BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2010

Bromley Joint Strategic Needs Assessment 2010

Foreword

NHS Bromley and the London Borough of Bromley in partnership are pleased to present this year's JSNA, which brings the information on the health and well being of Bromley residents up to date and highlights areas which need to be developed.

Summaries of in depth analyses of each of the following issues are included with recommendations for further action:

- Learning Disability and Autism Spectrum Disorder
- End of Life Care
- Substance Misuse
- Alcohol Use, Prevention & Treatment
- Childhood Immunisation
- Pharmaceutical Services

The annual JSNA reports are proving a valuable tool in developing and planning improvements in services. To illustrate this, we have included updates on the recommendations from last year's JSNA

We hope that you will find the JSNA a useful source of information.

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INTRODUCTION

The Joint Strategic Needs Assessment (JSNA) describes a process that identifies current and future health and wellbeing needs in the light of existing services, and informs future service planning taking into account evidence of effectiveness.

This JSNA report is divided into two main sections.
The first section brings together routinely available data to describe Bromley in the following terms:

- Demographics
- Social and environmental context
- Disease burden.

This section identifies health and well being priorities for future action.
The second section includes summaries of needs assessments and health equity audits that have been carried out through the year. The topic areas for these assessments and audits were identified through information analysis (as in the first section of the JSNA) and also through issues raised by the partnership groups involved with health and well being issues in Bromley.
Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.
Health equity audits aim to identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas. They aim to highlight the priority actions needed to provide services relative to need and so result in the recommendation of measures focused on reducing health inequalities.
The health needs assessments and health equity audits offer a more in depth analysis of particular health issues and include specific recommendations for action. The programme of needs assessments and health equity audits is ongoing and is constantly being updated.

The JSNA provides an objective analysis of local need which is also used to inform social care commissioning strategies. Demographic information, and the targeted needs assessments and equity audits of different groups and geographic areas help to identify where health issues are likely to result in demand for social care services.

For example the projected increase in the number of older people in the population, particularly in the over 80 age group, will impact on the need for more service to support people with dementia and in particular in the south of the borough where there is likely to be a more significant rise in numbers. As life expectancy for people with learning disabilities improves there is consequently more demand for social care services to support them through to older adulthood.

The JSNA provides the evidence base for joining together commissioning decisions across both health and social care in respect of health improvement, prevention, management of long term conditions, and rehabilitation, recovery and re-ablement services

Information relating to children and young people is limited in this year's JSNA, as the Annual Public Health Report for 2010 *Happy and Healthy* deals with issues relating to children and young people in Bromley. This report can be accessed at http://www.bromley.nhs.uk/your-health/annual-public-health-report . In addition, the needs of children and young people, including Looked After children and young people, are outlined in the Children and Young People's Needs Assessment which can be found at http://www.childrenstrust.bromleypartnerships.org/ .

Section 2 ends with an update on the recommendations from last year's JSNA and an introduction to the work planned for next year's JSNA.

1. SECTION 1

1.1 DEMOGRAPHIC OVERVIEW

Introduction

This chapter considers 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 (2010) estimate of the resident population of Bromley is 300,855, having risen by 5,280 since 2001
- This is expected to fall to 300,652 by 2015 and 299,492 by 2020.
- The number of 0 to 4 year olds will peak in 2011 to 29,173 but will then drop by 48% in 2031 to 15,236.
- The number of older people in Bromley is expected to increase from 19% of the population in 2010 to 20% by 2015 and 21.3% by 2020. There is predicted to be a rise in the population aged 80 years and over from 5.1% in 2010 to 5.8% in 2020.
- The pattern of population change in the different age groups is variable between wards, with some wards such as Bromley Town experiencing a large rise in the proportion of young people and Biggin Hill experiencing a large rise in the over 75s.
- The number of births has risen considerably in recent years and is likely to continue to do so.
- The latest (2008) estimates show 12.3% of the population are made up of BME groups; an increase from 8.4% in 2001.
- The BME group experiencing the greatest increase within Bromley's population is the Black African community, a 2.7% increase to 3.2% in 2025.

What does this mean for our JSNA?

Current needs: Older people and people with children are higher users of services and are more likely to need regular access to GP practices, hospitals, clinics, pharmacies, etc.

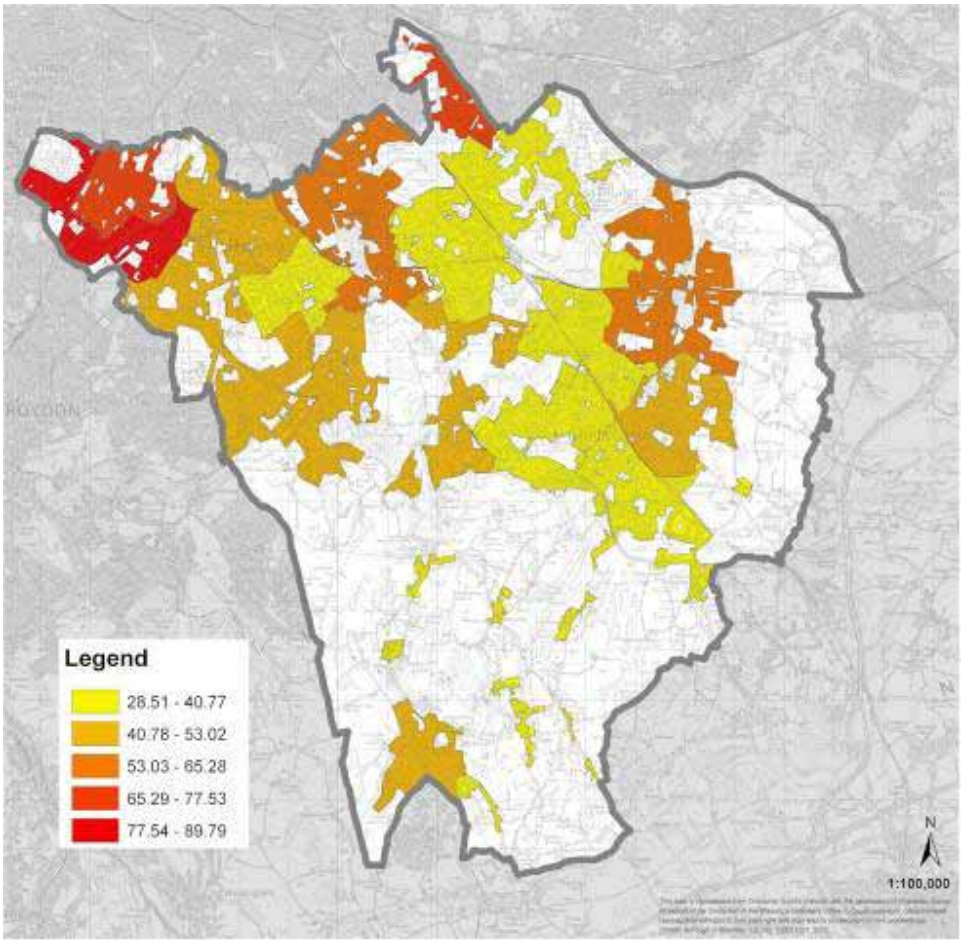
Current Picture

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. The population density of Bromley is 2,011 people per square kilometre. This compares with a population density of over 4,900 persons per square kilometre for London, which has a population density that is ten times that of the second most densely populated region in the UK.

Figure 1 Density, persons per hectare



Source: Information Department, London Borough of Bromley

Although Bromley is a relatively prosperous area, the communities within Bromley differ substantially. The northeast and northwest 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 Nature sites

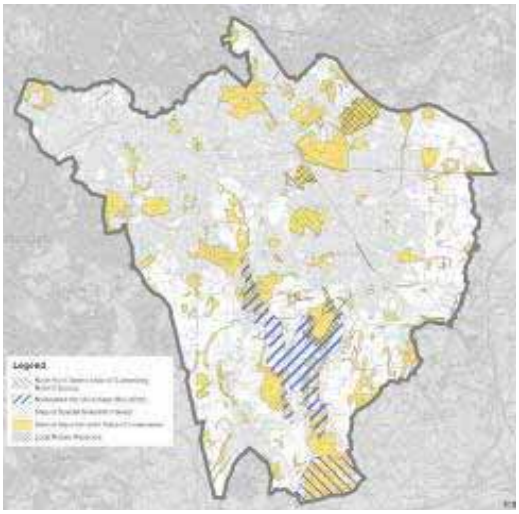
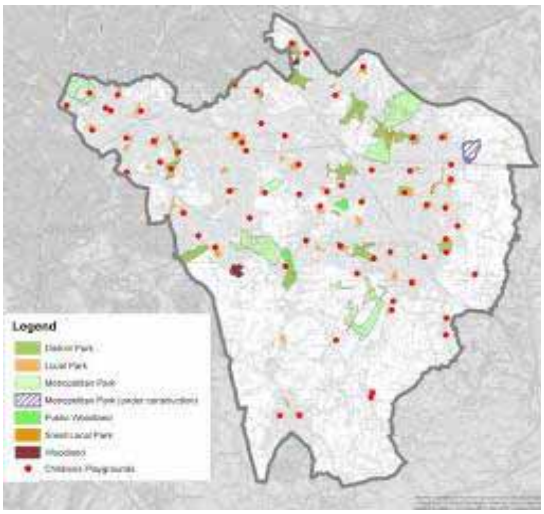


Figure 3 Public Parks & Open Spaces



Total Population

The latest (2010) estimate of the resident population is 300,855[1]. This compares with 320,807 registered with GPs in the borough (June 2010)[2]. The borough council is responsible for providing services to its residents. While the PCT is responsible for providing services to all of those who are registered with a Bromley GP regardless of where they live, it also has a responsibility for the health of the borough's residents at a population level. This chapter has used the Greater London Authority (GLA) resident population as its basis.

The population rose by 5,280 (1.8%) between 2001 and 2010. The main reasons for this increase are due to the increase of the number of births within the borough as well as migration of new entrants into the borough from Eastern Europe.

There is some variation of the population structure amongst the wards. Cray Valley West has the highest proportion of young people and Copers Cope the lowest. Chislehurst has the highest proportion of over 75s and Penge and Cator the lowest (table 1).

[1] GLA Mid-2009 Population Projections Borough SYA
[2] Primary Care Information System, Bromley PCT

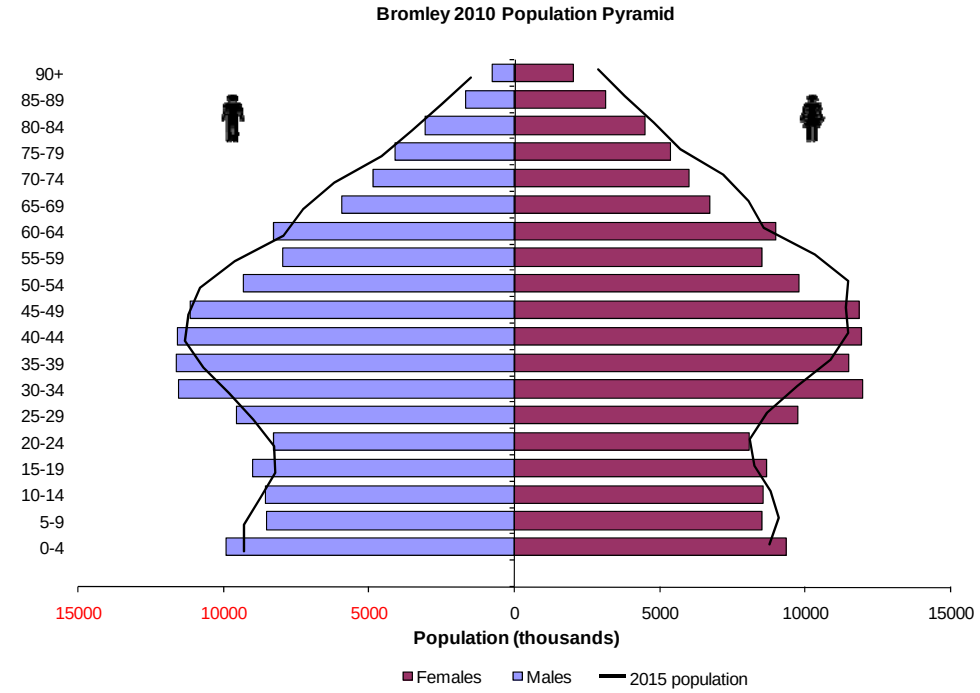
Table 1 Age structure across the wards in Bromley

	Percentage aged 0 to 19 yrs	Percentage aged >75 yrs
Bickley	23.8	9.9
Biggin Hill	26.2	5.7
Bromley Common and Keston	25.2	7.9
Bromley Town	21.3	6.8
Chelsfield and Pratts Bottom	25.7	8.3
Chislehurst	22.9	11.2
Clock House	23.0	5.7
Copers Cope	13.4	7.5
Cray Valley East	23.4	7.5
Cray Valley West	30.2	8.0
Crystal Palace	24.1	4.9
Darwin	20.6	8.4
Farnborough and Crofton	21.0	10.6
Hayes and Coney Hall	24.2	9.9
Kelsey and Eden Park	24.6	8.3
Mottingham and Chislehurst North	27.3	6.9
Orpington	24.1	9.8
Penge and Cator	26.5	3.8
Petts Wood and Knoll	22.8	9.5
Plaistow and Sundridge	23.1	7.3
Shortlands	19.9	10.2
West Wickham	25.6	10.9

Source: GLA Mid-2009 Population Projections

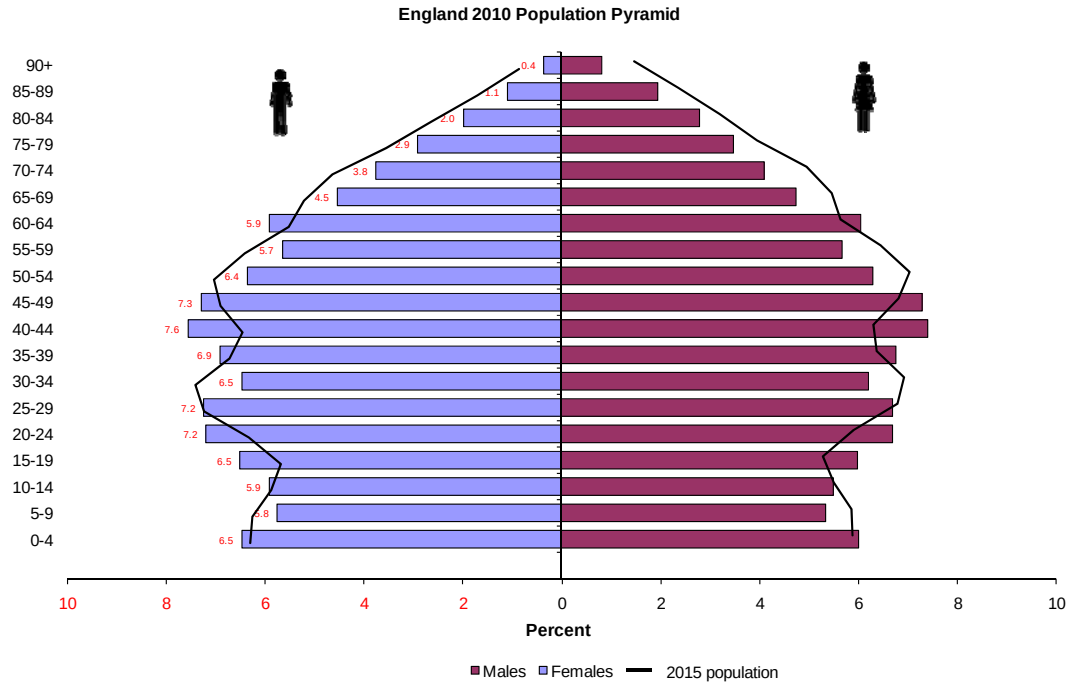
The age distribution of people in Bromley is very similar to that for England as a whole, as illustrated in the population pyramids (Figures 4 and 5).

Figure 4



Source: GLA 2009 Round Demographic Projections - RLP Low

Figure 5



Source: ONS 2008-based Subnational Population Projections

Population Projections

The population of Bromley is just over 300,000, and is projected to fall by 0.1% over the next 5 years. (Table 2).

Table 2

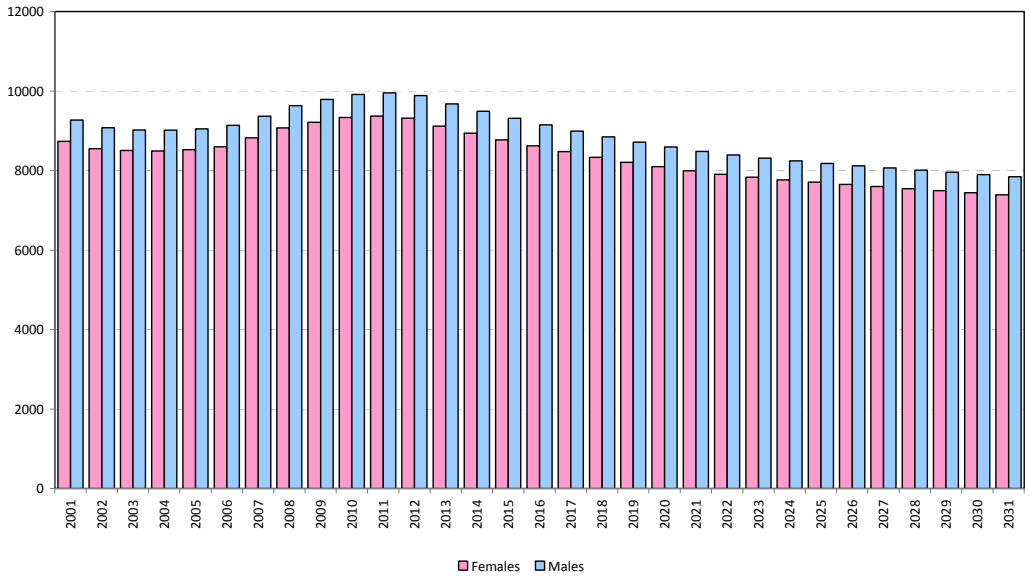
	2010	2015	2020
Total population	300,855	300,652	299,492
0 to 4y (%)	6.4%	6.0%	5.6%
5 to 10y (%)	6.8%	7.4%	7.0%
11 to 18y (%)	9.3%	8.7%	9.2%
Working Age (%)*	63.1%	62.3%	61.2%
Post Retirement (%)¥	19.0%	20.0%	21.3%
80y and over (%)	5.1%	5.4%	5.8%

Source: GLA 2009 Round Demographic Projections - RLP Low

* Working age =16 to 65y males and 16 to 60y females
¥ Post retirement = Over 60y females and over 65y males

The number of 0 to 4 year olds has gradually been increasing since 2004 and will peak in 2011 (29,173) but will then begin to decrease again, dropping by 48% in 2031.

Figure 6 Population projections of Bromley children aged 0-4 years



Source: GLA 2009 Round Demographic Projections - RLP Low

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 (Bromley Town is projected to have a 14% rise in this age group),

and others experiencing a large rise in the population of over 75s (Biggin Hill is projected to have a 40% increase in over 75s).
In contrast, the largest reduction in the under 20 year age group will be seen in Farnborough & Crofton (5%). For over 75s, the largest reduction will be in Cray Valley West (8%) (Figures 7 and 8).

Figure 7

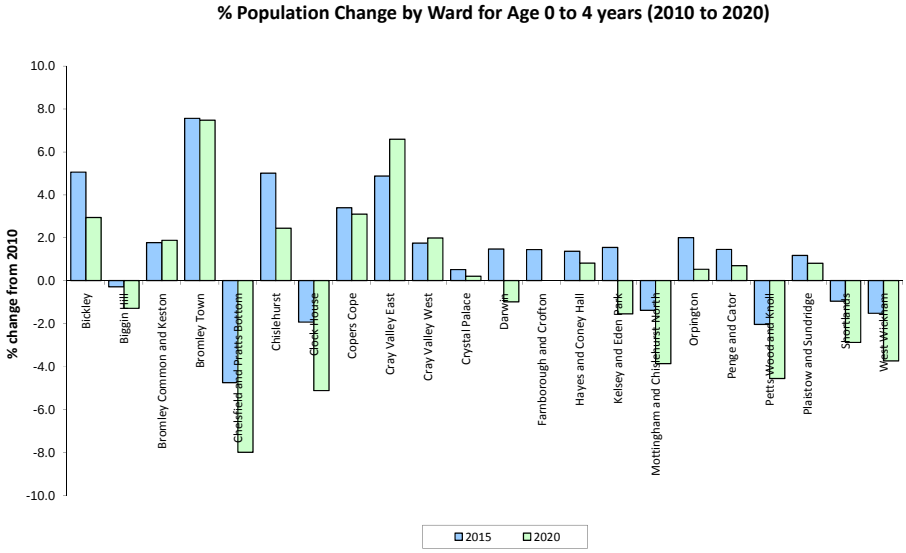
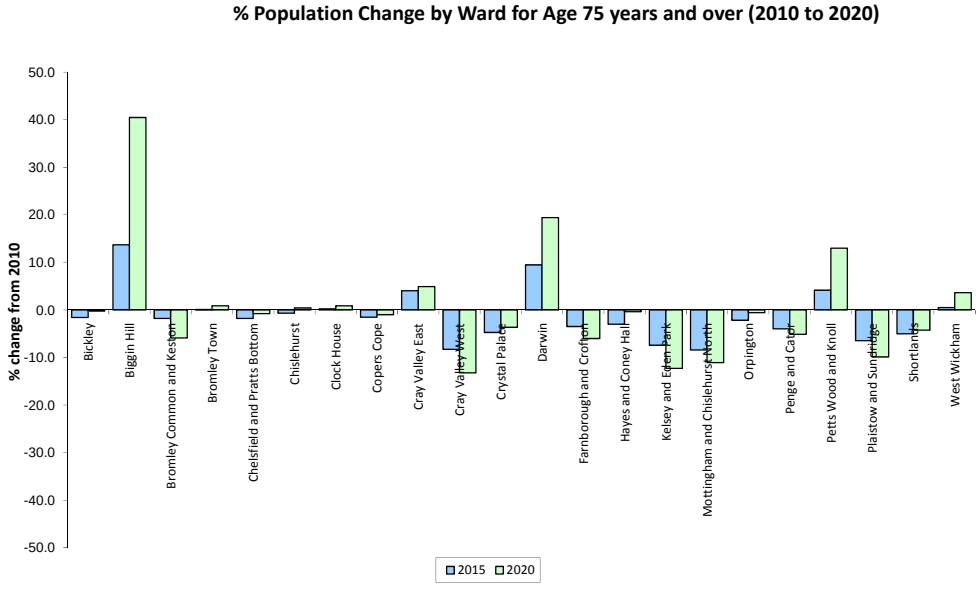


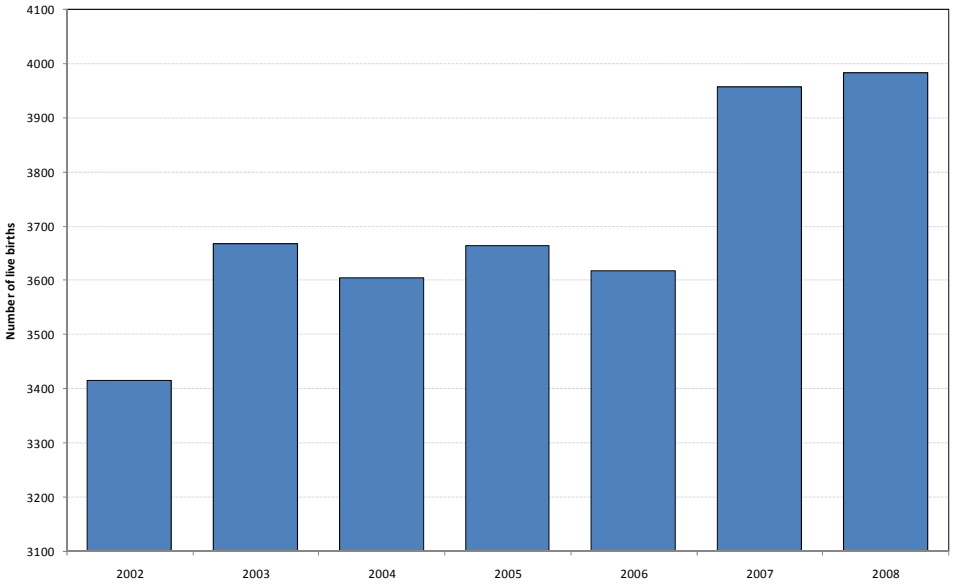
Figure 8



Source: GLA Mid-2008 Population Projections Low PLP

The number of live births in Bromley has been increasing over the last few years.

Figure 9 Number of live births in Bromley



Source: ONS Vital Statistics

What does this mean for our JSNA?

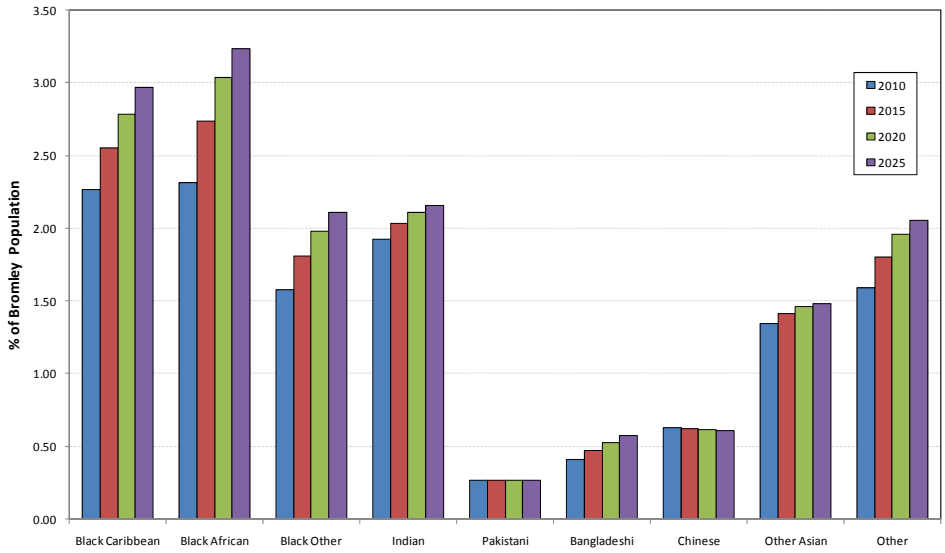
Current situation: The upper half of the borough is heavily populated. This increases pressure for land to become available as more housing and services are required for the population increase.
It is important to keep abreast of these changes as service provision may have to adapt to the needs of new communities.

Future situation: The rise in the number of 0 to 4 year olds in the next few years will have an impact on the provision of primary and secondary school places in the near future, and will also affect the usage of health services.

Ethnic groups

The proportion of the population represented by ethnic minority groups will rise from 12.3% in 2010 to 14.7% in 2020 (Figure 10). The greatest increase (2.7%) will be in the Black African group which will form 3.2% of the Bromley population by 2025.

Figure 10 Percentage of the Population by Ethnic Group



Data Source: GLA 2008 Round Demographic Projections - PLP Low

The 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.

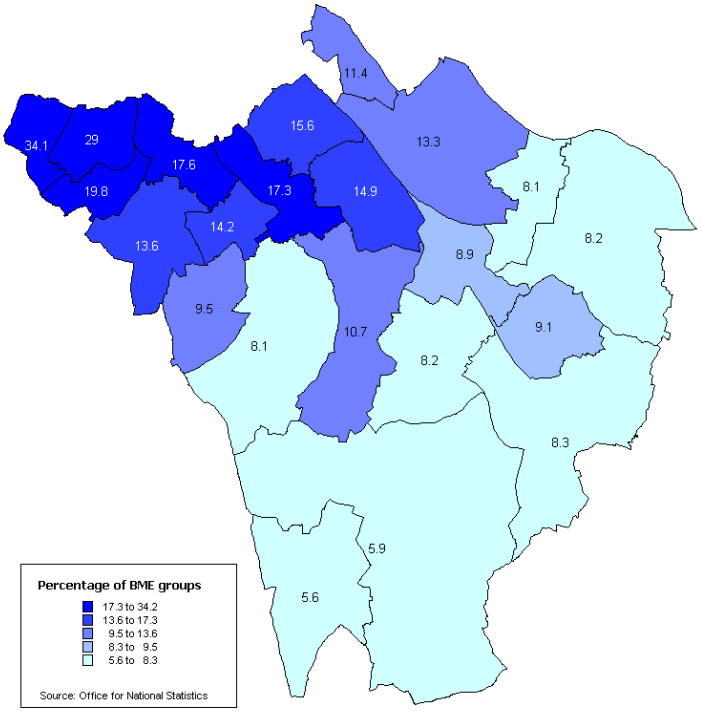
It is important to take account of the proportion of ethnic minorities in the population in planning health services in particular. There is strong evidence that the health experience of different ethnic groups is not uniform e.g. the percentage of the population that report their health as 'not good' 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.

Data from the 2001 census shows that the North West of Bromley has the highest proportion of ethnic minority population (Figure 11). We do not have projections for changes in population by ethnicity at ward level.

Figure 11 Percentages of BME Groups by Ward

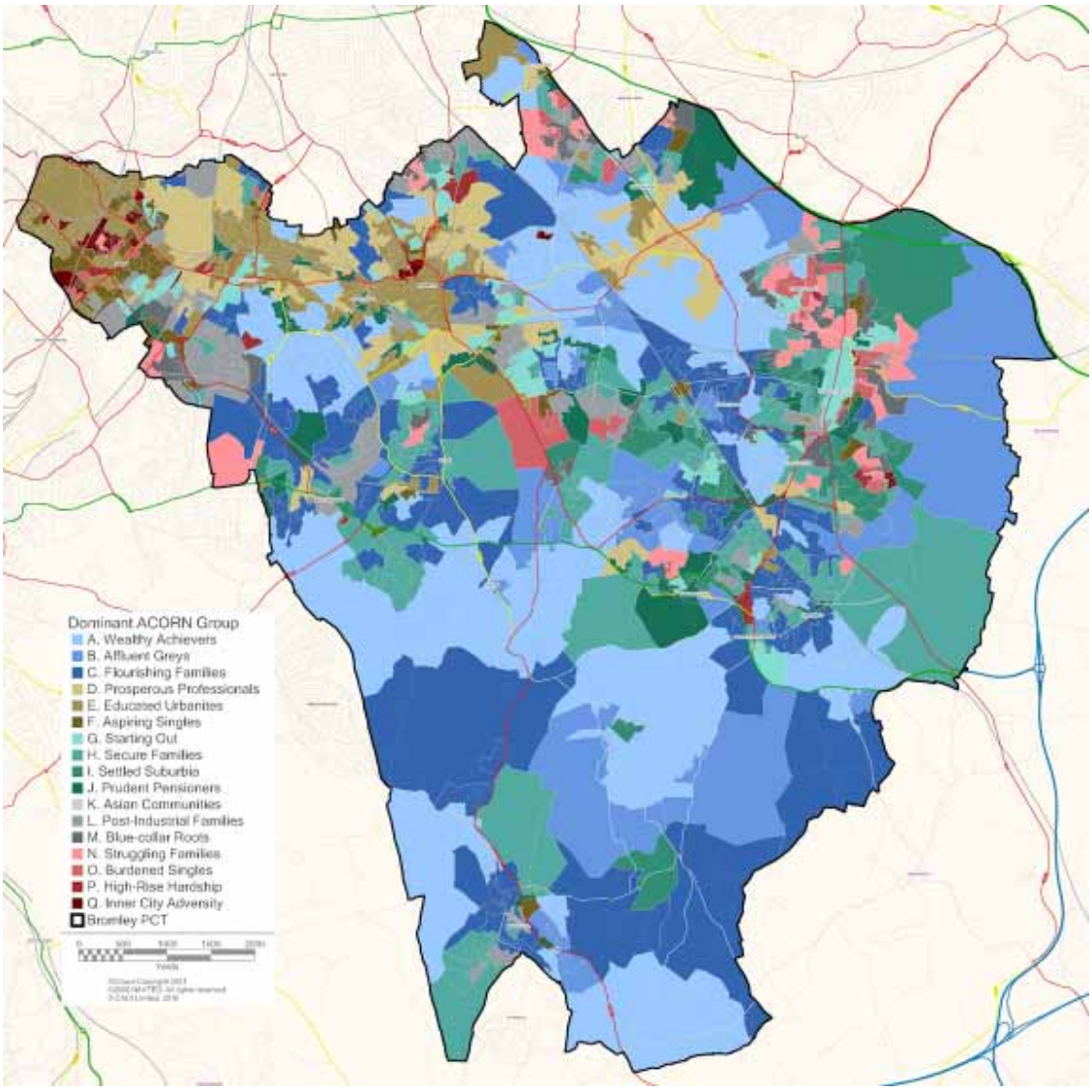


1.2 Geodemographic Segmentation

Geodemographic segmentation describes the classification of small areas and the use of geography to help us draw general conclusions about the characteristics and behaviours of the people who live in them. The underlying premise is that similar people live in similar places, do similar things and have similar lifestyles.

ACORN is a powerful, reliable consumer classification tool that provides categorised, detailed demographic data and lifestyle information for the UK and is used in the figure below to show the geodemographic makeup of the borough's population.

Figure 12 Geodemographic population of Bromley



Source: Acorn

Analysis of the Acorn dataset reveals that there are a number of dominant groups in Bromley – in particular:

- Group A (wealthy achievers)
- Group B (affluent greys)
- Group C (flourishing families)
- Group D (prosperous professionals)

Description of ACORN groups

Group A – Wealthy Achievers

These are some of the most successful and affluent people in the area. They live in wealthy, high-status rural, semi-rural and suburban areas. Middle-aged or older people predominate, with many empty nesters and wealthy retired. Some neighbourhoods contain large numbers of well-off families with school-age children particularly the more suburban locations.

These people live in large houses, which are usually detached with four or more bedrooms. Almost 90% are owner-occupiers with half of those owning their home outright. They are well educated and most are employed in managerial and professional occupations. Many own their own business.

Car ownership is high, with many households running two or more cars. Incomes are high, as are levels of savings and investments. There people are established at the top of the social ladder; they are healthy, wealthy and confident consumers.

Group B – Affluent Greys

These people tend to be older empty nesters and retired couples. Many live in rural towns and villages, often in areas where tourism is important. Others live in the countryside where the economy is underpinned by agriculture.

The Affluent Greys are prosperous, live in detached homes and many have two cars. Over the past five years, more of these people have been buying one, or more, second homes and now nearly one in six families will do so. Employment is typically in managerial and professional roles. Given the rural locations, there is also a significant number of farmers. Unemployment is low but rising faster than average, with skilled traders being badly hit.

These are high-income households and even those who have retired have good incomes. Since it contains older people, it is unsurprising that 10% of the income of this group is in the form of a pension – a significantly greater proportion than any other group. A further 12% of income comes from benefits of one form or another, perhaps for carers, the disabled, and incapacity benefit. Across the group as a whole benefit income is double the income derived from investments.

Group C – Flourishing Families

These are wealthy families with mortgages. They live in established suburbs, new housing developments around commuter towns, and villages and rural areas. Houses tend to be detached or larger semi-detached properties often with four bedrooms.

While these are generally family areas, there are also some empty nesters and better-off retired couples.

Flourishing Families are younger than other affluent groups, so most households are still likely to be making mortgage repayments.

Incomes are good, since many have managerial and professional occupations. These are the occupations that have suffered less from the rising unemployment in these areas. However, despite the rise, unemployment remains below average. Many will have cars, pensions and health cover provided by their employer. Car ownership is high and many of these families will have two or more cars.

They take regular holidays; some people are quite active, enjoying sports, playing golf or going to the gym. A number enjoy the countryside through activities such as walking or bird-watching.

Group D – Prosperous Professionals

These are the most prosperous people living in our borough. They are very well educated and tend to be employed in senior managerial and professional occupations. Bonuses are more likely to be part of people's income than in any other group. One in ten earns more than 10% of their income as bonuses. Working unpaid overtime is more frequent in this group than any other.

Households are a mix of families, couples, singles and some retired. Given the urban nature of these areas, property is a mix of terraced and detached houses, and converted and purpose-built flats. The houses tend to be large, with four or more bedrooms. Some of the flats are occupied by young professionals sharing.

Over 80% of the housing is owner-occupied, with mortgages tending to be larger than in any other areas.

These are affluent neighbourhoods so car ownership is high even if travel to work is often by public transport. Incomes are high and these individuals have high levels of savings and investments. Technologically sophisticated, they regularly use the internet for financial services, as well as buying other products and services.

They spend relatively large amounts on clothes and restaurants. More than half live within a mile of where they do food shopping and a third might walk to do their shopping. They are more likely to buy eco-friendly products and to want to help the environment. Having chosen an urban lifestyle, these consumers have the money and education to make the most of what London has to offer.

Health ACORN

Health ACORN data is geodemographic data but specifically based on health.

The largest Health Acorn group in Bromley is *Possible Future Concerns*, followed by the *Healthy* group. There are small proportions of the population in the *Existing* and *Future Problem* groups.

Description of Health ACORN groups

Group 1- Existing Problems

These areas cover a fifth of the population of the country and are places where the levels of illness are above average. The proportion of people with angina is 60% higher than average, the proportion who have suffered a heart attack 45% above average. The incidence of diabetes, high blood pressure and high cholesterol are also all above average, and this is the only group where this is the case.

This is to some extent due to the demographics of these areas, which are older and less well-off. The age profile shows more pensioners and fewer youngsters. Over the group, the level of social housing is double the national average.

The population includes more over-weight people than average and a few more smokers.

Group 2 - Future Problems

The areas classified as harbouring future problems do not generally have high incidence of existing illnesses. Exceptions to this are depression, asthma and migraine, which occur more in this group than any other.

The indicators of potential ill health are the high incidence of smoking and obesity compared to other groups. Diet tends to be poor. Relatively few people eat many vegetables, and the consumption of both fast food and sugary drinks is above average.

This group appear to be averse to stir frying as a method of food preparation.

In these areas the demographics include a younger age profile, more children, and above average levels of single people and single parents. Typically the levels of unemployment, low status employment and social housing are above average.

Group 3 - Possible Future Concerns

These are areas with lower levels of smoking, obesity and average, or slightly below average, incidence of illnesses. However diet, while not exceptionally poor, does sometimes give cause for concern. While consumption of vegetables is highest in this group so too is the consumption of fat, sugar and confectionery. These are areas of better-off, often older couples. The proportions of professionals and managers is above average. Car ownership is high and mortgages tend to be lower, or paid off.

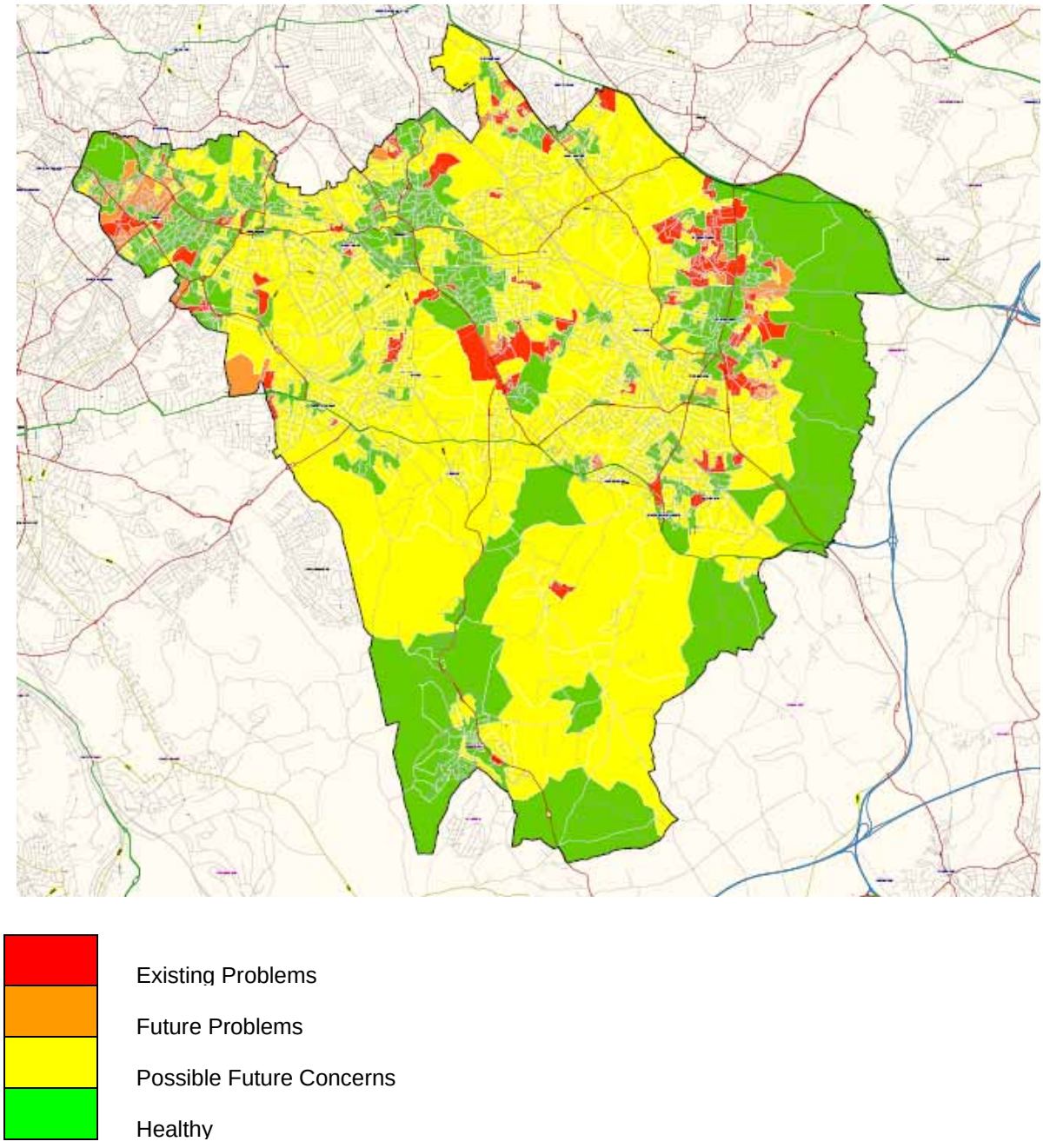
Group 4 - Healthy

The healthy areas tend to have a younger demographic with some singles and sharers.

As a result it is not surprising that the proportions of people with high blood pressure, angina, diabetes and high cholesterol are lower than average.

In addition to being younger and in relatively good health this group are likely to take more exercise and less likely to be smokers or overweight.

Figure 13 Health ACORN Groups



1.3 SOCIAL AND ENVIRONMENTAL CONTEXT

Introduction

This section outlines some of the factors affecting the social and environmental context within which the population of Bromley lives. It focuses on deprivation in the borough, issues around housing, employment and qualifications.

Summary

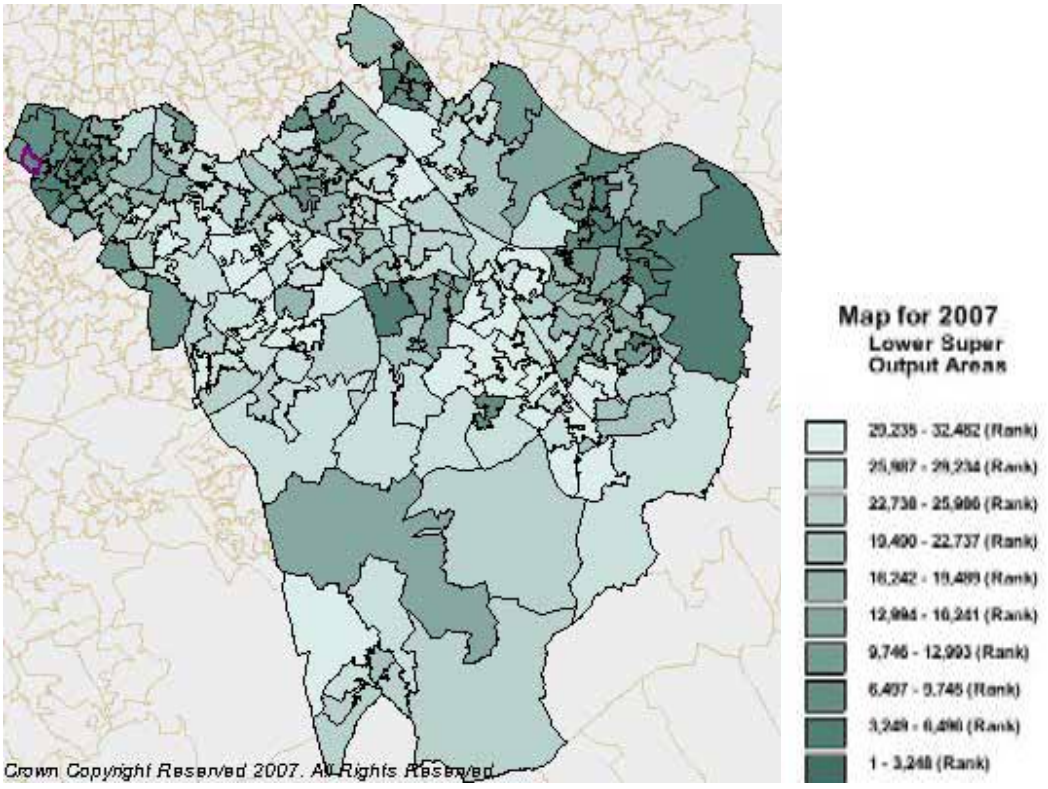
- Bromley is ranked 228th out of 354 local authorities in England in terms of deprivation (1st is the most deprived).
- Growth in the number of people of working age within Bromley is set to increase slightly over the next two years.
- 80.2% of Bromley's working age population is economically active[3].
- One third of the working age population are either managers or in professional occupations.
- The unemployment rate in Bromley has risen during the current recession, with numbers of unemployed rising from 4500 in 2007/08 to 8300 in 2008/09.
- There is higher unemployment in Penge and Cator, Crystal Palace and the Crays than in the rest of Bromley. These wards are also experiencing benefit claimant counts higher than the sub-regional average – and closer in level to the inner London wards.
- The current recession is likely to lead to an overall increase in deprivation of various types, but its precise effects cannot yet be known.
- The Borough has a relatively low-level density of development with 60% of the Borough being protected Greenbelt or Metropolitan Open Land.
- Over a third of all reported crime in Bromley is for Criminal Damage.

[3] Economically active refers to people who are aged 16 or over who are either in employment or actively seeking employment.

Deprivation and inequality

Although overall the borough is considered to be comparatively affluent, there are pockets of real deprivation evidenced by the Index of Multiple Deprivation (IMD) with contrasting conditions experienced not just between wards (figure 14), but also within wards at Super Output Area (SOA) level.

Figure 14 Index of Multiple Deprivation 2007



The most deprived areas of Bromley are in the north west of the borough, Mottingham and Chislehurst North, The Crays and Bromley Common. However, even within wards there is a range of deprivation between super output areas. Overall the Orpington ward has a relatively low level of deprivation – but there is an enormous range between the different SOAs within that ward – with some in the "worst" scoring category and others in the "best". A similar wide range can also be seen in the Bromley Common & Keston ward.

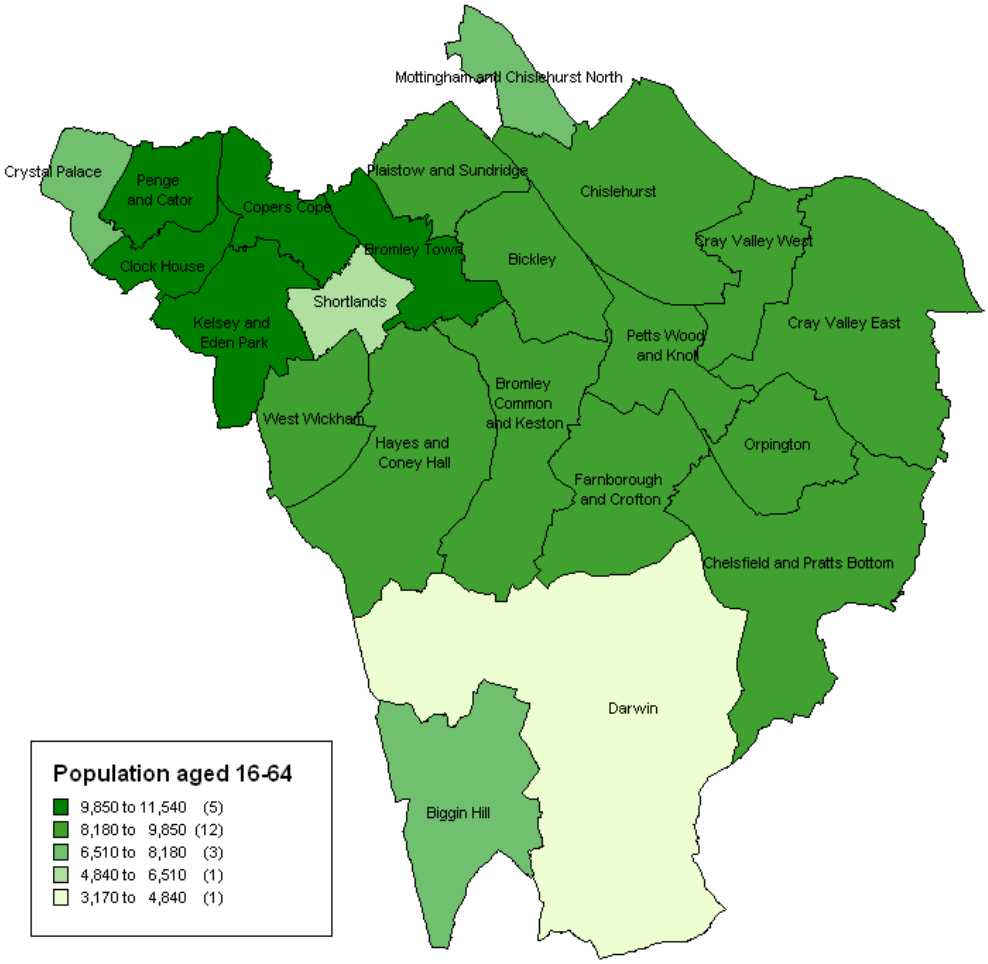
The Working Age Population

The working age population aged 16 to 64 years in Bromley numbers 195,593, representing 65% of the total population (300,242).

This sector of the population has grown steadily since 2001 with greater numbers of females than males, reflecting the increase in numbers of females generally within the local population. Growth in the number of people of working age within Bromley is set to increase slightly over the next two years and then reduce gradually over the period 2012 -2020 based upon the Greater London Authority population projections.

The geographical spread of Bromley's working age population is not uniform with greatest numbers seen in the areas around Penge and Cator, Clock House, Kelsey and Eden Park, Copers Cope and Bromley Town (Figure 15). Lowest numbers are seen in Darwin.

Figure 15 Distribution of the Working Age Population by Ward



Source: GLA Round Population Projections Low, GLA 2009

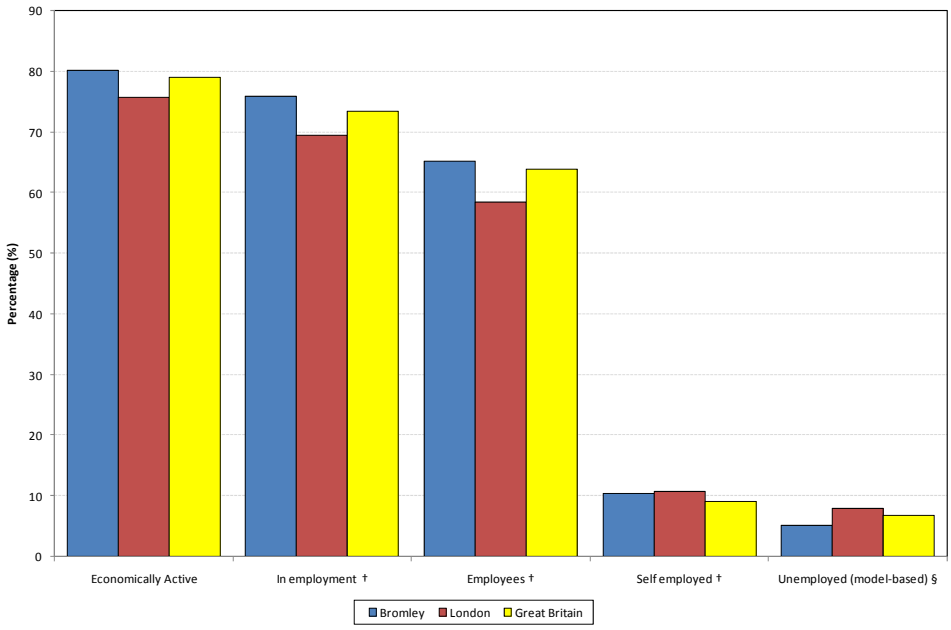
Employment Status

The majority (80.2%) of Bromley's working age population is economically active (Figure 16). Economical inactivity is defined as people who are neither in employment nor unemployed. This group includes, for example, all those who are looking after a home or retired, as well as carers.

Bromley's rate of economic activity is high in the London context (75.5% across London) and one of the highest in South London and has increased by 0.2% during the five years to 2008.

Of those who are economically active, 65.1% are employees, 10.4% are self employed and 5.1% are unemployed. The proportion of unemployed is lower than the rate for London (8%) and for Great Britain (6.8%).

Figure 16 Employment Status of Bromley Residents Compared with London and Great Britain (January to September 2009)



Source: ONS annual population survey

† numbers are for those aged 16 and over, % are for those of working age (16-59/64)
§ numbers and % are for those aged 16 and over. % is a proportion of economically active

Table 3: Economic activity amongst Bromley residents compared with South London boroughs

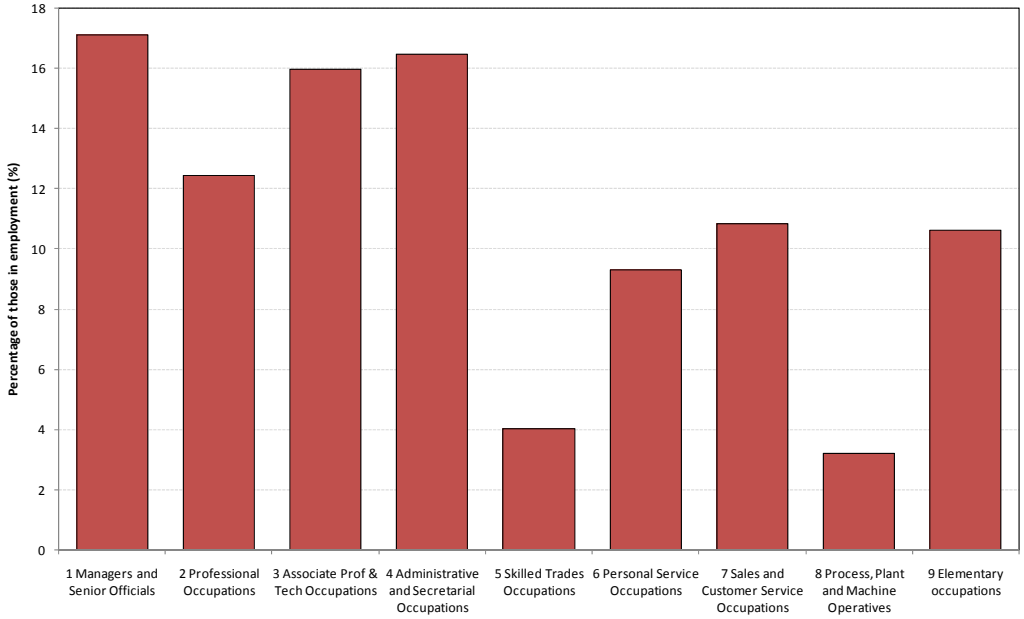
Economic Activity Rate 2004-2008 (%)						
Local Authority	**2004**	**2005**	**2006**	**2007**	**2008**	**% change 2004-08**
Bromley	**83.3**	**84.4**	**81.5**	**85.1**	**83.5**	**0.2**
Merton	81.6	77.2	80.0	82.3	83.3	1.7
Bexley	80.6	82.4	81.6	79.4	80.9	0.3
Richmond upon Thames	75.1	80.0	80.0	82.4	80.7	5.6
Croydon	80.4	81.0	78.5	79.9	80.5	0.1
Sutton	80.2	84.6	82.9	81.4	80.0	-0.2
Lewisham	77.3	76.4	77.3	75.7	77.9	0.6
Lambeth	75.4	72.8	71.0	77.0	77.4	2.0
Kingston upon Thames	78.7	78.4	79.4	75.9	76.5	-2.2
South London Average	78.2	78.3	78.1	78.8	76.4	-1.8
London Average	74.5	74.5	75.1	75.0	75.5	1.0
Greenwich	74.2	75.6	74.2	75.4	73.2	-1.0
Southwark	73.0	68.8	72.6	72.7	73.2	0.2

Source: Nomis, Annual Population Survey.

A quarter of all the Borough's employed residents work in the business and finance industry, although public services remain the largest employment sector.

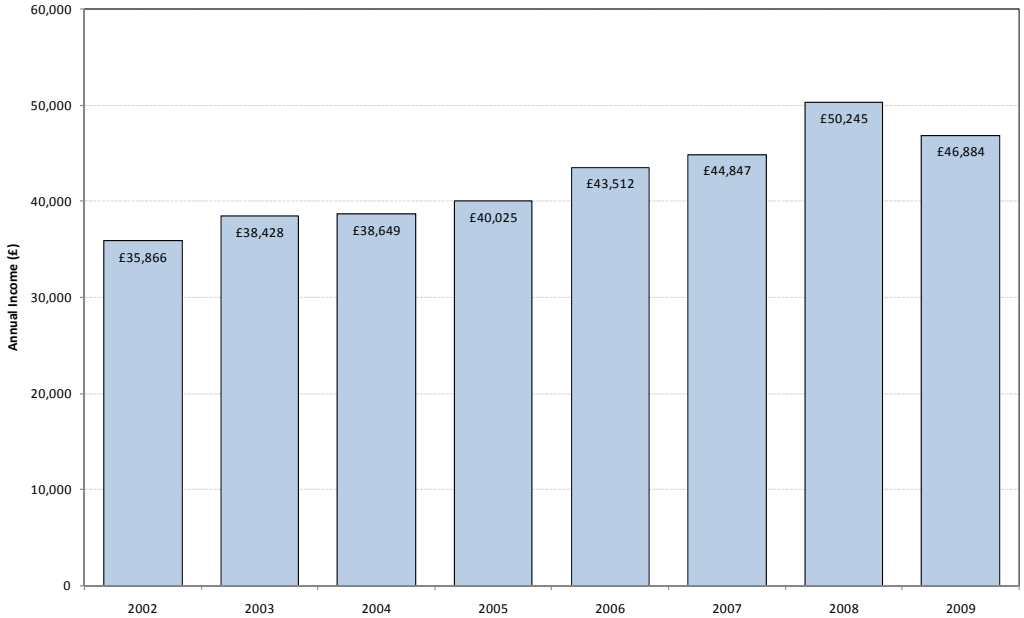
One third of the working age population are either managers or in professional occupations (Figure 17).

Figure 17 Occupations of People in Bromley (January to September 2009)



Source: ONS Crown Copyright Reserved [from Nomis on 15 June 2010]

Figure 18 Average annual income in Bromley



Source: ONS Crown Copyright Reserved [from Nomis on 29 June 2010]

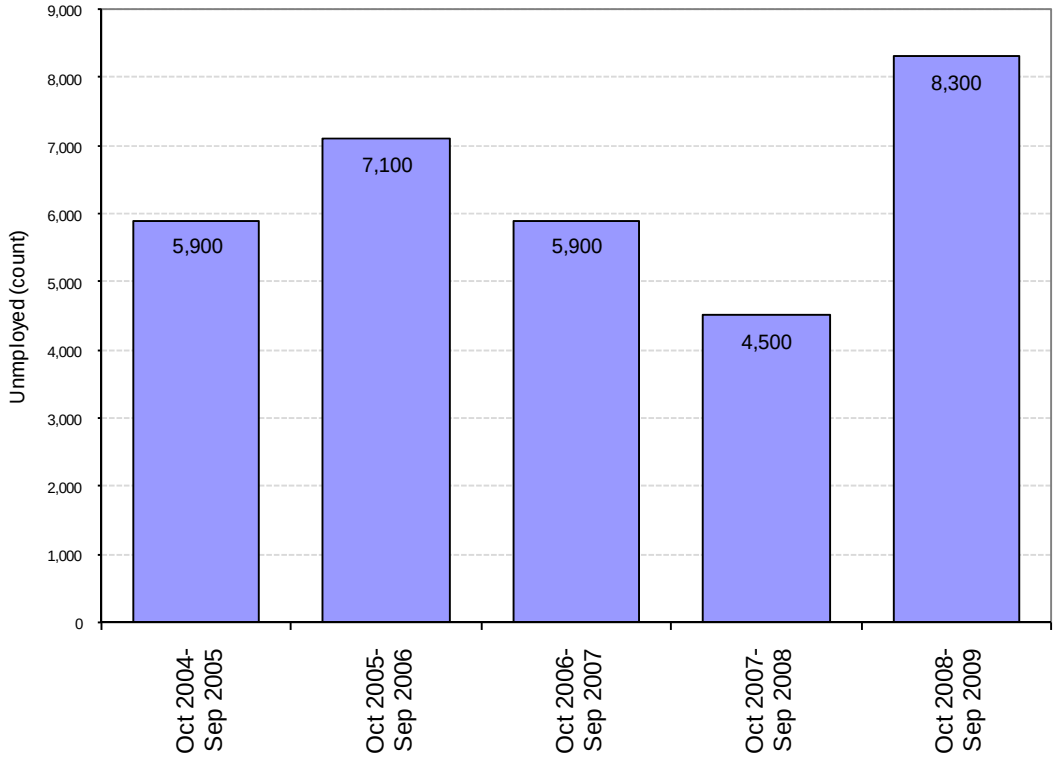
Although the average annual income for people living in Bromley is above the national average (£31,323), workplace earnings for people employed in Bromley are amongst the lowest amongst South London boroughs and remain well below the London averages, i.e. people working in Bromley earn less than those working in other parts of London.

Mean weekly earnings for both full and part time workers in Bromley (at £622.20 and £191.40) are still significantly lower than the earnings for Bromley's residents (Full time: £788.70 and Part time: £298.20).

Unemployment

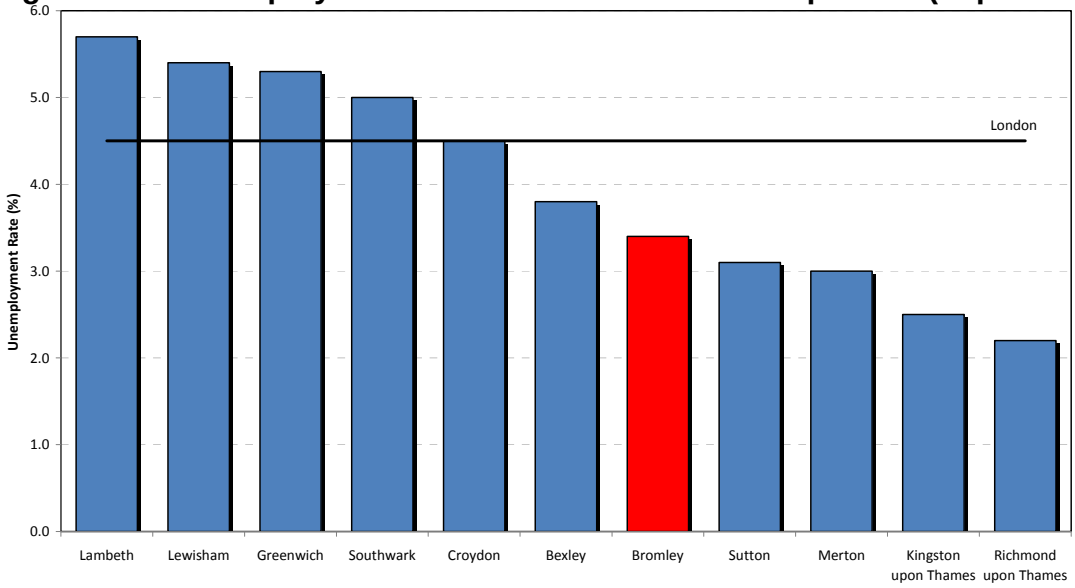
In line with the figures for London, the unemployment rate in Bromley has risen during the current recession, with numbers of unemployed rising from 4500 in 2007/08 to 8300 in 2008/09 (Figure 19).

Figure 19 Unemployment trends



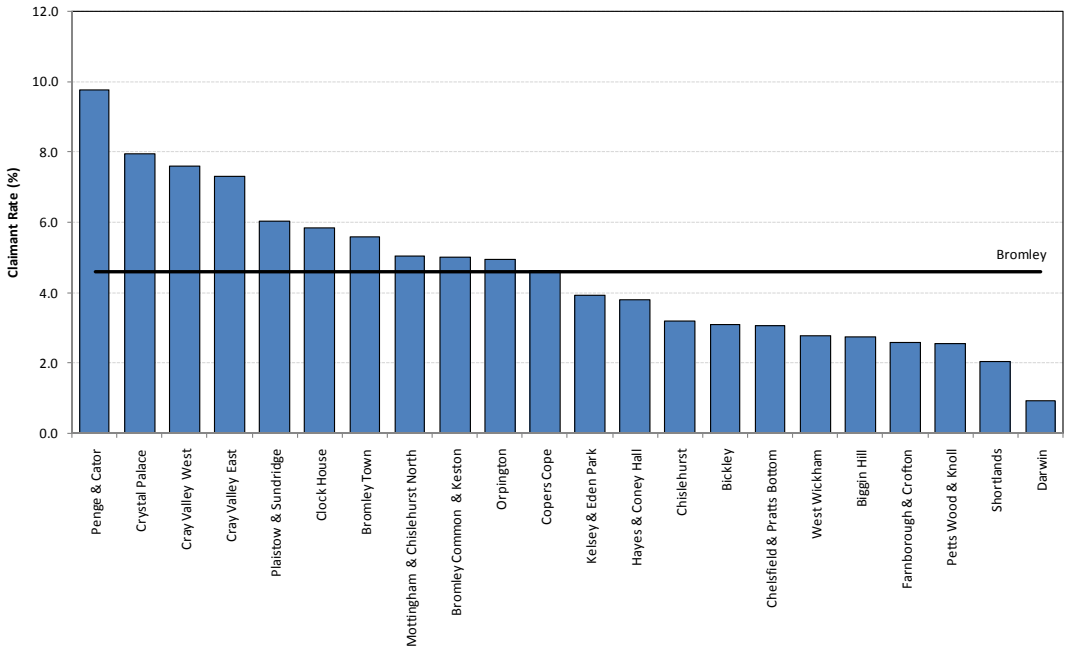
The average unemployment rate for the borough was 3.4% in September 2009 and is relatively low for South London and London, which has an average rate of 4.5%.

Figure 20 Unemployment rates – South London comparison (Sept 2009)



The overall rate does however mask pockets of much higher unemployment – with some wards such as Penge and Cator, Crystal Palace and the Crays experiencing claimant counts higher than the sub-regional average – and more akin to inner London wards.

Figure 21 Job Seekers Allowance (JSA) claimant rate (%) by ward, 2009/10



Source: Nomis: Claimant count with rates and proportions, ONS

Housing

The Borough of Bromley has the lowest average population density in London. The Borough has a relatively low-level density of development with 60 percent of the Borough being protected Greenbelt or Metropolitan Open Land. The area is well served with parks and open spaces. The Borough is proud of its image as a 'green', relatively affluent, outer London suburb, which offers a high quality of life for residents.

House prices have increased over the last year, along with the rest of London.

Table 4 House Price Trend SE London

Average	Average Price May 2010	Average Price April 2010	Monthly Change	Average Price May 2009	Annual Change
Bromley	£339,134	£338,608	0.2%	£307,811	6.0%
London	£420,203	£421,822	-0.4%	£397,646	5.7%
South East	£285,783	£281,583	1.5%	£284,601	0.4%

Source: Right Moves UK

There are small pockets of residents who live in housing association or registered social landlord accommodation. These people tend to be poorer and have fewer resources. This is likely to have an impact on the health of these communities and so the usage of health services in the area.

Figure 22 Percentage of households in Housing Association or Registered Social Landlord Accommodation by LSOA

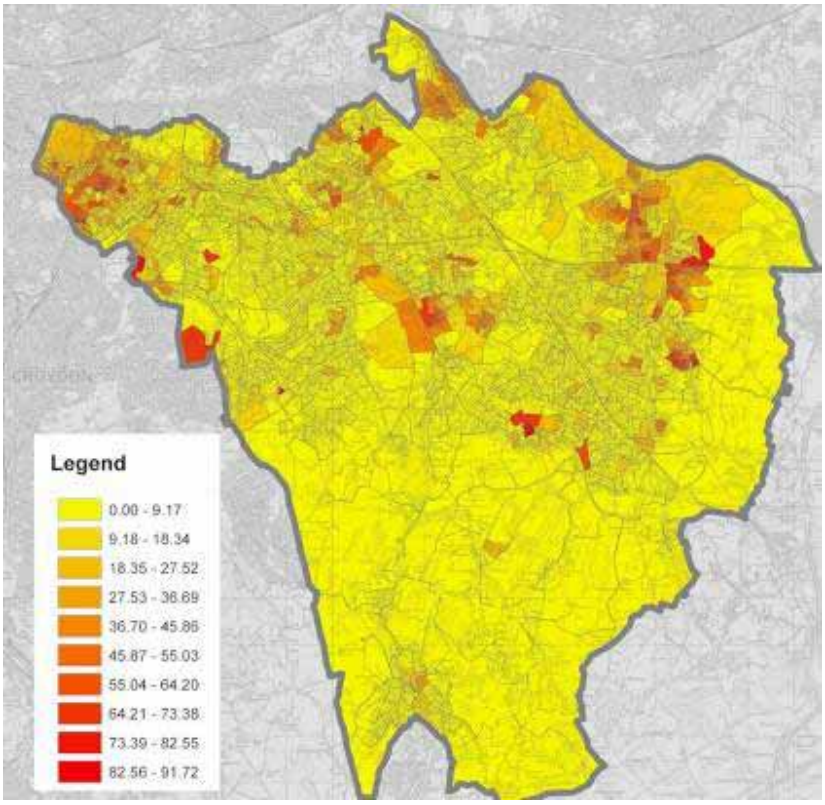
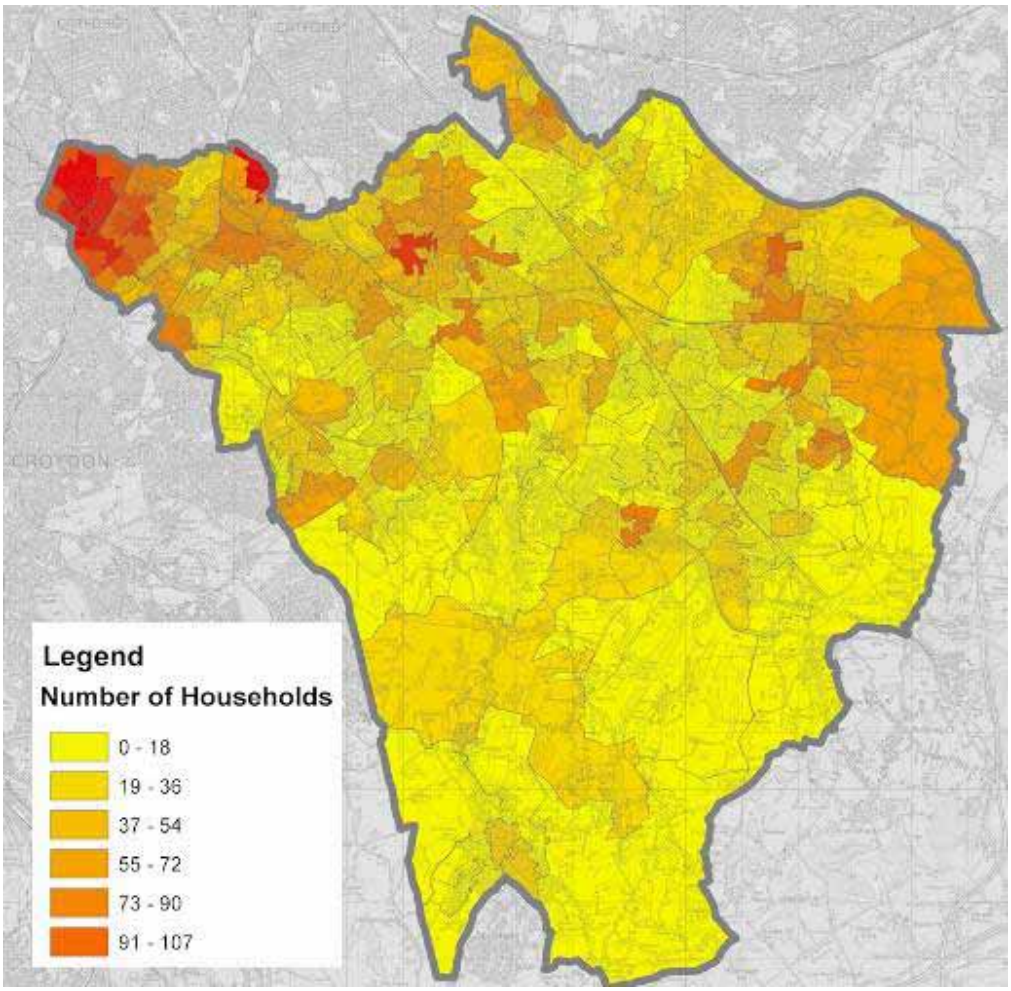


Figure 23 Overcrowded Housing



The figure above shows the numbers of households in different areas of Bromley classified as overcrowded. The red areas, chiefly situated in the North of the borough represent the greatest density of overcrowded housing.

Modes of Travel to Work

As the geographic breakdown of the borough varies from ward to ward, the mode of travel to work by Bromley's residents reflects the rurality of each area.

For example, in figure 24 we can see that those who live in the more rural areas of the borough are high car users for travelling to work. Comparing those residents who live in the more suburban, built-up areas of Bromley, the use of trains and buses is more prevalent (figure 25and 26).

Figure 24

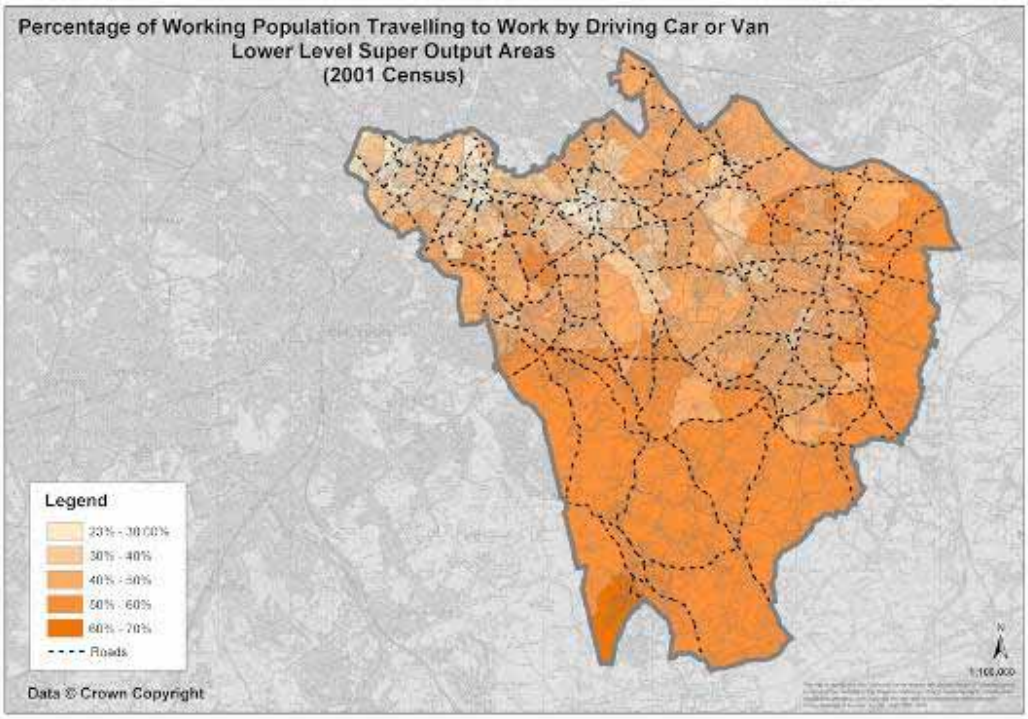


Figure 25

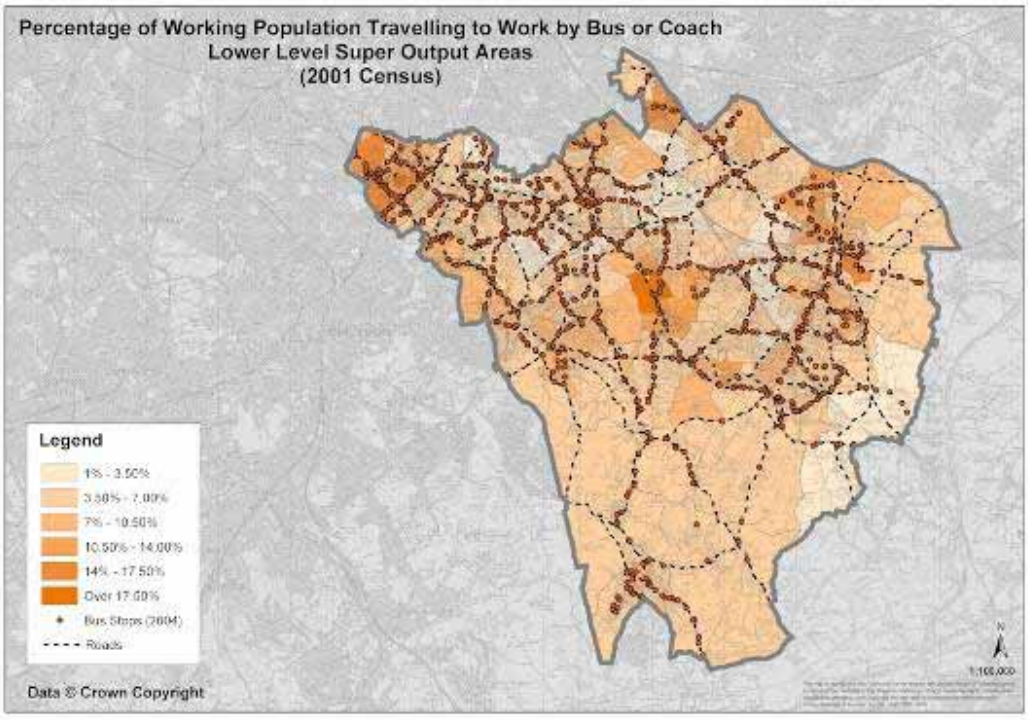
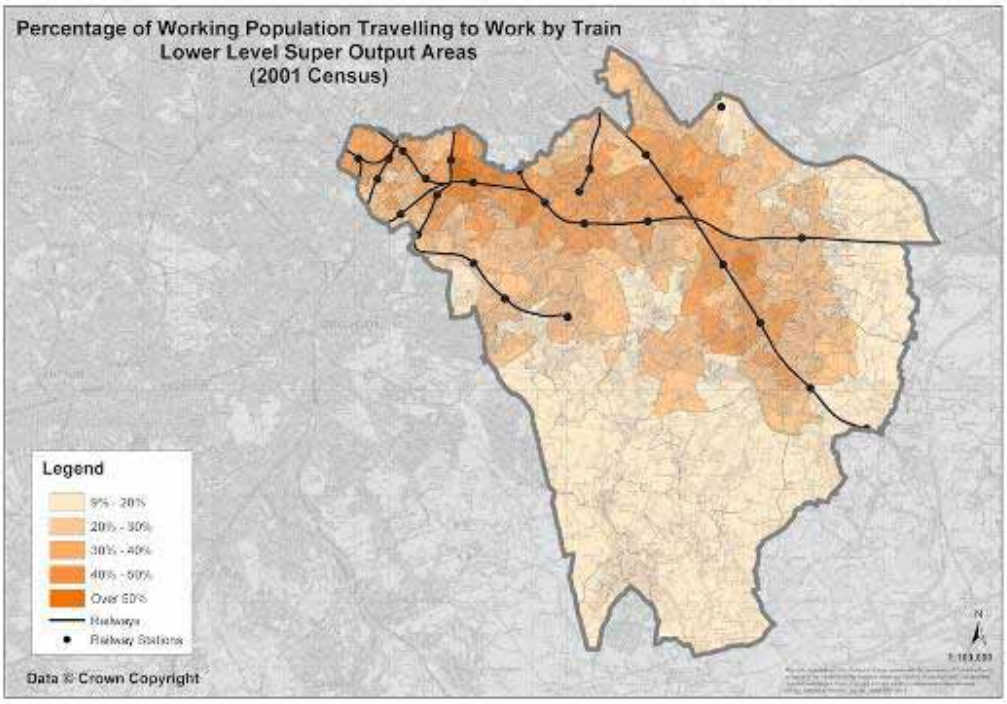


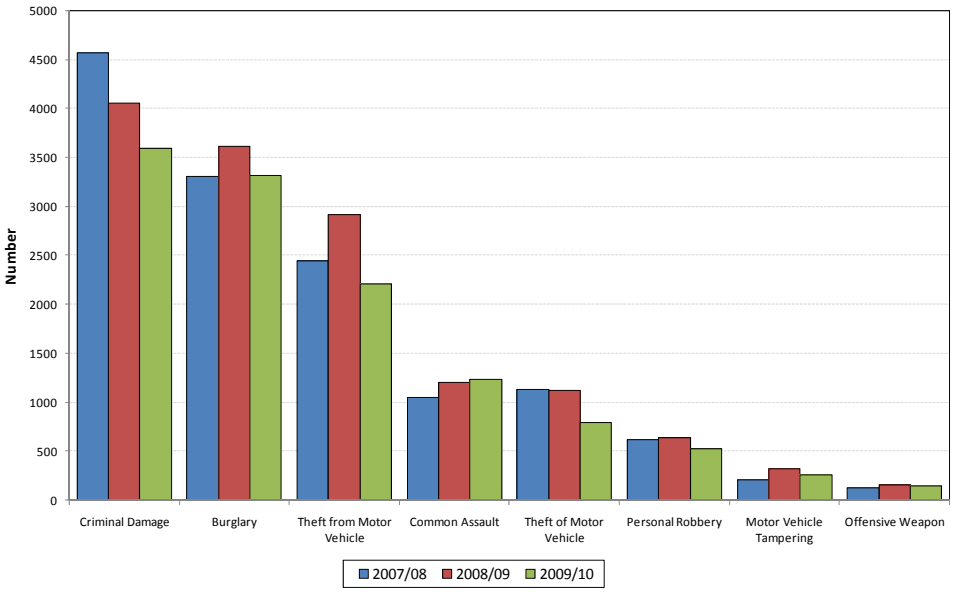
Figure 26


Percentage of Working Population Travelling to Work by Train
Lower Level Super Output Areas
(2001 Census)
Legend
Railways
Railway Stations
Data © Crown Copyright

Crime in Bromley

Bromley is one of the safest boroughs in London.

Figure 27 Crime statistics across Bromley 2007/08, 2008/09, 2009/10



There are, however, areas of concern relating to crime:

- Over a third of all reported crime in Bromley is for Criminal Damage. Criminal Damage offences perpetuate the 'fear of crime' within the community.

- Due to operational initiatives theft from the Person offences have decreased by 15% in 2009/10 compared with 2007/08.

- Antisocial behaviour is a priority for each Ward in the borough and has been defined as; of youths, of motorists, of safer shopping, of estates or alcohol related.

- The Antisocial Behaviour Survey 2007/08 shows that there is a widening gap between the white Bromley residents and the BME Bromley residents, in relation to their satisfaction with the way the police and the local council dealt with antisocial behaviour (the survey of 2007/08 shows 69% of white residents [59%] and 54% of BME residents [57%] as satisfied).

The Safer Bromley Partnership was set up in line with the Crime and Disorder Act 1998 to ensure that the public sector agencies, voluntary groups and

businesses work together with local communities to reduce crime and improve safety.

Members of the SBP include chief officers from the Council, Police, Health, Probation, Fire Service, Ambulance Service, Metropolitan Police Authority and Affinity Sutton.

The Safer Bromley Partnership has identified the following key priorities for action during 2008-2011:

- Crime against the person
- Antisocial behaviour
- Crimes against property
- Drugs and alcohol
- Youth crime and victimisation

1.4 BURDEN OF ILL HEALTH

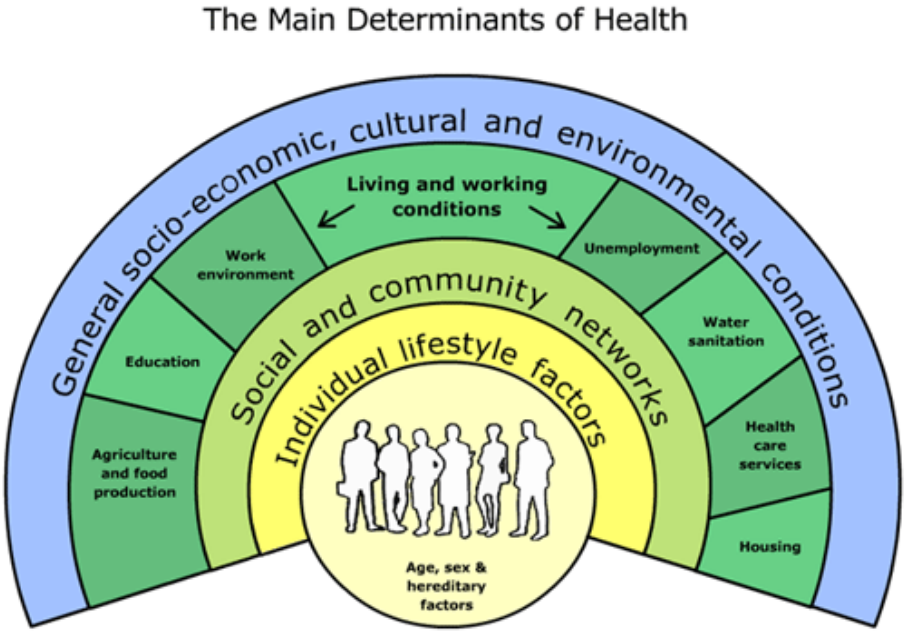
Introduction

In order to commission appropriate and relevant health and social care services it is essential that we understand which diseases and conditions are causing mortality and morbidity in Bromley. In order to understand the issues, trends in disease patterns are considered and comparisons between Bromley and other areas are made to identify priority areas for action.

Overall, Bromley has a healthy population.

Although age, sex and genetic make-up influence people's health potential, other factors in the surrounding layers of the model below can potentially be modified to achieve a positive impact on population health:

- Individual lifestyle factors such as smoking, diet and physical activity have the potential to promote or damage health;
- Interactions with friends, relatives and mutual support within a community can sustain people's health;
- Wider influences on health include living and working conditions, food supplies, access to essential goods and services, and the overall economic, cultural and environmental conditions prevalent in society as whole.



Source: G Dahlgren and M Whitehead, *Policies and strategies to promote social equity in health,* Institute of Futures Studies, Stockholm, 1991

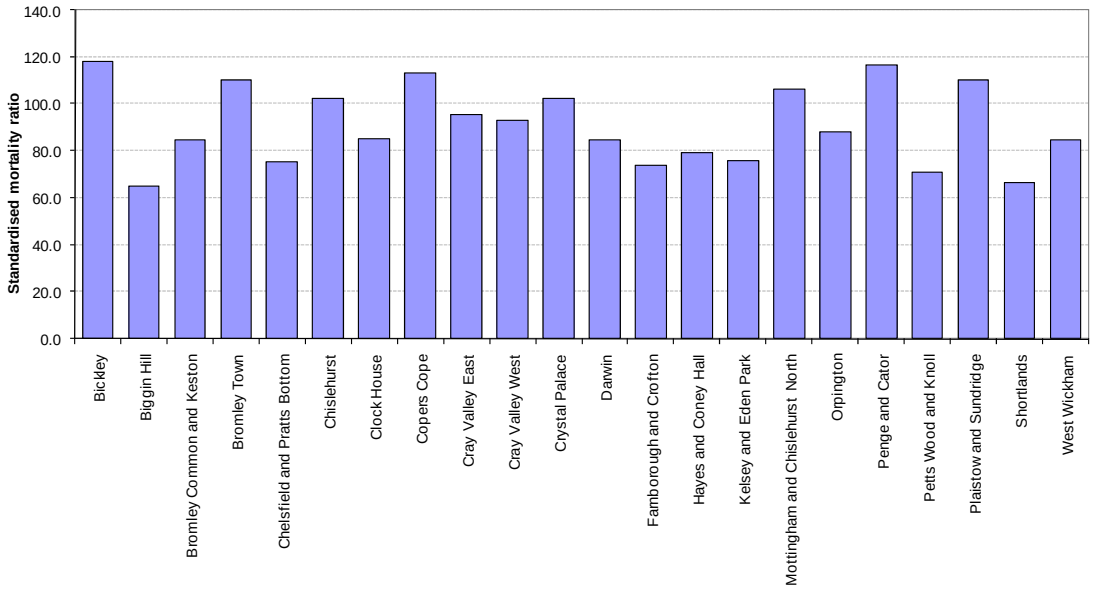
Summary

- Bromley has lower all cause mortality rates and infant mortality rates than the national average.
- There are inequalities in Bromley with some wards experiencing worse mortality rates and life expectancy than the national average.
- Bickley, Copers Cope, Crystal Palace and Penge have the highest rates of mortality in the borough, with the lowest rates in Biggin Hill and Shortland wards.
- Life expectancy has been consistently low in Crystal Palace and Penge & Cator wards for both men and women, additionally in Mottingham & Chislehurst North for men.
- The three main causes of death over the last five years (2005-2009) in Bromley have been cancer, circulatory disease and respiratory disease.
- Although coronary heart disease is still a major cause of death, the mortality rate in Bromley has fallen to less than half the 1993 level, in line with the trend for England & Wales as a whole.
- Diabetes is now the most prevalent chronic disease in Bromley, with 12,509 people on the diabetes register in 2009. This reflects a continuous rise in prevalence over the last 8 years from 1.6% to 4.75%.
- The prevalence of obesity is rising, and the characteristics of the Health Acorn group “Possible Future Concerns” (the predominant group in Bromley) promote the rise in obesity levels.

All Cause Mortality

All cause mortality was above the national average in 8 wards: Chislehurst, Crystal Palace, Mottingham & Chislehurst North, Bromley Town, Plaistow & Sundridge, Copers Cope, Penge & Cator and Bickley, in ascending order (Figure 28).

Figure 28 All cause mortality (SMR) by ward, 2003-07



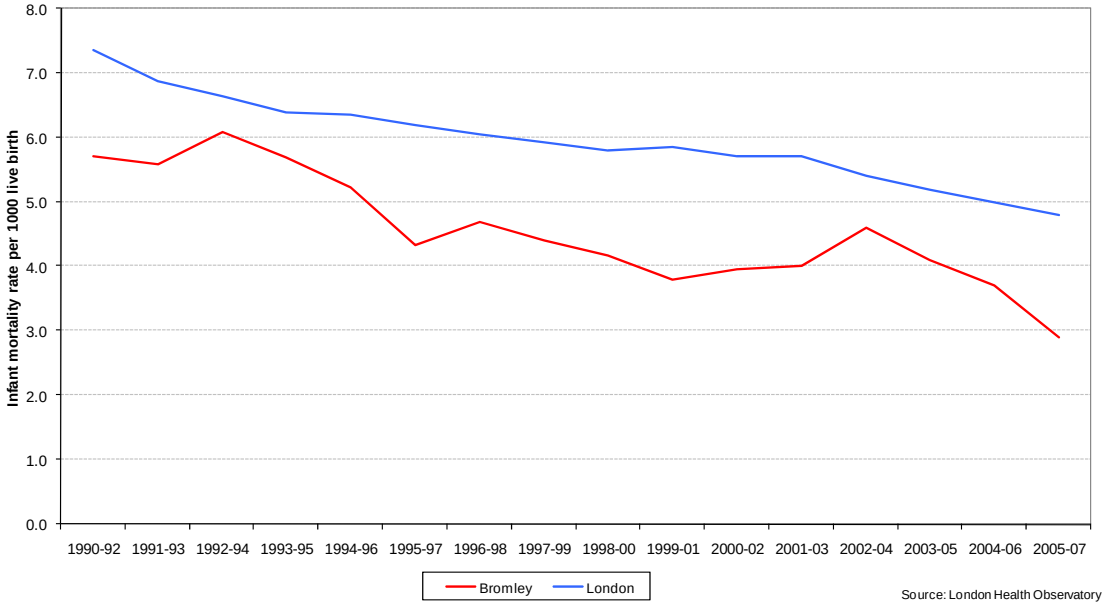
Source: London Health Observatory

There is more detail about the main causes of mortality in a later section.

Infant Mortality

The trend in infant mortality has been almost continually downward since 1990 (Figure 29). Infant mortality rates are lower for Bromley (2.9 per 1000 live births) than for London (4.8 per 1000 live births) and England (4.9 per 1000 live births).

Figure 29 Three year average infant mortality rate per 1000 live births, 1990-2007



Source: London Health Observatory

Life Expectancy

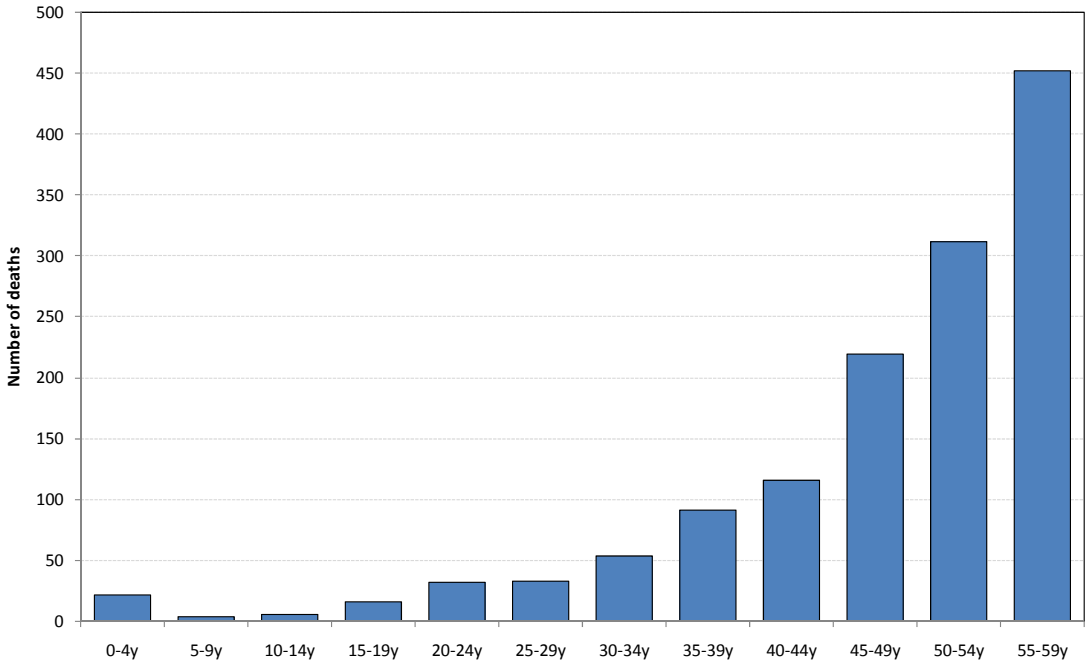
Between 1998 and 2007, life expectancy for men in Bromley overall rose from 77.3 years to 78.8 years, and for women, from 81.7 years to 82.7 years.
The gap between wards with the highest and lowest life expectancy has reduced between 1998 and 2007 by 3.1 years to 7.5 years for men and by 3.7 years to 7.0 years for women (Figures 31 & 32).
Between 1998 and 2007, life expectancy for men has fallen in 2 wards (Copers Cope and Bromley Town) although this was by less than 1 year in both wards. For women, life expectancy over this period fell in 7 wards (Plaistow & Sundridge, Chislehurst, Cray Valley East, Bromley Town, Mottingham & Chislehurst North, Darwin and Biggin Hill) The greatest reduction (2.6 years) being seen in Biggin Hill.

Table 5 Wards with the Lowest Life Expectancy (2003-07)

Lowest Male Life Expectancy (yrs)		Lowest Female Life Expectancy (yrs)	
Penge & Cator	74.8	Mottingham & Chislehurst North	80.0
Crystal Palace	75.1	Plaistow & Sundridge	80.1
Cray Valley West	76.3	Penge & Cator	80.2

It is important to note that a reduction in life expectancy is not simply a case of dying a few years earlier (e.g. at 74 years rather than 78 years) but reflects increased mortality in all age groups under the age of 75 years (from infancy onwards, Figure 3) and indicates a poorer health experience throughout life for the population in an area of low life expectancy.

Figure 30 Deaths in Bromley before age 60 years, 2005-2009 (total=1357)



Source: Public Health Mortality Files

Figure 31: Female Life Expectancy (2003-07)

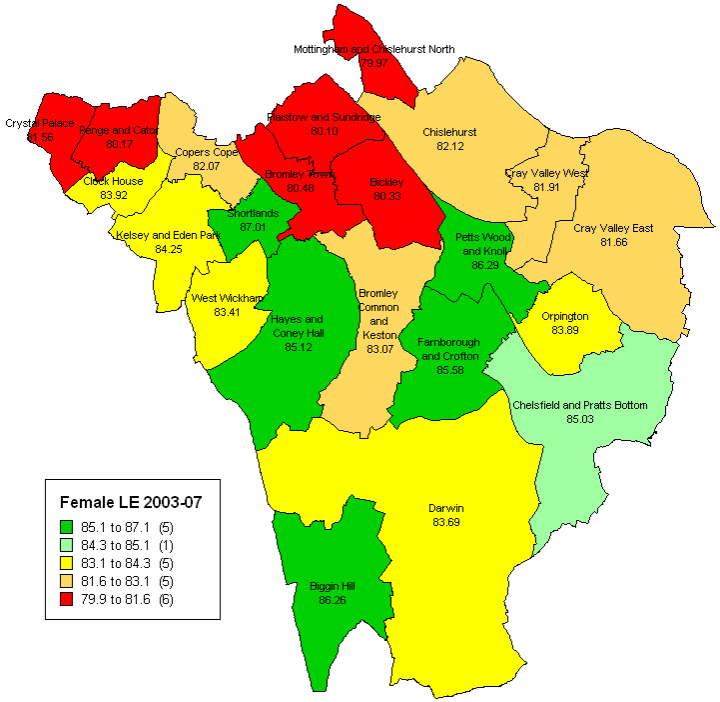
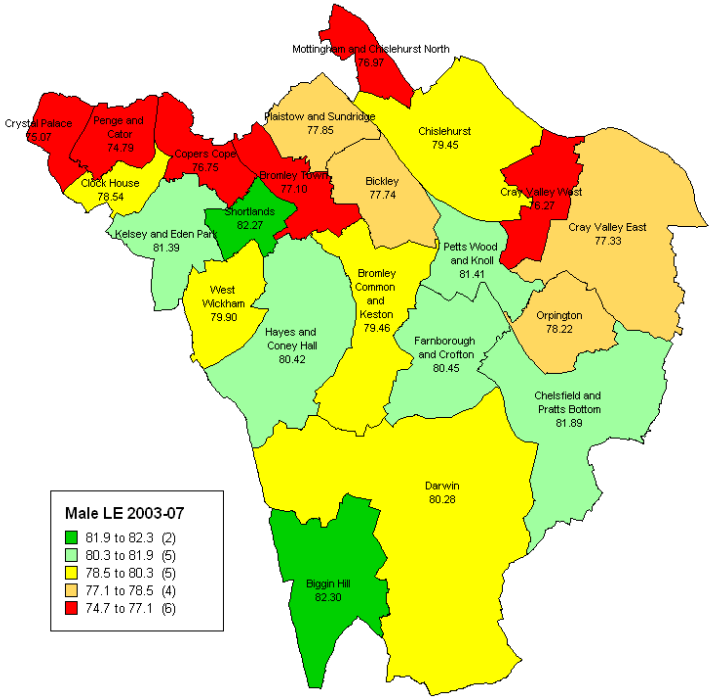


Figure 32: Male Life Expectancy (2003-07)



Source: London Health Observatory

Life expectancy gap

Bromley has a higher life expectancy overall than England for both men and women, but this gap is less marked now for women than 20 years ago.

Figure 33 Gap analysis of female life expectancy at birth for England and Bromley highlighting time periods 1991-93 and 2006-08

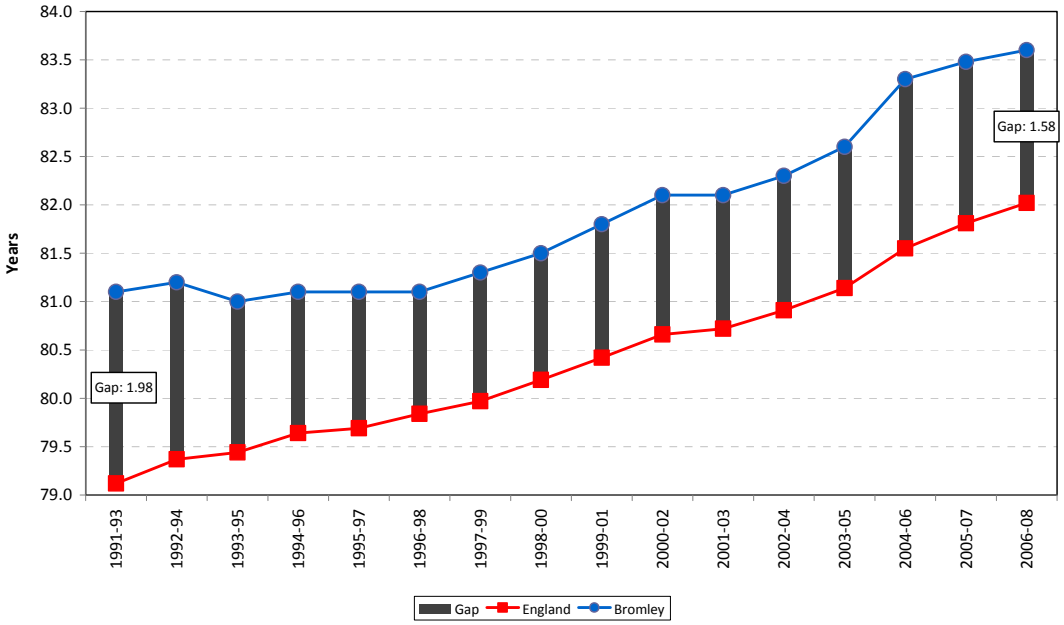
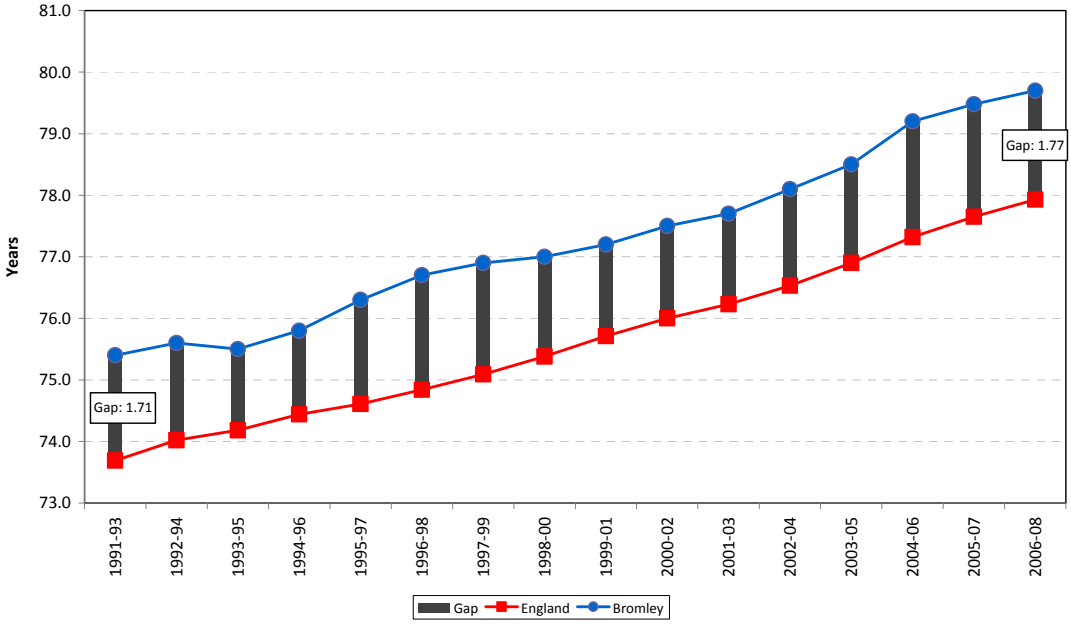


Figure 34 Gap analysis of male life expectancy at birth for England and Bromley highlighting time periods 1991-93 and 2006-08



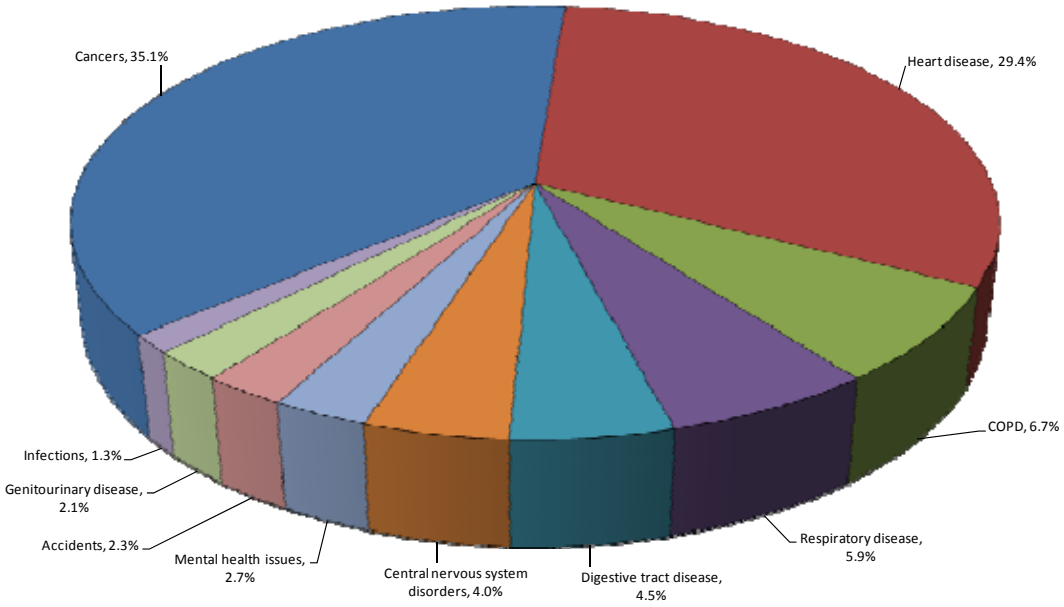
KEY DISEASE AREAS

Summary

The three main causes of death over the last five years in Bromley have been:

- Cancer
- Circulatory disease
- Respiratory Disease

Figure 35 Main causes of death in Bromley (all ages), 2005-2009



Source: Public Health Mortality Files

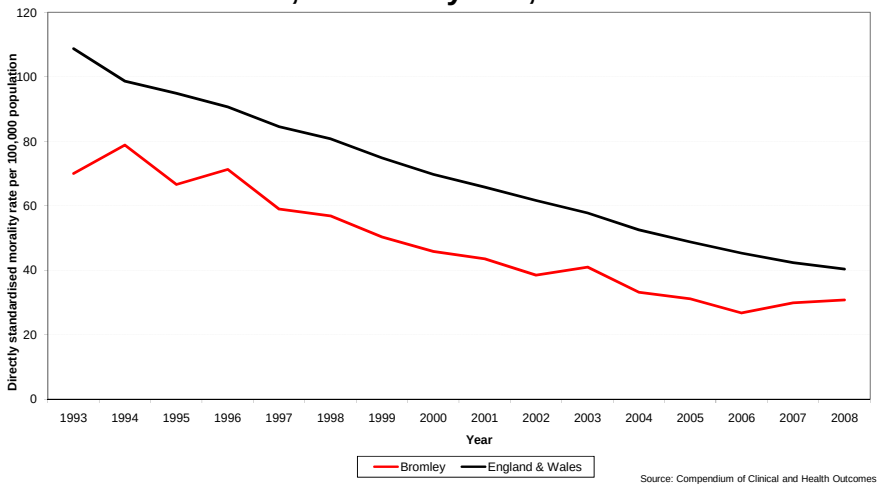
What follows is a summary of the health surveillance data for the key causes of death and other areas identified as of concern.

Circulatory Disease

Coronary Heart Disease (CHD)

Although CHD is still a major cause of death, the directly standardised mortality rate for CHD mortality in Bromley has fallen to less than half the 1993 level, in line with the trend for England & Wales as a whole (Figure 36).

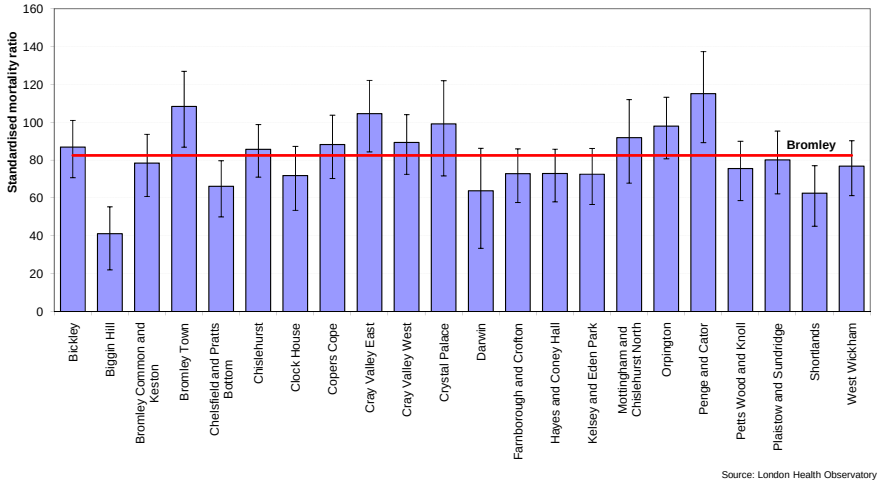
Figure 36 Directly age standardised mortality rate of Coronary Heart Disease, under 75 years, 1993-2008



Source: Compendium Clinical & Health Outcomes Knowledge Base

In addition, Bromley as a whole has a lower standardised mortality rate (SMR) than the national level, with only three wards having higher SMRs (Cray Valley East 104.5, Bromley Town 108.3 and Penge & Cator 115.1) Figure 37.

Figure 37 Coronary heart disease mortality (SMR), all ages, 2003-2007



Source: London Health Observatory

Primary Care data shows that the prevalence of CHD in Bromley has remained fairly stable over the last four years (Table 6). This is encouraging, given that Health Survey for England data showed a rising prevalence of CHD between 1994 and 2003.

Table 6 QOF CHD Prevalence

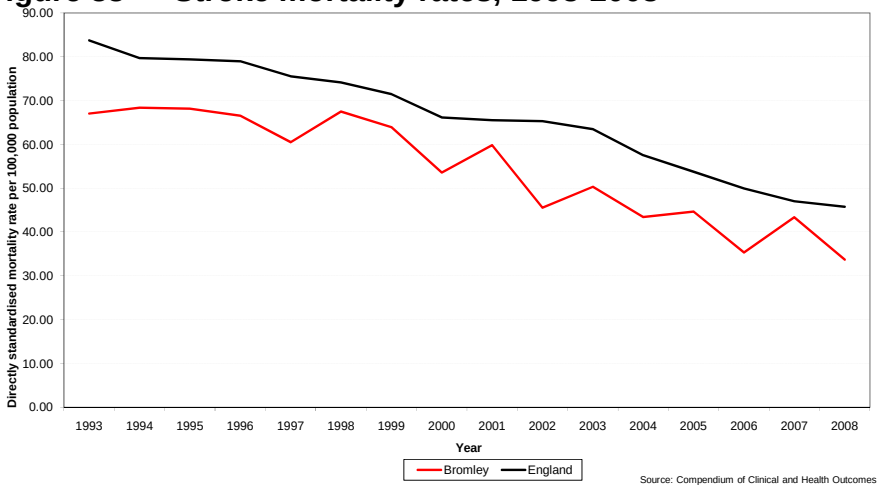
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
No. on practice CHD register	9668	9798	9717	9790	9859	9984
CHD Prevalence	2.68%	2.98%	3.76%	3.58%	3.75%	3.79%

Source: QMAS

Stroke

Although stroke is still a major cause of death, the directly standardised mortality rate for stroke mortality in Bromley has fallen to almost half the 1993 level (Figure 38).

Figure 38 Stroke mortality rates, 1993-2008



Source: Compendium Clinical & Health Outcomes Knowledge Base

Primary Care data shows that the prevalence of stroke in Bromley has fallen slightly in the last year (Table 7).

Table 7 QOF Stroke Prevalence

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
No. on practice stroke register	4447	4825	4908	5017	5125	5184
Stroke Prevalence	1.23%	1.47%	1.90%	1.83%	1.95%	1.61%

Source: QMAS

The prevalence of stroke is lower in Bromley than across England as a whole (England average 1.7%), but is higher than the average prevalence for London (1.1%).

Diabetes

The number of people with diabetes has increased over time. There were 4846 people on the diabetes register in 2002, as compared with 12,509 in 2009. This reflects a continuous rise in prevalence over the last 8 years from 1.6% to 4.75% (Table 8). This rise has particular significance because diabetes is classed as a vascular disease which is often a precursor to heart disease or stroke.

Table 8 QOF Diabetes Prevalence

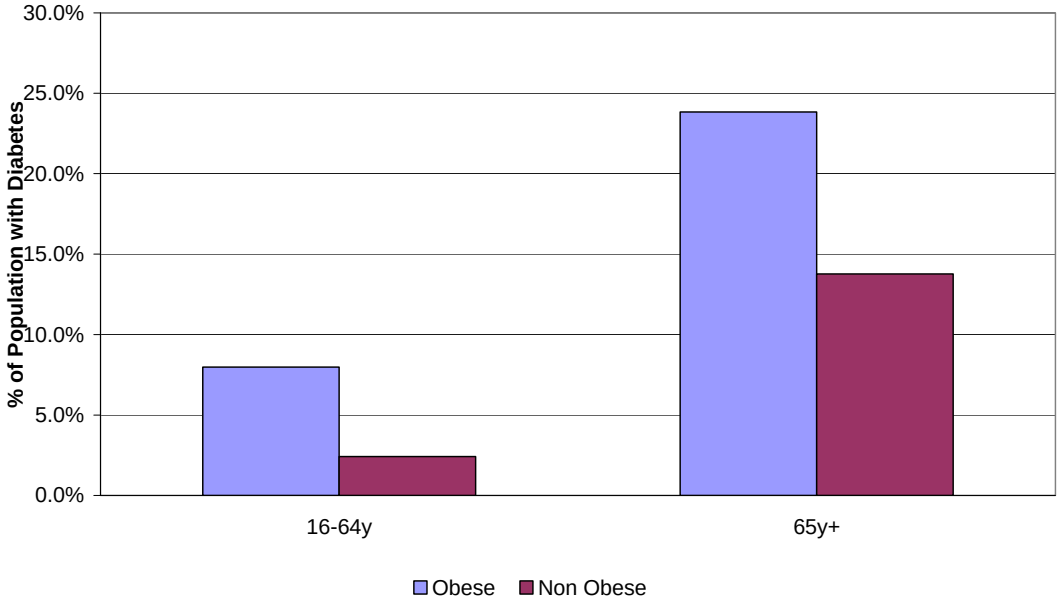
	2001/02	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
No. on practice diabetic register	4846	8661	9244	10084	10504	11261	11979	12509
DM Prevalence	1.6%	2.73	2.56%	3.07%	4.06%	4.12%	4.56%	4.75%

Source: QCI & QMAS

Since diabetes is the leading cause of blindness in the UK, there is a national programme of diabetic retinopathy screening in place. In Bromley, we are currently screening 82% of people with diabetes.

There is strong evidence that the rise in diabetes prevalence is related to the rise in levels of obesity, and this is illustrated in local Bromley data gathered from GP practices (Figure 39). This shows that a higher proportion of obese people than non-obese people suffer from diabetes in both the under 65 and over 65 year age groups.

Figure 39 The association between the prevalence of Type II Diabetes and obesity

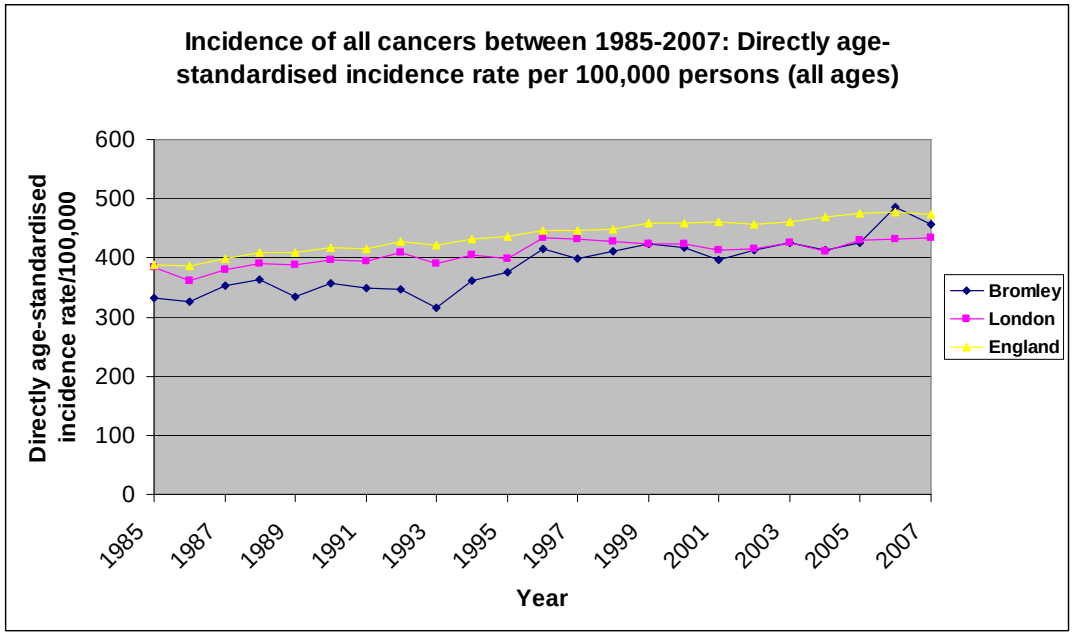


Source: CVD Audit 2009

Cancer

Cancer incidence in Bromley has risen in recent years, with incidence rates rising above both the London and England averages for all cancers in 2006 (Figure 40).

Figure 40 Trends in incidence of all cancers between 1985-2007 for Bromley, London and England



Source: Cancer Registry

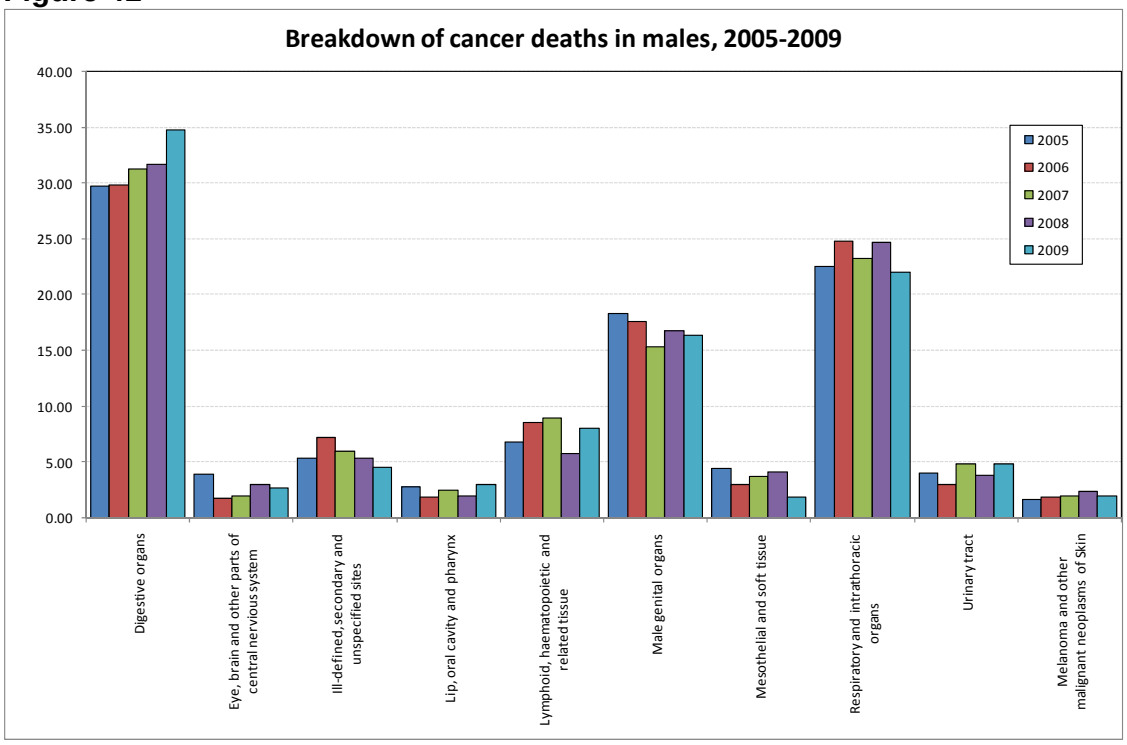
This rise in incidence rate may be attributable to a number of factors including increasing age of the population, increase rates of diagnosis, and increased uptake of screening. Of the commonest cancers in Bromley, the incidence of breast, colorectal and prostate cancer has increased.

Table 9 Incidence of Cancer by type for all ages per 100,000 persons in 2007

Cancer Type	All Cancers	Lung Cancer	Breast Cancer	Colorectal Cancer	Prostate Cancer	Stomach Cancer	Cervical Cancer
England	472.54	46.83	100.82	45	98.86	9.11	8.17
London	434.38	46.86	101.30	40.22	101.30	9.14	6.64
Bromley	456.21	34.12	98.86	38.41	100.82	5.34	11.69

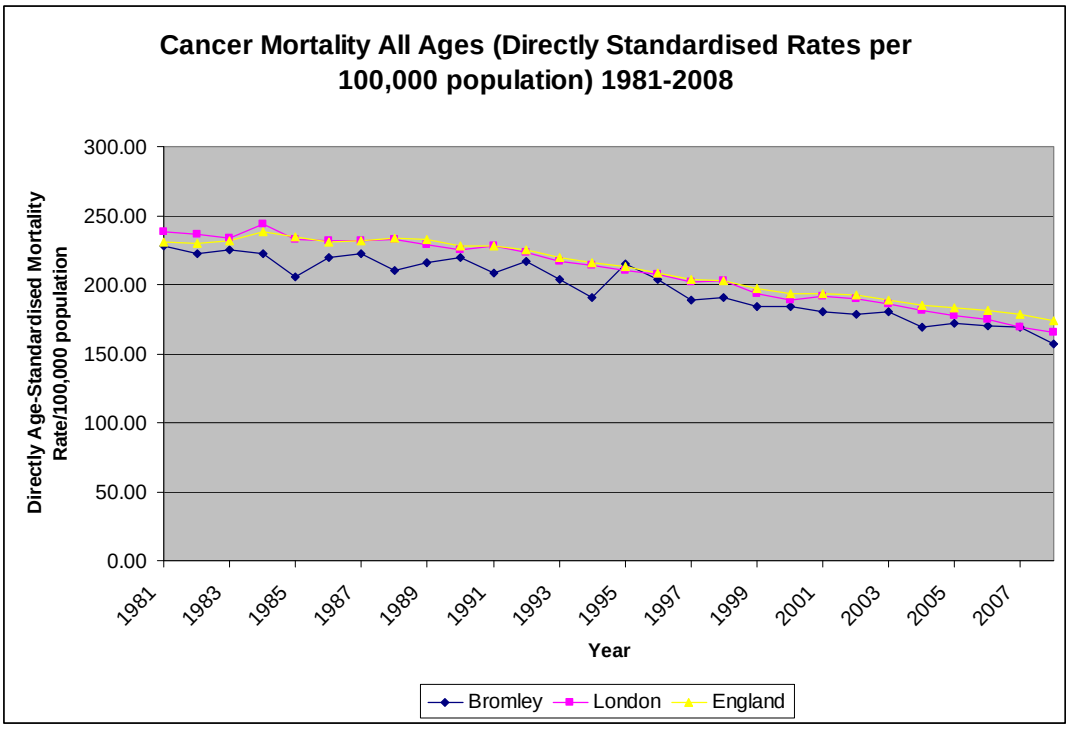
The most common cause of cancer death in both males and females is cancer of the digestive organs. The second most common cause of cancer deaths is cancer of the respiratory tract (Figures 41 & 42). Breast cancer is an important cause of death in females.

Figure 41



Cancer mortality has been decreasing steadily both locally and nationally over the past decade. In Bromley cancer mortality has largely remained below the national and London averages year on year (Figure 5).

Figure 42 Trends in Cancer Mortality in Bromley, London and England (1981-2008)

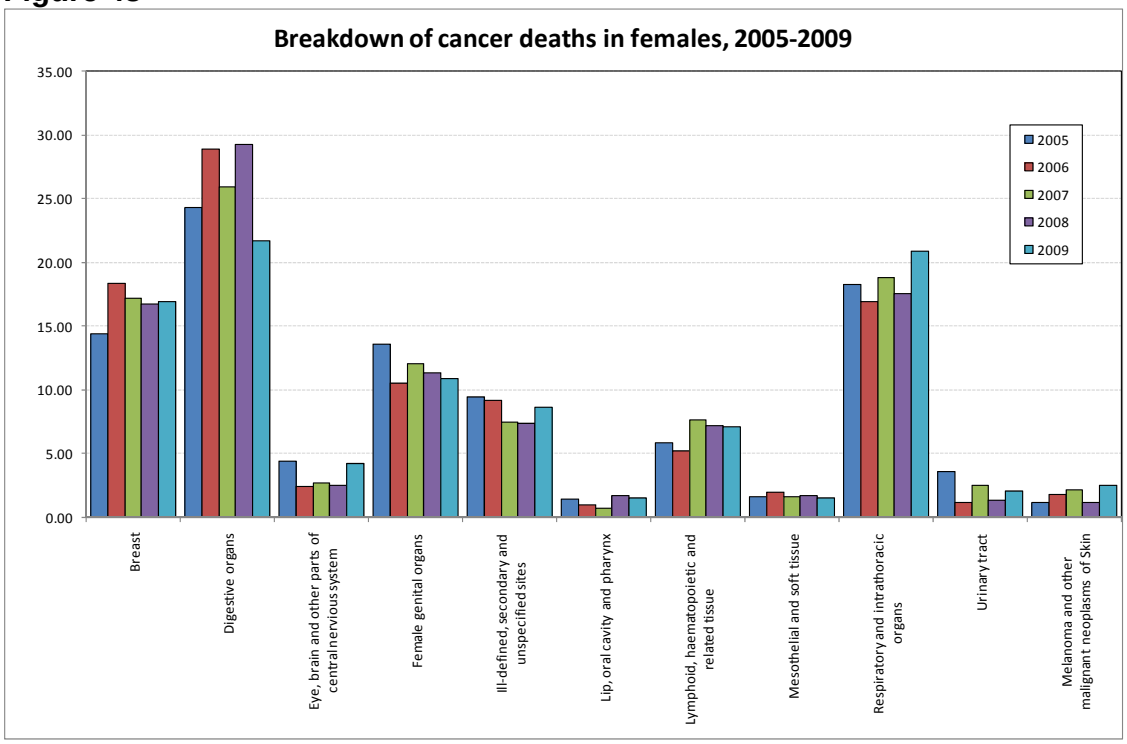


Source: Cancer Registry

When looking at the mortality rates of the four most common cancers, lung and breast cancer mortality has steadily fallen over the years, with mortality rates for these cancers being below the England and London averages in 2008. Mortality rates for colorectal and prostate cancer have however risen in recent years, with mortality for these cancer types being above the national and London averages. The reasons for this are not entirely clear but may reflect the increase in incidence of these

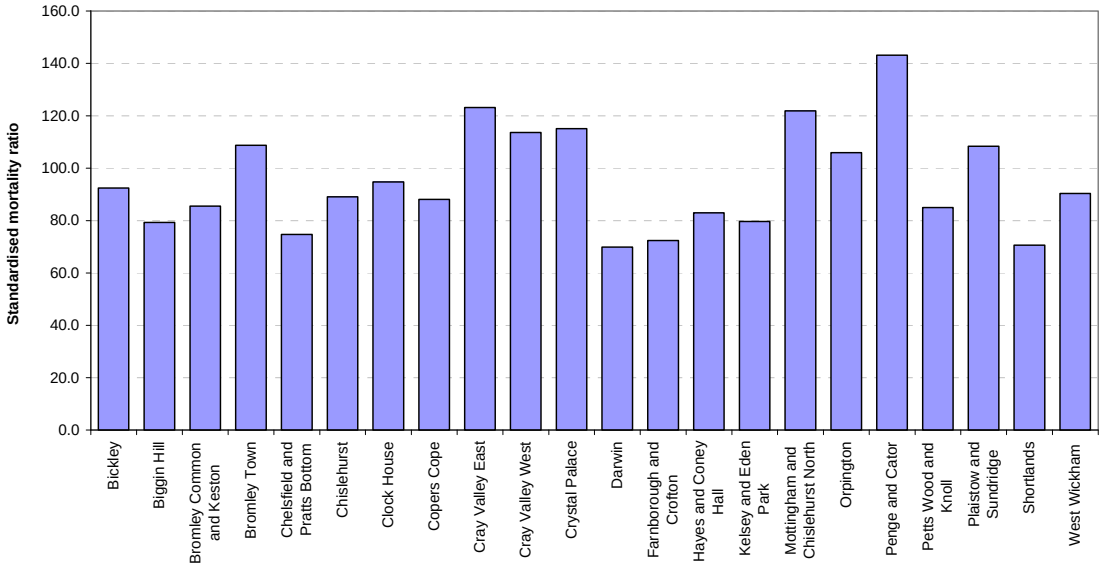
Cancer mortality rates are lower in Bromley than in London or in England as a whole. There has been a consistent downward trend in cancer mortality since 1981, although cancer now represents the highest proportion of deaths in Bromley.

Figure 43



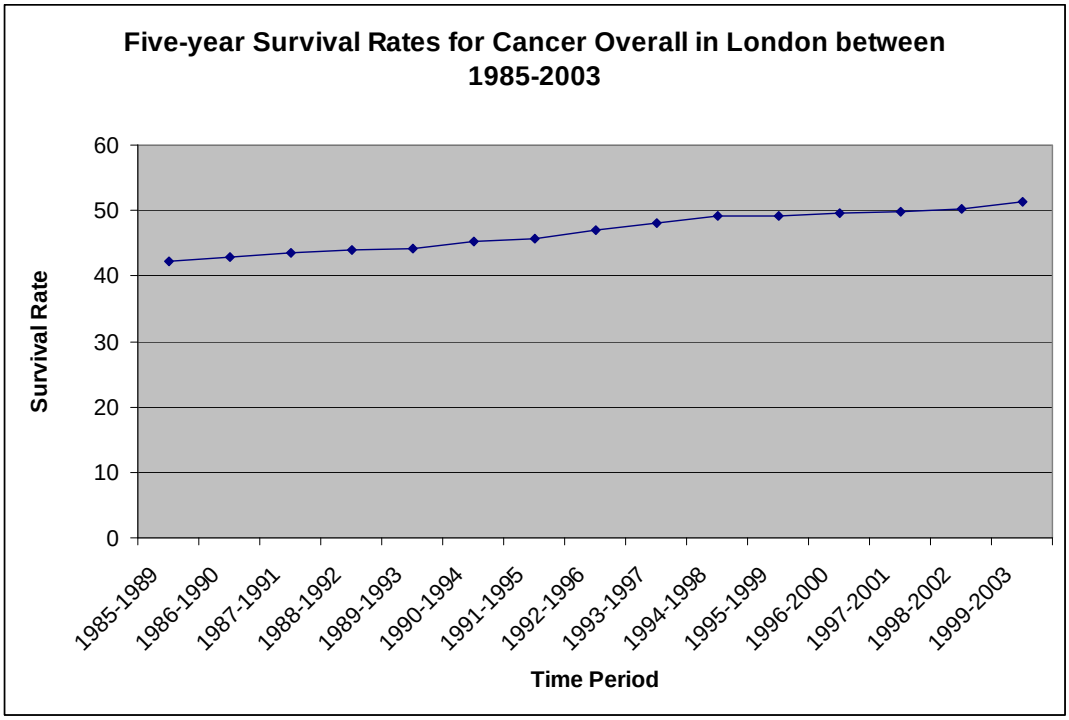
There is a variation in cancer mortality rates between wards (figure 44). Seven wards have SMRs above the England average for under 75s: Bromley Town, Cray Valley East, Cray Valley West, Crystal Palace, Mottingham & Chislehurst North, Orpington, Penge & Cator and Plaistow & Sundridge.
Penge & Cator has a standardised mortality rate for cancer which is 40% higher than the national average.

Figure 44 All cancer mortality ratios per ward, under 75s, 2003-2007



Cancer Survival has been rising steadily in London over the past 18 years (Figure 45). This has also been the case in England; however there is still much work to be done to improve cancer survival rates both locally and nationally, as England's cancer survival rates continue to be below those of many other European countries.

Figure 45 London five-year survival rates for cancer overall between 1985 and 2003



Source: Cancer Registry

One-year survival rates can be used as a good proxy measure for stage of presentation and wider burden of disease for the local population. Five-year survival can be used as an indicator of overall outcomes, including both stage of presentation and quality of care provided [1, 2]. When examined for the four major cancers in Bromley some interesting patterns are observed (Tables 10 and 11).

Table 10 One-Year Relative Survival Rates for breast, colon, lung and prostate cancer diagnosed between 2002-2006 in Bromley, South East London, London and England

	Bromley PCT	South East London Cancer Network (SELCN)	London Strategic Health Authority	England
Breast	**96.6%**	95.7%	95.2%	95.4%
Colon	**73.8%**	72.1%	71.6%	72.6%
Lung	**31.8%**	30.1%	30.8%	28.4%
Prostate	**92.2%**	93.3%	94.5%	94.3%

Source: NCIN/APHO/UKACR from Cancer E-Atlas 2010

Table 11 Five-Year Relative Survival Rates for breast, colon, lung and prostate cancer diagnosed between 1998-2002 in Bromley, South East London, London and England

	Bromley PCT	South East London Cancer Network (SELCN)	London Strategic Health Authority	England
Breast	**85.7%**	80.7%	80.8%	82%
Colon	**45.5%**	48.2%	50.0%	51.9%
Lung	**8.1%**	7.3%	8.8%	7.5%
Prostate	**70.2%**	78.6%	81.0%	78%

Source: NCIN/APHO/UKACR from Cancer E-Atlas 2010

One and five-year survival rates for breast cancer are good in Bromley and are currently above the SELCN, London and England averages. This is similar for lung cancer, although Bromley's 5-year survival rate is below the average for London. As mentioned above both of these cancer types have mortality rates which are steadily falling and currently below the London and national averages.

For colorectal cancer, survival is good at 1 year but falls below the local and national averages at 5 years. Survival for prostate cancer is below the local and national averages at both 1 and 5 years. Some further investigation as to why this may the case is required.

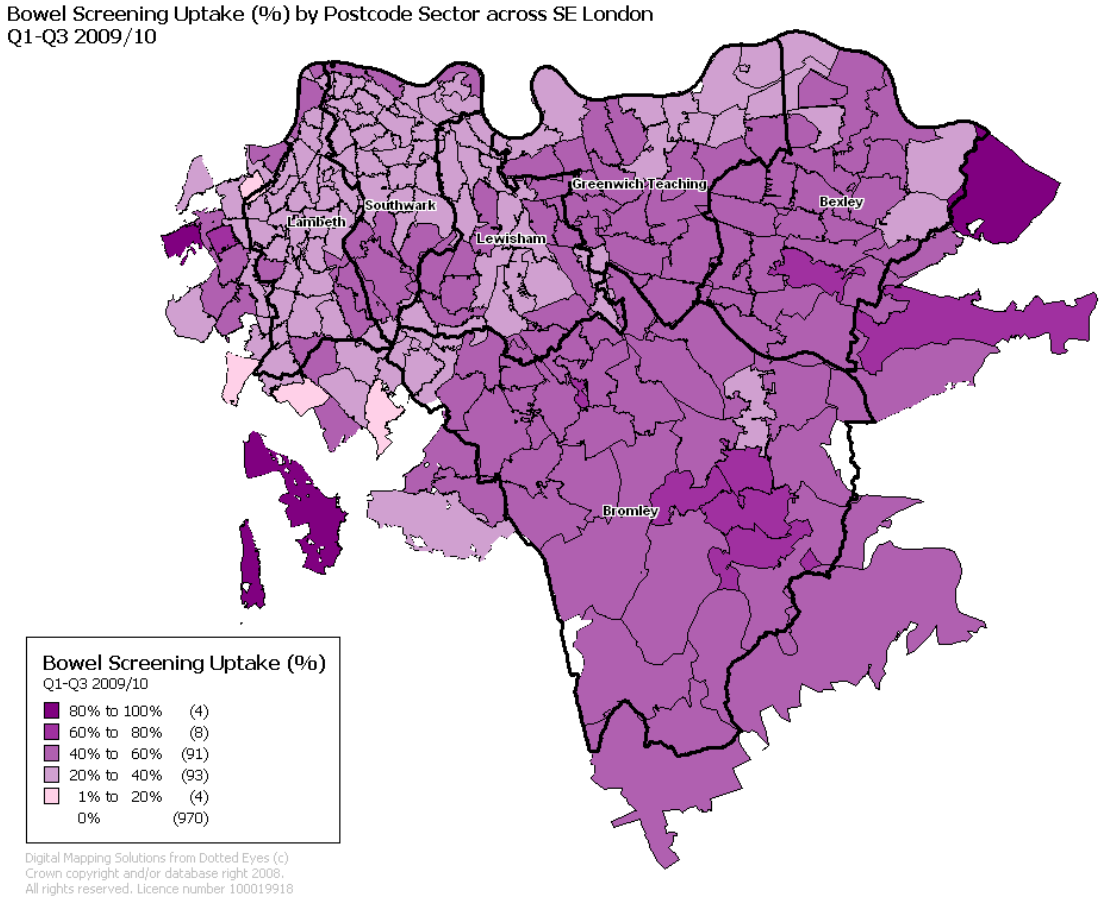
Screening

There are national screening programmes for both breast and colorectal cancer.

The breast cancer screening programme in Bromley has good levels of uptake 70.3% in 2008-09 (target level 70%). However, a health equity audit of breast screening in 2006 (updated in 2007) showed a definite association between deprivation and low levels of breast screening uptake in Bromley, indicating where work might be targeted to improve breast screening coverage even further.

The colorectal screening programme started this year in Bromley, and became available in all areas of Bromley in April 2010.

Figure 46 Bowel Screening Uptake Across SE London



Respiratory Disease

COPD

The prevalence of COPD has been rising over the last three years (Table 12). This is likely to reflect improvements in case finding and recording of COPD rather than a rise in prevalence, since the main risk factor for COPD, smoking, has been reducing in prevalence.

Table 12 QOF COPD Prevalence

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
No. on practice COPD register	3102	3342	3509	3735	4006	4143
COPD Prevalence	0.86%	1.02%	1.36%	1.37%	1.52%	1.57%

Source: QMAS

Infectious Diseases

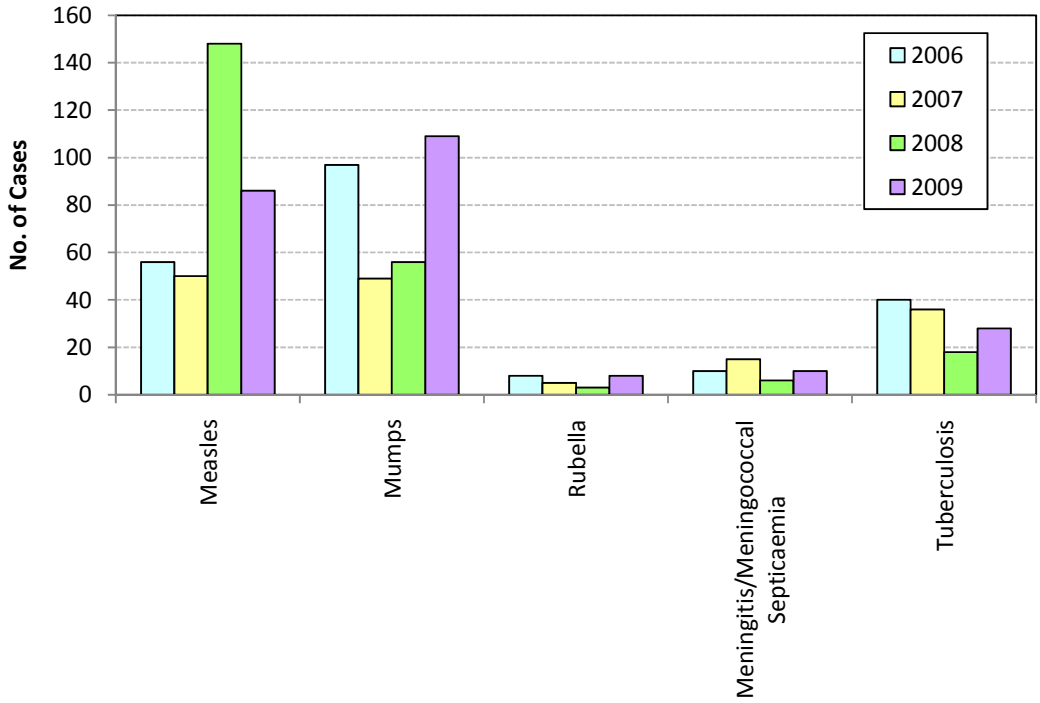
Notifications of infectious diseases in Bromley have fallen in number since 2005, but have seen an increase between 2007 and 2009 (Table 13).

Table 13 Infectious Disease Notifications in Bromley 2005-2007

Disease	**2005**	**2006**	**2007**	**2008**	**2009**
Acute encephalitis	1	0	0	0	0
Cholera	0	0	0	0	0
Dysentery	0	6	2	1	1
Food Poisoning	471	479	314	378	395
Leptospirosis	0	0	0	0	0
Malaria	2	2	13	2	4
Measles	21	56	50	148	86
Meningitis	0	7	11	6	5
Meningococcal Septicaemia	1	3	4	0	5
Mumps	464	97	49	56	109
Ophthalmia neonatorum	0	0	0	0	0
Paratyphoid fever	0	2	1	0	0
Rubella	5	8	5	3	8
Scarlet Fever	9	44	12	14	45
Tuberculosis	29	40	36	18	32
Typhoid Fever	1	2	2	0	0
Viral Hepatitis	6	2	5	5	3
Whooping Cough	6	3	2	7	4
Total	**1016**	**753**	**506**	**638**	**683**

The largest rises in incidence in the last year have been in mumps and scarlet fever cases (Figure 47).

Figure 47 Infectious Disease Notifications in Bromley 2006 to 2009



Measles and Mumps

Measles is a preventable disease which can cause significant morbidity and mortality.

- 1 in 15 children will have further illness such as diarrhoea, vomiting, conjunctivitis, meningitis and pneumonia.
- Measles causes 1 million deaths world wide each year and in the year the vaccine was introduced 16 children in the UK died. Measles is preventable through immunisation with 2 doses of the MMR vaccine.
- The World Health Organisation's target is for 95% of eligible children to be vaccinated using the MMR vaccination

Table 14 MMR Vaccination Bromley versus National Average Uptake

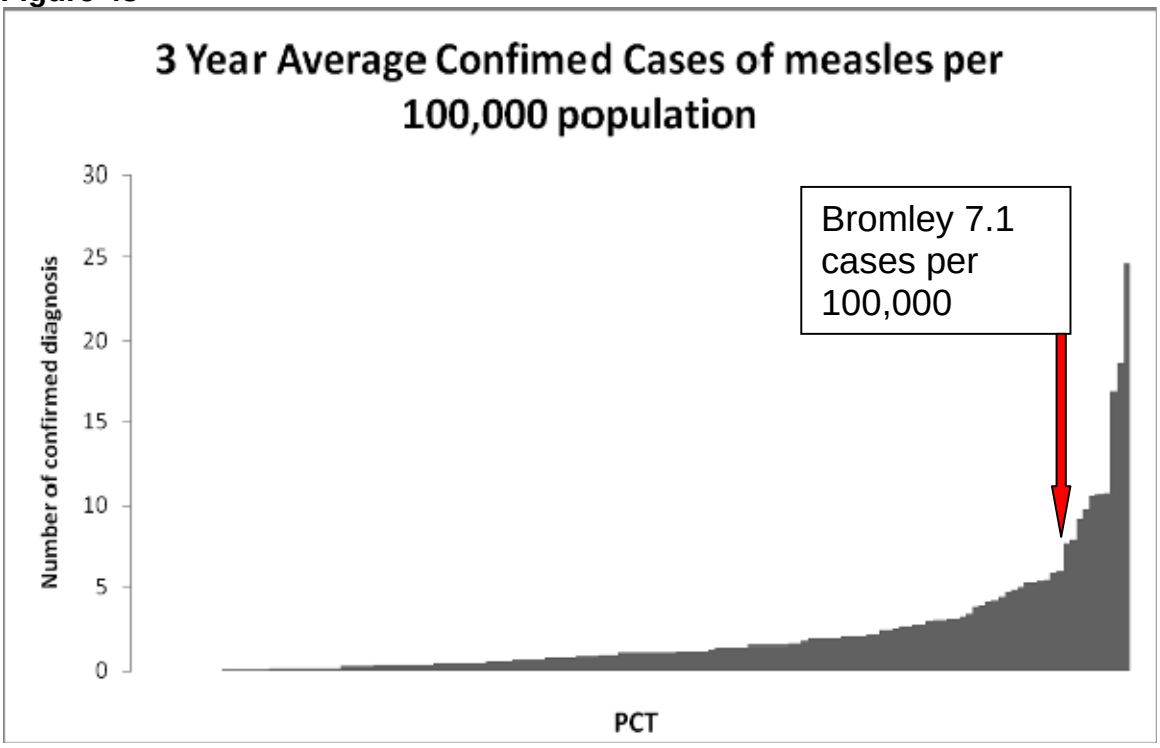
	Bromley	National Average	Position of Bromley PCT of 152 PCTs
Percentage uptake of MMR first dose by 2 years	82.2 %	84.9 %	**34th Lowest Uptake**
Percentage uptake of second dose by 5 years	71 %	78 %	**25th Lowest Uptake**

Uptake of the MMR vaccine is important to consider alongside Measles rates to look at the impact of the vaccination rates on the burden of disease.

The 3 year average number of confirmed cases of Measles per 100,000 population within Bromley is 7.9 compared with a national average of 2.

This means Bromley has the 9th highest Measles rate of the 152 PCTs in the country

Figure 48



HPV Vaccine

There are more than 100 types of HPV (human papillomavirus), including 40 which can infect the genital tract and are sexually acquired. Genital HPV infections are frequently asymptomatic and resolve without causing disease.

HPV infections are extremely common in the sexually active population and are particularly common in the first few years after onset of sexual activity.

Certain HPV infections can cause cervical cancer. HPV types associated with cancer are called oncogenic or 'high risk' types; 13 have been recognised by the WHO International Agency for Research on Cancer.

Cervical cancer is the second most common cancer in females worldwide and is the 12th most common cancer in females in the UK. Over 70% of cervical cancers are attributed to two types: HPV 16 and 18.

In the UK, a national HPV immunisation programme was introduced for all girls aged 12-13 years (school year 8) in Autumn 2008, and will protect girls against infection with HPV 16 and 18
In Bromley uptake of all 3 doses of Human Papillomavirus vaccine by girls aged 12-13 years is equal to the national average of 80.1%

Sexually Transmitted Diseases

National Chlamydia Screening Programme (NCSP)

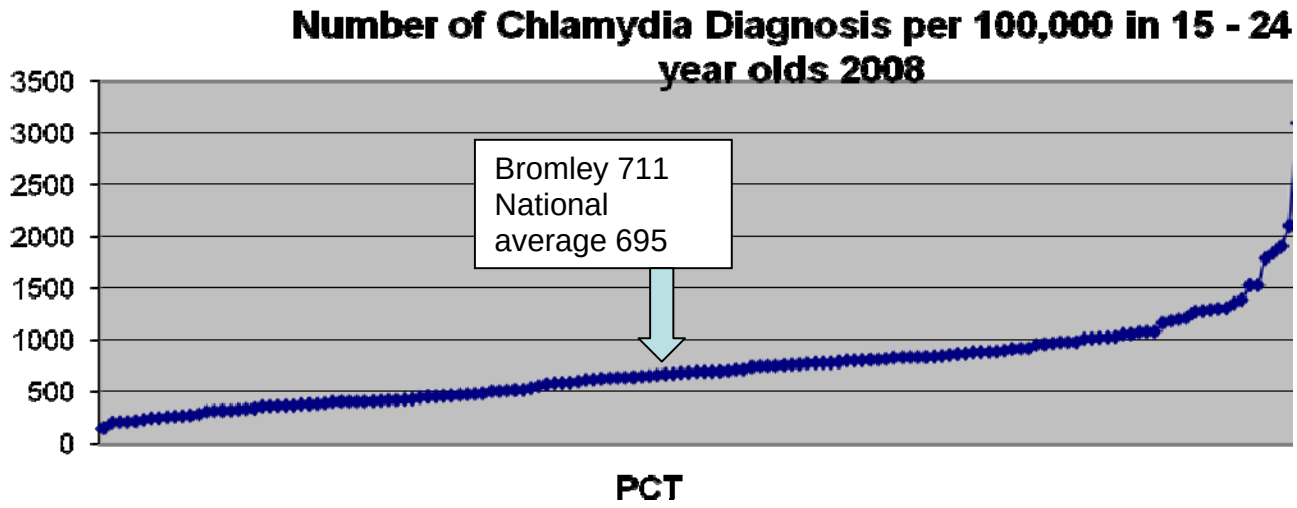
Genital Chlamydia trachomatis is the most common sexually transmitted infection (STI) diagnosed and treated in the United Kingdom. Highest rates are seen in mainly young men and women under 25 years old**.** Up to 80% of females and 50% of males with the infection have no symptoms

The NCSP in England was established in 2003 with the objective of controlling chlamydia through the early detection and treatment of asymptomatic infection, thus preventing the development of complications of the infection and reducing onward disease transmission. Young adults between 15-24 years are targeted in the screening programme

Untreated Chlamydia infection can have serious long-term consequences, particularly for women, in whom it can lead to pelvic inflammatory disease (PID), ectopic pregnancy and tubal factor infertility. In men it can result in urethritis and epidydimitis and in both men and women it may lead to arthritis

In 2008, over 702 diagnoses per 100,000 15-24 year olds were made in Bromley, which is higher than the national average

Figure 49



HIV

HIV is a viral infection which leads to an impaired immune system resulting in serious illness.

HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and high number of potential years of life lost. Each year, many thousands of individuals are diagnosed with HIV for the first time. The infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed. Highly active antiretroviral therapies have resulted in substantial reductions in AIDS incidence and deaths in the UK.

Individuals aged 15-59 years diagnosed with HIV and aware of their infection who accessed HIV-related care at an NHS site were counted in 2007. The number of HIV diagnosed individuals per 1,000 resident population was calculated for each PCT.

In Bromley there was a value of 1.8 HIV diagnoses per 1,000 of the population. This means there are approximately 540 individuals living in Bromley accessing HIV related care. This is higher than the national average of 1.6 diagnoses per 1,000 of the population.

Late Diagnosis of HIV

Individuals diagnosed with HIV infection with CD4 cell counts less than 200 cells per mm3 (a measure of the number of cells in the blood) are considered late as they cannot start anti-HIV therapy as guidelines recommend. Therefore they may not fully benefit from therapy and have a higher risk of HIV-related death. Timely diagnosis is therefore essential for the initiation of effective treatment.

In 2008, 57% of HIV-infected individuals who died were diagnosed in the same year with a CD4 count <200 cells/mm3.

In 2008 there were fewer patients diagnosed late with HIV in Bromley (28%) than the national average (32%).

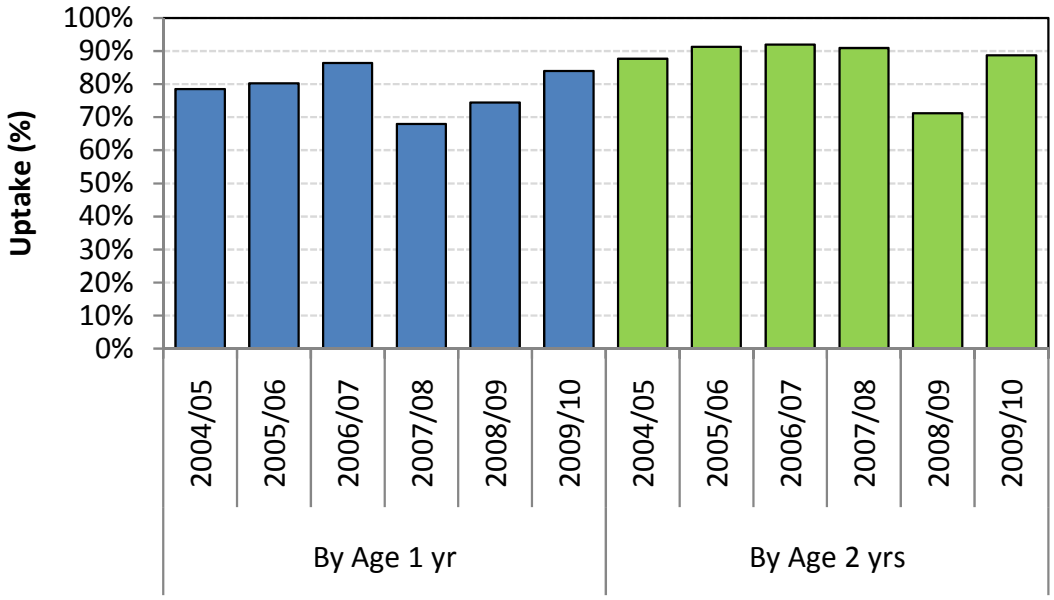
Food Poisoning

Food poisoning was the most commonly notified disease in Bromley (and in S.E London) in the years 2005-2009. A number of these outbreaks occurred in schools and nurseries. Although there has been a reduction in food poisoning rates since 2005, the findings suggest that food poisoning and gastrointestinal infections are a key area that should be targeted in Bromley.

Meningitis/Meningococcal Septicaemia

The numbers of cases of meningitis and meningococcal septicaemia are low, but the seriousness of these illnesses means that it is important to try to protect people against them.
Figure 50 below shows that Meningitis C vaccination coverage has increased in the last year, following a dip the year before.

Figure 50 Uptake of Meningitis C Vaccination



Source: COVER

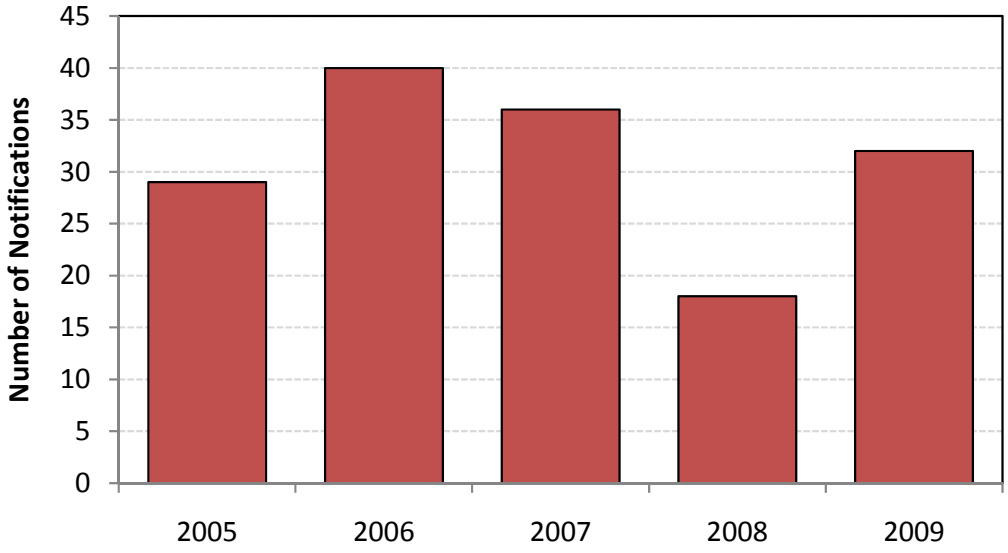
Tuberculosis

Tuberculosis cases in Bromley are low in number, and there was a reduction in 2008 to 18, half the number seen in the previous year. However this has increased to 32 cases in 2009. These apparently large fluctuations in case numbers from year to year reflect the fact that relatively small numbers are involved (other SE London boroughs such as Lambeth, Southwark and Greenwich have over 100 cases a year).
Cases of TB are more common in the Northwest of the borough, in young adults and people of Black African ethnic origin.

Table 15 Number of TB Notifications 2009 by Ethnic Group, Bromley PCT

Ethnicity	No. Notifications
White	6
Indian	5
Pakistani	1
Bangladeshi	2
Black-Caribbean	5
Black-African	9
Black-Other	0
Chinese	1
Other	3
Unknown	0
Total notifications	**32**

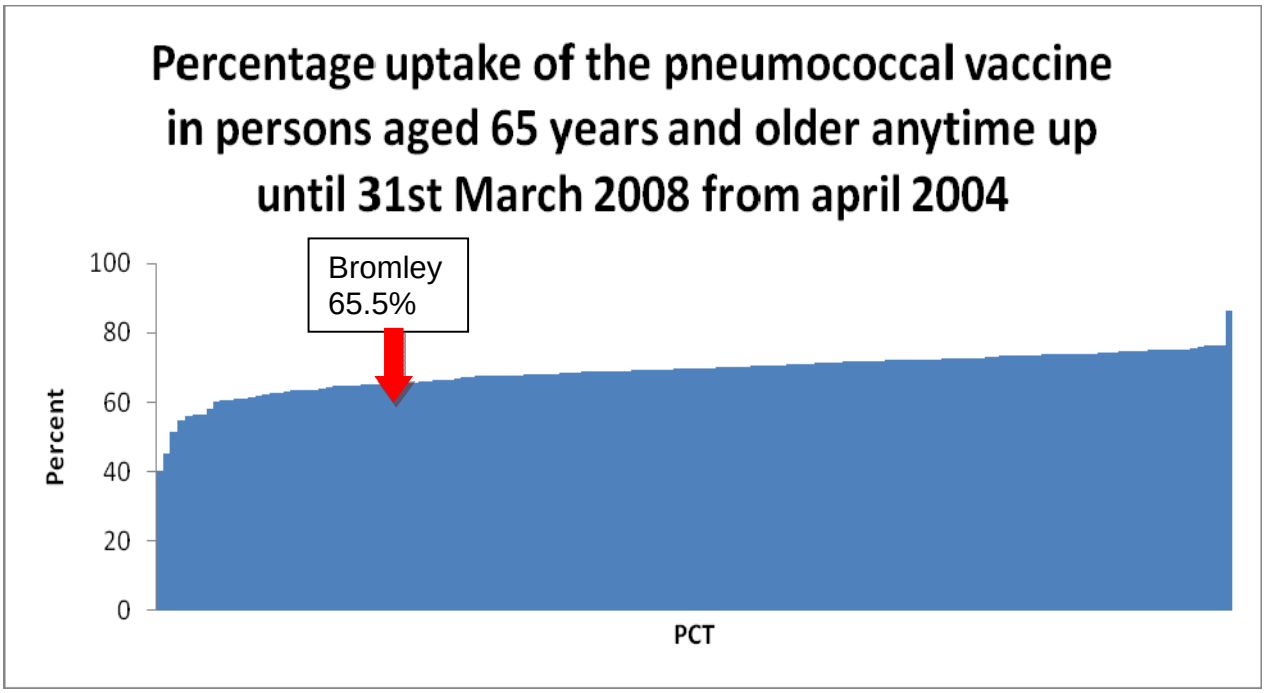
Figure 51 Number of TB Notifications



Respiratory Indicators

Pneumococcal disease is a major cause of morbidity and mortality both globally and in the UK. It particularly affects the very young, the elderly, those with an absent or non-functioning spleen and other causes of impaired immunity. Bromley has a low uptake of Pneumococcal Vaccine making it the 35th Lowest PCT.

Figure 52



There is a marked seasonal pattern in Pneumococcal disease, with the greatest reports occurring in December and January each year. There are an estimated 40,000 hospitalisations due to pneumococcal pneumonia, and 40,000 GP consultations for pneumococcal related community acquired pneumonia each year.

Seasonal flu vaccine

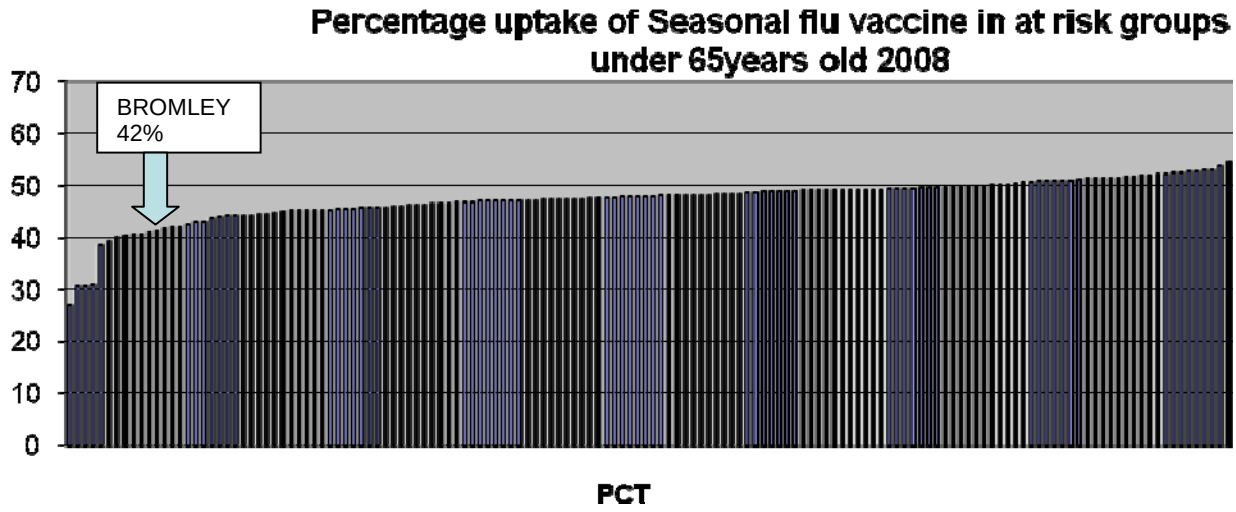
The seasonal flu vaccine is formulated each year to protect against the main strains of Influenza which are circulating that year.

It is recommended that persons aged under 65 and in specific at risk groups (Chronic Heart Disease, Chronic Respiratory Disease, Chronic Renal Disease, Chronic Liver Disease, Diabetes, Immunosuppression, Stroke/TIA, Chronic Degenerative Neurological Disease) receive the vaccine as well as those aged over 65 years.

It is important for these at risk groups to receive the flu vaccination. For most people influenza infection is just a nasty experience, but flu for an individual in one of the at risk groups can lead to more serious illnesses. The most common complications of influenza are bronchitis and secondary bacterial pneumonia. These illnesses may require treatment in hospital and can be life threatening.

Uptake of the seasonal flu vaccine in persons at risk under the age of 65 years is 42%. This is 5% below the national average making Bromley the 15th lowest rated PCT for uptake of seasonal flu Vaccine in at risk individuals less than 65 years of age.

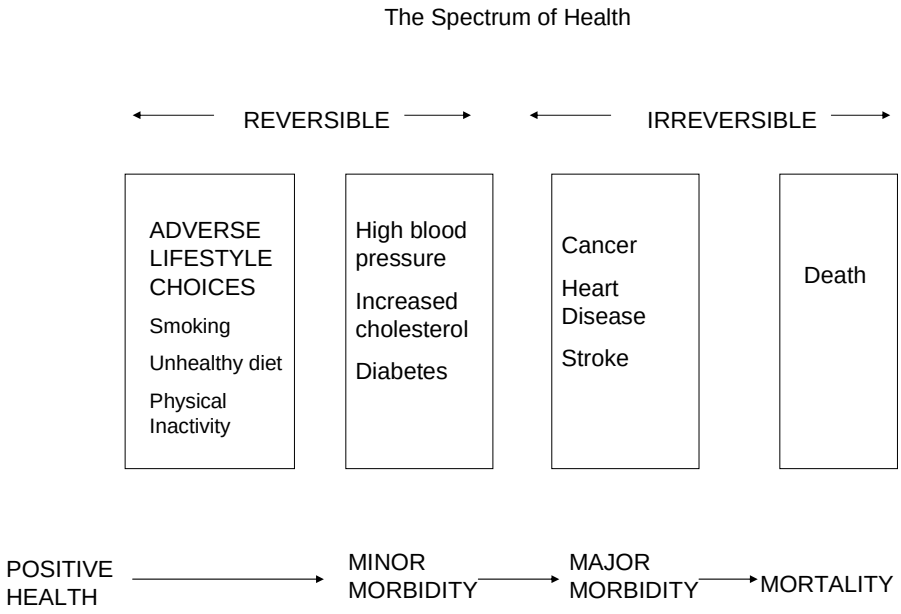
Figure 53



Risk Factors for Chronic Disease

We can view our health as lying on a spectrum between positive health (physical, mental and emotional wellbeing) and death.

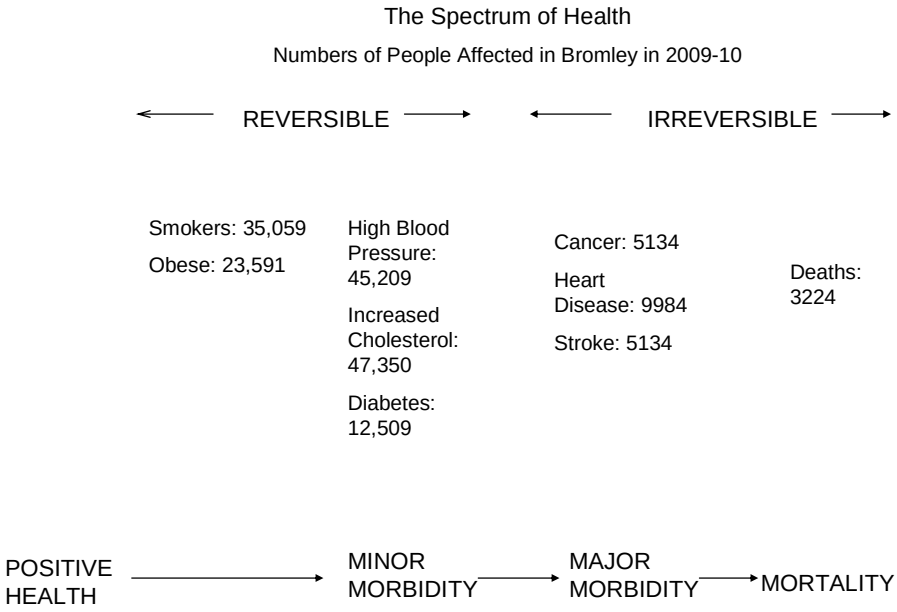
Figure 54 The Spectrum of Health



We can shift along the spectrum from a position of positive health to illness by making adverse lifestyle choices, such as smoking or eating an unhealthy diet. Continuing unhealthy behaviours can lead to irreversible events, such as heart attack or stroke. However, adopting a more healthy lifestyle (stopping smoking, eating a healthy diet, exercising) can reverse early changes, such as high blood pressure and increased cholesterol levels, reducing the risk of progression to more serious disease. People who already have established heart disease or who have had a stroke, will also benefit from a healthier lifestyle by reducing the severity and progression of the disease.

By adding local figures to the Spectrum of Health diagram, we can see the numbers of people at risk of or already suffering from chronic disease in Bromley.

Figure 55 The Spectrum of Health in Bromley



Data Source: QOF 2009-10, PHMF (2009), CVD Audit 2009

It should be noted that we do not have a record of the smoking status, body mass index, blood pressure or cholesterol level of everyone in Bromley, so the numbers are likely to be higher than presented here. The numbers of people with diabetes, heart disease and stroke, and the numbers of deaths are likely to be more accurate, since recording of these conditions is more complete.

Although some of the people counted here as having adverse lifestyle choices and minor morbidity, already have major morbidity, there are still large numbers of Bromley residents (over 45,000) who have the opportunity to reverse the progression to major morbidity and early death.

Table 16 shows the attributable risks for different diseases. The attributable risk represents the proportion of cases resulting from exposure to a particular risk factor e.g. 87% of cases of lung cancer are directly related to the effects of smoking.

Table 16 Attributable risks

Risk Factor	Disease	Attributable Risk	Percentage of Deaths Attributable
Smoking	Lung Cancer Cervical cancer Heart Disease Stroke Hip Fracture	87% 32% 22% 37% 10%	33%
Physical Inactivity	Heart Disease Stroke	35% 60%	23%
Obesity	Breast Cancer Heart Disease	12% 17%	24%
Raised Cholesterol	Heart Disease	43%	23%

Circulatory disease and cancer are the main causes of death and also the main contributors to health inequalities in Bromley, so it makes sense to focus on the key risk factors for these diseases, namely: smoking and obesity, physical inactivity and alcohol abuse.

Smoking

Smoking is the greatest preventable cause of premature death and avoidable illness. As Table 1 shows, it is a key risk factor for heart disease, stroke and cancer.
Nationally, 24% of people aged 16 years and over smoke. Smoking prevalence in Bromley is estimated to be 21.9% (approximately 65,000 smokers). In Bromley, GPs have a record of smoking status for approximately 70% of registered patients aged 16 years and over; 35,000 people have told their GP that they smoke.

Smoking prevalence is highest in the following wards:

- Crystal Palace
- Penge & Cator
- Mottingham & Chislehurst North
- Cray Valley East
- Cray Valley West

Although evidence suggests that 75% of those who smoke want to give up, the numbers of smoking quitters are relatively low. In 2009-10, over 1600 smokers in Bromley quit through NHS Stop Smoking Services. Although this is a significant

improvement on previous years, it represents less than 5% of smokers in Bromley.

Obesity

Obesity is a key risk factor for circulatory disease and cancer, and also for diabetes, which is a precursor to circulatory disease.
Obesity has an attributable risk for Type 2 diabetes of 24%. Therefore, any changes in the prevalence of obesity will have significant impact on the prevalence of diabetes.

The data from the Health Survey for England (2006) shows the national prevalence of 22% in men and 23% in women. The expected rise is greater in men than in women, potentially leading to a 29.7% and 27.8% prevalence in 2010 in men and women respectively.

Primary Care data shows that 23,591 people aged over 16 years in Bromley have been recorded by their GP as being obese (Body Mass Index >30). This is 9% of the registered population aged over 16 years. However, we know that body mass index has only been recorded in approximately 29% of registered patients aged 16 years and over in the last 15 months. The obesity level among those with a BMI recorded is 26%.

The Health Acorn data places the bulk of Bromley's population in the category *possible future concerns*.
This category comprises areas with lower levels of smoking, obesity and average, or slightly below average, incidence of illnesses – so far, so good. However, diet, while not exceptionally poor, does sometimes give cause for concern. **Although consumption of vegetables is highest in this group so too is the consumption of fat, sugar and confectionery**.
Awareness of illnesses and the causes are likely to be good with higher than average education levels; but perhaps knowledge is not always translated into action and the relative wealth of this group means that whilst they try and live healthily – they're able to **reward themselves with treats** and enjoy **some of the finer things in life** which might not always be the best for their health now or in the future.

Data on the prevalence of childhood obesity were recorded systematically for the first time in 2005/6 as part of the National Child Measurement Programme (NCMP) and show that there are particular geographic areas with a higher proportion of obese children in the more northerly parts of the borough, such as the Crays and Penge. (Figure 56a and b).

Table 17 Childhood Obesity Trends in Bromley

Year Group	Bromley				National			
	2005/06	2006/07	2007/08	2008/09	2005/06	2006/07	2007/08	2008/09
Reception: Overweight	6.9%	11.9%	10.0%	12.3%	12.8%	13.0%	13.0%	13.2%
Reception: Obese	8.3%	8.4%	7.3%	7.3%	10.0%	9.9%	9.6%	9.6%
Year 6: Overweight	12.8%	12.5%	12.4%	15.5%	13.8%	14.2%	14.3%	14.3%
Year 6: Obese	12.5%	15.5%	15.7%	16.0%	17.3%	17.5%	18.3%	18.3%

Source: Bromley PCT, Department of Public Health

When comparing 'obese children' against all children generally (based on the NCMP data set), those children that come from homes and households that can be classified as 'Future Problems', using the Health ACORN classification, are over-represented.

Whilst from a volume perspective 'Possible Future Concerns' group contribute a greater number of children generally, those with obesity/ weight problems are more likely to come from the 'Future Problems' group. In Bromley, 7% of households can be classified as this type and whilst this is lower than the UK average – these households are likely to have unhealthy lifestyles and are likely to suffer from illnesses in the future.

Figure 56a Obesity prevalence, Year 6, 2008/0956

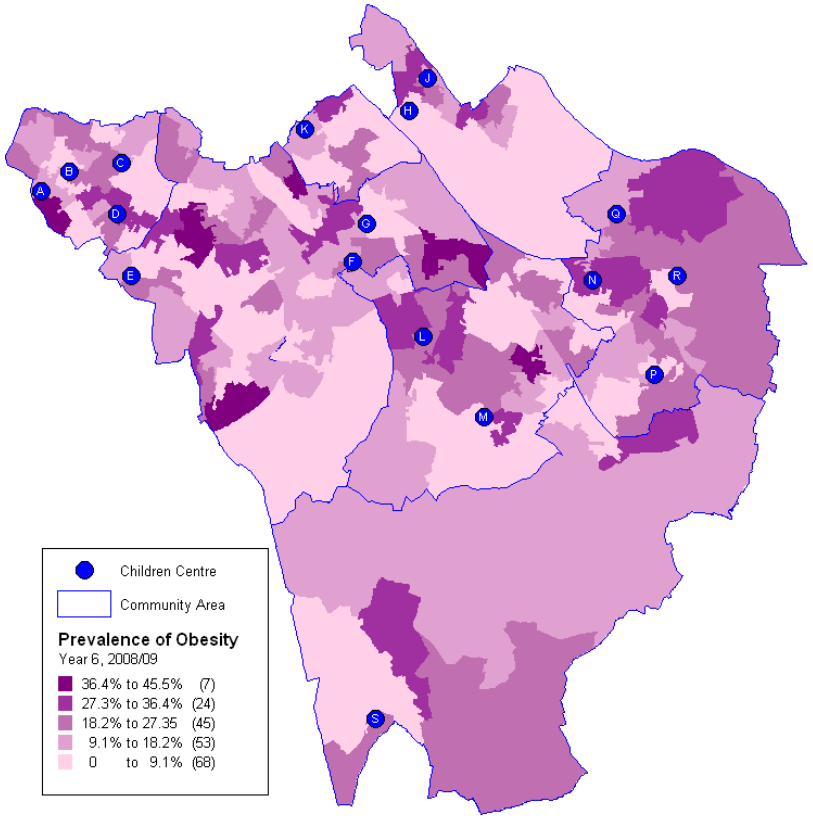


Figure 56b Obesity prevalence, Reception, 2008/09

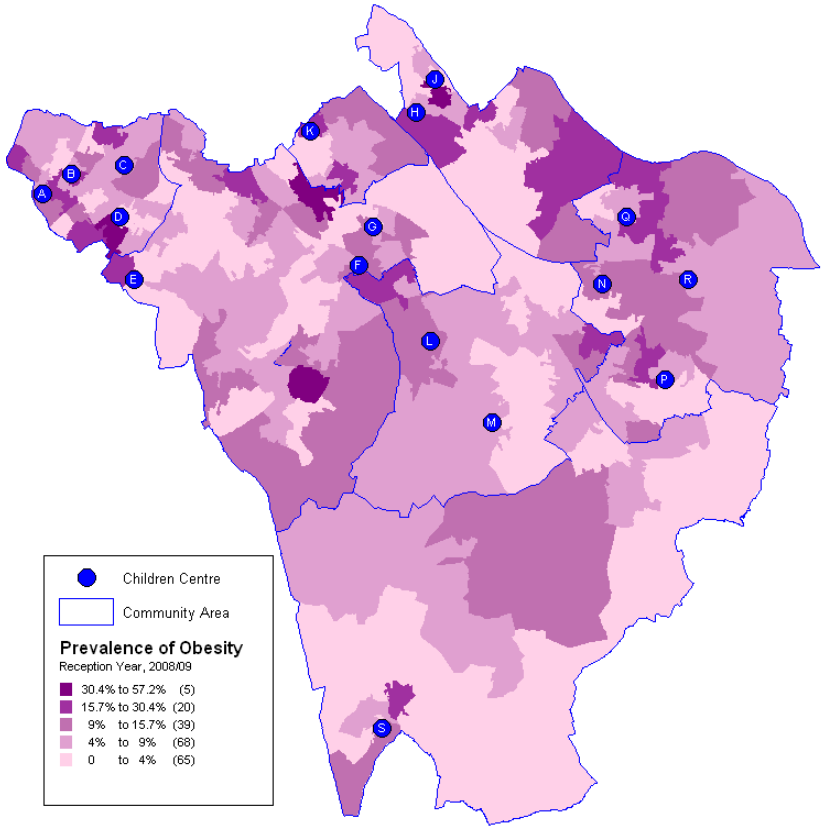
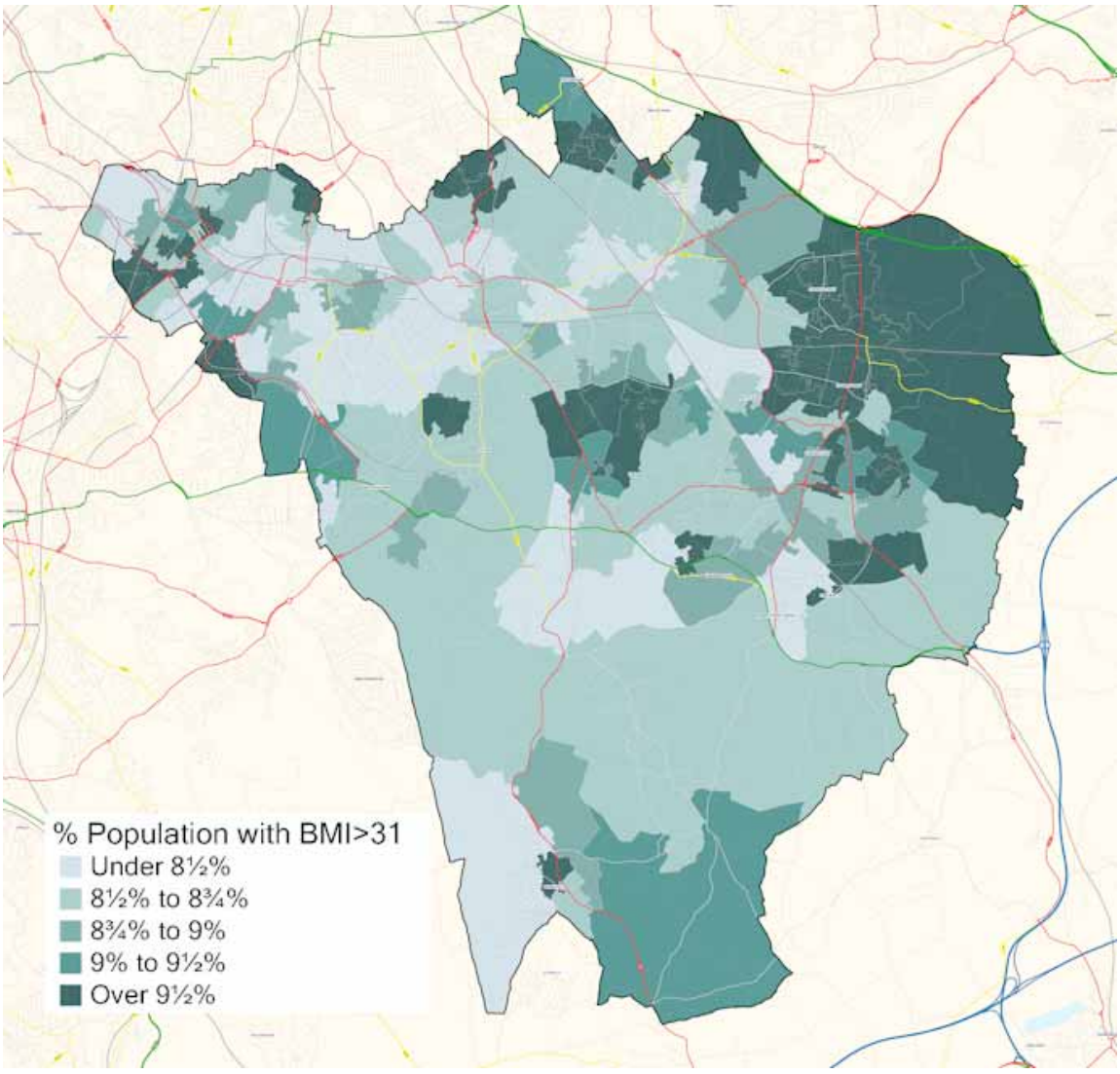


Figure 57 Modelled Population with BMI Greater than 31



Source: CACI, CVD Audi

Alcohol

Alcohol consumption accounts for 4% of all disease burden worldwide, and accounted for 3.1% of all deaths in England in 2005[4].

Young people are disproportionately affected by alcohol use, with 26.6% of all deaths estimated to be attributable to alcohol consumption, compared with 1.4% among those aged 75 years and over.

In those aged less than 35 years, deaths are most likely to occur from the acute consequences of alcohol consumption, in particular, intentional self-harm and road traffic accidents.

Beyond the age of 35 years, liver cirrhosis, cancer of the oesophagus and breast, and hypertensive diseases are the most common causes of death attributable to alcohol.

In Bromley, the synthetic estimates of increasing risk and higher risk are lower than the national and regional averages. Although the rate of binge drinking for Bromley is lower than the national average, it is slightly higher than the London regional average.
The incidence of alcohol-related recorded crimes and violent crimes in Bromley are higher than the national average, but lower than the London regional average.
Alcohol-attributable hospital admissions have been rising over the past 5 years.
Alcohol-attributable mortality in men was falling in the four years to 2008, but saw a rise in 2008. Alcohol-attributable mortality in women has been rising over the three years to 2008.

Table 18 Alcohol Related Statistics for Bromley

Indicator	Measure	National Rank[1]	Regional Average
Increasing Risk Drinking[2]	18.7	49	18.8
Higher Risk Drinking[2]	4.4	38	5.1
Binge Drinking[2]	14.4	20	14.3
Alcohol-related recorded crimes	9.2	101	12.2
Alcohol-related violent crimes	6.4	102	8.5
Alcohol-attributable mortality (males)[3]	30.8	31	35.2
Alcohol-attributable mortality (females)[3]	14.0	61	12.8

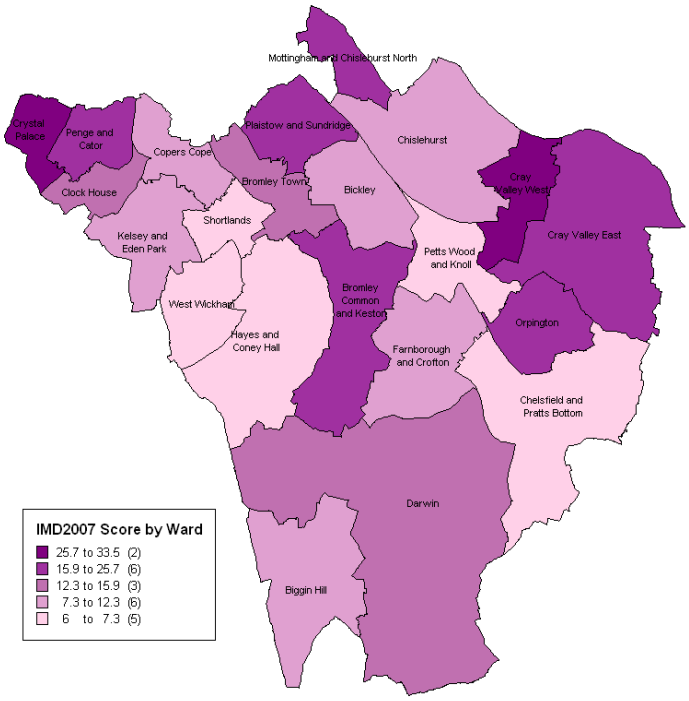
1. Rank of 1 is the best Local Authority, rank of 152 is the worst.
2. Synthetic estimate, % of the population aged 16 years and over
3. Directly standardised rate per 100,000 population
Source: Local Alcohol Profiles for England 2010

[4] Alcohol-attributable fractions for England, Lisa Jones, Mark A Bellis, Dan Dedman, Harry Sumnall, Karen Toque, Centre for Public Health, Faculty of Health and Applied Social Sciences, Liverpool John Moores University. June 2008

1.5 Inequalities in Bromley

A health inequality is a difference in health and well being between different groups of people. Health inequalities are not distributed randomly, but show a consistent pattern in most populations.
Mortality and morbidity increase with declining social position and poverty. In Bromley this is illustrated by poorer health outcomes in areas of higher deprivation.

Figure 58 Map Showing Index of Multiple Deprivation by Ward



In general, the five most deprived wards in Bromley are consistently amongst those with the poorest health outcomes.

These wards are:

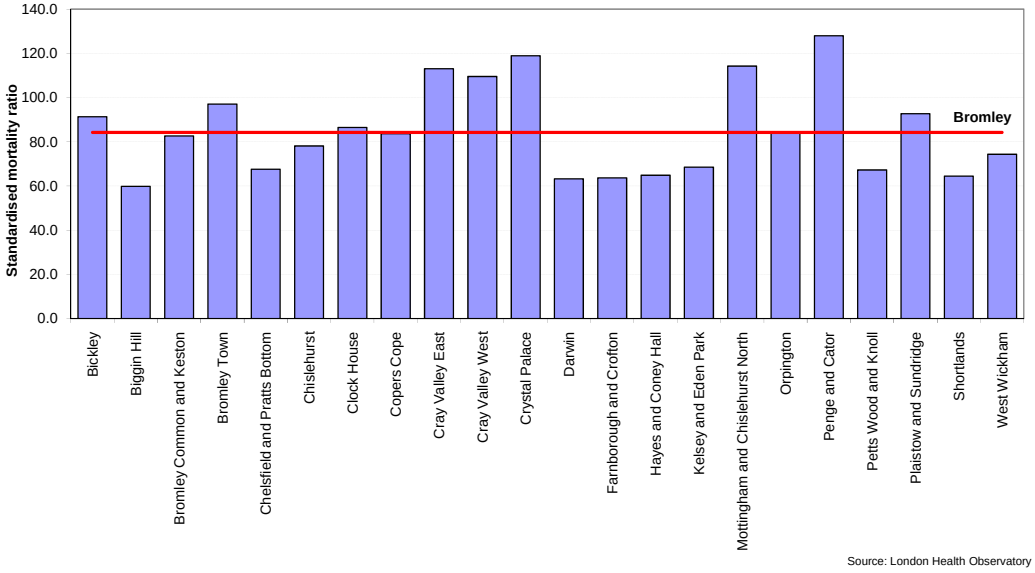
- Penge & Cator
- Crystal Palace
- Mottingham & Chislehurst North
- Cray Valley East
- Cray Valley West

Life Expectancy

Life expectancy is lowest for men in Penge & Cator (74.8 years) and for women in Mottingham & Chislehurst North (80.0 years).

Similarly, all cause mortality in the under 75 year age group (i.e. premature mortality), is highest in Penge & Cator, Crystal Palace, Mottingham & Chislehurst North, Cray Valley East and Cray Valley West.

Figure 59 All cause mortality by ward, less than 75 years, 2003-2007



Source: London Health Observatory

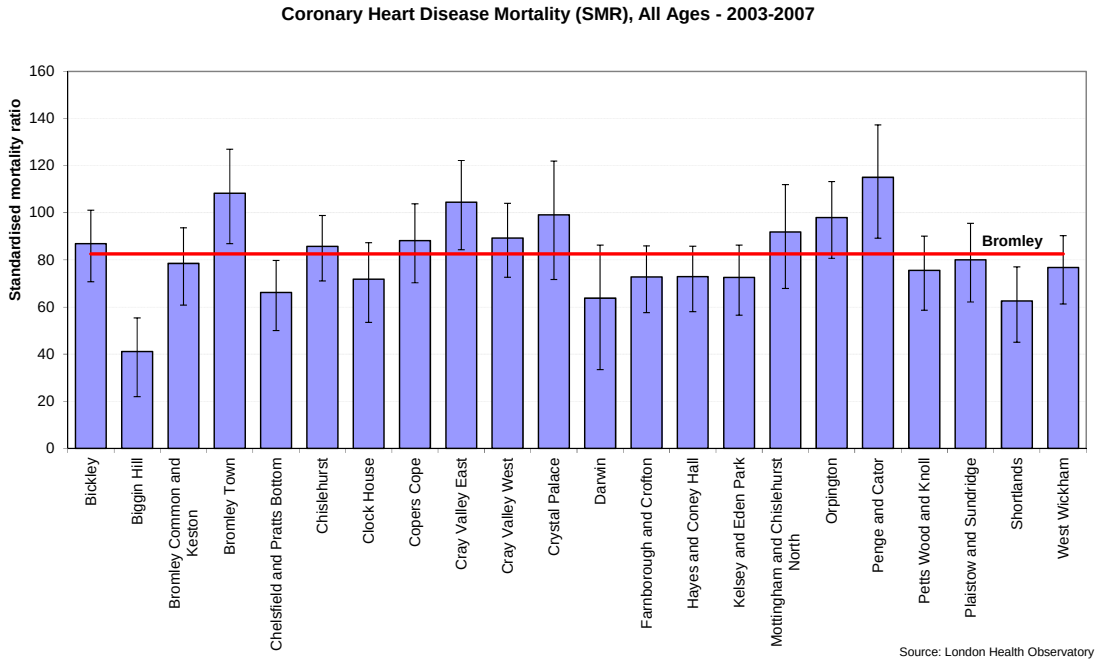
There is a 68% difference between the ward with the highest mortality rate under the age of 75 years (Penge & Cator) and the ward with the lowest mortality rate (Biggin Hill).

Coronary Heart Disease

Although coronary heart disease (CHD) mortality in Bromley is below the national average, inequalities exist in CHD mortality. There are three wards (Bromley Town, Cray Valley East and Penge & Cator) where CHD mortality exceeds the national average.

The other most deprived wards (Crystal Palace, Mottingham & Chislehurst North and Cray Valley West) have higher CHD mortality than the Bromley average.

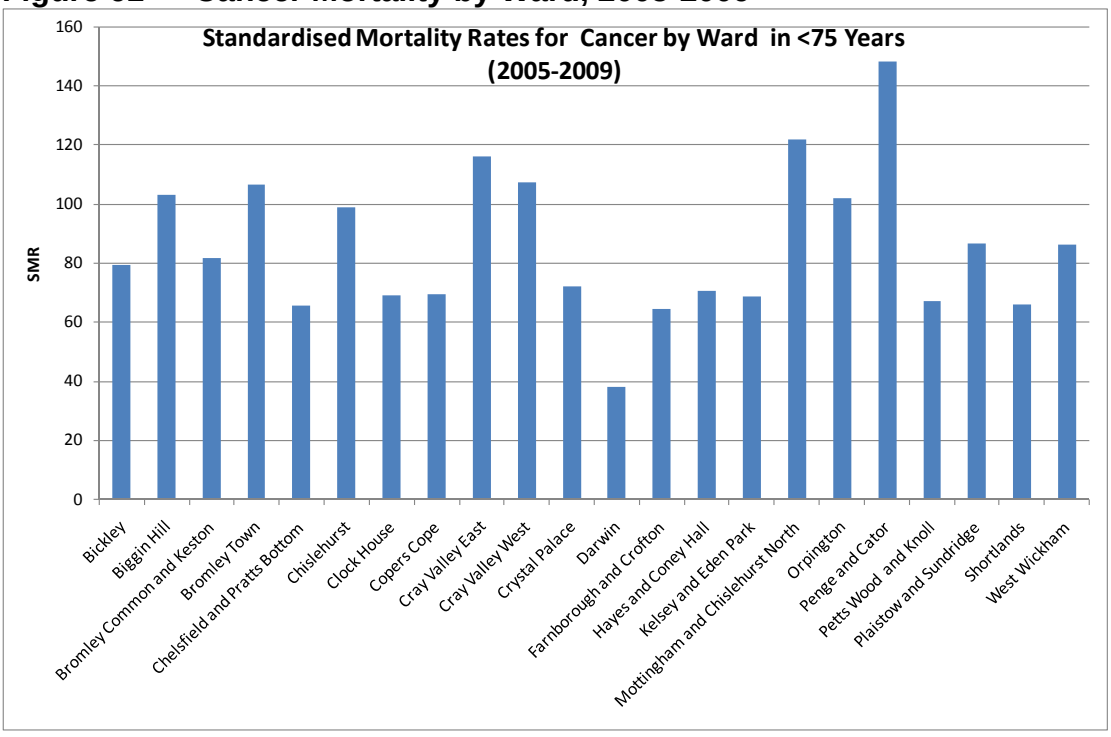
Figure 60 Coronary Heart Disease Mortality by Ward, 2003-2007



Cancer

Inequalities can also be seen in cancer outcomes.
Standardised mortality rates for premature cancer deaths (under the age of 75 years) are higher than the national average in seven wards in Bromley, of which four (Cray Valley East, Cray Valley west, Mottingham & Chislehurst North, Penge & Cator are in the most deprived group.

Figure 61 Cancer Mortality by Ward, 2005-2009



In addition, there is evidence from health equity audits that uptake of cancer screening services (breast cancer) is lower in the more deprived wards.

Immunisation
The Immunisation Health Equity Audit summary included in Section 2 of this JSNA report, shows that there is a variation in childhood immunisation uptake rates between Bromley wards.
Childhood immunisation uptake is lowest overall in Penge & Cator, and Mottingham & Chislehurst North, again two of the most deprived wards in Bromley.

Childhood Obesity
Obesity is a key risk factor for both coronary heart disease and for cancer. The data on childhood obesity (described earlier in this section) show that levels of childhood obesity are highest in the Crays and Penge & Cator.

Teenage Pregnancy
Whilst levels of teenage pregnancy are below the national average in Bromley, there are two wards with significantly higher rates: Crystal Palace and Cray Valley East.

Action
In recognition of these inequalities, NHS Bromley last year set out a five year plan to reduce inequalities, setting targets for the following areas:
• Life Expectancy
• Proportion of children completing MMR immunisation by their 5th birthday
• Smoking quitters
• Circulatory Disease mortality
• Coronary Heart Disease mortality
and identifying the five most deprived wards to receive targeted interventions to improve health outcomes (Penge & Cator, Mottingham & Chislehurst North, Crystal Palace, Cray Valley East, Cray Valley West).

Progress has been made in reducing the life expectancy gap by 0.9 years for men and by 0.2 years for women in the last year.
Targets for increasing the numbers of smoking quitters in the five wards have also been met.

SECTION 2

2.1 Needs Assessment Summary Introduction

The following section includes summaries of needs assessments and health equity audits carried out in the last year, together with recommendations for future action.

A consistent methodology is used for health needs assessments, based on the method described by Stevens and Raftery[5].

Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

Health equity audits aim to identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas. They aim to highlight the priority actions needed to provide services relative to need and so result in the recommendation of measures focused on reducing health inequalities.

Each summary ends with a list of recommendations for further action.

Section 2 ends with an update on the recommendations from last year's JSNA and an introduction to the work planned for next year's JSNA.

[5] Health care needs assessment: the epidemiologically based needs assessment
By Andrew Stevens, James Raftery, Wessex Institute of Public Health Medicine

2.2 The Health Needs of People with Learning Disability and Autism Spectrum Disorder

What is Learning Disability?

Learning Disability (LD) is a spectrum of reduced intellectual functioning. The three core criteria are:

- Significant impairment of intellectual functioning
- Significant impairment of adaptive/ social functioning
- Age of onset before adulthood

People with learning disabilities find it harder than others to learn, understand and communicate. People with profound and multiple learning disabilities (PMLD) need full-time help with every aspect of their lives including, eating, drinking, washing, dressing and toileting. In terms of this needs assessment, the definition of learning disability is based on the ability of an individual to function in life, as this is most important in terms of service needs.

This definition should be viewed alongside the **social model of disability** which proposes that systemic barriers, negative attitudes and exclusion by society (purposely or inadvertently) are the ultimate factors defining who is disabled and who is not in a particular society. The model does not deny that some individual differences lead to individual limitations or impairments, but rather that these are not the cause of individuals being excluded.

Background

People with learning disabilities have more health problems than other people, but find it harder to access the services they need. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities.

There has been a succession of shocking and high profile reports about continuing poor practice in service delivery to people with LD, highlighting a growing concern that people with learning disabilities are effectively invisible

to mainstream NHS services. Professionals working in general healthcare often have limited knowledge of learning disabilities, there is poor partnership working between agencies, and people with LD are not routinely identified in health data.

Aims of the needs assessment

The aim of the needs assessment was to assess current and future health needs of adults with learning disabilities, autism and Asperger syndrome, and to assess the degree to which needs are being met. The full report, which is summarized here, describes the current and predicted levels of health need over the next 10-20 years. It also describes current health services for this group, the problems that service users encounter, and the gaps between what users need and the services they are receiving. In doing this, we consulted with a wide range of staff and users in the health service, the local authority and the voluntary sector.

The policy context

A number of reports on the health inequalities faced by people with learning disabilities[1,2,3] resulted in the publication of *'Valuing People Now: A new three year strategy for people with learning disabilities'* (DH 2009).

Reasons for health inequalities among people with LD include:

- difficulties in accessing services
- difficulties in communicating with health professionals
- more health problems than the normal population
- under-diagnosis and under-treatment due to low awareness of LD among health professionals
- poorer access to health promotion and screening.
- lack of data on people with LD.

Included in the report's recommendations are

- more staff awareness training
- increasing use of annual health checks

- adjustments to services to improve access
- personal health plans, including health promotion
- better data collection

How many people have a learning disability?

There has been a tenfold increase in the learning disabled population since the middle of the 20th century, from around 2.5 per 1000 population to around 2.5%.This is likely to be due to a combination of reduced infant mortality and increased ascertainment. The numbers of adults with LD are expected to rise by 11% by 2021, and older people by 36%. There is a higher prevalence of learning disability among some ethnic groups from south Asia. About 60% of adults with LD live with their families.

In Bromley, there are an estimated 1062 people with moderate/severe LD, and 6250 with mild/moderate LD. Numbers of people with moderate or severe LD are expected to rise by around 80 by 2025, with the largest increases in the 25-34 and 55-64 age groups (Table 1 and Fig 1).

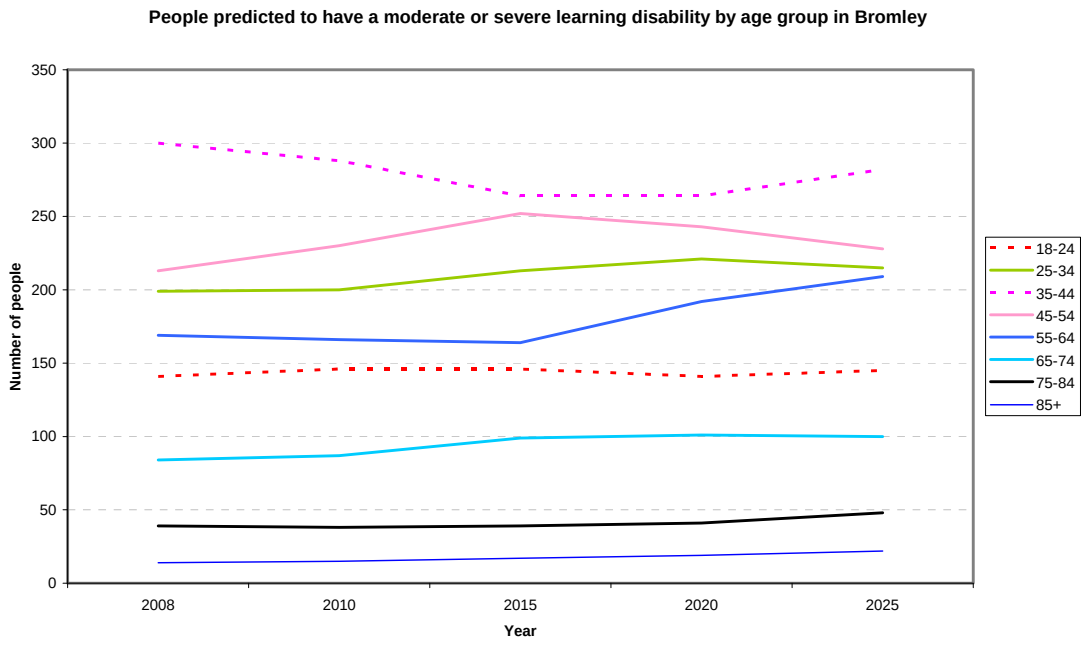
Table 1. Estimated prevalence of people with LD in Bromley

	Estimated prevalence	Estimated no. in Bromley
People with moderate/high LD	**0.425%**	**1062**
Those living in parental home	50%	530
Those living with elderly carers	33%	350
Those living in care homes	30%	340
Those living in supported housing	12%	130
Those living in NHS care	4%	40
People with mild/moderate LD	**2.5%**	**6250**

Because more babies with birth trauma and congenital disorders are surviving, an ongoing increase is expected in the numbers of people with

severe LD and complex needs. The number of men with autism and challenging behaviour is also rising.

Figure 1



Source: www.pansi.org.uk (18-64); www.poppi.org.uk (>65)

Approximately 800 adults with LD are in receipt of local social services in Bromley, representing approximately 75% of the estimated total number of people with moderate to severe LD in the area. Of these 800, 55 (28%) are from BME, and two out of three are men. This means that males, and people from BME groups, are both overrepresented among the group of people receiving social care services.

Bromley is experiencing a higher than average increase in the numbers of young people transitioning into adult care, with more and more complex conditions. This is probably due to the high standard of services for children with LD in Bromley. The greater the complexity of the condition, the higher the costs, therefore these young people will have a disproportionate effect on costs.

The health of people with learning disabilities

The number of health problems among people with learning disabilities has been estimated to be 2.5 times greater than among other people, and mortality rates are higher[1]. Health problems which are more common in people with LD include: respiratory disease (which is responsible for most deaths), epilepsy, swallowing difficulties, constipation, mental health problems, communication problems, visual and dental problems and coronary heart disease. Life expectancy is shortest for those with the greatest support needs and the most complex and/or multiple (co-morbid) conditions.

Reasons for higher mortality rates include: co-morbid conditions, reduced access to services, health problems not being fully investigated by health professionals; infections or other health problems not being identified by carers or residential home staff. Also, people with LD do not have as good access to mainstream health promotion services, such as screening and immunisation. Data on health problems in people with LD is not routinely collected in Bromley, either in primary or secondary care, however the following table provides estimates based on the 800 people with LD in Bromley for whom health needs are known.

Table 2. Estimates of the number of people in Bromley with a severe learning disability and a co-existing physical, emotional or behavioural problem

Type of problem	Average occurrence (%)	Range of estimates[6] (%)	Bromley estimate (number)	Bromley range of number of people
Sight	40	23 – 57	320	184 – 456
Hearing	25	6 – 60	200	48 – 480
Dental disease	20	11 – 29	160	88 – 232
Epilepsy	20	16 – 34	160	128 – 272
Psychiatric	12	10 –14	96	80 -112
Behaviour	n/a	17 – 56	n/a	136 – 448
Cerebral Palsy	30	n/a	240	n/a
Dementia (65yrs+)	22	n/a	176	n/a

(Based on the 800 people with a severe learning disability who are in contact with services)[4]

Annual general health checks have been shown to be effective in identifying health needs and providing opportunities for preventative interventions.

Health Services for people with Learning Disabilities

Specialised health services for adults with LD are provided by the Community Learning Disability Team (CLDT), and managed by Oxleas Trust. The team provides services for assessment of health and social needs, mental health, challenging behaviour, epilepsy, dementia, physiotherapy, transition planning, health promotion, occupational therapy, and LD specialist intervention and advice. The Assessment and Support team provides LD awareness raising training for staff, both in primary and secondary care. Newly developing services include a dementia service, a nurse specialist in Attention Deficit Hyperactivity Disorder (ADHD), and a service for adults with ASC.

Primary care services are being enhanced through practice registers of people with LD, and a Directly Enhanced Services scheme whereby annual checks and personal health plans are provided for people with LD. So far, 16 practices have joined the DES scheme, and 145 annual health checks had been done by the end of the first year.

Users report their main problem with local services as being staff not knowing how to communicate with them, especially GP receptionists and hospital staff. They express appreciation for some recent developments including personal health plans and direct transfer of prescriptions to pharmacies.

The needs of people with LD need to be addressed in all contracts with health service providers. The main challenges for the future are increasing numbers of older people with LD, young people with severe LD and complex needs, people with autism and people with ADHD.

Autistic Spectrum Disorder (ASD)

Autistic Spectrum Disorder (ASD) is a lifelong condition which causes difficulty with social communication, interaction and imagination. Around 50% of people with ASD also have a learning disability.

Based on national estimates, there are around 2,500 adults with ASD in Bromley. There is no current service in Bromley for adults with ASD who have neither a learning disability nor a mental health problem, but the CLDT has plans to provide a diagnostic and sign-posting service for these people.

Guidance for commissioners on assessment and support for people with ASD is laid out in '*Services for adults with autistic spectrum conditions' 2009,* but plans for local services will not be confirmed until the forthcoming bill on ASD is made public.

Bromley Autistic Trust and Bexley and Bromley Advocacy provide invaluable support to people with ASD.

Conclusions and Recommendations

What do we do well in Bromley?

Specialist services

The Community Learning Disability Team provides excellent, well-staffed, services for people with moderate to severe LD, covering many areas of need, including challenging behaviour and epilepsy. The team is already anticipating the increase in numbers of older people with LD, by developing a new dementia service, and is working to meet the diagnostic needs of adults with high-functioning autism, and the increasing numbers of people with ADHD.

Primary Care

Nearly all practices in Bromley have started a register for people with LD, and 30% of practices joined the DES in the first year, and have conducted a total of 145 annual health checks. Some users report that staff attitudes have improved recently.

Health Improvement and preventive programmes

Screening programmes for breast and cervix have specially designed materials for people with LD, and the vascular and Chlamydia screening programmes are currently making adjustments to their information materials.

The needs of people with LD will be written into the new strategy for sexual health and also into the programme for reducing obesity.

Acute services

The SLHT is working with the CLDT to make services more sensitive to people with LD, including staff training and ward packs.

Areas for improvement

Specialist services

- The appointment or designation of someone as a strategic health facilitator for LD, as recommended in *Valuing People Now*, would increase the rate in implementation of recommended practice in terms of health action plans and facilitate monitoring of progress and future planning.
- Increased liaison between the CLDT and other agencies in the borough (the PCT, mainstream services, the borough, preventive and screening services) would help to raise awareness of people with LD among staff and support them in improving the accessibility of their services.
- More consistent involvement of users and carers in planning and evaluating services would improve the extent to which the service meets their needs, and help to monitor the success of any measures taken.
- The development of a diagnostic service for high-functioning adults with autism should be supported. Further developments may be required following the forthcoming government bill on services for autism, although services are expected to be concentrated in borough rather than health services.

Primary Care

- The provision of clear criteria for the identification of people with moderate/severe LD in primary care would provide more complete and validated registers, and enable more accurate estimates of need.
- We should aim to increase the number of GP practices involved with DES, and thus the number practices with good access and appropriate care for people with LD, and the number of people having annual health checks.
- Awareness of the needs of people with LD needs to be raised more widely in primary care, including the need to look out for health problems that are particularly prevalent in this group.
- IT systems are needed that allow sharing of data between primary care LD and chronic disease registers and health action plans. This would enable better assessment of local needs: numbers, health needs, and demographic information.

Acute services

- People with LD should be identified in secondary care IT systems, to enable better assessment of health needs and how well those needs are being met would be possible.
- Raising awareness of LD among hospital staff should continue, with training in communication a priority.
- All contracts with acute trusts should include requirements for ensuring equal access for people with LD.

Community and other services

- Contracts with the community trust should include requirements for ensuring equal access for people with LD, and appropriate training of staff.
- Increased liaison between community and specialist services would improve continuity and appropriateness of care.

Health improvement and other services

- Liaison between the Assessment and Support team and the Health Improvement Service is needed to ensure that people with LD receive appropriate health promotion advice and support.
- People with LD who attend screening programmes should be identifiable by the system, to enable uptake and success of local measures to be monitored.
- Problems that many people with LD have in terms of body weight should be highlighted with specialist teams, primary care, residential care staff, carers and the Health Improvement Service, to enable the delivery of appropriate advice, opportunities for exercise and referral to the dietetics service.
- Sexual health services should make appropriate adjustments to enable people with LD to have access to the support they need, including the provision of easy read educational materials.

For further information and more detailed analysis please contact:

Dr Anita Houghton, Consultant in Public Health, Bromley PCT
Anita.Houghton@bromleypct.nhs.uk

References:

1. Healthcare for All (Report from the Independent Inquiry chaired by Sir Jonathan Michael, 2008)

2. A life like any other? Human rights of adults with learning disabilities. March 2008. House of Commons. The Stationary Office.

3. Death by Indifference. Mencap. 2007.

4. Fulfilling Lives, Active Citizens – a strategy for people with learning disabilities in Bromley 2009-2012. London Borough of Bromley.

2.3 End of Life Care in Bromley: where do people die?

Main points

- During 2005 and 2009, there were 12,701 deaths in Bromley, of which 28% had cancer as an underlying cause.
- 59% of all deaths between 2005 and 2009 took place in hospital, compared with 58% in England. This % fell slightly in 2009.
- 19% of deaths occurred at home, and this proportion has not increased.
- People with cancer were much less likely to die in hospital than people with non-cancer (43% v 65%).
- Females and people over 85 were more likely to die in care/nursing homes.
- There was considerable variation in place of death from ward to ward. Much of this was related to proximity of services.
- Wards (Clock House, Crystal Palace and Copers Cope) close to St. Christopher's hospice had the highest proportions of hospice deaths.
- Wards with the highest numbers of care/nursing homes in Bromley tended to have the highest proportions of care/nursing home deaths.
- Areas where there are more people from ethnic minorities had fewer homes deaths. eg Penge and Cator.
- Analysis by GP showed wide variation in the proportions of registered patients dying at home (10% – 100%).
- From the results of this analysis it is clear that several inequalities in terms of place of death are existent in Bromley.

Background

Approximately half a million people die in England each year, and almost two thirds of those dying are aged over 75 years (1). Most deaths occur in NHS hospitals (58%), and around 18% occur at home, 17% in care homes, 4% in hospices and 3% elsewhere (1). It has however been recognised that the vast majority of people would prefer to die at home if possible. A systematic literature review performed by Higginson et al (2000) revealed that in all but

one of the studies examined the preference for death at home ranged from 49% to 100% among study respondents (2). These findings, alongside others, make it clear that although some people die in the setting of their choice, there continues to be a discrepancy between preferred and actual place of death for many.

In July 2008, the government published its 'End of Life Care Strategy', which aims to promote high quality care for all adults at the end of life. It was hoped that there would be a shift in the emphasis of care from the hospital to the community, so that more people die in the place of their choice. The strategy addresses the following twelve key areas (1):

- Raising the profile of end of life care
- Strategic commissioning
- Identifying people approaching the end of life
- Care planning
- Co-ordination of care
- Rapid access to care
- Delivery of high quality services in all locations
- Last days of life and care after death
- Involving and supporting carers
- Education and training and continuing professional development
- Measurement and research
- Funding

This strategy builds on the NHS End of Life Care Programme which ran from 2004-2007. The End of Life Care Programme enabled the implementation of several important initiatives such as the Liverpool Care Pathway for the Dying Patient (LCP) and the Gold Standards Framework (GSF), which aims to optimise the palliative care delivered by generalist providers. (1).

In Bromley, the End of Life Care Strategy Group is working to implement the strategy locally. The local strategy, which was developed in collaboration with key stakeholders, uses a six step care pathway as a basis for Bromley's end of life care action plan.

One of the key aims of the local strategy is to ‘Ensure that patient choice is central to the care pathway, and is at the heart of the decision making process’. (3). With preferred place of death being an important element of both the national and the local strategy, a place of death analysis has been performed for Bromley.

A place of death analysis

This analysis aims to support the work of the End of Life Care Strategy Group and enhance the work of local commissioners and service providers by:

- Providing an overview of where people die in Bromley
- Investigating the demographic or geographical factors that may affect where people die in Bromley
- Reporting on how Bromley GPs are performing in terms of helping their patients to die in the place of their choice.

Data Analysis

Bromley mortality data between 2005 - 2009, and demographic data from the 2001 Census were analysed as follows:

- Place of death for cancer deaths and non-cancer deaths, with trends over time
- Place of death by age and gender
- Place of death by electoral ward
- Correlation between place of death and deprivation, number of care/nursing homes and proportion of ethnic minorities per ward.
- Place of cancer deaths by registered GP

Results

During 2005 to 2009, there were 12,701 deaths in Bromley, of which 28% had cancer as an underlying cause. On average there were 2,540 deaths each year in Bromley with 30% of those deaths being due to cancer (Table 1).

Table 1. Number of deaths in Bromley between 2005-2009

	Hospital	Home	Care/Nursing Home	Hospice	Other	Total
Cancer Deaths	1532	936	369	717	1	3555
Non-Cancer Deaths	5902	1507	1539	71	127	9146
Total Deaths	7434	2443	1908	788	128	12701

Place of death

Fifty-nine per cent of all deaths between 2005 and 2009 took place in hospital, compared with 58% in England. However, there was a marked difference between deaths due to cancer and deaths due to other causes. People with cancer were much less likely to die in hospital than people with other conditions (43% v 65%) and much more likely to die in a hospice (20% v 1%) (See figures 1a and 1b).

Figure 1a

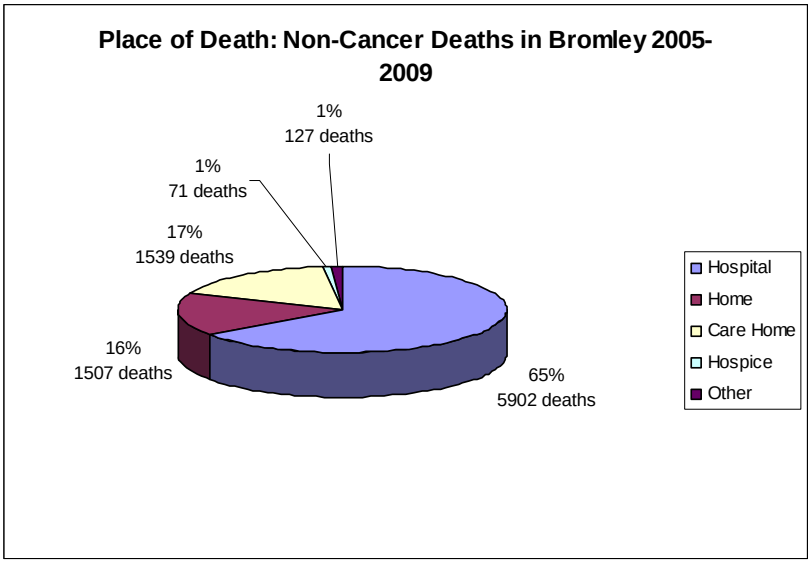
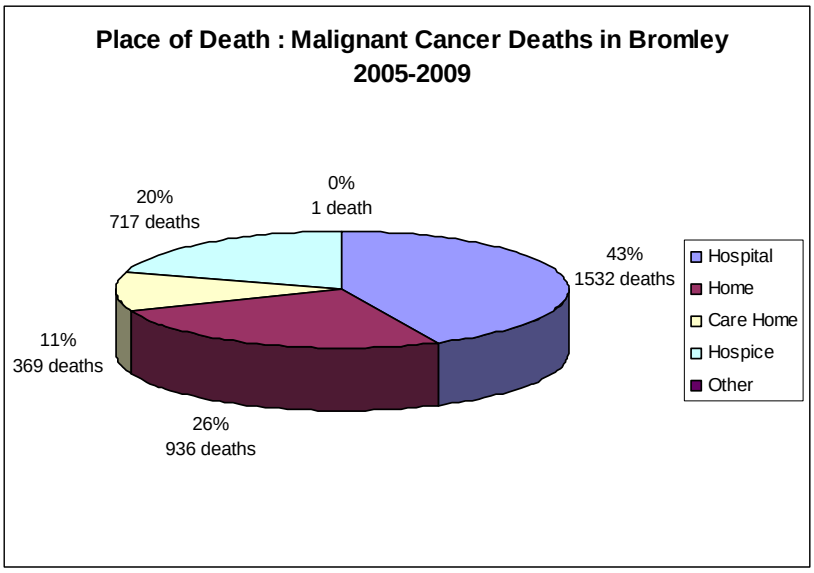


Figure 1b



The proportion of people dying in hospital has dropped by 2% between 2005 and 2009, equally for both cancer and non-cancer deaths. The decrease appears to be due to a slight increase in the number of non-cancer deaths taking place in care homes, and a slight increase in the number of cancer deaths taking place in hospices. There has been no detectable increase in deaths at home - if anything they have decreased (Tables 2 and 3).

Table 2. Place of death (Non-Cancer deaths) in Bromley 2005-2009

Year	Hospital	Home	Care Home	Hospice	Other
2005	65%	17%	16%	1%	1%
2006	65%	17%	16%	1%	1%
2007	66%	16%	16%	0%	2%
2008	63%	17%	18%	1%	1%
2009	63%	16%	19%	1%	1%

Table 3. Place of death (Cancer deaths) in Bromley 2005-2009

Year	Hospital	Home	Care Home	Hospice	Other
2005	43%	27%	11%	19%	0%
2006	43%	27%	9%	21%	0%
2007	45%	27%	9%	19%	0%
2008	42%	26%	12%	20%	0%
2009	42%	25%	11%	22%	0%

There was a small variation in place of death between men and women. Higher proportions of female deaths occurred in care or nursing homes, with

higher proportions of male deaths occurring in hospital, at home or in a hospice. For both cancer and non-cancer deaths, higher proportions of female deaths also occurred in nursing/care homes (Table 4).

Table 4. Place of Male and Female Deaths in Bromley 2005-09

	Hospital	Home	Care/Nursing Home	Hospice	Other
Male	60%	22%	10%	7%	1%
Female	58%	17%	20%	6%	0%

Higher proportions of deaths in those aged over 85 years occurred in care or nursing homes in Bromley than for younger people. For cancer deaths, much higher proportions of deaths in those aged below 64 years occurred in hospices than for those dying aged 85 years or above (Tables 5,6)

Table 5. Place of Cancer Deaths in Bromley by age 2005-09

Age (years)	Hospital	Home	Care/Nursing Home	Hospice	Other
0-64	44%	27%	2%	27%	0%
65-84	42%	28%	9%	21%	0%
85+	45%	21%	22%	12%	0%

Table 6. Place of Non-Cancer Deaths in Bromley by age 2005-09

Age (years)	Hospital	Home	Care/Nursing Home	Hospice	Other
0-64	60%	30%	2%	1%	7%
65-84	70%	18%	10%	1%	1%
85+	62%	12%	26%	0%	0%

Ward Level Analysis

There was a variation in place of death from ward to ward. The wards with the highest proportions of people with cancer dying in hospital were the Crays, Farnborough and Crofton, and Petts Wood (range 36% - 55%). For non-cancer deaths, the proportion dying in hospital was 70-75% in 14/22 wards, with a range of 53% (Chislehurst) to 75% (Kelsey to Eden Park).

Kelsey and Eden Park have one of the highest proportions of hospital deaths for non-cancer, and one of the lowest for cancer. (St Christopher's Hospice is

nearby, and 28% of cancer deaths take place there). Other wards that are close to the hospice also have high rates of hospice deaths. The variation between wards is much less for non-cancer deaths than for cancer deaths. (Figures 2a and 2b)

Figure 2a Place of Death by Ward for Malignant Cancer Deaths in Bromley

2005 to 2009

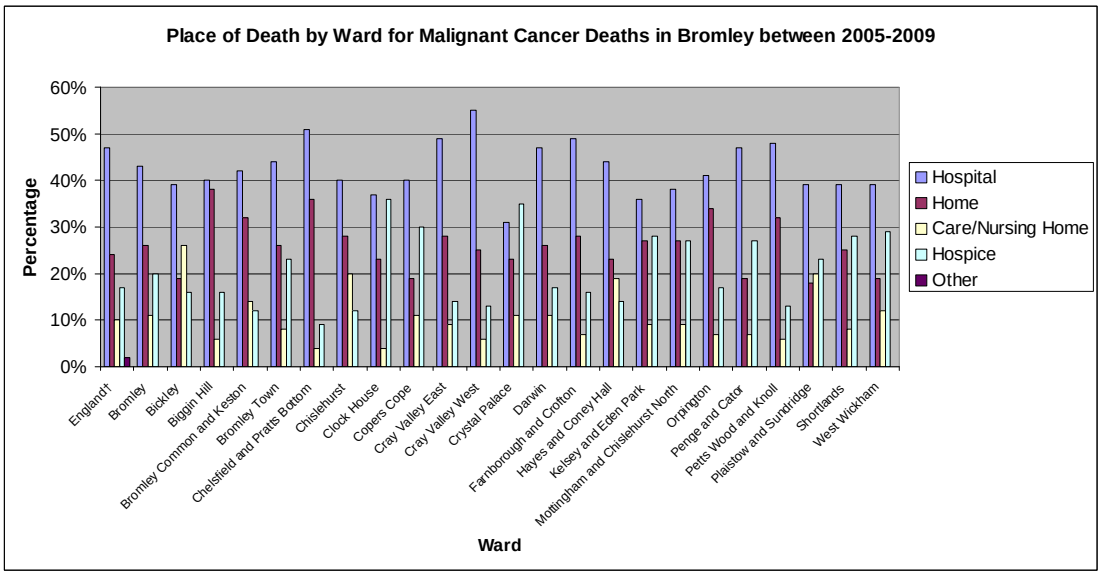
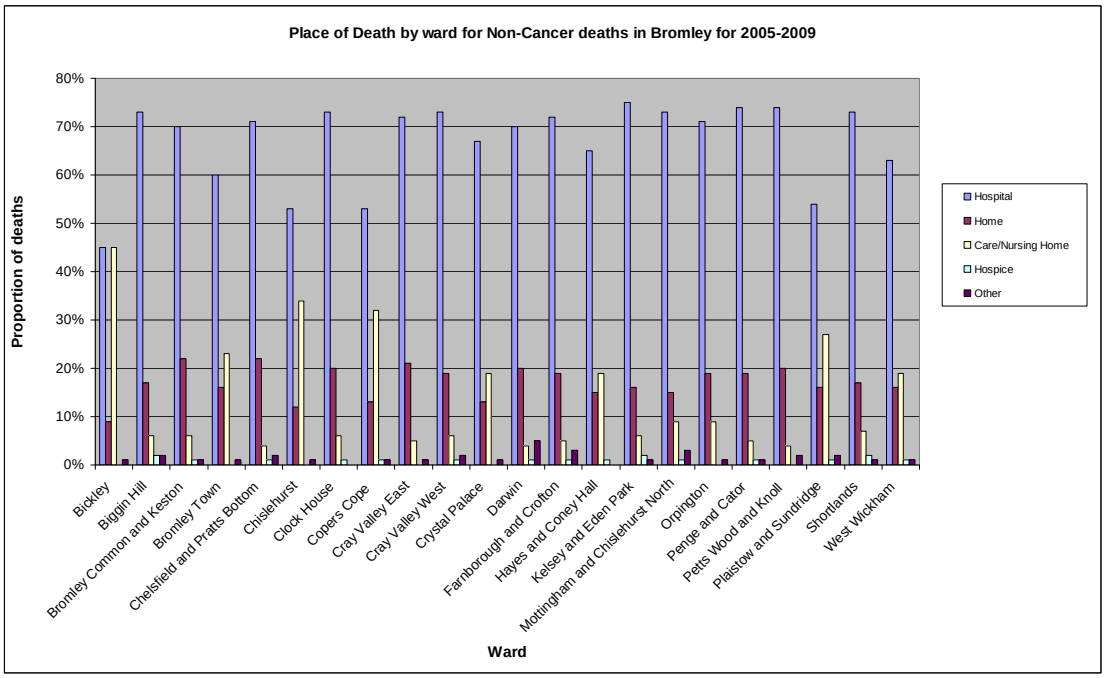


Figure 2b Place of Death by Ward for Non-cancer Deaths in Bromley

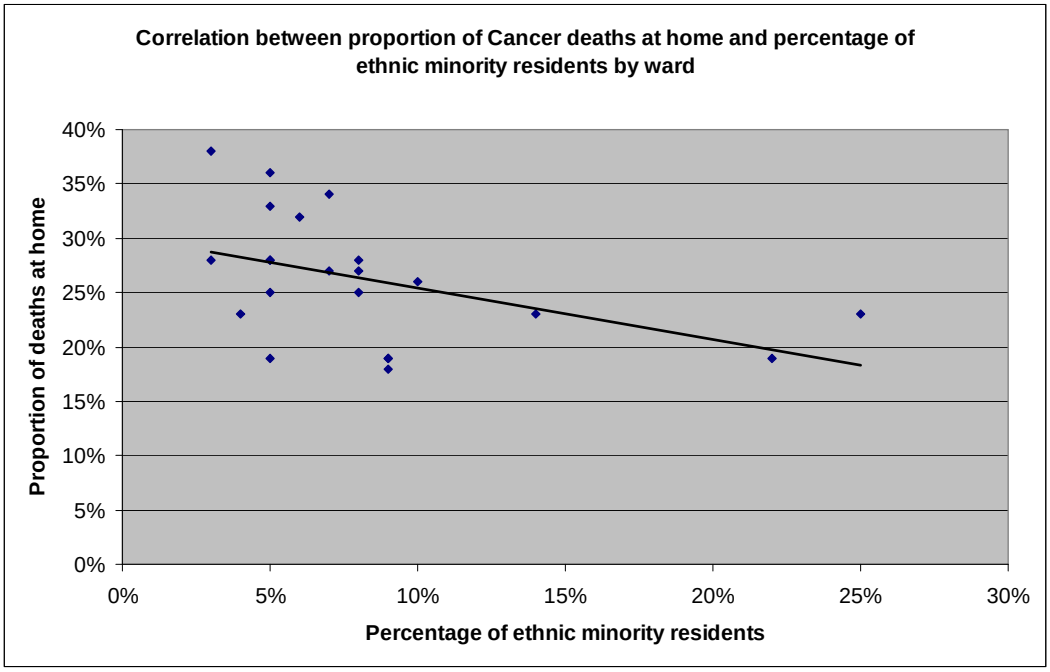
2005 to 2009



When looking at place of death by ward against key demographic variables, few clear relationships could be found. The highest correlation was found

between the proportion of home cancer deaths and proportion of ethnic minority residents per ward. Areas with the highest proportions of ethnic minorities had the lowest number of home deaths (Figure 3). There was no clear relationship between ward deprivation and the proportion of non-cancer deaths at home, but fewer cancer deaths took place at home in areas of higher deprivation.

Figure 3 Scatter plot of proportion of cancer deaths at home against percentage of ethnic minority residents by electoral ward in Bromley



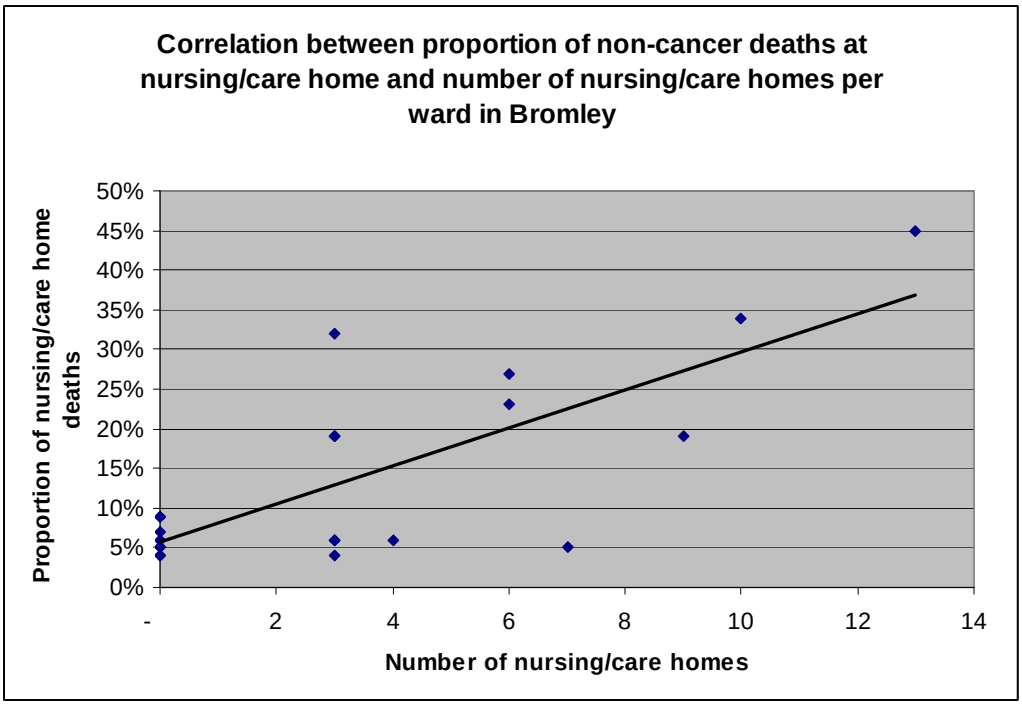
Correlation Coefficient: -0.46

As one would expect, there was also a clear relationship between the proportions of both home and nursing/care home deaths in a ward and the number of care/nursing homes (Figures 4 and 5), with a higher proportion of deaths in homes in areas where the number of homes was higher. This was true for both cancer and non-cancer deaths. Correspondingly, deaths at home are lower in these areas.

There was a marked correlation between the number of hospice deaths and proximity to St Christopher's Hospice (Figure 6), and the number of home deaths and proximity to Harris Hospice Care, which specialises in supporting people to die at home (Figure 7). The number of home deaths was also higher in Biggin Hill.

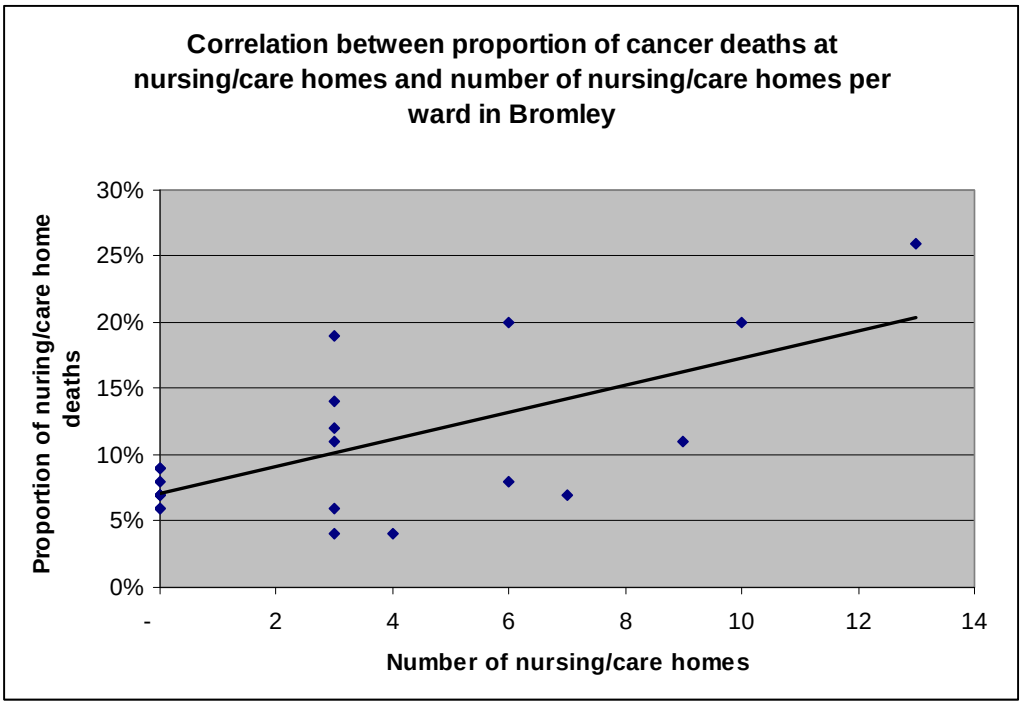
Deaths in hospital showed a pattern, with more hospital cancer deaths in the south and east of the borough, while hospital deaths were more uniformly high for non-cancer deaths (Figs 8, 9).

Figure 4 Scatter plot of proportion of non-cancer deaths at nursing/care home against number of nursing/care homes by electoral ward in Bromley



Correlation Coefficient: 0.76

Figure 5 Scatter plot of proportion of cancer deaths at nursing/care home against number of nursing/care homes per electoral ward in Bromley



Correlation Coefficient: 0.66

Figure 6

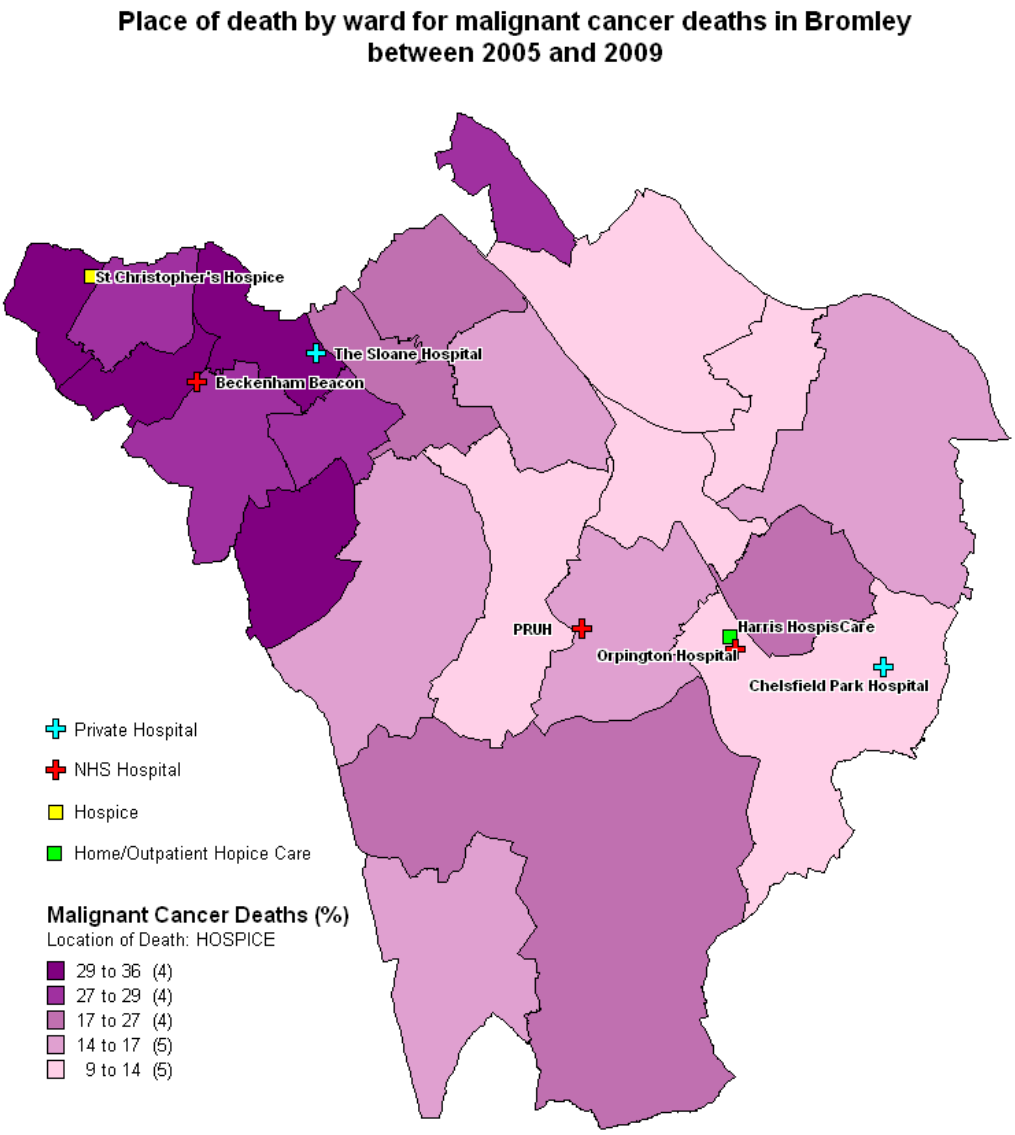
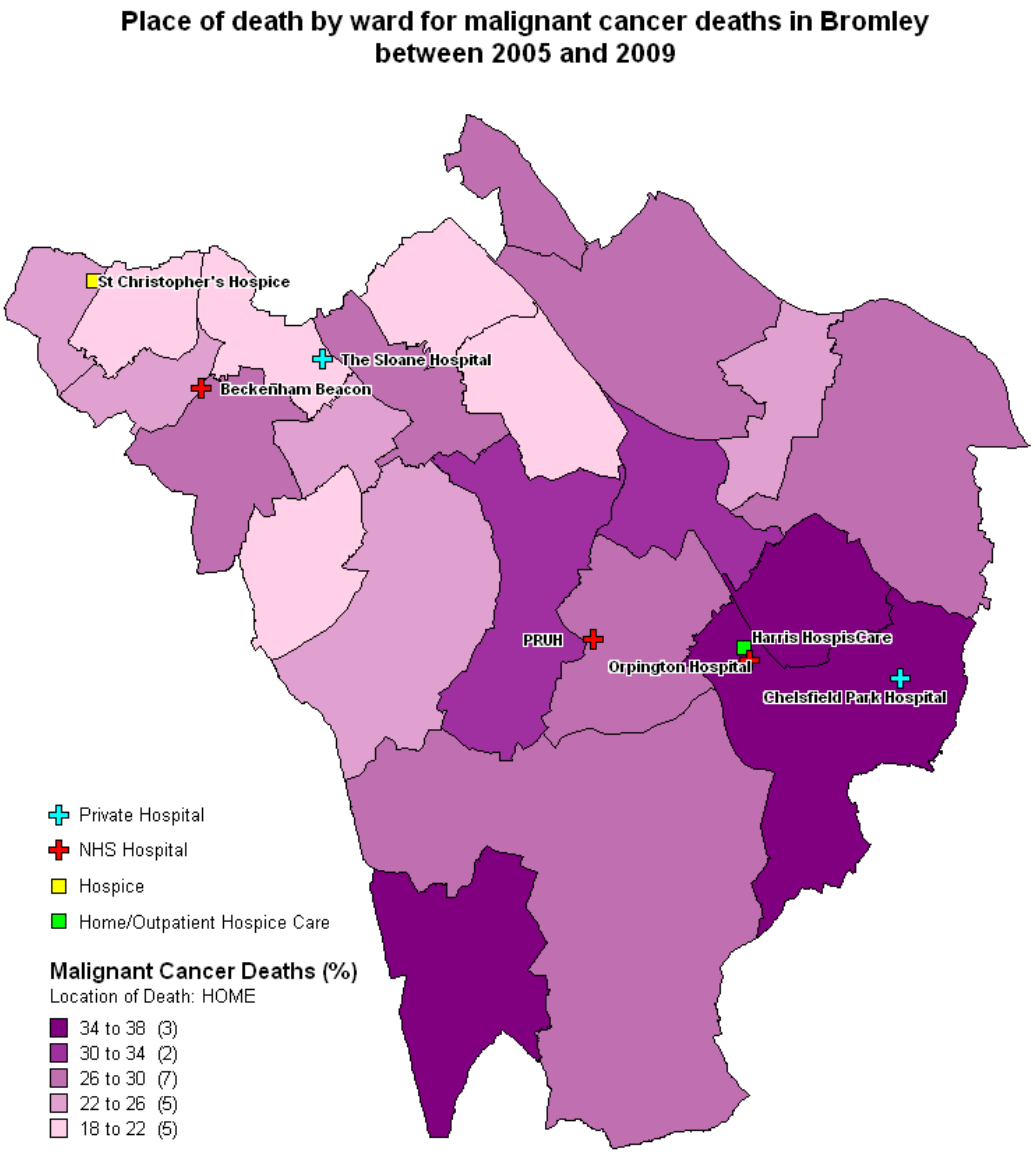

Place of death by ward for malignant cancer deaths in Bromley between 2005 and 2009
St Christopher's Hospice
The Sloane Hospital
Beckenham Beacon
PRUH
Harris HospisCare
Orpington Hospital
Chelsfield Park Hospital
Private Hospital
NHS Hospital
Hospice
Home/Outpatient Hopice Care
Malignant Cancer Deaths (%)
Location of Death: HOSPICE
29 to 36 (4)
27 to 29 (4)
17 to 27 (4)
14 to 17 (5)
9 to 14 (5)

Figure 7


Place of death by ward for malignant cancer deaths in Bromley between 2005 and 2009
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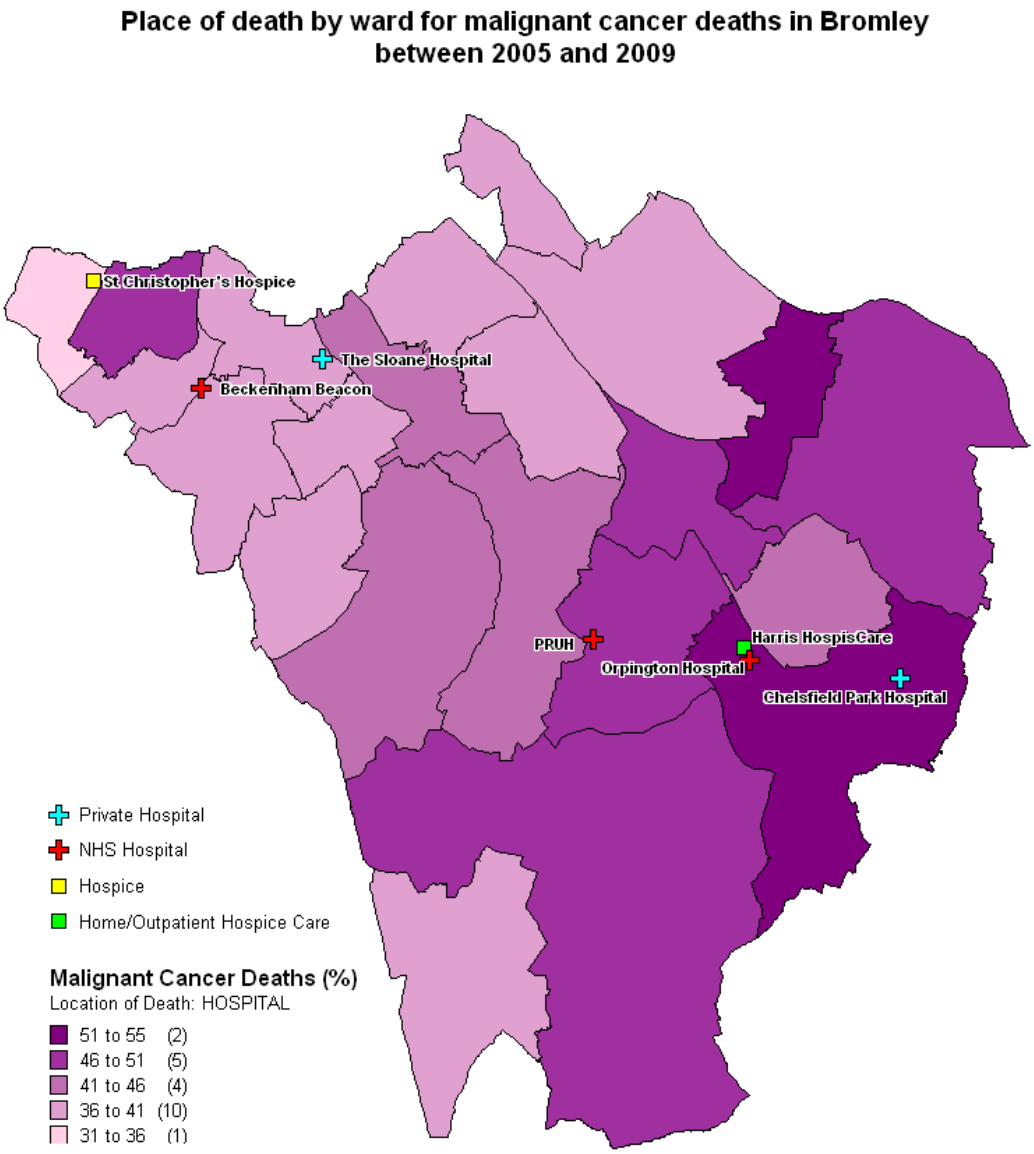
The Sloane Hospital
Beckenham Beacon
PRUH
Harris HospisCare
Orpington Hospital
Chelsfield Park Hospital
Private Hospital
NHS Hospital
Hospice
Home/Outpatient Hospice Care
Malignant Cancer Deaths (%)
Location of Death: HOME
34 to 38 (3)
30 to 34 (2)
26 to 30 (7)
22 to 26 (5)
18 to 22 (5)

Figure 8


Place of death by ward for malignant cancer deaths in Bromley between 2005 and 2009
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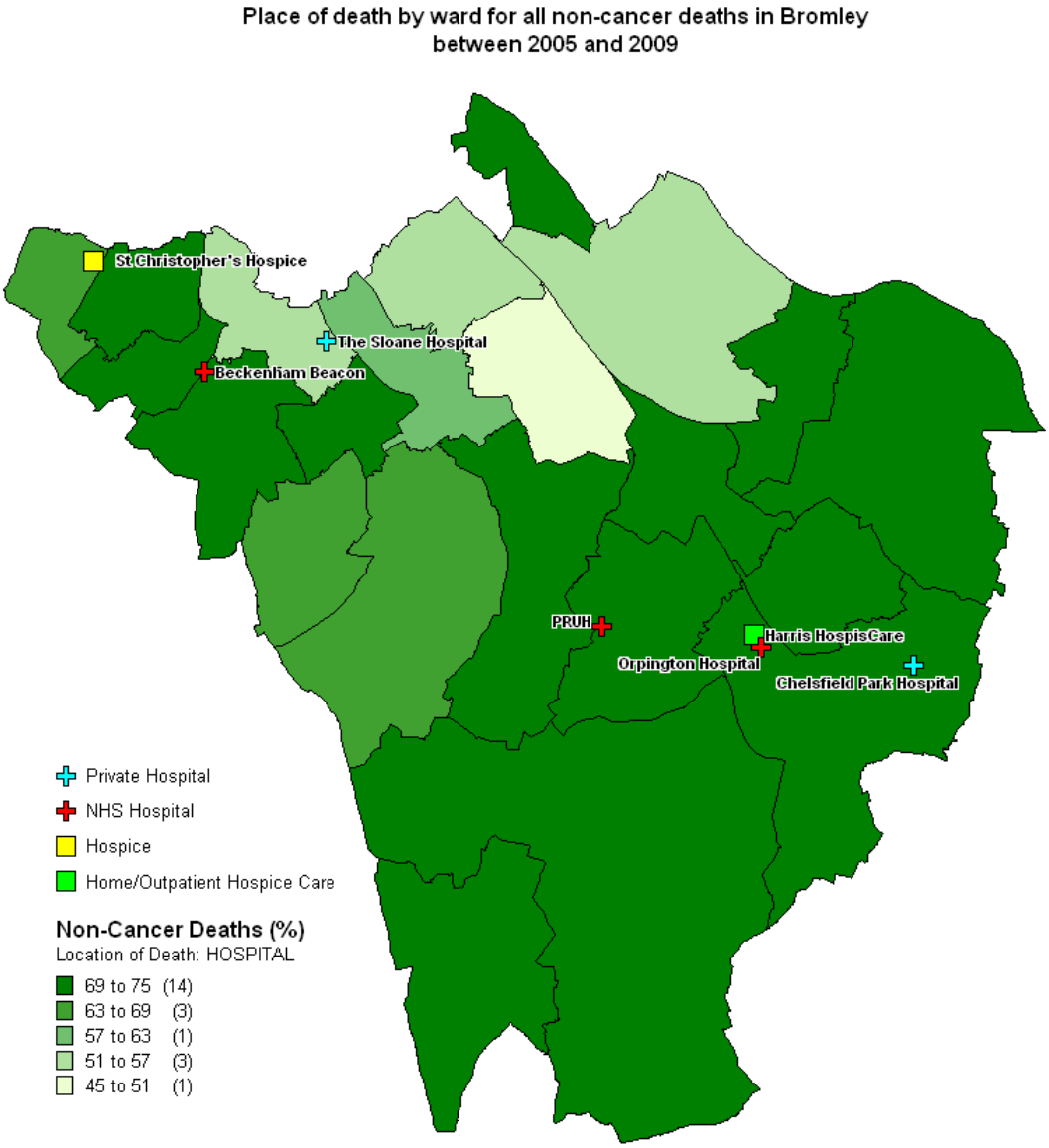
The Sloane Hospital
Beckenham Beacon
PRUH
Harris HospisCare
Orpington Hospital
Chelsfield Park Hospital
Private Hospital
NHS Hospital
Hospice
Home/Outpatient Hospice Care
Malignant Cancer Deaths (%)
Location of Death: HOSPITAL
51 to 55 (2)
46 to 51 (5)
41 to 46 (4)
36 to 41 (10)
31 to 36 (1)

Figure 9



Combining home and care/nursing home deaths.

Because care/nursing homes are often effectively a person's home, there is an argument for treating deaths in homes as 'home deaths'. The 2010 annual report on End of Life care from the Department of Health confirms that they

are planning to change the Vital Sign to reflect this. When nursing/care home deaths and home deaths are combined, the variation in the proportions of home deaths between wards changes considerably. The range across the district for cancer home deaths became 26% (Penge and Cator) to 48% (Chislehurst), and 22% (Kelsey and Eden Park) to 54% (Bickley) for non-cancer deaths. Whereas Penge and Cator also had one of the lowest 'true' home deaths, Bickley had one of the lowest 'true' home deaths but has the highest 'combined' home deaths, along with Chislehurst. Not surprisingly these two wards have the highest number of care/nursing homes.

Place of death by registered GP

The proportion of home cancer deaths by GP ranged from 10-100% (Fig 10). The three GPs with the lowest proportions of home cancer deaths were all situated in Penge and Cator. However, proximity to St Christopher's means that hospice deaths are more common in this area. The three practices with the highest proportions of hospital deaths were situated in Cray Valley East and Petts Wood and Knoll. These represent one of the most deprived and one of the most affluent wards in Bromley respectively.

Figure 10. Proportion of Home Cancer Deaths by GP surgery, 2005-09

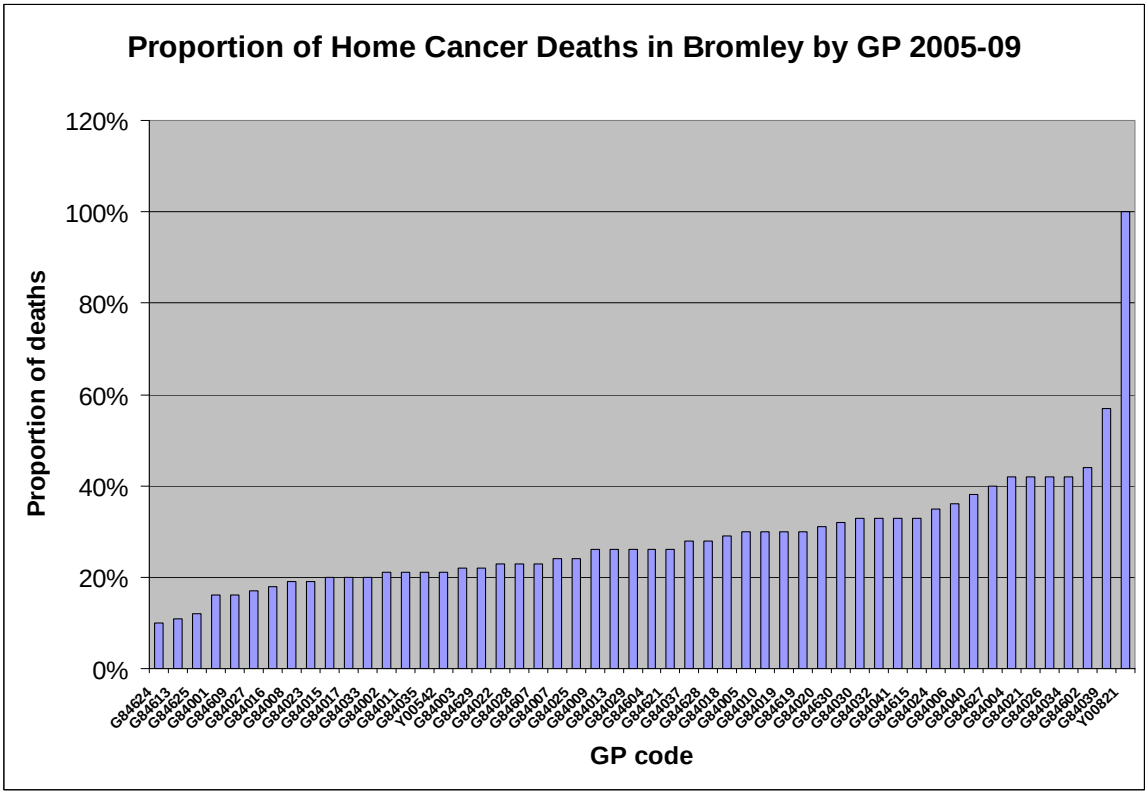
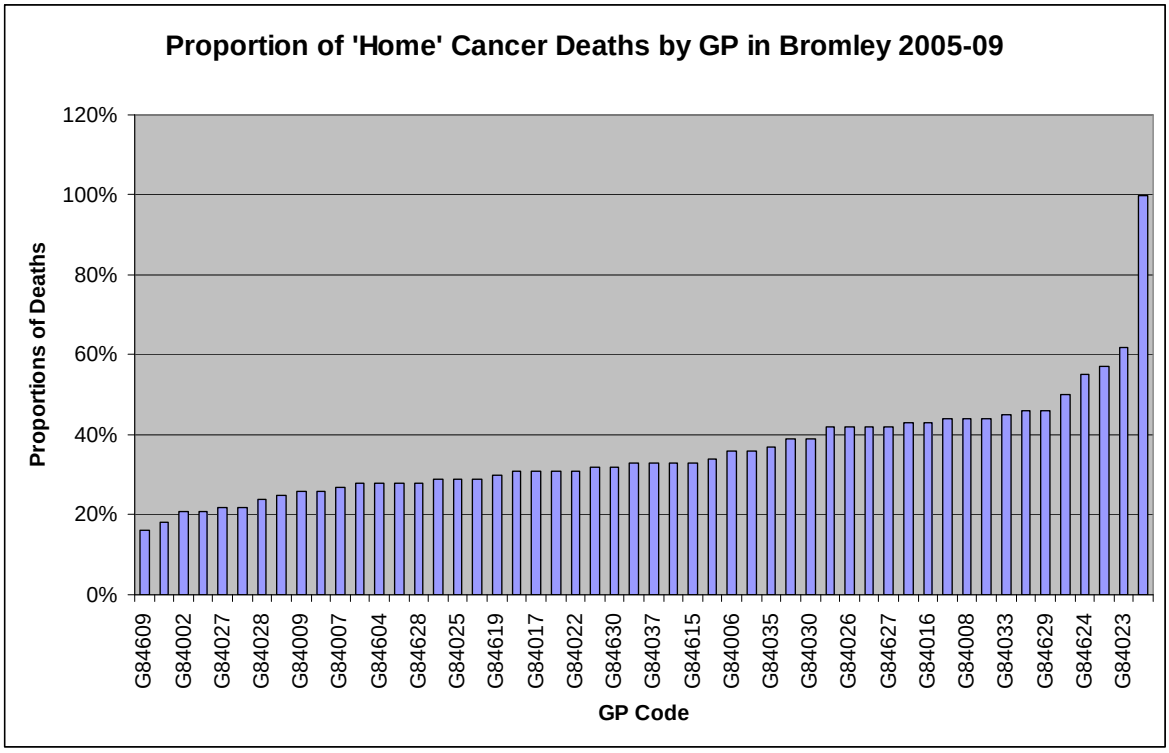


Figure 11



'Home' = home deaths + care home deaths

Conclusions and recommendations

Place of death in Bromley is comparable to the national picture, including the inequality between people with cancer and non-cancer. The numbers of home deaths did not increase between 2005 – 2009. Whereas there was a significant inverse relationship between home deaths and deprivation (ie more deprived areas had fewer home deaths) in people with cancer, this was not the case for non-cancer deaths. There is significant variation in place of death between wards that seems to be predominantly related to the proximity of hospitals, hospices and nursing/care homes. There is also some relationship to concentrations of people from ethnic groups, gender, age and GP practice.

In the analysis by GP practice, there was a wide variation in the proportions of registered patients dying at home, hospital, hospice and care home. Because the number of home deaths are affected by the proximity of hospice care and care/nursing homes, the proportion of hospital deaths is probably a more reliable indicator. However it is important to note that small numbers

were often involved in this part of the analysis, so fluctuations may appear to be significant even when they are not (4).

It is recommended that we:

- Encourage audit of patients' preferred place of death by GPs and palliative care teams, and actual place of death.
- Address inequalities revealed by this analysis (geographical, age, gender, ethnic origin, GP), through further investigation and targeted interventions.
- Review the Bromley End of Life Care Action plan in the light of these results.
- Continue to perform place of death data analyses annually in order to monitor progress and highlight any areas for particular focus.

For further information and more detailed analysis please contact:

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Anita.Houghton@bromleypct.nhs.uk

References

1. Department of Health (July 2008). *End of life Care Strategy: Promoting high quality care for all adults at the end of life.*
2. Higginson IJ, Sen-Gupta GJ. Place of care in advanced cancer: a qualitative systematic literature review of patient preferences. *J Palliat Med* 2000; **3**(3): 287-300.
3. NHS Bromley (2009). Bromley End of Life Care Strategic Implementation Plan (2009-2012).
4. Higginson IJ, Jarman B, Astin P, Dolan S. Do social factors affect where patients die: an analysis of 10 years of cancer deaths in England. *J Publ Hlth Med* 1999; **21**(1): 22-28.

2.4 Substance Misuse Needs Assessment Summary 2009/10

Background

Studies consistently show that the UK has among the highest rates of recorded illegal drug misuse in the western world.

Substance misuse is associated with a number of negative impacts on the individual, their family and the wider community:

- Drug misusers may have a range of health and social care problems, which may or may not be associated with drug misuse
- Drug misusers (especially injecting drug users) are particularly vulnerable to contracting and spreading blood-borne viruses and other infections
- Drug misuse can place an enormous strain on the families of drug misusers, including the children of drug-using parents and can have a serious negative impact on the long-term health and wellbeing of family members.
- Drug-related crime has been estimated to inflict a major cost on local communities and the national economy.

For these reasons, it is important to have in place well-delivered, evidence based treatment services for substance misuse.

Introduction

This needs assessment focuses chiefly on Problematic Drug Users (defined as users of crack cocaine or heroin in a behaviour detrimental to the individual, their significant others and/or the wider community). However, it is recognised that there is a significant proportion of users of powder cocaine or other stimulants in Bromley who are not defined as PDUs, so there is also an attempt to address these in the needs assessment.

Epidemiology

Prevalence

Estimates show that there are 1893 opiate and crack users in Bromley.

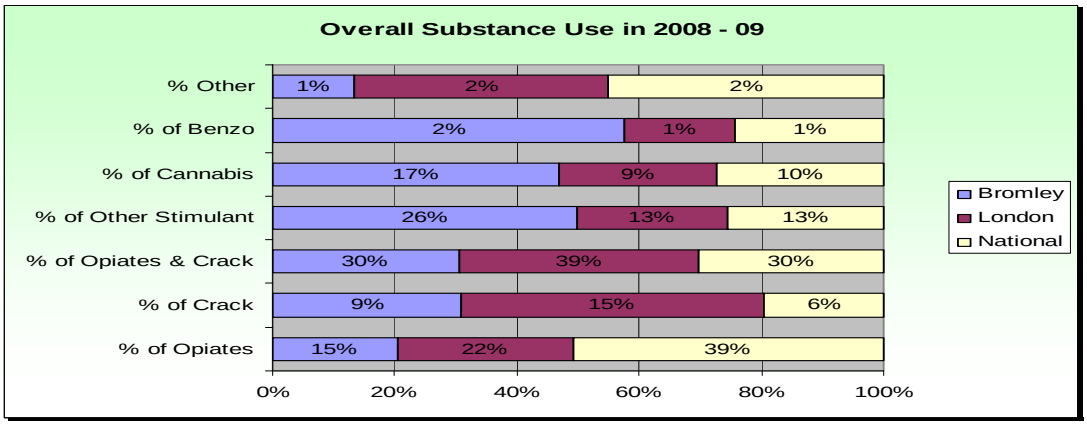
Table 1 Estimated Numbers of Drug Users in Bromley

Category	Estimated Numbers in Bromley
Opiate and Crack	1893
Crack	1163
Opiates	1161
Injecting	455

Data Source: Glasgow University smoothed prevalence estimates.

There were 355 new presentations of PDUs to treatment in the financial year 2008/09. The total number in treatment year to date was 735. As demonstrated in *Figure 1* below, this equates to around 30% of all substance users in Bromley using opiates and crack cocaine. This is equal to the national average but lower than the London average of 39%. There is a significant higher proportion reported as other stimulant and cannabis users, when compared with the national and London averages. This emphasises the importance of the Bromley Drug and Alcohol Team (DAT) to focus not only on PDUs, but on wider substance misusers.

Figure 1 Substance Misuse Levels, Bromley. London, National 2008-09



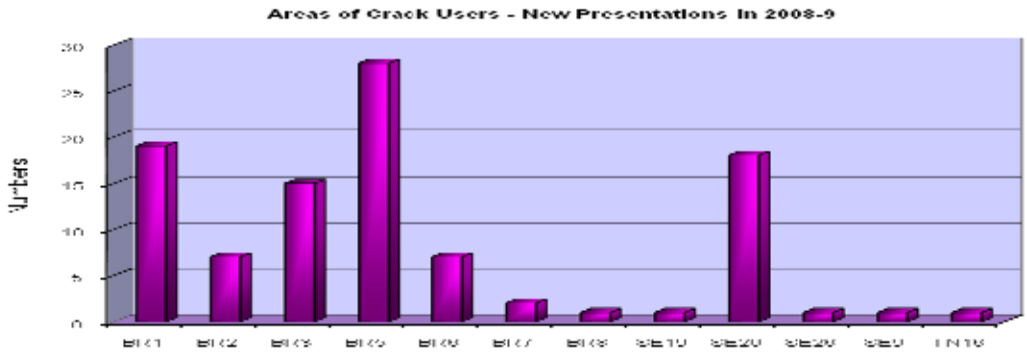
Age Range

Out of the total number of PDUs in treatment in Bromley, 58% (177) were 35-64yrs old, 31% (96) were 25-34yrs old and 11% (33) 15-24yrs old. It is important to note, for service provision, that not only does Bromley have one of the highest proportions of older people within its population, but it also has an above average number of children compared to neighbouring boroughs.

Geographical distribution

It is well known that deprivation is closely linked to substance misuse. This is pertinent as although Bromley is considered to be an affluent borough, there are specific areas which display significant deprivation. Crystal Palace and Penge & Cator have above the London average of unemployment at 5.75% and 5.04% respectively. Thus the North and North West of the borough, in particular, display signs of deprivation which will need to be closely considered when planning services, including prevention for substance misusers.

Figure 2 Distribution of Crack Users in Bromley



Consequences of Substance Misuse

1. Infections

Infections are acquired by injecting drug users (IDUs) either directly through sharing needles, or indirectly through sharing of equipment used in the preparation of the drug. These infections can be localised to the injecting site, particularly if being injected in to the groin or injecting crack cocaine, both of which are now becoming more common. Systemic infections include hepatitis B and HIV and currently the most important infection amongst IDUs, hepatitis C. It is known that 80% of those who acquire hepatitis C become chronic carriers and can thus lead on to developing fatal complications such as liver cirrhosis and cancer. Furthermore, there is a positive correlation between prevalence of hepatitis C and years of injecting, for example, 20% of IDUs who have been injecting for 1-2 years are infected and this figure increases to 60% for those who have been injecting for 15 years or longer.

2. Drug Related Deaths

During 2008, there were 1490 notifications of drug related deaths in the UK. There were 6 reported cases in Bromley giving a rate of 3.31 per 100,000 population compared to 3.57 in London.

3. Drug Related Hospital Admissions

There have been a total of 138 drug-related hospital admissions in Bromley between 2004 and 2010. 33% of these admissions were due to cocaine poisoning and 13% due to heroin.

Numbers in Treatment

As displayed in *figure 2*, the number of PDUs in treatment in Bromley was reported as 306 on the 31st March 2009. This is some improvement from the figure of 273 in 2007/08, however this is still not equating to the higher rate seen in 2006/07. The treatment penetration rate has increased by 3% from last year's 26.4% to the current 29.8%, however in comparison to London (47.2%) and national figures (61.4%), it is clear that this is an area which needs focus.

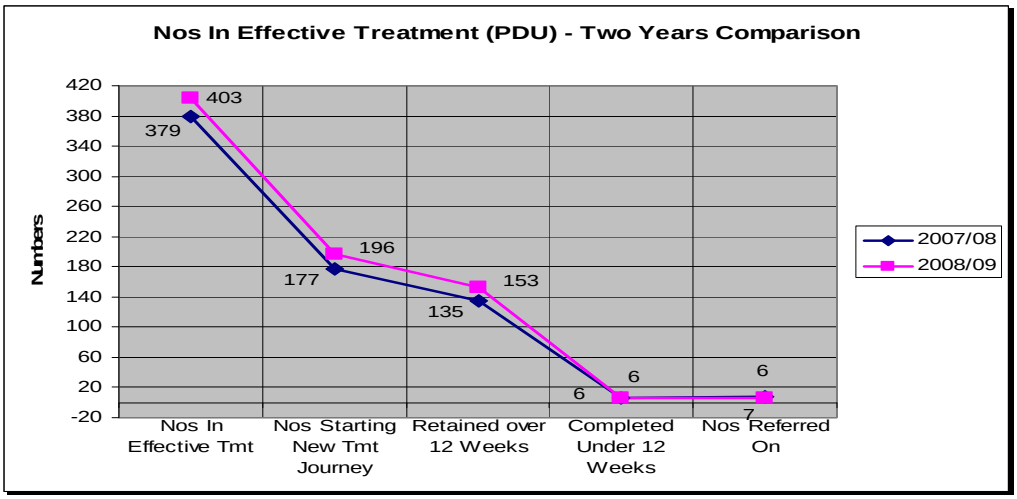
Table 2 Numbers of PDUs in Treatment

Opiate &/or Crack Users				
	2005/06	**2006/07**	**2007/08**	**2008/09**
In Treatment now	289	413	273	306
In Treatment last year	116	89	141	135
Known to Treatment, but not treated last year	117	91	87	124
In Contact with DIP, but not with the treatment system	35	82	3	113

There is a high number of PDUs in contact with a Drug Intervention Programme (DIP) but not with the treatment system in 2008/09. This may be due to an increase in client engagement, however the figure is significantly higher than that of only 3 in 2007/08. Much of the latter may be attributed to under reporting.

Effective treatment is defined as either retaining in treatment for 12 weeks, or exiting treatment in a care planned way within 12 weeks. 81% of PDUs in treatment were in effective regimes in 2008/09, an increase from the 79% in 2007/08. The actual figures are displayed and compared in *figure 3* below. There is a small improvement observed which clearly needs more attention bearing in mind that the national average is 85%.

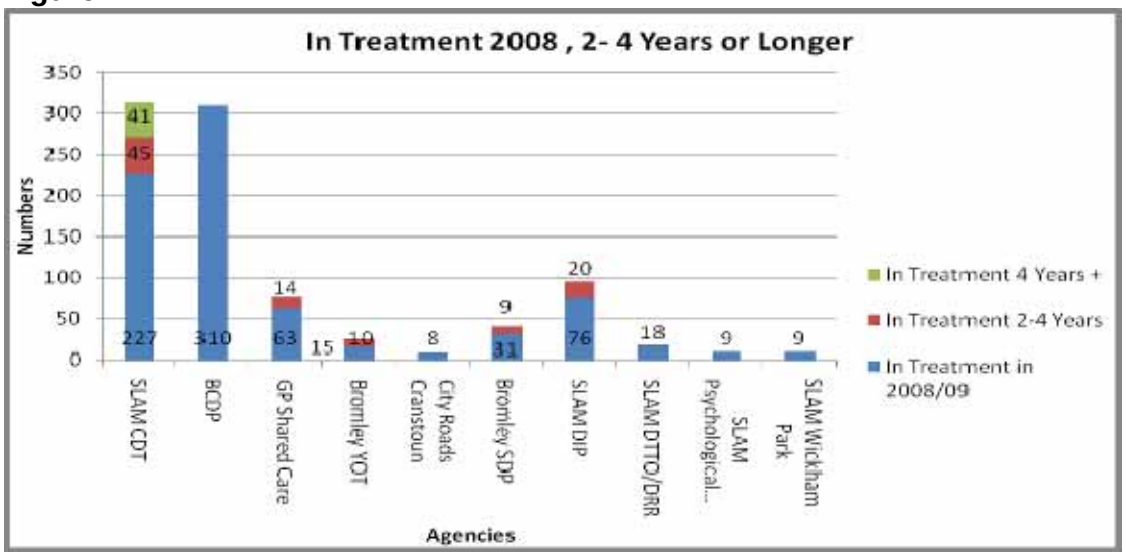
Figure 3 Trend for PDUs in Effective Treatment



Length of Time in Treatment

A number of clients have been in treatment for 2 to 4 years or more, as a result of the prevailing clinical culture and overloaded services (*Figure 4*).

Figure 4

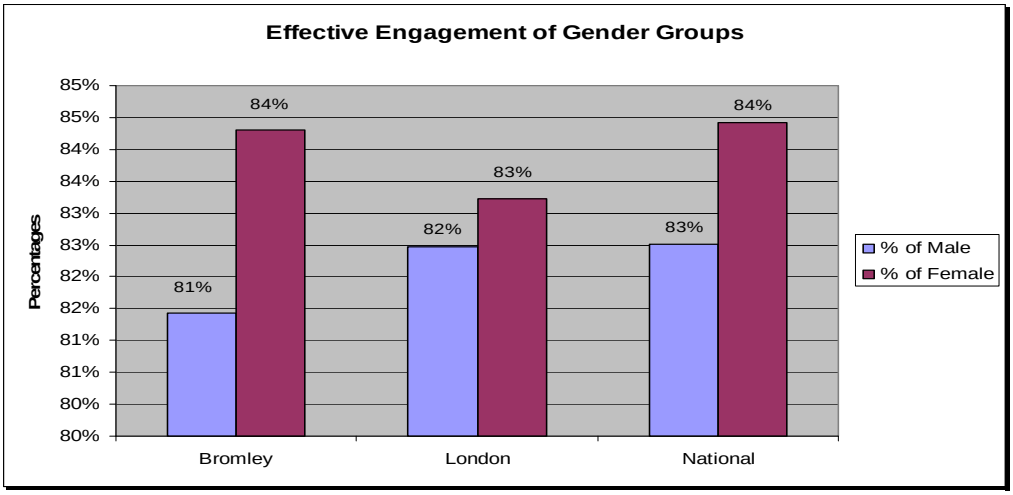


Under the proposed service specifications, there will be a multi agency case review for any client in treatment for longer than 10 - 12 months. We are also expanding the capacity in Shared Care to create resilience within the treatment system and this will enable clients to progress from complex, chaotic status through stabilisation and then onto community prescribing. This process will ensure that we have adequate capacity within the treatment system to address local needs

Gender

Trends show good progress in both gender groups regarding engagement in effective treatment. As depicted in *figure 5*, the 84% seen in females is in line with the national average.

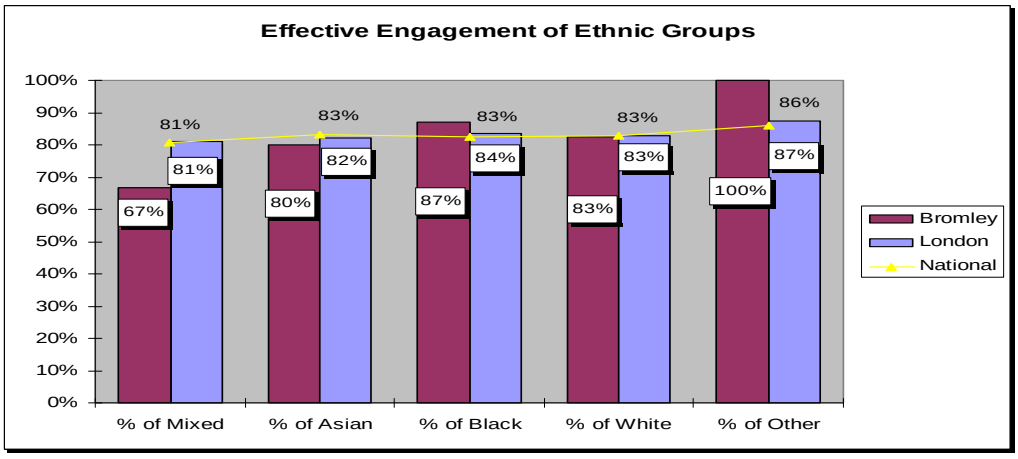
Figure 5



Black and Minority Ethnic (BME) Groups

BME groups accounted for 14% of the total number of new presentations of PDUs in 2008/09. Rates of effective engagement in treatment, currently reflect both the local and national averages, *figure 6*.

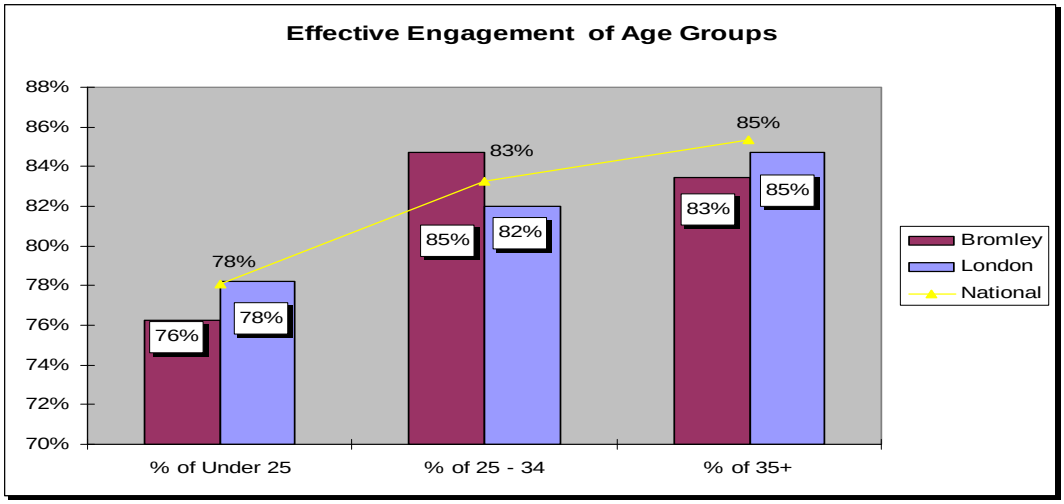
Figure 6



Age Groups

Bromley has been shown to be engaging well with the 25-34 age group with 85% in effective treatment regimes, slightly above the local and national average. Effective engagement in the under 25 and above 35 age groups harbour figures reflecting those of the local and national averages, *figure 7*.

Figure 7



Criminal Justice System (CJS) Clients

Between July 08 and June 09, the probation database has recorded 157 offenders as having substance misuse problems in Bromley. Despite this, only 22 referrals were made from probation. However, figures are showing that Bromley is better in engaging CJS clients than the London and national average. This may be due to the development of CJIT practitioners seeing the rapid delivery of reports at court, and the implementation of the drug intervention program and weekly satellite clinic at Orpington probation.

Services

Bromley residents have access to all modalities of care prescribed by and quality assessed against National and local Guidance. These include: inpatient care, specialist prescribing, GP prescribing, psychosocial interventions, structured day programmes and residential rehabilitation.

1. Bromley Advice and Information Service (BAIS) and Community Prescribing

BAIS provides a multi-disciplinary service to clients with a variety of interventions, including “open access” clinics, hepatitis vaccination and prescribing programmes.

There are 5 GP surgeries in Bromley, mainly located in the north of the borough, which provide services for community prescribing. These services are constantly being overwhelmed, particularly with patients who are successfully stabilised but then, due to the lack of maintenance services, are unable to be referred back in to the community. This is currently being explored and new arrangements, involving commissioned services, are in progress.

2. Needle Exchange

There are 10 pharmacies in Bromley which provide a needle exchange enhanced service which involves providing clean injecting equipment, paraphernalia and advice to injecting drug users. The pharmacies also receive sharps boxes from drug users. Unsurprisingly, these pharmacies are mainly located north of the borough to meet demand. Further pharmacies are being identified to provide this service.

3. Bromley Community Drug Project (BCDP)

The BCDP provides a confidential service for drug users and their families/friends in Bromley. It includes the provision of counselling, information, community detoxification and onwards referral if necessary. BCDP Aftercare is a service which works with clients to provide continuation of care via 4 weekly sessions. These sessions comprise of 1 structured session, 2 feelings groups and 1 evening open session. This is a fairly new service, however feedback from clients has been positive so far. It is clear

that this project will need to work on expanding resources to meet the anticipated demand.
All these services can be accessed directly or through a walk in gateway point (REACH).

Recommendations

Prevention

Most of the services in Bromley focus on treatment provision. It is recognised that more work needs to be conducted to implement preventative services. This involves the use of appropriate materials being delivered in a variety of places to target the right population, such as at GP surgeries, GUM clinics, pharmacies and job centres. BME clusters also need special consideration, with services needing to be culturally astute and account for any translation of literature.

As Bromley currently has a higher than average number of children, it is anticipated that the working and 18-25 age groups will be dominating the expected rise in population. Clearly this needs to be considered when developing and refining services, including written materials.

Improving Access

There is established need to improve access to services, particularly for those hard to reach clients. Satellite provision could aid this which would focus on these particular clients through partnerships with GPs, hospitals and walk in centres. Extra training of, for example nurses and doctors, in substance misuse and Bromley services would improve access through primary care settings such as A+E.

Exits

Clients exiting treatment services need appropriate and adequate follow up in a planned format. It is recognised that this needs to be improved upon and the development of a discharge policy will ensure that the outreach team is fully involved. Indeed, improvements in case tracking should prevent clients from exiting treatment plans prematurely.

The DAT is currently in the process of implementing and integrating these recommendations to services. Although Bromley does seem to be exceeding London and national averages in many areas, there are specific gaps which do need focus. Continuous auditing and re-evaluation will ensure that these gaps are being addressed.

For further information and more detailed analysis please contact:

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2.5 Alcohol Health Needs Assessment for Bromley

INTRODUCTION

Alcohol has wide ranging social impact and it is clear that alcohol consumption nationally has been increasing for some time. There are large societal, health and individual costs associated with alcohol excess. Nationally deaths caused by alcohol consumption have doubled in the last 20 years and trends show hospital admissions and mortality from alcohol -related diseases such as cirrhosis of the liver are increasing. Alcohol is also associated with anti-social behaviour, crime, and in young people with sexual activity and unwanted pregnancy.

Alcohol is a socially acceptable drug; most people do not recognize that they have a problem, and do not seek treatment until their alcohol problems are prolonged, causing severe health problems or involvement in the criminal justice system. The World Health Organization and Health England ranked increases in taxation to reduce alcohol consumption top of fourteen other preventive initiatives in 2009. Alcohol treatment is highly cost effective with every pound on treatment saving £5 elsewhere, yet nationally the prevention of alcohol -related harm is neglected.

Bromley's alcohol needs assessment has been developed to provide an informed picture of the needs of people who have an alcohol problem in Bromley. This includes:

- Identifying the key issues in relation to alcohol misuse
- Defining a local picture of the need
- Assessing the health and social impact of alcohol misuse
- Assess the effectiveness of the current treatment system
- Identifying any gaps
- Identifying key priorities for further action

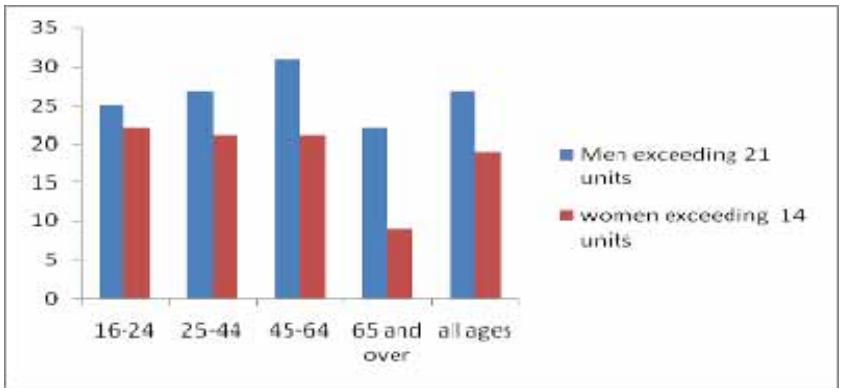
In April 2006 an alcohol harm reduction strategy for Bromley was developed but not fully adopted. This strategy outlined priorities for action in the five following areas: education and communication, identification and treatment, protecting children, young people and vulnerable adults, addressing alcohol related violence, crime and disorder and supply and industry responsibility Work has continued on these priorities and some of the recommended actions which have impacted on alcohol services have informed this needs assessment.

EPIDEMIOLOGY OF ALCOHOL MISUSE AND THE IMPACT IN BROMLEY

Patterns of alcohol consumption

Nationally alcohol consumption has been rising over recent years. Men have higher consumption levels than women, and higher alcohol associated morbidity and mortality. The number of deaths in men and women rose in England between 2001 and 2007. There are regional differences in alcohol consumption with the highest rates in the North West England. White men are more likely to be alcohol dependent /report hazardous drinking than men of minority ethnic groups. Single divorced and cohabitating men and women are more likely to be heavy consumers of alcohol /alcohol dependent. There is a linear association between household income and alcohol consumption in both men and women, though alcohol dependence shows a U -shaped curve in relation to income. Nationally drinking in women and very young adolescents is increasing. Women are less likely than men to exceed the weekly recommended amounts of alcohol. For females, younger women aged 16 -24 years are most at risk and males aged 45-64 in the male cohort.

Figure 1 Percentage exceeding specified amounts in one week, by sex and age in 2008



Source: GHS 2008

The Adult Psychiatric Morbidity Survey (2007) provided estimates of the prevalence of hazardous drinking in England. Although APMS 2007 may have underestimated the prevalence figures, (since they surveyed private households, and homeless adults and those in an institutional setting will have been under- represented) the figures from this survey can be used to estimate the figures for Bromley:

In Bromley 80,000 people or 1 in 4 adults in Bromley are estimated to be drinking over safe alcohol limits. St Paul Cray, St Mary Cray and Penge are areas where prevalence is highest. These areas are also linked to high deprivation and poor life chances.

- **Hazardous drinking:** *individuals drinking above the recognised "sensible" levels but not yet experiencing harm; (22-50 units per week for men and 15-35 units per week for women)* In Bromley 32,008 men and 25,944 women over 16 are hazardous drinkers

- **Harmful drinking:** *individuals drinking above recommended levels for sensible drinking and experiencing physical and / or mental harm (> 50 unit for men per week and > 35 units for women per week*). In Bromley the percentage of people with harmful drinking habits (synthetic estimate 2005) 4.3% which equates to 13,207

- **Alcohol dependence**: *individuals drinking above sensible levels*, *experiencing an increased drive to use alcohol and difficulty in controlling its use*. In Bromley the percentage of people who are alcohol dependent (estimate based on national APMS 2007 survey) is 6% equates to 14,359

- **Binge drinking:** Percentage binge drinking (over 16 years) (synthetic estimate 2003-5) is 10.7% which equates to 32.191

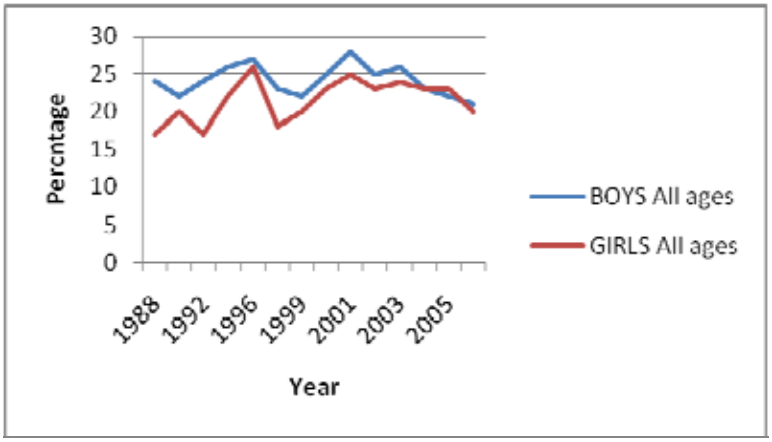
What this means for Bromley

- young people aged between16-24 years were significantly more likely than people in other age groups to have exceeded the recommended daily number of units of men aged 16-24, 30% drank at a harmful level, compared with 4% aged 65 or over. Of 16-24 year old women, 22% drank a harmful amount of alcohol on at least one day in the preceding week, compared with 1% of women in the oldest age group.

Patterns of alcohol consumption in young people

New national research published earlier this year highlighted that more than one in three young adults go out drinking with the specific intention of getting drunk. In 2008, 52% of 11-15 year olds reported that they had drunk alcohol which is a significant decrease from 1998 at 62%. Similarly, 13% of young people within the same age cohort reported that they drank at least once a week which is a decrease since 2001. This highlights again that though the overall proportion of young people that have consumed alcohol has decreased, there has been an increase in the number of units that have been consumed per week. Thus in 1994, the average consumption of alcohol was 6.4 units, in 2007 this had increased to 12.7 units.

Figure 2 Percentage of children aged 11 to 15 years who drank alcohol in the last week, by sex and age, 1988 to 2006, England



Source: Department of Health (2007). Smoking, Drinking and Drug Use among Young People in England in 2006.

The proportion of children who have ever had an alcohol drink rises with age from 22% of 11 year olds to 86% of 16 years olds, 54%% of 15-16 year olds reported binge drinking (defined as five or more drinks in a row in this survey) in the past 30 days. People who binge drink in adolescence are more likely to binge drink as adults. Frequent drinking and binge drinking in adolescence increase the risk of developing alcohol dependence in young adulthood. Mean adult alcohol use at age 36-42 years is inversely related to the age at which binge drinking or frequent drinking begins.

The TellUs3 survey is a national survey conducted annually of pupils in years 6, 8 and 10 to find out their views about the local area they live in. Questions around alcohol are contained within the survey. TellUs in Bromley showed that 11% of young people had been drunk twice or more in the past 4 weeks. This was the highest percentage in London along with Richmond. In relation to alcohol use, Bromley's score is 7% which is twice that for the region but very close to the national average. Kingston also scores 7% and Richmond 6%. In spring 2010, the TellUs4 survey highlighted that 42% of those surveyed had drunk alcohol and 13% had been drunk in the past week. It must however be stressed that information stemming from the TellUS surveys is useful as an indication of a problem rather than a robust evidence base with only three schools taking part in the survey. This highlights an increase in the number of young people getting drunk in the last week from the previous year.

What this means for Bromley

- Targeting young people in effective communications about alcohol harm will be the key to reducing young people's alcohol use

Patterns of alcohol consumption in black and ethnic minority groups

The Alcohol Needs Assessment Research Project (2004) found that Black and Minority Ethnic (BME) communities have considerably lower prevalence of hazardous/harmful alcohol use but a similar prevalence of alcohol dependence compared with the white population. More recently a scoping study (Thom et al 2010) was commissioned by the Department of Health to explore the issues relating to alcohol related harm, BME communities and service provision. The report found that facets of diversity in addition to culture, religion and race should be considered such as socio economic status, gender and age. The interaction between these factors has different importance for drinking and service use in different BME groups. An example of this was that evidence showed that Indian women in higher income brackets are more likely to exceed the recommended guidelines for alcohol consumption (Becker et al 2006). The literature highlights that Irish people report frequent and heavy alcohol use and that Black Caribbean, Black British, Black African people consume less than the general population. There are also lower rates of consumption among Chinese people. Changes in drinking rates have been identified with an increase in drinking for white and South Asian young people and that second generations are more likely to drink than first generations. Increases in heavy drinking among Indian women have been noted as have factors such as education, income and divorce a predictor of women's drinking. Interethnic friendships were also found to predict drinking levels and rates. In terms of alcohol-related disease, black people present with a lower of liver cirrhosis, with South Asian / Sikh men presenting with a high prevalence of alcohol-related liver damage and liver cirrhosis. Women with liver cirrhosis were found to be mainly from white backgrounds and Irish, Scottish, Indian men and Irish and Scottish women having high rates of alcohol-related mortality. Minority ethnic groups are underrepresented in seeking help and advice. A range of barriers to seeking help were identified within the study. These included lacking confidence to approach services, language barriers, racism, feeling marginalised within the system and misconceptions about alcohol services.

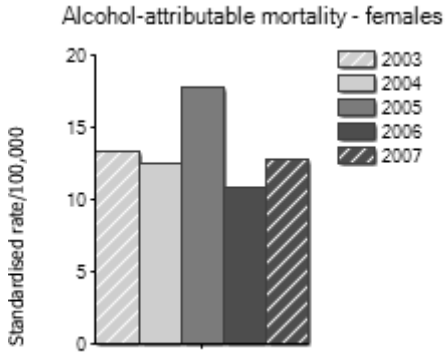
What this means for Bromley

- In Bromley, the numbers of people from BME communities that present to services would suggest that individuals are accessing services, although more detailed work is required on the number of people from BME communities presenting with alcohol attributable physical health problems.

The effects of alcohol on mortality

Alcohol attributable mortality appears to be decreasing in men, but not women. There was significant increase in mortality of women in 2005 due to alcohol which decreased in 2006 but this rose again in 2007. Men have seen a constant reduction in alcohol attributable mortality from its peak in 2004.

Figure 3 Alcohol-attributable mortality in Bromley 2003 – 2007



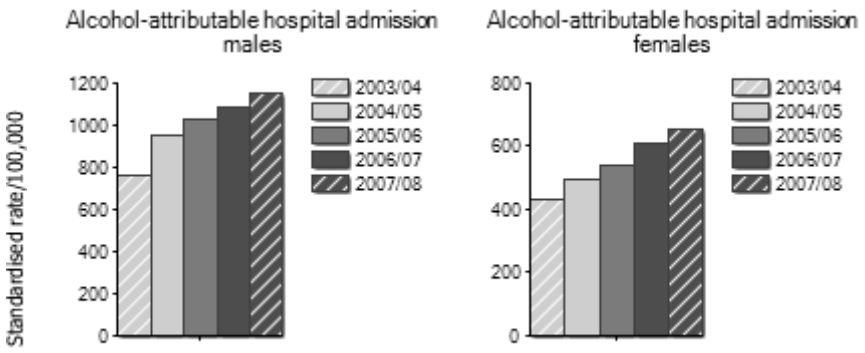
Source: LAPE: Local Alcohol Profiles for England

What this means for Bromley

- There is a need to understand and address the increase in female mortality in Bromley due to alcohol which contrasts with the decreasing rates of mortality for men

Admissions to hospital due to alcohol can be used as a proxy indicator for physical health of the population. Attributable chronic conditions such as liver cirrhosis rise progressively with age; this underlines the need for early detection of alcohol problems in young people in order to prevent these admissions in the future. In Bromley the number of hospital admissions among under 18 years between 2005/6- 2006/7 were 118, the total number of alcohol attributable hospital admissions 2007/8 were 4625. Alcohol attributable admissions rose in both women and men from 2003 - 2007.

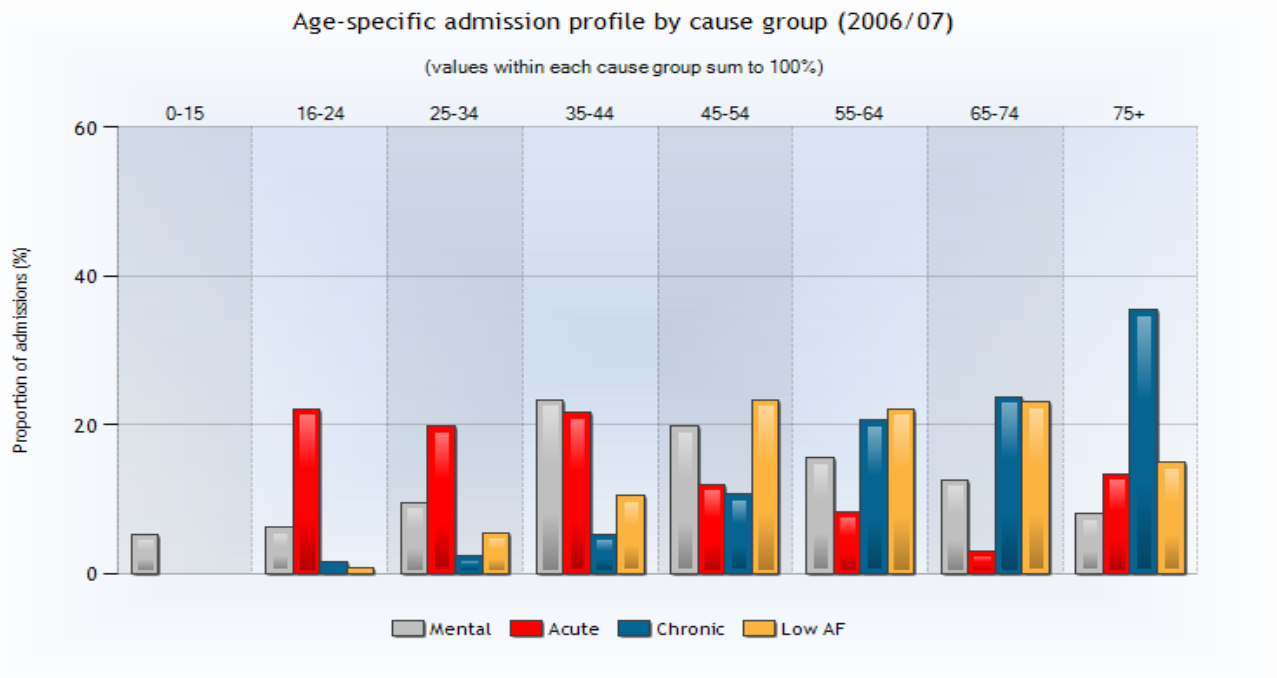
Figure 4 Alcohol-attributable hospital admissions in Bromley 2003 – 2007



Source: LAPE: Local Alcohol Profiles for England

The rise in admissions between 2003/04 – 2008/09 appears to be due to mental or behavioural disorders due to alcohol while the number of admissions due to acute intoxication fell. Admission rates rose at a steeper rate in Bromley than in comparable PCTs between 2003/4 and 2008/9. The admission rates for people under 18 years are higher in Bromley compared to London and comparable PCTs (except Bexley).

Figure 5

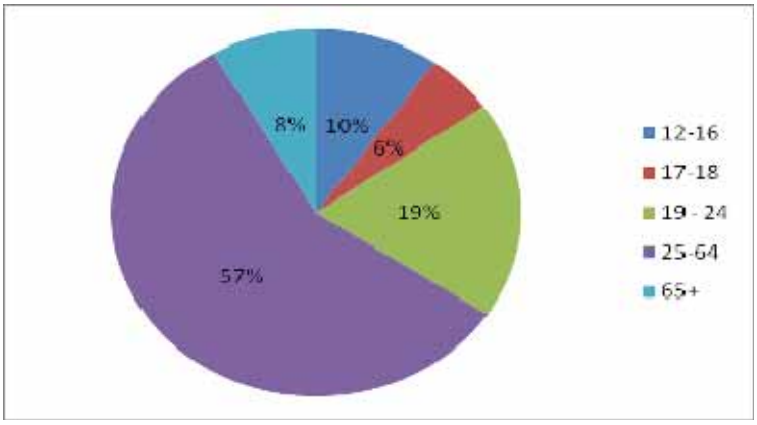


Source: NWPHO. Note that according to the NI39 definition, children aged under 16 are only counted for those conditions which are wholly attributable to alcohol. Consequently, nearly all relevant admissions for the 0-15 age group fall into the two categories of Mental and Behavioural, and Acute conditions. AF = Attributable fraction. Low AF refers to conditions such as cancer of the colon.

Admissions to Accident and Emergency services are also an indicator of the impact of alcohol related conditions: In 2009/10 the South London Healthcare

Trust had 204 Accident and Emergency attendances for alcohol- related conditions (0.02% of all attendances) of which 31% led to a hospital admission. The youngest attendees were aged 12 years. The breakdown by age is shown below.

Figure 6 Accident and Emergency attendances 2009/10 by age (years)



Source: South London Healthcare Trust

What this means for Bromley

- There is a need to address the increase in hospital admissions in Bromley to reduce the pressure on hospital services and ensure that individual needs are met to reduce harmful alcohol consumption
- There needs to continue to be effective engagement with Accident and Emergency departments to develop an effective pathway to treatment for people presenting in crisis

Not only can alcohol have an impact on individual well being but also people with mental health problems or drug misuse problems are more likely to be hazardous drinkers. The estimated number of women in Bromley who are alcohol dependent and also have a mental health problem for which they are undergoing treatment is 1090. For men it is slightly lower at 914. An additional number of hazardous drinkers also have a mental health problem for which they are undergoing treatment.

Table 1 Treatment currently received for a mental or emotional problem (age standardized) by level of problem

	hazardous alcohol use	Hazardous alcohol use	Alcohol dependent
Men			
Not receiving treatment for a mental health problem	95%	93%	91%
On treatment (medication+- counselling)	5%	7%	9% (914)
Women			
Not receiving treatment for a mental health problem	91%	94%	74%
On treatment(medication +- counselling)	9%	6%	26% (1090)

Source: APMS 2007

Within Bromley there is also an increase in the number of people with hazardous alcohol use or who are alcohol dependent who have developed mental health problems who are admitted to acute mental health in-patient beds for detoxification. In a recent survey on the use of in patients beds within Bromley Oxleas NHS Trust found that 11% of all bed days were used by people for detoxification. Protocols are being explored to ensure access to the appropriate services for individuals from the acute mental health services.

What this means for Bromley

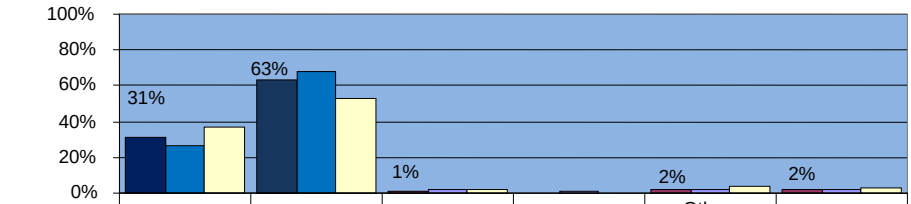
- There is a need to ensure that the acute admission unit for mental health has direct access to detoxification beds with appropriate gate keeping protocols to ensure that individuals are treated appropriately and to reduce the pressure on the in-patient beds

Alcohol and the misuse of other substances

One third of people who misuse either drugs or alcohol also misuse other substances, for example one third of drug users misuse alcohol and almost one third of alcohol users also use a secondary substance especially cannabis.

Nationally alcohol and cannabis are by far the most prevalent drugs of choice in the overall under 18s population. This trend is mirrored in Bromley's own profile (2008/09). There has been an increase in the numbers of young people presenting in treatment with alcohol and cannabis misuse since 2007. This trend can be observed both in terms of first and second drug of choice with alcohol increasing from 21% as a first drug in 07/08 to 31% in 08/09. As a secondary drug, alcohol has increased from 29% in 07/08 to 34% in 08/09.

Figure 8 Primary Drugs of choice for young people2008/09



	Alcohol	Cannabis	Opiates	Crack	Other Stimulants	Other
Bromley	31%	63%	1%	0%	2%	2%
London	26%	68%	2%	1%	2%	2%
National	37%	53%	2%	0%	4%	3%

The effect of alcohol on sexual health

According to the National Alcohol Strategy (2004) there are strong links between alcohol consumption and a range of risk factors such as teenage pregnancy. The strategy proposed that among 14-15 year olds who drank within the last month were more likely to engage in sexual activity. Nationally, the number of conceptions fell for under 18s. There were 9,440 under-18 conceptions, compared with 9,921 in the same period in 2008.

In Bromley the quarter one (Jan- Mar) 2009 teenage pregnancy data highlights that both the rate and the actual number of conceptions have increased in comparison to the same quarter in the previous year; 63 actual conceptions at the rate of 46.0% per 1000 as opposed to 49 and 35.0 per 1000 respectively. Anecdotal data indicates that in many these cases alcohol use was a factor and increased the likelihood of young people risk taking behaviour.

Within the borough, teenage pregnancy midwives collect data on whether contraception had been used and where possible the circumstances surrounding risks that occurred that led to the pregnancy in the first place. Whatever the circumstances, alcohol has been found to lower people's inhibitions, thus if this is related to young people, a proportion who became sexually active prematurely, may not have otherwise made these choices if they had not been under the influence of alcohol. Teenage pregnancy is tackled through a range of programmes. An example being include 'Your Choice, Your Voice' which is delivered in schools and focuses on alcohol, drugs, relationships and sex. The aim is to equip young people to make appropriate choices and decisions and understand the possible consequences of these.

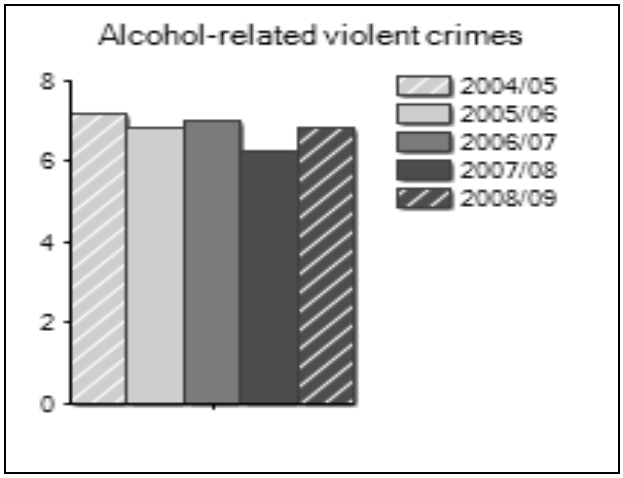
What this means for Bromley

- Data on alcohol consumption is not routinely collected in Genitourinary Medicine (GUM) clinics, and is not reported on. Furthermore, because of the confidential nature of GUM services, data about sexually transmitted diseases is not collected on a geographical basis, only on a clinic basis, so to get a true Bromley figure is difficult.

The effects of alcohol on Crime

The Local Alcohol profile for Bromley shows that the borough does significantly worse than average, for all alcohol-related crime, and for violent crime. Bromley is ranked 256 for Alcohol-attributable recorded crimes out of 326 local authorises in England, significantly higher than most of Bromley's comparable boroughs except for Barking and Dagenham & Hillingdon. The total estimated number of alcohol attributed crimes (2008/9) was 3067; of these 2060 were estimated for violent crimes attributable to alcohol and 293 estimated sexual crimes attributed to alcohol (2008/9). There has been a slight decrease in alcohol related violent crime between 2004/5 – 2008/9, assuming that reporting and recording of such crime has remained the same. However whilst a potentially valuable indicator the Local Alcohol Profiles for England uses percentage of crime being alcohol attributable based on the % of people arrested for a particular type of crime who test positive for alcohol in an arrestee survey (1999-2001). This formula is then applied to crime data. This may result in an understatement the role of alcohol in offending. Also a proportion of the crimes counted as alcohol related may also be counted as drug-related if arrestees had tested positive for both alcohol and drug use.

Figure 9



Source: LAPE: Local Alcohol Profiles for England

The above figures relate to all arrest in Bromley not just people who are residents, of 11982 people arrested in Bromley for a variety of offenses 7012 people were resident in Bromley (58%) as shown below.

Table 2 Arrest data 2008/09

		Numbers	Percent
Total arrests		**11982**	
	RTA - Positive Breath Test	406	3%
	RTA - Refused Breath Test	53	0.4%
	RTA - S4 Unfit - Drink	51	0.4%
Bromley arrests		**7012**	58%
	RTA - Positive Breath Test	322	4.6%
	RTA - Refused Breath Test	39	0.5%
	RTA - S4 Unfit – Drink	47	0.6%
	Drunk and Disorderly	65	1%
	Criminal Damage – Dwelling	230	3.2%
	Criminal Damage - Motor Vehicle	127	1.8%
	Criminal Damage - Non Dwelling	115	1.6%
	Criminal Damage – Other	53	0.7%
	All Criminal Damage	587	8.3%
	Public order. Other	332	4.7%

Source: Bromley metropolitan police 2008/09

The proportion of Bromley residents who test positive for alcohol after a road traffic accident was 4.6% which is significantly higher that the non Bromley residence arrested for the same crime (1.7%). It is interesting to note that Bromley residents committed 587 (8.3%) offences for criminal damage, a proportion of these would have been directly alcohol related

The contribution of alcohol to domestic violence incidents is not routinely recorded in the Crime Intelligence System but significant levels of domestic violence incidents are thought to be alcohol related and domestic violence itself may lead to alcohol abuse in the victim. In Bromley, a system for gathering data to capture true incidence of domestic violence needs to be developed.

Safe: Sensible: Social- the next steps in the *National Alcohol Strategy (2004*) highlights that drinking among young people under the age of 18, especially frequent drinking, is associated with criminal and disorderly behaviour. Nearly half of all 10-17 year olds who drink once a week or more admitted to some sort criminal behaviour or disorderly behaviour; approximately two-fifths reported getting into an argument and about a fifth stated they had got into a fight during or after drinking. In September 2009, it was identified that an increasing number of young people were being arrested for offences which involved drugs or alcohol. Statistics provided by the Drug Intervention Programme (DIP) within Bromley estimated that 83 young people were arrested between January and June 2009 for drug/alcohol related offences.

What this means for Bromley

- Bromley needs to do more work around prevention and the damages of driving whilst under the influence of drugs and/or alcohol
- Further work is required to understand the local impact of alcohol on domestic violence
- Bromley needs to continue to provide interventions and initiatives to ensure that crime and alcohol related crime continues to reduce

Prevention

In 2006, the Government launched the 'Know Your Limits' campaign- the first national campaign to target 18-24 year old binge drinkers. Its aim was to increase awareness and consideration of the consequences of drinking responsibly, increase knowledge about sensible drinking levels and highlight where to get more help and treatment. This was updated in 2008 to raise awareness of units and sensible drinking specifically to over 25's with the aim being to increase understanding of the consequences of excessive drinking and provide the motivation to act on information and change behaviour.

Locally, alcohol is discussed as part of substance misuse delivery in School Personal Health and Social Education classes under "risky behaviour". There have been local health promotion campaigns on alcohol at Christmas 2009, and some work in health weeks. Some work has been done around responsible bar owners/servers obtaining "Best bar none" status. Many more new Premises Licenses are granted than revoked per annum Trading standards are involved in the enforcement of alcohol sales to underage young people, and the review of Licensing of premises which service alcohol on a 3 yearly basis. Bromley implemented a management of drug and alcohol related incidents strategy with secondary schools in the borough.

The Junior Citizens programme which is run by the Metropolitan Police is delivered to year 6 Primary School children in the borough. It consists of scenarios in which the children are invited to think about how they react and deal with the kind of situations they will come across as they move onto secondary school.

Treatment services

Services are involved in prevention, screening and delivering a range of treatments, to reduce problematic alcohol misuse and alcohol- related harm. These treatment services are provided in tiers depending on the severity and impact that alcohol has on the individual. Pharmacies play an important role in delivering appropriate advice, information and signposting to services. This is an area that needs further development.

Tier 1 services are mainly delivered by GPs in Bromley the number of people seen by GPs for screening and brief interventions. A survey was undertaken on three sample general practices, this revealed poor recording of data, and alcohol consumption was only recorded at new patient visits. One sample practice had recorded that 6% of the practice population had a screening health check, 3% a brief intervention and no one had been referred for treatment. This highlights the need for appropriate and consistent training for GP's to help them to gain a greater understanding of the need of this client group as well as the importance of accurate data recording. Under the Alcohol-Direct Enhanced Scheme there has been a significant increase in the number of participating practices offering Alcohol health checks. In 2008/09 14 surgeries participated in the scheme has risen to 23 in 09/10 with more

expressing interest to participate in 2010/11. Apart from screening and brief advice, the surgeries have been signposting those considered at risk for Tier 2 support
In 2009/10 there were 1350 prescription items, for an unknown number of individuals, prescribed for alcoholic relapse prevention by GPs. It is difficult to interpret this other than those GPs are prescribing at Tier 3 but not recording their activity with people with alcohol problems.

People with acute alcohol -related problems may also come into contact with Emergency departments, with general physicians, and psychiatrists. People with chronic problems may come into contact with community alcohol and drug services, and psychiatrists as well as social care, domestic violence and housing teams all of whom will provide information and guidance.

Tier 2 services are unstructured interventions which are provided by Bromley Community Alcohol Service (BCAS). The services include individual sessions, drop- in services, and the alcohol clinic currently being delivered within REACH open access services. REACH open access is currently the gateway service into tier 3 and 4 treatments. Alcoholics Anonymous and SMART (self help support groups) are active in Bromley and provide tier 2 support for individuals. There is a separate service for young people provided by Bromley Young People's Alcohol Service (BYPASS).

Tier 3 services provide structured interventions through the Bromley Community Alcohol Service (BCAS). Individuals can access services to reduce or stabilize their drinking, and to achieve and maintain abstinence. The service also prepares people for in-patient detoxification and home detoxification which are monitored in conjunction with the client's GP. The commonest sources of referral to Tier 3 services were the non- statutory drug service –55% the statutory drug service – 8.7 % and family and friends – 10%. GPs made 15 referrals in 2009/10. This is at odds with the national profile where 22% of referrals come from a GP and 38% are self referrals.

Tier 4 services provide in patient or residential detoxification. There are a range of services to met individual needs which include:

- Individuals with more complex needs are referred via the Bromley Advice and Information Service to Bethnal Addiction Services currently provided by South London & Maudsley NHS Trust. The service currently operates three units for specific interventions depending on need.

- Individuals who require stabilisation or crisis intervention can also self refer to City Road crisis centre. In 2009/10 there was an increase in referrals to City Roads crisis center. As a result of this trend, improvements have been made to improve access to beds for individuals who may be more chaotic.

- Placement in a residential rehabilitation centre. During 2008/09 30 service users have been through the residential rehabilitation. The

analysis below breaks down the 30 service users who entered residential treatment Average placement prices ranged from £500 - £740, now average first placement price ranges have reduced from £550 to £400 making it more cost effective. This is due to increased emphasis on negotiation with the service providers without compromising service delivered. The average weekly charge for Residential rehabilitation in 2008/09 was £482.00; this was reduced in 2009/10 to £457.00 (5% reduction).

- Individuals following detoxification have a number of options for services to meet their needs which may include utilising Bromley community services to undertake a structured treatment intervention, attending a structured day program outside of Bromley or being placed in a residential rehabilitation centre.

Table 3 Numbers of people in treatment by Treatment Type 2009/10

Treatment Type Provision	2009/10
Inpatient Treatment	43
Structured psychosocial intervention	9
Structured day programme	2
Residential rehabilitation	2
Other structured intervention	15
Residential rehabilitation	3
Community Prescribing	2
Structured psychosocial intervention	190
Structured day programme	1
Other Structured Treatment	60
Brief Intervention	1
YP psychosocial intervention	74
YP harm reduction service	16
YP family work	1
Missing Intervention	15
Total	435

Source: NDTMS

There has been an increase in the number of people accessing and starting a structured treatment from 08/09 – 09/10. It is interesting to note that with the increasing numbers the ratio of males to females has remained similar, with the male cohort still being highest. The under 16 cohort which has increased by 53% (17 people), the 60 – 64 cohort reduced by 33 % (6 people) the 40-44 cohort also reduced by 16 % (11 people) but overall the picture for Bromley's is that the numbers of individuals in treatment is increasing.

The following chart shows wide variance between Bromley and national alcohol services in the treatment type provided. This is likely to be a coding difference and /or small numbers involved. However Bromley appears to treat more people as in- patients, which will have an impact on costs.

Table 4 Treatment Type Provision in Bromley compared nationally

Treatment Type Provision	Bromley (2009/10)	Percentage for each treatment type	National percentage 2008/9 (covers adults aged 18+ only)	Variance % between Bromley and national percentage
Adults 18+				
Structured psychosocial intervention	199	58	26	32
Other Structured Treatment	75	22	31	-9
Structured day programme	3	0.8	4	-3.2
In-patient Treatment	43	12.5	2	10.5
Residential rehabilitation	8	2.3	1	1.3
Community Prescribing	2	0.5	4	-3.5
Total interventions – adults 18+	344	100		-

Source: NDTMS data, 2009/10

The age profile of service users suggests the age profile in Bromley is very similar to national rates except that people aged 18-24 years appear to be accessing services less

Table 5 Age profile of those aged 18+ in treatment compared to England percentage in 2009/10

Age on starting treatment	Number	Bromley % in treatment	England % in treatment in 2008/9	variance %
18	5	1.5	9 (18-24 yrs)	-7.3
19	2	0.6		
20 – 24	10	3.0		
25 – 29	23	6.9	9	-2.1
30 – 34	39	11.6	12	-0.4
35 – 39	53	15.8	16	-0.2
40 – 44	58	17.3	17	0.3
45 – 49	58	17.3	14	3.3
50 – 54	37	11.0	10	1
55 – 59	26	7.8	7	0.8
60 – 64	12	3.6	4	-0.4
65+	12	3.6	2	1.6
all 18+	335	100	100	-

Source; NTDMS 2009/10 and NATMS 2010

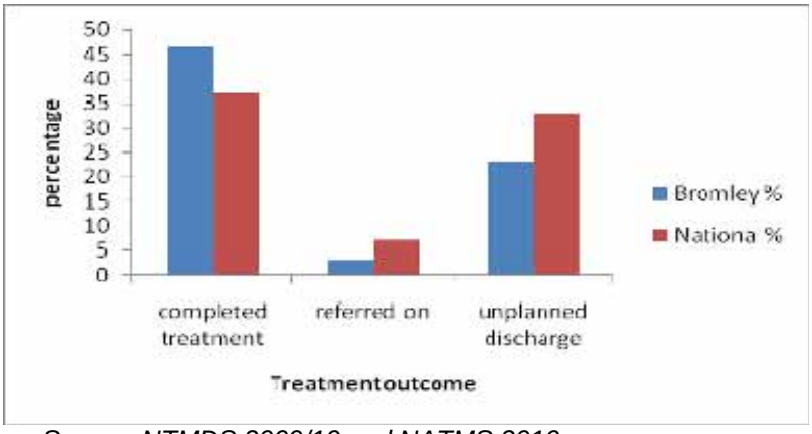
What this means for Bromley

- Bromley is very similar to national rates except that people aged 18-24 years appear to be accessing services less, work needs to undertaken to understand what the obstacles may be and to ensure if necessary this age is targeted for treatment provision

- Bromley appears to treat more people as in- patients, which will have an impact on costs, the use of in-patient residential facilities will be reviewed as part of the review of the model of service provision.

In 2009/10 160/435 (37%) clients completed treatment. Compared to national rates Bromley had a higher percentage of people completing treatment and a lower percentage having an unplanned discharge in 2009/10. Ten clients were referred on for in- patient detoxification /dual diagnosis/complex problems, and 80 people quit treatment early.

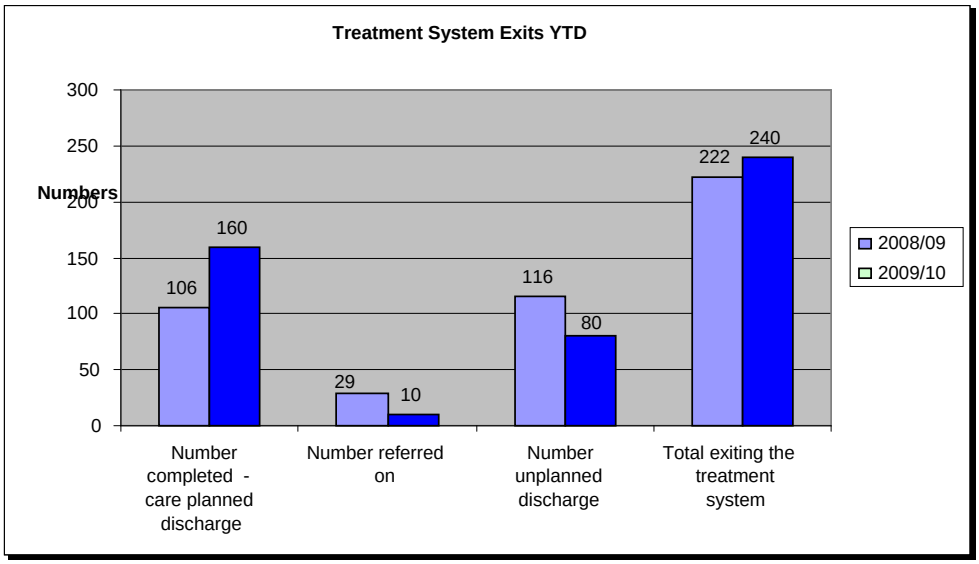
Figure 10 Treatment Outcome in Bromley and England 2009/10



Source; NTMDS 2009/10 and NATMS 2010

In Bromley the number of individuals that completed (care plan discharge) has increased by 51% in 2009/10, the number of clients leaving treatment in an 'unplanned' way has reduced by 31 %. The evidence shows that improvements made in the re-modelling of BCAS have impacted on outcomes.

Figure 11



Source: NDTMS data, 2008/09 & 2009/10

GAPS AND PRIORITIES FOR BROMLEY

The Local Alcohol profile for Bromley shows that the borough does better in all areas except crime, and significantly better in twelve of the twenty-three

indicators. It does significantly worse than average, however, for all alcohol-related crime, and for violent crime. However whilst Bromley appears to be providing services to reduce the harm that alcohol causes there are still areas which need to be developed alongside continuing to provide important services for people to access treatment and support. These fall into six main categories, Community Safety, Prevention, Primary care, Access to treatment services, Information and data:

Community Safety

Crime figures would indicate that although crime is decreasing there are areas which require further development whilst maintaining the existing initiatives and services. These include:

- more work around prevention of driving whilst under the influence of drugs and/or alcohol
- Continued to enforce controlled access to alcohol especially at the points of sale with rigorous vetting of age before sale. A national Home Office led campaign *Tackling Underage Sales of Alcohol Campaign (TUSAC)* used to target worst offending off-licenses known to Trading Standards and the Police.

- Continued to enforce zero tolerance of drinking in public places like parks by young people using Community Police to confiscate drinks from under 18 drinkers.

- To continue to work with drug and alcohol agencies to ensure that contracts are sufficiently flexible to enable agencies to support local borough and police initiatives which promote access into treatment.

- Drug Intervention Programme workers are not currently contracted to provide advice and support to young people under 18 years of age however are able to signpost to the appropriate service. Further work will need to be done to appropriately address this gap in provision

Prevention

Whilst there is ongoing work in schools, retail outlets and with parents this needs to be increased in the following areas:

- In line with the Chief Medical Officer's guidance; agencies in Bromley need to continue to communicate with parents, carers and professionals the message of strict abstinence for under 15s and supervised drinking if at all for the 15-17 age group to minimise alcohol harm both in the short term and in the long term
- Frontline services need to be more visible and welcoming in a non stigmatising way to increase access to support for young people and families with alcohol related issues

- Need for increased alcohol awareness and education amongst young people especially within the educational establishments highlighting the importance of accurate and consistent messages in relation to harm reduction, safer drinking limits, and prevention, including high visibility campaigns in the community to sensitize young people to the dangers of alcohol (similar to “Talk to Frank”).

Primary care

GP’s and primary care services provide a valuable point of contact for individuals, both in terms of providing information on alcohol harm and also in identifying health consequences of alcohol consumption. To support this work the following will be undertaken:

- Expand the Alcohol-Direct Enhanced Scheme to further increase the number of practices offering Alcohol health checks.

- To address the assertion of under-recording of alcohol consumption in primary care by auditing the recording of alcohol on GP registration and ongoing care

- To continue to provide by direct contact with GP’s and by continued participation in GP training information on the services and treatments available in Bromley.

Access to treatment services

Services in Bromley continue to meet the demands of people accessing services although there are a number of issues which need to be addressed, firstly that people aged 18-24 years appear to be accessing services less, work needs to undertaken to understand what the obstacles may be and to ensure if necessary this age is targeted for treatment provision. Secondly that Bromley appears to treat more people as in- patients, which will have an impact on costs, the use of in-patient residential facilities will be reviewed as part of the review of the model of service provision. Further work will also be undertaken in the following areas:

- Increase the numbers of points of access to treatment for problematic drinkers, including expanding outreach services.

- To support NICE guidance regarding school based initiatives providing support to schools identified as needing, or requesting additional support from the Healthy Communities Team .and to inform schools of the referral pathway into specialist young people’s drug and alcohol services.

- To increase access to services for those who are currently underrepresented within local provision including working with local agencies to target those under 24 years of age.

- Protocols are being explored to ensure access to the appropriate detoxification services for individuals from the acute mental health services.

- To explore further the needs of older people in relation to harmful alcohol consumption and access to services

- There is a need to address the increase in hospital admissions in Bromley to reduce the pressure on hospital services and ensure that individual needs are met to reduce harmful alcohol consumption

- To undertake a review of the care pathway for alcohol services with a focus on the A&E department**,** In-patient services in mental health and aftercare provision.

Information and data

- There is limited data on the effects of alcohol on the elderly – most data sources available suggest that alcohol problems are an issue for young people and up to age 65 and not so much for the over 65+ but this may reflect a lack of awareness and recording issue.

- To develop an alcohol data to monitoring across partnership agencies.

- There is a need to understand and address the increase in female mortality in Bromley due to alcohol which contrasts with the decreasing rates of mortality for men

- Data on alcohol consumption is not routinely collected in Genitourinary Medicine (GUM) clinics, and is not reported on. Furthermore, because of the confidential nature of GUM services, data about sexually transmitted diseases is not collected on a geographical basis, only on a clinic basis, so to get a true Bromley figure is difficult.

2.6 Childhood Immunisation Health Equity Audit

Introduction

Immunisation is a proven tool for controlling and eliminating life-threatening infectious diseases and is estimated to avert over 2 million deaths each year worldwide (1). In England, the uptake of immunisation has resulted in a significant reduction in the rate of infectious diseases. The World Health Organisation has set a target for 95% of children to complete all of their immunisations by the time they are 18 years of age. In the UK, similar national and local targets have been set in order to achieve high levels of immunisation uptake.

Childhood Immunisations in Bromley

London immunisation coverage rates have been known to be significantly below the World Health Organisation target. Immunisation coverage trajectories have therefore been set at a lower level. In Bromley, the trajectories and performance against them can be seen in table 1 below.

Table 1 Immunisation Trajectories for Bromley PCT

Immunisation	Actual 2008-09	Trajectories 2010-11
Immunisation rate for children aged 1 who have completed immunisation for diphtheria, tetanus, polio, pertussis, Haemophilus influenzae type b (Hib) - (i.e. all 3 doses of DTaP/IPV/Hib)	75.5%	90%
Immunisation rate for children aged 2 who have completed immunisation for pneumococcal infection (i.e. received Pneumococcal booster) (PCV)	75.4%	90%
Immunisation rate for children aged 2 who have completed immunisation for Haemophilus influenzae type b (Hib), meningitis C (MenC) - (ie received Hib/MenC booster)	82.2%	95%
Immunisation rate for children aged 2 who have completed immunisation for measles, mumps and rubella (MMR) - (i.e. 2 doses of MMR)	82.2%	90%
Immunisation rate for children aged 5 who have completed immunisation for diphtheria, tetanus, polio, pertussis (DTaP/IPV) (i.e. all 4 doses)	74.3%	95%
Immunisation rate for children aged 5 who have completed immunisation for measles, mumps and rubella (MMR) (i.e. 2 doses)	71.1%	90%

Inequalities in immunisation

Within areas which have high immunisation uptake overall there may still be groups of children, young people and adults that are either unimmunised or not completely immunised and therefore at risk (2). This is highlighted in the recent NICE guidance entitled 'Reducing differences in the uptake of immunisations among children and young people aged under 19 years'. Evidence used in the guidance formation has also shown that particular groups of children and young people are at increased risk of not completing their vaccinations (2). These include:

- children in care
- young people who missed previous immunisations
- children with physical or learning difficulties
- children of lone parents
- children not registered with a general practitioner
- children in larger families
- children who are hospitalised
- minority ethnic groups
- vulnerable adults such as asylum seekers, traveller groups and the homeless

Although Bromley met some of its trajectories for childhood immunisations in 2008-09, inequalities in uptake between different geographical areas of Bromley and different population groups may exist.

An Immunisations Project Board was established at Bromley PCT in 2009 to improve immunisation uptake rates locally. An action plan for immunisations was devised which outlined how the PCT would work together with their key partners to improve uptake rates. One of the planned actions was to perform a health equity audit to identify any inequalities in immunisation service provision.

Health Equity Audit

Health equity audits aim to identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas. They aim to highlight the priority actions needed to provide services relative to need and so result in the recommendation of measures focused on reducing health inequalities (3).

The main aims of this health equity audit were to identify any inequalities in immunisation service provision and provide recommendations for directed measures to improve equity in childhood immunisation uptake. The rate of immunisation uptake was used as the measure of immunisation service provision.

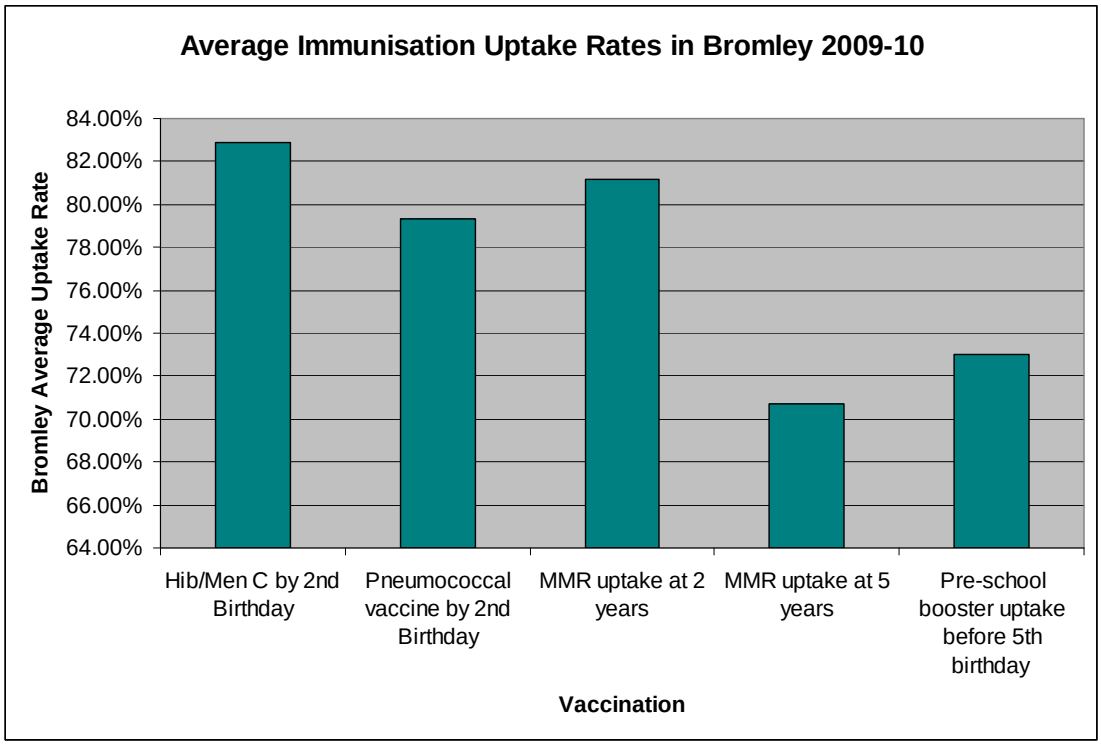
To achieve these aims, the geographical variation in immunisation uptake rates by electoral ward in Bromley was examined in relation to the following demographic variables:

- Proportion of ethnic minority residents by ward
- Proportion of lone parent families by ward
- Index of multiple deprivation (IMD) by ward

Immunisation uptake rates among looked after children (LAC) were also examined. Looked after children were selected as an appropriate group to study as they were one of the groups specified by NICE as being ‘at risk’ of not being fully immunised. They were also an easily identifiable group for which data concerning immunisations could be obtained.

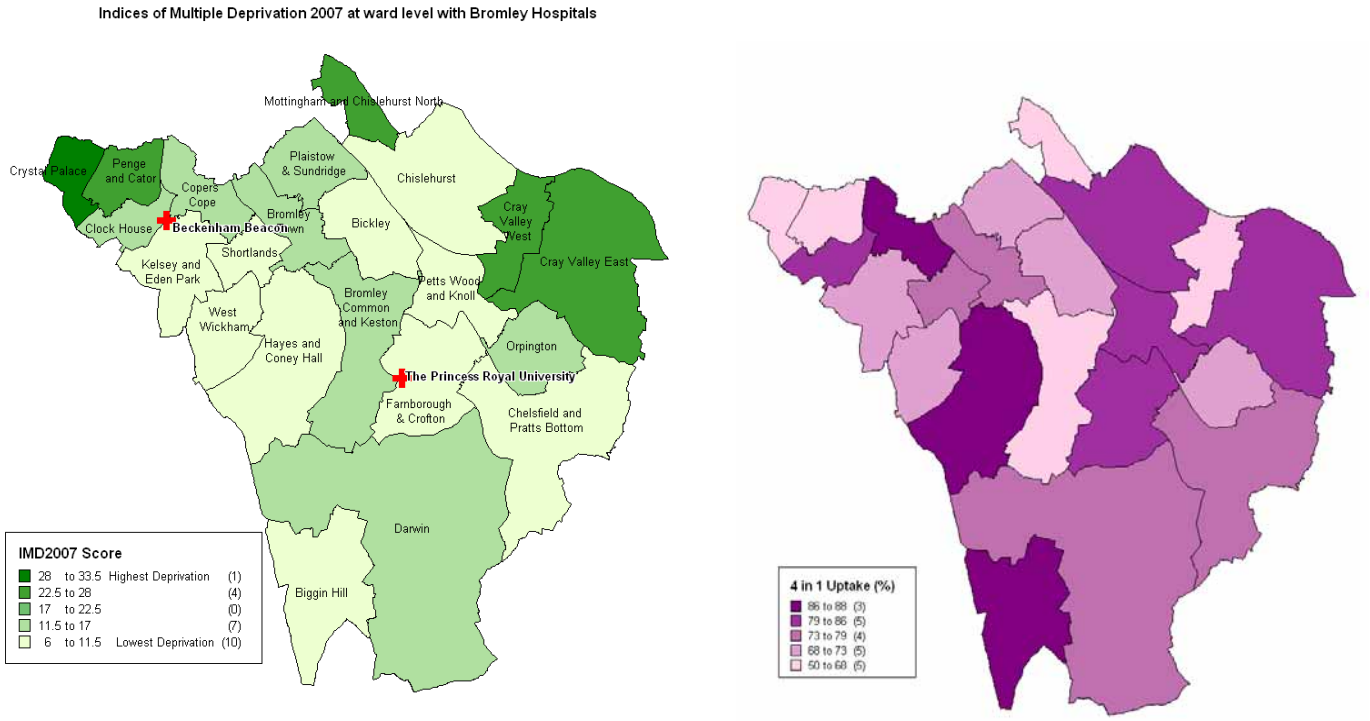
The results of this audit showed that overall, immunisation uptake rates were highest in Bickley, Chelsfield and Pratts Bottom and Hayes and Coney Hall. Uptake rates were lowest overall in Penge and Cator, and Mottingham and Chislehurst North. Across the wards, uptake rates tended to be higher for the earlier immunisations e.g. Hib/MenC by 2 years of age (Bromley average 83%, range 62%-93%), than for immunisations given later in the schedule e.g. the 4in1 pre-school booster by 5 years of age (Bromley average 73%, range 50%-88%) (Figure 1).

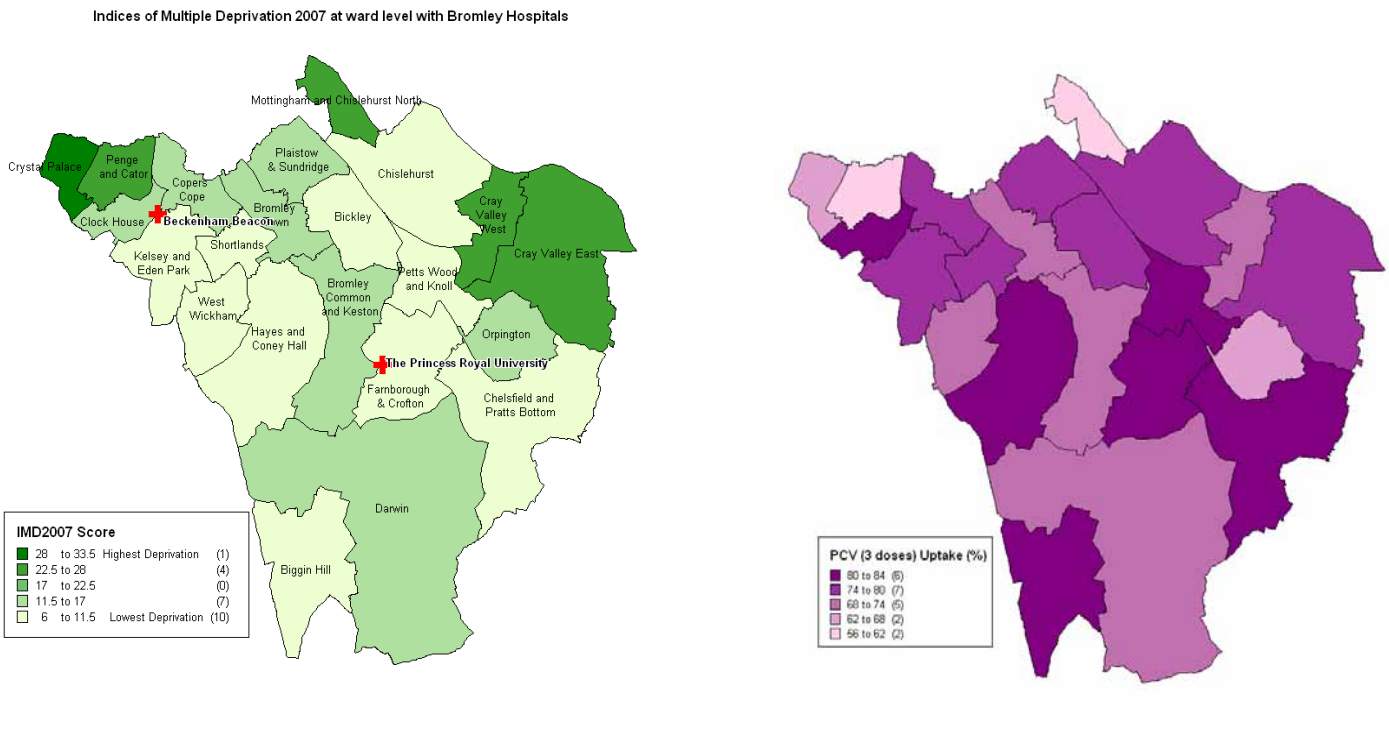
Figure 1. Average Immunisation Uptake Rates in Bromley 2009-10



The variations in uptake rates for these later immunisations were also more strongly associated with variations in IMD and the proportion of lone parent families in Bromley. Strong negative correlations were identified between IMD and the uptake of the 4in1 pre-school booster and complete course of PCV (Figure 2) i.e. the more deprived a ward was the lower the uptake rate of these vaccinations tended to be. This was also the case for the proportion of lone parent families and these immunisations. For looked after children, immunisation uptake rates were found to be lower than the Bromley averages for the Hib/MenC, two doses of PCV, three doses of PCV and 4in1 pre-school booster when calculated overall.

Figure 2. Maps of Index of Multiple Deprivation (2007), Uptake of 4in1 pre-school booster and complete course of PCV (2009-10) by electoral ward in Bromley





Map produced by Public Health, Bromley PCT.
Digital Mapping Solutions from Dotted Eyes

The results of this audit present possible population groups i.e. lone parent families and deprived communities, within which targeted measures could be taken to improve uptake rates for both the 4in1 booster and complete course of PCV immunisations in Bromley.

The following recommendations to reduce inequalities in immunisation uptake in Bromley have been made as a result of this audit:

- Consider targeting 4in1 booster and PCV immunisation initiatives to more deprived communities or lone parent families in Bromley.

- Consider setting up targeted 4in1 booster, Hib/MenC and PCV immunisation initiatives among looked after children in Bromley.

For further information and more detailed analysis please contact:

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2. National Institute for Health and Clinical Excellence (2009). *Reducing the differences in uptake of immunisations among children and people aged under 19 years.* London: NICE.
3. National Institute for Health and Clinical Excellence (2003). Health Equity Audit Made Simple: A briefing for Primary Care Trusts and Local Strategic Partnerships. London: NICE. Available at: http://www.nice.org.uk/niceMedia/documents/equityauditfinal.pdf

2.7 Pharmaceutical Needs Assessment Summary

NHS Bromley is fortunate to have high quality community pharmacy services across the borough. Part of NHS Bromley's responsibility is to ensure that the services commissioned from them meet the needs of Bromley residents and fit with our primary care and health improvement strategies. This document sets out an assessment of the need for pharmaceutical services in Bromley that we have conducted over the past year. It has been developed by a steering group comprising key stakeholders and has also been informed by an exceptionally good response from the public to a postal questionnaire about their local pharmacies and the services they offer.

Why do a Pharmaceutical Needs Assessment?

Because it is now a legal requirement and the duty of all PCTs to produce one. It is also a rigorous and helpful process.

The purpose of a Pharmaceutical Needs Assessment (PNA) is:

- To inform and support the PCT's commissioning plans for pharmaceutical services
- To inform and support the PCT's decision-making process in relation to market entry, this function requires further enabling regulation which is expected in the autumn of 2010.

National background

This PNA has been prepared at a time of significant change in the NHS, when two important factors will influence the future;

- The recent White Paper, Equity and Excellence: *Liberating the NHS,* has set in motion a significant programme of change which will have an impact on how we plan and use pharmaceutical services in the future. It is too early to say how this change will affect the PNA or pharmaceutical services. We expect that some aspects of pharmaceutical services will be managed by the NHS Commissioning Board.

- At the same time the NHS is being asked to contain rising costs and improve productivity as, following a period of sustained growth over a number of years, resources for the NHS will now effectively stand still. As a result, all areas of NHS spending, including pharmaceutical services will be scrutinised to ensure that money is spent to deliver the outcomes expected by patients and the public and with the greatest possible efficiency.

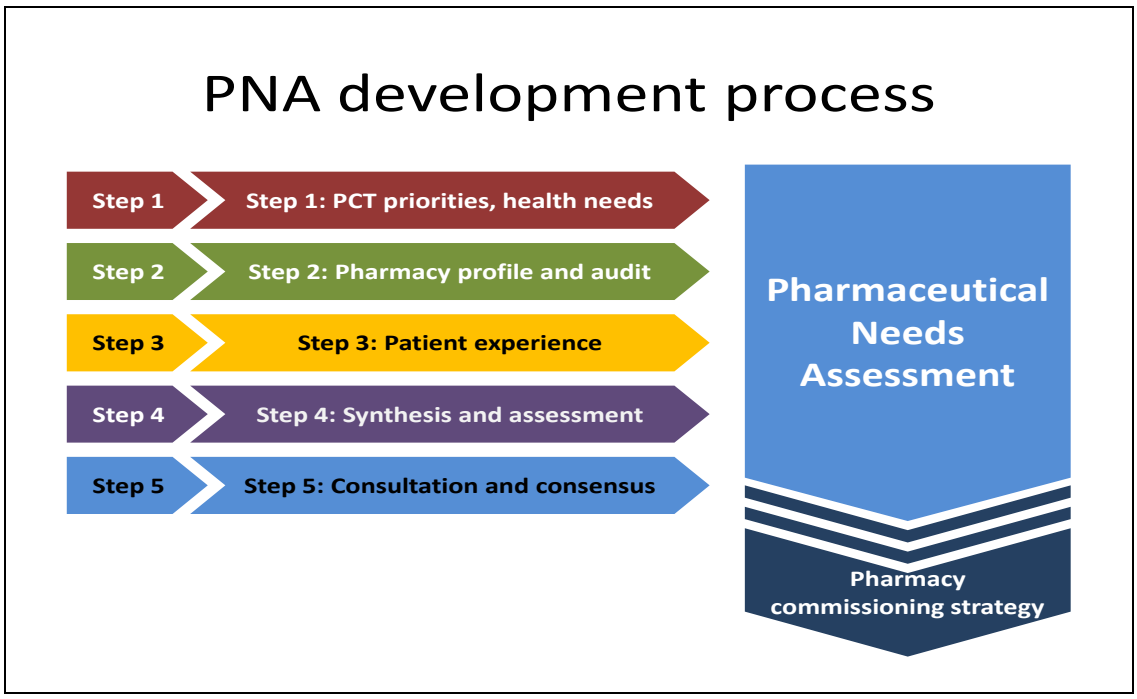
Bromley background

Pharmaceutical services in Bromley are provided through a network of 59 pharmacy contractors, including four 100 hour contracts. Over the last five years pharmacy services have changed considerably through the development a new national contract and through local commissioning. As a result, patients can access a wider range of services from pharmacies than ever before. Bromley pharmacies now provide a range of national and locally commissioned services to the population including; stop smoking advice, emergency contraception, Chlamydia testing and treatment, needle exchange and supervised drug dependency treatment.

In undertaking this assessment the PCT has tried to balance the need for a high quality, accessible network of pharmacies with the needs of patients for services when and where they find them most useful.

The process of developing the PNA

The graphic below summarises the steps that we have taken to get to the point of consultation on the Bromley PNA.



The development process combines the PCT's strategic plans, draws on the Joint Strategic Needs Assessment that describes the health needs of the population and links these to the commissioning of pharmacy services. The PNA provides a foundation for further work to develop a pharmacy commissioning strategy for the PCT.

Summary of the assessment of current services

This section summarises the main finding from the review of each of these services in the PNA:

Essential services e.g. Dispensing prescriptions	Dispensing of NHS prescriptions is a fundamental service, it is commissioned nationally by the NHS and all pharmacies in Bromley offer this service. Consequently, the PCT considers that essential services, is a **necessary service** the current need for which is secured through our existing pharmacy contractors. The PCT has concluded that there are no current gaps in essential services but has identified a number of issues which will need to be addressed if a gap in provision is to be avoided in the future, these are described in detail in section 9 of the PNA
Advanced services e.g. Medicines Use Reviews which involve a discussion between the pharmacist and the patient that is intended to improve the patient's understanding and use of medicines.	Evidence for MUR remains mixed and with limited local levers to control the quality and targeting of MUR the PCT has concluded that it is a **relevant service** for our population. There are no gaps in provision; however the PNA has highlighted some opportunities to improve the provision of this service. We will work with our existing contractors in areas of need to ensure that there is provision where there is the greatest demand specifically, Penge and Anerley (particularly Crystal Palace), Mottingham and Chislehurst and The Crays
Locally commissioned services	
Needle exchange Exchanging used injecting equipment for clean equipment for injecting drug users	The needle exchange service is an important public health service which reduces risk to drug users and the general population. In Bromley 11 of the 59 pharmacies are commissioned to provide this service. Consequently the PCT has concluded that the provision of the needle exchange service from pharmacies is a **necessary service**. The current provision is consistent with the needs of the population and the PCT has concluded that there are no gaps in provision.
Supervised consumption The pharmacist supervises the taking of drug treatment for drug users in a treatment programme	The supervised consumption service performs a critical role in supporting drug users in treatment to manage their treatment programme while minimising the diversion of drug treatment onto the streets. In Bromley 13 of the 59 pharmacies are commissioned to provide this service. The PCT has concluded that the supervised consumption service from pharmacies is a **necessary service**. The provision is consistent with the needs of the population and the PCT has concluded that there are no gaps in provision.
Emergency Hormonal Contraception The pharmacist supplies women with	The EHC service through pharmacies provides important access to EHC for women in Bromley. In Bromley 21 of the 59 pharmacies are commissioned to provide this service. The PCT considers the EHC service is a **necessary service**. The provision from pharmacies in Bromley is

emergency contraception ("the morning after pill")	generally good, however there is currently no pharmacy provision in Cray Valley West or Mottingham and Chislehurst North, both wards have high levels of teenage pregnancy. The PCT will work with the existing pharmacy contractors to ensure that there is adequate provision in these areas.
Smoking Cessation Service The pharmacist provides counselling on giving up smoking and supplies therapy to help smokers to quit	The stop smoking service through pharmacies is an important strand of the PCT's efforts to reduce smoking rates among the population. Pharmacy is a unique provider with the ability to provide access to Nicotine Replacement Therapy (NRT) at the point of care. In Bromley 42 of the 59 pharmacies are commissioned to provide this service. The PCT has concluded that the smoking cessation service is a **necessary service**. There is pharmacy provision of stop smoking services in Bromley, including those areas with high prevalence rates. Pharmacy provision in Mottingham and Chislehurst is limited, rates of smoking are high in this area and it is possible that further pharmacy provision is required in the future. The PCT will keep this under review.
Chlamydia screening and treatment Pharmacies issue screening tests and offer treatment for Chlamydia	The Chlamydia screen and treat service provides an accessible source of advice and screening on the high street to young people. In Bromley 38 of the 59 pharmacies are commissioned to provide this service. However activity has been low and the service has yet to fully develop. The PCT has concluded that the Chlamydia screening and treatment service is a **relevant service**. The PCT will review the uptake and commissioning of this service to ensure that it continues to meet its objectives.
On demand availability of drugs Selected pharmacies maintain a stock of drugs that may be needed urgently in end of life care.	This service ensures that patients and their carers can get immediate access to drugs used in end of life care from four strategically located pharmacies. This important service is a **necessary service** for the population. The provision from the four strategically place providers meets the needs of the population at this time.
NHS Health Checks Some pharmacies are providing a health screening service to identify people at risk of heart disease.	The NHS Health Check's service has been piloted through community pharmacy and is now being rolled out to pharmacies that have been offered alternative provider status for the NHS Health Checks programme in Bromley At this time, the PCT has concluded, that the NHS Health Check's service is a **relevant service** for the population. The PCT will revise this assessment as the roll our progresses and more information about the uptake and outcomes of the service are available.
Monitored dosage system service Some pharmacies dispense medicines into reminder devices to help patients take	The MDS service seeks to reduce unintended errors in dosing and to promote independence for patients. This service is currently under review by the PCT which is seeking to understand how patients who require support with their medicines can be supported while maintaining independence.

their treatment at the right time.	The PNA has provided some insight into the views of patients and pharmacists which will be used to inform the review process and any subsequent commissioning by the PCT.

Future Services

This PNA will also inform the PCT's commissioning intentions in the future. The PNA process has included reviewing potential future services to identify some services that should be considered as part of the commissioning process. These include:

- **Minor ailments service**
- **Flu vaccination**
- **Weight management**
- **Diabetes monitoring**
- **Long term contraception supply**
- **Condom supply**
- **Pregnancy testing**
- **Anticoagulation checks**
- **Gluten free foods supply**
- **Brief interventions for alcohol use**
- **COPD management**
- **Hepatitis C screening**

These potential services will need to be considered alongside the changes taking place within the NHS and the future role that the PCT will have in commissioning services from pharmacies.

Next steps

Looking at the needs of the population of Bromley and the current provision from pharmacies, the PNA process found that the population enjoys good access to pharmaceutical services with a broad range of services available when and where they are needed. The PNA also highlighted how pharmacy services could be improved and where there are opportunities to develop services in the future.

Pharmacies in Bromley provide many local services which are intended to address the challenge of reducing ill health through screening and prevention, however there is scope to do more and use pharmacies to deliver services that help tackle the challenge of long term conditions, maintaining people at home and avoiding hospital admissions.

This is the PCT's first PNA under the new regulations, NHS Bromley is now consulting on this draft needs assessment with its stakeholders and partners to ensure that it is accurate both as a reflection of the situation in Bromley and in the way that it interprets the information we have gathered to inform it.

For further information and more detailed analysis please contact:

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2.8 Update on Recommendations from JSNA 2009

The needs assessments include in last year's JSNA all included recommendations for future action. This section provides an update on these recommendations as well as on the recommendations from the 2009 Annual Public Health Report.

Health Section

There were a number of recommendations related to health outcomes in the JSNA for 2009.

A number of measurable outcomes were selected, against which improvement would be measured.

These included:

- Health Inequalities
- Life Expectancy
- Proportion of children completing MMR immunisation by their 5th birthday
- Smoking quitters
- Circulatory Disease mortality
- Coronary Heart Disease mortality
- Chronic Obstructive Pulmonary Disease prevalence
- % of people screened for diabetic retinopathy
- % of all deaths that occur at home

The progress towards these recommendations is detailed in the table below.

In addition, five wards with lower life expectancy and higher circulatory disease mortality rates were identified to receive targeted interventions to improve health outcomes. These wards are:

- Penge & Cator
- Mottingham & Chislehurst North
- Crystal Palace
- Cray Valley East
- Cray Valley West

In the last year, life expectancy has increased in three of these wards for both men and women. For the remaining two, life expectancy has increased in men in Cray Valley East, and in women in Cray Valley West. Mortality from coronary heart disease has fallen in all of these wards except Cray Valley East.

Progress on Health Outcomes

Outcome	Previous Position	Target	Latest Position
Life Expectancy	Male: 78.5y Female: 82.5y	Increase overall life expectancy for males by 2 years and females by 1.5 years over 5 year period.	Male: 78.8y Female: 82.7y
Life Expectancy Gap	Male: 8.4y Female: 7.2y	Reduce gap between best and worst wards by 0.5 years for males and by 0.3 years for females.	Male: 7.5y Female: 7.0y
MMR Uptake at age 5 Years	71.1% (2008-09)	75.1% Aspiration: 95%	77.9% (Q1 2010-11)
Smoking Quitters	2008–09: 1287	1299 Aspiration: 1,444	1630
Circulatory Disease Mortality	56.23/100,000 (2005-07)	Aspiration: Continue downward trend	53.17/100,000 (2006-08)
Coronary Heart Disease Mortality (<75y)	29.36/100,000 (2005-07)	Aspiration: Continue downward trend	29.14/100,000 (2006-08)
COPD prevalence	1.20%	Aspiration: 2.0%	1.27%
Diabetic Retinopathy Screening Uptake	79.8%	80% Aspiration: 90%	72.7%
Deaths Occurring at Home		20.4% Aspiration: 25%	19.1% (2008-09)

Rapid Health Needs Appraisal

Area	Recommendations	Actions/Progress
Mottingham	Work to improve social cohesion in the area More work with young people, directed both at reducing the fear of young people which so inhibits older people from leaving their houses from late afternoon onwards and at providing young people with something “to do” A focus on healthy eating using a holistic strategy	The Health Improvement Service has a Service Level Agreement with LBB to support health improvement activities through Mottingham Community and Learning shop. This year’s agreement included delivery of a healthy eating and living course, and ways to promote healthy eating further are under discussion with the shop. HIS has delivered: • workshops on healthy eating for young people • the HENRY programme which promotes healthy lifestyles with families with young children workshops on self esteem for young women relationships, contraception and sexual health workshops at local youth and children’s centres.
Penge, Crystal Palace & Anerley	Improving access to information. A strategy to develop public confidence in the area, counter the fear of crime and improve social cohesion. More support to minority communities to enhance access to services.	The Health Improvement Service worked with the New Neighbours Project in Penge to ensure 24 newly arrived refugees have access to health services, organised a health and wellbeing day for refugees and asylum seekers, and provided a drop in health visitor service at two refugee day centres. Health Improvement has worked with Somali Well Women to promote ‘Know Your Numbers’ blood pressure week amongst the Somali community and supported the Partnership for Better Health Initiative which seeks to increase the rate of early maternity booking among black women in Penge and Anerley. A worker for Sexual Health and Vulnerable groups continued to promote the AHEAD Condom Distribution Scheme and HIV awareness.

The Crays & The Ramsden Estate	Supporting adult learning at a very local level. A Youth strategy. A healthy eating strategy.	Health Improvement Service have delivered outreach work with the youth service and Priory School on healthy lifestyles (such as smoking cessation, self-esteem, healthy eating, contraception etc.), including the Happier Healthier programme and a self-esteem programme. Sexual health and relationship workshops for staff and pupils were held at two pupil referral units. Sexual health, relationship and contraception sessions have been held elsewhere through the year including the Ramsden estate, Orpington College, and with teenage mothers. . Last year HIS joined a youth bus to promote smoking cessation with young people on a monthly basis. The Health Improvement Service SLA with LBB also supports health improvement activities through Cotmandene Community Resource Centre, including delivery of a cookery course this year. The HENRY healthy lifestyles programme was delivered at a children's centre, alongside The Incredible Years Parenting programme.

Gypsies & Travellers Needs Assessment

Recommendations

- Formation of a Gypsy Traveller Multi-agency strategy for Bromley
- To improve Education
- Establishment of community engagement mechanisms across agencies
- Establishment of a Gypsy and Traveller Forum for members of the community
- Continued provision of health visitor outreach work and increased provision of health improvement services in particular smoking cessation, mental health and diet,
- Further additional research into areas not fully explored in this needs assessment, particularly child and maternal health and sexual health

Progress

A draft strategy was presented to the Health, Housing and Social Care Partnership Board.

The steering group continues to meet.

The Health Improvement Service undertook a training needs assessment with Health Visitors in June 2010 and will be piloting a Gypsy and Traveller cultural awareness course for health practitioners in November 2010. Gypsies and Travellers will be represented at an annual multi-agency Equality and Diversity event for the first time this year. Within the NHS an additional code has been introduced for ethnic monitoring.

The HELP card multi-agency initiative was launched in July 2010 to help address literacy barriers for Gypsies and Travellers in particular, but also any other groups with literacy difficulties. The plastic card enables service users to ask for discreet help with reading or writing. It has been distributed to 50 organisations in Bromley whose clients may benefit.

The Traveller Education Service has been part of a National Strategies Project for Gypsy, Roma and Traveller pupils working with three primary schools and one secondary school – they are St. Paul's Cray CE Primary, Leesons Primary, Manor Oak Primary and The Priory Secondary school. This project ran for two years ending in July 2010 and involved working with families and schools to raise achievement and attendance of GRT pupils. This included a boxing project for Years 5 and 6 pupils held at The Priory, a peer mentoring project to help with secondary transfer and the commissioning of a

Cray Valley history DVD with reference to the Gypsy/Traveller community to use in schools as part of the local history element of the curriculum thereby raising awareness of the Traveller community.
Within the NHS a permanent 0.5 specialist health visitor post was filled in January this year and a drop in clinic established at the Bromley Gypsy Traveller Project (BGTP), with services including child health checks, general health information and advice, pregnancy testing, Chlamydia testing and immunisation. MMR vaccinations were offered in the light of a recent outbreak of measles in the Gypsy Traveller community. Three community workers specialising in Gypsies and Travellers were trained to support smoking cessation in the community, resulting in an increased number of quitters.
A child and maternal health needs assessment was led by PCT and LBB commissioners, and a midwife now attends the Gypsy Traveller project once a week to deliver a service to Gypsy Travellers.

Sexual Health Needs Assessment

Recommendations:

There were three main areas to be addressed.
A Vulnerable groups and individuals. Both prevention and service provision needs to be tailored to specific groups who are at high risk of poor sexual health. Vulnerable individuals need to be identified and counselled.

B Service provision. An integrated service is needed which provides STI diagnosis and treatment, contraception advice and provision, and health promotion. These new services need to be provided equitably across the borough, at times that local people can access them, and with sufficient capacity to avoid the current problem whereby people are turned away or have to wait for long periods.

C Cultural attitudes and beliefs. The obstacles to sexual health posed by attitudes and beliefs of both young and older people need to be addressed in the health improvement strategy.

Progress

A service specification for an integrated sexual health service has been developed, and discussions between the PCT and SLHT are underway to agree delivery.

Although there is as yet no specific health improvement strategy in place, a Local Enhanced Scheme on sexual health with primary care has been put in place. This will improve access for vulnerable groups, and as it is set in primary care, will reduce obstacles related to attitudes and beliefs by normalising the availability of sexual health services.

Maternity Services Needs Assessment

Recommendations	Progress
The population of women of childbearing age in Bromley has been increasing faster than expected. This increase together with a raised fertility rate has resulted in an increased birth rate in Bromley since 2003. Services should plan for a continuing increase in births of 3% per year for the foreseeable future.	Birth rates now seem to have stabilised. There was minimal change in the birth rate in 09/10 compared to 08/09.
The slight increase in stillbirths in Bromley in recent years should be investigated by a review of the factors known to be associated with those stillbirths in Bromley.	Analysis shows there was an increase in stillbirths in 2008 which has now reduced again to levels seen in 2007. The reasons for this are being explored together with local maternity units. The stillbirth rate is being closely monitored while detailed analysis of cases is undertaken.
Pro-active services are needed to improve the rate of early booking in some groups such as women with mental health or drug use problems, and some ethnic minority groups.	An Action Learning set with the Race Equality Foundation was set up in 2010 to explore reasons for late booking in some black communities and mechanisms for encouraging early booking. A report of this work is due in late 2010 for dissemination to key local stakeholders.
The high emergency caesarean section rates in primips and the high elective caesarean section rates overall are of concern and should be addressed.	The Caesarean Section rate is still of concern but appears to be reducing. Work across Bexley, Bromley and Greenwich is being led by a Consultant Obstetrician who has reduced Caesarean Section rates in Greenwich to below the national average.
The joint application with the PCT for Baby Friendly assessment should be used as the basis for local sustained	Local work has identified need for further support for breastfeeding both in hospital and in community (community midwifery

improvement in breastfeeding, both while in hospital and after discharge into the community.

support and Health Visitor team support). A pilot of increased breastfeeding support in two areas of Bromley is due to start early in 2011.

Mental Health Needs Assessment

Recommendations

- The population profile and relative social deprivation with the resulting health inequalities in some wards within the borough suggests that there will be areas of significant need. Services will need to take account of this in the pattern of provision.

- The issues of self harm as an indicator of mental ill health and the response of services will need to be taken forward.

- Specific consideration needs to be given to the needs of black and minority ethnic communities in access to mental health services and in the factors that affect mental well being. These will be considered with each service development to ensure these needs are met.

Progress

In 2010 the Mental Health Needs Assessment has been used to inform priorities for mental health strategy in Bromley which has included:

- The promotion of well being
- An increase and further development of access to psychological therapies
- Continuing the programme to reduce the reliance on residential services
- An increase in access to employment, volunteering and education
- The reconfigured secondary care mental health services in Bromley that should ensure improved efficiency and quality of services.
- An Oxleas guide to assessment and management of risk guidelines to ensure consistency of risk management and assessment.

The Increasing Access to Psychological Therapies (IAPT, Bromley) is a new service to meet the needs of individuals with symptoms of anxiety and/or depression. The service has been developed as part of the National Improving

Access to Psychological Therapy Programme. IAPT in Bromley will build on existing service capacity and will enhance (and replace) the existing services provided by the Primary Care Mental Health Team and the Guided Self Help service provided by Bromley Mind. From October 2010, both providers will be working in partnership to provide a new integrated service model with a single point of access. IAPT in Bromley will provide a range of clinical interventions in line with NICE guidelines for the treatment of anxiety and/or depression. The services will mainly be providing Cognitive Behavioural Therapy (CBT) interventions, using a system of stepped care.

There has also been a concerted effort to deliver the 'five a day' for mental health programme as part of the implementation of the Mental Health Promotion Strategy which has included the delivery of the Mental Health First Aid Training across the statutory and voluntary sector.

APHR 2009 Striking the Balance: Work & Health

Last year's Annual Public Health Report *Striking the Balance, Work and Health"* took the theme of health in the workplace.

As a follow up to this report, work is in progress to develop a process for working to support local employers with improving the health of the workforce in Bromley.

2.9 Plans for JSNA 2011

Work is already underway to prepare for next year's JSNA.

Two key areas have been identified:

- A Physical Disability and Sensory Impairment Needs Assessment
- The interface between health and the Local Authority's Core Strategy.

Outlines for each of these pieces of work are included below:

Physical Disability and Sensory Impairment Needs Assessment

Discussions are currently underway with the Physical Disability and Sensory Impairment Partnership Board about how this needs assessment will be taken forward and which issues will be included.

The Local Development Framework Core Strategy

The Local Development Framework (LDF) is a collection of documents produced by local authorities which set the spatial planning framework for managing development and change over a 15 to 20 year period. The Core Strategy is the main document of the LDF. It reflects, on the ground, the intentions of the Community Strategy, agreed by the Local Strategic Partnership (LSP). The Core Strategy will provide a vision, strategic objectives and delivery strategy to set out the scale and location of development envisaged in the borough and when and how it is to be delivered.

The Core Strategy provides the overall policy context for decisions on planning applications and promotes development in a sustainable manner. It should promote healthy communities and seek to improve access to health facilities.

In next year's JSNA, we will explore the health impact of the immediate environment on the population.