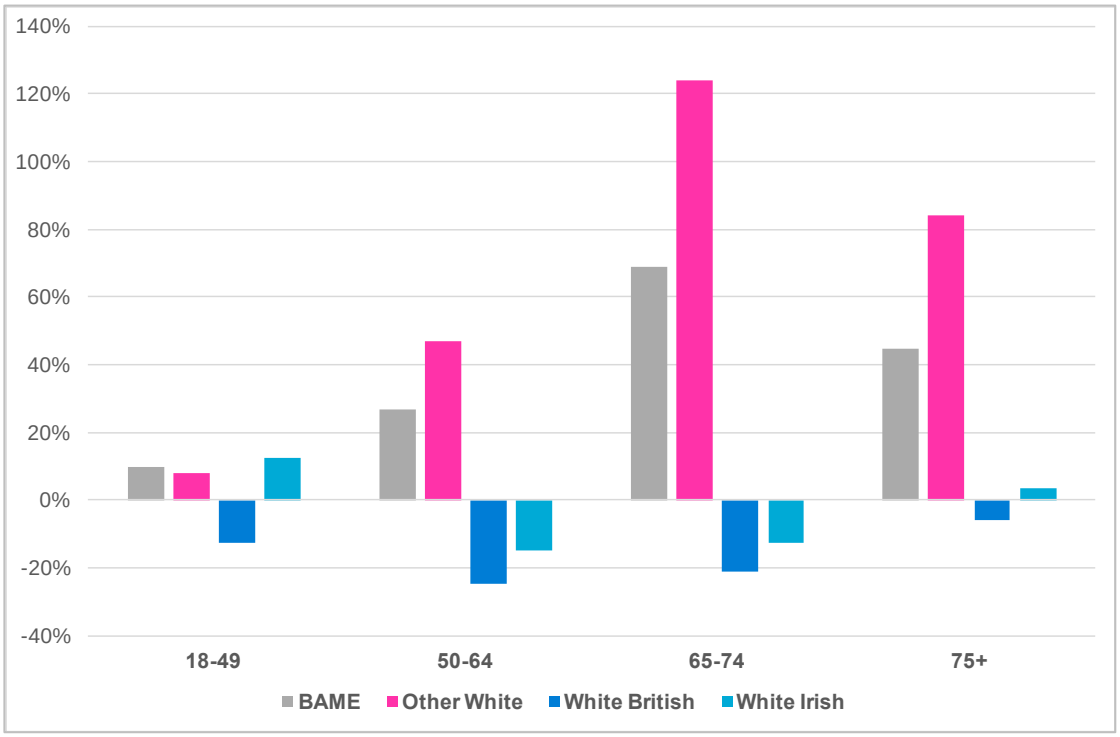
Data Source: ONS 2014-based Subnational Population Projections with Components of Change

Figure 7: Projected changes 2016-2026 (% increase) by broad age groups



Data Source: ONS 2014 based SNPP for LA and CCG

Figure 8: Projected changes 2016-2026 (% change) by ethnicity by broad age group



Data Source: GLA Trend in EGPP

Other factors that may have an impact on population changes.

Newham development plan

Newham development plan proposes to build about 49,595 housing units from 2011 to 2027/28. Between 2011 and 2015/16 8931 new units were delivered with another 16,589 planned to be delivered by 2020/21. The GLA 2015 based projections housing linked indicate an increase of 16.9% for adult population.

KEY MESSAGE

- Newham has a young and diverse population.
- Similar with other areas, the population is growing older.

What should we focus on to improve the health of the population?

The key advantage for Newham is the opportunity for targeting health promotion in the current younger population to avoid future ill-health costs of the population as it ages.

Further, a higher proportion of the adult population are in employment and therefore, workplace health promotion should be an important focus with potential high returns to the borough.

Nottingham has recently successfully implemented county-wide workplace health promotion with over 90 organisations (public sector and private sector) signed up to implement the national workplace health charter to improve health outcomes of the working population and their families.

Such a borough wide work place health promotion programme can be explored for Newham as part of the prevention agenda.

Health promotion programmes will need to consider the ethnic diversity and religious and cultural beliefs of the population if it is to be effective.

Communities and voluntary sector have a crucial role to play in health promotion and they need to be engaged in the health promotion programme

DATA SOURCES

The following data were used in the analyses for this chapter:

1. The Office for National Statistics 2014 based population projections for Local Authorities 2014 based SNPP population persons
2. Population projections - local authority based by single year of age extracted from NOMIS https://www.nomisweb.co.uk
3. ONS Mid-2014 Population Estimates for Clinical Commissioning Groups (CCGs) in England by Single Year of Age and Sex ZS released 26 May 2016
4. GLA 2015 Round Trend LTM Ethnic Group Population Projections released Nov 2016 extracted from London Data Source http://data.london.gov.uk/demography/
5. GLA 2015 based Projections housing linked incorporating data from 2013 SHLAA
6. ONS Census 2011 Religion by age extracted from NOMIS Reference DC2107EW, https://www.nomisweb.co.uk
7. ONS 2014-based Subnational Population Projections with Components of Change (Births, Deaths and Migration) for Local Authorities and Higher Administrative Areas in England, published May 2016

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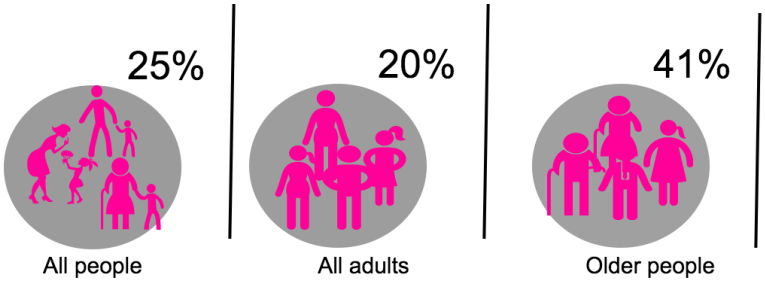
1. Becares L, Cooper C, Kelly C and Karlsen S ICLS Briefing Note 2 Ethncity and Health, International Centre for Life Studies, UCL 2010
2. Becares L . which ethnic groups have the poorest health? Ethnic health inequalities 1991-2011, ESRC Centre for Ethnic Dynamics , Univeristy of Manchester and JRF , 2013
3. Becares L, Finney N and Nazroo J Diversitty or deprivation –what is the issue ? Univeristy of Manchester
4. Barnard H and Turner C Poverty and ethnicity , a review of evidence Joseph Rowntree Foundation 2011

6.0 WIDER DETERMINANTS OF HEALTH

KEY STATISTICS FOR NEWHAM

Income poverty



Housing

Housing Affordability

Median cost of house is 14 times higher than the median gross annual salary

On average , weekly rent in private sector is 66% of gross weekly wage

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Overcrowding

35% of total households
50% of households in private housing
20% of households in social housing

Fuel poverty

13.6 % of households were fuel poor

Crime and fear of crime

About 25,000 crimes reported

51% of people were fearful of crime

Outdoor living enviroment

Newham ranked tenth worst for air pollution index in the country.

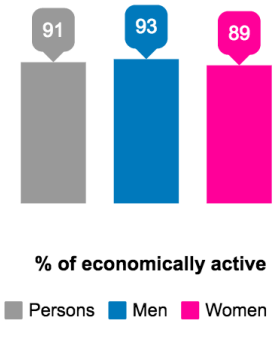
For traffic accidents it ranked 21 worst in the country.

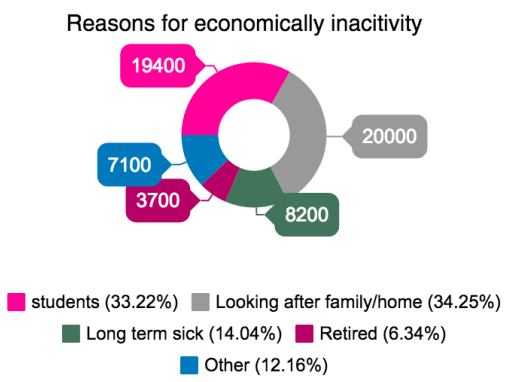
Education and English literacy

87% of young people aged less than 21 years of age do not enter higher education

35% of working age population have no or low qualifications or cannot speak English

Employment





BACKGROUND

Research on the pathways through which the social determinants influence health has led to calls to action to tackle the wider determinants.[1,2]

Research suggests that these factors make a 50-60% contribution to health as explained in the chapter 4. Further these factors influence the midstream factors such as health behaviours. For example, increase in local area violent crime with injury leads to a statistically significant reduction in physical activity, both walking and indoor physical activity. [3,4] Walking is the most common form of physical activity and reductions in walking result in physical activity related diseases such as diabetes. Tackling violent crime and perceptions of community safety are therefore as important in reducing rates of diabetes as is encouraging individuals to exercise more and reduce calorie intake.

Previous review of literature on wider determinants of health [5] shows indicated wider determinants of health act via different pathways including immediate mechanisms such as stress, a direct impact of cold on the vascular system or via increased risk of transmission of respiratory infections in houses where there is overcrowding. Other pathways include an intermediate step such as crime, increasing access to illegal tobacco markets which reduce the costs of smoking, and lead to increased risk of e.g. cancers. Widespread income deprivation can result in large groups of the population not having the physical or emotional capacity to take up healthy behaviours, and thus lead to obesity and diabetes.

Overcrowding impacts directly on most people affected by it, and income deprivation impacts on all major health disorders identified in Newham. Fuel poverty increases winter deaths by cold directly impacting on the body's blood clotting mechanism resulting in increases in cardiovascular deaths within 7 to 10 days of a cold snap. Cold increases hypertension, a further risk factor for stroke. Crime, particularly violent crime impacts on people's health directly via additional stress and anxiety because of crime, but also from a wider impact on increases in community fears of crime.

DEPRIVATION: INDEX OF MULTIPLE DEPRIVATION

In England, the composite indicator, the Index of multiple deprivations, IMD, captures many of the upstream determinants of health– income, employment, access to housing and services, quality of living environment – quality of housing, education, skills and training.

It is the official measure of deprivation in England. This is a useful indicator as it allows local areas to measure their position relative to rest of England. In line with other national statistics, IMD collects and publishes small area statistics

Box 1: Definition of census small areas

Lower super output area (LSOA) is a geographical area with an average of roughly 1,500 residents and 650 households. Measures of proximity and social homogeneity such as type of dwelling – for example, detached/semi-detached etc. - and nature of tenure -owner-occupied, private rented are used to define LSOA.

Middle super output area (MSOA) are geographical areas made up of LSOA and have a minimum size of 5,000 residents and 2,000 households with an average population size of 7,500.

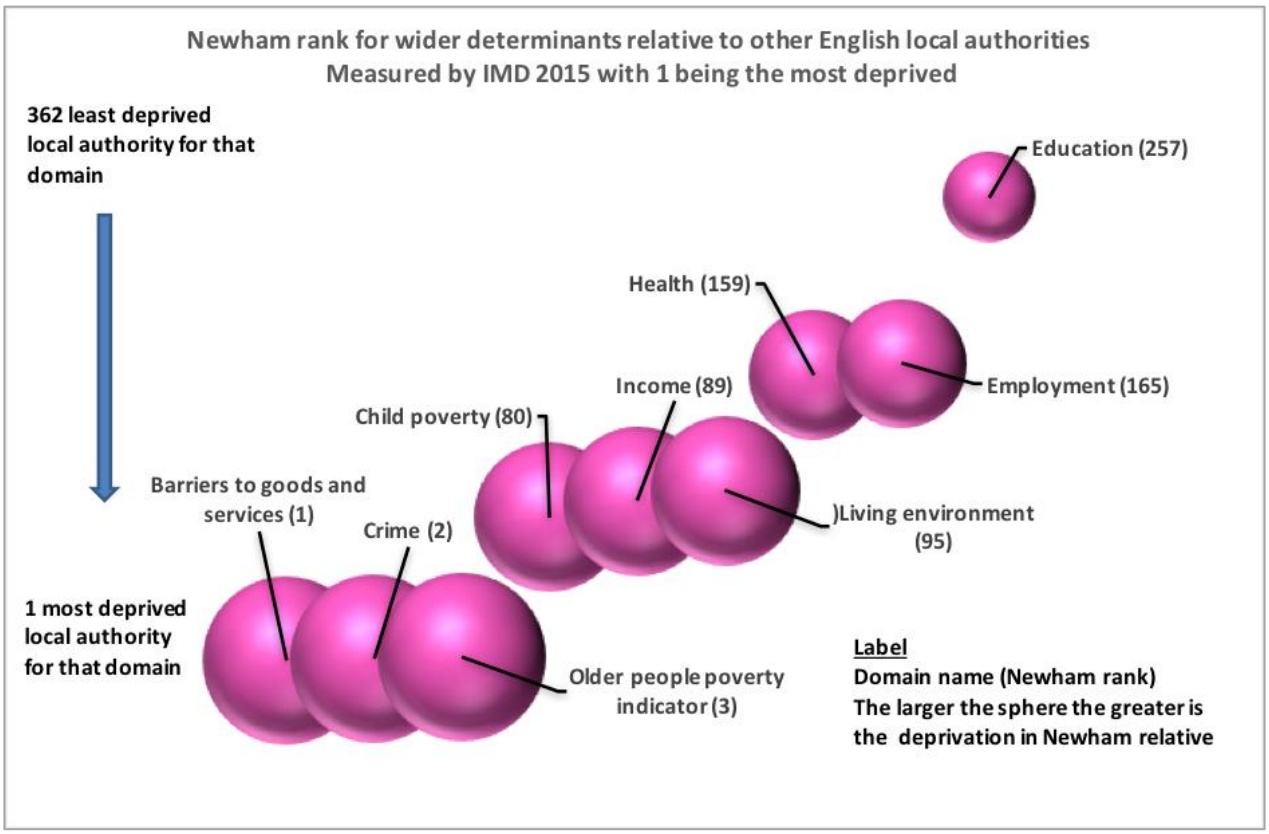
In the last 5 years from 2010 to 2015, Newham's ranking in the index changed from being the 2nd most deprived borough in 2010 to 25th in 2015

Figure 1 presents the ranking for Newham local authority for each of the domains that make up IMD based on proportion of small areas (LSOA) that fall within the 10% most deprived areas within England.

Newham ranks substantially high for education at 257, comparable with many of the London boroughs. It falls in the middle range for employment and health. It fares among the worst local authority for barriers to goods and services, crime and income deprivation affecting older people. However, if one looks at the scale of income deprivation i.e. number of people affected by income deprivation Newham ranks 13th worst nationally.

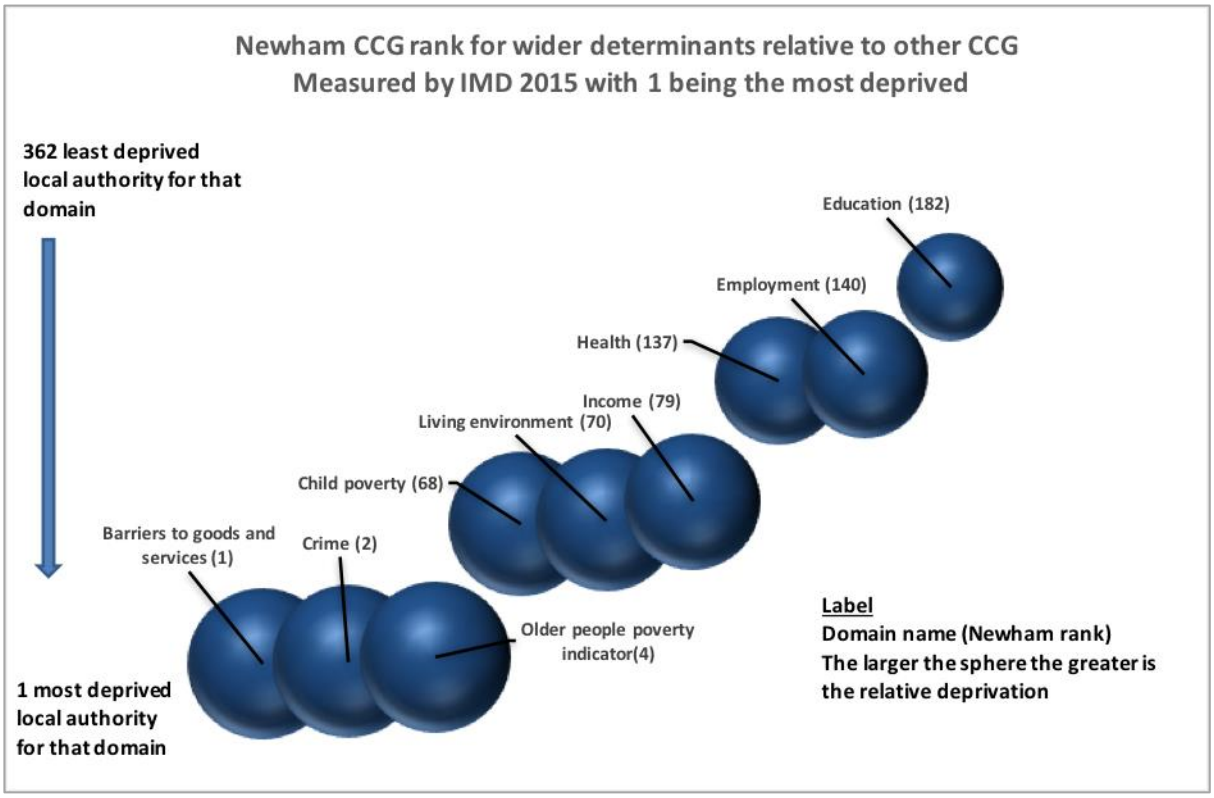
Figure 2 shows that Newham CCG also has similar ranking for crime, barriers to goods and services for older people poverty but ranked lower than the council on the other domains. The adult skills and English language competency is lower in the registered population compared with the resident population.

Figure 1: London Borough of Newham rank of IMD domains and two poverty indicators



Data Source: DCLG IMD 2015 Summaries

Figure 2: Newham CCG rank of IMD domains and two poverty indicators

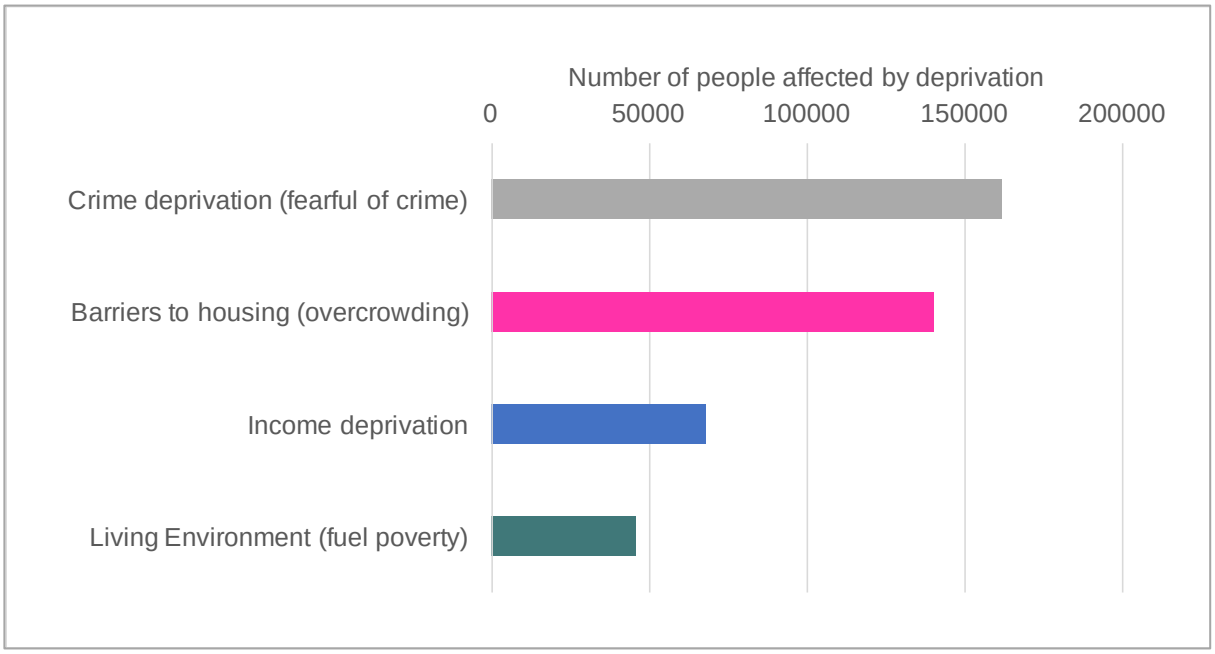


Data Source: IMD 2015 CCG summaries

Scale of deprivation: Number of people facing deprivation

To provide an estimate of the scale of the problem, the number of people in Newham facing deprivation is provided in Figure 3. This provides an indication of population level impact of the wider determinants of health. Many of these people may be facing deprivation in multiple domains for example income and overcrowding.

Figure 3: Scale of deprivation in Newham (IMD 2015)



Data source IMD 2015 and Department of energy and climate change –Fuel poverty 2014 updated June 2016

Income

In 2012/2013, Newham had the lowest median annual household income in London at £28,780 (*GLA Modelled Household Income Estimates for small areas, London 2001-2012*) This was about £10,000 lower than that for London. It was comparable with median incomes in North West England and the East Midland. Over a decade (from 2001/2 to 2012/13), the median income in Newham has increased by 60% which was higher than the increase nationally (46%) or London (44%). The median incomes in Newham were historically low (£17,950) therefore the current median income (£28,780) even after 60% increase is lower than London.

Newham had the highest income poverty in 2012 in London with about 68,000 people on low income based on the IMD indicator. This includes those claiming out of work and in work benefits. Table 1 shows the median annual income and number of people estimated to be in income poverty in North East London.

Table 1: Median Income and income poverty in North East London Boroughs

Local authority (NE London)	Median Household Income (2012/13) §	Estimate of number of people in income poverty (IMD2015) ‡	IMD rank by scale of income poverty (out of 350, with rank of 1 being most deprived‡
Barking and Dagenham	£29,420	45,100	45
City of London	£63,620	450	325
Havering	£36,670	31,600	84
Newham	£28,780	68,000	13
Redbridge	£36,860	42,900	50
Tower Hamlets	£34,930	66,400	15
Waltham Forest	£33,080	50,500	38

Data Source: ‡IMD 2015 and §GLA median income estimates

Housing

Table 2 below provides the IMD 2015 deprivation indicators related to housing deprivation. These indicators are from the two domains -Barriers to goods and services and living conditions.

The population of Newham had the 4th worst ability within England to enter the housing market (ownership or private rental sector) based on the housing affordability index indicator in the IMD 2015 after Tower Hamlets, Brent and Enfield.

The three North East London Boroughs -The City of London, Tower Hamlets and Newham had the highest proportion of households living in overcrowded conditions in England.

Table 2: Housing deprivation in North East London Local Authorities

Local Authority (North East London)	Housing Affordability Index (A higher score indicates a lesser ability to enter housing market as owner or private housing tenant)	Overcrowding (% of households living in overcrowded conditions)	Proportion of houses that do not meet the Decent Homes Standard
Barking and Dagenham	2.7	20%	23%
City of London	1.1	36%	33%
Havering	1.0	7%	18%
Newham	2.8	35%	23%
Redbridge	1.9	17%	20%
Tower Hamlets	3.1	35%	23%
Waltham Forest	2.6	23%	24%

Data Source: IMD 2015 underlying indicators

Case Study Overcrowded House in Multiple Occupation

Context

The subject of this case study is a Victorian 2 storey mid terrace house which was found to be an unlicensed HMO during a multiagency operation carried out during October 2013.
The property had five rooms used for sleeping, two on the ground floor, three on the first floor and one bathroom and one kitchen both situated at ground level.

How many people permitted to live in this HMO?

The number of permitted occupiers in a House in Multiple Occupation (HMO) is determined by measuring the floor space of each of the available rooms that can be used as sleeping or living accommodation [7]. Kitchen is also measured to determine how many occupiers may use it safe of hazard arising due to the layout, size, design or other feature giving rise to risk of burns or scalds caused by contact with flames, liquids or hot surfaces.

The main bedroom (Room1) on the first floor was 14.77M^2, suitably sized for two persons regardless of age to occupy, living as one household i.e. a couple. The other two bedrooms

(Room 2 and 3) at first floor level both had floor spaces measuring 8.93M^2 and as such were suitably sized for occupation by one person only regardless of age.
On the ground floor were two rooms One of these rooms was used as a bedroom measuring 10.43M^2 suitably sized for a couple, whilst the other at 8.56M^2 is suitably sized for one person.

Hence, it would appear on the room sizes alone that there is room for 7 persons, but then account should be taken of the kitchen floor space which measured 8.93M^2 this meant that the property was suitable to be occupied as an HMO by 6 persons. Given that two of the rooms were big enough for 2 couples each, and the other three rooms were suitable for single occupiers this meant that the property could safely be occupied by six people consisting of 5 households

How many people were living at the property?

Room 1 which was suitable for a couple was found to house four unrelated adult males. Four single beds all crammed into the available space as shown in picture 1.

Picture 1: Picture of living arrangements for 4 unrelated male adults in a bedroom appropriate for a couple found at the property.

Rooms 2 and 3 which were suitable for single occupant were occupied by three adult males, and the other had two adult male occupants. None of these occupiers, were related to each other, and thus could not be considered as a household

The ground floor two rooms were used by a single female who had fraudulently claimed benefit, claiming to be a single person living in a ground floor flat.

Hence 10 people were occupying the property and were all unrelated, equivalent to 10 separate households in a property that was suitable for six people in 5 households.

What other health and safety risks were prevalent at this property?

One of the hazards noted in this property was a high accumulation of mould within the bedrooms, as shown in picture 2. This is typical in rooms where beds are crammed in and situated too close to heating appliances. Over occupancy and moisture movement from activities such as bathing are highly causative of mould spore formation. With only one bathroom to use amongst 10 occupiers this increases the moisture burden above that which the dwelling is designed to deal with. The causal pathways of condensation and higher humidity increase risk of exposure to associated health risks [8].

Picture 2: Mould in the rooms at the property as a result of overcrowding

The other health risk was the conditions found in the kitchen where the kitchen cooker was encrusted with food overspill providing potential harbourage for pathogens and organisms as shown in picture 3.

What was the outcome from the Council Inspection?

The landlord was prosecuted for failing to licence the property as well as multiple offences relating to the poor management and filthy conditions. The landlord was found guilty and fined £8431.65. Since prosecution the property is now managed by a separate agent and is a licensed HMO for occupation by six people consisting of 5 households.

Why overcrowding is a public health issue?

The health effects of living in overcrowded conditions where there is a lack of privacy, include psychological distress and mental disorders. Increased heart rate, perspiration, increased hygiene risks, accidents, spread of disease and inability to concentrate are also reported effects.

The tuberculosis rate in Newham is high and living in overcrowded conditions can exacerbate the spread of this disease. Not only that, but for people living in overcrowded conditions are at higher risk of reinfection after having completed treatment [8].

Lack of cleanliness in common parts such as kitchens and bathrooms is also a risk factor in exposing occupiers to pathogens. It was found in this property that none of the occupiers had any sense of ownership and viewed the property as a temporary occupation, thus none of them cleaned the common areas.

What local policies are in place to tackle the housing deprivation in Newham?

Nearly half of Newham residents now live in privately rented accommodation. Central government policies have limited the availability of social housing. High house prices have made ownership unrealistic for many people. And some residents have chosen to rent because it allows them to move at short notice. Newham has already pioneered a number of approaches to address the biggest challenges in the housing market.

In 2006 Newham established a unique Housing Association, Local Space, which the Council has worked in partnership with to provide 1,800 units of high quality and stable housing for

Newham's homeless families, moving away from traditional short term temporary accommodation and we have agreed plans for an additional 800 new units.
The Council provides around 17,000 homes for social rent. Housing Associations in the borough provide a further 11,000 homes – with the Council retaining nomination rights for many of these. Despite restrictive central government policy, the Council continue to expand its stock where possible – most recently acquiring 210 homes at 10 Victoria Street.

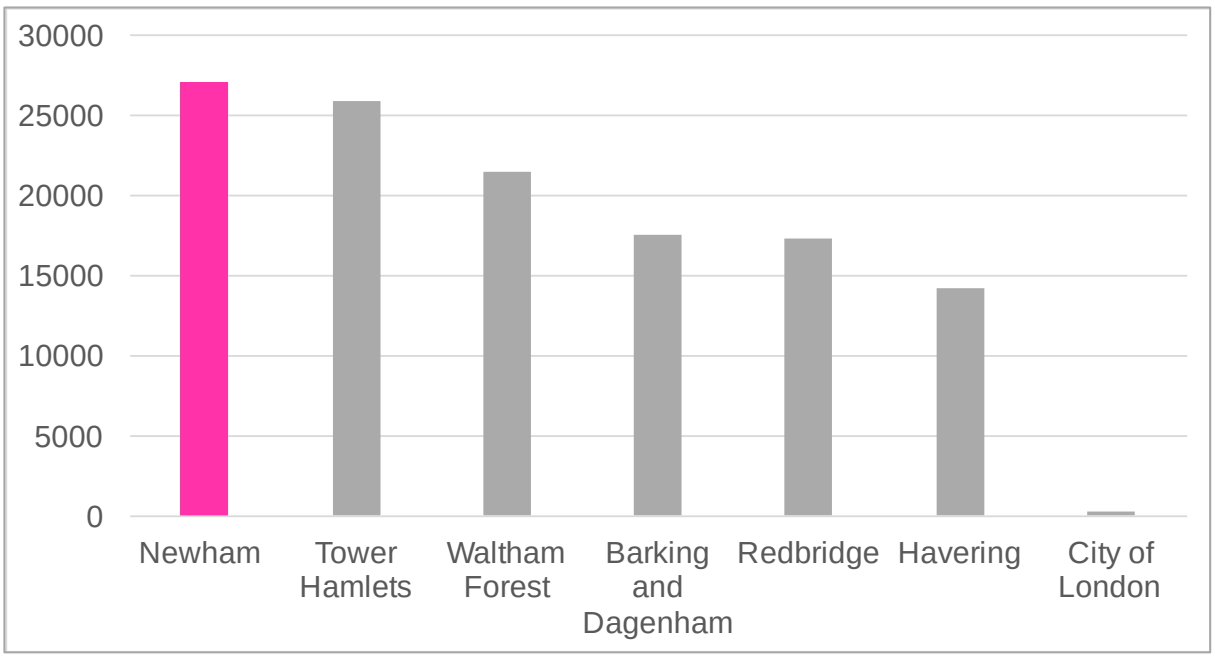
In 2013, Newham launched the first borough-wide landlord licensing scheme in England to tackle rogue landlords exploiting residents and exposing them to unsafe or dehumanising conditions. 60,000 Newham residents now fall under the protection of the scheme [9]. The Council has made nearly 1,000 prosecutions against criminal landlords, issued more than 120 rent repayment orders, and banned landlords relating to more than 230 properties.

In May 2016, the Mayor of Newham announced a New Deal for Housing aimed at more closely linking people's rents with their incomes. With this aim the Council has established an affordable housing vehicle to purchase properties and offer to residents for a fair rent which includes a guarantee of quality, security of tenure, and affordability.

Employment

Newham was among the boroughs with higher employment deprivation based on the IMD 2015. Based on the scale, namely, the number of people that are facing employment deprivation it was in the ranked 21 in the country and the worst in London. Figure 4 provides the scale of employment deprivation in North East London Boroughs.

Figure 4: Employment deprivation (IMD 2015) in North East London



Data source: IMD 2015 Local authority summaries

Local case study

What policies are in place locally to tackle employment and income deprivation?

Employment is central to the Council's vision for resilience. It allows people to escape poverty, exercise choice, develop skills and achieve their potential. In 2007 Newham established Workplace its flagship employment service. Workplace brings together local services around the individual to address the barriers preventing people from moving into work and offers a tailored and individualised package of support to residents. Newham starts by understanding the needs of employers and then offers residents support and training focused on those real jobs. This Workplace model of delivery has seen more than 30,000 jobs filled by Newham residents since it opened in 2007. Newham's employment rate has shown the greatest increase across the whole of London, rising 11.8 per cent between 2011 and 2015.

In line with a Newham Mayoral promise, MoneyWorks was launched in March 2016. It is part of the Council's wider efforts to build the economic resilience of local people by improving access to employment, decent pay, and good quality financial products. MoneyWorks offers a range of services and products to help prevent residents from falling into unmanageable debt, including:

- Access to fair, low-cost loans as an alternative to the pay-day lenders and loan sharks, working with the London Community Credit Union (LCCU).
- Money management services, including budgeting support and workshops to help residents make the most of their money whatever their circumstances.
- A range of exclusive deals for Newham residents to help people to make vital savings, working with local businesses

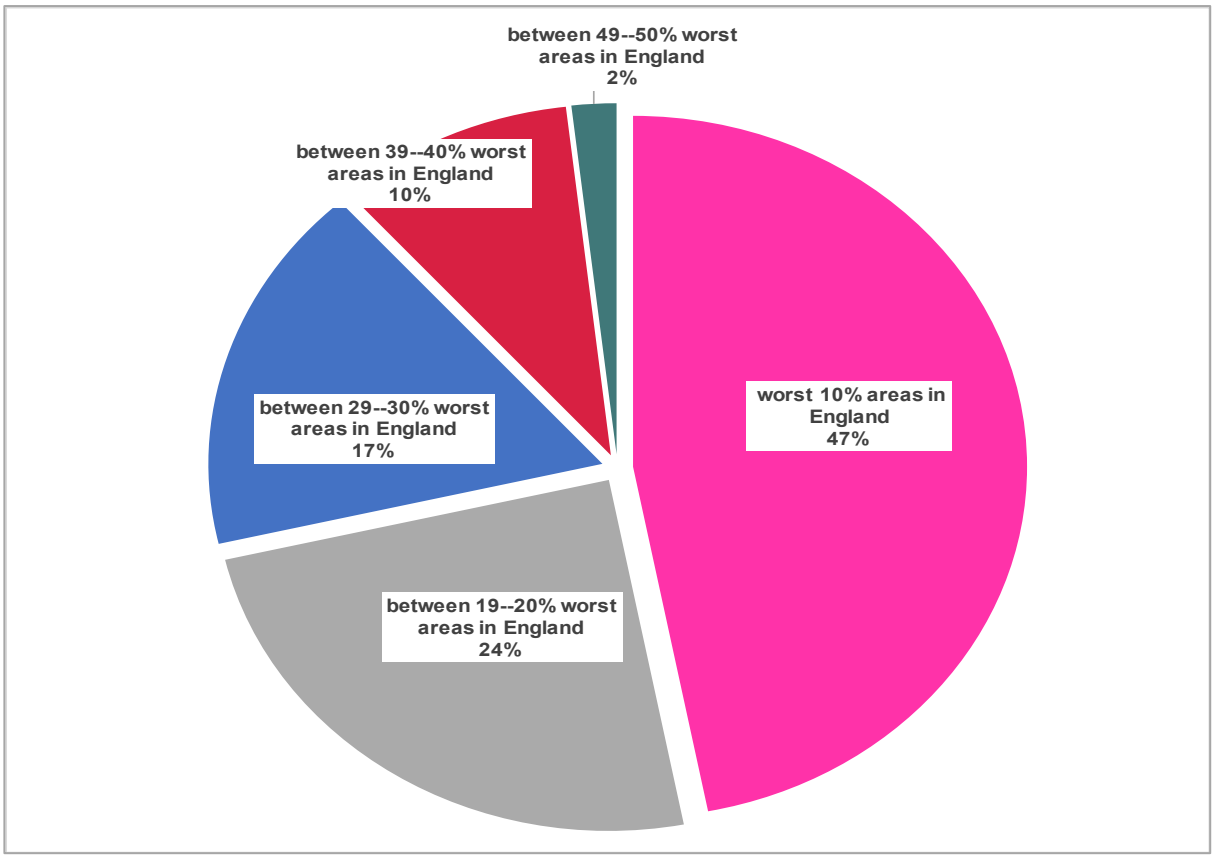
Building on a previous pilot, the Council has also established a Life Changing Fund as part of MoneyWorks, providing loans up to £1,000 at 0 per cent interest for things that could make a significant and permanent difference to a recipient's life. This might include training to improve job prospects, tools and equipment for work, or paying for transport costs to get to work. The Council also provides Emergency Loans through MoneyWorks, replacing the crisis loans and community care grants that were previously administered by the Department for Work and Pensions. The MoneyWorks branch is located at the Stratford Centre, making it easily accessible for residents to drop in for advice and guidance.

Crime

Figure 5 shows the distribution of Newham small areas (LSOA) within deciles of crime deprivation. Newham was ranked as second worst borough for crime in the country after Lambeth based on proportion of the small areas (LSOA) that fell in the 10% most deprived areas for crime.

The neighbouring boroughs of Tower Hamlets and Barking and Dagenham in North East London were ranked 5th and 6th worst boroughs for crime deprivation in the country. The City of London had the least crime deprivation within NE London with a ranking of 220 in the country.

Figure 5: Proportion of Newham small area (LSOA) falling in each decile of deprivation.



Data Source: IMD 2015

What policies are in place to tackle crime deprivation?

Crime and enforcement

Newham Council has a strong track record on enforcement. Multiagency operations have seen the Council prosecute more rogue landlords than the rest of London put together. Working with local police, immigration enforcement teams, and across Council departments from housing to planning, Newham's enforcement model is creating significant change and identifying areas previously invisible to agencies. Where there are violations of licensing conditions there are likely to be other forms of criminal activity or anti-social behaviour and vice versa. This strategic approach allows the Council to drive out poor practice.

We have a clear offer and expectation for local businesses. This is backed by tough enforcement for those who exploit vulnerable residents, undercut those who abide by the law, and make it harder for legitimate businesses to operate and thrive. From health and safety to illegal immigration; seizing illegal goods to handing out fixed penalty notices and ensuring arrests are made in the most serious cases; the council is using its frontline presence and local intelligence to target practices which are driving down standards in the borough and damaging our local economy.

The Council has also called for powers to intervene in minimum wage enforcement because independent research (Newham Household Panel Survey) shows that nearly one in five

working residents in Newham is paid less than the National Living Wage. Council enforcement officers are in the best position to know which local businesses are likely to be paying their employees too little, based on shared information within the organisation regarding non-compliance in a range of other areas. That is why the Council believes it should have full enforcement powers to investigate non-compliance with the National Living Wage. The Council feels it is important that it has the levers to cut off those who are serving the black economy through exploitation whether it be through underpayment, poor housing conditions and beyond.

PUBLIC HEALTH OUTCOMES FRAMEWORK: WIDER DETERMINANTS OF HEALTH

Table 3 shows how Newham is performing in the wider determinants of health as measured by indicators in the Public Health Outcomes Framework (PHOF). Newham is performing poorly on employment (persons and women), admissions to hospital due to violent crime, noise, homelessness, utilisation of outdoor space and parks for exercise and fuel poverty.

The trends show that offences for violent crime and sexual offences are both increasing. Homelessness is showing an increasing trend. The trend in employment is increasing although compared with the rest of the country women employment rate is lower. Road traffic casualties are lower in Newham compared with the rest of the country.

Table 3: Newham performance on PHOF wider determinants of health outcomes

Indicator	Period	Newham Value	Newham Recent Trend	Comparison with England		
						better/higher
						similar
						worse
People aged 16-64 in employment (%)						not compared
Men	2015/16	77.6	↑	●	-	data unavailab
Women	2015/16	57.3	↑	●	*	data suppresse
Working days lost due to sickness absence (%)	2012 - 14	0.6	-	●		
Killed and seriously injured (KSI) casualties on England's roads (per 100 000 population)	2013 - 15	19.8	-	●		
People using outdoor space for exercise/health reasons (%)	Mar 2014 - Feb 2015	10.1	-	●		
Noise complaints (per 1000 population)	2014/15	20.0	→	●		
Homelessness & Poverty						
Eligible homeless people not in priority need (per 1000 households)	2015/16	2.5	↑	●		
Households in temporary accommodation (per 1000 households)	2015/16	35.0	↑	●		
People experiencing fuel poverty (%)	2014	13.6	-	●		
Social Isolation						
Adult social care users who have as much social contact as they would like (%)	2015/16	42.2	-	●		
Adult carers who have as much social contact as they would like (%)	2014/15	38.0	-	●		
Crime			-			
Reported domestic abuse incidents (per 1000 population)	2014/15	21.6	-	○		
Hospital admissions for violence (ASR, per 100 000 population)	2012/13 - 14/15	67.8	-			
Violence offences per 1,000 population	2015/16	25.7	↑	○		
Sexual offences per 1,000 population	2015/16	2.2	↑	○		
Offenders who re-offend (%)	2014	25.8	→	○		
First time offenders (per 100 000 population)	2015	458.2	-	○		

KEY MESSAGE

The population of Newham face multiple challenges, the most severe are related to low income, and housing affordability.

The consequences of the combination of low income and higher rents are overcrowding and poor housing conditions.

The median income in Newham is comparable with North West England and East Midlands. But the cost of housing and other services in London are higher in London. For example, the local authorities in East Midlands and North West England with worst housing affordability are Boston and Manchester. In these local authorities, the monthly median rent in private sector as proportion of monthly median salary is 39%. In Newham, it is 66%. Whilst in Boston and Manchester, on average people living in private rented housing can expect to have about 60% of their monthly salary to spend on other living costs, in Newham on average people in private rented accommodation can expect to have about 44% of their monthly salary to spend on other living costs.

Poverty in the older population in Newham needs to be considered alongside income for working age population. Newham ranked 3rd worst in the country after Hackney and Tower Hamlets.

The other major challenge that the population faces is that of crime. About 77% of the small areas (LSOA) in Newham fall within the 20% most deprived areas in the country for crime. This has an impact on both the mental health and use of parks and open space for exercise. Both mental health and low levels of physical activity are an issue for Newham as described in later chapters.

What should we focus on to improve population health?

As described by the case studies, Newham Council is tackling these issues through local policies such as borough wide licensing for private landlords and Newham Workplace.

However, if the population of Newham is to see a rise in living conditions, that in turn can have a positive impact in health outcomes, then regional and national government policies on housing, employment and wages in London must pay attention to the challenges in boroughs such as Newham.

DATA SOURCES

1. The data utilised in the analyses in this chapter are from the following sources.
2. ONS Index of Multiple Deprivation 2015, Oct 2015
    a. File 2 Domains of deprivation
    b. File 4 Sub domains of deprivation
    c. File 8 underlying indicators of deprivation
    d. File 10 Local Authority summaries
    e. File 13 Clinical commissioning group summaries
3. ONS 2016, NOMIS official labour statistics, Local Authority Profiles
4. ONS 2016, Housing Summary Measures 2015
5. GLA Modelled Household Income Estimates for smaller areas, July 2015
6. Department for Energy and Climate Change, 2016 Fuel Poverty Sub-regional tables 2014, updated June 2016
7. PHE 2016, PHOF indicators for wider determinants of health

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3. Janke K, Propper C and Shields MA, Assaults, murders and walkers: The impact of violent crime on physical activity Journal of Health Economics , vol 47 May 2016, 34-49
4. Foster S, Knuiman M, Hooper P et al Do changes in residents' fear of crime impact their walking? Longitudinal results from RESIDE Prev Med. 2014 May; 62:161-6. doi: 10.1016/j.ypmed.2014.02.011. Epub 2014 Feb 16.
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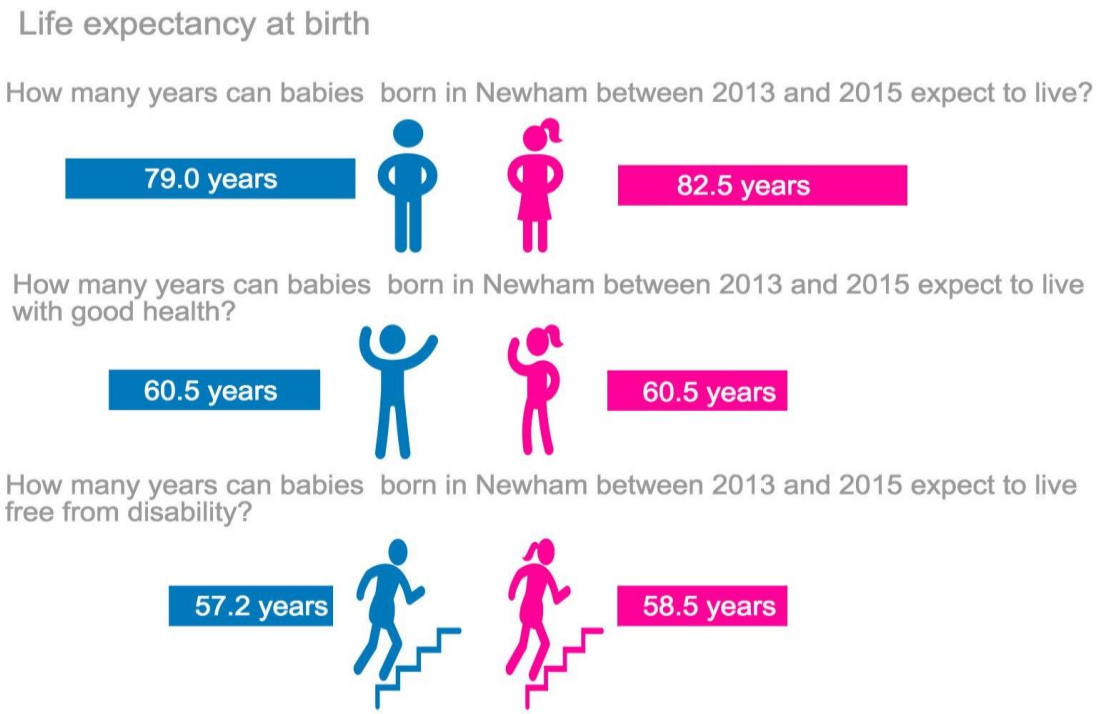
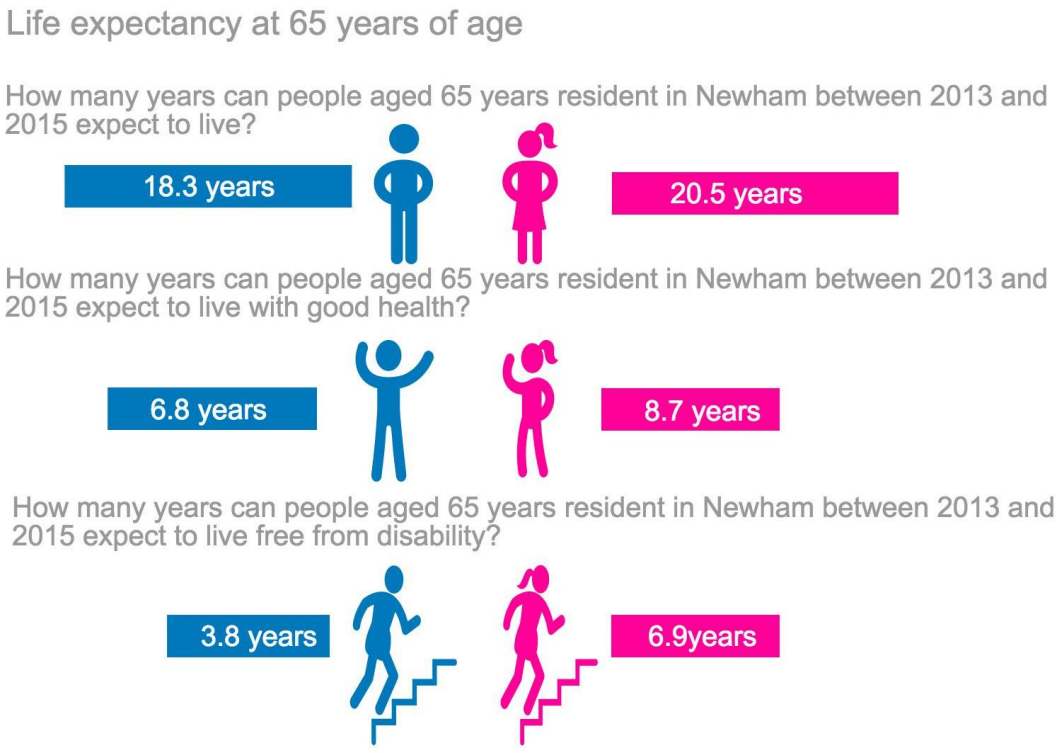
6. Department of Communities and Local Government. The English Indices of Deprivation 2015 Statistical Release, 30 Sept 2015
7. LACORS - Regulation of 'crowding and space' in residential premises (2009) London London. ISBN 978-1-84049-679-6
8. Uys P, Brand H, Warren R, van der Spuy G, Hoal EG, van Helden PD (2015) The Risk of Tuberculosis Reinfection Soon after Cure of a First Disease Episode Is Extremely High in a Hyperendemic Community. PLoS ONE 10(12): e0144487. doi:10.1371/journal.pone.0144487
9. London Borough of Newham – Private Rented Property Licensing Guide for Landlords and Managing Agents. (June 2012) [online.] Available from: https://www.newham.gov.uk/Documents/Housing/PropertyLicensingGuideLandlordsAndManagingAgents.pdf [Accessed 21st December 2016.]

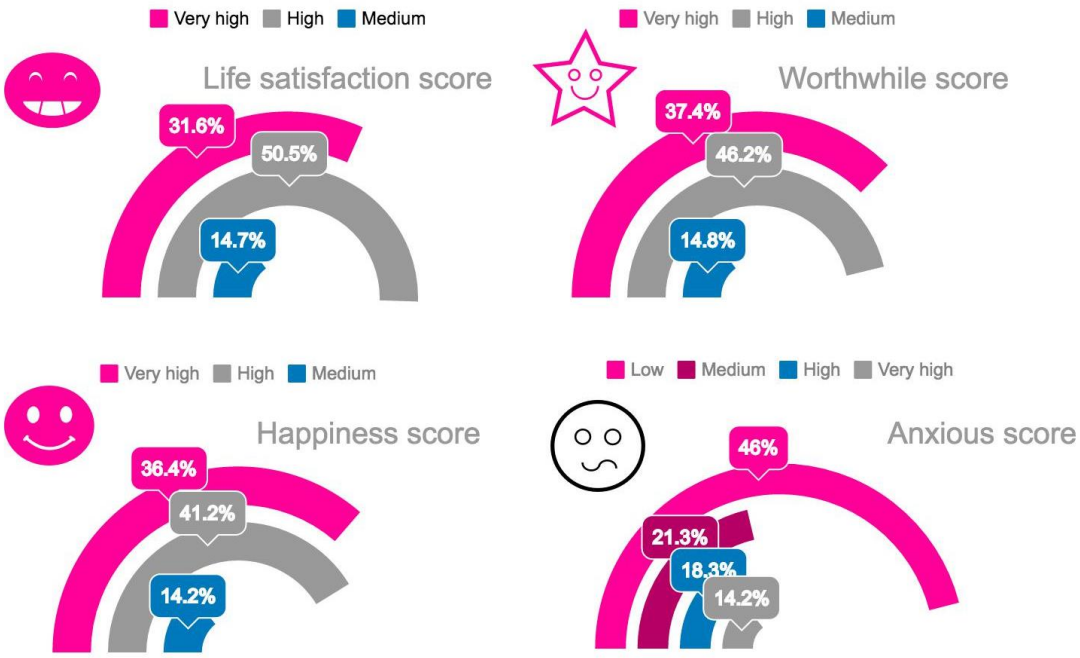
7.O HIGH LEVEL HEALTH AND WELLBEING OUTCOMES

KEY STATISTICS FOR NEWHAM

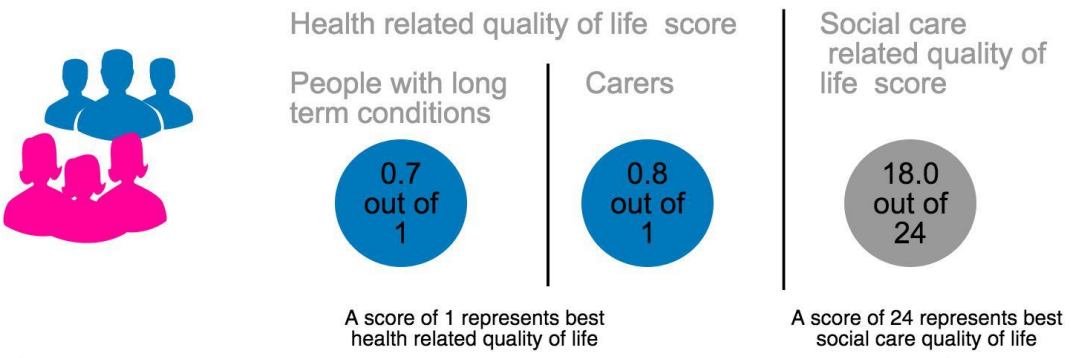


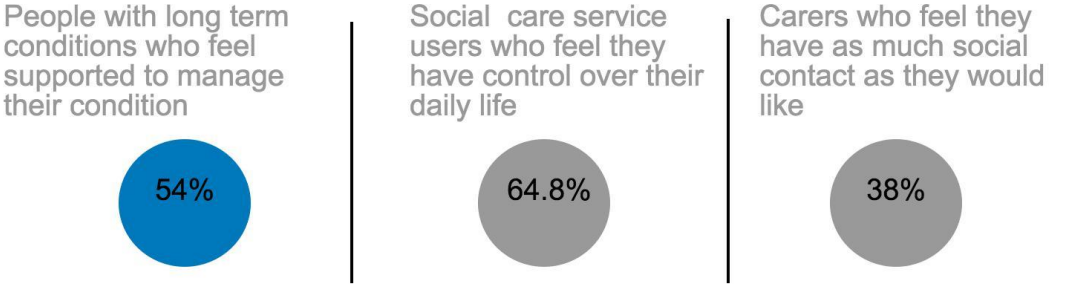


How adults in Newham scored their wellbeing in 2015/2016?



Quality of life of users of health and care services and thier carers





BACKGROUND

The factors described in the Dahlgren and Whitehead model act together to determine on average how long we live, how much of the life is lived free from disabilities and in good health.

Life expectancy is a high-level objective population measure of how long people can expect to live on average. Subjective measures such as self-reported health status and limiting long terms conditions adjusted life expectancy are population measures of how much of the life will be lived in good health and free from disability[1].

In the UK, personal well-being, a subjective measure of how people rate their wellbeing is reported as part of the official national well-being statistics. General perception of health and health status is found to be strongly associated with personal well-being[2]. People with long terms conditions rate their well-being lower than those without a limiting long term condition. Health status can have a negative impact on quality of life. Health related quality of life (HRQoL) measures the impact of an illness and its treatment on the quality of life. It is collected through the national health service data set for each clinical commissioning group (CCG). A similar measure for social care, social care related quality of life (SCRQoL) is collected through the adult social care data set. These measures allow assessment of quality of life of health and social care service users and their carers.

These high- level population health and well-being measures are included in the national outcomes framework for public health, NHS and social care. Performance on these measures provide an assessment of population health status relative to national, regional and other comparators. It provides insights on where partners need to focus their efforts to improve population health.

Table 1: High level population health and wellbeing outcomes performance indicators

Public Health Outcomes Framework (PHOF)	NHS outcomes Framework (NHSOF)	Adult Social Care Outcomes Framework (ASCOF)
Life Expectancy (LE) at birth and age 65 years Healthy Life Expectancy (HLE) at birth and age 65 years	Life expectancy at 75 years	
Personal well-being: Self-reported wellbeing- low score on life satisfaction Self-reported wellbeing- low score on how worthwhile life is Self-reported wellbeing- low score on happiness Self-reported wellbeing- high score on anxiety Proportion of people who use services and carers who reported that they had as much social contact as they would like	Health related quality of life for people with long term conditions (HR QoL) and their carers Health-related quality of life for carers) Proportion of people with long term conditions who feel they are supported to manage their condition.	Social Care related quality of life quality of life score (SCR QoL) of users and carers Proportion of people who use services who have control over their daily life Carer-reported quality of life score Proportion of people who use services and carers who reported that they had as much social contact as they would like

LIFE EXPECTANCY

Life expectancy at birth

Male babies born in Newham between 2013 and 2015 can on average expect to live to 79 years which is comparable with 79.2 years for England but 1.2 years less than London.

Female babies born in Newham between 2013 and 2015 can on average expect to live to 82.5 years which is 0.6 years less than England and 1.6 years less than London.

Female babies born in Newham appear to be more disadvantaged as described by life expectancy at birth compared with male babies born in Newham and female babies on average in England and London.

Figure 1a and 1b compare the trends in life expectancy of Newham with England and London from 2002-2004 to 2012-2014.

MALE LIFE EXPECTANCY

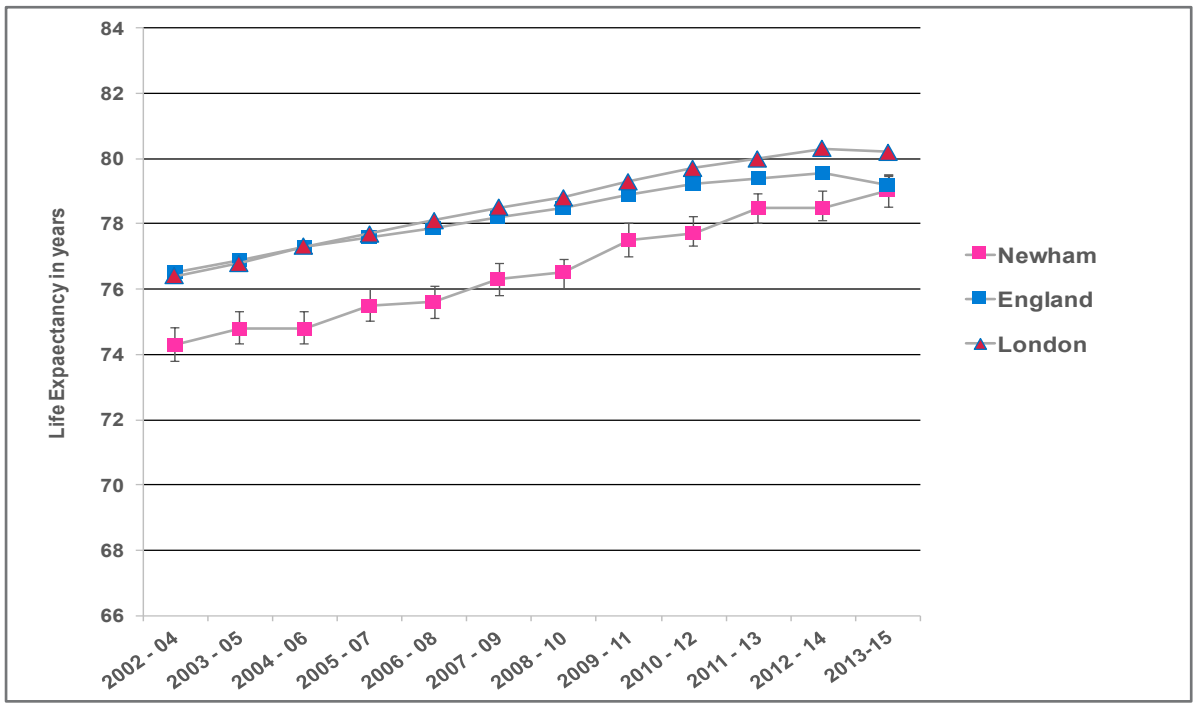
- Men in Newham have had significantly lower life expectancy compared with England or London throughout the last decade.
- However, the rate of improvement in Newham has been relatively greater than England or London which has reduced the absolute gap.
- The figures for the latest years show that London and England have moved in a downward direction which is not the case for Newham.
- It is not possible from one time point to conclude if London and England are moving in the wrong direction. Newham trend remains in the right direction.
- Men have shorter life expectancy compared with women

FEMALE LIFE EXPECTANCY

- Women in Newham have had significantly lower life expectancy compared with England and London before 2010.
- From 2010 to 2014 there were no significant gaps between Newham and England
- The gap between Newham and London had reduced but female life expectancy in Newham has remained significantly lower than London throughout the last decade.

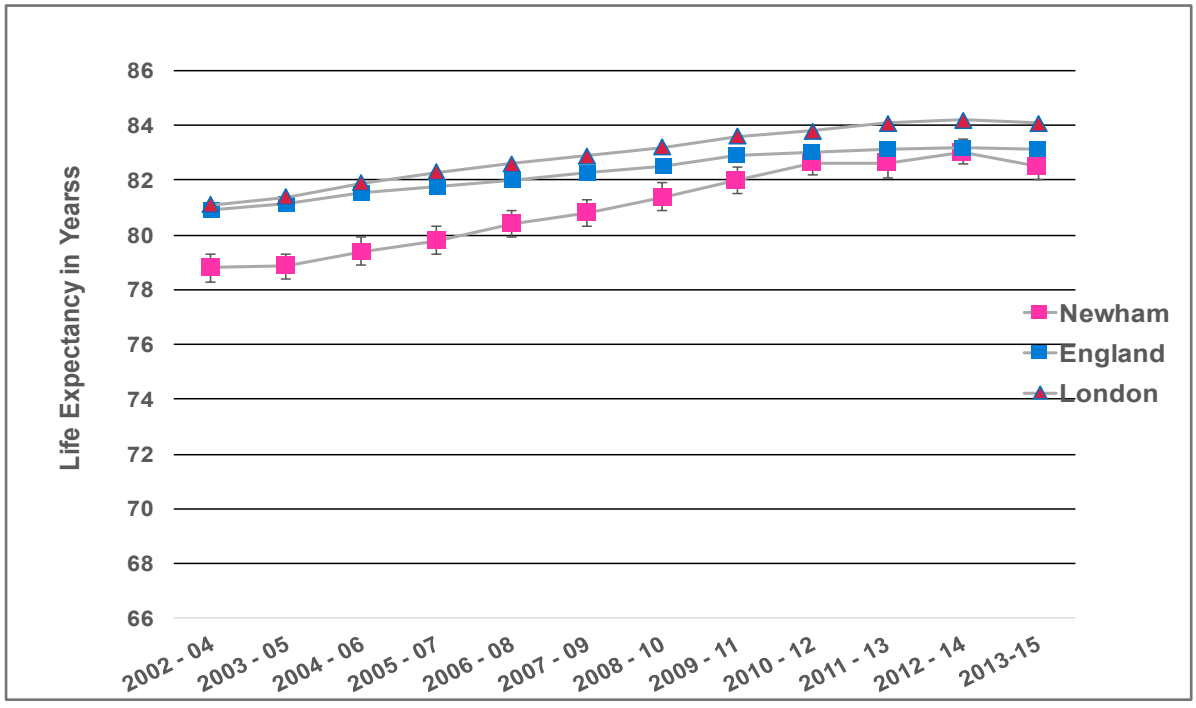
  The latest figures for 2013-2015 indicate the gap between Newham and England and London is significant. Life expectancy was lower for this period compared with previous years. The trend for women needs to be monitored to see if the trend is moving in the downward direction in Newham. The trends in London and England seem to have plateaued.

Figure 1a: Trends in male life expectancy at birth Newham, London and England



Data Source: PHE PHOF data

Figure 1b: Trends in female life expectancy at birth in Newham, London and England



Data Source: PHE PHOF data

Life expectancy at age 65 years

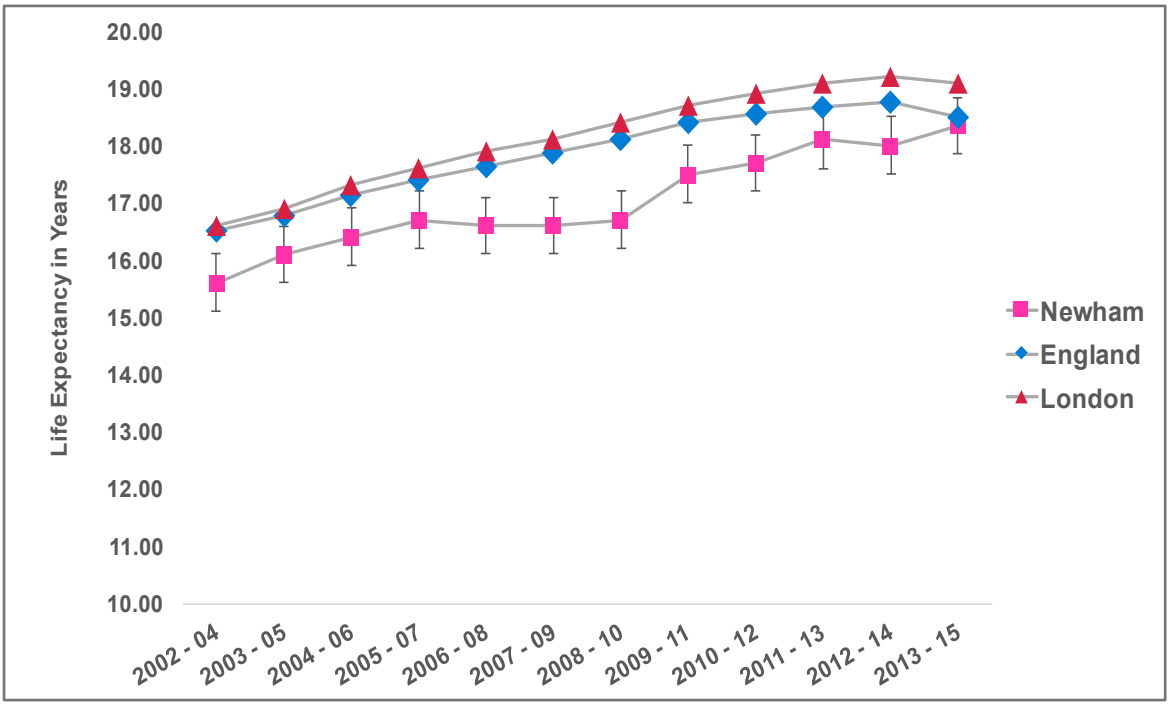
Men who were resident in Newham and were aged 65 years between 2013 and 2015 could on average expect to live for another 18.3 years which is comparable to the rest of England. It was 0.8 years less than London.

Women who were resident in Newham and were aged 65 years between 2013 and 2015 could on average expect to live for another 20.5 years which is 0.6 years less than the rest of England and 1.2 years less than London.

Women aged 65 years resident in Newham appear to be more disadvantaged relative to their counterparts in London and England compared with men of the same age resident in Newham.

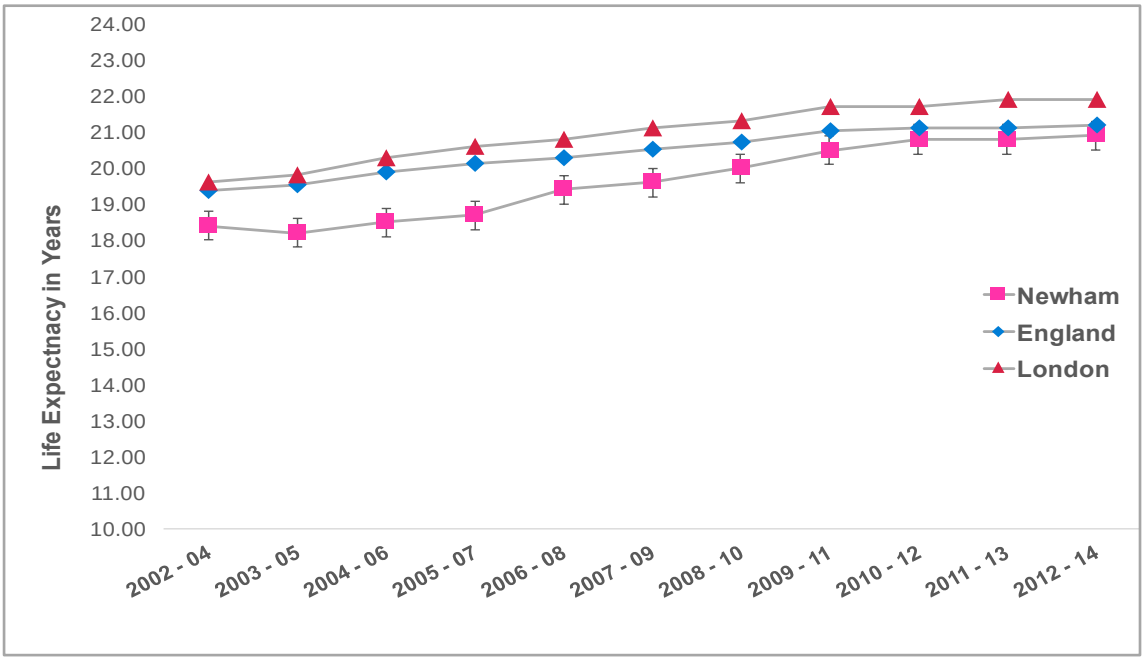
Figure 2a and 2b compare the trend for male and female life expectancy at age 65 years in Newham with England and London, respectively. The gap between Newham and London has remained above one year for both men and women, although the latest figure shows that for men the gap has reduced to below one.

Figure 2a: Trend in male life expectancy at age 65 years in Newham, England and London



Data Source: PHE PHOF data

Figure 2b: Trend in female life expectancy at age 65 years in Newham, England and London

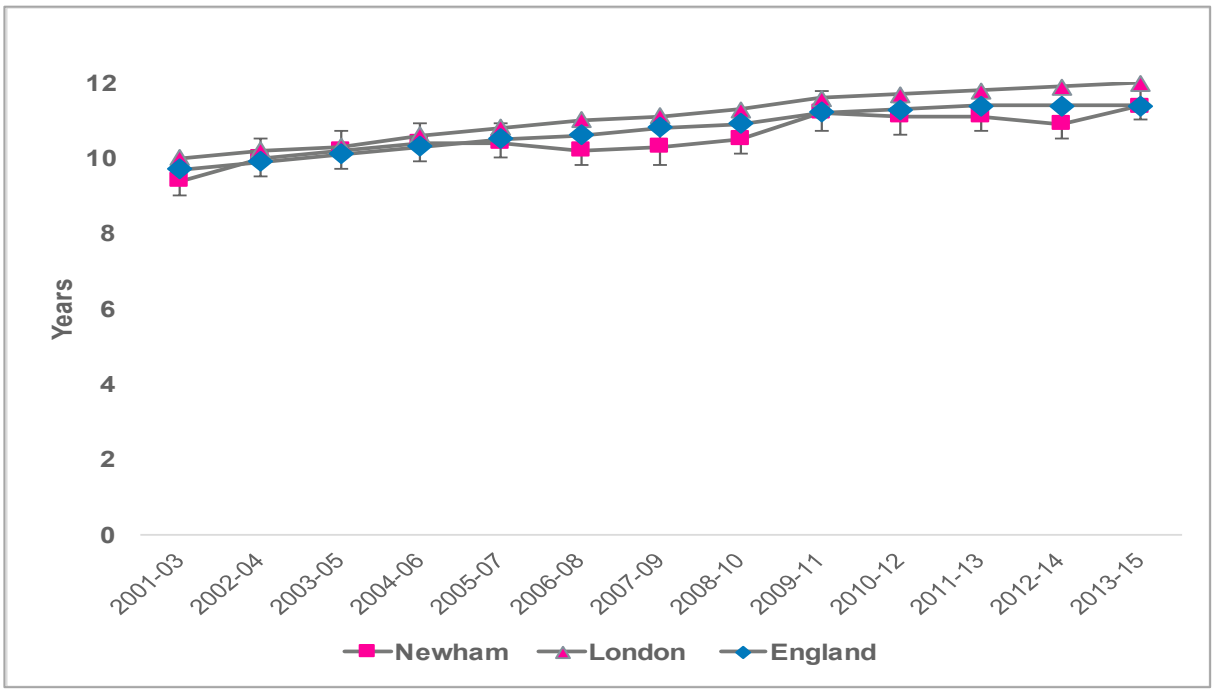


Data Source: PHE PHOF data

Life expectancy at age 75 years

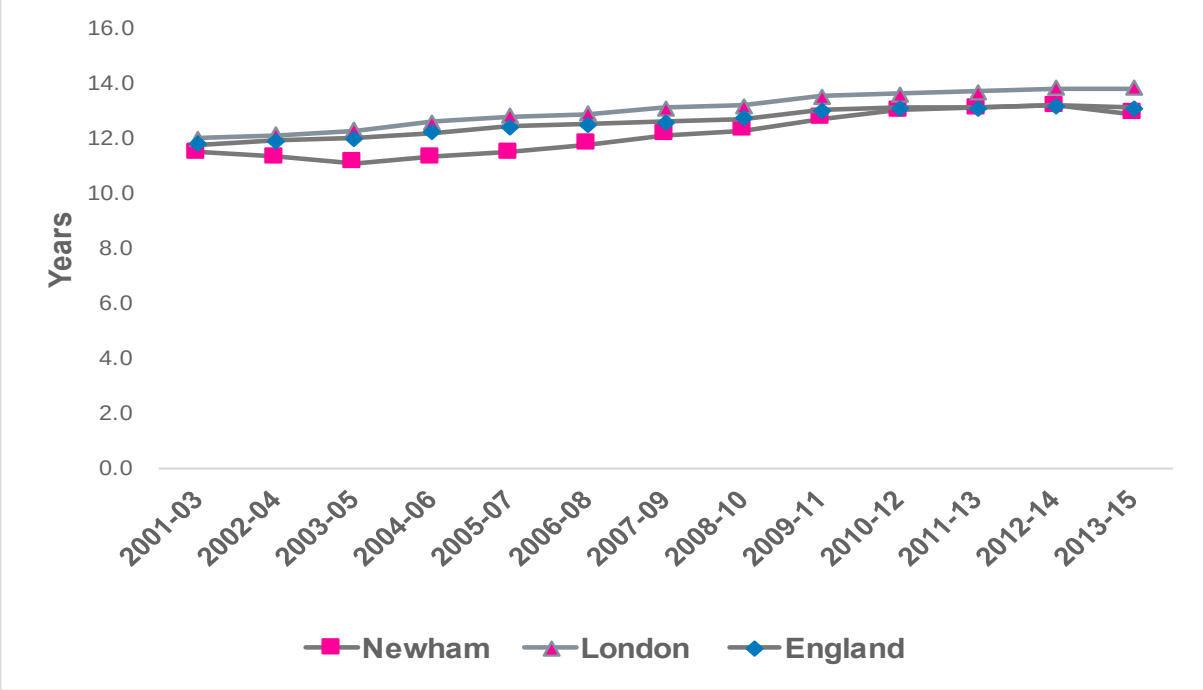
Figure 3a and 3b show trends in life expectancy at age 75 years. These trends are similar with those at birth and 65 years, with Newham improving at a faster rate than the national rate. This has resulted in narrowing of the gap between Newham and England.

Figure 3a: Trends in male life expectancy at age 75 years in Newham, England and London



Data Source: NHS digital indicator portal: NHSOF indicator 1b

Figure 3b: Trends in female life expectancy at age 75 years in Newham, England and London

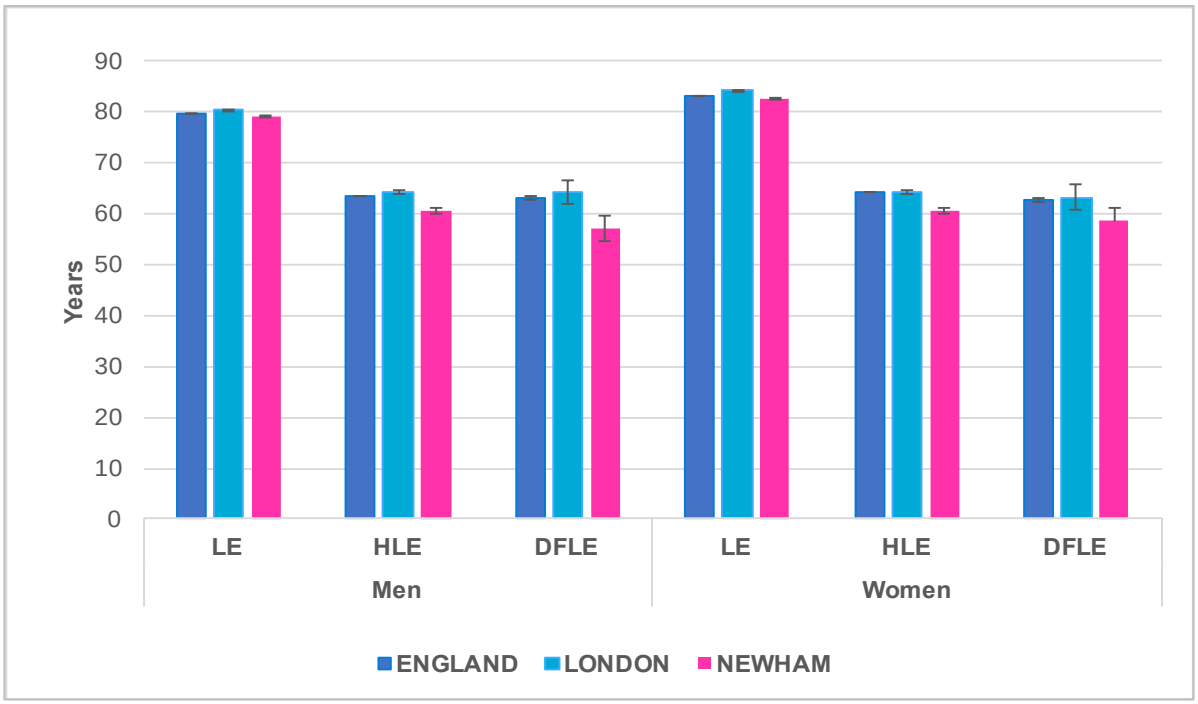


Data source: NHS digital indicator portal: NHSOF 1b

Health status life expectancy

Figure 4a shows life expectancy, health status life expectancy and disability free life expectancy for men and women in Newham compared with England and London. As described in the previous section the gap in life expectancy between Newham and England and London has narrowed. However, the gap in the age at which Newham residents can expect to live in a state of good health or free from disability is comparatively higher. Table 2 provides the gap between Newham and England and London for all three measures of life expectancies at birth and at age 65 years. The greatest gap is observed in disability free life years. Men in Newham are the most disadvantaged as described by life expectancy free from disabilities.

Figure 4a: Life expectancy, Health status life expectancy and disability free life expectancy for men and women (2013-2015)



Data source: ONS Health status life expectancy

Table 2: Gap in years between Newham and England and London for life expectancies

Gender →	Men			Women		
Measure →	LE	HLE	DFLE	LE	HLE	DFLE
At birth						
Newham England	-0.5	-2.9	-5.9	-0.6	-3.6	-4.2
Newham London	-1.2	-3.6	-7.0	-1.5	-3.6	-4.6
At age 65 years						
Newham England	-0.3	-3.6	-6.2	-0.2	-2.5	-3.3
Newham London	-0.8	-3.6	-6.2	-1.2	-2.5	-3.0

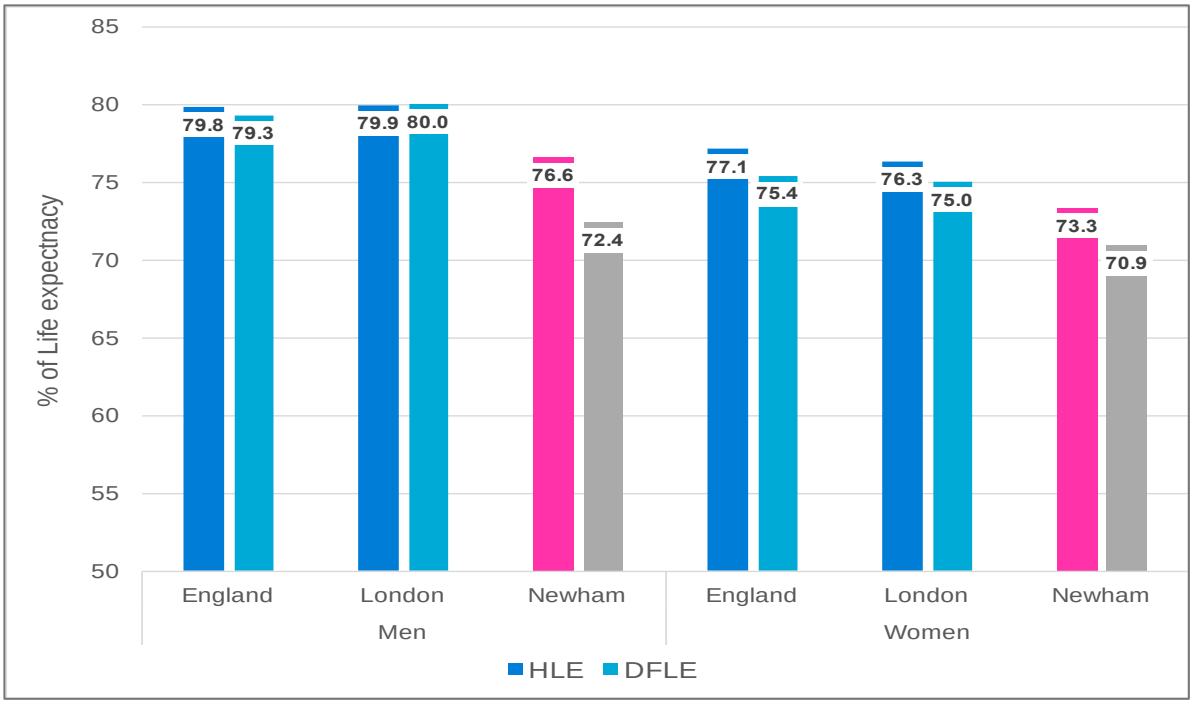
Data source: ONS Health status life expectancy

Figure 4b compares the expected proportion of life expectancy at birth and at age 65 years spent in a state of good health and free from disability on average between men and women for Newham, England and London.

For all areas, women spent a lower proportion of their life in a state of good health or free from disability compared with men. Women may live longer than men as described by life expectancy but they spend a lower proportion of years of life in a state of good health or free from disability.

Table 3 shows the gender gap in years on all measures of life expectancy for Newham compared with England and London.

Figure 4a: Proportion of life expectancy spent in good health and free from disability



Data source: ONS Health status life expectancy

Table 3: Gender gap in life expectancies for Newham, England and London

	England	London	Newham
At birth (men vs women)			
Life expectancy	-3.6	-3.8	-3.5
Health status life expectancy	-0.7	0.0	0.0
Disability free life expectancy	0.4	1.1	-1.3
At age 65 years (men vs women)			
Life expectancy	-2.4	-2.6	-2.2
Health status life expectancy	-0.7	-0.3	-1.9
Disability free life expectancy	-0.2	-0.1	-3.1

Data source: ONS Health status life expectancy

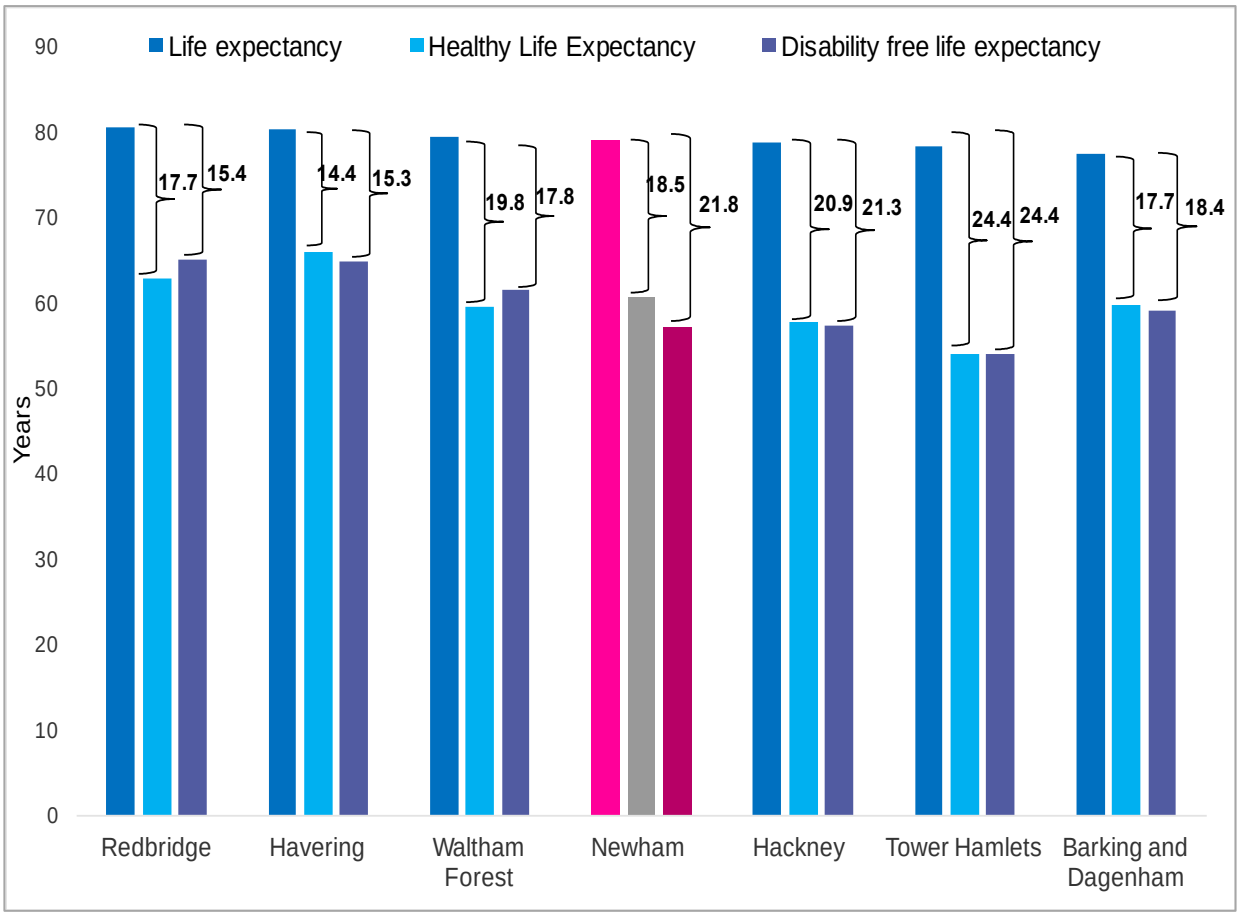
Men have shorter lives compared with women. The gap in life expectancy between men and women in Newham is comparable with England and London. The gender gap disappears for healthy life expectancy, suggesting any benefits that women have in life expectancy over men are not realised in good health status. For London and England men enjoy longer lives free from disability, which is not the case for Newham.

Figure 5a and 5b show the difference in male and female life expectancies within north east London. Women had a greater gap between life expectancy and good health adjusted life expectancy compared with men in all boroughs similar with the national trend.

Residents in Tower Hamlets had the greatest gap between life expectancy and good health status and disability free life expectancy. They had less than 70% of life expectancy in good health.

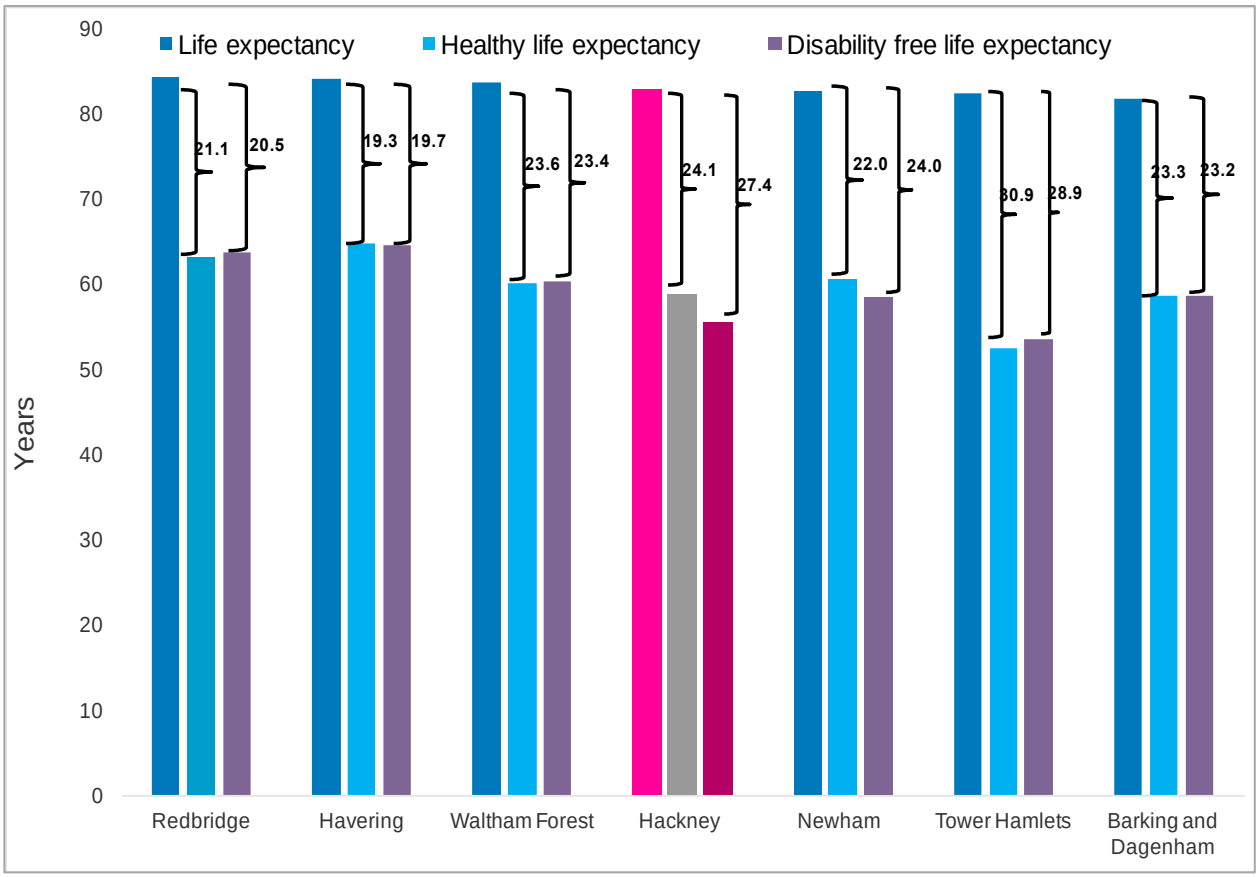
Men in Newham had more than 3 years of difference between disability free years and good health.

Figure 5a: Gaps in male life expectancy and health status and disability free life expectancy at birth in NE London boroughs



Data source: ONS Health status life expectancy

Figure 5b: Gaps in male life expectancy and health status and disability free life expectancy at birth in NE London boroughs



Data source: ONS Health status life expectancy

WELLBEING AND QUALITY OF LIFE

Self-reported personal well-being

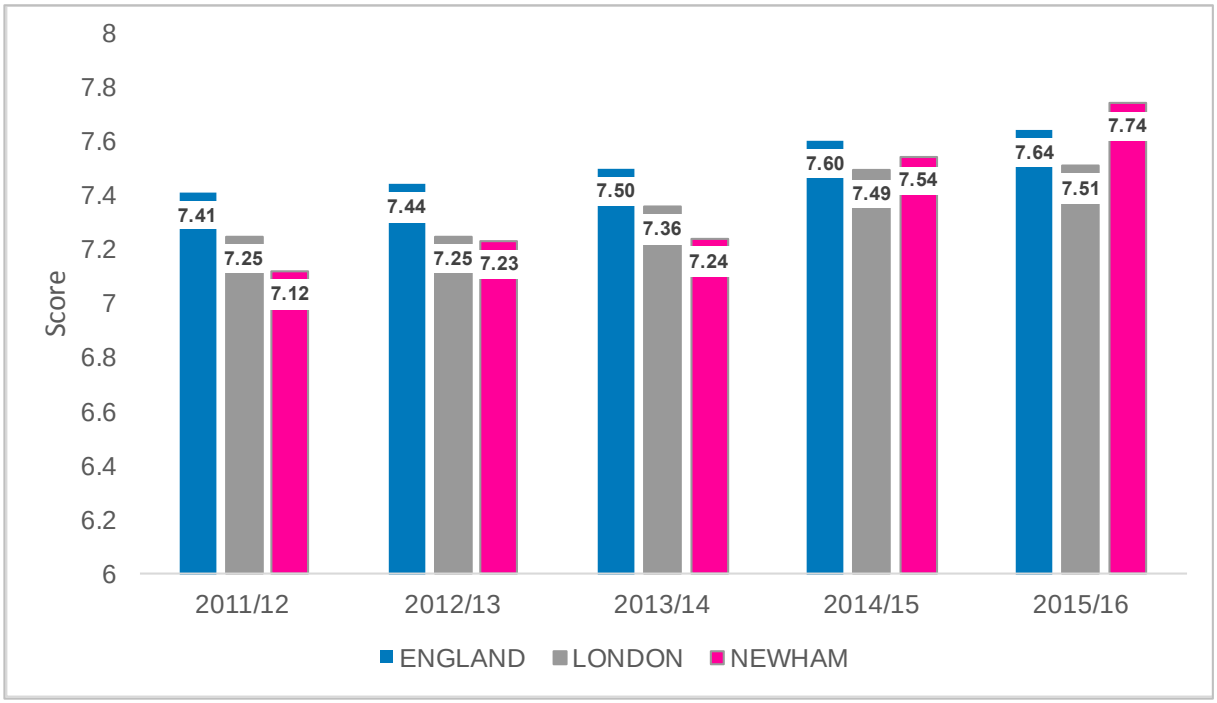
Figure 6a to 6d show the trend in well-being scores for Newham compared with England and London. The ratings are based on four questions [3]

1. overall, how satisfied are you with your life nowadays?
2. overall, to what extent do you feel the things you do in your life are worthwhile?
3. overall, how happy did you feel yesterday?
4. overall, how anxious did you feel yesterday?

People are asked to respond on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely".

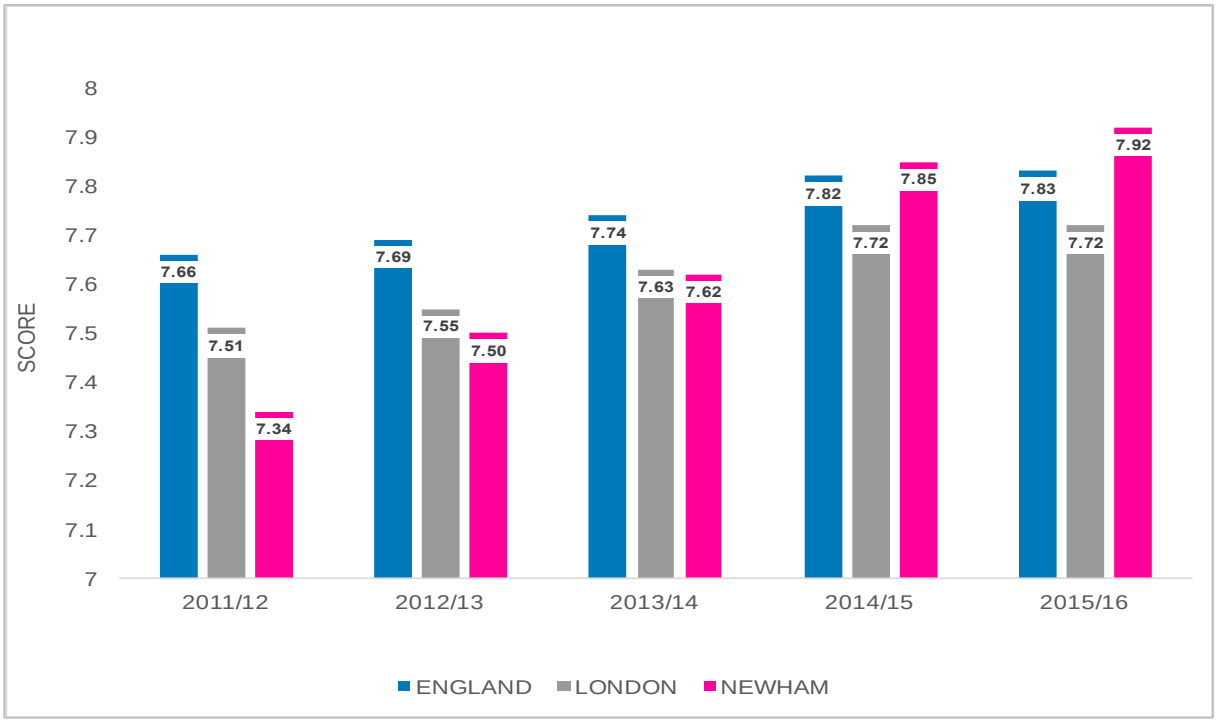
Newham has seen a greater improvement in scores on all four measures of personal wellbeing compared with England or London. Personal well-being is associated with health, relationships and employment. The greater improvement in median income and employment may be a contributing factor in Newham. Newham had the third highest personal well-being scores in London. It is worth noting that London has the lowest personal well-being scores among all the regions.

Figure 6a: Trends for well-being- life satisfaction mean rating for Newham, England and London



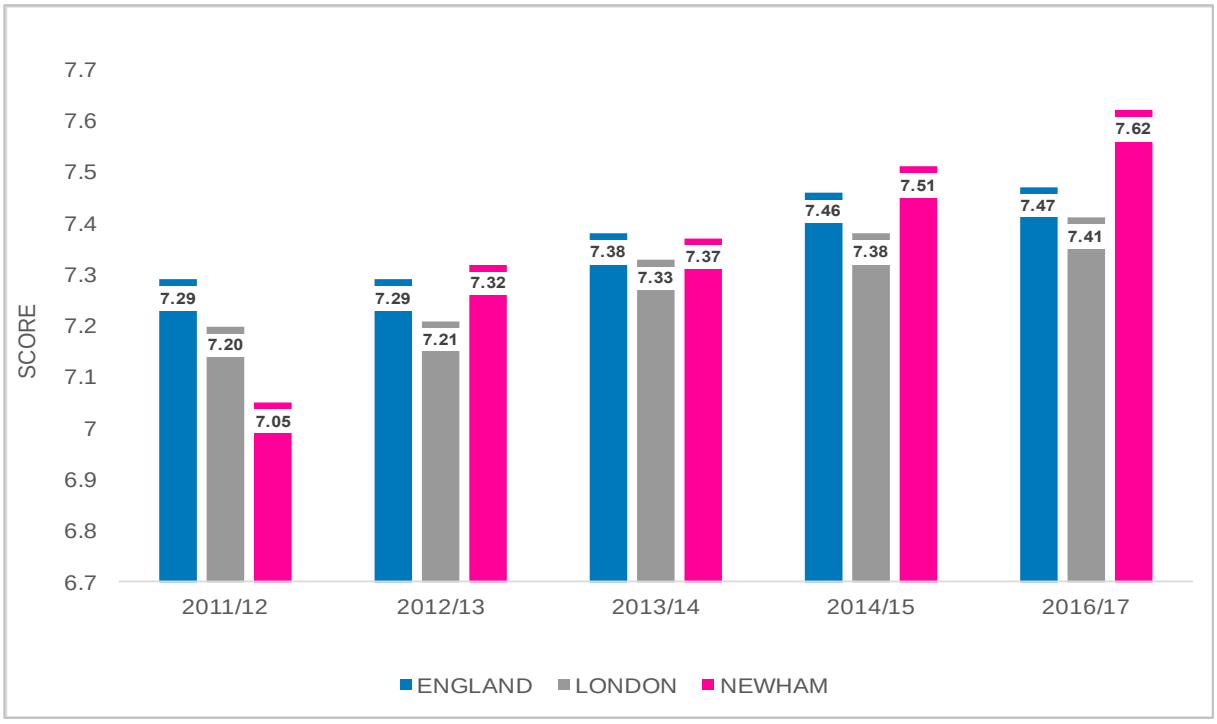
Data source: ONS personal wellbeing for local authorities April 2015 to March 2016

Figure 6b: Trends for wellbeing- worthwhile mean rating for Newham, England and London



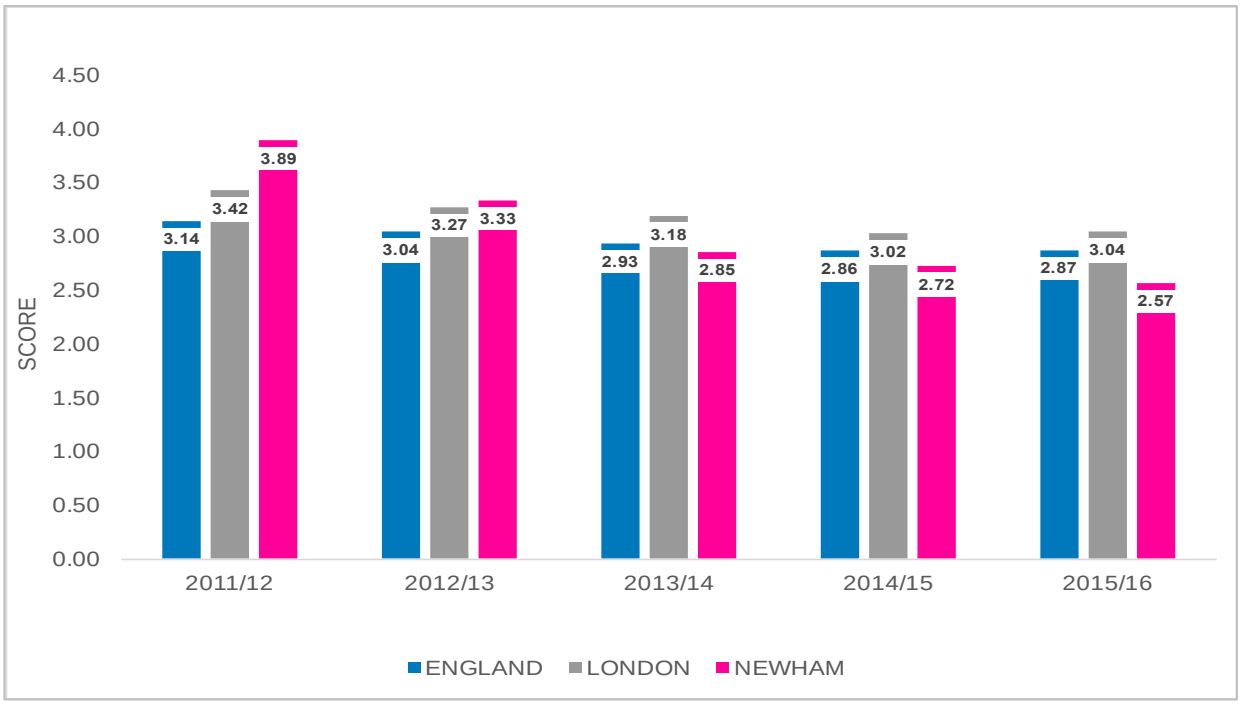
Data source: ONS personal wellbeing for local authorities April 2015 to March 2016

Figure 6c: Tends for wellbeing- happiness mean rating for Newham, England and London



Data source: ONS personal wellbeing for local authorities April 2015 to March 2016

Figure 6c: Tends for wellbeing- anxious mean rating for Newham, England and London



Data source: ONS personal wellbeing for local authorities April 2015 to March 2016

Quality of life of people with long term conditions and their carers

Quality of life is strongly associated with health. Health related quality of life provides a measure of the impact of the health condition on daily living.

Caring for a person with long term condition or aged can have an impact on health and quality of life of the carer.

HEALTH CARE QUALITY OF LIFE

This indicator measures how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible.

This indicator measures health-related quality of life for people who identify themselves as having one or more long-standing health conditions. Health-related quality of life refers to the extent to which people [4]:

- have problems walking about;
- have problems performing self-care activities (washing or dressing themselves);
- have problems performing their usual activities (work, study etc.);
- have pain or discomfort;
- feel anxious or depressed.

Each of the above statement is scored at three levels

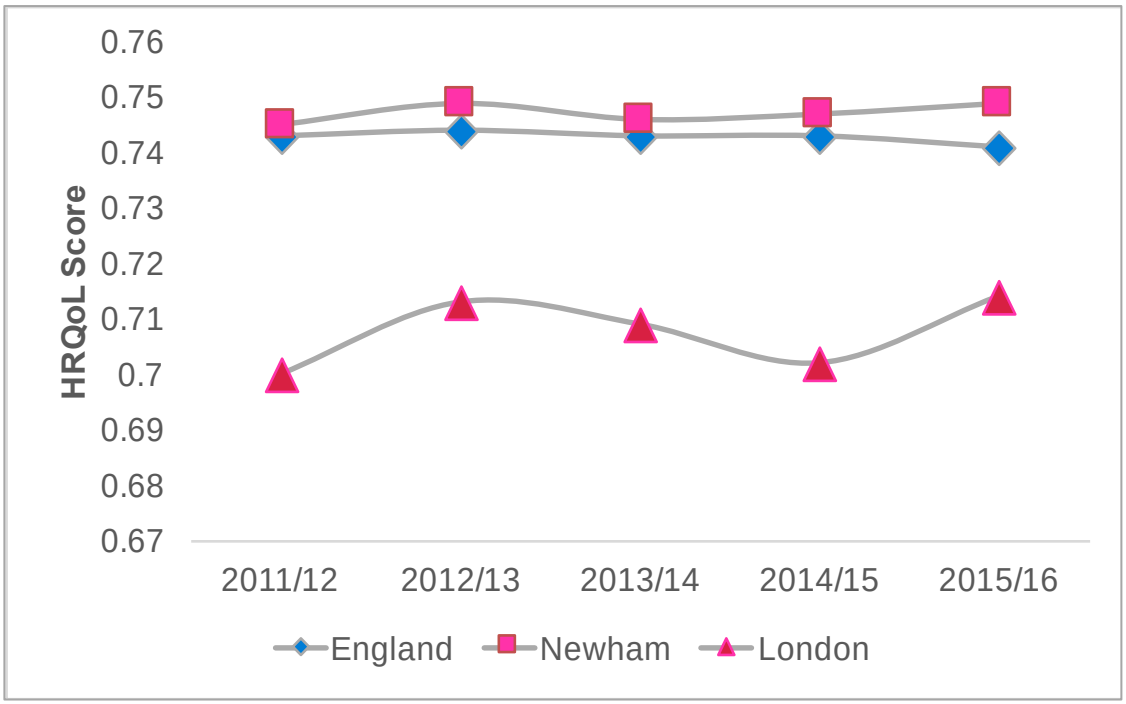
1. No problem
2. Some problems
3. Extreme problem

People are also asked how their health status is on the day from 100 being best to 0 worst. Based on these a single value of index is calculated to describe the health status with 1 assigned to the best possible health. It can be used to assess quality of life of different patient groups or for assessing an intervention.

Figure 7a compares the trend for HRQoL for Newham with England and London. Similar with the personal well-being scores, people with long term condition (LTC) rate the quality of life better compared with regional or national scores. The mean London scores are lower compared with the national scores.

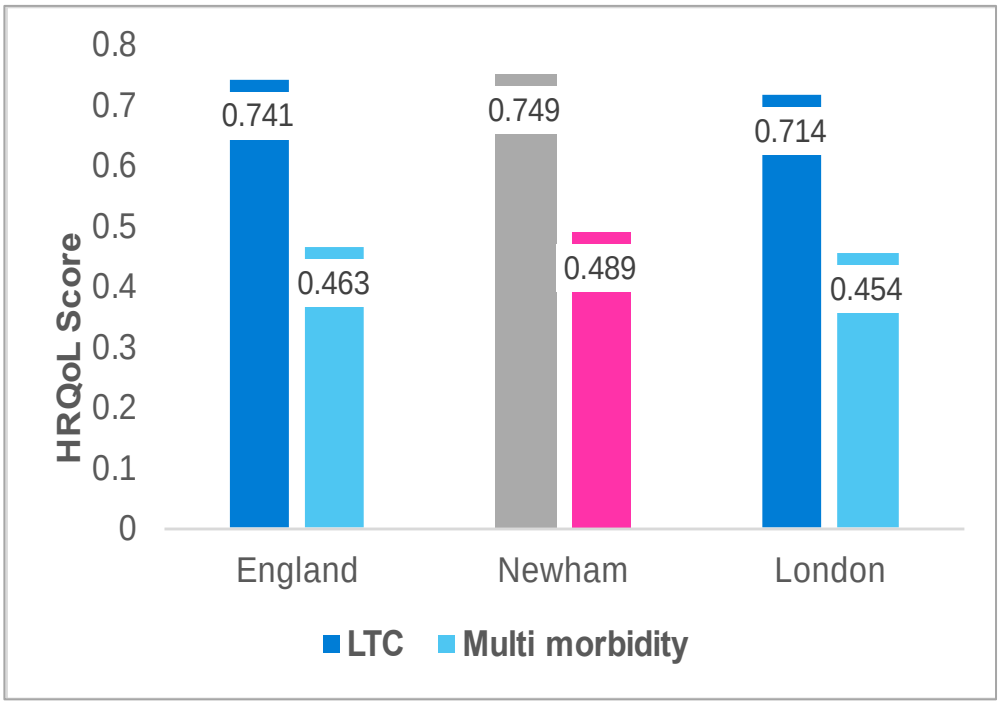
Figure 7b compares the HRQoL of population with multi (more than 3 or more) LTC with the mean of the cohort with LTC. For all areas people with multi-morbidity rate their quality of life lower than the mean for LTC.

Figure 7a: Trends in HRQoL score for people with LTC in Newham compared with England and London



Data source: NHS portal indicator: NHSOF indicator 2

Figure 7b: HRQoL scores for population with multi-morbidity with the mean scores for population with LTC

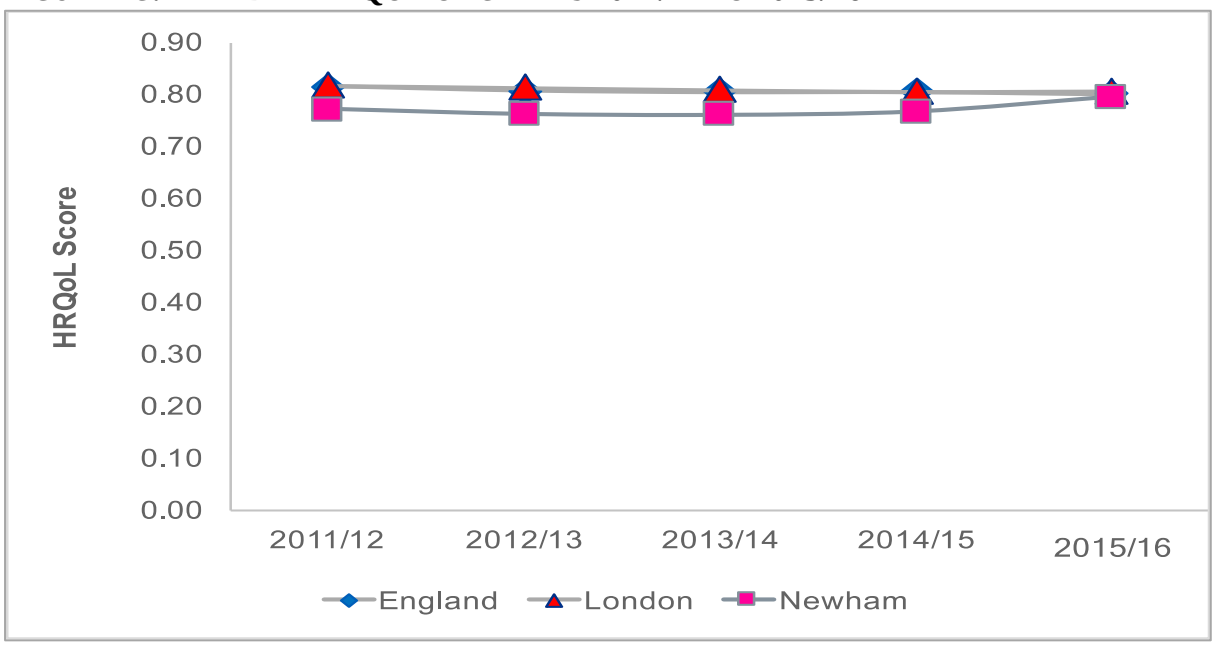


Data source: NHS portal indicator: NHSOF indicator 2

HEALTH RELATED QUALITY OF LIFE OF CARERS

This measure describes how people who care for people with LTC or mental health illness are supported to have a good quality of life. Unlike other wellbeing and quality of life measures, the carers in Newham had lower scores compared with regional or nation values ,although it has now become comparable.

FIGURE 7C: TREND IN HRQOL OF CARERS 2011/12 TO 2015/16

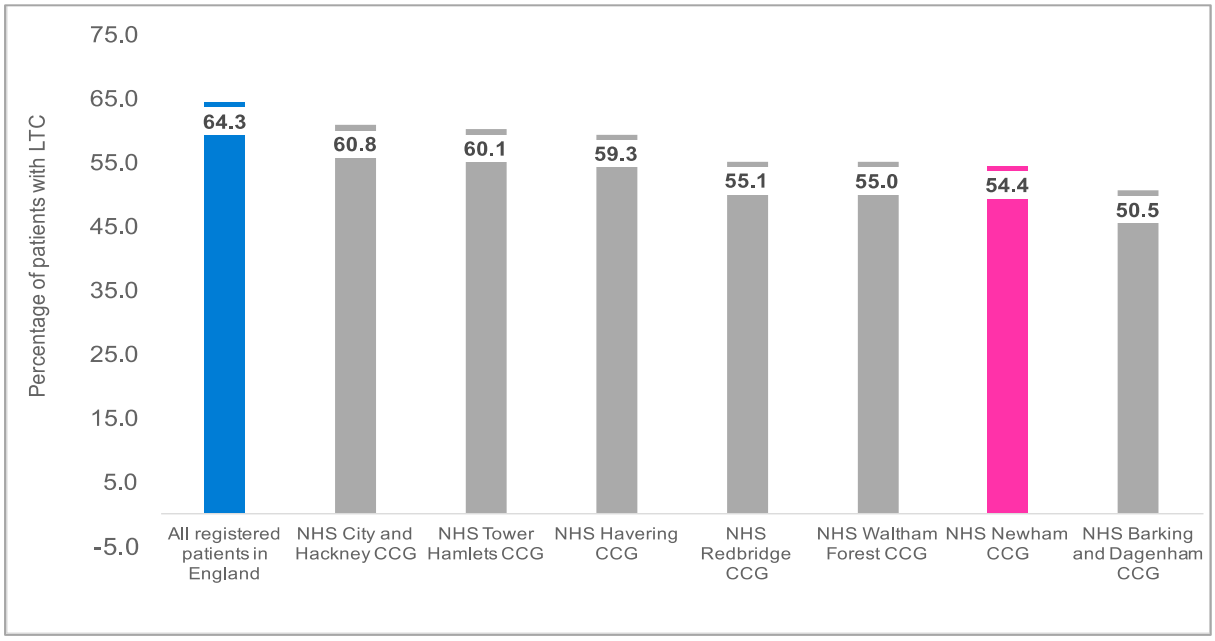


Data source: NHS portal indicator: NHSOF indicator 2

SUPPORTED TO MANAGE THEIR LONG-TERM CONDITION

About 54% of the population with LTC in Newham felt that they were supported to manage their condition compared with 64% nationally.

Figure 7d: Proportion of patients with LTC who felt supported to manage their condition



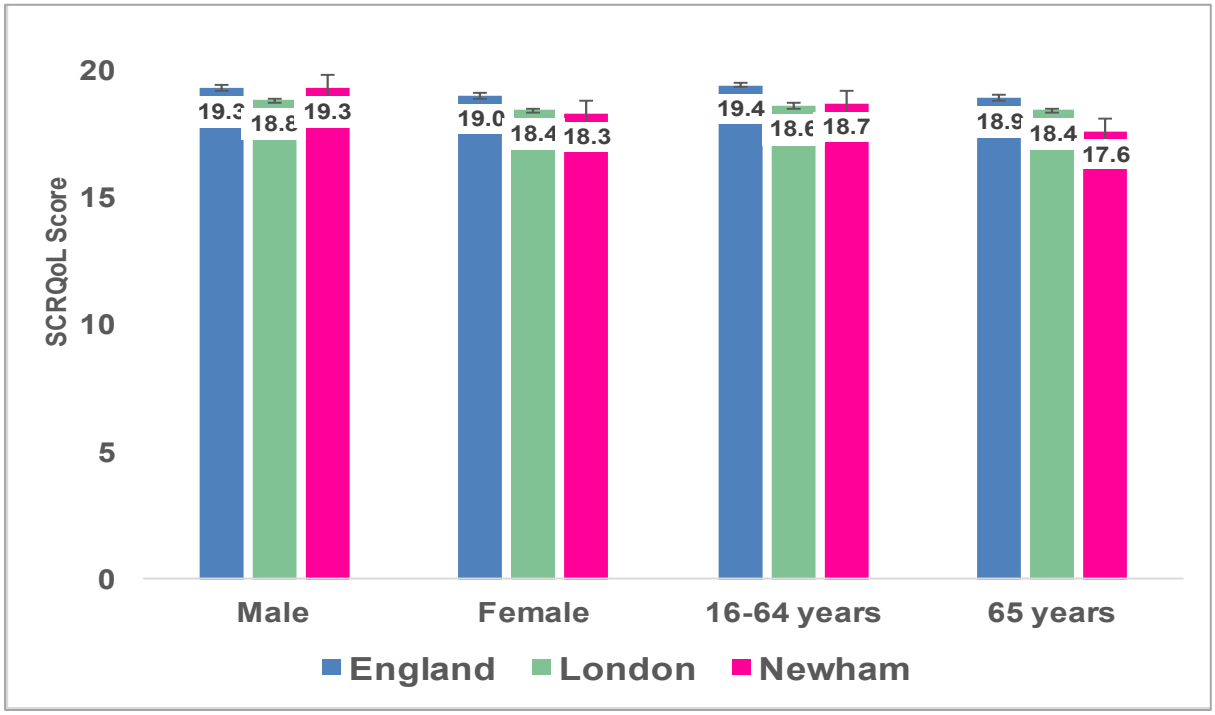
Data source: NHS portal indicator: NHSOF indicator 2

SOCIAL CARE QUALITY OF LIFE

Figure 8a and 8b shows the social care related quality of life (SCRQoL) as measured by the Adult Social Care Outcomes Framework(ASCOF). This measure is derived from a number of questions answered by people in receipt of support from Adult Social care.

The results from 2015/16 show no significant differences between Newham, London and England. There were no gender differences either. There were significant differences between the scores for the younger service users (16-64 years) and the older service users (65 years and above). As described in the HRQoL the older population may also have people with multiple morbidities.

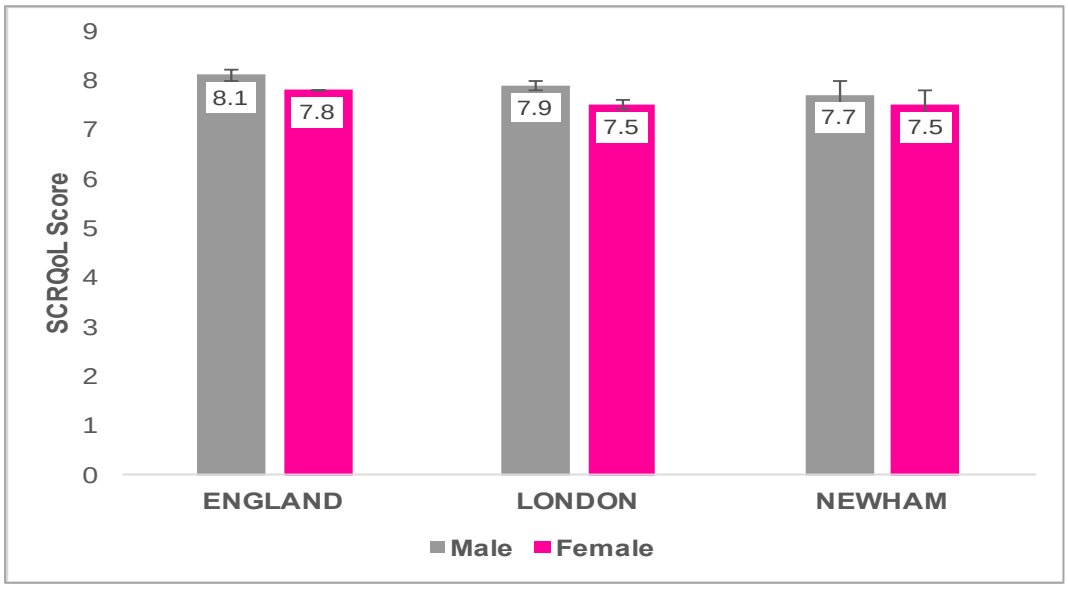
Figure 8a: Social care quality of life scores



Data source: NHS portal indicator: ASCOF indicators

The scores for carers in London and Newham were lower than that for England. This pattern was comparable with that for HRQoL.

Figure 8a: SCRQoL for carers



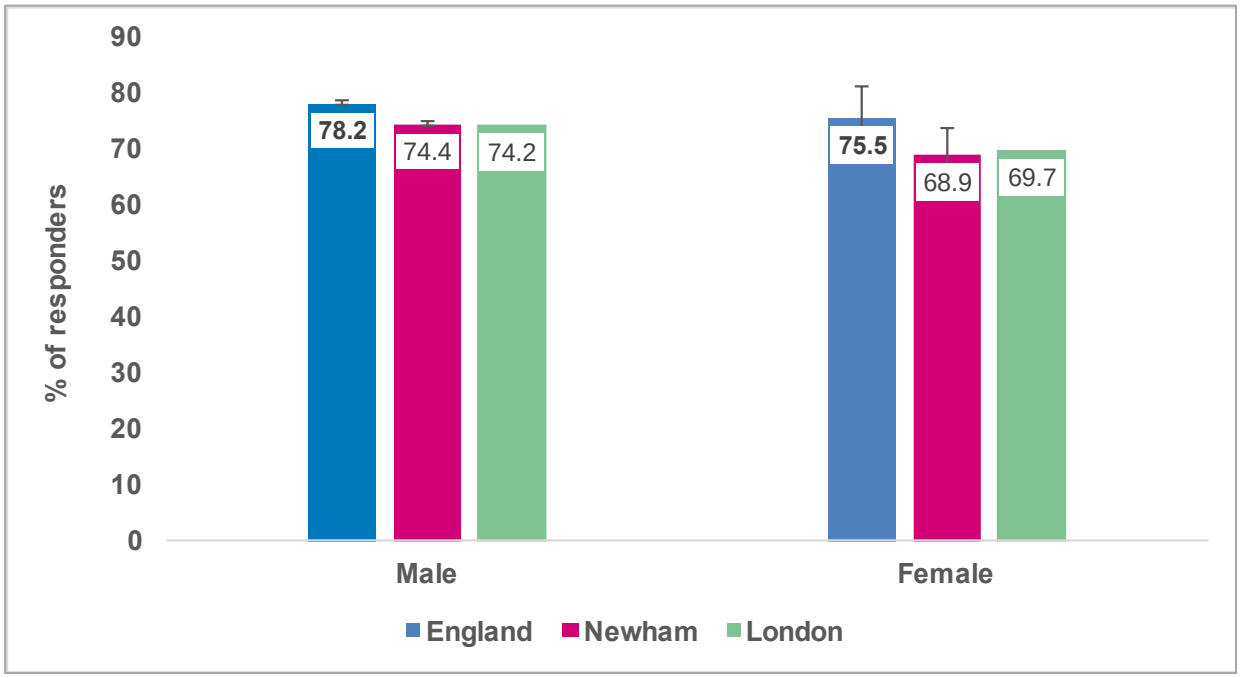
Data source: NHS portal indicator: ASCOF indicators

CONTROL OVER DAILY LIFE

Figures 9a and 9b show control over daily life by gender and by age group, respectively. This measure shows the proportion of service users who have control over their daily life, and is calculated from data collected in the Adult Social Care Survey.

About 74.4% of men and 69.9% of women in Newham felt they had control over their daily lives. The proportion of Newham service users who felt that they have control over their daily lives was lower compared with England but similar for London for men. Newham women service users had the lowest proportion who felt they had the control over daily life.

Figure 9a: Customers who felt they had control over daily life by gender



Data source: NHS portal indicator: ASCOF indicators

Older service users felt they had less control over their daily lives compared with the younger service users. The gap between the older and younger people was greatest in Newham, with only about 57% of 65+ age group reporting they had control over their daily lives.

Figure 9b: Customers who felt they had control over daily life by age

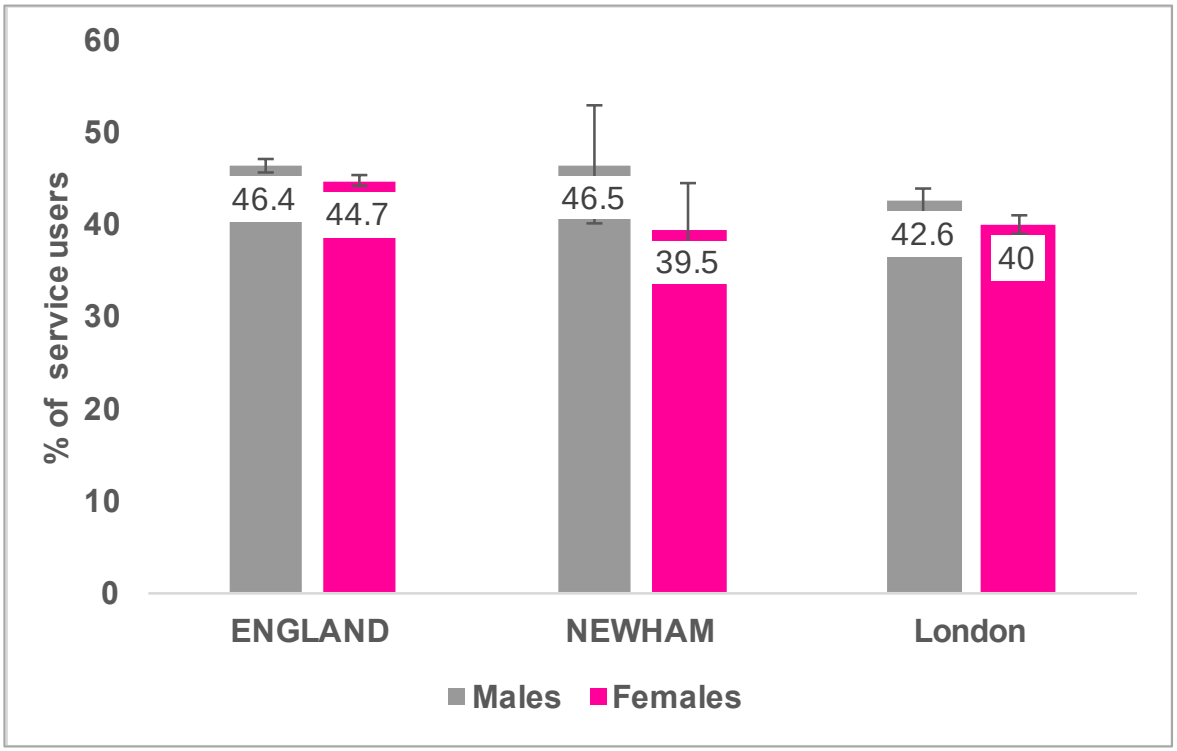
Data Source: NHS digital indicator portal: ASCOF

SOCIAL CONTACT

There is a clear link between loneliness and poor mental and physical health. This measure draws on self-reported levels of social contact as an indicator of social isolation for service users.

On average, less than 50% of the responders felt that they had as much social contact as they would like in England. Women reported lower contact compared with men. This pattern was similar in Newham with only about 39% reporting enough contact. The figures were higher for 16-65 years compared with 65+ years. The proportion of carers in Newham who felt they had sufficient social contact was comparable with England and London and is not shown here.

Figure 10a: Customers who felt they had as much social contact as they would like



Data Source: NHS digital indicator portal: ASCOF

How is Newham improving social care?

Newham has seen its results for the ASCOM indicators improve, so that our relative position compared to other London boroughs is in the top half for most of the outcomes, and in the top third for many. This improvement is the result of a concerted effort on improving personalisation of services, with all customers receiving an individual personal budget allocation following an assessment that they can choose to take as a direct payment if they wish. A care and support plan is produced in partnership with the customer, taking them through the available options to support their care. Services are commissioned in partnership with a vibrant customer groups (known as 'co-production), and the benefits are being seen through improved outcomes in this survey, both in terms of improved results against national targets, and increased satisfaction levels:

- 100% of Adult Customers and Carers receive Self-Directed Support, the joint highest level in London and England. (ASCOF 1C(1a),(1b))
- In 2015/16 LBN was in the top quartile for performance on reduction of Delayed Transfers of Care From Hospital (ASCOF 2C(1). It was the second best performing borough in London for delays attributable to Adult Social Care (2C(2))
- Between 2014/15 and 2015/16, the proportion of Adults with learning disabilities in paid employment rose from 4.4% to 7.8%, and is now higher than the London average, and two percentage points higher than the England average. (1E)

Despite this demonstrable progress, there are still areas where further improvement is necessary to improve people's experience and satisfaction with their care. LBN is committed to ensuring that there is a wide range of relevant and high quality services available for individuals to choose their care from. Ongoing national budgetary constraints are providing a challenge for all authorities commissioning in this area, but through a combination of

strategic market management, regular customer engagement and strong contract monitoring, the service offer, should continue to improve in the coming years.

PUBLIC HEALTH OUTCOMES FRAMEWORK

Table 4 show shows the current performance of Newham on high level indicators in comparison with England. Whilst there have been improvements, some of the indicators are worse than England.

Table 4: Newham performance on PHOF high level indicators

Indicator		Period	Newham Value	Comparison with England		
						better/higher
						similar
						worse
	Men	2013-15	79			not compared
	Women	2013-15	82.5		-	data unavailable
Life expectancy at 65 years					*	data suppressed
	Men	2013-15	18.3			
	Women	2013-15	20.5			
Healthy life expectancy at birth						
	Men	2013-15	60.5			
	Women	2013-15	60.5			
Slope Index of Inequality regarding healthy life expectancy based on deprivation within Middle Super Output Areas						
	Men	2009-13	3.8			
	Women	2009-13	3.1			

KEY MESSAGE

The historic gap between Newham and England has reduced over the years for some of the high-level health and well-being outcomes. The exception to this is health status life expectancy, disability free life years and health related quality of life for carers.

Women in Newham are more disadvantaged compared with women on average in London and England as described by all three measures of life expectancies. There is a gender gap in Life expectancy and disability free life expectancy.

Newham residents rated their well-being higher compared with London residents on average. Newham service users (health and social care). Recent improvements in income may be a contributing factor.

Where should we focus our efforts for improving population health?

- Reducing disability, for example, incidence of diabetes at younger age should be a key area of focus for Newham. Some of the risk factors are described in the next chapter.
- Newham residents should be made aware of the impact of disability to their quality of life and more should be done to support people to manage their condition. More work needs to be undertaken to understand why carers have lower quality of life and how this can be improved.
- Improving social contact through community networks in partnership with voluntary sector should be explored.

DATA SOURCES

The data used in this chapter were from:

1. ONS Life expectancy, Health state life expectancy and disability free life expectancy at birth and age 65 years 2013-2016 published Nov 2016 and corrected December 2016
2. PHE Trends in Life expectancy at birth and age 65 years PHOF data published August 2016
3. ONS Personal well-being scores April 2015-March 2016 for local authorities published 27 September 2016
4. HSCIC NHS digital indicator portal
    a. NHSOF- Domain 1 1.b Life expectancy at age 75 years
    b. NHSOF Domain 2 HRQoL
    c. ASCOF data

REFERENCES

1. ONS Healthy life expectancy at birth and age 65 by upper tier local authority and area deprivation: England, 2012 to 2014 Statistical Bulletin March 2016
2. Chanfreau J, Lloyd S, Byron C et al Predicting Wellbeing Natcen 2013
3. ONS Measuring wellbeing background information https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/localauthorityupdate2015to2016#background-information
4. HSCIC NHS indicator portal Domain 2 indicator specification https://indicators.hscic.gov.uk/webview/

8.0 HEALTH IMPROVEMENT

KEY STATISTICS FOR NEWHAM

Healthy diet

Proportion of adult population estimated to meet the healthy diet guideline of 5 portions of food and vegetables per day

41%

Physical activity

Proportion of adult population estimated to meet the physical activity guideline of at least 30 minutes five times a week

59.7%

Proportion of adult population estimated that are physically inactive

30.4%

Smoking

Proportion of adult population estimated to be smokers

20%

Proportion of population in routine and manual occupations population estimated to be smokers

28.5%

Alcohol and drugs

Age standardised rate for alcohol related admissions

604 per 100,000

Age standradised rate of opiate and/or crack . cocaine use (15-64 years)

13.1 per 100,000
2.4 per 1000 injectors

Excess weight (overweight and obesity)

Proportion of adult population estimated as overweight or obese

63%

High fasting blood sugar (recorded diabetes)

Prevalnce of recorded diabetes in adult population (age 17+ years)

8% = 22,904 adults

Proportion of people with diabetes whose blood glucose is well controlled

59.4%

Proportion of people with diabetes whose blood pressure is well controlled

75.8%

Proportion of people with diabetes whose blood cholesterol is well controlled

73.9%

Proportion of people with diabetes who had their feet checked

84.4%

High blood pressure (recorded hypertension)

Prevalnce of recorded hypertension in adult population

10.6% = 39,866 adults

Proportion of patients with hypertension whose blood pressure is under control

79%

Proportion of newly diagnosed patients with hypertension (30-74 years) with high cardiovascular risk or are treated with statins

78.5%

NHS Health Checks

Number of eligible people (30-70 years) who were offered NHS health check

42,474

Number of eligible people (30-70 years) who were recieved NHS health check

30,149

BACKGROUND

How we live our lives plays a significant role on the state of our health. Findings from the global burden of disease analyses for England suggests that behaviour (life style) and metabolic (physiologic) factors explained 40% of all disability adjusted life years (DALYS) overall in England [1]. However, for cardiovascular disease (a leading cause of death) they accounted for 84% of DALYS, 47% for cancers and 62% of chronic respiratory diseases and 50% for injuries.

Table 1: Key behavioural and metabolic risk factors

Key behavioural factors	Key metabolic risk factors
Poor diets	High body mass index (overweight and obesity)
Physical inactivity	High blood pressure (hypertension)
Smoking	High fasting blood glucose (glucose intolerance or diabetes)
Alcohol	High cholesterol

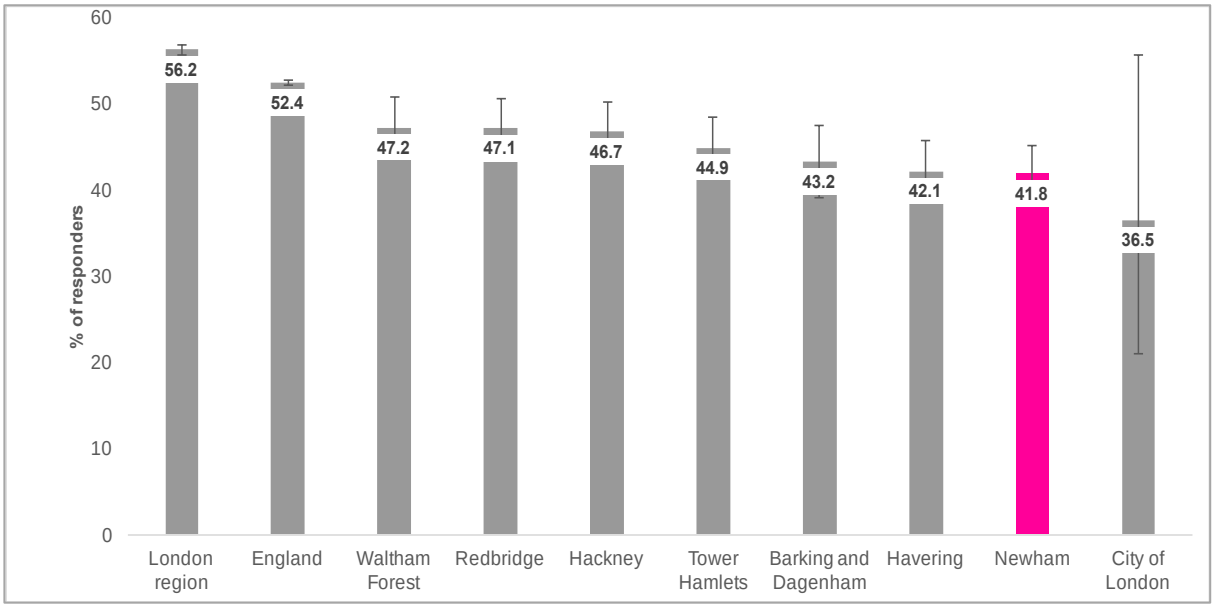
LIFE STYLE FACTORS

Five a day fruit and vegetables

What we eat, makes us healthy or if the diet is not healthy, it can lead to diseases such heart disease, stroke, diabetes and cancers. The recommendations to eat five portions of fruit and vegetable is based on evidence that populations with diets rich in soluble fibre and antioxidants such as found in fruits and vegetables are less likely to have such diseases.

Figure 1 shows the proportion of adult population that are estimated to meet this guideline. In Newham just about 42% % of the population are eating sufficient amounts of fruit and vegetables. This is lower than the London and England average.

Figure 1: Proportion of adults meeting the 5 a day recommendations



Data Source: PHE PHOF data

All the boroughs in North East London have lower proportions of people eating sufficient fruit and vegetables. Newham has a very diverse population many of whom have origins in countries where fruit and vegetables are available abundantly and form part of daily diet.

Physical activity

Box 1 gives the Chief Medical Officers (CMOs) recommendations on physical activity for adults. These are based on evidence on evidence that exercise reduces risk of a range of diseases, e.g. coronary heart disease, stroke, type 2 diabetes, helps maintain a healthy weight and the ability to perform everyday tasks with ease. It improves self-esteem Reduces symptoms of depression and anxiety. Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.

Box 1: CMO guidelines[2] for physical activity for adults and older adults

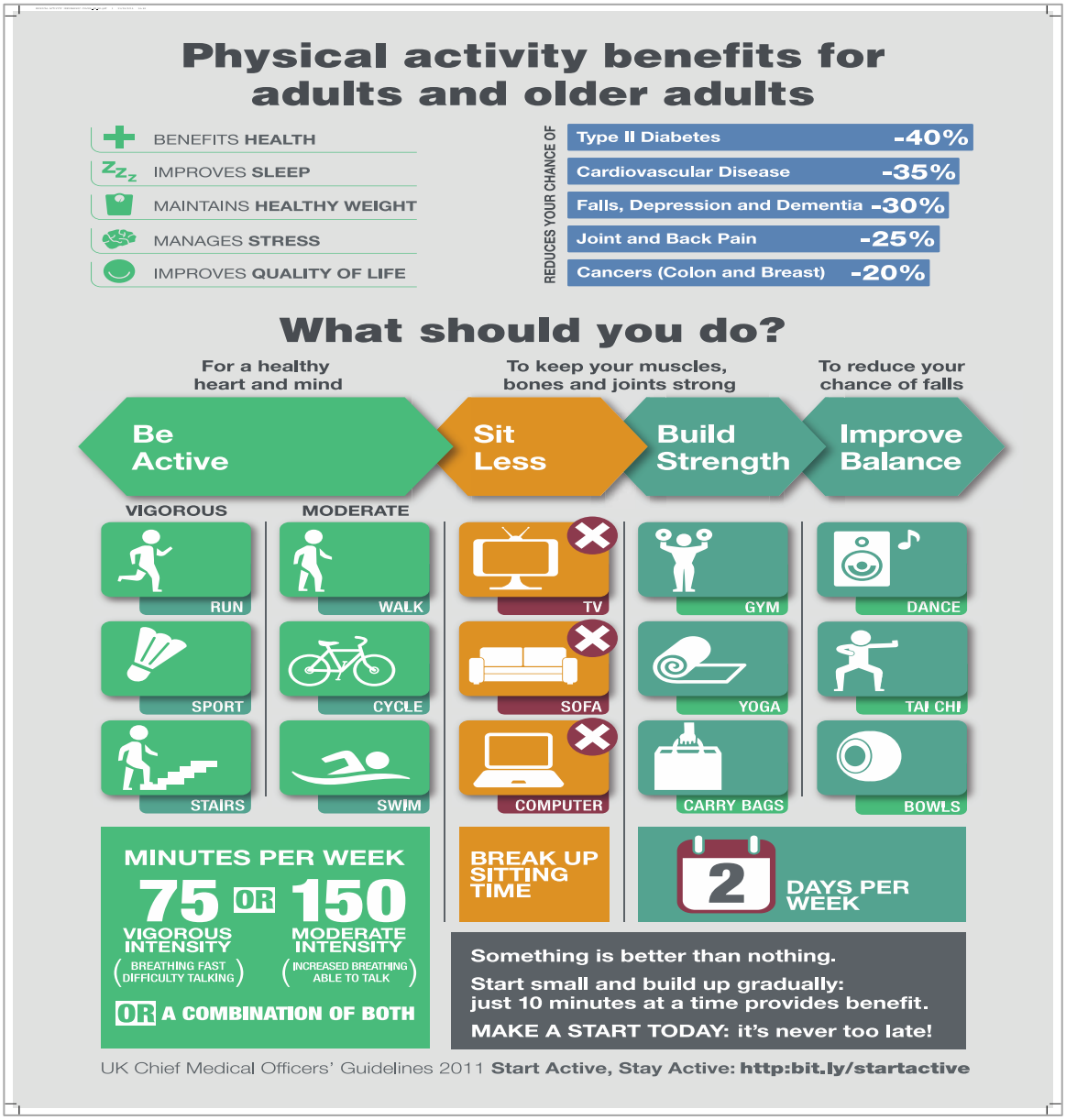
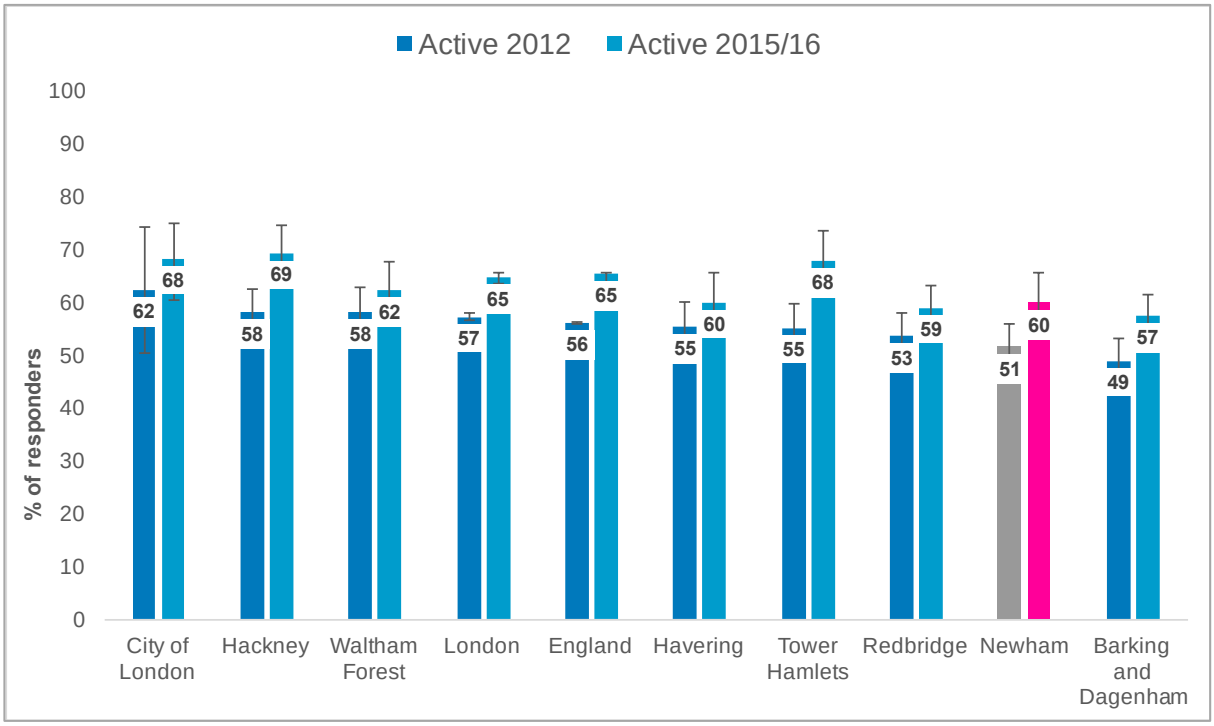


Figure 2 shows the proportion of adults that were estimated to have likely met the physical activity guideline of at least 30 minutes five times a week (or 150 equivalent minutes per week) of moderate exercise in 2012 and 2015/16.

Newham has increased from 51% in 2012 to 59.6% in 2015/16. 2012 was the Olympic year and that may be a contributing factor. Newham has good facilities. For some communities and areas, crime and fear of crime could be a contributing factor as Newham has lower levels of use of open spaces and parks for exercise.

Figure 2: Proportion of adults that are estimated to meet the guidelines for physical activity for health



Data Source: PHE PHOF data (2012 PA) and Sport England Life Style Survey 205/16

What are we doing to improve physical activity among the adult population?

Our Community Neighbourhood service works with residents across Newham to get them active and connected. A variety of physical activity sessions, including Zumba and walking groups take place in our libraries, community centres and public spaces, much of it commissioned through the *Get Active Get Healthy* programme focused on over 50s.

Programmes often reach people who may have limited funds to access physical activity provision where costs are prohibitive, and who may be more comfortable doing things in a social and less formal sports venue.

The service has also supported the delivery of community focused mass participation activity such as Beat the Streets and the Newham Million Mile Challenge, which encourage and capture less formal exercise such as walking and dancing at home.

Adult activity commissioned via Leisure & Sport includes;

- Management & operation of the council's leisure centre portfolio facilitating an estimated 1.7 million visits each year. This includes opening Manor park Fitness Centre and Atherton Leisure Centre.
- Management of events and sports facility bookings in parks
- Provision of allotment services at eight sites across the borough offering growing opportunities.
- Co-ordination of the Newham Community Gardens Network to support communities to participate in food growing activities
- Management and operation of Newham City Farm and East Ham Nature Reserve with more than 70,000 visits each year
- US Girls programme targeting women and girls to get back into sport and physical activity. More than 7000 attendances.
- Park lives programme targeting free, fun activity in parks at young people, adults and families. More than 14000 attendances in 2016.
- Delivery of the Council's volunteering service with more than 700 people giving 25,000 hours back to the community each year.

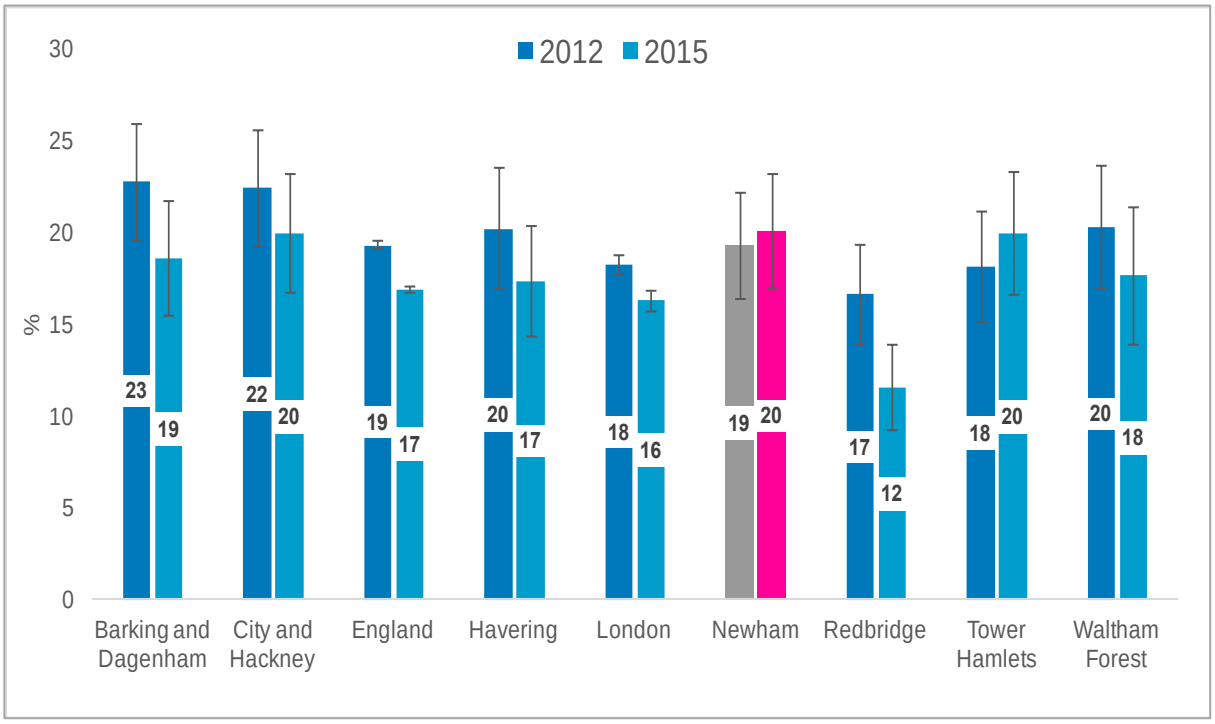
Smoking

Smoking is a contributory factor for many diseases, such as coronary heart disease, stroke, lung cancer and contributes to demand on health care. In 2013/14, in England smoking was an attributable factor in people age 35 years and over for [3]:

- 4% for all hospital admissions
- 23% of admissions with a primary code as diseases of respiratory system
- 15% for admissions with a primary code as diseases of circulatory system
- 10% of admissions with a primary code as cancer
- 17% of all deaths

Figure 3a shows the adult smoking rates between 2012 and 2015. The rates of smoking (21%) are significantly higher than London (16%) or England (17%). Between 2012 and 2015, England and London saw significant decrease in smoking rates. Newham saw a non-significant increase.

Figure 3a: Adult smoking rates in NE London, London and England



Data Source: PHE PHOF data

Occupational class and diverse communities could explain the higher rates.

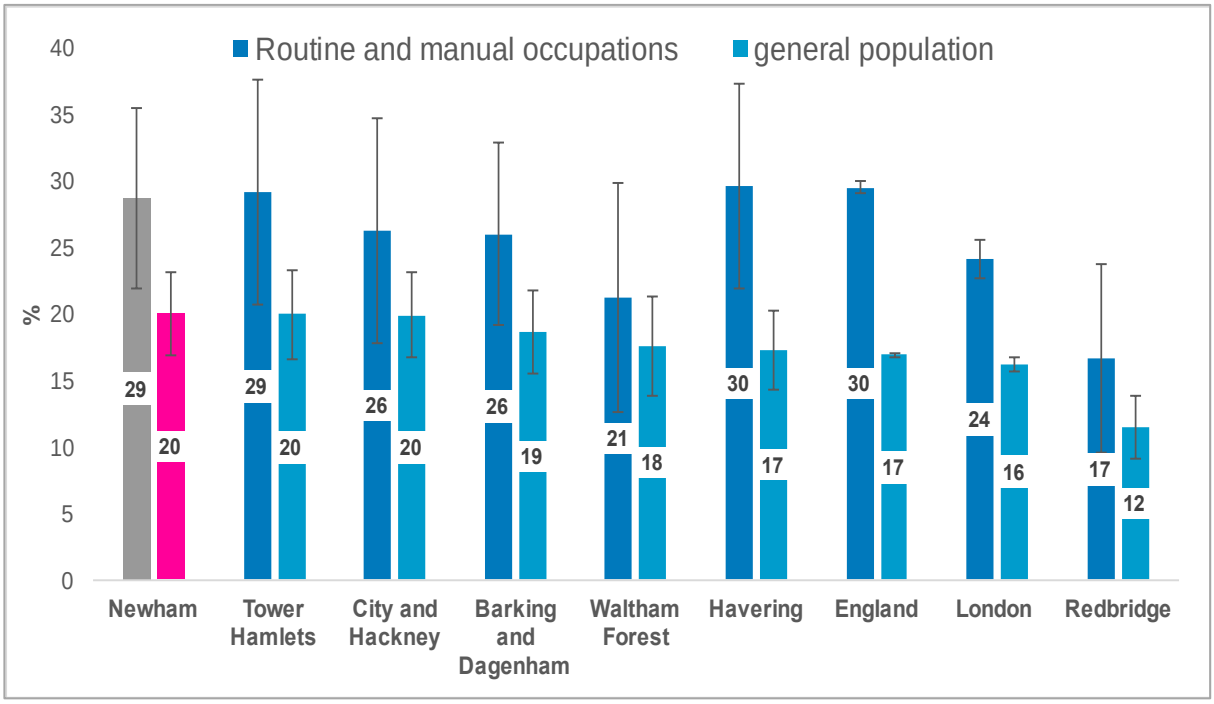
There is a social gradient in smoking[4]

- Managerial and professional occupations – 12.1%
- Intermediate- 18%
- Routine and Manual occupations – 28%:

Newham has a higher proportion of people in occupations with higher smoking rates, for example the proportion of residents in Newham in routine and manual occupations is 24.5% compared with 13.9% in London (*NOMIS data for 2015/16*). On the other, hand Newham has lower proportion of residents in occupations that have lower smoking rates for example, proportion in managerial and professional occupation (39.1% compared with London 54.5%.)

Figure 3b compares smoking in general population and in manual and routine occupation in NE London boroughs, London and England. There is no significant difference in smoking in manual and routine occupations.

Figure 3b: Adult smoking rates in general population and routine and manual occupations



Data Source: PHE PHOF data

The diversity of communities in Newham means that there will be some communities, for example Irish and Eastern European that have higher rates compared with other communities. As the other white communities are likely to grow as described in section on population projections in chapter five, the current increasing trend smoking can be expected to continue in Newham.

On the GP practice registers in 2014/15, 54,380 people were recorded as smokers (GP practice range: 8.1% to 32.1%)

Stop Smoking Services in Newham

London Borough of Newham commissions Stop Smoking services from 19 community pharmacists to provide free support and advice to anyone living in Newham, over the age of 12 and a smoker.

Four key groups within the smoking population who suffer worse health outcomes from smoking related illness have been identified and prioritised as most likely to benefit from stop smoking support interventions. This has been determined by reviewing the national evidence and local performance data. These groups are:

Pregnant women.
Young People (>25).
Residents with Long Term Conditions (LTCs).
Residents with a Serious Mental Illness (SMI).

These groups will be the focus of future commissioning development work to improve uptake and successful completions of quit attempts.

Areas of priority and development

LBN intentions to improve and develop services include;

Increase uptake through local marketing campaigns to promote the service.
Increase uptake of the service amongst the priority groups by working with the market to develop referrals pathways and proactive outreach in the community.
Support framework providers achieve a quit rate of 35-70%
Achieve a validation rate of 85% amongst all providers.

Alcohol

Alcohol contributes to mortality and morbidity. The alcohol attributed risk is calculated by

- Alcohol specific risk- where all cases are due to alcohol (100%)
- Alcohol related risk- where alcohol causes some but not all cases

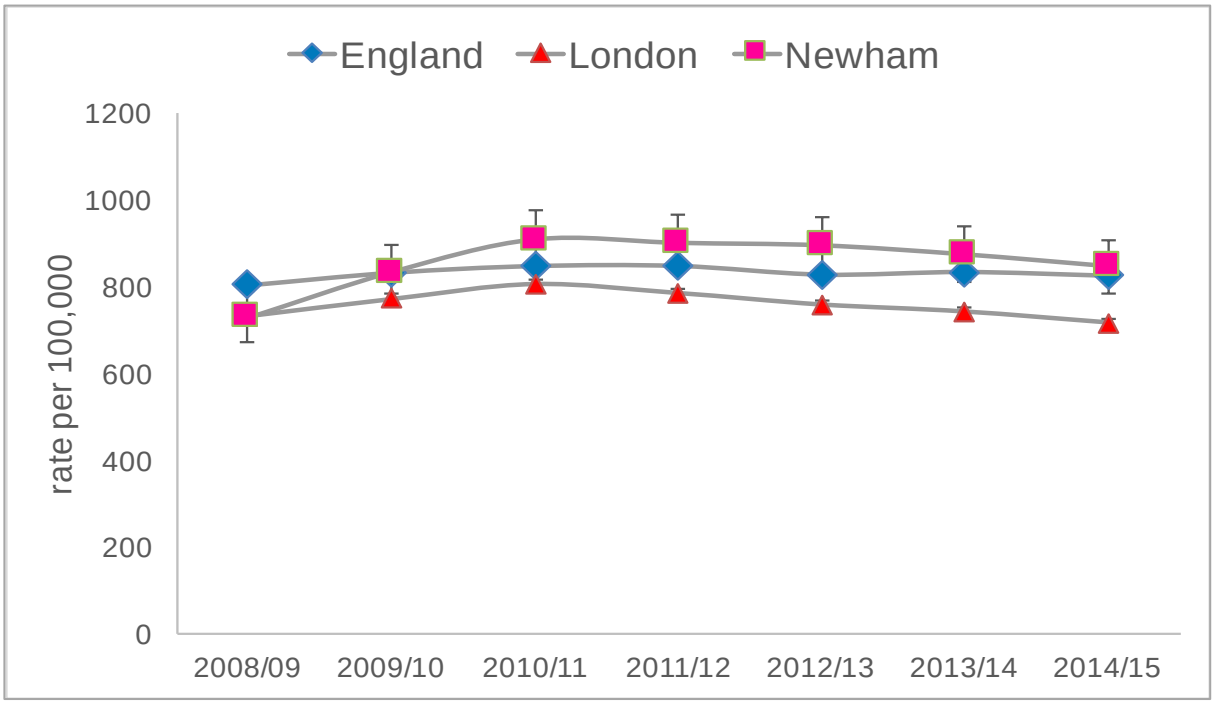
These are conditions for example where the primary diagnosis is cardiovascular disease, behavioural and mental health conditions and alcohol is a contributory factor.

Figure 4a and 4b show trends in alcohol specific admissions rate for Newham for all ages compared with England and London. Newham has similar profiles for alcohol specific admissions to England but higher compared with London in men but for women it is comparable with London and lower than England. The reasons for male specific rates in Newham to be higher than London are not clear and this may need to be explored further.

Figure 4c compares male and female alcohol specific admissions in NE London. All boroughs had higher male admission rates compared with women.

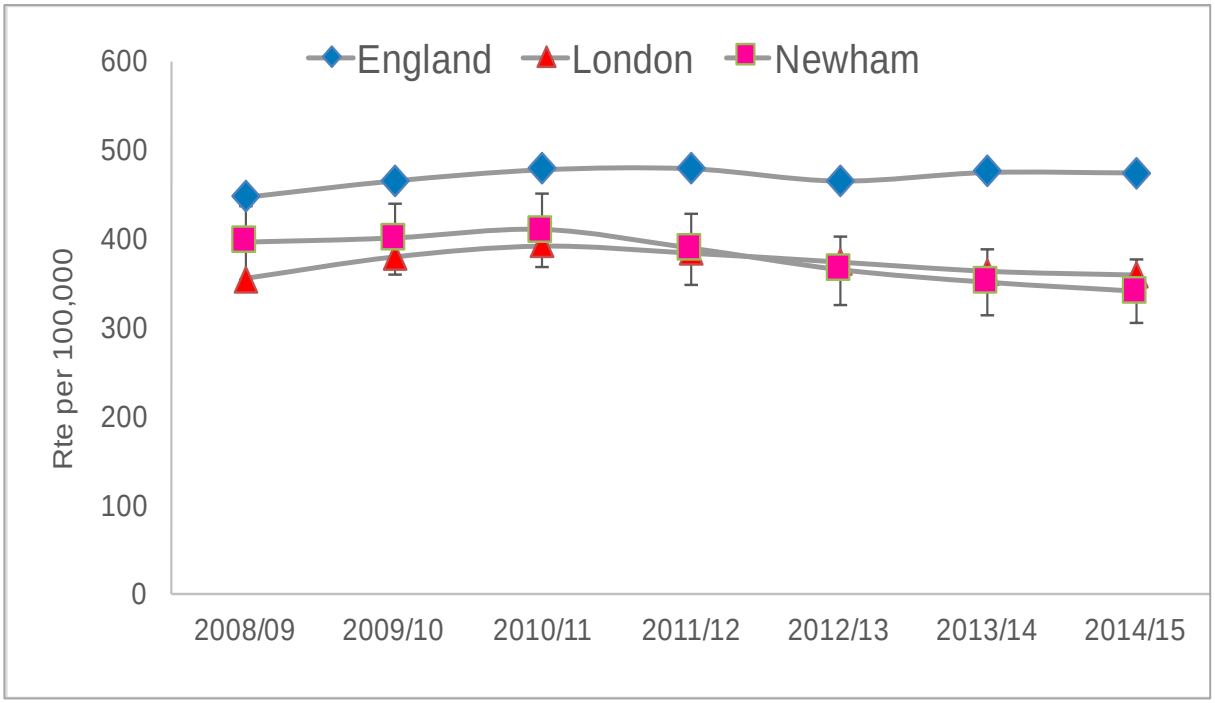
Women in Newham had higher rates compared with Havering, Redbridge and Waltham Forest

Figure 4a: Trends in male alcohol specific admissions 2008/09 to 2014/15



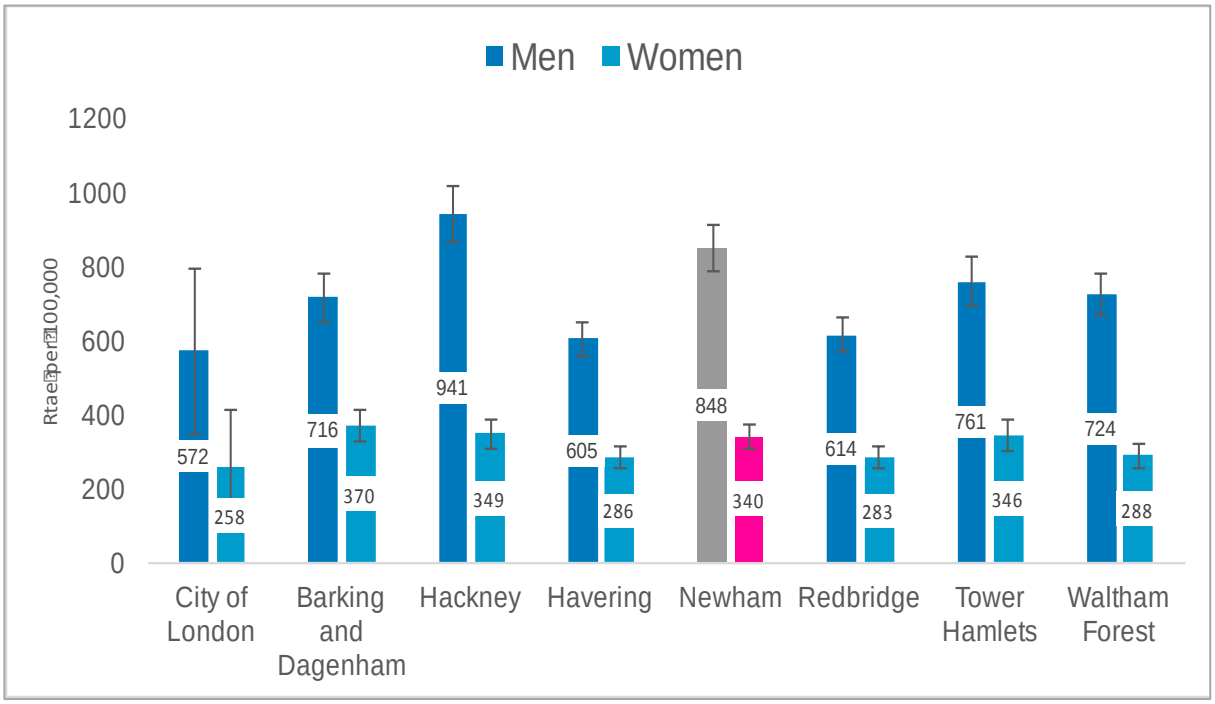
Data Source: PHE Local Alcohol profiles

Figure 4b: Trends in female alcohol related admissions 2008/09 to 2014/15



Data Source: PHE Local Alcohol profiles

Figure 4c: Alcohol related admissions for male and female in NE London



Data Source: PHE Local Alcohol profiles

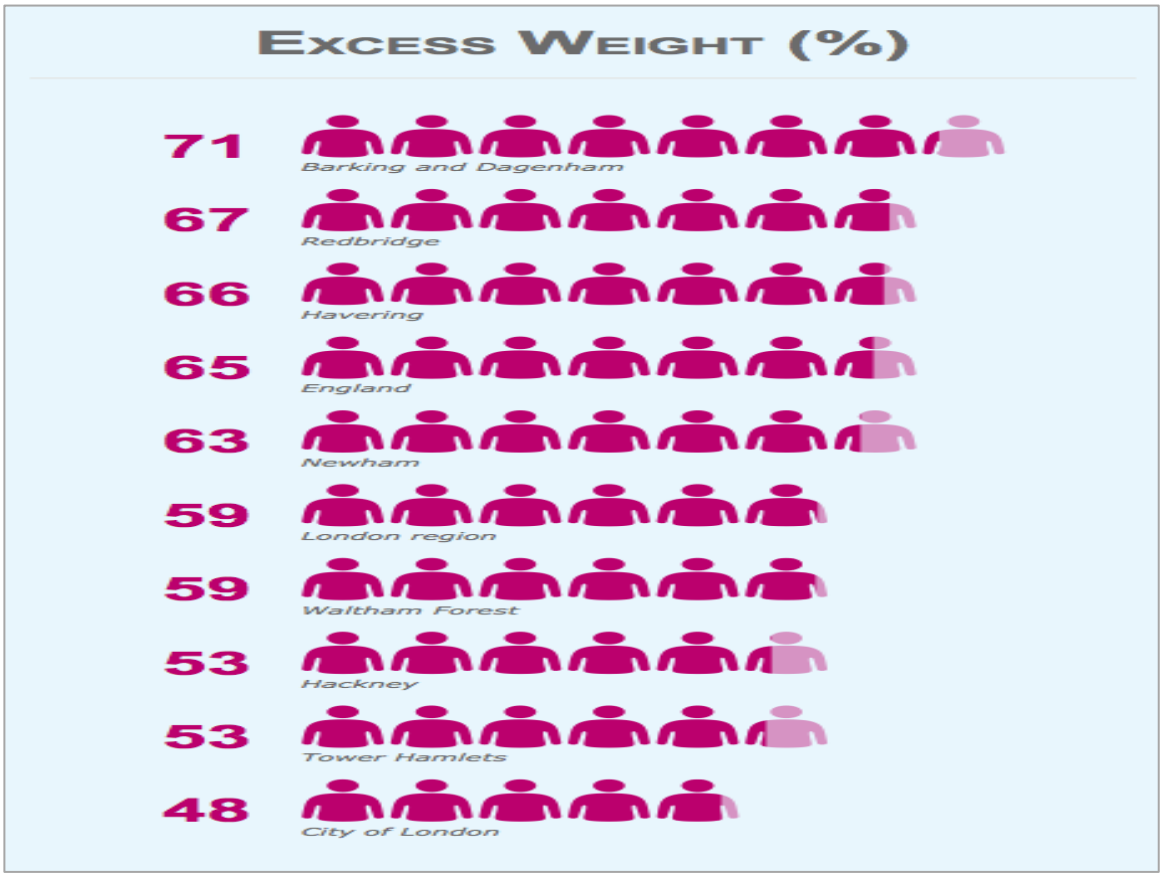
METABOLIC FACTORS

Excess weight

Excess weight is a risk factor for chronic conditions. Excess weight is mainly a consequence of imbalance between food energy from diets (high in sugar and fat) and lower energy expenditure through physical activity (sedentary life style). Evidence from relation between body mass index (BMI), a measure of weight standardised for height, indicates that population level BMI greater than 24.99 (kg/m^2) raises the risk of mortality from all causes. It is a risk factor that predisposes to earlier onset of age related chronic conditions. Excess weight is defined as a BMI above 24.99 kg/m^2. A BMI over 29.99 kg/m^2 poses higher risk and is clinically defined as obesity.

Figure 5 shows the proportion of people with excess weight in NE boroughs compared with England and London. Newham is comparable England but higher than London. Tower Hamlets, a neighbouring local authority with higher deprivation has 10% percentage points lower excess weight.

Figure 5: Excess weight in NE London 2013-15 (Overweight and obese)



Data Source: PHE PHOF data

The nationally published data for 2014/15 by PHE suggests that 10.5% of the registered patients in Newham CCG were obese which is higher than the national figure of 9%. Tower Hamlets that is more deprived and similar proportion of registered population from Asian background had 6.5% obesity levels.

Local data analyses of BMI from GP records minimum of 53,000 people recorded on GP records as obese (31,000, 23%, women and 22,000, 14%, men). About 14% of the adult population in Newham did not have a recorded weight on their GP records. The 2013 Newham Panel Survey (wave 7) found overall obesity level of 16% for women and 14% for men.

This figure rises to 67,000 (37,000 (28%) women, 30,000 (20%) men) when the lower cut-off point for obesity (BMI≥27.5 is used as recommended by the World Health Organisation for the Asian population)[5]. The lower cut-off point is recommended because there is evidence that Asians have higher risk of obesity related diseases at lower BMI (WHO 2004, NICE 2014)[6]. Evidence of the same higher risk at lower BMI in the Black population is contradictory and therefore only the Asian specific lower cut-off has been used.

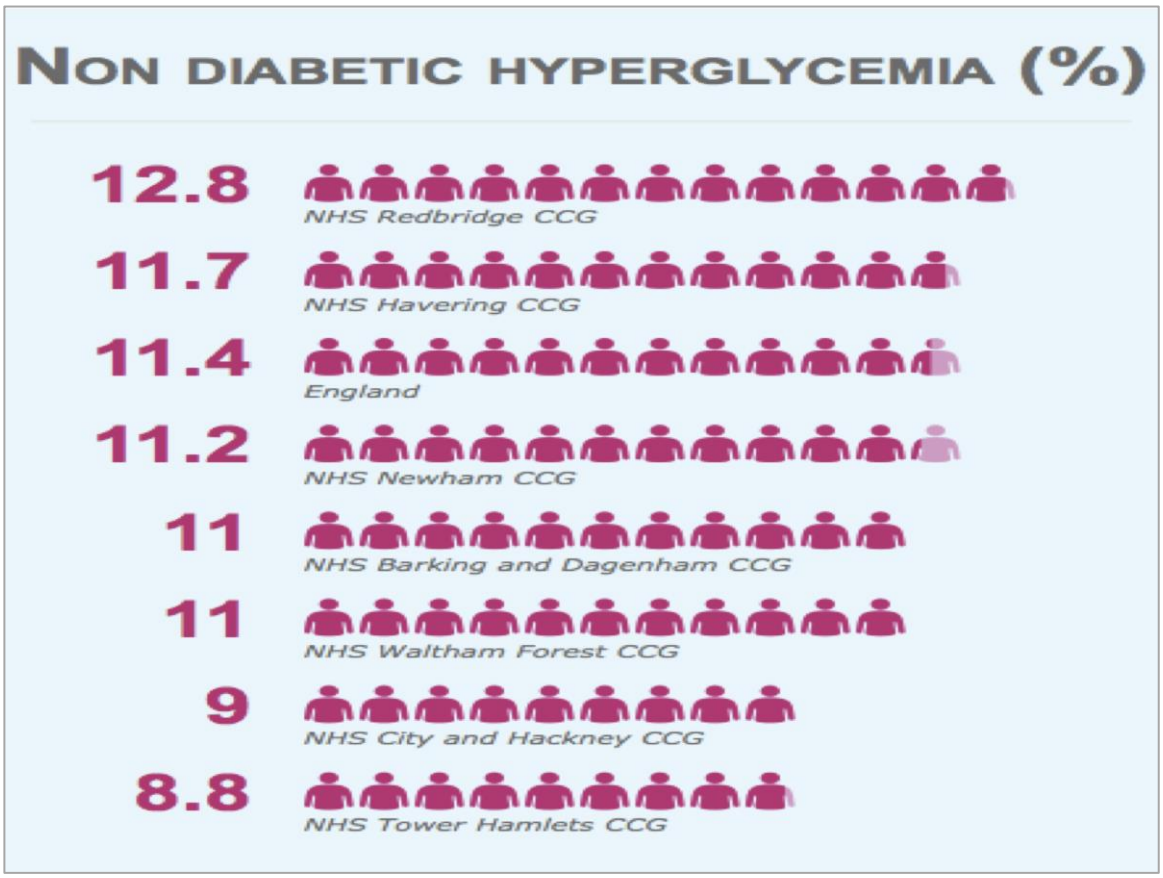
Overall including overweight (BMI≥25 and ≥23 for the Asian population) 53% of men and 55% of all women in Newham CCG are recorded as overweight or obese. This is lower compared with the estimated figure of 63% for resident population.

High fasting blood glucose (non-diabetic hyperglycemia)

High fasting blood sugar at thresholds known as glucose intolerance (prediabetes) or diabetes has been increasing rapidly globally. People of Asian origin are at a higher risk of diabetes. Uncontrolled diabetes results in death from heart disease, blindness and foot amputation.

Reducing weight and increasing physical activity both protect against type 2 diabetes.

Figure 6: Proportion of adult patients (16+ years) in primary care recorded as having non-diabetic hyperglycemia†



Data Source: PHE CVD and Diabetes profiles

† Non-diabetic hyperglycaemia was defined as an HBA1c value between 6.0% (42mmol/mol) and 6.4% (47mmol/mol), excluding those who had already been diagnosed with diabetes with an HBA1c value in this range.

What interventions are in places locally to prevent /delay diabetes in those at risk?

The following services are commissioned to reduce the risk of diabetes in high risk people population.

Lifestyle, intensive, individual-based interventions

• Newham Community Prescription

Tailored programme of physical activity usually lasting from 10 to 12 weeks. Expected to increase the level of physical activity, leading to

positive changes in health behaviours over the long term

• The Healthier You Programme (NHS DPP)
Newham is running the national Intensive behavioural intervention targeting those at risk of Type 2 diabetes aimed to reduce their risk of progressing to diabetes, by focussing on weight loss, achievement of dietary recommendations and achievement of physical activity recommendations. Designed as a long-term intervention, made up of at least 13 sessions (1-2 hours), over a minimum of 9 months

• Post GDM intervention

Lifestyle intervention (nutritional advice, physical activity, motivational interviewing) targeting women with an history of GDM

One-off intervention
• EPCS pathway

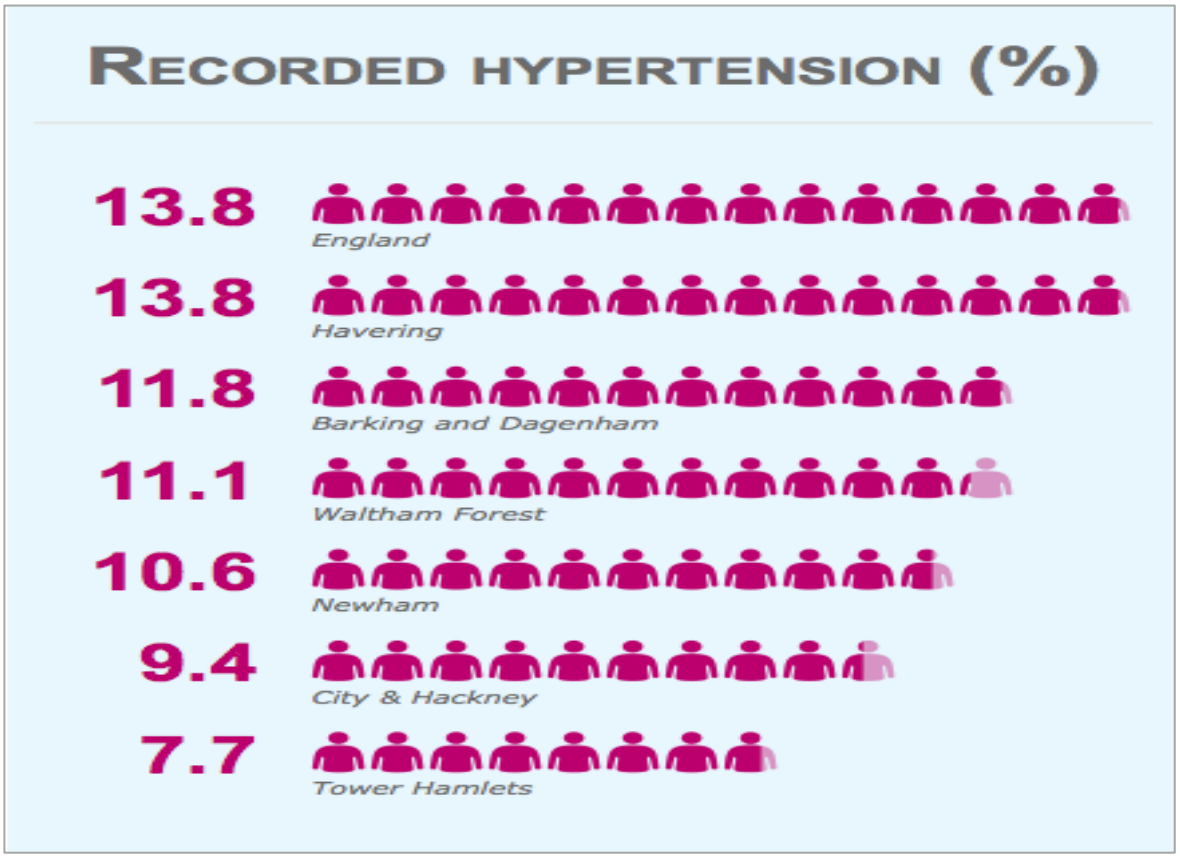
• Prediabetes education session

High blood Pressure

High blood pressure is the second largest contributor to the burden of disease. Figure 7 shows the prevalence of recorded patients with hypertension. The prevalence of hypertension in Newham is lower than England but this is to be expected as hypertension increases with age, but the extent to which Newham should be lower is unclear. The proportion of actual to expected hypertension derived from a national model is low in Newham.

There were over 38,600 patients with a diagnosis of hypertension in Newham registered population in 2014/15. This was an increase of about 1000 patients from 2011/12. Of the 39,866 There is a high variation in the proportion of actual to predicted hypertension by general practice in Newham, ranging from one practice identifying 82% of the patients predicted to be hypertensive to another practice identifying just 23% of the predicted number of hypertensive patients. This suggests there could be significant under-detection of hypertension in Newham. Furthermore 20% of the population of Newham is Black African, Black Caribbean or Black other. Research has found in the UK that people of African and Caribbean origin have a hypertension rate three to four times greater than the White population across varying age-bands after age 30 years[7].

Figure 7: Proportion of patients in primary care recorded as having hypertension



Data Source: PHE CVD profiles

PUBLIC HEALTH OUTCOMES FRAMEWORK

Table 2 shows the Newham's current performance on the health improvement outcomes

Table 2: PHOF for health improvement

Indicator	Period	Newham Value	Newham Recent Trend	Comparison with England	better/hi / similar / worse / not comp	
Lifestyles						
Proportion of adults meeting the recommended '5-a-day' on a 'usual day'	2015	41.8	-		-	data una
Proportion of adults meeting the recommended physical activity levels	2015	44.8	-		*	data sup
Smoking Prevalence in adults (%)	2015	20.0	-			
Smoking Prevalence in adult in routine and manual occupations (%)	2015	28.7	-			
Overweight or obese adults (%)	2013-15	63.2	-			
Deaths from drug misuse	2013-15		-			
Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison (%)	2015/16	13.1	-			
GP-registerd patients (>17 years) with diagnosed diabetes (%)	2014/15	8.0				
Admission episodes for alcohol-related conditions (age-standardized per 100 000 population)						
Men	2014/15	848	-			
Women	2014/15	340	-			
Cancer & Screening						
Cancer diagnosed at early stage (experimental statistics) (%)	2014	39.5	-			
Cancer screening coverage - breast cancer (%)	2016	64.9				
Cancer screening coverage - cervical cancer (%)	2016	63.9				
Cancer screening coverage - bowel cancer (%)	2016	41.8	-			
Abdominal Aortic Aneurysm Screening - Coverage	2015/16	74.0	-			
Eligible population aged 40-74 offered an NHS Health Check (%)	2013/14-15/16	67.5	-			
Eligible population aged 40-74 who received an NHS Health check (%)	2013/14-15/16	47.9	-			
People reporting a high anxiety score (%)	2015/16	14.3	-			
Falls						
Injuries due to falls in people aged 65 and over (Men, per 100 000 population)	2014/15	2063	-			
Injuries due to falls in people aged 65 and over (Women, per 100 000 population)	2014/15	2632	-			
Mortality attributable to particulate air pollution	2015	6.0	-			
Flu vaccinations (adults age 65+, %)	2015/16	72.4				
HIV late diagnosis (%)	2013-15	40.5				
Incidence of Tuberculosis (per 100 000 population)	2013-15	85.6	-			
Treatment completion for Tuberculosis	2014	86				
NHS organisations with a board approved sustainable development management plan (%)	2014/15	40				

KEY MESSAGE

Newham residents generally have a poorer life style profile on key risk factors that are known to influence the burden of disease related to the major killer diseases- coronary heart disease, stroke, cancer. Less than half the population meet the evidence based guidelines on fruit and vegetable consumption and 30% of the population is physically inactive. In addition, smoking and alcohol profile indicates many of the communities may have a cluster of risky life style factors that interact to increase risk of major long term conditions at younger age as witnessed by the incidence of type 2 diabetes in children.

The combination of lower socio-economic occupations, ethnic predisposition and life-style risk factors predicts a rising cost to health and social care unless interventions to support the population to adopt healthier life styles are implemented now.

DATA SOURCES

1. PHE PHOF profiles November 2016
2. PHE Longer Lives dataset 2016
3. PHE National cardiovascular intelligence network
    a. CVD profiles
    b. Prevalence estimates of non-diabetic hyperglycemia , March 2016
4. HSCIC Statistics on Smoking England 2015
5. ONS Cigarette smoking by occupations and country (2014) Released October 2016

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1. Newton J et al Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013 The Lancet, Volume 386, Issue 10010, 2257 – 2274
2. Chief Medical Officers New Guidelines for physical activity for UK, 2011, infographic 2016, Department for Heath, UK
3. Lifestyle Statistics Team, Statistics on Smoking, England Health and Social care Information Centre May 2015
4. Vizard T, Integrated Household Survey Experimental Statistics January to December 2014, Sexual identity, Smoking prevalence and perceived general health , ONS Oct 2015
5. World Health Organisation, 2004. Appropriate body-mass index for Asian populations and its implications for policy and intervention strategies. *The Lancet*, pp. 157-63.
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7. Agyemang, Roger W. Humphry, Bhopal R; Divergence With Age in Blood Pressure in African-Caribbean and White Populations in England: Implications for Screening for Hypertension. *Am J Hypertens* 2012; 25 (1): 89-96. doi: 10.1038/ajh.2011.160

9.0 BURDEN OF DISEASE

KEY STATISTICS FOR NEWHAM

Key conditions that cause the greatest burden of illness

Number of people attended GP practice with pain and or loss of function such as walking or self-care

46,000

Estimated number of people with common mental health problem

46,000

Estimated number of people with diabetes

21,500

Emergency admissions that have scope for improvement through primary care

Chronic obstructive lung disease (COPD) and asthma emergency admissions in Newham are twice that for England 406/100,000 COPD and 189/100,000 for asthma

Emergency admissions for dementia are higher in Newham compared with England 4747/100,000

Mortality in Newham

Total number of deaths (2012-14) = 3,900

♂ Male deaths =2100 (54% of all deaths)

♀ Female deaths =1880 (46% of all deaths)

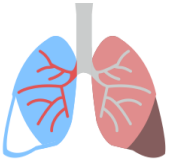
Key causes for deaths

Deaths from cardiovascular diseases = 1,100 (28% of all deaths)

540 deaths were in people under 75 years of which 69% deaths in men and 53% were estimated as preventable

Deaths from cancers = 1,050 (26.9% of all deaths)

About 60% of deaths from cancer in under 75 years of age were estimated to be preventable



Deaths from respiratory diseases = 530 (13.6% of all deaths)

49% deaths in men under 75 years and 56% in women under 75 years were estimated to be preventable

BACKGROUND

The World Health Organisation (WHO) initiated a project in 1990 to study the burden of disease for each country [1]. The burden of disease is measured by combining two indicators; the number of years of life lost to disease (YLL) and the number of years lived with disability as a result of disease (YLD). Both these indicators are combined to give an overall measure of burden of disease, namely disability adjusted life years (DALYs). One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

Public Health England as part of this project has published the burden of disease for England and the regions [2]. The Institute of Health Metrics and Evaluation (IHME) has published the country profiles for 2015[3]. The picture for England in 2015 is shown in the table below.

Table 1: Top ten causes of burden of disease in England 2015

Top ten causes of years lived with disability 	Top ten causes of premature deaths 	Top ten causes of years lived with disability and deaths combined 
1.Low back and neck pain 2. Sense organ disease 3. Depressive disorders 4. Skin diseases 5. Migrane 6. Other Musculoskeletal conditions 7. Asthma 8.Anxiety disease 9. Oral disease 10. Iron deficiency anaemia	1. Ischaemic heart disease 2. Lung cancer 3. Cerebrovascular diseases 4. Chronic obstructive pulmonary disease 5. Lower respiratory infections 6. Alzheimer 's disease 7. Colorectal cancer 8. Breast Cancer 9. Self-harm 10. Other cardiovascular diseases	1. Ischaemic heart disease 2. Lower back and neck pain 3. Lung cancer 4. Cerebrovascular disease 5. Sense organs 6. Chronic obstructive pulmonary disease 7. Alzheimer's disease 8. Depressive disorder 9. Skin disease 10. Lower respiratory infections

Infographic table based on data from IHME England Country Profile 2015

Based on the trends, WHO[4] has projected the causes of mortality in the regions. For Europe, the top 10 causes of mortality in 2030 are projected to be

1. Ischaemic Heart Disease (IHD)
2. Stroke
3. Colon and rectal cancer
4. Lung cancer
5. Chronic obstructive lung disease (COPD)
6. Alzheimer' s and other dementia
7. Hypertensive heart disease
8. Lower respiratory infection
9. Liver cirrhosis
10. Diabetes

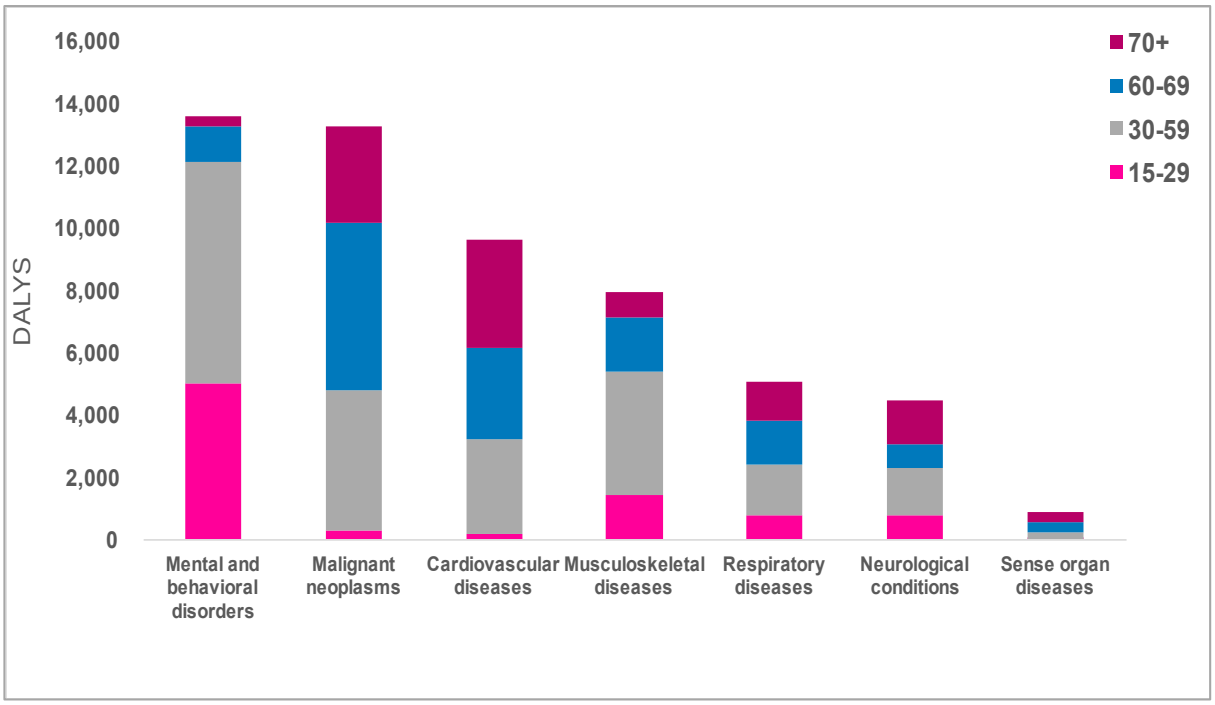
The risk factors that lead to many of these conditions that result in burden of disease are discussed in chapter 8. This chapter describes the burden of disease in Newham based on the two metrics (YLL and YLD) and public health outcomes framework indicators.

BURDEN OF DISEASE IN NEWHAM

DISABILITY ADJUSTED LIFE YEARS (DALYS) FOR NEWHAM

Applying the WHO figures for DALYs for United Kingdom by age to the Newham age structure, provides a modelled estimate of the burden of disease by broad age categories and disease groups as shown in Figure 1.

Figure 1: Estimated DALYs for Newham from leading causes by age group



Data Source: Modelled estimates from WHO data for DALYS by age for UK

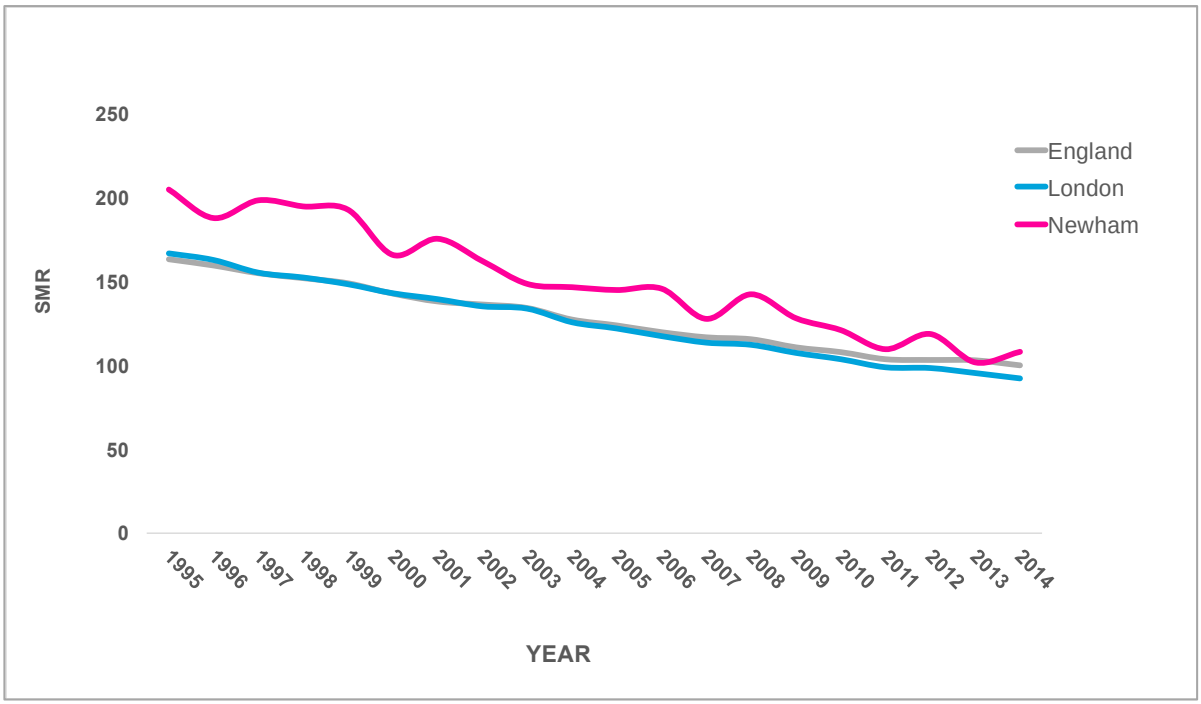
The figure above based on modelling gives an indication of the distribution of the burden from different conditions in the different age bands. Because Newham has a younger age profile, the burden from mental and behavioural problems is the highest.

ALL CAUSE MORTALITY

Advances in medical care and preventative healthcare such as screening, immunisation, smoking cessation have seen a reduction in all age all cause mortality nationally and regionally. The rate in improvement in areas such as Newham which had higher mortality has been greater resulting in narrowing of the gap over the last 20 years.

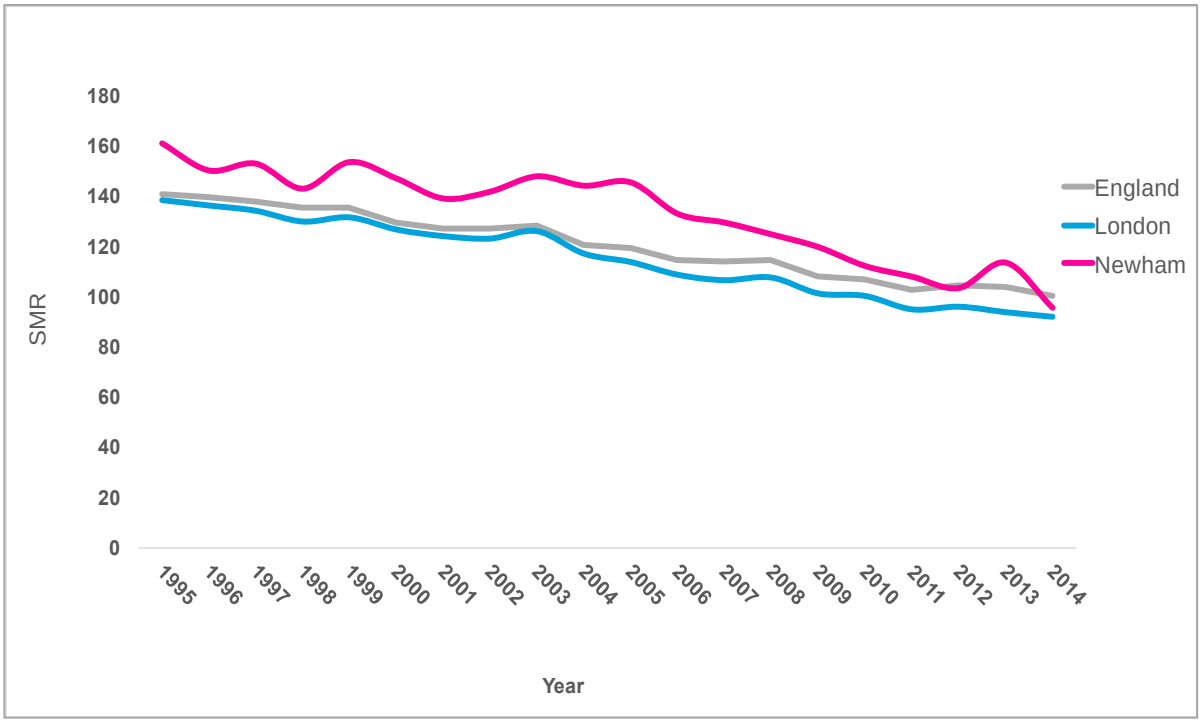
Figure 2a and 2b show the trends for standardised mortality ratio (SMR) for males and females. The SMR is a ratio of observed death rate to expected death rate. The expected death rates are calculated by applying age specific death rates in England to the area. The SMR allows to assess if mortality rates are different to that for England, taking into consideration the age structure of the area. The rate for England in 2014 is used as the standard (100) to which all other death rates are compared.

Figure 2a: All age all cause SMR trends for males, Newham compared with England and London



Data Source: NHS digital indicator portal –Compendium of population health

Figure 2b: All age all cause SMR trends for females, Newham compared with England and London



Data Source: NHS digital portal Compendium of population health

Table 2 shows the SMR for all cause mortality for the broad age groups. Female mortality in Newham is significantly different from England in the age group 65-74 years. The key causes where Newham has higher deaths rates in females compared with England is coronary heart disease (SMR 168.4 95% CI 117.9 , 233.1) and stroke (SMR 189.7, 95% CI 120-284.6).

Table 2: All cause mortality SMR (95% CI) for broad age range for Newham (2012-2014)

Age group	Male	Female	Persons
All age	107.6 (103-112)*	101.8 (97-106)	104.6 (101.6-108.2)*
Under 75 years	107.8 (101-114)*	104.3 (96-112)	106.4 (101.5-111.6)*
16-64 years	106.7 (98-115)	98.5 (88-109)	103.6 (97.3-110.3)
65-74 years	111.0 (95.6-123.3)	115.8 (102.0-130.3)*	113.0 (104.0-122.3)*
Under 15 years	103.4 (77.8 -134.6)	86.9 (61.9.5-121)	96.5.4 (77.8-118.4)

Source: NHS digital compendium of population health
*denotes significant different from England

Male mortality in Newham is significantly different from England for all age and under 75 years.

The SMR gives an indication of how far the local mortality rates are from England rates. It is a good indicator to describe the inequalities in mortality between areas, taking into consideration the different age structures. SMR does not describe how much mortality is avoidable.

YEARS LIFE LOST

Years of life lost (YLL) is a measure of premature mortality. Its primary purpose is to compare the relative importance of different causes of premature death within a population. It can therefore be used by health planners to define priorities for the prevention of such deaths. It can also be used to compare the premature mortality experience of different populations for a cause of death. The concept of years of life lost is to estimate the length of time a person would have lived had they not died prematurely. By including the age at which the death occurs, rather than just the fact of its occurrence, the calculation is an attempt to better quantify the burden, or impact, on society from the specified cause of mortality. The next section describes years of life lost.

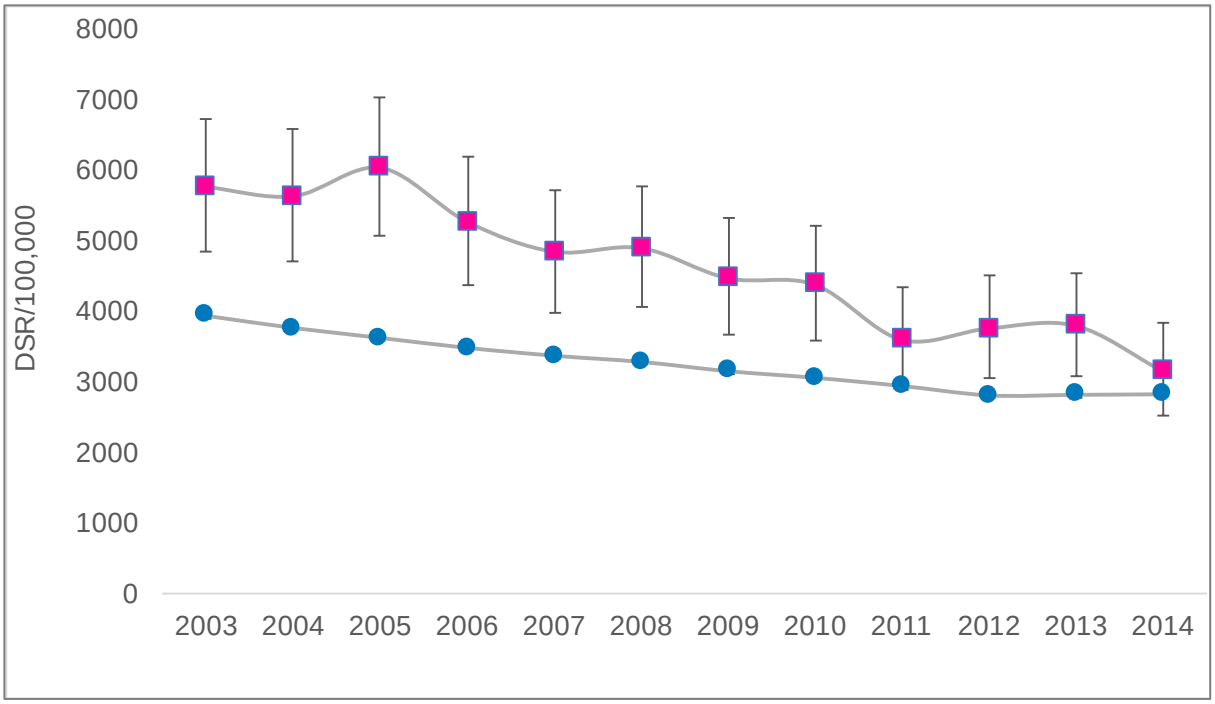
Potential years of life lost (PYLL) from all causes

The NHS framework outcome indicator PYLL an estimate of number of years of life lost by every 100,000 adults aged 20 and over dying from a condition which is usually treatable, (amenable by healthcare) measured in a way which allows for comparisons between populations with different age profiles and over time.

Figure 3 shows a ten year trend in PYLL (persons) for Newham and England. Newham has seen a greater rate of improvement with the inequality gap between Newham and England

reducing over time. In 2014, there was no significant difference between Newham and England PYLL for persons.

Figure 3: Ten year trend in PYLL (persons) for Newham compared with England



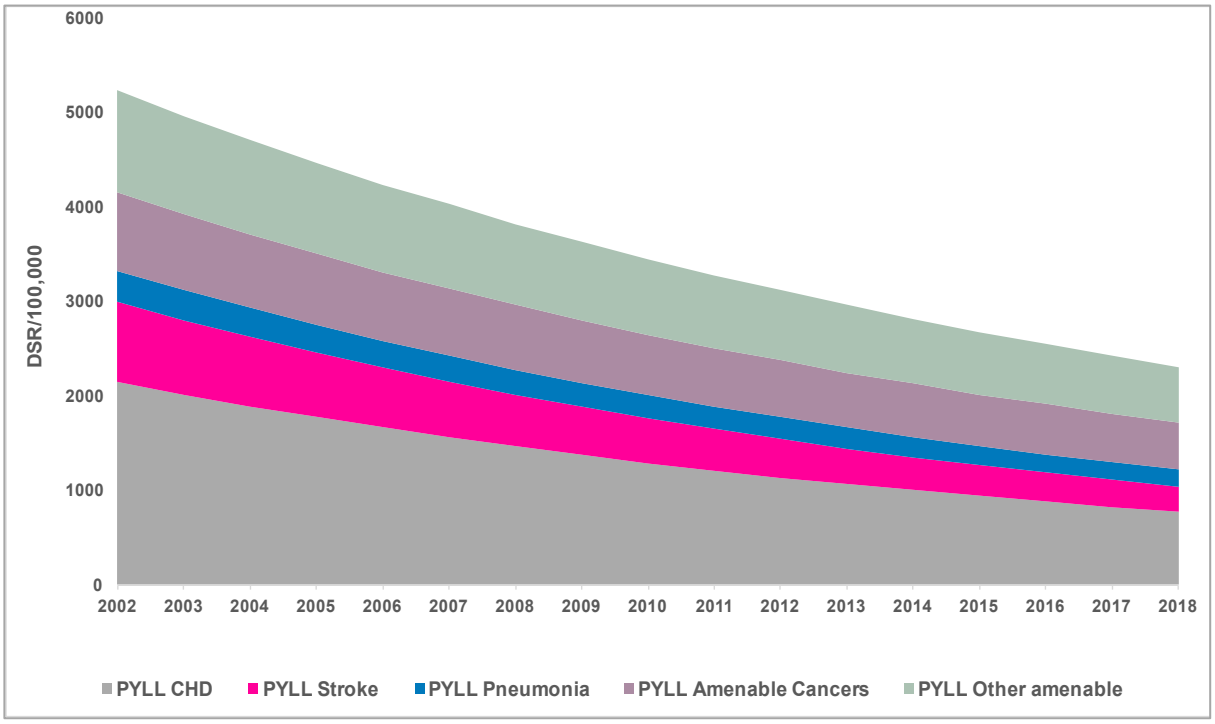
Data Source: NHS indicator portal NHSOF Domain 1

Years life lost by cause

Figure 4 shows the trends in PYLL due to major causes of death in Newham projected to 2018. Figure 5 shows the PYLL due to the key conditions as percentage of total PYLL as projected for 2018 based on current trends.

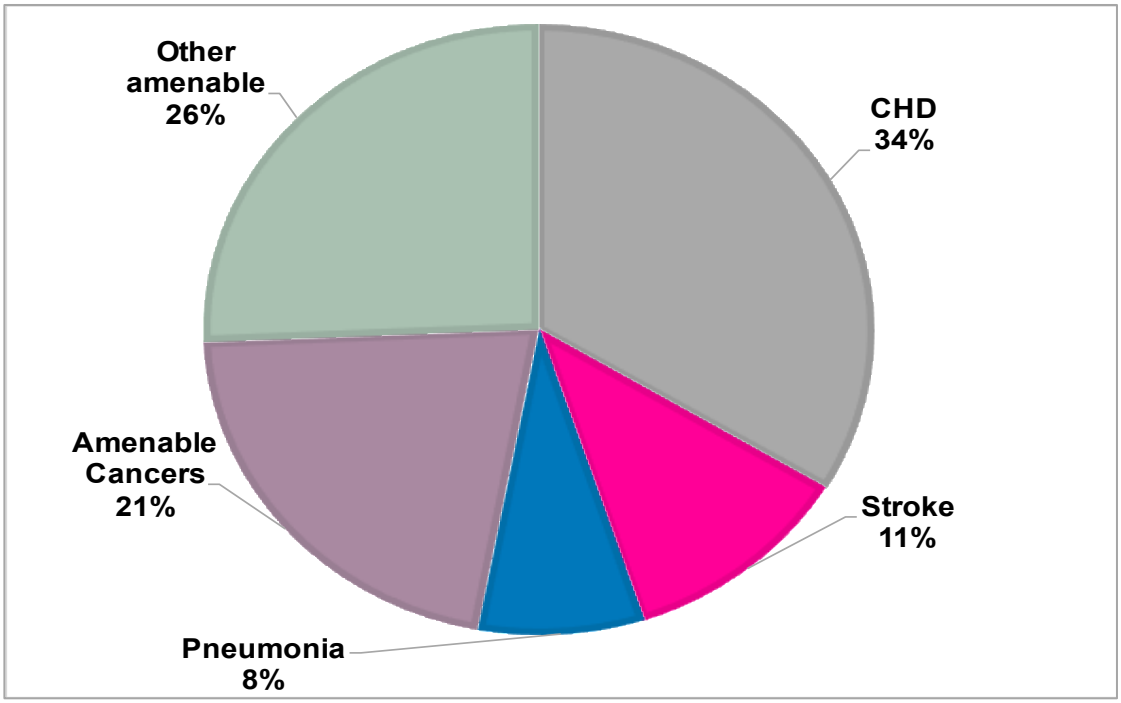
Coronary heart disease, stroke and cancers will continue to be the largest cause of YLL in Newham. This profile is similar with the WHO projected profile for England in 2030 with IHD (CHD) stroke and cancer (lung and colorectal) cancers as the main causes of YLL.

Figure 4: Trends in YLL (persons) by cause projected to 2018



Data Source: PHE data YLL indicator tool

Figure 5: Projected YLL by cause (persons) 2018



Data source NHS digital indicator portal compendium of population health

The sections below provide a YLL for male and females across the north-east London

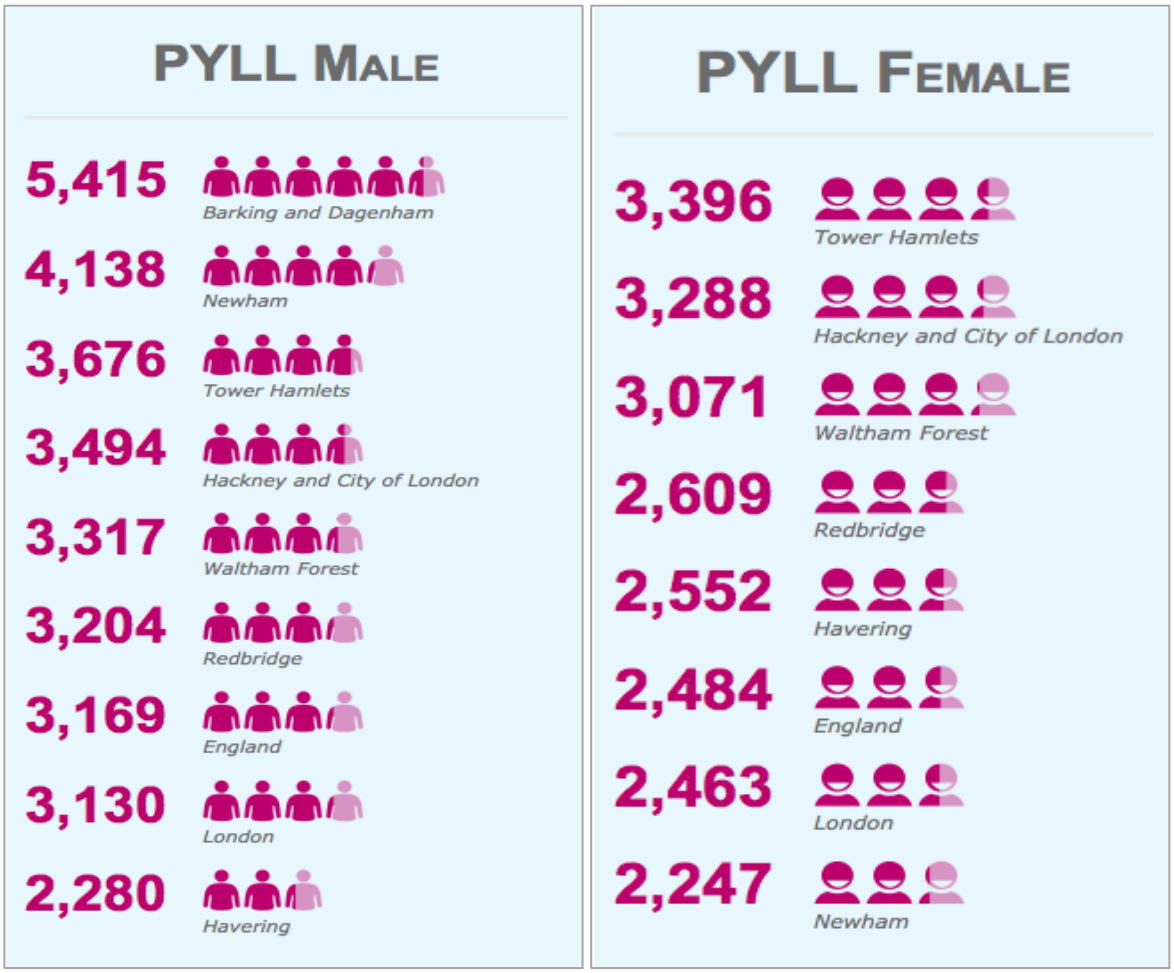
Years of life lost due to circulatory diseases.

Figure 3 shows the YLL for all circulatory conditions for northeast London local authorities, England and London.

Both Male YLL and female YLL in Newham from circulatory diseases is significantly higher than the national and regional YLL.

For males in Newham, coronary heart disease (CHD) caused 61% of all circulatory YLL and stroke a further 13%. For females, CHD contributed 49% of YLL and stroke 30%.

Figure 3: Potential years of life lost directly standardized rates (DSR) per 100,000 population (2014)



Date source: NHS digital indicator portal: NHSOF

Figure 3: YLL (DSR/100,000) from all circulatory conditions (2012-2014 pooled)

Data Source : NHS digital indicator portal Compendium of Population Health Indicators

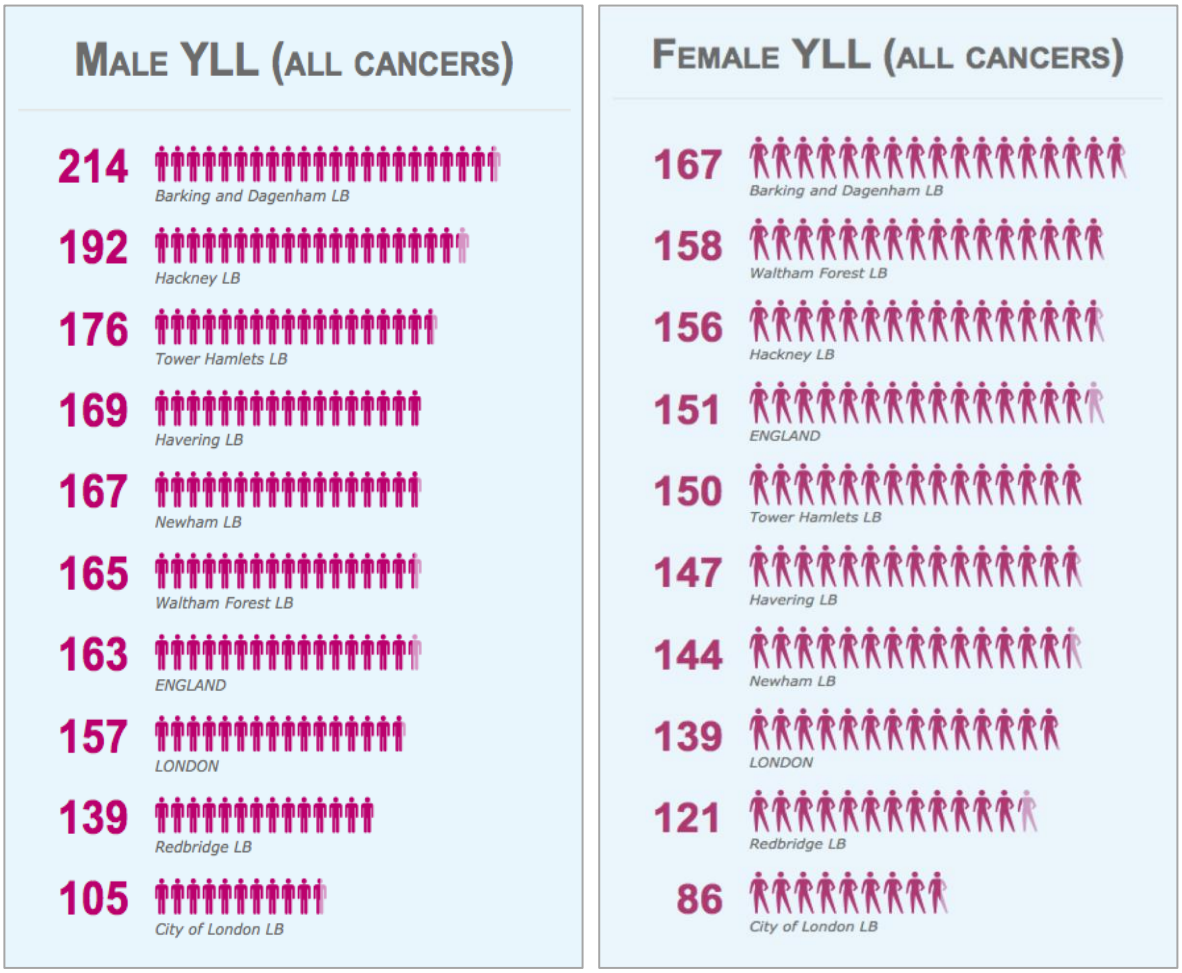
YLL from all cancers

Figure 4 shows the YLL from all cancers. Newham Male YLL from all cancers is significantly higher compared with England and London, whilst Newham female YLL is significantly lower than London and England.

In Newham, lung cancer causes the highest YLL among all cancers in men. It contributes to about one-third of all cancer YLL. Colorectal and stomach cancer contribute about 10% and 7% respectively. Prostrate cancer contributes to less than 5% of YLL.

In women, breast cancer is the largest contributor (26%) of cancer YLL. Lung cancer causes 18% of the YLL and colorectal cancer just above 5%.

Figure 4: YLL (DSR/100,000) from all cancers (2012-2014 pooled)

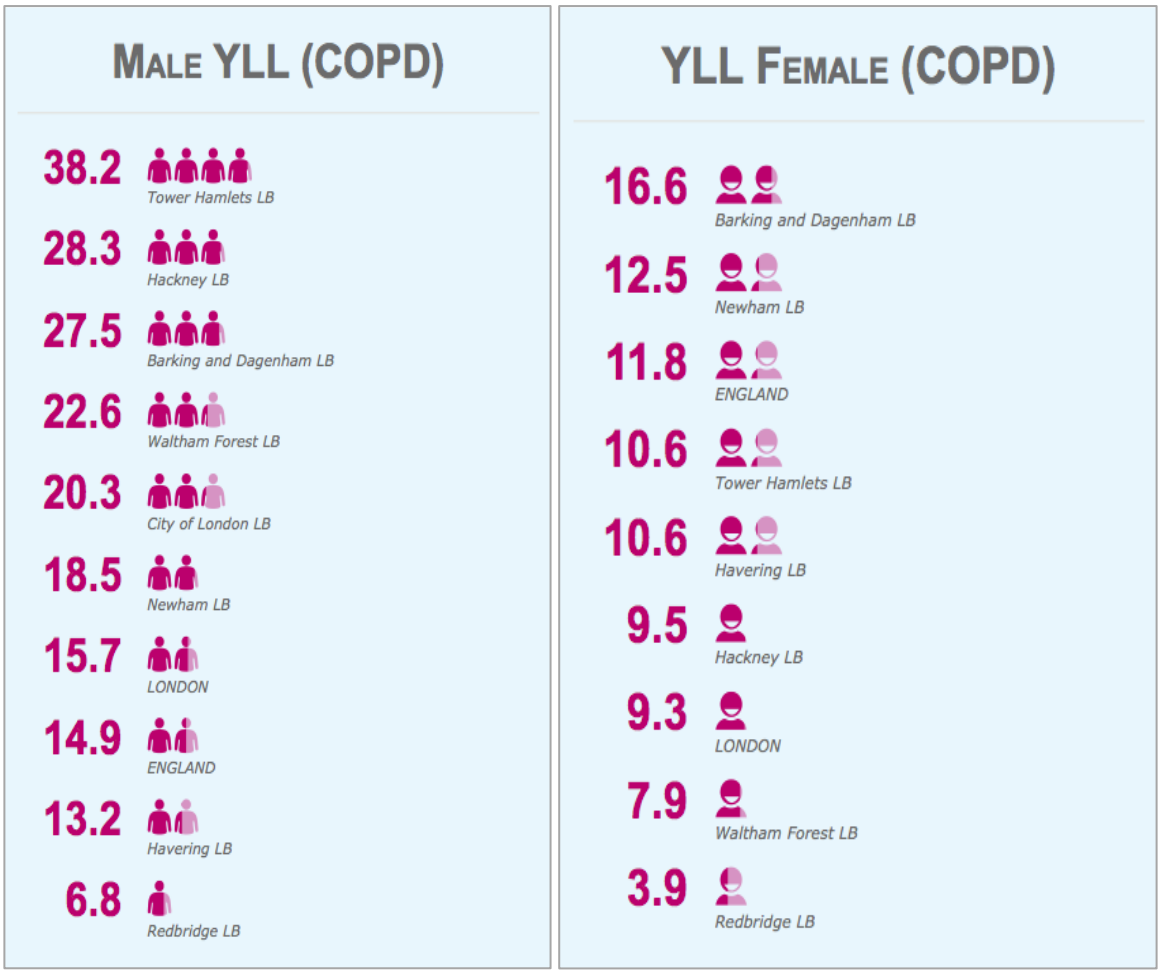


Data Source : NHS digital indicator portal Compendium of Population Health Indicators

YLL from chronic obstructive pulmonary disease (COPD)

Figure 5 shows the YLL due to COPD. Newham Male and female YLL from COPD are significantly higher compared with London and England. Newham male YLL from COPD is significantly higher compare with Newham female COPD.

Figure 5: YLL (DSR/100,000) from all chronic obstructive pulmonary disease (2012-2014 pooled)



Data Source : NHS digital indicator portal Compendium of Population Health Indicators

PREVALENCE AND INCIDENCE

The above section described the years of life lost due to mortality. This section describes the incidence and prevalence of diseases. The epidemiology of each disease is not described here as it will be described in the topic based health needs assessment.

Prevalence of diseases that contribute the greatest burden

Prevalence is the number of people in a given population with a particular condition at a point in time. Prevalence of diseases for local areas is estimated based on national health surveys and the disease registers.

The diagnosed prevalence of a condition calculated from the returns submitted to the Health and Social Care Information Centre (HSCIC) as part of the Quality and Outcomes Framework (QOF) by each GP practice. Diagnosed prevalence is the number of all patients who are on a practice's disease register on 31 March in a given financial year. Practice returns are combined to calculate a prevalence rate for the local CCG.

The estimated prevalence of disease is calculated by applying the national disease prevalence from the health survey of England to the local population taking into consideration age, sex, ethnicity, smoking status and deprivation.

The ratio or difference between the expected and disease register (diagnosed) gives an indication of the potential number of people with a higher risk in the population that may benefit from some preventative intervention for that condition.

Table 3 below gives the disease prevalence in Newham compared with England and London.

Heart failure is included as it is a common and an important complication of coronary heart disease and other conditions. There is good evidence that appropriate treatment including up-titration of ace inhibitors and beta blockers in heart failure due to LVSD can significantly improve symptom control and quality of life, and improve outcomes for patients. Despite this, around a quarter of people with heart failure are undetected and untreated. And amongst those who are diagnosed, there is significant variation in the quality of care.

Atrial fibrillation (AF) is included here as it increases the risk of stroke by a factor of 5, and strokes caused by AF are often more severe with higher mortality and greater disability. Anticoagulation substantially reduces the risk of stroke in people with AF. Despite this, AF is underdiagnosed and under treated: up to a third of people with AF are unaware they have the condition and even when diagnosed inadequate treatment is common – large numbers do not receive anticoagulants or have poor anticoagulant

Diabetes is the most prevalent disease followed by asthma.

Table 3: Prevalence of key causes of YLL

	Newham QoF register %	Newham Expected %	Strategic clinical Network %	England %
Coronary heart disease	1.8%	3.4%	2.1%	3.2%
Heart failure	0.5%	1.1%	0.5%	0.7%
Stroke	0.8%		1.1%	1.7%
Atrial fibrillation	0.5%	1.1%	0.9	1.6
Diabetes (17 + years)	8.0%	10.2%	6.1%	6.4%
COPD (all ages)	0.9%	2.67%	1.1%	1.9%
Asthma (all ages)	4.5%	8.97%	4.6%	5.9%

Data Source : PHE CVD and respiratory disease profiles

Figure 6 shows the number of people that are on disease register (recorded with a diagnosis) and number of people that are undiagnosed based on the expected number from the disease model (all ages) for Newham.

About 78% of the expected diabetic population is diagnosed and recorded on GP practices. There are about 7000 people with undiagnosed diabetes. This, in addition to the 33,000 expected potential numbers of people with non-diabetic hyperglycaemia provides a good insight into the burden of diabetes in the population. The diabetic population is expected to rise to 8,000 to 12,000 in the next 10-15 years.

People with diabetes has a higher risk of cardiovascular complications (heart attack, angina, heart failure and stroke) and end stage kidney disease. Newham diabetic population is at greater risk of developing complications compared with the average for England.

Table 4: Additional risk of complications in diabetic population compared with non-diabetic population

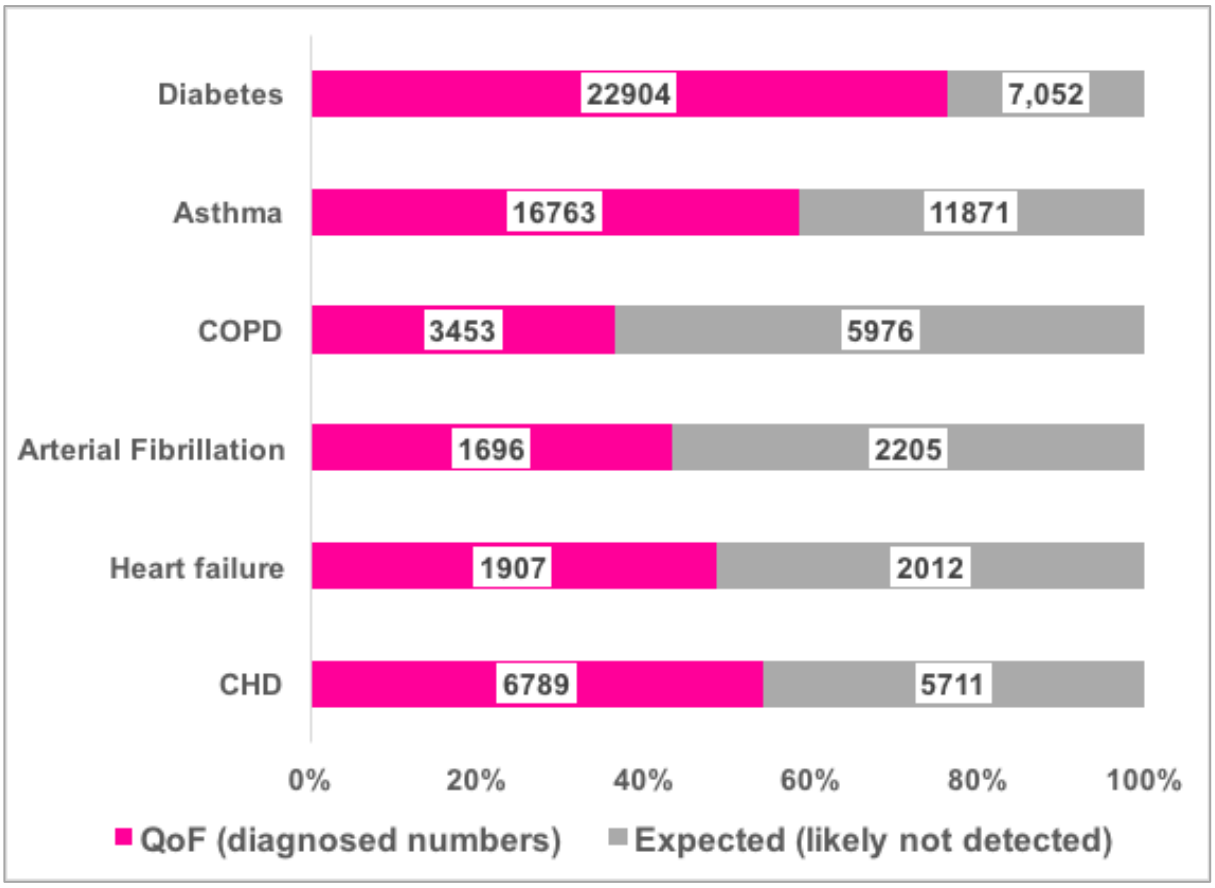
Complication	Additional risk (%) Newham diabetic population	Additional risk (%) England Diabetic population
Angina	198%	137%
Heart Attack	145%	109%
Heart failure	212%	150%
Stroke	84%	81%
Renal Replacement therapy	307%	293%

Data Source: PHE CVD profiles

About 59% of people expected to have asthma are recorded whilst for COPD it is only 39%. For circulatory disease, about 54% of people expected to have CHD are recorded on the disease register, 49% for heart failure and 43% for arterial fibrillation.

This could be an area that may need to be explored further with primary care to explore options of early diagnosis and prevention. Practice variation can be a starting point to investigate that if the practices performed to the best practice within Newham – how much of the avoidable morbidity and mortality could be avoided.

Figure 6: Number of patients with a recorded diagnosis and expected undiagnosed cases by disease in Newham (2015)



Data Source: PHE CVD profiles and CVD primary care intelligence packs

Incidence

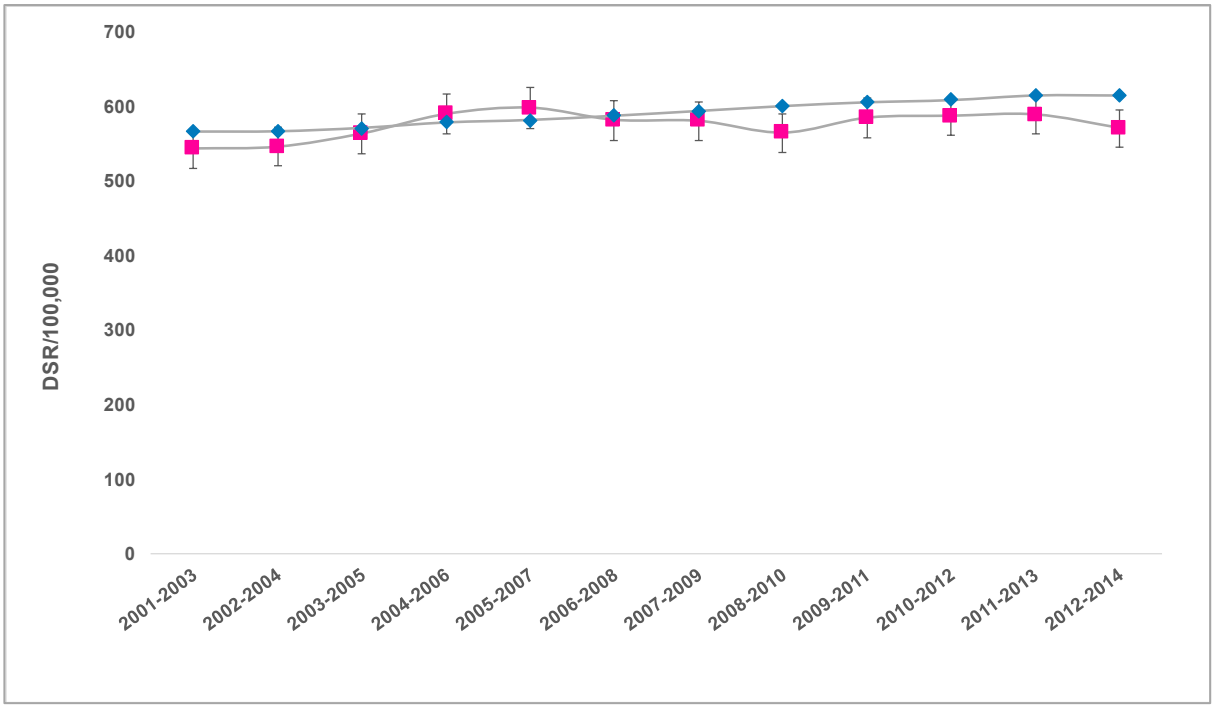
Incidence rates describe new cases diagnosed in an area during a time period. Figure 7 shows the incidence of cancer (all cancers) in Newham compared with England.

The incidence rate for all cancers is lower in Newham compared with England. Similar wth England, the incidence was higher in 2012-14 compared with 2001-2003.

The data on cancer incidence by site for Newham and England are shown in table 4. Breast cancer incidence in Newham, is significantly lower compared with England. The incidence of all other cancers in Newham are similar with that for England.

Most cancers are now treatable with good outcomes if diagnosed and treated early. This will be discussed further in the JSNA on quality of health and care services.

Figure 7: Trends in incidence of all cancers for all ages (DSR/100,000) in Newham CCG and England (all CCGs)



Data Source: Cancer Intelligence network

Table 4: Directly standradised incidence of cancer in Newham compared with national incidence (rate per 100,000) 2012-2014

Site of cancer	Incidence rate per Newham CCG (100,000 standardised population)	National (all CCG) incidence rate(100,000 standardised population)
All cancers	556.6*	614.8
Lung cancer	84.2	79.9
Breast cancer	121.2*	169.9
Bowel cancer	61.4	72.9
Prostrate cancer	201.7	181.4
Cervical	10.0	9.6
Oesophagal	13.0	15.7
Ovarian	18.2	24.0
Stomach	13.4	12.2

Source: Local area statistics from cancer research website
*Significantly lower than England

KEY MESSAGE

The gap in mortality between Newham and England has decreased over the years, although it remained higher for men. For women, the mortality rates were higher compared with England in the 65-74 age group. Newham has also seen a decrease in the potential years of life lost due to conditions that are treatable, which indicates the improvement in healthcare and preventable medicine services.

The healthcare improvements in Newham have contributed to the reduction in inequalities in health outcomes as measured by mortality between Newham and England, there is yet a high burden of disease across the age span that can be prevented. The five key areas are mental health, cancers, cardiovascular disease, musculoskeletal diseases and respiratory diseases. In the younger age groups the burden from mental health and musculoskeletal diseases is higher whilst in the older age, the burden from cancer and cardiovascular disease is higher.

Coronary heart disease remains and is projected to remain the disease which contributes to the greatest (about one third) cause of years of life lost. Diabetes which is one of the key risk factor for heart disease is higher in Newham and the risk of heart disease in people with diabetes is higher in Newham compared with England. To reduce the years life lost due to CHD, it will be necessary to reduce both the risk of diabetes and the risk of complications of diabetes. Stroke, cancers amenable to healthcare and pneumonia are other areas where further improvements will lead to reduction in avoidable deaths.

The prevalence of disease data indicates that most of the diabetes that is expected to be prevalent in the population is diagnosed and recorded. There is under diagnosis of other diseases, respiratory diseases (Asthma and COPD). This has implications for emergency admissions as people unaware and untreated are likely to have first presentation at the emergency services.

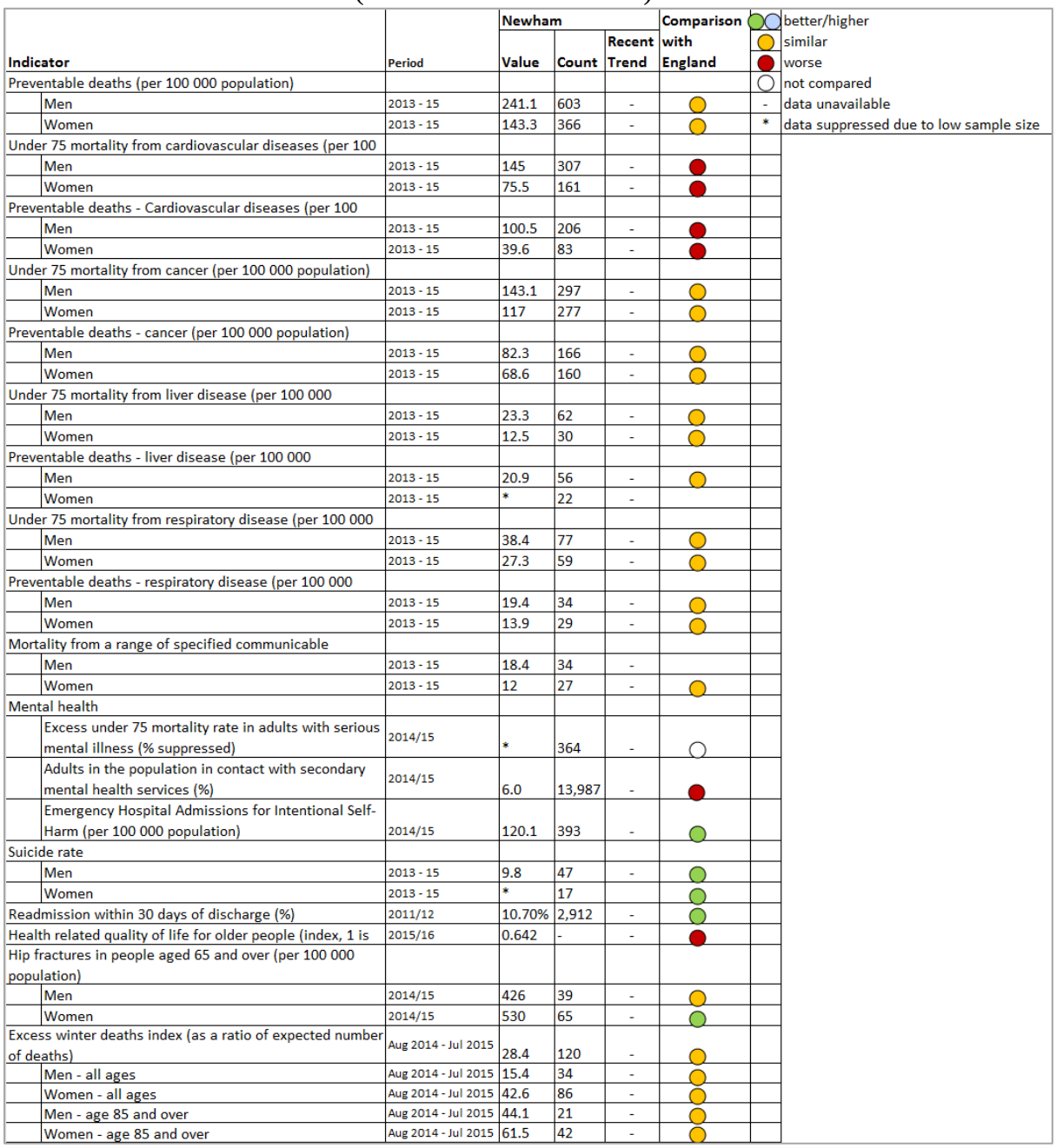
Atrial fibrillation, a risk factor for strokes which are likely to have worst outcomes than non-AF strokes is another underdiagnosed condition. In Newham, 50 % of AF strokes who were not on anticoagulation treatment had moderate to serious disability requiring social assistance, with about 20% of them requiring social care. Another 20% required continuing nursing care.

Under recognised hypertension and non-diabetic hypergylycemia were discussed in the previous chapter. Early recognition (patient awareness) and diagnosis (doctor presentation) of these risk factors and conditions can reduce the burden on health and care services. For example, the wide implementation of the GRASP-AF tool in GP practices for case finding of probable AF patients, pulse checking in appropriate settings such as flu clinics, pharmacists can be explored locally.

PUBLIC HEALTH OUTCOMES FRAMEWORK

Table 5 Performance on PHOF (Public Health Healthcare)

Indicator	Period	Newham Value	Newham Count	Newham Recent Trend	Comparison with England
Preventable deaths (per 100 000 population)					
Men	2013 - 15	241.1	603	-	
Women	2013 - 15	143.3	366	-	
Under 75 mortality from cardiovascular diseases (per 100					
Men	2013 - 15	145	307	-	
Women	2013 - 15	75.5	161	-	
Preventable deaths - Cardiovascular diseases (per 100					
Men	2013 - 15	100.5	206	-	
Women	2013 - 15	39.6	83	-	
Under 75 mortality from cancer (per 100 000 population)					
Men	2013 - 15	143.1	297	-	
Women	2013 - 15	117	277	-	
Preventable deaths - cancer (per 100 000 population)					
Men	2013 - 15	82.3	166	-	
Women	2013 - 15	68.6	160	-	
Under 75 mortality from liver disease (per 100 000					
Men	2013 - 15	23.3	62	-	
Women	2013 - 15	12.5	30	-	
Preventable deaths - liver disease (per 100 000					
Men	2013 - 15	20.9	56	-	
Women	2013 - 15	*	22	-	
Under 75 mortality from respiratory disease (per 100 000					
Men	2013 - 15	38.4	77	-	
Women	2013 - 15	27.3	59	-	
Preventable deaths - respiratory disease (per 100 000					
Men	2013 - 15	19.4	34	-	
Women	2013 - 15	13.9	29	-	
Mortality from a range of specified communicable					
Men	2013 - 15	18.4	34	-	
Women	2013 - 15	12	27	-	
Mental health					
Excess under 75 mortality rate in adults with serious mental illness (% suppressed)	2014/15	*	364	-	
Adults in the population in contact with secondary mental health services (%)	2014/15	6.0	13,987	-	
Emergency Hospital Admissions for Intentional Self-Harm (per 100 000 population)	2014/15	120.1	393	-	
Suicide rate					
Men	2013 - 15	9.8	47	-	
Women	2013 - 15	*	17		
Readmission within 30 days of discharge (%)	2011/12	10.70%	2,912	-	
Health related quality of life for older people (index, 1 is	2015/16	0.642	-	-	
Hip fractures in people aged 65 and over (per 100 000 population)					
Men	2014/15	426	39	-	
Women	2014/15	530	65	-	
Excess winter deaths index (as a ratio of expected number of deaths)	Aug 2014 - Jul 2015	28.4	120	-	
Men - all ages	Aug 2014 - Jul 2015	15.4	34	-	
Women - all ages	Aug 2014 - Jul 2015	42.6	86	-	
Men - age 85 and over	Aug 2014 - Jul 2015	44.1	21	-	
Women - age 85 and over	Aug 2014 - Jul 2015	61.5	42	-	



DATA SOURCES

1. World Health Organisation Global Burden of Disease
   DALY , YLL and YLD estimates 2010-2015
   http://www.who.int/healthinfo/global_burden_disease/estimates/en/index2.html
   Projections from 2015 to 2030
   http://www.who.int/healthinfo/global_burden_disease/projections/en/
2. Institute of Health Metrices
   http://ghdx.healthdata.org/gbd-results-tool
3. NHS digital indicator portal https://indicators.hscic.gov.uk/webview/,

a. Compendium of population health indicators published Dec 2015
    i. Mortality by all causes indirectly standardised rates all age all cause trend (ICD10 A00-Y99)
    ii. Mortality by all causes less than 75 years, 3 year averages 2012-2014 pooled years
    iii. Mortality by all causes 16-64 years 3 year averages 2012-2014 pooled years
    iv. Mortality by all causes less than 15 years, 3 year averages 2012-2014 pooled years
    v. YLL due to mortality from CHD (ICD 10 I20-25), DSR 2012-2014 pooled (Age 1-74 years)

Mortality from all causes – indirectly standardised rates
CCG outcomes indicators domain 1 preventing people from dying prematurely Potential YLL

4. PHE data and analyses tools https://www.gov.uk/guidance/phe-data-and-analysis-tools
   Potential Years of Life Lost tool by disease group
   https://fingertips.phe.org.uk/profile/cardiovascular
   https://fingertips.phe.org.uk/diabetes
   https://fingertips.phe.org.uk/profile/inhale
   https://fingertips.phe.org.uk/profile/health-profiles
   https://www.cancerdata.nhs.uk/dashboard#?tab=Overview

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3. IHME, http://www.healthdata.org/gbd/data-visualizations

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