Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	JSNA Annual Report
Board Lead:	Sue Milner, Interim Director of Public Health
Report Author and contact details:	Ade Abitoye, Interim Head of Public Health Intelligence

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☒ Priority 2: Improved identification and support for people with dementia
- ☒ Priority 3: Earlier detection of cancer
- ☒ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

- Local authorities and clinical commissioning groups have equal and joint duties to prepare Joint Strategic Needs Assessments, through the Health and Wellbeing Board (HWB) in order that the health and social care needs of the population are properly assessed and proper plans and services may be put in place.
- The HWB delegates this function to the Director of Public Health through the Joint Strategic Needs Assessment (JSNA) Steering Group.
- This is the annual report of the JSNA Steering Group to the HWB
- The JSNA work programme is developed by the steering group. A new approach was adopted last year to provide a more streamlined and fit-for-purpose JSNA, which informed the development of a new work programme. The work programme is being delivered and is on track.
- The JSNA now consists of a suite of inter-related web-based products which, taken together, provide an overview of health and social care needs of the borough and one or two carefully chosen 'deep dives' per year.

Health and Wellbeing Board

- Key JSNA resources and products have been published in the last year and more are about to be published.

RECOMMENDATIONS

The Board is asked to:

- Consider this report, the JSNA programme and the progress made
- Suggest any necessary amendments and additions

REPORT DETAIL

Background

In 2015, there was a review of the JSNA work programme and approach. This led the JSNA steering group to make the following key changes:

- The Director of Public Health assumed the chair of the steering group.
- Membership of the group was reviewed and expanded to make it more representative of partners in the local health and wellbeing economy.
- Terms of reference of the group were refreshed.
- A more streamlined work programme was established.

The JSNA Work Programme

The new JSNA approach focused on the production of a number of overarching resources plus undertaking one or two carefully chosen 'deep dives' per year.

The JSNA work programme in the last year (2015/16 till date) is as follows:

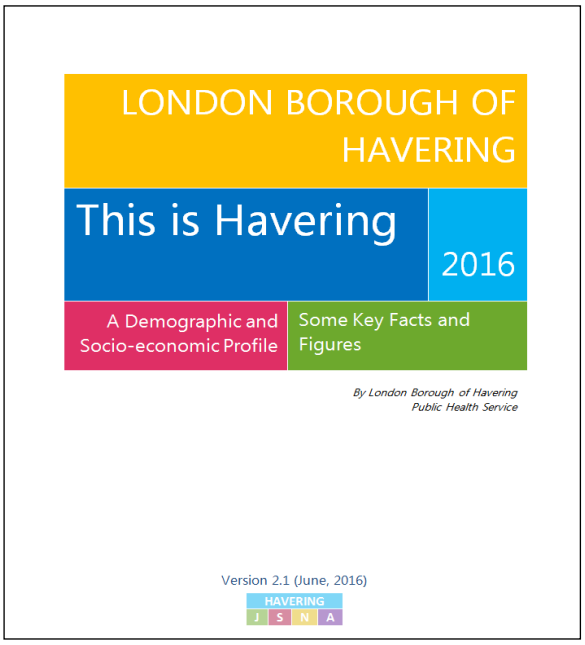
- This is Havering – a demographic and socioeconomic profile
- Overview of Health and Social Care Needs
- Interactive Ward Health Profiles
- Obesity Needs Assessment – *agreed deep dive for 2015/16*
- Special Educational Needs and Disability (SEND) Needs Assessment – *agreed deep dive for 2016/17*
- Diabetes – *agreed potential deep dive for 2016/17*
- Accountable Care Organisation (ACO) Population Health Workstream
- Public Health Outcomes Framework (PHOF) Report and list of (and links to) publicly available profiles/resources

Published JSNA resources and products are available at:
http://www.haveringdata.net/jsna/

This report summarises key features of the work programme.

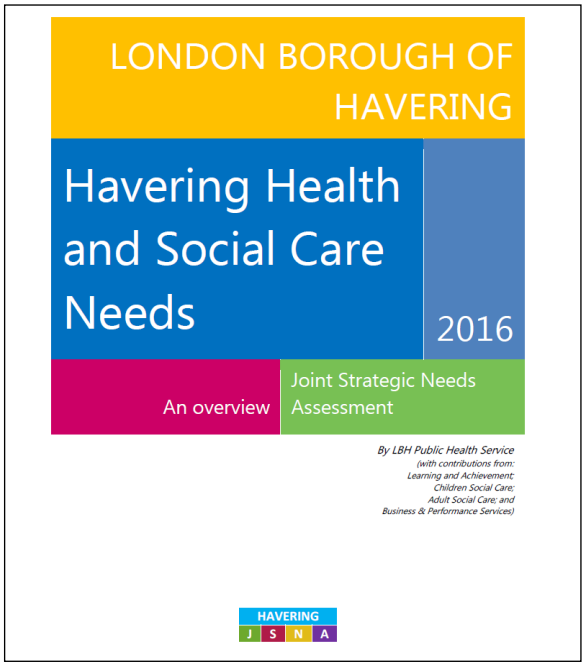
Health and Wellbeing Board

This is Havering – a demographic and socioeconomic profile



- Published originally in September 2015 and updated every quarter.
- Current version was published in June 2016 and the next is due at the end of September.
- It has been adopted as the "one version of the truth" in relation to the *demographic and socioeconomic profile of Havering*
- The product is available in 3 different formats:
    - Main document (front page pictured on the left)
    - PowerPoint Presentation
    - Infographic summary (see attachment a)

Overview of Health and Social Care Needs



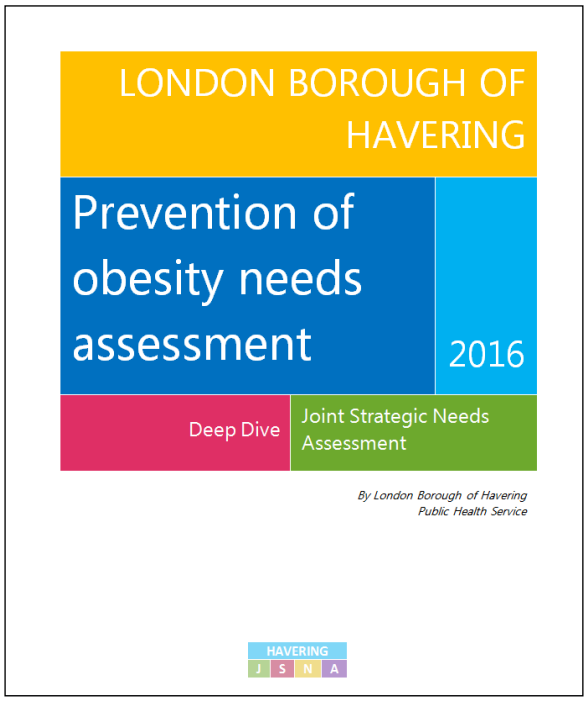
- Published in February 2016 (front page pictured on the left).
- It is updated and improved annually – the next update is due by the end of March 2017.
- The resource provides a summary of Havering's health and social care needs. It describes the pattern of risk factors for ill health, the status of health and wellbeing and how people use local services.

Interactive Ward Health Profiles

- The aim is to provide an informative and interactive insight of ward health and wellbeing issues in Havering
- Councillors were engaged in helping to shape it (see attachment b for presentation provided to councillors who attended the first of three sessions for Members)
- The product is being finalised and should be published by the end of July.
- It will be demonstrated very briefly during the Board meeting.

Health and Wellbeing Board

Obesity Needs Assessment



- Published on the JSNA website in July 2016 (front page pictured on the left).
- It was the agreed 'deep dive' for 2015/16 – more than 100 pages long.
- The Executive Summary of this needs assessment has previously been taken to the Board (as part of a report on the Obesity Strategy).
- It underpins the Obesity Strategy.
- It will underpin the upcoming Annual Director of Public Health Report.

Special Educational Needs and Disability (SEND) Needs Assessment

- Agreed 'deep dive' for 2016/17
- Impending OFSTED visit partly informed its choice.
- Currently underway – a first 'complete' draft (currently more than 100 pages long) almost ready.
- It may be brought to the Board for consideration when completed.

Diabetes Needs Assessment

- Potential second deep dive for 2016/17, which may be done for the tri-borough, i.e. Barking & Dagenham, Havering and Redbridge (BHR), subject to agreement.
- The Havering CCG initially put this forward but it has also been recognised as a priority area across the 3 boroughs based on work done as part of the Accountable Care Organisation (ACO) Population Health workstream.
- Currently on hold. Some discussions and agreements are required before work on this can begin. Work unlikely to start this summer.

ACO (Accountable Care Organisation) Population Health workstream

- On-going support work, as/when required, for the ACO Business Case (Population Health Workstream).
- An example of what has been done under this workstream is a RIGHT care review. Its aim was to identify priority health programmes which offer the best opportunities for improving healthcare for populations, the value that patients receive from their healthcare and the value that populations receive

from investment in their local health system. This was undertaken on a BHR footprint. (see attachment c).

Public Health Outcomes Framework

- A Public Health Outcomes Framework (PHOF) Report has been produced (see attachment d).
- The report is a summary for Havering, which will be updated annually.
- In addition, a list of (and links to) publicly available profiles/resources has been compiled.
- Both to be published to the JSNA website by the end of July 2016.

BACKGROUND PAPERS

The following documents are attached to this report:

a. Infographic summary of “This is Havering – a demographic and socioeconomic profile”
b. Presentation to councillors on Ward Health Profile
c. Right Care Priority Areas Report
d. PHOF Annual Report

This is Havering 2016

An infographic summary of

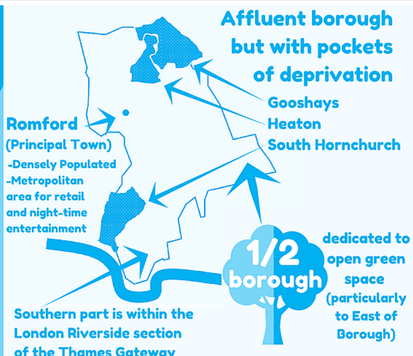
This is Havering: a demographic and socio-economic profile

Main Documents available here: www.haveringdata.net/custom/jsna.htm

GEOGRAPHY

3rd largest borough in London

43 miles² (Size)



POPULATION

Oldest borough in London

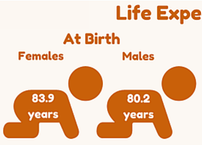
40 years (Median Age)

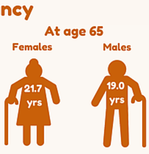
Ethnicity

Country of Birth

90% born in UK

Life Expectancy

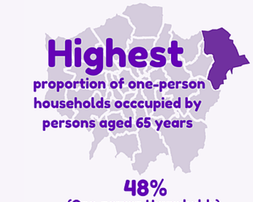




Following a net population loss of 6.3% from 1983 to 2002 the population has increased year on year from 2002, with a 10.7% increase from 2002 to 2015

Population Trend

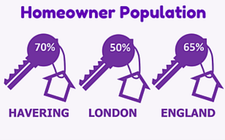
HOUSEHOLD



Highest proportion of one-person households occupied by persons aged 65 years

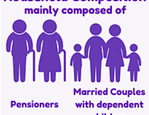
48% (One-person Households)

Homeowner Population

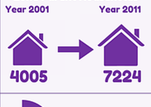


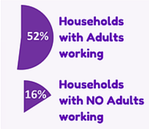
Household Composition

mainly composed of



Lone Parent Households





Bedrooms per household

Statutory Homeless Households

Traveller Caravans on unauthorised sites

Short-term International Migration

32% of elderly population

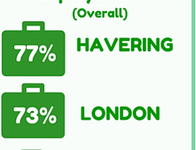
live in one person households

ECONOMY

7th highest proportion of working-age residents in employment in London

78% (Employment)

Employment Rate (Overall)



Out of Work Benefits

Average gross income per household

Car Ownership

Child Poverty

30-33% of children live in poverty*

Children in income-deprived households

HAVERING JSNA

Havering LONDON BOROUGH

Produced by Public Health Intelligence

Havering

LONDON BOROUGH

www.havering.gov.uk

Clean • Safe • Proud

HAVERING 50 YEARS 1965-2015

Ward Health Profile

05 April 2016

Ade Abitoye

Interim Head of Public Health Intelligence

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Havering
LONDON BOROUGH

5-Stage Approach

1. Formulate **the brief**
2. Acquire, prepare and familiarise with **the data**
3. Determine **the editorial focus**
4. Conceive **the visualisation design**
5. Construct, evaluate and launch **the product**

Adapted from Andy Kirk's visualisation design methodology

The brief (I)

Aim

- To provide an informative and interactive insight of ward health and wellbeing issues in Havering

Objectives

- To produce an engaging, informative and interactive Havering-focused ward profile
- To highlight issues within Havering wards in comparison to Borough, England and statistical comparators
- To inform evidence-based decision-making & policy-making & commissioning
- To produce a high-level resolution profile

The brief (II)

Stakeholders

- Councillors, Health and Wellbeing Board, General Public, Council staff (e.g. Children's services, Adult Social Care), Academic Partners, Commissioners, CCG, BHRUT, GPs, Havering Public Health Team, Neighbouring boroughs, London KIT/PHE

Constraints

- No London data, possibly time(?), possible limitation with Tableau Public (?), updating of data (depends on when data becomes available, in what format etc)

The brief (III)

Resources

- Technical - Tableau Desktop software to construct product and (free) Tableau Public to publish it

Project Team

- Public Health Intelligence team: Ade Abitoye, Syed Rahman, Benhildah Dube, Mayoor Sunilkumar (and briefly Hasna Begum & Raza Nadim)
- Advice and feedback also sought from other analysts in the council

The data – Inclusion Criteria

Data for indicators must:

- Be publicly available and at ward level
- Be available at national level (England) for comparator purposes
- Be a measure (not numbers) e.g. rate, percentage, etc
- Have confidence intervals and/or confidence intervals can be calculated
- Be as recent as possible and/or within last 5 years, (if multiple-year average/period should at least include years 2011 or after)
- Add value (e.g. not duplicate another indicator's value)

The data – Indicator set

Indicators currently included are:

- Mainly from PHE Local Health indicator set (from various data sources)
- From some GLA indicators (mainly sourced from Census 2011 data)
- From some other relevant publicly available sources

The editorial focus – Domains

WARD PROFILE TITLE	DOMAIN	INDICATORS WOULD INCLUDE?
1. WHO IS IN THE AREA?	DEMOGRAPHY	**Age, Ethnicity, Languages, Religion, Marital Status, Place of Birth**
2. WHAT BEHAVIOUR CHOICES ARE AFFECTING OUR HEALTH?	LIFESTYLE	**Physical Activity, Sexual Health, Drugs & Alcohol**
3. WHAT OTHER FACTORS ARE AFFECTING OUR HEALTH?	WIDER DETERMINANTS	**Deprivation, Child Poverty, Green Spaces, Housing tenure, Crime Qualification, Employment, Unemployment**
4. WHAT IS MAKING US ILL?	DISEASE & POOR HEALTH	**Prevalence of long-term conditions**
5. WHAT ARE WE DYING OF?	LIFE EXPECTANCY & MORTALITY	**Life Expectancy, Mortality**

The visualisation design

The ward health profile is planned to have four main views:

- Front page
- Ward view
- Domain view
- Indicator view

Overview

FRONT PAGE

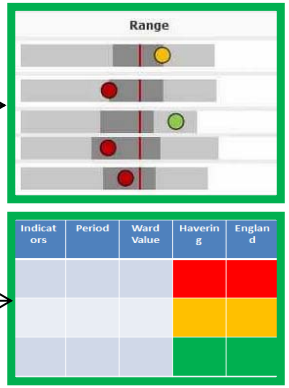
WARD VIEW

What are the priorities for the ward?

Select 1 of 18 Wards

OR

Select Ward



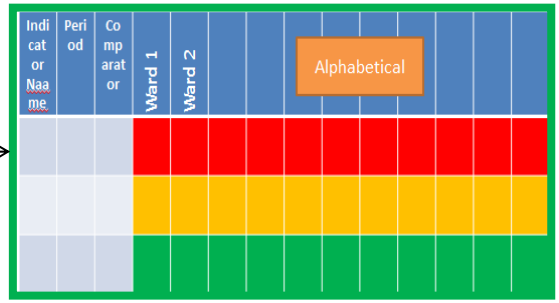
DOMAIN VIEW

What is the variation across wards for different indicators within a domain?

Select 1 of 5 Domains

D1 D2 D3

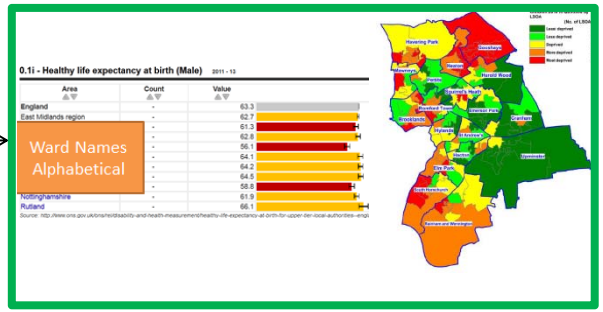
D4 D5



INDICATOR VIEW

What is the variation across wards for a specific indicator?

Select Indicator



The product

- …will now be demonstrated
- Please feel free to ask questions along the way
- Aim is to publish and/or “launch” it before the end of June 2016 or asap afterwards

Contact Details: *ade.abitoye@havering.gov.uk; ☎ 01708 431830*

RIGHT CARE review for ACO CCG area: Barking & Dagenham, Havering and Redbridge CCGs

Summary

The cluster peer group analysis implies the following:

- The programme areas that should be reviewed across the ACO CCG area are:
  - Value for money – diabetes
  - Quality only – diabetes
  - Spend only – gastrointestinal and genitourinary

- Over 100 lives could be saved if the ACO CCG area achieved the scores of the best 5 CCGs in their peer groups
  - Cancer – 48 lives
  - Neurological- 4 lives
  - Circulation – 19 lives
  - Respiratory – 12 lives
  - Gastrointestinal – 9 lives
  - Trauma and Injuries – 8 lives

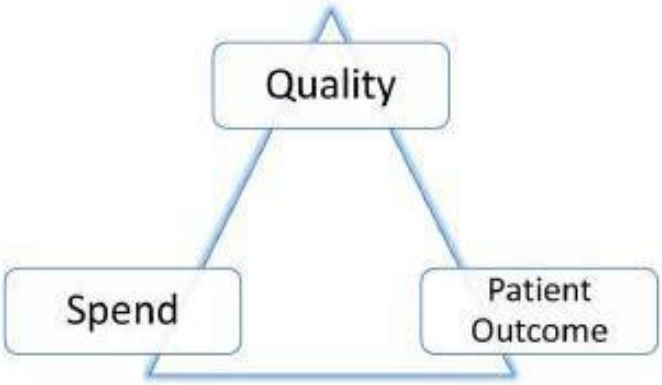
- The greatest savings could be made in the following programmes: GU, GI, Circulation, Respiratory and MSK and combined total (11 programme areas) £36M.
  - In terms of elective spend the potential opportunity is £4.2M if the ACO CCG area achieves the average score for their peer group and at best £11.1M if the ACO CCG area achieves the score of the best 5 CCGs in their peer group.
  - In terms of non-elective spend the potential opportunity is £7.5M if the ACO CCG area achieves the average score for their peer group and at best £15.7M if they achieve the score of the best 5 CCGs in their peer group.
  - In terms of primary care prescribing the potential opportunity is £1.3M if the ACO CCG area achieves the average score for their peer group and at best £7M if they achieve the score of the best 5 CCGs in their peer group.

Commissioning for Value

Commissioning for Value[1] is about identifying priority programmes which offer the best opportunities to improve healthcare for populations; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

Commissioning for Value is not intended to be a prescriptive approach for commissioners, rather a source of insight which supports local discussions about prioritisation and utilisation of resources. It is a starting point for CCGs and partners, providing suggestions on where to look to help them deliver improvement and the best value to their populations. It also supports CCGs to meet their legal duties to have regard to reduce health inequalities.

Figure 1: Elements of value



Source: Commissioning for Value: Where to Look 2016:

The Right Care approach

Examples of the population healthcare and system impact of adopting the Right Care approach include:

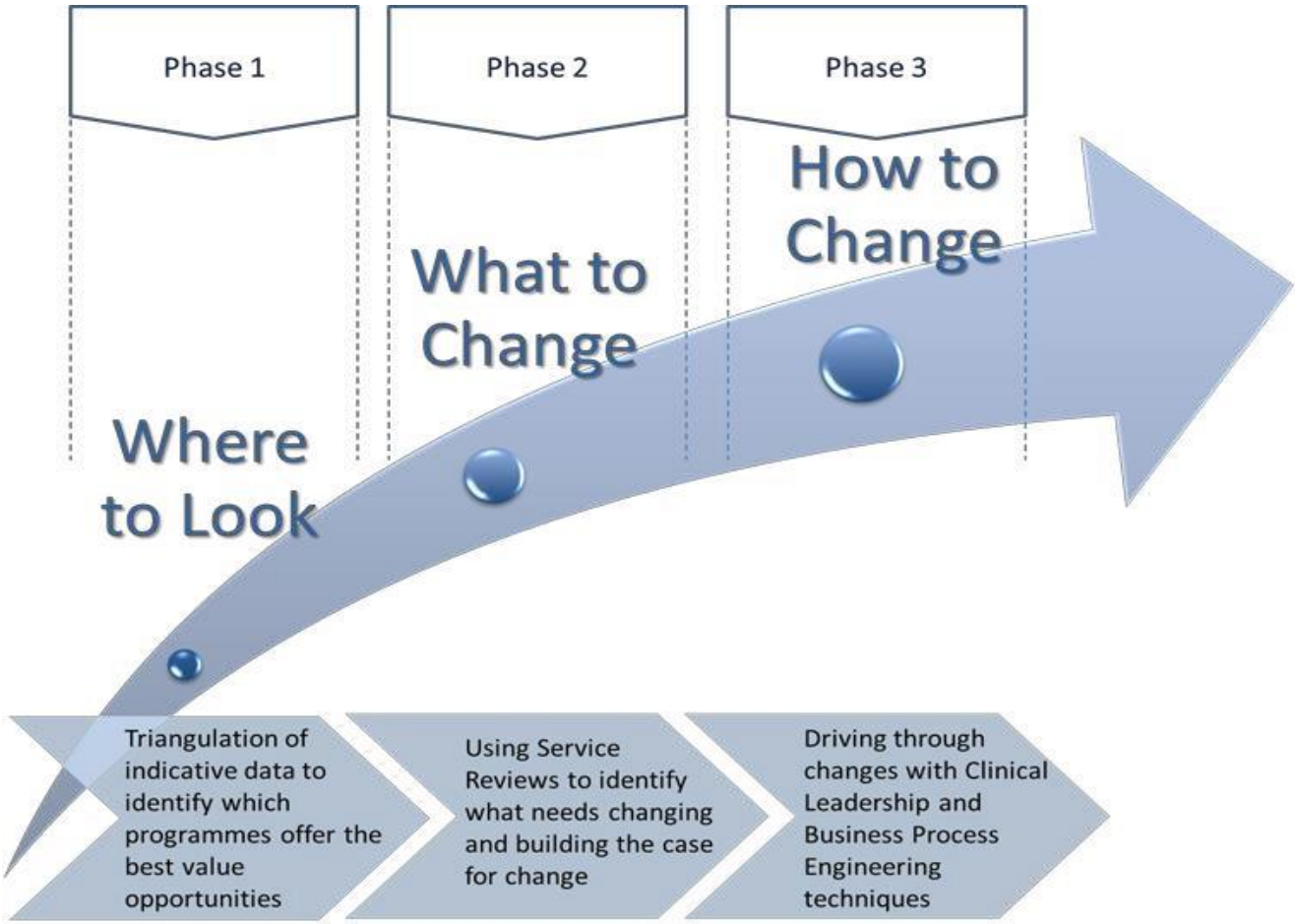
- 1000s more people at risk of or already with Type 2 diabetes detected and being supported with their primary and secondary prevention (Bradford City and Bradford Districts CCGs).
- 36% reduction in GP referrals to acute MSK services via a locally-run triage system using locally derived protocols (Ashford CCG).
- Significant reductions in unplanned activity amongst people with complex care needs via proactive primary care (Slough CCG).
- 30% reduction in COPD emergency activity from a full pathway redesign (Hardwick CCG).
- 98% reduction in calls from frequent callers via enhanced integrated care and pathway navigation (Blackpool CCG).

NHS Right Care provides a number of resources to support healthcare teams nationally, regionally and locally to reduce unwarranted variation and subsequently increase value and improve quality. These include the 2015 NHS Atlas of Variation in Healthcare, the CCG Spend and Outcomes Tool, a Quadrant analysis tool, and updated Commissioning for Value packs for 2016.

[1] Commissioning for Value: Where to Look January 2016 Barking & Dagenham CCG. Gateway ref: 04599; Commissioning for Value: Where to Look January 2016 Havering CCG. Gateway ref: 04599; Commissioning for Value: Where to Look January 2016 Redbridge CCG. . Gateway ref: 04599

The Right Care approach provides a reliable and valid methodology for quality improvement, led by clinicians. The approach begins with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement. Value opportunities exist where a health economy is an outlier and will most likely yield the greatest improvement to clinical pathways and policies. Phases two and three then move on to explore *What to Change* and *How to Change.*

Figure 2: Right Care Methodology



Source: Commissioning for Value: Where to Look 2016:

Phase 1 – Where to Look

Each CCG is clustered with 10 CCGs who have the most similar population. This comparator group is used to identify realistic opportunities to improve health and healthcare for the CCG population. You may find it a powerful improvement tool to compare your opportunities with those of your similar CCGs as part of Phase 1 of the process set out earlier in the pack. By doing so, it may be possible to identify those CCGs which appear to have much better opportunities for populations with similar demographics against both your similar 10 CCGs and the average of the best five performers in the similar CCGs.

CCG performance is compared to the best 5 peer group average to calculate an 'opportunity'. Indicators (100) are a combination of PHOF, QOF and NHSOF and measurable at CCG level. The Clinical Commissioning Group Outcomes Indicators have been selected on the basis that they help contribute to better outcomes across the five domains of the NHS Outcomes Framework.

The spend indicators are based on non-elective, elective and prescribing activity by programme. For mental health spend is based on primary care prescribing

Table 1: Peer CCGs

Barking & Dagenham	*Havering*	*Redbridge*
- Greenwich CCG - Haringey CCG - Waltham Forest CCG - Slough CCG - Enfield CCG - North Manchester CCG - Luton CCG - Birmingham South and Central CCG - Croydon CCG - Sandwell and West Birmingham CCG	- Dudley CCG - Fareham and Gosport CCG - Bromley CCG - Basildon and Brentwood CCG - Solihull CCG - Nottingham North & East CCG - Bexley CCG - South Gloucestershire CCG - Trafford CCG - South East Staffs and Seisdon Peninsular CCG	- Slough CCG - Ealing CCG - Harrow CCG - Barnet CCG - Luton CCG - Birmingham South and Central CCG - Hillingdon CCG - Sandwell and West Birmingham CCG - Hounslow CCG - North Kirklees CCG

Note: London CCGs underlined
Source: Commissioning for Value: Where to Look 2016:

Table 2: List of the indicator areas for each programme budget category

Programme	Indicators
Cancer	breast lung and colorectal, screening(breast and bowel), smoking quitters; mortality
Genitourinary	chronic kidney disease, dialysis, renal replacement therapy
Gastrointestinal	alcohol related admissions, mortality GI and liver disease
Musculoskeletal	hip & knee replacement; fragility fractures ; emergency readmissions
Circulation	coronary heart disease, hypertension, TIA and stroke; mortality; atrial fibrillation; emergency readmissions
Respiratory	COPD, asthma, emergency re admissions, mortality
Endocrine	diabetic care and complications, retinopathy screening
Neurological	Epilepsy- emergency admissions, mortality, drug treatment

Source: Commissioning for Value: Where to Look 2016:

Figure 3 is a summary of priority areas by individual CCG, where 1 is the highest priority and the programme that is the biggest opportunity.

Figure 3: Headline opportunity areas – Outcomes ('Quality'), Spend, and Spend & Outcomes ('Value for money') compared to 5 best of 10 peer CCGs by order of priority for individual CCG, Barking & Dagenham, Havering and Redbridge

Order of priority	Opportunity Area / CCG								
	Outcomes			Spend			Spend & Outcomes		
	Barking & Dagenham	Havering	Redbridge	Barking & Dagenham	Havering	Redbridge	Barking & Dagenham	Havering	Redbridge
1	Musculoskeletal	Gastro-intestinal	Musculoskeletal	Respiratory	Genito-urinary	Genito-urinary	Gastro-intestinal	Gastro-intestinal	Musculoskeletal
2	Gastro-intestinal	Maternity	Endocrine	Gastro-intestinal	Gastro-intestinal	Circulation	Musculoskeletal	Genito-urinary	Genito-urinary
3	Cancer	Endocrine	Circulation	Genito-urinary	Circulation	Gastro-intestinal	Cancer	Circulation	Circulation
4	Endocrine	Circulation	Genito-urinary	Cancer	Respiratory	Endocrine	Endocrine	Endocrine	Endocrine
5	Neurological	Genito-urinary		Endocrine	Musculoskeletal	Musculoskeletal	Neurological	Respiratory	

Data Source: Commissioning for Value: Where to Look 2016:

Headline opportunity area: Outcomes (Quality)
Tri-borough issue: Endocrine
Two borough issue: Gastrointestinal (B, H), Genitourinary (H, R), Circulation (H, R)
Single borough issue: Cancer (B), Neurological (B), Respiratory (H), Musculoskeletal (R).

Headline opportunity area: Spend
Tri-borough issue: Gastrointestinal, Genitourinary
Two borough issue: Endocrine (B, R), Musculoskeletal (H, R), Circulation (H, R)
Single borough issue: Cancer (B), Respiratory (H)

Headline opportunity area: Spend & Outcomes ('Value for money')
Tri-borough issue: Endocrine
Two borough issue: Gastrointestinal (B, H), Genitourinary (H, R), Circulation (H, R), Musculoskeletal (B, R)
Single borough issue: Cancer (B), Neurological (B), Respiratory (H)

Savings opportunity across BHR

Across the ACO area the greatest savings could be made in the following (Top 5) programme areas: GU, GI, Circulation, Respiratory and MSK

Table 3: Scale of savings opportunity across BHR

Disease area	Barking & Dagenham	Havering	Redbridge	Total
Genitourinary(GU)	1,466k	3,068k	2,231k	**6,765K**
Gastrointestinal(GI)	2,001k	2,384k	1,912k	**6,297K**
Circulation Problems	906k	2,480k	2,058k	**5,444K**
Respiratory	2,312k	1,969k	663k	**4,944K**
MSK	1,018k	1,646k	1,194k	**3,858K**
Endocrine, Nutritional and Metabolic	1,132k	861k	1,552k	**3,545K**
Cancer & Tumours	1,186k	1,313k	715k	**3,214K**
Trauma and Injuries	160k	836k	97k	**1,093K**
Neurological	379k	255k	287k	**921K**
Mental Health	288k	0	27k	**315K**
Maternity and Reproductive (primary care prescribing)	20k	0	23k	**43K**
Total	**10,868K**	**14,812K**	**10,759K**	**36,439K**

Source: Commissioning for Value: Where to Look 2016:

Elective admissions

Table 4 shows the savings opportunity with respect to elective admissions. For some programmes the ACO area CCG spend is similar to the average of the peer CCGs; so the potential savings will only arise if they perform at the level of the best 5 peer CCGs.
For example 450 k could be saved in the cancer programme if the ACO area CCGs achieved the score of the best 5 CCGs in their peer group, but no savings if they achieve the average score for the peer group; or as much as 2.7M could be saved in the gastrointestinal category if the ACO area CCGs achieved the score of the best 5 CCGs in their peer group, and 1.7M if they achieved the average score for the peer group.
Across the programme areas listed, the potential opportunity across the ACO CCG area is 4.2M and at best 11.1M.

Table 4 Elective admissions

Programme	Average peer CCGs	Average + Best 5 of peer CCGs
Cancer	0	450k
Endocrine	0	140k
Neurological	0	255k
Circulation	0	460k
Respiratory	995k	1.5 M
Gastrointestinal	1.7M	2.7 M
Musculoskeletal	0	3.2M
Trauma and Injuries	92k	388k
Genitourinary	1.5M	2M
Total	**4.1M**	**11.1M**

Source: Commissioning for Value: Where to Look 2016:

Non- elective admissions

Table 5 shows the savings opportunity with respect to non-elective admissions. For the programme areas listed, the potential opportunity across the ACO CCG area is 7.5M if the average score for peer CCGs is achieved and 15.7M if the score of the best 5 CCGs is achieved.

Table 5 Non-elective admissions

Programme	**Average peer CCGs**	**Average + Best 5 of peer CCGs**
Cancer	1.4M	1.9M
Endocrine	227k	460k
Neurological	0	0
Circulation	1.2M	2.8M
Respiratory	639k	2.5M
Gastrointestinal	1.6M	2.9M
Musculoskeletal	0	1.2M

Programme	Average peer CCGs	Average + Best 5 of peer CCGs
Trauma and Injuries	0	437k
Genitourinary	2.4M	3.5M
Total	**7.5M**	**15.7M**

Source: Commissioning for Value: Where to Look 2016:

Primary care prescribing,

Table 6 shows the savings opportunity with respect to primary care prescribing. For the programme areas listed, the potential opportunity across the ACO CCG area is 1.3M if the average score for peer CCGs is achieved and 7M if the score of the best 5 CCGs is achieved.

Table 6 Primary care prescribing

Programme	Average peer CCGs	Average + Best 5 of peer CCGs
Cancer	0	152k
Endocrine	307k	1.5M
Neurological	82k	379k
Circulation	0	469k
Respiratory	579k	1.4M
Gastrointestinal	280k	950k
Musculoskeletal	12k	1.3M
Trauma and Injuries	45k	169k
Genitourinary	276k	633k
Total	**1.3M**	**7M**

Source: Commissioning for Value: Where to Look 2016:

Quality indicators- quality improvement opportunities by programme budget category

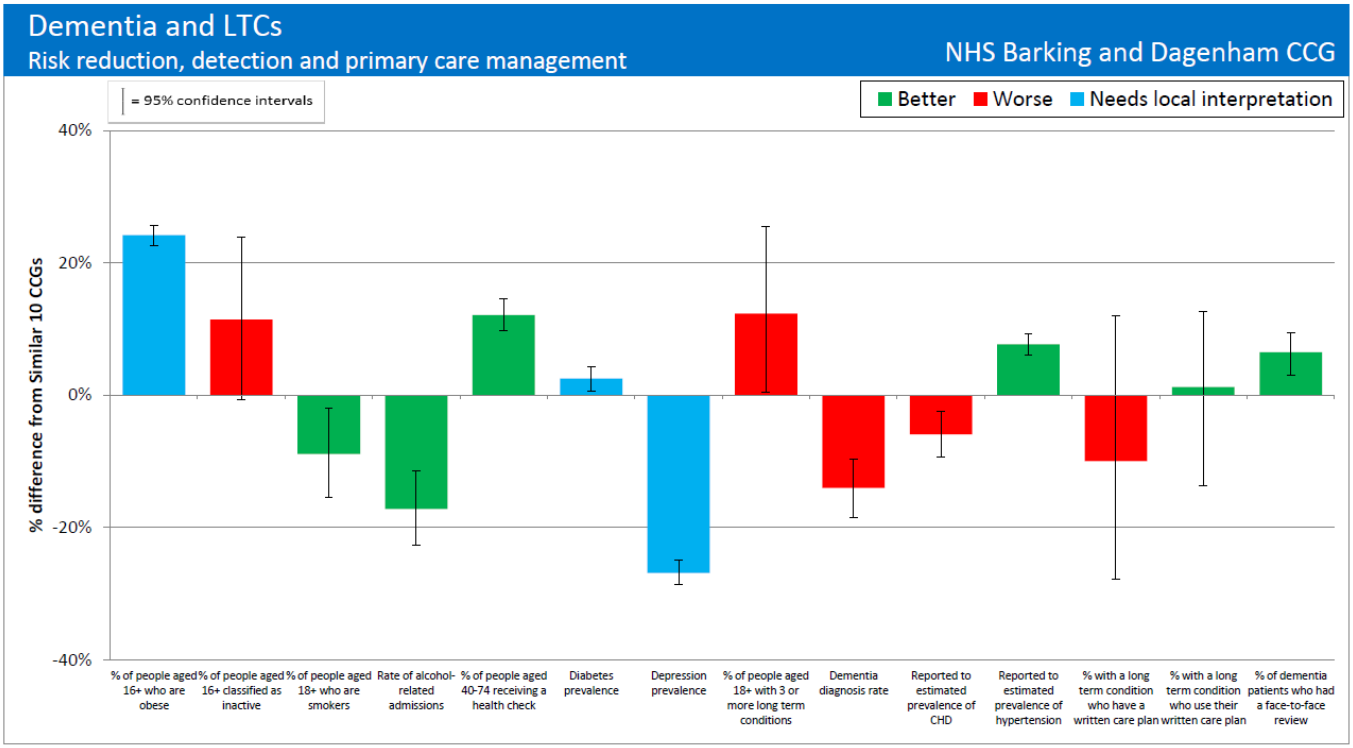
Table 7 shows the opportunity for improvements when quality indicators are compared with peer CCGs. For example 2880 more people need to be screened across the ACO CCG area to match peer CCGs.

Pathways

The pathways produced in the Right Care pack describe graphically the % difference from the average of peer CCGs for the relevant indicators (see Figure 4 Dementia and LTCs pathway as an example).

Table 8 looks at each pathway and the relevant indicators across the ACO CCG area to identify where there is an ACO area opportunity.

Figure 4: Example of a Right Care Pathway



Source: Commissioning for Value: Where to Look 2016:

Healthy London Partnership Right care analysis for NE London

The Healthy London Partnership produced a series of Right Care analysis for NE London[2], to support the development of the Sustainability and Transformation Plans (STP).

The report uses the information from the Right Care Programme but the method of analysis differs from that of the Right Care Approach (Where to look). However, the areas of poor performance across the ACO CCG area align with those highlighted in the original Right Care 2016 report. A summary is included here for information.

ACO CCGs were considered within the bottom quintiles (4th and 5th) compared to England for

- cancer 1 year survival
- place of death indicators
- child weight in 10 - 11 year olds
- antibiotic prescribing
- emergency admissions with dementia
- childhood immunisations
- A&E attendances
- Diabetics receiving NICE recommended care processes

[2] Healthy London Partnership- Right Care Analysis for London, Report for NEL STP Area March 2016

ACO CCGs were considered within the bottom 30% of their peer cluster for

- cancer 1 year survival
- Diabetics receiving NICE recommended care processes
- Rate of Barium enema procedures
- Emergency admissions with dementia

Improvement opportunity for the ACO cluster:

- cancer 1 year survival (all CCGs)
- Rate of emergency admissions to hospital of people with dementia aged 65 years and over
- Rate of COPD emergency admissions to hospital
- Percentage of people aged 16 years and over who were classified as physically inactive
- Child weight age 4-5 years
- hospital admission for heart failure in diabetic patients
- Percentage of people in the National Diabetes Audit (NDA) with Type 1 and Type 2 diabetes who received NICE-recommended care processes
- Rate of mortality in infants aged under one year

So what does the Right Care approach mean for the ACO?

The following is a worked example of a programme identified as an opportunity across all CCGs in the ACO area.

Diabetes (Endocrine)

The Right Care analysis for the ACO CCG area (see Fig 5) indicates that Diabetes (Endocrine programme category) could be improved in terms of value for money and quality of care. The next section describes in brief the added value of an ACO in relation to diabetes care.

There are statistically significant differences between the ACO CCG area and the peer group average for the following indicators:

1. % diabetes patients cholesterol <5 mmol/l
2. % diabetes patients HbA1C is 64mmol/mol
3. % receiving 8 care processes

The risk of stroke is also higher in diabetics within the ACO CCG area but not statistically significant.

There are also a number of other indicators where quality improvements are needed including those described as 'needing local interpretation' such as obesity prevalence, diabetes prevalence, and primary care prescribing.

The expected outcomes would be an additional
1213 diabetic patients with a recorded cholesterol <5mmol/l;
2388 diabetic patients with a recorded HbA1C of 4 mmol/mol
6573 diabetic patients that received the '8 care processes' and
187 less diabetic patients at risk of heart failure

In terms of spends the analysis indicates the following efficiencies:
Elective admissions – 140k
Non-elective admissions – 460k
Primary care prescribing – 1.5M

The ACO response to Diabetes prevention could include:
Primary prevention

1. Consistent offer across the ACO area that addresses lifestyle risk factors for diabetes. This will also lower the risk of developing other conditions such heart disease, cancers and dementia and therefore the demand for services to meet the health and social care needs that arise.
2. Consistent approach to screening ' Health Checks'- targeted with an improvement in uptake and early identification of those at risk (less expensive interventions required to manage at risk patients)
3. Strong proposal to be in the next wave of the National Diabetes Prevention Programme to support 'pre diabetics'

Secondary prevention

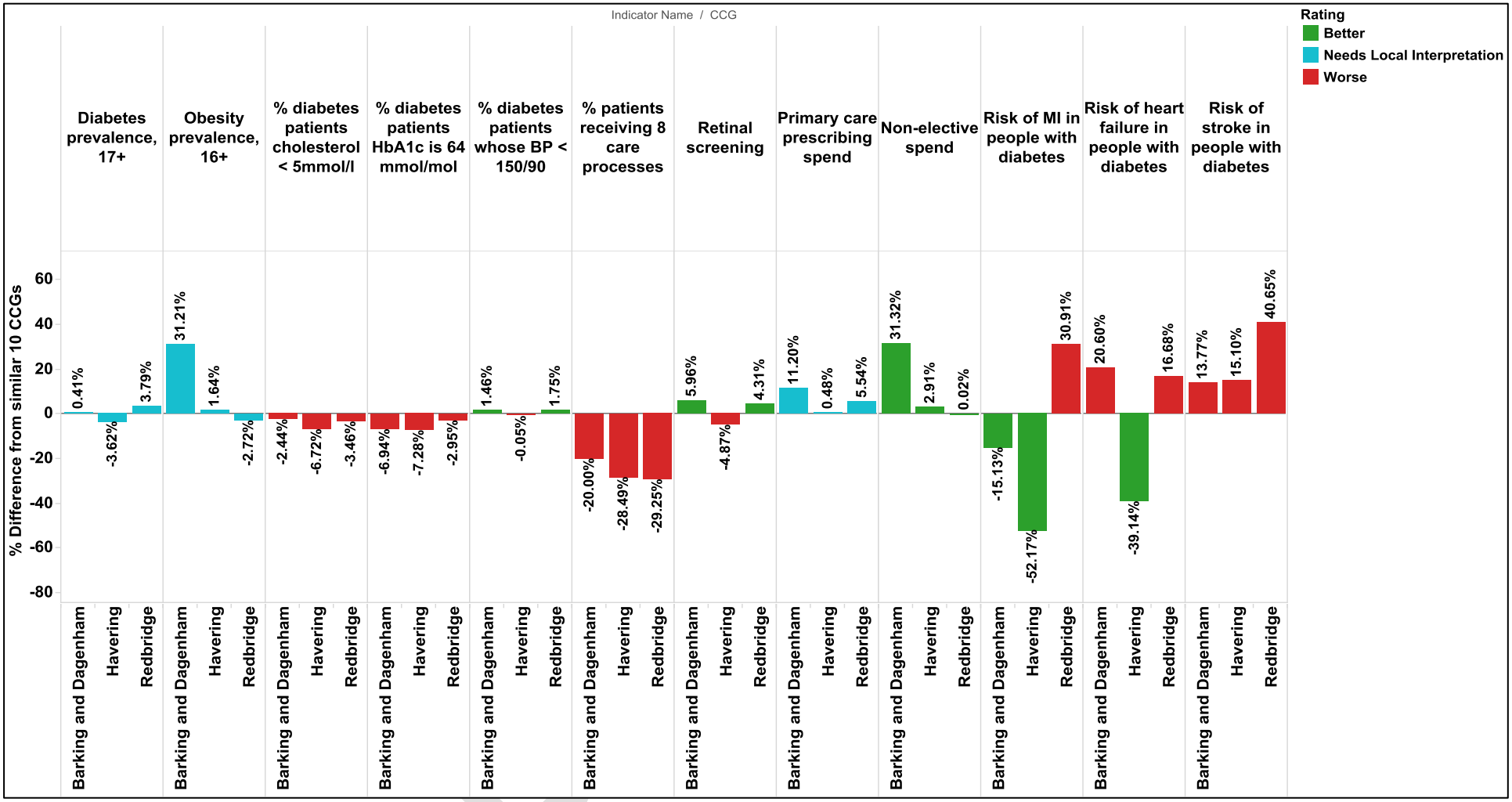
4. Consistent offer in primary care so that there is reduction in variation in quality across the ACO CCG area. This includes completeness of QOF registers for Diabetes; implementation of NICE recommended 8 care processes; lifestyle advice and prescribing/medicines management; diabetic retinopathy screening.
5. Consistent offer in relation to planned and urgent and emergency care. This will include the use of care plans that address the needs of patients with uncomplicated diabetes, those with diabetic complications and those with other long term conditions.

Tertiary prevention

6. Consistent approach to rehabilitation and re-ablement for diabetic patients who have had amputations; visual impairment; strokes etc.

Outcome indicators can be mapped to each aspect of this prevention 'strategy'.

Figure 5 Diabetes Pathway for the ACO CCG area



Data Source: Commissioning for Value: Where to Look 2016:

Table 7: Quality indicators- quality improvement opportunities by programme budget category

The quality indicators show the opportunity for improvements when compared to peer CCG.

Please note that a value of zero means that for the indicator the CCG is doing as well as its peer CCGs.

Disease area	Indicator	Barking & Dagenham	Havering	Redbridge	ACO
Cancer	Receiving 1st definitive treatment within 2 months of urgent GP referral	22	28	21	**71**
	Successful quitters, 16+	112	14	17	**143**
	Bowel cancer screening	878	1361	641	**2880**
Circulation	TIA cases with a higher risk who are treated within 24 hours	11	13	23	**47**
	% hypertension patients whose BP < 150/90	294	0	605	**899**
	Emergency readmissions within 28 days	7	6	10	**23**
Endocrine	% diabetes patients cholesterol < 5 mmol/l	360	914	759	**1213**
	% diabetes patients HbA1c is 64 mmol/mol	702	929	757	**2388**
	% patients receiving 8 care processes	949	1991	3633	**6573**
	Risk of heart failure in people with diabetes	90	0	97	**187**
Gastrointestinal	Emergency admissions for alcohol related liver disease	39	32	0	**71**
Genitourinary	Creatinine ratio test used in last 12 months	339	517	1,108	**1964**
Maternity and Reproductive Health	Teenage conceptions	48	31	0	**79**
	Smoking at time of delivery	148	87	0	**235**
	Live and stillbirths ,2500 grams	0	31	43	**74**
	Breastfeeding initiation (first 48 hrs.)	214	97	234	**545**
	Breastfeeding at 6-8 weeks	406	499	0	**905**
	% receiving 3 doses of 5-in-1 vaccine by age 2	173	333	134	**640**
	% receiving 2 doses of MMR vaccine by age 5	157	281	499	**937**
	Flu vaccine uptake by pregnant women	0	397	196	**593**
Mental Health	Reported to estimated prevalence of dementia	353	441	240	**1034**

Disease area	Indicator	Barking & Dagenham	Havering	Redbridge	ACO
	(%)				
	Assessment of severity of depression at outset	110	0	126	**236**
	Access to IAPT services	860	982	2243	**4085**
	Completion of IAPT treatment	0	200	183	**383**
	Service users on CPA	191	839	486	**1516**
Musculoskeletal Excludes trauma	Hip replacement, EQ-5D index, average health gain	3	0	4	**7**
	% osteoporosis patients 50-74 treated with Bone Sparing Agent	4	0	7	**11**
Neurological	Mortality from epilepsy under 75 years	2	0	2	**4**
Respiratory	Emergency admission rate for children with asthma, 0-18 years	0	21	58	**79**
	% of COPD patients with a record of FEV1	0	175	89	**264**
	% of COPD patients with review (12 months)	0	60	89	**149**
Trauma and Injuries	% fractured femur patients returning home within 28 days	13	0	26	**39**

Source: Commissioning for Value: Where to Look 2016:

Table 8: A review of the indicators by programme pathway for the ACO CCGs (X implies it is an opportunity for the CCG; 0 implies no opportunity)

Pathway	Indicator	Barking & Dagenham	Havering	Redbridge
Breast Cancer	% First definitive treatment within 2 months	X	X	X
	<75 Mortality from breast cancer	X	0	0
Gastrointestinal Cancer	Bowel Cancer Screening	X	X	X
	% First definitive treatment within 2 months	X	X	X
	Lower GI detected at an early stage	X	0	0
Lung Cancer	Successful quitters	X	0	0
	% First definitive treatment within 2 months	X	X	X
	Non elective spend	X	X	0
	Lung cancer detected at an early stage	X	X	X
	<75 Mortality from breast cancer	X	0	X
	1 year survival (breast, lung, colorectal)	X	0	0
Diabetes	% diabetes patients cholesterol <5 mmol/l	X	X	X
	% diabetes patients HbA1C is 64mmol/mol	X	X	X
	% receiving 8 care processes	X	X	X
	Non elective spend	X	X	0
	Risk of heart failure in people with diabetes	X	0	X
	Risk of stroke in people with diabetes	X	X	X
Psychosis	Service users on a CPA	X	X	X
	People on CPA in employment	X	X	X
Common mental health disorder	Assessment of severity of depression at outset	X	0	X
	Access to IAPT	X	X	X
	IAPT- % receiving treatment	X	X	0
	IAPT-% achieving reliable improvement	0	X	X
Heart Disease	Reported to estimated prevalence of CHD	X	X	0
	Non-elective spend	X	X	X

Pathway	Indicator	Barking & Dagenham	Havering	Redbridge
Stroke	% of stroke/TIA patients on anti0platelet agent	0	X	X
	TIA cases treated within 24 hours	X	X	X
	Non-elective spend	X	X	X
	Emergency readmissions within 28 days	X	X	X
COPD	Non-elective spend	X	X	0
	<Mortality from bronchitis, emphysema and COPD	X	X	0
Asthma	% patients (8yrs) with asthma	0	X	X
MSK	% osteoporosis pats 50074 treated with bone sparing agent	X	0	X
	EQ5D health gain	X	0	X
	Hip replacement emergency readmissions 28 days	X	0	X
Trauma and injury	Hip fractures in people aged 65+	X	X	X
	Hip fractures in people aged 80+	X	X	X
	% fractured femur patients returning home within 28 days	X	0	X
Renal	Reported to estimated prevalence of CKD	X	X	X
	Creatinine ration test in last 12 months	X	X	X
	Non-elective spend	X	X	X
	% of patients on RRT who have a transplant	X	X	0
Maternity and early years	Under 18 conception rate	X	X	0
	Flu vaccine	0	X	X
	Smoking at time of delivery	X	X	0
	% LBW babies	X	X	X
	% receiving 3 doses 5 in 1 vaccine	X	X	X
	A&E attendance for <5s	X	X	0
	% children 405 who are overweight	X	X	0
	% receiving 2 doses of MMR by age 5	X	X	X

Source: Commissioning for Value: Where to Look 2016:

Public Health Outcomes Framework 2016

Summary for Havering

Annual Report
Based on May 2016 PHOF Data

Version 1.0
(July 2016)

By London Borough of Havering
Public Health Service

Contents

Introduction

This document summarises performance pertaining to the health and wellbeing of residents of Havering, sourced from Public Health England's Public Health Outcomes Framework.

The Department of Health published the Public Health Outcomes Framework (PHOF) for England 2013-2016 in January 2012. It sets the desired outcomes for Public Health and how outcomes will be measured. The framework consists of 66 outcomes in total: an **overarching domain** (consisting of 2 outcomes) and **four domains** (consisting of the remaining 64 outcomes, covering the full spectrum of public health and the life course) – see Table 1.

Table 1: Public Health Outcomes Framework – domains and outcomes

OVERARCHING	**To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest**
DOMAIN 1	**Improving the wider determinants of health** ***Improvements against wider factors which affect health and wellbeing and health inequalities***
DOMAIN 2	**Health Improvement** ***People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities***
DOMAIN 3	**Health Protection** ***The population's health is protected from major incidents and other threats, whilst reducing health inequalities***
DOMAIN 4	**Healthcare public health and preventing premature mortality** ***Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities***

Source: Public Health Outcomes Framework 2013-2016, Department of Health

Indicators across outcomes

The 66 outcomes of the PHOF consist of a total of 224 indicators. There is more than one indicator associated with some outcomes because there may be a number of sub-indicators (e.g. based on either gender/age).

Table 2 provides a summary of indicator breakdown across the domains.

Table 2: Distribution of number of outcomes and indicators across the different domains of the Public Health Outcomes Framework

	Number of Outcomes	Number of Indicators
Total	66	224
Overarching	2	20
Domain 1: Improving the wider determinants of health	18	52
Domain 2: Health improvement	23	61
Domain 3: Health Promotion	7	25
Domain 4: Healthcare public health and preventing premature mortality	16	66

Source: Public Health Outcomes Framework 2013-2016, Department of Health

Purpose of Report

The main aim of this annual report is to provide an overview of PHOF indicators for Havering compared to England[1] (based on PHOF May 2016 update).[2] However, in many cases, it is advisable to also consider comparisons with other relevant comparators (such as London and boroughs that are most similar to Havering).

Therefore, this report also provides summary information (in the appendix) of Havering indicators that are benchmarked with both England and London averages (to identify if Havering is significantly different); their rank (1 = Best) among London boroughs (out of 32) and statistical comparators (out of 16)[3]; and trend (most recent performance compared to previous years – time period dependent on each indicator).

Overview

164 of 224 PHOF indicators (73%) can be statistically compared with national (England) values as either better or worse.

- 27% of the 164 PHOF comparable indicators (44) for Havering are better than England.
- 20% of the 164 PHOF comparable indicators (32) for Havering are worse than England.
- 54% of the 164 PHOF comparable indicators (88) for Havering are similar than England.

Table 3 provides similar overview for all and individual domains.

[1] *Only 164 of the 224 indicators of the PHOF can be statistically compared with England for significance.*

[2] *PHOF updates are staggered at periodic intervals across the year by Public Health England, with approximately 25% of the data set being updated each February, May, August and November. Resultantly, all of the metrics within the PHOF are updated on an annual basis.*

[3] *Statistical comparators provide a method for benchmarking progress. For each local authority (LA), statistical models designate a number of other LAs deemed to have similar characteristics (e.g. age, demography, geography, socio-economic factors etc). These designated LAs are known as statistical neighbours.*

Table 3: Distribution of indicators that are statistically comparable with England for significance

PUBLIC HEALTH OUTCOMES FRAMEWORK											
	All		Overarching		Domain1		Domain2		Domain3		Domain4	
INDICATORS	164		8		27		48		18		63	
Better	44	27%	5	63%	9	33%	22	46%	1	6%	7	11%
Worse	32	20%	0	0%	3	11%	9	19%	11	61%	9	14%
Similar	88	54%	3	38%	15	56%	17	35%	6	33%	47	75%

Data Source: Public Health England's Public Health Outcomes Framework

Overarching Indicators

5 of the 8 Havering indicators that can be statistically compared with national (England) values are better and the others (3) are similar to England. See Table 4 for these indicators.

In addition, see Appendix 2 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see the Public Health Outcomes Framework website.

Table 4: Overarching Indicators: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Life Expectancy at Birth (M, F) • Life Expectancy at 65 (F) • Gap in Life Expectancy at Birth (M,F)	• Healthy Life Expectancy at Birth (M, F) • Life Expectancy at 65 (M)	

M=Male; F=Female. (M, F) means same indicator but for male and female (counted as 2 indicators)
Data Source: Public Health Outcomes Framework

Domain 1 – Wider Determinants of Health

9 of the 27 Havering indicators (33%) in this domain are better than the national values. Only 3 of the 27 indicators (11%) are worse than the national values (see Table 5).

In addition, see Appendix 3 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see Public Health Outcomes Framework website.

Table 5: Domain 1 - Wider Determinants of Health: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Children in poverty (all dep. children <20) • Children achieving good level of development at end of reception (M,P) • First time entrants to youth justice system • 16-18 year olds NEET[4] • Killed & seriously injured England's roads • Hospital admissions for violence • Complaints about noise • Fuel poverty	• Children in poverty (<16s) • Children achieving a good level of development at the end of reception (F) • FSM Children achieving a good level of development at end of reception (M, F, P) • Year 1 pupils achieving the expected level in the phonics screening check (M,F,P) • FSM Year 1 pupils achieving the expected level in phonics screening check (M,F,P) • Employees who had at least one day off in the previous week • Working days lost due to sickness absence • Utilisation of outdoor space for exercise	• Pupil Absence • Households in temporary accommodation • Adult social care users who have as much contact as they would like

M=Male; F=Female; P=Persons. (M, F, P) means same indicator but for male, female and persons (counted as 3 indicators)

Data Source: Public Health Outcomes Framework

Domain 2 – Health Improvement

22 of 48 Havering indicators (46%) in this domain are better than the national values. 19% (9 indicators) are worse than the national values (see Table 6).

Also see Appendix 4, Appendix 5, and Appendix 6 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see Public Health Outcomes Framework website.

Table 6: Domain 2 - Health Improvement: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years, 0-4 years,15-24 years) • Current smoker prevalence at	• Low birth weight of term babies • Breastfeeding initiation • Smoking status at time of delivery • Conceptions in those aged <	• Excess weight in 4-5 year olds • Excess weight in 10-11 year olds • Population meeting '5-a-day' fruit

[4] NEET - Not in Education, Employment or Training

BETTER ▲	SIMILAR	WORSE ▼
age 15 • Regular smoker prevalence at age 15 • Successful completion of drug treatment - non-opiate users • Admission episodes for alcohol-related conditions - narrow definition (M,F,P) • Breast cancer screening coverage • Cervical cancer screening coverage • Newborn bloodspot screening coverage • Abdominal aortic aneurysm screening • Eligible pop. offered NHS Health Check • Falls injuries people aged 65+ (M,F,P) • Falls injuries people aged 65-79 (M,F,P) • Falls injuries people aged 80+ (F,P)	18 and <16 • Occasional smoker prevalence at age 15 • Excess weight in Adults • Physically active adults • Physically inactive adults • Smoking prevalence • Smoking prevalence - routine and manual • Successful completion of drug treatment - opiate users • People with substance dependence issues entering prison previously unknown to community treatment • Newborn hearing screening coverage • Self-reported wellbeing - low happiness score • Self-reported wellbeing - high anxiety score • Falls injuries people aged 80+ (M)	• Portions of fruit consumed daily • Portions of vegetables consumed daily • Bowel cancer screening coverage • Access to diabetic retinopathy screening programmes • Eligible pop. offered NHS Health Check who received NHS Health Check • Eligible pop. received NHS Health check

M=Male; F=Female; P=Persons. (M, F, P) means same indicator but for male, female and persons (counted as 3 indicators)

Data Source: Public Health Outcomes Framework

Domain 3 – Health Protection

Only 1 of the 18 Havering indicators in this domain is better than the national value. 11 of the 17 indicators are worse than the national values (see Table 7).

In addition, see Appendix 7 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see Public Health Outcomes Framework website.

Table 7: Domain 3 - Health Protection: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Dtap / IPV / Hib (1 year old)	• PCV • Hib / MenC booster 5 years old • HPV • HIV late diagnosis • Treatment completion for TB	• Chlamydia detection rate (15-24 years old) • Dtap / IPV / Hib (2 years old) • Hib / Men C booster (2 years old) • MenC

BETTER ▲	SIMILAR	WORSE ▼
	• Incidence of TB	• PCV booster • MMR for one dose 2 years old and 5 year olds • MMR for two doses (5 years old) • PPV • Flu (aged 65+) and Flu (at risk individuals)

Data Source: Public Health Outcomes Framework

Domain 4 – Healthcare and Premature Mortality

7 of the 63 Havering indicators (11%) in this domain are better than the national values. 9 of 63 indicators (14%) are worse than the national values (see Table 8).

In addition, see Appendix 8 for information on Havering indicators benchmarked against both England and London averages; their rank among London boroughs and statistical comparators; and trend (most recent performance compared to previous years – time period dependent on each indicator). For more information, see Public Health Outcomes Framework website.

Table 8: Domain 4 - Healthcare and premature mortality: significantly better, worse, similar to England

BETTER ▲	SIMILAR	WORSE ▼
• Tooth decay in children aged 5 • Mort. rate causes preventable (M,F,P) • Suicide rate (P) • Hip fractures in people aged 65-79 (F)	• Infant mortality • <75 mort. rate CVD (M,F,P) • <75 mort. rate CVD preventable (M,F,P) • <75 mort. cancer (M,F,P) • <75 mort. cancer preventable (M,F,P) • < 75 mort. liver disease (M,F,P) • <75 mort. liver disease preventable (M,F,P) • < 75 mort. resp disease (M,F,P) • <75 mort. resp disease preventable (M,F,P) • Mortality communicable diseases (M,F,P) • Suicide rate (M) • Emergency readmissions within 30 days of discharge from hospital (P,M) • Preventable sight loss: • AMD, glaucoma, diabetic eye disease • Health related QoL* for older people	• Emergency readmissions within 30 days of discharge from hospital (F) • Preventable sight loss - sight loss certifications • Hip fractures in people aged 65+ (M) • Hip fractures in people aged 80+ (P,M) • EWDI* (single year, all ages) (F) • EWDI* (single year, 85+) (F,P) • EWDI* (3 years, age 85+) (F)

BETTER ▲	SIMILAR	WORSE ▼
	• Hip fractures in people aged 65+ (F,P) • Hip fractures in people aged 65-79 (M,P) • Hip fractures in people aged 80+ (F) • EWDI* (single year, all ages) (M,P) • EWDI* (single year, 85+) (M) • EWDI* (3yrs, all ages) (M,F,P) • EWDI* (3 years, age 85+) (P,M)	

**QoL = Quality of Life; EWDI = Excess Winter Deaths Index*
M=Male; F=Female; P=Persons. (M, F, P) means same indicator but for male, female and persons (counted as 3 indicators)
Data Source: Public Health Outcomes Framework

Other

There are a couple of indicators that are not categorised as significantly better or worse, compared to England, but are categorised as either significantly higher or lower. These are shown below in Table 9.

Table 9: Other Public Health Outcomes Framework indicators (categorised as significantly higher, lower, or similar to England

HIGHER ▲	SIMILAR	LOWER ▼
		• Statutory Homelessness (homelessness acceptances) • Recorded Diabetes

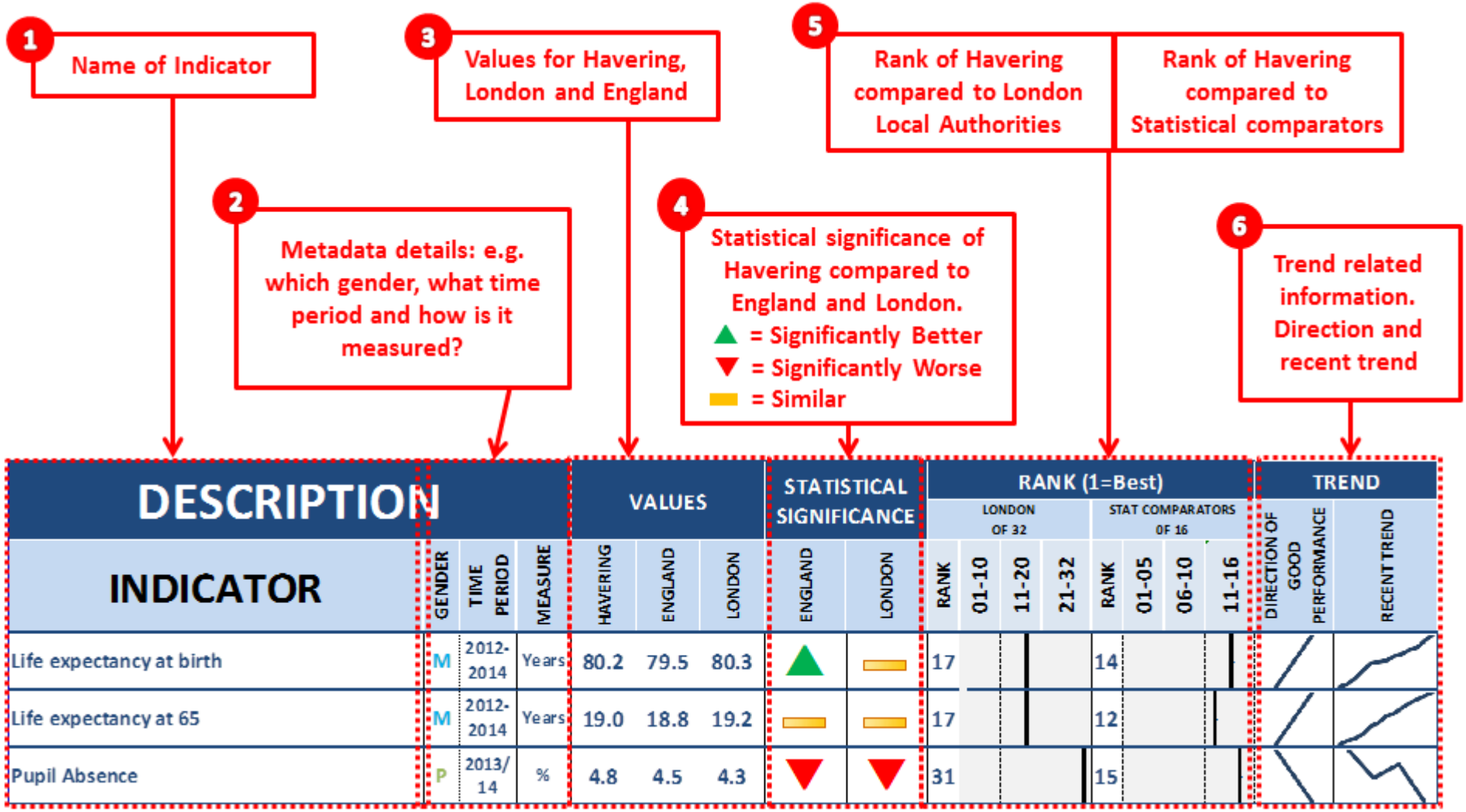
Data Source: Public Health Outcomes Framework

Appendix

Appendix 1: Public Health Outcomes Framework Data Tables

Tables in the appendix provide a summary of those Havering PHOF indicators that are significantly better/worse than England. However, for the table on overarching indicators only, Havering indicators similar to England have also been included.

How to interpret the tables:



DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Life expectancy at birth	M	2012-2014	Years	80.2	79.5	80.3	▲	▬	17				14					
Life expectancy at 65	M	2012-2014	Years	19.0	18.8	19.2	▬	▬	17				12					
Pupil Absence	P	2013/14	%	4.8	4.5	4.3	▼	▼	31				15					

Appendix 2: Overarching indicators

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS 0F 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Healthy life expectancy at birth	M	2012-2014	Years	64.0	63.4	64.0	–	–	18				13					
	F			66.4	64.0	64.1	–	–	6				5					
Life expectancy at birth	M	2012-2014	Years	80.2	79.5	80.3	▲	–	17				14					
	F			83.9	83.2	84.2	▲	–	17				11					
Life expectancy at 65	M	2012-2014	Years	19.0	18.8	19.2	–	–	17				12					
	F			21.7	21.2	21.9	▲	–	17				11					
Gap in life expectancy at birth between each local authority and England as a whole	M	2012-2014	Years	0.7	0.0	0.8	▲	–	16				3					
	F			0.7	0.0	1.0	▲	–	13				4					

Appendix 3: Domain 1 – Wider Determinants

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Children in poverty (all dependent children under 20)	P	2013	%	17.5	18.0	21.8	▲	▲	8				8					
Children achieving a good level of development at the end of reception	P	2014/15	%	68.5	66.3	68.1	▲	▬	13				7					
	M			61.3	58.6	61.1	▲	▬	13				7					
Pupil Absence	P	2013/14	%	4.8	4.5	4.3	▼	▼	31				15					
First time entrants to the youth justice system	P	2014	Rate per 100,000	234.6	409.1	425.7	▲	▲	2				2					
16-18 year olds not in education employment or training	P	2014	%	4.0	4.7	3.4	▲	▼	24				13					
Killed and seriously injured (KSI) casualties on England's roads	P	2012-14	Rate per 100,000	24.1	39.3	29.8	▲	▲	13				10					
Violent crime (including sexual violence) - hospital admissions for violence	P	2012/13-14/15	DSR per 100,000	27.8	47.5	45.9	▲	▲	5				5					
Complaints about noise	P	2013/14	Rate per 100,000	2.7	7.4	17.4	▲	▲	1				1					
Statutory homelessness - households in temporary accommodation	P	2014/15	Rate per 1,000	6.5	2.8	14.0	▼	▲	7				5					
Fuel poverty	P	2013	%	7.5	10.4	9.8	▲	▲	1				1					
Adult social care users who have as much social contact as they would like	P	2014/15	%	39.2	44.8	41.8	▼	▬	9				3					

Appendix 4: Domain 2 – Health Improvement

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Excess weight in 4-5 year olds	P	2014/15	%	23.7	21.9	22.2	▼	▼	25				15					
Excess weight in 10-11 year olds	P	2014/15	%	35.9	33.2	37.2	▼	–	12				10					
Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years)	P	2014/15	Rate per 10,000	76.9	109.6	83.3	▲	–	13				7					
Hospital admissions caused by unintentional and deliberate injuries in children (0-4 years)	P	2014/15	Rate per 10,000	100.2	137.5	100.4	▲	–	17				9					
Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years)	P	2014/15	Rate per 10,000	82.4	131.7	98.6	▲	▲	8				5					
Current smoker prevalence at age 15	P	2014/15	%	5.8	8.2	6.1	▲	–	15				7					
Regular smoker prevalence at age 15	P	2014/15	%	3.5	5.5	3.4	▲	–	16				7					
Population meeting recommended '5-a-day'	P	2015	%	42.1	52.3	49.4	▼	▼	30				16					
Portions of fruit consumed daily	P	2015	Average	2.1	2.5	2.5	▼	▼	31				16					
Portions of vegetables consumed daily	P	2015	Average	2.1	2.3	2.2	▼	▼	24				14					
Successful completion of drug treatment - non-opiate users	P	2014	%	46.1	39.2	39.4	▲	▲	8				6					

Appendix 5: (continued...Pg2) Domain 2 – Health improvement

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Admission episodes for alcohol-related conditions - narrow definition	P	2014/15	Rate per 100,000	429.7	640.8	526.2	▲	▲	2				1					
	M			604.9	826.9	716.8	▲	▲	6				5					
	F			286.1	474.2	358.0	▲	▲	4				3					
Breast cancer screening coverage	F	2015	%	78.7	75.4	68.3	▲	▲	1				1					
Cervical cancer screening coverage	F	2015	%	76.3	73.5	68.4	▲	▲	2				2					
Bowel cancer screening coverage	P	2015	%	50.6	57.1	47.8	▼	▲	11				11					
Newborn bloodspot screening coverage	P	2014/15	%	98.2	95.8	97.2	▲	▲	11				6					
Access to diabetic retinopathy screening programmes	P	2012/13	%	75.5	79.1	77.0	▼	▼	18				9					
Abdominal aortic aneurysm screening	M	2014/15	%	99.8	97.4	99.1	▲	▲	11				7					
Eligible population offered an NHS Health Check	P	2013/14-14/15	%	39.8	37.9	44.6	▲	▼	21				7					
Eligible population offered an NHS Health Check who received an NHS Health Check	P	2013/14-14/15	%	43.3	48.9	48.1	▼	▼	22				12					
Eligible population who received an NHS Health check	P	2013/14-14/15	%	17.2	18.6	21.5	▼	▼	26				10					

Appendix 6: (continued...Pg3) Domain 2 – Health improvement

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Admission episodes for alcohol-related conditions - narrow definition	P	2014/15	Rate per 100,000	429.7	640.8	526.2	▲	▲	2				1					
	M			604.9	826.9	716.8	▲	▲	6				5					
	F			286.1	474.2	358.0	▲	▲	4				3					
Injuries due to falls in people aged 65 and over	P	2014/15	DSR per 100,000	1677.6	2124.6	2253.4	▲	▲	2				1					
	M			1512.6	1739.8	1932.7	▲	▲	5				2					
	F			1842.7	2509.5	2574.2	▲	▲	1				1					
Injuries due to falls in people aged 65 and over - aged 65-79	P	2014/15	DSR per 100,000	689.2	1012.0	1137.7	▲	▲	1				1					
	M			625.9	825.7	1026.1	▲	▲	2				2					
	F			752.5	1198.2	1249.3	▲	▲	1				1					

Appendix 7: Domain 3 – Health Protection

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS 0F 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Chlamydia detection rate (15-24 year olds)	P	2014	Rate per 100,000	1383	2313	2035	▼	▼	26				10					
Population vaccination coverage - Dtap / IPV / Hib (1 year old)	P	2014/15	%	95.2	94.2	90.6	▲	▲	2				1					
Population vaccination coverage - Dtap / IPV / Hib (2 years old)	P	2014/15	%	92.3	95.7	92.5	▼	▬	21				12					
Population vaccination coverage - MenC	P	2012/13	%	92.0	93.9	89.9	▼	▲	10				7					
Population vaccination coverage - Hib / Men C booster (2 years old)	P	2014/15	%	91.2	92.1	86.8	▼	▲	3				2					
Population vaccination coverage - PCV booster	P	2014/15	%	90.9	92.2	86.4	▼	▲	2				1					
Population vaccination coverage - MMR for one dose (2 years old)	P	2014/15	%	90.4	92.3	87.3	▼	▲	5				4					
Population vaccination coverage - MMR for one dose (5 years old)	P	2014/15	%	93.3	94.4	90.7	▼	▲	7				4					
Population vaccination coverage - MMR for two doses (5 years old)	P	2014/15	%	85.5	88.6	81.1	▼	▲	10				5					
Population vaccination coverage - PPV	P	2014/15	%	67.3	69.8	64.9	▼	▲	9				5					
Population vaccination coverage - Flu (aged 65+)	P	2014/15	%	70.7	72.7	69.2	▼	▲	10				5					
Population vaccination coverage - Flu (at risk individuals)	P	2014/15	%	47.9	50.3	49.8	▼	▼	20				9					

Appendix 8: Domain 4 - Healthcare and premature mortality

DESCRIPTION				VALUES			STATISTICAL SIGNIFICANCE		RANK (1=Best)								TREND	
									LONDON OF 32				STAT COMPARATORS OF 16					
INDICATOR	GENDER	TIME PERIOD	MEASURE	HAVERING	ENGLAND	LONDON	ENGLAND	LONDON	RANK	01-10	11-20	21-32	RANK	01-05	06-10	11-16	DIRECTION OF GOOD PERFORMANCE	RECENT TREND
Tooth decay in children aged 5	P	2011/12	Mean DMFT per child	0.5	0.9	1.2	▲	▲	4				6				\	
Mortality rate from causes considered preventable	P	2012-14	DSR per 100,000	159.3	182.7	169.5	▲	▲	9				8				\	↘
	M			202.7	230.1	219.0	▲	▬	11				10				\	↘
	F			120.7	138.4	124.7	▲	▬	14				10				\	↘
Under 75 mortality rate from all cardiovascular diseases	P	2012-14	DSR per 100,000	68.5	75.7	78.7	▲	▲	8				6				\	↘
Suicide rate	P	2012-14	DSR per 100,000	6.5	8.9	7.0	▲	▬	9				9				\	∿
Emergency readmissions within 30 days of discharge from hospital	F	2011/12	ISR	12.1	11.5	11.7	▼	▬	21				10				\	↗
Preventable sight loss - sight loss certifications	P	2013/14	Rate per 100,000	56.6	42.5	30.2	▼	▼	32				16				\	∿
Hip fractures in people aged 65 and over	M	2014/15	DSR per 100,000	554.6	425.1	394.5	▼	▼	32				16				\	/
Hip fractures in people aged 65 and over - aged 65-79	F	2014/15	DSR per 100,000	192.3	311.6	269.9	▲	▬	4				2				\	\
Hip fractures in people aged 65 and over - aged 80+	P	2014/15	DSR per 100,000	1852.2	1534.6	1367.5	▼	▼	32				16				\	↗
	M			1524.5	1174.1	1026.3	▼	▼	31				15				\	/
Excess winter deaths index (single year, all ages)	F	Aug-13 - Jul-14	Ratio	27.5	13.2	12.9	▼	▼	32				16				\	∿
Excess winter deaths index (single year, age 85+)	P	Aug-13 - Jul-14	Ratio	36.5	15.8	18.5	▼	▼	30				16				\	∿
	F			54.7	15.5	19.2	▼	▼	32				16				\	∿
Excess winter deaths index (3 years, age 85+)	F	Aug-11 - Jul-14	Ratio	39.9	22.5	25.1	▼	▼	31				16				\	∿