Royal Borough of Greenwich

Director of Public Health Annual Report

2019

Cabinet Member Foreword

As Cabinet Member with responsibility for Public Health, I am delighted to be able to present this year's Annual Public Health report with its focus on the important challenges to the health of our residents.

This report provides us with a review of some of the emerging issues that were identified in last year's report , highlighting some serious health inequalities. It also aims to provide the Council and partners with guidance to address inequalities across the life course and to understand the main socio-economic factors that can positively or negatively impact on health. This should be helpful in assisting partners in the Borough to address the challenges and opportunities to improve health over the next 5 years.

I look forward to working with colleagues across the Council and with our partners on these emerging issues so we can continue to strive to improve the health of our population.

Councillor Averil Lekau
Cabinet Member for Adult's Social Care and Health

ROYAL borough of GREENWICH

Director's foreword

I am pleased to introduce my annual report for 2019.
In my last report I reflected on the changes in the health of people in Greenwich over the previous five years and highlighted emerging issues that require a better understanding through further investigation and analysis.

I took a life course approach concentrating on health outcomes for children (Starting Well), adults (Staying Well), and older people (Ageing Well). I also looked at the other factors that have a significant influence on health (Living Well) such as employment, housing, the environment and poverty.

The report identified a number of emerging issues that needed further investigation. While it has not been possible to investigate all of these issues over the last year, this report has focused on some key priorities, specifically:

- Starting Well: For Children and Young People I focused on
    - What is driving higher levels of Infant Mortality?
    - What is driving higher admissions in Children and young people, in particular respiratory admissions
- Staying Well: For young people and adults I focussed on
    - When people in Greenwich experience a Mental Health crisis are they able to access the services they need (looking both at Children and Adolescent Mental Health Services (CAMHS) and emergency admission to hospital for adults)?
    - What is driving Inequalities in early or preventable death for people in Greenwich?
- Ageing Well: For Older people I focussed on
    - What is driving our older people to become frail? Who is at risk and what do we need to do to reduce the impact?
- Living Well: For this area I focussed on
    - Domestic abuse, who is at high risk and what do we need to know to support victims better?

In last year's report I said I wanted to ensure that my annual reports are as helpful as possible to strategic partners, assisting them to prioritise and commission appropriate services to meet the health needs of the people of Greenwich. I hope that the analyses that have been undertaken this year provide that help and I welcome feedback to ensure that this aim is achieved in future years

Steve Whiteman
Director of Public Health

Starting Well

Infant Mortality

What is driving….

- **poor child mortality**

In 2016/17 an audit of infant deaths was undertaken:

25

infant deaths were reviewed and found that

- **18** Died prematurely (72%) of which 17 were neonates (0-27 days)
  - 11 were extremely premature (less than 28 weeks gestation)
  - 6 were pre-viable (less than 24 weeks)
- **18** cases were from families living in the 1st and 2nd most deprived quintiles (72%)
  - 2 were from 3rd most deprived quintile – the remaining were unknown
- **5** had congenital disease (found before or at birth)
- **10** cases were known to be late booking for antenatal care (after 12 weeks)
  - in a further 4 cases the information was unavailable
- **4** mothers smoked in pregnancy (16%)
  - in a further 3 cases smoking status was unknown
- **4** mothers were known to have Mental ill-health at booking (16%)
- **12** mothers were overweight (6) or obese (6) (48%)
  - in a further 4 cases the BMI was unknown

Modifiable risk factors identified in the Audit

- Late booking
- Smoking in pregnancy
- Obesity

The Audit has highlighted three key modifiable risk factors that if addressed could have potentially mitigated against the infant death.

The Audit also identified that parental consanguinity is a significant risk factor in our ethnic communities

What are Modifiable risk factors

Modifiable risk factors that those factors that can be modified and if they had been could have potentially mitigated against the infant death

Starting Well

Modifiable Risk Factors

1. Smoking in Pregnancy – what are the risks

Risk Factor	Impact of smoking during pregnancy	Impact of second-hand smoke during pregnancy
Low Birth Weight	Average 250g lighter (if below 2,500g, baby is more at risk of educational and health needs)	Average 30-40g lighter
Still birth	Doubles the likelihood	Increased risk
Miscarriage	24-32% more likely to happen	Possible risk
Preterm birth	27% (over 1 in 4 chances)	Increased risk
Heart Defects	50% more likely (1 in 2 chances)	Increased risk
Sudden Infant Death	3 times more likely	45% more likely

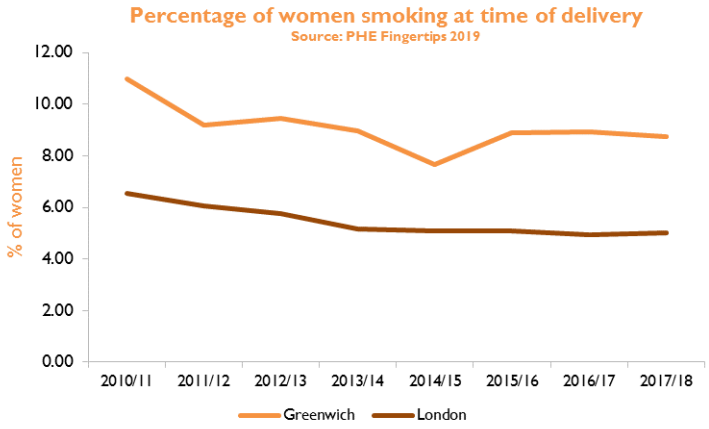
Source: Action on Smoking – Smoking in Pregnancy Challenge Group. Review of the Challenge 2018

2. Obesity in Pregnancy – what are the risks

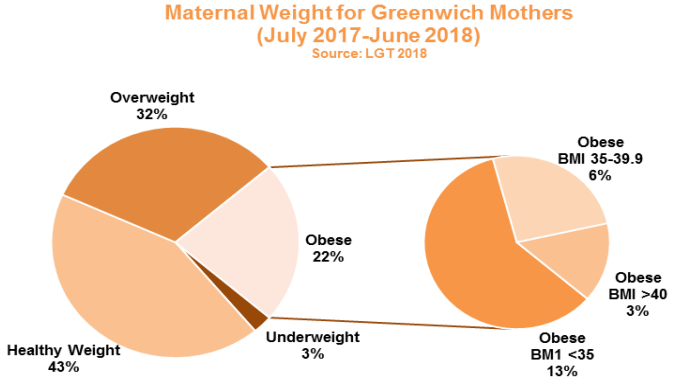
Risk Factor	Impact of obesity during pregnancy
Still birth/Infant Death	2-3 times higher in women who were obese at the start of pregnancy compared to those with a healthy BMI
Miscarriage	3.5 times more likely to happen in women with a BMI over 30
Congenital Abnormalities	1.2-2 times more likely (depending on condition). That is a 1 in 14 risk in general population compared to 1 in 9 risk for women with a BMI above 30
Preeclampsia	3 times more likely. That is a 1 in 25 risk in women with a healthy BMI compared to 1 in 7 for women with a BMI over 30

Source: PHE Maternal Obesity Briefing 2015

What is happening in Greenwich?



In 2017/18 nearly 9% of women in Greenwich are still smoking at the time of delivery
(compared to 5% in London – 1 in 11 vs 1 in 20)



In 2017/18 22% of women in Greenwich had a BMI of over 30 (clinical definition) – this means 1 in 5 women have an increased risk of stillbirth due to obesity alone

Starting Well

3. Late Booking – what are the issues

Issues for Late Booking

Delayed access to maternity services ('late booking') is linked to increased maternal, foetal and infant mortality and morbidity.
Five United Kingdom (UK) Maternal Mortality reports have identified late booking as a significant risk factor for maternal death.

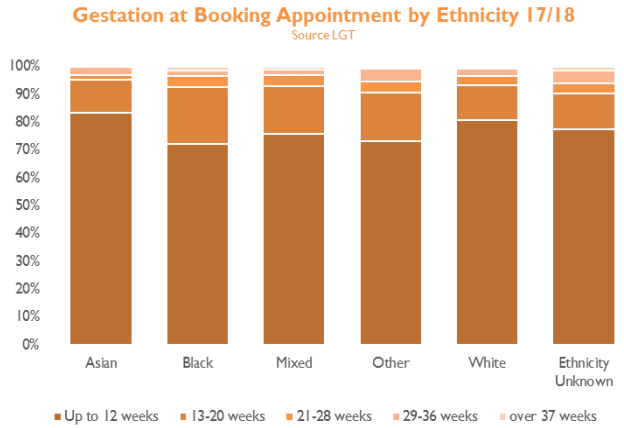
UK guidance recommends that all pregnant women should have had their first antenatal appointment with a midwife by 10–12 completed weeks of pregnancy, in order to identify and respond to clinical and social risk factors, and that all antenatal screening should be completed before 21 weeks gestation

Observational Studies suggest that 'late bookers' for antenatal care are typically from

- socially excluded groups; ethnicity in particular where there is language issues
- young age
- low income or nil recourse to public funds
- poorer educational level where there is a lack of support
- those who are more chaotic such as women with substance misuse problems

Source: Centre for Maternal and Child Enquiries (CMACE) Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. BJOG
Rowe RE, Garcia J. Social class, ethnicity and attendance for antenatal care in the United Kingdom: a systematic review. J Public Health Med. 2003;25:113–119.

What is happening in Greenwich?



In 2017/18 overall 78% of women in Greenwich had booked into maternity services by 12 weeks gestations
This means 1 in 5 women book late and this appeared to be influenced by ethnicity with some ethnic groups more likely to book later

Other risk factors which significant impact

- **Parental Consanguinity** (where both parents are closely related)

One of the largest categories of deaths of infants is chromosomal, congenital and genetic anomalies (18% of all deaths between 2008 and 2016). Parental consanguinity is a contributory factor to child deaths in Greenwich. This is likely to represent the 'tip of the iceberg' as many other children born in the context of parental consanguinity will be living with disability. While Greenwich is not exceptional, this risk factor for poor child health is seen elsewhere in London. A brief audit conducted in 16/17 found that 86 pregnant women that booked for maternal care with Queen Elizabeth Hospital, Greenwich, reported conception within a consanguineous relationship. The ethnic background of the majority of cases (73%) is 'Asian' or 'Other', including unknown.

What needs to be done?

Partners are coming together to develop a preconception strategy to support

- reduction in smoking preconception and during pregnancy
- supporting prospective mothers to achieve being a healthy weight before pregnancy
- to ensure women know how and when to book for antenatal care

Further work is being carried on behalf of the Child Death Overview Panel to understand the impact for children and parents of parental consanguinity and how this risk can be mitigated.

Starting Well

What is driving…. High use of Health Services specifically emergency admissions for respiratory conditions

In the annual report last year it was identified that children had high levels of hospital admissions for respiratory conditions but it wasn't clear what was driving these high rates.

A review of hospital admissions has been undertaken to see whether air quality might be a contributory factor.

Air Pollution – what is it?

Air pollution is where substances occur in the air that wouldn't normally be there and could cause harm. The pollutants whose levels are of concern today are

- small-particulate matter caused by solid particles such as dust, pollen, ash (often referred to as PM10 and PM2.5 – particles smaller than 10 microns and 2.5 microns respectively),
- Nitrogen Dioxide (NO_2),
- Ground-level ozone (O_3)

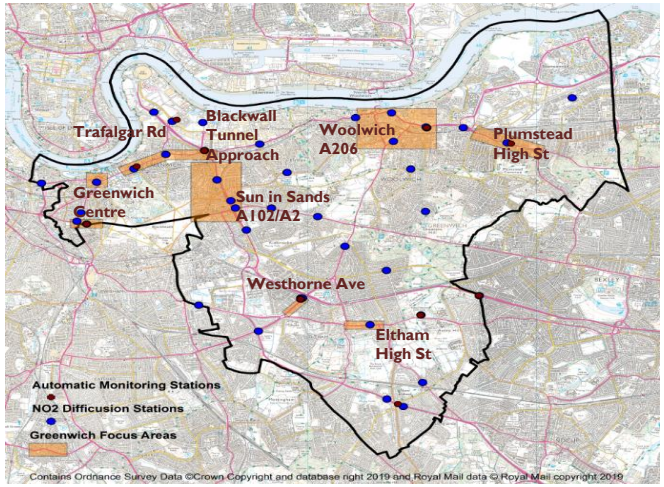
Currently, there is no clear evidence of a safe level of exposure to these pollutants below which there is no risk of adverse health effects. In Greenwich, $PM_{2.5}$, and PM_{10} are below EU limits while NO_2 is above EU limits. However, even though the level of emission of particulate matter is below the legal limit, the levels are still high enough to cause health problems,.

Air Pollution - where does it come from?

Air pollutants are emitted from a range of natural and man made sources, often from everyday activities such as cooking (indoor pollutants), but the predominant sources of pollutants outside are from manufacturing, construction and vehicles particularly involving the use of fossil fuel (coal, gas and oil)

Pollutants can have both short and long term effects on health and disproportionately impact on people from deprived communities, who are living close to main roads, the young and those with long term conditions.

The most significant source in Greenwich is from road traffic (Crosby, 2016)



In Greenwich there are greater rates of air pollution close to major roads. The North and West of the borough has been particularly affected, due to the major road network (A2 and South Circular) and partly by volume of traffic (which will be affected by the level of regeneration within the borough). There are 7 Air Quality Focus Areas (AQFA) in Greenwich (shown on the map). From 2020/21 four of these areas will fall within the Mayors Ultra Low Emissions Zones that will be associated with charging, to encourage the use of less polluting vehicles

Greenwich as a whole is an 'Air Quality Management Area'. for which we have an Air Quality Action Plan (2017 – 2021), and report annually to the GLA on implementation

Starting Well

What is driving…. High use of Health Services specifically emergency admissions for respiratory conditions

What are the Impacts?

When air pollutants enter the body, they can have effects on various different organs and systems, not just the respiratory system. This includes the eyes, nose and throat, the lungs and respiratory system and the heart and blood vessels causing health conditions as outlined in the table above.

Emerging evidence suggests that air pollution may also affect the brain and is possibly linked to dementia and cognitive decline. There is also emerging evidence associating air pollution with early life effects such as low birth weight, similar to the impact of smoking in pregnancy.

	Impact of exposure to poor air quality (pollution)
Pre-birth	Low-birth weight
Children	Asthma, Wheezing, Cough, slower development of Lung Function, development problems, start of atherosclerosis
Adults	Asthma, Coronary Heart Disease, Lung Cancer, Chronic Obstructive Pulmonary Disease, Diabetes
Elderly	Asthma, accelerated decline in Lung Function, Lung Cancer, Diabetes, Dementia, Heart Attacks, Heart Failure and Stroke

Source: PHE 2019

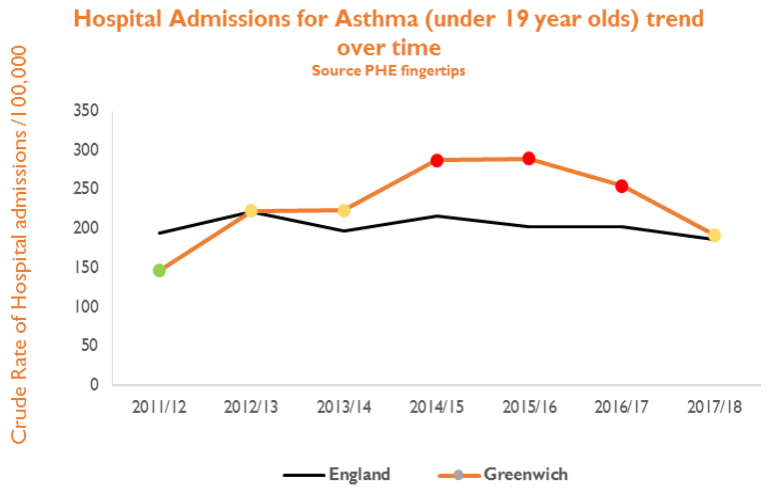
Impact of Air Quality on Health in Greenwich

Greenwich has lower life expectancy than the average for London and England, and although life expectancy had been increasing, progress appeared to have slowed by 2015-17.

Rates of mortality amongst people aged 75 or less from Cardiovascular Disease, Cancers, and Respiratory Illness are amongst the greatest in London, and there are high rates of emergency admissions of children including emergency admissions due to asthma amongst children aged 0-9 and emergency admissions due to lower respiratory infections amongst infants aged 1 (PHE Fingertips, 2019)

Rates of emergency admissions amongst children and young people aged under 19 as a result of asthma had been significantly above the average for London and England although the levels have fallen since 2016/17.

In 2017-18, the main cause of emergency admissions amongst 0-19 and in 0-4 year olds were respiratory illness both 'acute upper respiratory infections', and 'other acute lower respiratory infections'.

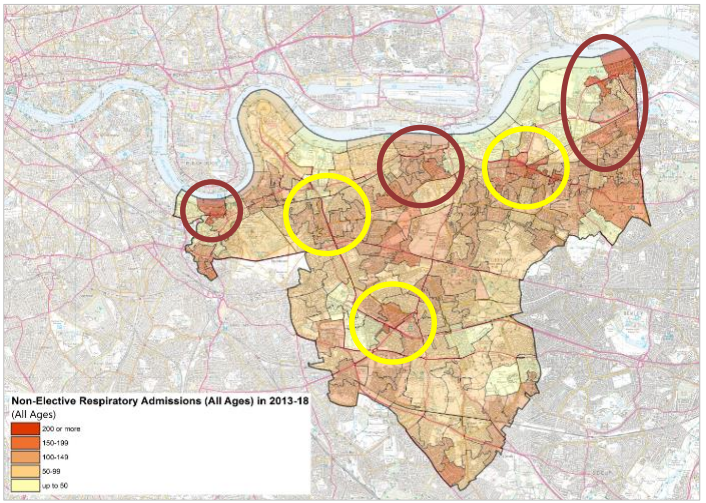


Starting Well

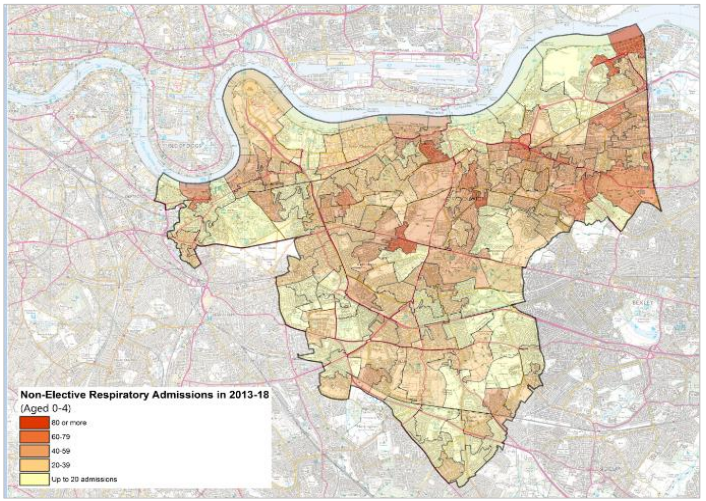
Is air quality a factor in hospital admissions for children?

A detailed geographical examination of hospital activity data over a 5 year period (2013-2018) indicates that there are greater numbers of cases of respiratory admissions for 0-19 year olds amongst Greenwich residents living near to main roads, and the higher rates are often seen close to big intersections (circled yellow). Other areas of high admissions are less obviously linked to highways but may be more influenced by higher levels of building development with associated increased air particulates (circled red)

Map of Emergency admissions (2013-2018) by LSOA for 0-19 year olds

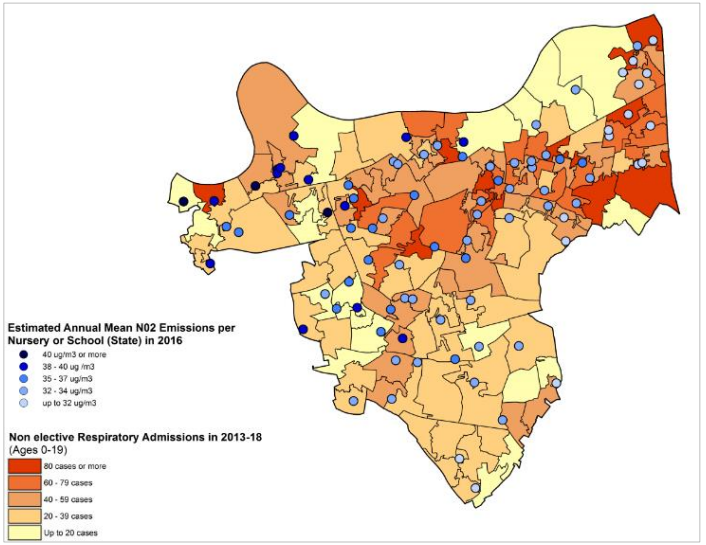


Map of Emergency admissions (2013-2018) by LSOA for under 5 year olds



High admissions in some areas appear close to schools and other educational establishments and could suggest that areas around schools have high congestion/poor air quality.

However, a more detailed comparison of the annual mean NO_2 emissions by school would suggest the biggest influence is more likely to be the main roads where children live and their routes to school rather than where they attend school



What are we doing to tackle poor air quality?

The analysis supports the evidence between poor health and poor air quality and specifically demonstrates a relationship between high levels of hospital admissions for children for respiratory conditions and poor air quality. This is of particularly importance for young children under 5 years (second map) who are more vulnerable because their lungs are still developing and are therefore more prone to damage. The impact on health has the potential to cause long term ill-health which supports evidence that adults in Greenwich have a shorter life expectancy which is linked to premature mortality due to respiratory disease (See Staying Well section).

By far the most significant source of air pollution within Greenwich is road traffic. Brakes and tyres produce much particulate matter, not only exhaust fumes which add to the pollution levels. Opportunities to encourage a shift away from motor vehicles towards active forms of transport is an important way to tackle pollution but has the additional health benefits of improving physical activity. There is also growing evidence that free flowing traffic is associated with lower levels of pollution than stationary traffic or low speed traffic queues. Therefore reducing the amount of traffic and/or encouraging the use of cleaner vehicles will have a positive impact on air quality.

In Greenwich we are tackling poor air quality through encouraging active travel (cycling, walking and public transport) and the use of cleaner vehicles by

- Working towards the Mayors transport strategy target for the Royal Borough of Greenwich of 75% of all travel being active (walking, cycling or using public transport), by 2041
- Improving local infrastructure including cycle lanes and pedestrian areas
- Increasing the charging point infrastructure in the Borough to support the use of electric vehicles
- Supporting reduced car ownership through supporting car clubs
- Supporting the Mayors ultra low emission zones expansion

Other sources of pollution include construction sites which can emit large amounts of particulate matter. This was seen in the pattern of hospital admissions for children. While building development is important in improving peoples living conditions and housing, ways in which we can mitigate pollution generated by the construction industry need to be further considered within our programme of building development including regeneration to reduce the potentially harmful effects on our children.

The Council passed a Climate Change Emergency motion in 2019, requiring us to develop a Carbon Neutral Plan with ambition for carbon neutrality in the Borough by 2030 (ahead of Government deadlines). This will encompass the existing Air Quality Action Plan and wider factors relating to carbon emissions.

Staying Well

Who is in Mental Health crisis and are the people of Greenwich able to access the services they need?

There is a growing understanding and recognition that mental health is more than the absence of mental illness and that good mental health underpins everything we do, how we think, feel, act and behave.

Good mental health and wellbeing is profoundly important to growth, development, learning and resilience and can be understood as 'how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole'[1].

A survey of local people conducted in October 2018 showed that:

- The **three biggest barriers** to being happier that people highlighted were **money** (23%), **community, connection and loneliness** (15%) and having **a safe and pleasant environment** (13%)

- In terms of what needed to change locally, people wanted to see **improvements in services** (30%), **additional support** such as **self-help groups, mindfulness and safe spaces** (17%) and **community and equalities** (17%)

Recognising we need to understand more about our services for Mental Health, we have undertaken two pieces of research to understand our mental health services better, for children and adults, to identify opportunities for improvement.

A Health Equity Audit of Services for Children and Young People (Level 1 (targeted universal services) and Level 2 (specialist) Children and Adolescent Mental Health Services (CAMHS)) found that:

- Nationally, some evidence that the need for mental health services is lower in Asian (Indian) and Black children but this is being challenged
- Locally, strong evidence that White British children are more likely to be referred to CAMHS; Black and Asian children are less likely to be referred, across all referral sources (Education Primary Care and Social Care)
- Nationally and locally this pattern is also seen by other services (including SEN and hospital services)
- Locally there is evidence that children of different ethnicities have similar likelihood of being accepted into CAMHS once referred
- National and local evidence suggests there is a gender difference in diagnosis, with more stress, self harm and affective conditions in girls, and more behaviour-related conditions in boys

A review of acute mental health admissions[2] for Adults found that:

- Greenwich has higher rates of admissions for Mental and Behavioural disorders for Adults compared to London and nationally
- There are variations in admissions due to age, gender and ethnicity - Black and Asian populations present proportionally more with diagnosis of Schizophrenia where as white populations present proportionally more with a diagnosis of Mental and Behavioural disorders due to substance misuse
- There is an over-representation of black young people (18-24 year olds) in Hospital Admissions for Mental Health
- Admissions for mental and behavioural disorders due to Substance Misuse are primarily due to Alcohol and Multiple Drug Use
- Average number of admissions per person is in line with London - the high admission rate is more likely due to increased numbers of people attending rather than a few attending often

[1]New Economics Foundation
[2]Data for this Study from NHS Digital HES Online 2018

This research has identified

There is a disconnect between under-representation of black young people referred to Children and Adolescence Mental Health Services (CAMHS) and over-representation of black young people (18-24 year olds) with non-elective admissions (inpatients)

This has led to further questions

What is the reason for black young people over represented in adult (18-24) emergency admissions but under-represented in CAMHs?

- Late onset of condition?
- Presenting as something different under 18 years?
- Stigma in families?

What is the reason for high numbers of admissions in Greenwich with substance misuse?

- Is it a coding issue
- Are these young people already known to services?
- Do we have a higher level of dual diagnosis (population issues/availability)?
- Are people self medicating to alleviate their conditions (lack of support in the community)

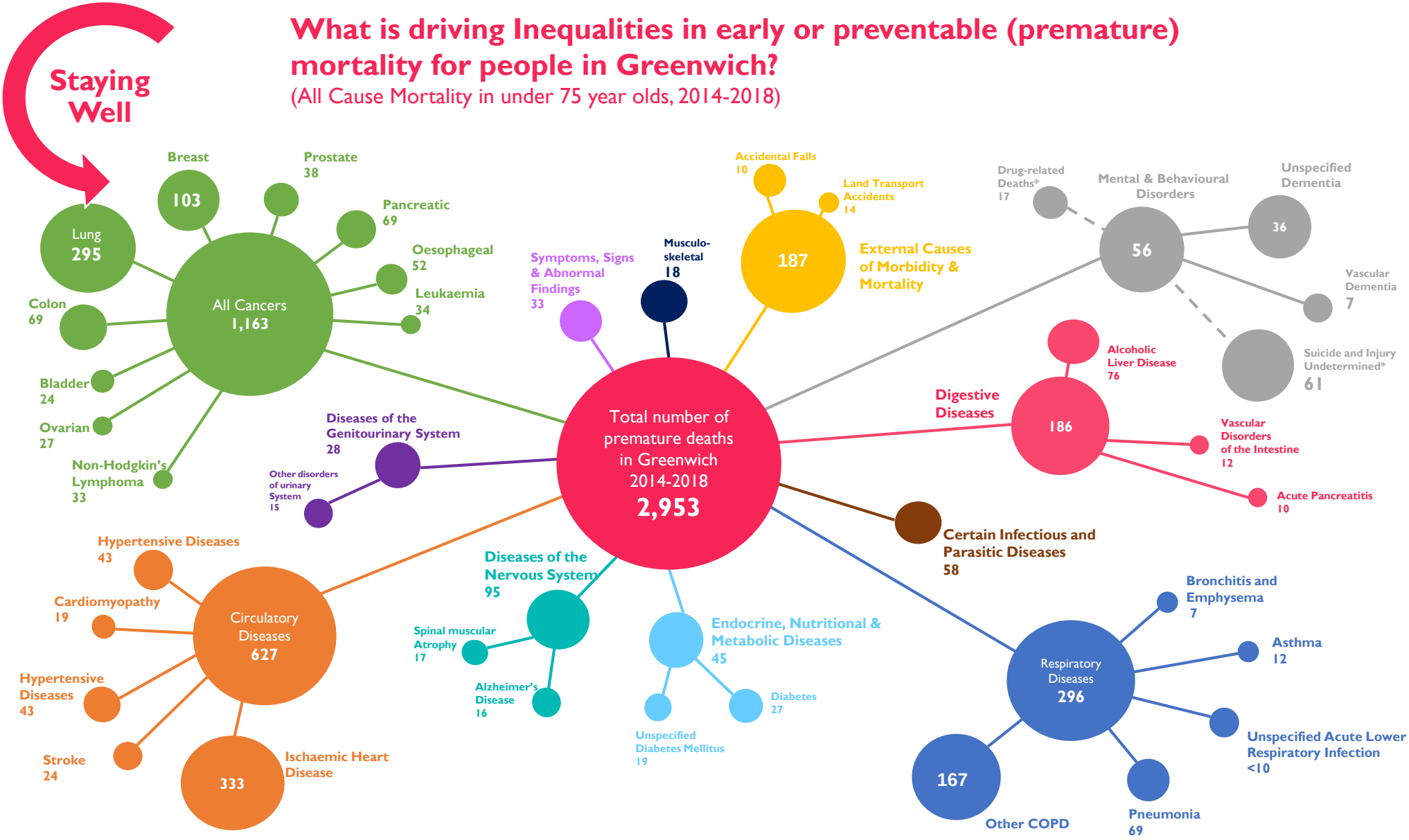
Next Steps

In order to answer the questions a qualitative research project has been started with professionals who refer into CAMHS including teachers, GP's, and social care to understand their perceptions of Mental Health conditions in children and young people and how this might impact on access to CAMHS

In addition work has started with Adult Mental Health Services to undertake an audit of young black adults who are being admitted in crisis to inpatient care to identify whether they were previously known to services as child or young person. This audit will include quantitative analysis and some focus group work with a group of young adults to understand their journey

What is driving Inequalities in early or preventable (premature) mortality for people in Greenwich?

(All Cause Mortality in under 75 year olds, 2014-2018)



This analysis reveals that Cancer, Circulatory Disease and Respiratory Diseases have the biggest impact on mortality (death rate) and will also therefore have a significant impact on the level of morbidity (illness)

NB However, what causes the major burden of illness and disability for our residents is not always the conditions that cause early mortality.

Source: NHS Digital Primary Care Mortality Database

Data extracted where date of death was in 2014, 2015, 2016, 2017 & 2018 and county district of residence was E09000011

** These two categories are not mutually exclusive as some deaths from drug poisoning may also have been classified as event of undetermined intent*

Staying Well

Life expectancy and healthy life expectancy are two of the overarching measures of the health of a population. Differences in Life expectancy and healthy life expectancy in different communities starkly show where inequalities exist.

Inequalities in life expectancy are driven by causes of death at both national and local area level and are linked to deaths before the age of 75 years (which are considered to be premature deaths). Targeting the causes of death which contribute most to the life expectancy gap would have the biggest impact on reducing inequalities.

What is driving inequalities in the premature mortality for the people of Greenwich?

There were 2,950 premature deaths, accounting for 38% of all deaths between 2014 and 2018.

Over one third of premature deaths (39%, n=1,163) were due to **cancer** and over one fifth (21%, n= 627) were **circulatory diseases**[1]

In Greenwich men have a higher premature mortality rate than women. In 2015-16 the Greenwich rate for men was 441 per 100,000 compared to 289 per 100,000 for women.

Over the last decade premature mortality had been decreasing. However, this trend plateaued in the last few reported time periods and remains significantly higher than then national and regional averages demonstrating that people living in Greenwich have poorer health overall. In addition to comparison to populations outside of Greenwich, the overall downward trend in premature mortality is not consistent across the borough which demonstrates inequalities within Greenwich. People living in the most deprived parts of Greenwich are more likely to die before they reach the age of 75 than people living in the least deprived areas.

Woolwich Common, Woolwich Riverside and Abbeywood have the highest premature mortality rates in Greenwich.

The table shows the premature deaths in Greenwich by condition and the relative rank out of the 33 boroughs in London showing that premature mortality outcomes in Greenwich are ranked in the lowest 25% of all London boroughs for all cancers, respiratory diseases and cardiovascular disease.

[1]NHS Digital - Primary Care Mortality Database.

Ranking out of 33
(Low ranking is good)

Ranking out of 33 (Low ranking is good)	
27th	**Under 75s Mortality from Cancer** 143.1 (DSR per 100,000 persons)
25th	**Under 75s Mortality from Respiratory Disease** 37.9 (DSR per 100,000 persons)
25th	**Under 75s Mortality from Colorectal Cancer** 13.1 (DSR per 100,000 persons)
24th	**Under 75s Mortality from Cardiovascular Disease** 84.7 (DSR per 100,000 persons)
24th	**Under 75s Mortality from Heart Disease** 46.4 (DSR per 100,000 persons)
20th	**Under 75s Mortality from Breast Cancer** 21.3 (DSR per 100,000 persons)
19th	**Under 75s Mortality from Stroke** 14.1 (DSR per 100,000 persons)

Staying Well

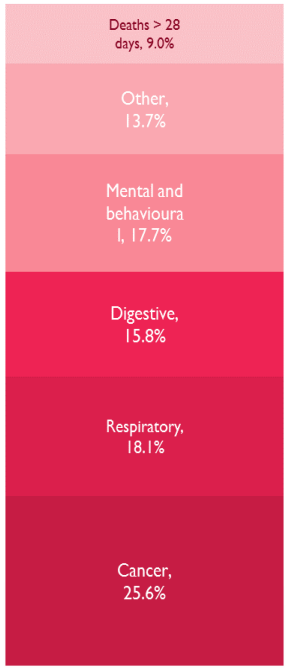
What is driving inequalities in Greenwich?

Inequalities in Health

Data for each clinical cause of death shows the percentage contribution that each makes to the overall life expectancy gap between Greenwich and England and the most deprived quintile and the least deprived quintile in Greenwich.
(If a cause shows a contribution of 0, this means that the cause of death does not make any contribution to the life expectancy gap).

Compared to England The biggest clinical factor contributing to the gap in life expectancy in men is cancer which accounts for % of the gap. In women, the biggest clinical contributory factors are classed as mental and behavioural causes which includes Dementia, accounting for 42.0% of the gap.

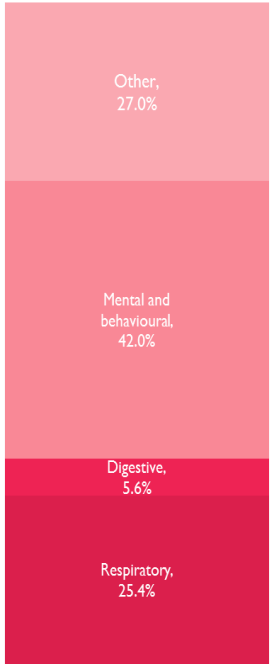
Differences in mortality rates for men living in Greenwich compared to England
Source: PHE Inequalities



In more detail; for men, the biggest contributors of inequalities (the years of live lost) compared to England are

- Dementia and Alzheimer's (on average 3 months of life lost). This condition is associated with vascular conditions such as Diabetes and heart disease which are associated with smoking and obesity.
- Lung Cancer (on average 3 months of life lost) Circulatory disease (on average 1 month of life lost) and Chronic lower respiratory disease (1 month of life lost) all 3 conditions are strongly associated with smoking and poor air quality.
- In addition Neonatal deaths (deaths before 28 days) is significantly higher in Greenwich compared to England) . More details on this are in Starting Well Section

Differences in mortality rates for women living in Greenwich compared to England
Source: PHE Inequalities



In more detail; for women, the biggest contributors of inequalities (the years of live lost) compared to England are

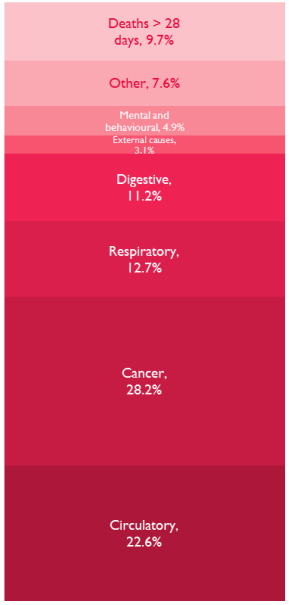
- Dementia and Alzheimer's (on average 2 months of life lost). This condition is associated with vascular conditions such as Diabetes and heart disease which are associated with smoking and obesity.
- Lung Cancer (on average 1 months of life lost) Circulatory disease (on average 1 month of life lost) and Chronic lower respiratory disease (2 month of life lost) all 3 conditions are strongly associated with smoking and poor air quality.
- In addition Neonatal deaths (deaths before 28 days) is significantly higher in Greenwich compared to England). More details on this are in Starting Well Section

Staying Well

Compared across Greenwich: Between the most and least deprived communities

The clinical causes of death driving inequalities in life expectancy between the most deprived quintile and the least deprived quintile within Greenwich are cancer in men (28.2%), and respiratory conditions in women (43.4%).

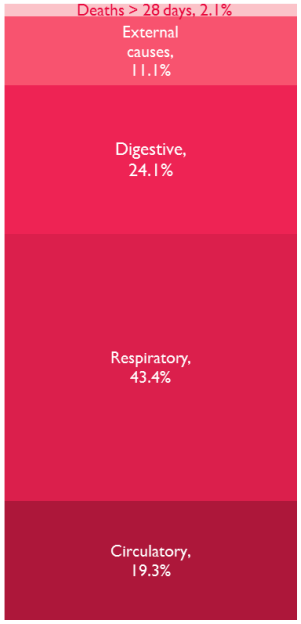
Differences in mortality rates for men living in Greenwich compared to Greenwich
Source: PHE Inequalities



For men the biggest contributors for inequalities within Greenwich include

- Lung cancer (9 months of life lost), heart disease (over 18 months of life lost) and chronic respiratory disease (6 months of life lost) all are associated with smoking and/or obesity and environmental factors such as poor air quality
- Dementia and Alzheimer's (7 months of life lost) also linked to Smoking and Obesity
- Digestive diseases which includes alcohol-related conditions such as chronic liver disease and cirrhosis (nearly 4 months of life lost)
- Neonatal deaths seem to be higher in the least deprived population but the numbers are small

Differences in mortality rates for women living in Greenwich compared to Greenwich
Source: PHE Inequalities



For women the biggest contributors for inequalities within Greenwich include

- Lung cancer (3 months of life lost), heart disease (over 5 months of life lost) and chronic respiratory disease (5 months of life lost). These are associated with smoking and/or obesity and environmental factors such as poor air quality
- Dementia and Alzheimer's (5 months of life lost) also linked to Smoking and Obesity
- Death from Alcohol-related conditions such as chronic liver disease and cirrhosis appears to be higher in the least deprived but the numbers are small
- Other Cancers (5 months of live lost)

What Next ?

Smoking, Obesity and Air Quality are having a significant impact on the inequalities within Greenwich and compared to England. Additionally alcohol is having an impact on inequalities within Greenwich for men but less so for women

A focus on having a consistent emphasis on supporting people to stop smoking and attain a healthy weight change in addition to initiatives to improve air quality could have a major impact on reducing inequalities in health outcomes as well as reducing costs to the NHS and the Council

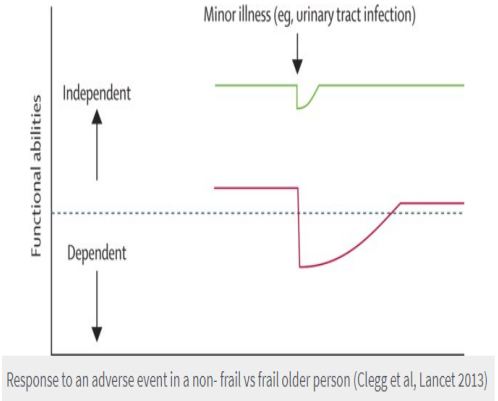
Ageing Well

Setting the Scene: The Greenwich picture of frailty

What is Frailty?

Frailty defines an increase in vulnerability experienced by some people who consequently are at higher risk of adverse outcomes such as falls, disability, long-term care and death. It is linked to the ageing process, and whilst more common in older age groups it can affect younger people too.

Response to adverse event in frail persons



Response to an adverse event in a non-frail vs frail older person (Clegg et al, Lancet 2013)

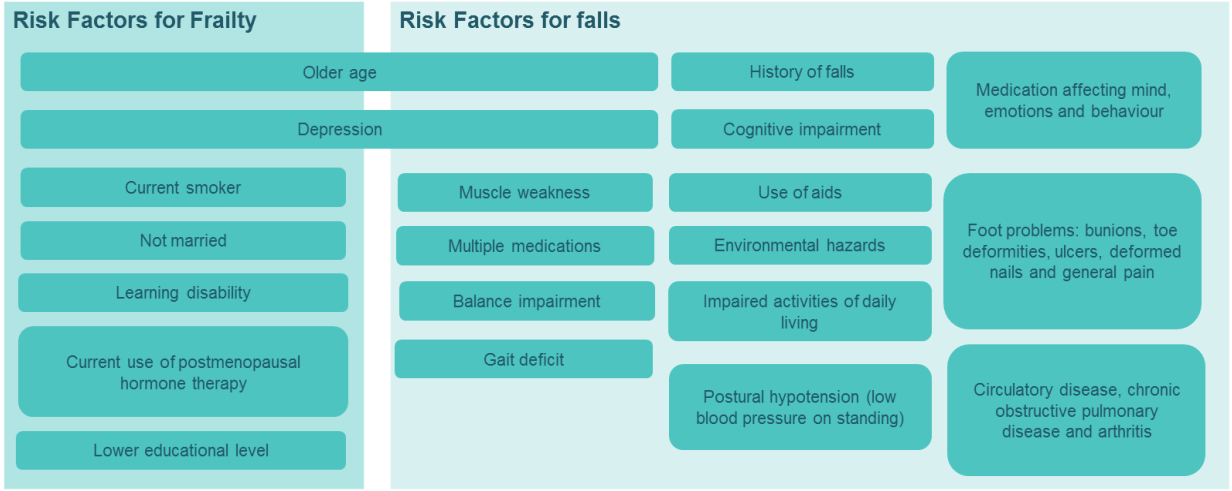
People who are frail respond to adverse events less well than people who are independent

Frailty: Who is at risk ?

- There are a number of disease conditions, states and factors that increase a person's risk of frailty.
- In Greenwich **women aged 65+ are more likely to experience an emergency admission due to a fall than Greenwich men.** Women nationally are also more likely to experience a fall than men (PHOF 17/18 data).
- Greenwich **men and women aged 65-79 were more likely to experience an emergency admission due to a fall than the average for England** and the rate for Greenwich women was also greater than the average for London (PHOF 17/18 data).
- White women are more likely to experience a fragility fracture compared to Black women and all men. Fragility factors appear to be associated with social deprivation in men but not in women (Curtis E M. et al, 2016[1]).

Influences on frailty

Frailty develops as a consequence of age-related decline which makes a person vulnerable to minor events such as infections or falls. People with frailty have a much greater risk of falls, disability, and death, and an increased likelihood of requiring long-term care. While the causes of falls are complex, frail older people are particularly vulnerable because of conditions such as delirium, heart problems, poor eyesight, and strength and mobility problems.



([1]Curtis E M. et al, 2016 https://www.sciencedirect.com/science/article/abs/pii/S8756328216300655)

Ageing Well

Setting the Scene: The Greenwich picture of frailty

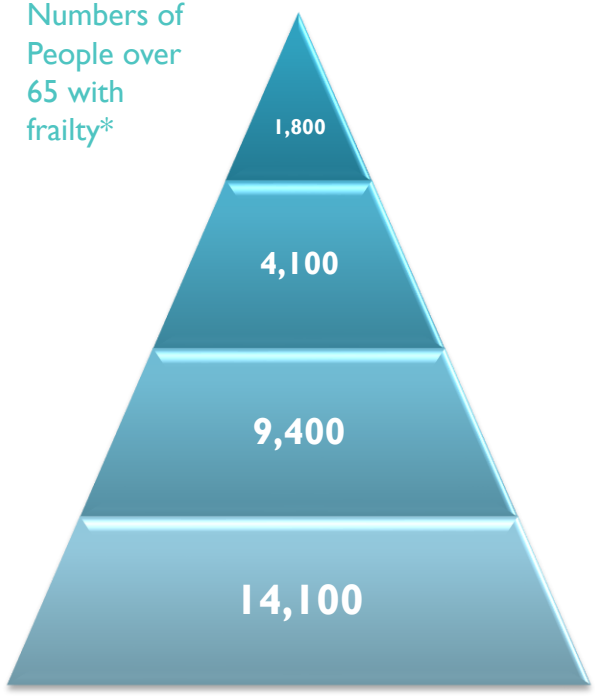
1st year Greenwich eFI data (17/18) suggests

- 17.8% have moderate frailty
- 5.2% have severe frailty

Data not used to estimate population level frailty due to incomplete data set

Estimated Frailty in the Greenwich Population

Numbers of People over 65 with frailty*



1,800 (6%) of over 65s live with severe frailty	This group accounts for 32% of falls (n=3600)
4,100 (14%) of over 65s live with moderate frailty	This group accounts for 27% of falls (n=3000)
9,400 (32%) over 65s live with mild frailty	This group accounts for 26% of falls (n=2900)
14,100 (48%) over 65s live a mostly healthy life	This group accounts for 16% of falls (n=1800)

The Frailty Index (eFi), is a validated tool, which can be used by GPs to identify patients most at risk of frailty, enabling preventative measures to be put in place. It is defined on the basis of the accumulation of a range of 35 deficits which are clinical signs, symptoms , conditions, and disabilities. Whilst there are data quality issues with Greenwich data currently, the tool provides a mechanism to identify and influence care, whilst also providing more rigorous data.

* Population level frailty data in Greenwich, is estimated based on Camden frailty population (eFI) figures.

Ageing Well

Setting the Scene: Frailty and Falls

Approximately 1 in 3 of people aged over 65 years fall at least once a year. This increases to 1 in 2 for people aged over 80 years

Falls are the most common cause of death from injury in the over 65 year olds and cost the NHS over £2bn a year and over 4 million bed days.

In 2017/18 there was a 10% increase in the number of emergency admissions from the previous year. Greenwich ranks in the top third of all London Boroughs for emergency admissions due to falls in people aged over 65 across London, and has a higher than the London and England average.

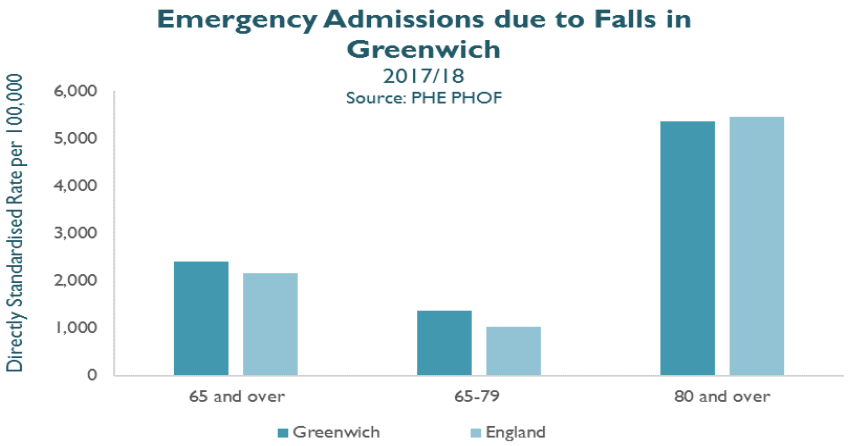
- In 2017/18 there were 702 emergency hospital admissions due to falls in people aged 65 and over (2,401 per 100,000 persons)
- In 2017/18 there were 186 persons aged 65 and over admitted to hospital with a fractured hip (639 per 100,000 people)
- In 2017/18 there were 289 emergency hospital admissions due to falls in people aged 65 – 79 years (1,376 per 100,000 persons)
- In 2017/18 there were 67 persons aged 65 – 79 years admitted to hospital with a fractured hip (325 per 100,000 people)
- In 2017/18 there were 413 emergency hospital admissions due to falls in people aged 80 years and over (5,375 per 100,000 persons)
- In 2017/18 there were 119 persons aged 80 years and over admitted to hospital with a fractured hip (1,549 per 100,000 people)

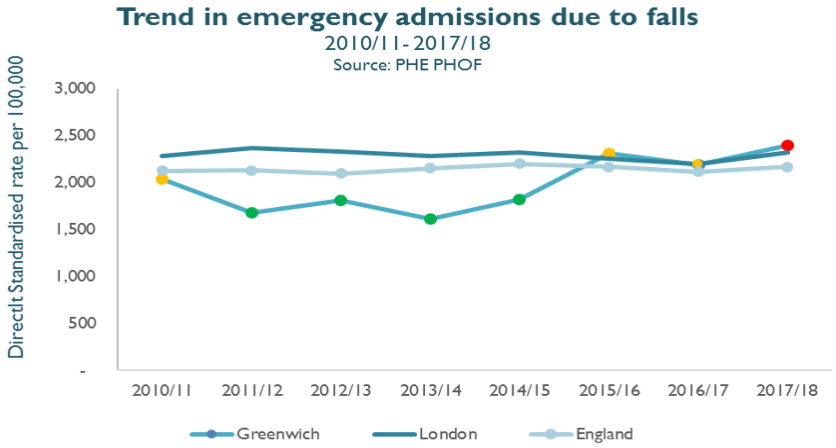
Source: PHE PHOF

In Greenwich :

Emergency hospital admissions for injuries due to falls increase with age. In 2017-18, the rate increased from **1,376 per 100,000** population in the 65-79 years old to **5,375 per 100,000** in the over 80s.

The rate of emergency admission due to falls in the over 65s has been increasing, in 17/18 there was a 10% increase in one year





Setting the Scene: Frailty and Falls

Based on population projections to 2030 there are likely to be:

- at least **2400** more residents with moderate to severe frailty (based on 14% +6% of an additional 12200 people),
- an additional **4700** falls,
- **950** more ambulance callouts for falls,
- **650** A&E attendances as a result of ambulance callouts and
- an additional **296** emergency admissions per year

Impact of Falls; Hip Fractures

Falls are the main cause of hip fractures, a particularly devastating injury for older people and 95% of hip fractures occur as a result of a falls (Todd and Skelton, 2004)[1].

In 2017/18 there were 186 hip fractures in Greenwich; a rate of 639 per 100,000. This was greater than both London (515/100,000) and England (578/100,000).

The rate has increased substantially in the last five years from 581 per 100,000 in 2012/13. An ageing population means that the number is likely to increase.

What works to reduce the impact of falls

One of the key positive impacts in reducing the risk and impact of falls is becoming physically active and maintaining good strength and balance

Action being taken to reduce the impact of falls

- **Greenwich Clinical Commissioning Group (CCG) is developing a community frailty pilot and a Greenwich-wide falls prevention service.** These has been approved in principle, including active patient engagement feeding into the design of the specification

- **There is an extension of the care home liaison pilot and take home and settle service. Greenwich and Bexley are working together to develop an approach to delivery of home-based urgent/acute step-up and step-down care**

- **The Council is leading the implementation of Greenwich Get Active;** implementation of a Physical Activity and Sports strategy to support people to get active and improve strength and balance

[1]Todd and Skelton, 2004 - http://www.euro.who.int/__data/assets/pdf_file/0018/74700/E82552.pdf

Living Well

Domestic abuse, who is at high risk and what do we need to know to support victims better?

Domestic abuse

- can affect people of any age, race, religion, gender, sexual orientation and income bracket, as survivors, victims or perpetrators
- is commonly a gendered issue with women most likely to be affected as victims and survivors of male perpetrators.
- crosses many social barriers, there will be individuals who are survivors, victims and perpetrators who are not necessarily known to local statutory services and are therefore difficult to reach.
- is estimated that 1 in 4 women experiences domestic violence in their lifetime[1]

National estimates from Crime survey reports suggest that 7.9% of women and 4.2% of men have experienced domestic abuse in the year to March 2018[2]; the majority of victims of domestic abuse, as measured by the Crime Survey, will not report their experiences to the police and therefore understanding the true extent of Domestic Abuse is complex and involves estimates from a number of data sets.

In 2014 the Chief Medical Officer (CMO)[3] identified that

"Domestic violence is a major public health issue worldwide, and may account for up to 7% of the overall burden of disease in women, largely as a result of its impact on mental illness".

"Six per cent of participants in the Crime Survey for England and Wales report past year domestic violence (where most victims, particularly of repeated or severe domestic violence are women). Therefore, by extrapolation, in 2012 around 1.2 million women suffered domestic abuse, over 400,000 women were sexually assaulted, 70,000 women were raped and thousands more were stalked."

In addition, the CMO identified that being a victim of sexual or domestic violence in adulthood is associated with the onset and persistence of depression, anxiety, eating disorders, substance misuse disorders, psychotic disorders and suicide attempts.

[1]Focus on Violent Crime and Sexual Offences, 2014/15
[2]Office for National Statistics (ONS) https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2018#prevalence-of-domestic-abuse
[3]CMO Report. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf

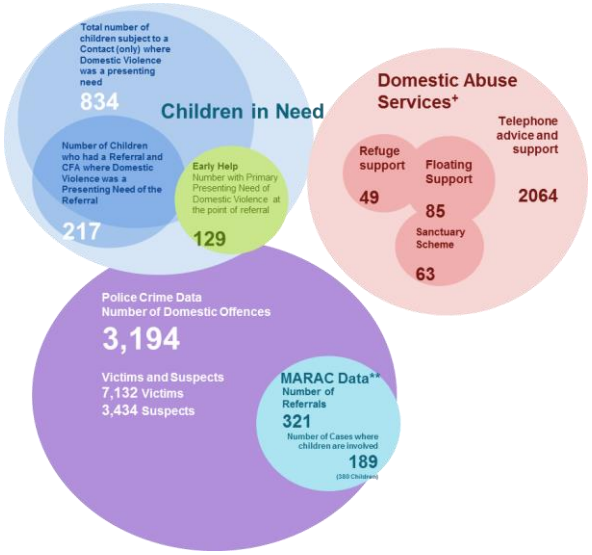
Living Well

Domestic abuse, who is at high risk and what do we need to know to support victims better?

Domestic Abuse: The scale of the issue

There is no definitive data-set that identifies all of our residents who have been affected by Domestic Abuse either as a victim or a perpetrator.

However there are a number of data sets[1] available that can be used to estimate the prevalence. By using 2016 /17 data we identified about between 2-3,000 families affected by Domestic Abuse in contact with services. However it is not clear how many are known to more than one service (therefore are double counted) or how many people/families in the Borough are affected by Domestic Abuse aren't in contact with services.



Reviewing all the sources of data for residents identified as affected by domestic abuse and using the national figure of 1 in 4 women are likely to be affected by Domestic Abuse it was estimated that there are approximately

- **30,000** women (or men) likely to affected by Domestic Abuse
- **3,000** in contact with targeted support
- **300** requiring intensive support

Support on Domestic Abuse is provided at a number of levels,

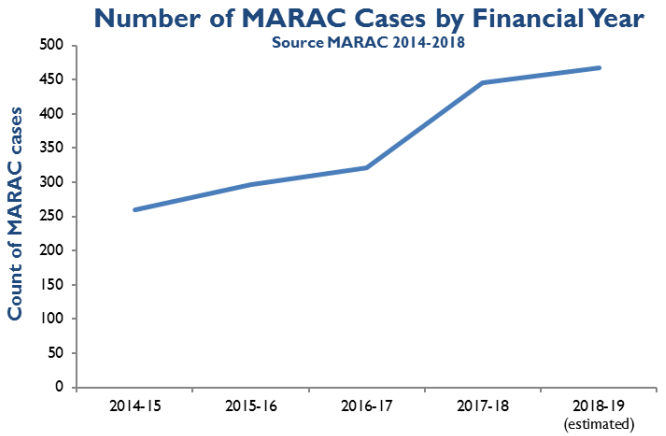
- Universal awareness raising through all services
- Targeted Support through Statutory services
- Intensive support through MARAC

What do we know about the high need cases?

Cases referred to MARAC tend to be high risk and higher need cases.

Over the past five years there has been a significant increase in the number of cases referred to MARAC. In order to understand those at high risk and in high need we have analysed five years worth of MARAC data to look at the profiles of Victims and Perpetrators of Domestic Abuse in Greenwich

Significant increase has been seen since 2014 which corresponds to the awareness campaigns in the Borough. However there was a stark increase between 2016/17 and 2017/18, which was also seen across London. This increase coincides with the recognition of coercive control as a form of domestic abuse through both legislation (December 2015) and the findings of domestic homicides which led to increased training and awareness for the Police and other agencies



[1]Data Sources for figure;
MARAC; Children in Need (LAIT Tool https://www.gov.uk/government/publications/local-authority-interactive-tool-lait); Service level data RBG internal data

Living Well

What do we know about our high risk cases?

Recognised risk factors for Domestic Abuse

- Housing/overcrowding
- Low income/Deprivation
- Pregnancy/new births (especially with young mothers)
- Young age (below 30)
- Long terms illness or disability
- Poor relationships
- Previous victim/Offending behaviour
- Toxic Duo (Mental Ill-health and Substance Misuse)

Comparing the rates of Domestic Abuse offences by ward with some of the risk factors for domestic abuse identified that within Greenwich the following risk factors have a strong association (above 60%)

- high rates of unemployment
- overcrowding
- lone parent households

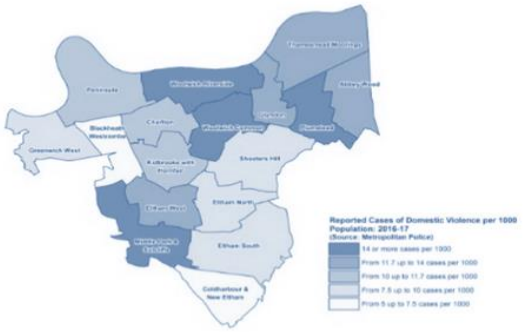
Where do the victims come from?

This map demonstrates over a 5 year period where victims represented at MARAC were living. The higher counts are shown in the darker colours and demonstrates the complexity of Domestic Abuse. Although there is clear link with deprivation there are high numbers of cases in areas whether the density of housing is higher. This supports the risk factor of overcrowding.

The picture by ward looks somewhat different from the smaller area analysis but more in line with the rate of offences by ward. In order to understand the implications of this data it would be helpful to understand where people who are receiving floating support live and whether this could inform a more targeted approach to awareness raising and where services are situated

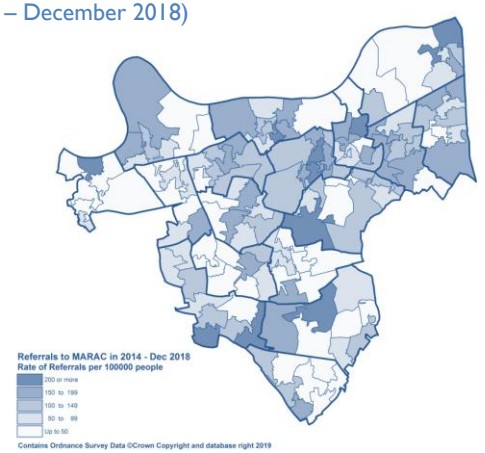
Map of Rate of Domestic Abuse offences by Ward

(2016/17)



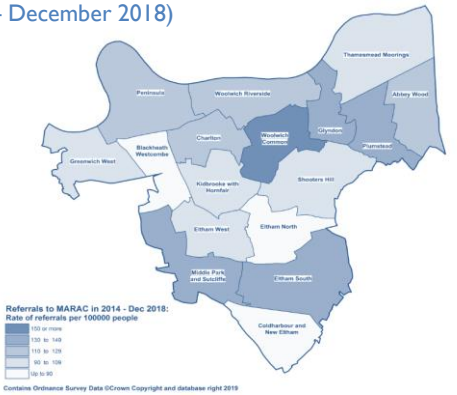
Map of MARAC cases: Rate of referrals by LSOA

(April 2014 – December 2018)



Map of MARAC cases: Rate of referrals by Ward

(April 2014 – December 2018)



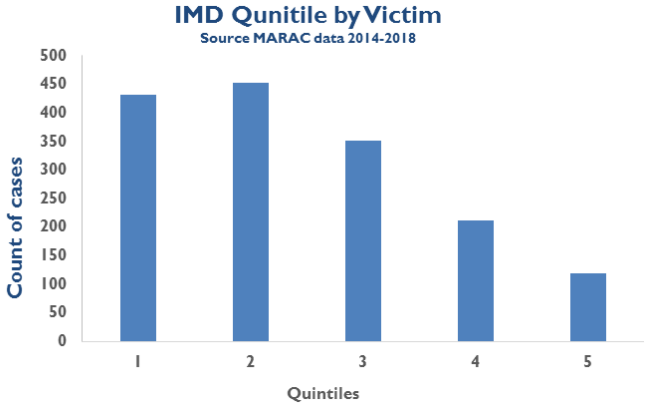
Living Well

What do we know about our high risk cases?

Deprivation

In terms of Victims, there are more victims represented in MARAC living in the two most deprived areas in Greenwich.

In terms of perpetrators the data is less clear with significant numbers either living outside of Greenwich or where the no address is recorded so no conclusions can be drawn.



Age

In terms of Victims, proportionally more cases are seen in the 25-40 year age group with 18-25 years the next highest.

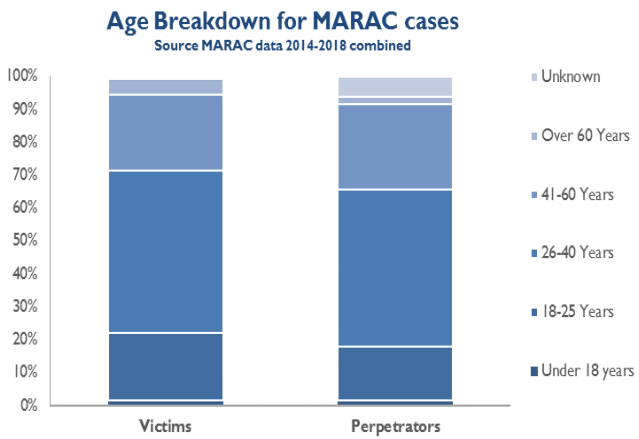
There are some differences for perpetrators; perpetrators tend to be older with proportionally more in the 25-40 and 41-60 year age groups

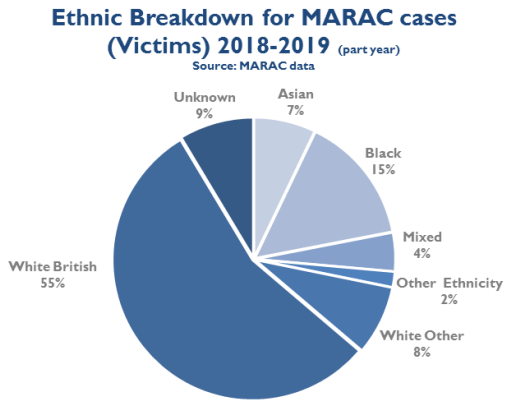
Ethnicity

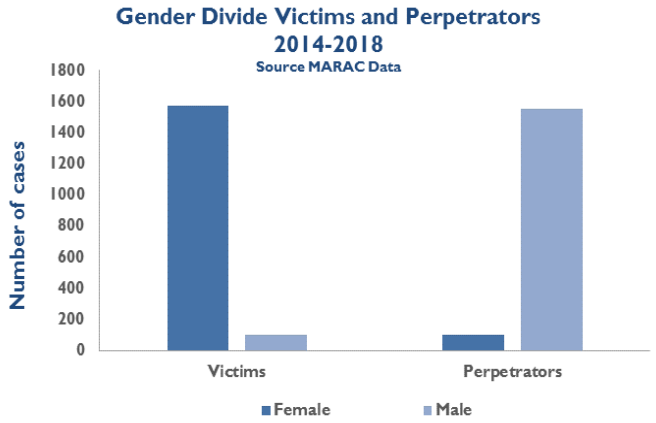
In terms of Victims, the white population is overrepresented in MARAC compared to the population in Greenwich, with all other ethnic groups under-represented. Recording of ethnicity in terms of perpetrators is less definitive so no conclusions can be drawn. However the underrepresentation of different ethnicities overall for victims needs to be investigated further to understand if this represents less incidence among ethnic groups or that ethnic minorities are not accessing the support they need

Gender

In terms of Victims, the majority are female but not exclusively. Equally although the majority of perpetrators are male, there are a number who are female. Support needs of male victims need to be considered in the light of this particularly in same sex relationships.





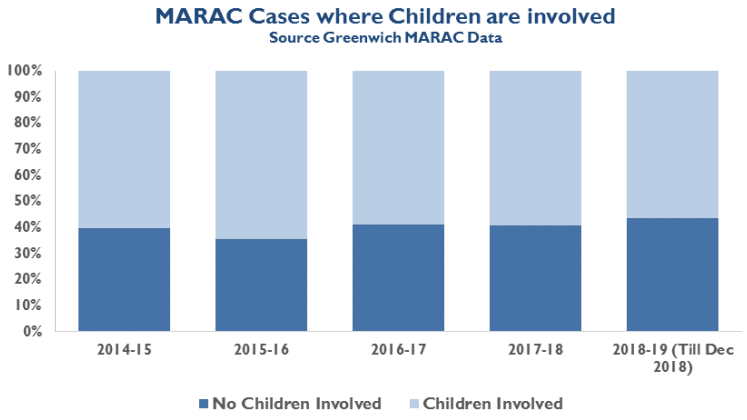


Living Well

What do we know about our high risk cases?

Children

In terms of cases involving children; since 2014/15 the proportion of cases involving children has been reasonable consistent 3 cases in 5. However this has been reducing and since 2015/16 the proportion has reduced from 64% to 57%.



An audit of MARAC cases in 2016/17 found that:

MARAC clearly has a positive impact (58% reduction in offences, 72% reduction in high impact offences)

6 key factors that may predict post-MARAC (re)offences are cases where

- Age is between 26-40
- Children are involved
- The Victim and perpetrator are ex-partners
- The Victim has issues with substance misuse or dependency
- The Victim and Perpetrator are known to Mental Health services
- There is no set actions for follow up by any agency for the Victim or Perpetrator

Following the findings of this Audit MARAC cases are now capturing the risk factors as part of the action planning to reduce the likelihood of reoffending.

What is less clear is whether the likelihood of reoffending increases with more than one risk factor. However the level of risk almost certainly increases.

What Next?

The analysis of the MARAC data has identified some significant issues that require further investigation to support the commissioning of services. In particular we need to understand better whether

- the underrepresentation from ethnic minority groups is due to reduced need or whether there are issues of cultural differences in accepting domestic abuse and/or for these communities in understanding and accessing support services

- access to early intervention services reflects access to MARAC and how much impact they can have to prevent more intensive levels of service (higher need)

Tackling the challenges; making opportunities

As I alluded to last year we live in a complex world. Helping people remain healthy is not only about individual choices, it requires looking at our environment, our housing, the educational achievement of our younger generation, and the employment prospects for everyone.

Complex problems require complex solutions and while many people are able and do look after themselves and their families, there are those that need more help and support.

Understanding the challenges we face is critical to understanding what the solutions are that we need to support our local people and their communities to be resilient and stay healthy.

In last years report I identified 14 areas that needed further investigation. In this years report I have looked at 6 of those areas and have made a number of recommendations. Some of the recommendations relate to specific work we as partners need to undertake to improve services and interventions. These include

Tackling our high infant rate by developing preconception strategy with our partners to support

- reduction in smoking preconception and during pregnancy
- supporting prospective mothers to achieve being a healthy weight before pregnancy
- to ensure women know how and when to book

Tackling areas of high pollution through supporting active travel (cycling, walking and using public transport), and encouraging the use of cleaner vehicles. In addition we need to look at how we mitigate poor air quality caused by construction in areas of building development.

Undertaking further research on mental health to help us understand better

- Why there are differences in the way that our children and young people access mental health services
- Whether this is linked to a disproportionate number of our young black adults are admitted to hospital in mental health crisis.

Tackling the causes of inequality in life and healthy life expectancy across our population, focusing not only on the lifestyle issues that are a cause but also to look at what more we can do together to improve the environmental factors that influence health.

Looking at the service improvements we can make to reduce the impact of falls in our older people but also working as partners across Greenwich to support and encourage everyone to be more active, improving balance and strength to prevent people falling at all.

Undertaking further work to help us understand better how if and how we can intervene earlier to prevent domestic abuse

There is much being done but always more we can do. Where we have had success (and there has been much) it is invariably because of the work we all do together – local people working with all of the partners to improve and enhance support that is available.

In South East London, there is a new Healthier Greenwich Alliance which brings together key partners across the health and care system. This will bring with it further opportunities for more integrated and effective strategies to improve health, improve health and care services and tackle the unjust health inequalities that some of our residents continue to experience.

Acknowledgements:

This report has been a joint effort involving a number of colleagues across the Council

I would particularly like to give thanks to

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