Bromley Clinical Commissioning Group

THE LONDON BOROUGH
www.bromley.gov.uk

BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT

2017

For more information visit www.bromley.gov.uk/JSNA or contact JSNA@bromley.gov.uk

JSNA Report Contents

The report consists of a collection of chapters, each available as separate documents from www.bromley.gov.uk/JSNA:

1. Demography
2. Life Expectancy & the Burden of Disease
3. Aspects of Health Protection and Health Improvement
4. Adult Mental Health and Suicide
5. Drug Misuse in Adults
6. Domestic Violence

Table of contents

Acknowledgements

JSNA Steering Group Members

Linda Gabriel	Chair, Healthwatch Bromley
Dr Nada Lemic	Director of Public Health, LBB
Helen Buttivant	Consultant in Public Health, LBB
Dr Ruchira Paranjape	GP Clinical Lead, Bromley Clinical Commissioning Group
Folake Segun	Director, Healthwatch Bromley
Dr Jenny Selway	Consultant in Public Health, LBB
Gill Slater	Planner, LBB
Representative	Voluntary Sector Strategic Network
Stephen John	Director, Adults Social Care, LBB
Sara Bowrey	Director, Housing, LBB
Alastair Baillie	Environmental Developmental Manager, LBB
Susie Clark	Communications Executive, LBB

Contributors

Victoria Roberts	Interim DV & VAWG Commissioner, LBB
Maureen Lymer	Public Health Intelligence Analyst
Cordery Rebecca	Consultant in Communicable Disease Control, PHE
Catriona Ellis	Principal Auditor, LBB
Laura Austin-Croft	Specialist Public Health Trainee, LBB
Esther Dias	Health Protection Specialist Nurse, LBB
Finola O'Driscoll	Children and Young People Programme Lead, LBB
Gillian Fiumicelli	Vascular Programme Lead, LBB
Alice Attabong	Group Manager, Housing Support Services, LBB
Susan Mubiru	Senior Public Health Intelligence Analyst, LBB
Mark Bray	Senior Information Analyst, NHS Digital
Emma Burke	Programme Manager Alcohol and Drugs,PHE
Jane Walker	Interim Substance Misuse Programme Lead, LBB
Helene Green	Clinical Data Administrator, CGL
Zena Josiah	Commissioning Officer, LBB
Mimi Morris-Cotterill	Assistant Director of Public Health, LBB
Andy Edney	Principle Systems Officer, BT
Cosmo Manancourt-Adolphe	Graduate Intern, LBB

Executive Summary

2. The Population

The population of Bromley continues to grow, to a size of over 330,000 in 2017. It is predicted to increase by a further 10% in the next 10 years to 351,841 in 2027.

There has been an overall increase of 27% in the number of live births in the borough in the last 15 years with a total of 4326 live births in 2016.
The number of young children (aged 0-4) in the borough is predicted to rise slightly over the next 15 years from 21,600 in 2017 to 22,300 in 2032. However the number of young children as a proportion of the total population in Bromley will decrease from 6% to 7% over the 15 year period.

The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17% in 2017 (57,800 people) to 20% in 2032 (76,100). This equates to an additional 18,300 people aged 65+ living in the borough in the next 15 years, including an additional 7900 people aged 80+.
Health and social care planning should take account for this rise in the numbers of older people, particularly in the south of the borough which will see the largest increase in the numbers of over 75s.

The latest (2017) GLA population projection estimates show that, in 2017, the ethnic minority population of Bromley is 19.8%. This proportion varies by age group, with the greatest proportion of the BME population being in children and young people. 19% of 0-4 year olds in Bromley are from BME groups compared to 5% of those post retirement age. The overall ethnic minority population of Bromley is projected to rise to 23% by 2027. The greatest proportional rise is in the Black African group which is predicted to grow in size by 45% over the next decade. Because the health risks of ethnic minority populations differ from the general population, attention should be given in health and social care planning in particular to the North West of the Borough which has the highest proportion of ethnic minorities, and also to the Cray Valley area which houses the Gypsy Traveller population, who tend to experience poor health outcomes.

3. Life Expectancy and the Burden of Disease

Life expectancy in Bromley has been increasing steadily for the last 20 years and is currently 81.3 years for men and 85.1 years for women (2013-15). However, there is a gap between wards with the highest and lowest life expectancy of 8.3 years for men and 6.4 years for women. There is a negative correlation between levels of life expectancy and area deprivation. The wards with the lowest life expectancy for both men and women in Bromley are Crystal Palace (76.6 years and 81.6 years) and Plaistow & Sundridge (78.1 years and 82.4 years).

The infant mortality rate in Bromley has been consistently below the national average and has decreased overall over the last decade (from 4.6 to 2.7 deaths per 1000 live births). There has been a rise in infant mortality rates in Bromley over the last 2 monitoring periods (2013/15 and 2014/16). This could be attributed to changes in the definition of still births and more accurate recording practices. Further monitoring over a longer period is required to establish if this is an enduring trend.

The main causes of death in Bromley are cancer (29.5% of deaths), circulatory disease (27.9%) and respiratory disease (13.9%). The proportion of deaths caused by circulatory disease has been falling since 2012 and in 2017 the proportion of deaths from cancer was greater than the proportion of deaths from circulatory disease for the first time.

The rates of premature death (death before age 75) for cardiovascular disease (CVD), cancer and respiratory diseases are generally better than the regional or national averages. Premature mortality rates from CVD in Bromley have been falling steadily since 1995 and are currently considerably lower than the regional or national average (56.4 per 100,000 compared to 74.9 per 100,000 in London and 73.5 per 100,000 in England). However these figures mask variation within the borough. There is a significant inequality in CVD premature mortality rates between men and women in Bromley (81.8 per 100,000 compared to 33.8 per 100,000 respectively). There is a positive correlation between premature mortality from CVD and levels of deprivation across the borough.

Evidence suggests that there are still many people living in Bromley with undiagnosed hypertension and undiagnosed atrial fibrillation (potentially 32,500 people with undiagnosed hypertension and potentially 3530 people with undiagnosed atrial fibrillation). Data also suggests that those who have been diagnosed are not receiving the optimal treatment required to adequately control these conditions. These people are at higher risk of stroke, kidney disease heart disease and other conditions.

The NHS Health Check programme is intended to improve the early identification of circulatory disease risk and prevent the development of those conditions listed above. Information on the outcomes of the NHS Health Check Programme in Bromley is provided in the section on Aspects of Health Protection and Health Improvement.

Although survival rates from cancer in Bromley are improving there have been over 10,000 deaths from cancer in Bromley in the last 10 years. A significant proportion of cancers in Bromley are only detected in the later stages which will adversely impact survival rates (36.3 % of cancers were detected early, at stage 1 or 2, in Bromley compared to 48.2% nationally). The incidence of all cancers in Bromley is still rising with nearly 1600 new cancer registrations annually, indicating the need for good prevention strategies. The four most common cancers registered in Bromley in the last 10 years are breast, prostate, lung and colorectal cancer. The incidence of prostate cancer in men in Bromley has increased over the last decade from 119 to 213 cases per 100,000. In contrast the incidence of lung and colorectal cancer in men and women and breast cancer in women has fallen. Cancer screening coverage rates in Bromley have been consistently higher than the regional average and similar to the national average.

The number of people with diabetes in Bromley continues to rise and presents a growing challenge for individuals and services. In 2016/17 there were over 15,000 people diagnosed with diabetes registered with Bromley GPs. There were a further 15,000 people with non-diabetic hyperglycaemia (NDHG, the precursor for diabetes). Modelling estimates suggest the actual numbers of people at risk of developing diabetes in the borough is twice this amount at almost 30,000.

The prevalence of dementia in the Bromley population is steadily increasing with an estimated 4380 people aged over 65 living with dementia within the borough in 2017. It is likely that many of these cases will not be known to services. The rate of growth is predicted to increase with an estimated 6034 people aged over 65 expected to be living with dementia in the borough by 2030.

Further information on the mental health of the Bromley population can be found in the section on Adult Mental Health and Suicide.

4. Health Protection and Health Improvement

Further work is needed to encourage the uptake of childhood immunisations as vaccination rates for several categories, such as MMR, MenC, PCV and HPV, remain below the national recommendation of 95% coverage.

There remains a potential for measles and mumps outbreaks, particularly in older children and young adults due to poor immunisation uptake, as seen in the spike in the rate of confirmed measles cases across South London in 2016.

While the reported incidence of pertussis in Bromley remains raised; it is imperative that the efforts to increase the pertussis immunisation rates, particularly for the maternal pertussis vaccination, are continued.

Uptake of the seasonal flu vaccination in all eligible groups in Bromley is significantly lower than that of England, and a large proportion of at risk individuals remain vulnerable to the serious health effects of flu. Coverage rates for the Shingles vaccination for older people also remains significantly below the England average with substantial room for improvement.

There is a continued need to improve the uptake of NHS Health Checks across most areas in the borough particularly the north and central Bromley.

As a result of NHS Health Checks in Bromley in 2016/17:

- 23 people were diagnosed with diabetes
- 134 people were diagnosed with hypertension
- 11 people were diagnosed with atrial fibrillation
- 8 people were diagnosed with Chronic Kidney Disease

A considerable number of people were identified as having risk factors for developing these diseases:

- 1442 people were found to have a moderate or high cardiovascular risk score.
- 1203 people had raised blood pressure
- 243 people had pre-diabetes
- 108 were found to have an irregular pulse

In Bromley, work to improve the pathways for patients identified at risk of atrial fibrillation, hypertension and diabetes have been prioritised for review to ensure that the opportunities to prevent the onset or progression of disease identified via the NHS Health Check are maximised.

5. Adult Mental Health and Suicide

There has been a steady increase in the prevalence of people registered with depression in GP records in Bromley. The depression register size has increased by 7428 cases in Bromley over the last four years, averaging around 1800 new cases each year. In 2016/17 there were over 23,000 people diagnosed with depression. This equates to a prevalence of 8.5% of the total registered population and places Bromley as the 3rd highest borough in London.

There has also been a steady increase in the number of people diagnosed with severe mental illness in Bromley, rising from 1667 (0.5%) in 2005/06 to 2904 (0.84%) in 2016/17. Schizophrenia is the most common form of severe mental illness in Bromley, closely followed by all psychosis (accounting for 31% and 29% of all SMI respectively). More men than women are affected by schizophrenia, but women have a higher recording for the other three classified disorders.

The demographic profile of people diagnosed with either a common mental health disorder (CMD) or severe mental illness (SMI) in the borough share similarities, with most people being middle aged and living in the most deprived areas of the borough. However, the proportion of people from a BME group known to have a common mental health disorder is lower than expected based on the ethnic profile of the borough whereas the proportion of people from a BME group known to have a severe mental illness is higher than expected.

More women than men in Bromley are recorded as having either a common mental health disorder or severe mental illness. This may be a true reflection of levels of mental ill health in women, but might also be explained by the greater tendency by woman to seek medical help for mental health issues.

People in Bromley with common mental health disorders or severe mental illness have higher levels of chronic ill health, particularly heart and respiratory disease, than the general population. People in Bromley with CMD and severe mental illness also have higher rates of obesity and smoking than the general population.

The premature mortality rate for adults with SMI in Bromley is 366, meaning that those with an SMI in Bromley have a 366% increased risk of death under the age of 75 years than those without SMI in the borough. This is higher than the average rate for London (327) but lower than the England national rate of 370. The rate in Bromley has steadily increased over the last 3 years.

Better recording of data on the lifestyle behaviours of people with both SMI and CMD in Bromley would help to establish how health promotion messages could be best delivered to this patient group to improve physical health and wellbeing and reduce the risk of developing co-morbidities.

Bromley has the 5th highest intentional self-harm rate in the region and ranks 16th out of 33 London boroughs on suicide rates (where 1 is lowest). Suicides continue to be more prevalent in males, up to three times the rate in females, whilst rates of admission for intentional self-harm continue to be more prevalent in women and young people.

The numbers of suicides in Bromley are very erratic year on year but on average about 20 people take their own lives in Bromley each year. The most common methods of suicide in Bromley are hanging, strangulation or suffocation. The proportion of suicides by self-poisoning is reducing, whilst the proportion of suicides by jumping from a height or in front of a moving object is increasing.

Rates of hospital admissions for intentional self-harm have fluctuated in Bromley over the last decade with a peak in 2009-11. Although rates have declined since then, there appears to be the beginning of an upward trend.

The proportion of hospital admissions for intentional self-harm is highest in people aged 20-49. Although there are fewer admissions of intentional self-harm in older residents, research shows that older people who self-harm are three times more likely to commit suicide than the younger people who self-harm.

The relationship between deprivation and hospital admissions for intentional self-harm in Bromley is not linear but analysis at ward level show that hospital admission rates are significantly higher in the Cray Valley wards and Penge and Cator than the rest of the borough.

6. Drug Misuse in Adults

Bromley has the 7th lowest estimated rate of Opiate and/or Crack use in the region and lower overall rates of drug use compared to the regional and national average. However the estimated consumption rate for Opiate and/or Crack use in young people in Bromley (age 15-24) is higher than the regional or national average. Rates of combined Opiate and/or Crack use are also rising in the older population (age 35-64).

The estimated level of unmet need (those with problematic substance misuse but not currently in contact with treatment services) in Bromley is much higher than the England average. It is estimated that 63% of drug users in Bromley are not known to treatment services, ranking Bromley second highest in the region.

The rate of hospital admissions for substance misuse in young people in Bromley is significantly higher than the national and regional average. The rates for young people are increasing more steeply in Bromley than across London or England as a whole. Hospital admission rates for substance misuse in Bromley positively

correlate with levels of socioeconomic deprivation. In contrast there is no observable link between drug-related death rates and deprivation in Bromley.

There were a total of 50 drug-related deaths in Bromley between 2012 and 2016. The rate of drug-related deaths in Bromley is lower than other local authorities in the same socioeconomic deprivation bracket and among the lowest in the region. The average age at the time of death was 47 years. 67% of local drug-related deaths were classified as accidental poisonings, compared to 55% nationally.

Whilst the illicit use of drugs in Bromley is increasing, the number entering treatment is decreasing. Opiate users still dominate adult treatment, these clients generally face a more complex set of challenges and it is more challenging to achieve positive and sustainable outcomes.

Of those in contact with treatment services in Bromley nearly 50% of clients are age 40+, this is slightly higher than the national average. The age profile, of clients newly presenting for treatment, has also shifted to an older population.

In 2016/17 there were 100 children known to be living with people misusing drugs in Bromley who had presented to substance misuse services for the first time in that period.

Bromley has a higher proportion (37%) of new clients presenting with a co-occurring mental health condition (dual diagnosis) compared to England (24%). Half of all women who present new to treatment, for non-opiate or non-opiate and alcohol misuse have a co-occurring mental health condition.

16% of all people presenting to drug treatment services in Bromley cited a problem with prescription only or over the counter medication (POM/OTC) this is similar to the national average (15%). Only 11% of new clients in Bromley, who were eligible for hepatitis B vaccination and accepted to be vaccinated, actually started a course of vaccination.

17% of all drug treatment clients in Bromley successfully completed treatment compared to 15% in England. Locally the current treatment drop-out rate is lower than the national average (12% in Bromley compared to 17% nationally). Men were more likely to drop-out early across all substance groups both locally and nationally.

Opiate clients have the lowest proportion of successful completions compared to rates for the other substance groups (8% in Bromley, 7% nationally). In Bromley the rates of opiate users achieving abstinence within 6 months is currently the same as the national average (39%). Women in Bromley presenting to treatment for opiate use had higher successful completion rates compared to men (12% compared to 6%).

7. Domestic Violence

There were 2568 domestic violence offences reported in Bromley between Oct16-Sept 17. This is a rise of nearly 60% over the previous 5 years. The number of high risk domestic violence cases referred to MARAC in Bromley rose by 6% in the last year, predominantly driven by an increase in referrals from the police. The rate of cases discussed at MARAC is lower in Bromley than the national average (13 cases per 1000 population compared to 35 cases per 1000 population nationally).

There were 476 referrals to the Bromley Domestic Abuse Advocacy Project (BDAAP). The number of referrals has increased consistently from just over 300 in 2014/15. The highest volume of referrals was from residents living in Cray Valley Clock House and Penge & Cator.

82% of the referrals to BDAAP were women. Women of childbearing age form a significant proportion of referrals received. In 2016/17, 212 dependents of the victims of domestic abuse were known to the BDAAP. There has been a decline in the proportion of referrals from people from a Black or Black British background over the last 3 years. However the highest proportion of referrals from the BME community still comes from this group.

1. Introduction

This report describes the main issues affecting the health and wellbeing of the population of Bromley. Its purpose is to provide the basis for an understanding of the current and future health and wellbeing needs of the population over both the short term (three to five years), and the longer term future (five to ten years) to inform strategic planning, commissioning of services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities.

The JSNA helps organisations in Bromley to fulfil the Equality Duty by considering the needs of all individuals in Bromley.

Much of the information in the JSNA is based on information from routine data sources and from health profiles which allow us to benchmark our position in Bromley against London and England. However, as in previous years, the editorial team has invited and received useful input from stakeholders with a special interest in specific groups of the population.

This is the second of a two-part JSNA delivered across 2016-2017. The contents of this year's report have been revised and it contains updates and analysis in the following chapters:

- Demography
- Life Expectancy and Burden of Disease
- Aspects of Health Protection and Health Improvement
- Domestic violence

There are also 2 in-depth chapters providing a more detailed review of the health needs of two vulnerable groups within Bromley:

- Adults who misuse drugs
- Adults with mental illness

An update to the separate Health Needs Assessment for Children and Young People is expected later on this year.

This is the 5th JSNA published for Bromley since the implementation of the Health and Social Care Act (2012) and the transfer of public health teams to the local authority. A comprehensive evaluation of the Bromley JSNA is proposed; reviewing the process, outputs and outcomes of the provision of the JSNA. A plan will be developed, in response to the findings, to revise the process, content and format of the JSNA to ensure it is fit for purpose and able to provide the intelligence needed to inform the complex strategic commissioning decisions of the future.

2. The Population of Bromley: Demography

This chapter considers the population of Bromley and how demographic, social and environmental factors impact on the health and wellbeing of its residents and influence the needs and demands for health and social care services. It also considers the impact of estimated population changes in the future.

Key Points

- The latest (2017) estimate of the resident population of Bromley is 330,909*, having risen by 28,235* since 2001.
- The resident population is expected to increase to 342,548* by 2022 and 351,841* by 2027.
- The number of 0 to 4 year olds is projected to decrease by the year 2022 to 21,300* and then to 20,750* by 2027.
- The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17% of the population in 2017 to 18 % by 2022 and 19% by 2027.
- The pattern of population change in the different age groups is variable between wards, with some wards, such as Darwin, experiencing a large rise in the proportion of young people and others such as Biggin Hill experiencing a large rise in the proportion of over 75s.
- The latest (2017) GLA population projection estimates show that 19% of the population is made up of Black and minority ethnic (BME) groups^.
- Children and young people make up the highest proportion of the BME population in Bromley.
- The BME group experiencing the greatest increase within Bromley's population is the Black African community, from 4.7% of the population in 2017 to 6.6% of the population in 2031^.

* GLA 2015 round SHLAA-based population projections: Capped Household Size Model, Released February 2017

^ GLA Intelligence Update (12-2015) - 2014 Round Ethnic Group Population Projections

What this means for residents in Bromley:

The numbers of older people in Bromley are rising and health and social care provision needs to reflect the increased need.

Current Picture

When looking at the information in this chapter, it is important to bear in mind that the borough's demographic profile is heavily influenced by a large part of the borough being mainly rural. This means that areas in the south of the borough, such as Darwin and Biggin Hill, have small communities spread over a large rural area as compared to other, more densely populated areas such as the North West of the borough.

Overall Description of Bromley

Located in South-East London, Bromley is the largest London borough in the city. At approximately 150 square kilometres it is 30% larger than the next largest borough. It has over 45 conservation areas and a wide range of historic and listed buildings. Although Bromley is a relatively prosperous area, the communities within Bromley differ substantially. The North-East and North-West of the borough contend with similar issues (such as higher levels of deprivation and disease prevalence) to those found in the inner London Boroughs we border (Lambeth, Lewisham, Southwark, Greenwich), while in the South, the borough compares more with rural Kent and its issues. Bromley benefits from a good number of public parks and open spaces as well as sites of natural beauty and nature conservation (**Figures 2.1** and **2.2**).

Total Population

The latest (2017) estimate of the resident population of Bromley is 330,909. This compares with 348,196 registered with GPs in the borough (October 2017). The borough council is responsible for providing services to its residents. While local health commissioners are responsible for providing services to all of those who are registered with a Bromley GP regardless of where they live, they also have a responsibility for the health of the borough's residents at a population level. Whilst population figures are available from a number of sources, chiefly the Office for National Statistics (ONS) and the Greater London Authority (GLA), this chapter has used the Greater London Authority (GLA) resident population as its basis. There is some variation in the population structure between the wards. Mottingham & Chislehurst North and Cray Valley West have the highest proportions of young people aged 0-19 years and Copers Cope the lowest. Farnborough & Crofton has the highest proportion of over 75s and Crystal Palace the lowest (see **Figures 2.3** and **2.4**).

Figure 2. 1

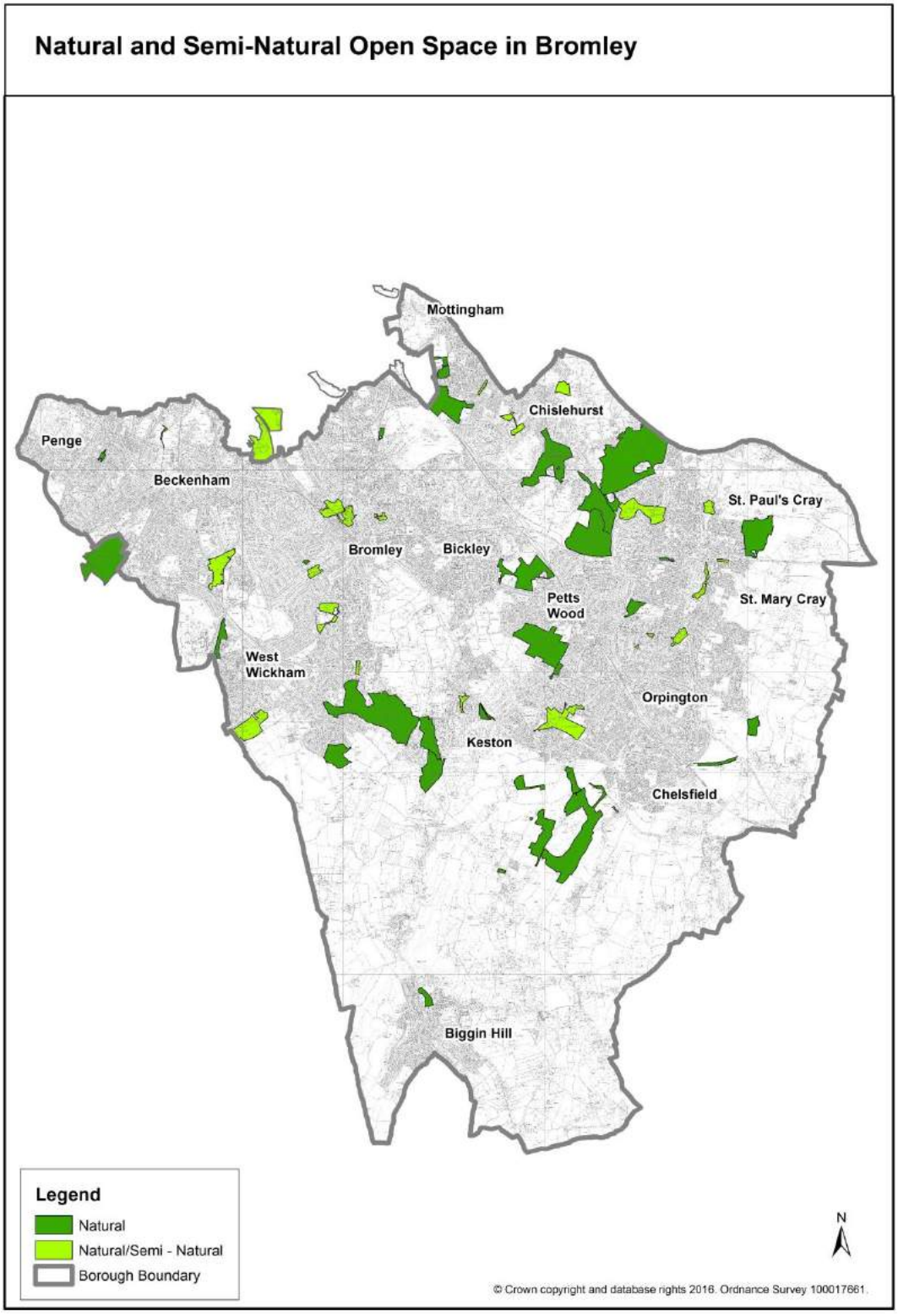

Natural and Semi-Natural Open Space in Bromley
Mottingham
Chislehurst
Penge
Beckenham
St. Paul's Cray
Bromley
Bickley
Petts Wood
St. Mary Cray
West Wickham
Orpington
Keston
Chelsfield
Biggin Hill
Legend
Natural
Natural/Semi - Natural
Borough Boundary
N
© Crown copyright and database rights 2016. Ordnance Survey 100017661.

Figure 2. 2

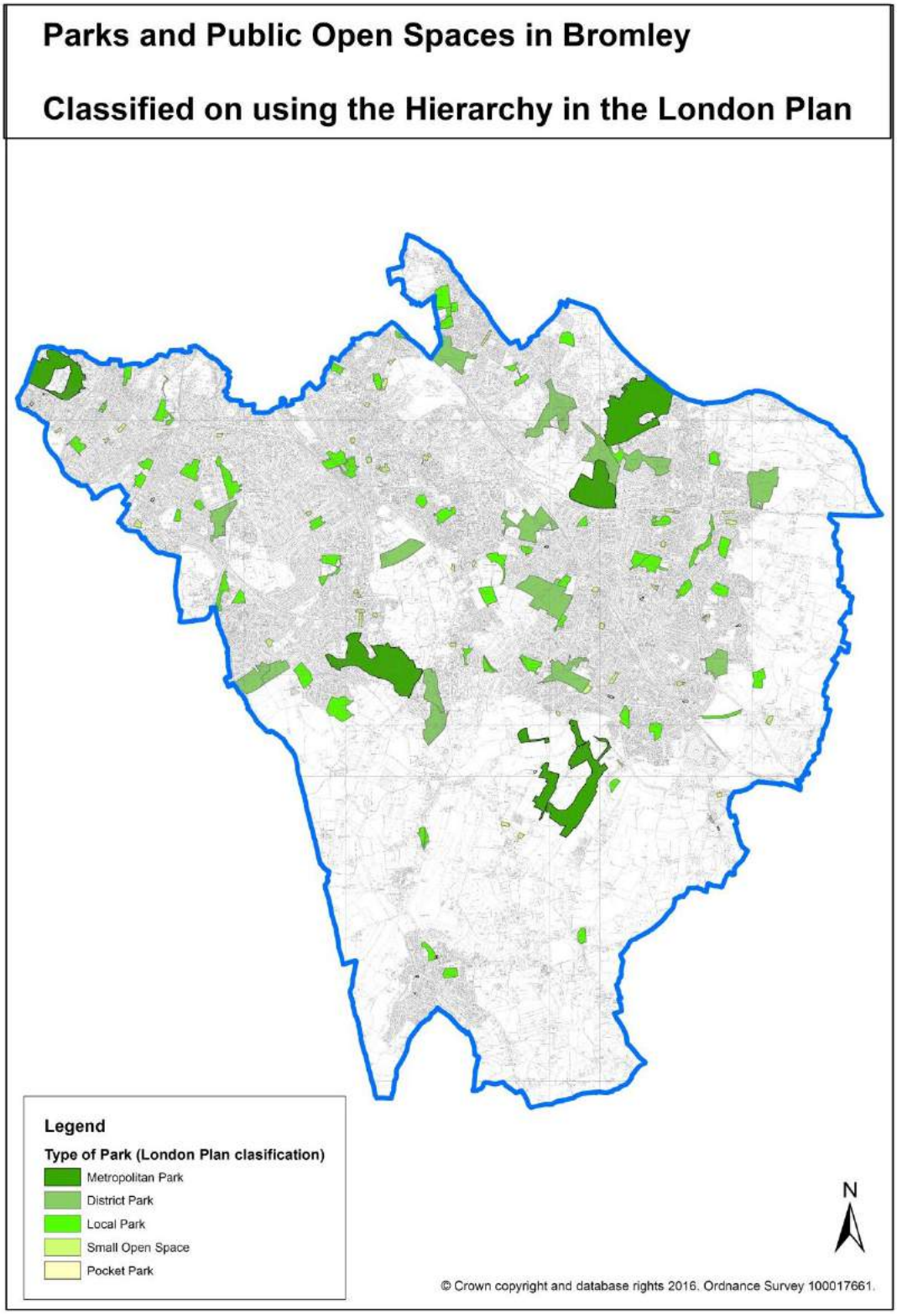
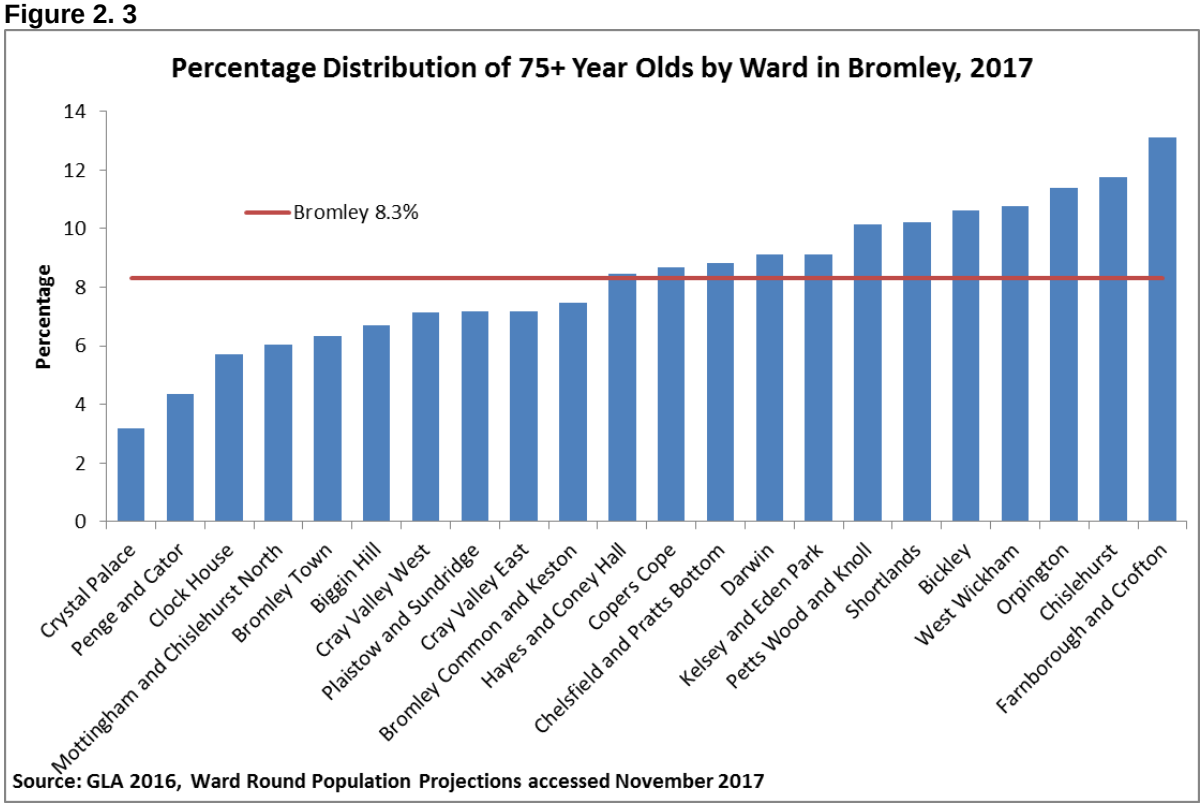
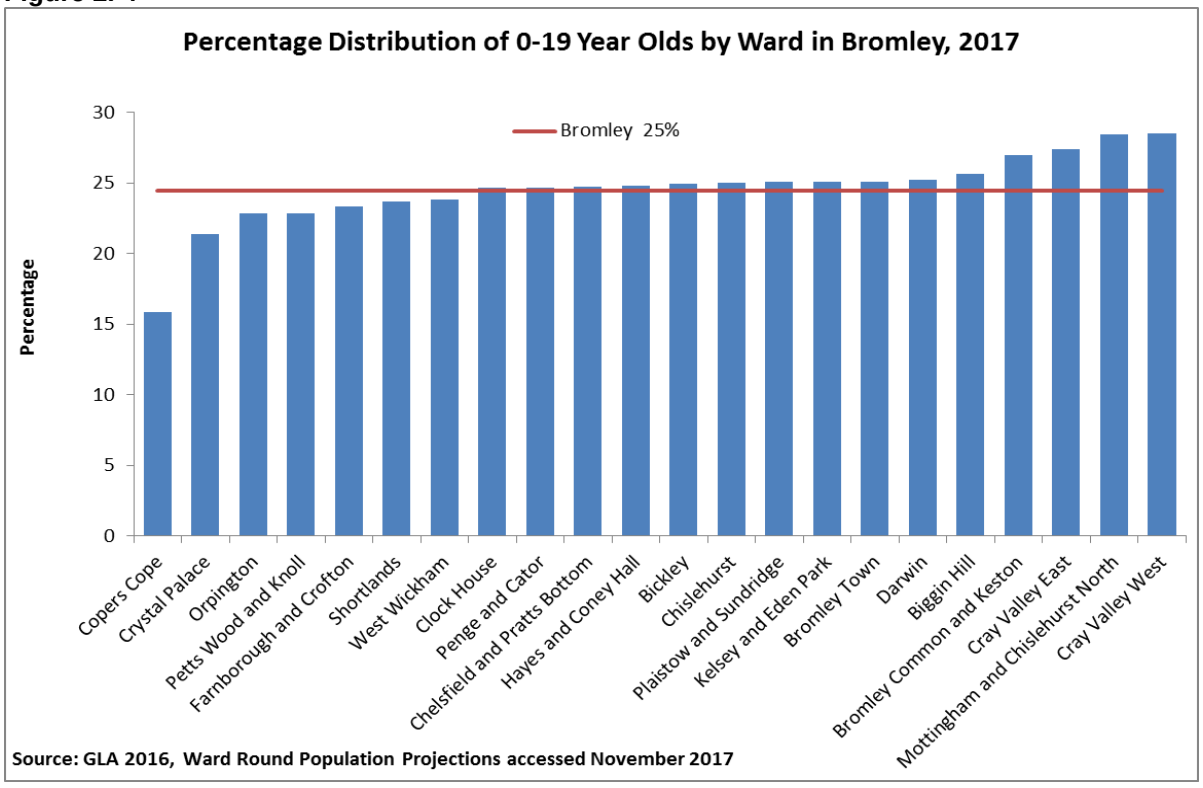

Parks and Public Open Spaces in Bromley
Classified on using the Hierarchy in the London Plan
Legend
Type of Park (London Plan clasification)
Metropolitan Park
District Park
Local Park
Small Open Space
Pocket Park
N
© Crown copyright and database rights 2016. Ordnance Survey 100017661.

Figure 2. 3



Source: GLA 2016, Ward Round Population Projections accessed November 2017

Figure 2. 4



Source: GLA 2016, Ward Round Population Projections accessed November 2017

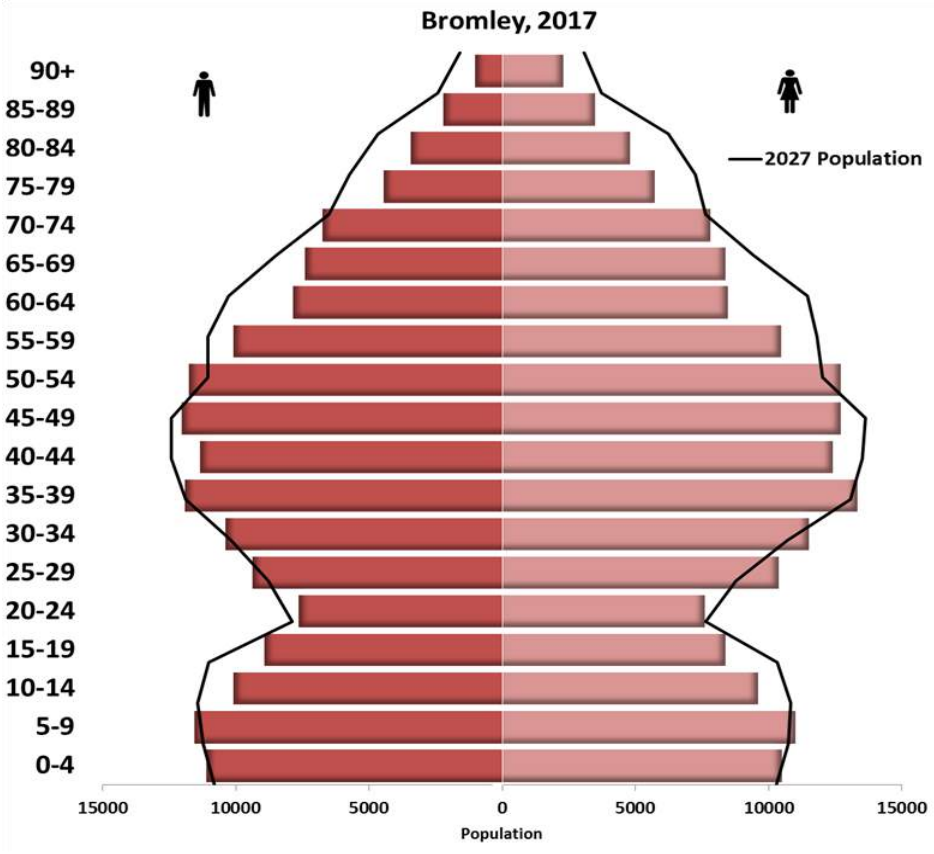
Table 2. 1

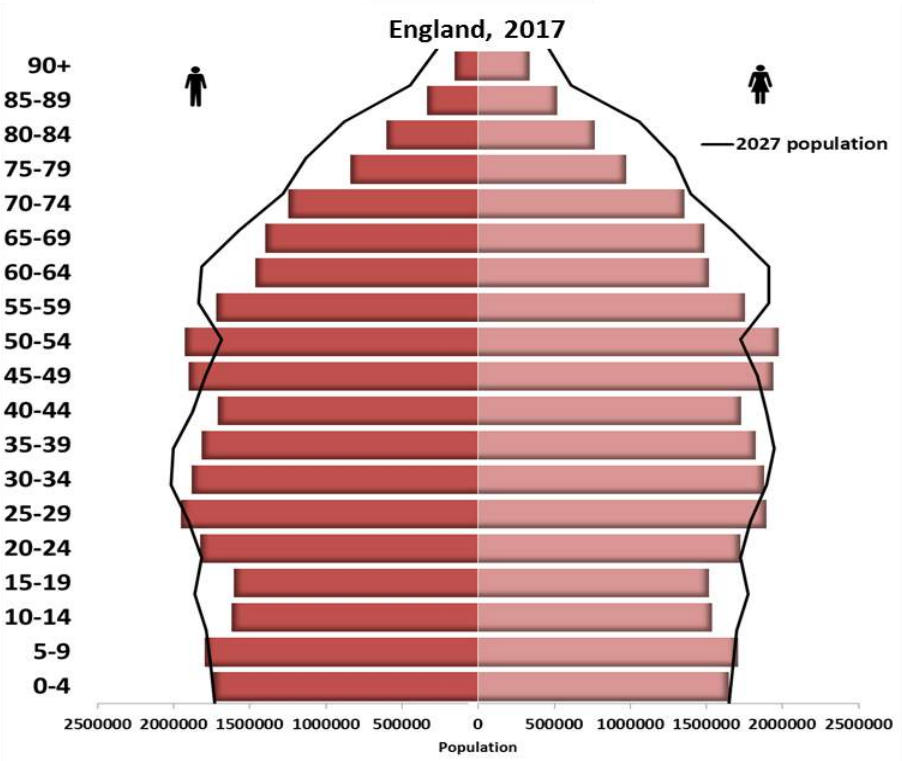
	0-19 Years		75+ Years	
	No	%	No	%
Bickley	4035	24.9	1715	10.9
Biggin Hill	2745	25.7	717	6.5
Bromley Common and Keston	4799	27.0	1326	7.4
Bromley Town	4781	25.1	1210	6.4
Chelsfield and Pratts Bottom	3765	24.7	1345	8.9
Chislehurst	4169	25.0	1959	11.8
Clock House	4126	24.7	952	5.7
Copers Cope	2637	15.9	1440	8.5
Cray Valley East	4528	27.4	1189	7.3
Cray Valley West	4970	28.5	1248	7.2
Crystal Palace	2877	21.4	426	3.4
Darwin	1398	25.2	506	9.4
Farnborough and Crofton	3523	23.3	1978	13
Hayes and Coney Hall	4114	24.8	1406	8.5
Kelsey and Eden Park	4192	25.1	1525	9
Mottingham and Chislehurst North	3007	28.4	639	6.2
Orpington	3564	22.8	1778	11.4
Penge and Cator	4494	24.7	793	4.4
Petts Wood and Knoll	3284	22.9	1455	10.2
Plaistow and Sundridge	4086	25.1	1168	7.2
Shortlands	2448	23.7	1058	10.2
West Wickham	3637	23.8	1643	10.6
Bromley	**81179**	**24.5**	**27476**	**8.3**

Source: GLA 2016-based Ward population projections, SHLAA based; Capped Household Size model (Accessed November 2017)

The age distribution of people in Bromley is very similar to that for England as a whole, as illustrated in the population pyramids (**Figure 2.5**).

Figure 2. 5


Bromley, 2017
90+
85-89
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
2027 Population
15000
10000
5000
0
5000
10000
15000
Population


England, 2017
90+
85-89
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
2027 population
2500000
2000000
1500000
1000000
500000
0
500000
1000000
1500000
2000000
2500000
Population

Population Projections

The population of Bromley is over 330,000, and is projected to rise by 4% over the next 5 years (**Table 2.2**).

Table 2. 2

	2017		2022		2027		2032	
Total Population	330,909		342,548		351,841		360,298	
0 - 4 yrs (%)	21,601	7%	21,536	6%	21,079	6%	20,635	6%
5 - 10 yrs (%)	26,693	8%	26,729	8%	26,348	7%	25,925	7%
11 - 18 yrs (%)	30,134	9%	34,092	10%	35,986	10%	35,264	10%
Working age (%)*	205,749	62%	211,147	62%	215,178	61%	217,005	60%
Post Retirement (%)¥	57,815	17%	60,795	18%	66,724	19%	74,564	21%
80+ (%)	17,284	5%	18,223	5%	21,690	6%	24,709	7%

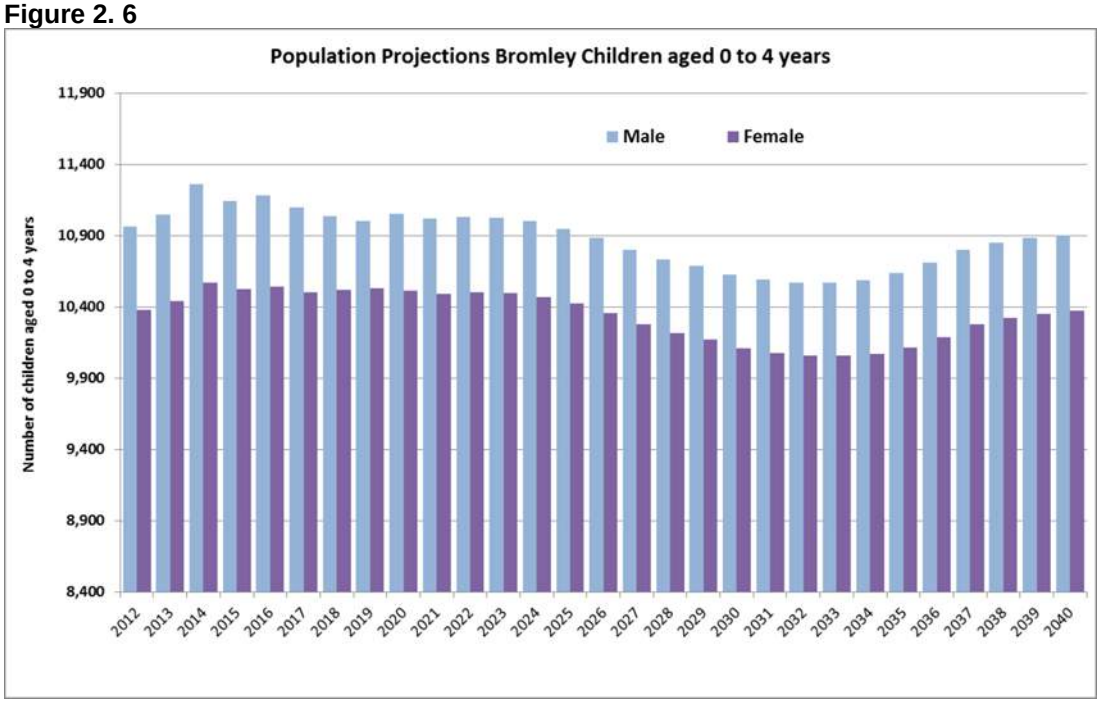
Source: GLA 2016-based Population Projections Housing-led Model (Accessed November 2017)

* Working age =16 to 64y for males and females

¥ Post retirement = Over 64y males and females

The number of 0 to 4 year olds has gradually been increasing since 2011 and peaked in 2014 (21,828) but is then projected to decrease again to a minimum of 26,035 in 2032.

Figure 2. 6



Source: GLA 2016 based Housing led Model Population Projections (November 2017)

Ward Population Projections

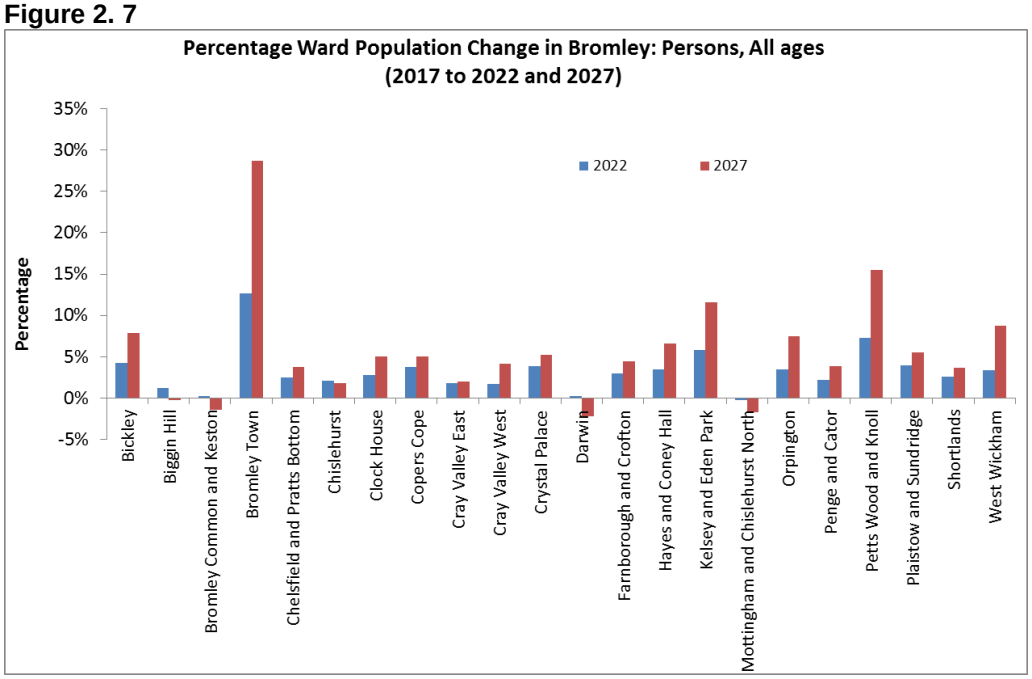
Overall, there is a projected increase in residents across all wards in Bromley. Bromley Town and Petts Wood & Knoll are expected to have the highest percentage increase in all wards in 2022 and 2027.

Table 2. 3

	Population projections			Change in numbers	
	2017	**2022**	**2027**	**2022**	**2027**
Bickley	16175	16867	17448	692	1273
Biggin Hill	10695	10828	10668	133	-27
Bromley Common and Keston	17776	17824	17533	48	-243
Bromley Town	19054	21462	24516	2408	5462
Chelsfield and Pratts Bottom	15222	15600	15795	378	573
Chislehurst	16683	17039	16992	356	309
Clock House	16718	17191	17565	473	847
Copers Cope	16595	17219	17436	624	841
Cray Valley East	16537	16833	16871	296	334
Cray Valley West	17437	17732	18160	295	723
Crystal Palace	13453	13976	14152	523	699
Darwin	5544	5558	5423	14	-121
Farnborough and Crofton	15093	15549	15760	456	667
Hayes and Coney Hall	16588	17164	17690	576	1102
Kelsey and Eden Park	16708	17681	18651	973	1943
Mottingham and Chislehurst North	10577	10549	10399	-28	-178
Orpington	15607	16152	16782	545	1175
Penge and Cator	18199	18608	18898	409	699
Petts Wood and Knoll	14348	15388	16577	1040	2229
Plaistow and Sundridge	16305	16949	17215	644	910
Shortlands	10340	10604	10721	264	381
West Wickham	15254	15775	16588	521	1334
Bromley	**330908**	**342548**	**351,840**	**11640**	**20932**

Source: GLA 2016-based Ward Population Projections Housing-led Model; Accessed November 2017

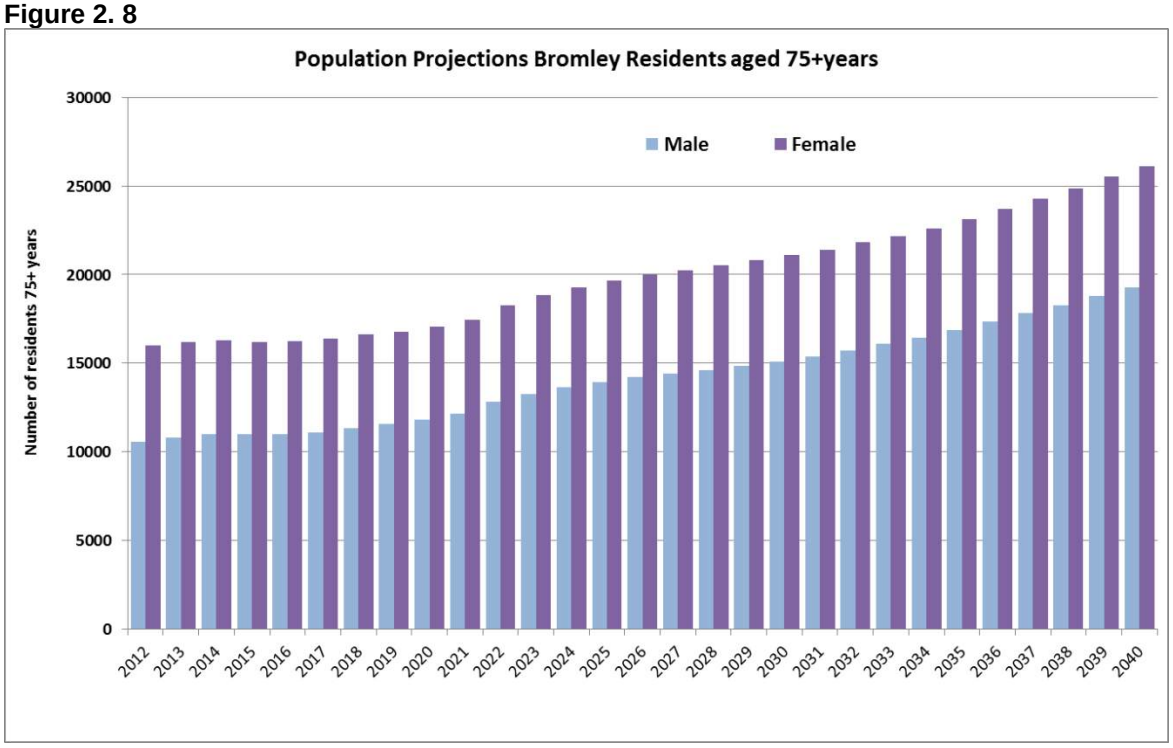
Figure 2. 7



Source: GLA 2016-based Ward Population Projections Housing-led Model (Accessed: November 2017)

The population of Bromley residents aged 75 years and over has been fairly stable, but is predicted to rise after 2019.

Figure 2. 8

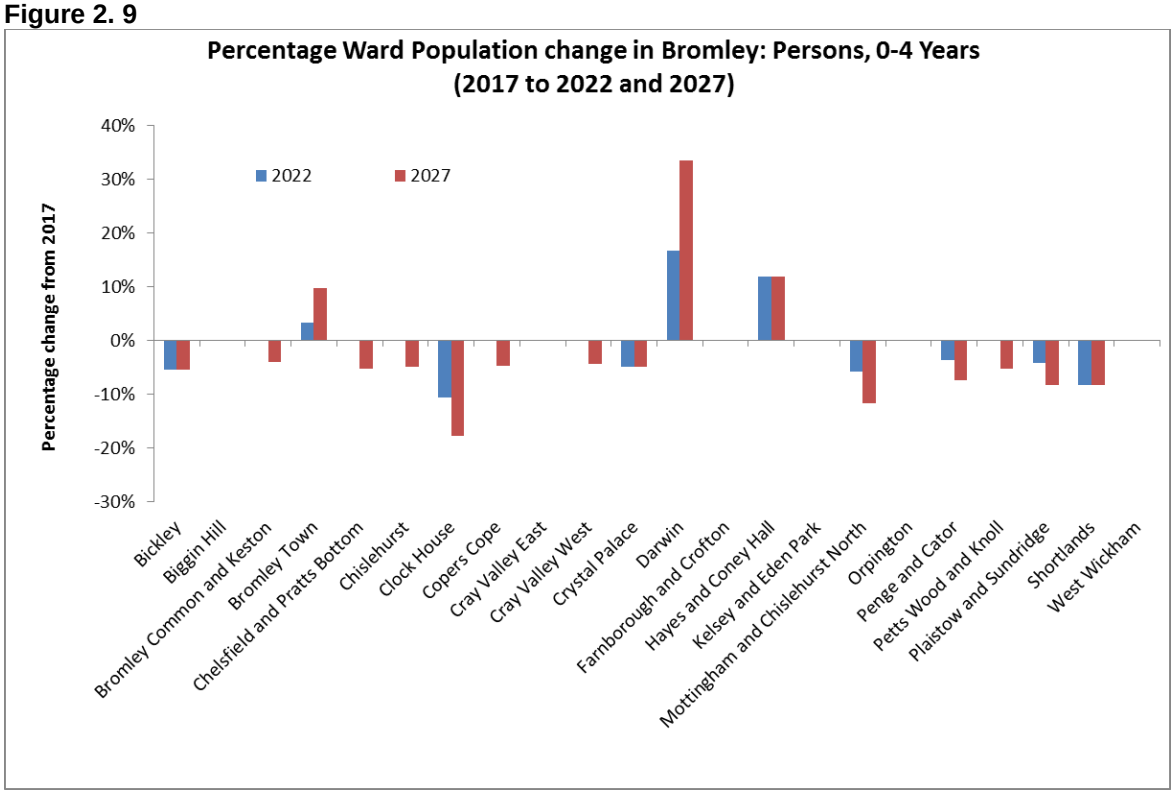


Source: GLA 2016 based Housing led Model Population Projections (November 2017)

The pattern of population change in the different age groups is not consistent between wards, with some wards experiencing a large rise in the proportion of young people and others experiencing a large rise in the population of over 75s.

The largest reduction in the 0-4 year age group will be seen in Clock House (18%). For over 75s, the population is projected to increase and the largest increase will be in Biggin Hill (31%), Penge & Cator (24%) and Petts Wood & Knoll (21%), as seen in **Figures 2. 9** and **2.10.**

Figure 2. 9



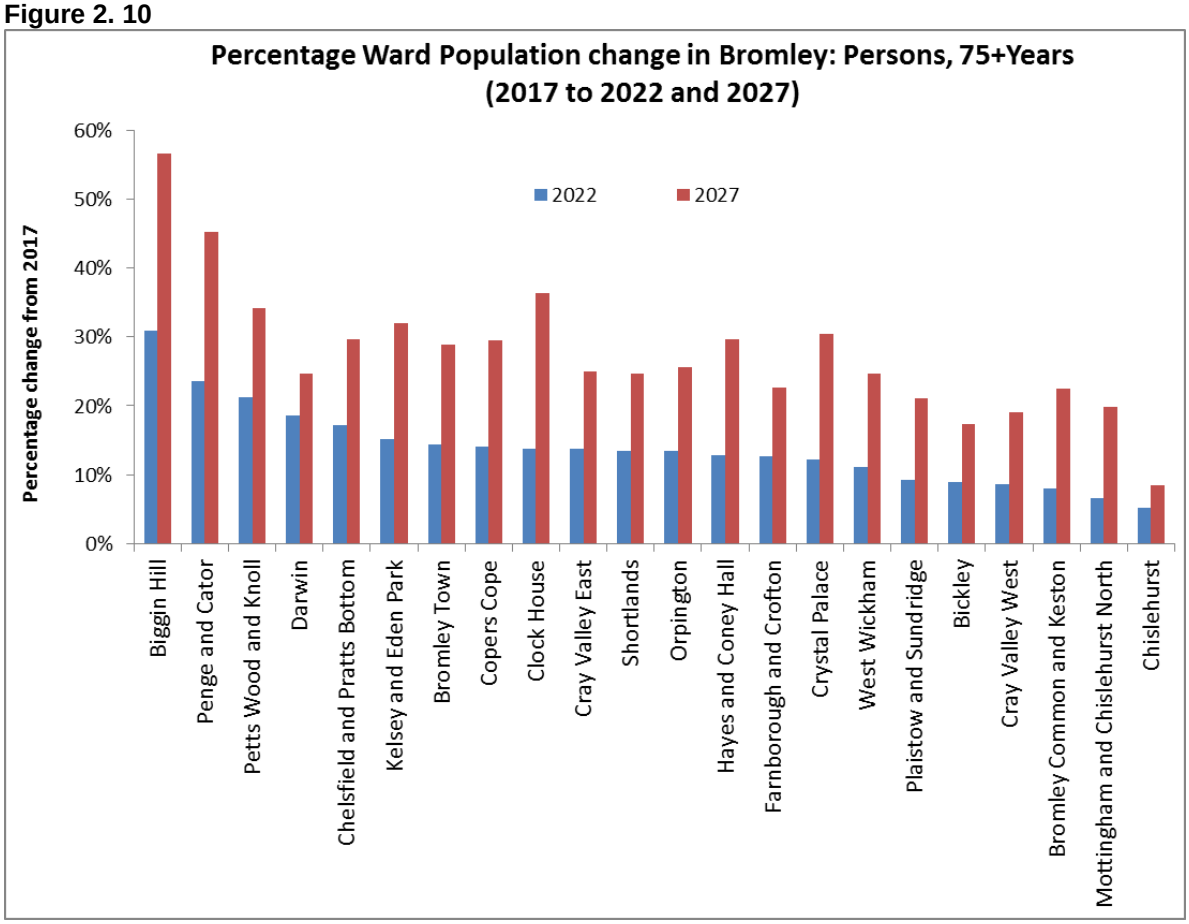
Source: GLA 2016-based Ward Population Projections Housing-led Model (Accessed November 2017)

Table 2. 4

Population aged 0-4 years in Bromley					
	Population projections			Change in numbers	
	2017	2022	2027	2022	2027
Bickley	900	850	850	-50	-50
Biggin Hill	650	650	650	0	0
Bromley Common and Keston	1250	1250	1200	0	-50
Bromley Town	1550	1600	1700	50	150
Chelsfield and Pratts Bottom	950	950	900	0	-50
Chislehurst	1000	1000	950	0	-50
Clock House	1400	1250	1150	-150	-250
Copers Cope	1050	1050	1000	0	-50
Cray Valley East	1200	1200	1200	0	0
Cray Valley West	1150	1150	1100	0	-50
Crystal Palace	1000	950	950	-50	-50
Darwin	300	350	400	50	100
Farnborough and Crofton	700	700	700	0	0
Hayes and Coney Hall	850	950	950	100	100
Kelsey and Eden Park	900	900	900	0	0
Mottingham and Chislehurst North	850	800	750	-50	-100
Orpington	900	900	900	0	0
Penge and Cator	1350	1300	1250	-50	-100
Petts Wood and Knoll	950	950	900	0	-50
Plaistow and Sundridge	1200	1150	1100	-50	-100
Shortlands	600	550	550	-50	-50
West Wickham	750	750	750	0	0
Bromley	**21500**	**21300**	**20750**	**-200**	**-750**

Source: GLA 2016-based Ward Population Projections Housing-led Model (Accessed November 2017)

Figure 2. 10



Source: GLA 2016-based Ward Population Projections Housing-led Model (Accessed November 2017)

Table 2. 5

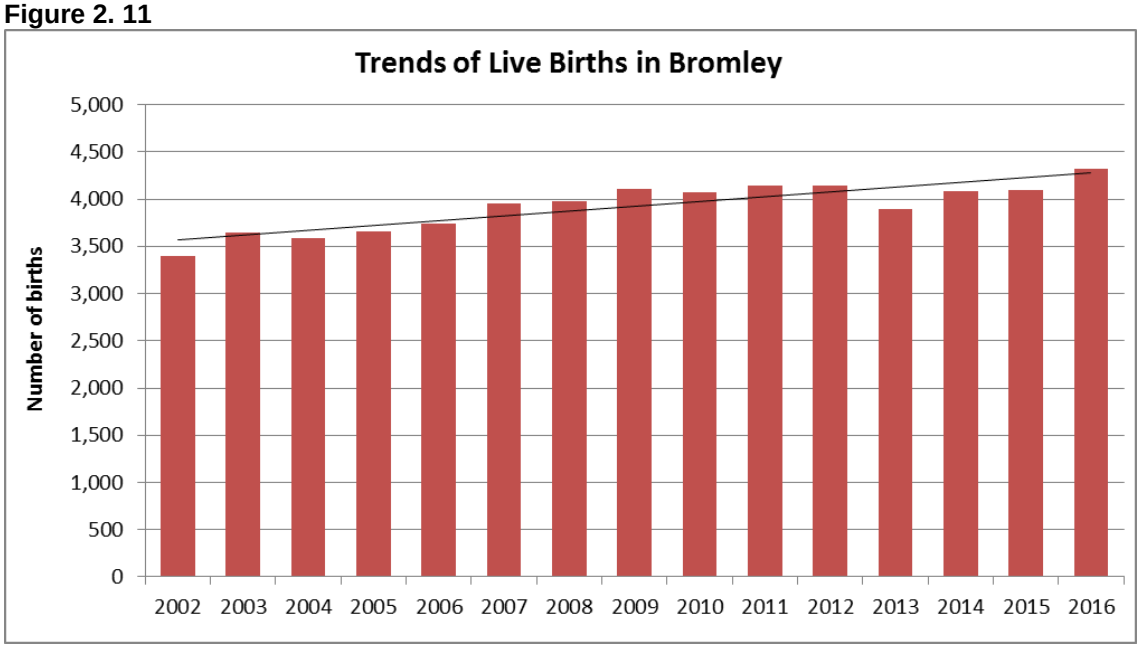
Population aged 75+ years in Bromley					
	Population projections			Change in numbers	
Biggin Hill	717	939	1123	222	406
Penge and Cator	793	980	1152	187	359
Petts Wood and Knoll	1455	1764	1952	309	497
Darwin	506	600	631	94	125
Chelsfield and Pratts Bottom	1345	1577	1745	232	400
Kelsey and Eden Park	1525	1756	2013	231	488
Bromley Town	1210	1384	1560	174	350
Copers Cope	1440	1643	1864	203	424
Clock House	952	1083	1298	131	346
Cray Valley East	1189	1352	1487	163	298
Shortlands	1058	1200	1319	142	261
Orpington	1778	2016	2232	238	454
Hayes and Coney Hall	1406	1586	1824	180	418
Farnborough and Crofton	1978	2227	2427	249	449
Crystal Palace	426	478	556	52	130
West Wickham	1643	1826	2048	183	405
Plaistow and Sundridge	1168	1275	1415	107	247
Bickley	1715	1868	2013	153	298
Cray Valley West	1248	1355	1486	107	238
Bromley Common and Keston	1326	1432	1624	106	298
Mottingham and Chislehurst North	639	681	766	42	127
Chislehurst	1959	2061	2123	102	164
Bromley	**27476**	**31083**	**34658**	**2022**	**2027**

Source: GLA 2016-based Ward Population Projections Housing-led Model (Accessed November 2017)

Births

The number of live births in Bromley has been increasing over the last few years. In 2002 there were 3,400 births in Bromley, which rose to 4,326 in 2016.

Figure 2. 11



Source: ONS 2016, Accessed September 2017

Ethnic groups

The GLA Round Ethnic Group Projections estimate that, in 2017, the ethnic minority population of Bromley is 19.8%. This proportion varies by age group, with the greatest proportion of the BME population being in children and young people. 19% of 0-4 year olds in Bromley are from BME groups compared to 5% of those post retirement age.

The overall ethnic minority population of Bromley is projected to rise to 23% by 2027. The greatest proportional rise is in the Black African group.

Figure 2. 12

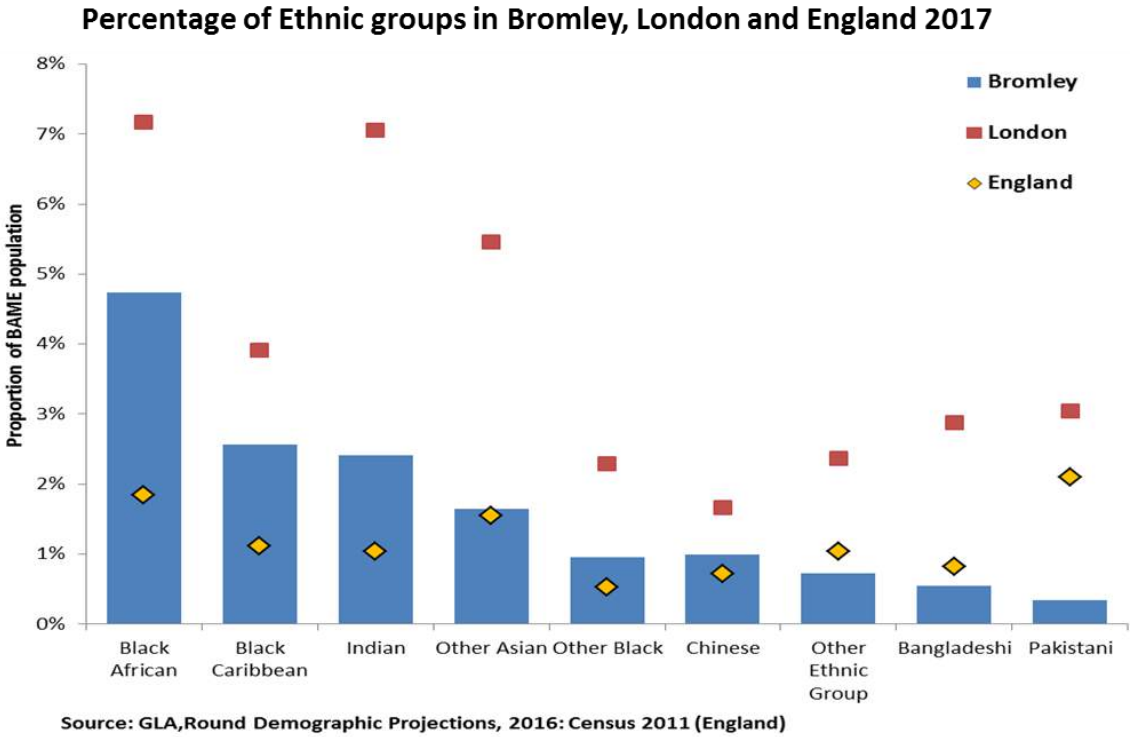
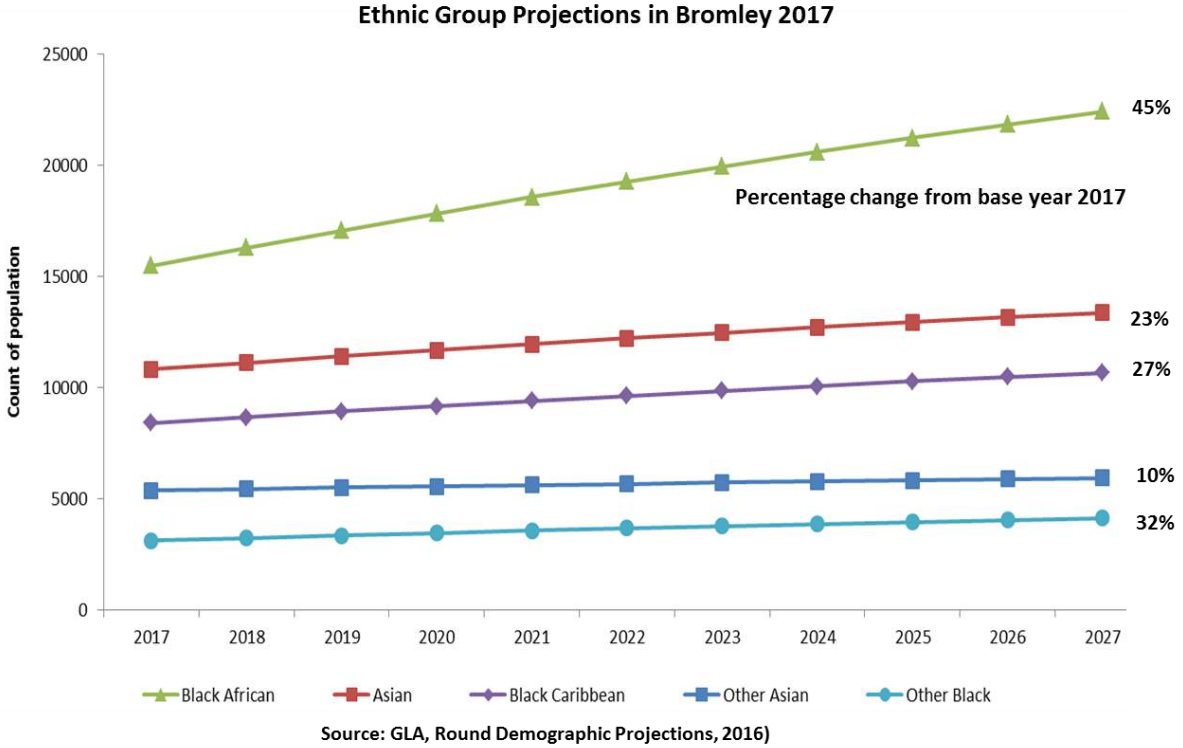


Figure 2. 13



Source: GLA 2014 Round SHLAA Capped Ethnic Group Borough Projections (October 2015)

Table 2. 6: Proportion of BMEs in Bromley by age group

Total Population	2017	
0-4 years (%)	4010	19%
5 -10 years (%)	4750	18%
11 - 18 years (%)	5530	18%
Working age (%)*	33520	16%
Post retirement (%)¥	3160	5%
80+ years (%)	650	4%

Source: GLA- 2015 Round- Long Term Migration Variant (January 2018)

* Working age =16 to 64y for males and females

¥ Post retirement = Over 64y males and females

It is important to take account of the proportion of ethnic minorities in the population in planning health services in particular. There is strong evidence that the health experience of different ethnic groups is not uniform e.g. the percentage of the population that report their health as 'not good' is highest among the Pakistani and Bangladeshi populations. People born in these countries, but living in England and Wales, have the highest mortality rates from circulatory disease.

A higher than average proportion of hospital admissions due to diabetes is found in the Asian groups, Black Caribbean and Black Other group in most regions, reflecting the higher prevalence of diabetes in these groups.

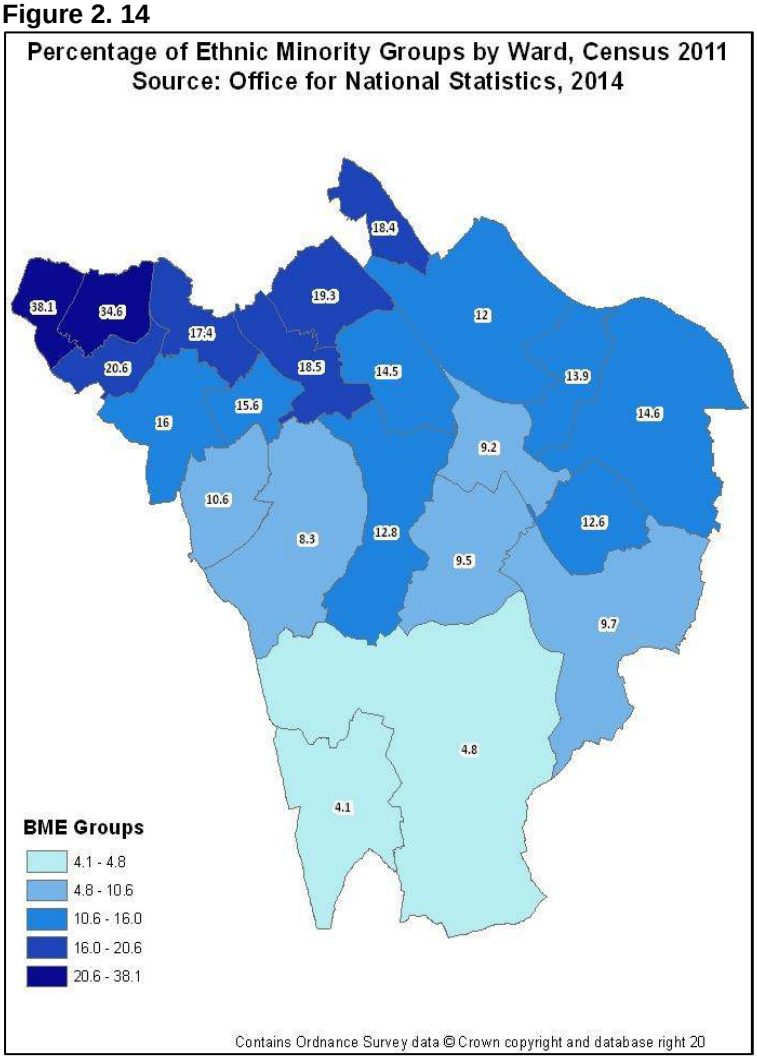
Among ethnic minority groups, Black Africans comprise the largest proportion of those seen for HIV care in all regions. Along with the 'Other' ethnic group, Black Africans also have the highest rates of tuberculosis.

Table 2. 7

Higher Risk of Disease Burden/Health Issues	Vulnerable Groups
CHD	Bangladeshi
	Pakistani
	Indian
Diabetes	Bangladeshi
	Pakistani
	Indian
	Black Caribbean
Sickle Cell and Thalassaemia	Bangladeshi
	Pakistani
	Indian
	Black Caribbean
HIV	Black African
Tuberculosis	Black African
	Other Ethnic Group

Data from the 2011 census shows that the North-West of Bromley has the highest proportion of ethnic minority population (**Figure 2.14**). We do not have projections for changes in population by ethnicity at ward level.

Figure 2. 14



The GLA population projections do not include Gypsy Travellers as an ethnic minority, although they do form a distinct ethnic group with particular needs. Bromley has a large Gypsy Traveller community concentrated chiefly in the Crays.

Bromley has a large settled Gypsy Traveller Community living in brick and mortar concentrated chiefly in the east of the borough in the Crays.

The borough also owns and manages two traveller sites in the Cray at Star Lane with 22 pitches and Old Maidstone Road with 14 pitches. There are also a number of Traveller families on five small private sites across the borough (12 authorised pitches) and a notable cluster on 4 private sites, to the western borough boundary with Croydon (near New Addington) which have a history of occupation by travellers and are proposed to be allocated as ‘Traveller sites’ in the draft Local Plan).

Additionally, the Borough is home to a large community of Travelling Show people, also located close to the boundary with Croydon (New Addington).

There is evidence that Gypsies and Travellers are the most excluded ethnic minority in this country[i].

What this means for residents in Bromley:

The upper half of the borough is heavily populated. This increases pressure for land to become available as more housing and services are required for the population increase.

It is important to keep abreast of the changes in population structure as service provision may have to adapt to the needs of new communities.

The rise in the number of over 75 year olds since 2010 has had and will continue to have an impact on the provision of health and social care services in Bromley.

3. The Health of People in Bromley: Life Expectancy and the Burden of Disease

Premature mortality is the major determining factor for the life expectancy of a population. Therefore any examination of the life expectancy of a population must include not just information on the major causes of mortality, but also about the diseases predisposing to these causes and the risk factors for disease.

This section will report on:

- All Cause Mortality
- Life Expectancy
- Infant Mortality
- Health Inequalities
- Key Causes of Mortality and Major Health Issues

Mortality & Life Expectancy

All Cause Mortality

The all-cause mortality rate for Bromley (846/100,000, DSR) is lower than both the London and England average rates. Bromley has the ninth lowest all-cause mortality rate in London.

Figure 3. 1

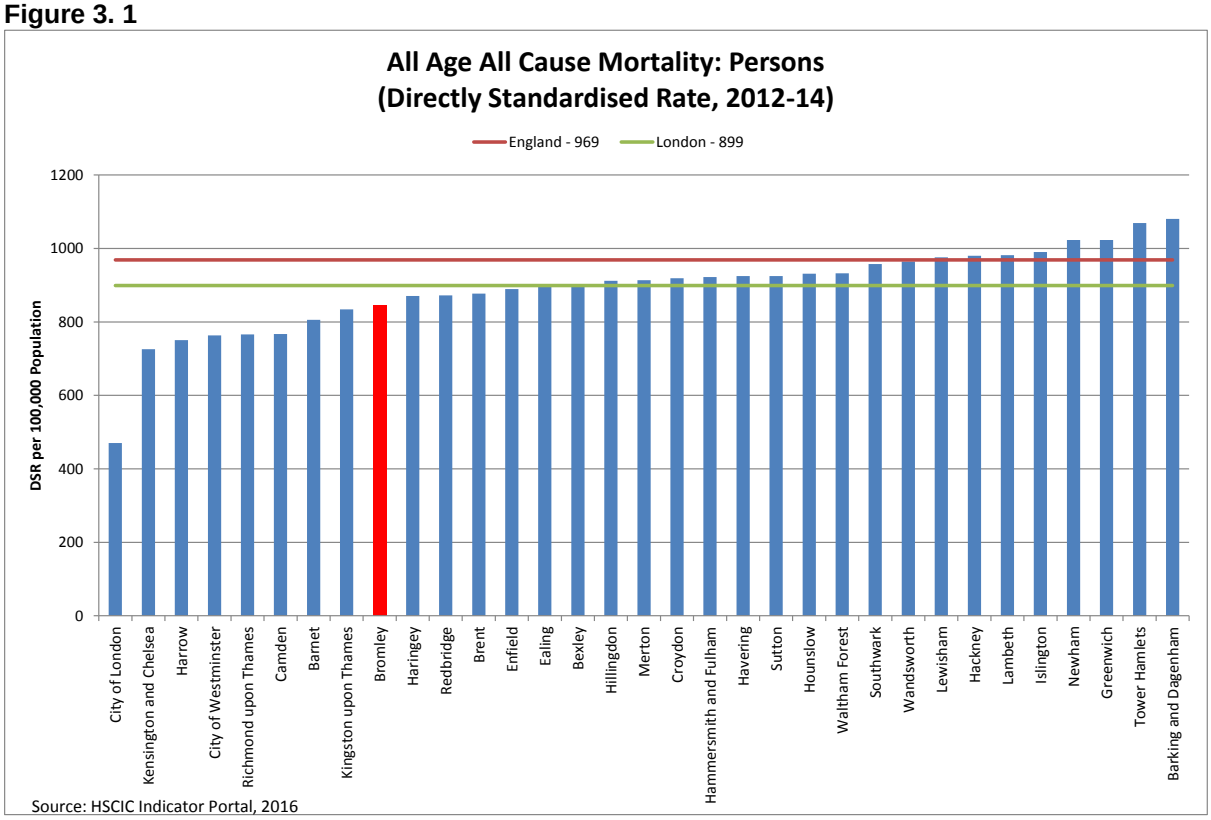
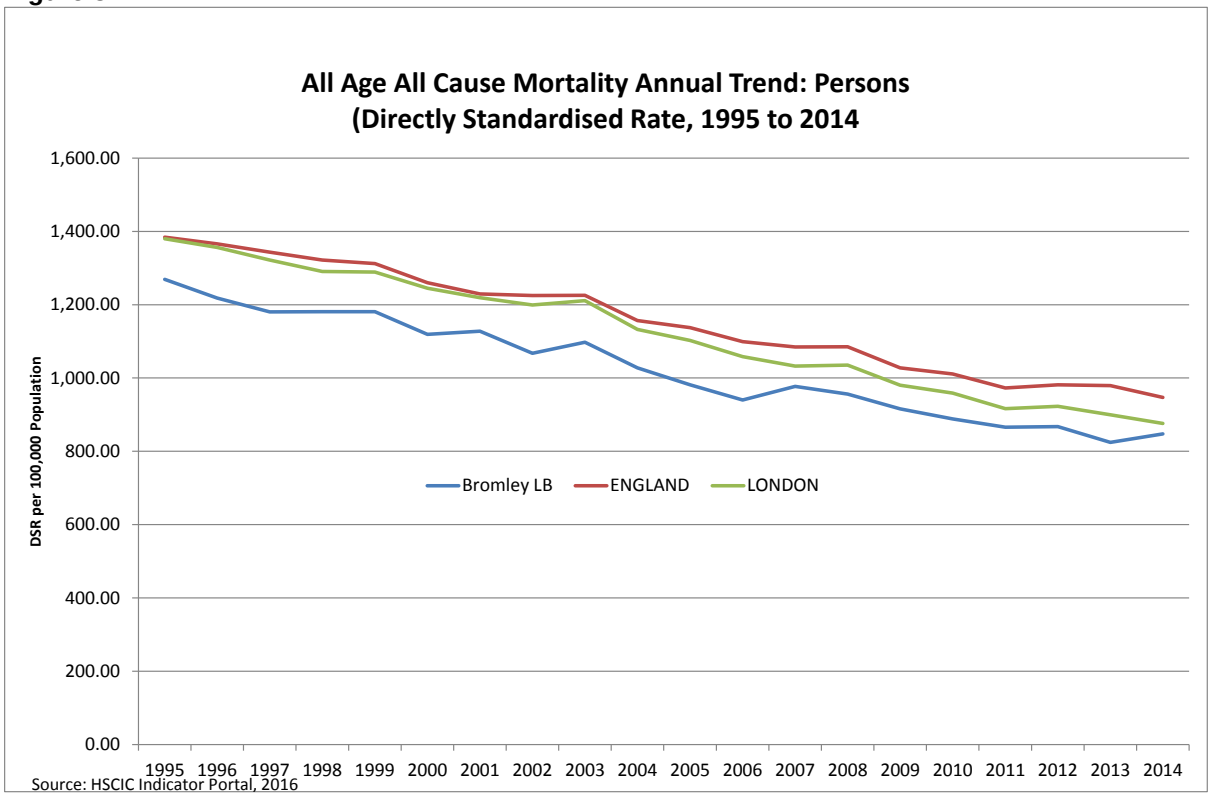


Figure 3. 2



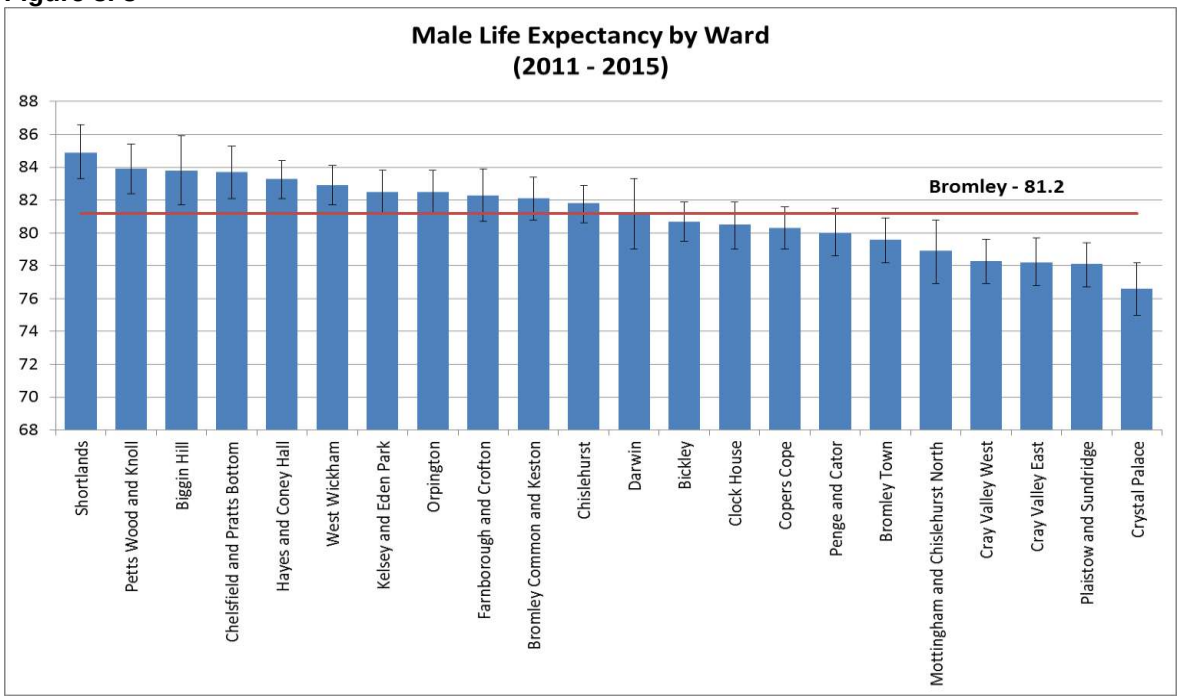
Source: HSCIC Indicator Portal, 2016

Life Expectancy

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, and the latest figures (2013-15) report a life expectancy of 81.3 years for men and 85.1 years for women. These averages rank 136th and 143rd respectively out of 152 local authorities in England, where 1 is the lowest life expectancy. However, life expectancy across Bromley is not uniform. The gap between wards with the highest and lowest life expectancy for the years 2011-15 was 8.3 years for men and 6.4 years for women.

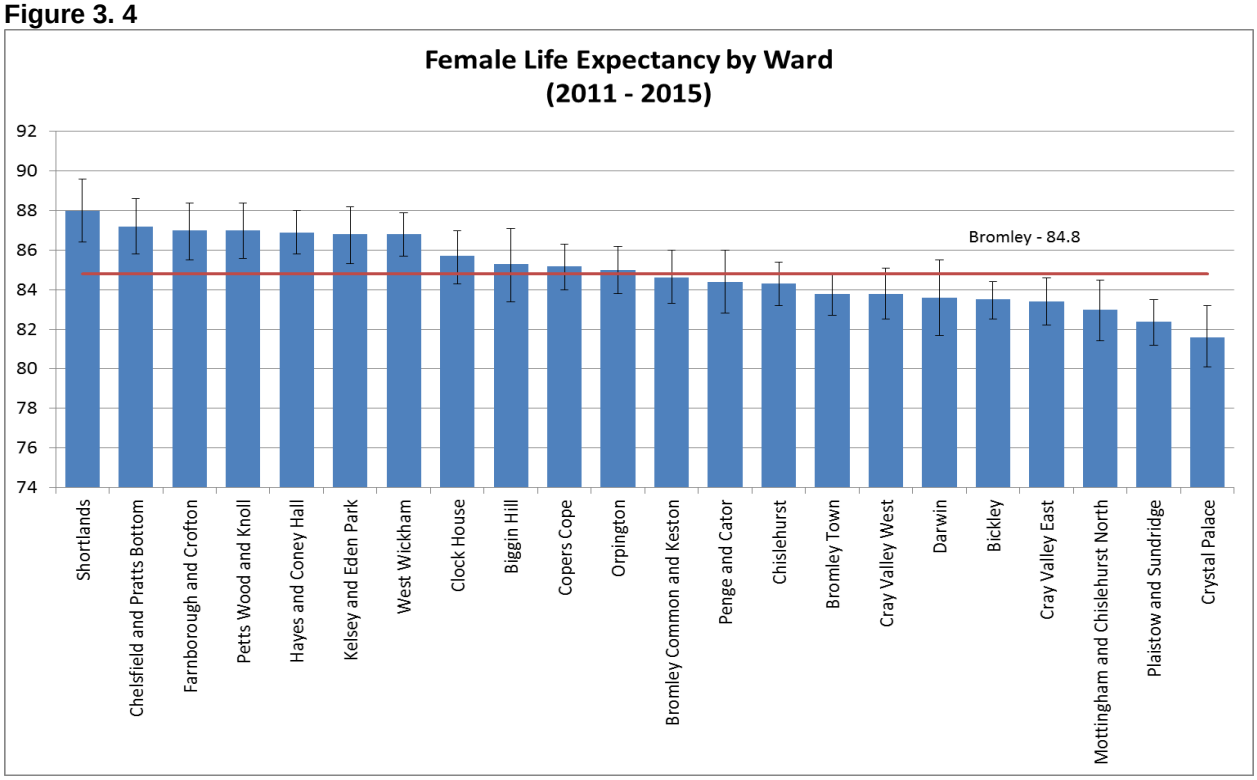
Life expectancy is lowest for men and for women in Bromley in Crystal Palace (76.6 years and 81.6 years) and Plaistow & Sundridge (78.1 years and 82.4 years) wards.

Figure 3. 3



Source: PHE-Local Health, 2017

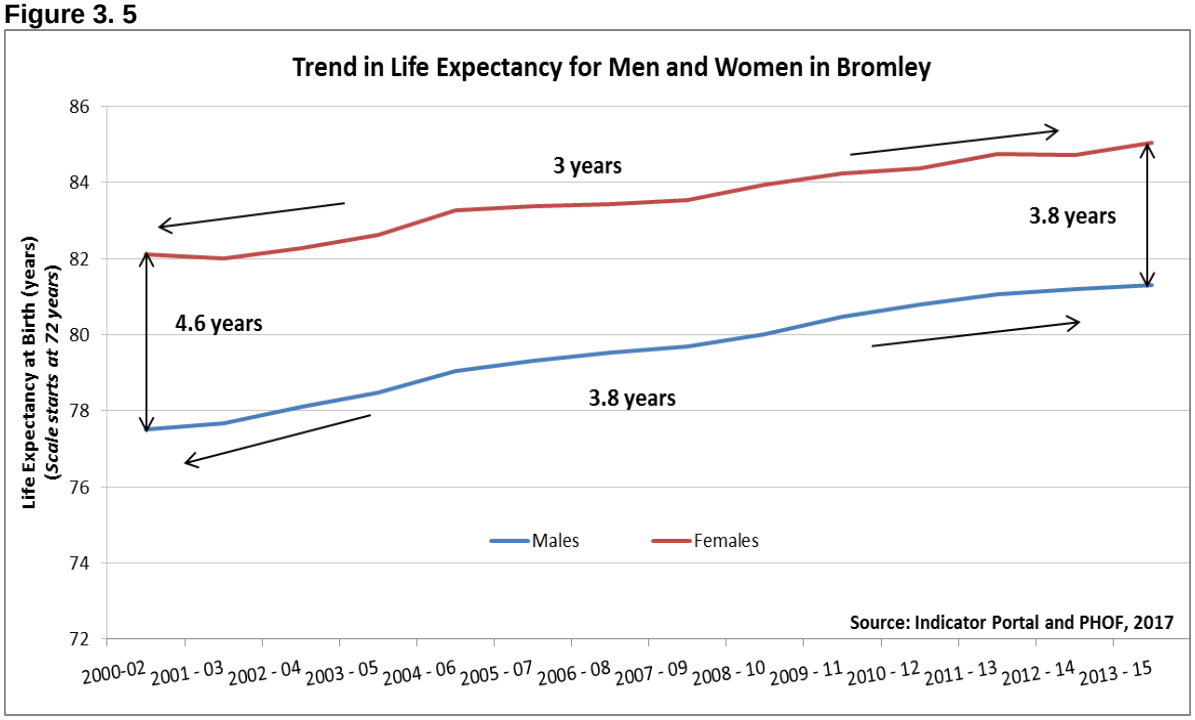
Figure 3. 4



Source: PHE- Local Health, 2017

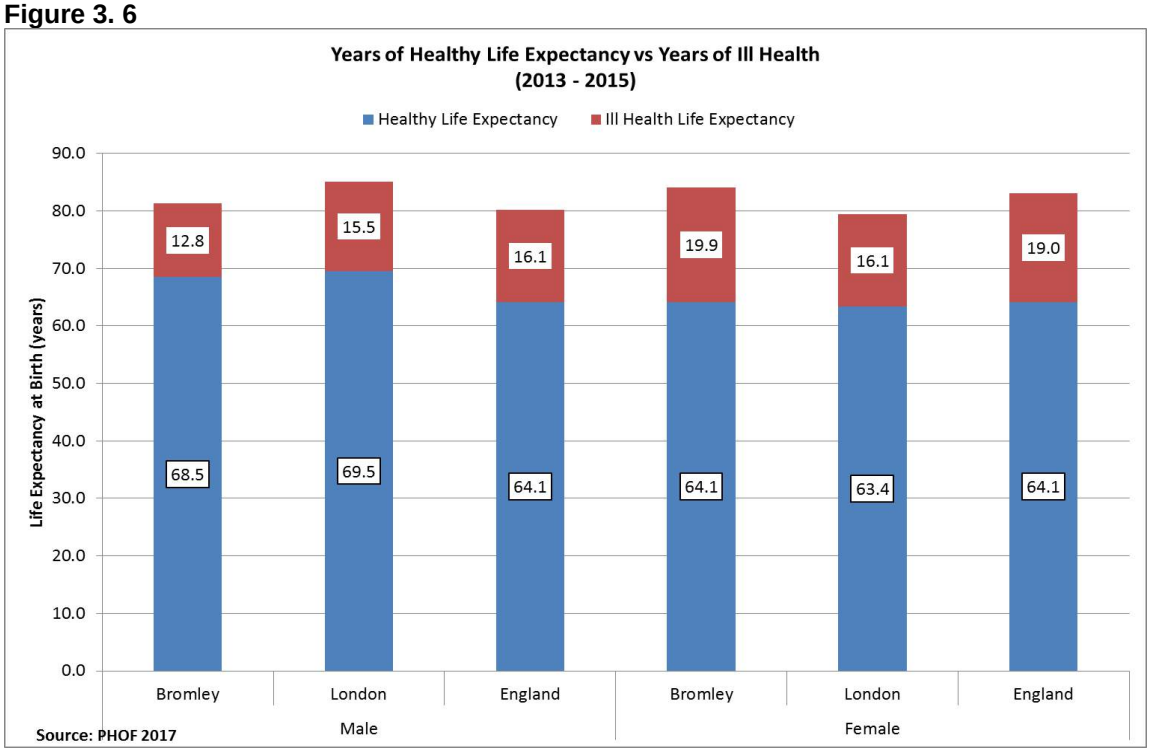
Men have a lower life expectancy than women, but over the last fifteen years, there has been a reduction in the life expectancy gap between men and women from 4.6 years to 3.8 years, with life expectancy increasing for both men and women over the same period.

Figure 3. 5



It is not just longevity that is important, but healthy life expectancy. **Figure 3.6** shows that men in Bromley can expect to live more years without illness than the England average but not the London average.

Figure 3. 6



Another important measure of life expectancy is Disability-Free Life Expectancy (DFLE). This is assessed by asking respondents whether they have any health problems or disabilities that they expect will last for more than a year, and whether these health problems or disabilities, when taken singly or together, substantially limit their ability to carry out normal day-to-day activities.

Bromley is ranked 6th and 30th out of 326 local authorities in England for DFLE at birth for women (at 68.7 years) and for men (at 63.5 years) respectively (ONS, 2012-2014).

Infant Mortality

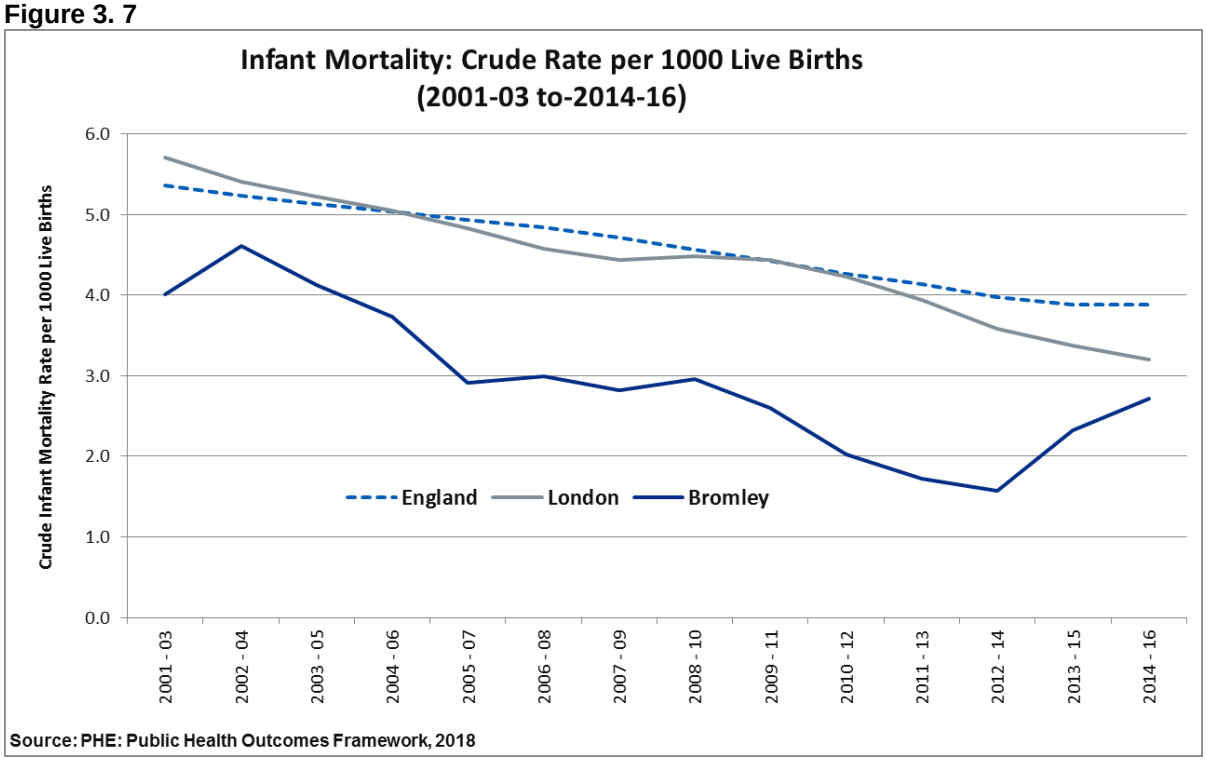
The infant mortality rate looks at deaths under the age of 1 year and is an indicator of the overall health of a population.

The infant mortality rate in Bromley (2.7 per 1000 live births) is lower than in England as a whole (3.9 per 1000 live births).

There was a steady decrease in infant mortality rates in Bromley over a 10 year period; this appears to have reversed in more recent years. The reverse could be attributed to changes in the definition of still births and more accurate recording. Further monitoring is required to establish if this upward trend is enduring.

The rate is currently significantly lower than the 1990-92 rate of 5.7 per 1000 live births. **Figure 3.7** shows some fluctuation, which reflects the small numbers involved. Individual causes are not described as numbers are small.

Figure 3. 7



Health Inequalities

Health inequalities are differences in the health status of groups and individuals that are both avoidable and unjust.

Health inequalities arise from social inequalities, themselves the result of unequal distribution of factors influencing health (e.g. housing, environment, social background, income, employment and education).

The Slope Index of Inequality (SII) is a measure of health inequalities in life expectancy at birth within a local area.

For the period 2013 to 2015, the SII for men in Bromley was 7.4, and for women, 5.9. This can be interpreted as a 7.4 year difference in life expectancy at birth between males living in the most and least deprived areas of Bromley, and 5.9 years for females.

Although there is less difference in the level of life expectancy inequalities seen between males and females in Bromley, in the last eleven years, there has been an increase in inequalities in life expectancy within gender for females but a reduction for males since records in 2002-04 (**Figure 3.10**).

Figure 3. 8

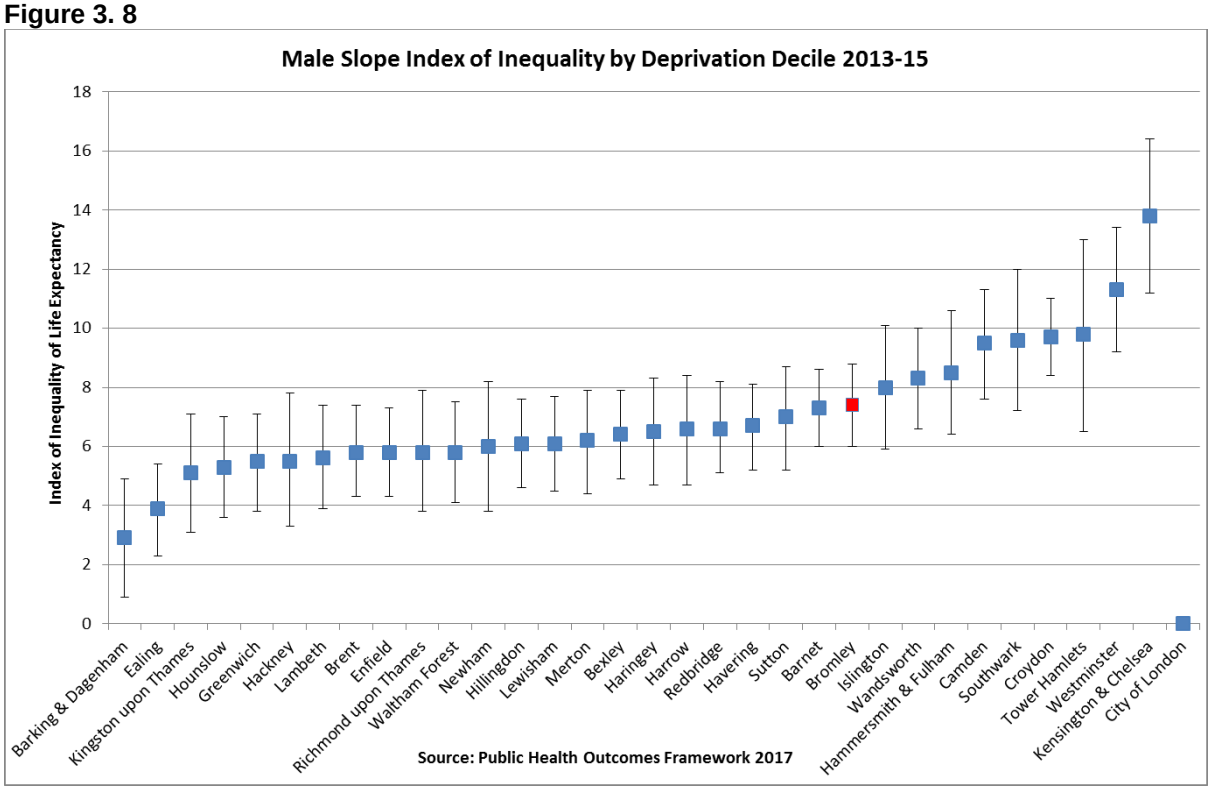
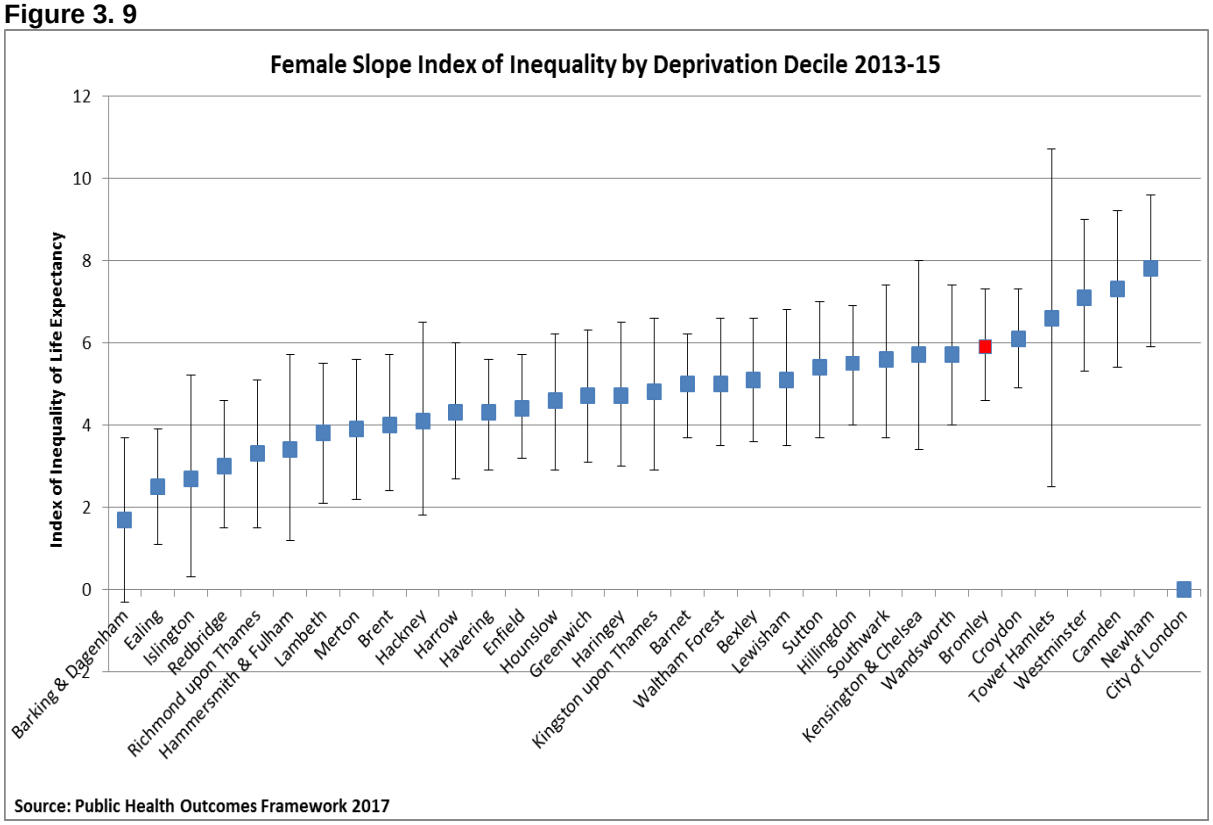
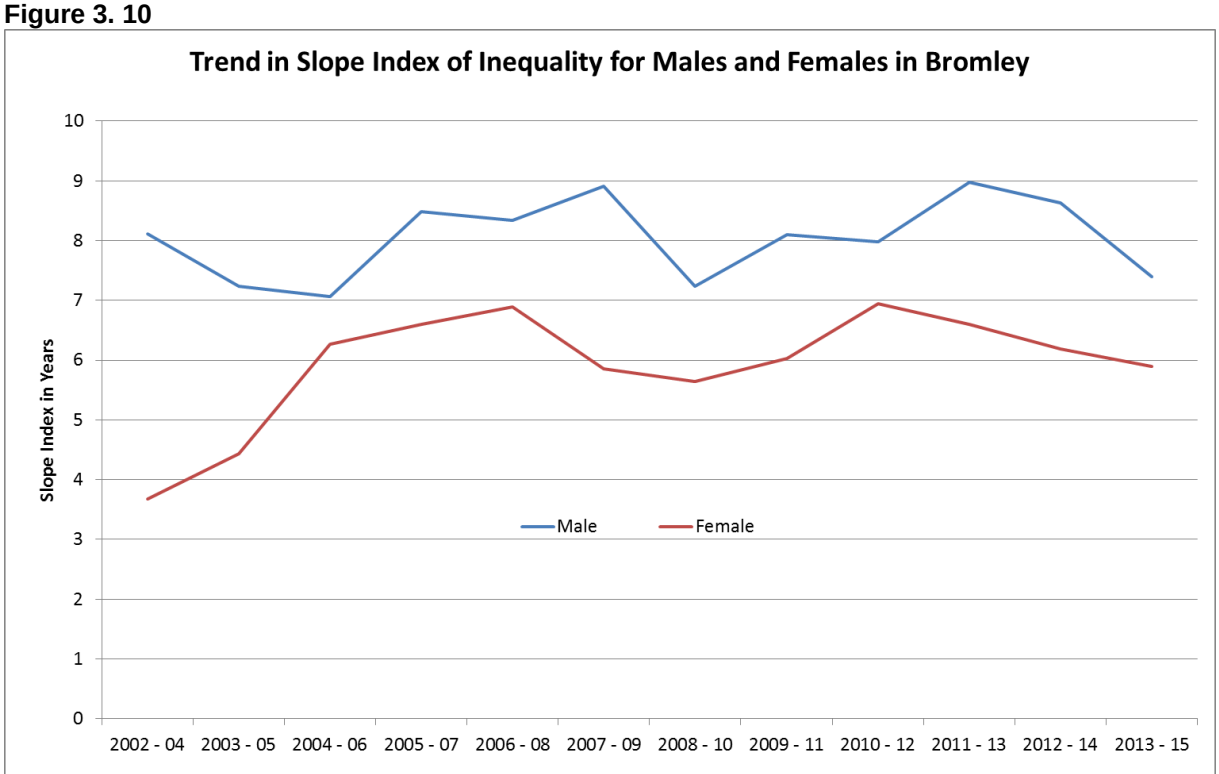


Figure 3. 9



Source: Public Health Outcomes Framework 2017

Figure 3. 10



Source: Public Health Outcomes Framework, 2017

There is significant variation in mortality rates for coronary heart disease and cancer between wards in Bromley (**Figures 3. 11** and **3.12**).

Crystal Palace, Cray Valley East, Cray Valley West, Penge & Cator, Bromley common & Keston and Clock House wards have significantly higher than average premature mortality rates for heart disease, while Mottingham & Chislehurst North and Plaistow & Sundridge wards have significantly higher than average premature rates for cancer.

Figure 3. 11

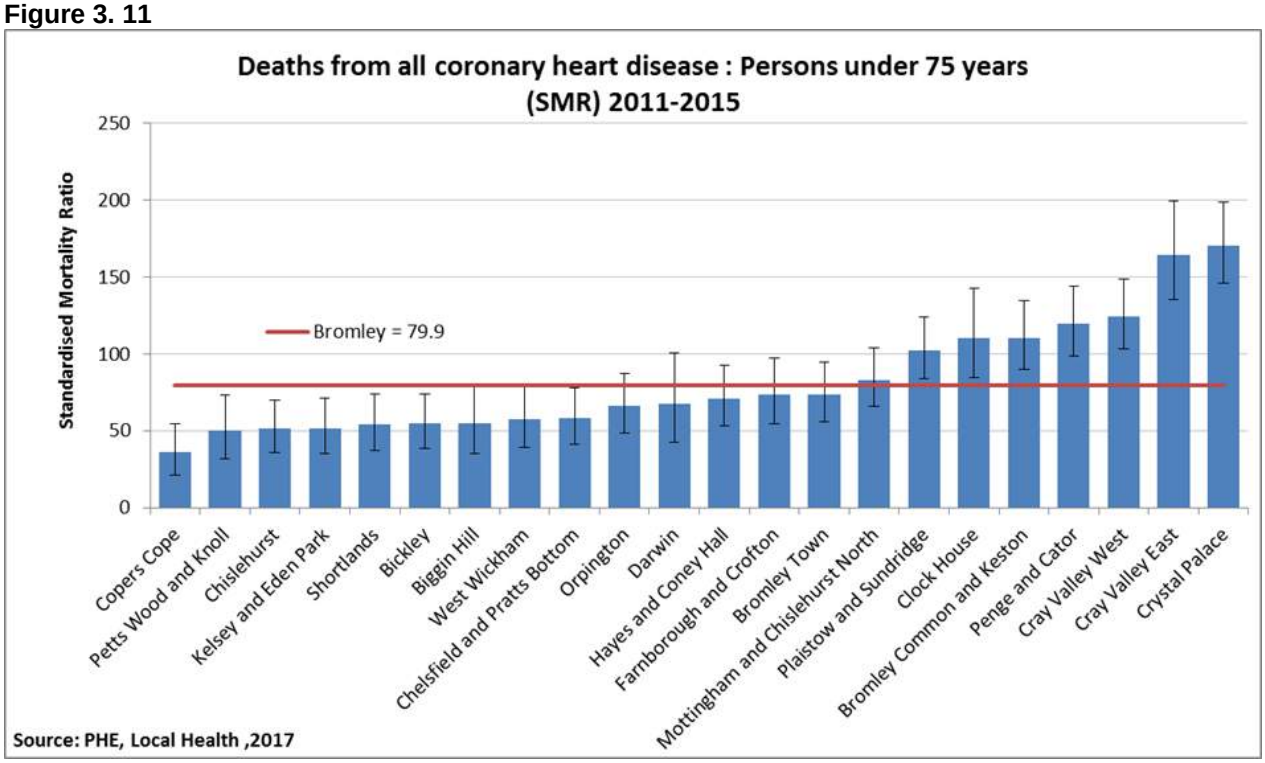
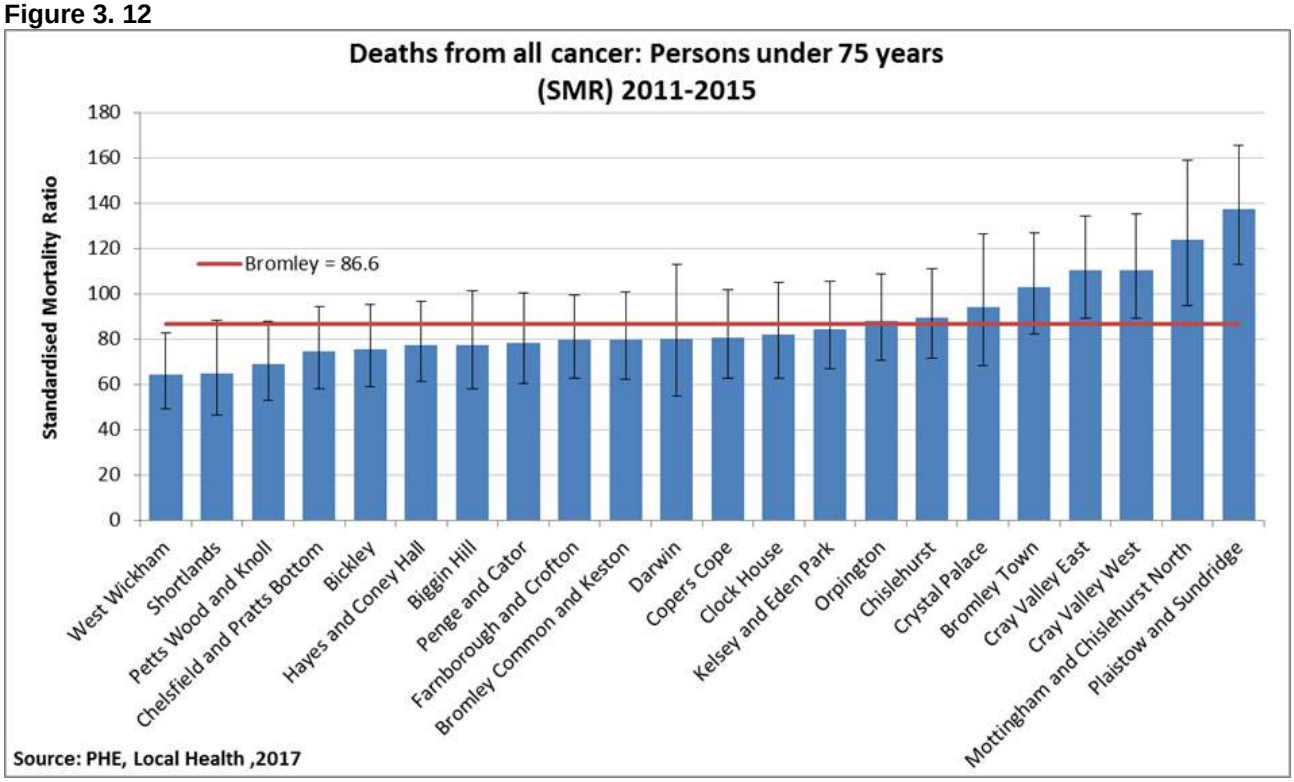


Figure 3. 12

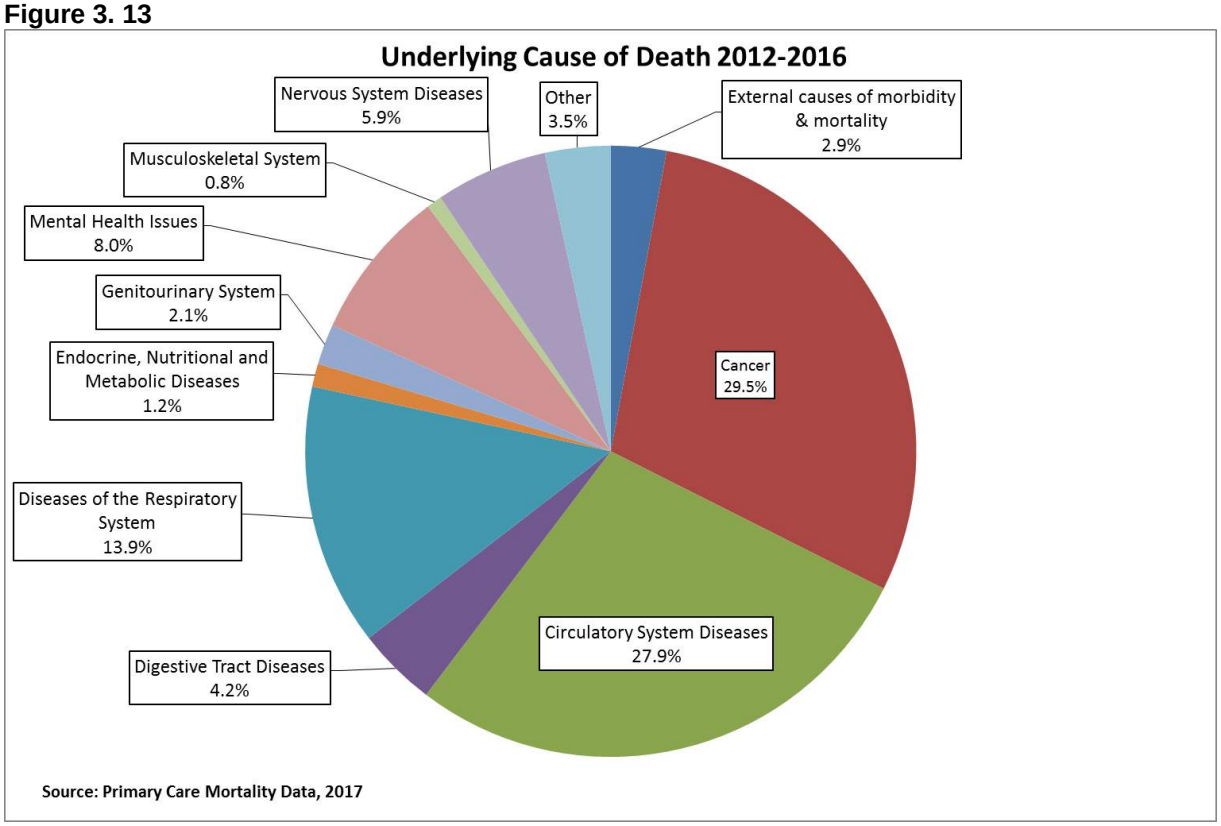

Deaths from all cancer: Persons under 75 years
(SMR) 2011-2015
Standardised Mortality Ratio
180
160
140
120
100
80
60
40
20
0
Bromley = 86.6
West Wickham
Shortlands
Petts Wood and Knoll
Chelsfield and Pratts Bottom
Bickley
Hayes and Coney Hall
Biggin Hill
Penge and Cator
Farnborough and Crofton
Bromley Common and Keston
Darwin
Copers Cope
Clock House
Kelsey and Eden Park
Orpington
Chislehurst
Crystal Palace
Bromley Town
Cray Valley East
Cray Valley West
Mottingham and Chislehurst North
Plaistow and Sundridge
Source: PHE, Local Health ,2017

Key Causes of Mortality & Major Health Issues

The key causes of death in Bromley remain:

- Cancer
- Circulatory disease
- Respiratory disease

Figure 3. 13



The proportion of deaths caused by circulatory disease has been falling since 2012 and in 2017 the proportion of deaths from cancer was greater than the proportion of deaths from circulatory disease for the first time.

Cardiovascular Disease

The term cardiovascular disease (CVD) describes a family of diseases (including heart disease, stroke and peripheral vascular disease) sharing a common set of risk factors. Chronic kidney disease and diabetes are also included in the CVD family of diseases as they have similar risk factors and are associated with a greater risk of CVD. Hypertension is a predisposing condition for CVD.

It is important to reduce the number of people living with ill health and dying prematurely, while reducing the gap between communities. A key indicator for this objective is early mortality from cardiovascular disease.

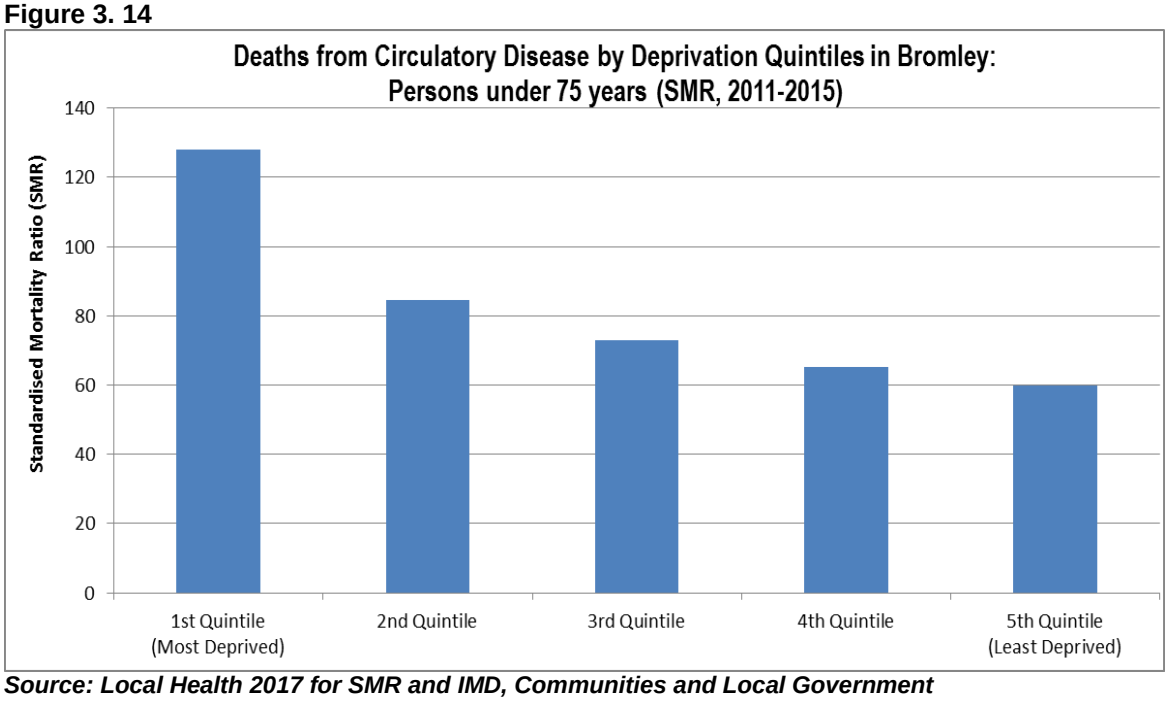
Between 2014 and 2016, the under 75 mortality rate in Bromley from cardiovascular disease considered preventable was 35.9 per 100,000 population (as compared with 46.7 for England and 46.2 for London).

The early mortality rate for cardiovascular disease (CVD) in Bromley is lower than the rate for England, and has been falling steadily since 1995.

Although the under 75 CVD mortality rate in Bromley for the period 2014-16 was (at 56.4 per 100,000) lower than England (73.5) and London (74.9), there are gender differences within the borough[ii].

- Male under 75 CVD mortality rates are significantly higher than female under 75 CVD mortality rates (81.8 and 33.8 respectively).
- CVD mortality rates are higher in wards in the most deprived areas of the borough, compared with wards in the least deprived quintile.

Figure 3. 14



Source: Local Health 2017 for SMR and IMD, Communities and Local Government

Coronary Heart Disease (CHD)

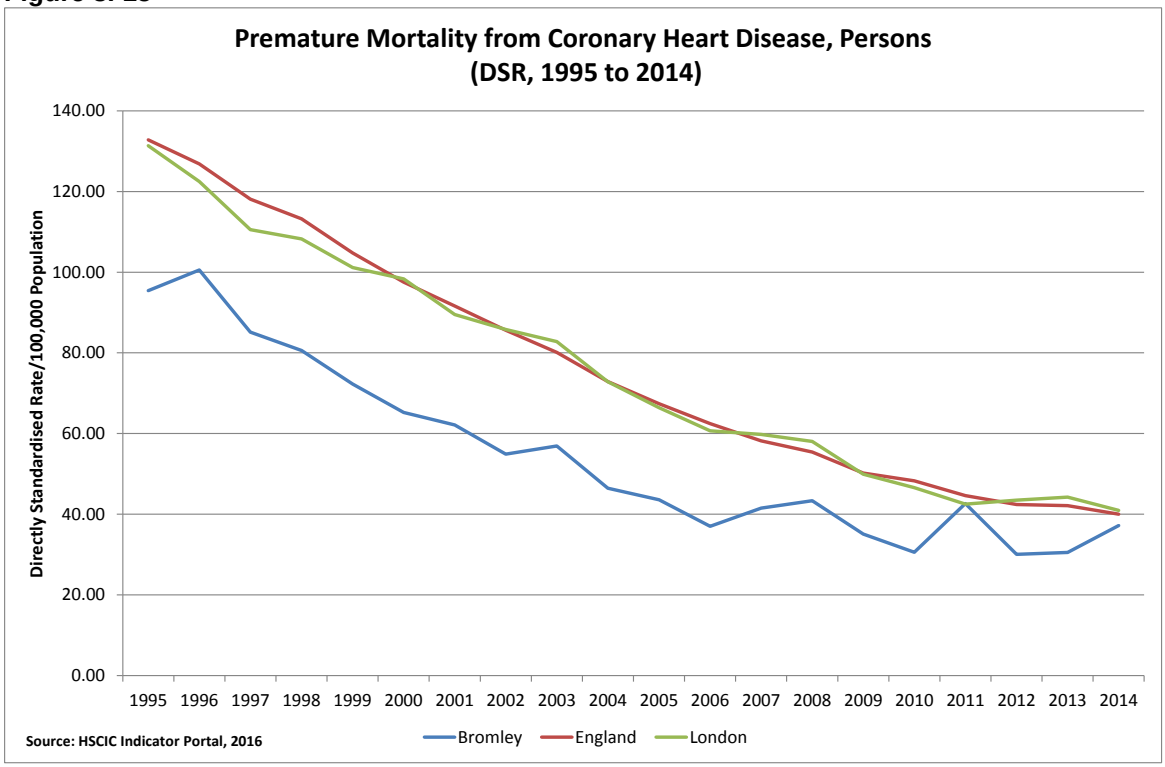
In 2016-17 there were 9,846 people who had been diagnosed with CHD in Bromley. However, based upon Health Survey for England results applied to Bromley, the total number of expected CHD cases is likely to be around 14,200. The prevalence of heart disease based on identified cases in Bromley has been declining over the last few years.

Table 3. 1: Prevalence of Coronary Heart Disease

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
CHD Register Size	9798	9717	9790	9859	9984	10253	10177	10165	10,065	9,898	9,846	9,793
CHD Prevalence	2.98%	3.76%	3.58%	3.75%	3.79%	3.79%	3.75%	3.10%	3.00%	2.93%	2.88%	2.83%
Source: NHS Digital-QOF, 2017												

The Public Health Outcomes Framework includes an objective for reducing numbers of people dying prematurely. One of the indicators for this objective is mortality under 75 from cardiovascular disease and CHD is the largest contributor for cardiovascular disease (45%). In the three year period 2013-15, the early mortality rate for CHD in NHS Bromley CCG was 32.1 per 100,000. This is a decrease of 23.9% since 2004-06. In England, the mortality rate has decreased by 40% over this time period and the rate in the South East London STP has decreased by 40%.

Figure 3. 15



Management of blood pressure levels in patients with CHD in Bromley is less effective than the national average, with 87.4% achieving optimal blood pressure management (as compared with 88.2% for England).

In contrast, patients with CHD in Bromley are more likely than the national average to be receiving treatment with aspirin or equivalent (93% vs 91.8%) and appropriate drug treatment post heart attack (74.5% vs 69.1%).

In 2015-16 the admission rate for CHD was 482.2 per 100,000 (1,418 admissions). This is lower than England (527.9 per 100,000).

Stroke

The recorded prevalence of stroke has been stable at about 1.5% over the last 5 years. In 2016/17 there were 5,110 people who had been diagnosed with a stroke in NHS Bromley CCG. In 2015/16 there were 373 admissions recorded on the Sentinel Stroke National Audit Programme.

Table 3. 2: Prevalence of Stroke

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Stroke Register Size	4,825	4,908	5,017	5,125	5,184	5,362	5,277	5,122	5,121	5,086	5,094	5,110
Stroke Prevalence	1.47%	1.90%	1.83%	1.95%	1.61%	1.61%	1.94%	1.50%	1.53%	1.51%	1.49%	1.48%
Source: NHS Digital-QOF, 2017												

Of those people diagnosed with stroke, a lower proportion achieves optimal control of blood pressure (82%) in Bromley than the England average (84%).

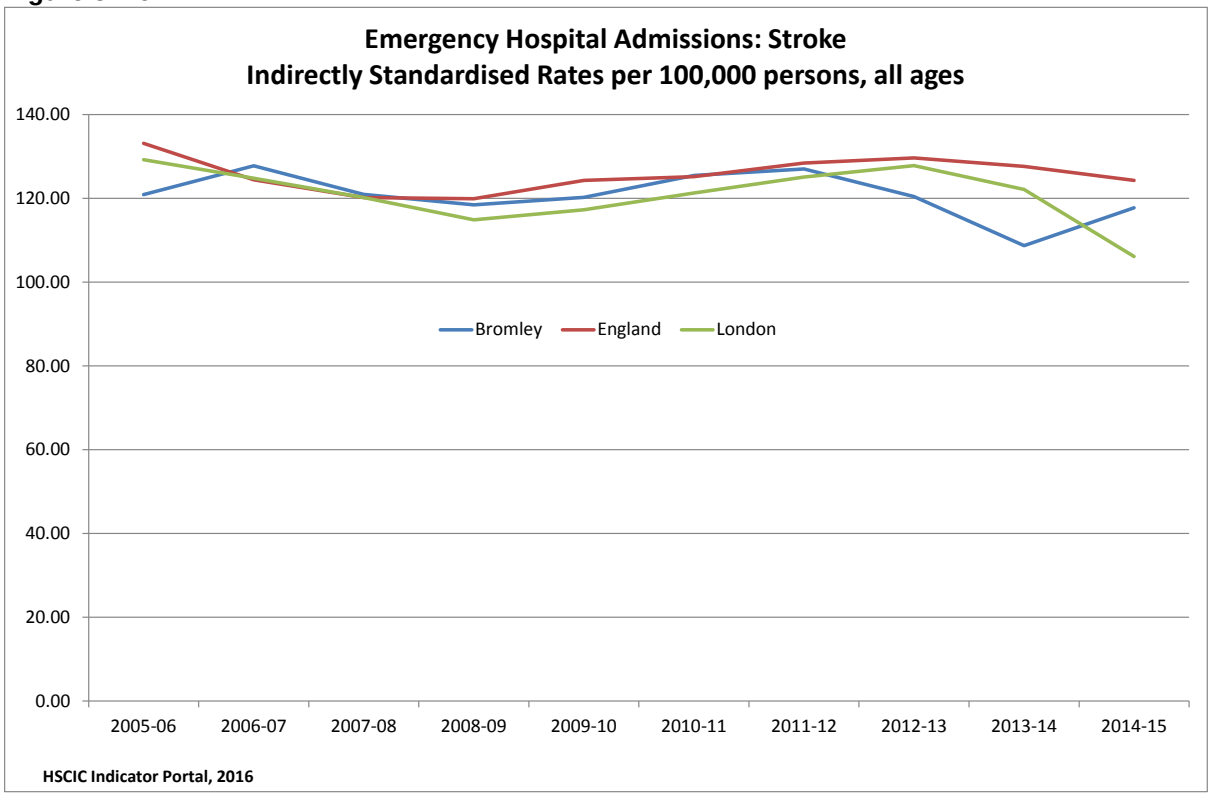
The proportion of patients with a non-haemorrhagic stroke who have a record of anti-platelet or anti-coagulant therapy (91.4%) is also lower than the national average (91.8%).

Atrial fibrillation (AF) is a known risk factor for stroke. The diagnosed prevalence of AF in Bromley is 1.9% and the estimated prevalence is 2.5%[iii], indicating that there could be an additional 3530 people with undiagnosed AF in the Bromley registered population[iv].

Treating appropriate patients with atrial fibrillation with anticoagulants lowers the risk of stroke. In Bromley, 54.0% of stroke patients admitted who had a history of atrial fibrillation were not prescribed anticoagulation prior to their stroke. This is higher than the England rate (52.5%).

In 2015-16, the admission rate for stroke in Bromley was 138.6 per 100,000 (422 admissions). This is significantly lower than England (171.9). The admission rate for stroke in Bromley decreased by 0.2% between 2005-06 and 2015-16.

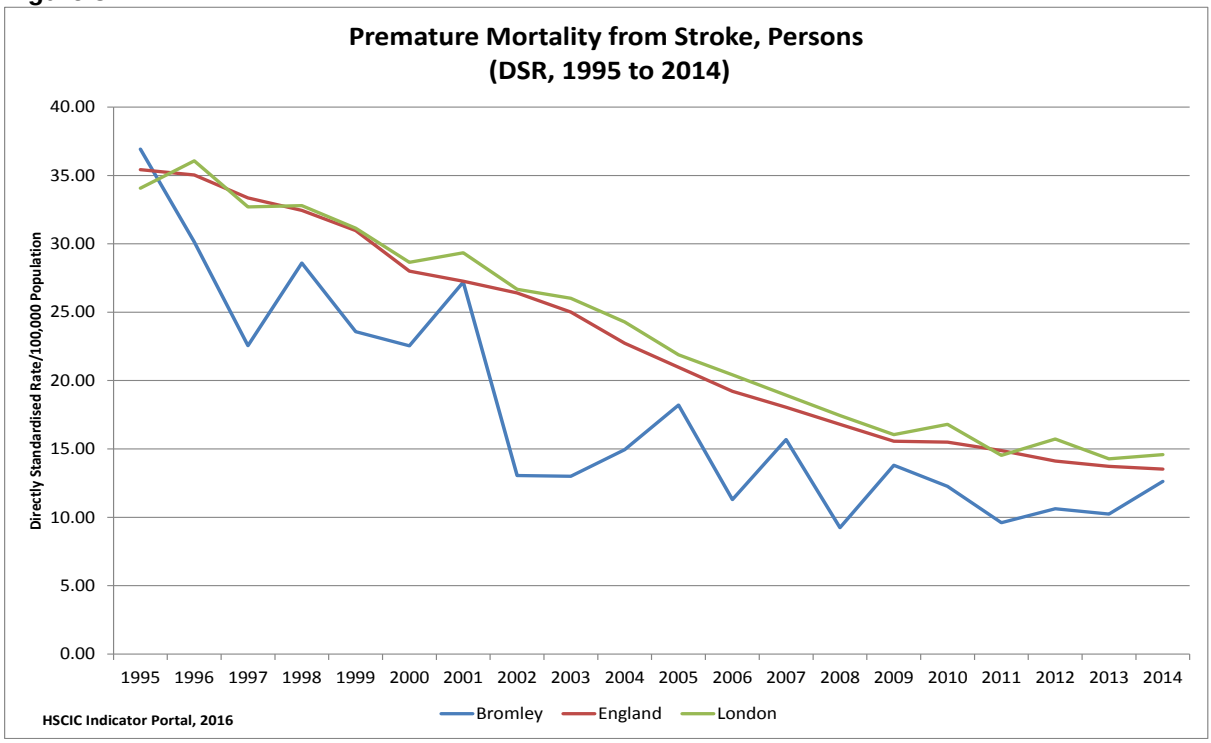
Figure 3. 16



It is a requirement of the National Stroke Strategy in England that all eligible patients receive a six month assessment after their discharge from hospital following a stroke. This is key to assessing the outcomes of stroke care. In 2015-16, Bromley assessed 8.5% of eligible patients at six months, which is lower than in 2013-14 when it was 32.1%. The level nationally was 24.5%.

The early mortality rate (under 75 years) due to stroke was 10.7 per 100,000 in 2013-15. The early mortality rate is significantly lower than England (13.6 per 100,000). Later mortality (over 75 years of age) rate from stroke in Bromley was 528.0 per 100,000 people. This was lower than the England rate (594.7).

Figure 3. 17



Hypertension

The prevalence of recorded hypertension has been reducing slightly since 2010.

The prevalence of recorded hypertension in Bromley (13.5%) is similar to the national average (13.8%). However, the expected prevalence of hypertension in Bromley is higher at 24.4%, indicating under-identification. There could be 32,500 undiagnosed hypertensives in Bromley (NCVIN, 2016 estimates). In Bromley, the percentage of patients aged 45 years and over who have a record of blood pressure in the preceding 5 years, is (90%), which is similar to the national percentage of 90.6%[iii].

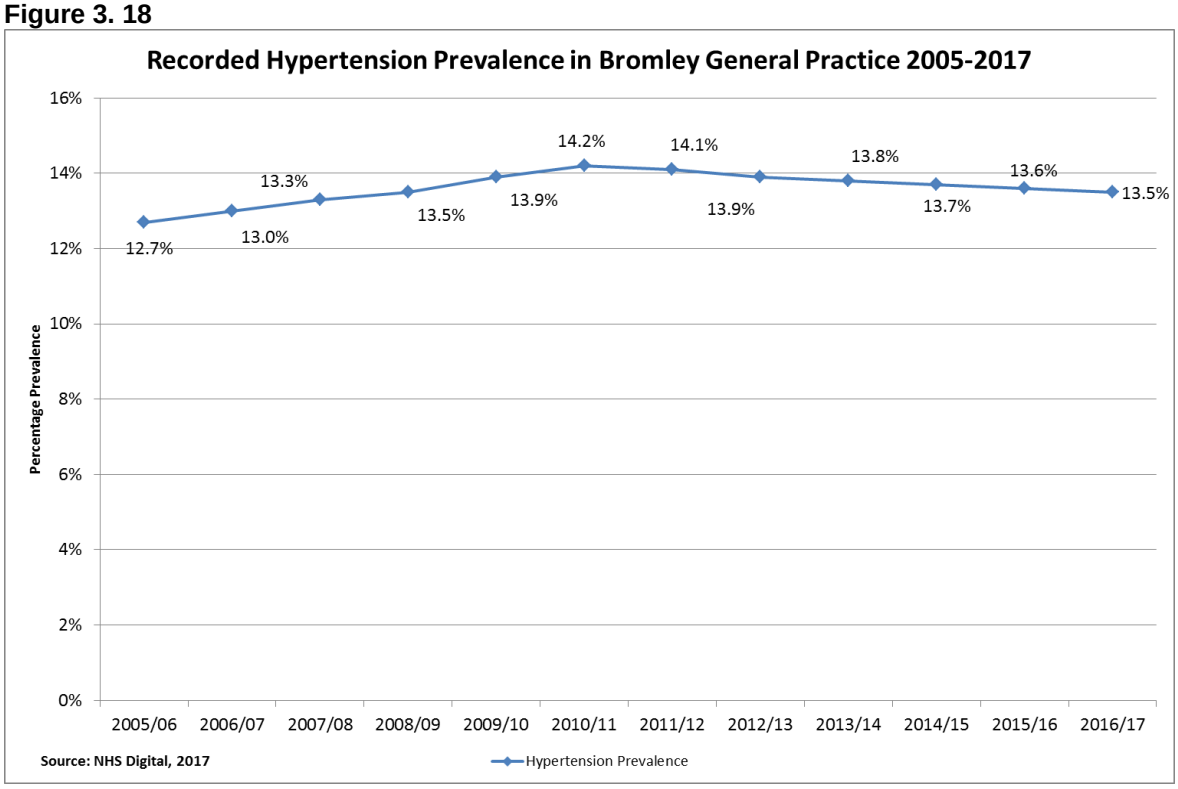
Table 3. 3: Hypertension Prevalence

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Hypertension Register Size	40,333	41,509	42,663	43,924	45,209	45,778	45,977	46,028	46,266	46,370	46,526	46,815
Hypertension Prevalence	12.7%	13.0%	13.3%	13.5%	13.9%	14.2%	14.1%	13.9%	13.8%	13.7%	13.6%	13.5%
Source: NHS Digital/QOF 2016												

Optimal management of hypertension reduces the risk of developing cardiovascular disease. In Bromley, optimal management is achieved in almost similar proportions of hypertensives as the national average. 78% of patients with hypertension have their blood pressure controlled to 150/90 or less, as compared with 80% nationally.

The risk of developing cardiovascular disease can be reduced in patients with hypertension by careful management of blood pressure and other cardiovascular risk factors such as physical inactivity and smoking. In Bromley, 88% of patients aged 15 years and over who were recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months, as compared with 89% nationally[iii].

Figure 3. 18



What this means for residents in Bromley:

The evidence shows that there are many people living in Bromley with undiagnosed hypertension and undiagnosed atrial fibrillation, as well as a number of people with known hypertension which has not been adequately controlled. These people are at a higher risk of stroke, kidney disease, heart disease and other conditions.

Chronic Kidney Disease

In 2016-17 there were 9473 people aged 18 years and over who had been diagnosed with Chronic Kidney Disease (CKD) in Bromley. This represents 3.5% of the registered population aged 18 years and over.

Table 3. 4

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16	2016/17
CKD Register Size	9,593	10,011	10,173	10,868	10,776	10,693	10,183	10,050	9,779	9,560	9,560	9,473
CKD Prevalence	*3%	*3.1%	4.0%	4.2%	4.2%	4.2%	3.9%	3.8%	3.7%	3.6%	3.6%	3.5%
Source: NHS Digital/QOF 2016 *(* Unadjusted Prevalence)*												

CKD is classified into five stages. The prevalence quoted relates to stages 3 to 5 (stage 5 representing more severe disease).

Across the country, estimates for the numbers of people with CKD are higher than the numbers diagnosed.

Table 3. 5

	Modelled CKD Prevalence	Diagnosed CKD Prevalence
England	6.1%	4.1%
Bromley	6.4%	3.7%

Patients with CKD benefit from early treatment which is proven to reduce mortality and slow progressive decline in kidney function.

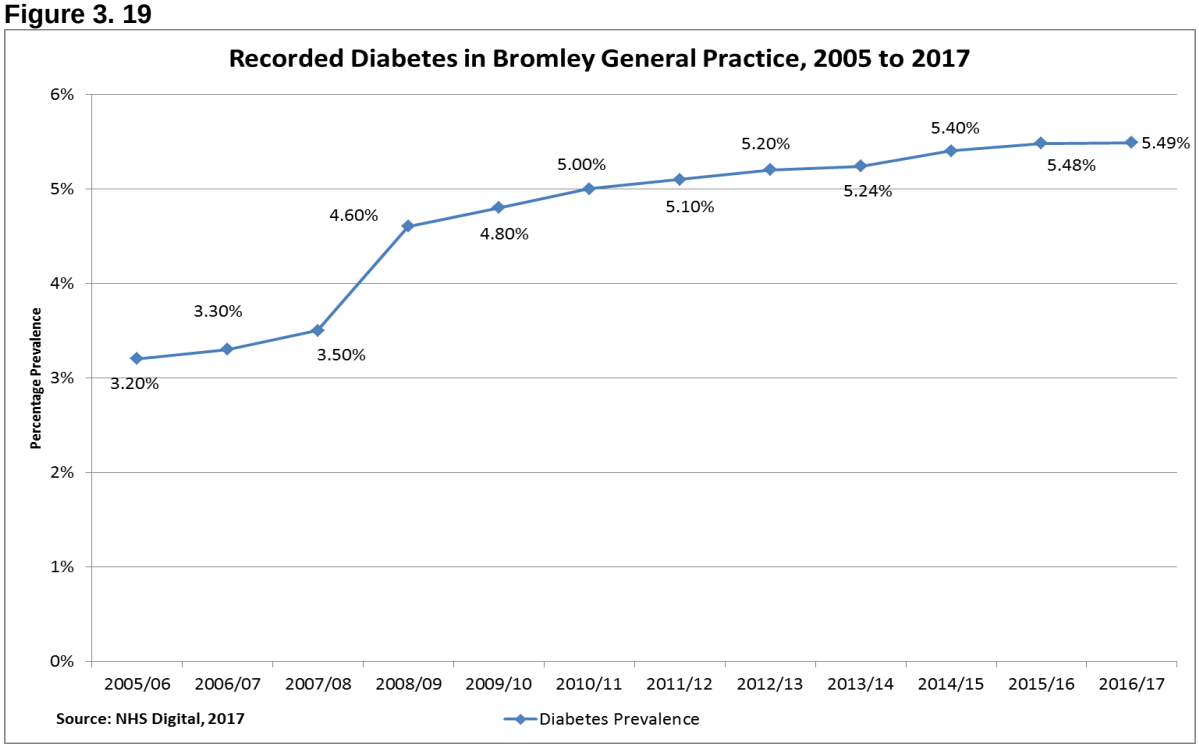
Diabetes

The number of people with diabetes has increased over time. There were 4,846 people on the diabetes register in 2002, as compared with 15107 in 2016-17 (**Table 3.6**). The prevalence of diabetes in Bromley is 5.5%, as compared with 6.5% for England as a whole. This rise has particular significance because diabetes is classed as a vascular disease which is often a precursor to heart disease or stroke.

Table 3. 6: Diabetes Prevalence

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Diabetes Register Size	8,861	9,244	10,084	10,504	11,261	11,979	12,509	13,307	13,335	13,681	14,013	14,493	14,901	15,107
Diabetes Prevalence	2.73%	2.56%	3.07%	4.06%	4.12%	4.56%	4.75%	5.00%	4.91%	5.20%	5.24%	5.40%	5.48%	5.49%
Source: NHS Digital -QOF, 2017														

Figure 3. 19



In addition, there are a large number of people with non-diabetic hyperglycaemia (NDHG) who are at high risk of developing diabetes. In 2015, national prevalence modelling predicted that there were 29,872 people with NDHG in Bromley. A search of GP systems in 2016 found that approximately 15,419 people have blood test results indicating that they have NDHG, indicating that many have not been identified.

In response to the rising levels of diabetes and pre-diabetes in the Bromley population, the Annual Report of the Director of Public Health 2017 will focus on Diabetes epidemiology and prevention. A link to the report will be inserted here when it is published.

What this means for residents in Bromley:

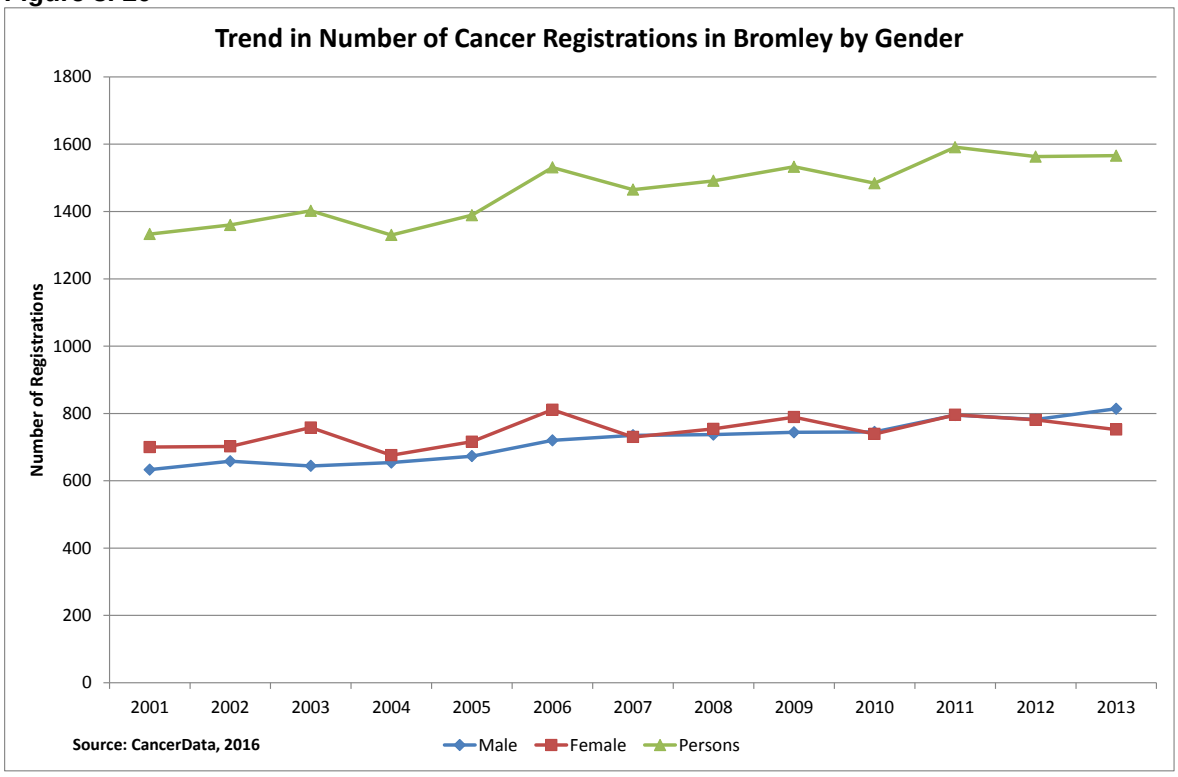
The number of people in Bromley with diabetes continues to rise and control of associated risk factors for circulatory disease in diabetics is lower than the national level.

Cancer

There were 8,851 patients recorded with a diagnosis of cancer on GP registers in 2016-17. There were over 10,000 cancer deaths in the last 10 years.

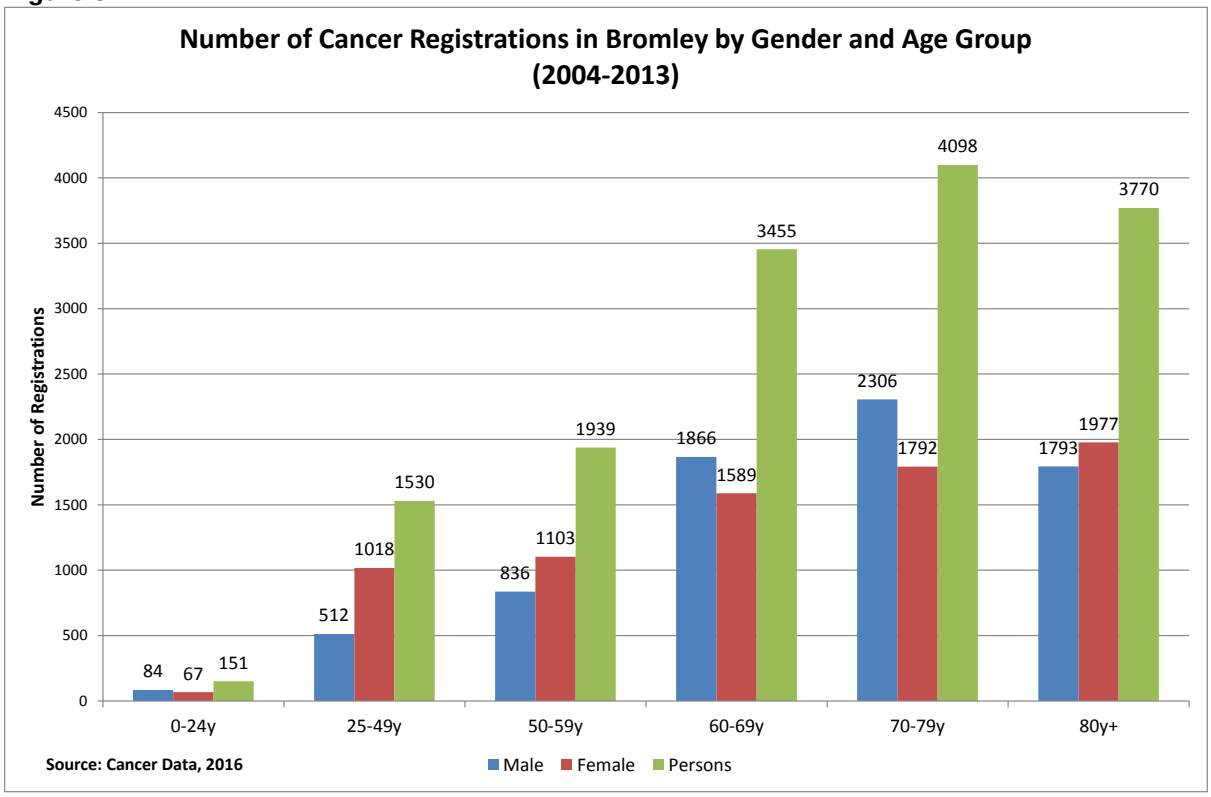
The number of cancer registrations per year has increased as shown in **Figure 3. 20**.

Figure 3. 20



The number of people diagnosed with cancer increases with age, to a peak in the 75 to 79 year age group (**Figure 3. 21**).

Figure 3. 21



The four most common cancers registered in Bromley in the last 10 years are breast, prostate, lung and colorectal cancer.

Table 3. 7: Number of Cancer Registrations by Site in Bromley, 2004-2013

Site of Cancer	Male	Female	Persons
Breast	13	2448	2461
Lung	953	752	1705
Colorectal	969	842	1811
Prostate	1949	0	1949
All Cancers*	7399	7544	14943

** Excluding non-melanoma skin cancer*

Source: Cancer Data, 2016

Table 3. 8: Incidence Rates for Cancer at Different Tumour Sites in 2013

Tumour Site	Age Standardised Rate per 100,000	
	Bromley	England
All Malignant Neoplasms Excluding Non Melanoma Skin	552.7	614.9
Malignant Neoplasm Of Prostate	212.8	185.7
Malignant Neoplasm Of Breast	142.8	170.0
Malignant Neoplasm Of Trachea, Bronchus And Lung	66.0	78.9
Malignant Neoplasm Of Colon And Rectum	57.8	71.6
Malignant Neoplasm Of Uterus	31.8	29.0
Malignant Neoplasm Of Ovary And Fallopian Tubes	24.3	23.9
Malignant Neoplasm Of Bladder	23.7	19.6
Non Hodgkins Lymphoma	21.5	23.8
Malignant Melanoma Of Skin	19.3	25.2
Malignant Neoplasm Of Pancreas	15.8	16.7
Malignant Neoplasm Of Oesophagus	14.8	15.6
Malignant Neoplasm of Kidney, Except Renal Pelvis	13.6	18.0
Leukaemia	11.6	16.8
Multiple Myeloma And Malignant Plasma Cell Neoplasms	10.1	10.2
Malignant Neoplasm Of Stomach	9.9	12.4
Malignant Neoplasm Of Brain And Other Parts Of Central Nervous System	8.9	9.2
Malignant Neoplasm Of Liver And Intrahepatic Bile Ducts	4.2	9.5
Bromley rate higher than England rate		
Source: CancerData, 2016		

Figure 3. 22

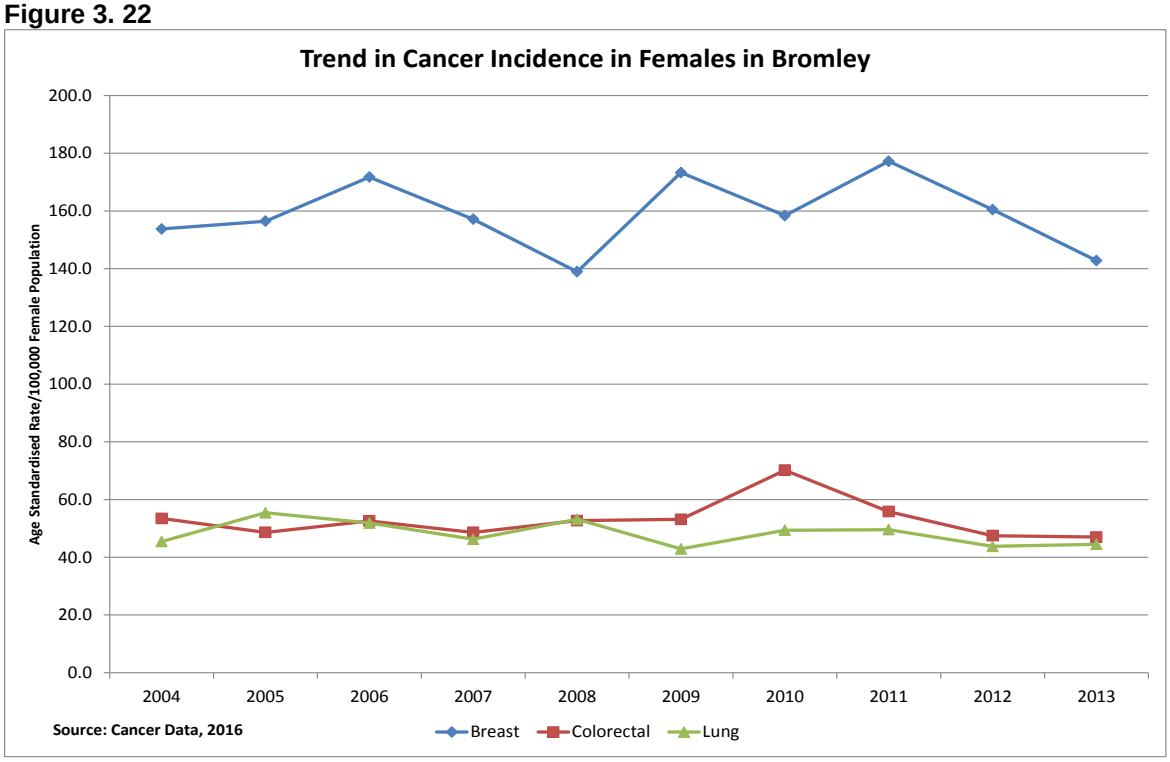
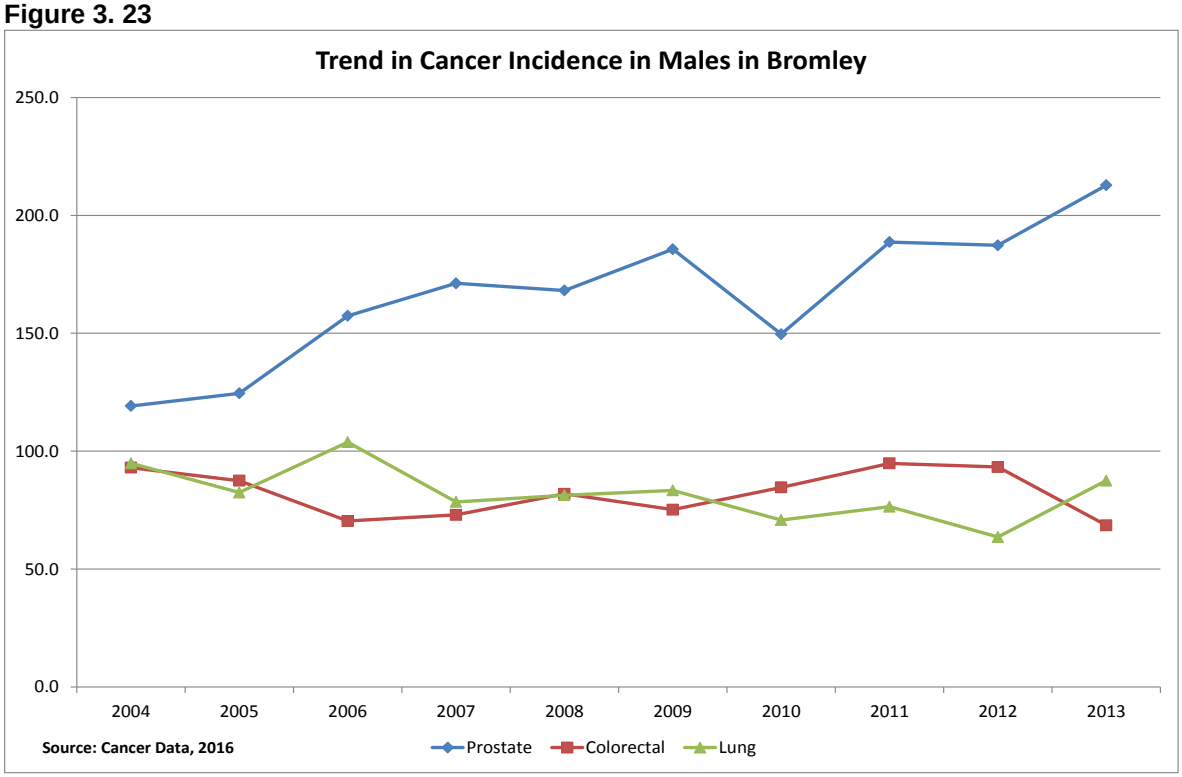


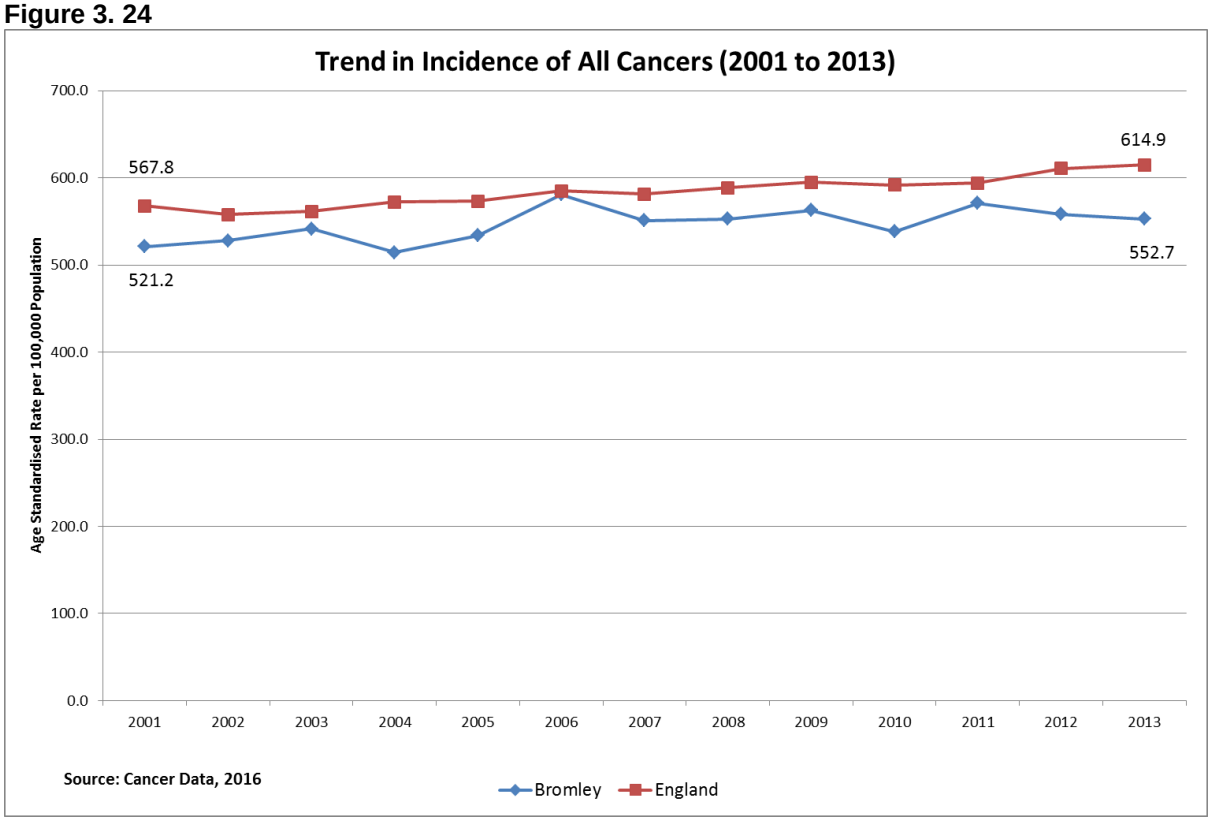
Figure 3. 23



The incidence for all cancers in Bromley has been consistently lower than the incidence for England over the last decade.

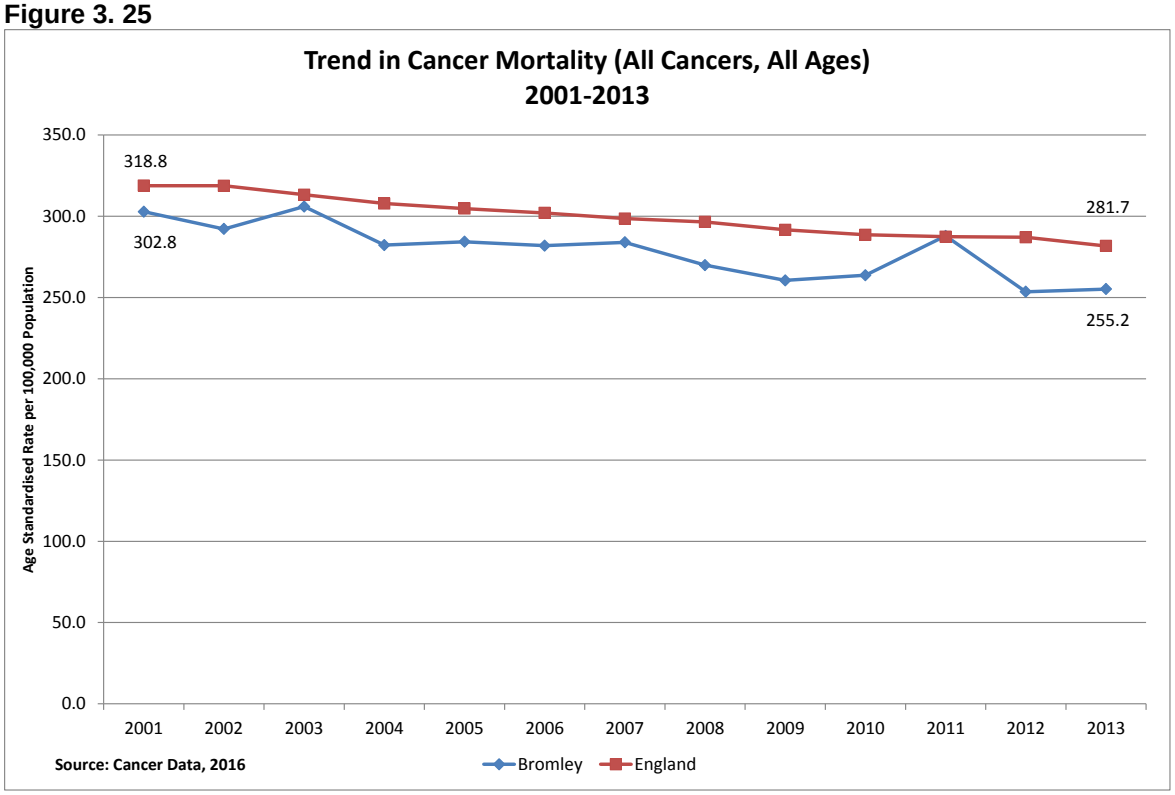
The incidence of lung, colorectal (in both men and women) and breast cancer (in women) in Bromley has fallen over the last ten years. In contrast, the incidence of prostate cancer in men in Bromley has increased (from 119 to 213 per 100,000).

Figure 3. 24



Overall cancer mortality has been falling over the last 13 years as shown in **Figure 3. 25**.

Figure 3. 25



Improvements in cancer survival times are due to improvements in early detection of cancer through increased awareness and good uptake of screening programmes, as well as to improved treatment for cancer.

Nevertheless, a relatively small proportion of cancers in Bromley were detected early in 2012 and 2013 as shown in **Figure 3.26** below**.** This is lower than for England as a whole.

Figure 3. 26

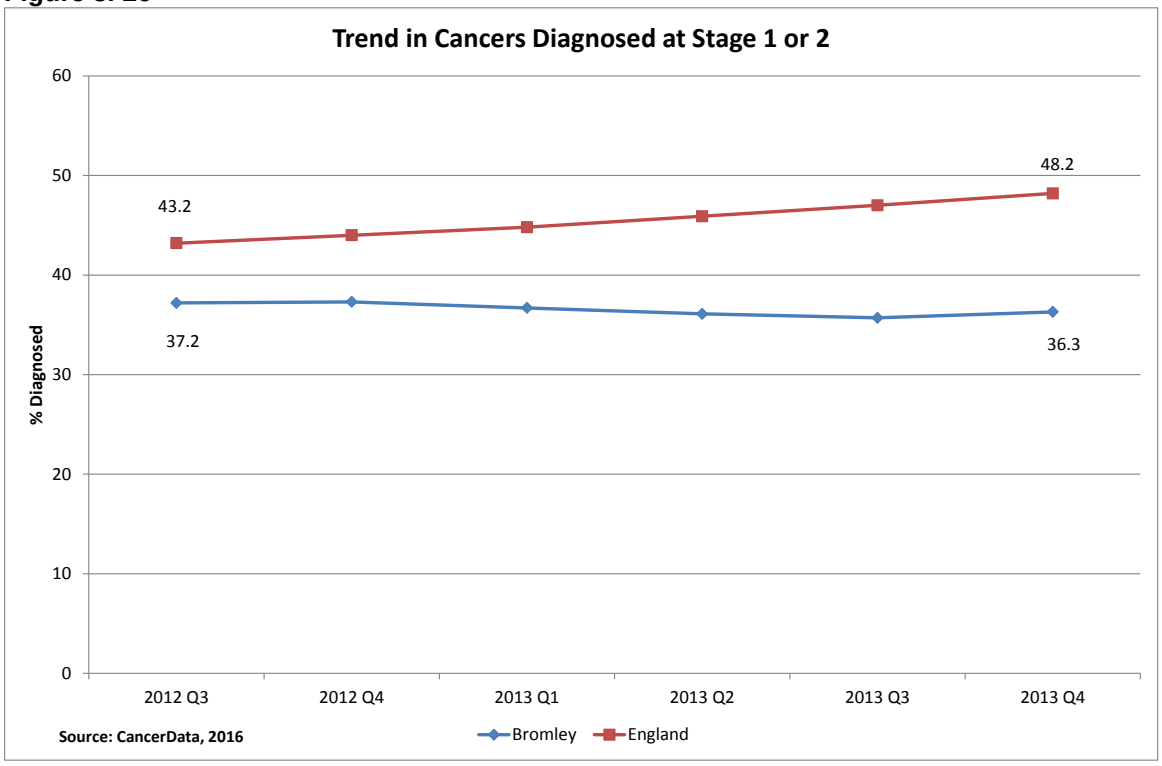
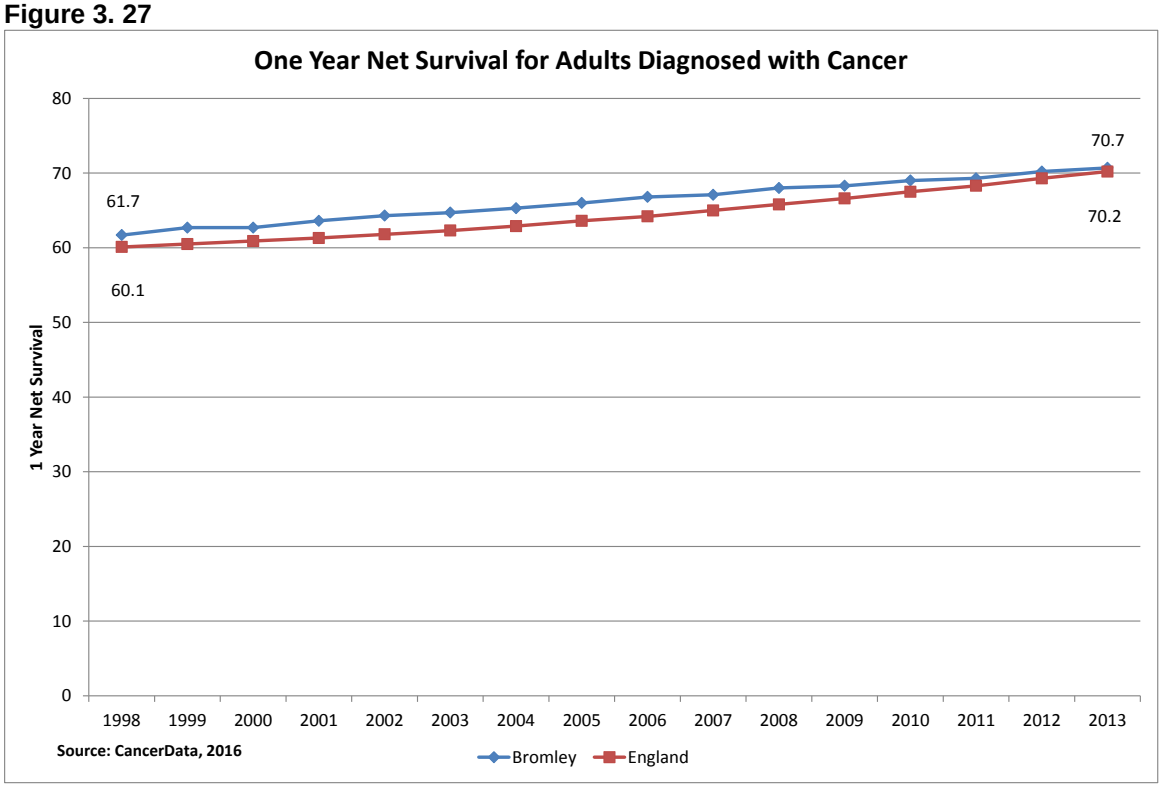


Figure 3. 27

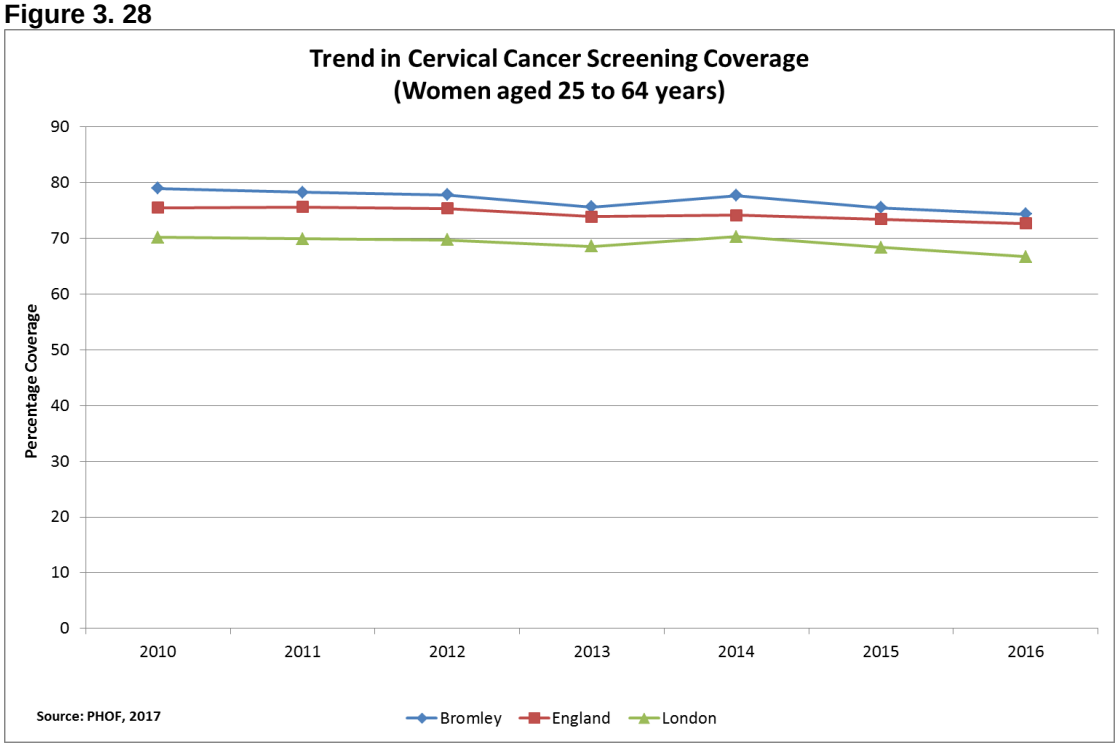


One year survival for cancers in adults has been above the England average since 1998. Five year survival figures are not available for Bromley, but have been increasing over the last 10 years for England as a whole.

Cancer Screening

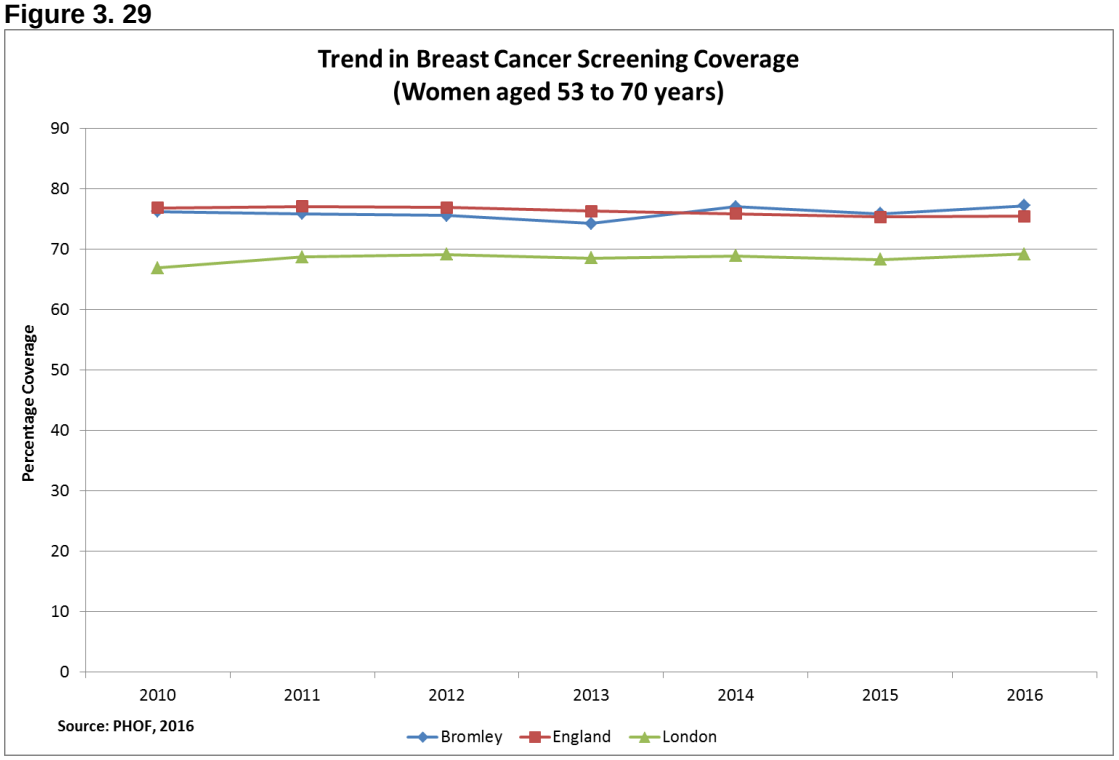
Cervical cancer screening uptake in women aged 25 to 64 years in Bromley has been consistently better than the London and national average over the last five years (**Figure 3. 28**). However, it is worth noting that the cervical cancer screening uptake in Bromley has fallen by about 5% in the last 6 years.

Figure 3. 28



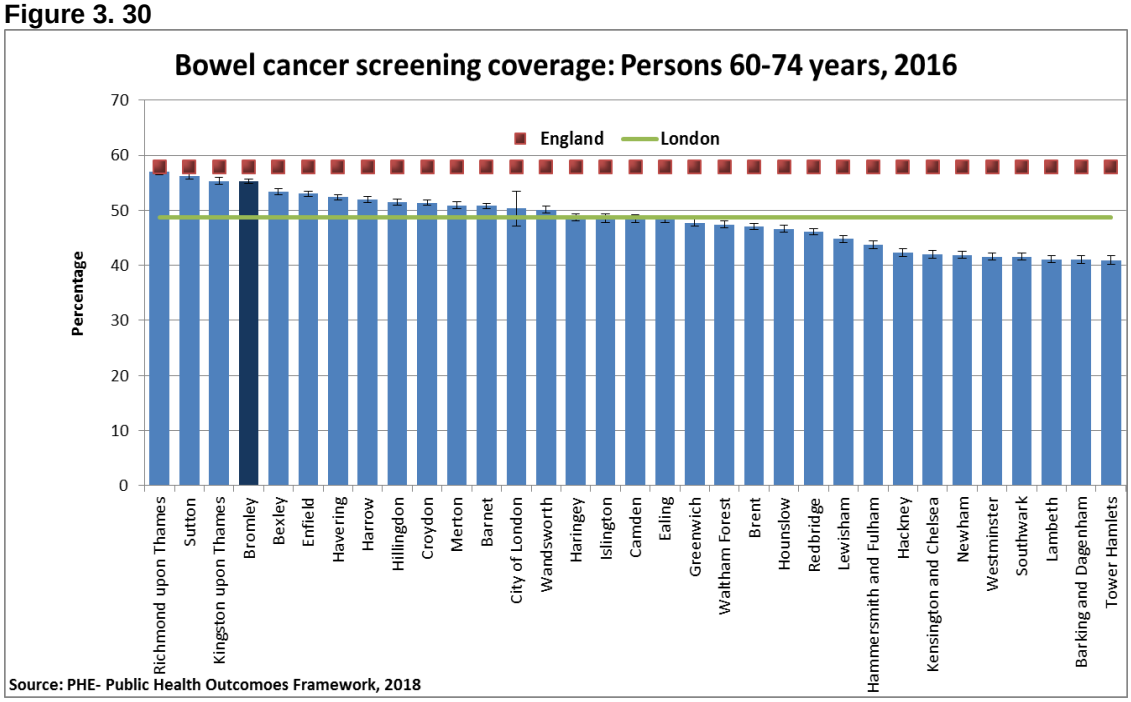
Breast cancer screening uptake in Bromley has improved. It has remained on par with the national average, and has consistently performed over 7% better than London (**Figure 3.29**).

Figure 3. 29



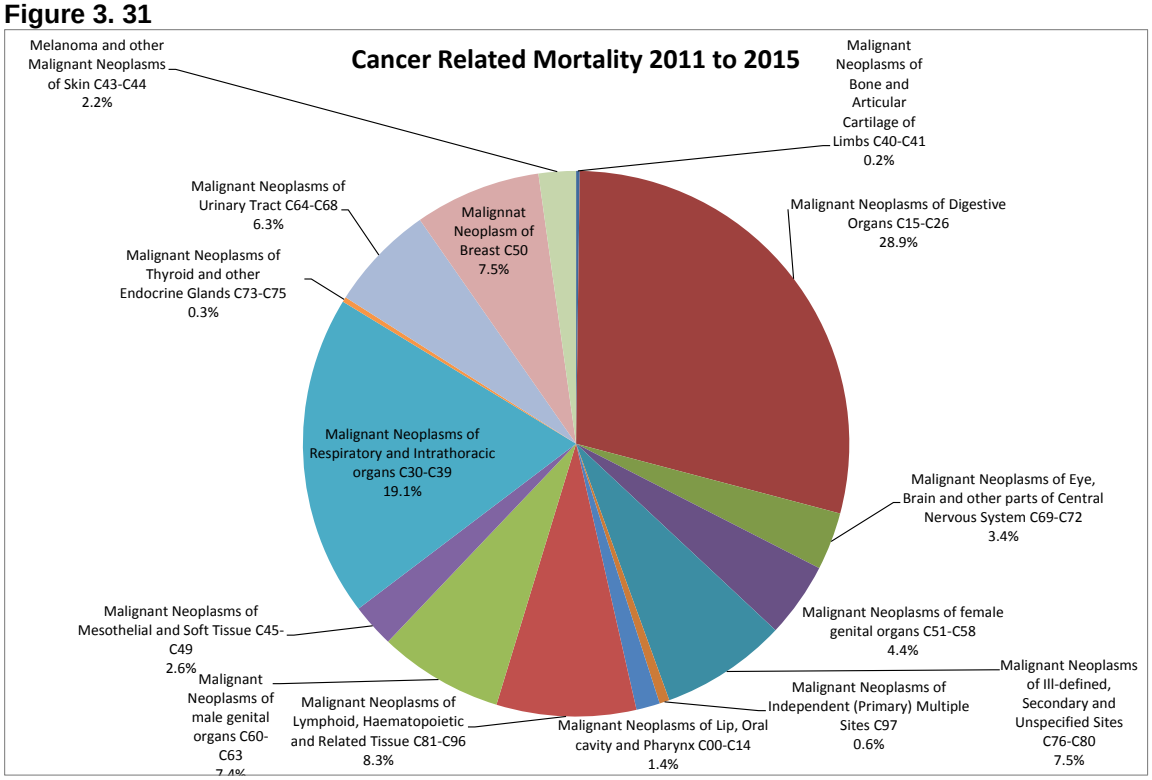
The percentage of people eligible for bowel cancer screening who were screened adequately is higher locally (55%) compared to the region (49%) but not nationally (58%). Bromley has the 4th highest coverage rates in the region. The difference seen in Bromley and many of the local authorities with the lowest rates is statistically significant. There is no trend data to ascertain if the rates are enduring.

Figure 3. 30



The highest proportion of deaths in Bromley (28.9%) is related to cancer of the digestive organs.

Figure 3. 31



Source: Primary Care Mortality Database, 2016

What this means for residents in Bromley:

Cancer remains one of the key causes of mortality in Bromley, and although survival rates have been improving, incidence of all cancers is rising, indicating the need for good prevention strategies.

A significant proportion of cancers are diagnosed only in the later stages, which will adversely impact survival rates.

Respiratory Disease

About 13.9% of deaths in Bromley are caused by respiratory disease. This includes influenza and COPD. The under 75 years mortality rate from respiratory disease is lower in Bromley (25.3 per 100,000) than for England (33.8 per 100,000)[ii].

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is mainly caused by smoking. According to the Annual Population Survey, 14% of the residents in Bromley aged 18 year and over are current smokers, lower than the England average (16%)[v]. However, smoking prevalence is higher in routine and manual workers in Bromley at 28%[ii].

There are 4636 people in Bromley diagnosed with COPD, giving a prevalence of 1.34%. The recorded prevalence of COPD in Bromley is lower than the value for England (1.9%).

Table 3. 9: COPD Prevalence

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
COPD Register Size	3342	3525	3747	4006	4143	4178	4232	4371	4455	4520	4590	4,636
COPD Prevalence	1.10%	1.10%	1.20%	1.20%	1.30%	1.30%	1.30%	1.30%	1.33%	1.34%	1.34%	1.34%
Source: NHS Digital/QOF 2016 *(* Unadjusted Prevalence)*												

Asthma

The prevalence of recorded asthma in Bromley is 5.1% (17,717 people), which is slightly lower than the value for England (6.0%).

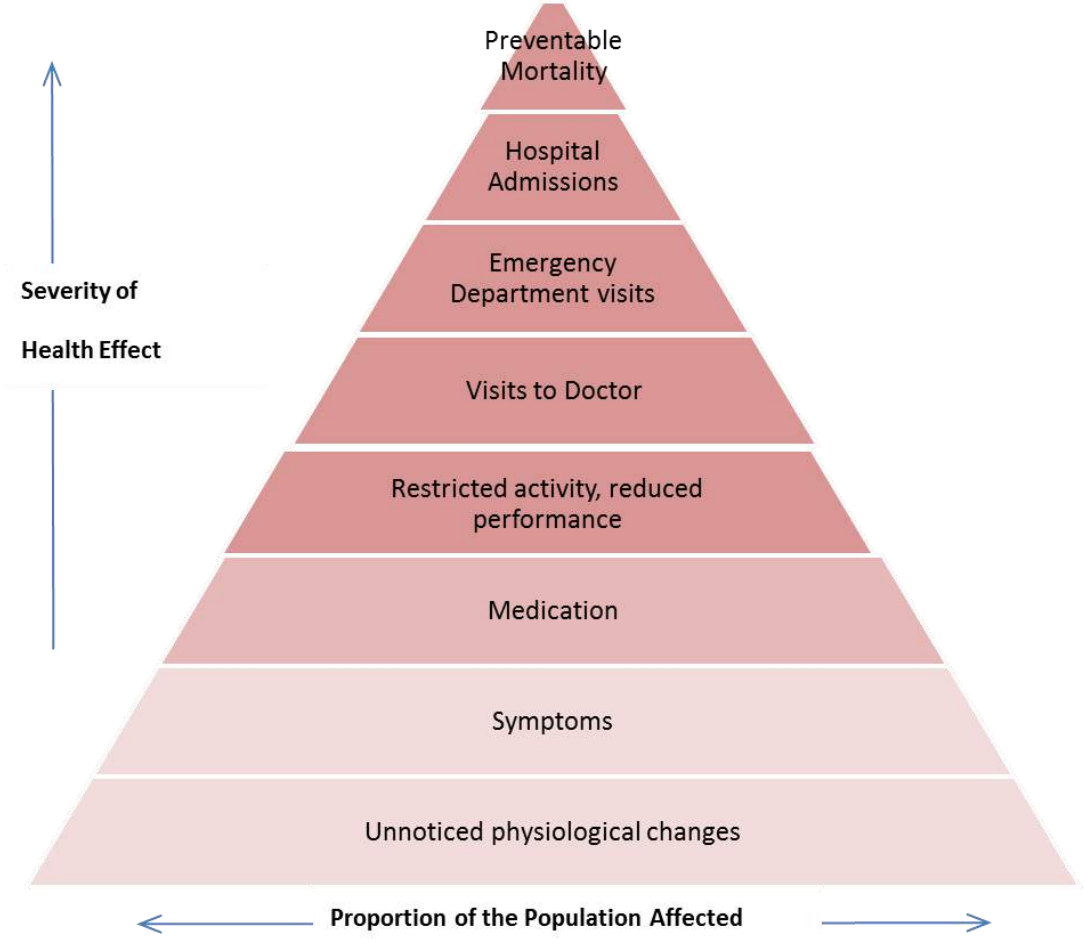
Air Quality

Air pollution refers to substances in the air that harm human health, welfare, plant or animal life. Most pollution in London is caused by road transport and domestic and commercial heating systems.

Air pollution affects everyone who lives and works in London. The most vulnerable groups are children, older people and those with heart and respiratory. People living in deprived areas are also more affected by poor air quality, partly because these areas are often near busy roads.

The long term impacts upon health of air pollution can be represented by a pyramid structure, as shown in **Figure 3.32** below. For the majority of the population, the effects of air pollution are not usually immediately obvious, although some individuals may notice symptoms such as irritation to eyes and throats when pollution levels are elevated. Smaller numbers of the population are more vulnerable to the effects of air pollution, as exposure to pollution can exacerbate existing health conditions including cardiovascular and respiratory disease. This can lead to restricted activity, hospital admissions and even premature mortality.

Figure 3. 32: Impact of Air Pollution on Health

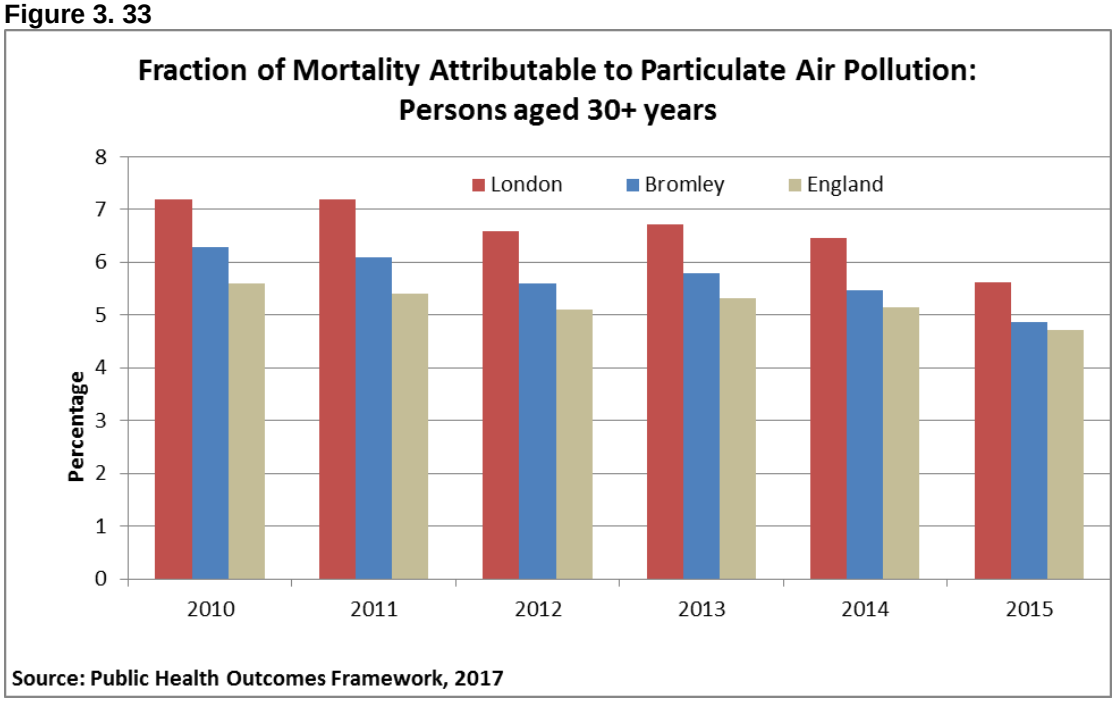


WHO, 2005

The Public Health Outcomes Framework includes a benchmark tool, which enables the comparison of the fraction (%) of mortality attributable to long term exposure to PM2.5 in each local authority in the UK. This can be compared to the UK average which is 5.6% of mortality attributable to long term exposure to PM2.5.

The figure for Bromley in 2015 was 4.9%, which is higher than the England average (4.7%) but lower than the London average (5.6%) and the best of all the London boroughs. There has been a year on year reduction in the fraction of mortality attributable to particulate air pollution since 2010 (**Figure 3.33**).

Figure 3. 33



Mental Illness

Mental health problems affect a large proportion of the population, with approximately 12% of people completing the GP patient survey reporting that they feel moderately severely or extremely anxious or depressed[vi].

GP recorded levels of depression are lower in Bromley compared with England at 8.5% (23,073 people) and 9.1% respectively.

Table 3. 10: Depression Prevalence

	2012/13	2013/14	2014/15	2015/16	2016/17
Depression Register Size	15645	16789	18140	20970	23,073
Depression Prevalence	6.00%	6.38%	6.85%	7.83%	8.50%
Source: NHS Digital/QOF 2017					

Of those people completing the GP patient survey in Bromley, 5% reported suffering from a long term mental problem, as compared with 6% across England[vi].

At the more severe end of the spectrum, over 2,500 people in Bromley (0.84% of the adult population) have been identified by GPs as suffering from serious mental illness. This is lower than the recorded rate for England of 0.92%.

Table 3. 11

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Severe Mental Illness Register Size	1667	2165	2265	2351	2389	2447	2544	2616	2667	2738	2808	2904
Severe Mental Ilness Prevalence	0.50%	0.70%	0.70%	0.70%	0.70%	0.80%	0.80%	0.80%	0.79%	0.81%	0.82%	0.84%
Source: NHS Digital/QOF 2017												

Dementia

The incidence of dementia has risen nationally over the last seven years.

In 2012, it was estimated that there were 4,102 people with dementia in Bromley; a relatively small population of these from black and minority ethnic groups.

By 2030 the number of people with dementia in Bromley is estimated to increase to 6047.

Table 3. 12: Predicted changes in the number of people living in Bromley with Dementia

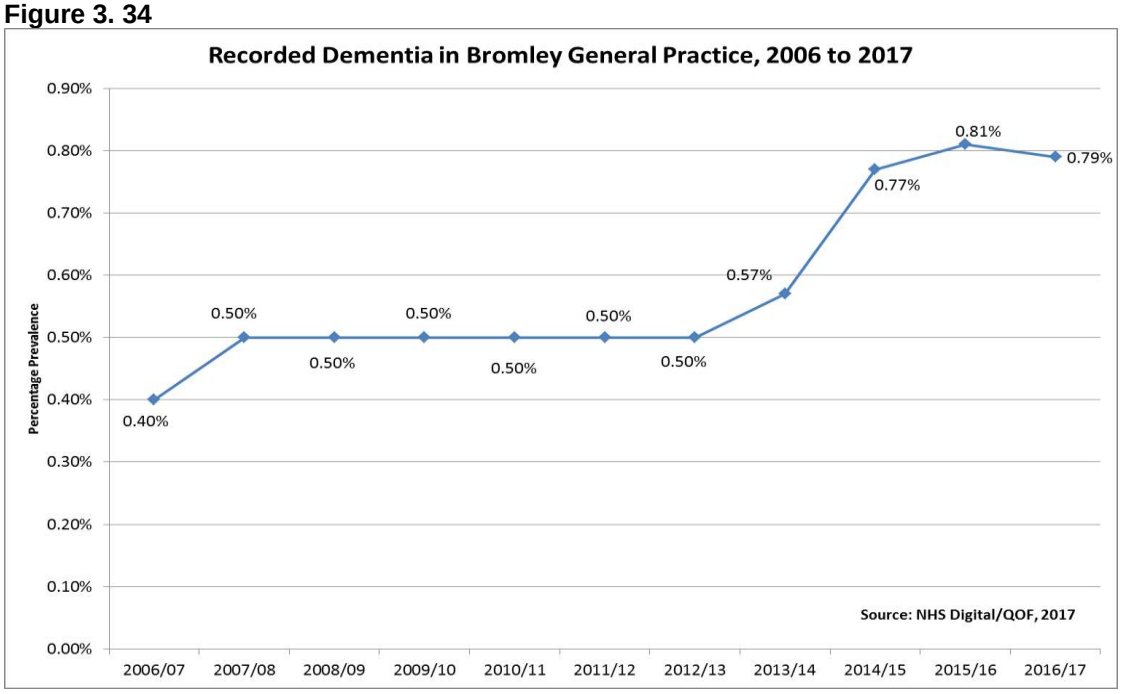
		2030	2020	2018	2017	2016
People aged 65-69 predicted to have dementia	↑	256	186	190	196	211
People aged 70-74 predicted to have dementia	↑	442	433	419	400	362
People aged 75-79 predicted to have dementia	↑	757	663	623	605	600
People aged 80-84 predicted to have dementia	↑	1,169	1,029	1,006	982	982
People aged 85-89 predicted to have dementia	↑	1,450	1,178	1,183	1,183	1,128
People aged 90 and over predicted to have dementia	↑	1,660	1,161	1,044	1,013	985
Total population aged 65 and over predicted to have dementia	↑	6,034	4,650	4,465	4,380	4,268
Source: Projecting Older People Population Information System, August 2016						

GP registers identify 2721 patients with dementia, suggesting that some cases are not known to clinical services. Recording has increased significantly over the last two years following case finding initiatives.

Table 3. 13: Dementia Prevalence (Quality Outcomes Framework(QOF))

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Dementia Register Size	1423	1452	1489	1499	1542	1690	1794	1902	2615	2755	2721
Dementia Prevalence	0.40%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.57%	0.77%	0.81%	0.79%
Source: NHS Digital/QOF 2017											

Figure 3. 34



What this means for residents in Bromley:

Mental health problems affect a large proportion of the population, with approximately 10.7% of people completing the GP patient survey reporting that they feel moderately or extremely anxious or depressed.

A needs assessment of the physical health of people with mental illness in Bromley is underway and due to be completed early in 2018. This will help to inform a local action plan to reduce premature mortality in people living with severe mental illness, identified as a priority in the new Bromley Mental Health Strategy.

A summary of the provisional findings from this needs assessment can be found in the Mental Health and Suicide section of this JSNA.

4. Aspects of Health Protection and Health Improvement

Health Protection

South London Health Protection Team (SLHPT) leads Public Health England's (PHE) response to all health related incidents in South London. The team provides specialist support to prevent and reduce the impact of; infectious diseases, chemical and radiation hazards and major emergencies. The team specifically investigates and manages health protection incidents and outbreaks of a wide range of infectious diseases.

SLHPT works closely with the Public Health and Environmental Health teams in the London Borough of Bromley, as well as other multidisciplinary colleagues. There is much collaborative proactive work to plan and reduce risks from infectious diseases and other hazards.

Summary of Notifiable Diseases Reported to SLHPT

A wide range of infections are notified to the health protection team. These include meningococcal disease, invasive Group A Streptococcal and pneumococcal disease and VTEC *E coli* infections, all of which can be serious and result in long term complications and poor outcomes.

Table 4.1 shows the number of suspected cases reported to SLHPT for Bromley residents in 2016 for a range of infectious diseases with trends in reporting from 2012.

Table 4. 1: Selection of reported cases of clinically suspected infectious disease for LB Bromley 2012-16 (confirmed, probable and possible cases; excludes cases testing negative for the infection)

Infectious disease	2012	2013	2014	2015	2016
Salmonella (species non-typhoid)	22	20	19	29	39
Cryptosporidium	21	8	11	19	27
Measles	18	34	26	19	30
Mumps	56	57	56	34	25
Scarlet Fever	24	23	148	233	228
Tuberculosis	37	32	18	25	15
Whooping cough	41	42	24	50	52
Total	243	238	330	428	447

Measles

The UK recently received WHO measles elimination status and so the overall risk of measles to the UK population is low. However, there are ongoing measles outbreaks in Europe and we continue to see cases in unimmunised individuals. People who have recently travelled to or who are planning to travel to Europe, who have not had 2 doses of MMR vaccine are particularly at risk. Limited onward spread of measles may occur in communities with low MMR coverage and in age groups with very close mixing[1]. For example, a rise in cases in 2012/13 occurred amongst those attending music festivals in the UK. Cases were concentrated in the cohort of young people who were babies during the time of the MMR vaccine "scare" and coverage dropped[2].

Table 4.2 shows laboratory confirmed and clinically suspected measles cases reported 2012 - 2016 in the LB Bromley.

Table 4. 2: Clinically suspected cases of measles reported in LB Bromley 2012-16

Year	Confirmed	Possible	Probable
2012	<5	15	<5
2013	11	19	<5
2014	<5	25	<5
2015	10	6	<5
2016	5	19	6

Confirmed = laboratory confirmed
Possible and probable = clinical diagnosed infection
Excluded discarded cases = tested negative.

PHE continue to encourage uptake of the measles, mumps and rubella (MMR) vaccine to ensure children and young people are protected.

Whooping Cough (Pertussis)

A national outbreak of pertussis was declared in April 2012. Reported incidence remained raised in 2016 compared to pre-2012 levels but overall, disease levels in 2016 did not reach those seen in 2012[vii].

Table 4.3 shows laboratory confirmed and clinically suspected pertussis cases

[1] *Public Health England travel advice.*
https://www.gov.uk/government/news/measles-outbreaks-in-europe-easter-travel-advice

[2] *Health Protection Report volume 11 (2017)*
https://www.gov.uk/government/publications/health-protection-report-volume-11-2017/hpr-volume-11-number-34-news-29-september

reported 2012 - 2016 in the LB Bromley.

Table 4. 3: Clinically suspected cases of whooping cough reported in LB Bromley 2012-16

Year	Confirmed	Probable	Possible
2012	20	11	10
2013	14	<5	24
2014	14	<5	8
2015	24	13	13
2016	26	18	8

Confirmed = laboratory confirmed
Possible and probable = clinical diagnosed infection
Excluded discarded cases = tested negative.

The prenatal pertussis vaccine programme aims to minimise disease, hospitalisation and deaths in young infants. Vaccine coverage in pregnant women reached 74% in mothers resident in LB Bromley in 2016, in line with that reached in England by December 2016 (at 76.2%).

Scarlet Fever

Scarlet fever is an infection caused by group A streptococci (GAS) bacteria. It occurs most often in winter and spring and symptoms include a rash, sore throat, flushed cheeks and swollen tongue. As reported last year, there have been three elevated seasons for scarlet fever, with activity peaking in 2015-16. Seasonal activity remains raised but has been lower in 2016-17 and rates have been lower in London compared to those seen in other regions of England.

Table 4.4 shows notifications of scarlet fever 2012 – 2016 in LB Bromley.

Table 4. 4: Notification of scarlet fever 2012-16 in LB Bromley

Year	Confirmed	Probable	Possible
2012	-	16	8
2013	-	<5	21
2014	-	83	65
2015	-	225	8
2016	<5	225	<5

Confirmed = laboratory confirmed
Possible and probable = clinical diagnosed infection
Excluded discarded cases = tested negative.

Vaccination is one of the most effective public health interventions in the world for saving lives and promoting good health. It offers safe and effective protection against many major infectious diseases.

An overview of the current NHS vaccination schedule is available here:

https://www.nhs.uk/conditions/vaccinations/pages/vaccination-schedule-age-checklist.aspx

The aim of any vaccination programme is to achieve "herd immunity". This refers to the process by which individuals who are not vaccinated or have not developed natural immunity, receive indirect protection from the disease. This occurs when a sufficiently high proportion of individuals in that population are immune or have been vaccinated which reduces the likelihood of the spread of disease. The level of vaccination required to achieve herd immunity varies by disease but the European Region of the World Health Organisation recommends that all European countries should aim for 95% coverage for all childhood vaccination programmes in order to maximise the likelihood of herd immunity being achieved in this population[viii].

Achieving the target level of coverage for many of the vaccination programmes in Bromley remains a challenge. Vaccination coverage in Bromley is one of the public health areas in which the borough performs less well compared to the rest of England and coverage rates for some vaccines are also poorer than the London average.

The table below highlights those vaccination programmes for which the level of coverage in Bromley is currently below target and significantly worse than the England average.

Table 4. 5: Vaccine coverage rates in Bromley for programmes not achieving target coverage 2015/16

Vaccine	National Coverage Target	% population coverage			Comparative Performance
		Bromley	London	England	
MMR* 2 doses at age 5 years	95%	84.1	81.7	88.2	Significantly worse than England
PPV	75%	62.9	64.3	69.8	Significantly worse than England and below London Average
Flu age 65+	75%	67.0	65.1	70.5	Significantly worse than England
Flu at risk individuals	55%	45.2	47.1	48.6	Significantly worse than England and below London Average
Flu age 2-4 years	65%	36.7	29.2	38.1	Significantly worse than England
Shingles* age 70+	60%	48.8	47.1	54.9	Significantly worse than England

* Data is for 2015/16, data for 2016/17 not yet available from this source

Source: PHE Public Health Outcomes Framework, Dec 2017

The latest data on vaccine coverage, for all programmes, for local areas is published quarterly and is available here:
https://www.gov.uk/government/collections/vaccine-uptake

A review of the annual performance of local areas, including regional and national comparisons and trend analysis, is available here:
https://fingertips.phe.org.uk/profile/health-protection

The reasons for poor vaccine uptake are complex. It can be influenced by factors relating to vaccine programme delivery such as; access, awareness and acceptability and factors relating to the characteristics of the target population such as; socioeconomic status, gender, ethnic group and religious belief[ix].

Tuberculosis

The rate of TB remains low across the borough at 6.7 per 100,000 in 2016 and has remained stable in recent years. This is much lower than the 25 per 100,000 for London and below the England average of 10.5 per 100,000. Of those notified in 2014, 100% of patients completed treatment by 12 months[x].

What this means for residents in Bromley:

Further work is needed to encourage the uptake of childhood immunisations as vaccination rates for several categories, such as MMR, MenC, PCV and HPV, remain below the national recommendation of 95% coverage.

There remains a potential for measles and mumps outbreaks, particularly in older children and young adults due to poor immunisation uptake, as seen in the spike in the rate of confirmed measles cases across South London in 2016.

While the reported incidence of pertussis in Bromley remains raised; it is imperative that the efforts to increase the pertussis immunisation rates, particularly for the maternal pertussis vaccination, are continued.

Uptake of the seasonal flu vaccination in all eligible groups in Bromley is significantly lower than that of England, and a large proportion of at risk individuals remain vulnerable to the serious health effects of flu.

Coverage rates for the Shingles vaccination for older people also remains significantly below the England average with substantial room for improvement.

Health Improvement - NHS Health Checks

Overview of the NHS Health Checks Programme

The NHS Health Checks Programme is a national public health programme aimed at preventing heart disease, stroke, diabetes, chronic kidney disease and vascular dementia.

The NHS Health Check involves an assessment of an individual's level of risk of developing cardiovascular disease. Participants receive personalised advice on how to manage and reduce that risk. Depending on the findings some people may need further investigations and follow up to reduce their risk of developing some of the most disabling, but preventable illnesses.

Individuals aged between 40 and 74 years, without established cardiovascular disease, are eligible to receive an NHS Health Check. This programme runs over a rolling five year period, so 20% of the eligible population should be invited each year.

For 2016-17 the eligible population in Bromley was 95,190 people. The population eligible for an NHS Health Check continuously changes as people age, or develop conditions which exclude them, or move in or out of the borough. Therefore it is important to assess the invitations, uptake and checks received, cumulatively. This is reflected in the Public Health Outcome Framework (PHOF) measures which assess progress since April 2013. The Public Health Outcome Framework Indicators comparing Bromley performance against England and London is shown in **Table 4.6.**

Table 4. 6: NHS Health Checks PHOF indicators 2013-14 – 2016-17

2.22	Take up of NHS Health Check by those eligible	Time period	Bromley	London	England
2.22iii	Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	2013/14 - 2016/17	85.7	85.0	74.1
2.22iv	Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14 - 2016/17	39.8	48.1	48.9
2.22v	Cumulative percentage of the eligible population aged 40-74 who received an NHS Health Check	2013/14 - 2016/17	34.1	40.9	36.2

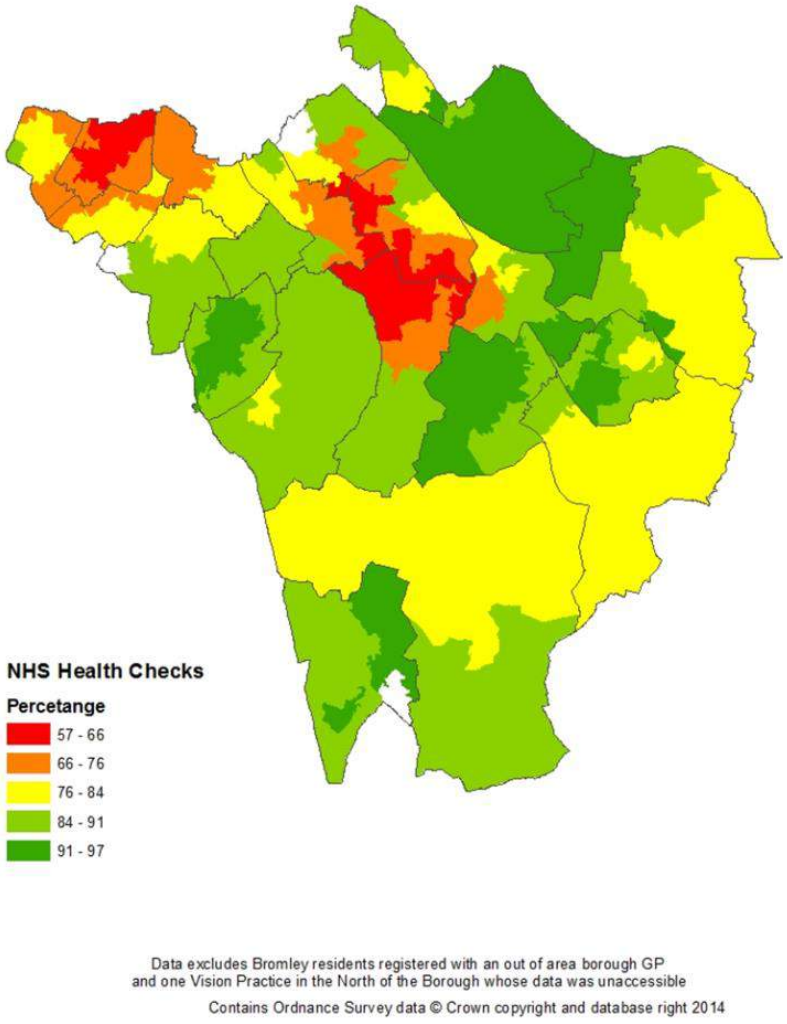
Source: Public Health Outcomes Framework. http://www.phoutcomes.info/

When examining the cumulative coverage of the programme from April 2013, Bromley has a higher percentage of offers than the regional and national average but the uptake against offers is lower than the London and England averages.

Geographical analysis of NHS Healthcheck data on Bromley highlights variation in

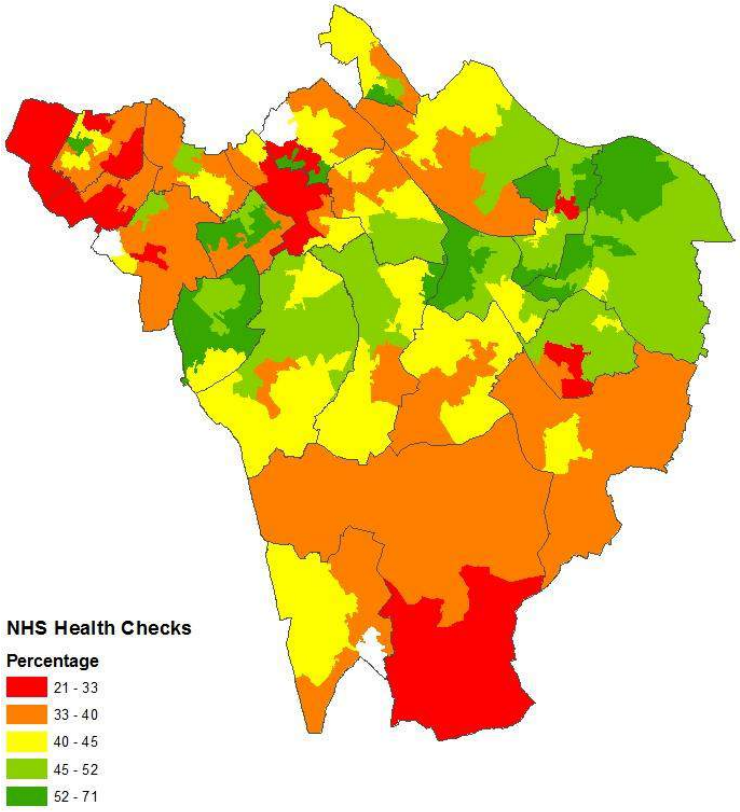
the offer and uptake of healthchecks across the borough and enables the identification of areas requiring specific targeting to improve uptake. Coverage of the eligible population offered an NHS Health Check since April 2011 is shown in **Map 4.1** by Lower Super Output Area (LSOA).

Map 4. 1: Percentage of eligible population at March 2017 who have been OFFERED an NHS Health Check in the previous 6 years



Source: Bromley NHS Health Check Programme, 2017

Map 4. 2: Percentage of eligible population at March 2017 who have RECEIVED an NHS Health Check in the previous 6 years



Source: Bromley NHS Health Check Programme, 2017

Map 4.1 and **4.2** show that coverage of NHS Health Checks across the borough remains variable. The proportion of eligible people offered a health check appears lower in the north of the borough and in central Bromley but invitation rates are relatively good elsewhere in the borough (**Map 4.1**).

Patterns of healthcheck uptake are more variable (**Map 4.2**) with poor rates of uptake more widespread across the borough. It is of note that some of the areas which demonstrate good invitation coverage rates, such as parts of Orpington and Darwin, have relatively poor uptake rates suggesting that there may be an issue with access to the NHS Healthcheck service in these areas.

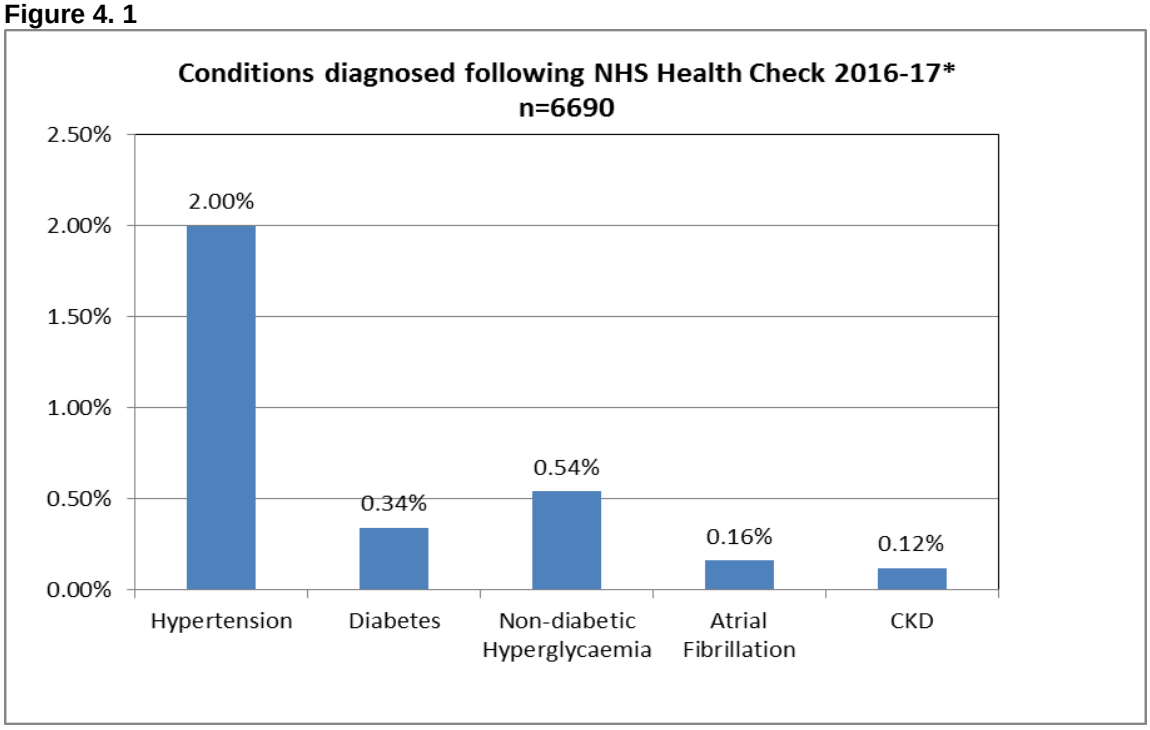
It should be noted that this data is aggregated over 5 years and performance in some areas may have improved considerably but be masked by previous poor performance.

The NHS Health Check includes a cardiovascular risk assessment tool (Qrisk2) which is used to assess whether an individual is at low, moderate or high risk of developing cardiovascular disease (CVD) in the next 10 years. In 2016-17, 310

(4.6%) individuals were found to have a high cardiovascular risk score. An additional 1,132 (17%) people were assessed as having a moderate 10 year cardiovascular risk score. These 1,442 (21%), individuals should be offered interventions including statin therapy and support with lifestyle behavioural changes, to reduce their risk of developing cardiovascular disease.

The NHS Health Check also identifies individuals eligible for further screening for hypertension (high blood pressure), diabetes, non-diabetic hyperglycaemia (raised blood glucose but not diabetic), chronic kidney disease (CKD) and atrial fibrillation (AF). Early diagnosis of these conditions is beneficial in reducing progression to more severe cardiovascular disease such as heart attacks, stroke and vascular dementia. A number of individuals were diagnosed with conditions for which they can now receive treatment to try to reduce cardiovascular risk and prevent disease progression. These levels are shown in **Figure 4.1**.

Figure 4. 1



Source: Bromley GP Practice data 2017

*These figures are likely to be an underestimation as there can be a time delay between having an NHS Health Check and making the linked diagnoses as these require further investigation.

At the time of the NHS Health Check, 1,203 (18%) of participants had a raised blood pressure, although not all would be expected to have a diagnosis of hypertension. All those with a high blood pressure should have received a blood test to assess kidney function to identify those with undiagnosed Chronic Kidney Disease (CKD).

The NHS Health Checks programme uses a diabetes filter to identify which patients require a blood test for diabetes risk; the criteria for this includes people with high blood pressure or a body mass index in the obese category. In 2016/17 the assessment of diabetes risk found 243 (3.6%) individuals with an HbA1c blood test in the pre-diabetic range and a further 23 people with undiagnosed diabetes.

The NHS Health Check includes a pulse rhythm check. 108 people were found to have an irregular pulse at their NHS Health Check and required a further test to assess if they had atrial fibrillation, a heart rhythm disorder. Following this 11 people were diagnosed with atrial fibrillation as a result of their NHS Health Check. These individuals are at high risk of stroke and are offered medication which significantly reduces the likelihood of stroke occurring.

All individuals identified with established disease or risk factors should have follow up investigation and assessment, and where appropriate offered interventions to reduce their risk of progression to more serious cardiovascular disease. Improving the outcomes of NHS Healthchecks in the prevention and early identification of risk and diagnosis of high risk conditions is supported by the Public Health England and NHS England Rightcare pathway for CVD prevention. (https://www.england.nhs.uk/rightcare/products/pathways/cvd-pathway/)

What this means for residents in Bromley:

As a result of NHS Health Checks in Bromley in 2016/17*:

- 23 people were diagnosed with diabetes
- 134 people were diagnosed with hypertension
- 11 people were diagnosed with atrial fibrillation
- 8 people were diagnosed with Chronic Kidney Disease

**Measured at 31.3.17. therefore likely to be an underestimation as some people at risk will be still undergoing investigation and may be diagnosed after this date*

A considerable number of people were identified as having risk factors for developing these diseases:

- 1442 people were found to have a moderate or high cardiovascular risk score
- 1203 people had raised blood pressure
- 243 people had pre-diabetes
- 108 were found to have an irregular pulse

There is a continued need to improve the uptake of NHS Health Checks across most areas in the borough particularly the north and central Bromley.

An additional provider has been commissioned to target areas of lower uptake to ensure that variation in uptake does not widen health inequalities across the borough.

In Bromley work to improve the pathways for patients identified at risk of atrial fibrillation, hypertension and diabetes have been prioritised for review to ensure that the opportunities to prevent the onset or progression of disease identified via the NHS Health Check are maximised.

5. Adult Mental Health and Suicide

Introduction

Improvements to mental health and wellbeing are associated with a wide range of better outcomes for people of all ages and backgrounds. These include; improved physical health and life expectancy, better educational achievement, reduced health risk and behaviours, such as smoking and alcohol misuse, improved employment rates and productivity and higher levels of social interaction and participation. Conversely, mental health problems can have a negative impact on all aspects of life and lead to; poverty, discrimination, relationship breakdown and addiction which in turn can contribute to a cycle of deteriorating physical and mental health[xi]. People with severe and prolonged mental illness die on average 10 to 20 years earlier than other people[xii], largely as a result of poorer physical health and greater rates of long term conditions.

Mental Health problems are also calculated to be the largest single source of disability in the United Kingdom, with an estimate that they account for 23 per cent of the total 'burden of disease'[xiii] but only 11 per cent of spending on secondary health care[xiv]. Mental health problems are likely to occur alongside other chronic diseases (co-morbidities). The Kings Fund review of research in this area shows that people with long-term health conditions are two to three times more likely to experience mental health problems than the general population[xv]. However, mental health care is also often treated separately from other health interventions, in contrast to a whole person care approach which addresses mental health, physical health and social needs together[xvi].

This chapter describes what we know about mental health in Bromley, focussing on rates of severe mental illness (SMI) and common mental health (CMH) conditions, and examining the physical health and lifestyle patterns of these groups compared to the average Bromley population. This will help identify what is contributing to the gap in life expectancy between people with SMI and the general population in Bromley and assist service commissioners and providers in identifying the most effective action they can take to narrow this gap. This issue will be considered in a more in-depth mental health needs assessment for Bromley to be published in 2018. The final section of this chapter reviews the findings from a recent in-depth analysis of the trends in rates of suicide and self-harm in Bromley.

The Social Determinants of Mental Health and Mental Illness

The social determinants of health refer to the conditions in which people live, such as housing and employment, and the role they play in influencing health outcomes. For example, evidence suggests that poverty and unemployment often increase the duration of a Common Mental Health Disorder episode[xvii]. Understanding the social determinants of health can also help to understand why certain health conditions are more common in certain population groups than others. For example, the prevalence of severe mental illness and depression is higher in the more deprived areas of the Borough. This may be a consequence of the illness as well as a causative factor. The Healthwatch report *Exploring mental health in the London borough of Bromley*[xviii] identified a range of factors, through questionnaires and focus groups, which people in the area felt contributed to mental illness. These include; employment status, education, housing conditions (specifically overcrowding), levels of social care, lone parenthood and lack of awareness of mental support services on offer. These factors can often bear a relationship to someone's socio economic status.

Public Health England uses indicators, such as those identified in the Healthwatch report, to create a mental health risk profile of a local area[xix]. Bromley overall, has a more favourable mental health risk profile when looking at these indicators compared to the England average. For example, its index of multiple deprivation score, calculated by using data from a number of domains including employment, income, housing, living environment and crime, is 15.2 which is lower than England's average of 21.8 (a lower score showing less overall deprivation). This pattern is the same for all the other risk indicators provided, including child poverty, older people living in poverty and the percentage of the population with a long-term health problem or disability. However, the number of people experiencing these risk factors in Bromley is still significant. For example, using 2011 Census data 15% of Bromley's population has a long-term health problem or disability which represents 46,323 people living in the borough.

What this means for residents in Bromley:

In order to address the difference in life expectancy between people with mental health conditions and the general population, it is important to look at how healthcare services can support physical health alongside mental health needs.

It is also important to understand how the population of Bromley experience the social factors that contribute to poorer mental health. This can provide intelligence on where and how best to target services and develop understanding as to how other areas of the local authority can play a role in protecting and promoting mental health and wellbeing.

A detailed assessment of the Physical Health Needs of people with Severe Mental Illness in Bromley will seek to answer many of these questions. This report is due in Spring 2018.

Severe Mental Illness amongst Adults in Bromley

Severe mental illness (SMI) refers to a mental disorder that is persistent, can impair day to day functioning and may require high levels of care. The International Classification of Diseases includes the following under the term SMI[xx]:

- schizophrenic and delusional disorders
- mood (affective) disorders, including depressive, manic and bipolar forms
- neuroses
- behavioural disorders
- personality disorders

The QOF severe mental illness register for 2016/17 records the prevalence of Severe Mental Illness in adults 18 years plus in each CCG. In Bromley CCG the prevalence of SMI in its registered population is 0.84%. This is slightly lower than the England average of 0.9%[xxi]. **Figure 5.1** shows a similar pattern for Bromley, London and England in terms of a steady increasing prevalence of SMI since 2006, though London's prevalence is higher than that for England and Bromley.

Figure 5. 1

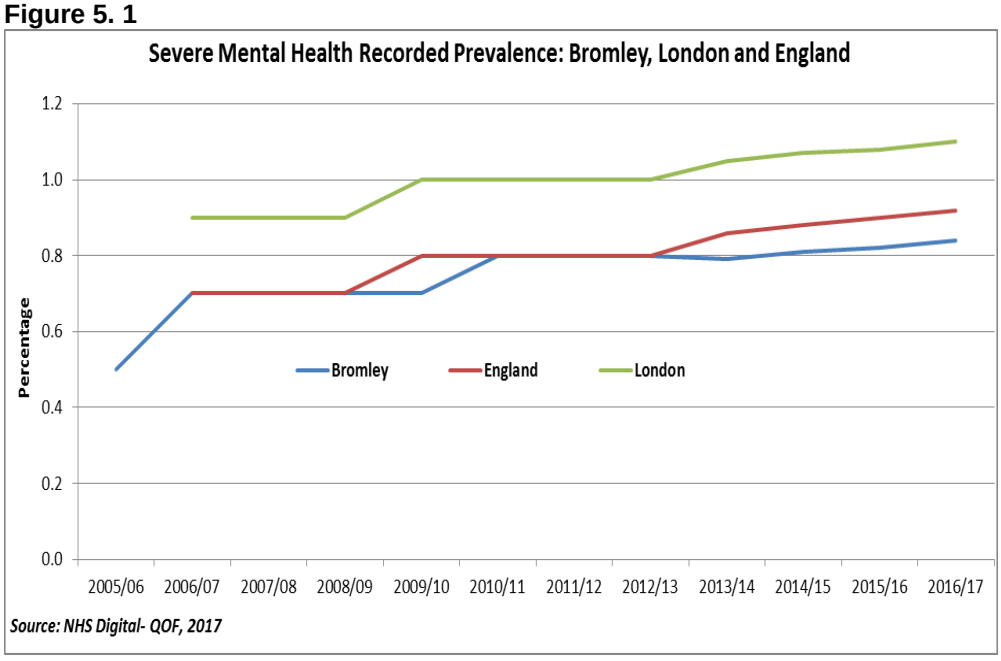


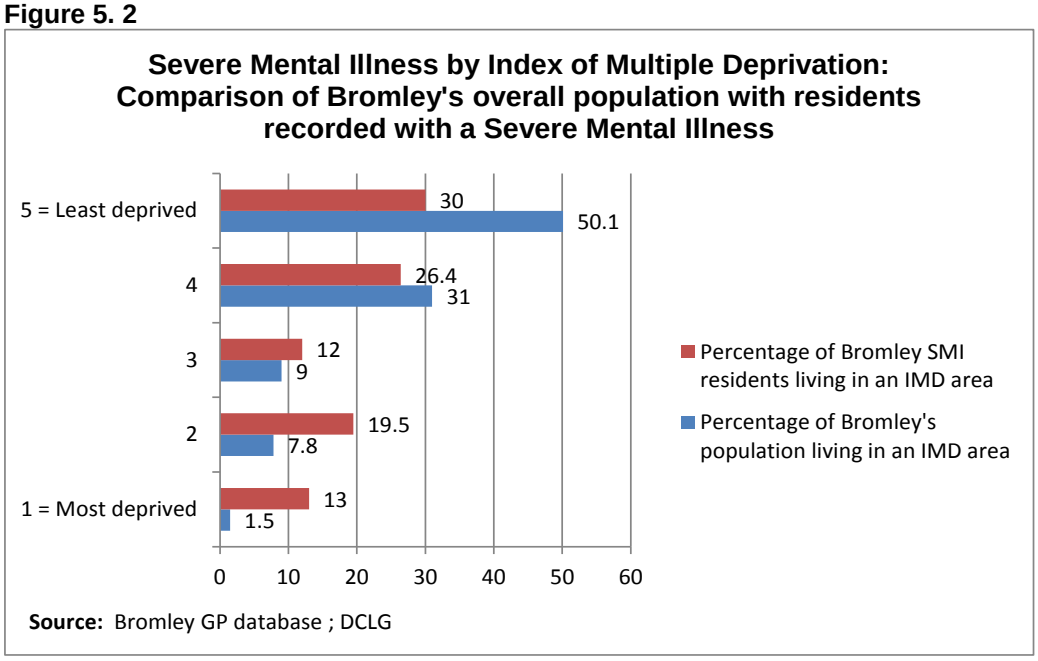
Table 5. 1: Changes in the Severe Mental Illness register size and prevalence in Bromley: 2005/06 to 2016/17

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Severe Mental Illness Register Size	1667	2165	2265	2351	2389	2447	2544	2616	2667	2738	2808	2904
Severe Mental Illness Prevalence	0.50%	0.70%	0.70%	0.70%	0.70%	0.80%	0.80%	0.80%	0.79%	0.81%	0.82%	0.84%
Source: NHS Digital/QOF 2017												

Analysis of Primary Care records in Bromley in 2016 found that there were 2,598 adults with a diagnosed severe mental illness registered with GPs in Bromley. This represents around 1% of the GP registered adult population. This is higher than the QOF prevalence data, which may be explained by primary care records also including patients in remission from a severe mental illness.

Adults diagnosed with severe mental illness are not evenly distributed across the borough. This can be observed when comparing levels of SMI and deprivation based on patients' area of residence. **Figure 5.2** presents the percentage of patients with SMI by IMD quintile (1 is most deprived and 5 the least deprived) compared to the spread of Bromley's overall population. Adults with an SMI are over-represented in the most deprived areas. 13% of people with an SMI in Bromley live in the most deprived areas of the borough whereas only 1.5% of the total population of Bromley live in these areas. Conversely, whilst over 50% of people diagnosed with SMI live in the two most affluent areas of Bromley, this is lower than the proportion of the total Bromley population living in those areas which is just over 80%, suggesting that the proportion of adults with a severe mental illness is actually lower than expected in these areas.

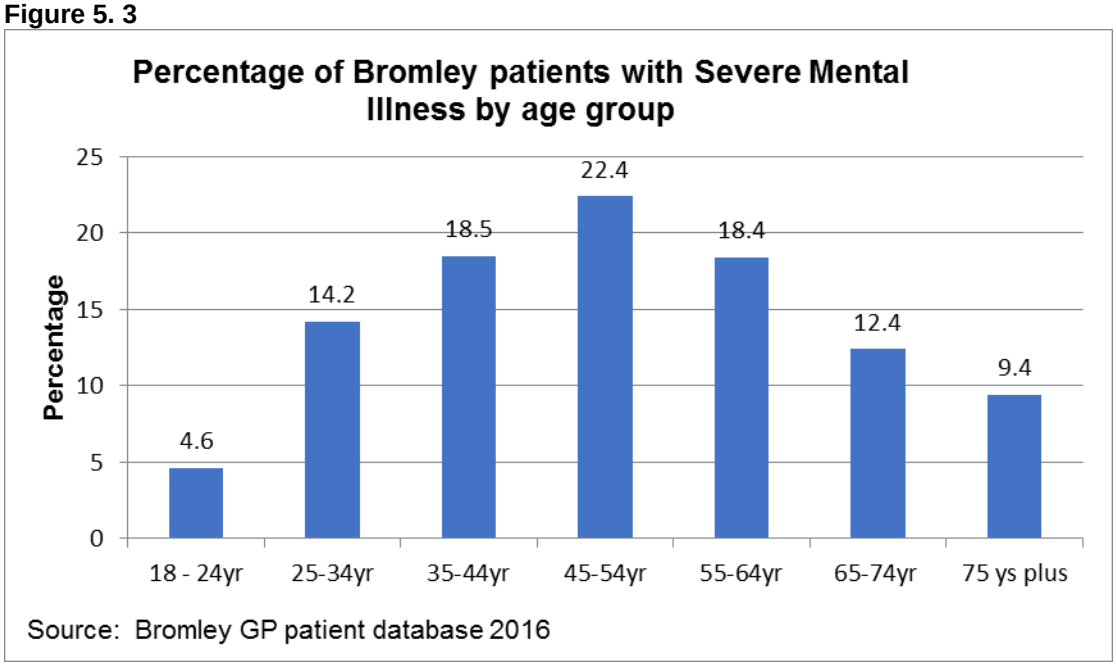
Figure 5. 2



SMI by age

The highest proportion of Bromley patients with diagnosed Severe Mental Illness are between 45 and 54 years old (22.4%) (see **Figure 5.3**). The majority, (60%), of adults with an SMI in Bromley are between 35 and 64 years of age.

Figure 5. 3



Severe mental illness by type

Analysis of the type of SMI experienced by adults in Bromley is presented in **Table 5.2**, with its findings summarised below:

- Schizophrenia is the most common form of severe mental illness in Bromley, closely followed by all psychosis (accounting for 31% and 29% of all SMI respectively).
- More men than women are affected by schizophrenia, but women have a higher recording for the other three classified disorders. As a point of comparison, GLA (Greater London Authority) population estimates for 2015 calculate that 48% of Bromley's population are men and 52% women[xxii]. Psychosis is the only SMI that closely follows this population split, with 49% men and 51% women diagnosed.
- Black and ethnic minority (BME) groups[3] are over represented in terms of schizophrenia, psychosis and severe depression compared to Bromley's overall BME population (estimated at 19%[xxiii]).

20% of people diagnosed with SMI in Bromley are from a BME group, compared to BME estimates in the local population of 19%xxiii. The broad umbrella category of 'BME' makes it challenging to identify any specific ethnic groups which may be over represented in these statistics. In general, people from ethnic minority groups are more likely to be diagnosed with poor mental health and admitted to hospital.

[3] The Black and ethnic minority category was identified as any different ethnic group to 'White British' or 'White'. Fifty-nine patient records had a blank field for ethnic group, so the numbers below may reflect an underestimate.

The reasons for this are complex and may reflect higher rates of poverty amongst these communities and challenges in accessing culturally appropriate treatment[xxiv]. Recent analysis published in the Lancet did not show evidence that excess mortality from SMI was higher in any one ethnic group than another[xxv].

Table 5. 2: Severe mental illness by type:

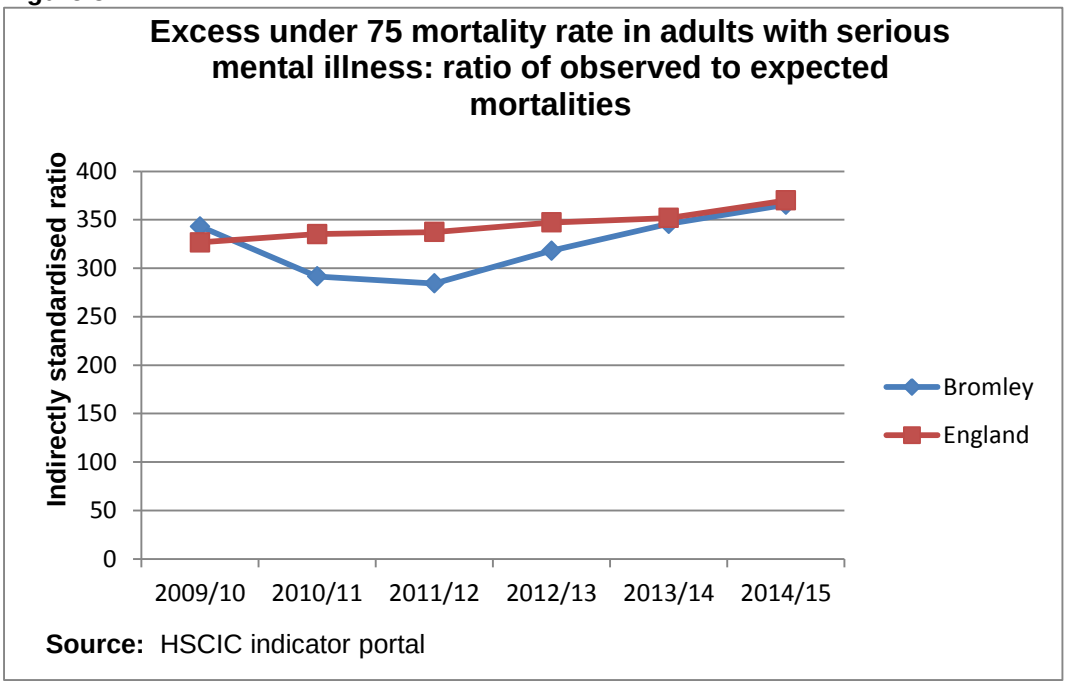
	Number of adults aged 18 years plus			
Mental health diagnosis	Total count	Men	Women	BME
Schizophrenia	797 (31%)	463 (58%)	334 (42%)	194 (24%)
All psychosis	742 (29%)	367 (49%)	375 (51%)	133 (18%)
All bipolar disorder	635 (25%)	251 (40%)	384 (60%)	96 (15%)
Severe depression	96 (3.7%)	35 (36%)	61 (64%)	37 (39%)
Other	328 (12.2%)	-	-	-
Total	2,598	1,116 (49%)	1,154 (51%)	460 (20%)

Source: Bromley GP Primary Care Database, 2016

Severe Mental Illness: Life expectancy

Deaths under the age of 75 are considered premature. Comparing the rates of premature deaths in those with SMI to those without SMI provides a measure of the extent adults with a severe mental illness die younger than adults in the general population. The excess under 75 mortality rate for adults with SMI in Bromley is 366, meaning that those with an SMI in Bromley have a 366% increased risk of death under the age of 75 years than those without an SMI in the borough. This is higher than the average rate for London (327) but lower than the national rate of 370. **Figure 5.4** shows the trends in excess under 75 mortality for people with SMI in Bromley compared to England over the last 6 years. Looking both nationally and locally there has been an overall upward trend in excess premature mortality for people with SMI over the last 3 years. The relatively small numbers of people with SMI in Bromley in comparison with the total number in England may account for the fluctuation in rates seen at a local level compared to nationally.

Figure 5. 4



Source: HSCIC indicator portal

What contributes to this gap in life expectancy will be considered below.

Severe mental illness: Physical health needs

Severe mental illness is linked to physical health conditions, such as heart disease and obesity. In addition, having a chronic physical condition is associated with having a lower level of mental wellbeing. This pattern is the same for men and women[xvii].

Table 5.3 below shows the prevalence of physical illness alongside a diagnosis of severe mental illness or co-morbidity (as noted in the Bromley Primary Care data set 2016). There is also a comparison with the level of disease recorded across the overall Bromley CCG population using QOF data for 2015-16[4]. The list sizes between the two datasets do vary, which can account for differences in the number of cases of illness. Yet despite this, a strong difference is observed in the majority of these disease categories in terms of the higher number of cases (prevalence) recorded for patients with an SMI.

[4] To note, this analysis took place before 2016/2017 QOF data became available.

Table 5. 3: People with Severe Mental Illness in Bromley with a recorded physical health condition compared to overall borough prevalence: QOF 2015/16

Physical health condition	Number	Condition prevalence for people recorded with SMI	Recorded disease prevalence, Bromley CCG
Hypertension (blood pressure)	519	20%	13.6% (46,526)
Chronic Obstructive Pulmonary Disorder	163	6.3%	1.3% (4,420)
Diabetes	141	5.4%	**5.4% (14,493)
Chronic Kidney disease	139	5.4%	*3.6% (9,560)
Coronary heart disease	109	4.2%	2.9% (9,846)
Cancer	91	3.5%	2.5% (8,455)
Epilepsy	96	3.7%	*0.62% (1,672)

Source: Bromley Primary Care database, 2016

Key

*List size 18 years plus

** List size 17 years plus

The lifestyle behaviours of both groups (those with SMI and the general population) were also compared. As a means to improve the physical health of people with SMI, NICE recommends monitoring weight and cardiovascular indicators of this population group such as blood pressure and cholesterol, as well as offering lifestyle change management programmes[xxvi]. This means that there is relatively recent and comprehensive recording of data in the Bromley Primary Care database with which to analyse how measurements such as obesity and lifestyle behaviours such as smoking and drinking compare between the population with SMI and the general population average. The following can be summarised from the findings:

- The Public Health Outcomes Framework 2016 estimated that 63.8% of Bromley's population are either overweight or obese[xxvii]. According to Bromley

Primary Care records, 72.5% of patients categorised with Severe Mental Illness are overweight or obese (measured as having a BMI of over 25kg/m^2).

- Around 37% of people with an SMI in Bromley are current smokers. This is over double the estimated smoking rate in the general population in Bromley which is 14.2%.

What this means for residents in Bromley:

Most people diagnosed with Severe Mental Illness in the borough are middle aged and live in the most deprived areas of the borough.

More women are recorded as having an SMI than men and there is a higher proportion of cases recorded amongst people from a black and minority ethnic group than the overall population estimate for the borough.

Bromley sees an excess in its under 75 mortality rate in adults with serious mental illness and this rate is higher than the London average.

People in Bromley with severe mental illness have higher rates of obesity and smoking than the general population and higher levels of chronic ill health, particularly heart and respiratory disease.

Improving the physical health of people with an SMI therefore is a logical step to reduce differences in life expectancy between this group and the general population.

Common Mental Health Disorders

A common mental disorder (CMD) describes types of depression and anxiety. These disorders can disrupt the ability to carry out daily activities but differ from severe mental illness in usually not affecting insight or cognition. Their high prevalence in the population (with a recent study estimating that depression affects more than 4 in 10 people[xxviii]) results in a high cost to society if the condition is untreated. For example:

- a loss in workplace productivity
- a breakdown in personal relationships
- Uptake of risky lifestyle behaviours such as high consumption of alcohol and/ or drug taking.

Common mental health disorders can be difficult to quantify as people do not always seek treatment when they experience an episode of mental ill health. **Box 5.1** defines the different ways depression is classified in addition to the different theories in terms of the causes of this illness.

Box 5.1

What is depression?

Depression is generally classified at three levels, according to the extent it impacts on daily activities:

- Mild depression describes some impact on daily life
- Moderate depression describes significant impact on daily life
- Severe depression can make carrying out daily activities almost impossible. A small proportion of people with severe depression may have psychotic symptoms.

Causes of depression can include an adverse life event, such as unemployment or divorce (referred to as reactive depression). Depression is also accompanied by physical changes, for example a change in levels of chemicals in the brain. This can be influenced through hormone change, such as depression associated with pregnancy or childbirth. Family history also plays a part, with a family history of depression increasing its likelihood. Studies are also investigating different versions of a gene (5-HTT) and its links to depression.

Prevalence of Common Mental Health Disorders in Bromley

There are various sources of prevalence measures for common mental health disorders in Bromley.

For example, NHS England estimates the prevalence of common mental health disorders amongst Bromley residents aged 16 to 74 years of age as 14.9% (compared to the London average of 16.4% and an England average of 15.6%). This is based on historic Primary Care Trust prevalence data published to help inform provision of psychological therapy services, and is therefore likely to be out of date (for example, it does not take into account changes in overall population size or age distribution). In the Adult Psychiatric Morbidity Survey (APMS), one in six (17%) people aged 16 years and over were identified with a CMD the week before interview[xvii]. The APMS is a household sample survey of treated and untreated mental health conditions in the English adult population.

QOF 2016/17 data for Bromley shows that 8.5% of Bromley registered patients have been diagnosed with **depression**. This places Bromley as the third highest London borough for recorded depression (see **Figure 5.5**). The prevalence of depression in Bromley is higher than the London average of 6.63% but its prevalence is lower than the England average at 9.09%. The range across London boroughs is 4.92% in Redbridge to 9.03% in City and Hackney borough.

Figure 5. 5

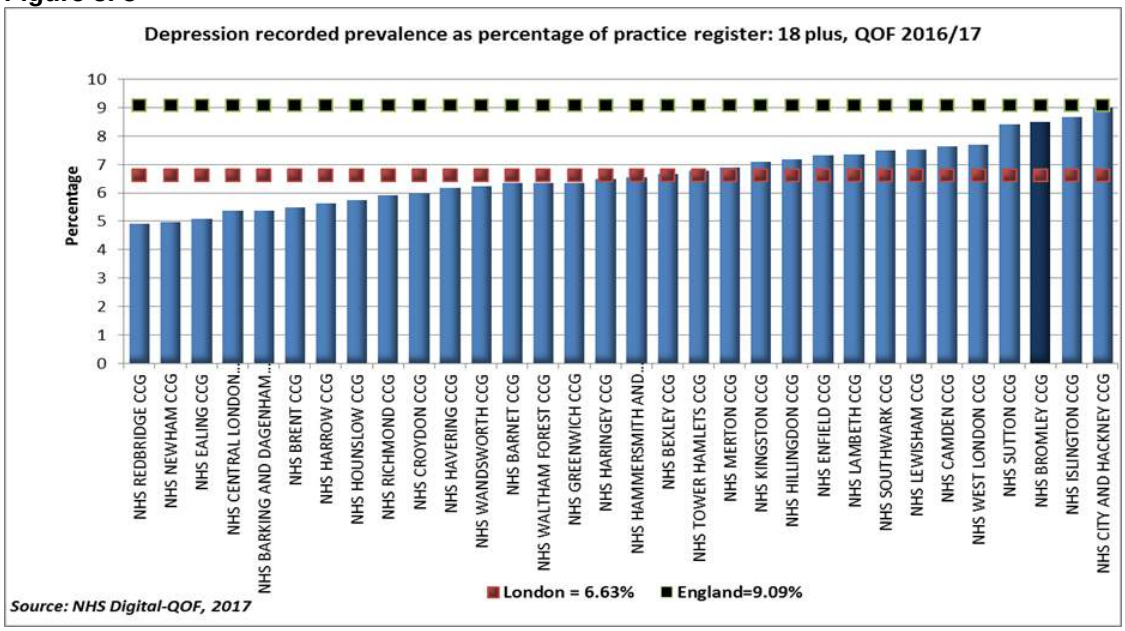


Figure 5. 6

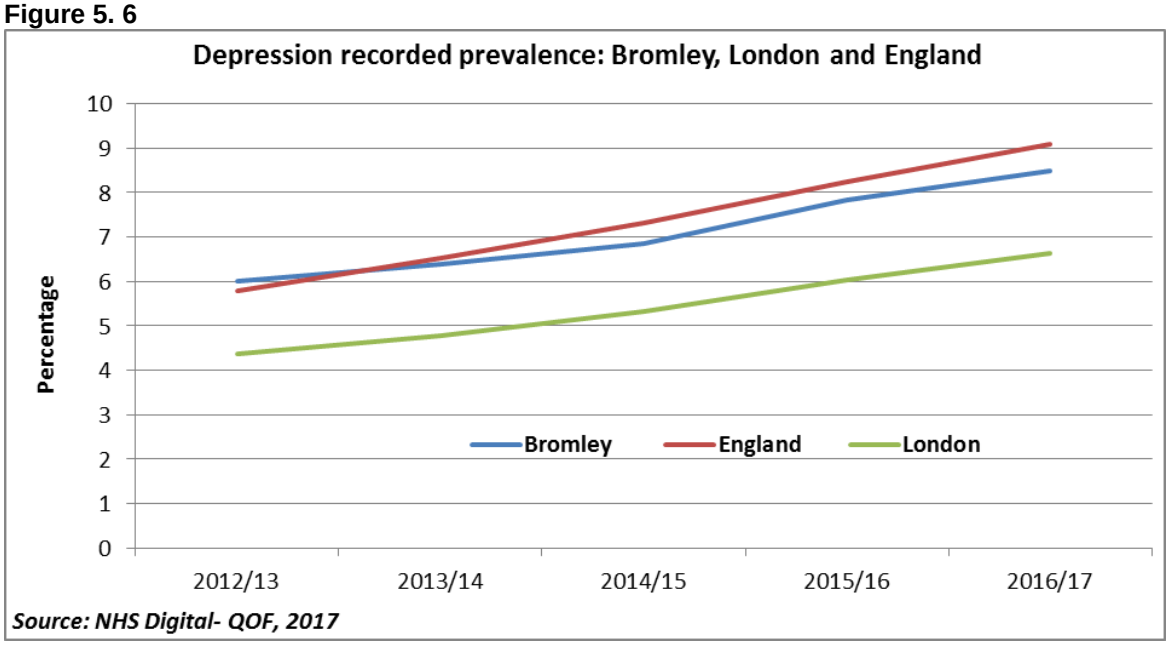


Table 5. 4: Changes in the prevalence of people with depression as recorded by GP practice in Bromley from 2012/13 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
Depression Register Size	15645	16789	18140	20970	23,073
Depression Prevalence	6.00%	6.38%	6.85%	7.83%	8.50%
Source: NHS Digital/QOF 2017					

Figure 5.6 and **Table 5.4** show a steady increase in the number of existing cases (prevalence) of depression in Bromley. For example, the depression register size in Bromley has increased by 7,428 cases over a 4-year period, averaging around 1,800 new cases each year. This could be due to better data recording and/ or an increase in the number of people presenting themselves to primary care with depression. This increase also seems to follow a regional and national trend (see **Figure 5.6).**

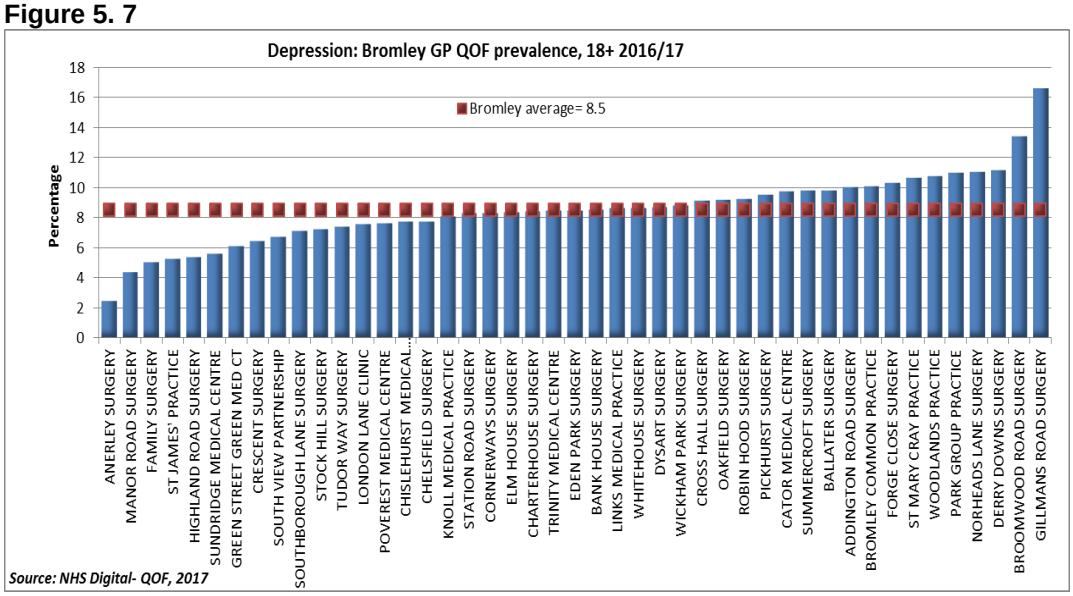
Prevalence of Depression by GP Practice and Levels of Deprivation

The prevalence of recorded depression varies substantially across GP practices in Bromley from just over 2% of the registered population to over 16% of the registered population. This information is presented in **Figure 5.7**.

This range may indicate under presentation or under diagnosis of depression in certain GP practice areas. However, it also suggests that the number of cases of

depression can be influenced by place (for example, relative deprivation of the area as seen in the analysis of the Primary Care database below).

Figure 5. 7



Prevalence of Depression: Bromley Primary Care database

According to data captured from the Bromley primary care database in 2016 the prevalence of patients recorded with a depressive term (a proxy for common mental health disorders) is 13.9% (a total of 37,063 or 1 in 7 patients). This is higher than the QOF average of 8.5%. As with severe mental illness, the differences in these estimates may be explained by the primary care records including patients now in remission.

65% of patients registered with a depressive term are women (compared to population estimates that women make up 52% of Bromley's population[xxii]) and 13% are recorded as being from a Black and Minority Ethnic Group (19% of Bromley's population is estimated to be from an ethnic minority group[xxiii]). In terms of a representation of ethnic minority groups this is likely to reflect an underestimate of need. For example, Bromley's Mind recovery works service records 24% of clients from a BME background and IAPT services (talking therapies) recorded 28.5% of referrals from a BME background in the first quarter of 2017/18[xxix]. The greater proportion of depressive terms recorded for women may be a true reflection of a greater number of depressive incidents amongst women, but might also be explained by the greater tendency by woman to seek medical help for depression.

Table 5. 5: Number and proportion of people on Bromley GP register with depression term: Men, women and Black and Minority ethnic group

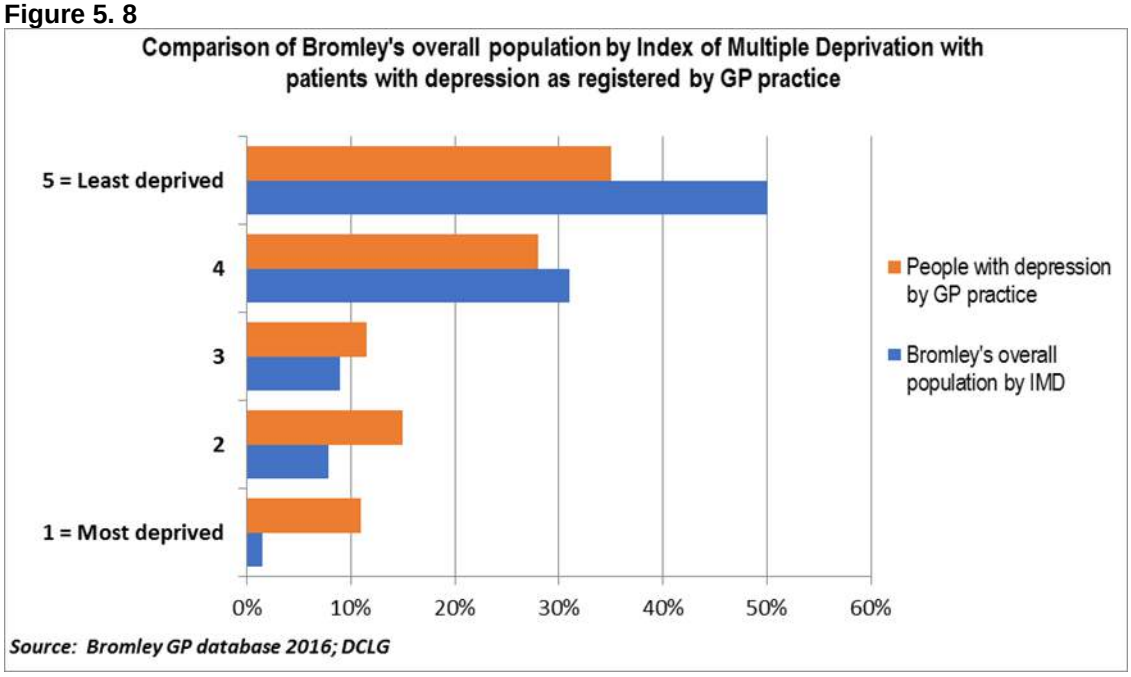
Men	Women	BAME
12,879 (35%)	24,184 (65%)	4,953 (13%)

Source: Bromley GP register, 2016

The Adult Psychiatric Morbidity Survey showed nationally a slight but steady increase in the proportion of women with symptoms of common mental health disorders (CMD) compared to 2009, but no noticeable increase for men[xvii]. The national survey also noted that the increase in prevalence for women was mostly at the severe end of the scale.

As with SMI, more patients with a depressive term (proxy for CMD) live in areas of higher deprivation. For example, 11% (4,052) of patients with depression live in the most deprived areas of the borough compared to 1.5% of Bromley's overall population (see **Figure 5.8**).

Figure 5. 8



In terms of the age distribution of people recorded with a depressive term, the distribution is fairly similar to what is observed for Severe Mental Illness, with the highest prevalence in the 45-54 year age range (23.2%) and then 17% and 19% for the age groups 35 to 44 years old and 55 to 64 years old. 9.3% of this population group is over 75 years old. Bromley's IAPT service noted the high needs they see in the younger adult age group (18 to 25 years old) which can be observed in **Figure 5.9.** To note, this is based on only 3 months of referral data and analysis over at least a year is required to establish if this is a true reflection of the age profile of the population presenting to this service.

Figure 5. 9

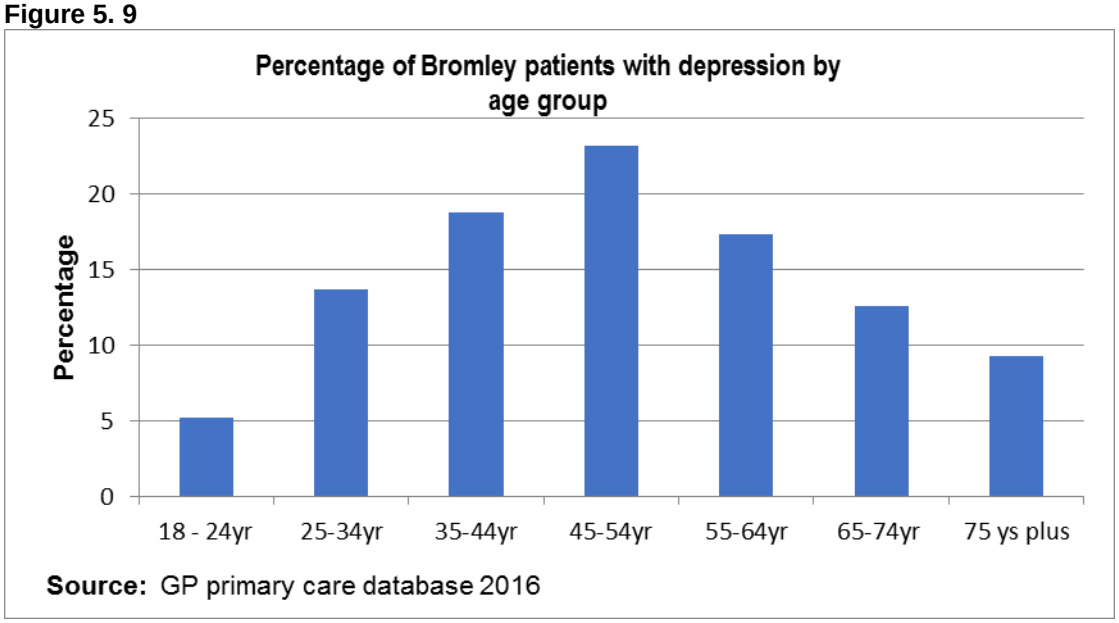
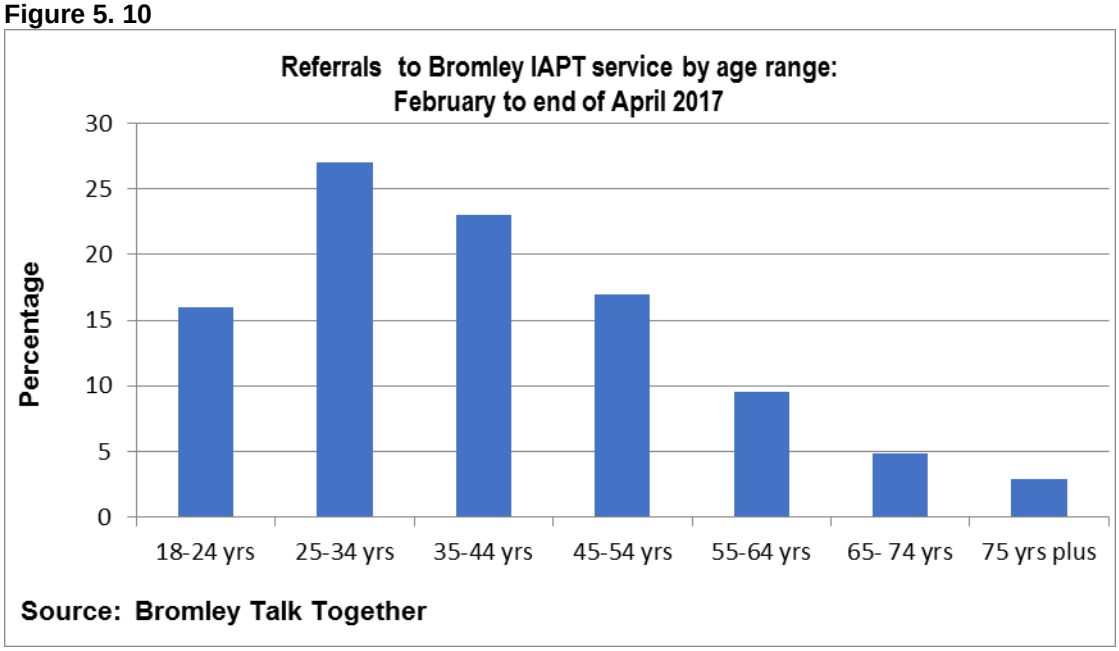


Figure 5. 10



Common Mental Health Disorders and Physical Health Needs

As with severe mental illness, the prevalence of physical health conditions in those with a recorded depressive term can be compared to the prevalence of these conditions in the overall Bromley registered population. These results are set out in **Table 5.6**. This shows the prevalence of physical illness alongside a diagnosis of depression (as noted in the Bromley Primary Care data set 2016). It is then compared with the level of disease recorded across the overall Bromley CCG population using QOF data for 2015-16.

Table 5. 6: Physical health condition for people with a depressive term: QOF data 2015/16

Physical health condition	Number	Percentage	Recorded disease prevalence – CCG level
Hypertension	7258	20%	13.6% (46,526)
Coronary heart disease	1767	4.8%	2.9% (9,846)
Chronic Obstructive Pulmonary Disorder (COPD)	2265	6.1%	1.3% (4,420)
Diabetes	1273	3.4%	**5.4% (14,493)
Chronic Kidney disease	1517	4.1%	*3.6% (9,560)
Cancer	1681	4.5%	2.5% (8,455)
Epilepsy	729	2%	*0.62% (1,672)

Source: Bromley Primary Care database, 2016

Key

*List size 18 years plus

** List size 17 years plus

Similarly to Severe Mental Illness, physical health conditions show a greater prevalence in people with a depressive term, with the exception of diabetes. This correlates with the higher prevalence of certain lifestyle behaviours amongst people with depression, for example higher smoking rates may explain some of the difference in COPD. Just over half the total population of people with COPD at the CCG level have depression as a co-morbidity. However, it is likely that managing a chronic health condition such as COPD can also contribute to depression. A similar association is likely for the other listed physical health conditions, such as coronary heart disease, chronic kidney disease and cancer.

The condition which is unusual in terms of its lower prevalence amongst people with a depressive term is diabetes, which differs from national trends where there is a higher recording of depression amongst people with diabetes compared to the

general population[5][xvii]. This may indicate that levels of depression are being underestimated within this patient group in Bromley.

Patients with a Depressive Term and Lifestyle Factors

As with Severe Mental Illness, people with common mental health disorders often exhibit lifestyle behaviours that can worsen physical health. For example, the Adult Psychiatric Morbidity Survey 2014 found that CMDs were more prevalent in people who smoked cigarettes[xvii]. This does not suggest a causative relationship (for example, it may be that social disadvantage is a stronger link between both smoking and poor mental well-being). However, it does mean that lifestyle behaviour factors need to be considered in patients with common mental health disorders.

The points below summarise analysis exploring Bromley patients with a depressive term with regards to weight, smoking habits and alcohol use.

- 32% of patients diagnosed with a common mental health disorder had their weight recorded in the past two years, this is similar to the proportion of people with any long term health condition who have had their weight monitored over the same period. Of these patients, 68.1% had a BMI value of over 25 (defined as excess weight). This compares to an estimated rate of excess weight of 63.8% of Bromley's general population.
- Of the patients with CMD with a smoking status recorded (29% of the total), 37.4% (13,880) are recorded as current smokers. This compares to a Bromley population estimate of 14.2% (a 14.8% difference).

Dual Diagnosis: Mental Health & Substance Misuse

Mental health problems are common among those needing treatment for substance misuse and substance misuse is common among those with a mental health problem. Particular population groups may be more affected by this dual diagnosis, for example alcohol dependence in combination with poor mental health is frequent in homeless people and prisoners[xxx].

Analysis of the profile of patients with co-occurring mental health and drug misuse issues, both nationally and locally, is presented in the JSNA section on Drug Misuse in Adults.

[5] NHS Digital cites that there is a 24 per cent lifetime prevalence of co-morbid depression in individuals with diabetes mellitus, which is three times higher than the prevalence rate in the general population[5].

What this means for residents in Bromley:

The profile of people living with a common mental health disorder (CMD) in Bromley is similar to that of the population living with severe mental illness in terms of their age and deprivation profile.

The number of people from a BME group with a CMD is lower than expected based on data from total population estimates. This could be due to data recording issues or patterns in how people from BME groups with CMD present to services.

People in Bromley with common mental health disorders have higher rates of chronic ill health, particularly heart and respiratory disease, than the general population. Surprisingly the level of diabetes is lower amongst people recorded with a CMD than the population average, which goes against evidence collated at a national level. This may benefit from further investigation.

Better recording of data on the lifestyle behaviours of people with CMD in Bromley would help to establish how health promotion messages could be best delivered to this patient group to improve physical health and wellbeing and reduce the risk of developing co-morbidities.

Suicide Audit, 2017

This section provides a summary of the Bromley Suicide Audit 2017 a copy of the full report is available on request from: JSNA@bromley.gov.uk

The report aims to compare local and national rates of suicide and self-harm, understand local trends and make recommendations to reduce the number of local suicides in line with national strategies.

Summary Facts

National[xxxi]

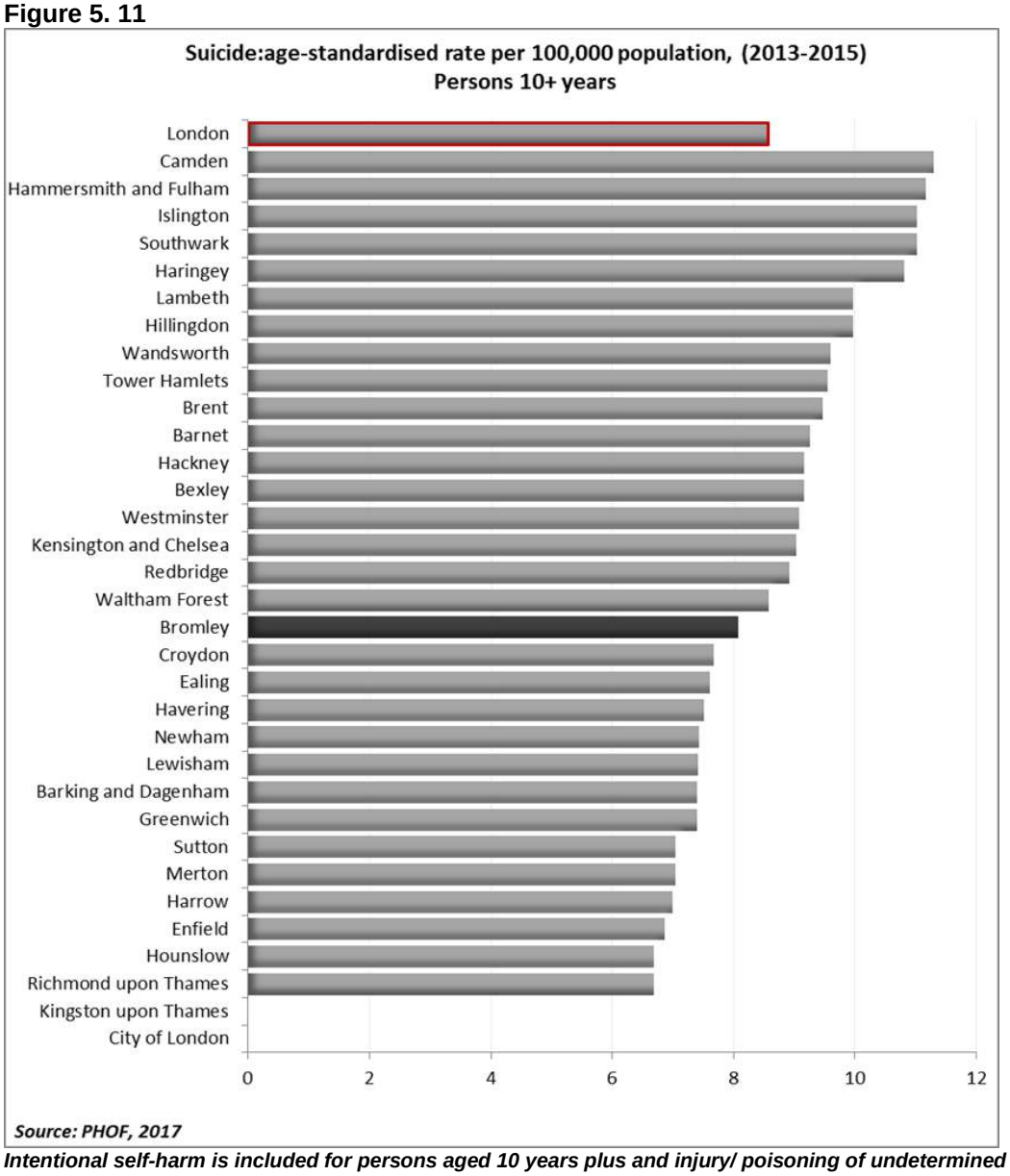
10 things that everyone needs to know about suicide prevention:	
1 - Suicide takes a high toll	There were 4,880 deaths from suicide registered in England in 2015. For every person who dies at least 10 people are directly affected.
2 – There are specific groups of people at risk of suicide	Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.
3 – There are specific factors that increase the risk of suicide	The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse greatly contribute to suicides. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.
4 – Preventing suicide is achievable	The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. The involvement of directors of public health and health and wellbeing boards is crucial in co-ordinating local suicide prevention efforts and making sure every area has a strategy in place.
5 – Suicide is everybody's business	A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.
6 – Restricting access to the means for suicide works	This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention.
7 – Supporting people bereaved by suicide is an important component of suicide prevention strategies	Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.
8 – Responsible media reporting is critical	Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour.
9 – The social and economic cost of suicide is substantial and adds to the case for suicide prevention work	The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.
10 – Local suicide prevention strategies must be informed by evidence	Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

Local

Suicide

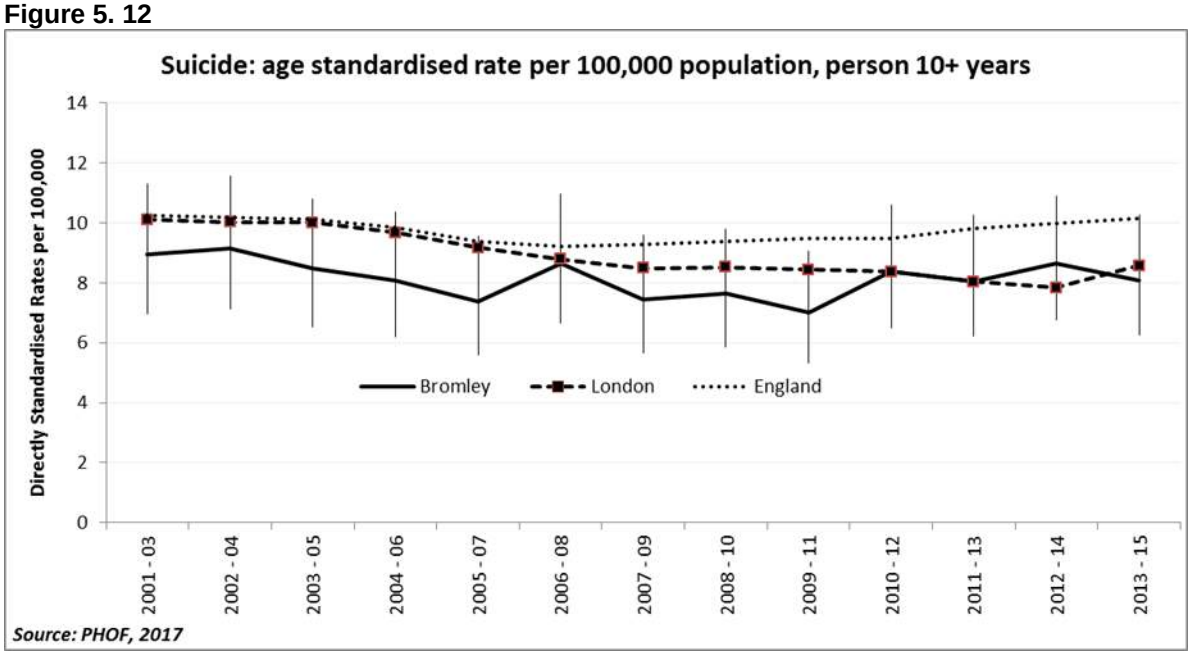
Bromley experiences a relatively low number of deaths from suicide each year; on average about 20 people. In 2013-2015 the suicide rate in Bromley was 8.08 deaths per 100,000 population aged 10 years and over. This rate is lower than the 2012-2014 rate at 8.65 deaths per 100,000 **(Figure 5.12).** Bromley ranks 16th out of the 33 London boroughs on suicide rates (where 1 is lowest) as shown in **Figure 5.11**. The borough wide rates mask local community variation; however the small numbers behind the rates affect the ability to further investigate links to wider determinants locally.

Figure 5. 11



Intentional self-harm is included for persons aged 10 years plus and injury/ poisoning of undetermined intent is included for persons aged 15+

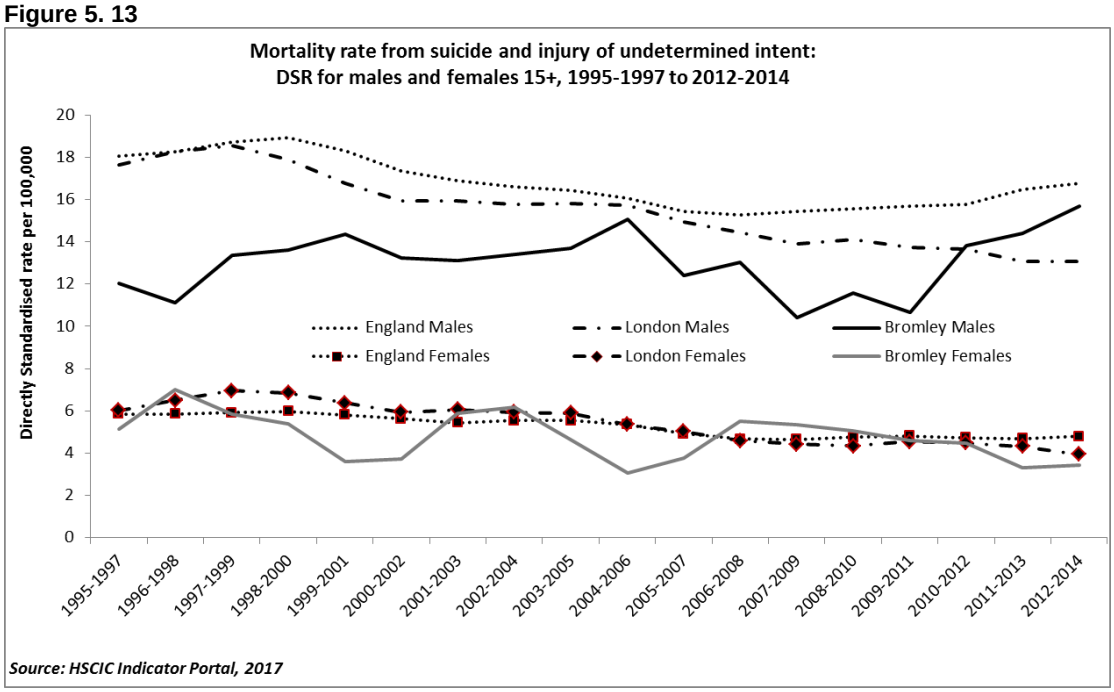
Figure 5. 12



Intentional self-harm is included for persons aged 10 years plus and injury/ poisoning of undetermined intent is included for persons aged 15+

Figure 5.13 shows that nationally, regionally and locally suicides continue to be more prevalent in males, up to three times the rate in females.

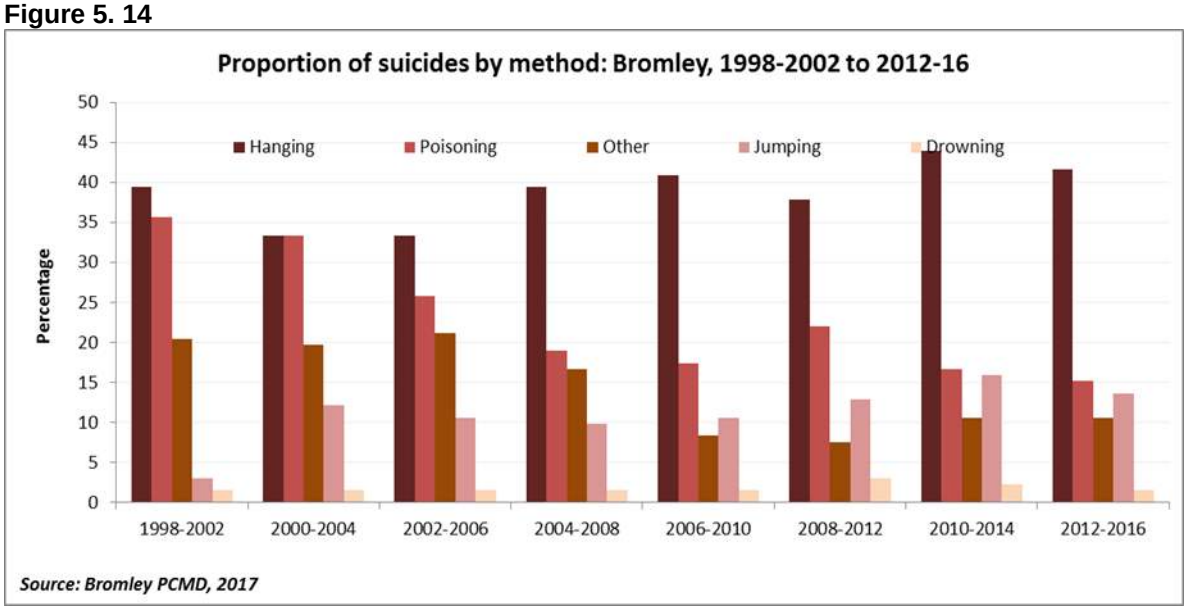
Figure 5. 13



In Bromley, the most common methods of suicide are similar to the UK with hanging, strangulation or suffocation being the most common methods, followed by poisoning (**Figure 5.14**). The proportion of suicides by self-poisoning is reducing, whilst the proportion of suicides by jumping from a height or in front of a moving

object is generally increasing, although the overall proportion using this method remains low.

Figure 5. 14



Social Context and Prior Contact with Health and Care Services

The National Suicide Strategy 2012[xxxii] identified the following groups at high risk of suicide:

- Young and middle-aged men
- People in the care of mental health services, including inpatients
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers
- People with a history of self-harm

It was not possible to analyse the social circumstances or patterns of prior contact with services of the people who took their lives in Bromley in the current audit but previous suicide audits in Bromley have showed that:

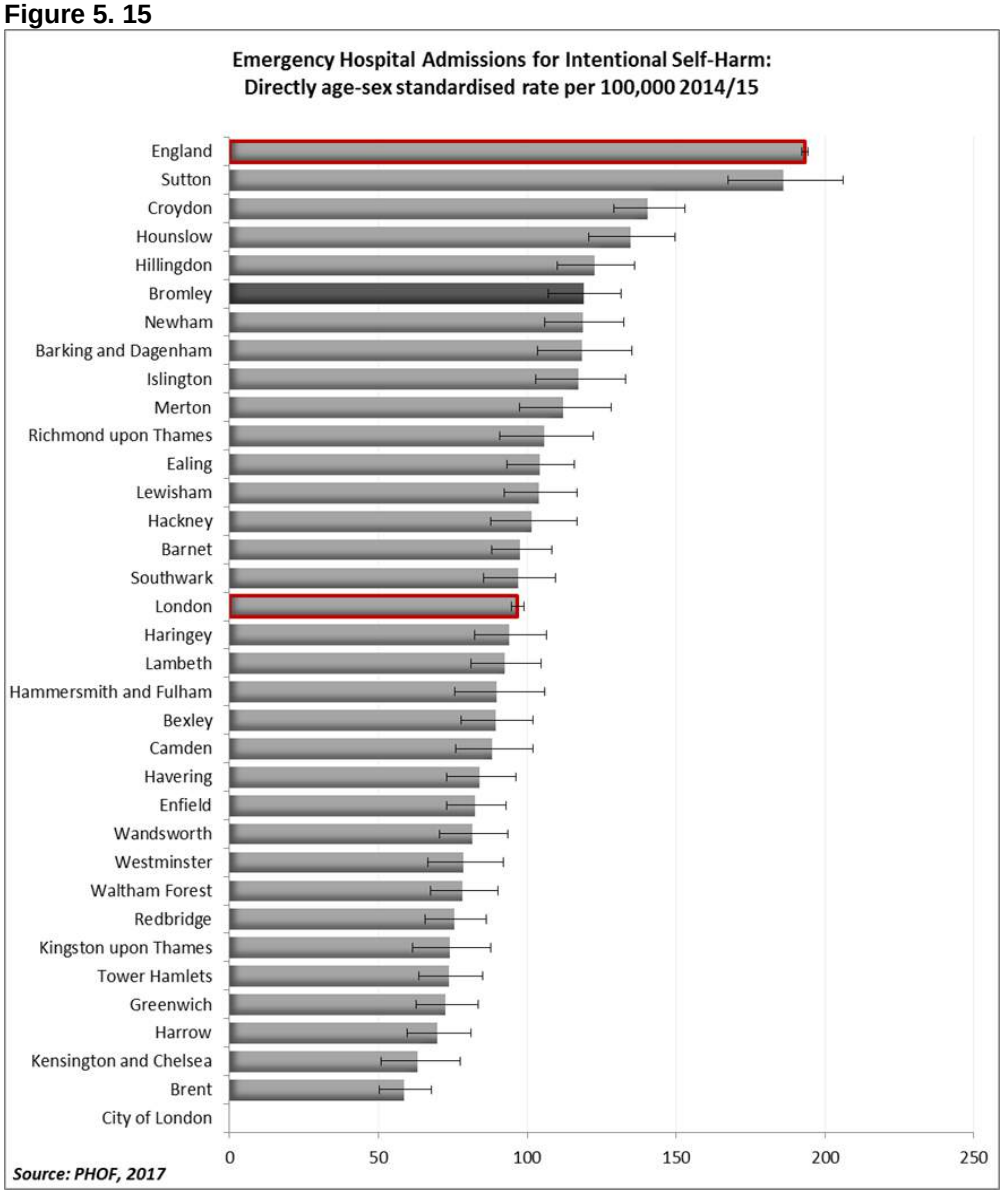
- many people had a documented suicide risk
- there was history of poor physical health and a mental illness diagnosis
- there was history of self-harm and a previous suicide attempt
- contact with Primary Care within 12 months prior to death
- previous contact with mental health services and some had a diagnosis of mental illness 12 months prior to the death, including depressions

Self-harm

Self-harm is presented alongside suicide because suicide is a form of self-harm. Self-harm with no suicidal intent is more common than suicidal behaviour and its outcomes cause less physical harm. The difference between self-harm and suicide lies in the intent. Research shows that repeated behaviour of self-harm increases the risk of a completed suicide by between 50-100 times[xxxiii]. In many cases of suicide there is an episode of self-harm shortly before someone takes their own life.

Bromley has the 5th highest intentional self-harm rates in the region **(Figure 5.15)**.

Figure 5. 15

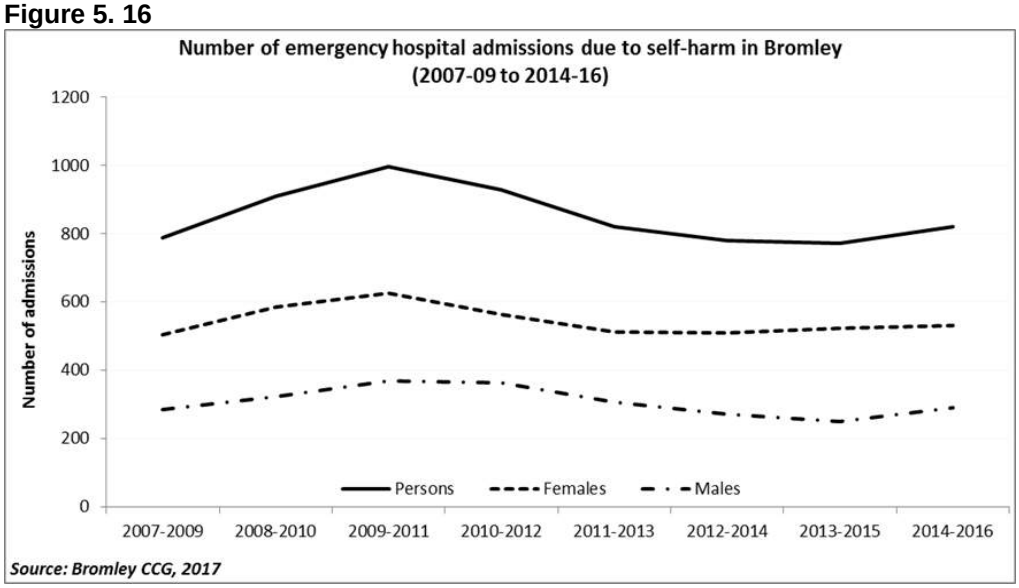


The age standardised admission rate for intentional self-harm in 2014/15 in Bromley was 118.83 per 100,000 population compared with 96.79 in 2013/14. The

2014/15 rate is significantly higher than London but significantly lower than England at 96.65 and 193.23 per 100,000 respectively. The figures are subject to reporting and recording bias. The practice of recording intent is variable across NHS Trusts and practitioners.

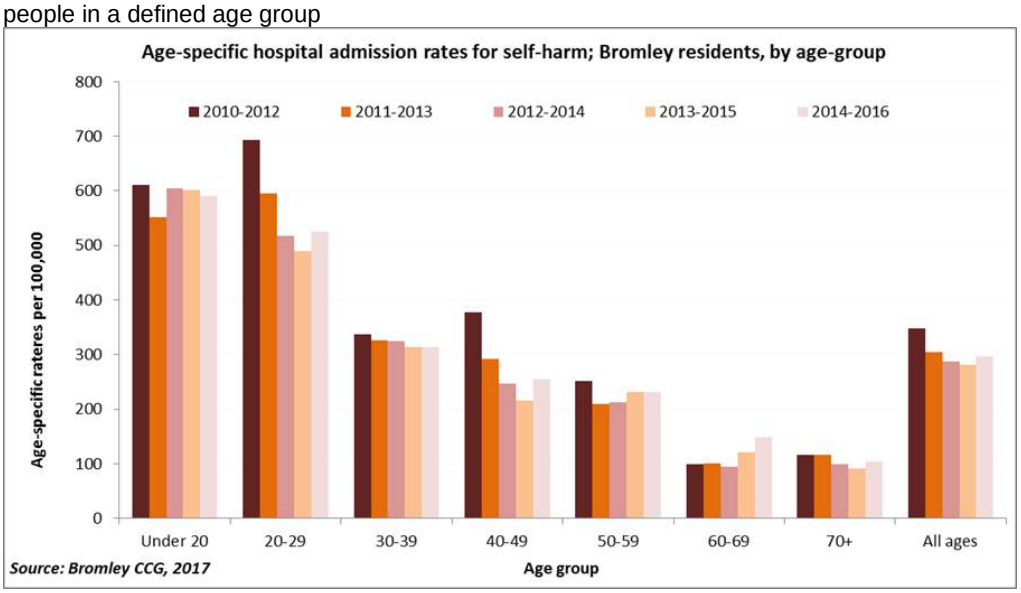
Rates of hospital admissions for intentional self-harm in both genders have fluctuated in Bromley over the last decade with a peak in 2009-11 (**Figure 5.16**). Although rates have declined since then there appears to be the beginning of an upward trend. Continued monitoring is required to assess if this upward trend is enduring.

Figure 5. 16



More females are hospitalised year on year for intentional self-harm than men. In 2014/15, the female rate was 150 per 100,000 population compared to the male rate at 87 per 100,000. For every male hospitalisation for intentional self-harm there are nearly two female hospitalisations. There is need for work to identify further risk factors in people who intentionally self-harm in Bromley and tailor services for the affected local population.

Figure 5. 17: Age-specific rates refer to the frequency with which self-harm occurs relative to the number of people in a defined age group



The proportion of hospital admissions for intentional self-harm is highest in people aged 20-49. Analysis of age –specific rates (**Figure 5.17**) also shows that people aged <30 are more represented in hospital for intentional self-harm than the general population. However it is worth noting that although there are fewer admissions of intentional self-harm in older residents, 60 years and over, research shows that older people who self-harm are three times more likely to commit suicide than the younger people who self-harm. Therefore older adults who intentionally self-harm should be a target group for services and support.

The relationship between deprivation and hospital admissions for intentional self-harm in Bromley is not linear and is marked by wide confidence intervals (**Figure 5.18**). However the difference seen in rates between women living in the most and least deprived deciles is significant. Analysis at ward level shows that hospital admission rates are significantly higher in the Cray Valley wards and Penge and Cator than the rest of the borough (**Figure 5.19**).

Figure 5. 18: 5 years of data are aggregated to increase events in the deprivation deciles

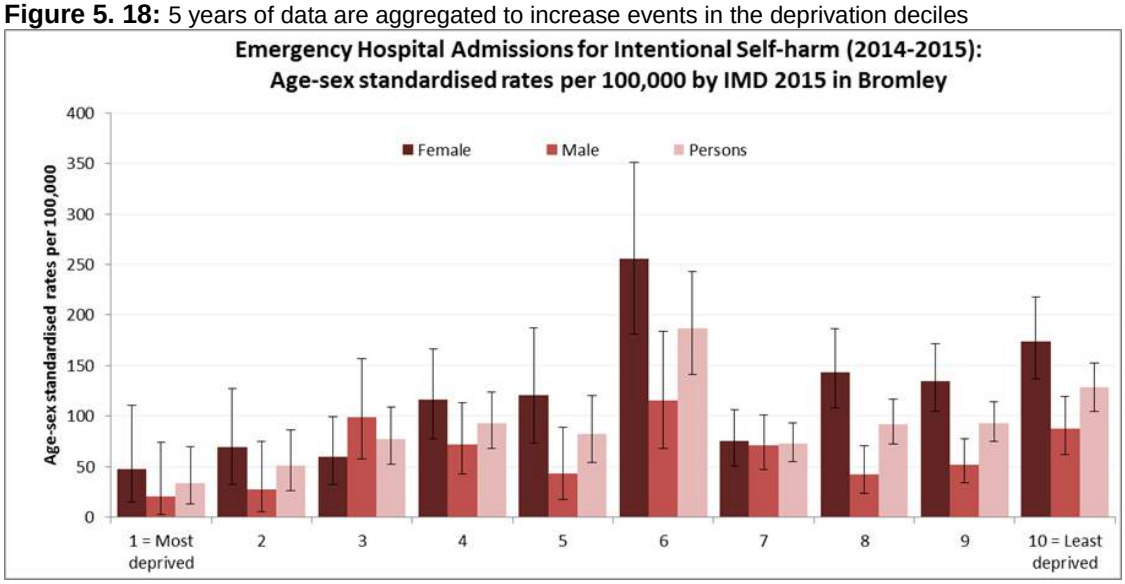
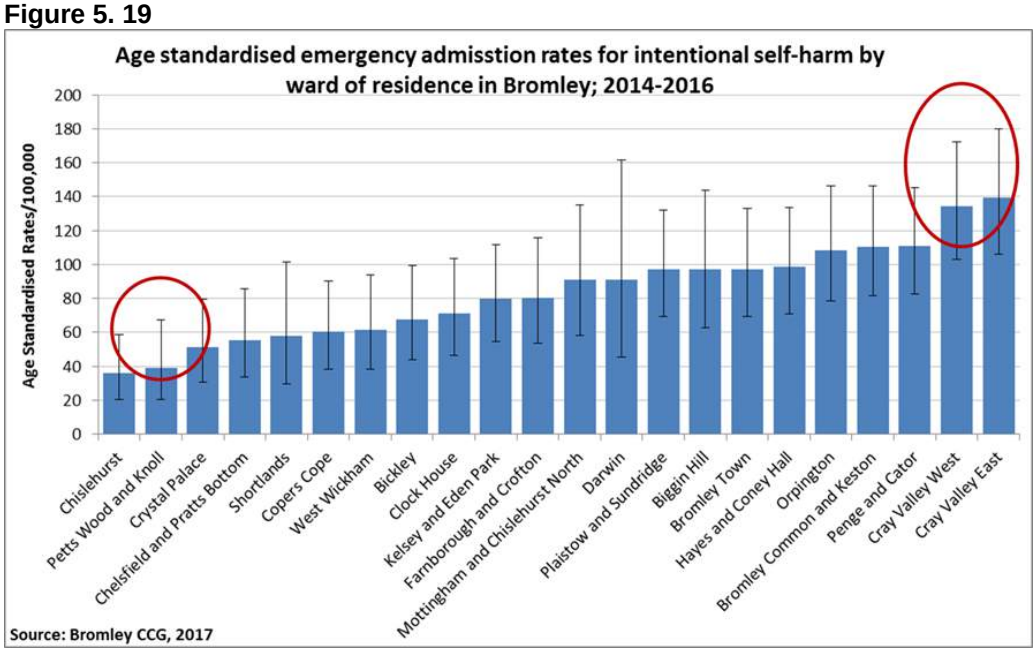


Figure 5. 19



What this means for residents in Bromley:

Bromley has the 5th highest intentional self-harm rates in the region and ranks 16th out of 33 London boroughs on suicide rates (where 1 is lowest).

Suicides continue to be more prevalent in males, up to three times the rate in females, whilst rates of admission for intentional self-harm continue to be more prevalent in women and young people.

The numbers of suicides in Bromley are very erratic year on year but on average about 20 people take their own lives in Bromley each year.

The most common methods of suicide in Bromley are hanging, strangulation or suffocation. The proportion of suicides by self-poisoning is reducing, whilst the proportion of suicides by jumping from a height or in front of a moving object is increasing.

Rates of hospital admissions for intentional self-harm have fluctuated in Bromley over the last decade with a peak in 2009-11. Although rates have declined since then there appears to be the beginning of an upward trend.

The proportion of hospital admissions for intentional self-harm is highest in people aged 20-49. Although there are fewer admissions of intentional self-harm in older residents, research shows that older people who self-harm are three times more likely to commit suicide than the younger people who self-harm.

The relationship between deprivation and hospital admissions for intentional self-harm in Bromley is not linear but analysis at ward level show that hospital admission rates are significantly higher in the Cray Valley wards and Penge and Cator than the rest of the borough.

6. Drug Misuse in Adults

Introduction

The World Health Organisation defines substance misuse as the use of a substance for a purpose not consistent with legal or medical guidelines[xxxiv].

In the UK illegal drugs are classified, according to the harms they are considered to cause, into three main categories; A, B or C. Class A drugs are considered to be those which can cause the most harm.

Table 6. 1

Class	Drug
A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth)
B	Amphetamines, barbiturates, cannabis, codeine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (e.g. mephedrone, methoxetamine), ketamine
C	Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat

Adapted from UK Drug Classifications[xxxv]

Drug misuse is recognised as a major public health issue in the UK.

It is estimated nationally, that drug supply gives rise to £10.7 billion a year in social and economic costs – of which, £6 billion, is attributed to drug- related acquisitive crime[xxxvi]. Drug misuse is both a cause and consequence of wider factors including; physical and mental ill-health, and wider determinants. Harms caused by drug misuse are far reaching and affect lives at every level[xxxvi].

A recent review of the evidence of patterns of drug misuse and treatment outcomes in England was undertaken as part of the development of the new national Drug Strategy 2017[xxxvii]. The review identified a range of patterns in substance misuse and their impact that are evident or emerging in England:

- The proportion of people in treatment with entrenched dependence and complex needs, particularly older heroin users, will increase. Evidence shows it is challenging to support those with complex needs and a long treatment history to achieve recovery, consequently the rates of successful treatment completion with continue to fall.

- The number of deaths related to drug misuse has risen significantly over the last 20 years, and particularly rapidly in the last 3 years. Older heroin users (those aged 40 and over who may have started using heroin in the 1980s and 1990s) who now have multiple health conditions, are more susceptible to overdose. Drug misuse deaths in those in treatment for opiate dependency are predicted to continue to rise rapidly, due to overdoses and deaths from long-term conditions.

- There are reports of increasing problems of misuse and dependence associated with some prescription and over-the-counter medicines. The use of new psychoactive substances (NPS) is also increasing, and is a particular problem in prisons. New patterns of drug use and health risk behaviour are also becoming established including NPS used by injection, and drugs used alongside high-risk sexual behaviour ('chemsex').

These trends are likely to influence the future harms and costs of substance misuse in England and impact on the effectiveness and outcomes of local substance misuse harm reduction, treatment and recovery services.

This report will focus on drug misuse in adults and aims to draw on the latest available statistics to provide a profile of the patterns and trends in drug use in the population of Bromley and make regional and national comparisons.

Analysis and recommendations will be provided to inform the planned reprocurement of substance misuse services for adults, children and young people in Bromley in 2018.

Details of the patterns, impact and treatment of alcohol misuse in Bromley can be found in the "Alcohol" section on p. 246 of the JSNA 2016:
https://bromley.mylifeportal.co.uk/media/20397/final-report-jsna-2016.pdf

A review of patterns of substance misuse in children and young people and the impact of parental substance misuse can be found in the Child Wellbeing Needs Assessment 2016:
http://cds.bromley.gov.uk/documents/s50045892/Child%20wellbeing%20needs%20assessment%20for%20Review%2028.09.16.pdf

Causes and Patterns of Drug Misuse

Problem drug use is viewed as a medical condition in the UK, and there is neurobiological evidence to suggest that this is the case. There are both genetic and social risk factors for drug misuse, which are most potent in combination.

Most people start taking illicit drugs in their teens and early twenties, with most reducing or stopping use as they move into adulthood. Dependency on opioids tends to start a few years after first use.

Dependency causes long-lasting changes in the brain, which cause tolerance, craving and withdrawal. As a result it is a chronic condition, characterised by periods of remission and relapse.

Drug use and misuse tend to be clustered; for example, areas of relatively high social deprivation have a higher prevalence of illicit opiate and crack cocaine use and larger numbers of people in treatment. The association between social factors and illicit drug use is reciprocal; drug misuse can cause social disadvantage, and socio-economic disadvantage may lead to drug use and dependence. Social factors can also moderate drug treatment outcomes. Unemployment and housing problems have a marked negative impact on treatment outcomes and exacerbate the risk that someone will relapse after treatment. Addressing the wider issues of health inequality and social exclusion are therefore fundamental to improving treatment outcomes[xxxvi].

Epidemiology of Drug Misuse

Adapted from Public Health England[xxxviii]

Because of the illicit nature of drug misuse, direct counts for the number of opiate and /or crack cocaine users (OCU) are not readily available through administrative datasets. Instead indirect techniques are used to provide estimates of prevalence.

There are currently two sources of prevalence information: the Crime Survey for England and Wales[lxvi] and estimates of problematic opiate use and crack cocaine use for England from 2014 to 2015[xxxix].

Crime Survey for England and Wales

According to the 2016/17 CSEW, 1 in 3 (34.2%) adults aged 16 to 59 and 35.7% young adults aged 15-24 years had used a drug at some point in their lives (10.8 million people and 2.2 million people respectively)[lxvi].

Around 1 in 12 (8.5%) adults aged 16-59 in England and Wales had taken an illicit drug in in the last year[lxvi]. This equated to around 2.8 million people, and was similar to the 2015/16 survey (8.4%).

Around 1 in 5 (19.2%) young adults aged 16 to 24 in England and Wales had a taken a drug in the last year[lxvi]. This proportion was more than double that of the wider age group, and equates to 1.2 million people. The level of drug use was similar to the 2015/16 survey (18.0%).

The drug most cited as ever used was cannabis. However cannabis use is lower than a decade ago and rates have been stable since 2009-10. Estimates of

ecstasy use among those aged between 16-24 years have increased and are currently similar to levels a decade ago (4.5% in 2015-2016 compared with 4.3% in 2005-2006).

The 2016/17 survey estimated that in the last year 7.6% of adults aged 16 to 59 had taken a prescription-only painkiller not prescribed to them for medical reasons[lxvi], similar to the estimate of 7.4 per cent in the 2015/16 survey.

While use of new psychoactive substances among the general population is low (0.7% of 16-59 year olds reported having used a new psychoactive substance in 2015-2016), they continue to appear rapidly on the market, and use among certain groups is problematic, particularly among the homeless population and in prisons. In addition, there is emerging use of image and performance enhancing drugs (including intravenous use); and use of multiple drugs ('poly-substance misuse').

Prevalence Estimates- Bromley Compared to Region and Nation

These estimates bring together datasets available at a local and national level. For further information on the methodology, follow the link below http://www.cph.org.uk/wp-content/uploads/2017/09/Estimates-of-the-Prevalence-of-Opiate-Use-and-crack-cocaine-use-2014-15.pdf.

Table 6. 2

Number of Drug users (Rate per 1000 adult Population) 2014/15			
	Opiate &/or Crack Users	Opiate	Crack
Bromley	1221 (5.96)	870 (4.24)	837 (4.08)
London	52487 (8.87)	40750 (6.89)	39226 (6.63)
England	300783 (8.57)	257476 (7.33)	182828 (5.21)

Source: National Treatment Agency, 2017[xl]

Bromley has lower estimated rates of opiate and or crack use than London and England in all categories **(Table 6.2)**. The number of people using drugs in all categories has increased since the last estimates in 2011/12.The local trend is similar to the national trend but not regional, where the numbers have fallen in all

categories (**Table 6.3**). It is estimated that three quarters of the population using OCU and crack and two thirds of opiate users in Bromley are currently not in treatment.

Table 6. 3

Difference between 2014/15 and 2011/12 estimates			
	Opiate &/or Crack Users	Opiate	Crack
Bromley ↑	104	56	87
England ↑	6,904	1,313	16,188
London ↓	-2,498	-3,168	-854

Source: PHE Adults- drugs commissioning support pack 2018/19 & National Treatment Agency, 2017

Bromley has the 7th lowest rates (out of 33 boroughs) of estimated combined opiate and or crack use in the region (**Figure 6.1**), as well as the 5th lowest estimated rates of opiate use (**Figure 6.2**) and crack use in the region (**Figure 6.3**). Although the rates of drug use are significantly below the region and national average, Bromley fares worse than two of the four local authorities in the region in a similar socioeconomic deprivation bracket (Merton, Sutton, Harrow, City of London).

Figure 6. 1

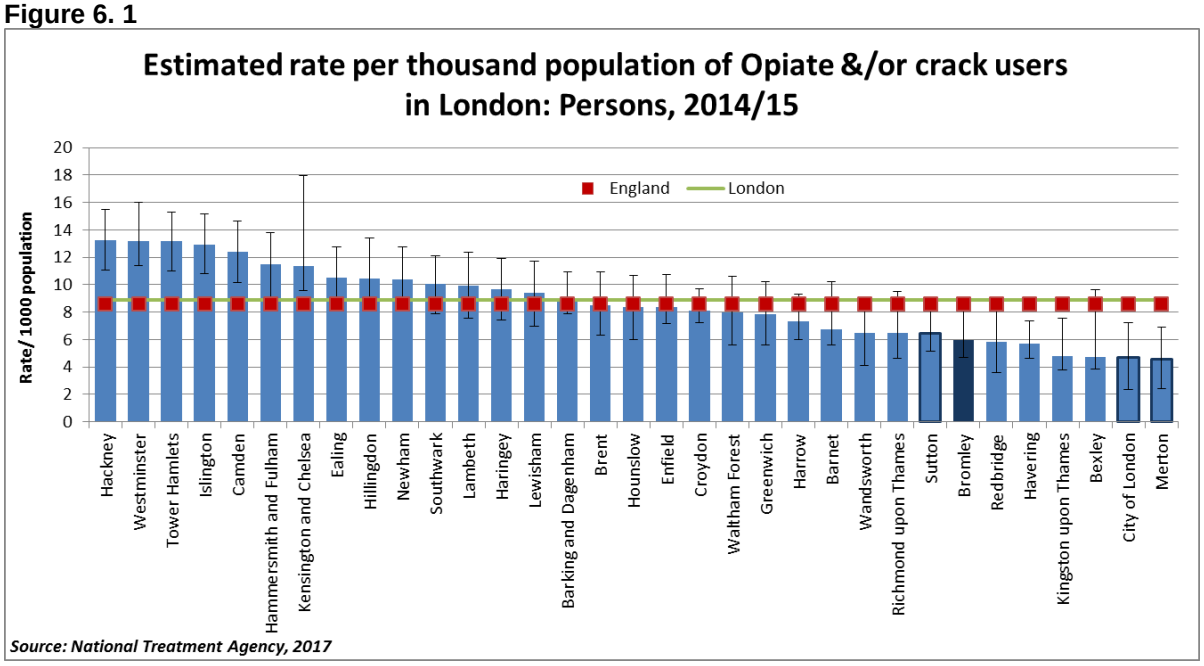


Figure 6. 2

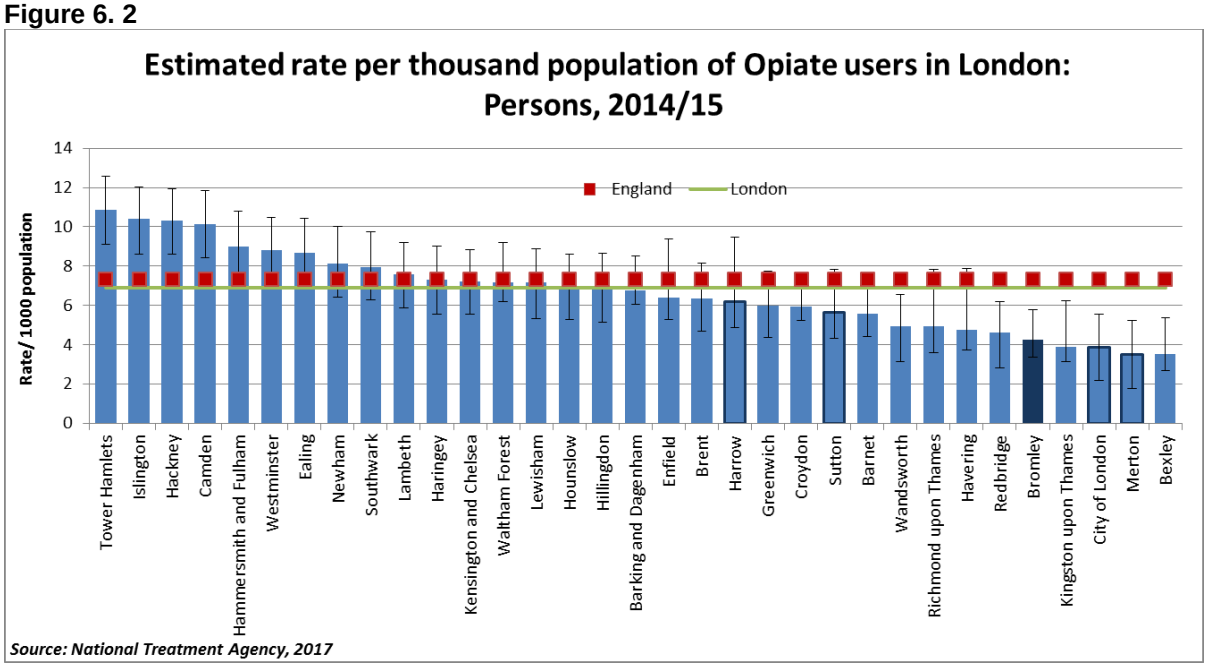
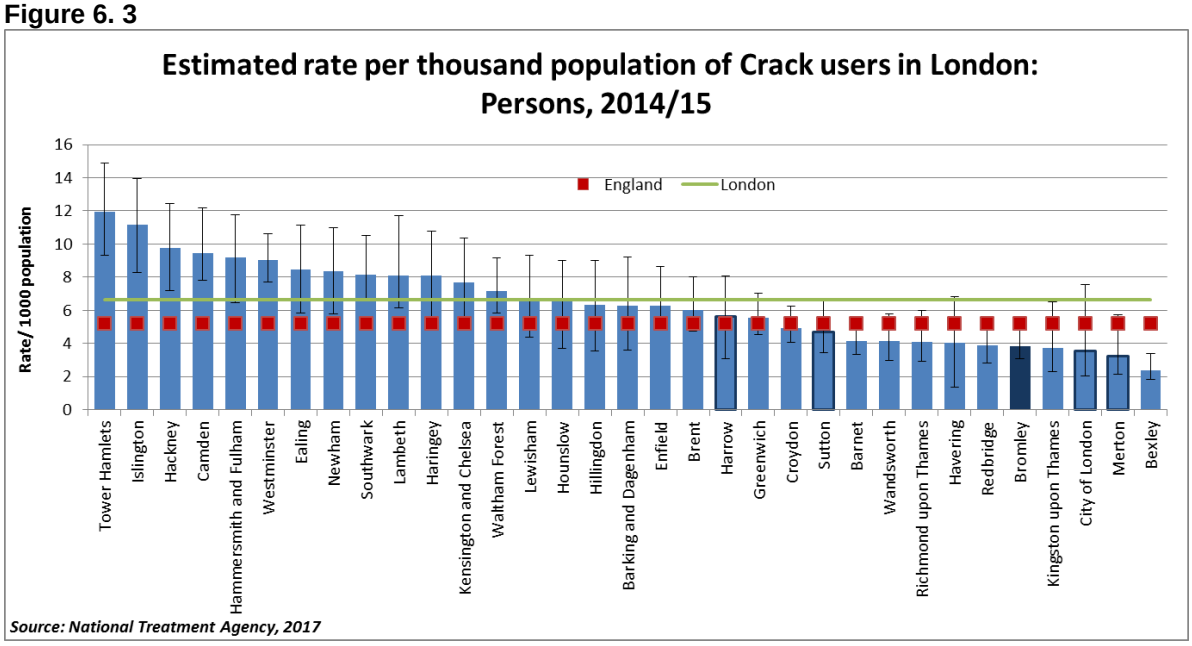


Figure 6. 3



Demographic characteristics- Age

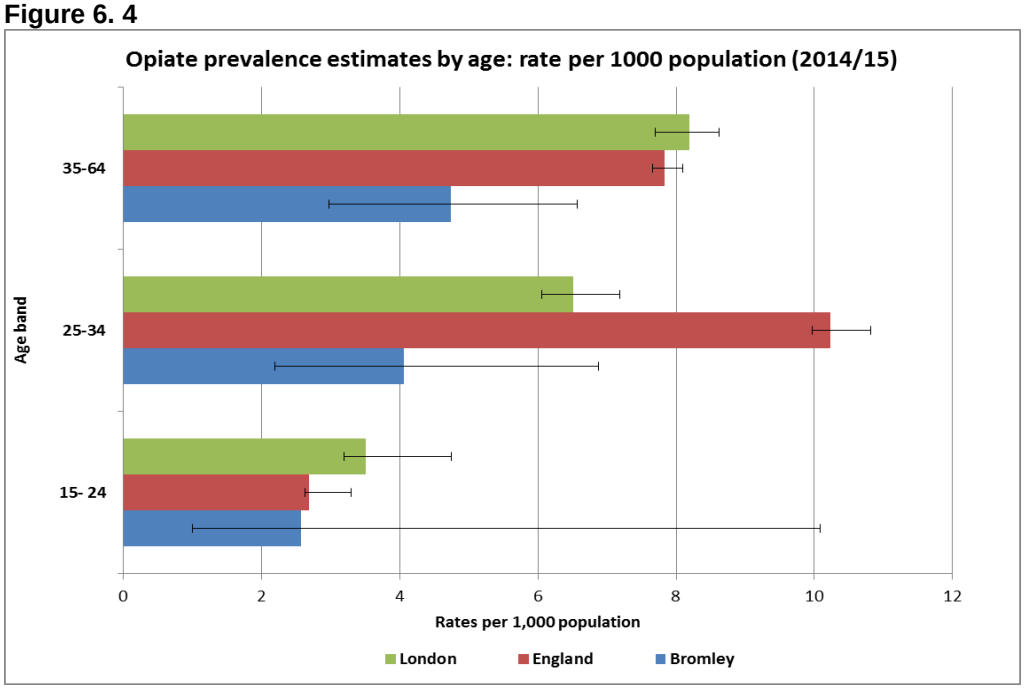
In England and Wales, younger people were more likely to take drugs than older people[lxvi]. The level of any drug use in the last year was highest among the youngest age groups in England and Wales; 16.5% of 16 to 19 year olds and 21.2% of 20 to 24 year olds reported any drug use in the last year[lxvi]. Levels of drug use then decreased as age increased, from 11.4% of 25 to 29 year olds to 2% of 55 to 59 year olds[lxvi].

There is no local information on combined drug use by age; the data available splits drug use by the different categories (opiate and/or crack users and opiate users but no data on crack use).

The estimated rates of opiate consumption in 15-24 year olds is similar in Bromley to that in London and England whereas opiate consumption rates in the older age groups are lower in Bromley in comparison to national and regional figures (**Figure 6.4**). The wide and overlapping confidence intervals are indicative of the small numbers.

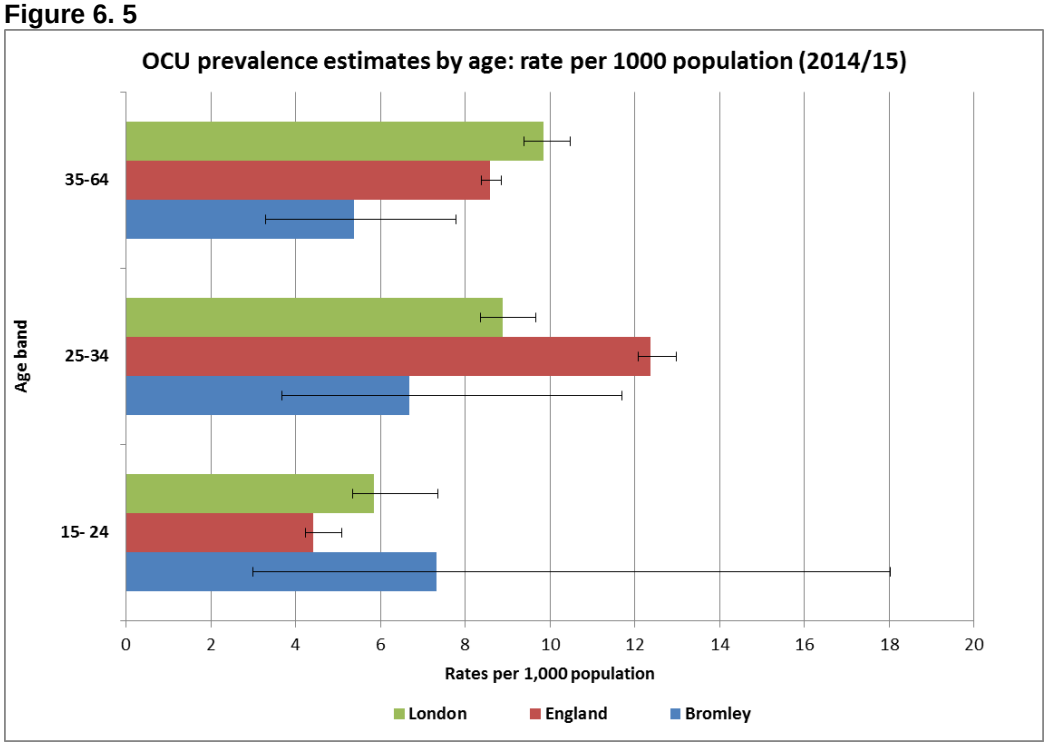
For combined opiate and/or crack use rates (**Figure 6.5**), the estimated consumption rates are actually higher in Bromley's young people (age 15-24) than the regional or national average.

Figure 6. 4



Source: ***National Treatment Agency, 2017***

Figure 6. 5



Source: ***National Treatment Agency, 2017***

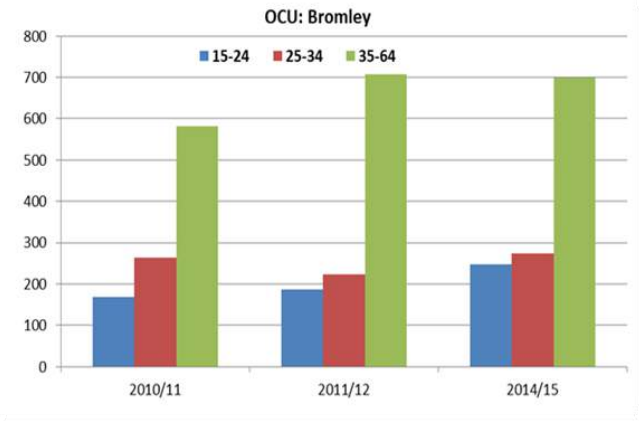
Analysis of trends in prevalence rates over time show an overall increase in the estimated number of older drug users (**Figure 6.6**).

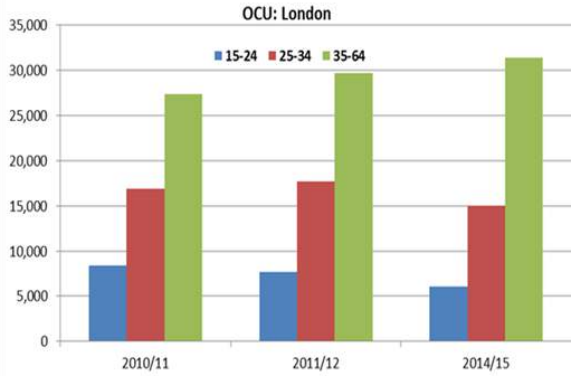
In England, there has been a significant increase in those aged 35 and over who use opiates and or crack, rising from 130,628 in 2010-11 to 163,180 in 2014-15. A large proportion of heroin/opiate users in treatment in 2016-17 will have started using heroin in the epidemics of the 1980s and 1990s and are now over 40 years of age, having been using heroin for a significantly long period of time[xli]. The long term use significantly impacts on the burden of disease (particularly increasing complexity of cases with long term conditions) and mortality. Evidence shows that the aging cohort contributed to the worsening trend of drug related death ratesxxxvi. Drug related deaths are discussed later in the report.

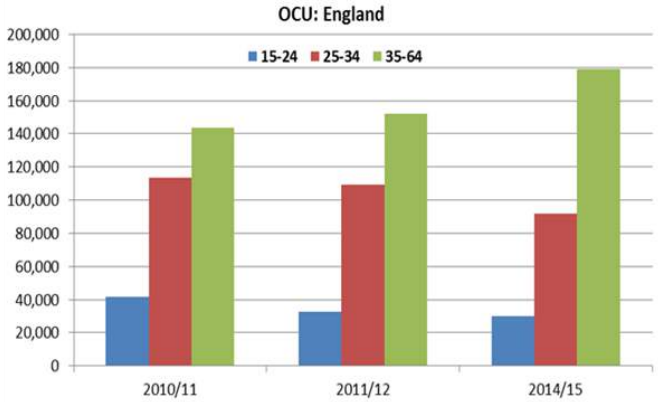
In Bromley, the estimated prevalence of opiate and or crack users in those aged 35-64 years in 2014/15 (609) is slightly lower than the previous estimates (707, 2011/12), (**Figure 6.6**).

Figure 6. 6

Estimated Number of Opiate &/or Crack Users by Age band (2014/15)







- **Overall increase in the 35-64 year olds across all areas.**
- **General increase across all age bands for Bromley**
- **In London, there is a year on year decrease in the 15-24 year olds. The trend is inconsistent for 25-34 year olds**
- **Year on year reduction in all age groups in England except 35-64 year olds**

Source: National Treatment Agency, 2017.

Demographic characteristics- Gender

National statistics show that men were more likely to take drugs than women. Around 1 in 9 (11.5%) men aged 16 to 59 had taken any drug in the last year, compared with 1 in 18 (5.5%) women[lxvi].

The estimated levels of male opiate users in Bromley is about four times the estimated rates for females, whilst it's about three times in the region and the nation (**Table 6.4**).

Table 6. 4: The estimated number and (rate per 1000 population) of Opiate users by gender: 2014/15

	Female	Male
Bromley	158 (1.49)	712 (7.18)
London	9427 (3.19)	31323 (10.58)
England	61682 (3.51)	195794 (11.18)

Source: National Treatment Agency

In the 2016/17 CSEW, nationally, men were more than twice as likely to report using cannabis in the last year as women (9.0% of men, compared with 4.2% of women). Men were almost three times more likely than women to take powder cocaine (3.3% compared with 1.3%) and were also twice as likely to have taken ecstasy (1.7% compared with 0.9%) in the last year. Unfortunately at a local level, drug use analysis by gender is only available for opiate use and not the other categories of drug. So we are unable to make comparisons of the local gender profile for users of other types of drugs.

Figure 6.7 and 6.8 shows that Bromley has the second lowest rates of opiate use in women and men in the region. Bromley rates are lower than the four local authorities in the region in a similar socioeconomic deprivation bracket (Harrow, Merton, Sutton and City of London). The wide over lapping confidence intervals are worth noting, indicative of the small numbers behind these data and the indeterminate statistical significance.

Figure 6. 7

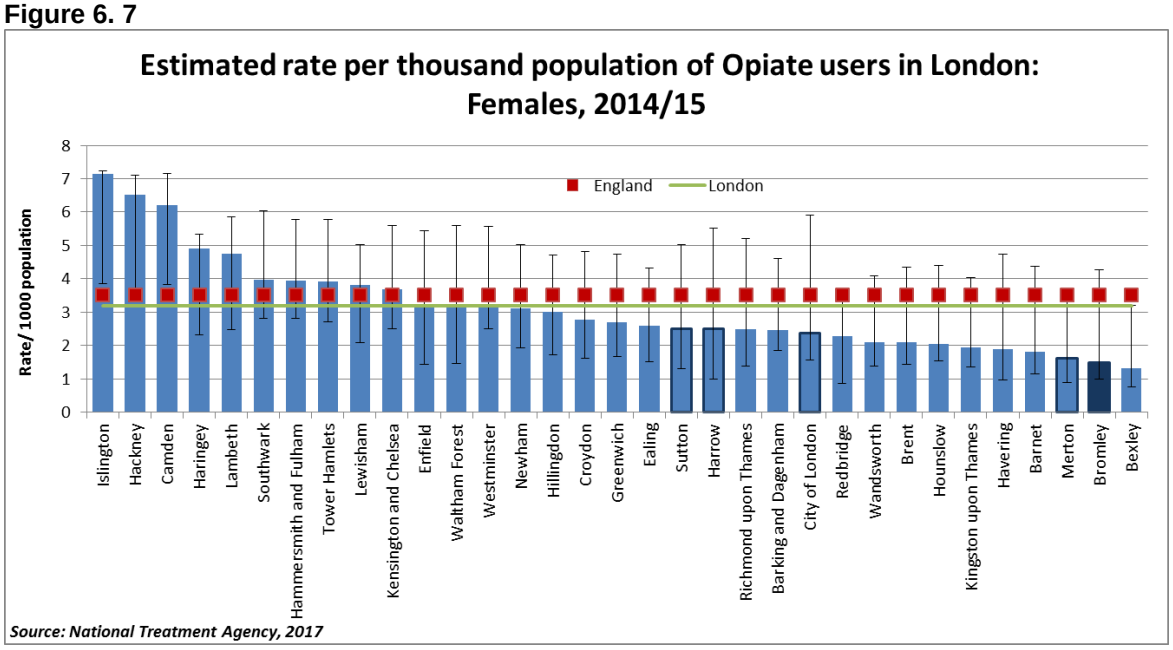
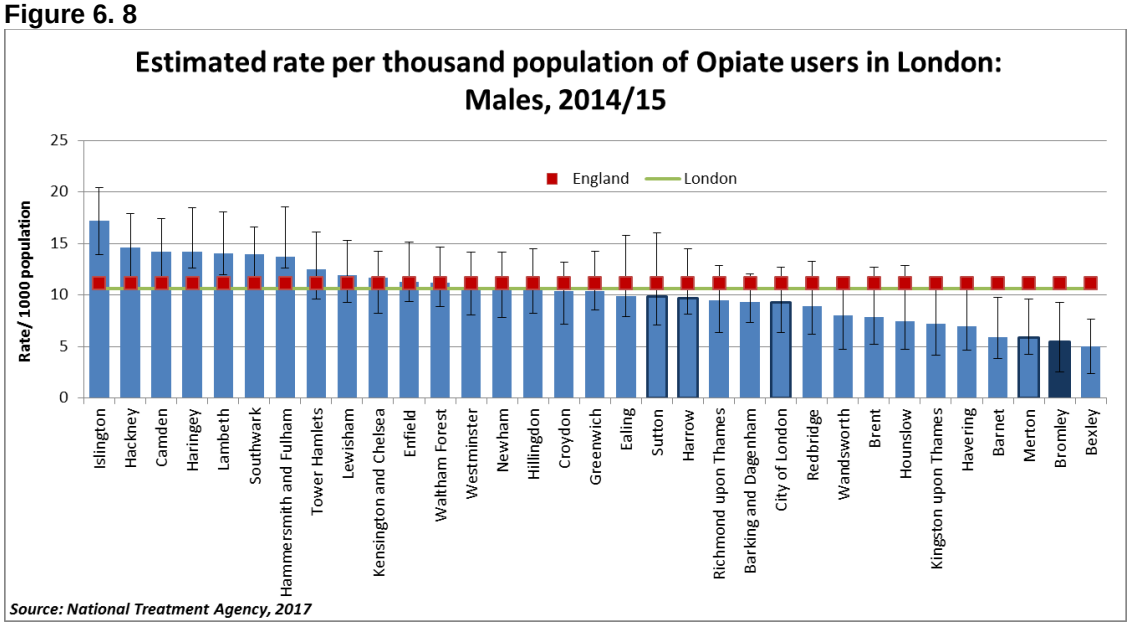


Figure 6. 8



Prevalence of Over the Counter and Prescription Only Medication

Addiction to prescription-only medicines (POMs) and over the counter medicines (OTC) has become an increasing problem in recent yearsxl. OTC/POM drugs come under four main groups:

- Benzodiazepines and z-drugs, prescribed mainly for anxiety (benzodiazepines only) and insomnia
- Opioid and some other pain medicines, both prescribed and bought over-the-counter
- Stimulants, prescribed for ADHD or slimming
- Some OTC cough and cold medicines, and anti-histamines and stimulants.

There are distinct but overlapping populations using these medicines:

- Those who use prescription and OTC medicines as a supplement or alternative to illicit drugs, or as a commodity to sell
- Those who overuse prescription or OTC medicines to cope with genuine or perceived physical or psychological symptoms
- Those for whom the prescribed use of a medicine inadvertently led to dependence, sometimes called involuntary or iatrogenic addiction.
- Whilst there is evidence in the USA of a very substantial rise in the misuse of opioid analgesic medication and heroin use, there is currently no evidence of this gateway into heroin and other illicit substance use in England. It is however important that opioid prescribing levels are monitored to ensure they remain proportionate to need and that there are measures in place to prevent and treat dependence.

16% of all people presenting to drug treatment services in Bromley cited a problem with prescription only or over the counter medication (POM/OTC). Of these, 11% cited illicit use [6] and 5% are presenting to treatment for non-illicit use [xlii]. The proportion of people citing POM/OTC use in Bromley is similar to England (15%). Of the 15% citing use in England, 12% were illicitly using while 3% were non-illicit [7]users.

New Psychoactive Substances and Club Drugs

Club drugs and New Psychoactive Substances (NPS) bring together a number of different substances typically used by people in bars and nightclubs, at concerts and festivals, before and after a night out.

The definition of NPS and Club Drugs has evolved over the years, reflecting the rapid and constant change in the characteristics of the drugs that are encompassed by the definition and the way in which they are used. A UK report [xliii] in 2015 cited the following definitions:

NPS are those substances that are deliberately designed to mimic the effects of controlled drugs while at the same time "designed" to be outside the scope of the Misuse of Drugs Act.

Club drugs are those controlled drugs (primarily used on the club/dance/festival scene) that are cause for growing concern (older drugs causing newer problems) either because of increasing acute incidents (such as MDMA/PMA) or their association with longer term, chronic conditions (such as GHB/GBL, ketamine and methamphetamine).

NPS can be further sub-divided into 4 main groups:

1. Synthetic cannabinoid receptor agonists (SCRAs) – traded under names such as; Clockwork Orange and Black Mamba. The chemicals in these drugs act on the brain in a similar way to cannabis.
2. Stimulant-type drugs – The effects of these drugs replicate those experienced with amphetamine and MDMA. Examples of these NPS include; BZP, mephedrone, MPDV, NRG-1 and Benzo Fury.
3. Hallucinogenic NPS – Examples include; Bromo-Dragonfly, 25i-NBOMe & methoxyetamine
4. Opiates – there is some evidence of opiate type NPS, such as kratom, available in Europe but currently no evidence of significant use in the UK.

The 2015/16 CSEW showed that some behaviours make it statistically significantly more likely that an individual will have used an NPS in the last year such as; alcohol consumption, visited a night club and evening pub or bar visit.

---

[6] *Using Prescription only medicine to supplement the abuse of traditional illicit drug use and/or complement the effects of illicit drug use*

[7] *Addiction to prescription only medicine and taking prescription only medicine for reasons, or in ways or amounts not intended by the prescriber*

The populations citing NPS/club drug use can also be split into two distinct groups; i) those also using opiates and ii) those citing NPS/club drug use and possibly other drugs but not opiates. Non-opiate using club drug users typically have good personal resources- job, relationships, accommodation- that means they are more likely to make the most of treatment[xlii]. In contrast a UK report recently described the profile of a NPS user as; a vulnerable young person, living in a socio-economic deprived environment (possibly on the streets or in the prison population), too young to be on the club drug scene and with little disposable income but who now has access to easily available (supposedly legal) substances with which to get intoxicated[xliii].

Among the club drug users in Bromley citing opiate use (who were new to treatment in 2016/17), Mephedrone was the commonly used drug. While among those with no additional opiate use, Ecstasy (60%) was the drug most commonly used followed by NPS other (40%). Of those citing NPS other, 20% was predominantly cannabinoid and 20% others (JSNA Support Pack, 2018/19). The data is subject to small numbers year on year random variation and disclosure controls which inhibit further analysis.

Among the club drug users in England citing opiate use (who were new to treatment in 2016/17), NPS other (69%) was the most commonly used drug, which was dominated by cannabinoids (42%) and other (18%). Among the club drug users with no additional opiate use, the three top most cited drugs were; Ecstasy (32%), NPS other (29%) and Ketamine (21%).

Both nationally and locally, the club drug users with or without opiate use, citing NPS other, also mainly cited Cannabinoid predominant drugs followed by other category.

Treatment Population

This section describes the characteristics of people who were in structured drug treatment in 2016-17. These services are a key part of drug treatment and recovery systems. The section includes a profile of all those in treatment and then goes on to describe the characteristics of specifically those who were new to treatment[8] in that year. This doesn't include any information on the population of drug users who are not receiving treatment. The potential level of unmet need in the population who are not in contact treatment services is discussed further later on.

In 2016/17, there were 279,793 people aged 18-99 attending structured treatment for drug misuse in England, 28% (78,663) of them were new to treatment in this period.

[8] Mix of individuals at their first point of contact with treatment system and those previously known to the service who are representing for further treatment.

In 2016/17, 460 clients attended drug treatment services in Bromley, 50% (231) were new to treatment in this period. The proportion of clients who were new to treatment is considerably higher in Bromley compared to the national average, however, it is indeterminate the proportion of clients re-presenting to service and those at first point of contact.

Table 6.5 shows that the most common reason for seeking treatment, both locally and nationally, is opiate use.

Over half of those in treatment nationally (52%, 146,536) were misusing opiates. This proportion is higher in Bromley with 66% (304) of clients in Bromley seeking treatment for opiate misuse.

The proportion of clients seeking treatment for opiate use is slightly lower in those who were new to treatment in 2016/17 in Bromley (53%) but this is still the predominant substance type for which treatment is sought. The proportion of those clients new to treatment in Bromley who sought help for non-opiate or non-opiate and alcohol misuse is considerably larger than in the total treatment population in Bromley (47% of the new to treatment population compared to 34% in the total treatment population).

Table 6. 5: Numbers in treatment and new presentations by main substance group 2016/17

Bromley	In treatment Total		New presentations	
	Number	%	Number	%
Opiate	304	66	122	53
Non-opiate only	62	13	43	19
Non-opiate & alcohol	94	20	66	29
All	460		231	

England	In treatment		New presentations	
	Number	%	Number	%
Opiate	146,536	52	43,142	55
Non-opiate only	24,561	9	16,775	21
Non-opiate & alcohol	28,242	10	18,716	24
All	279,793		78,633	

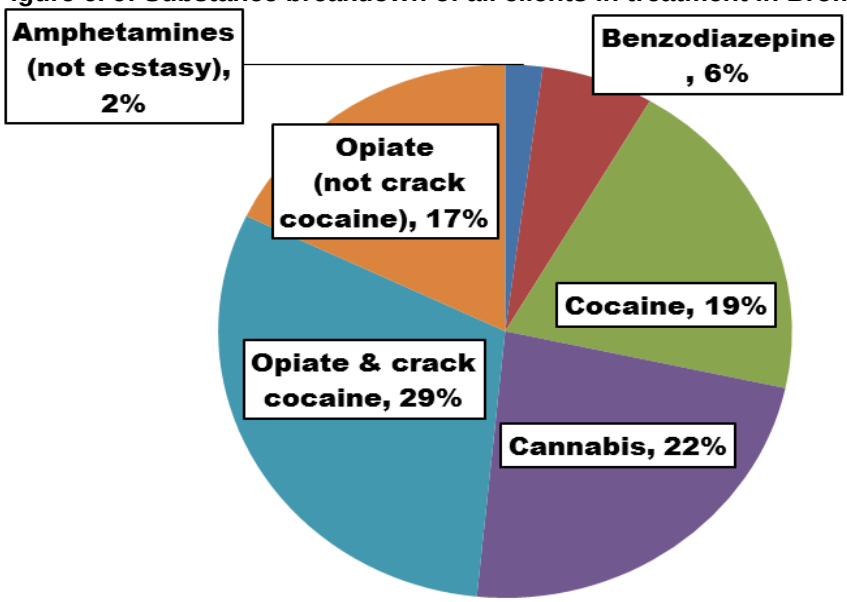
Source: National Drug Treatment Service, 2017

Drug use profile

Individuals may present to treatment citing problems with more than one substance (including alcohol). However, clients that are in treatment for alcohol only are excluded from this analysis. The adjunctive substances clients present to treatment

with differ by the main drug groups. Opiate clients in Bromley tend to present with crack cocaine, making crack cocaine the biggest adjunctive substance (29%). Non-opiate clients accessing treatment in Bromley, either alone or in conjunction with alcohol, tend to present with cocaine and cannabis misuse. **Figure 6.9** shows substance use profile of all clients in treatment in Bromley in 2016/17.

Figure 6. 9: Substance breakdown of all clients in treatment in Bromley: 2016-17



Source: NDTMS Trend Report, 2016-17

Treatment population trends

The number of clients in contact with treatment services has fallen gradually for both Bromley and England as shown in **Figures 6.10** and **6.11.** The data presented combines all three main substance groups- opiate, non-opiate and alcohol and non-opiate only. Alongside the reduction in the number of clients in treatment, there is a downward trend in the number of new clients entering treatment (**Figure 6.12** and **6.13**).

Figure 6. 10

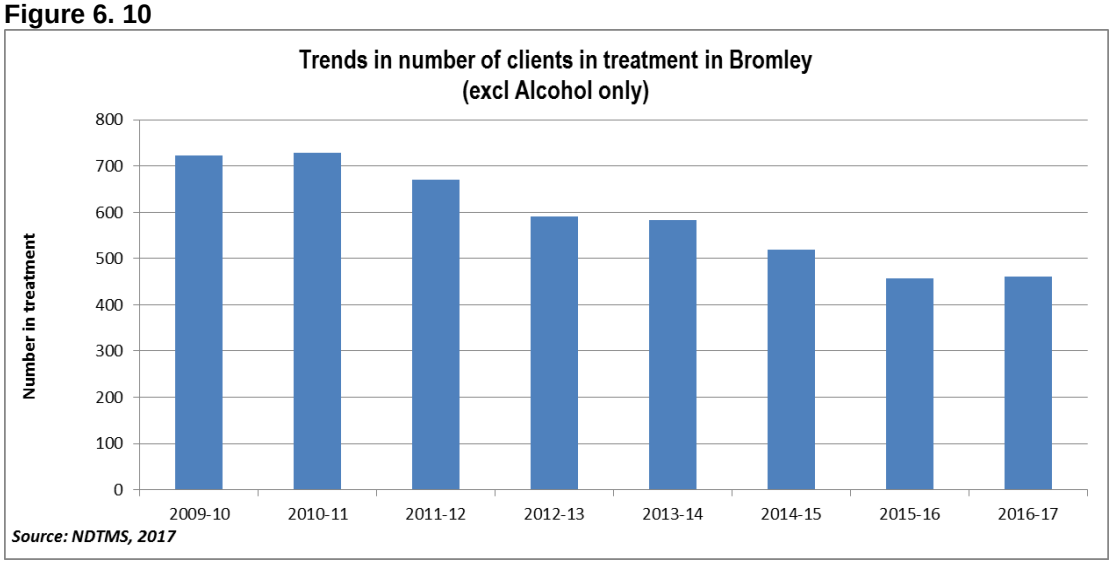
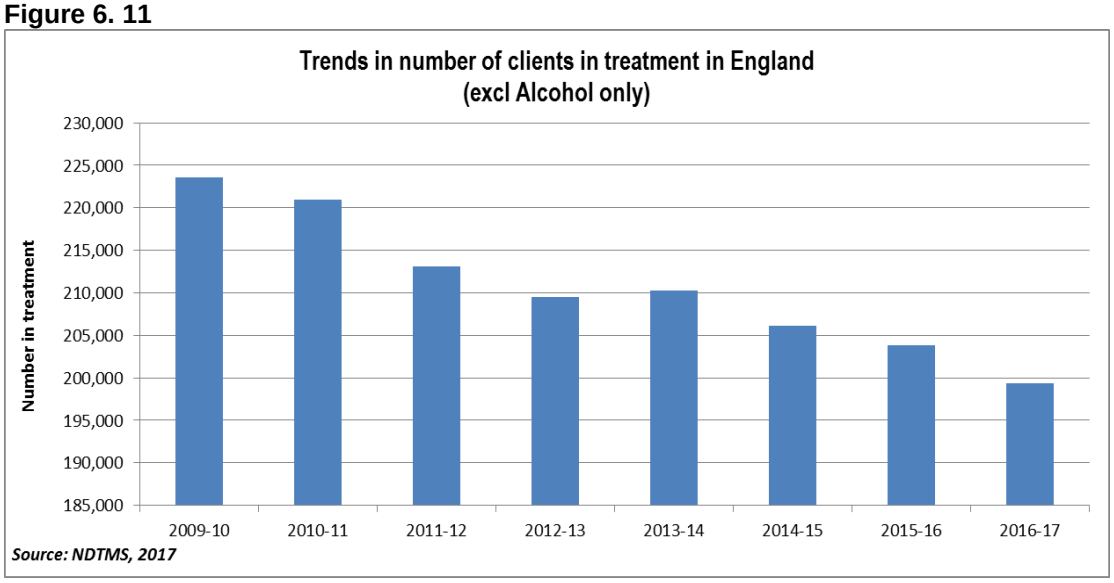


Figure 6. 11



The spikes and troughs in the number of new clients entering treatment in Bromley follow a similar pattern to the England trends (**Figure 6.12** and **6.13**).

Figure 6. 12

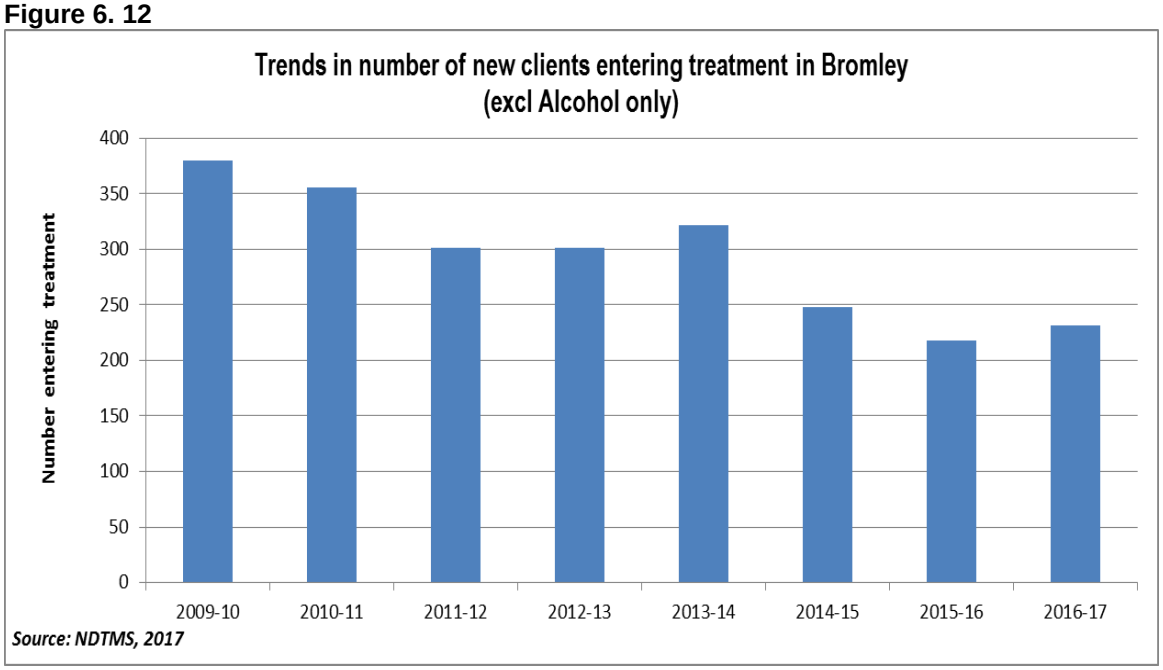
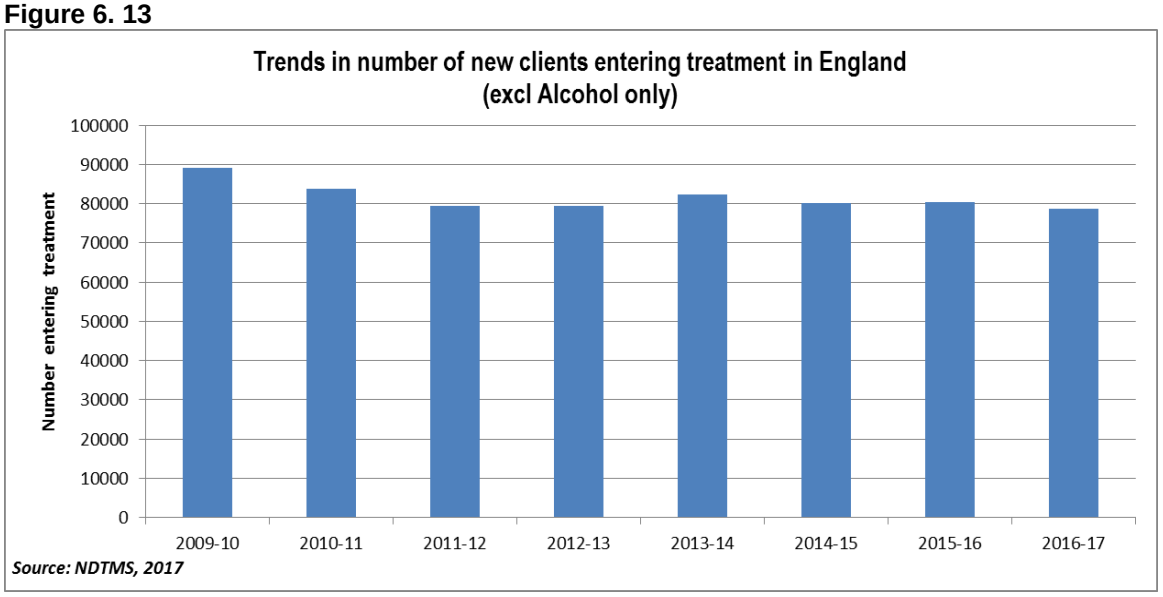


Figure 6. 13



Treatment Population Profile: Age

On average individuals are most likely to start using drugs in their late teens and early twenties.

The age distribution of individuals in treatment mirrors the patterns seen in the prevalence estimates, presented earlier (**Figures 6.4** and **6.5**).

The pattern of age distribution across the drug treatment population in Bromley is similar to England with the peak age group being 30-39 years. However the treatment population in Bromley appears to be slightly older on average compared to England. Nearly 50% of clients in treatment in Bromley are age 40+ compared to 44% in England. (**Figure 6.14**)

Figure 6. 14

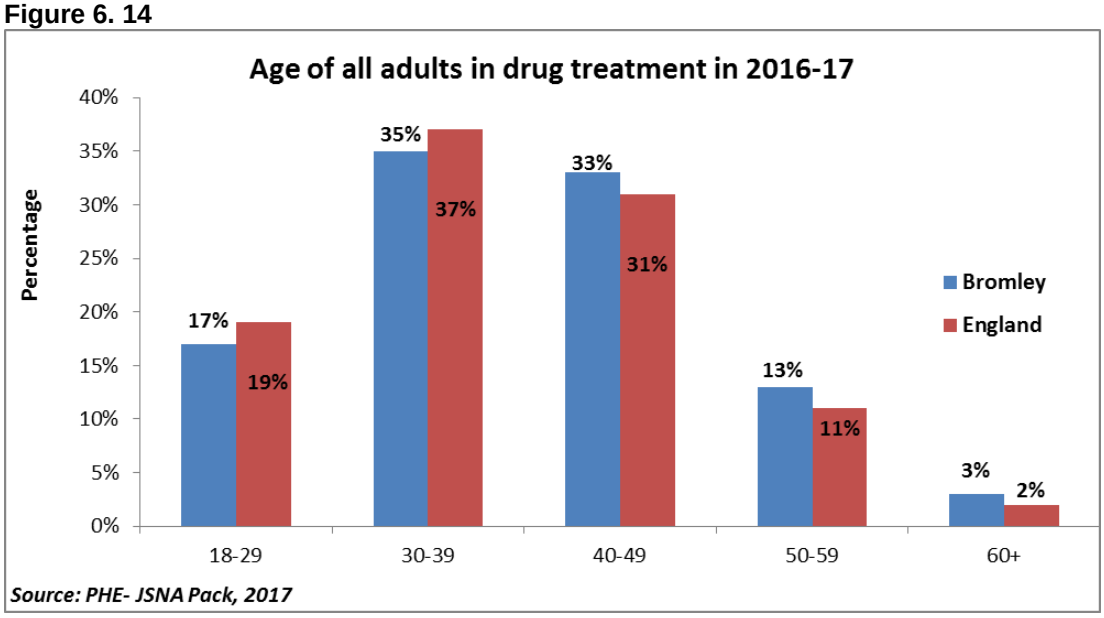
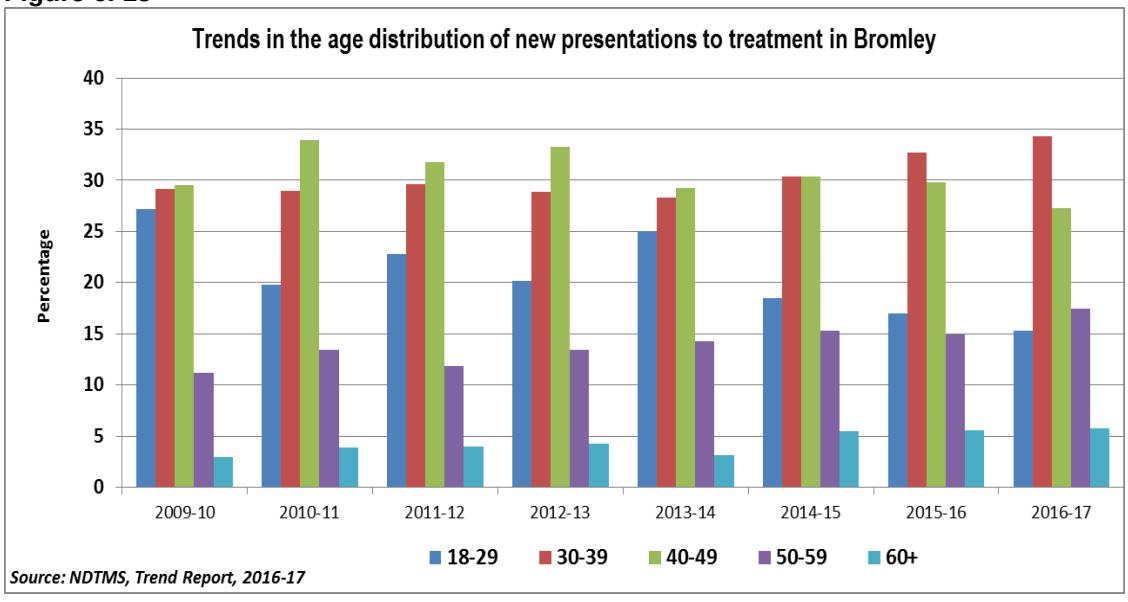


Figure 6.15 shows the trends in the age distribution of new presentations to treatment from 2009-10 to 2016-17 in Bromley. This indicates that the age profile of those presenting new to treatment in Bromley has shifted to an older population. There has been an overall decrease in the proportion of people presenting new to treatment aged 18-29 and an overall increase in the proportion of people age 50-59 and 60+.

This reflects the national trend which has seen a 27% increase in the number of clients aged 45 and over presenting new to treatment and a corresponding decrease of 38% in the numbers of those under 30 presenting to treatment.

Figure 6. 15



Treatment Population Profile: Gender

In Bromley, there were 460 adults in drug treatment services in 2016/17; of which two thirds (68%) were male, compared to three quarters (73%) in England. The gender split varied depending on the presenting substances both locally and nationally. Nationally, women make up 27% of adults in drug treatment, lower than Bromley at 32%. Women presenting to treatment often experience poor mental health, domestic violence and abuse, which may impact upon their recovery, and they are more likely to be carers of children[xlii].

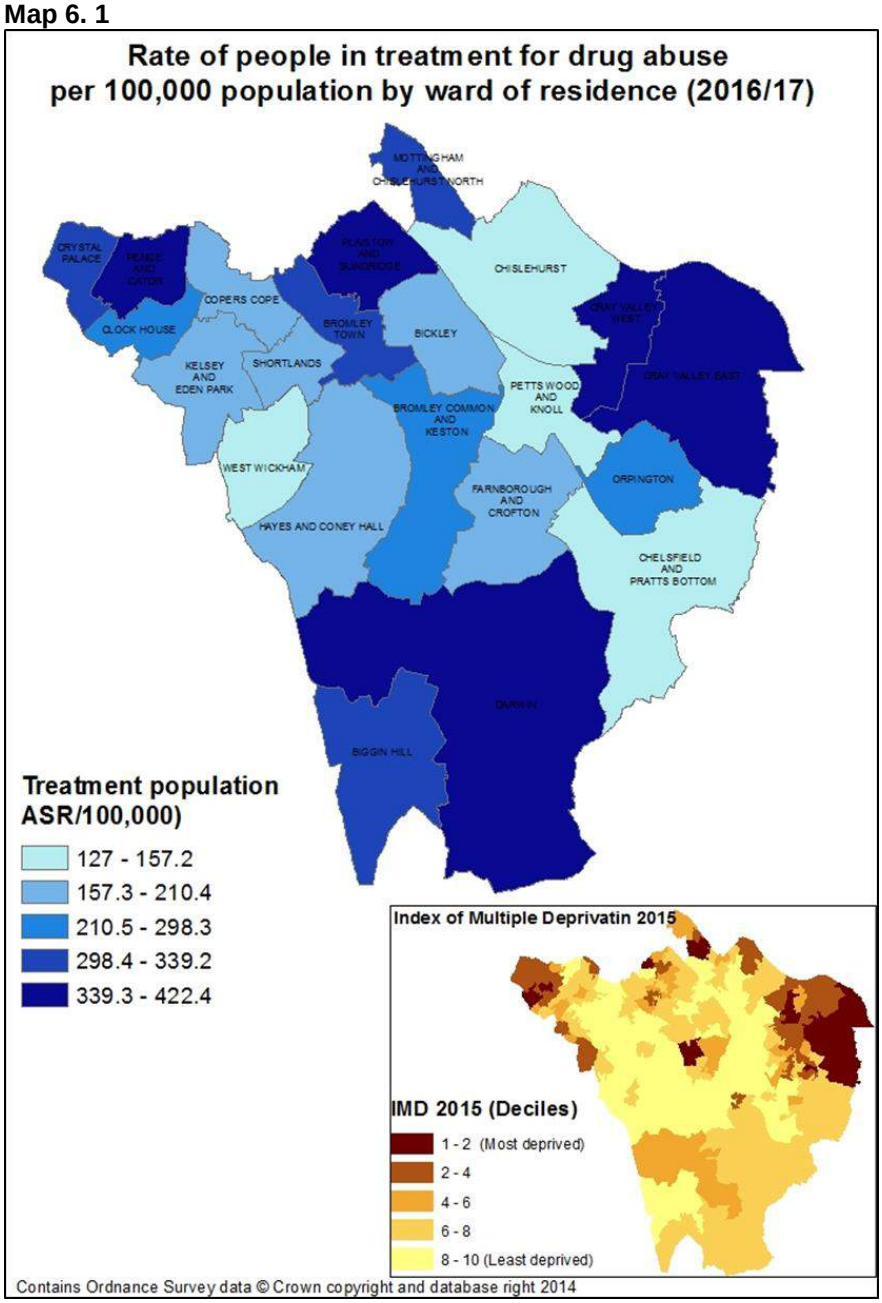
Treatment Population Profile: Geographical analysis

The relationship between deprivation and illegal drug use has been highlighted in a number of research studies. Evidence shows that deprivation is associated with the problematic use of particular drugs such as heroin and crack cocaine. Although the use of these drugs is not exclusively related to deprivation, it is much more common among people living in deprivation[xliv].

In Bromley the majority of clients in treatment in 2016/17 were living in the more deprived areas of the borough (**Map 6.1**). The map depicts the rates of treatment access across the wards in Bromley. In terms of the actual numbers of clients accessing treatment in 2016/17 the greatest number were living in the Crays, Penge and Cator, Crystal Palace and Mottingham and Chislehurst North.

Rates were highest in the Crays, Penge and Cator and Plaistow and Sundridge in the north and Darwin in the south of the borough. It should be noted that this doesn't represent a geographical analysis of the entire population of people currently misusing drugs in Bromley. It only represents those that had accessed and were receiving treatment in 2016/17. Further work is needed to better understand the unmet need amongst drug users in the population of Bromley who are not accessing services.

Map 6. 1


Rate of people in treatment for drug abuse
per 100,000 population by ward of residence (2016/17)
CRYSTAL PALACE
COPERS COPE
CLOCK HOUSE
BROMLEY TOWN
BICKLEY
CHISLEHURST
KELSEY AND EDEN PARK
SHORTLANDS
PETTS WOOD AND KNOLL
BROMLEY COMMON AND KESTON
WEST WICKHAM
FARNBOROUGH AND CROFTON
ORPINGTON
HAYES AND CONEY HALL
CHELSFIELD AND PRATTS BOTTOM
BIGGIN HILL
Treatment population
ASR/100,000)
127 - 157.2
157.3 - 210.4
210.5 - 298.3
298.4 - 339.2
339.3 - 422.4
Index of Multiple Deprivatin 2015
IMD 2015 (Deciles)
1 - 2 (Most deprived)
2 - 4
4 - 6
6 - 8
8 - 10 (Least deprived)
Contains Ordnance Survey data © Crown copyright and database right 2014

Treatment population with prior convictions

Table 6.6 presents the proportion of treatment clients with a prior conviction. The cohort is comprised of all clients in treatment at that point, but also includes clients who were in treatment at any point within the preceding year. Non-opiate and alcohol users contributed the highest number of clients with a prior conviction in Bromley in contrast to England, where opiates represented the highest group. However there were similar proportions of non-opiates, with 1 out of 3 clients both locally and nationally having a prior conviction.

Opiates had the lowest number of clients with a prior conviction in Bromley, representing 23% of the opiate treatment population in Bromley. England had higher proportions of opiate clients with a prior conviction compared to Bromley. Drug use coupled with prison sentence compounds the person's chances of recovery and re-integration into society. There is a need for continued work to engage with prison services.

Table 6. 6

Number and proportion of clients in the treatment population in 2012 with convictions in the two years preceding treatment				
	Bromley		England	
	number	%	number	%
Opiate	31	23%	14.646	32%
Non-opiate	47	20%	13,164	21%
Non-opiate and alcohol	50	36%	9470	36%
All	128		22649	

Source: PHE- PCC Support Pack, 2017

New to Treatment Population Profile: Gender and Ethnicity

Half (50%) of the drug treatment population in Bromley in 2016/17 were new to treatment compared to 39% of the national drug treatment population. Gender wise in Bromley, 53% of the males in treatment were new compared to 43% of the females.

The majority (84%) of new presentations to drug treatment in Bromley self-reported as White British, this is in keeping with the general ethnic profile of the borough. In line with the majority presenting, 93% of clients also reported UK as their country of origin. In terms of sexuality, 3% of the new presentations to Bromley drug treatment services self-reported as Gay, Lesbian or Bi –Sexual. 15% of the clients entering treatment self-reported as having at least one disability. It is important that treatment services in Bromley are able to adapt to the needs of these client groups.

Predicting the future treatment population

As part of its evidence review for the new National Drugs Strategy, Public Health England produced estimates of the size and characteristics of the drug treatment population in England over the next 4 years (to 2020)[xxxvi].

- Overall, it is projected that the number of people in treatment for opiate misuse will fall over the next four years, with fewer people starting treatment than leaving, particularly those new to treatment.
- The proportion of opiate users, both in and out of treatment, aged 45 and over will continue to increase and this will have significant implications for their health and mortality risks. Drug treatment will need to respond to a range of age-related, long-term health conditions (which may be exacerbated by other drug use and smoking) and actively support referrals for primary and specialist care.
- As treatment services become more widely populated by those with entrenched drug use it is predicted that overall, the rate of completions for opiate users is likely to fall and local areas should take this into account when considering setting any performance target. It is much harder to effect behaviour change with people who have very entrenched patterns of use and their likelihood of achieving positive outcomes are greatly diminished when compared to opiate users who engage after a shorter period of use
- Overall, it is projected that the number of non-opiate users in treatment will remain relatively stable over the next four years, as has been the case in recent years.
- It is projected that the age profile of non-opiate clients will not change that much over the next four years, with the majority of presentations continuing to come from the under 35 age group.
- Changes may be seen in the types of non-opiate substances that individuals are presenting for, with a rise in the use of NPS and the decline seen over the last 10 years in benzodiazepine and crack cocaine presentations
- NPS will attract new populations to using drugs and the development of new referral pathways and partnerships to reach new and emerging groups of users will be essential. As will staff with the competences to work with new users and patterns of use.
- While drug treatment services should always have high aspirations for all people in treatment, it is important that expectations are also realistic and reflect different populations in treatment, with very different likelihoods of success.

Route into treatment

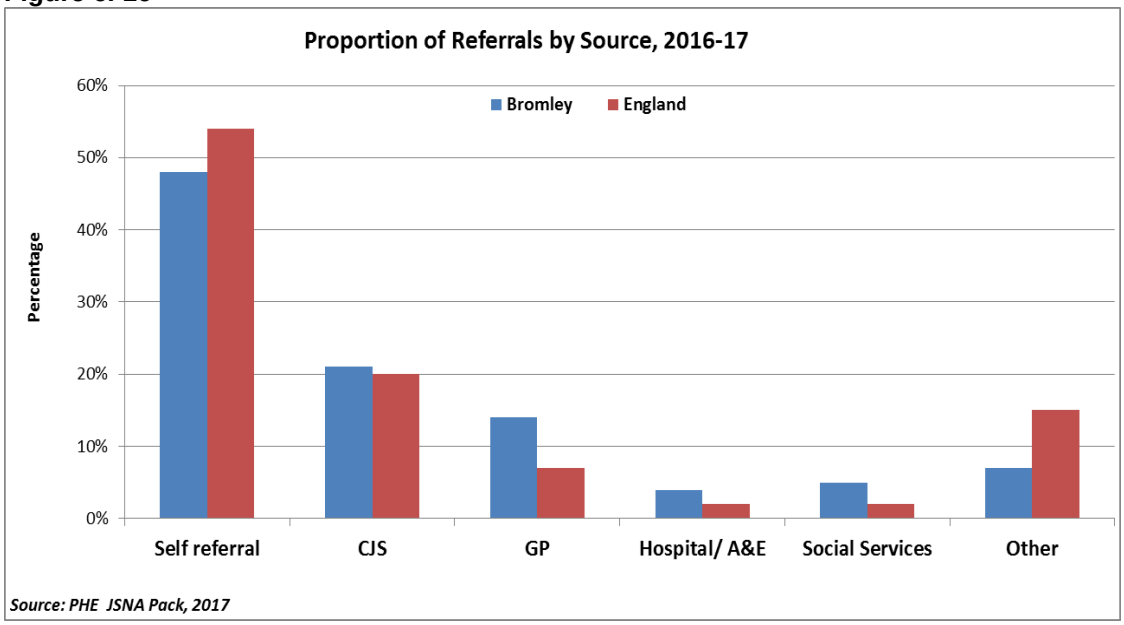
There are various possible sources of referral into treatment services

The most common source of referral for all drugs clients in both Bromley and England was referrals from self, family and friends. The second most common source of referrals was the Criminal Justice system (CJS) both locally and nationally. The proportion of referrals from “other” sources is higher nationally than in Bromley (15% compared to 7% respectively).

The groupings used in **Figure 6.16** and **Figure 6.17** differ as the trend data is grouped slightly differently to the data for the current year in the data source.

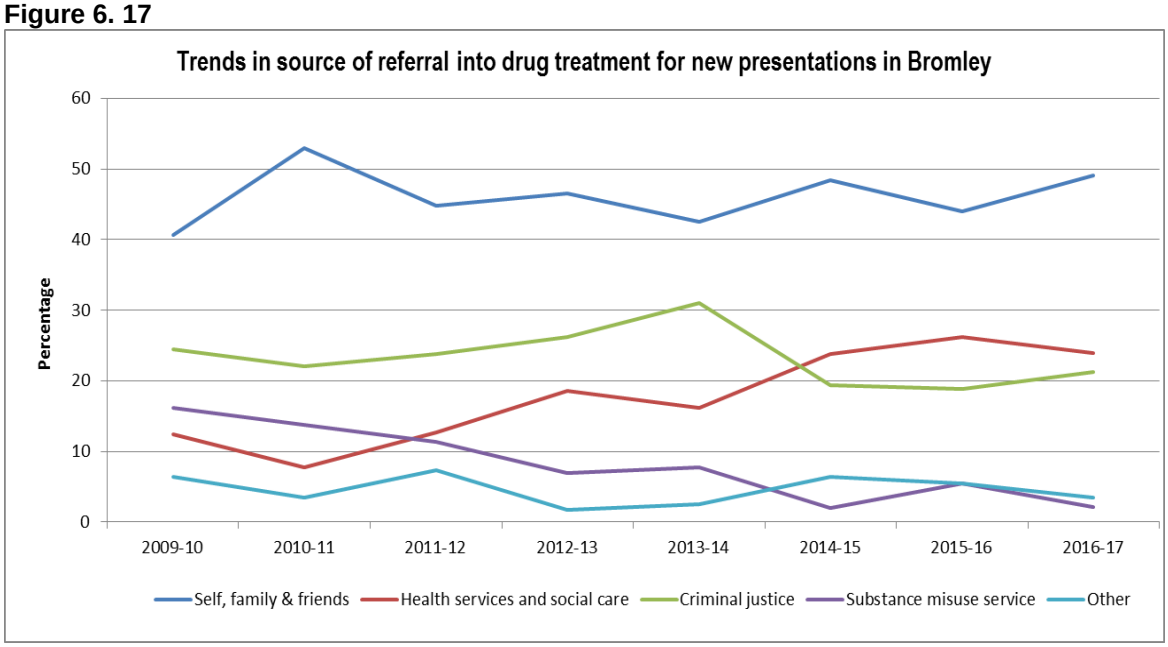
Trends show that self, family and friends still contribute greatly to referrals into treatment services. This means that the local community is a huge asset in improving service penetration in the high prevalence communities. The proportion of referrals through the health services and social care has generally increased while referrals from other substance misuse services[9] have seen a complete year on year reduction since 2009-10 (**Figure 6.17**).

Figure 6. 16



[9] Substance misuse services refers to any referral from another substance misuse service; including out of area substance misuse services or internal referral between agencies in the same area.

Figure 6. 17



Source: NDTMS Trend Report, 2016-17

Not in Treatment Population

Table 6.7 below presents the estimated proportion of drug users by substance group currently not in treatment. This gives an indication of unmet need in Bromley compared to England. Bromley has a higher estimated rate of individuals not in treatment for all substance groups compared to England.

Table 6. 7: Percentage drug users not in treatment by substance group

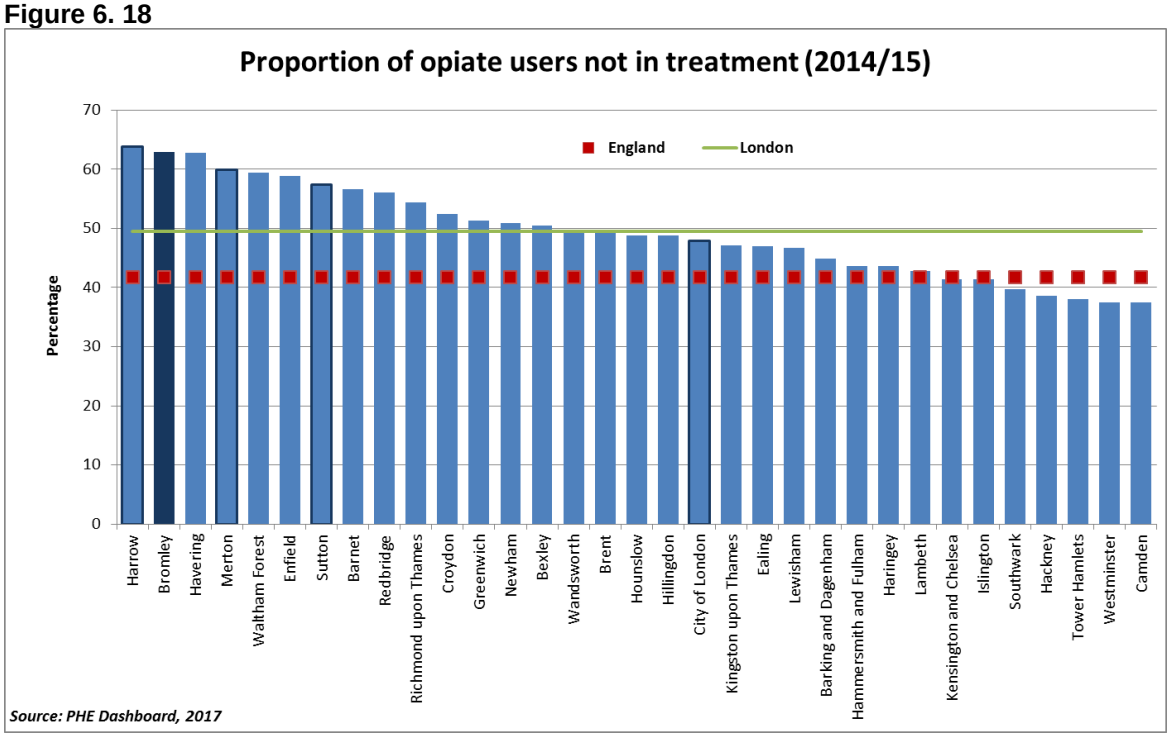
Percentage unmet need, 2014/15			
	Opiate &/or Crack	Opiate	Crack
Bromley	75	66	76
England	50	43	62

Source: PHE- JSNA Support Pack, 2018/19

Of note is the juxtaposition between the comparably low estimated prevalence of opiate use in Bromley (**Figure 6.2**) and the higher rates of substance users not in treatment (**Table 6.7** and **Figure 6.18**). The estimated number of opiate and or crack users and the rate of unmet need, together, could have a significant impact on crime, unemployment, safeguarding children and long term benefit reliance.

Data shows that 63% of drug users in Bromley are not known to treatment services (**Figure 6.18**). With this rate, Bromley ranks second highest in the region, comparable to the second lowest rates of Opiate use, lower than areas in the same national socioeconomic deprivation bracket. Bromley levels of unmet are second to only one LA in the region. In addition, Bromley ranks 14th out of 15 local authorities in England in the same socioeconomic deprivation bracket on proportion of unmet need in opiate users; where 1 is the lowest. Further work is planned to identify and profile drug users who are not in treatment in Bromley in order to inform strategies to target and successfully engage those in need of treatment.

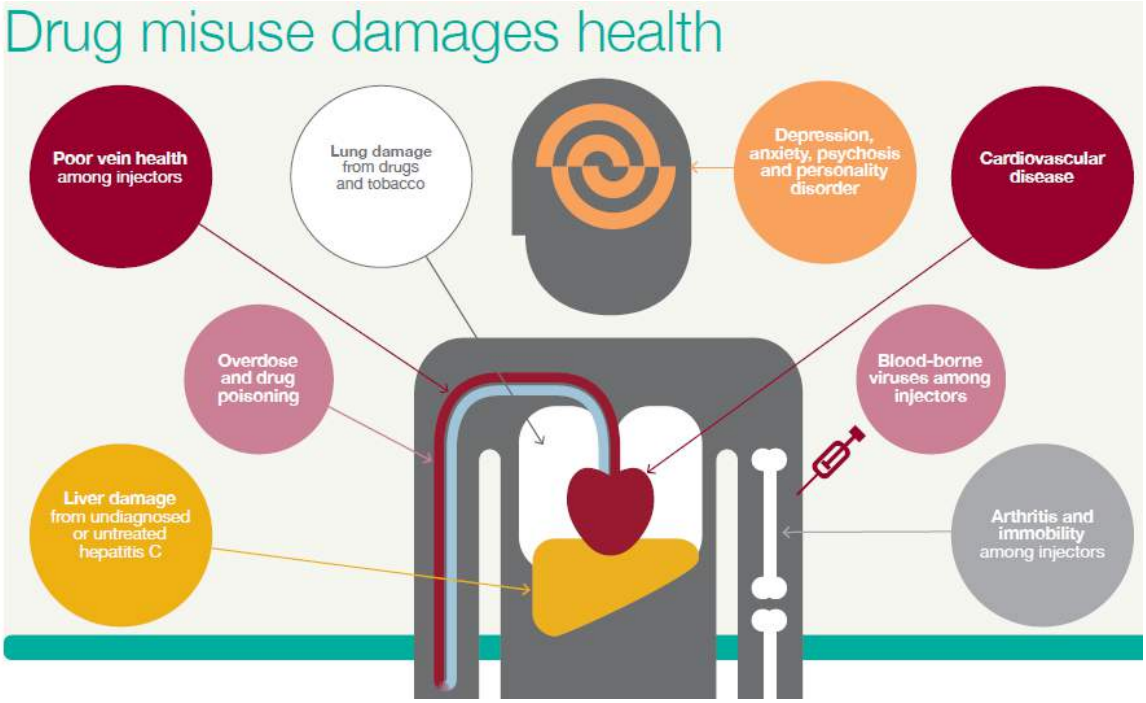
Figure 6. 18



Impact on Health and Wellbeing

Drug misuse can have a wide range of short and long term, direct and indirect effects on physical and mental health effects. The nature of these effects are often dependant on a multitude of factors, for instance; the specific drug or combination of drugs used, how they are taken, quantity taken, the person's underlying health, social factors and environmental factors[xlv].

Whilst people who misuse any type of illicit substance are at risk of health harms and even death, the most harmful effects of drug misuse are seen among opioid users. These include increased risk of death from overdose, increased risk of infection with blood-borne viruses (HIV, hepatitis B and hepatitis C), high levels of depression and anxiety disorders, social problems such as disrupted parenting, unemployment and homelessness, and increased participation in the acquisitive crime required to fund the habit.



Adapted from Public Health England[xxxviii]

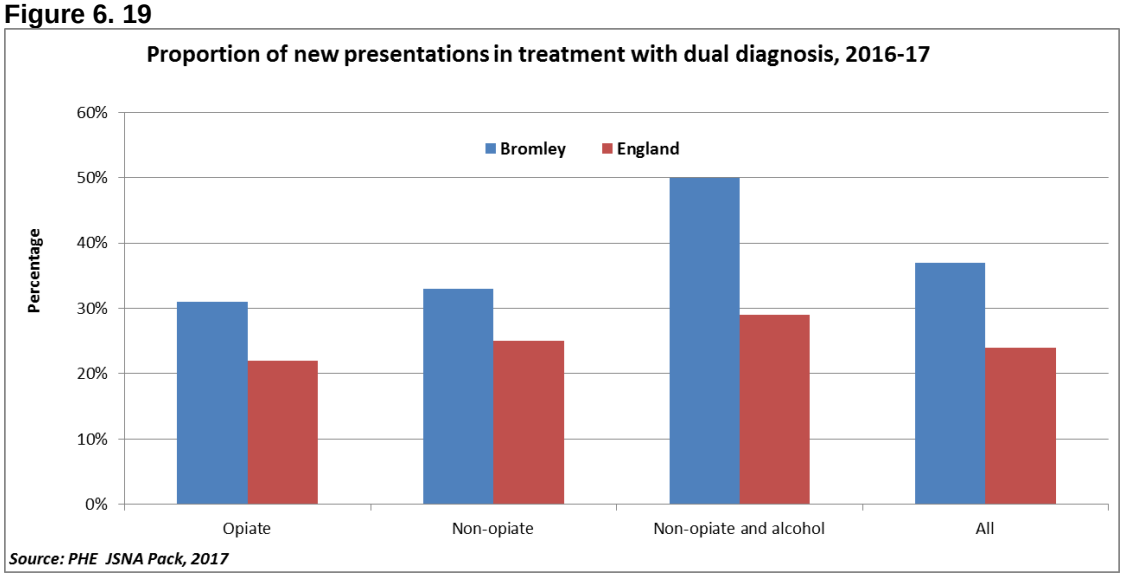
Mental Health (Dual Diagnosis)

Drug misuse is common among people with mental health problems and the relationship between the two is complex. Evidence shows that up to two thirds of people in drug services experience mental health problems[xlvi] and that people with co-occurring conditions have an elevated risk of other health problems and premature mortality[xlvi].

Psychiatric comorbidity is common in drug misuse populations, with anxiety and depression generally common and antisocial and other personality disorders more prevalent than in the non-user population[xlvii]. Drug misuse disorders complicated by other comorbid mental disorders have been recognised as having a poorer prognosis and being more difficult to treat than those without comorbid disorders[xlviii].

Figure 6.19 presents the proportion of clients entering treatment in 2016-17 who were also receiving care from a mental health service for reasons other than substance misuse. It is worth noting the incompleteness of reporting on dual diagnosis as well as the variation across partnerships in how dual diagnosis is defined in practice. With that said, Bromley seems to have higher proportions (37%) of new clients with a co-occurring mental health condition compared to England (24%). Analysis by substance group in Bromley shows that a similar proportion (around a third), of the new client group presenting for either opiate or non-opiate misuse were also receiving care from mental health services. However this proportion is higher in those who present for treatment for both non-opiate drug misuse combined with alcohol misuse. Half of new clients in this group were also receiving care from mental health services. The reasons behind the differing proportions of dual diagnosis clients in different treatment groups are likely to be complex.

Figure 6. 19



13% of new clients with missing or incomplete dual diagnosis status. Variation across partnerships in definition and recording of dual diagnosis

Figure 6.20 shows further analysis of the new presentations to treatment with a co-occurring mental health condition by substance group and gender. Overall, the proportion of women who are new to treatment and have a co-occurring mental health condition is higher than that in men both locally and nationally. (44% of all women in Bromley presenting new to treatment had a co-occurring mental health condition and compared to 33% of all men) and(nationally (the national proportions are 31% of all women and 22% of all men new to treatment have a dual diagnosis). Of note in Bromley, is the fact that half of the women new to treatment for non- opiate and non –opiate and alcohol presented with a dual diagnosis.

Figure 6. 20

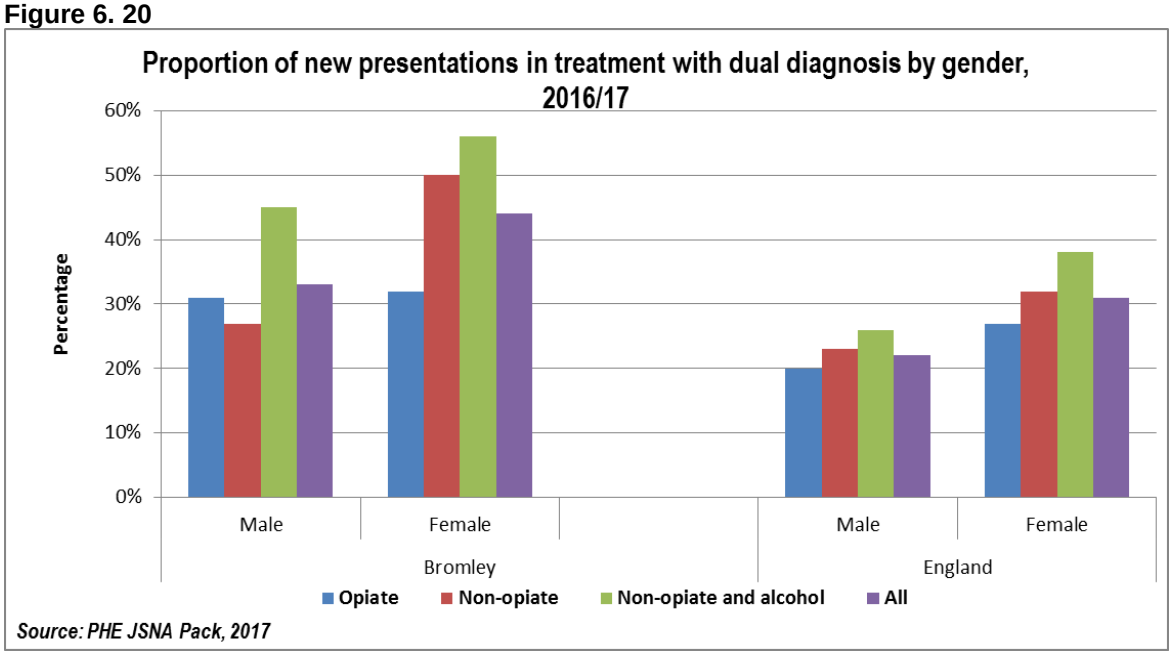


Figure 6.21 shows rates of dual diagnosis in Bromley compared to other London boroughs. This measure is indicative of levels of co-existing mental health problems in the overall drug treatment population and doesn't account for levels of co-existing substance misuse and mental health problems in the wider population not currently in contact with services. Bromley has the fifth lowest rates in the region, and significantly lower rates than the London average. When compared to other boroughs in the region with similar socioeconomic deprivation levels, Bromley rates are still lower.

Figure 6. 21

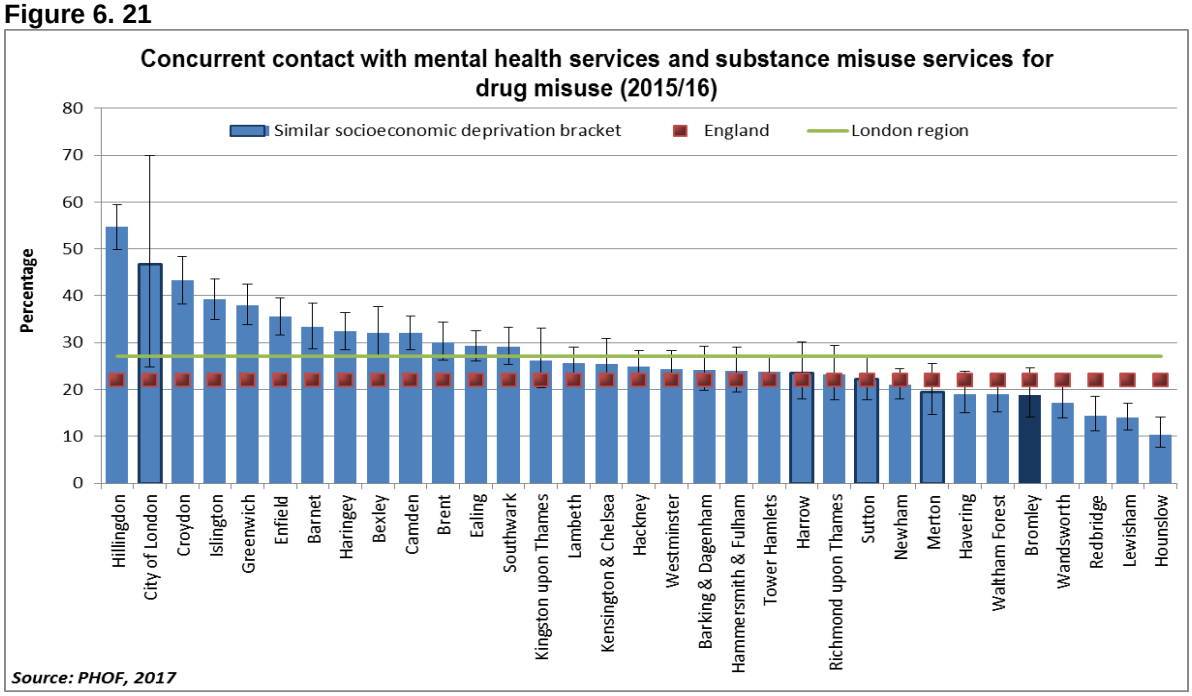
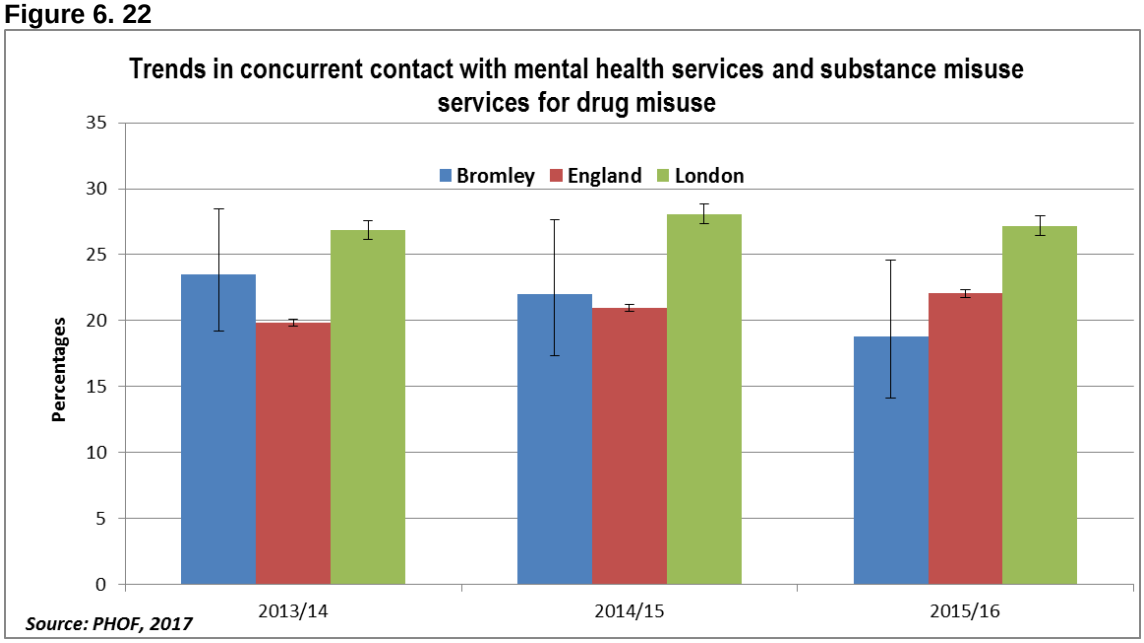


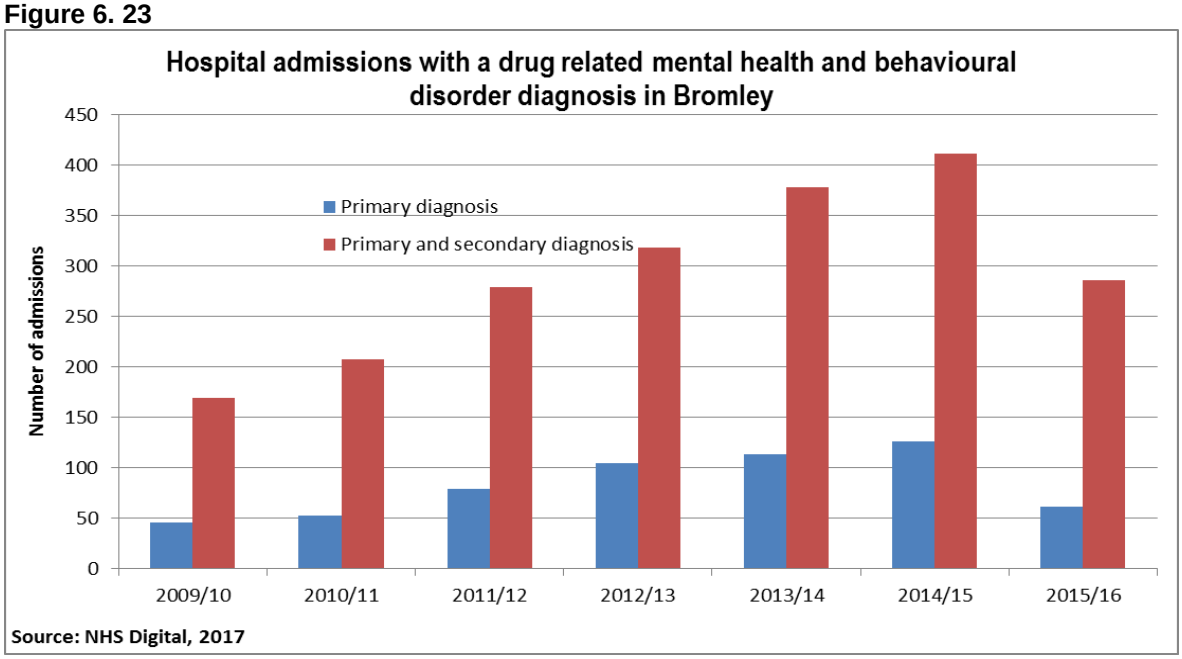
Figure 6.22 shows a downward trend of the proportion of people in concurrent contact with mental health services and substance misuse services in Bromley in contrast with the upward trend regionally and nationally. The wide overlapping confidence intervals in Bromley are indicative of the small numbers. However, in 2015/16, Bromley had significantly lower rates of clients in concurrent contact with mental health and substance misuse services than the regional average.

Figure 6. 22



In 2015/16 there were 286 hospital admissions in Bromley for drug related mental health and behavioural disorders (including primary and secondary cause of admission). **Figure 6.23** shows that, the number of admissions for drug related mental health and behavioural disorders in Bromley and were increasing year on year up until the latest recording period where rates fell for the first time in 5 years. It is worth noting that, admissions don't represent counts of patients, as a person may have more than one admission a year.

Figure 6. 23



Morbidity: Blood Borne Infections

Injecting drug users are at great risk of blood borne infections such as Hepatitis C and HIV, due to poor and non-sterile injecting techniques. Sharing injecting equipment is the single biggest factor in blood borne virus transmission among individuals who use and inject drugs and it elevates mortality risk. Providing opioid substitution therapy (OST), sterile injecting equipment and antiviral treatments is crucial in action to protect the users and their communities, and to provide long-term health savings.

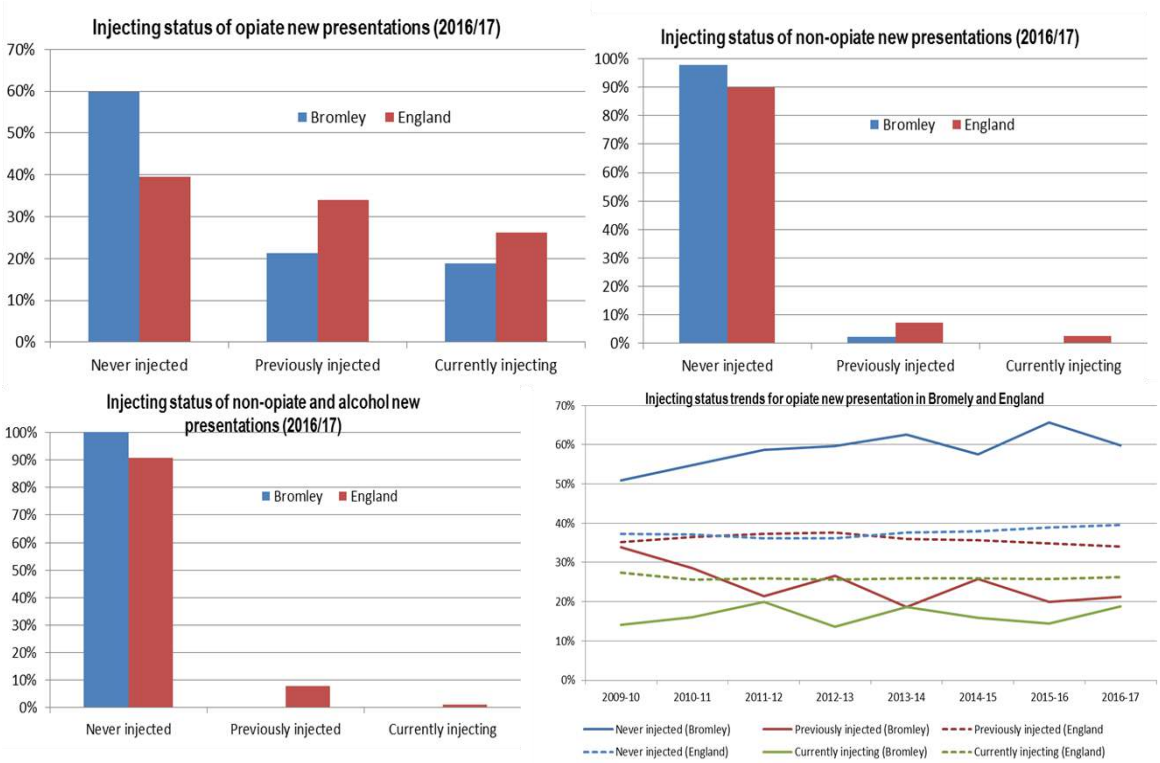
There are also concerns that some NPS are injected. This appears to be linked to members of three distinct populations: those who only use NPS but do so frequently; older drug users who appear to be supplementing or switching from established drugs that are prepared for injection; and those engaging in chemsex. A frequent pattern of NPS injecting among all these groups represents a significant concern for blood born virus transmission and health damage[xxxvii].

The majority of clients entering treatment have never injected drugs. However, among clients that reported injecting drug use, there is a variation between substance groups. Opiate clients were more likely to report injecting drug use

compared to all other substance groups (**Figure 6.24**). Bromley has higher proportions of clients presenting to treatment having never injected drugs compared to England in all substance groups (**Figure 6.24**).

Trends show consistently higher proportions in Bromley of new presentations reporting never having injected drugs and lower proportions in all other categories compared to England (**Figure 6.24**). The majority of non-opiate clients who inject are likely to be individuals using methamphetamine and mephedrone[xxx]. Due to disclosure controls on small numbers, it is not possible to present detailed analysis.

Figure 6. 24



Source: NDTMS Trend Report, 2017

HIV

HIV levels remain low but the risks of transmission in those injecting drugs remain.

In the UK, around 1 in 100 people who inject drugs is living with HIV. Most have been diagnosed and will be accessing HIV care. However, the diagnosis often occurs at a late stage among injecting drug users[xlix]. Once diagnosed the uptake of HIV related care, including anti-retroviral therapy, is relatively high.

The level of HIV infection and the uptake of HIV related care among those injecting image and performance enhancing drugs is similar to that among those injecting psychoactive drugs.

Statistics show that over the last decade, around 1% of Bromley residents diagnosed with HIV and are accessing care probably acquired the infection

through injecting drug use compared to 2% in England. On average, 40% of all adults diagnosed with HIV in Bromley are diagnosed late.

Hepatitis C and Hepatitis B

Hepatitis C remains the most common infection among people who inject drugs, 90% of all cases of Hepatitis C diagnosed in the UK occur as a result of injecting drugs. Around 2 out of every five people who inject psychoactive drugs, such as heroin and mephedrone, are living with hepatitis C; half of these infections are undiagnosed. About 1 in 20 of those who inject image and performance enhancing drugs, such as anabolic steroids, are living with hepatitis C[xlix].

Hepatitis B is now rare, but vaccine uptake needs to be sustained. In the UK, around 1 in every 200 people who injected psychoactive drugs is living with hepatitis B infection. About three quarters of people who inject psychoactive drugs report taking up vaccines against hepatitis B, but the uptake level is no longer increasing. Vaccine uptake is much lower among people who inject image and performance enhancing drugs[xlix].

Due to the elevated risk of blood borne infection in this population, injecting drug users accessing treatment for substance misuse are tested for Hepatitis B and C and, if appropriate, vaccinated.

In 2016/17, 52% of new presenters to drug services in Bromley eligible for a hepatitis B vaccination accepted one, compared with the national average of 39%. It is worth noting that the vaccination conversion and completion rate in this treatment population is very low. Only 11% of those who accepted to be vaccinated actually started a course of vaccination and furthermore, only 12% of those completed a course of hepatitis B vaccination.

During the same period (2016/17), 79% of previously or currently injecting clients in treatment in Bromley received a Hepatitis C test, as compared with the national average of 83%. Nationally, there are similar proportions of men (83%) and women (84%) receiving hepatitis C tests, while in Bromley; more women (81%) received the test in comparison to men (77%) in 2016/17.

Drug users with Long term conditions

Statistics on drug users with long term conditions is not readily available through administrative datasets; although it is known that they often have health and mental health problemsxxxvi. In early 2014, the medical records of ten out of twelve patients who had died from drug related causes in the previous 12 months in Bromley were examined. It was found that half of these patients had one or more, some had a history of depression, and a smaller proportion had been in contact with services for their drug use.

Hospital Admissions

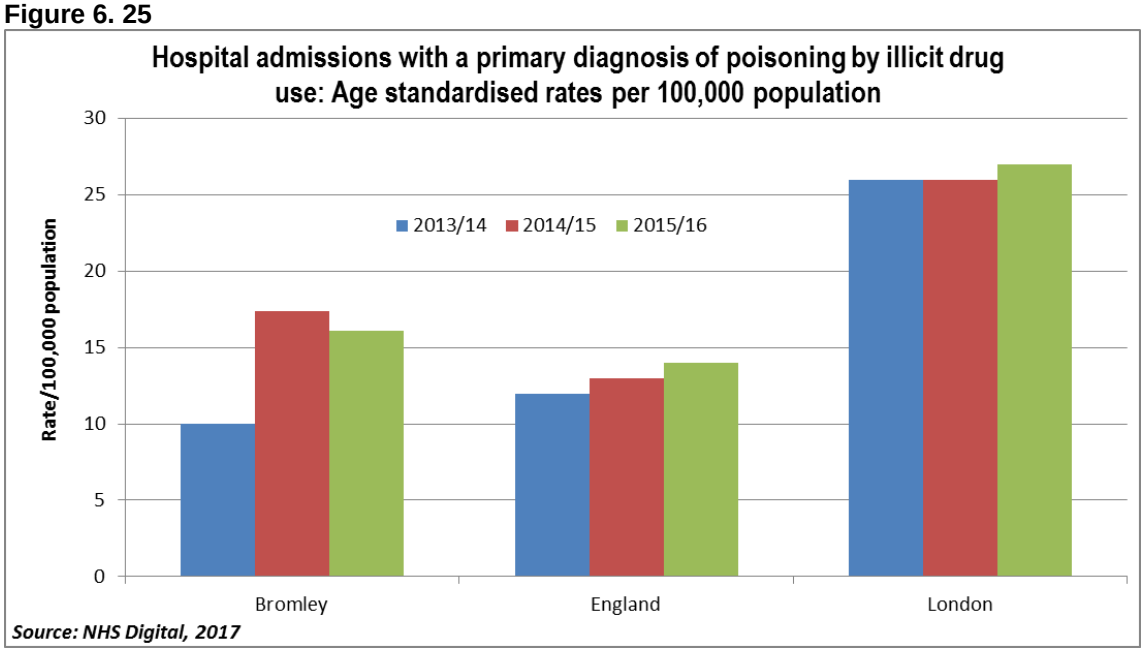
As well as being a key issue for secondary care, hospital admissions due to drug poisoning can be an indicator of future deaths. Evidence shows that people who experience non-fatal overdoses are more likely to experience a future fatal overdose[l].

In 2016/17, hospital admission rates[10] for drug poisoning in Bromley were significantly lower than the national rate at 22.3/100,000 and 52.3 per 100,000 respectively. These include admissions where drug poisoning was the primary or secondary cause of admission and also includes poisonings by “other opioids” which may include poisonings by non-illicit or prescribed opioids.

Figure 6.25 presents admission trends with a primary diagnosis of poisoning by illicit drug use. These rates are not comparable to the 2016/17 data because of the exclusion of admissions with a secondary diagnosis of drug poisoning, meaning that it isn’t a complete picture of illicit drug poisoning inpatient activity in Bromley. That said, the rates in Bromley are erratic over the last three years, in contrast to the upward trends in England and London. It is not known if the difference seen within and between the geographies is statistically significant.

[10] All persons, crude rate per 100,000 (PHE- JSNA Support Pack, 2018/19)

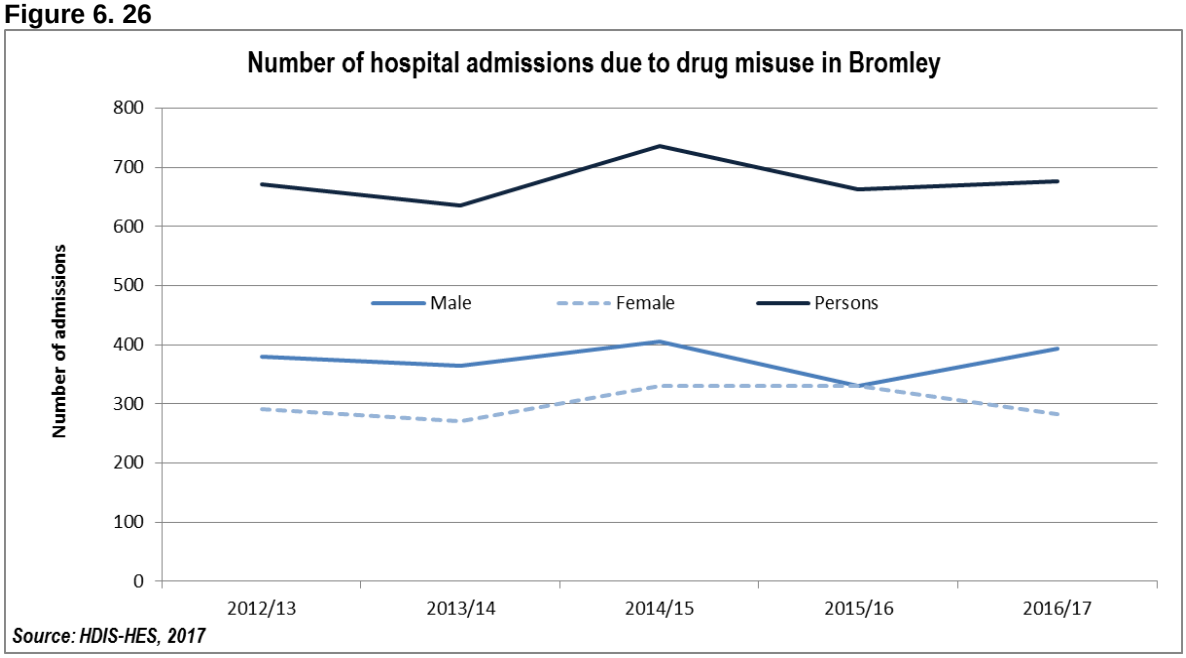
Figure 6. 25



Hospital admissions: age and gender

Local data indicates that, in 2016/17, there were 677 admissions with a primary or secondary diagnosis of drug misuse[11] in Bromley 15 years and over. Admissions in men were 1.3 times those in women.

Figure 6. 26

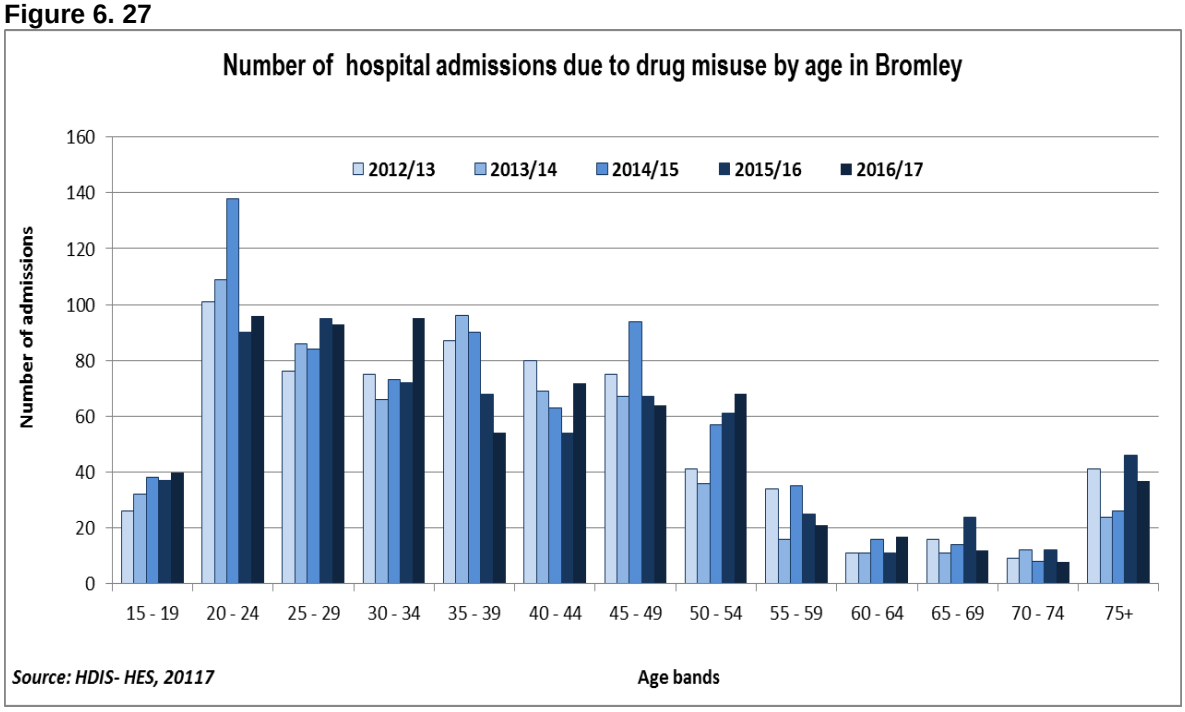


Analysis of local hospital episodes data shows that rates of hospital admissions for substance misuse are highest in young people. The high rate in the under 25s is

[11] For Further information on relevant ICD-10 codes refer to Table 2 in the Appendix

particularly driven by those aged 20-24 years (**Figure 6.27**). The numbers of admissions across the age groups follow varied trends, with some groups going up (15-19 years, 25-29 years and 50-54 years) while others are erratic or reducing (35-39 years and 55-59 years).

Figure 6. 27



Comparative and trend analysis **(in Figure 6.28 and 6.29)** shows that Bromley has significantly higher rates of hospital admission rates for substance misuse in young people 15-24 years old[12] than England and London and data shows a worsening trend. The rate in Bromley is worse than all the London boroughs in the same socioeconomic deprivation bracket (Merton, Sutton and Harrow). Although hospital admission rates in young people are increasing year on year; nationally and regionally, the increase in Bromley is steeper (**Figure 6.29**).

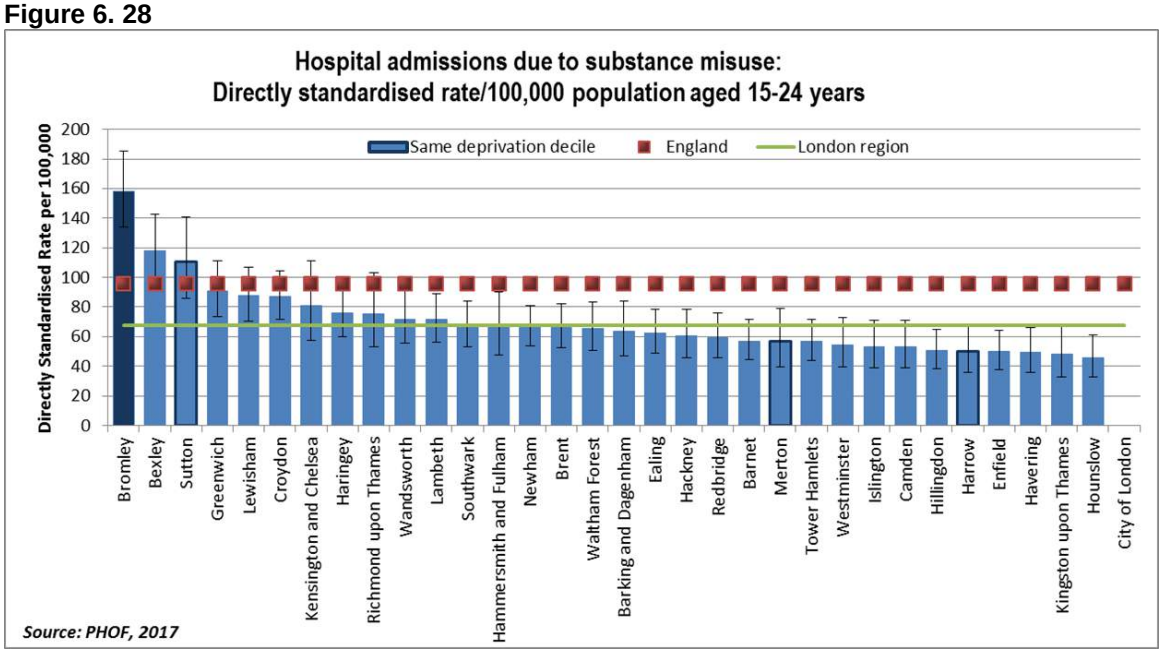
The estimates of the prevalence of opiate and crack use in Bromley, previously presented in this report (**Figure 6.6**), show that the rates of use of these types of substances in young people is relatively low. However the estimates suggest an upward trend in this age group which may be contributing to the high volume of inpatient activity for substance misuse in this cohort in Bromley.

Among young people, drug use is linked to increased likelihood of a range of adverse experiences and behaviour including; truancy, exclusion from school, homelessness, time in care and serious or frequent offending[xlii].

[12] *This statistic doesn't include admissions related to alcohol; it is specifically related to the misuse of drugs and other substances.*

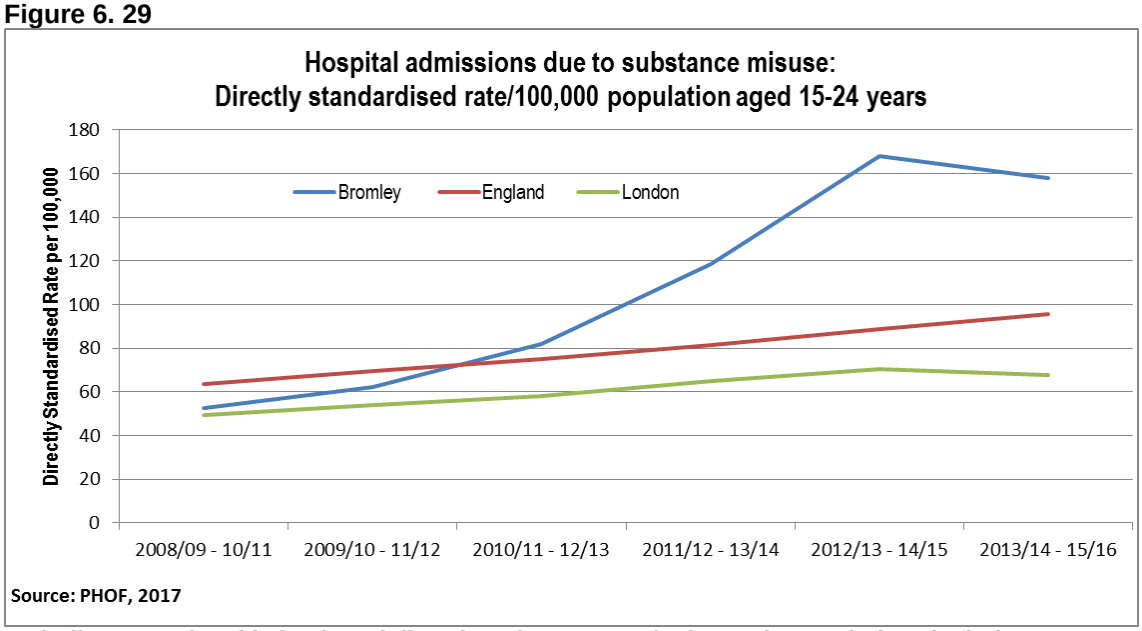
Further investigation of this increasing trend in hospital admissions for young people will be undertaken as part of the refresh of the new Children and Young People's Health Needs Assessment early in 2018.

Figure 6. 28



Including Mental and behavioural disorders due to use of tobacco but excludes alcohol

Figure 6. 29



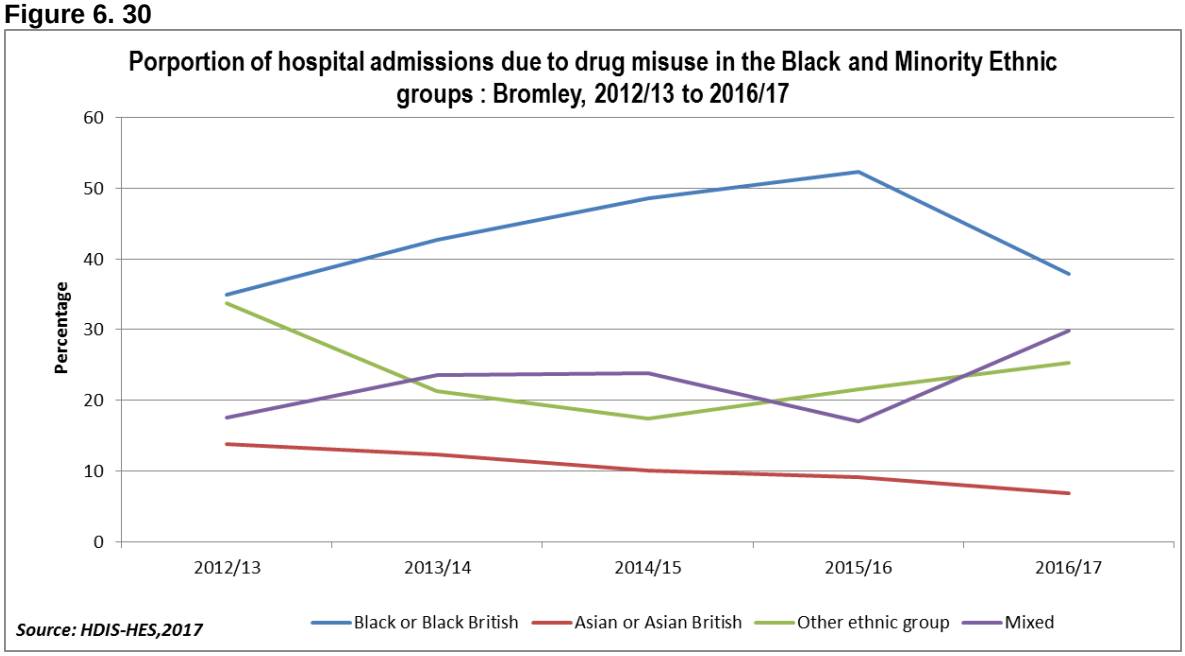
Including Mental and behavioural disorders due to use of tobacco but excludes alcohol

Ethnicity

In keeping with the general ethnic profile of Bromley, between 75% - 80% of hospital admissions are among the White British. The data for White British is excluded from **Figure 6.30** below to allow for visibility of the difference within and between the other groups. **Figure 6.30** shows the proportion of hospital admissions in the Black and Ethnic Minority groups. There has been a year on year increase in drug misuse admissions for people from Black or Black British

background as shown in **Figure 6.30** until the 27% reduction in the latest period. Admissions for Asian or Asian British are the lowest and have followed a steady downward trend, whilst the mixed and “other ethnic group” are erratic. The analysis does not allow for standardised comparison.

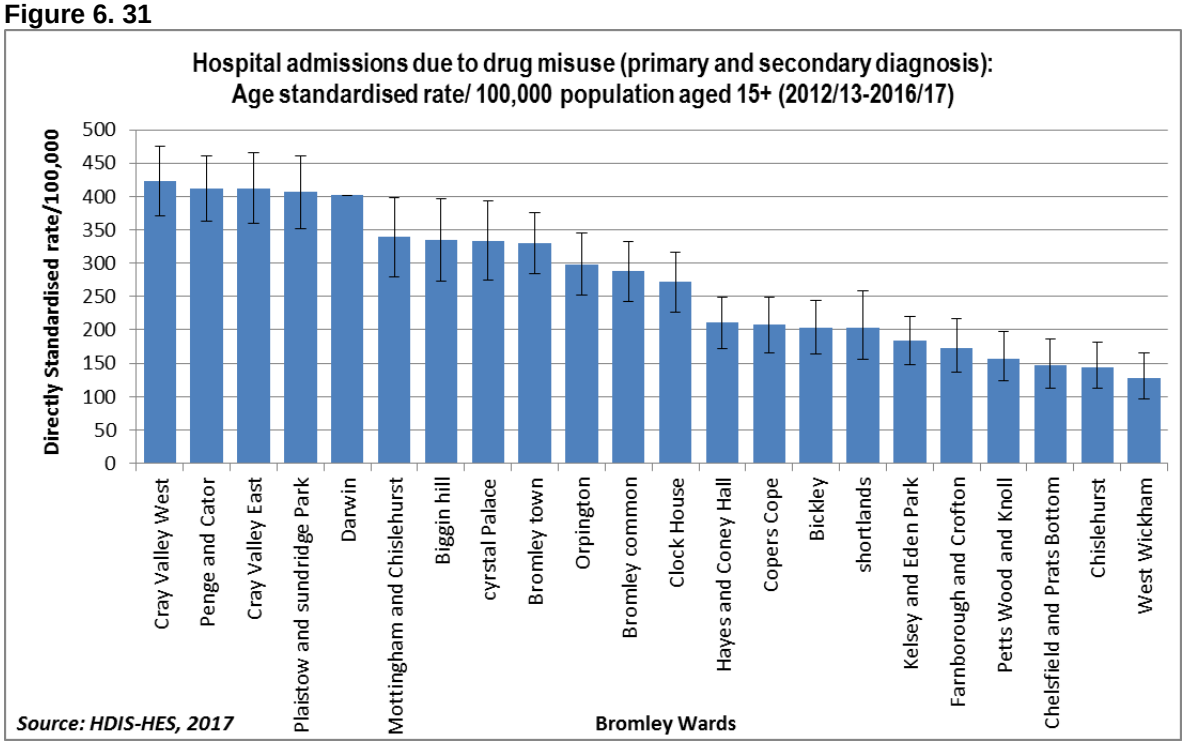
Figure 6. 30



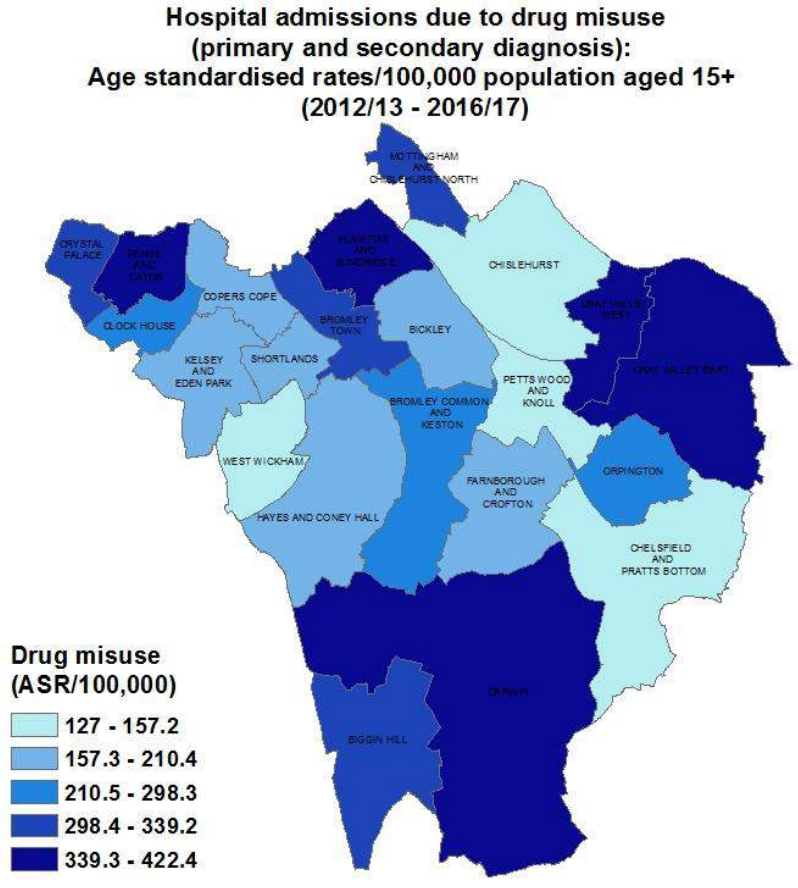
Geographical differences

It has been shown that rates of hospital admission due to drugs correlate strongly with area deprivation. In Bromley, the most deprived wards have the highest rates of hospital admissions as shown in **Figure 6.31** and **map 6.2.** There is a statistically significant difference between the 4 wards with the highest rates of hospital admissions and 10 wards with the lowest rates as shown in the figure below. It is worth noting that the wards with the highest rates of admissions for substance misuse are home to some of the most vulnerable people in Bromley, who experience poorer health outcomes and have significantly lower life expectancy than the average for Bromley.

Figure 6. 31



Map 6. 2



Mortality

Drug use and drug dependence are known causes of premature mortality. In 2016, there were 3,744 drug related deaths in England and Wales. There has been a dramatic increase in drug related deaths year on year since 2012 and mortality rates are now the highest since comparable records began in 1993.

The factors driving this increase are multiple and complex[xxxvii]:

- Deaths involving heroin have more than doubled from 2012 to 2015.
- Whilst drug poisoning deaths now account for 1 in 6 deaths amongst. people aged 20-30, there has also been a significant rise in drug related deaths in the older cohort of drug users (age 30-70).
- It is likely that many more deaths are occurring in people who are aging, long term users of heroin who are more susceptible to the risk of drug overdose due to their worsening health.
- Other factors include increasing suicides, increasing deaths among women, an increase in poly-drug and alcohol use, and an increase in the prescribing of some medicines.
- Deaths caused by new psychoactive substances are also increasing. It is likely that NPS deaths may be under-reported because they may not be tested for during post-mortems as widely or comprehensively as other drugs.

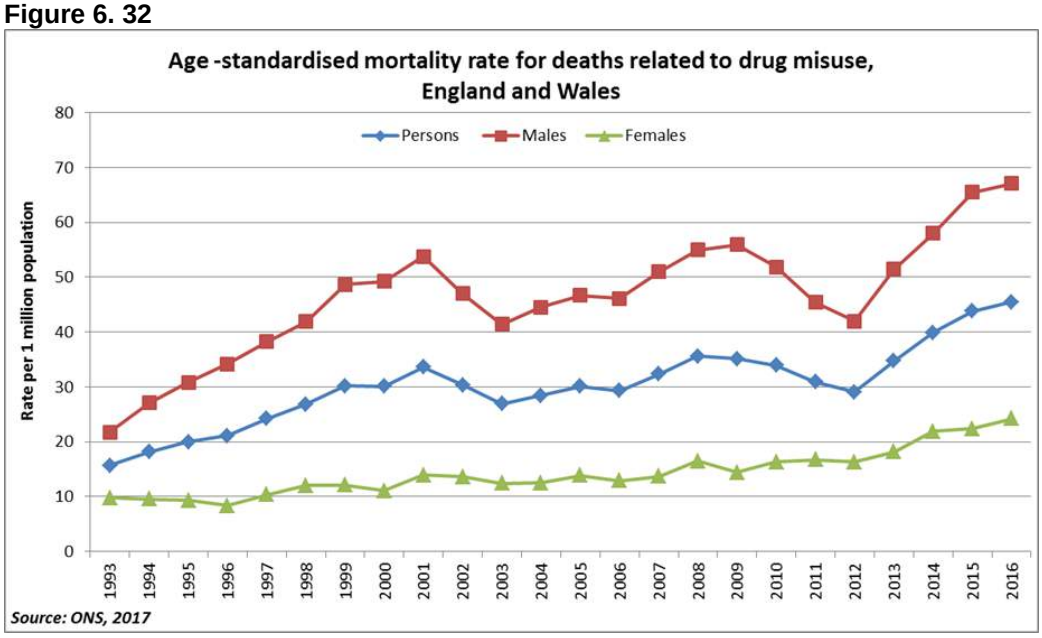
Mortality data are currently presented for two distinct groups, those where the underlying cause is:

- drug abuse/dependence on an illegal drug, and
- drug poisoning involving a controlled drug (legal or illegal).

Deaths from opioids may be counted in either group, depending on whether death was due to a drug-related condition or whether it was due to overdose or poisoning. The second category includes many other drugs, including those that are prescribed, such as Tramadol and anti-depressants.

Age-standardised death rates for drug misuse in England and Wales have increased since 1993, with peaks in 2001 and 2008, and another increase from 2013. Deaths in males have increased by 87% since 1993 and by 19% for women (**Figure 6.32**).

Figure 6. 32



Deaths due to drug poisoning in England have showed a similar trend; with a peak in 2009, a fall until 2012, and a year on year increase from 2013. Of the 3,744 drug poisoning deaths (involving both legal and illegal drugs) registered in 2016 in England and Wales, over two thirds were in males. Female drug misuse deaths have increased steadily from 2009, and by 52%, from 459 in 2012 to 697 in 2016. In 2016, males aged 40 to 49 years had the highest mortality rate from drug misuse, followed by males aged 30 to 39 years.

Heroin and morphine remain the substances most commonly involved in drug poisoning deaths. 1209 deaths involved heroin or morphine in 2016; a steady rise from 579 deaths in 2012. Deaths involving tramadol have fallen, with 184 deaths in 2016. However, this is still double the number seen in 2009 (87 deaths). Deaths related to the misuse of cocaine and benzodiazepines have continued to rise nationally and there have been recent increases for some new psychoactive substances, like synthetic cannabinoids (often referred to as SCRAs)[li].

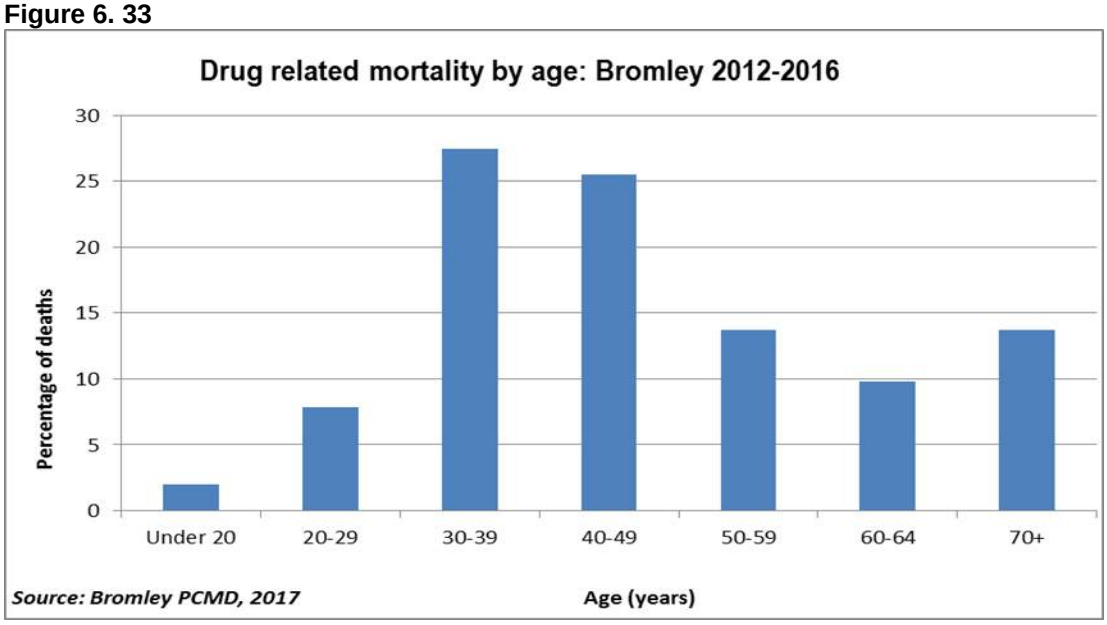
Deaths in Bromley

In Bromley, there were a total of 50 drug-related deaths between 2012 and 2016. The local data should be treated with caution due to the small number of observed deaths. The data has been aggregated over a five year period to increase events to levels which are more meaningful statistically and allow for easier illustration of underlying trends.

Demographic profile: Age and gender

Of the 50 drug related deaths in Bromley in 2012 and 2016, 57% were men. In terms of age, the highest proportions of drug-related deaths were among those aged 30-39 years (27.5%); and 40-49 years old (25.5%), (**Figure 6.33**). However, gender analysis by age shows the highest number of deaths in women, was in those aged 50-59 years and in men, those aged 30-39 years. The average age at the time of death was 47 years, ranging from 15 to 94 years old, and was 32 to 36 years less than the average life expectancy for men and women born in Bromley.

Figure 6. 33

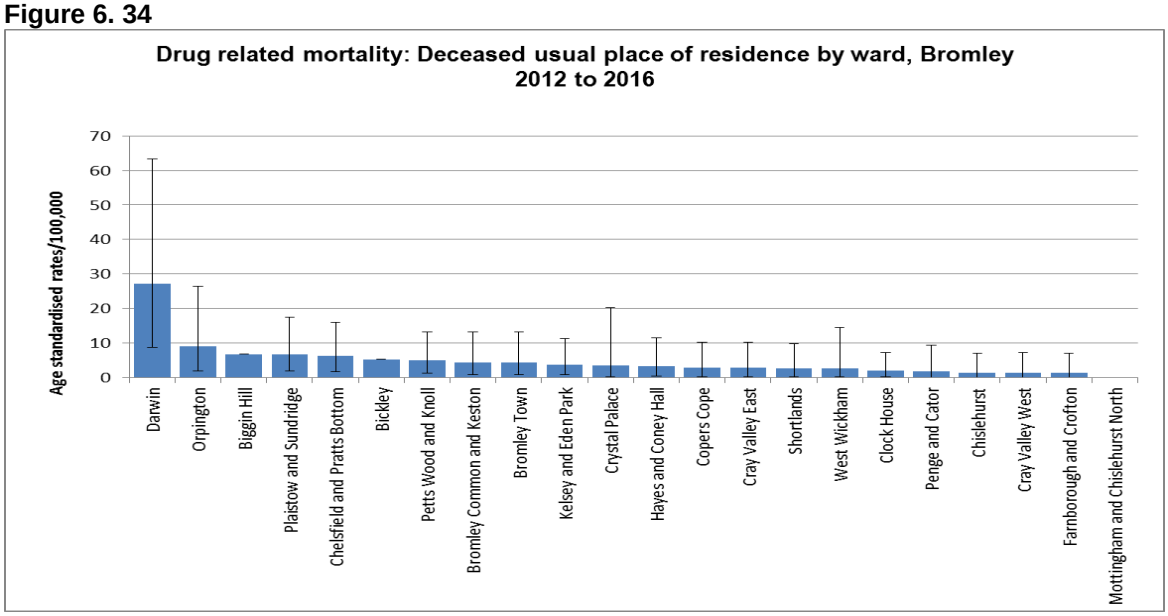


Place of Residence

Geographical analysis by usual place of residence shows that the highest mortality rate was found in Darwin (27.2 deaths per 100,000 population). There is no observable link between drug related death rates and deprivation in Bromley (**Figure 6.34**). Wards with relatively high deprivation scores have low mortality rates (Mottingham & Chislehurst, Cray Valley West and Penge & Cator) and at the same time also having high rates (Orpington). Due to the small numbers, Bromley rates have wide confidence intervals; meaning there is likelihood that the variation between wards is not precise estimate of the true underlying value, apart from the

difference between the ward with the highest rates (Darwin) and the ward with the lowest rates (Mottingham and Chislehurst North).

Figure 6. 34



Cause of Death

Table 6.8 shows drug related deaths in Bromley by the underlying cause of death. Accidental poisonings contribute hugely to the proportion of drug related deaths in both males and females both locally (67%) and nationally (55%). In 2016, 82% (1561) male deaths and 72% (501) female deaths were due to accidental poisoning in England and Wales. Due to small numbers in Bromley, deaths for 5 years combined have been considered. In 2012/16, 69% (20) male deaths and 64% (14) female deaths were due to accidental poisoning.

Table 6. 8: Drug related deaths 2012 to 2016

Drug related underlying cause of death by ICD-10 codes	% of deaths
Mental and behavioural disorders due to drug use (excluding alcohol and tobacco)	4
Accidental poisoning by drugs, medicaments and biological substances	67
Intentional self-poisoning by drugs, medicaments and biological substances	20
Poisoning by drugs, medicaments and biological substances, undetermined intent	10
Assault by drugs, medicaments and biological substances	-

Source: Bromley Primary Care Mortality Database, 2017

Trends

Local numbers are too small to analyse for trends in deaths from individual drugs.

Figures 6.35 and **6.36** show that nationally & regionally drug-related death rates have increased consistently since 2011/13. However in Bromley the trend is more erratic. There was a consistent rise in drug-related deaths between 2010/12 and 2012/14, in line with national and regional trends. However this was followed by a drop in local rates from 2013/15 to 2014/16. It is worth noting that Bromley rates are very erratic due to the relatively small number of drug –related deaths occurring each year, making it difficult to establish the overall direction of travel without smoothing these variations by analysing data over a longer time period.

Figure 6. 35

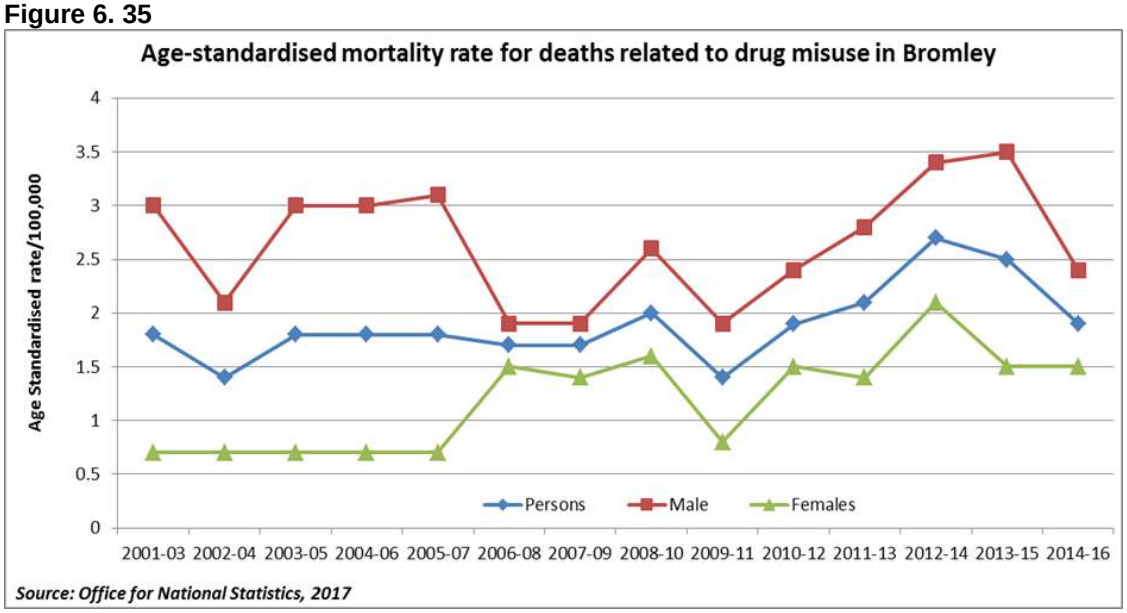
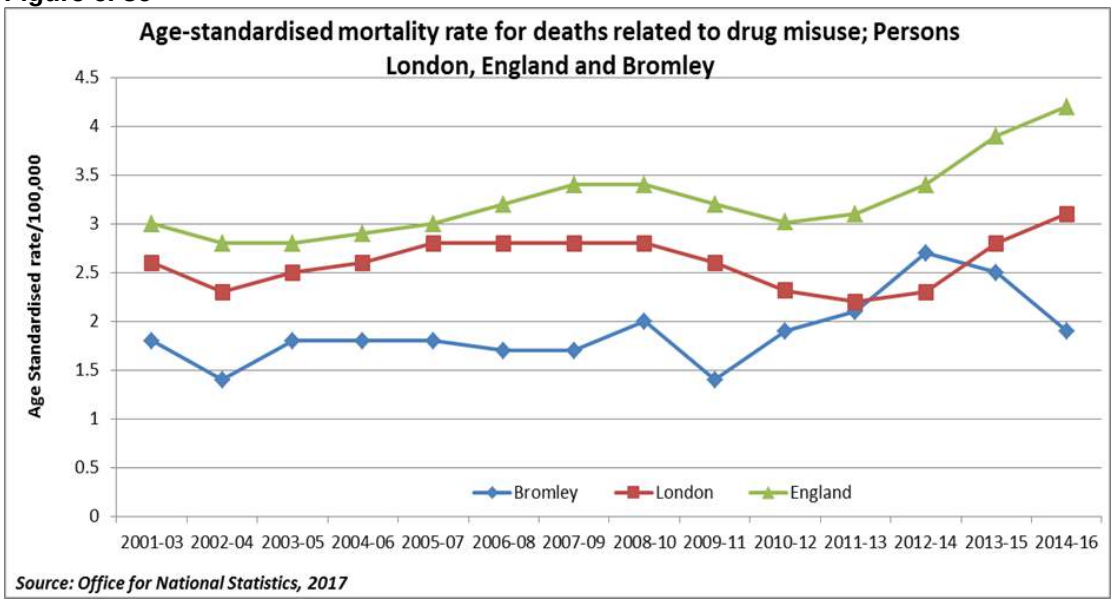


Figure 6. 36



Mortality: deaths in those not engaged in treatment

For many drug users, engaging in treatment is the catalyst for getting the medical help they need to address their physical and mental health problems. Getting drug users into treatment services is a challenge but is central to saving lives[lii]. The majority of drug misuse deaths in England occur among people who are not in treatment, and evidence shows that being in treatment is protective against the risk of mortality. Modelling shows that drug treatment in England prevented an average of 880 opioid-related poisoning deaths each year between 2008 and 2011[liii]. However every year, a small percentage of clients die while they are in contact with the treatment system.

Figure 6.37 provides a ratio comparing the observed number of deaths among adults in treatment over a three year period to the expected number if the local authority experienced the same age specific mortality rates as the whole drug treatment population in England. The ratio in Bromley is lower than expected and is among the lowest in the region, even lower than local authorities in the same socioeconomic deprivation bracket in the region (Harrow, Merton, Sutton). This shows that services in Bromley are contributing to reducing the risk of death amongst those clients that engage in treatment. The wide overlapping confidence intervals are indicative of small numbers and there is likelihood that the differences seen are not a precise estimate of the true underlying value.

Figure 6. 37

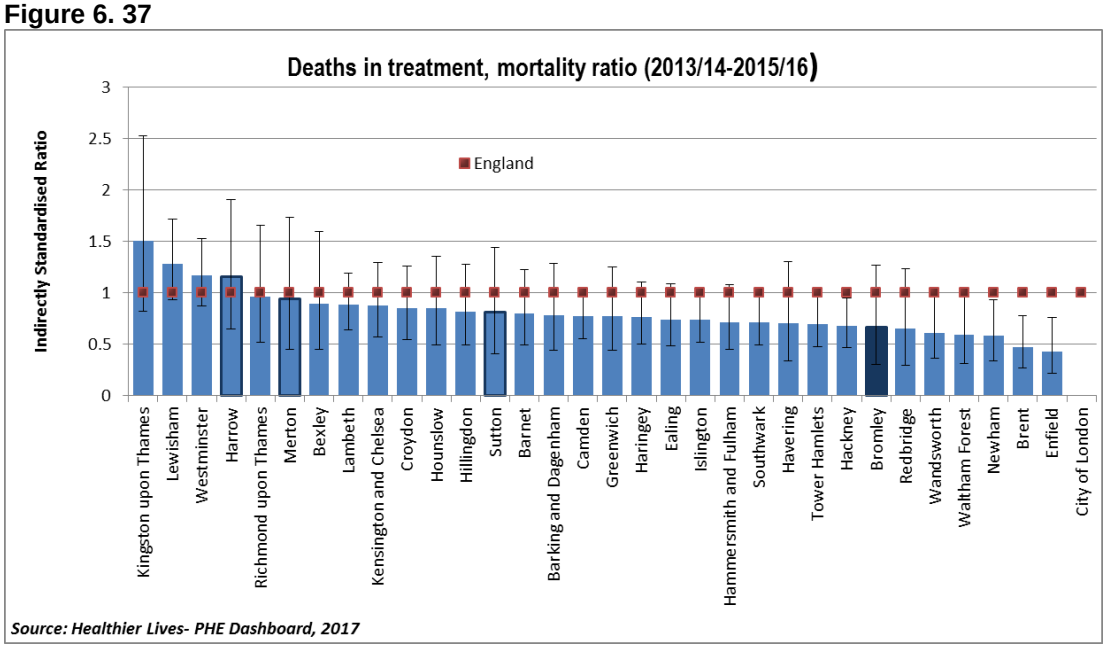
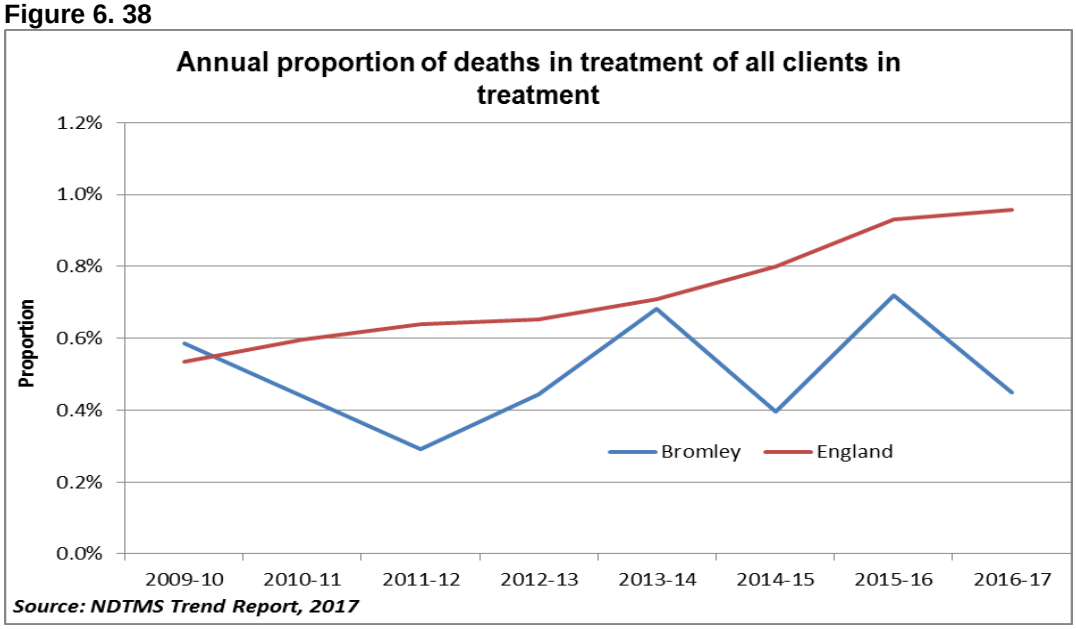


Figure 6.38 shows proportion of deaths in treatment of all the client population. National trends show there has been an increase in the proportion of deaths in treatment from 0.5% in 2009-10 to 1.0% in 2016-17. The rates in Bromley have consistently remained below the England average since 2009-10. However it should be noted that due to the small numbers, Bromley rates are very erratic and have wide confidence intervals. Although the death rates are low locally and nationally, every death is a tragedy which is potentially preventable and one which can have devastating and far reaching impacts.

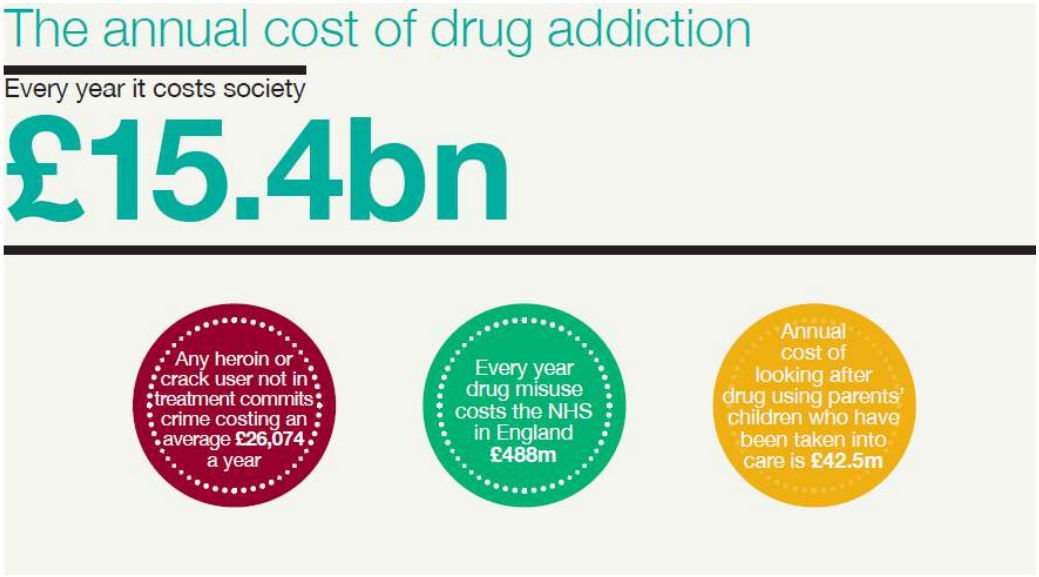
Figure 6. 38



Socioeconomic Impact

Today, drug misuse and dependency is associated with a range of harms including poor physical and mental health, unemployment, homelessness, family breakdown and criminal activity. The health and wellbeing of family members and carers can also be affected. Heroin and cocaine are associated with the majority of social costs associated with drug misuse[xxxvi]. People with heroin dependence usually develop a tolerance through daily use, which can result in an expensive addiction and a motivation to commit acquisitive crime. It was estimated in 2009 that adult drug users not in treatment typically spent £94/£231 (median/mean) a week in current prices on drugs and 40% of all acquisitive crime was drug-related[xxxvi]. It is further estimated that, any heroin or crack user not in treatment commits crime costing an average £26,074 per year in England.

As well as the social and economic impact on the individual, drug misuse causes a substantial economic burden to society and including costs to the health and care system and criminal justice system.



Adapted from Public Health England[xxxviii]

The Social Return on Investment in Local Drug Treatment Services

Investment in drug treatment can substantially reduce the economic and social costs of drug-related harm. Recent estimates suggest that the net cost-benefit ratio for evidence-based drug treatment in England is £1:£2.50, indicating that for every £1 spent on drug treatment services there is a net economic benefit to society of £2.50[xxxvii].

Public Health England have produced estimates for local areas on the social return on investment (SROI) of local drug treatment services. The following provides a

summary of some of the estimated gross cost-savings accrued to the borough of Bromley and its residents as a result of drug treatment provision in 2016/17.

Crime

Six billion of the social and economic cost of drug supply in England and Wales is attributed to drug-related acquisitive crime such as burglary, robbery shoplifting etc. Drug-related and drug-enabled activities are key drivers of both new and traditional crime: the possession of illicit substances; the crimes committed to fund drug dependence; the production and supply of harmful substances perpetrated by serious and organised criminals alongside drug market violence associated with human trafficking and modern slavery. Drugs can also play a part in facilitating child sexual exploitation and abuse and the illicit use of drugs in prisons is a driver of rising violence, self-harm and suicide[xxxvi].

It is estimated that, any heroin or crack user not in treatment commits crime costing an average £26,074 per year in England.

PHE estimate that a total of 33,951 crimes were committed in Bromley due to drug use in 2016/17 but drug treatment prevented approximately a further 6500 crimes being committed in the borough.

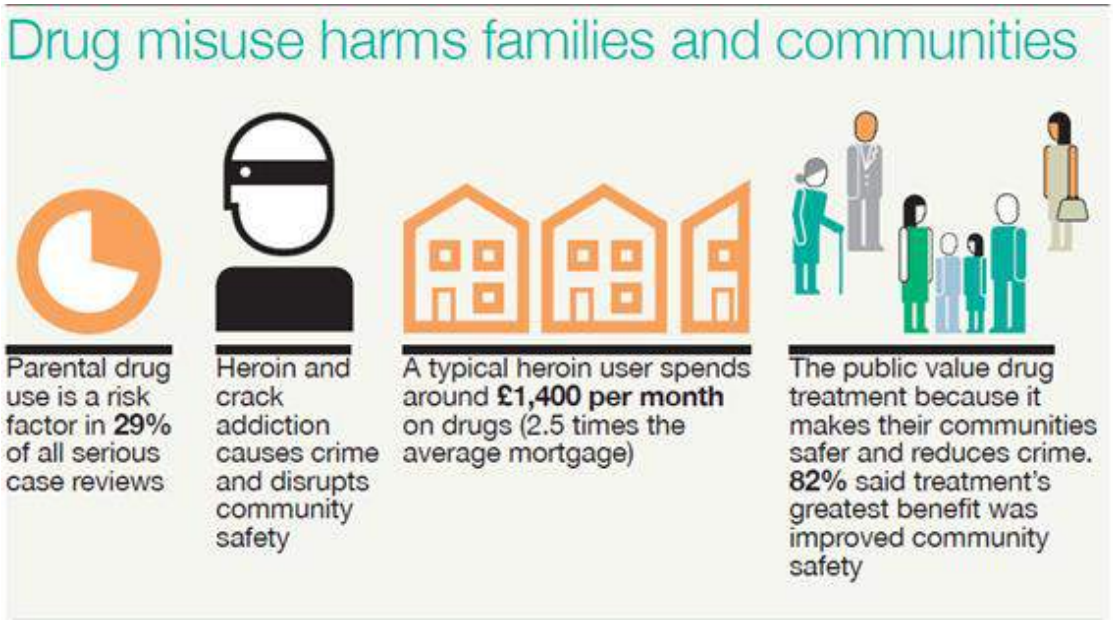
This reduction in crime has been estimated to be equivalent to a saving of over £2.4 million to the Bromley economy (the estimated socio-economic impact of the crimes avoided).

For more information about the methodology used to calculate these cost/benefits please refer to the full SROI tool and guidance document available here: https://www.ndtms.net/ValueForMoney.aspx

Health and Care Costs

The cost of drug misuse to health services in England including; primary care, emergency departments, inpatient care, community mental health, and inpatient mental healthcare, is estimated at £488 million per year[xxxviii]. The cost of healthcare alone for adult drug users not in structured treatment is estimated to be £5,380 per person per annum. Healthcare costs are estimated to fall by 31% when drug users are in treatment[xxxvii].

Children and Families



Adapted from Public Health England[xxxviii]

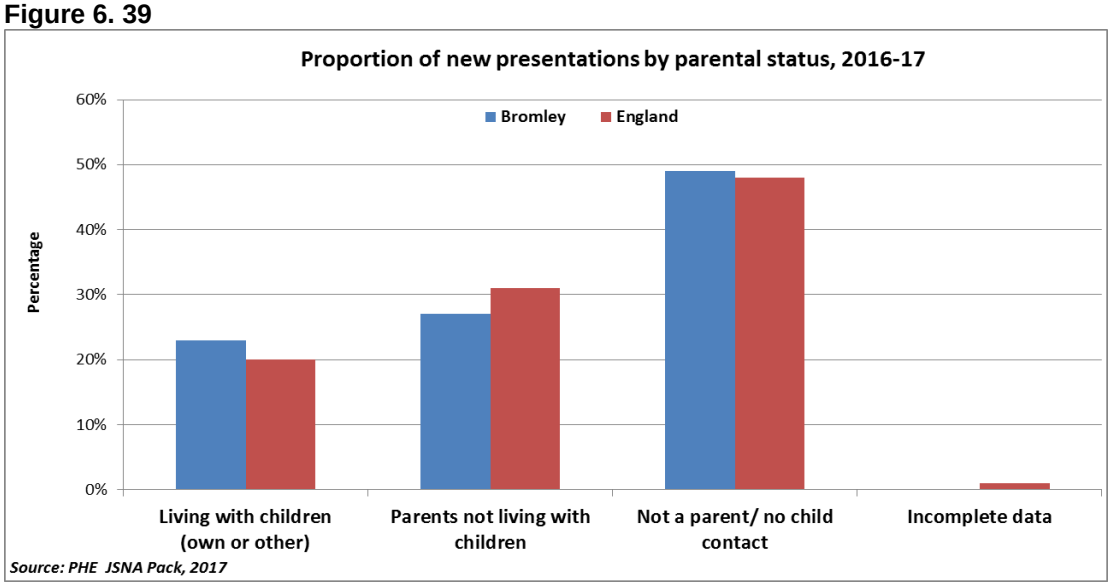
Substance misuse can reduce a parent's ability to provide care. The effects on the child can include neglect, educational problems, emotional difficulties and abuse. Children and young people can do little to protect themselves from the effects of parental substance misuse and can suffer emotional distress, neglect or physical injuryxxxvi.

The annual cost to the family members and carers of heroin and/or crack cocaine users is estimated to be £2 billion. The evidence considers the costs of being a victim of crime, lost employment opportunities and health service use, as well as financial support given to relatives[xxxvii]. While use of opioids does not necessarily impact on parenting capacity, registration on UK child protection registers for neglect has been correlated strongly with parental heroin use, and parental problem drug use has been shown to be one of the commonest reasons for children being received into the care system[liii].

Figure 6.39 shows that majority of people entering treatment were neither parents nor had contact with children (49% Bromley and 51% England). However, Bromley has a higher proportion, compared to England, of people entering treatment who live with children (23% and 20% respectively).

There were 100 children in Bromley living with drug users who entered treatment services in 2016/17. Many of these families may require specialist support to help them stabilise and strengthen and protect their children from harm. This will have implications for health and social care services in Bromley who must work together to provide effective, whole-family responses for those in treatment who have parental responsibilities.

Figure 6. 39



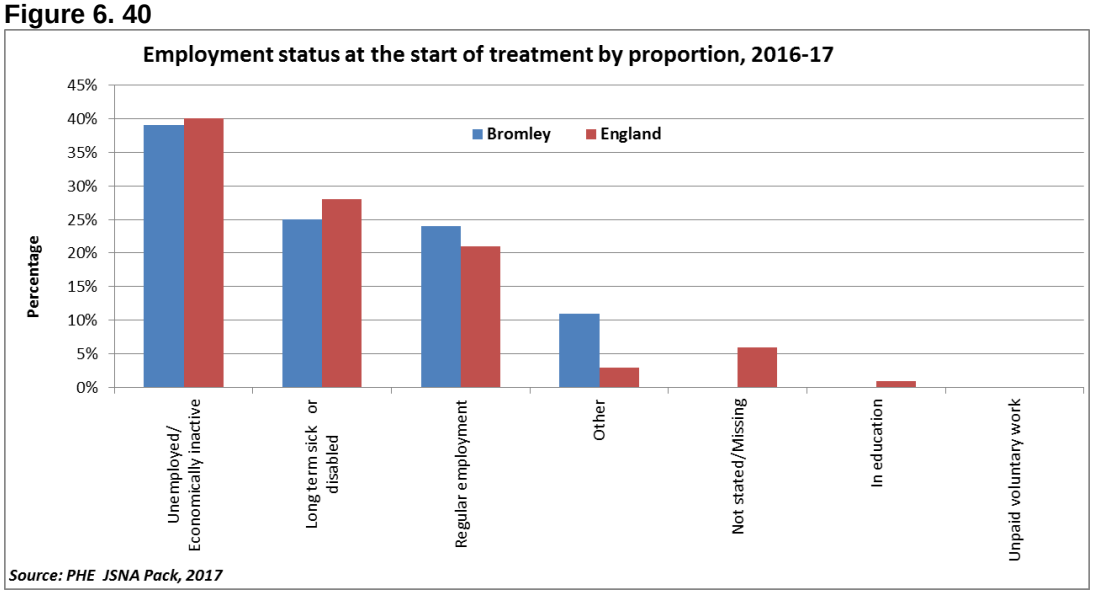
Social Services, Housing and Benefits

Social factors, including housing and employment and deprivation, are associated with substance misuse and these social factors moderate drug treatment outcomes. Lost productivity and unemployment increase with the severity and duration of drug misuse.

Unemployment has a marked negative impact on treatment outcomes and exacerbates the risk that someone will relapse after treatment. It is therefore important to provide longer- term employment support, including in-work support to help people maintain employment[xxxvii].

Figure 6.40 below shows self-reported employment status at the start of treatment in 2016-17. The majority of the clients reported unemployment or economic inactivity in Bromley (39%) and England (40%) at the start of their treatment. Bromley had higher proportions (24%) of those reporting being in work compared to England (21%) and lower proportions reporting long term sick (25% and 28% respectively). The high proportion of people in regular employment contributes to improved chances of better treatment outcomes for local clients.

Figure 6. 40



Employment status amongst drug treatment clients is also reviewed during treatment and at exit Analysis of the data shows that, of the number of new entrants in Bromley self-reporting not working at the start of treatment, at the time of review, had reduced by 11% while the number in full time work had increased by 32%. At planned exit, the number reporting not in work had reduced by 17% and those reporting being in full time work had increased by 32%. These figures are favourable in comparison to the national average where the number of new clients self- reporting not working at the start of treatment, on review had reduced by 3% while the number in full time work had increased by 16%. At planned exit, the number reporting not in work had reduced by 6% and those reporting being in full time work had increased by 23%. It is of note that, of the clients dropping out of treatment in Bromley, 88% (86% in England) were not in work at the start and remained out of work. Improving job outcomes is key to sustaining recovery and requires improved multi-agency responses.

Housing and homelessness

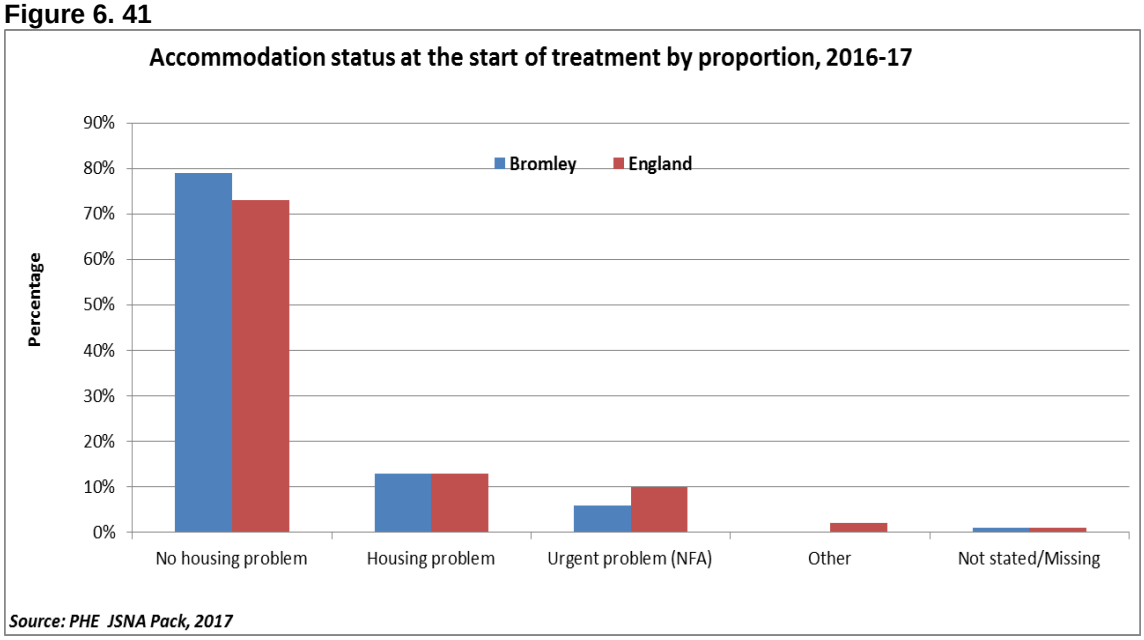
Evidence suggests that the relationship between substance misuse and homelessness is complex with both being mutually reinforcing. Homelessness is often compounded by substance misuse, as well as poor physical and mental healthxxxvi. Substance misuse among homeless people is strongly associated with economic marginalisation, social isolation and mental health problems. Substance misuse, in itself, is not a necessary or sufficient condition for homelessness to occur as other factors appear to be involved[liv].

Figure 6.41 shows self- reported housing status of adults at the start of treatment. Bromley has a higher proportion (79%) of clients reporting no housing problem

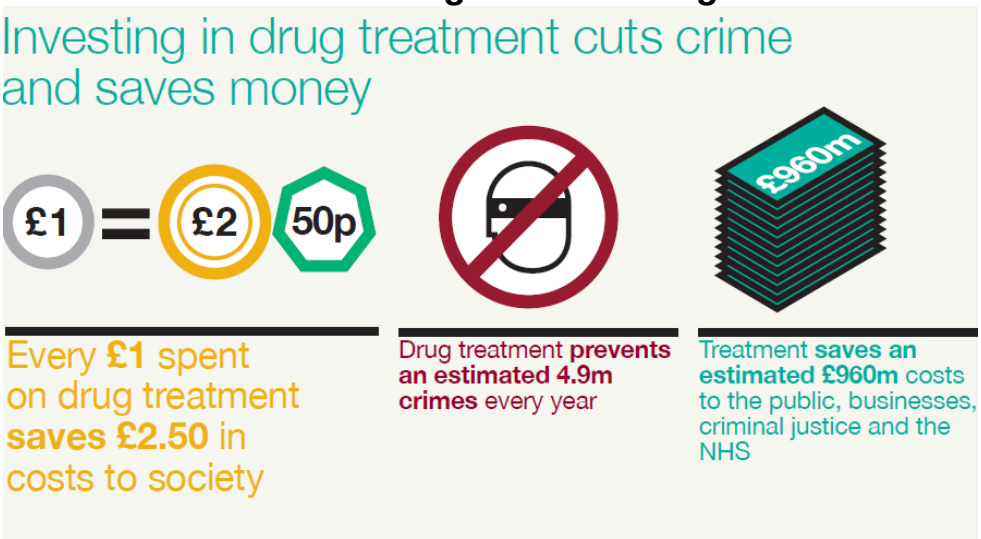
compared to England (73%) and contrariwise a lower proportion (6%) of clients reporting an urgent housing problem at the start of treatment compared to England (10%). There are similar proportions (13%) of new clients reporting a housing problem. Evidence shows a safe stable home environment enables people to sustain their recovery.

These data should be interpreted in line with the overall number of decisions taken on homelessness applications in the area[13]. Bromley has a higher rate of decisions taken compared to England at 9.1 per 1,000 households and 5.0 per 1,000 households respectively. Engaging with local housing and homelessness agencies can help ensure that the full spectrum of homelessness is understood and picked up: from statutorily homeless, single homeless people and rough sleepers to those at risk of homelessness.

Figure 6. 41



[13] Data specific to drug users is unavailable



Adapted from Public Health England[xxxviii]

The main aims of treatment are:

1. Harm reduction – preventing or reducing negative health and social consequences of drug use, including infections and overdose.

2. Maintenance oriented treatments – reducing an individual's level of drug use, mainly by substitute prescribing.

3. Abstinence-oriented treatments – reducing drug use with the ultimate aim of abstinence, using a range of interventions including detoxification, psychosocial interventions and residential rehabilitation.

Drug treatment has been evaluated across a wide range of outcome measures, including drug use, abstinence from drug use, drug injecting, overdose, health and mortality, crime, social functioning included employment, housing, family relations, and the perceptions of service users about their recovery status. The breadths of these measures reflect the broad range of benefits anticipated from drug treatment.

The general principles of treatment are that; no single treatment is appropriate for all individuals, treatments should be accessible and begin when and where the service user presents, and there should be the capacity to address multiple needs. It is also accepted that treatments will change over time. Research suggests that treatment does not need to be voluntary to be successful, and is ethical when given as an alternative to other penal sanctions[xlv].

A recent evidence review made the following comparisons between drug treatment outcomes in England and those in other countries, according to the scientific literature in England[xxxvii]:

- The treatment penetration rate (60%) is among the highest reported

- Access to treatment (97% within three weeks) is comparable to other countries
- The rate of drug injecting among all 15-64 year olds (0.25%) is relatively low
- The rate of drop out from treatment before three and six months (18% and 34%, respectively) is comparable to the literature (28% on average)
- England has a very low rate of HIV infection among the injecting drug user population (1%), which compares favourably internationally. The rate of HCV infection (50%) is also lower than several other countries with available data The rate of stopping injecting at 3, 6 and 12 months, is comparable with, or better than, the scientific literature

- Successful completion of treatment rates for non-opiate drug users, who only receive psychosocial interventions, have increased from 14% in 2005/6 to 37% in 2014/15 for non-opiate drug and alcohol users, and from 13% in 2005/6 to 42% in 2014/15 for users of non-opiate drugs alone

The evidence review also pointed to two key areas where there were opportunities for improvement in outcomes in comparison to evidence in the scientific literature and international comparisons:

- The rate of illicit opiate abstinence after three and also six months of treatment in England (46% and 48%, respectively) points to relatively poorer performance in comparison with the literature (56% on average)

- The drug-related death rate in England (34 per million in 2013) is substantially lower than in the USA but considerably higher than elsewhere in Europe

Key factors influencing recovery

Helping people to overcome drug dependence is a core function of the local drug treatment system.

When engaged in and completing treatment, people use fewer illegal drugs, commit less crime, improve their health, and manage their lives better. This makes a real contribution to community safety. The data below shows the proportion of drug users who complete their treatment free of dependence, the progress made on people successfully completing treatment, and those successfully completing who do not relapse and re-enter treatment.

Although drug treatment services treat dependence for all drugs, opiate users remain the group with most complex problems. In Bromley, opiate and/or crack cocaine users (OCUs) make up the overwhelming majority of clients in treatment, followed by users of cannabis and cocaine.

Treatment Pathways

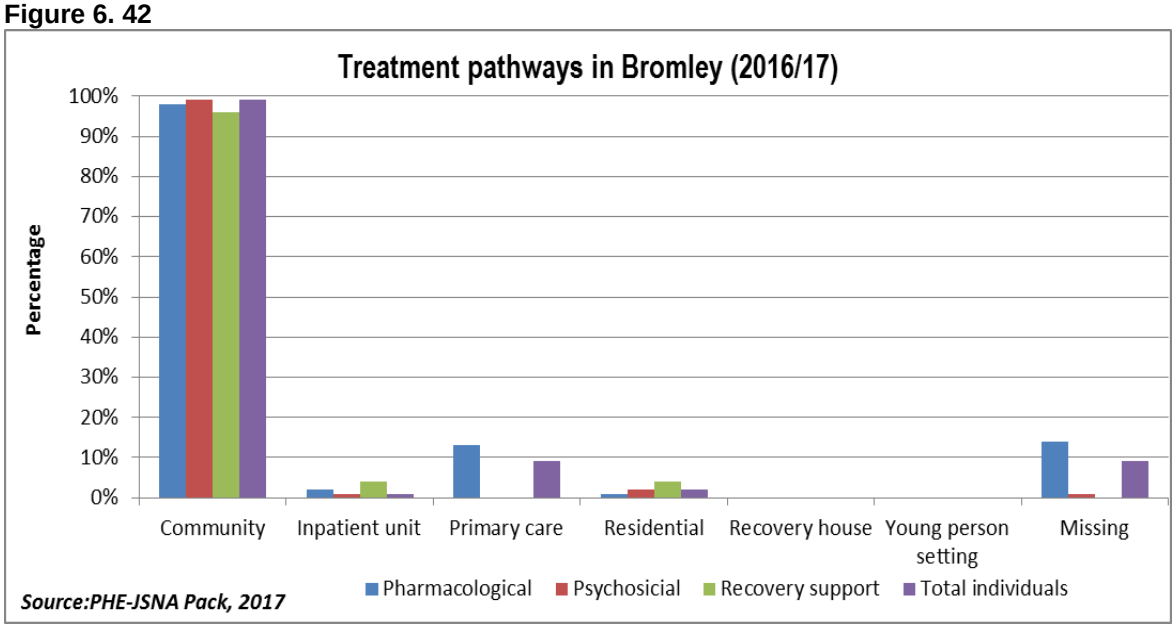
Analysis by substance group shows that in Bromley, the most common pathway in to treatment pathway for opiate clients was 'Prescribing & Psychosocial' with 95% of the referred clients attending. There were 23 clients who successfully completed this pathway at a successful completion rate of approximately 8%. Given the borough's opiate user profile, the expected successful completion rate is 5%. The most common pathway for non-opiate clients was 'Psychosocial only' (88%), with 36% of clients on this pathway successfully completing, compared with an expected 41% successful completion rate.

Intervention Type and Setting Delivered

We know that the types of interventions delivered to service users will have an impact on their achievement of recovery outcomes.

Figure 6.42 shows the numbers of people in Bromley receiving treatment via different available pathways. Bromley practice is in line with what is known about effectiveness, in that prescribing-only is much less effective in achieving sustained abstinence than when combined with psychological support.

Figure 6. 42

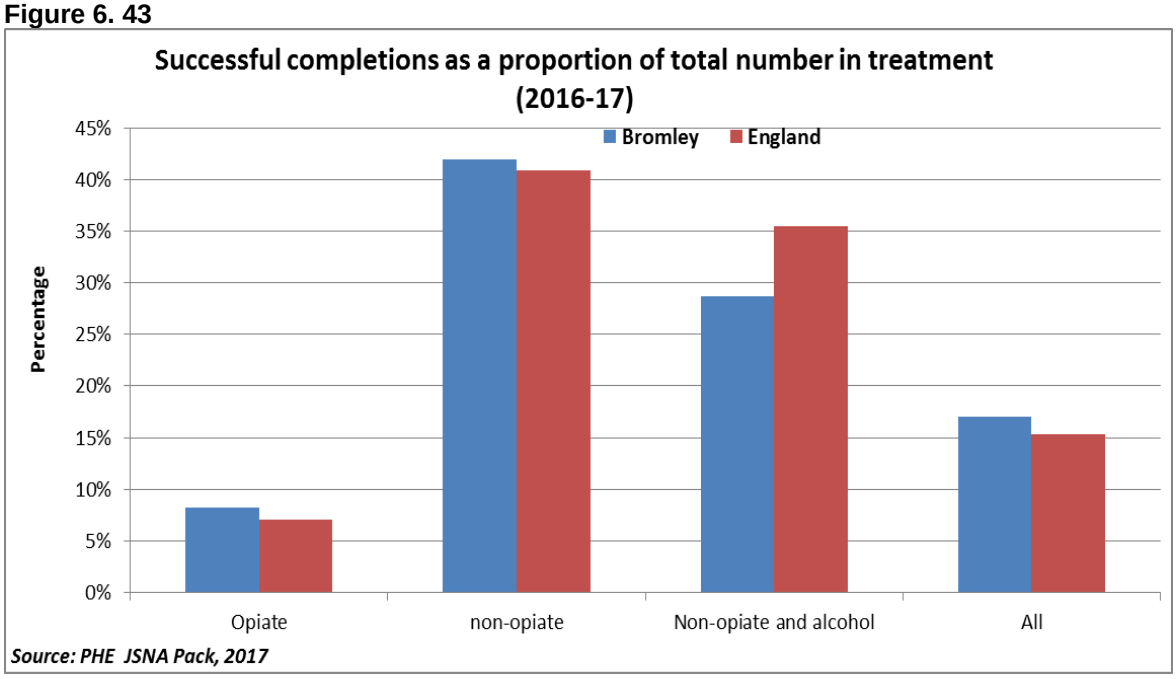


Successful completion

Figure 6.43 below shows the number of drug users who completed their drug treatment successfully (free of drug(s) of dependence) as a proportion of the total number in treatment for 2016/17. In that time period, 17% of all drug treatment clients in Bromley successfully completed treatment compared to 15% in England. Opiate clients have the lowest proportion of successful completions compared to rates for the other substance groups. Locally, 8% of opiate clients successfully completed treatment compared to 7% nationally. In contrast, 42% of non–opiate and 27% of non-opiate and alcohol clients successfully completed treatment in the same time period in Bromley. This compares to 41% and 36% respectively in England, showing a higher rate in non-opiate and alcohol clients in England compared to Bromley.

It is noteworthy that women in Bromley presenting to treatment for opiate use had higher successful completion rates (12%) compared to the local men (6%) in the same category.

Figure 6. 43



Successful completion trends

In England, the number and proportion of individuals completing treatment free of dependence have increased from 2009-10 to a peak in 2013/14 and has since fallen (**Figure 6.44** and **6.45**). Opiate clients have the lowest proportion of successful completions compared to rates for the other substance groups, while non-opiates consistently have the highest completion rates. There are similar patterns of change across the different substance groups (**Figure 6.45**).

Figure 6. 44

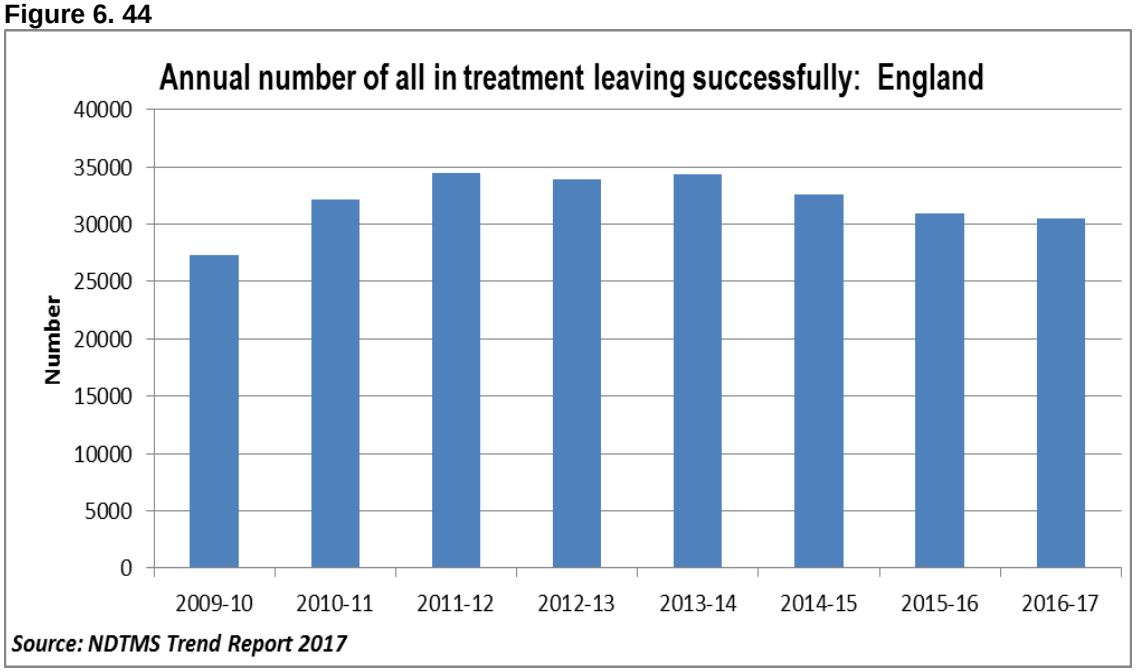
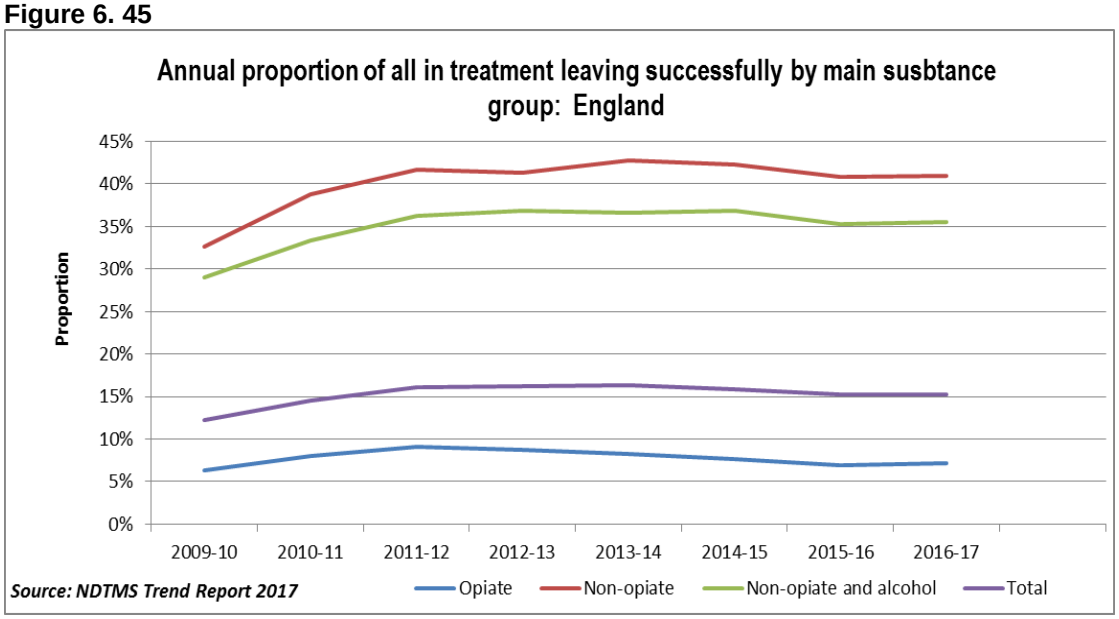


Figure 6. 45



In Bromley, the number and proportion of individuals completing treatment free of dependence have not followed a consistent pattern. There was a fall in 2011 from a peak in 2009-10 and then peak again in 2013/14 only to fall again (**Figure 6.46** and **6.47**). Opiate clients have the lowest proportion of successful completions compared to rates for the other substance groups, while non-opiates consistently have the highest completion rates. The rates in non-opiates and non-opiates and alcohol are very erratic and possibly contribute to the overall local successful completion trends (**Figure 6.47**).

Figure 6. 46

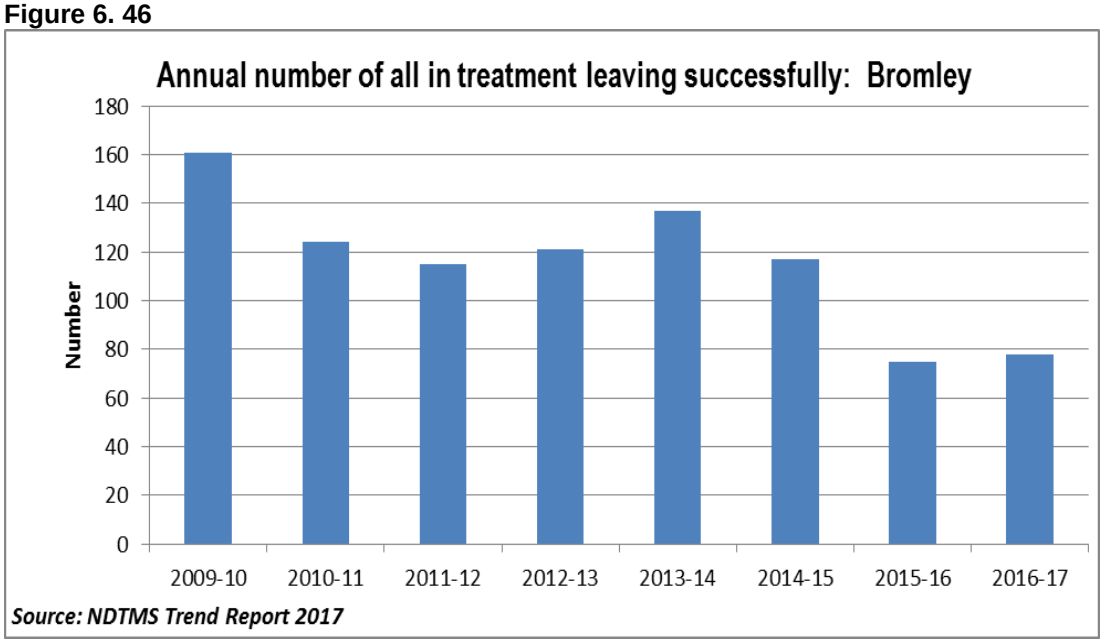
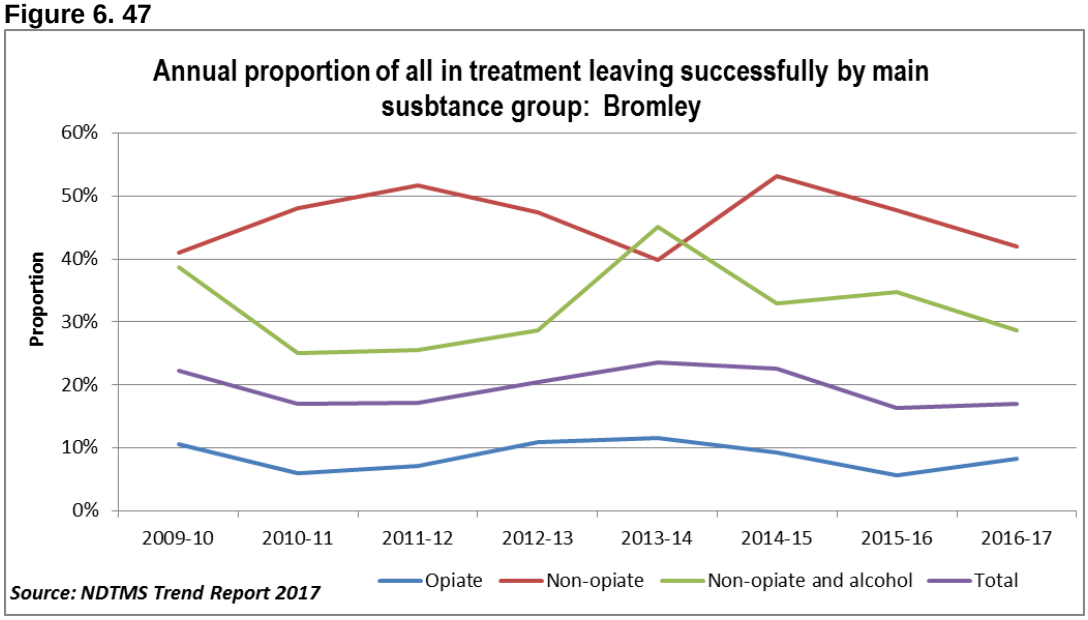


Figure 6. 47



Successful completion and not representing

The proportions of opiate and non-opiate clients in Bromley who successfully complete treatment and do not relapse and re- enter treatment also show no overall trend. The local rates have wide and overlapping confidence intervals, which are indicative of the small numbers and there is likelihood that the variation is not a precise estimate of the true underlying value (**Figure 6.48** and **6.49**).

Figure 6. 48

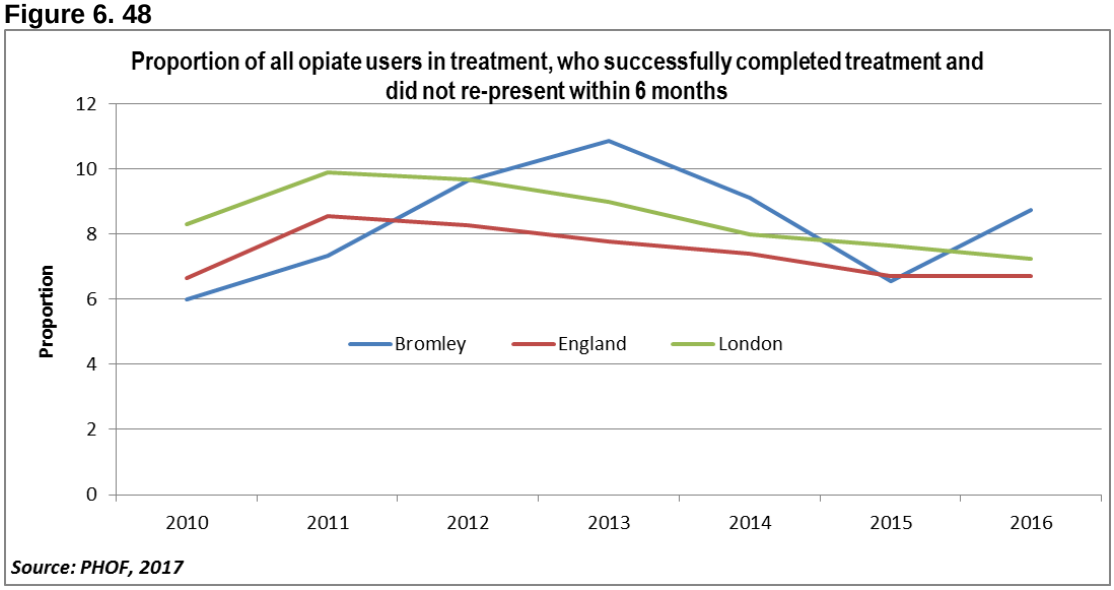
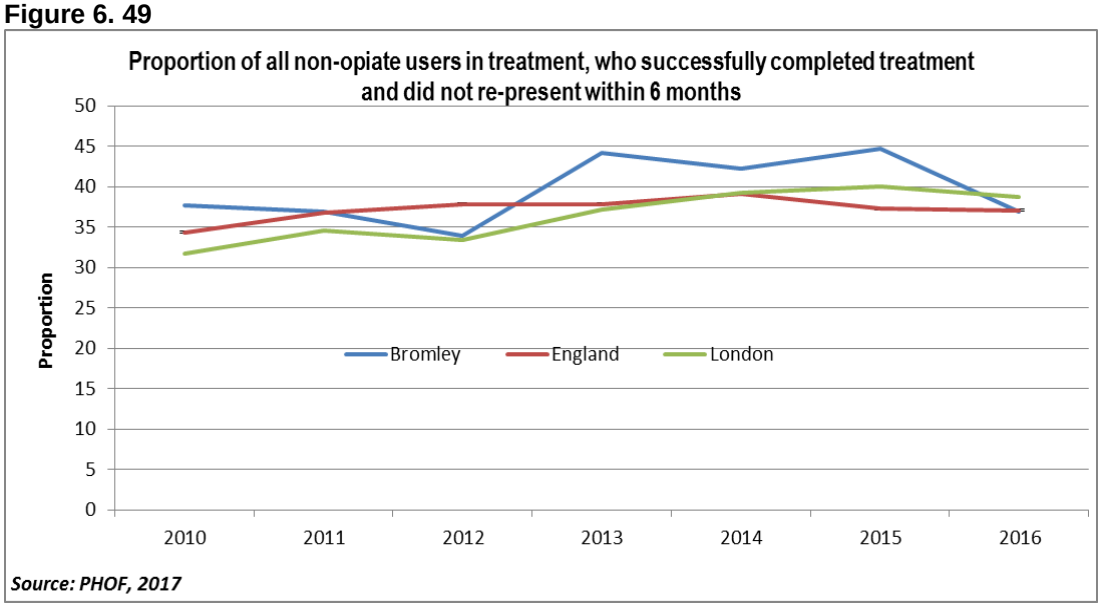


Figure 6. 49



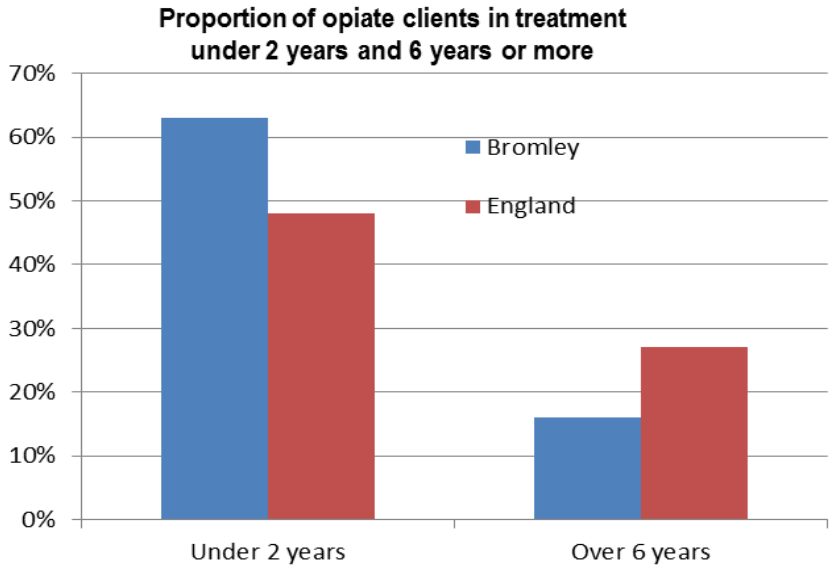
Length of time in treatment

Although many individuals will require a number of separate treatment episodes spread over many years, most individuals who complete successfully do so within two years of treatment entry. Clients that have been in treatment for long periods of time (six years or over for opiate clients and over two years for non-opiate clients) are most likely to be entrenched users who will find it harder to successfully complete treatment. Current data shows that opiate clients who successfully complete within two years of first starting treatment have a higher likelihood of achieving sustained recovery. Data also shows that non opiate clients are more likely to successfully complete treatment within two years.

In Bromley, there was no record of non-opiate clients in treatment for two years or more compared to the 3% in England. And only 1% of clients using both opiates and alcohol were in treatment for two years or more in Bromley compared to 4% in England.

For opiate clients, the majority also were in treatment under two years; 63% in Bromley (compared to 48% in England).Conversely, Bromley has lower proportions of opiate clients staying in treatment 6 years or more compared to England at 16% and 27% respectively (**Figure 6.50**).

Figure 6. 50



Source: PHE- JSNA Support Pack, 2017

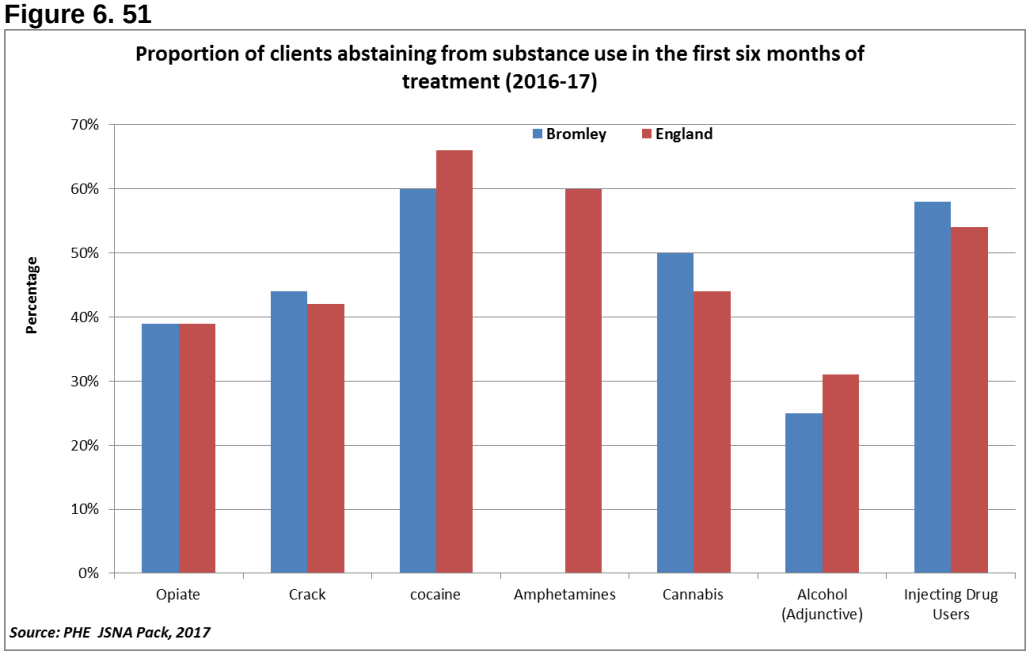
Treatment Outcomes

Treatment Outcomes at 6 Months

Figure 6.51 presents data drawn from the Treatment Outcomes Profile (TOP), which tracks the progress drug users make in treatment. Data from NDTMS suggests that clients who stop using illicit opiates in the first six months of treatment are almost five times more likely to complete successfully than those who continue to use.

Clients presenting with cocaine had the highest abstinence rates, both locally (60%) and nationally (66%), followed by injecting drug users (58% and 54% respectively). Bromley had similar proportions to England of opiate users achieving abstinence within 6 months (39%).

Figure 6. 51



Analysis of data on abstinence in the first 6 months by substance and gender shows a varied picture. Where men achieved better abstinence levels for some substances (opiate, cocaine and injecting drug use) and women achieved higher levels on others (crack, cannabis and alcohol as the adjunctive drug). It is worth noting that no women injecting drugs were found to be abstinent in the first 6 months (**Figure 6.52**). Women presenting to treatment often experience poor mental health, domestic violence and abuse, which may impact upon their recovery. Unfortunately there is no data to ascertain trends by substance and gender.

Figure 6. 52

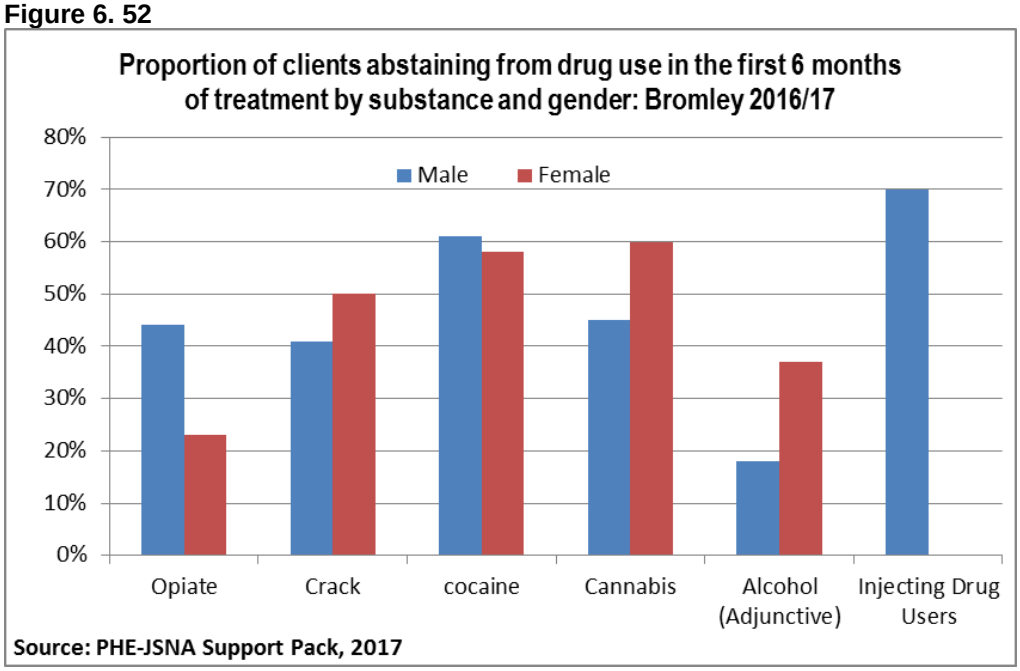
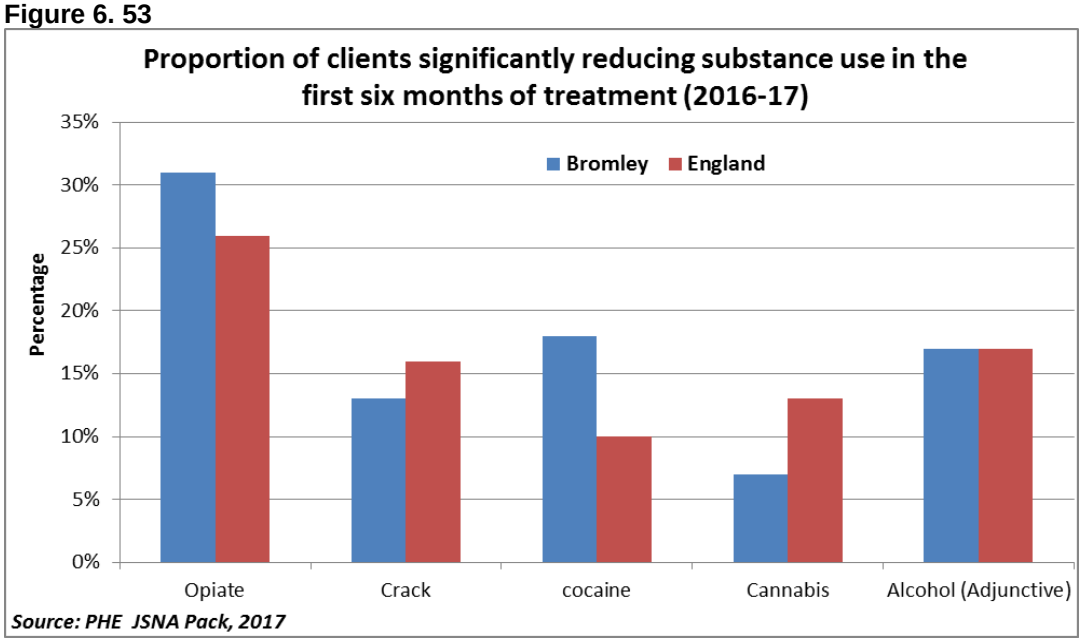


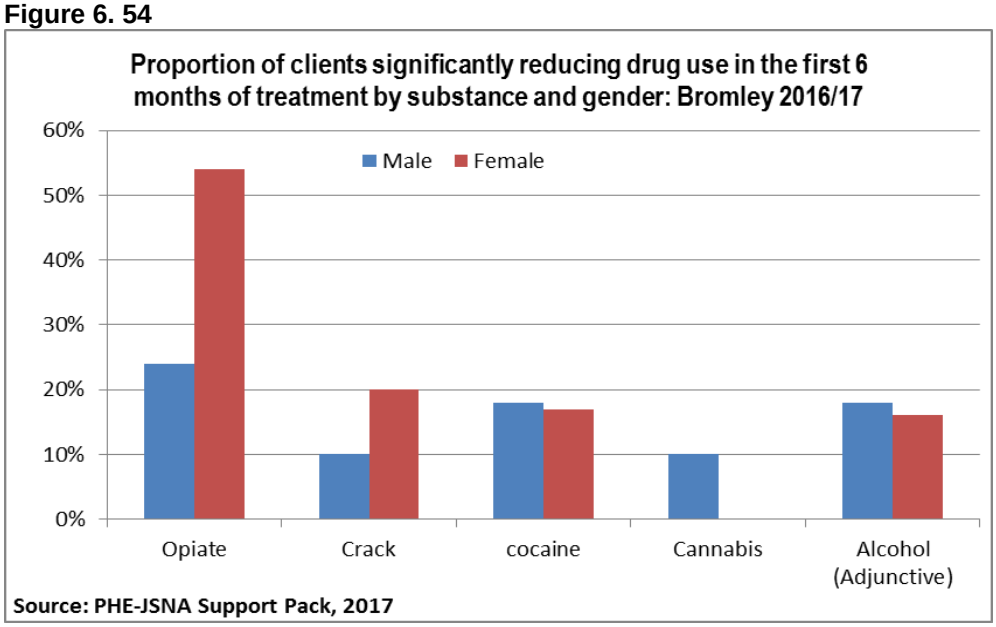
Figure 6.53 shows proportions of clients significantly reducing drug use in the first six months by the problem drug. Although opiate clients have the lowest successful completion rates, they have the highest proportions of significant reductions both locally (31%) and nationally (26%). This may be indicative of the complex problems in this group and the work involved overcoming addiction. Higher proportions of the clients presenting with cocaine locally (18%) than nationally (10%) reported significant reduction. However, among the cannabis clients and crack clients, England had higher proportions (13%, 16%) than Bromley (7%, 13%) respectively. Bromley had similar proportions to England among clients presenting with alcohol as an adjunctive drug (17%).

Figure 6. 53



Analysis of the same data by substance and gender locally shows a varied picture. Where men achieved better reduction levels for some substances (cocaine, cannabis and where alcohol as an adjunctive drug) and women achieved higher levels on others (opiate and crack). It is worth noting that no women injecting drugs were reported in this category (**Figure 6.54**). Unfortunately there is no data to ascertain trends.

Figure 6. 54



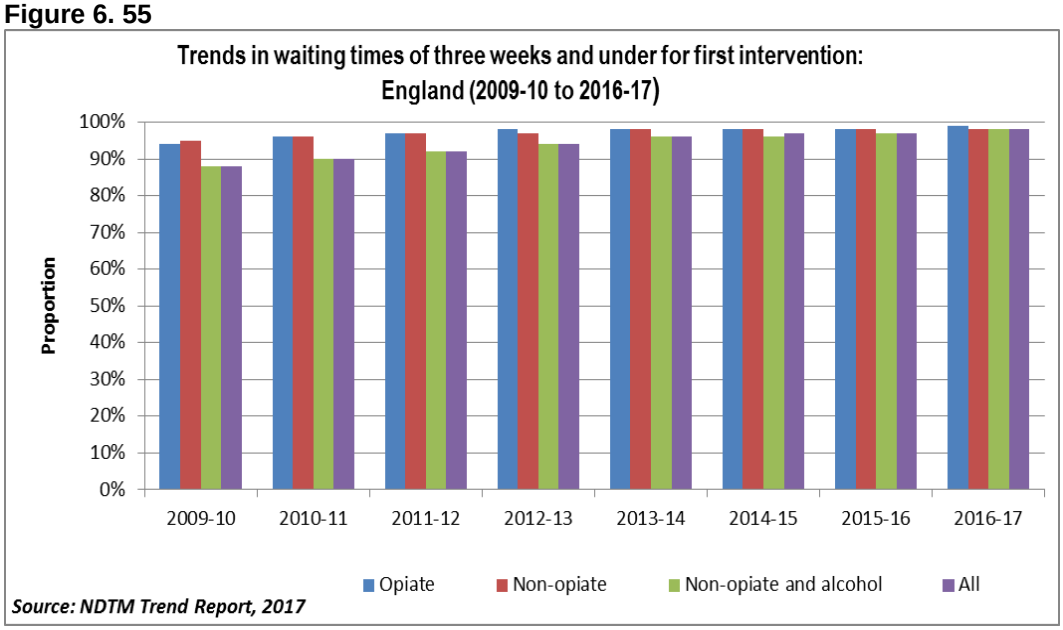
Waiting times

Drug users need prompt help if they are to recover from dependence. Local efforts to keep waiting times low means that the national average waiting time is less than one week. Keeping waiting times low plays a vital role in supporting recovery and ensuring that substance misuse treatment is accessible for all of those who need it.

Figure 6.55 & **6.56** shows that opiate clients, both locally (96%) and nationally (99%), had the highest proportion of individuals experiencing short waiting times defined as waiting three weeks or less from being identified as having a treatment need to being offered an appointment to start an intervention.

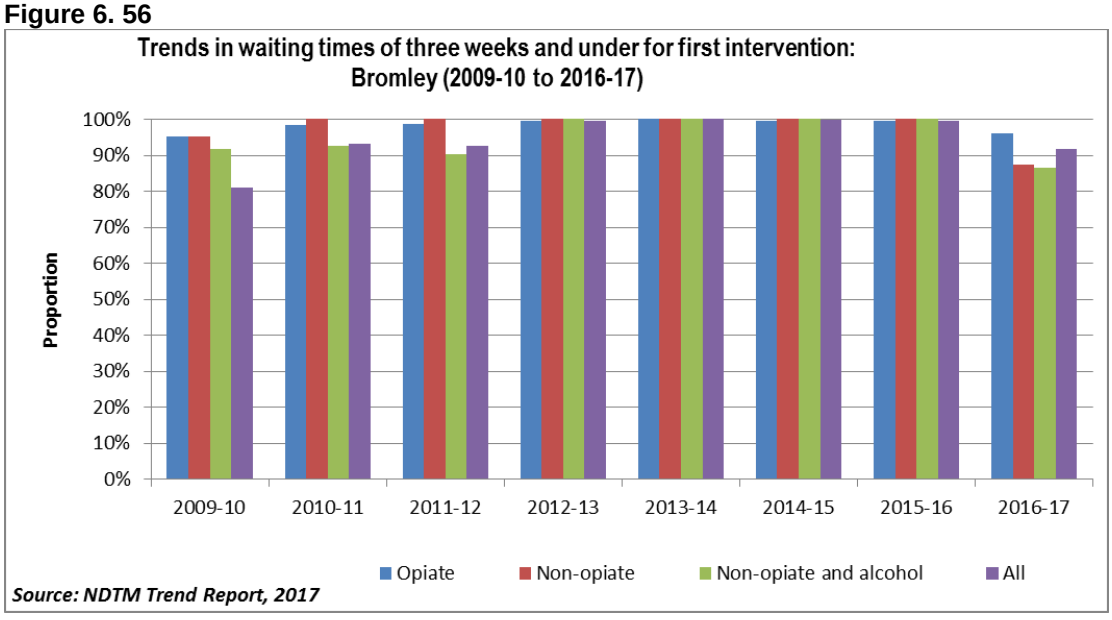
Figure 6.55 presents trends in the proportion of individuals experiencing short waiting times in England. Overall, the proportion waiting three weeks or less has increased across all substance groups since 2009-10 to 2016-17, with 99% of opiate clients in the most current year waiting 3 weeks or less to start an intervention. The largest improvements in waiting times have been seen in individuals presenting with problematic non-opiate and alcohol use. Among this group, the proportion waiting less than 3 weeks to start an intervention has risen from 88% in 2009-10 to 98% in 2016-17.

Figure 6. 55



Overall in Bromley, the proportion of people experiencing short waiting times has been increasing across all substance groups since 2009-10 until recently. Non-opiate and alcohol clients were the most affected by the longer waiting times with a 13% reduction between 2015/16 and 2016/17 (**Figure 6.56**).

Figure 6. 56

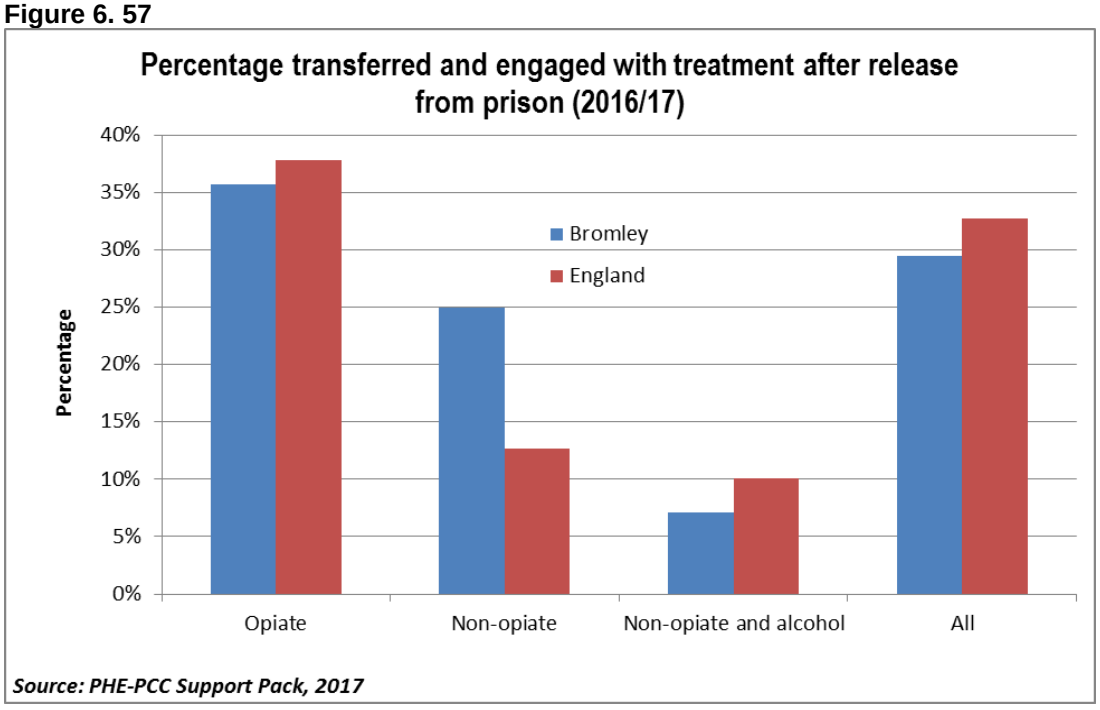


Prison Release and Transfer to Treatment

Figure 6.57 shows the percentage of individuals in 2016-17 who at the point of release from prison were transferred to a community treatment provider for structured treatment interventions and other support and were successfully engaged.

A total of 15 HMP prisons transferred clients to drug treatment in Bromley for structured treatment interventions and other support in 2016/17. Of those transferred, 29% successfully engaged with services in Bromley compared to 33% in England. Both locally and nationally, there were higher numbers and proportions of transfers and engagement among opiate clients. There are no prisons within Bromley borough; Bromley residents are remanded all over the country which could impact on timely and successful transfer of individuals released from prison into treatment service.

Figure 6. 57



Source: PHE-PCC Support Pack, 2017

Early Unplanned Exits

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better – which also benefits the community. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. Unplanned exit or early drop out refers to adults entering treatment who left in an unplanned way before 12 weeks commonly.

Locally the current treatment drop-out rate is lower than the national average (12% in Bromley compared to 17% nationally). Locally, there were higher drop-out rates among clients presenting with opiate abuse at 20%. In England, the rate was highest among those presenting to treatment for non-opiate drug abuse at 18%. Analysis by gender shows that men were more likely to drop-out early across all substance groups both locally and nationally.

Residential Rehabilitation

Drug treatment mostly takes place in the community, near to drug users' families and support networks. However residential rehabilitation may be cost effective for someone who is ready for active change and a higher intensity treatment at any stage of their treatment, and this option is encouraged as part of an integrated recovery-orientated system.

With that said, only a small number and proportion of users were in residential rehabilitation during the latest period of treatment. In Bromley, 2% of the adult population in drug treatment attended residential rehabilitation compared to 3% nationally. Local data shows that there were more men in attendance.

What this means for residents in Bromley:

Substance misuse is a complex area. Individuals with substance misuse problems may also have other difficulties including mental health problems, poverty, relationship issues, family breakdown, unemployment and involvement with the criminal justice system. In Bromley, there is also the challenge of an aging population of opiate users with multiple physical health problems and entrenched use.

Bromley residents require specialist substance misuse services that can respond to the changing nature of substance misuse in the borough. The contract for existing substance misuse services for adults and young people in Bromley are due to expire later in 2018. A new service specification has been designed (incorporating the findings of this needs assessment) and new services will be commissioned to come into effect in December 2018.

The new service will be presented with a number of local challenges to address including the following:

- To increase numbers of individuals in treatment
- To find innovative ways if working with older opiate users with more complex needs
- To respond to the emerging needs of individuals using NPS and over the counter/prescribed medications
- Develop strategies to prevent drug related deaths
- To engage with problematic alcohol users who may be treatment naïve

A primary focus for the new service will be the identification and engagement of substance misusers. Partnership working with a range of key partners in the borough will be essential in supporting more individuals into treatment. This will include joint working with the Criminal Justice Services, Hospitals, LBB services including Children's Services, Community Health Services, the Voluntary Sector and Primary Care.

Aftercare and Reintegration has been cited as important for sustained recovery. The new service will offer wraparound support and on-going contact as well as pathways to specialist education, housing and employment support and advice.

It is anticipated that the integrated treatment system will provide a holistic service to support successful and sustained recovery for those who misuse substances in Bromley. Improved partnership working and early identification and referral will improve outcomes and treatment completion rates.

7. Domestic Violence

Introduction

Domestic Violence and Abuse (DVA) is a complex and multi-faceted issue that touches many people's lives in many different ways. Domestic violence is like no other crime insofar as the perpetrator has intimate and constant access to the victim. Domestic violence and abuse can be experienced by adults and children from all backgrounds, and many domestic incidents remain unreported[lv] and often result in devastating consequences for long-term mental and physical health[lvi]. DVA crosses all ethnicities, sexual orientations, class and age, with the impact of abuse on the elderly and those with complex and multiple needs often poorly reported.

In this section we focus on the needs of women and girls due to the disproportionate number of cases of DVA against women and girls[lvii]. A study based on police reports, which accounted for the dynamics of domestic violence, found that only 5% of domestic violence incidents were perpetrated by women in heterosexual relationships[lviii]. However, this does not mean that men are never victims of domestic violence, rape or forced marriage nor that woman are not occasionally the perpetrator.

Forms and Definitions of Violence Against Women and Girls (VAWG)

The UN defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”[lix]. This includes physical, sexual and psychological/emotional violence, economic abuse and sexual exploitation. VAWG can take place at home, work or in public places such as on the street or public transport. In March 2013, the Home Office introduced a new official definition of domestic violence, this was expanded to include 16 to 17-year-olds[lx].

Forms of violence against women and girls can include, but are not limited to[lxi]:

- Domestic violence and abuse
- Female Genital Mutilation (FGM)
- Forced marriage
- ‘Honour’-based violence
- Prostitution and trafficking
- Sexual violence including rape
- Sexual exploitation
- Sexual harassment
- Stalking
- Faith-based abuse

Domestic Violence – A National Profile

Estimated Incidence

It is estimated that 1.9 million adults (aged 16-59 years old) experienced domestic abuse in the last year, equating to a prevalence rate of 6 in 100 adults[lxii]. It was also estimated that in 2015, approximately 120,000 older people (age 65+) had experienced at least one form of abuse[lxiii].

An estimated 7.5% of women (1.2 million) experienced domestic abuse last year compared to 4.3% of men (713,000)[lxii]. Approximately 3 women are killed every fortnight in England and Wales by a current or former partner.

The difference between the estimated number of male and female victims is at its lowest compared to previous years[lv]. However, the estimates do not take account of the context and impact.

For all age groups, 16 to 19 year olds were the most likely to say they had experienced domestic abuse in the last year (11% women, 7% men)[lv].

The most common type of domestic abuse experienced in the last year was partner abuse (4.5% of adults), with a greater proportion of women (5.9%) reporting partner abuse than men (3%)[lv]. However, there were similar proportions of men and women who reported experiencing family abuse which includes; non-physical abuse, threats, force, sexual assault or stalking[lv].

Linking across all sub categories of intimate violence, estimates for women were statistically significantly higher than estimates for men[lv]. Overall, 26.3% of women and 13.6% of men had experienced any domestic abuse since the age of 16 years old, equivalent to an estimated 4.3 million female victims and 2.2 million male victims a year[lv].

Research by the NSPCC found that 1 in 5 children in England had witnessed domestic abuse[lxiv]. A third of these children will also experience another form of abuse. There is a growing amount of evidence of the long-term effect is of domestic abuse on children which includes; aggressive, anti-social, fearful and/or inhibited behaviour and depression or trauma-related symptoms[lxv].

Research by SafeLives found that older victims of domestic violence (aged >60) experience abuse for twice as long as younger victims but they are under represented among domestic abuse services[lxiii]. They are also more likely to have a disability, much more likely to experience abuse from an adult family member or current intimate partner and more likely to be living with the perpetrator after seeking support[lxiii].

Reported Crimes

Most recent figures estimate that 79% of victims of partner abuse did not report the abuse to the police[lv].

According to the Violent Crime figures, police recorded 511,319 offences that were domestic abuse related in the year ending June 2017, an 18% increase on the previous year's record[lxvi]. However, it is important to note that the increase is likely to be driven by improved recording and reporting practice[lxvi].

Violent Crime figures for the year ending June 2017 showed that violence against the person offences were the most likely to be flagged as domestic abuse related (32%), followed by sexual offences (13%)[lxvi]. However, as the "flagging" of offences relies on manual intervention, local area statistics are variable and maybe subject to recording bias[lxvi].

Nationally, violent crime figures show that despite a downward trend in violent crime, police recorded domestic abuse continues to rise[lxvi].

The Crown Prosecution Service (CPS) provided statistics on domestic violence cases referred to the CPS by the Police. The latest statistics show[lv]:

- There were 110,833 police referrals of domestic abuse-related cases to the CPS, a 6% fall from the previous year.
- Of the cases referred, 93,590 proceeded to prosecutions and convictions were secured for 76% of court prosecutions.
- 92% of defendants were men and 65% of victims were female, reflecting the profile of victims and perpetrators.

Multi-Agency Risk Assessment Conference (MARAC)

The MARAC is a process which aims to allow statutory and voluntary agencies to give a consistent and structured response to managing the risk in cases of domestic abuse[lxvii]. MARAC is used to consider cases of domestic abuse that are categorised as high risk[lxviii]. The MARAC is generally held on a monthly basis and relevant agencies are able to share up to date risk information, with a comprehensive assessment of a victim's needs and decide upon the most appropriate way to lower or manage the identified risks[lxviii].

A total of 83,136 high-risk cases were discussed at multi-agency risk assessment conferences in the year ending March 2017, equating to 36 cases per 10,000 adult females[lv].

Data from the pan London Domestic Violence Needs Assessment Report 2016 shows that across London the number of referrals to MARAC has risen annually since 2013, from 6,995 referrals to 9,919 in December 2015[lxix]. In 2015 all 33 local authorities held at least one MARAC meeting per month with an average of 310 cases discussed per borough indicating a rise in MARAC referrals[lxix]. Referrals to MARAC are an indication of the need across London for high risk support.

Economic Impact

Domestic Abuse cost the UK an estimated £15.7 billion in 2008[lxx]. Domestic abuse has a significant impact on a wide range of services including housing, criminal justice and social services provision[lxx]. The Trust for London and the Henry Smith Charity estimated the total costs of domestic violence in England at £5.5bn, which comprises of[lxxi]:

- £1.6bn for physical and mental health costs
- £1.2bn in criminal justice costs
- £268m in social services costs
- £185.7m in housing and refuge costs
- £366.7m in civil legal costs
- £1.8bn in lost economic output

It is estimated that £918 million of the total cost is incurred in London[lxxi].

Domestic Violence – A Local Profile

The Crime and Disorder Act 1998 places a statutory requirement on local authorities to monitor the level of domestic abuse in their communities and establish partnerships in order to reduce the problem as well as work together with other agencies to highlight the issue and coordinate a response[lxxii].

Due to the hidden nature of violence against women and girls, there is limited data locally to enable accurate mapping of the prevalence, and wider issues of violence against women and girls in Bromley.

Reported Crimes

The reported Domestic Abuse and Sexual Violence incident rate in Bromley from September 2016 to September 2017 was 13 victims per 1000 of the local population, this equates to roughly 4426 victims and of these 2568 were domestic abuse offences. In contrast, the rate across London from September 2016 to September 2017 was 144,594 of which 76,297 were domestic offences (September 16-September 2017).

Data from the Mayor's Office for Police and Crime (MOPAC) shows that between September 2016 and September 2017 there were 2568 reported domestic abuse offences in Bromley[lxxiii]. This is a rise of nearly 60 % since the same period in 2011/12.

Multi-Agency Risk Assessment Conferences (MARAC)

From October 2016 to September 2017, 166 cases were discussed at MARAC in Bromley, this is an annual increase of 6% (see **Table 7.1**). This rise was predominantly driven by an increase in the number of referrals from the police (rising from 39% in 2015/16 to 48% in 2016/17).

The rate of cases discussed is lower in Bromley than the national average (1.3% compared to 3.5%) but a higher proportion are repeat cases in Bromley (38% compared to 27% nationally). Bromley also had a higher proportion (22%) of cases from Black and Asian Minority Ethnic groups compared to England (16%).

The majority (52%) of the referrals locally were from partner agencies compared to nationally where the majority (65%) were from police. This could be indicative of good local partnerships and domestic violence support networks in Bromley.

Table 7.1 also shows that there is a small proportion (3.6%) of the cases with a disability. Disabled people experience disproportionately higher rates of domestic abuse. They also encounter differing dynamics of domestic abuse, which may include more severe coercion, control or abuse from carers

[lxxiv]. The risk is exacerbated by the fact that disabled people experience more barriers to accessing support, such as health and social care services and domestic abuse services[lxxiv].

Table 7. 1: Bromley MARAC Data October 2016-Septemeber 2017

	National	Bromley
Cases discussed	88,740	166
Cases per 1000 population	35	13
Children in household	114,222	240
Year on year change in cases	4% ↑	6% ↑
Repeat cases	27%	38%
Police referrals	65%	48%
Partner agency referrals	35%	52%
BME	16%	21.7%
LGBT	1.1%	0.6%
Disability	5.7%	3.6%
Males	4.8%	0.6%

Source: MARAC, 2018

Referrals to Domestic Abuse Support Services

The Independent Domestic Abuse Advocacy Project (IDAAP)

The Domestic Abuse Advocacy Project is part of local action to tackle domestic violence which aims to:

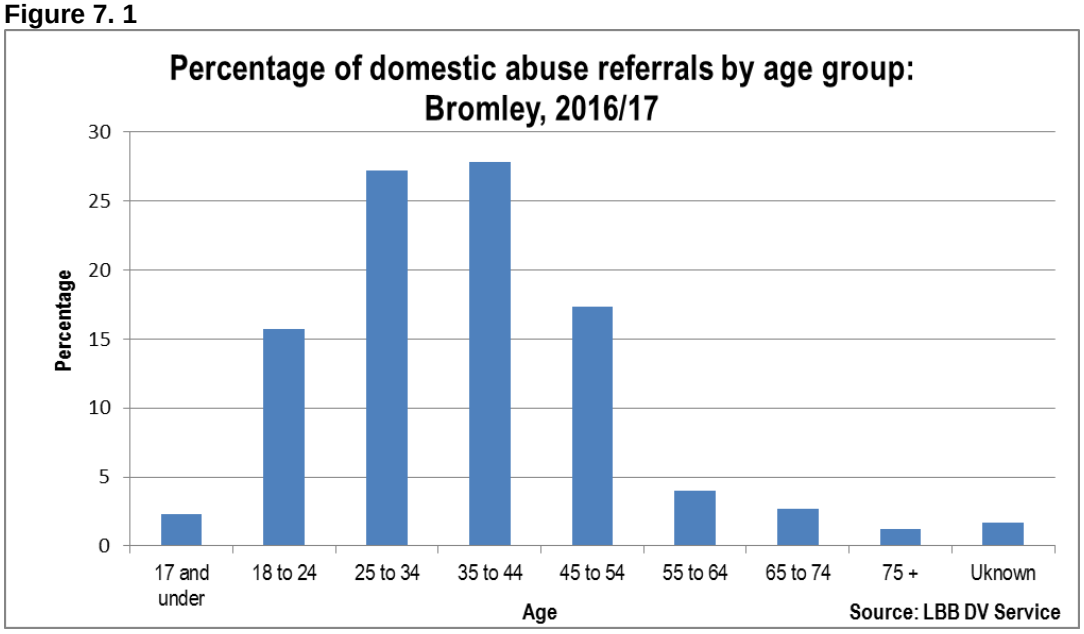
- Increase victim safety
- Improve conviction rates for domestic abuse crimes
- Provide dedicated support, advocacy and advice to victims
- Streamline reporting from community and police

This section describes the characteristics of referrals to the local Domestic Abuse Advocacy service.

In 2016-2017, there 476 referrals to the domestic abuse support service, of which 82% were females. It should be noted that, this is not a count of people but volume of activity as an individual can be referred more than once.

Over half (55%) of the referrals were from residents aged between 25 and 44 years old. It is noteworthy that, women in their childbearing years form a huge part of the referrals (**Figure 7.1**). This in turn has implications for the children born into those homes.

Figure 7. 1



There was a combined figure of 212 dependants of the victims of domestic abuse known to this service in 2016/17. **Figure 7.2** shows the rate of children subject to a child protection plan with initial category of abuse. Although Bromley has significantly lower rates (13.3/10,000) than the region and England at 21/10,000 and 20.8/10,000 respectively, no child should be exposed to abuse[lxxv].

Figure 7. 2

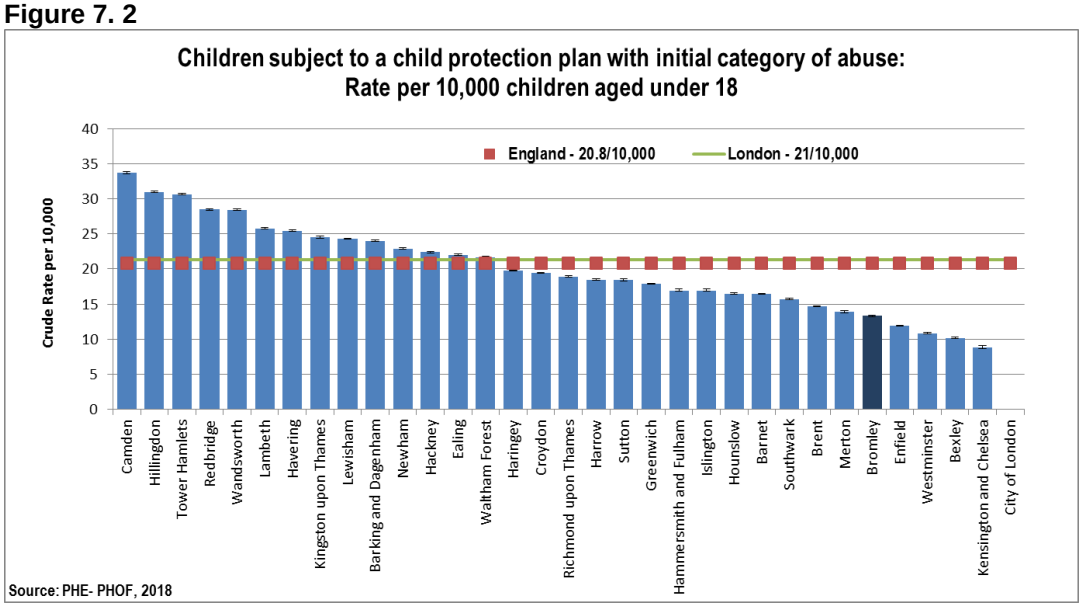
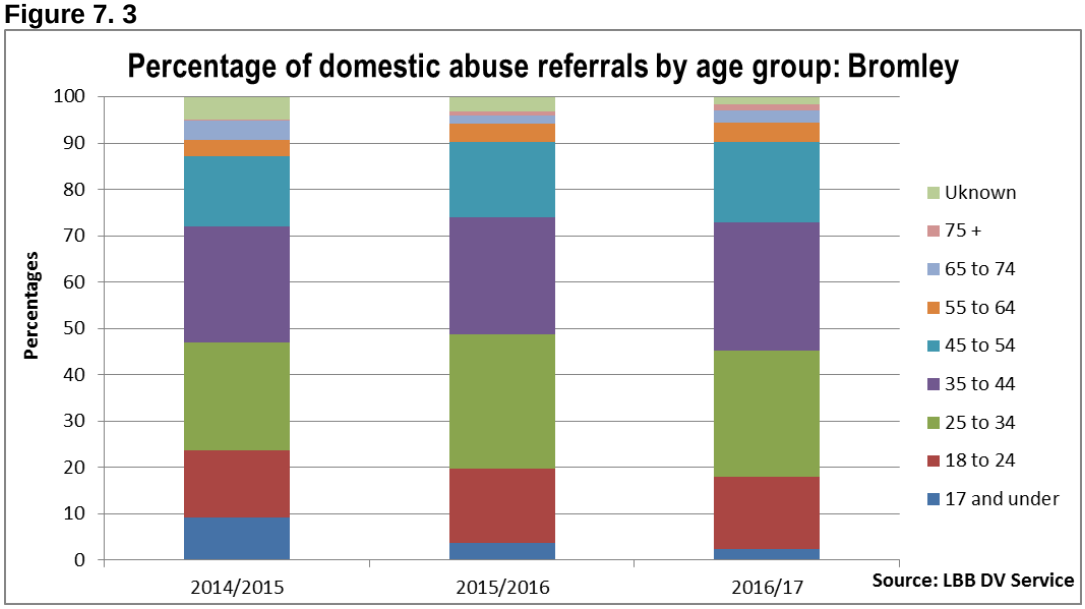


Figure 7.3 shows that, on average, referrals for domestic violence increase with age until 44 years of age and then the reverse is seen. There is an upward trend in all age groups except those under 18 years of age. However, it is not known if this is a reflection of the recurrent nature of domestic violence, good signposting to service, or an accurate representation of trends.

Figure 7.3 shows a declining trend in the referrals of those under 18. However, according to a UK survey, a quarter (25%) of girls and 18% of boys 13-17 years reported having experienced some form of physical violence from an intimate partner in 2009[lxxvi]. The local trend is therefore likely to be a reflection of changes in the provision and access to domestic violence support services for children and young people. This has recently been addressed and therefore levels of referrals for those 17 and under are likely to rise again.

Figure 7. 3



In keeping with the general ethnic profile of Bromley, 82% of referrals to the service in 2016/17 were among the White British. The data for White British is excluded from **figure 7. 4** below, to allow for visibility of the difference within and between the other groups. **Figure 7. 4** shows the proportion of domestic violence referrals within the Black and Ethnic Minority group. People from Black or Black British background make up the highest proportion of BME referrals, but there has been a year on year decrease in the proportion of referrals from this group since records began. This is worth monitoring to see if the trend is enduring.

Figure 7. 4

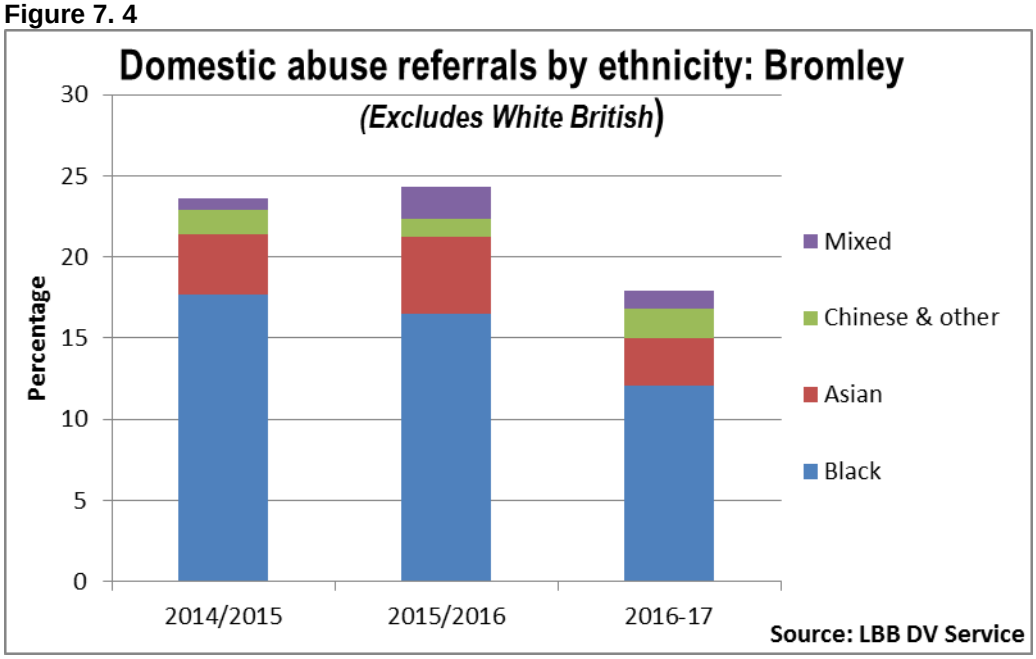


Figure 7.5 shows analysis of the referrals by crime type where violence with injury contributed 3 out of every 7 referrals in 2016/17. The high volume of violence with injury referrals has implications, not only for the physical health of the affected person but also for the local health services especially A&E services.

Research has shown that the NHS is often the first or only point of contact for women experiencing domestic abuse[lxxvii].

Figure 7.5 also shows a shift in the crime burden, from violence without injury to violence with injury. Over half (55%) of referrals in 2014/15 presented with violence without injury but by 2016/17 the rate was more than halved (21%) and violence with injury was 1.6 times the rate in 2014/15. Referrals citing sexual offences have reduced.

Figure 7. 5

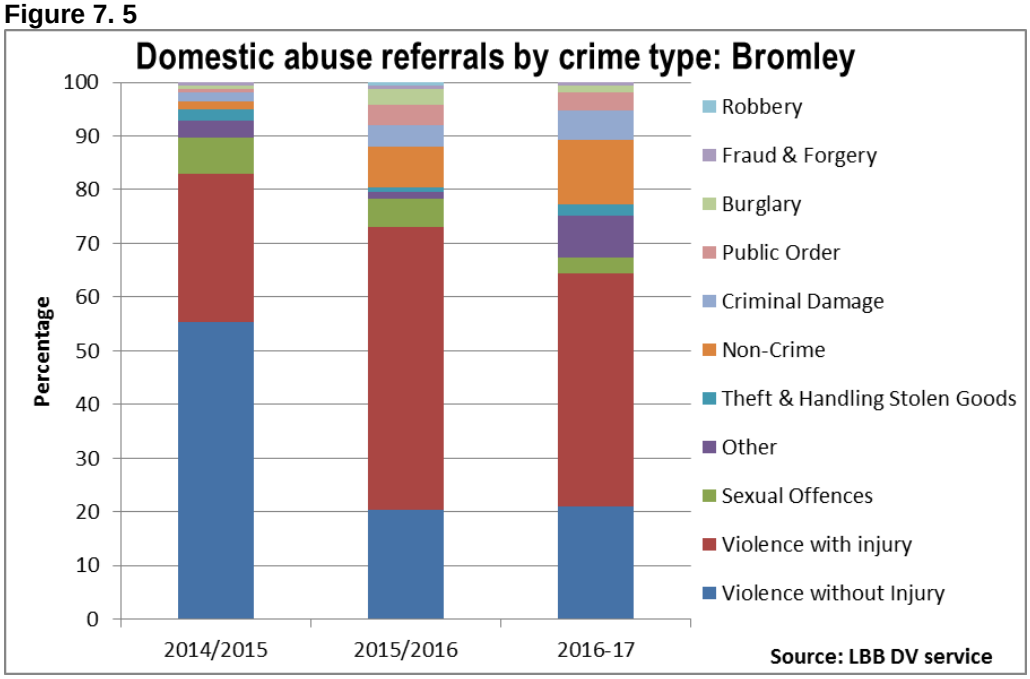
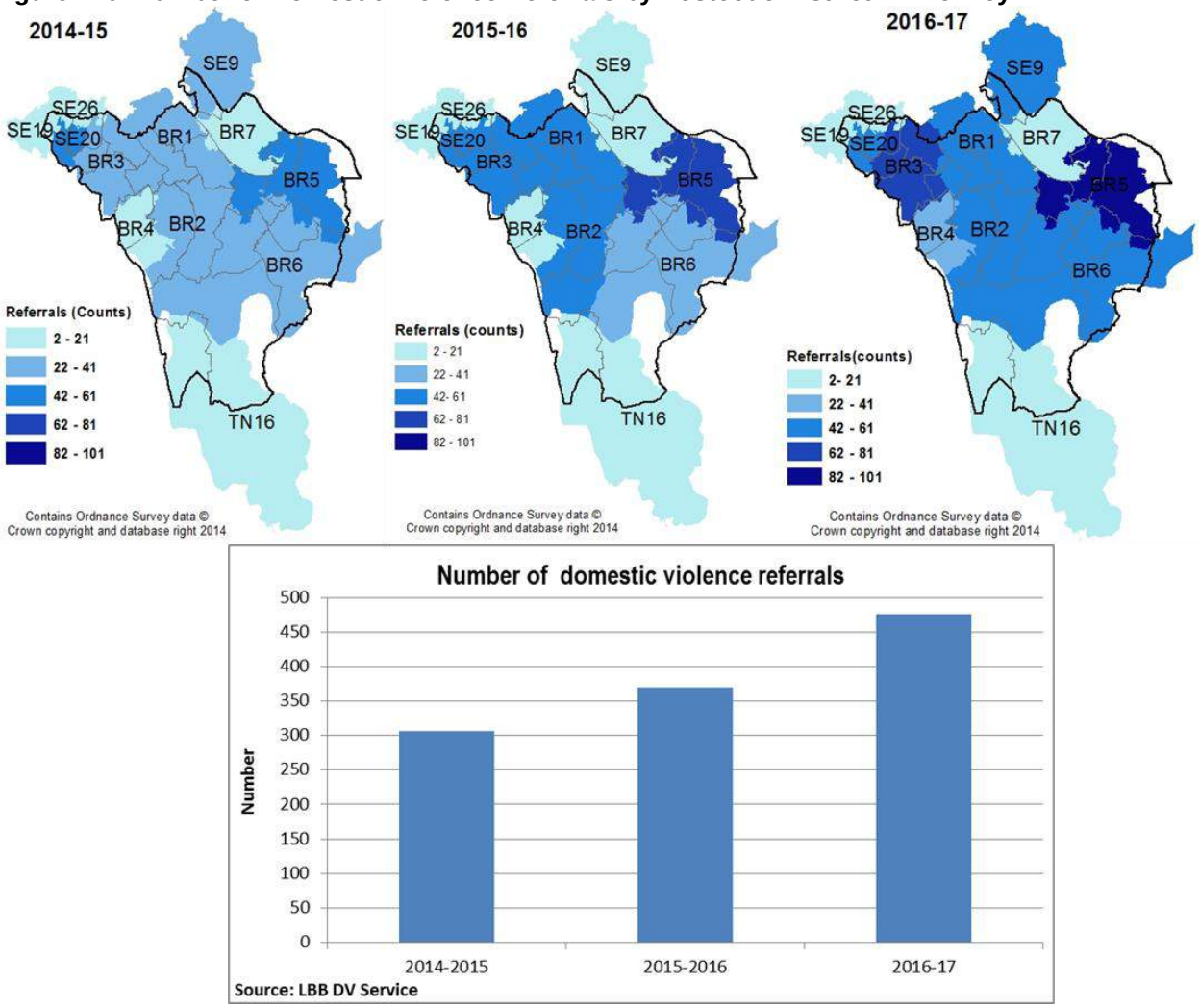


Figure 7.6 shows the geographical analysis of the referrals. The highest volume of referrals in 2016/17 was from residents living in the Cray Valley area at 1 in 5.of all referrals in that time period, followed by the areas of Clock House and Penge & Cator. It should be noted that postcode district areas mask the variation at a lower geography, making it difficult to pinpoint more accurately the areas of highest need in the borough.

Figure 7.6 also shows a year on year increase in the volume of referrals. It should be noted that the increase seems to be concentrated in the same areas. It is possible that, due to the recurrent nature of domestic violence, these victims have found a safe place to go, or this is a reflection of improved service capacity.

The relationship between deprivation and domestic violence is unknown; however, locally there is a leaning to a high volume of referrals in areas of deprivation as shown in the map below. There is a need for further analysis to understand if the differences seen are significant.

Figure 7. 6: Number of Domestic Violence Referrals by Postcode District in Bromley



Domestic Violence Intervention Project (DVIP)

The Domestic Violence Intervention Project is part of local action to address intimate partner domestic violence through interventions for the perpetrator.

In a two year period (2015/2016 and 2016/2017)

- 80 Perpetrators were referred to the project
- There were 7 self-referrals in a two year period
- 42 of the referred perpetrators attended assessment meetings
- 38 perpetrators were assessed as suitable for the programme
- 17 men completed 30 hours of treatment

One Stop Shop (OSS)

The OSS is a crucial starting point for both male and female victims on domestic abuse because in many cases the victim has probably never spoken to anyone about their situation before. The OSS supports vulnerable victims by offering a

wide range of services under one roof including a Police Officer, a family law solicitor, Bromley Metropolitan Police and other DV service providers. In the year 2016/2017 324 clients attended the One Stop Shop. The figures below demonstrate the range of support received by those attending:

- 219 sought advice from a solicitor
- 102 sought advice from housing
- 51 sought advice from the Police
- 147 sought advice from specialist domestic violence/abuse services

Victim/Survivor Support Group (VSSG)

Victim/survivor support groups are of a similar design to the 'Freedom Programme'. The programme is a 12 week course with the overarching aim to:

- To help women who have experienced domestic violence make sense of and understand what has happened to them.
- To recognise potential future abusers.
- To help women gain self-esteem and the confidence to improve their lives.

The support groups are available in Children and Family Centres and cover all parts of the borough. In 2016/2017 the support group received:

- A total of 109 referrals
- 21 referrals from Bromley Children's Social Care
- 23 self-referrals
- 11 referrals from the Bromley Children's Project

Identification and Referral to Improve Safety (IRIS)

The IRIS project is a GP based domestic violence and abuse training programme provided in collaboration with Bromley CCG and Victim Support. It was relaunched in October 2016. The training includes; safe enquiry, providing immediate support and onward referrals to specialist agencies.

Since the relaunch of the project in October 2016:

- 25 GP practices within the borough have been awarded IRIS Accreditation
- IRIS Bromley has received 122 referrals from GP Practices
- At least 12 service users have reported the domestic abuse to the Police and have continued through the criminal justice system

What this means for residents in Bromley:

There were 2568 domestic violence offences reported in Bromley between October 2016-September 2017. This is a rise of nearly 60% over the previous 5 years.

The number of high risk domestic violence cases referred to MARAC in Bromley rose by 6% in the last year, predominantly driven by an increase in referrals from the police.

The rate of cases discussed at MARAC is lower in Bromley than the national average (13 cases per 1000 population compared to 35 cases per 1000 population nationally).

There were 476 referrals to the Bromley Domestic Abuse Advocacy Project (BDAAP). The number of referrals has increased consistently from just over 300 in 2014/15.

The highest volume of referrals was from residents living in Cray Valley Clock House and Penge & Cator.

82% of the referrals to BDAAP were women. Women of childbearing age form a significant proportion of referrals received. In 2016/17, 212 dependents of the victims of domestic abuse were known to the BDAAP.

There has been a decline in the proportion of referrals from people from a Black or Black British background over the last 3 years. However, the highest proportion of referrals from the BME community still comes from this group.

APPENDIX

Data Sources and Definitions

In order to understand mortality and morbidity due to drugs for Bromley, local PCMD and Hospital Episodes Statistics extracts have been used.

The **Primary Care Mortality Database** (PCMD) provides a list of all deaths recorded as drug poisoning. PCMD collates deaths by place of death, CCG of residence and date of death. The underlying cause of death is recorded for all deaths in the PCMD using the World Health Organisation's (WHO) International Classifications of Diseases version 10 (ICD 10). The relevant codes are listed in a **table** in the appendix.

This definition of drug deaths includes accidents, suicides and assaults involving drug poisoning, as well as deaths from drug abuse and drug dependence. It does not include other adverse effects of drugs (for example anaphylactic shock). Deaths are included where one of the ICD-10 codes shown in the Table is the underlying cause of death.

Due to various organisation and regulation changes, access to datasets (**Coroner records** and **GP clinical records**) that complement the PCMD extract is no longer possible. The absence of those datasets eliminates the soft intelligence around drug related deaths which is vital in prevention strategies.

The **Hospital Episodes Statistics** (HES) extract pulls together inpatient and day patient hospital admissions for drug poisoning. The **primary** and **secondary** cause of admission is recorded for all admissions in the HES using the World Health Organisation's (WHO) International Classifications of Diseases version 10 (ICD 10). The relevant codes are listed in a table in the appendix.

Primary diagnosis is defined as the main condition treated or investigated during the relevant episode of healthcare, and where there is no definitive diagnosis, the main symptom, abnormal findings or problem.

Secondary diagnosis describes those conditions that co-exist at the time of admission, or develop subsequently, and that affect the patient care for this current episode of care. Clinicians record up to 19 secondary diagnoses.

Other Sources:

- Crime Survey for England and Wales
- National Drug Treatment Monitoring system
- Public Health England Commissioning Support Pack 2018/19
- Public Health England JSNA support Pack, 2018/19
- Public Health England Police and Crime Commissioners support pack, 2018/19
- Public Health Outcomes Framework

Data caveats for consideration

The report specifically focuses on drug misuse to the exclusion of alcohol. However, CGL is contracted to offer a combined drug and alcohol treatment and support service for Bromley residents. Therefore data presented in this report has been cleansed of alcohol and thus may differ from the routine data sources listed above.

The definition of drug related deaths does not include every death that involved drugs, for example, transport accidents where the driver was under the influence of drugs are excluded.

In common with most other mortality statistics, figures for drug-related deaths are presented for deaths registered in a particular calendar year, rather than deaths occurring each year. Due to the length of time it takes to complete a coroner's inquest, there can be a considerable delay between when the death occurred and when it was registered. The local data can be influenced by geographical variations in registrations delay.

Hospital admissions for alcohol related and alcohol specific conditions have been excluded from the discussion of this report as this report specifically focuses on drugs misuse. These hospital admissions will be included in a separate report specific to alcohol.

Table 1

Underlying Cause of Death : Drug related Deaths	
ICD- 10 Code	**Description**
F11-F16,F18-F19	Mental and behavioural disorders due to drug use (excluding alcohol and tobacco)
X40-X44	Accidenctal poisoning by drugs, medicaments and biological susbtances
X60-X64	Intentional self-poisoning by drugs, medicaments and biological substances
Y10 -Y14	Poisoning by drugs, medicaments and biological substances, undetermined intent
X85	Assaults by drugs, medicaments and biological substances

Useful References:

Aspects of Health Protection and Health Improvement

Tuberculosis in London: Annual review (2016 data) Data from 2000 to 2016 PHE
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662597/Tuberculosis_in_London_annual_review_2016_data.pdf

PHE: Health matters: reducing the burden of tuberculosis. Published 20 October 2016
https://www.gov.uk/government/publications/health-matters-reducing-the-burden-of-tuberculosis/health-matters-reducing-the-burden-of-tuberculosis

WHO Global eradication of measles: Sixty-third World Health Assembly Report by the Secretariat March 2010
http://apps.who.int/gb/ebwha/pdf_files/wha63/a63_18-en.pdf

WHO: Fifth meeting of the European Regional Verification Commission for Measles and Rubella Elimination (RVC), 24-26 October 2016
http://www.euro.who.int/__data/assets/pdf_file/0005/330917/5th-RVC-meeting-report.pdf?ua=1

PHE: Analysis of data for statutory notifications of infectious diseases (NOIDS) in England and Wales in 2018: Notifiable diseases: weekly reports for 2018
https://www.gov.uk/government/publications/notifiable-diseases-weekly-reports-for-2018

G.Amirthalingam, et.al. "Sustained Effectiveness of the Maternal Pertussis Immunization Program in England 3 Years Following Introduction *Clinical Infectious Diseases, Volume 63, Issue suppl_4, 1 December 2016, Pages S236–S243*
https://doi.org/10.1093/cid/ciw559

PHE: Pertussis vaccination programme for pregnant women update: vaccine coverage in England, July to September 2017 Health Protection Report Volume 12 Number 1 5 January 2018
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/672129/hpr0118_prntl-prtsss.pdf

Adult Mental Health

‘Preventing Suicide in England, a cross-government outcomes strategy to save lives’ (2012), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

‘Five Year Forward View For Mental Health’ (2016)https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

‘Fiver Year Forward View For Mental Health; One Year On’ (2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf

‘Preventing Suicide In England: third progress report of the cross-government outcomes strategy to save lives’ (2017) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

‘Healthier Lives Public Health England, Suicide Prevention’ (2016), http://healthierlives.phe.org.uk/topic/suicide-prevention

‘Mental Health and Prevention: taking local action for better mental health’ (2016) file:///M:/mental-health-and-prevention-taking-local-action-for-better-mental-health-july-2016.pdf

‘Understanding Mental Health Problems’ Mind (2016) https://www.mind.org.uk/media/3244655/understanding-mental-health-problems-2016.pdf

‘Transforming Children and Young People’s Mental Health Provision: a Green Paper’ (2017) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

‘The Mental Health of Children and Young People in England’ (2016), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf

‘YoungMinds’ https://youngminds.org.uk

References

[i] Ministry of Housing, Communities & Local Government. (2006). Gypsies and Travellers: facts and figures. [online] Available at: http://webarchive.nationalarchives.gov.uk/20120920073148/http://www.communities.gov.uk/documents/housing/pdf/158454.pdf [Accessed 19/12/2017].

[ii] Public Health England. (2017). *Public Health Outcomes Framework*. [online] Available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework [Accessed 19/12/2017].

[iii] NHS Digital. (2017). *Quality and Outcomes Framework – 2016-17*. [online] Available at: http://digital.nhs.uk/catalogue/PUB30124 [Accessed 19/12/2017].

[iv] Public Health England. (2017). *Cardiovascular disease data and analysis: guide for health professionals*. [online] Available at: https://www.gov.uk/guidance/cardiovascular-disease-data-and-analysis-a-guide-for-health-professionals [Accessed 20/12/2017].

[v] Office for National Statistics. (2017). *Annual Population Survey: January to December 2016*. [online] Available at: https://www.gov.uk/government/statistics/annual-population-survey-january-to-december-2016 [Accessed 20/12/2017].

[vi] NHS England. (2017). *GP Patient Survey 2017*. [online] Available at: http://results.gp-patient.co.uk/report/explanation.aspx [Accessed 20/12/2017].

[vii] Public Health England. (2017). *Pertussis vaccination programme for pregnant women update: vaccine coverage in England, January to March 2017*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/616198/hpr1917_prntl-prtsssVC.pdf [Accessed 20/12/2017].

[viii] World Health Organisation - Regional Office for Europe. (1999). *HEALTH 2:The health for all policy framework for the WHO European Region*. [online] Available at: http://www.euro.who.int/__data/assets/pdf_file/0010/98398/wa540ga199heeng.pdf [Accessed 20/12/2017].

[ix] Thomson, A., Robinson, K. and Vallée-Tourangeau, G. (2016). *The 5As: A practical taxonomy for the determinants of vaccine uptake*. Vaccine, 34, 1018-1024. [online]. Available at: https://www.sciencedirect.com/science/article/pii/S0264410X15017466 [Accessed 20/12/2017].

[x] Public Health England- Field Epidemiology Services (South East London). (2017). *Tuberculosis in London: annual review (2016 data)*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662597/Tuberculosis_in_London_annual_review_2016_data.pdf [Accessed 20/12/2017].

[xi] The King's Fund. (2016). *Bringing together physical and mental health: a new frontier for integrated care*. [online] Available at: https://www.kingsfund.org.uk/publications/physical-and-mental-health [Accessed 19/12/2017].

[xii] The Academy of Medical Royal Colleges and the Royal Colleges of General Practitioners, Nursing, Pathologists, Psychiatrists, Physicians, the Royal Pharmaceutical Society and Public Health England. (2016). *Improving the physical health of adults with severe mental illness: essential actions*. [online] Accessed at: http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op100.aspx [Accessed 19/12/2017].

[xiii] Department of Health. (2011). *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*. Available at: https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-mental-health-outcomes-strategy-for-people-of-all-ages-a-call-to-action [Accessed 19/12/2017].

[xiv] Department of Health (2011) *No health without mental health: a cross-government mental health outcomes strategy for people of all ages. Supporting document – The economic case for improving efficiency and quality in mental health*. Available at: https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health [Accessed 19/12/2017].

[xv] The King's Fund. (2012). *Long-term conditions and mental health: The cost of co-morbidities*. [report] Available at: https://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health [Accessed 19/12/2017].

[xvi] The King's Fund. (2017). *Mental health and new models of care – lessons from the vanguard*. [online] Available at: https://www.kingsfund.org.uk/publications/mental-health-new-care-models [Accessed 19/12/2017].

[xvii] NHS Digital. (2014). *Adult psychiatric morbidity survey: survey of mental health and wellbeing, England, 2014*. [online] Available at: http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf [Accessed 19/12/2017].

[xviii] Healthwatch Bromley. (2015). *Exploring mental health in the London Borough of Bromley*. [online]. Available at: http://d34t0xjev7wfjs.cloudfront.net/2017/03/06212631/Mental_Health_Report_-_2015.pdf [Accessed 19/12/2017].

[xix] Public Health England. (2017). *Public health profiles*. [online] Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/data#page/0/gid/1938132920/pat/6/par/E12000007/ati/102/are/E09000006 [Accessed 19/12/2017].

[xx] Wing, J.K. (2017). 'Severe Mental Illness' in University of Birmingham: *an introduction to Health Care Needs Assessment (HCNA).* [online] Available at:

https://www.birmingham.ac.uk/research/activity/mds/projects/HaPS/PHEB/HCNA/chapters/index.aspx [Accessed 19/12/2017].

[xxi] Jamie, G. (2017). *Mental health-UK - QOF database*. [online] Available at: https://www.gpcontract.co.uk/browse/UK/Mental%20Health/17 [Accessed 19/12/2017].

[xxii] Greater London Authority Intelligence. (2017). *GLA population and household projections* [online] Available at: https://data.london.gov.uk/dataset/projections/ [Accessed 19/12/2017].

[xxiii] Greater London Authority Intelligence. (2017). *GLA 2015 Round Trend-based ethnic group projections, short-term migration scenario* [online] Available at: https://data.london.gov.uk/dataset/gla-population-projections-custom-age-tables [Accessed 19/12/2017].

[xxiv] Mental Health Foundation. (2017). *Black, Asian and minority ethnic (BAME) communities*. [online] Available at: https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities [Accessed 19/12/2017].

[xxv] Das-Munshi, J., Chang, C., Dutta, R., Morgan, C., Nazroo, J., Stewart, R. and Prince, M. (2017). *Ethnicity and excess mortality in severe mental illness: a cohort study*. The Lancet Psychiatry, 4, 389-399. Available at: http://www.sciencedirect.com/science/article/pii/S2215036617300974 [Accessed 19/12/2017].

[xxvi] National Institute for Health and Care Excellence. (2017). *Bipolar disorder: assessment and management - guidance and guidelines*. [online] Available at: https://www.nice.org.uk/guidance/cg185 [Accessed 19/12/2017].

[xxvii] Bromley Council. (2017). *Bromley Joint Strategic Needs Assessment 2016*. [online] Available at: https://bromley.mylifeportal.co.uk/media/20397/final-report-jsna-2016.pdf [Accessed 19/12/2017].

[xxviii] Mental Health Foundation. (2017). *Surviving or thriving? The state of the UK's mental health*. [online] Available at: https://www.mentalhealth.org.uk/publications/surviving-or-thriving-state-uks-mental-health [Accessed 19/12/2017].

[xxix] Public Health England. (2017). *Public health profiles: common mental health disorders.* [online] Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/4/gid/8000042/pat/46/par/E39000018/ati/153/are/E38000023/iid/90744/age/168/sex/4 [Accessed 19/12/2017].

[xxx] Light, M., Grant, E. and Hopkins, K. (2013). *Gender differences in substance misuse and mental health amongst prisoners: results from Surveying Prisoners Crime Reduction (SPCR) longitudinal cohort study of prisoners*. Available at: http://www.antoniocasella.eu/archipsy/Light_2013.pdf [Accessed 19/12/2017].

[xxxi] Public Health England. (2016). *Local suicide prevention planning: A practice resource*. [online]. Available at: http://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf [Accessed 11/09/2017].

[xxxii] Department of Health (2014). *Preventing suicide in England: a cross-government outcomes strategy to save lives*. Available at: https://www.gov.uk/government/publications/suicide-prevention-report [Accessed 19/12/2017].

[xxxiii] Royal College of Psychiatrists. (2010). *Self-harm, suicide and risk: a summary*. [online] Available at: https://www.rcpsych.ac.uk/pdf/PS03-2010x.pdf [Accessed 19/11/2017].

[xxxiv] World Health Organisation (WHO). Lexicon of alcohol and Drug Terms Published by the World Health Organisation. (1994). [online] Available at: http://www.who.int/substance_abuse/terminology/who_ladt/en/ [Accessed 13/11/2017].

[xxxv] Alere. (2017). *UK drug classifications*. [online] Available at: https://www.aleretoxicology.co.uk/en/home/support/drug-classifications.html [Accessed 14/11/2017].

[xxxvi] HM Government. (2017). *2017 Drug Strategy*. [online] Available at: https://www.gov.uk/government/publications/drug-strategy-2017 [Accessed 13/11/2017].

[xxxvii] Burkinshaw, P., Anders, P., Knight, J., Eastwood, B., Musto, V., White, M. and Marsden, J. (2017). *An evidence review of the outcomes that can be expected of drug misuse treatment in England*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf [Accessed 7/12/2017].

[xxxviii] Public Health England. (2014). *Alcohol and drugs prevention, treatment and recovery: why invest*. [online] Available at: http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf [Accessed 15/11/2017].

[xxxix] Public Health England. (2017). *Opiate and crack cocaine use: prevalence estimates for local populations*. [online] Available at: https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations [Accessed 15/11/2017].

[xl] National Treatment Agency for Substance Misuse. (2017). *Addiction to medicine: an investigation into the configuration and commissioning of treatment services to support those who develop problems with prescription-only or over-the-counter medicine*. [online] Available at: http://www.nta.nhs.uk/facts-prevalence.aspx [Accessed 15/11/2017].

[xli] Knight, J., Brand, P., Willey, P. and Van der Merwe, J. (2017). *Adult's substance misuse statistics from the National Drug Monitoring Service (NDTMS*). [online] Available at: https://www.ndtms.net/Publications/downloads/Adult%20Substance%20Misuse/Adult-statistics-from-the-national-drug-treatment-monitoring-system-2016-17.pdf [Accessed 24/11/2017].

[xlii] Public Health England (2017). *Adults - drugs commissioning support pack 2018-19: key data. Planning for drug prevention, treatment and recovery in adults.* [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/647095/Adult_drug_commissioning_support_pack_2018-19_-_key_data.pdf [Accessed 15/12/2017].

[xliii] Shapiro, H. (2015). *Not for human consumption: an updated and amended status report on new psychoactive substances (NPS) and 'club drugs' in the UK*. [online] Available at: http://www.drugwise.org.uk/wp-content/uploads/not-for-human-consumption.pdf [Accessed 15/12/2017].

[xliv] DrugWise. (2017). *Is drug use mainly in deprived areas?* [online] Available at: http://www.drugwise.org.uk/is-drug-use-mainly-in-deprived-areas/ [Accessed 20/12/2017].

[xlv] National Institute on Drug Abuse. (2017). Treatment Approaches for Drug Addiction. [online] Available at: https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction [Accessed 15/12/2017].

[xlvi] Public Health England. (2017). *Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf [Accessed 7/12/2017].

[xlvii] Crome, I.B. (2006). *An epidemiological perspective of psychiatric comorbidity and substance misuse: The UK experience/ example in Baldacchino, A and Corkery*, *J*. Journal of Comorbidity: Perspectives across Europe, (ECCAS Monography No 4), 45-60 [Accessed 4/12/2017].

[xlviii] Marsden, J. (2000). *Psychiatric symptoms among clients seeking treatment for drug dependence: intake data from the National Treatment Outcome research study*. The British Journal of Psychiatry, 176, 285-289. [online] Available at: https://www.ncbi.nlm.nih.gov/pubmed/10755078 [Accessed 4/12/2017].

[xlix] Public Health England. (2017). *Shooting up: infections among people who injected drugs in the UK, 2015*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/567231/Shooting_Up_2016_Update.pdf [Accessed 6/12/2017].

[l] Stoove, M.A., Dietze, P.M. and Jolley, D. (2009). *Overdose deaths following previous non-fatal heroin overdose: record linkage of ambulance attendance and death registry data*. Drug and Alcohol Review, 28, 347-352. [online] Available at: https://www.ncbi.nlm.nih.gov/pubmed/19594787 [Accessed 15/12/2017].

[li] Public Health England: National Intelligence Network (2016). *Drug health harms – national intelligence*. [online] Available at: http://www.nta.nhs.uk/uploads/national-intelligence-network-on-drug-health-harms-021215.pdf [Accessed 15/12/2017].

[lii] Fenton, K. (2017). *Health Matters: Preventing drug misuse deaths-public health matters.* [online] Available at: https://publichealthmatters.blog.gov.uk/2017/03/01/health-matters-preventing-drug-misuse-deaths/ [Accessed 7/12/2017].

[liii] National Institute for Health and Care Excellence (2007). *Drug misuse in over 16s: opioid detoxification.* [online] Available at: https://www.nice.org.uk/guidance/cg52 [Accessed 15/12/2017].

[liv] Pleace, N. (2008). *Effective services for substance misuse and homelessness in Scotland: evidence from an international review*. [online] Available at: http://www.gov.scot/Resource/Doc/233172/0063910.pdf [Accessed 12/12/2017].

[lv] Office for National Statistics. (2017). *Domestic abuse in England and Wales: year ending March 2017*. [online] Available at : https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2017 [Accessed 24/01/2018].

[lvi] Ouellet-Morin, I., Fisher, H.L., York-Smith, M., Fincham-Campbell, S., Moffitt, T.E. and Arseneault, L. (2015). *Intimate partner violence and new-onset depression: a longitudinal study of women's childhood and adult histories of abuse*. Depression and Anxiety, 32, 316-324. [online] Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418177/ [Accessed 24/01/2018].

[lvii] HM Government. (2016). *Ending violence against women and girls: strategy 2016 – 2020*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF [Accessed 24/01/2018].

[lviii] Hester, M. (2013*). Who does what to whom? Gender and domestic violence perpetrators in English police records*. European Journal of Criminology, 10, 623-637. [online] Available at: http://journals.sagepub.com/doi/abs/10.1177/1477370813479078 [Accessed 24/01/2018]

[lix] United Nations. (1993). *Declaration on the elimination of violence against women*. [online] Available at: http://www.un.org/documents/ga/res/48/a48r104.html [Accessed 24/01/2018].

[lx] Home Office. (2013) *Domestic violence and abuse: guidance*. [online] Available at: https://www.gov.uk/guidance/domestic-violence-and-abuse [Accessed 24/01/2018].

[lxi] United Nations Women (2010). *Defining violence against women and girls*. [online] Available at: http://www.endvawnow.org/en/articles/295-defining-violence-against-women-and-girls.html [Accessed 24/01/2018].

[lxii] Office for National Statistics. (2017). *Sexual offences in England and Wales: year ending March 2017*. [online] Available at https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2017 [Accessed 24/01/2018].

[lxiii] SafeLives. (2016). *Safe Later Lives: older people and domestic abuse*. [online] Available at: http://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf [Accessed 24/01/2018].

[lxiv] Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. and Collishaw, S. (2011). *Child abuse and neglect in the UK today: research into the prevalence of child maltreatment in the United Kingdom*. [online] Available at: https://www.nspcc.org.uk/services-and-resources/research-and-resources/pre-2013/child-abuse-and-neglect-in-the-uk-today/ [Accessed 24/01/2018].

[lxv] Devaney, J. (2015). *Research review: the impact of domestic violence on children*. Irish Probation Journal, 12, 79-94. [online] Available at: https://pure.qub.ac.uk/ws/files/17369087/Research_review_impact_of_domestic_violence_on_children.pdf [Accessed 24/01/2018].

[lxvi] Office for National Statistics. (2017). *Crime in England and Wales: year ending June 2017*. [online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/june2017 [Accessed 24/01/2018].

[lxvii] SafeLives. (2014). *Frequently asked questions - Multi-Agency Risk Assessment Conferences (MARAC)*. [online] Available at: http://www.safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf [Accessed 24/01/2018].

[lxviii] Home Office Violent and Youth Crime Prevention Unit (VCYU) and Research and Analysis Unit (RAU). (2011). *Research into Multi-Agency Risk Assessment Conferences (MARACs)*. [online] Available at: http://www.cjp.org.uk/EasysiteWeb/getresource.axd?AssetID=5224&type=full. [Accessed 24/01/2018].

[lxix] Safer London. (2016). *Pan-London domestic violence needs assessment report – summer 2016*. [online] Available at: https://saferlondon.org.uk/wp-content/uploads/2016/12/PLDV-Needs-Assessment-Final-low-res.pdf [Accessed 24/01/2018].

[lxx] Walby, S. (2009). *The cost of domestic violence: up-date 2009*. [online] Available at: http://eprints.lancs.ac.uk/88449/1/Cost_of_domestic_violence_update_4_.pdf [Accessed 24/01/2018].

[lxxi] Trust for London. (2011). *Domestic violence costs £5.5bn a year in England*. [online] Available at: https://www.trustforlondon.org.uk/news/domestic-violence-costs-55bn-year-england/ [Accessed 24/01/2018].

[lxxii] HM Government. (1998). *Crime and Disorder Act 1998*. [online] Available at: https://www.legislation.gov.uk/ukpga/1998/37/contents [Accessed 24/01/2018].

[lxxiii] Greater London Authority. (2017). Domestic and sexual violence dashboard. [online] Available at:: https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/crime%20/domestic-and-sexual [Accessed 25/01/2018].

[lxxiv] Public Health England. (2015). *Disability and domestic abuse - risk, impacts and response*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf [Accessed 25/01/2018].

[lxxv] Public Health England. (2018). Public health profiles. [online] Available at: https://fingertips.phe.org.uk/search/Domestic%20Abuse [Accessed 25/01/2018].

[lxxvi] Barter, C., McCarry, M., Berridge, D. and Evans, K. (2009). *Partner exploitation and violence in teenage intimate relationships*. [online] Available at: https://www.nspcc.org.uk/globalassets/documents/research-reports/partner-exploitation-violence-teenage-intimate-relationships-report.pdf [Accessed 25/01/2018].

[lxxvii] Taskforce on the Health Aspects of Violence Against Women and Children. (2010). Responding to violence against women and children – the role of the NHS. [online] Available at: http://www.health.org.uk/sites/health/files/RespondingtoViolenceAgainstWomenAndChildrenTheRoleofTheNHS_guide.pdf [Accessed 25/01/2018].