

HEALTH & ADULTS SCRUTINY SUB- COMMITTEE

Monday, 8 July 2019 at 6.30 p.m.

Committee Room One - Town Hall Mulberry Place

This meeting is open to the public to attend.

Members:

Chair: Councillor Kahar Chowdhury
Vice-Chair: to be appointed.

Councillor Shad Chowdhury, Councillor Marc Francis, Councillor Denise Jones, Councillor Gabriela Salva Macallan and Councillor Andrew Wood

Substitutes:

Councillor Shah Ameen, Councillor Zenith Rahman and Councillor Helal Uddin

Co-opted Members:

David Burbidge (Healthwatch Tower Hamlets Representative)

[The quorum for this body is 3 voting Members]

Contact for further enquiries:

Rushena Miah - Democratic Services
1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, E14 2BG
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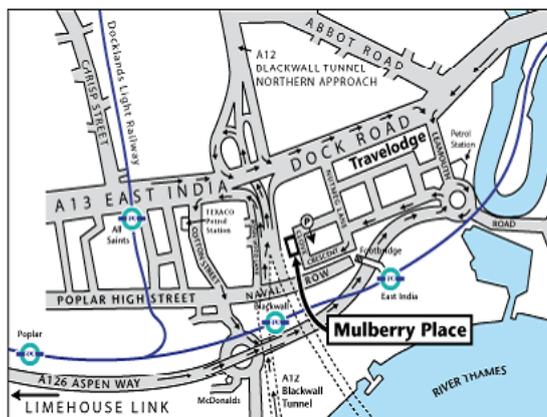
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APOLOGIES FOR ABSENCE

- 1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS 5 - 8**

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Monitoring Officer.

- 2. HEALTH & ADULTS SCRUTINY SUB-COMMITTEE TERMS OF REFERENCE, MEMBERSHIP AND DATES OF MEETINGS 2019/20 9 - 18**

- 3. APPOINTMENT OF VICE-CHAIR**

For the Committee to appoint a Vice-Chair.

- 4. APPOINTMENT OF INEL JHOSC REPS**

For the Committee to appoint one INEL JHOSC representative and one substitute INEL JHOSC representative.

- 5. REPORTS FOR CONSIDERATION:**

- 6. Healthy Life Expectancy in Tower Hamlets - Annual Public Health Report of the Director of Public Health 2018 19 - 72**

- 7. Adult Social Care Charging Impact Assessment - Follow-Up 73 - 90**

- 8. ANY OTHER BUSINESS**

Next Meeting of the Sub-Committee

The next meeting of the Health and Adults Scrutiny Sub-Committee will be held on Monday, 2 September 2019 at 6.30 p.m. at Town Hall Mulberry Place.

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Agenda Item 1

DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:

Asmat Hussain, Corporate Director of Governance & Monitoring Officer,
Telephone Number: 020 7364 4800

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	<p>Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member.</p> <p>This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.</p>
Contracts	<p>Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority—</p> <p>(a) under which goods or services are to be provided or works are to be executed; and</p> <p>(b) which has not been fully discharged.</p>
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	<p>Any tenancy where (to the Member's knowledge)—</p> <p>(a) the landlord is the relevant authority; and</p> <p>(b) the tenant is a body in which the relevant person has a beneficial interest.</p>
Securities	<p>Any beneficial interest in securities of a body where—</p> <p>(a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and</p> <p>(b) either—</p> <p>(i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or</p> <p>(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.</p>

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<p>Non-Executive Report of the:</p> <p>Health & Adults Scrutiny Sub-Committee</p> <p>8 July 2019</p>	 <p>TOWER HAMLETS</p>
<p>Report of: Asmat Hussain – Corporate Director of Governance</p>	<p>Classification: Unrestricted</p>
<p>Health & Adults Scrutiny Sub-Committee Terms of Reference, Quorum, Membership and Dates of Meetings 2019/20</p>	

<p>Originating Officer(s)</p>	<p>Rushena Miah – Committee Officer</p>
<p>Wards affected</p>	<p>All</p>

Executive Summary

This report sets out the Terms of Reference, Quorum, Membership and Dates of Meetings of the Health & Adults Scrutiny Sub-Committee for the Municipal Year 2019/20 for the information of Members of the Children and Education Scrutiny Sub-Committee.

Recommendations:

The Health & Adults Scrutiny Sub-Committee is recommended to:

1. Note its Terms of Reference, Quorum, Membership, and Dates of future meetings as set out in the appendices of this report.

1. REASONS FOR THE DECISIONS

- 1.1 This report is for the information of the sub- committee and no specific decisions are required.

2. ALTERNATIVE OPTIONS

- 2.1 This is not applicable to a report for noting

3. DETAILS OF THE REPORT

- 3.1 At the Annual General Meeting of Council held on 15 May 2019, the Authority approved the review of proportionality, establishment of the Committees, Panels of the Council and the appointment of Members. It delegated authority to the Overview and Scrutiny Committee to establish its sub-committees.
- 3.2 The Overview and Scrutiny Committee met on the 20 May 2019 and agreed to set up three sub-committees, including this one, on which occasion they agreed the terms of reference for all three sub-committees. The groups have since submitted their nominations for membership which have been agreed by the Corporate Director for Governance.
- 3.3 It is within tradition that following the Annual General Meeting of the Council at the start of the Municipal Year, at which various committees are established, that those committees note their Terms of Reference, Quorum and Membership for the forthcoming Municipal Year. These are set out in the appendices of the report.
- 3.4 The Sub-Committee's meetings for the remainder of the year have been agreed by the Corporate Director for Governance and are set out in Appendix 3 of this report.
- 3.5 Meetings are scheduled to take place at 6.30pm except where the meeting falls within the month of Ramadan where they will aim to take place at 5.30pm. The Sub-Committee may wish to discuss an appropriate start time that suits it's Members at the first meeting of the Sub-Committee.
- 3.6 It may be necessary to convene additional meetings of the Sub-Committee should urgent business arise. Officers will consult with the Chair and Members as appropriate.

4. EQUALITIES IMPLICATIONS

- 4.1 Not applicable to this report.

5. OTHER STATUTORY IMPLICATIONS

5.1 This section of the report is used to highlight further specific statutory implications that are either not covered in the main body of the report or are required to be highlighted to ensure decision makers give them proper consideration. Examples of other implications may be:

- Best Value Implications,
- Consultations,
- Environmental (including air quality),
- Risk Management,
- Crime Reduction,
- Safeguarding.
- Data Protection / Privacy Impact Assessment.

5.2 Not applicable.

6. COMMENTS OF THE CHIEF FINANCE OFFICER

2. This report recommends that the Health & Adults Scrutiny Sub-Committee note its Terms of Reference, Quorum, Membership, and Dates of future meetings as set out in appendices 1 & 2. There are no direct financial implications arising from this report.

6.1

7. COMMENTS OF LEGAL SERVICES

7.1 Sections 244-247 of the National Health Service Act 2006 govern the Council's health scrutiny function. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Regulations"), which are aimed at supporting local authorities to discharge their scrutiny functions effectively. The Council has the power to review and scrutinise matters relating to the planning, provision and operation of the health service in the area and can make recommendations and require a response from NHS bodies. The terms of reference, quorum, membership and dates of meetings are consistent with the legal framework and Part 3.3.4, Part 4.5 and Article 6 of the Council's Constitution.

Linked Reports, Appendices and Background Documents

Linked Report

- None.

Appendices

- Appendix 1 – Health & Adults Scrutiny Sub-Committee Terms of Reference.
- Appendix 2 – Proportionality and Membership of Health & Adults Scrutiny Sub-Committee

- Appendix 3 – Meeting procedure and dates of meeting.

Local Government Act, 1972 Section 100D (As amended)

List of “Background Papers” used in the preparation of this report

List any background documents not already in the public domain including officer contact information.

- None.

Officer contact details for documents:

N/A

Health and Adults Scrutiny Sub-Committee

Summary Description: The Health and Adults Scrutiny Sub-Committee has been established to undertake the Council's responsibilities in respect of Scrutinising local health services and adult social care, covering services provided by the Council as well as those provided by the Council's partners.	
Membership: 6 non-executive councillors – the chair and five councillors.	
Functions	Delegation of Functions
1. Reviewing and/or scrutinising decisions made or actions taken in connection with the discharge of the Council's health and adult social care functions	None
2. Advising the Mayor or Cabinet of key issues/questions arising in relation to health and adult social care reports due to be considered by the Mayor or Cabinet	None
3. Making reports and/or recommendations to the Council and/or Mayor or Cabinet in connection with the discharge of health and adult social care functions	None
4. Delivering (3) by organising an annual work programme, drawing on the knowledge and priorities of the Council, registered providers and other stakeholders, that will identify relevant topics or issues that can be properly scrutinised	None
5. Holding service providers to account, where recent performance fails to meet the recognised standard, by looking at relevant evidence and make recommendations for service improvements	None
6. Considering health and adult social care matters affecting the area or its inhabitants, including where these matters have been brought to the attention of the sub-committee by tenant and resident associations, or members of the general public	None
7. The sub-committee will report annually to the Overview and Scrutiny Committee on its work	None
8. To discharge the Council's Scrutiny functions under the National Health Service Act 2006 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Including to: <ul style="list-style-type: none"> • Review and scrutinise matters relating to the health service within the Council's area and make reports and recommendations in accordance with any regulations made thereunder; • Respond to consultation exercises undertaken by an NHS body; and • Question appropriate officers of local NHS bodies in relation to the policies adopted and the provision of services. 	None
Quorum: Three voting Members	
Additional Information: Is contained in: <ul style="list-style-type: none"> • Constitution Part A Section 9 (Overview and Scrutiny Committee and 	

Scrutiny Sub-Committees / Panels

- Constitution A Part 1.6 and Article 6 (Overview and Scrutiny Committee and Scrutiny Sub-Committees / Panels)
- Constitution A Part 3.3.4 (Health Scrutiny Sub-Committee)
- Constitution A Part 4.5 (Overview and Scrutiny Rules)

LONDON BOROUGH OF TOWER HAMLETS
SCRUTINY COMMITTEE MEMBERSHIPS 2019- 2020
AS AGREED BY THE CORPORATE DIRECTOR FOR GOVERNANCE

HEALTH & ADULTS SCRUTINY SUB-COMMITTEE (Seven members of the Council)			
<i>Labour Group (6)</i>	<i>Conservative Group (1)</i>	<i>Ungrouped (0)</i>	<i>Co-opted Members (6)</i>
Councillors: Kahar Chowdhury (Chair) Shad Chowdhury Marc Francis Denise Jones Gabriela Salva Macallan Andrew Wood <u>Substitutes</u> Councillors: Zenith Rahman Helal Uddin Cllr Shah Ameen	Councillor Andrew Wood Substitutes:- Councillor Peter Golds	N/A	David Burbidge (Healthwatch Representative) 1 vacant position

Quorum: The quorum for the committee is 3.

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HEALTH & ADULTS
SCRUTINY SUB-COMMITTEE

MEETING PROCEDURE AND SCHEDULE OF MEETING DATES
2019 -2020

1. Chair and Membership

- 1.1 Sub-Committees will be chaired by a Member of the Overview and Scrutiny Committee. For this Sub-Committee it will be the Lead Scrutiny Member for Health & Adults for 2019/20. The membership of the Health and Adults Scrutiny Sub-Committee has been determined by the Overview and Scrutiny Committee.

2. Frequency of meetings

- 2.1 The Health and Adults Scrutiny Sub-Committee will meet 5 times a year. The following dates are available in the Corporate Diary for 2019/20:

- Monday 8 July 2019
- Monday 2 September 2019
- Tuesday 5 November 2019
- Thursday 12 March 2020
- Tuesday 28 April 2020

Meetings are scheduled to take place at 6.30pm (unless they fall during the month of Ramadan where they will endeavour to start at 5.30pm). The Sub-Committee may arrange other meetings as and when necessary to consider any urgent issues as well as arranging meetings for detailed scrutiny reviews and challenge sessions.

Support to the Sub-Committee

- 4.1 The Divisional Director for Strategy, Policy and Performance, will be the senior officer lead and champion the work of the Sub-Committee.
- 4.2 The servicing of meetings will be undertaken by the Council's Democratic Services Team which will include:
- (a) Meeting room bookings, refreshments
 - (b) Agenda preparation and dispatch

- (c) Taking minutes and recording of actions/decisions
- (d) Dissemination of minutes and decisions

The Health and Adult Care Strategy and Policy Team will provide policy support to the Sub-Committee which will include:

- (e) Research and analysis
- (f) Work programme development
- (g) Support with undertaking reviews and challenge sessions
- (h) Drafting review reports and challenge sessions

5. Proceedings

5.1 The Health and Adults Scrutiny Sub-Committee will generally meet in public and conduct its proceedings in accordance with the rules and procedure contained in the Council's Constitution such as the:

- (a) Council Procedure Rules
- (b) Access to Information Procedure Rules, and
- (c) The Overview and Scrutiny Procedure Rules.

<p>Non-Executive Report of the:</p> <p>Health and Adults Scrutiny Sub-Committee</p> <p>8 July 2019</p>	 <p>TOWER HAMLETS</p>
<p>Report of: Denise Radley - Corporate Director, Health, Adult and Community Services</p>	<p>Classification: UNRESTRICTED</p>
<p>Report Title: Healthy Life Expectancy in Tower Hamlets - Annual Public Health Report of the Director of Public Health 2018</p>	

<p>Originating Officer(s)</p>	<p>Somen Banerjee, Director of Public Health</p>
<p>Wards affected</p>	<p>All wards</p>

Executive Summary

The Annual Public Health Report for 2018 focusses on the Healthy Life Expectancy Figures for Tower Hamlets. Healthy Life Expectancy is a high level indicator of the Strategic Plan.

The report was presented to the Health and Wellbeing Board on the 14th of January 2019 and was aimed at initiating discussion of the strategic priorities of the new Health and Wellbeing Strategy which will need to be developed through 2019 (the current strategy runs until 2020).

The report explores how Healthy Life Expectancy (HLE) is constructed, why it is an important measure and what explains the figures for Tower Hamlets. Specifically, it highlights that HLE has consistently been in the lowest five of local authority areas for both males and females (apart from the most recent data which shows a sharp improvement for males).

However, life expectancy has been improving significantly. Because of the construction of HLE, this means that it is poorer self-rated health that particularly weights the figures for Tower Hamlets. It is also relatively unusual that female healthy life expectancy is lower than male healthy life expectancy.

In order to explore this further, the report reviews a range of data related to health and wellbeing where Tower Hamlets is a particular outlier in order to ascertain how Tower Hamlets particularly differs from other populations from a health perspective.

Amongst the key issues where Tower Hamlets is a significant outlier in relation to health and its determinants include diabetes, common mental health issues, maternal health, behavioural risk factors for health (particularly smoking and diet), environmental factors and multiple deprivation (income, poverty, adult literacy). The data also highlights the specific vulnerabilities at both ends of the life course.

The report provides a strong connection between the aspiration and place priorities of the Strategic Plan and how they are likely to impact on healthy life expectancy. It also reflects the importance of all four themes of the Community Plan in contributing to improvement in healthy life expectancy (resilient and safe communities, better health and wellbeing, good jobs and employment and a better deal for young people).

The report will also be used to inform future priorities of a range of strategies and plans across the health and care system including the refresh of the Health and Wellbeing strategy, Tower Hamlets Together local plans and the Council for Voluntary Service (CVS) health and wellbeing strategy.

The report is available online at:

https://www.towerhamlets.gov.uk/Documents/Public-Health/Tower_Hamlets_Public_Health_Report_2018.pdf

Recommendations:

The Health and Adults Scrutiny Sub-Committee is recommended to:

1. Comment on the report with a particular focus on the section with 'considerations for the Health and Wellbeing Board'

1. REASONS FOR THE DECISIONS

N/A

2. ALTERNATIVE OPTIONS

2.1 N/A

3. DETAILS OF THE REPORT

3.1 Please see attached presentation and full report

4. EQUALITIES IMPLICATIONS

4.1 The between report is focussed on equalities - raising issues about inequalities Tower Hamlets and elsewhere as well as within the borough. It also highlights considerations for partners to address these.

5. OTHER STATUTORY IMPLICATIONS

5.1 Local authorities are responsible for understanding and promoting local population health under the provisions of the Health and Social Care Act 2012.

6. COMMENTS OF THE CHIEF FINANCE OFFICER

6.1 There are no financial implications arising from the recommendations within this report.

7. COMMENTS OF LEGAL SERVICES

7.1 Section 116 of the Local Government and Public Involvement in Health Act 2007 places a duty on the Health and Wellbeing Board to undertake a joint strategic needs assessment. The duty to prepare this plan falls on local authorities and the Clinical Commissioning Group, but must be discharged by the Health and Wellbeing Board. Utilising the Annual Public Health report to inform future priorities of the refresh of the health and wellbeing strategy is consistent with this duty.

Linked Reports, Appendices and Background Documents

Linked Report

- Summary presentation of Annual Public Health Report

Appendices

- Healthy Life Expectancy in Tower Hamlets: Annual Public Health Report of the Director of Public Health 2018

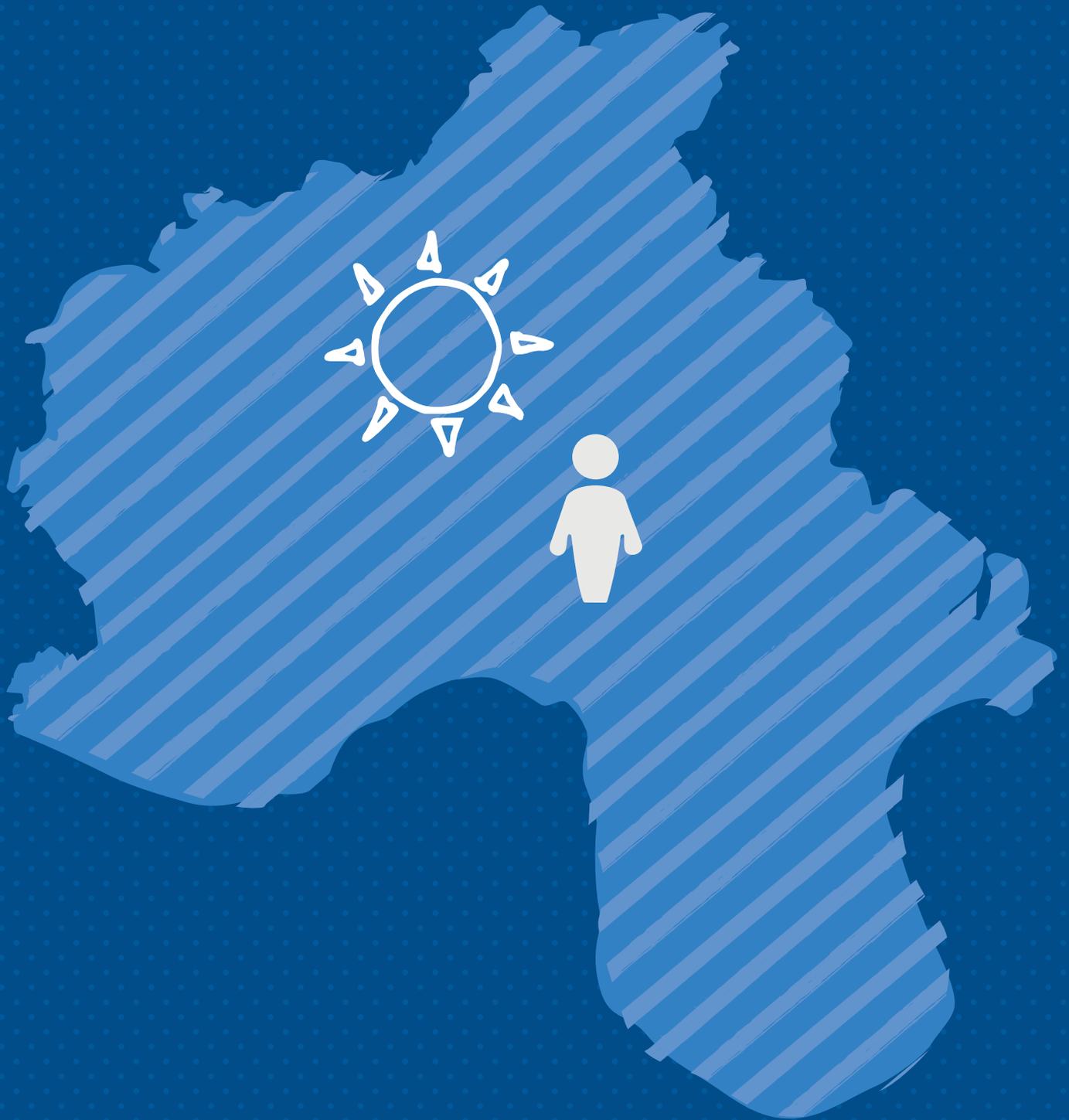
Local Government Act, 1972 Section 100D (As amended)
List of “Background Papers” used in the preparation of this report

- NONE

Officer contact details for documents:

Somen Banerjee, Director of Public Health

somen.banerjee@towerhamlets.gov.uk



Healthy Life Expectancy in Tower Hamlets

Annual Public Health Report of the
Director of Public Health

2018

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Foreword

The Annual Public Health Report for 2018 focusses on the healthy life expectancy figures for Tower Hamlets. Healthy life expectancy is a high level indicator of the Strategic Plan and this report explores how it is constructed, why it is an important measure and what explains the figures for Tower Hamlets.

Specifically, it highlights that local healthy life expectancy has consistently been in the lowest five of local authority areas for both males and females (apart from the most recent data which shows a sharp improvement for males).

However, life expectancy (rather than healthy life expectancy) has been improving significantly. Because of how healthy life expectancy is measured, this means that it is poorer self-rated health that particularly lowers the figures for Tower Hamlets. It is also unusual that female healthy life expectancy is lower than male healthy life expectancy.

In order to explore this further, the report reviews a range of data related to health and wellbeing where Tower Hamlets is a particular outlier, in order to ascertain how Tower Hamlets differs from other populations from a health perspective. The report is therefore not intended to be a comprehensive summary of health issues in the borough (these are available through Borough Profile and Joint Strategic Needs Assessment reports).

Amongst the key issues where Tower Hamlets is a significant outlier in health and its determinants are diabetes, common mental health issues, maternal health, behavioural risk factors for health (particularly smoking and diet), infectious diseases, environmental factors and multiple deprivation (income, poverty, adult literacy). The data also highlights the specific vulnerabilities at both ends of the life course (children/families and older people).

The report provides a strong connection between the aspiration and place priorities of the Council's Strategic Plan, and how they are likely to impact on healthy life expectancy.

It also reflects the importance of all four themes of the Partnership's Community Plan in contributing to improvement in healthy life expectancy (resilient and safe communities, better health and wellbeing, good jobs and employment and a better deal for young people).

The report will be used to help inform future priorities of a range of strategies and plans across the health and care system, including the refresh of the Health and Wellbeing strategy, Tower Hamlets Together plans and the Council for Voluntary Service (CVS) Health and Wellbeing strategy.

Somen Banerjee
Director of Public Health



Key messages

1. Healthy life expectancy is an important headline measure of the Health and Wellbeing Strategy and the Strategic Plan of the Council
2. It provides an insight into how people's life circumstances and the place they live in are impacting on their health and perception of their health

Healthy Life Expectancy in Tower Hamlets

3. Tower Hamlets has amongst the lowest healthy life expectancy in the country (although this improved significantly for men in the most recent data release 2014-16)
4. Healthy life expectancy varies significantly across the borough and this is linked to deprivation
5. Female healthy life expectancy is lower than male healthy life expectancy - this is unusual
6. Life expectancy has been improving rapidly over the past decade in Tower Hamlets which means that it is self-perceptions of health that are lowering the healthy life expectancy figure in the borough
7. There has been a significant improvement in male healthy life expectancy in 2014-16 - this is not easy to explain in the context of previous trends and further time series data will be needed to understand this further

What contributes to explaining why healthy life expectancy is lower than elsewhere?

Deprivation?

8. Compared to ten years ago, a lower proportion of neighbourhoods are in the most deprived wards nationally. However, Tower Hamlets has the third highest proportion of the population living in the most deprived areas - this suggests that the impacts of deprivation could be becoming increasingly concentrated in the borough

Levels of early death and long term health issues?

9. Tower Hamlets is no longer the extreme outlier for early deaths from the major killers (cancer, cardiovascular disease and respiratory disease, liver disease) that it was a decade ago
10. Because Tower Hamlets has such a young population it is not straightforward to estimate the level of long term conditions in the population compared to elsewhere
11. However, Tower Hamlets has higher levels of diabetes compared to elsewhere and this may help explain relatively lower self-perceptions of health in the population
12. Tower Hamlets has a higher level of common mental health conditions compared to elsewhere and this is likely to be an important contributor to poorer self-rated health

Health behaviours?

13. Higher levels of low birth weight in Tower Hamlets are a marker for poorer maternal health
14. Higher levels of childhood obesity and poor oral health are a marker for wider issues in the Tower Hamlets population as a whole around physical activity, diet and mental health
15. Evidence suggests that the diet of the adult population in Tower Hamlets is significantly less healthy than elsewhere
16. Despite improvement, Tower Hamlets still stands out as having amongst the highest levels of smoking in the country
17. Tower Hamlets stands out as having amongst the highest level of sexually transmitted infections as well as HIV in the country and this contributes to poor self-rated health in the population
18. The high levels of substance misuse in the Tower Hamlets population is a marker of the underlying issues impacting on individuals and household's lives that impact on healthy life expectancy
19. The lower uptake of screening services in Tower Hamlets is a marker for the extent to which prevention and early diagnosis services are taken up by the population

The physical environment?

20. The physical environment in Tower Hamlet supports people's health and wellbeing significantly less than elsewhere and is likely to be contributing to poorer self-rated health in the population
21. High levels of crime in Tower Hamlets compared to elsewhere are likely to impact adversely on people's sense of safety and therefore self-rated health

Social and economic factors?

22. Lower levels of employment in Tower Hamlets compared to elsewhere are likely to be significant contributors to lower self-perceived health in the population and the specific gender differentials in employment may contribute to the lower healthy life expectancy of women in Tower Hamlets compared to men
23. The levels of income deprivation in Tower Hamlets compared to elsewhere will impact profoundly on lower self-perceptions of health in the borough and particularly on health and wellbeing at both ends of the life course (children/families and older people)
24. The excellent educational outcomes of children in Tower Hamlets will mitigate the impacts of deprivation in children and affect future life expectancy.
25. However, although the data is from 2011, the higher levels of poor English language skills (particularly in women) is likely to be a contributor to poorer health in the Tower Hamlets population through impacts on core needs for wellbeing
26. The impacts of higher levels of insecure housing and overcrowding on core needs for wellbeing is likely to be a significant contributor to poorer self-rated health in the Tower Hamlets population
27. Healthy life expectancy in older people in Tower Hamlets is a significant outlier and this is likely to be due to deprivation and its consequences including social isolation

1 Introduction

Understanding the health of people in a population is a little like trying to nail jelly to the wall.

This is even more the case in a place like Tower Hamlets where the population is growing fast and also changing in its composition.

However, one thing that has been consistent historically in this borough is that taken as a whole, people's health has been on average worse than elsewhere.

Until recently, the most commonly used statistic to provide a clue about the health of people in a place has been life expectancy i.e. how long you are likely to live.

However, one of the problems with this statistic is that it does not say enough about the quality of life of people. You may be living longer but are you enjoying health and wellbeing in these extra years?

Healthy life expectancy is a statistic that seeks to provide a bit more insight into this. It relates to how long a person is likely to consider their health to be good. It is about how you feel about your health.

Since statistics on life expectancy were published for local authorities, Tower Hamlets has consistently had lower life expectancy than the rest of London and the rest of the country. It has always been in the lowest fifth of boroughs for life expectancy.

However, the situation has been significantly more extreme for the healthy life expectancy statistic.

For both men and women, healthy life expectancy has been in the bottom five boroughs in the country, apart from the most recent statistic for men which show a significant improvement (fig 1).

This report is an exploration into why healthy life expectancy for Tower Hamlets is such an outlier compared to the rest of the country, and what this tells us about where we need to focus to improve health and wellbeing in the borough.

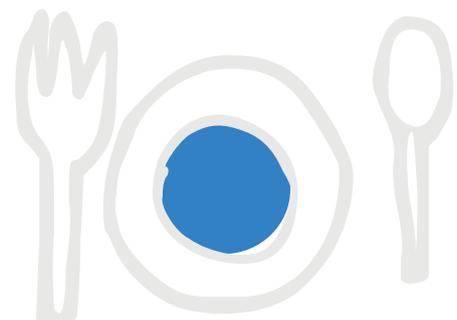
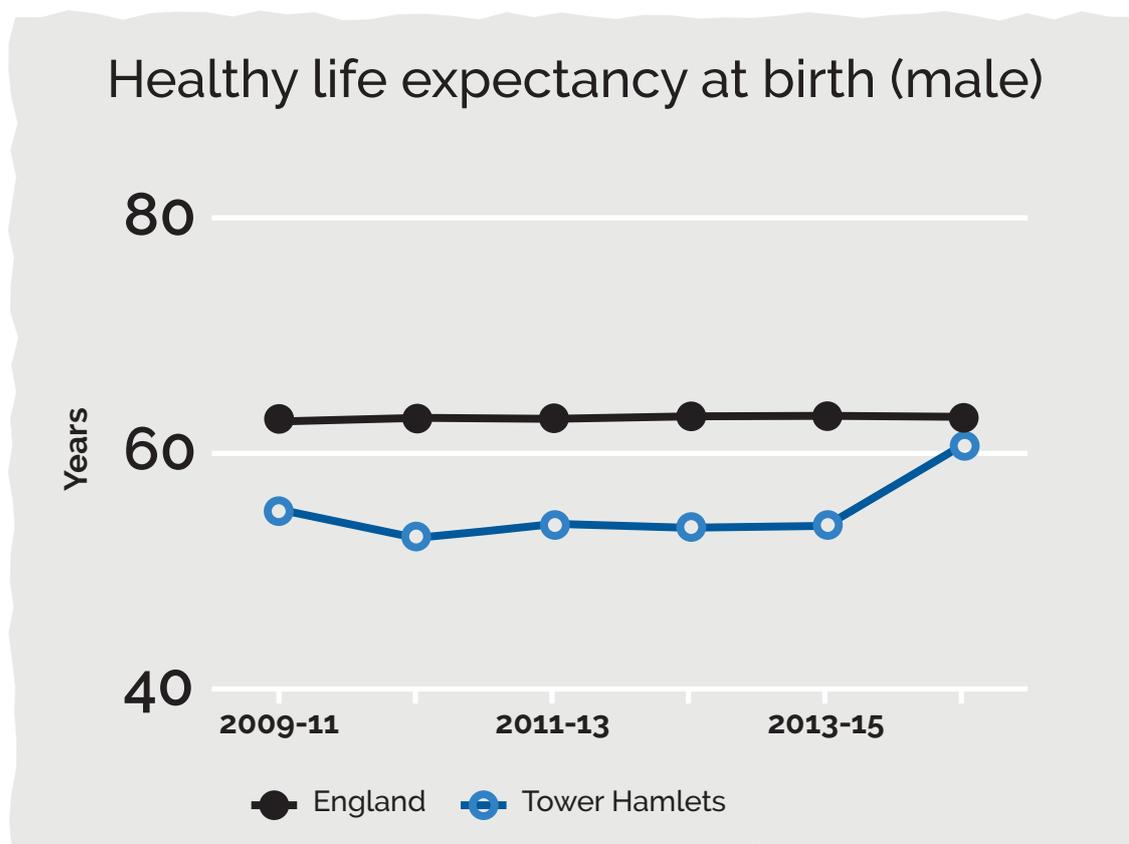
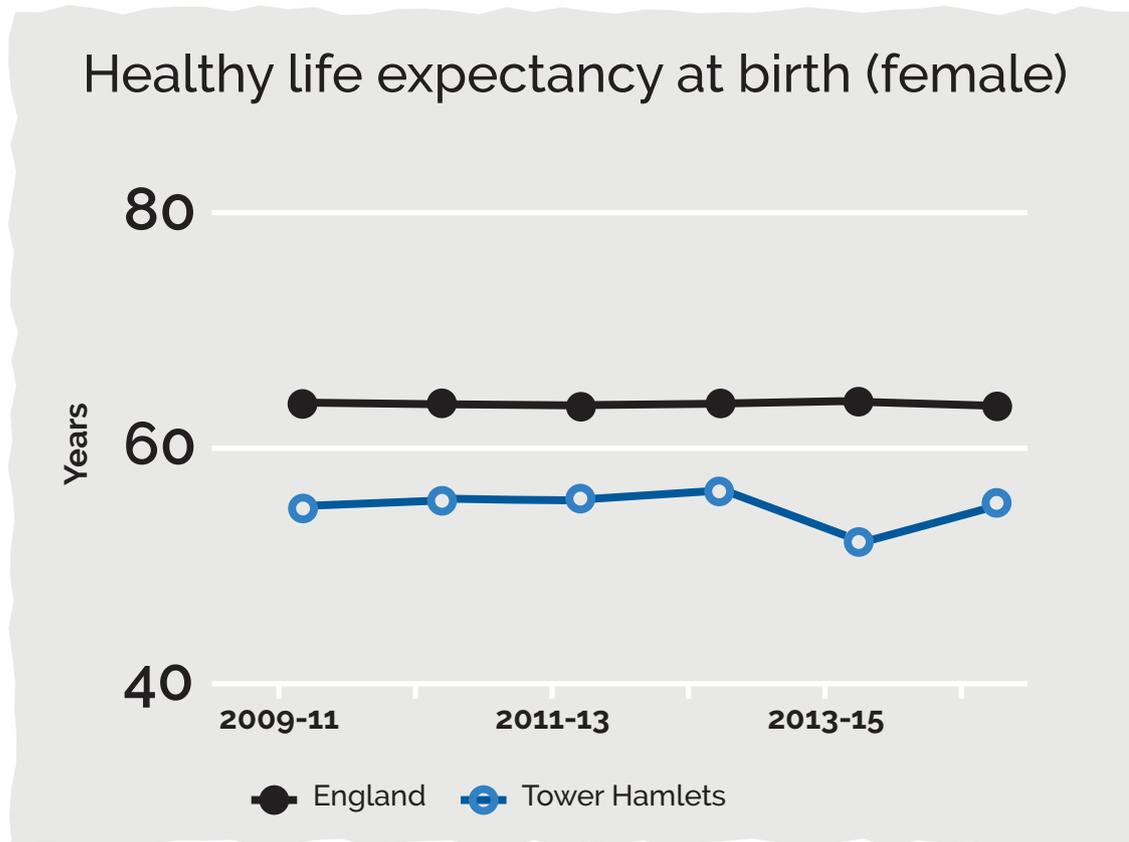


Figure 1: Tower Hamlets healthy life expectancy Trends (blue line)



2 What is healthy life expectancy and why is it important?

Life expectancy is an estimate of how many years a child born today is likely to live if it shares the current health characteristics of the population as a whole.

Healthy life expectancy is an estimate of how many years a child born today would be expected to live in good health.

It is determined by two factors (figure 2). Firstly, how long people are expected to live (life expectancy). Secondly, how people rate their health (self-perceived health).

This means that even if life expectancy in an area is high, it does not necessarily follow that healthy life expectancy would be high, as this would also depend on how people rate their health.

For example, based on the most recent data (2014-16) Tower Hamlets has the 3rd lowest female healthy life expectancy of local authorities in England but the 51st lowest female life expectancy.

In males, there is a closer link between healthy life expectancy and life expectancy. Male healthy life expectancy was the 55th lowest in the country and the 56th lowest life expectancy (2014-16).

Healthy life expectancy is an important headline statistic in understanding the health of people in a population. It provides an insight into how their life circumstances and the place they live in are impacting on their health along with self-perception of their health.

Just as an individual may report feeling well or unwell, healthy life expectancy says something about the 'state of health of a population'. It provides a context for further investigation of the important factors that underlie these figures.

The context for Tower Hamlets is that apart from the most recent healthy life expectancy figure for males, Tower Hamlets has consistently had figures in the lowest five of all local authorities in England for both males and females. Understanding why this has been the case is therefore particularly important for the borough.

In a place that is as complex and dynamic as Tower Hamlets, the available data can never fully capture the reality of the lives of people in the borough and the factors that are influencing their health. However, they can provide clues, particularly if the facts and figures are linked to what people themselves are saying.

The following sections seek to make sense of the vast amount of data that is available to explain why the healthy life expectancy figures for Tower Hamlets follow the pattern that they do.

Figure 2: The relationship between healthy life expectancy and life expectancy



3 What determines healthy life expectancy?

Following on from the previous section, the two important factors determining healthy life expectancy are:

- Life expectancy (how long people would be expected to live)
- People's perception of the state of their health (how well they feel).

3.1 Life expectancy

The level of life expectancy in a population can only be fully understood by looking at the whole context of people's lives. Crudely, it is estimated that in looking at differences in life expectancy:

- 40% is explained by the direct impact of social and economic factors
- 30% by health behaviours
- 10% by the physical environment in which people live
- 10% by quality of health and care services
- 10% by genetic factors.

People's life expectancy is influenced by how these interrelated factors affect them through their lives.

3.2 Perceptions of health

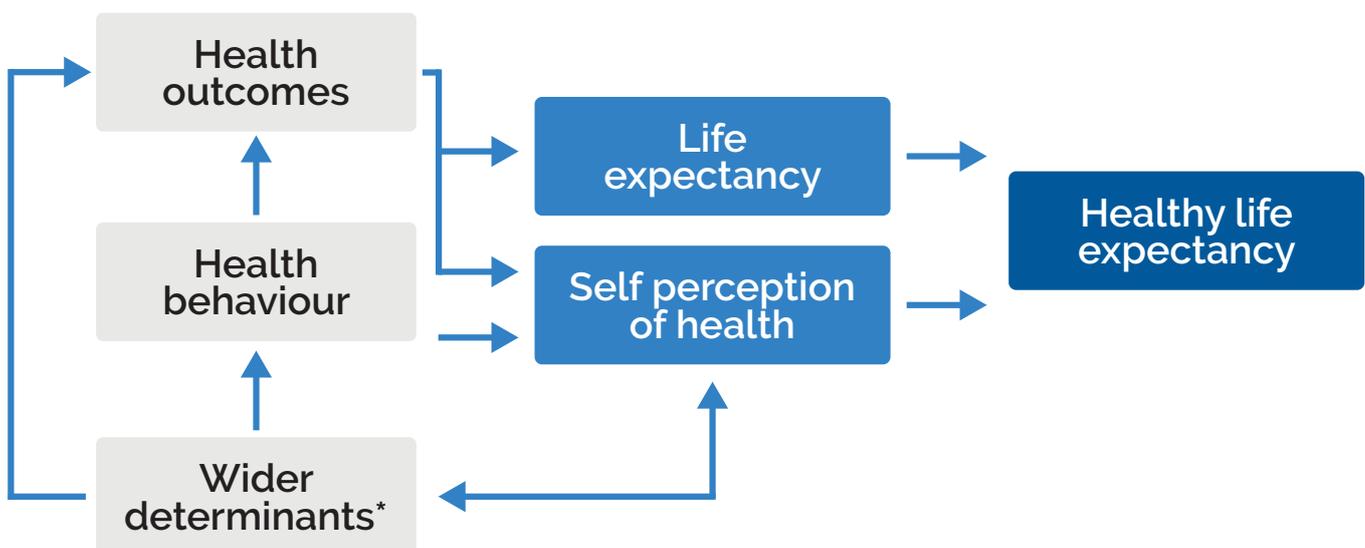
Subjectively, people's perceptions of their health and wellbeing (and their physical health) are strongly linked to the extent to which their core needs are met or not met. These include core needs for:

- Safety (physical, social, economic)
- Satisfaction (sense of purpose and control)
- Connection (family, friends, and community) are fulfilled.

Self-perception of health is linked to physical health conditions but is also linked to lifestyle, socio-economic factors and psychosocial factors such as distress and low self-esteem. This means that although people's physical health may be 'clinically' similar, their self-rated health may differ due to a range of other factors.

Figure 3 aims to provide a framework for thinking about the relationship between determinants of health, life expectancy, self-perceptions of health and healthy life expectancy that informs the analysis of Tower Hamlets data in the next sections.

Figure 3: Factors determining healthy life expectancy



* wider determinants includes cultural and psychosocial factors, as well as a diverse range of social, economic and environmental factors which impact on people's health

4 What are the healthy life expectancy life figures for Tower Hamlets?

The healthy life expectancy figures for Tower Hamlets are set out below (figures 4 and 5)

Figure 4 Healthy life expectancy at birth (male)

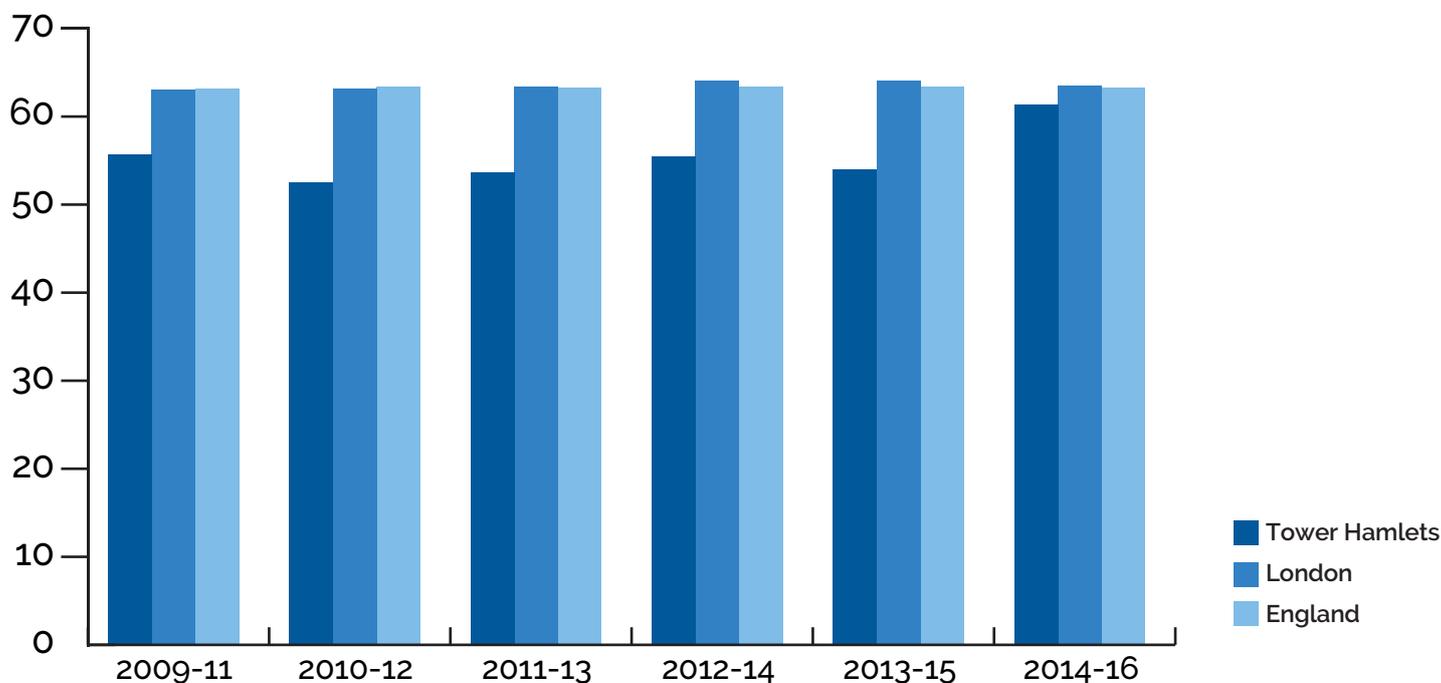
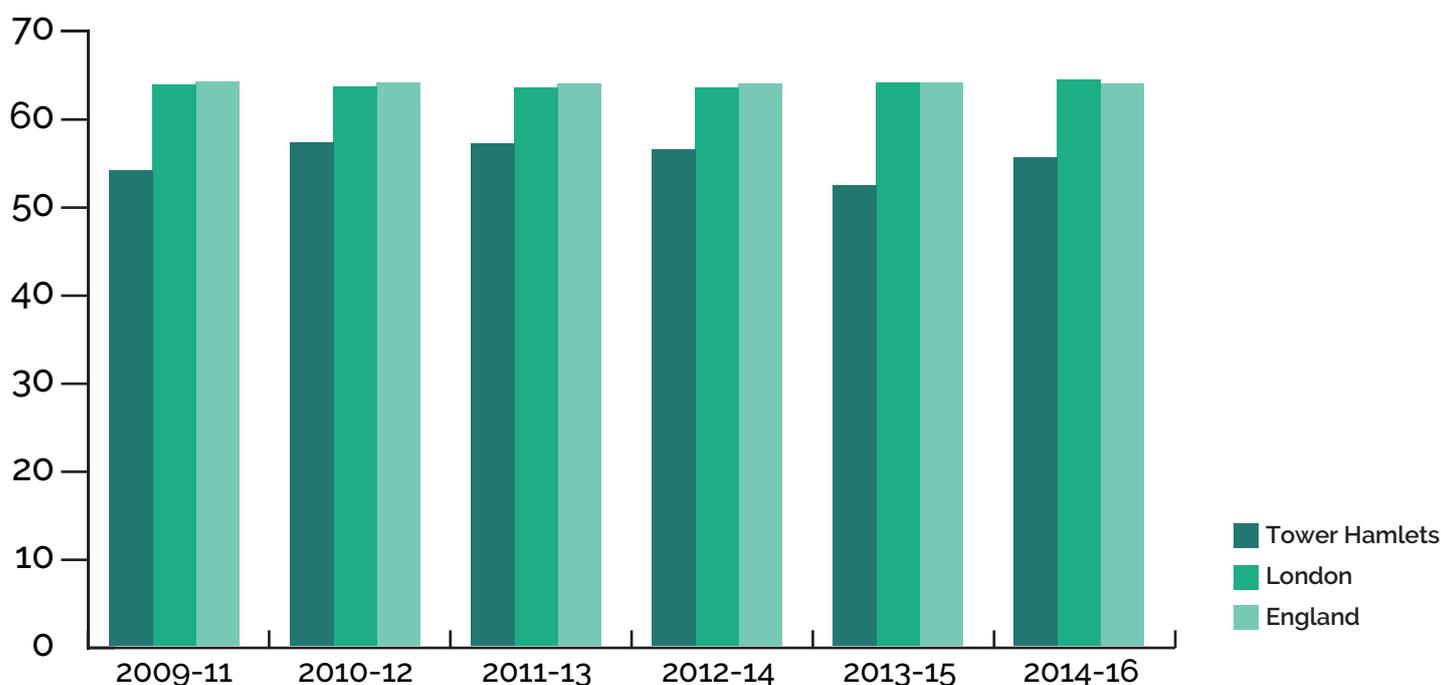


Figure 5 Healthy life expectancy at birth (female)



There are several important insights to draw from this data.

1. Tower Hamlets has amongst the lowest healthy life expectancy in the country

Between 2009 and 2015 the figures have been consistently in the bottom five local authorities for males and females. This highlights at a high level how the health of people in Tower Hamlets and their perceptions of their health have been lagging behind the rest of the country. The extent of this difference is stark. Compared with local authorities with the highest life expectancy in England, women on average had 15.5 fewer years of good health and men had 8.6 fewer years based on 2014-16 data. It should be noted that based on 2013-15 data the difference in men was 17.1 years.

2. Healthy life expectancy varies significantly across the borough and this is linked to deprivation

Based on 2011 data (due to sample size it is not possible to get ward or sub-ward level since then), there is significant variation in healthy life expectancy within the borough (figure 7). These differences correlate with levels of deprivation as measured by Index of Deprivation (figure 8 - also see section 5.1 for more on this measure).



Figure 6: Comparison of healthy life expectancy for women in Tower Hamlets and Wokingham (2014-16)

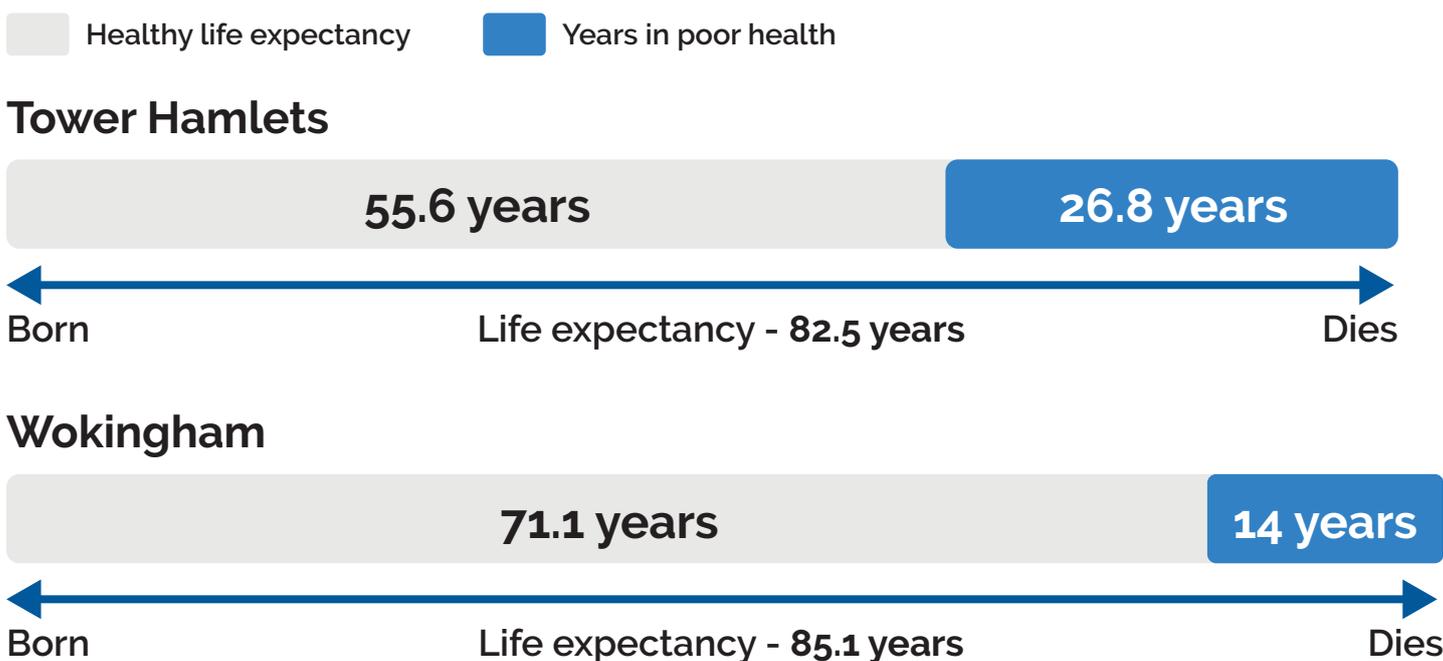
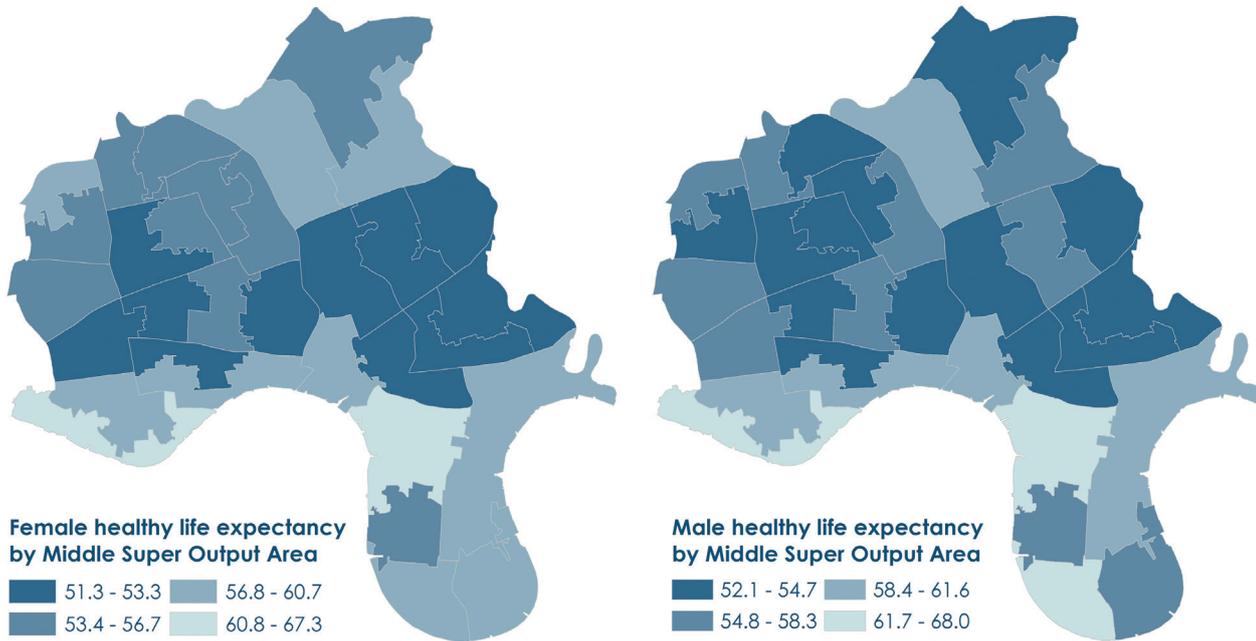


Figure 7 Healthy life expectancy for men and women by MSOA (2009 - 2013)

Healthy life expectancy in Tower Hamlets, 2009 - 2013

Healthy life expectancy is the average number of years that an individual might expect to live in "good" health in their lifetime. These estimates are a snapshot of the health status of the population during 2009 to 2013, based on self-reported health status at the 2011 Census and mortality rates for each area in that period.

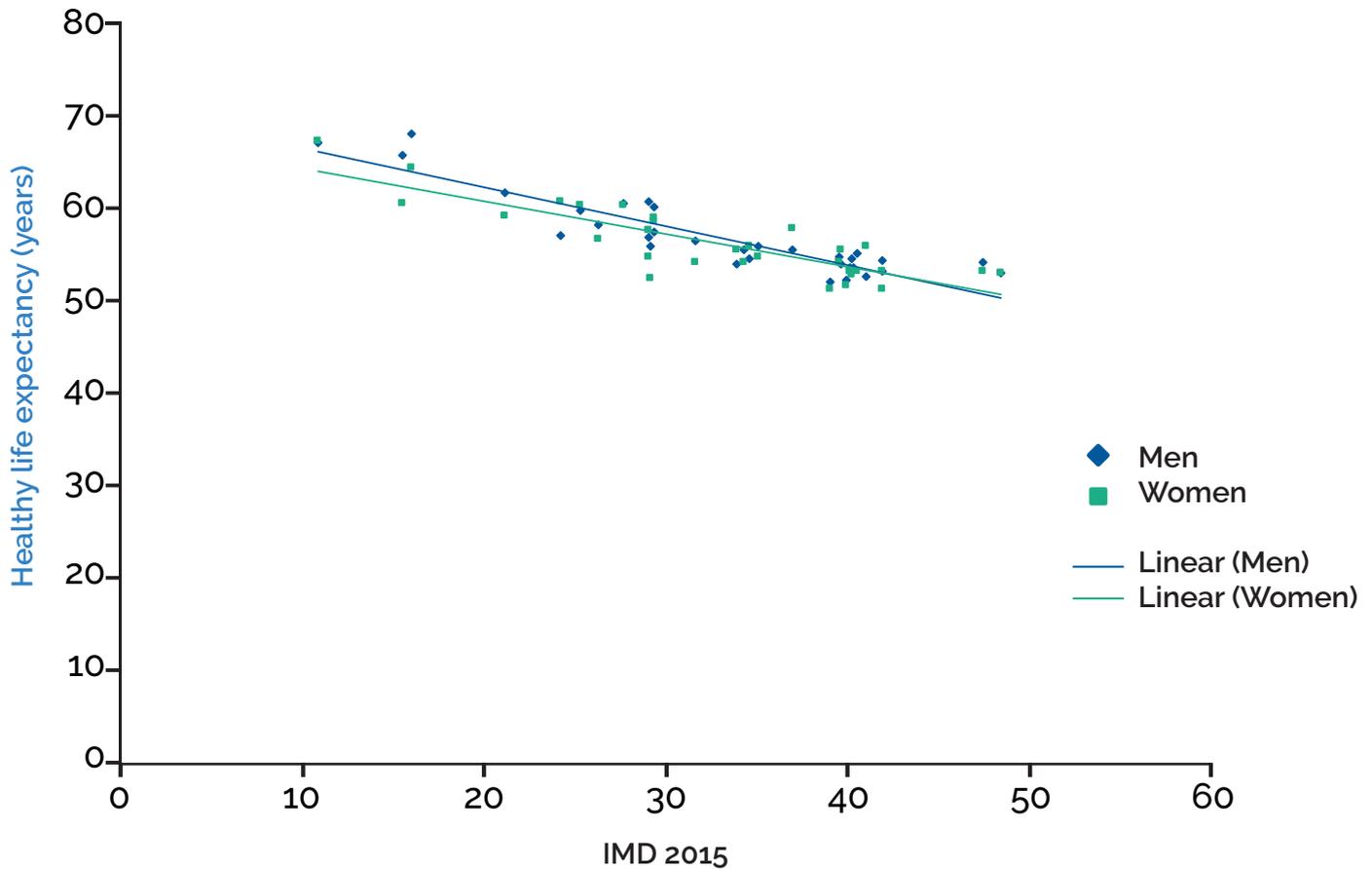
Source of data: ONS © Crown Copyright 2017.



Data has been classified by natural breaks (Jenks' method) for Tower Hamlets. The maps do not show confidence intervals and any geographic variation is not necessarily statistically significant.

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Figure 8 Healthy life expectancy and Index of Multiple Deprivation



3. Female healthy life expectancy is lower than male healthy life expectancy - this is relatively unusual

Even before the most recent improvement in male healthy life expectancy, it is unusual that female healthy life expectancy is lower than male healthy life expectancy at local authority level (it is higher at national level). This should be seen within a context of life expectancy in females being longer than males (which is also the case nationally). This suggests in Tower Hamlets an important issue about how women in the borough perceive their health (this is explored further in section 5).

4. Life expectancy has been improving rapidly over the past decade in Tower Hamlets which means that it is self-perceptions of health that are lowering the healthy life expectancy figure

Life expectancy in Tower Hamlets over the past decade has not been an extreme outlier. In 2014-16 it was 79.5 for men (84th lowest) and 82.4 for women (94th lowest). Although relatively low compared to national figures (men 83.7 and female 86.7), the figures are not the extreme outliers they were in the first decade of the century. Because healthy life expectancy is calculated from life expectancy and self-perceived health (based on a national annual survey), this means that Tower Hamlets' low healthy life expectancy figures are particularly lowered by people's perceptions of their health.

5. There has been a significant improvement in male healthy life expectancy in 2014-16 - this is not easy to explain

There was an unexpected increase in healthy life expectancy for men between 2013- 2015 and 2014-16. Comparatively, this moved from the 4th lowest in the country to the 55th lowest. This trend has been observed in some neighbouring boroughs, although with not as large an improvement as in Tower Hamlets, and it is not easy to explain this trend (see tables 1 and 2 in the appendix).

The size of the increase in healthy life expectancy is surprising but there is no evidence of data error as these results have been checked with the Department of Health. It may be that this is a true improvement in the healthy life expectancy of men in the borough, and this improvement will be sustained in subsequent years. However, it will only be possible to know if this is a trend when there is more than one data point.

Tower Hamlets is known to have high rates of population turnover, with the 12th highest rate in the UK, and changes in demographics can affect the healthy life expectancy. If there has been a large movement of young men into Tower Hamlets in the past three years, then this could skew the results. Due to the way healthy life expectancy is calculated, a younger person has a greater impact on healthy life expectancy than an older person does.

As well as population turnover, recent years have seen high levels of population increase. This could have the effect of improving average health outcomes, without materially improving the health of the preexisting population. This warrants further investigation and analysis beyond routine health data.

However, it should be noted that an improvement in healthy life expectancy at age 65 was also seen in males for 2014-16 (see section 5.6) so this is unlikely to be the only explanation. It should be noted, however, that only a modest improvement was seen in the disability free life expectancy for 2014-16 (see the appendix for further information). The Office of National Statistics is changing how healthy life expectancy is calculated, and it will be interesting to see if these improvements are sustained with the next release of data.

SUMMARY

In summary, the healthy life expectancy data for Tower Hamlets indicate that men and women in Tower Hamlets tend to rate their health as poor earlier in their lives than elsewhere and live more of their lives in poor health with the associated social, economic and health impacts that this causes.

5 What explains healthy life expectancy figures in Tower Hamlets?

To get a deeper insight into why healthy life expectancy has been so low for Tower Hamlets, it is proposed to use the framework in section 3 as a guide to review data where there are national benchmarks on health outcomes and determinants of health.

The focus will be particularly on those indicators in which Tower Hamlets is a significant outlier and which are likely to have significant population impact. This will incorporate review of deprivation, health outcomes (early death rates, level of health conditions), health behaviours and wider determinants of health (environmental, socioeconomic).

5.1 Deprivation

Deprivation is fundamentally about the extent to which people have the necessities to meet core needs. From a health and wellbeing perspective, this relates to the extent that they are able to feel safe, satisfied and connected in their lives. This correlates with health outcomes and self-rated health.

Compared to ten years ago, a lower proportion of neighbourhoods in Tower Hamlets are in the most deprived nationally. However, Tower Hamlets has the third highest proportion of the population living in the most deprived areas - this suggests that the impacts of deprivation could be becoming increasingly concentrated in the borough

Deprivation is commonly measured using the Index of Multiple Deprivation (IMD). This is an overall measure of deprivation experience by people living in an area. It is calculated from 37 separate indicators of deprivation across seven different domains, and these are weighted and combined into a single overall measure – the Index of Multiple Deprivation.

Each of the seven domains represents a specific type of deprivation experienced by people, which can be measured using a number of different indicators. These are income; employment; health and disability; education, skills and training; barriers to housing and services; living environment; and crime.

In the context of the rapid population growth and demographic change that Tower Hamlets has been experiencing over the past decade, the deprivation picture in Tower Hamlets has been changing.

Tower Hamlets has historically been a very deprived area and is the most deprived local authority for income deprivation in children and older people. In 2010 it was ranked 7th in the country for the Index of Multiple Deprivation for the proportion of LSOAs which were the in the 10% most deprived in England. As of 2015, Tower Hamlets is ranked 24th in the country and this suggest that the borough is now on one measure relatively less deprived.

However, it is important to highlight that based on the 'extent' measure of the Index of Multiple Deprivation. Tower Hamlets is still ranked the 3rd most deprived local authority in the country. The 'extent' measure looks at the proportion of a population living in the most deprived sub ward areas (lower super output areas), but is a weighted measure of the population living in the 30% most deprived nationally. It gives greater weight to the most deprived 10% and gradually less weight to each subsequent percentage. The argument for using the extent measure is that it still focusses on the most deprived areas, but avoids a sharp cut-off and gives a more balanced view of change in relative deprivation over time.

In essence, this means that whilst local areas in Tower Hamlets are getting less deprived, compared to other places a higher proportion of people live in the most deprived areas of the Borough.

SUMMARY

In summary, whilst Tower Hamlets has relatively fewer areas in the 10% most deprived nationally than in the past, it is still amongst the most deprived local authorities in England. This deprivation stretches across all age groups, from young to old, and can impact people in all aspects of their lives, from employment to housing to the environment they live in.

So whilst many parts of the borough may be relatively less deprived, others are still not. As discussed in previous sections, this impacts on the extent to which people's core needs for safety, satisfaction and connection are being met. This helps to provide further evidence as to why there is low healthy life expectancy in the borough.

5.2 Early death rates

Twenty years ago it would have been straight forward to explain why Tower Hamlets figures for healthy life expectancy would have been amongst the lowest in the country (at that time it had not been introduced as an indicator). Tower Hamlets had amongst the lowest life expectancy in the country and this was reflected in amongst the highest levels of premature deaths from the major killers in the population: cardiovascular disease, cancer and respiratory disease.

However, this picture has been changing.



1. Tower Hamlets is no longer the extreme outlier for early deaths (under 75s) from the major killers (cancer, cardiovascular disease and respiratory disease that it was)

Firstly, Tower Hamlet has historically been an outlier for early deaths from cardiovascular disease. However, it is no longer the extreme outlier that it was, although it is still at the lower end of the bottom quartile and is the 28th highest nationally. The rate of early death in 2014-16 was 97.6 per 100,000 compared to an England figure of 73.5 per 100,000. By comparison, Manchester has the highest premature death rate in the country of 141.3 per 100,000.

Secondly, Tower Hamlets is no longer the outlier it has been in the past for early deaths from cancer. Ten years ago, Tower Hamlets had the highest early death rates from cancer in London. It now has the 5th highest rate in London (146.4 per 100,000) and nationally it is no longer in the bottom quartile.

Thirdly, a similar pattern applies to early deaths from respiratory disease. In 2001-03, Tower Hamlets had the highest in London rates at 71.3 per 1000 and was comfortably in the bottom quartile nationally. Its rate is currently 39.8 per 100,000, which is fourth highest in London and it is no longer in the bottom quartile nationally. By comparison, Barking and Dagenham have the highest rate in London (55 per 100,000) and Manchester the highest in the country (70.2). The England average is 33.8.

Finally, other causes of premature death are smaller in number (looking at 2014-16 data). These include suicide (63), liver disease (73). Neither of these have early death rates in the bottom quartile.

SUMMARY

In summary, whilst Tower Hamlets is well below national averages in relation to early deaths from the major long terms conditions this is not sufficient to explain why Tower Hamlets has had such low healthy life expectancy.

5.3 People living with long term conditions

Whilst there may be decreasing levels of premature deaths in the population, it is possible that there are higher levels of people living with long term conditions and this is affecting how people rate their health.

1. Because Tower Hamlets has such a young population it is not straightforward to estimate the level of long term conditions in the population compared to elsewhere.

It is difficult to test whether Tower Hamlets has a higher level of long term health issues than elsewhere because it is such an extreme outlier in its population composition. The proportion of the population that is 65+ is by some distance the lowest in London at 5.6% (GP registered population in 2017) compared to 10.9% in London overall and 17.3% in England. This explains why the proportion of adults (18+) reporting that they are living with a long-term condition is also the lowest in London at 42% compared to 47.7% for London and 53.5% in England.

In order to make a meaningful comparison between levels of long-term conditions in Tower Hamlets and elsewhere it would be necessary to adjust for age. Unfortunately, most national or London data is not adjusted in this way so at a crude level, prevalence of conditions in 2016/17 such as diagnosed heart disease (1.6%), chronic kidney disease (2.3%), cancer (1.0%), stroke (0.7%), rheumatoid arthritis (0.4%), chronic respiratory disease (1.3%) are amongst the lowest in London.

2. Tower Hamlets has high levels of diabetes compared to elsewhere and this may help explain lower self-perceptions of health

Diagnosed diabetes prevalence in Tower Hamlets (6.8%) is the 12th highest in London (16,985 people had a diagnosis of diabetes and an estimated 3,500 are undiagnosed).

Type 2 diabetes prevalence increases with age, so though this may not appear to be high comparatively, it needs to be seen in the context of an area such as Havering in which 17.8% of the population is over 65 compared to 5.6% in Tower Hamlets (diabetes prevalence increases with age). Despite this, Havering's diagnosed diabetes prevalence is lower than Tower Hamlets at 6.5% compared to 6.8%.

Two significant drivers of diabetes are deprivation and South Asian ethnicity. Tower Hamlets had the highest deprivation score in London (35.7 compared to 21.8 nationally) in 2015 and the 4th highest proportion of the population of Asian or Asian British ethnic group (41.1% compared to 18.5% based on 2011 census data).



3. Tower Hamlets has a higher level of common mental health conditions compared to elsewhere and this is likely to be an important contributor to poorer self-rated health.

Based on the GP patient survey in 2016/17, Tower Hamlets had the highest self-reported levels of depression and/or anxiety in London (16.1% compared to 12.4%) and the 4th highest levels of long-term mental health problems (6.4%).

This is consistent with data from social care which highlights that 62% of social care users report experiencing depression and/or anxiety. This is the second highest in London.

The data highlights the extent to which mental health issues are widespread in the Tower Hamlets population and provides a level of explanation for why self-rated health is lower in the borough. It is also important to highlight the extent to which mental health also impacts adversely on physical health which will also impact on self-rated health.

SUMMARY

In summary, it is difficult to assess from the data how the Tower Hamlets population differs from other populations in relation to the level of long-term conditions that could impact on healthy life expectancy. However, there is sufficient evidence to indicate that compared to other borough populations, the Tower Hamlets population particularly stands out in terms of the impact of common mental health conditions and diabetes.

5.4 Health Behaviours

Health behaviours such as diet, physical activity, smoking, alcohol consumption, substance misuse and sexual health behaviours can impact on healthy life expectancy in two ways.

Firstly, they are linked to the levels and progression of long-term conditions in the population such as heart disease, stroke, lung disease, cancers and diabetes.

Secondly, they are linked to levels of wellbeing in themselves, both positively and negatively. This in turn could be linked to how people rate their health.

The availability of quality data on healthy behaviours with robust benchmarks is somewhat variable. However, review of existing data, directly or indirectly linked to health behaviours, provides some evidence of areas where Tower Hamlets may be an outlier.

1. Higher levels of low birth weight in Tower Hamlets are a marker for poorer maternal health.

Tower Hamlets has the 4th highest level of low birth weight babies in the country. 4.48% of babies are born with low birth weight compared to 2.79% nationally. Whilst this has implications for the future health of these babies it is also a marker for issues around the health of mothers through pregnancy which could impact on how they perceive their health (socioeconomic factors as well as health behaviours). In turn, this may be one element in explaining the particularly poor healthy life expectancy of women in the borough



2. Higher levels of childhood obesity and poor oral health are a marker for wider issues in the Tower Hamlets population as a whole around physical activity and diet

Tower Hamlets has the 8th highest levels of child excess weight nationally (overweight or obese). 42.5% of 10-11 year olds are classified as having excess weight compared to 34.2% nationally. It is also in the bottom quartile for proportion of five year old children free from dental decay and for decayed, missing or filled teeth in five year olds. In themselves, these results are unlikely to impact significantly on the healthy life expectancy figures. However, if viewed within a wider context of families, it might be seen as a marker for poorer nutrition and more sedentary lifestyles in the population as a whole. This may in itself impact on how people rate their health.

3. Evidence suggests that the diet of the adult population in Tower Hamlets is on average less healthy than elsewhere

Tower Hamlets adults are estimated to have the ninth lowest levels of consumptions of '5-a-day' in the country. 49.4% of the adult population meet the recommended daily intake of fruit and vegetables compared to 57.4% nationally. Again, this is a marker of poorer diet generally and this could be a contributor to lower levels of self-perceived health in the adult population.



4. Despite improvement, Tower Hamlets still stands out as having amongst the highest levels of smoking in the country

Tower Hamlets has always had amongst the highest levels of smoking in the country and this has been a strong driver of health inequalities between the borough and elsewhere. Although its relative position has been improving, Tower Hamlets has the eleventh highest smoking prevalence in the country. 19.7% of the adult population smoke (46,000) compared to 14.9% nationally.

Whilst the high levels of smoking in the borough are self-evidently linked to significant life-threatening conditions covered in the previous section such as heart disease, stroke and lung cancer, there is also a further link to self-perceived health through the impact smoking has on susceptibility to everyday health conditions, such as respiratory conditions, flu, dental health and joint conditions.

Also, continued smoking will increase the severity of existing long term conditions (such as chronic lung disease and heart disease) and could impact on self-reported health through this route.

5. Tower Hamlets stands out as having amongst the highest level of sexually transmitted infections as well as HIV in the country and this contributes to poor self-rated health in the population

Tower Hamlets is a significant outlier nationally on sexual health and HIV on a number of measures (although similar to other inner London boroughs). Overall, it has the sixth highest rates of new sexually transmitted infections in the country (2,268 per 100,000 compared to 794,000 nationally).

It also has the sixteenth highest HIV diagnosed prevalence rate in the country (6.35/1,000 aged 15-59 compared to 2.32/1,000 nationally) and the seventh highest rate of new HIV diagnosis (32/100,00 aged 15+ compared to 8.7/100,00 nationally).

Sexual health is an integral component of self-perceived health. These figures indicate that it is likely to be another contributor to the relatively low self-perceived health component of the healthy life expectancy figures for the borough.

6. The high levels of substance misuse in the Tower Hamlets population is a marker of the underlying issues impacting on individuals and household's lives that impact on healthy life expectancy

Alcohol and drug misuse is a key component of healthy life expectancy, both in terms of prevalence of harmful use and also the effectiveness of local health, criminal justice and social care systems in identifying and motivating people to engage with treatment. According to data from 2014-15, Tower Hamlets has the highest prevalence of opiate and/or crack drug users in London at 2798 (although this represents a 20% drop in number from 2011-12). Even though a large proportion of the local population abstains from alcohol, Tower Hamlets still has the seventh highest number of dependent drinkers in London, at approximately 3400.

The causes of alcohol and substance misuse are a complex interplay of deprivation, poverty, trauma and increased rates of mental ill health. Although the health, criminal justice and social care systems have increased the effectiveness of identifying, referring, and successful completion of treatment, substance misuse and alcohol continue to have a major impact on healthy life expectancy in Tower Hamlets.



7. The lower uptake of screening services in Tower Hamlets is a marker for the extent to which prevention and early diagnosis services are taken up in the population

Uptake of screening services can be seen as a marker of how a population takes up services more generally and Tower Hamlets has always been an outlier. In 2017 the borough had the 6th lowest uptake for cervical cancer screening nationally (61.8% of eligible women compared to 72% nationally), the 24th lowest for breast cancer screening (68.7% compared to 75.4% nationally) and the 4th lowest for bowel cancer (43% compared to 58.8%).

Whilst these figures are themselves a cause for concern, they raise wider questions about how people in Tower Hamlets seek early help to engage with services to maintain their health or address health issues. This can manifest in late diagnosis of conditions and increased severity when they are diagnosed, which could in turn be linked to lower self-rated health. Although this has improved significantly in recent years, Tower Hamlets has historically been a significant outlier in relation to late diagnosis of cancer.

SUMMARY

In summary, this section has focussed on those issues relating to health behaviours where the data indicates that Tower Hamlets is a significant outlier. Taken together they do start to provide some evidence of why Tower Hamlets healthy life expectancy is particularly low in the context of the impact of the levels of risk factors for health on self-perceived health.

In terms of population impact, the impact of smoking on self-perceived health is likely to play an important part. Also, the data on low birth weight and the association with maternal health may be one factor (but by no means the only factor) in explaining the particularly low healthy life expectancy of women in the borough.

5.5 Environment

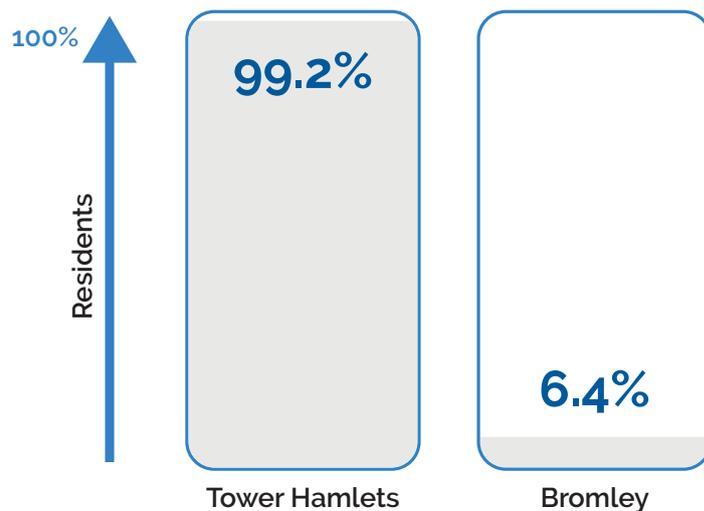
The environment in which one lives ones daily life can be significantly impact on health e.g. air quality, noise pollution, road safety, green spaces and access to local services and amenities. This can impact on healthy life expectancy the relationship of the environment to health conditions that impact on life expectancy (e.g. cardiovascular disease, respiratory disease) but also through self-rated health (e.g. mental wellbeing).

Tower Hamlet is an outlier in terms of how the environment adversely impacts on health.

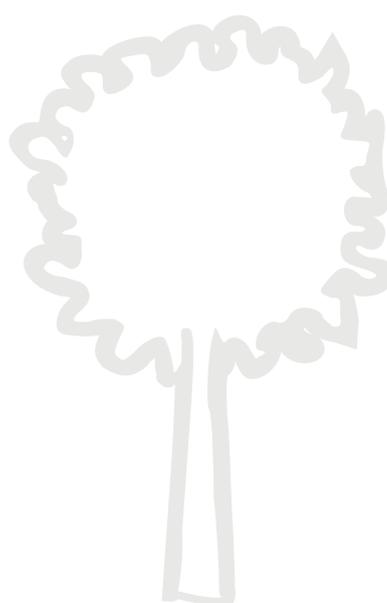
1. The physical environment in Tower Hamlet supports people's health significantly less than elsewhere and is likely to be contributing to poorer self-rated health in the population

The Access to Healthy Assets and Hazards (AHAH) index is a composite indicator which provides an overview of the extent to which areas have environments that support health. It consists of three domains covering access to retails services, health services and the physical environment, including access to green spaces and air pollution. 99.2% of Tower Hamlets residents live in lower super output areas (sub ward areas) which score in the poorest performing 20% on the Access to Healthy Assets and Hazards Index, which is the sixth highest in the country. In contrast, in Bromley this figure is 6.4% (fig 6).

Figure 9 Proportion of residents living in lower super output areas which score in the poorest performing 20% on the AHAH index



Tower Hamlets has the 11th highest levels of air pollution nationally as measured by fine particulate matter (11.8 micrograms per cubic metre compared to 9.3 nationally), 8th highest level of road/rail/air transport noise of 65 decibels or more in daytime (15.1 dB compared to the national average of 5.2dB) and 12th highest density of fast food outlets (124.6 per 100,000 compared to 88.2 per 100,000 nationally).



2. High levels of crime in Tower Hamlets compared to elsewhere are likely to impact adversely on people's sense of safety and therefore self-rated health

High levels of crime in an area will impact on core needs of feeling safe, having a sense of satisfaction and pride in the place one lives and a sense of connection and community. This will in turn have the potential to impact on resident's health and wellbeing and their self-perceptions of their health. Crime Deprivation is a composite indicator of violence, burglary, theft and criminal damage in an area. Tower Hamlets score was the 12th highest in the country.

SUMMARY

In sum, the high-level data on the environment and health indicates that environmental factors are an important contributor to the low healthy life expectancy figures in Tower Hamlets.

This is reflected in the adverse balance of health assets (eg access to healthy foods, green spaces) and health hazards (eg pollution, crime, fast food outlets) in neighbourhoods in the borough.

5.6 Socio-economic factors

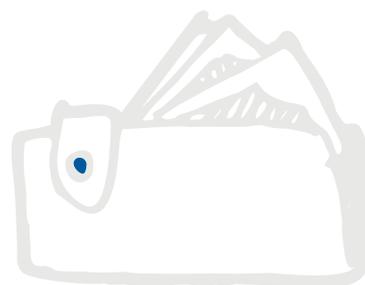
The health behaviour data set out in the previous section takes place within a context of the social, economic and cultural circumstances of people's lives. At a psychological level, health and wellbeing is most profoundly influenced by the extent to which one's core needs are met through life. These relate to core needs around safety (having a space in life free of threat), satisfaction (having a sense of purpose and control) and connection (having fulfilling relationships with others).

Simply put, the more an individual's core needs are met, the better his/her physical and mental health is likely to be. This is why social and economic factors are so critical to health, and it is also where Tower Hamlets is a significant outlier.

1. Lower levels of employment in Tower Hamlets compared to elsewhere are likely to be significant contributors to lower self-perceived health in the population and the specific gender differentials in employment may contribute to the lower healthy life expectancy of women in Tower Hamlets compared to men

Good employment is fundamental to meeting core needs around safety (financial security), satisfaction (a sense of purpose) and connection (relationships with work colleagues). Based on 16/17 data, Tower Hamlets had the 11th lowest employment rate in the country (65.3% of those responding to the Labour Force Survey were classified as employed compared 74.4% nationally) and the 7th highest unemployment rate (7.9% of 16+ compared to 4.8% nationally).

The employment rate for white residents in Tower Hamlets averaged 83 % during 2014-2016, compared with 59 % for BAME residents. This gap in employment rates was almost twice as wide as for London. Women in Tower Hamlets have lower employment rates than men (60% vs 78%) and this gender gap is also wider than for London. In addition, within the BAME population, 48% of BAME women are in work, compared with 70 per cent of BAME men. This gender gap is also evident in the white population but is narrower. The ethnic gap in employment rates between white women and BAME women is twice as wide as in London.



2. The levels of income deprivation in Tower Hamlets compared to elsewhere will impact profoundly on lower self perceptions of health in the borough and particularly on health and wellbeing at both ends of the life course (children/families and older people)

Having sufficient income is fundamental to meeting core needs for health and wellbeing. In 2015 Tower Hamlets had the fifth highest levels of income deprivation nationally, with 25.3% of the working age population with insufficient income to meet the costs of accommodation and daily living compared to 14.7% nationally. It also had the highest proportion of children aged 0-15 living in income deprived households (39.3% compared to 19.9% nationally) and the highest proportion of people aged 60 or over experiencing income deprivation (49.7% compared to 16.2% nationally).

3. The excellent educational outcomes of children in Tower Hamlets will mitigate the impacts of income deprivation in children and affect future life expectancy but, although the data is from 2011, the higher levels of poor English language skills (particularly in women) is likely to be a contributor to poorer health in the Tower Hamlets population through impacts on core needs for wellbeing

Education and skills are fundamental to enabling people to meet core needs around safety (e.g. security of income, employment), satisfaction (sense of control and purpose) and connection (capacity to participate fully in society). Based on 2014/15 data, it is a remarkable achievement that Tower Hamlets had the highest proportion in the country of children with free school meal status with GCSE 5 A*-C including English and Maths (60% compared to a national average of 33.3%). The current impact of this on healthy life expectancy is marginal although the future impact will be profound.

However, based on 2011 census data, 7.97% of Tower Hamlets' population had limited English language skills, which was the joint lowest in London. The picture for women was worse, with 10.29% having limited English language skills compared with 5.77% for men in Tower Hamlets and 4.85% for women in London.

4. The impacts of higher levels of insecure housing and overcrowding on core needs for wellbeing is likely to be a significant contributor to poorer self-rated health in the Tower Hamlets population

Housing and the home environment are critical to wellbeing as they impact on core needs for safety (both physical and psychological), satisfaction (sense of pride in one's home and the area one lives in, enjoyment) and connection (relationships with household members e.g. family, friends, cohabiters). In 2017 there were 18,726 households on the housing waiting list, which was the second highest in London, and 37% of these were living in overcrowded conditions. In 2016/17 there were 17 households per 1000 in temporary accommodation, which is the 12th worst in England. For the reasons outlined above, this is likely to significantly affect healthy life expectancy figures through the impacts on self-perceived health of sense of security, satisfaction with housing and relationships within a household.



5. Healthy life expectancy in older people is a significant outlier and this is likely to be due to deprivation and its consequences including social isolation

In relation to older people there is direct data on healthy life expectancy (see below and in the appendix). In 2014-16 Tower Hamlets had the 2nd lowest healthy life expectancy at age 65 in London for both men and women (figures 10 and 11).

Figure 10 Healthy life expectancy at age 65 (male)

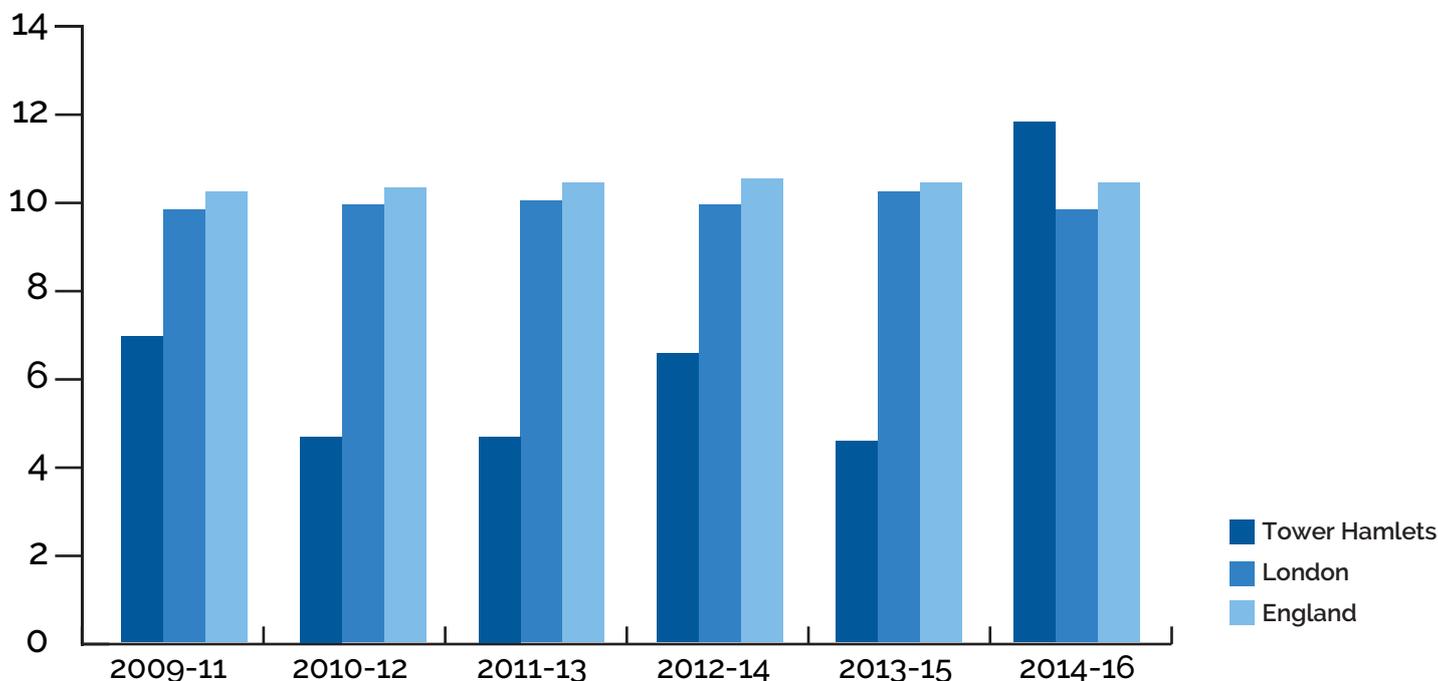
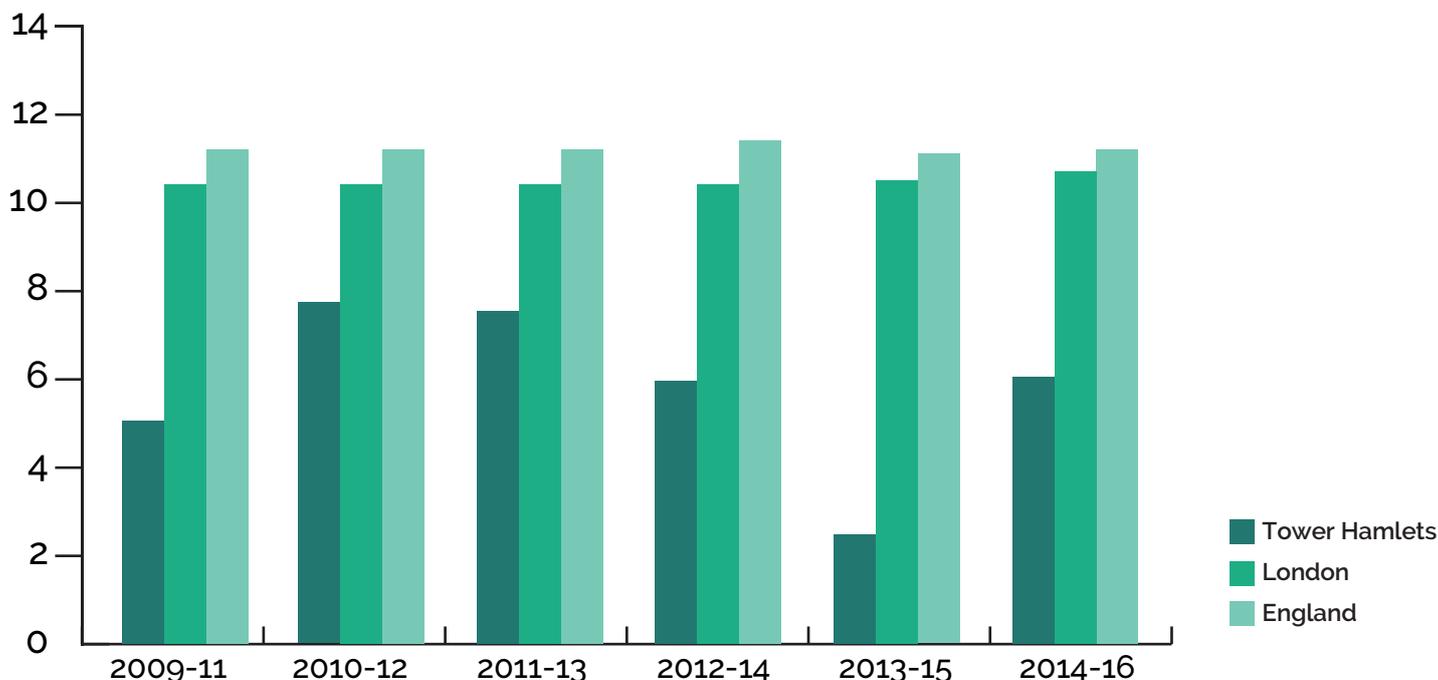


Figure 11 Healthy life expectancy at age 65 (female)



Behind this data, older people in Tower Hamlets had the highest level of income deprivation in the country based on 2015 data. A model developed by Age UK using 2011 census data to estimate risk of loneliness in over 65s scored Tower Hamlets amongst the highest of local authority areas. It is also notable that based on 2016 data, Tower Hamlets had the third lowest proportion of deaths in the usual place of residence nationally (29.9% compared to 47.2% nationally). Linking this to the data on loneliness, it is possible that this is partly explained by a relative absence of family or community support within older people households compared to elsewhere.

Taken together this data provides insight into issues that significantly impact on the foundations of wellbeing of older people living in Tower Hamlets relating particularly to financial security and social connection.

SUMMARY

In summary, sufficient income, good employment, adequate housing, skills to enable full participation in society, a secure home environment and positive social connections all come together to provide the basis for meeting the core needs of individuals that provide the foundations of wellbeing (safety, satisfaction and connection) and by extension good healthy life expectancy. The data reviewed in this section provides some evidence that compared to other local authority areas, these conditions are not in place for a significant proportion of the people in the borough, and this provides a strong explanation for the lower healthy life expectancy in the borough.

The purpose of this report has been to identify how the Tower Hamlets population differs from other populations in terms of factors that impact on health and to use this assessment to explain why the borough has had particularly low healthy life expectancy figures (the most recent improvement for males is significantly against trend and the reasons for this are being explored with Public Health England).

In summary, the assessment has confirmed that Tower Hamlets is not an extreme outlier around life expectancy and the underlying factors that drive it (early deaths from heart disease, stroke, cancer and respiratory disease). However, diabetes and the prevalence of common mental health problems stand out as particularly important differentiating characteristics of the population.

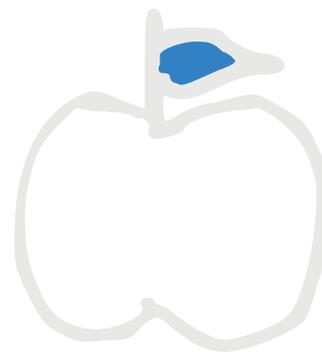
Taking together the outlier figures for Tower Hamlets around low birth weight, poor oral health and childhood obesity, it is helpful to see this within the context of families and the extent to which risk factors for health in children reflect those within the family as a whole. This is reflected in outlier adult figures for diet, smoking and sexual health.

Tower Hamlets is also an outlier in terms of the extent to which environmental factors that support health are lower than elsewhere. However, as mentioned in section 3 the strongest determinants of health are social and economic factors.

The cluster of outlier data on employment, income, literacy, housing and household dynamics and how these directly impact the foundations of wellbeing (safety, satisfaction and connection) provide the strongest explanation as to why the self-perception of health element of the health life expectancy figure weights the Tower Hamlets figures so significantly.

It should also be highlighted that is unusual in a population for women's healthy life expectancy to be lower than that of men. The data on social and economic determinants of health highlights specific issues around employment and literacy, especially for women, which are likely to be important drivers around this. In turn, these may link to maternal health issues that are indicated by the data on low birth weight.

At both ends of the life course the data highlights greater vulnerabilities than elsewhere in relation to health and wellbeing of children and older people in Tower Hamlets.



7 Considerations for Health and Wellbeing Board

It is not the purpose of this report to provide specific recommendations. However, particularly in the context of the development of the new Health and Wellbeing Strategy in 2020, suggested considerations for the Board based on this analysis of healthy life expectancy are as follows:

1. Trends in deprivation in the borough indicate deprivation is increasingly concentrated and potentially masked by an overall reduction in deprivation - this highlights the particular importance of targeted approaches to improving health and wellbeing of those with greatest health need
2. Whilst there have been substantial improvements in early deaths from the three big killers (cancer, cardiovascular disease and respiratory disease), Tower Hamlets remains well below the national average and these need to continue to be important areas of focus
3. Diabetes and diabetes prevention needs to remain a particular focus in the context of the higher prevalence in the Tower Hamlets population driven by its association with South Asian ethnicity and deprivation
4. The levels of common mental health issues (eg anxiety and depression) in the population are amongst the highest in the country - this provides a challenge around how to address this at scale
5. It is unusual that women's healthy life expectancy is lower than male healthy life expectancy but the supporting data provides potential explanations for this - this may be an issue that the Board may wish to consider
6. The data on health behaviours from early years to adulthood continues to highlight how these contribute to lower life expectancy and healthy life expectancy and particularly highlight issues relating to:
 - a. Maternal health
 - b. Family/Household approaches to promoting healthy lives
 - c. Smoking as a continued driver of health inequalities between Tower Hamlets and elsewhere
 - d. Substance misuse and sexual health as drivers of poor self-rated health in the borough
7. The data on environmental factors and local assets impacting on health continues to support Healthy Place as an important priority of the Health and Wellbeing Strategy in addressing the balance between health assets and hazards in neighbourhoods in the borough
8. The wider socioeconomic determinants of health (eg education, housing, income and employment) continue to account for poorer healthy life expectancy in the borough and this highlights the importance of the Health and Wellbeing Board being connected to the wider strategic context of the partnership
9. At both ends of the life course the data highlights greater vulnerability than elsewhere in relation to health and wellbeing of children and older people and this links to a wider issue around ensuring that the health and care system is delivering for the population based on a principle of equity (ie proportionate to need)
10. The Foundations of Wellbeing Framework (safety, satisfaction and connection) may be helpful in thinking about an approach to the new strategy that focusses on what matters to people

Appendix 1 - data tables

Table 1 Healthy life expectancy Olympic boroughs (male)

Male Healthy Life Expectancy at Birth						
	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Tower Hamlets	55.7	52.5	53.6	55.4	54	61.3
Barking and Dagenham	59.7	59.4	61.1	59.5	59.8	58.2
Greenwich	61.7	62.1	61	60	61.3	60.7
Hackney	58	58.9	57.9	58.4	57.7	59.1
Newham	59.7	58.8	59.2	58.3	60.5	65.4
Waltham Forest	61.3	62.7	60.5	61.3	59.6	62.4
London	63	63.2	63.4	64	64.1	63.5
England	63.2	63.4	63.3	63.4	63.4	63.3

Table 2 Healthy life expectancy Olympic boroughs (female)

Female Healthy Life Expectancy at Birth						
	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Tower Hamlets	54.1	57.2	57.1	56.5	52.4	55.6
Barking and Dagenham	57.7	57.3	55.5	54.6	58.5	60.7
Greenwich	63	63.3	64.3	63.5	61.6	58.5
Hackney	60.3	57.8	57.5	58.1	58.7	61.3
Newham	55.7	56.4	57.7	61	60.5	60.6
Waltham Forest	59.5	57.9	59.1	59.4	60.2	66.3
London	63.8	63.6	63.5	63.5	64.1	64.4
England	64.2	64.1	63.9	64	64.1	63.9

Disability free life expectancy

The calculation of disability free life expectancy is based life expectancy and on a self-rated assessment of how health limits an individual's ability to carry out day-to-day activities. This self-rated assessment data was obtained from the Annual Population Survey (APS) over a three-year period to achieve sufficiently large sample sizes to enable meaningful statistical comparison.

Table 3 Disability free life expectancy Olympic boroughs (male)

Male Disability-Free Life Expectancy at Birth						
	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Tower Hamlets	59.6	56.1	53.1	55.1	54.0	56.9
Barking and Dagenham	62.4	60.6	60.3	59.0	59.0	61.0
Greenwich	61.5	62.2	57.9	59.3	55.6	57.4
Hackney	60.7	60.7	59.7	58.7	57.4	57.7
Newham	58.8	58.4	58.0	56.2	57.2	63.1
Waltham Forest	65.1	63.3	60.8	61.4	61.5	62.7
London	64.5	64.4	63.7	64.0	64.1	63.8
England	63.9	63.9	63.4	63.3	63.0	62.8

Table 4 Disability free life expectancy Olympic boroughs (female)

Female Disability-Free Life Expectancy at Birth						
	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Tower Hamlets	55.6	55.7	54.6	52.7	53.5	56.4
Barking and Dagenham	62.1	56.7	57.1	55.0	58.5	61.1
Greenwich	61.2	62.0	63.0	62.1	58.7	58.5
Hackney	63.7	60.3	58.0	59.8	55.4	61.6
Newham	56.4	58.5	58.0	59.0	58.5	58.5
Waltham Forest	60.5	57.5	61.0	59.8	60.3	67.1
London	65.2	64.5	64.5	64.2	63.1	63.7
England	64.4	64.1	63.8	63.2	62.6	62.3

Healthy life expectancy at age 65

Table 5 Healthy life expectancy at age 65 (male)

Male Healthy Life Expectancy at Age 65						
	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Tower Hamlets	7	4.7	4.7	6.6	4.6	11.9
Barking and Dagenham	7.2	7.8	8.7	9.3	8.1	6.6
Greenwich	8.2	7.7	9.5	7.8	8	7.8
Hackney	8.7	9.6	8.9	10	7.4	7.8
Newham	7	7.6	6.5	5.4	6.8	12.4
Waltham Forest	7.5	9.2	8.1	8.5	6.5	7.8
London	9.9	10	10.1	10	10.3	9.9
England	10.3	10.4	10.5	10.6	10.5	10.5

Table 6 Healthy life expectancy at age 65 (female)

Female Healthy Life Expectancy at Age 65						
	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Tower Hamlets	5.1	7.8	7.6	6	2.5	6.1
Barking and Dagenham	7.2	7.6	5.9	8.2	8.7	8.8
Greenwich	10.3	10	9.8	9.1	9.2	8.1
Hackney	9.8	9	9.1	8.6	7.2	7.4
Newham	5.9	6.6	7.1	10	8.7	8.7
Waltham Forest	9.1	9.4	7.5	7.7	7.3	10
London	10.5	10.5	10.5	10.5	10.6	10.8
England	11.3	11.3	11.3	11.5	11.2	11.3

References

Unless otherwise stated, all references are from PHE Fingertips at <https://fingertips.phe.org.uk/>

Appendix 2 - community insight quotes

Community insights (resident quotes from community insight work to be used contextually in the online version of the report)

During February and March 2018, community insights researchers carried out an engagement exercise with people living, studying and working in the borough. The focus was on the key themes identified in the Tower Hamlets Partnership's plan and vision for the future. The quotes below will be used to illustrate points:

"I feel safe in my community because everyone grew up together. But I don't feel safe in certain areas of Tower Hamlets.."

"All kids in Tower Hamlets see gang violence"

"Things are improving for older people. There are some good programs and services – for example healthy living groups and activities for over 50s at the leisure centre."

"There are a lot of pollution in certain parts of the borough such as Commercial Road, leading into the city which isn't good as it is next to the hospital. This makes asthma worse."

"You can find a lot of jobs in London, but that doesn't mean they are good."

"A lot of high paid jobs in Tower Hamlets are for people who don't live in Tower Hamlets e.g. Canary Wharf."

"Employment and networking support available from housing associations, advice centres and community organisations on the Isle of Dogs is good."

"There are good schools, primary and secondary – some are outstanding."

"I don't feel safe in the parks – there are too many drugs, too many bullies."

"Schools need to have more after school clubs to allow young children to develop further."

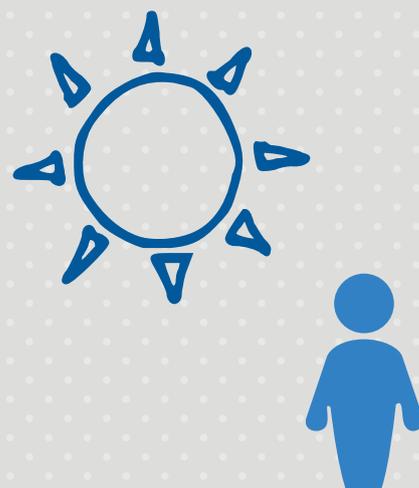
Acknowledgements

This report is a product of the Tower Hamlets Public Health Division within the Health, Adults and Community Directorate of London Borough of Tower Hamlets. Thank you to everyone involved for their contribution.

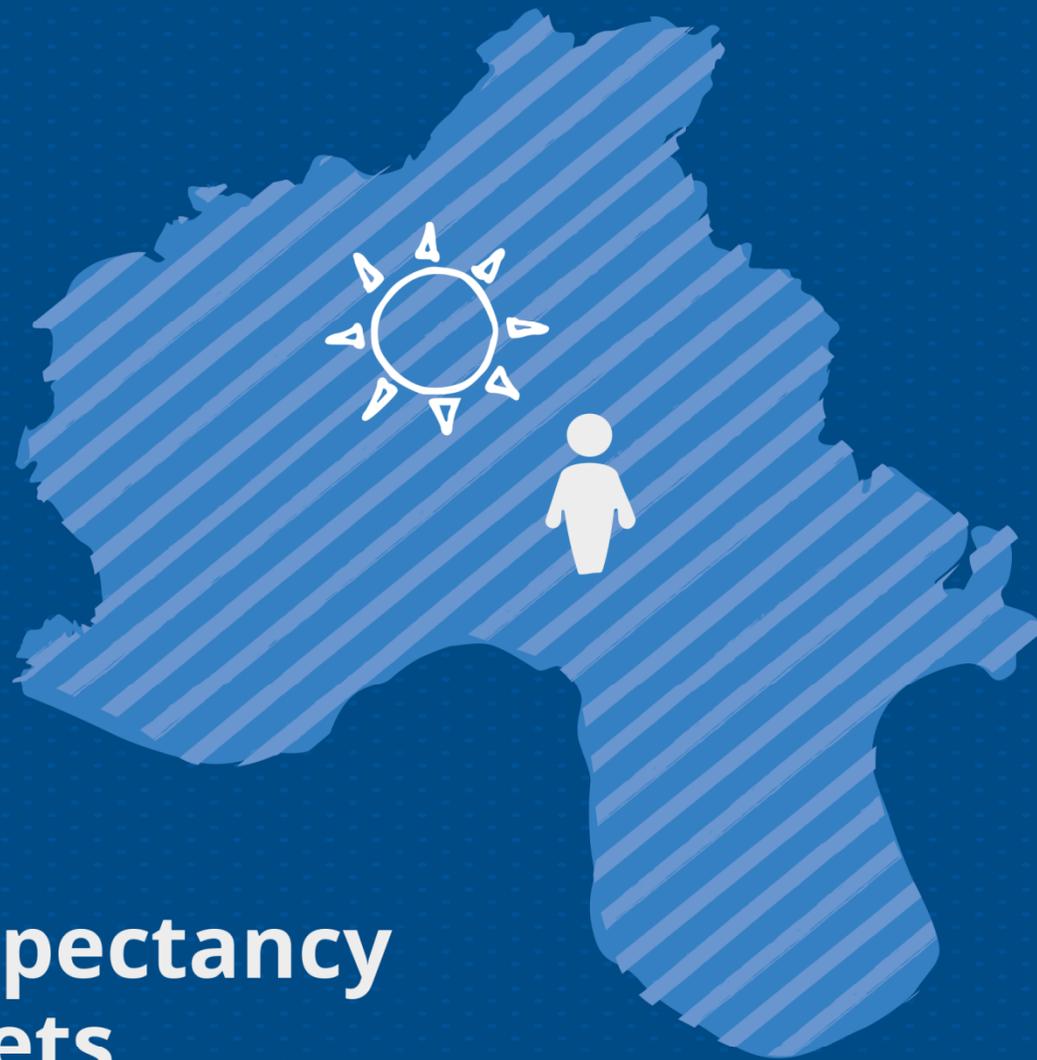
I would particularly like to thank Sarah Williams for her hard work in coordinating the delivery of the report. Many thanks also to Katy Scammell, Abigail Knight, Katie Cole, Chris Lovitt and their teams for their invaluable contributions.

For further information on Public Health please access the Public Health webpage on the Tower Hamlets Council website (link to be added when live)

Dr Somen Banerjee
Director of Public Health
London Borough of Tower Hamlets



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Healthy Life Expectancy in Tower Hamlets

Annual Public Health Report of the
Director of Public Health

2018



TOWER HAMLETS

Tower Hamlets

Tower Hamlets has a fast growing and changing population – this makes it challenging to understand the health of the population

- The population's health has been worse than elsewhere
 - Why is healthy life expectancy such a significant outlier?
 - What do we need to do to improve health and wellbeing in Tower Hamlets?



What is healthy life expectancy?

- An estimate of how many years a child born today would be expected to live in good health
- Is an important headline statistic

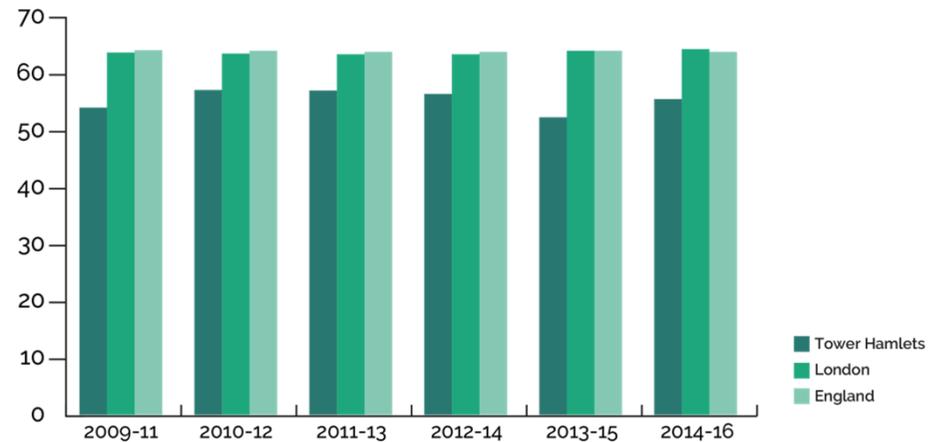
The relationship between healthy life expectancy and life expectancy



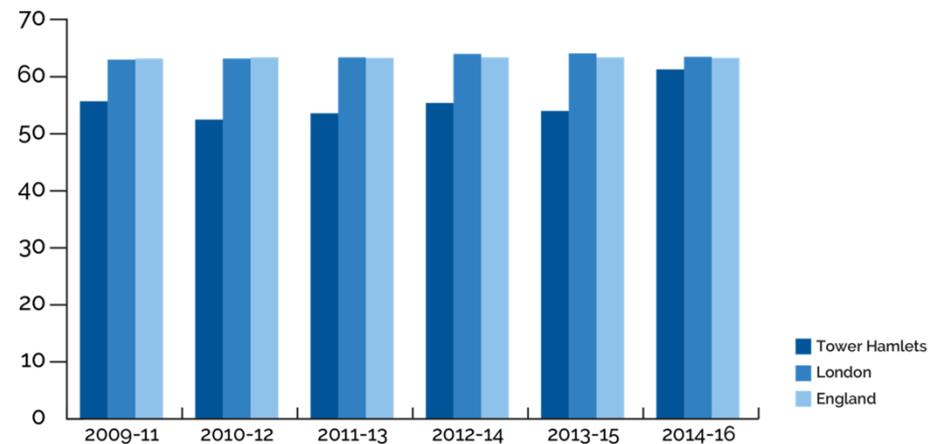
Healthy life expectancy in Tower Hamlets

- Amongst the lowest healthy life expectancy in the country
- Variation within the borough linked to deprivation
- Female is lower than male
- Life expectancy has been improving rapidly

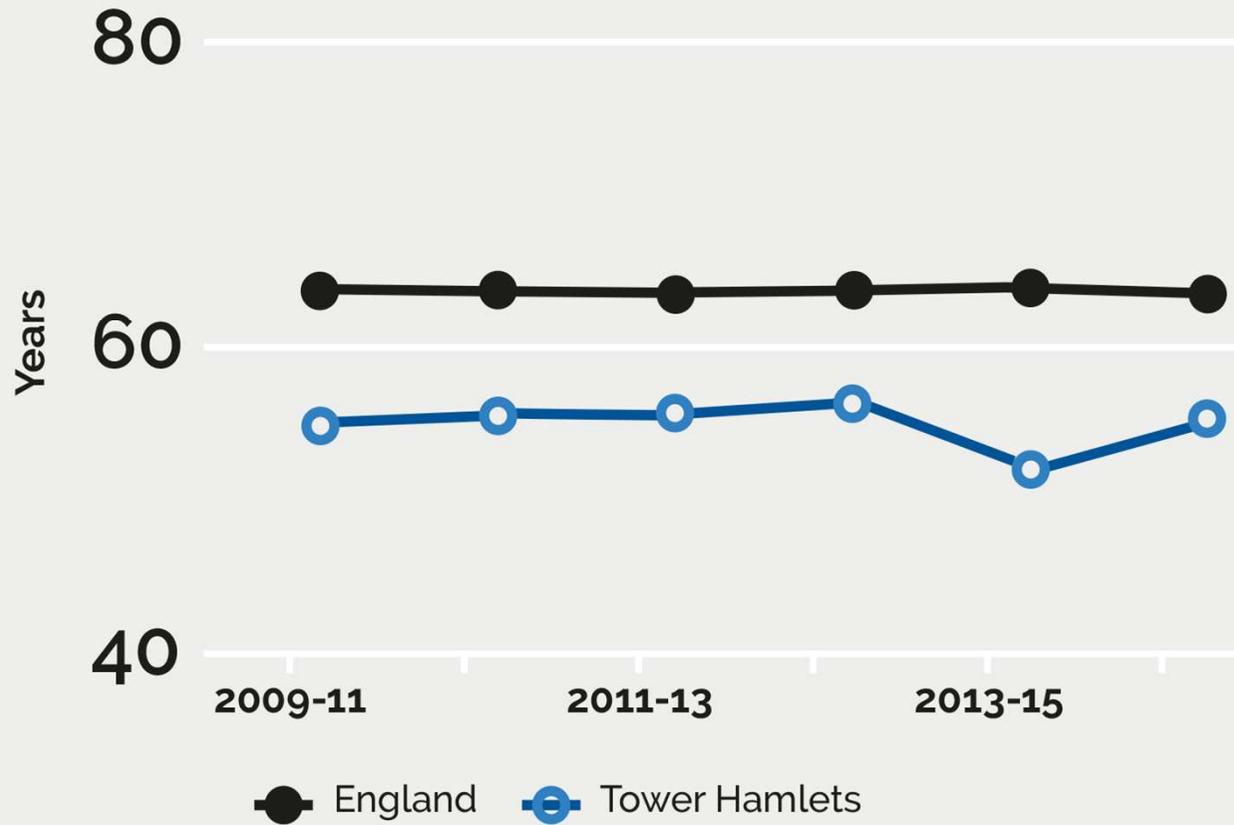
Healthy life expectancy at birth (female)



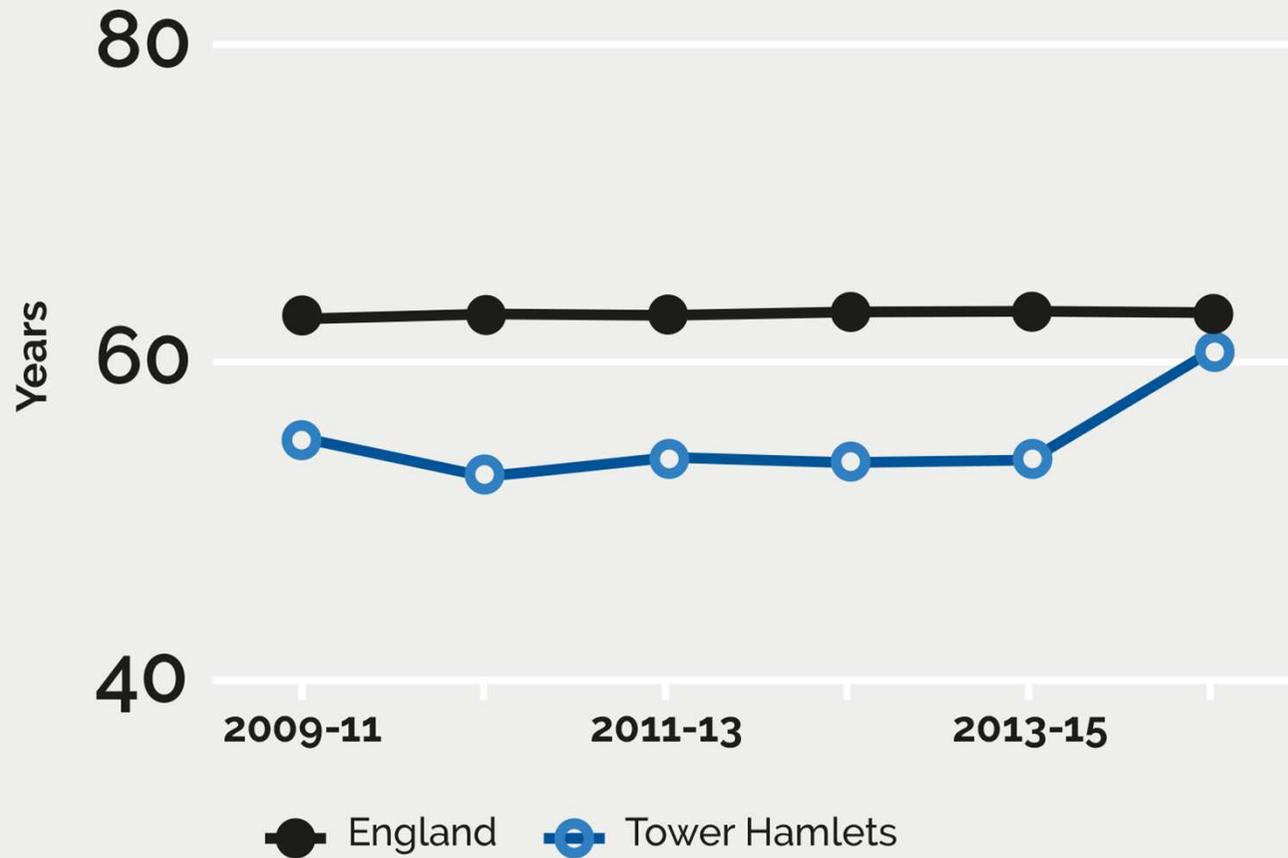
Healthy life expectancy at birth (male)



Healthy life expectancy at birth (female)

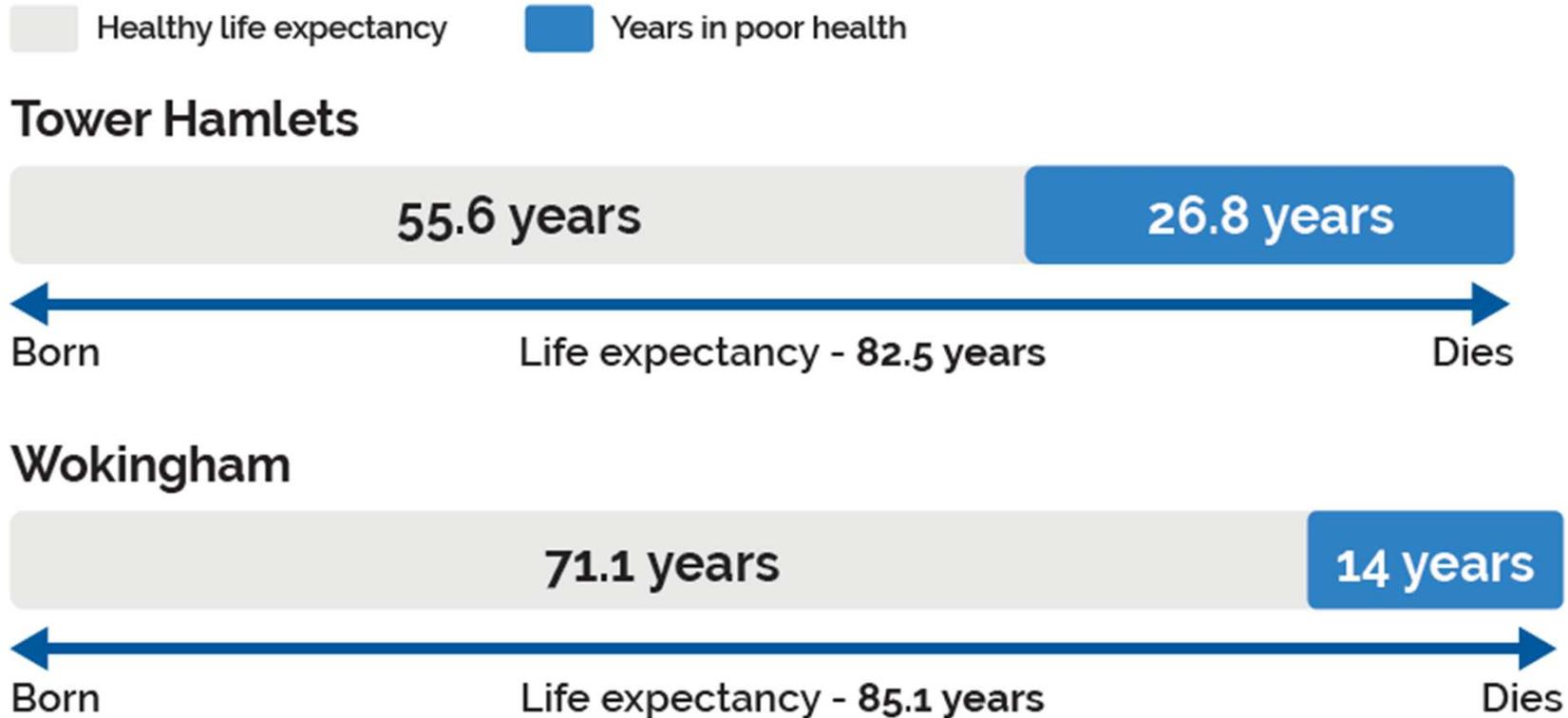


Healthy life expectancy at birth (male)



What is the difference?

Comparison of Healthy Life Expectancy of Women in Tower Hamlets and Wokingham (2014 – 2016)



Healthy Life Expectancy in Tower Hamlets

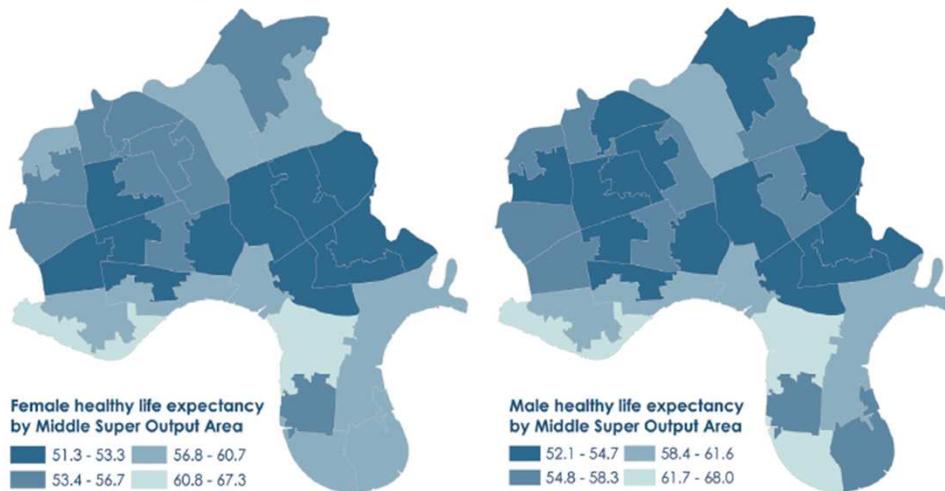
How healthy life expectancy varies in Tower Hamlets

- Healthy life expectancy varies significantly across the borough and this is linked to deprivation

Healthy life expectancy in Tower Hamlets, 2009 - 2013

Healthy life expectancy is the average number of years that an individual might expect to live in "good" health in their lifetime. These estimates are a snapshot of the health status of the population during 2009 to 2013, based on self-reported health status at the 2011 Census and mortality rates for each area in that period.

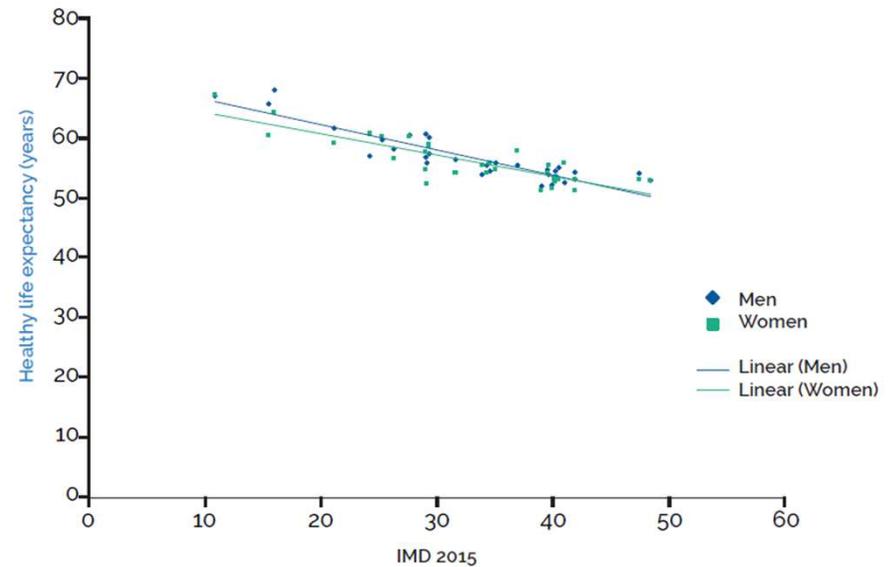
Source of data: ONS © Crown Copyright 2017.



Data has been classified by natural breaks (Jenks' method) for Tower Hamlets. The maps do not show confidence intervals and any geographic variation is not necessarily statistically significant.

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Healthy Life expectancy and Index of Multiple Deprivation

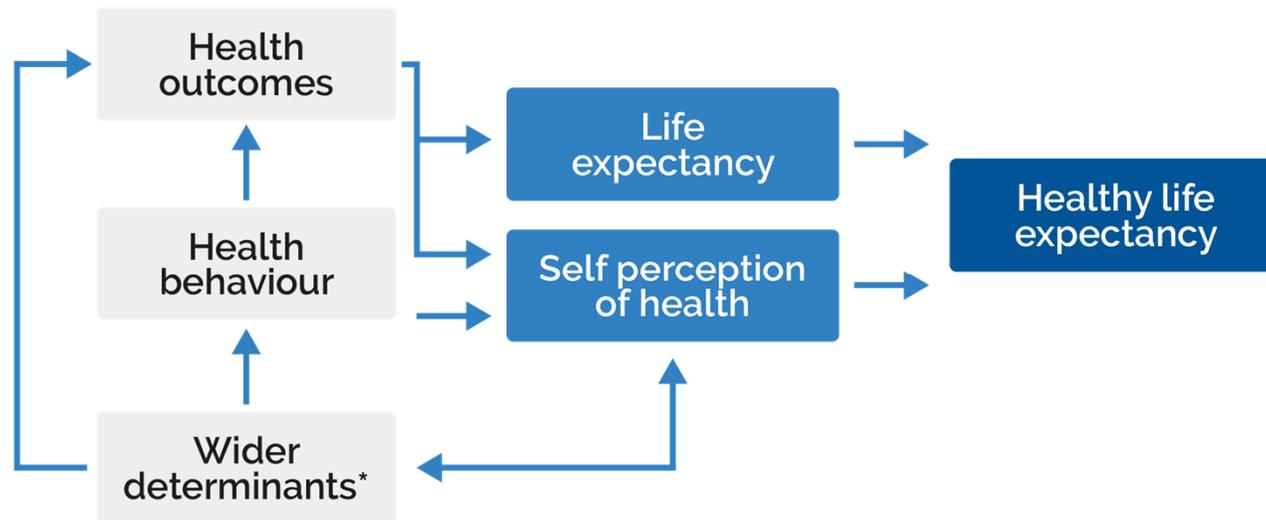


What determines healthy life expectancy?

- Life expectancy and how people rate their health (self-perception)
- Perception of health and wellbeing is strongly linked to the extent to which core needs are met or not met

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Factors determining healthy life expectancy



** wider determinants includes cultural and psychosocial factors, as well as a diverse range of social, economic and environmental factors which impact on people's health*

What explains the healthy life expectancy figures in Tower Hamlets?

We will consider:



- Deprivation
- Early death rates
- People living with long-term conditions
- Health behaviours
- Environment
- Socio-economic factors

Deprivation and early death rates

Deprivation

- Now fewer areas in the 10% most deprived nationally
- But still amongst the most deprived boroughs in England
 - All ages
 - All aspects from employment to housing to environment

Early death rates

- Twenty years ago had amongst the lowest life expectancy in the country
 - Some of the highest levels of premature deaths from cardiovascular disease, cancer and respiratory disease
- No longer the extreme outlier that it was

Long-term conditions and health behaviours

Long-term conditions

- Complicated by young population
- But...
 - High levels of diabetes
 - High levels of common mental health problems
- May help explain why Tower Hamlets has lower self-perceptions of health

Health behaviours

- Diet, physical activity, smoking, substance misuse and sexual health behaviours
- Linked to progression of long-term conditions, and levels of wellbeing

Environment and socio-economic factors

Environment

- The physical environment supports people's health significantly less than elsewhere
- High levels of crime compared to elsewhere:
 - Impact people's sense of safety and therefore self-rated health

Socio-economic factors

- Lower levels of employment than elsewhere
- High levels of income deprivation, insecure housing and overcrowding

Considerations for Health and Wellbeing Board

1. Importance of targeted approaches to improving health and wellbeing of those with greatest health need
2. Important to continue to focus on the three big killers (cancer, cardiovascular and respiratory disease)
3. Diabetes needs to remain a particular focus
4. High levels of common mental health needs
5. Women's HLE is lower than men's, which is unusual
6. Health behaviour can lower life expectancy and HLE
7. Environmental factors and local assets can impact on health

Considerations for Health and Wellbeing Board

8. Wider socioeconomic determinants of health continue to affect HLE, which highlights the importance of the HWB being connected to the wider strategic context
9. Greater vulnerability of children and older people – links to the wider issue of the health and care system delivering for the population based on a system of equity
10. The Foundations of Wellbeing Framework (safety, satisfaction and connection) may be helpful in thinking about an approach to the new strategy that focusses on what matters to people

From GNP to Gross National Happiness

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One indicator out of 33 relates to per capita income

<http://www.grossnationalhappiness.com/>

GNH Economic Model	GDP Economic Model
Sufficiency	Growth
Happiness achieved through serving others, living in harmony with nature, and realisation of our highest potential	Happiness achieved through maximising utility and preference satisfaction through goods and services
Based on needs satisfaction which are satiable	Based on satisfaction of wants which are insatiable
Active development of happiness skills (inner transformation)	Not included. Preferences and values are 'given'.
Good work and Right Livelihood	Work as a disutility
Focus on broad range of factors that contribute to wellbeing	Focus on material standard of living
Earth is alive and sacred	Environment as a tradeable and regulated commodity

OECD 'Beyond GDP':



Current Wellbeing

Material Conditions		Quality of Life		
	Income and wealth		Health status	 Subjective wellbeing
	Jobs		Work-life balance	 Safety
	Housing		Education and skills	 Social connections
			Civic engagement & governance	 Environmental quality

Resources for Future Wellbeing

	Natural capital		Human capital	 Social capital
			Economic capital	

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<p>Non-Executive Report of the:</p> <p>Health and Adults Scrutiny Sub-Committee</p> <p>8 July 2019</p>	 <p>TOWER HAMLETS</p>
<p>Report of: Denise Radley - Corporate Director, Health, Adult and Community Services</p>	<p>Classification: UNRESTRICTED</p>
<p>Report Title: Adult Social Care Charging Impact Assessment – Follow-Up</p>	

Originating Officer(s)	Joanne Starkie, Head of Strategy and Policy for Health, Adult and Community Services
Wards affected	All wards

Executive Summary

The Adult Social Care Charging Policy was agreed by Cabinet in 2016, and implemented with effect from October 2017. An assessment of the impact of charging for community-based support was presented to the Mayor’s Advisory Board in October 2018 and to the Health Overview and Scrutiny Committee in December 2018. This presentation provides a general update to the last impact assessment. It aims to answer two main questions

1. What have we done since the impact assessment was carried out?
2. Is there evidence that the impact has changed since the last assessment?

Recommendations:

The Health Overview and Scrutiny Committee is recommended to:

1. Note the contents of this presentation.

1. REASONS FOR THE DECISIONS

- 1.1 This report and presentation provides a general update to the last impact assessment presented to the Health Overview and Scrutiny Committee in December 2018. At the December meeting, the Committee requested this update to enable further scrutiny on the impact of charging.

2. ALTERNATIVE OPTIONS

- 2.1 n/a

3. DETAILS OF THE REPORT

3.1 Introduction

The Adult Social Care Charging Policy was agreed by Cabinet in 2016, and implemented with effect from October 2017. An assessment of the impact of charging for community-based support was presented to the Mayor's Advisory Board in October 2018 and to the Health Overview and Scrutiny Committee in December 2018. This presentation provides a general update to the last impact assessment. It aims to answer two main questions

- i. What have we done since the impact assessment was carried out?
- ii. Is there evidence that the impact has changed since the last assessment?

3.2 What have we done since the impact assessment was carried out?

We have moved forward on a number of issues that were identified in the original impact assessment, including agreeing to pay net direct payments and clarifying guidance on Disability Related Expenditure. We have improved our communication with service users– a critical issue highlighted in the last impact assessment - through a programme of activity.

3.3 Is there evidence that the impact has changed since the last assessment?

We have looked at a core set of information and identified the following:

- i. 44 per cent of people (1167 individuals) in community-based services were being charged an amount of money as of 30th April 2019. This is very similar to the proportion being charged in the last impact assessment.
- ii. Compared to the last impact assessment, more people are paying by direct debit, fewer people have an outstanding Financial Declaration form and fewer people are requesting a reassessment. These can all be seen as indications that the system is improving, but there is scope for more.
- iii. There is no clear evidence that charging is stopping people from coming forward for help, but further analysis is needed to understand the trends as cause and effect cannot be established. The number of people getting in contact with us is similar to the last impact assessment. The number of assessments has gone down.

- iv. As of 30th April, 88 care packages have been stopped due to charging. There is a system in place to safeguard adults who want to end or reduce their support due to charging, if doing so would put them at significant risk of harm. Risks or issues are discussed at a Charging Waiver Panel. To date, nine cases have been reviewed, resulting in charges being waived in four cases.
- v. The self-reported wellbeing of adult social care users has gone down slightly. Satisfaction levels with social care have increased. Whilst we can't conclude any direct causation between this and charging, the information provides context that we will continue to try to understand and monitor.

4. EQUALITIES IMPLICATIONS

4.1 The report does not include an equalities analysis. However, the original impact assessment in 2018 found that:

- Older people were more likely to be paying the full cost of their care (up to the maximum amount)
- People with a learning disability were less likely to be paying a contribution towards the cost of their care.
- People of a White ethnic background were more likely to be paying the full cost of their care (up to the maximum amount). People of an Asian ethnic background were less likely to be paying full cost, and were more likely to be paying no charge.
- There was no noticeable trend in terms of charging and gender.

Given that the last impact assessment was relatively recent and that the proportion of adult social care users being charged has changed little since then, it is likely that the trends described above are still in place. The report generally suggests that charging processes have improved, which would have a positive impact on the groups identified as being most affected.

5. OTHER STATUTORY IMPLICATIONS

5.1 The legal framework for charging in adult social care is articulated in the 2014 Care Act.

6. COMMENTS OF THE CHIEF FINANCE OFFICER

6.1 For the financial year 2018-19 invoices were raised to the value of £2.3m for community-based charging, in-line with the budgeted expectation.

6.2 There are no direct financial implications associated with this charging impact follow up assessment.

7. COMMENTS OF LEGAL SERVICES

- 7.1 The Care Act 2014 (“the Act”) provides that a local authority may make a charge for meeting eligible needs under the Act, and this applies to all types of care provision, whether through the provision of residential care or domiciliary care. The associated regulations and statutory guidance prohibit a local authority from making a charge in specified circumstances; and set an amount beyond which a person’s income cannot fall after paying any charges, which acts as a safeguard to residents. The Council has some flexibility in respect of setting charges, for example the flexibility to disregard certain sources of income, set maximum charges, or charge a person a percentage of disposable income.
- 7.2 The Equality Act 2010 requires the Council in the exercise of its functions to have due regard to the need to avoid discrimination and other unlawful conduct under the Act, the need to promote equality of opportunity and the need to foster good relations between people who share a protected characteristic and those who do not (the public sector equality duty). A proportionate level of equality analysis is required in order to enable the Council properly discharge this duty and the duty to act fairly applies.
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Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- Appendix 1 Adult Social Care Charging Impact Assessment – Follow Up

Local Government Act, 1972 Section 100D (As amended)

List of “Background Papers” used in the preparation of this report

List any background documents not already in the public domain including officer contact information.

- NONE

Officer contact details for documents:

N/A

Adult Social Care Charging Impact Assessment – Follow-up

8th July 2019

Health Scrutiny Panel

Joanne Starkie & Claudia Brown

Charging in Adult Social Care

Background

- Means-tested charging for community-based adult social care services started in October 2017
- Prior to this, Tower Hamlets was one of two local authorities in England who provided community-based support for free
- Our charging policy was agreed on the premise that only those who can afford to pay will do so
- A detailed impact assessment was carried in October 2018 and was presented to Health Scrutiny in December 2018.

Charging in Adult Social Care

Background

A follow-up impact assessment has now been carried out, aiming to answer the following two questions:

1. What have we done since the impact assessment was carried out?
2. Is there evidence that the impact has changed since the last assessment?

Charging in Adult Social Care

What have we done since the impact assessment was carried out?

We have focused on the 9 areas for improvement that were identified in the impact assessment:

1. Strengthening communication
2. Future approach to respite and replacement care
3. Future approach to Disability Related Expenditure
4. Strengthening how we help people to maximise their income
5. Preventing debt and encouraging direct debits
6. Future approach to direct payments
7. Developing an Appeals Policy
8. Future approach to impact assessments
9. Reviewing how we ensure people who end support due to charging are not at risk

Charging in Adult Social Care

What have we done since the impact assessment was carried out?

We have:

- Improved our communication with service users— a critical issue highlighted in the last impact assessment - through a programme of activity
- Clarified guidance on Disability Related Expenditure
- Agreed to typically pay net direct payments
- Started to use pre-paid cards
- Started to clarify the financial implications if our policy on charging, respite and replacement care changes
- Continued a detailed programme of work to help people maximise their income and avoid debt
- Agreed an ongoing, core set of measures to monitor the impact of charging in adult social care

Charging in Adult Social Care

Is there evidence that the impact has changed since the last assessment?

We have looked at:

1. How many people are being charged?

2. The profile of those being charged

3. How is the system working?

4. Is there an impact on demand for support?

5. Is there an impact on wellbeing?

6. Is there an impact on satisfaction?

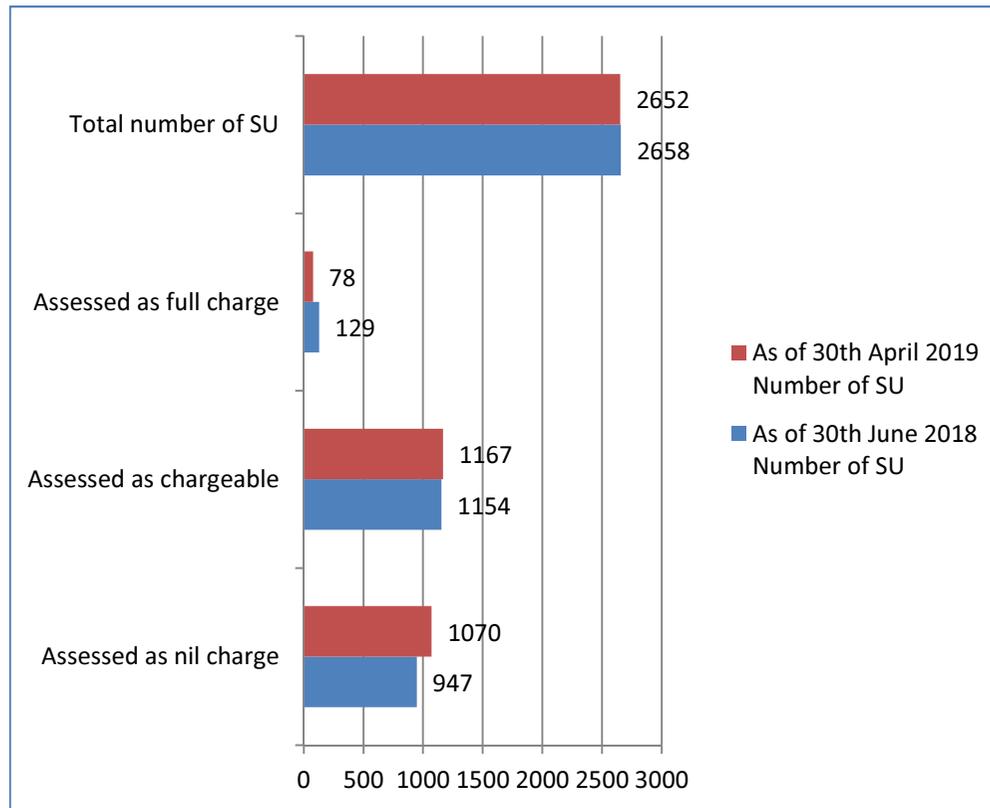
Charging in Adult Social Care

How many people are being charged?

- **1167** people were being charged an amount of money as of 30th April (44% of people in community based services)
- This is strikingly similar to the last assessment: **1154** people were being charged an amount of money as of 30th June 2018 (43% of people in community based services)

Charging in Adult Social Care

The profile of those being charged



Demographics not analysed, but likely to be similar to the 2018 assessment, which found:

- Older people and people of a White ethnic background are more likely to be paying the full cost of care up to the maximum amount.
- People with a learning disability and people of an Asian ethnic background are less likely to be paying cost and have a lower average weekly charge compared to other groups.

Charging in Adult Social Care

How is the system working?

- **352** people paid by direct debit as of April 2019, compared to **248** in June 2018
- **171** people had not yet completed a Financial Declaration form as of April 2019, compared to 240 in June 2018
- An average of **54** people per month requested a reassessment in 2018-19, compared to 147 people per month between October 2017 and March 2018



Improvement, but with scope for more

Charging in Adult Social Care

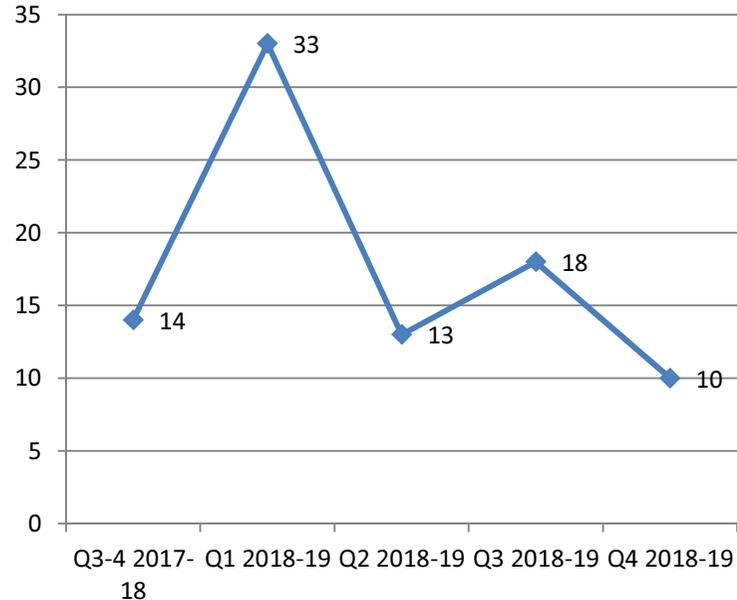
Is there an impact on demand for support?

- No clear evidence that charging is stopping people from coming forward for help, but further analysis is needed to understand the trends as cause and effect cannot be established.
 - The average number of people getting in contact with us each month is similar, moving from 1088 to 1077.
 - The average number of people who have an assessment completed each month has reduced from 204 to 154.

Charging in Adult Social Care

Is there an impact on demand for support?

To date, 88 care packages have been stopped due to charging:



- There is a system in place to safeguard adults who want to end or reduce their support due to charging, if doing so would put them at significant risk of harm.
- Risks or issues are discussed at a Charging Waiver Panel. To date, nine cases have been reviewed, resulting in charges being waived in four cases.

Charging in Adult Social Care

Is there an impact on wellbeing?

60% of all service users getting community-based support rated their quality of life as good in February 2019, compared to 62% the year before.

Is there an impact on satisfaction?

63.5% of service users in community-based services said they were extremely or very happy with their care and support, compared to 59% the year before

...Although we cannot establish cause and effect, these provide context to the impact of charging for adults social care users.

Next steps

Through the Stakeholder Reference Group, we will continue to:

- Regularly analyse the impact of charging, using the core measures described here
- Continue to make progress with the action plan – e.g. rolling out prepaid cards, continuing to carry out communication activity on charging

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