



Bromley Clinical Commissioning Group

BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2015

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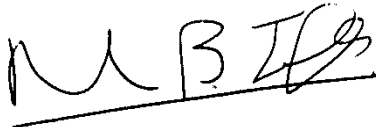
Foreword

As chairman of the Health & Wellbeing Board, I have great pleasure in presenting the Bromley Joint Strategic Needs Assessment (JSNA) for 2015.

I commend this document to commissioners, providers and users of health and social care services and hope that they will use it to inform the design and targeted delivery of interventions that will achieve better health and wellbeing outcomes whilst reducing inequalities.

We always welcome any suggestions on how to improve both the format of the JSNA and the information sources used. Should you wish to contact us please e-mail health.partnership@bromley.gov.uk.

Finally, I would like to thank the editorial team and the steering group plus all contributors who have worked hard to produce this document for which I hope the data and analysis presented will be a useful resource to continue making Bromley a happier and healthier place to live, work and enjoy.

A handwritten signature in black ink, appearing to read 'D. Jefferys', written over a horizontal line.

Councillor David Jefferys
Chairman of Bromley Health & Wellbeing Board

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Executive Summary

2. The Population

The population of Bromley continues to grow, to a size of over 320,000 in 2015, and is predicted to expand still further over the next ten years.

Although the number of 0 to 4 year olds is projected to decrease by the year 2020 to 20,300 and then to 20,100 by 2025, there has been an increase in the number of live births since 2002.

The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17.7% of the population in 2015 to 17.9% by 2020 and 18.7% by 2025. 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 numbers of over 75s.

The latest (2015) GLA population projection estimates show that 17.9% of the population is made up of Black and minority ethnic (BME) groups. The BME group experiencing the greatest increase within Bromley's population is the Black African community, from 3.8% of the population in 2015 to 5% of the population in 2030. 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 at birth in Bromley has been rising steadily over the last 20 years, currently at 81.3 years for men and 84.9 years for women. However, there is a gap of 9 years for men and 7.6 years for women between the highest and lowest life expectancy wards in Bromley, with the lowest life expectancy in the most deprived wards.

Mortality in Bromley is chiefly caused by circulatory disease (30.4%) and cancer (30%) with higher mortality rates for both conditions in the more deprived areas of the borough.

There is a need for continued action to address health inequalities associated with deprivation. One avenue is to improve early identification of increased circulatory disease risk through the NHS Health Checks Programme. There is a need to improve the low uptake of NHS Health Checks across most wards in the borough particularly in Crystal Palace. Improving access and targeting areas of higher cardiovascular disease mortality and low levels of NHS Health Checks coverage, is

important to ensure the programme does not widen health inequalities in the borough.

Evaluation is necessary to monitor the pathways to ensure appropriate follow up of the NHS Health Checks when risks have been identified, in order to maximise early diagnosis of high risk conditions. Where conditions are identified and managed early, people are less likely to progress onto more severe cardiovascular disease of stroke, heart attack or vascular dementia.

In addition, there is evidence to show that there are many people living in Bromley with undiagnosed hypertension, and a number of people with known hypertension which has not been adequately controlled. These people are at higher risk of stroke, kidney disease heart disease and other conditions.

Diabetes represents a continuing challenge in Bromley. The number of people affected has been rising since 2002, and for those diagnosed, control of the associated risk factors for circulatory disease is less effective than nationally. New prevalence modelling has estimated that there are 29.8 thousand people in Bromley at high risk of developing diabetes. Work is necessary both to prevent and to improve identification of diabetes.

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. In addition, a significant proportion of cancers are diagnosed outside the two week referral pathway, leading to later diagnoses, which will adversely impact survival rates, as will the low cancer screening uptake in the more deprived parts of the borough.

Although the rate of sexually transmitted infections (STIs) is lower in Bromley than nationally, young people between 15 and 24 years old in Bromley continue to have the highest rates of new STIs. Males of all ages are more affected by new STIs than females. There is cause for concern at the increasing incidence rate of Syphilis and Gonorrhoea. The majority of new cases of Syphilis and Gonorrhoea occur in men who have sex with men (MSM), indicating that MSM are a high risk group in Bromley.

Although the HIV prevalence rate in Bromley is steadily rising, it remains at just above the 2 per 1000 threshold. However there are areas in Bromley where the prevalence rate has risen from 6 per 1000 population to over 8 per 1000 population similar to high prevalence boroughs in London.

Heterosexual residents are the highest group diagnosed with HIV but there are more Black African women diagnosed than Black African men. The numbers of MSM cases are gradually increasing year by year.

Teenage conception rates are continuing to fall in Bromley as well as the proportion that result in abortion. Although these figures show Bromley is demonstrably better than the London average this year and the decrease is greater, it is still not as good as England overall.

The latest data indicates that the provision of preventative methods - condoms, Long Acting Reversible Contraception (LARC) methods and Sex and Relationship Education (SRE) programmes has begun to make an impact on avoiding unwanted pregnancies.

The number of live births is rising, reflecting the rising trends in the general fertility rates. The trends have implications for Bromley primary schools and children services in the borough.

There are higher birth rates in Bromley women aged 25-39 than England and London and there is a rising trend towards older motherhood. There is a need for reproductive healthcare services to reflect the population changes.

Abortion rates in women in their 20s are high. These women are also more likely to report a previous termination than other age groups. There is therefore a need to understand contraception use and terminations particularly in women in their 20s in Bromley.

Further work is needed to encourage the uptake of childhood immunisations as vaccination rates for several categories, such as MMR, PCV, Hib/MenC, DTaP/IPV (pre-school), remain below the national recommendation of 95% coverage.

There remains a potential for measles outbreaks, particularly in older children and young adults due to poor immunisation uptake. There were 14 confirmed cases of pertussis (whooping cough) in 2014, highlighting the importance of immunisation against pertussis, in particular the uptake of maternal pertussis vaccination programme.

Seasonal flu vaccination rate in Bromley is lower than that of England, meaning a large proportion of at risk individuals remain vulnerable to the serious health effects of flu. Shingles and Pneumococcal vaccine (PCV) coverage for older people could be improved as it is lower than England.

Bromley's smoking prevalence decreased from 17.8% in 2012 to 14.0% in 2014, however, smoking prevalence in routine and manual (R&M) occupational groups is consistently higher than the general population, currently 16.3% in 2014.

Smoking continues to have a negative impact on Bromley's morbidity and mortality rates, local economy, health inequalities, local environment, hospital admission, re-admission and post-operative complication rates. Stopping smoking is a priority within Bromley for routine and manual workers, pregnant women, those with a mental health condition and patients in secondary care (hospital admission, re-admission and post-operative complications).

Bromley has the sixth highest levels of adult overweight and obesity in London, 63.8% are either overweight or obese and the prevalence is rising. There has been little change in the prevalence of childhood obesity in Reception Year between 2005 and 2014, ranging between 7% and 8% annually. With each cohort the prevalence of obesity tends to almost double between Reception Year and Year 6. For example, in 2007/8, 7.3% of the Reception Year children in Bromley were classified as obese. In 2013/14, when this cohort was in Year 6, 15.4% were classified as obese. Excess weight contributes significantly to the incidence and progression of diseases such as type 2 diabetes, circulatory disease and cancer. A significant proportion of Bromley's residents (21.2% obese) are at higher risk of these conditions and of premature death.

There is scope to increase levels of physical activity participation in Bromley to increase health benefits. More than a quarter of the Bromley population were not participating in even 30 minutes of activity a week (25.6%) in 2014, which is an increase from 24.1% in 2013.

There is a need to deliver physical inactivity strategies independently of obesity and weight management, prioritise and resource physical inactivity programmes to the same level as other top tier public health risks, invest in evidence-based programmes that engage inactive groups and to consider the impact of physical inactivity in regeneration and planning regulations.

4. Housing & Homelessness

Housing is a fundamental need for good health and wellbeing and inequalities in a range of health issues can be tracked to the quality of housing.

The number of households in Bromley is predicted to increase steadily over coming years with the average household size set to decrease.

Approximately 71% of dwellings in Bromley are in owner occupation and approximately 13% are in the private rented sector, with 14% of social rented housing is supplied through Housing Associations.

Over the last ten years there has been a fall in the level of owner occupation and a growth in the private rental sector most likely as a result of the general economic downturn. The increase in demand in the private rental sector has driven a significant rise in rental prices for lower quartile rents.

A study of private sector housing conditions (2009 report) indicated that approximately 36% of private sector dwellings in the Borough fail the Government's Decent Homes Standard.

More than 3000 households present at imminent risk of homelessness each year. One third of homelessness is due to eviction from private rented accommodation, and 39% is due to family and friends no longer being able to accommodate (many of these are households who were previously in independent accommodation). An increasing number of households face a shortfall between benefits and housing

costs and there are increasing numbers of households and children residing in temporary accommodation, in particular, outside the borough boundaries. Of those in priority need for housing support, 66% have dependent children. There is an increasing demand for housing support for young people aged 16 to 24 years, for people with mental health needs, and for private and intermediate older person's accommodation in Bromley.

5. Older People's Health

The population of Bromley includes a significant proportion of older people (17.4% over the age of 65 years). Population projections suggest that this proportion will increase over the next five years (to 17.9%) and over the next ten years (to 18.9%). In the over 65 year population, deaths are more likely to be from cancer in the 65 to 74 year age group and to be from circulatory disease in the older age groups. The over 65s make a significant contribution to the burden of long term conditions overall, representing over 75% of the overall disease burden for most conditions. Whilst nearly 40% of 65 to 74 year olds have no long term conditions, by the age of 85 years, this has reduced to only 13.4%. Although prevalence of long term conditions (LTCs) is similar in the most and least deprived areas, because life expectancy is higher in the less deprived areas, there are relatively higher numbers of people with LTCs in these areas.

The most frequent primary diagnoses recorded for emergency hospital admissions of Bromley patients in 2013 -14 were pneumonia, urinary tract infection, and ischaemic heart disease. The most frequent underlying diagnoses recorded for emergency hospital admissions of Bromley patients in 2013 -14 were hypertension, ischaemic heart disease, atrial fibrillation and cancer. These underlying causes of admission are amenable to prevention and improved management at an earlier stage.

6. People in Care Homes

There are 67 nursing and residential care homes in Bromley with a total of 2055 beds and these include homes for older people, people with a learning disability and people with mental health needs. There are in addition a number of sites offering extra care housing in Bromley.

Across 22 practices in Bromley, 1110 patients resident in care homes and extra care housing were identified. Of these, 828 (74.6%) were female, and 740 (66.7%) were aged 85 years or over. The proportion of women is similar to the national figure (73.5%), but the proportion over the age of 85 years is much higher than the national figure (59.1%).

In comparison with the over 65 year population in Bromley as a whole, care home residents are far more likely to have a diagnosis of dementia or stroke, and overall more likely to be suffering from heart disease, kidney disease, cancer or diabetes. People in care homes are more likely than the general population over the age of 65 years to have two or more comorbidities. The care home population present a more complex healthcare challenge.

Of the 1,110 patients identified in 2015, a significant proportion, 48.9% (543) were found to be new to the practice during that 18 month period.

A comparison of people living in extra care housing with those resident in care homes, showed that the proportion of people over the age of 85 years in extra care housing is lower than that in care homes, the extra care housing residents tend to have a higher number of comorbidities than the care home residents, but care home residents are more likely to suffer from dementia, and to have mobility problems (arthropathies, fractures) than the extra care housing residents.

7. Excess Winter Deaths

Excess Winter Deaths are higher in Bromley than England and there are around 150 potentially preventable winter deaths each year, accounting for 6% of all Bromley deaths.

People especially at risk include those living in poorly heated or expensive to heat homes, the elderly and those with underlying respiratory and cardiac conditions. Relative deprivation in Bromley is not necessarily associated with excess winter mortality and poorly heated housing can occur in the owner occupier or privately rented sector. This means the risk of Excess Winter Deaths is widely distributed across the elderly population.

Given the high Excess Winter Deaths Index and the underlying risk factors present, efforts to understand and address Excess Winter Deaths needs multi stakeholder efforts across statutory and voluntary sector involved in health, social care, housing, planning and environmental services in Bromley.

NICE issued guidance in 2015 on excess winter deaths and illnesses associated with cold homes to further inform action on this issue.

8. Vulnerable Young People

London Borough of Bromley continues to support 43 children in mainstream schools with complex health needs, including some requiring airway support, Hickman lines, support for complex diabetes and gastrostomy tube feeding.

There are currently just under 8000 children in Bromley schools with Special Educational Needs, and just over 1600 with Statements of Special Educational Needs, the percentage of such pupils is above the national and London average and above the three closest statistical neighbours. In particular, the proportion of pupils with speech, language and communication needs is significantly above average, there are higher rates of children with severe, profound and multiple learning difficulties, and pupils on the autistic spectrum and there are more pupils with social emotional and mental health needs in Bromley compared to the statistical neighbours.

Pupils who have a significant degree of Special Educational Needs and Disability perform less well than their peers at all Key Stages and subjects.

The number of looked after children (LAC) has remained relatively stable, ranging between 250 and 286 each year over the last seven years. The rate of 38 looked

after children per 10,000 population under 18 is lower than for inner London, outer London and nationally. There is an increase in the percentage of looked after children from black and minority ethnic (BME) groups. A high proportion of looked after children (72%) have special educational needs, and 41.2% of LAC have a Statement of Special Educational Needs.

There are a relatively low number of unaccompanied asylum seeking children in Bromley.

75% of looked after children are in foster placements, and the percentage of children with 3 or more placement moves is currently 12%, in line with comparator groups.

The percentage of looked after children placed out of the borough and more than 20 miles from where they used to live is currently 20% of looked after children compared to 15% of children in statistical neighbour authorities, and 13% nationally. It has reduced from 22% in 2012/13.

A new team has been formed to look after the emotional health needs of LAC and adopted children. The most common presenting problems were extreme neglect and emotional abuse, with 43% of referrals having experienced at least one of these.

In 2013/14, 43% of Bromley LAC were not in education, employment or training, this is a higher percentage than our statistical neighbours and London.

9. Children and Young People

Indicators of child health in Bromley are mostly rated better than the national average for most aspects. However, family homelessness and A&E attendances in children are rated as higher than the national average and the child mortality rate is also higher than the national and London rate.

Although A&E attendances are higher than the national rate, a relatively low proportion of those children are admitted as an in-patient, indicating that a proportion of those children could have been managed in primary care.

Although educational attainment in Bromley schools is generally above the national average, certain groups of children, in particular those in receipt of Free School Meals do not make the desired rate of progress and there are small but significant number of schools where sustainable improvement is not yet achieved.

Improvements in these areas need to remain a priority for Bromley schools.

10. Older People

An increasing number of older people are being supported within their own home, which will have an increasing impact on community based services by all organisations that are required.

The increasing complexity of needs of the older people in residential care will impact on the services required to be provided by care homes.

Community based services need to continue to support people with complex needs within their own homes – including trained workforce

An integrated approach to the commissioning and provision of services for people with dementia and their carers is needed.

Bromley has a higher percentage of adult social care users who have less social contact than they would like when compared to London and England.

11. Learning Disability

The number of people with learning disabilities under the age of 64 years is predicted to rise by 5% over the next five years. Medical advances mean that more young people with profound and multiple disabilities are surviving to adulthood and increasing numbers of children with learning disabilities are making the transition to adult services.

Nationally, the median age at death for people with Learning Disabilities is approximately 24 years (30%) younger than for those who do not have learning disabilities; therefore it is important to ensure that good healthcare is available for people with learning disabilities. However identification of people with learning disabilities by GPs in Bromley is still lower than the expected level, and in addition, a low proportion receive health checks, although there have been improvements made over the last year. This may be a contributing factor to the high rates of emergency admissions to hospital for adults with learning disability in Bromley, but further work needs to be undertaken to establish the reasons for high rates of emergency admissions.

There is a need to improve the identification of people with learning disabilities in primary care, to promote the use of patient held Health Action Plans and hospital passports where appropriate and to raise awareness of the liaison nurse role/contact details within the local hospital(s).

Work is being done to promote the independence of people with learning disabilities through schemes such as the travel training programme.

Further work needs to be undertaken to increase the number of adults with a learning disability who live in stable and appropriate accommodation.

12. Sensory Impairment and Physical Disability

The number of people in Bromley with physical disability or sensory impairment continues to increase.

The majority of people with hearing loss are in the older age groups and as the numbers of older people in Bromley increase, there is a need to minimise and address the consequences of hearing impairment, such as social isolation, depression and dementia.

Smoking, obesity, excessive alcohol consumption, hypertension and diabetes are all risk factors for the development of visual impairment, therefore their prevention and management should be a high priority.

There continues to be insufficient local data on levels of paid and unpaid employment, and employment opportunities for disabled people.

13. Mental Health

The prevalence of people with depression over 18 in Bromley is similar (6.38%) to the average in England (6.52%).

Over 2,600 people in Bromley (almost 1% of the adult population) have been identified by GPs as experiencing serious mental illness. Although Bromley has low levels of serious mental illness (SMI) and record high levels of primary care checks there is still relatively high mortality. There are higher levels of specialist posts in Early Intervention Teams so cost per caseload is high even though level of interventions delivered by teams is low in comparison to London and England. Expenditure for people with psychotic disorders is low for a London Borough. The majority of spend is on secondary care.

The percentage of adults on the Care Programme Approach in Employment, although not significantly different from England and London remains at just 6%. Within the next five years there will be an increase of over 400 people with dementia with the greatest increase in the over 85 years: as well as dementia, this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,100.

The suicide rates for Bromley males are increasing in line with the England trend, while the rates in women, although significantly lower than males, seem to be reducing. Overall, suicide rates for men are about three times higher than for women.

In the year 2000, there were 122 hospital admissions for deliberate self-harm at all ages in Bromley. In 2013 this number had increased to 318. 78% of all deliberate self-harm emergency admissions are for self-poisoning using prescription and over the counter medications, narcotics and substance abuse. In addition, 5 out of 7 of the emergency admissions following deliberate self-harm are in females.

14. End of Life Care

Good quality end of life care is critically important in giving the individual patient and their family a positive experience of care at a difficult time in their lives.

Evidence shows that the majority of people express a preference to die at home; however, in Bromley between 2011 and 2013, over half of deaths (53.5%) occurred in hospital. There has, however, been a consistent reduction in the proportion of hospital deaths and increase in the proportion of deaths at home and in care homes since 2006. There is scope to improve the proportion of deaths in the preferred place of death in Bromley.

Non-cancer deaths are still more likely to occur in hospital than cancer deaths.

The Bromley Care Coordination Service has shown promising results in the first year in supporting patients who would otherwise not have been referred for palliative care. End of Life Care planning by General Practice and by nursing care homes has improved, but there is scope for further improvement.

Consideration should be given to an end of life programme for residential care homes in Bromley.

15. Carers

Data from the 2011 census indicates that 10% of Bromley's population (approximately 31,000 people) are unpaid carers. There continues to be insufficient local data/ joint identification of carers (adult carers, young carers and mutual carers).

The 2014/15 national Carers Survey Bromley indicates that 37% of the 782 Bromley Carers responding to the survey provide intensive care of more than 50 hours per week

Carers may neglect their own health needs if support services are not available to enable carers to attend hospital/GP appointments. Carers' assessments have a low take up and how they are presented to carers needs to be revisited in terms of the benefits.

A joint commissioning strategy on Bromley's adult carers will be developed with Bromley Clinical Commissioning Group describing how services will support Bromley's carers over the next five years.

Given the high number of people with dementia, their reliance on carers and the complexity of supporting them, particular attention needs to be given to ensuring their needs are met effectively

Although it is difficult to identify the actual number of young carers in the borough, the number of young carers known to Carers Bromley has increased 65% since June 2009

16. Substance Misuse

The Crime Survey for England and Wales suggests that approximately 17,000 residents took illicit drugs in Bromley in 2014/2015.

The substances most commonly misused by those in treatment in Bromley are opiates (44%) and alcohol (41%).

The population in treatment is predominantly male (64.8%) and of White British ethnicity (82.6%).

The highest proportion of substance misusers in treatment in Bromley are in the 40 to 49 year age group, in contrast to the national picture, which is 35 to 44 years.

There were 80 drug-related deaths in Bromley between 2006 and 2013. The average age at death was 48 years; more than thirty years lower than average life expectancy for Bromley. Deaths were most frequent in deprived wards.

There were 518 drug-related hospital admissions in Bromley 2013/14. Admission rates have been steadily increasing since 2009, the numbers greatest in the 25-44 year age group.

Bromley had a higher proportion of successful treatment completers than the national value in all categories of substance misuse in 2014-15.

Of the 90 young people in treatment in Bromley in 2014-15, 70% were using two or more substances (this may include alcohol) and 97% began using their main problem substance before the age of 15 years.

17. Alcohol

Over a quarter of the Bromley population over 16 are drinking above the levels recommended by the Department of Health.

More men are drinking at hazardous and harmful levels than women at every age.

The proportion of men drinking at harmful levels between the ages of 16-75 years is three to four times that for women.

In 2013 there were 107 alcohol-related deaths in Bromley.

The alcohol-related mortality rate for men and women in Bromley is lower than the national and regional levels. The alcohol-related mortality rate for men in Bromley is almost twice that for women.

In Bromley, hospital admission rates for alcohol-related conditions are significantly lower than those for London and for England. The hospital admission rate for males is almost twice the rate for females in Bromley.

Amongst those aged 15 years and under the most common cause of admission was for mental and behavioural disorders. Alcoholic liver disease contributed significantly to hospital admissions for men across all ages. Falls contributed significantly to hospital admissions for both men and women across all the age groups.

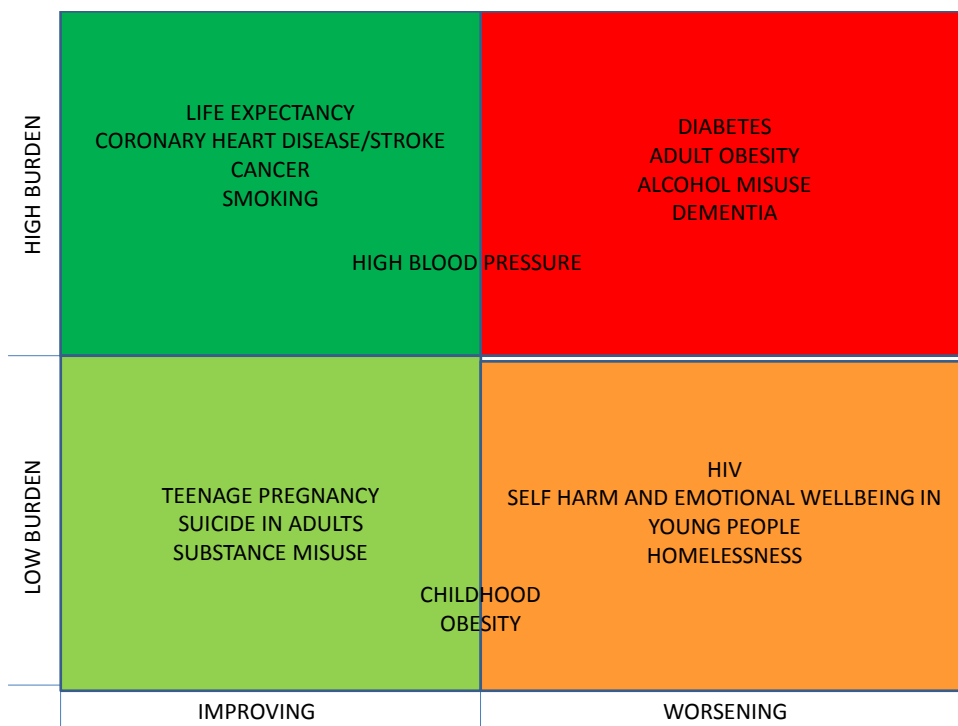
Specialist Alcohol Treatment Services provide treatment to those whose drinking is harmful or who are alcohol dependent. In 2014-15, 240 adults received treatment, of whom 39% completed treatment successfully and did not return within 6 months, this is similar to the national figure of 38%.

JSNA Priorities

In order to decide where best to focus our efforts to improve the health of the population it is helpful to use a prioritisation framework. A simple way of considering the relative priority of different health issues is to consider the burden in terms of the numbers of people affected, and then whether the problem is improving or worsening over time. The highest priority is allocated to the issues creating the highest burden which seem to be worsening over time.

The table below has been populated to show the relative priorities of the key issues. The red box represents the highest priority issues according to this framework.

The orange box should be considered as a warning box i.e. areas where more in-depth work is necessary to understand and manage evolving problems.



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.

At the end of each section, we have included a table showing performance on the Public Health Outcomes Framework (PHOF) indicators related to that section.

Any updates on progress from last year are included in a separate chapter.

The structure of the JSNA this year has been amended to include an in depth focus on a few key areas:

- Housing and Homelessness
- Older People's Health Needs
- The Characteristics and Health Needs of People who are Resident in Care Homes.
- Excess Winter Deaths
- Vulnerable Young People.

The topics for these in-depth sections were selected in a number of ways:

- Areas for which Bromley was an outlier on the Public Health Outcomes Framework e.g. excess winter deaths, statutory homelessness.
- Areas of concern for the CCG (population in care homes)
- Populations of importance to Bromley, which had not been considered in depth before (older people's health)
- Areas of concern to LA commissioners (vulnerable young people).

It is hoped that this new format will prove useful to readers.

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 (2015) estimate of the resident population of Bromley is 320,100, having risen by 21,775 since 2001.
- The resident population is expected to increase to 327,100 by 2020 and 335,500 by 2025.
- Although the number of 0 to 4 year olds is projected to decrease by the year 2020 to 20,300 and then to 20,100 by 2025, there has been an increase in the number of live births since 2002. However, there is less certainty over these projections over time.
- The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17.7% of the population in 2015 to 17.9% by 2020 and 18.7% by 2025.
- 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 (2015) GLA population projection estimates show that 17.9% of the population is made up of Black and minority ethnic (BME) groups.
- The BME group experiencing the greatest increase within Bromley's population is the Black African community, from 3.8% of the population in 2015 to 5% of the population in 2030.

What does this mean for Bromley residents and for children 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

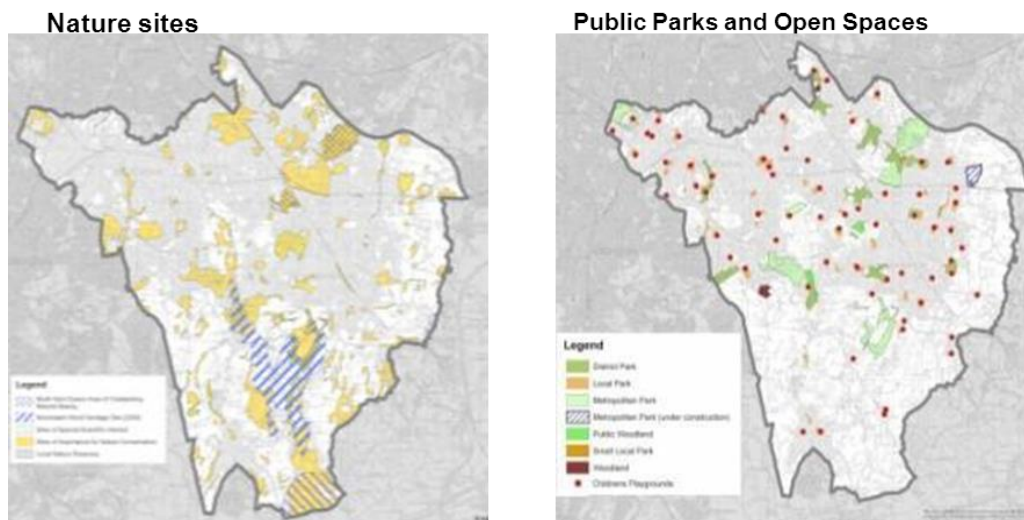
When looking at the information in this chapter, it is important to bear in mind that the borough’s demographic profile is heavily influenced by a large part of the borough being mainly rural. This means that areas in the south of the borough, such as Darwin and Biggin Hill, have small communities spread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

Figure 2. 1



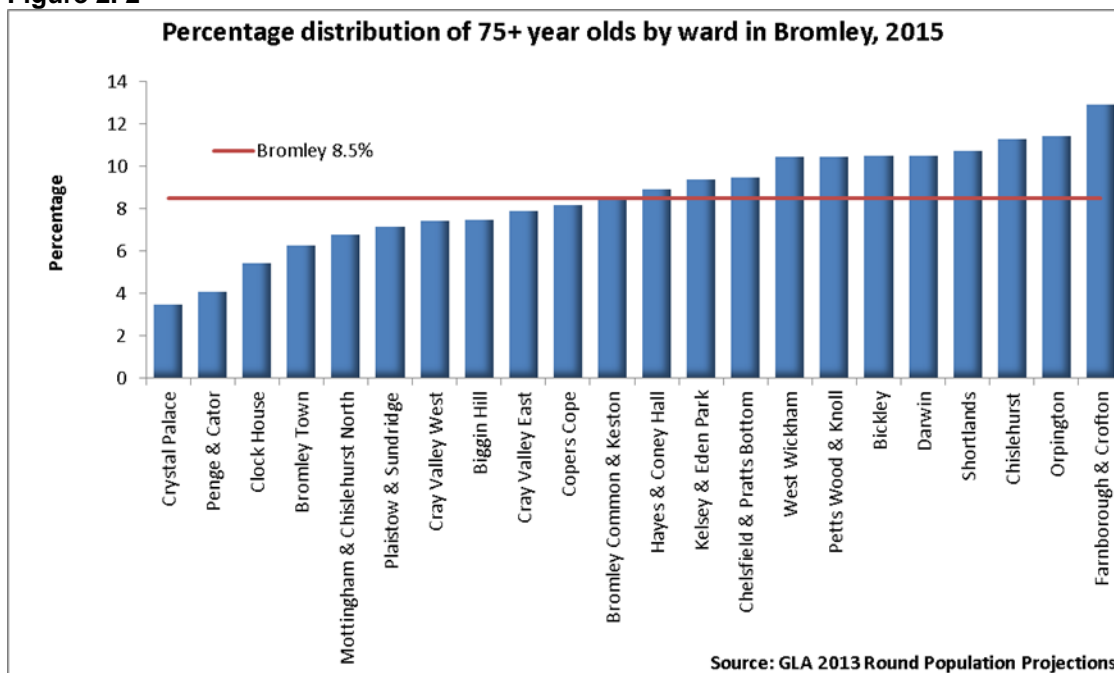
Total Population

The latest (2015) estimate of the resident population is 320,100¹. This compares with 337,148 registered with GPs in the borough (April 2015)². 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. Cray Valley West has the highest proportion of young people and Copers Cope the lowest. Farnborough and Crofton has the highest proportion of over 75s and Crystal Palace the lowest (**see table 2.1**).

Figure 2. 2



¹ Source: GLA 2013 Round SHLAA Population Projections SYA

² Health and Social Care Information Centre

Figure 2.3

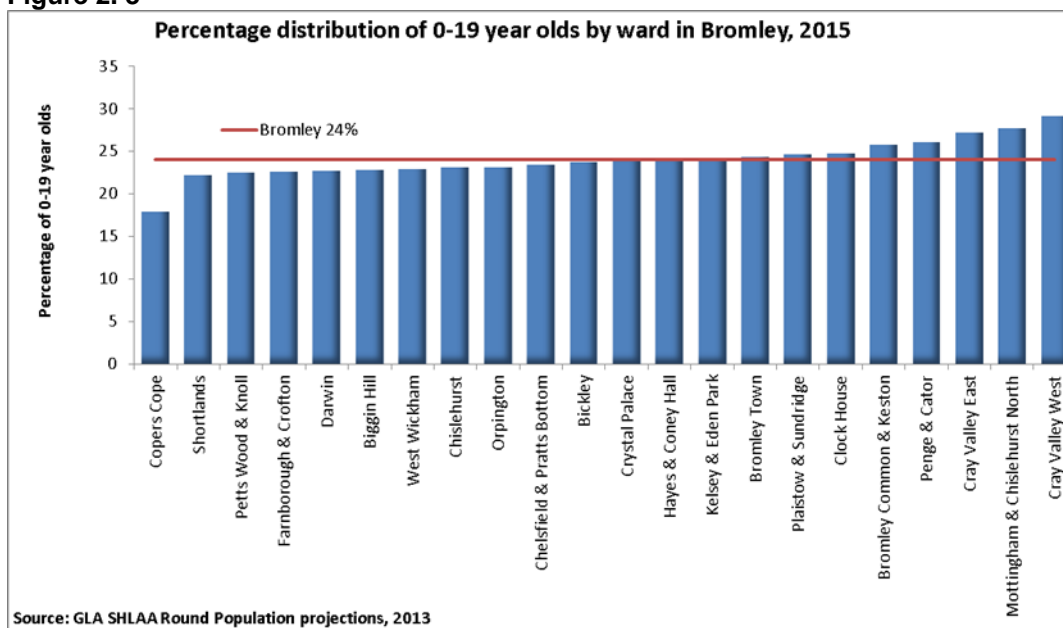


Table 2.1 Age structure across the wards in Bromley, 2015

	0-19 years		75+ years	
	No	%	No	%
Bickley	3651	23.6	1625	10.5
Biggin Hill	2331	22.7	766	7.5
Bromley Common & Keston	4170	25.7	1392	8.6
Bromley Town	4517	24.3	1169	6.3
Chelsfield & Pratts Bottom	3459	23.4	1403	9.5
Chislehurst	3545	23.0	1739	11.3
Clock House	3962	24.7	873	5.4
Copers Cope	2854	17.9	1304	8.2
Cray Valley East	4299	27.1	1257	7.9
Cray Valley West	4987	29.1	1276	7.4
Crystal Palace	3072	23.7	451	3.5
Darwin	1200	22.6	558	10.5
Farnborough & Crofton	3344	22.5	1920	12.9
Hayes & Coney Hall	3867	23.8	1449	8.9
Kelsey & Eden Park	3874	23.8	1529	9.4
Mottingham & Chislehurst N	2853	27.7	698	6.8
Orpington	3612	23.1	1788	11.4
Penge & Cator	4653	26.0	730	4.1
Petts Wood & Knoll	3131	22.4	1463	10.5
Plaistow & Sundridge	3840	24.6	1119	7.2
Shortlands	2246	22.1	1090	10.7
West Wickham	3482	22.8	1596	10.5
Bromley	76941	24.0	27201	8.5

Source: GLA 2013, Round Population Projections accessed July 2015

The age distribution of people in Bromley is very similar to that for England as a whole, as illustrated in the population pyramids (Figures 2.4 and 2.5).

Figure 2.4

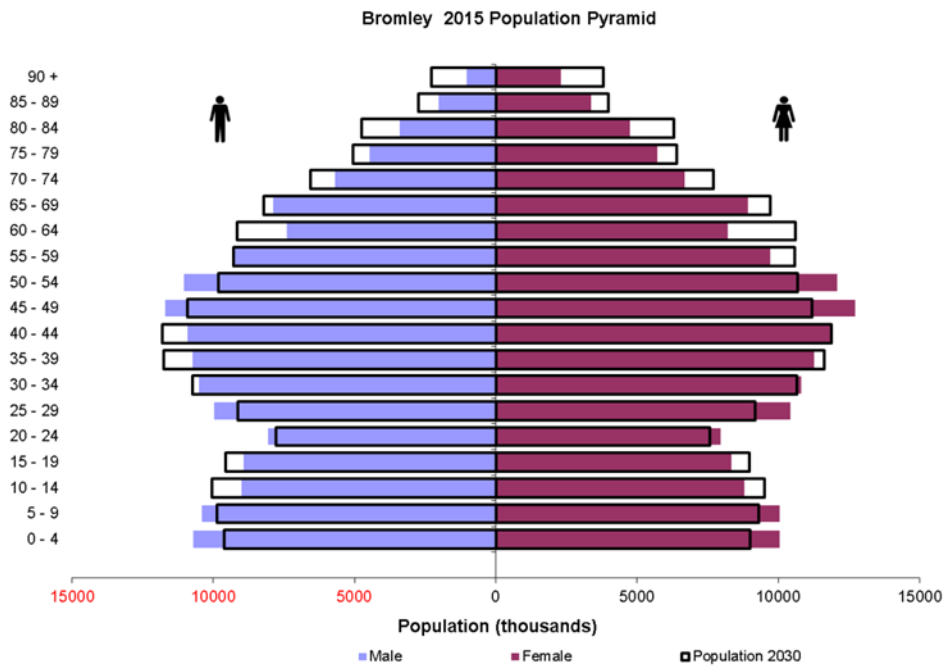
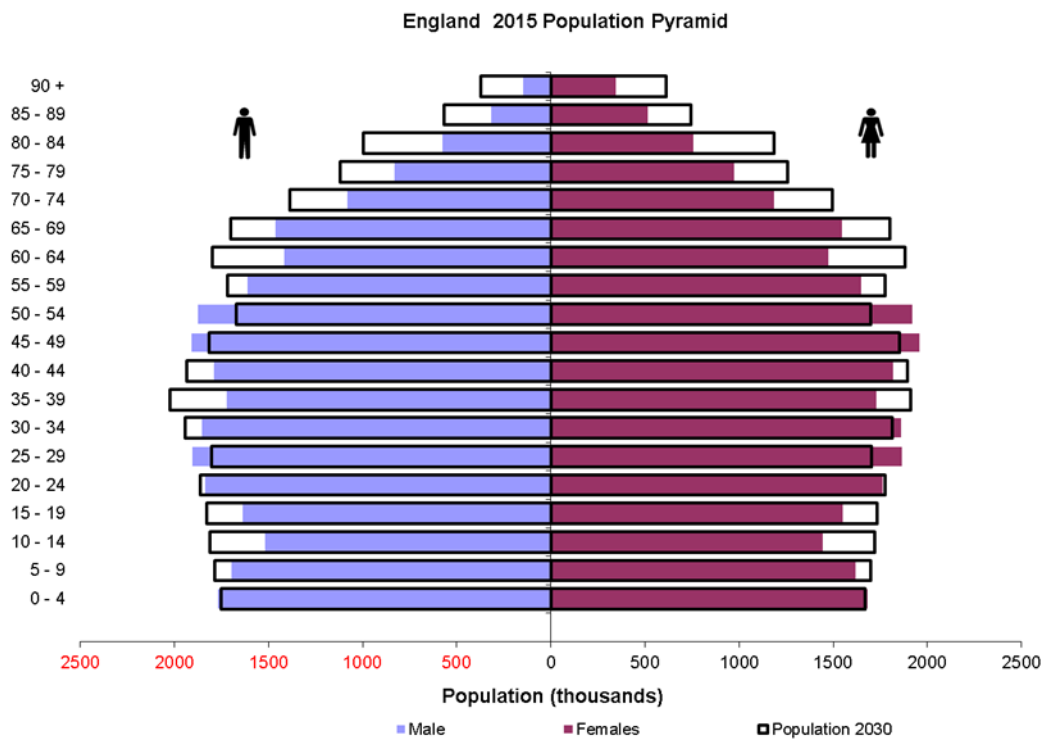


Figure 2.5



Source: GLA 2013 Round SHLAA Based Population Projections

Population Projections

The population of Bromley is just over 320,000, and is projected to rise by 2.2% over the next 5 years. (Table 2.2).

Table 2. 2

	2015	2020	2025	2030
Total population	320,100	327,100	335,500	341,500
0 to 4years (%)	21,000 (6.6%)	20,300 (6.2%)	20,100 (6.2%)	19,600 (5.7%)
5 to10 years (%)	24,300 (7.6%)	25,300 (7.7%)	24,700 (7.4%)	24,200 (7.1%)
11 to 18 years(%)	29,000 (9.1%)	30,300 (9.3%)	33,100 (9.9%)	32,900 (9.6%)
Working Age (%)*	200,500 (62.6%)	203,200 (62.1%)	207,000 (61.7%)	208,000 (60.9%)
Post Retirement (%)‡	56,500 (17.7%)	58,600 (17.9%)	62,800 (18.7%)	69,200 (20.3%)
80 years and over (%)	17,000 (5.3%)	18,100 (5.5%)	20,300 (6.1%)	24,800 (7.1%)

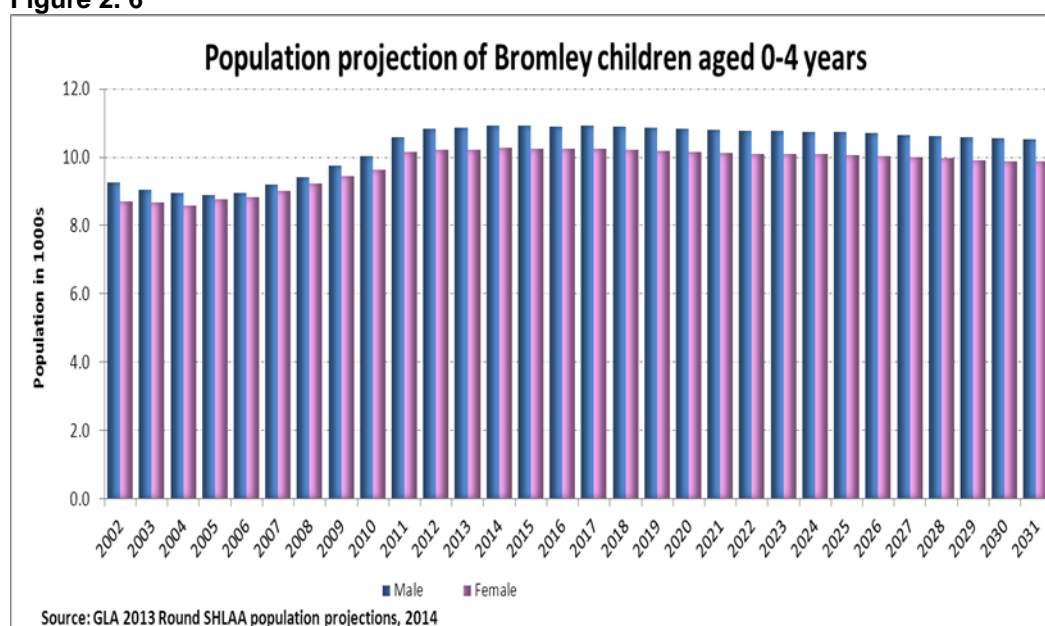
Source: GLA 2013 Round SHLAA population projections, accessed July 2015

* 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 2006 and will peak in 2017 (21,196) but is then projected to decrease again to 20,381 in 2031.

Figure 2. 6



Ward Population Projections

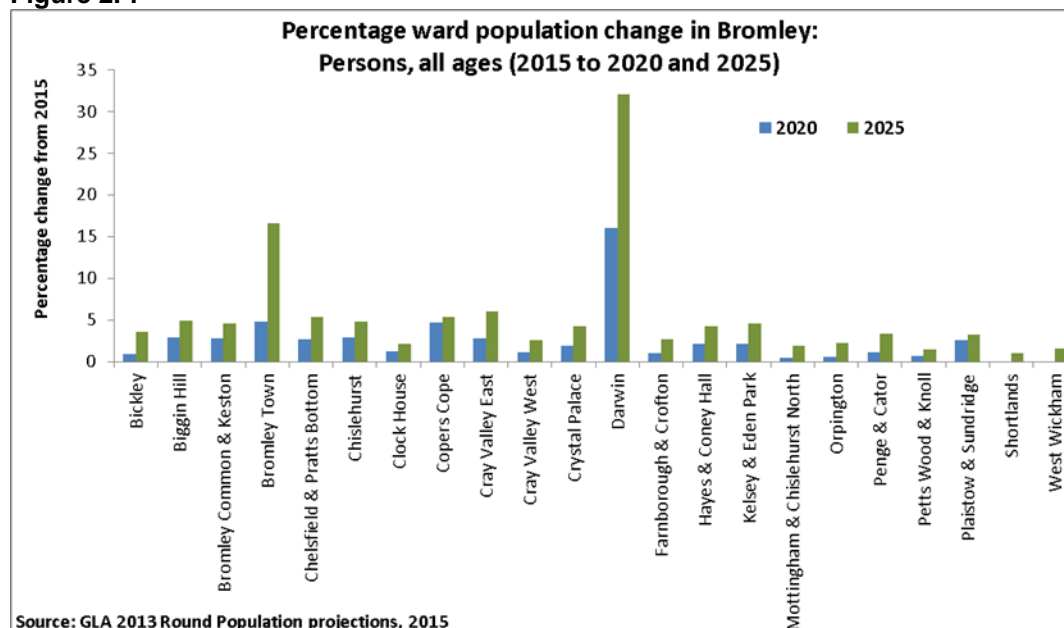
Overall, there is a projected increase in residents across all wards in Bromley. Bromley Town and Darwin are expected to have the highest percentage increase in all wards in 2020 and 2025.

Table 2. 3

Ward Population Projections; Persons, all ages					
	Population projections			Change in numbers	
	2014	2019	2024	2019	2024
Bickley	15471	15888	16355	417	884
Biggin Hill	10263	10694	11017	431	754
Bromley Common & Keston	16101	16948	17407	847	1306
Bromley Town	18315	19736	21878	1421	3563
Chelsfield & Pratts Bottom	14850	15413	15934	563	1084
Chislehurst	15372	16067	16563	695	1191
Clock House	16032	16559	16846	527	814
Copers Cope	15936	16927	17286	991	1350
Cray Valley East	15868	16526	17194	658	1326
Cray Valley West	17182	17656	18055	474	873
Crystal Palace	12916	13470	13861	554	945
Darwin	5309	6098	6998	789	1689
Farnborough & Crofton	14914	15269	15636	355	722
Hayes & Coney Hall	16329	16862	17347	533	1018
Kelsey & Eden Park	16286	16844	17398	558	1112
Mottingham & Chislehurst North	10300	10582	10775	282	475
Orpington	15731	16053	16386	322	655
Penge & Cator	17913	18448	18972	535	1059
Petts Wood & Knoll	14002	14299	14527	297	525
Plaiستow & Sundridge	15589	16242	16554	653	965
Shortlands	10122	10368	10510	246	388
West Wickham	15284	15574	15868	290	584
Bromley	322099	334542	345391	14457	23292

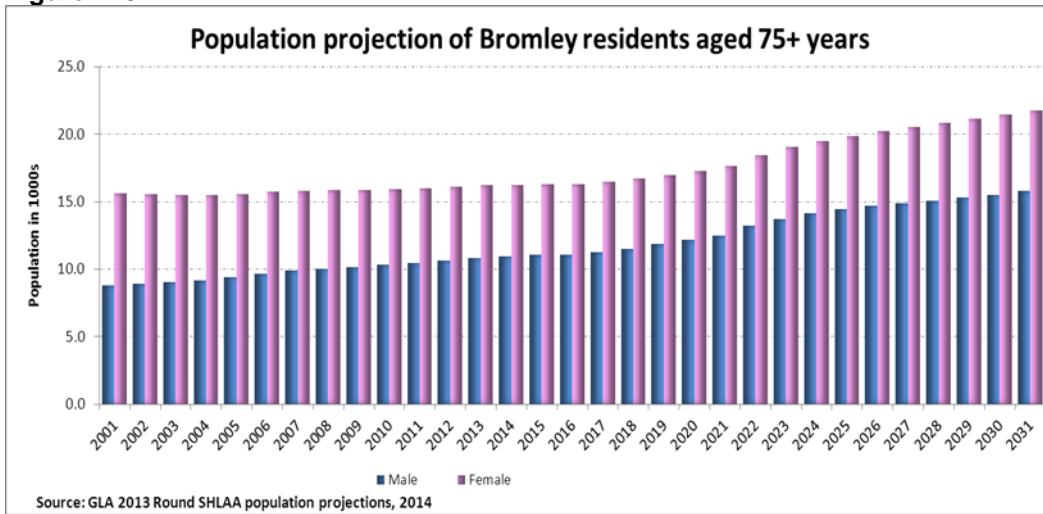
Source: GLA 2013 Round SHLAA population projections, accessed July 2015

Figure 2. 7



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

Figure 2. 8



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 (15%). For over 75s, the population is projected to increase and the largest increase will be in Biggin Hill, Darwin and Petts Wood and Knoll (33%, 27% and 17% respectively) (Figures 2.9 and 2.10).

Figure 2. 9

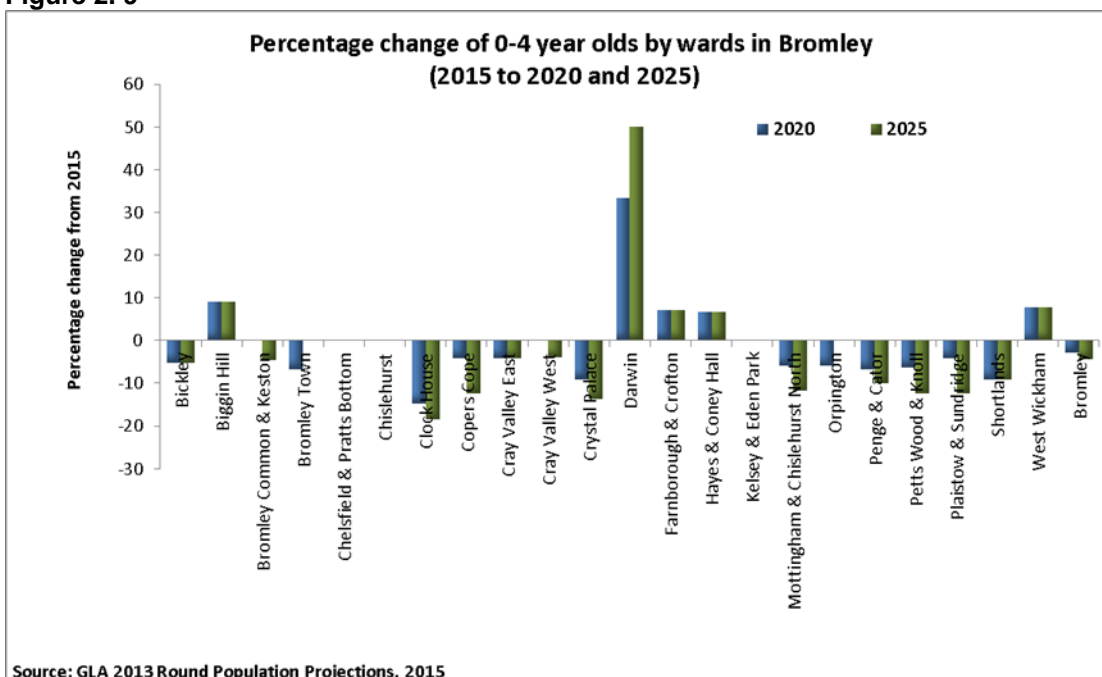
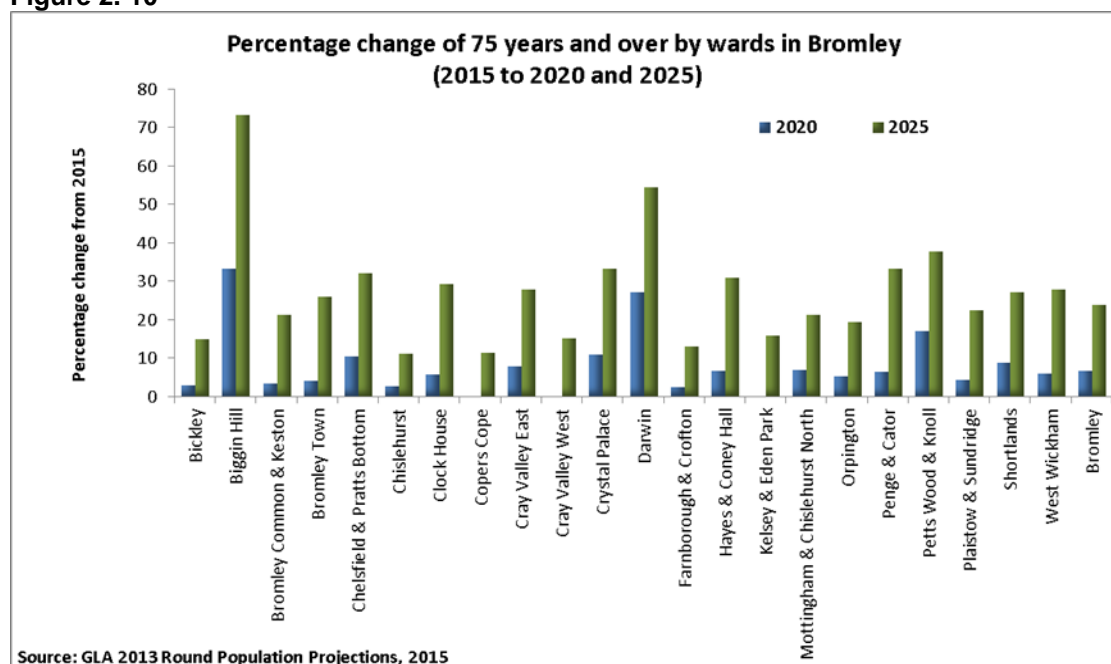


Table 2. 4

People aged 0-4 years in Bromley					
	Population projections			Change in numbers	
	2015	2020	2025	2020	2025
Bickley	950	900	900	-50	-50
Biggin Hill	550	600	600	50	50
Bromley Common & Keston	1100	1100	1050	0	-50
Bromley Town	1500	1400	1500	-100	0
Chelsfield & Pratts Bottom	800	800	800	0	0
Chislehurst	950	950	950	0	0
Clock House	1350	1150	1100	-200	-250
Copers Cope	1200	1150	1050	-50	-150
Cray Valley East	1200	1150	1150	-50	-50
Cray Valley West	1300	1300	1250	0	-50
Crystal Palace	1100	1000	950	-100	-150
Darwin	300	400	450	100	150
Farnborough & Crofton	700	750	750	50	50
Hayes & Coney Hall	750	800	800	50	50
Kelsey & Eden Park	850	850	850	0	0
Mottingham & Chislehurst North	850	800	750	-50	-100
Orpington	850	800	850	-50	0
Penge & Cator	1500	1400	1350	-100	-150
Petts Wood & Knoll	800	750	700	-50	-100
Plaiestow & Sundridge	1200	1150	1050	-50	-150
Shortlands	550	500	500	-50	-50
West Wickham	650	700	700	50	50
Bromley	20950	20350	20050	-600	-900

Source: GLA, 2013 Round Population Projection accessed July 2015

Figure 2. 10



Source: GLA 2013 Round Population Projections, 2015

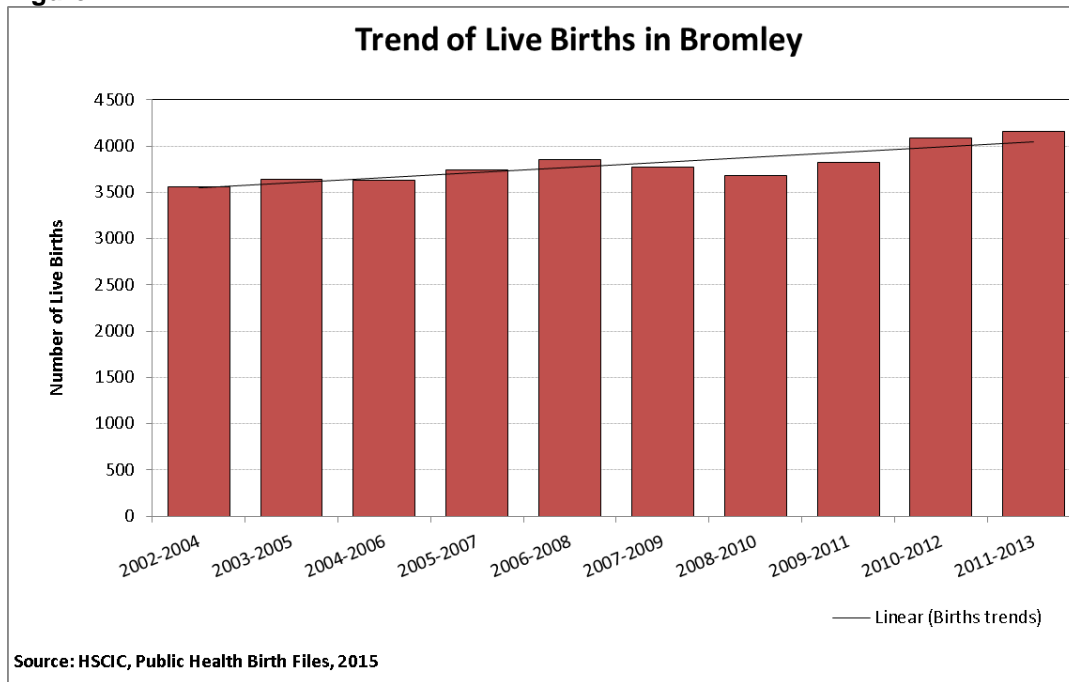
Table 2. 5

People aged 75years and over in Bromley					
	Population projections			Change in numbers	
	2015	2020	2025	2020	2025
Bickley	1650	1700	1900	50	250
Biggin Hill	750	1000	1300	250	550
Bromley Common & Keston	1400	1450	1700	50	300
Bromley Town	1150	1200	1450	50	300
Chelsfield & Pratts Bottom	1400	1550	1850	150	450
Chislehurst	1750	1800	1950	50	200
Clock House	850	900	1100	50	250
Copers Cope	1300	1300	1450	0	150
Cray Valley East	1250	1350	1600	100	350
Cray Valley West	1300	1300	1500	0	200
Crystal Palace	450	500	600	50	150
Darwin	550	700	850	150	300
Farnborough & Crofton	1900	1950	2150	50	250
Hayes & Coney Hall	1450	1550	1900	100	450
Kelsey & Eden Park	1550	1550	1800	0	250
Mottingham & Chislehurst North	700	750	850	50	150
Orpington	1800	1900	2150	100	350
Penge & Cator	750	800	1000	50	250
Petts Wood & Knoll	1450	1700	2000	250	550
Plaistow & Sundridge	1100	1150	1350	50	250
Shortlands	1100	1200	1400	100	300
West Wickham	1600	1700	2050	100	450
Bromley	27200	29050	33750	1850	6550

Source: GLA, 2013 Round Population Projections accessed July 2015

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 3,899 in 2013.

Figure 2. 11



What does this mean for Bromley residents and for children in Bromley?

Current situation: 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.

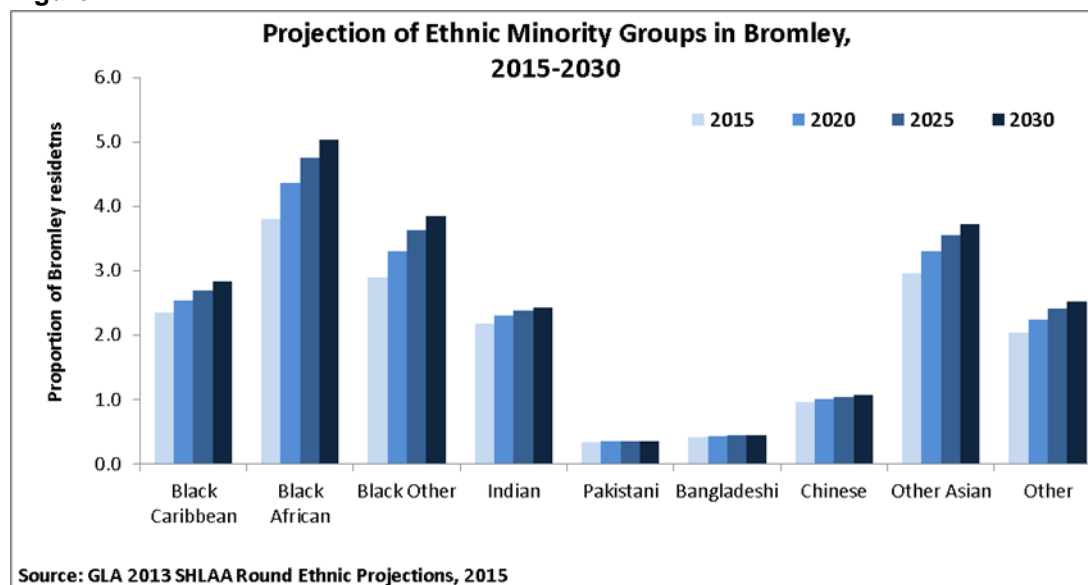
It is important to keep abreast of the changes in population structure as service provision may have to adapt to the needs of new communities.

The rise in the number of 0-4 year olds since 2010 has had and will continue to have an impact on the provision of primary and secondary school places in Bromley. It also impacts on the usage of health services.

Ethnic groups

The GLA 2013 Round Ethnic Group Projections estimate that, in 2015, the ethnic minority population of Bromley is 17.9%, and this is projected to rise to 20% by 2025. The greatest proportional rise is in the Black African group.

Figure 2. 12



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 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.

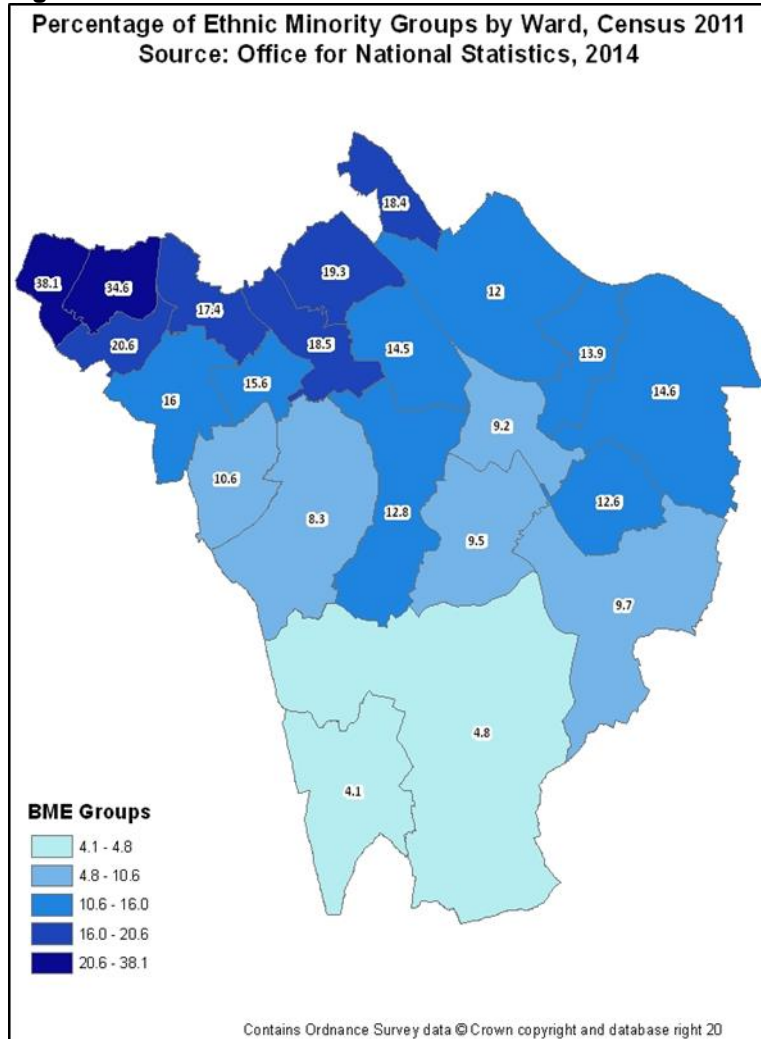
Among ethnic minority groups, Black Africans comprise the largest proportion of those seen for HIV care in all regions. Along with the 'Other' ethnic group, Black Africans also have the highest rates of tuberculosis.

Table 2. 6

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 2.13**).

Figure 2. 13



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.

The borough contains seven authorised Traveller sites, including Gypsy and Traveller sites at Star Lane (22 pitches) and Old Maidstone Road (12 pitches), both of which are owned and managed by the Local Authority, as well as four private Gypsy and Traveller sites at Bromley Common, Biggin Hill, Cudham Lane North, Hockenden Lane and a Travelling Showman’s Ground (Keston). Planning applications for further private sites which have been in long term use are anticipated or pending at a further private site in Hockenden Lane and sites in Layham’s Road. (This information is correct as of early September 2015).

There is evidence that Gypsies and Travellers are the most excluded ethnic minority in this country³.

What does this mean for Bromley residents and for children in Bromley?

The BME population is not consistent across Bromley and certain wards have a higher concentration of ethnic minorities than others. The North-West of Bromley has the highest proportion of ethnic minority population.

These areas may therefore have higher disease burden due to the increased risk amongst certain BME groups.

Gypsy Travellers are mainly situated in the North-East of the borough. Evidence suggests that we can expect to see a lower life expectancy amongst this group as well as higher prevalence of long term illness.

For more information please contact Susan.Mubiru@Bromley.gov.uk

³ Communities and Local Government, *Facts about Gypsies and Travelers*

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
- Major Health Issues
- Lifestyle Risk Factors for Disease

Mortality & Life Expectancy

All Cause Mortality

The all-cause mortality rate for Bromley (852/1000, DSR) is lower than both the London and England average rates. Bromley has the eighth lowest all-cause mortality rate in London.

(The rates are different from the previous publications due to revisions in the European Standard Population and latest ONS population revisions.)

Figure 3. 1

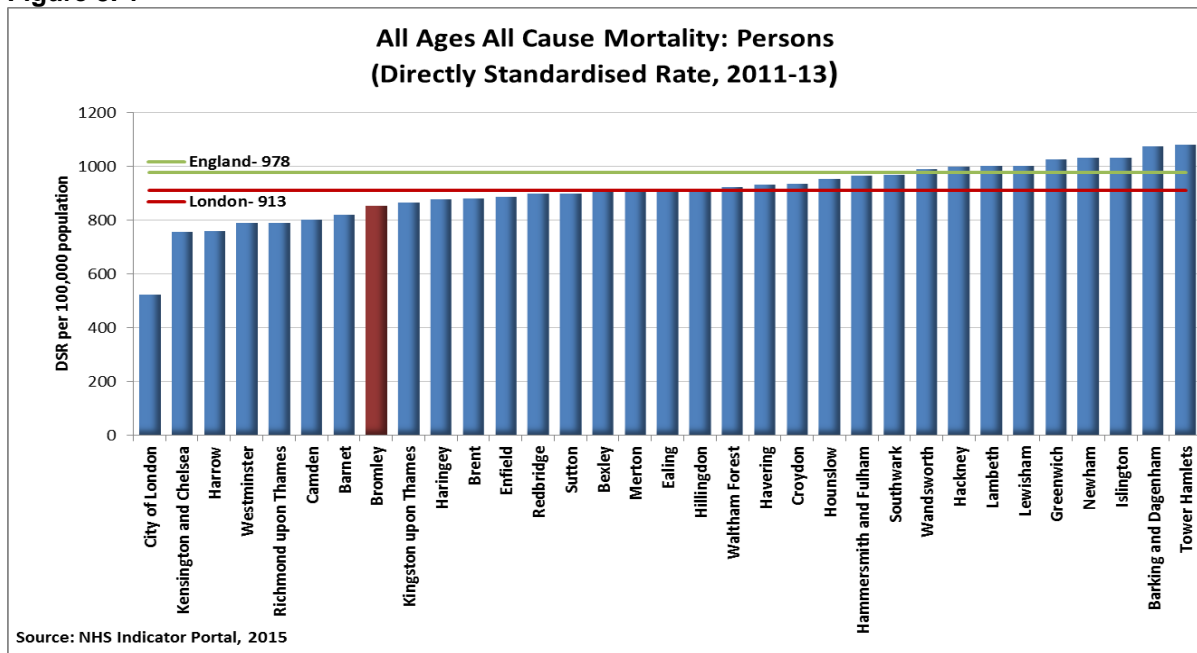
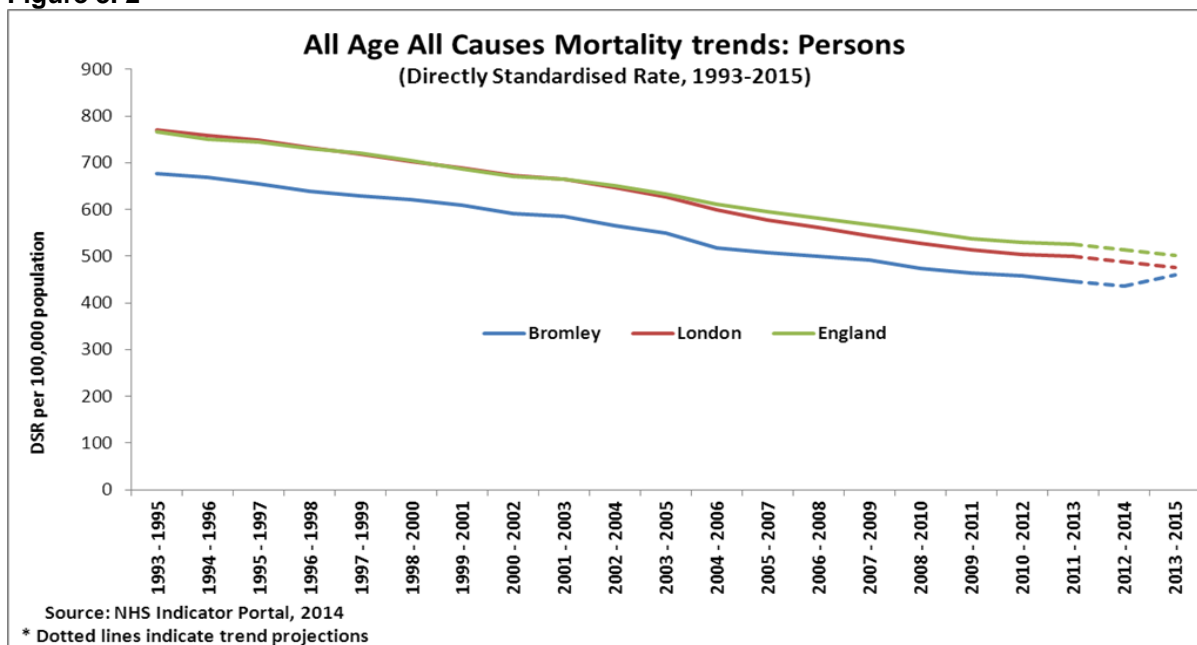


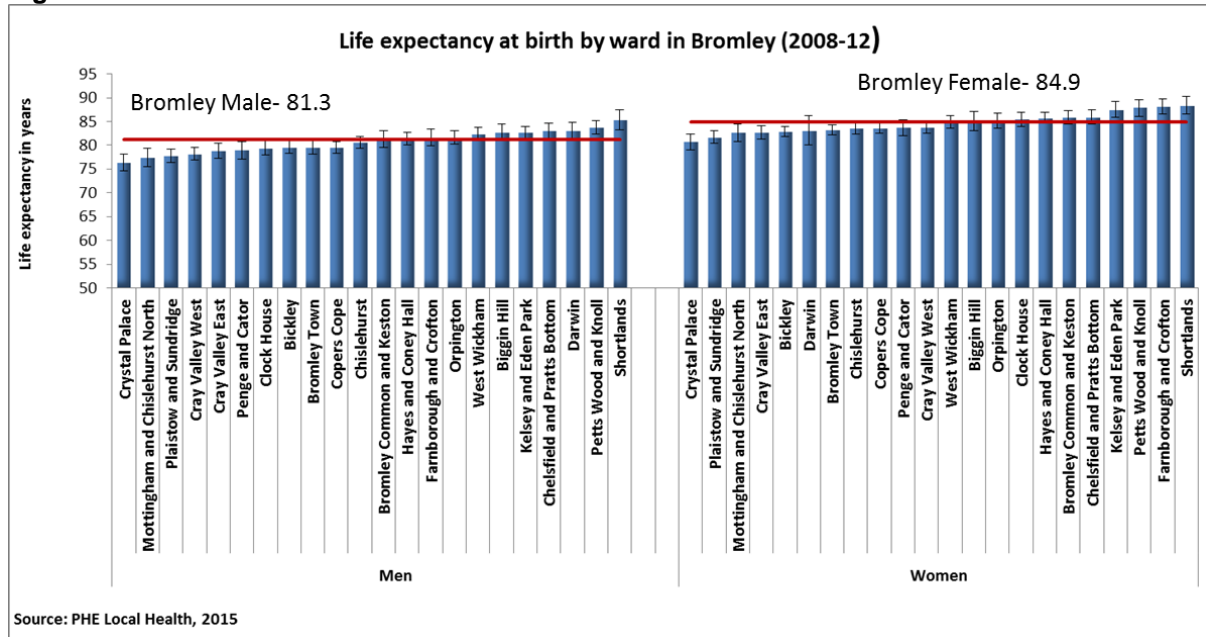
Figure 3. 2



Life Expectancy

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, and the latest figures (2011-13) report a life expectancy of 81.3 years for men and 84.9 years for women. These averages rank 49th and 35th respectively in the national order. However, life expectancy across Bromley is not uniform. The gap between wards with the highest and lowest life expectancy for the years 2008-12 was 9 years for men and 7.6 years for women.

Figure 3.3

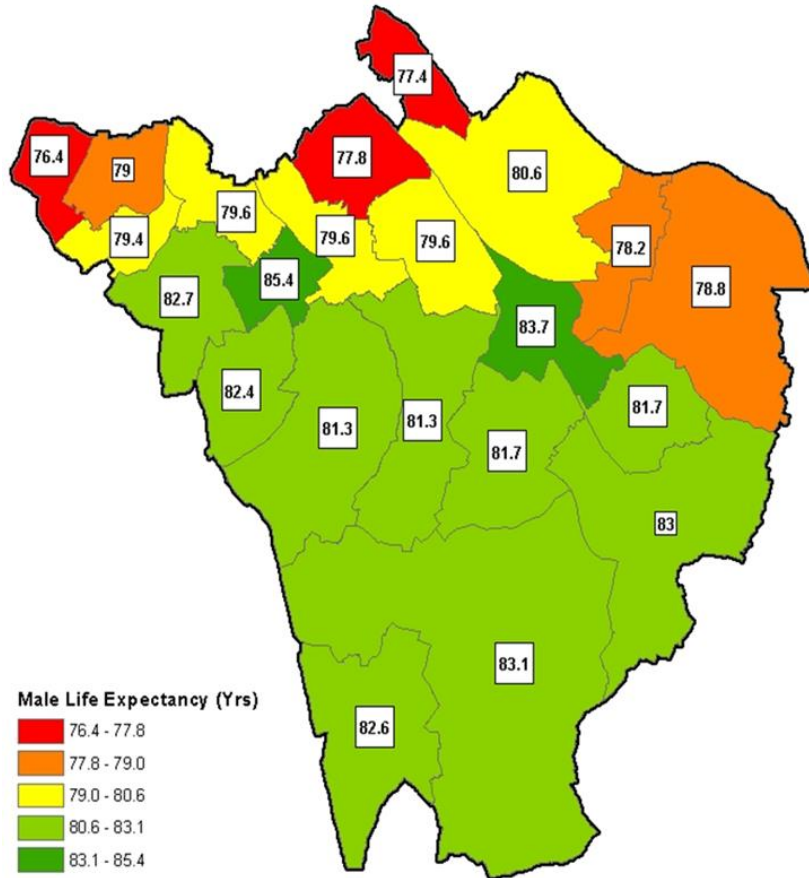


Life expectancy is lowest for men in Crystal Palace (76.4y) and in Mottingham & Chislehurst North (77.4y), and for women, is lowest in Crystal Palace (80.8y) and in Plaiستow & Sundridge (81.7y).

The 2015 Health Profile for Bromley reports that life expectancy is 9 years lower for men and 6.6 years lower for women in the most deprived areas of Bromley than in the least deprived areas (based on the Slope Index of Inequality

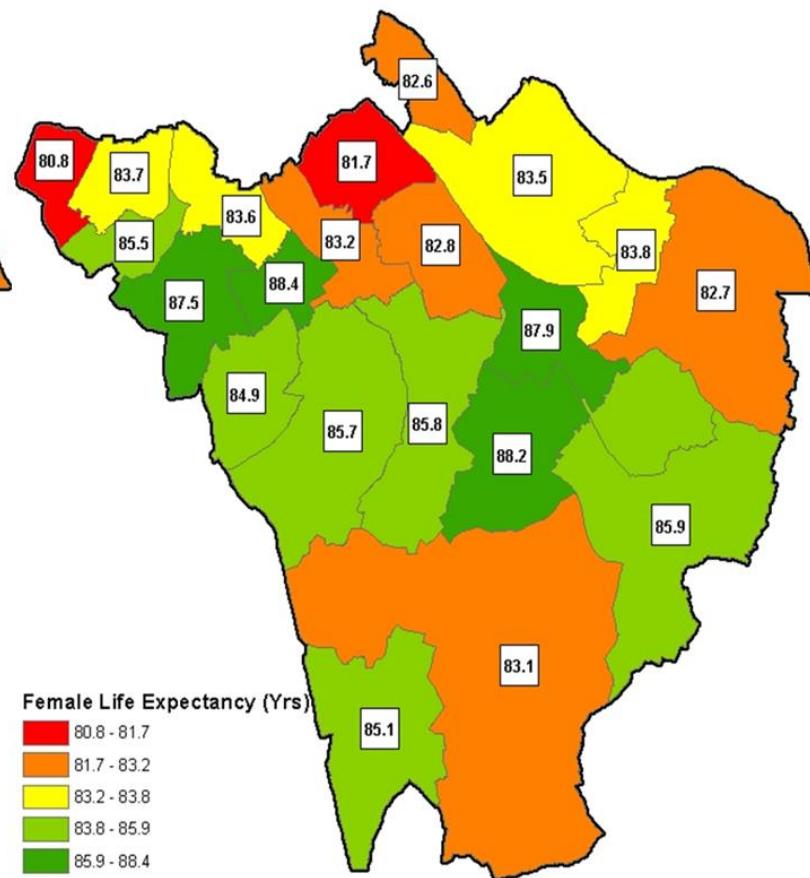
Figure 3. 4

Male Life Expectancy at Birth by Ward, 2008-12
Source: PHE, Local Health



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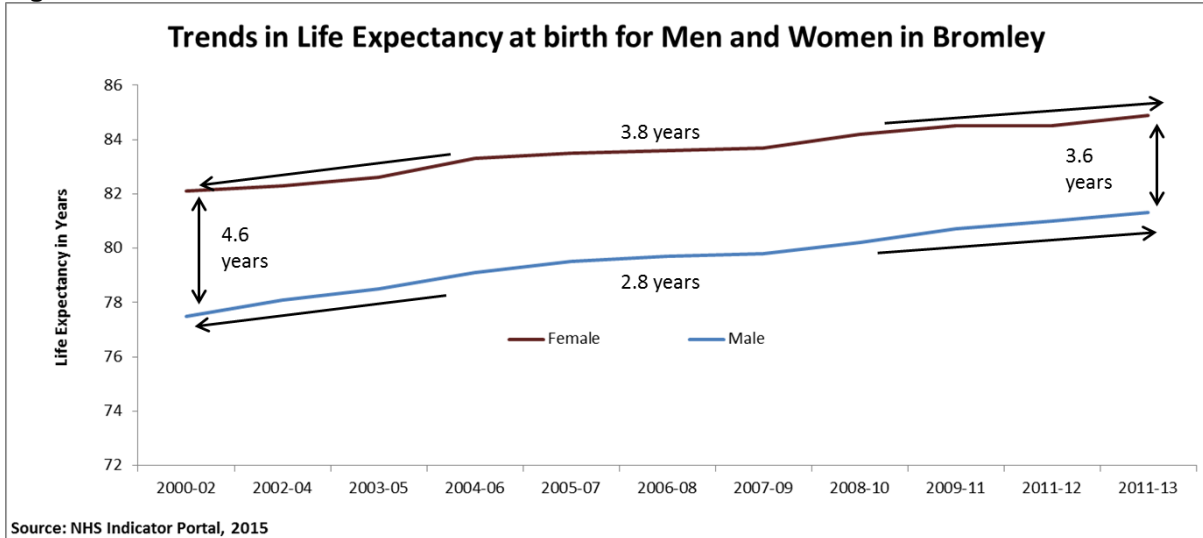
Female Life Expectancy at Birth by Ward, 2008-12
Source: PHE, Local Health



Contains Ordnance Survey data © Crown copyright and database right 2014

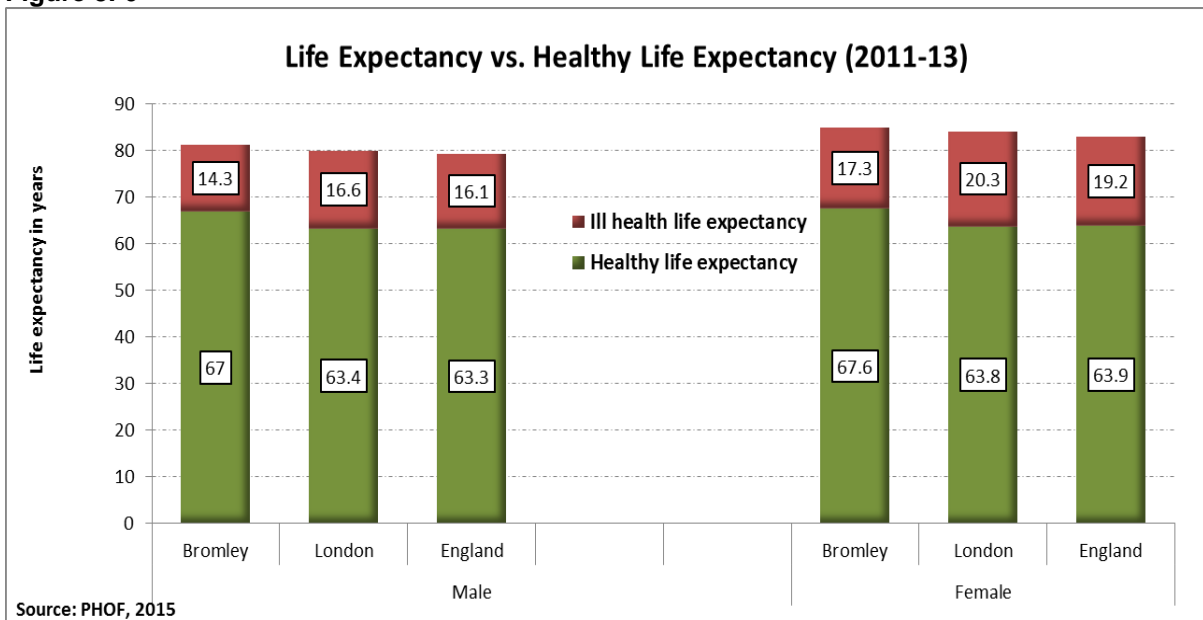
Men have a lower life expectancy than women, but over the last ten years, there has been a reduction in the life expectancy gap between men and women from 4.6 years to 3.6 years, with life expectancy increasing for both men and women over the same

Figure 3.5



It is not just longevity that is important, but healthy life expectancy. **Figure 3.6** shows that people in Bromley can expect to live more years without illness than the England and 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 you 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 10th in the country for DFLE at birth for men (at 67.9 years) and 2nd in the country for women (at 71.6 years).

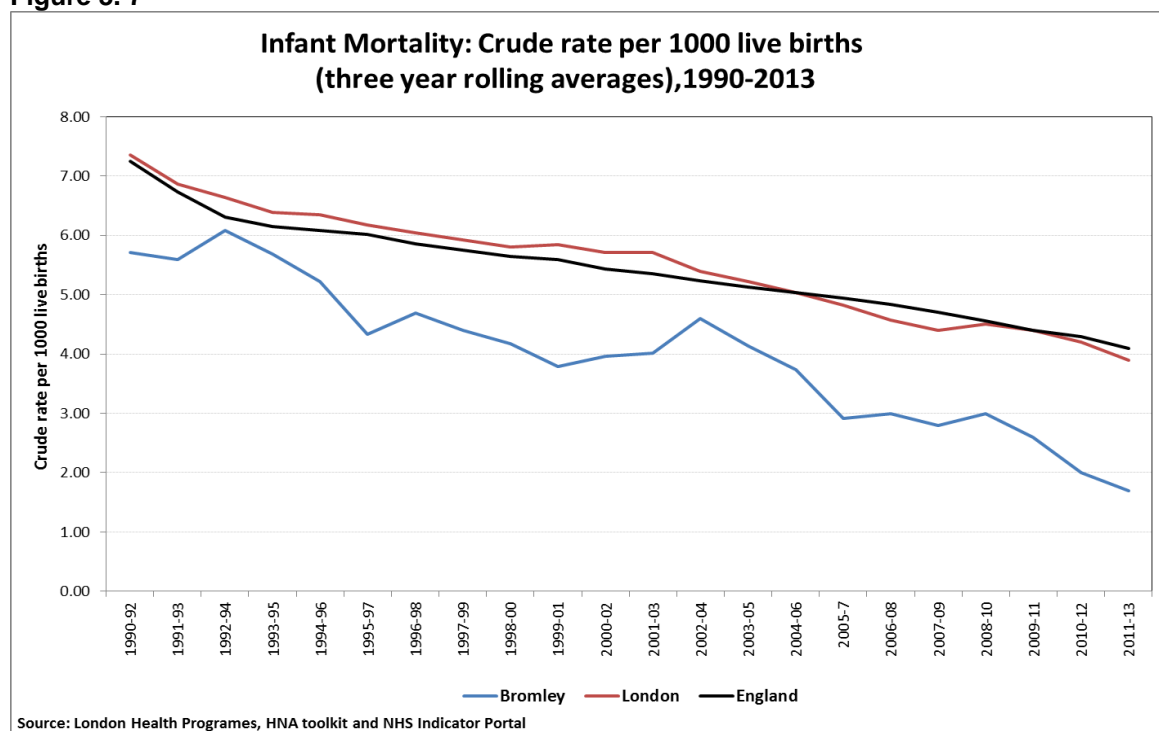
Infant Mortality

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 (1.6 per 1000 live births) is lower than in England as a whole (4 per 1000 live births), and has been fairly steady over the last 5 years. The rate is now lower than half the 1990-92 rate of 5.7 per 1000 live births.

Individual causes are not described as numbers are small (fewer than 5 deaths a year).

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 2011 to 2013, the SII for men in Bromley was 9, and for women, 6.6. This can be interpreted as a 9 year difference in life expectancy at birth between males living in the most and least deprived areas of Bromley, and 6.6 years for females.

The level of inequality is below the England average for both men and women (Figures 3.8 and 3.9).

Figure 3.8

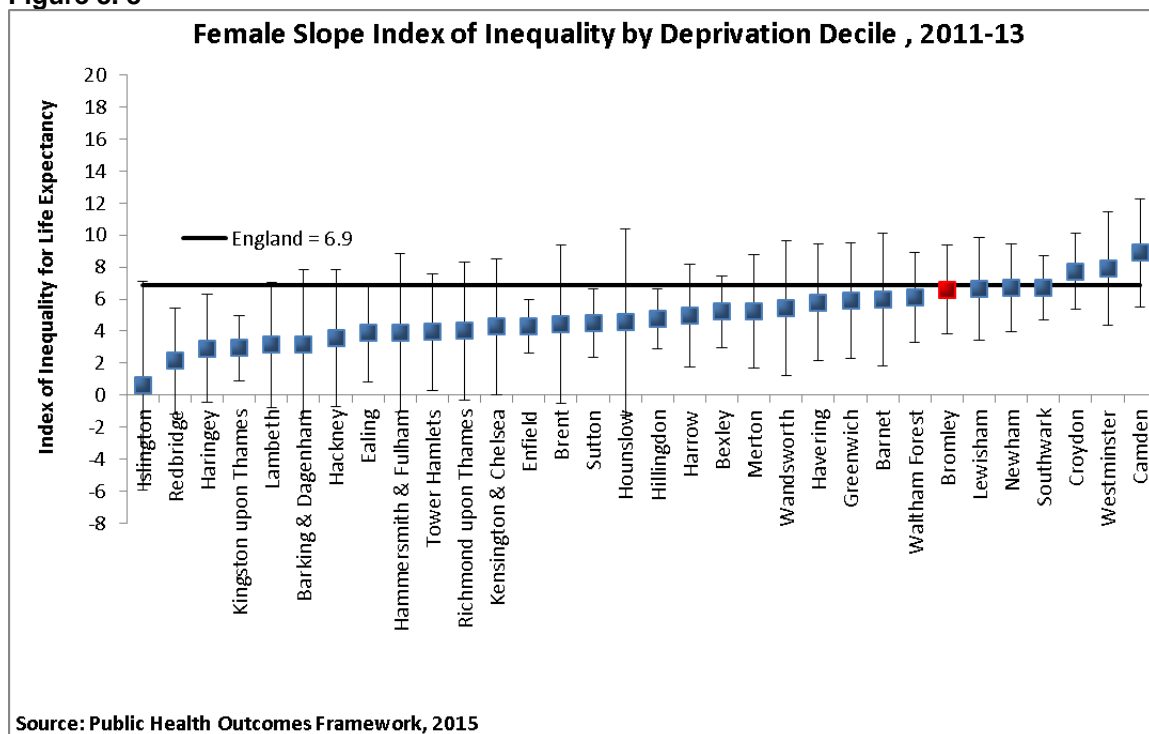
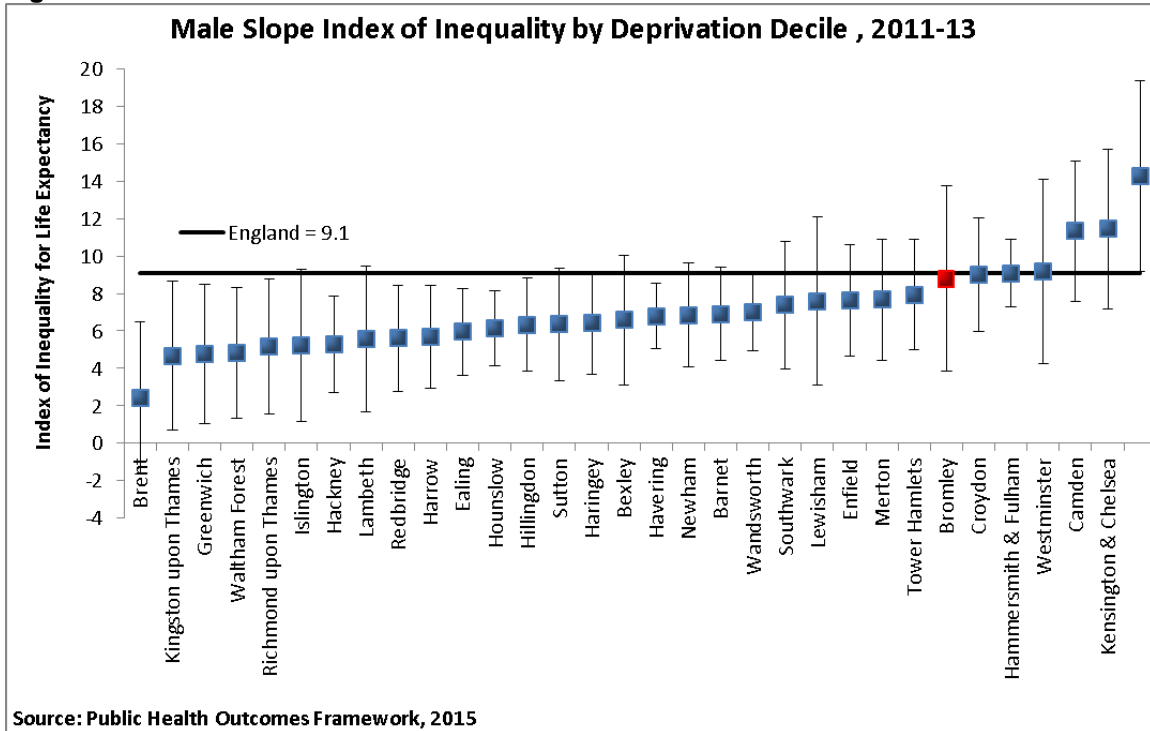
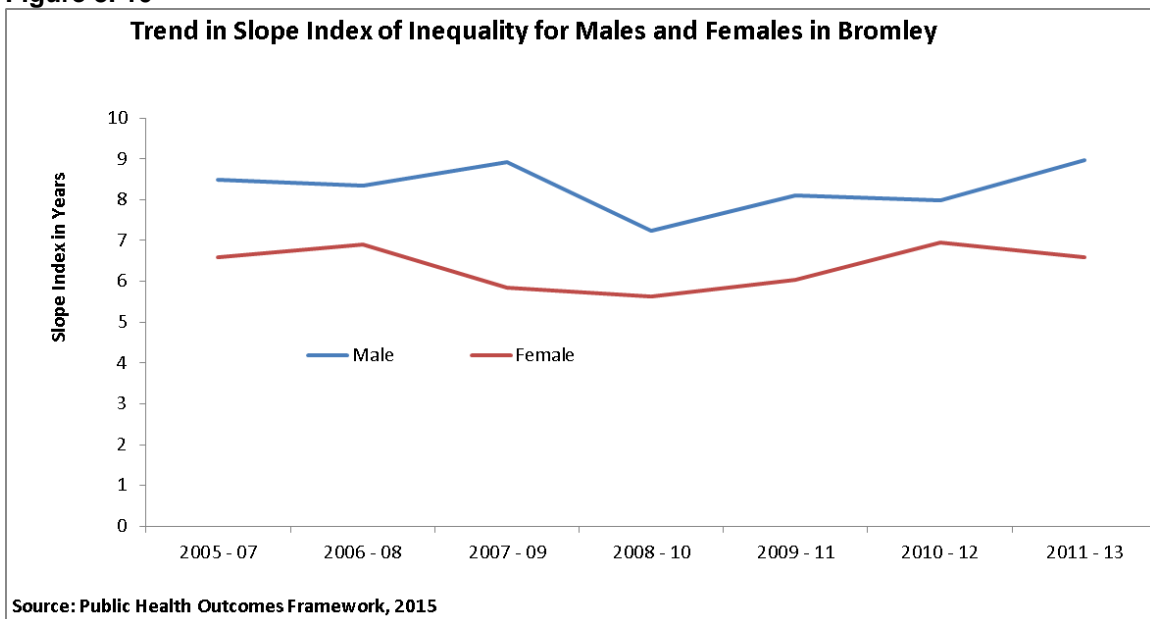


Figure 3.9



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 (**Figure 3.10**).

Figure 3.10



The Public Health Observatories' Health Inequalities Intervention Tool can be used to ascertain the relative contribution to the life expectancy gap of specific disease groups. For Bromley, the inequalities are chiefly related to circulatory disease, cancer and respiratory disease, with the main contribution being from circulatory disease (32%) for men and (25%) for women (**Figure 3.11**).

Figure 3. 11: Breakdown of the life expectancy gap between Bromley most deprived quintile and Bromley least deprived quintile, by cause of death, 2009-2011

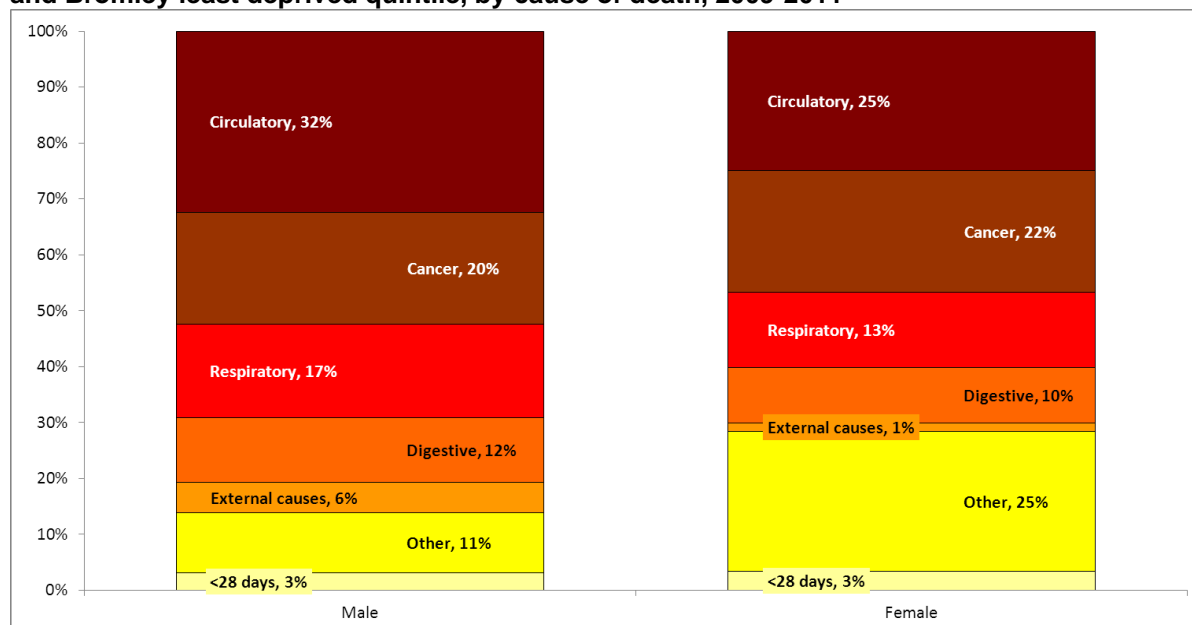


Figure 3. 12: Breakdown of the life expectancy gap between Bromley most deprived quintile and Bromley least deprived quintile, by cause of death, 2009-2011

Broad cause of death	Cause of death	Male			Female		
		Number of deaths in most deprived quintile	Number of excess deaths in most deprived quintile	Contribution to the gap (%)	Number of deaths in most deprived quintile	Number of excess deaths in most deprived quintile	Contribution to the gap (%)
Circulatory diseases	Coronary heart disease	121	56	20.1	97	44	15.4
	Stroke	29	15	5.2	52	12	4.5
	Other circulatory diseases	62	22	7.1	67	14	5.0
Cancer	Lung cancer	48	29	9.6	46	16	8.0
	Other cancers	141	24	10.4	159	31	13.8
Respiratory diseases	Pneumonia	33	20	5.5	38	14	3.6
	Chronic obstructive airways disease	42	26	8.4	37	25	8.1
	Other respiratory diseases	17	10	2.8	16	7	1.7
Digestive diseases	Chronic liver disease including cirrhosis	16	14	5.7	6	3	1.9
	Other digestive diseases	23	17	5.8	32	21	8.1
External causes	Suicide	8	4
	Other external causes	24	13	5.5	11	2	1.4
Other causes	Infectious and parasitic diseases	8	5	1.7	10	7	2.9
	Mental and behavioural disorders	17	3	1.0	59	41	11.4
	Other	59	15	8.0	91	31	10.8
<28 days	Deaths under 28 days	4	4	3.1	3	3	3.3
Total		651		100	728		100

There is significant variation in mortality rates for coronary heart disease and cancer between wards in Bromley (**Figures 3.13** and **3.14**). Cray Valley East ward has significantly higher than average mortality rates for both heart disease and cancer, and Mottingham & Chislehurst North and Cray Valley West wards for heart disease.

Figure 3. 13

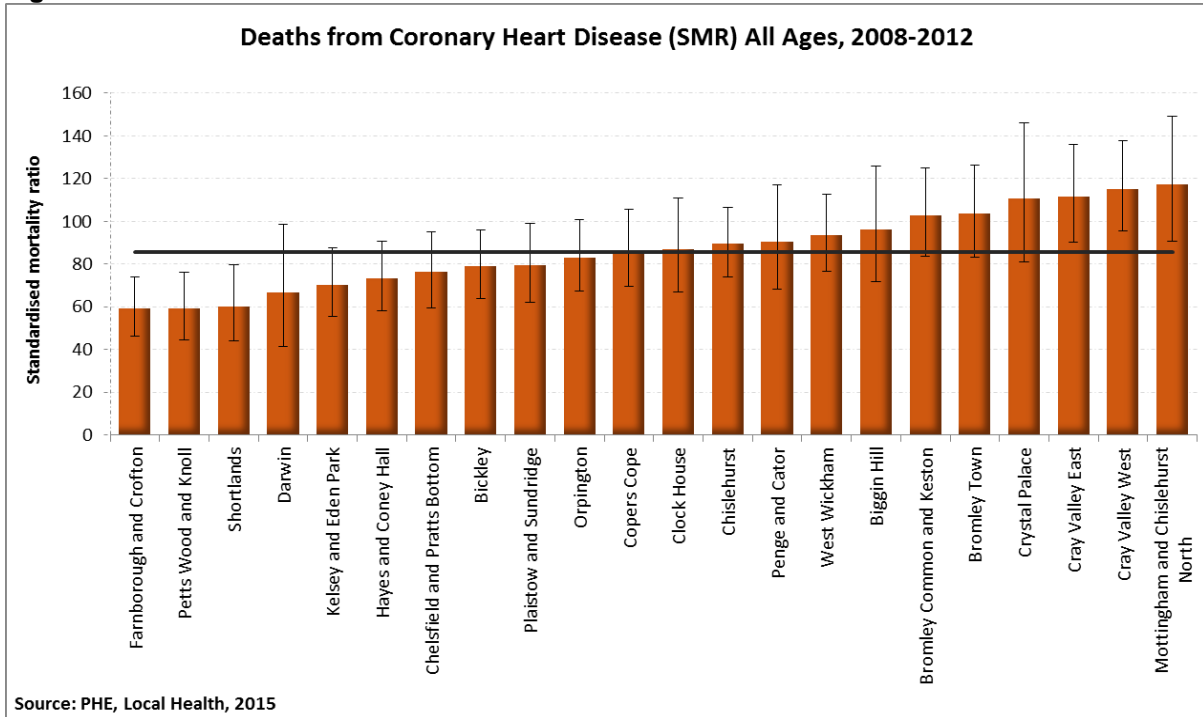


Figure 3. 14

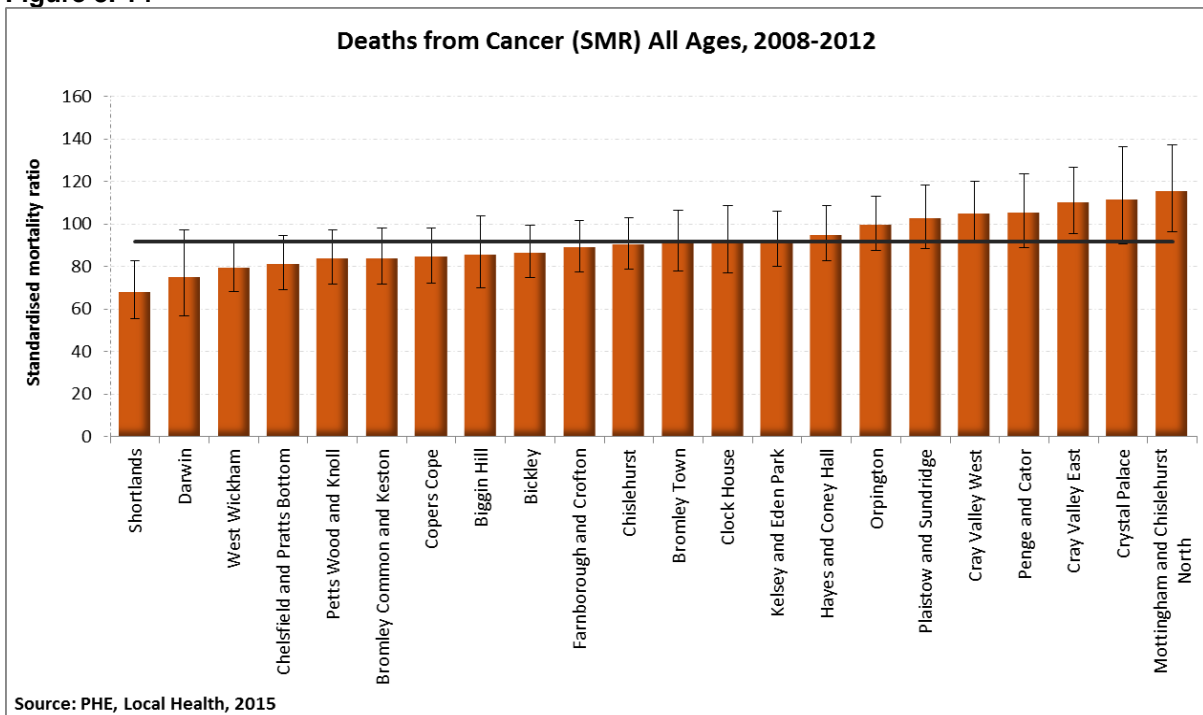


Table 3. 1: Life Expectancy Related PHOF Indicators, 2015

Indicator	Sex	Age	Time Period	Bromley	London	England
0.1i - Healthy life expectancy at birth	Male	All ages	2011 - 13	67.0	63.39	63.27
0.1i - Healthy life expectancy at birth	Female	All ages	2011 - 13	67.6	63.82	63.95
0.1ii - Life Expectancy at birth	Male	All ages	2011 - 13	81.3	80.00	79.41
0.1ii - Life Expectancy at birth	Female	All ages	2011 - 13	84.9	84.10	83.12
0.1ii - Life Expectancy at 65	Male	65	2011 - 13	19.7	19.10	18.67
0.1ii - Life Expectancy at 65	Female	65	2011 - 13	22.2	21.90	21.13
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area	Male	All ages	2011 - 13	9.0	0.59	
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area	Female	All ages	2011 - 13	6.6	0.98	
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	Male	All ages	2011 - 13	1.9	7.28	
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	Female	All ages	2011 - 13	1.8	4.81	
4.01 - Infant mortality	Persons	< 1 yr	2001 - 03	4.01	5.65	5.32
4.01 - Infant mortality	Persons	< 1 yr	2002 - 04	4.89	5.35	5.18
4.01 - Infant mortality	Persons	< 1 yr	2003 - 05	4.31	5.25	5.12
4.01 - Infant mortality	Persons	< 1 yr	2004 - 06	3.73	5.05	4.99
4.01 - Infant mortality	Persons	< 1 yr	2005 - 07	2.64	4.79	4.88
4.01 - Infant mortality	Persons	< 1 yr	2006 - 08	2.91	4.46	4.74
4.01 - Infant mortality	Persons	< 1 yr	2007 - 09	2.82	4.34	4.58
4.01 - Infant mortality	Persons	< 1 yr	2008 - 10	2.96	4.38	4.43
4.01 - Infant mortality	Persons	< 1 yr	2009 - 11	2.44	4.34	4.29
4.01 - Infant mortality	Persons	< 1 yr	2010 - 12	1.94	4.14	4.11
4.01 - Infant mortality	Persons	< 1 yr	2011 - 13	1.56	3.84	3.98

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

What this means for Bromley residents and the children in Bromley

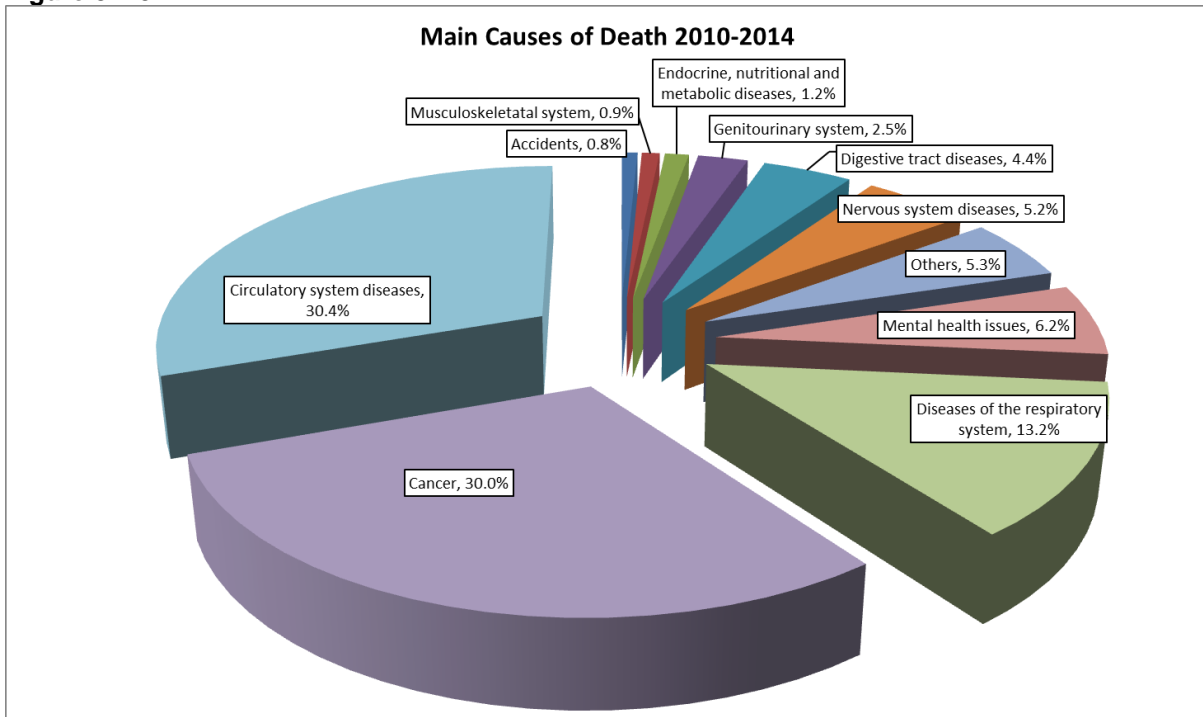
There is a need for continued action to address health inequalities with the disparity in life expectancy between the most and least deprived areas of the Borough.

Key Causes of Mortality & Major Health Issues

The key causes of death in Bromley remain:

- Cardiovascular disease
- Cancer
- Respiratory disease

Figure 3. 15



Source: Primary Care Mortality Database, 2015

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. In 2014, the early CVD mortality rate in Bromley for persons under the age of 75 years was 37.7 (as compared with 50.1 for England and 51.2 for London). In Bromley this represents a 39.7% decrease over the last 10 years.

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

Although the CVD mortality rate in Bromley for the period 2011-13 was (at 64.4 per 100,000) lower than England (78.2) and London (80.1), there are differences within the borough. (*PHOF*)

- Male CVD mortality rates are significantly higher than female CVD mortality rates (94.8 and 37.3 respectively). (*PHOF*)
- CVD mortality rates are higher in the most deprived areas of the borough, 176.3 per 100,000 in the most deprived quintile, compared with 109.8 in the least deprived quintile. In the most deprived quintile of the borough, the CVD mortality rate is 1.2 times greater than the CVD mortality rate for Bromley and 1.6 times greater than the CVD mortality rate in the least deprived areas of Bromley.

Coronary Heart Disease (CHD)

In 2013-14 there were 10,065 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 14,100. The prevalence of heart disease based on identified cases in Bromley has been declining over the last 4 years.

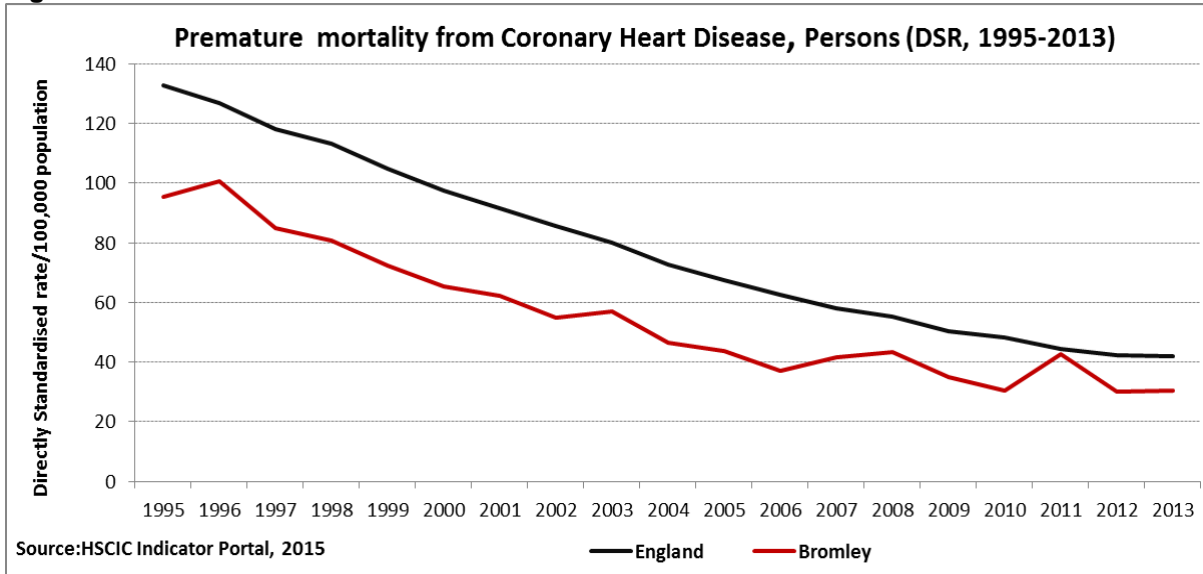
Table 3. 2: Prevalence of Coronary Heart Disease

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
CHD Register Size	9798	9717	9790	9859	9984	10253	10177	10165	10,065
CHD Prevalence	2.98%	3.76%	3.58%	3.75%	3.79%	3.79%	3.75%	3.10%	3.00%

Source: HSCIC/ QOF, 2015

Mortality from heart disease has been steadily declining since 1995 as shown in **Figure 3.16**. In 2013, the early mortality rate (under 75 years) for CHD in Bromley was 30.5 per 100,000, significantly lower than the national rate. This is a decrease of 46% since 2003, which is similar to the England change. In England, the mortality rate has decreased by 47% over the same 10 years. The rate in the London Strategic Clinical Network area has decreased by 47% over the same time period.

Figure 3. 16



Management of blood pressure and cholesterol levels in patients with CHD in Bromley is less effective than the national average, with 87.9% achieving optimal blood pressure management (as compared with 88.9% for England) and 72.9% achieving optimal cholesterol management (as compared with 73.2% for England).

In contrast, patients with CHD in Bromley are more likely than the national average to be receiving treatment with aspirin or equivalent (92.4% vs 91.4%) and appropriate drug treatment post heart attack (75.4% vs 70.2%).

In 2013-14 the admission rate for CHD was 610.4 per 100,000 (1,757 admissions). This is significantly higher than England (560 per 100,000).

BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2015

Table 3. 3: Cardiovascular related PHOF Indicators, 2015

Indicator	Time Period	Sex	Bromley	London	England
4.04i - Under 75 mortality rate from all cardiovascular diseases	2001 - 03	Persons	102.1	145.7	138.7
4.04i - Under 75 mortality rate from all cardiovascular diseases	2002 - 04	Persons	89.7	138.1	130.2
4.04i - Under 75 mortality rate from all cardiovascular diseases	2003 - 05	Persons	87.0	129.0	121.5
4.04i - Under 75 mortality rate from all cardiovascular diseases	2004 - 06	Persons	78.2	118.7	112.8
4.04i - Under 75 mortality rate from all cardiovascular diseases	2005 - 07	Persons	75.0	111.0	105.6
4.04i - Under 75 mortality rate from all cardiovascular diseases	2006 - 08	Persons	71.0	105.4	99.5
4.04i - Under 75 mortality rate from all cardiovascular diseases	2007 - 09	Persons	72.9	99.4	93.5
4.04i - Under 75 mortality rate from all cardiovascular diseases	2008 - 10	Persons	69.3	93.9	89.0
4.04i - Under 75 mortality rate from all cardiovascular diseases	2009 - 11	Persons	69.7	86.9	84.4
4.04i - Under 75 mortality rate from all cardiovascular diseases	2010 - 12	Persons	65.5	83.1	81.1
4.04i - Under 75 mortality rate from all cardiovascular diseases	2011 - 13	Persons	64.4	80.1	78.2
4.04i - Under 75 mortality rate from all cardiovascular diseases	2001 - 03	Male	154.6	205.9	193.8
4.04i - Under 75 mortality rate from all cardiovascular diseases	2002 - 04	Male	133.9	196.2	182.3
4.04i - Under 75 mortality rate from all cardiovascular diseases	2003 - 05	Male	125.0	183.3	170.3
4.04i - Under 75 mortality rate from all cardiovascular diseases	2004 - 06	Male	110.9	169.5	158.2
4.04i - Under 75 mortality rate from all cardiovascular diseases	2005 - 07	Male	109.2	159.0	147.9
4.04i - Under 75 mortality rate from all cardiovascular diseases	2006 - 08	Male	103.4	150.5	139.3
4.04i - Under 75 mortality rate from all cardiovascular diseases	2007 - 09	Male	104.7	141.4	131.4
4.04i - Under 75 mortality rate from all cardiovascular diseases	2008 - 10	Male	101.1	133.8	125.5
4.04i - Under 75 mortality rate from all cardiovascular diseases	2009 - 11	Male	105.4	124.6	119.4
4.04i - Under 75 mortality rate from all cardiovascular diseases	2010 - 12	Male	98.7	118.1	114.0
4.04i - Under 75 mortality rate from all cardiovascular diseases	2011 - 13	Male	94.8	113.5	109.5
4.04i - Under 75 mortality rate from all cardiovascular diseases	2001 - 03	Female	56.6	91.4	88.0
4.04i - Under 75 mortality rate from all cardiovascular diseases	2002 - 04	Female	51.4	85.5	82.1
4.04i - Under 75 mortality rate from all cardiovascular diseases	2003 - 05	Female	54.1	79.8	76.3
4.04i - Under 75 mortality rate from all cardiovascular diseases	2004 - 06	Female	49.9	72.5	70.6
4.04i - Under 75 mortality rate from all cardiovascular diseases	2005 - 07	Female	45.3	67.3	66.1
4.04i - Under 75 mortality rate from all cardiovascular diseases	2006 - 08	Female	42.6	64.2	62.2
4.04i - Under 75 mortality rate from all cardiovascular diseases	2007 - 09	Female	45.0	61.0	57.9
4.04i - Under 75 mortality rate from all cardiovascular diseases	2008 - 10	Female	41.2	57.4	54.6
4.04i - Under 75 mortality rate from all cardiovascular diseases	2009 - 11	Female	38.2	52.3	51.4
4.04i - Under 75 mortality rate from all cardiovascular diseases	2010 - 12	Female	36.0	51.1	50.1
4.04i - Under 75 mortality rate from all cardiovascular diseases	2011 - 13	Female	37.3	49.6	48.6
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2001 - 03	Persons	69.3	99.5	98.6
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2002 - 04	Persons	63.6	93.4	91.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2003 - 05	Persons	60.0	85.8	85.3
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2004 - 06	Persons	52.3	77.5	78.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2005 - 07	Persons	48.7	72.3	73.4
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2006 - 08	Persons	47.5	69.5	68.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2007 - 09	Persons	47.5	65.4	64.3
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2008 - 10	Persons	44.9	60.9	60.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2009 - 11	Persons	44.5	55.1	56.6
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2010 - 12	Persons	40.5	52.0	53.5
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2011 - 13	Persons	39.8	50.2	50.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2001 - 03	Male	115.0	150.1	147.4
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2002 - 04	Male	105.6	141.8	137.8
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2003 - 05	Male	97.7	130.6	128.4
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2004 - 06	Male	84.3	118.8	118.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2005 - 07	Male	77.5	110.9	110.5
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2006 - 08	Male	72.0	105.6	103.6
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2007 - 09	Male	70.1	98.6	97.1
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2008 - 10	Male	67.8	92.1	91.8
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2009 - 11	Male	71.7	84.0	85.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2010 - 12	Male	65.1	79.3	80.8
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2011 - 13	Male	64.6	76.4	76.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2001 - 03	Female	29.9	53.9	53.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2002 - 04	Female	27.4	49.7	49.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2003 - 05	Female	27.4	45.2	45.5
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2004 - 06	Female	24.5	40.1	41.8
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2005 - 07	Female	23.4	37.2	38.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2006 - 08	Female	26.0	36.6	36.4
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2007 - 09	Female	27.5	35.2	33.5
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2008 - 10	Female	24.6	32.5	31.4
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2009 - 11	Female	20.6	28.6	28.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2010 - 12	Female	18.6	27.0	27.6
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2011 - 13	Female	17.7	26.3	26.5

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

NHS Health Checks

The NHS Health Checks Programme is a national public health programme aimed to prevent heart disease, stroke, diabetes, chronic kidney disease and vascular dementia. Individuals aged between 40 and 74 years without established cardiovascular disease are invited to attend for a health check to assess and manage their risk of developing cardiovascular disease. This programme runs over a five year period, so 20% of the eligible population should be invited each year. It is recommended that local programmes aim to increase their percentage uptake each year. The aspiration from Public Health England is to achieve an uptake of 75%. The England average uptake was 49% for 2014-15.

The programme in Bromley commenced in 2010 with gradual implementation progressing to full rollout of 20% invitation target achieved in 2011-12 and achieved each subsequent year. Bromley increased its percentage uptake to 40% in 2014-15. NHS Health Check numbers achieved to date are shown in **Table 3.4**

Table 3. 4: Number of NHS Health Checks Offered and delivered 2011-2015

	Number of people eligible for an NHS Health Check in Bromley	Number of people invited for an NHS Health Check	Percentage of eligible population invited (target 20% each year)	Number of people who had an NHS Health Check completed	Percentage of people that received an NHS Health Check of those offered
2011-12	99,949	20,995	21%	7617	36%
2012-13	100,037	23,033	23%	8958	39%
2013-14	92,080	23,867	25%	9028	38%
2014-15	93,215	21,400	23%	8533	40%
TOTAL		89,295		34,136	

Source: London Borough of Bromley

The Public Health Outcome Framework Indicators comparing Bromley performance against England and London is shown in **Table 3.5**.

Table 3. 5: NHS Health Checks Public health outcome framework indicators 2013-14 – 2014-15

2.22	Take up of the NHS Health Check programme – by those eligible	Time period	Bromley	London	England
2.22iii	Cumulative % of the eligible population aged 40-74 offered an NHS Health Check	2013/14-2014/15	48.6	44.6	37.9
2.22iv	Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14-2014/15	38.8	48.1	48.9
2.22v	Cumulative % of the eligible population aged 40-74 who received an NHS Health Check	2013/14-2014/15	18.8	21.5	18.6

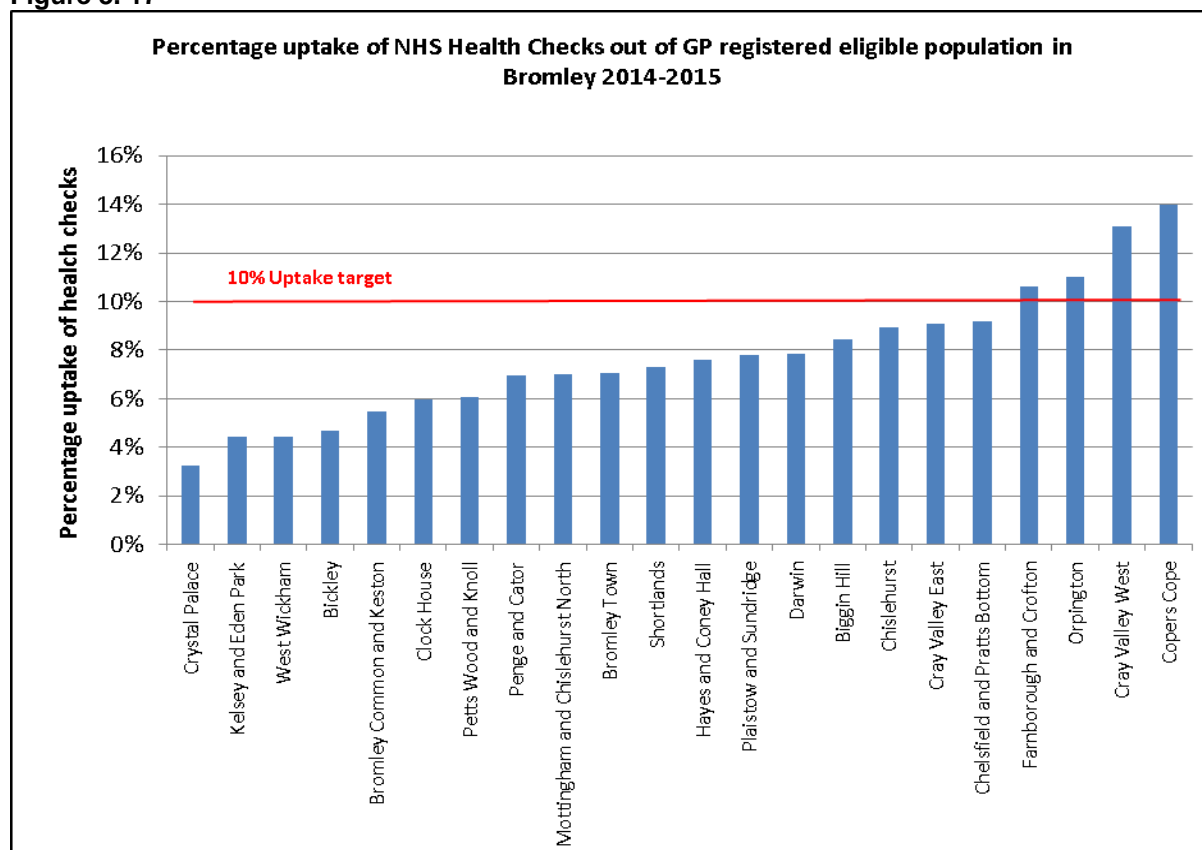
Source: Public Health Outcomes Framework. <http://www.phoutcomes.info/>

Bromley has a similar performance to the national figure when comparing uptake of eligible population receiving an NHS Health Check. However, Bromley has a higher

percentage of offers and therefore uptake against offers is lower than the London and England percentage.

Coverage of NHS Health Checks across the borough remains variable although some improvements have been seen in Biggin Hill, Darwin and Penge & Cator wards which were lowest in 2013-14. Coverage for 2014-15 is shown in **Figure 3.17**.

Figure 3. 17



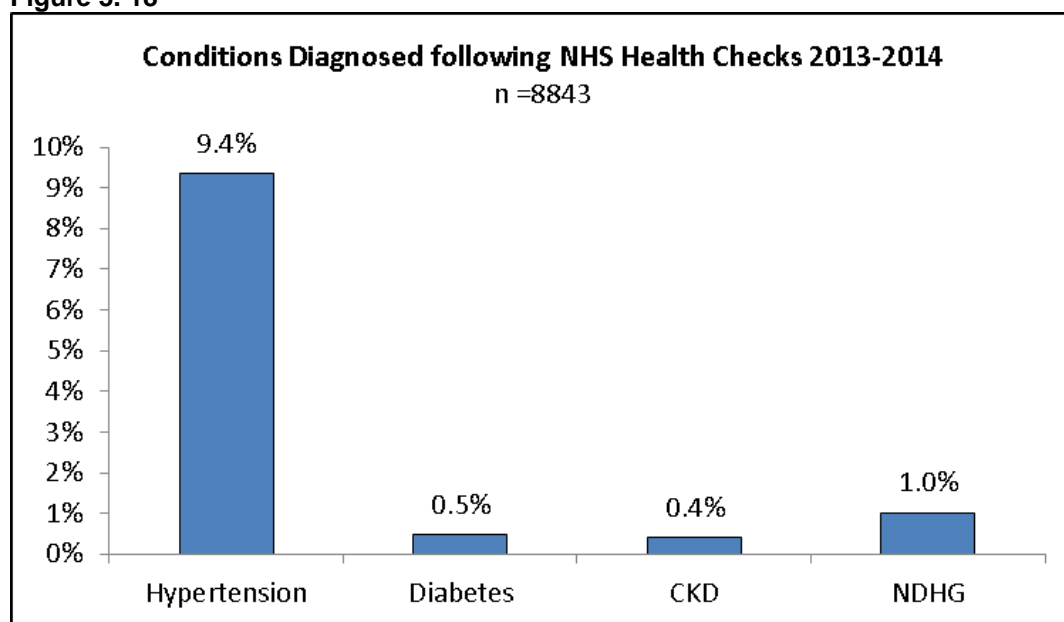
Source: Bromley NHS Health Check Programme 2015

It was expected that approximately half of the those invited would take up the opportunity to have their NHS Health Check, however only 4 wards reached the required uptake of 10% of the eligible population. Uptake was highest in Copers Cope ward and lowest in Crystal Palace for 2014-15.

During the NHS Health Check a cardiovascular risk assessment tool (Qrisk2) is used to assess whether an individual is at low, moderate or high risk of developing cardiovascular disease (CVD) in the next 10 years. A risk score of greater than or equal to 20% is considered high risk. In 2013-14, 482 (5.5%) individuals were found to have a high cardiovascular risk score. This is lower than the national expectation of 9.7%. These individuals will have been offered interventions to try and reduce their risk of developing cardiovascular disease in addition to being offered annual reviews at the GP Practice.

The NHS Health Check also identifies individuals eligible for further screening for diabetes, hypertension and chronic kidney disease (CKD). Early diagnosis of these conditions is beneficial in reducing progression to more severe cardiovascular disease such as heart attacks, stroke and vascular dementia. There is an on-going area of work with primary care to ensure people who identified as requiring further investigation and follow up are managed according to the relevant pathway of care. 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 3.18**

Figure 3. 18



Source: GP Practice data 2014

These figures may 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. Numbers of people identified as having Hypertension increased from 224 (2.6%) in 2012-13 to 827 (9.4) in 2013-14.

A key priority of the NHS Health Check is to identify people at high risk of developing diabetes who can be targeted for interventions to reduce their risk and prevent progression onto develop Type 2 Diabetes. Non-diabetic hyperglycaemia (NDHG) is the umbrella term which is now being promoted as the term for people at high risk of diabetes. Formerly more specific terms such as impaired glucose tolerance and impaired fasting glucose were used. With adoption of the national recommendation that the HbA1c blood test is now recommended to identify these people these more specific codes cannot no longer be applied with accuracy. The NHS Health Check results from 2013-14 for assessment of diabetes risk found 90 (1%) of individuals had a diagnostic code indicating this increased risk, however 531 (6%) of individuals

were found to have an HbA1c blood test in the pre-diabetic range but did not have a diagnostic code.

Interventions are being made to improve the follow up post NHS Health Check of those meeting the diabetes filter, to ensure they have the required blood test. Improvement has been seen in this follow up from 58% in 2013-14 to 79% in 2014-15.

What this means for Bromley residents in Bromley

There is a need to improve the low uptake of NHS Health Checks across most wards in the borough particularly in Crystal Palace. Improving access and targeting areas of higher CVD mortality and low levels of NHS Health Checks coverage, is important to ensure the programme does not widen health inequalities in the borough.

Evaluation is necessary to monitor the pathways to ensure appropriate follow up of the NHS Health Checks when risks have been identified, in order to maximise early diagnosis of high risk conditions. Where conditions are identified and managed early, people are less likely to progress onto more severe cardiovascular disease of stroke, heart attack or vascular dementia. Of particular importance is the need to improve identification of people who have Pre-Diabetes (non-diabetic hyperglycaemia) and offer them intensive programmes of lifestyle intervention to prevent the progression onto development of diabetes.

Stroke

The recorded prevalence of stroke has fluctuated between 1.5% and 1.94% over the last 9 years. In 2013/14 there were 5,121 people who had been diagnosed with a stroke in NHS Bromley CCG. This recorded prevalence of 1.5% is lower than the modelled estimate of prevalence of 1.9%. In the same period there were 396 admissions recorded on the Sentinel Stroke National Audit Programme.

Table 3. 6: Prevalence of Stroke

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Stroke Register Size	4825	4908	5017	5125	5184	5362	5277	5122	5121
Stroke Prevalence	1.47%	1.90%	1.83%	1.95%	1.61%	1.61%	1.94%	1.50%	1.50%
<i>Source: HSCIC/QOF, 2015</i>									

Of those people diagnosed with stroke, lower proportions achieve optimal control of blood pressure (83.8%) and cholesterol levels (67.7%) in Bromley than the England average (85.5% and 68.4% respectively). (Source CVD profiles).

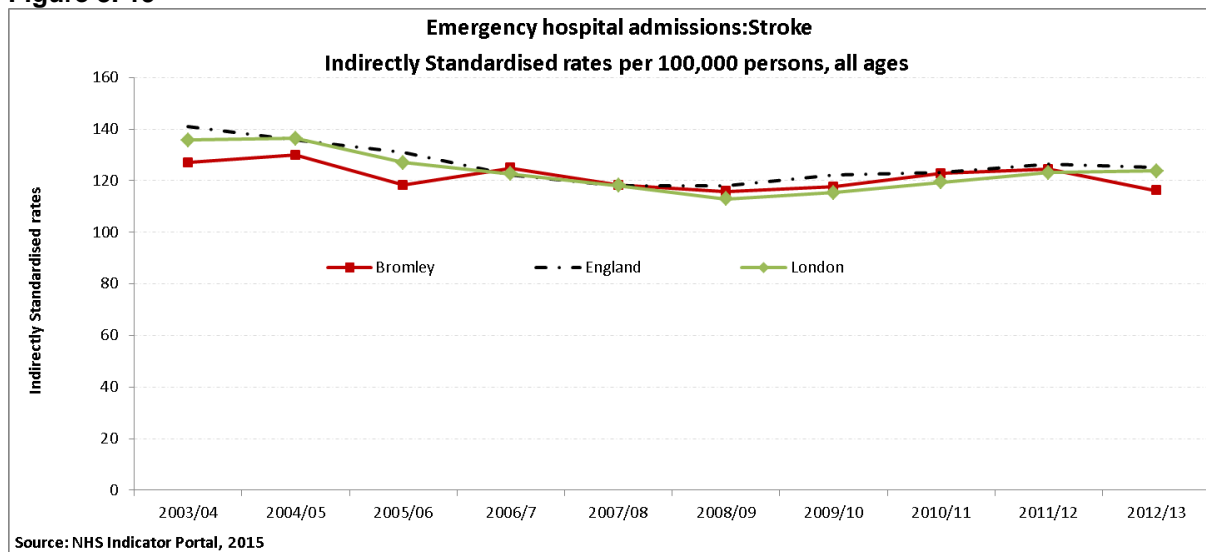
The proportion of patients with a non-haemorrhagic stroke who have a record of anti-platelet or anti-coagulant therapy (89.8%) is also lower than the national average (91.3%).

Atrial fibrillation (AF) is a known risk factor for stroke. The diagnosed prevalence of AF in Bromley is 1.6%, and the estimated prevalence is 2.5%, indicating that there could be an additional 3000 people with undiagnosed AF in the Bromley registered population.

Of those patients diagnosed with atrial fibrillation, there is an above average proportion who have had stroke risk assessed using a risk stratification scoring system (97.5%, compared with 95% nationally).

In 2013-14, the emergency admission rate for stroke in Bromley was 138.9 per 100,000 (414 admissions). This is significantly lower than England (174.3). The admission rate for stroke in Bromley decreased by 9.1% between 2003-04 and 2013-14.

Figure 3. 19

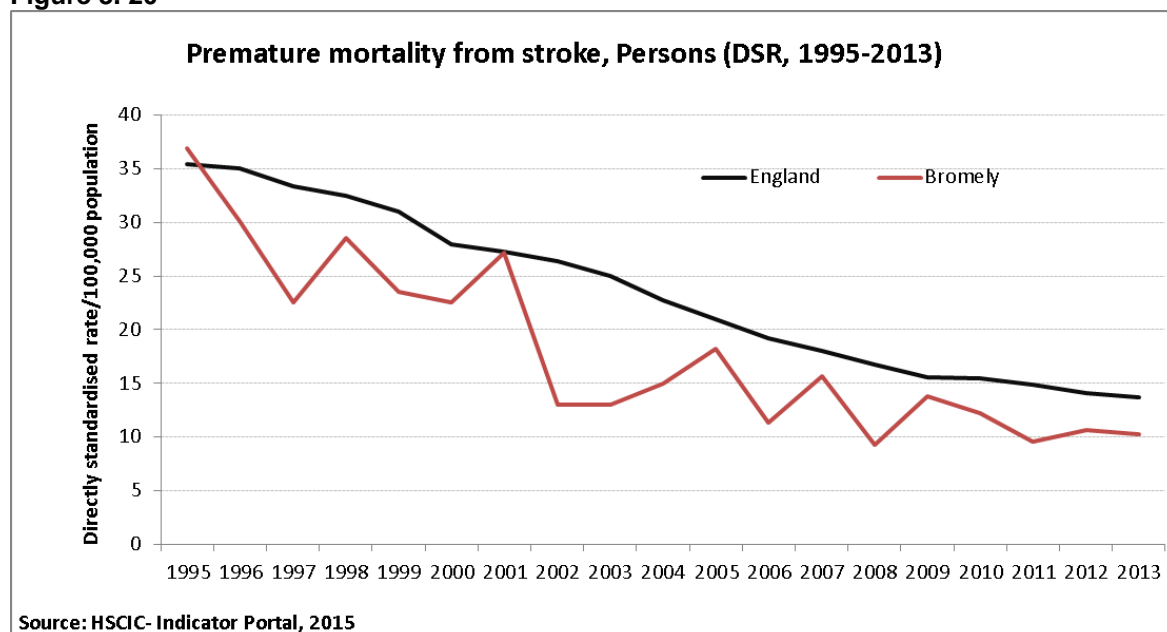


Treating appropriate patients with atrial fibrillation with anticoagulants lowers the risk of stroke. Of the stroke admissions in Bromley in 2013-14, a higher proportion (40.2%) were prescribed anticoagulation prior to their stroke than the national average (39.7%).

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. Bromley assessed 32.1% of eligible patients at six months, which is appreciably higher than the level nationally of 17.3%.

The stroke mortality rate in Bromley has been steadily falling since 1995, and is significantly lower than the rates for England. The early mortality rate (under 75 years) due to stroke was 10.2 per 100,000 in 2013. Later mortality (over 75 years of age) rate from stroke in Bromley was 489.5 per 100,000 people. This was significantly lower than the England rate (601.8).

Figure 3. 20



Hypertension

The prevalence of hypertension rose between 2005 to 2011, but has levelled off in the last 3 years.

The prevalence of recorded hypertension in Bromley (13.8%) is similar to the national average (13.7%). However, the expected prevalence of hypertension in Bromley is higher at 24.4%, indicating under-identification. There could be 36,000 undiagnosed hypertensives in Bromley.

Figure 3. 21: Hypertension Prevalence

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Hypertension Register Size	40,333	41,570	42,651	43,924	45,209	47,088	46,376	46,028	46,266
Hypertension Prevalence	12.4%	16.30%	15.8%	17.0%	17.5%	17.9%	17.1%	17.2%	17.1%

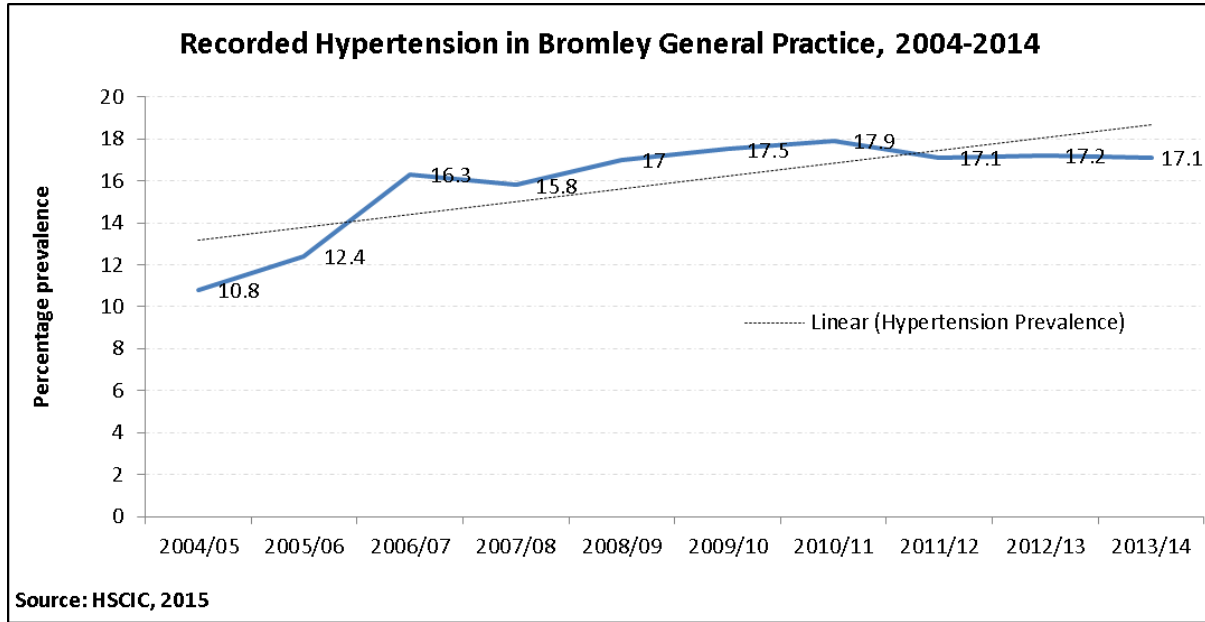
Source: HSCIC/ QOF, 2015

Optimal management of hypertension reduces the risk of developing cardiovascular disease. In Bromley, optimal management is achieved in a lower proportion of

hypertensives than the national average. 76.6% of patients with hypertension have their blood pressure controlled to 150/90 or less, as compared with 79.2% nationally.

A higher proportion of hypertensives (79.6%) are given lifestyle advice in Bromley than the national average (79%).

Figure 3. 22



What this means for Bromley residents and children in Bromley

The evidence shows that there are many people living in Bromley with undiagnosed hypertension, and 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 2012-13 there were 10,183 people aged 18 years and over who had been diagnosed with Chronic Kidney Disease (CKD) in Bromley. This represents 3.9% of the registered population aged 18 years and over. The figure given for 2013-14 is under review as a coding issue has led to under-reporting.

Table 3. 7

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
CKD Register size	9,593	10,011	10,173	10,868	10,776	10,693	10,183	10,050
CKD Prevalence	*3.0%	*3.1%	4.0%	4.2%	4.2%	4.2%	3.9%	3.8%

Source: HSCIC QOF, 2015 (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. 8

	Modelled CKD Prevalence	Diagnosed CKD Prevalence
England	6.1%	4.3%
Bromley	6.4%	3.9%

Source: Cardiovascular Disease Profile Kidney Disease March 2015

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

Blood pressure control is important in CKD, and in Bromley 67.5% of CKD patients have good blood pressure control as compared with 71.6% nationally.

A lower proportion of CKD patients in Bromley have had a urine albumin:creatinine ratio test in the previous 15 months than the national average.

There were 279 Bromley residents receiving renal replacement therapy (RRT) in 2013. The number receiving RRT has increased by 13.9% between 2008 and 2013.

In Bromley in 2013, the percentage of people receiving RRT who have had a renal transplant was 60.9%, a further 9.3% received home dialysis and 29.7% received hospital dialysis.

Diabetes

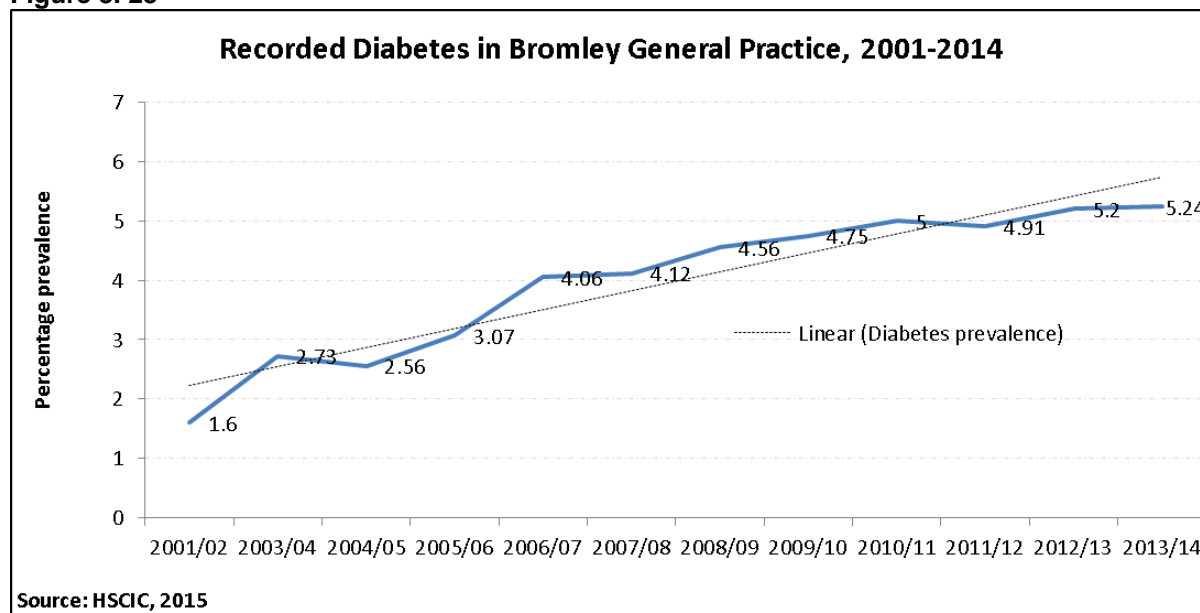
The number of people with diabetes has increased over time. There were 4,846 people on the diabetes register in 2002, as compared with 14,013 in 2013. (**Table 3.9**). This rise has particular significance because diabetes is classed as a vascular disease which is often a precursor to heart disease or stroke. However, despite this rise in the incidence of recorded diabetes, it is estimated that there are a further 5000 adults with undiagnosed diabetes.

Table 3. 9

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
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
Diabetes Prevalence	2.73%	2.56%	3.07%	4.06%	4.12%	4.56%	4.75%	5.00%	4.91%	5.20%	5.24%

Source: HSCIC/ QOF, 2015

Figure 3. 23



In addition, there are a large number of people with non-diabetic hyperglycaemia (NDHG) who are at high risk of developing diabetes. National prevalence modelling predicts that there are 29, 800 people with NDHG currently in Bromley. A search of GP systems in 2014 found that approximately 11,500 people have blood test results indicating that they have NDHG, indicating that many have not been identified.

A National Diabetes Prevention Programme is being developed, and Bromley has commissioned a pilot diabetes prevention programme, which is a one year intensive lifestyle intervention for 120 people with NDHG. This is due to complete in 2016, and the outcomes are being evaluated.

Control of diabetes, as measured by an HbA1c of ≤ 59 mmol/mol is lower in Bromley (67%) than in England as a whole (70%). However, there is a range of variation between practices. (QOF 2013-14)

Control of blood pressure (to $<+140/80$ mmHg) in diabetic patients in Bromley is lower than the England average, 72.1% vs 78.5% while cholesterol control is similar 78.5% vs 72.3% for both Bromley and England respectively. Again, there is a range of variation between practices. (QOF 2013-14).

Across the time period 2010 to 2013, people with diabetes in Bromley had a risk of stroke which was 86.8% higher, and a risk of heart attack which was 118.5% higher than that of the population without diabetes.

Table 3. 10: Diabetes Related PHOF Indicators, 2015

Indicator	Time Period	Sex	Bromley	London	England
2.17 - Recorded diabetes	2010/11	Persons	5.01	5.4	5.5
2.17 - Recorded diabetes	2011/12	Persons	5.10	5.6	5.8
2.17 - Recorded diabetes	2012/13	Persons	5.17	5.8	6.0
2.17 - Recorded diabetes	2013/14	Persons	5.24	6.0	6.2
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2010/11	Persons	86.26	76.0	79.2
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2011/12	Persons	84.70	78.7	80.9
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2012/13	Persons	86.87	77.0	79.1
4.12iii - Preventable sight loss - diabetic eye disease	2010/11	Persons	3.04	4.6	3.6
4.12iii - Preventable sight loss - diabetic eye disease	2011/12	Persons		4.5	3.8
4.12iii - Preventable sight loss - diabetic eye disease	2012/13	Persons	1.87	4.1	3.5
4.12iii - Preventable sight loss - diabetic eye disease	2013/14	Persons		4.2	3.4

Source: Public Health Outcomes Framework, 2015 <http://www.phoutcomes.info/>

What this means for Bromley residents and children 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.

The work to prevent diabetes in high risk patients and the work to improve the identification of diabetes should be fully evaluated to inform future commissioning.

Cancer

There were 7,346 patients recorded with a diagnosis of cancer on GP registers in 2013-14, although the Thames Cancer Registry reported 14,652 registered cancer patients registered in Bromley alive at 31st December 2013. 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 3.24**. The number of people diagnosed with cancer increases with age, to a peak in the 75 to 79 year age group (**Figure 3.25**).

Figure 3. 24

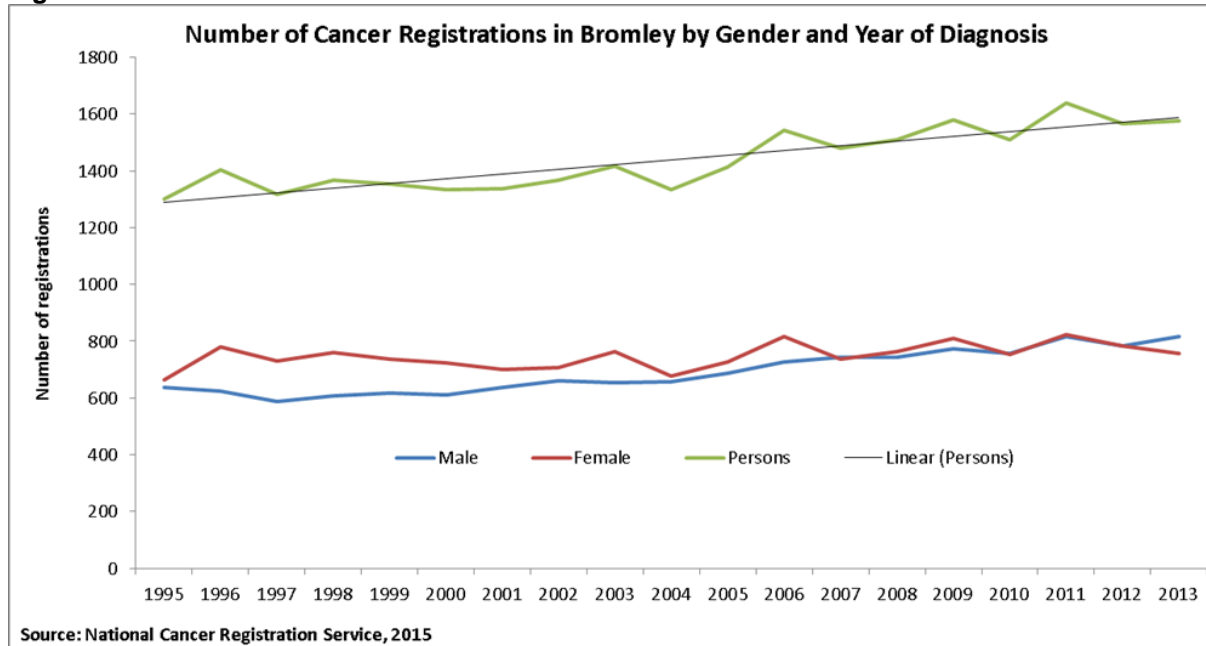
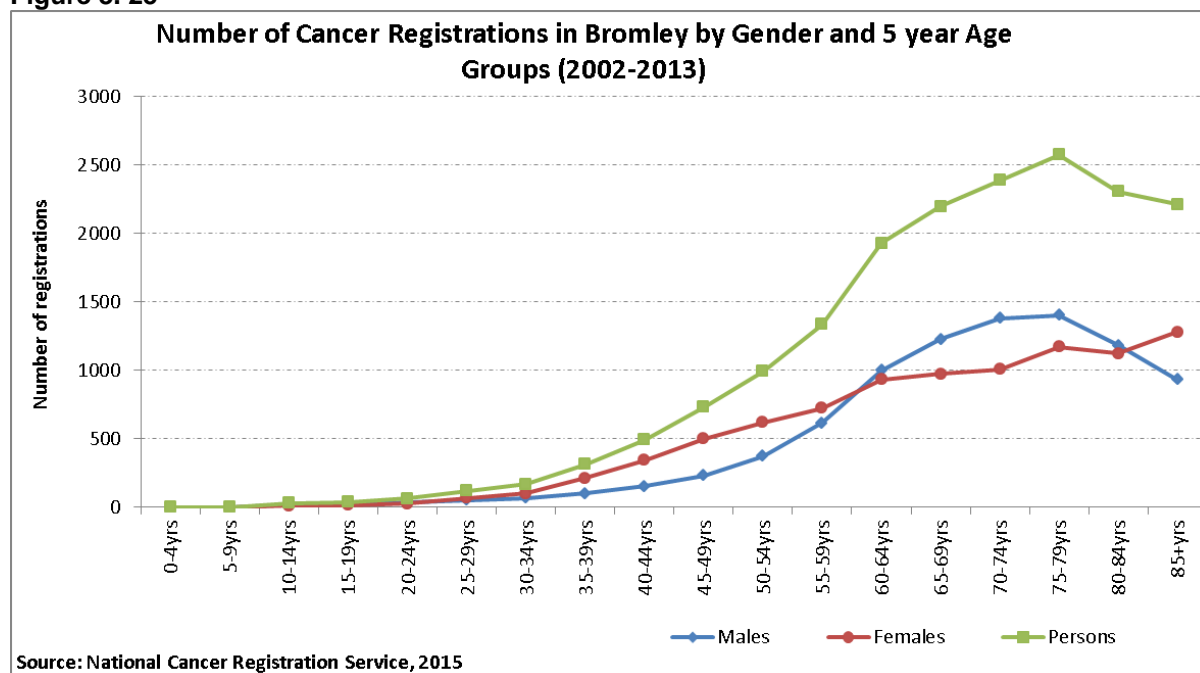


Figure 3. 25



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

Table 3. 11: Number of Cancer Registrations by Site in Bromley, 2002-2012

Site of cancer	Male	Female	Persons
Breast		2728	2728
Lung	840	674	1975
Colorectal	987	879	2047
Prostate	1975		1975
All cancers	3802	4281	8725

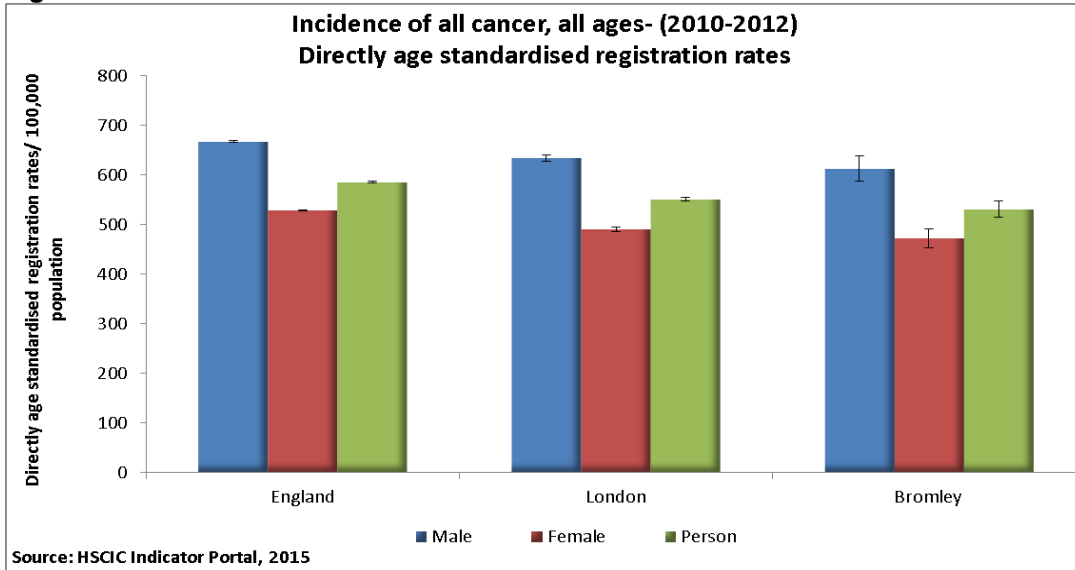
Totals in persons do not add up to the female male columns as is in the source dataset.

Source: HSCIC Indicator Portal, 2015

The incidence of all cancers in Bromley has been rising over the last 28 years; but mortality has been falling as survival has been improving.

All cancer incidence in Bromley is lower than for London and England. Incidence of lung cancer and cervical cancer are both significantly lower compared with London and England. Breast and colorectal cancer – diseases of more affluent living – are higher compared with London but not significantly so.

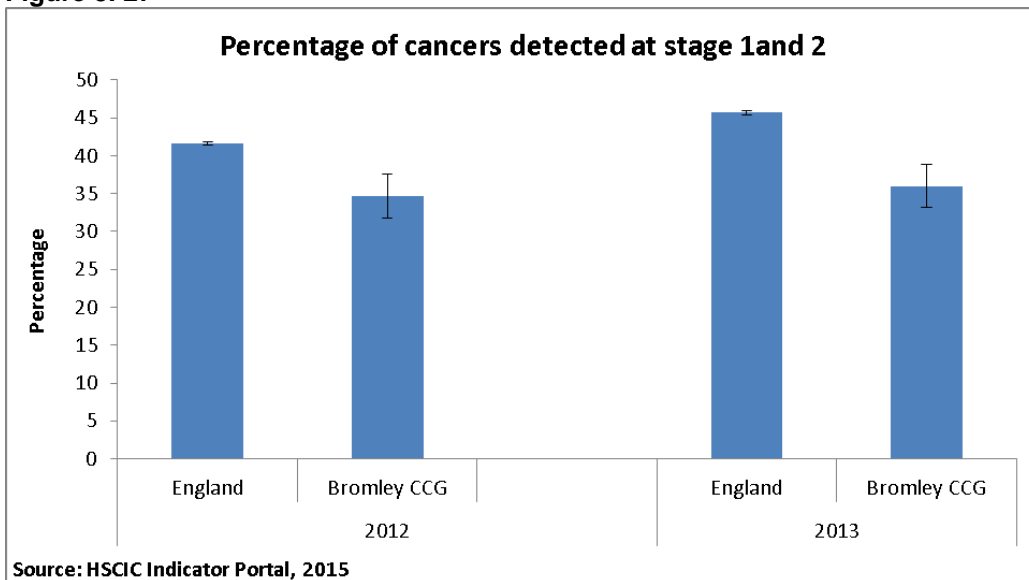
Figure 3. 26



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.

Only a third of cancers were detected early in 2012 and 2013 as shown in **Figure 3.27** below.

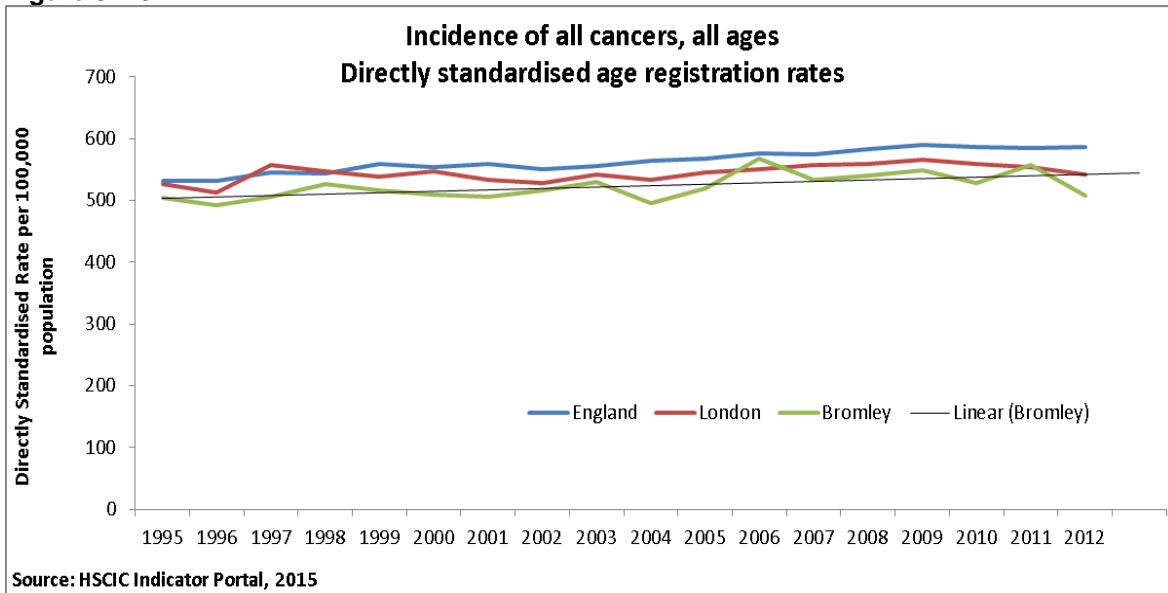
Figure 3. 27



The incidence for all cancers in Bromley has been consistently lower than the incidence for England over the last decade, with approximately 40/100,000 fewer cancers annually. In contrast to most cancers, the incidence of lung cancer in

Bromley has fallen by almost a third from 101.6/100,000 in 1995 to 63.5/100,000 in 2012.

Figure 3. 28



Overall cancer mortality has been falling over the last 20 years as shown in **Figure 3.29**.

Figure 3. 29

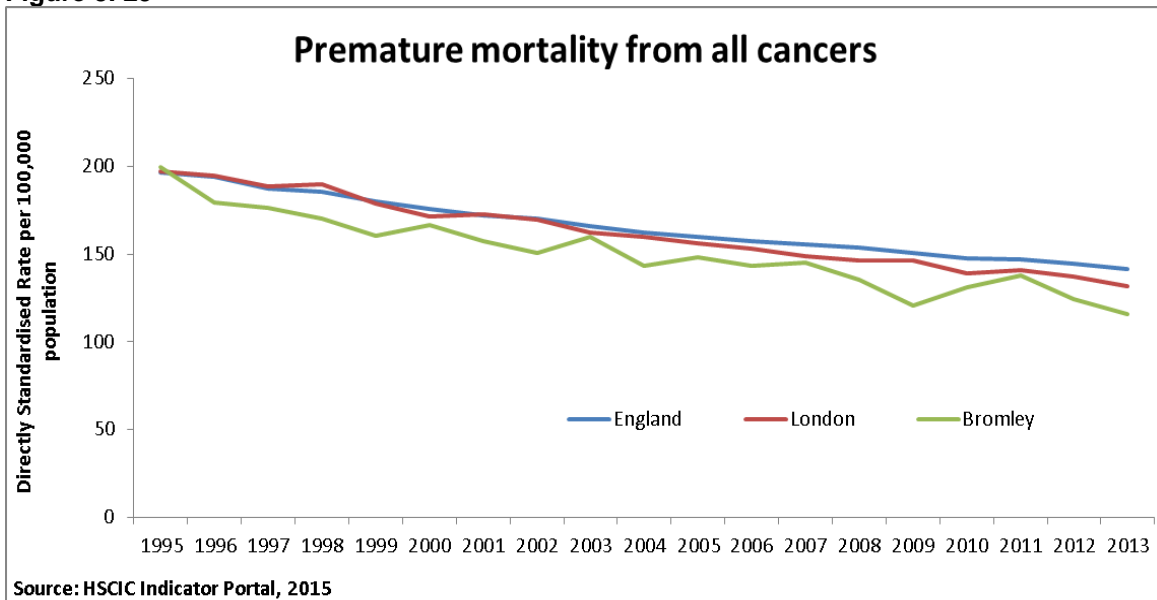
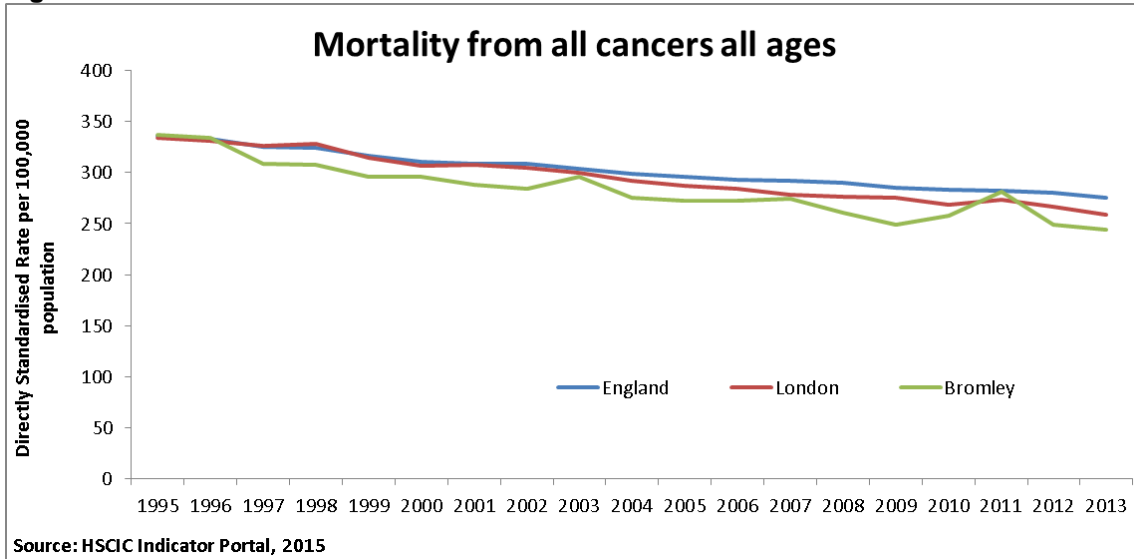
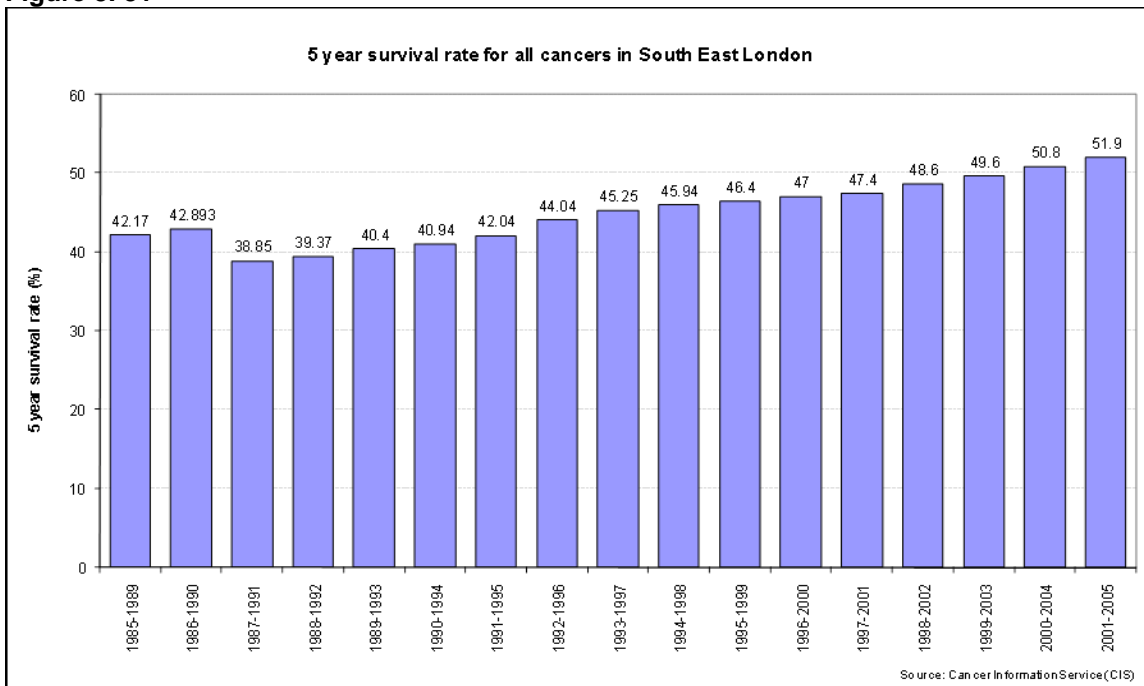


Figure 3. 30



The 5 year survival rate for cancer in South East London has been increasing over the period since 1985 -1989, and in Bromley, 5 year survival rates have been improving for three of the most common cancers, breast, lung and lower gastrointestinal tract.

Figure 3. 31

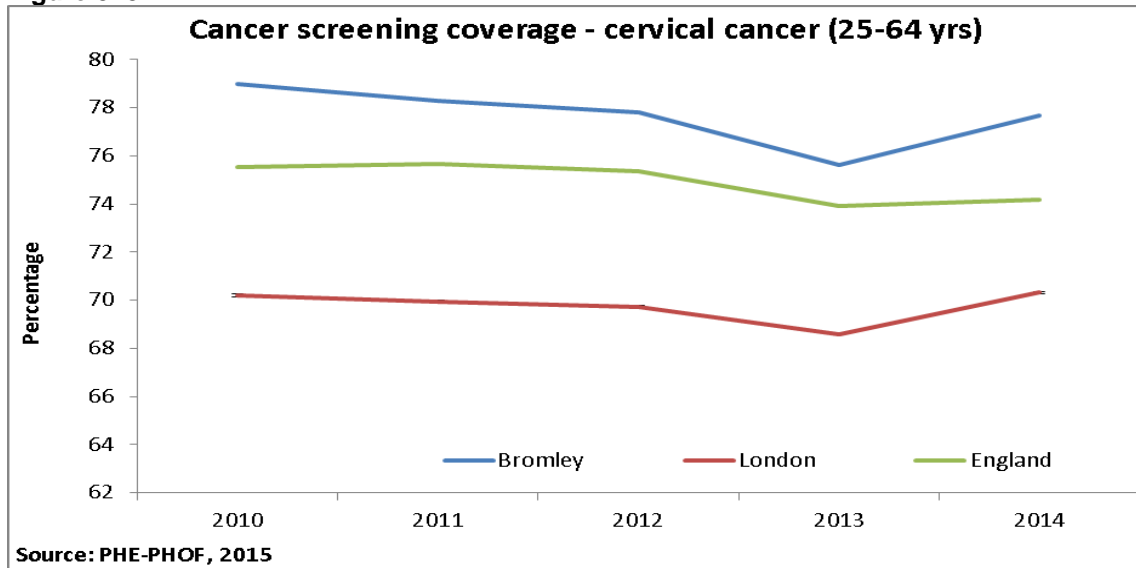


Cancer Screening

Cervical cancer screening uptake in women aged 26 to 64 years in Bromley has been consistently better than the London and National average over the last five

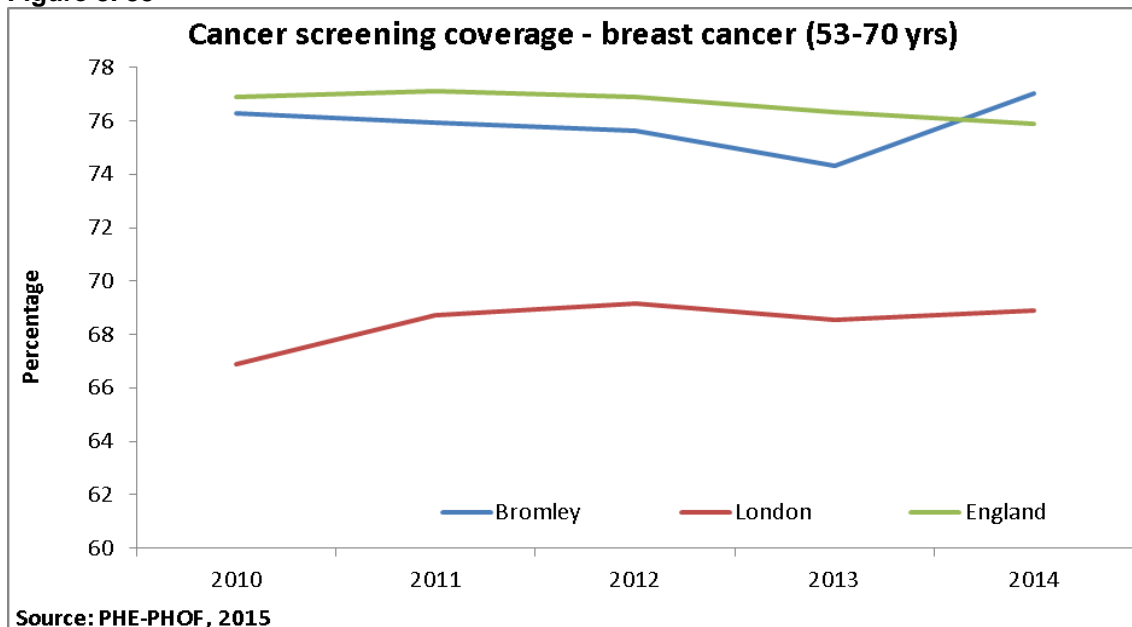
years (**Fig 3.32**). However, it is worth noting that the cervical cancer screening uptake in Bromley has fallen by about 3% in the last 5 years.

Figure 3.32



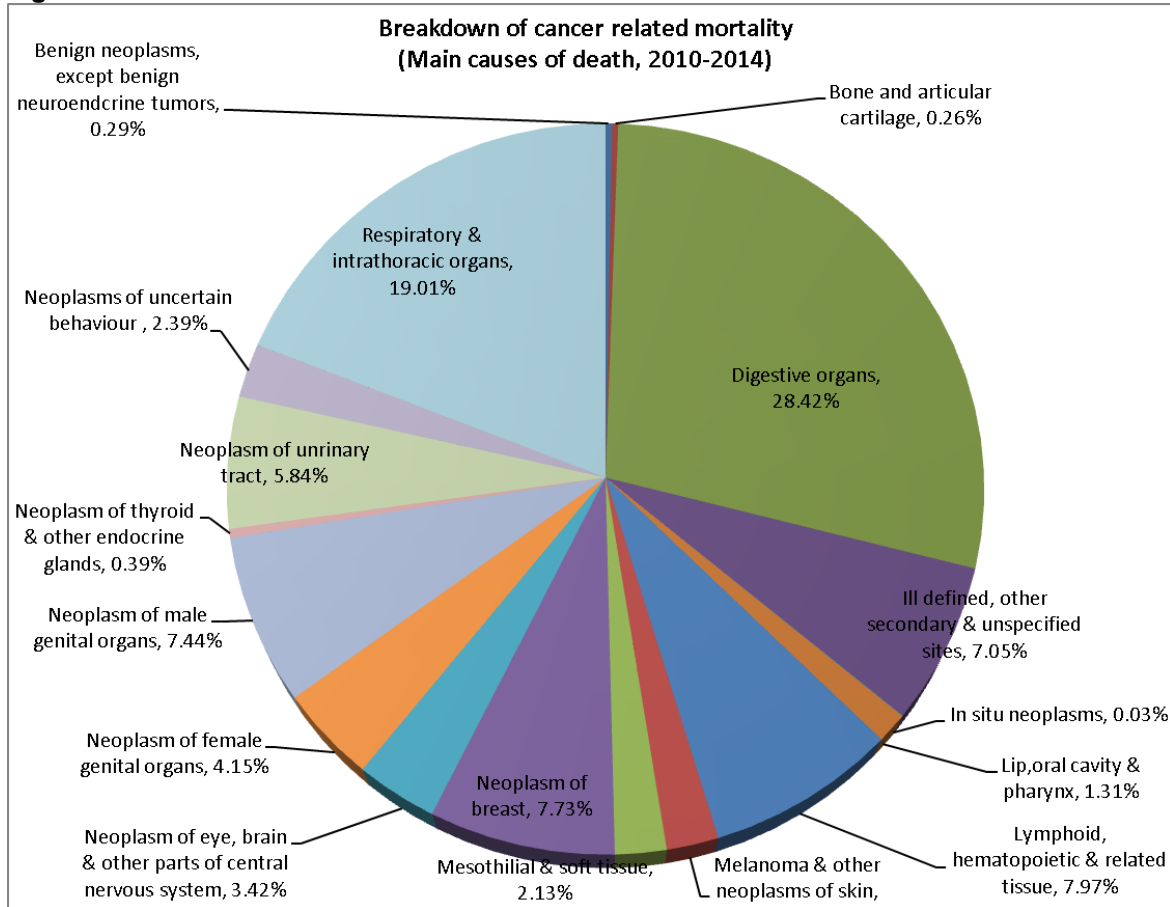
Breast cancer screening uptake in Bromley has improved. It has remained on par with the National average, and has consistently performed about 10% better than London (**Figure 3.33**).

Figure 3.33



The highest proportion of deaths in Bromley (28.42%) is related to cancer of the digestive organs.

Figure 3. 34



Source: ONS Primary Care Mortality Database, 2015

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Table 3. 12: Cancer Related PHOF Indicators, 2015

Indicator	Period	Sex	Bromley	London	England
4.05i - Under 75 mortality rate from cancer	2001 - 03	Persons	155.8	168.3	169.4
4.05i - Under 75 mortality rate from cancer	2002 - 04	Persons	151.5	164.0	166.2
4.05i - Under 75 mortality rate from cancer	2003 - 05	Persons	150.7	159.6	162.7
4.05i - Under 75 mortality rate from cancer	2004 - 06	Persons	145.0	156.6	160.0
4.05i - Under 75 mortality rate from cancer	2005 - 07	Persons	145.5	152.7	157.8
4.05i - Under 75 mortality rate from cancer	2006 - 08	Persons	141.4	149.5	155.7
4.05i - Under 75 mortality rate from cancer	2007 - 09	Persons	133.6	147.1	153.2
4.05i - Under 75 mortality rate from cancer	2008 - 10	Persons	129.1	144.0	150.6
4.05i - Under 75 mortality rate from cancer	2009 - 11	Persons	130.1	142.2	148.5
4.05i - Under 75 mortality rate from cancer	2010 - 12	Persons	131.5	139.1	146.5
4.05i - Under 75 mortality rate from cancer	2011 - 13	Persons	126.0	136.5	144.4
4.05i - Under 75 mortality rate from cancer	2001 - 03	Male	178.2	193.7	193.6
4.05i - Under 75 mortality rate from cancer	2002 - 04	Male	175.3	188.5	189.7
4.05i - Under 75 mortality rate from cancer	2003 - 05	Male	173.8	182.5	184.7
4.05i - Under 75 mortality rate from cancer	2004 - 06	Male	168.8	179.8	181.0
4.05i - Under 75 mortality rate from cancer	2005 - 07	Male	165.2	174.2	177.7
4.05i - Under 75 mortality rate from cancer	2006 - 08	Male	157.2	170.9	174.9
4.05i - Under 75 mortality rate from cancer	2007 - 09	Male	148.1	167.4	171.8
4.05i - Under 75 mortality rate from cancer	2008 - 10	Male	149.5	164.0	168.9
4.05i - Under 75 mortality rate from cancer	2009 - 11	Male	150.3	161.5	166.3
4.05i - Under 75 mortality rate from cancer	2010 - 12	Male	155.2	158.6	163.6
4.05i - Under 75 mortality rate from cancer	2011 - 13	Male	147.8	155.6	160.9
4.05i - Under 75 mortality rate from cancer	2001 - 03	Female	137.3	145.9	147.9
4.05i - Under 75 mortality rate from cancer	2002 - 04	Female	131.5	142.5	145.4
4.05i - Under 75 mortality rate from cancer	2003 - 05	Female	131.4	139.5	143.0
4.05i - Under 75 mortality rate from cancer	2004 - 06	Female	124.9	136.0	141.2
4.05i - Under 75 mortality rate from cancer	2005 - 07	Female	129.2	133.7	139.7
4.05i - Under 75 mortality rate from cancer	2006 - 08	Female	128.0	130.6	138.2
4.05i - Under 75 mortality rate from cancer	2007 - 09	Female	121.6	129.3	136.3
4.05i - Under 75 mortality rate from cancer	2008 - 10	Female	111.6	126.3	133.8
4.05i - Under 75 mortality rate from cancer	2009 - 11	Female	112.8	125.0	132.1
4.05i - Under 75 mortality rate from cancer	2010 - 12	Female	111.1	121.9	130.8
4.05i - Under 75 mortality rate from cancer	2011 - 13	Female	107.4	119.6	129.2
4.05ii - Under 75 mortality rate from cancer considered preventable	2001 - 03	Persons	86.3	97.2	97.0
4.05ii - Under 75 mortality rate from cancer considered preventable	2002 - 04	Persons	86.5	94.8	95.2
4.05ii - Under 75 mortality rate from cancer considered preventable	2003 - 05	Persons	84.5	92.5	93.3
4.05ii - Under 75 mortality rate from cancer considered preventable	2004 - 06	Persons	79.9	90.4	92.0
4.05ii - Under 75 mortality rate from cancer considered preventable	2005 - 07	Persons	78.1	88.3	90.9
4.05ii - Under 75 mortality rate from cancer considered preventable	2006 - 08	Persons	79.4	87.0	90.1
4.05ii - Under 75 mortality rate from cancer considered preventable	2007 - 09	Persons	74.3	86.1	89.1
4.05ii - Under 75 mortality rate from cancer considered preventable	2008 - 10	Persons	73.7	84.6	87.8
4.05ii - Under 75 mortality rate from cancer considered preventable	2009 - 11	Persons	72.9	83.1	86.3
4.05ii - Under 75 mortality rate from cancer considered preventable	2010 - 12	Persons	73.9	81.5	84.9
4.05ii - Under 75 mortality rate from cancer considered preventable	2011 - 13	Persons	70.8	79.6	83.8
4.05ii - Under 75 mortality rate from cancer considered preventable	2001 - 03	Male	100.4	109.0	109.0
4.05ii - Under 75 mortality rate from cancer considered preventable	2002 - 04	Male	99.4	106.4	106.5
4.05ii - Under 75 mortality rate from cancer considered preventable	2003 - 05	Male	93.8	103.3	103.8
4.05ii - Under 75 mortality rate from cancer considered preventable	2004 - 06	Male	89.7	102.0	101.5
4.05ii - Under 75 mortality rate from cancer considered preventable	2005 - 07	Male	83.7	99.0	99.8
4.05ii - Under 75 mortality rate from cancer considered preventable	2006 - 08	Male	87.2	97.8	98.4
4.05ii - Under 75 mortality rate from cancer considered preventable	2007 - 09	Male	82.3	95.9	97.3
4.05ii - Under 75 mortality rate from cancer considered preventable	2008 - 10	Male	85.7	94.1	96.0
4.05ii - Under 75 mortality rate from cancer considered preventable	2009 - 11	Male	85.1	92.4	94.5
4.05ii - Under 75 mortality rate from cancer considered preventable	2010 - 12	Male	86.1	91.4	92.7
4.05ii - Under 75 mortality rate from cancer considered preventable	2011 - 13	Male	82.4	89.1	91.3
4.05ii - Under 75 mortality rate from cancer considered preventable	2001 - 03	Female	74.7	87.0	86.5
4.05ii - Under 75 mortality rate from cancer considered preventable	2002 - 04	Female	75.8	84.9	85.2
4.05ii - Under 75 mortality rate from cancer considered preventable	2003 - 05	Female	76.8	83.0	84.0
4.05ii - Under 75 mortality rate from cancer considered preventable	2004 - 06	Female	71.7	80.4	83.5
4.05ii - Under 75 mortality rate from cancer considered preventable	2005 - 07	Female	73.6	79.0	83.0
4.05ii - Under 75 mortality rate from cancer considered preventable	2006 - 08	Female	73.1	77.5	82.7
4.05ii - Under 75 mortality rate from cancer considered preventable	2007 - 09	Female	67.8	77.6	81.7
4.05ii - Under 75 mortality rate from cancer considered preventable	2008 - 10	Female	63.5	76.3	80.3
4.05ii - Under 75 mortality rate from cancer considered preventable	2009 - 11	Female	62.5	75.0	78.9
4.05ii - Under 75 mortality rate from cancer considered preventable	2010 - 12	Female	63.5	72.9	77.9
4.05ii - Under 75 mortality rate from cancer considered preventable	2011 - 13	Female	61.0	71.2	76.9

Table 3. 13: Cancer Related PHOF Indicators, 2015

Indicator	Time Period	Sex	Bromley	London	England
2.19 - Cancer diagnosed at early stage (Experimental Statistics)	2012	Persons			41.6
2.19 - Cancer diagnosed at early stage (Experimental Statistics)	2013	Persons		43.12	45.66
2.20i - Cancer screening coverage - breast cancer	2010	Female	76.291	66.91	76.91
2.20i - Cancer screening coverage - breast cancer	2011	Female	75.929	68.73	77.13
2.20i - Cancer screening coverage - breast cancer	2012	Female	75.629	69.15	76.92
2.20i - Cancer screening coverage - breast cancer	2013	Female	74.305	68.57	76.32
2.20i - Cancer screening coverage - breast cancer	2014	Female	77.043	68.91	75.9
2.20ii - Cancer screening coverage - cervical cancer	2010	Female	79.004	70.21	75.53
2.20ii - Cancer screening coverage - cervical cancer	2011	Female	78.298	69.94	75.67
2.20ii - Cancer screening coverage - cervical cancer	2012	Female	77.802	69.74	75.36
2.20ii - Cancer screening coverage - cervical cancer	2013	Female	75.644	68.61	73.93
2.20ii - Cancer screening coverage - cervical cancer	2014	Female	77.685	70.31	74.16

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

Respiratory Disease

About 13% 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 (21.0 per 100,000) than for England (28.1 per 100,000).

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is mainly caused by smoking. The prevalence of smoking in Bromley is 16%, lower than the England average (18.4%). However, smoking prevalence is higher in routine and manual workers at 33.7%.

There are 4455 people in Bromley diagnosed with COPD, giving a prevalence of 1.3%, this is short of the estimated number of 10,232 (3.15%).

The recorded prevalence of COPD in Bromley is lower than the value for England (1.8%), but the estimated prevalence of COPD in Bromley is higher than that for England (2.91%), indicating that identification rates are lower in Bromley.

Table 3. 14

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
COPD Register Size	3342	3509	3735	4006	4143	4296	4247	4371	4455
COPD Prevalence	1.02%	1.36%	1.37%	1.52%	1.57%	1.57%	1.56%	1.3%	1.30%

Source: HSCIC/ QOF, 2015

Asthma

The prevalence of recorded asthma in Bromley is 5.2% (17,412 people), which is slightly lower than the value for England (5.9%) but significantly lower than the estimated prevalence (9.12%)⁴.

Emergency admissions for asthma per 1000 population in Bromley are lower (0.49) than for England (1.09), and the mean length of stay is shorter (1.72 days vs 2.36 days)⁴.

⁴ Inhale – INteractive Health Atlas of Lung conditions in England

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Table 3. 15

Indicator	Time Period	Sex	Bromley	London	England
4.07i - Under 75 mortality rate from respiratory disease	2001 - 03	Persons	36.16	43.99	40.54
4.07i - Under 75 mortality rate from respiratory disease	2002 - 04	Persons	33.51	42.38	39.80
4.07i - Under 75 mortality rate from respiratory disease	2003 - 05	Persons	30.84	42.04	39.38
4.07i - Under 75 mortality rate from respiratory disease	2004 - 06	Persons	26.97	39.76	37.61
4.07i - Under 75 mortality rate from respiratory disease	2005 - 07	Persons	26.23	37.98	37.05
4.07i - Under 75 mortality rate from respiratory disease	2006 - 08	Persons	26.28	36.60	36.55
4.07i - Under 75 mortality rate from respiratory disease	2007 - 09	Persons	27.19	34.57	36.01
4.07i - Under 75 mortality rate from respiratory disease	2008 - 10	Persons	24.28	33.65	35.34
4.07i - Under 75 mortality rate from respiratory disease	2009 - 11	Persons	20.48	32.14	34.22
4.07i - Under 75 mortality rate from respiratory disease	2010 - 12	Persons	20.61	32.65	33.52
4.07i - Under 75 mortality rate from respiratory disease	2011 - 13	Persons	22.44	31.91	33.17
4.07i - Under 75 mortality rate from respiratory disease	2001 - 03	Male	41.09	55.22	48.45
4.07i - Under 75 mortality rate from respiratory disease	2002 - 04	Male	37.47	52.74	47.38
4.07i - Under 75 mortality rate from respiratory disease	2003 - 05	Male	37.54	52.76	47.00
4.07i - Under 75 mortality rate from respiratory disease	2004 - 06	Male	32.99	49.86	45.10
4.07i - Under 75 mortality rate from respiratory disease	2005 - 07	Male	30.86	48.23	44.32
4.07i - Under 75 mortality rate from respiratory disease	2006 - 08	Male	28.72	46.13	43.50
4.07i - Under 75 mortality rate from respiratory disease	2007 - 09	Male	32.54	44.28	42.72
4.07i - Under 75 mortality rate from respiratory disease	2008 - 10	Male	30.54	42.51	41.75
4.07i - Under 75 mortality rate from respiratory disease	2009 - 11	Male	25.89	40.53	40.43
4.07i - Under 75 mortality rate from respiratory disease	2010 - 12	Male	25.76	40.64	39.55
4.07i - Under 75 mortality rate from respiratory disease	2011 - 13	Male	26.31	40.14	39.10
4.07i - Under 75 mortality rate from respiratory disease	2001 - 03	Female	32.04	33.98	33.43
4.07i - Under 75 mortality rate from respiratory disease	2002 - 04	Female	30.24	33.13	32.95
4.07i - Under 75 mortality rate from respiratory disease	2003 - 05	Female	25.13	32.41	32.45
4.07i - Under 75 mortality rate from respiratory disease	2004 - 06	Female	21.65	30.64	30.76
4.07i - Under 75 mortality rate from respiratory disease	2005 - 07	Female	22.13	28.69	30.36
4.07i - Under 75 mortality rate from respiratory disease	2006 - 08	Female	24.00	27.97	30.13
4.07i - Under 75 mortality rate from respiratory disease	2007 - 09	Female	22.51	25.83	29.78
4.07i - Under 75 mortality rate from respiratory disease	2008 - 10	Female	18.81	25.68	29.40
4.07i - Under 75 mortality rate from respiratory disease	2009 - 11	Female	15.73	24.58	28.44
4.07i - Under 75 mortality rate from respiratory disease	2010 - 12	Female	16.08	25.43	27.91
4.07i - Under 75 mortality rate from respiratory disease	2011 - 13	Female	19.04	24.51	27.64
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2001 - 03	Persons	17.68	20.89	20.44
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2002 - 04	Persons	15.41	20.08	19.66
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2003 - 05	Persons	14.69	20.33	19.36
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2004 - 06	Persons	12.79	19.42	18.24
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2005 - 07	Persons	13.12	18.35	18.04
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2006 - 08	Persons	12.66	17.80	17.86
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2007 - 09	Persons	12.46	16.82	17.58
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2008 - 10	Persons	11.38	16.59	17.44
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2009 - 11	Persons	11.20	16.16	17.25
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2010 - 12	Persons	11.99	17.06	17.58
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2011 - 13	Persons	13.73	17.14	17.85
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2001 - 03	Male	21.07	26.67	24.24
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2002 - 04	Male	17.59	25.39	23.14
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2003 - 05	Male	17.72	26.04	22.70
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2004 - 06	Male	14.31	24.80	21.56
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2005 - 07	Male	14.71	23.85	21.18
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2006 - 08	Male	13.30	22.85	20.83
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2007 - 09	Male	14.80	22.10	20.25
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2008 - 10	Male	14.21	21.33	19.99
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2009 - 11	Male	14.29	20.69	19.73
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2010 - 12	Male	14.53	21.40	20.13
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2011 - 13	Male	15.14	21.62	20.35
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2001 - 03	Female	14.89	15.75	17.07
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2002 - 04	Female	13.61	15.36	16.54
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2003 - 05	Female	12.07	15.21	16.33
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2004 - 06	Female	11.42	14.57	15.21
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2005 - 07	Female	11.70	13.39	15.14
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2006 - 08	Female	12.00	13.25	15.13
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2007 - 09	Female	10.34	12.08	15.11
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2008 - 10	Female	8.85	12.34	15.08
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2009 - 11	Female	8.45	12.09	14.94
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2010 - 12	Female	9.78	13.15	15.22
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2011 - 13	Female	12.51	13.11	15.53

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

Mental Illness

Mental health problems affect a large proportion of the population, with approximately 158 people per 1,000 of the Bromley population aged 16 to 74 years suffering from a mild to moderate disorder (i.e. anxiety and/or depression). At the more severe end of the spectrum, over 2,500 people in Bromley (1% of the adult population) have been identified by GPs as suffering from serious mental illness. Mental illness is discussed more extensively in the chapter on Mental Health, for further details refer to the Mental Health chapter.

Table 3. 16

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Mental Health Register Size	1,667	2,173	2,270	2,351	2,389	2,511	2,563	2,616	2,667
Serious Mental illness Prevalence	0.5%	0.9%	0.8%	0.9%	0.9%	1.0%	0.94%	0.8%	0.80%

Source: HSCIC/ QOF, 2015

Dementia

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.

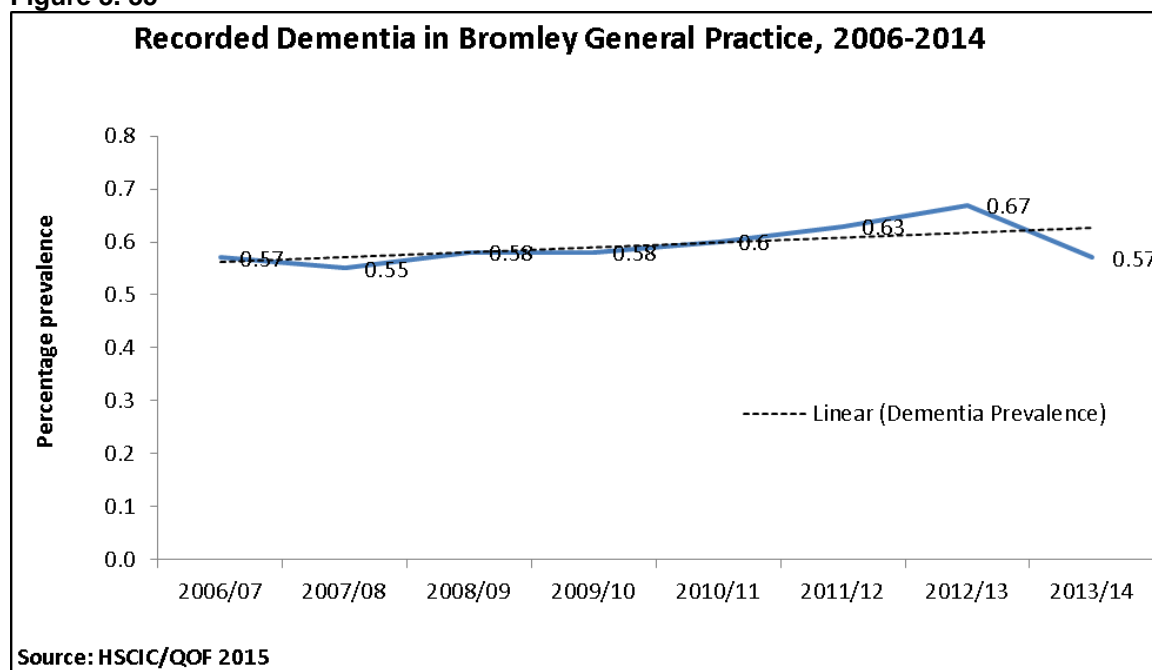
GP registers identify 1,902 patients with dementia, suggesting that some cases are not known to clinical services. Dementia is discussed more extensively in the chapter on Older People, for further details refer to the Older People chapter.

Table 3. 17

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Dementia Register Size	1448	1477	1489	1499	1572	1703	1794	1902
Dementia Prevalence	0.57%	0.55%	0.58%	0.58%	0.60%	0.63%	0.67%	0.57%

Source: HSCIC/ QOF, 2015

Figure 3. 35



Sexual Health

Introduction

About 80% of the population aged 15-69 years have had sex with someone of the opposite sex and approximately 2% with someone of the same sex. Good sexual health is therefore important to individuals and society.

Sexual ill-health can affect all parts of society but it is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conception and abortions, with the highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and Black African and ethnic minority groups. Similarly, HIV infection in the UK disproportionately affects MSM and Black African groups.

Sexually Transmitted Infections

2035 new STIs were diagnosed in residents of Bromley in 2013 (**1159 in males** and **870 in females**), a rate of **620 per 100,000** residents (males 768.4 and females 533.1)

Table 3. 18

Diagnosis	Rate 2012	Rate 2013	Rate 2014	% Change 2013-2014	Rank England 2014 *	Rate England Residents 2014
New STIs	617.1	648	620	-4	155	797.2
New STIs (Excluding Chlamydia)	723.2	706.8	694.6	-1.7	156	828.7
Chlamydia	204.3	276.1	261.0	-5.5	185	374.9
Gonorrhoea**	39.5	48.1	57.6	19.8	63	63.4
Syphilis	2.5	5.1	7.2	41.2	43	7.82
Genital Warts***	117.2	108.9	107.6	-1.2	194	128.4
Genital Herpes	61.8	47.1	46.9	-0.42	187	57.8

Source: Sexual and Reproductive Health Profiles, 2015

*Out of 326 local authorities in England, 1st has the highest rates

**Increase in Gonorrhoea diagnosis may be due to the increased use of highly sensitive Nucleic Acid Amplification Tests (NAATs) and additional screening of extra-genital sites in MSM

***Decrease in Genital Warts diagnosis may be due to a moderately protective effect of the HPV vaccination.

Chlamydia

Chlamydia infection is the most common bacterial sexually transmitted infection worldwide, especially among young people under the age of 25 years. Since Chlamydia is most often asymptomatic, a high diagnosis rate reflects success in 'detecting' infections by targeting and screening the most at risk individuals. Infections left untreated may lead to serious reproductive and medical health consequences.

Table 3. 19: Chlamydia testing data in 15-24 year olds: 2014

	Number of Chlamydia tests GUM	NCSP + other settings	Total number of tests	Positive infection detected	% of population tested	% positive tests
Bromley	2312	5377	7689	543	22.4%	7.1%
London	125984	167096	293080	22875	27.9%	7.8%
England	567345	1071700	1639045	135663	23.9%	8.3%

Source: National Chlamydia Screening Programme, PHE

Table 3. 20: Rates per 100,000 population of chlamydia diagnosis in 15-24 year olds in Bromley local authority, London PHE Centre and England: 2014

Bromley	London	England	Rank within London	Rank within England
1583.5	2179.3	2015.6	23	196

Source: Sexual Reproductive and health profiles, 2015

The prevalence rate of Chlamydia in Bromley is known to be below the national average. This is in line with its low prevalence of all STIs compared to other London boroughs. The current positivity rate indicates that Bromley has maintained an adequate detection rate. The focus should continue to be on detecting a higher proportion of infections in at risk individuals identified as most in need.

Figure 3. 36

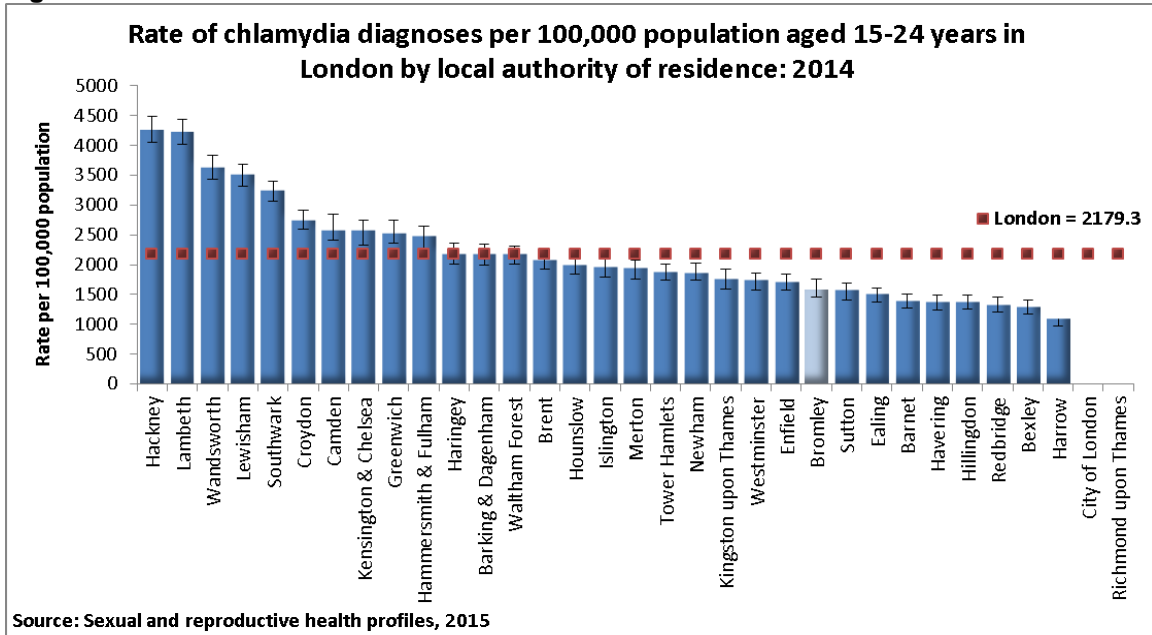


Figure 3. 37

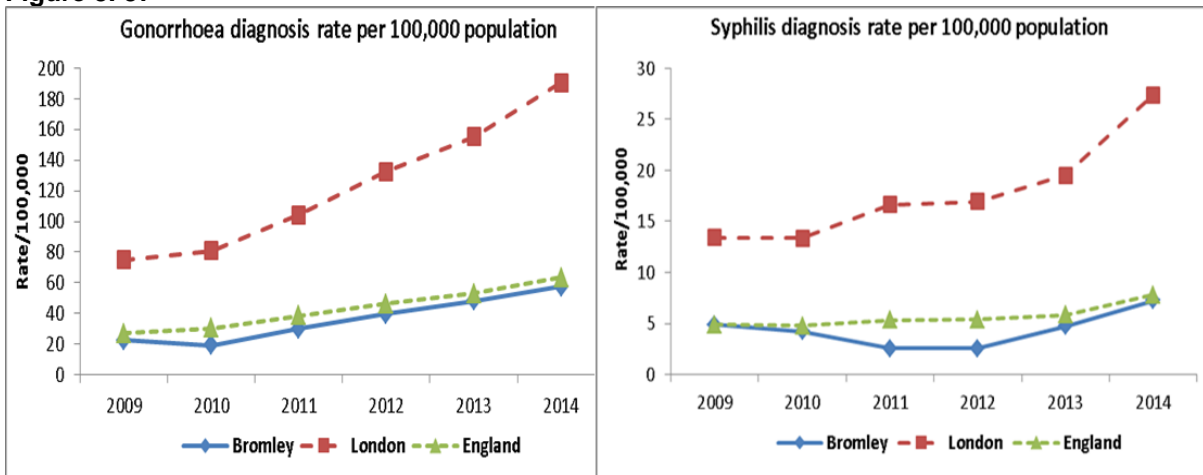
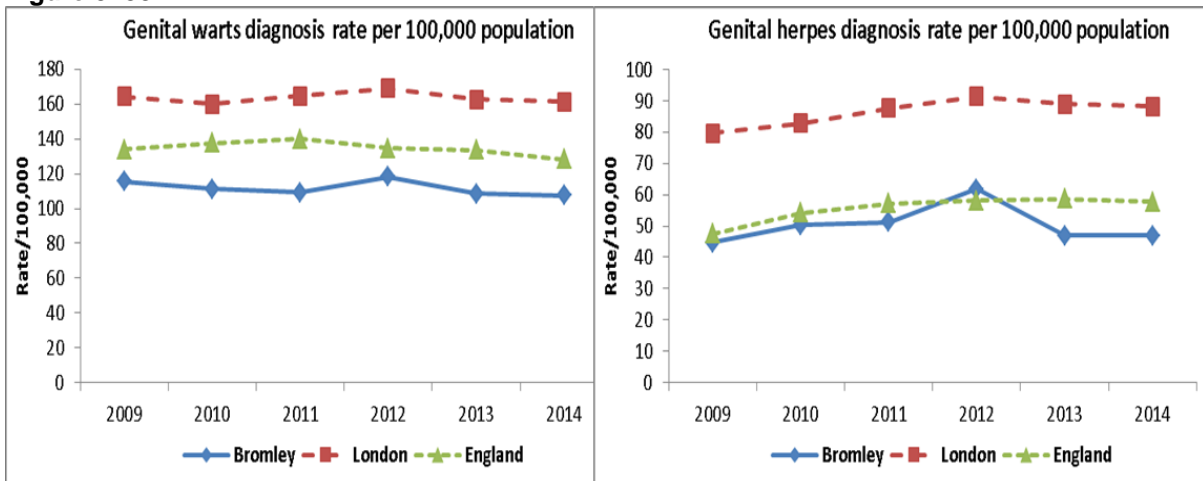


Figure 3. 38

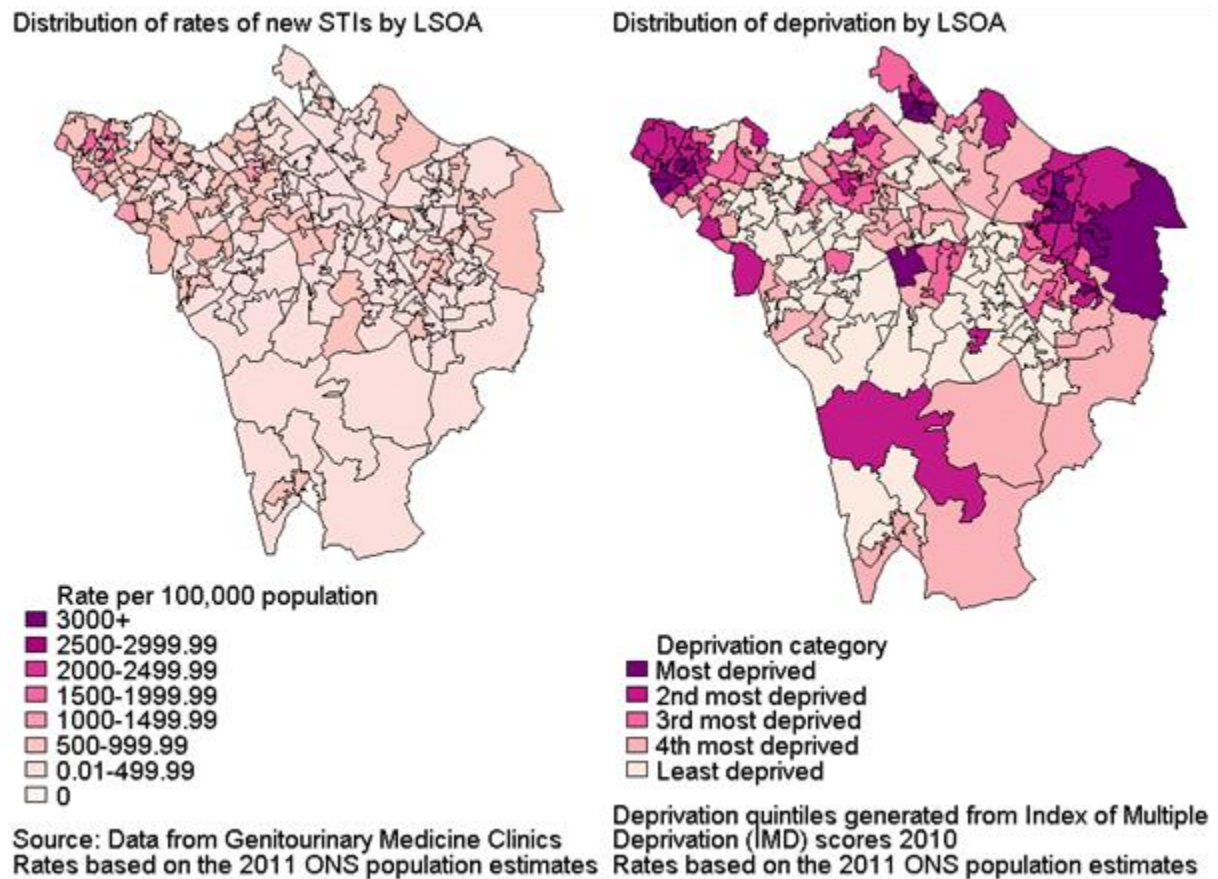


Where high rates of Gonorrhoea and Syphilis are seen in a population, this reflects high levels of risky sexual behaviour. While the rate of these two STIs in Bromley is below the England rate, both have risen. The diagnosis rate of Gonorrhoea has risen in line with the national rise over the last four years, but the diagnosis rate of Syphilis has risen at a faster rate than the England increase over the last two years. This warrants further investigation.

Distribution of new STIs and Deprivation

The prevalence of STIs in Bromley is the second lowest among London Boroughs. This overall low prevalence masks wide variations across the borough. There is considerable geographic variation in the distribution of STIs for Bromley, this is highlighted in **Figure.3.39** below.

Figure 3. 39: Rates of new STIs and deprivation by LSOA* in Bromley (GUM diagnoses only): 2013



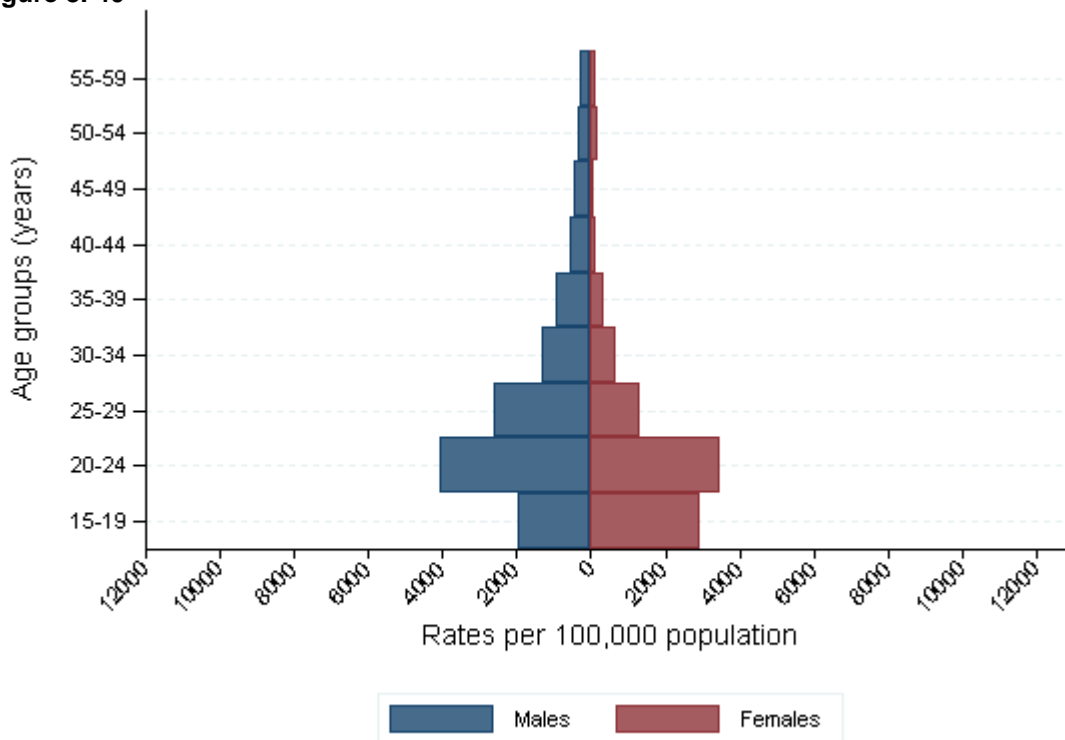
Socio-economic deprivation (SED) is a known determinant of poor health outcomes and data from GUM (Sexual Health) clinics show a strong positive correlation between rates of new STIs and the index of multiple deprivation across England. The relationship between STIs and SED is probably influenced by a range of factors such as the provision of and access to health services, education (SRE), health awareness, health-care seeking behaviour and sexual behaviour.

Rates of STIs overall in Bromley have been increasing since 2009 although they remain lower than the rates for both London and England. The increase is partly due to improved testing and reporting but also due to increased risk taking behaviours, especially among MSM individuals of all ages and young people under the age of 25 years.

Young people

Young people between 15 and 24 years of age experience the highest rates of new STIs. In Bromley, 52% of diagnoses of new STIs were in young people aged 15-24 years. The age profile is shown in **Figure.3.40** below.

Figure 3. 40

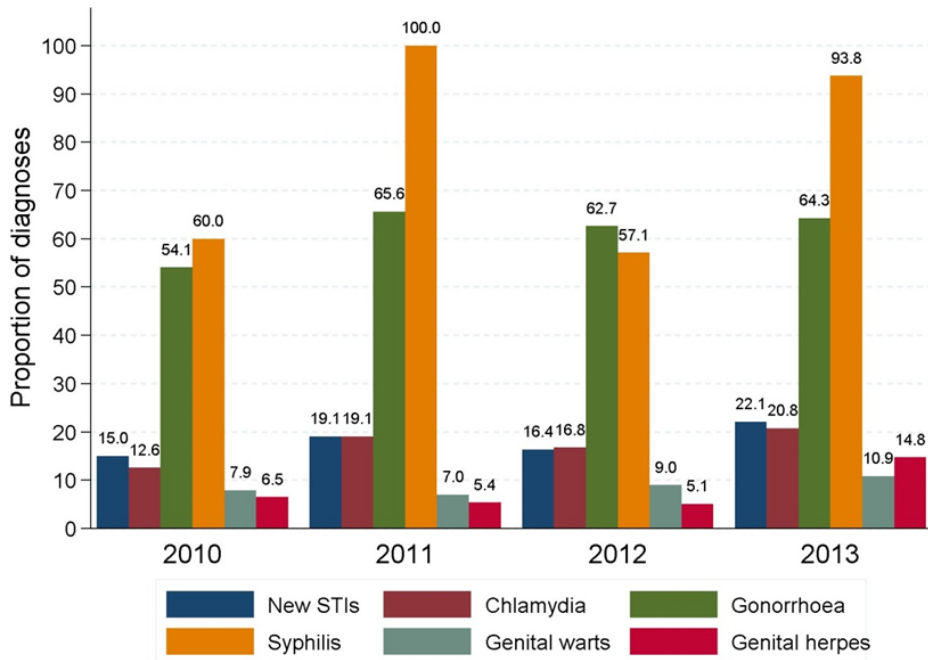


Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)
Rates based on the 2012 ONS population estimates

Men who have sex with men (MSM)

In Bromley in 2013, for cases in men where sexual orientation was known, 22.1% (n=219) of new STIs were among MSM. In 2010, the proportion of new STIs among MSM was 15.0% (n=118). (NB: the numbers for MSM presented in this report include homosexual and bisexual men).

Figure 3. 41: Proportion of new STIs, chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM among men in Bromley (GUM diagnoses only)



Source: Data from Genitourinary Medicine clinics
 Excludes chlamydia diagnoses made outside GUM
 For cases in men with known information on sexual orientation
 See Figure 5 for denominator

Figure 3.41 shows that infections in MSM account for almost all (93.8%) new cases of Syphilis and the majority (64.3%) of cases of Gonorrhoea.

Reinfection of STIs

Reinfection with an STI is a marker of persistent risky behaviour. In Bromley, an estimated 5.1% of women and 8.6% of men presenting with a new STI at a GUM (Sexual Health) clinic during the five year period from 2009 to 2013 became re-infected with a new STI within twelve months. Nationally, during the same period of time, an estimated 6.9% of women and 8.8% of men presenting with a new STI at a GUM clinic became re-infected with a new STI within twelve months

In Bromley, an estimated 3.8% of women and 7.2% of men diagnosed with gonorrhoea at a GUM clinic between 2009 and 2013 became re-infected with gonorrhoea within twelve months. Nationally, an estimated 3.7% of women and 8.0% of men became re-infected with gonorrhoea within twelve months.

In view of the rising prevalence in Gonorrhoea infections and PHE concern that this infection could become resistant to antibiotics in as little as 3 years, a test for

Gonorrhoea is now included in the NCSP test that can be performed from the same sample.

What does this mean for Bromley residents?

Young people between 15 and 24 years old continue to have the highest rates of new STIs.

Males of all ages are more affected by new STIs than females.

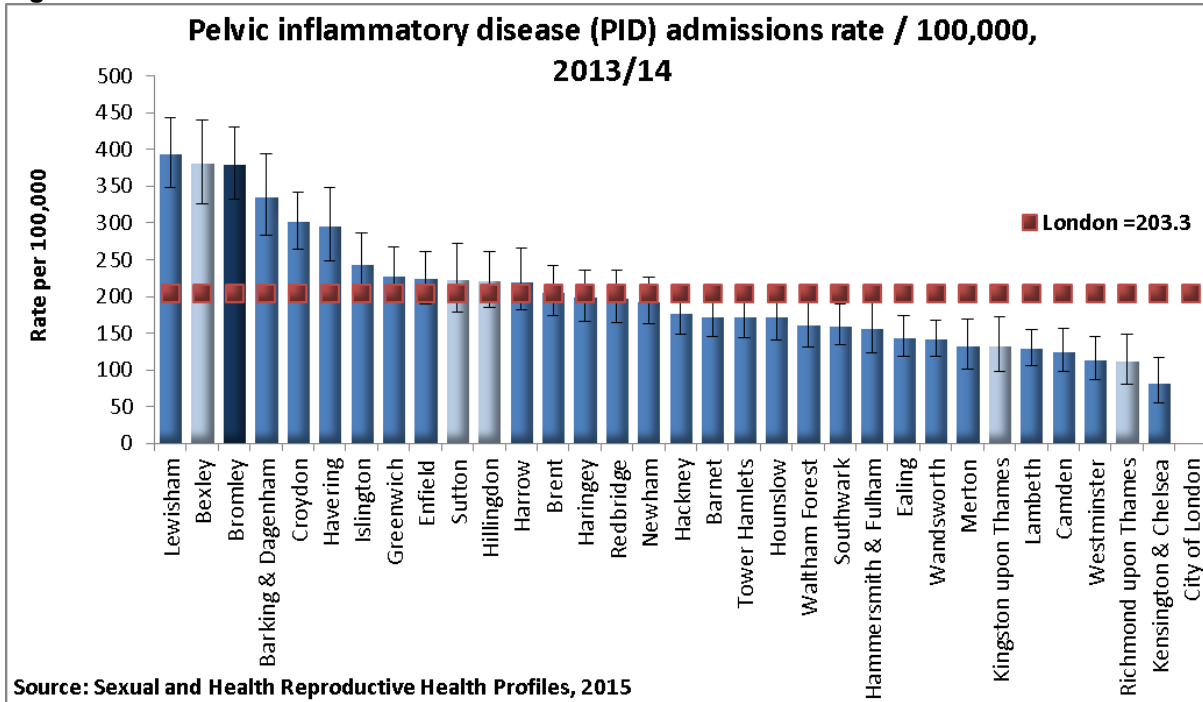
The majority of new cases of Syphilis and Gonorrhoea occur in MSM, indicating that MSM are a high risk group in Bromley.

There is cause for concern at the increasing incidence rate of Syphilis and Gonorrhoea.

Pelvic Inflammatory Disease

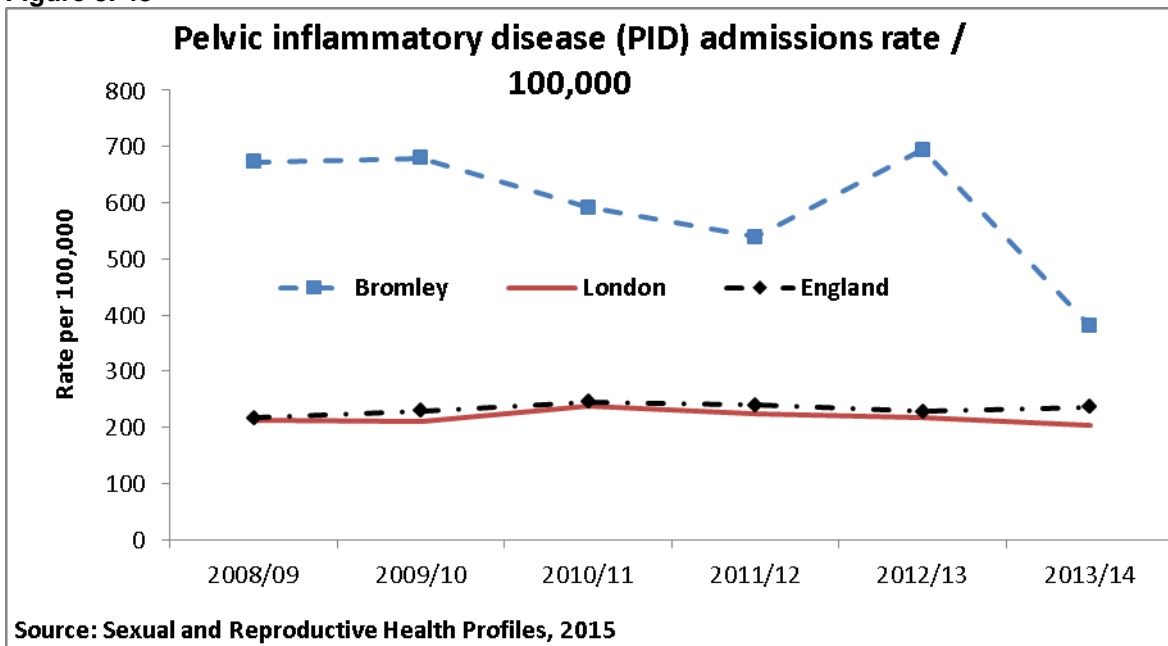
Pelvic inflammatory disease (PID) is a generic term for inflammation of the female uterus, fallopian tubes and/or uterus which progresses to scar formation with adhesions to nearby tissues and organs. PID can result in infertility, ectopic pregnancy and chronic pain. Although there are many possible causes, sexually transmitted infections such as Chlamydia and gonorrhoea increase the risk of pelvic inflammatory disease and contracting of repeat infections in particular. Hospital admission rates for PID may give some idea of the extent of untreated sexually transmitted infections in the population.

Figure 3. 42



High levels of PID have been reported for Bromley over the last few years, despite the borough showing a consistently low prevalence of STIs, such that the coding and accuracy of this information was called into question. The HPA and PHE were commissioned to investigate this further, but initial findings have been unable to establish with any certainty whether the rate is as a result of genuine disease. Despite this, up to date data clearly shows a sharp decline in PID admissions. Further investigation is still on-going.

Figure 3. 43



What does this mean for Bromley residents?

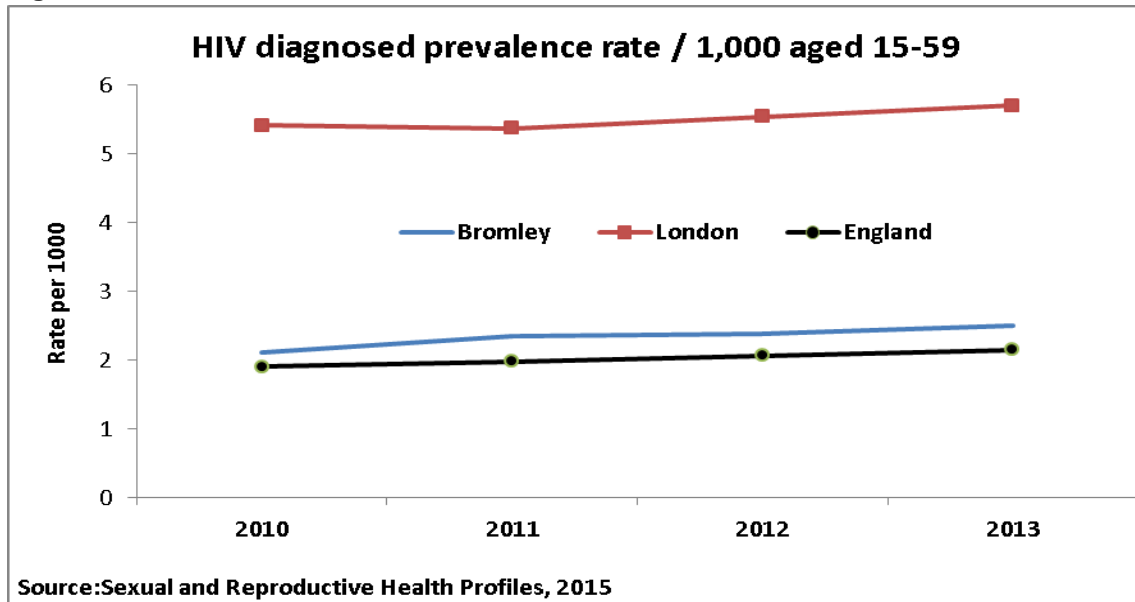
The findings of the PHE investigation point to other possible explanations of the unusually high rates of PID admissions and further investigation is recommended. These are being considered by commissioners who will put in place a prioritised plan of action.

HIV

The number of Bromley residents living with diagnosed HIV continues to rise. The latest available data shows a year on year increase from 462 in 2011 475 in 2012 to 508 in 2013. The diagnosed HIV prevalence rate has now risen to 2.5 per 1,000 population aged 15-59 years, compared to 2.1 per 1,000 in England (see **Figure 3.44** below).

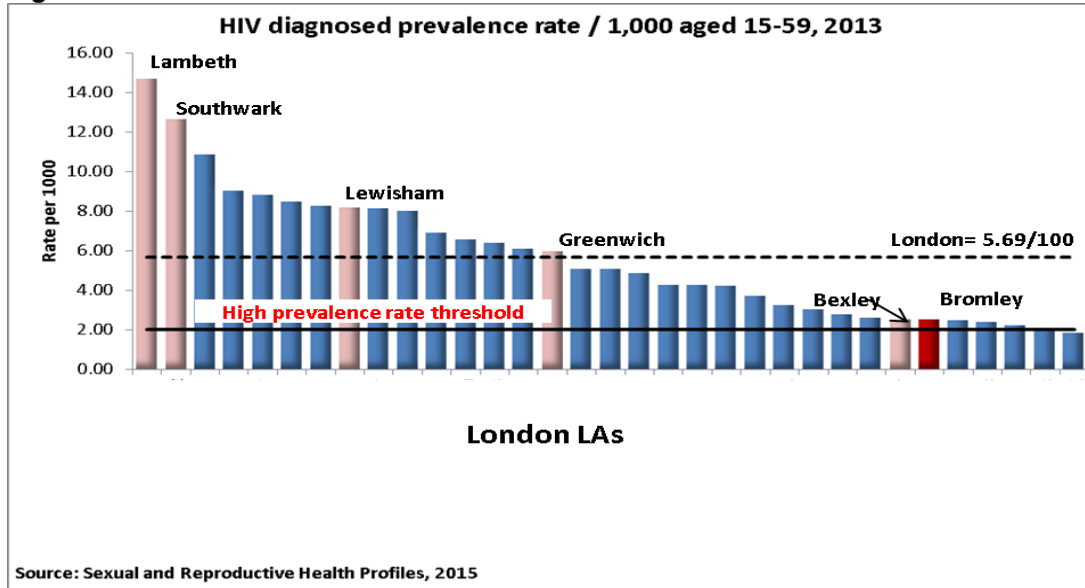
An age-specific prevalence rate of 2 per 1,000 population (aged 15-59) or higher denotes a high prevalence area and routine HIV testing to detect the infection is recommended (NICE).

Figure 3. 44



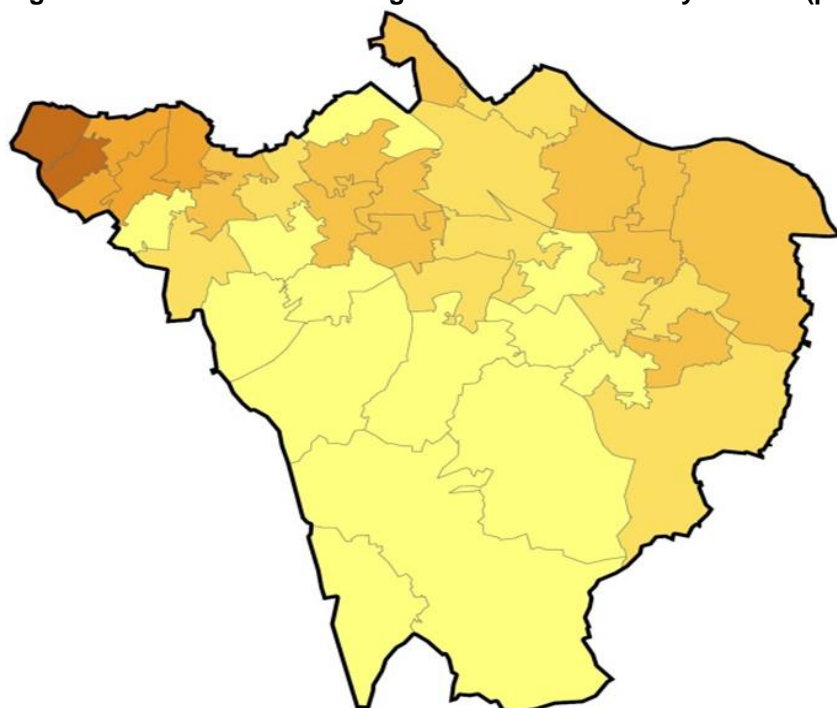
While Bromley remains one of the lowest ‘high prevalence’ areas in London, this overall prevalence rate masks local variation. There are areas in Bromley where the prevalence rate has risen from 6 per 1000 population to over 8 per 1000 population.

Figure 3. 45

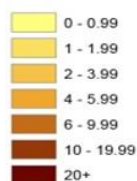


The highest rates of HIV in Bromley (8 per 1000) continue to be found in the North-West spur of the borough. Prevalence rates of higher than 2 per 1000 occur in half of middle layer super output areas (MSOAs) in Bromley as shown in **Figure 3.46** below.

Figure 3. 46: Prevalence of diagnosed HIV in 15 to 59 year olds (per 1,000) by MSOA: 2013



Prevalence of diagnosed HIV infection
per 1,000 population aged 15-59

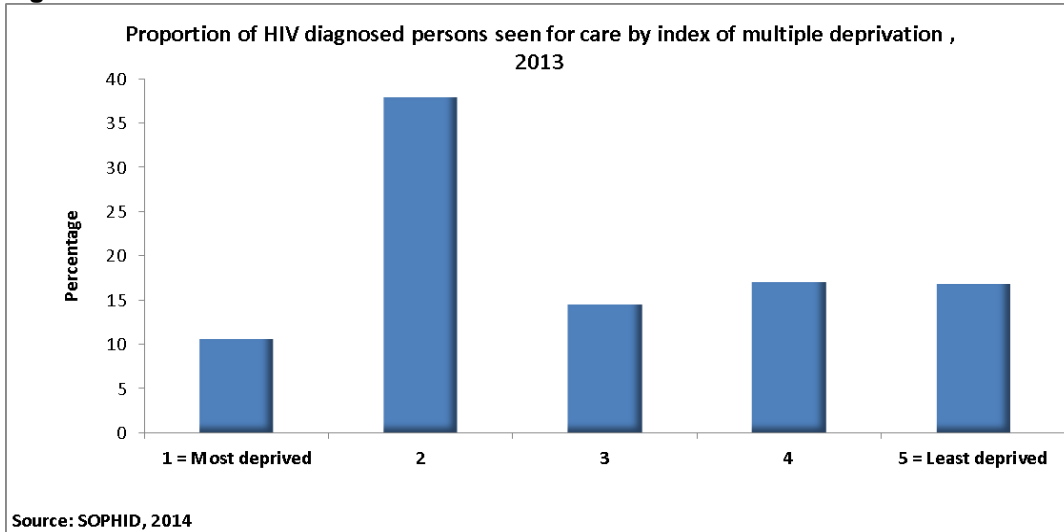


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Source: Local Authority Sexual Health Epidemiology Report (LASER) 2013

The pattern of HIV prevalence in Bromley is consistently not linked to deprivation. Prevalence in the 2nd most deprived quintile remains higher than any other quintile in the borough with the most deprived quintile having the lowest prevalence rate. Data since 2008 shows a higher proportion of residents accessing HIV care live in the 2nd most deprived areas of the borough.

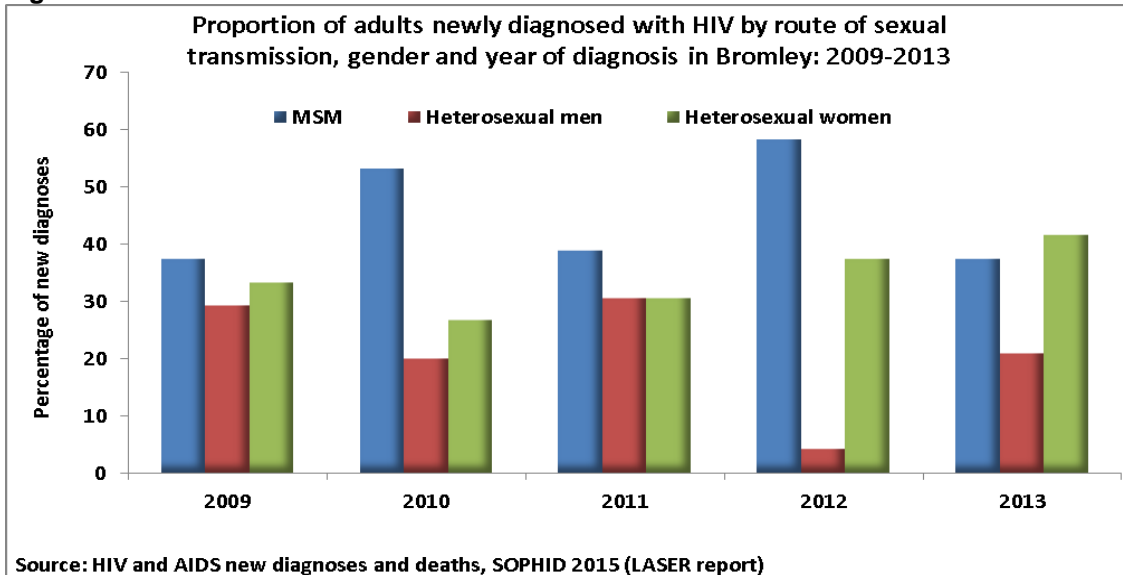
Figure 3. 47



New Diagnoses

In 2013, there were 25 new HIV diagnoses in Bromley (SOPHID). Heterosexual individuals form the largest group among those who acquired their HIV through sex. For the first time since 2009, there were more newly diagnosed heterosexual women than heterosexual men and MSM (**Figure 3.48**).

Figure 3. 48

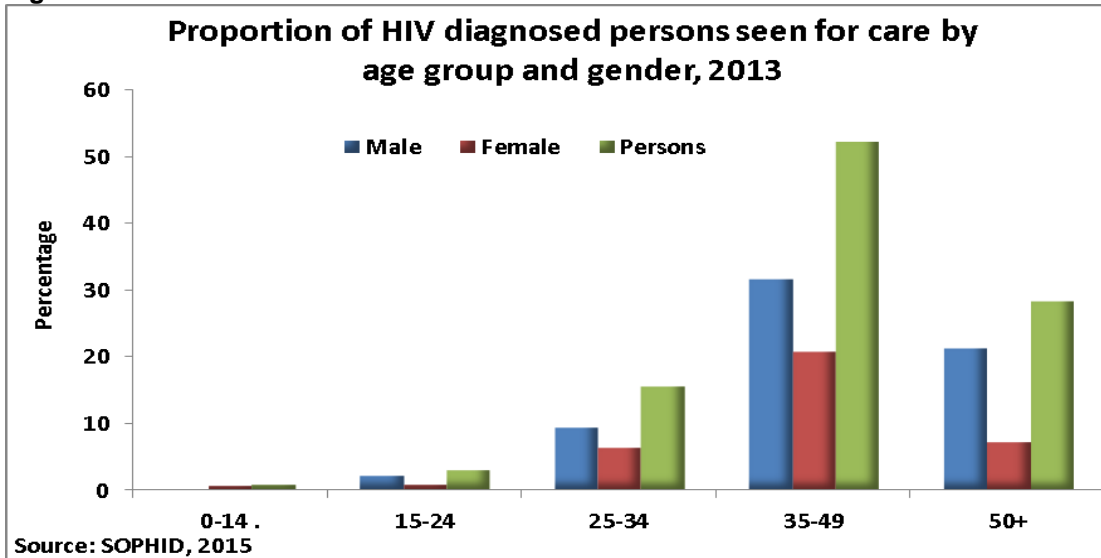


HIV Care

The percentage of HIV diagnosed persons seen for care by gender and age in Bromley remain the same. Men continue to be the majority (65%) and the biggest contribution to HIV diagnoses in Bromley is from people aged 35-49 years, followed by those aged 50 years and over (see **Figure 3.49** below).

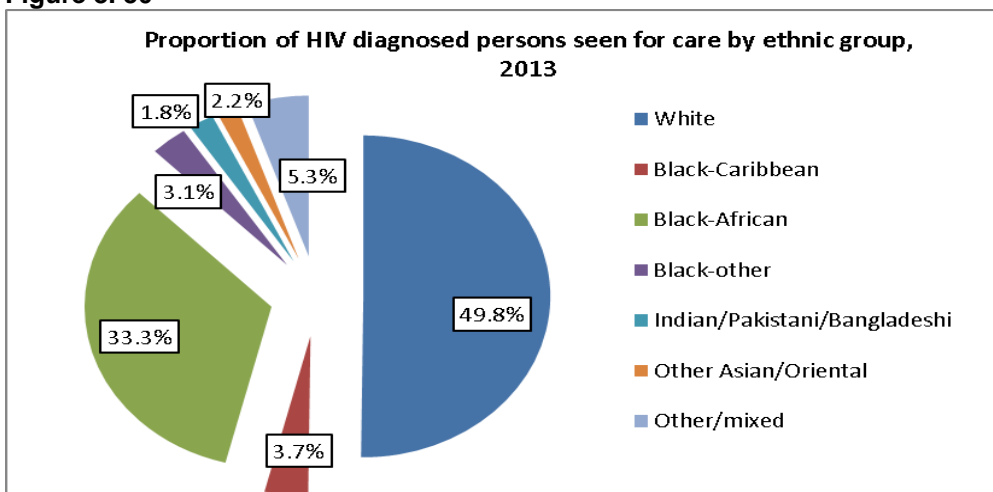
This is similar to the national trend which is attributed to continued transmission and improved survival. Both signal a need to develop services appropriate to changing sexual behaviour and increasingly an ageing population.

Figure 3. 49



Data analysis by ethnicity shows that two ethnic groups contribute the majority of known HIV infections diagnosed in Bromley - White (253) and Black African (169) as shown in **Figure 3.50**. HIV infection is most prevalent in White and Black African ethnic groups. This not only reflects the ethnic makeup of the population of Bromley but also routes of infection of HIV, with those whose probable route of infection was men who have sex with men (MSM) more likely to be White and those acquiring HIV through heterosexual contact more likely to be Black African. Analysis shows that 89% of the 253 infections in the White ethnic group were in males whilst in Black African ethnic group, 66% of the 169 infections were in females.

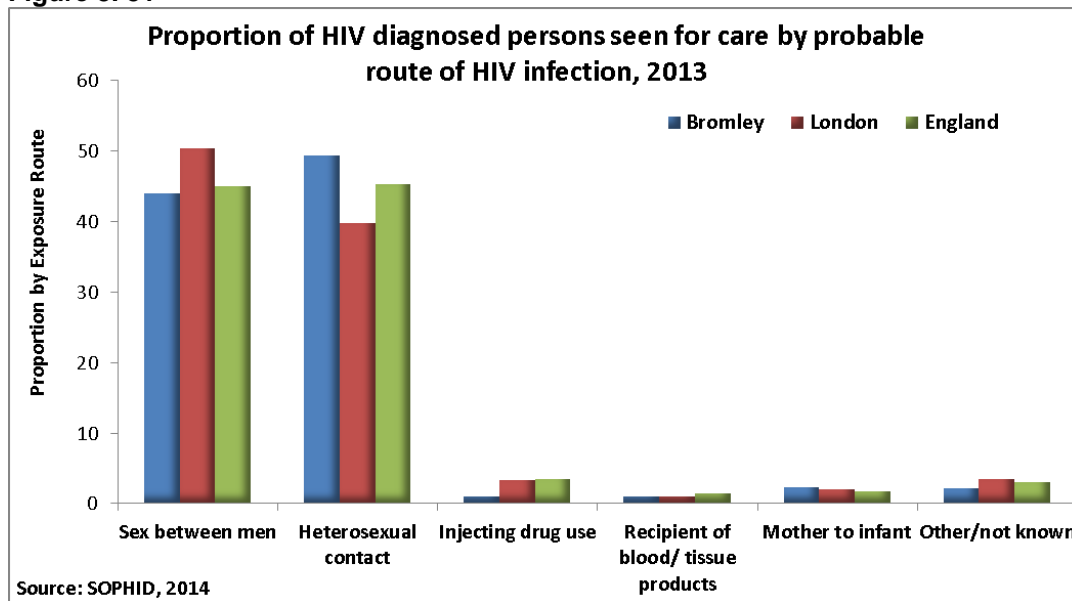
Figure 3. 50



HIV Transmission Routes

In Bromley, the most common probable routes of HIV transmission remain heterosexual intercourse and men who have sex with men (MSM). Heterosexual contact accounts for the largest proportion (251, 49%) of residents diagnosed with HIV who are accessing care. This is higher than London and England at 40% and 45% respectively. MSM account for a significant proportion (44%, 224) of HIV diagnoses in Bromley, lower than London (50%) but similar to England (45%) as shown in **Figure 3.51** below.

Figure 3. 51

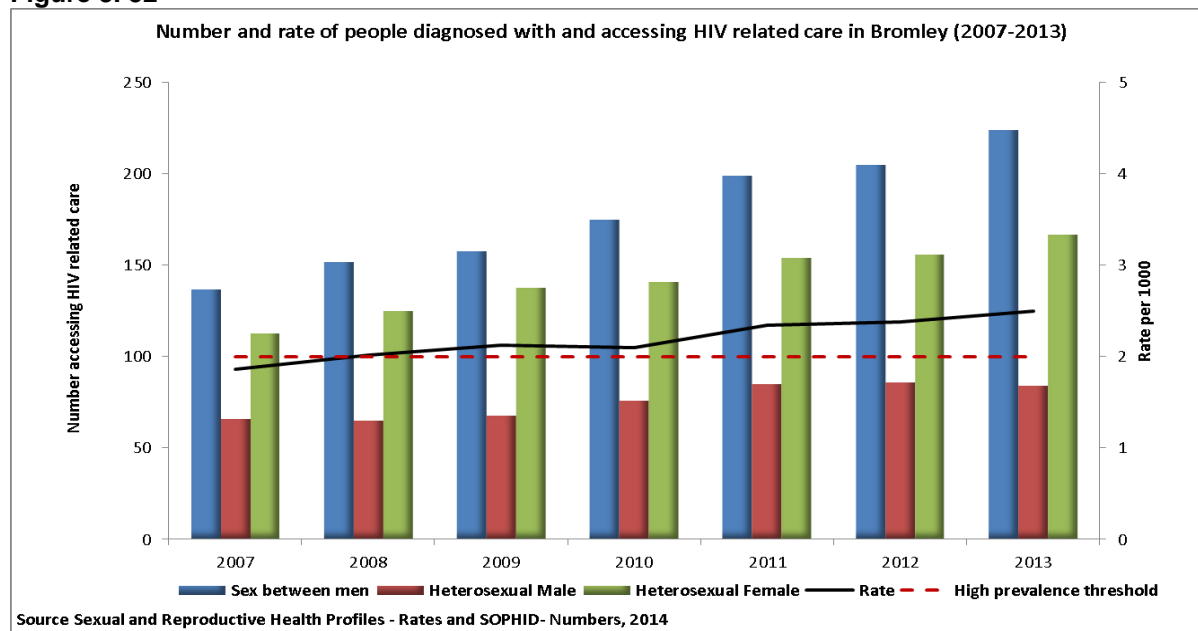


HIV transmission from mother to child makes up only a small proportion (2.4%) of all transmissions in Bromley but it remains the third highest route of transmission and the rate is higher in Bromley than London and England. It is important therefore to improve HIV infection awareness and early diagnosis and encourage early antenatal booking for all women, but especially amongst Black African women in areas where prevalence is high.

The rate and number of people diagnosed with and accessing HIV related care in Bromley is rising year on year, especially in men who have sex with men and heterosexual females (**Figure 3.52**). The upward trend is likely to be due to a combination of factors- increased testing, improved recording and increasing incidence. Whereas heterosexual men, the highest proportion of whom are Black Africans, remain a concern as most probably they are unaware of their HIV status and continue to carry the risk of onward transmission.

This highlights the importance of targeting efforts on raising HIV infection awareness, early diagnosis and early access to HIV care in MSM and heterosexuals especially Black Africans.

Figure 3. 52



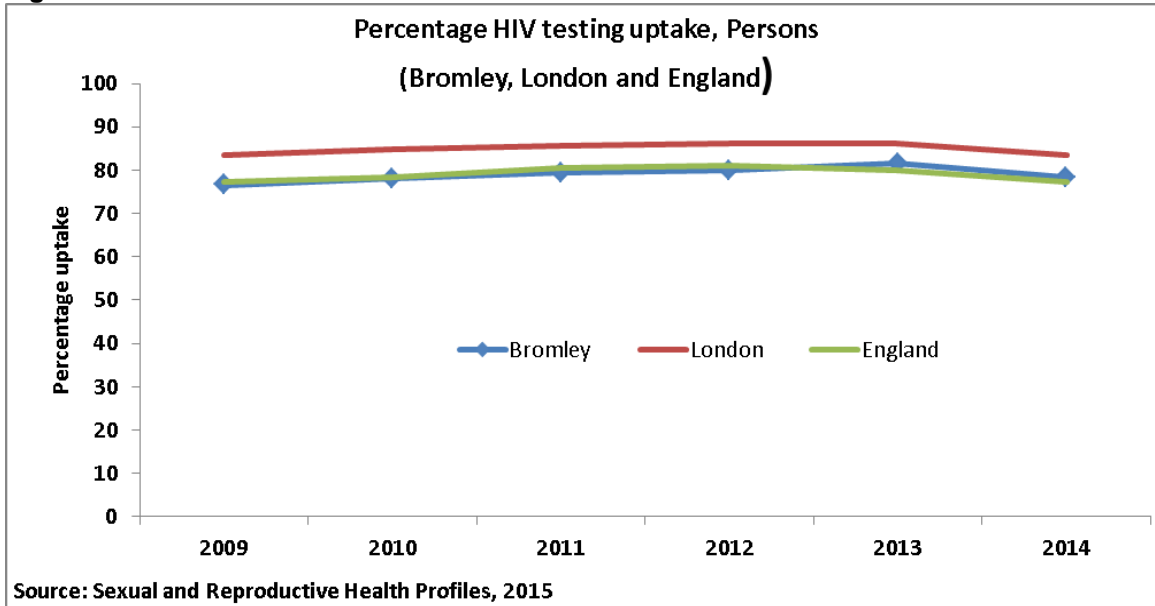
HIV late diagnoses

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. This is important as people living with diagnosed HIV can expect a near-normal life expectancy, provided they are diagnosed early in the course of their infection. Late presenters (those diagnosed with a CD4 <350 – below the threshold at which treatment should have begun) carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed promptly. Remaining undiagnosed also carries a greater risk of onward transmission.

In Bromley, between 2011 and 2013, 44% (95% CI 34-55) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 45% (95% CI 44-46) in England. 32% (95% CI 18-50) of men who have sex with men (MSM) and 53% (95% CI 38-68) of heterosexuals were diagnosed late.

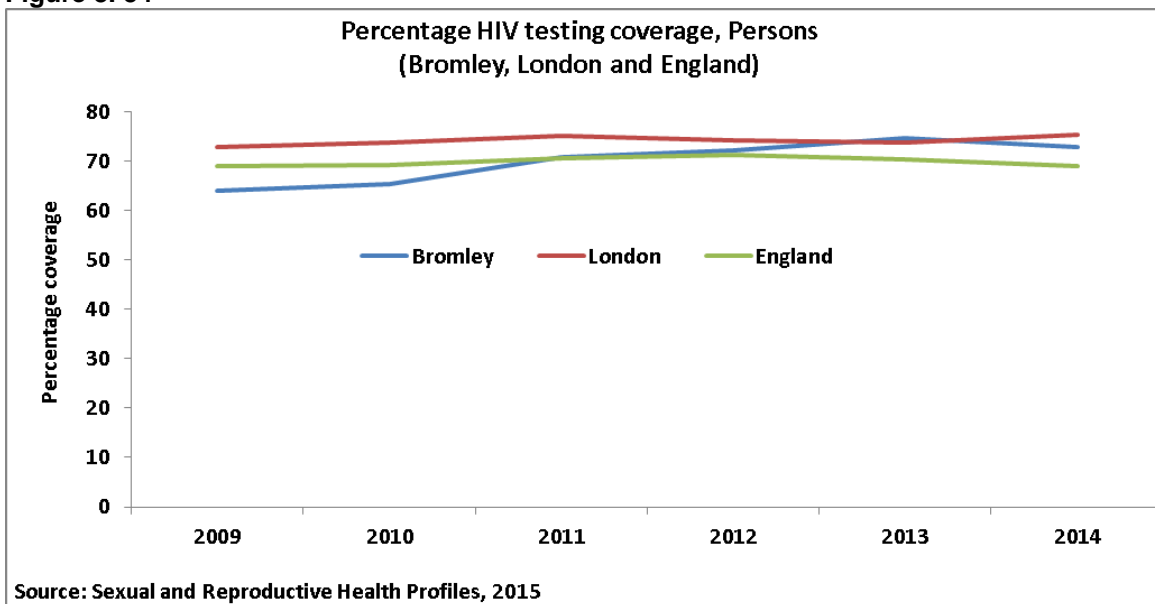
Monitoring HIV late diagnoses is essential to evaluate the success of expanded HIV testing. When comparing Bromley data on uptake and coverage of HIV testing at GUM clinics between 2009 and 2014, both uptake and coverage rates of HIV testing are slightly above England but below London.

Figure 3. 53



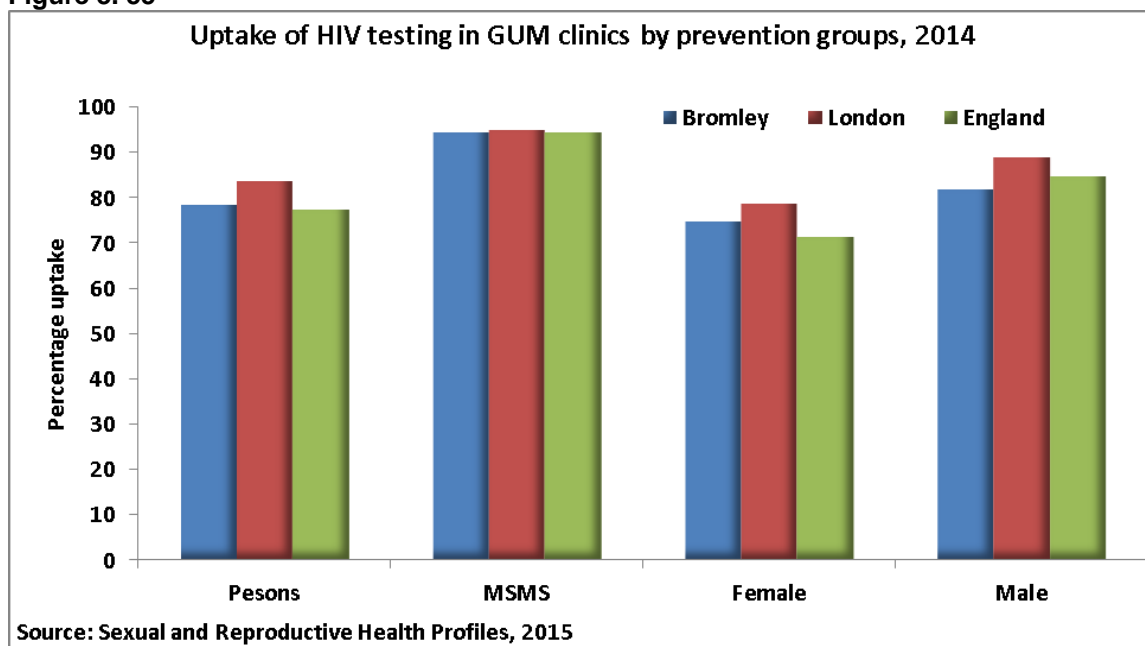
Note: Multiple episodes of HIV test offer and uptake are included per individual within a year.

Figure 3. 54



The 2014 data on uptake rates of HIV testing in prevention groups (MSM, women and men) indicate that MSM is similar to England and London rates but heterosexual men are below England and London rates with women slightly above national, but below London levels.

Figure 3. 55



Uptake is the number of eligible new GUM episodes where a HIV test was accepted as a percentage of those where a HIV test was offered. Multiple episodes of HIV test and offer are included per individual within a year.

Given that Bromley has a higher rate for the late and very late diagnosis of HIV infections than the London average, HIV testing was expanded in primary and community settings since 2013 as a proven way of tackling late diagnosis and onward transmission of this infection.

An audit of HIV testing in primary care between 2013/14 to 2014/15 found that:

- While more HIV tests were requested by and performed in primary care in these two years, there was a 4.24% drop in the number of tests actually being performed in 2014/15 compared to 2013/14.
- Tests requested were mostly for those that fall between the ages of 17-44 years and yet the audit data indicates that the 45-54 year age group had the highest HIV prevalence of 35.2% in Bromley between 2013/14 and 2014/15.
- Of those HIV positives diagnosed by GPs between the two year periods, significant numbers were coded as Black African Females and White British males but further analysis on MSM risk group was not possible as sexual orientation is not routinely collected.

What does this mean for Bromley residents?

Although the HIV prevalence rate in Bromley is steadily rising, it remains at just above the 2 per 1000 threshold. However there are areas in Bromley where the prevalence rate has risen from 6 per 1000 population to over 8 per 1000 population similar to high prevalence boroughs in London.

Those diagnosed with HIV, are mostly in the older age groups of 34 – 44 years followed by the 45-54 year age group.

Heterosexual residents are the highest group diagnosed with HIV but there are more Black African women diagnosed than Black African men. The numbers of MSM cases are gradually increasing year by year.

Given the HIV population profile and the rate of late diagnosis, focus should continue on improving;

- HIV infection awareness,
- early diagnosis and
- early access to HIV care,

particularly in the most common routes of transmission (MSM and Black African men and women) and the older age group.

More work is therefore required to understand the sexual health behaviour and explore the range of targeted services and innovative solutions to reach the above groups.

Teenage pregnancy

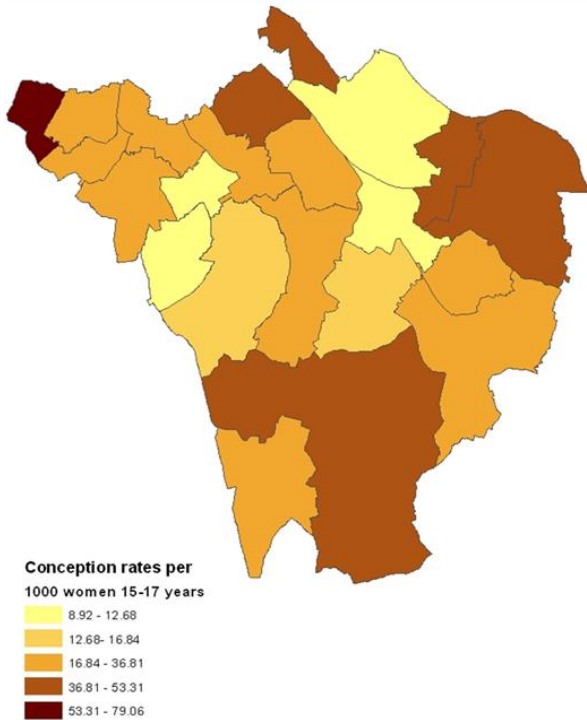
Teenage Pregnancy continues to be associated with adverse health and social outcomes for children, young parents and families.

- Poor educational attainment
- Poor physical and emotional health
- Poor social and economic outcomes

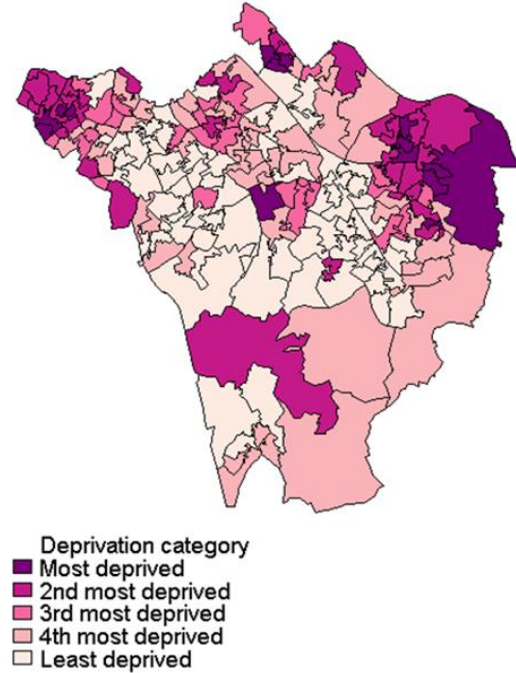
The picture of teenage pregnancy in Bromley is directly linked to deprivation as shown in **Figure 3.56**. While the rate per 1000 appears high in Darwin ward, the absolute number is small in a large rural area. Hence this distorts the actual low level of teenage pregnancy in the area.

Figure 3. 56

Teenage conception rates in Bromley, 2009-11



Distribution of deprivation by LSOA



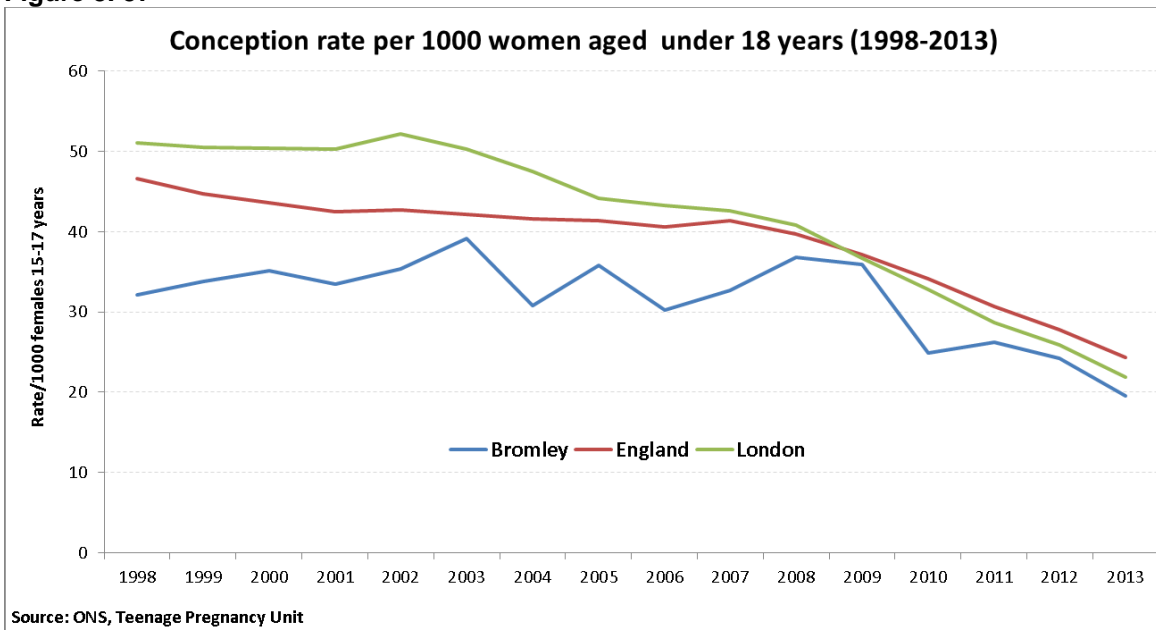
Deprivation quintiles generated from Index of Multiple Deprivation (IMD) scores 2010
Rates based on the 2011 ONS population estimates

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In 2013, the total number of conceptions in young people under the age of 18 years continued to fall from 137 in the preceding year to 108. This represents a rate of 19.5 per 1,000 Bromley population compared to the national rate of 24.3. Significantly it is the lowest in Bromley since 1998. The declining trend suggests that Bromley may have sustained a continual drop in teenage pregnancy.

Figure 3. 57

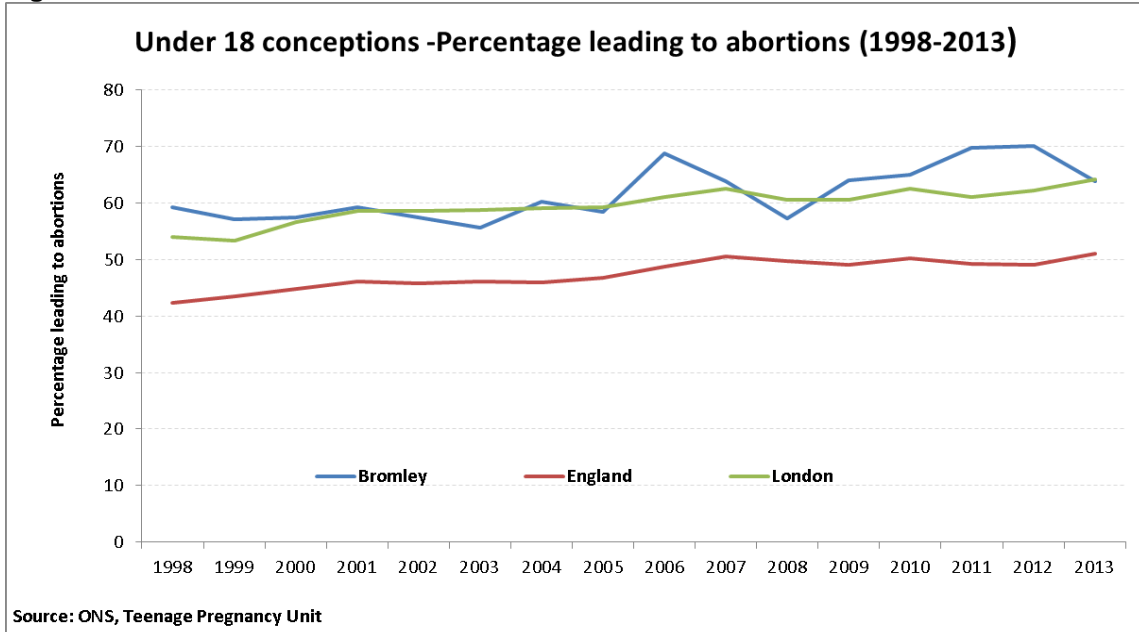
Conception rate per 1000 women aged under 18 years (1998-2013)



Source: ONS, Teenage Pregnancy Unit

Teenage conceptions that lead to abortions in Bromley have dropped to 63.9% in 2013 from 70% in 2012. This proportion remains above the national rate but it is more in line with other London Boroughs this year. (Figure 3.58)

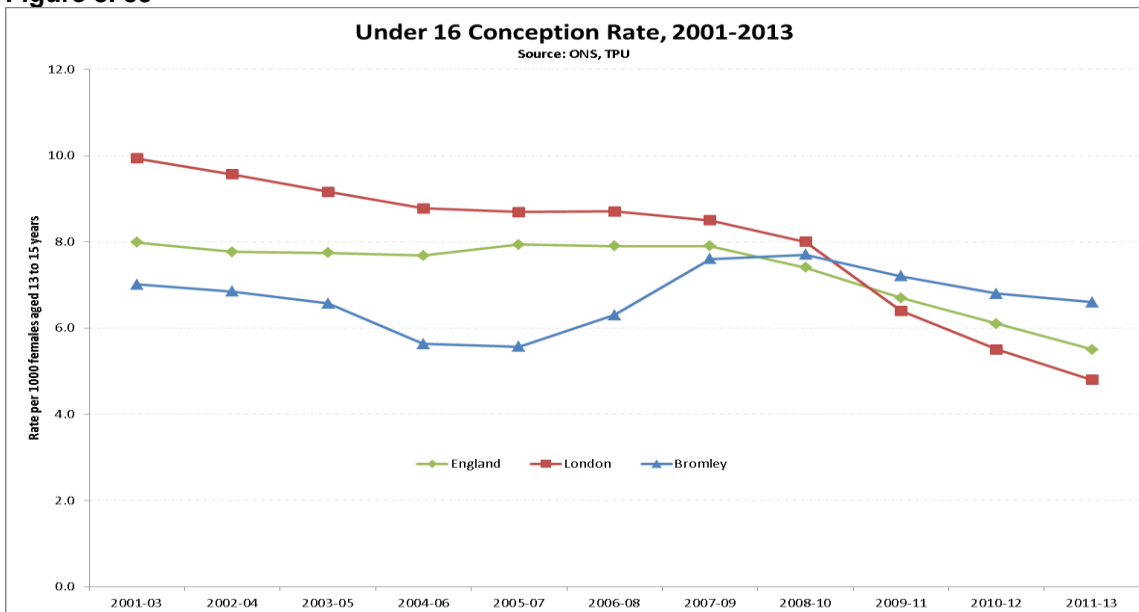
Figure 3. 58



Under 16s Conceptions

27% of the total teenage pregnancies in Bromley are under the age of 16 years. This conception rate was 36/1000 in 2012 and the rate is now down to 30/1000 2013 but still remains above regional and national figures. The proportional drop in Bromley figures this year is greater than that seen nationally. (see figure 3.59)

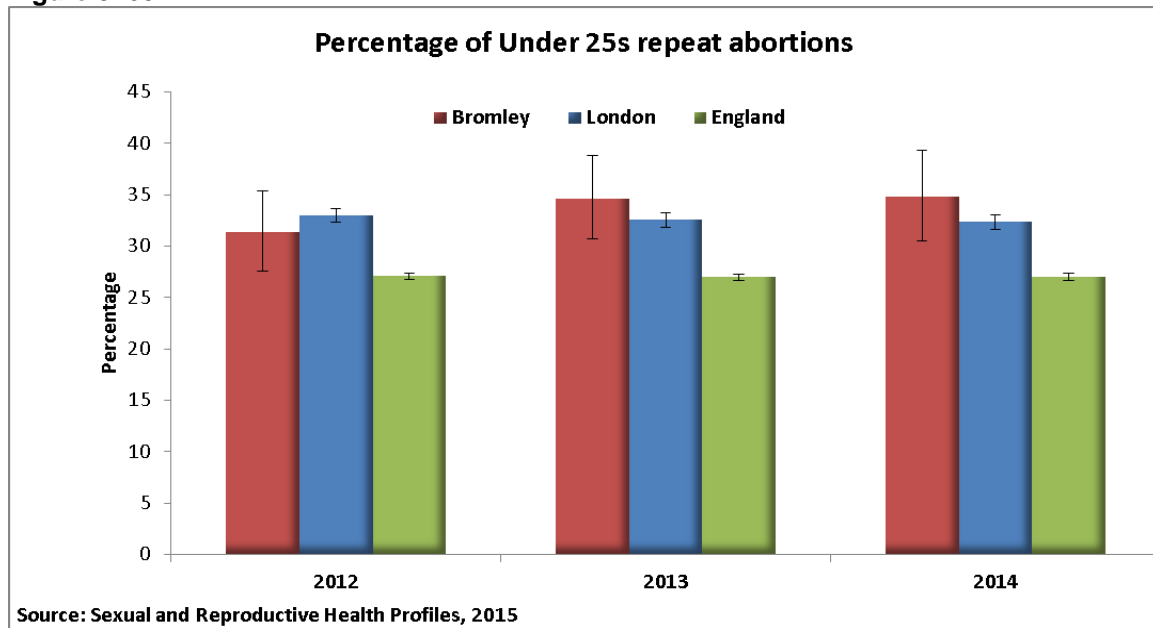
Figure 3. 59



Under 25 year Repeat Abortions

Although repeat abortion figures in Bromley remain higher in young people above the age of 18 years and under 25 years, [compared with those under 18 figures] rates are similar to those of other London Boroughs but higher than England as demonstrated (figure.3.60)

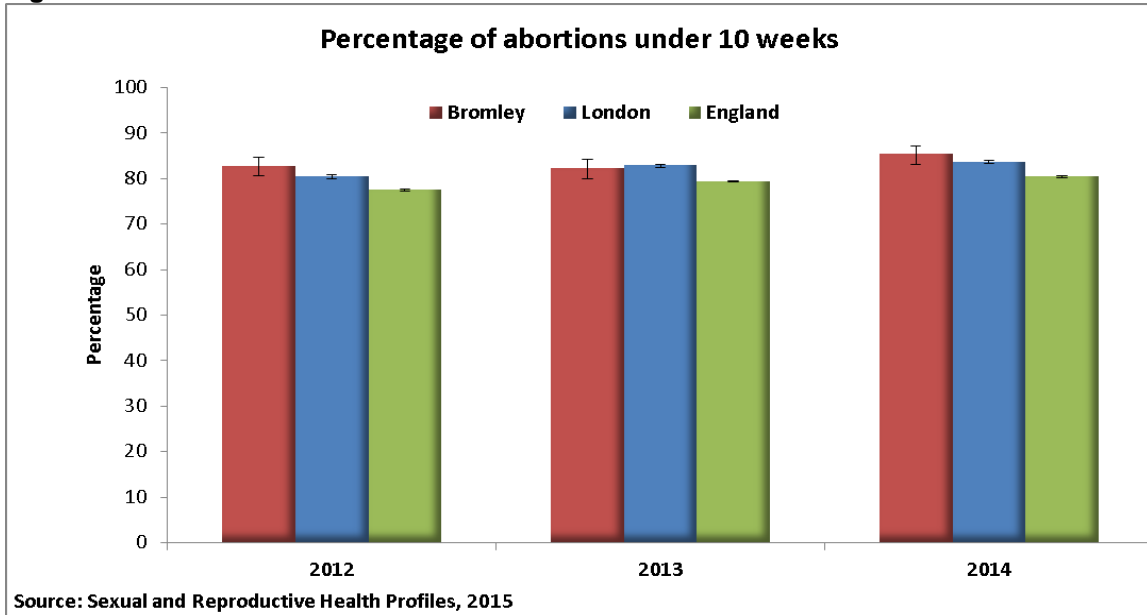
Figure 3. 60



Terminations of Pregnancy below 10 Weeks

Bromley continues to achieve a higher than London or England proportion of these terminations taking place at under 10 weeks gestation, therefore minimising complications and costs from those that take place surgically or at a later gestational date.

Figure 3. 61

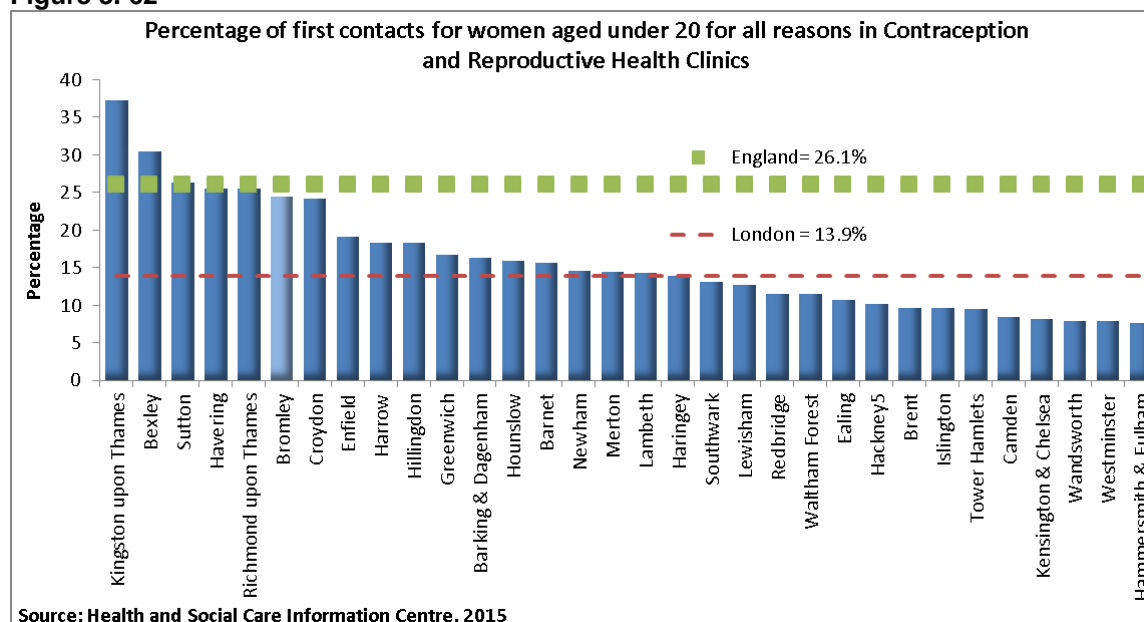


Contraception use in Bromley

In 2013/14, there were 6,700 first contacts with Bromley women attending contraception and reproductive health clinics (C&RH). Of these, 79% (5,300) attended for contraception related reasons. The remaining 1,400 attended for activities such as those associated with health education and complex contraception consultations.

Of the 6,700 first time contacts in contraception and reproductive health clinics, half of them were at the peak of their reproductive years (20-34 years). Women aged below 20 years and those aged 35 years and over contacted the service in similar proportions 25% and 26% respectively.

Figure 3. 62



Source: *KT31&SHRAD return, HSCIC, 2015*

Contraception and Reproductive Health Clinics use by women aged below 20 years is similar to the England average at 24.5% but significantly higher than the London average (**Figure 3.62** above). London boroughs with the highest contacts have population indicators similar to Bromley.

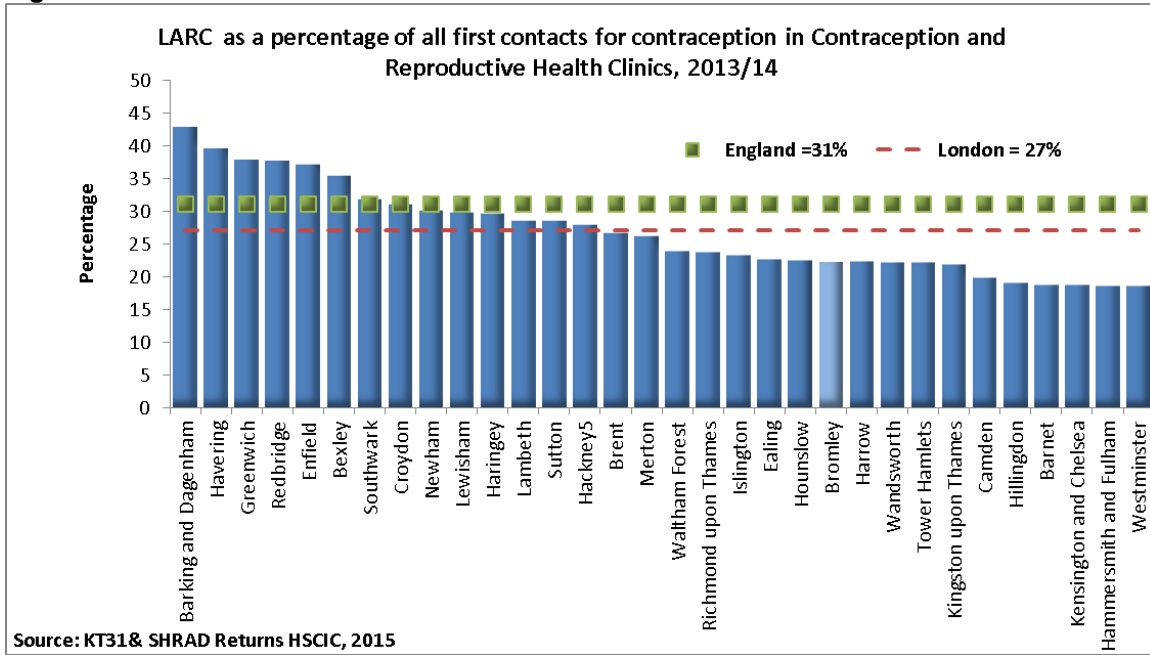
Of the 5,300 contacts with C&RH clinics for contraception reasons, the majority (76%) preferred user dependent methods such as pills and condoms etc. 2 women out of every 9 preferred long acting reversible contraception [LARC] as shown in **Table 3. 21** below. LARC use in Bromley women is below the London and England average and Bromley ranks 11th in the worst performing boroughs in London (**Figure 3.63**).

Table 3. 21: Percentage of first contacts for contraception reasons by contraception method

	LARC	User Dependent methods	Other Methods	No method provided/non-contraception reasons
England	31	67	2.4	23
London	27	69	4	28
Bromley	22	76	1.3	21

Source: *KT31&SHRAD return, HSCIC, 2015*

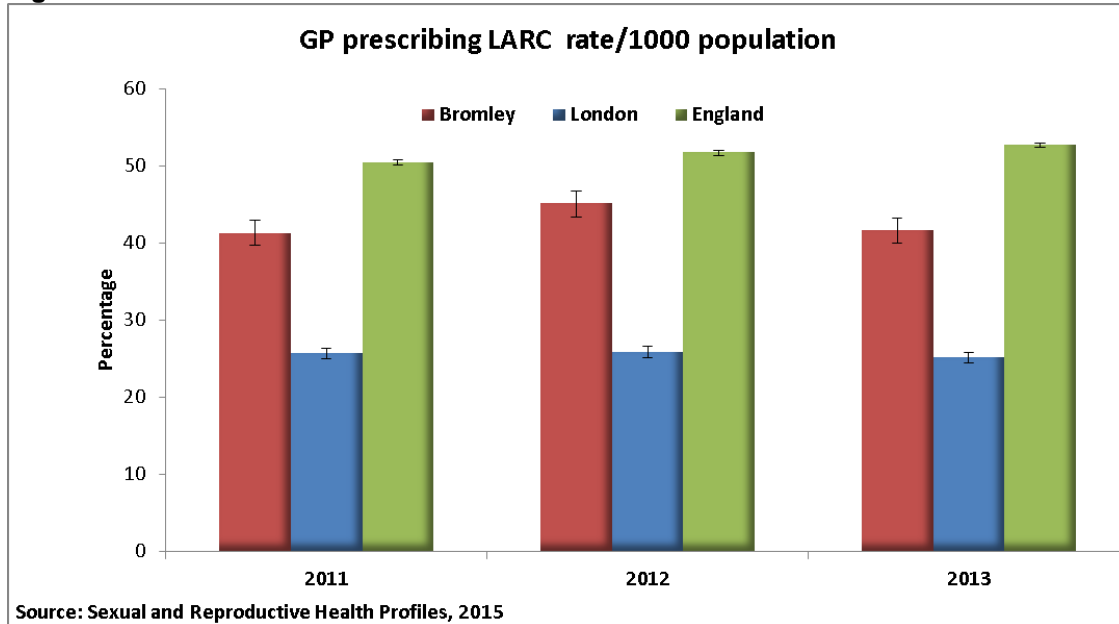
Figure 3. 63



LARC in General Practice

LARC methods [Long Acting Reversible Contraception] such as contraceptive injections, implants and inter-uterine systems [IUS] are more effective methods of contraception as they do not depend on daily actions by individuals and tend to be cost effective compared to other methods if used for over a year.

In 2013, Bromley ranked 265 out of 326 local authorities in England for GP prescribed LARC methods (1st being the highest) with a rate of 41.6 per 1,000 women aged 15 – 44 years compared to 52.7 in England. In response, the Service Level Agreement with 33 local GP practices has been strengthened to increase the provision of this service as well as being available in Local Contraception Clinics. However, an audit which compares the rate of LARC (implant) insertions and removals suggests that further work is needed to understand the high removal rate.

Figure 3. 64

Cervical Cancer

Cervical cancer is one of the few cancers that is preventable. Nearly all cases of cervical cancer have been linked to particular strains of the sexually transmitted human papillomavirus (HPV) infection. Women who smoke are more likely to get cervical cancer than those who don't.

Cervical cancer can take many years to fully develop. This indicator is a measure of the degree to which a combination of HPV vaccination in teenagers, cervical cancer screening and treatment of cell abnormalities have been effective.

The rate of cervical cancer registration in Bromley is (6.8 per 100,000) lower than London and England at 7.9 per 100,000 and 9.2 per 100,000 population respectively.

Human Papilloma Virus vaccination consisting of three injections over 12 months is given to 12-13 year old girls, largely through secondary schools. Research has shown that the HPV vaccine provides effective protection for at least 20 years which should cover the irregularity of the HPV incubation period.

In Bromley, 86.8% of year eight girls were vaccinated in 2013/14 by their 12th -13th birthday, a rate higher than London at 80% and comparable to that of England at 86.7%.

What does this mean for Bromley residents and for children in Bromley?

Teenage conception rates are continuing to fall in Bromley as well as the proportion that result in abortion. Although these figures show Bromley is demonstrably better than the London average this year and the decrease is greater, it is still not as good as England overall.

The latest data indicates that the provision of preventative methods - condoms, LARC methods and SRE programmes has begun to make an impact on avoiding unwanted pregnancies. To sustain the continual fall in teenage conceptions and unwanted pregnancies, further work and evaluation is necessary especially on the planned programme of SRE in schools targeting those in areas of need.

As repeat TOPs remain relatively high in Bromley compared to England, with falling levels of LARC uptake, emphasis should focus on increasing the uptake of LARC methods, especially the percentage of all first contacts for contraception in all settings. At the same time, further work is required to improve the ratio between insertion and removal rates.

BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2015

Table 3. 22: Sexual Health Related PHOF Indicators, 2015

Indicator	Time Period	Sex	Bromley	London	England
2.04 - Under 18 conceptions	1998	Female	32.1	51.1	46.6
2.04 - Under 18 conceptions	1999	Female	33.8	50.5	44.8
2.04 - Under 18 conceptions	2000	Female	35.1	50.4	43.6
2.04 - Under 18 conceptions	2001	Female	33.5	50.3	42.5
2.04 - Under 18 conceptions	2002	Female	35.4	52.1	42.8
2.04 - Under 18 conceptions	2003	Female	39.2	50.3	42.1
2.04 - Under 18 conceptions	2004	Female	30.9	47.5	41.6
2.04 - Under 18 conceptions	2005	Female	35.8	44.2	41.4
2.04 - Under 18 conceptions	2006	Female	30.2	43.3	40.6
2.04 - Under 18 conceptions	2007	Female	32.7	42.6	41.4
2.04 - Under 18 conceptions	2008	Female	36.8	40.8	39.7
2.04 - Under 18 conceptions	2009	Female	36.0	36.7	37.1
2.04 - Under 18 conceptions	2010	Female	24.9	32.8	34.2
2.04 - Under 18 conceptions	2011	Female	26.3	28.7	30.7
2.04 - Under 18 conceptions	2012	Female	24.2	25.9	27.7
2.04 - Under 18 conceptions	2013	Female	19.5	21.8	24.3
2.04 - Under 18 conceptions: conceptions in those aged under 16	2009	Female	7.7	7.2	7.3
2.04 - Under 18 conceptions: conceptions in those aged under 16	2010	Female	6.3	6.4	6.7
2.04 - Under 18 conceptions: conceptions in those aged under 16	2011	Female	7.7	5.7	6.1
2.04 - Under 18 conceptions: conceptions in those aged under 16	2012	Female	6.5	4.4	5.6
2.04 - Under 18 conceptions: conceptions in those aged under 16	2013	Female	5.5	4.3	4.8
3.02 - Chlamydia detection rate (15-24 year olds)	2012	Persons	1313.8	2214.6	2074.4
3.02 - Chlamydia detection rate (15-24 year olds)	2013	Persons	1749.7	2213.1	2071.6
3.02 - Chlamydia detection rate (15-24 year olds)	2014	Persons	1583.5	2177.9	2012.0
3.02 - Chlamydia detection rate (15-24 year olds)	2012	Male	992.2	1580.7	1439.9
3.02 - Chlamydia detection rate (15-24 year olds)	2013	Male	1298.0	1568.6	1424.0
3.02 - Chlamydia detection rate (15-24 year olds)	2014	Male	995.3	1532.7	1355.3
3.02 - Chlamydia detection rate (15-24 year olds)	2012	Female	1621.3	2790.8	2688.9
3.02 - Chlamydia detection rate (15-24 year olds)	2013	Female	2168.2	2792.0	2717.0
3.02 - Chlamydia detection rate (15-24 year olds)	2014	Female	2156.5	2756.5	2664.2
3.04 - People presenting with HIV at a late stage of infection	2009 - 11	Persons	40.2	46.7	49.8
3.04 - People presenting with HIV at a late stage of infection	2010 - 12	Persons	45.7	44.6	47.9
3.04 - People presenting with HIV at a late stage of infection	2011 - 13	Persons	44.3	40.5	45.0

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

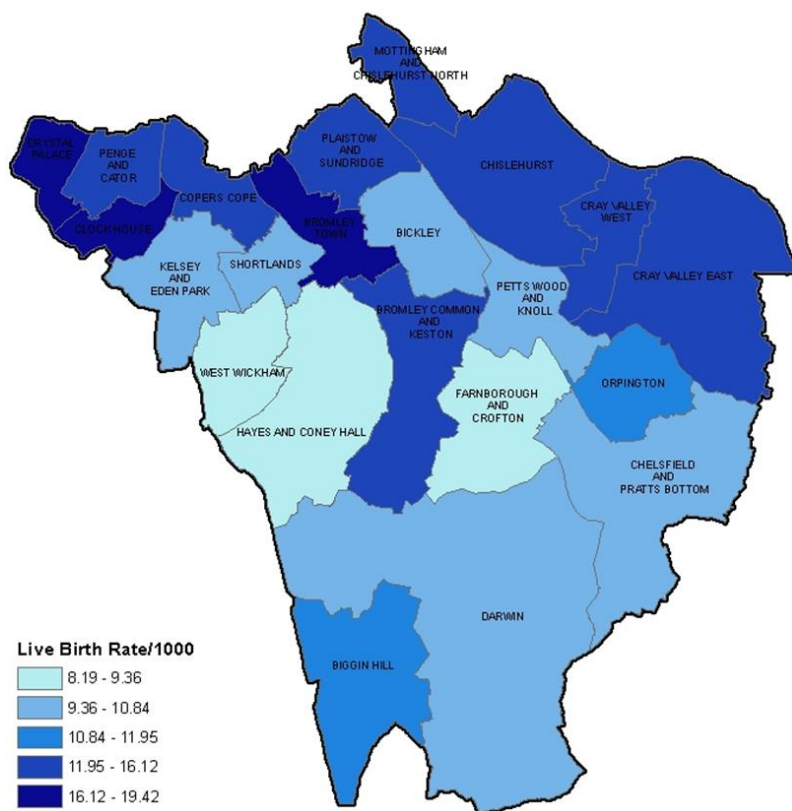
For more information please contact Mimi.Morris-Cotterill@Bromley.gov.uk

Pregnancy and Maternity

The live birth rate in Bromley is 12.3 per 1000 total population. This is lower than the London rate (15.2 per 1000), but the same as the England rate (12.3 per 1000). The live birth rate in Bromley has been rising since 2002, with the highest rates in Crystal Palace, Bromley Town and Clock House wards as shown in **Figure 3.65**. The number of births in Bromley has risen from 3500 in 2002, to over 3899 in 2013.

Figure 3. 65

Birth rate: Live births per 1000 total Population, 2014
Source: ONS Birth Files



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Figure 3. 66

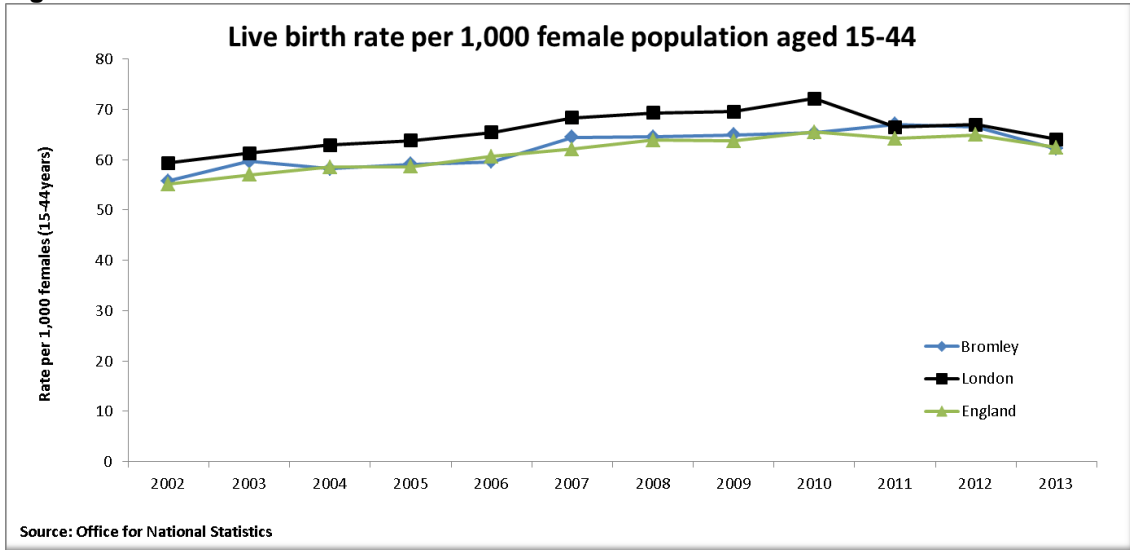
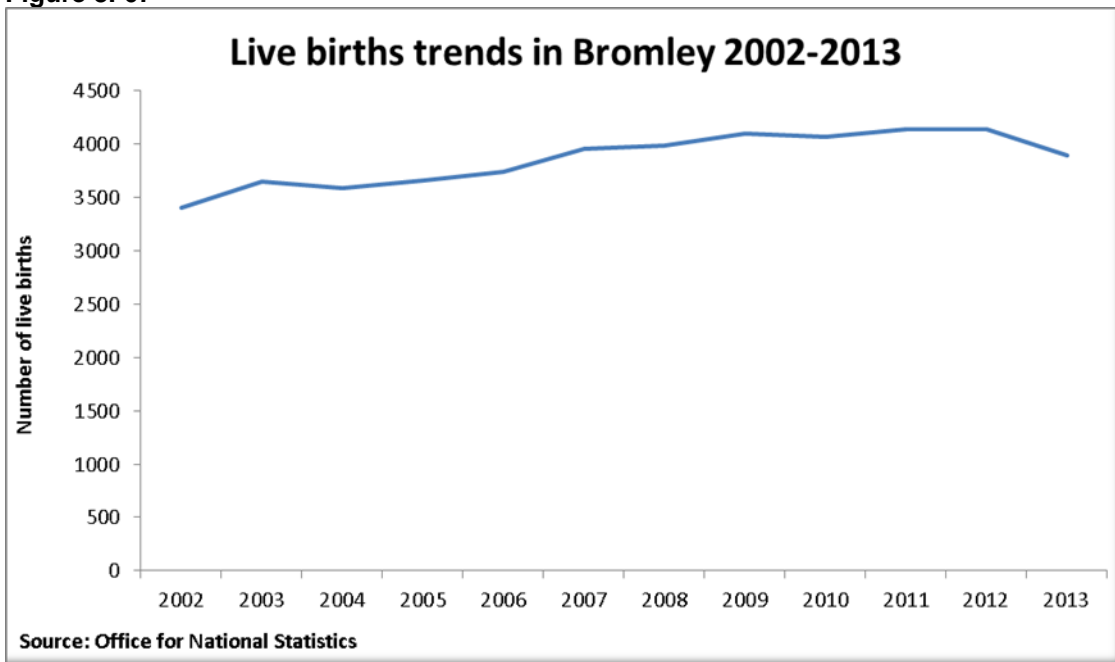


Figure 3. 67



The proportion of births in older mothers (aged 35 to 39 years) in Bromley is higher than that for London and for England. In 2013, 80% of births were to mothers in Bromley aged 25 to 39 years the same as for London (80%) but higher than the 75% across England (**Figure 3.68**).

Age specific birth rates confirm the increased birth rates particularly in the 30 to 34 year age group in Bromley (**Figure 3.69**). It is important, therefore, that reproductive healthcare services (contraception, termination and maternity care) address the need associated with this trend towards older motherhood.

Figure 3. 68

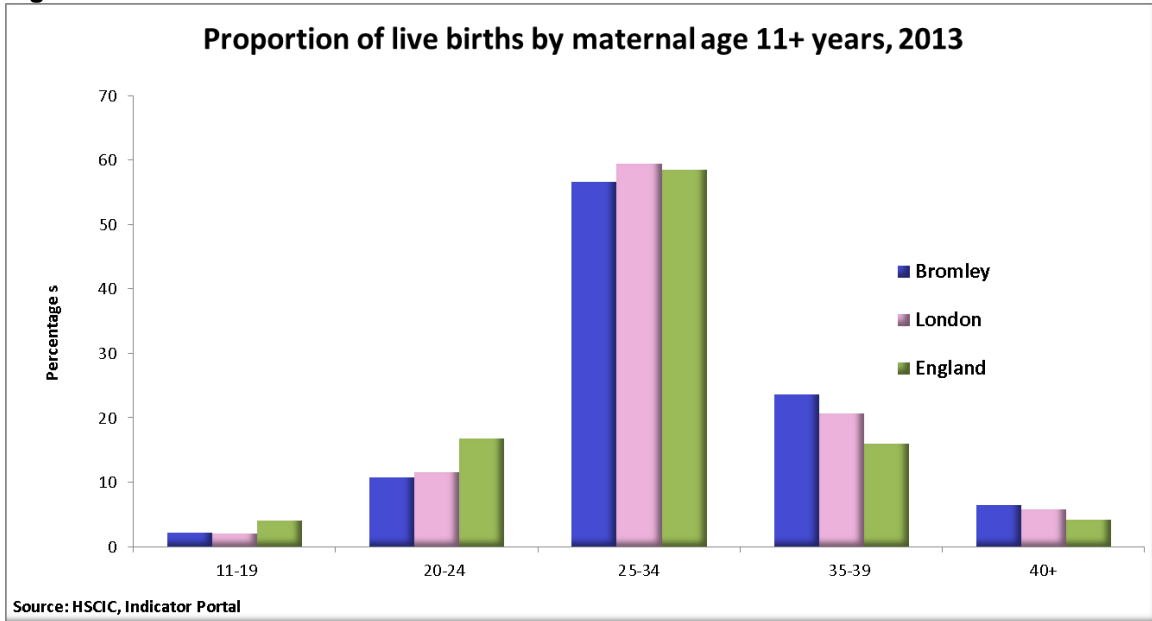
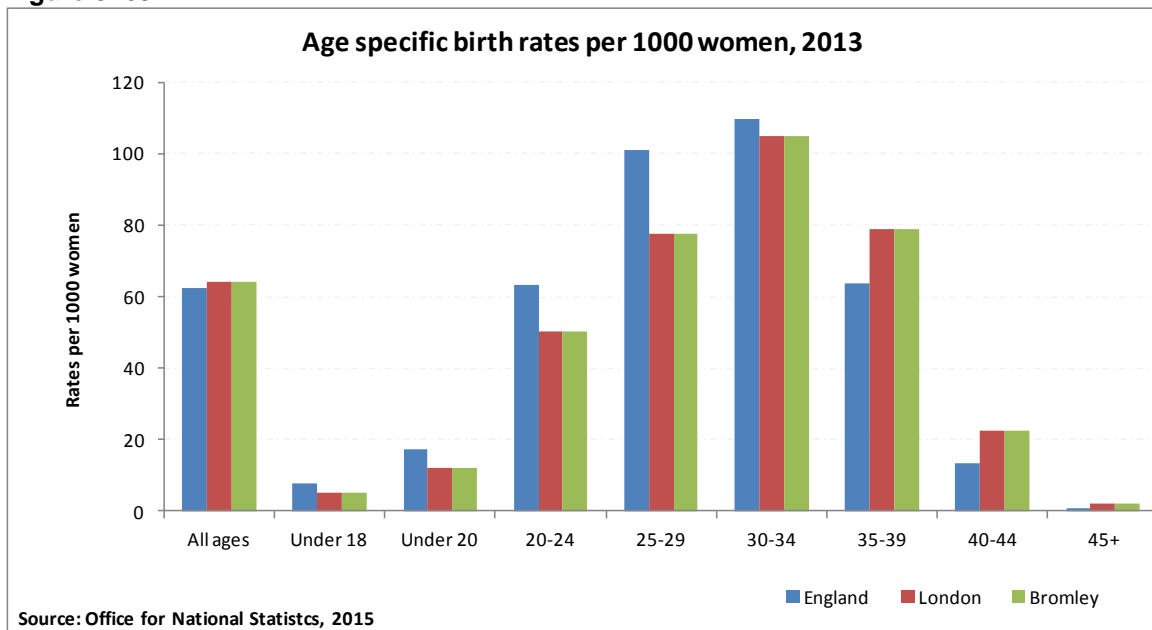
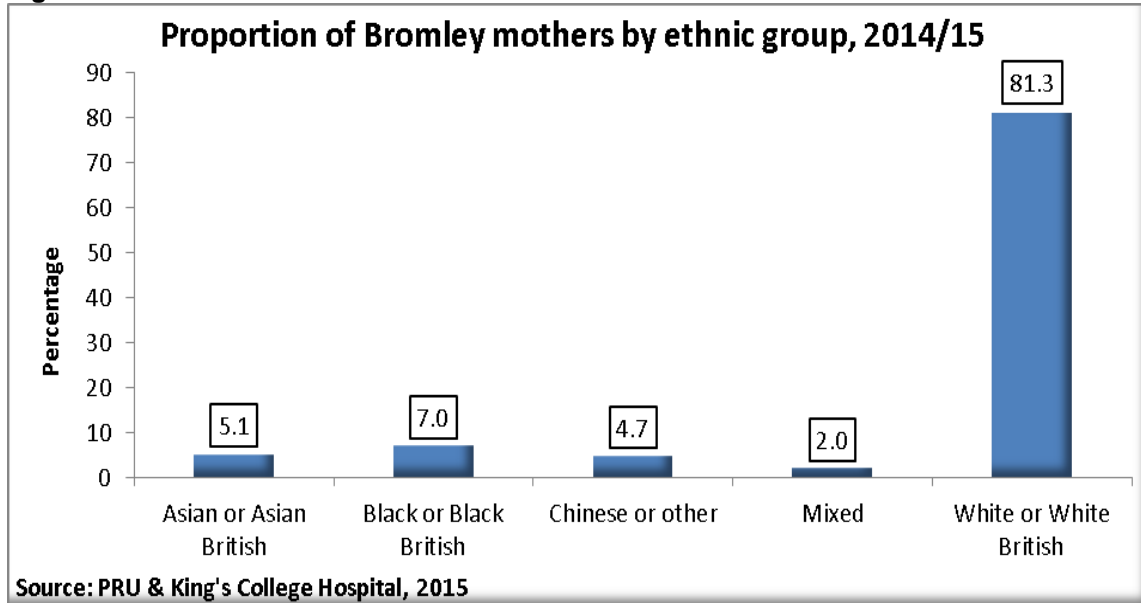


Figure 3. 69



Local data from the Princess Royal University Hospital (PRUH) and King’s College Hospital (KCH) gives more detail for the 85% of Bromley resident mothers who received care at these sites in 2014/15

This data shows that of the 66% of women whose ethnicity was recorded, the majority were White, reflecting the ethnic make-up of the borough.

Figure 3. 70

Early booking to antenatal care, that is a woman booking with a midwife before 13 weeks (12 weeks plus 6 days) gestation, is essential to make certain that women have the best support to ensure early risk assessments, accurate assessment of gestation, uptake of folic acid and Vitamin D, and where unable to continue with a pregnancy, the opportunity for early termination.

The national antenatal screening policy recommends that screening be done in early pregnancy to look for abnormalities in the unborn child and to identify any maternal health problem.

- 8-10 weeks for Sickle cell & Thalassaemia
- 11-14 weeks for Down's syndrome.

The national initiative to improve early antenatal access sets a 12 weeks and 6 days target for at least 90% of pregnant women and 10 weeks of pregnancy for at least 50% women to have had a full health and social risk assessment.

According to local data, 78% of Bromley women booked for antenatal care before 13 weeks of pregnancy in 2014/15 which is below the 90% national target. However, this is an improvement on the 58.9% achievement in 2013/14 (**Figure 3.71**). There is therefore a need to improve access to early antenatal booking in Bromley.

Figure 3. 71

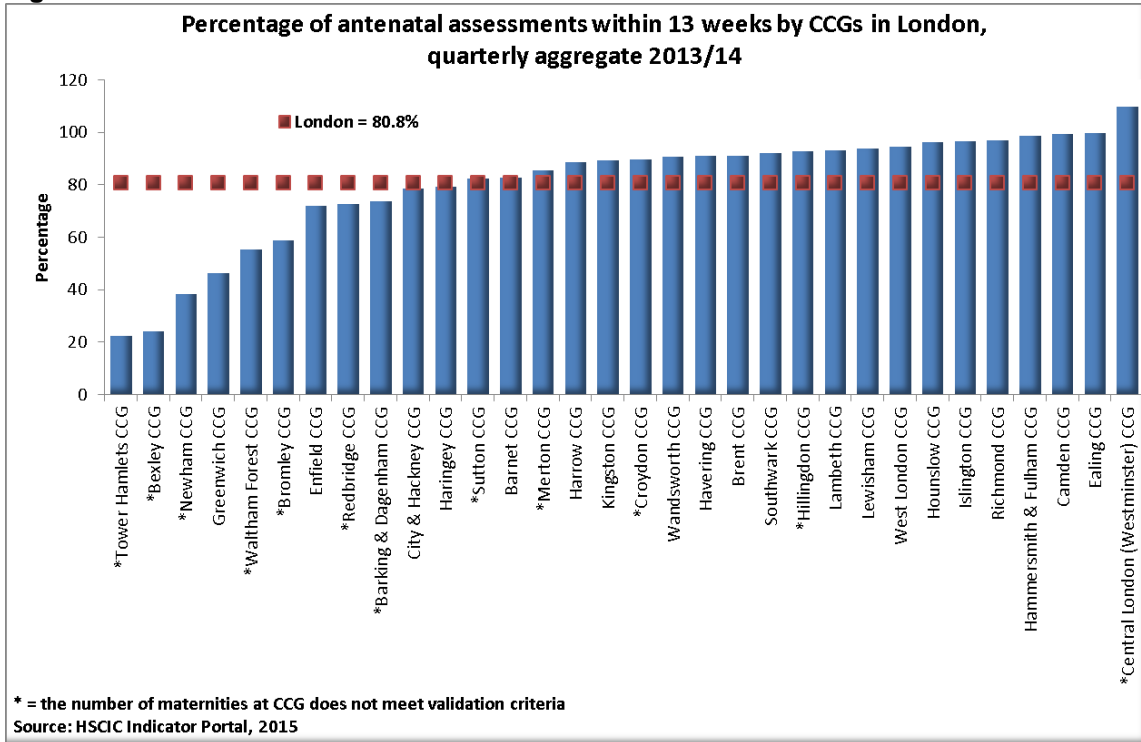
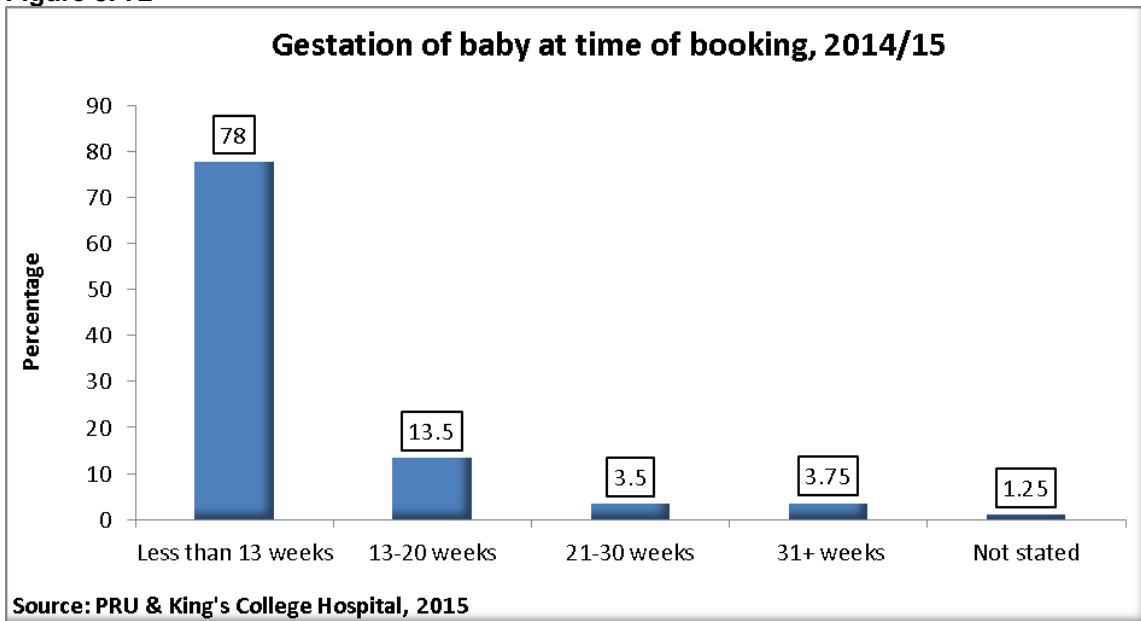
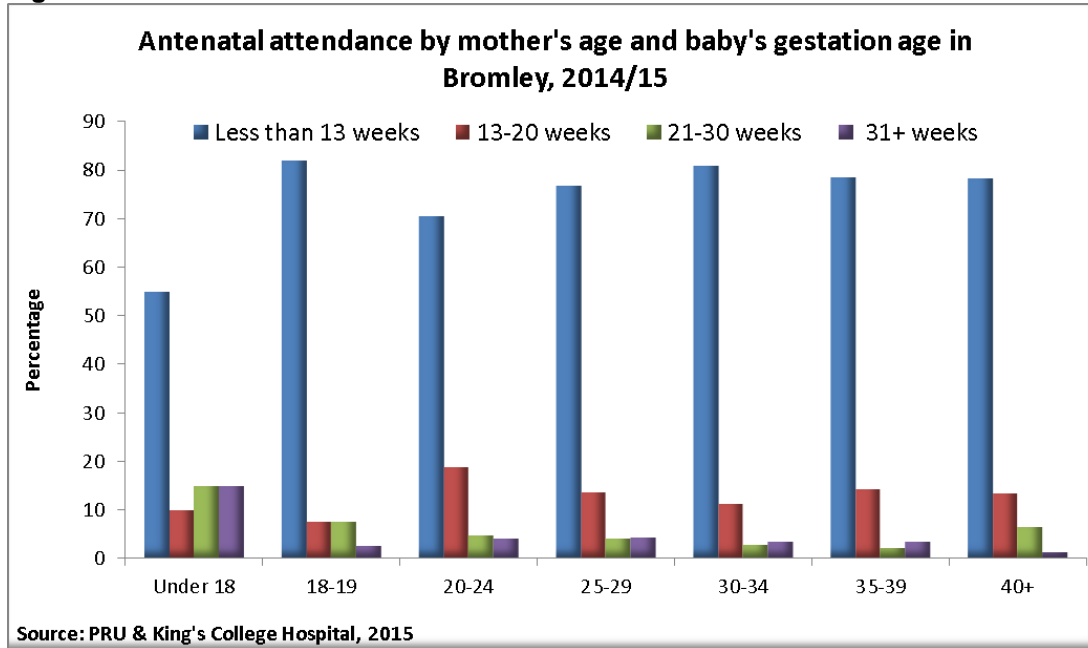


Figure 3. 72



The age of the mother seems to influence the time of booking. More than half of mothers aged under 18 years booked for antenatal care later than 13 weeks gestation in 2014/15 in Bromley. It should however, be noted that mothers under the age of 20 years account for only a small proportion of all pregnancies. Over three quarters of women aged 25 years and above booked before their 13th week gestational age (Figure 3.73).

Figure 3.73

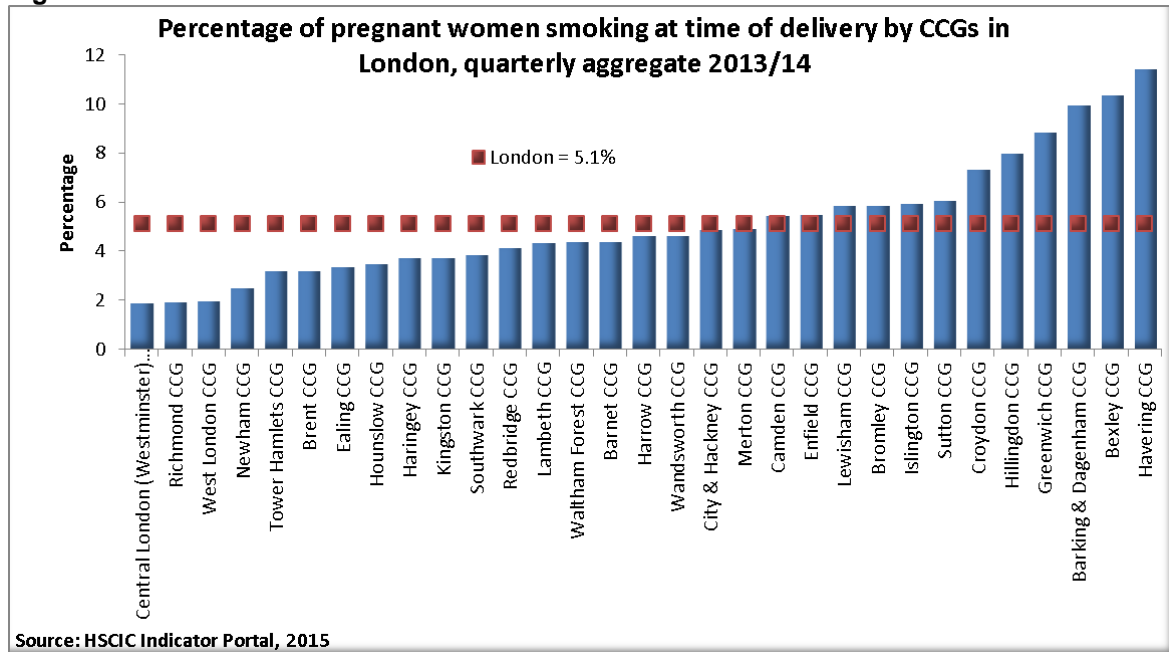
Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. Smokers can have an increased risk of negative pregnancy outcomes including miscarriage, preterm birth, low birth weight and stillbirth. It has been linked to sudden infant death syndrome, childhood respiratory illness and behavioural problems. Infants and children of parents who smoke are twice as likely to suffer from a serious respiratory infection and asthma as the children of non-smokers.

Supporting pregnant women to stop smoking may help them to quit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

It is worth noting that statistics on women who smoke during their pregnancy rely on self-reporting and can be subject to some under reporting. National statistics highlight maternal smoking is associated with various factors including age and socio-economic position.

National benchmarking data shows smoking rates at time of delivery in Bromley (5.9%) are above London (5.1%) average. Although the proportions are low, work is needed to further drive down the rates in line with national trends which are also decreasing (**Figure 3.74**).

Figure 3. 74

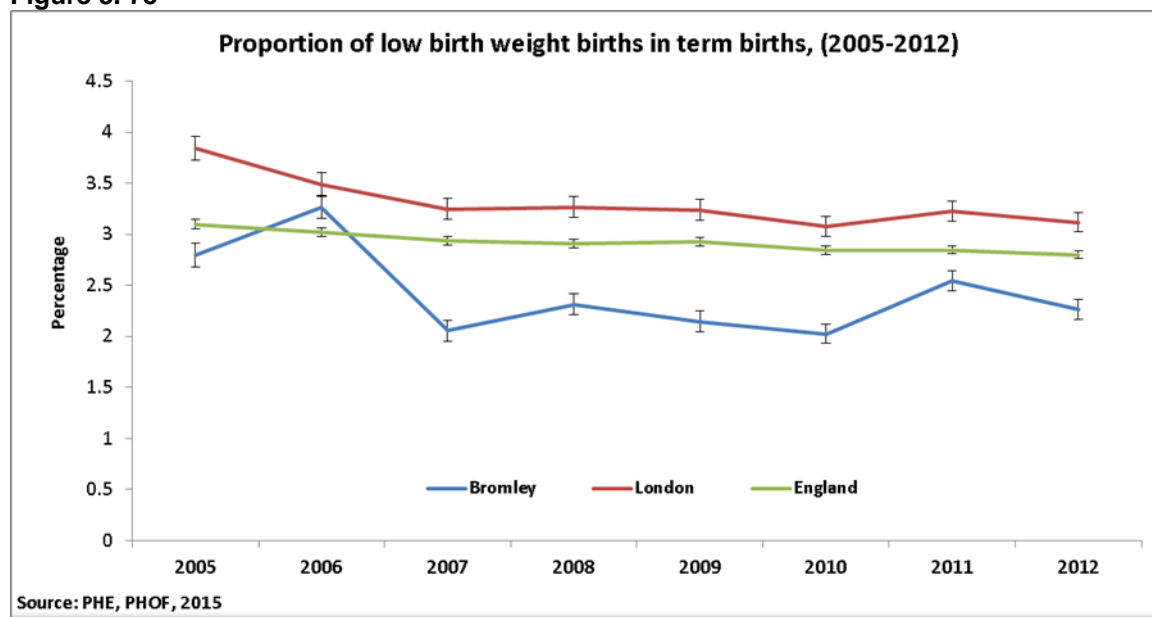


Children born with reduced birth weights, both premature and full-term, tend to have more health problems than those with normal birth weights. The effects can include respiratory, neurological and psychological problems. There are also risks of various diseases in adulthood including the development of non-communicable diseases, such as diabetes and heart disease.

The Public Health Outcomes Framework indicator measures low birth weight in term babies which is live births with a recorded birth weight under 2500g of term babies (babies born after 37 weeks).

About 90 full term babies were born weighing less than 2,500 grams in Bromley in 2012. The rates, (2.26%) although affected by random variation due to small numbers, are consistently significantly lower than both London (3.12%) and England (2.8%) (**Figure 3.75**).

Analysis of local data shows that 12.6% of babies are classified as large for gestational age (LGA) at more than 4,000grams. LGA babies are also at great risk of perinatal morbidity and mortality. One of the risk factors for LGA is poorly controlled diabetes particularly gestational diabetes, pre-existing diabetes mellitus and excessive weight gain in pregnancy.

Figure 3.75

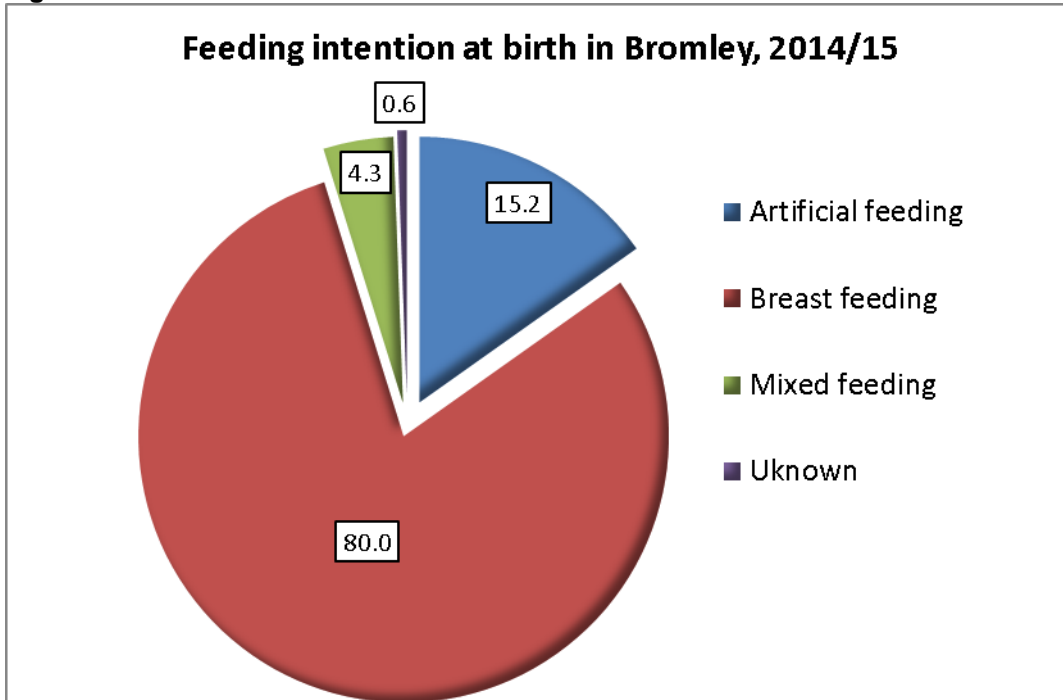
Breastfeeding is recognised as promoting health and preventing ill health in the short and long-term for both baby and mother.

For baby these include protection against gastroenteritis, respiratory infection, otitis media (inflammation of the ear), urinary tract infections and diabetes mellitus. Studies looking at the long term benefits of breastfeeding for infants suggest lower blood pressure and protection against obesity in childhood (and into adulthood).

For the mother, there is a level of protection against pre-menopausal breast, ovarian and endometrial cancers. Breastfeeding can lay the foundations of a close bond between the mother and her child in the early years of life, offering hours of closeness and nurturing every day.

According to local data, over 80% of women intended to breastfeed at birth in Bromley, either exclusively or with supplement in 2014/15 (**Figure 3.76**).

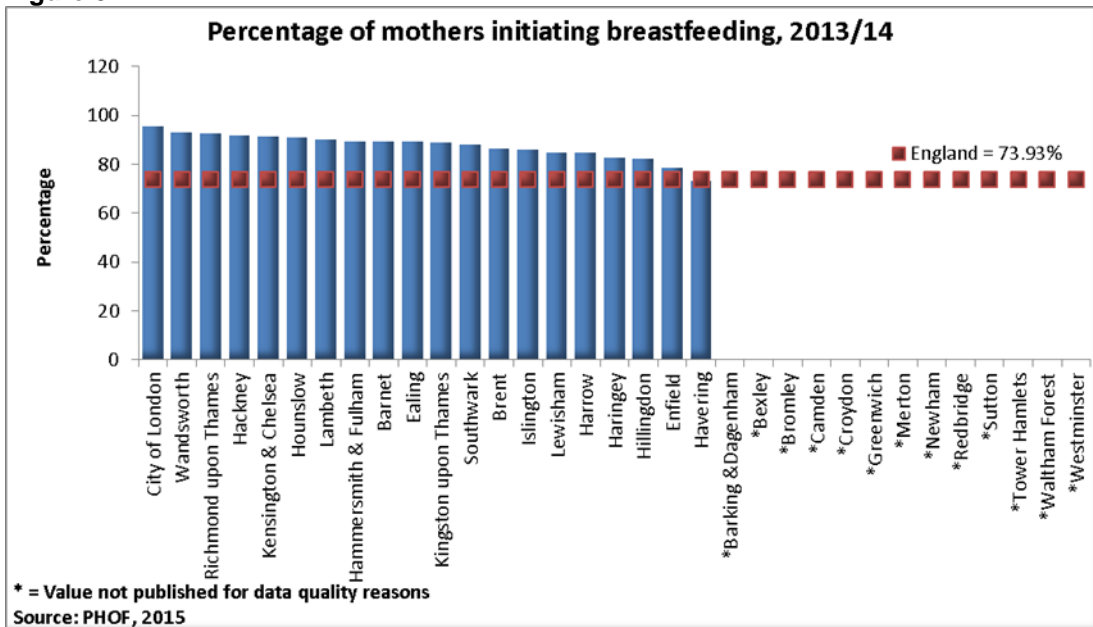
Figure 3.76



Source: Princes Royal University Hospital, 2015

Unfortunately, data on the percentage of mothers who actually do start breastfeeding and those who sustain it for at least 6-8 weeks in Bromley is not of sufficient quality to be reliable. (Figure 3.77).

Figure 3.77



Terminations of Pregnancy

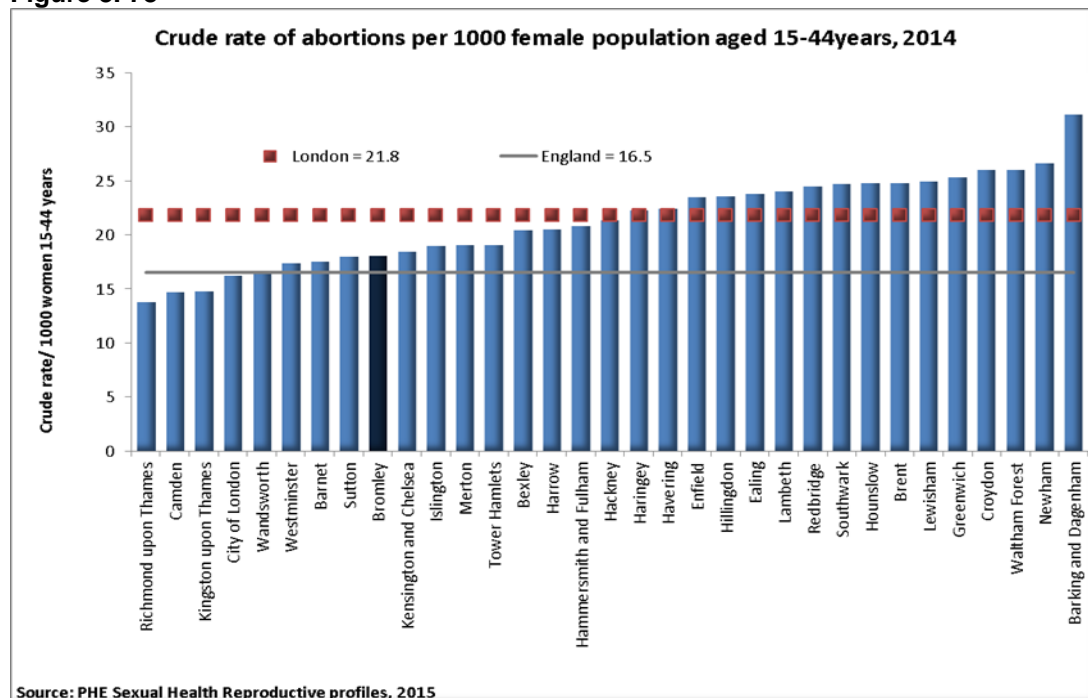
In the UK it is legal for terminations to be carried out up to 24 weeks of pregnancy. Marie Stopes International (MSI) and British Pregnancy Advice Service (BPAS) perform terminations of pregnancy up to 24 weeks whilst most NHS hospitals perform terminations of pregnancy up to 15 weeks. Termination under 10 weeks gestation has been associated with safer health outcomes for the woman.

All abortions are notified to the Chief Medical Officer and this data is used to compare rates regionally and nationally, but in order to understand abortions in Bromley, local data from the independent providers of abortion services, BPAS and MSI have been used. This data should be treated with caution; it is only indicative and does not include services to Bromley residents provided by NHS Hospitals.

According to national figures, in 2014 there were 1,136 terminations performed on Bromley residents. The termination rate in Bromley in 2014 was 18.12 per 1,000 women aged 15-44 which was higher than the national rate (16.5 per 1000 population), but lower than London (21.81 per 1000 population).

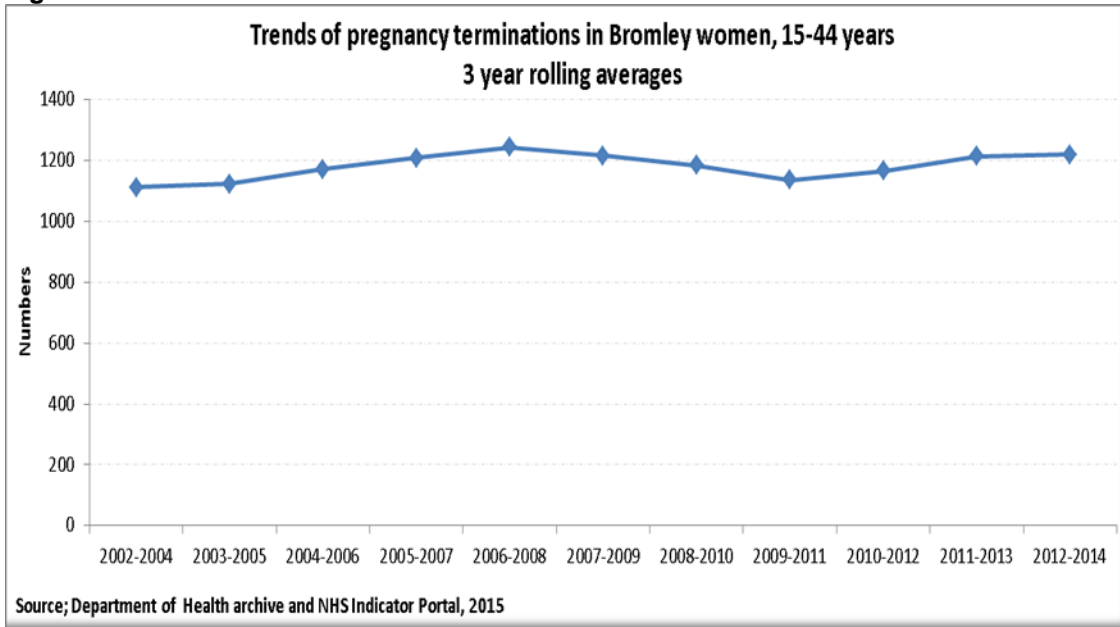
The rising age of motherhood means that women are less likely to have children at the peak of their fertile years, leading to a greater need to control their fertility through contraception and abortion. This is evidenced by higher numbers of older mothers in Bromley. Late age of motherhood is also associated with an increased risk of fetal anomaly which increases the proportion of women facing the decision of terminating their pregnancy. These two factors make a significant contribution to the Bromley pregnancy termination rate.

Figure 3. 78



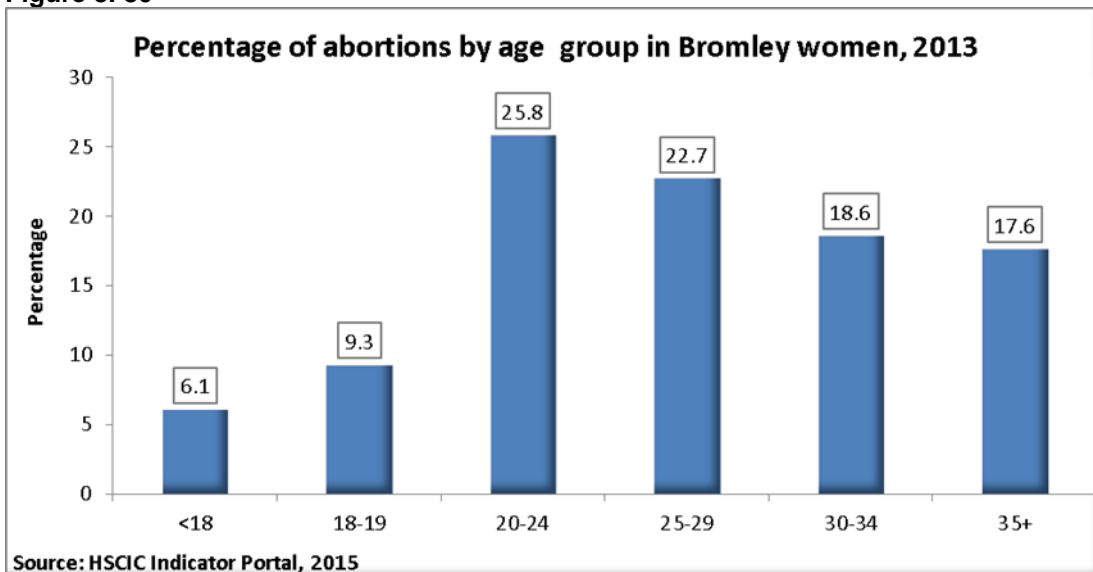
Generally abortions have become more widely available and less stigmatised. Three year rolling averages show the trends of abortions in women aged 15-44 years are stable over the years.

Figure 3. 79



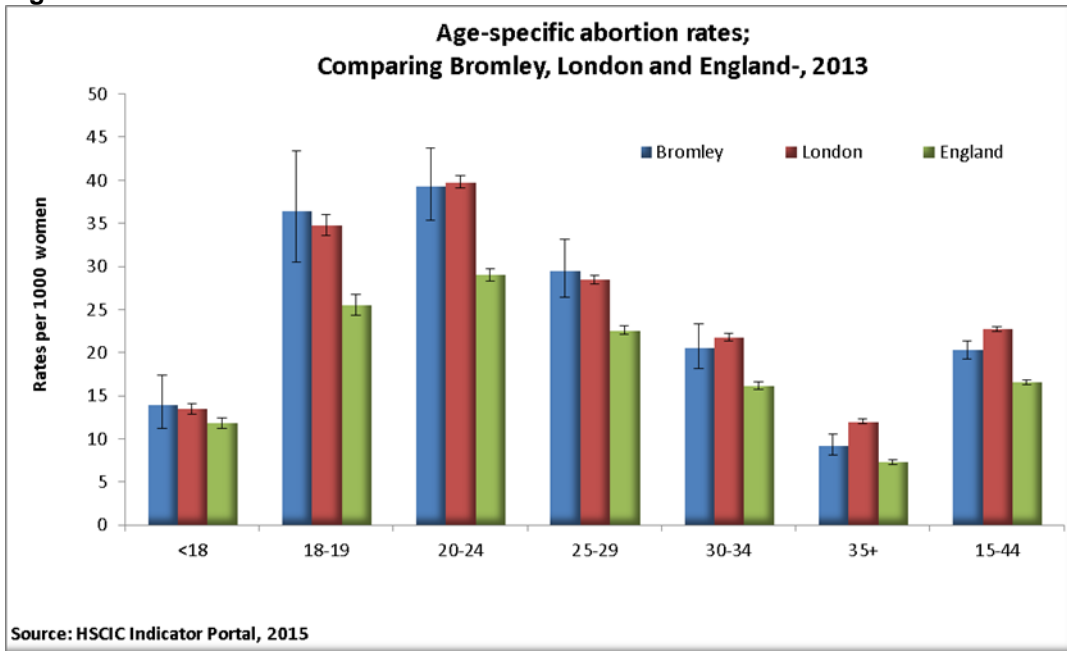
Abortion numbers are largely concentrated within the middle of the reproductive life-span. In Bromley the highest number of abortions (328) were performed in women aged 20-24, followed by the 25-29 age group (288). Women aged under-25 have a repeat termination rate of 34.8%. There is a need for more work focusing on prevention and ensuring good access to and uptake of a comprehensive range of contraception services particularly for young women, not just those under 18 but also women in their 20's.

Figure 3. 80



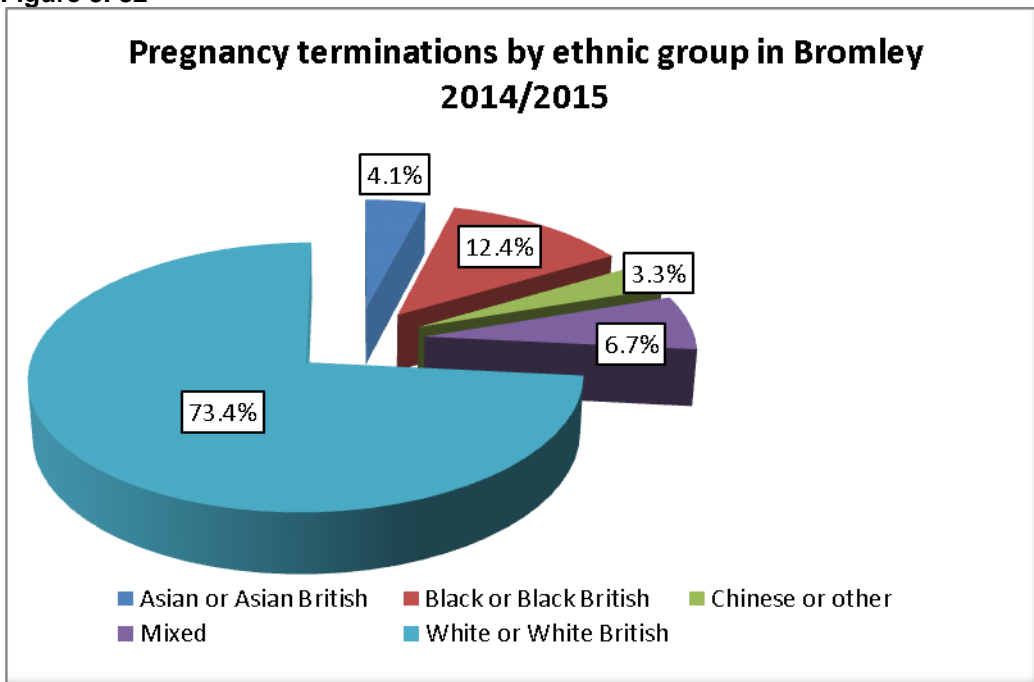
Focusing on teenage conception and abortion rates can obscure the need for abortions by women in their 20s. **Figure 3.81** shows the rates are significantly highest in women aged 20-24. Although the numbers are smaller, Bromley has significantly higher rates than England across all ages.

Figure 3. 81



Latest available local data from independent providers in **Figure 3.82** shows that the majority of terminations are in women from White ethnic groups although data completeness is only at 76%.

Figure 3. 82

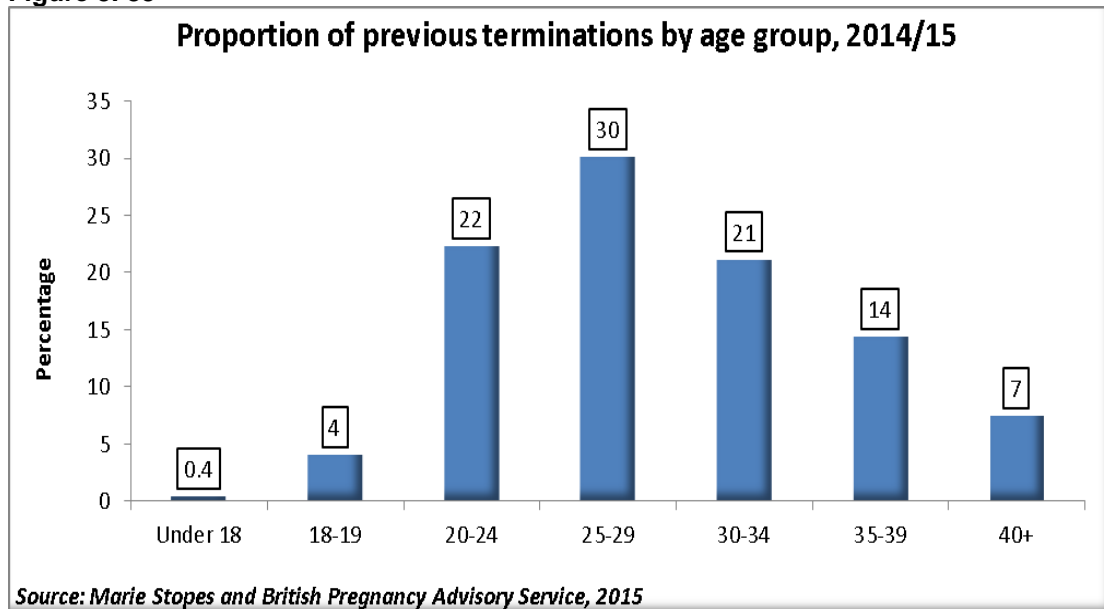


It is important to ascertain the proportion of women who have had one or more previous abortions. Previous unintended pregnancy and subsequent abortion is associated with increased pregnancy risks. Furthermore, previous abortions may reflect access to contraception and education about contraception as well as other more complex social factors especially in women under 25 years.

It should, however, be noted that the data on previous abortions is based on self-reports by the women undergoing abortion and should therefore be treated with caution.

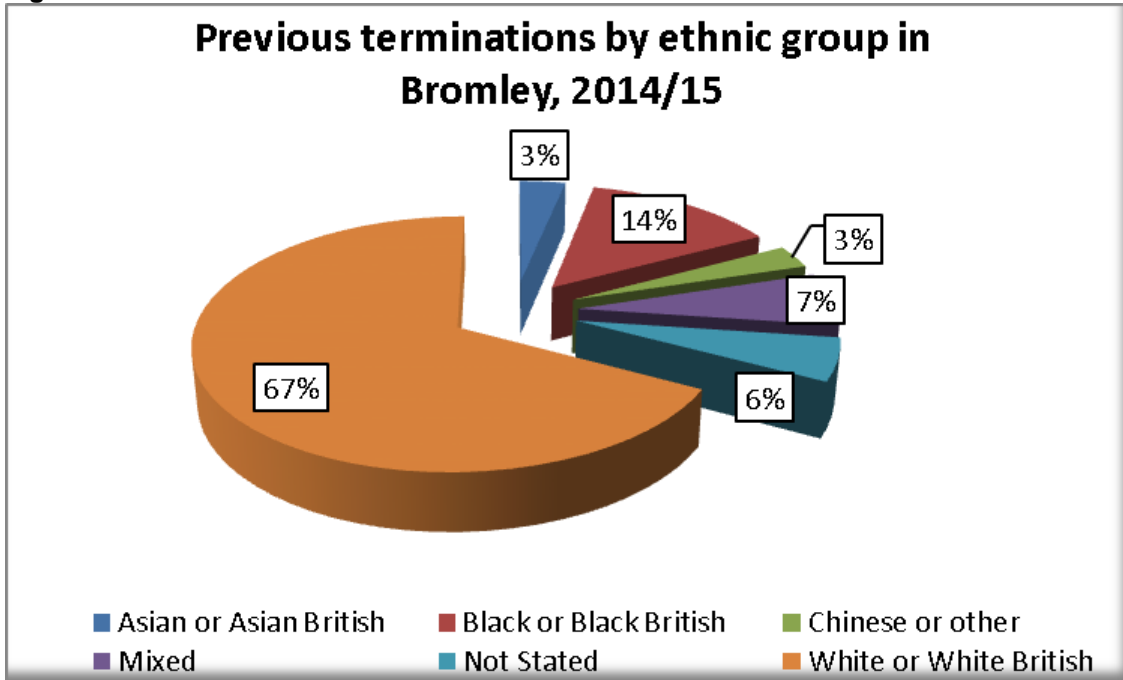
Data from Independent providers shows that 38% of all Bromley women attending the abortion clinics in 2014/15 reported having had a previous abortion. More women 25-29 years reported to have had one or more previous abortions than any other age group.

Figure 3. 83



Analysis of repeat terminations by ethnicity shows a higher proportion in women from White or White British background, followed by Black or Black British women-reflecting the ethnic profile of Bromley.

Figure 3. 84



What does this mean for Bromley residents and for children in Bromley?

The number of live births is rising, reflecting the rising trends in the general fertility rates. The trends have implications for Bromley primary schools and children services in the borough.

There are higher birth rates in Bromley women aged 25-39 than England and London and there is a rising trend towards older motherhood. There is a need for reproductive healthcare services to reflect the population changes.

Abortion rates in women in their 20s are high. These women are also more likely to report a previous termination than other age groups. There is therefore a need to understand contraception use and terminations particularly in women in their 20s in Bromley.

Table 3. 23: Pregnancy and Maternity Related PHOF Indicators, 2015

Indicator	Time Period	Sex	Bromley	London	England
2.01 - Low birth weight of term babies	2005	Persons	2.8	3.8	3.1
2.01 - Low birth weight of term babies	2006	Persons	3.3	3.5	3.0
2.01 - Low birth weight of term babies	2007	Persons	2.1	3.2	2.9
2.01 - Low birth weight of term babies	2008	Persons	2.3	3.3	2.9
2.01 - Low birth weight of term babies	2009	Persons	2.1	3.2	2.9
2.01 - Low birth weight of term babies	2010	Persons	2.0	3.1	2.8
2.01 - Low birth weight of term babies	2011	Persons	2.5	3.2	2.8
2.01 - Low birth weight of term babies	2012	Persons	2.3	3.1	2.8
2.02i - Breastfeeding initiation	2010/11	Female	83.0	86.4	73.7
2.02i - Breastfeeding initiation	2011/12	Female	83.6	87.0	74.0
2.02i - Breastfeeding initiation	2012/13	Female	84.7	86.8	73.9
2.02i - Breastfeeding initiation	2013/14	Female			73.9
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth	2010/11	Persons	52.8	65.1	46.1
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth	2011/12	Persons	57.2	67.5	47.2
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth	2012/13	Persons	59.0	68.5	47.2
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth	2013/14	Persons			45.8
2.03 - Smoking status at time of delivery	2010/11	Female	7.5	6.3	13.5
2.03 - Smoking status at time of delivery	2011/12	Female	6.1	6.0	13.2
2.03 - Smoking status at time of delivery	2012/13	Female	5.2	5.7	12.7
2.03 - Smoking status at time of delivery	2013/14	Female	5.9	5.1	12.0

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

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Health Protection in Bromley

Health protection is an important part of Public Health. It specifically focuses on protecting the public from infectious diseases, non-infectious environmental hazards e.g. lead poisoning; and major incidents such as flooding.

In Bromley, the South East London Health Protection Team (SELHPT) has responsibility for the management of cases and outbreaks of a wide range of infectious diseases as notified to them under the Health Protection Regulations 2010. SELHPT works closely with the Public Health and Environmental Health teams in the London Borough of Bromley, as well as other multidisciplinary colleagues, to manage cases and outbreaks of infectious disease and environmental hazards. There is also much collaborative proactive work to plan and reduce risks from infectious diseases and other hazards.

Summary of notifiable diseases reported to SELHPT

Some infections remain a serious cause of morbidity and mortality even with the wide use of antibiotics and major advances in health care. These include meningococcal disease, invasive Group A Streptococcal and pneumococcal disease and VTEC *E coli* infections, all of which can result in long term complications and poor outcomes.

Table 3.24 shows the number of individual cases formally notified to SELHPT for Bromley residents in 2014 and also for the previous years, 2006-2013. Primary care clinicians notify cases to the local authority and Health Protection Team via an electronic notification system. This has been in place for some years and so data from Bromley tends to be more complete than that in other London Boroughs.

Table 3. 24: Infectious disease notifications for Bromley, 2006-2014

Disease	2006	2007	2008	2009	2010	2011	2012	2013	2014
Cholera	-	-	-	-	-	-	-	0	-
Dysentery	6	2	1	1	0	2	-	-	-
Enteric Fever (Typhoid/Paratyphoid fever)	4	3	0	0	0	1	0	0	1
Food poisoning	479	314	378	395	293	183	230	220	244
Infectious blood diarrhoea	-	-	-	-	-	-	4	3	7
Invasive group A streptococcal disease	-	-	-	-	-	-	1	4	1
Legionaires' Disease	-	-	-	-	-	-	0	1	1
Malaria	2	13	2	4	2	3	3	3	3
Measles	56	50	148	86	34	31	27	49	32
Meningitis	7	11	6	5	2	1	1	1	-
Meningococcal Septicaemia	3	4	0	5	0	0	0	-	1
Mumps	97	49	56	109	96	66	68	66	78
Rubella	8	5	3	8	3	6	3	3	2
Scarlet Fever	44	12	14	45	18	14	22	20	127
Tuberculosis	40	36	18	32	34	47	37	32	18
Viral Hepatitis	2	5	5	3	0	1	3	1	-
Whooping Cough	3	2	7	4	3	0	20	19	13
Other	-	-	-	-	-	-	6	3	8
Total	751	506	638	697	485	355	425	425	536

Source: South East London Health Protection Team, 2014 & Centre for Infection and Disease Control via SELHPT 2015

Scarlet fever seasonal activity was high across England in 2013-14 and this has continued in 2015, although London has had lower notification rates compared to other parts of the country. The majority of cases were reported in children under 10 years of age, with the peak in 1- 4 year olds.

The health protection team provided advice to local schools and nurseries with clusters of infection.

Mumps cases continue to be identified nationally, predominately in young adults aged between 15 and 30 years of age. In 2014, there were 171 confirmed mumps cases in South London residents. This included 14 laboratory confirmed cases and 32 suspected cases, resident in Bromley. National data suggest that over a third of recently reported cases have received at least one dose of MMR vaccination in childhood suggesting that transmission may in part be due to some waning of immunity (Health Protection Report Vol 9 No.18. May 2015 and Vaccine Preventable diseases/COVER report: South London Area Team PHE).

Key Vaccine Preventable Diseases: measles, pertussis, pneumococcal disease and influenza

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. Despite the benefits however, barriers still exist which prevent optimal coverage and where recommended childhood, adult and travel-associated vaccines are often poorly adopted leaving individuals and communities susceptible to infection.

Vaccine preventable diseases include diphtheria, tetanus, Haemophilus influenzae type B (Hib), Human papilloma virus, influenza, measles, meningitis A, C W & Y, mumps, rubella, tetanus, tuberculosis and whooping cough (pertussis). The Cover of Vaccination Evaluated Rapidly (COVER) programme monitors immunisation coverage data for children in the UK who reach their first, second and fifth birthdays during each evaluation quarter.

Table 3.25 shows the annual data for the latest available year (2013-14) for Bromley⁵

Table 3. 25: Percentage of children immunised by birthday, Bromley, London and England, 2013 – 14

	Bromley (%)	London (%)	England (%)
By 1st Birthday			
DTaP/IPV/Hib (Primary)	94.5	89.8	94.3
PCV (primary)	93.5	89.7	94.1
By 2nd Birthday			
DTaP/IPV/Hib (Primary)	96.1	93.1	96.1
MMR (1st dose)	91.2	87.5	92.7
Hib/MenC (booster)	90.6	86.8	92.5
PCV (booster)	90.0	86.3	92.4
By 5th Birthday			
DTaP/IPV/Hib (Primary)	96.4	92.5	95.6
DTaP/IPV (booster)	81.6	79.3	88.8
MMR (1st dose)	94.3	90.6	94.1
MMR (1st and 2nd dose)	88.4	80.7	88.3
Hib/MenC (booster)	92.1	87.2	91.9

Source: Cover of vaccination evaluated rapidly (COVER) programme: annual data. PHE 2015

DTaP/IPV/Hib = diphtheria, tetanus, polio, pertussis, haemophilus influenza B

MenC = meningococcal group C conjugate

PCV = pneumococcal conjugate;

MMR = measles, mumps, rubella

DTaP/IPV = diphtheria, tetanus, polio & pertussis

Hib/MenC = Haemophilus influenzae B & meningococcal group C

⁵ Full data can be found at: <https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-annual-data>

Routine HPV immunisation is given to girls in England in School Year 8. Coverage reports show the percentage of girls who had completed their course of three HPV immunisations by the end of the school year (**Table 3.26**). The vaccination has proved to be very effective and so since September 2014 it has been possible to move to 2 doses of vaccine in the routine HPV programme in the UK.

Table 3. 26: HPV coverage data of first, second and third dose for the routine cohort at 31 August 2014. (Doses given 1st September 2013 to 31st August 2014)

	Bromley (Local authority)	London (Area team)	England
1 st Dose	89.9	85.3	91.1
2 nd Dose	89.4	83.7	89.8
3 rd Dose	86.8	80.0	86.7

Source: PHE <https://www.gov.uk/government/statistics/annual-hpv-vaccine-coverage-2013-to-2014-by-pct-local-authority-and-area-team>

Whilst COVER figures are higher in Bromley than London as a whole, and generally similar to the rest of England, there is still more work to be done.

The percentage of children currently immunised with MMR, PCV and Hib/MenC vaccines by 2 years of age falls below the national recommendation of 95% coverage, as does coverage with two doses of MMR and the diphtheria, tetanus, polio and pertussis booster, at 5 years of age. HPV vaccination coverage is higher than London but lower than England for first dose but similar to England for 2nd and third doses.

Measles

There were 21 confirmed cases of measles infection reported in South London residents in 2014 (including only one confirmed case resident in Bromley). This is the lowest annual rate for the last 5 years. A total of 60 confirmed cases were reported in London in total. The incidence rate is 0.7 per 100,000 inhabitants, the same in South London as in London as a whole. (Reference: Vaccine Preventable diseases/COVER report: Public Health England, South London Area Team.

Pertussis (whooping cough)

In April 2012 a national outbreak of pertussis was declared. Pertussis activity increased beyond levels reported in the previous 20 years and extended into all age groups, including infants less than three months of age. In response the Department of Health announced that pertussis immunisation would be offered to pregnant women from 1 October 2012. This programme aims to passively protect infants from birth, through intra-uterine transfer of maternal antibodies, until they can be actively protected with the first dose of pertussis vaccine scheduled at eight weeks of age. In

June 2014 the Joint Committee on Vaccination and Immunisation (JCVI) considered available data relating to the coverage, effectiveness and safety of the programme, its impact on disease and current epidemiology. The programme has been highly successful and so it has advised that it should continue for a further five years. There were 253 confirmed cases of pertussis infection amongst South London residents in 2014. The incidence rate in South London has remained consistently higher than the London average over the last 5 years at 8.0 per 100,000 residents (compared to 5.0/100,000 in London). Infants under 6 months of age accounted for 4% of South London cases in 2014 compared to a median of 13% between 2010 and 2013 (reference: Vaccine Preventable diseases/COVER annual report 2014: Public Health England, South London Area Team.) There were 14 lab confirmed cases in Bromley in 2014.

The Health Protection Team assist local clinicians with advising vulnerable individuals exposed to pertussis infection and managing potential exposures of patients and staff in hospital and community settings e.g. nurseries.

Uptake of the maternal pertussis vaccination programme in London was 51.0% in December 2014. This is lower than the England average of 62.3% in the same period. It is important for Public Health England, NHS England, primary care and maternity services to work together to improve maternal vaccination uptake to prevent unnecessary illness and mortality from pertussis in infants.

Influenza

Seasonal influenza is a major cause of morbidity and mortality. Analysis of Health Protection Agency data (England 2010-11) allowed estimates of the increased risk of death associated with flu. Death in 'at risk' groups is 11 times higher and this rises to 47 times higher for some groups such as those with immunosuppression. Flu vaccination remains a safe and effective way to protect those vulnerable in the population. In 2014/15 the following people were eligible for flu vaccination:

- those aged 65 years and over
- those aged six months to under 65 in clinical risk groups
- pregnant women
- all two, three and four year olds
- carers
-

Data for influenza vaccinations given from 1 September 2014 to 31 January 2015 shows that vaccine uptake levels in Bromley are lower than England for every at risk group. Compared to London the picture is more mixed, with Bromley performing better in some groups, such as most of the categories of 2 – 4 year olds, but worse for other groups namely aged 2 and in a clinical risk group and at risk patients aged 6 months to 65 years. Bromley performance is the same as London for 65 and over

and pregnant women. More work is needed in Bromley to match the England average. Other area teams nationally have shown it is possible to exceed the national average.

Table 3.27 shows the uptake of seasonal flu vaccine in at risk groups in Bromley.

Table 3. 27: Final cumulative uptake data for England on influenza vaccinations given from 1 September 2014 to 31 January 2015

	Bromley (local authority) %	London (Area team) %	England %
65 and over	69.2	69.2	72.7
At risk patients aged 6 months to under 65 years	45.8	49.8	50.3
Pregnant women	39.9	39.9	44.1
Aged 2 and IN a clinical risk group	45.1	47.6	53.7
Aged 2 and NOT IN a clinical risk group	31.6	29.9	38.1
All 2-year-olds (combined)	32.0	30.3	38.5
Aged 3 and IN a clinical risk group	52.1	50.8	56.4
Aged 3 and NOT IN a clinical risk group	36.0	32.1	40.7
All 3-year-olds (combined)	36.5	32.7	41.3
Aged 4 and IN a clinical risk group	46.6	45.8	52.3
Aged 4 and NOT IN a clinical risk group	25.1	22.7	31.9
All 4-year-olds (combined)	26.1	23.6	32.9

Source: Data on GP registered patients. Influenza Immunisation Vaccine Uptake Monitoring Programme Public Health England (PHE)

Vaccines for older people

In addition to seasonal flu vaccination, older people are also offered routine pneumococcal vaccination and shingles vaccination. The shingles vaccination programme was introduced nationally in September 2013 for individuals aged 70 years old with phased implementation of a catch-up programme. This year (1 September 2014 to 31 August 2015) the shingles vaccine should be offered to patients aged 70 years for the routine programme and patients aged 78 and 79 years for the catch-up programme. Eligibility is determined by the patient's age on 1 September 2014. The programme aims to reduce the incidence and severity of shingles by boosting individuals' pre-existing varicella zoster virus immunity. For the period September 2014 to February 2015 Bromley has a lower proportion of people vaccinated than England in every age cohort.

Table 3. 28: Shingles vaccine coverage report, Bromley and England, September 2014 to February 2015

	Percentage of GP practices reporting	Percentage of age cohort vaccinated to end February		
		Routine 70 years	Catch-up 79 years	Catch-up 78 years
ENGLAND	97.0	48.7	50.3	48.1
NHS BROMLEY CCG	100.0	39.4	46.1	41.5

Source: Shingles Immunisation Vaccine Uptake Monitoring Programme, Public Health England (PHE)2015

It is important to ensure high uptake of pneumococcal vaccine to prevent clusters of cases particularly in vulnerable settings such as care homes. **Table 3.29** gives the uptake of pneumococcal (PPV) vaccination in over 65s in Bromley. Coverage is lower in Bromley than London and England.

Table 3. 29: Percentage of 65 years and older receiving the pneumococcal vaccine anytime up until the 31st March 2014

	Bromley (local Authority)	London (area Team)	England
PPV in adults aged 65 years and over	61.6	63.6	68.9

Source: Pneumococcal polysaccharide vaccine (PPV): vaccine coverage estimates. PHE 2014

Vaccine Indicators in Public Health Outcomes Framework

Indicator 3.03 of the PHOF reports population vaccination coverage of various vaccines over the four most recent years of data. Results for Bromley, London and England are shown in **Table 3.30**. Bromley's performance against the national goal for coverage is shown in red where it falls below the goal and green where it meets the goal. This highlights Bromley not meeting goals for 2 does of MMR at age 5, PPV and flu.

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Table 3. 30: Population Vaccine Coverage PHOF Indicators

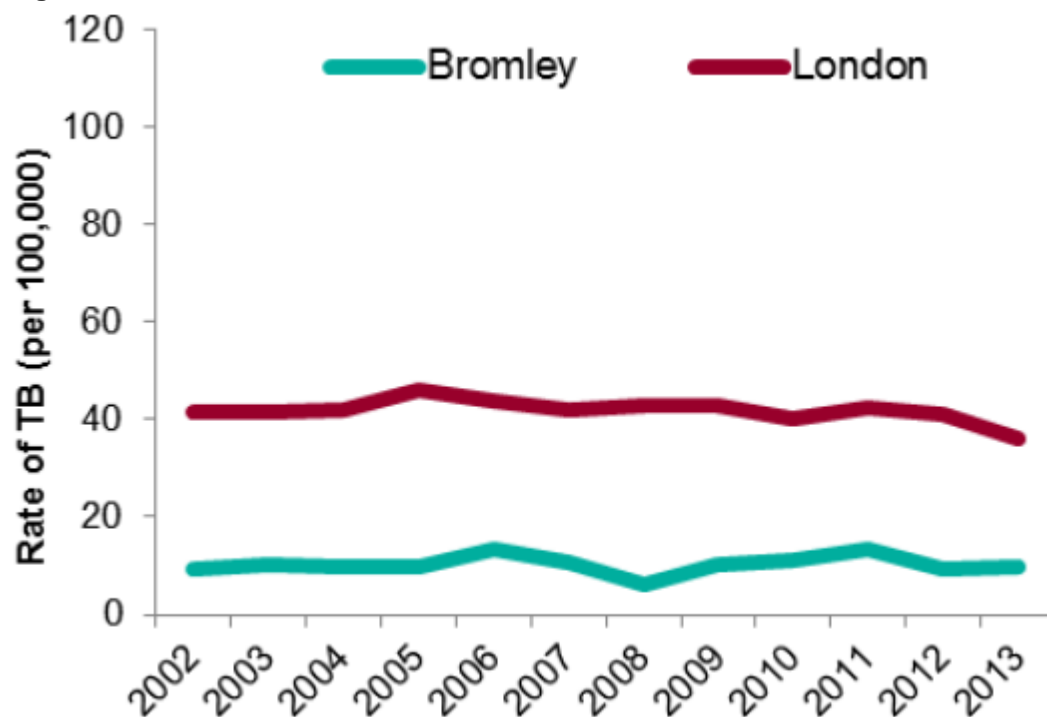
Indicator	Time Period	Sex	Age	Bromley	London	England	Bromley Comparison to Benchmark (Goal)
3.03i - Population vaccination coverage - Hepatitis B	2010/11	Persons	1 yr	81.25			
3.03i - Population vaccination coverage - Hepatitis B	2011/12	Persons	1 yr	100.00			
3.03i - Population vaccination coverage - Hepatitis B	2012/13	Persons	1 yr	100.00			
3.03i - Population vaccination coverage - Hepatitis B	2013/14	Persons	1 yr	87.50			
3.03i - Population vaccination coverage - Hepatitis B	2010/11	Persons	2 yrs	85.71			
3.03i - Population vaccination coverage - Hepatitis B	2011/12	Persons	2 yrs	75.00			
3.03i - Population vaccination coverage - Hepatitis B	2012/13	Persons	2 yrs	100.00			
3.03i - Population vaccination coverage - Hepatitis B	2013/14	Persons	2 yrs	100.00			
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	2010/11	Persons	1 yr	90.64	90.73	94.15	Better than Goal 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	2011/12	Persons	1 yr	95.13	91.27	94.67	Better than Goal 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	2012/13	Persons	1 yr	95.01	91.10	94.74	Better than Goal 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	2013/14	Persons	1 yr	94.47	89.76	94.34	Better than Goal 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	2010/11	Persons	2 yrs	93.42	92.85	95.98	Better than Goal 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	2011/12	Persons	2 yrs	96.40	93.33	96.14	Better than Goal 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	2012/13	Persons	2 yrs	95.96	93.58	96.30	Better than Goal 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	2013/14	Persons	2 yrs	96.07	93.08	96.14	Better than Goal 90%
3.03iv - Population vaccination coverage - MenC	2010/11	Persons	1 yr	90.09	89.27	93.39	Better than Goal 90%
3.03iv - Population vaccination coverage - MenC	2011/12	Persons	1 yr	94.06	89.95	93.89	Better than Goal 90%
3.03iv - Population vaccination coverage - MenC	2012/13	Persons	1 yr	94.90	89.94	93.89	Better than Goal 90%
3.03v - Population vaccination coverage - PCV	2010/11	Persons	1 yr	90.15	89.58	93.58	Better than Goal 90%
3.03v - Population vaccination coverage - PCV	2011/12	Persons	1 yr	94.46	90.40	94.22	Better than Goal 90%
3.03v - Population vaccination coverage - PCV	2012/13	Persons	1 yr	94.51	90.83	94.43	Better than Goal 90%
3.03v - Population vaccination coverage - PCV	2013/14	Persons	1 yr	93.52	89.72	94.07	Better than Goal 90%
3.03vi - Population vaccination coverage - Hib / MenC booster	2010/11	Persons	2 yrs	85.72	84.88	91.59	Worse than Goal 90%
3.03vi - Population vaccination coverage - Hib / MenC booster	2011/12	Persons	2 yrs	91.86	86.78	92.34	Better than Goal 90%
3.03vi - Population vaccination coverage - Hib / MenC booster	2012/13	Persons	2 yrs	90.45	87.35	92.66	Better than Goal 90%
3.03vi - Population vaccination coverage - Hib / MenC booster	2013/14	Persons	2 yrs	90.56	86.81	92.51	Better than Goal 90%
3.03vi - Population vaccination coverage - Hib / Men C booster	2011/12	Persons	5 yrs	92.09	80.14	88.63	Better than Goal 90%
3.03vi - Population vaccination coverage - Hib / Men C booster	2012/13	Persons	5 yrs	91.60	86.92	91.49	Better than Goal 90%
3.03vi - Population vaccination coverage - Hib / Men C booster	2013/14	Persons	5 yrs	92.13	87.16	91.93	Better than Goal 90%
3.03vii - Population vaccination coverage - PCV booster	2010/11	Persons	2 yrs	82.71	82.40	89.34	Worse than Goal 90%
3.03vii - Population vaccination coverage - PCV booster	2011/12	Persons	2 yrs	91.66	85.28	91.49	Better than Goal 90%
3.03vii - Population vaccination coverage - PCV booster	2012/13	Persons	2 yrs	90.27	86.58	92.47	Better than Goal 90%
3.03vii - Population vaccination coverage - PCV booster	2013/14	Persons	2 yrs	90.05	86.31	92.44	Better than Goal 90%
3.03viii - Population vaccination coverage - MMR for one dose	2010/11	Persons	2 yrs	83.56	83.75	89.13	Worse than Goal 90%
3.03viii - Population vaccination coverage - MMR for one dose	2011/12	Persons	2 yrs	91.49	86.08	91.25	Better than Goal 90%
3.03viii - Population vaccination coverage - MMR for one dose	2012/13	Persons	2 yrs	90.59	87.14	92.32	Better than Goal 90%
3.03viii - Population vaccination coverage - MMR for one dose	2013/14	Persons	2 yrs	91.16	87.46	92.66	Better than Goal 90%
3.03ix - Population vaccination coverage - MMR for one dose	2010/11	Persons	5 yrs	88.92	88.17	91.92	Worse than Goal 90%
3.03ix - Population vaccination coverage - MMR for one dose	2011/12	Persons	5 yrs	95.16	89.70	92.90	Better than Goal 90%
3.03ix - Population vaccination coverage - MMR for one dose	2012/13	Persons	5 yrs	94.04	90.58	93.87	Better than Goal 90%
3.03ix - Population vaccination coverage - MMR for one dose	2013/14	Persons	5 yrs	94.30	90.64	94.11	Better than Goal 90%
3.03x - Population vaccination coverage - MMR for two doses	2010/11	Persons	5 yrs	77.01	76.62	84.21	Worse than Goal 90%
3.03x - Population vaccination coverage - MMR for two doses	2011/12	Persons	5 yrs	88.49	80.21	86.02	Worse than Goal 90%
3.03x - Population vaccination coverage - MMR for two doses	2012/13	Persons	5 yrs	87.52	80.77	87.72	Worse than Goal 90%
3.03x - Population vaccination coverage - MMR for two doses	2013/14	Persons	5 yrs	88.42	80.70	88.32	Worse than Goal 90%
3.03xii - Population vaccination coverage - HPV	2010/11	Female	12-13 yrs	80.92	75.59	84.16	
3.03xii - Population vaccination coverage - HPV	2011/12	Female	12-13 yrs	82.98	78.89	86.83	<previous year's England value
3.03xii - Population vaccination coverage - HPV	2012/13	Female	12-13 yrs	83.94	78.88	86.08	<previous year's England value
3.03xii - Population vaccination coverage - HPV	2013/14	Female	12-13 yrs	86.76	79.98	86.70	>previous year's England value
3.03xiii - Population vaccination coverage - PPV	2010/11	Persons	65+ yrs	65.82	64.97	70.46	
3.03xiii - Population vaccination coverage - PPV	2011/12	Persons	65+ yrs	56.69	62.61	68.34	<previous year's England value
3.03xiii - Population vaccination coverage - PPV	2012/13	Persons	65+ yrs	61.68	64.24	69.09	<previous year's England value
3.03xiii - Population vaccination coverage - PPV	2013/14	Persons	65+ yrs	61.58	63.57	68.94	<previous year's England value
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2010/11	Persons	65+ yrs	72.01	71.44	72.84	Worse than Goal 75%
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2011/12	Persons	65+ yrs	73.67	72.24	74.02	Worse than Goal 75%
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2012/13	Persons	65+ yrs	73.48	71.24	73.38	Worse than Goal 75%
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2013/14	Persons	65+ yrs	69.90	70.02	73.21	Worse than Goal 75%
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2010/11	Persons	6 months-64 yrs	46.05	48.92	50.39	Worse than Goal 75%
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2011/12	Persons	6 months-64 yrs	47.68	51.43	51.62	Worse than Goal 75%
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2012/13	Persons	6 months-64 yrs	45.49	50.94	51.29	Worse than Goal 75%
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2013/14	Persons	6 months-64 yrs	46.46	51.97	52.26	Worse than Goal 75%

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

Tuberculosis

TB incidence in Bromley remains very low compared to the average London rate (**Figure 3.85**). There were a total of 30 TB cases in Bromley in 2013. Young males aged 20 to 39 years old were the most common age group notified as cases of TB. Almost a third of Bromley TB patients were born in the UK: a higher proportion than usually seen in London but numbers are low and so should be interpreted with caution. The most common ethnic group was Indian followed by black African, but again numbers were very small. Social risk factors, such as homelessness, imprisonment, drug or alcohol misuse, were above the London average, particularly among those with pulmonary disease.

Figure 3. 85: Annual TB incidence rate 2002 – 2013



Source: PHE Bromley TB profile (2013)

TB remains an urgent public health problem in London as the city overall has the highest number of TB cases of any major city in Western Europe. Rates of infection have stabilised and started to decline over the last few years but there is much work to be done, in particular to ensure those who are vulnerable and in socially deprived groups have access to services. TB control has been identified as a priority for Public Health England, with a collaborative, multiagency approach.

Healthcare associated infections

SELHPT has a role in supporting acute trusts and community health providers in

monitoring healthcare associated infection (HCAI) rates and trends over time. The work has expanded outside of MRSA and *Clostridium difficile* infections to include management of cases and outbreaks of a wide variety of highly resistant organisms. Mandatory and voluntary surveillance schemes are in place to monitor blood stream infections caused by methicillin-resistant and methicillin-sensitive *Staphylococcus aureus*, *E coli* and glycopeptide-resistant organisms, carbapenem resistant organisms, *Clostridium difficile* infections and surgical site infections. PHE publishes data quarterly and annually for acute trusts and clinical commissioning groups. Bromley CCG had between 4 and 11 cases of C difficile in patients over 2 years of age each month between May 2014 and May 2015 (total 107 cases) and a total of 4 cases of Methicillin Resistant Staphylococcus aureus bacteraemia in the same period. Full HCAI data for the acute trusts in SE London can be found by following the appropriate links from <https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis#management-of-healthcare-associated-infections-hcai>

Outbreaks

Table 3. 31: Norovirus Outbreaks 2014

	Number of outbreaks
Care Home	2
Food Outlet/Restaurant	1
Hospital	3
School	8
Grand Total	14

Scarlet Fever Outbreaks 2014

There were two recorded outbreaks of Scarlet Fever in schools across Bromley in 2014

Other selected Health protection Indicators in Public Health Outcomes Framework

Table 3.32 shows other selected health protection indicators included in the PHOF. Over recent years Bromley has been similar or better than England in terms of TB treatment completion, TB incidence, and mortality from communicable disease.

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Table 3. 32: Health Protection Related PHOF Indicators

Indicator	Time Period	Sex	Age	Bromley	London	England	Bromley Comparison to Benchmark (England)
3.05i - Treatment completion for TB	2003	Persons	All ages	69.20	Value missing	69.60	Similar
3.05i - Treatment completion for TB	2004	Persons	All ages	61.50	Value missing	70.10	Similar
3.05i - Treatment completion for TB	2005	Persons	All ages	69.20	Value missing	70.30	Similar
3.05i - Treatment completion for TB	2006	Persons	All ages	76.30	Value missing	75.50	Similar
3.05i - Treatment completion for TB	2007	Persons	All ages	81.50	Value missing	78.10	Similar
3.05i - Treatment completion for TB	2008	Persons	All ages	Value suppressed	Value missing	79.90	
3.05i - Treatment completion for TB	2009	Persons	All ages	83.90	Value missing	81.80	Similar
3.05i - Treatment completion for TB	2010	Persons	All ages	83.30	Value missing	82.60	Similar
3.05i - Treatment completion for TB	2011	Persons	All ages	92.50	Value missing	81.80	Similar
3.05i - Treatment completion for TB	2012	Persons	All ages	79.30	Value missing	83.30	Similar
3.05ii - Incidence of TB	2004 - 06	Persons	All ages	11.03	43.85	14.69	Better
3.05ii - Incidence of TB	2005 - 07	Persons	All ages	11.41	43.89	15.00	Better
3.05ii - Incidence of TB	2006 - 08	Persons	All ages	10.24	42.96	14.98	Better
3.05ii - Incidence of TB	2007 - 09	Persons	All ages	9.19	42.65	15.13	Better
3.05ii - Incidence of TB	2008 - 10	Persons	All ages	9.24	42.02	15.07	Better
3.05ii - Incidence of TB	2009 - 11	Persons	All ages	11.66	41.86	15.25	Better
3.05ii - Incidence of TB	2010 - 12	Persons	All ages	11.25	41.23	15.11	Better
3.05ii - Incidence of TB	2011 - 13	Persons	All ages	10.72	39.62	14.75	Better
4.08 - Mortality from communicable diseases	2001 - 03	Persons	All ages	102.40	122.53	99.04	Similar
4.08 - Mortality from communicable diseases	2002 - 04	Persons	All ages	101.44	118.22	97.67	Similar
4.08 - Mortality from communicable diseases	2003 - 05	Persons	All ages	93.57	114.13	96.69	Similar
4.08 - Mortality from communicable diseases	2004 - 06	Persons	All ages	82.22	105.55	92.63	Better
4.08 - Mortality from communicable diseases	2005 - 07	Persons	All ages	81.20	101.49	91.40	Better
4.08 - Mortality from communicable diseases	2006 - 08	Persons	All ages	83.51	97.05	88.38	Similar
4.08 - Mortality from communicable diseases	2007 - 09	Persons	All ages	81.16	90.46	83.87	Similar
4.08 - Mortality from communicable diseases	2008 - 10	Persons	All ages	68.94	82.71	77.49	Better
4.08 - Mortality from communicable diseases	2009 - 11	Persons	All ages	56.01	72.95	70.04	Better
4.08 - Mortality from communicable diseases	2010 - 12	Persons	All ages	52.50	68.12	64.84	Better
4.08 - Mortality from communicable diseases	2011 - 13	Persons	All ages	53.58	64.07	62.23	Better
4.08 - Mortality from communicable diseases	2001 - 03	Male	All ages	115.48	141.04	115.64	Similar
4.08 - Mortality from communicable diseases	2002 - 04	Male	All ages	117.72	132.76	112.81	Similar
4.08 - Mortality from communicable diseases	2003 - 05	Male	All ages	116.26	127.18	110.78	Similar
4.08 - Mortality from communicable diseases	2004 - 06	Male	All ages	98.16	115.97	106.06	Similar
4.08 - Mortality from communicable diseases	2005 - 07	Male	All ages	92.16	112.07	104.35	Similar
4.08 - Mortality from communicable diseases	2006 - 08	Male	All ages	96.66	108.35	100.88	Similar
4.08 - Mortality from communicable diseases	2007 - 09	Male	All ages	94.52	102.78	95.62	Similar
4.08 - Mortality from communicable diseases	2008 - 10	Male	All ages	82.64	94.30	88.64	Similar
4.08 - Mortality from communicable diseases	2009 - 11	Male	All ages	62.63	82.90	80.93	Better
4.08 - Mortality from communicable diseases	2010 - 12	Male	All ages	55.17	78.33	75.06	Better
4.08 - Mortality from communicable diseases	2011 - 13	Male	All ages	54.33	74.75	72.06	Better
4.08 - Mortality from communicable diseases	2001 - 03	Female	All ages	94.43	111.14	90.12	Similar
4.08 - Mortality from communicable diseases	2002 - 04	Female	All ages	92.84	108.56	89.31	Similar
4.08 - Mortality from communicable diseases	2003 - 05	Female	All ages	83.24	104.94	88.72	Similar
4.08 - Mortality from communicable diseases	2004 - 06	Female	All ages	74.74	97.51	84.90	Better
4.08 - Mortality from communicable diseases	2005 - 07	Female	All ages	76.67	93.38	83.86	Similar
4.08 - Mortality from communicable diseases	2006 - 08	Female	All ages	77.55	88.85	81.05	Similar
4.08 - Mortality from communicable diseases	2007 - 09	Female	All ages	74.15	81.98	76.79	Similar
4.08 - Mortality from communicable diseases	2008 - 10	Female	All ages	61.09	74.67	70.65	Better
4.08 - Mortality from communicable diseases	2009 - 11	Female	All ages	52.04	66.10	63.42	Better
4.08 - Mortality from communicable diseases	2010 - 12	Female	All ages	51.04	61.26	58.65	Better
4.08 - Mortality from communicable diseases	2011 - 13	Female	All ages	52.73	57.08	56.22	Similar

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

What does this mean for Bromley residents and children in Bromley?

Further work is needed to encourage the uptake of childhood immunisations as vaccination rates for several categories, such as MMR, Hib/MenC, DTaP/IPV (pre-school), and HPV, remain below the national recommendation of 95% coverage.

There remains a potential for measles outbreaks, particularly in older children and young adults due to poor immunisation uptake, as seen in the 21 confirmed measles cases in South London in 2014.

There were 253 confirmed cases of pertussis in South London in 2014, highlighting the ongoing importance of immunisation against pertussis, in particular of ensuring good uptake of maternal pertussis vaccination.

Seasonal flu vaccination rate in Bromley is lower than that of England, and a large proportion of at risk individuals remain vulnerable to the serious health effects of flu.

Shingles and PCV coverage for older people could be improved as it is lower than England

Appendix - Surveillance systems and data sources

HPZone

The data produced in this report come mainly from the HPZone case management system used in SELHPT. This is a national web-based system used by Public Health England (PHE) to manage cases, outbreaks and enquiries. The HPZone system is used to upload clinical notifications of infectious diseases (NOIDS), mandatory laboratory reports from acute trust laboratories, and telephone and email notifications of infections for the residents of SE London. All diseases case managed by the HPT are entered onto the HPZone system along with all NOIDS. The HPZone system contains an early alerting system for potential outbreaks and clusters of illness within the population nationally, as well as locally.

The London TB Register (LTBR)

This is a Regional web-based register implemented in 2002 and managed by the PHE London Field Epidemiology Service (FES). All notifications of TB are entered directly into the database in all, except one, of the TB clinics in SE London.

Cover of Vaccination Evaluated Rapidly (COVER) data

The COVER programme evaluates childhood immunisation in England. PHE collates immunisation coverage data from computerised child health information systems for children aged one, two and five years old. This information is promptly fed back to local level, creating the opportunity to improve coverage and to detect changes in vaccine coverage quickly.

For more information on Health Protection please contact
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Modifiable Lifestyle Risk Factors

Unhealthy lifestyles are a major contributor to the key causes of morbidity and mortality in Bromley. Smoking, excess weight and physical inactivity are all independent modifiable risk factors.

Smoking

Smoking is the number one cause of preventable death in the country, resulting in more deaths than the next six causes combined. Treating tobacco dependence is the single most cost effective lifesaving intervention.

Smoking is a major risk factor for cardiovascular disease (heart disease and stroke), Chronic Obstructive Pulmonary Disease (emphysema, bronchitis and asthma) and many cancers (in particular lung, bowel and breast cancer). Smoking kills nearly 80,000 people in England every year, smokers are much more likely to die prematurely (up to 16 years of lost life expectancy). 1 in 2 long-term smokers die from a smoking related illness.

Smoking prevalence

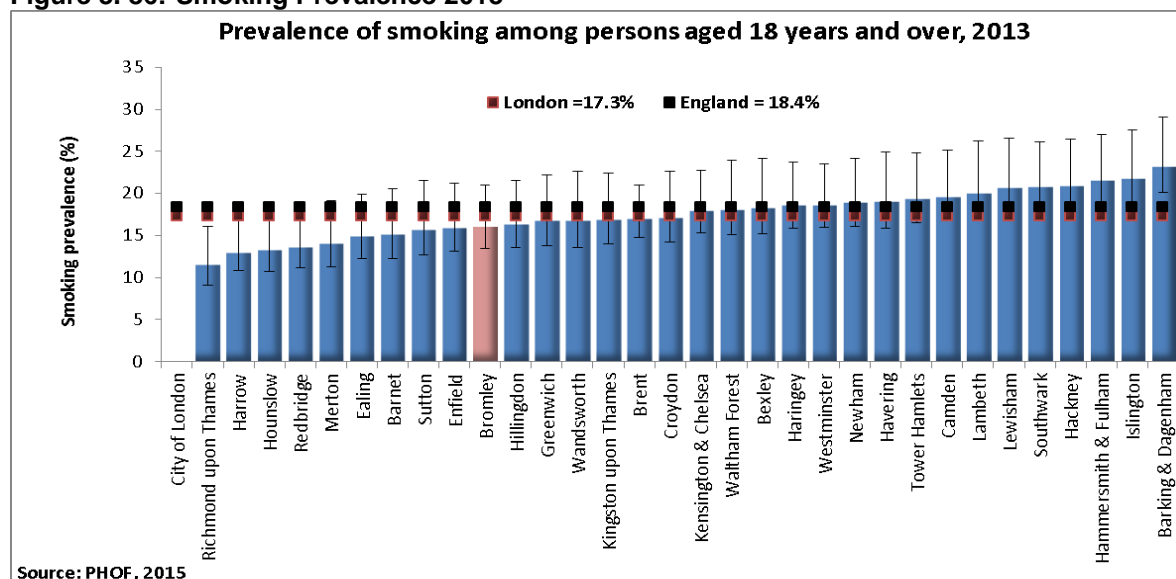
The total population of adult smokers is decreasing in the UK. In Bromley, the current adult smoker population (18+ years) is over 35,000 (14.0%) compared with 18% smoking prevalence for England and 17% for London. Bromley was ranked 16th highest in order of smoking prevalence across London in 2012, this position has improved and Bromley was ranked 25th out of 32 London boroughs in 2014. However, one in seven residents still smoke, which has a major impact on their health and the wellbeing of those around them. Smoking prevalence has been falling over the last two years (**Table 3.33**).

Table 3. 33: Smoking Prevalence Trend in Bromley

Year	Smoking Prevalence
2010	17%
2011	17.5%
2012	17.8%
2013	16%
2014	14%

Source: *PHOF 2015*

Figure 3. 86: Smoking Prevalence 2013



In 2012-13, the wards with the highest smoking prevalence were; Bromley Town (5,968, 33.26%), Cray Valley West (3,217, 18.87%), and Orpington (3,018, 19.41%). Cray Valley West (406), Cray Valley East, (309) followed by Biggin Hill (141) had the highest percentage of smokers attempting to quit. Cray Valley West (12.88%), Cray Valley East (9.39%), and Orpington (7.42%) had the highest number of successful quitters.

Table 3. 34: Stop Smoking Activity by Ward, 2012/13

Ward	Population*	Smoking Population		Attempt to Quit	4 Week Quit	Quit (%)	Efficacy (%)
		No	(%)				
Bickley	15350	969	6.31	77	35	2.22	45.45
Biggin Hill	10150	1422	14.01	141	59	3.74	41.84
Bromley Common & Keston	15750	2311	14.67	175	94	5.96	53.71
Bromley Town	17750	5968	33.62	136	77	4.89	56.62
Chelsfield & Pratts Bottom	14700	1361	9.26	113	63	4.00	55.75
Chislehurst	15200	1613	10.61	120	72	4.57	60.00
Clock House	15800	2089	13.22	130	83	5.27	63.85
Copers Cope	15750	1829	11.61	112	57	3.62	50.89
Cray Valley East	15650	2656	16.97	309	148	9.39	47.90
Cray Valley West	17050	3217	18.87	406	203	12.88	50.00
Crystal Palace	12600	1478	11.73	113	57	3.62	50.44
Darwin	5250	662	12.61	50	24	1.52	48.00
Farnborough & Crofton	14850	1475	9.93	91	48	3.05	52.75
Hayes & Coney Hall	16200	1801	11.12	127	66	4.19	51.97
Kelsey & Eden Park	16150	2303	14.26	103	64	4.06	62.14
Mottingham & Chislehurst North	10200	405	3.97	105	50	3.17	47.62
Orpington	15550	3018	19.41	202	117	7.42	57.92
Penge & Cator	17650	2120	12.01	146	73	4.63	50.00
Petts Wood & Knoll	13850	1301	9.39	78	49	3.11	62.82
Plaistow & Sundridge	15400	825	5.36	159	78	4.95	49.06
Shortlands	10050	980	9.75	36	26	1.65	72.22
West Wickham	15150	1471	9.71	60	33	2.09	55.00
Bromley	316050	41272	13.06	2989	1576	100.00	52.73

*Ward population data and smoking prevalence. Source: BHC Stop Smoking Service, 2013/2014³

The current burden of smoking in Bromley

Impact of smoking

Smoking attributable mortality – The age-standardised mortality rate for smoking attributable causes was lower in Bromley during 2011-13 (249.5 per 100,000 population) than the overall London and England rate (275.9 compared to 288.7 per 100,000 population, respectively).

Smoking attributable deaths from heart disease –The age-standardised rate for smoking attributable deaths from heart disease was lower in Bromley during 2011-13 (29.1 per 100,000 population) than in London and England (30.2 compared to 32.7 per 100,000 population, respectively).

Smoking attributable deaths from stroke – The age-standardised mortality rate for these deaths was 9.2 in Bromley, 10.7 in London compared with 11.0 per 100,000 population in England as a whole.

Smoking attributable hospital admissions – The age-standardised rate for smoking attributable hospital admissions in Bromley was 1,365 per 100,000 population aged 35 years and over, as compared with 1,608 in London and 1,688 in England in 2012/13.

Two thirds of hospital re-admissions are associated with smoking; therefore smoking cessation offers the best opportunity to reduce admissions and re-admission rates. Post-operative Hospital Acquired Infection (HAI) is between three and eight times more prevalent among smokers than non-smokers. Evidence shows that even four to eight weeks of smoking cessation before a planned admission will reduce the risk of developing post-operative complications. For example, smokers have a one in three risk of post-operative breathing problems. This can be reduced to one in ten if they stop smoking eight weeks before the operation. Stopping smoking before hospital admission can produce the following benefits:

- Reduce wound-related, lung and heart complications
- Decrease wound healing time
- Reduce bone fusion time after fracture time
- Reduce length of stay

Stopping smoking has been identified as a priority to be delivered within hospitals in Bromley. In 2014 – 2015, identified nursing staff will aim to increase the number of smoking quitters by offering all patients on identified wards Very Brief Advice (VBA) on the benefits of stopping smoking and making referrals to local stop smoking services where appropriate.

Inequalities

Routine and Manual

Smoking prevalence continues to be higher in the most deprived wards in Bromley, undermining the health of the most disadvantaged communities. Smoking has been identified as the single biggest cause of inequality in death rates between social classes in the UK. Smokers are more likely to live in poverty; a twenty-a-day smoker will spend more than £3,000 a year on cigarettes.

Smoking prevalence in routine and manual (R&M) occupational groups is higher than in the general population. Prevalence rates are estimated based on fairly small surveys (approximately 100 people from R&M groups in Bromley per year) so are subject to quite large fluctuations year on year.

Table 3. 35: Smoking Prevalence Trend in Routine & Manual Groups in Bromley

Year	Smoking Prevalence in R&M Groups
2011	24.3%
2012	26.1%
2013	33.7%
2014	16.3%

Source: *PHOF 2015*

Smoking prevalence in R&M workers was 28% in England and 25.3% in London in 2014.

Pregnant Smokers

In 2013/14, 5.1% of pregnant women were smoking at time of delivery in London. The prevalence in Bromley is higher at 5.9% of pregnant women. This is the 8th highest prevalence in London. In 2012, there were 4,160 births in Bromley, equating to approx. 245 women smoking at time of delivery assuming the same birth rate.

- Pregnant mothers are an identified priority group nationally. Smoking during pregnancy can cause serious health problems and is associated with complications during labour, increased risk of miscarriage, premature birth, still-birth, low birth weight, respiratory conditions, attention and hyperactivity difficulties, learning difficulties and sudden unexpected death in infancy. Infants born to smokers are much more likely to become smokers themselves.
- Mothers aged 20 or under are five times more likely than those aged 35 and over to have smoked throughout pregnancy (45% and 9% respectively)

- Mothers in routine and manual occupations are more than four times as likely to smoke throughout pregnancy – compared to those in managerial and professional occupations (29% and 7% respectively).
- Exposure to second hand smoke (SHS) leads to exposure to toxins which contributes to: asthma, middle-ear infections, Sudden Infant Death Syndrome (SIDS), pneumonia and bronchitis.

Smoking prevalence in young people.

Smoking status at age 15 years has now been recorded in 2014/15, which shows that Bromley has a greater number of current, regular and occasional smokers at this age than London and England. This is of concern as two thirds of smokers start smoking before the age of 18 years.

Table 3. 36

Smoking Status at age 15, 2014/15	Bromley	London	England
Current smokers	9.9%	8.2%	6.1%
Regular smokers	6.6%	5.5%	3.4%
Occasional smokers	3.3%	2.7%	2.7%

Source: PHOF, 2015

Mental Health

Smoking is approximately twice as common among people with mental disorders and even higher among those with more severe disease. Smokers with mental health disorders are just as likely to want to quit as those without, but are more likely to be heavily addicted to smoking, to anticipate difficulty quitting smoking, and are historically much less likely to succeed in any attempt to quit. This is a priority group for Bromley.

Bromley Stop Smoking Services

Evidence has shown that a smoker is four times more likely to quit if they are supported to do so by a trained stop smoking advisor. However, the number of smokers accessing stop smoking services has decreased in the past 2 years across the country; in 2013/14, 19% fewer people set quit dates through stop smoking services in England compared to in 2012/13, which was a lower figure in turn by 11% compared with 2011/12⁴.

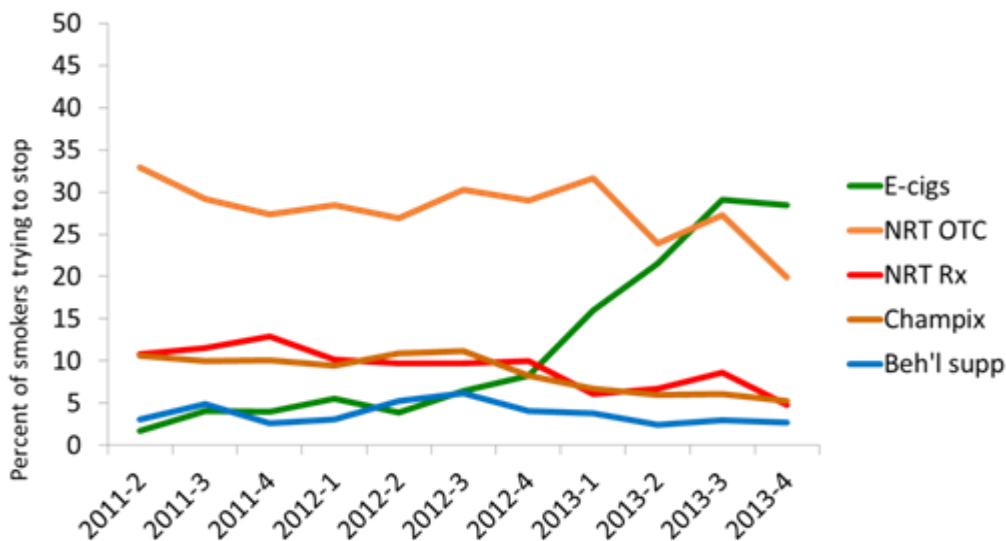
The Bromley Stop Smoking Service records the number of people who have quit smoking and are abstinent at 4-weeks in line with national guidance. In 2014-15, the SSS achieved 1,346 quitters a 53% efficacy rate which is just above the efficacy rate for England (51%)⁵. In addition, the service recorded the number of long term quitters. Of those followed up, 72.2% were still abstinent from smoking at 12 months.

Harm reduction latest guidance – vaping devices / e-cigarettes.

A consistent message to all smokers remains that they should stop completely, immediately and permanently. However, those who are unable or unwilling to stop smoking should be encouraged to adopt a ‘Harm Minimisation’ approach to move them closer to becoming smokefree. Although existing evidence is not clear about the health benefits of smoking reduction, those who reduce the amount they smoke are more likely to stop smoking eventually, particularly if they are using licensed nicotine-containing products (NICE PH45)⁶

There is no legislation and long term research on the effects of e-cigarettes therefore services have been advised not to recommend e-cigarettes until a legislated product is available. E-cigarettes are now the most popular support when quitting.

Figure 3. 877: Frequency of smoking aids used when attempting to quit smoking in England



N=4,540 adults who smoke and tried to stop or who stopped in the past year

Source: *Copyright of Action on Smoking and Health, 2014*

How much is smoking costing in Bromley?

Every £1 spent on smoking cessation saves £10 in future health care costs and health gains.

The total annual cost of smoking in Bromley is £15,389,039*, which can be broken down as:

- NHS Costs: £9,753,958
- Costs to businesses (productivity losses): £5,473,233
- Passive smoking costs: £152,899 (adults: £108,649; children: £44,250).

The number of accidental fires ignited by smoking related materials has fallen from 3,828 fires in 2009/10 to 3,143 fires in 2012/13, a fall of 18% in three years⁷.

*The model does not factor in other potential costs associated with tobacco smoking e.g. social care costs apart from costs associated with stroke patients, related house fires, the loss in productivity from smoking breaks and cleaning up cigarette butts as the evidence base is not robust.

What this means for Bromley residents and the children of Bromley

Smoking is still the number one cause of preventable death in the country, resulting in more deaths than the next six causes combined.

Treating tobacco dependence is the single most cost effective lifesaving intervention.

Bromley's smoking prevalence decreased from 17.8% in 2012 to 14.0% in 2014. However, smoking prevalence in routine and manual (R&M) occupational groups is consistently higher than the general population, currently 16.3% in 2014.

Stopping smoking is a priority within Bromley for routine and manual workers, pregnant women, those with a mental health condition and patients in secondary care (hospital admission, re-admission and post-operative complications).

References

1. Public Health England. Tobacco Control Profile 2014.
2. Public Health England. Public Health Outcomes Framework 2014.
3. Department for Health. Ward population data and smoking prevalence, Bromley Healthcare Stop Smoking Service data 2013/14.
4. Public Health England. Local stop smoking services: service delivery and guidance.
5. Health and Social Care Information Centre. Statistics on NHS Stop Smoking Services in England April 2014 – March 2015. August 2015.
6. Good practice prompts for planning comprehensive interventions in 2015-16

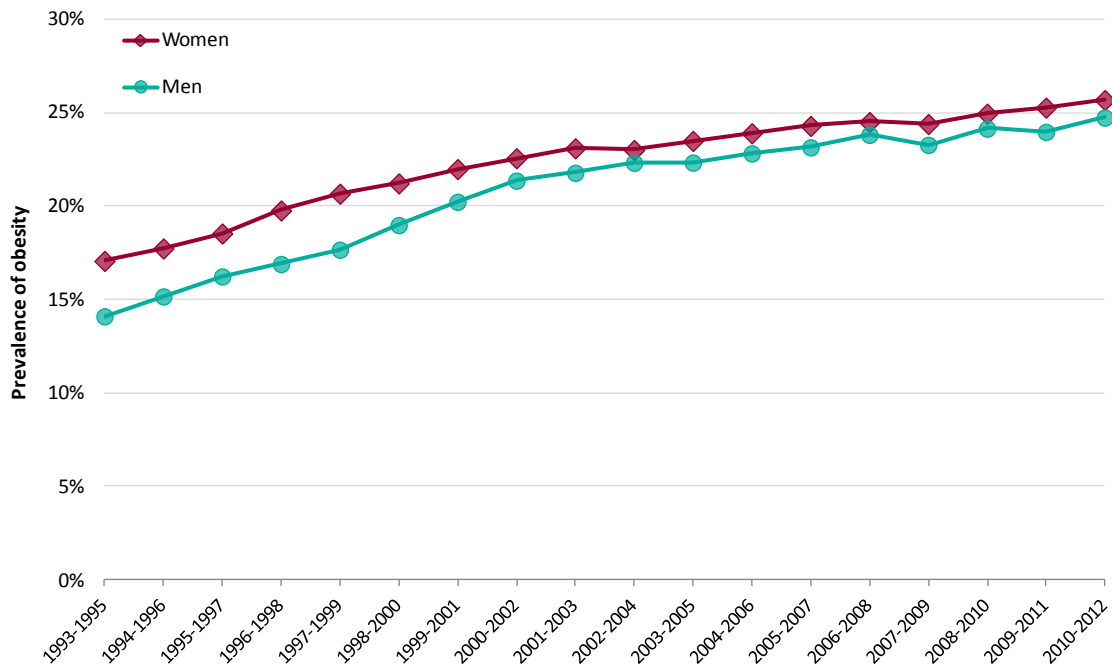
7. National Institute for Health and Care Excellence. Return on Investment Tool.
September 2013

Obesity

Prevalence of obesity and overweight

Obesity presents one of the major health challenges globally, nationally and locally. In 1980, eight per cent of adult women and six per cent of adult men were classified as obese. In less than 35 years, the majority of people are now overweight or obese; In England 63.8% and in London 57.3% of adults are either overweight or obese. Overweight and obesity in adults is predicted to reach 70% by 2034.

Figure 3. 88: Trend in obesity prevalence among adults



Source: Health Survey for England 1993-2012 (3-year average)¹

More than 6 out of 10 men are overweight or obese (66.5%)



More than 5 out of 10 women are overweight or obese (57.8%)



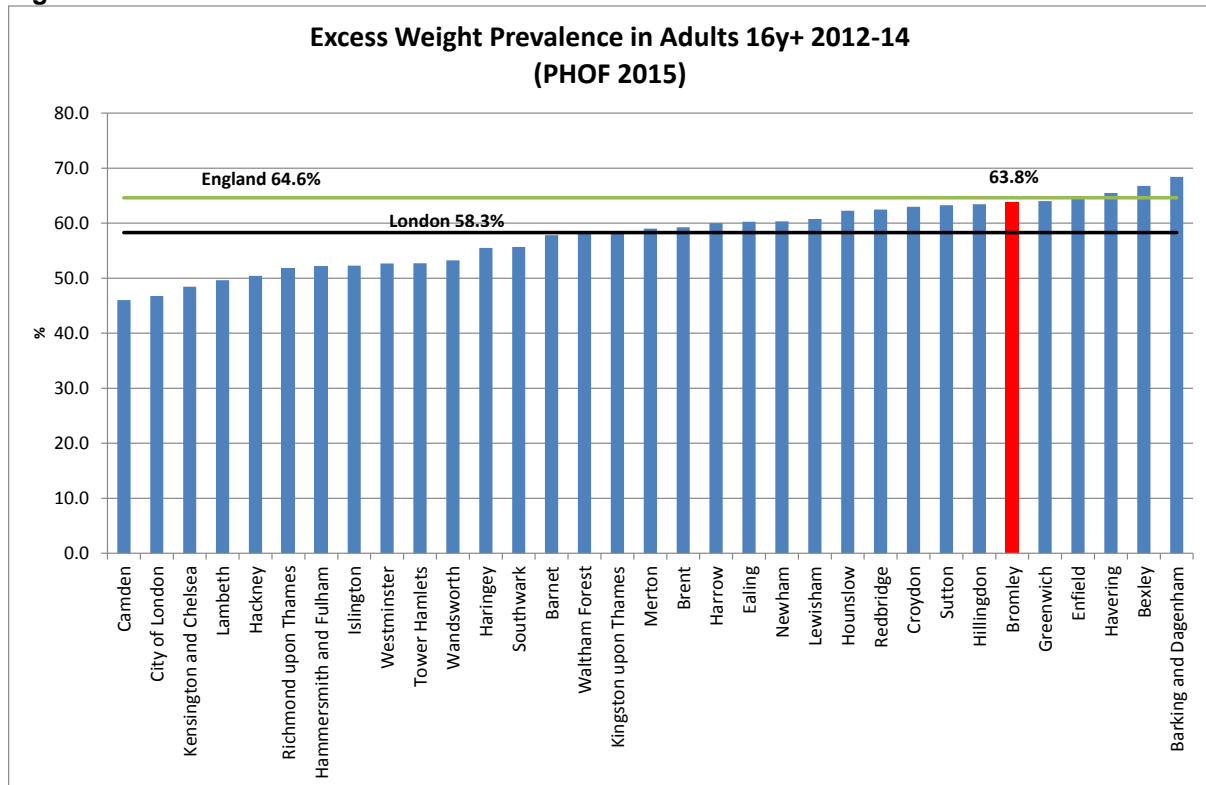
Adult (aged 16+) overweight and obesity: BMI \geq 25kg/m²

Source: Health Survey for England 1993-2012 (3-year average)¹

The current burden of obesity in Bromley

The Public Health Outcomes Framework 2015 reported that 64% of Bromley’s over 16 year population are either overweight (>25 BMI) or obese (>30 BMI), which represents approximately 163,966 adults. The estimated prevalence of obesity in adults is 21.2% (2014 Health Profile), which represents 54,484 adults. Bromley is ranked as the sixth highest prevalence of excess weight in London, higher than populations with similar populations such as Hillingdon and Sutton.

Figure 3. 89



Source: PHOF, 2015²

Childhood obesity

In 2013-14 the National Childhood Measurement Programme (NCMP) highlighted that over 21% of children in Reception and 30% in Year 6 were either overweight or obese. Around 8% and 15%, respectively, were obese, this equates to over three hundred 4/5 year olds and four hundred & eighty 10/11 year olds in Bromley. The prevalence of obesity is strongly linked with socioeconomic deprivation and is more prevalent in urban areas of the borough.

There has been little change in the prevalence of obesity in Reception Year between 2005 and 2014, ranging between 7% and 8% annually. With each cohort the prevalence of obesity tends to almost double between Reception Year and Year 6. For example, in 2007/8, 7.3% of the Reception Year children in Bromley were

classified as obese. In 2013/14, when this cohort was in Year 6, 15.4% were classified as obese. Half of parents do not recognise that their children are overweight or obese (Making the Case for Tackling Obesity, 2015 PHE)³.

Health implications of obesity.

Obesity reduces life expectancy by an average of 3 years and severe obesity reduces it by 8-10 years and has a considerable impact on quality of life. Those that are severely obese are 3 times more likely to need social care than those who are a healthy weight (Making the Case for Tackling Obesity, 2015 PHE)³.

Obesity has an attributable risk for Type 2 diabetes of 24%. In tandem with the rising levels of obesity in Bromley, there has been a significant increase in the prevalence of diabetes and residents at risk of diabetes⁴ (see diabetes section). In addition, obesity is a key risk factor for circulatory disease and cancer, which were accountable for 60.4% of the deaths in Bromley between 2010 and 2014.

Table 3. 36: The benefits of a 10 kilogramme weight loss

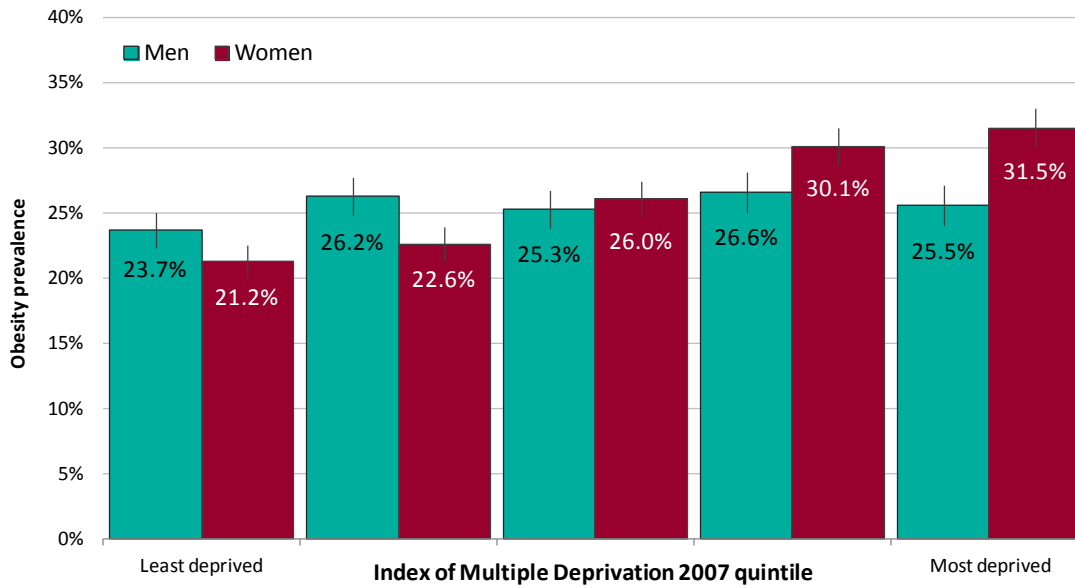
Mortality	Over 20% fall in total mortality
	Over 30% fall in diabetes-related deaths
	Over 40% fall in obesity-related cancer deaths
Blood pressure (in hypertensive people)	Fall of 10 mmHg systolic
	Fall of 20 mmHg diastolic
Diabetes (in newly diagnosed people)	Fall of 50% in fasting glucose
Lipids	Fall of 10% total cholesterol
	Fall of 15% low density lipoprotein
	Fall of 30% triglycerides
	Increase of 8% high density lipoproteins
Other benefits	Improved lung function, and reduced back and joint pain, breathlessness, and frequency of sleep apnoea
	Improved insulin sensitivity and ovarian function when more than 5% weight loss occurs

Table 3.37: The management of obesity and overweight: an analysis of reviews of diet, physical activity and behavioural approaches (2003)⁵.

Inequalities

Obesity in women falls steadily with rising levels of household income, and there is a significant difference in prevalence between the highest and lowest income groups. The differences are smaller for men and the trend is less clear-cut.

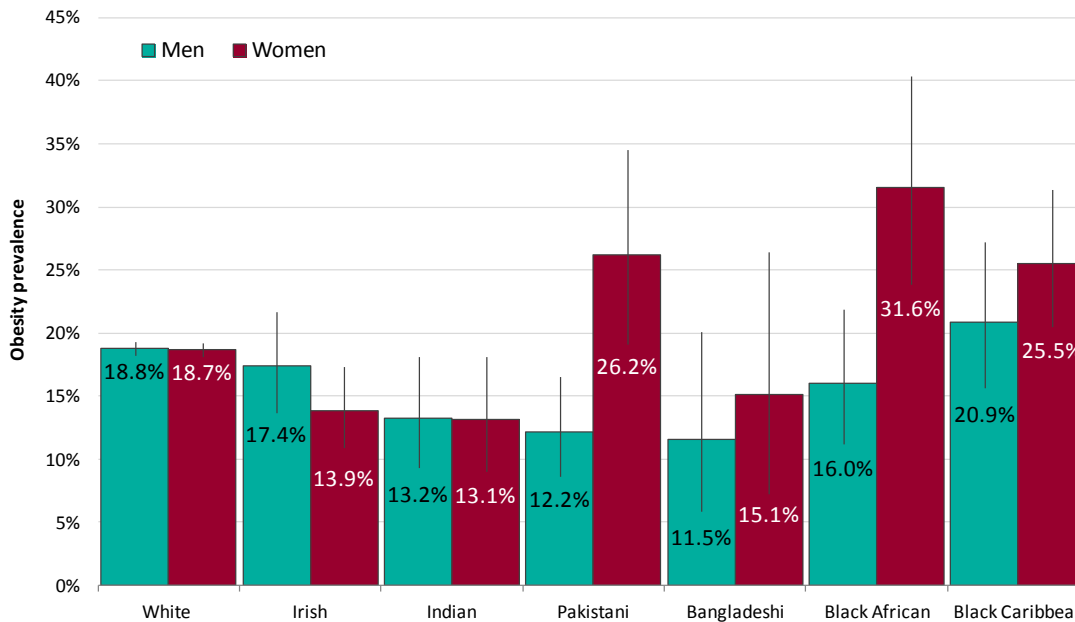
Figure 3. 88: Adult obesity prevalence by deprivation in England



Source: Health Survey for England 2007-2011⁶

Obesity prevalence is higher in Pakistani, Black African and Black Caribbean populations in the UK as shown in **Figure 3.91** below.

Figure 3. 89



Source: Health Survey for England 2006-2010⁷

How much is Obesity costing in Bromley?

Increasing rates of obesity present a major challenge to the health of local people and failure to tackle this will have a significant impact on the Council, NHS and other public service providers.

Annual Cost of Obesity:

- Cost to the wider economy = £27 billion
- Cost to NHS = £5.1 billion
- Cost to Social Care = £352 million
- Obesity attributed sick days = £16 million
- Obesity medication = £13.3 million
- Societal costs of stigma and mental health issues

Source: Public Health England, February 2015⁸.

For every participant who undertakes a 12 session commercial weight management programme, the NHS stands to save £230 over their lifetime⁸.

What this means for Bromley residents and the children in Bromley

Bromley has the sixth highest levels of overweight and obesity in London, 63.8% are either overweight or obese and the prevalence is rising.

Excess weight contributes significantly to the incidence and progression of diseases such as type 2 diabetes, circulatory disease and cancer.

A significant proportion of Bromley's residents (21.2% obese) are at higher risk of these conditions and of premature death.

No single solution creates sufficient impact to reverse obesity: only a comprehensive, systemic program of multiple interventions is likely to be effective.

References – Obesity.

1. Health Survey for England
2. Public Health England. Public Health Outcomes Framework, 2015.
3. Public Health England. Making the Case for Tackling Obesity, 2015.
4. Public Health England. Adult obesity and type two diabetes. July 2014.
5. The management of obesity and overweight: an analysis of reviews of diet, physical activity and behavioural approaches (2003).
6. Health Survey for England 2007-2011
7. Health Survey for England 2006-2010
8. Public Health England, Why invest in obesity. February 2015.
9. National Institute for Clinical Excellence. 2006. CG43 Obesity: NICE guideline

Physical Activity

Physical inactivity is known to be the fourth leading cause of global mortality. A report by the Association of Directors of Public Health showed that if everyone in England met Chief Medical Officer (CMO) guidelines for activity, nearly 37,000 deaths a year could be prevented. Many of the leading causes of ill health in today's society, such as coronary heart disease, cancer and type 2 diabetes, could also be prevented if more inactive people were to become active. In the UK, the incidence of non-communicable disease can be reduced by increasing physical activity.

Table 3. 37: Physical Activity contribution to reduction in risk of mortality and long term conditions

Disease	Risk Reduction	Strength of Evidence
Colon Cancer	30-50%	Strong
Type 2 diabetes	35-40%	Strong
Death	20-35%	Strong
CHD stroke	20-35%	Strong
Hypertension	33%	Strong
Functional Limitation, elderly	30%	Strong
Prevention of falls	30%	Strong
Breast Cancer	20%	Strong
Osteoarthritis disability	22-80%	Moderate
Hip Fracture	36-68%	Moderate
Depression	20-30%	Moderate
Alzheimer's Disease	20-30%	Moderate

Source: Department of Health. Start Active, Stay Active (2011)¹.

In addition to reducing premature death and the incidence of disease, participating in physical activity also has benefits for mental health and wellbeing, quality of life and maintaining independent living in older age. It can play a key role in reducing health and social inequalities. As a result of this wide-reaching impact, physical activity has been described as the 'best buy in public health'.

Prevalence of Physical Activity

National guidance for physical activity

The Chief Medical Officer's national ambition for physical activity:

To have a year on year increase in the number of adults doing 150 minutes of exercise per week (in bouts of 10 minutes or more) and a year on year decrease in those who are inactive, defined as doing less than 30 minutes of exercise per week (in bouts of 10 minutes or more).

CMO Physical Activity Guidelines²;

1. Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
2. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.
3. Adults should also undertake physical activity to improve muscle strength on at least two days a week.
4. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Adult physical activity levels

Gender

Two thirds of men meet national physical activity recommendations* (67%)



Around half of women meet national physical activity recommendations* (55%)



***150 minutes of moderate intensity physical activity per week**
Source: Health Survey for England 2012 (base aged 16 and over)³

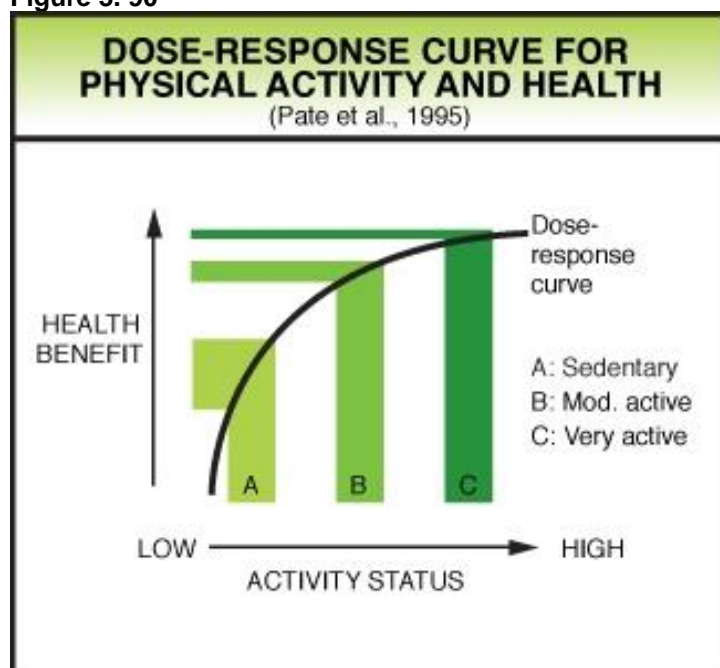
There are good adherence rates to physical activity in Bromley, 58.1% of Bromley population meet the recommended physical activity guidelines of 150 minutes in 2014, which decreased from 62.1% in 2013. The level in Bromley is higher than the London (55.5%) and England (55.6%) average but there is scope to increase levels of physical activity participation in Bromley for health benefits, particularly within the inactive population⁴.

Inactive populations

Although activity rates are high, more than a quarter of the Bromley population were not participating in even 30 minutes of activity a week (25.6%) in 2014, which

increased from 24.1% in 2013. This is less than the London (28.4%) and England (28.9%) proportion of recorded sedentary individuals⁵.

Figure 3. 90



Targeting those adults who are significantly inactive (that is, engaging in less than 30 minutes of activity per week) will produce the greatest reduction in chronic disease. On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual⁶.

How much is Physical Inactivity costing in Bromley?

There are 213.8 premature deaths per 100,000 people per year in Bromley due to physical inactivity⁷.

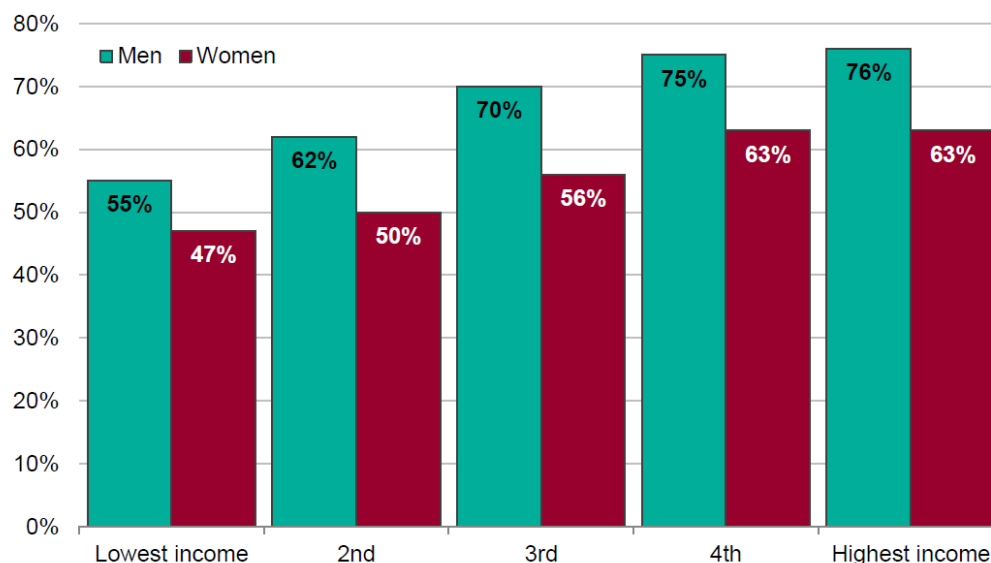
There are additional economic and social benefits of being active, for example a reduction in absenteeism, reduced health and social care costs.

It is estimated that the direct and indirect costs of inactivity in the UK total £20bn a year. According to the National Institute for Health and Care Excellence (NICE), inactivity is costing the national economy in England £8.2 billion per year⁸.

Inequalities and inactivity

Physical activity levels are related to household income. Areas of high socio-economic deprivation are more likely to have higher levels of inactivity⁹. Supporting inactive groups provides the maximum financial return on investment and is the most effective means of narrowing health inequalities.

Figure 3. 91

Figure 4: Proportion of adults meeting physical activity recommendations, by equivalised^a household income and sex, 2012 (base: aged 16 and over)

Source: Health Survey for England 2012 Report *

Some groups in society such as disabled people, older people and some ethnic minority groups are less likely to be active than others. Attracting the hardest to reach groups is challenging and requires specific, attractive, targeted interventions for these groups.

Active Environments

Active Transport - Walking and Cycling

Walking is reported to be the most common activity, and cycling is the fourth most common recreational and sporting activity undertaken by adults in Britain. Walking (for any purpose) accounted for between 37% and 45% of the time that women of all ages spent doing moderate or vigorous-intensity physical activity and between 26% and 42% of the time devoted by men of all ages. Walking and cycling are also important means of transport as well as recreational and sporting activities. In Bromley, walking accounted for 26.5% of all transport trips¹⁰ originating in the Borough between 2010/11 and 2012/13. As a result, it is the most likely way all adults can achieve the recommended levels of physical activity¹¹.

Table 3. 38: Modifiable Risk Factor Related PHOF Indicators

Indicator	Time Period	Sex	Bromley	London	England
1.16 - Utilisation of outdoor space for exercise/health reasons (16+yrs)	Mar 2011 -	Persons	4.3837	8.128	14.015
1.16 - Utilisation of outdoor space for exercise/health reasons (16+yrs)	Mar 2012 -	Persons	14.256	10.5	15.329
1.16 - Utilisation of outdoor space for exercise/health reasons (16+yrs)	Mar 2013 -	Persons	13.638	11.77	17.13
2.06i - Excess weight in 4-5 year olds	2006/07	Persons	20.3	23.2	22.9
2.06i - Excess weight in 4-5 year olds	2007/08	Persons	17.3	22.9	22.6
2.06i - Excess weight in 4-5 year olds	2008/09	Persons	19.7	23.6	22.8
2.06i - Excess weight in 4-5 year olds	2009/10	Persons	20.6	24.4	23.1
2.06i - Excess weight in 4-5 year olds	2010/11	Persons	20.8	23.5	22.6
2.06i - Excess weight in 4-5 year olds	2011/12	Persons	20.3	23.3	22.6
2.06i - Excess weight in 4-5 year olds	2012/13	Persons	21.1	23.0	22.2
2.06i - Excess weight in 4-5 year olds	2013/14	Persons	21.3	23.1	22.5
2.06ii - Excess weight in 10-11 year olds	2006/07	Persons	28.0	35.6	31.7
2.06ii - Excess weight in 10-11 year olds	2007/08	Persons	28.1	36.2	32.6
2.06ii - Excess weight in 10-11 year olds	2008/09	Persons	31.5	36.0	32.6
2.06ii - Excess weight in 10-11 year olds	2009/10	Persons	31.3	36.9	33.4
2.06ii - Excess weight in 10-11 year olds	2010/11	Persons	30.9	37.0	33.4
2.06ii - Excess weight in 10-11 year olds	2011/12	Persons	31.3	37.5	33.9
2.06ii - Excess weight in 10-11 year olds	2012/13	Persons	32.0	37.4	33.3
2.06ii - Excess weight in 10-11 year olds	2013/14	Persons	29.9	37.6	33.5
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15	Persons	9.9	6.1	8.2
2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey)	2014/15	Persons	6.6	3.4	5.5
2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey)	2014/15	Persons	3.3	2.7	2.7
2.12 - Excess Weight in Adults	2012	Persons	65.0	57.3	63.8
2.13i - Percentage of physically active adults	2012	Persons	62.1	57.2	56.0
2.13i - Percentage of physically active adults	2013	Persons	58.7	56.2	56.0
2.13i - Percentage of physically active adults	2014	Persons	60.2	57.8	57.0
2.13ii - Percentage of physically inactive adults	2012	Persons	24.1	27.5	28.5
2.13ii - Percentage of physically inactive adults	2013	Persons	24.5	27.5	28.3
2.13ii - Percentage of physically inactive adults	2014	Persons	24.0	27.0	27.7
2.14 - Smoking Prevalence	2010	Persons	17.0	19.4	20.8
2.14 - Smoking Prevalence	2011	Persons	17.5	19.5	20.2
2.14 - Smoking Prevalence	2012	Persons	17.8	18.0	19.5
2.14 - Smoking Prevalence	2013	Persons	16.0	17.3	18.4
2.14 - Smoking prevalence - routine & manual	2011	Persons	24.3	27.5	30.3
2.14 - Smoking prevalence - routine & manual	2012	Persons	26.1	25.7	29.7
2.14 - Smoking prevalence - routine & manual	2013	Persons	33.7	24.9	28.6

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

What this means for Bromley residents and the children in Bromley

There is scope to increase levels of physical activity participation in Bromley to increase health benefits. Targeting inactive populations will produce the greatest reduction in chronic disease.

References Physical Activity

1. Department of Health. Start Active, Stay Active. A report on physical activity for health from the four home countries' Chief Medical Officers (2011).
<http://www.bhfactive.org.uk/userfiles/Documents/startactivestayactive.pdf>
2. Department of Health. UK physical activity guidelines (2011).
<https://www.gov.uk/government/publications/uk-physical-activity-guidelines>
3. Data from the Health Survey for England report, 2012, published by the Health and Social Care Information Centre www.hscic.gov.uk/catalogue/PUB13218
4. Public Health England. Public Health Outcomes Framework 2014.
5. Public Health England. Public Health Outcomes Framework 2014
6. British Heart Foundation. Economic Costs of Physical Inactivity (2013).
<http://www.bhfactive.org.uk/userfiles/Documents/economiccosts.pdf>
7. UK Active. Turning the tide of inactivity (2014).
http://ukactive.com/downloads/managed/Turning_the_tide_of_inactivity.pdf
8. National Institute for Health and Care Excellence. Costing report: Four commonly used methods to increase physical activity (2006).
<https://www.nice.org.uk/guidance/ph2/resources/four-commonly-used-methods-to-increase-physical-activity-costing-report2>
9. Data from the Health Survey for England report, 2012, published by the Health and Social Care Information Centre www.hscic.gov.uk/catalogue/PUB13218
10. Transport for London: London Travel Demand Survey 2015
11. National Institute for Health and Care Excellence. Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation (2012).
<http://www.nice.org.uk/guidance/ph41/resources/guidance-walking-and-cycling-local-measures-to-promote-walking-and-cycling-as-forms-of-travel-or-recreation-pdf>
12. National Obesity Observatory. Standard Evaluation Framework for physical activity interventions, 2012.

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In Depth Analysis

4. Housing and Homelessness

Housing is a fundamental need for good health and wellbeing, and inequalities in a range of health issues can be tracked back to the quality of housing. Everyone is potentially at risk from the effect of poor housing conditions as there is clear evidence that links poor health with poor housing. Furthermore, the location, type of housing and access to amenities also contributes to the health inequalities. Those most susceptible are children, older people and those with chronic health problems. For many already deprived communities, the only housing available is substandard thus worsening pre-existing health conditions and making vulnerable individuals more housebound and at risk of homelessness.

The threat of homelessness remains an issue for an increasing number of people in Bromley. Homelessness can be defined as: a lack of (or imminent threat of a lack of) safe, secure accommodation that is appropriate to the household's needs. This can be:

- caused by personal circumstances such as relationship breakdown, family unwilling to accommodate, debt, addiction and substance misuse.
- as a consequence of external environmental factors such as a lack of affordable housing, difficult housing market conditions, a strained economic climate and policy reforms with knock on effects on welfare, poverty and unemployment.

The Local Housing Market

Based on 2011 Census data, in Bromley there were 130,862 households, this figure is predicted to increase steadily over coming years with the average household size set to decrease. Currently, approximately 31% are single person households and based on socio-economic trends this is predicted to continue rising. 2011 Census data shows 135,036 dwellings within Bromley, of which approximately 71% are in owner occupation and approximately 13% are in the private rented sector. The Council no longer owns any housing stock and all social rented housing is supplied through Housing Associations (Registered Providers) which accounts for around 14% of the Borough's dwellings. **Table 4.1** shows the change in tenure mix over the last ten years. The falling level of owner occupation is likely to be a result of fewer first time buyers entering the market, partly due to a decrease in availability of mortgage finance in an increasingly inflated housing market.

The growth of the private rental sector (8.5% to 13.3% of dwellings) reflects the fall in home ownership and it is difficult to speculate over the impacts this shift in tenure may have. Although housing standards are largely unregulated within the private rented sector (unlike the social rented sector), as the increase in private renting is

assumed to be from households who would have, under past market conditions, purchased their own property, it may be a reasonable assumption that these households are less likely to be low income households and are therefore less likely to be in the poorer quality (lower quartile) of private rented sector properties. However, the knock on effects are unknown and the general increase in demand for private rental sector housing is unlikely to increase housing standards within this lower quartile. What is clear is that the increase in demand has driven a significant rise in rental prices for lower quartile rents. These are estimated to have risen about 5% over the last year within the Borough (SELHP Housing Market Bulletin average lower quartile rental price for a two bed flat), whilst average household income is believed to have stagnated. These trends are even more extreme in the adjoining southeast London boroughs, such as LB Greenwich where the private rental sector has doubled from approximately 10% to 20% of dwellings over the same 10 year period.

Table 4. 1: Percentage Household Tenure in Bromley

	2001	2011
Owens outright (%)	32.5	33.4
Owens with a mortgage or loan (%)	42.7	37.5
Shared ownership (part owned and part rented) (%)	0.9	0.8
Social rented: Rented from council (Local Authority) (%)	1.4	1.5
Social rented: Other (%)	12.7	12.6
Private rented: Private landlord or letting agency (%)	7.8	12.4
Private rented: Other (%)	0.7	0.9
Living rent free (%)	1.2	0.9

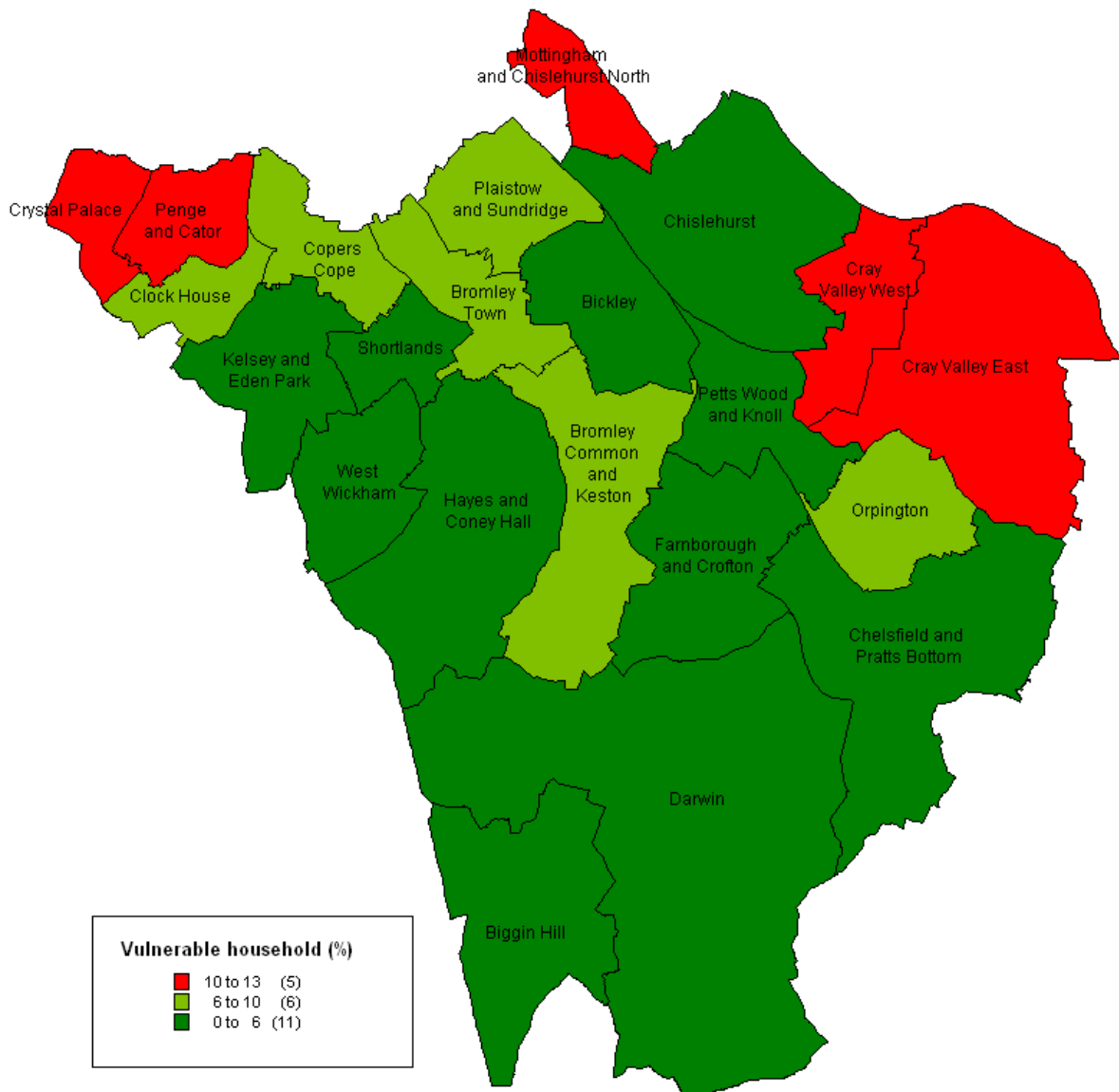
Source: ONS Census 2011

A study of private sector housing conditions (2009 report) indicated that approximately 36% of private sector dwellings in the Borough fail the Government's Decent Homes Standard. The properties in poorest condition are, unsurprisingly, often within the lower quartile of rental prices, and are therefore more likely to be occupied by those on low household incomes. A disproportionate number of vulnerable people, particularly older people, fall within this category.

The number of vulnerable households occupying non-decent dwellings highlights inequalities across the borough. Vulnerable households are four times more likely to occupy non-decent dwellings if they live in certain wards within the borough, illustrated below.

Figure 4. 1:

Vulnerable households in non decent dwellings as a percentage of all dwellings



Source: P1E Quarterly return: Households dealt with under the homelessness provisions of the 1996 Housing Act, and homelessness prevention and relief DCLG.

This is an area where local data (such as the number of referrals for minor adaptation or reports on disrepair) is needed to inform evidence on the current and future impact on health.

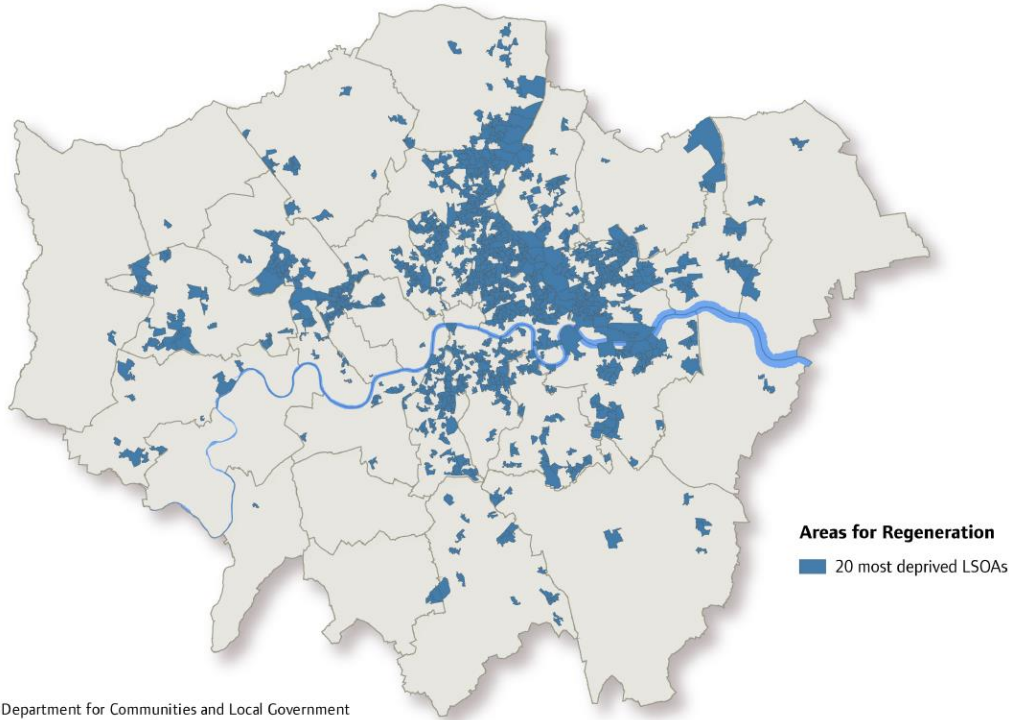
Local issues and evidence

The London Plan Map in **Figure 4.2** (copied below) identifies 6 areas in Bromley, as Regeneration Areas. The areas include:

- Betts Park area
- Maple Rd, Franklin Rd area
- Turpington Lane area

- Cotmandene Cres, Whippendell Way area
- Blacksmith Lane, Wooten Green, Rookery Gardens area
- Quilter Road, Ramsden area

Figure 4. 2



Source: Department for Communities and Local Government
ONS Super Output Area Boundaries.
© Crown copyright. All rights reserved.
Greater London Authority 100032379 (2009)

The London Plan Review Draft Consultation Plan (2009)

The London Plan highlights these areas based on information about

- income,
- employment,
- health deprivation and disability,
- education, skills and training,
- barriers to housing,
- crime.

Generally Bromley Borough scores favourably, however the pattern of deprivation scores, set out in detail in the Bromley Joint Strategic Needs Assessment (JSNA) 2011 is varied within the Borough, with concentrations of poorer scores to the north west of the Borough in Crystal Palace, Penge and Anerley, to the north in Mottingham, and to the east in the Cray Valley, as well as centrally through Downham and Bromley Common.

The London Plan notes that addressing issues in these areas provide the greatest opportunity to improve health and reduce health inequalities. However, areas the

London Plan map are a snapshot highlighting tightly drawn artificial electoral districts. They do not take account of changes taking place over time, the picture in the wider area or other areas where the Council and partner organisations are already seeking to address issues of renewal, notably other parts of Crystal Palace, Penge & Anerley, the Cray Valley and Mottingham.

The Need for Housing that is Affordable:

The Council has a duty to seek where possible to prevent homelessness and where not, to provide appropriate advice and assistance to enable households to secure alternative suitable accommodation.

Homeless prevention can be defined as giving people the ways and means to assist them to meet their housing need in order not to experience homelessness. Early intervention is almost if not always the key to ensure timely interventions which could include providing housing related support as required. This approach not only prevents the loss of accommodation but also reduces the impact such experiences may have on peoples' health such as increased anxiety and depression, feelings of helplessness and worthlessness, increased dependency on services and reduced self-reliance and sometimes self-belief.

This approach has enabled us to significantly reduce the number of homeless households living in temporary accommodation. However the demand for, and supply of housing that is affordable have both been severely impacted by the current housing market and welfare reform, resulting in increasing difficulty in securing prevention solutions and accessing the private rented sector for low-income and benefit dependent households. As a result the number of homeless households in temporary accommodation year on year is increasing with many families being placed outside of the borough boundaries. The level of demand from London Boroughs has also seen a rise in the number of households having to be placed into emergency shared facility accommodation.

Currently, there are 40 families in shared facilities, 26 of which have exceeded the 6 weeks threshold. This is the highest level it has been in the last five years. The **table 4.2** below demonstrates the steady increase and includes statutory quarter 1 figures for households living in temporary accommodation

Table 4.2: Households living in temporary accommodation

2010/11	2011/12	2012/13	2013/14	2014/15	Current
427	612	764	824	1010	1051

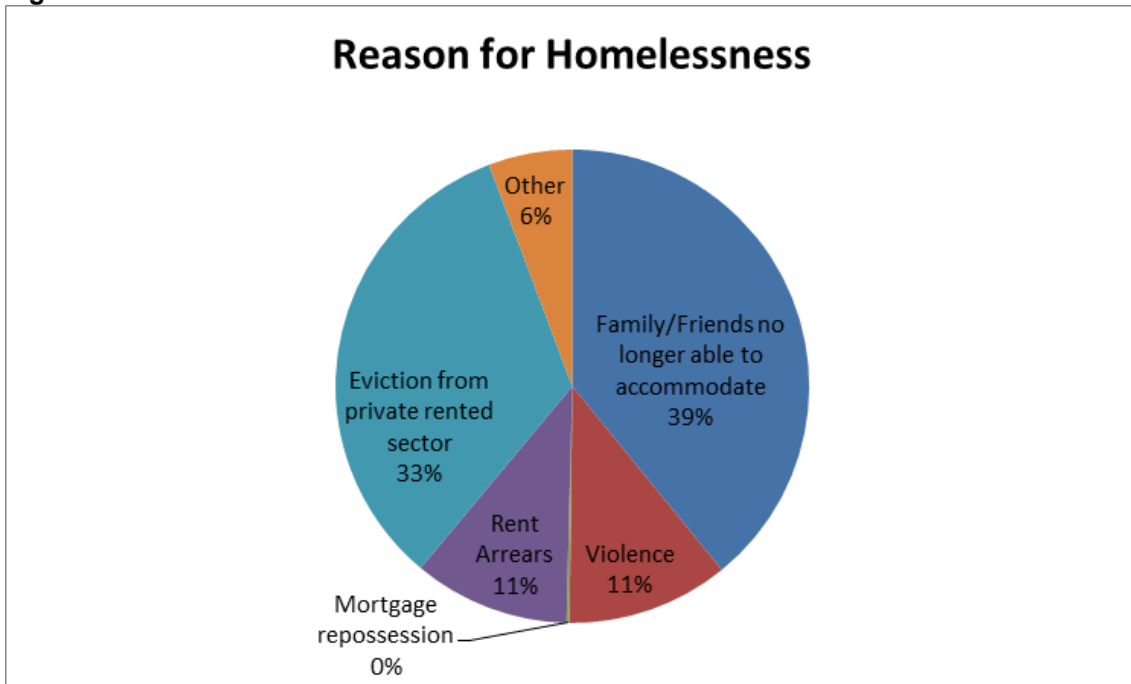
Source: P1E Quarterly return: Households dealt with under the homelessness provisions of the 1996 Housing Act, and homelessness prevention and relief DCLG.

The impact of temporary housing goes beyond the uncertainty and unsettledness that results from feeling displaced and can impact both physically and mentally on homeless households. Co-ordination of services to these groups is critical to ensure that they have the necessary information to enable them to exercise decisions or choice over their situation and are able to access health and support services.

Accepted Homeless Cases:

More than 3,000 households present at imminent risk of homelessness each year. More than 60% of these households can be assisted through housing advice and support intervention to prevent or resolve their homelessness. Of those where homelessness cannot be prevented, a full assessment is undertaken to establish whether the council owes a statutory homelessness duty. During 2014/15 a full statutory rehousing duty was accepted towards 551 households. The number presenting is rising again this year, with predictions of further increases arising from the next tranche of welfare reform.

Figure 4.3: Loss of Accommodation

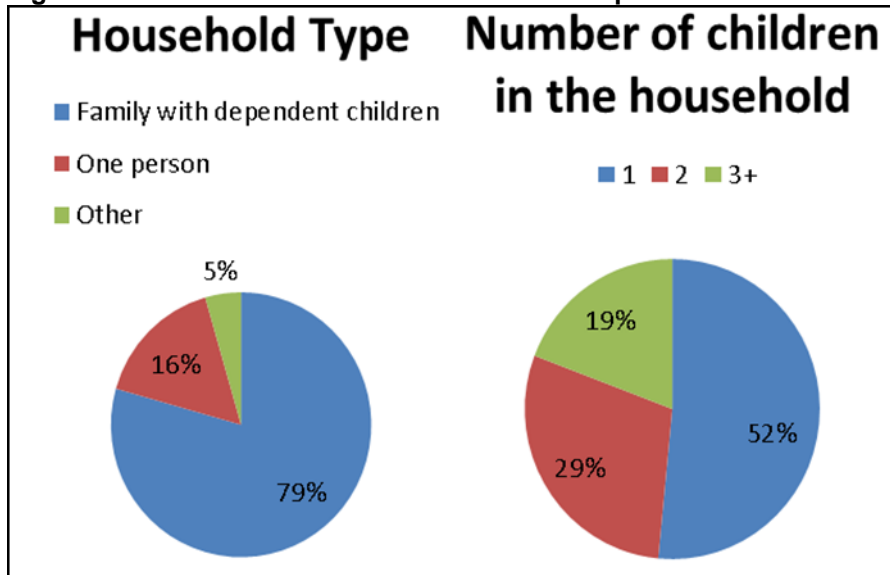


Source: 2014-15 P1E Quarterly return: Households dealt with under the homelessness provisions of the 1996 Housing Act, and homelessness prevention and relief DCLG.

Whilst the largest cause of homelessness is that family and friends are no longer willing to accommodate, this in fact conceals many other factors. Increasingly many of these families had independent accommodation and have had to move back into very overcrowded conditions with family and friends mainly because of either affordability or relationship breakdown and this arrangement cannot be sustained in

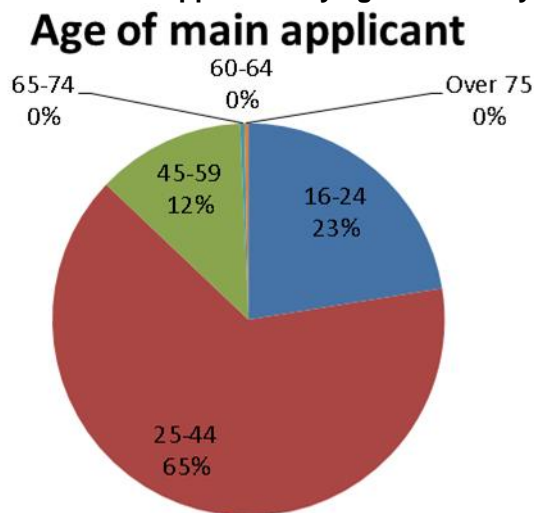
the longer term. With an increasing lack of options in the private sector for lower income households they end up presenting as homeless. For some of these families, the impact on their health is evident whilst others are likely to develop stress and anxiety thus increasing the demand and reliance on primary or secondary health services.

Figure 4. 4: Homeless Households – household profile



Source: 2014-15 P1E Quarterly return: Households dealt with under the homelessness provisions of the 1996 Housing Act, and homelessness prevention and relief DCLG.

Figure 4. 5: Main applicants by age in Bromley.



Source: 2014-15 P1E Quarterly return: Households dealt with under the homelessness provisions of the 1996 Housing Act, and homelessness prevention and relief DCLG.

Figure 4.4 indicates that most homeless approaches are from family household types with 1 or 2 dependent children who in the main would require 2 bedroom accommodation. The demand for this size of accommodation in Bromley is by far the largest. This is reflective of many London boroughs in terms of the level of need for 2

bedroom accommodation, however, unlike many inner London boroughs, Bromley does have a smaller percentage than average of larger households. This size of accommodation is also one of the most difficult to source in the private rented sector due to overall demand.

In terms of family profile, approximately 82% declare that they are a lone parent household. However, in many cases there may be a partner who is not living permanently with them for a number of reasons.

Welfare Reform:

Since the introduction of the Welfare Reform in 2012, more than 200 households in Bromley have been affected predominantly by the household benefit cap and 1,500 households by the removal of the spare room subsidy. Households have also experienced further changes in their income levels resulting from welfare reform including changes in council tax support and personal independence payments.

Currently households are entitled to a maximum of £26,000 per year in benefits. The proposal to reduce this figure further to £23,000 per year means that households will experience a further decrease in income of approximately £57 per week. This change within Bromley will initially affect a further 276 households.

Anecdotal evidence from direct contact with clients suggests that the decrease in disposal income contributes to poor emotional wellbeing. The majority of the households seen during our debt advice appointments are almost always very distressed and upset. For some, their self-confidence is eroding, thus decreasing their self-belief in taking proactive actions to improve their circumstances which could lead to some form of mental health issues. For those with already diagnosed mental health problems, these reforms add more strain and exacerbate their condition.

The trends that have thus far been identified from the work undertaken by the Debt Advice Officer suggest that some households experience complex issues in addition to the pressures and strains from the welfare reform.

- For large single parent households, going out to work is almost impossible due to child care challenges.
- Households are more likely to borrow in order to breach the shortfall or meet a need
- With increased borrowing, the likelihood of falling into debt is increased which if not managed would have a direct impact on their mental health, child poverty, substance misuse and ultimately a loss of their accommodation.
- Households are faced with the difficult decision of living in the borough or moving to other areas (sometimes away from support networks)

- The move-on options for those in B&B and affected by the Welfare Reforms are very limited, thus extending the time that they spend within this type of accommodation which most often is not suitable.

Despite the focus on homeless prevention and housing options, the above factors continue to increase the level of homelessness, homeless acceptances and the waiting times to secure permanent suitable and affordable housing with a resultant effect on health and wellbeing.

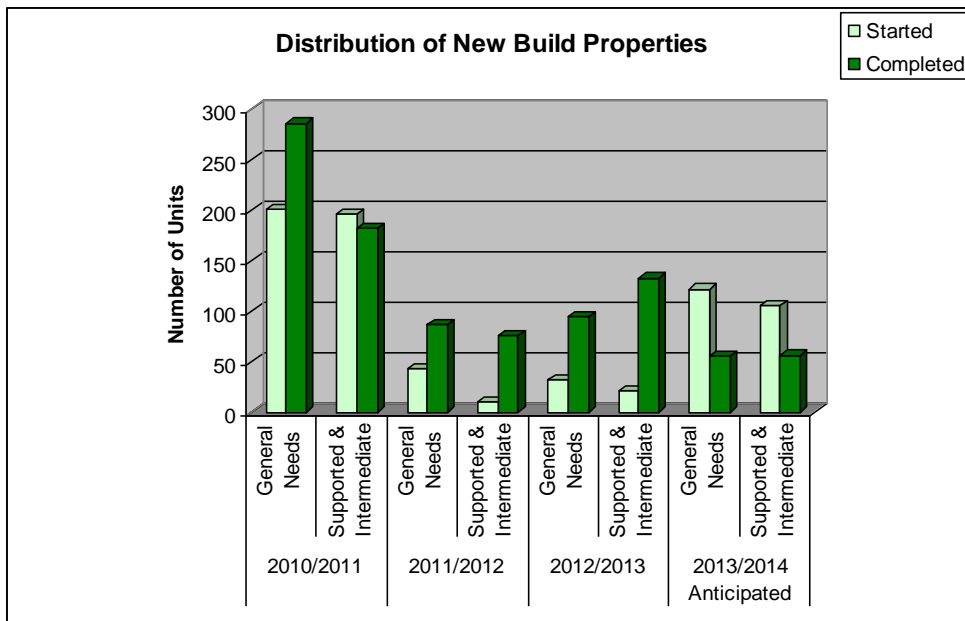
A more targeted and intensive approach is required so that professionals can identify affected households early and sign post them to the relevant services so that preventive work can ensue to prevent or delay loss to accommodation.

Housing Supply

The length of time households remain in temporary accommodation is increasing as move-on options become more limited.

The number of new build housing association properties has reduced and this is a trend which seems set to continue given the funding changes for housing associations. In terms of new affordable housing supply, with the average construction time for a new build development being approximately 18 months, the falling number of new-build affordable units starting on site during 2011/12 and 2012/13 is now translating into a reduction in affordable completions available to let. Currently there are only around 80 new build completions expected during the next 2 to 3 financial years.

Figure 4. 6



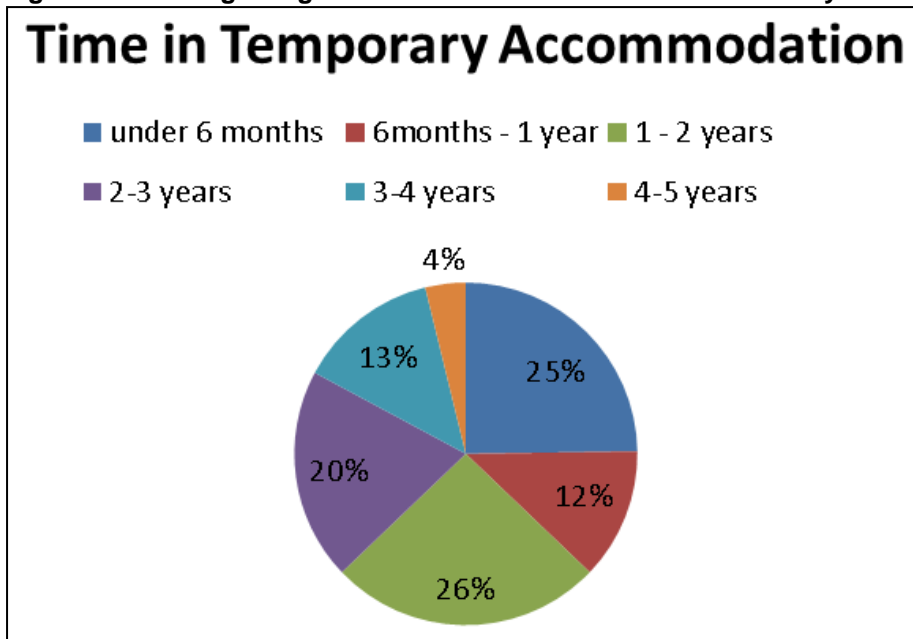
Source: Live Planning Register Data 2013/14

Housing association re-lets have reduced significantly as there is less churn in the social housing stock. Many housing associations are undertaking remodelling of their development programmes in light of the announcements in the Summer Budget and are reporting an anticipated reduction in new builds alongside greater difficulty in acquiring affordable family sized units.

Increasing rental prices in the private rented sector and more restrictive access to mortgages has also made it increasingly difficult for lower income households (including many working households) to access accommodation in the private sector. As such, more households are presenting as homeless and having to be placed in temporary accommodation. With reduced move-on options from temporary accommodation they have to remain in accommodation for increasingly longer periods of time.

The current cost of temporary accommodation for the council is essentially the top up which has to be paid between the amount those households can afford for accommodation (either paying directly or through housing benefit claims) and the amount private landlords are able to command in the current housing market.

Figure 4.7: Average length of time in TA when homelessness duty ended



Source: 2014-15 P1E Quarterly return: Households dealt with under the homelessness provisions of the 1996 Housing Act, and homelessness prevention and relief DCLG.

Whilst the average overall waiting time to secure permanent accommodation is usually under 3 years there are currently many households, particularly those with larger families or with specific location requirements who have been in temporary accommodation in excess of 6 years. The longest waiting time is for 2 bedroom accommodation.

Based on lettings that took place between 01/04/2014 and 31/03/2015, the following are the average waiting times for rehousing from the housing register:

Sheltered:	10 months
0/1 Bed:	15 months
2 Bed:	31 months
3 Bed:	18 months
4 Bed:	26 months

Housing Register:

Number on the housing register as at April 2015:

By Bedsize Requirement:

Table 4. 3

Bedsize Requirement	Count	Banding Category	Count
Bedsit/one bed	981	Housing association tenant transfer	627
2 bed	1485	Homeless bands	1224
3 bed	603	waiting list priority bands	1148
4+ bed	159	Social Care quota queues	229
Total	3228	Total	3228

Source: 2015 Live Data from our Housing Register.

366 out of the 3228 households on the housing register require older persons accommodation,. The remainder require general needs housing stock.

Housing Allocations:

Lettings outturn for housing association stock to which LBB has nomination rights for 2014/15:

Table 4. 4

	Sheltered	0/1 bed	2 bed	3 bed	4+ bed	Total
Homeless - emergency prevention/relieved	11	37	20	10	0	78
Accepted homeless support move-on	12	63	155	67	8	305
leaving care	2	18	2	0	0	22
learning disability	0	16	4	0	0	20
general waiting list	0	4	0	0	0	4
total	45	23	16	29	6	119
total	70	161	197	106	14	548

Source: Housing letting plan LBB

Of the 548 lettings, 70 units were sheltered older persons accommodation.

During 2014/15, 3,714 households applied to go onto the housing register. Of these 2,476 were rejected on the grounds that whilst there was a housing need it did not meet the threshold for inclusion onto the housing register.

The recession has continued to affect the pace of new developments, both when schemes commence and complete. The number of new planning applications being submitted has fallen considerably and a number of new developments have been put on hold by private developers which, in turn, delays the delivery of affordable units secured on those sites. Furthermore, some owners of sites with existing planning permission have sought to reduce the proportion of affordable housing and/or increase its price or reduce/remove the amounts of Payments in Lieu (PiL), arguing that it is no longer financially viable to meet the planning permission requirements. In some cases the developer's arguments have been won on appeal.

Meanwhile, the whole process and methodology whereby the Great London Authority (GLA) / Homes and Communities Agency (HCA) funds new affordable housing development changed from April 2011. Under the adopted Affordable Rent regime Registered Providers (RP) are able to charge up to 80% of local market rent in order to help fund new development and counter the lower levels of public subsidy being invested into new build affordable housing. The rent level changes have particularly affected London and, slightly less, the South. In many parts of the country RP rents are already near or the same as market rents so the capacity to generate extra income from increasing rents is mainly in London and the South.

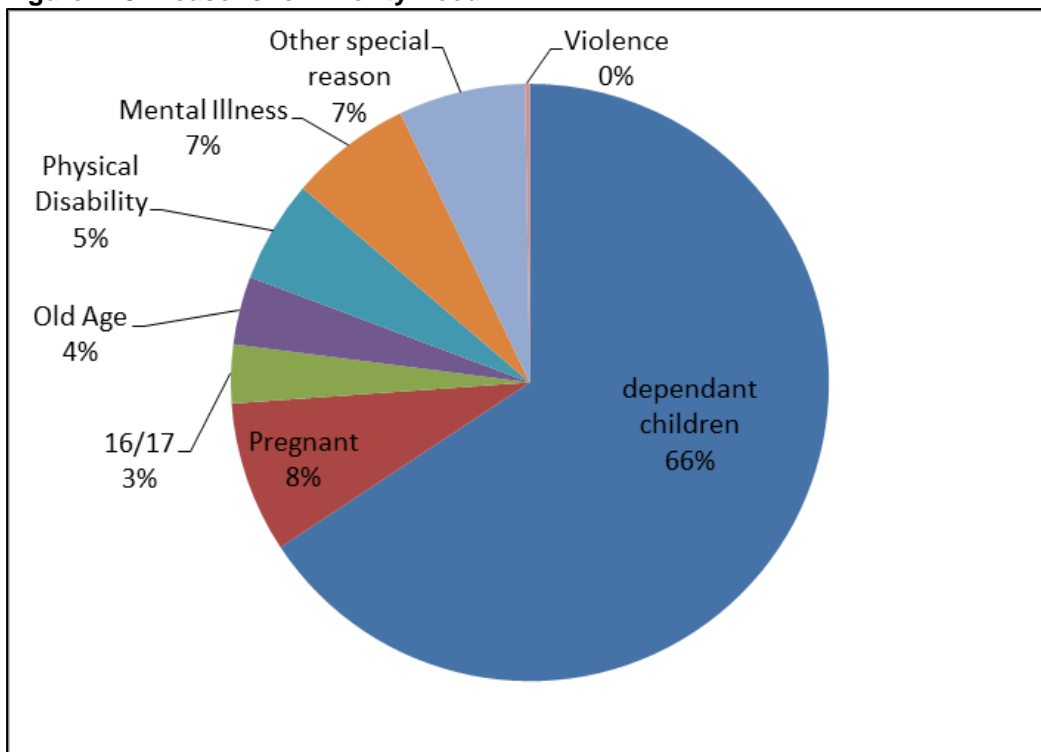
The economic downturn and changes in affordable housing policy take time to fully impact upon new supply. In 2009-10, the bulk of starts on site and completion were already in the development pipeline before the economic downturn hit and changes to affordable housing policy took effect. During 2011/12 and 2012/13 the impact on starts on site has been more obvious with only 53 affordable housing units starting on site during 2011/12 in comparison with the 373 units starting onsite in 2009/10.

The number of new sites coming forward has fallen and those already with planning consent are delayed until grant or sufficient funding is available. In addition, even as the economy starts to re-stabilise, the effects will continue to be felt for some time, given the lead in period for new planning applications and then development to start on site, factors that will also be affected by availability of mortgage lending and deposits to enable people to purchase.

The reduction in planning applications coupled with the marked reduction in new building also significantly increases the difficulty in finding opportunities for the specialist accommodation supply required to meet the range of needs with groups such as those with learning disabilities, physical disabilities, older people etc.

The supply of affordable social housing available to let has steadily declined over the last few years and has contributed to the reported unmet homeless demand figures. Homelessness derives partly from an inadequate supply of social housing but often reflects wider issues, for example, when people face inherent or complex social and financial problems that make it difficult for them to sustain their accommodation.

Figure 4. 8: Reasons for Priority Need



Source: 2014-15 P1E Quarterly return: Households dealt with under the homelessness provisions of the 1996 Housing Act, and homelessness prevention and relief DCLG.

Housing Need and Supply for People with Support Needs:

The provision of specialist and supported housing in the borough is limited for people with mental health problems, 16/17 year olds, people with physical or sensory impairments, drug and alcohol problems and ex- offenders.

Young People

Based on the ages of lead applicants, 23% of the accepted homeless cases are 16-24 year olds and this is set to rise. As the needs of this group become more complex and challenging, the demand for suitable supported environment to enable them develop the required life skills and support to access Education, Training and Employment (ETE) remains crucial and could increase. The prevalence of domestic and associated violence within this group has significantly increased as evidenced by the number of incident and safeguarding reports generated by our current provider. Whilst this trend is worrying, additional monitoring and analysis of the data will be undertaken to identify whether this is an area of need where more support

and resources are needed through structured education and intensive support for this group.

People with Mental Health Needs

Supported housing for people with mental health problems is provided in a variety of forms, from hostel accommodation with shared facilities, to self-contained units offering more privacy and flexibility. Housing support is delivered to tenants in both supported housing and general needs accommodation through the Council's Housing Support Service and through floating support workers. This service provides a co-ordinated and holistic approach to meeting the housing needs of people with mental health problems

The service operates dedicated surgery days at the Green Parks House Psychiatric Unit at the Princess Royal University Hospital with the added flexibility to undertake hospital visits to provide housing advice, options and when necessary take homeless application in a timely manner. This approach ensures timely intervention and planned discharges and minimises the added pressure for the patients resulting from the presenting housing need and promotes speedy recovery process for the patients.

Table 4. 5: Supported accommodation units funded by Bromley (contract monitoring team)

Type	Number
Refuge Spaces	37
People with Learning Disability	12
Ex-Offenders	9
Homeless People	49
Young People/Looked After Children	59

Source: London Borough of Bromley

As the number of people presenting as homeless continues to rise, with more applicants presenting with complex needs, the demand for more specialist schemes to meet their housing need will also increase. Anecdotally, we have seen an increase in the number of applicants with undiagnosed mental health problems and the resulting impact on their ability to maintain their tenancy which eventually leads to homelessness. It is clear that at some point these clients would have sought support from one or more agencies and the opportunity for early intervention was missed. In the long term, substantial cost is incurred not only in terms of housing but also on the demand on other health care and emergency services.

There are pockets of good practice with joined up working between Children's Social Care and housing for 16/17 year olds with a dedicated Senior Practitioner based within the housing department. This ensures that at the point of access, the needs of the Young Person are identified through a holistic joint assessment and a clear

pathway established to meet identified needs. Housing is also represented on the Mental Health and Substance Misuse panels which adopt an action based approach on cases discussed to minimise the long term impact on the individual's health.

Older People

Within the social rented sector, Bromley has an adequate supply of older person's accommodation including sheltered accommodation, however, there is a shortfall of private specialist elderly provision and, to a lesser extent, for shared ownership. This need is set out in The London Plan (2015) Annex 5 which gives an indicative annualised strategic benchmark of 140 private sale units per year and 65 units per year for "intermediate sale". Population projections suggest that this demand is likely to continue. The emerging Bromley Local Plan will consider how best to address this private and intermediate need and an initial evidence based paper on the accommodation choices for an ageing population, has been produce to support the development of draft planning policy.

http://www.bromley.gov.uk/downloads/file/1899/elderly_persons_accommodation_march_2014

Extra care housing is a type of sheltered housing that can offer care and support on site and is ideal for people who are less able to manage on their own. Extra care housing typically offers people aged over 55 years the opportunity to live in a home of their own, even when they have high level care and support needs. It provides a range of housing and care/support services tailored to meet individual needs available 24 hours a day, 7 days a week. The amount of care provided at any time can be flexible to accommodate fluctuating needs, and can be supported by in-built "smart technology" or "telecare" (for example call alarms or sensors to alert staff to particular circumstances). Schemes may be specifically designed to cater for specialist needs, such as for people with dementia. Living within the wider community can help people to maintain and build up the skills needed to retain their independence.

Bromley has recently re-provided much of its accommodation for older people through the development of three new extra care housing developments.

Accessible Housing

Table 4. 6: Housing Register Applicants requiring accessible housing

	Wheelchair Access	Other accessibility	Total
0 Bed	10	21	31
1 Bed	5	7	12
2 Bed	22	19	41
3 Bed	19	13	32
4 Bed	7*		7
Total	60	27	123

Source: 2015 Live Housing Register data LBB

Accessible housing refers to the construction or modification of housing to enable independent living for persons with disabilities. Accessible housing is achieved through architectural design, but also by integrating accessibility features such as ramps, modified furniture, shelves and cupboards, or electronic devices such as lifts in the home. The purpose of accessible design is to achieve complete inclusion to, within and from the living space, to the local community and beyond, and enablement to participate in the usual socio-economic pursuits accessible to any ambulant person.

A sufficient good quality supply of accessible housing to meet local need is critical to the wellbeing of service users through preventing delayed discharges, falls and keeping people independent for longer.

The housing service currently has a dedicated occupational therapist (OT) post who not only works with existing service users to secure suitable accommodation or the provision of aids and adaptations to existing accommodation, but also has a role in securing the development and supply of new accessible housing units.

Up until October 2015 Bromley has relied upon various national and regional standards to cater for the needs of wheelchair accessible living in the UK. The Mayor of London's Accessible Housing Guide produced advice on how to implement the London Plan policy on wheelchair accessible housing which states that at least 10% of new homes should be designed to be accessible or easily adaptable for residents who are wheelchair users.

In addition the South East Housing Partnership devised sub-regional guidelines with standards for accessible living to ensure that new affordable homes for wheelchair users met with the necessary standards and were totally suitable for wheelchair users.

From October 2015, there will be national implementation of the new revised housing standards. The Housing OT role will need to play a critical part in identifying the level and nature of need and ensuring that these requirements are accurately reflected in planning requirements.

It is important that those involved in strategic planning and meeting housing needs locally and regionally, have a thorough grasp of the demographic requirements for housing and are able to calculate well in advance which areas most require accessible housing, and are able to track changing trends in population, so that the correct levels of accessibility can be forecast and provided for. Close liaison with local wheelchair service providers and professionals via the housing OT may assist in determining where the larger types of housing stock is required or where more level terrain is required.

Table 4. 7: Housing Related PHOF Indicators, 2015

Indicator	Time		Bromley	London	England
	Period	Sex			
1.15i - Statutory homelessness acceptances	2010/11	N/A	3.2	3.1	2.0
1.15i - Statutory homelessness acceptances	2011/12	N/A	4.8	3.9	2.3
1.15i - Statutory homelessness acceptances	2012/13	N/A	4.1	4.6	2.4
1.15i - Statutory homelessness acceptances	2013/14	N/A	3.7	5.0	2.3
1.15ii - Statutory homelessness - households in temporary accommodation	2010/11	Persons	3.2	11.1	2.2
1.15ii - Statutory homelessness - households in temporary accommodation	2011/12	Persons	4.6	11.3	2.3
1.15ii - Statutory homelessness - households in temporary accommodation	2012/13	Persons	5.5	11.9	2.4
1.15ii - Statutory homelessness - households in temporary accommodation	2013/14	Persons	6.1	12.8	2.6

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

What does this mean for Bromley residents and for children in Bromley?

There is a need for availability and quick access to good advice and information to manage the expectations of those who are not in a statutory rehousing category.

There is:
increasing demand for affordable accommodation

increasing loss of private rental accommodation and financial difficulties in affording accommodation.

a decreasing supply of affordable housing, exacerbating the gap between supply and demand.

There are:
increasing numbers of households facing a shortfall between benefits and housing costs.

increasing numbers of households and children residing in temporary accommodation and in particular away from the locality.

an increased number of households presenting with minor mental health related issues with increasing pressure on primary care services.

There is increasing demand for private and intermediate older persons' accommodation.

The decrease in disposable income erodes the possibility of people adopting healthy lifestyle choices.

There is a need for more joined up working between services.

For further information please contact Alice Atabong Group Manager, Housing Support (Alice.Atabong@bromley.gov.uk).

5. Older People's Health

The population of Bromley includes a significant proportion of older people (17.4% over the age of 65 years). Population projections suggest that this proportion will increase over the next five years (to 17.9%) and over the next ten years (to 18.9%).

National evidence shows that people aged over 65 years make up one sixth of the population, but use more than one sixth of some health and social care resources⁶, therefore it is important to understand the health needs of this group in order to commission local health and social care services effectively.

This section describes the demography of the population of older people in Bromley and describes their health status.

The Population of Older People in Bromley

There are approximately 56,500 people over the age of 65 years in Bromley (17.4% of the population)⁷

Table 5. 1: Older People Population Projections for Bromley

	2015		2020		2025	
	No.	%	No.	%	No.	%
65 to 74 years	29,300	9.0%	30,000	9.1%	30,200	8.9%
75 to 84 years	18,600	5.7%	19,600	5.9%	23,000	6.8%
85 years and over	8,600	2.6%	9,700	2.9%	11,000	3.2%
All over 65 years	56,500	17.4%	59,300	17.9%	64,200	18.9%

Source: *GLA 2013 Round SHLAA population projections*

Table 5.1 shows that there is a projected increase in the population of over 65s from 17.4% in 2015 to 18.9% in 2025. This increase is chiefly in the 75 to 84 year and over 85 year age groups, which will increase by 23.7% and 27.9% respectively. This is significant, since it is likely that these older age groups will have greater health and care needs.

Whilst the proportion of non-white ethnic populations is 17.9% in the overall population of Bromley, this group represents a much smaller proportion of the over 65 year age group, at only 5.6%.

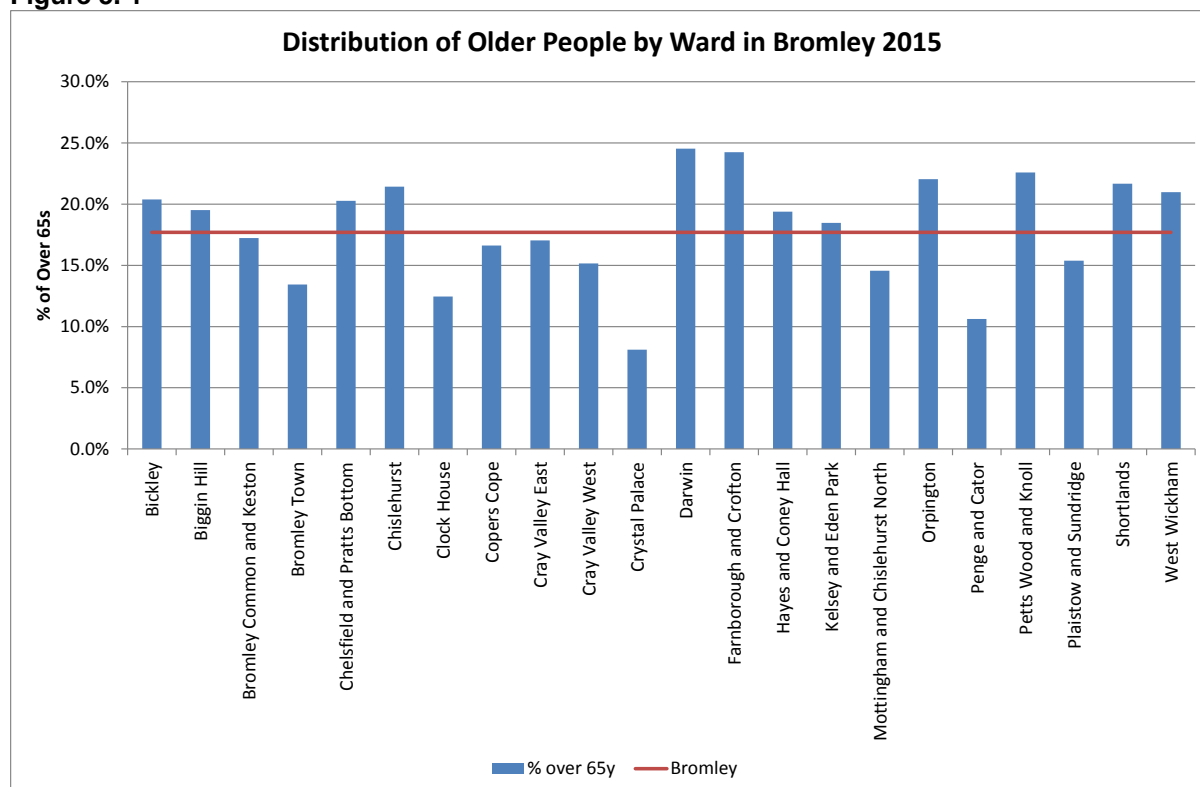
⁶ Focus on the health and care of older people June 2014, Health & Social Care Information Centre

⁷ GLA: 2014 round-trend borough projections long term migration range (April, 2015)

There are a higher proportion of women than men in Bromley in the older age groups, this matches the national picture and is a consequence of the higher life expectancy of women.

The proportion of older people living in Bromley varies between wards in the Borough, from 8.1% in Crystal Palace to 24.5% in Darwin (**Figure 5.1**)

Figure 5. 1



Source: GLA, 2013 Round Population Projection accessed July 2015

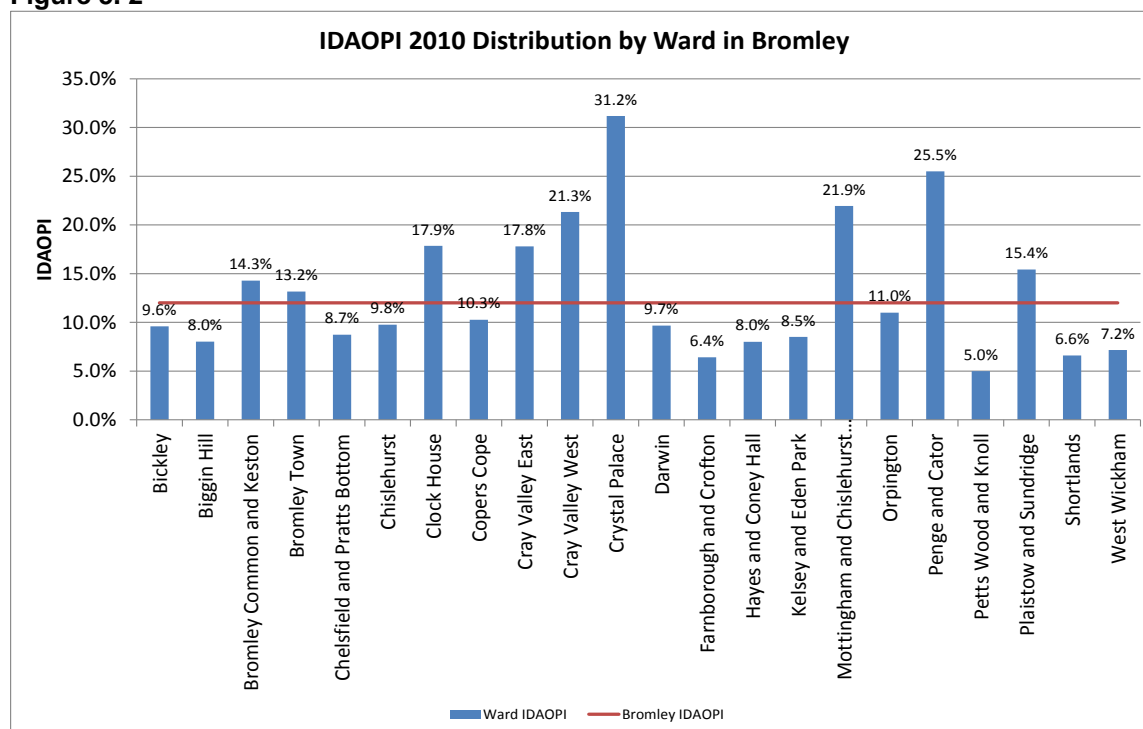
The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of adults aged 60 years or over living in pension credit households as a percentage of all adults aged 60 years or over. It is a measure of older people living in poverty. People living in more deprived areas have greater need for health services.

Bromley has an IDAOPI of 12, which is below the value for England (18).

There is a variation between wards in Bromley as shown in **Figure 5.2**.

Interestingly, Crystal Palace and Penge & Cator wards, which have low numbers of older people, have the highest proportion living in poverty.

Figure 5.2



Source: Greater London Authority calculations based on the Department of Communities and Local Government's Indices of Deprivation 2010.

A significant proportion (29.8%) of over 65s in Bromley live alone. Of these, 75% live in owner occupied housing and 18.6% live in social rented accommodation, this is slightly higher than the figures for households at all ages in Bromley (71.7% and 14.1% respectively).

Life Expectancy at Age 65 Years

Life expectancy upon reaching the age of 65 years in England has been consistently increasing over the last three decades, and in 2011-13, was 18.7 remaining years for men and 21.1 remaining years for women. In Bromley, the life expectancy at age 65 years is higher than for England, at 19.7 years for men and 22.2 years for women⁸

Of more significance to both the individual and to commissioners of health and care services, is the proportion of one's life that one can expect to remain free of limiting long-standing illness or disability - the Disability Free Life Expectancy (DFLE). For the years 2009-11, in Bromley, the DFLE was 12.6 years for men and 14.4 years for women, both significantly higher than the England estimate⁹

This means that men in Bromley at age 65 years can expect 65.4% of their life to be disability free, and women can expect 65.6% of their life to be disability free.

⁸ Public Health Outcomes Framework May 2015

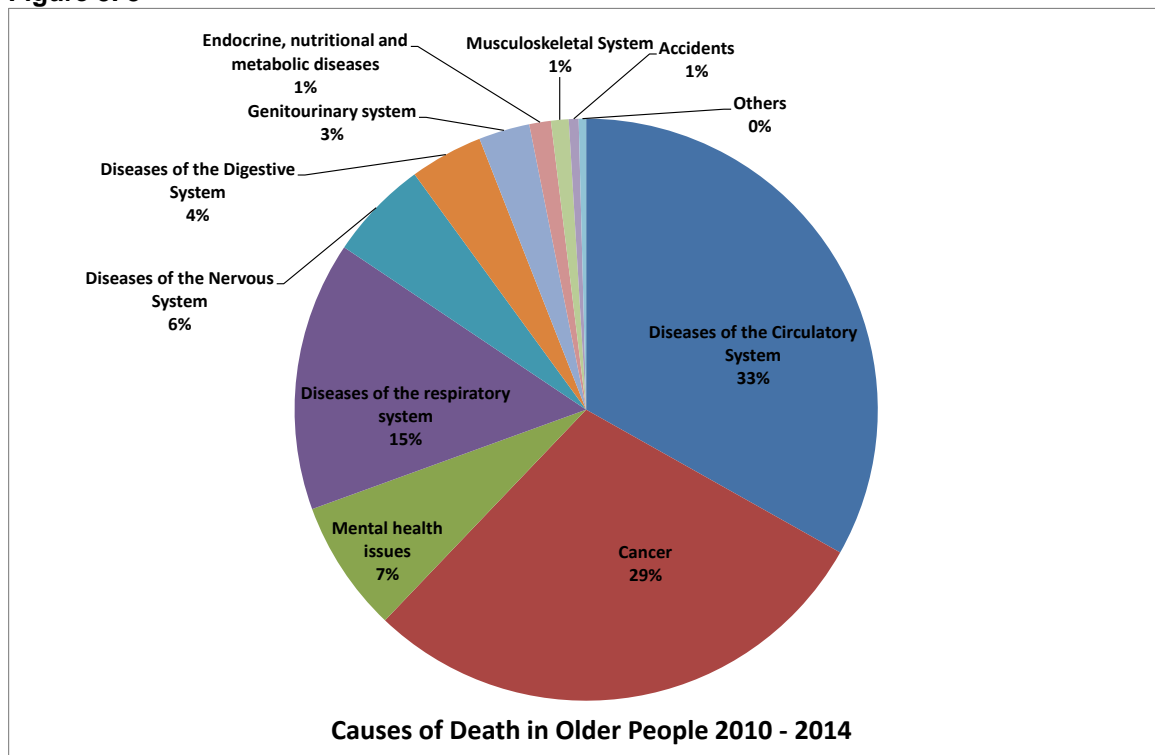
⁹ ONS Disability Free Life Expectancy by Upper Tier Local Authority at age 65, England 2009-11

Causes of Death in Older People

In the five years from 2010-2014 in Bromley, there were 12,783 deaths in people of all ages, of which 11,100 (86.8%) were in people over the age of 65 years. It is therefore unsurprising that the key causes of death are the same for older people as for the overall population. There is a slightly higher proportion of deaths from circulatory disease than from cancer in the older population.

The primary cause of death was given as senescence (old age) in 897 deaths (8.1% of deaths in over 65s), and 1925 (17.3%) of death certificates mentioned senescence at some level of cause of death.

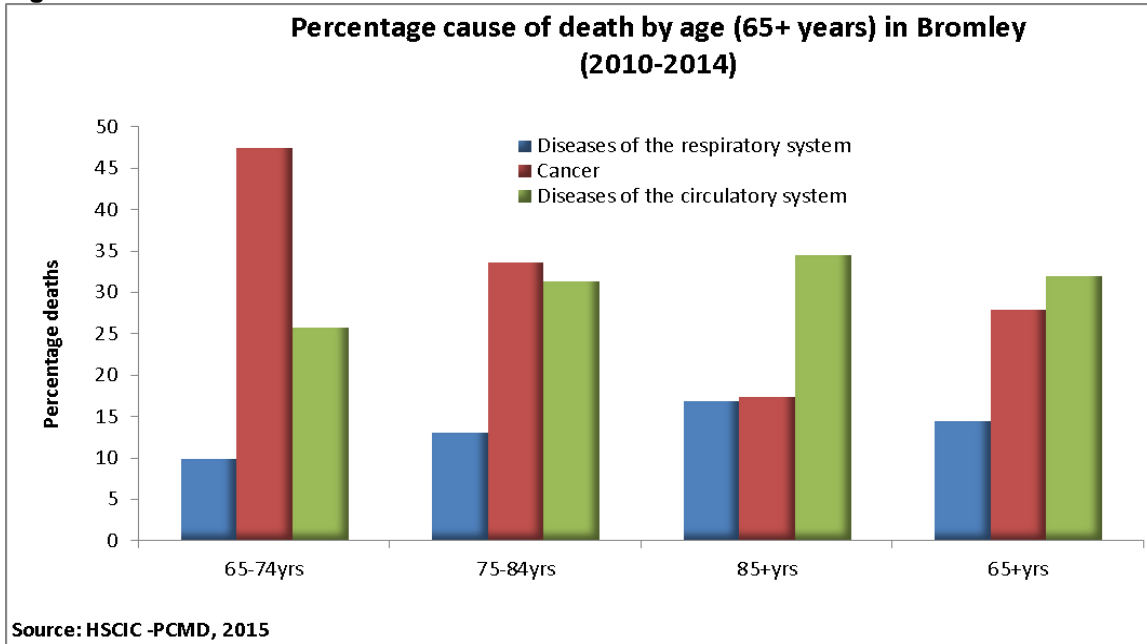
Figure 5.3



Source: PCMD 2015

In the over 65 year population, deaths are more likely to be from cancer in the 65 to 74 year age group and to be from circulatory disease in the older age groups.

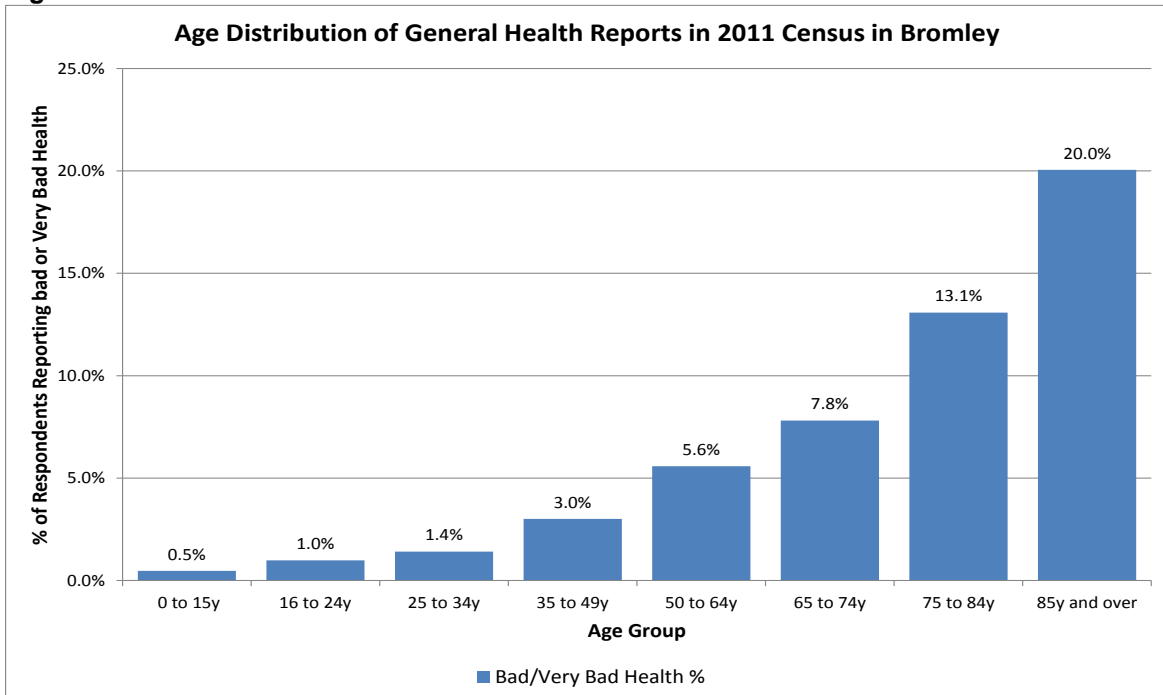
Figure 5.4



Longer Healthier Lives

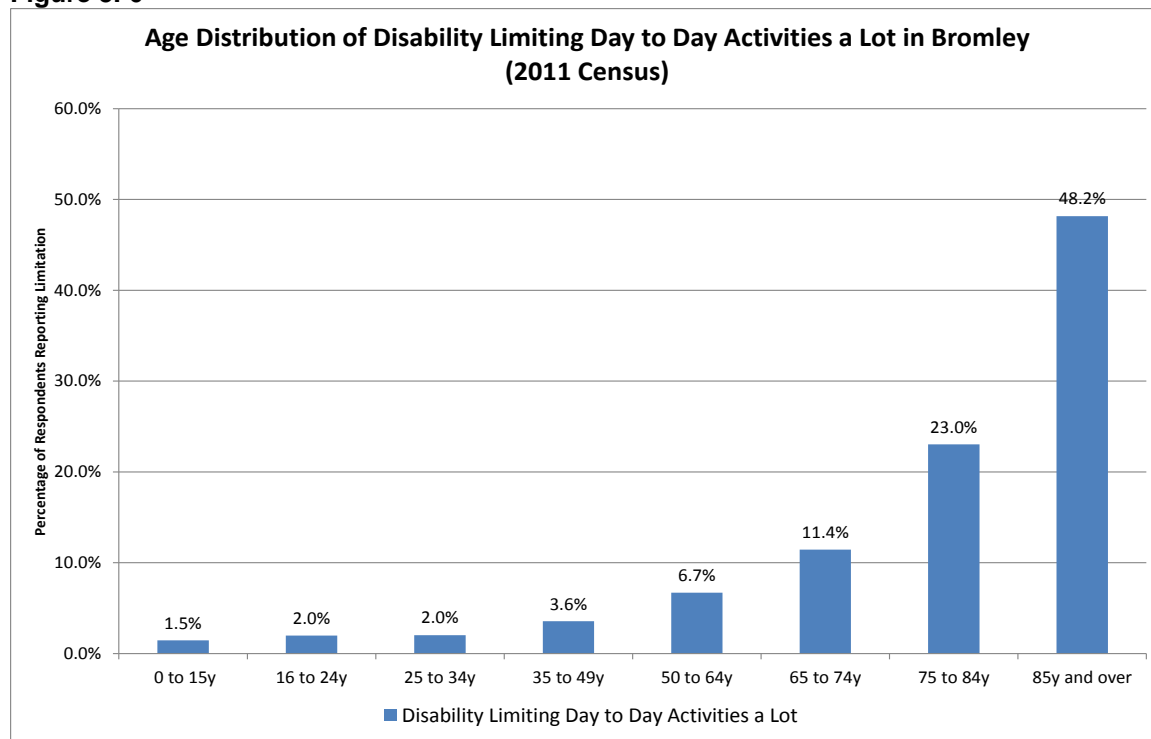
Overall in Bromley, the proportion of people reporting bad or very bad health in the 2011 Census was low at 3.9%, however, as can be seen in **Figure 5.5**, there is an increasing proportion of people reporting bad/very bad health with increasing age, and a particularly sharp rise over the age of 65 years.

Figure 5.5



The picture is similar for the reporting of disability which limits day to day activities a lot (**Figure 5.6**). Overall for Bromley, 8% of people reported this level of limitation through disability, but this proportion rises to 48.2% in those aged over 85 years.

Figure 5.6



Source: ONS Census 2011

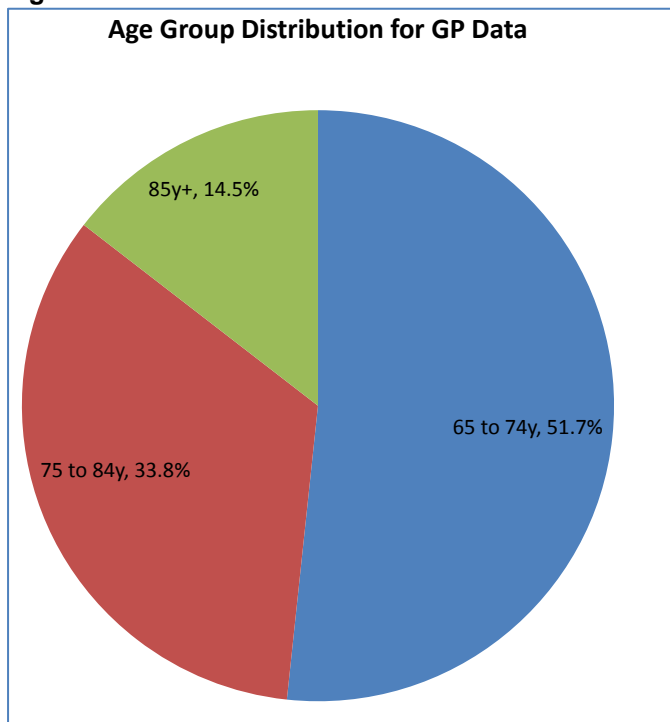
Long Term Conditions in Older People

Long term conditions are more prevalent in older people.

In order to explore the prevalence of long term conditions in older people, Bromley GP Disease Register data from 2013 was accessed and analysed. This included data from all but one of the Bromley practices, and results were available for 57,202 patients aged over 65 years. This figure is greater than the resident population estimate for this age group as the GP registered population is larger than the resident population.

Of this sample, as can be expected, the largest number of people were in the youngest (65 to 74 year) age group and the majority of all over 65s were women (56.2%).

Figure 5.7



Source: Bromley GP Systems 2013

Data were available for a number of key long term conditions as shown in **Table 5.2**. Unfortunately, data for mental illness, other than dementia, was not available. There is also a gap in information as regards a number of other conditions which may cause significant morbidity, such as musculoskeletal or arthritic conditions.

Table 5.2

Condition	Number	% of Over 65s	QOF 2012-13 No.	% Over 65 contribution
Hypertension	29169	51.0%	46028	63.4%
Atrial Fibrillation	5046	8.8%	5252	96.1%
Ischaemic Heart Disease	7961	13.9%	10165	78.3%
Asthma	4085	7.1%	17348	23.5%
COPD	3439	6.0%	4371	78.7%
Diabetes	7753	13.6%	13681	56.7%
Chronic Kidney Disease Stages 3-5	8412	14.7%	10183	82.6%
Heart Failure	1957	3.4%	2252	86.9%
Stroke	4390	7.7%	5122	85.7%
Cancer	4202	7.3%	6813	61.7%
Dementia	1439	2.5%	1794	80.2%

Source: Bromley GP Systems 2013

It can be seen that the over 65s make a significant contribution to the burden of long term conditions overall, representing over 75% of the overall disease burden for most conditions.

The prevalence of conditions in older people is also available from POPPI (Projecting Older People Population Information System) which uses national surveys and research studies to estimate prevalence rates and projected numbers of people suffering from particular conditions. As can be seen from the table below, these are in some cases at marked variance from the Bromley GP disease registers, but may provide valuable information for conditions not included in our search of these registers.

Whilst figures for diabetes and obesity are comparable between the two data sources, GP registers underestimate the number of older people with dementia. It is known that there is under identification of older people with dementia, and measures have been introduced to improve this situation. However, the estimates from POPPI for stroke and COPD fall far short of the numbers on GP registers, despite prevalence modelling from elsewhere indicating that there is under identification in Bromley for these conditions. This may be because POPPI uses surveys and research studies from the years 2005 to 2007 as the basis for its modelling. Therefore, the estimates from POPPI for those conditions for which data was not collected or unavailable from GP registers should be considered as rough estimates only.

Table 5. 3: Comparing Numbers of People Over Age 65 Years in Bromley with Conditions Recorded on POPPI and GP Registers

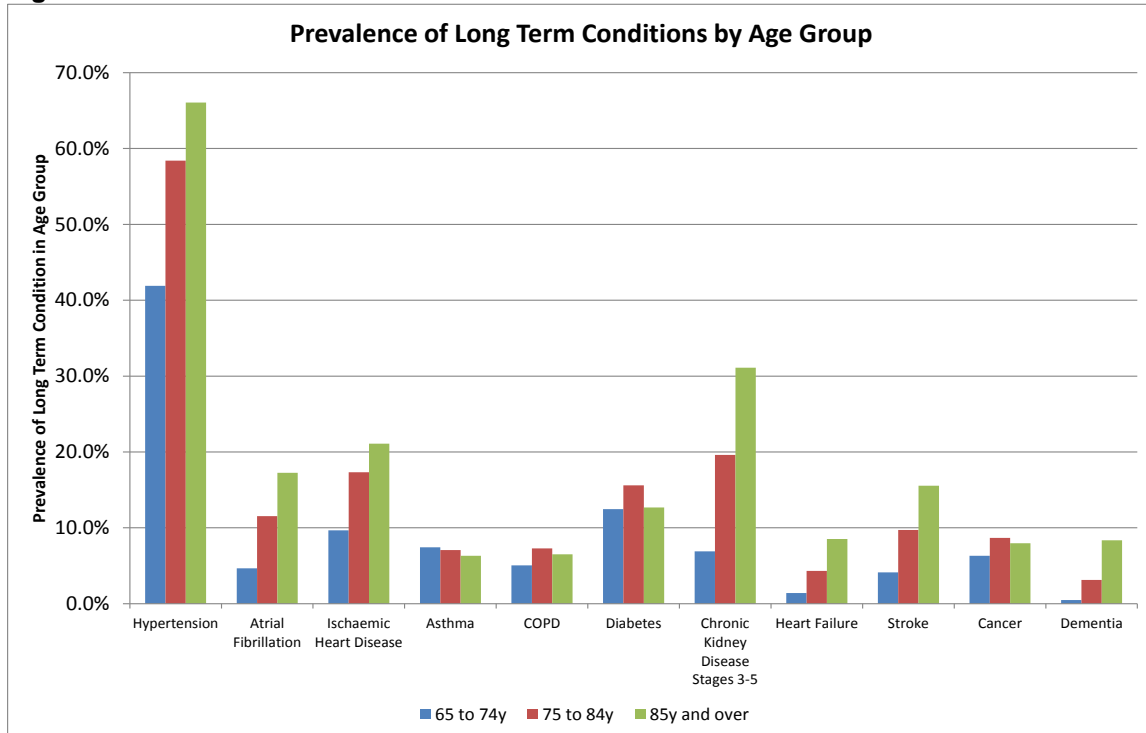
Condition	POPPI Estimate for Bromley 2015	No. of patients on GP Registers in Bromley
Depression	4,956	Not Available
Severe Depression	1,584	Not Available
Dementia	4,222	1,439
Heart Attack	2,776	Not Available
Stroke	1,310	4,390
Bronchitis/Emphysema	953	3,439
Falls	15,402	Not Available
Falls & Admission	1,214	Not Available
Bladder Problem >=x1/week	9,435	Not Available
Poor Mobility	10,777	Not Available
Obesity	14,798	12,591
Diabetes	7,065	7,753
Moderate/Severe Visual impairment	1,754	Not Available
Moderate/Severe/Profound Hearing Impairment	25,269	Not Available

Source: POPPI and London Borough of Bromley GP Systems

As reported elsewhere in the JSNA, there are significant numbers of older people in Bromley with visual and hearing impairment, which has consequences for their health, predisposing them to isolation, depression and falls. Sight loss in particular is amenable to preventive measures which could help to reduce the overall disease burden in the population.

Many conditions increase in prevalence with age, with the exceptions of asthma, which reduces consistently with age, and COPD, diabetes, and cancer which increase in prevalence up to the age of 84 years and are less prevalent thereafter (**Figure 5.8**).

Figure 5.8



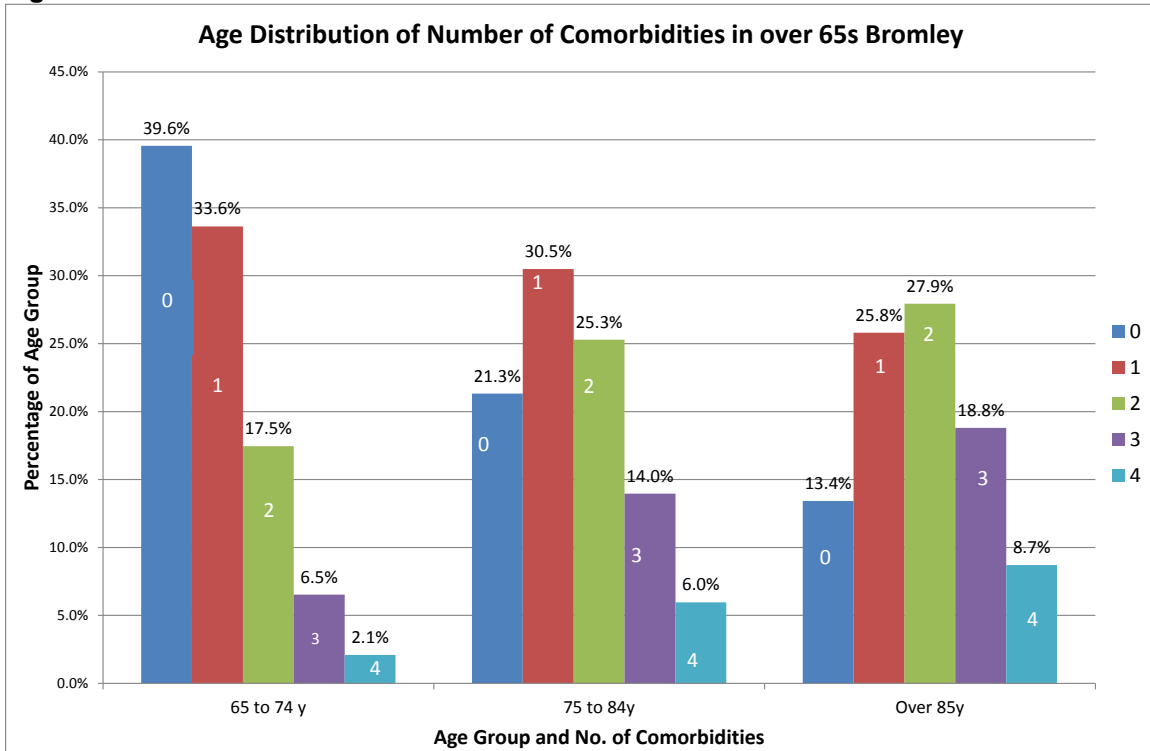
Source: Bromley GP Systems 2013

The number of comorbidities also increases with age, increasing the complexity of healthcare for the individual and the likelihood of polypharmacy, with its consequent risks. The Health Survey for England 2013 reports that more than half of participants aged 65-74 and more than 70% of those aged 75 and over are taking at least three prescribed medicines. Although appropriate polypharmacy will extend life expectancy and improve quality of life, problematic polypharmacy can lead to an increased risk of drug interactions and adverse drug reactions, together with impaired adherence to medication and quality of life for patients¹⁰

Whilst nearly 40% of 65 to 74 year olds have no long term conditions, by the age of 85 years, this has reduced to only 13.4%.

¹⁰ Kings Fund, Polypharmacy and medicines optimisation, Making it safe and sound, November 2013, Martin Duerden, Tony Avery, Rupert Payne

Figure 5.9

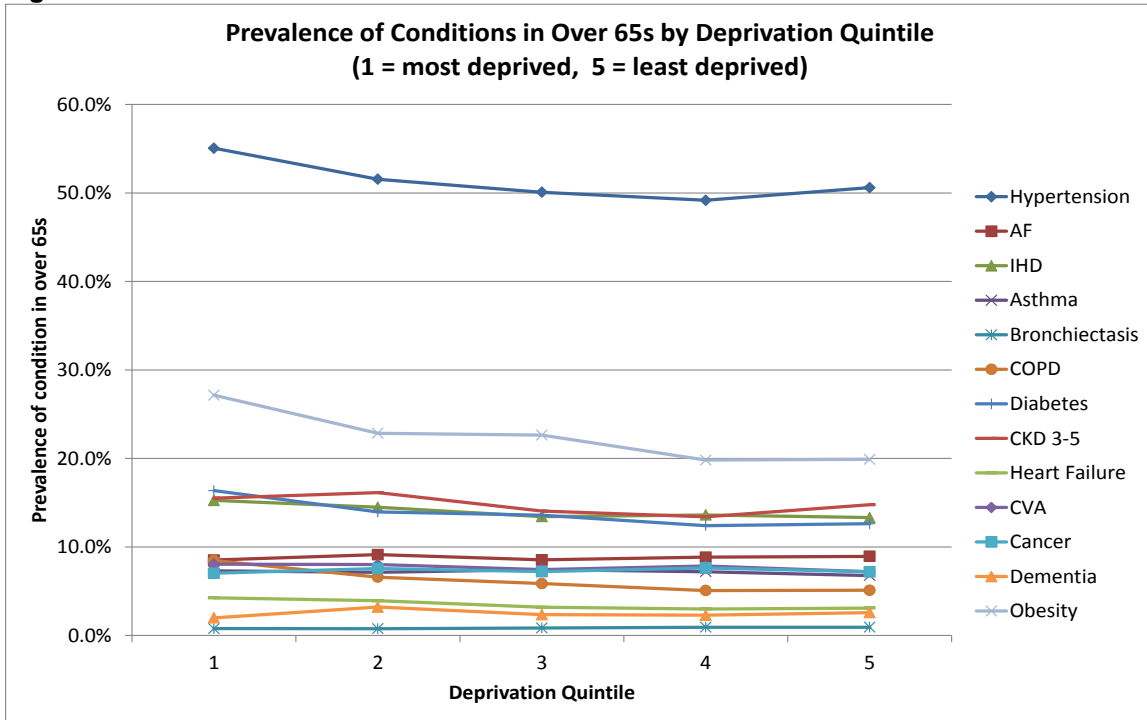


Source: Bromley GP Systems 2013

(Comorbidities included: hypertension, atrial fibrillation, ischaemic heart disease, asthma, COPD, diabetes, chronic kidney disease, heart failure, dementia, stroke cancer)

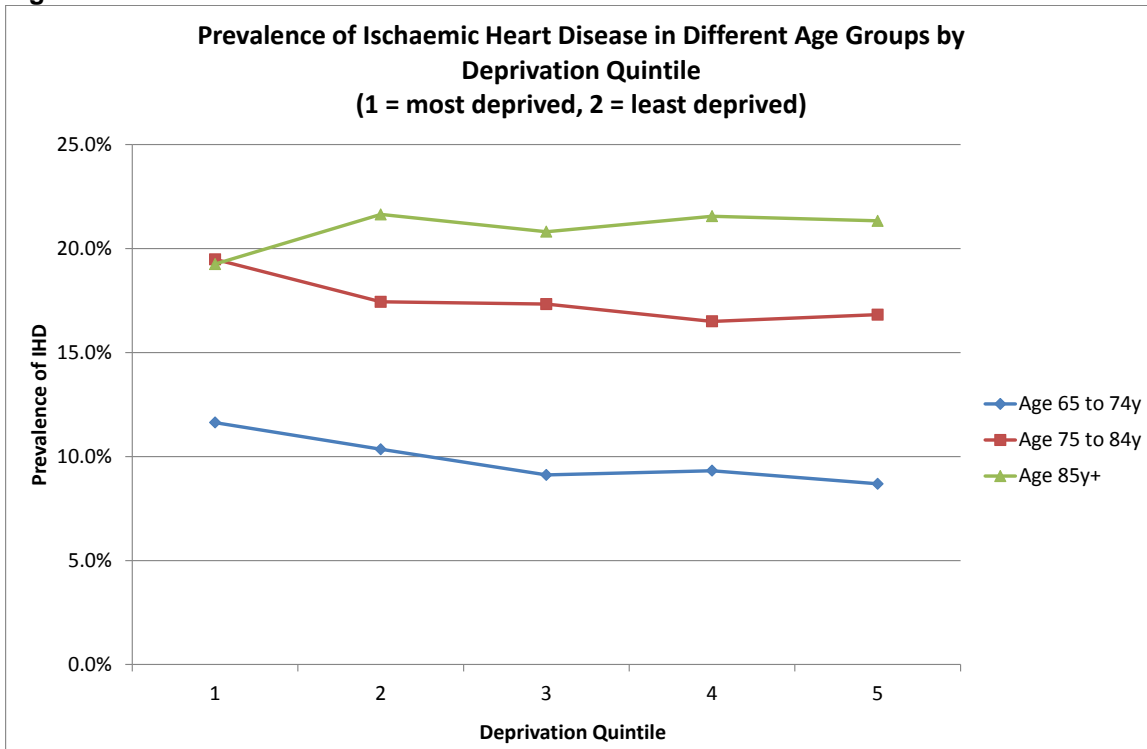
Figure 5.10 shows the prevalence of conditions in over 65s by deprivation quintile. It can be seen that most conditions follow the same pattern, with not much difference in prevalence between the most and least deprived areas. What is far more important than deprivation is the effect of age. Most conditions (except asthma) are more prevalent with increasing age and follow a pattern similar to that shown in **Figure 5.11** for ischaemic heart disease.

Figure 5. 10



Source: Bromley GP Systems 2013

Figure 5. 11

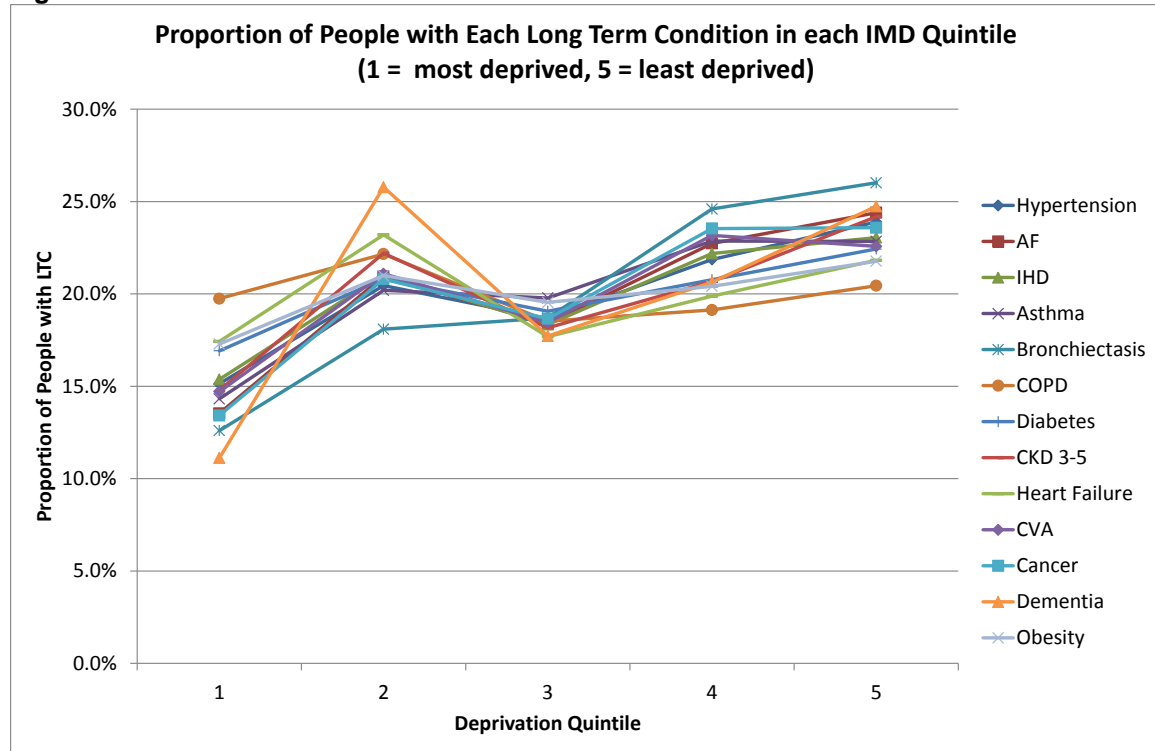


Source: Bromley GP Systems 2013

In terms of commissioning and provision of services, it is useful to also consider where the greatest numbers of people with long term conditions live. Although

prevalence is similar in the most and least deprived areas, because life expectancy is higher in the less deprived areas, there are relatively higher numbers of people with LTCs in these areas, as shown in **Figure 5.12**.

Figure 5. 12



Source: Bromley GP Systems 2013

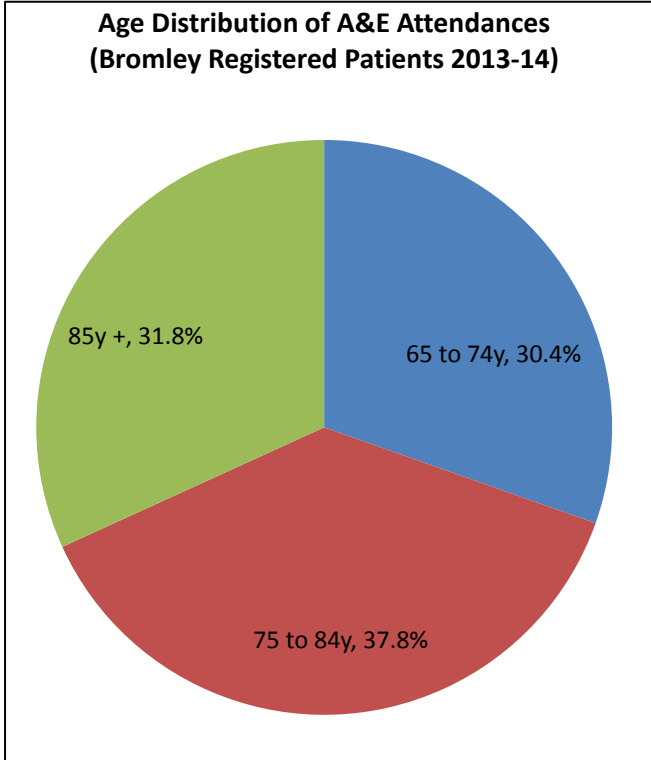
A&E Attendances

There were 21,870 A&E attendances by Bromley registered patients over the age of 65 years in 2013-14. This represents 30.3% of total A&E attendances by Bromley registered patients for that year.

The age groups attending were roughly evenly split, with the greatest proportion (37.8%) being from the 75 to 84 year age group (**Figure 5.13**).

Although the majority of A&E attenders (88.8%) were of White British ethnicity, ethnic minority populations were slightly over-represented at 7.7%, as compared with 5.6% across the older people's population in Bromley (3.6% had no record of ethnicity).

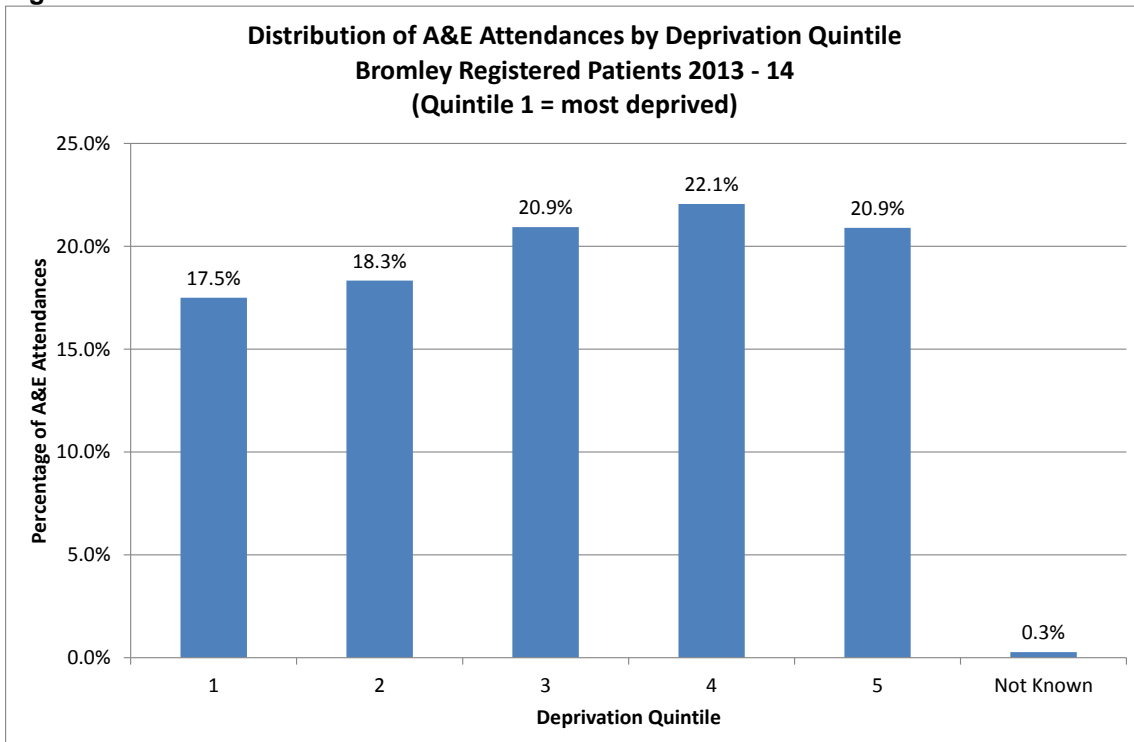
Figure 5. 13



Source: CSU Data Warehouse 2015

There were a lower proportion of A&E attendances by older people living in more deprived areas (Figure 5.14).

Figure 5. 14



Source: CSU Data Warehouse 2015

Hospital Admissions

In 2013-14, there were 11,511 emergency admissions to hospital of Bromley registered patients over the age of 65 years. This represented almost 54% of all emergency admissions, and was almost 53% of the A&E attendance figure (**Table 5.4**).

Table 5. 4

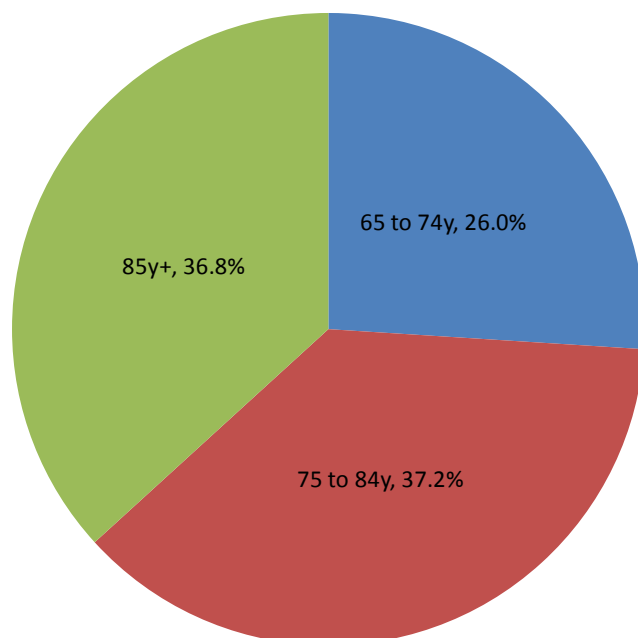
Admission Type	65y Plus	All ages (including 65y plus)	65y Plus %
Emergency Admissions	11511	21333	53.96%
Elective Admissions	18739	41559	45.09%
A&E Attendances	21870	72129	30.32%

Source: SUS Data July 2015

As might be expected, with the higher prevalence of disease, emergency admission numbers are higher in the older age groups within the over 65 year age cohort (**Figure 5.15**).

Figure 5. 15

Proportion of Emergency Admissions in Over 65 Year Cohort by Age Group 2013-14, Bromley Registered Patients



Source: CSU Data Warehouse 2015

The most frequent primary diagnoses recorded for emergency hospital admissions of Bromley patients in 2013 -14 were pneumonia, urinary tract infection, and ischaemic heart disease (**Table 5.5**).

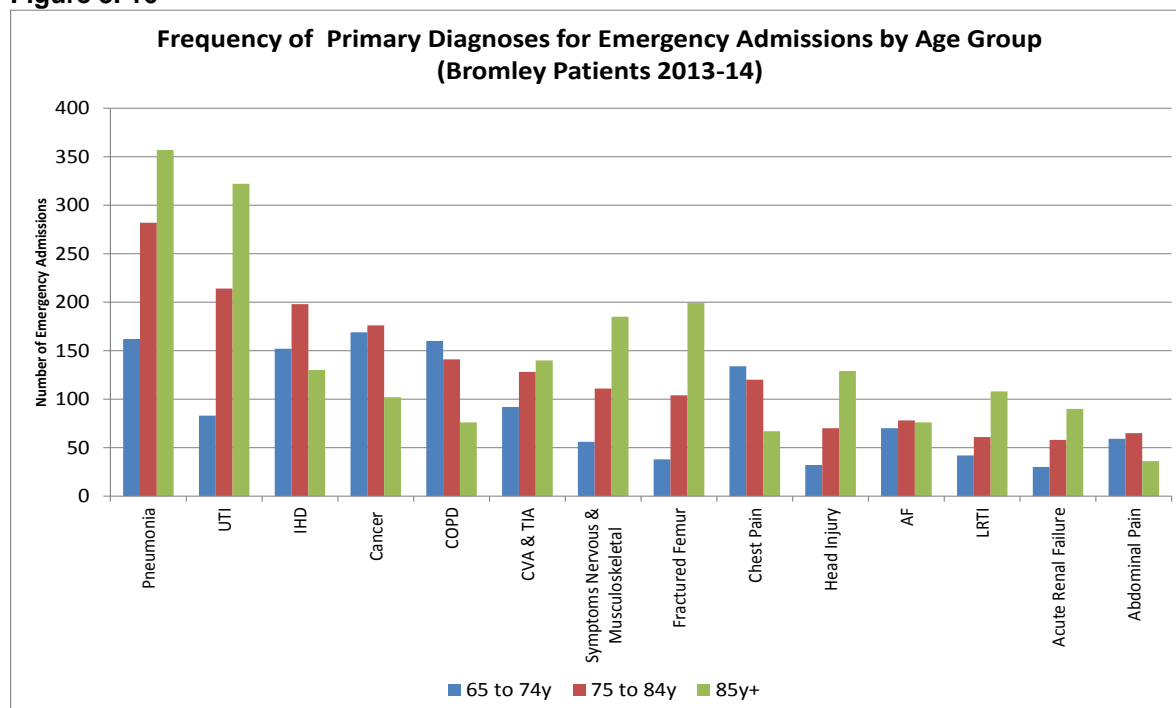
Although this is fairly consistent as patients get older, it can be seen in **Figure 5.16** that pneumonia, urinary tract infection, head injury, fractured femur and stroke are more common in the older age groups, whilst ischaemic heart disease, cancer and COPD are more common in the younger age groups.

Table 5. 5

Primary Diagnosis	Number of Over 65s	% of Over 65s
Pneumonia	801	7.0%
Urinary Tract Infection	619	5.4%
Ischaemic Heart Disease	480	4.2%
Cancer	447	3.9%
COPD	377	3.3%
Stroke (CVA & TIA)	360	3.1%
Symptoms Nervous & Musculoskeletal	352	3.1%
Fractured Femur	341	3.0%
Chest Pain	321	2.8%
Head Injury	231	2.0%
Atrial Fibrillation	224	1.9%
Lower Respiratory Tract Infection	211	1.8%
Acute Renal Failure	178	1.5%
Abdominal Pain	160	1.4%
Total Emergency Admissions for those aged over 65y	11511	

Data Source: SUS 2015

Figure 5. 16



Source: CSU Data Warehouse 2015

It is useful to consider not only the primary diagnosis triggering admission, but also underlying causes of admission, as this may indicate areas where prevention or improved management may reduce the risk of admission.

Only 2.2 % of all emergency admissions in over 65s had no underlying cause, but this proportion reduced with increasing age (**Table 5.6**).

Table 5. 6

Age Group	Number of Emergency Admissions	Number with No Underlying Cause	% with No Underlying Cause
All aged over 65y	11511	249	2.2%
65 to 74y	2994	118	3.9%
75 to 84y	4284	80	1.9%
Over 85y	4233	51	1.2%

Source: CSU Data Warehouse 2015

The most frequent underlying diagnoses recorded for emergency hospital admissions of Bromley patients in 2013 -14 were hypertension, ischaemic heart disease, atrial fibrillation and cancer (**Table 5.7**).

Acute renal failure may be a consequence of the presenting illness, rather than a pre-existing condition.

Table 5. 7

Underlying Diagnosis	Number of Over 65s	% of Over 65s
Hypertension	3135	9.1%
Ischaemic Heart Disease	2016	5.8%
Atrial Fibrillation	1678	4.9%
Cancer	1562	4.5%
Symptoms Nervous & Musculoskeletal	1164	3.4%
Diabetes	1162	3.4%
Acute Renal Failure	930	2.7%
Dementia	890	2.6%
COPD	740	2.1%
Fall	735	2.1%
Chronic Renal Failure	724	2.1%
Total Underlying Diagnoses	34533	

Source: CSU Data Warehouse 2015

Although this list of top diagnoses is similar for each of the over 65 year age groups, the proportion of emergency admissions in older age groups is higher for conditions

such as dementia, falls, chronic renal failure, hypertension and atrial fibrillation (Figure 5.17).

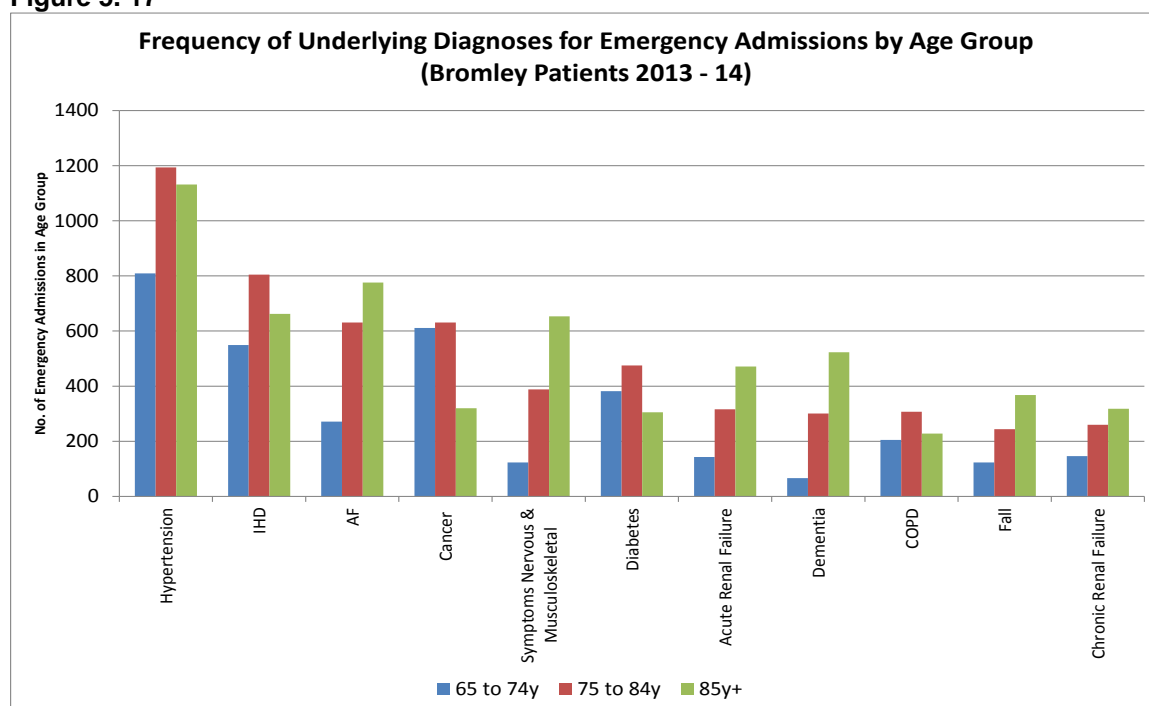
It should be noted that a number of long term conditions amenable to prevention and improved management appear in the list of top underlying diagnoses.

Other sections of the JSNA report:

- significant numbers of people with undiagnosed hypertension and the need for tighter control of blood pressure in those who have been diagnosed,
- significant numbers of people with undiagnosed atrial fibrillation and the need for treatment optimisation in those who have been diagnosed,
- the rising incidence of diabetes in the population.
- the need to improve follow up and management of patients identified with risk factors at NHS Health Check,
- the need for improvements in the early detection of cancer.

This highlights the importance of considering prevention in these areas and the potential consequences of not addressing prevention.

Figure 5. 17



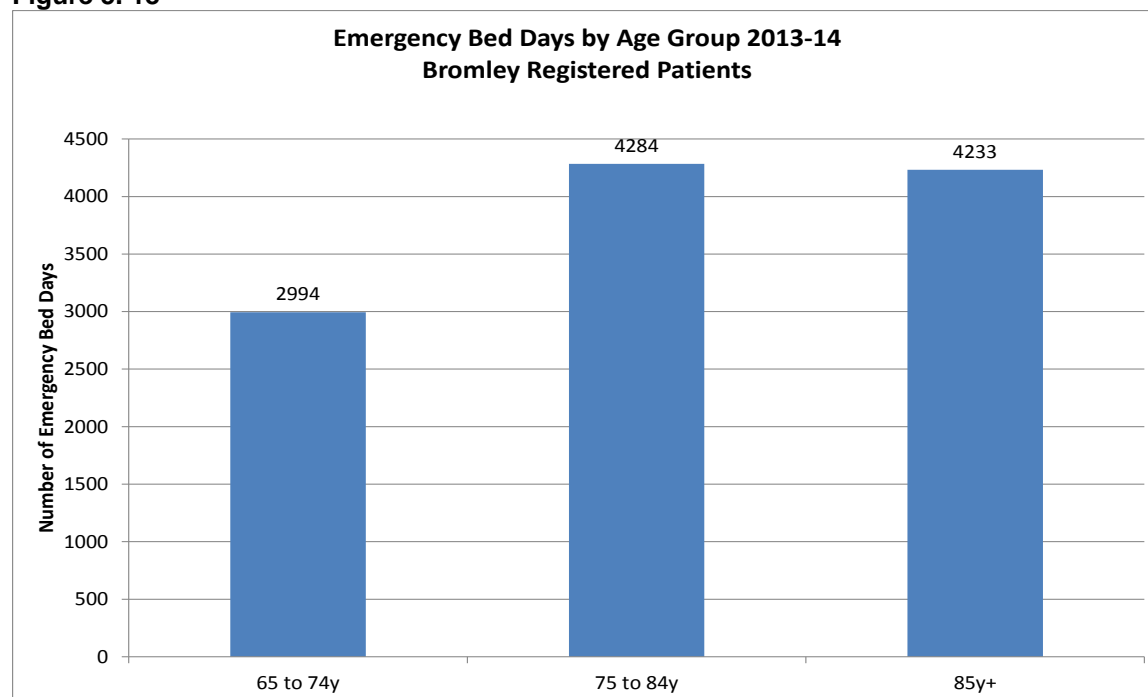
Source: CSU Data Warehouse 2015

Length of stay for emergency admissions in older people in 2013-14 ranged from zero to 157 days, with an average stay of 8.3 days and a median stay of 4 days. This is slightly lower than the national average, which was found (by the King's Fund in

their report exploring variation in emergency bed use by older people¹¹ to be an average of nine days. This compares unfavourably with the national average of 3 days for people under the age of 65 years.

The highest number of emergency bed days are for the 75 to 84 year age group, closely followed by the over 85 year age group (**Figure 5.18**). Longer lengths of stay are more common in the older age groups (**Figure 5.19**).

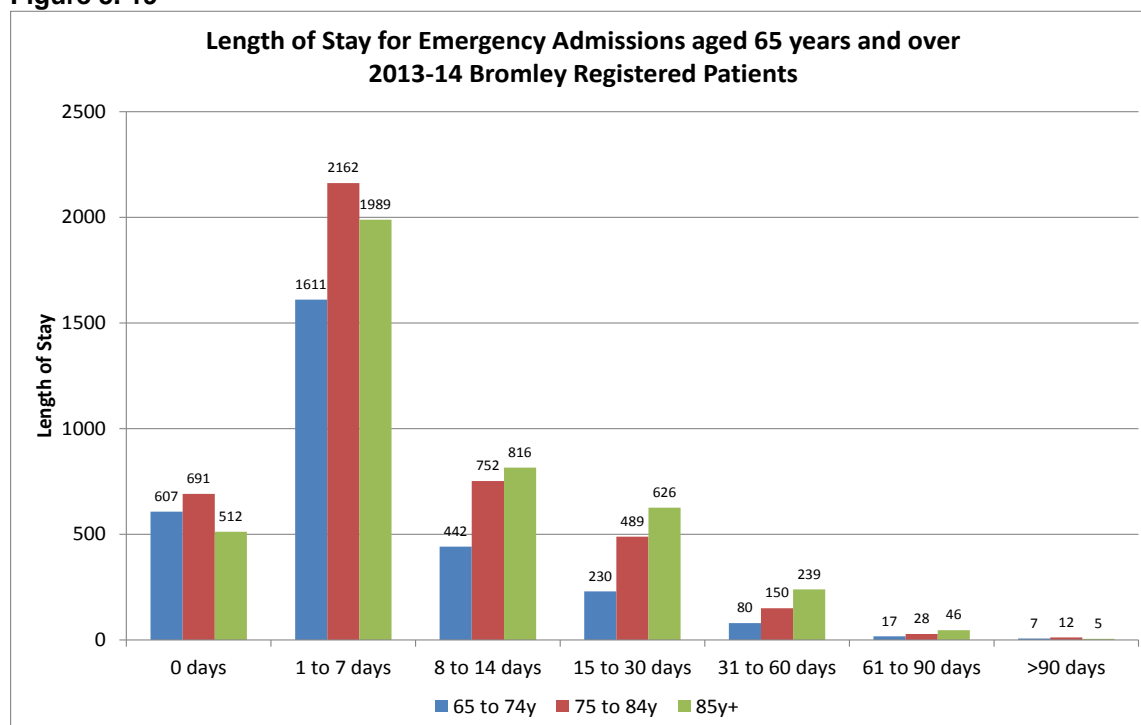
Figure 5. 18



Source: CSU Data Warehouse 2015

¹¹ Imison, Poteliakhoff, Thompson Older people and Emergency Bed Use, Exploring Variation. King’s Fund 2012

Figure 5. 19



Source: CSU Data Warehouse 2015

Elective admissions of people over the age of 65 years, accounted for 45% of all elective admissions of Bromley registered patients in 2013-14.

Elective admissions are classified as day cases, ordinary admissions and other. The majority (79.5%) of elective admissions in 2013-14 in Bromley for older people were as day cases (**Table 5.8**).

Table 5. 8

Type of Elective Admission	Number	%
Day Case	14902	79.5%
Ordinary Admission	3148	16.8%
Other	689	3.7%
Total	18739	100.0%

Source: CSU Data Warehouse 2015

The length of stay for ordinary admissions ranges from zero (18.7%) to 194 days, with a median stay of 2 days.

Day case elective admissions are most commonly for cancer, eye conditions and investigation and treatment of digestive system disorders (**Table 5.9**).

Table 5. 9: Top Conditions for Day Case Admissions in Older People

ICD Chapter for Day Cases	Number	%
Neoplasms	4406	29.6%
Diseases of the eye and adnexa	2365	15.9%
Diseases of the digestive system	2247	15.1%
Diseases of the musculoskeletal system and connective tissue	1711	11.5%
Diseases of the circulatory system	831	5.6%
Factors influencing health status and contact with health services	794	5.3%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	589	4.0%
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	562	3.8%
Diseases of the genitourinary system	446	3.0%

Source: CSU Data Warehouse 2015

The admissions for cancer are most commonly for chemotherapy (25%) or plasma exchange (12%), 79% of those for eye conditions are for cataract treatment, and the admissions for digestive system disorders are mainly for endoscopic diagnostic or treatment procedures.

Table 5. 10: Older People Related PHOF Indicators, 2015

Indicator	Time Period	Sex	Bromley	London	England
4.13 - Health related quality of life for older people	2011/12	Persons	0.77	0.72	0.73
4.13 - Health related quality of life for older people	2012/13	Persons	0.76	0.72	0.73
4.14i - Hip fractures in people aged 65 and over	2010/11	Persons	571.43	550.09	579.90
4.14i - Hip fractures in people aged 65 and over	2011/12	Persons	581.81	542.82	576.02
4.14i - Hip fractures in people aged 65 and over	2012/13	Persons	496.81	531.83	568.13
4.14i - Hip fractures in people aged 65 and over	2013/14	Persons	508.47	529.94	579.98
4.14i - Hip fractures in people aged 65 and over	2013/14	Persons	371.86	399.03	423.24
4.14i - Hip fractures in people aged 65 and over	2013/14	Persons	645.07	660.85	736.72
4.14ii - Hip fractures in people aged 65-79	2010/11	Persons	211.36	231.64	244.97
4.14ii - Hip fractures in people aged 65-79	2011/12	Persons	242.44	236.80	241.96
4.14ii - Hip fractures in people aged 65-79	2012/13	Persons	197.36	222.25	237.29
4.14ii - Hip fractures in people aged 65-79	2013/14	Persons	174.56	221.46	240.09
4.14ii - Hip fractures in people aged 65-79	2013/14	Persons	117.64	175.21	163.81
4.14ii - Hip fractures in people aged 65-79	2013/14	Persons	231.48	267.72	316.37
4.14iii - Hip fractures in people aged 80+	2010/11	Persons	1615.64	1473.62	1551.20
4.14iii - Hip fractures in people aged 80+	2011/12	Persons	1565.98	1430.26	1544.79
4.14iii - Hip fractures in people aged 80+	2012/13	Persons	1365.21	1429.60	1527.55
4.14iii - Hip fractures in people aged 80+	2013/14	Persons	1476.79	1424.52	1565.66
4.14iii - Hip fractures in people aged 80+	2013/14	Persons	1109.11	1048.09	1175.61
4.14iii - Hip fractures in people aged 80+	2013/14	Persons	1844.48	1800.94	1955.72

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

What does this mean for residents in Bromley?

The population of older people in Bromley is significant in number and in that it carries a large disease burden and contributes a large percentage of secondary care activity.

In comparison to other areas in England, the older people of Bromley enjoy good health and are disability-free to a higher age.

Many of the conditions in older people which result in hospital admission are amenable to preventive measures, such as not smoking, healthy diet and physical activity throughout life.

For more information please contact Agnes.Marossy@Bromley.gov.uk

6. People in Care Homes

A care home has been defined as a residential setting where older people live, usually in single rooms, and have access to on-site care services and where residents do not legally own or rent their home.

Care homes are often categorised by the type of care they provide as *residential* or *nursing*. In England, the Care Quality Commission defines both as *residential social care* referring to them as *care homes with nursing services* or those *without*.

In Bromley there are also a number of sites offering Extra Care Housing. People who live in Extra Care Housing have their own self-contained homes, their own front doors and a legal right to occupy the property. However, this type of housing is designed with the needs of frailer older people in mind and with varying levels of care and support available on site.

The Demography of the Care Home Population

In 2011, more than a quarter of a million (291,000) people aged 65 and over were living in care homes in England and Wales, representing 3.2% of the total population at this age. This number has remained almost stable since 2001 when 290,000 people were living in care homes, representing a slightly higher proportion, 3.5% of the population aged 65 and over at that time. Increases in the usual resident population of England and Wales have outstripped changes in the resident care home population. At age 65 and over, the resident care home population grew by just 0.3% between 2001 and 2011 compared to an overall increase of 11.0% in the usual resident population¹².

There are a number of possible reasons for this stability in the face of an increasingly aged population:

- the improvement in the health of the population between 2001 and 2011 (this may also explain why the care home population of those aged 85 and over has increased).
- the increase in unpaid carers; there were an additional 600,000 unpaid carers in 2011 compared to 2001.
- relatives and/or friends may be more inclined to provide unpaid care to relieve the financial burden of care home costs.
- Care in the community may also encourage people to stay at home for longer as it ensures people who are in need of long-term care are able to live at home and receive care.

¹² Office for National Statistics Changes in the Older Resident Care Home Population between 2001 and 2011, August 2014

Table 6. 1: Resident Care Home Population in England and Wales 2011

Age	Resident Care Home Population 2011	Proportion of Usual Resident Population (%)
65 to 74 years	31,000	0.6
75 to 84 years	88,000	2.8
85 years and over	172,000	13.7
All over 65 years	291,000	3.2

Source: ONS

The majority (59.1%) of older people in care homes are aged 85 years and over, an increase from 56.5% in 2001 and this older age group are more likely to be resident in a care home (13.7%) than the younger over 65s.

Table 6. 2

Age	Female Resident Care Home Population 2011	Male Resident Care Home Population 2011
65 to 74 years	16,000	15,000
75 to 84 years	60,000	28,000
85 years and over	138,000	34,000
All over 65 years	214,000	77,000

Source: ONS

There are many more women (73.5%) than men resident in care homes, although between 2001 and 2011, the number of women residing in care homes aged 65 and over declined by 4.2 per cent, whilst for men aged 65 and over there was an overall increase of 15.2% in the resident care home population.

Length of Stay in Care Homes

A study published in 2012¹³ looking at the length of stay in publicly funded care homes in three local authorities in England found that for people admitted to permanent residential care, the median length of stay was 17.9 months and for nursing care only 9 months. There was significant variation between the three local authorities, and for the LA in an outer London suburb, the median length of stay was found to be 22.4 months for residential care and 14.7 months for nursing care. Turnover of residents in care homes is therefore relatively high, if the complexity of care needs is taken into consideration.

¹³ Estimating length of stay in publicly-funded residential and nursing care homes: a retrospective analysis using linked administrative data sets. Steventon and Roberts *BMC Health Services Research* 2012 **12**:377

The Health and Healthcare Needs of People in Care Homes

Many older people who live in care homes have high levels of healthcare needs. Bupa carried out a profile of residents in their care homes across the world in 2009, and found that of those in the UK¹⁴

- 90% had high support needs (defined as having one or more of dementia, confusion, challenging behaviour, dual incontinence, severe hearing or visual impairment, or total dependence in mobility).
- 75% had some form of neurological or mental disorder (dementia 43.6%, stroke 20.2%, depression 11%, epilepsy 5.6%, Parkinson's disease 4.9%).
- The most commonly occurring non-neurological or mental conditions were heart disease (20.6%), arthritis (18.3%), diabetes and endocrine (14.4%), fractures (12.5%), osteoporosis (9.1%), lung or chest disease (7.8%) and cancer (7.3%).
- Just under 70% experienced some form of incontinence and nearly a half (47.6%) had severe mobility problems.

Addressing the Needs of the Care Home Population

Residents of care homes have complex healthcare needs, reflecting multiple long term conditions, significant disability and frailty. However, it has been recognised that there is unmet need, unacceptable variation and suboptimal care provided across the country¹⁵

The key problems raised in the British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes are shown in the box below:

¹⁴ The Changing Role of Care Homes Lievesley, Crosby and Bowman. Bupa and Centre for Policy on Ageing 2011.

¹⁵ Quest for Quality. British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A call for Leadership, Partnership and Quality Improvement. 2011.

1. *Residents of Care homes have complex healthcare needs, reflecting multiple long-term conditions, significant disability and frailty.*
2. *The social care model is central but insufficient to meet residents' health needs.*
3. *As the independent sector grew to take on this area of care over the last three decades, the NHS gradually withdrew its expertise and support. Most geriatricians and old age psychiatrists now play no part.*
4. *Regulation can highlight problems and promote improvement but care home providers cannot achieve this without necessary support.*
5. *No model of co-ordinated healthcare has been developed to meet the needs of care home residents. „Traditional“ general practice in many areas does not appear equipped or supported to fill this void.*
6. *Our report shows that many care home residents are denied equitable access to suitable NHS primary and secondary healthcare. While NHS policy makers, commissioners or managers acknowledge that there are problems, they have little consensus on their obligations to address this. Ensuring effective healthcare for individual residents and effective support for care homes seems to be a low priority. As a result, residents are denied the necessary healthcare resources, support and expertise they need and many are inappropriately admitted to hospital.*
7. *Care homes will continue to be an important component of care provision for frail older people. But healthcare for residents remains a “Cinderella” service in the NHS. This is a betrayal of older people, an infringement of their human rights and is unacceptable in a civilised society.*

Visiting Medical Officers

In terms of primary care, all care home residents are entitled to the free provision of general medical services.

The National Assistance Act (1948) set out duties to be provided by Visiting Medical Officers (VMOs) to support Local Authority councils with advice in carrying out certain functions in residential care homes, such as illness prevention and medication administration. Responsibilities of VMOs never included direct medical care for individual residents, but care homes often secured the input of a local GP by appointing them as a VMO.

There are no national specific standards for primary care for care home residents, and provision of care is highly variable.

Considerations include:

- maintaining continuity of care by retaining the pre-admission GP, which has the disadvantage of potentially many doctors attending each care home which is a barrier to collaborative working.
- Not all GPs are willing to accept responsibility for the residents of a care home because of the workload and a lack of expertise.
- Some CCGs have entered into a Local Enhanced Service agreement with GPs to pay a practice to provide a specifically higher than usual level of care.

The Care Home Population in Bromley

There are 67 nursing and residential care homes in Bromley with a total of 2055 beds and these include homes for older people, people with a learning disability and people with mental health needs.

There are in addition a number of sites offering extra care housing in Bromley.

This report will consider people over the age of 65 years resident in care homes or in extra care housing.

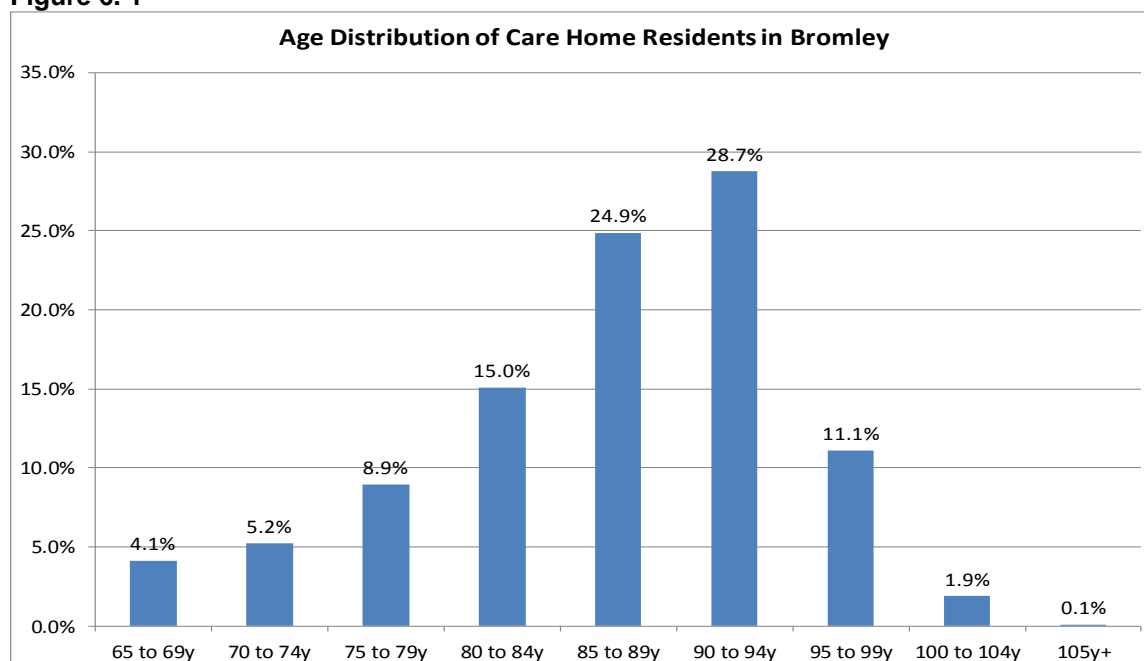
Bromley has operated a Local Enhanced Service for Visiting Medical Officers to care homes, but the specification for this has been under review over the last year.

Demography of the Care Home Population in Bromley

In order to describe the health needs of the care home population in Bromley, searches were made of GP systems in 22 practices who act as VMO for or have patients in one or more care homes in Bromley. No patient identifiable information was extracted.

Across the 22 practices, 1110 patients resident in care homes and extra care housing were identified. Of these, 828 (74.6%) were female, and 740 (66.7%) were aged 85 years or over. The proportion of women is similar to the national figure (73.5%), but the proportion over the age of 85 years is much higher than the national figure (59.1%).

Figure 6.1



Source: Bromley GP Data 2015

The search identified the presence of a number of medical conditions, as shown in **Table 6.3**.

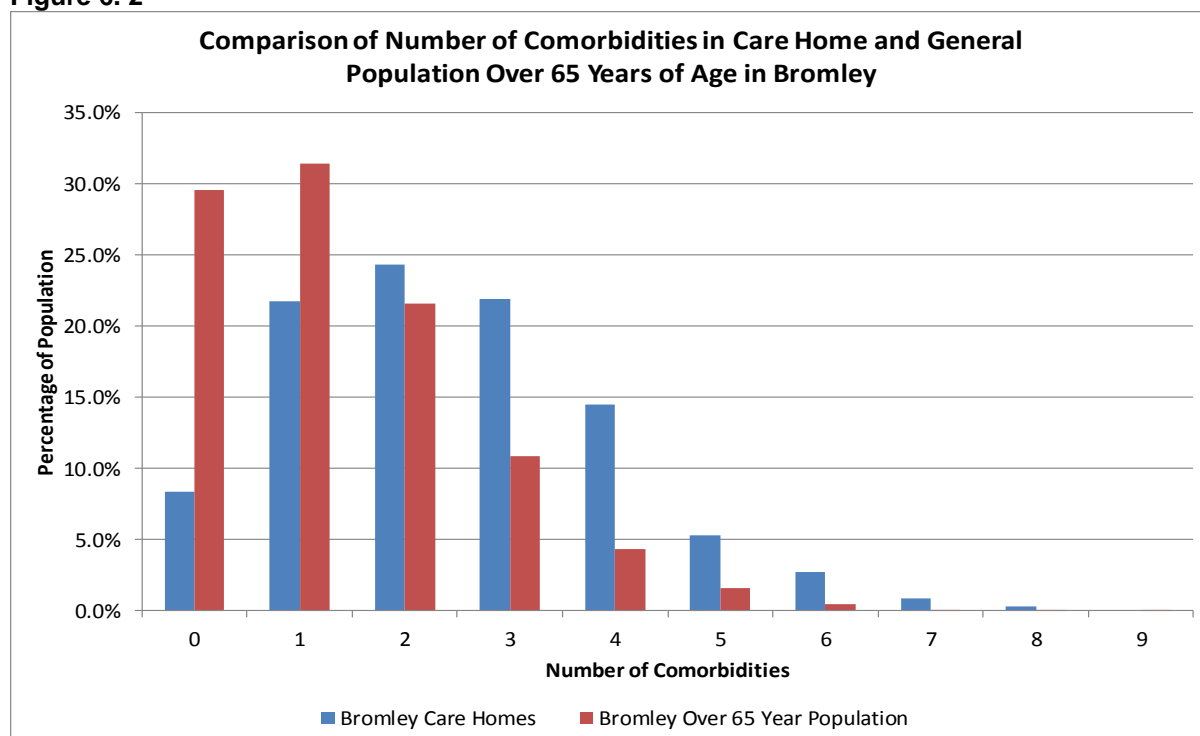
In comparison with the rates of conditions found in the audit of Bupa care homes, residents of Bromley care homes are less likely to have heart or respiratory disease and more likely to have suffered a stroke or be suffering from dementia or arthropathies. This is likely to be a reflection of the criteria for social care funding of care home places (although some of the care home patients on Bromley GP registers will be self-funding).

In comparison with the over 65 year population in Bromley as a whole, care home residents are far more likely to have a diagnosis of dementia or stroke, and overall more likely to be suffering from heart disease, kidney disease, cancer or diabetes (**Figure 6.3**).

Comorbidities

People in care homes are more likely than the general population over the age of 65 years to have two or more comorbidities. The care home population present a more complex healthcare challenge.

Figure 6. 2



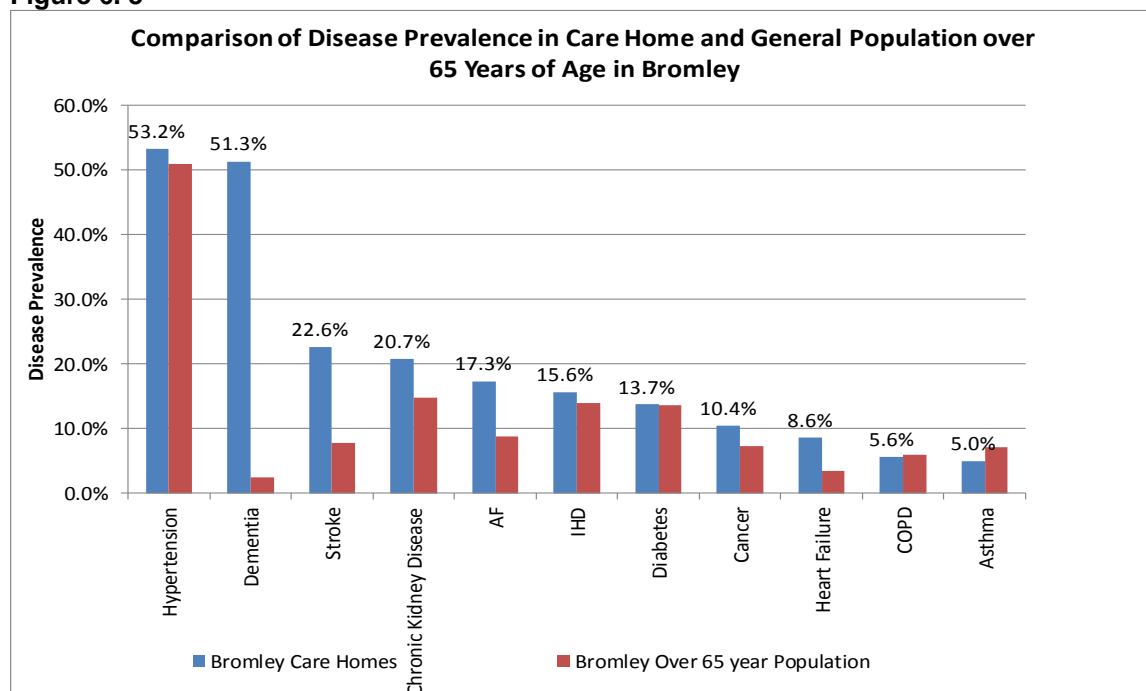
Source: Bromley GP Data 2015

Table 6. 3: Comparison of Prevalence of Conditions between People in Bromley Care Homes, the Bupa Care Homes Study and the Bromley Population aged 65 years and over

Condition	Bromley Care Homes		Bupa Care Homes	Bromley 65 years and over year Population
	Number	%	%	
Hypertension	591	53.2%		51%
AF	192	17.3%		8.8%
IHD	173	15.6%	20.6%	13.9%
Heart Failure	96	8.6%		3.4%
COPD	62	5.6%	7.8%	6%
Asthma	56	5.0%		7.1%
Diabetes	152	13.7%	14.4%	13.6%
Hypothyroidism	34	3.1%		
Chronic Kidney Disease	230	20.7%		14.7%
Epilepsy	44	4.0%	5.6%	
Stroke	251	22.6%	20.2%	7.7%
Depression	177	20.1%	11%	
Dementia	569	51.3%	43.6%	2.5%
Mental Illness	59	5.3%		
Osteoporosis	131	14.9%		
Arthropathies	351	39.8%	18.3%	
Parkinson's Disease	44	5.0%	4.9%	
Fracture <5 years	192	21.8%		
Fracture <10y	322	36.5%		
Cancer	115	10.4%	7.3%	7.3%
Smoker	28	2.5%		
Obese	68	12.8%		

Source: Bromley GP Data 2015

Figure 6. 3

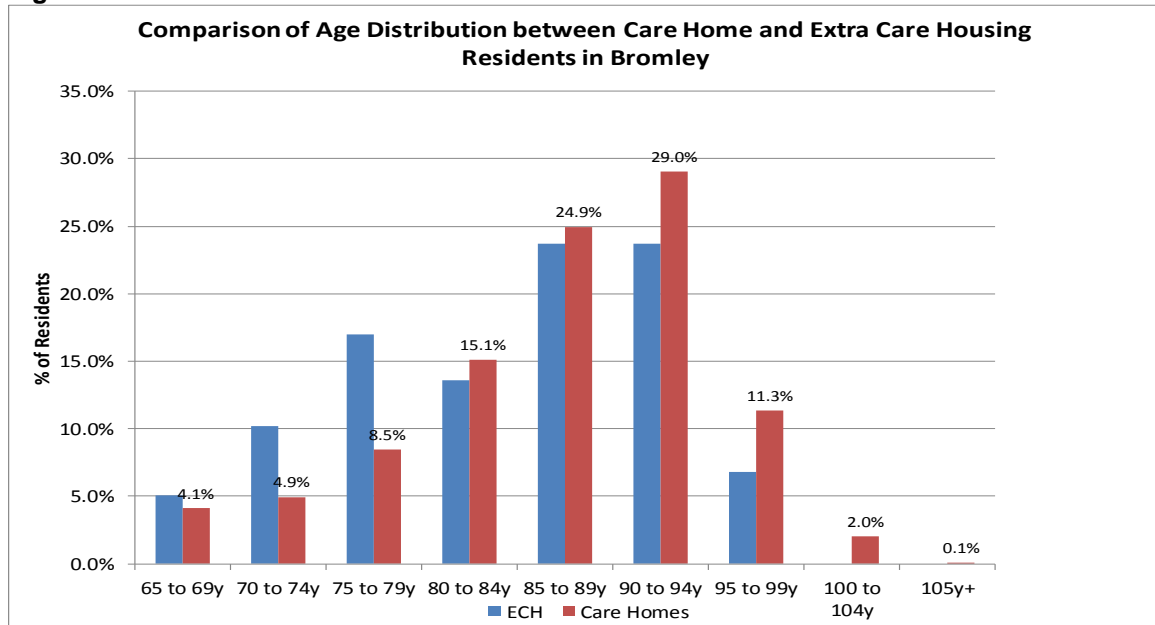


Source: Bromley GP Data 2015

Extra Care Housing

As described earlier, extra care housing is an alternative to care home admission and offers care support to older people in housing which they own. The GP register searches identified 59 people living in extra care housing in Bromley, of whom 71.2% were female, which is similar to the care home population. The proportion of people over the age of 85 years is lower than that in care homes, however, at 54.2%.

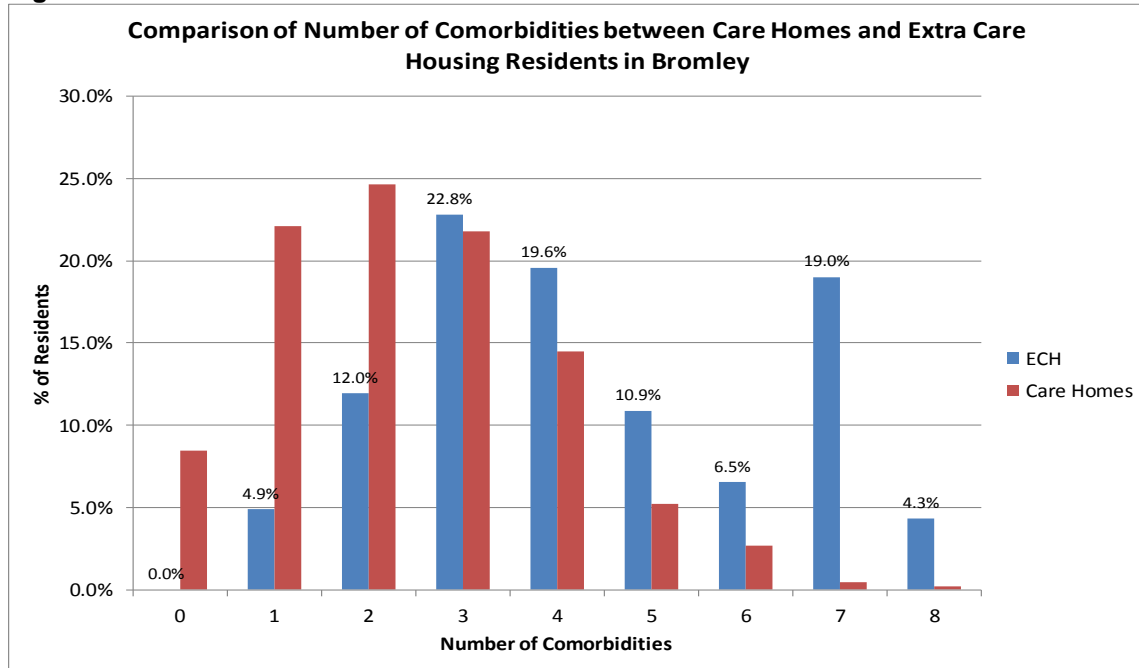
Figure 6.4



Source: Bromley GP Data 2015

Interestingly, the extra care housing residents tend to have a higher number of comorbidities than the care home residents.

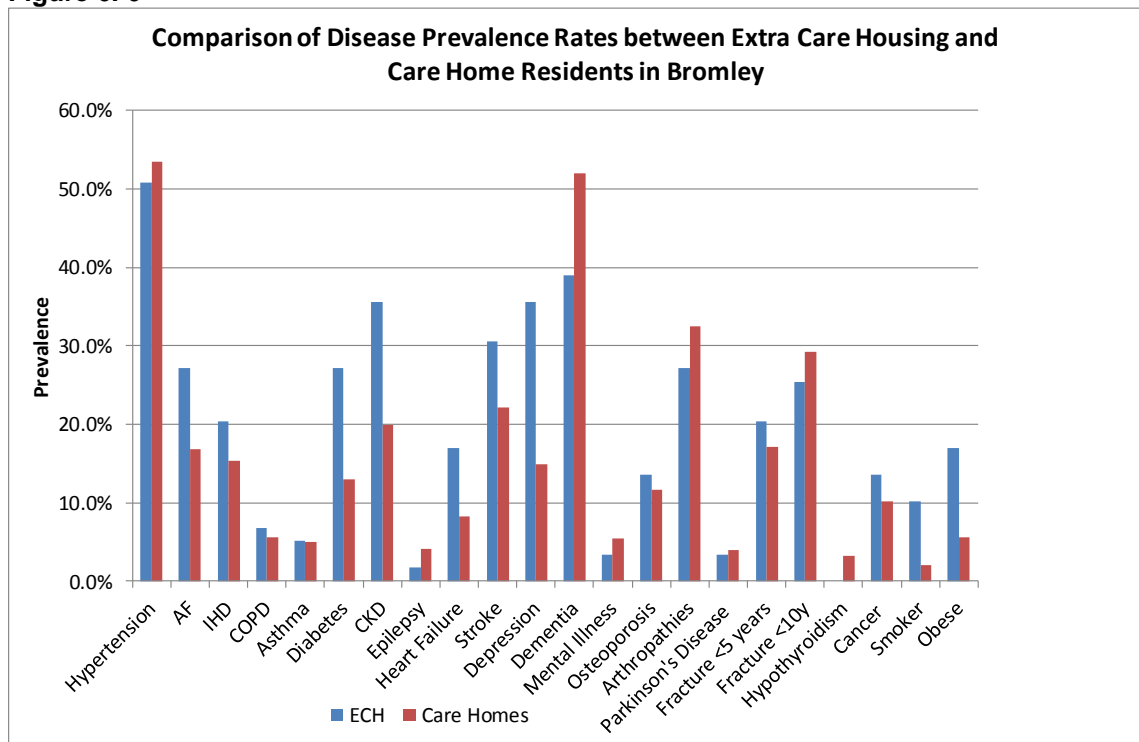
Figure 6.5



Source: Bromley GP Data 2015

Looking at the types of long term conditions, however, reveals that the care home residents are more likely to suffer from dementia, and to have mobility problems (arthropathies, fractures) than the extra care housing residents.

Figure 6.6



Source: Bromley GP Data 2015

Hospital Attendances

It is not possible to identify hospital attendances/admissions from care homes from routine data sources.

However, London Ambulance Service compiles data on call outs and conveyances from care homes and extra care housing sites across London.

In the five month time period between April 2014 and August 2014, there were 863 instances of call outs to care homes in Bromley. Of these, 734 (85.1%) required the person to be conveyed to hospital.

The care home and extra care housing population aged 65 years and over in Bromley is approximately 1500 people (CCG continuing care team assesses 1422 people in the year to April 2015).

There was therefore, approximately one emergency hospital attendance by ambulance transport per 2 residents of care homes in a five month period.

This contrasts with 21,870 A&E attendances in the whole year 2013-14 by people over the age of 65 years from a population of 56,500 (1 in 2.6 people).

This is an indication of the high level of need in this population.

Of the LAS call outs, almost a quarter were for falls.

Table 6. 4: Top Reasons for London Ambulance Call Out to Care Homes in Bromley (April to August 2014)

Reason for Ambulance Call Out	No.	%
Falls	207	24.0%
Health Care Professional Admission Protocol	206	23.9%
Sick Person (Specific Diagnosis)	90	10.4%
Unknown	89	10.3%
Breathing problems	69	8.0%
Unconscious/Fainting (Near)	35	4.1%
Haemorrhage/Lacerations	31	3.6%
Chest Pain (Non-Traumatic)	29	3.4%
Stroke (CVA)	23	2.7%
Diabetic problems	20	2.3%
Psychiatric/Abnormal Behaviour/Suicide Attempt	11	1.3%
Traumatic Injuries (specific)	10	1.2%

Source: London Ambulance Service

There is a variation between care homes in the number of call outs, which range from 0 to 92, with a median of 10 per care home. The extra care housing sites represent 31.2% of the call outs.

From the section on Older People's Health (Section 5), it can be seen that the average length of stay in hospital for older people is 8.3 days. People are no longer admitted to hospital for long stays as in the past (in long stay geriatric wards), and it

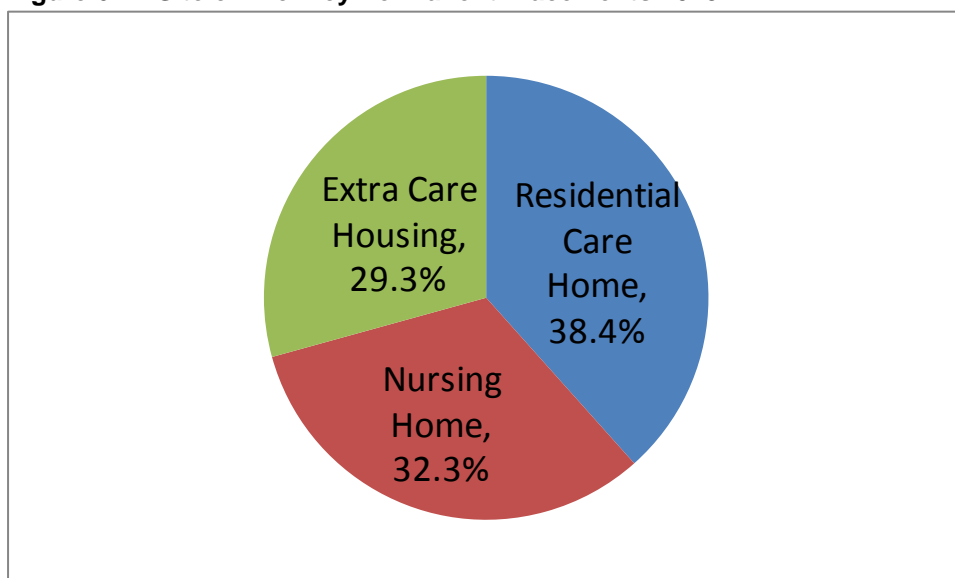
is likely that those people are now cared for in nursing homes, which therefore have to manage people with more complex health needs than in the past.

The Social Care Funded Care Home Population

Data was also accessed from the social care database, which provided information on Bromley residents in permanent placements in residential and nursing care homes and in extra care housing for whom Bromley funds social care. This data included out of borough placements and represents the position as at 31st March 2015.

Of the 792 people in permanent placements, the highest proportion were in residential care homes (38.4%), and the lowest proportion in extra care housing (20.3%).

Figure 6. 7: Site of Bromley Permanent Placements 2015



Source: Bromley Social Care 2015

In residential care homes, over half of the residents are aged 85 years and over, in contrast to extra care housing where this age group represents only 41.4%. Both of these figures are lower than those found amongst the GP registered patients, indicating a difference between those receiving social care funding and those not. The majority of permanent placements are of white ethnicity, although at about 87%, this is below the proportion seen in the general Bromley over 65 year population (94.4% white). A quarter to a third of these residents are male, which is similar to the national picture of care home residents.

A higher proportion of residential care than nursing home residents have a mental health problem, with the reverse true for those with physical disability. Extra care housing has a higher proportion of residents with physical disability than residential or nursing homes, and a far lower proportion with mental health problems.

Table 6. 5

Characteristics		Residential Care Home	Nursing Home	Extra Care Housing
Age Group	65 to 74 years	13.8%	14.5%	20.3%
	75 to 84 years	29.3%	35.9%	38.4%
	85 years and over	56.9%	49.6%	41.4%
Gender	Male	25.3%	30.1%	29.7%
Ethnicity	White	87.2%	87.5%	84.9%
Type of Need	Physical Disability	42.1%	49.7%	55.6%
	Mental Health Problem	49.7%	32.9%	15.8%

Source: Bromley Social Care 2015

Turnover in Care Homes

Evidence shows that the average length of stay in a care home is less than two years. Considering the complexity of these patients in terms of healthcare needs, this is significant for both the care home staff and the GPs providing care for these patients. Because patients admitted to care homes are often moved to a different area, they are required to register with a new GP, who is taking on the care of a person who has often been through a crisis and presents with multiple comorbidities.

Bromley Social Care data identifies the average length of placement at time of death in residential or nursing homes or extra care housing.

It can be seen in **Figures 6.8** and **6.9** that there is variation between males and females and between types of residence. However, the longest average placement for males before death is less than three and a half years, and for females, less than four and a half years. This is in line with the relatively short care home stays seen nationally, and highlights the relatively high turnover. This is further supported by the results of a study which found a mean length of stay before death in care homes of 20 months, with a median of 8 months, this study included Bromley care homes and was carried out between 2008 and 2011¹⁶

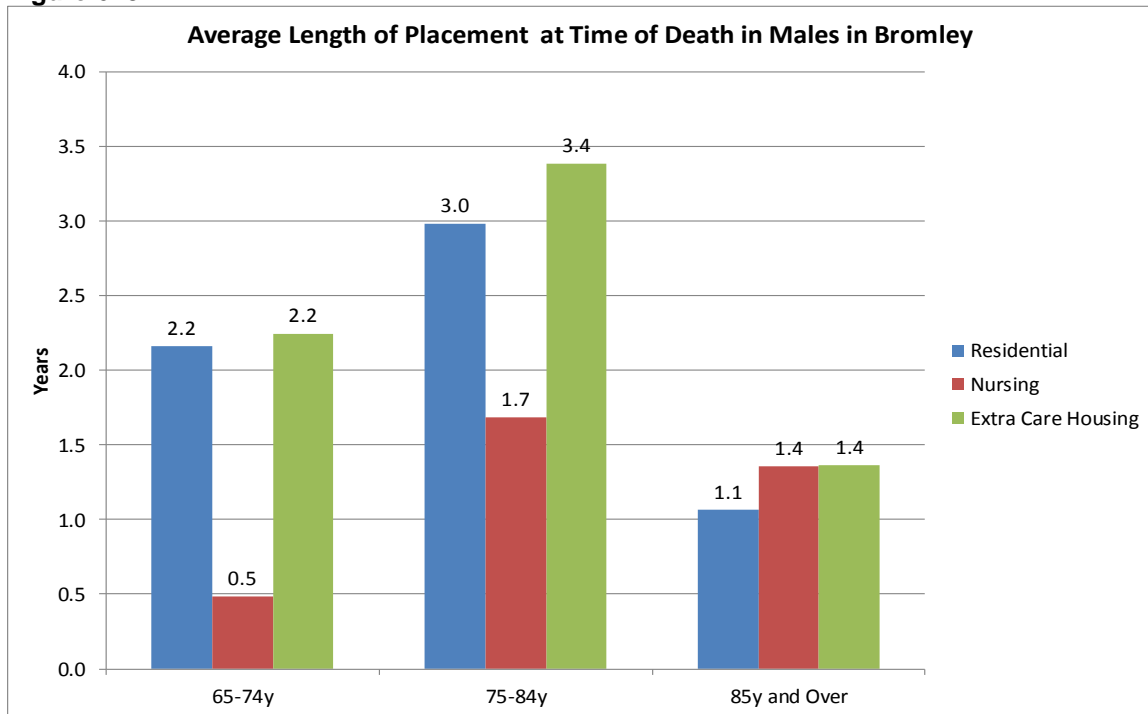
The Clinical Commissioning Group has a responsibility to assess eligibility for NHS Continuing Healthcare of all potential care home admissions.

At April 2015, of the 1422 care home residents over the age of 65 years, 752 (52.9%) had been found to be eligible for NHS Continuing Healthcare funding (i.e. had a primary health need), and 663 (46.6%) were found to be eligible for NHS

¹⁶ Kinley, Stone et al. The effect of using high facilitation when implementing the Gold Standards Framework in Care Homes programme: A cluster randomised controlled trial. *Palliative Medicine* 2014, 28(9) 109-1109.

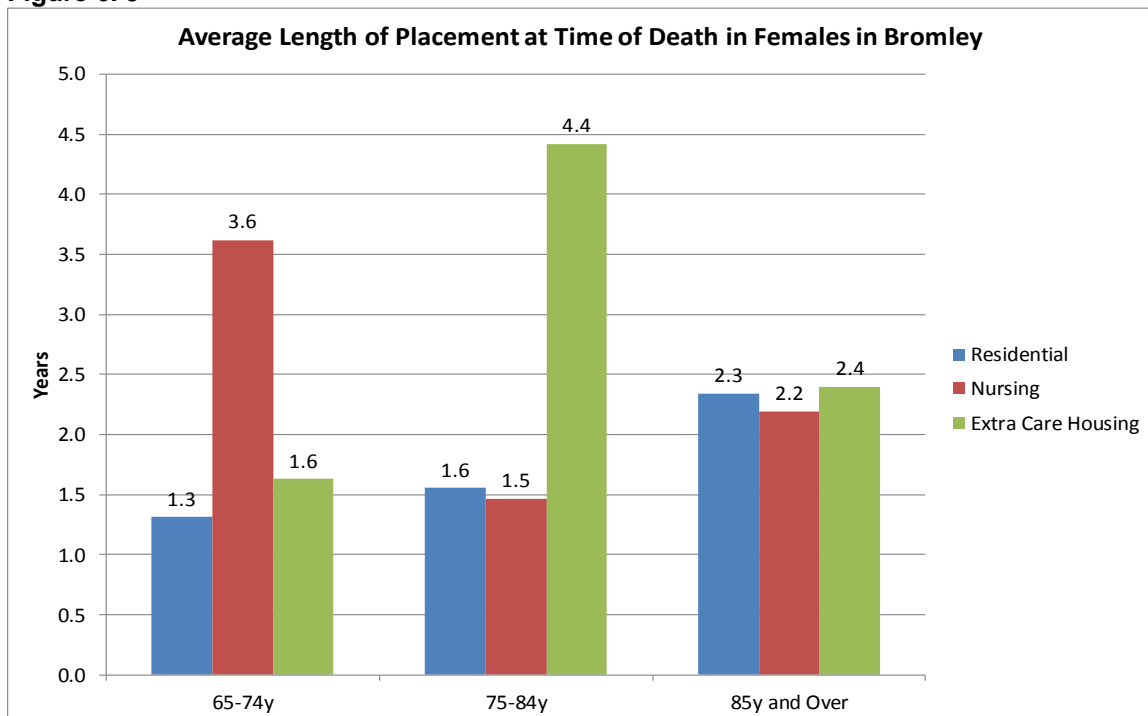
funded nursing care (i.e. were assessed as requiring nursing care in a care home). This gives an indication of the level of healthcare needs.

Figure 6.8



Source: Bromley Social Care 2015

Figure 6.9



Source: Bromley Social Care 2015

From the practice searches, it was possible to identify whether patients resident in care homes at the time of the 2015 search were registered with the same practice at the time of a previous search 18 months earlier in 2013.

Of the 1,110 patients identified in 2015, a significant proportion 48.9% (543) were found to be new to the practice during that 18 month period. There was some variation between practices, with one practice registering as many as 92 new care home patients in that time period, the median across practices being 21 patients. This represents a high workload for primary care.

Other Considerations

This report has focused on health conditions suffered by residents of care homes and has excluded a number of significant contributors to the care profile of this population i.e. conditions which increase care needs such as confusion, incontinence, and mobility problems because this information was not readily available.

There is evidence that residents of care homes are potentially disadvantaged in their access to primary and secondary care services, and this has not been explored in this report.

What does this mean for the residents of Bromley?

There are 67 nursing and residential care homes in Bromley with a total of 2055 beds and these include homes for older people, people with a learning disability and people with mental health needs. There are in addition a number of sites offering extra care housing in Bromley.

In comparison with the over 65 year population in Bromley as a whole, care home residents are far more likely to have a diagnosis of dementia or stroke, and overall more likely to be suffering from heart disease, kidney disease, cancer or diabetes. People in care homes are more likely than the general population over the age of 65 years to have two or more comorbidities. The care home population present a more complex healthcare challenge, and this needs to be reflected in the skills and training offered to care home staff.

Extra care housing residents tend to have a higher number of comorbidities than the care home residents, but care home residents are more likely to suffer from dementia, and to have mobility problems (arthropathies, fractures) than the extra care housing residents.

Care home residents have a relatively short (3 to 4 year) average length of stay before death, indicating that palliative care needs are important in this population.

For more information please contact Agnes.Marossy@Bromley.gov.uk

7. Excess Winter Deaths

Introduction

What is Excess Winter Deaths?

It is well established that in the UK the death rate is higher during the winter months (December – March). The cold of winter is hazardous to health - especially for the elderly and the sick. Direct effects of winter weather include an increase in incidence of heart attack, stroke, respiratory disease and influenza. The impact of cold weather on health is predictable and mostly preventable. For every degree Celsius the outdoor temperature falls below 5 degrees in London, deaths rise by around 4%.

Deaths in Bromley increased by around 20% during the winter months in 2010 - 2013 compared to other seasons of the year. This is termed Excess Winter Deaths (EWD). Excess deaths are not just deaths of those who would have died anyway in the next few weeks or months due to illness or old age. There is strong evidence that some of these winter deaths are indeed “extra” and are related to factors such as cold temperatures, living in cold homes as well as infectious diseases such as influenza. The last winter influenza epidemic occurred in 1999/2000 and was associated with a high level of excess winter mortality. In the years without flu epidemics, cold is shown to be the most important factor in excess winter deaths.

The Public Health Outcomes Framework (PHOF) reports on EWD, signalling the public health importance of this issue to the health of the population. Generally Bromley’s population fairs similarly or better than England in the PHOF indicator reports, but EWD has been a rare exception to this. Bromley has a high level of EWD compared to London or England, meaning we have more unexpected deaths in the winter months.

Although there are several factors contributing to winter illness and death, in many cases simple preventative action could avoid many of the deaths, illnesses and injuries associated with the cold. Mortality in winter increases more in England compared to other European countries with colder climates, suggesting that it is more than just lower temperatures that are responsible for the excess mortality in winter. In the recent past, the rate of winter deaths in England was twice the rate observed in some northern European countries, such as Finland. The importance of housing conditions is emphasised by international comparisons that show lower rates of excess winter deaths in countries where homes are more energy-efficient. For any given temperature people living in areas of higher EWD have been found to have lower indoor temperatures and to take fewer precautions against outdoor temperatures.

The winter period not only sees a significant rise in deaths but also a substantial increase in illnesses, which places additional stress on health and social care services and negatively impact people's physical and mental well-being. Studies into the impact of living in cold house have shown that, compared with those who live in a warmer house, respiratory problems are roughly doubled in children, arthritis and rheumatism increase, and mental health can be impaired at any age. Adolescents who live in a cold house have a fivefold increased risk of multiple mental health problems. Living in a cold house has indirect effects, some of which persist throughout life. In many such households, educational attainment is affected, emotional resilience is impaired, and the financial burden of heating a poorly insulated house impacts dietary intake. The excess winter death statistics are the extreme end of a spectrum of winter and cold related mortality and morbidity which occurs every year.

Understanding the Bromley picture

Calculating EWD and EWDI in Bromley

EWDs are the number of additional deaths each winter than the expected number given the deaths rates in non-winter months. In other words they are the difference between the number of deaths in December to March and the average number of deaths occurring in the preceding August to November and the following April to July. For the most recent year of data, August 2012 – July 2013, there were 150.5 excess winter deaths in Bromley. As Excess winter deaths are thought to be largely due to preventable factors, this represents 6% of Bromley deaths in this period that could have been prevented.

The Excess Winter Death Index (EWDI) indicates whether there are higher than expected deaths in the winter compared to the rest of the year by showing the percentage of deaths above that if deaths were evenly distributed throughout the year. The EWDI is calculated so that comparisons can be made between sexes, age groups and regions. It is calculated as the number of

Worked EWD and EWDI calculations for Bromley:

The total number of people dying over the year August 2012 – July 2013 was 2546.

949 people died in the winter months (December – March) compared to an average of 1597 deaths in non-winter months. Average non winter deaths are the deaths in August to November and April to July divided by 2. In this case 798.5 deaths.

$EWD = \text{winter deaths} - \text{average non-winter deaths}$

This gives an excess winter deaths figure of 150.5 additional deaths in the winter months

To turn this into an EWDI the EWD are divided by the average non winter deaths and multiplied by 100 or $EWDI = EWD / \text{average non winter deaths} \times 100$

excess winter deaths divided by the average non-winter deaths multiplied by 100. In the single year 2012 – 2013 the EWDI in Bromley was 19%, meaning deaths were 19% higher in the winter months.

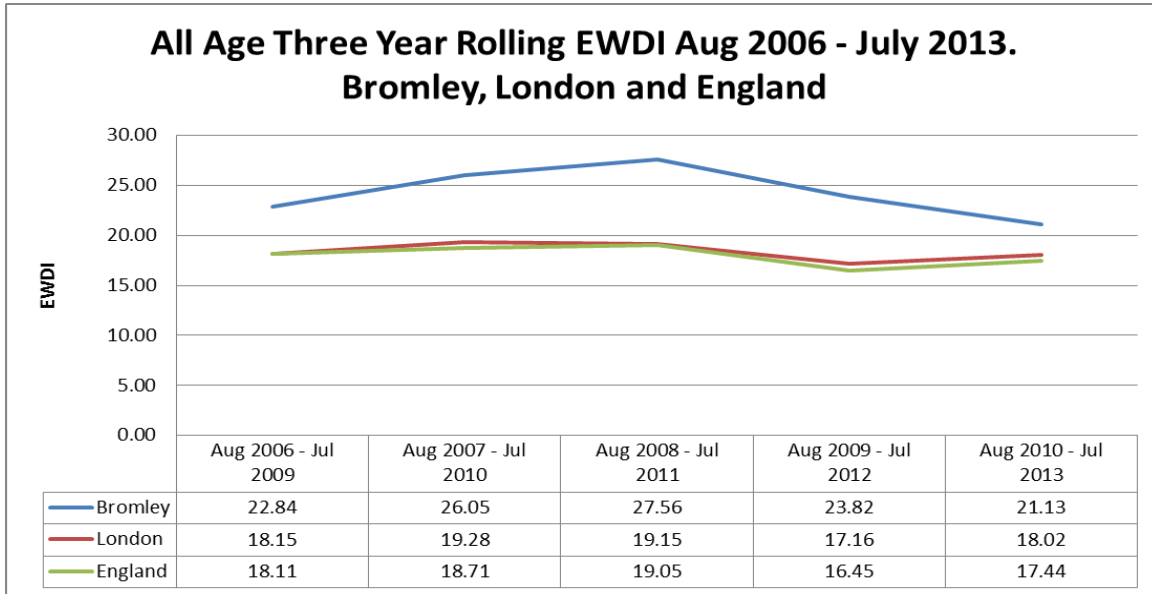
It is important to note that the most recent Bromley data released in 2015 by PHOF and ONS reports on EWDs up to July 2013. This unavoidable time lag is due to the time it takes for ONS to finalise mortality data and the PHOF to prepare the local level analysis. The most recent 3 year EWDI available covers the period 1st August 2010 to 31st July 2013.

Comparing Bromley EWDI with London and England

The nature of excess winter deaths leads to high variation year on year. Using 3 year rolling averages, some of the variation is smoothed out making it easier to see a trend and to make comparisons between areas. **Figure 7 1** shows the 3 year rolling all age EWDI for Bromley versus England and London. Bromley has a higher EWDI compared to both England and London. Bromley deaths in the winter months were between 21% and 28% higher than the summer months compared to between 16% and 19% higher in the winter months for England as a whole over the most recent 7 years for which we have data.

This is a statistically significant higher level compared to England between August 2007 and July 2012 (all age) and a statistically significant higher level compared to London between August 2008 and July 2012. The statistically significant higher level means we can be very sure the Bromley level is really higher than England or London and that this is not likely to have occurred purely by chance. As stated above, this higher level is not simply due to the fact we have large numbers of older people in Bromley as our population is similar to that of England. The most recent data shows a level of EWD in Bromley higher than London and England but this difference is not statistically significant.

Figure 7. 1: Three Year rolling Excess Winter Deaths in Bromley, London and England

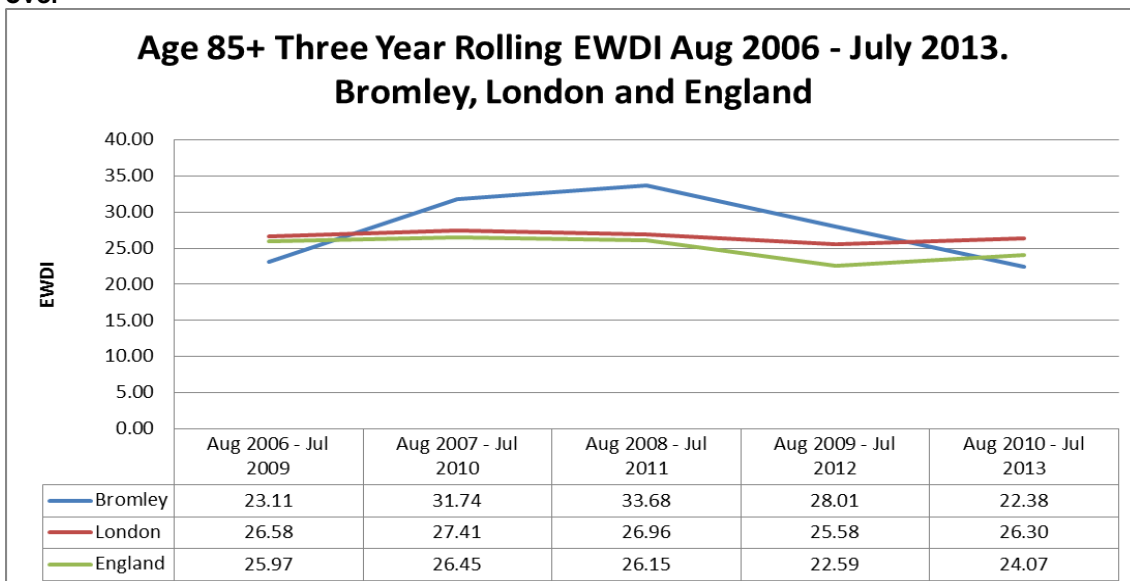


Source: PHOF, Feb 2015

EWDI and Age in Bromley

EWDI increases with age, with the elderly the group most susceptible to higher death rates in winter. This is true in Bromley when comparing the 3 year all age EWDI with the 3 year 85 years and over EWDI. Unlike the all age 3 year EWDI, the 85 and over Bromley population did not have a significant difference in EWDI (3 year) compared to London or England over recent years. Bromley deaths in the 85 years or older age group were between 22% and 34% higher in winter months than the summer months between 2006 and 2013 (Figure 7.2).

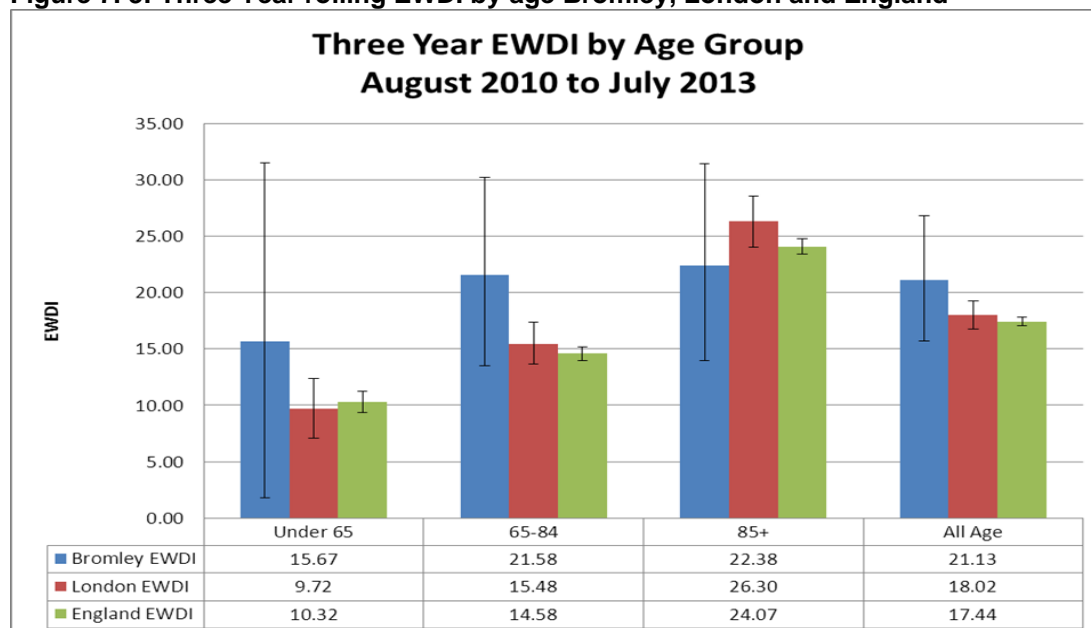
Figure 7. 2: Three Year rolling EWD in Bromley, London and England for people aged 85 and over



Source: PHOF, 2015

Further investigation into EWDI by age group, for the period August 2010 to July 2013, shows the EWDI increases with age in Bromley as in London and England. However, the upwards trend with age is less pronounced in Bromley with the 65-84 year, over 85 years and all age 3 year EWDI being more similar in Bromley than either London or England (**Figure 7.3**). Bromley appears to have higher EWDI compared to England and London for the under 65 year and 65-84 year age groups but this is not statistically significant (**Figure 7.3**).

Figure 7.3: Three Year rolling EWDI by age Bromley, London and England



Source: PHE West Midlands. Provided Feb 2015

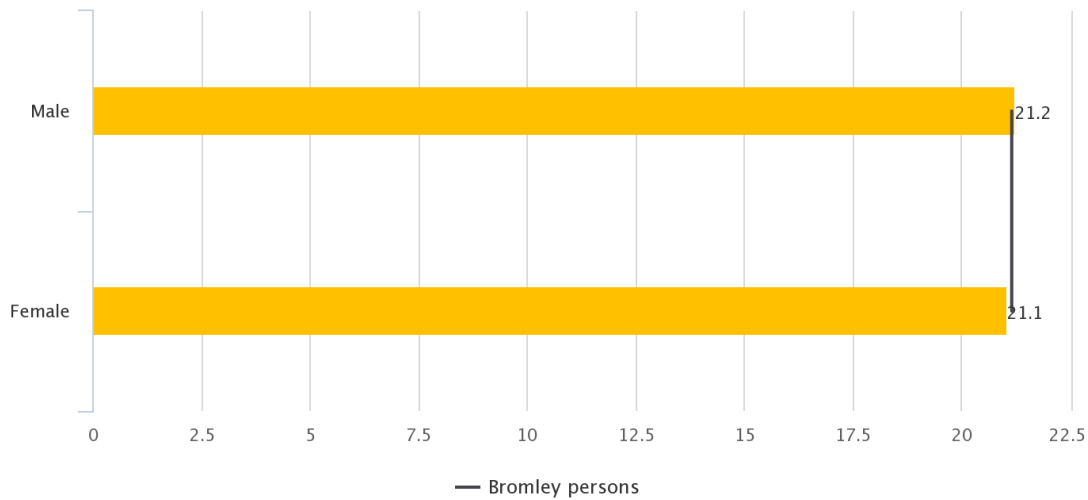
Given the 3 year EWDI for all age is higher than England, but the 3 year EWDI for 85 years and over is not, and given the pattern in **Figure 7.3** it could be that Bromley needs to consider the risk of EWD across a wider age range of older people and vulnerable groups, although the most elderly still have the highest EWDI.

EWDI and Gender

The most recent 3 year EWDI for Bromley shows men with a slightly higher EWDI than women, although this is not a significant difference so the EWDI in both genders can be considered similar (**Figures 7.4 and 7.5**).

Figure 7. 4: Bromley 3 year all age EWDI by gender

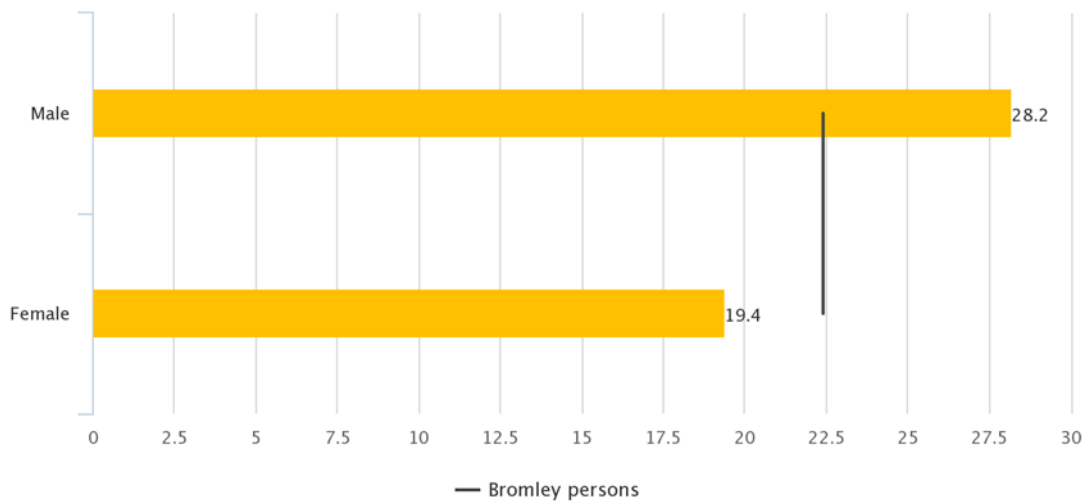
4.15iii – Excess Winter Deaths Index (3 years, all ages) (Persons) – Bromley, Aug 2010 – Jul 2013 – Data partitioned by Sex



Source: PHOF, 2015

Figure 7. 5: Bromley 3 year age 85+ EWDI by gender

4.15iv – Excess Winter Deaths Index (3 years, ages 85+) (Persons) – Bromley, Aug 2010 – Jul 2013 – Data partitioned by Sex

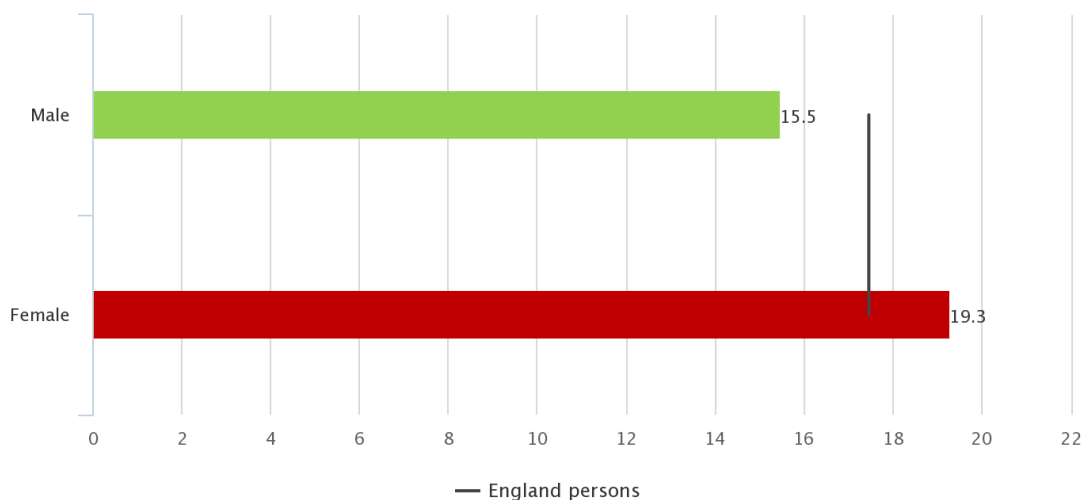


Source: PHOF, 2015

This is a difference from England where the most recent all age EWDI shows females have a higher EWDI than men, which is statistically significant (**Figure 7.6**). The 85 year+ EWDI for England in the same period shows no difference between the genders.

Figure 7. 6: England 3 year all age EWDI by Gender

4.15iii – Excess Winter Deaths Index (3 years, all ages) (Persons) – England, Aug 2010 – Jul 2013 – Data partitioned by Sex

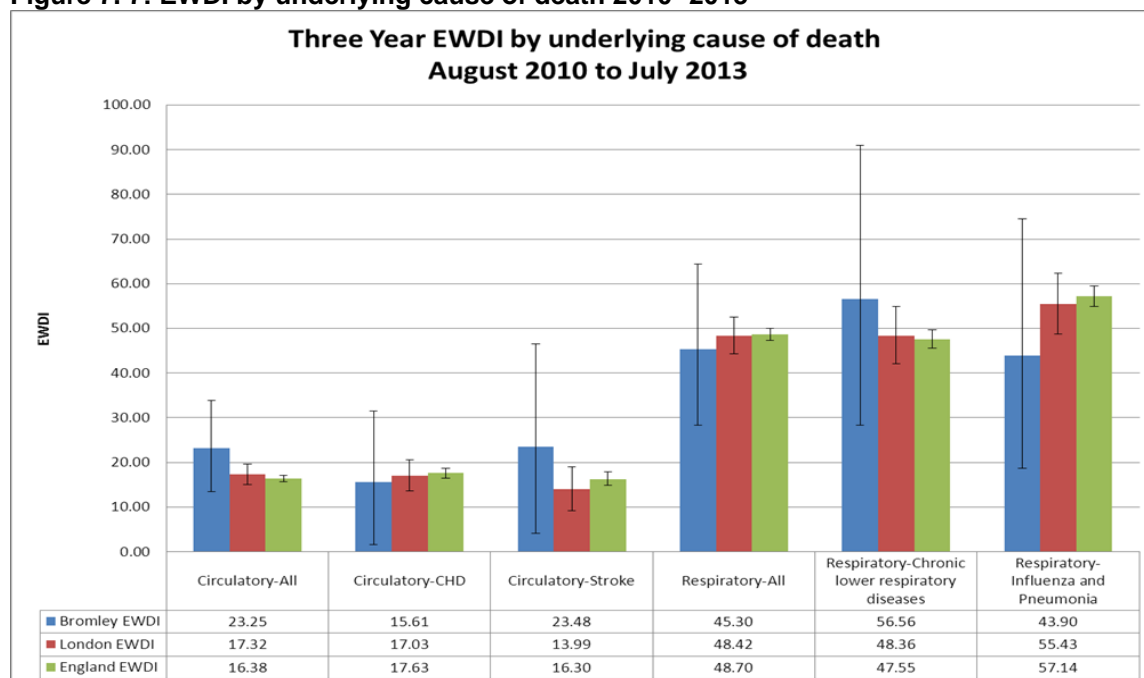
**Source: PHOF, 2015****EWDI by Condition**

Excess winter deaths can be attributed to nearly all the main causes of death. However certain conditions are known to be exacerbated during winter months. Previous studies have shown that circulatory and respiratory diseases contribute to most (70%) of the excess winter deaths in England. In non-epidemic years influenza accounts for around 10% of deaths.

EWDI broken down by underlying cause of death between 2010 – 2013 shows respiratory causes had the highest EWDI in Bromley, as in London and England. In the 3 years 2010 – 2013 45% more people died from all respiratory diseases in the winter, compared with the non-winter period. 23% more people died from all circulatory diseases in the winter than in the non-winter months (**Figure 7.7**). Circulatory diseases were one of the main causes of mortality in 2013 and the number of circulatory disease deaths remains high throughout the year, and the seasonal effects on mortality are not as high as seen with respiratory diseases. However, compared to London and England, Bromley's EWDI for all circulatory deaths appear higher and all respiratory deaths and influenza deaths appear lower (**Figure 7.7**).

This could be evidence that factors connected with the cold, causing circulatory deaths, may be more of an issue in Bromley than factors connected with influenza, when comparing Bromley to London or England.

Figure 7. 7: EWDI by underlying cause of death 2010 -2013

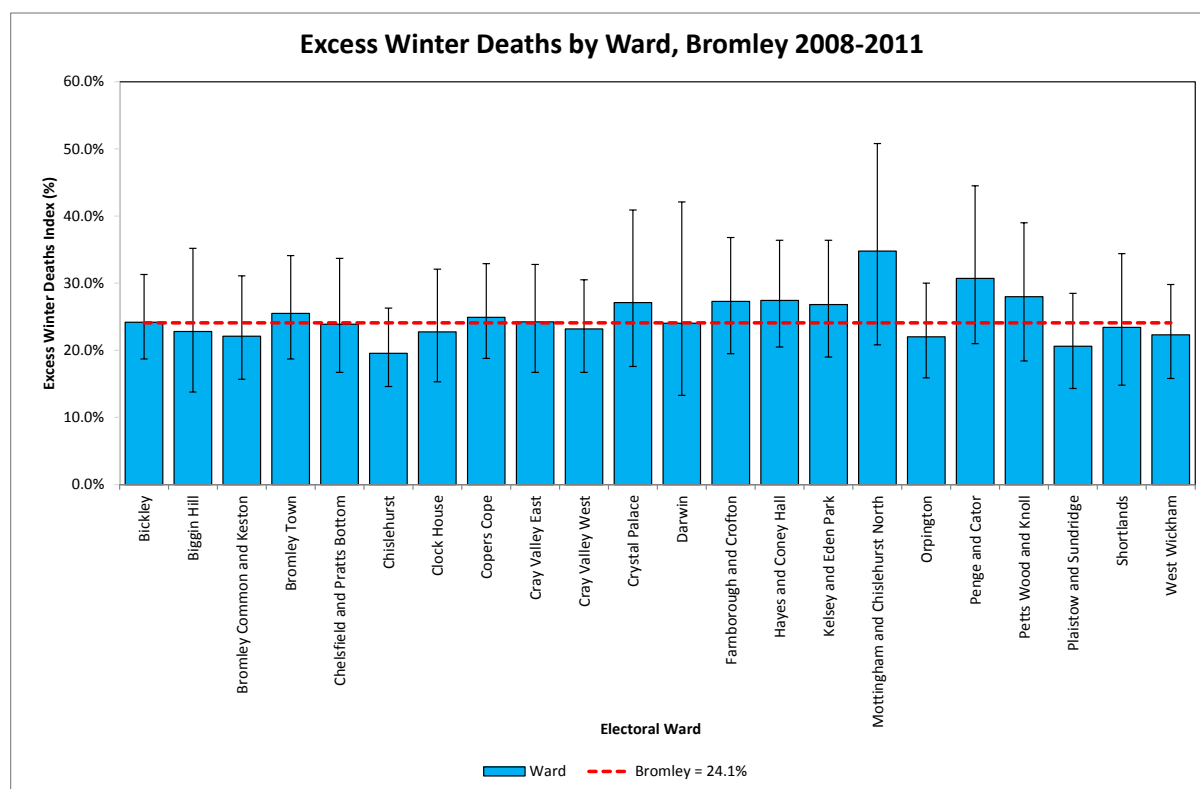


Source: PHE West Midlands. Provided Feb 2015

EWDI by Ward

A breakdown of EWDI by Bromley wards was conducted on the 2008 – 2011 data. The wards with the highest EWDI, above the Bromley average, were Mottingham & Chislehurst North, Penge & Cator and Petts Wood & Knoll. Wards with a statistically significant difference to England were Hayes and Coney Hall, Mottingham & Chislehurst North, and Penge & Cator. Some of these wards are areas with high deprivation, (Mottingham & Chislehurst North and Penge & Cator) but equally Petts Wood & Knoll and Hayes & Coney Hall are low deprivation areas. EWDs appear to be distributed across different levels of deprivation in Bromley (**Figure 7.8**). The Bromley average for this data appears slightly lower than the PHOF figure (Figure 7.1) since local data was used to allow ward estimates to be made.

Figure 7. 8: EWDI by Bromley Wards



Source: Primary Care Mortality Database (PCMD)

Comparison with Other Boroughs

Bromley is part of the ONS cluster ‘Thriving London Periphery’, with comparison areas being Hillingdon, Kingston upon Thames, Reading UA, Richmond upon Thames, and Sutton. Bromley had a higher all age EWDI than all comparison areas apart from Reading between 2006 and 2012. For the latest 3 year EWDI (2010 – 2013) Reading and Kingston were both higher than Bromley. Only Bromley and Reading had EWDI that were statistically significantly higher than England between August 2009 and July 2012 and only Kingston was significantly worse than England in the latest 3 year EWDI. Bromley is, therefore, not the only relatively affluent outer London area with a high EWDI. Equally other boroughs similar to Bromley do not have such high levels, suggesting more action could be taken on EWD in Bromley.

Summary

Bromley has a higher EWDI level than London and England and for an extended period between August 2007 and July 2012 the EWDI in Bromley was statistically significantly higher. The pattern of EWDI in Bromley might suggest EWD is a risk in a wider age range compared to the national situation and that circulatory causes are more prominent than nationally. The ward level breakdowns do not necessarily show a correlation between EWDI and deprivation in Bromley.

Underlying causes in Bromley

National evidence on underlying factors

Cold weather

In the years without flu epidemics, cold is shown to be the most important factor in excess winter deaths. The relationship between temperature, influenza and winter mortality is complex. The strongest link is between respiratory deaths and the cold. But because generally more people die from cardiovascular disease, cardiovascular illnesses and deaths account for most of the health problems.

Analysis confirms a rise in deaths associated with a 1 degree Celsius drop in temperature below the cold threshold (**table 7.1**). This threshold varies by region but is around 6 degrees Celsius.

Table 7. 1: Percentage change in deaths for every 1°C decrease in temperature below the ‘cold threshold’ (Data from Hajat et al 2013).

Region:	Threshold (°C)	% change in deaths (95% CI)
North East	6	3.99 (2.74, 5.23)
North West	5	2.82 (2.04, 3.61)
Yorkshire & Humberside	5	4.22 (3.15, 5.31)
East Midlands	7	4.11 (3.16, 5.07)
West Midlands	7	4.38 (3.43, 5.34)
East England	4	5.39 (4.43, 6.35)
London	5	3.96 (3.21, 4.71)
South East	5	2.66 (1.98, 3.34)
South West	8	3.35 (2.43, 4.28)

Housing

The high prevalence of cold, damp, poorly energy efficient households in the UK is considered one of the main reasons why the UK continues to have higher excess deaths over the winter period when compared with other European countries. International comparisons show lower rates of excess winter deaths in countries where homes are more energy-efficient.

Indoor temperature and markers of thermal efficiency of dwellings, including property age, are associated with increased vulnerability to winter death from cardiovascular disease. Wilkinson et al reported that the death rate rises about 2.8% for every degree Celsius drop in the external temperature for those in the coldest 10% of homes. This compares with a 0.9% rise in deaths for every degree Celsius drop in the warmest 10% of homes. Although not conclusive, these findings suggest that

substantial public health benefits can be expected from measures that improve the thermal efficiency of homes and the affordability of heating them.

Local public health teams report that paradoxically EWDs tend to be higher in more affluent areas, thought likely to represent owner occupiers living in older, colder homes. Studies from England suggest that people in social or local authority housing tend to have lower standardised heating costs (and higher standardised indoor temperatures) compared to owner occupiers or those in private rented accommodation. Other London boroughs with higher than national average EWDI in our ONS cluster have pointed to high excess winter mortality being due to pensioners living in under-occupied private housing which is expensive to heat adequately

The London Assembly Housing Committee published a report in 2013 which advised there would be are tremendous gains from providing older Londoners with the type of homes they need. These gains would be to the individuals in heating costs, to the NHS in health costs from old related illness and trip and falls, as older housing often has trip hazards. In additional by downsizing to specialist housing much needed family housing is also made available for other Londoners.

Fuel Poverty

Recent UK publications suggest that some 10% of excess winter deaths are directly attributable to fuel poverty and a fifth of excess winter deaths are attributable to the coldest quarter of homes. However, the relation to socio-economic deprivation is somewhat weak. The National Institute for Health and Care Excellence (NICE) have concluded the evidence is unclear in relation to socio-economic deprivation and to some extent even fuel poverty. This means that intervention strategies aimed only at low income and fuel poor households will not address a substantial part of the population burden of winter and cold-related mortality and morbidity.

Attitudes and behaviour with regards to warmth

At national level, evidence shows that older people, especially owner occupiers, often live in cold homes due to sub optimal behaviours and attitudes to keeping warm, notwithstanding whether they officially fall into fuel poverty. Factors usually associated with fuel poverty do not fully explain why some older people live in cold homes. Low home temperatures are not always explained by income and fuel cost and preferences for low temperatures not just held by those living in deprived areas. This weak relationship with socio- economic factors, the importance of age, and the wide range of health outcomes affected, suggest that the risk of winter- and cold-related mortality and morbidity is fairly widely distributed, especially in the elderly population, which has bearing on the targeting of interventions. But targeting action on socio-economically disadvantaged populations would nonetheless contribute to reducing inequalities in health.

The UK in comparison to colder countries at the same outdoor temperature has colder living rooms, bedrooms are less likely to be heated and individuals are less likely to wear appropriately warm clothing outside. While some of these differences may be due to poor housing, poor thermal efficiency or fuel poverty an element of behaviour is also at play.

Personal vulnerability factors

A number of demographic and other characteristics are associated with risk of winter and cold-related mortality and morbidity. These include age, female gender, and risks in relation to a wide range of disease outcomes, especially cardiorespiratory illnesses, which reflects vulnerability arising in relation to underlying medical conditions.

Recent evidence reviews conducted for the National Institute for Health and Care Excellence (NICE) have concluded age is probably the single most important determinant of vulnerability to winter and cold-related mortality and morbidity. Excess winter death is predominantly a problem that affects the elderly population. There are some winter health issues that may affect children in particular, such as respiratory symptoms and the adverse effects of housing on mental well-being, but younger population groups generally have a lower risk of adverse mortality outcomes than older population groups.

There is reasonably consistent evidence from a number of studies that women have slightly greater vulnerability to excess winter death than men. This may in part be explained by the fact women have a longer life expectancy than men and are overrepresented among the oldest age groups in the population. However, there is some evidence that they have slightly greater vulnerability even when age and other confounding factors are taken into account.

Many disease outcomes show seasonal increases during winter and have clear exposure-response relationships with low outdoor temperatures. Cardiorespiratory outcomes have relatively strong associations with cold. But many other causes of mortality, such as malignancies, also show some association with the cold. This suggests that many forms of illness and many pathophysiological pathways can be adversely affected by the cold and other winter-related factors. Respiratory conditions, especially chronic obstructive pulmonary disease, appear to have a comparatively steep response to low temperature, suggesting the link with low temperature and respiratory death is strongest. However, because of their greater underlying prevalence, the burdens of excess winter mortality and morbidity are greatest for cardiovascular outcomes, despite their somewhat shallower relationships with low ambient temperature.

Bromley factors

Underlying cardiovascular and respiratory disease in Bromley

Information on the prevalence of CHD, Stroke and COPD in Bromley are given in detail elsewhere in this JSNA.

When considering mortality from these conditions the mortality rates for cardiovascular disease (CVD), stroke and COPD in Bromley are lower than the rate for England. The PHOF also measures early mortality and preventable mortality (in those under 75) from cardiovascular disease and respiratory as a marker of people living with ill health and dying prematurely. The early CVD and respiratory mortality rates in Bromley for persons under the age of 75 years are statistically significantly better than England and London. Emergency admission rates for CHD, stroke and COPD in Bromley are lower than England and London.

As early preventable deaths from cardiovascular and respiratory causes and emergency admissions for CHD, stroke and COPD are better than regional and national levels it would suggest that control of these conditions and care for them is generally good in Bromley, compared to the country as a whole. Thus the general cardiovascular and respiratory health of the population or the care of these conditions is not likely to be a major contributing factor to the high EWDI in Bromley.

Influenza

At national level there has not been an influenza epidemic in the timeframe of the most recent 3 year EWDI. The winter of 2010/11 did have higher level of influenza than other recent years but equally 2011/12 was the lowest on record, and 2009 /10 levels of influenza were below baseline levels for most of the winter. It therefore seems unlikely, based on national data, that the high EWDI in the recent past is due to an increase in influenza activity; although local data would need to be explored further to rule this out.

Historical seasonal flu vaccination coverage, according to Public Health Outcomes Framework data, for the over 65 year age group in Bromley between 2010 and 2013 was over 70% and better or similar to London and England. However, for at risk populations in Bromley it was under 50% and worse than London and England (statistically significant difference). There may be a vulnerable population in Bromley, therefore, that was not protected against influenza and at increased risk of EWD contributing to the high all age EWDI. However, this population, and thus its contribution to total EWD, is small. Of note is that influenza vaccination uptake for at risk groups remains worse than England in the most recent PHOF data.

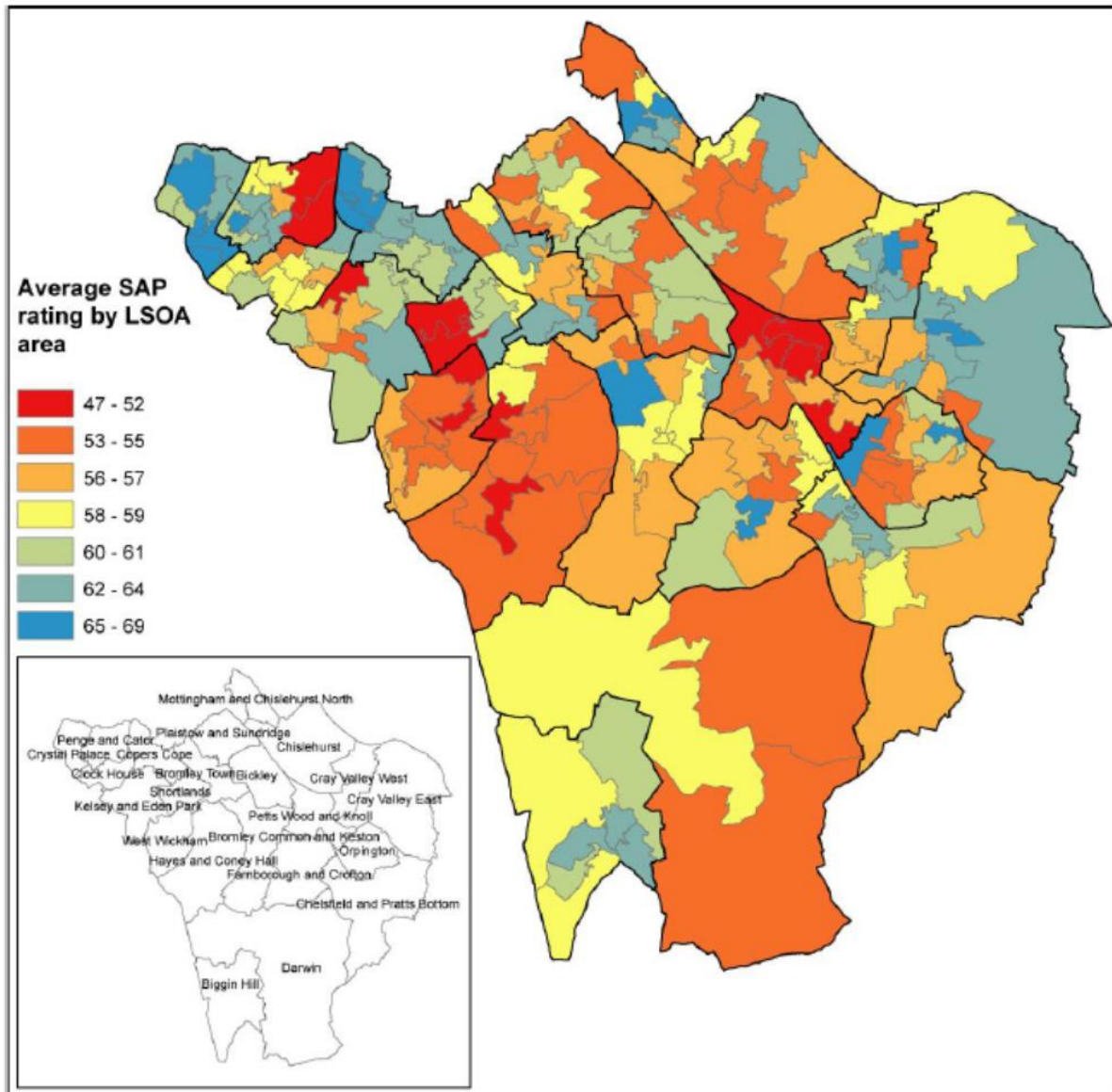
Cold Housing

Cold housing in Bromley is likely to be an important factor in the high EWDI. In Bromley we have a large proportion of older owner occupiers, many living in older less thermally efficient housing stock, and hence at risk of a cold home and EWD.

The link between EWDI and deprivation and thermal efficiency and deprivation are not clear in Bromley. The Government's recommended system for home energy rating is the Standard Assessment Procedure (SAP) which produces an energy cost rating known as the SAP rating or SAP score. The national average SAP score is 60. Looking at the SAP rating for local areas within wards, many local areas with an average SAP of under 55 are in wards which are relatively affluent (**Figure 7.9**).

This underlines national findings that there is not an exact link between fuel poverty, cold housing and EWD. EWD affects the whole elderly population. Interventions aimed only at low income and fuel poor households will not address a substantial part of the at risk population in Bromley.

Figure 7.9: SAP ratings within wards



Source: Bromley CROHM report. Parity Projects.

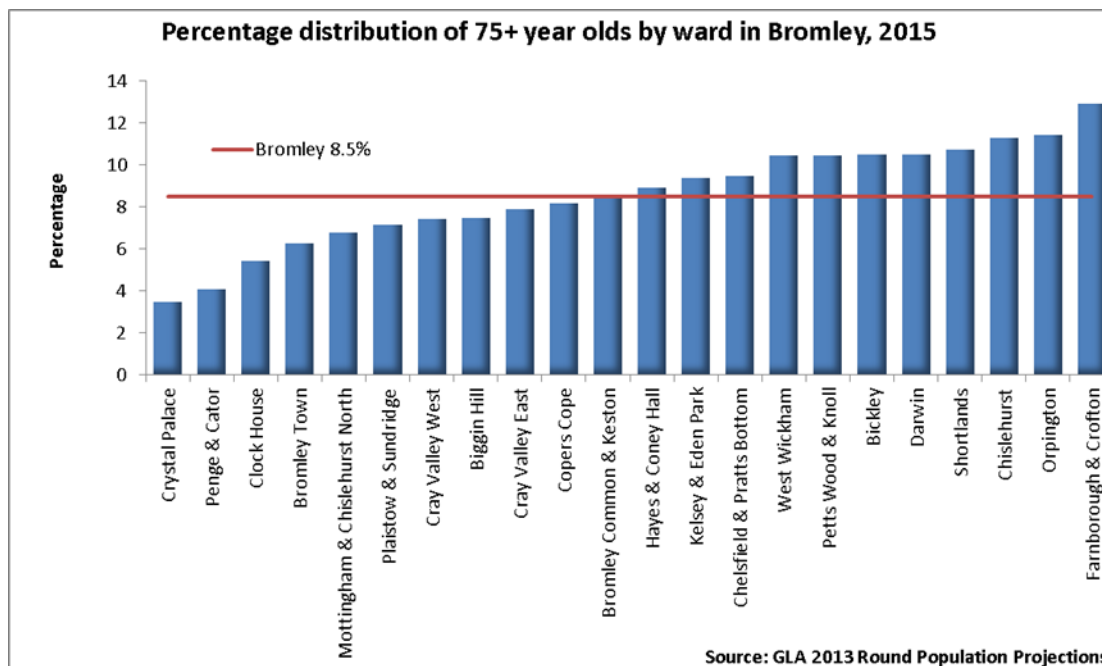
Bromley Populations at risk

As noted above, the entire elderly Bromley population is at risk of EWD, although those in the coldest homes, of the greatest age and with the highest burden of ill health are likely to be the most at risk. Individuals with these risk factors may live anywhere in the borough, but at ward level certain areas have less thermally efficient properties, older populations or higher levels of cardiovascular and respiratory disease which may point to particularly vulnerable areas for EWD. In Bromley, female gender does not appear to pose a greater risk of EWD.

Figure 7.9 above showed the areas with lowest thermal efficiency of housing. The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17.7% of the population in 2015 to 17.9% by 2020 and 18.7% by

2025. Over 75s are currently distributed with Farnborough & Crofton, Chislehurst and Orpington having the greatest proportions. Going forward the pattern of population change in different age groups is variable between wards, with some wards, such as Biggin Hill projected to experience a large rise in the proportion of over 75s.

Figure 7. 10: Distribution of over 75s in Bromley



Areas with highest levels of certain cardiovascular conditions (coronary heart disease (CHD) and stroke) and respiratory disease (chronic obstructive pulmonary disease or COPD) are shown below in **table 7.2**.

Table 7. 2: Wards with highest levels of cardiovascular and chronic obstructive pulmonary disease

Wards with highest % recorded COPD	Wards with highest % recorded CHD	Wards with highest % recorded stroke
Cray Valley West	Orpington	Orpington
Orpington	Farnborough & Crofton	Bickley
Cray Valley East	Darwin	Kelsey & Eden Park

Source: JSNA, 2014

There is some overlap in the areas with higher levels of older people and cardiovascular or respiratory disease (Orpington, Farnborough & Crofton). This does not overlap with the wards which contain the areas with worse SAP ratings for housing (47- 52) but there is some overlap with wards containing areas with SAP ratings below 55 (dark orange in **Figure 7.9**). Risk factors for disease, older populations and poorer energy efficiency are likely to co-exist to a greater extent in areas within Farnborough & Crofton and Orpington and these might form areas to particularly target with measures to counter EWD.

Mobile homes are particularly difficult and expensive to heat. A vulnerable group may therefore be Bromley's Gypsy Traveller and travelling show people populations living in caravans. Bromley Borough is believed to have one of the largest groups of Gypsies and Travellers in England. Gypsies and Travellers suffer significantly more health problems than any other minority ethnic groups in the UK, and report up to five times more health problems than the general population. The total in caravans is small, around 120 caravans, but should be remembered in targeted interventions. In addition there are eight LBB Licensed Mobile Home Residential Sites with 145 units whose residents may similarly find it difficult to heat their homes.

High EWD is likely to be a continuing problem in Bromley given that there is a growing elderly population and it is unlikely that a rapid change will occur with regards the energy efficiency of housing stock or the proportion of older people living as owner occupiers.

Conclusion

Interpreting Bromley EWDI is complex and depends on the indicator and timeframe analysed. The all age 3 year rolling average, which smooths out the large variation that occurs in single years, would point towards Bromley having a higher level of EWD than England for an extended period of time between August 2007 and July 2012. The most recent all age 3 year rolling EWDI for Bromley is higher than England, but not statistically significant. This may indicate that the EWDI levels have improved in Bromley to a level similar to England. But given the extended period of time that EWDI was higher, on-going attention to this issue is needed.

Table 7. 3: Excess Winter Deaths Index Related PHOF Indicators, 2015

Indicator	Time Period	Sex	Bromley	London	England
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2006 - Jul 2007	Persons	17.88	13.44	15.56
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2007 - Jul 2008	Persons	19.15	17.61	16.02
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2008 - Jul 2009	Persons	33.03	24.74	24.01
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2009 - Jul 2010	Persons	27.06	16.24	17.21
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2010 - Jul 2011	Persons	23.44	17.31	17.01
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2011 - Jul 2012	Persons	21.74	19.11	16.12
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2012 - Jul 2013	Persons	18.85	18.87	20.15
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2012 - Jul 2013	Male	18.83	17.78	17.53
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2012 - Jul 2013	Female	18.87	19.92	22.60
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2006 - Jul 2007	Persons	15.27	21.82	22.47
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2007 - Jul 2008	Persons	18.40	23.55	21.86
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2008 - Jul 2009	Persons	36.92	34.51	33.80
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2009 - Jul 2010	Persons	41.84	24.39	24.05
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2010 - Jul 2011	Persons	23.26	22.23	21.22
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2011 - Jul 2012	Persons	20.00	30.18	22.85
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2012 - Jul 2013	Persons	23.85	26.53	28.19
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2012 - Jul 2013	Male	38.74	26.53	26.66
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2012 - Jul 2013	Female	16.56	26.54	29.07
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2006 - Jul 2009	Persons	22.84	18.15	18.11
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2007 - Jul 2010	Persons	26.05	19.28	18.71
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2008 - Jul 2011	Persons	27.56	19.15	19.05
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2009 - Jul 2012	Persons	23.82	17.16	16.45
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2010 - Jul 2013	Persons	21.13	18.02	17.44
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2010 - Jul 2013	Male	21.21	16.16	15.48
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2010 - Jul 2013	Female	21.06	19.86	19.28
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	Aug 2006 - Jul 2009	Persons	23.11	26.58	25.97
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	Aug 2007 - Jul 2010	Persons	31.74	27.41	26.45
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	Aug 2008 - Jul 2011	Persons	33.68	26.96	26.15
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	Aug 2009 - Jul 2012	Persons	28.01	25.58	22.59
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	Aug 2010 - Jul 2013	Persons	22.38	26.30	24.07
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	Aug 2010 - Jul 2013	Male	28.21	26.12	23.21
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	Aug 2010 - Jul 2013	Female	19.39	26.40	24.56

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

What does this mean for Bromley residents and for children in Bromley?

EWDI in Bromley is worse than England and there are around 150 potentially preventable winter deaths each year, accounting for 6% of all Bromley deaths. People especially at risk include those living in poorly heated or expensive to heat homes, the elderly and those with underlying respiratory and cardiac conditions.

Relative deprivation in Bromley is not necessarily associated with excess winter mortality and poorly heated housing can occur in the owner occupier or privately rented sector. This means the risk of EWD is widely distributed across the elderly population.

Given the high EWDI and the underlying risk factors present, efforts to understand and address EWD needs multi stakeholder efforts across statutory and voluntary sector involved in health, social care, housing, planning and environmental services in Bromley.

NICE issued guidance in 2015 on excess winter deaths and illnesses associated with cold homes to further inform action on this issue.

The full report on Excess Winter Deaths is available on request.
For further information please contact Dr Agnes Marossy
(Agnes.Marossy@Bromley.gov.uk)

8. Vulnerable Young People

Children with Special Educational Needs and Disabilities (SEND)

Children with complex health needs, but no Statement or EHC Plan

London Borough of Bromley continues to support **43** children in mainstream schools with complex health needs, including some requiring airway support, Hickman lines, support for complex diabetes and gastrostomy tube feeding. This support has been implemented across **30** primary and secondary schools in the Borough, without necessitating a full Statement or EHC Plan. Support is also offered from the integrated team for specialist equipment to meet both health and learning needs.

This section provides a range of information for children with Special Educational Needs and Disabilities within the following sections:

- Educational needs
- Health needs

Educational needs

The number of pupils in Bromley schools with Special Educational Needs is currently at 7,956 pupils (based on the January 2014 school census), which has however decreased by 580 children since 2011 - as illustrated in **Table 8.1**.

Table 8. 1

Pupils in Bromley Schools with Special Educational Needs							
	2009	2010	2011	2012	2013	2014	2015
Number of pupils in Bromley schools with SEN	8,340	8,337	9,465	9,205	8,885	7,956	7,771
Difference	328	497	628	-260	-320	-929	-185
% of pupils in Bromley schools with SEN	17.9%	17.8%	18.4%	17.8%	16.9%	16.5%	14.5%

Source: Department for Education

The number of pupils in Bromley with Statements of Special Educational Needs increased from 1,645 in 2009 to 1,901 in 2013, followed by a decrease of 210 to 1,691 in 2014.

Table 8. 2

Pupils in Bromley Schools with Statements of Special Educational Needs or EHC Plan							
	2009	2010	2011	2012	2013	2014	2015
Number of pupils in Bromley schools with statement of SEN	1,645	1,704	1,786	1,779	1,901	1,691	1,726
Difference		59	82	-7	122	-210	35

Source: Department for Education

However this does not include all pupils with statements maintained by London Borough of Bromley. This figure shows a smaller fall in 2014.

Table 8. 3: Numbers of pupils with statements maintained by Bromley

2010	2011	2012	2013	2014
1885	1940	1975	1975	1915

Source: London Borough of Bromley

Despite this small reduction in numbers, the percentage of pupils with statements in Bromley schools is above the national and London average and above the three closest statistical neighbours.

Table 8. 4: Percentage of pupils with statements based on where they attend school

	2009	2010	2011	2012	2013	2014	2015
England	2.8	2.8	2.8	2.8	2.8	2.8	2.8
London	2.7	2.7	2.7	2.7	2.7	2.7	2.8
Bromley	3.2	3.3	3.5	3.4	3.6	3.4	3.2
Hertfordshire	2.1	2.0	2.0	2.0	1.9	1.9	1.9
Trafford	2.5	2.9	3.0	3.2	3.3	3.5	3.4
Sutton	3.1	3.1	3.2	3.2	3.1	3.0	2.9

Source: Department for Education

Table 8. 5: Statements issued by Bromley by type of school

	2012	2014
Maintained special schools	482	493
SEN units in mainstream	184	146
Maintained mainstream schools	1059	1008
Independent non-maintained schools	204	208
Other	60	69
TOTAL	1989	1924

Source: London Borough of Bromley

It is helpful to review the percentage of each type of need of pupils with statements. These are mostly similar to those of 38 other authorities, with the following exceptions:

- Specific learning difficulties – above average (1.77% Bromley, 0.77% statistical neighbours)

- Moderate learning difficulties – below average (2.60% Bromley, 3.24% statistical neighbours)
- Speech, language and communication needs (SLCN) -significantly above average
- (10.12% Bromley, 3.16% statistical neighbours) 64 children with SLCN (9%) in independent non-maintained schools against statistical neighbours average of 6%.

Patterns of service use of pupils with SEN show some differences to other areas:

- Pupils with speech and language and communication needs are more likely to be attending maintained mainstream schools but are less likely to attend maintained special schools in Bromley compared to the statistical neighbours (16% and 22% respectively).
- There are slightly more pupils with Behavioural, Emotional and Social Difficulties (BESD, now known as Social Emotional and Mental Health needs, SEMH) in Bromley compared to the statistical neighbours). The rate for Bromley per 1,000 population is 2.97 compared to 2.65 across statistical neighbours.
- Students with SEMH/BESD are more likely to attend maintained mainstream schools but the proportion is slightly lower compared to the statistical neighbours (24% and 27% respectively).
- More Bromley pupils with SEMH/BESD are likely to attend independent schools compared to statistical neighbours (24% and 15% respectively).
- Bromley has higher rates of pupils with specific and moderate learning difficulties compared to the other boroughs, and they are more likely to attend mainstream schools compared to other pupils with similar needs from statistical neighbours.
- In addition, there are more pupils in Bromley who have severe or profound and multiple learning difficulties and are more likely to be attending maintained special schools.
- There are higher numbers of pupils with Autistic Spectrum Disorder in Bromley compared to statistical neighbours; 5.20 compared to average rate of 4.54. They are more likely to attend mainstream schools (51% compared to statistical neighbours average of 45%) or SEN units in mainstream schools compared with statistical neighbours.

Educational attainment

Pupils who have a significant degree of Special Educational Needs and Disability perform less well than their peers at all Key Stages and subjects. This makes closing the attainment gap for children with SEND difficult, as the severity of SEN and disabilities in some pupils means that some pupils will never reach the expected level of attainment.

The following tables provide the performance of pupils with Special Educational Needs at the following levels Statemented, School Action, and School Action Plus compared to pupils who have no SEN.

Table 8. 6

Performance at Key Stage 1 in 2013 and 2014: % Achieving Level 2+							
	No. of pupils 2014	Reading		Writing		Maths	
		2013 %	2014 %	2013 %	2014 %	2013 %	2014 %
No SEN	3095	97	98	94	96	98	98
School Action	284	77	75	64	61	75	81
School Action Plus	230	57	61	40	50	52	70
Statement or EHC Plan	146	41	25	33	18	41	28

Source: Department for Education

What does this tell us?

In 2014, pupils at School Action and Statemented pupils performed less well than the previous year but pupils at School Action Plus performed better.

Table 8. 7

Performance at Key Stage 4 in 2013 and 2014				
	No. of pupils 2014	% 5 A*-C inc. English and maths		England
		2013	2014	2014
No SEN	2793	85	73	66
School Action	217	36	35	25
School Action Plus	198	31	25	21
Statement or EHC Plan	87	18	21	8

Source: Department for Education

What does this tell us?

The proportion of SEN pupils in Bromley who achieved 5 or more GCSE A*-C grades (including English and mathematics) is lower than that of pupils who have no SEN and lower than last year. However, performance in all groups is above the national average.

What does this mean for Bromley residents and for children in Bromley?

Compared to similar areas there are higher rates in Bromley of children with speech, language and communication needs, children with severe, profound and multiple learning difficulties, and pupils on the autistic spectrum. Pupils with behavioural, emotional or mental health needs are more likely to attend independent schools.

For more information on Children with Special Educational Needs and Disabilities please contact Georgina.Sanger@Bromley.gov.uk

8.2 Looked After Children (Children in Care)

Children in Care are some of the most vulnerable children in society; living away from their families because their parents faced difficulties and pressure in providing for their care or because the children have suffered abuse or neglect whilst in the care of their families.

Children in Care (also known as Looked After Children) are provided with care and accommodation which meet their needs. Most often this will be with foster carers but young people may also be placed in residential schools, care homes, or units. Most children spend a short time in the care of the council either returning to their families or moving to permanent arrangements such as adoption, but for others their stay may be for several years lasting to adulthood.

General Profile of Looked After Children (LAC) in Bromley

- The number of looked after children as at the end of each financial year has remained relatively stable, ranging between 250 - 286 over the last seven years.
- The rate of 38 looked after children per 10,000 population under 18 is lower than comparator groups. The rate is 64 for inner London, 48 for outer London and 60 nationally.
- There is an increase in the percentage of looked after children from black and minority ethnic (BME) groups.
- A high proportion of looked after children (72%) have special educational needs, and 41.2% of LAC have a Statement of Special Educational Needs.
- There are relatively low number of unaccompanied asylum seeking children in Bromley

Placements and Stability

- 75% of looked after children are in foster placements, of these 62.9% are placed with in-house foster carers.
- Placement stability – the percentage of children in long term placements (over 2 years) has always been an area of good performance for Bromley.
- The percentage of children with 3 or more placement moves is currently 12% a 1% reduction on the previous year and is in line with comparator groups.
- The percentage of looked after children placed out of the borough and more than 20 miles from where they used to live is currently 20% of looked after children compared to 15% of children in statistical neighbour authorities, and 13% nationally. It has reduced from 22% in 2012/13.

Adoption Performance

- In 2013/14, 14 children and young people were adopted.
- The average length for care proceedings in Bromley is 48 weeks which is the national average

Outcomes for Looked After Children

- Educational attainment has varied widely over the years. This is predominantly due to very small numbers in each national curriculum year group and the high proportion of children and young people with statements of educational need.
- The overall school absence level for looked after children is lower than comparator boroughs. However persistent absence is higher at 8.2% compared to 5.5-6.5%.
- There have been no permanent exclusions of looked after children from school in the last 6 years. The percentage of LAC with at least 1 fixed term exclusion is 16.5% which is higher than comparator boroughs.
- 46% of care leavers are currently in education employment and training. This compares to 48% for statistical neighbours, 54% for London and 45% nationally. 43% of Bromley care leavers are “Not in Employment, Education or Training” (NEET). For 11% of care leavers their status is unknown.
- 94% of looked after children have up to date immunisations which is higher than comparator boroughs. 83% have had regular dental checks which is lower than our comparators.
- There has been an increase in the emotional health (SDQ) questionnaire score which is currently 14.6. This is slightly higher than comparator boroughs and an increase on the previous year.

Bromley has a relatively high proportion of older children. This reflects a similar trend across the statistical neighbours, London and England.

Ethnicity of LAC

The number of LAC from BME groups has fluctuated between 25-28% over the last 4 years. In March 2014 this was 31% (85 young people) from BME groups when compared against the 2014 DFE analysis of Looked After Children this rate is higher than the 20% statistical neighbour average but lower than the outer London average of 51% and the inner London average of 68%. This rate is higher than the resident population BME figure of 18%, but does reflect the BME population demographic for the areas where LAC are coming from within the borough.

Table 8. 8

	2014		2013		2012		2011		2010	
	% All SEN	% with Statements	% All SEN	% with Statements	% All SEN	% with Statements	% All SEN	% with Statements	% All SEN	% with Statements
Bromley *	71.8% (95)	41.2% (55)	67.8% (80)	38% (45)	77.7% (95)	38.0% (45)	89.4% (120)	43.9% (60)	83.9 (95)	46.4% (50)
Statistical Neighbours	66.7%	30.2%	67.2%	29.4%	71.8%	31.6%	72.8%	31.2%	73.1%	31.6%
London	67.6%	30.1%	68.7%	29.6%	73.0%	30.7%	73.0%	30.7%	73.0%	30.7%
England	66.6%	29.0%	67.8%	28.5%	71.5%	29.4%	71.5%	29.4%	71.5%	29.4%

*Numbers of young people in brackets

Source: Department for Education

Unaccompanied Asylum Seekers (UASC)

There are declining numbers of UASC particularly in outer London boroughs. This is in part due to a legislation change in 2007 whereby a number of UASCs are diverted to 50-60 LAs throughout England to ease the pressure on London authorities. The numbers in Bromley are very small compared to authorities such as Croydon.

Health of Looked After Children

Bromley is successful in making sure that immunisations and health assessments are up to date. 94.4% of immunisations were up to date compared to 82% for statistical neighbours and 87% nationally. The proportion of young people attending dental checks each year is slightly lower than comparators but increasing.

Table 8. 9: Health Checks completed on time

	Number of children looked after for at least 12 months	Number of children whose immunisations were up to date		Number of children who had their teeth checked by a dentist		Number of children who had their annual health assessment	
		Number	%	Number	%	Number	%
Bromley 2014	180	170	94.4%	150	83.3%	160	88.8%
Bromley 2013	175	165	94.2%	140	80.0%	155	88.5%
Bromley 2012	185	165	89%	145	78%	165	89%
<i>Statistical Neighbours</i>	3,035	2,500	82.4%	2,555	84.1%	2,610	85.9%
<i>London</i>	6,550	5,520	84.2%	5,750	87.8%	6,040	92.2%
<i>England</i>	47,670	41,510	87.0%	40,240	84.4%	42,140	88.4%

Source: Department for Education

“Strength and difficulties questionnaires” (SDQs) are required annually to assess the emotional health of LAC aged 4 to 16 who have been looked after continuously for at least twelve months. The questionnaire is completed by the carer. A higher score on the SDQ indicates more emotional difficulties. A score of 0-13 is considered normal, 14-16 is considered borderline cause for concern and a score of 17 and over is a cause for concern. Bromley has averaged a score of 13 over the last 4 years. In 2014 however this has increased to 14.6.

Bromley has a smaller proportion of normal scores than its statistical neighbours and a higher proportion of scores causing concern based on the 2014 data. This has changed from 2013 where we had a higher proportion of normal scores and a lower proportion of those causing concern.

Table 8. 10: Emotional health SDQ analysis 2014

	Percentage of eligible children with an SDQ score considered:		
	Normal	Borderline	Concern
Bromley	49%	11%	39%
<i>Statistical Neighbours</i>	50%	12%	37%
<i>London</i>	53%	13%	40%
<i>England</i>	50%	13%	37%

Source: Department for Education

Table 8. 11: Emotional health average score per child over time

	2014	2013	2012	2011
Bromley	14.6	13.5	13.8	13.1
Statistical Neighbours	14.0	14.6	14.6	13.6
London	13.4	13.5	13.6	13.6
England	13.9	14.0	13.9	13.9

Source: Department for Education

Bromley CAMHS Looked After and Adopted Children's (LAAC) Specialist Mental Health Team

A new team has been formed to look after the emotional health needs of LAC and adopted children. In the first 6 months of operation (December 2014 to May 2015), 42 referrals were accepted, of which 12 were adopted children. During the same time period from the previous year (December 2013-May 2014) a total of 19 referrals were accepted by the team (only Looked After Children). The increased number of young people seen reflects increasing need for CAMHS support in LAC and extending the service to include adopted children.

All referrals are triaged via the Wellbeing service initially. The majority of the original referrals (61%) came from the child's social worker, and 14% of referrals from the child's GP.

Of the 42 cases seen by the team, 6 were placed outside of Bromley. 5 of the children accepted into the service had known developmental diagnosis, for example autism, ADHD or severe to profound learning difficulties

The most common presenting problems were extreme neglect and emotional abuse, with 43% of referrals having experienced at least one of these. Eleven per cent of referrals were known to social care to have sexual abuse histories. Almost 30% of children had been physically abused, while 20% had witnessed domestic violence in the family. Eleven per cent of children had a parent with mental health difficulties and almost 30% of children had at least one parent with substance abuse difficulties. 20% of children referred had also experienced multiple placement breakdowns since being in foster care.

There was a wide range of interventions requested by services. The most requested intervention was for an assessment of mental health (37%), followed by individual therapy (28%), assessment to inform care proceedings (12%), Parent-Child/Family Therapy (10%), Carer Support (5%), Consultation (2%) and combinations of support e.g. Individual and Carer support or this with the addition of consultation (3%).

Educational attainment of LAC

When looking at the attainment of Looked After Children the key factor worth noting are the very small numbers in each cohort.

Key Stage 1

Table 8. 12: Percentage of children achieving level 2+ at Key Stage 1

	Reading	Writing	Speaking and Listening	Maths
2014	56%	56%	63%	56%
2013	60%	60%		60%
2012	57%	57%		42%
2011	76%	44%		76%
Statistical Neighbours (2014)	77%	68%		79%
London (2014)	68%	61%		70%
England (2014)	71%	61%		72%

Source: Department for Education

In the 2014 Key Stage 1 assessments 11 pupils formed the reporting cohort of which 56% of pupils achieved Level 2+ (the expected level for KS1). This is lower than the London and National averages. The small numbers in the cohort each year does mean that performance fluctuates. Six of the 11 pupils in the cohort have a Statement of Special Educational Needs.

Key Stage 2 (KS2)

Table 8. 13: Percentage of children achieving level 4+ at Key Stage 2

	2014 (provisional)	2013	2012	2011	2010	2009	2008
NI 99: Percentage of children in care reaching level 4 in Reading at KS2	Combined Reading, Writing and Maths scores 63%	Combined Reading, Writing and Maths scores 55%	28%	50%	100%	40%	40%
NI 100: Percentage of children in care reaching level 4 in maths at KS2			28%	40%	80%	20%	20%
<i>England - Percentage of children in care reaching level 4 in Reading* at KS2</i>	48%	59%	60%	54%	50%	48%	50%
<i>England - Percentage of children in care reaching level 4 in maths at KS2</i>			56%	52%	49%	48%	47%

* 2014 the DFE measured performance in English and maths changed to Reading, writing and maths combined. Comparator groups have not been included here as data is suppressed due to small reporting cohorts

Source: Department for Education

There were 8 looked after pupils in the 2014 reporting cohort. Of this 8 pupils, 3 (36%) have SEN and 1 pupil has a Statement of Special Educational Needs. 63% of the cohort achieved Level 4 and above in reading, writing and maths combined.

In terms of levels of expected progress, 7 out of the 8 pupils (88%) made 2 levels of progress or more in English and 6 out of 8 pupils (75%) have made 2 or more levels of progress in maths. This compares favourably to progress in previous years.

GCSE

The issues faced at KS2 are also factors at KS4; small cohort numbers and high levels of SEN. This means that performance in the national indicator of 5⁺ A*-C including English and maths does fluctuate.

Table 8. 14: A summary of GCSE performance over the last five years

	2013	2012	2011	2010	2009
5 A* - C including English and Maths	16%	11 %	8.6%	25%	10%
5 A* - C	21%	22.2%	25.7%	43%	29%
5 A*-G	21%	55%	48.6%	63%	47.6%
1 A*-G	26%	88%	74.3%	75%	71.4%
England average 5A*-C including English and maths	15.3%	14.6%	13.6%	12.5%	10.9%

Source: Department for Education

Exclusions and School Attendance

There have been no Bromley Looked After Children permanently excluded from school in the last 6 years. Bromley's fixed term exclusion rate had been decreasing from the 2009 figure, but increased again to 16.5% in 2013/14. This pertains to 22 young people out of a cohort of 133. This is higher than statistical neighbours, London and national data.

Table 8. 15: Percentage of children with at least one fixed term exclusion

	2013	2012	2011	2010	2009	2008
Bromley	16.5%	9.1%	10.3%	12.8%	16.5%	12.0%
Statistical Neighbours	11.4	13.4%	13.2%	14.7%	17.2%	16.6%
London	10.0	12.5%	12.9%	13.5%	13.2%	13.2%
England	9.8	11.4%	11.8%	12.6%	13.3%	14.2%

Source: Department for Education

Table 8. 16: Absence of children looked after

	2013		2012		2011		2010		2009	
	Overall Absence %	Persistent Absence %	Overall Absence %	Persistent Absence %	Overall Absence %	Persistent Absence %	Overall Absence %	Persistent Absence %	Overall Absence %	Persistent Absence %
Bromley	4.1	8.2	4.3	6.0	5.5	10.1	6.0	8.3	7.2	11.1
Statistical Neighbours	4.3	6.5	4.9	8.4	5.7	8.7	5.7	8.8	6.3	9.8
London	4.5	5.5	4.7	6.4	5.4	7.4	6.1	8.7	6.1	8.2
England	4.4	5.0	4.7	6.0	5.5	7.3	5.8	7.8	6.2	8.8

Source: DFE 903 Return. Notes: Data collected each year based on 5 half terms. The percentage attendance is calculated by the number of sessions missed due to overall absence expressed as a percentage of the total number of possible sessions. Persistent absentees are defined as having round 15% overall absence rate for 5 terms this equates to 46 or more sessions.

Looked after Children and young people in Bromley have an overall attendance rate in line with our statistical neighbours and national comparators. However the level of persistent absence is higher. The level in 2013 was 8.2% compared to 5.0 nationally and 5.5% in London.

Not in education, employment or training (NEET)

In 2013/14, 43% of Bromley LAC were NEET, 46% were in education employment and training (EET) and 11% of LAC whose status was not known. Bromley has a higher percentage of NEET than our statistical neighbours and London.

Table 8. 17: Care leavers NOT in education, employment or training

	Percentage of young people aged 19 who were looked after aged 16 who were not in education, employment or training			
	2014	2013	2012	2011
Bromley	43%	47%	49%	29%
Statistical Neighbours	35%	31.7%	32.2%	29.5%
London	33%	23.0%	29.8%	21.0%
England	37%	34%	36%	33%

Source: Department for Education

Table 8. 18: Care Leavers - The percentage in education employment and training (EET) by type 2014

	All children now aged 19, 20 and 21 who were looked after for a total of at least 13 weeks after their 14th birthday including some time after their 16th birthday	In higher education i.e. studies beyond A level	In education other than higher education	In training or employment	Total percentage in education, employment or training
Bromley	150	5%	23%	18%	46%
Statistical Neighbours	2,405	5%	21%	22%	48%
London	5,900	10%	27%	17%	54%
England	27,220	6%	19%	20%	45%

Source: Department for Education

An area of focus is to reduce the number of young people for whom we do not know their whereabouts. This is currently 11% (15 young people). Work is being undertaken with the Virtual school team, leaving care team and the Targeted Youth Support Service (TYSS) to make sure that we have data recorded for each young person and that work is undertaken with them to increase their chances of going into education employment or training.

Care Leavers in Suitable Accommodation

Bromley has always had a high percentage of young people in suitable accommodation. The figure dropped in 2013 to 87% and further in 2014 to 83%. The figure is higher than statistical neighbours and national comparators and in line with the London average.

Table 8. 19: Care leavers in suitable accommodation

	Percentage of young people aged 19 who were looked after aged 16 who were in suitable accommodation			
	2014	2013	2012	2011
Bromley	83%	87%	91%	91%
Statistical Neighbours	76%	90.3%	78.8%	80.8%
London	82%	87.5%	85.2%	89.5%
England	78%	88%	88%	90%

Source: Department for Education

Youth Offending and Substance Misuse

In 2014 of the 180 young people who had been LAC for longer than 12 months 10 were identified as having a substance misuse problem. This is 5 less than in 2012/13. This represents 4.4% of the Bromley LAC population. All of these young people were offered an intervention.

Table 8. 20: Substance misuse data

	Number of children looked after at 31 March who had been looked after for at least twelve months ¹	Number identified as having a substance misuse problem during the year	Percentage identified as having a substance misuse problem during the year
Bromley	180	10	4.4
Statistical Neighbours	3,035	125	7.5
LONDON	6,550	400	6.1
ENGLAND	47,670	1,680	3.5

Data SSD903 2014

Looked after Children - offending data

In 2014, 9.6% of 10-17 year old LAC young people in Bromley were convicted or subject to a final warning or reprimand during the year, a drop from 13.4% in 2012/13. This is higher than our statistical neighbours, London and England. There are small numbers in the cohort however so the percentage can vary widely. **Table 8.21** provides a further breakdown.

Table 8. 21: The number and percentage of looked after young people who received a warning or conviction during the year

	Number of children looked after at 31 March who had been looked after for at least twelve months ¹	Number of children aged 10 - 17 at 31 March ²	Number convicted or subject to a final warning or reprimand during the year	Percentage convicted or subject to a final warning or reprimand during the year
Bromley	180	125	10	9.6
Statistical Neighbours	3,035	2,220	105	5.1
LONDON	6,550	4,750	270	5.7
ENGLAND	47,670	30,660	1,710	5.6

Source: Department for Education

Table 8. 22: Looked After Children PHOF Indicators, 2015

Indicator	Time Period	Sex	Age	Bromley	London	England
2.08 - Emotional well-being of looked after children	2010/11	Persons	5-16 yrs	13.1	13.6	13.9
2.08 - Emotional well-being of looked after children	2011/12	Persons	5-16 yrs	13.8	13.6	13.9
2.08 - Emotional well-being of looked after children	2012/13	Persons	5-16 yrs	13.5	13.5	14
2.08 - Emotional well-being of looked after children	2013/14	Persons	5-16 yrs	14.6	13.4	13.9

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

What does this mean for Bromley residents and for children in Bromley?

The data on Looked After Children shows a very variable picture. The measures of health tend to be measures of processes (for example number of health checks or dental checks) rather than information on actual levels of health. Where this information is available, for example the mental health of LAC or offending behaviour, the findings are concerning. Other measures, for example on substance use in this group, are more reassuring. Some of the findings may be related to the relatively high rates of LAC with Special Educational Needs in Bromley.

All of this data is monitored closely and appropriate interventions such as CAMHS support are available when required.

For more information on Children's Safeguarding and Social Care please contact Ailsa.Reid-Crawford@Bromley.gov.uk

Updates on Populations of Interest

9. Children and Young People

This section focuses on the needs of particular groups of the Borough's children and young people:

- An Overview of the Health of Children in Bromley
- A&E, in-patient and out-patient use by children and young people in Bromley
- Educational attainment
- Children's Safeguarding and Social Care

Overview of Child Health in Bromley

Table 9.1 presents a summary of almost all available child health data which is available at borough, region (London) and national level. Alongside the health indicators for Bromley, England and London is presented the data from other London boroughs which are similar to Bromley in health terms. The information is presented using Public Health England RAG ratings as well as the value of each indicator and a definition of each indicator.

Those indicators marked green are where the indicator is better than the national rate. 29 of the 41 indicators in Bromley are green. Even when compared to the boroughs with similar health profiles (Bexley, Havering and Sutton), Bromley children and young people are rated higher in many health indicators.

Only 3 indicators for Bromley are rated "red": Two of these were rated "red" last year: family homelessness and A&E attendances. These issues are discussed further in the relevant parts of the JSNA, but it should be noted that these 2 indicators are red for almost every London borough. An indicator which was not red last year, but is this year is "Hospital admissions due to substance misuse: Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse". This will be investigated further.

Some of the indicators marked "amber" are still of concern. The rate of conceptions in girls aged under 16 remains higher than both the London and national rates, and the child mortality rate also remains higher than the national and London rate. There is one indicator where Bromley has the best performance (lowest rate) in London – the Infant Mortality Rate. Unfortunately this may not reflect the true rate of

infant deaths as the distinction between babies who are born stillborn and those who die shortly after birth may not always have been clear. Some of the babies who have been classified as stillborn probably should have been recorded as infant deaths as they showed some sign of life at birth. The number of infant deaths in Bromley has increased recently as the “sign of life” classification is applied more robustly. As both stillbirths and infant deaths are investigated rigorously this should not make any difference to local services or the families concerned but are likely to be reflected in the indicators in future.

The data for 2013/14 shows the proportion of children classified as obese in reception year and in Year 6 is better than the national and London average. There were more children attending reception class in Crystal Palace, Mottingham, and Chislehurst who were obese followed by pupils attending reception in Cray Valley East, Penge, Cator, Plaistow and Sundridge.

Pupils in reception who were obese were more likely to remain obese at year 6 in the following wards: Crystal Palace, Mottingham, Chislehurst North, Cray Valley East and Cray Valley West.

It is noted that although the rate of childhood obesity in children aged 4-5 years is one of lowest rates in London, the rate of overweight children at this age is 21.3% which is rated amber.

It is noted that breastfeeding initiation data is not available for Bromley this year. A Breastfeeding Strategy is being developed for Bromley.

BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2015

Table 9. 1

Indicator	Period	England	London	Bexley	Bromley	Havering	Sutton
1. Healthy Life Expectancy at birth (Male)	2011-13	63.3	63.4	66.2	67	63.4	65.9
2. Healthy Life Expectancy at birth (Female)	2011-13	63.9	63.8	66.9	67.6	65.8	66.6
3. Life Expectancy at birth (Male)	2011-13	79.4	80	80.3	81.3	79.8	80.8
4. Life Expectancy at birth (Female)	2011-13	63.9	84.1	84.3	84.9	83.8	84.1
5. Children in poverty (under 16s)	2012	19.2	23.7	19.1	16.2	19.6	15.3
6. School Readiness: The percentage of children achieving a good level of development at the end of reception	2013/14	60.4	62.2	72.9	67.2	65.5	59.6
7. School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2013/14	44.8	52.3	61.9	51	49	40.4
8. Obese children (4-5 years)	2013/14	9.5	10.8	11.3	8.1	11.6	7.3
9. Obese children (10-11 years)	2013/14	19.1	22.4	22.5	15.4	20.5	18.2
10. Excess weight in 4-5 year olds	2013/14	22.5	23.1	27.4	21.3	25.8	19.2
11. Excess weight in 10-11 year olds	2013/14	33.5	37.6	38.1	29.9	35.4	33.6
12. Pupil absence	2013/14	4.51	4.33	4.01	4.26	4.76	4.26
13. Family homelessness	2013/14	1.7	4.1	3.5	2.9	1.4	2
14. First time entrants to the Youth Justice System	2014	409	426	300	317	235	291
15. 16-18 year olds not in education employment or training	2014	4.7	3.4	3.4	4.3	4	3.2
16. Low birth weight of term babies	2012	2.8	3.1	2.3	2.3	2.5	2.9
17. Low birth weight all babies	2013	7.4	7.9	6.4	7.1	7	7.9
18. Breastfeeding initiation	2013/14	73.9	*	*	*	73.3	*
19. Breastfeeding at 6-8 weeks	2013/14	*	*	*	*	*	*
20. Smoking status at time of delivery	2013/14	12	5.1	10.4	5.9	11.4	6.1
21. Under 18 conceptions	2013	24.3	21.8	23.3	19.5	26.2	17.8
22. Conceptions in those aged under 16	2013	4.8	4.3	4.5	5.5	4.9	4.1
23. Teenage mothers	2013/14	1.1	0.5	0.7	0.5	0.6	0.8
24. New Sexually Transmitted Diseases including Chlamydia	2013	3433	4039	2697	3075	3228	3976
25. A&E attendances	2013/14	525.6	675.3	577	576.1	628.1	674.7
26. Hospital admissions for accidental and deliberate injuries in children (aged 0-4 years)	2013/14	140.8	105	119.2	89.2	110.8	129.9
27. Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2013/14	112.2	86.8	88.1	75.2	79.7	101.5
28. Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2013/14	136.7	101.5	92.2	100.9	87.9	133.1
29. Children killed or seriously injured in road traffic accidents	2011-13	19.1	13.7	10.4	12.4	20.7	10.3
30. Children in care	2014	60	54	46	38	39	45
32. Children in care with up to date immunisations	2014	87.1	84.3	83.3	94.4	91.7	95.7
33. Infant mortality	2011-13	4	3.8	2.9	1.6	4.1	2.6
34. Child mortality rate	2011-13	11.9	12.2	11.4	12.7	15.6	10.4
35. Tooth decay in children aged 5	2011/12	0.94	1.23	*	0.52	0.54	0.8
36. Children with 1 or more decayed, missing, filled teeth	2011/12	27.9	32.9	*	21.5	19.8	27.9
37. Hospital admissions due to alcohol specific conditions	2011/12 2013/14	40.1	26.6	15.9	25.9	20.7	49.3
38. Hospital admissions due to substance misuse	2011/12 2013/14	81.3	65.2	101.7	118.7	76.8	84.7
39. Hospital admissions for asthma	2013/14	197.1	204.8	165.2	140.3	126.6	191.1
40. Hospital admissions for mental health conditions	2013/14	87.2	101.9	122	63.9	88.3	98.5
41. Hospital admissions as a result of self harm	2013/14	412.1	228	186.6	233.4	202.8	407.1

Source: PHOF, 2015 <http://www.phoutcomes.info/> * no data available

Definitions of Indicators

1. & 2. Healthy life expectancy at birth: the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health; **3. & 4.** Life expectancy at birth: the number of years a person would expect to live based on contemporary mortality rates; **5.** Children in poverty (under 16): % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income; **6.** School readiness: % children with good level development end Yr R; **7.** School readiness: % children on free school meals with good development end Yr R; **8.** Obese children (4-5 years): % school children in Reception year classified as obese using UK 1990 BMI thresholds; **9.** Obese children (10-11 years): % school children in Year 6 classified as obese UK 1990 BMI thresholds; **10. & 11.** Excess weight in 4-5 or 10-11 year olds: proportion of children classified as overweight or obese (BMI on or above 85th centile of UK 1990 growth reference rates); **12.** Pupil absence: % half days missed by pupils (authorised and unauthorised absence); **13.** Family homelessness: applicant households eligible for assistance (1996 Housing Act), unintentionally homeless and in priority need, per 1000; **14.** First time entrants to the youth justice system: rates of juveniles receiving their first reprimand, warning or conviction per 100,000 10-17 yr old population; **15.** 16-18 year olds not in education, employment or training: the estimated number of 16-18 yr olds not in education employment or training divided by total number 16-18 year olds; **16.** Low birth weight of term babies: number of live births of at least 37 weeks gestation weighing less than 2500g divided by all live births weighing less than 2500g; **17.** Low birth weight of all babies: % of live and still births weighing less than 2500g; **18.** Breastfeeding initiation: % of mothers initiating breastfeeding in first 48 hours after birth; **19.** Breastfeeding at 6-8 weeks: % infant who are totally (breast fed only) or partially breastfed (breastmilk and formula milk given) at 6-8 weeks; **20.** Smoking status at time of delivery: % of mothers current smokers at time of delivery; **21.** Under 18 conceptions: Conceptions in females aged under 18 years per 1000 females aged 15-17 yrs; **22.** Under 16 conceptions: Conceptions in females aged under 16 years per 1000 females aged 13-15 yrs; **23.** Teenage mothers: % of delivery episodes where the mother is aged under 18 years; **24.** Acute sexually transmitted infections: a combination of diagnoses made by Genito-urinary clinics, the National Chlamydia Screening programme and other sexual health services; **25.** A&E attendances: crude rate per 1,000 (age 0-4 years) of A&E attendances; **26.** Hospital admissions for injuries aged 0-4 years: Crude rate per 10,000 (age 0-4 years) for emergency hospital admissions following injury; **27.** Hospital admissions for injuries aged 0-14 years: Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury; **28.** Hospital admissions for injuries aged 15-24 years: Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury; **29.** Children killed or seriously injured in road traffic accidents: Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population; **30.** Children in care: Children looked after at 31 March (rate per 10,000 population aged under 18 years); **31.** Emotional well-being of looked after children: Total difficulties score for all looked after children aged 5-16 at date of latest assessment, who have been in care for at least 12 months on 31 March; **32.** Children in care with up to date immunisations: proportion of children in care for at least 12 months whose immunisations were up to date; **33.** Infant mortality rate: Mortality rate per 1,000 live births (age under 1 year); **34.** Child mortality rate: Directly standardised rate per 100,000 children age 1-17 years; **35.** Tooth decay in children: % children aged 5 years with one or more decayed, missing or filled teeth; **36.** Children with one or more decayed, missing or filled teeth: % children with 1 or more obviously decayed, missing (due to decay) and filled teeth; **37.** Hospital admissions due to alcohol specific conditions: Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions (Alcohol specific conditions are those that are wholly related to alcohol); **38.** Hospital admissions due to substance misuse: Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse; **39.** Hospital admissions for asthma: Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma; **40.** Hospital admissions for mental health conditions: Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health disorders; **41.** Hospital admissions as a result of self harm: Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm.

Summary of A&E, in-patient and out-patient use in Bromley

This is a new area of analysis for the JSNA. This section presents a few outline details about use by children and young people in Bromley of these services. This area of work will be developed over the coming year.

A&E attendance for period April 2014- March 2015

- In 2011/12, there were 12,543 A&E attendances by Bromley children aged 4 years and under. This gives a rate which is higher than the England average. The data for 2013/14 shows a slight reduction (n=12,144) on the previous year but the rate remains worse than the England average.
- The hospital admission rate for injury in children and young people is lower than the England average.
- The majority of Bromley patients between 0-17 years of age attended urgent and emergency care at PRUH A&E Department and Kings, Denmark Hill. Other trusts which received Bromley children at A&E were, in decreasing order of magnitude: Lewisham and Greenwich NHS Trust, Croydon, and Guys & St Thomas' Trust.
- More than half of the presentations by Bromley children and young people at A&E across all trusts were between the hours of 8am-6pm (54%), when GP practices are open.
- After presenting to A&E, more than half of patients were discharged without follow up required (52.7%) while a further 15.5% were discharged with follow up treatment to be provided by their GP.

A&E activity – general findings

- Among 0-4 year olds attending KCH, the highest proportion of presentations were between the hours of 4pm-8pm (27.2%) followed by 12noon -4pm (23.8%), 7am-12noon (18.9%) and 8pm-midnight (19.8%).
- In terms of age of children and young people presenting at A&E; there were more children 4 years and under presenting at A&E (n=5985) compared to children and young people from 5-17 years (n=4221).
- The admission conversion rate (proportion of all attendances who require admission to hospital) for children 4 years and under was 14.2% compared to 18.5% of children from 5-17 years age group.
- Among the 0-4 cohort admitted; there were more children admitted who were 1 year old and younger (neonatal), followed by 2 year olds, 4 year olds and 3 year olds.
- Most children and young people (0-17 years) who were admitted stayed on the ward for 1 day or less.
- The main diagnoses for those admitted for 1 day or less was viral infection and tonsillitis. Among those children and young people admitted for 1 day, viral

infection and asthma were the key diagnoses. For children and young people who were admitted for 2 days, the main diagnoses were viral infection and fever.

- The reasons for admission varied by age of the child. Due to their vulnerability the threshold for admission of very young children under the age of 1 is lower. This group is analysed separately.

Inpatient data – key findings (Denmark Hill and PRUH sites)

Table 9. 2: Top 9 primary diagnoses for under 1s

0 Years	No. of Admissions
Acute bronchiolitis, unspecified	51
Neonatal jaundice, unspecified	26
Fever, unspecified	13
Urinary tract infection, site not specified	12
Other feeding problems of new-born	11
Acute upper respiratory infection, unspecified	11
Other lack of expected normal physiological development	10
Viral infection, unspecified	10
Other and unspecified abnormalities of breathing	8
Accounts for 48% of total emergency admissions for 0-1 years	152

Source: King's College Hospital (Denmark Hill and PRU sites)

Tables 9.2 and **9.3** show that the commonest diagnosis on admission for very young children was acute bronchiolitis, but admissions over the age of 2 with this condition is rare. Some reasons for admission were relatively common for all ages such as viral infection, lower respiratory tract infection, acute tonsillitis and febrile convulsion.

Table 9. 3: Primary diagnoses on admission for 1-4 year olds

Primary diagnosis	1 year (Age)	2-4 years (Age)
Viral infection, unspecified	76	103
Acute bronchiolitis, unspecified	25	-
Unspecified acute lower respiratory infection	19	23
Fever, unspecified	19	15
Acute upper respiratory infection, unspecified	17	12
Gastroenteritis and colitis of unspecified origin	13	5
Acute tonsillitis, unspecified	10	24
Acute obstructive laryngitis [croup]	7	5
Febrile convulsions	7	19
Rash and other nonspecific skin eruption	6	4
Lobar pneumonia	-	7
Epilepsy	-	6
Other convulsions	-	13
Asthma		19
Sickle Cell Anaemia with crisis		5
Total	199	270

Source: King's College Hospital (Denmark Hill and PRU sites)

More than half (54%) of patients were admitted from accident and emergency department.

Two in five patients (41%) were either booked from the waiting list or a planned admission. Of these, about one in three (31%) were elective admissions for a day case¹⁷.

Table 9. 4

Age	Hospital admissions
<1 Year	21%
2-5 years	30%
6-10 years	21%
11-17 years	28%

Source: King's College Hospital (Denmark Hill and PRU sites)

In 2014/15 there were 800 elective admissions of which 609 were day case admissions.

Of the day admissions, there were 140 children who were 4 years and under and 469 children and young people aged 5-17 years.

¹⁷ Patient's admission is planned with intention to keep the patient in hospital overnight

Outpatient data – key findings

52% of first outpatient appointments were referred by a GP, 22% of referrals were referred from a consultant, other than in an accident and emergency department, and 14% were referred from an accident and emergency department (including minor injuries units and walk in centres).

Almost a third of outpatients were children 4 years and under (31.5%). More children in this group were likely to be attending for follow up appointments face to face.

Table 9. 5

Age	Out-patient appointments
0-6 years	45%
7-10 years	20%
11-14 years	20%
15-17 years	15%

Source: King's College Hospital (Denmark Hill and PRU site)

In terms of outpatient activity by treatment, at PRUH; the highest treatments were trauma and orthopaedics followed by paediatrics, ophthalmology and ENT. At the Beckenham Beacon site; the top outpatient by treatment was paediatrics, physiotherapy and dietetics.

Activity at Urgent Care Centres at PRUH and Beckenham Beacon sites for 0-17 years from January to March 2015

Three months of data is provided between January to March 2015 to provide a snapshot for what's happening at UCC for patients aged 17 years of age or under.

- Most patients self-referred (86%) with 111 referrals being the next most frequent source of referrals (12%) made to Urgent Care Centres at PRUH and Beckenham Beacon.
- Over the three month period (January –March 2015), 7802 patients aged between 0-17 years of age attended the UCC (either Beckenham Beacon or the PRUH).
- One in four patients attended the Beckenham Beacon Site (42%), with 58% of patients attending the UCC at the PRUH.
- 65% of these attendances were related to illness and 35% were related to injury.
- There were 3046 self-referrals to UCC at Beckenham Beacon and 3727 self-referrals to PRUH site.

- CYP under 17 years were more likely to present for illness than injury (n=2113 and n=1158 respectively) at Beckenham Beacon. Same pattern emerges at PRUH (n=3031 and n=1500 respectively).
- Injuries were more common on both sites for children aged 5-17 years than for children less than 4 years of age.
- The most common diagnoses were soft tissue injury, "illness-other", tonsillitis, upper respiratory tract infection and viral illness
- Almost all under 17s attending UCC at Beckenham Beacon presented between the hours of 8am-7pm, but less than two-thirds of patients at PRUH UCC site attended between 8am-7pm. At the PRUH UCC 29% attended the UCC between the hours of 7pm and midnight.
- Attendance at both UCCs was more frequent on Saturdays and Sundays.

Community children's health services

Referrals to community children's services by GPs in 2014/15 were, in order of frequency, to community paediatrics, physiotherapy, audiology, dietetics, school nursing and speech and language therapy.

An audit conducted in Nov 2013 showed that roughly one fifth of children attending the two special schools in Bromley had epilepsy. Children with epilepsy in Bromley may be seen by a paediatrician with a special interest in epilepsy at PRUH, in a joint clinic with a consultant paediatric neurologist from Evelina Children's Hospital, or by other general paediatricians and paediatric neurologists in nearby hospitals (Queen Mary's Hospital (QMH), Sidcup, Lewisham hospital, Great Ormond Street Hospital).

What does this mean for Bromley residents and for children in Bromley?

A key finding is that although the attendances at A&E by children are higher than the national rate, a relatively low proportion of those children are admitted as an in-patient, indicating that a proportion of those children could have been managed in primary care.

The time of day at which children and young people attend A&E or the UCCs is useful in planning service provision, and the primary diagnosis on admission provides information on the level and type of support these children may need.

This data provides a baseline which can be used to monitor changes in service use and to compare local services with those in similar areas.

Educational Attainment

Introduction

The overall pupil population within maintained and academy schools, and the Pupil Referral Service provision in Bromley is 48,627 pupils - including post-16 years (January pupil census 2015).

About 20% of the borough's school intake comes from neighbouring boroughs – predominantly Lewisham and Croydon. This has a significant impact on the profile of the children and young people in Bromley schools. For example, Bromley's schools have an average Black and Minority Ethnic (BME) profile of 33% compared to the resident BME children and young people population of 17%.

Attainment of Pupils in Bromley Schools

The national curriculum includes assessments (both informal and formal tests) at varying stages of a child's school life.

Table 9. 6

Assessment	Stage of School Life	Comments
Early Years Foundation Stage	Reception age – aged 5	This is an informal assessment made by the class teacher
Key Stage 1	Year 2 – aged 7	This comprises a set of teacher assessments which assess ability in reading, writing and maths
Key Stage 2	Year 6 – aged 11	This comprises tests and teacher assessments in reading, writing, grammar, maths and science
Key Stage 4	Year 11 – aged 16	GCSE and equivalent tests

Source: London Borough of Bromley

Evidence shows that many vulnerable groups such as pupils who are in receipt of Free School Meals (FSM), Special Educational Needs (SEN), and Looked After Children tend to perform less well than their peers. The Government has charged local authorities and schools with closing the gap in performance between these groups and the main cohort of pupils, with a view to raising attainment of vulnerable groups and closing the gap in performance over time.

FSM is used as a proxy measure for poverty and used to assess outcomes for children from low income families. However it is only a proxy measure as many children from these backgrounds do not always take up their entitlement to free school meals (FSM).

Within this section FSM gap results are reported due to their significance in relation to children’s well-being and life chances

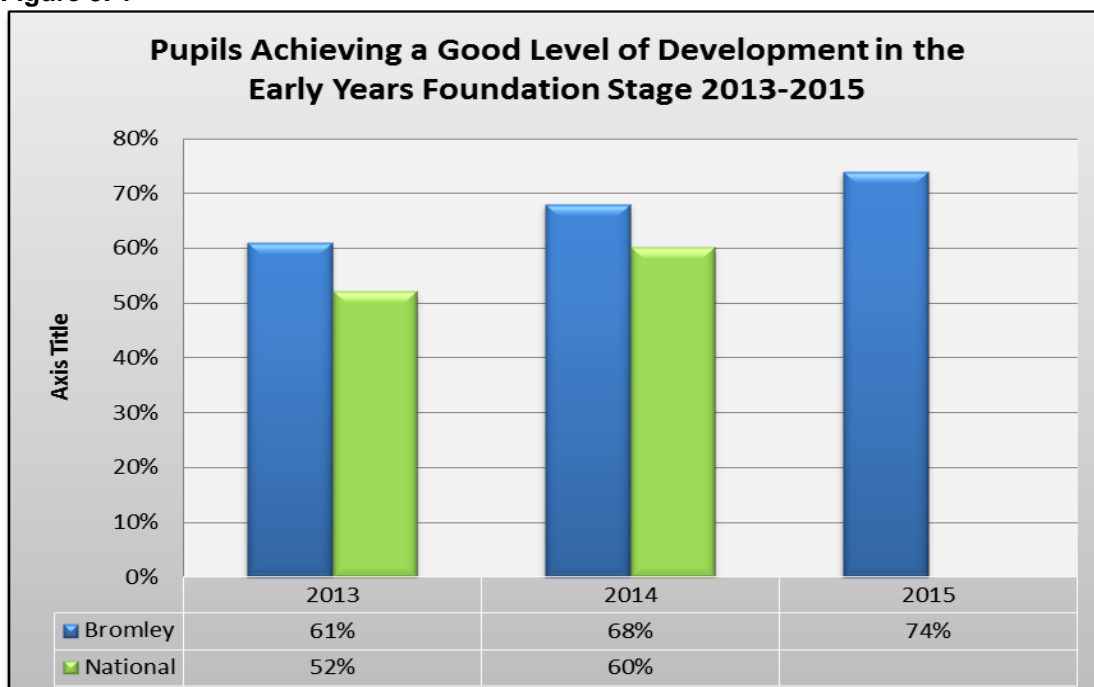
Foundation Stage Profile

The current Early Years Foundation Stage (EYFS) Framework was introduced in September 2013, with the progress of children in the EYFS measured against 17 learning goals. Children are assessed as ‘Emerging’, ‘Expected’ or ‘Exceeding’. A pupil is considered to have achieved a ‘Good Level of Development’ if they reach ‘Expected’ or ‘Exceeded’ in Communication and Language, Physical Development, Personal, Social and Emotional Development, Literacy and Mathematics.

Pupils are also given a total points score for their achievements, where emerging has a score of 1, expected has a score of 2 and exceeding has a score of 3. These are added for each of the 17 early learning goals to give the overall score. The total points score for Bromley in 2015 was 35.2, compared with 34.5 in 2014 and 33.4 in 2013.

In 2015, 74% of Bromley pupils attained a good level of development, compared with 68% in 2014 and 61% in 2013. The 2014 national result was 60% (2015 data is not available until October 2015).

Figure 9. 1



Source: London Borough Of Bromley

The gap in performance at the Early Years Foundation Stage (Good Level of Development) between pupils eligible for Free School Meals (FSM) and non-eligible

for 2015 was 24%. In 2014, the gap was 19%, the same as the 2014 national figure. This was a reduction from the 2013 figure of 25%, compared to 19% nationally. In 2015, 53% of children eligible for FSM reached the Good Level of Development compared with 77% of those not eligible for FSM. This level of gap requires attention.

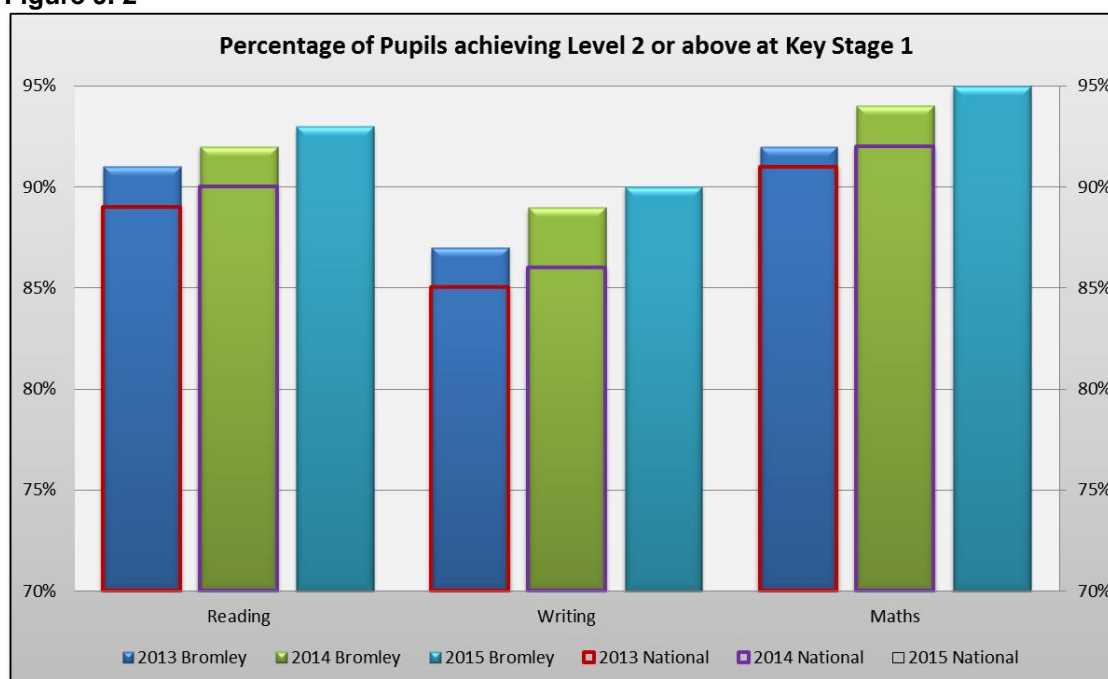
Key Stage 1

At age 7 (end of Key Stage 1) pupils are expected to achieve a Level 2 in each subject in the Key Stage 1 assessments. The 2015 results show that 93% of pupils achieved Level 2+ in reading, 90% in writing and 95% in maths.

Bromley’s performance at Key Stage 1 is consistently around 2 percentage points higher in all areas than performance nationally.

However, the gap in performance at Key Stage 1 between pupils eligible for Free School Meals (FSM) and non-eligible is not narrowing. Pupils not eligible for FSM consistently perform better than those eligible. The gap in reading for 2013 was 15% compared to 12% nationally, in writing the gap was 20% compared to 15% nationally and in maths was 13% compared to 10% nationally.

Figure 9. 2



Source: London Borough of Bromley and Department for Education

Table 9. 7

Key Stage 1 Results	2013	2013	2014	2014	2015	2015
	Bromley	National	Bromley	National	Bromley	National
Reading	91%	89%	92%	90%	93%	
Writing	87%	85%	89%	86%	90%	
Maths	92%	91%	94%	92%	95%	

Source: London Borough of Bromley and Department for Education

Key Stage 2

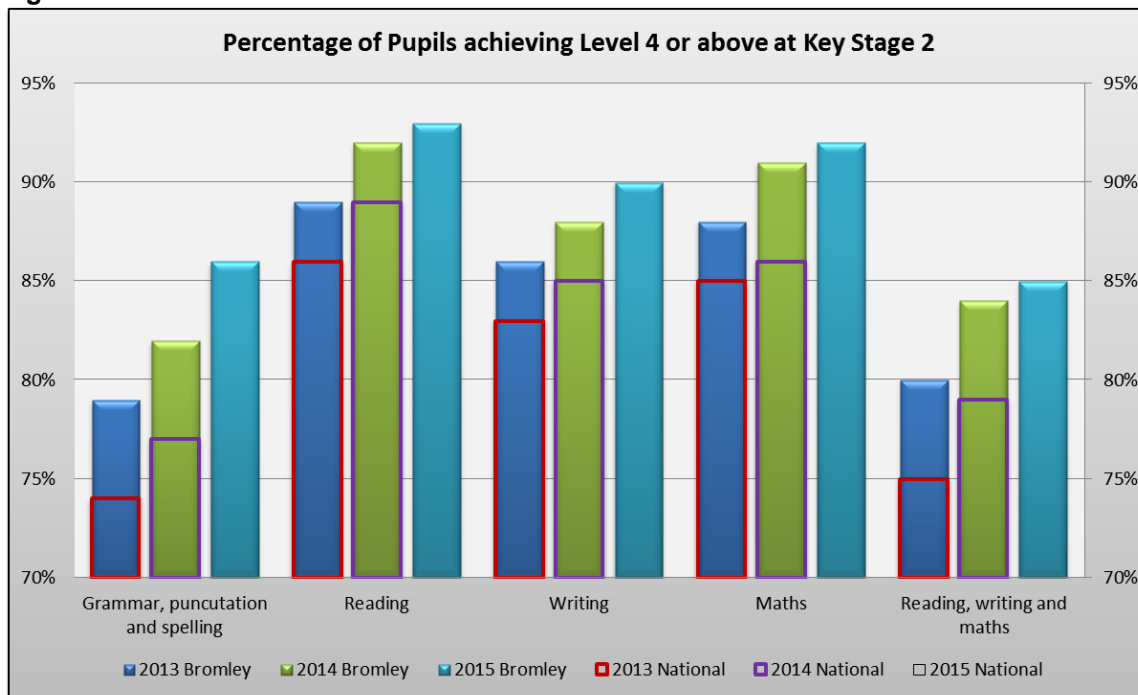
At age 11 (end of Key Stage 2) pupils are expected to achieve a Level 4 in each subject in the Key Stage 2 assessments. In 2013, there was a change in the assessments at Key Stage 2, with the introduction of a Grammar, Punctuation and Spelling test to replace an overall English result. Results are reported separately for reading (test), writing (teacher assessment), grammar (test) and maths (test). The combined English and maths measure previously used is now based upon the combined reading, writing and maths results.

In 2015, 86% of pupils achieved a Level 4 or above in the grammar, punctuation and spelling test (from 82% in 2014), 93% in reading (from 89% in 2014), 90% in writing (from 85% in 2014) and 92% in mathematics (from 85% in 2014). The national averages for 2015 are not yet available, but the national results in 2014 were 77% for grammar, 89% for reading, 85% for writing and 86% for mathematics.

This continues the trend of previous years where pupils in Bromley schools attain above the national average.

Attainment at Level 4 and above in combined reading, writing and mathematics increased from 80% in 2013 to 84% in 2014, to 85% in 2015, against the national attainment of 75% in both 2013 and 79% in 2014 (see **figure 9.3**).

Figure 9. 3



Source: London Borough of Bromley and Department for Education

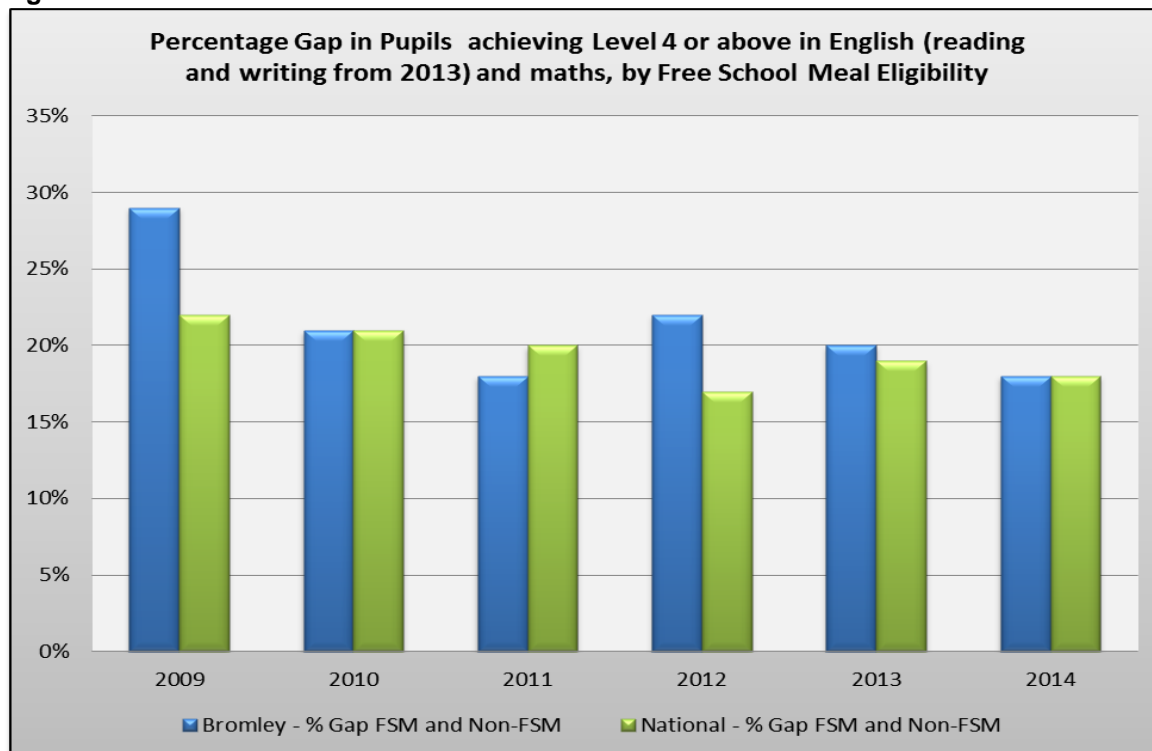
Table 9. 8

Key Stage 2 Results	2013	2013	2014	2014	2015	2015
	Bromley	National	Bromley	National	Bromley	National
Grammar, punctuation and spelling	79%	74%	82%	77%	86%	
Reading	89%	86%	92%	89%	93%	
Writing	86%	83%	88%	85%	90%	
Maths	88%	85%	91%	86%	92%	
Reading, writing and maths	80%	75%	84%	79%	85%	

Source: London Borough of Bromley and Department for Education

At Key Stage 2, the gap in attainment in the new combined reading, writing and mathematics measure between those pupils eligible for Free School Meals and those who are not was 20% in 2013 compared to the national gap which was 19%.

Figure 9. 4



Source: London Borough of Bromley and Department for Education

Table 9. 9

% achieving Level 4 or above in reading, writing and maths, by Free School Meal Eligibility	2009	2010	2011	2012	2013	2014
Bromley - % Gap FSM and Non-FSM	29%	21%	18%	22%	20%	18%
National - % Gap FSM and Non-FSM	22%	21%	20%	17%	19%	18%

Source: London Borough of Bromley and Department for Education

Primary Value added – how a pupil progresses through the school

Value added is designed to measure a child’s progress through the school in order to assess the ‘added value’ the school has made to the outcomes of each child. It looks at prior attainment (the pupil’s performance in tests/assessments already undertaken) and plots this against the expected level that a child is likely to achieve in the next set of assessments. The model used for value added in primary schools is KS1-KS2 and each child is expected to make two levels of progress between KS1 and KS2.

A higher percentage of pupils in Bromley schools made the expected amount of progress between the Key Stage 1 and Key Stage 2 assessments in 2014 than nationally, with 94% in reading (compared with 91% nationally), 95% in writing (compared with 93% nationally) and 94% in mathematics (compared with 90% nationally). All of these were increases on the 2013 results. 2015 results are not yet

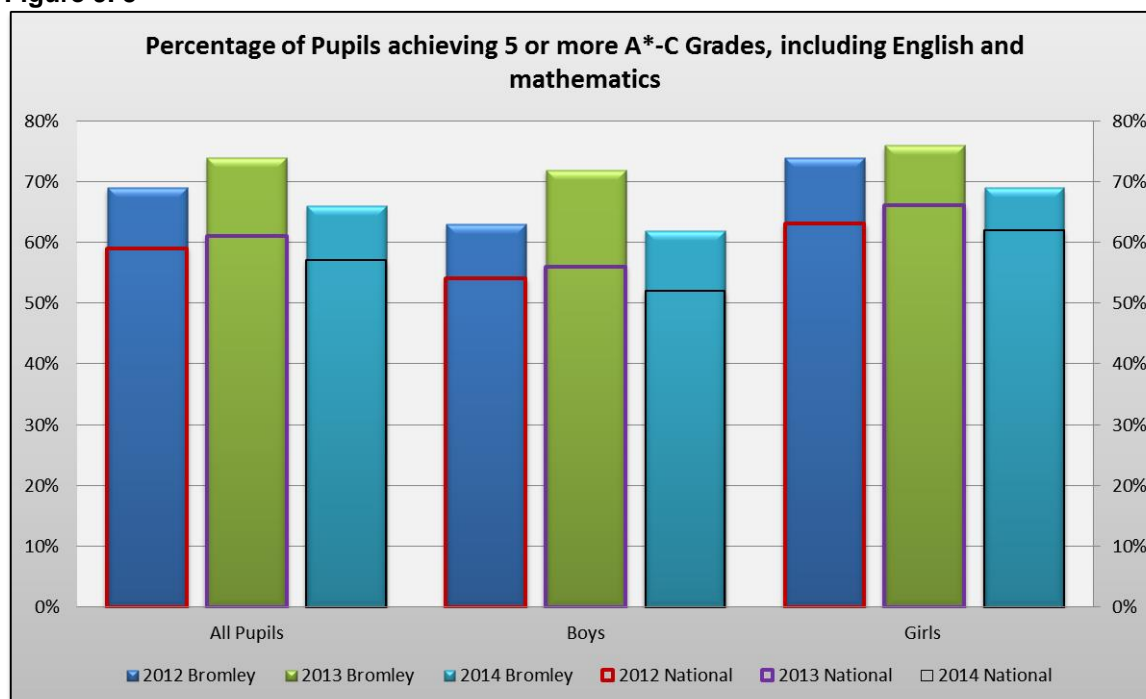
available.

Key Stage 4

At GCSE, Bromley pupils also achieve higher than the national average, with 66% of pupils gaining 5+ A*-C grades (including GCSE English and mathematics) in 2014, compared with 57% nationally. The apparent dip in the 2014 results, both in Bromley and nationally reflects the changes in policy relating to the Wolf Report into the Reform of Vocational Education and the introduction of a new early entry policy, both of which affect the 5 A*-C including English and mathematics measure. Comparisons between 2014 and previous years should not be made without further reference to these changes at (http://www.education.gov.uk/schools/performance/secondary_14/s3-1.html).

Figure 9.5 below shows the trend for Bromley and nationally.

Figure 9.5



Source: London Borough of Bromley and Department for Education

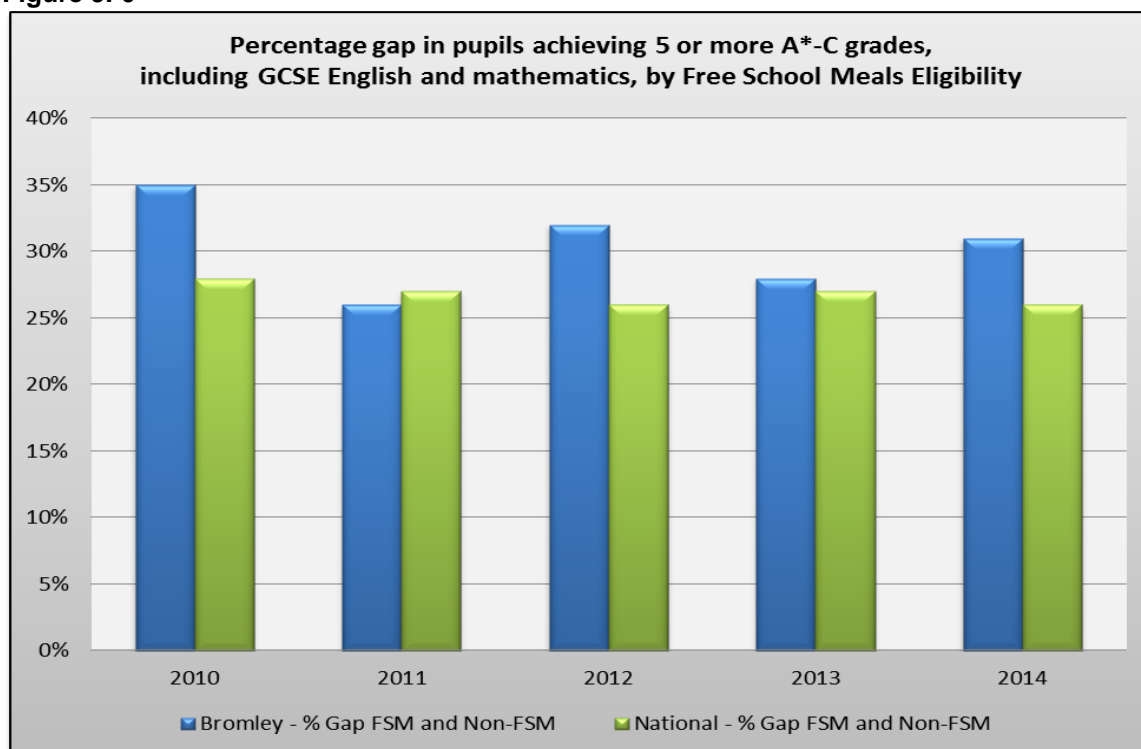
Table 9.10

% achieving 5 or more A*-C grades, including GCSE English and mathematics	2012	2012	2013	2013	2014	2014
	Bromley	National	Bromley	National	Bromley	National
All Pupils	69%	59%	74%	61%	66%	57%
Boys	63%	54%	72%	56%	62%	52%
Girls	74%	63%	76%	66%	69%	62%

Source: London Borough of Bromley and Department for Education

At Key Stage 4, the Free School Meal/Non Free School Meal gap has fluctuated over the last 3 years when looking at attainment of 5+ A*-C grades including English and mathematics. The gap was 26% in 2011 rising to 32% in 2012 and falling to 28% in 2013.

Figure 9. 6



Source: London Borough of Bromley and Department for Education

Table 9. 11

% achieving 5 or more A*-C grades, including GCSE English and mathematics, by Free School Meal Eligibility	2010	2011	2012	2013	2014
Bromley - % Gap FSM and Non-FSM	35%	26%	32%	28%	31%
National - % Gap FSM and Non-FSM	28%	27%	26%	27%	26%

Source: London Borough of Bromley and Department for Education

What does this mean for Bromley residents and for children in Bromley?

Although attainment in Bromley schools is generally above the national average, certain groups of children, in particular those in receipt of Free School Meals do not make the desired rate of progress and there are small but significant number of schools where sustainable improvement is not yet achieved. Improvements in these areas need to remain a priority for Bromley schools.

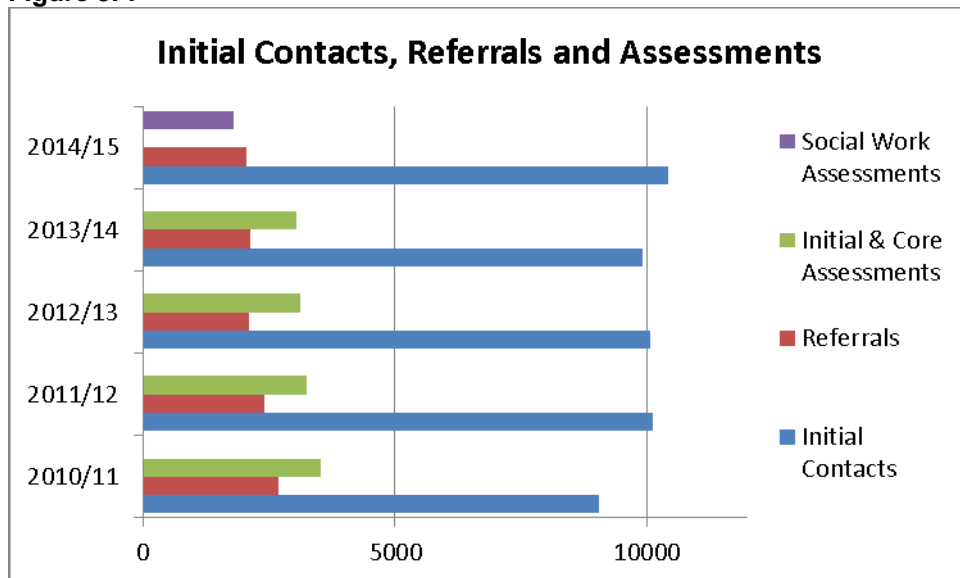
Children’s Safeguarding and Social Care Referrals

Children’s Social Care services have a duty to safeguard and promote the welfare of children. Last year over 10,000 initial contacts were made to Children’s Social Care services.

Within Bromley, initial contacts have remained relatively stable over the last 3 years. There has been a decrease in the number of safeguarding referrals which have decreased by 24% (from 2,679 in 2010/11 to 2049 in 2014/15). In July 2011 a new multiagency support hub (MASH) service was introduced to address the pressures, and by forming an effective triage service has resulted in a continued reduction in the number of initial contacts going onto a referral.

Since June 2014, initial and core assessments have ceased to exist and following a referral, children are assessed under a single continuous assessment known locally in Bromley as a Social Work Assessment. This change has been made nationally over the last few years following the recommendations of Munro. This assessment should be completed within 45 days and in Bromley all assessments are reviewed by a manager after 10 days.

Figure 9.7



Source: London Borough of Bromley

What does this mean for Bromley residents and for children in Bromley?

Initial contacts to assessments by children’s social care services have begun to level off and in the case of referrals decrease significantly based on levels prior to 2011. This is likely to be due to the success of the targeted approach of the MASH service

10. Older People

Introduction

This section focuses on the care needs of the Borough's older people. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- Context - new legislation and focus on community based support
- Bromley demographics
- Impact of increasing populations and related needs
- What service users are telling us

Context

Care Act 2014

The Care Act 2014 modernises existing laws around adult social care. It also introduces new duties for local authorities to change the way adult social care is funded in the future. The first tranche of changes were implemented in April 2015 with the revised funding rules coming into effect from April 2020. Alongside the Care Act 2014, the Government has also introduced the Better Care Fund, which will help Local Authorities to work with health partners for a more joined up approach in delivering social care and health services.

- People's wellbeing at the heart of every decision
- Carers rights on the same footing as the people they care for
- Preventing and delaying need for care and support
- Personal budgets giving people greater control over their care
- Information and advice about the care and support system
- Promoting the diversity and quality of the local care market, shaping care and support around what people want
- New guarantees to ensure continuity of care
- Equity of funding

Changes implemented in April 2015 include general responsibilities on local authorities to promote people's wellbeing, focusing on prevention and providing information and advice.

Better Care Fund (shift from hospital to community)

The London Borough of Bromley serves a population of over a third of a million in partnership with a co-terminous Clinical Commissioning Group and two community health providers. The Better Care Fund represents an opportunity to increase the

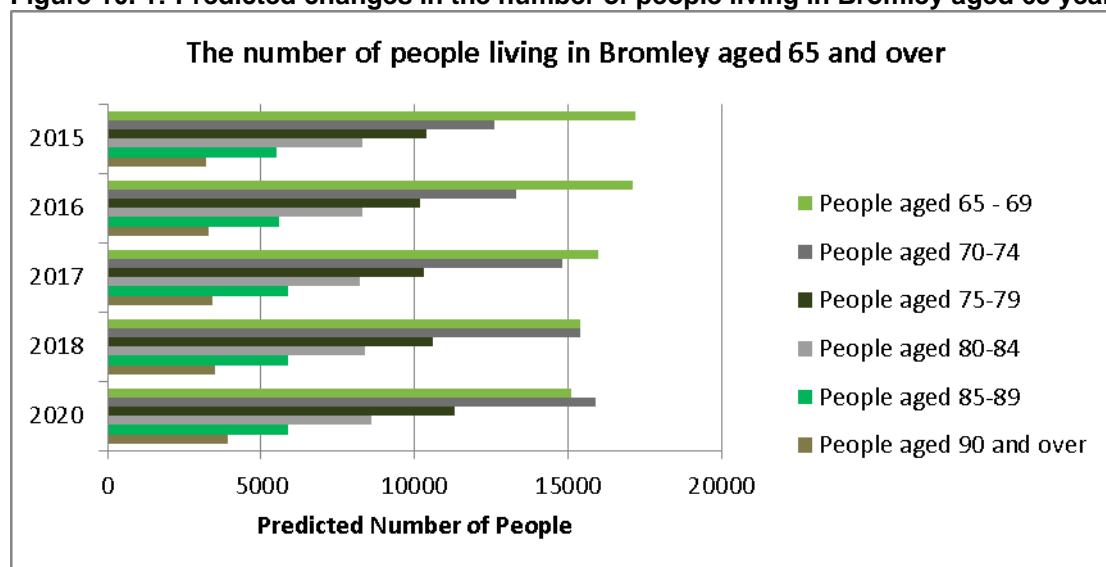
scale and ambition around health and social care integration and taking a whole system approach to health and care services across the borough.

Demographic Information

Bromley has the largest population of older people of all the London boroughs, with 57,200 people aged 65+ years in 2015 (POPPI, June 2015). It is expected that this will increase to 57,800 by 2016 (1% increase) and 60,700 (6% increase) by 2020. (These figures differ from the GLA population projections).

Of this cohort, as at 31st March 2014, 1,866 received LBB commissioned or funded community based services, with the largest proportion supported by Homecare.

Figure 10. 1: Predicted changes in the number of people living in Bromley aged 65 years+



Source: *Projecting Older People Population Information System, June 2015*

Table 10. 1

The number of people living in Bromley aged 65 and over		2020	2018	2017	2016	2015
People aged 65 - 69	↓	15,100	15,400	16,000	17,100	17,200
People aged 70-74	↑	15,900	15,400	14,800	13,300	12,600
People aged 75-79	↑	11,300	10,600	10,300	10,200	10,400
People aged 80-84	↑	8,600	8,400	8,200	8,300	8,300
People aged 85-89	↑	5,900	5,900	5,900	5,600	5,500
People aged 90 and over	↑	3,900	3,500	3,400	3,300	3,200
Total	↑	60,700	59,200	58,600	57,800	57,200

Source: *Projecting Older People Population Information System, June 2015*

Whilst overall, the older people's population is predicted to increase by 3,500 over the next five years; the 65-69 year cohort is expected to fall by 2,100.

Impact of increasing populations and health needs

The implication of this growing demographic situation is the increased demand for social care services from people who desire to stay and are living at home longer. As people's needs become more complex it may be the case that support packages will become increasingly expensive to deliver and will put pressure on already constrained budgets. This is compounded by the fact that many of Bromley's older population are 'asset rich but cash poor' and unable to contribute to the cost of their care packages as their money is tied up with their properties. People's expectations are also increasing with the introduction of more self directed support and less reliance on residential care. This section will explore the following:

- Older People's Health Needs
- Falls
- Excess winter deaths
- Living with Dementia
- NHS Health Check Programme
- Advice and Information
- Increased demand for complex need care packages
- Delayed Hospital Discharges
- Partnership working & Integration (health and social care)

Older People's Health

For a detailed analysis of 'Older People's Health' please see Chapter 5 of the JSNA.

Falls

The Public Health Outcomes Framework for 2013/14 (**table 10.2**) reflects that when compared to London and England, Bromley's 'age-sex standardised rate of emergency admissions for injuries due to falls in persons aged 65 and above per 100,000 population' is low.

Table 10. 2: PHOF Injuries due to falls in older people

Indicator	Time Period	Sex	Age	Bromley	London	England
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-80	2013/14	Persons	65-79 yrs	735.66	1097.69	989.27
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+	2013/14	Persons	80+ yrs	4135.79	5384.80	5181.73

Source: Public Health Outcomes Framework, 2015

The 'Projecting Older People Population Information System' predicted in July 2015 that 15,402 people aged over 65 in Bromley would have a fall during the year. This is 27% of the borough's over 65 population and in all age bands, the rates for women reporting at least one fall in twelve months was higher than men.

Admissions to hospital as a result of unintentional falls for 2015 are predicted, by the Projecting Older People Population Information System, to be 1,214, with 1,008 being in the 75 plus age group.

As part of the Winter Resilience arrangements, additional funding has been made available to support up to 43 'non weight bearing' people as a result of falls or fracture, to receive short term support in a residential care setting before they can start their rehabilitation.

Excess Winter Deaths

Bromley has a high level of Excess Winter Deaths compared to London or England. The winter period not only sees a significant rise in deaths but also a substantial increase in illnesses, which places additional stress on health and social care services and negatively impacts on people's physical and mental wellbeing.

The entire elderly Bromley population is at risk of Excess Winter Deaths, although those in the coldest homes, of the greatest age, and with the highest burden of ill health, are likely to be most at risk. Individuals with these risk factors may reside anywhere in the borough, but at ward level certain areas have less thermally efficient properties, older populations, or higher levels of cardiovascular and respiratory disease which may point to particularly vulnerable areas for Excess Winter Deaths.

This is explored more fully in Chapter 7 of the JSNA, 'Excess Winter Deaths'

A full Winter Resilience Action Plan was implemented to cope with pressures over the winter period. Between October 2014 and January 2015, 157 people had been supported by the plan. Of these, approximately 25% were to avoid hospital admissions and the remaining 75% to support hospital discharges.

Living with Dementia

The incidence of dementia has risen nationally over the last seven years, a trend which is reflected in the projections for Bromley over the next five years in the 70 and older age group (see **Table 10.3** below).

Dementia is clinically defined as an age related progressive disease associated with cognitive impairment, disorientation, memory loss, change in personality, difficulties with activities of daily living and behaviour that is out of character¹⁸. There are

¹⁸ Nice, 2001, Cummings and Jeste, 1999

currently over 4,000 (POPPI, 2015) people living in Bromley with dementia, and with the ageing population the incidence of dementia is set to rise by 428 people by 2020 and will increase by a further 1,384 people by 2030.

Table 10. 3: Predicted changes in the number of people living in Bromley with Dementia

	2020	2018	2017	2016	2015
People aged 65 - 69 predicted to have dementia	186	190	196	211	213
People aged 70-74 predicted to have dementia	433	419	400	362	343
People aged 75-79 predicted to have dementia	663	623	605	600	612
People aged 80-84 predicted to have dementia	1029	1006	982	982	995
People aged 85-89 predicted to have dementia	1178	1183	1183	1128	1106
People aged 90 and over predicted to have dementia	1161	1044	1013	985	954
Total	4650	4465	4379	4268	4223

Source: Projecting Older People Population Information System, June 2015

- Approximately 1,800 people were identified as being on the dementia registers of Bromley GP practices in 2013/14 (Quality and Outcomes Framework).
- In 2013/14, a total of 762 people received social care services for dementia; approximately 60% of these were supported in the community, 25% in residential homes and 15% in nursing homes¹⁹.

Specialist secondary care provision is provided through the Memory Clinic. There were 1,175 referrals in 2014, which is a 76% increase in referral activity since 2011. Bromley currently has the 4th lowest diagnosis rate in London at 49.99% against a national target of 67%²⁰.

Over the winter, two specialist dementia nurses from Oxleas offered assessments to people living in residential homes. Diagnosis rates improved by 5% in December alone and work continues between the London Borough of Bromley, Oxleas and all providers to develop further pathways in the care for people with dementia and cognitive impairment.

¹⁹ RAP Table P1, 2013/14

²⁰ Health and Wellbeing Report 'Development of Local Care Networks: Integrated health and social care for people with dementia and cognitive impairment' 26th March 2015

Whilst those with severe needs will require high intensity health and social care support, it is proposed to use Better Care Programme funding set aside specifically to support post diagnosis of dementia in the community to:

- establish dementia care advisors,
- increase practical training and support to reduce carer breakdown

Bromley Community Mental Health profiles are explored in Chapter 13 of the JSNA Mental Health Section. Issues relating to 'Mental Health and Older People' and 'Dementia' are detailed in sections 13.

Advice & Information

Over the period April 2014 to March 2015, there were 42,116 visits to Bromley MyLife seeking information, advice and guidance, compared to 27,517 for April 2013 to March 2014.

For the year 2014/15, there were over 45,000 contacts via Bromley Social Services Direct (now the Adult Early Intervention Service), of which approx. 39,000 were not referred to Adult Social Care and were predominately satisfied by the provision of information, advice, or guidance.

As part of the ongoing review of how future care and support needs are met, the 'front door' to adult social care for those with care and support needs, and their families, has been strengthened. Residents of Bromley, and those who support them, may seek information through Bromley's corporate website www.bromley.gov.uk, Bromley MyLife <http://bromley.mylifeportal.co.uk>, Bromley Social Services Direct (now Adult Early Intervention Service) or face to face.

The right information, advice and guidance about what is available is paramount to improve people's wellbeing and care. It may be a piece of equipment to help with daily living, a targeted short term intervention such as re-ablement, or a service provided by a strategic partner to help an older person who feels isolated. The Adult Early Intervention Service went live in March 2015 and is designed to help prevent and delay the need for long term care packages at a later stage by giving people the opportunity to stay healthy and well and keep their independence for as long as possible.

Increased demand for complex need care packages

There is an increasing move, both within Bromley and across England, for older people to maintain their independence by being supported either within their own home, or for families to arrange or support their own care. Although the Council provides services to only a relatively small number of people with dementia, the

expected significant increase in the population will have a direct impact on the number of older people eligible to receive support from the Council.

Bromley supports over 7,000 people with care needs, most of them in their own home. During 2013/14, 3,709 people aged 65 and above received community based support, an increase of 297 on 2012/13, with the largest proportion supported by Homecare, and 240 choosing to manage their support package through a direct payment.

Table 10.4 illustrates the changes in the number of older people receiving Adult Social Care services from the London Borough of Bromley between 2012/13 and 2013/14:

Table 10. 4: Older People receiving Adult Social Care Services

	2012-13	2013-14
Older People receiving Community based services	3,412	3,709
Older People who choose to manage their support through a Direct Payment	236	240
Older People receiving Residential Care	349	332
Older People receiving Nursing Care	241	258

Source: London Borough of Bromley Local Account 2012/13 and 2013/14

Of the residential and nursing care placements in 2013/14:-

- The average annual cost of a residential care placement was £31k per annum
- The average annual cost of a nursing placement was £34k per annum
- 192 placed in residential care had dementia or other mental health issues
- 111 placed in nursing and care had dementia or other health issues²¹.

For a detailed analysis of 'People in Care Homes', please see Chapter 6 of the JSNA

Delayed Hospital Discharges

Reablement is an intensive short term service used to support people to relearn daily skills and regain their confidence to live independently.

Reablement may be used after a spell in hospital, an illness or accident and can also prevent hospital admissions. The service commenced in February 2010 and of the 3,111 people who have received the service between the start of the programme and March 2015, 1,977 (64%) did not require ongoing support. The reablement and hospital discharge service continue to work closely to facilitate discharge and to support people whose more intense immediate support requirements would have

²¹ London Borough of Bromley Adult Social Care Local Account 2013/14

historically been met by the provision of a care package prior to commencement of reablement.

Table 10. 5: Older People Delayed Transfers of Care from Hospital 2013/14

	Bromley	Comparator*	England
Delayed Transfers of Care from hospital per 100,000 population	3.5	6.2	9.6
Delayed Transfers of Care from hospital which are attributable to adult social care per 100,000 population	0.5	1.8	3.1

* Compared to CIPFA (Chartered Institute of Public Finance and Accountancy) Comparator Group

Source: Health and Social Care Information Centre ASCOF Comparator Report 2013/14.

Table 10.5 above reflects that when compared to Bromley's comparator group and England as a whole, the level of delayed discharges in Bromley, both as a whole and attributable to social care, is low.

Work has been undertaken with the Bromley Clinical Commissioning Group, Bromley Healthcare and hospitals to create a bureau where the point of hospital discharge will be decided by one of the consultants and will be led as a multi partner operation. It is envisaged that this will streamline the process from referral, admittance to hospital, assessment and referral to care home (if required).

Partnership working and Integration (health and social care)

The NHS community provider is reorganising its teams to operate as co-located locality teams comprising a dedicated team leader and team co-ordinator, community matron, district nurses, physiotherapists, occupational therapists, nurse rehabilitation assistants, healthcare assistants and physiotherapy assistants. In one of the localities, the team has already been joined by a co-located social care manager and community psychiatric nurse to support joint assessment via a single point of entry. The allocation of a lead professional is based on prevailing/overriding need and the improved coordination of care and care planning. The evaluation of the pilot is expected to lead to integrated health and social care teams across each of the community localities.

The effective and efficient delivery of integrated and co-ordinated care relies on health and social care teams being able to access and share relevant information in a timely manner. Plans are therefore in place to give limited 'read only' access to essential elements of LB Bromley's care record system, by nominated healthcare professionals from partner organisations. This will provide up-to-date information on a client's care plans, what services are already in place and key contacts, and will be

particularly beneficial when a client is in an emergency situation. Sharing will be subject to an individual giving consent to do so.

Bromley will continue to build on positive relationships with providers, and the voluntary and community sector that support the delivery of a diverse sustainable and robust local care and support market.

What service users are telling us

The **National Adult Social Care survey**, carried out between January and March 2015 invited 1,806 Bromley service users receiving adult social care to say how these services have affected and/or improved users' quality of life.

The survey told us that, of the 686 (38%) people who responded:

- 70% (482) had control over their daily life
- 51% (350) found it easy to find information
- 66% (449) stated that they feel as safe as they want
- 76% (519) had adequate, or better, social contact with people

The Public Health Outcomes Framework (PHOF) reflected that in 2013/14, 38.70% of adult social care users had as much social contact as they would like. This is lower than the London and England percentages of 40.70 and 44.50 respectively.

The '**Your Future, Your Support, Your Say**' consultation ran from 27th May 2014 to 15th June 2014 and was designed to seek feedback from members of the public about their low level care needs now and in the future. Of the 672 responses received on line, 238 (35%) were from people aged 65 and over, with one in ten aged over 80, and they reported their health and fitness to be as follows:-

- 109 (46%) are currently healthy and independent, but with concerns for the future
- 31 (13%) are living with a long term condition or illness, needing no extra help or support
- 32 (13%) are living with a long term condition or illness needing some/long term help and support
- 43 (26%) are caring for someone with a long term condition or illness, of which 19 (8%) have their own health and care needs

The majority of people aged 65+ (114 (48%)) reported that their health was good or very good, although 109 (46%) had concerns for the future. Of the 38 people aged 85 and over, five cited their health as 'good', with the remainder stating that it was 'fair' or worse.

28% (121) reported a physical disability or sensory impairment, with 17% (72) reporting mobility problems. Of the 16 (4%) who reported dementia, nine were aged 85+ and all nine reported their health as 'fair' or worse.

79% (190) reported their level of fitness as fair or better with the most popular activities being 'light' and informal exercise such as gardening (124 (34%)), gentle exercise (68 (18%)), and brisk walking (51(14%)).

14% (55) of people reported being involved in voluntary and charitable activities with 13% (50) taking part in faith based activities. Those over 70 are more likely to take part in faith based activities than younger people.

55% (131) of respondents were interested in finding out about Health Checks with 22% (52) wishing to have more information about weight management and 21% (51) about physical activity. Following on from this,

- the Community Outreach Health Checks programme visited libraries throughout the borough to promote the initiative.
- the NHS Health Checks section on the Bromley MyLife website is being rebuilt <http://bromley.mylifeportal.co.uk/nhshealthchecks>
- a new Healthy Weight section (including healthy eating, exercise and obesity) is being developed within the 'staying healthy' section of Mylife <http://bromley.mylifeportal.co.uk/staying-healthy.aspx>

41% (165) would prefer to receive information about activities to improve health and fitness via their GP with 18% (72) citing their health clinic. People aged over 75 stated that they would prefer to receive paper versions of information and those over 80 also wanted such information from home visits.

The '**Living Well with Dementia in Bromley**' survey was carried out for four weeks between January and February 2015 and informed the Adult Services Stakeholder conference held on 11th March 2015. The purpose of the consultation was to talk to people about their experiences of living with dementia in Bromley or caring for someone with dementia.

Of the 48 people who completed the survey online,

- 55% have Alzheimer's disease
- 25% have vascular dementia

Of the 163 people who were engaged through face to face sessions, focus groups and on line, 6 out of 10 people received information from the Memory Clinic. This service provides assessment, diagnosis and treatment for people who are

experiencing difficulties with their memory such as dementia. Patients are usually people aged 65 and over, though in some cases they may be younger. People currently diagnosed received an information pack but those with a historic diagnosis or who did not have a formal diagnosis reported greater difficulty obtaining the information they needed and felt that there were still basic gaps in their knowledge.

People were very positive about activities taking place in the borough with some people able to do something every day, especially if they have a family member to take them. Some people reported that apart from one day a week at a day centre, they don't go out or see anybody for the rest of the week, although a cohort reported that some people with dementia refuse to go to a day centre and carers therefore miss out on respite. In general, people wanted someone to talk to and help them go out for a walk or visit the local shops, and for activities to be affordable and available at the weekend.

Feedback from the conference has resulted in the development of the dementia section of the Bromley MyLife website.

Residents of Bromley have told us

From our recent engagement activities, the following themes have emerged:-

- Requirement for more up to date information, advice and guidance available through a central, easy to find location, both online and in paper format
- Increasing need for providers of all shaped and sizes to come together to offer residents choice and flexibility to help maximise their independence for longer

These are being addressed through:-

- Review and redesign of Bromley MyLife 'Care and Support' web pages including bringing together information about adult social care and support options into a single page.
- Introduction of a section on support for people with dementia and being a carer in Bromley
- Production of a new Adult Care and Support Services Directory, available online and in paper format providing information about care or support both for people funding their own care and those receiving support from the Council or from health services
- <http://bromley.mylifeportal.co.uk/careandsupportdirectory/#.Vbo9nbFwY3E>
- Emphasising to providers through the Market Position Statement gaps in service provision to support them in the development of their business models. This will support improvement in the 'social isolation' Public Health

indicator as detailed overleaf.

Table 10. 6: Social Isolation related PHOF Indicators

Indicator	Time Period	Sex	Age	Bromley	London	England
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	2013/14	Persons	18+ yrs	38.70	40.70	44.50

Source: PHOF Indicators

What does this mean for Bromley residents and for children in Bromley?

- \The Care Act changes will:
 - require some changes to how we deliver assessment services in Bromley
 - mean that potentially the Local Authority could be required to fund an increase in packages from 2020
 - potentially raise expectations about the support that the Local Authority should be providing in partnership with Health
- An increasing number of older people are being supported within their own home which will have an increasing impact on community based services by all organisations that are required
- The increasing complexity of needs of the older people in residential care will impact on the services required to be provided by care homes, and the cost to the Council
- Community based services need to continue to support people with complex needs within their own homes – including trained workforce
- Integrated approach to the commissioning and provision of services for people with dementia and their carers
- Bromley has a higher percentage of adult social care users who have less social contact than they would like when compared to London and England
- Six month evaluation of the Adult Early Intervention Service to ensure effective deliver of initial contact services.

For more information on Older People please contact Catriona.Ellis@bromley.gov.uk

11. Learning Disability

Introduction

This section focuses on the needs of the Borough's adults with learning disabilities. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- Demographic information
- Issues and impact
 - Health
 - People supported by adult social care
 - Employment and social inclusion
 - Disability hate crime

Demographic Information

National Information

It is estimated that in 2013, there were 1,068,000 people with learning disabilities in England²²

This includes:

- 224,930 children (identified at School Action Plus or statements in DfE statistics as having either a primary or secondary Special Educational Need associated with learning disabilities);
- 900,900 adults of whom:
 - 177,389 (20%) were eligible for annual health checks
 - 206,132 (23%) were known to GPs as people with learning disabilities

429,530 (48%) were recorded by the Department of Work and Pensions as being eligible to receive either Disability Living Allowance or Attendance Allowance

Local Information

The projected figure for the number of adults up to the age of 64 with a mild, moderate or severe learning disability in Bromley in 2015 is 4,728; this is predicted to increase by 5% over the next 5 years²³. One area of growth is the number of children making the transition to adult services. Medical advances mean that more young people with profound and multiple disabilities are surviving to adulthood.

²² Public Health England - People with Learning Disabilities in England 2013

²³ Projecting Adult Needs and Service Information Systems, June 2015

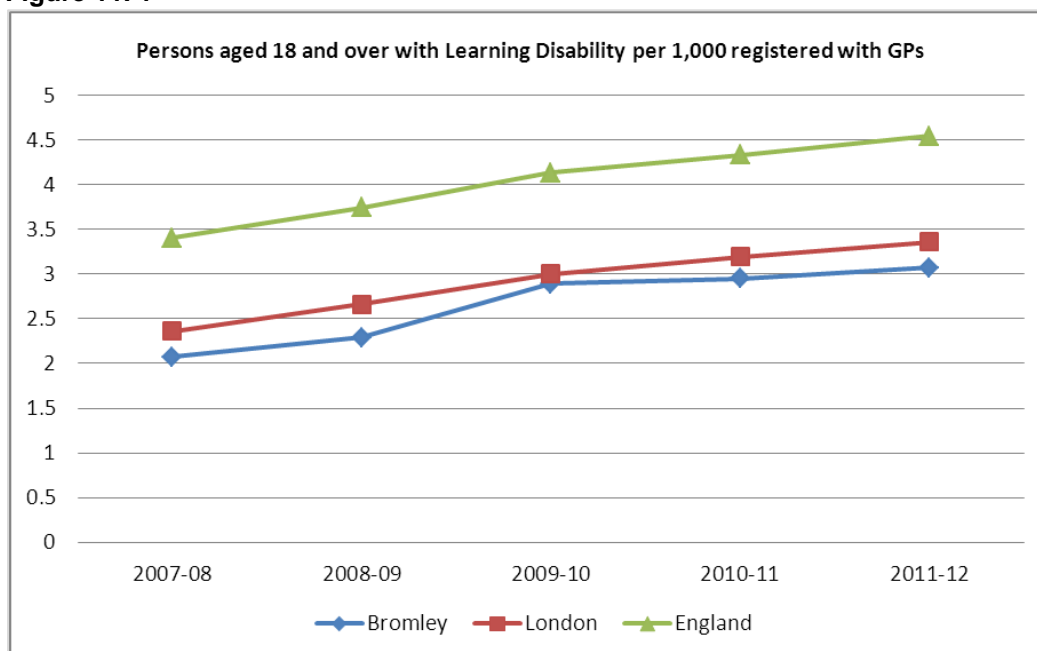
Table 11. 1

	Bromley		National	
	2015	2020	2015	2020
Learning Disability (18-64 yr)	4,728	4,949	811,445	823,660
Moderate/Severe Learning Disability (18-64 yr)	1,082	1,132	184,866	187,714
Autistic Spectrum Disorder (18-64)	1,895	1,987	332,097	338,061
Learning Disability (65+)	1,180	1,265	201,620	222,664
Moderate/Severe Learning Disability (65+)	159	168	27,469	29,722
Autistic Spectrum Disorder (65+)	514	550	90,067	99,638

Source: Projecting Older People Population Information System and Projecting Adults Needs Service Information June 2015

Of those adults with Learning Disabilities, 1,082 have moderate or severe Learning Disabilities and 1,895 have autistic spectrum disorder²⁴. Bromley identification rates are significantly lower than the England average.

Figure 11. 1



Source: Learning Disability Profile, 2013

Local Authority data gives a higher figure than GP disease registers for adults with a Learning Disability aged 18 to 64 years at 955 (2010-11), but this is still lower than the projected figure for moderate and severe Learning Disabilities.

²⁴ Projecting Adult Needs and Services Information Systems June 2015

This discrepancy in identification of adults with Learning Disabilities has implications for the health and social care provision to this patient group, some of which are explored in the next section.

Issues and Impact

Health

Nationally, Public Health England (Gyles Glover and Mark Brodigan) estimate that there were 216,000 patients on the Learning Disability Register in 2013/14, with 94,647 Health Checks carried out (44%). In Bromley, 26 out of 48 practices opted to participate in the Direct Enhanced Scheme and of the 424 eligible cohort, 255 checks were carried out in nine months (60%) which would equate to a full year figure of 340 (80%); an increase on the 2012/13 figure of 269.

Table 11. 2: Learning Disabilities Direct Enhanced Scheme Outcomes for 2013/14

Annual Health Check Register eligible patients	424	
Number of verified Health Checks undertaken in nine months	255	60%
Number of 'Did Not Attend' reported	32	8%
Number of patients proactively declining the invitation	11	3%

Source: Bromley CLDT August 2014

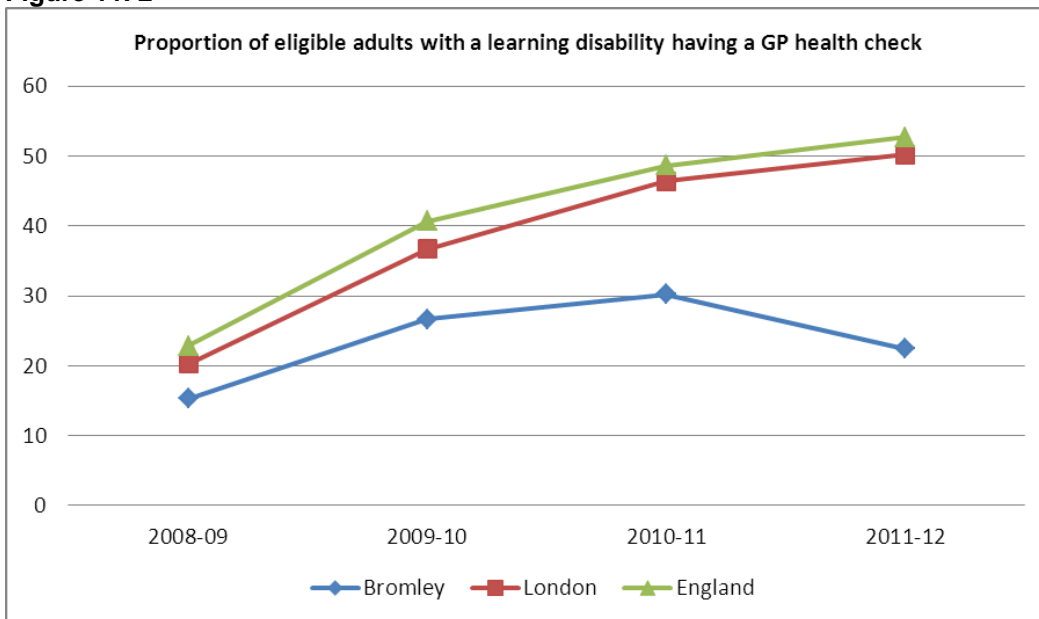
Some health conditions associated with learning disability increase the risk of premature death, for example, people with Down's syndrome have higher rates of congenital heart disease. People with learning disabilities have a higher prevalence of certain health problems such as epilepsy, dementia, gastro-oesophageal reflux disease and gastrointestinal cancer. They also have more difficulty than others in recognising health problems and getting treatment for them, therefore, it is advisable for GPs to offer regular health checks to make sure that important health problems are identified and treated. The Confidential Enquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) found that the most common underlying causes of death were heart and circulatory disorders (22%) and cancer (20%) although they were less prevalent than the general population (29% and 30% respectively). The final event leading to death was most frequently a respiratory infection²⁵

As well as these problems, people with learning disability are susceptible to the same health risks as the rest of the population, for example obesity and physical inactivity. Both of these are exacerbated by a sedentary lifestyle and a restricted range of opportunities to exercise or eat healthily.

²⁵ See also Health Inequalities and People with Learning Disabilities in the UK, 2011

Nationally, the median age at death for people with Learning Disabilities is approximately 24 years (30%) younger than for those who do not have learning disabilities. The population pyramid for people with learning disabilities shows a sharp reduction in numbers above the age of 49 years due to reduced life expectancy as well as a suggestion of a sharp increase in numbers for males under the age of 20 years, which may reflect increased survival rates amongst more severely disabled children. The findings into the Confidential Enquiry into Premature Deaths of People with Learning Disabilities (CIPOLD), published in 2012, reported a slightly higher median age at death (65 years for men and 63 years for women).

Figure 11. 2



Source: Learning Disabilities Profiles, 2013

A further consequence of low levels of identification of adults with LD is reflected in admission rates to hospital.

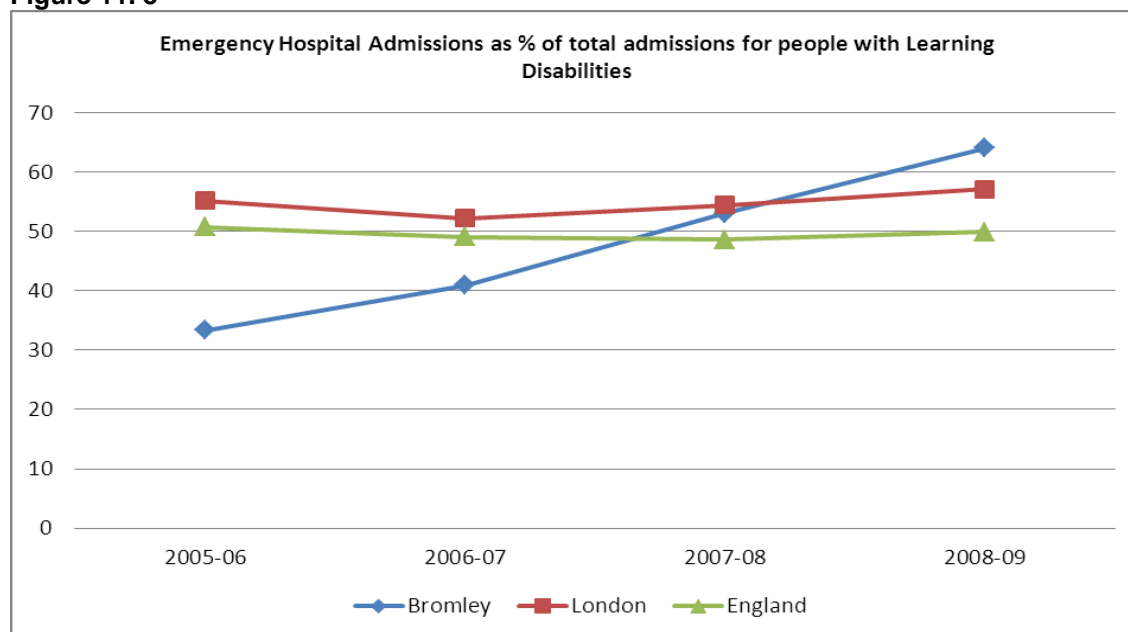
Bromley has significantly higher rates of emergency admissions for adults with learning disability (64.05%) than the England average (49.96%). The trend shows a year on year rise in these emergency admissions. However, it should be noted that this data only covers the period to 2009, so may not be representative of the current position.

A high level of emergency admissions can be an indication that earlier opportunities to manage a condition out of hospital have been missed.

Emergency admissions do not allow for advance planning to accommodate the needs of people with learning disabilities in hospital.

There is a high prevalence rate of sight loss amongst adults with learning disabilities. An estimated 96,500 adults with learning disabilities in the UK, including 42,000 known to the statutory services, are blind or partially sighted. This means that nearly one in ten adults with learning disabilities is blind or partially sighted. Adults with learning disabilities are 10 times more likely to be blind or partially sighted than the general population²⁶

Figure 11.3



Source: Learning Disabilities Profiles, 2013

People Supported by Adult Social Care

During 2013/14,

- 782 adults with a learning disability received community based services²⁷. 97 of these chose to manage their support package through a direct payment
- 141 received permanent residential care, with 10 new placements made during the year²⁸
- 10 received nursing care, with no new placements made during the year²⁹

Employment and Social Inclusion

In 2013/14, 11.5% of adults with learning disabilities in Bromley were reported to be in some form of paid employment. Nationally, the Public Health Outcomes

²⁶ Emerson and Robertson, 2011

²⁷ Community Based Services include:- Home care, day care, short term residential (not respite), direct payments, professional support, equipment and adaptations (RAP P2f)

²⁸ ASC CAR Table S1 and S2

²⁹ ASC CAR Table S3

Framework (PHOF) estimates that in 2013/14, the gap between the employment rate of those with a learning disability and the overall employment rate was 65% (London 60.90%), and in Bromley 65.60%.

During 2014/15, the Bromley Mencap Jobmatch service received 96 referrals and supported 36 candidates to enter paid employment. A further 37 candidates were on the main Jobmatch waiting list to receive support.

Living in settled accommodation is deemed to improve safety and reduce the risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care. The Public Health Outcomes Framework (PHOF) reflects that in Bromley in 2013/14, 47.7% of adults with a learning disability lived in stable and appropriate accommodation compared to 68.5% in London and 74.8% in England.

Disability Hate Crime

The combined 2011/12 and 2012/13 Crime Survey for England and Wales dataset indicates that there were 62,000 disability motivated hate crimes per year on average.

In 2012/13, the police recorded 1,841 disability hate crimes as compared with 1,757 offences the previous year (a 5% increase). Disability hate crimes accounted for four percent of all hate crimes recorded by the police in 2012/13. There was little variation in the proportion recorded by forces with the exception of Norfolk or Suffolk whose disability hate crimes accounted for 19 per cent and 20 per cent respectively of all hate crimes those forces recorded.

A third (32%) of disability hate crimes involved violence against the person; of these offences, 61% involved injury. Public order offences accounted for 30% of disability hate crimes.

In Bromley, the Disability Hate Crime Project is a partnership of disability organisations that has been established by Community Links Bromley, in association with the Metropolitan Police, to tackle the issues of disability hate crime. This project works with all age groups and disabilities, including mental health. The second conference took place in December 2014 and the aims of the project are:

- To work with the Metropolitan Police to up-skill members of the force in recognising and responding appropriately to disability hate crimes

- To raise awareness across the public, voluntary and community sectors on what a disability hate crime is and the role that people and organisations can play both at the preventative stage, as well as responding in sensitive and appropriate ways when hate crimes do occur
- To educate disabled people as to their rights when disability hate crimes occur
- To work with schools to raise awareness of disability hate crime.

Additional Work

Bromley is working on implementing changes to the Care Act. 85 children and young adults with learning disabilities have completed, or are currently being supported through, the travel training programme to become independent travellers, opening up opportunities to participate in further and higher education, work experience/employment opportunities.

Children and Families Act

For detail on implementation of the Children and Families Act, which has signalled far reaching reforms for children and young people with special educational needs and disabilities, and their families, as part of a new birth to age 25 Special Educational Needs system, please see Section 8.

Table 11. 3: Learning Disability Related PHOF Indicators

Indicator	Time Period	Sex	Age (yrs)	Bromley	London	England
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2011/12	Persons	18-64	57.80	65.70	70.00
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2012/13	Persons	18-64	52.40	68.10	73.50
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2013/14	Persons	18-64	47.70	68.50	74.80
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2012/13	Male	18-64	51.00	66.60	73.20
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2013/14	Male	18-64	46.20	67.70	74.50
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2012/13	Female	18-64	54.60	70.10	74.00
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2013/14	Female	18-64	50.10	69.70	75.30
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2011/12	Persons	18-64	56.20	58.70	63.20
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2013/14	Persons	18-64	65.60	60.90	65.00
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2013/14	Male	18-64	71.40	67.60	69.50
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2013/15	Female	18-64	60.40	54.40	60.70

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

What does this mean for Bromley residents?

- There is a need to improve the identification of people with learning disabilities in primary care
- promote the use of patient held Health Action Plans and hospital passports where appropriate
- raise awareness of the liaison nurse role/contact details within the local hospital(s).
- There is a considerable shortfall in the number of people identified with learning disability who have had an annual health check.
- The NHS Health Check has been adapted for people with a learning disability and is being undertaken by members of the integrated team.
- Further work to be undertaken to raise awareness with GPs of Health Checks and to establish reasons for non-attendance.
- Promoting independence of people with learning disabilities through schemes such as the travel training programme.

- Further work needs to be undertaken to increase the number of adults with a learning disability who live in stable and appropriate accommodation.
- Further work needs to be undertaken to establish the reasons for high rates of emergency admissions.

For more information please contact Catriona.Ellis@bromley.gov.uk

12. Physical Disability and Sensory Impairment

Introduction

This section focuses on the needs of the Borough's adults with sensory impairment and physical disabilities. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- Sight impairment
- Hearing impairment
- Physical disabilities

Sight Impairment

Nationally, the World Health Assembly views blindness as a public health issue directly linked with lifestyle and demographic factors³⁰. Currently, almost two million people in the UK are living with some degree of sight loss and this number is rapidly increasing. This figure includes around 360,000 people registered as blind or partially sighted, who have severe and irreversible sight loss³¹. By 2050, it is predicted that four million people will have sight loss.

The UK population is ageing, and it is projected to continue to age over the next few decades, with the fastest population increases in the numbers of those aged 85 and over. This is the age group more at risk of eye disorders causing vision impairment³²

Two thirds of registered blind and partially sighted people of working age are not in paid employment³³, and nearly half of blind and partially sighted people feel 'moderately' or 'completely' cut off from people and things around them³⁴

Sight loss impacts on a community on many different levels: on a personal level it can be a deeply traumatic life event. On an economic level, it is estimated that in 2008, sight loss cost the UK £22 billion.

In Bromley, 665 people were registered blind and 615 partially sighted as at 31st March 2014

³⁰ Bromley Vision Strategy, February 2013

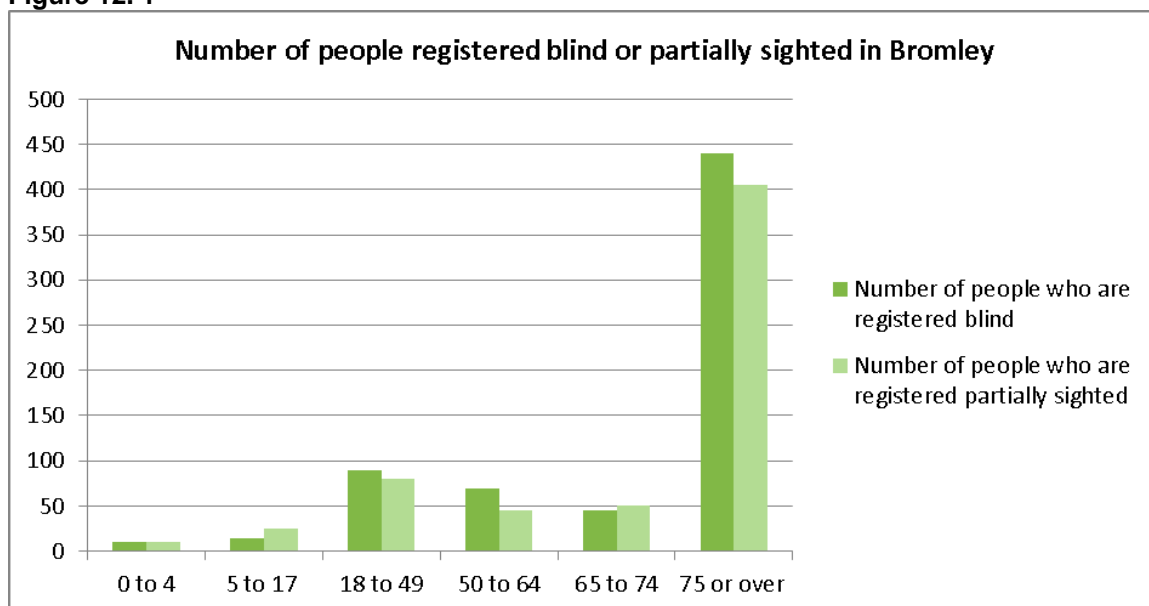
³¹ Access Economics, 2009

³² UK Vision Strategy, 2013-2018

³³ Douglas et al, Network 1000, 2006

³⁴ Pey, Nzegwu and Dooley, 2006

Figure 12.1



Source: Registered Blind and Partially Sighted People year ending 31 March 2014 England www.hscic.gov/pubs/blindpartiallysighted14

	0 to 4	5 to 17	18 to 49	50 to 64	65 to 74	75 or over	Total
Number of people in Bromley registered blind	10	15	90	70	45	440	665
Number of people in Bromley registered partially sighted	10	25	80	45	50	405	615

Note: Numbers may not sum up due to rounding

Source: Registered Blind and Partially Sighted People year ending 31 March 2014 England www.hscic.gov/pubs/blindpartiallysighted14

The Bromley Vision Strategy February 2013 and the 2015 Public Health Needs Assessment on Eye Health have found that:-

- **Ageing** is a risk factor in many eye conditions and in other health conditions which may lead to sight loss. Age related Macular Degeneration (AMD), Cataract, Glaucoma and to an extent Diabetic Retinopathy (i.e. duration or diagnosis) all show a positive association with age.

Smoking increases the risk of sight loss; Research has shown that cessation programmes which link sight loss and smoking provide a motivation for people to reduce or give up smoking³⁵.

³⁵ AMD Alliance, 2005

- **Obesity** has been shown to be a risk factor in all four major eye diseases, Macular Degeneration, Glaucoma, Diabetic Retinopathy and Cataracts. The 2014 Health Profile gives a modelled estimate for obesity prevalence in Bromley of 21.2% of those aged 16 years and over, representing approximately 54,000 adults.
- There are clear associations between excessive consumption of **alcohol** over a sustained period of time and the development of all four main eye diseases. In addition, alcohol consumption by women during pregnancy has also been linked to ocular abnormalities in children.
- The restriction of blood to the eye (as occurs with high blood pressure) can cause damage to the retina and result in deterioration of eye health. Heart health and good circulation are therefore essential to maintaining good health. In Bromley, the prevalence of hypertension is higher than the national average. In 2013-14, there were approximately 46,000 people on Bromley GP hypertension registers. This is likely to further strain the provision of local sight loss services.
- **Stroke** is a risk factor in the development of visual impairment and will have an impact on the provision of local visual impairment services.
- **Diabetes** is the leading cause of sight loss in working age people. As such, it could be considered to be one of the most economically damaging factors leading to sight loss. In 2013/14, there were 14,013 people in Bromley diagnosed with Diabetes. This reflects a continuous rise in the prevalence over the last 12 years. Given that 40% of people with Type 1 Diabetes and 20% of those with Type 2 Diabetes will go on to develop Diabetic Retinopathy, diabetes related visual impairment will become a major pressure on local low vision and rehabilitation services. It is estimated that there are 29,800 people in Bromley at high risk of diabetes.

People with Learning Disabilities are ten times more likely to have eye problems than the rest of the population³⁶. A pathway for adults and young people with learning disabilities has been developed by the Local Optical Committee Support Unit (LOCSU) to ensure that it reflects the needs of people with learning disabilities and is based on established successful learning disability services provided by community optometrists in a number of areas in England.

In Bromley, the numbers of adults between the ages of 18 and 64 years of age with a serious visual impairment is 127, predicted to rise to 141 by 2030³⁷

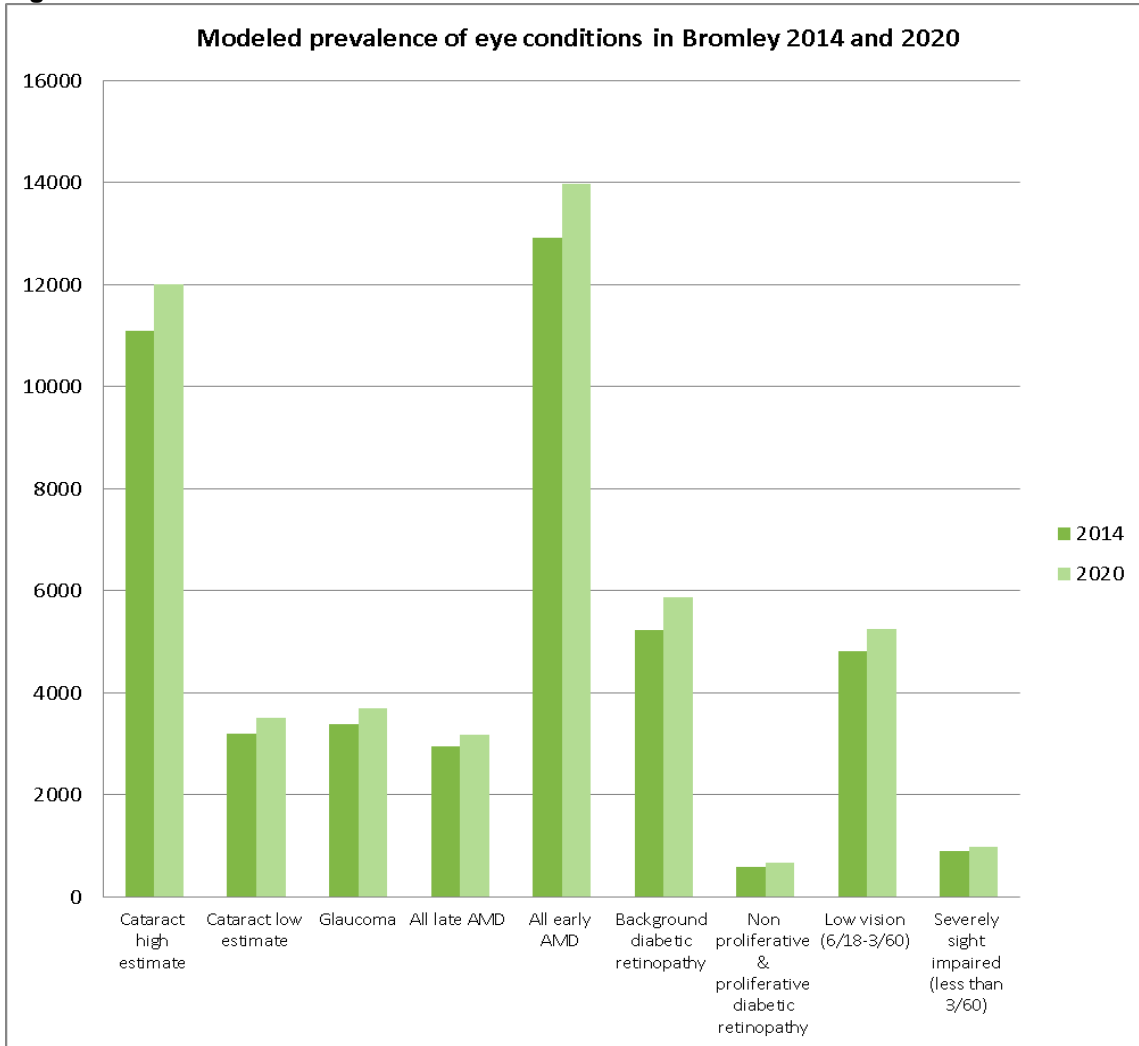
In the older age groups (over 65 years) there are larger numbers of people with moderate or severe visual impairment, 5,067 (predicted to rise to 6,821 by 2020). Age related Macular Degeneration is the most common cause of registrable sight loss in older people³⁸.

³⁶ See Ability and RNIB 2011

³⁷ Projecting Adult Needs and Services Information Systems, June 2015

³⁸ Projecting Older People Population Information Systems, June 2015

Figure 12. 2



Source: National Eye Health Epidemiological Model (NEHM) base prevalence applied to GLA population estimates expect for Diabetic retinopathy which is Yorkshire and Humber Public Health Observatory (YHPHO) Diabetes Prevalence Model for Local Authorities

Associated Impacts of eye disease

There are significant adverse health impacts associated with sight loss, such as an increased risk of depression and falls³⁹. People with sight problems are also likely to have additional disabilities and to live alone, indicating that those affected by sight loss are among the most vulnerable and isolated. A study by Frick and Kymes (2006) argues that these findings rank the absolute economic burden of sight loss with that of cancer, dementia and arthritis.

More broadly, the needs of blind and partially sighted people are often not taken into account by designers or planners. For example, the design of transport systems, signage, labelling, public buildings and shared space environments often fail to take

³⁹ Evans et al, Legood et al 2002

into account the needs of people with sight loss⁴⁰. Half of people with sight loss say they experience difficulty getting into and moving around buildings⁴¹.

Falls

A recent review of evidence on the link between falls and sight loss found that almost half of all falls sustained by blind and partially sighted people were directly attributable to their sight loss⁴². On average, the estimated medical cost of falls nationally is £269 million. Of the total cost of treating all accidental falls in the UK, 21% was spent on the population with visual impairment⁴³. A number of studies have demonstrated the cost benefits of cataract surgery in improving life quality and reducing the number of falls⁴⁴.

Quality of Life and Emotional Wellbeing

Evidence suggests a strong link between sight loss and reduced psychological wellbeing, particularly amongst older people who develop sight loss later in life⁴⁵. People living with sight loss report lower feelings of wellbeing, reduced self-confidence and lower satisfaction with their health⁴⁶.

Older people with sight loss are almost three times more likely to experience depression than people with good vision⁴⁷. Patients with bilateral neovascular Age related Macular Degeneration report a substantially lower quality of life, poorer vision-related functioning, greater anxiety and depression, more frequent falls and fractures, and greater dependency on carers⁴⁸.

Hearing Impairment

Nationally, the Action on Hearing Loss report 'Hearing Matters' states, that in 2011, hearing loss affected more than 10 million people in the UK (one in six of the population). By 2031, it is estimated that this figure will have risen to 14.5 million. The World Health Organisation predicts that by 2030, adult onset hearing loss will be in the top 10 disease burdens in the UK and other high and middle income countries, above cataracts and diabetes.

There are four different levels of hearing loss defined as:-

⁴⁰ RNIB, 2011

⁴¹ McManus and Lord 2012

⁴² Boyce et al 2013

⁴³ Boyce et al 2013

⁴⁴ RNIB and Royal College of Ophthalmologist 2011

⁴⁵ Hodge et al, 2010

⁴⁶ McManus and Lord 2012

⁴⁷ Evans et al, 2007

⁴⁸ Prokofyeva and Zrenner 2012

- **Mild hearing loss** – can sometimes make following speech difficult, particularly in noisy situations
- **Moderate hearing loss** – may have difficulty following speech without hearing aids
- **Severe hearing loss** – usually need to lip read or use sign language, even with hearing aids
- **Profound deafness** – usually need to lip read or use sign language

Hearing loss has significant personal and social costs and can lead to high levels of isolation and consequent mental ill health, more than doubling the risk of depression in older people. People with mild hearing loss also have nearly double the chance of developing dementia and this risk increases significantly for those with moderate and severe hearing loss. People with hearing loss are likely to withdraw from social activities involving large groups of people⁴⁹.

A 2005 MORI Poll of more than 2,000 people showed that almost a quarter (22%) are worried that people will think they are getting old if they wear a hearing aid.

Age related damage to the cochlea, or presbycusis, is the single biggest cause of hearing loss. This process occurs naturally as part of the ageing process. The vast majority of people with hearing loss are older and the prevalence increases with age⁵⁰.

People with hearing loss may also have other additional disabilities or long term health conditions that limit their daily activities such as arthritis and mobility problems. This includes half of older people⁵¹ whilst as many as 40% of deaf children will have additional or complex needs⁵². This often means that barriers to inclusion and feelings of isolation are compounded, so managing hearing loss can be fundamental to effective management of other conditions⁵³.

An estimated 250,000 people will have dual sensory loss and this number is set to grow as the population ages, however this is considered a gross underestimate⁵⁴. People with hearing loss are also highly likely to have problems such as tinnitus and balance disorders which contribute as risk factors for falls and other accidental injuries⁵⁵.

⁴⁹ RNID, Hidden Crisis, 2009

⁵⁰ Davis 1995

⁵¹ RNID Annual Survey 2010

⁵² NDCS Policy on Audiology 2010

⁵³ RNID Annual Survey 2008

⁵⁴ Deafblind UK 2006

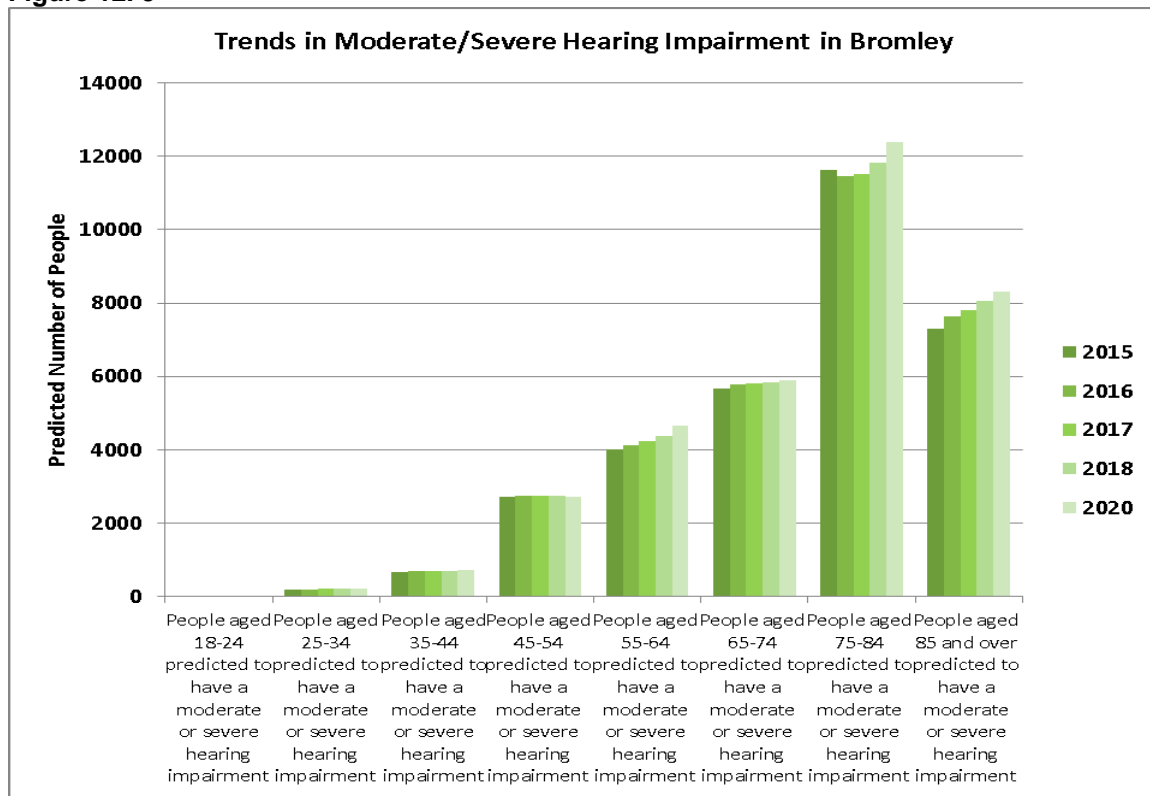
⁵⁵ Davis et al 2007

There are more than 45,000 deaf children across the UK⁵⁶ and many more children experience temporary conditions as a result of conditions such as glue ear. Half of all deaf children are born deaf, whilst half acquire deafness during childhood⁵⁷.

In 2009 in England, 71% of deaf children failed to achieve the government benchmark of five GCSEs at grades A* to C, including English and Maths. Research conducted in 2007 found that even at times of low unemployment, people with severe and profound levels of deafness were four times more likely to be unemployed than the general population.

In Bromley, there are over 32,000 adults over the age of 18 years with moderate or severe hearing impairment (predicted to rise to 35,000 by 2020) and a further 737 with profound hearing impairment (predicted to rise to 807 by 2020)⁵⁸.

Figure 12.3



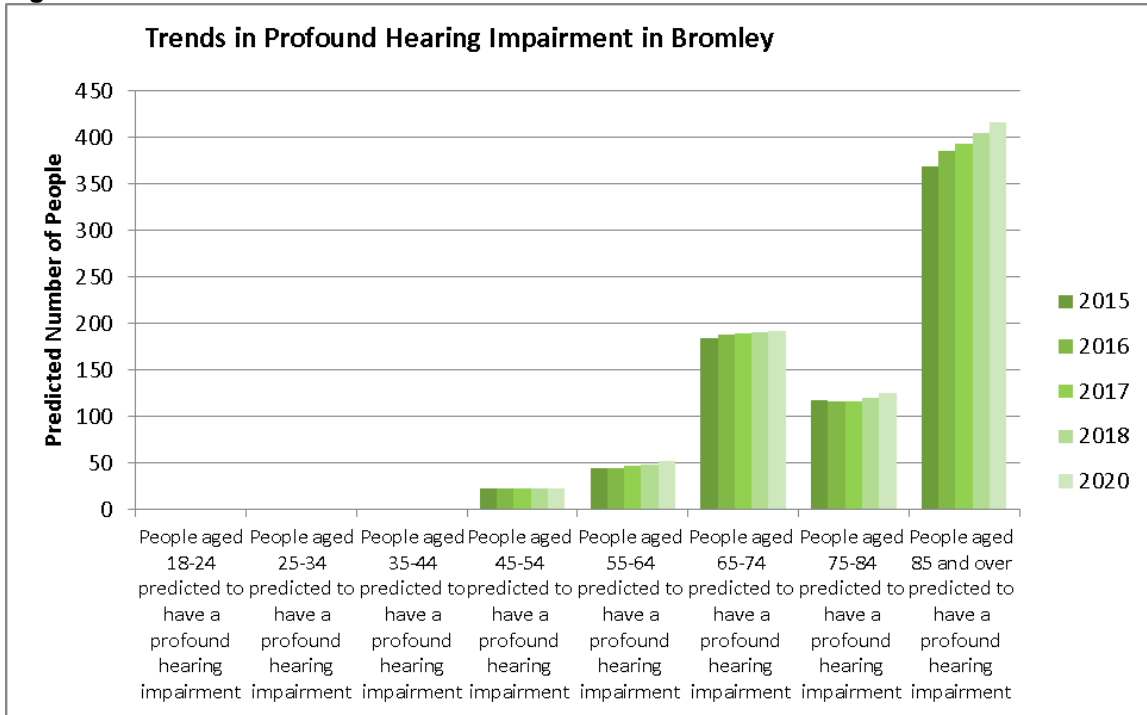
Source Projecting Adult Needs and Service Information and Projecting Older People Population Information System June 2015

⁵⁶ NDCS, 2009

⁵⁷ NDCS Technology Appraisal 2007.

⁵⁸ Projecting Adults Needs and Service Information System. Projecting Older People Population Information System. July 2015

Figure 12.4



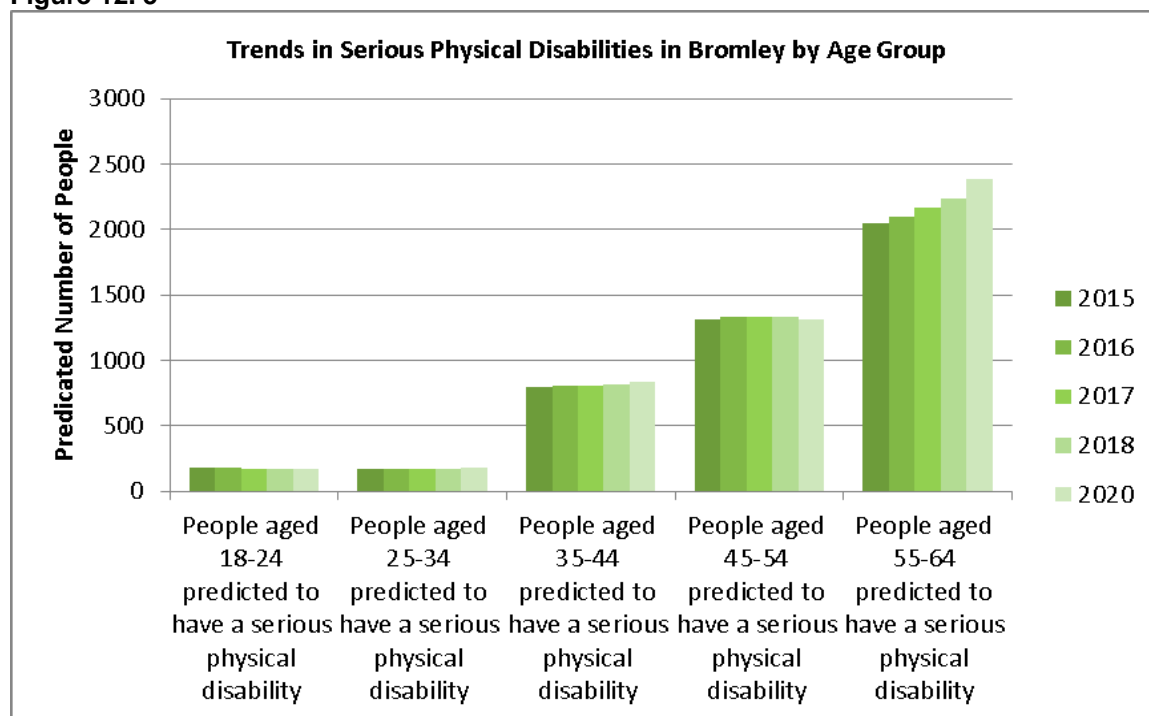
Source *Projecting Adult Needs and Service Information and Projecting Older People Population Information System June 2015*

Physical Disabilities

It is estimated that there are 19,770 people of working age in Bromley who have a physical disability, about 10% of the population aged 18-64. This figure is projected to increase to 21,196 by the year 2020⁵⁹.

⁵⁹ Projecting Adult Needs and Service Information June 2015

Figure 12.5



Source: *Projecting Adult Needs and Service Information June 2015*

The Bromley needs assessment for people with Physical Disability and Sensory Impairment (June 2011) identified the following priorities

- Disability awareness among staff and public,
- Empowering people with disabilities
- Accessible public transport to enable independent travel
- Access to services and premises within the borough
- Paid and unpaid employment opportunities

Progress to date

Improving accessibility has been made a priority. Transport issues have been addressed by the Mobility Forum, which contributed extensively to the development of Bromley South station, is contributing to plans at Bromley North and has developed an action plan for the coming year.

A Vision Strategy group has been set up, with support from external specialist agencies, and a strategy developed. A counselling support group for newly registered people with visual impairment has been set up and reports say that this is very much appreciated by, and beneficial to, participants.

Disabled Go has performed an annual review of venues in Bromley and has reported a number of improvements relating to access, with 24% of venues implementing non-structural changes such as:

- The introduction of disability equality training
- Provision of hearing assistance
- Provision of an email address as an alternative method of contact.

In addition, 5% of venues had some form of structural change to improve access, and encouragingly these premises included GP and dental surgeries, pharmacies and opticians.

The government's Health and Social Care reforms, changes in the way benefits are provided and stricter criteria for access to those benefits, such as mobility allowance, will all have an impact on local disabled people.

Profound and Multiple Learning Disabilities

Children and adults with Profound and Multiple Learning Disabilities (PMLD) have more than one disability, the most significant of which is a profound learning disability. All people who have profound and multiple learning disabilities will have great difficulty communicating. Many people will have additional sensory or physical disabilities, complex health needs or mental health difficulties. The combination of these needs and/or the lack of right support may also affect behaviour. Some other people, such as those with autism or Down's syndrome, may also have profound and multiple learning disabilities. All children and adults with profound and multiple learning disabilities will need high levels of support with most aspects of daily life.

Table 12. 1

Indicator	Time Period	Sex	Age	Bromley	London	England
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2010/11	Persons	65+ yrs	114.35	102.43	131.46
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2011/12	Persons	65+ yrs	91.60	100.73	129.15
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2012/13	Persons	65+ yrs	110.82	91.74	123.06
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2013/14	Persons	65+ yrs	137.16	87.68	118.8
4.12ii - Preventable sight loss - glaucoma	2010/11	Persons	40+ yrs	6.40	13.94	11.826
4.12ii - Preventable sight loss - glaucoma	2011/12	Persons	40+ yrs	8.23	14.91	12.839
4.12ii - Preventable sight loss - glaucoma	2012/13	Persons	40+ yrs	13.77	12.49	12.461
4.12ii - Preventable sight loss - glaucoma	2013/14	Persons	40+ yrs	11.13	14.63	12.858
4.12iv - Preventable sight loss - sight loss certifications	2010/11	Persons	All ages	32.73	32.36	42.743
4.12iv - Preventable sight loss - sight loss certifications	2011/12	Persons	All ages	35.74	33.80	44.469
4.12iv - Preventable sight loss - sight loss certifications	2012/13	Persons	All ages	38.85	29.92	42.336
4.12iv - Preventable sight loss - sight loss certifications	2013/14	Persons	All ages	38.69	30.19	42.533

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

What does this mean for Bromley residents?

- As age is a key risk factor for both vision and hearing loss, numbers suffering these conditions are expected to rise.
- There is great scope for prevention of sight loss through addressing smoking, obesity, diabetes and circulatory disease.
- There continues to be insufficient local data on levels of paid and unpaid employment, and employment opportunities for disabled people.

For more information please contact Catriona.Ellis@bromley.gov.uk

13. Mental Health

Introduction

Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality and higher levels of social interaction and participation.

Some mental health problems are long lasting and can significantly affect the quality of people's lives, especially if they are not treated. Some people only experience a single episode of mental ill health. Others, who may have longer standing problems, can enjoy a high quality of life and fulfilling careers. However, the personal, social and economic costs of mental ill health can be considerable.

Key Health Issues

Having mental health problems is distressing to individuals, their families, friends and carers, and affects their local communities. It may also impact in all areas of people's lives. People with mental health problems often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation. They are also more likely to have poor physical health.

Mental Health can also contribute to perpetuating cycles of inequality through generations. However, early interventions, particularly with vulnerable children and young people, can improve lifetime health and well-being, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. Such interventions not only benefit the individual during their childhood and into adulthood, but also improve their capacity to parent, so their children in turn have a reduced risk of mental health problems and their consequences.

Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16-25 years sooner than the general population. They have higher rates of respiratory, cardiovascular and infectious disease and of obesity, abnormal lipid levels and diabetes. They are also less likely to benefit from mainstream screening and public health programmes.

Increased smoking is responsible for most of the excess mortality of people with severe mental health problems. Adults with mental health problems, including those who misuse alcohol and drugs, smoke 42% of all tobacco used in England. Over 40% of children who have conduct and emotional disorders are smokers.

Mental health problems such as depression are also much more common in people with physical illness and having both physical and mental health problems delays recovery from both. Children with a long term physical illness are twice as likely to suffer from emotional or conduct disorder problems. People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven times more likely to have depression. Adults with both physical and mental health problems are less likely to be in employment.

Adult Mental Health Need in Bromley

Nationally, mental health/psychological symptoms are common in the adult population affecting up to 1 in 3 people. Applied to Bromley, this prevalence would mean that 64,000 people are suffering from one of these symptoms at any one time. About half of those with symptoms, 1 in 6, will suffer from a recognised mental health problem including depression, phobias, obsessive compulsive disorder, panic disorder, generalised anxiety disorder and mixed anxiety and depressive disorder. In Bromley, this would equate to about 32,000 people, of whom about 4,000 people will be known to secondary care services such as Oxleas Foundation Mental Health Trust.

Table 13.1 below shows the estimated number of people with a variety of conditions and predicted numbers for future years. It should be noted that the survey upon which the figures are based only included people living in private households. Common mental disorders include different types of depression and anxiety, and women are more likely to be affected than men. Those with a common mental disorder are most likely to be treated in primary care. Data from GP registers in 2013/14 shows that the prevalence of people with depression over 18 in Bromley is similar (6.38%) to the average in England (6.52%).

Table 13. 1: Bromley - People aged 18-64 predicted to have a mental health problem projected to 2020

People aged 18-64 predicted to have:	2012	2014	2016	2018	2020
common mental disorder	30,949	31,581	32,341	33,121	33,837
Borderline personality disorder	868	886	907	929	949
Antisocial personality disorder	652	665	681	698	713
Psychotic disorder	770	785	804	824	841
Two or more psychiatric disorders	13,757	14,038	14,377	14,723	15,040

Based upon Adult Psychiatric Morbidity in England, 2007 (does not include people in secondary care) and ONS data

Over 2,600 people in Bromley (almost 1% of the adult population) have been identified by GPs as experiencing serious mental illness, as illustrated in **Table 13.2** below.

Table 13. 2: Quality and Outcomes Framework Serious Mental Illness Prevalence

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Mental Health Register Size	1,667	2,173	2,270	2,351	2,389	2,511	2,563	2,616	2,667
Serious Mental illness Prevalence	0.5%	0.9%	0.8%	0.9%	0.9%	1.0%	0.94%	0.8%	0.80%

Source: HSCIC/ QOF, 2015

Bromley Community Mental Health Profiles

The Community Mental Health Profiles (CMHP) present a range of mental health information for Local Authorities in England. The CMHP are designed to give an overview of mental health risks, prevalence and services at a local, regional and national level using an interactive mapping tool. The data should be used to inform commissioners of health and social care services in their decision making, leading to the improvement of mental health, and mental health services. In Bromley the CMHP demonstrates the need to consider the following:

- Percentage of adults aged 18+ with depression is almost similar (6.38%) to England (6.52%) but higher than London (4.8%).
- Serious Mental Illness prevalence is significantly lower than England and London.
- Detentions under the Mental Health Act per 100,000, population are significantly lower than England and London.

- Attendances at A and E for a psychiatric disorder per 100,000, population is significantly lower than both England and London.
- Number of bed days used in Mental Health Services is significantly lower than England and London.
- Carers of mental health clients receiving assessments are significantly lower than both England and London.
- Percentage of people with Serious Mental Illness on the Care Programme Approach in settled accommodation is significantly higher than both England and London.
- Percentage of adults on the Care Programme Approach in Employment although not significantly different from England and London remains at just 6%.

Bromley Community Mental Health Profile 2013

Indicator	Period	Bromley		Sub region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Depression: QOF prevalence (18+)	2012/13	15,645	6.0%	-	5.8%	2.9%		11.5%
Depression: QOF incidence (18+)	2012/13	2,741	1.0%	0.8%	1.0%	0.5%		1.9%
Depression and anxiety prevalence (GP survey)	2012/13	559	10.2%	11.2%	12.0%	8.1%		19.5%
Mental health problem: QOF prevalence (all ages)	2012/13	2,616	0.79%	1.03%	0.84%	0.48%		1.46%
% reporting a long-term mental health problem	2012/13	192	3.8%	-	4.5%	2.5%		8.2%
Patients with a diagnosis recorded	2013/14 Q1	1,598	31.6%	37.4%	17.8%	1.1%		63.2%
Patients assigned to a mental health cluster	2013/14 Q1	3,560	70.5%	77.1%	69.0%	1.9%		94.8%
Patients with a comprehensive care plan	2012/13	2,020	88.4%	-	87.3%	79.9%		95.0%
Patients with severity of depression assessed	2012/13	2,041	87.4%	88.6%	90.6%	77.4%		97.8%
Antidepressant prescribing (ADQs/STAR-PU)	2012/13	7,040,876	4.6	3.9	6.0	2.7		9.0
People with a mental illness in residential or nursing care per 100,000 population	2012/13	80	42.0	33.0	32.7	0.0		124.3
Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital	2013/14 Q3	124	2.4%	3.1%	2.4%	0.7%		12.3%
Detentions under the Mental Health Act per 100,000 population	2013/14 Q1	13	5.3	20.2	15.5	0.0		44.5
Attendances at A&E for a psychiatric disorder per 100,000 population	2012/13	123	39.2	215.8	243.5	3.0		925.5
Number of bed days per 100,000 population.	2013/14 Q1	7,526	3,079	5,397	4,686	685		11,073
People in contact with mental health services per 100,000 population	2013/14 Q1	5,053	2,067	2,143	2,160	115		5,422
Carers of mental health clients receiving of assessments	2012/13	15	6.1	68.5	68.5	0.0		343.4

	Significantly lower than England
	Similar to England
	No significance
	Significantly higher than England

Source: PHE <http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data>

Bromley Psychosis Needs Assessment

In order to support integration of public mental health intelligence into JSNAs UCL partners have created a mental health intelligence platform. This platform provides fast, comprehensive mental health needs assessment data which systematically outlines coverage of prevalence, incidence and predisposing risk factors, as well as the provision of health and care.

The highlights from the Bromley report found that:

- Primary Care score for average of six physical health checks in people with SMI was high for London Boroughs.
- Proportion of people with SMI with a documented comprehensive care plan was low for London but higher than England.
- Expenditure for people with psychotic disorders is low for a London Borough. The majority of spend is on secondary care. There are significant savings to be made if all people estimated to be at risk of developing psychosis received preventative intervention.
- Excess mortality is mid-range.
- The rate of hospital admissions for schizophrenia is low.

Bromley Early Intervention Analysis

The London early intervention analysis 2015 Bromley report summarises findings of the pan-London project to explore first episode psychosis and the wider acute pathway. The main highlights for Bromley were:

- Access to Early Intervention Teams (EIT) is good in Bromley with an average waiting time of just over two weeks with a DNA rate lower than London and England.
- Caseloads are low in Bromley, however this may reflect population need. Of those in Early Intervention Teams, the percentage of the caseload on the Care Programme Approach (CPA) is above the highest quartile at 95%. Bromley has the lowest EIT caseload per 100,000, population in London.
- Referrals received from Primary Care, Community Mental Health Teams (as % of all referrals received) were low, however referrals were higher from inpatient care.

- The number of contacts per service user on the caseload was high in Bromley with a low length of time on the caseload at point of discharge.
- The percentage of patients in Bromley on the caseload with a diagnosis of 'other diagnosis' is high whereas it was low in all other diagnostic categories (this is unusual for EIT).
- The number of patients on the caseload per CPN, consultant psychiatrist, psychologist, occupational therapist and social worker are all low in Bromley.
- The EIT have lower costs per 100,000, population than London and England, however EIT annual costs per patient on the caseload is higher than both London and England.

In Summary

Although Bromley has low levels of SMI and record high levels of primary care checks there is still relatively high mortality. There are higher levels of specialist posts in Early Intervention Teams so cost per caseload is high even though the level of interventions delivered by teams is low in comparison to London and England. This information suggests that attention should be given to whether case identification is sufficient, and that the skill mix might not be the most appropriate. Redesigning the clinical pathway for Early Intervention seems to be indicated by this benchmarking exercise.

Mental Health and Older People

Bromley has the highest number of people aged 65+ years and 85+ years in London and is projected to continue to have the highest number in these age groups. People over 65 in Bromley make up approximately 17.66% of the population in 2015. Population projections indicate that the older population in Bromley is due to rise by 6% that is 3,500 people between 2015 and 2020. The largest rises are expected to be in the 70 - 74 years group.

The number of older people living alone is predicted to increase in line with the general rise in numbers of older people which may lead to an increase in social isolation.

The second National Psychiatric Morbidity Survey (2007) showed that in this age group there were lower rates of common mental health problems such as worry, irritability and depression compared to the adult population.

Table 13. 3: Estimated percentage of older people with depressive illness in England and Wales, and estimated numbers for Bromley

Mental Health Condition	% of older adults	Estimated number of people in Bromley aged 65+
Major depression	3-5%	1,561 _ 2,602
Minor depression	10-15%	5,204 _ 7,806

Source: Census 2011 population

A study carried out by Cambridge University in the same year which focussed on older people showed slightly lower rates for those with depression and severe depression. The overall prevalence of depression was 8.7%, increasing to 9.7% if subjects with concurrent dementia were included. Depression was more common in women (10.4%) than men (6.5%) and was associated with functional disability, co-morbid medical disorder, and social deprivation. Prevalence remained high into old age, but after adjustment for other associated factors, it was lower in the older age groups.

Table 13. 4: Predicted estimates of depression in older people in Bromley from the study by Cambridge University

Age breakdown	2014		2018	
	Depression	Severe depression	Depression	Severe depression
65-69	1,445	425	1300	380
70-74	1,004	194	1269	245
75-79	892	364	909	371
80-84	800	255	800	255
85+	770	332	856	374
65+	4,910	1569	5133	1625

Source: POPPI- data based on ONS population estimates

Dementia

Dementia is clinically defined as an age-related progressive disease associated with cognitive impairment, disorientation, memory loss, change in personality, difficulties with activities of daily living and behaviour that is out of character.

A Dementia Needs Assessment carried out in Bromley in 2012 provided information relating to the incidence of dementia in Bromley and included projections of future numbers based on the Dementia UK report of 2007.

It is estimated that there are around 4,222 people in Bromley with dementia in 2015. Although the prevalence of dementia is lower in women there are actually more

women than men with dementia in Bromley because life expectancy is higher in women. There are more men with dementia in the 65 – 74 age groups, but women outnumber men in the higher age groups. By 2030 the number of people with dementia in Bromley is set to increase to 6,034. Within the next five years there will be an increase of over 400 people with the greatest increase in the over 85 years: as well as dementia this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,100.

Table 13. 5: Predicted estimates of dementia in older people in Bromley

Age breakdown	2015		2018	
	Male	Female	Male	Female
65-69	122	91	107	83
70-74	180	163	220	199
75-79	235	377	240	384
80-85	357	638	367	638
85-89	351	755	384	799
90+	279	675	307	737
65+	1523	2699	1625	2840
Total Persons 65+ years	4222		4465	

Source: POPPI data based on ONS population estimates

The Dementia Needs Assessment, 2012 also contains information from Healthcare for London which estimated the number of people in Bromley with mild, moderate and severe dementia in **table 13.6** below. Those with the most severe forms of the condition will have much higher medical, social and mental health needs in comparison to those with mild or moderate disease who may be able to function relatively independently.

Table 13. 6: Estimated number of people with dementia by level of severity in Bromley

Severity of dementia	Number aged 65 and over
Mild	2,008
Moderate	1,190
Severe	482
Total	3,680

Source POPPI

Suicide

Suicide is one of the leading causes of death for all ages worldwide with more than one million deaths per year globally. Suicide is defined as acts of deliberate self-harm that result in death. The Office for National Statistics defines suicide as deaths with an underlying cause of self-harm or an injury/poisoning of undetermined intent.

Context of suicide statistics

Suicide is a major public health issue that has devastating effects on families and society. Recently, suicide has been acknowledged as a priority in public health policy and has been addressed through national strategic documents.

Years of life lost is a measure of premature mortality, estimating the length of time a person would have lived had they not died prematurely. Years of life lost due to mortality from suicide and injury of undetermined intent is an attempt to better quantify the burden or impact suicide and injury of undetermined intent has on a population.

Figure 13. 1: Years of life lost due to mortality from suicide and injury of undetermined intent, 2015

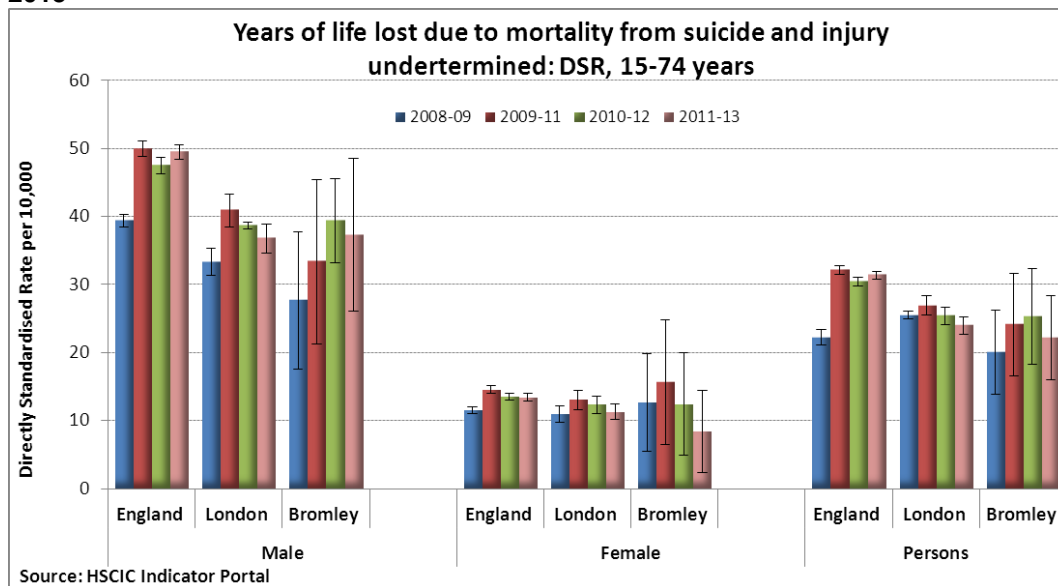


Figure 13.1 above shows that generally women are experiencing significantly lower premature mortality from suicides and injury of undetermined intent than men. The rate of years of life lost is increasing in Bromley year on year, particularly driven up by loss of life in men.

When Bromley is compared to England and London, there is a mixed picture. The rate of life lost is lower than England but not London. But significance of difference seen cannot be defined statistically because of small numbers in Bromley deaths.

Age-standardised rates

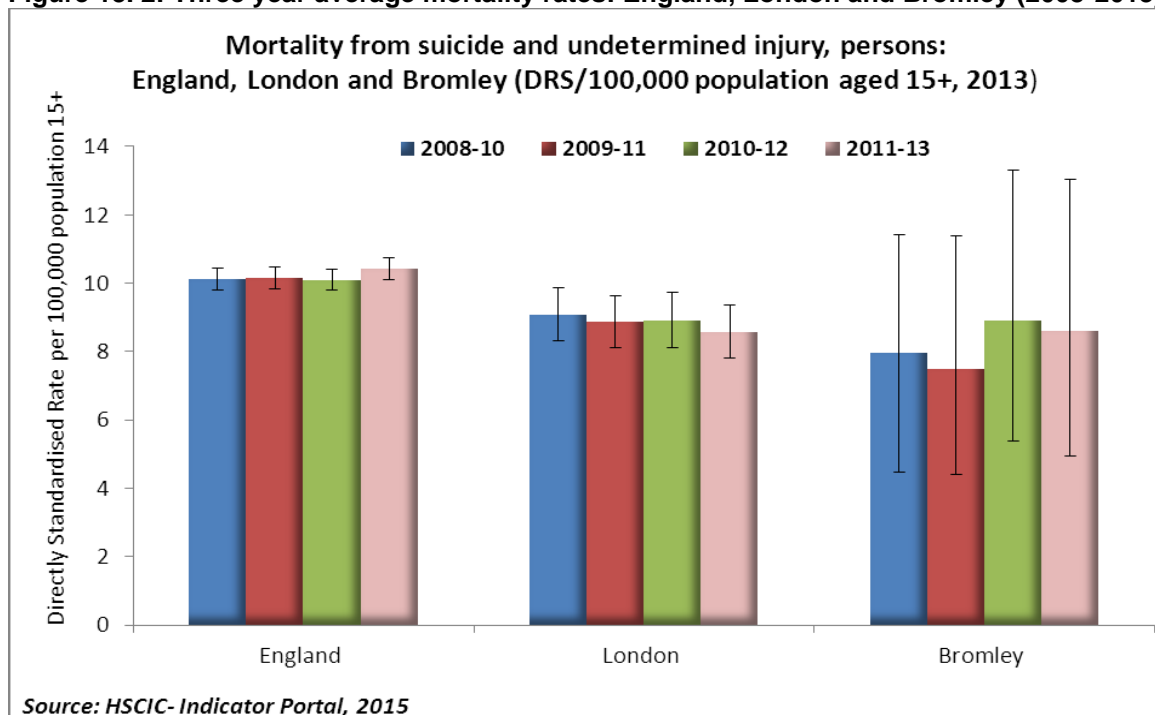
In London, there were 516 deaths attributed to suicide and undetermined injury in 2013, which equates to a rate of 7.9 per 100,000 people (15+ years) which is lower than the England rate (10.7 per 100,000).

In 2013 in Bromley, there was a rate of 7.5 per 100,000 in the population aged 15 years and over, lower than the 2012 rate of 9.9 per 100,000 population aged 15 years and over. The local data should be treated with caution as it is subject to random variation attributed to the small number of observed deaths.

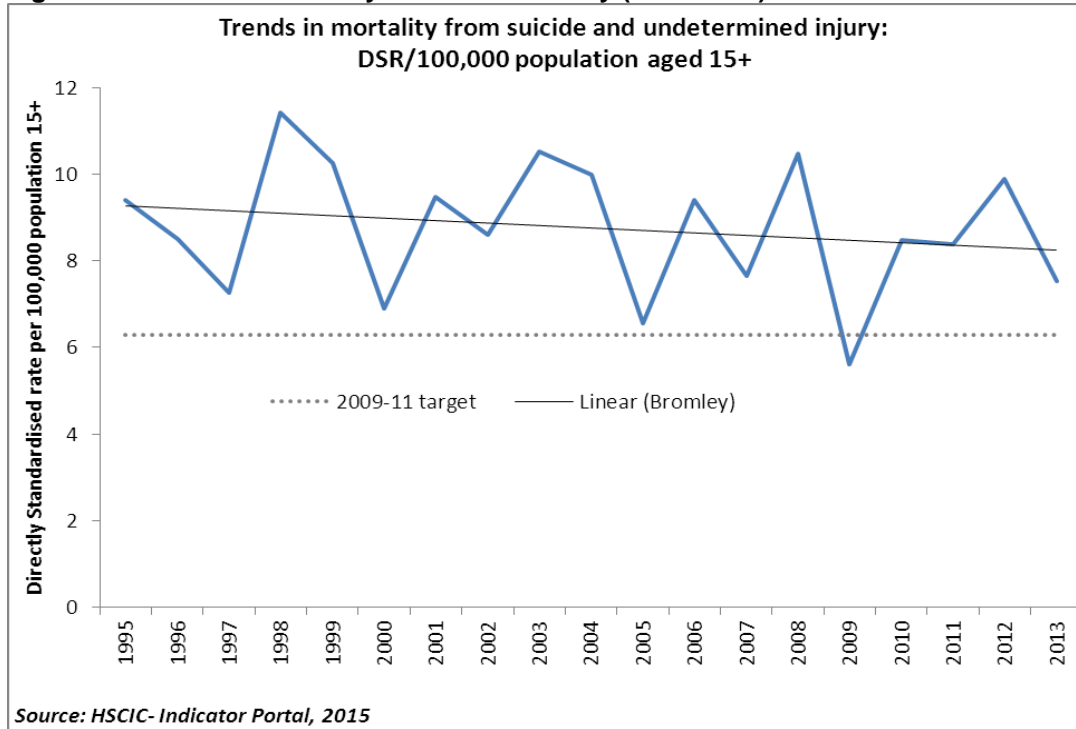
In **figure 13.2**, the mortality rates have been aggregated over three years to increase the number of events to levels which are more statistically meaningful.

The mortality rates from suicide and undetermined injury in Bromley have been consistently lower than the London and England rates.

Figure 13. 2: Three year average mortality rates: England, London and Bromley (2008-2013)



The 2010 target for Bromley was set at 6.3 per 100,000. Despite the fluctuations due to small numbers, **Figure.13.3**. shows that Bromley has not yet achieved the target but fluctuates around it. It is worth pointing out that the rates in **figure 13.3** may not be comparable to rates previously published in Bromley Suicide Audit reports due to population denominator revisions.

Figure 13. 3: Annual Mortality trends in Bromley (1995-2013)

National Patterns by age and gender

The latest Suicide Prevention Strategy for England reiterates the message that suicides are three times more common in males, with middle-aged men continuing to be one of the high-risk groups. A report by the Samaritans suggested that middle-aged men, especially those from poorer socio-economic backgrounds are particularly at risk of suicide due to a combination of factors. These include social and cultural changes (for example, greater solo living) that have particularly impacted on the lives of this cohort of men who are now aged 35-59 years.

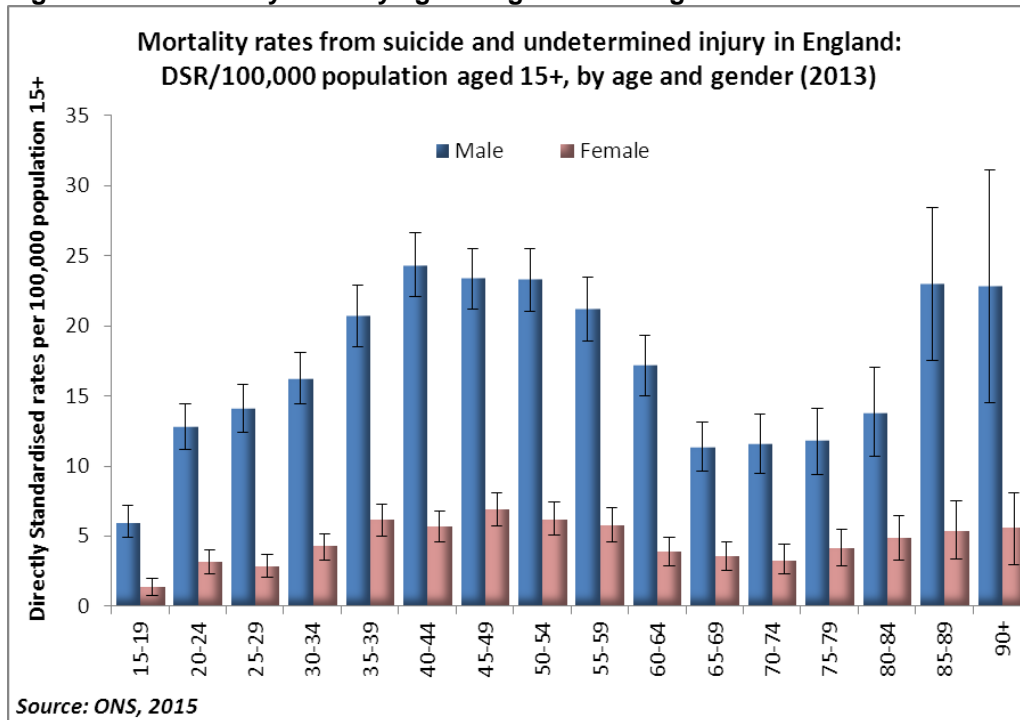
Men

- Men continue to be more than three times at greater risk of suicide than women. Most suicides are among men aged under 59 years. Men aged 35-49 years are now the group with the highest suicide rate.
- Older men (over 75) also have higher rates of death by suicide and injury of undetermined intent, which may reflect the impact of depression, social isolation, bereavement or physical illness.

Figure 13.4 shows the age standardised mortality rate for males and females in England. The majority of suicides continue to occur in young adult males, that is, those under 50 years. In comparison to women of the same age, younger men are

more likely to take their own lives. The peak difference is the 35-50 age group as there are four male suicides to each female. The average ratio between men and women of all ages is almost three male suicides to each female. Once people pass 50 years of age, the ratio gradually reduces, to around 2.1 male suicides to each female suicide in the 80 year and over age group.

Figure 13. 4: Mortality rates by age and gender in England

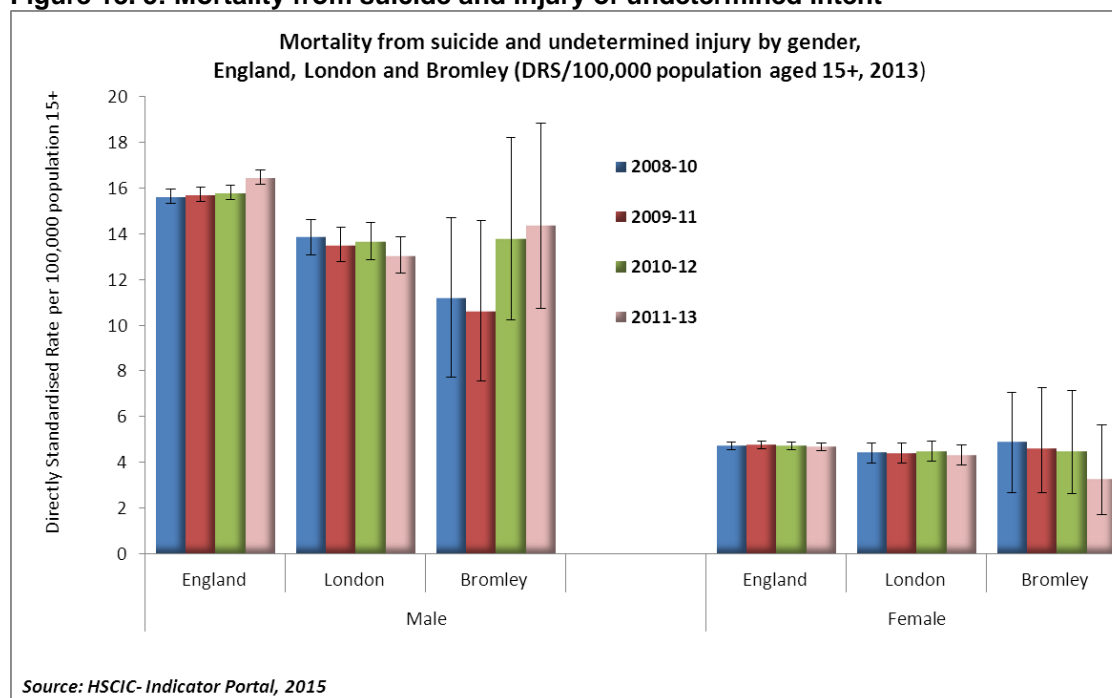


Local Patterns by Age and Gender

In Bromley there are gender differences in mortality rates from suicides and undetermined injury. Overall, suicide rates for men are about three times higher than for women.

Figure 13.5 shows the age standardised mortality rate for males and females in Bromley compared to London and England. The suicide rates for Bromley males are increasing in line with the England trend, while the rates in women, although significantly lower than males, seem to be reducing. The difference seen between Bromley and London or England in both genders is not statistically significant due to the wide confidence intervals in Bromley.

Figure 13. 5: Mortality from suicide and injury of undetermined intent



The majority of suicides in Bromley are aged 40 years and over and are mainly males. In Bromley 2013, 89% of all people dying by suicide were men, of which the majority of deaths were in males aged 35-64.

Ethnicity

Data on ethnicity is limited; it is not fully available from death certificates or general practice records. Place or country of birth is being used as a proxy indicator for ethnicity; however, it doesn't take into account the relatively large number of people from Black and other minority ethnic groups who are born in the UK. This situation is now changing since the 2011 census where ethnicity is being recorded on all birth and death records. This will facilitate more effective monitoring in the future.

Less than half of the local deaths from suicides and undetermined injury in 2013 had a recorded ethnicity. Deaths where ethnicity was recorded were from the White and White British ethnic group. In addition, recorded place of birth on the Primary Care Mortality database shows that 85% of deaths were people born in the UK.

Other information

Occupation

National Evidence has shown that there is an increased rate of suicide among the unemployed and that certain occupation groups can have an elevated risk of suicide.

Local data show that there were more deaths (69%) in people from routine and manual employment. This is the first time that the suicide audit has reported on suicide by occupation. It is hoped that over time trends can be identified within Bromley and lead to better targeted prevention approaches.

Recorded living status and employment were incomplete from the records on the Primary Care Mortality Database and a lack of access to coroner’s records has prevented further analysis.

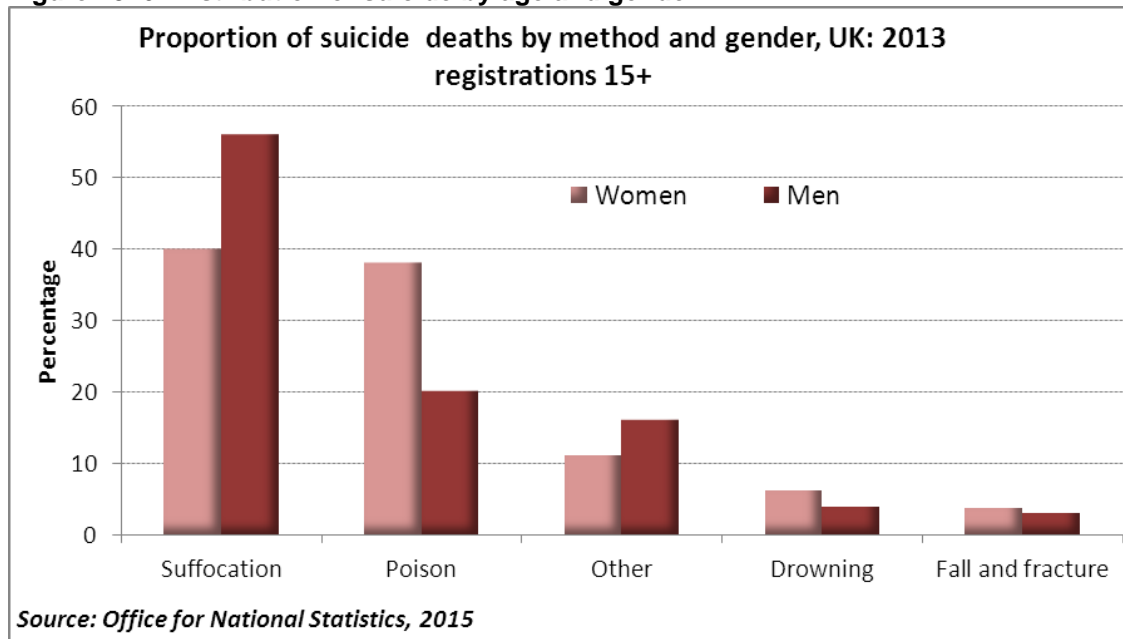
Coroner Information

Method of suicide

National data in **Figure 13.6** shows that suffocation is now by far the most common method used in suicide deaths. Suffocation accounts for more than half of all male suicide deaths and a considerable proportion of female deaths too.

Nationally, in women, drug-related poisoning was the second most common method, accounting for 38% of all female suicide deaths, closely following hanging and suffocation at 40% of all female deaths in 2013.

Figure 13. 6: Distribution of suicide by age and gender



In Bromley, method of suicide was not recorded on the Primary Care Mortality Database in 30% of deaths. These deaths may have been the ‘open verdict’ deaths and therefore it was not possible to supplement this information with Coroner’s

records. However for those deaths where a record was obtained, hanging or strangulation was the most common method used, followed by self-poisoning.

Place of suicide

In 2013, 85% of suicides were recorded as having taken place in the person's own home. Only a small proportion died in hospital and there were no deaths recorded outside Bromley.

In general, suicides are more common in areas of high deprivation. However this general pattern is complicated by the easier access to means by people in professions such as doctors, nurses, vets, dentists and farmers. Analysis examining the association between suicide and area-based deprivation and social fragmentation has shown that suicide mortality is more strongly associated with social fragmentation than deprivation, whereas deaths from other causes were more closely related to deprivation.

Contributory factors

The lack of access to coroner's records has meant that it is not possible to report trends around social circumstances. However GP records show depression and mental ill health and substance misuse are the most common contributing factors recorded for these deaths.

Primary Care Contact

The National Confidential inquiry into Suicide and Homicide by Mental Illness (NCISH) states that most people who die by suicide have seen their general practitioner (GP) in the previous 12 months before death. The NCISH notes that although this may provide an opportunity for prevention, identifying patients who are at particular risk is challenging.

In Bromley, 54% of suicides had contact with primary care within 12 months prior to death. Of those accessing primary care within 12 months prior to death, the numbers were evenly distributed between physical health and mental health reasons for contact with their GP.

In Bromley, 38% of suicides had a diagnosis of mental ill health 12 months prior to death including depression.

Depressive illness accounts for the vast majority of mental illness in patients who commit suicide in Bromley. It is present in 80% of all mental illness diagnoses in 2013, followed by mental ill health consequences of substance misuse.

Treatment for those diagnosed with mental illness included pharmacological medication, talking therapies and social interventions. However only half adhered to the treatment plan prescribed.

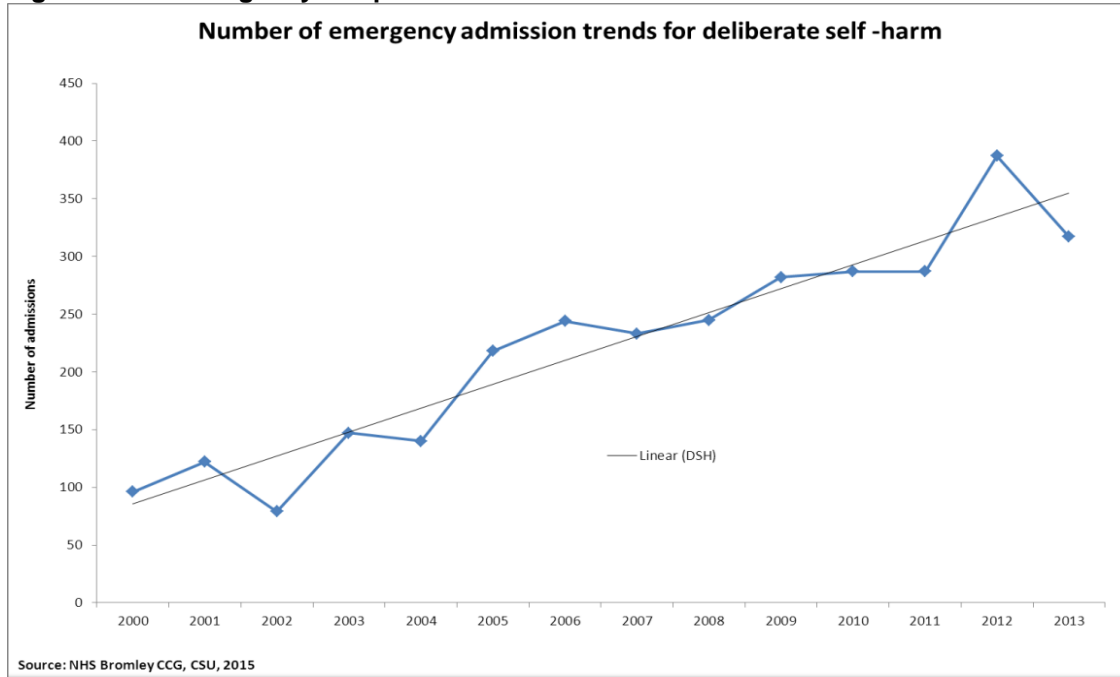
Deliberate Self Harm

Deliberate self-harm is a way of coping with life and most commonly starts in teenage years. There is a link between self-harm and completed suicide.

It is also known that one of the most important risk factors for suicide is having a history of self-harm and that the more a person self-harms the greater the risk that they will eventually die by suicide. Around half of all people who die by suicide have a history of self-harm and self-harm is a sign of serious emotional distress in its own right. Reducing and preventing self-harm is thought to have a preventive measure in reducing suicides. Identifying local trends can lead to targeted approaches. Bromley Public Health Department has carried out a clinical audit of self-harm in A and E and the recommendations from this report have been used to design new approaches in prevention.

National figures show Deliberate Self Harm (DSH) methods as including overdose, electrocution and wounding, although the most commonly used is self-poisoning, by both men and women. This picture is reflected in Bromley where self-poisoning continues to be the most common method of self-harm.

In 2000 there were 122 hospital admissions for deliberate self-harm in Bromley. In 2013 this number had increased to 318. Analysis shows an upward trend in the number of emergency admissions for deliberate self-harm in Bromley as shown in **figure 13.7** below.

Figure 13. 7: Emergency Hospital admissions for Deliberate self-harm

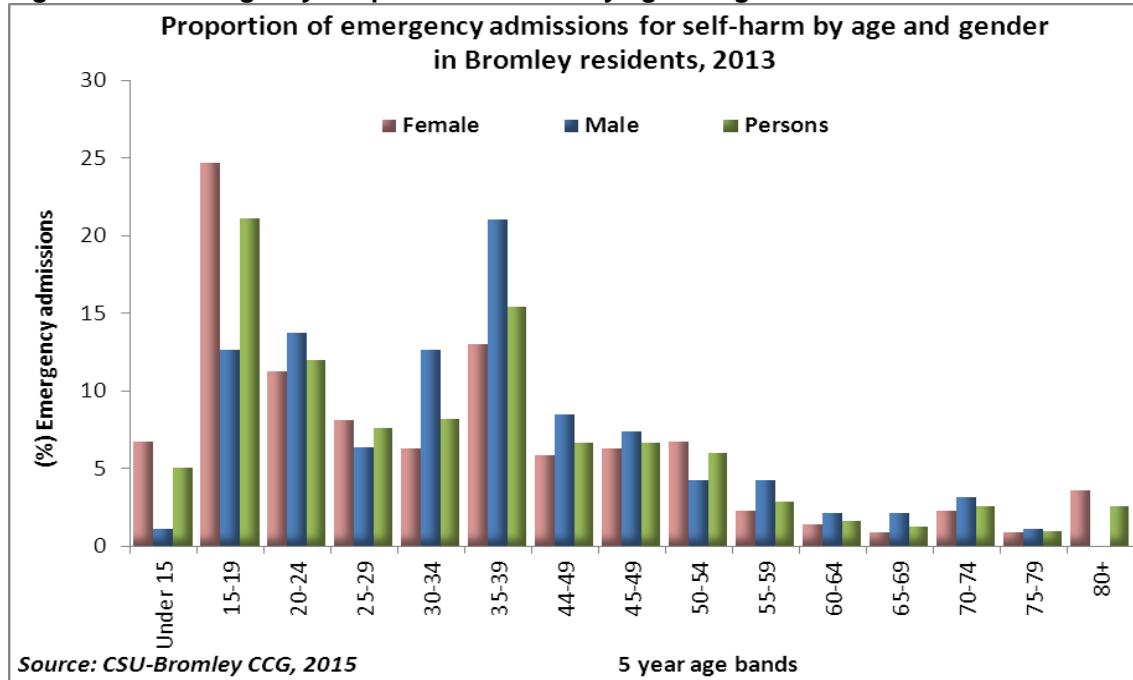
Deliberate Self Harm in Bromley

There are age and gender differences in hospital admissions for deliberate self-harm. Deliberate self-harm is more prevalent (70%) in women especially younger women as shown in **figure 13.8**. The 15 -19 year old age band have the highest number of hospital admissions following self-harm, numbers remain high and throughout life up to the age of 54 years for women.

Evidence suggests that;

- a) older adults who self- harm are known to have high suicide rates.
- b) older adults presenting to hospital with self-harm are at higher risk for subsequent suicide, especially men

Figure 13. 8: Emergency hospital admissions by age and gender

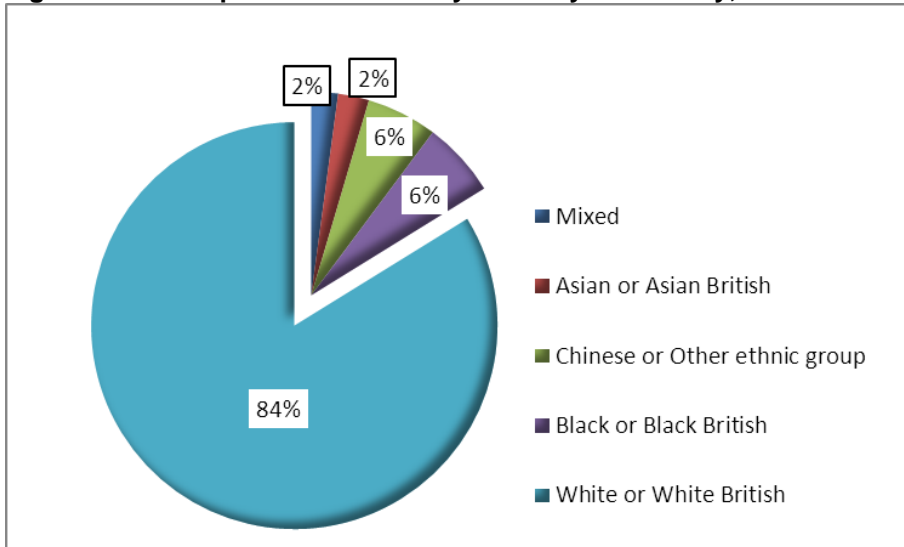


Self-harm hospital admissions by ethnicity

Most information about self-harm is based on data showing that proportions are greater in white populations. In Bromley, 84% of those who attended as emergency hospital admissions for self-harm were from a white background. 11% had no recorded ethnicity.

Although only 16% of the admissions for self-harm were in Black and minority ethnic groups as shown in **figure 13.9**, there is national evidence to suggest that this group, especially women, are less likely to receive psychiatric assessment and often re-present with self-harm.

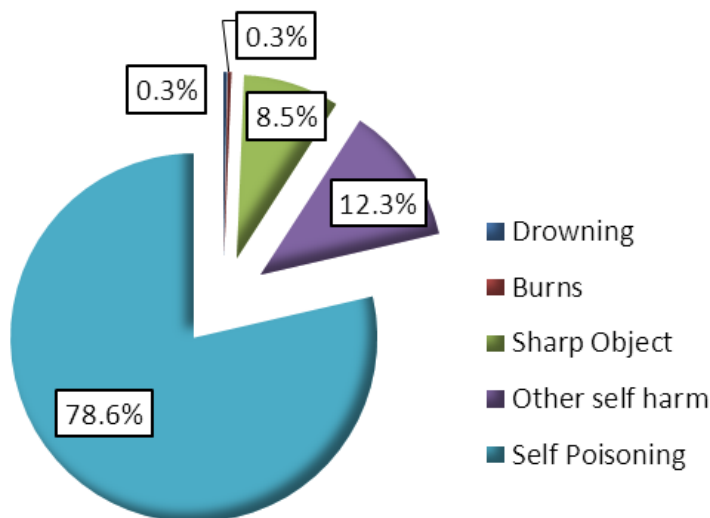
Figure 13. 9: Hospital admissions by ethnicity in Bromley, 2013



Source: NHS Bromley CCG-CSU, 2015

78% of all deliberate self-harm emergency admissions are for self-poisoning using prescription and over the counter medications, narcotics and substance abuse. In addition, 5 out of 7 of the emergency admissions following deliberate self-harm are in females.

Figure 13. 10: Percentage of emergency admissions for DSH by method: Bromley, 2013



Source: NHS Bromley CCG- CSU, 2015

Duration of spell in hospital

Age, severity of injury and underlying conditions are important contributors to length of stay in hospital. Most (78%) of the admissions in 2013 lasted between 0-1 days and only a small proportion (6%) lasted longer than 5 days.

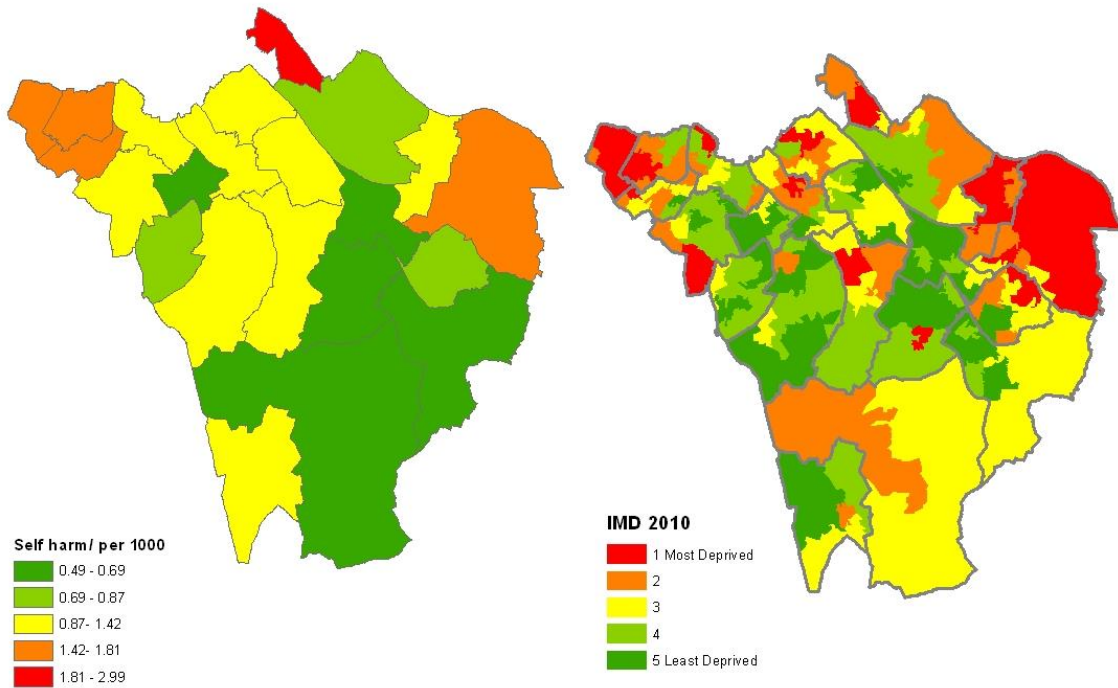
Geographical distribution of self-harm

Deliberate Self-Harm acts seem to be concentrated around deprived areas within Bromley. However, since deliberate self-harm is also most concentrated in young people, these deprived wards also have higher numbers of young people.

Figure 13. 11: Emergency admissions for self-harm and Index of Multiple Deprivation

Emergency admissions rates for self-harm by ward of residence, 2013
 Source: NHS Bromley CCG-CSU

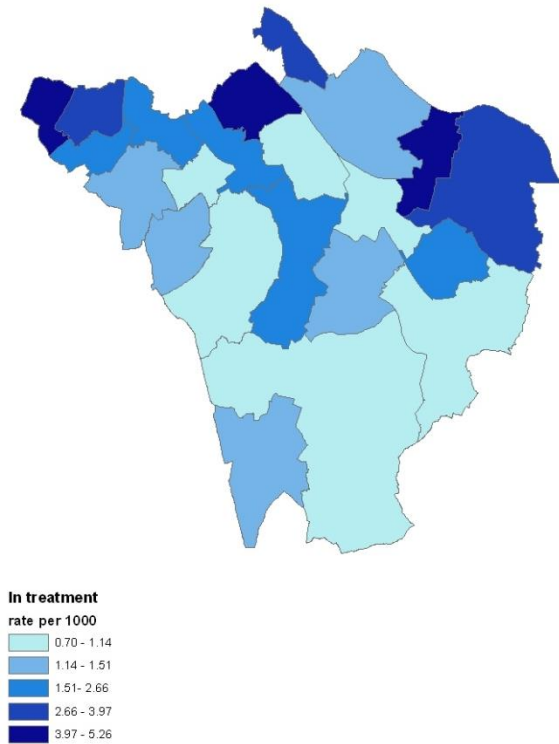
Index of multiple deprivation (IMD) 2010



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Rate of people in treatment for substance misuse per 1000 by place of residence in Bromley, 2014



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It is interesting to see the pattern of people self-harming shown in map 1 above on the left is similar to the pattern of people in treatment for substance misuse known in Bromley (shown in the blue map).

Observing the patterns alongside each other (people in treatment and self-harm), raises the question whether there is a relationship between substance misuse and self-harm in Bromley in these areas.

This needs further investigation.

Summary Facts on Suicide and Self Harm

In Bromley 2013:

- The suicide rates for Bromley males are increasing in line with the England trend, while the rates in women although significantly lower than males seem to be reducing.
- Local data shows that there were more deaths (69%) in people from routine and manual employment
- For those deaths where a record was obtained, hanging or strangulation was the most common method used, followed by self-poisoning
- The lack of access to coroner's records has meant that it is not possible to report trends around social circumstances. However, GP records show depression and mental ill health and substance misuse are the most common contributing factors recorded in these deaths.
- In 2000 there were 122 hospital admissions for deliberate self-harm in Bromley. In 2013 this number had increased to 318.

- 78% of all deliberate self-harm emergency admissions are for self-poisoning using prescription and over the counter medications, narcotics and substance abuse. In addition, 5 out of 7 of the emergency admissions following deliberate self-harm are in females.
- In Bromley there are gender differences in mortality rates from suicides and undetermined injury. Overall, suicide rates for men are about three times higher than for women.
- In 2013 in Bromley, there was a suicide rate of 7.5 per 100,000 population aged 15 years and over, lower than the 2012 rate of 9.9 per 100,000 population aged 15 years and over.
- 61% of deaths were males aged 50 years and over. Although small numbers, the majority of deaths within this age group had a history of poor physical health and a mental illness diagnosis.
- 77% of deaths had no documented suicide risk recorded.
- 36% of all the deaths had a recorded health condition such as heart disease or COPD.
- 54% had contact with Primary Care in the 12 months prior to death.
- 38% of all deaths had a previous contact with mental health services.
- 38% had a diagnosis of mental illness 12 months prior to the death.

BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2015

Table 13. 7: Mental Health Related PHOF Indicators, 2015

Indicator	Period	Sex	Bromley	London	England
1.06ii - % of adults in contact with secondary mental health services living in stable & appropriate accommodation	2011/12	Persons	63.4	73.1	54.6
1.06ii - % of adults in contact with secondary mental health services living in stable & appropriate accommodation	2012/13	Persons	73.3	79.4	58.5
1.06ii - % of adults in contact with secondary mental health services living in stable & appropriate accommodation	2013/14	Persons	72.0	78.6	60.8
1.06ii - % of adults in contact with secondary mental health services living in stable & appropriate accommodation	2011/12	Male	64.1	71.6	53.8
1.06ii - % of adults in contact with secondary mental health services living in stable & appropriate accommodation	2012/13	Male	73.1	77.9	57.3
1.06ii - % of adults in contact with secondary mental health services living in stable & appropriate accommodation	2013/14	Male	71.1	76.8	59.4
1.06ii - % of adults in contact with secondary mental health services living in stable & appropriate accommodation	2011/12	Female	62.5	75.0	55.5
1.06ii - % of adults in contact with secondary mental health services living in stable & appropriate accommodation	2012/13	Female	73.6	81.5	59.8
1.06ii - % of adults in contact with secondary mental health services living in stable & appropriate accommodation	2013/14	Female	73.4	81.3	62.4
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2009/10	Persons	343.1		326.7
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2010/11	Persons	291.6		335.3
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2011/12	Persons	284.3		337.4
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2012/13	Persons	318.1		347.2
4.10 - Suicide rate	2001/03	Persons	8.0	9.1	9.2
4.10 - Suicide rate	2002/04	Persons	8.2	9.0	9.1
4.10 - Suicide rate	2003/05	Persons	7.6	9.0	9.0
4.10 - Suicide rate	2004/06	Persons	7.2	8.7	8.8
4.10 - Suicide rate	2005/07	Persons	6.6	8.2	8.4
4.10 - Suicide rate	2006/08	Persons	7.7	7.9	8.2
4.10 - Suicide rate	2007/09	Persons	6.7	7.6	8.3
4.10 - Suicide rate	2008/10	Persons	6.8	7.6	8.4
4.10 - Suicide rate	2009/11	Persons	6.3	7.5	8.5
4.10 - Suicide rate	2010/12	Persons	7.5	7.5	8.5
4.10 - Suicide rate	2011/13	Persons	7.2	7.2	8.8
4.10 - Suicide rate	2001/03	Male	11.0	13.4	14.2
4.10 - Suicide rate	2002/04	Male	11.3	13.3	13.9
4.10 - Suicide rate	2003/05	Male	11.5	13.3	13.8
4.10 - Suicide rate	2004/06	Male	12.6	13.2	13.5
4.10 - Suicide rate	2005/07	Male	10.4	12.5	13.0
4.10 - Suicide rate	2006/08	Male	10.9	12.1	12.9
4.10 - Suicide rate	2007/09	Male	8.8	11.7	13.0
4.10 - Suicide rate	2008/10	Male	9.7	11.8	13.1
4.10 - Suicide rate	2009/11	Male	8.9	11.5	13.2
4.10 - Suicide rate	2010/12	Male	11.6	11.5	13.3
4.10 - Suicide rate	2011/13	Male	12.1	11.0	13.8
4.10 - Suicide rate	2001/03	Female		5.1	4.6
4.10 - Suicide rate	2002/04	Female		5.0	4.7
4.10 - Suicide rate	2003/05	Female		5.0	4.7
4.10 - Suicide rate	2004/06	Female		4.5	4.5
4.10 - Suicide rate	2005/07	Female		4.2	4.1
4.10 - Suicide rate	2006/08	Female		3.9	3.9
4.10 - Suicide rate	2007/09	Female		3.8	3.9
4.10 - Suicide rate	2008/10	Female		3.7	4.0
4.10 - Suicide rate	2009/11	Female		3.8	4.1
4.10 - Suicide rate	2010/12	Female		3.8	4.0
4.10 - Suicide rate	2011/13	Female		3.6	4.0

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

What does this mean for residents and for children in Bromley?

Data from GP registers in 2013/14 shows that the prevalence of people with depression over 18 in Bromley is similar (6.38%) to the average in England (6.52%).

Over 2,600 people in Bromley (almost 1% of the adult population) have been identified by GPs as experiencing serious mental illness.

Percentage of adults on the Care Programme Approach in Employment although not significantly different from England and London remains at just 6%.

Expenditure for people with psychotic disorders is low for a London Borough. The majority of spend is on secondary care

Although Bromley have low levels of SMI and record high levels of primary care checks there is still relatively high mortality. There are higher levels of specialist posts in Early Intervention Teams so cost per caseload is high even though level of interventions delivered by teams is low in comparison to London and England.

Within the next five years there will be an increase of over 400 people with dementia with the greatest increase in the over 85 years: as well as dementia this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,100.

The suicide rates for Bromley males are increasing in line with the England trend, while the rates in women although significantly lower than males seem to be reducing.

In 2000 there were 122 hospital admissions for deliberate self-harm in Bromley. In 2013 this number had increased to 318.

78% of all deliberate self-harm emergency admissions are for self-poisoning using prescription and over the counter medications, narcotics and substance abuse. In addition, 5 out of 7 of the emergency admissions following deliberate self-harm are in females.

In Bromley there are gender differences in mortality rates from suicides and undetermined injury. Overall, suicide rates for men are about three times higher than for women.

Notes

1. Substance and Alcohol Misuse are dealt with in section 16 and 17 respectively of the JSNA
2. Emotional Wellbeing in Children is discussed in detail in the Children and Young People section
3. Dementia is also discussed in the Older People section

For more information please contact Paula.Morrison@Bromley.gov.uk

14. End of Life Care

Introduction

It is recognised that good quality end of life care is critically important in giving the individual patient and their family a positive experience of care at what can be a difficult time in their lives.

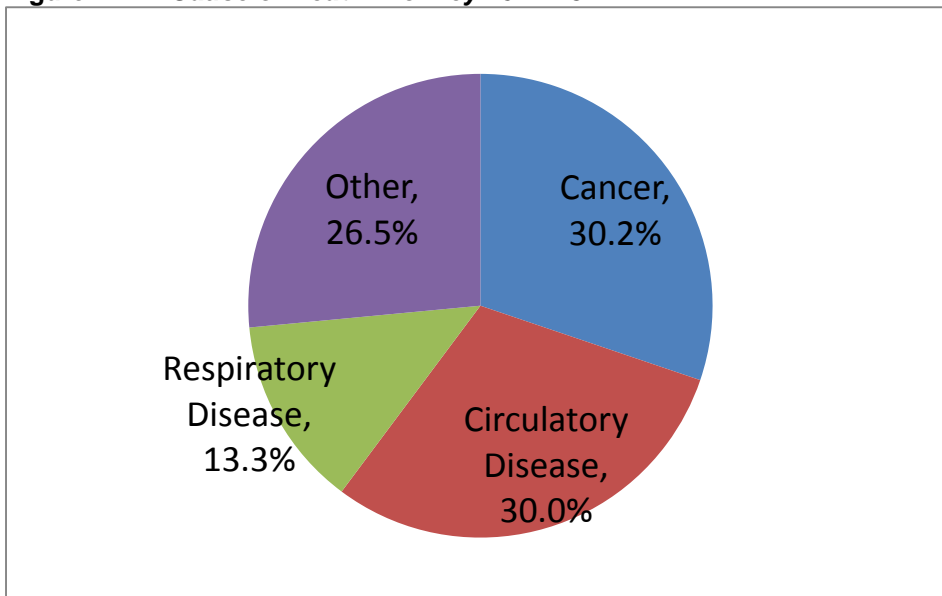
Therefore, there is value in identifying this group of patients correctly and in raising awareness of good end of life care through education particularly for health and social care professionals.

Good end of life care is about predicting and meeting need at the right time rather than giving defined timescales. There is good evidence that people are more likely to receive well co-ordinated, high quality care if improvements are made in predicting people at the end of life whatever their diagnosis and including them on a register.

Deaths in Bromley

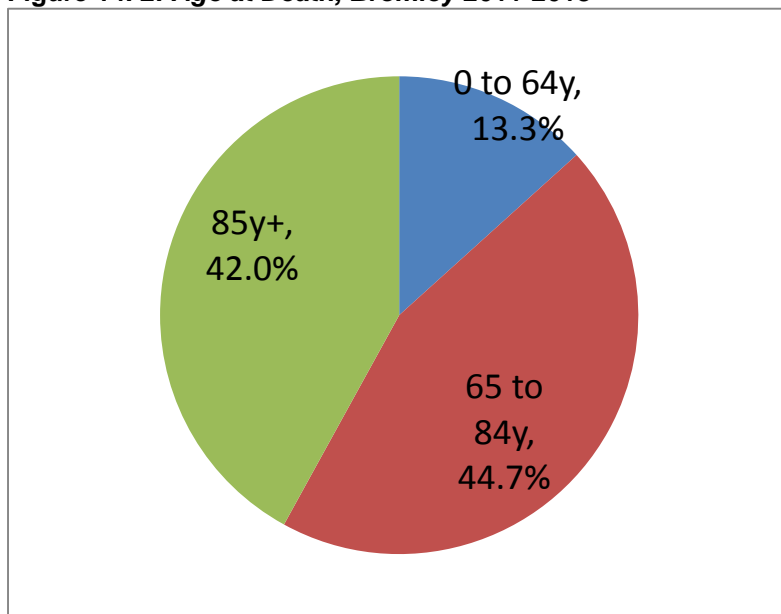
In the period between 2011 and 2013, there were 7,641 deaths in Bromley. The majority of these deaths were in those aged over 65 years, and were due to non-cancer causes.

Figure 14. 1: Cause of Death Bromley 2011-13



Source: PCMD, 2015

Figure 14. 2: Age at Death, Bromley 2011-2013



Source: PCMD, 2015

Place of Death

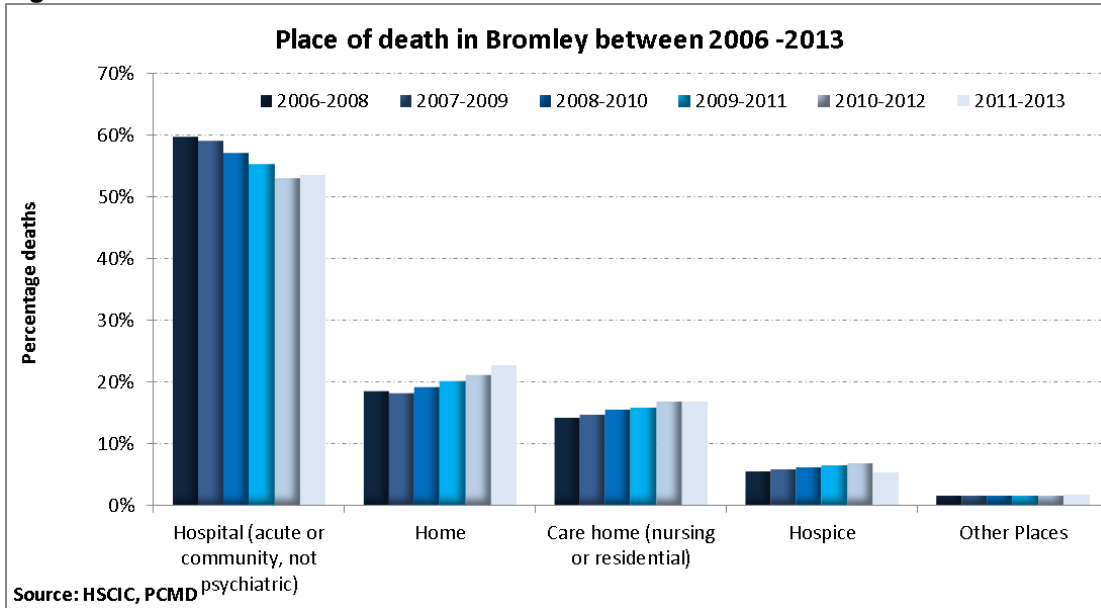
The period 2011-13 saw a reduction in hospital and hospice deaths and an increase in deaths at home and in care homes compared with the period 2009-11.

Table 14. 1: Place of Death Bromley

	2009-11	2011-13
Hospital (acute or community, not psychiatric)	55.0	53.5
Home	20.0	22.7
Care home (nursing or residential)	16.0	16.7
Hospice	6.9	5.3
Other Places	1.8	1.7

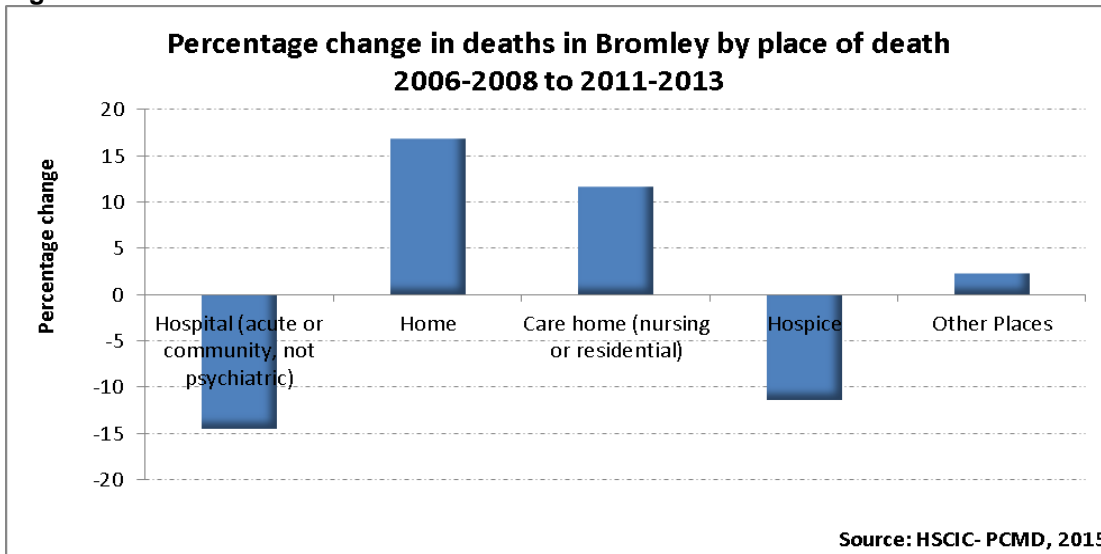
Source: HSCIC/ PCMD, 2015

Figure 14. 3



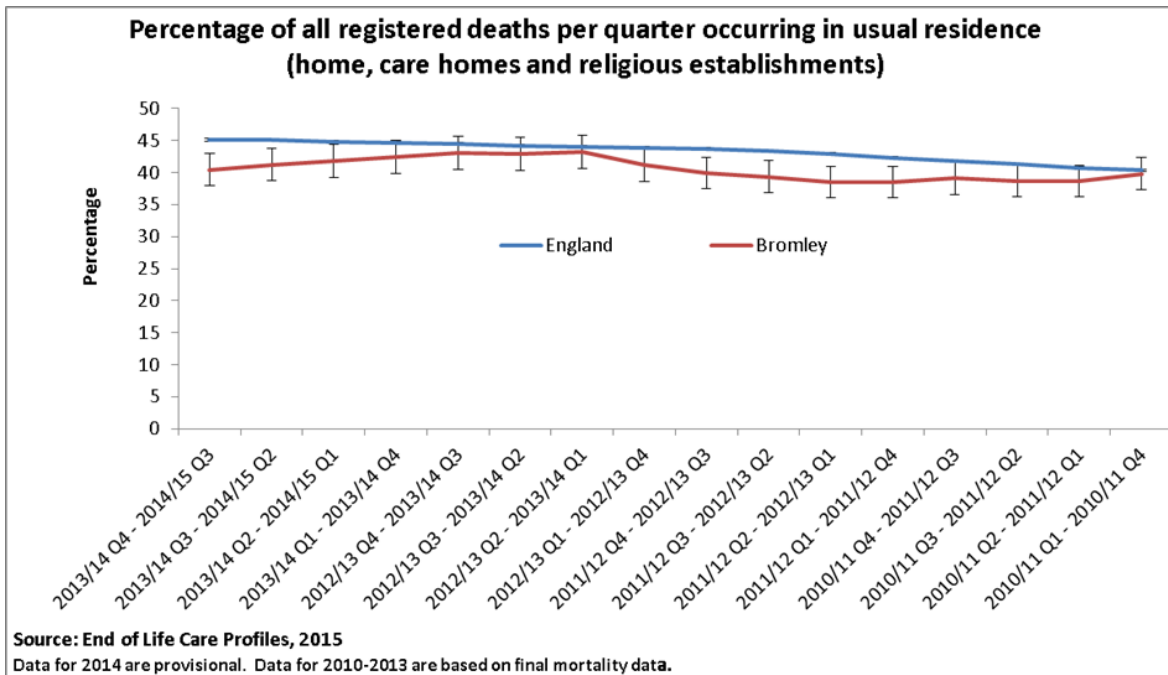
Since 2006, there has been a consistent reduction in the proportion of hospital deaths and a consequent increase in deaths at home and in care homes.

Figure 14. 4



The proportion of deaths occurring in usual place of residence in Bromley has been consistently lower than the England average over the last two years.

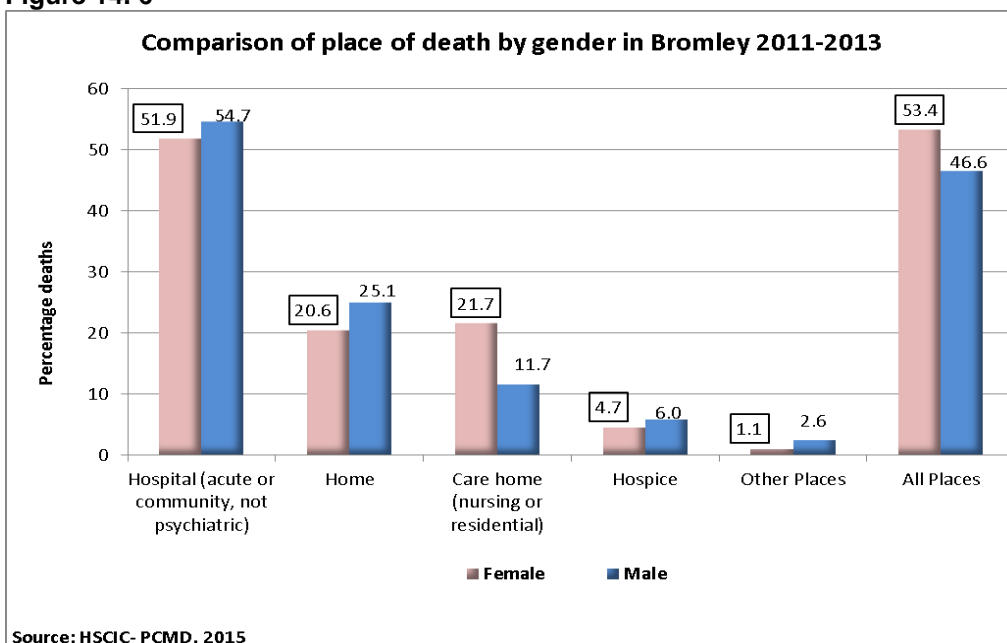
Figure 14. 5



Place of death by gender

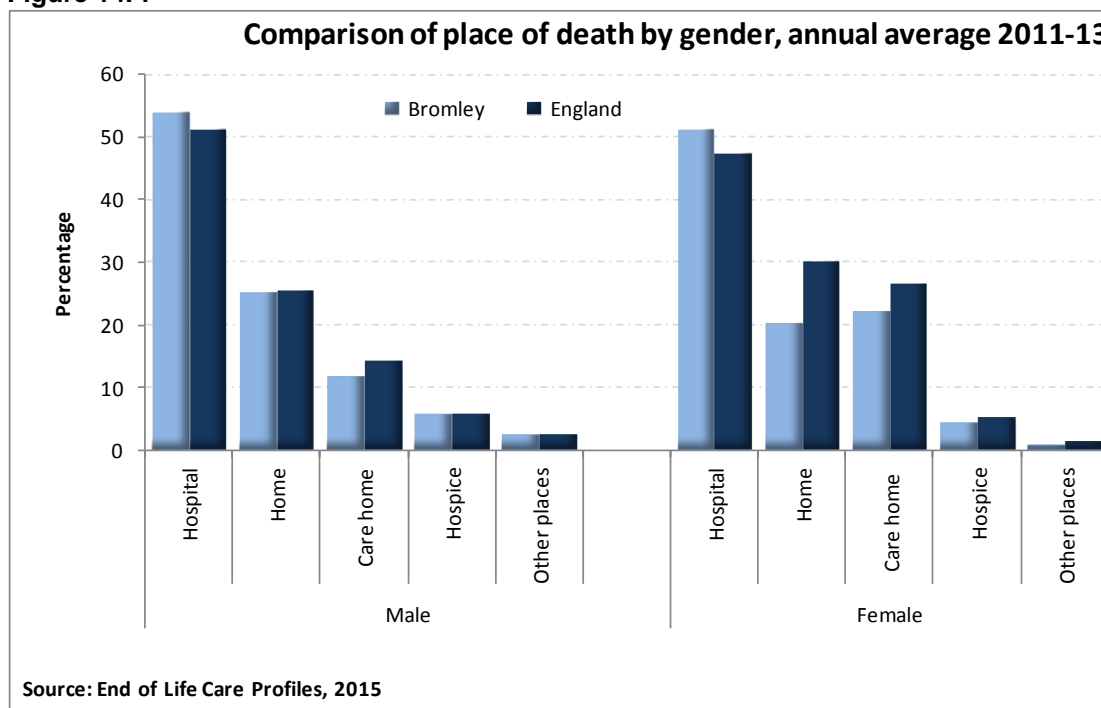
Hospital is still the most common place of death for both men and women, but the next most frequent place of death is care homes for women and home for men. Only 11.7% of men die in care homes as compared with 21.7% of women, which is reflective of the higher proportion of women residing in care homes due to their longer life expectancy.

Figure 14. 6



Both men and women in Bromley are more likely to die in hospital than the national average.

Figure 14.7



Place of death by underlying cause of death

Over the period 2011-13, there were differences in place of death between cancer and non-cancer deaths. Non-cancer deaths were more likely to occur in hospital (58%) than cancer deaths (39%), although this was the most common place of death for both.

The most striking difference is the far higher proportion of cancer deaths (18%) in a hospice than non-cancer deaths (only 1%).

Of the non-cancer deaths, a higher proportion of circulatory deaths occur at home than those from other causes (Figure 14.8).

Figure 14. 8

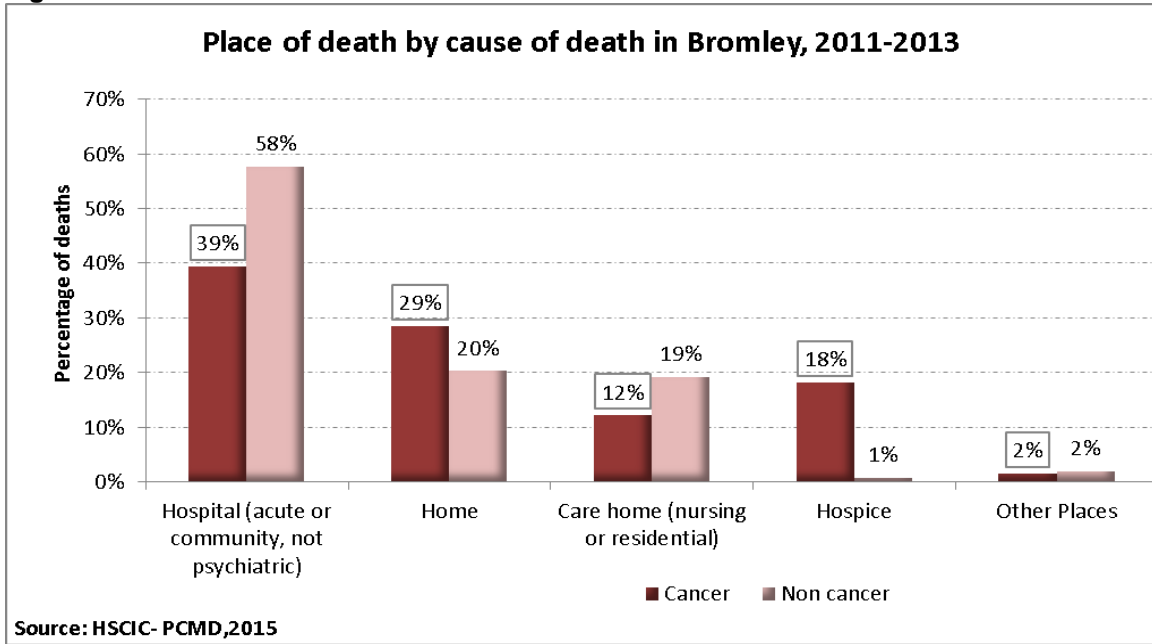


Figure 14. 9

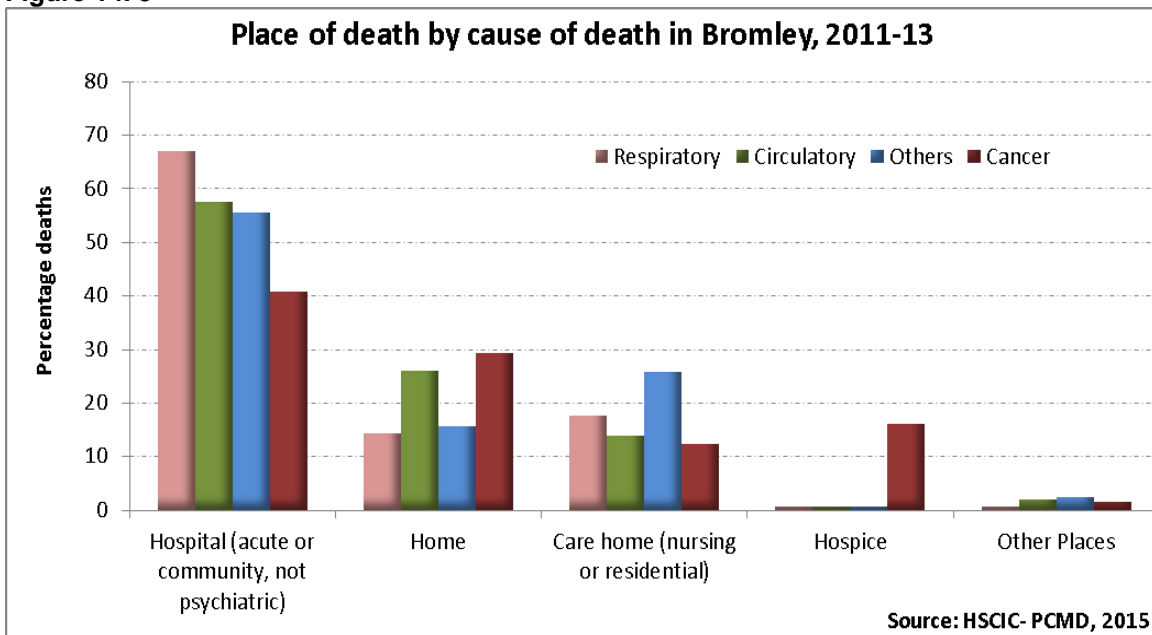
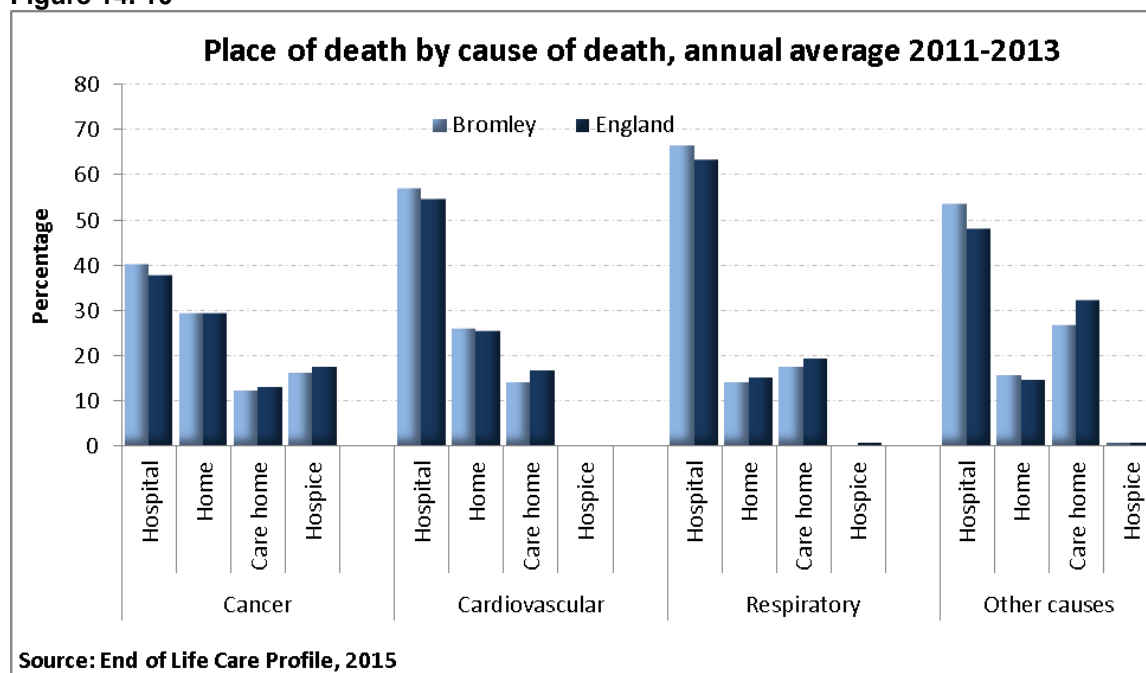


Figure 14. 10



Differences in place of death also occur with age. Whilst hospital remains the most common site for all age groups, under 65s are more likely to die at home or in a hospice than the older age groups. Over 85s are more likely to die in a care home.

Table 14. 1: Place of death by age and gender, annual average 2011-2013

		Bromley (Percentages)				England (Percentages)			
		<65yrs	65-84yrs	85+yrs	All ages	<65yrs	65-84yrs	85+yrs	All ages
Male	Hospital	46.89	54.95	56.52	54.10	45.47	52.70	52.34	51.17
	Home	31.93	26.87	19.17	25.27	34.99	26.76	17.17	25.60
	Care home	2.52	9.69	20.67	11.98	2.52	11.94	26.97	14.44
	Hospice	8.74	7.01	2.75	5.95	8.23	6.98	2.59	5.96
	Other places	9.92	1.48	0.89	2.70	8.79	1.61	0.92	2.83
Female	Hospital	52.84	55.04	48.02	51.23	49.40	51.57	43.72	47.58
	Home	27.65	24.16	16.30	20.49	29.84	22.66	13.00	18.94
	Care home	3.46	13.13	33.17	22.41	3.00	17.10	40.71	26.62
	Hospice	13.33	6.47	1.74	4.73	14.09	7.28	1.52	5.37
	Other places	2.72	1.20	0.77	1.13	3.66	1.39	1.03	1.49

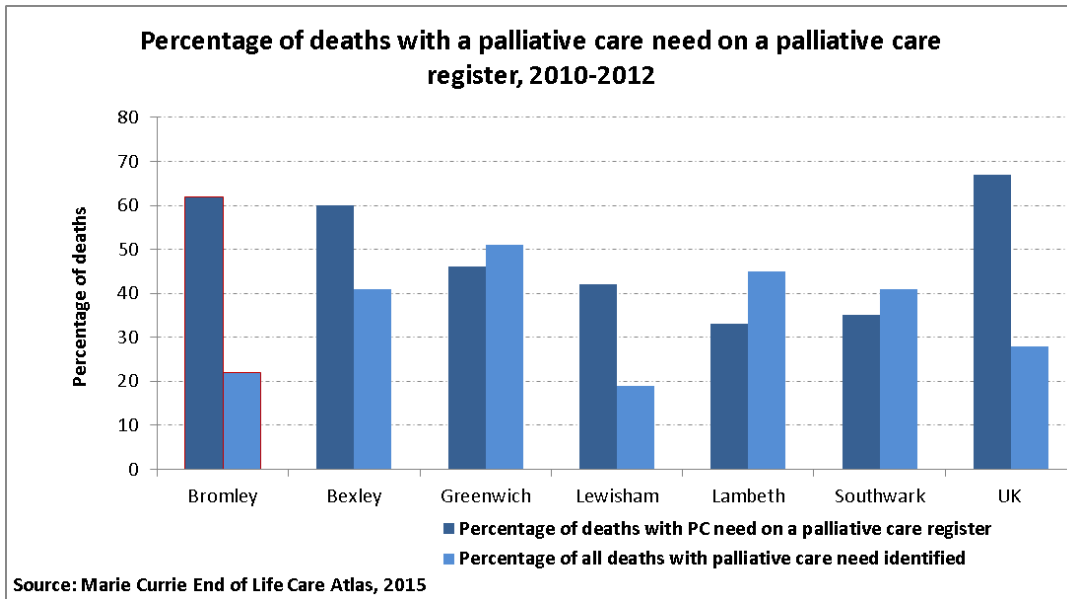
Source: End of Life Care Profiles, 2015

Palliative Care

There is good evidence that people are more likely to receive well-coordinated, high quality care if they are recognised to be at the end of life. Practices now maintain palliative care registers, which identify people with palliative care needs who would benefit from a palliative care plan.

In Bromley, a lower proportion of patients are identified as having a palliative care need than in neighbouring boroughs, indicating that improvements could be made.

Figure 14. 11: Percentage of deaths with palliative care need on a palliative care register, 2008/10



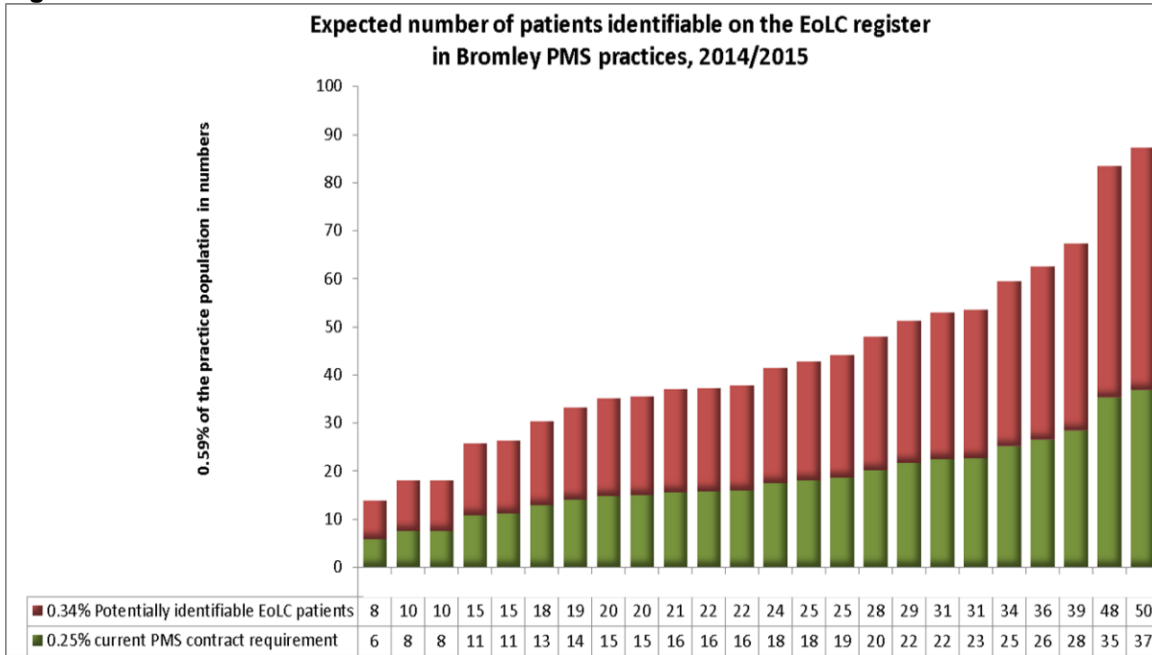
There have been improvements in Bromley in the use of Coordinate My Care (CMC), which is a clinical service that coordinates the care of patients nearing the end of life, giving them choice and improved quality of care. For example, it gives out of hours services access to patient information.

Over the past twelve months, 467 Bromley residents have been added to the CMC register, of whom 91 have died over the same period.

CMC research indicates that, at any time, 0.59% of London’s population could be identifiable by healthcare professionals as likely to die within the next twelve months. In Bromley, the number on the CMC register represents 25% of the expected end of life population.

In Bromley, 24 practices with PMS contracts have been commissioned to identify 0.25% of their practice population as appropriate for end of life care on their End of Life Care Register. **Figure 14.12** shows that this still leaves an appreciable number (approximately 600) unidentified.

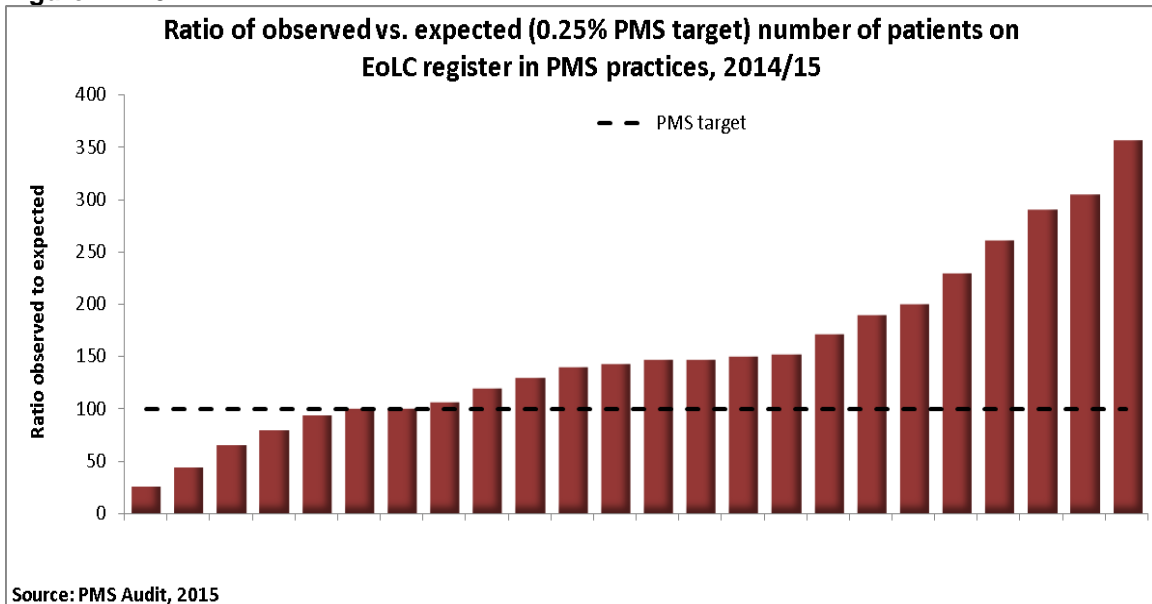
Figure 14. 12



Source: PMS audit, 2015

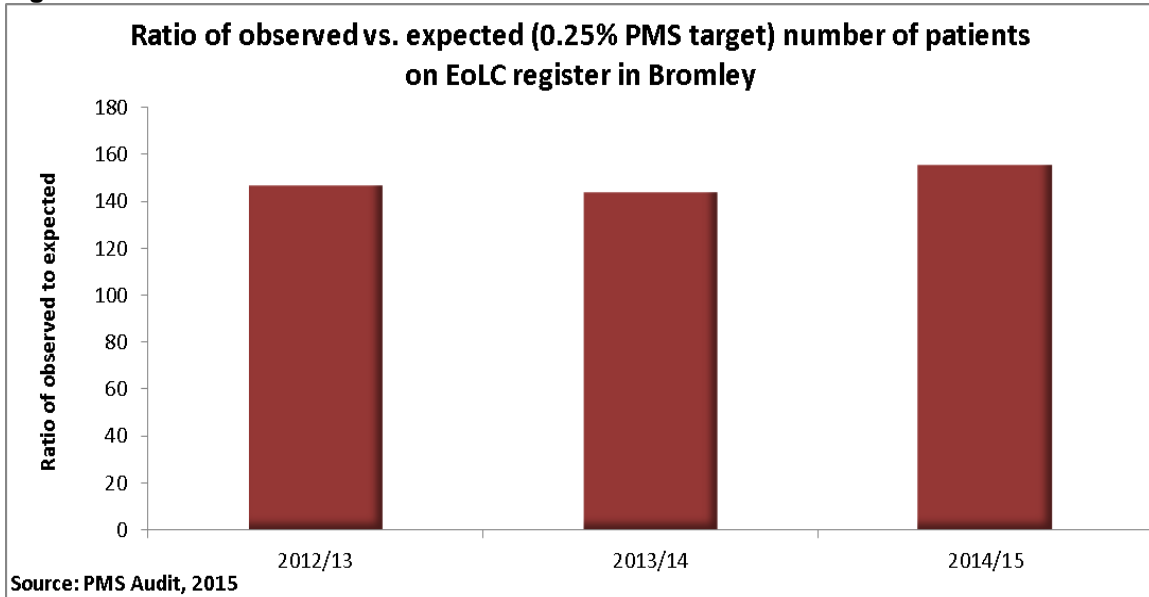
There is considerable variation between practices in the identification of patients at the end of life (**Figure 14.13**), but overall, there has been a slight improvement in the level of identification since 2012 (**Figure 14.14**).

Figure 14. 13



Source: PMS Audit, 2015

Figure 14. 14



One of the key benefits to palliative care planning is the opportunity to support a patient to die in their preferred place of death. In Bromley, the proportion of patients dying in their preferred place of death is subject to a large degree of variation between practices (Figure 14.15), and it appears that overall, since 2011, there has been a reduction in the proportion of people dying in their preferred place of death (Figure 14.16).

Figure 14. 15

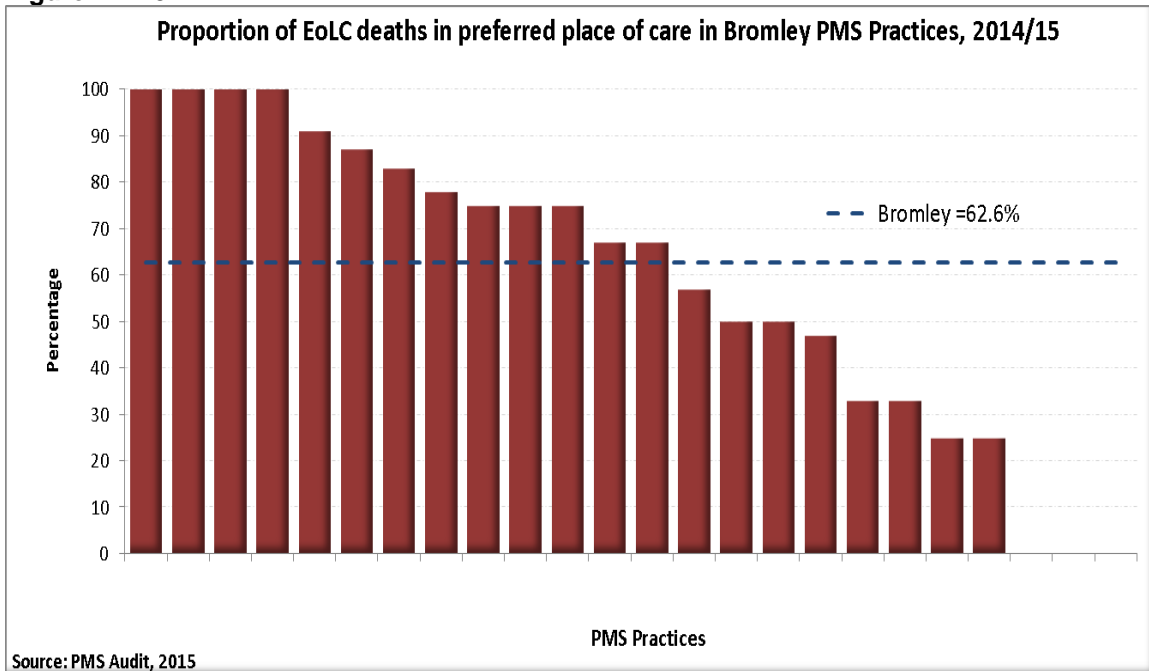
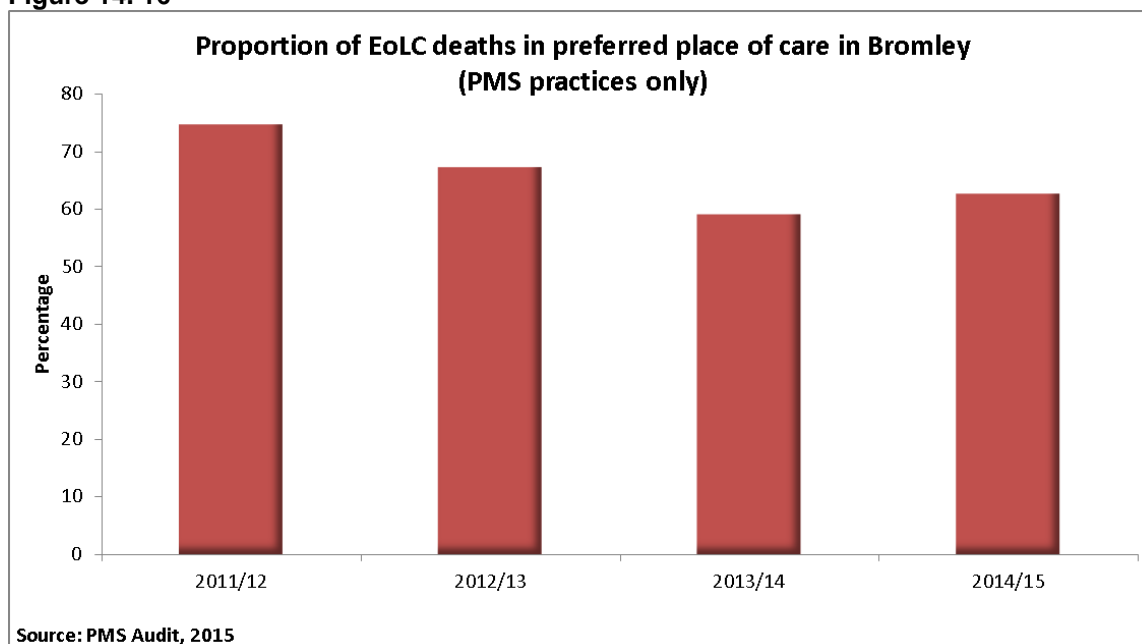


Figure 14. 16

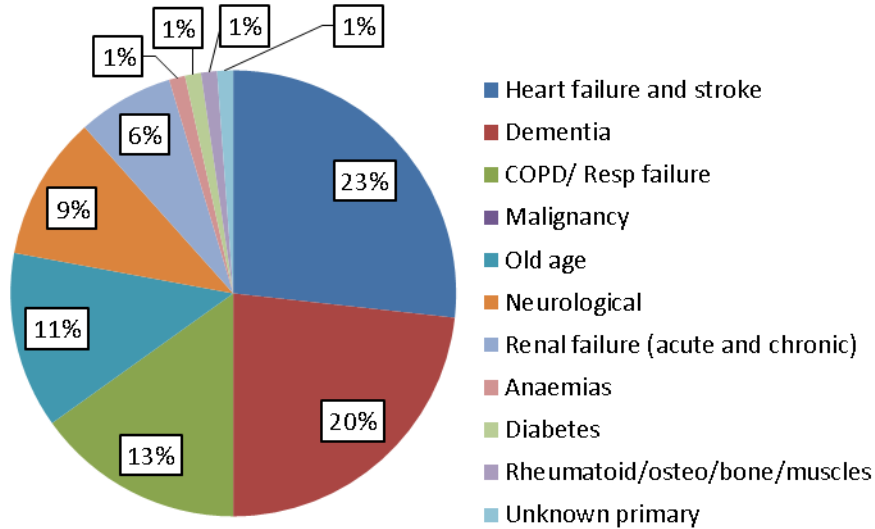
It is recognised that there are greater numbers of cancer patients on End of Life Care Registers than non-cancer patients, even though there are more non-cancer deaths. This is because it is more difficult to determine the end of life phase in non-cancer conditions, due to a more erratic trend of decline and recovery.

The Bromley Care Coordination Service (delivered by St Christopher's Hospice) was commissioned to provide end of life care in individuals who would not traditionally have been referred for palliative care.

In the first year (2013-14), 386 referrals were made to the services, largely from GPs. Of these patients, 87% were suffering with non-cancer conditions (**Figure 14.17**) and over half were aged 85 years or older (**Figure 14.18**). This contrasts with the usual hospice care service population of 80% cancer patients, the majority of whom are under the age of 75 years.

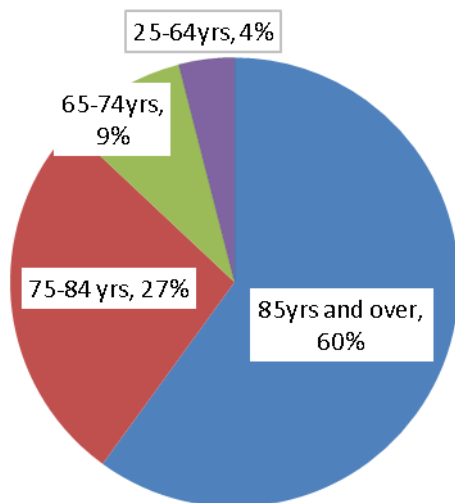
This service has been successful in supporting 90% of those who died to die in their preferred place of death, with 83% of the deaths occurring at the patient's home

Figure 14. 17: Diagnoses of Referrals to BCC 2013-14



Source: St Christopher's BCC annual review, 2015

Figure 14. 18: Age Distribution of BCC Referrals 2013-14



Source: St Christopher's BCC review, 2015

Gold Standards Framework

The Gold Standards Framework (GSF) is a coordinated programme of care for those in the last twelve months of life, irrespective of diagnosis. Its aim is to enable every patient to have a “good death” in the place of their choice.

This means that patients who need palliative/supportive care towards the end of life need to be identified, their needs, symptoms, preferences and any issues important to them assessed, and care planned around those needs and preferences.

The GSF is delivered by General Practice and nursing care homes. In Bromley, it is not known how many practices are GSF accredited, however, all practices achieve the maximum score for the palliative care component of the Quality and Outcomes Framework (which requires practices to have a palliative care register and to conduct three monthly multidisciplinary team meetings to discuss patients on the register).

Of the 22 nursing care homes in Bromley, half are GSF accredited, and a further six are working towards accreditation. The remaining nursing homes are committed to another end of life care programme. Bromley's 61 residential and nursing care homes have over 1000 residents, all of whom are likely to need end of life care. Staff turnover in care homes is high, so there is continuous need for training in end of life care. The table below shows the improvements in end of life care in nursing care homes as greater numbers of homes have been engaged with training and the GSF since 2008-09. At present, residential care homes are not included in this training.

Table 14. 2: Residents' place of death and completion of specific end of life documentation (ACP, DNaCPR orders and ICP) between 2008-9 and 2013-4

	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/14
Percentage of deaths occurring in nursing care home	76% 212/279 deaths (14 NHs)	81% 220/273 deaths (16 NHs)	86% 341/397 deaths (19 NHs)	86% 310/361 deaths (19 NHs)	82% 315/386 deaths (20 NHs)	78% 253/324 deaths (21NHs)
Percentage of completed ACP documentation	Pre GSFCH	51%	63%	79%	84%	89%
Percentage of decision with a DNaCPR order	Pre GSFCH	54%	71%	76%	88%	91%
Percentage of residents with ICP documentation	Pre GSFCH	17%	37%	59%	58%	60%

Source: St Christopher's End of Life Care in Care Homes Commissioner's Report 2013-14 (ACP – Advance Care Plan, DNaCPR – Do Not Attempt Cardiopulmonary Resuscitation, ICP -Integrated Care Plan)

What does this mean for the residents of Bromley?

There is scope to improve the proportion of deaths in the preferred place of death in Bromley.

Non-cancer deaths are still more likely to occur in hospital than cancer deaths.

The Bromley Care Coordination Service has shown promising results in the first year in supporting patients who would otherwise not have been referred for palliative care.

End of Life Care planning by General Practice and by nursing care homes has improved, but there is scope for further improvement.

Consideration should be given to an end of life programme for residential care homes in Bromley.

For more information please contact Agnes.Marossy@Bromley.gov.uk

15. Carers

Introduction

This section focuses on the needs of the Borough's carers. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- New Legislation
- Adult Carers
 - Demographic information
 - Census and national surveys
 - Local surveys and engagement with carers
 - Carers' health and support needs
- Young Carers
 - Demographic information (Census and local information)

New Legislation

The Care Act 2014 recognises, for the first time, carers in law in the same way as those they care for, and gives local authorities a responsibility to assess a carer's needs for support.

The Care Act relates mostly to adult carers (people 18 and over who are caring for another adult). Young carers (aged under 18), and adults who care for disabled children, are supported under the Children and Families Act 2014.

Both Acts recognise the need to look at family circumstances when assessing the need for care which means, for example, making sure that the position of a young carer within a family is not overlooked.

Adult Carers

Definition

An adult carer is defined by the Care Act as: **“an adult who provides or intends to provide care for another adult”**. Carers Bromley, the local authority's strategic partner in the provision of practical advice, support and information to carers, define carers as **“anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support”**.

Carers play a huge, unpaid role in supporting people with their health and social care needs. Without this support, there would be far greater pressure on both health and

local authority services. However, carers often experience significant health difficulties, loneliness and isolation, and may struggle financially or with work commitments. Carers therefore often need support in order to be able to retain choices in their own lives and stay well. It is estimated that the care provided, unpaid, by the nation's carers is worth an estimated £119bn per year⁶⁰.

Demographic Information

Census and National Surveys

The 2011 **Census** indicated **nationally** that:

- Around 5.4 million people (10.3%) of the population in England were unpaid carers
- Unpaid care is highest for both men and women in the 50-64 age range with women providing a higher share across ages 0-64
- The possibility of becoming an unpaid carer increases up to age 64
- People in the 50-64 age range are the most likely to have an elderly parent to care for
- Becoming an unpaid carer in your 50s increases your chances of leaving the labour market permanently, is associated with health problems and restricts your social and leisure activities.

Between 2001 and 2011, unpaid care provision increased at a faster pace than population growth⁶¹ with the number of unpaid carers increasing by 600,000 and the largest increase being in the provision of fifty or more hours of care per week⁶².

In Bromley, the 2011 **Census** showed that 31,012 people (10% of the population) were unpaid carers. This is comparable to the national average but is higher than the London average of 8.5%.

- 6,299 (20%) carers stated that they provide more than 50 hours of unpaid care per week

⁶⁰ Carers UK Policy Briefing May 2014

⁶¹ NHS England's commitment to carers May 2014 (Office for National Statistics (2013) *Census analysis: Unpaid care in England and Wales, 2011 and comparison with 2001*

⁶² NHS England's commitment to carers May 2014 (Office for National Statistics (2013) *Census analysis: Unpaid care in England and Wales, 2011 and comparison with 2001*

- 3,439 (11%) carers stated that they provide between 20 and 49 hours of unpaid care per week
- 21,274 (69%) carers stated that they provide between 1 and 19 hours of care per week.

Between 2001 and 2011, the number of people identifying themselves as carers in Bromley increased by 2,726 (9.3%), from 28,386 to 31,012. The population of Bromley increased by 4.7% over the same period.

In Bromley, 782 carers were invited to take part in the **National Carers Survey** 2014/15. Information gathered from the 340 people who responded on quality of life and how any care and support may have affected it, is used to drive service improvement. The responses (**table 15.1 and table 15.2**) indicated that a significantly higher percentage of carers responding to the survey provide more than 50 hours of care per week in Bromley than reported in the 2011 Census, and that 42.5% (145) of respondents cared for a person with dementia.

Table 15. 1

Number of hours spent caring per week	2011 Census (Bromley)	2014/15 National Carers Survey (Bromley)
0-19 hours	69%	18.5%
20-49 hours	11%	12.5%
50 hours and over	20%	37%
Varies - under 20 hours per week		4.5%
Varies - over 20 hours per week		4%
Other		20%
Carers did not answer the question		3.5%

Source: Census 2011 and National Carers Survey (Bromley respondents) 2014/15

Table 15. 2

Carer reported health issues of cared for person	Number	Percentage
Dementia	145	42.5%
A Physical Disability	140	41%
Problems connected to ageing	123	36%
A Mental Health problem	122	35.5%
Long standing illness	98	28.5%
Sight or hearing loss	81	23.5%
A learning disability or difficulty	29	8.5%
Terminal illness	20	5.5%
Alcohol or drug dependency	12	3.5%

Source: National Carers Survey (Bromley respondents) 2014/15

686 Bromley recipients of adult social care responded to the national **Adult Social Care Survey** for 2014/15. This survey gathers information on how services are

affecting people's lives and helps identify areas where outcomes can be improved in a very challenging financial climate.

- 43.5% (293) of responders stated that they receive practical support from their spouse, partner, friends, neighbours or family members living in their household and 51% (350) from someone living in another household
- 38.5% receive practical support from their spouse, partner, friends, neighbours or family members on a daily basis.

Local Surveys and Engagement with Carers

In July 2014, the results of Bromley's '**Your Future, Your Support, Your Say**' consultation (30th May to 8th July) were published. The purpose of this engagement with Bromley residents was to find out:

- what services would enable them to access advice, information and guidance
- what early help and support needs they have
- what would prevent or delay the need for more intensive long term services.

Face to face sessions with carers of people with care and health needs and people with dementia were undertaken; the consultation was widely promoted through Carers Bromley and other organisations providing support for carers including Bromley Mencap, and engagement sessions took place through organisations including the Carers Forum, an independent forum supported by Carers Bromley.

105 (17%) of respondents described themselves as caring for someone with a long term condition or illness and 55 (9%) described themselves as caring for someone with a long term condition or illness **and** having their own health and care needs.

Responses to the question, 'do you have any family or friends that could or do provide help and support to you?' reflected that one in three people who are carers and have their own care and health needs do not have any family or friends to help them. Of those who do, half said that the people who could support them live close enough to provide regular help and support.

The '**Living Well with Dementia**' survey was carried out between 20th January and 15th February 2015 and informed the Adult Services Stakeholder conference held on 11th March 2015. The purpose of the consultation was to talk to people about their experiences of living with dementia in Bromley or caring for someone with dementia. In particular, the Council wanted to find out:

- how easily people can get the information, advice and guidance they need

- what helps them to live independently at home
- what helps them to live independently in the community
- what activities they would like to see provided locally
- what it is like to care for someone with dementia

and to bring this information together and work with local organisations and businesses to make Bromley a better place to live for those affected by dementia.

82 (50%) of the 163 people who responded either on line or through the face to face sessions and focus groups were carers.

- Eight carers stated that they had been offered support by their GP to meet their own health needs
- Half of the carers responding stated that they had received the information, advice and guidance they needed to support them in their caring role, with a third receiving the support they needed to help the person they cared for to live independently in the community
- Respondents highlighted that more sitting services, especially available at short notice, would enable carers to attend their own health appointments.

Carers' Health and Support Needs

Carers are often at greater risk of developing health problems than the general population. This section explores the following:

- Carers Health
- Carers of people with Dementia
- Preventing Hospital admissions

Carers' Health

Nationally, 84% of carers surveyed for the 2013 State of Caring survey said that caring has had a negative impact on their health, up from 2011-12⁶³. Many carers feel that their contribution to society goes unrecognised and instead of being supported, they often find that their needs are overlooked, they have to fight to get support and that the support available is insufficient or poor quality. As the number of older people and children with complex needs rises and their life expectancy increases, so the number of carers in Bromley and the number of years they spend caring increases. The age of carers is likely to increase as spouses/partners and children need to care for longer.

⁶³ NHS England's commitment to carers May 2014 (*Carers UK (2013) The State of Caring 2013*)

Only a small proportion of carers receive any support in their caring role and a significant number of carers are themselves over 65 years. One survey found that 65% of carers aged over 60 have a long term condition or disability themselves, that nearly 70% said caring had a negative impact on their mental health, and one third said they had cancelled treatment for themselves due to their caring responsibilities⁶⁴. In the recent National Carers Survey report, it stated that almost one in seven adult carers felt that they neglected their own needs due to their caring duties (nationally 15% gave this response when asked if they get enough sleep or eat well (Bromley 13%), an increase of 1% since 2012/13)⁶⁵.

Carers providing high levels of care are twice as likely to be permanently sick or disabled. Carers also experience difficulties in staying in work. One in five carers gives up employment to care and, on average, carers retire eight years earlier than the rest of the population⁶⁶.

A potential increase in the number of people who can no longer be supported by their carer could lead to increasing pressure on an already stretched health and social care budget.

Social care that delivers early, preventative, personalised support to families to promote the independence of older and disabled people will indirectly support carers too. Care services, employers, the tax and benefit system all have a part to play to ensure carers are properly supported to manage care and to have a life of their own. Evidence of comparative poor health of carers includes:

- a four year study of 392 carers and 427 non carers aged 66-92, which found that carers who were reporting feelings of strain had a 63% higher likelihood of death in that period than non-carers or carers not reporting strain⁶⁷
- carers providing high levels of care being associated with a 23% higher risk of stroke⁶⁸
- 52% of carers providing substantial care in one study being treated for stress related disorders⁶⁹
- more than 80% of carers report that their caring role has damaged their health⁷⁰

⁶⁴ The Princess Royal Trust for Carers (2011), Always on Call, Always Concerned

⁶⁵ HSCIC <http://www.hscic.gov.uk/article/6716/Survey-shows-one-in-seven-adult-carers-feel-they-neglect-their-own-needs>

⁶⁶ ('Real Change, Not Short change: Time to Deliver for Carers' (2007). Carers UK. Buckner, L, Yeandle, S (2007a), 'Carers and Caring in EU Member States'. Eurocarers

⁶⁷ Schultz, R & Beach, S 'Caregiving as a Risk Factor for Mortality'. Journal of American Medical Association, Dec 1999. Vol. 282 (23), 2215-2219.

⁶⁸ Haley, W et al (2010), 'Caregiving Strain and Estimated Risk for Stroke and Coronary Heart Disease among Spouse Caregivers. Stroke, 41:331-336.

⁶⁹ Henwood, M (1998), 'Ignored and Invisible: carers' experiences of the NHS'. Carers National Association

⁷⁰ General Household Survey, (2000). Office for National Statistics licenced under the Open Government Licence v1.0

- carers providing more than 50 hours of care per week are twice as likely to report ill health as those not providing care⁷¹

Carers in Bromley responding to the 2014/15 National Carers Survey reported a number of health issues, with one in five reporting a physical impairment or disability.

Table 15. 3

Carers' self reported health issues	Number	Percentage
Physical impairment or disability	70	20.5%
Long standing illness	59	17.5%
Sight or hearing loss	42	12%
Other	37	10.5%
Mental health problem or illness	19	5.5%
Learning disability or difficulty	2	0.5%
None of the above	160	47%
No response provided	24	7%

Source: National Carers Survey (Bromley respondents) 2014/15

In the 2015 **GP Patient Survey**, 62,363 patients registered with Bromley GP surgeries identified themselves as having a caring responsibility. This is 18.5% of the list size. Percentages reported by individual surgeries varied from 24.7% to 6.95%.

Through the Public Health Outcomes Framework **Table 15.4**, Bromley carers have reported a level of social isolation comparable with London but higher than nationally.

Table 15. 4: Carers Related PHOF Indicators

Indicator	Time Period	Sex	Age	Bromley	London	England
1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like	2012/13	Persons	All ages	36.00	36.50	41.30

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

Carers of People with Dementia

In the UK, there are an estimated 800,000 people with dementia and 670,000 family and friends acting as primary carers to somebody with dementia. The current annual financial cost of dementia to the NHS, local authorities and families is £23bn, rising to £27bn by 2018.

⁷¹ Census (2001). Office for National Statistics licences under the Open Government Licence v1.0

The majority of people with dementia are cared for at home by a relative or friend, with the average age of unpaid family carers being between 60 and 65 years. Dementia can be complex, unpredictable and progressive in nature and carers of people with dementia are likely to have higher than normal levels of stress and report higher levels of depression than carers of older people unaffected by dementia. This can lead to an especially high need for practical and emotional support to relieve the stress of caring⁷².

For more information on 'people living in Bromley with dementia', please see section 13 of the 'Older People' chapter 10.

Preventing Hospital Admissions

Hospital admissions can be an indication of a breakdown in the caring relationship, because the carer is no longer able to care, often as a result of the strain of caring causing physical or mental ill health. A significant number of admissions may be due to problems associated with the carer rather than the person admitted.

One study found that problems with the carer contributed to readmission in 62% of cases. Carers of people readmitted were more likely than other carers to

- be experiencing ill health, fatigue and interrupted sleep,
- be conducting at least one intimate task⁷³

A whole system study tracking a sample of people over 75 years old who had entered the health and social care system, found that 20% of those needing care were admitted to hospital because of a breakdown of a single carer on whom the person was mainly dependent⁷⁴

Support to Carers

The London Borough of Bromley and Bromley Clinical Commissioning Group have jointly commissioned a 'strategic partnership' contract with Carers Bromley. As a strategic partner, Carers Bromley is funded to be the first port of call for all carers requiring information, advice and guidance. Indeed, the 'Your future, your support, your say' consultation of 2014 told us that 152 (23%) of respondents would go to Carers Bromley to find out about help and support in Bromley.

⁷² Newbronner, L., Chamberlain, R., Borthwick, R., Baxter, M., Glendinning, C. 2013. *A Road Less Rocky: Supporting Carers of people with dementia*. Carers Trust, London

⁷³ Williams, E, Fitton, F (1991), 'Survey of carers of elderly patients discharged from hospital'. *British Journal of General Practice*, 41, 105-108.

⁷⁴ Castleton, B (1998), *Developing a whole system approach to the analysis and improvement of health and social care for older people and their carers: A pilot study in West Byfleet, Surrey*. Unpublished. Referenced by Banks, P (1998). 'Carers: making the connections'. *Managing Community Care*, vol 6, issue 6.

In addition to the strategic partnership with Carers Bromley, the Local Authority and Bromley Clinical Commissioning Group also commission respite services and other support services to carers which may be wholly subsidised or which may be subject to a contribution from the service user. Some of the services provide support both to the service user and carer, for example day services which provide social stimulation to the service-user during the day as well as a break for the carer.

The 'Mutual Caring Project'⁷⁵ set up to help promote recognition of good practice and develop improved service provision for older families where the balance between the long term family carer (often a parent), and the person with learning disabilities (normally an adult son or daughter), has changed. It found that there needs to be:-

- access to person centred planning support that involves all family members who can usefully contribute including older family carers and siblings
- Carers' assessments carried out with both the family carer and the carer with learning disabilities leading to practical, joined up outcomes including robust emergency plans.

Young Carers

Definition

The Children and Families Act 2014 defines a young carer as **“someone under 18 who helps look after someone in their family, or a friend, who is ill, disabled or misuses drugs or alcohol”**.

The Young Carers (Needs Assessments) Regulations came into force on 1st April 2015. These state that a local authority must carry out a young carer's needs assessment in a manner which is appropriate and proportionate to the needs and circumstances of the young carer to whom it relates.

Census Information

The 2011 Census indicated that of the approx. 5.4 million carers in England, 166,000 are young carers, with 54% of young carers being girls and 46% boys. 11% of identified young carers care for more than 20 hours a week and a further 9% care for more than 50 hours per week.

⁷⁵ Foundation For People with Learning Disabilities

Table 15. 5: Provision of unpaid care per week for 5-17 year olds in England and Wales

Number of hours unpaid care per week	Number of young carers	Percentage of young carers
1-19 hours	142,768	80.2%
20-49 hours	19,422	10.9%
50 hours or more	15,728	8.8%
	177,918	

Source Census 2011

London had the highest proportion of young people providing 50 hours or more care per week in 'not good' health at 17.1% ('not good' is defined as the 2011 census responses 'fair', 'bad' or 'very bad' to the general health question).

As young carers grow older, they become more heavily involved in caring, particularly with regard to personal and intimate care and there are gender differences in the roles they typically undertake. One third of young women who are carers in the 16 to 28 year age group undertake intimate care, compared with 17% of young men who are carers⁷⁶. Support needs to be provided to whole families to ensure that young carers are not required to undertake caring roles which impact negatively on their health, education, or personal development.

Local Information

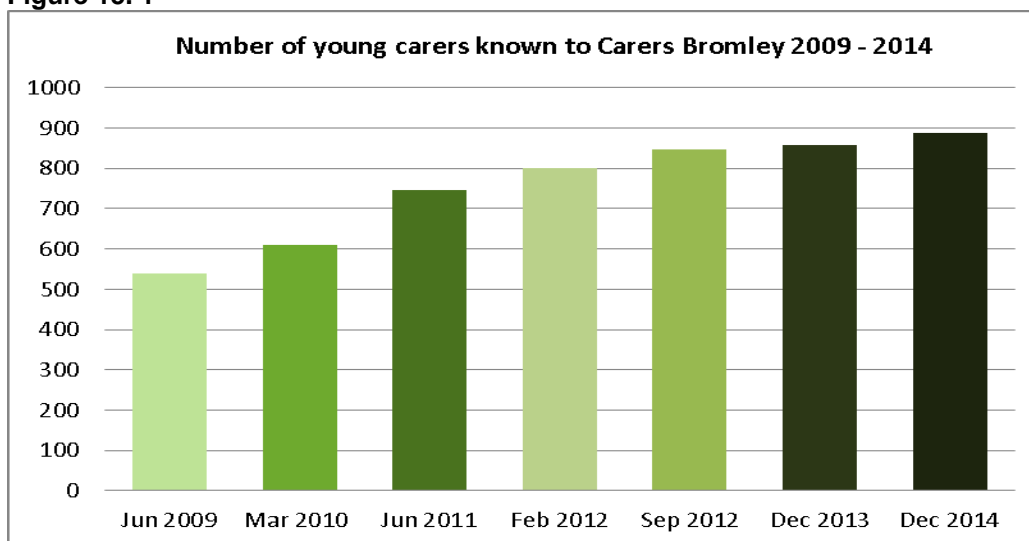
The number of young carers identified and supported by Carers Bromley has increased significantly over the past few years; however, it should be noted that from national research it is expected that these are only a portion of the actual number of young carers within the Borough.

In December 2014, a total of 888 young carers were known to Carers Bromley compared to 539 in June 2009, showing an increase of 65%.

This also reflects an increase of 22% between June 2011 (693) and September 2012, and an increase of 11% since February 2012 (802), as illustrated in **table 15.6**

⁷⁶ Becker, F, Becker, S (2008), 'Young Adult Carers in the UK: Experiences, Needs and Services for Carers aged 16–24'. The Princess Royal Trust for Carers (secondary analysis of UK Census 2001)

Figure 15. 1



Source: Carers Bromley

Table 15. 6

	Jun 2009	Mar 2010	Jun 2011	Feb 2012	Sep 2012	Dec 2013	Dec 2014
Number of Young Carers	539	611	745	802	847	857	888
Difference	-	13%	22%	8%	6%	1%	4%

Source: Carers Bromley

Impact of being a young carer

- Many young carers experience bullying: having caring responsibilities is one of the most common characteristics of young people between 14 and 16 who have been bullied. (Characteristics of bullying victims in schools DFE 2010 July 2010 <http://www.natcen.ac.uk/study/the-characteristics-of-bullying-victims-in-schools-/our-findings#hotlink3>)
- Young carers between 16 and 18 are twice as likely not to be in education, employment or training (NEET) as their peers⁷⁷
- Being a young carer, especially where personal and practical support is lacking, can affect elements of a child’s transition to adulthood
- Young carers can experience substantial physical, emotional or social problems, and encounter difficulties in school and elsewhere
- ‘Hidden from View’ produced by the Children’s Society http://www.childrenssociety.org.uk/sites/default/files/tcs/hidden_from_view_-

⁷⁷ (‘Against the Odds’, Audit Commission, p19, July 2010)

[final.pdf](#) in May 2013 draws on government commissioned data on over 15,999 pupils aged 13 and 14 and the experiences of young carers in England. Key findings include:-

- 166,363 young carers in England according to census data released on 16th May 2013, compared with 139,000 in 2001, an increase of 20%
 - Young carers have significantly lower educational attainment than their peers the equivalent to nine grades lower overall
 - Around 1 in 20 misses school due to their caring responsibilities
 - Young carers are 1.5 times more likely than their peers to have a Special Educational Need or Disability
- The Mental Health Foundation 2010 <http://www.mentalhealth.org.uk/our-news/news-archive/2010/2010-12-03/> found that:-
 - 50,000 young people in the UK live with a parent with severe mental health problems
 - Many lack support, with the group being overlooked in policy making and service planning

Young carers' own physical and mental health is being put at risk.

What does this mean for the residents of Bromley?

- There continues to be insufficient local data/ joint identification of carers (adult carers, young carers and mutual carers)
- The 2014/15 national Carers Survey Bromley indicates that 37% of the 782 Bromley Carers responding to the survey provide intensive care of more than 50 hours per week
- Carers may neglect their own health needs if support services are not available to enable carers to attend hospital/GP appointments
- A joint commissioning strategy on Bromley's adult carers will be developed with Bromley Clinical Commissioning Group describing how services will support Bromley's carers over the next five years.
- Carers assessments have a low take up and how they are presented to carers needs to be revisited in terms of the benefits
- Given the high number of people with dementia, their reliance on carers and the complexity of supporting them, particular attention needs to be given to ensuring their needs are met effectively

- Although it is difficult to identify the actual number of young carers in the borough, the number of young carers known to Carers Bromley has increased 65% since June 2009

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16. Substance Misuse

Introduction

About 4 million people in the UK use illicit drugs each year. The most commonly used drugs in the UK, in order, are cannabis, cocaine and crack, and opioids. Opioids are used by about 50,000 people in the UK, and are responsible for the greatest damage to individuals and society. Abuse of New Psychoactive Substances (NPS), 'legal highs', is on the increase, but there is currently little data. The Government has announced that a new Bill will make the selling of NPS illegal. Injecting of steroids, to enhance appearance and performance, is rapidly increasing among younger people. Again, data is scant.

Causes and patterns of use

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.

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

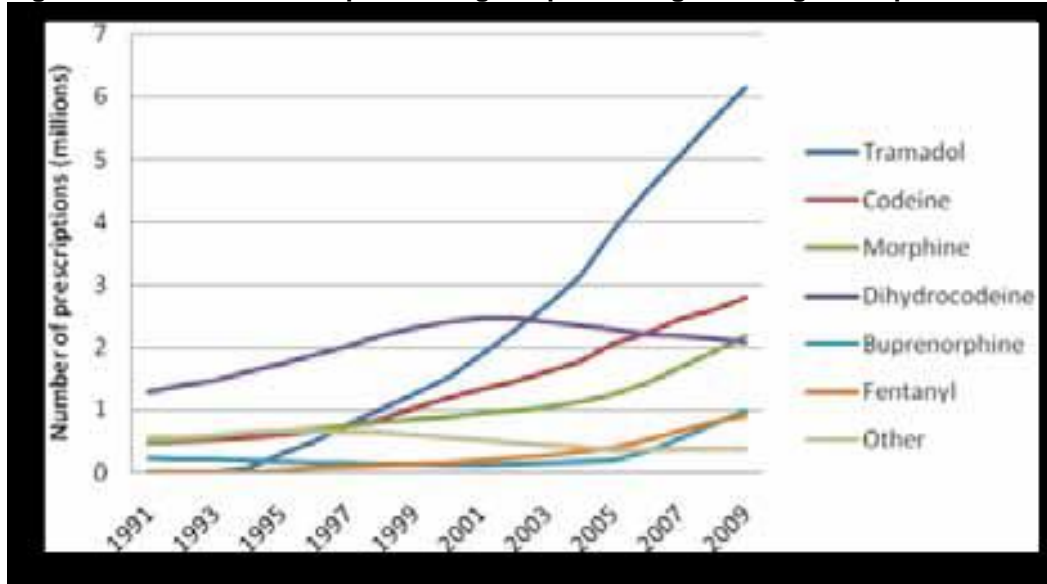
- Benzodiazepines and z-drugs, prescribed mainly for anxiety (benzodiazepines only) and insomnia
- Opioid and some other pain medicines, both prescribed and bought over-the-counter
- Stimulants, prescribed for ADHD or slimming
- Some OTC cough and cold medicines, and anti-histamines and stimulants.

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.

Opioid analgesics are the most commonly used drug in OTC/POM treatment populations, and national GP prescribing data show that the numbers of prescriptions for prescription-only opiates has been going up since the late 1990s. The most commonly prescribed opiate is Tramadol, the prescription of which has increased ten-fold since 1991.

Figure 16. 1: Trends in the prescribing of opiate analgesics in general practice in England



Source: National Prescribing Data DH, 2011

12.5% of all people presenting to drug treatment services have a problem with prescription only, or over the counter medicines (POM/OTC). Of these, over four fifths (10.4% of total treatment population) are also taking illegal substances. In addition, 2% of people presenting to alcohol services also report problems with OTC/POM (Source: NTA 2009-10). Among drug users in treatment, the most common prescribed drug used by those also using illegal drugs are benzodiazepines. Among those who are not using illegal drugs, the most commonly used drugs are prescribed opiates.

35- 40% of those presenting with OTC/POM problems to specialist drug treatment centres are self-referred, whether they also use illegal drugs or not, and performance data suggests these clients stay in drug treatment for a significant period of time (ten months plus), engage well in treatment services and achieve better success rates than other drug users.

Epidemiology of drug misuse

Because of the illicit nature of drug misuse, direct prevalence data is not available. Instead we have to rely on indirect data from national surveys, crime data, and data on people in treatment, hospital admissions and drug-related deaths.

The crime survey for England and Wales suggests that approximately 17,000 residents took illicit drugs in Bromley in 2014/15. The estimated prevalence of Class A drug use was 6,400 in Bromley in 2014/15, at a rate of 3.2% of the adult population.

Drug use is more common in males, single adults, white ethnic groups and those on low incomes. There is a relationship, however, between affluence and early use of cannabis.

The annual Glasgow Prevalence Estimation seeks to estimate prevalence by combining all available data on drug use and then estimating the hidden population to provide a prevalence estimate for each area. The data sources include: treatment data, police and criminal justice data, hospital admissions and mortality data, and apply only to opiate, crack and injecting drug users.

Table 16.1 shows the estimated numbers and rates of illicit drug use in Bromley as compared with London and England.

Table 16. 1

	Number of Drug Users (Rate per 1000 Adult Population)			
	Opiate & Crack User	Opiate User	Crack User	Injecting
Bromley	1,117 (5.55)	814 (4.05)	750 (3.73)	119 (0.59)
London	54,985 (9.55)	43,918 (7.63)	40,080 (6.96)	11,351 (1.97)
England	293,879 (8.4)	256,163 (7.32)	166,640 (4.76)	87,302 (2.49)

Source: Glasgow Prevalence Estimates (2011/12)

Bromley has lower rates of drug use than London and England in all categories. While the number of people using opiate and crack have increased over the last two years (as in London as a whole), numbers in other categories have fallen. Although we know that the number of steroid injecting users is rising rapidly, we do not yet have data on this.

Drug users in Bromley

The most accurate data we have on drug users comes from the National Drug Treatment and Monitoring Service (NDTMS), as this is data collected diligently from those who attend drug treatment services. They provide an incomplete picture of drug use in the community, inevitably, as many drug users never access services, and the ones who do, tend to have more serious problems and to be taking opioids and/or crack. However, they do give indications of drug use in the wider community,

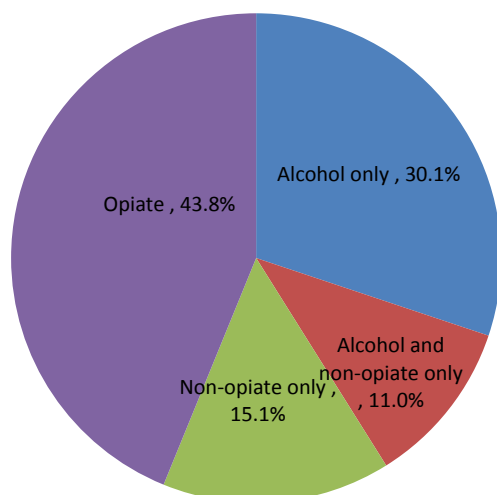
with trends over time, and they also provide valuable information about who uses treatment services, and how effective that treatment is.

The numbers of people in alcohol and drug treatment have fallen in the last year with 730 people in contact with alcohol and drug treatment services in Bromley in 2014-15, as compared with 863 in 2013-14.

In the year 2014-15, there were 381 new presentations for substance misuse treatment.

The substances most commonly misused by those in treatment in Bromley are opiates (44%) and alcohol (41%). Nationally, the proportion of those using opiates is higher at 52%, whilst the proportion using alcohol is similar at 41% and those using non-opiates lower at 19%.

Figure 16. 2
Substances Used by People in Treatment in Bromley during 2014-15
(n=730)

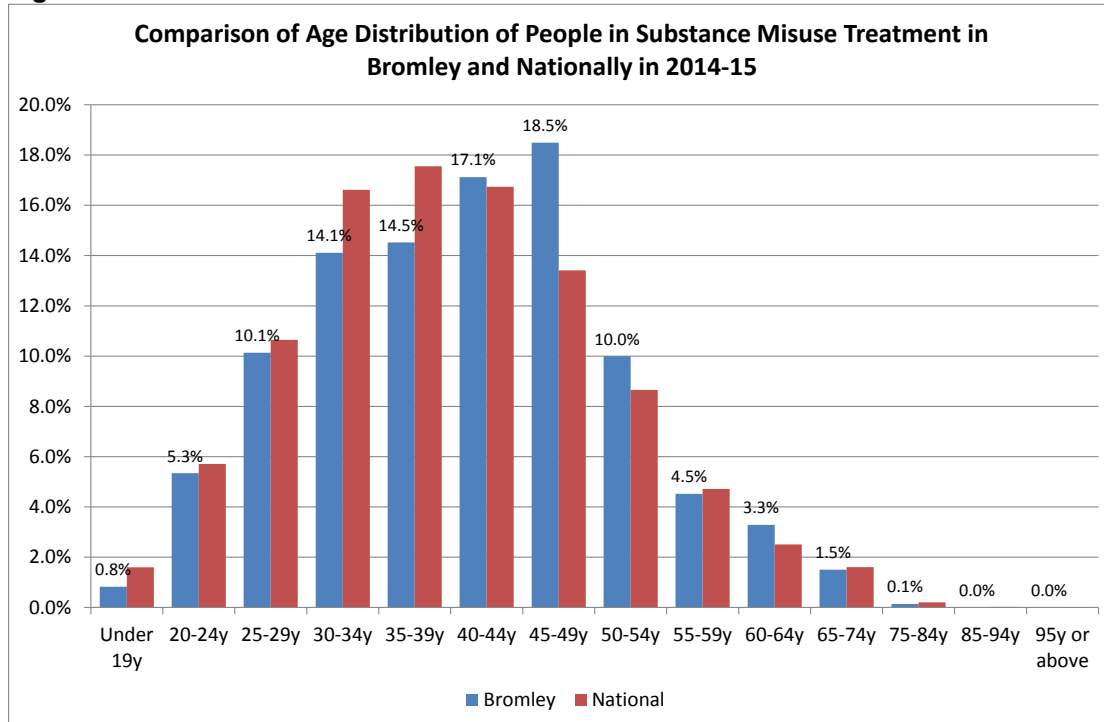


Source: NDTMS 2015

The population in treatment is predominantly male (64.8%) and of White British ethnicity (82.6%). Pregnant women represent 5% of the treatment population, which is higher than the national value of 2.3%.

The highest proportion of substance misusers in treatment in Bromley are in the 40 to 49 year age group, in contrast to the national picture, which is 35 to 44 years.

Figure 16.3



Source: NDTMS 2015

The highest proportion of presentations are self/family referrals (43.6%), with 19.9% being referred by GPs, and 15.5% through the criminal justice system.

Although 2.1% of referrals were from mental health or other health services, it is significant that there were no referrals from A&E in the year 2014-15 (although even nationally, A&E referrals made up only 0.3% of referrals).

Impact on Health and Wellbeing

Substance misuse is detrimental to health and leads to increased hospital admissions and increased mortality.

While health problems and death are seen in users of all classes of drugs, 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 crime required to fund the habit.

Mortality

Mortality rates related to drug use have been increasing since 1993, with heroin and morphine the most commonly implicated drugs.

Drug use and drug dependence are known causes of premature mortality, with drug poisoning accounting for nearly one in seven deaths amongst people in their 20s and 30s in 2013.

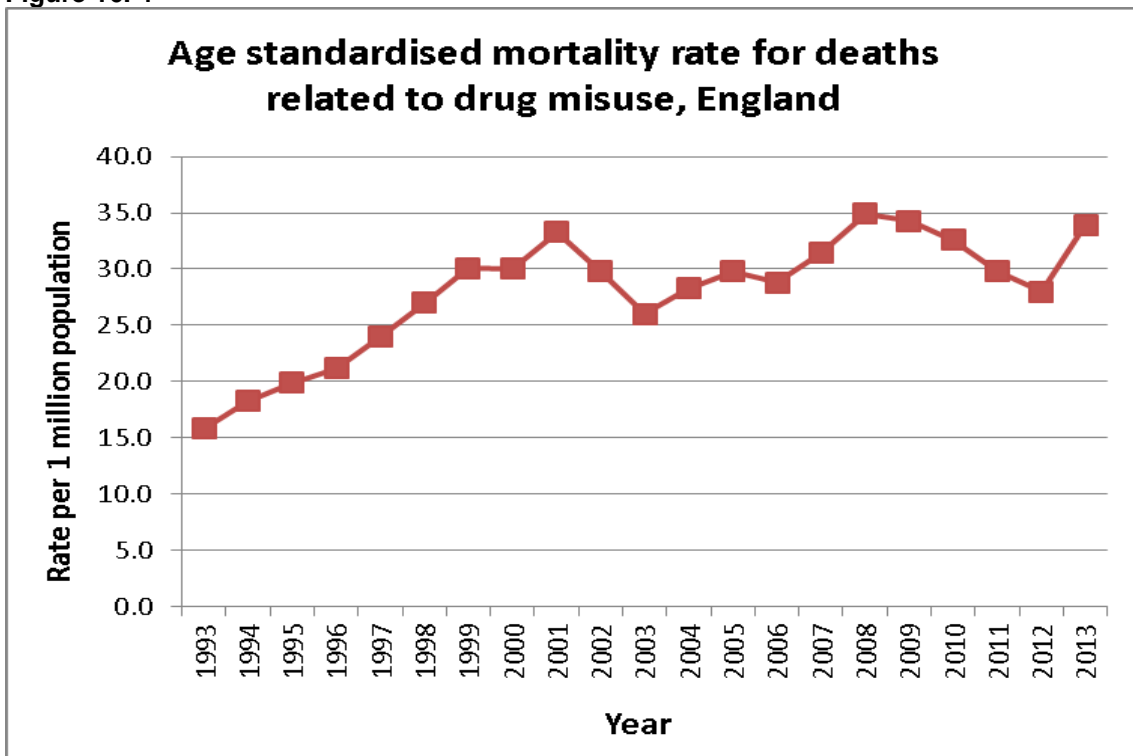
Mortality data are currently presented for two distinct groups, those where the underlying cause is:

- 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 (as opposed to poisoning), have increased since 1993, with peaks in 2001 and 2008, and another increase in 2013 (Figure 16.4).

Figure 16.4



Source: Health and Social Care Information Centre, 2015

Deaths due to drug poisoning have showed a similar trend, with a peak in 2009, a fall until 2012, and then a 19% increase in 2013. Of the 2,955 drug poisoning deaths (involving both legal and illegal drugs) registered in 2013 in England and Wales, over two thirds were in males, an increase of 23% from 2012. Female drug misuse deaths have increased steadily from 2009, and by 12%, from 459 in 2012 to 513 in 2013. In 2013, males aged 30 to 39 had the highest mortality rate from drug misuse, followed by males aged 40 to 49 years of age.

Heroin and morphine remain the substances most commonly involved in drug poisoning deaths. 765 deaths involved heroin or morphine in 2013; a sharp rise of 32% from 579 deaths in 2012. Deaths involving tramadol have continued to rise, with 220 deaths in 2013. This is almost 2.5 times the number seen in 2009 (87 deaths).

Drug Related Deaths in Bromley

Between 2006 and 2013 there were 80 drug related deaths (43 male, and 37 female) in Bromley, 29 of which were due to accidental poisoning. The average age at the time of death was 48 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. As with the national picture, the number of deaths peaked between 2007 and 2009 where there were between 13 and 16 deaths for each of those years. The number of deaths has been lower in subsequent years; 6 in 2010, 9 in 2011, 8 in 2012 and 8 in 2013.

The highest number of drug related deaths between 2006 and 2013 have occurred in people residing in the following wards; Penge and Cator – 10, Bromley Town – 8, Cray Valley West – 8, Crystal Palace – 7, and Cray Valley – 6. All the other wards have had five or fewer deaths, and Darwin and Shortlands have not had any drug related deaths.

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

In early 2014 the medical records of ten out of twelve patients who had died from drug related causes in the previous 12 months were examined. It was found that half these patients had one or more significant medical conditions – asthma, Chronic Obstructive Pulmonary Disease, ischaemic heart disease and alcohol-related problems, five had a history of depression, and only three had been in contact with services for their drug use.

Blood borne Infections

Injecting drug users are at great risk of blood borne infections, due to poor and non-sterile injecting techniques. The National Drug Treatment and Monitoring Service (NDTMS) recently reported that:

- 90% of cases of Hepatitis C diagnosed in the UK occurs 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 one in 30 of those who inject image and performance enhancing drugs, such as anabolic steroids, are living with hepatitis C.
- Hepatitis B is now rare and vaccine uptake has improved. Hepatitis B infection among people who inject psychoactive drugs has declined in recent years, probably reflecting the marked increase in the uptake of the hepatitis B vaccine. However, vaccine uptake levels have been stable in recent years,

even though they could be increased further. Vaccine uptake is much lower among people who inject image and performance enhancing drugs.

- HIV levels remain low and the uptake of care is good. Around one in every 100 people who inject drugs is living with HIV. The level of HIV infection among those injecting image and performance enhancing drugs is similar to that among those injecting psychoactive drugs, and the uptake of HIV related care, including anti-retroviral therapy, is high.
- Injecting risk behaviours have declined but remain a problem. Reported needle and syringe sharing has halved over the last 10 years, but around one in seven people injecting psychoactive drugs share needles and syringes and almost one in three had injected with a used needle that they had attempted to clean.
- Bacterial infections remain a major problem. A quarter of people who inject psychoactive drugs report a recent symptom of an injecting site bacterial infection. One in six of those injecting image and performance enhancing drugs report having had a symptom of an injecting site bacterial infection.
- Changing patterns of psychoactive drug injection are a cause for concern. There has been a recent increase in the injection of amphetamines and amphetamine-type drugs, such as mephedrone. The injection of these drugs has been associated with higher levels of infection risk. Although the injection of these drugs is much less common than the injection of opiates, crack-cocaine, or image and performance enhancing drugs, this increase is a concern.
- Provision of effective interventions needs to be maintained. The provision of effective interventions, such as needle and syringe programmes, opioid substitution treatment and other drug treatment, which act to reduce risk and prevent infections, needs to be maintained. These interventions need to be responsive to any changes in patterns of drug use. Vaccinations and diagnostic tests for infections should continue to be routinely offered to people who inject drugs and treatment made available to those testing positive.

Due to this risk of blood borne infection, injecting drug users accessing treatment for substance misuse are tested for Hepatitis B and C and, if appropriate, vaccinated. In 2014/15, 57% of eligible new presenters to drug services in Bromley accepted Hepatitis B vaccinations, compared with the national average of 40%. However, of those who accepted Hepatitis B vaccination, 35% started a course and only 8% completed a course of vaccination in Bromley, as compared with 22% starting and completing nationally.

During the same period, 94% of previously or currently injecting clients in treatment in Bromley received a Hepatitis C test, as compared with the national average of 81%.

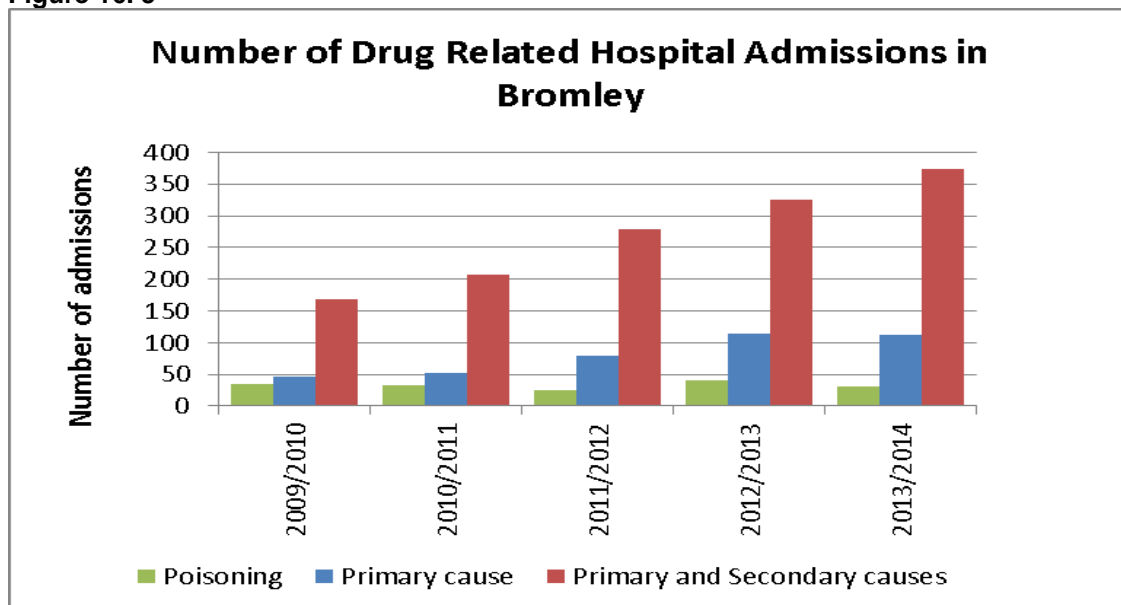
Mental health problems

Psychiatric comorbidity is common in drug misuse populations, with anxiety and depression generally common with antisocial and other personality disorders more prevalent than in the non-user population. Psychiatric problems may both be caused by drug misuse, and be a risk factor for it. The national US Epidemiological Catchment Area study of the prevalence of mental health disorders reported a lifetime prevalence rate of substance misuse (drugs and alcohol) among people with schizophrenia and bipolar disorder of 47% and 60% respectively, compared with 16% in the general population. Around one in five of the people in the same sample had previously received treatment for a psychiatric health problem other than substance misuse. 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.

Hospital admissions

In 2013/14 there were 518 drug-related admissions in Bromley. These include admissions where drug use was the primary or secondary cause of admission, as well as where admission was due to drug poisoning. While the numbers of admissions due to poisoning have remained fairly constant, and relatively low, over the last five years (**Figure 16.5**), the numbers of drug-related admissions where drug use is the primary or secondary cause have steadily increased. For example, there were 169 admissions where drug use was the primary or secondary cause in 2009, and 374 admissions for the same reasons in 2013, more than double.

Figure 16. 5

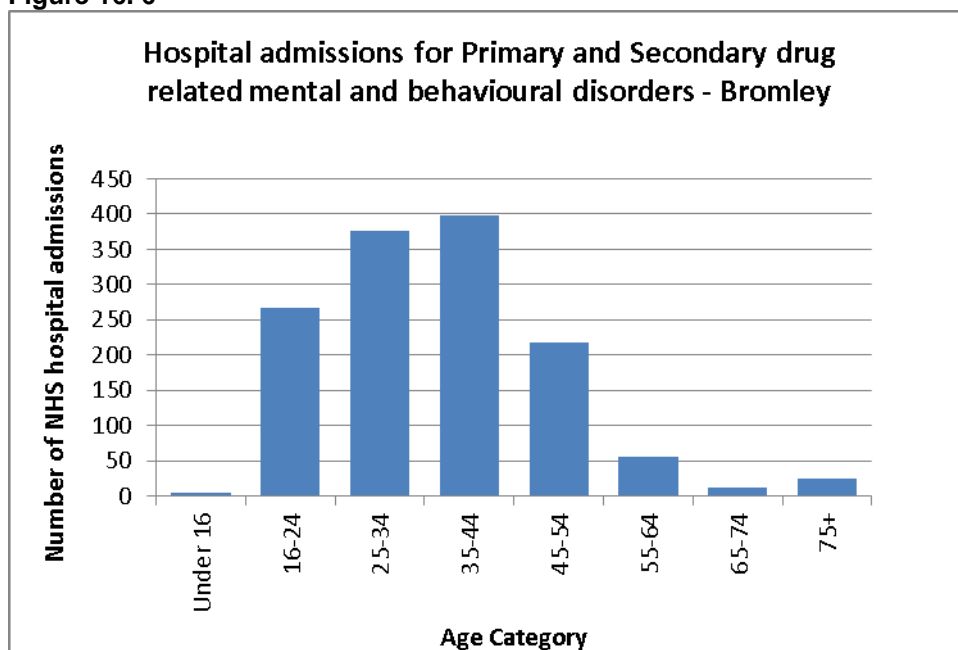


Source: Health and Social Care Information Centre, 2015

The age distribution of those admitted where drug use was a primary or secondary cause is shown in **Figure 16.6**. The majority were aged between 16-44 years, with

the peak in the 25-44 year age group. Where drug use is the primary cause of admission, or where poisoning is the cause, the age distribution moves towards the younger age groups. Where poisoning is the cause of admission, there are also greater numbers in the over 65 year age groups, probably reflecting the increase in suicide attempts in older people.

Figure 16. 6



Source: Health and Information Centre Lifestyle statistics, 2013

Socioeconomic Impact

Drug use carries a substantial economic burden, associated as it is with high healthcare and social costs as a result of ill health, crime, homelessness and family breakup.

Increased costs are associated, mainly as a result of transmission of infectious disease, crime and violence. Chronic health problems comprise a significant element of the health and social care costs of drug misuse. It has been estimated that the prevalence of HIV among new injecting drug users in London is 4.2%.

The National Treatment Outcomes Research Study (NTORS) found that 61% of a sample of people entering treatment had committed crimes other than drug possession in the three months prior to starting treatment, the most common being shoplifting. The main sources of illegal income required to fund an illicit drug habit were theft and fraud.

Lost productivity and unemployment increase with the severity and duration of drug misuse, and personal relationships are placed under considerable strain by

dependent drug use. Problems with accommodation are also common in such groups.

Drug misuse may also have a negative impact on children and families. In the UK it is estimated that 2–3% of all children under the age of 16 years have parents with drug problems. 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 (NICE guideline No.52).

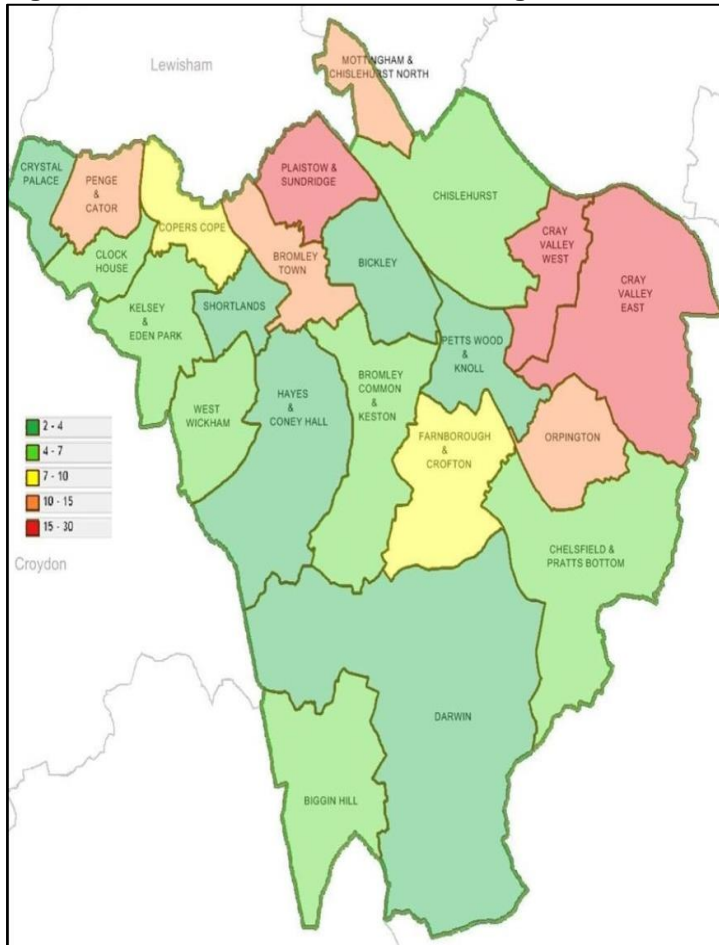
Crime

It is well known that drug dependence is associated with a high incidence of criminal activity and it has been estimated that 40% of all acquisitive crime is drug-related. Criminal justice costs include costs associated with drug arrests for acquisitive crimes, stays in police custody, appearances in court, and stays in prison; crime victim costs refer to material or physical damage, crime victims' loss and expenditures taken in anticipation of crime.

In order to combat drug-related crime, by increasing opportunities for diverting drug misusing offenders out of crime and into treatment and reducing associated criminality, from January 2013, the Metropolitan Police Service extended drug testing across all 32 boroughs in London, including Bromley. **Figure 16.7** shows the distribution of positive tests across Bromley in 2013-4.

A person testing positive for drugs on arrest is obliged to attend a drug assessment, regardless of whether convicted of the offence. Failure to attend is an offence which may result in arrest. These assessments can result in individuals being persuaded into drug treatment. Between January and June 2013 approximately 39% of people who tested positive were referred into treatment. The Police work closely with Arrest Referral workers, who are part of the Bromley drug and alcohol service.

Figure 16. 7: Distribution of Positive Drug Tests, 2013/14



Source: Metropolitan Police Drug Intervention Program

The Treatment and Management of Drug Misuse

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.

Few treatments are given in isolation, and indeed tend to be less effective if they are.

It is important to understand the nature of drug misuse and dependency, and in particular that dependency is a chronic illness for which there is no cure.

Treatment in Bromley

Bromley Drug and Alcohol Service provides:

- brief interventions, both at BDAS and community settings
- 6-8 week psychological interventions for non-opiate users
- longer psychological interventions for opiate users
- residential care for opiate users who have significant physical, mental and social problems

Adults Attending Drug Treatment Services in Bromley

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 improved outcomes.

A measure of effective treatment engagement is the number of people who have been in treatment for three months or more. In 2014-15, 462 people effectively engaged in treatment in Bromley, this represents 89% of the treatment population (519), slightly lower than the 93% seen nationally.

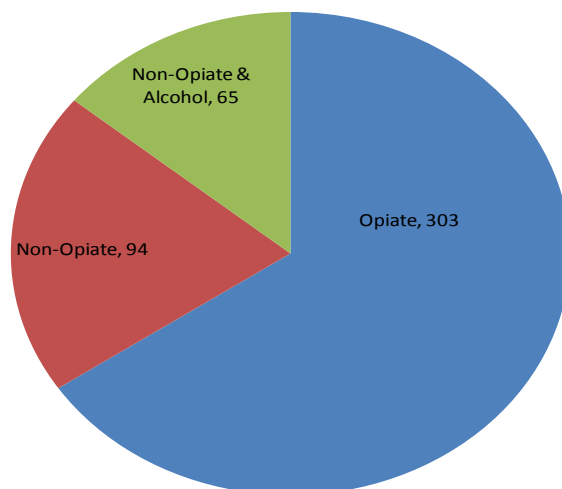
Opiate users represent the largest group in treatment.

Of those in treatment for substance misuse, 51 reported illicit use of prescription only or over the counter medicines.

The number of people new in treatment in 2014-15 reporting use of new psychoactive substances or club drugs (such as ecstasy) was less than ten.

Figure 16. 8

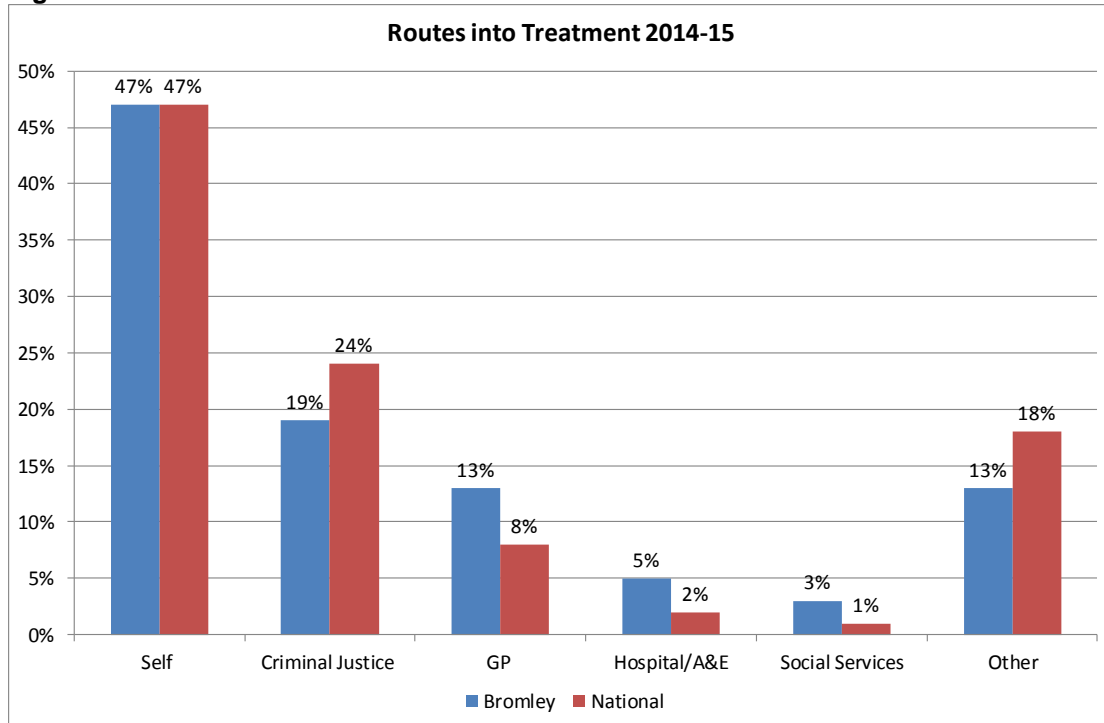
Numbers Effectively Engaging in Treatment by Substance in Bromley 2014-15



Source: NDTMS JSNA Support Pack 2015

Almost half of patients self-refer into substance misuse services both in Bromley and nationally. Health services (GPs and hospital) refer a higher proportion into treatment in Bromley (18%) than nationally (10%).

Figure 16.9



Source: NDTMS JSNA Support Pack 2015

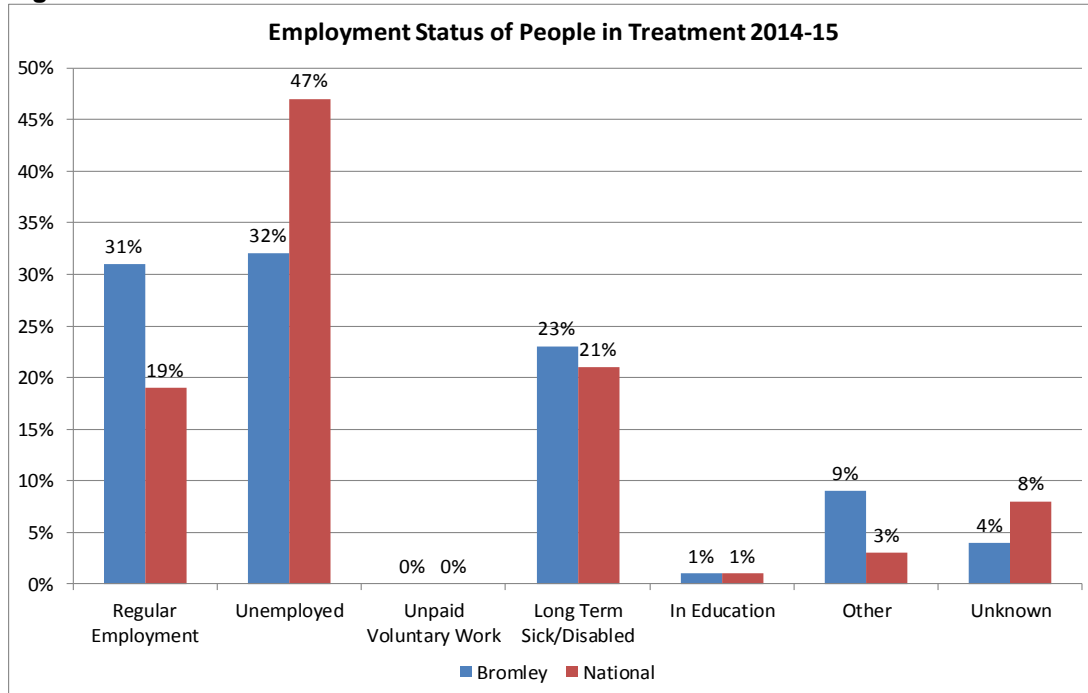
The majority of substance misusers receive treatment in the community, with pharmacological, psychosocial and recovery support interventions all playing a part. In 2014-15, 2% of individuals received interventions as an inpatient and 2% attended residential rehabilitation.

It is important to know the numbers of drug users in treatment who have childcare responsibilities so that adequate support can be provided. In 2014-15, 117 (23%) of those in treatment were living with children, with a further 157 (30%) recorded as parents, but not living with their children. Almost half (9245, 47%) were not a parent and had no child contact.

Recovery from substance misuse is dependent to some extent on the social, physical and financial assets of the individual – so called recovery capital. In Bromley, almost a third (31%) of those in treatment reported being in regular employment in 2014-15, as compared with under a fifth of people nationally.

A similar proportion (32%) were unemployed, much lower than the national figure of 47%.

Figure 16. 10

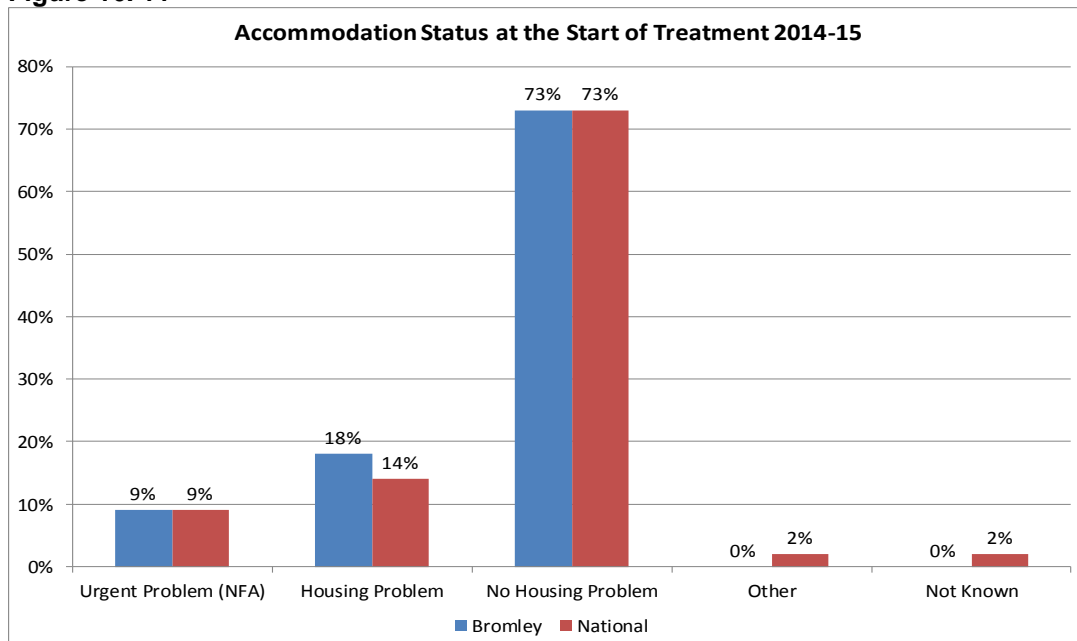


Source: NDTMS JSNA Support Pack 2015

A safe stable home environment enables people to sustain their recovery; insecure housing and homelessness threatens it.

In Bromley in 2014-15, the proportion of people with urgent (9%) or other housing problems (18%) was similar to the national picture.

Figure 16. 11



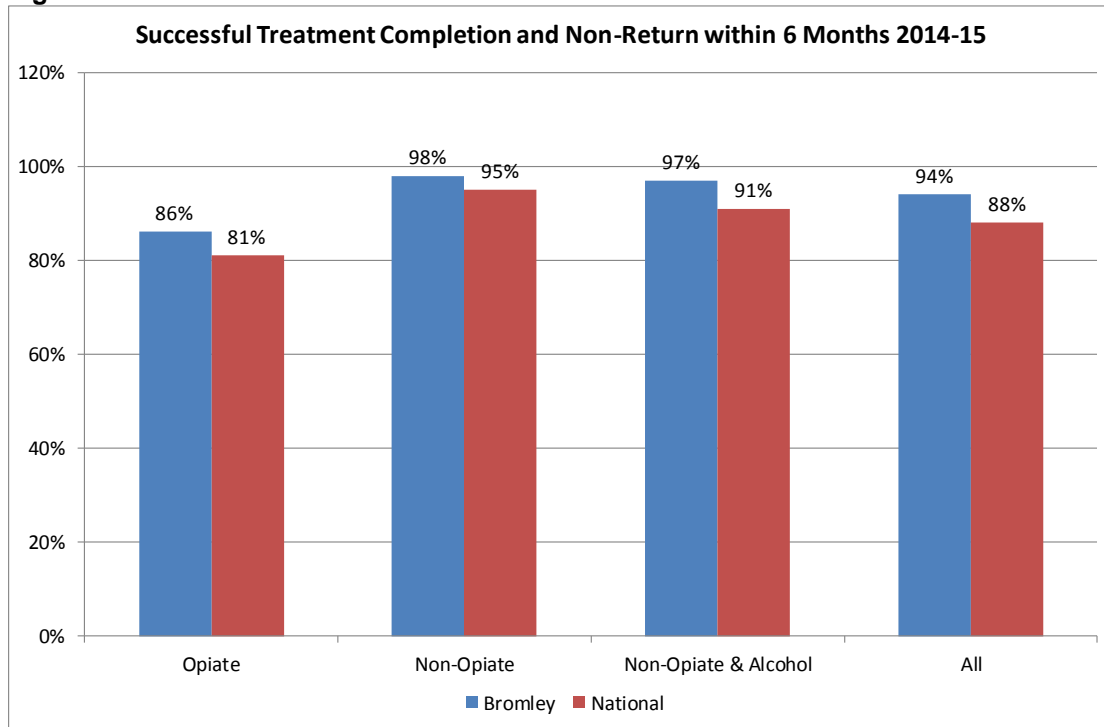
Source: NDTMS JSNA Support Pack 2015

Treatment Outcomes for Adults

The key measure of successful treatment is the proportion of people who successfully completed treatment and did not return within 6 months. Bromley had a higher proportion of successful completers than the national value in all categories of substance misuse in 2014-15 (**Figure. 16.12**).

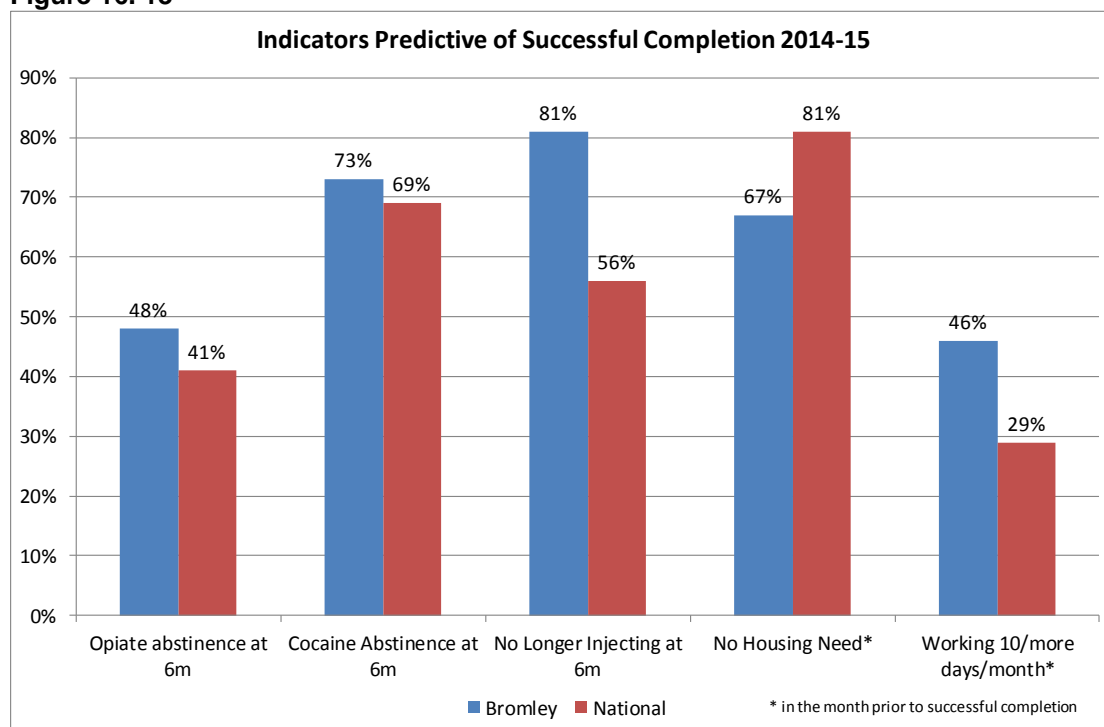
For those still in treatment, there are a number of indicators at six month review which suggest that treatment is likely to be successful. These are abstinence from drugs, significant reductions in drug use and injecting, secure housing and being in work. In general these indicators are better for Bromley than nationally, with one notable exception, which is the proportion of people with resolved housing needs; at 67% this is significantly lower than the national figure of 81% (**Figure. 16.13**).

Figure 16. 12



Source: NDTMS JSNA Support Pack 2015

Figure 16. 13



Source: NDTMS JSNA Support Pack 2015

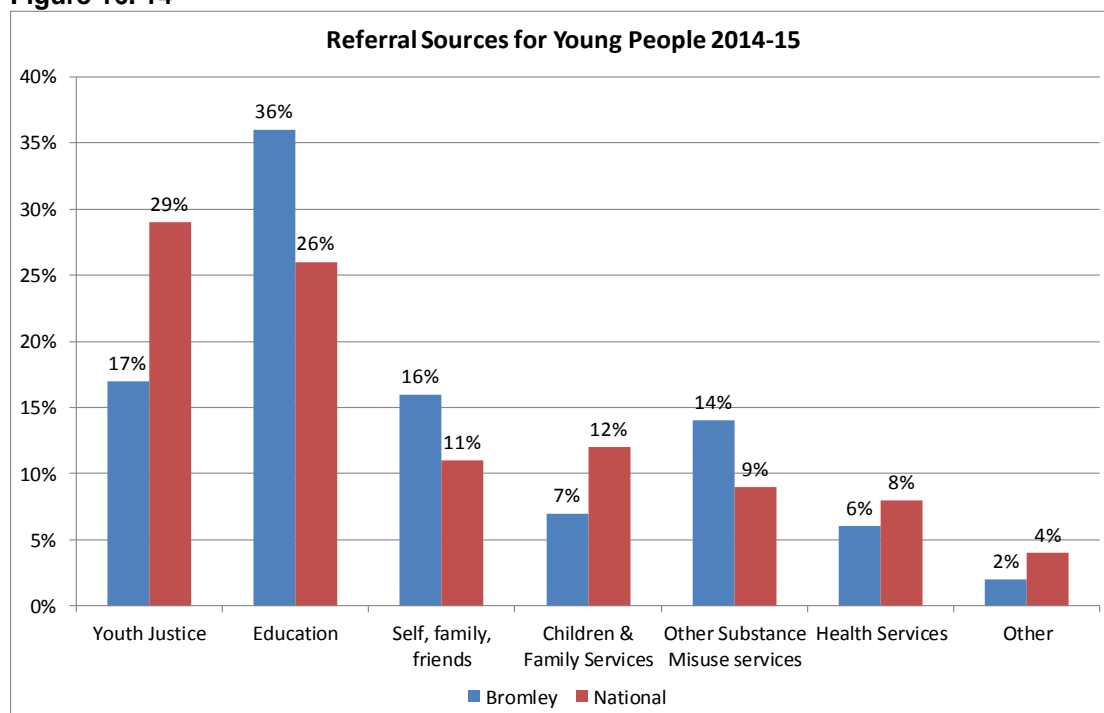
Young People Attending Drug Treatment Services in Bromley

While the majority of young people do not use drugs, and most of those that do are not dependent, drug and alcohol misuse have a major impact on young people’s education, their health, their families and their long-term chances in life.

Between April and October 2014, 90 young people accessed specialist substance misuse treatment services in Bromley.

Of these, the largest proportion (36%) were referred from education services, with 17% being referred through the Youth Justice system and only 16% being self-referrals. 6% of referrals were from health services including A&E.

Nationally, there are a higher proportion of referrals from Youth Justice (29%) and a lower proportion from education (26%).

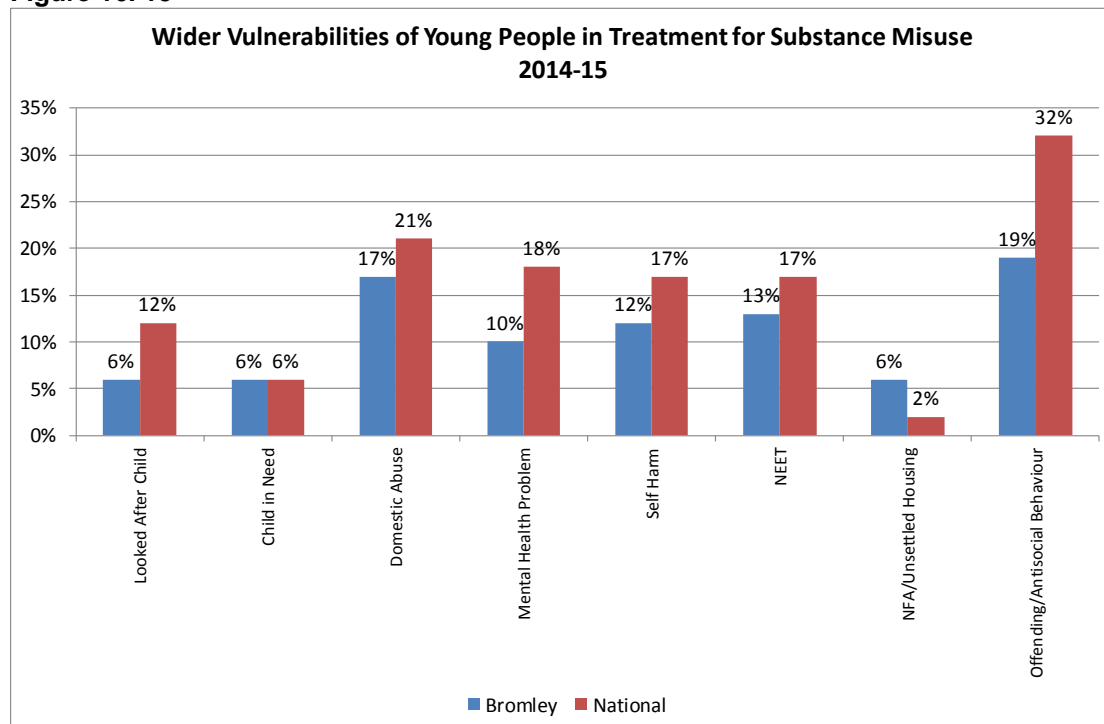
Figure 16.14

Source: NDTMS JSNA Support Pack 2015

Many young people receiving specialist interventions for substance misuse have a range of vulnerabilities. They are more likely to be not in education, employment or training (NEET), have contracted a sexually transmitted infection, experiencing domestic violence, experiencing sexual exploitation, or be in contact with the youth justice system (**Figure. 16.15**).

Of the young people in treatment in Bromley in 2014-15, 70% were using two or more substances (this may include alcohol) and 97% began using their main problem substance before the age of 15 years.

Figure 16. 15



Source: NDTMS JSNA Support Pack 2015

Of those in treatment in 2014-15, 98% required psychosocial interventions only, and 1% required additional pharmacological interventions.

Of all those who exited treatment, 94% did so in a planned way in Bromley. This is a higher proportion than nationally (79%).

Young people’s circumstances can change, as does their ability to cope. If they re-present to treatment, this is not necessarily a failure and they need reassessment to inform a new care plan. In the last financial year, 4% of young people who left specialist substance misuse interventions in a planned way re-presented to young people’s or adult specialist services within six months.

Table 16. 2: Substance Misuse Related PHOF Indicators, 2015

Indicator	Period	Sex	Bromley	London	England
2.15i - Successful completion of drug treatment - opiate users	2010	Persons	6.03	8.31	6.65
2.15i - Successful completion of drug treatment - opiate users	2011	Persons	7.32	9.91	8.56
2.15i - Successful completion of drug treatment - opiate users	2012	Persons	9.71	9.69	8.24
2.15i - Successful completion of drug treatment - opiate users	2013	Persons	10.90	8.98	7.76
2.15ii - Successful completion of drug treatment - non-opiate users	2010	Persons	37.98	31.88	34.38
2.15ii - Successful completion of drug treatment - non-opiate users	2011	Persons	37.14	34.50	36.64
2.15ii - Successful completion of drug treatment - non-opiate users	2012	Persons	35.03	33.53	37.65
2.15ii - Successful completion of drug treatment - non-opiate users	2013	Persons	43.97	37.16	37.66
2.16 - People entering prison with substance dependence issues who are previously not known to community treatment	2012/13	Persons	50.00	57.11	46.87

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

What This Means for Residents and Children in Bromley

The Crime survey for England and Wales suggests that approximately 17,000 residents took illicit drugs in Bromley in 2014/2015.

The substances most commonly misused by those in treatment in Bromley are opiates (44%) and alcohol (41%).

The population in treatment is predominantly male (64.8%) and of White British ethnicity (82.6%).

The highest proportion of substance misusers in treatment in Bromley are in the 40 to 49 year age group, in contrast to the national picture, which is 35 to 44 years. There were 80 drug-related deaths in Bromley between 2006-2013. The average age at death was 48. More than thirty years lower than average life expectancy for Bromley. Deaths were most frequent in deprived wards.

There were 518 drug-related hospital admissions in Bromley 2013/14. Admission rates have been steadily increasing since 2009, the numbers greatest in the 25-44 age group.

Bromley had a higher proportion of successful treatment completers than the national value in all categories of substance misuse in 2014-15.

Of the 90 young people in treatment in Bromley in 2014-15, 70% were using two or more substances (this may include alcohol) and 97% began using their main problem substance before the age of 15 years.

For more information please contact Paula.Morrison@bromley.gov.uk

17. Alcohol

Alcohol plays a significant part in the social lives of many people and while the majority of people are able to enjoy a few drinks without suffering long term health problems, it remains a concern that over a quarter of the Bromley population over 16 are drinking above the levels recommended by the Department of Health.

A large number of people do not know how much they drink. Weekly sales of alcohol are twice as much as the population estimate they drink. This suggests we underestimate what we drink by a huge 50%. There is a need to develop an approach in Bromley which gives people the tools to understand and reduce their alcohol consumption.

The Annual Public Health Report 2014 and the Alcohol Needs Assessment 2014 have presented a strong evidence base for the development of more prevention services. This would help to address problem drinking and promote safe, sensible drinking as the social norm in Bromley.

What are the dangers of too much alcohol?

Alcohol related harms are broad ranging and can be associated with even moderate levels of drinking. Health-related problems include: hypertension, cardiovascular disease, cancer, liver disease, mental illness, accidents in the home and on the road, violence and premature death. In most cases the relationship between alcohol and health is simple: the more you drink the greater the risk of harm.

But harm is not limited to health. Alcohol misuse and dependency can affect work productivity, resulting in poor performance, disciplinary procedures and eventually dismissal, which in turn can result in financial difficulties for the individual and their family. It invariably affects relationships, creating barriers between the drinker and their partner and children, and sometimes verbal and physical abuse. Children and young people can do little to protect themselves from the effects of parental drinking and can suffer emotional distress, neglect or physical injury.

Nationally, in around half of all violent crimes, victims believed their attackers had been drinking. Alcohol is also a common feature of domestic and sexual violence. High levels of alcohol consumption are associated with increased risk taking generally, particularly among young people, including unsafe sex and drink driving.

Classification of drinking behaviours

The most common classifications of alcohol consumption are based on quantity. The World Health Organisation and the National Institute of Clinical Excellence (NICE) refer to classifications as follows:

Table 17. 1: Classification of Drinking Behaviours

RISK			Men	Women
1	Lower risk This level of drinking means that in most circumstances you have a low risk of causing yourself future harm.	Sensible drinking Drinking within the recommended limits.	No more than 3-4 units a day on a regular* basis	No more than 2-3 units a day on a regular* basis
2	Increasing risk Drinking at a level that increases the risk of damaging your health and could lead to serious medical conditions.	Hazardous drinking A pattern of alcohol consumption that increases risk of harm.	More than 3-4 units a day on a regular* basis	More than 2-3 units a day on a regular* basis
3	Higher risk This level of drinking has the greatest risk of health problems.	Harmful drinking A pattern of alcohol consumption that is causing mental and physical damage.	More than 50 units per week (or more than 8 units per day) on a regular* basis	More than 35 units per week (or more than 6 units per day) on a regular* basis

*Regular in this context means drinking at this sort of level every day or most days of the week; whilst for weekly drinking, it refers to the amounts drunk most weeks of the year.

Adapted from Gravesham County NHS.

http://www.gravesham.gov.uk/_data/assets/pdf_file/0007/62359/Units_Poster.pdf last accessed 16/09/14

Binge drinking

The definition of binge drinking used by the NHS and National Office of Statistics is drinking more than double the lower risk guidelines for alcohol in one session. Binge drinking for men, therefore, is drinking more than 8 units of alcohol – or about three pints of strong beer. For women, it's drinking more than 6 units of alcohol, equivalent to two large glasses of wine.

Dependence

Drinkers can also be classified by their addiction to alcohol, known as dependence. Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Someone who is alcohol-dependent may

persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations.

- **Mild dependence:**
may crave an alcoholic drink when it is not available or find it difficult to stop drinking.
- **Moderate dependence:**
Likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking.
- **Severe dependence:**
May have withdrawal fits (delirium tremens: e.g. confusion or hallucinations usually starting between two or three days after the last drink); may drink to escape from or avoid these symptoms.

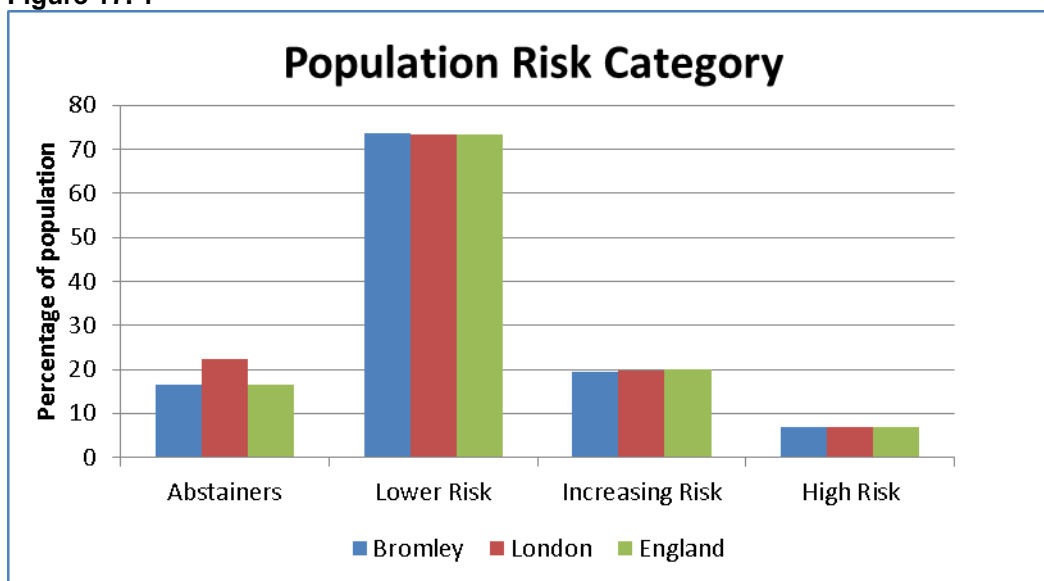
Abstainers are considered to be people who have reported not consuming alcohol in the previous 12 months. This may include people who have once been dependent on alcohol but are no longer consuming it.

Alcohol Consumption in Bromley

Obtaining reliable information about drinking behaviour is difficult, and social surveys consistently record lower levels of consumption than would be expected from the data on alcohol sales. However, a range of data sources which are available locally were extracted and analysed to understand patterns and trends in alcohol consumption in the Bromley population.

People in Bromley are not thought to drink any more than the average for London or England. In 2012 an estimated 73.6% of all drinkers in Bromley were in the lower risk category and drinking within the recommended levels, compared to 73.4% for London. There were 19.5% of drinkers at increasing risk, and a further 6.9% at high risk, which was no different to the London average. **Figure 17.1** shows the most recent estimates of people consuming alcohol locally and nationally.

Figure 17.1



Source: Local Alcohol Profile for England 2014 (dataset)

* Abstainers include people who may have had harmful or dependent drinking patterns in the past but may have stopped drinking since. They are not included in the estimation of lower risk drinkers.

The North West Public Health Observatory has used data from the general household survey in 2005 to estimate the levels at which people are drinking shown in **table 17.2**. These have been applied to the Bromley population shown in **table 17.3**.

With the exception of those who do not drink alcohol (labelled 'None') all the other groups are at increasing risk of alcohol-related harm. The risk increases with increasing levels of consumption. There are slightly lower limits of consumption for women and raised limits for men. The majority of the population drink at the lower levels.

- More men are drinking at hazardous and harmful levels than women at every age.
- The proportion of men drinking at harmful levels between the ages of 16 and 75 years is three to four times that for women.
- When the proportions are applied to Bromley, there are 22,164 men and 7,771 women who would be consuming 40g (5 units) of alcohol or more per day. That is around 30,000 people drinking alcohol at harmful or hazardous levels in Bromley.

Table 17. 2: Age specific distribution of alcohol consumption(grams of alcohol per day)- % of population

ENGLAND										
Age	MALES (g/day)					FEMALES (g/day)				
	None	01-19	20-39	40-74	75+	None	01-19	20-39	40-74	75+
16 to 24	18.1%	43.5%	20.5%	9.9%	7.9%	23.8%	51.3%	16.2%	5.2%	3.5%
25 to 34	17.8%	42.0%	20.7%	13.2%	6.3%	23.9%	56.2%	13.7%	4.8%	1.4%
35 to 44	12.4%	45.6%	22.9%	14.7%	4.5%	23.1%	55.3%	15.1%	4.9%	1.5%
45 to 54	12.4%	42.7%	22.0%	14.5%	8.4%	25.5%	52.9%	14.3%	6.1%	1.2%
55 to 64	13.9%	44.8%	19.4%	16.0%	5.9%	30.3%	51.3%	12.2%	5.2%	1.1%
65 to 74	20.0%	49.2%	16.7%	9.9%	4.1%	43.5%	46.2%	7.8%	1.7%	0.9%
75+	28.5%	49.6%	12.9%	7.5%	1.5%	52.3%	41.4%	4.8%	1.2%	0.2%
16-75	16.5%	45.0%	19.9%	12.9%	5.7%	30.2%	51.5%	12.5%	4.4%	1.4%

Source: NPHO from the General Household Survey 2005

Table 17. 3: Age specific distribution of alcohol consumption (grams of alcohol per day)- number of people

BROMLEY										
Age	MALES (g/day)					FEMALES (g/day)				
	None	01-19	20-39	40-74	75+	None	01-19	20-39	40-74	75+
16 to 24	2738	6581	3101	1498	1195	3656	7881	2489	799	538
25 to 34	3400	8022	3953	2521	1203	4942	11620	2833	992	289
35 to 44	2778	10217	5131	3294	1008	5616	13445	3671	1191	365
45 to 54	2795	9623	4958	3268	1893	6097	12649	3419	1459	287
55 to 64	2305	7430	3217	2653	978	5441	9212	2191	934	198
65 to 74	2567	6314	2143	1270	526	6414	6812	1150	251	133
75+	3014	5245	1364	793	159	8362	6619	767	192	32
16-75	19662	53622	23713	15372	6792	40152	68471	16619	5850	1861

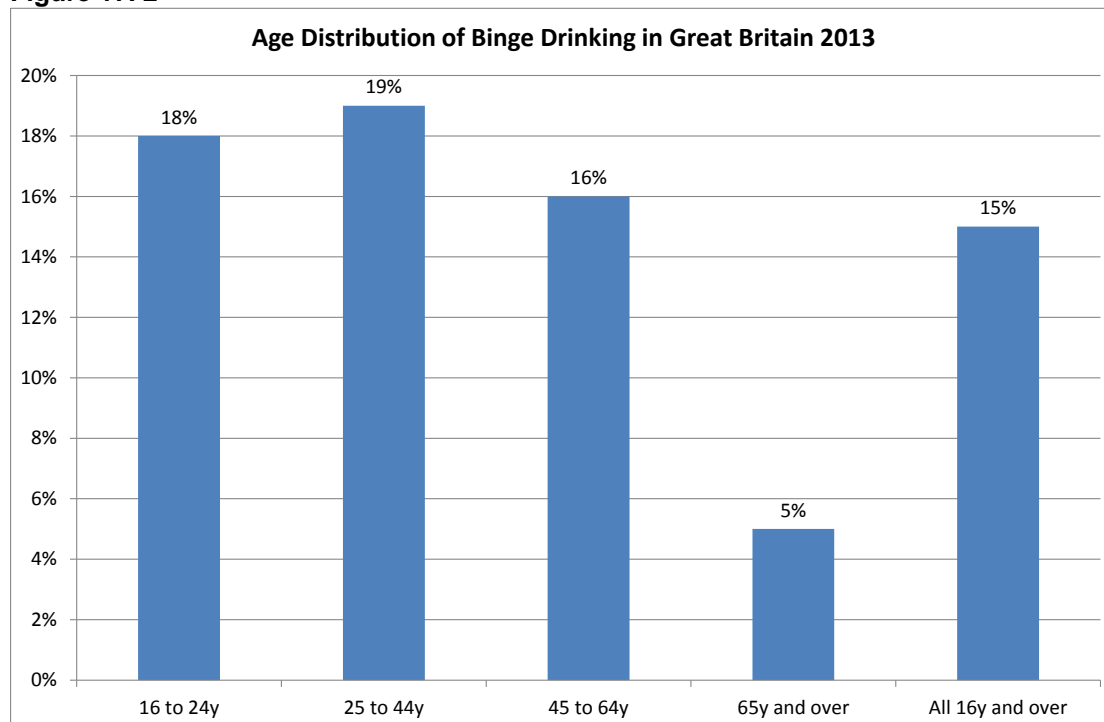
Note: Based on table 3 in Attributable Fractions for England. The estimates from the national report were applied to the Bromley ONS 2012 Mid-Year Estimates

Prevalence of binge drinking

There has been a reduction in the prevalence of binge drinking across Great Britain since 2005, with 15% of those aged 16 years and over binge drinking in 2013, as compared with 18% in 2005.

The prevalence of binge drinking is higher in the younger age groups with 18% of 16 to 24 year olds and 19% of 25 to 44 year olds binge drinking.

There are no recent local Bromley estimates for the level of binge drinking available.

Figure 17.2

Source: *HSCIC Lifestyle Statistics 2015*

Alcohol Related Mortality

National

In England, in 2013 there were 22,049 alcohol-related deaths. There has been a gradual decrease in numbers since 2008. Males accounted for a larger proportion of all alcohol-related deaths than women in England (66% in 2013). The most common reason for alcohol-related death is alcoholic liver disease which accounted for 77% (17,432) of all alcohol-related deaths in 2013.

Local

In 2013 there were 107 alcohol-related deaths in Bromley. The mortality rate from alcohol-related causes in Bromley has risen for women whilst remaining level for men in the period between 2008 and 2013.

The alcohol-related mortality rate for men and women in Bromley is lower than the national and regional levels. The alcohol-related mortality rate for men in Bromley is almost twice that for women.

Figures 17.3 and 17.4 show the trend in alcohol-related deaths in Bromley, London and England by gender.

Figure 17.3

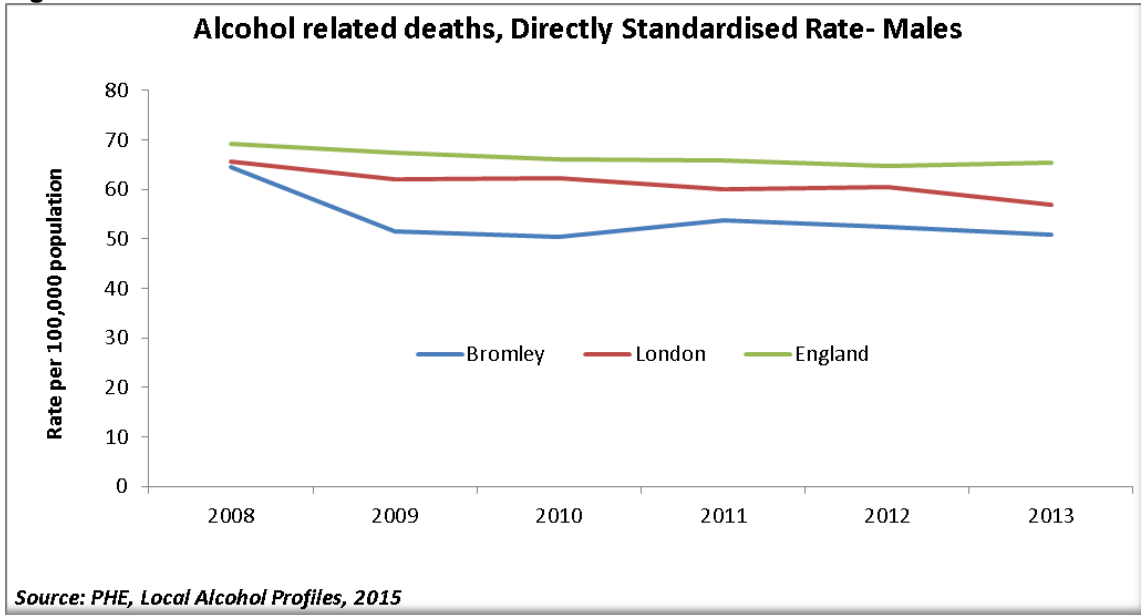
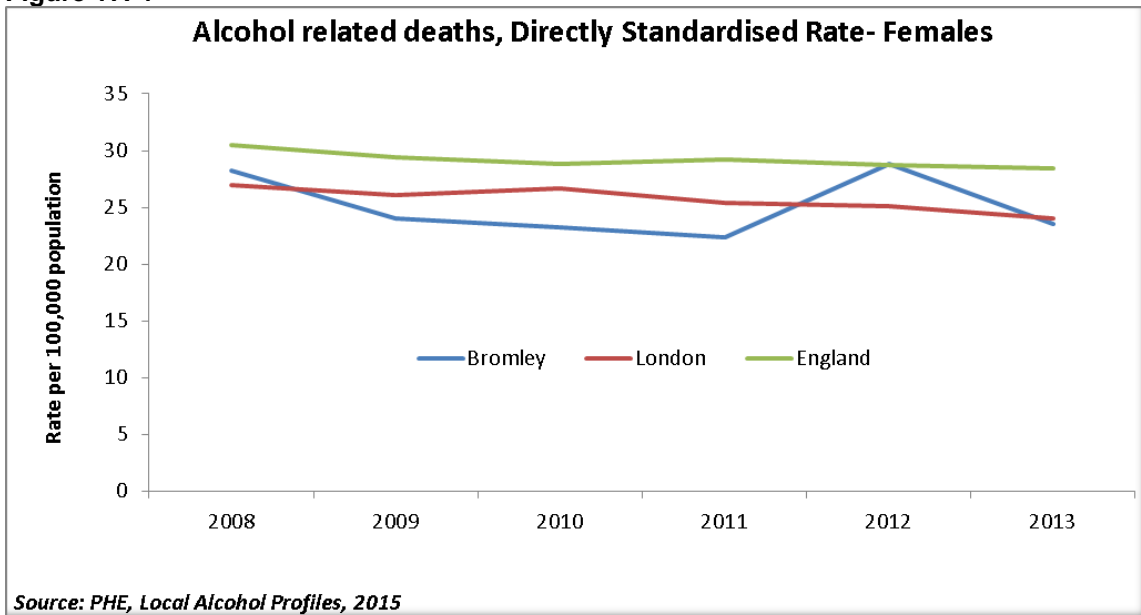


Figure 17.4



Although the number of alcohol-attributable deaths varied by age, overall, men and women appear to have been equally affected by their alcohol consumption. Younger people were disproportionately affected by their alcohol use.

Main causes of alcohol attributable death

The leading causes of alcohol-related deaths in the UK are alcoholic liver disease and cancer of the oesophagus for men and women aged 16-75+. Additionally, breast cancer is the third commonest cause for women and colorectal cancer for men.

Other important causes of alcohol-related death are intentional self-harm (predominantly amongst men), road/pedestrian traffic accidents, and poisoning.

Medical and Mental Health History

An analysis of deaths looking at past medical history was carried out by public health and presented in a report entitled 'Drug and Alcohol Related Deaths' in Bromley 2012 and 2013.

The report looked at the past medical and mental health histories for each death which are often not recorded with the mortality data. GP records were available to be reviewed for 69 alcohol related deaths.

The report found that 80% (55) of the deaths had one or more significant past medical conditions, with over half of them having between one and three significant past medical conditions in addition to the cause of death.

A total of 147 different significant medical conditions were recorded for all the 69 deaths. The commonest conditions were alcohol-related such as gastrointestinal bleeding, reflux disease and pancreatitis. Other conditions recorded were hypertension, diabetes, neurological disease, and respiratory diseases such as asthma and chronic obstructive pulmonary disease.

Over half of the people who died had up to two mental health problems. Depression was the commonest condition reported followed by anxiety disorder. Among the people who suffered from mental health problems a few had a history of self-harm and attempted suicide.

Contact with Health & Treatment Service

The report also looked at previous contact with health care services for each of the deaths. From the GP records, the details of first presentation to the health care and treatment services with alcohol-related problems were reviewed.

It was found that 51 out of 69 people had presented with alcohol-related problems to the various health services previously, including GP, hospital clinics, mental health units, accident and emergency and private hospitals. Around 3 in 4 people had seen their GP previously as their first presentation.

Common reasons for presentation to the GP were abnormal liver function test, or symptoms of liver failure as well as depression or anxiety. Some of the people had already sustained irreversible damage to the liver (for example liver cirrhosis) on first presentation to health services. Thus, intervention to treat their alcohol problems at that point was too late to reverse the damage caused by alcohol.

In addition, reviewing consultation notes showed that the focus of many consultations was on monitoring and treating the liver problems rather than the alcohol problem itself. Where brief advice to reduce alcohol consumption was offered, no clear follow up was mentioned. Some but not all had documented advice

to contact alcohol treatment services, whilst other patients had refused help. In many cases, no clear follow-up plan was noted.

Some patients presented their alcohol problems during hospital outpatient clinics, often when their liver problems were being investigated. This was followed by presentation to the mental health service during consultation for other mental health issues; whilst some people presented to the A&E, often with acute liver failure or alcohol intoxication. However, similar to the people presenting to their GPs, no clear follow-up plan could be found.

The timing of their first presentations varied, with some presenting to the health service over 10 years prior to death, or up to a few months prior to death.

In terms of contact with alcohol treatment services, only 22 people (32%) had reported contact with alcohol treatment services prior to their death. Of those who did have contact with alcohol services the majority (73% of 22) had contact with alcohol treatment services in Bromley. The remainder reported seeking help from Alcoholics Anonymous (18% of 22) or other alcohol treatment service.

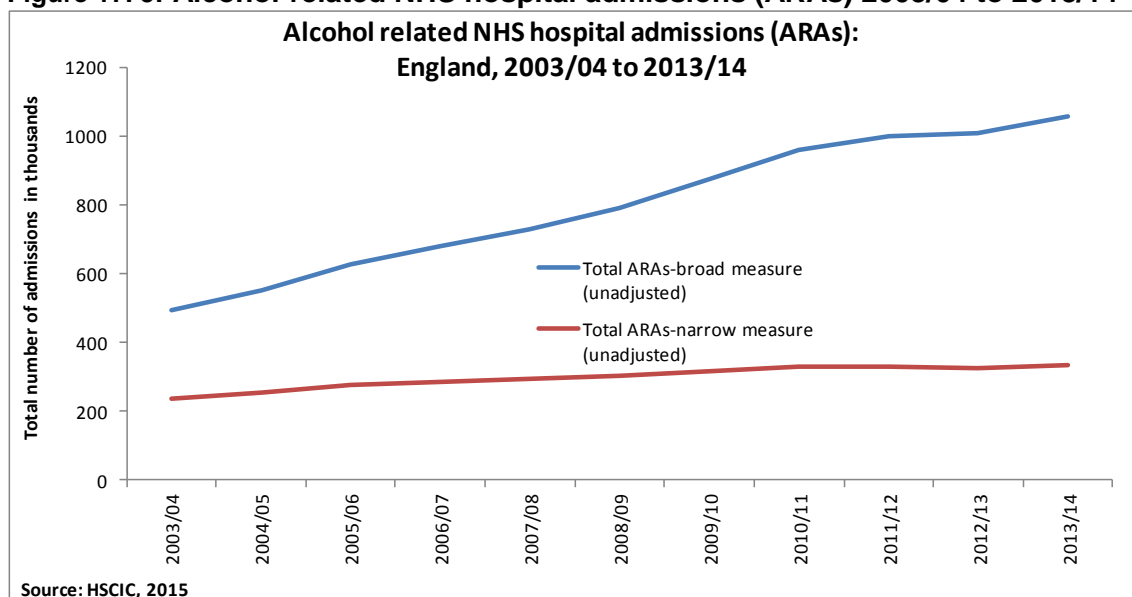
Hospital Admissions-burden of ill-health due to alcohol

National

The rate of alcohol-related hospital admissions in England had been rising fast since 2003/04 as shown in **figure 17.5** below.

In 2013-14, the highest proportion of admissions (48%) were due to cardiovascular disease.

Figure 17. 5: Alcohol-related NHS hospital admissions (ARAs) 2003/04 to 2013/14



In 2013/14, there were an estimated 333,010 hospital admissions in England where the primary diagnosis or alcohol-related external causes recorded in secondary diagnosis fields were attributable to the consumption of alcohol (the narrow measure) (HSCIC, 2015).

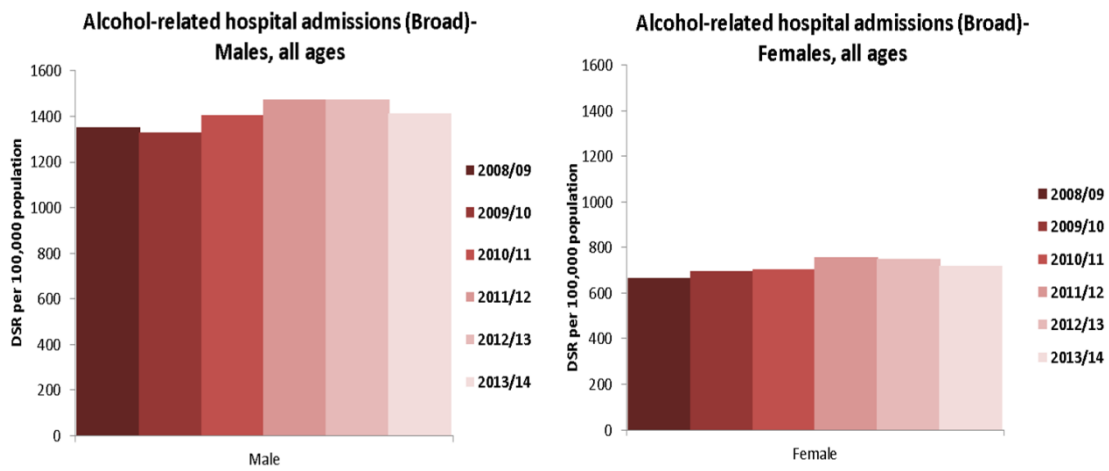
Nationally, more males than females are admitted to hospital with alcohol-related conditions. However, amongst the under 16s, the opposite is true where females are more likely to be admitted to hospital with alcohol-related diseases, injuries and conditions than males, with females accounting for 56% of all admissions.

Local

In Bromley, hospital admission rates for alcohol-related conditions for both men and women have been increasing since 2008 to a peak in 2010-11, with the rate reducing in 2013-14. These rates are significantly lower than those for London and for England.

The hospital admission rate for males is almost twice the rate for females in Bromley. The rates are shown in **Figure 17.6**.

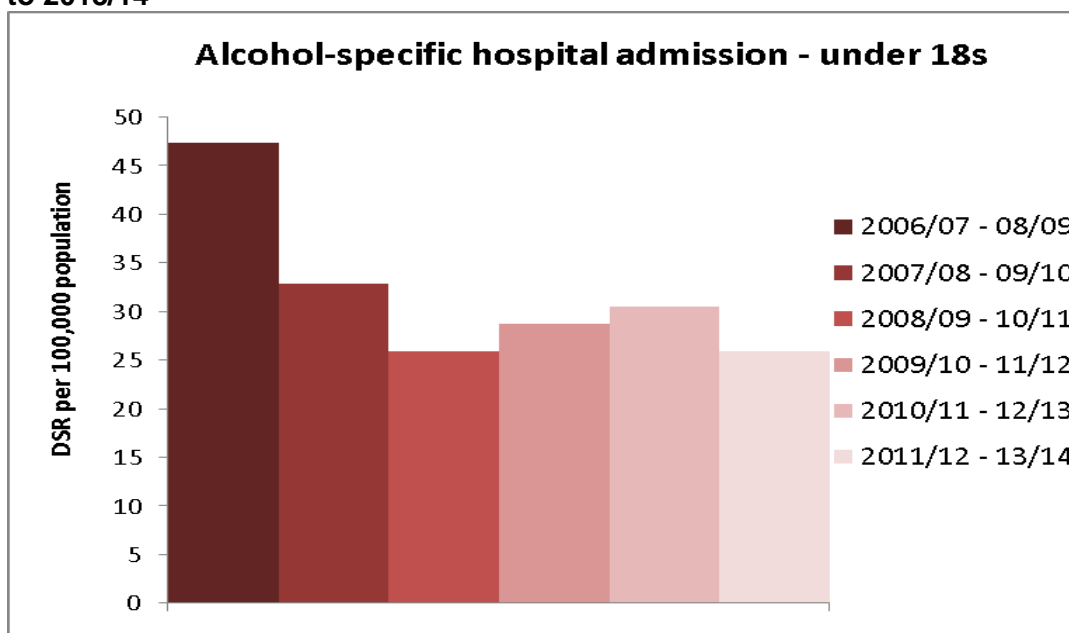
Figure 17. 6: Alcohol-related hospital admissions for men and women in Bromley 2008/09 - 2013/14



Source: Local Alcohol Profiles for England, 2015

The alcohol-specific admission rate for under 18 year olds in Bromley has been gradually increasing in the last two years until last year which saw a 15% reduction, and is comparable with the rate for London, but significantly lower than the rate for England (40.05 per 100,000 population). In 2013/14 the rate was 25.87 admissions per 100,000 population compared to 26.55 for the London region.

Figure 17. 7: Alcohol-related hospital admissions for young people in Bromley 2008/09 to 2013/14



Source: Local Alcohol Profiles for England, 2015

The rates of alcohol-related hospital admissions (narrow measure) for Bromley and the London region are shown in **table 17.4** below.

Table 17. 4: Crude rate of hospital admissions per 100,000 population

	Bromley	London
Males	421.21	548.81
Females	231.55	257.84

Source: Local Alcohol Profiles for England, 2015

Alcohol-attributable hospital admissions

People aged 45-54 tend to contribute most to the total burden of alcohol-attributable hospital admissions and those aged 0-15 contribute the least as shown in **table 17.5**.

Table 17. 5: Estimated number of alcohol-attributable hospital admissions by age and sex (5yr 2009-2014)

	2009/10		2010/11		2011/12		2012/13		2013/14	
	M	F	M	F	M	F	M	F	M	F
0-15	0	1	0	2	0	5	0	4	0	2
16-24	30	13	19	14	24	17	30	11	25	13
25-34	13	14	10	25	11	23	20	13	16	12
35-44	32	42	21	44	19	61	25	33	18	26
45-54	52	34	64	39	78	46	65	18	52	11
55-64	49	30	53	34	48	54	58	23	45	26
65-74	4	72	-4	62	-2	75	-7	54	-12	53
75+	51	10	38	9	69	20	62	17	55	9
Total	230	216	200	229	249	300	253	173	197	152

Source: Hospital Inpatient Data from Secondary User Services – Bromley CCG

Causes of hospital admission

National – latest available 2013/14 data (Source: HSCIC, 2015)

Amongst those aged 15 years and under the most common causes of admission were for mental and behavioural disorders, and low birth weight arising from maternal alcohol use.

For men in the 16-24 and 25- 34 year age groups, the largest contributors by disease area to hospital admissions were neuropsychiatric illnesses, followed by injuries. Among the older age groups, the largest contributors were cardiovascular disease and neuropsychiatric illness.

Women followed a similar pattern, but with breast cancer being another major contributor among women aged 35 to 74 years of age.

Local

Table 17.6 summarises the top 3 causes of morbidity in each age group within Bromley. Due to small numbers in some age groups, five year data was pooled from 2009-10 to 2013/14. Low birth weight was not included at the analysis as this is a new diagnosis included in the alcohol fractions.

- Amongst those aged 15 years and under the most common cause of admission was for mental and behavioural disorders.
- Alcoholic liver disease contributed significantly to hospital admissions for men across all ages.
- Falls contributed significantly to hospital admissions for both men and women across all the age groups.

Table 17. 6: Top three causes of alcohol-attributable hospital admissions (number) in Bromley 5yr 2009-2014.

	Male		Female	
	Condition	n	Condition	n
16-24	Intentional self-harm/Event of undetermined intent	26	Mental and behavioural disorders due to use of alcohol	22
	Assault	25	Intentional self-harm/Event of undetermined intent	21
	Epilepsy and status epilepticus	19	Epilepsy and status epilepticus	18
25-34	Alcoholic liver disease	15	Fall Injuries	25
	Intentional self-harm/Event of undetermined intent	13	Intentional self-harm/Event of undetermined intent	21
	Road traffic accident non-pedestrian	10	Assault	16
35-44	Alcoholic liver disease	54	Malignant neoplasm of breast	56
	Acute and chronic pancreatitis	24	Fall Injuries	29
	Epilepsy and status epilepticus	18	Intentional self-harm/Event of undetermined intent	27
45-54	Alcoholic liver disease	97	Malignant neoplasm of breast	166
	Fall Injuries	53	Mental and behavioural disorders due to use of alcohol	22
	Epilepsy and status epilepticus	36	Malignant neoplasm of oesophagus	12
55-64	Alcoholic liver disease	90	Malignant neoplasm of breast	172
	Cardiac arrhythmias	30	Fall Injuries	40
	Malignant neoplasm of oesophagus	24	Malignant neoplasm of lip, oral cavity and pharynx	29
65-74	Malignant neoplasm of oesophagus	59	Malignant neoplasm of breast	123
	Alcoholic liver disease	28	Fall Injuries	65
	Malignant neoplasm of lip, oral cavity and pharynx	26	Cardiac arrhythmias	48
75+	Fall Injuries	154	Malignant neoplasm of breast	67
	Malignant neoplasm of oesophagus	65	Cardiac arrhythmias	49
	Cardiac arrhythmias	61	Fall Injuries	34
16-75+	Alcoholic liver disease	294	Malignant neoplasm of breast	584
	Fall Injuries	261	Fall Injuries	203
	Malignant neoplasm of oesophagus	153	Cardiac arrhythmias	130

Source: Hospital Inpatient Data from Secondary User Services – Bromley CCG

Alcohol Treatment Services

Effective specialist alcohol treatment services are provided in Bromley and deliver good treatment outcomes for people using the service. The treatment outcomes are measured using a number of national standards and targets with Bromley placed within the top quartile nationally for good treatment outcomes.

However, from survey work in 2014 Public Health has identified that some practitioners do not feel confident on how to refer into specialist treatment services. It has also been identified that Screening and Brief Intervention Advice is not always happening in Accident and Emergency, in Primary Care settings or with other professional or voluntary sector groups. Therefore, there is a need to build up the confidence and capacity within the workforce on how to refer to specialist treatment

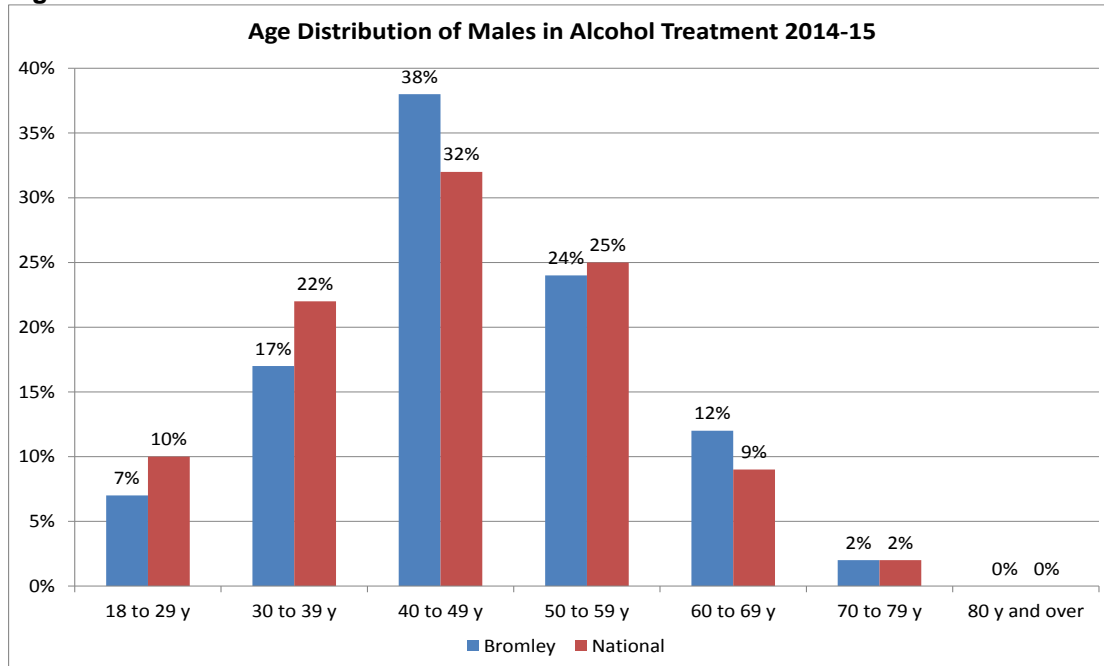
and also other support services for people who are not ready to enter treatment. A number of data sources and statistical analysis for Bromley has also identified middle aged men and middle aged women as a population who are consuming alcohol at levels to cause harm but are under-represented in Treatment Services.

Adults in Alcohol Treatment Services

In 2014-15, 240 people received specialist alcohol treatment in Bromley. Of these 19% were also receiving treatment from mental health services for reasons other than substance misuse.

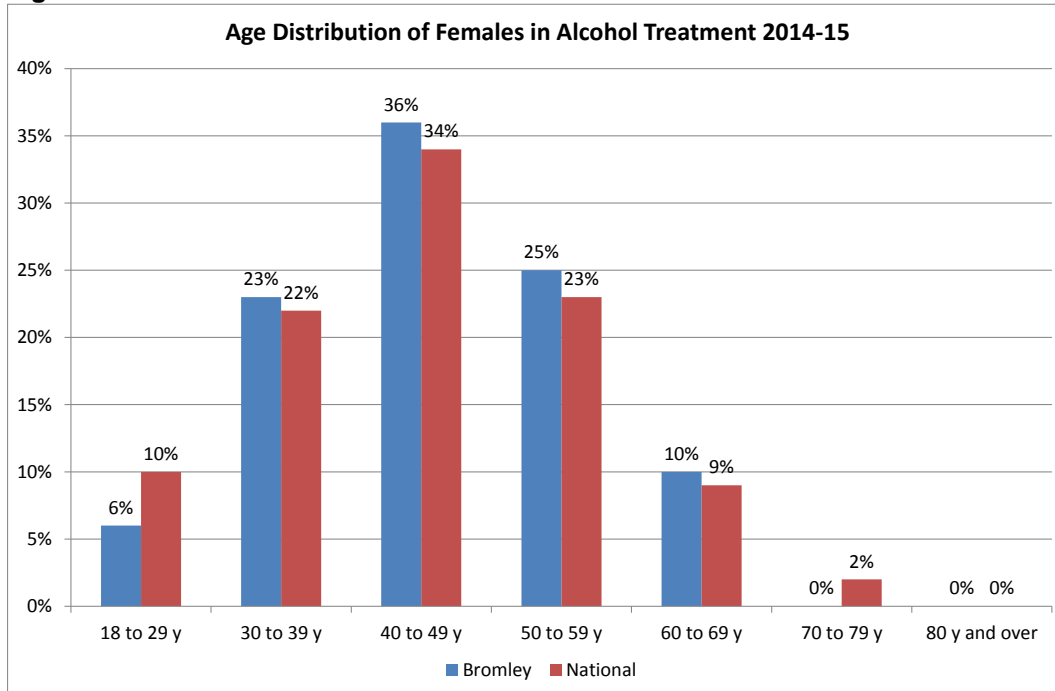
In addition, there were 152 people who were also using opiates or non-opiates.

Figure 17. 8



Source: NDTMS JSNA Support Pack 2015

Figure 17.9

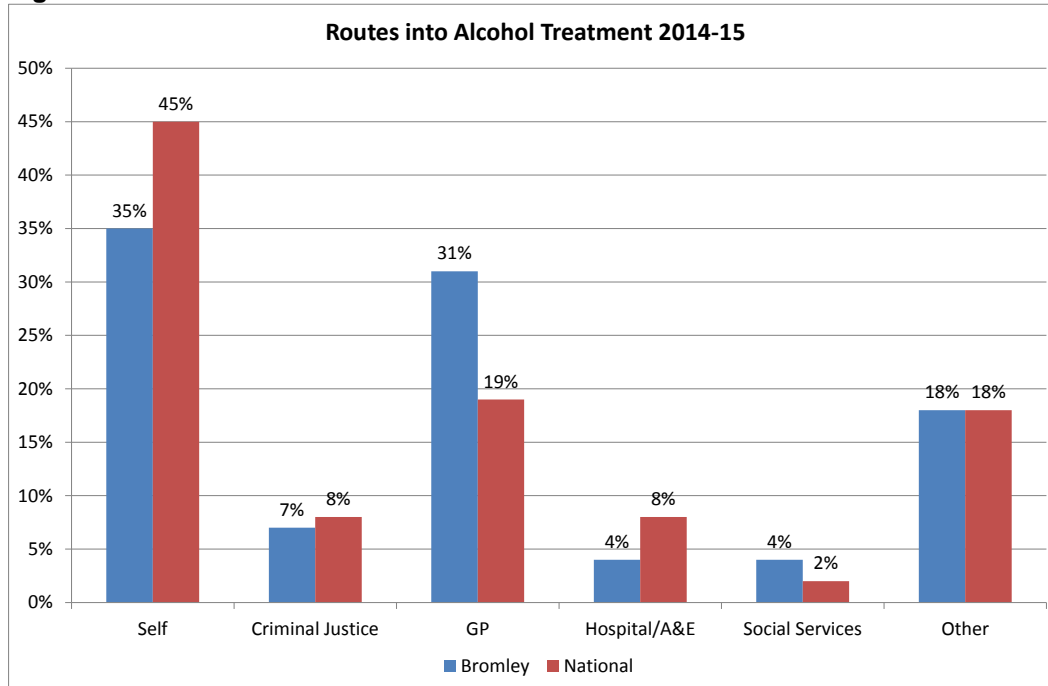


Source: NDTMS JSNA Support Pack 2015

In Bromley, as nationally, the peak age group in alcohol treatment is the 40 to 49 year age group for both men and women. Bromley has a lower proportion of young people in alcohol treatment than the national value.

Self-referral is the most common route into alcohol treatment both locally and nationally. However, GP referrals are much higher in Bromley (31%) than nationally (19%), in contrast to hospital referrals which are higher nationally (8%) than locally (4%).

Figure 17. 10



Source: NDTMS JSNA Support Pack 2015

Of those needing treatment, 95% received treatment in the community (a combination of pharmacological, psychosocial and recovery support) and 8% required treatment at an inpatient unit in 2014-15.

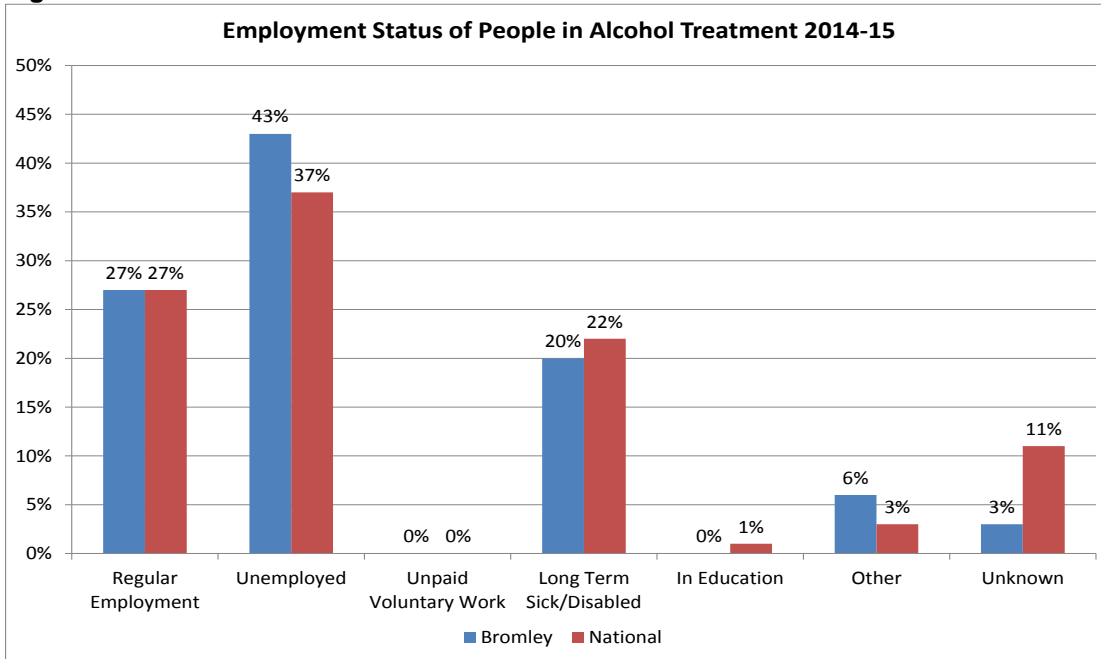
It is important to know the numbers of people in alcohol treatment who have childcare responsibilities so that adequate support can be provided. In 2014-15, 75 (31%) of those in treatment were living with children, with a further 53 (22%) recorded as parents, but not living with their children. Almost half (112, 47%) were not a parent and had no child contact.

Recovery from alcohol misuse is dependent to some extent on the social, physical and financial assets of the individual – so called recovery capital.

In Bromley, over a quarter (27%) of those in treatment reported being in regular employment in 2014-15, which was the same proportion as nationally.

A higher proportion (43%) were unemployed, higher than the national figure of 37%.

Figure 17. 11

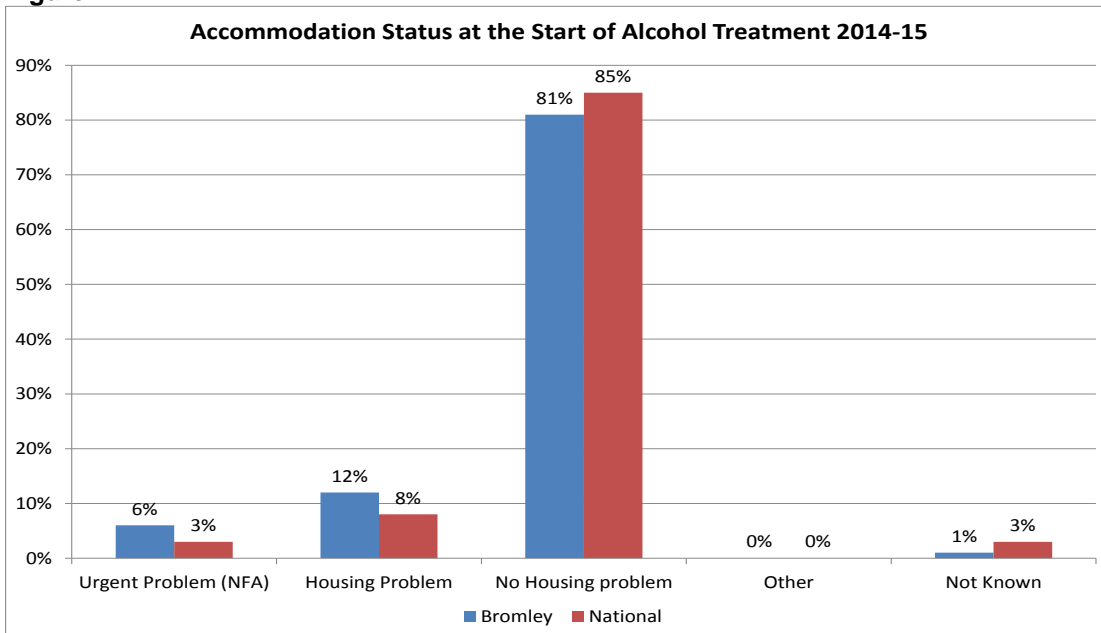


Source: NDTMS JSNA Support Pack 2015

A safe stable home environment enables people to sustain their recovery; insecure housing and homelessness threatens it.

In Bromley in 2014-15, the proportion of people with urgent (6%) or other housing problems (12%) was higher than the national picture.

Figure 17. 12



Source: NDTMS JSNA Support Pack 2015

Treatment Outcomes for Adults

The key measure of successful treatment is the proportion of people who successfully completed treatment and did not return within 6 months.

Bromley had a similar proportion of successful completers (39%) to the national value (38%) for alcohol treatment in 2014-15.

Table 17. 7: Alcohol Related PHOF Indicators, 2015

Indicator	Time Period	Sex	Bromley	London	England
4.06i - Under 75 mortality rate from liver disease	2001 - 03	Persons	13.12	20.82	15.85
4.06i - Under 75 mortality rate from liver disease	2002 - 04	Persons	13.70	21.00	16.40
4.06i - Under 75 mortality rate from liver disease	2003 - 05	Persons	15.92	20.62	16.78
4.06i - Under 75 mortality rate from liver disease	2004 - 06	Persons	14.43	20.38	17.14
4.06i - Under 75 mortality rate from liver disease	2005 - 07	Persons	13.85	20.17	17.53
4.06i - Under 75 mortality rate from liver disease	2006 - 08	Persons	12.66	19.93	17.93
4.06i - Under 75 mortality rate from liver disease	2007 - 09	Persons	13.45	19.27	17.87
4.06i - Under 75 mortality rate from liver disease	2008 - 10	Persons	13.89	19.51	17.91
4.06i - Under 75 mortality rate from liver disease	2009 - 11	Persons	13.39	19.24	18.00
4.06i - Under 75 mortality rate from liver disease	2010 - 12	Persons	14.56	18.94	18.04
4.06i - Under 75 mortality rate from liver disease	2011 - 13	Persons	13.61	17.91	17.91
4.06i - Under 75 mortality rate from liver disease	2001 - 03	Male	17.16	28.93	20.90
4.06i - Under 75 mortality rate from liver disease	2002 - 04	Male	19.04	29.52	21.65
4.06i - Under 75 mortality rate from liver disease	2003 - 05	Male	20.03	29.49	22.32
4.06i - Under 75 mortality rate from liver disease	2004 - 06	Male	18.78	29.52	22.70
4.06i - Under 75 mortality rate from liver disease	2005 - 07	Male	17.60	28.99	23.26
4.06i - Under 75 mortality rate from liver disease	2006 - 08	Male	17.35	28.46	23.80
4.06i - Under 75 mortality rate from liver disease	2007 - 09	Male	16.27	27.11	23.68
4.06i - Under 75 mortality rate from liver disease	2008 - 10	Male	17.27	27.28	23.81
4.06i - Under 75 mortality rate from liver disease	2009 - 11	Male	16.81	26.79	23.76
4.06i - Under 75 mortality rate from liver disease	2010 - 12	Male	18.63	26.37	23.69
4.06i - Under 75 mortality rate from liver disease	2011 - 13	Male	17.03	25.16	23.57
4.06i - Under 75 mortality rate from liver disease	2001 - 03	Female	9.48	13.23	11.01
4.06i - Under 75 mortality rate from liver disease	2002 - 04	Female	8.85	13.01	11.37
4.06i - Under 75 mortality rate from liver disease	2003 - 05	Female	12.20	12.34	11.48
4.06i - Under 75 mortality rate from liver disease	2004 - 06	Female	10.39	11.82	11.82
4.06i - Under 75 mortality rate from liver disease	2005 - 07	Female	10.38	11.91	12.03
4.06i - Under 75 mortality rate from liver disease	2006 - 08	Female	8.37	11.91	12.30
4.06i - Under 75 mortality rate from liver disease	2007 - 09	Female	10.78	11.90	12.29
4.06i - Under 75 mortality rate from liver disease	2008 - 10	Female	10.79	12.17	12.24
4.06i - Under 75 mortality rate from liver disease	2009 - 11	Female	10.20	12.13	12.46
4.06i - Under 75 mortality rate from liver disease	2010 - 12	Female	10.89	11.95	12.61
4.06i - Under 75 mortality rate from liver disease	2011 - 13	Female	10.47	11.14	12.47
4.06ii - Under 75 mortality rate from liver disease considered preventable	2001 - 03	Persons	10.44	17.41	13.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	2002 - 04	Persons	11.09	17.63	14.26
4.06ii - Under 75 mortality rate from liver disease considered preventable	2003 - 05	Persons	13.44	17.55	14.63
4.06ii - Under 75 mortality rate from liver disease considered preventable	2004 - 06	Persons	12.53	17.39	14.98
4.06ii - Under 75 mortality rate from liver disease considered preventable	2005 - 07	Persons	12.18	17.13	15.36
4.06ii - Under 75 mortality rate from liver disease considered preventable	2006 - 08	Persons	11.22	16.80	15.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	2007 - 09	Persons	11.54	16.12	15.73
4.06ii - Under 75 mortality rate from liver disease considered preventable	2008 - 10	Persons	11.96	16.52	15.73
4.06ii - Under 75 mortality rate from liver disease considered preventable	2009 - 11	Persons	11.35	16.52	15.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	2010 - 12	Persons	12.78	16.55	15.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	2011 - 13	Persons	12.30	15.72	15.70
4.06ii - Under 75 mortality rate from liver disease considered preventable	2001 - 03	Male	13.98	24.55	18.59
4.06ii - Under 75 mortality rate from liver disease considered preventable	2002 - 04	Male	15.78	25.13	19.25
4.06ii - Under 75 mortality rate from liver disease considered preventable	2003 - 05	Male	16.79	25.35	19.88
4.06ii - Under 75 mortality rate from liver disease considered preventable	2004 - 06	Male	16.23	25.68	20.27
4.06ii - Under 75 mortality rate from liver disease considered preventable	2005 - 07	Male	15.44	25.04	20.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	2006 - 08	Male	15.96	24.62	21.34
4.06ii - Under 75 mortality rate from liver disease considered preventable	2007 - 09	Male	14.86	23.13	21.19
4.06ii - Under 75 mortality rate from liver disease considered preventable	2008 - 10	Male	16.22	23.54	21.29
4.06ii - Under 75 mortality rate from liver disease considered preventable	2009 - 11	Male	15.77	23.33	21.23
4.06ii - Under 75 mortality rate from liver disease considered preventable	2010 - 12	Male	17.42	23.34	21.14
4.06ii - Under 75 mortality rate from liver disease considered preventable	2011 - 13	Male	15.81	22.44	21.11
4.06ii - Under 75 mortality rate from liver disease considered preventable	2001 - 03	Female	7.26	10.72	9.16
4.06ii - Under 75 mortality rate from liver disease considered preventable	2002 - 04	Female	6.85	10.60	9.49
4.06ii - Under 75 mortality rate from liver disease considered preventable	2003 - 05	Female	10.39	10.27	9.61
4.06ii - Under 75 mortality rate from liver disease considered preventable	2004 - 06	Female	9.10	9.64	9.92
4.06ii - Under 75 mortality rate from liver disease considered preventable	2005 - 07	Female	9.16	9.73	10.17
4.06ii - Under 75 mortality rate from liver disease considered preventable	2006 - 08	Female	6.89	9.46	10.43
4.06ii - Under 75 mortality rate from liver disease considered preventable	2007 - 09	Female	8.43	9.56	10.47
4.06ii - Under 75 mortality rate from liver disease considered preventable	2008 - 10	Female	8.10	9.91	10.39
4.06ii - Under 75 mortality rate from liver disease considered preventable	2009 - 11	Female	7.30	10.13	10.53
4.06ii - Under 75 mortality rate from liver disease considered preventable	2010 - 12	Female	8.62	10.18	10.61
4.06ii - Under 75 mortality rate from liver disease considered preventable	2011 - 13	Female	9.09	9.45	10.52

Indicator	Time Period	Sex	Bromley	London	England
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2008/09	Persons	472.42	530.35	614.63
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2009/10	Persons	459.14	562.98	638.07
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2010/11	Persons	459.62	586.57	651.92
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2011/12	Persons	484.56	572	652.81
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2012/13	Persons	505.81	553.77	636.85
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2013/14	Persons	441.14	541.22	645.13
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2008/09	Male	621.8	731.97	805.6
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2009/10	Male	561.39	773.05	833.39
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2010/11	Male	552.47	809.38	848.32
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2011/12	Male	583.35	787.86	848.58
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2012/13	Male	573.24	760.15	829.36
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2013/14	Male	531.36	743.45	835.3
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2008/09	Female	352.16	354.02	446.17
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2009/10	Female	375.12	379.24	464.91
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2010/11	Female	386.46	392.09	477.87
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2011/12	Female	406.45	383.9	479.08
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2012/13	Female	456.08	373.33	464.87
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2013/14	Female	368.76	362.52	474.78

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

What does this mean for Bromley residents and for children in Bromley?

Over a quarter of the Bromley population over 16 are drinking above the levels recommended by the Department of Health.

More men are drinking at hazardous and harmful levels than women at every age. The proportion of men drinking at harmful levels between the ages of 16-75 years is three to four times that for women.

In 2013 there were 107 alcohol-related deaths in Bromley.

The alcohol-related mortality rate for men and women in Bromley is lower than the national and regional levels. The alcohol-related mortality rate for men in Bromley is almost twice that for women.

In Bromley, hospital admission rates for alcohol-related conditions are significantly lower than those for London and for England. The hospital admission rate for males is almost twice the rate for females in Bromley.

Amongst those aged 15 years and under the most common cause of admission was for mental and behavioural disorders. Alcoholic liver disease contributed significantly to hospital admissions for men across all ages. Falls contributed significantly to hospital admissions for both men and women across all the age groups.

Specialist Alcohol Treatment Services provide treatment to those whose drinking is harmful or who are alcohol dependent. In 2014-15, 240 adults received treatment, of whom 39% completed treatment successfully, this is similar to the national figure of 38%.

For more information please contact Paula.Morrison@Bromley.gov.uk

18. Updates on Progress from Last Year's JSNA

3 Modifiable Risk Factors – Smoking

Stopping smoking is highlighted as a priority within Bromley for routine and manual workers, pregnant women, those with a mental health condition and patients in secondary care (hospital admission, re-admission and post-operative complications). Work is being undertaken to de-normalise smoking and drive down smoking prevalence in priority groups. This includes:

Actions to de-normalise smoking:

- The Princess Royal University Hospital and Orpington Hospital will join Beckenham Beacon in becoming smoke free sites launched in Stoptober 2015.
- Every patient, visitor and staff member in acute care will be given brief advice about stopping smoking, given alcohol and physical activity advice and offered a referral into local support services.
- Trading standards, Public Health and the South East London Illicit Tobacco Control Alliance work together to tackle the inflow and sale of illicit and counterfeit tobacco; enforcing smoke-free legislation and reducing under-age sales.

Work with priority groups:

- The Stop Smoking Service mobile bus targets priority communities via outreach clinics in the specified hard to reach communities.
- To evidence that the service drives down smoking prevalence, the number of people that have quit with the service and still abstinent from smoking at 12 months was recorded, 72.2% were still abstinent.

Modifiable Risk Factors – Obesity

The JSNA acknowledges that no single solution creates sufficient impact to reverse obesity: only a comprehensive, systemic program of multiple interventions is likely to be effective. A sustainable, whole-system approach to combat obesity is the only effective resolution. Improvements are needed across prevention, identification and weight management interventions, involving a range of partners. Work includes:

Prevention: The Bromley Health and Wellbeing Board established an Obesity Sub-Group to identify and investigate the impact of Obesity in Bromley in 2015. This sub-group will work to deliver 4 priority actions through the newly established Healthy Weight Forum, a multiple stakeholder working group.

The Healthy Weight Forum will provide a network where a co-ordinated approach is used to tackle and impact the obesogenic environment. This partnership will:

- Develop a Healthy Weight Pathway – from Healthy Weight to Morbidly Obese.
- Support the development of local planning policy to consider healthy weight environments.
- Develop and deliver a healthy weight communications plan.
- Implement local interventions that have the potential to impact obesity and healthy living.

Identification: Deprivation is linked to increased obesity prevalence. Therefore, identification of residents who require obesity services, but who are less likely to visit their GP to be referred, are being identified and referred via an outreach wellbeing service.

Intervention: Obesity is identified as a chronic medical condition that is worsening. Additional services are needed to serve those with complex co-morbidities caused by obesity.

- Implementation of Tier 3 weight management programme to be commissioned by the CCG as of April 2016.
- Implementation of the Diabetes Prevention Programme which is being addressed through a pilot intensive lifestyle intervention commissioned by Public Health.
- Increase the capacity of the weight management service to cover 3% of the obese population. In 2012/13, 2.6% of the population was covered, in 2014/15 population covered reduced to 1.8% due to budgetary constraints.

Modifiable Risk Factors- Physical Activity

Targeting inactive people was set as a priority, getting this group active is likely to produce the greatest reduction in chronic disease. Work is being undertaken to target physically inactive residents:

- Partnership working through the new Health and Wellbeing board obesity sub-group are focusing on interventions and environmental changes to prompt and encourage an increase in daily activity and active transport.
- Pro-Active Bromley, the independent Sport and Physical Activity Network attracted £375,000 of external and in-kind funding to develop multiple sport and physical activity initiatives from 2014-17, a large proportion designated to attractive inactive people.
- In 2014/15, 343 residents at high risk of type 2 diabetes undertook a walking programme called 'Walking Away From Diabetes'. It is designed to lower the risk of developing diabetes by increasing the number of steps a person undertakes per day, aiming to achieve the Chief Medical Officers recommendation of 10,000 steps/day. The programme continues in 2015/16.

- Healthcare Professionals refer physically inactive patients with one or more existing medical conditions to the Exercise Referral Hub which signposts patients to a 12 week prescribed programme of supported exercise in the gym. Or alternative activities in the borough (e.g. walking and cycling) if medically appropriate. Physical activity is used as the treatment for existing medical conditions, 62% of participants who were previously inactive completed the programme are now meeting the physical activity guidelines (150minutes per week of moderate intensity exercise or 75minute of vigorous intensity).

9 Children and Young People

Long Term Conditions in children in Bromley Diabetes Mellitus (DM)

Table 18.9 1: Diabetes Mellitus (DM) in children

	Admissions	Bed days	Average length of stay (days)
NHS Bromley (number)	19	56	2.67
Rate per 100,000 population	25.5	75.2	
England (rate)	57.1	129.7	2.18
London (rate)	44.7	129.7	2.74
4 similar CCGs	44.3	76.4	1.72
Significance*	Same	Same	Higher**
Rank (of 221 CCGs) 1 indicates 'best'	7	40	171

Source: CHIMAT

*When compared to the average of the 4 most similar CCGs

** Not tested for statistical significance

Asthma

Table 18.9 2: Asthma in Children

	Admissions per 100,000 population	Bed days per 100,000 population	Average length of stay (days)
NHS Bromley (number)	108	193	1.77
Rate per 100,000 population	145.0	259.0	
England (rate)	197.5	242.1	1.21
London (rate)	206.6	243.7	1.15
4 similar CCGs	76.4	179.1	1.35
Significance*	Worse	Worse	Higher**
Rank (of 221 CCGs) 1 indicates 'best'	71	140	198

Source: CHIMAT

** Not tested for statistical significance

Epilepsy

Table 18.9 3: Epilepsy in children

	Admissions	Bed days	Average length of stay (days)
NHS Bromley (number)	43	92	2.14
Rate per 100,000 population	57.7	123.5	
England (rate)	77.8	153.9	1.93
London (rate)	70.8	151.6	2.09
4 similar CCGs	55.7	100.8	1.81
Significance*	Same	Same	Higher**
Rank (of 221 CCGs) 1 indicates 'best'	54	102	147

What does this mean for Bromley residents and for children in Bromley?

Length of stay once admitted to hospital is too long for all 3 long term conditions. However, the management of patients with asthma is also worse for admission rate and number of bed days. Work to improve asthma care for children is taking place across London and should help to address some of the local issues.

13. Mental Health

Investment in Improving Access to Psychological Therapies (IAPT) to reach 15% of the Bromley population continues to be a priority in recognition of the burden of mental health caused by moderate depression and anxiety disorders. Bromley CCG is currently reviewing this service to further improve access.

There is continued investment in Dementia services to improve and assist in developing treatment and earlier diagnosis approaches. Bromley CCG is also developing plans for community post diagnostic support. Dementia is one of the priorities of the Health and Wellbeing Board.

Following the London benchmarking exercise on Early Intervention in Psychosis, Oxleas NHS Trust has reviewed services and developed an action plan for change.

A review of employment services in Bromley is also under review as unemployment rates remain high for people with Serious Mental Illness.

16. Substance Misuse- Drugs

There were 80 drug related deaths in Bromley between 2006 and 2013. The average age at death was 48, more than thirty years lower than average life expectancy for Bromley Borough.

There were 518 drug related hospital admissions in Bromley in 2013/14. Admission rates have been steadily increasing since 2009, the numbers greatest in the 25-44 age group.

In 2012/13 34% of eligible new presenters to drug services in Bromley accepted Hepatitis B vaccinations, compared with the national average of 47%. During the same period, 91% of previously or currently injecting clients in treatment in Bromley received a Hepatitis C test, as compared with the national average of 72.5%.

While the numbers of people presenting at drug treatment services in Bromley has been falling, the proportion of those going on to be in effective treatment has been rising from 66% in 2006 to 89% in 2013.

The numbers of clients who successfully complete treatment has been rising, from 5% in 2006, to 19% in 2013.

17. Alcohol

It remains a concern that over a quarter of the Bromley population over 16 is drinking alcohol above the levels recommended by the Department of Health. In Bromley there were 19.5% of drinkers at increasing risk, and a further 6.9% at high risk, which was similar to the London average.

More men are drinking at hazardous and harmful levels than Women at every age with the proportion of men drinking at harmful levels between the age of 16 and 75 years at three to four times that for women.

The Mortality rate from Alcohol-related causes in Bromley has risen for women, whilst remaining level for men.

The Alcohol-related mortality rate for Women in 2012 was 27.4 deaths per 100,000 population which exceeded the regional average of 24.5 deaths per 100,000 population.

The Alcohol Mortality rate for men in Bromley is almost twice that for Women.

The Annual Public Health Report 2014 and the Alcohol Public Health Needs Assessment 2014 have presented a strong evidence base for the development and redesign of prevention services.

Opportunities exist to further develop educational programmes with Bromley Schools to implement the NICE guidance recommendations on Alcohol and Young people.

Public Health Survey work in 2014 identified that some practitioners do not feel confident on how to refer into specialist treatment services.

There is a strong evidence base to show that people benefit from Brief Advice provided by healthcare professionals who are not alcohol specialists. The benefits of using a brief intervention are most clearly seen when it is used with people who are unaware that alcohol is compromising their mental or physical wellbeing.

19. Useful References

Alcohol

The Government's Alcohol Strategy. Home Office. (2012)

<http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary>

Local Alcohol Profiles for England 2015

<http://www.lape.org.uk/>

Alcohol Needs Assessment 2014 (contact Paula.Morrison@bromley.gov.uk)

NICE Quality Standard 11: *Alcohol dependence and harmful alcohol use* (August 2011)

<http://publications.nice.org.uk/alcohol-dependence-and-harmful-alcohol-use-quality-standard-gs11>

NICE Clinical Guideline 115 (2011) Alcohol use disorders – diagnosis, assessment and management of harmful drinking and alcohol dependence

<http://publications.nice.org.uk/alcohol-use-disorders-diagnosis-assessment-and-management-of-harmful-drinking-and-alcohol-cg115>

NICE Public Health Guidance 24 (2010): *Alcohol use disorders – preventing harmful drinking*

<http://publications.nice.org.uk/alcohol-use-disorders-preventing-harmful-drinking-ph24>

NICE Clinical Guideline 100 (2010): *Alcohol use disorders – physical complications*

<http://publications.nice.org.uk/alcohol-use-disorders-diagnosis-and-clinical-management-of-alcohol-related-physical-complications-cg100>

NICE Public Health Guidance 7 (2007): School-based interventions on alcohol

<http://publications.nice.org.uk/school-based-interventions-on-alcohol-ph7>

Cardiovascular Disease

NICE Quality Standard 100 (2015) - Cardiovascular Risk Assessment and Lipid Modification

<http://nice.org.uk/guidance/qs100>

NICE Clinical Guideline 181 (2014) – *Cardiovascular disease: risk assessment and reduction, including lipid modification*

<http://guidance.nice.org.uk/CG181>

NICE Quality Standard 28 (2013): *Hypertension*

<http://publications.nice.org.uk/quality-standard-for-hypertension-qs28>

NICE Quality Standard 35 (2013): Hypertension in pregnancy

<http://publications.nice.org.uk/hypertension-in-pregnancy-qs35>

NICE Commissioning Guide 45 (2012): Integrated commissioning for the prevention of cardiovascular disease

<http://www.nice.org.uk/usingguidance/commissioningguides/integratedcommissioningforpreventionofcvd/CardiovascularDisease.jsp>

NICE Clinical Guidance 127 (2011) – Hypertension

<http://www.nice.org.uk/guidance/CG127>

NICE Clinical Guideline 107 (updated 2011): Hypertension in pregnancy

<http://publications.nice.org.uk/hypertension-in-pregnancy-cg107>

NICE Quality Standard 2 (2010) – *Stroke in adults*

<http://www.nice.org.uk/guidance/qualitystandards/stroke/strokequalitystandard.jsp>

NICE Public Health Guidance 25 (2010) - *Prevention of cardiovascular disease*

<http://guidance.nice.org.uk/PH25>

NICE Public Health Guidance 15 (2008) – *Identifying and supporting people most at risk of dying prematurely*

<http://guidance.nice.org.uk/PH15>

NICE Clinical Guideline 68 (2008): *Stroke – diagnosis and initial management of acute stroke and transient ischaemic attack*

<http://publications.nice.org.uk/stroke-cg68>

UK National Screening Committee – UPDATED The Handbook for Vascular Risk Assessment, Risk Reduction and Risk Management (2012)

<http://www.screening.nhs.uk/publications>

Diabetes

NHS Diabetes Prevention Programme (NHS DPP) Non-diabetic hyperglycaemia

Produced by: National Cardiovascular Intelligence Network (NCVIN) August 2015

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456149/Non_diabetic_hyperglycaemia.pdf

NICE Guidance 17 (2015) - *Type 1 Diabetes in Adults: diagnosis and management*

<http://www.nice.org.uk/guidance/NG17>

NICE Guidance 18 (2015) - *Diabetes (type 1 and type 2) in children and young people: diagnosis and management*

<http://www.nice.org.uk/guidance/NG18>

NICE Guidance 19 (2015) – *Diabetic Foot Problems (prevention and management)*

<http://www.nice.org.uk/guidance/NG19>

NICE Guidance 3 (2015) – *Diabetes in Pregnancy: management from pre-conception to the post-natal period*

<http://www.nice.org.uk/guidance/NG3>

NICE Public Health Guidance 38 (2012) – *Preventing type 2 diabetes: risk identification and interventions for individuals at high risk*

<http://www.nice.org.uk/guidance/PH38>

NICE Public Health Guidance 35 (2011) – *Preventing type 2 Diabetes*

<http://guidance.nice.org.uk/PH35>

NICE Quality Standard 6 (2011) - *Diabetes in Adults*

<http://www.nice.org.uk/guidance/qs6>

NICE Clinical Guideline 87 (2009) - *Type 2 diabetes (newer agents)*

<http://guidance.nice.org.uk/CG87>

NICE Clinical Guideline 66 (2008) – *Type 2 Diabetes*

<http://guidance.nice.org.uk/CG66>

Drug Misuse

Hidden Harm; Responding to the needs of children of problem drug users. Advisory Council on the Misuse of Drugs (2003).

<http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/hidden-harm-full>

Pathways to Problems - Hazardous use of tobacco, alcohol and other drugs by young people in the UK and its implications for policy. Advisory Council on the Misuse of Drugs (September 2006).

http://www.drugequality.org/files/Pathways_to_Problems_2006.pdf

Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12: Sweep 8 report. Hay G et al. The Centre for Public Health, Liverpool John Moores University

<http://www.nta.nhs.uk/uploads/estimates-of-the-prevalence-of-opiate-use-and-or-crack-cocaine-use-2011-12.pdf>

Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales (2nd Edition). Home Office (July 2012). Crown Copyright

<http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/drugs-misuse-dec-1112/>

NICE Public Health Guideline 52 (2014) - *Needle and syringe programmes*

<http://www.nice.org.uk/guidance/ph52>

NICE Quality Standard 23 (2012) - *Drug use disorders*

<http://publications.nice.org.uk/quality-standard-for-drug-use-disorders-qs23>

NICE Quality Standard 11 (2011) – *Alcohol use disorders: diagnosis and management*

<http://www.nice.org.uk/guidance/qs11>

NICE Public Health Guideline 24 (2010) – *Alcohol use disorders: prevention*

<http://www.nice.org.uk/guidance/ph24>

NICE Public Health guidance 4 (2007) – *Interventions to reduce substance misuse among vulnerable young people*

<http://guidance.nice.org.uk/PH4>

NICE Clinical guideline 51(2007) - *Drug misuse: psychosocial interventions*

<http://www.nice.org.uk/guidance/cg51>

NICE Clinical guideline 52 (2007) - *Drug misuse: opioid detoxification*

<http://publications.nice.org.uk/drug-misuse-opioid-detoxification-cg52>

Substance Misuse Needs Assessment 2015

(contact: Anita.Houghton@bromley.gov.uk)

Education

Legislation:

Academies Act 2010 (July 2010)

www.legislation.gov.uk/ukpga/2010/32/contents

Education Act 2011 (November 2011)

www.legislation.gov.uk/ukpga/2011/21/contents

White Papers:

The Higher Education White Paper (2011), *Students at the Heart of the System*, Department for Business, Innovation and Skills

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/31384/11-944-higher-education-students-at-heart-of-system.pdf

The School White Paper (2010), *The Importance of Teaching*, Department for Education

www.education.gov.uk/schools/teachingandlearning/qualifications/alevels/b0068570/the-importance-of-teaching/

Support and aspiration: A new approach to special educational needs and disability
Progress and next steps

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/180836/DFE-00046-2012.pdf

Policy, Statutory Guidance and Reviews:

Early Education and Child Care Information, Department for Education
www.education.gov.uk/childrenandyoungpeople/earlylearningandchildcare/

The Bew Review of Key Stage 2 Testing, Assessment and Accountability (2011),
Department for Education
www.education.gov.uk/ks2review

The Tickell Review of the Early Years Foundation Stage (2011), *The Early Years:
Foundations for life, health and learning*, Department for Education
www.education.gov.uk/tickellreview

The Wolf Review of Vocational Education for 14- to 19-year-olds (2011), Department
for Education
www.education.gov.uk/16to19/qualificationsandlearning/a0074953/review-of-vocational-education-the-wolf-report

NICE Public Health guidance 12 (2008): *Social and emotional wellbeing in primary
education*

<http://guidance.nice.org.uk/PH12>

NICE Public Health guidance PH20 (2009): *Social and emotional wellbeing in
secondary education*

<http://guidance.nice.org.uk/PH20>

NICE Public Health guidance 23 (2010) - *Smoking prevention in schools*
<http://guidance.nice.org.uk/PH23>

End of Life Care

End of Life Care Strategy, 2014

http://www.ncpc.org.uk/sites/default/files/End%20of%20Life%20Care%20Strategy%20New%20Ambitions%20Report_WEB.pdf

Actions for End of Life Care: 2014-16

<http://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf>

End of Life Care Profiles

<http://fingertips.phe.org.uk/profile/end-of-life>

Excess Winter Deaths

ONS 2014. Excess Winter Mortality in England and Wales, 2013/14 (Provisional) and 2012/13 (Final).

<http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/2013-14--provisional--and-2012-13--final-/index.html>

NICE 2015. Excess winter deaths and morbidity and the health risks associated with cold homes (NICE guideline)

<http://www.nice.org.uk/guidance/ng6/resources/excess-winter-deaths-and-morbidity-and-the-health-risks-associated-with-cold-homes-51043484869>

NICE evidence reviews related to NICE guidance above:

- Evidence review 1: Factors determining vulnerability to winter- and cold-related mortality/morbidity
- Evidence review 2: Interventions and economic studies
- Evidence review 3: Delivery and implementation of approaches for the prevention of excess winter deaths and morbidity

All available from <http://www.nice.org.uk/guidance/NG6/evidence>

PHE 2014. Cold weather plan for England 2014.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365756/CWP_2014.pdf

Health Inequalities

Marmot, M (2010) Fair Society, Healthy Lives: Strategic review of health inequalities in England post 2010

<http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

Health Profiles

Health Profile 2015 Bromley

<http://www.apho.org.uk/resource/view.aspx?RID=50215&LA=50146&SPEAR=>

Community Mental Health Profile 2014

<http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp>

Bromley CVD Profile 2014

<http://fingertips.phe.org.uk/profile/cardiovascular>

Bromley Diabetes Prevalence Profile 2013

<http://fingertips.phe.org.uk/diabetes>

End of Life Care Profiles for CCGs and Local Authorities

http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/

Bromley Learning Disability Profile 2013

<http://fingertips.phe.org.uk/profile/learning-disabilities>

Bromley Maternity Profile 2011

<http://www.londonhp.nhs.uk/wp-content/uploads/2012/03/Bromley.pdf>

Bromley Stroke Pathway Profile 2012

<http://www.londonhp.nhs.uk/wp-content/uploads/2012/12/Bromley-stroke-2012.pdf>

Local Alcohol Profiles for England 2015

<http://fingertips.phe.org.uk/profile/local-alcohol-profiles>

Child Health Profile 2014

<http://www.chimat.org.uk/default.aspx?RID=102616>

London Wellbeing Scores-Ward Level

<http://data.london.gov.uk/datastore/package/london-ward-well-being-scores>

Health & Wellbeing Strategy

Bromley Health and Wellbeing Strategy 2012 -2015

<http://bromley.mylifeportal.co.uk/content/doc.aspx?id=3077>

Immunisation

NICE Public Health Guidance 21 (2009) – *Immunisations: reducing differences in uptake in under 19s*

<http://guidance.nice.org.uk/PH21>

Learning Disabilities

NICE Quality Standard 101 (2015) *Learning Disabilities: Challenging behaviour*

<http://www.nice.org.uk/guidance/qs101>

NICE Guidance 11 (2015) *Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges*

<http://www.nice.org.uk/guidance/ng11>

NICE Quality Standard 53 (2014) *Autism*

<http://www.nice.org.uk/guidance/qs53>

[Home Office, an overview of Hate Crime in England and Wales](#)

[Confidential Enquiry into premature deaths of people with Learning Disabilities \(CIPOLD\) - Final Report](#)

Maternity

NICE Quality Standard 98 (2015) – *Maternal and child nutrition*

<http://www.nice.org.uk/guidance/qs98>

NICE Quality Standard 37 (2013) – *Postnatal Care*

<http://www.nice.org.uk/guidance/qs37>

NICE Quality Standard 35 (2013) - *Hypertension in Pregnancy*

<http://publications.nice.org.uk/hypertension-in-pregnancy-qs35>

NICE Public Health guidance 40 (2012) - *Social and emotional wellbeing – early years*

<http://guidance.nice.org.uk/PH40>

NICE. Quality Standard 22 (2012) – *Antenatal Care*

<http://guidance.nice.org.uk/QS22>

NICE Public Health guidance 26 (2010): *Quitting smoking in pregnancy and following childbirth*

<http://www.nice.org.uk/ph26>

NICE Public Health Guidance 27 (2010): *Weight Management before, during and after pregnancy*

<http://publications.nice.org.uk/weight-management-before-during-and-after-pregnancy-ph27>

NICE Public Health guidance 11 (2008): *Maternal and child nutrition*

<http://www.nice.org.uk/guidance/ph11>

Mental Health

London Early Intervention Analysis 2015: Report for Bromley. NHS Strategic Clinical Networks, Benchmarking Network.

Bromley Psychosis Needs Assessment, Integrated Mental Health Programme, 2015. UCL Partners, Academic Health Science Partnership.

Joint Commissioning Panel for Mental Health. Guidance for commissioners of Primary Mental Health Care Services.

Department of Health. Closing the Gap: Priorities for essential change in Mental Health. 2014. Department of Health.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

Preventing Suicide in England: One year on, first annual report on the cross-government outcomes strategy to save lives. 2014. HM Government.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278119/Annual_Report_FINAL_revised.pdf

Mental Health Crisis Care Concordat-Improving outcomes for people experiencing mental health crisis. 2014 HM Government.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

Department of Health. Prime Minister's challenge on Dementia-delivering major improvements in dementia care and research by 2015.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215101/dh_133176.pdf

No health without mental health - A cross-government mental health outcomes strategy for people of all ages 2011

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

Dementia Needs Assessment 2012, Bromley Public Health Department

<http://bromley.mylifeportal.co.uk/content/doc.aspx?id=3080>

No Health without Public Mental Health, Royal College of Psychiatrists

<http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/nohealthwithout.aspx>

Long term Conditions and Mental Health – The Cost of co-morbidities February 2012

<http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health>

Mental Health and Wellbeing Needs Assessment, Bromley Public Health Department
(contact: Paula.Morrison@bromley.gov.uk)

Suicide Audit 2013, Bromley Public Health Department

<http://bromley.mylifeportal.co.uk/content/doc.aspx?id=3080>

Self-Harm in Bromley Report, Bromley Public Health Department

(contact: Paula.Morrison@bromley.gov.uk)

Annual Public Health Report 2010 – Happy and Healthy. Children and Young People in Bromley

<http://bromley.mylifeportal.co.uk/content/doc.aspx?id=10284>

Mental Health Strategy for Bromley 2012-2015

(contact: Paula.Morrison@bromley.gov.uk)

Talking therapies: A four-year plan of action. A supporting document to No health without mental health. A cross-government mental health outcomes strategy for people of all ages.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123985.pdf

Sainsbury Centre for Mental Health (2003) The economic and social costs of Mental Illness, Policy paper three

http://www.centreformentalhealth.org.uk/pdfs/costs_of_mental_illness_policy_paper_3.pdf

NICE Quality Standard 95 (2015) *Bipolar Disorder in Adults*

<http://www.nice.org.uk/guidance/qs95>

NICE Quality Standard 88 (2015) *Personality Disorders: Borderline and antisocial*

<http://www.nice.org.uk/guidance/qs88>

NICE Quality Standard 80 (2015) *Psychosis and Schizophrenia in Adults*

<http://www.nice.org.uk/guidance/qs80>

NICE Quality Standard 53 (2014) *Anxiety disorders*

<http://publications.nice.org.uk/anxiety-disorders-qs53>

NICE Quality Standard 34 (2013) *Self Harm*

<http://www.nice.org.uk/guidance/qs34>

NICE Quality Standard 30 (2013) *Dementia: Independence and Wellbeing*

<http://www.nice.org.uk/guidance/qs30>

NICE Quality standard 14 (2011): *Service user experience in adult mental health*

<http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-health-qs14>

NICE Quality Standard 8 (2011) - *Depression in adults*

<http://www.nice.org.uk/guidance/qualitystandards/depressioninadults/home.jsp>

NICE Clinical Guideline 123 (2011) – *Common mental health problems: identification and pathways to care*

<http://www.nice.org.uk/guidance/cg123>

NICE Clinical Guideline CG113 (2011) – *Generalised anxiety disorder and panic disorder in adults: management*

<http://www.guidance.nice.org.uk/CG113>

NICE Clinical Guideline 90 (2010) - *Depression in Adults (update)*

<http://guidance.nice.org.uk/CG90>

NICE Public Health Guidance 22 (2009) – Promoting mental well-being at work

<http://guidance.nice.org.uk/PH22>

NICE Public Health Guidance 16 (2008) – *Mental Wellbeing and Older People*

<http://guidance.nice.org.uk/PH16>

NICE Clinical Guideline 28 (2005) - *Depression in children and young adults*

<http://guidance.nice.org.uk/CG28>

NICE Clinical Guideline CG113 – Anxiety

Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care

<http://www.guidance.nice.org.uk/CG113>

London Health Programmes – Mental health services case for change for London

<http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/1.-Case-for-change-low-res.pdf>

Obesity – Adults and Children

Healthy Lives, Healthy People

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129334.pdf

Start Active, Stay Active

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128210.pdf

NICE Quality Standard 94 (2015) – *Obesity in children and young people: preventing and lifestyle weight management programmes*

<http://www.nice.org.uk/guidance/qs94>

NICE Quality Standard 6 (2011) - *Diabetes in adults*

<http://www.nice.org.uk/guidance/qualitystandards/diabetesinadults/diabetesinadultsqualitystandard.jsp>

NICE Clinical Guideline 189 (2014) – *Obesity: identification, assessment and management*

<http://www.nice.org.uk/guidance/cg189>

NICE Public Health guidance 47 (2013) – *Managing overweight and obesity in children and young people*

<http://publications.nice.org.uk/managing-overweight-and-obesity-among-children-and-young-people-lifestyle-weight-management-ph47>

NICE Public Health guidance 44 (2013) - *Physical activity: brief advice for adults in primary care*

<http://guidance.nice.org.uk/PH44>

NICE Public Health Guidance 46 (2013) - *BMI and waist circumference: black, Asian and minority ethnic groups*

<http://guidance.nice.org.uk/PH46>

NICE Public Health Guidance 38 (2012) – *Preventing Type 2 Diabetes: Risk identification and interventions for individuals at high risk*

<http://guidance.nice.org.uk/PH38>

NICE Public Health guidance 41 (2012) - *Walking and cycling*

<http://guidance.nice.org.uk/PH41>

NICE Public Health guidance 42 (2012) – *Obesity: working with local communities*

<http://publications.nice.org.uk/obesity-working-with-local-communities-ph42>

NICE Public Health Guidance 35 (2011) – *Preventing Type 2 Diabetes: Community and population interventions*

<http://guidance.nice.org.uk/PH35>

NICE Public Health Guidance 27 (2010) – *Weight management before, during and after pregnancy*

<http://guidance.nice.org.uk/PH27>

NICE Public Health Guidance 17 (2009) – *Promoting physical activity for children and young people*

<http://guidance.nice.org.uk/PH17>

NICE Public Health Guidance 8 (2008) – *Physical activity and the environment*

<http://guidance.nice.org.uk/PH8>

NICE Public Health Guidance 11 (2008) - *Maternal and child nutrition*

<http://guidance.nice.org.uk/PH11>

NICE Public Health Guidance 13 (2008) – *Promoting physical activity in the workplace*

<http://guidance.nice.org.uk/PH13>

NICE Clinical Guideline 43 (2006) - *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children*

<http://guidance.nice.org.uk/CG43>

NICE Public Health Guidance 2 (2006) – *Four commonly used methods to increase physical activity*

<http://guidance.nice.org.uk/PH2>

The Royal College of Physicians – Action on obesity: *comprehensive care for all* (2013)

<http://www.rcplondon.ac.uk/sites/default/files/action-on-obesity.pdf>

The Information Centre - *National Child Measurement Programme - England, Publications*

<http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22national+child+measurement+programme%22&area=&size=10&sort=Relevance>

UK Physical Activity Guidelines (2013)

<http://www.nhs.uk/Livewell/fitness/Pages/physical-activity-guidelines-for-adults.aspx>

The School Food Plan – a series of actions to improve food in schools

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

Tackling Obesity through the Healthy Child Programme

http://www.noo.org.uk/uploads/doc/vid_4865_rudolf_TacklingObesity1_210110.pdf

Physical Activity Guidelines for Children (under 5 years)

<http://www.nhs.uk/Livewell/fitness/Pages/physical-activity-guidelines-for-children.aspx>

Physical Disabilities and Sensory Impairment – Hearing Impairment

[Hearing Matters, Action on Hearing Loss](#)

Poverty

Welfare Reform Act 2012

www.legislation.gov.uk/ukpga/2012/5/contents

The Welfare Reform White Paper (2010), *Universal Credit: welfare that works*, Department for Work and Pensions

www.dwp.gov.uk/policy/welfare-reform/legislation-and-key-documents/universal-credit/

Child Poverty Information

<https://www.gov.uk/childrens-services/child-poverty>

The Field Review on Poverty and Life Changes (2010), *The Foundation Years: Preventing Poor Children Becoming Poor Adults*, HM Government

<http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf>

The Strategy for Social Mobility (2011), *Opening Doors, Breaking Barriers: A Strategy for Social Mobility*, HM Government

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61964/opening-doors-breaking-barriers.pdf

Planning and Environment

Health Issues in Planning – Best Practice Guidance

<http://legacy.london.gov.uk/mayor/strategies/sds/docs/bpg-health.pdf>

London Plan 2011 and Revisions 2013 and 2015

<http://www.london.gov.uk/priorities/planning/londonplan>

The London Housing Strategy

<https://www.london.gov.uk/priorities/housing-land/draft-london-housing-strategy>

Travel In London Report No.7 (TfL 2014)

<http://content.tfl.gov.uk/travel-in-london-report-7.pdf>

National Planning Policy Framework 2012

<http://www.communities.gov.uk/documents/planningandbuilding/pdf/2116950.pdf>

NICE Public Health guidance 41 (2012) Walking and cycling – local measure to promote walking and cycling as forms of travel or recreation

<http://guidance.nice.org.uk/PH41>

NICE Public Health Guidance 30 (2010) *Preventing unintentional injuries among under-15s in the home: providing safety equipment and home risk assessments*

<http://www.nice.org.uk/guidance/PH30>

NICE Public Health Guidance 31 (2010) *Preventing unintentional road injuries among under-15s: road design*

<http://guidance.nice.org.uk/PH31>

NICE Public Health Guidance 29 (2009) Strategies to prevent unintentional injuries among under-15s

<http://www.nice.org.uk/guidance/PH29>

NICE Public Health Guidance 8 (2008) – Physical activity and the environment

<http://guidance.nice.org.uk/PH8>

Poverty

Welfare Reform Act 2012

www.legislation.gov.uk/ukpga/2012/5/contents

The Welfare Reform White Paper (2010), Universal Credit: welfare that works, Department for Work and Pensions

www.dwp.gov.uk/policy/welfare-reform/legislation-and-key-documents/universal-credit/

Child Poverty Information

<https://www.gov.uk/childrens-services/child-poverty>

The Field Review on Poverty and Life Changes (2010), *The Foundation Years: Preventing Poor Children Becoming Poor Adults*, HM Government

<http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf>

The Strategy for Social Mobility (2011), *Opening Doors, Breaking Barriers: A Strategy for Social Mobility*, HM Government

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61964/opening-doors-breaking-barriers.pdf

Public Health

Healthy lives, healthy people: our strategy for public health in England.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

Introduction to the Public Health Outcomes Framework 2013-2016

<https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>

Safeguarding and Social Care

Legal Aid, Sentencing and Punishment of Offenders Act 2012 (May 2012)

www.legislation.gov.uk/ukpga/2012/10/contents

The Offending Green Paper (2010), *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offending*, Ministry of Justice

<http://webarchive.nationalarchives.gov.uk/20120119200607/http://www.justice.gov.uk/consultations/docs/breaking-the-cycle.pdf>

The Special Educational Needs and Disabilities Green Paper (2011), *Support and aspiration: A new approach to special educational needs and disability*, Department for Education

<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/standard/publicationdetail/page1/cm%208027>

NICE Quality Standard 85 (2015) *Medicines Management in Care Homes*

<http://www.nice.org.uk/qs85>

NICE Quality Standard 50 (2013) *Mental wellbeing of older people in care homes*

<http://guidance.nice.org.uk/QS50>

NICE Quality Standard 30 (2013) *Supporting people to live well with Dementia*

<http://guidance.nice.org.uk/QS30>

NICE Quality Standard 31 (2013): *Health and wellbeing of looked-after children and young people*

<http://guidance.nice.org.uk/QS31>

NICE Quality Standard 1 (2010) *Dementia: support in health and social care*

<http://www.nice.org.uk/guidance/qs1>

NICE Public Health Guidance 28 (2010), *Looked-after children and young people*,

<http://guidance.nice.org.uk/PH28>

The Munro Review of Child Protection (2011), *A child-centred system*, Department for Education

www.education.gov.uk/munroreview

Adoption Information

<https://www.gov.uk/childrens-services/adoption>

Family Justice Review (2011), Ministry of Justice

<https://www.gov.uk/government/publications/family-justice-review-final-report>

Working Together to Safeguard Children 2015

<https://www.gov.uk/government/publications/working-together-to-safeguard-children-2>

Sexual Health & HIV

NICE Public Health guidance 51 (2014): Contraceptive services with a focus on young people up to the age of 25

<http://publications.nice.org.uk/contraceptive-services-with-a-focus-on-young-people-up-to-the-age-of-25-ph51>

NICE Public Health Guidance 43 (2012) Hepatitis B & C: testing people at risk of infection

<http://www.nice.org.uk/guidance/ph43>

NICE Public Health Guidance 33 (2011) - Increasing the uptake of HIV testing among black Africans in England

<http://guidance.nice.org.uk/PH33>

NICE Public Health Guidance 34 (2011) - Increasing the uptake of HIV testing among men who have sex with men

<http://guidance.nice.org.uk/PH34>

NICE Public Health Guidance 3 (2007) *Prevention of sexually transmitted infections and under-18 conceptions*

<http://guidance.nice.org.uk/PH3>

HIV Treatment for Overseas Visitors to England, Guidance for the NHS.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212952/DH-Guidance-HIV-and-NHS-Charging-fORMATED.pdf

HIV in the United Kingdom: HPA 2013 Report

<http://www.hpa.org.uk/Publications/InfectiousDiseases/HIVAndSTIs/1311HIVintheUk2013report/>

National Chlamydia Screening Programme

<http://www.chlamydia-screening.nhs.uk/>

Sexual and Reproductive Health Profiles, 2015

<http://fingertips.phe.org.uk/profile/sexualhealth>

Sexual and reproductive health in England: A guide to local and national data

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/395207/PHE_Guide_to_National_Local_Sexual_Reproductive_Health_Data.pdf

Smoking

NICE Quality Standard 92 (2015) *Smoking: Harm reduction*

<http://www.nice.org.uk/guidance/qs92>

NICE Quality Standard 82 (2015) *Smoking: reducing and preventing tobacco use*

<http://www.nice.org.uk/guidance/qs82>

NICE Quality Standard 43 (2013): *Smoking cessation – supporting people to stop smoking*

<http://publications.nice.org.uk/smoking-cessation-supporting-people-to-stop-smoking-qs43>

NICE Public Health guidance 45 (2013): Tobacco harm reduction

<http://guidance.nice.org.uk/PH45>

NICE Public Health guidance 48 (2013) - Smoking: acute, maternity and mental health services

<http://guidance.nice.org.uk/PH48>

NICE Public Health Guidance 39 (2012) - Smokeless tobacco: South Asian communities

<http://www.nice.org.uk/ph39>

NICE Public Health Guidance 23 (2010) – Smoking prevention in schools

<http://guidance.nice.org.uk/PH23>

NICE Public Health Guidance 26 (2010) – Quitting smoking in pregnancy and following childbirth

<http://guidance.nice.org.uk/PH26>

NICE Public Health Guidance 10 (2008) – *Stop Smoking services*

<http://guidance.nice.org.uk/PH10>

NICE Public Health Guidance 14 (2008) – *Smoking: preventing uptake in children and young people*

<http://guidance.nice.org.uk/PH14>

NICE Public Health Guidance 15 (2008) - *Identifying and supporting people most at risk of dying-prematurely*

<http://publications.nice.org.uk/identifying-and-supporting-people-most-at-risk-of-dying-prematurely-ph15/recommendations>

NICE Public Health Guidance 5 (2007) – Smoking: workplace interventions

<http://guidance.nice.org.uk/PH5>

NICE Technology Appraisal 123 (2007) – *Varenicline for smoking cessation*

<http://guidance.nice.org.uk/TA123>

NICE Public health Guidance 1 (2006) Smoking: brief interventions and referrals

<http://guidance.nice.org.uk/PH1>

The Royal College of Physicians and UK Centre for Tobacco Control Studies - *Fifty years since Smoking and health Progress, lessons and priorities for a smoke-free UK* (2012)

<http://www.rcplondon.ac.uk/sites/default/files/fifty-years-smoking-health.pdf>

Wellbeing

Measuring what matters. the new measures of national well-being being developed by the Office of National Statistics.

<http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/index.html>

20. Glossary

Acronym	Definition
A&E	Accident & Emergency
ACP	Advance Care Plan (End of Life Care)
ADHD	Attention Deficit Hyperactivity Disorder
AF	Atrial Fibrillation
AMD	Age related Macular Degeneration
B&B	Bed and Breakfast (Accommodation)
BESD	Behavioural, Emotional and Social Difficulties
BME	Black and Minority Ethnic
BPAS	British Pregnancy Advisory Service
C&RH	Contraception and Reproductive Health
CAMHS	Child and Adolescent Mental Health
CCG	Clinical Commissioning Group
CD4	Cluster of Differentiation 4 (Type of White Blood Cell)
CHD	Coronary Heart Disease
CHIMAT	Child and Maternal Health Observatory
CIPOLD	Confidential Enquiry into Premature Deaths of People with Learning Difficulties
CKD	Chronic Kidney Disease
CMC	Coordinate My Care (End of Life Care)
CMHP	Community Mental Health Profiles
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
COVER	Cover of Vaccination Evaluated Rapidly
CPA	Care Programme Approach (Mental Health)
CPN	Community Psychiatric Nurse
CSU	Commissioning Support Unit
CVA	Cerebrovascular Accident
CVD	Cardiovascular Disease
DfE	Department for Education
DFLE	Disability-Free Life Expectancy
DM	Diabetes mellitus
DNaCPR	Do Not Attempt Cardiopulmonary Resuscitation
DSH	Deliberate Self Harm
DSR	Directly Standardised Rate
DTaP	Diphtheria, Tetanus and Pertussis Vaccine
ECH	Extra Care Housing
EHC	Education, Health and Care
EIT	Early Intervention Team
ENT	Ear Nose and Throat

Acronym	Definition
EoLC	End of Life Care
ETE	Education, Training and Employment
EWD	Excess Winter Deaths
EWDI	Excess Winter Deaths Index
EYFS	Early Years Foundation Stage
FE	Further Education
FSM	Free School Meals
GCSE	General Certificate of Secondary Education
GLA	Greater London Authority
GOSH	Great Ormond Street Hospital
GP	General Practitioner
GSF	Gold Standards Framework
GUM	Genitourinary Medicine
HbA1C	Glycosylated Haemoglobin
HCAI	Healthcare Associated Infection
HCAI	Homes and Communities Agency (Housing)
Hib	Haemophilus influenza type b
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSCIC	Health and Social Care Information Centre
IAPT	Improving Access to Psychological Therapies
ICP	Integrated Care Plan
IDAOPi	Income Deprivation Affecting Older People Index
IPV	Inactivated Polio Vaccine
JCVI	Joint Committee on Vaccination and Immunisation
JSNA	Joint Strategic Needs Assessment
KCH	King's College Hospital
KS 1-4	Key Stage 1-4
KS1	Key Stage 1
LA	Local Authority
LAAC	Looked After and Adopted Children
LAC	Looked After Children
LARC	Long Acting Reversible Contraception
LAS	London Ambulance Service
LBB	London Borough of Bromley
LGA	Large for Gestational Age
LHO	London Health Observatory
LOCSU	Local Optical Committee Support Unit
LRTI	Lower Respiratory Tract Infection
LTBR	London TB Register
LTC	Long Term Condition

Acronym	Definition
MASH	Multi Agency Support Hub
MenC	Meningitis C
MMR	Measles Mumps and Rubella vaccine
MRSA	Multi Resistant Staphylococcus aureus
MSI	Marie Stopes International
MSM	Men who have Sex with Men
MSOA	Middle Layer Super Output Area
NAATS	Nucleic Acid Amplification Tests
NCISH	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
NCMP	National Child Measurement Programme
NCSP	National Chlamydia Screening Programme
NDHG	Non-Diabetic Hyperglycaemia
NDTMS	National Drug Treatment Monitoring Service
NEET	Not in Employment, Education or Training
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NOIDS	Notification of Infectious Diseases
NPS	New Psychoactive Substances
NTORS	National Treatment Outcomes Research Study
NWPHO	North West Public Health Observatory
ONS	Office for National Statistics
OT	Occupational Therapist
OTC	Over The Counter
PCMD	Primary Care Mortality Data
PCV	Pneumococcal Conjugate vaccine
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PID	Pelvic Inflammatory Disease
PiL	Payments in Lieu
PMLD	Profound and Multiple Learning Disabilities
PMS	Personal Medical Services (GP Contract)
POCT	Point of Care Testing
POM	Prescription Only Medicine
POPPI	Projecting Older People Population Information System
PPV	Pneumococcal Vaccine
PRUH	Princess Royal University Hospital
QMH	Queen Mary's Hospital
QOF	Quality and Outcomes Framework (GP Contract)
R&M	Routine and Manual (Employment)
RAG	Red Amber Green (Traffic Light Rating)

Acronym	Definition
RP	Registered Providers
RRT	Renal Replacement Therapy
SAP	Standard Assessment Procedure (home energy rating)
SDQ	Strengths and Difficulties Questionnaire
SED	Socioeconomic Deprivation
SELHP	South East London Housing Partnership
SELHPT	South East London Health Protection Team
SEMH	Social, Emotional and Mental Health Needs
SEN	Special Educational Needs
SEND	Special Educational Needs and Disability
SHIP	Sexual Health in Primary Care
SHLAA	Strategic Housing Land Availability Assessment
SHS	Second Hand Smoke
SIDS	Sudden Infant Death Syndrome
SII	Slope Index of Inequality
SLCN	Speech, Language and Communication Needs
SMI	Serious Mental Illness
SMR	Standardised Mortality Ratio
SRE	Sex and Relationship Education
STI	Sexually Transmitted Infection
SUS	Secondary Users Service (Hospital Data)
TB	Tuberculosis
TIA	Transient Ischaemic attack
TOP	Termination of Pregnancy
TWR	Two Week Referral
TYSS	Targeted Youth Support Service
UASC	Unaccompanied Asylum Seekers
UCC	Urgent Care Centre
UCL	University College London
UTI	Urinary Tract Infection
VMO	Visiting Medical Officer
VTEC	Vero cytotoxin-producing Escherichia coli