



Bromley Clinical Commissioning Group



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

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Foreword

I have great pleasure in presenting the Bromley Joint Strategic Needs Assessment (JSNA) for 2014.

The JSNA is an important document setting out, through comprehensive data and analysis, the health, care and wellbeing needs of the borough's population over the short and long term along with the inequalities that exist.

The JSNA helps inform strategic planning for the commissioning of health services in the borough and also informs the design and targeted delivery of interventions that will achieve better health and wellbeing outcomes whilst reducing inequalities.

I am also excited to present, for the first time, individual electoral ward profiles for the borough which through a range of health outcome indicators, provide a comparison between each and allow councillors and residents to better understand the particular needs and inequalities locally.

As chairman of the Health & Wellbeing Board, I am determined to focus upon the identified inequalities and address them through the partnerships that exist between the Council, the Bromley Clinical Commissioning Group, healthcare providers, Bromley Healthwatch, and the voluntary sector.

Our Health & Wellbeing Strategy continues to identify the most important priorities for us to focus upon born out of the findings of the JSNA, with four priorities namely dementia, diabetes, obesity and children's mental health being given an even greater focus in the coming year by the Health & Wellbeing Board.

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

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

Councillor Peter Fortune
Chairman of Bromley Health & Wellbeing Board

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Executive Summary

2. The Population

The population of Bromley continues to grow, to a size of over 320,000 in 2014, and is predicted to expand further still over the next ten years.

Whilst the number of under 4 year olds has reached a plateau after ten years of growth, the proportion of older people in Bromley will continue to increase from 17.7% of the population in 2014, to 18.3% by 2024. Health and social care planning should take account for this rise in the numbers of older people particularly in the South of the Borough which will see the largest increase in numbers of over 75s.

The proportion of the population in Bromley which is made up of Black and minority ethnic groups has increased from 8.45% in 2001 to 17.3% in 2014. This increase has been mainly in the Black African community. Because the health risks of ethnic minority populations differ from the general population, attention should be given in health and social care planning in particular to the North West of the Borough which has the highest proportion of ethnic minorities, and also to the Cray Valley area which houses the Gypsy traveller population, who tend to experience poor health outcomes.

3. Life Expectancy and the Burden of Disease

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, currently at 80.7 years for men and 84.5 years for women. However, there is an 8.7 year gap for men and 7.9 years for women between the highest and lowest life expectancy wards in Bromley, with the lowest life expectancy in the most deprived wards.

Mortality in Bromley is chiefly caused by circulatory disease (32%) and cancer (30%) with higher mortality rates for both conditions in the more deprived areas of the borough.

There is a need for continued action to address health inequalities associated with deprivation. One avenue is to improve early identification of increased circulatory disease risk through the **NHS Health Checks Programme**.

However, evaluation of this programme shows low levels of uptake, particularly in the more deprived North West of the borough. Results from the programme also show that there is suboptimal follow up of patients who the programme has identified at need of further testing for diabetes, hypertension and chronic kidney disease.

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

Diabetes represents a continuing challenge in Bromley. The number of people affected has been rising since 2002, and for those diagnosed, control of the associated risk factors for circulatory disease is less effective than nationally. Work is necessary both to prevent and to improve identification of diabetes.

Cancer remains one of the key causes of mortality in Bromley, and although survival rates have been improving, incidence of all cancers is rising, indicating the need for good prevention strategies. In addition, a significant proportion of cancers are diagnosed outside the two week referral pathway, leading to later diagnoses, which will adversely impact survival rates, as will the low cancer screening uptake in the more deprived parts of the borough.

The rate of **sexually transmitted infections** is lower in Bromley than in London or nationally. The low prevalence of chlamydia in Bromley means that it has been necessary to adopt a targeted screening programme, which is proving successful with a high proportion of those tested proving positive for the disease.

Although Bromley as a whole has a low **HIV** prevalence, the HIV rate in the north West of the Borough is four times the Borough average and the prevalence is rising steadily. Whilst it is understood that migration from neighbouring boroughs is a contributing factor to the steady increase, further work is required to understand and ascertain if there are other contributing factors that require a particular approach to tackling the rise.

While early testing using Point of Care Testing in acceptable settings has been commissioned, further work is required to address perception of risk and transmission awareness with a view to increase the overall likelihood of actively seeking testing especially among at-risk females and also to understand which communities are more likely to confront stigma as a result of having a HIV test.

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

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

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

There is currently a gap in local data on Emergency Hormonal Contraception and Long Acting Reversible Contraception use which has created a gap in

understanding of the need and use by different population groups. Further work is planned to understand the contraception service need and use in the borough.

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

There remains a potential for **measles outbreaks**, particularly in older children and young adults due to poor immunisation uptake, as seen in the 11 confirmed measles cases in 2013.

There were 14 confirmed cases of **pertussis** (whooping cough) in 2013, highlighting the importance of immunisation against pertussis, in particular the uptake of maternal pertussis vaccination programme.

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

There is a rising prevalence of **smoking** in Bromley, this has a negative impact on Bromley's morbidity and mortality rates, local economy, health inequalities, local environment, hospital admission, re-admission and post-operative complication rates

Bromley has a particularly high smoking prevalence within routine and manual worker groups, prevalence is 8% higher than the general population in Bromley and continues to increase (prevalence was 24.3% in 2011-12, rising to 26.1% in 2012-13). There is evidence that illicit tobacco and shisha use are becoming more common in Bromley.

Bromley has the third highest levels of overweight and **obesity** in London, 65% are either overweight or obese and the prevalence is rising. The prevalence of **childhood obesity** is higher than the England average and is now reducing slowly in reception year children, but continues to rise in the Year 6 cohort. Excess weight contributes significantly to the incidence and progression of diseases such as type 2 diabetes, circulatory disease and cancer. A significant proportion of Bromley's residents (21.2% obese) are at higher risk of these conditions and of premature death.

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

There is evidence that interventions in the following areas have a positive impact on the health of the physically inactive:

- environmental changes designed to increase daily activity
- active transport – walking and cycling
- physical activity programmes for people with long term conditions
- physical activity for children in schools.

5. Housing

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

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

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

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

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

The volume of households faced with homelessness has risen dramatically during recent years predominantly in response to complex economic factors and the ensuing impact on housing markets, the onset of the recession and the welfare reform programme. The most significant area of increase continues to be the loss of private rented accommodation, which now accounts for more than one third of all homeless acceptances. An increasing number of households face a shortfall between benefits and housing costs and there are increasing numbers of households and children residing in temporary accommodation, in particular, outside the borough boundaries.

There is an increasing demand for private and intermediate older person's accommodation in Bromley.

6. Children and Young People

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

Rates of **Type 1 Diabetes** in the children of Bromley are slightly lower than predicted rates based on national data and rates of **Type 2 Diabetes** (obesity-related) in Bromley are similar to predicted rates based on national data.

Although admissions to hospital for diabetic children are relatively low they could be lower if pro-active specialist support were in place. This specialist support is being increased in Bromley and future measures of both process measures and outcomes in Bromley's diabetic children is expected to improve.

Although admissions to hospital for asthma and epilepsy have been low in Bromley, the most recent data shows an increase in admissions for both conditions. Length of stay in hospital once admitted also tends to be high in

Bromley. Arguably Bromley should be matching the best 5% of areas for both admissions and length of stay.

These data indicate that we should be looking to reduce emergency admissions and length of hospital stay for Bromley children with asthma and epilepsy. The provision of specialist paediatric nurses for these conditions may be key to achieving this.

Self harm appears to be an increasing issue for young people in Bromley, and there is some evidence that rates of presentation to services with self harm are higher in Bromley than in most London boroughs. In Bromley, most of the attendees presented due to self-cutting as opposed to self-poisoning suggesting a possible shift in self-harming behaviours. Of particular note were the common 'triggers' of a new episode of self-harm that presented to A&E, which included family arguments, bullying and already being an inpatient on a mental health unit. The most frequent chronic stressors of having separated parents, adoption, being a looked after child, having experienced domestic violence in the family or having been a victim of physical or sexual abuse highlights the significant psychological impact these can have on a child. The evidence that self-harm may be reduced by psychological well-being programmes for young people and gatekeeper training for those who they may present to is being taken forward in secondary schools, A&E at the PRUH and CAMHs services in the borough.

Teenage conception rates are falling in Bromley, however a higher percentage of these conceptions lead to terminations year on year. This upward trend of terminations is clearly an indication of unplanned or unwanted pregnancies.

It is therefore important to understand contraception service needs of teenagers in the borough by evaluating the impact of the provision of service such as condom provision, long acting contraceptive provision and Sex and Relationship Education (SRE) programmes in schools and FE Colleges with a view to establish if these have made a difference to avoiding unwanted teenage pregnancies.

Educational attainment at all levels in Bromley is generally above the national average, with girls outperforming boys at all levels. Despite this good achievement, however, there are certain groups of children, in particular those in receipt of Free School Meals who do not make the desired rate of progress. Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life. The increase in numbers and complexity of needs of children with learning difficulties and/or disabilities has required more specialist and high cost provision to be made available.

There has been an increase in the number of children in care over the last three years. Bromley is improving its efficiency in the amount of time it takes to move a child in with their adoptive family from coming into care. There are a higher

number of children in care with 3 or more placements than the national average.

7. Older People

The number of older people in Bromley has been increasing, and is projected to continue to rise. One of the key consequences of this is a rise in the numbers of people with **dementia**. There is considerable work being done to develop an integrated approach to the commissioning and provision of services for people with dementia and their carers. Despite this, there is still under identification of people with dementia.

An increasing number of older people are being supported within their own home with a commensurate increase in demand on community services. A corollary of this is that those older people cared for in residential and nursing homes have more complex needs.

8. Learning Disability

The number of people with learning disabilities under the age of 64 years, is predicted to rise by 9.2% over the next eight years. Medical advances mean that more young people with profound and multiple disabilities are surviving to adulthood and increasing numbers of children with learning disabilities are making the transition to adult services.

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

9. Sensory Impairment and Physical Disability

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

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

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

Although there have been improvements in disabled access across Bromley, work is on-going in this area.

10. Mental Health

In Bromley, one person in six has a mental health problem at any one time, and one in four will have a problem during their lifetime. The percentage of over 18s with depression is significantly higher in Bromley than the percentages for both England and London, however, the suicide rate in Bromley is below the England average.

In 2012, 91% of all people dying by suicide were men, of which the 45 years and over age group had the highest number of male deaths.

The number admitted to hospital with deliberate self harm have been rising over the last ten years, with the highest numbers in the 15 to 19 year age group. Consequently, implementation of the Mental Health Strategy and CCG Mental Health Programme are key tasks over the next few years, in particular the development of Primary Mental Health Care Services.

The number of people in Bromley with dementia continues to rise, especially in the over 85 year age group, however identification of dementia is below expected levels. Implementation of the Prime Minister's challenge on Dementia is important to improve this position.

11. End of Life Care

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

Evidence shows that the majority of people express a preference to die at home, however, in Bromley between 2010 and 2012, over half of deaths (53%) occurred in hospital. There has, however, been a consistent reduction in the proportion of hospital deaths and increase in the proportion of deaths at home, in care homes and hospices since 2006.

Coordinate My Care, a clinical service which coordinates care of patients nearing the end of life has been successful nationally in increasing the proportion of patients dying in their preferred place of death. This service has been introduced in Bromley, but an audit of some practices has shown that there is still scope for improvement in recognising patients as appropriate for end of life care and ensuring that it is possible for them to die in their preferred place of death.

Cancer patients are more likely than non-cancer patients to die at their preferred place of death, partly because it is more difficult to predict the end of life phase in these patients. Work is therefore being done in Bromley to introduce key workers to assist in proactive care planning for the end of life.

12. Carers

Data from the 2011 census indicates that 10% of Bromley's population (approximately 31,000 people) are carers. Just over 6000 of these carers provide more than 50 hours of unpaid care per week. The number of carers

known to services in Bromley is much smaller. The 2013 Bromley Carers Survey found that only 45% of the respondents had undergone a Carers Assessment, which is significant given that many (particularly older) carers have a long term condition or disability themselves, and also many report that caring has a negative impact on their mental health.

There has been significant increase in the numbers of young carers identified in Bromley, however, as with adults, not all carers are known to support services. Young carers are known to experience bullying, educational difficulties and emotional problems, and so would benefit from good support.

The Carers and Young Carers Strategies are currently being refreshed.

13. Substance Misuse

Although estimates suggest that approximately 15,000 Bromley residents will have taken an illicit drug in the last year, the number of opiate, crack and injecting drug users is estimated to be under 3000.

The rates of opiate, crack and injecting drug use have been falling over the last two years and are lower than the rates for London and England.

In 2012-13, there were 529 treatment episodes for substance misuse in Bromley and an increase in the number of opiate users successfully completing treatment.

There is a higher proportion of older (60 years+) people being treated for substance misuse in Bromley. This age group often present with more complex problems which will impact on health and social care services.

14. Alcohol

Alcohol misuse is a significant public health issue, with over 26% of the population regularly consuming quantities of alcohol sufficient to damage their health. This is similar to national levels, which have been showing a trend towards an increasing proportion of people in higher risk groups.

Despite the extent of this problem, recording of alcohol consumption in primary care is low and needs to be improved.

Of concern is the trend of increasing alcohol specific hospital admission rates in under 18 year olds in Bromley.

Although alcohol-related crime rates in Bromley are lower than the national average, and have been falling, there is a gap in information relating to alcohol-related domestic violence as there are currently no national figures on prevalence.

Specialist Alcohol Treatment Services provide treatment to those whose drinking is harmful or who are alcohol dependent (5.9% of the population). In 2012-13, 380 adults received treatment, of whom 37% completed treatment successfully, this was an improvement on the previous year, but is lower than the national figure of 40%.

15. Frequent Attenders to Unscheduled Care

Increasing pressure has been put on Accident and Emergency (A&E) Departments across the country in recent years with rising numbers of attendances. Amongst these attendances are a proportion which can be attributed to a sub group referred to as A&E Frequent Attenders (attend A&E three or more times in a year).

The issue with A&E frequent attenders highlights the question of whether the healthcare needs of these patients are being met by the current service provision, and if these needs should be met by the emergency services or other alternative care pathways. Although these frequent attenders do not represent all the service users, we could see that a significant amount of resource could be saved if the number of frequent attendances could be reduced.

In 2012-13 in Bromley, 5,362 A&E frequent attenders accounted for 22.4% of all A&E attendances. The frequency of attendances ranged from 3 to 135 times, with an average of 4 visits per year. There was a particularly high proportion of frequent attenders under the age of 5 years (17.5%), with 41% of these being under the age of 1 year. The commonest presenting complaints in frequent attenders related to respiratory illness, feeling unwell, and abdominal pain.

However, there were a significant numbers of attendances relating to conditions which might be better dealt with in settings other than A&E e.g. attendance for intramuscular or intravenous injections, catheter problems, blood tests, feeding tube problems.

Only a third of visits by frequent attenders resulted in hospital admission, with just under half of attendances (49%) resulting in discharge with either no follow up, or follow up by GP.

A sub group of 43 patients attended A&E 15 or more times in the year, of these, 72% were male and 23% were from outside the borough. This group of patients were most likely to present with chest pain, alcohol-related problems or mental health problems.

There are indications that improving/ developing primary and community care services could reduce the number of frequent attenders.

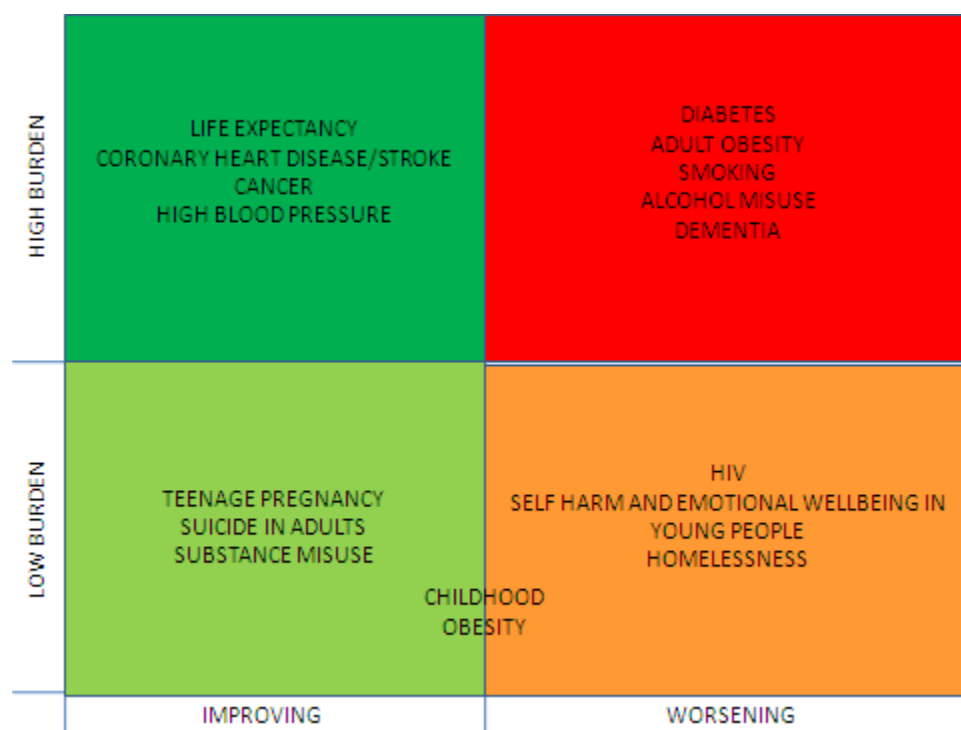
There is scope for further work to assess the needs of A&E frequent attenders.

JSNA Priorities

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

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

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



1. Introduction

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

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

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

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

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

There are three new sections in the JSNA this year;

- ward profiles
- asset based community development and
- frequent attenders to unscheduled care

which we hope will be useful additions to our JSNA.

2. The Population of Bromley: Demography

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

Key Points

- The latest (2014) estimate of the resident population of Bromley is 320,057, having risen by 21,775 since 2001.
- The resident population is expected to increase to 330,361 by 2018 and 339,154 by 2023.
- Although the number of 0 to 4 year olds is projected to decrease by 2019 to 21,016 and then to 20,825 by 2024, there has been an increase in the number of live births since 2002.
- The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17.74% of the population in 2014 to 17.84% by 2019 and 18.28% by 2024.
- The pattern of population change in the different age groups is variable between wards, with some wards, such as Darwin, experiencing a large rise in the proportion of young people and others such as Biggin Hill experiencing a large rise in the proportion of over 75s.
- The latest (2014) GLA population projection estimates show that 17.34% of the population is made up of Black and minority ethnic (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, from 1.1% of the population in 2001 to 4.7% of the population in 2024.

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

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

Current Picture

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

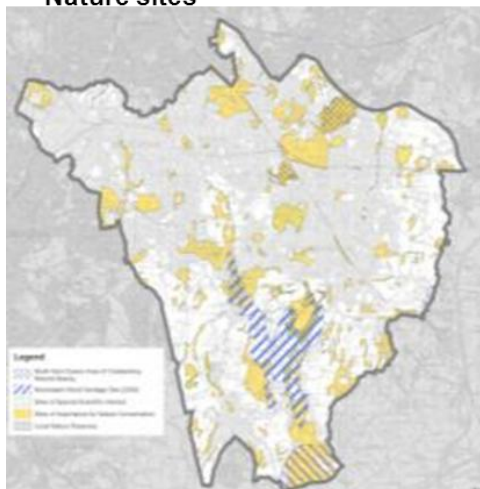
Overall Description of Bromley

Located in South-East London, Bromley is the largest London borough in the city. At approximately 150 square kilometres it is 30% larger than the next largest borough. It has over 45 conservation areas and a wide range of historic and listed buildings.

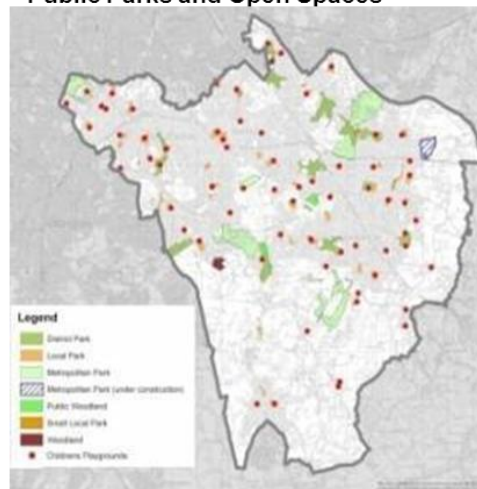
Although Bromley is a relatively prosperous area, the communities within Bromley differ substantially. The North-East and North-West of the borough contend with similar issues (such as higher levels of deprivation and disease prevalence) to those found in the inner London Boroughs we border (Lambeth, Lewisham, Southwark, Greenwich), while in the South, the borough compares more with rural Kent and its issues.

Bromley benefits from a good number of public parks and open spaces as well as sites of natural beauty and nature conservation.

Figure 2. 1
Nature sites



Public Parks and Open Spaces



Total Population

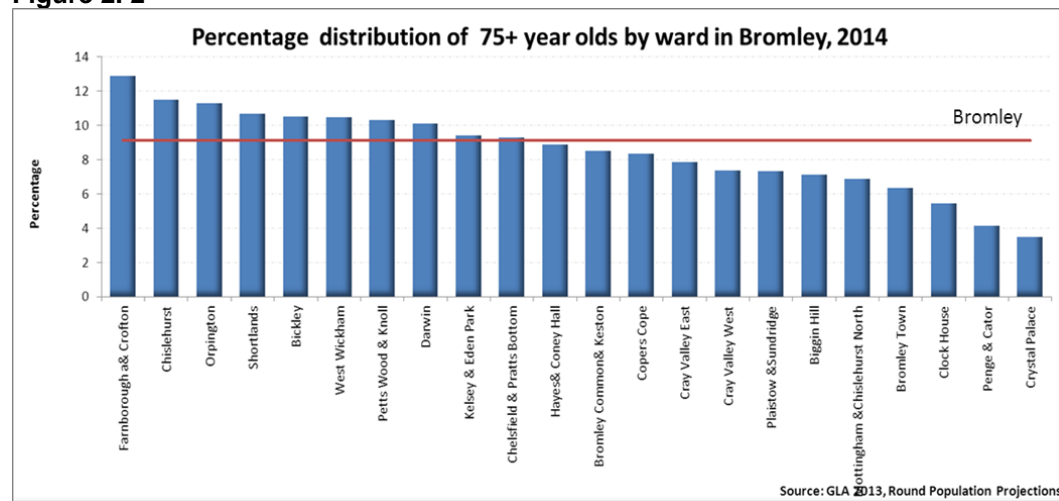
The latest (2014) estimate of the resident population is 320,057¹. This compares with 335,657 registered with GPs in the borough (January 2014)². The borough council is responsible for providing services to its residents. While local health commissioners are responsible for providing services to all of those who are registered with a Bromley GP regardless of where they live, they also have a responsibility for the health of the borough's residents at a population level.

Whilst population figures are available from a number of sources, chiefly the office for National Statistics (ONS) and the Greater London Authority (GLA), this chapter has used the Greater London Authority (GLA) resident population as its basis.

The population rose by 24,482 (8%) between 2001 and 2014. The main reasons for this increase are the increase of the number of births within the borough and migration of new entrants into the borough from Eastern Europe.

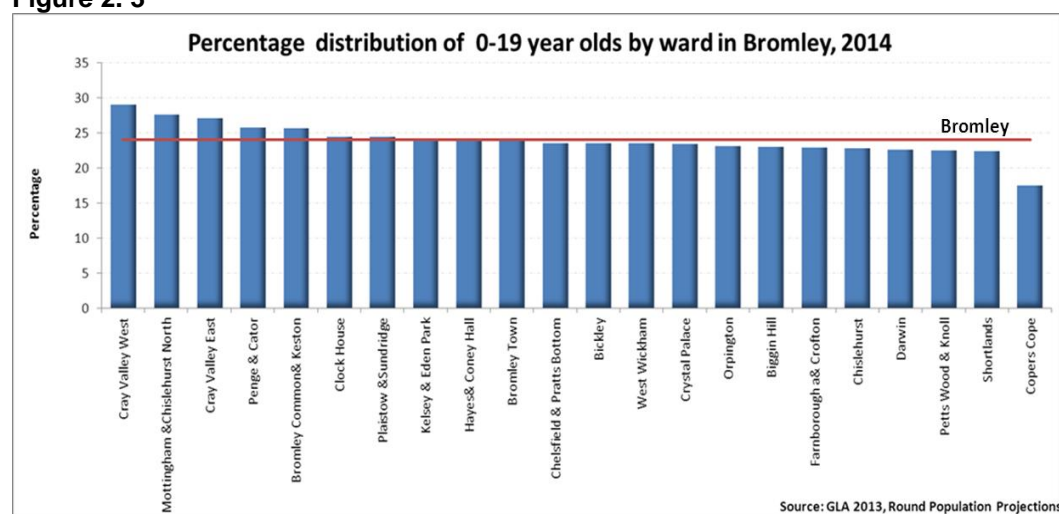
There is some variation in the population structure between the wards. Cray Valley West has the highest proportion of young people and Copers Cope the lowest. Chislehurst has the highest proportion of over 75s and Penge & Cator the lowest (**see table 2.1**).

Figure 2. 2



¹ Source: GLA 2013 Round SHLAA Population Projections SYA

² Health and Social Care Information Centre

Figure 2. 3**Table 2. 1: Age structure across the wards in Bromley, 2014**

	0-19 years		75+ years	
	No	%	No	%
Bickley	3649	23.6	1626	10.5
Biggin Hill	2363	23.0	732	7.1
Bromley Common& Keston	4132	25.7	1374	8.5
Bromley Town	4401	24.0	1166	6.4
Chelsfield & Pratts Bottom	3503	23.6	1381	9.3
Chislehurst	3515	22.9	1767	11.5
Clock House	3929	24.5	876	5.5
Copers Cope	2792	17.5	1334	8.4
Cray Valley East	4304	27.1	1246	7.9
Cray Valley West	4999	29.1	1270	7.4
Crystal Palace	3029	23.5	451	3.5
Darwin	1199	22.6	538	10.1
Farnborough a& Crofton	3414	22.9	1926	12.9
Hayes& Coney Hall	3941	24.1	1453	8.9
Kelsey & Eden Park	3943	24.2	1536	9.4
Mottingham & Chislehurst North	2842	27.6	708	6.9
Orpington	3639	23.1	1779	11.3
Penge & Cator	4629	25.8	739	4.1
Petts Wood & Knoll	3153	22.5	1443	10.3
Plaistow & Sundridge	3812	24.5	1142	7.3
Shortlands	2267	22.4	1083	10.7
West Wickham	3594	23.5	1601	10.5
Bromley	77049	24.1	29185	9.1

Source: GLA 2013, Round 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 2.4 and 2.5**).

Figure 2. 4

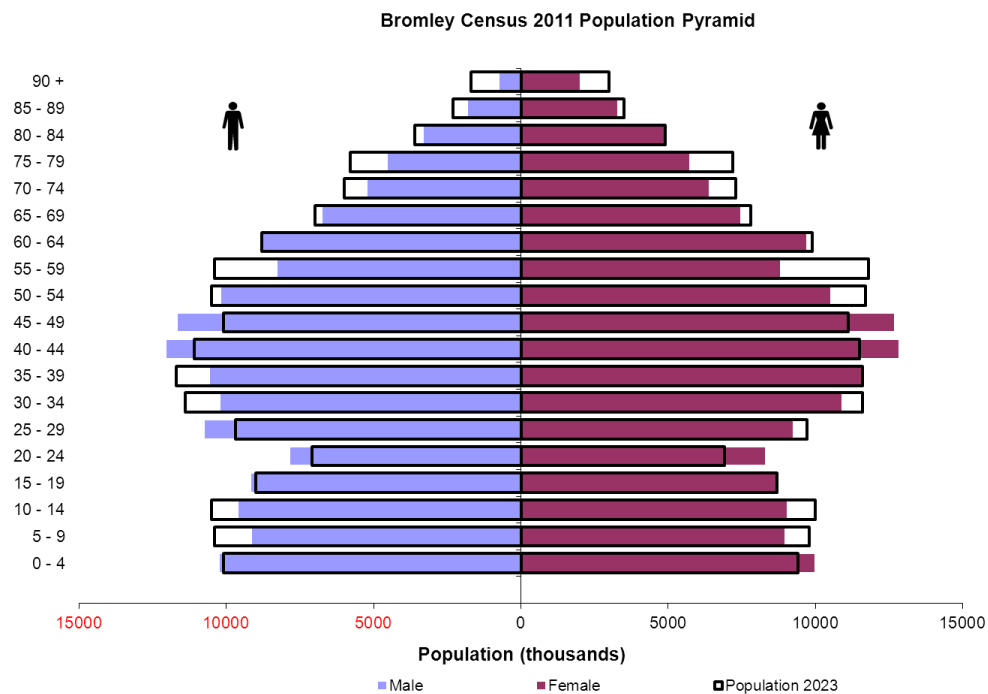
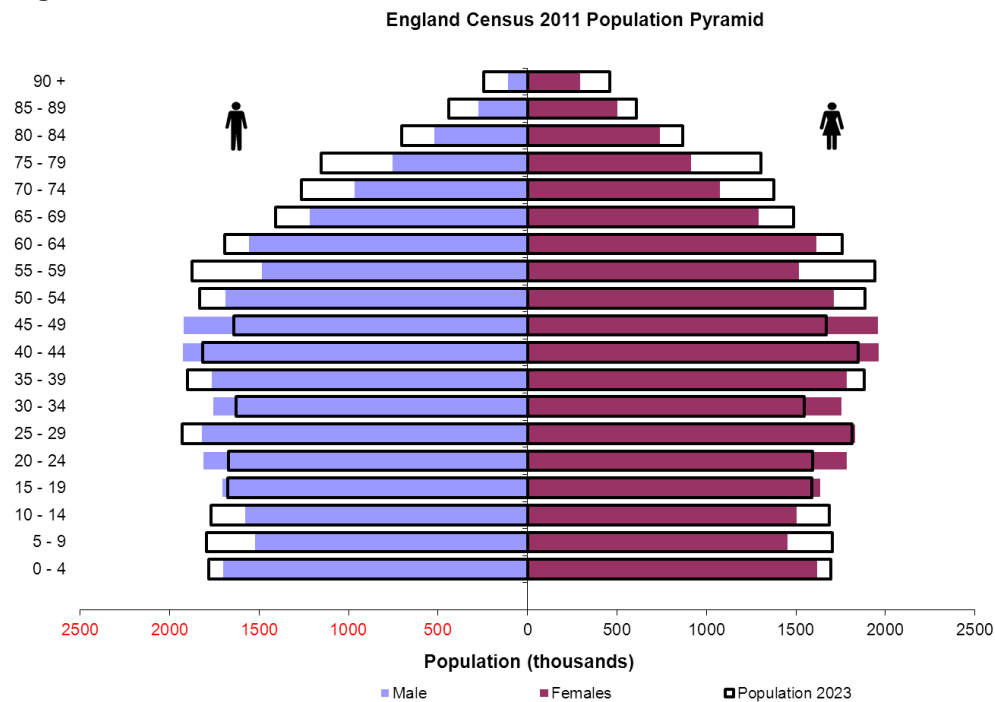


Figure 2. 5



Source: ONS 2012-based National Population Projections

Population Projections

The population of Bromley is just over 320,000, and is projected to rise by 3.9% over the next 5 years. (**Table 2.2**).

Table 2. 2

	2011 (Census)	2014	2019	2024
Total population	309,300	320,057	332,536	343,362
0 to 4years (%)	20,104 (6.5%)	21,196, (6.62%)	21,016, (6.32%)	20,825,(6.07%)
5 to10 years (%)	21,681 (7.01%)	23,823, (7.44%)	25,752,(7.74%)	25,690, (7.48%)
11 to 18 years(%)	30,156 (9.75%)	29,310,(9.16%)	30,220, (9.09%)	33,528, (9.76%)
Working Age (%)*	196,715, (63.6%)	200,964, (62.79%)	207,300,(62.34%)	212,705, (61.95%)
Post Retirement (%)¥	52,024 (16.82%)	56,776, (17.74%)	59,318, (17.84%)	62,771,(18.28%)
80 years and over (%)	16,053 (5.19%)	17,066, (5.33%)	18,364,(5.52%)	20,013,(5.83%)

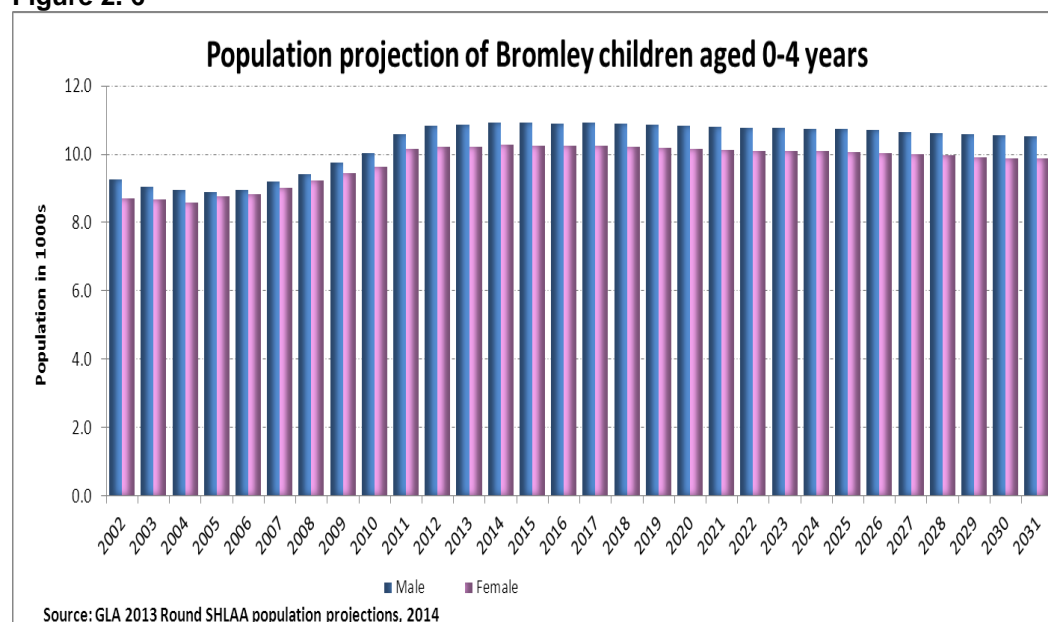
Source: ONS Census 2011 and GLA 2013 Round SHLAA population projections, 2014

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

¥ Post retirement = Over 64y males and females

The number of 0 to 4 year olds has gradually been increasing since 2006 and will peak in 2017 (21,196) but will then begin to decrease again to 20,381 in 2031.

Figure 2. 6



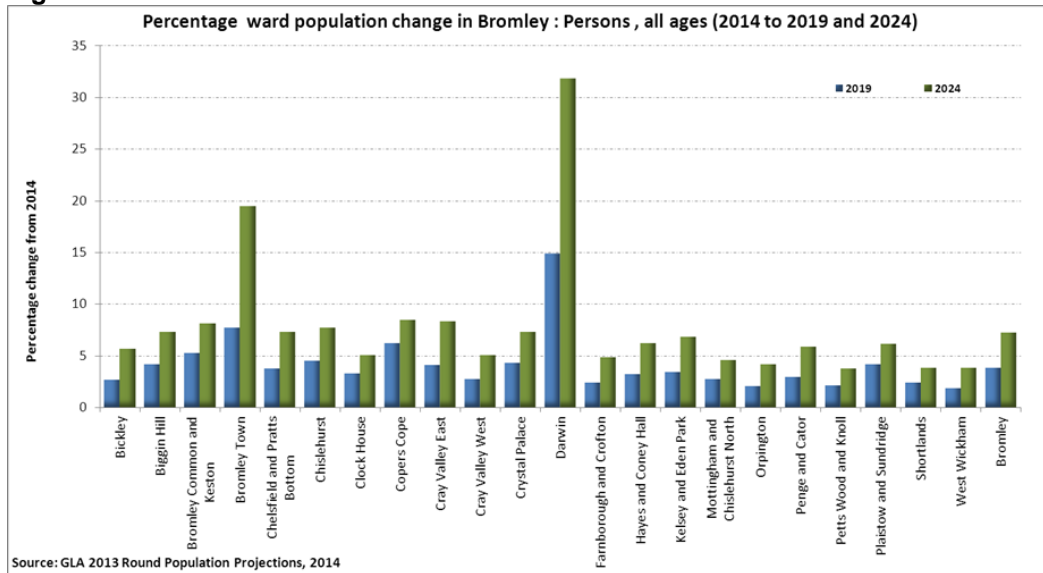
Ward Population Projections

Overall, there is a projected increase in residents across all wards in Bromley. Bromley Town and Darwin are expected to have the highest percentage increase in all wards in 2019 and 2024.

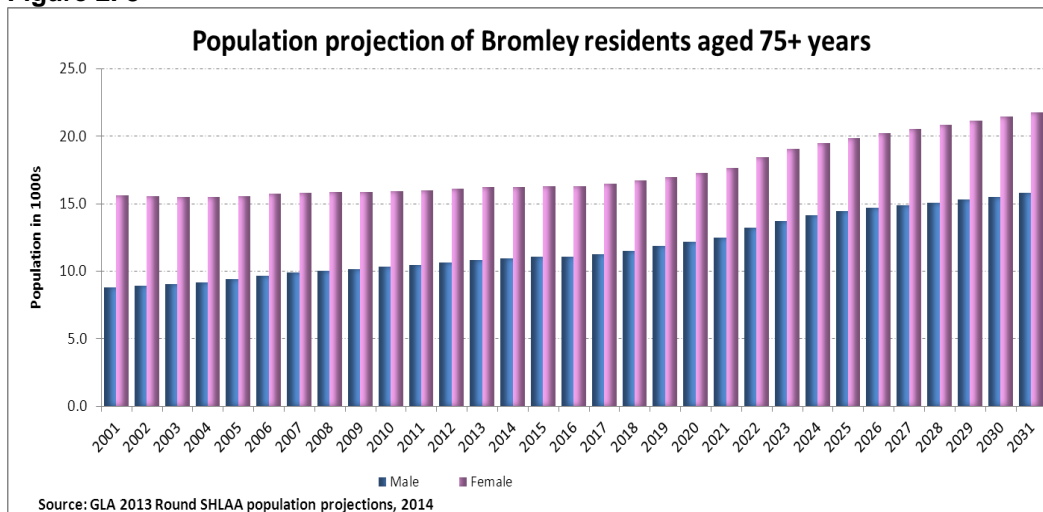
Table 2. 3

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

Source: GLA 2013 Round SHLAA population projections, 2014

Figure 2. 7

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

Figure 2. 8

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

The largest reduction in the 0-4 year age group will be seen in Clock House (11%). For over 75s, the population is projected to increase and the largest

increase will be in Biggin Hill and Darwin (32% and 25% respectively) (**Figures 2.9 and 2.10**).

Figure 2. 9

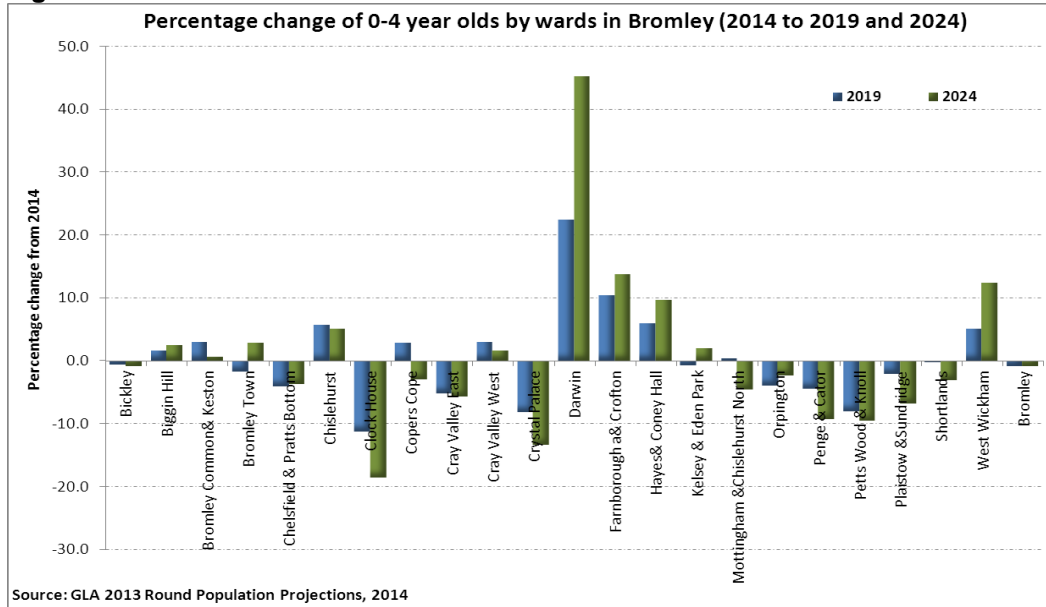


Table 2.4

	0-4 persons				
	Population projections			Change in numbers	
	2014	2019	2024	2019	2024
Bickley	930	925	922	-5	-3
Biggin Hill	585	595	600	10	5
Bromley Common & Keston	1105	1138	1112	33	-26
Bromley Town	1496	1471	1539	-25	68
Chelsfield & Pratts Bottom	849	815	818	-34	3
Chislehurst	937	991	985	54	-6
Clock House	1384	1228	1128	-156	-100
Copers Cope	1156	1189	1122	33	-67
Cray Valley East	1252	1188	1182	-64	-6
Cray Valley West	1307	1346	1328	39	-18
Crystal Palace	1116	1025	967	-91	-58
Darwin	307	376	446	69	70
Farnborough & Crofton	688	760	783	72	23
Hayes & Coney Hall	772	818	847	46	29
Kelsey & Eden Park	852	846	869	-6	23
Mottingham & Chislehurst North	833	837	795	4	-42
Orpington	881	846	861	-35	15
Penge & Cator	1544	1476	1402	-68	-74
Petts Wood & Knoll	822	756	744	-66	-12
Plastow & Sundridge	1203	1179	1121	-24	-58
Shortlands	524	523	508	-1	-15
West Wickham	657	691	739	34	48
Bromley	23214	23038	22842	-176	-196

Source: GLA, 2013 Round Population Projections

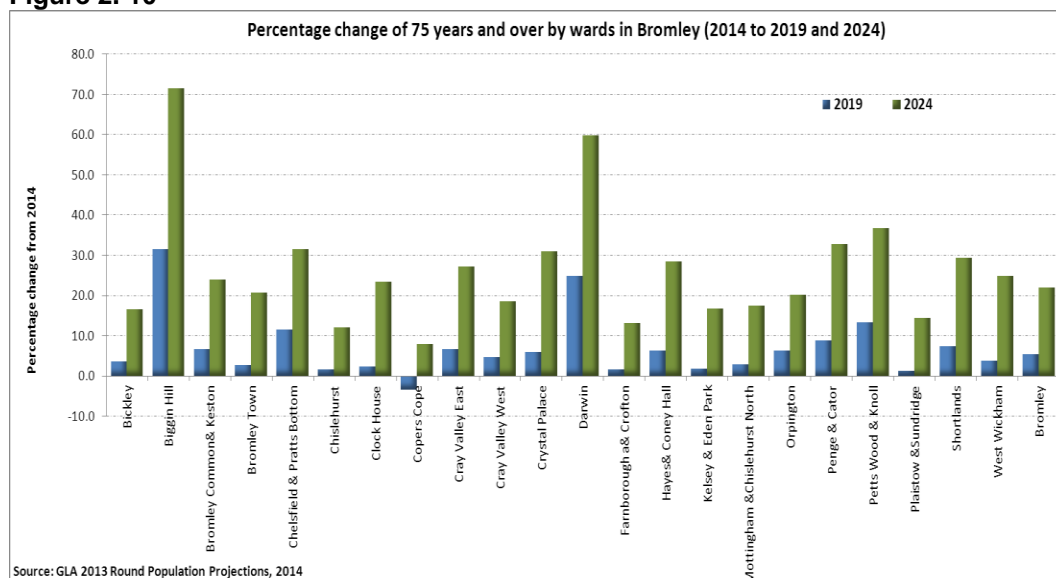
Figure 2. 10

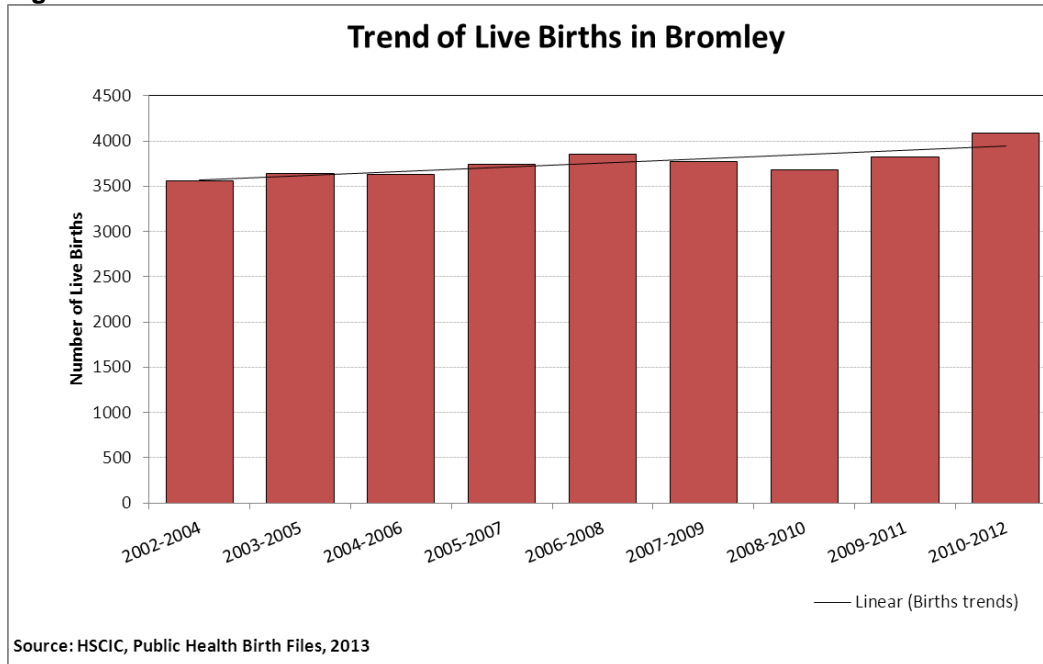
Table 2. 5

	75+ persons				
	Population projections			Change in numbers	
	2014	2019	2024	2019	2024
Bickley	1626	1685	1895	59	210
Biggin Hill	732	963	1255	231	292
Bromley Common & Keston	1374	1467	1704	93	237
Bromley Town	1166	1198	1407	32	209
Chelsfield & Pratts Bottom	1381	1541	1816	160	275
Chislehurst	1767	1796	1981	29	185
Clock House	876	897	1081	21	184
Copers Cope	1334	1288	1440	-46	152
Cray Valley East	1246	1330	1586	84	256
Cray Valley West	1270	1330	1505	60	175
Crystal Palace	451	478	591	27	113
Darwin	538	672	860	134	188
Farnborough & Crofton	1926	1957	2179	31	222
Hayes & Coney Hall	1453	1546	1868	93	322
Kelsey & Eden Park	1536	1564	1795	28	231
Mottingham & Chislehurst North	708	729	832	21	103
Orpington	1779	1891	2138	112	247
Penge & Cator	739	805	982	66	177
Petts Wood & Knoll	1443	1636	1975	193	339
Plaistow & Sundridge	1142	1156	1306	14	150
Shortlands	1083	1163	1401	80	238
West Wickham	1601	1663	1999	62	336
Bromley	29185	30774	35620	1589	4846

GLA, 2013 Round Population Projections

The number of live births in Bromley has been increasing over the last few years. In 2002 there were 3,400 births in Bromley, which rose to 4,160 in 2012.

Figure 2. 11



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

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

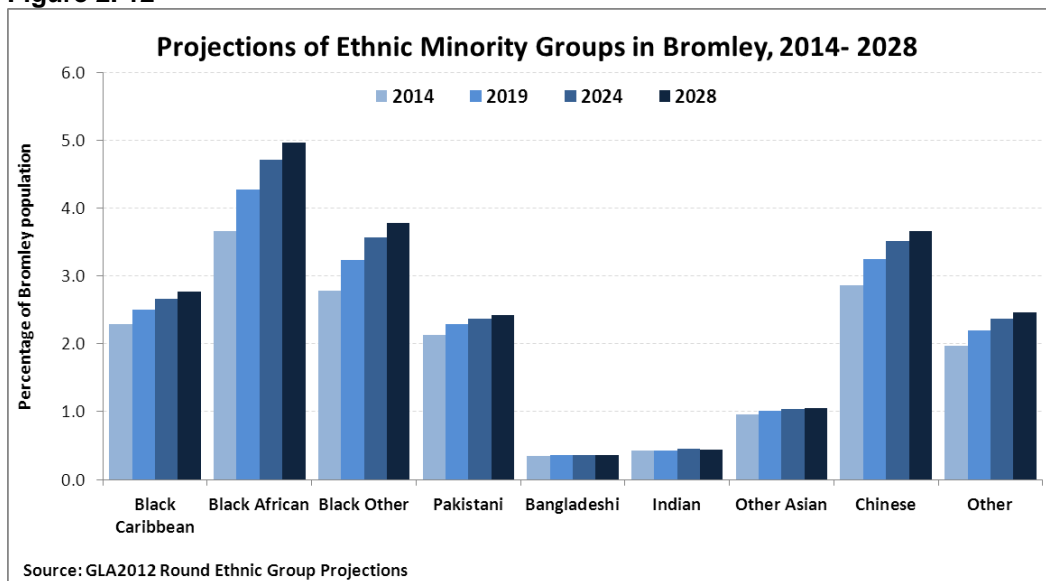
It is important to keep abreast of the changes in population structure as service provision may have to adapt to the needs of new communities.

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

Ethnic groups

There is a discrepancy between the Census results and GLA population projections for the proportion of the population represented by ethnic minority groups. The 2011 Census recorded 22.6% of the Bromley population as ethnic minorities. In contrast, the GLA 2012 Round Ethnic Group Projections estimate that, in 2014, the ethnic minority population of Bromley is 17.4%, and this is projected to rise to 21% by 2024. The greatest proportional rise is in the Black African group, from 1.1% of the population in 2001, to 3.2% of the population in 2022.

Figure 2. 12



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

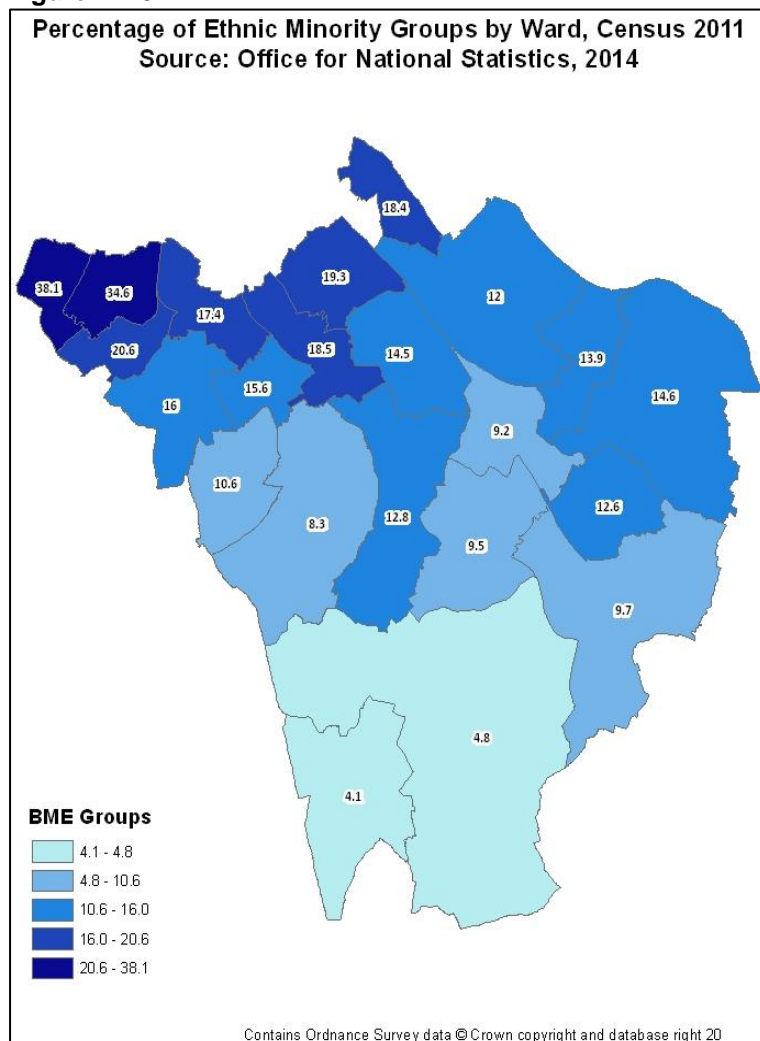
A higher than average proportion of admissions due to diabetes is found in the Asian groups, Black Caribbean and Black Other group in most regions, reflecting the higher prevalence of diabetes in these groups.

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

Table 2. 6

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

Data from the 2011 census shows that the North-West of Bromley has the highest proportion of ethnic minority population (**Figure 2.13**). We do not have projections for changes in population by ethnicity at ward level.

Figure 2. 13

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

In the 2011 census, 0.2% of the residents were recorded in the Gypsy or Irish travellers ethnic category. The borough also contains two authorised sites, Star Lane with 22 pitches and Old Maidstone Road with 12 pitches, both of which are owned and managed by the Local Authority. There are also unauthorised sites at Walden's Farm, Biggin Hill and Bromley Common.

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

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

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

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

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

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

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

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

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

This section will report on:

- All Cause Mortality
- Life Expectancy
- Infant Mortality
- Health Inequalities
- Key Causes of Mortality
- Major Health Issues
- Lifestyle Risk Factors for Disease

Mortality & Life Expectancy

All Cause Mortality

The all-cause mortality rate for Bromley is lower than both the London and England average rates. Bromley has the eighth lowest all-cause mortality rate in London.

Figure 3. 1

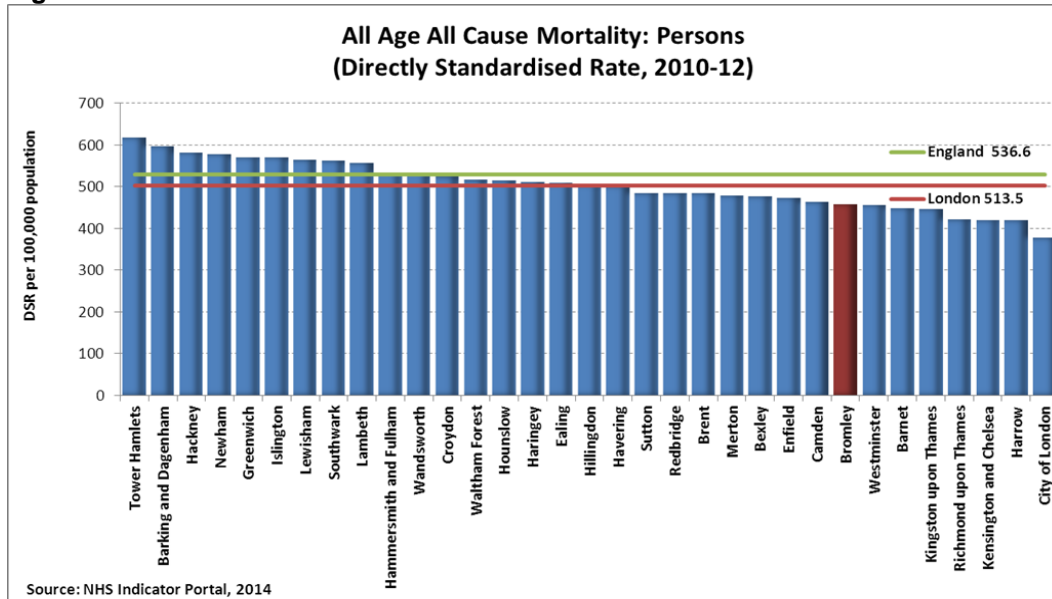
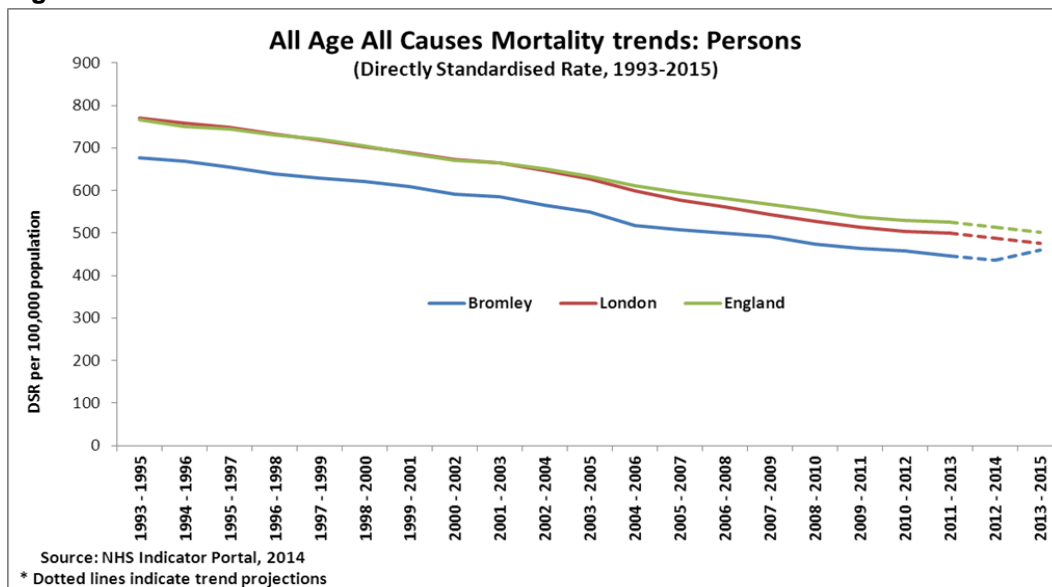


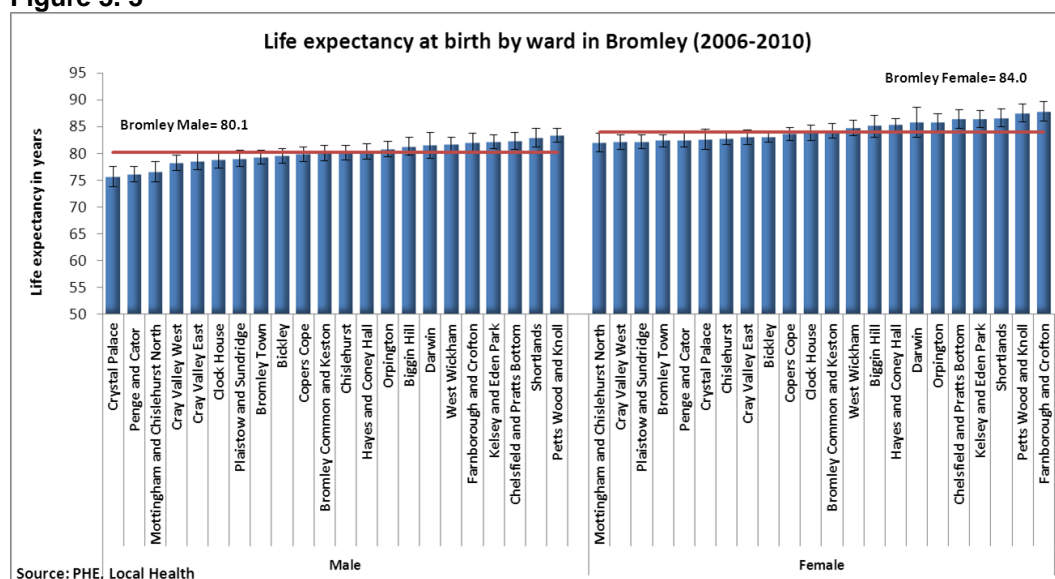
Figure 3. 2



Life Expectancy

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, and the latest figures (2009-11) report a life expectancy of 80.7 years for men and 84.5 years for women. Whilst these averages rank 66th and 53rd respectively in the national order, there are areas of Bromley with lower life expectancy. The gap between wards with the highest and lowest life expectancy for the years 2006-10 was 8.7 years for men and 7.9 years for women.

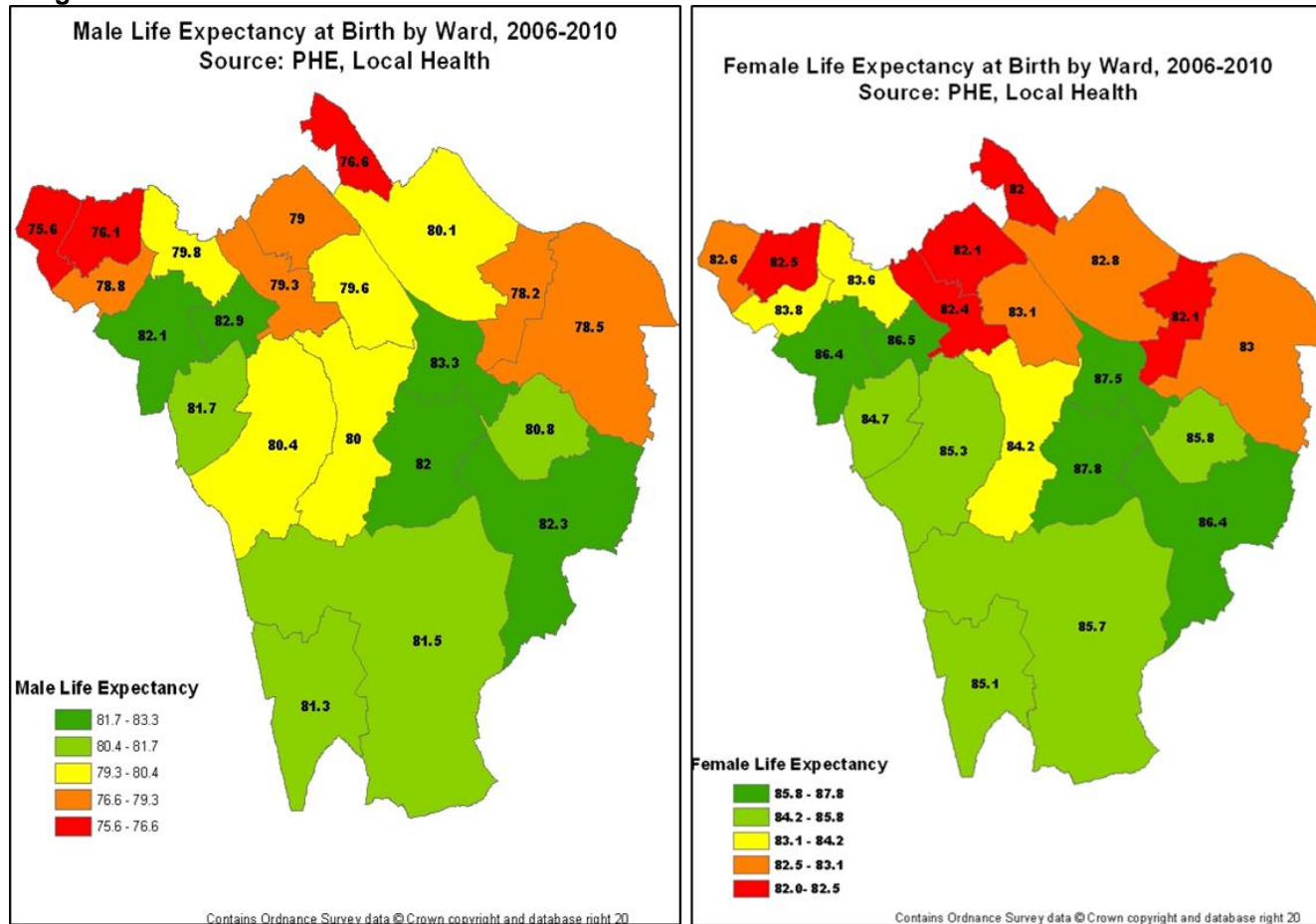
Figure 3. 3



Life expectancy is lowest for men in Crystal Palace (75.6y) and in Penge & Cator (76.1y), and for women, in Mottingham & Chislehurst North (82 y) and in Cray Valley West (82.1y).

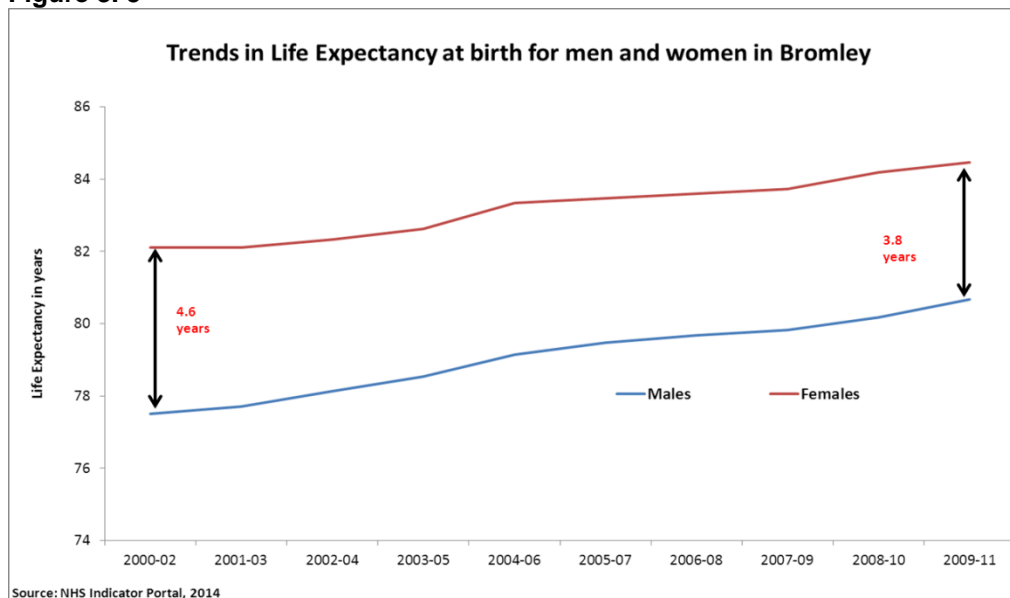
The 2014 Health Profile for Bromley reports that life expectancy is 8.0 years lower for men and 6.9 years lower for women in the most deprived areas of Bromley than in the least deprived areas (based on the Slope Index of Inequality).

Figure 3. 4



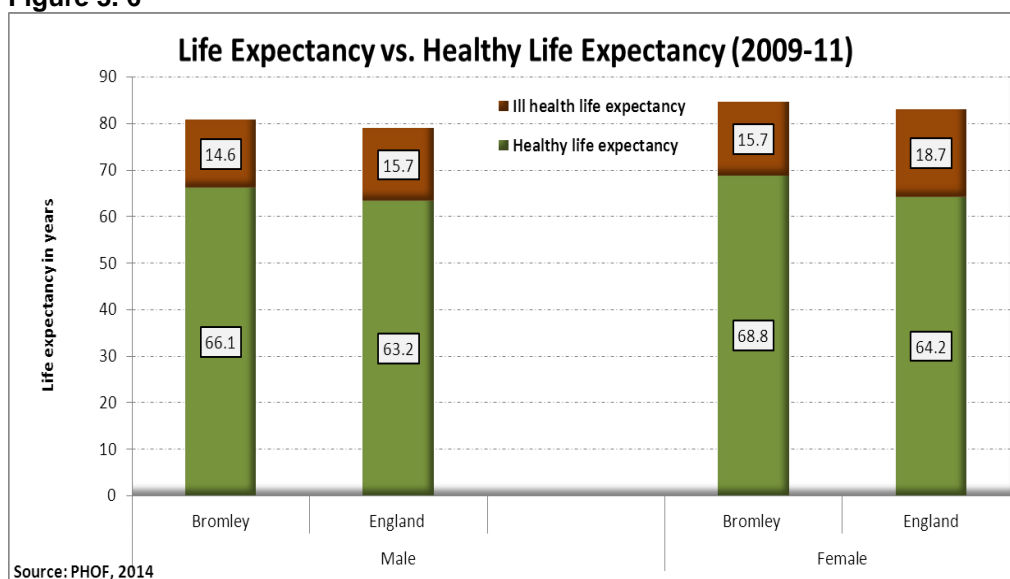
Trends show that the gap between life expectancy for men and for women has reduced over the last 10 years from 4.6 years to 3.8 years (**Figure 3.5**). The trends in life expectancy mirror the downward trends seen in all age all cause mortality.

Figure 3. 5



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

Figure 3. 6



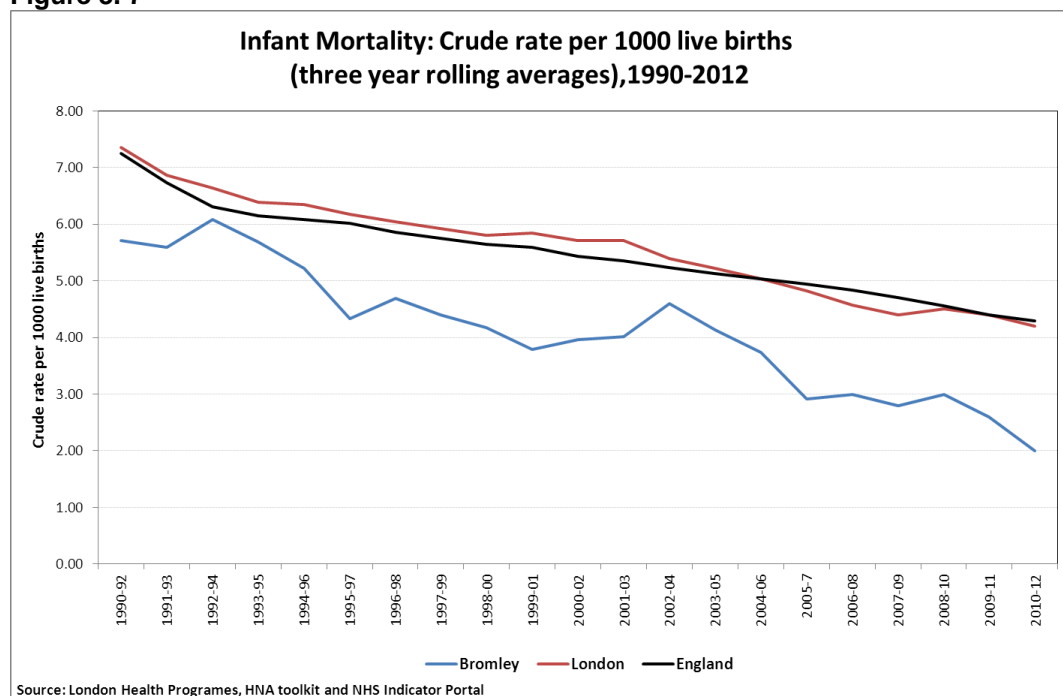
Infant Mortality

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

The infant mortality rate in Bromley (2 per 1000 live births) is lower than in England as a whole (4.3 per 1000 live births), and has been fairly steady over the last 5 years. The rate is now lower than half the 1990-92 rate of 5.7 per 1000 live births.

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

Figure 3. 7



Health Inequalities

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

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

Michael Marmot's *Strategic Review of Health Inequalities in England post-2010* highlighted an unambiguous social gradient in health i.e. a direct correlation between socioeconomic status and health outcomes.

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

For the period 2009 to 2011, the SII for men in Bromley was 8.4, and for women, 6.6. This can be interpreted as a 8.4 year difference in life expectancy at birth between the most and least deprived males within Bromley, and 6.6 years for females.

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

Figure 3. 8

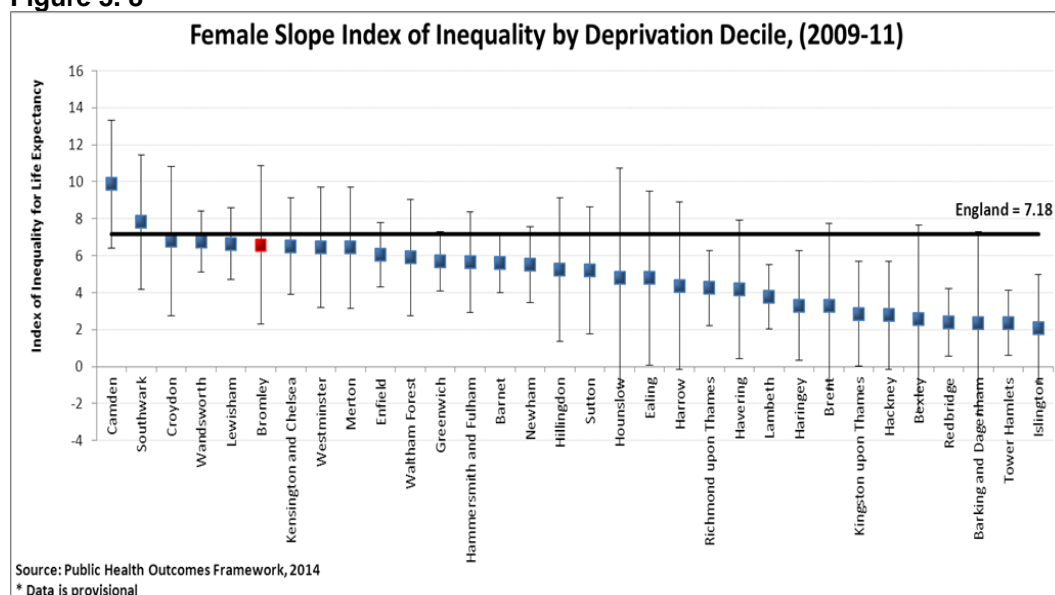
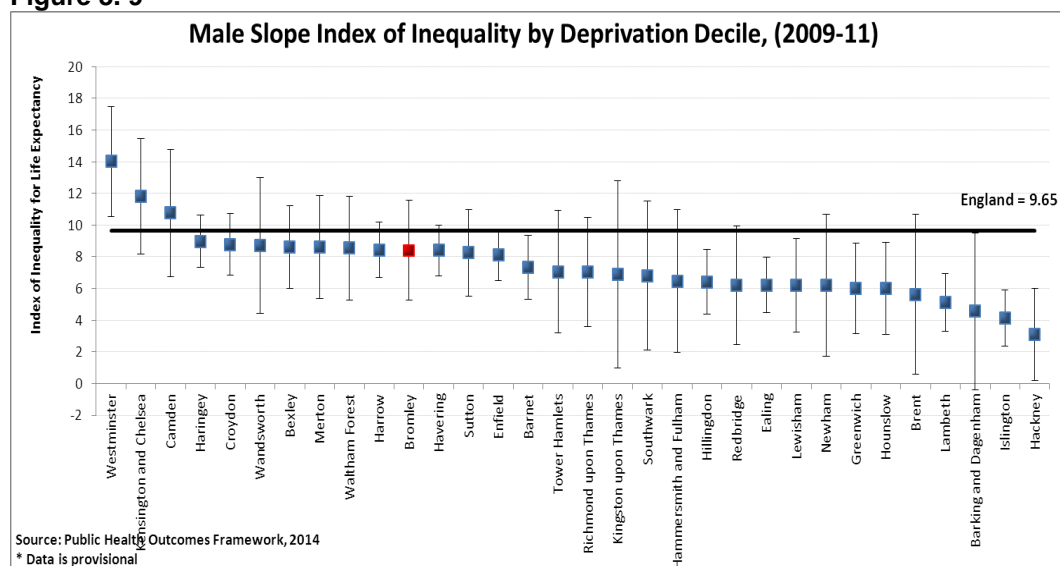
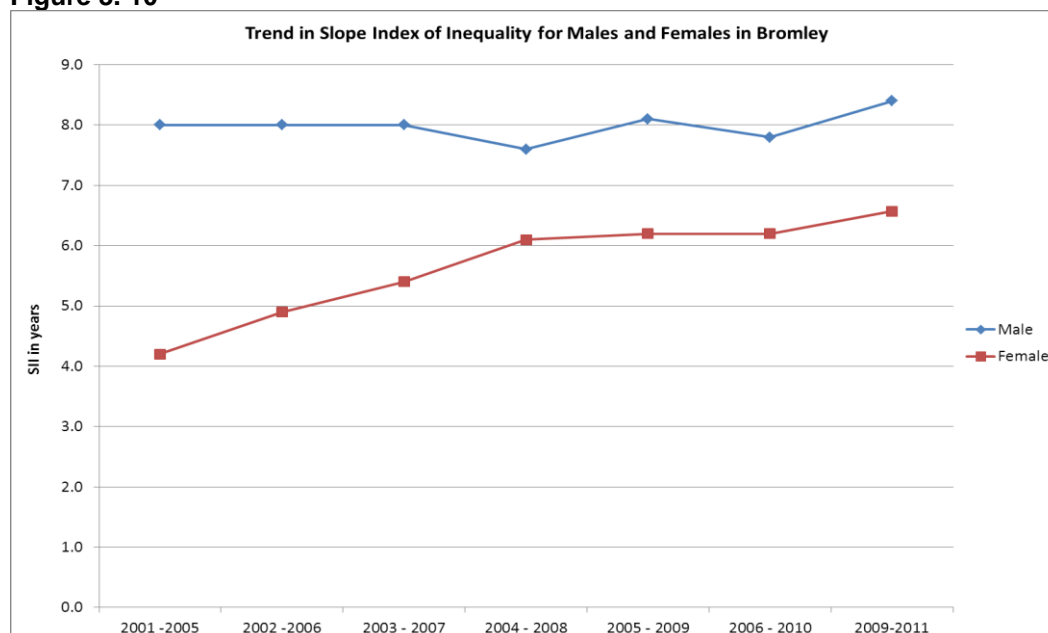


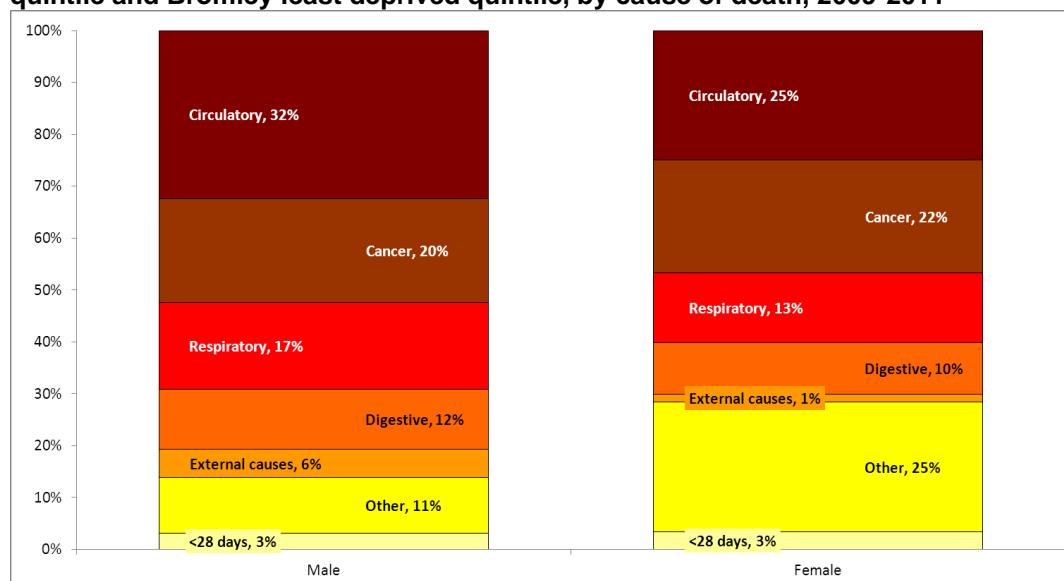
Figure 3. 9

Although there is less difference in the level of life expectancy inequalities seen between males and females in Bromley, in the last eleven years, there has been an increase in inequalities in life expectancy within gender especially between women living in the most and least deprived areas of Bromley.

Figure 3. 10

Source: PHE. Public Health Outcomes Framework

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

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

Source: Public Health England

Table 3. 1: Breakdown of the life expectancy gap between Bromley most deprived quintile and Bromley least deprived quintile, by cause of death, 2009-2011

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

Source: Public Health England

Looking at the relative mortality rates for heart disease and cancer between Bromley wards, it is clear that there are wards with significantly higher than average mortality rates (**Figures 3.12 and 3.13**). Cray Valley East ward has significantly higher than average mortality rates for both heart disease and

cancer, and Mottingham & Chislehurst North and Cray Valley West wards for heart disease.

Figure 3. 12

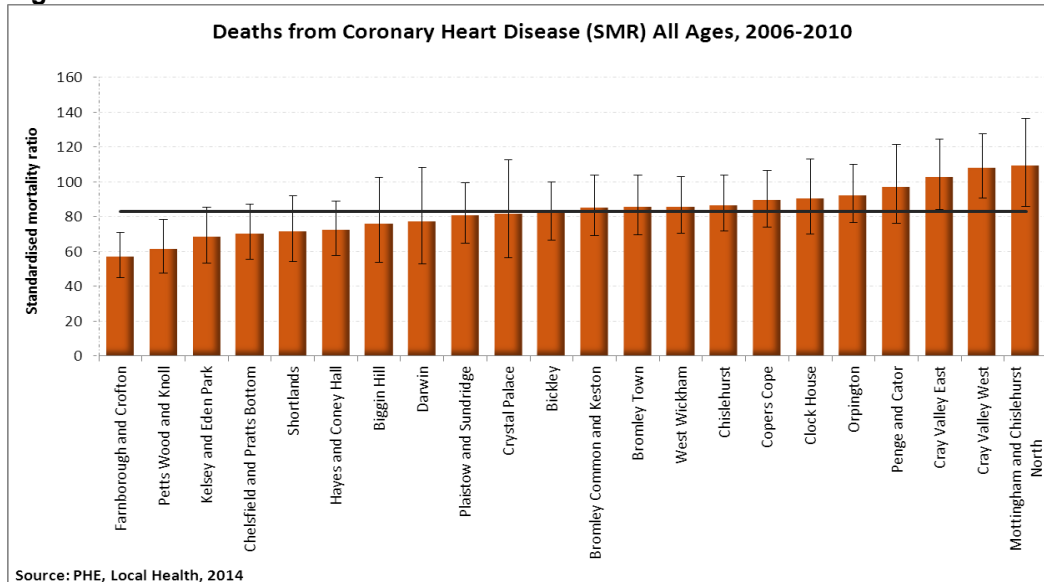


Figure 3. 13

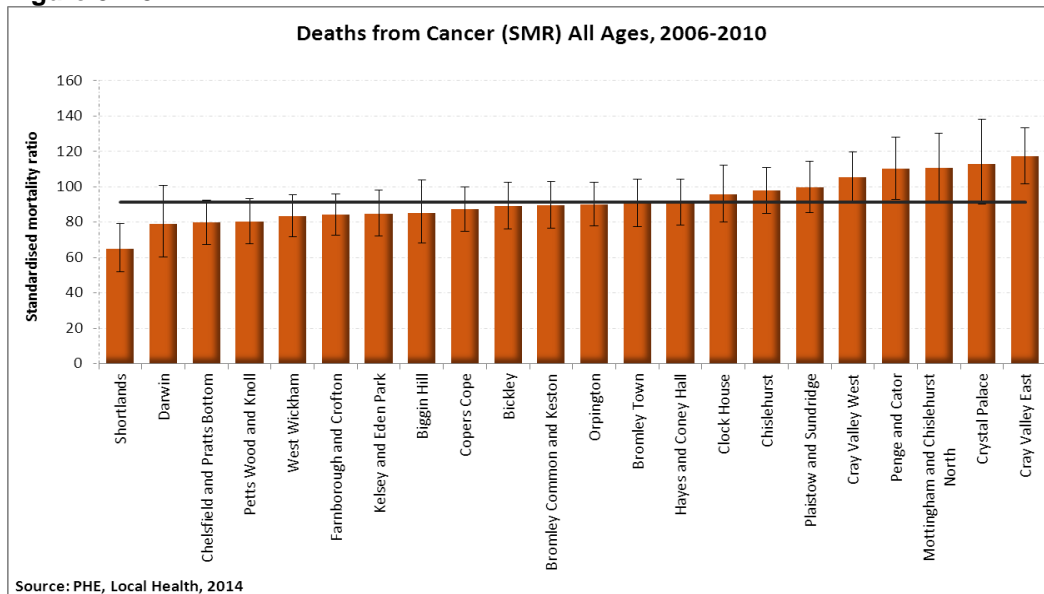


Table 3. 2: Life Expectancy Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
0.1i - Healthy life expectancy at birth	Male	All ages	2009 - 11	66.10	63.00	63.22
0.1i - Healthy life expectancy at birth	Female	All ages	2009 - 11	68.80	63.80	64.15
0.1ii - Life Expectancy at birth	Male	All ages	2009 - 11	80.70	79.30	78.91
0.1ii - Life Expectancy at birth	Male	All ages	2010 - 12	81.00	79.70	79.21
0.1ii - Life Expectancy at birth	Female	All ages	2009 - 11	84.50	83.60	82.89
0.1ii - Life Expectancy at birth	Female	All ages	2010 - 12	84.50	83.80	83.01
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional)	Male	All ages	2010-12	7.98		
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional)	Female	All ages	2010-12	6.94		
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	Male	All ages	2009 - 11	1.79	.39	
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	Male	All ages	2010 - 12	1.79	.49	
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	Female	All ages	2009 - 11	1.61	.71	
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	Female	All ages	2010 - 12	1.49	.79	

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

What this means for Bromley residents and the children in Bromley

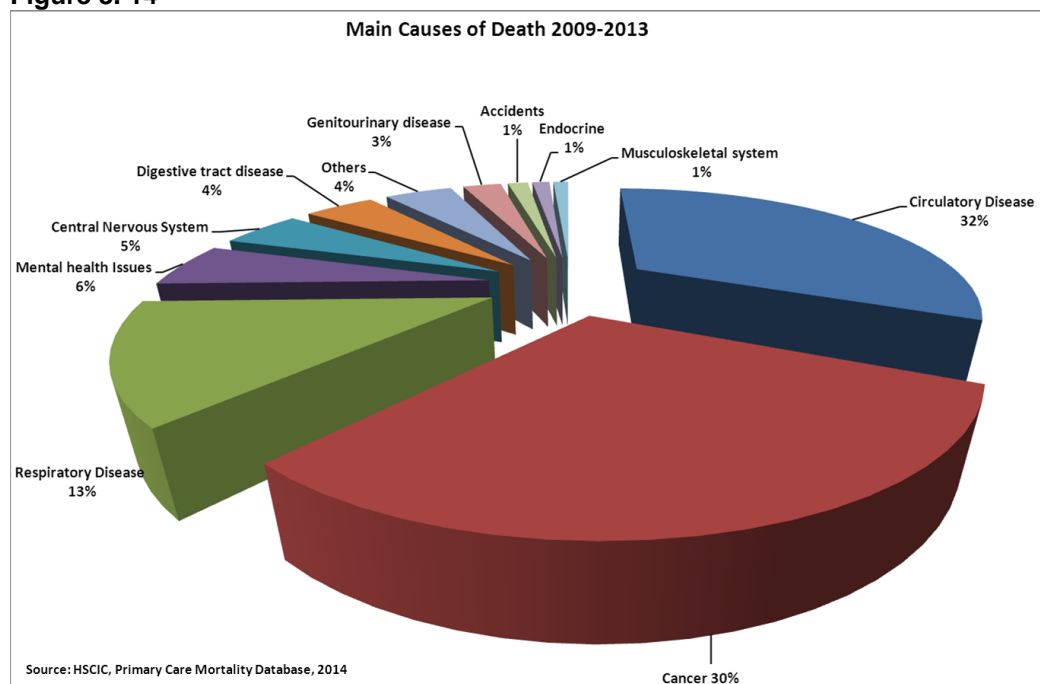
There is a need for continued action to address health inequalities with the disparity in life expectancy between the most and least deprived areas of the Borough.

Key Causes of Mortality & Major Health Issues

The key causes of death in Bromley remain:

- Circulatory disease
- Cancer
- Respiratory disease

Figure 3. 14



Source: *Public Health Mortality Files*

Circulatory Disease

Circulatory disease comprises heart disease and stroke, for which predisposing conditions include hypertension and diabetes.

One of the objectives of the Public Health Outcomes Framework is to reduce the number of people living with ill health and dying prematurely, while reducing the gap between communities. A key indicator for this objective is early mortality from cardiovascular disease (CVD). In 2014, the early CVD mortality rate in Bromley for persons under the age of 75 years is predicted to be 37.7 (as compared with 50.1 for England and 51.2 for London). In Bromley this represents a 39.7% decrease over the last 10 years.

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

Although the CVD mortality rate in Bromley for the period 2009-11 was (at 141.3 per 100,000) lower than England (155.6) and London (151.3), there are differences within the borough.

- Male CVD mortality rates are significantly higher than female CVD mortality rates (182.9 and 108.5 respectively).
- CVD mortality rates are higher in the most deprived areas of the borough, 176.3 per 100,000 in the most deprived quintile, compared with 109.8 in the least deprived quintile. In the most deprived quintile of the borough, the CVD mortality rate is 1.2 times greater than the overall mortality rate for Bromley and 1.6 times greater than the mortality rate in the least deprived areas of Bromley.

Coronary Heart Disease (CHD)

Mortality from heart disease has been steadily declining since 1993, and the prevalence of heart disease has been stable over the last 4 years. However, the observed prevalence for CHD is less than two thirds of the estimated prevalence.

Figure 3. 15

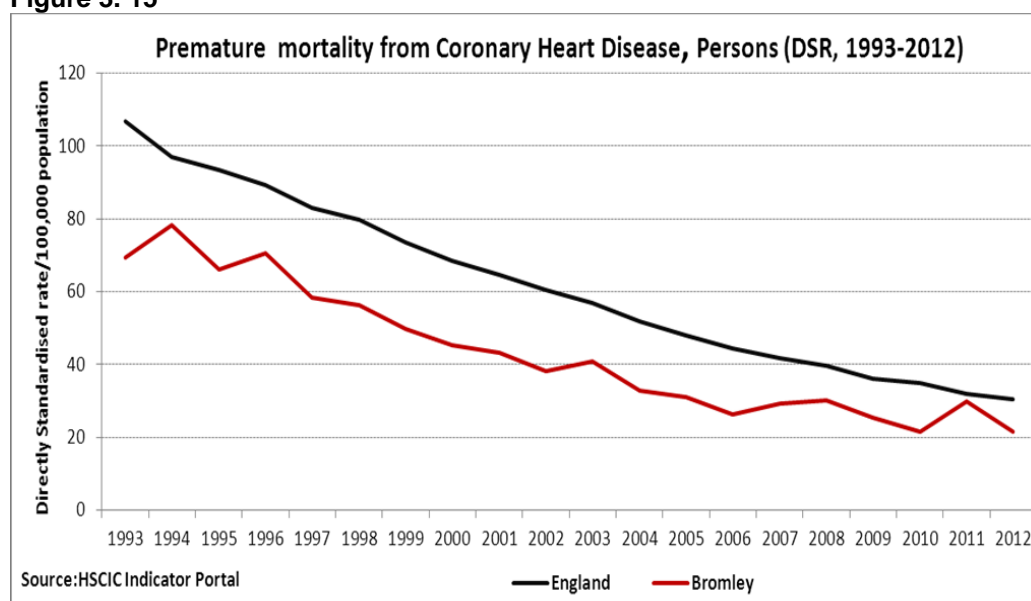


Table 3. 3: Prevalence of Coronary Heart Disease

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

Source: HSCIC/ QOF, 2014

In 2011-12 the emergency admission rate for CHD was 163.8 per 100,000 (720 admissions). This is significantly lower than England (198.3 per 100,000) and significantly lower than London (205.5 per 100,000).

Male CHD emergency admissions are significantly higher than female CHD emergency admission rates.

The emergency admission rates for CHD are 1.8 times greater for people who live in the most deprived areas of Bromley as compared with those living in the least deprived areas.

Table 3. 4: Cardiovascular Disease Related PHOF Indicators

Indicator	Sex	Time Period	Bromley	London	England
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2001 - 03	102.07	145.74	138.65
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2002 - 04	89.66	138.12	130.18
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2003 - 05	86.99	129.05	121.50
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2004 - 06	78.17	118.71	112.81
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2005 - 07	75.02	111.01	105.63
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2006 - 08	71.00	105.37	99.50
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2007 - 09	72.88	99.38	93.52
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2008 - 10	69.29	93.92	88.99
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2009 - 11	69.70	86.86	84.44
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	2010 - 12	65.49	83.14	81.15
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2001 - 03	154.58	205.90	193.78
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2002 - 04	133.92	196.24	182.33
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2003 - 05	125.03	183.29	170.31
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2004 - 06	110.88	169.45	158.19
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2005 - 07	109.20	158.95	147.94
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2006 - 08	103.40	150.45	139.29
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2007 - 09	104.68	141.35	131.44
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2008 - 10	101.13	133.75	125.46
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2009 - 11	105.43	124.58	119.40
4.04i - Under 75 mortality rate from all cardiovascular diseases	Male	2010 - 12	98.71	118.11	113.98
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2001 - 03	56.61	91.37	87.98
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2002 - 04	51.41	85.51	82.07
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2003 - 05	54.07	79.81	76.28
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2004 - 06	49.89	72.55	70.56
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2005 - 07	45.29	67.25	66.08
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2006 - 08	42.62	64.18	62.16
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2007 - 09	44.96	60.99	57.85
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2008 - 10	41.16	57.41	54.61
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2009 - 11	38.16	52.29	51.43
4.04i - Under 75 mortality rate from all cardiovascular diseases	Female	2010 - 12	36.01	51.11	50.13
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2001 - 03	69.32	99.48	98.64
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2002 - 04	63.60	93.42	91.95
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2003 - 05	59.96	85.77	85.31
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2004 - 06	52.27	77.53	78.89
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2005 - 07	48.66	72.30	73.39
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2006 - 08	47.54	69.50	68.90
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2007 - 09	47.47	65.44	64.30
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2008 - 10	44.94	60.93	60.70
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2009 - 11	44.50	55.07	56.57
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	2010 - 12	40.49	51.96	53.45
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2001 - 03	115.03	150.06	147.39
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2002 - 04	105.60	141.85	137.76
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2003 - 05	97.68	130.63	128.35
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2004 - 06	84.30	118.79	118.74
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2005 - 07	77.53	110.88	110.54
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2006 - 08	71.99	105.57	103.57
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2007 - 09	70.08	98.57	97.13
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2008 - 10	67.83	92.05	91.82
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2009 - 11	71.66	84.05	85.87
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Male	2010 - 12	65.15	79.29	80.81
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2001 - 03	29.86	53.86	53.88
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2002 - 04	27.44	49.69	49.72
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2003 - 05	27.36	45.15	45.50
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2004 - 06	24.47	40.06	41.85
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2005 - 07	23.42	37.16	38.70
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2006 - 08	26.02	36.59	36.41
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2007 - 09	27.53	35.20	33.46
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2008 - 10	24.61	32.47	31.40
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2009 - 11	20.56	28.59	28.93
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Female	2010 - 12	18.57	27.00	27.62

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

NHS Health Checks

The NHS Health Checks Programme is a national public health programme aimed to prevent heart disease, stroke, diabetes, chronic kidney disease and vascular dementia. Individuals aged between 40 and 74 years without established cardiovascular disease are invited to attend for a health check to assess and manage their risk of developing cardiovascular disease. This programme runs over a five year period, so 20% of the eligible population should be invited each year. It is recommended that local programmes aim to increase their percentage uptake each year. The England average uptake in 2013/2014 was 49% of those offered, compared to Bromley at 39% in the same year.

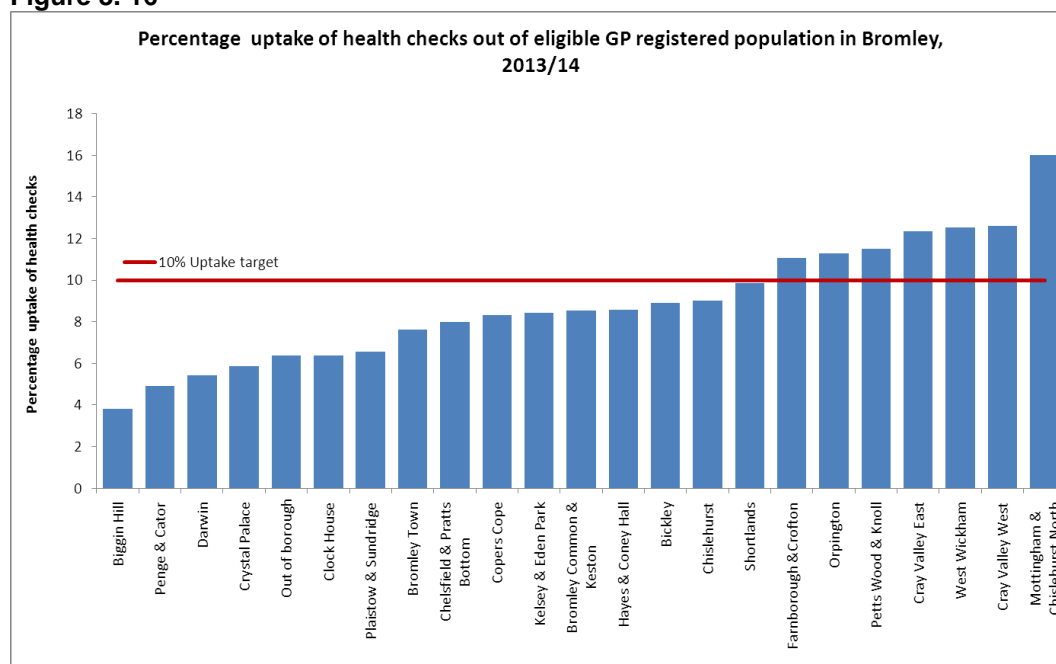
The programme in Bromley commenced in 2010 with gradual implementation progressing to full rollout of 20% invitation target achieved in 2011-12 and achieved each subsequent year. NHS Health Check numbers achieved to date are shown in **Table 3.5**.

Table 3. 5: Number of NHS Health Checks Offered and delivered 2010-2014

	Number of people eligible for an NHS Health Check in Bromley	Number of people invited for an NHS Health Check	Percentage of eligible population invited (target 20% each year)	Number of people who had an NHS Health Check completed	Percentage of people that received an NHS Health Check of those offered (uptake)
2010-11	100,363	5,706*	6%*	3,150	*
2011-12	99,949	20,995	21%	7,617	36%
2012-13	100,037	23,033	23%	8,958	39%
2013-14	92,080	23,867	25%	9,028	38%
TOTAL		49,818		22,458	

**2010-11 had gaps in documentation of invitations so uptake not assessed for that year.*

Although numbers of NHS Health Checks delivered in Bromley have increased year on year, percentage uptake of those invited has not improved and is below national average. However when comparing uptake with those who are eligible, regardless of invitation, Bromley has the same percentage uptake as the national average of 9% for 2013-14. Coverage of NHS Health Checks across the borough has been variable as shown in **Figure 3.16**.

Figure 3. 16

Source: Bromley NHS Health Check Programme, 2014

The invitation target of 20% of the eligible population was met in 18 out of 22 wards. It was expected that approximately half of the those invited would take up the opportunity to have their NHS Health Check, however only 7 wards reached the required uptake of 10% of the eligible population. Uptake was highest in Mottingham & Chislehurst North ward. The wards in the north of the borough e.g. Penge & Cator, Crystal Palace and Biggin Hill and Darwin had the lowest uptake for 2013-14.

During the NHS Health Check, a cardiovascular risk assessment tool (Qrisk2) is used to assess whether an individual is at low, moderate or high risk of developing Cardiovascular Disease (CVD) in the next 10 years. A risk score of greater than or equal to 20% is considered high risk. In 2012-13, 729 (9%) individuals were found to have a high cardiovascular risk score compared to 557 (8%) in 2011-12. This is closer to the national expectation of 10%. These individuals will have been offered interventions to try and reduce their risk of developing cardiovascular disease in addition to being offered annual reviews at the GP Practice.

The NHS Health Check also identifies individuals eligible for further screening for diabetes, hypertension and chronic kidney disease (CKD). Early diagnosis of these conditions is beneficial in reducing progression to more severe cardiovascular disease such as heart attacks, stroke and vascular dementia. Not all of those eligible for such further screening have received it, which is an on-going area of work with primary care, nevertheless, a number of individuals were diagnosed with conditions for which they can now receive treatment to try

to reduce cardiovascular risk and prevent disease progression. These levels are shown in **Figure 3.17**.

Figure 3. 17

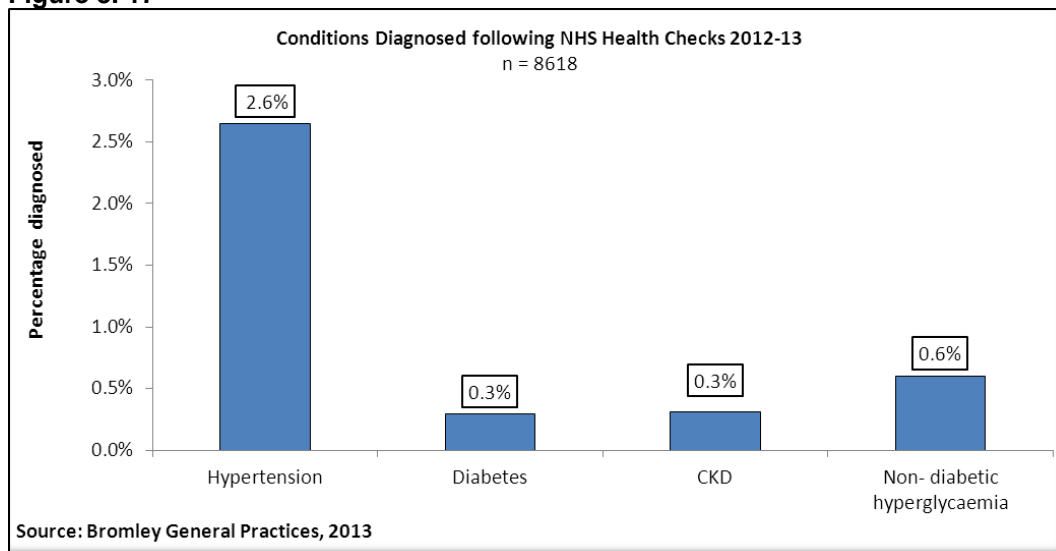


Table 3. 6: NHS Health Checks Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	Persons	40-74 yrs	2011/12	21.30	18.97	13.95
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	Persons	40-74 yrs	2012/13	23.11	20.60	16.48
2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	Persons	40-74 yrs	2011/12	36.28	45.98	4.29
2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	Persons	40-74 yrs	2012/13	39.11	45.23	.94

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

What this means for Bromley residents in Bromley

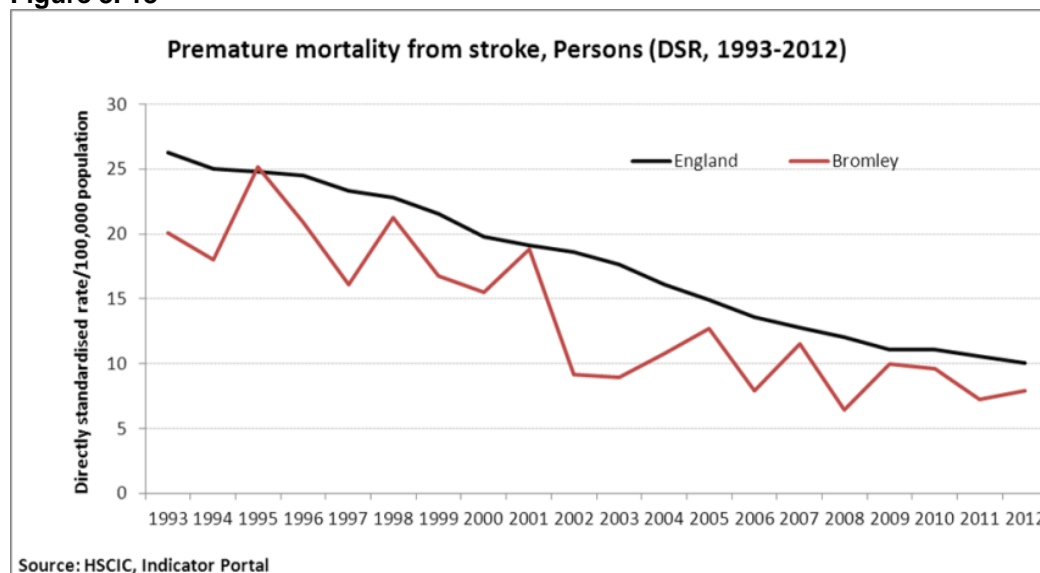
There is a need to improve the low uptake of NHS Health Checks across most wards in the borough particularly in Penge, Crystal Palace and Biggin Hill. Improving access and targeting areas of higher CVD mortality and low levels of NHS Health Checks coverage is important to ensure the programme does not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

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

Stroke

The stroke mortality rate in Bromley has been steadily falling since 1993, and is significantly lower than the rates for England and London.

Figure 3. 18



The observed prevalence for stroke in Bromley is 65.5% of the estimated prevalence (this compares to 68.4% for England and 52.6% for London).

The recorded prevalence of stroke has fluctuated between 1.5% and 1.94% over the last 8 years.

Table 3. 7: Prevalence of Stroke

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Stroke Register Size	4825	4908	5017	5125	5184	5362	5277	5122
Stroke Prevalence	1.47%	1.90%	1.83%	1.95%	1.61%	1.61%	1.94%	1.50%

Source: HSCIC/ QOF, 2014

Of those people diagnosed with stroke, a lower proportion have monitoring and control of blood pressure and cholesterol in Bromley than the England average.

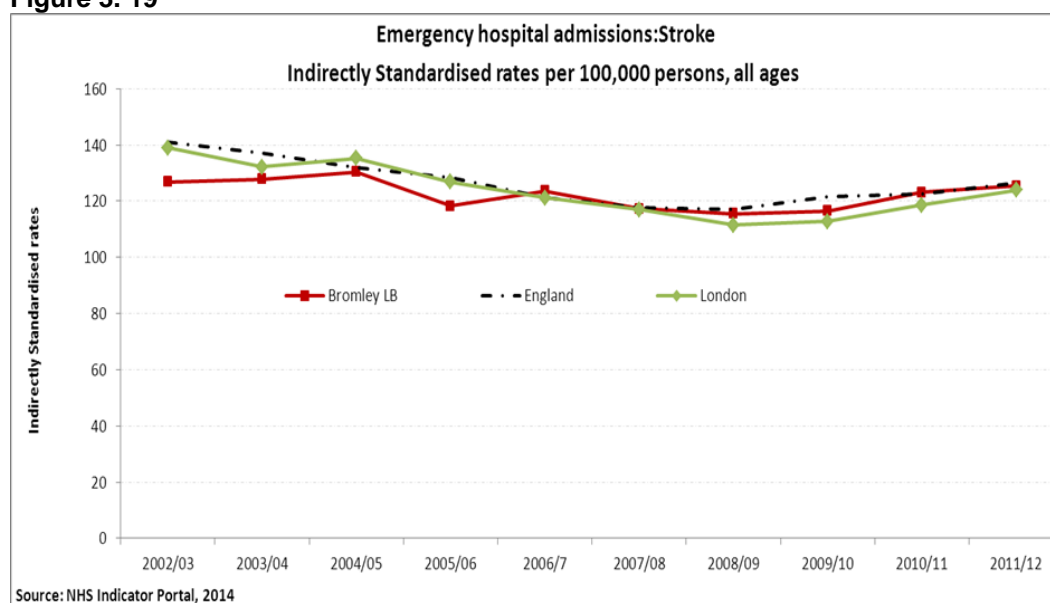
In 2011-12, the emergency admission rate for stroke in Bromley was 82.4 per 100,000 (432 admissions). This is lower than England (89.5) and significantly lower than London (100.3).

Male stroke emergency admission rates are significantly higher than female stroke emergency admission rates.

The emergency admission rate for stroke in 2011-12 for persons who live in the most deprived areas of Bromley was 90.4. This is 1.2 times greater than the emergency admission rates for persons who live in the least deprived areas of Bromley (73.3).

The emergency admission rate for stroke in Bromley has increased by 7.8% between 2004-05 and 2011-12 (England 3% increase, London 10.6% increase).

Figure 3. 19



Hypertension

The prevalence of hypertension rose between 2005 and 2011, but has levelled off in the last 2 years.

The prevalence of recorded hypertension is higher in Bromley than the national average. However, recorded prevalence of hypertension in Bromley is only 44.9% of the estimated prevalence (this figure is 46% for England and 41.5% for London).

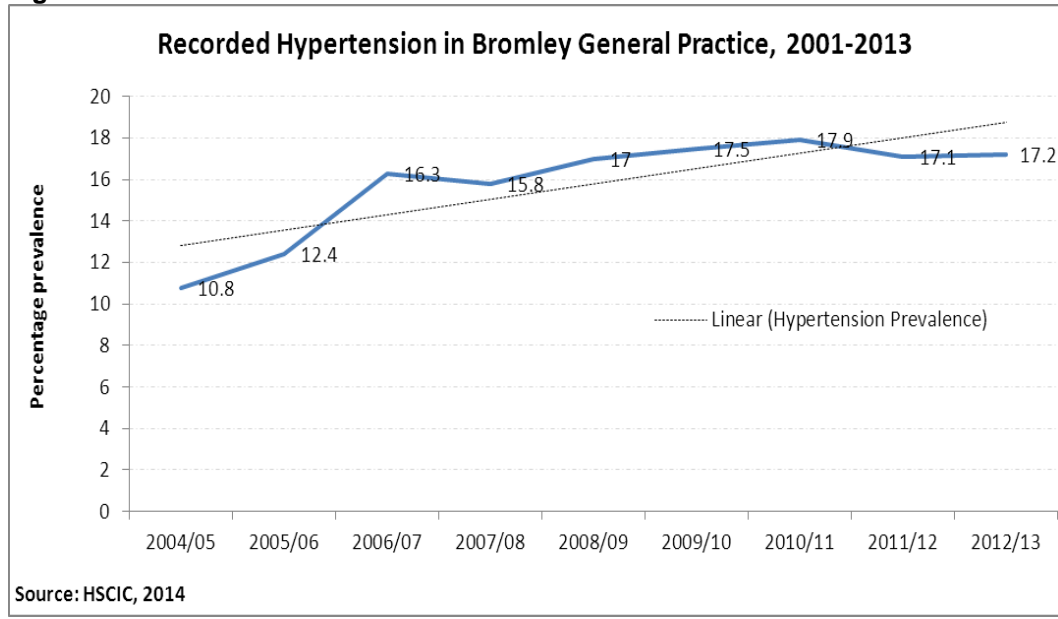
A survey two years ago in Bromley revealed a low level of awareness of hypertension amongst the public and a false perception that it is a benign condition. Further work is planned in this area.

Table 3. 8: Hypertension Prevalence

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Hypertension Register Size	40,333	41,570	42,651	43,924	45,209	47,088	46,376	46,028
Hypertension Prevalence	12.4%	16.30%	15.8%	17.0%	17.5%	17.9%	17.1%	17.2%
<i>Source: HSCIC/ QOF, 2014</i>								

Alongside the under detection of hypertension, the proportion of cases who have had their blood pressure checked in the last 9 months (87%) and who achieve the QOF standard of 150/99 mmHg (74%) is lower than the London (89%, 76.7%) and England (89%, 77%) averages. This is particularly significant given that NICE Guidelines recommend a stricter blood pressure control target (140/90 mmHg) than the target in QOF.

Hypertension has been one of the Health & Wellbeing Strategy priorities and an action plan has been developed to address improvements in awareness, diagnosis and management of hypertension.

Figure 3. 20

What this means for Bromley residents and children in Bromley

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

Diabetes

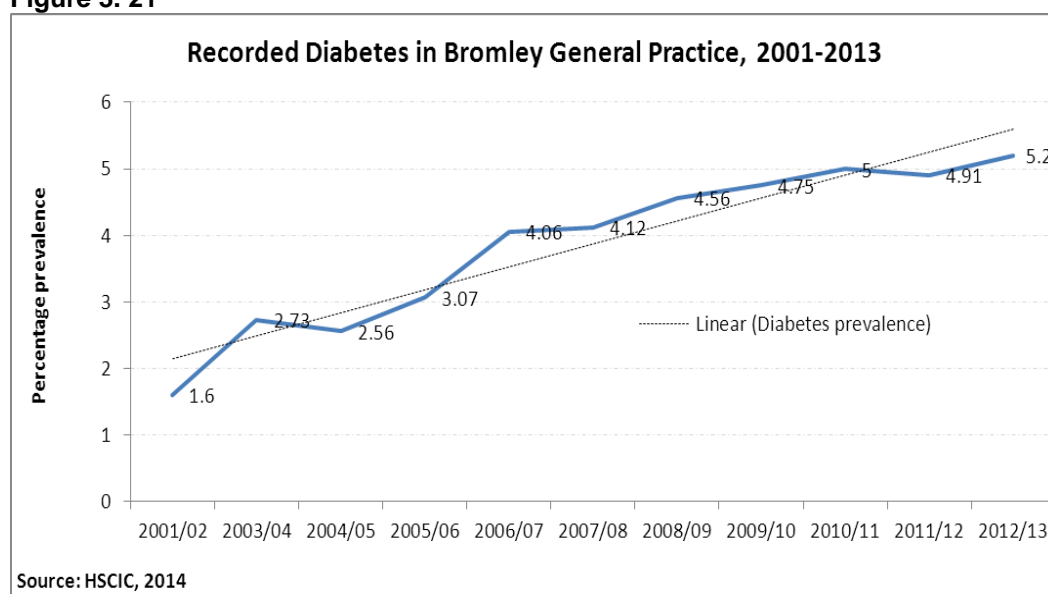
The number of people with diabetes has increased over time. There were 4,846 people on the diabetes register in 2002, as compared with 13,681 in 2012. (**Table 3.9**). This rise has particular significance because diabetes is classed as a vascular disease which is often a precursor to heart disease or stroke. However, despite this rise in the incidence of recorded diabetes, it is estimated that there are a further 5292 adults with undiagnosed diabetes. Work is being undertaken to improve the identification of diabetes in Bromley and a pilot diabetes prevention programme is planned.

Table 3. 9: Diabetes Prevalence

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Diabetes Register Size	8,861	9,244	10,084	10,504	11,261	11,979	12,509	13,307	13,335	13,681
Diabetes Prevalence	2.73%	2.56%	3.07%	4.06%	4.12%	4.56%	4.75%	5.00%	4.91%	5.20%

Source: HSCIC/ QOF, 2014

Figure 3. 21



Control of diabetes, as measured by an HbA1c of <59mmol/mol is higher in Bromley (63.4%) than in England as a whole (59.6%). However, there is variation between practices, with a range between 40.7% and 78.6%.

Control of cholesterol and blood pressure in diabetic patients in Bromley is lower than the England average, 71% vs 72.9% for cholesterol and 62.2% vs 67.2% for blood pressure. Again, there is a range of variation between practices.

According to the Diabetes Clinical Commissioning Group Profile 2013, people with diabetes in Bromley were 70% more likely to have a myocardial infarction, 41.4% more likely to have a stroke, 67.8% more likely to have a hospital admission related to heart failure and 34.5% more likely to die than the general population in the same area.

Table 3. 10: Diabetes Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
2.17 - Recorded diabetes	Persons	17+ yrs	2010/11	5.01	5.36	5.54
2.17 - Recorded diabetes	Persons	17+ yrs	2011/12	5.10	5.59	5.76
2.17 - Recorded diabetes	Persons	17+ yrs	2012/13	5.17	5.82	6.01
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	Persons	12+ yrs	2010/11	86.26	75.99	79.22
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	Persons	12+ yrs	2011/12	84.70	78.72	80.88
4.12iii - Preventable sight loss - diabetic eye disease	Persons	12+ yrs	2010/11	3.04		3.56
4.12iii - Preventable sight loss - diabetic eye disease	Persons	12+ yrs	2011/12			3.85

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

What this means for Bromley residents and children in Bromley

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

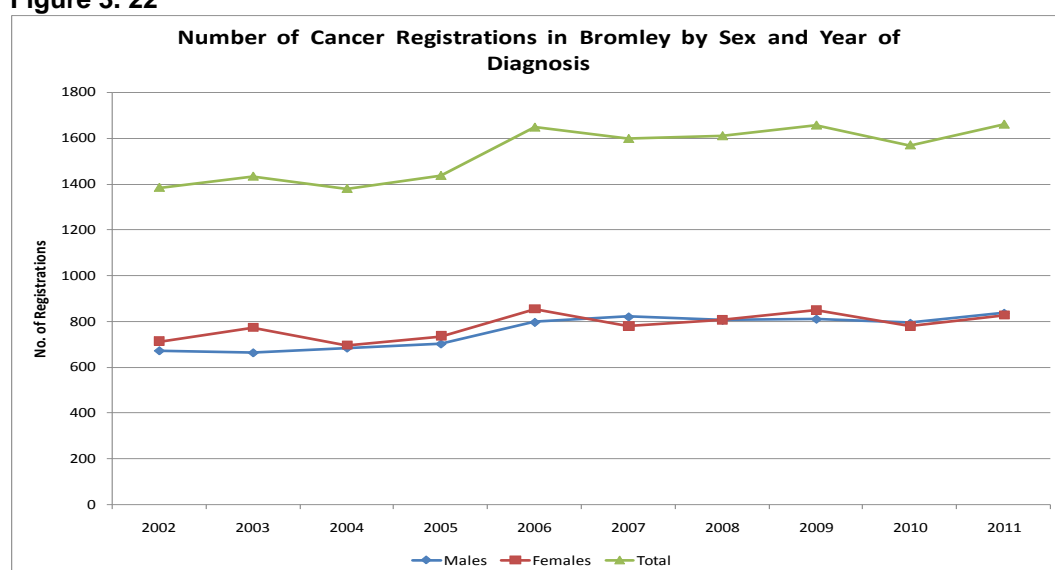
The work to prevent diabetes in high risk patients and the work to improve the identification of diabetes should be fully evaluated to inform future commissioning.

Cancer

There were 6,813 patients recorded with a diagnosis of cancer on GP registers in 2012-13, although the Thames Cancer Registry reported 11,262 registered cancer patients registered in Bromley alive at 31st December 2011. There were over 10,000 cancer deaths in the last 10 years.

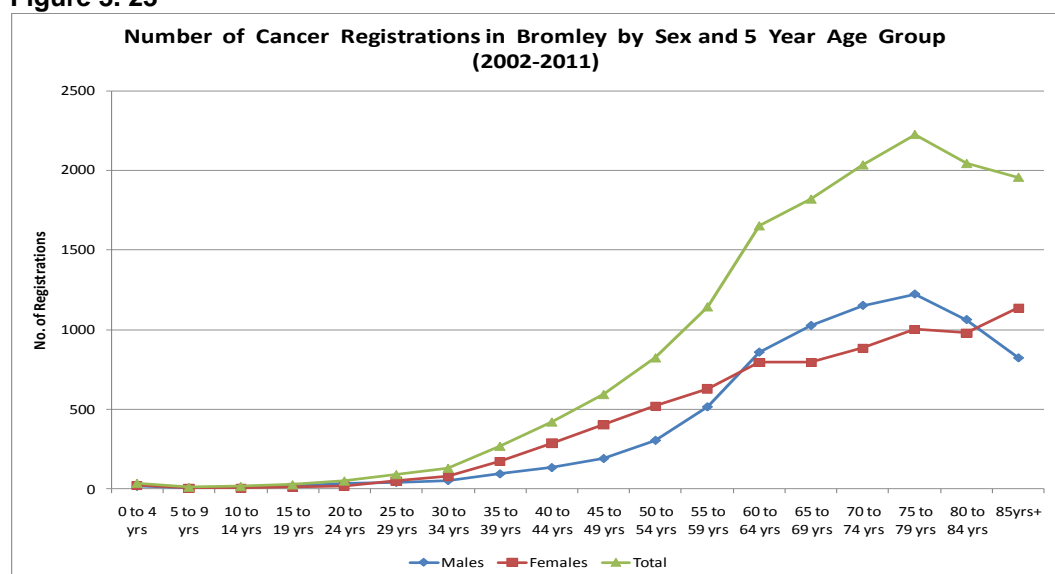
The number of cancer registrations per year has increased since 2002, but been fairly stable since 2006. The number of people diagnosed with cancer increases with age, to a peak in the 75 to 79 year age group.

Figure 3. 22



Source: Thames Cancer Registry

Figure 3. 23



Source: Thames Cancer Registry

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

Table 3. 11: Number of Cancer Registrations by Site in Bromley, 2002-2011

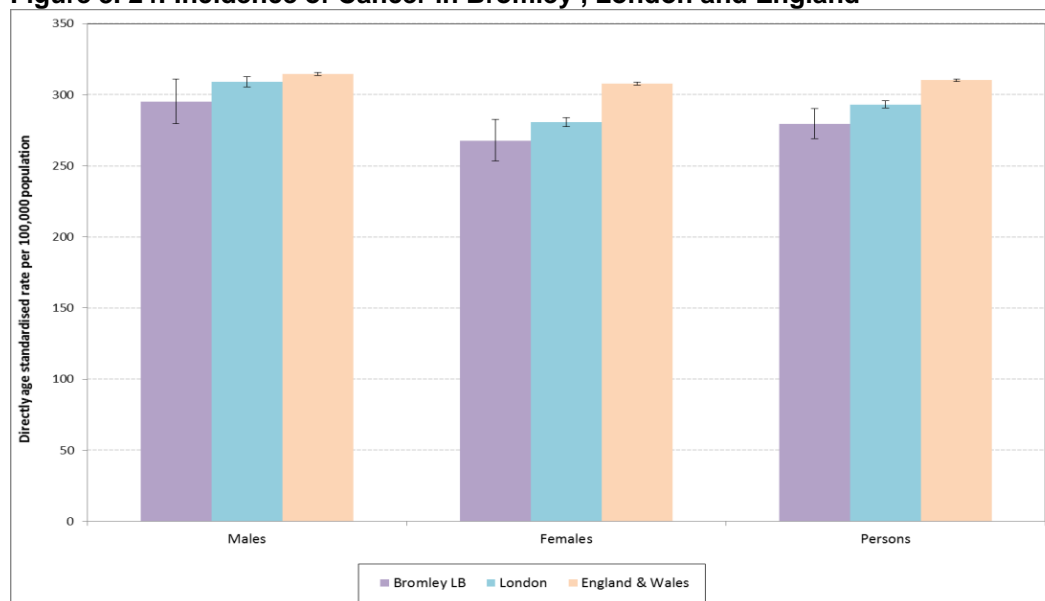
Site of Cancer	Males	Females	Total
Breast		2499	2499
Lung	979	772	1751
Colorectal	960	856	1816
Prostate	1755		1755

Source: Thames Cancer Registry

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

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

Figure 3. 24: Incidence of Cancer in Bromley , London and England



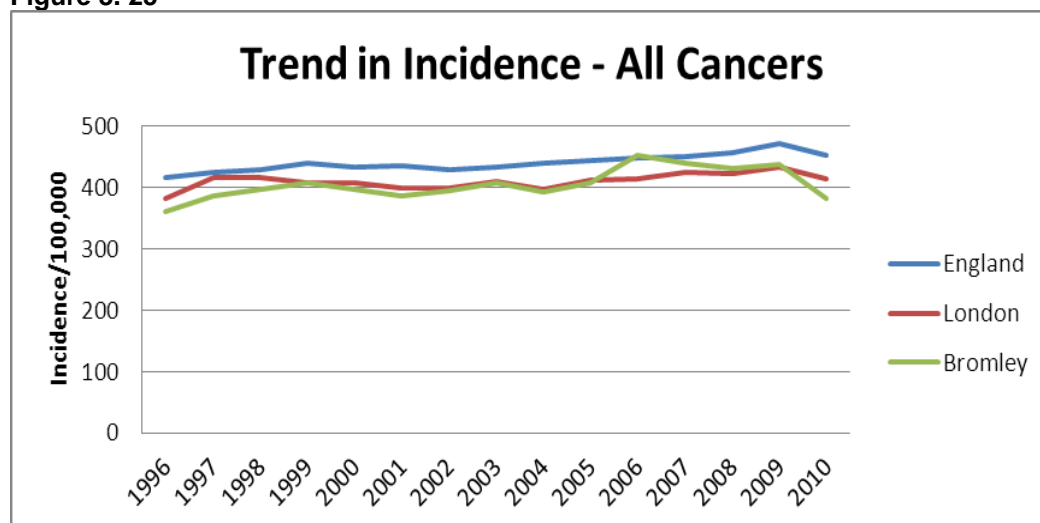
Source: HSCIC Indicator Portal

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

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

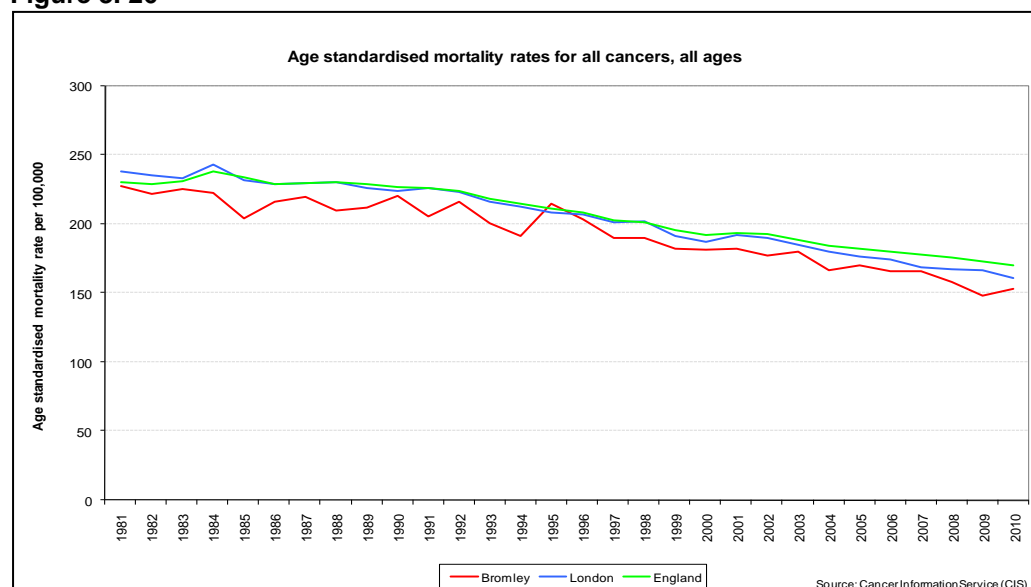
Bromley has fallen by almost a third from 58.7/100,000 in 1997 to 39.7/100,000 in 2010.

Figure 3. 25

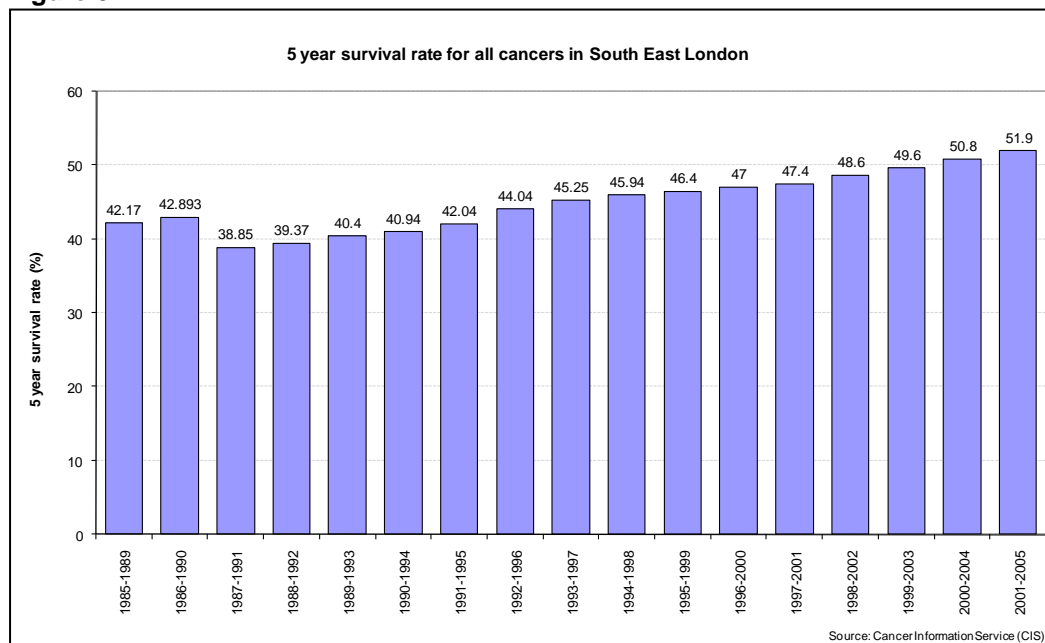


Overall cancer mortality has been falling over the last 20 years as shown in **Figure 3.26**.

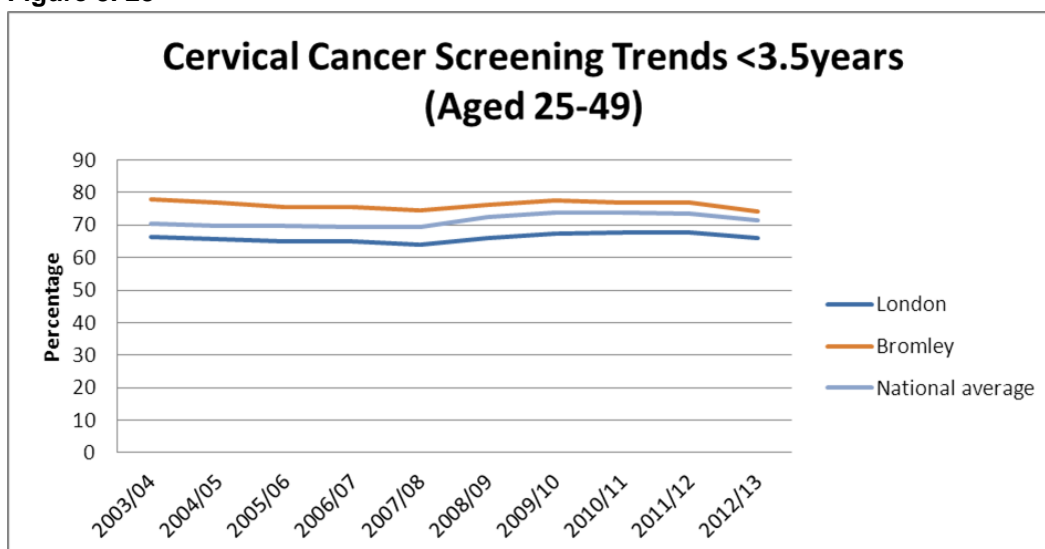
Figure 3. 26



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

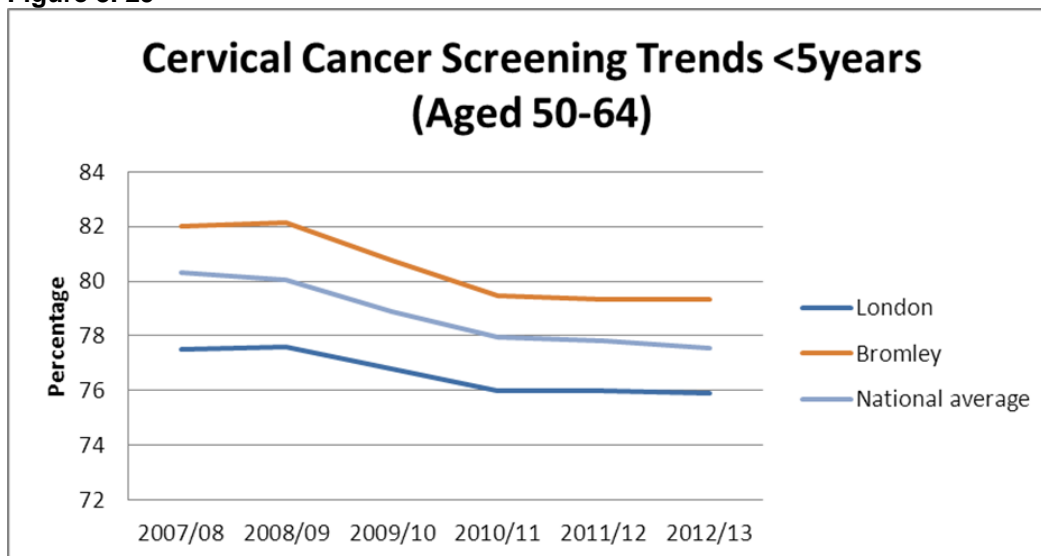
Figure 3. 27

Cervical cancer screening uptake in Bromley has been consistently better than the London and National average across both 25-49 year and 50-64 year age groups (**Fig 3.28** and **Fig 3.29**). While this is reassuring, it is worth noting that in all areas the <5 years cervical cancer screening uptake in the 50-64 year age group has fallen by about 3% in the last 5 years.

Figure 3. 28

Source: Cancer Commissioning Toolkit, 2014

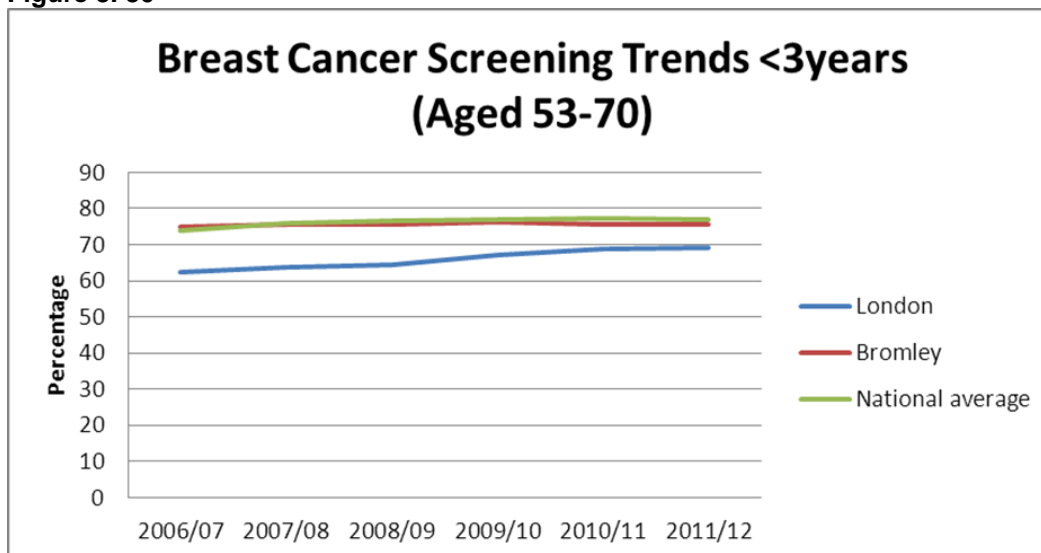
Figure 3. 29



Source: *Cancer Commissioning Toolkit, 2014*

Breast cancer screening uptake in Bromley has shown gradual improvement in both 53-64 year and 53-70 year age groups, growing from about 74% to 77% in the last 5 years. It has remained on par with the National average, and has consistently performed about 10% better than London (Figure 3.30).

Figure 3. 30



Source: *Cancer Commissioning Toolkit, 2014*

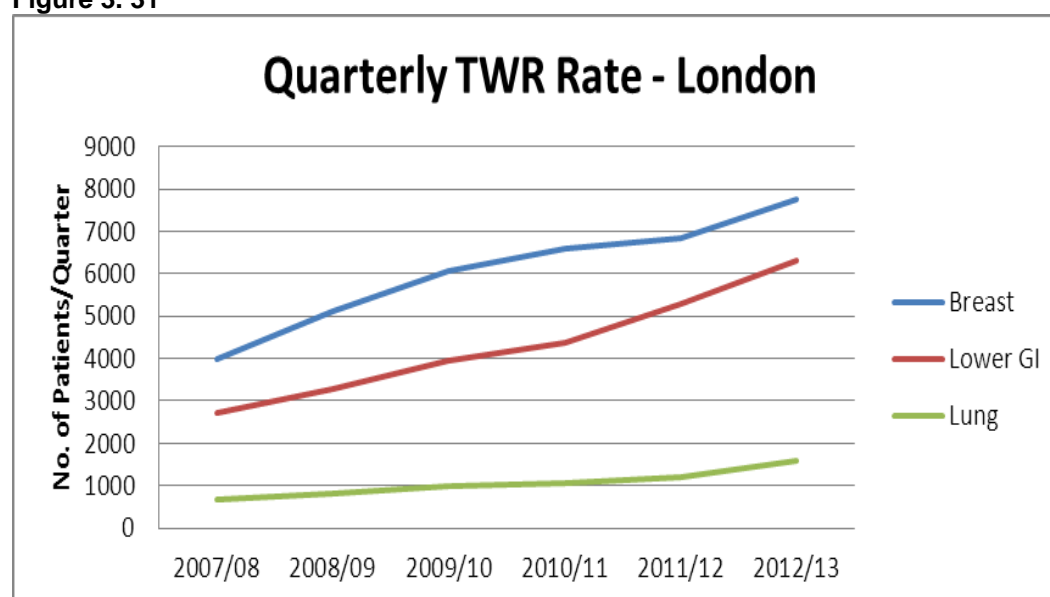
The screening programme for bowel cancer has now been established, but there are lower uptake rates for the more deprived areas of the borough.

Patients with suspected cancer are referred by GPs to specialist care by a system known as Two Week Referral (TWR), which as the name suggests, ensures that patients are seen by a specialist within two weeks of referral. The

reason for this is that early diagnosis of a disease may mean more effective treatment and better outcomes. A significant proportion of patients have cancer diagnosed outside the two week referral pathway – presenting as emergencies, identified at screening, or incidental findings.

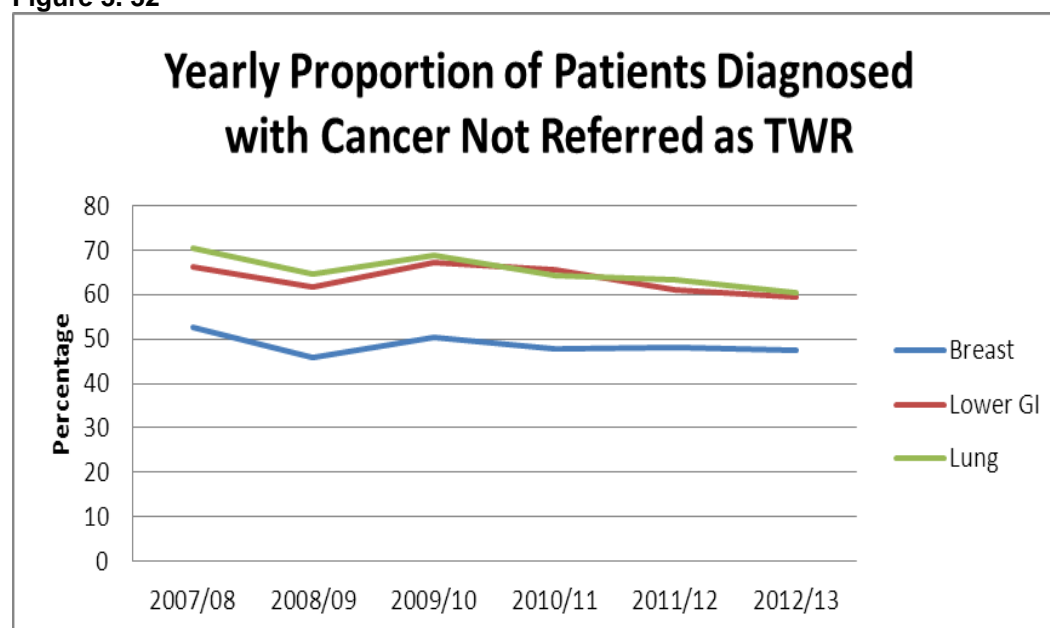
Two week referral rates have more than doubled in London for breast, lung and lower GI cancers over the last 5 years. However, the proportion of patients diagnosed with cancer not referred as TWR remains fairly high for these cancers.

Figure 3. 31



Source: *Cancer Commissioning toolkit, 2014*

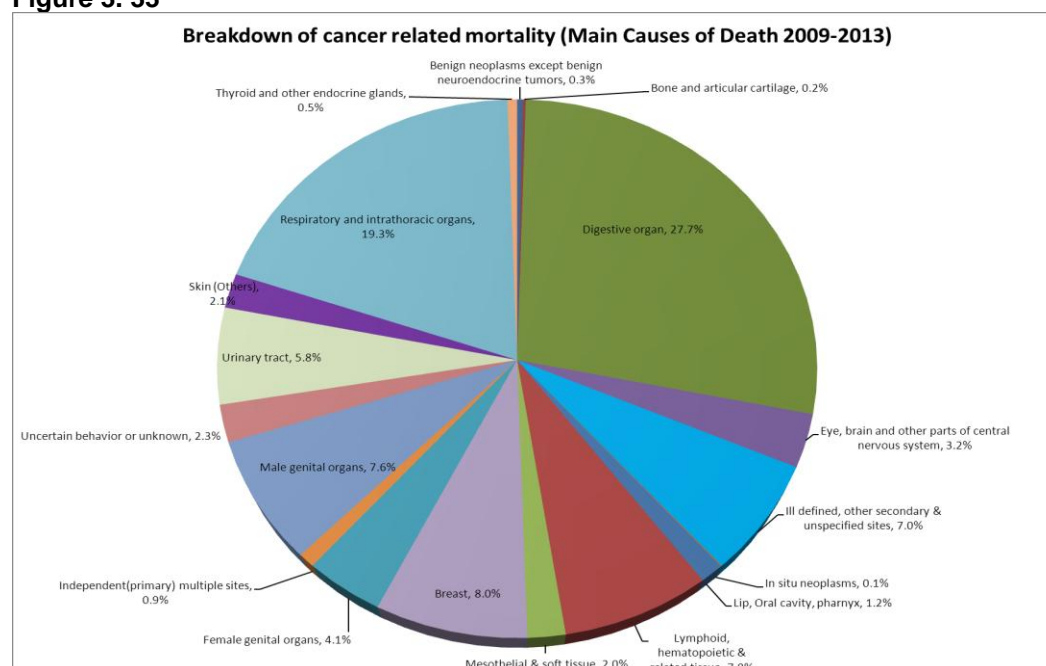
Figure 3. 32



Source: *Cancer Commissioning toolkit, 2014*

The highest proportion of cancer deaths (27.7%) is related to cancer of the digestive organs.

Figure 3. 33



Source: ONS Primary Care Mortality Database

What this means for Bromley residents and children in Bromley

A significant proportion of cancers are diagnosed outside the two week referral pathway.

Screening uptake is lower in the more deprived areas of the Borough.

Table 3. 12: Cancer Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
2.20i - Cancer screening coverage - breast cancer	Female	53-70 yrs	2010	76.29	66.91	76.91
2.20i - Cancer screening coverage - breast cancer	Female	53-70 yrs	2011	75.93	68.73	77.13
2.20i - Cancer screening coverage - breast cancer	Female	53-70 yrs	2012	75.63	69.15	76.92
2.20i - Cancer screening coverage - breast cancer	Female	53-70 yrs	2013	74.30	68.57	76.32
2.20ii - Cancer screening coverage - cervical cancer	Female	25-64 yrs	2010	79.00	70.21	75.53
2.20ii - Cancer screening coverage - cervical cancer	Female	25-64 yrs	2011	78.30	69.94	75.67
2.20ii - Cancer screening coverage - cervical cancer	Female	25-64 yrs	2012	77.80	69.74	75.36
2.20ii - Cancer screening coverage - cervical cancer	Female	25-64 yrs	2013	75.64	68.61	73.93
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2001 - 03	155.81	168.29	169.44
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2002 - 04	151.51	164.03	166.25
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2003 - 05	150.72	159.64	162.71
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2004 - 06	144.95	156.57	160.02
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2005 - 07	145.52	152.71	157.75
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2006 - 08	141.42	149.47	155.66
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2007 - 09	133.64	147.13	153.22
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2008 - 10	129.07	144.03	150.59
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2009 - 11	130.07	142.15	148.46
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	2010 - 12	131.45	139.14	146.48
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2001 - 03	178.25	193.71	193.63
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2002 - 04	175.34	188.54	189.66
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2003 - 05	173.75	182.55	184.72
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2004 - 06	168.76	179.84	180.99
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2005 - 07	165.16	174.24	177.75
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2006 - 08	157.25	170.89	174.91
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2007 - 09	148.13	167.38	171.78
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2008 - 10	149.45	164.05	168.89
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2009 - 11	150.29	161.52	166.28
4.05i - Under 75 mortality rate from cancer	Male	<75 yrs	2010 - 12	155.19	158.59	163.57
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2001 - 03	137.28	145.93	147.93
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2002 - 04	131.48	142.50	145.38
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2003 - 05	131.36	139.49	143.05
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2004 - 06	124.88	136.00	141.17
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2005 - 07	129.19	133.69	139.66
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2006 - 08	128.02	130.55	138.15
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2007 - 09	121.62	129.30	136.28
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2008 - 10	111.59	126.30	133.81
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2009 - 11	112.84	124.97	132.07
4.05i - Under 75 mortality rate from cancer	Female	<75 yrs	2010 - 12	111.05	121.90	130.78
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2001 - 03	86.33	97.23	97.01
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2002 - 04	86.54	94.83	95.15
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2003 - 05	84.53	92.48	93.29
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2004 - 06	79.93	90.45	91.98
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2005 - 07	78.07	88.33	90.94
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2006 - 08	79.43	86.95	90.14
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2007 - 09	74.29	86.09	89.11
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2008 - 10	73.70	84.58	87.77
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2009 - 11	72.89	83.10	86.31
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	2010 - 12	73.87	81.54	84.95
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2001 - 03	100.37	109.02	108.98
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2002 - 04	99.43	106.35	106.47
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2003 - 05	93.82	103.35	103.78
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2004 - 06	89.75	101.98	101.53
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2005 - 07	83.69	99.00	99.85
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2006 - 08	87.17	97.77	98.43
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2007 - 09	82.28	95.87	97.32
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2008 - 10	85.66	94.12	96.01
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2009 - 11	85.06	92.36	94.46
4.05ii - Under 75 mortality rate from cancer considered preventable	Male	<75 yrs	2010 - 12	86.06	91.41	92.75
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2001 - 03	74.73	87.01	86.50
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2002 - 04	75.84	84.86	85.19
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2003 - 05	76.76	83.04	84.03
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2004 - 06	71.72	80.38	83.54
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2005 - 07	73.63	79.01	83.01
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2006 - 08	73.14	77.51	82.73
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2007 - 09	67.81	77.61	81.72
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2008 - 10	63.54	76.32	80.31
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2009 - 11	62.52	75.03	78.93
4.05ii - Under 75 mortality rate from cancer considered preventable	Female	<75 yrs	2010 - 12	63.51	72.89	77.87

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

Respiratory Disease

About 13% of deaths in Bromley are caused by respiratory disease. This includes influenza and COPD.

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is mainly caused by smoking. The prevalence of smoking in Bromley is 18.1%, lower than the England average (20%). However, smoking prevalence is higher in routine and manual workers at 26.1%.

Mortality from COPD is lower than the London and England average. Bromley residents are almost three times less likely to die from COPD before the age of 75 years compared to people living in the local authority with the highest premature COPD death rate in England.

Modelled figures for COPD prevalence suggest a rate of 4.2%, which is higher than the prevalence measured using QOF register data. This register data may more accurately reflect the disease burden than the modelling, which may include people with spirometric changes but without symptoms.

Table 3. 13: COPD Prevalence

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

Source: HSCIC/ QOF, 2014

The overall emergency COPD admission rate is significantly lower than the national average. Bromley residents are 3.5 times less likely than residents in the local authority with the highest admission rate to be admitted for COPD.

Once admitted for COPD, patients from Bromley spend significantly less time in hospital than other patients in England; over three days less than the local authority with the longest length of stay.

Readmission rates within 90 days of an emergency admission for COPD are statistically similar to the national average. However, more than 40% of Bromley patients admitted for COPD return to hospital within 90 days.

Table 3. 14: Respiratory Disease Related PHOF Indicators

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

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

Mental Illness

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

Table 3. 15: Serious Mental Illness Prevalence (QOF)

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Mental Health Register Size	1667	2173	2270	2351	2389	2511	2563	2616
Serious Mental illness Prevalence	0.5%	0.9%	0.8%	0.9%	0.9%	1.0%	0.94%	0.8%

Source: HSCIC/ QOF, 2014

Dementia

In 2012 it was estimated that there were 4102 people with dementia in Bromley; a relatively small proportion of these from black and minority ethnic groups.

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

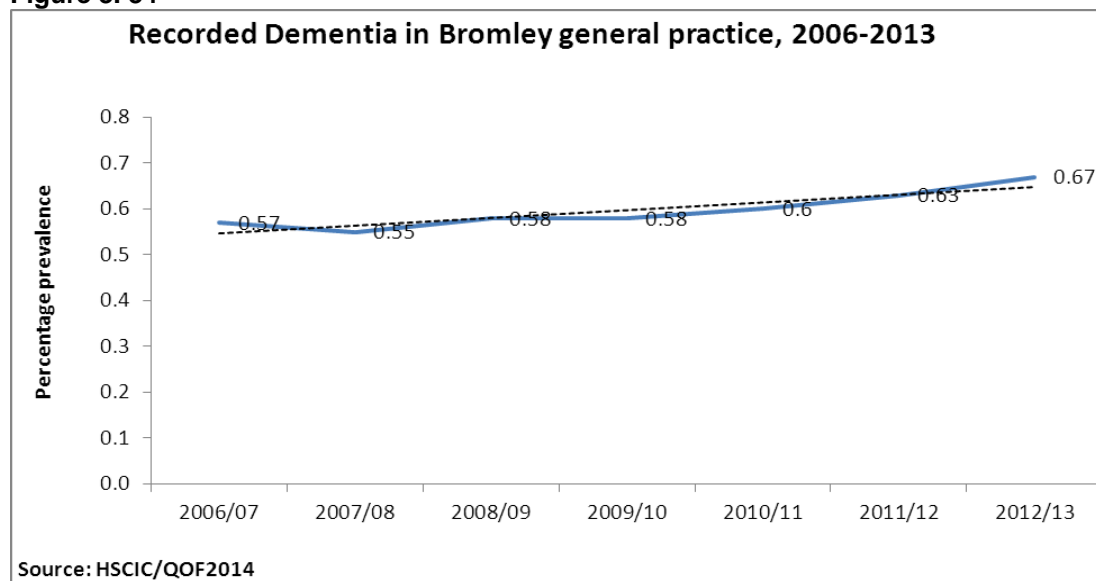
GP registers identify 1,794 patients with dementia, suggesting that some cases are not known to clinical services. Dementia is discussed more extensively in the chapters on Mental Health and Older People, for further details refer to the Mental Health and Older People chapters.

Table 3. 16: Dementia Prevalence (QOF)

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

Source: HSCIC/ QOF, 2014

Figure 3. 34



Section 10 gives more detailed information on mental health issues in Bromley

Neurological Conditions

A 'long-term neurological condition' results from disease of, injury or damage to the body's nervous system (i.e. the brain, spinal cord and/or their peripheral nerve connections) which will affect the individual and their family in one way or another or the rest of their life.

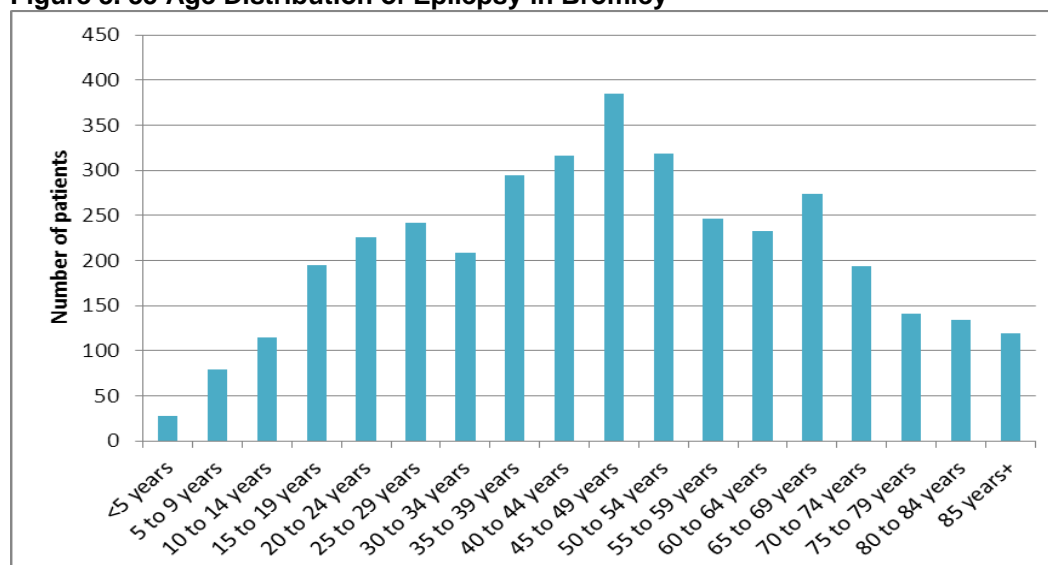
Three of the most prevalent long-term neurological conditions in adults in Bromley are: Epilepsy, Parkinson's Disease, and Multiple Sclerosis.

Epilepsy

Epilepsy is the most common serious neurological disorder, characterised by sudden recurrent fits or seizures which occur as a result of spontaneous abnormal electrical discharge in any part of the brain. Different types of epilepsy have different causes. Epilepsy can affect people of any age but is most often diagnosed before the age of 18 or after the age of 65. Men and women are equally affected. Two-thirds of people with active epilepsy have their epilepsy controlled satisfactorily with anti-epileptic drugs (AEDs).

Data collected by local GP practices 2012-2013 as a part of QOF, demonstrated that there were an estimated 3747 patients registered with GP practices in Bromley who have a diagnosis of epilepsy. 416 of these patients are under the age of 19, the majority of whom would be cared for by paediatric services. 3331 are aged 20 or over. The prevalence of epilepsy in Bromley increases with age up to approximately 50 years of age, then begins to decline (**Figure 3.35**). The patient population with epilepsy is divided almost equally in terms of gender, with 50.1% of the patients being female, 49.9% male.

Figure 3.35 Age Distribution of Epilepsy in Bromley



Source: Bromley General Practice Disease Register, 2013

This data from the local epilepsy disease register suggests that there are more people diagnosed with epilepsy in Bromley than we would expect on the basis of national figures, which estimate a prevalence of 9.5 per 1000 population (3008 people). The higher prevalence may represent better detection and diagnosis rates in the borough than elsewhere in the country, or may be the result of the Bromley population being typically more engaged with health services.

Parkinson's Disease

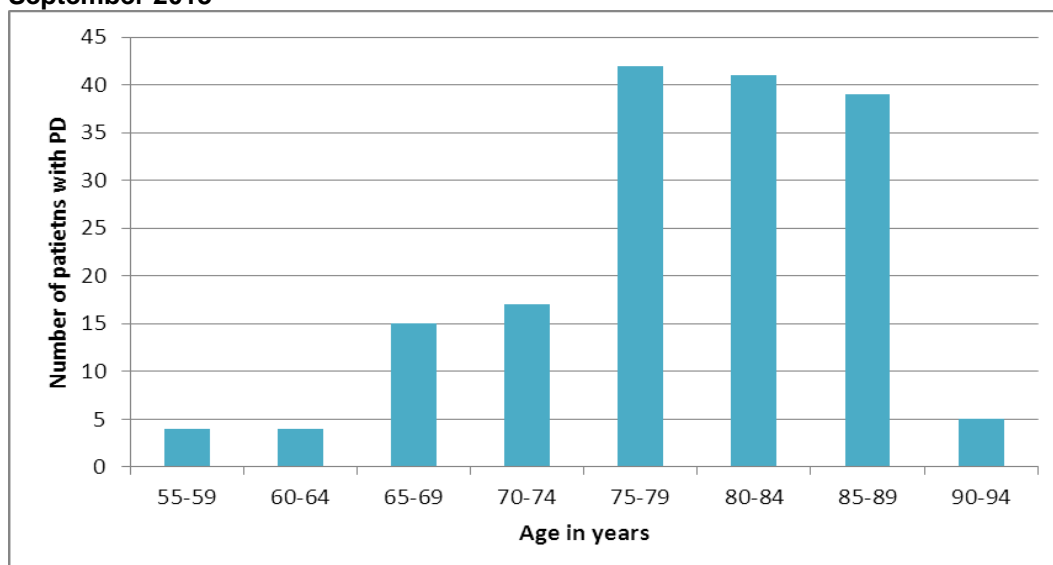
Parkinson's Disease (PD) is a common, chronic, progressive neurodegenerative condition resulting from the death of the dopamine-containing cells of the substantia nigra. People with PD classically present with the symptoms and signs associated with Parkinsonism, namely bradykinesia (slowness of movement), rigidity and resting tremor. The diagnosis is primarily clinical, based on history and examination. Although PD is predominantly a movement disorder, other impairments frequently develop including psychiatric problems such as depression and dementia. Autonomic disturbances and pain may later ensue, and the condition progresses to cause significant disability and handicap with impaired quality of life for the affected person.

PD is estimated to affect 100-180 per 100,000 of the population. There is a rising prevalence with age and a higher prevalence and incidence of PD in males. Using these estimates, one would expect there to be approximately 886 people with Parkinson's Disease in Bromley.

There is no local primary care register of people with Parkinson's Disease living in Bromley based on General Practice data. However, we know that the Parkinson's Clinical Nurse Specialist (CNS) at the Princess Royal University Hospital has a case load of approximately 520 patients. This figure is significantly lower than the estimated prevalence for PD in Bromley, but there are likely to be a number of patients who are not under the care of the CNS.

Hospital data available for Bromley patients who attended South London Healthcare Trust between April 2012 and September 2013 demonstrates that 167 Bromley patients were admitted during this time period who had either a primary or secondary diagnosis of Parkinson's disease. Of these, 132 were emergency admissions. The median age of admission was 80 years. 76% of admissions were in patients over the age of 75. The mean duration of an inpatient stay was 4.1 days.

Figure 3. 36: Distribution of patients with PD admitted to SLHT by age, April 2012-September 2013



Source: South London Healthcare NHS Trust

Of the Parkinson's patients admitted as an emergency, the most common primary/secondary diagnoses were falls (8.3%), urinary tract infection (8.3%), aspiration pneumonia (6.1%), constipation (5.3%), abnormalities of gait/mobility (4.5%), lower respiratory tract infection (4.5%).

Multiple Sclerosis

Multiple Sclerosis (MS) is a disease of the central nervous system in which white matter within the brain or spinal cord periodically becomes inflamed and then destroyed by the person's own immune system. These inflamed areas become scarred, giving the disease its name: **multiple** areas of hardening (**sclerosis**) within the brain or spinal cord.

MS usually starts in early adult life. There is no cure. There are recognised ways of describing the different patterns of MS:

- **Relapsing/remitting MS:** symptoms come and go, periods of good health (remission) are followed by sudden symptoms or relapse. 80% of people at onset.
- **Secondary Progressive MS:** follows on from relapsing/remitting MS. Symptoms gradually increase or worsen with fewer remissions. 50% of those with relapsing/remitting MS develop secondary progressive MS during the first 10 years of their illness.
- **Primary progressive MS:** from the beginning symptoms gradually develop and worsen over time. 10-15% of people at onset.

There are varying methods of estimating the prevalence of MS. On the basis of the NICE guideline estimates for the UK prevalence of MS, we would expect there to be approximately 317-380 people with Multiple Sclerosis living in Bromley, and approximately 10-22 new diagnoses in the borough per year. On the basis of the more up to date General Practice Research Database (GPRD) data, we would expect there to be approximately 644 people with MS living in Bromley and approximately 31 new diagnoses per year.

There is no local GP register data or hospital admissions data available for patients with Multiple Sclerosis. We do know, however, that the MS nurse in Bromley has a caseload of 516 people. There are likely to be a number of people with MS in the borough who are not under the care of the CNS and are managed solely by their GPs which may account for the discrepancy between the estimated number of MS patients and the MS CNS's caseload.

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

Sexual Health

Teenage Pregnancy

Teenage pregnancy can be associated with adverse health and social outcomes.

These include: higher rates of infant mortality than for children born to older mothers, babies are more likely to be born prematurely, which has serious implications for the baby's long-term health and children have higher rates of admission to A&E.

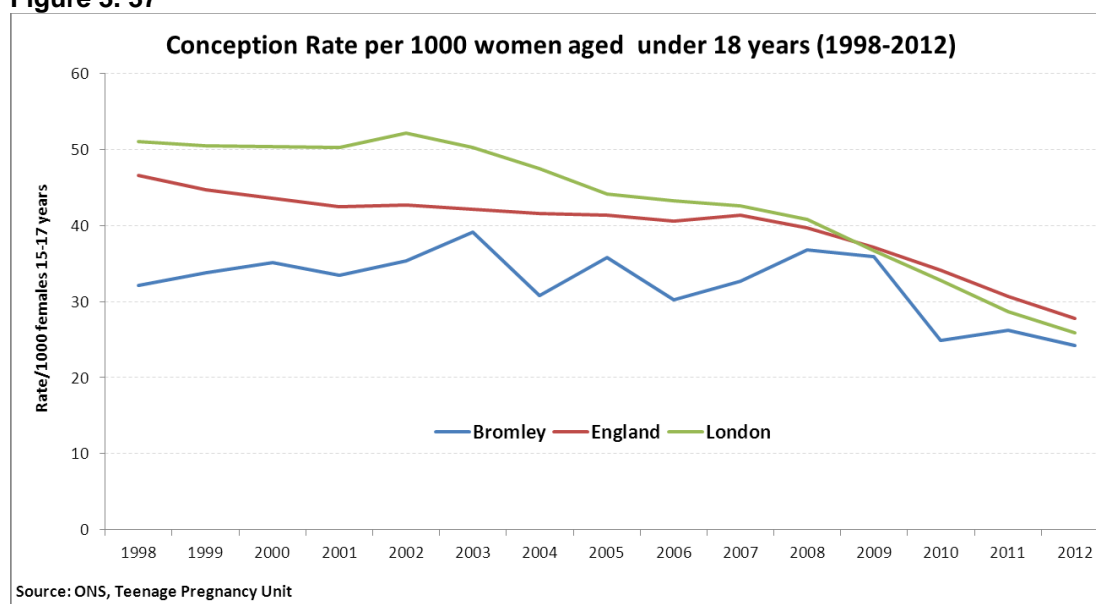
In the longer term, children of teenage mothers experience lower educational attainment and are at higher risk of economic inactivity as adults.

The pressures of early parenthood result in teenage mothers experiencing high rates of poor emotional health and well-being, which impacts on their children's behaviour and achievement.

Teenage parents often do not achieve the qualifications they need to progress into further education and, in some cases, have difficulties finding childcare and other support they need to participate in Education, Employment or Training (EET).

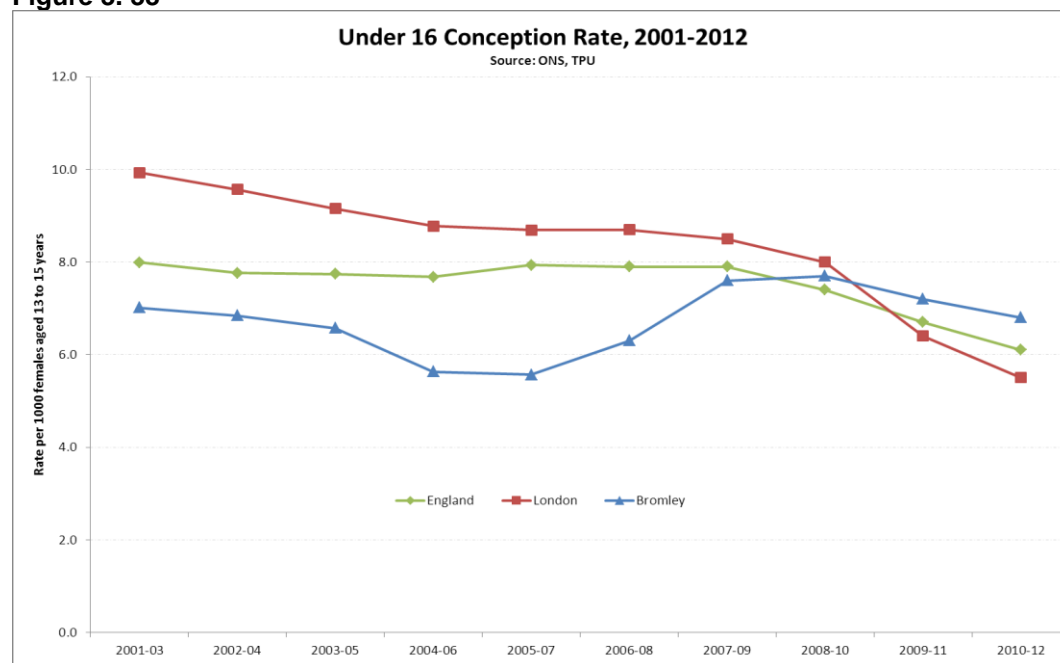
In 2012 there were 137 conceptions in females aged between 15 and 17 years. This represents a rate of 24.2 per 1000 female population aged 15 to 17 years, which is lower than both the London rate (25.87) and the England rate (27.75). There has been a 25% reduction in the under 18 conception rate since 1998.

Figure 3. 37



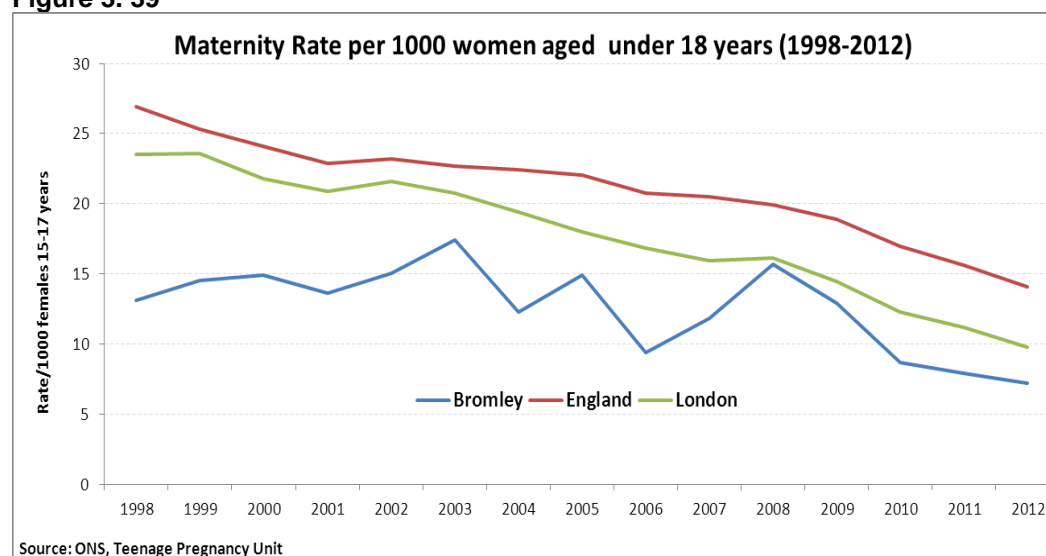
Over the three years between 2010 and 2012, there were 113 conceptions in females aged 13 to 15 years which represents a rate of 6.8 per 1000 female population aged 13 to 15 years. The Bromley rate is higher than the London and England rates (5.5 and 6.1 respectively). In recent years the under 16 conception rate in Bromley has been decreasing as shown in **Figure 3.38**.

Figure 3. 38



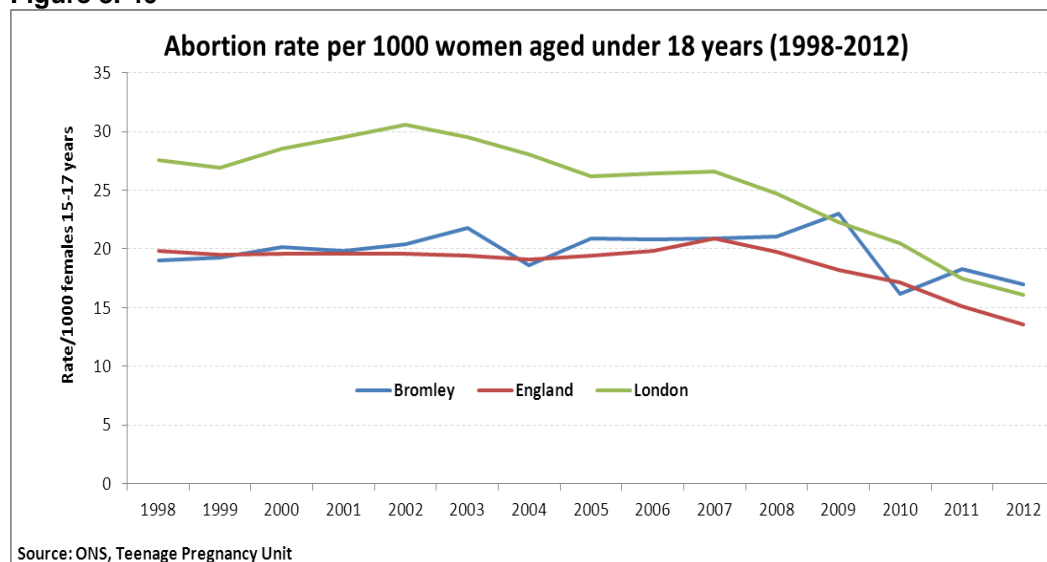
Maternity rate is defined as the number of all births (live and still births) per 1000 women. The maternity rate in women under the age of 18 years has been falling since 2008.

Figure 3. 39

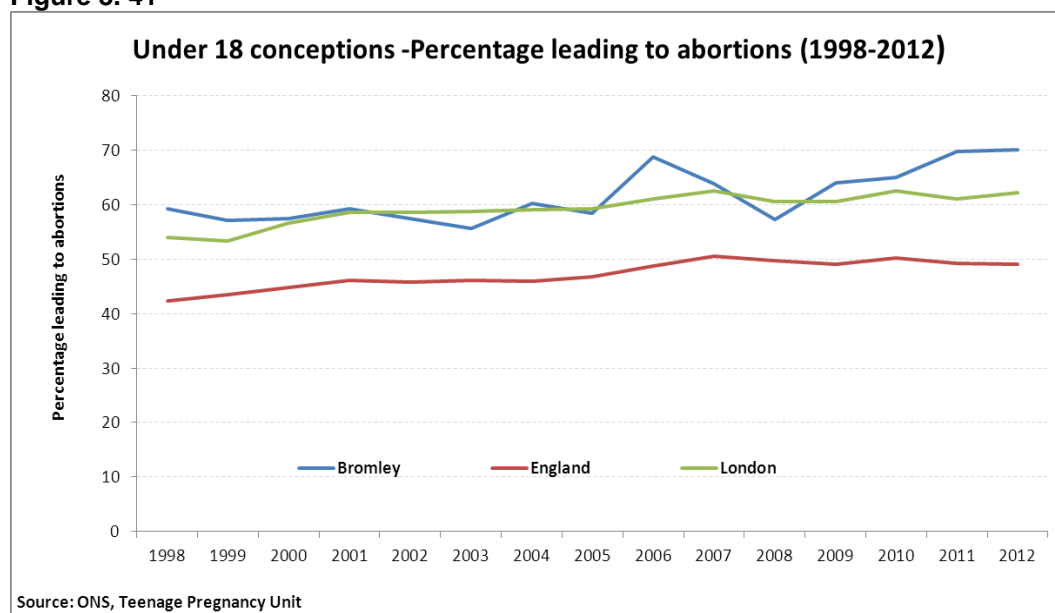


The recent data (2012) on rates of abortion in Bromley shows that the rate is higher (17 per 1000 population) than both England (13.6 per 1000 population) and London (16.1 per 1000 population). However the trends are declining as illustrated in **Figure 3.40**, in line with the conception rates.

Figure 3. 40



Of the 137 under 18 conceptions in 2012, 104 (70%) resulted in a termination of pregnancy putting Bromley at the third highest rate among London Boroughs. This is significantly higher than both England (49.1%) and London (62.2%). Although Bromley has a lower conception rate than the London and England averages, the three year rolling averages from the 1998 baseline show that the proportions of teenage conceptions leading to terminations are increasing in Bromley as shown in **Figure 3.41**. The proportion of all teenage conceptions leading to abortions has increased by 18% since the 1998 baseline, higher than London and England at 15% and 16% respectively.

Figure 3. 41

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

Teenage conception rates are falling in Bromley , however a higher percentage of these conceptions lead to terminations year on year. This upward trend of terminations is clearly an indication of unplanned or unwanted pregnancies.

It is therefore important to understand the contraception service needs of teenagers in the borough by evaluating the impact of the following provision with a view to establishing whether these have made a difference in avoiding unwanted teenage pregnancies:

- Use of condoms
- Long-acting Reversible Contraception (LARC) methods
- Sex and Relationship Education (SRE) programmes in schools and FE Colleges

Sexually Transmitted infections

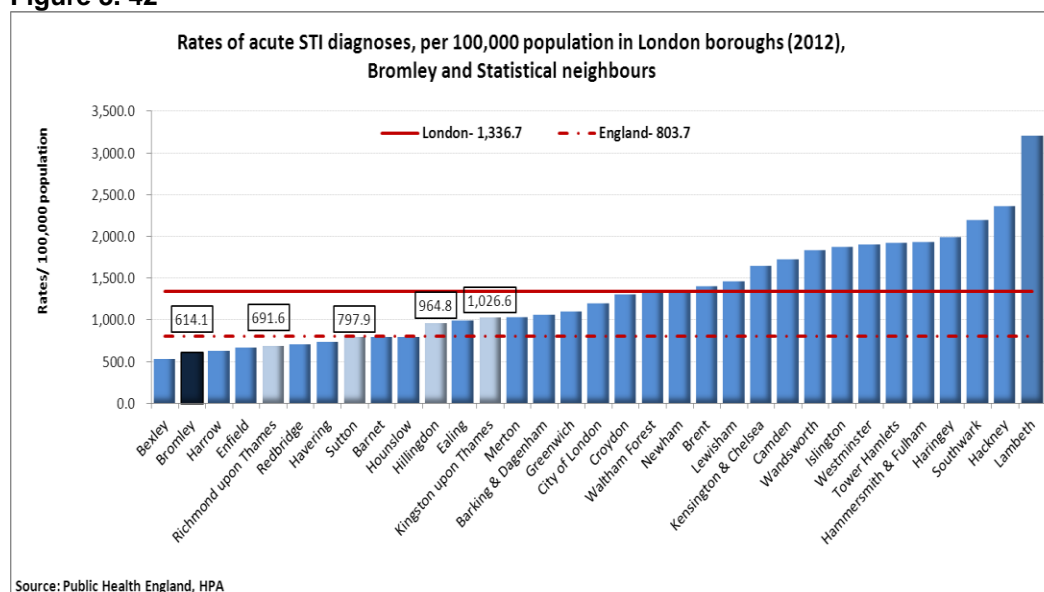
The rate of sexually transmitted infections (STIs) in Bromley in 2012 (614.1 per 100,000 population) is significantly lower than the London rate (1336.7) and the England rate (803.7).

Table 3. 17

Sexually Transmitted Infections	Rates of diagnoses per 100,000 population 2012		
	Bromley	London	England
Gonorrhoea	38.3	129.8	45.9
Herpes	62.5	91.4	58.4
Syphilis	2.6	17.0	5.4
Warts	118.5	167.9	134.6
Chlamydia (15-24)	1299.8	2159.1	1979.1
Chlamydia (25+)	79.8	325.0	160.0
All Chlamydia	201.9	512.2	371.6
All Acute STIs*	614.1	1336.7	803.7
Source: Public Health England, HPA			
*All Acute STIs includes Acute HIV infection			

The prevalence of STIs in Bromley is the second lowest among London Boroughs as shown in **Figure 3.42**. This overall low prevalence masks variations across the borough, where some areas have markedly high STI rates; HIV in the North West spur of the borough.

Rates of STIs overall have been increasing since 2009 although they remain lower than the rates for both London and England. The increase could be a result of improved reporting and not increasing incidence. However it is not possible to compare 2012 data with the previous years due to changes in the data collection and analysis methodology.

Figure 3. 42

Chlamydia

The Public Health Outcomes Framework includes an indicator to assess progress in controlling chlamydia in sexually active young adults under 25 years of age: the annual diagnostic rate amongst the resident 15-24 years of age population. The diagnosis rate reflects both National Chlamydia Screening Programme (NCSP) coverage and the proportion testing positive at all sites, including Genitourinary Medicine (GUM) diagnoses as well as those made outside GUM.

Since Chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. PHE recommends that local areas aim to achieve ;

- a rate of at least 2,300 per 100,000 resident 15-24 year olds,
- aim to screen 25% or more of the cohort, and
- maintain a positive diagnosis rate between 5%- 12% a level which is expected to produce falls in chlamydia prevalence.

Areas already achieving this rate should aim to maintain or increase it, other areas should work towards it. Such a level can only be achieved through the ongoing commissioning of high-volume, good quality screening services across primary care and sexual health services.

The chlamydia diagnosis rate in 15-24 year olds in Bromley in 2012 was 1,299.8 per 100,000, 20% of 15-24 year olds were tested for chlamydia with a 6.8% positivity rate. Nationally, 25.8% of 15-24 year olds were tested for

Chlamydia with a 7.7% positivity rate. The number of tests, annual coverage and positivity, and the diagnosis rate per 100,000 and the rank in London region and England are shown in **Table 3.18** and **Figure 3.43**.

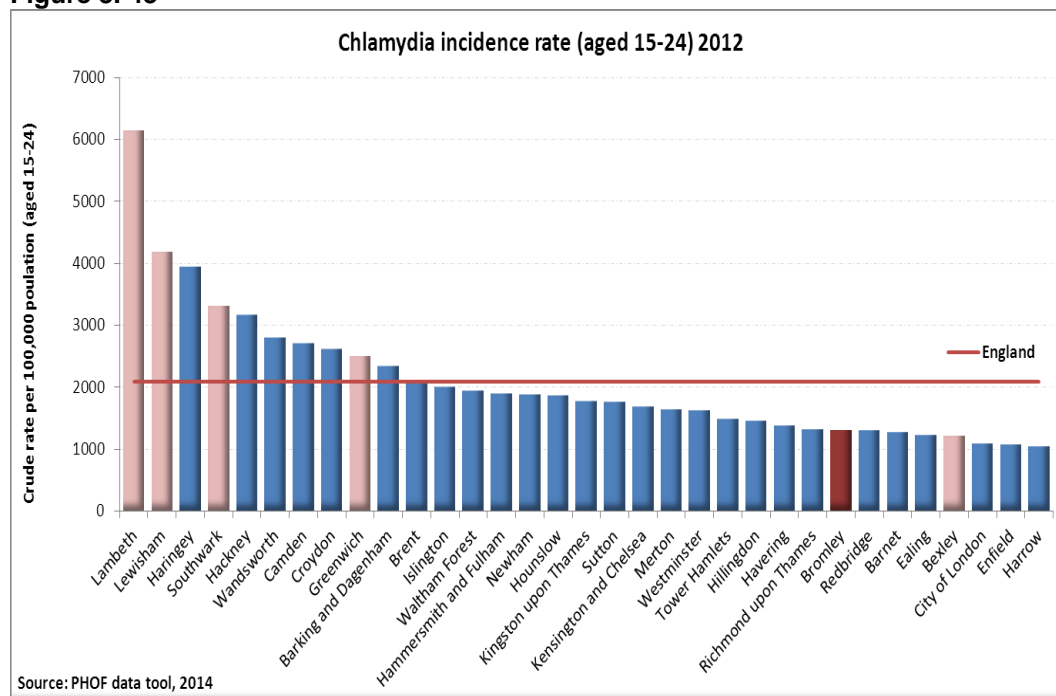
The prevalence rate in Bromley is known to be below national average, therefore irrespective of the level of investment it is not feasible to try to achieve the recommended diagnosis rate. However, what is important is that the programme maintains an adequate positivity rate so Bromley will focus on maintaining the current positivity rate of 6.8% with an aspiration to achieve a higher rate.

Table 3. 18

	Number of tests			Number of positives (all settings)	%age of population tested (all settings)	Rate of diagnosis (per 100,000)
	In other settings	in GUM	TOTAL			
Bexley	2,821	1,709	4,530	373	14.70	1,208
Bromley	4,578	2,277	6,855	447	19.90	1,300
Greenwich	10,399	2,203	12,602	896	35.10	2,497
Lambeth	18,667	5,086	23,753	2,460	59.20	6,132
Lewisham	15,037	1,612	16,649	1,536	45.30	4,179
Southwark	10,115	5,821	15,936	1,409	37.40	3,306
London	186,584	122,704	309,288	23,639	28.2	2,159
England	1,253,752	528,370	1,782,122	136,961	25.8	1,979

Source: PHE, 2013

Figure 3. 43

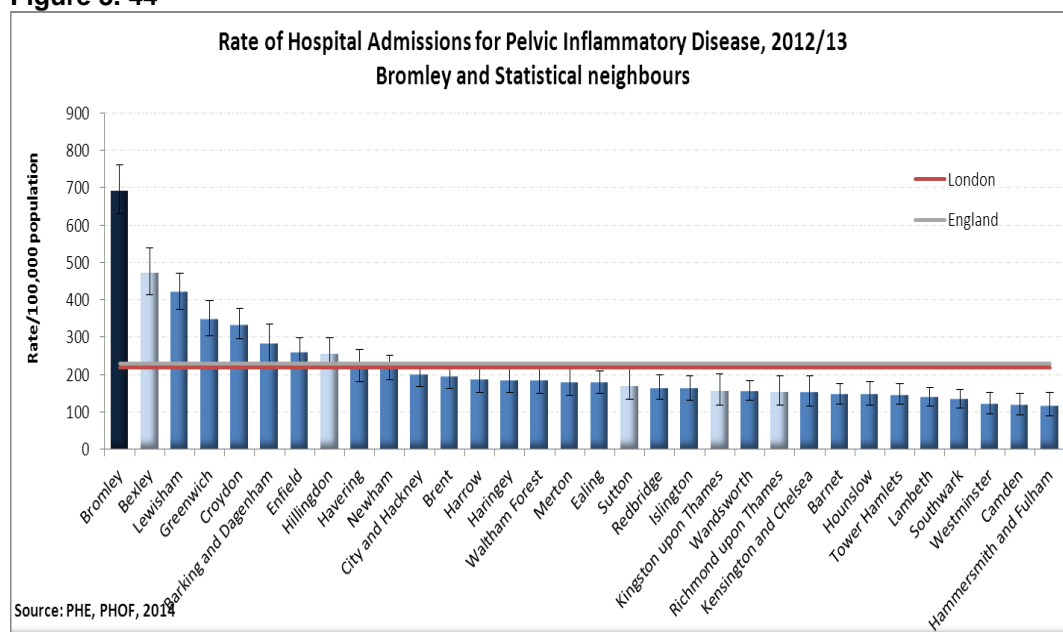


Pelvic Inflammatory Disease

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

Bromley has a high rate of hospital admissions with any mention of pelvic inflammatory disease in women aged 15 to 44 years in 2012/13 (693.9 per 100,000 population) as compared with the London rate (217.6) and the England rate (228.3). This high rate in Bromley was noted in last year's JSNA and initial investigation indicated that this could be a coding issue that led to the uncharacteristically high rate in Bromley. This has now been escalated to the Health Protection Team in PH England who have undertaken to look into the potential cause of this anomaly.

Figure 3. 44



What does this mean for Bromley residents

The high positivity rate within the Chlamydia screening programme indicates that testing is being targeted appropriately. However we have still to see whether this will result in reduction in the Pelvic Inflammatory Disease rate in the longer term, if the high rate is attributed to factors other than coding.

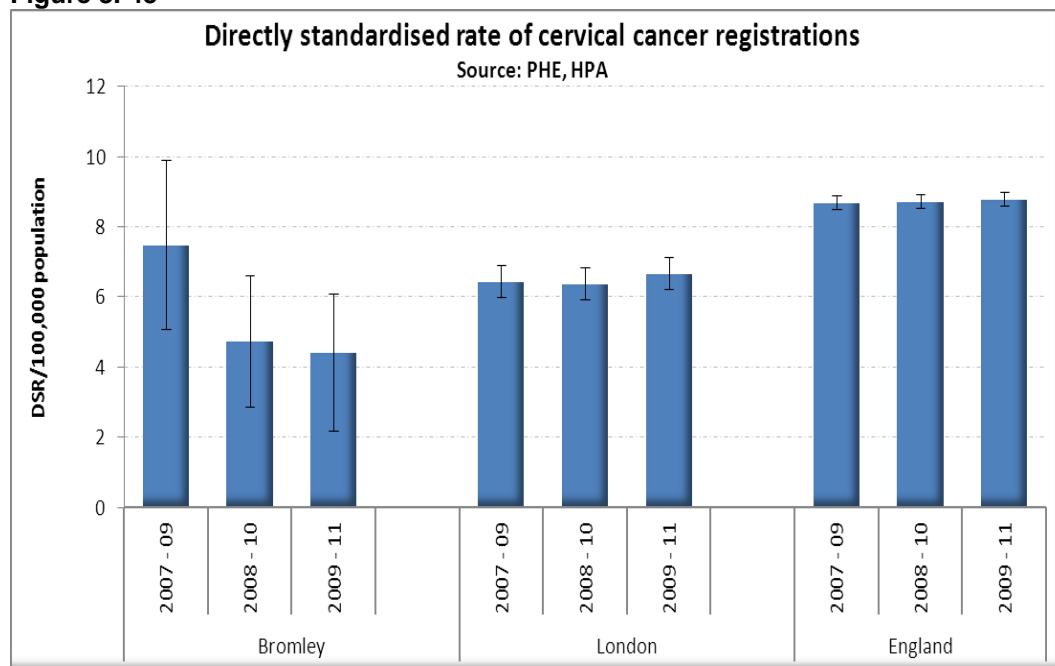
Cervical Cancer

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

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

The rate of cervical cancer registration in Bromley is (4.42 per 100,000) lower than London and England at 6.67 per 100,000 and 8.79 per 100,000 population respectively. **Figure 3.45** shows a downward trend in registrations of cervical cancer; indicative of the combined effect of various interventions.

Figure 3. 45



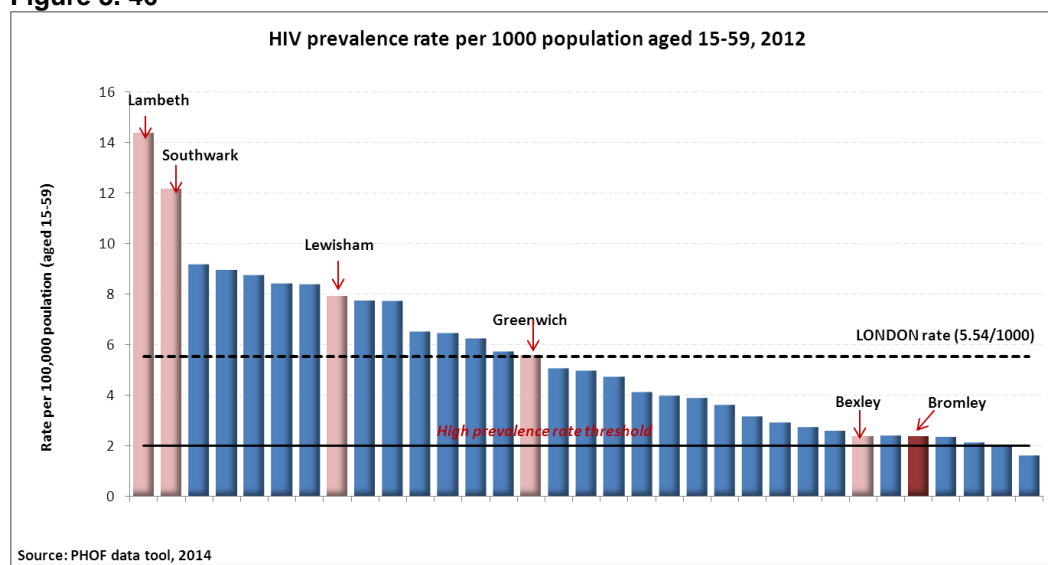
Human Papilloma Virus vaccination consisting of three injections over 12 months is given to 12-13 year old girls, largely through secondary schools. Research has shown that the HPV vaccine provides effective protection against cervical cancer for at least 20 years which should cover the irregularity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

In Bromley, 83.9% of year eight girls were vaccinated in 2012/13 by their 12th - 13th birthday, a rate higher than London at 78.9% but lower than England at 86.1%.

HIV

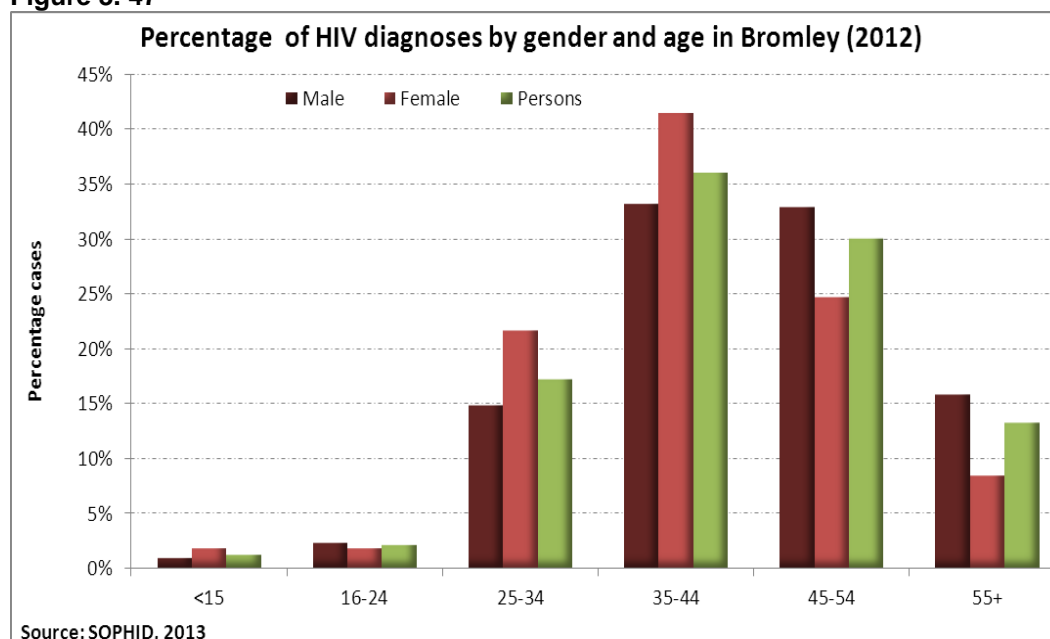
In 2012, the age-specific prevalence rate for Bromley residents was 2.38 per 1000 population aged 15-59 years - higher than the prevalence across England (2.05). Although the rate is significantly lower than the prevalence for London (5.54) and is one of the lowest rates in the region, an age-specific prevalence rate of 2 per 1,000 population (aged 15-59) or higher denotes a high prevalence area. In these high prevalence areas it is recommended that routine HIV testing is implemented for all general medical admissions as well as new registrants to primary care⁴. It is the commissioner's view that the recommendation of **routine** HIV testing for all general medical admissions would be excessive for Bromley which has an overall prevalence rate of just over 2 per 1000. However, investments should continue to be made to target areas with a higher prevalence rate, to increase awareness and encourage testing in both these settings.

Figure 3. 46

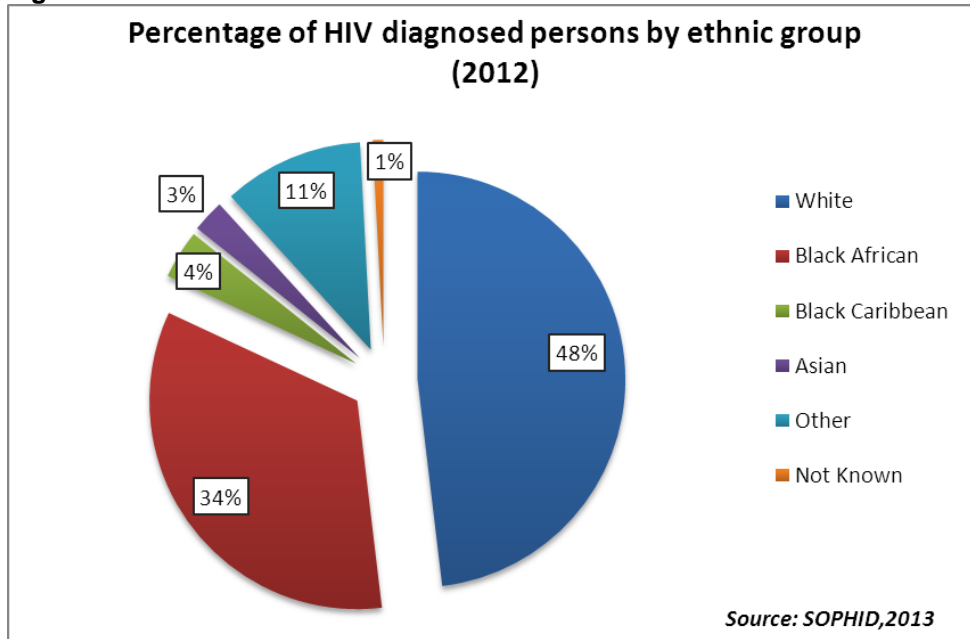


The majority of the diagnoses in 2012 were men (65%, 310) as shown in **Figure 3.47**. The biggest contribution to HIV diagnoses in Bromley is from people aged 35-44 years (172, 36%) and aged 45-54 (143, 30%).

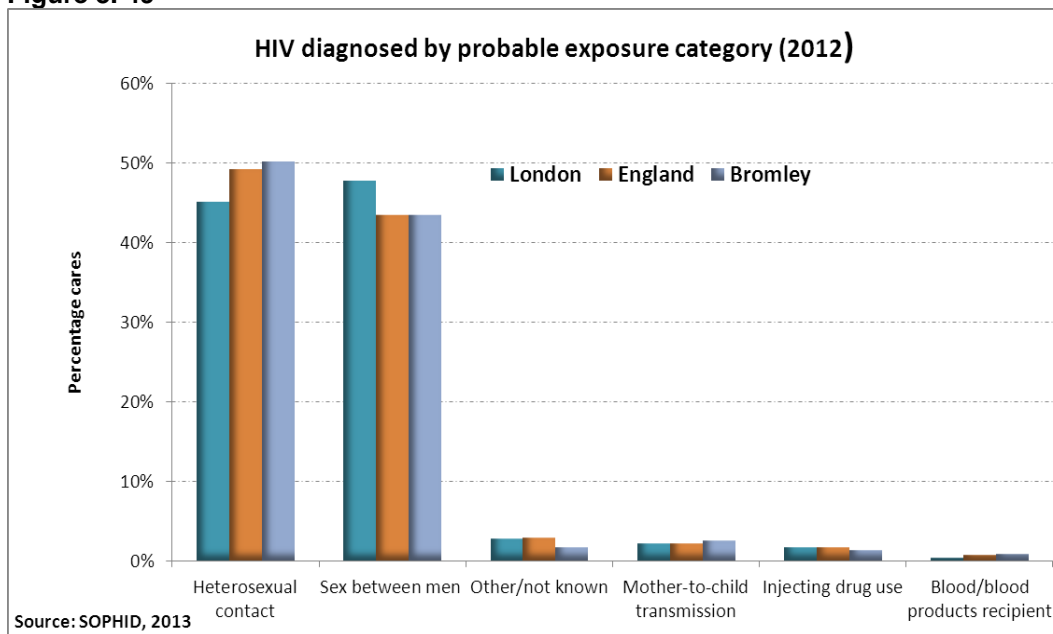
⁴ http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1221722386448

Figure 3. 47

Data analysis by ethnicity shows that two ethnic groups contribute the majority of known HIV infections diagnosed in Bromley - White (229) and Black African (161) as shown in **Figure 3.48**. HIV infection is most prevalent in White and Black African ethnic groups; this not only reflects the ethnic makeup of the population of Bromley but also routes of infection of HIV, with those whose probable route of infection was men who have sex with men (MSM) more likely to be White and those acquiring HIV through heterosexual contact more likely to be Black African. Analysis shows that 89% of the 229 infections in the White ethnic group were in males whilst in Black African ethnic group, 63% of the 161 infections were in females.

Figure 3. 48

The most common probable routes of HIV transmission the world over are heterosexual intercourse and men who have sex with men (MSM). In Bromley, heterosexual contact accounts for the largest proportion (239, 50%) of residents diagnosed with HIV and are accessing care. This is higher than London at 45% but similar to England at 49%. MSM account for a significant proportion (43%, 207) of HIV diagnoses in Bromley, lower than London but similar to England as shown in **Figure 3.49**.

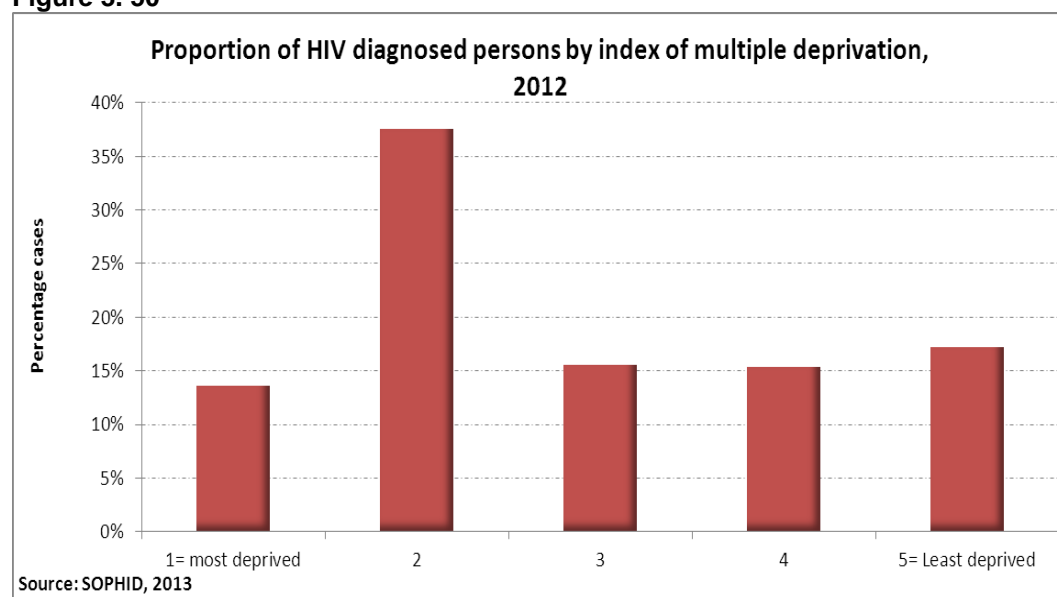
Figure 3. 49

Although HIV transmission from mother to child makes up only a small proportion (3%) of all transmissions, the rate is higher in Bromley than London and England. Mother to child transmission is the third highest route of transmission in Bromley. It is important therefore to encourage HIV infection awareness, early diagnosis and early antenatal booking for all women, but particularly in groups where the prevalence is higher i.e. in the North West of the Borough and amongst the Black African Population.

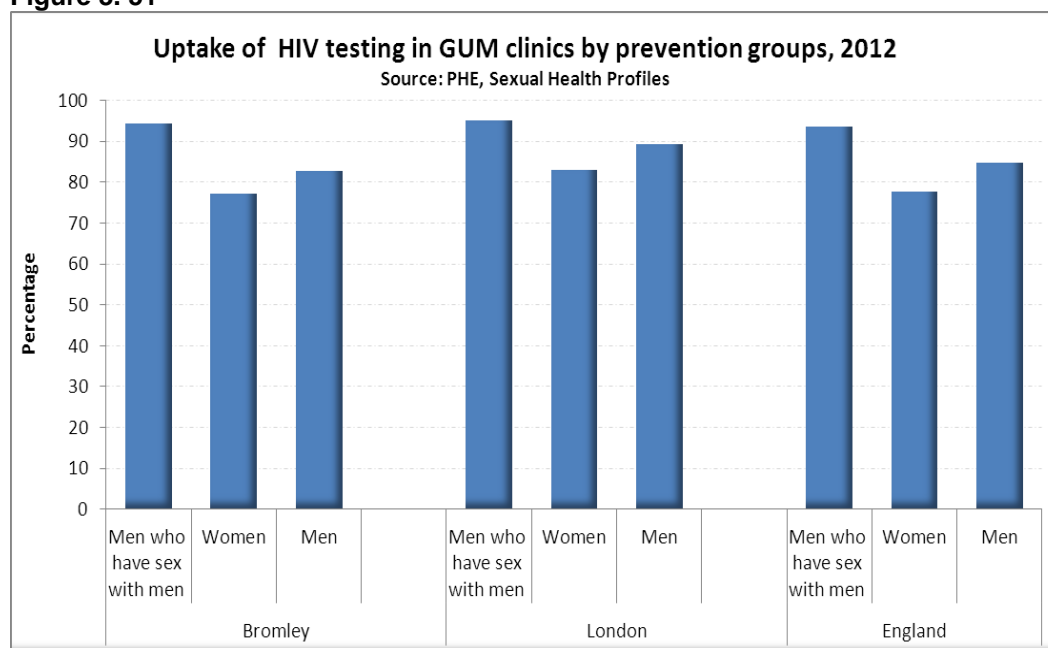
This has implications for HIV infection awareness, early diagnosis and early access to HIV care in Black African women.

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

Figure 3. 50



Uptake of HIV testing in GUM clinics in Bromley (80%) is comparable to the level for England (81%), but lower than the rate for London (86%). Uptake of HIV testing in prevention groups is higher in men who have sex with men in Bromley, similar across London and England.

Figure 3. 51

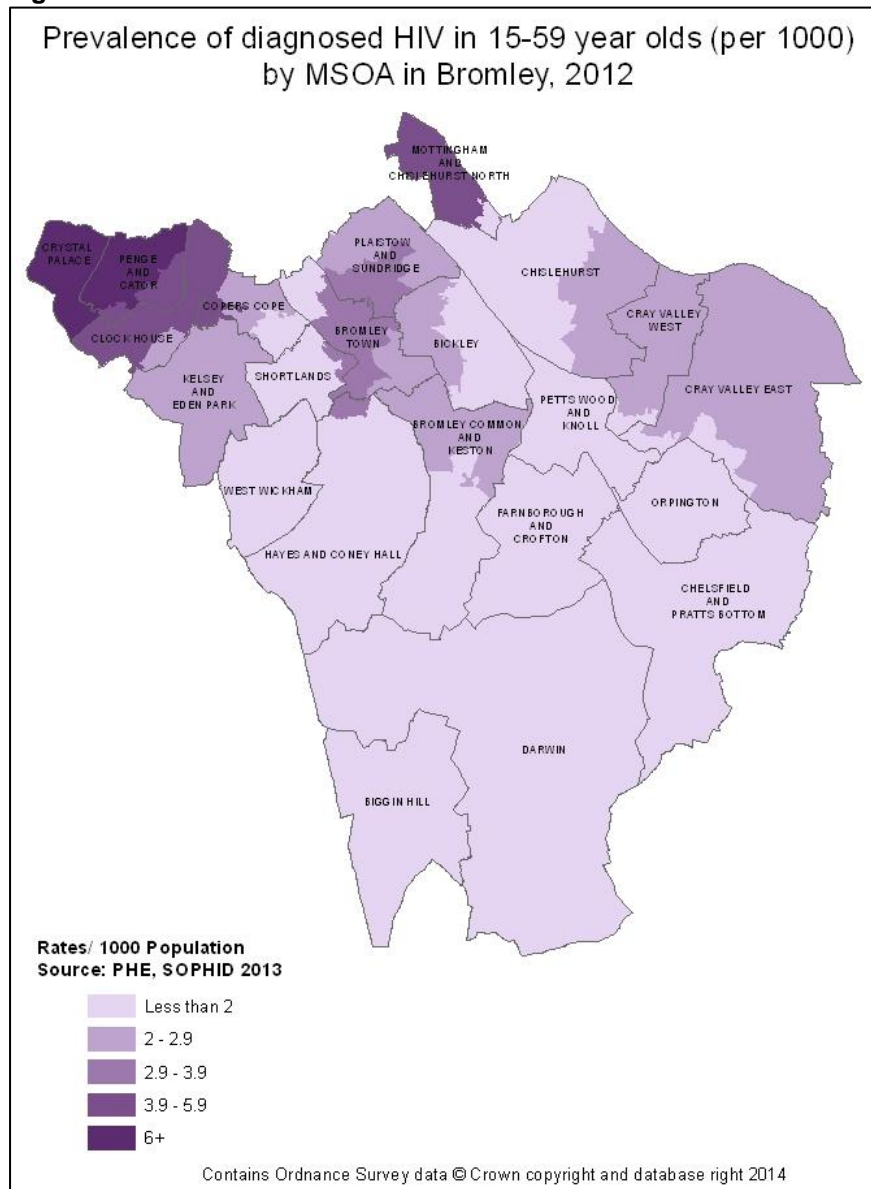
Prevention Groups

HIV and STIs are not uniformly distributed in the UK population. There are population groups at particular risk of acquiring HIV and STIs, these are populations that require targeted prevention. The prevention groups include: young adults, men who have sex with men, people who inject drugs, Black African and Black Caribbean people, pregnant women and healthcare workers.

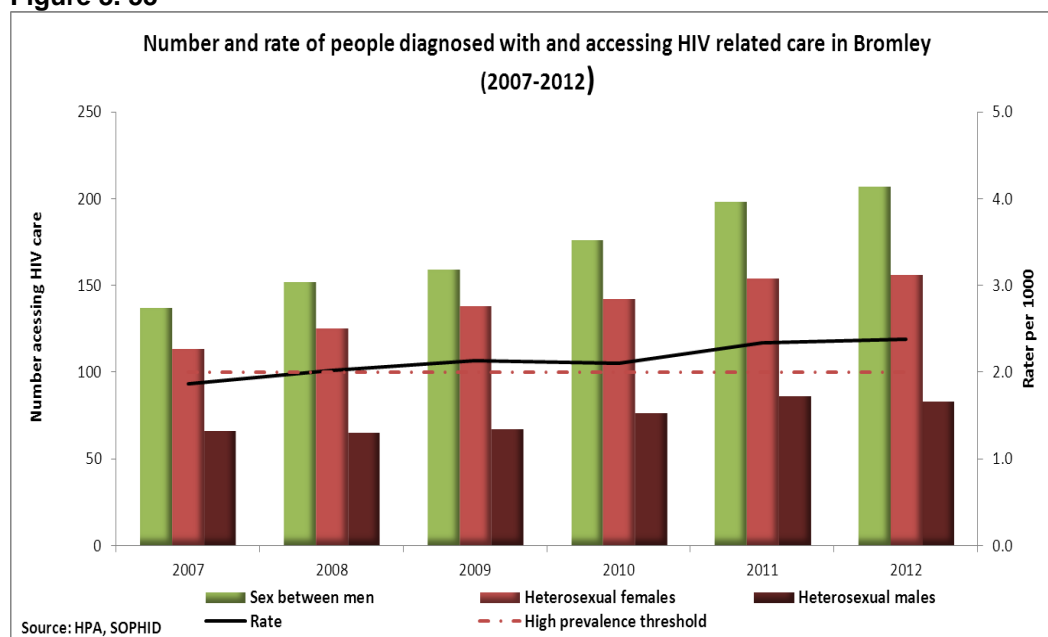
The proportion of late diagnoses of HIV for the period 2010-12 is higher in Bromley (46.7%) than for London (44.9%) but lower than for England (48.3%). This is important as people living with diagnosed HIV can expect a near-normal life expectancy, provided they are diagnosed early in the course of their infection. Late presenters (those diagnosed with a CD4 <350 – below the threshold at which treatment should have begun) carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed promptly. Remaining undiagnosed also carries a greater risk of onward transmission.

Although overall the prevalence of HIV in Bromley is just above the 2 per 1000 threshold, the overall low prevalence masks local variation with high rates of up to 8 per 1000 population in places.

The highest rates of HIV in Bromley (8 per 1000) are found in the North-West spur of the borough. Prevalence rates of higher than 2 per 1000 occur in half of middle layer super output areas (MSOAs) in Bromley.

Figure 3. 52

The rate and number of people diagnosed with and accessing HIV related care in Bromley is rising year on year, especially in men who have sex with men and heterosexual females (**Figure 3.53**). The upward trend is likely due to a combination of factors- increased testing, improved recording and increasing incidence.

Figure 3. 53**Table 3. 19: Sexual Health Related PHOF Indicators**

Indicator	Sex	Age	Time Period	Bromley	London	England
2.04 - Under 18 conceptions	Female	<18 yrs	1998	32.09	51.05	46.64
2.04 - Under 18 conceptions	Female	<18 yrs	1999	33.78	50.51	44.75
2.04 - Under 18 conceptions	Female	<18 yrs	2000	35.10	50.36	43.64
2.04 - Under 18 conceptions	Female	<18 yrs	2001	33.48	50.35	42.48
2.04 - Under 18 conceptions	Female	<18 yrs	2002	35.42	52.14	42.76
2.04 - Under 18 conceptions	Female	<18 yrs	2003	39.21	50.31	42.12
2.04 - Under 18 conceptions	Female	<18 yrs	2004	30.86	47.48	41.60
2.04 - Under 18 conceptions	Female	<18 yrs	2005	35.83	44.16	41.43
2.04 - Under 18 conceptions	Female	<18 yrs	2006	30.19	43.26	40.59
2.04 - Under 18 conceptions	Female	<18 yrs	2007	32.73	42.58	41.38
2.04 - Under 18 conceptions	Female	<18 yrs	2008	36.79	40.83	39.67
2.04 - Under 18 conceptions	Female	<18 yrs	2009	35.98	36.75	37.11
2.04 - Under 18 conceptions	Female	<18 yrs	2010	24.90	32.83	34.17
2.04 - Under 18 conceptions	Female	<18 yrs	2011	26.29	28.74	30.70
2.04 - Under 18 conceptions: conceptions in those aged under 16	Female	<16 yrs	2009	7.70	7.20	7.25
2.04 - Under 18 conceptions: conceptions in those aged under 16	Female	<16 yrs	2010	6.27	6.36	6.71
2.04 - Under 18 conceptions: conceptions in those aged under 16	Female	<16 yrs	2011	7.69	5.70	6.08
3.02i - Chlamydia diagnoses (15-24 year olds) - Old NCSP data	Persons	15-24 yrs	2010	1844.35	2565.76	2220.37
3.02i - Chlamydia diagnoses (15-24 year olds) - Old NCSP data	Persons	15-24 yrs	2011	1778.80	2496.21	2124.64
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	Female	15-24 yrs	2012	1602.04		2568.39
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	Persons	15-24 yrs	2012	1299.83		1979.05
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	Male	15-24 yrs	2012	984.79		1367.68
3.04 - People presenting with HIV at a late stage of infection	Persons	15+ yrs	2009 - 11	42.68	46.87	49.99
3.04 - People presenting with HIV at a late stage of infection	Persons	15+ yrs	2010 - 12	46.74	44.89	48.26

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

What this means for the JSNA

There is a steady increase in the HIV prevalence rate. While the overall HIV prevalence rate in Bromley remains at just above 2 per 1000 threshold, there are areas in Bromley where the prevalence rate has risen from 6 per 1000 population to 8 per 1000 population.

It is understood that migration from neighbouring boroughs is a contributing factor to the steady increase, further work is required to understand and ascertain if there are other contributing factors that require a particular approach to tackling the rise.

While early testing using Point of Care Testing in acceptable settings has been commissioned, the following further work is also required and strategies developed to address the rising trend in Bromley:

- address perception of risk and transmission awareness with a view to increase the overall likelihood of actively seeking testing especially among those at-risk females.
- understand which communities are more likely to confront stigma as a result of having a HIV test.

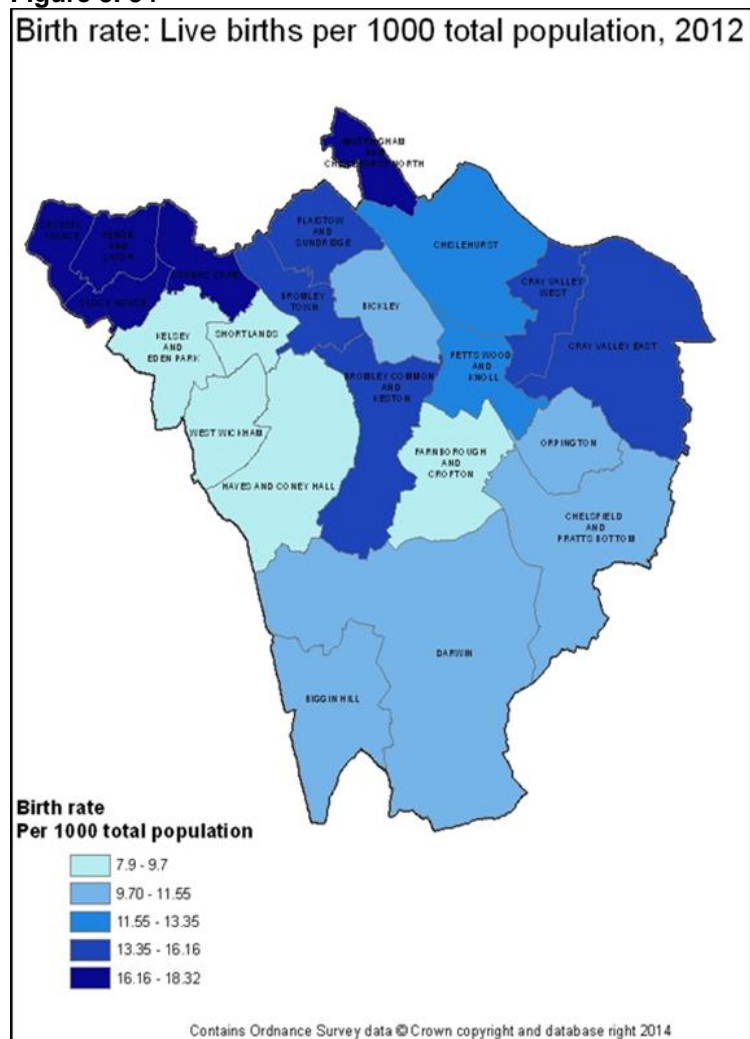
For more information on Sexual Health please contact Mimi.Morris-Cotterill@Bromley.gov.uk

Pregnancy and Maternity

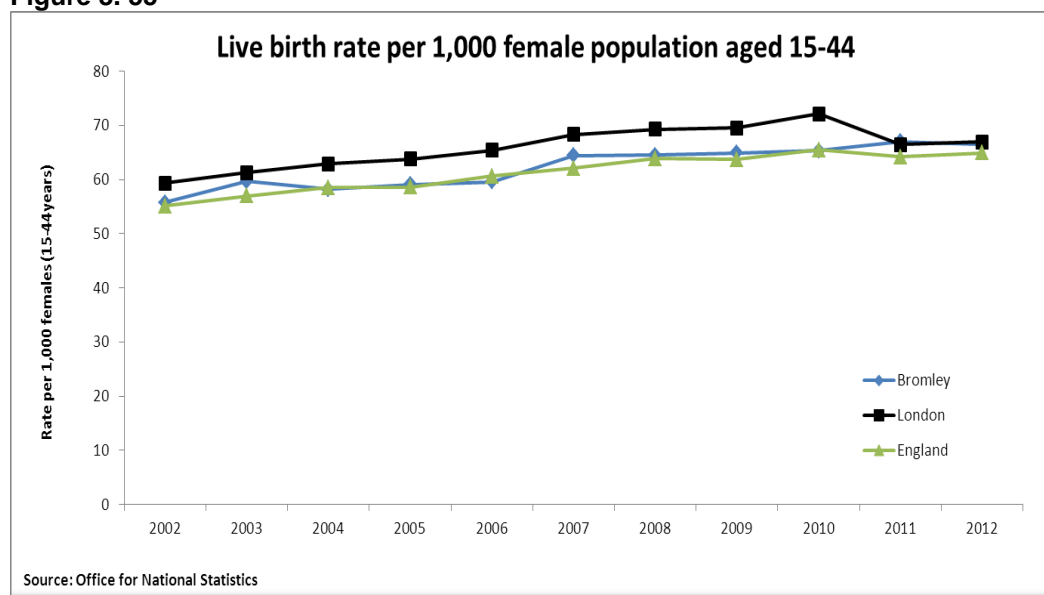
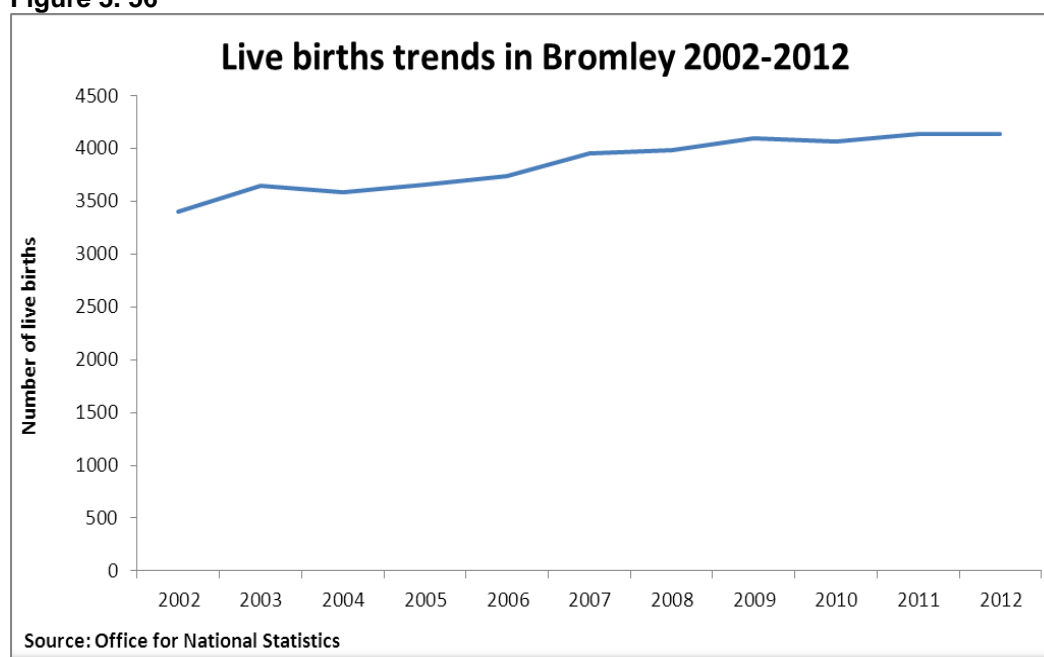
The live birth rate in Bromley is 13.38 per 1000 total population. This is lower than the London rate (16.4 per 1000), but higher than the England rate (13 per 1000).

The live birth rate in Bromley has been rising since 2002, with the highest rates in Mottingham & Chislehurst North and Clock House wards. The number of births in Bromley has risen from 3500 in 2002, to over 4000 in 2102.

Figure 3. 54



Source: Public Health Birth Files (ONS)

Figure 3. 55**Figure 3. 56**

The proportion of births in older mothers (aged 35 to 39 years) in Bromley is higher than that for London and for England. In 2012, 81% of births were to mothers in Bromley aged 25 to 39 years as compared with 79% in London and 73% across England (**Figure 3.57**).

Age specific birth rates confirm the increased birth rates particularly in the 30 to 34 year age group in Bromley (**Figure 3.58**). It is important, therefore, that

reproductive healthcare services (contraception, termination and maternity care) address the need associated with this trend towards older motherhood.

Figure 3. 57

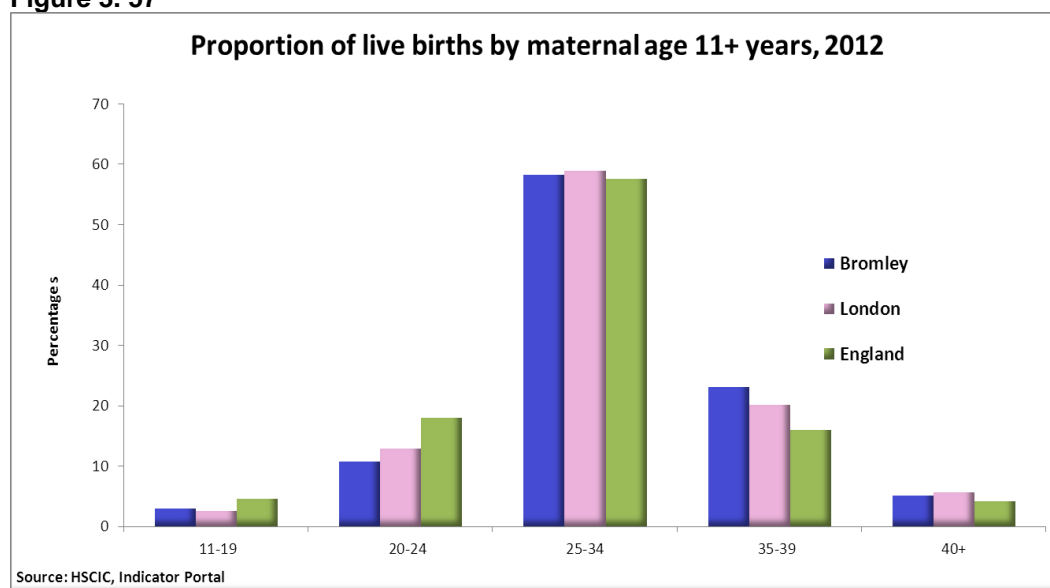
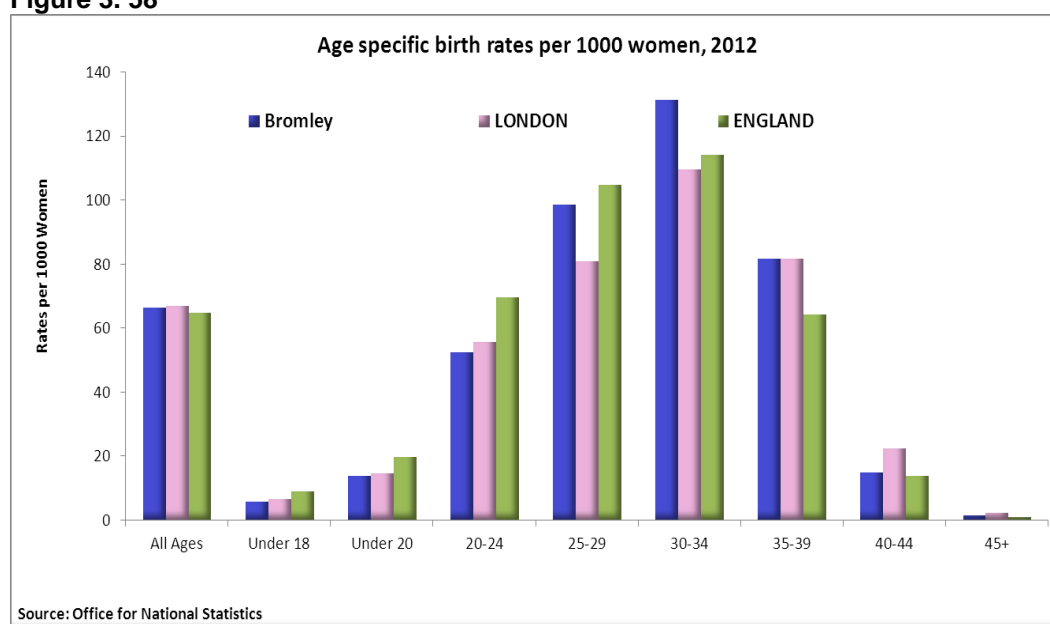
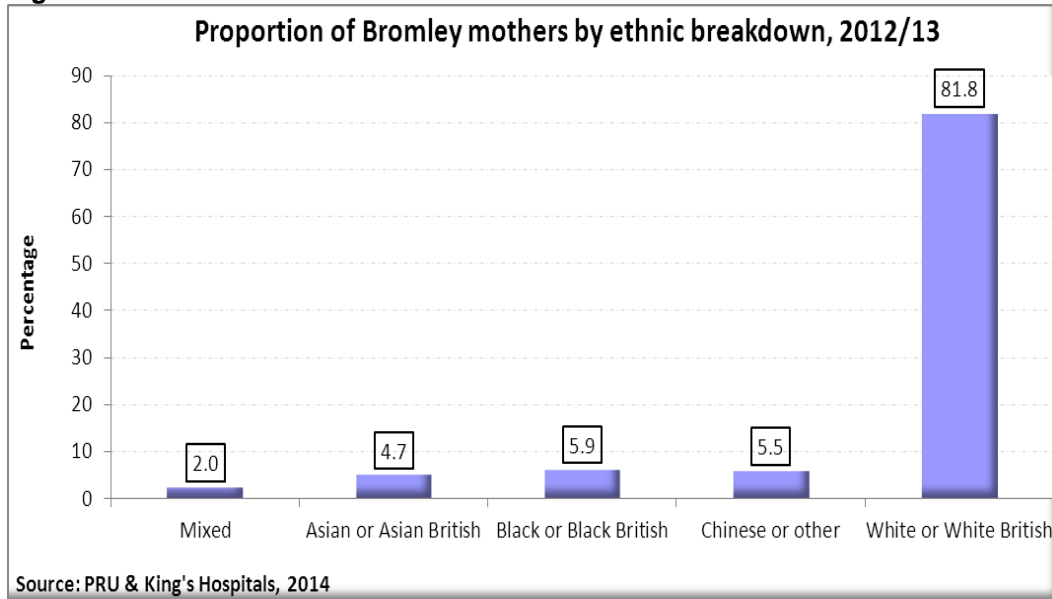


Figure 3. 58



Local data from the Princess Royal University Hospital (PRUH) and King's College Hospital (KCH) gives more detail for the 85% of Bromley resident mothers who received care at these sites in 2012.

This shows that of the 67% of women whose ethnicity was recorded, the majority were White, reflecting the ethnic make-up of the borough.

Figure 3. 59

Parity is defined as the number of times a woman has given birth with a gestational age of 24 weeks or more, regardless of whether the child was born alive or was stillborn.

Three out of five of all women who gave birth in 2012/2013 were first time mothers. One out of four already had a child. Approximately 15% of mothers had two or more children.

Figure 3. 60

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

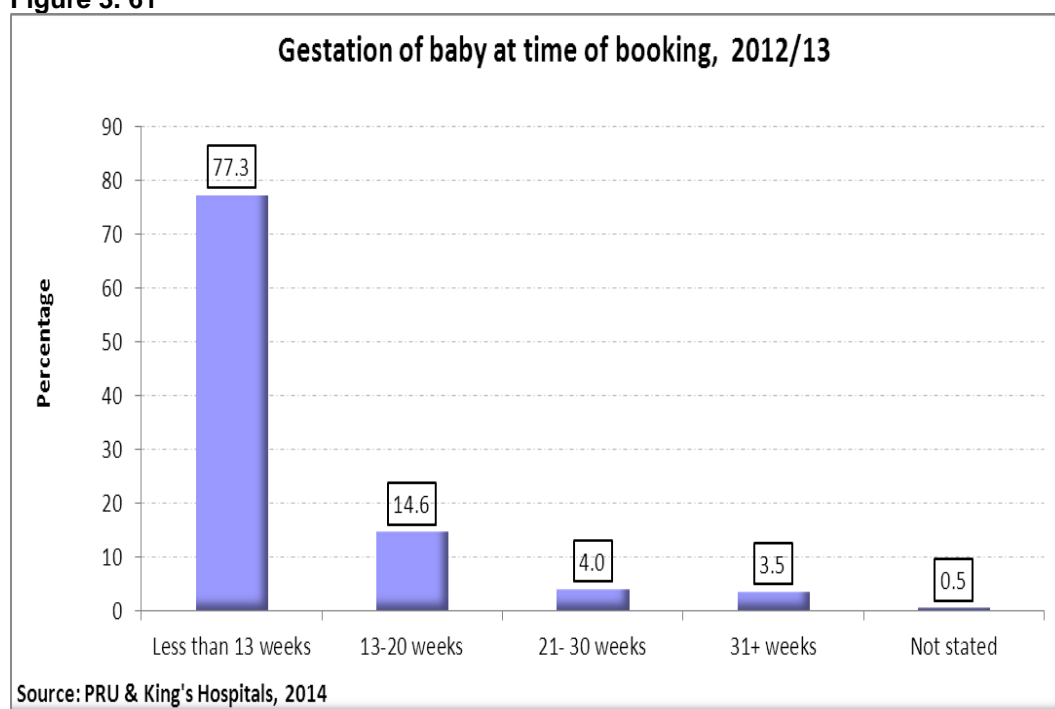
The national antenatal screening policy recommends that screening be done in early pregnancy to look for abnormalities in the unborn child and to identify any maternal health problems.

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

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

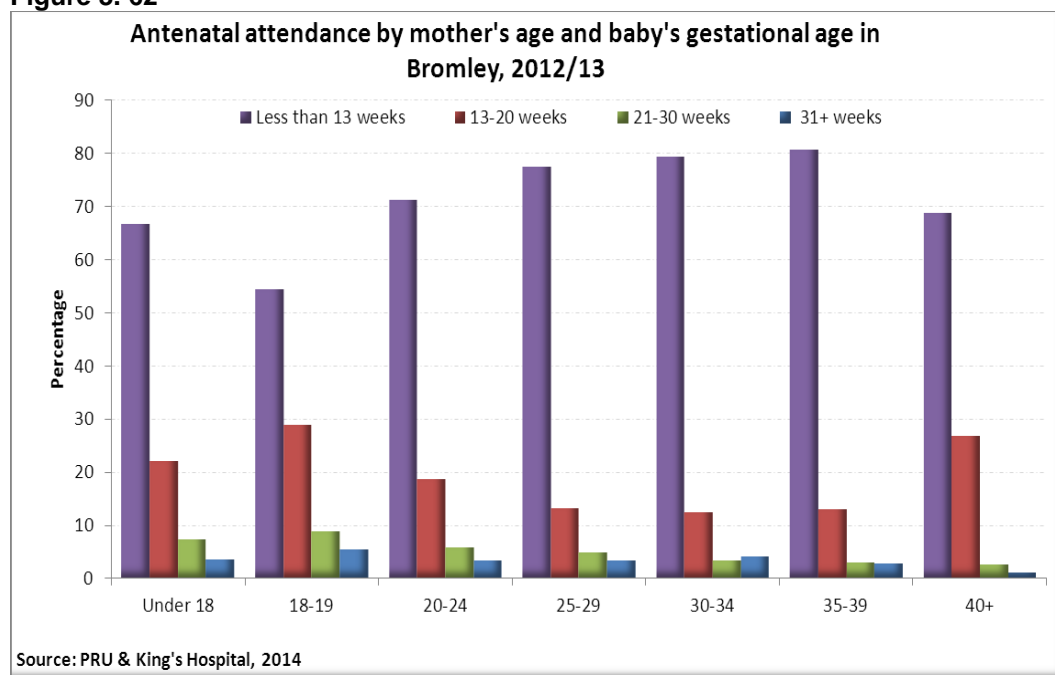
According to local data, 77% of Bromley women booked for antenatal care before 13 weeks of pregnancy in 2012/13 which is below the 90% national target. However national data shows 89.7% of Bromley mothers booked before 13 weeks of pregnancy (CHIMAT, Q3- 2012/13). The data from the hospitals may be an underestimate for a number of reasons, such as not recording when a woman moves her care to Kings or PRUH but has previously booked for maternity care elsewhere.

Figure 3. 61



The age of the mother seems to influence the time of booking. Mothers aged 18-19 years tend to book for antenatal care later than 13 weeks gestation, with more than half booking after 13 weeks gestation in 2012/13 in Bromley. Over three quarters of women aged 25 years and above booked before their 13th week gestational age (**Figure 3.62**).

Figure 3. 62



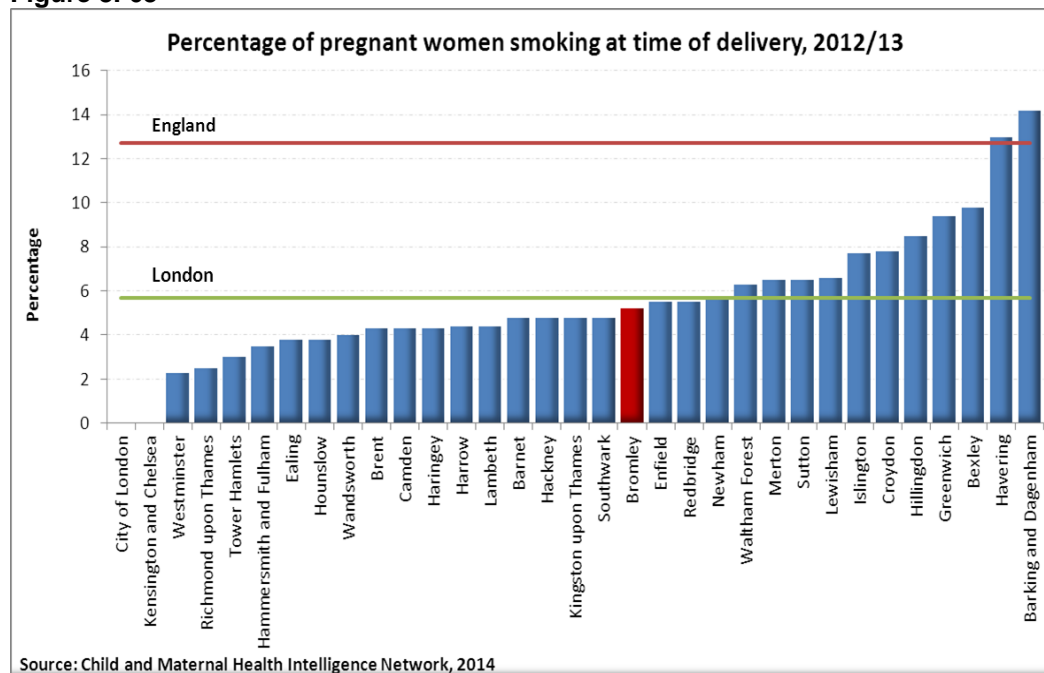
Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. Smokers can have an increased risk of negative pregnancy outcomes including miscarriage, preterm birth, low birth weight and stillbirth. Smoking has been linked to sudden infant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

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

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

National benchmarking data shows smoking rates at time of delivery in Bromley (5.2%) are below London (5.7%) and England (12.7%) averages. Although the proportions are low, work is needed to further drive down the rates in line with national trends which are also decreasing (**Figure 3.63**).

Figure 3. 63



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

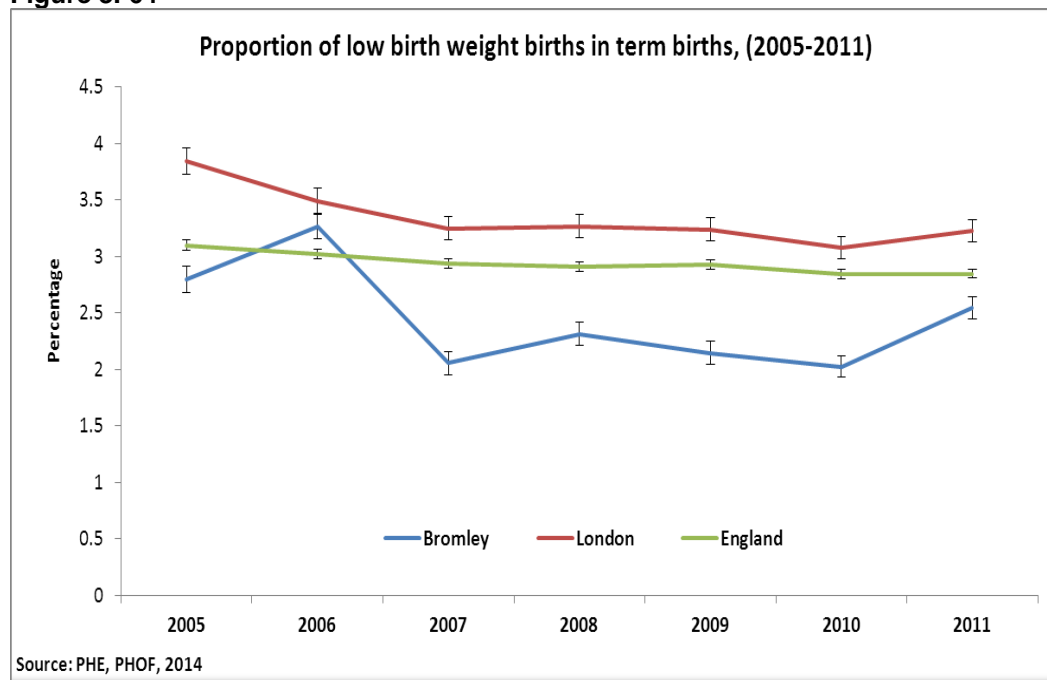
The Public Health Outcomes Framework indicator measures low birth weight in term babies, which is live births with a recorded birth weight under 2500g of term babies (babies born after 37 weeks).

About 100 full term babies were born weighing less than 2,500 grams in Bromley in 2011. The rates, (2.5%) although affected by random variation due to small numbers, are consistently significantly lower than both London (3.2%) and England (2.85%) (**Figure 3.64**).

Analysis of local data shows that 11% of babies are classified as large for gestational age (LGA) at more than 4,000 grams. LGA babies are also at great risk of perinatal morbidity and mortality. Some of the risk factors for LGA are:

poorly controlled diabetes particularly gestational diabetes, pre-existing diabetes mellitus and excessive weight gain in pregnancy.

Figure 3. 64



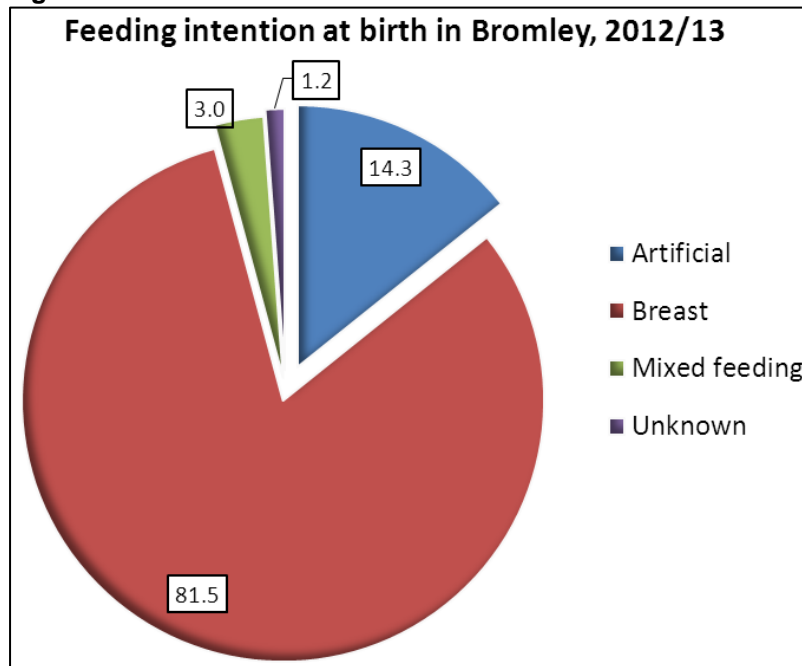
Breastfeeding is recognised as promoting health and preventing ill health in the short and long-term for both baby and mother.

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

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

Over 80% of women intended to breastfeed at birth in Bromley, either exclusively or with supplement in 2012/13 (**Figure 3.65**).

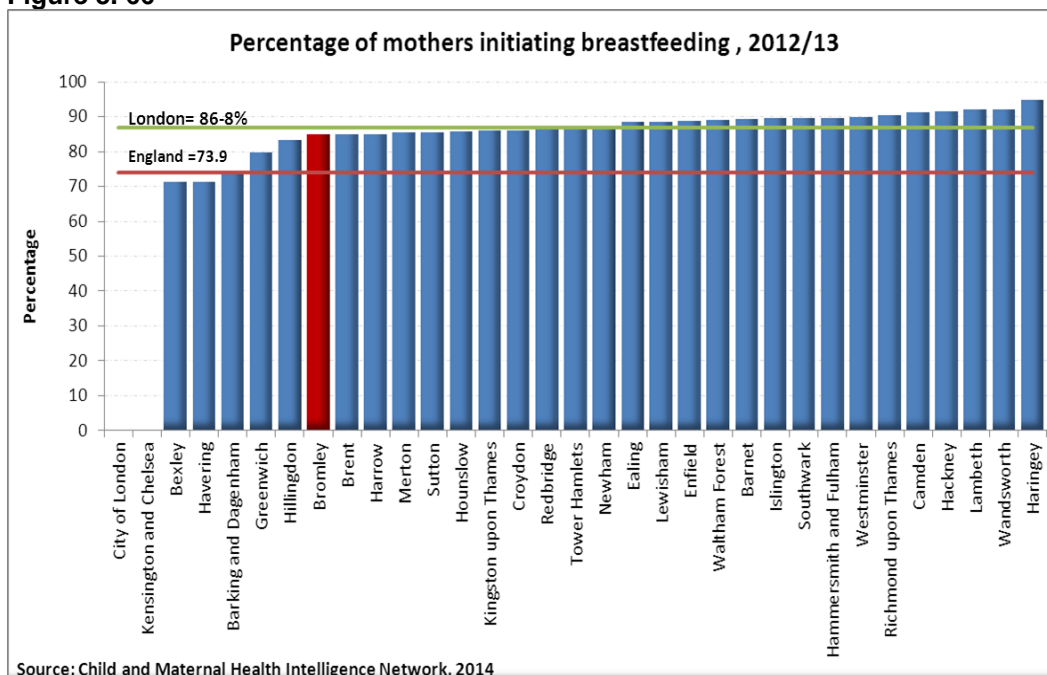
Figure 3. 65



Although the percentage of mothers who actually do start breastfeeding in Bromley is higher than the England average at 85%, it is lower than the regional average and we are the 8th lowest borough in London (**Figure 3.66**).

Breastfeeding drops to 58% at 6-8 weeks in Bromley, although higher than England at 47%, the rates are lower than the regional average at 68.5%.

Figure 3. 66



Source: Child and Maternal Health Intelligence Network, 2014

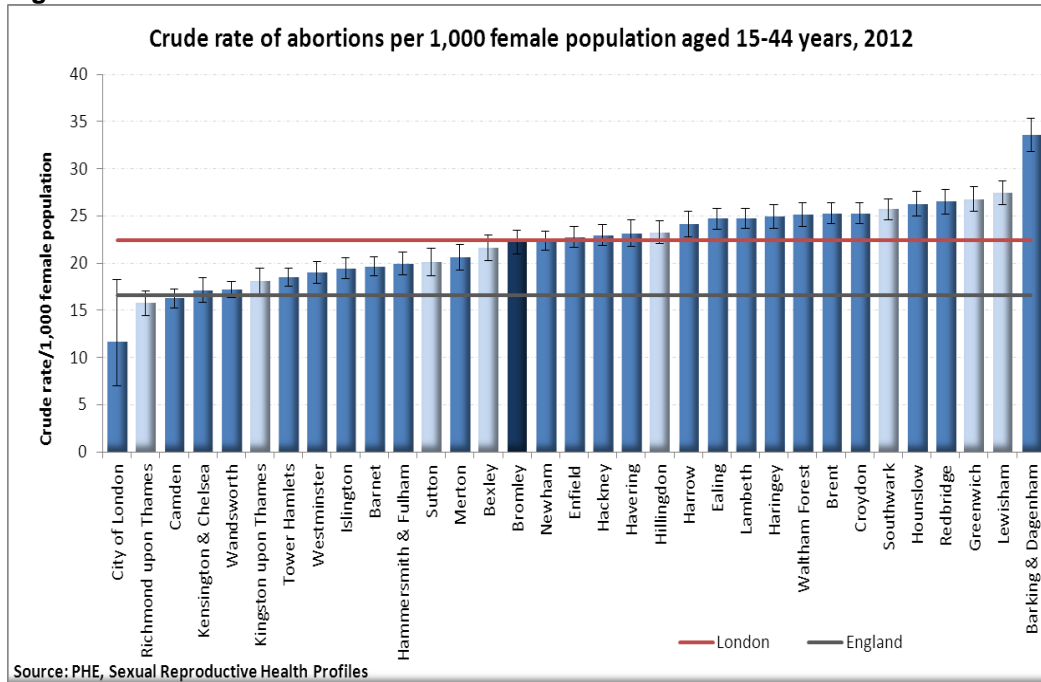
Terminations of Pregnancy

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

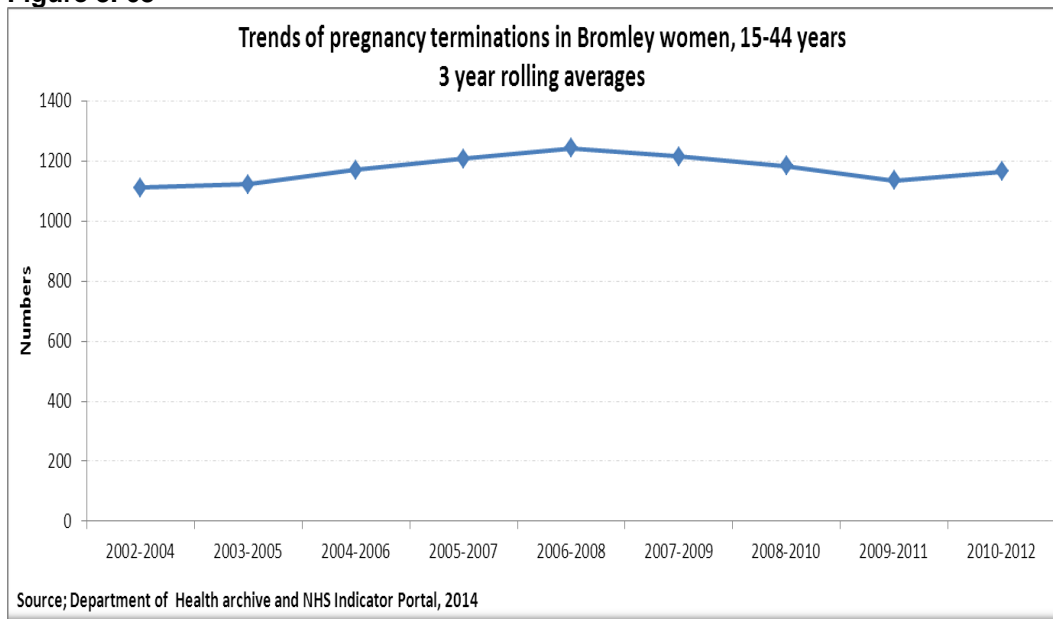
All abortions are notified to the Chief Medical Officer and this data is used to compare rates regionally and nationally, but in order to understand abortions in Bromley, local data from the independent providers of abortion services, BPAS and MSI have been used. This data should be treated with caution;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

According to national figures, in 2012 there were 1,253 terminations performed on Bromley residents. The termination rate in Bromley in 2012 was 22.2 per 1,000 women aged 15-44 which was higher than the national rate (16.62 per 1000 population), but lower than London (22.39 per 1000 population).

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

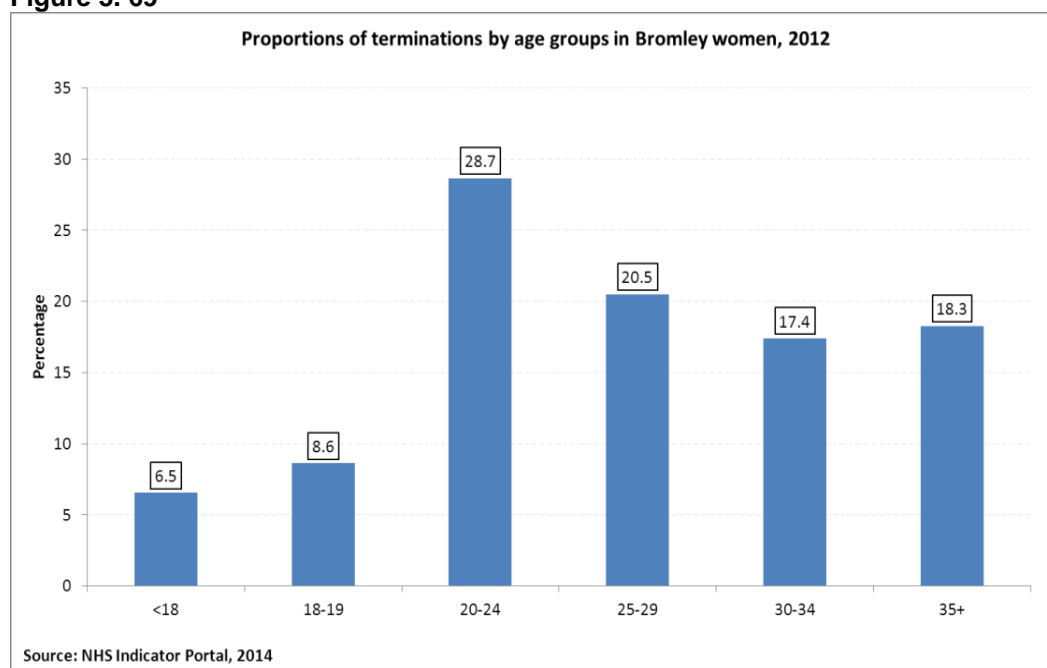
Figure 3. 67

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

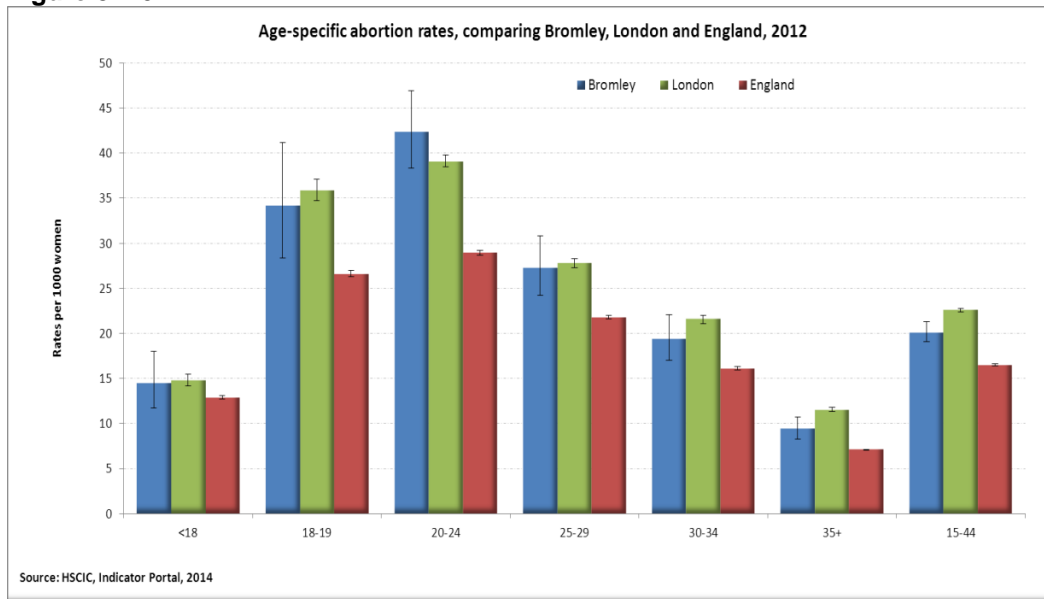
Figure 3. 68

Abortion numbers are largely concentrated within the middle of the reproductive life-span. In Bromley the highest number of abortions (275) were performed in women aged 20-24, followed by the 25-29 age group (234). Women aged under-25 have a repeat termination rate of 31.3%. There is a need for more work focusing on prevention and ensuring good access to and uptake of a comprehensive range of contraception services particularly for young women, not just those under 18 but also women in their 20's.

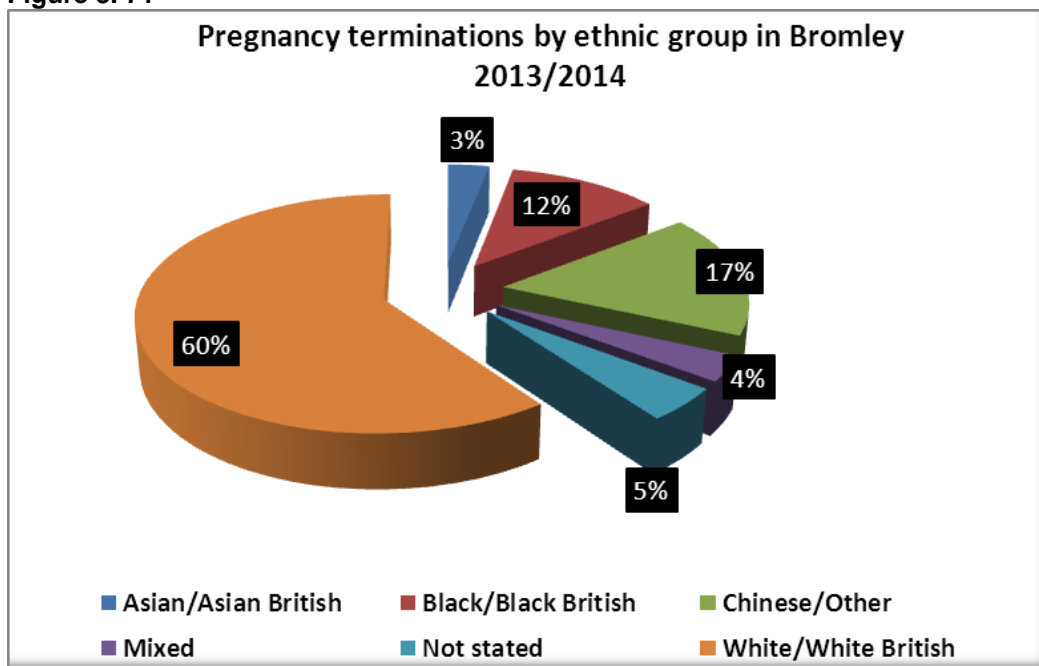
Figure 3. 69



Focusing on teenage conception and abortion rates can obscure the need for abortions by women in their 20s. **Figure 3.70** shows the rates are significantly highest in women aged 20-24. Although the numbers are smaller, Bromley has significantly higher rates than England across all ages and lower rates than London in all ages except women aged 20-24.

Figure 3. 70

Latest available local data from independent providers in **Figure 3.71** shows that the majority of terminations are in women from White ethnic groups.

Figure 3. 71

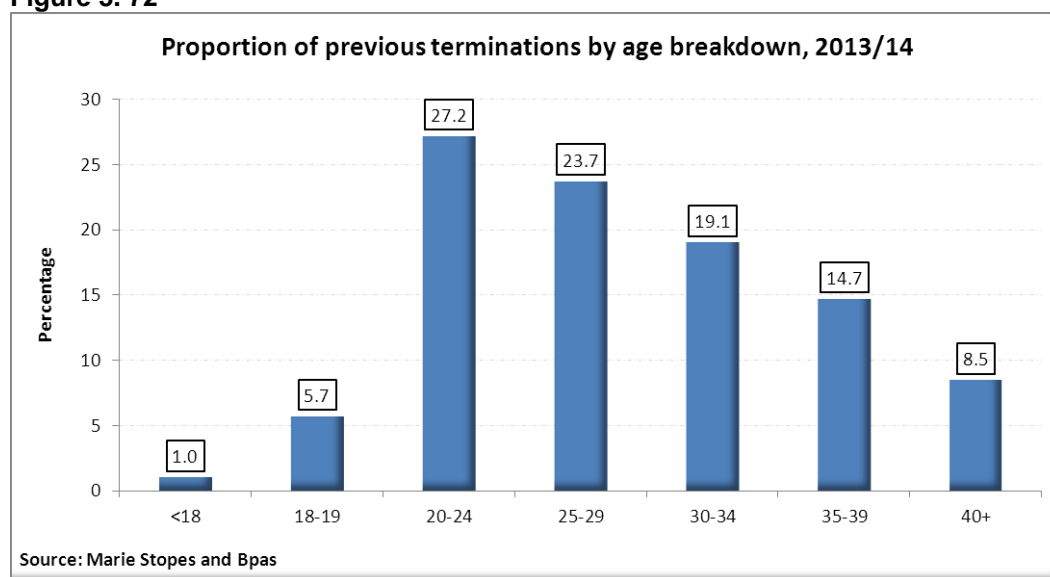
Source: Marie Stopes International and British Pregnancy Advisory Service

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

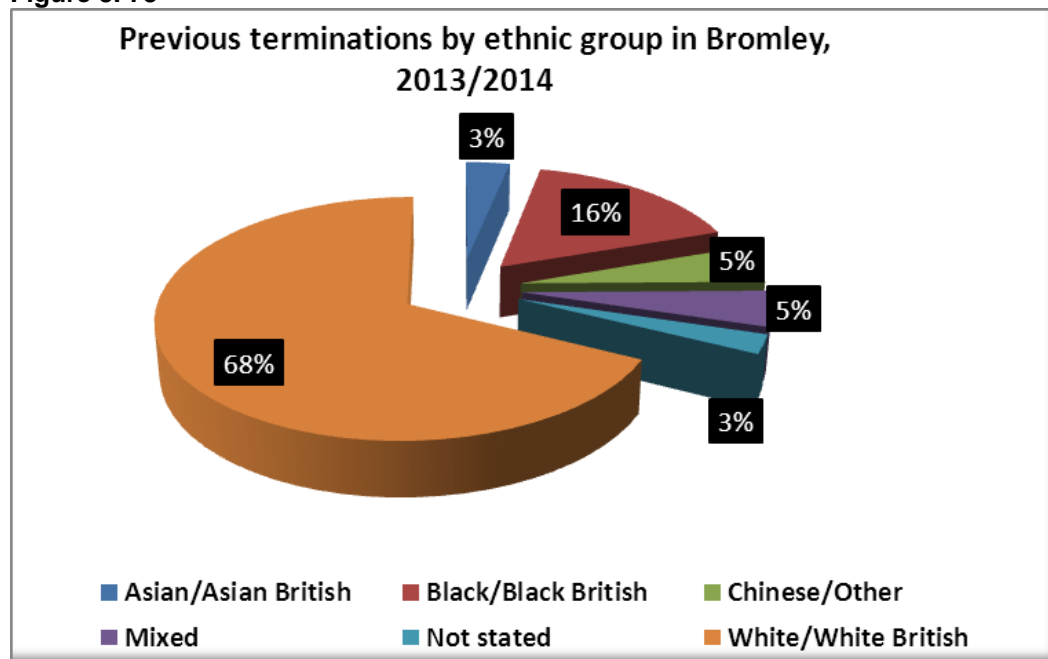
Data from Independent providers shows that 37% of all Bromley women attending the abortion clinics in 2013/2014 reported having had a previous abortion. More women 20-24 years reported to have had one or more previous abortions than any other age group. 20-24 years is at the peak of a woman's fertility and research shows that this cohort is less likely to be actively considering starting a family.

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

Figure 3. 72



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

Figure 3. 73

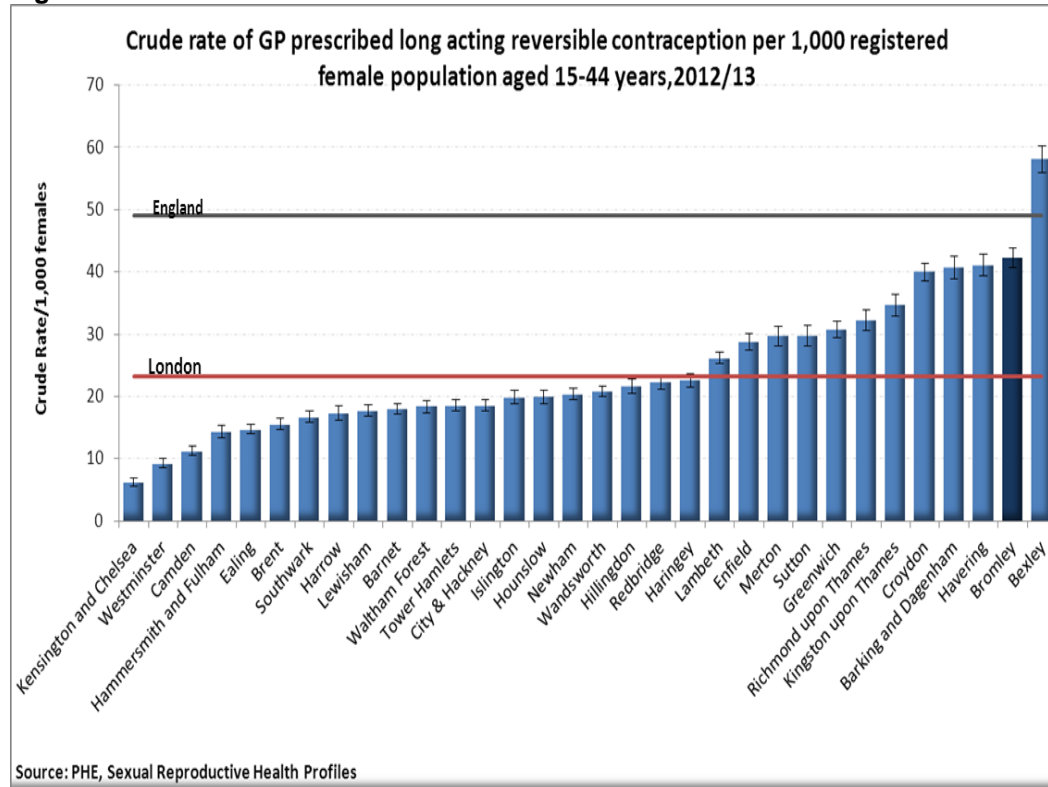
Source: Marie Stopes International and British Pregnancy Advisory Service

Contraception –Long acting reversible contraception

General practices are very instrumental in contraception provision. It is estimated nationally that three quarters of all access to contraception is through general practice. NICE guidance recommends clinicians move to Long-acting reversible contraception (LARC) methods which have very low typical use failure rates.

The average LARC prescription rate for Bromley in 2012/13 was 42 prescriptions per 1000 women aged 15-49 compared to London at 23 per 1000 and England at 49 per 1000 women.

Figure 3.74 presents CCG data, it is not exclusive to Bromley residents, showing how Bromley CCG LARC prescribing compares to the rest of London and England. Prescription of LARC in Bromley general practice is the second highest in London CCGs.

Figure 3. 74**Table 3. 20: Pregnancy and Maternity Related PHOF Indicators**

Indicator	Sex	Age	Time Period	Bromley	London	England
2.02i - Breastfeeding initiation	Female	All ages	2010/11	83.00	86.40	73.69
2.02i - Breastfeeding initiation	Female	All ages	2011/12	83.59	87.04	74.00
2.02i - Breastfeeding initiation	Female	All ages	2012/13	84.67	86.77	73.86
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth	Persons	6-8 weeks	2010/11	52.81	65.11	46.14
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth	Persons	6-8 weeks	2011/12	57.22	67.52	47.21
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth	Persons	6-8 weeks	2012/13	58.96	68.52	47.22
2.03 - Smoking status at time of delivery	Female	All ages	2010/11	7.48	6.32	13.53
2.03 - Smoking status at time of delivery	Female	All ages	2011/12	6.08	6.01	13.19
2.03 - Smoking status at time of delivery	Female	All ages	2012/13	5.22	5.72	12.69

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

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

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

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

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

There is currently a gap in local data on Emergency Hormonal Contraception and Long Acting Reversible Contraception use which has created a gap in understanding of the need and use by different population groups. Further work is planned to understand the contraception service need and use in the borough.

For more information on Pregnancy and Maternity please contact
Jenny.Selway@Bromley.gov.uk

Health Protection in Bromley

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

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

Summary of notifiable diseases reported to SELHPT

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

Table 3.21 shows the number of individual cases managed by SELHPT for Bromley residents in 2013 and also for the previous years, 2006-2012. Primary care clinicians notify cases to the local authority and Health Protection Team via an electronic notification system. This has been in place for some years and so data from Bromley tends to be more complete than that in other London Boroughs.

Table 3. 21: Infectious disease notifications for Bromley, 2006-2013

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

Source: South East London Health Protection Team, 2014

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

Vaccination is one of the most effective public health interventions in the world for saving lives and promoting good health. It offers safe and effective protection against many major infectious diseases. Despite the benefits however, barriers still exist which prevent optimal coverage and where recommended childhood, adult and travel-associated vaccines are often poorly adopted leaving individuals and communities susceptible to infection.

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

Table 3.22 shows the annual data for the latest available year (2012-13) for Bromley. Full data may be found at:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/VaccineCoverageAndCOVER/>

Table 3. 22: Percentage of children immunised by birthday, Bromley, London and England, 2012-13

	Bromley	London	England
By 1st birthday			
DTaP/IPV/Hib (3 doses)	95.0	91.1	94.7
Men C (2 doses)	94.9	89.9	93.9
PCV (2 doses)	94.5	90.8	94.4
By 2nd birthday			
DTaP/IPV/Hib (3 doses)	96.0	93.6	96.3
MMR1	90.6	87.1	92.3
Hib/Men C (booster)	90.4	87.3	92.7
PCV (3 doses)	90.3	86.6	92.5
By 5th birthday			
DTaP/IPV	83.8	79.9	88.9
MMR1	94.0	90.6	93.9
MMR2	87.5	80.8	87.7
Hib/Men C (booster)	91.6	86.9	91.5
School year 8 girls (12-13 years)			
HPV1	86.8	84.4	90.9
HPV2	85.6	82.6	89.6
HPV3	83.9	78.9	86.1

Source: South East London Health Protection Team, 2014

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

MenC = meningococcal group C conjugate

PCV = pneumococcal conjugate; MMR = measles, mumps, rubella

DTaP/IPV = diphtheria, tetanus, polio & pertussis

Hib/MenC = Haemophilus influenzaeB & meningococcal group C

Whilst COVER figures are generally good in Bromley there is still more work to be done. The percentage of children currently immunised with MMR, and Hib/MenC vaccines by 2 years of age falls below the national recommendation of 95% coverage, as does coverage with two doses of MMR and the diphtheria, tetanus, polio and pertussis booster, at 5 years of age. HPV vaccination coverage is lower than the average for England.

Measles

In the UK, high numbers of measles cases were seen in the first quarter of 2013 despite the highest ever national MMR vaccination level being achieved in England (94% of 5 year olds receiving one dose and 88% receiving 2 doses). There has been a shift in the age groups most affected by measles to the 10-14 year old age group. This can mostly be explained by the high proportion of unprotected 10-16 year olds across the country that missed out on vaccination in the late 1990s and early 2000s.

In Bromley, there were 11 laboratory confirmed cases in 2013. The majority of these confirmed cases were associated with a single cluster in a local primary school. The potential remains for small outbreaks, particularly in older children and young adults due to poor immunisation uptake.

In April 2013, the Government implemented a national MMR vaccination catch-up programme for 10-16 year olds. The coverage target of 95% was achieved overall in England but it is recognised that the campaign had a lesser impact inside London. Approximately 11% of previously unimmunised young people were reached by the intervention overall. Further work is planned to understand on-going barriers to the vaccination of children who remain unimmunised at the end of this programme.

Pertussis (whooping cough)

In April 2012 a national outbreak of pertussis was declared following a marked increase in cases commencing in the third quarter of 2011. Whilst the majority of cases were notified in adolescents and adults, significant morbidity and increased mortality relating to the infection was particularly seen in babies under 3 months of age. In response the Department of Health announced the introduction of a temporary immunisation programme for pregnant women between 28-38 weeks of pregnancy. The primary purpose of this programme is to boost antibodies by vaccinating women in late pregnancy so that higher levels of pertussis antibodies are passed from mother to baby.

In Bromley, the reported incidence rate of confirmed pertussis was 6.5 per 100,000 in 2012 compared to 0.3 in 2011. In 2013, there were 19 reported cases of pertussis (of which 14 were laboratory confirmed) (see **Table 3.12**).

Uptake of the maternal pertussis vaccination programme in London was 40% in September 2013. This is lower than the England average of 56% in the same period. Early indications suggest the programme has been successful in reducing the number of cases in young infants and as such immunisation of pregnant women will continue in England until further notice. Regardless of the

decline in cases in 2013, it is important for Public Health England, NHS England, primary care and maternity services to work together to improve maternal vaccination uptake to prevent unnecessary illness and mortality from pertussis in infants.

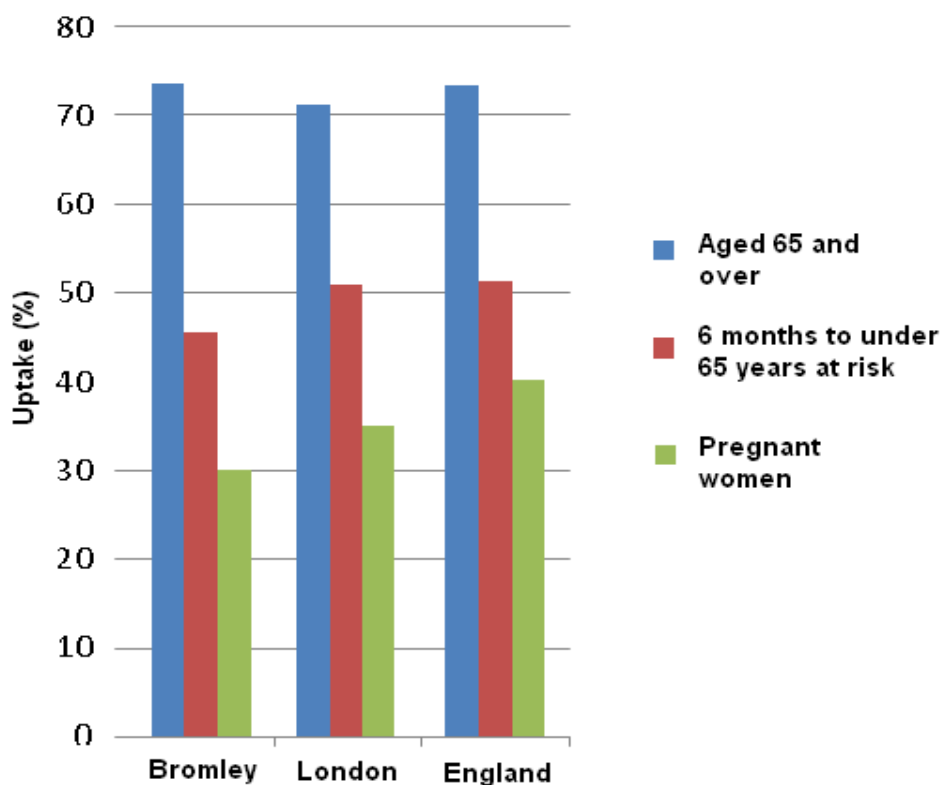
Influenza

Seasonal influenza is a major cause of morbidity and mortality. Public Health England estimate excess winter deaths every year and whilst these cannot be directly attributable to flu, they give an indication of the number of deaths potentially attributable, and therefore, the severity of a flu season. The highest number of excess deaths in the last decade in England and Wales was seen in 2008-9 at 10,351 deaths. Analysis of Health Protection Agency data (England 2010-11) allowed estimates of the increased risk of death associated with flu: age-adjusted relative risk of influenza for those in a risk group is 11.3 and is very high for some risk groups such as those with immunosuppression at 47.3.

Flu vaccination remains a safe and effective way to protect those vulnerable in the population i.e. those over 65 years of age and those in a clinical risk group (who have a chronic disease which puts them more at risk of severe illness), including pregnant women.

In 2013/14 the routine seasonal flu vaccination programme was extended to include healthy children aged 2 and 3 years of age. The success of this programme is currently under review and will inform the potential roll out to older children over the next few years. Provisional data for 2013-14 for Bromley (for incomplete season, September 2013- end January 2014) suggests uptake of 43.7% in 2 year olds and 39.4% in 3 year olds overall (but with higher uptake in 2 and 3 year olds in clinical risk groups at 51.4 and 53.6% respectively).

Figure 3.75 and **Table 3.23** show the uptake of seasonal flu vaccine in at risk groups in Bromley.

Figure 3. 75: Seasonal influenza vaccination uptake in Bromley, London and England, 2012-13

Source: South East London Health Protection Team, 2014

Table 3. 23: Percentage uptake of seasonal flu vaccinations by different patient groups 2013-14

	Bromley	London	England
Aged > 65 years	69.9	70.0	73.2
6 months to <65 years at risk	46.5	52.0	52.3
Pregnant women	32.3	35.9	39.8

Source: South East London Health Protection Team, 2014

Data for September 2013 – January 2014 shows that vaccine uptake levels in Bromley are comparable to those seen in London for residents aged 65 and over. Uptake in clinical risk groups (6 – 65 years) and pregnant women is lower than London and England uptake level.

Vaccines for older people

In addition to seasonal flu vaccination, older people are also offered routine pneumococcal vaccination and shingles vaccination. The shingles vaccination programme was introduced nationally in September 2013 for individuals aged 70 years old with phased implementation of a catch-up programme. As yet there is no data on uptake for the Shingles programme but indications suggest that the vaccination has been well received.

It is important to ensure high uptake of pneumococcal vaccine to prevent clusters of cases particularly in vulnerable settings such as care homes. **Table 3.24** gives the uptake of pneumococcal (PPV) vaccination in over 65s in Bromley.

Table 3. 24: Pneumococcal vaccination uptake, 2012-13

Borough	Bromley	London	England
Aged 65 years & over	61.7%	64.2%	69.1%

Source: South East London Health Protection Team, 2014

Table 3. 25: Health Protection Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
3.03i - Population vaccination coverage - Hepatitis B	Persons	1 yr	2010/11	81.25		
3.03i - Population vaccination coverage - Hepatitis B	Persons	1 yr	2011/12	100.00		
3.03i - Population vaccination coverage - Hepatitis B	Persons	1 yr	2012/13	100.00		
3.03i - Population vaccination coverage - Hepatitis B	Persons	2 yrs	2010/11	85.71		
3.03i - Population vaccination coverage - Hepatitis B	Persons	2 yrs	2011/12	75.00		
3.03i - Population vaccination coverage - Hepatitis B	Persons	2 yrs	2012/13	100.00		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	Persons	1 yr	2010/11	90.64	90.73	94.15
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	Persons	1 yr	2011/12	95.13	91.27	94.67
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	Persons	1 yr	2012/13	95.01	91.10	94.74
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	Persons	2 yrs	2010/11	93.42	92.85	95.98
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	Persons	2 yrs	2011/12	96.40	93.33	96.14
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	Persons	2 yrs	2012/13	95.96	93.58	96.30
3.03iv - Population vaccination coverage - MenC	Persons	1 yr	2010/11	90.09	89.27	93.39
3.03iv - Population vaccination coverage - MenC	Persons	1 yr	2011/12	94.06	89.95	93.89
3.03iv - Population vaccination coverage - MenC	Persons	1 yr	2012/13	94.90	89.94	93.89
3.03v - Population vaccination coverage - PCV	Persons	1 yr	2010/11	90.15	89.58	93.58
3.03v - Population vaccination coverage - PCV	Persons	1 yr	2011/12	94.46	90.40	94.22
3.03v - Population vaccination coverage - PCV	Persons	1 yr	2012/13	94.51	90.83	94.43
3.03vi - Population vaccination coverage - Hib / MenC booster	Persons	2 yrs	2010/11	85.72	84.88	91.59
3.03vi - Population vaccination coverage - Hib / MenC booster	Persons	2 yrs	2011/12	91.86	86.78	92.34
3.03vi - Population vaccination coverage - Hib / MenC booster	Persons	2 yrs	2012/13	90.45	87.35	92.66
3.03vi - Population vaccination coverage - Hib / MenC booster	Persons	5 yrs	2011/12	92.09	80.14	88.63
3.03vi - Population vaccination coverage - Hib / MenC booster	Persons	5 yrs	2012/13	91.60	86.92	91.49
3.03vii - Population vaccination coverage - PCV booster	Persons	2 yrs	2010/11	82.71	82.40	89.34
3.03vii - Population vaccination coverage - PCV booster	Persons	2 yrs	2011/12	91.66	85.28	91.49
3.03vii - Population vaccination coverage - PCV booster	Persons	2 yrs	2012/13	90.27	86.58	92.47
3.03viii - Population vaccination coverage - MMR for one dose	Persons	2 yrs	2010/11	83.56	83.75	89.13
3.03viii - Population vaccination coverage - MMR for one dose	Persons	2 yrs	2011/12	91.49	86.08	91.25
3.03viii - Population vaccination coverage - MMR for one dose	Persons	2 yrs	2012/13	90.59	87.14	92.32
3.03viii - Population vaccination coverage - MMR for one dose	Persons	5 yrs	2010/11	88.92	88.17	91.92
3.03viii - Population vaccination coverage - MMR for one dose	Persons	5 yrs	2011/12	95.16	89.70	92.90
3.03viii - Population vaccination coverage - MMR for one dose	Persons	5 yrs	2012/13	94.04	90.58	93.87
3.03x - Population vaccination coverage - MMR for two doses	Persons	5 yrs	2010/11	77.01	76.62	84.21
3.03x - Population vaccination coverage - MMR for two doses	Persons	5 yrs	2011/12	88.49	80.21	86.02
3.03x - Population vaccination coverage - MMR for two doses	Persons	5 yrs	2012/13	87.52	80.77	87.72
3.03xii - Population vaccination coverage - HPV	Female	12-13 yrs	2010/11	80.92	75.59	84.16
3.03xii - Population vaccination coverage - HPV	Female	12-13 yrs	2011/12	82.98	78.89	86.83
3.03xii - Population vaccination coverage - HPV	Female	12-13 yrs	2012/13	83.94	78.88	86.08
3.03xiii - Population vaccination coverage - PPV	Persons	65+ yrs	2010/11	65.82	64.97	70.46
3.03xiii - Population vaccination coverage - PPV	Persons	65+ yrs	2011/12	56.69	62.61	68.34
3.03xiii - Population vaccination coverage - PPV	Persons	65+ yrs	2012/13	61.68	64.24	69.09
3.03xiv - Population vaccination coverage - Flu (aged 65+)	Persons	65+ yrs	2010/11	72.01	71.44	72.84
3.03xiv - Population vaccination coverage - Flu (aged 65+)	Persons	65+ yrs	2011/12	73.67	72.24	74.02
3.03xiv - Population vaccination coverage - Flu (aged 65+)	Persons	65+ yrs	2012/13	73.48	71.24	73.38
3.03xv - Population vaccination coverage - Flu (at risk individuals)	Persons	6 months-64 yrs	2010/11	46.05	48.92	50.39
3.03xv - Population vaccination coverage - Flu (at risk individuals)	Persons	6 months-64 yrs	2011/12	47.68	51.43	51.62
3.03xv - Population vaccination coverage - Flu (at risk individuals)	Persons	6 months-64 yrs	2012/13	45.49	50.94	51.29

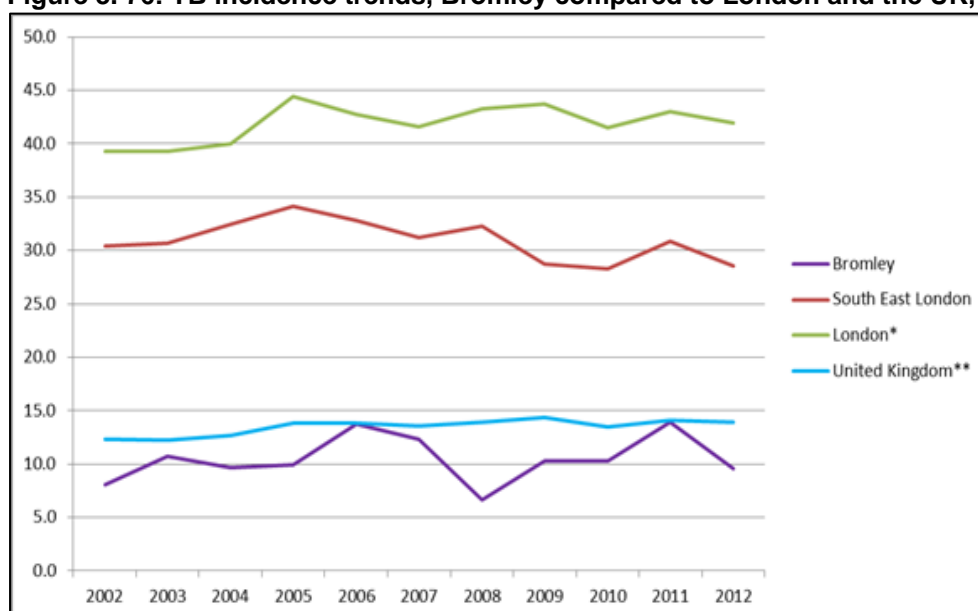
Source: Public Health Outcomes Framework. <http://www.phoutcomes.info/>

Tuberculosis

The overall incidence of TB in Bromley is below the average for London at 9.6 cases per 100,000 population compared to 41.9 per 100,000 population in London in 2012 (**Figure 3.76**). This is a 30% reduction from 2011. Some wards in Bromley are culturally diverse and have higher rates of TB (**Figure 3.77**).

Figures 3.78 and 3.79 show TB notifications in Bromley residents by ethnicity and age. Men and women were equally affected in 2012 (73% of cases in women were aged 35 years or over compared to 73% of notification in men occurring in those aged 0-39 years).

Figure 3. 76: TB incidence trends, Bromley compared to London and the UK, 2002-2012

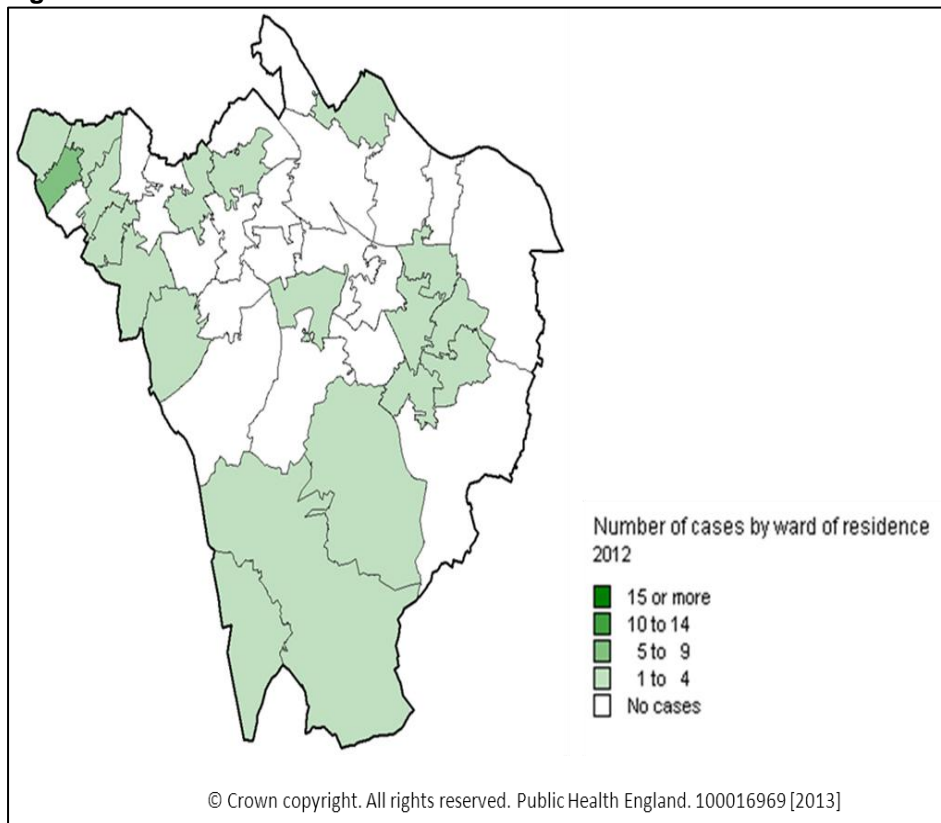


Source: London TB Register

*Tuberculosis in London: Annual review (2012 data), 2013. London: Public Health England, October 2013**

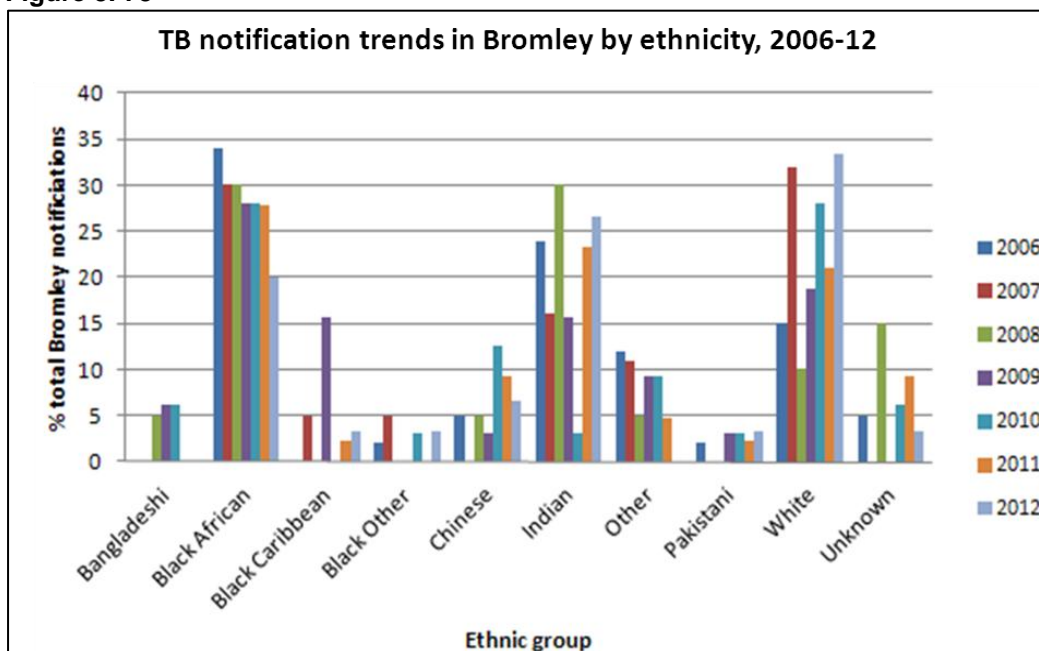
** Tuberculosis in the UK: Annual report on tuberculosis surveillance in the UK, 2013. London: Public Health England, August 2013

Figure 3. 77

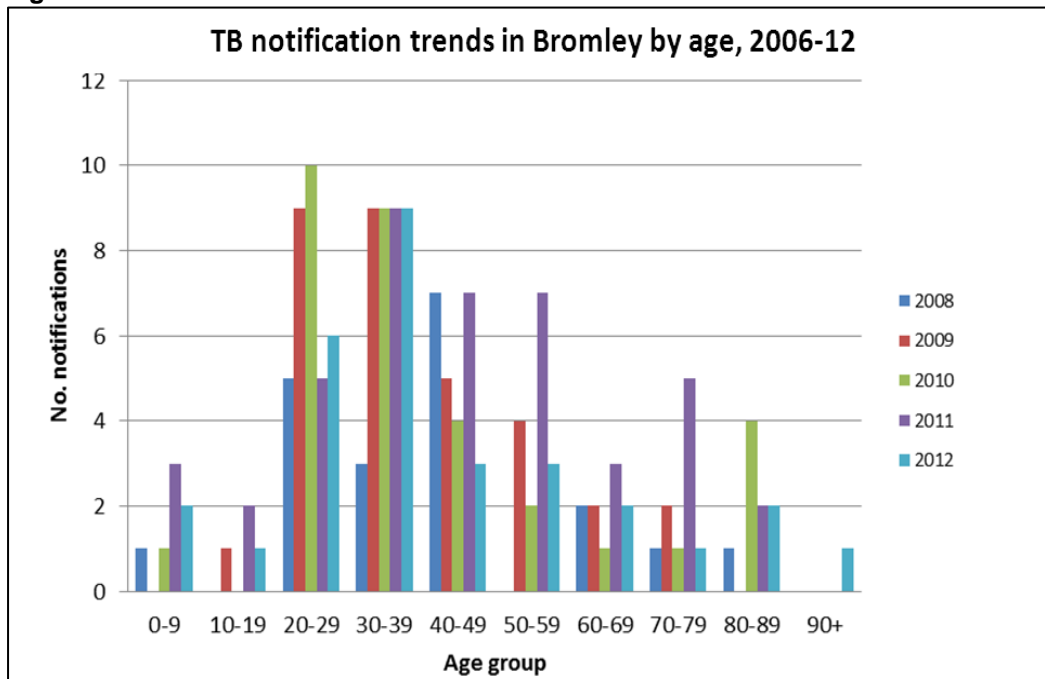


Source: SE London TB report, 2013

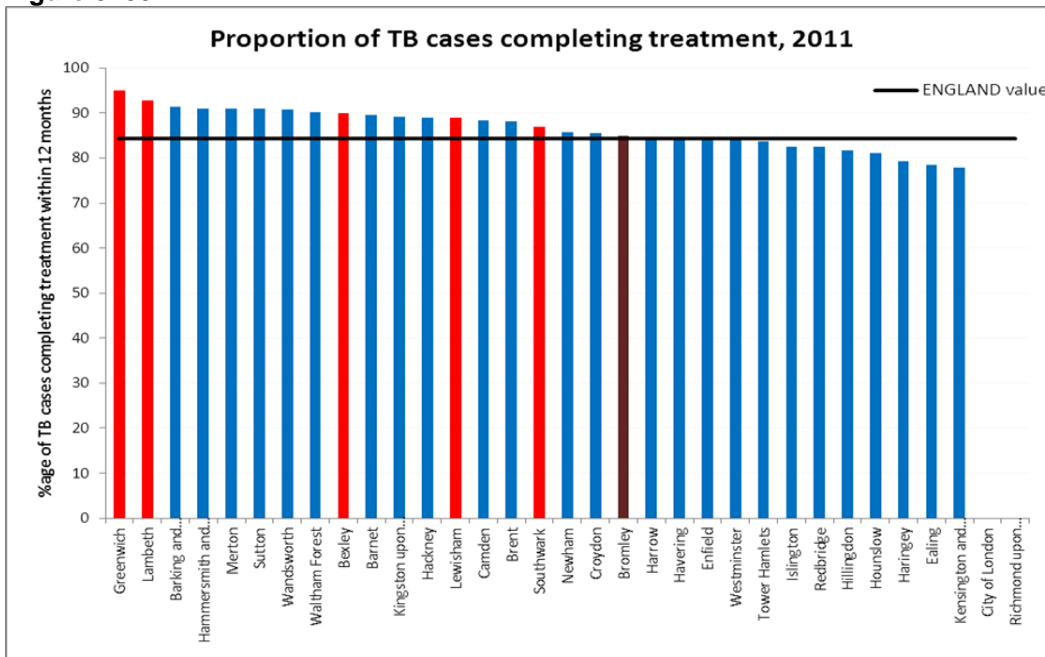
Figure 3. 78



Source: SE London TB report 2013

Figure 3. 79

Source: SE London TB report 2013

Figure 3. 80

Source: PHOF data tool

Figure 3.80 shows the proportions of TB cases completing treatment across London. The proportion of new patients resident in Bromley completing treatment within one year, reached 90.5% in 2011. Joint Work is ongoing between SELHPT and Bromley Public Health Team on targeted projects with local communities with a high incidence.

Healthcare associated infections

SELHPT has a role in supporting acute trusts and community health providers in monitoring healthcare associated infection (HCAI) rates and trends over time. The work has expanded outside of MRSA and *Clostridium difficile* infections to include management of cases and outbreaks of a wide variety of highly resistant organisms.

Mandatory and voluntary surveillance schemes are in place to monitor blood stream infections caused by methicillin-resistant and methicillin-sensitive *Staphylococcus aureus*, *E coli* and glycopeptide-resistant organisms, *Clostridium difficile* infections and surgical site infections. PHE publishes data quarterly and annually for acute trusts and clinical commissioning groups.

Full HCAI data for the acute trusts in SE London can be found at:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI/>

Table 3. 26; Health Protection Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
3.05i - Treatment completion for TB	Persons	All ages	2011	84.85	86.00	84.28
3.05i - Treatment completion for TB	Persons	All ages	2012	90.50	85.80	82.80
3.05ii - Incidence of TB	Persons	All ages	2009 - 11	11.67	41.92	14.94
3.05ii - Incidence of TB	Persons	All ages	2010 - 12	11.31	41.38	15.22
4.08 - Mortality from communicable diseases	Persons	All ages	2001 - 03	102.40	122.53	99.04
4.08 - Mortality from communicable diseases	Persons	All ages	2002 - 04	101.44	118.22	97.67
4.08 - Mortality from communicable diseases	Persons	All ages	2003 - 05	93.57	114.13	96.69
4.08 - Mortality from communicable diseases	Persons	All ages	2004 - 06	82.22	105.55	92.63
4.08 - Mortality from communicable diseases	Persons	All ages	2005 - 07	81.20	101.49	91.40
4.08 - Mortality from communicable diseases	Persons	All ages	2006 - 08	83.51	97.05	88.38
4.08 - Mortality from communicable diseases	Persons	All ages	2007 - 09	81.16	90.46	83.87
4.08 - Mortality from communicable diseases	Persons	All ages	2008 - 10	68.94	82.71	77.49
4.08 - Mortality from communicable diseases	Persons	All ages	2009 - 11	56.01	72.95	70.04
4.08 - Mortality from communicable diseases	Persons	All ages	2010 - 12	52.50	68.12	64.84
4.08 - Mortality from communicable diseases	Male	All ages	2001 - 03	115.48	141.04	115.64
4.08 - Mortality from communicable diseases	Male	All ages	2002 - 04	117.72	132.76	112.81
4.08 - Mortality from communicable diseases	Male	All ages	2003 - 05	116.26	127.18	110.78
4.08 - Mortality from communicable diseases	Male	All ages	2004 - 06	98.16	115.97	106.06
4.08 - Mortality from communicable diseases	Male	All ages	2005 - 07	92.16	112.07	104.35
4.08 - Mortality from communicable diseases	Male	All ages	2006 - 08	96.66	108.35	100.88
4.08 - Mortality from communicable diseases	Male	All ages	2007 - 09	94.52	102.78	95.62
4.08 - Mortality from communicable diseases	Male	All ages	2008 - 10	82.64	94.30	88.64
4.08 - Mortality from communicable diseases	Male	All ages	2009 - 11	62.63	82.90	80.93
4.08 - Mortality from communicable diseases	Male	All ages	2010 - 12	55.17	78.33	75.06
4.08 - Mortality from communicable diseases	Female	All ages	2001 - 03	94.43	111.14	90.12
4.08 - Mortality from communicable diseases	Female	All ages	2002 - 04	92.84	108.56	89.31
4.08 - Mortality from communicable diseases	Female	All ages	2003 - 05	83.24	104.94	88.72
4.08 - Mortality from communicable diseases	Female	All ages	2004 - 06	74.74	97.51	84.90
4.08 - Mortality from communicable diseases	Female	All ages	2005 - 07	76.67	93.38	83.86
4.08 - Mortality from communicable diseases	Female	All ages	2006 - 08	77.55	88.85	81.05
4.08 - Mortality from communicable diseases	Female	All ages	2007 - 09	74.15	81.98	76.79
4.08 - Mortality from communicable diseases	Female	All ages	2008 - 10	61.09	74.67	70.65
4.08 - Mortality from communicable diseases	Female	All ages	2009 - 11	52.04	66.10	63.42
4.08 - Mortality from communicable diseases	Female	All ages	2010 - 12	51.04	61.26	58.65

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

What does this mean for Bromley residents and children in Bromley

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

There remains a potential for measles outbreaks, particularly in older children and young adults due to poor immunisation uptake, as seen in the 11 confirmed measles cases in 2013.

There were 14 confirmed cases of pertussis in 2013, highlighting the importance of immunisation against pertussis, in particular the uptake of maternal pertussis vaccination programme.

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

Appendix - Surveillance systems and data sources

HPZone

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

The London TB Register (LTBR)

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

Cover of Vaccination Evaluated Rapidly (COVER) data

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

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

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

Smoking

Smoking is a major risk factor for cardiovascular disease (heart disease and stroke), Chronic Obstructive Pulmonary Disease (emphysema, bronchitis and asthma) and many cancers (in particular lung, bowel and breast cancer). Smokers are much more likely to die prematurely (up to 16 years of lost life expectancy). Every year, over 100,000 smokers in the UK die from smoking related causes. Smoking accounts for over one-third of respiratory deaths, over one-quarter of cancer deaths, and about one-seventh of cardiovascular disease deaths⁵.

Smoking prevalence

There are about 10 million adults who smoke cigarettes in the UK (2014):

- This is about a sixth of the total UK population
- 22% of adult men and 19% of adult women are smokers

In Bromley, the current adult smoker population (18+ years) is 43,192 (17.84%) compared with 19.53% smoking prevalence for England (2012). Smoking prevalence has been rising since 2010 (**Table 3.27**).

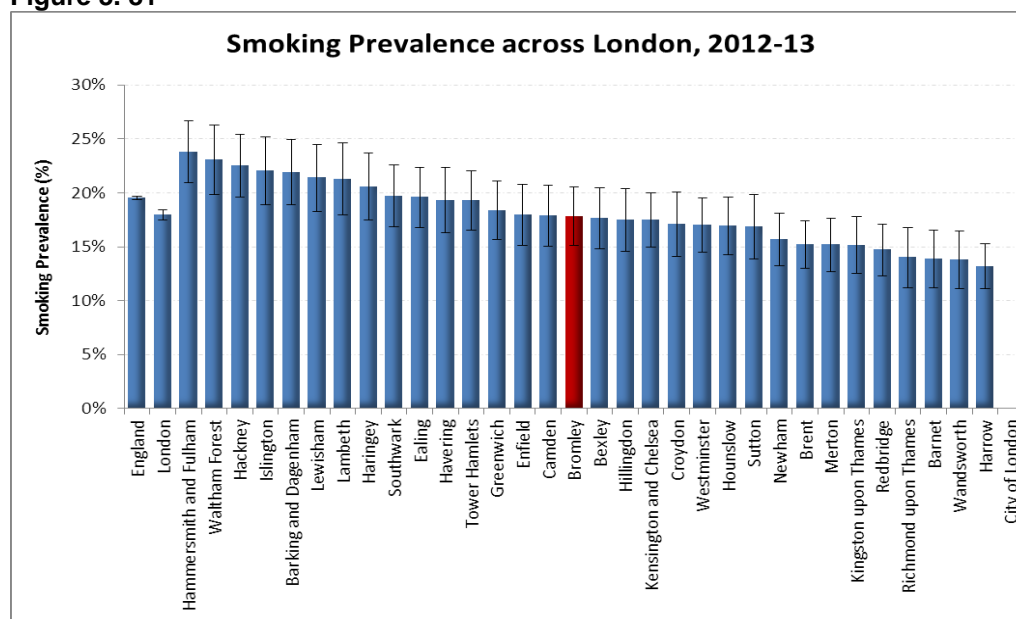
Table 3. 27: Percentage smoking prevalence

Year	Smoking Prevalence
2010	17.01%
2011	17.54%
2012	17.84%

Source: Tobacco Control Profile 2014

Bromley was ranked 20th in order of smoking prevalence across London in 2012, this position has worsened to 16th highest across London in 2013.

⁵ ASH Action on Smoking and Health. Smoking Statistics: Who Smokes and How Much (2013).

Figure 3. 81

Source: PHOF, 2014

The current burden of smoking in Bromley

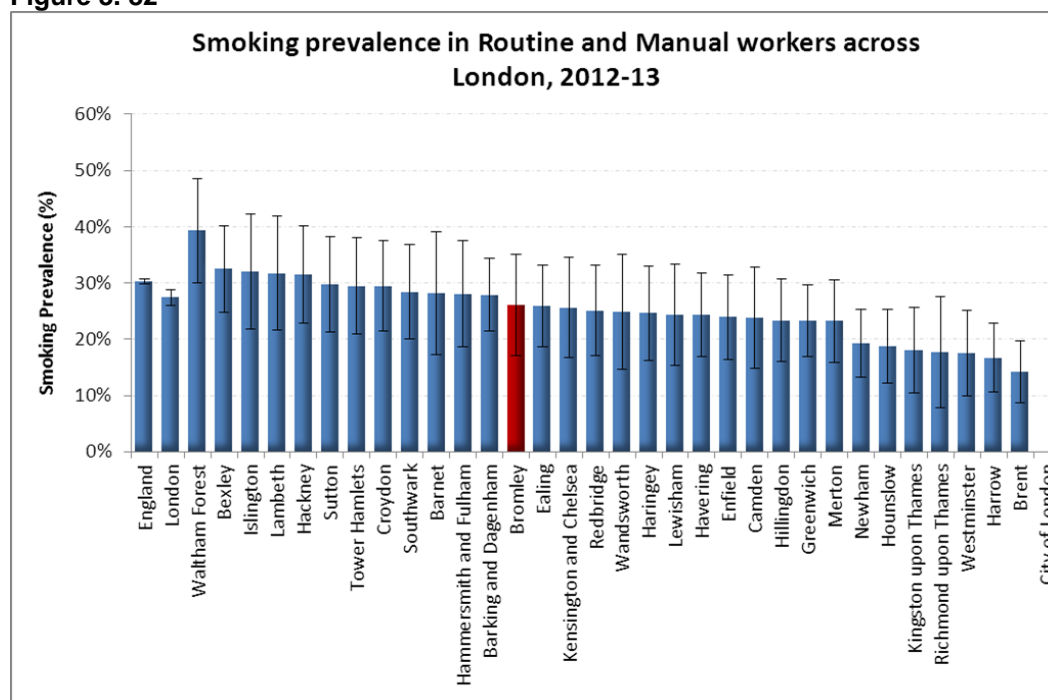
Inequalities

Smoking continues to undermine the health of the most disadvantaged communities. Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. Smokers are more likely to live in poverty; a twenty-a-day smoker will spend more than £2,000 a year on cigarettes.

Smoking prevalence in routine and manual occupational groups is 8% higher than the general population in Bromley. Smoking prevalence in this group is continuing to increase, prevalence was 24.3% in 2011-12, rising to 26.1% in 2012-13, this is 0.4% higher than the London population prevalence of routine and manual workers of 25.7%.

Pregnant mothers are another identified priority group nationally, those smoking at time of delivery is low in Bromley (5.2%) compared to London (5.7%) and England (12.7%). Parental smoking is a major contributor to reinforcing the inter-generational cycle of health inequalities as smoking becomes normalised within everyday life.

Bromley is ranked 13th in order of Smoking Prevalence in Routine and Manual Workers across London 2012-13 (**Figure 3.82**).

Figure 3. 82

Source: PHOF

Smoking and the environmental impacts

The council has a statutory duty to reduce smoking-related litter and exposure to second-hand smoke, prevent illegal sales of tobacco products to young people and enforce smoke-free legislation. The impact of tobacco use in Bromley communities extends beyond smoking and causes a number of secondary impacts:

- Increased noise, litter and smoke drift create community tensions and if left without intervention, can negatively affect community cohesion
- The visual appearance of cigarette-related litter is unsightly and lowers the perceptions of Bromley town centres and neighbourhoods
- Cigarette filters can take up to 12 years to degrade
- Cigarette butts are harmful to birds and wildlife
- Cigarette related litter (cigarette ends, matchsticks and discarded cigarette packets) accounted for over 90 per cent of city centre streets in the UK⁶.

⁶ ENCAMS (Keep Britain Tidy Campaign), Smoking Related Litter (2013).
http://www.ciwm.co.uk/CIWM/InformationCentre/AtoZ/SPages/Smoking_Related_Litter.aspx

Smoking in Secondary Care

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

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

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

How much is smoking costing in Bromley?

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

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

* The model does not factor in other potential costs associated with tobacco smoking e.g. social care costs apart from costs associated with stroke patients, related house fires, the loss in productivity from smoking breaks and cleaning up cigarette butts as the evidence base is not robust⁷.

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

Stop smoking interventions are very cost effective ranging between £2000-3000 per Quality Adjusted Life Year gained (QALY), compared to £17,000 per QALY for the average medical intervention. In addition, smoking cessation is by far more favourable in the Numbers Needed to Treat (NNT) to prevent a death at one year (16-40 patients for smoking cessation vs. 700 patients for antihypertensive therapy).

Illicit and Niche Tobacco

Over the last few years there has been increasing use of niche tobacco products such as shisha and smokeless tobacco products. Tobacco-free shisha is not safe since it generates dangerous levels of carbon monoxide. Most types of smokeless tobacco contain at least 28 different carcinogenic chemicals. Young people who use smokeless tobacco are more likely to become cigarette smokers.

The prevalence of shisha use in the UK was 8% in 2012 and increasing. In London there are approximately 600 shisha lounges and more than 1000 retail outlets selling the products (six shops found in Bromley in 2012).

A niche tobacco survey was carried out by the South-East London Illicit Tobacco Control Partnership in six South-East London (SEL) boroughs in 2013; it explored shisha usage among 200 adults. The results showed that 68% of adults in Bromley were aware of shisha (average across SEL 72.4%), 25% had tried shisha (average across SEL 27%), 13% had smoked shisha in the last year (average across SEL 16.4%), but only 0.5% of the 200 Bromley residents surveyed stated they smoke shisha most weeks (average across SEL 0.9%). The same survey targeting 500 young people was carried out in Greenwich only in 2012, they found by the age of sixteen, 30% of young people had tried shisha at least once. Schools in Bromley have expressed concern over the use of shisha pens and their bright attractive child focused marketing.

A survey about illicit tobacco was carried out in 2012 in South-East London, 250 smokers in Bromley were asked whether they have been offered cheap cigarettes or hand rolling tobacco in the last year. The results showed that 32.8% of those asked had been offered and 22% had bought cheap tobacco products in the last year⁸³.

E-cigarettes are becoming increasingly popular. They are being promoted as a form of harm reduction and a 'healthier' way to smoke. However, due to the lack of scientific testing on the exact content of the e-cigarette and the highly

⁸ The South East London Smoking Survey: Buying and Selling Illicit Cigarettes and Hand Rolling Tobacco in South East London 'Seeking insight into a covert market' December 2012

addictive nicotine content the Stop Smoking Services are not advocating their use.

Research has shown that no single measure for reducing smoking prevalence will be successful in isolation. A universal prevention approach to tobacco control, including primary, secondary and tertiary smoking cessation activities, are needed if Bromley is to become a greener, healthier and wealthier place to live and work.

Public Health Outcomes Framework

Indicator	Sex	Age	Time Period	Bromley	London	England
2.14 - Smoking Prevalence	Persons	18+ yrs	2010	17.01	19.44	20.79
2.14 - Smoking Prevalence	Persons	18+ yrs	2011	17.54	19.48	20.21
2.14 - Smoking Prevalence	Persons	18+ yrs	2012	17.84	17.97	19.53
2.14 - Smoking prevalence - routine & manual	Persons	18+ yrs	2011	24.27	27.47	30.28
2.14 - Smoking prevalence - routine & manual	Persons	18+ yrs	2012	26.12	25.75	29.70

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

What this means for the JSNA

Smoking: There is a rising prevalence of smoking in Bromley, this has a negative impact on Bromley's:

- Morbidity and mortality rates
- Local economy
- Health inequalities
- The local environment
- Hospital admission, re-admission and post-operative complication rates

Bromley has a particularly high smoking prevalence within routine and manual worker groups, prevalence is 8% higher than the general population in Bromley and continues to increase (prevalence was 24.3% in 2011-12, rising to 26.1% in 2012-13). There is evidence that illicit tobacco and shisha use are becoming more common in Bromley.

Obesity

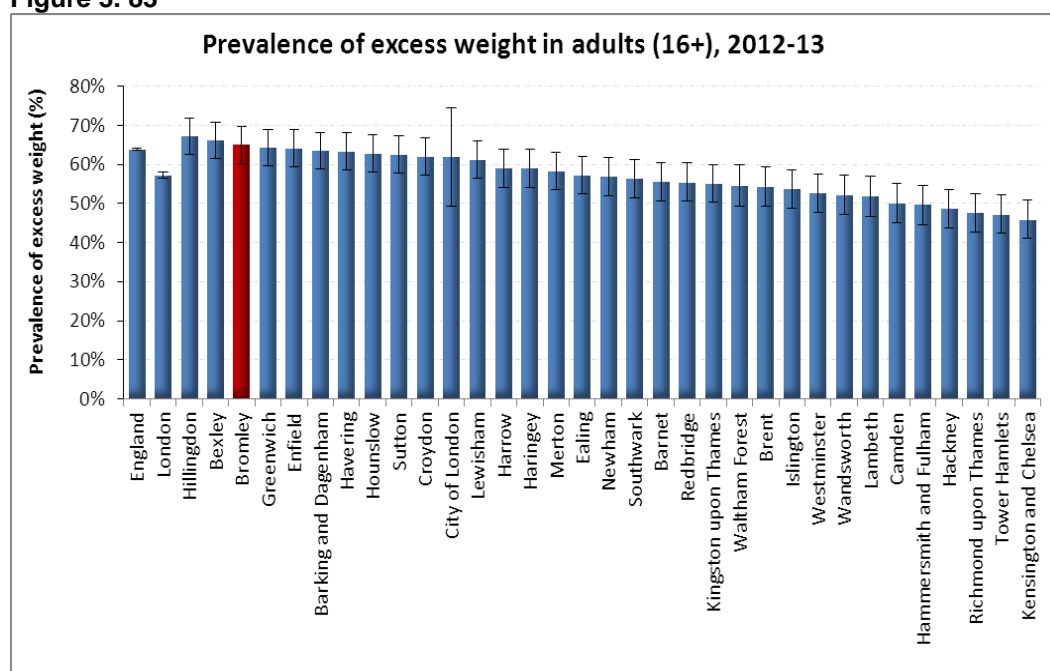
Prevalence of obesity and overweight

Obesity presents one of the major health challenges globally, nationally and locally. In 1980, eight per cent of adult women and six per cent of adult men were classified as obese. Since then the obesity prevalence has dramatically increased (in England). By 2050, 60% of men and 50% of women could be clinically obese (Department of Health, 2013). In less than 35 years, the majority of people are now overweight or obese; In England 61.9% of adults and 28% of children aged between 2 and 15 are either overweight or obese.

The current burden of obesity in Bromley

The public health outcomes framework 2013 reported that 65% of Bromley's population are either overweight (>25 BMI) or obese (>30 BMI), which represents approximately 205,820 adults. This is higher than the England average (63.8%), and is ranked as the third highest prevalence of excess weight in London. In Bromley, the estimated prevalence of obesity is 21.2% (2014 Health Profile), which represents 52,672 adults.

Figure 3. 83



Source: PHOF

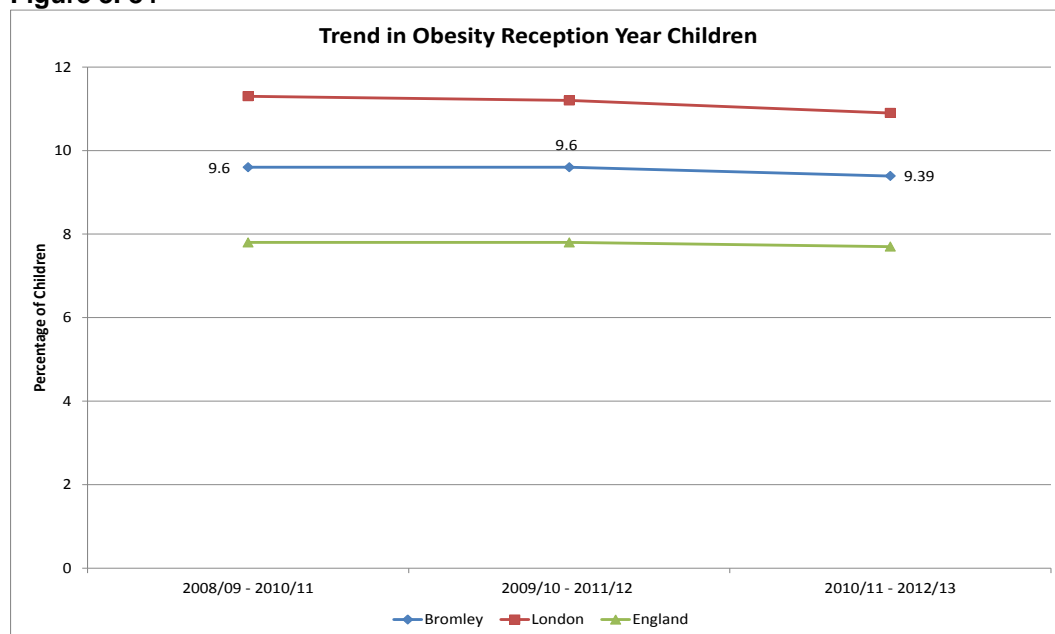
GP obesity registers identified 25,772 people over the age of 16 years in Bromley with a BMI over 30 indicating obesity. However, a search in 2013 found that only 55% of patients were found to have had a recording of BMI by

GPs within the last three years. This indicates a significant level of under identification of obesity.

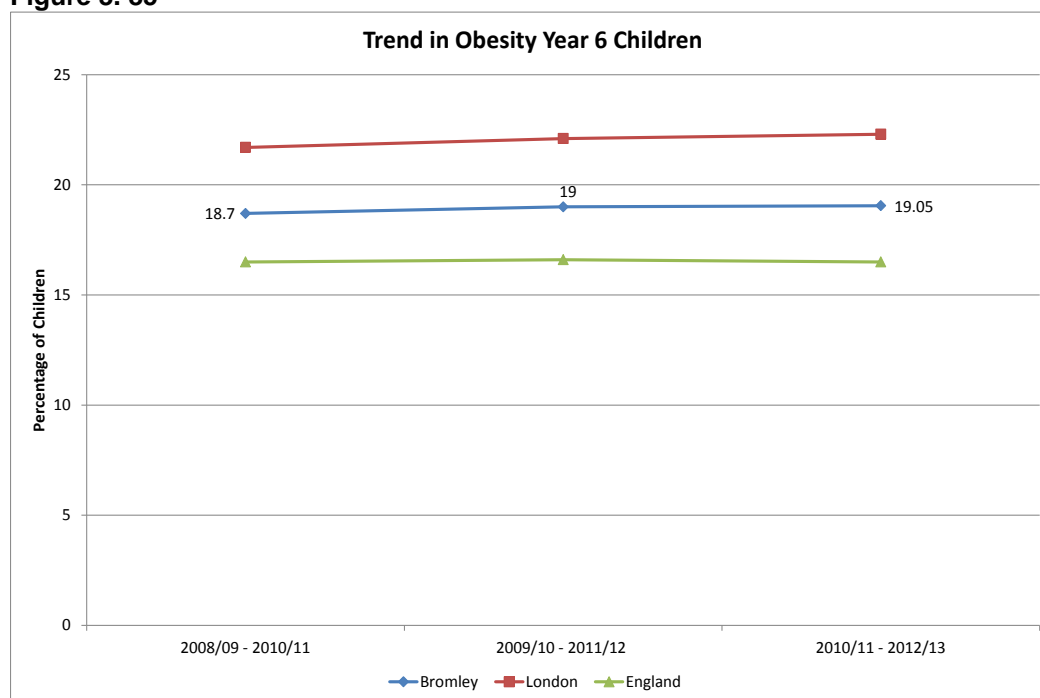
Severe obesity is defined as a BMI of 35–39 (obesity II) in the presence of co-morbidities, or a BMI of 40 or more regardless of co-morbidities (obesity III). Surgery is increasingly being used as a treatment option for obesity. The number of NHS commissioned bariatric surgery procedures in England has increased from 470 in 2003/2004 to over 6,500 in 2009/10, which is equivalent to less than 1% of adults with morbid obesity. In 2012 around 80 Bromley patients underwent bariatric surgery (SLHT data).

The prevalence of **childhood obesity** in Bromley is higher than the England average and is now reducing slowly in reception year children, but continues to rise in the Year 6 cohort.

Figure 3. 84



Source: HSCIC NCMP Data

Figure 3. 85

Source: HSCIC NCMP Data

Health implications of obesity.

Obesity has an attributable risk for Type 2 diabetes of 24%. In tandem with the rising levels of obesity in Bromley, there has been a significant increase in the prevalence of diabetes, with 13,681 cases on the GP registers in 2012/13, as compared to 4,846 in 2002. In addition, obesity is a key risk factor for circulatory disease and cancer, which were accountable for 62.3% of the deaths in Bromley in 2012.

How much is Obesity costing in Bromley?

The Foresight Report: Tackling Obesities: Future Choices includes a model for estimating the costs of overweight and obesity to the NHS. The results for Bromley are shown in **Table 3.29** below:

Table 3. 28

	2010	2015
Estimated annual costs to the NHS of diseases related to overweight and obesity	£80.1m	£85.7m
Estimated annual costs to the NHS of diseases related to obesity	£43.4m	£49.8m

Source: Foresight Report

What this means for the JSNA

Obesity: Bromley has the third highest levels of overweight and obesity in London, 65% are either overweight or obese and the prevalence is rising.

Excess weight contributes significantly to the incidence and progression of diseases such as type 2 diabetes, circulatory disease and cancer. A significant proportion of Bromley's residents (21.2% obese) are at higher risk of these conditions and of premature death.

References-Obesity

National Institute for Clinical Excellence. 2006. CG43 Obesity: NICE guideline

² South East London Treatment Access Policy, 2012

³ SLHT data

⁴ The management of obesity and overweight: an analysis of reviews of diet, physical activity and behavioural approaches (2003).

Physical Activity

Physical Inactivity

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

- 10.5% of coronary heart disease (CHD) cases
- 18.7% of colon cancer cases
- 17.9% of breast cancer cases
- 13.0% of type 2 diabetes cases
- 16.9% of premature all-cause mortality⁹

In addition to reducing premature death and the incidence of disease, participating in physical activity also has benefits for mental health and wellbeing, quality of life and maintaining independent living in older age. It can play a key role in reducing health and social inequalities. As a result of this wide-reaching impact, physical activity has been described as the 'best buy in public health'¹⁰. Targeting those adults who are significantly inactive (that is, engaging in less than 30 minutes of activity per week) will produce the greatest reduction in chronic disease³. On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual.

Prevalence of Physical Activity

National guidance for physical activity

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

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

⁹ UK Active (2014). Turning the tide of inactivity

¹⁰ UK Active (2014). Turning the tide of inactivity

Participation rates - Adults

There are good adherence rates to physical activity in Bromley higher than the London and England average but there is scope to increase levels of physical participation in Bromley for health benefits, particularly within the inactive population.

Table 3. 29

	Bromley	London	England
Physically Active Adults - (achieving at least 150 minutes per week*)	62.1%	57.2%	56.0%
Moderately Active Adults - (achieving more than 30 minutes but less than 150minutes of activity per week*)	13.8%	15.3%	15.5%
Physically inactive adults – (achieving less than 30 minutes of exercise per week*)	24.1%	27.5%	28.5%

Source: Public Health Outcomes Framework 2013. *there has been a change in the inclusion criteria from 2012 which is responsible for the increase in activity prevalence.

How much is Physical Inactivity costing in Bromley?

There are 213.8 premature deaths per 100,000 people per year in Bromley due to physical inactivity⁶. There are additional economic and social benefits of being active, for example a reduction in absenteeism, reduced health and social care costs, it is estimated that the direct and indirect costs of inactivity in the UK total £20bn a year. According to the National Institute for Health and Care Excellence (NICE), inactivity is costing the national economy in England £8.2 billion per year¹¹.

Inequalities and inactivity

Areas of high socio-economic deprivation are more likely to have higher levels of inactivity. In England the most deprived areas have on average 32% adult inactivity compared to 24% in the least deprived areas. Supporting inactive groups provides the maximum financial return on investment and is the most effective means of narrowing health inequalities. Some groups in society such as disabled people, older people and some ethnic minority groups are less likely to be active than others. Attracting the hardest to reach groups is challenging and requires specific, attractive, targeted interventions for these groups.

¹¹ National Institute for Health and Care Excellence. Costing report: Four commonly used methods to increase physical activity (2006).

Active Environments

Active Transport Walking and Cycling

Walking is reported to be the most common activity, and cycling is the fourth most common recreational and sporting activity undertaken by adults in Britain. Walking (for any purpose) accounted for between 37% and 45% of the time that women of all ages spent doing moderate or vigorous-intensity physical activity and between 26% and 42% of the time devoted by men of all ages. Walking and cycling are also important means of transport as well as recreational and sporting activities. In Bromley, walking accounted for 26.5% of all transport trips¹ originating in the Borough between 2010/11 and 2012/13. As a result, it is the most likely way all adults can achieve the recommended levels of physical activity¹².

A trip is a complete door-to-door movement by an individual to achieve a specific purpose (e.g. to go from home to work).

Cycling

Cycling is ideally placed to contribute to overall activity levels as it is one of the few activities, like walking, that can be carried out as part of daily life.

Based on 2009/10 to 2011/12 data, cycling trips in Bromley accounted for 1.1% (around 7,600 cycle trips a day) of all journeys originating in the Borough. The size of the Borough and its outer rural terrain create barriers to cycling. That said, Bromley does have a higher percentage of trips by bicycle than neighbouring boroughs, Bexley (0.6%) and Croydon (0.8%) but is below the outer London average of 1.6% and that of the south sub region of 2.6%.

Analysis shows that more than half of the potentially cyclable trips in the Capital are in Outer London. These total around 2.4 million a day, most of which are made by car. Cycling in Outer London is mostly low, with great potential for improvement. In Bromley, 32% of all trips currently made by motorised modes are potentially cyclable by bike. This was calculated on the total number of trips made within Bromley that were no more than 8km, did not include those made overnight (8pm – 6am), carrying heavy/bulk load, nor any trips involving those under 5 or over 64 years of age or those with a disability.

TFL have provided boroughs with an insight into the population groups most likely to cycle at present and most amenable to cycling in the future. This group tend to be quite young, well-educated and reasonably well-off. They have busy

¹² National Institute for Health and Care Excellence. Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation (2012)

lifestyles and usually live close to town centres with many choosing to live without a car. Areas of the borough where cycling propensity is greatest therefore include Bromley North, Shortlands, Copers Cope, Beckenham and around Crystal Palace. These should therefore be localities where cycling promotion and activity should be targeted to generate the greatest return.

Active travel modes to school vary across the borough. Often this variance is related to the ease of accessibility to the school with those in more rural parts of the borough such as Cudham relying more heavily on the car. From data collected during 2012/13, 44.7% of school students in the borough walk or cycle to school.

Table 3. 30: Modifiable Risk Factors Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
1.16 - Utilisation of outdoor space for exercise/health reasons	Persons	16+ yrs	Mar 2011 - Feb 2012	4.38	8.13	14.02
1.16 - Utilisation of outdoor space for exercise/health reasons	Persons	16+ yrs	Mar 2012 - Feb 2013	14.26	10.50	15.33
2.12 - Excess Weight in Adults	Persons	16+ yrs	2012	65.01	57.29	63.78
2.13i - Percentage of physically active adults	Persons	16+ yrs	2012	62.14	57.20	56.03
2.13ii - Percentage of physically inactive adults	Persons	16+ yrs	2012	24.08	27.47	28.51
2.14 - Smoking Prevalence	Persons	18+ yrs	2010	17.01	19.44	20.79
2.14 - Smoking Prevalence	Persons	18+ yrs	2011	17.54	19.48	20.21
2.14 - Smoking Prevalence	Persons	18+ yrs	2012	17.84	17.97	19.53
2.14 - Smoking prevalence - routine & manual	Persons	18+ yrs	2011	24.27	27.47	30.28
2.14 - Smoking prevalence - routine & manual	Persons	18+ yrs	2012	26.12	25.75	29.70

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

What this means for the JSNA

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

There is evidence that interventions in the following areas have a positive impact on the health of the physically inactive:

- environmental changes designed to increase daily activity
- active transport – walking and cycling
- physical activity programmes for people with long term conditions
- physical activity for children in schools.

References Physical Activity

UK Active (2014). Turning the tide of inactivity

² Health Survey for England 2008 Report.

World Health Organisation, Global Strategy on Diet, Physical Activity and Health (2014). [http:// www.who.int/dietphysicalactivity/pa/en/](http://www.who.int/dietphysicalactivity/pa/en/)

³ Sport England, Active People Survey, Survey 7 (2013).

http://www.sportengland.org/research/active_people_survey/active_people_survey_7.aspx

³ Department of Health, Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (2011).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf

⁵ National Institute for Health and Care Excellence. Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation (2012).

⁶ National Institute for Health and Care Excellence. Costing report: Four commonly used methods to increase physical activity (2006).

For more information on Modifiable Risk Factors please contact Carolyn.Piper@Bromley.gov.uk

The Places where People Live

4. Ward Profiles

Introduction

The ward profiles are a range of indicators for each ward showing a range of determinants of health and of health outcomes combined with a comparison to other wards in Bromley.

The traffic light indicators provide a comparison of the ward to all the other wards in Bromley. This is not a league table. The profiles don't compare the ward with a particular *standard*, but rather show wards which are behaving very differently from other wards. This is probably the most useful way to make comparisons, as there are no well-defined standards for most of the indicators used. In this way, it can be seen whether and how a ward deviates from the majority of wards.

In the ward profiles, a high value for an indicator means that it is likely to be associated with poorer health outcomes e.g. a high level of deprivation is associated with poor health outcomes.

High values have been shaded red and low values have been shaded green.

For further details of the indicator methodology, please see the Appendix.

The Indicator and Indicator Value columns show the name and actual value of the indicator itself. A fuller description of each indicator is included in the appendix.

Interpretation

The purpose of the ward profiles is to prompt consideration of the answers to the following questions about each ward:

- What factors are present in the ward which may have a detrimental impact on the health of the population?
- Is this ward experiencing poor health outcomes?
- What action could be taken to improve health outcomes in the ward?

These questions and their answers are important to inform the planning of services to the population so that their health needs can be adequately met.

Some of the determinants of health cannot be controlled or influenced, for example: age, gender and ethnicity.

Other factors, are generally outside an individual's control, but can be improved by support from the Government, Local Authority, NHS, for example: socioeconomic status, education, employment prospects, physical environment, social environment and access to health services.

Lifestyle choices which impact on health e.g. smoking, diet, alcohol consumption and physical activity are more in the control of the individual. However, while individual behaviours may seem the most amenable to change through 'informed choice', in reality many apparently free choices are strongly influenced by socioeconomic, cultural and environmental factors.

The Indicators

Our health and wellbeing is influenced by a wide range of factors, many of which lie outside the remit of health and social care services. These include economic issues, the quality of the local environment and of housing, and connections to wider society.

Determinants of Health

Demography

It is important to understand the nature of the population in an area in order to be able to provide appropriate health care services. Older people and young children have higher use of services than other groups. The prevalence of some diseases is increased in particular ethnic groups e.g. diabetes is more prevalent in Black Caribbean and Asian communities. Children in lone parent households have a higher risk of living in poverty than children in couple families. Lone pensioners may suffer loneliness and isolation; they also have an increased chance of having difficulties with accessing health services.

Deprivation

How deprived an area is in comparison to another is measured using the Indices of Multiple deprivation (IMD). The IMD combines 38 separate indicators into 7 weighted domains of: Income, Employment, Health, Education, Crime, Access to services and Living Environment to make up a single IMD score. The assessment is done at small area level comprising around 1500 people, therefore an average score has been considered for the ward. Deprivation is strongly linked to poor health and life outcomes and is central to action tackling health inequalities.

An indicator for child deprivation is also included: IDACI stands for the Income Domain Affecting Children Index and is defined as the percentage of children aged 0-15 living in income-deprived households.

Families are classed as income-deprived if they are in receipt of income support, income based jobseekers allowance or pension credit, or child tax credit with an equivalised income (excluding housing benefits) below 60% of the national median before housing costs.

Employment

Employment is one of the most strongly evidenced determinants of health. People's employment status and the nature of their work have a direct bearing on their physical and mental health and even their life expectancy. This is related to income, a sense of making a valuable contribution and increased social networks gained through work.

Education

People with more education (years and qualifications) are likely to live longer to experience better health outcomes, and to practice health promoting behaviours such as exercising regularly, refraining from smoking, and obtaining timely health care check-ups and screenings. People with more education are likely to have better access to services and be better able to negotiate their healthcare. Evidence suggests that obesity prevalence decreases with increasing levels of educational attainment.

The indicators of educational attainment included are;

- Good level of development at age five which measures how ready children are for school at the end of reception across a wide range of developmental areas.
- The percentage achieving Level 4 or above in English and Maths at Key Stage 2.
- The percentage achieving five or more GCSE grades A*-C including English and maths.

It is noteworthy that the data presented only refers to residents in Bromley state funded schools excluding independent schools and or residents going to out-of-borough schools.

Housing

Housing conditions affect people's health. Inadequate housing causes or contributes to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer. Research shows strong links between overcrowding and stress, anxiety and mental health disorders. There is a direct link between income loss and house repossession orders especially in light of the recent economic downturn.

Two economic downturn related indicators are presented; Landlord repossession and mortgage repossession orders.

Landlord orders include all types of landlord whether social or private sector, and cover actions made using both the standard and accelerated possession procedures.

Mortgage orders include all types of lenders whether local authority or private. Housing repossession orders don't indicate how many houses have actually been repossessed through the courts. Repossessions can occur with or without a court order being made while not all court orders result in repossessions.

Crime

The link between crime and health is well established. There is a direct link to health through violent injury, rape and other offences against the person and less directly via the psychological trauma of experiencing crimes such as burglary or vandalism. Fear of crime affects the health of the wider community via, for example, restrictions on unsupervised outdoor play for children and social isolation in older people.

Crime reduces the effectiveness of healthcare systems through violence against NHS staff, damage to property, and costs of replacement, repairs and security. Alcohol and illegal drug dependency increase crime, and have an impact on health care services including accident and emergency, maxillofacial surgery and trauma departments.

Public Transport Accessibility levels (PTAL)

Public Transport Accessibility Levels (PTAL) are a detailed and accurate measure of the accessibility of a point to the public transport network, taking into account walk access time and service availability. The method is essentially a way of measuring the density of the public transport network at any location within Greater London.

PTAL ratings are divided into bands, with Band 1 representing a low level of accessibility and Band 6 a high level.

Public transport accessibility is important because travel poverty is strongly associated with the inability to participate, since it can result in lack of access to both essential and 'non-essential' services and facilities; work, hospitals, shops and education are examples.

Social Care

Social care services provide services for people who are disabled or ill, so that they and their carers get the care they need and can live as independently as possible. To make sure the available support goes to the most vulnerable Bromley residents, Fair Access to Care (FACS) criteria as set out by the Department of Health are applied for adults 18-64 years of age, who have a permanent disability or long-term care needs.

There are people who do not meet the criteria for funding of social care, who self-fund, these people are not included in this indicator.

Wellbeing Scores

Ward level well-being scores present a combined measure of well-being indicators of the resident population based on 12 different indicators. Where possible each indicator score is compared with the England and Wales average, which is zero. Scores over 0 indicate a higher probability that the population on average will experience better well-being according to these measures.

The 12 measures included are shown in the table below:

Category	Indicator
Health	Life and Expectancy
	Incapacity Benefits claimant rate
Economic security	Unemployment rate
	Income Support claimant rate
Safety	Crime rate
	Deliberate Fires
Children	Unauthorised Pupil Absence
Families	Children in out-of-work families
Transport	Public Transport Accessibility Scores
Environment	Access to public open space & nature
Community	Elections Turnout
Education	GCSE point scores

These wellbeing scores are indicators and are not exact measures of wellbeing. Whilst the wellbeing indicators are not causes of wellbeing, they do indicate whether the resident population of an area is more or less likely to be satisfied with life which could in turn affect their mental and physical wellbeing.

Smoking

Smoking is a modifiable lifestyle risk factor. Smoking is the single biggest cause of preventable ill health and early death. Evidence shows that smoking causes cancers, cardiovascular disease and respiratory disease. Smoking in pregnancy increases the risk of low birth weight and infant mortality and contributes to health inequalities.

Substance Misuse

Substance misuse is the patterned use or consumption of drugs and alcohol in amounts and or ways that are harmful. The indicator refers to residents in treatment for the abuse of either alcohol and drugs or both. Substance misuse is a complex subject. Although the numbers of recorded problematic drugs and alcohol abuse might be small, there are far reaching individual and societal implications. Substance misuse negatively impacts both health and its wider determinants. There is evidence associating alcohol abuse with heart disease, high blood pressure, cancer. There is an increased risk of contracting blood born viruses such as HIV with injecting drug use. There is also an increased risk of; accidents, crime and violence, mental health problems, unemployment, homelessness, poor sexual behaviour and an additional increased risk of early death when risk factors interact.

Children of substance abusers are at increased risk of low educational attainment, substance abuse, living in poverty, teenage pregnancy and thus perpetuating the cycle of deprivation into adult life. Substance misuse is often challenging and costly to treat, thus prevention and early intervention is essential.

Teenage Pregnancy

Teenage pregnancy refers to conceptions to women aged under 18 years. Teenage pregnancy can be associated with adverse health and social outcomes.

These include: higher rates of infant mortality than for children born to older mothers, babies are more likely to be born prematurely, which has serious implications for the baby's long-term health and children have higher rates of admissions to A&E.

In the longer term, children of teenage mothers experience lower educational attainment and are at higher risk of economic inactivity as adults. The pressures of early parenthood result in teenage mothers experiencing high rates of poor emotional health and well-being, which impacts on their children's behaviour and achievement.

Teenage parents often do not achieve the qualifications they need to progress into further education and, in some cases, have difficulties finding childcare and other support they need to participate in Education, Employment or Training (EET). Consequently, they struggle to compete in an increasingly high-skill labour market.

Childhood Obesity

Obesity in children is determined by body mass index (BMI) percentiles. The percentile indicates the relative position of the child's BMI number among children of the same sex and age. Being overweight or obese in childhood has consequences for health in both the short term and the longer term. Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood.

Some obesity-related conditions can develop during childhood. Type 2 diabetes, previously considered an adult disease, can now be seen in overweight children as young as five.

The emotional and psychological effects of being overweight are often seen as the most immediate and most serious by children themselves. They include teasing and discrimination by peers; low self-esteem; anxiety and depression. Obese children may also suffer disturbed sleep and fatigue.

Adult obesity

Obesity in adults is defined as anyone with a body mass index over 30. Obesity in adults is associated with a range of mental and physical health problems including social isolation, cardiovascular disease, cancer, type 2 diabetes. There is strong evidence indicating that obesity is a good predictor of increased risk of death.

Obesity risk factors are complex having behavioural, genetic, environmental and social elements thereby greatly contributing to health inequalities.

Binge drinking

Binge drinking is defined as drinking heavily in a short period of time to get drunk or feel the effects of alcohol. Evidence shows that binge drinking may have significantly worse health implications than frequently drinking small amounts.

Binge drinkers are at increased risk of; accidents and falls due to impaired balance and coordination, alcohol overdose and its complications and early death.

Health Outcomes

Life Expectancy

Life expectancy at birth is defined as the average number of years that a newborn could expect to live, if he or she were subject to the age-specific

mortality rates of a given period. In Bromley the average life expectancy for males is 80.3 years and for females 84.3 years. Lower levels of life expectancy represent higher numbers of deaths at younger ages.

Disease Burden

A high proportion of people with certain conditions (such as heart disease and diabetes) in an area is an indicator of poor health and will result in lower life expectancy for people living in that area. Poor health is associated not only with genetic susceptibility and lifestyle behaviour choices (e.g. smoking), but also with what are called wider determinants. These wider determinants include education, housing, and the living environment. For those areas with a high disease burden, therefore, consideration should be given to addressing the wider determinants of health.

Additional Information on Maps

Fair access to health services is a founding principle of the National Health Services. The Tackling Health Inequalities – 2002 cross-cutting review demonstrated the significant impact that differential access to public services, including health services and local authority services, has on health inequalities.

Green Spaces (Parks and Playgrounds)

There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage – especially walking, running and cycling. They reduce the risk of flooding and absorb airborne pollutants.

Pharmacies

Pharmacies traditionally dispense drugs and medicines in the community. They are a point of call for minor ailments and are also widely being used to deliver health services for instance; contraception and STI testing, smoking cessation, health advice as well as sign posting to other health services.

General Practice

Primary care is of major importance to health. Access to good primary care reduces the cost of the health care system as a whole. Evidence suggests that high quality primary care is associated with improved health outcomes. This

association is strongest in deprived areas, suggesting that high quality primary care may play an important role in reducing health inequalities.

Schools and Children's Centres

Education is important factor in adult employment and income.

The maps only show locations of state funded schools and academies.

Children's centres working with multi-agency partners provide a range of services that support parents and carers to give their child the best start in life. The Marmot Review of health inequalities recognised that disadvantage starts before birth and accumulates throughout life. Children's centres are well placed to support early years before mainstream education.

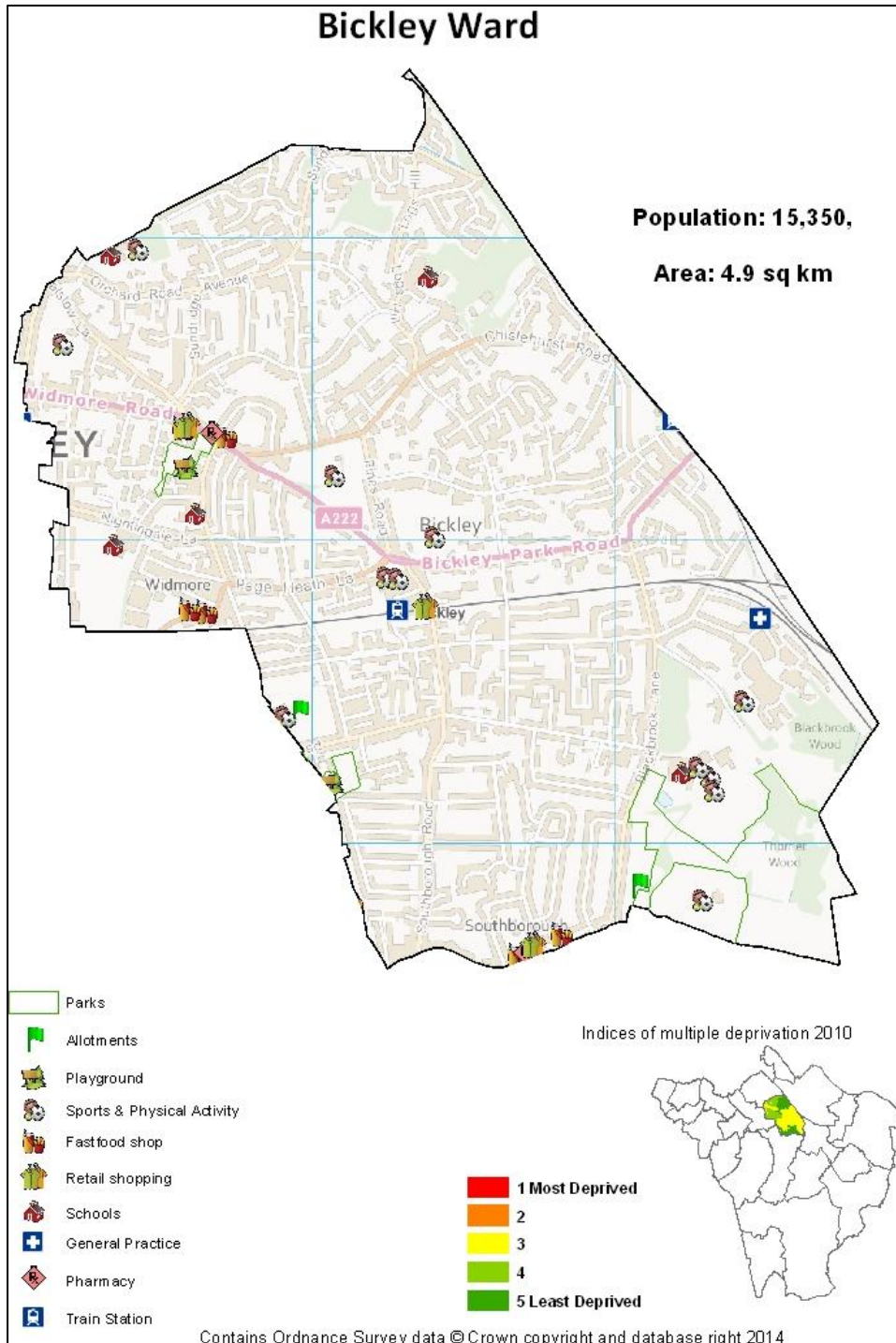
Fast-food shops and allotments

People who eat fast food have a greater calorie intake than those who do not and therefore have a greater risk of overweight or obesity. There is a strong association between deprivation and the density of fast food outlets, with more deprived areas having more fast food outlets.

Allotments have an obvious link to healthy eating and physical activity. However there is also opportunity to link with children and adult education, social inclusion, mental health and improved general well-being.

Note

Data for disease burden and smoking have been extracted from Bromley GP disease registers. These data exclude Bromley residents registered with GPs outside the borough and the patients of one Bromley practice (with a catchment area including residents of Penge & Cator, Mottingham & Chislehurst North and Crystal Palace) where data extraction was not possible.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Bickley		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	15350		
		2013	Population density (GLA)	3091.84	10	43.2
		2013	% Children (0-4)	5.90	11	47.7
		2013	% Older people (75+)	10.70	19	84.1
		2011	% Lone parent households	4.66	4	15.9
		2011	% Lone pensioner households	13.00	9	38.6
		2011	% BAME	14.50	12	52.3
		2011	% Not Born in UK	15.70	15	65.9
	Deprivation	2010	IMD 2010 (Mean)	8.56	7	29.5
		2010	IDACI 2010 (Score)	0.08	6	25.0
	Employment and Education	2011	% with no qualifications	14.50	4	15.9
		2011	% Never worked/Long term unemployed (16-64)	1.20	1	2.3
		2012/2013	% Average workless benefit claimants	8.70	7	29.5
		2011	% Routine and semi - routine workers	10.78	3	11.4
		2012/2013	% Good level of development at age 5	66.24	14	61.4
		2012/2013	Key stage 2: Level 4 and above achievement	84.68	15	65.9
		2012/2013	GCSE: 5+A*-C achievement	81.51	21	93.2
	Housing and the Neighbourhood	2011	% Overcrowded households	4.89	9	38.6
		2011	% Social rented households	7.00	8	34.1
		2011	Mortgage Repossession Orders	10.00	7	29.5
		2011	Landlord Repossession Orders	10.00	5	20.5
		2012/13	Crime rate per 1000	46.70	7	29.5
		2011	Average Public Transport Accessibility score	2.30	7	29.5
	Well-being and Lifestyle	2011	% reporting bad and very bad health	4.00	13	56.8
		2011	% Funded Social care (18+)	5.62	1	2.3
		2012	Overall wellbeing probability score	6.00	15	65.9
		2012-2013	% Recorded smokers	6.31	1	2.3
		2012-2013	Substance misuse (in treatment) per 1000	1.04	5	20.5
		2009-2011	Teenage conception rates	26.94	8	34.1
		2009/10- 2011/12	% Obese children in 4 -5 year olds	4.70	1	2.3
		2009/10- 2011/12	% Obese children in 10-11 year olds	12.20	5	20.5
		2006-2008	Obesity estimate (16+)	19.30	1	2.3
		2006-2010	Healthy eating estimates	40.10	20	88.6
		2006-2010	Binge drinking estimates (16+)	12.40	7	29.5
	HEALTH OUTCOMES	2006-2010	Female life expectancy	83.10	9	38.6
		2006-2010	Male life expectancy	79.60	9	38.6
		2012/2013	% Recorded Diabetes (16+)	4.39	14	61.4
		2012/2013	% Recorded Stroke	2.29	21	93.2
		2012/2013	% Recorded Serious Mental Illness	0.38	8	34.1
		2012/2013	% Recorded COPD	1.13	14	61.4
		2012/2013	% Recorded Asthma	4.74	3	11.4
		2012/2013	% Recorded Epilepsy	1.28	17	75.0
		2012/2013	% Recorded Learning disability	0.10	11	47.7
		2012/2013	% Recorded Dementia	1.10	22	97.7
		2012/2013	% Recorded Coronary Heart Disease	3.58	18	79.5
		2012/2013	% Recorded Chronic Kidney Disease	3.37	18	79.5
		2012/2013	% Recorded Heart Failure	0.90	21	93.2
		2012/2013	% Recorded Atrial Fibrillation	2.12	15	65.9
		2012/2013	% Recorded Hypertension	14.21	12	52.3
		2012/2013	% Recorded Cancer	2.18	14	61.4

Summary of Key Issues

Bickley is located in the north west of Bromley town but unlike other parts of the borough the area doesn't have a clearly defined centre.

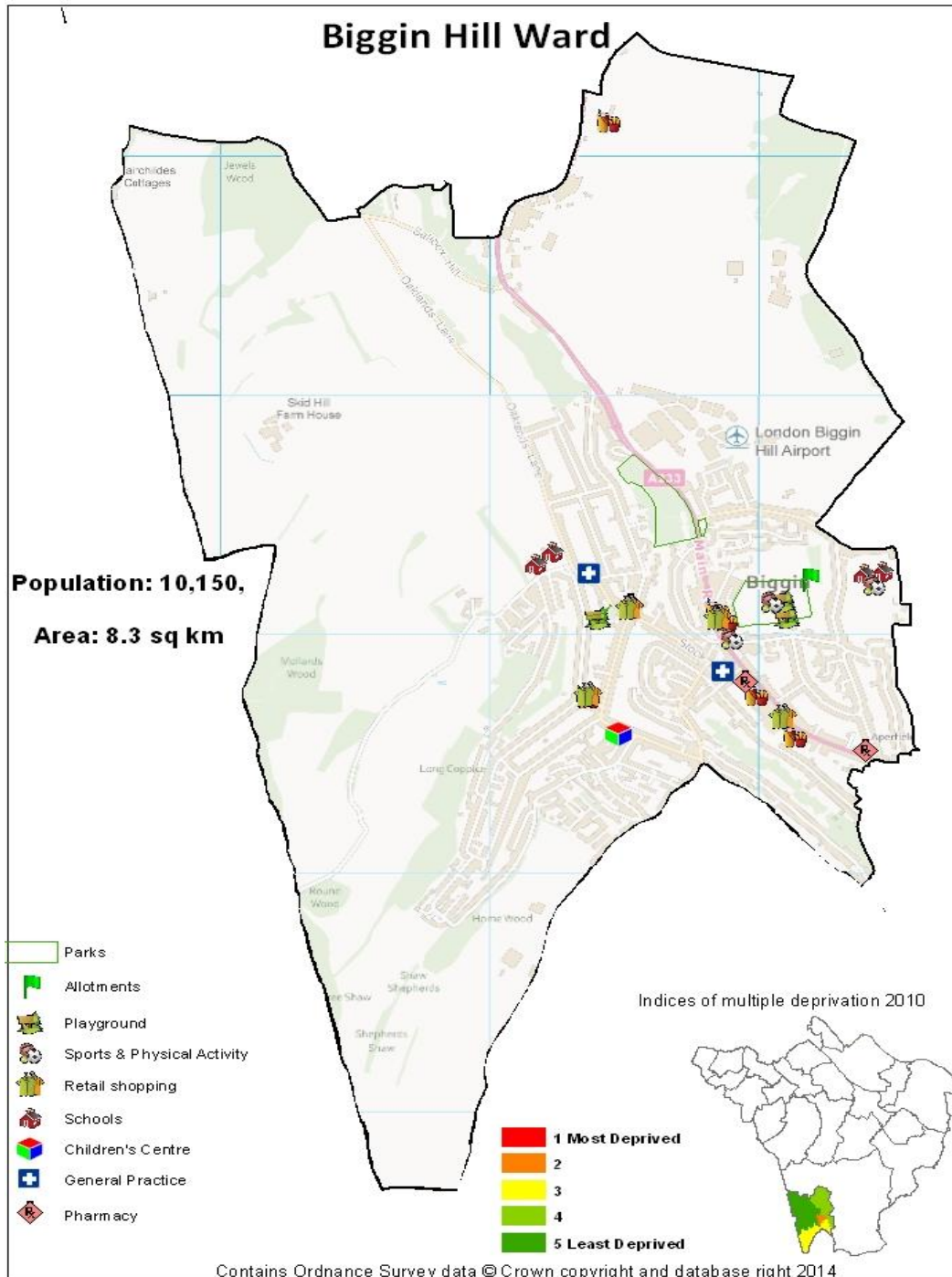
This is an area with low deprivation levels, an older population and is home to a considerable non-UK born community and an average proportion of ethnic minority groups. Despite having a considerable older population, the proportion of lone pensioner households is low.

A significant proportion of the working age population are economically active in professional positions. It is worth noting that Bickley records the lowest proportion of 16-64 years olds who have never worked or in Long term unemployment in the borough.

Educational attainment in pupils in state funded schools is above average especially GCSE attainment. There is a very low proportion of social rented households and overcrowded households in the area and population density is below borough average. There is a low rate of recorded crime in the area. There is a significant proportion of residents in receipt of state funded social care.

Although public open space is limited in Bickley, there are large gardens associated with well-spaced properties. Overall there is a favourable profile of the determinants of health presented except public transport accessibility which is below average. Access to health services is negatively impacted by poor public transport links especially with an older population who are less likely to drive with age.

There is a sense of wellbeing and people are reporting good and very good health as well as making healthy lifestyle choices. There is low recording of smoking, binge drinking and obesity while healthy eating is above average. The burden of disease reflects the age profile of this population, with high levels of diseases of old age- stroke, dementia, coronary heart disease, chronic kidney disease and heart failure.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Biggin Hill		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	10150		
		2013	Population density (GLA)	1319.28	4	15.9
		2013	% Children (0-4)	5.40	5	20.5
		2013	% Older people (75+)	6.90	5	20.5
		2011	% Lone parent households	6.37	13	56.8
		2011	% Lone pensioner households	11.15	3	11.4
		2011	% BAME	4.10	1	2.3
		2011	% Not Born in UK	5.10	1	2.3
	Deprivation	2010	IMD 2010 (Mean)	8.93	8	34.1
		2010	IDACI 2010 (Score)	0.10	10	43.2
	Employment and Education	2011	% with no qualifications	18.30	15	65.9
		2011	% Never worked/Long term unemployed (16-64)	1.40	8	34.1
		2012/2013	% Average workless benefit claimants	7.90	5	20.5
		2011	% Routine and semi - routine workers	17.65	15	65.9
		2012/2013	% Good level of development at age 5	57.66	9	38.6
		2012/2013	Key stage 2: Level 4 and above achievement	79.61	11	47.7
	Housing and the Neighbourhood	2012/2013	GCSE: 5+A*-C achievement	54.47	5	20.5
		2011	% Overcrowded households	3.61	4	15.9
		2011	% Social rented households	4.60	4	15.9
		2011	Mortgage Repossession Orders	20.00	20	88.6
		2011	Landlord Repossession Orders	0.00	1	2.3
		2012/13	Crime rate per 1000	53.50	10	43.2
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	1.70	2	6.8
		2011	% reporting bad and very bad health	3.40	6	25.0
		2011	% Funded Social care (18+)	1.73	2	6.8
		2012	Overall wellbeing probability score	7.00	16	70.5
		2012-2013	% Recorded smokers	14.01	14	61.4
		2012-2013	Substance misuse (in treatment) per 1000	1.28	7	29.5
		2009-2011	Teenage conception rates	30.04	12	52.3
		2009/10- 2011/12	% Obese children in 4 -5 year olds	8.20	13	56.8
		2009/10- 2011/12	% Obese children in 10-11 year olds	15.10	9	38.6
		2006-2008	Obesity estimate (16+)	26.70	19	84.1
		2006-2010	Healthy eating estimates	32.80	4	15.9
		2006-2010	Binge drinking estimates (16+)	14.20	15	65.9
		2006-2010	Female life expectancy	85.10	14	61.4
		2006-2010	Male life expectancy	81.30	15	65.9
HEALTH OUTCOMES	Disease and Death	2012/2013	% Recorded Diabetes (16+)	3.94	9	38.6
		2012/2013	% Recorded Stroke	1.35	9	38.6
		2012/2013	% Recorded Serious Mental Illness	0.24	2	6.8
		2012/2013	% Recorded COPD	1.09	11	47.7
		2012/2013	% Recorded Asthma	10.25	17	75.0
		2012/2013	% Recorded Epilepsy	1.00	12	52.3
		2012/2013	% Recorded Learning disability	0.06	3	11.4
		2012/2013	% Recorded Dementia	0.21	5	20.5
		2012/2013	% Recorded Coronary Heart Disease	2.65	7	29.5
		2012/2013	% Recorded Chronic Kidney Disease	3.24	15	65.9
		2012/2013	% Recorded Heart Failure	0.58	10	43.2
		2012/2013	% Recorded Atrial Fibrillation	1.51	7	29.5
		2012/2013	% Recorded Hypertension	14.18	11	47.7
		2012/2013	% Recorded Cancer	2.14	13	56.8

Summary of Key Issues

Biggin Hill is located in the south of the borough, bordering Tandridge. The rural nature of the area separates Biggin Hill from the rest of Bromley and the surrounding more urban areas leading to some isolation.

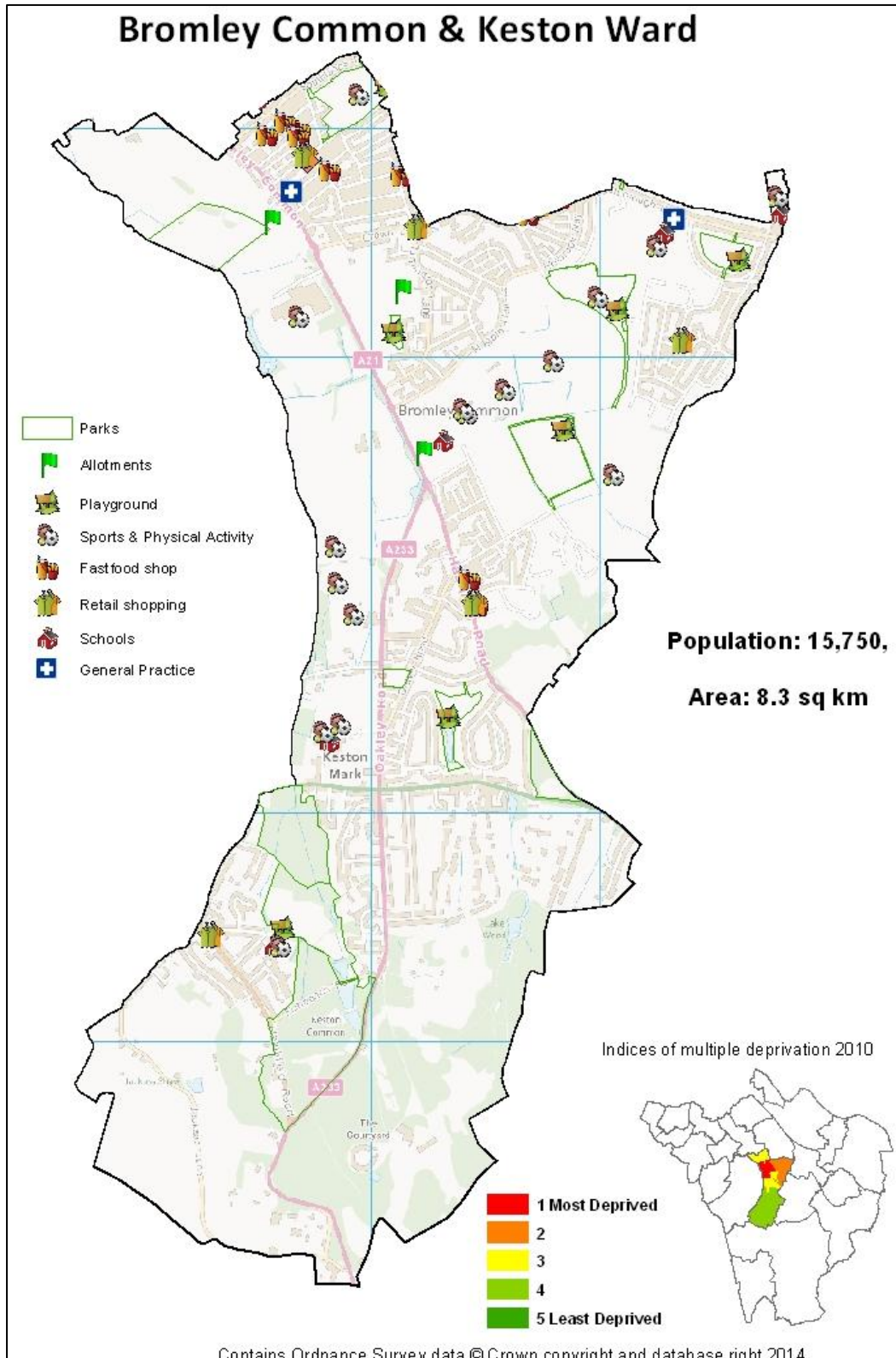
This is generally an affluent area with a predominantly working age population, high proportion of owner occupied houses and big green spaces but very limited public open spaces. Although Biggin Hill has a low proportion of children under 5 years of age, there is an average proportion of lone parent households.

Educational attainment overall is low -GCSE attainment in children attending state funded schools is very poor whilst the percentage of adult residents with no qualification is high. 1 in 6 of the working residents is in routine and semi routine employment.

The ward is home to Biggin Hill airport which is a significant employer in the area. There has been a considerable recording of mortgage repossession court orders, which is one of the measures of the impact of the economic downturn.

There is a sense of wellbeing and people are reporting good and very good health. Life expectancy is above average and the burden of disease is low except for asthma and chronic kidney disease which are high. The high prevalence of risk factors for disease including obesity, binge drinking and poor eating habits in a young population, is a likely indicator that disease could present later in life if risk factors are not modified. Teenage pregnancy rates are average and crime in the area is below average.

Biggin Hill has the second lowest PTAL score in the borough. Poor access to public transport in a working population indicates a high proportion of car usage which is a contributor to the carbon footprint and physical inactivity levels in the borough.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Bromley Common and Keston		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	15750		
		2013	Population density (GLA)	1861.45	7	29.5
		2013	% Children (0-4)	6.30	12	52.3
		2013	% Older people (75+)	8.90	11	47.7
		2011	% Lone parent households	8.86	17	75.0
		2011	% Lone pensioner households	13.30	13	56.8
		2011	% BAME	12.80	10	43.2
		2011	% Not Born in UK	12.10	10	43.2
	Deprivation	2010	IMD 2010 (Mean)	15.68	15	65.9
		2010	IDACI 2010 (Score)	0.19	15	65.9
	Employment and Education	2011	% with no qualifications	20.50	17	75.0
		2011	% Never worked/Long term unemployed (16-64)	2.40	16	70.5
		2012/2013	% Average workless benefit claimants	16.10	15	65.9
		2011	% Routine and semi - routine workers	17.69	16	70.5
		2012/2013	% Good level of development at age 5	54.19	7	29.5
		2012/2013	Key stage 2: Level 4 and above achievement	69.77	4	15.9
		2012/2013	GCSE: 5+A*-C achievement	72.62	13	56.8
	Housing and the Neighbourhood	2011	% Overcrowded households	6.12	12	52.3
		2011	% Social rented households	15.70	15	65.9
		2011	Mortgage Repossession Orders	15.00	14	61.4
		2011	Landlord Repossession Orders	20.00	11	47.7
		2012/13	Crime rate per 1000	50.10	8	34.1
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	2.30	8	34.1
		2011	% reporting bad and very bad health	4.40	15	65.9
		2011	% Funded Social care (18+)	7.70	2	6.8
		2012	Overall wellbeing probability score	3.00	9	38.6
		2012-2013	% Recorded smokers	14.67	16	70.5
		2012-2013	Substance misuse (in treatment) per 1000	2.29	14	61.4
		2009-2011	Teenage conception rates	27.93	10	43.2
		2009/10- 2011/12	% Obese children in 4 -5 year olds	9.50	16	70.5
		2009/10- 2011/12	% Obese children in 10-11 year olds	15.00	8	34.1
		2006-2008	Obesity estimate (16+)	22.60	11	47.7
		2006-2010	Healthy eating estimates	34.10	7	29.5
		2006-2010	Binge drinking estimates (16+)	13.10	10	43.2
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	84.20	12	52.3
		2006-2010	Male life expectancy	80.00	11	47.7
		2012/2013	% Recorded Diabetes (16+)	4.01	11	47.7
		2012/2013	% Recorded Stroke	1.45	11	47.7
		2012/2013	% Recorded Serious Mental Illness	0.25	3	11.4
		2012/2013	% Recorded COPD	1.38	19	84.1
		2012/2013	% Recorded Asthma	9.07	10	43.2
		2012/2013	% Recorded Epilepsy	0.90	4	15.9
		2012/2013	% Recorded Learning disability	0.11	12	52.3
		2012/2013	% Recorded Dementia	0.28	7	29.5
		2012/2013	% Recorded Coronary Heart Disease	3.31	17	75.0
		2012/2013	% Recorded Chronic Kidney Disease	2.55	9	38.6
		2012/2013	% Recorded Heart Failure	0.72	14	61.4
		2012/2013	% Recorded Atrial Fibrillation	1.68	11	47.7
		2012/2013	% Recorded Hypertension	12.95	8	34.1
		2012/2013	% Recorded Cancer	1.22	4	15.9

Summary of Key Issues

Bromley Common and Keston is in the centre of the borough, a mixed area interspersed with large areas of open land with a designated green belt.

Although Bromley Common and Keston overall has above average levels of deprivation, it presents a mixed picture of deprivation. The ward comprises a more urban and deprived northern area- which was highlighted as a renewal area in the previous JSNA and a more affluent, residential semi-rural southern area. Therefore use of the ward level deprivation indicator masks more localised variation.

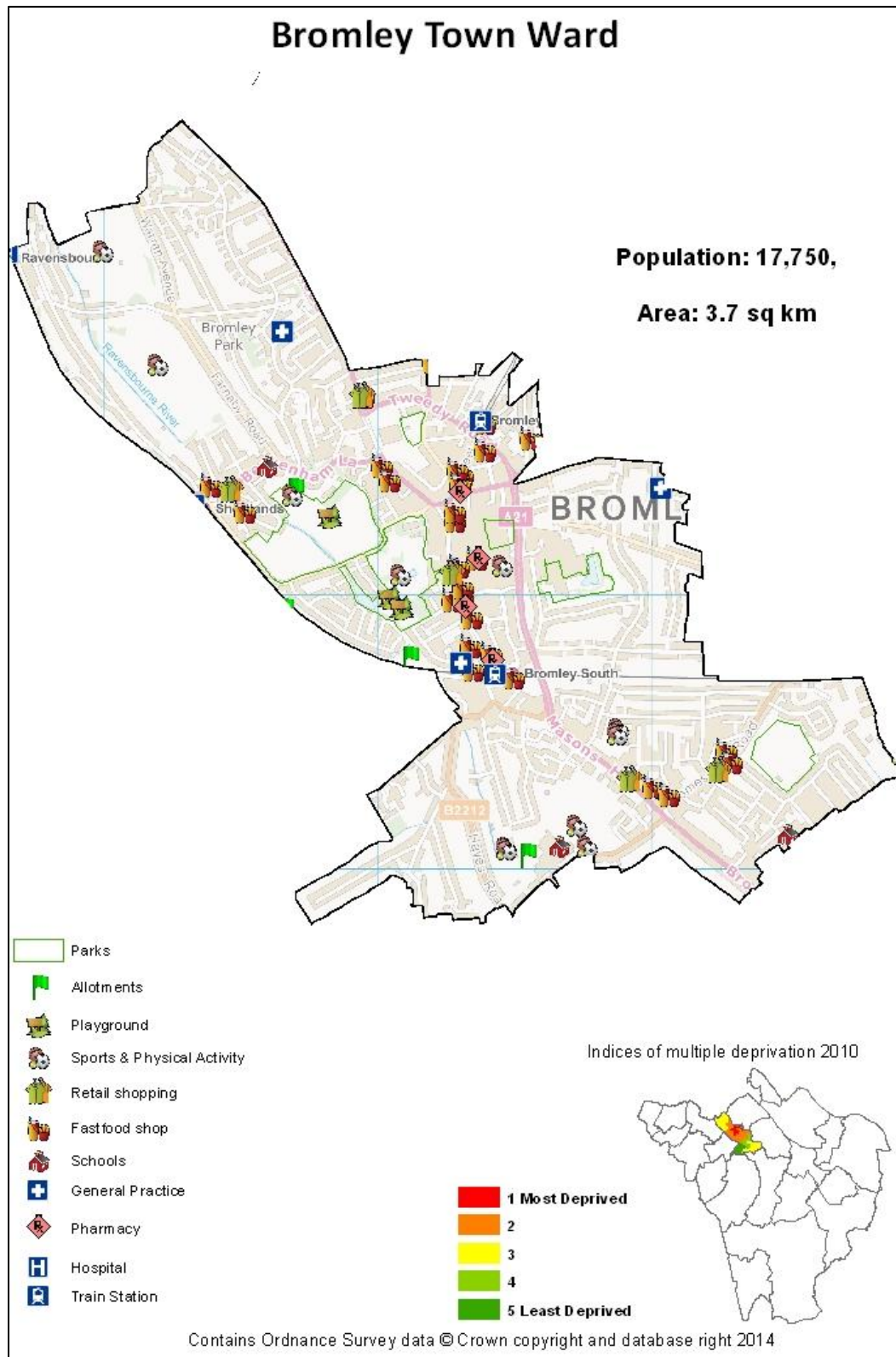
The population is fairly evenly distributed in age between children, working age and older people. There is a relatively high proportion of single parent households.

There is high economic inactivity in the working age population and life chances are compromised with low educational attainment levels especially at key stage 2. A significant proportion of the residents have no qualifications and are in routine and semi- routine work.

There is a considerable proportion of social rented households. It is also noteworthy that the lowest proportion of adults in receipt of social funded care in Bromley live in this area. The Trinity village development opened recently and includes 120 extra care housing units.

Overall the sense of wellbeing is poor, and higher than average proportions of people are reporting bad and very bad health. Levels of healthy eating are low and smoking levels are above average. There is a high prevalence of obesity in children 4-5 years of age but the pattern is not reflected in children 10-11years.

The burden of disease is average in the area except for heart failure, chronic obstructive pulmonary disease and coronary heart disease which are high. Overall the ward has a potential for worsening health outcomes as risk factors combine later in life unless risk factors are modified.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Bromley Town		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	17750		
		2013	Population density (GLA)	4581.08	18	79.5
		2013	% Children (0-4)	8.20	18	79.5
		2013	% Older people (75+)	6.80	4	15.9
		2011	% Lone parent households	6.30	12	52.3
		2011	% Lone pensioner households	12.27	7	29.5
		2011	% BAME	18.50	18	79.5
	Deprivation	2011	% Not Born in UK	19.90	19	84.1
		2010	IMD 2010 (Mean)	12.91	12	52.3
	Employment and Education	2010	IDACI 2010 (Score)	0.14	13	56.8
		2011	% with no qualifications	13.10	3	11.4
		2011	% Never worked/Long term unemployed (16-64)	2.00	13	56.8
		2012/2013	% Average workless benefit claimants	14.70	13	56.8
		2011	% Routine and semi - routine workers	13.17	6	25.0
		2012/2013	% Good level of development at age 5	66.14	12	52.3
		2012/2013	Key stage 2: Level 4 and above achievement	80.77	12	52.3
	Housing and the Neighbourhood	2012/2013	GCSE: 5+A*-C achievement	70.00	12	52.3
		2011	% Overcrowded households	10.90	20	88.6
		2011	% Social rented households	10.00	13	56.8
		2011	Mortgage Repossession Orders	15.00	15	65.9
		2011	Landlord Repossession Orders	25.00	14	61.4
		2012/13	Crime rate per 1000	140.80	22	97.7
		2011	Average Public Transport Accessibility score	3.80	19	84.1
	Well-being and Lifestyle	2011	% reporting bad and very bad health	3.40	7	29.5
		2011	% Funded Social care (18+)	5.06	20	88.6
		2012	Overall wellbeing probability score	3.00	10	43.2
		2012-2013	% Recorded smokers	33.62	20	88.6
		2012-2013	Substance misuse (in treatment) per 1000	2.48	15	65.9
		2009-2011	Teenage conception rates	36.81	16	70.5
		2009/10- 2011/12	% Obese children in 4 -5 year olds	4.50	1	2.3
		2009/10- 2011/12	% Obese children in 10-11 year olds	16.80	13	56.8
		2006-2008	Obesity estimate (16+)	18.50	3	11.4
		2006-2010	Healthy eating estimates	39.70	19	84.1
		2006-2010	Binge drinking estimates (16+)	15.50	19	84.1
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	82.40	4	15.9
		2006-2010	Male life expectancy	79.30	8	34.1
		2012/2013	% Recorded Diabetes (16+)	4.66	17	75.0
		2012/2013	% Recorded Stroke	1.76	17	75.0
		2012/2013	% Recorded Serious Mental Illness	0.79	22	97.7
		2012/2013	% Recorded COPD	1.21	16	70.5
		2012/2013	% Recorded Asthma	23.20	22	97.7
		2012/2013	% Recorded Epilepsy	1.42	20	88.6
		2012/2013	% Recorded Learning disability	0.16	15	65.9
		2012/2013	% Recorded Dementia	0.52	19	84.1
		2012/2013	% Recorded Coronary Heart Disease	3.18	12	52.3
		2012/2013	% Recorded Chronic Kidney Disease	2.55	8	34.1
		2012/2013	% Recorded Heart Failure	0.82	20	88.6
		2012/2013	% Recorded Atrial Fibrillation	1.71	13	56.8
		2012/2013	% Recorded Hypertension	15.05	15	65.9
		2012/2013	% Recorded Cancer	2.35	16	70.5

Summary of Key Issues

Bromley town is the home of the civic offices and the Glades shopping mall and is the largest town in the Borough.

This is an area of average deprivation levels, high population density and a high proportion of children under 5 years of age. Bromley town is home to a considerable minority ethnic and a non-UK born community.

The proportion of lone parent households and social rented households is average but there are high levels of overcrowded households in the area. There is a significant proportion of adults in receipt of funded social care.

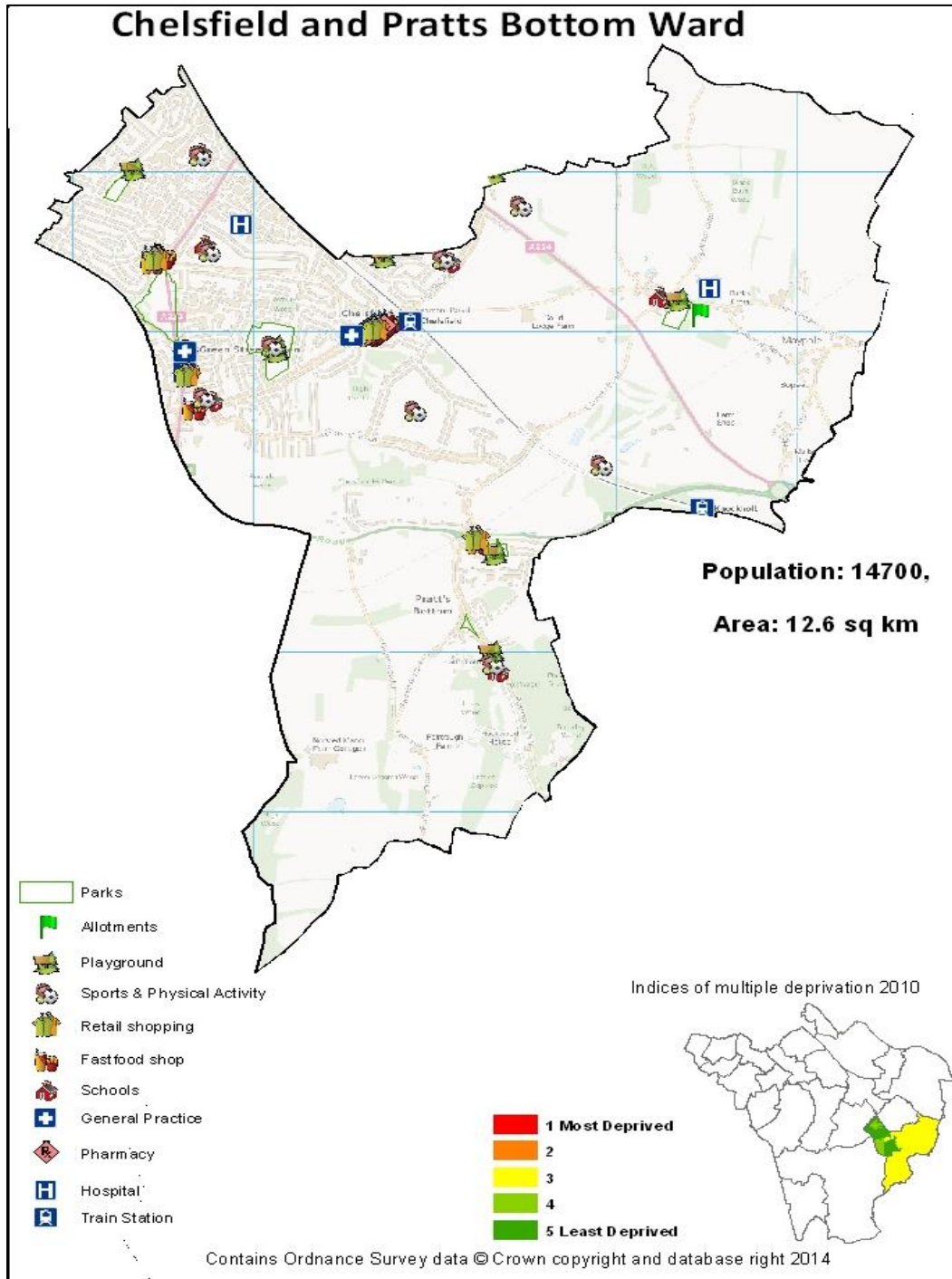
On average the working age population are economically active. A high proportion of residents have qualifications which is reflected in the low proportions of routine and semi- routine workers. Educational attainment is average as measured at age 5, Key stage 2 and GCSE in pupils attending state funded schools.

Bromley Town has the highest rate of recorded crime in the borough. Housing repossession orders have been average; however mortgage repossession court orders were slightly higher than landlord repossession court orders which are measures of the impact of economic downturn.

This area scores highly on the PTAL. There are two rail stations and buses which provide very good transport connections within the ward, the borough and the rest of London.

People are reporting good and very good health although overall sense of wellbeing is average. Healthy eating levels are high and obesity rates in both adults and children are low. However there is an above average number of people binge drinking, smoking and receiving treatment for substance misuse. Teenage pregnancy rates are also above average.

This is an area with a relatively high burden of disease recorded in primary care except for hypertension which is low. Life expectancy is significantly below average especially for women.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Chelshfield and Pratts Bottom		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	14700		
		2013	Population density (GLA)	1250	3	11.4
		2013	% Children (0-4)	5.80	9	38.6
		2013	% Older people (75+)	9.20	13	56.8
		2011	% Lone parent households	4.53	3	11.4
		2011	% Lone pensioner households	13.50	15	65.9
		2011	% BAME	9.70	6	25.0
		2011	% Not Born in UK	9.70	4	15.9
	Deprivation	2010	IMD 2010 (Mean)	5.99	2	6.8
		2010	IDACI 2010 (Score)	0.07	5	20.5
	Employment and Education	2011	% with no qualifications	16.40	10	43.2
		2011	% Never worked/Long term unemployed (16-64)	1.40	9	38.6
		2012/2013	% Average workless benefit claimants	8.80	8	34.1
		2011	% Routine and semi - routine workers	14.38	12	52.3
		2012/2013	% Good level of development at age 5	77.91	21	93.2
		2012/2013	Key stage 2: Level 4 and above achievement	82.66	14	61.4
		2012/2013	GCSE: 5+A*-C achievement	74.07	15	65.9
	Housing and the Neighbourhood	2011	% Overcrowded households	2.78	2	6.8
		2011	% Social rented households	4.60	5	20.5
		2011	Mortgage Repossession Orders	0.00	1	2.3
		2011	Landlord Repossession Orders	0.00	2	6.8
		2012/13	Crime rate per 1000	36.10	3	11.4
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	1.90	3	11.4
		2011	% reporting bad and very bad health	3.10	2	6.8
		2011	% Funded Social care (18+)	2.51	3	11.4
		2012	Overall wellbeing probability score	8.00	17	75.0
		2012-2013	% Recorded smokers	9.26	2	6.8
		2012-2013	Substance misuse (in treatment) per 1000	0.95	3	11.4
		2009-2011	Teenage conception rates	25.74	7	29.5
		2009/10- 2011/12	% Obese children in 4 -5 year olds	6.40	7	29.5
		2009/10- 2011/12	% Obese children in 10-11 year olds	16.90	14	61.4
		2006-2008	Obesity estimate (16+)	22.10	9	38.6
		2006-2010	Healthy eating estimates	35.70	11	47.7
		2006-2010	Binge drinking estimates (16+)	11.70	5	20.5
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	86.40	18	79.5
		2006-2010	Male life expectancy	82.30	20	88.6
		2012/2013	% Recorded Diabetes (16+)	4.09	12	52.3
		2012/2013	% Recorded Stroke	1.49	13	56.8
		2012/2013	% Recorded Serious Mental Illness	0.35	5	20.5
		2012/2013	% Recorded COPD	1.07	9	38.6
		2012/2013	% Recorded Asthma	8.84	8	34.1
		2012/2013	% Recorded Epilepsy	0.94	7	29.5
		2012/2013	% Recorded Learning disability	0.15	14	61.4
		2012/2013	% Recorded Dementia	0.37	14	61.4
		2012/2013	% Recorded Coronary Heart Disease	3.25	14	61.4
		2012/2013	% Recorded Chronic Kidney Disease	3.52	19	84.1
		2012/2013	% Recorded Heart Failure	0.58	8	34.1
		2012/2013	% Recorded Atrial Fibrillation	2.23	17	75.0
		2012/2013	% Recorded Hypertension	15.93	19	84.1
		2012/2013	% Recorded Cancer	1.97	9	38.6

Summary of Key Issues

Chelsfield & Pratts Bottom ward is in the south east of the borough to the border of Sevenoaks and parts of the ward are similar to neighbouring Kent. It is also one of the least densely populated areas of Bromley.

Chelsfield & Pratts Bottom overall is one of Bromley's affluent areas although the ward indicator masks areas within the ward with average deprivation levels. The ward has an average proportion of older people but contributes significantly to the lone pensioner households in Bromley. It is predominantly home to a White and White British community.

A high proportion of the working age population are economically active with average proportions of residents in routine and semi- routine employment and low proportions of workless benefits claimants.

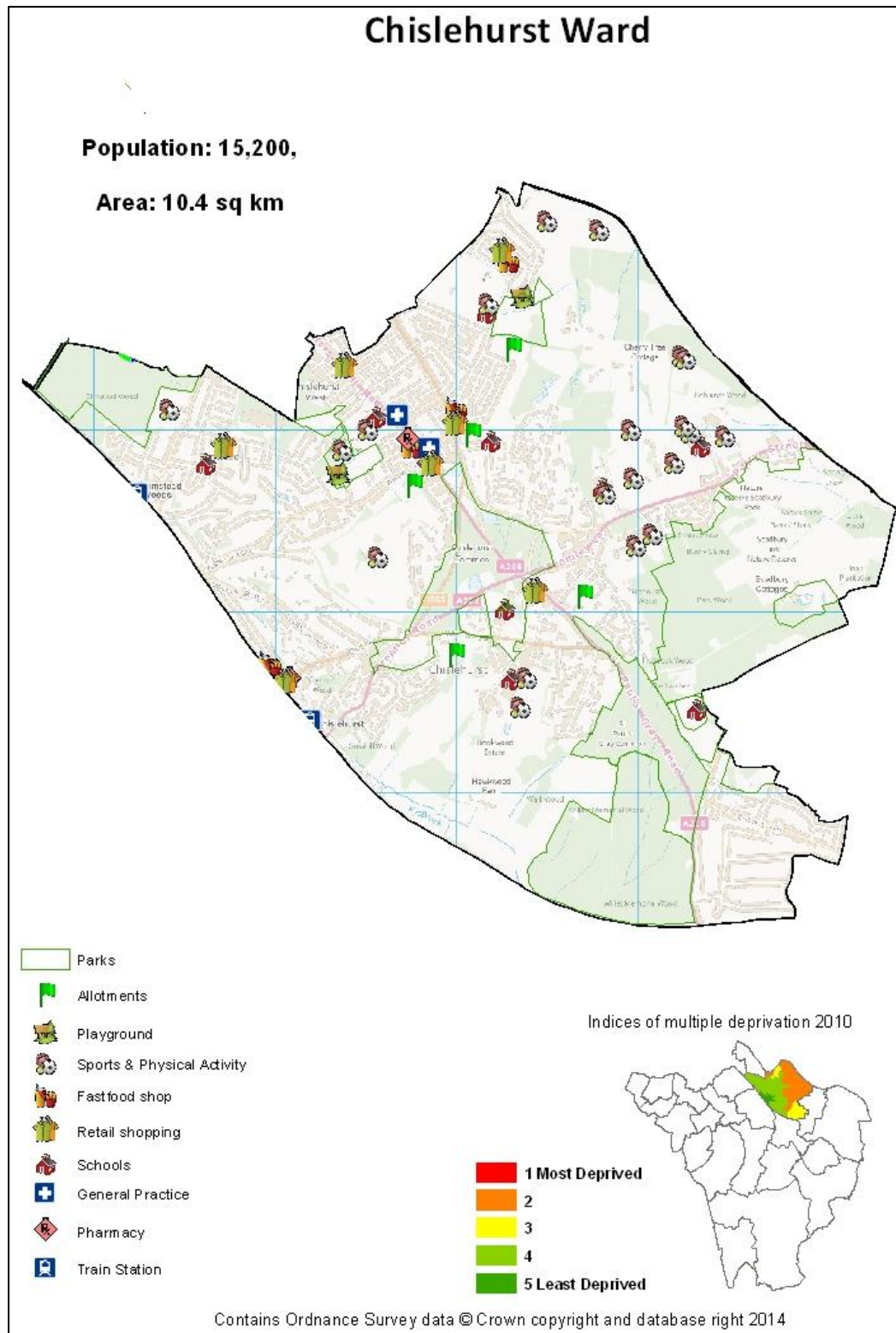
Educational attainment is average at Key stage 2 and GCSE but exceptional at age 5 in pupils attending state funded schools.

There are very low proportions of social rented households or overcrowded housing. There has been no record of mortgage or landlord repossession court orders in the area indicating financial resilience during the economic downturn. This area has very low recorded crime and low teenage conception rates.

The area scores low on average Public Transport Accessibility Index. Poor access to public transport impacts on service access especially with lone pensioners being unable to drive with age.

The people have a very high sense of wellbeing and are reporting good and very good health as well as making healthy lifestyle choices reflected in the low recording of smoking, binge drinking and people in treatment for substance misuse. Obesity rates are low in both adults and children and healthy eating estimates are high.

The area has significantly high life expectancy especially for men. The burden of disease in the area is average except for chronic kidney disease, hypertension and atrial fibrillation which have high levels.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Chislehurst		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	15200		
		2013	Population density (GLA)	1495.19	6	25.0
		2013	% Children (0-4)	5.60	6	25.0
		2013	% Older people (75+)	11.50	21	93.2
		2011	% Lone parent households	4.82	7	29.5
		2011	% Lone pensioner households	14.79	19	84.1
		2011	% BAME	12.00	8	34.1
		2011	% Not Born in UK	12.70	12	52.3
	Deprivation	2010	IMD 2010 (Mean)	11.04	9	38.6
		2010	IDACI 2010 (Score)	0.10	9	38.6
	Employment and Education	2011	% with no qualifications	15.80	9	38.6
		2011	% Never worked/Long term unemployed (16-64)	1.50	10	43.2
		2012/2013	% Average workless benefit claimants	8.40	6	25.0
		2011	% Routine and semi - routine workers	11.48	4	15.9
		2012/2013	% Good level of development at age 5	71.52	19	84.1
		2012/2013	Key stage 2: Level 4 and above achievement	81.63	13	56.8
		2012/2013	GCSE: 5+A*-C achievement	74.00	14	61.4
	Housing and the Neighbourhood	2011	% Overcrowded households	4.24	6	25.0
		2011	% Social rented households	7.10	9	38.6
		2011	Mortgage Repossession Orders	10.00	8	34.1
		2011	Landlord Repossession Orders	20.00	12	52.3
		2012/13	Crime rate per 1000	68.00	14	61.4
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	2.20	4	15.9
		2011	% reporting bad and very bad health	4.00	14	61.4
		2011	% Funded Social care (18+)	4.26	12	52.3
		2012	Overall wellbeing probability score	5.00	13	56.8
		2012-2013	% Recorded smokers	10.61	7	29.5
		2012-2013	Substance misuse (in treatment) per 1000	1.51	11	47.7
		2009-2011	Teenage conception rates	11.32	2	6.8
		2009/10- 2011/12	% Obese children in 4 -5 year olds	6.30	6	25.0
		2009/10- 2011/12	% Obese children in 10-11 year olds	16.00	12	52.3
		2006-2008	Obesity estimate (16+)	20.00	2	6.8
		2006-2010	Healthy eating estimates	39.20	17	75.0
		2006-2010	Binge drinking estimates (16+)	11.50	3	11.4
		2006-2010	Female life expectancy	82.80	7	29.5
HEALTH OUTCOMES	Disease and Death	2006-2010	Male life expectancy	80.10	12	52.3
		2012/2013	% Recorded Diabetes (16+)	3.82	8	34.1
		2012/2013	% Recorded Stroke	2.01	19	84.1
		2012/2013	% Recorded Serious Mental Illness	0.39	9	38.6
		2012/2013	% Recorded COPD	1.30	18	79.5
		2012/2013	% Recorded Asthma	9.70	14	61.4
		2012/2013	% Recorded Epilepsy	0.99	9	38.6
		2012/2013	% Recorded Learning disability	0.07	4	15.9
		2012/2013	% Recorded Dementia	0.75	21	93.2
		2012/2013	% Recorded Coronary Heart Disease	3.17	11	47.7
		2012/2013	% Recorded Chronic Kidney Disease	3.30	16	70.5
		2012/2013	% Recorded Heart Failure	0.79	19	84.1
		2012/2013	% Recorded Atrial Fibrillation	2.39	21	93.2
		2012/2013	% Recorded Hypertension	13.90	10	43.2
		2012/2013	% Recorded Cancer	2.24	15	65.9

Summary of Key Issues

Chislehurst is located in the north of the borough, bordering Greenwich and Bexley boroughs. This is typically a suburban area with a good range of green spaces accessible to the public.

This is an area with low deprivation levels, however the overall score masks variation within the ward. There is almost an even split with the west being significantly more affluent and the east being more deprived.

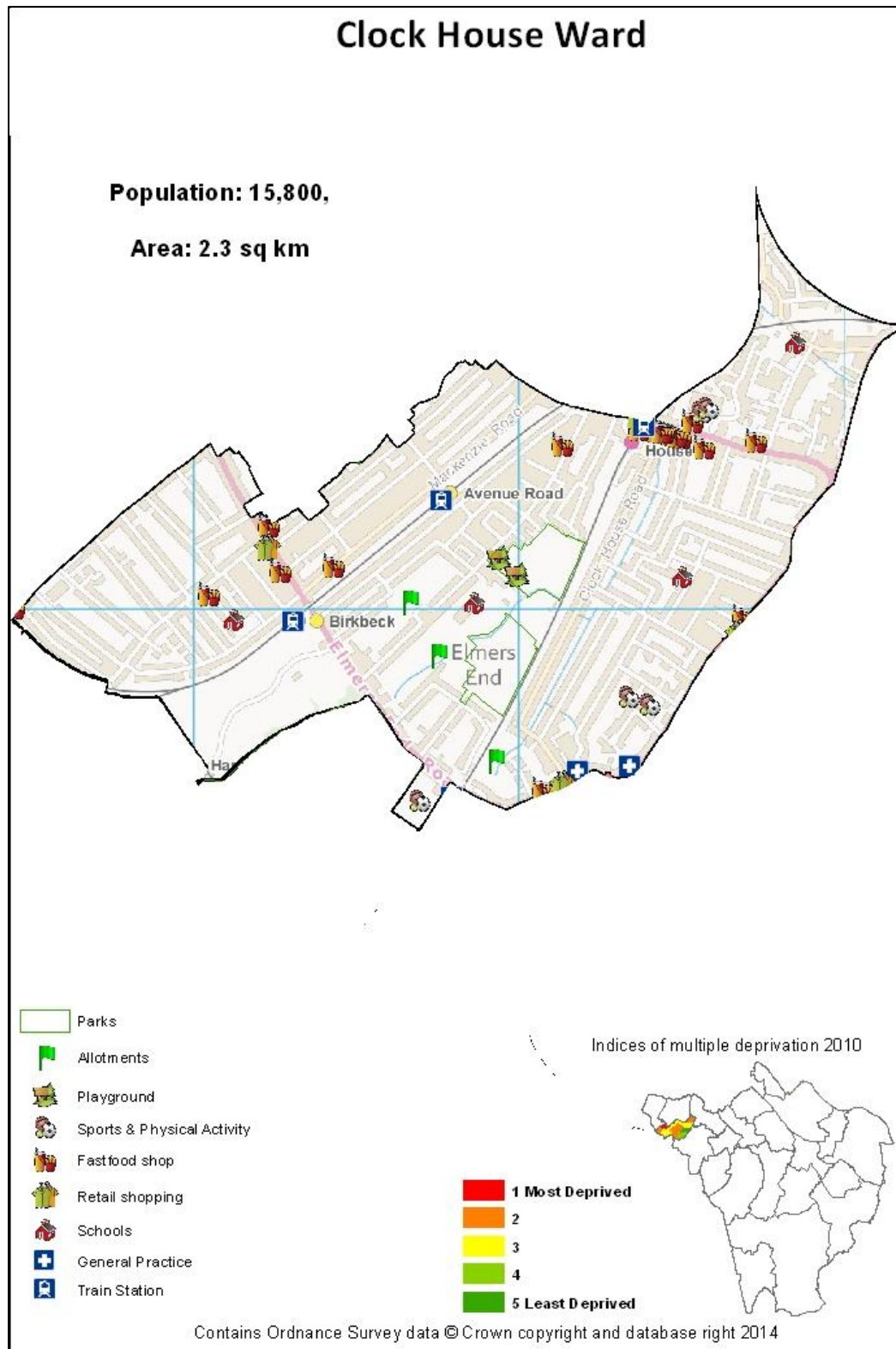
There is a significantly high proportion of older people. It is noteworthy that Chislehurst has the second highest proportion of Bromley residents aged 75 years and over and a significant proportion of them are living alone.

There is an average non- UK born community but a low proportion of Black and Asian minority ethnic groups. There are very low proportions of social rented households and overcrowded households in the area and population density is below borough average.

A high proportion of the working age population are economically active professionals in managerial or senior positions. Educational attainment is average at Key stage 2 and GCSE but exceptional at age 5 in pupils attending state funded schools.

There is a sense of wellbeing and people are reporting good and very good health as well as making healthy lifestyle choices as reflected in the healthy eating levels which are high and low levels of smoking, binge drinking and obesity. Chislehurst experiences the second lowest rate of teenage conceptions in all Bromley wards. The area scores poorly on the Public Transport Accessibility Index. Poor access to public transport impacts on service access especially with lone pensioners being unable to drive with age.

Life expectancy is below average. There are gender inequalities with women having higher life expectancy than men but within gender, women in Chislehurst experience life expectancy similar to the deprived wards in the borough although this is generally an affluent area. The burden of disease reflects the age profile of this population with high levels of diseases of old age- stroke, Chronic obstructive pulmonary disease, dementia, heart failure and atrial fibrillation.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Clock House		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	15800		
		2013	Population density (GLA)	7304.35	22	97.7
		2013	% Children (0-4)	8.90	21	93.2
		2013	% Older people (75+)	5.70	3	11.4
		2011	% Lone parent households	7.10	14	61.4
		2011	% Lone pensioner households	11.68	5	20.5
		2011	% BAME	20.60	20	88.6
	Deprivation	2011	% Not Born in UK	17.30	18	79.5
		2010	IMD 2010 (Mean)	14.07	13	56.8
	Employment and Education	2010	IDACI 2010 (Score)	0.12	12	52.3
		2011	% with no qualifications	15.20	5	20.5
		2011	% Never worked/Long term unemployed (16-64)	2.30	15	65.9
		2012/2013	% Average workless benefit claimants	15.10	14	61.4
		2011	% Routine and semi - routine workers	14.31	11	47.7
		2012/2013	% Good level of development at age 5	66.20	13	56.8
		2012/2013	Key stage 2: Level 4 and above achievement	78.79	9	38.6
	Housing and the Neighbourhood	2012/2013	GCSE: 5+A*-C achievement	60.56	6	25.0
		2011	% Overcrowded households	9.14	14	61.4
		2011	% Social rented households	12.60	14	61.4
		2011	Mortgage Repossession Orders	15.00	16	70.5
		2011	Landlord Repossession Orders	35.00	16	70.5
	Well-being and Lifestyle	2012/13	Crime rate per 1000	53.40	9	38.6
		2011	Average Public Transport Accessibility score	3.90	20	88.6
		2011	% reporting bad and very bad health	3.80	12	52.3
		2011	% Funded Social care (18+)	3.89	10	43.2
		2012	Overall wellbeing probability score	4.00	11	47.7
		2012-2013	% Recorded smokers	13.22	13	56.8
		2012-2013	Substance misuse (in treatment) per 1000	2.66	16	70.5
		2009-2011	Teenage conception rates	27.19	9	38.6
		2009/10- 2011/12	% Obese children in 4 -5 year olds	6.90	9	38.6
		2009/10- 2011/12	% Obese children in 10-11 year olds	18.20	16	70.5
HEALTH OUTCOMES	Disease and Death	2006-2008	Obesity estimate (16+)	22.20	10	43.2
		2006-2010	Healthy eating estimates	34.10	8	34.1
		2006-2010	Binge drinking estimates (16+)	17.00	20	88.6
		2006-2010	Female life expectancy	83.80	11	47.7
		2006-2010	Male life expectancy	78.80	6	25.0
		2012/2013	% Recorded Diabetes (16+)	3.30	5	20.5
		2012/2013	% Recorded Stroke	1.08	4	15.9
		2012/2013	% Recorded Serious Mental Illness	0.54	17	75.0
		2012/2013	% Recorded COPD	0.85	4	15.9
		2012/2013	% Recorded Asthma	9.58	13	56.8
		2012/2013	% Recorded Epilepsy	1.02	13	56.8
		2012/2013	% Recorded Learning disability	0.08	10	43.2
		2012/2013	% Recorded Dementia	0.15	4	15.9
		2012/2013	% Recorded Coronary Heart Disease	1.99	4	15.9
		2012/2013	% Recorded Chronic Kidney Disease	1.73	5	20.5
		2012/2013	% Recorded Heart Failure	0.47	4	15.9
		2012/2013	% Recorded Atrial Fibrillation	1.19	4	15.9
		2012/2013	% Recorded Hypertension	9.89	4	15.9
		2012/2013	% Recorded Cancer	1.34	5	20.5

Summary of Key Issues

Clock House is located to the north west of the borough, bordering Penge & Cator and the London Borough of Croydon. Clock House is Bromley's most densely populated ward with average deprivation levels. It is home to a considerable community of Black and Asian minority ethnic groups and non-UK born residents as well as having the second largest concentration of children under 5 in the borough.

There is an average proportion of lone parent households but an above average proportion of social rented households and overcrowded housing. There has been a high count of both mortgage and landlord repossession court orders which are measures of the impact of the economic downturn.

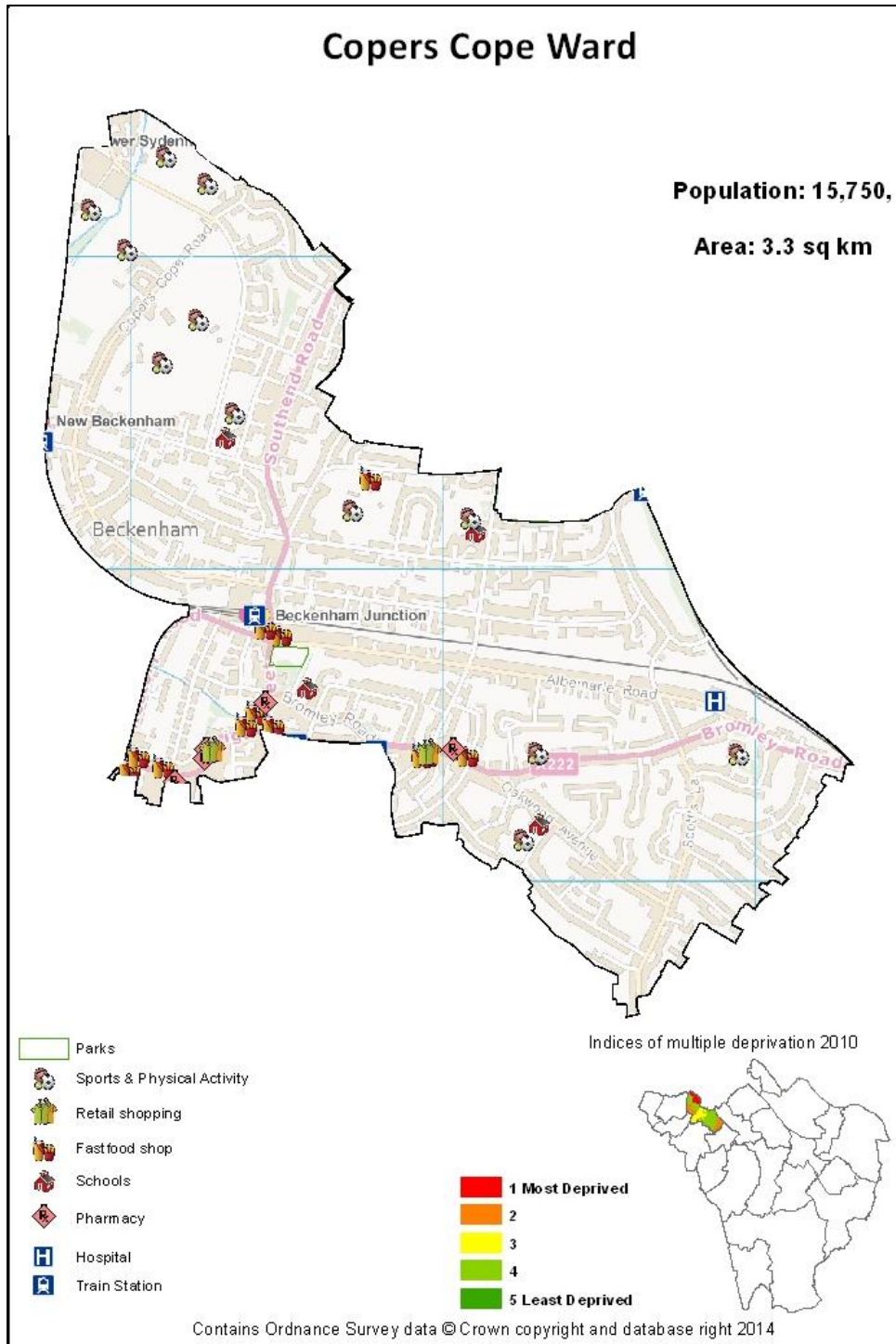
Educational attainment is a precursor to improved life opportunities but the school going population is not achieving academically especially at key stage 4. Although there are low proportions of residents with no qualifications, there is high economic inactivity in the working age population evidenced by high proportion of residents who have never worked or in long term unemployment and are claiming workless benefits.

The ward scores highly on the Public Transport Accessibility index. The area is well served by three train stations and the tram-link making for easier connections within and out of the borough.

On average, people are reporting good and very good health and there is a general sense of wellbeing. Lifestyle risk factors are average to poor. There is a high level of recording of binge drinking and people in treatment for substance misuse. Obesity overall is low except in children 10-11 years and estimated healthy eating is low.

In terms of health outcomes, male life expectancy is significantly below average. There is a low burden of disease except for serious mental illness which is high.

Teenage pregnancy rates and crime rates are low.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Copers Cope		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	15750		
		2013	Population density (GLA)	4803.03	19	84.1
		2013	% Children (0-4)	6.30	13	56.8
		2013	% Older people (75+)	8.60	10	43.2
		2011	% Lone parent households	5.03	8	34.1
		2011	% Lone pensioner households	13.31	14	61.4
		2011	% BAME	17.40	16	70.5
		2011	% Not Born in UK	20.30	20	88.6
	Deprivation	2010	IMD 2010 (Mean)	11.92	11	47.7
		2010	IDACI 2010 (Score)	0.17	14	61.4
	Employment and Education	2011	% with no qualifications	12.10	1	2.3
		2011	% Never worked/Long term unemployed (16-64)	1.80	12	52.3
		2012/2013	% Average workless benefit claimants	12.20	11	47.7
		2011	% Routine and semi - routine workers	10.36	2	6.8
		2012/2013	% Good level of development at age 5	67.14	15	65.9
		2012/2013	Key stage 2: Level 4 and above achievement	78.67	8	34.1
		2012/2013	GCSE: 5+A*-C achievement	66.67	10	43.2
	Housing and the Neighbourhood	2011	% Overcrowded households	9.79	17	75.0
		2011	% Social rented households	9.20	12	52.3
		2011	Mortgage Repossession Orders	10.00	9	38.6
		2011	Landlord Repossession Orders	35.00	17	75.0
		2012/13	Crime rate per 1000	66.20	13	56.8
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	3.00	18	79.5
		2011	% reporting bad and very bad health	3.50	8	34.1
		2011	% Funded Social care (18+)	4.37	13	56.8
		2012	Overall wellbeing probability score	2.00	8	34.1
		2012-2013	% Recorded smokers	11.61	9	38.6
		2012-2013	Substance misuse (in treatment) per 1000	1.97	12	52.3
		2009-2011	Teenage conception rates	30.36	13	56.8
		2009/10- 2011/12	% Obese children in 4 -5 year olds	7.50	10	43.2
		2009/10- 2011/12	% Obese children in 10-11 year olds	12.00	3	11.4
		2006-2008	Obesity estimate (16+)	17.10	1	2.3
		2006-2010	Healthy eating estimates	42.30	21	93.2
		2006-2010	Binge drinking estimates (16+)	17.00	21	93.2
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	83.60	10	43.2
		2006-2010	Male life expectancy	79.80	10	43.2
		2012/2013	% Recorded Diabetes (16+)	2.99	4	15.9
		2012/2013	% Recorded Stroke	1.28	7	29.5
		2012/2013	% Recorded Serious Mental Illness	0.49	15	65.9
		2012/2013	% Recorded COPD	0.66	2	6.8
		2012/2013	% Recorded Asthma	8.15	7	29.5
		2012/2013	% Recorded Epilepsy	0.98	8	34.1
		2012/2013	% Recorded Learning disability	0.06	2	6.8
		2012/2013	% Recorded Dementia	0.32	11	47.7
		2012/2013	% Recorded Coronary Heart Disease	2.50	6	25.0
		2012/2013	% Recorded Chronic Kidney Disease	2.30	7	29.5
		2012/2013	% Recorded Heart Failure	0.55	6	25.0
		2012/2013	% Recorded Atrial Fibrillation	1.68	12	52.3
		2012/2013	% Recorded Hypertension	11.08	6	25.0
		2012/2013	% Recorded Cancer	2.03	10	43.2

Summary of Key Issues

Copers Cope is located in the northern part of the borough bordering Lewisham. This is a densely populated area with average deprivation levels. Copers Cope has the highest proportion of working age population in Bromley and is home to a considerable minority ethnic and a non-UK born community.

Although there are few older people living in this area, there is a presence of lone pensioner households. Similarly there is an average proportion of social rented households but high levels of overcrowded housing. There has been a high record of landlord repossession court orders which is a measure of the impact of the economic downturn.

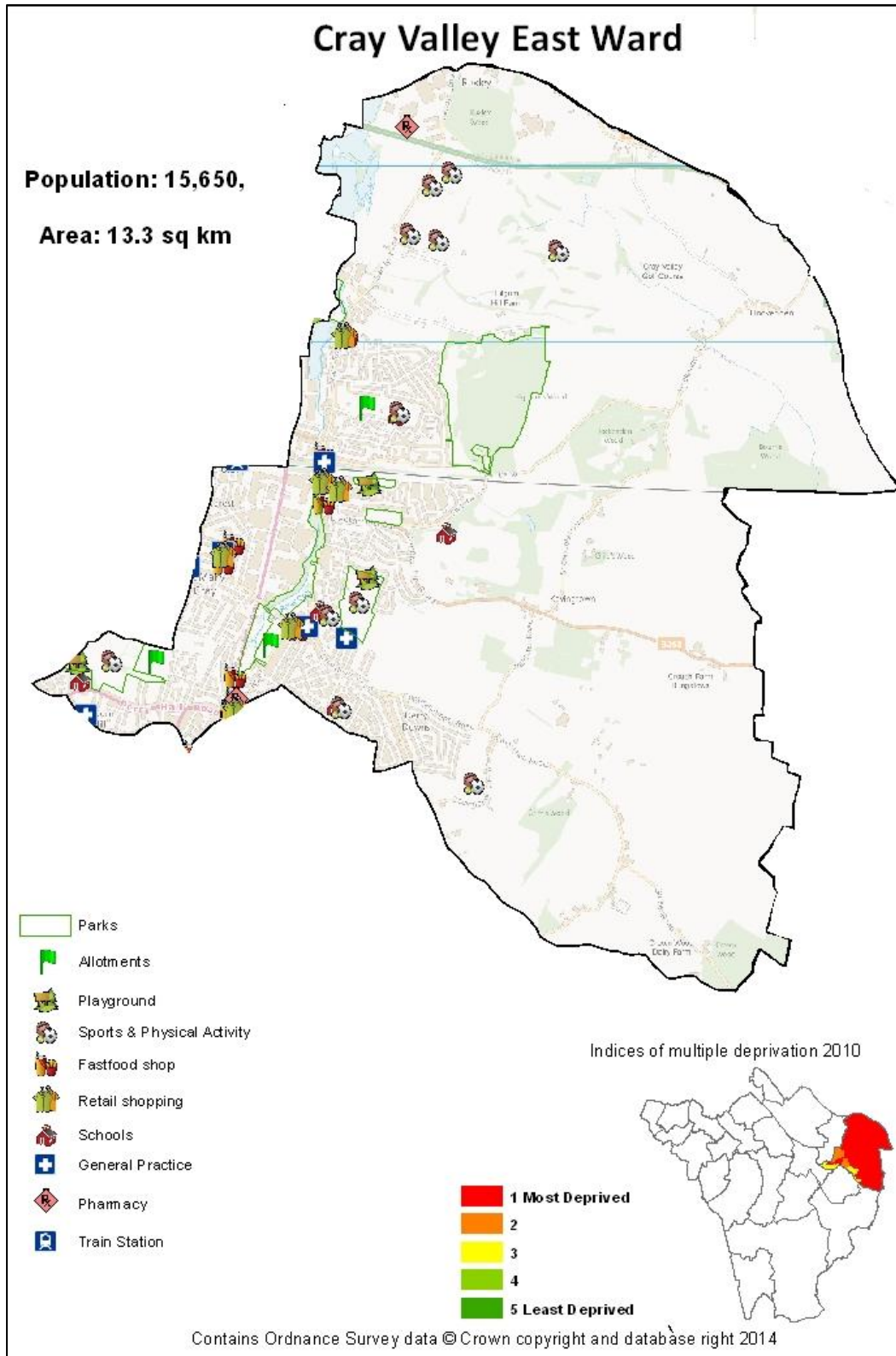
On average the working age population are economically active. A high proportion of residents have qualifications which is reflected in the low proportions of routine and semi-routine workers. There is variation in educational attainment in pupils attending state funded schools. Achievement of good level of development at age 5 is above average, GCSE attainment is average, whilst attainment at Key stage 2 is poor.

The ward is well served by two train stations and tram link making for easier connections within and out of the borough thus giving it a good score on the Public Transport Accessibility index.

Although there is no general practice situated within the ward boundaries, Beckenham Beacon is situated just outside the south west border of the ward which provides a range of planned care and urgent care facilities.

People are reporting good and very good health although overall sense of wellbeing is average. All lifestyle risk factors as measured by healthy eating, smoking, obesity in adults and children are good except for binge drinking which is high. The ward has the second highest record of binge drinking in the borough.

Life expectancy is significantly below average however there is a low burden of disease except for serious mental illness which is above average. The overall low burden of disease reflects the young age of the population, the other long term conditions could present later in life and have not yet become apparent.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Cray Valley East		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	15650		
		2013	Population density (GLA)	1176.69	2	6.8
		2013	% Children (0-4)	8.30	20	88.6
		2013	% Older people (75+)	7.70	9	38.6
		2011	% Lone parent households	12.07	20	88.6
		2011	% Lone pensioner households	13.15	11	47.7
		2011	% BAME	14.60	13	56.8
		2011	% Not Born in UK	12.30	11	47.7
	Deprivation	2010	IMD 2010 (Mean)	27.04	19	84.1
		2010	IDACI 2010 (Score)	0.35	20	88.6
	Employment and Education	2011	% with no qualifications	27.90	21	93.2
		2011	% Never worked/Long term unemployed (16-64)	3.40	19	84.1
		2012/2013	% Average workless benefit claimants	24.80	20	88.6
		2011	% Routine and semi - routine workers	25.81	21	93.2
		2012/2013	% Good level of development at age 5	55.14	8	34.1
		2012/2013	Key stage 2: Level 4 and above achievement	64.90	2	6.8
		2012/2013	GCSE: 5+A*-C achievement	43.66	2	6.8
	Housing and the Neighbourhood	2011	% Overcrowded households	9.58	15	65.9
		2011	% Social rented households	24.70	18	79.5
		2011	Mortgage Repossession Orders	20.00	21	93.2
		2011	Landlord Repossession Orders	35.00	18	79.5
		2012/13	Crime rate per 1000	101.00	21	93.2
		2011	Average Public Transport Accessibility score	2.30	9	38.6
	Well-being and Lifestyle	2011	% reporting bad and very bad health	5.70	20	88.6
		2011	% Funded Social care (18+)	4.50	15	65.9
		2012	Overall wellbeing probability score	-11.00	1	2.3
		2012-2013	% Recorded smokers	16.97	17	75.0
		2012-2013	Substance misuse (in treatment) per 1000	3.51	17	75.0
		2009-2011	Teenage conception rates	49.94	19	84.1
		2009/10- 2011/12	% Obese children in 4 -5 year olds	9.90	18	79.5
		2009/10- 2011/12	% Obese children in 10-11 year olds	22.40	21	93.2
		2006-2008	Obesity estimate (16+)	26.40	18	79.5
		2006-2010	Healthy eating estimates	30.40	3	11.4
		2006-2010	Binge drinking estimates (16+)	12.40	8	34.1
		2006-2010	Female life expectancy	83.00	8	34.1
HEALTH OUTCOMES	Disease and Death	2006-2010	Male life expectancy	78.50	5	20.5
		2012/2013	% Recorded Diabetes (16+)	5.02	21	93.2
		2012/2013	% Recorded Stroke	1.33	8	34.1
		2012/2013	% Recorded Serious Mental Illness	0.36	6	25.0
		2012/2013	% Recorded COPD	1.58	20	88.6
		2012/2013	% Recorded Asthma	9.41	11	47.7
		2012/2013	% Recorded Epilepsy	1.16	15	65.9
		2012/2013	% Recorded Learning disability	0.16	18	79.5
		2012/2013	% Recorded Dementia	0.28	8	34.1
		2012/2013	% Recorded Coronary Heart Disease	3.09	9	38.6
		2012/2013	% Recorded Chronic Kidney Disease	2.77	13	56.8
		2012/2013	% Recorded Heart Failure	0.69	12	52.3
		2012/2013	% Recorded Atrial Fibrillation	1.43	6	25.0
		2012/2013	% Recorded Hypertension	14.49	13	56.8
		2012/2013	% Recorded Cancer	1.96	8	34.1

Summary of Key Issues

Cray Valley East is located to the north west of the borough, bordering Bexley, Dartford and Sevenoaks. Cray Valley East has very high levels of deprivation. There is a high proportion of children and young people, most of them living with single parents and in poverty.

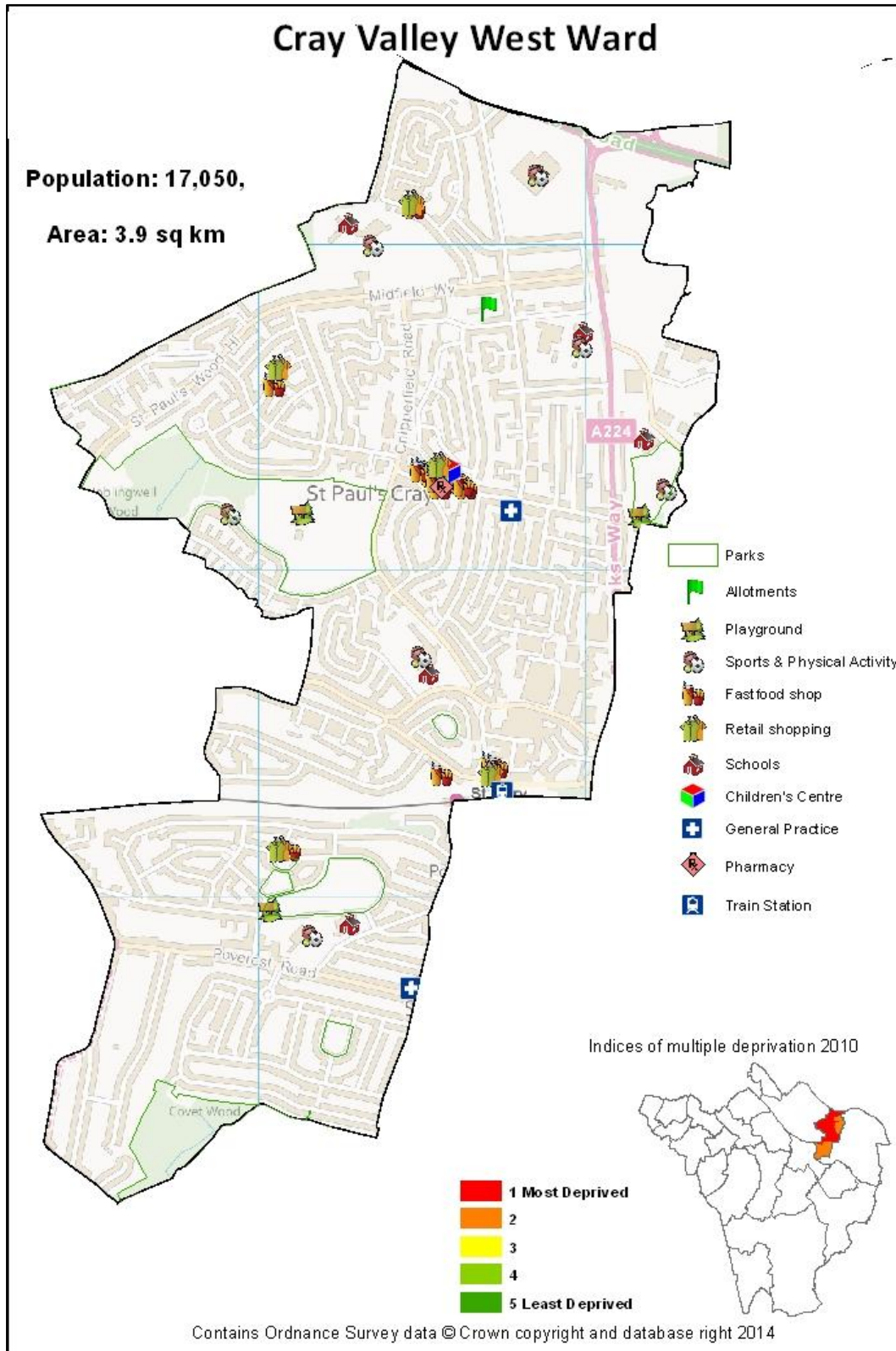
This area has the second highest proportion of Bromley residents with no qualifications. There is a low proportion of working age population, however most of them are economically inactive evidenced by high workless benefit claimants and high proportions of residents who have never worked or in long term unemployment. Of the economically active, most are in routine and semi-routine employment. Educational attainment is a precursor to improved life opportunities but educational attainment in state funded schools is low as measured at age 5, Key stage 2 and GCSE.

There is an above average proportion of social rented households and overcrowded housing. There has been a high count of both mortgage and landlord repossession court orders which is used to measure the impact of the economic downturn. This area has the second highest record of crime in Bromley. People perceive themselves to be in poor health and their wellbeing score is the lowest in the borough.

This ward houses a large settled Gypsy Traveller population and two council owned Traveller sites. Travellers tend to experience poorer health outcomes than the general population although perceptions of health in the area are good. They also tend to have low levels of accessing health services. The area has low scores on the Public Transport Accessibility Index. Poor public transport networks in a community that tends to have low levels of access to health services is likely to exacerbate poor service accessibility.

Life expectancy is significantly below average especially for men. Health outcomes are generally poor especially diabetes, dementia, chronic obstructive pulmonary disease and learning disability and are likely to be worsening given the relatively young population and poor lifestyle risk factors. There is a high prevalence of unhealthy eating, a high record of smoking, obesity rates in both children and adults are high and there are high rates of people in treatment for substance misuse.

Teenage conception rates This area has some of the worst indicators of health across Bromley. There are limited services of all types and this area was highlighted as a renewal area in last year's JSNA.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Cray Valley West		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	17050		
		2013	Population density (GLA)	4294.87	16	70.5
		2013	% Children (0-4)	7.30	15	65.9
		2013	% Older people (75+)	7.60	8	34.1
		2011	% Lone parent households	12.77	22	97.7
		2011	% Lone pensioner households	12.68	8	34.1
		2011	% BAME	13.90	11	47.7
	Deprivation	2011	% Not Born in UK	10.90	8	34.1
		2010	IMD 2010 (Mean)	29.24	21	93.2
	Employment and Education	2010	IDACI 2010 (Score)	0.33	19	84.1
		2011	% with no qualifications	28.50	22	97.7
		2011	% Never worked/Long term unemployed (16-64)	3.40	20	88.6
		2012/2013	% Average workless benefit claimants	29.20	22	97.7
		2011	% Routine and semi - routine workers	26.05	22	97.7
		2012/2013	% Good level of development at age 5	54.15	6	25.0
		2012/2013	Key stage 2: Level 4 and above achievement	75.59	7	29.5
		2012/2013	GCSE: 5+A*-C achievement	45.96	3	11.4
	Housing and the Neighbourhood	2011	% Overcrowded households	9.81	18	79.5
		2011	% Social rented households	33.50	22	97.7
		2011	Mortgage Repossession Orders	10.00	10	43.2
		2011	Landlord Repossession Orders	35.00	19	84.1
		2012/13	Crime rate per 1000	69.90	16	70.5
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	2.30	10	43.2
		2011	% reporting bad and very bad health	6.30	22	97.7
		2011	% Funded Social care (18+)	4.98	19	84.1
		2012	Overall wellbeing probability score	-9.00	2	6.8
		2012-2013	% Recorded smokers	18.87	18	79.5
		2012-2013	Substance misuse (in treatment) per 1000	4.40	20	88.6
		2009-2011	Teenage conception rates	46.58	18	79.5
		2009/10- 2011/12	% Obese children in 4 -5 year olds	8.70	14	61.4
		2009/10- 2011/12	% Obese children in 10-11 year olds	21.60	18	79.5
		2006-2008	Obesity estimate (16+)	25.30	16	70.5
		2006-2010	Healthy eating estimates	29.90	2	6.8
		2006-2010	Binge drinking estimates (16+)	13.20	11	47.7
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	82.10	2	6.8
		2006-2010	Male life expectancy	78.20	4	15.9
		2012/2013	% Recorded Diabetes (16+)	4.79	19	84.1
		2012/2013	% Recorded Stroke	1.50	14	61.4
		2012/2013	% Recorded Serious Mental Illness	0.57	18	79.5
		2012/2013	% Recorded COPD	2.12	22	97.7
		2012/2013	% Recorded Asthma	10.92	19	84.1
		2012/2013	% Recorded Epilepsy	1.31	18	79.5
		2012/2013	% Recorded Learning disability	0.16	16	70.5
		2012/2013	% Recorded Dementia	0.31	10	43.2
		2012/2013	% Recorded Coronary Heart Disease	3.26	15	65.9
		2012/2013	% Recorded Chronic Kidney Disease	2.79	14	61.4
		2012/2013	% Recorded Heart Failure	0.69	13	56.8
		2012/2013	% Recorded Atrial Fibrillation	1.55	8	34.1
		2012/2013	% Recorded Hypertension	13.79	9	38.6
		2012/2013	% Recorded Cancer	1.64	6	25.0

Summary of Key Issues

Cray Valley West is located to the north west of the borough, bordering Bexley. The Cotmandene shop is located within this ward which provides community services for the residents in the area.

Cray Valley West has very high levels of deprivation; it is the second most deprived ward in the borough. The proportion of children and young people is above average and most of them are living in poverty and are single parented. It is worth noting that this area has the highest proportion of lone parent households in Bromley.

This area has the highest proportion of Bromley residents with no qualifications. There is a low proportion of working age population however most of them are economically inactive evidenced by high workless benefit claimants and high proportions of residents who have never worked or in long term unemployment. Of the economically active most of them are in routine and semi-routine employment.

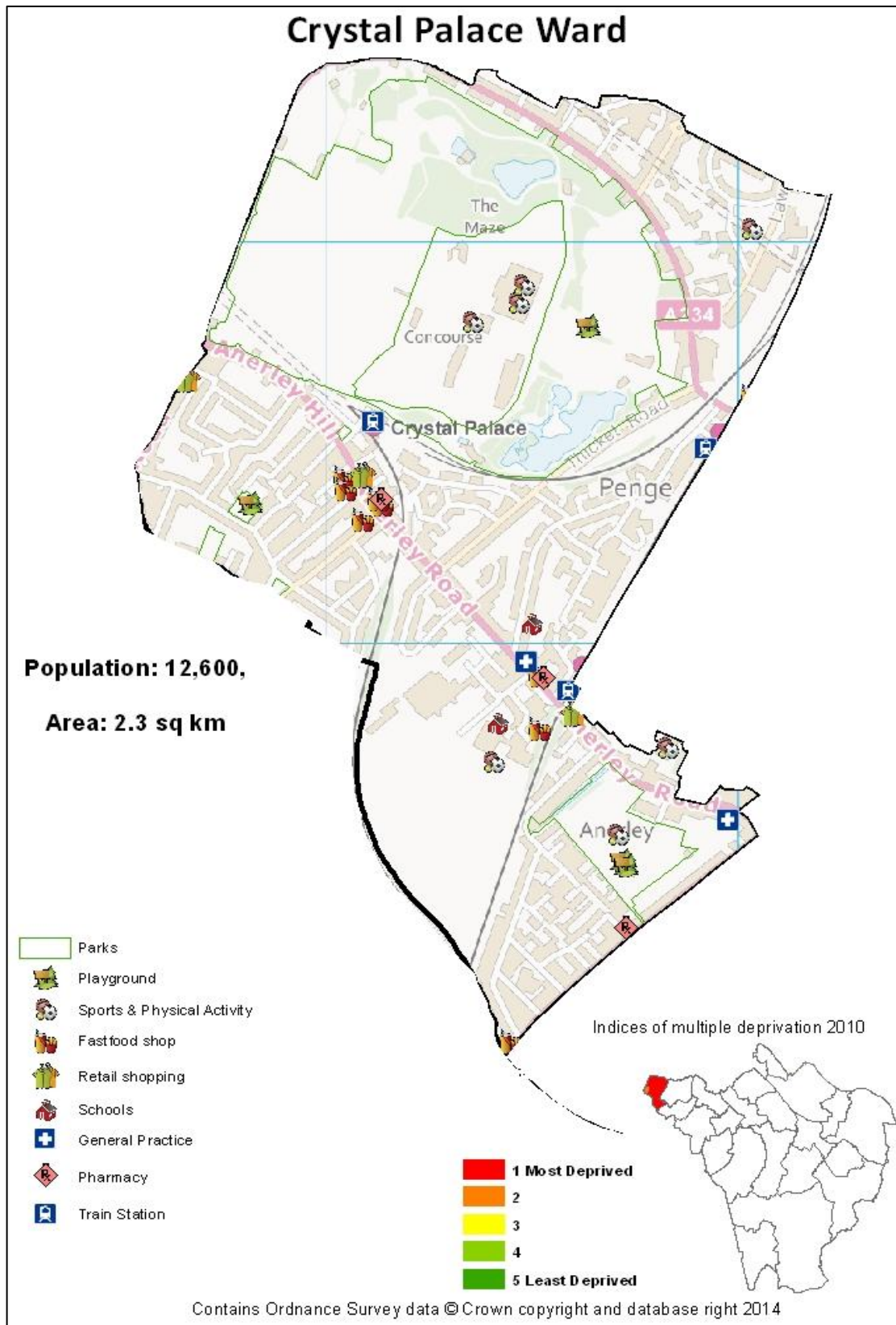
Educational attainment is a precursor to improved life opportunities but educational attainment in state funded schools is low as measured at age 5, Key stage 2 and GCSE.

Cray Valley West has the highest proportion of social rented households, most of them are overcrowded. There was a high count of landlord repossession court orders which is used to measure the impact of the economic downturn. There was a high record of crime in the area. People perceive themselves to be in poor health and the wellbeing score is the second lowest in the borough.

Life expectancy is significantly below average especially for women. There is a high burden of disease except for of cancer, hypertension and atrial fibrillation which are low. The high burden of disease in a young population and low life expectancy is indicative of low healthy life expectancy and a population dying prematurely from preventable illnesses.

In terms of lifestyle risk factors; healthy eating estimates in the area are low, there is a high record of smoking, obesity and people in treatment for substance misuse. Teenage conception rates and recorded crime are high in the area.

This area has some of the worst indicators of health across Bromley and was highlighted as a renewal area in last year's JSNA.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Crystal Palace		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	12600		
		2013	Population density (GLA)	5304.35	20	88.6
		2013	% Children (0-4)	9.10	22	97.7
		2013	% Older people (75+)	4.00	1	2.3
		2011	% Lone parent households	11.78	19	84.1
		2011	% Lone pensioner households	6.90	1	2.3
		2011	% BAME	38.10	22	97.7
		2011	% Not Born in UK	30.30	22	97.7
	Deprivation	2010	IMD 2010 (Mean)	32.54	22	97.7
		2010	IDACI 2010 (Score)	0.39	22	97.7
	Employment and Education	2011	% with no qualifications	16.90	11	47.7
		2011	% Never worked/Long term unemployed (16-64)	3.70	21	93.2
		2012/2013	% Average workless benefit claimants	23.20	19	84.1
		2011	% Routine and semi - routine workers	19.26	18	79.5
		2012/2013	% Good level of development at age 5	45.30	2	6.8
		2012/2013	Key stage 2: Level 4 and above achievement	63.64	1	2.3
		2012/2013	GCSE: 5+A*-C achievement	37.14	1	2.3
	Housing and the Neighbourhood	2011	% Overcrowded households	22.73	22	97.7
		2011	% Social rented households	33.20	21	93.2
		2011	Mortgage Repossession Orders	15.00	17	75.0
		2011	Landlord Repossession Orders	70.00	21	93.2
		2012/13	Crime rate per 1000	96.00	20	88.6
		2011	Average Public Transport Accessibility score	4.40	22	97.7
	Well-being and Lifestyle	2011	% reporting bad and very bad health	5.30	19	84.1
		2011	% Funded Social care (18+)	4.85	17	75.0
		2012	Overall wellbeing probability score	-9.00	3	11.4
		2012-2013	% Recorded smokers	11.73	10	43.2
		2012-2013	Substance misuse (in treatment) per 1000	4.44	21	93.2
		2009-2011	Teenage conception rates	79.06	22	97.7
		2009/10- 2011/12	% Obese children in 4 -5 year olds	12.40	20	88.6
		2009/10- 2011/12	% Obese children in 10-11 year olds	23.20	22	97.7
		2006-2008	Obesity estimate (16+)	22.70	12	52.3
		2006-2010	Healthy eating estimates	34.30	9	38.6
		2006-2010	Binge drinking estimates (16+)	18.90	22	97.7
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	82.60	6	25.0
		2006-2010	Male life expectancy	75.60	1	2.3
		2012/2013	% Recorded Diabetes (16+)	2.17	1	2.3
		2012/2013	% Recorded Stroke	0.44	1	2.3
		2012/2013	% Recorded Serious Mental Illness	0.42	12	52.3
		2012/2013	% Recorded COPD	0.58	1	2.3
		2012/2013	% Recorded Asthma	5.13	4	15.9
		2012/2013	% Recorded Epilepsy	0.63	1	2.3
		2012/2013	% Recorded Learning disability	0.16	17	75.0
		2012/2013	% Recorded Dementia	0.06	1	2.3
		2012/2013	% Recorded Coronary Heart Disease	1.08	1	2.3
		2012/2013	% Recorded Chronic Kidney Disease	0.63	1	2.3
		2012/2013	% Recorded Heart Failure	0.23	1	2.3
		2012/2013	% Recorded Atrial Fibrillation	0.46	1	2.3
		2012/2013	% Recorded Hypertension	5.83	1	2.3
		2012/2013	% Recorded Cancer	0.61	1	2.3

Summary of Key Issues

Crystal Palace is located to the north east of the borough with similar health characteristics to its neighbours; Lambeth, Southwark and Lewisham.

This is an area with the highest levels of deprivation in Bromley, a young population and a very high proportion of children living in poverty. Crystal Palace has higher proportions of ethnic minority and non- UK born communities than elsewhere in Bromley.

The proportion of residents with no qualification is below average. There is a high proportion of working age population, however most of these are economically inactive, evidenced by high workless benefit claimants and high proportions of residents who have never worked or in long term unemployment. Of the economically active, most are in routine and semi-routine employment. A higher than average proportion of the adult population are receiving funded social care.

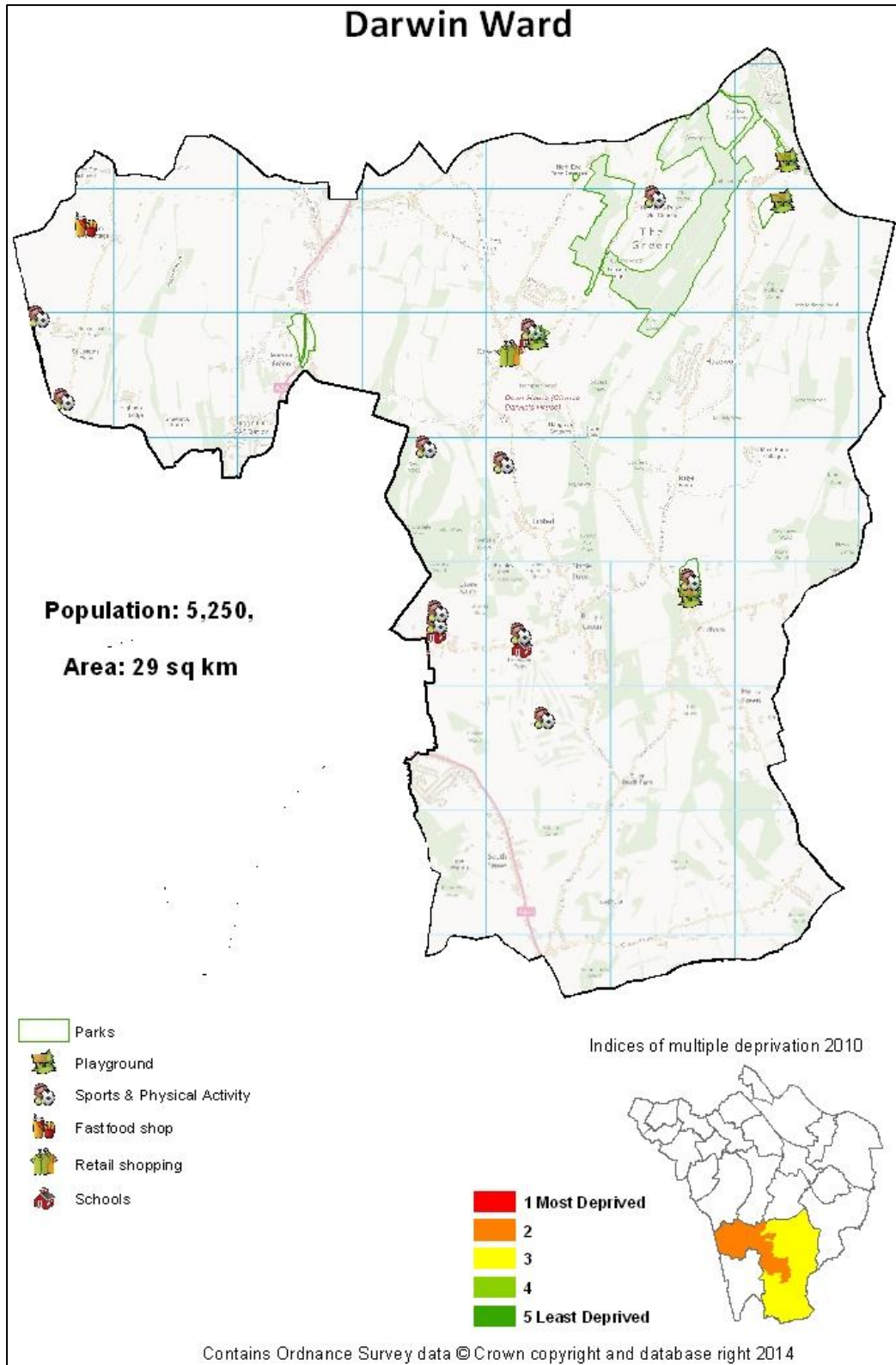
Educational attainment in the school going population is low as measured at age 5, Key stage 2 and GCSE. There is a high proportion of social rented households and overcrowded housing. There has been a high count of both mortgage and landlord repossession court orders which are measures of the impact of the economic downturn. This area has a high rate of recorded crime as compared with the Bromley average.

People perceive themselves to be poor health and their wellbeing score is low. There is very good access to public transport networks in Crystal Palace.

Life expectancy is significantly below Bromley average especially for men. There is an overall low burden of disease except for serious mental illness which is above average and learning disability which is high. There is a high prevalence of risk factors for disease, including obesity and binge drinking which are high, high rates of people in treatment for substance misuse and poor healthy eating estimates.

Although there is some missing disease burden data for this area, there is still an overall low burden of disease. The presence of many risk factors for disease in a young population is an indicator that disease may not yet be apparent but could present later in life unless risk factors are modified. There is also a possibility of under recording of disease in this community with residents registered to general practice outside Bromley borders.

Teenage pregnancy levels are high. Health is negatively impacted by; low levels of employment, poor lifestyles and high crime. This area was highlighted as a renewal area in last year's JSNA.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Darwin		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	5250		
		2013	Population density (GLA)	181.034	1	2.3
		2013	% Children (0-4)	5.70	8	34.1
		2013	% Older people (75+)	9.50	14	61.4
		2011	% Lone parent households	4.66	5	20.5
		2011	% Lone pensioner households	13.11	10	43.2
		2011	% BAME	4.80	2	6.8
		2011	% Not Born in UK	6.10	2	6.8
	Deprivation	2010	IMD 2010 (Mean)	14.73	14	61.4
		2010	IDACI 2010 (Score)	0.11	11	47.7
	Employment and Education	2011	% with no qualifications	21.90	18	79.5
		2011	% Never worked/Long term unemployed (16-64)	1.20	2	6.8
		2012/2013	% Average workless benefit claimants	3.10	1	2.3
		2011	% Routine and semi - routine workers	16.56	14	61.4
		2012/2013	% Good level of development at age 5	48.15	4	15.9
		2012/2013	Key stage 2: Level 4 and above achievement	78.85	10	43.2
		2012/2013	GCSE: 5+A*-C achievement	61.36	7	29.5
	Housing and the Neighbourhood	2011	% Overcrowded households	3.27	3	11.4
		2011	% Social rented households	5.50	6	25.0
		2011	Mortgage Repossession Orders	0.00	2	6.8
		2011	Landlord Repossession Orders	0.00	3	11.4
		2012/13	Crime rate per 1000	55.10	12	52.3
		2011	Average Public Transport Accessibility score	1.30	1	2.3
	Well-being and Lifestyle	2011	% reporting bad and very bad health	3.50	9	38.6
		2011	% Funded Social care (18+)	1.20	1	2.3
		2012	Overall wellbeing probability score	4.00	12	52.3
		2012-2013	% Recorded smokers	12.61	12	52.3
		2012-2013	Substance misuse (in treatment) per 1000	1.14	6	25.0
		2009-2011	Teenage conception rates	42.97	17	75.0
		2009/10- 2011/12	% Obese children in 4 -5 year olds	8.70	15	65.9
		2009/10- 2011/12	% Obese children in 10-11 year olds	15.90	11	47.7
		2006-2008	Obesity estimate (16+)	24.20	15	65.9
		2006-2010	Healthy eating estimates	34.60	10	43.2
		2006-2010	Binge drinking estimates (16+)	11.60	4	15.9
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	85.70	16	70.5
		2006-2010	Male life expectancy	81.50	16	70.5
		2012/2013	% Recorded Diabetes (16+)	4.90	20	88.6
		2012/2013	% Recorded Stroke	1.94	18	79.5
		2012/2013	% Recorded Serious Mental Illness	0.40	11	47.7
		2012/2013	% Recorded COPD	1.20	15	65.9
		2012/2013	% Recorded Asthma	10.08	15	65.9
		2012/2013	% Recorded Epilepsy	1.31	19	84.1
		2012/2013	% Recorded Learning disability	0.19	19	84.1
		2012/2013	% Recorded Dementia	0.30	9	38.6
		2012/2013	% Recorded Coronary Heart Disease	3.71	20	88.6
		2012/2013	% Recorded Chronic Kidney Disease	4.30	20	88.6
		2012/2013	% Recorded Heart Failure	0.78	18	79.5
		2012/2013	% Recorded Atrial Fibrillation	2.36	20	88.6
		2012/2013	% Recorded Hypertension	19.90	21	93.2
		2012/2013	% Recorded Cancer	2.36	17	75.0

Summary of Key Issues

Darwin is located to the south of the borough, bordering Sevenoaks. It is the most rural area in the borough, with low deprivation levels, low population density and big green spaces. There is an above average proportion of older people, a small community of ethnic minority groups and non- UK born residents.

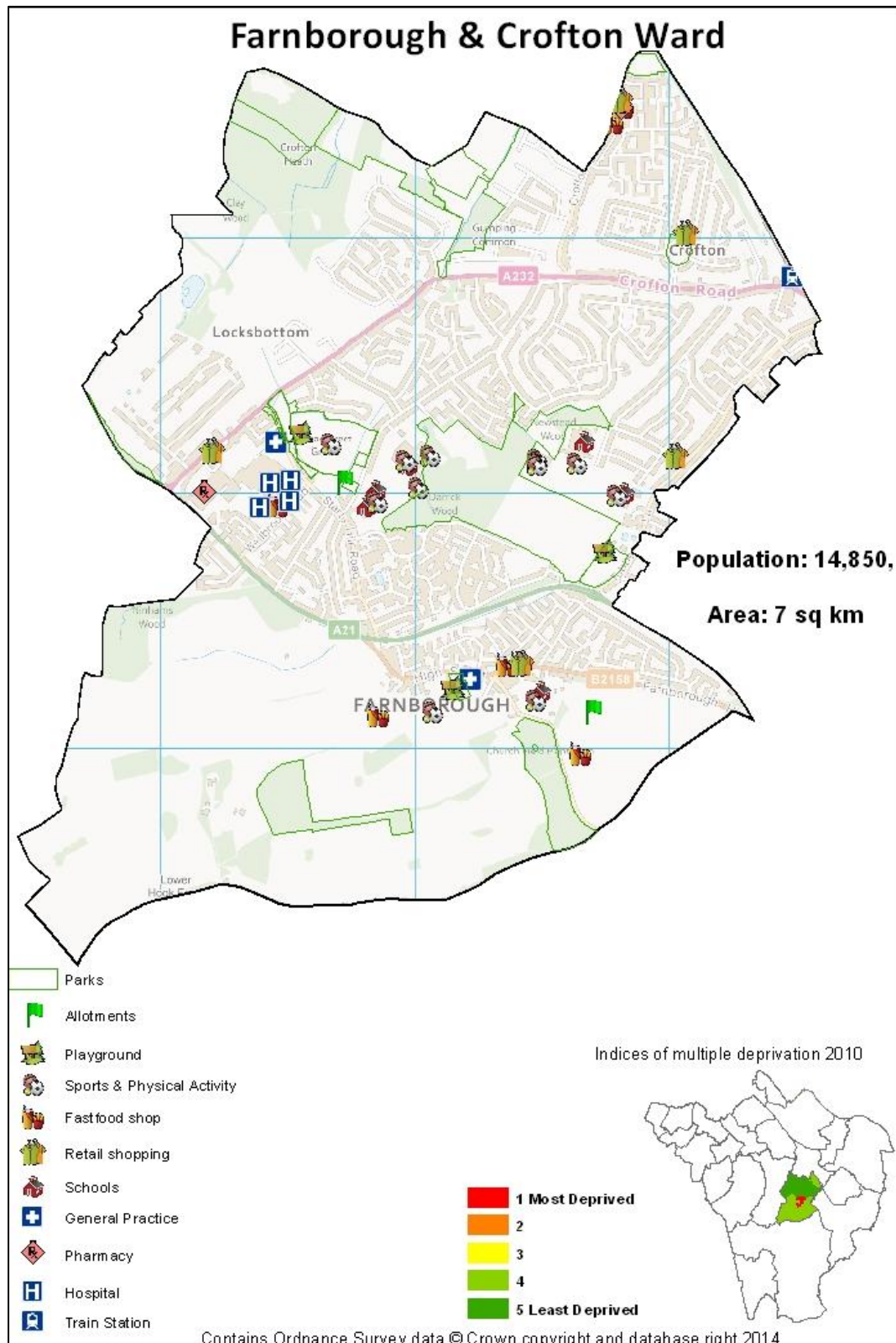
There is a high proportion of residents with no qualifications, however it is one of the areas in Bromley with the lowest proportions of economic inactivity. There is poor GCSE attainment in children attending state funded schools and poor school readiness in the 5 year olds but average levels of attainment in Key stage 2 pupils.

There is a very low proportion of social rented households and overcrowded housing. There has been no mortgage or landlord repossession court orders in this area indicating financial resilience during the economic downturn.

In terms of lifestyle, teenage pregnancy rates are high, obesity rates in both children and adults are high. There is a low prevalence of binge drinking in the area and the rate of people in treatment for substance misuse is also low.

Life expectancy is high for the area. The proportion of people reporting bad and very bad health is low, proportion in receipt of funded social care is low and the overall wellbeing score is average. Despite the high life expectancy, there is a high burden of disease in this small population indicative of poor healthy life expectancy in the population.

Darwin has a very poor score on the PTAL indicative of high car usage which contributes to the carbon footprint and physical inactivity levels in Bromley.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Farnborough and Crofton		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	14850		
		2013	Population density (GLA)	2114.29	8	34.1
		2013	% Children (0-4)	4.40	1	2.3
		2013	% Older people (75+)	12.80	22	97.7
		2011	% Lone parent households	5.92	11	47.7
		2011	% Lone pensioner households	17.50	22	97.7
		2011	% BAME	9.50	5	20.5
		2011	% Not Born in UK	10.00	6	25.0
	Deprivation	2010	IMD 2010 (Mean)	7.95	6	25.0
		2010	IDACI 2010 (Score)	0.09	8	34.1
	Employment and Education	2011	% with no qualifications	18.10	14	61.4
		2011	% Never worked/Long term unemployed (16-64)	1.30	6	25.0
		2012/2013	% Average workless benefit claimants	9.10	9	38.6
		2011	% Routine and semi - routine workers	14.20	10	43.2
		2012/2013	% Good level of development at age 5	72.39	20	88.6
		2012/2013	Key stage 2: Level 4 and above achievement	87.90	19	84.1
		2012/2013	GCSE: 5+A*-C achievement	76.34	16	70.5
	Housing and the Neighbourhood	2011	% Overcrowded households	4.80	7	29.5
		2011	% Social rented households	8.80	11	47.7
		2011	Mortgage Repossession Orders	0.00	3	11.4
		2011	Landlord Repossession Orders	10.00	6	25.0
		2012/13	Crime rate per 1000	39.40	5	20.5
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	2.20	5	20.5
		2011	% reporting bad and very bad health	3.60	10	43.2
		2011	% Funded Social care (18+)	4.58	16	70.5
		2012	Overall wellbeing probability score	10.00	19	84.1
		2012-2013	% Recorded smokers	9.93	6	25.0
		2012-2013	Substance misuse (in treatment) per 1000	1.48	10	43.2
		2009-2011	Teenage conception rates	16.79	5	20.5
		2009/10- 2011/12	% Obese children in 4 -5 year olds	4.80	2	6.8
		2009/10- 2011/12	% Obese children in 10-11 year olds	11.50	1	2.3
		2006-2008	Obesity estimate (16+)	21.30	6	25.0
		2006-2010	Healthy eating estimates	37.40	15	65.9
		2006-2010	Binge drinking estimates (16+)	11.40	2	6.8
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	87.80	22	97.7
		2006-2010	Male life expectancy	82.00	18	79.5
		2012/2013	% Recorded Diabetes (16+)	4.67	18	79.5
		2012/2013	% Recorded Stroke	1.37	10	43.2
		2012/2013	% Recorded Serious Mental Illness	0.27	4	15.9
		2012/2013	% Recorded COPD	1.23	17	75.0
		2012/2013	% Recorded Asthma	9.56	12	52.3
		2012/2013	% Recorded Epilepsy	1.00	11	47.7
		2012/2013	% Recorded Learning disability	0.07	7	29.5
		2012/2013	% Recorded Dementia	0.39	15	65.9
		2012/2013	% Recorded Coronary Heart Disease	3.75	21	93.2
		2012/2013	% Recorded Chronic Kidney Disease	4.78	21	93.2
		2012/2013	% Recorded Heart Failure	0.73	16	70.5
		2012/2013	% Recorded Atrial Fibrillation	2.22	16	70.5
		2012/2013	% Recorded Hypertension	17.10	20	88.6
		2012/2013	% Recorded Cancer	2.61	20	88.6

Summary of Key Issues

Farnborough & Crofton is a suburban area in the centre of the borough. This is a sparsely populated area with very low levels of deprivation. The area has the highest proportion of older people living alone. Although Farnborough and Crofton has the lowest proportion of children under 5 years of age in the borough, there is an average proportion of lone parent households.

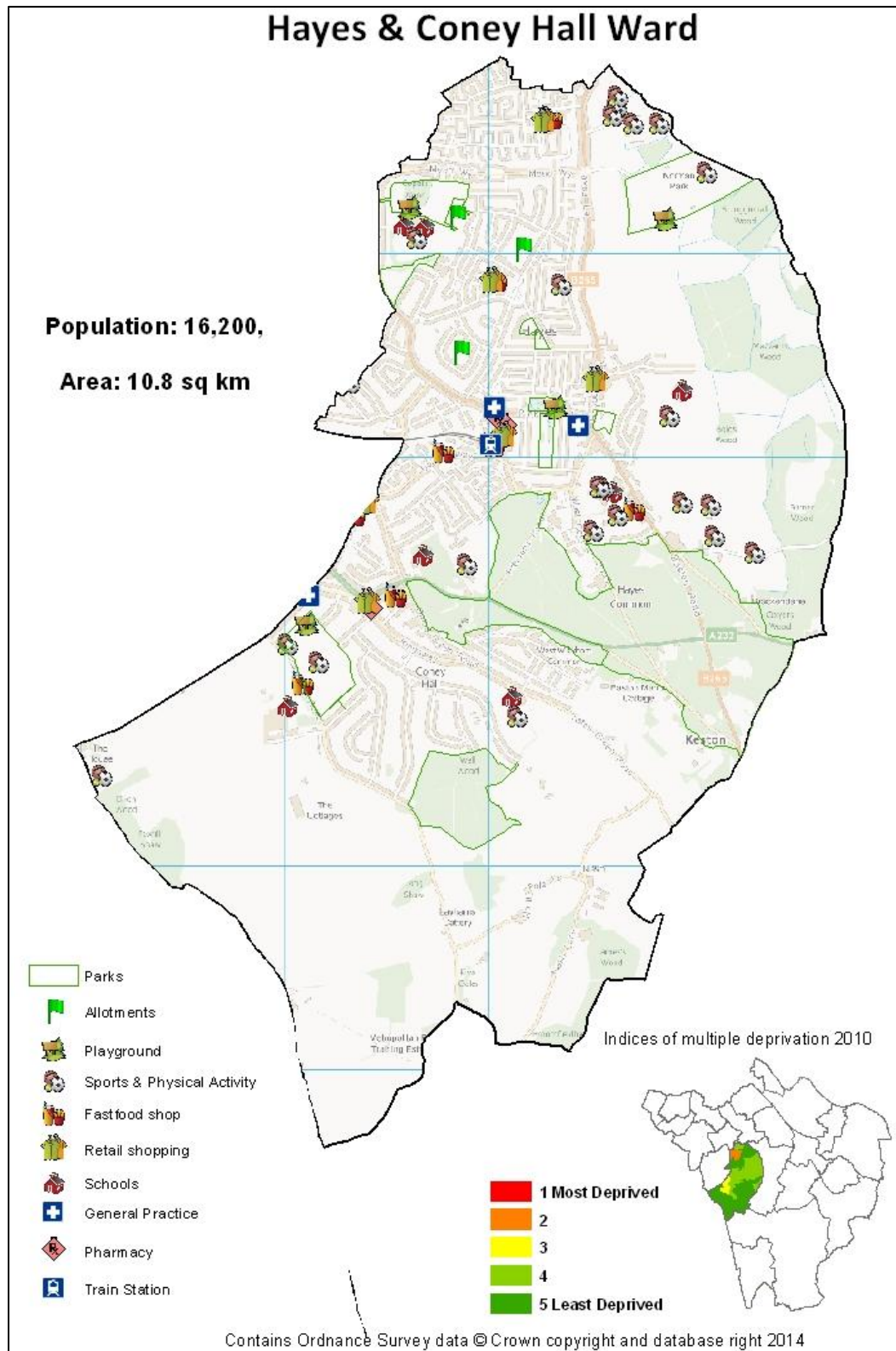
Educational attainment overall in children attending state funded schools is high. Children at age 5 are scoring high on school readiness, and there are good levels of attainment at Key stage 2 and GCSE. There is high economic activity in the area, average proportion of residents with no qualification and low proportions of routine and semi-routine manual workers.

There are average levels of social rented housing and very low overcrowded households. Housing repossession court order have been low, particularly there were no mortgage repossession court orders which is indicative of financial resilience during the economic downturn.

The area scores highly on the overall wellbeing index and people are reporting good and very good health despite the above average proportion of those receiving funded social care. People are leading healthy lifestyles; with low recording of smoking, binge drinking, obesity rates in children and adults. Teenage pregnancy rates are low and there are also low rates of people in treatment for substance misuse.

Life expectancy is significantly above average especially for women. Farnborough and Crofton has the highest life expectancy in Bromley women. The burden of disease reflects the age profile of this population with high levels of disease of old age- coronary heart disease, chronic kidney disease, hypertension, cancer, chronic obstructive pulmonary disease, dementia, diabetes, heart failure, atrial fibrillation.

Public transport accessibility in the ward is poor, which could be a concern for the big population of older lone pensioners. Poor access to public transport impacts on service access especially with lone pensioners being unable to drive with age. Farnborough & Crofton is home to the Princes Royal University Hospital with the borough's accident and emergency department.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Hayes and Coney Hall		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	16200		
		2013	Population density (GLA)	1425.93	5	20.5
		2013	% Children (0-4)	4.60	2	6.8
		2013	% Older people (75+)	9.00	12	52.3
		2011	% Lone parent households	4.70	6	25.0
		2011	% Lone pensioner households	14.06	16	70.5
		2011	% BAME	8.30	3	11.4
		2011	% Not Born in UK	8.70	3	11.4
	Deprivation	2010	IMD 2010 (Mean)	6.97	5	20.5
		2010	IDACI 2010 (Score)	0.07	4	15.9
	Employment and Education	2011	% with no qualifications	15.70	8	34.1
		2011	% Never worked/Long term unemployed (16-64)	1.30	7	29.5
		2012/2013	% Average workless benefit claimants	9.20	10	43.2
		2011	% Routine and semi - routine workers	13.57	8	34.1
		2012/2013	% Good level of development at age 5	62.63	11	47.7
		2012/2013	Key stage 2: Level 4 and above achievement	92.16	21	93.2
		2012/2013	GCSE: 5+A*-C achievement	77.58	18	79.5
	Housing and the Neighbourhood	2011	% Overcrowded households	3.86	5	20.5
		2011	% Social rented households	3.10	2	6.8
		2011	Mortgage Repossession Orders	10.00	11	47.7
		2011	Landlord Repossession Orders	10.00	7	29.5
		2012/13	Crime rate per 1000	36.50	4	15.9
		2011	Average Public Transport Accessibility score	2.30	11	47.7
	Well-being and Lifestyle	2011	% reporting bad and very bad health	3.10	3	11.4
		2011	% Funded Social care (18+)	3.09	7	29.5
		2012	Overall wellbeing probability score	10.00	20	88.6
		2012-2013	% Recorded smokers	11.12	8	34.1
		2012-2013	Substance misuse (in treatment) per 1000	0.99	4	15.9
		2009-2011	Teenage conception rates	16.84	6	25.0
		2009/10- 2011/12	% Obese children in 4 -5 year olds	6.40	8	34.1
		2009/10- 2011/12	% Obese children in 10-11 year olds	12.00	4	15.9
		2006-2008	Obesity estimate (16+)	21.70	8	34.1
		2006-2010	Healthy eating estimates	36.40	14	61.4
		2006-2010	Binge drinking estimates (16+)	13.80	13	56.8
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	85.30	15	65.9
		2006-2010	Male life expectancy	80.40	13	56.8
		2012/2013	% Recorded Diabetes (16+)	3.98	10	43.2
		2012/2013	% Recorded Stroke	1.53	15	65.9
		2012/2013	% Recorded Serious Mental Illness	0.45	14	61.4
		2012/2013	% Recorded COPD	1.10	13	56.8
		2012/2013	% Recorded Asthma	10.53	18	79.5
		2012/2013	% Recorded Epilepsy	1.27	16	70.5
		2012/2013	% Recorded Learning disability	0.23	22	97.7
		2012/2013	% Recorded Dementia	0.33	12	52.3
		2012/2013	% Recorded Coronary Heart Disease	3.09	10	43.2
		2012/2013	% Recorded Chronic Kidney Disease	2.56	10	43.2
		2012/2013	% Recorded Heart Failure	0.58	9	38.6
		2012/2013	% Recorded Atrial Fibrillation	1.66	10	43.2
		2012/2013	% Recorded Hypertension	14.90	14	61.4
		2012/2013	% Recorded Cancer	2.03	11	47.7

Summary of Key Issues

Hayes and Coney Hall is a suburban residential area to the south west of the borough on the Croydon border. This is an area of low deprivation, low levels of child poverty and low population density.

It is characterised by a big working age population, average proportions of older people but above average lone pensioner households. This area has the second lowest proportion of children under 5 years in Bromley paralleled by a below average proportion of lone parent households. Ethnic minority groups and non- UK born residents in the area are also in low proportions.

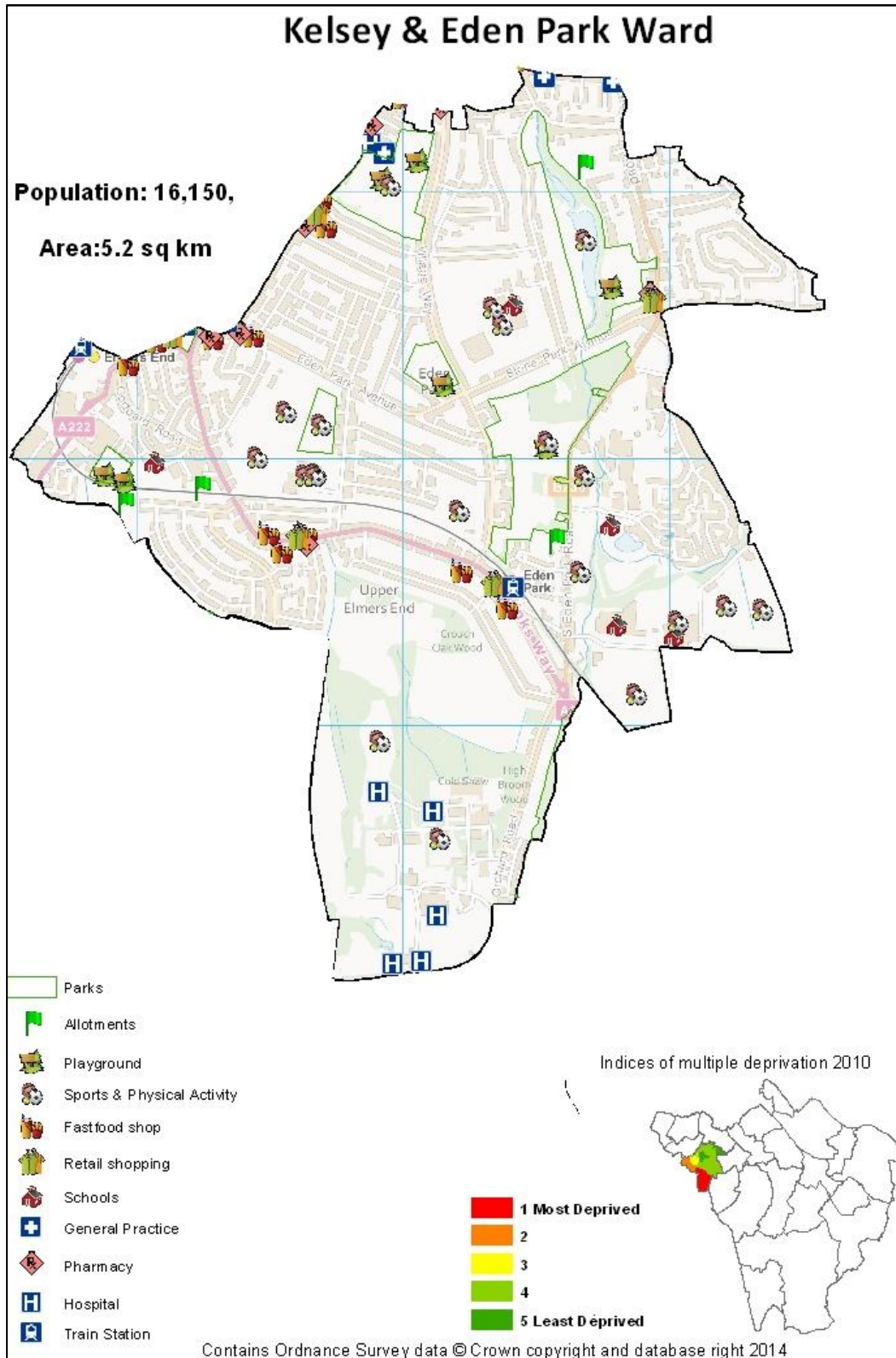
Educational attainment in state funded schools is significantly above average especially at key stage 2 and there is a low proportion of residents with no qualifications. Economic activity is high, mainly professionals with lower than average proportion of routine and semi-routine workers.

The area has low proportions of social rented and overcrowded housing. Housing repossession orders have been low indicating financial resilience in the economic downturn.

The area is well served by public transport and scores average on the PTAL. There is a general sense of wellbeing with people reporting good and very good health and very low proportions of residents receiving funded social care.

Analysis shows that residents are leading healthy lifestyles. There is low recording of smoking, low obesity rates in children and adults, the rate of people in treatment for substance misuse is low. Estimated healthy eating in the area is high. Teenage conception rates are low and recorded crime is low.

The ward fares quite well on almost all presented indicators of health, life expectancy is average. Health outcomes are average to poor, the burden of disease in primary care is low to average except for stroke, asthma and learning disability which are above average. This area has the highest proportion of people with learning disability in Bromley.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Kelsey and Edén Park		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	16150		
		2013	Population density (GLA)	3048.08	9	38.6
		2013	% Children (0-4)	5.60	7	29.5
		2013	% Older people (75+)	9.60	15	65.9
		2011	% Lone parent households	5.69	10	43.2
		2011	% Lone pensioner households	14.81	20	88.6
		2011	% BAME	16.00	15	65.9
		2011	% Not Born in UK	13.60	13	56.8
	Deprivation	2010	IMD 2010 (Mean)	11.73	10	43.2
		2010	IDACI 2010 (Score)	0.09	7	29.5
	Employment and Education	2011	% with no qualifications	17.10	13	56.8
		2011	% Never worked/Long term unemployed (16-64)	1.70	11	47.7
		2012/2013	% Average workless benefit claimants	12.30	12	52.3
		2011	% Routine and semi - routine workers	14.15	9	38.6
		2012/2013	% Good level of development at age 5	67.76	17	75.0
		2012/2013	Key stage 2: Level 4 and above achievement	87.14	16	70.5
		2012/2013	GCSE: 5+A*-C achievement	77.65	19	84.1
	Housing and the Neighbourhood	2011	% Overcrowded households	5.01	11	47.7
		2011	% Social rented households	8.60	10	43.2
		2011	Mortgage Repossession Orders	10.00	12	52.3
		2011	Landlord Repossession Orders	15.00	10	43.2
		2012/13	Crime rate per 1000	68.00	15	65.9
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	2.60	14	61.4
		2011	% reporting bad and very bad health	3.60	11	47.7
		2011	% Funded Social care (18+)	3.86	9	38.6
		2012	Overall wellbeing probability score	5.00	14	61.4
		2012-2013	% Recorded smokers	14.26	15	65.9
		2012-2013	Substance misuse (in treatment) per 1000	1.42	9	38.6
		2009-2011	Teenage conception rates	29.51	11	47.7
		2009/10- 2011/12	% Obese children in 4 -5 year olds	7.80	12	52.3
		2009/10- 2011/12	% Obese children in 10-11 year olds	15.20	10	43.2
		2006-2008	Obesity estimate (16+)	21.50	7	29.5
		2006-2010	Healthy eating estimates	35.80	12	52.3
		2006-2010	Binge drinking estimates (16+)	13.80	14	61.4
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	86.40	19	84.1
		2006-2010	Male life expectancy	82.10	19	84.1
		2012/2013	% Recorded Diabetes (16+)	4.48	16	70.5
		2012/2013	% Recorded Stroke	2.02	20	88.6
		2012/2013	% Recorded Serious Mental Illness	0.54	16	70.5
		2012/2013	% Recorded COPD	0.98	7	29.5
		2012/2013	% Recorded Asthma	12.01	20	88.6
		2012/2013	% Recorded Epilepsy	1.45	21	93.2
		2012/2013	% Recorded Learning disability	0.14	13	56.8
		2012/2013	% Recorded Dementia	0.50	18	79.5
		2012/2013	% Recorded Coronary Heart Disease	3.25	13	56.8
		2012/2013	% Recorded Chronic Kidney Disease	2.67	11	47.7
		2012/2013	% Recorded Heart Failure	0.72	15	65.9
		2012/2013	% Recorded Atrial Fibrillation	2.26	18	79.5
		2012/2013	% Recorded Hypertension	15.36	17	75.0
		2012/2013	% Recorded Cancer	2.43	18	79.5

Summary of Key Issues

Kelsey and Eden Park is situated in the northwest of the borough to the border of Croydon. Overall the ward has low deprivation levels, however the overall picture masks some local variations for example high deprivation levels towards the Elmers End area which has a high proportion of social housing.

Kelsey and Eden Park is home to a high proportion of older people and a very high proportion of lone pensioner households. There is an above average proportion of ethnic minority groups and non- UK born residents.

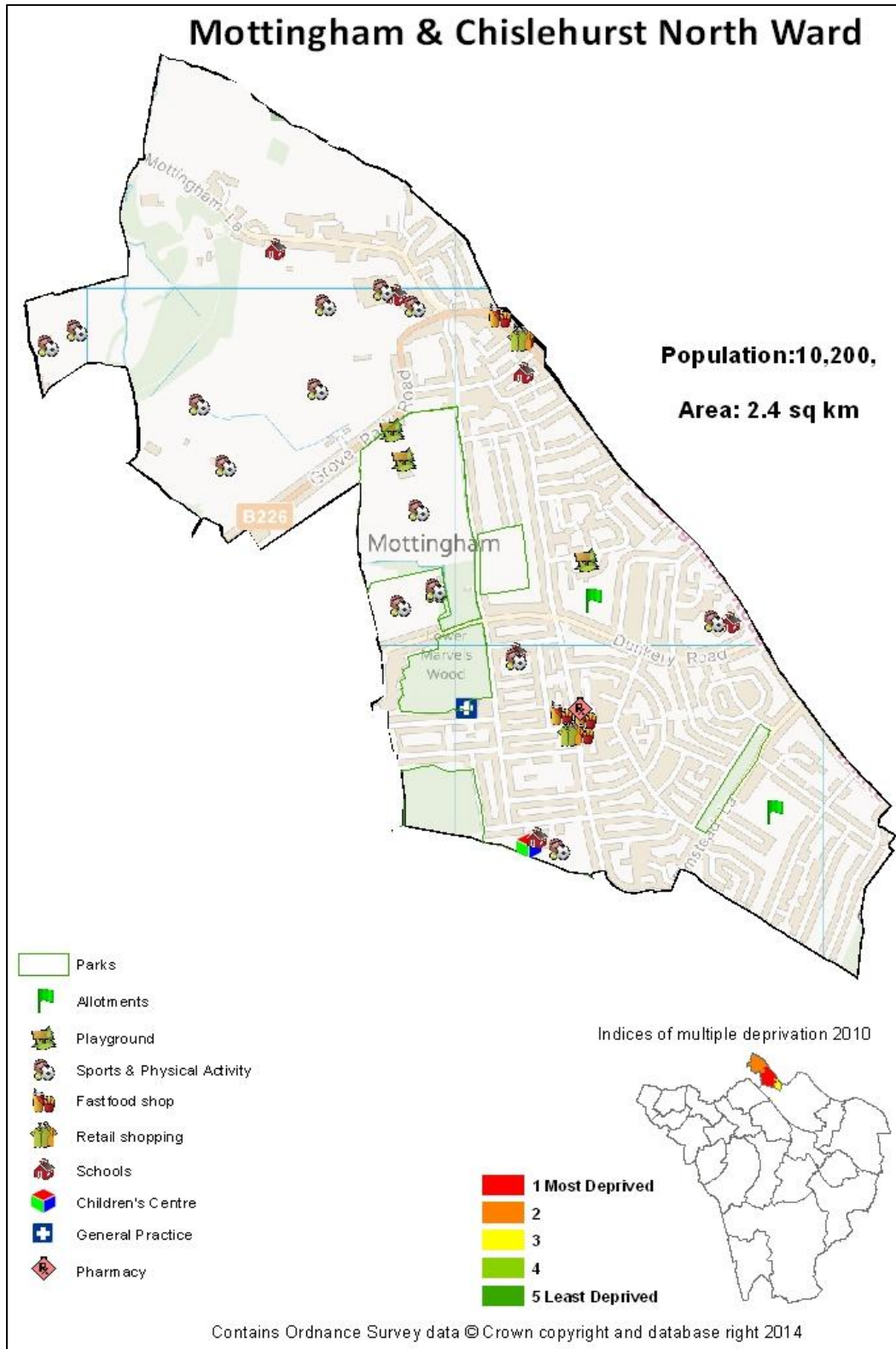
Educational attainment in state funded schools is high, particularly GCSE attainment, however the proportion of residents with no qualifications is average. Economic activity is average, with proportions of residents claiming workless benefits and those who have never worked or in long term unemployment being average. For the economically active, there are lower than average proportions of routine and semi-routine workers.

There are low proportions of social rented households and overcrowded households. Housing repossession orders in the ward have been average. There is an above average record of crime in the area.

Generally there is a sense of wellbeing in the area, people perceive themselves to be in good and very good health and there are low proportions of people receiving funded social care. There is a mixed picture of modifiable lifestyle risk behaviour in the ward with above average rates of smoking and binge drinking and below average levels of adult obesity.

There is a high burden of disease especially diseases of old age such as stroke, dementia, atrial fibrillation and cancer, although life expectancy is above average. Recorded levels of asthma and epilepsy are also above average. The high life expectancy and disease burden is indicative of the area having low healthy life expectancy. That is people living long, but with disease, which severely impacts on the quality of life.

This ward is home to the Beckenham Beacon which provides access to a range of planned care and primary care health services.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Mottingham and Chislehurst North		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	10200		
		2013	Population density (GLA)	4437.5	17	75.0
		2013	% Children (0-4)	7.40	16	70.5
		2013	% Older people (75+)	6.90	6	25.0
		2011	% Lone parent households	12.64	21	93.2
		2011	% Lone pensioner households	12.19	6	25.0
		2011	% BAME	18.40	17	75.0
		2011	% Not Born in UK	15.10	14	61.4
	Deprivation	2010	IMD 2010 (Mean)	29.06	20	88.6
		2010	IDACI 2010 (Score)	0.38	21	93.2
	Employment and Education	2011	% with no qualifications	26.00	20	88.6
		2011	% Never worked/Long term unemployed (16-64)	3.20	18	79.5
		2012/2013	% Average workless benefit claimants	18.60	17	75.0
		2011	% Routine and semi - routine workers	24.19	20	88.6
		2012/2013	% Good level of development at age 5	42.38	1	2.3
		2012/2013	Key stage 2: Level 4 and above achievement	71.30	5	20.5
		2012/2013	GCSE: 5+A*-C achievement	61.70	9	38.6
	Housing and the Neighbourhood	2011	% Overcrowded households	9.77	16	70.5
		2011	% Social rented households	31.90	20	88.6
		2011	Mortgage Repossession Orders	15.00	18	79.5
		2011	Landlord Repossession Orders	35.00	20	88.6
		2012/13	Crime rate per 1000	84.70	18	79.5
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	2.60	15	65.9
		2011	% reporting bad and very bad health	5.80	21	93.2
		2011	% Funded Social care (18+)	2.67	5	20.5
		2012	Overall wellbeing probability score	-9.00	4	15.9
		2012-2013	% Recorded smokers	3.97	1	2.3
		2012-2013	Substance misuse (in treatment) per 1000	3.82	18	79.5
		2009-2011	Teenage conception rates	53.31	21	93.2
		2009/10- 2011/12	% Obese children in 4 -5 year olds	12.40	21	93.2
		2009/10- 2011/12	% Obese children in 10-11 year olds	22.30	20	88.6
		2006-2008	Obesity estimate (16+)	25.80	17	75.0
		2006-2010	Healthy eating estimates	28.90	1	2.3
		2006-2010	Binge drinking estimates (16+)	14.50	16	70.5
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	82.00	1	2.3
		2006-2010	Male life expectancy	76.60	3	11.4
		2012/2013	% Recorded Diabetes (16+)	2.24	2	6.8
		2012/2013	% Recorded Stroke	0.79	2	6.8
		2012/2013	% Recorded Serious Mental Illness	0.39	10	43.2
		2012/2013	% Recorded COPD	1.08	10	43.2
		2012/2013	% Recorded Asthma	2.48	1	2.3
		2012/2013	% Recorded Epilepsy	0.76	3	11.4
		2012/2013	% Recorded Learning disability	0.07	5	20.5
		2012/2013	% Recorded Dementia	0.12	3	11.4
		2012/2013	% Recorded Coronary Heart Disease	1.38	3	11.4
		2012/2013	% Recorded Chronic Kidney Disease	1.62	3	11.4
		2012/2013	% Recorded Heart Failure	0.37	2	6.8
		2012/2013	% Recorded Atrial Fibrillation	0.75	3	11.4
		2012/2013	% Recorded Hypertension	7.14	2	6.8
		2012/2013	% Recorded Cancer	0.89	2	6.8

Summary of Key Issues

Mottingham & Chislehurst North is to the north of the borough, bordering Greenwich and Lewisham. The area is densely populated, has high and worsening deprivation levels and high proportion of children living in poverty.

The ward has a high proportion of under 5s and a significantly high proportion of lone parent households. There is a sizable community of people from ethnic minority groups and non- UK born residents.

This area has a high proportion of residents with no qualifications. There is a high proportion of working age population, however, most of are economically inactive as evidenced by high workless benefit claimants and high proportions of residents who have never worked or are in long term unemployment. Of the economically active, most are in routine and semi-routine employment.

Educational attainment is a precursor to improved life opportunities but educational attainment in the state funded schools is low as measured at age 5 for school readiness, Key stage 2 and GCSE.

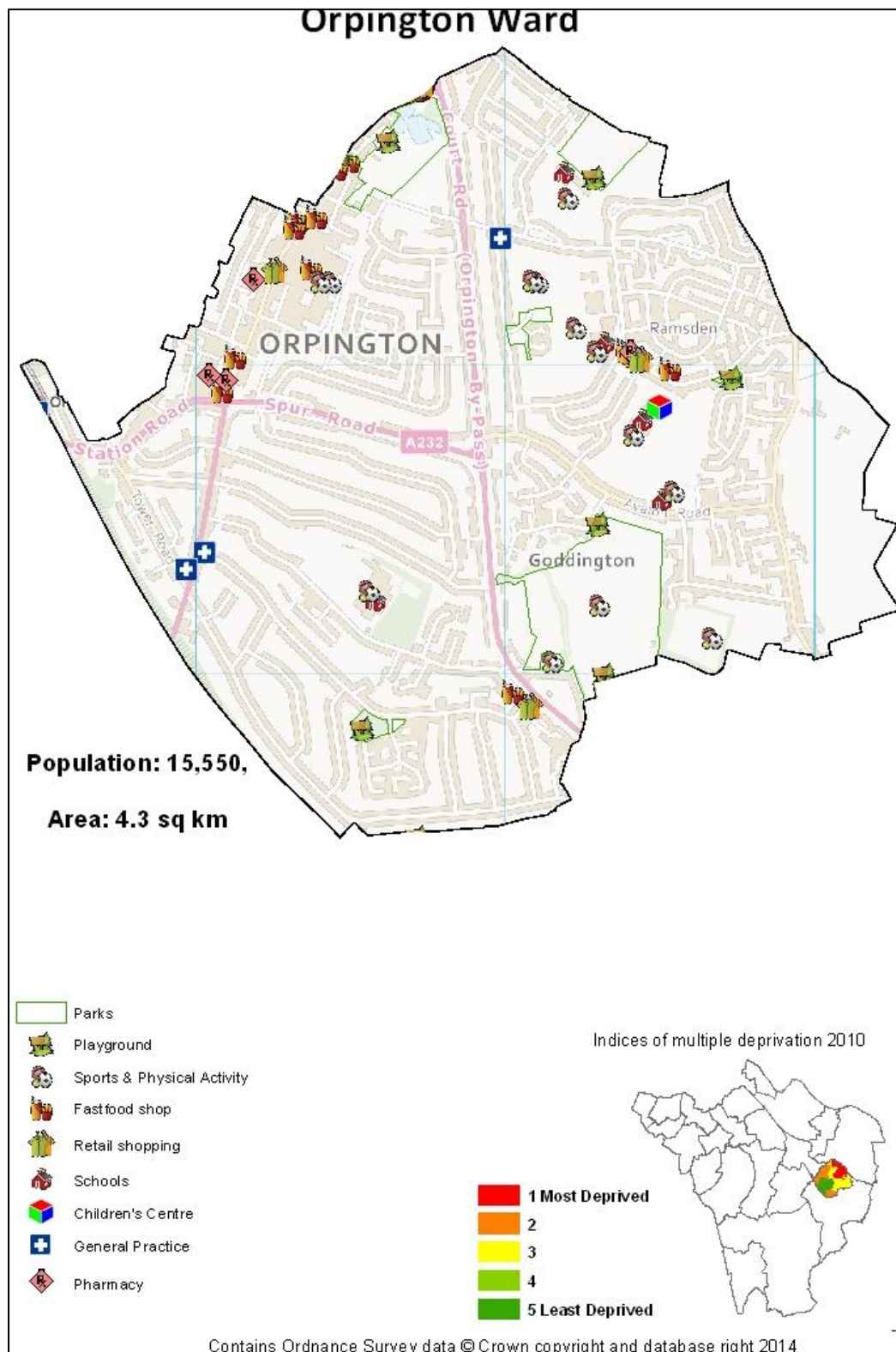
There is an above average proportion of social rented households and overcrowded housing. There has been a high count of both mortgage and landlord repossession court orders which is used to measure the impact of the economic downturn. This area has higher than average crime rates.

People perceive themselves to be in bad and very bad health, their wellbeing score is low and worsening year on year. The high proportion of people perceiving themselves to be in bad health in a fairly young population is an area of concern, however there are very low proportions of residents receiving funded social care.

Apart from the low prevalence of recorded smoking the ward has very poor lifestyle risk factors. The rate of people in treatment for substance misuse is high and teenage pregnancy rates are some of the highest in the borough. Obesity rates are high in both children and adults, healthy eating is estimated to be very low and there is a high prevalence of binge drinking.

Although life expectancy is well below the borough average, the overall burden of disease as recorded in primary care is low. The low disease burden and prevalence of many risk factors for disease reflects the young age of this population where disease is not yet apparent but could present later in life. There could also be under reporting of disease in the area with data from one practice in this area being unavailable at the time of extraction.

Public transport accessibility is good. Mottingham & Chislehurst North was highlighted as a renewal area in last year's JSNA.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Orpington		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	15550		
		2013	Population density (GLA)	3755.81	13	56.8
		2013	% Children (0-4)	5.80	10	43.2
		2013	% Older people (75+)	11.30	20	88.6
		2011	% Lone parent households	7.43	15	65.9
		2011	% Lone pensioner households	14.35	17	75.0
		2011	% BAME	12.60	9	38.6
		2011	% Not Born in UK	11.90	9	38.6
	Deprivation	2010	IMD 2010 (Mean)	18.40	17	75.0
		2010	IDACI 2010 (Score)	0.24	17	75.0
	Employment and Education	2011	% with no qualifications	22.30	19	84.1
		2011	% Never worked/Long term unemployed (16-64)	2.20	14	61.4
		2012/2013	% Average workless benefit claimants	16.30	16	70.5
		2011	% Routine and semi - routine workers	19.62	19	84.1
		2012/2013	% Good level of development at age 5	61.26	10	43.2
		2012/2013	Key stage 2: Level 4 and above achievement	72.85	6	25.0
		2012/2013	GCSE: 5+A*-C achievement	53.42	4	15.9
		2011	% Overcrowded households	6.50	13	56.8
	Housing and the Neighbourhood	2011	% Social rented households	15.80	16	70.5
		2011	Mortgage Repossession Orders	0.00	4	15.9
		2011	Landlord Repossession Orders	20.00	13	56.8
		2012/13	Crime rate per 1000	72.60	17	75.0
		2011	Average Public Transport Accessibility score	2.70	16	70.5
	Well-being and Lifestyle	2011	% reporting bad and very bad health	4.50	16	70.5
		2011	% Funded Social care (18+)	4.37	14	61.4
		2012	Overall wellbeing probability score	0.00	7	29.5
		2012-2013	% Recorded smokers	19.41	19	84.1
		2012-2013	Substance misuse (in treatment) per 1000	2.19	13	56.8
		2009-2011	Teenage conception rates	35.17	15	65.9
		2009/10- 2011/12	% Obese children in 4 -5 year olds	7.50	11	47.7
		2009/10- 2011/12	% Obese children in 10-11 year olds	19.20	17	75.0
		2006-2008	Obesity estimate (16+)	23.20	13	56.8
		2006-2010	Healthy eating estimates	33.90	6	25.0
		2006-2010	Binge drinking estimates (16+)	11.30	1	2.3
		2006-2010	Female life expectancy	85.80	17	75.0
HEALTH OUTCOMES	Disease and Death	2006-2010	Male life expectancy	80.80	14	61.4
		2012/2013	% Recorded Diabetes (16+)	7.02	22	97.7
		2012/2013	% Recorded Stroke	2.35	22	97.7
		2012/2013	% Recorded Serious Mental Illness	0.64	20	88.6
		2012/2013	% Recorded COPD	1.83	21	93.2
		2012/2013	% Recorded Asthma	15.00	21	93.2
		2012/2013	% Recorded Epilepsy	1.65	22	97.7
		2012/2013	% Recorded Learning disability	0.20	21	93.2
		2012/2013	% Recorded Dementia	0.53	20	88.6
		2012/2013	% Recorded Coronary Heart Disease	5.04	22	97.7
		2012/2013	% Recorded Chronic Kidney Disease	6.06	22	97.7
		2012/2013	% Recorded Heart Failure	1.18	22	97.7
		2012/2013	% Recorded Atrial Fibrillation	3.02	22	97.7
		2012/2013	% Recorded Hypertension	24.05	22	97.7
		2012/2013	% Recorded Cancer	3.38	22	97.7

Summary of Key Issues

Orpington is a major town centre and suburban commuter town, home to the Walnut shopping centre. This is an area with high levels of deprivation and a high proportion of children living in poverty. The overall deprivation levels mask local variation, particularly areas of the Ramsden estate, comprising social rented housing and the population with lower incomes, employment levels and educational qualifications.

There is a high proportion of lone parent households although the proportion of children under 5 years is below average. This is an older population with an above average lone pensioner households and high social rented households.

Educational attainment in state funded schools is poor particularly at GCSE level. Economic activity is low with a high proportion of routine and semi routine workers among those who are in work.

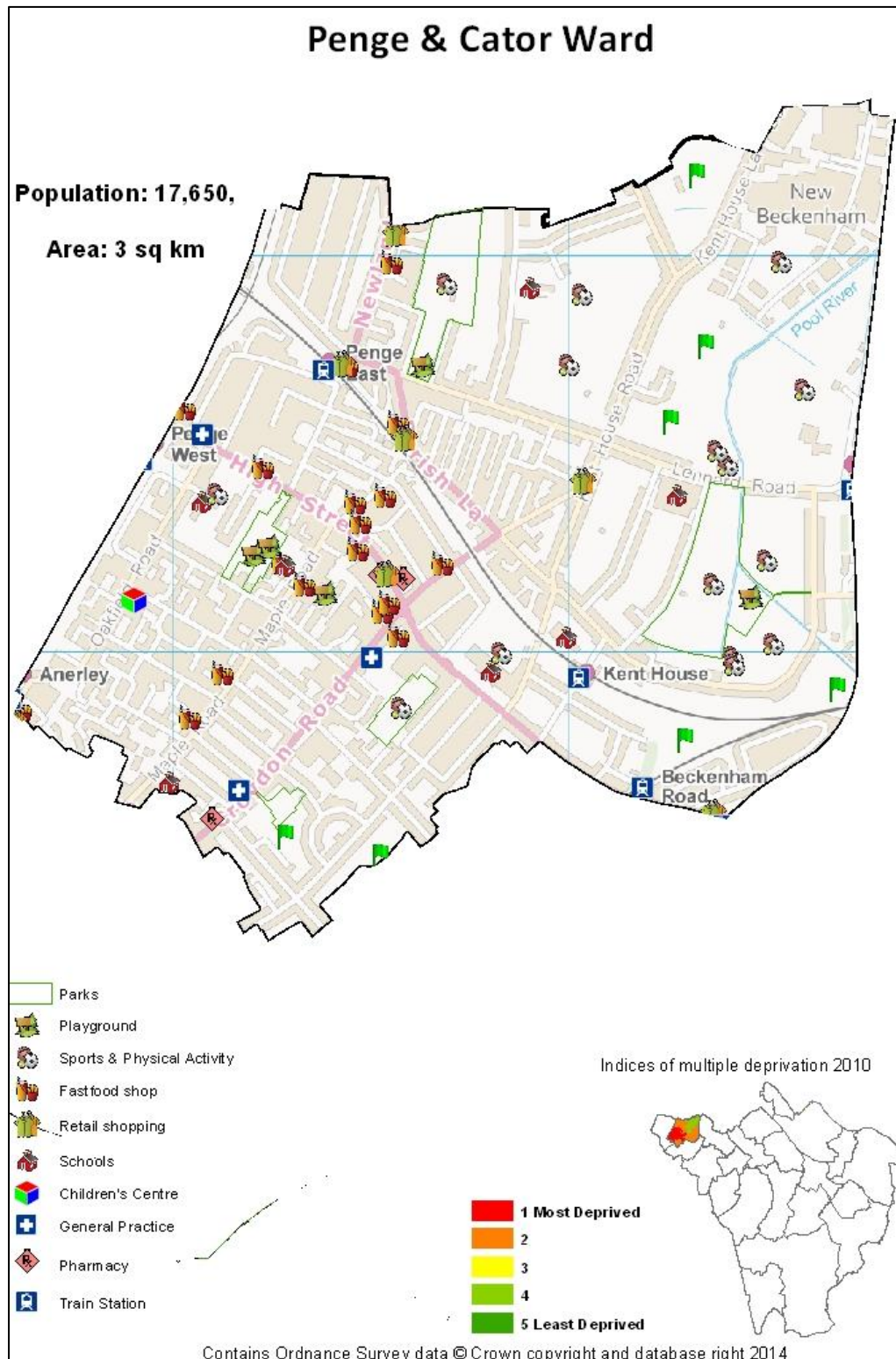
There are higher than average rates of recorded crime and the area is well served with public transport.

A high proportion of residents perceive themselves to be in bad and very bad health paired with a low sense general wellbeing. Above average proportions of residents are in receipt of funded social care.

Apart from the low prevalence of binge drinking in the area levels of other modifiable risk factors are poor. There are high rates of recorded smoking, obesity rates in children are poor especially in 10-11 year olds, healthy eating estimates are very low, teenage conception rates are high and the rate of people in treatment for substance misuse is average.

The area fares quite poorly on almost all health outcomes except life expectancy which is above average. There is a very high burden of disease. The high life expectancy and high disease burden is indicative of the area having low healthy life expectancy. That is people living long but with disease, which severely impacts on the quality of life as well as health and social care services.

Orpington was identified as a renewal area in last year's JSNA.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Penge and Cator		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	17650		
		2013	Population density (GLA)	5883.33	21	93.2
		2013	% Children (0-4)	8.20	19	84.1
		2013	% Older people (75+)	4.20	2	6.8
		2011	% Lone parent households	11.17	18	79.5
		2011	% Lone pensioner households	8.34	2	6.8
		2011	% BAME	34.60	21	93.2
	Deprivation	2011	% Not Born in UK	25.80	21	93.2
		2010	IMD 2010 (Mean)	25.75	18	79.5
	Employment and Education	2010	IDACI 2010 (Score)	0.30	18	79.5
		2011	% with no qualifications	17.00	12	52.3
		2011	% Never worked/Long term unemployed (16-64)	3.80	22	97.7
		2012/2013	% Average workless benefit claimants	28.40	21	93.2
		2011	% Routine and semi - routine workers	18.73	17	75.0
		2012/2013	% Good level of development at age 5	47.96	3	11.4
		2012/2013	Key stage 2: Level 4 and above achievement	68.50	3	11.4
	Housing and the Neighbourhood	2012/2013	GCSE: 5+A*-C achievement	61.63	8	34.1
		2011	% Overcrowded households	16.98	21	93.2
		2011	% Social rented households	29.80	19	84.1
		2011	Mortgage Repossession Orders	15.00	19	84.1
		2011	Landlord Repossession Orders	75.00	22	97.7
		2012/13	Crime rate per 1000	91.20	19	84.1
		2011	Average Public Transport Accessibility score	3.90	21	93.2
	Well-being and Lifestyle	2011	% reporting bad and very bad health	4.80	17	75.0
		2011	% Funded Social care (18+)	4.16	11	47.7
		2012	Overall wellbeing probability score	-5.00	5	20.5
		2012-2013	% Recorded smokers	12.01	11	47.7
		2012-2013	Substance misuse (in treatment) per 1000	3.97	19	84.1
		2009-2011	Teenage conception rates	30.79	14	61.4
		2009/10- 2011/12	% Obese children in 4 -5 year olds	9.90	19	84.1
		2009/10- 2011/12	% Obese children in 10-11 year olds	21.70	19	84.1
		2006-2008	Obesity estimate (16+)	23.60	14	61.4
		2006-2010	Healthy eating estimates	33.40	5	20.5
		2006-2010	Binge drinking estimates (16+)	15.40	17	75.0
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	82.50	5	20.5
		2006-2010	Male life expectancy	76.10	2	6.8
		2012/2013	% Recorded Diabetes (16+)	2.95	3	11.4
		2012/2013	% Recorded Stroke	0.80	3	11.4
		2012/2013	% Recorded Serious Mental Illness	0.61	19	84.1
		2012/2013	% Recorded COPD	0.88	5	20.5
		2012/2013	% Recorded Asthma	6.29	5	20.5
		2012/2013	% Recorded Epilepsy	0.75	2	6.8
		2012/2013	% Recorded Learning disability	0.08	9	38.6
		2012/2013	% Recorded Dementia	0.07	2	6.8
		2012/2013	% Recorded Coronary Heart Disease	1.36	2	6.8
		2012/2013	% Recorded Chronic Kidney Disease	1.29	2	6.8
		2012/2013	% Recorded Heart Failure	0.37	3	11.4
		2012/2013	% Recorded Atrial Fibrillation	0.57	2	6.8
		2012/2013	% Recorded Hypertension	8.14	3	11.4
		2012/2013	% Recorded Cancer	0.94	3	11.4

Summary of Key Issues

Penge & Cator neighbours Crystal Palace and is on the Bromley and Lewisham border. This is a densely populated area with high levels of deprivation and was identified as a renewal area in last year's JSNA. Despite the overall high levels of deprivation, there are areas to the east of the ward which are more affluent.

The ward mainly has a young population and a high proportion of minority ethnic groups and non – UK born residents. There are high proportion of children living in poverty and high proportions of lone parent households.

Attainment in education is a precursor to improved life opportunities but the school going population is not achieving academically, especially at key stage 4. There are average proportions of residents with no qualifications contrasted with high economic inactivity in the working age population evidenced by high proportion of those who have never worked or in long term unemployment and claiming workless benefits.

There is a high proportion of social rented households and a much higher proportion of overcrowded housing than most areas of the borough. There has been a high volume of housing repossession court orders particularly landlord repossessions which are measures of the impact of the economic downturn.

The ward is well served by three train stations and buses making for easier connections within and out of the borough thus giving it a good score on the Public Transport Accessibility index.

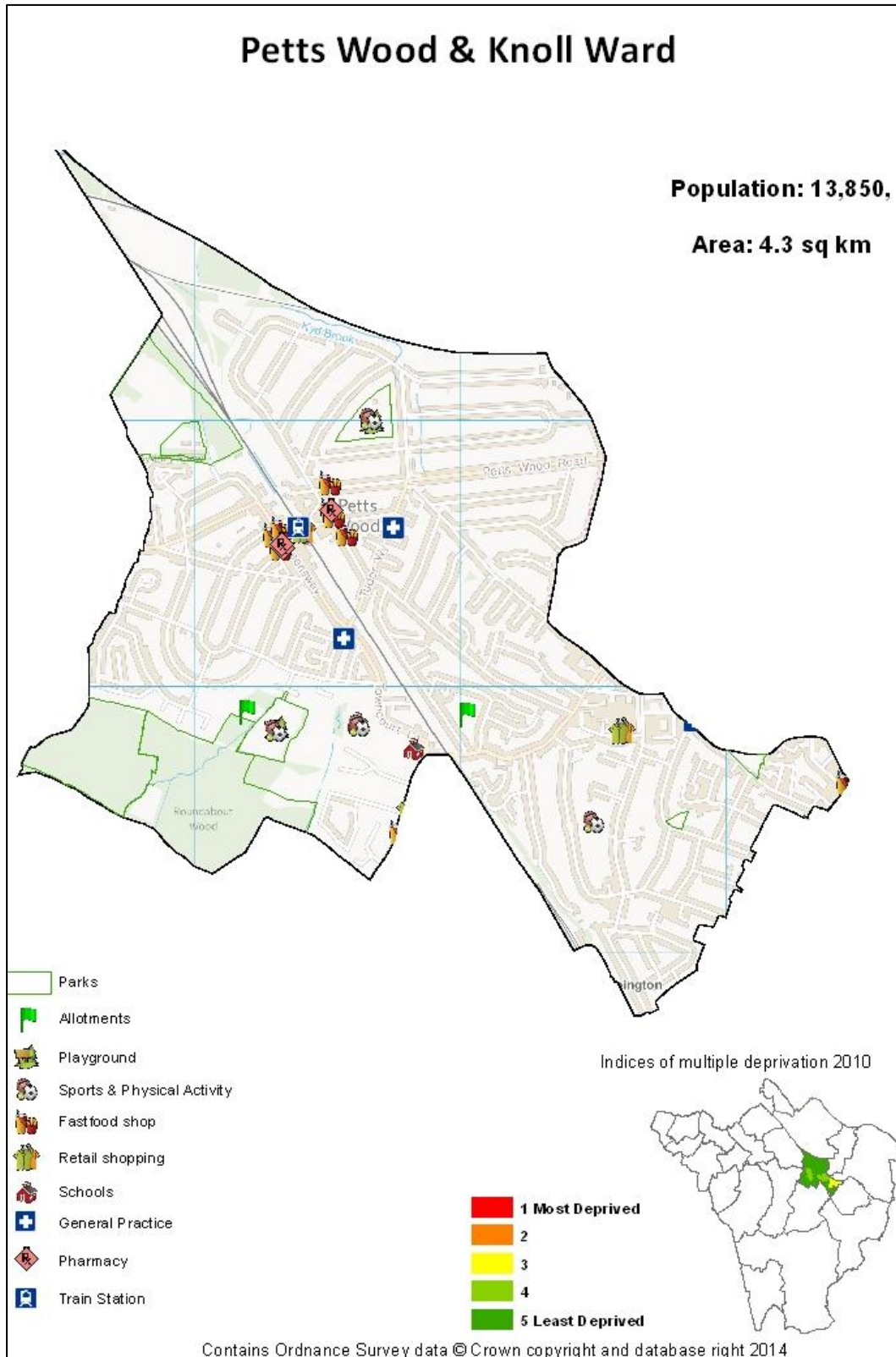
There is a high proportion of people reporting bad and very bad health and an average proportion receiving funded social care. There is generally a poor sense of overall wellbeing. Lifestyle factors are average to poor. Although smoking levels are average, childhood obesity rates are higher than average with below average levels of healthy eating, a high proportion of binge drinking and a high rate of people in treatment for substance misuse.

Life expectancy is lower than the Bromley average. Health is negatively impacted by:

- Low levels of education and employment
- Poor lifestyle factors
- Overcrowding
- High crime rate

Although there is some missing disease burden data for this area, there is still an overall low burden of disease. Aside from a high prevalence of serious mental illness and hypertension, the other long term conditions present later in

life and have not yet become apparent. It is also likely that there may be some under recording of disease in the area.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Petts Wood and Knoll		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	13850		
		2013	Population density (GLA)	3267.44	11	47.7
		2013	% Children (0-4)	6.50	14	61.4
		2013	% Older people (75+)	10.10	16	70.5
		2011	% Lone parent households	4.06	2	6.8
		2011	% Lone pensioner households	13.26	12	52.3
		2011	% BAME	9.20	4	15.9
		2011	% Not Born in UK	10.60	7	29.5
	Deprivation	2010	IMD 2010 (Mean)	4.90	1	2.3
		2010	IDACI 2010 (Score)	0.06	2	6.8
	Employment and Education	2011	% with no qualifications	15.20	6	25.0
		2011	% Never worked/Long term unemployed (16-64)	1.20	3	11.4
		2012/2013	% Average workless benefit claimants	6.40	3	11.4
		2011	% Routine and semi - routine workers	12.22	5	20.5
		2012/2013	% Good level of development at age 5	80.61	22	97.7
		2012/2013	Key stage 2: Level 4 and above achievement	92.98	22	97.7
		2012/2013	GCSE: 5+A*-C achievement	76.34	17	75.0
	Housing and the Neighbourhood	2011	% Overcrowded households	2.17	1	2.3
		2011	% Social rented households	2.70	1	2.3
		2011	Mortgage Repossession Orders	0.00	5	20.5
		2011	Landlord Repossession Orders	0.00	4	15.9
		2012/13	Crime rate per 1000	40.90	6	25.0
	Well-being and Lifestyle	2011	Average Public Transport Accessibility score	2.30	12	52.3
		2011	% reporting bad and very bad health	3.20	5	20.5
		2011	% Funded Social care (18+)	2.72	6	25.0
		2012	Overall wellbeing probability score	10.00	21	93.2
		2012-2013	% Recorded smokers	9.39	3	11.4
		2012-2013	Substance misuse (in treatment) per 1000	0.94	2	6.8
		2009-2011	Teenage conception rates	12.68	4	15.9
		2009/10- 2011/12	% Obese children in 4 -5 year olds	5.70	4	15.9
		2009/10- 2011/12	% Obese children in 10-11 year olds	12.30	7	29.5
		2006-2008	Obesity estimate (16+)	20.60	4	15.9
		2006-2010	Healthy eating estimates	39.40	18	79.5
		2006-2010	Binge drinking estimates (16+)	11.90	6	25.0
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	87.50	21	93.2
		2006-2010	Male life expectancy	83.30	22	97.7
		2012/2013	% Recorded Diabetes (16+)	4.40	15	65.9
		2012/2013	% Recorded Stroke	1.23	6	25.0
		2012/2013	% Recorded Serious Mental Illness	0.14	1	2.3
		2012/2013	% Recorded COPD	0.95	6	25.0
		2012/2013	% Recorded Asthma	8.14	6	25.0
		2012/2013	% Recorded Epilepsy	1.00	10	43.2
		2012/2013	% Recorded Learning disability	0.01	1	2.3
		2012/2013	% Recorded Dementia	0.26	6	25.0
		2012/2013	% Recorded Coronary Heart Disease	2.79	8	34.1
		2012/2013	% Recorded Chronic Kidney Disease	3.34	17	75.0
		2012/2013	% Recorded Heart Failure	0.68	11	47.7
		2012/2013	% Recorded Atrial Fibrillation	1.62	9	38.6
		2012/2013	% Recorded Hypertension	15.22	16	70.5
		2012/2013	% Recorded Cancer	1.83	7	29.5

Summary of Key Issues

Petts Wood & Knoll ward is generally affluent with low deprivation levels and low levels of children living in poverty.

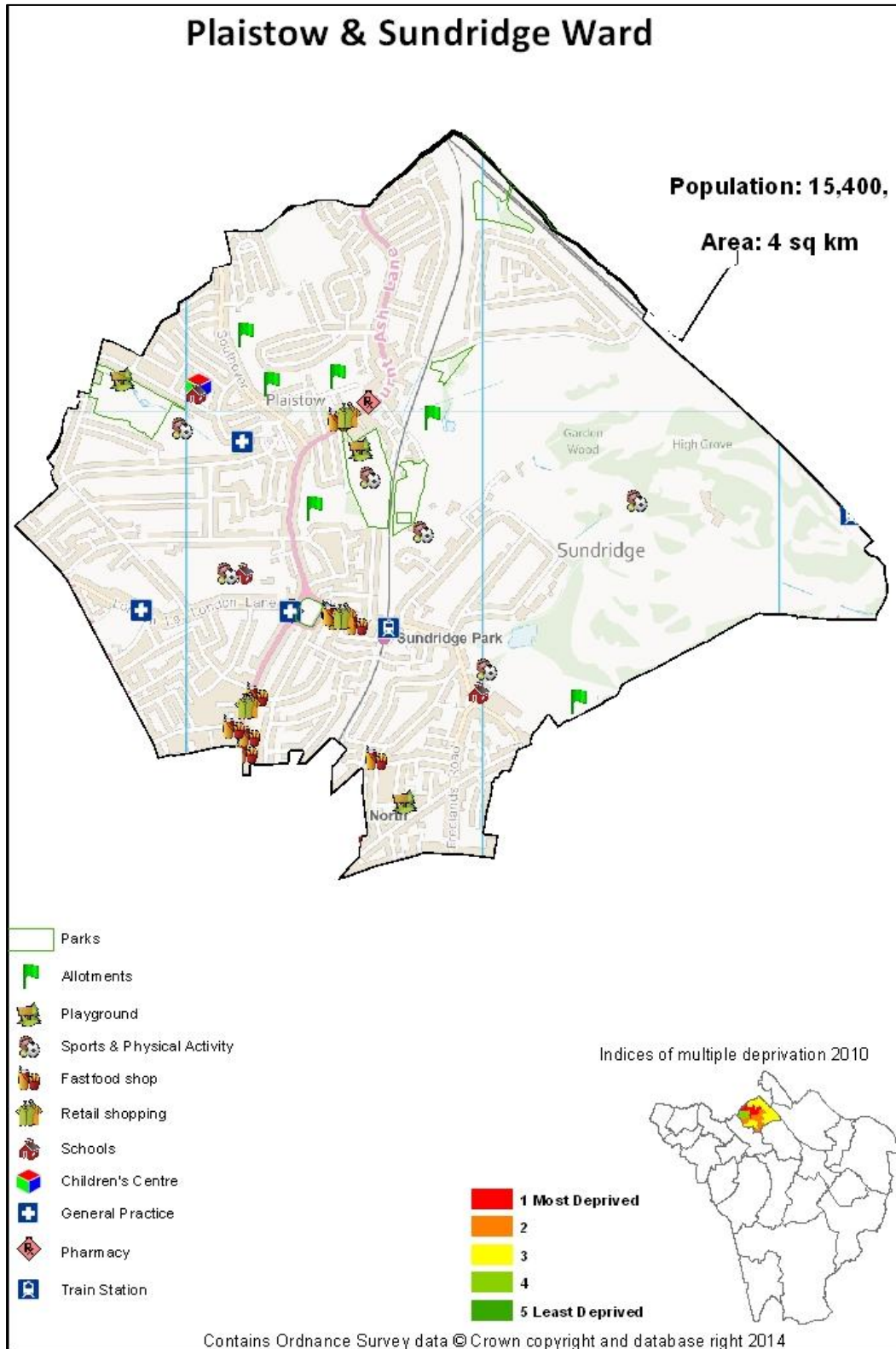
It is characterised by an above average proportion of children under 5 years of age and of older people. The proportion of ethnic minority groups and non- UK born residents in the area is well below borough average.

The proportion of the residents with qualifications is high as is the economically active population. The percentage of residents in routine and semi- routine employment is low reflecting the proportion of residents with qualifications. Educational attainment is well above average in the school going population as measured at age 5, key stage 2 and GCSE in state funded schools.

The area has the lowest proportion of social rented households and overcrowded housing in the borough. There has been no record of mortgage or landlord repossession court orders in the area indicating financial resilience during the economic downturn. There is also very low recorded crime and average access to public transport.

The people have a very high sense of wellbeing and are reporting good and very good health as well as making healthy lifestyle choices with low recording of smoking, binge drinking and people in treatment for substance misuse. Obesity rates are low in both adults and children and healthy eating estimates are high.

Petts Wood & Knoll fares quite well on almost all health determinants and health outcomes. It is one of the areas in the borough with the highest life expectancy for both men and women. However there is a mixed picture of disease prevalence with above average levels of diabetes, chronic kidney disease and hypertension and below average levels of most other conditions.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Plaistow and Sundridge		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	15400		
		2013	Population density (GLA)	3812.5	14	61.4
		2013	% Children (0-4)	7.50	17	75.0
		2013	% Older people (75+)	7.50	7	29.5
		2011	% Lone parent households	8.36	16	70.5
		2011	% Lone pensioner households	11.67	4	15.9
		2011	% BAME	19.30	19	84.1
		2011	% Not Born in UK	16.90	17	75.0
	Deprivation	2010	IMD 2010 (Mean)	17.37	16	70.5
		2010	IDACI 2010 (Score)	0.22	16	70.5
	Employment and Education	2011	% with no qualifications	18.60	16	70.5
		2011	% Never worked/Long term unemployed (16-64)	2.50	17	75.0
		2012/2013	% Average workless benefit claimants	18.80	18	79.5
		2011	% Routine and semi - routine workers	16.38	13	56.8
		2012/2013	% Good level of development at age 5	53.26	5	20.5
		2012/2013	Key stage 2: Level 4 and above achievement	87.16	17	75.0
		2012/2013	GCSE: 5+A*-C achievement	67.29	11	47.7
	Housing and the Neighbourhood	2011	% Overcrowded households	9.89	19	84.1
		2011	% Social rented households	17.40	17	75.0
		2011	Mortgage Repossession Orders	20.00	22	97.7
		2011	Landlord Repossession Orders	30.00	15	65.9
		2012/13	Crime rate per 1000	54.40	11	47.7
		2011	Average Public Transport Accessibility score	2.80	17	75.0
	Well-being and Lifestyle	2011	% reporting bad and very bad health	4.80	18	79.5
		2011	% Funded Social care (18+)	4.96	18	79.5
		2012	Overall wellbeing probability score	-1.00	6	25.0
		2012-2013	% Recorded smokers	5.36	2	6.8
		2012-2013	Substance misuse (in treatment) per 1000	5.26	22	97.7
		2009-2011	Teenage conception rates	52.27	20	88.6
		2009/10- 2011/12	% Obese children in 4 -5 year olds	9.70	17	75.0
		2009/10- 2011/12	% Obese children in 10-11 year olds	17.30	15	65.9
		2006-2008	Obesity estimate (16+)	20.50	3	11.4
		2006-2010	Healthy eating estimates	36.00	13	56.8
		2006-2010	Binge drinking estimates (16+)	15.40	18	79.5
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	82.10	3	11.4
		2006-2010	Male life expectancy	79.00	7	29.5
		2012/2013	% Recorded Diabetes (16+)	3.32	6	25.0
		2012/2013	% Recorded Stroke	1.14	5	20.5
		2012/2013	% Recorded Serious Mental Illness	0.64	21	93.2
		2012/2013	% Recorded COPD	1.03	8	34.1
		2012/2013	% Recorded Asthma	3.53	2	6.8
		2012/2013	% Recorded Epilepsy	0.92	6	25.0
		2012/2013	% Recorded Learning disability	0.19	20	88.6
		2012/2013	% Recorded Dementia	0.36	13	56.8
		2012/2013	% Recorded Coronary Heart Disease	2.19	5	20.5
		2012/2013	% Recorded Chronic Kidney Disease	1.65	4	15.9
		2012/2013	% Recorded Heart Failure	0.54	5	20.5
		2012/2013	% Recorded Atrial Fibrillation	1.34	5	20.5
		2012/2013	% Recorded Hypertension	10.75	5	20.5
		2012/2013	% Recorded Cancer	2.06	12	52.3

Summary of Key Issues

Plaistow & Sundridge ward is towards the north of the borough bordering Lewisham with a young population. Although overall deprivation levels are high including a high proportion of children living in poverty, it is an area of variable population character with a significant minority who are affluent.

There is a low proportion of older people and lone pensioner households. There is a high proportion of non- UK born residents and Black and Asian minority ethnic groups in the area and an above average proportion of lone parent households.

Educational attainment in the school going population is low as measured at age 5 and GCSE but the proportion of pupils achieving at Key stage 2 is high.

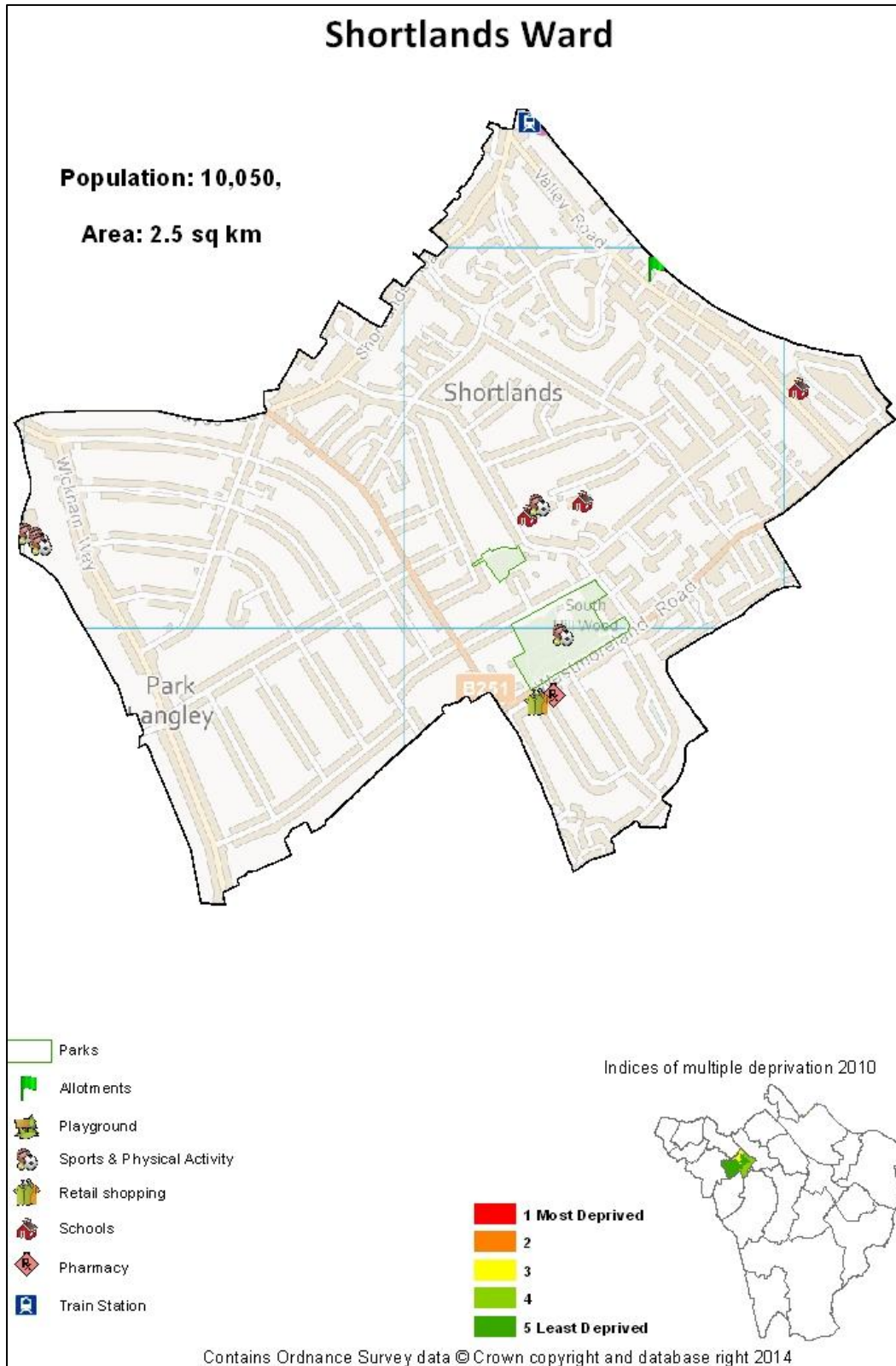
The proportion of residents with no qualification is above average. There is a high proportion of working age population, however, most are economically inactive evidenced by high workless benefit claimants and high proportions of residents who have never worked or are in long term unemployment. Of the economically active most are in routine and semi-routine employment. A higher than average proportion of the adult population are receiving funded social care.

There are higher than average proportions of social rented households and overcrowded households in the area and population density is above the borough average. Housing repossession orders have been high, particularly mortgage court orders which were the highest in the borough, indicating high income loss during the economic downturn.

People perceive themselves to be in poor health, and their wellbeing score is the low. An above average proportion are receiving funded social care. There is good access to public transport networks in Plaistow & Sundridge in comparison to some other parts of the borough. This area has a high rate of recorded crime in Bromley.

There is a mixed picture of prevalence of at risk behaviour with high binge drinking rates, high rates of people in treatment for substance misuse, and high teenage pregnancy rates, but low levels of smoking and adult obesity.

Life expectancy is significantly below Bromley average especially for women. The overall low burden of disease reflects the young age of the population. Levels of serious mental illness are above average reflecting the deprivation of the area. It is also likely that there may be some under recording of disease in the area and some missing data from the disease burden.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

Shortlands		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	10050		
		2013	Population density (GLA)	3940	15	65.9
		2013	% Children (0-4)	5.00	4	15.9
		2013	% Older people (75+)	10.40	17	75.0
		2011	% Lone parent households	3.87	1	2.3
		2011	% Lone pensioner households	14.69	18	79.5
		2011	% BAME	15.60	14	61.4
	Deprivation	2011	% Not Born in UK	16.00	16	70.5
		2010	IMD 2010 (Mean)	6.58	3	11.4
	Employment and Education	2010	IDACI 2010 (Score)	0.07	3	11.4
		2011	% with no qualifications	12.10	2	6.8
		2011	% Never worked/Long term unemployed (16-64)	1.20	4	15.9
		2012/2013	% Average workless benefit claimants	5.10	2	6.8
		2011	% Routine and semi - routine workers	10.23	1	2.3
		2012/2013	% Good level of development at age 5	68.29	18	79.5
		2012/2013	Key stage 2: Level 4 and above achievement	91.76	20	88.6
	Housing and the Neighbourhood	2012/2013	GCSE: 5+A*-C achievement	85.87	22	97.7
		2011	% Overcrowded households	4.95	10	43.2
		2011	% Social rented households	6.20	7	29.5
		2011	Mortgage Repossession Orders	0.00	6	25.0
		2011	Landlord Repossession Orders	10.00	8	34.1
		2012/13	Crime rate per 1000	31.00	1	2.3
		2011	Average Public Transport Accessibility score	2.50	13	56.8
	Well-being and Lifestyle	2011	% reporting bad and very bad health	2.90	1	2.3
		2011	% Funded Social care (18+)	2.64	4	15.9
		2012	Overall wellbeing probability score	9.00	18	79.5
		2012-2013	% Recorded smokers	9.75	5	20.5
		2012-2013	Substance misuse (in treatment) per 1000	0.70	1	2.3
		2009-2011	Teenage conception rates	12.66	3	11.4
		2009/10- 2011/12	% Obese children in 4 -5 year olds	5.40	3	11.4
		2009/10- 2011/12	% Obese children in 10-11 year olds	11.90	2	6.8
		2006-2008	Obesity estimate (16+)	17.80	2	6.8
		2006-2010	Healthy eating estimates	42.40	22	97.7
		2006-2010	Binge drinking estimates (16+)	13.20	12	52.3
	HEALTH OUTCOMES	2006-2010	Female life expectancy	86.50	20	88.6
		2006-2010	Male life expectancy	82.90	21	93.2
		2012/2013	% Recorded Diabetes (16+)	3.81	7	29.5
		2012/2013	% Recorded Stroke	1.48	12	52.3
		2012/2013	% Recorded Serious Mental Illness	0.37	7	29.5
		2012/2013	% Recorded COPD	0.69	3	11.4
		2012/2013	% Recorded Asthma	8.93	9	38.6
		2012/2013	% Recorded Epilepsy	0.91	5	20.5
		2012/2013	% Recorded Learning disability	0.07	6	25.0
		2012/2013	% Recorded Dementia	0.40	16	70.5
		2012/2013	% Recorded Coronary Heart Disease	3.27	16	70.5
		2012/2013	% Recorded Chronic Kidney Disease	2.17	6	25.0
		2012/2013	% Recorded Heart Failure	0.57	7	29.5
		2012/2013	% Recorded Atrial Fibrillation	2.08	14	61.4
		2012/2013	% Recorded Hypertension	12.56	7	29.5
		2012/2013	% Recorded Cancer	2.68	21	93.2

Summary of Key Issues

Shortlands ward borders Bromley Town and Kelsey & Eden Park. This is an area with low deprivation levels and average population density. Although access to public open spaces is poor, residents tend to have large gardens. Access to local services within the ward is low.

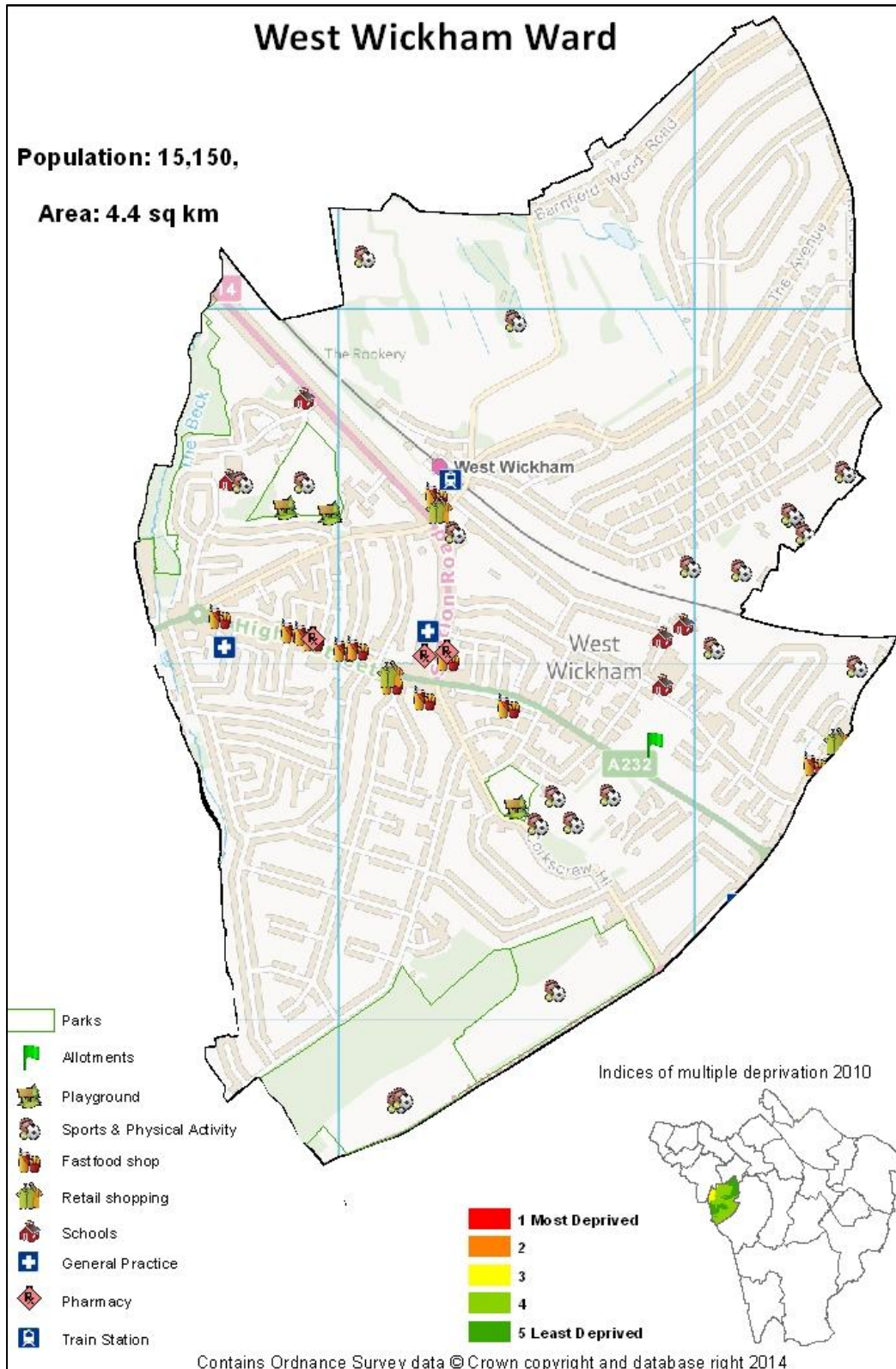
It is characterised by a very low proportion of children under 5 years of age and a considerably large proportion of older population of whom many are living alone. The proportion of ethnic minority groups and non- UK born residents in the area is above borough average.

The proportion of the residents with qualifications is high as is economic activity. The percentage of residents in routine and semi- routine employment is the lowest in the borough, in line with the high proportion of residents with qualifications. Educational attainment is very high in the school going population as measured at school readiness, key stage 2 and GCSE in state funded schools.

Shortlands has mostly owner occupied households with relatively low proportions of overcrowded housing in the area. There has been no record of mortgage or landlord repossession court orders in the area indicating financial resilience during the economic downturn. This area has the lowest rate of recorded crime in the borough and average access to public transport.

The people have a high sense of wellbeing and are reporting good and very good health as well as making healthy lifestyle choices in terms of low levels of smoking, people in treatment for substance misuse and obesity rates in both adults and children. However the proportion of people binge drinking is average.

Generally, Shortlands has a healthy community, scoring high on overall wellbeing and on almost all health determinants and health outcomes. It is one of the areas in the borough with the highest life expectancy for both men and women. The picture of disease prevalence reflects an older population with above average levels of cancer, dementia and coronary heart disease.



BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2014

West Wickham		Indicator Year	Indicator	Indicator value	Ward Rank	Percentile Rank
DETERMINANTS OF HEALTH	Demography	2013	Population (GLA)	15150		
		2013	Population density (GLA)	3397.73	12	52.3
		2013	% Children (0-4)	4.60	3	11.4
		2013	% Older people (75+)	10.60	18	79.5
		2011	% Lone parent households	5.13	9	38.6
		2011	% Lone pensioner households	14.96	21	93.2
		2011	% BAME	10.60	7	29.5
	Deprivation	2011	% Not Born in UK	9.70	5	20.5
		2010	IMD 2010 (Mean)	6.60	4	15.9
	Employment and Education	2010	IDACI 2010 (Score)	0.05	1	2.3
		2011	% with no qualifications	15.20	7	29.5
		2011	% Never worked/Long term unemployed (16-64)	1.20	5	20.5
		2012/2013	% Average workless benefit claimants	7.50	4	15.9
		2011	% Routine and semi - routine workers	13.18	7	29.5
		2012/2013	% Good level of development at age 5	67.68	16	70.5
		2012/2013	Key stage 2: Level 4 and above achievement	87.43	18	79.5
	Housing and the Neighbourhood	2012/2013	GCSE: 5+A*-C achievement	78.74	20	88.6
		2011	% Overcrowded households	4.81	8	34.1
		2011	% Social rented households	4.40	3	11.4
		2011	Mortgage Repossession Orders	10.00	13	56.8
		2011	Landlord Repossession Orders	10.00	9	38.6
		2012/13	Crime rate per 1000	34.70	2	6.8
		2011	Average Public Transport Accessibility score	2.20	6	25.0
	Well-being and Lifestyle	2011	% reporting bad and very bad health	3.10	4	15.9
		2011	% Funded Social care (18+)	3.09	8	34.1
		2012	Overall wellbeing probability score	10.00	22	97.7
		2012-2013	% Recorded smokers	9.71	4	15.9
		2012-2013	Substance misuse (in treatment) per 1000	1.32	8	34.1
		2009-2011	Teenage conception rates	8.92	1	2.3
		2009/10- 2011/12	% Obese children in 4 -5 year olds	6.10	5	20.5
		2009/10- 2011/12	% Obese children in 10-11 year olds	12.20	6	25.0
		2006-2008	Obesity estimate (16+)	20.70	5	20.5
		2006-2010	Healthy eating estimates	38.60	16	70.5
		2006-2010	Binge drinking estimates (16+)	12.80	9	38.6
HEALTH OUTCOMES	Disease and Death	2006-2010	Female life expectancy	84.70	13	56.8
		2006-2010	Male life expectancy	81.70	17	75.0
		2012/2013	% Recorded Diabetes (16+)	4.25	13	56.8
		2012/2013	% Recorded Stroke	1.66	16	70.5
		2012/2013	% Recorded Serious Mental Illness	0.45	13	56.8
		2012/2013	% Recorded COPD	1.10	12	52.3
		2012/2013	% Recorded Asthma	10.13	16	70.5
		2012/2013	% Recorded Epilepsy	1.15	14	61.4
		2012/2013	% Recorded Learning disability	0.08	8	34.1
		2012/2013	% Recorded Dementia	0.41	17	75.0
		2012/2013	% Recorded Coronary Heart Disease	3.60	19	84.1
		2012/2013	% Recorded Chronic Kidney Disease	2.69	12	52.3
		2012/2013	% Recorded Heart Failure	0.75	17	75.0
		2012/2013	% Recorded Atrial Fibrillation	2.34	19	84.1
		2012/2013	% Recorded Hypertension	15.91	18	79.5
		2012/2013	% Recorded Cancer	2.46	19	84.1

Summary of Key Issues

West Wickham is in the west of the borough bordering Croydon. It is relatively densely populated with good access to open spaces, including recreation grounds, playing fields and woodlands.

West Wickham is one of Bromley's affluent areas and has the lowest score for child poverty in the borough. The ward has a high proportion of older people and contributes significantly to the lone pensioner households in Bromley. It is predominantly home to a White community.

A high proportion of the working age population are economically active. There are very low proportions of residents in routine and semi-routine employment and workless benefit claimants. Educational attainment in the school going population is high as measured at age 5 and Key stage 2 but exceptional at GCSE in state funded schools.

There are very low levels of social rented households or overcrowded housing. There has been a low level of mortgage or landlord repossession court orders in the area indicating financial resilience during the economic downturn. This area has the second lowest crime rates in the borough and the lowest teenage conception rates.

The area scores low on average Public Transport Accessibility index. Poor access to public transport impacts on service access especially with lone pensioners being unable to drive with age.

There is a very high sense of wellbeing and people are reporting good and very good health as well as making healthy lifestyle choices reflected in the low levels of smoking, binge drinking and people in treatment for substance misuse. Obesity rates are low in both adults and children and healthy eating estimates are high.

There are gender inequalities in life expectancy. Although female life expectancy is higher, West Wickham men have a significantly higher life expectancy in comparison to men in some other wards in Bromley.

The burden of disease is above average in West Wickham. There is particularly a high prevalence of hypertension, cancer and coronary heart disease. The data presented shows a population that is ageing with disease which significantly impacts on health and social care service need.

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

5. Housing

Housing is a fundamental need for good health and wellbeing, and inequalities in a range of health issues can be tracked to the quality of housing. These effects can range from people becoming unwell or dying unnecessarily during periods of poor weather, due to poorly heated and insulated houses, through to people sleeping rough when their housing needs are not met at all. For many already deprived communities, the only housing available is substandard. The social and physical characteristics of the surrounding area are also vital in maintaining good health. The fact that poor quality accommodation is often situated in impoverished surroundings with few local amenities contributes further to making vulnerable individuals housebound.

Significant local intelligence exists on the housing needs and housing markets within Bromley and at a regional level. The issue at hand for housing is one of concerted effort and action on the key problems rather than a requirement for further information and analysis.

The Local Housing Market

Based on 2011 Census data, in Bromley there were 130,862 households, this figure is predicted to increase steadily over coming years with the average household size set to decrease. Currently, approximately 31% are single person households and based on socio-economic trends this is predicted to continue rising. 2011 Census data shows 135,036 dwellings within Bromley, of which approximately 71% are in owner occupation and approximately 13% are in the private rented sector. The Council no longer owns any housing stock and all social rented housing is supplied through Housing Associations (Registered Providers) which accounts for around 14% of the Borough's dwellings. **Table 5.1** shows the change in tenure mix over the last ten years. The falling level of owner occupation is likely to be a result of fewer first time buyers entering the market, partly due to a decrease in availability of mortgage finance and the general economic downturn.

The growth of the private rental sector (8.5% to 13.3% of dwellings) reflects the fall in home ownership and it is difficult to speculate over the impacts this shift in tenure may have. Although housing standards are unregulated within the private rented sector (unlike the social rented sector), as the increase in private renting is assumed to be from households who would have, under past market conditions, purchased their own property, it may be a reasonable assumption that these households are less likely to be low income households and are therefore less likely to be in the poorer quality (lower quartile) of private rented sector properties. However the knock on effects are unknown and the general increase in demand for private rental sector housing is unlikely to increase

housing standards within this lower quartile. What is clearer is that the increase in demand has driven a significant rise in rental prices for lower quartile rents. These are estimated to have risen about 5% over the last year within the Borough (based on SELHP Housing Market Bulletin average lower quartile rental price for a two bed flat), whilst average household income is believed to have stagnated. The average earnings by residence for full time workers living in Bromley in 2010, was estimated to be £652 per week¹³. These trends are even more extreme in the adjoining southeast London boroughs, such as LB Greenwich where the private rental sector has doubled from approximately 10% to 20% of dwellings over the same 10 year period.

Table 5. 1: Percentage Household Tenure in Bromley

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

Source: [2011 Census](#)

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

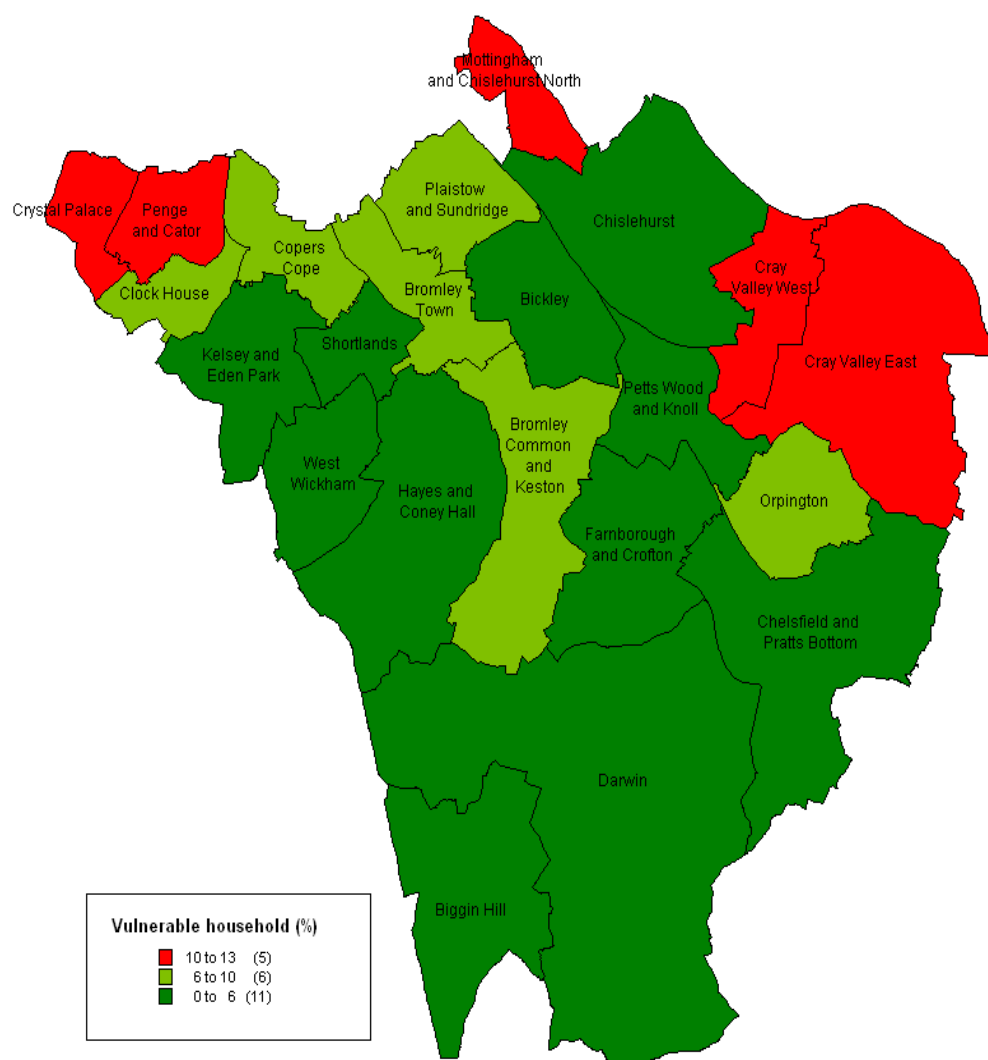
The number of vulnerable households occupying non-decent dwellings highlights inequalities across the borough. Vulnerable households are four

¹³ Source: Nomis

times more likely to occupy non-decent dwellings if they live in certain wards within the borough, illustrated below:

Figure 5. 1

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



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

According to the House Condition Survey; nationally 9.1 million homes have uninsulated cavity walls (60% of homes with cavity walls), and 6.3 million have poorly or non-insulated lofts (33% of homes with lofts).

Health Effects of Poor Housing

A recent study in the British Medical Journal reported that insulating existing houses led to a significantly warmer, drier indoor environment and resulted in improved self-rated health, self-reported wheezing, days off school and work,

and visits to GPs as well as a trend for fewer hospital admissions for respiratory conditions.

Falls

Home accidents caused by environmental hazards are most common among older people and very young children, especially in low income households. Most fatal falls are on stairs/steps among people aged 75 plus. Falls account for 71% of all deaths for those aged 65 years and over. In 2001, the combined NHS and social care costs for a single hip fracture in the UK were estimated to be over £20,000 (NOS, 2001).

Cold Housing

The main cause in Bromley of homes not meeting the Decent Homes Standard is lack of thermal insulation. This leads to cold homes, fuel poverty and related ill health.

Cold homes can cause or worsen hypothermia, asthma attacks, heart attacks, strokes or deep vein thrombosis, respiratory illness, arthritis, accidents and mobility problems, mental health conditions and sickle cell related problems.

Damp homes and condensation may promote mould growth and dust mites, causing respiratory problems, especially among young children, older people and allergy sufferers. Dampness and cold are also associated with mental health problems.

Housing design and environment

Housing type such as housing quality, high rise, or floor level have all been linked to mental ill health. High rise living can be associated with poorer mental health impact on children and mothers because of lack of play space and social isolation. Young mothers are particularly at risk and studies have shown that women in their early 20s are 3 times more likely to consult a GP for mental health problems if they live in flats.

The general design of a neighbourhood, access to communal areas and especially access to natural spaces have also been found to affect mental health and well-being. Children with Attention Deficit Hyperactivity Disorder (ADHD) have fewer behavioural problems when they spend more time in natural settings. Low income housing areas in London with less access to private gardens have higher prevalence of depression.

Inaccessible public spaces both indoors and outdoors can discourage physical activity and social participation, and may impair mental health and access to services and amenities.

The Need for Affordable Housing

The Housing Services seek wherever possible to prevent homelessness, or where not possible, to provide appropriate advice and assistance to enable a household to secure alternative suitable accommodation. This approach has significantly reduced homelessness levels in the Borough and halved the number of households living in temporary accommodation. Overall, more than 90% of households approaching are assisted to resolve their housing difficulty, preventing homelessness.

The volume of households approaching Housing Services faced with homelessness, unable to afford to access or sustain accommodation, has risen dramatically during recent years. This is predominantly in response to the impact of complex economic factors and the ensuing impact on housing markets, the onset of the recession and the welfare reform programme. The most significant area of increase continues to be the loss of private rented accommodation, which has increased year on year since the first tranche of welfare reform, and now accounts for more than one third of all homeless acceptances.

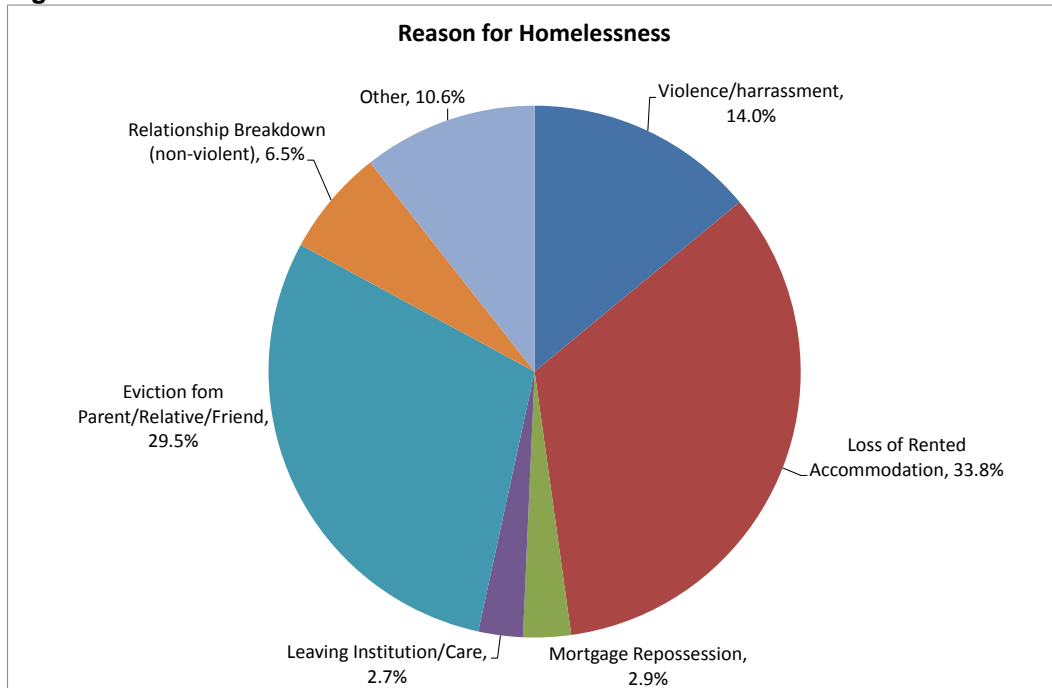
Table 5. 2: Level of Housing Need

	2009/10	2010/11	2011/12	2012/13	2013/14
Households Approaching	2057	2869	3948	5972	5428
Homeless Acceptances	414	426	634	566	586
Housing Register applications	5901	7638	8034	2572*	3052
Homelessness prevented	1,290	2122	2119	2137	2,121

* Reflected of new housing allocations scheme which raised the threshold for inclusion with a re-registration and assessment process for applicants.

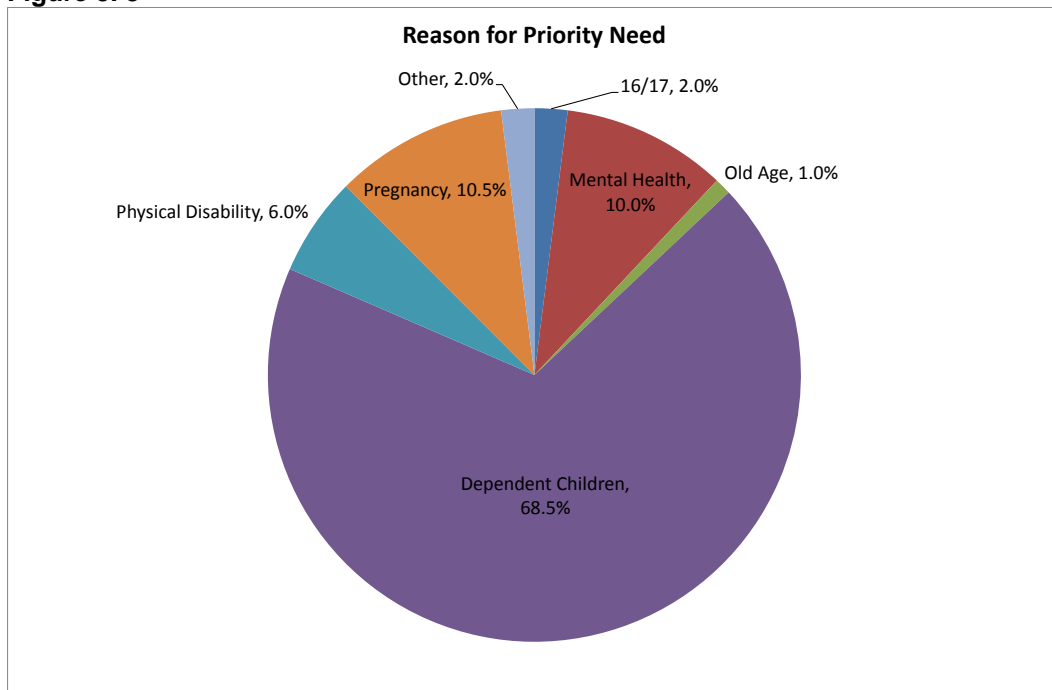
Source: P1E Quarterly return: Households dealt with under the homelessness provisions of the 1996 Housing Act, and homelessness prevention and relief DCLG

Figure 5. 2

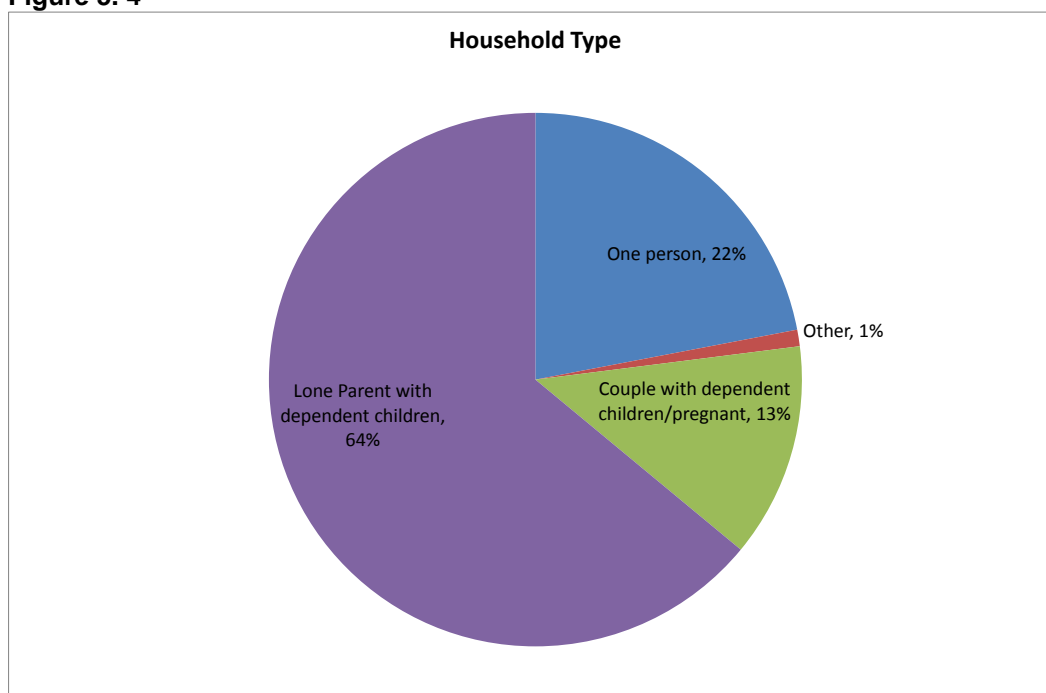


Source: P1E Quarterly return: Households dealt with under the homelessness provisions of the 1996 Housing Act, and homelessness prevention and relief DCLG

Figure 5. 3



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

Figure 5. 4

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

Table 5. 3

Housing Register Applications by Size Required				
1 Bed	2 Bed	3 Bed	4+ Bed	Total
945	1353	565	147	3010

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

Simultaneously, the supply of affordable housing, which can be accessed by these households, has reduced across all sectors. This has resulted in a significant rise in the number of households having to be placed in temporary accommodation.

The growing reliance on temporary accommodation to meet increased housing need until settled housing solutions become available is reflected across London as a whole. This is due to a combination of factors including the level of increased demand for temporary accommodation and private rented sector properties across the region, high and rising rental prices increasingly in excess of housing benefit local housing allowances levels payable, and reduced affordable housing nominations through re-lets and new build development.

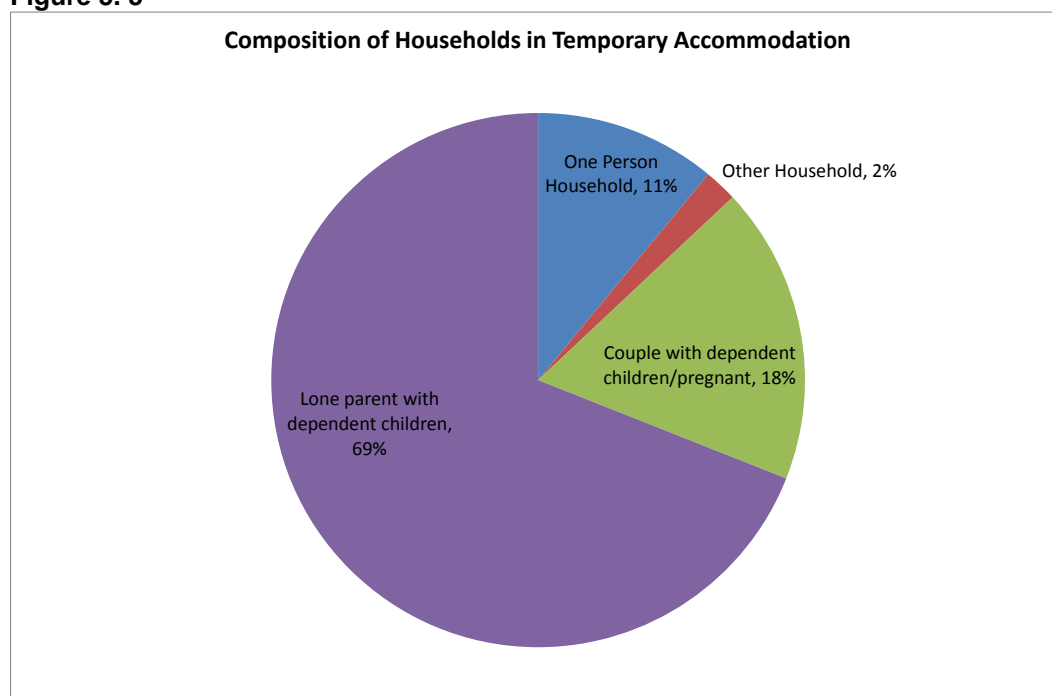
Affordable Social Housing lettings and temporary accommodation use:

Table 5. 4: Affordable Social Housing Lettings and Temporary Accommodation Use.

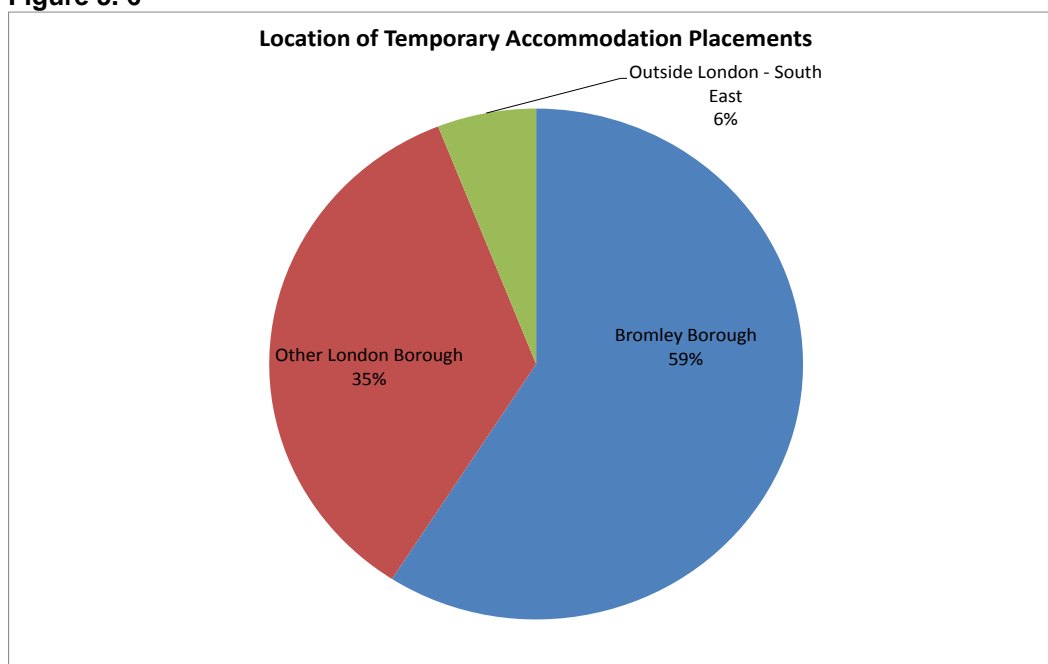
	2009/10	2010/11	2011/12	2012/13	2013/14
Number of housing association lettings	934	792	505	537	552
Number of households in temporary accommodation	477	427	612	764	824

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

Due to the volume of temporary accommodation required to meet the level of homelessness and difficulties being experienced in accessing a suitable supply of affordable housing, an increasing proportion of temporary accommodation has to be procured outside the borough boundaries. Whilst this accommodation is short term in nature, for many this presents increased difficulty in accessing support networks, education, employment and so on.

Figure 5. 5

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

Figure 5. 6

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

Welfare Reform: The welfare reform changes taking place will continue to have a significant impact housing affordability and accessibility. Whilst the overall number of households receiving housing benefit has not changed significantly in Bromley, there has been a significant increase in the number of housing benefit claimants having to make contribution towards their rent. Whilst the amount varies greatly across the different reforms the highest contribution is £294.06 per week for the largest family affected by the benefit cap. The increase financial demands placed on Bromley's more vulnerable residents is unfortunately likely to lead to escalating demands on Bromley services, in particular housing and social care.

The above factors mean that, despite the continued focus on homeless prevention and housing options work, the sheer level of increased demand continues to increase homeless acceptances and temporary accommodation placements. This position seems set to continue in the short to medium term, with further increases anticipated as a result of welfare reform.

Housing Development & Supply

Significant challenges affecting the supply of new affordable housing continue since the previous LB Bromley JSNA was produced in 2012. While local planning policy requires that planning applications of 10 or more dwellings or 0.4 hectares provide 35% affordable housing, currently a significant proportion of submitted planning applications propose a much lower percentage of

affordable housing-often 0% affordable housing- on the grounds that the provision of affordable housing will make the overall development financially unviable. In some cases the developer's financial case has been supported by the independent Planning Inspectorate on appeal.

In addition, the government approach to funding new affordable housing development changed from April 2011. Under the adopted Affordable Rent regime, Registered Providers (RPs) are now able to charge up to 80% of local market rent in order to help fund new development in order to counter the lower levels of public subsidy being invested into new build affordable housing. In practice this has provided challenges for RPs in bringing forward developments. In 2013/14 only 151 affordable units completed in the borough, substantially less than in previous years. The reduction in capital subsidy levels has also increased the challenge in finding opportunities for the specialist accommodation supply to meet the needs of groups such as those with learning disabilities, physical disabilities, older people.

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

Housing Need and Supply for People with Support Needs

Housing provision is insufficient for a number of groups with support needs. These include people with mental health problems, people with a physical disability or sensory impairment, people with drug and alcohol problems, ex-offenders and young people.

Older People

Whilst within the social rented sector Bromley has an adequate supply of older person's including sheltered accommodation, there may be a shortfall of private specialist elderly provision and, to a lesser extent, for shared ownership. Population projections suggest that this demand is likely to continue.

Much work has been done in recent years to work with partner housing associations to review and remodel a number of existing sheltered units including moving to more flexible forms of floating support which can be better tailored to meet changing needs and also to update and improve on the physical environment.

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

Extra Care Housing is provided by Bromley Education, Care and Health Services in partnership with a number of housing associations. It provides bedsit, studio and one and two-bedroom accommodation for people who are no longer able to live in their own home even with support and who do not need the level of help given by a care home.

The Extra Care Housing schemes some of which have been in existence for many years are located in various parts of the Borough. Over recent years LBB has been working in partnership with a number of organisations to build three new extra care housing developments, the first Crown Meadow Court being located at Bromley Common which opened in April 2011. The second Regency Court (the second phase in Bromley Common), which opened in September 2012, and the third Ann Sutherland Court in Penge due to open imminently.

People with Mental Health Needs

Supported housing for people with mental health problems is provided in a variety of forms, from hostel accommodation with shared facilities, to self-contained units offering more privacy and flexibility. Housing support is delivered to tenants in both supported housing and general needs accommodation through the Council's Assessment & Resettlement Team and through floating support workers.

The Assessment and Resettlement Service provides a co-ordinated and holistic approach to meeting the housing needs of people with mental health problems and we recently extended this service to a range of new clients, including homeless people with learning disabilities and 16 and 17 year olds.

People with Physical Disability or Sensory Impairment (PDSI)

There are 4 rehab flats for people with PDSI but currently no units of accommodation with support on site or floating support for this group.

The provision of aids and adaptations is one of the means by which the Council promotes independence for people with disabilities. The aids and adaptations service is provided jointly by Occupational Therapists, the Bromley Home Improvement Agency (part of Environmental Health), the Housing Division and local housing associations. There is currently a dedicated OT working across the PDSI and housing teams to review and streamline processes. Small Grants or loans are also available to this group to help reduce the risk of accidents and assist with housing repair issues.

Other Special Needs Groups

There are other groups with support needs who are sometimes missed in the provision of housing and housing support such as ex -offenders, people with drugs and alcohol problems, and care leavers.

Table 5. 5: Housing Related PHOF Indicators

Indicator	Age	Year	Bromley	London	England
1.15i - Statutory homelessness - homelessness acceptances		2010/11	3.20	3.14	2.03
1.15i - Statutory homelessness - homelessness acceptances		2011/12	4.77	3.92	2.31
1.15i - Statutory homelessness - homelessness acceptances		2012/13	4.10	4.57	2.37
1.15ii - Statutory homelessness - households in temporary accommodation		2010/11	3.23	11.05	2.22
1.15ii - Statutory homelessness - households in temporary accommodation		2011/12	4.60	11.33	2.32
1.15ii - Statutory homelessness - households in temporary accommodation		2012/13	5.54	11.91	2.44
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	18-64 yrs	2011/12	57.80	65.70	70.00
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	18-64 yrs	2012/13	52.40	68.10	73.50
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	18-69 yrs	2012/13	73.30	79.40	58.50

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

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

- Managing expectations of people who are not in a statutory rehousing category
- Increasing demand for accommodation
- Increasing loss of private rental accommodation and financial difficulties in affording accommodation
- Decreasing supply of affordable housing exacerbates the gap between supply and demand
- Increasing numbers of households facing a shortfall between benefits and housing costs
- Increasing number of households and children residing in temporary accommodation and in particular away from the locality
- Increasing demand for private and intermediate older person accommodation.

For more information on Housing please contact Sara.Bowrey@Bromley.gov.uk

Populations of Interest

6. Children and Young People

This section focuses on the needs of particular groups of the Borough's children and young people:

- 6.1) Educational attainment;
- 6.2) Children with Special Educational Needs (SEN) and Disabilities;
- 6.3) Children's Safeguarding and Social Care;
- 6.4) Children in Care
- 6.5) An Overview of the Health of Children in Bromley
- 6.6) Long Term Conditions in Children in Bromley
- 6.7) Self Harm In Young People

6.1. Educational attainment

Introduction

The overall pupil population within maintained and academy schools, and the Pupil Referral Service provision in Bromley is 48,208 pupils - including post-16 years [January pupil census 2014].

About 20% of the borough's school intake comes from neighbouring boroughs – predominantly Lewisham and Croydon. This has a significant impact on the profile of the children and young people in Bromley schools. For example, the ethnic composition of Bromley's schools varies greatly from the resident ethnic composition. Bromley's schools have an average Black and Minority Ethnic profile of 30% compared to the resident children and young people population of 17%.

Attainment of Pupils in Bromley Schools

The national curriculum consists of assessments (both informal and formal tests) at varying stages of a child's school life.

Table 6. 1

Assessment	Stage of School Life	Comments
Early Years Foundation Stage	Reception age – aged 5	This is an informal assessment made by the class teacher
Key Stage 1	Year 2 – aged 7	This comprises a set of teacher assessments which assess ability in reading, writing and maths
Key Stage 2	Year 6 – aged 11	This comprises tests and teacher assessments in reading, writing, grammar, maths and science
Key Stage 4	Year 11 – aged 16	GCSE and equivalent tests

Source: London Borough of Bromley

Closing the gap has been a phrase used by Government over recent years. It recognises that certain vulnerable groups such as pupils who are in receipt of Free School Meals (FSM), Special Educational Needs (SEN), and Children in Care tend to perform less well than their peers. Local authorities and schools have been charged with looking at the gap in performance between these groups and the main cohort of pupils, with a view to raising attainment of vulnerable groups and closing the gap in performance over time.

FSM is used as a proxy measure for poverty and in order to assess outcomes for children from low income families. However, it is only a proxy measure as many children from these backgrounds do not always take up their entitlement to free meals.

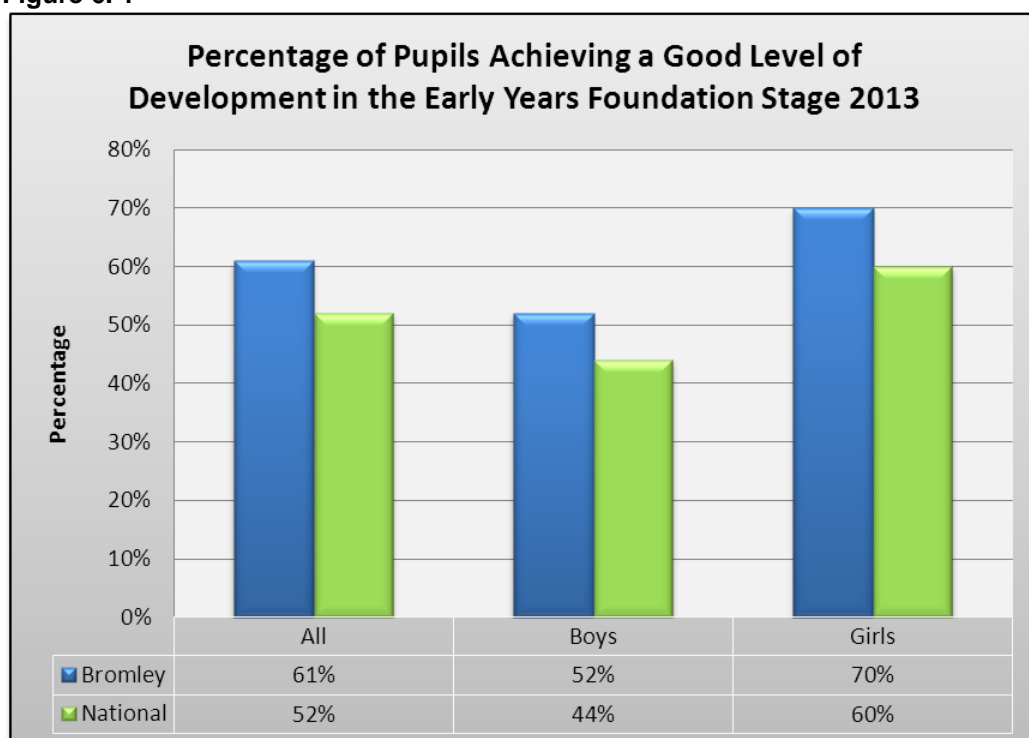
Foundation Stage Profile

The new Early Years Foundation Stage (EYFS) Framework was introduced in September 2013, with the progress of children in the EYFS measured against 17 learning goals. Children are assessed as 'Emerging', 'Expected' or 'Exceeding'. A pupil is considered to have achieved a 'Good Level of Development' if they reach 'Expected' or 'Exceeded' in Communication and Language, Physical Development, Personal, Social and Emotional Development, Literacy and Mathematics.

Pupils are also given a total points score for their achievements, where emerging has a score of 1, expected has a score of 2 and exceeding has a score of 3. These are added across the 17 early learning goals to give the overall score. The total points score for Bromley in 2013 was 33.4 compared with a national score of 32.8.

In 2013, 61% of Bromley pupils attained a good level of development, compared to 52% nationally. With this being the first year of the new framework, there is no trend data to report on.

Figure 6. 1



Source: London Borough of Bromley

The gap in performance at the Early Years Foundation Stage (Good Level of Development) between pupils eligible for Free School Meals (FSM) and non-eligible for 2013 was 24% compared to 19% nationally. 39% of children eligible

for FSM reached the Good Level of Development compared with 63% of those not eligible for FSM. Again, there is no trend data to report.

Key Stage 1

At age 7 (end of Key Stage 1), pupils are expected to achieve a level 2 in each subject in the Key Stage 1 assessments. The 2013 results show that 91% of pupils achieved Level 2+ in reading, 87% in writing and 92% in maths.

Bromley's performance at Key Stage 1 is consistently at or 1-2 percentage points higher in all areas than performance nationally.

However, the gap in performance at Key Stage 1 between pupils eligible for Free School Meals (FSM) and non-eligible is not narrowing. Pupils not eligible for FSM consistently perform better than those eligible. The gap in reading for 2013 was 15% compared to 12% nationally, in writing the gap was 20% compared to 15% nationally and in maths was 13% compared to 10% nationally.

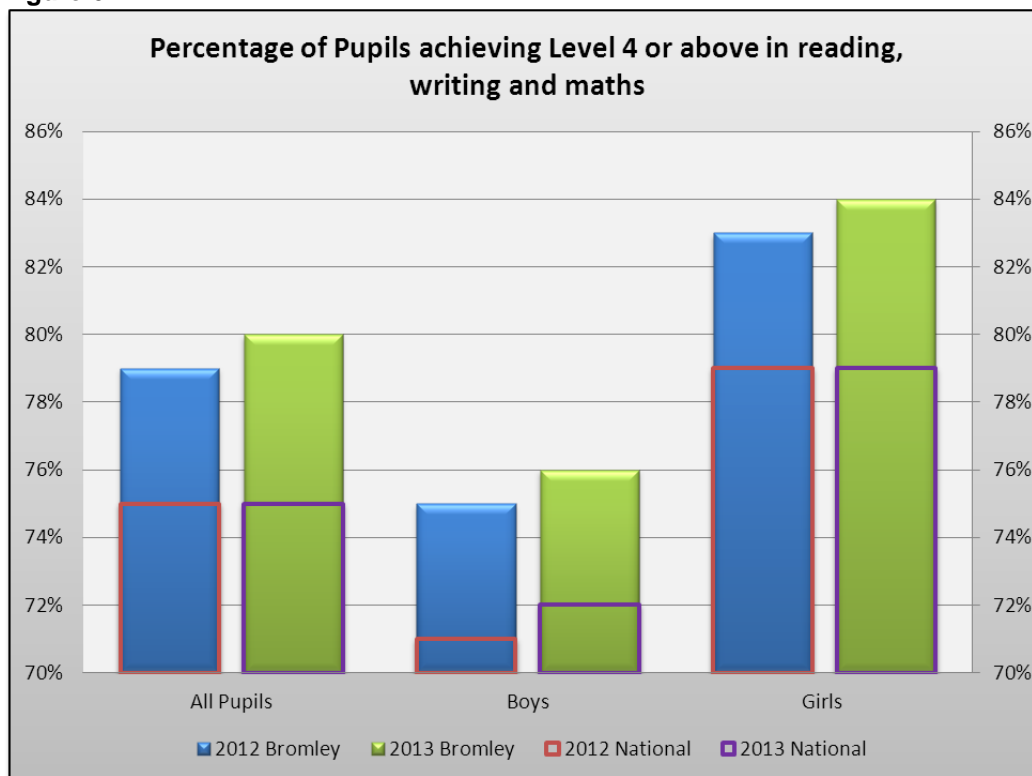
Key Stage 2

At age 11 (end of Key Stage 2) pupils are expected to achieve a Level 4 in each subject in the Key Stage 2 assessments. In 2013, there was a change in the assessments at Key Stage 2, with the introduction of a Grammar, Punctuation and Spelling test and the ceasing of an overall English result. Results are reported separately for reading (test), writing (teacher assessment), grammar (test) and maths (test). The combined English and maths measure previously used is now based upon the combined reading, writing and maths results.

The 2013 results show that 89% of pupils achieved Level 4 or above in reading (from 90% in 2012), 86% in writing (from 85% in 2012) and 88% in mathematics (from 86% in 2012), compared with the national averages of 86% for reading, 83% for writing and 85% for mathematics.

This continues the trend of previous years where pupils in Bromley schools attain above the national average.

Attainment at Level 4 and above in combined reading, writing and mathematics increased from 79% in 2012 to 80% in 2013, against the national attainment of 75% in both 2012 and 2013 (**see figure 6.2**).

Figure 6. 2

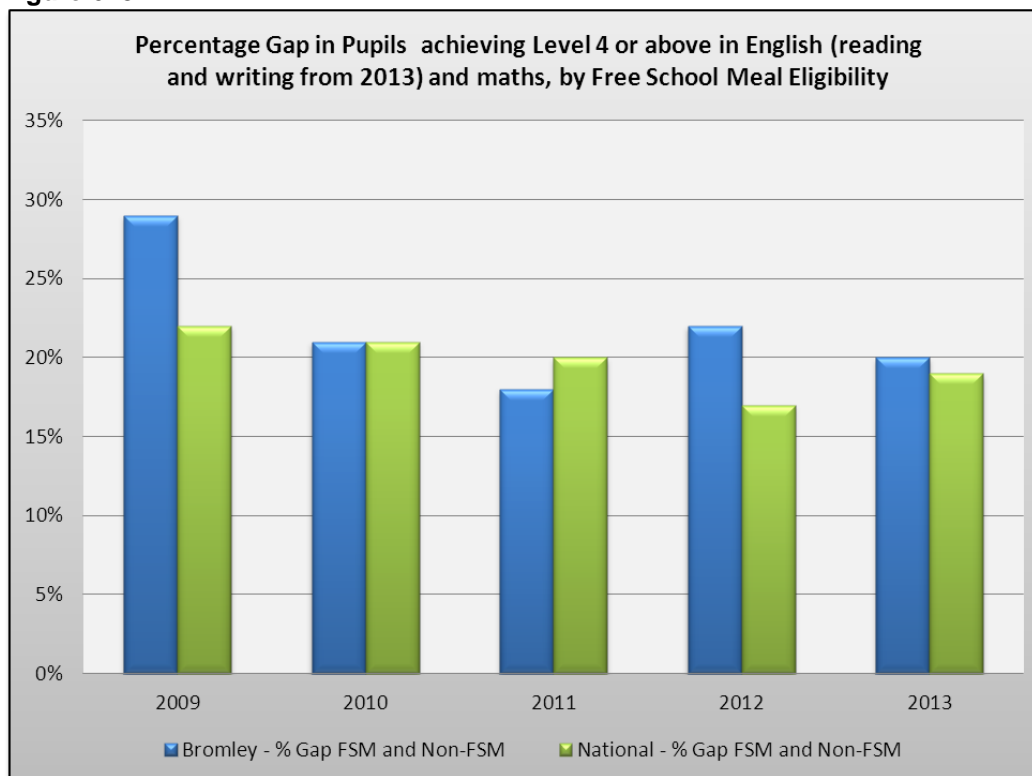
Source: London Borough of Bromley and Department for Education

Table 6. 2

Reading, Writing & Maths Combined - % Level 4 and above	2012	2012	2013	2013
	Bromley	National	Bromley	National
All Pupils	79%	75%	80%	75%
Boys	75%	71%	76%	72%
Girls	83%	79%	84%	79%

Source: London Borough of Bromley and Department for Education

At Key Stage 2, the gap in attainment in the new combined reading, writing and mathematics measure between those pupils eligible for Free School Meals and those who are not was 20% in 2013, compared to the national gap of 19%.

Figure 6. 3

Source: London Borough of Bromley and Department for Education

Table 6. 3

% achieving Level 4 or above in reading, writing and maths, by Free School Meal Eligibility	2009	2010	2011	2012	2013
Bromley - % Gap FSM and Non-FSM	29%	21%	18%	22%	20%
National - % Gap FSM and Non-FSM	22%	21%	20%	17%	19%

Source: London Borough of Bromley and Department for Education

Primary Value added – how a pupil progresses through the school

Value added is designed to measure a child's progress through the school in order to assess the 'added value' the school has made to the outcomes of each child. It looks at prior attainment (the pupil's performance in tests/assessments already undertaken) and plots this against the expected level that a child is likely to achieve in the next set of assessments. The model used for value added in primary schools is KS1-KS2 and each child is expected to make two levels of progress between KS1 and KS2.

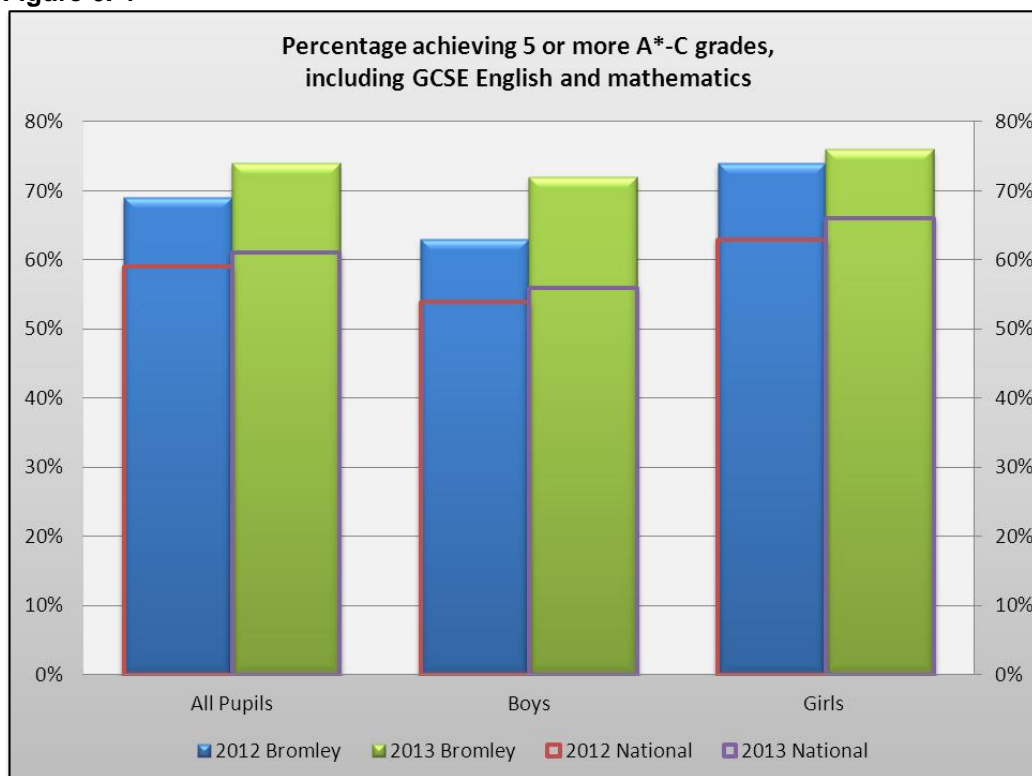
A higher percentage of pupils in Bromley schools made the expected amount of progress between the Key Stage 1 and Key Stage 2 assessments in 2013 than nationally, with 90% in reading (compared with 88% nationally), 92% in writing (compared with 91% nationally) and 91% in mathematics (compared with 88%

nationally).

Key Stage 4

At GCSE, Bromley pupils also achieve higher than the national average, with 74% of pupils gaining 5+ A*-C grades (including GCSE English and mathematics) in 2013, compared with 61% nationally. **Figure 6.4** below, shows the trend for Bromley and nationally.

Figure 6. 4



Source: London Borough of Bromley and Department for Education

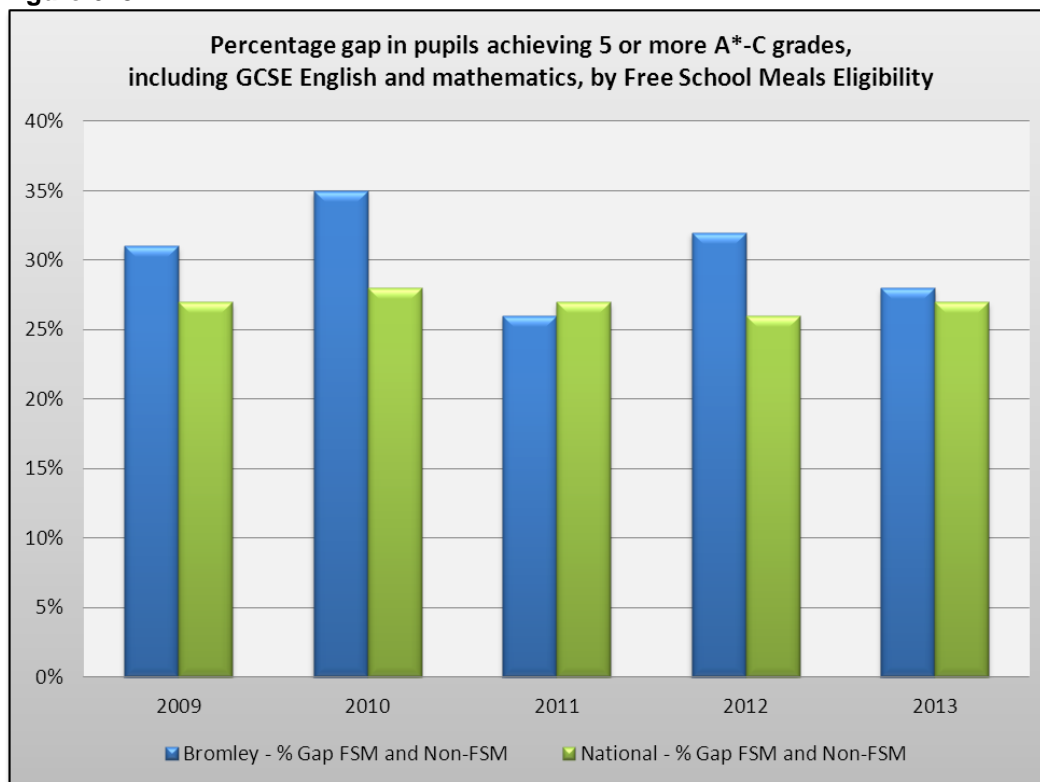
Table 6. 4

% achieving 5 or more A*-C grades, including GCSE English and mathematics	2011	2011	2012	2012	2013	2013
	Bromley	National	Bromley	National	Bromley	National
All Pupils	67%	58%	69%	59%	74%	61%
Boys	65%	54%	63%	54%	72%	56%
Girls	69%	62%	74%	63%	76%	66%

Source: London Borough of Bromley and Department for Education

At Key Stage 4, the Free School Meal/Non Free School Meal gap has fluctuated over the last 3 years when looking at attainment of 5+ A*-C grades including English and mathematics. The gap was 26% in 2011 rising to 32% in 2012 and falling to 28% in 2013.

Figure 6. 5



Source: London Borough of Bromley and Department for Education

Table 6. 5

% achieving 5 or more A*-C grades, including GCSE English and mathematics, by Free School Meal Eligibility	2009	2010	2011	2012	2013
Bromley - % Gap FSM and Non-FSM	31%	35%	26%	32%	28%
National - % Gap FSM and Non-FSM	27%	28%	27%	26%	27%

Source: London Borough of Bromley and Department for Education

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

Continue to develop and sustain relationships with schools which convert to academies to achieve jointly agreed outcomes to improve the lives of children and young people in the Borough. A main aim of the Education Portfolio Plan is to promote educational opportunity in the borough, ensuring all families have a choice of good and outstanding schools.

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

For more information on Educational attainment please contact
Georgina.Sanger@Bromley.gov.uk

6.2. Children with Special Educational Needs (SEN) and Disabilities

Introduction

Over the past year, LBB Specialist Support & Disability Services have been working towards the implementation of the Children & Families Bill, which has signalled the most far-reaching reforms for children and young people with special educational needs and disabilities and their families, as part of a new birth – 25 SEN system (Department for Education and Department of Health).

This brings new statutory duties for local authorities (children's services, social care and adult social care) and health partners, clinical commissioning groups and Health & Wellbeing Boards. The Children & Families Bill achieved Royal Assent in March 2014 and will become law from September. Key measures include:

- The replacement of SEN statements and Learning Difficulty Assessments (for 16-25 year-olds) with a single, simpler 0 to 25 assessment process and **Education, Health and Care Plan (EHCP)**. Statutory protections, comparable to the Statement, will be extended to age 25 (if in further education).
- A new **Code of Practice** (expected May 2014), which will include new health duties and responsibilities, including the NHS Mandate.
- Requirements for Local Authorities to publish a **local offer** showing support available to disabled children and young people and those with SEN, and their families. To include information on the Education, Health and Social Care services available locally and support from the voluntary sector.
- Giving parents or young people with EHCPs the right to a **personal budget** for their support
- Stating that Local Authorities and Clinical Commissioning Groups must make arrangements for **joint commissioning**

London Borough of Bromley (in a joint bid with London Borough of Bexley) became a Pathfinder in autumn 2011 and has since been testing the cultural and systematic changes required for delivery of the new reforms across education, health and care, in a more integrated birth – 25 system. In April 2013, LBB achieved National Pathfinder Champion status, with responsibility for supporting London non-Pathfinder authorities with the implementation of the new SEN and disabilities reform agenda.

Increasing birth rates and advances in modern medicine have contributed to more children with disabilities and complex needs surviving at birth and into school and later life; including three children in LBB with full ventilation

progressing with a jointly commissioned package to school (one into mainstream).

We were asked to deliver new pathways and processes leading to an EHC Plan within a reduced 20 week statutory timeline, one year in advance of non-Pathfinder local authorities. Since 1 September 2013, **107** children and young people have commenced the EHC Plan assessment process, with **44** having a draft plan completed between 1.9.13 and 31.3.14.

Children with complex health needs, but no Statement or EHC Plan

London Borough of Bromley continues to support **43** children in mainstream schools with complex health needs, including some requiring airway support, Hickman lines, support for complex diabetes and gastrostomy tube feeding. This support have been implemented across **30** primary and secondary schools in the Borough, without necessitating a full Statement or EHC Plan. Support is also offered from the integrated team for specialist equipment to meet both health and learning needs.

This section provides a range of information for children with Special Educational Needs (SEN) and Disabilities within the following sections:

- Educational needs
- Health needs

Educational needs

The main cost pressure in the Schools' Budget continues to be in SEN placements, which is volume driven and for which the Council has a statutory duty to make provision.

The number of pupils in Bromley schools with Special Educational Needs is currently at 7,956 pupils (based on the January 2014 school census), which has however decreased by 580 children since 2011 - as illustrated in **Table 6.6**:

Table 6. 6

Pupils in Bromley Schools with Special Educational Needs						
	2009	2010	2011	2012	2013	2014
Number of pupils in Bromley schools with SEN	8,340	8,337	9,465	9,205	8,885	7,956
Difference	328	497	628	-260	-320	-929
% of pupils in Bromley schools with SEN	17.9%	17.8%	18.4%	17.8%	16.9%	16.5%
Difference	0.60%	-0.1%	0.6%	-0.6%	-0.9%	-0.4%

Source: Department for Education

The number of pupils in Bromley with Statements of Special Educational Needs increased from 1,645 in 2009 to 1,901 in 2013, followed by a decrease of 210 to 1,691 in 2014.

Table 6. 7

Pupils in Bromley Schools with Special Educational Needs						
	2009	2010	2011	2012	2013	2014
Number of pupils in Bromley schools with SEN	1,645	1,704	1,786	1,779	1,901	1,691
Difference		59	82	-7	122	-210

Source: Department for Education

Educational attainment

Pupils who have a significant degree of Special Educational Needs and Disability perform less well than their peers at all Key Stages and subjects. This makes closing the attainment gap for children with SEN difficult, as the severity of SEN and disabilities in some pupils means that some pupils will never reach the expected level of attainment.

The following tables provide the performance of pupils with Special Educational Needs at the following levels Statemented, School Action, and School Action Plus, compared to pupils who have no SEN.

Table 6. 8

Performance at Key Stage 1 2013: % Achieving Level 2+						
[Source: Department for Education]						
	No. of pupils	% of Pupils	Reading	Writing	Maths	
No SEN	2899	81%	97%	94%	98%	
School Action	288	8%	77%	64%	75%	
School Action Plus	227	6%	57%	40%	52%	
Statemented	148	4%	41%	33%	41%	

What does this tell us?

In 2013, 28% of the 148 Statemented pupils in Bromley achieved the required level in reading, writing and mathematics compared to 91% of pupils who have no SEN. Due to the change in methodology for this measure, it cannot be compared with previous years, however, the number of children with Statements achieving a Level 4 or above in the individual subjects increased from 2012.

Table 6. 9

Performance at Key Stage 4 2013					
[Source: Department for Education]					
	No. of pupils	% of Pupils	% 5 A*-C	% 5 A*-C inc English and maths	% 5 A*-G
No SEN	2757	81%	97%	85%	100%
School Action	265	8%	88%	36%	97%
School Action Plus	230	7%	78%	31%	94%
Statemented	166	5%	58%	18%	78%

What does this tell us?

In 2013, 18% of the 166 Statemented pupils in Bromley achieved 5 or more GCSE A*-C grades (including English and mathematics) compared to 85% of pupils who have no SEN. This shows an increase from 2012, when 14% of 136 pupils achieved this compared to 79% of pupils who have no SEN.

Health needs

The increase in numbers and complexity of needs of children with learning difficulties and/or disabilities is leading to significant increases in the number of children requiring support from specialist services.

The number of referrals of children and young people to the Specialist Support and Disability Panel increased by 2% between 2011-12 and 2012-13 and by 7% between 2012-13 and 2013-14.

Table 6. 10

Referrals to the Specialist Support and Disability Panel				
	2010-11	2011-12	2012-13	2013-14
Number of Referrals	202	240	245	263
Difference		+38	+5	+18
% Change		+19%	+2%	+7%

Source: London Borough of Bromley

NB: The figures for SSDP are affected by a policy change partway through the year on the authorisation route for short breaks requests. For the last four months of the 2013-14 financial year, short breaks requests no longer came to

SSDP. In the first eight months (April 13 to November 13) there were 85 requests. Through extrapolation it could be estimated on average that 43 further short breaks referrals could have come to SSDP to the end of the year. This would have given a total 306 referrals of CYP rather than 263, and a percentage increase close to 25% between 2012-13 and 2013-14.

Bromley Supporting Inclusion in Pre-School (SIPS) programme supported 13% fewer pre-school children with severe and complex SEND in their pre-setting between 2011-12 and 2012-13. However, between 2012-13 and 2013-14 the number of pre-school children supported increased by 12% again.

Table 6. 11

Pre-School Children Supported by the SIPS Programme				
	2010-11	2011-12	2012-13	2013-14
Number of Children	161	182	158	177
Difference		+21	-24	-19
% Change		+13%	-13%	+12%

Source: London Borough of Bromley

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

Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life.

The increase in numbers and complexity of needs of children with learning difficulties and/or disabilities has required more specialist and high cost provision to be made available.

For more information on Children with Special Educational Needs and Disabilities please contact Georgina.Sanger@Bromley.gov.uk

6.3. Children's Safeguarding and Social Care Referrals

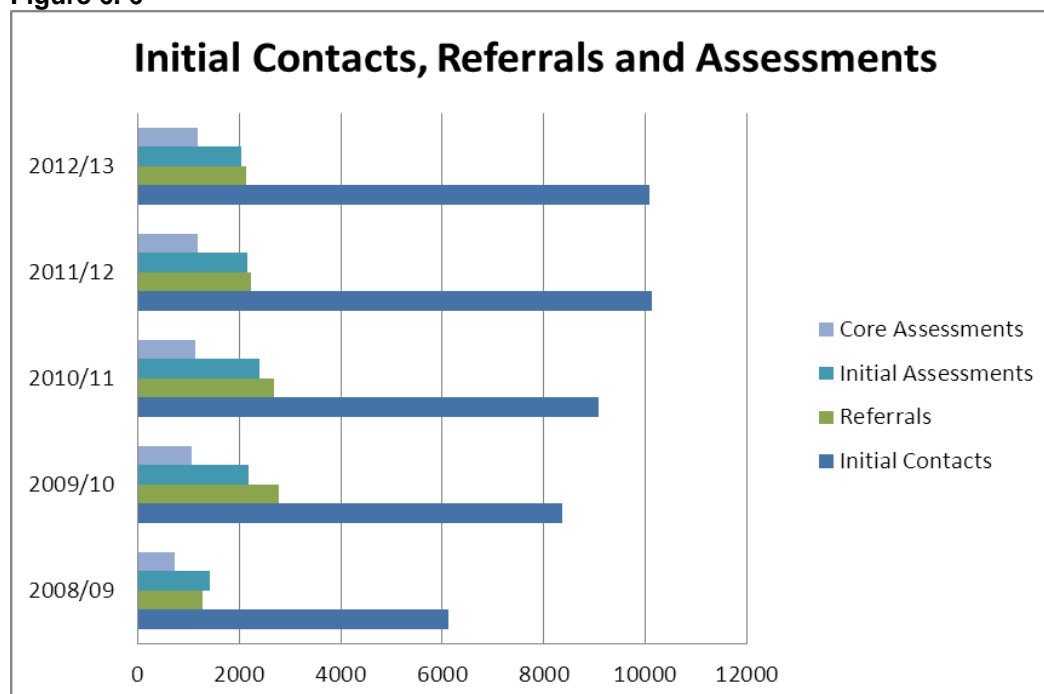
Children's Social Care services have a duty to safeguard and promote the welfare of children. Over the last few years there have been more than 8000 initial contacts made each year to Children's Social Care services.

Within Bromley initial contacts increased by almost 300% from 2008 to 2012 (from 3,425 in 2007/8 to 10,132 in 2011/12). This figure has now levelled off slightly at 10,069 for the 2012/13 year, but is not as low as the 2007/8 level. There was also an increase in the safeguarding referrals which have increased by 85% (from 1,441 in 2007/8 to 2,679 in 2010/11). In July 2011 a new multiagency support hub (MASH) service was introduced to address the pressures, and by forming an effective triage service has resulted in a decrease in the number of initial contacts going onto a referral. In 2012/13 this figure had dropped to 2,148.

The number of referrals and initial assessments increased significantly between 2007/8 and 2010/11 before decreasing slightly in 2011/12 and further in 2012/13. Core assessments have maintained a higher level although did decrease in 2012/13 to 1,176.

This activity is illustrated in **Figure 6.6** and **Table 6.12**

Figure 6. 6



Source: London Borough of Bromley

Table 6. 12

	2008/09	2009/10	2010/11	2011/12	2012/13
Initial Contacts	6109	8356	9064	10132	10069
Difference	2684	2247	708	1068	-63
Referrals	1289	2788	2679	2244	2148
Difference	-152	1499	-109	-435	-96
Initial Assessments	1416	2188	2410	2161	2052
Difference	276	772	222	-249	-109
Core Assessments	744	1064	1130	1192	1176
Difference	134	320	66	62	-16

Source: London Borough of Bromley

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

Initial contacts to assessments by children's social care services have begun to level off and, in the case of referrals, decrease significantly based on levels prior to 2011.

This will be in large part due to the success of the targeted approach of the MASH service.

6.4. Children in Care

Introduction

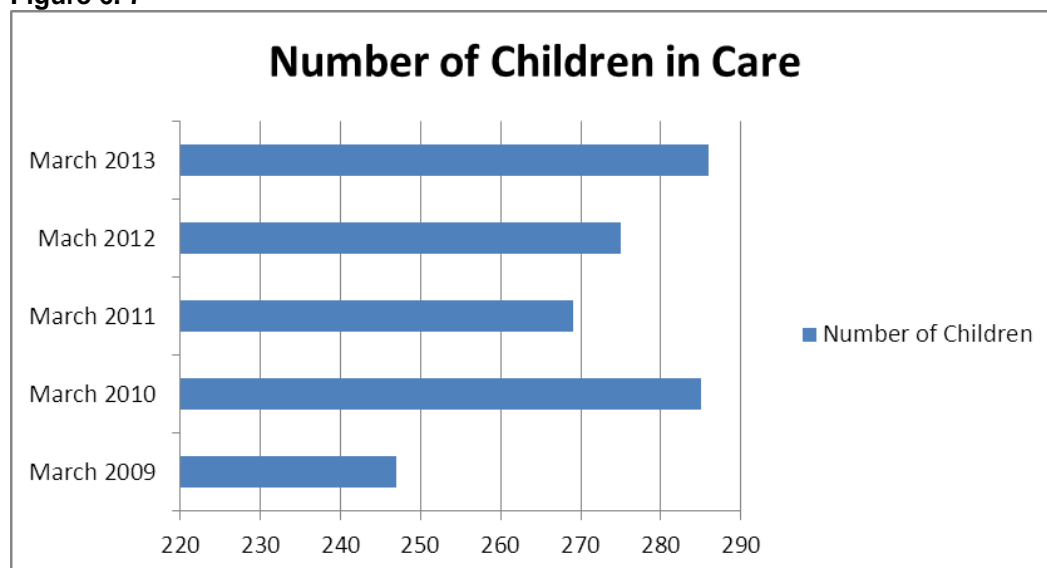
Children in Care are some of the most vulnerable children in society; living away from their families because their parents faced difficulties and pressure in providing for their care or because the children have suffered abuse or neglect whilst in the care of their families.

Children in Care are provided with care and accommodation which meet their needs. Most often this will be with foster carers, but young people may also be placed in residential schools, care homes, or units. Most children spend a short time in the care of the council, either returning to their families or moving to permanent arrangements such as adoption, but for others, their stay may be for several years, lasting to adulthood.

Number of Children in Care

The number of children in care in Bromley has increased by 39 between 2008/9 and March 2013, although there has been fluctuation in numbers over the last five years. Bromley's looked after children population peaked in 2010 and at one point in the year was over 300. This dropped in 2011, but has been increasing again each year since. **Figure 6.7** below illustrates that there has been an upward trajectory over a three year period.

Figure 6. 7



Source: London Borough of Bromley

Table 6. 13

	March 2009	March 2010	March 2011	Mach 2012	March 2013
Number of Children	247	285	269	275	286
Difference	-8	38	-16	6	26

Source: London Borough of Bromley

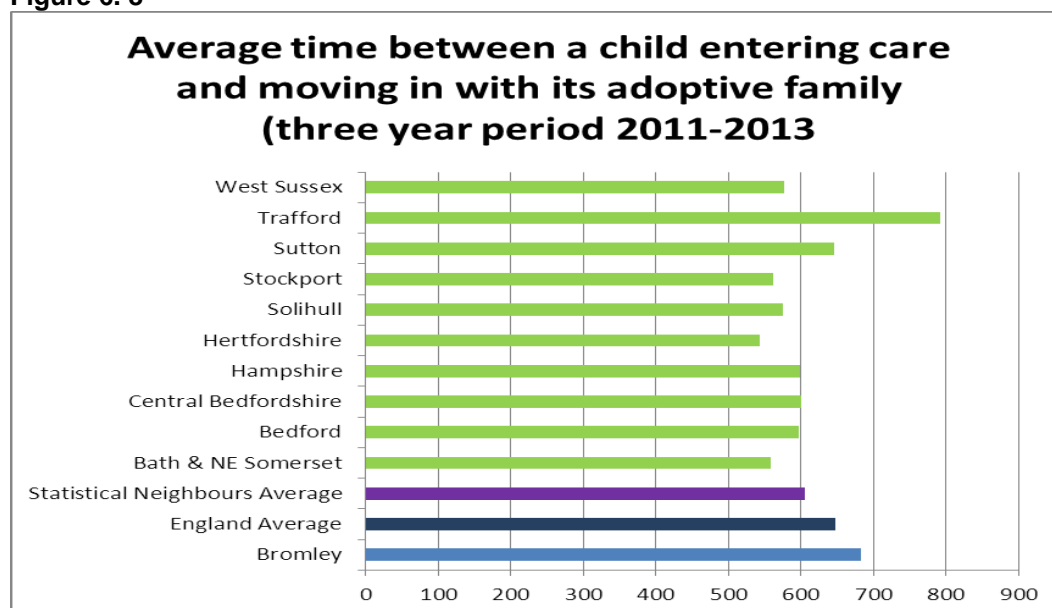
Supporting children through the adoption process

In recent years the Government has had an increasing focus on the performance of local authorities in supporting children through the adoption process. In particular, that when there is a decision that adoption is in the child's best interests, that the transition to a new well matched home is as efficient as possible.

This is monitored through the introduction of a national adoption scorecard.

The latest scorecard reports progress during the three year period from 2010-2013 and looks at the average time between a child entering care and moving in with its adoptive family; which for Bromley is 683 days. Performance is improving and shows a significant decrease from the average time between 2008-2011 which was 821 days.

However, this average is longer than both the average for England and the average of most of the Borough's statistical neighbours, as illustrated in **Figure 6.8**.

Figure 6. 8

Source: Department for Education

Looked After Children – Educational Outcomes

Primary phase

The data for Key Stage 2 (KS2) focuses on children at the end of primary school who have been continuously looked after for at least 12 months (as at 31st March). For 2013 this was 9 young people. It should be noted that of the 2013 cohort: 2 of the 9 young people have a statement of educational need and 2 were at school action plus.

Table 6. 14

	2010	2011	2012	2013
Percentage of Children in Care reaching Level 4 in English at Key Stage 2	100%	50%	28%	
Percentage of Children in Care reaching Level 4 in maths at Key Stage 2	80%	40%	28%	
Percentage of Children in Care reaching Level 4 in reading, writing and maths at Key Stage 2				66%

Source: London Borough of Bromley

In 2013 the way of measuring performance at Key Stage 2 changed to a combined level for reading, writing and maths. In Bromley, 66% of pupils achieved a Level 4 or above in this measure.

In addition, 88% made two or more levels of progress between Key Stage 1 and Key Stage 2 in reading, writing and maths.

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

Comparisons between year groups must be made with caution as the cohorts are so small (and therefore performance more variable) each year.

Secondary phase

The data for Key Stage 4 (KS4) focuses on children at the end of Key Stage 4 (year 11) who have been continuously looked after for at least 12 months (31st March). For 2013 this was 19 young people.

Table 6. 15

GCSE Results		2013 Reporting Cohort (19 pupils)	2013 All LAC Pupils (33 pupils)	2012	2011
5+ A*-C Including English and Maths	Bromley	16% (3 pupils)	18%	11% (2 pupils)	8.6% (3 pupils)
	National	15.3%	Not available	15.0%	13.6%
5 A*-C	Bromley	21%	27%	22.2%	25.7%
	National	36.6%	Not available	37.2%	33.4%
5A*-G	Bromley	21%	27%	55%	48.6%
1A*-G	Bromley	26%	33%	88%	74.3%
Sat GCSE or equivalent	Bromley	26%	36%	88%	66%

Source: London Borough of Bromley and Department for Education

Of the reporting cohort:

16% of pupils (3) achieved 5+ GCSEs at A*-C including English and Maths. This is above national outcomes for KS4 looked after children.

78% pupils (15) in the reporting cohort have identified SEN; 3 (16%) have Statements of Special Educational Needs.6 (32%) are at School Action Plus.

Changes in 2013 to the reporting of some non GCSE qualifications that were previously counted in the overall GCSE performance but have since been excluded has had a huge impact on reported performance, particularly those achieving 5 A*-G and 1 A*-G. Performance against these two measures has dropped to 21% and 26% respectively where they were 55% and 88% in 2012. This is a national issue which will affect all pupils who are doing qualifications that are not now included in the calculation.

Supporting young people leaving care

The Council has an essential duty as the corporate parent in supporting and preparing young people as they leave care and move into adulthood, and supporting them as they leave school.

Education Employment and training

Within Bromley the percentage of young people aged 19 who were looked after aged 16 who were in education employment or training has increased by 19%

between 2010 (31%) and 2013 (50%). This is improving and is catching up with the national average (58%).

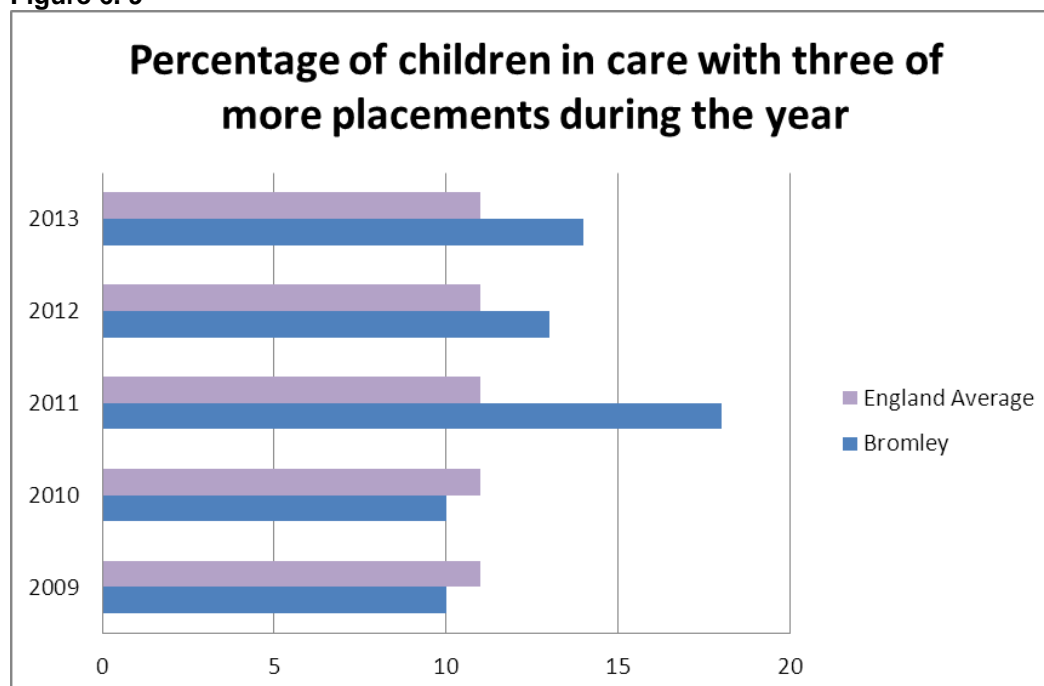
Suitable Accommodation

The percentage of young people aged 19 who were looked after aged 16 who were living in suitable accommodation has increased slightly between 2010 (84%) and 2013 (85%). This is just below the national average (88%) in 2013.

Placement stability

Whilst being in the care of the council it is acknowledged that it is important for children and young people to have stability in their placements. This means keeping movements between placements for a minimum. The graph and table below illustrate that Bromley has been above the England average for the percentage of children in care with three or more placements during the years since 2010.

Figure 6. 9



Source: Department for Education

Table 6. 16

	2009	2010	2011	2012	2013
Bromley	10	10	18	13	14
England Average	11	11	11	11	11

Source: Department for Education

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

There has been an increase in the number of children in care over the last three years.

Bromley is improving its efficiency in the amount of time it takes to move a child in with their adoptive family from coming into care.

There are a higher number of children in care with 3 or more placements than the national average.

For more information on Children's Safeguarding and Social Care please contact Ailsa.Reid-Crawford@Bromley.gov.uk

6.5. Overview of Child Health in Bromley

Tables 6.17-6.19 present a summary of almost all available child health data which is available at borough, region (London) and national level. Alongside the health indicators for Bromley, England and London is presented the data from other London boroughs which are similar to Bromley in health terms. The information is presented using Public Health England RAG ratings as well as the value of each indicator and a definition of each indicator. The data comes from the PHE Health Benchmarking Tool. Those indicators marked green are where the indicator is better than the benchmark, the national rate.

The initial impressions is that most of Bromley's indicators are green, and indeed this is true for 29 of the 42 indicators that are RAG rated. Compared to the boroughs with similar health profiles, Bromley children and young people are rated better than the national rate in more health indicators.

These indicators should be interpreted with caution. The data is sometimes a few years old, and the time period the data refers to is included so that this can be taken into account. Any indicator, apart from mortality data, only gives part of the picture. This is clearly shown in the analysis of data about children with diabetes in Bromley, where the high level data on admissions looks good but a detailed national audit shows that other outcome indicators which are harder to collect are not as favourable.

The indicators are also only compared to England data. Comparisons of child health indicators across developed countries show that child health in England is not particularly good. It may be more appropriate to compare child health data with England and a European comparator in future.

Only 2 indicators for Bromley are rated "red": These are family homelessness and A&E attendances. Family homelessness is included in the chapter on housing and is not discussed here. A&E attendances for children aged 0-4 years in Bromley has been discussed with local GPs and with A&E staff at the Princess Royal University Hospital. The feedback is that most attendances are for minor ailments which do not need to go to hospital, and the low admission rates support this view. Another factor in considering the relevance of this indicator is that in the context of London this rate is actually low. Frequent Attenders to unscheduled Care is discussed in more detail in section 15.

A few of the indicators which are not marked "red" are still of concern. The rate of conceptions in girls aged under 16 is higher than both the London and national rates, as are births to teenage mothers. The child mortality rate is also higher than the national and London rate. Each child death is reviewed for learning points to prevent future deaths. The rate of hospital admissions for self harm is also high. This is discussed in more detail.

Table 6. 17

Indicator	Period	England	London	Bexley	Bromley	Havering	Sutton
1. Healthy Life Expectancy at birth (Male)	2009-11	63.2	63	65.9	66.1	64.8	65.9
2. Healthy Life Expectancy at birth (Female)	2009-11	64.2	63.8	66.4	68.8	63.7	63.3
3. Life Expectancy at birth (Male)	2010-12	79.2	79.7	80.3	81	79.3	80.5
4. Life Expectancy at birth (Female)	2010-12	83	83.8	84.4	84.5	83.8	84
5. Children in poverty (under 16s)	2011	20.6	26.5	19.7	17.4	20	16.6
6. School readiness: % children with good level development end Yr R	2012/13	51.7	52.8	64.1	61	58.6	40.8
7. School readiness: % children on free school meals with good level development end Yr R	2012/13	36.2	43.1	47.4	39.8	39.5	26.6
8. Obese children (4-5 years)	2012/13	9.3	10.8	12.6	7.7	9.6	8.5
9. Obese children (10-11 years)	2012/13	18.9	22.4	24.3	17.3	19.7	19.9
10. Excess weight in 4-5 year olds	2012/13	22.2	23	26.8	21.1	20.9	20
11. Excess weight in 10-11 year olds	2012/13	33.3	37.4	39.7	32	35.1	33
12. Pupil absence	2011/12	5.11	4.82	4.55	4.87	5.13	4.84
13. Family homelessness	2012/13	1.7	3.6	2.5	3.2	1.8	1.6
14. First time entrants to the youth justice system	2012	537	585	491	356	419	388
15. 16-18 year olds not in education employment or training	2012	5.8	4.7	4	4.1	4.7	3.9

Source: PHOF, 2014 <http://www.phoutcomes.info/>

Table 6. 18

Indicator	Period	England	London	Bexley	Bromley	Havering	Sutton
16. Low birth weight of term babies	2011	2.85	3.2	2.6	2.54	2.4	2.2
17. Low birth weight of all babies	2012	7.3	7.9	6.8	6.5	7.6	6.7
18. Breastfeeding initiation	2012/13	74	86.8	71.1	84.7	71.3	85.5
19. Breastfeeding at 6-8 weeks	2012/13	47.2	68.5	48.4	59	41.6	59.6
20. Smoking status at time of delivery	2012/13	12.7	5.7	9.8	5.2	13	6.5
21. Under 18 conceptions	2012	27.7	25.9	25.8	24.2	26.4	25.8
22. Under 16 conceptions	2012	5.6	4.4	4	6.5	6.6	3.4
23. Teenage mothers	2012/13	1.2	0.7	0.8	1.3	0.9	0.6
24. Acute sexually transmitted infections (including chlamydia)	2012	34.4	41.9	23.8	28.7	31.2	37.4
25. A&E attendances	2011/12	510.8	692.8	631.9	621.3	642.1	733.8
26. Hospital admissions for accidental and deliberate injuries in children (aged 0-4 years)	2012/13	134.7	104.9	107.9	78.4	100.5	133.3
27. Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	103.8	84.6	85.1	61.7	76.7	103.6
28. Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	130.7	100.7	85.9	117.4	100.8	127.5
29. Children killed or seriously injured in road traffic accidents	2010-12	20.7	15.3	14	9.8	21.6	12.1

Source: PHOF, 2014 <http://www.phoutcomes.info/>

Table 6. 19

Indicator	Period	England	London	Bexley	Bromley	Havering	Sutton
30. Children in care	2013	60	55	47	40	36	39
31. Emotional well-being of looked after children	2012/13	14	13.5	13.9	13.5	14.6	17.6
32. Children in care with up to date immunisations	2013	83.2	76.5	71	94.3	88	90.9
33. Infant mortality	2010-12	4.29	4.34	2.72	2.44	4.04	2.31
34. Child mortality rate	2010-12	12.5	13.7	12	14.7	20.6	12
35. Tooth decay in children aged 5	2011/12	0.94	1.23		0.52	0.54	0.8
36. Children with one or more decayed, missing or filled teeth	2011/12	27.9	32.9	-	21.5	19.8	27.9
37. Hospital admissions due to alcohol specific conditions	2010/11 -12/13	42.7	28.8	15.4	30	30	45.3
38. Hospital admissions due to substance misuse	2010/11 -12/13	75.2	58.1	79.2	81.8	77.9	86.1
39. Hospital admissions for asthma	2012/13	221.4	212.3	167.6	128	104.5	144.2
40. Hospital admissions for mental health conditions	2012/13	87.6	87.1	102.6	84.8	77.8	113.7
41. Hospital admissions as a result of self harm	2012/13	346.3	201	157.4	259.1	172.7	329.1
42. Hospital admissions as a result of self harm (pooled)	2010/11 -12/13	352.3	204.8	190.5	291.4	205.7	246.6
43. GCSE achieved 5A*-C inc. English and Maths	2012/13	60.8	65.1	66	73.9	63.7	77

Source: PHOF, 2014 <http://www.phoutcomes.info/>

Definitions of Indicators

1. & 2. Healthy life expectancy at birth: the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health; **3. & 4.** Life expectancy at birth: the number of years a person would expect to live based on contemporary mortality rates; **5.** Children in poverty (under 16): % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income; **6.** School readiness: % children with good level development end Yr R; **7.** School readiness: % children on free school meals with good development end Yr R; **8.** Obese children (4-5 years): % school children in Reception year classified as obese using UK 1990 BMI thresholds; **9.** Obese children (10-11 years): % school children in Year 6 classified as obese UK 1990 BMI thresholds; **10. & 11.** Excess weight in 4-5 or 10-11 year olds: proportion of children classified as overweight or obese (BMI on or above 85th centile of UK 1990 growth reference rates); **12.** Pupil absence: % half days missed by pupils (authorised and unauthorised absence); **13.** Family homelessness: applicant households eligible for assistance (1996 Housing Act), unintentionally homeless and in priority need, per 1000; **14.** First time entrants to the youth justice system: rates of juveniles receiving their first reprimand, warning or conviction per 100,000 10-17 yr old population; **15.** 16-18 year olds not in education, employment or training: the estimated number of 16-18 yr olds not in education employment or training divided by total number 16-18 year olds; **16.** Low birth weight of term babies: number of live births of at least 37 weeks gestation weighing less than 2500g divided by all live births weighing less than 2500g; **17.** Low birth weight of all babies: % of live and still births weighing less than 2500g; **18.** Breastfeeding initiation: % of mothers initiating breastfeeding in first 48 hours after birth; **19.** Breastfeeding at 6-8 weeks: % infant who are totally (breast fed only) or partially breastfed (breastmilk and formula milk given) at 6-8 weeks; **20.** Smoking status at time of delivery: % of mothers current smokers at time of delivery; **21.** Under 18 conceptions: Conceptions in females aged under 18 years per 1000 females aged 15-17 yrs; **22.** Under 16 conceptions: Conceptions in females aged under 16 years per 1000 females aged 13-15 yrs; **23.** Teenage mothers: % of delivery episodes where the mother is aged under 18 years; **24.** Acute sexually transmitted infections: a combination of diagnoses made by Genito-urinary clinics, the National Chlamydia Screening programme and other sexual health services; **25.** A&E attendances: crude rate per 1,000 (age 0-4 years) of A&E attendances; **26.** Hospital admissions for injuries aged 0-4 years: Crude rate per 10,000 (age 0-4 years) for emergency hospital admissions following injury; **27.** Hospital admissions for injuries aged 0-14 years: Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury; **28.** Hospital admissions for injuries aged 15-24 years: Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury; **29.** Children killed or seriously injured in road traffic accidents: Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population; **30.** Children in care: Children looked after at 31 March (rate per 10,000 population aged under 18 years); **31.** Emotional well-being of looked after children: Total difficulties score for all looked after children aged 5-16 at date of latest assessment, who have been in care for at least 12 months on 31 March; **32.** Children in care with up to date immunisations: proportion of children in care for at least 12 months whose immunisations were up to date; **33.** Infant mortality rate: Mortality rate per 1,000 live births (age under 1 year); **34.** Child mortality rate: Directly standardised rate per 100,000 children age 1-17 years; **35.** Tooth decay in children: % children aged 5 years with one or more decayed, missing or filled teeth; **36.** Children with one or more decayed, missing or filled teeth: % children with 1 or more obviously decayed, missing (due to decay) and filled teeth; **37.** Hospital admissions due to alcohol specific conditions: Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions (Alcohol specific conditions are those that are wholly related to alcohol); **38.** Hospital admissions due to substance misuse: Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse; **39.** Hospital admissions for asthma: Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma; **40.** Hospital admissions for mental health conditions: Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health disorders; **41.** Hospital admissions as a result of self harm: Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm; **42.** As for 41 but pooled over 3 years; **43.** GCSE achieved 5A*-C, inc. English and Maths: 5 pupils achieving 5 or more GCSEs at grades A*-C, or equivalent.

6.6. Long Term Conditions in children in Bromley

“Long term conditions” is generally used to describe chronic health conditions in childhood, typically diabetes mellitus, asthma and epilepsy. Chronic neurodevelopmental conditions are considered separately.

Long term health conditions in childhood are primarily managed within health services, usually by a combination of a Paediatrician with a special interest based in the local hospital, a specialist nurse for that condition (usually working closely with the Paediatrician) and the child’s GP. Diabetes and epilepsy will usually be managed primarily by the Paediatrician with support from the GP. Asthma will generally be managed by the GP and the primary care team, with support from the Paediatrician as required.

As for adults, the effective pro-active management of long term conditions offers an opportunity to minimise interference of the condition on daily life, and prevent adverse outcomes such as emergency admissions to hospital.

1. Diabetes Mellitus (DM)

There are 139 children aged 18 or under in Bromley with a diagnosis of Diabetes Mellitus¹⁴.

- 135 children have a diagnosis of Type 1 DM which is insulin-dependent
- 4 children have Type 2 DM – a condition more usually seen in obese adults

Bromley GPs are looking after 153 children aged 18 or under with diabetes. 14 of these children have a Bromley GP but live outside the borough.

Table 6. 20

Type 1 DM	No. of children	
Age group	Male	Female
<5 years	6	0
5 to 9 years	10	18
10 to 14 years	17	28
15 to 19 years	33	23
Total	66	69

Source: Bromley GP Disease Register

¹⁴ Source: Bromley GP diagnosis dataset Sept 2013

There are only 4 young people in Bromley recorded as having Type 2 DM, and 3 of these are aged 15 and over. Three of the four are female.

It is helpful to compare the proportions of the population in Bromley with diabetes with national rates.

Table 6. 21

Age (Yrs)	% of children predicted to have Type 1 DM	Population size of each age group in Bromley	Predicted number of children with Type 1 DM	Actual number Type 1 DM	Actual number Type 2 DM
0–4	4%	20,000	8	6	0
5–9	19.1%	18,000	35	28	0
10–14	42.5%	18,600	79	45	1
15	11.4%	3,818	4	15	1
16	12.2%	3,900	5	13	1
17	10.7%	4,000	4	8	1
Total			135	115	4

Source: Growing up with Diabetes. Royal College of Paediatrics and Child Health, 2009

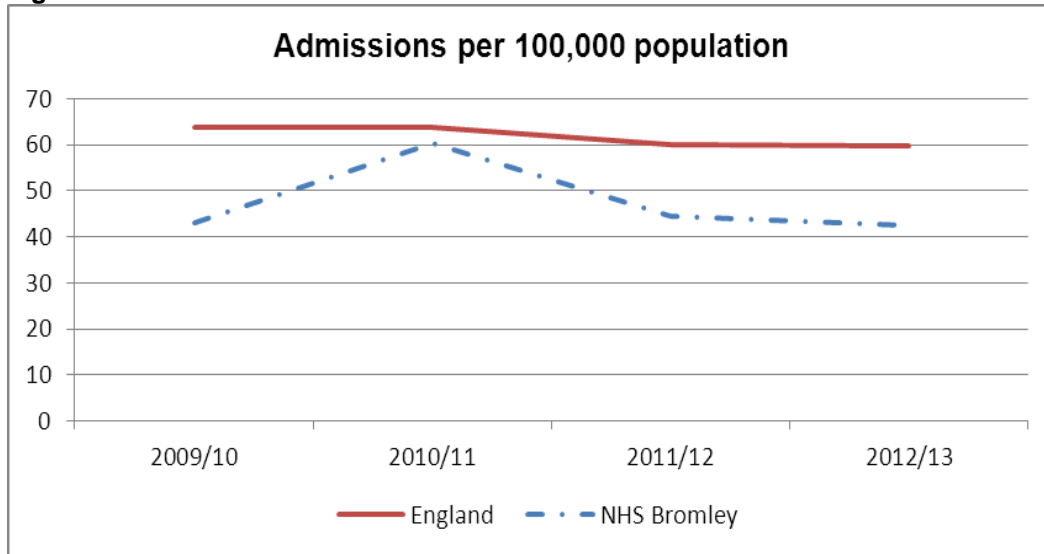
The predicted rate of Type 2 Diabetes in children varies by region in the UK. In London there are 4.9 cases per 100,000 children aged 0-17 years. This equates to between 3 and 4 children in Bromley, which is reflected in the actual picture of 4 children in Bromley.

Table 6.21 shows that the prevalence of diabetes seen in Bromley is roughly as expected (although lower) for Type 1 DM.

The geographical distribution of children diagnosed with diabetes in Bromley is not uniform. There are relatively high numbers of children with diabetes in Bromley Town, Cray Valley East, Farnborough & Crofton, and Hayes & Coney Hall.

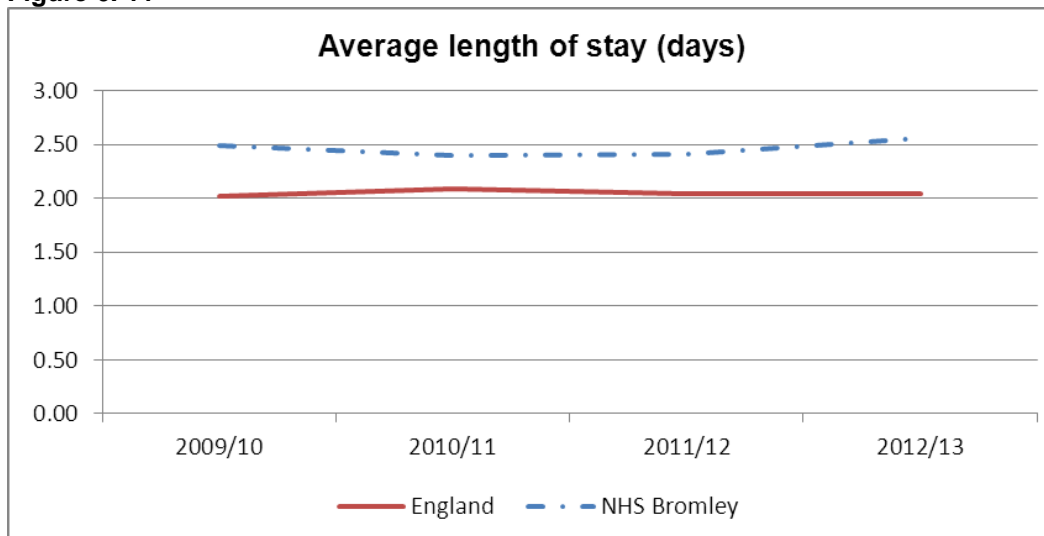
Outcomes for children with diabetes in Bromley

Unplanned hospitalisation admission rates are low compared to national rates. Data is from Hospital Episode Statistics unless indicated otherwise.

Figure 6. 10

Source: DMIT, CHIMAT

However, the average length of stay when a child is admitted to hospital is high relative to the national rate, and has been for some years in Bromley. This may indicate that those children who are admitted are more unwell and need longer in hospital.

Figure 6. 11

Source: CHIMAT

This analysis is challenged by comparing rates of admission and length of stay in Bromley with the best areas in the UK. This data indicates that both admission rates and length of stay could be considerably shorter.

Table 6. 22

Comparative data for 2012/13	Admissions per 100,000 population	Bed days per 100,000 population	Average length of stay
Bromley	42	112	2.56
London	49	126	2.48
England	60	127	2.04
Top 5% CCGs	27	45	0.94
Top 25% CCGs	37	68	1.34

Source: CHIMAT

A major factor in both admission rates and length of stay once admitted is likely to be the level of pro-active specialist support given to families where a child has diabetes.

The vast majority of Bromley's paediatric diabetic population is managed at the Princess Royal University Hospital (PRUH) by a Paediatrician with a specialist focus on diabetes and specialist Paediatric Diabetic Nurses.

Recent audits of process measures indicate that the majority of children in Bromley are not receiving all recommended key care processes to help manage their condition¹⁵, and fewer than the national average are managing to keep their diabetic control very tight. Haemoglobin A1c (HbA1c), or glycosylated haemoglobin, is a measure of long term blood sugar control and is used to monitor the effectiveness of the management of diabetes. It is measured every 3 months when the child visits the specialist diabetes team based in their local hospital. Ideally this should be maintained at below 7.5%, but in the 2010/11 audit only 15.7% of children managed this, and in Bromley only 11.1% managed to control their diabetes that well.

The findings from the 2010/11 National Paediatric Diabetes Audit are summarised in the following table. This audit is being repeated at the moment and all measures are expected to improve both nationally and locally.

¹⁵ NICE guidance

Table 6. 23: Diabetes management process measures in Bromley compared to London and England, 2010/11

	PRUH	London	England
% missing HbA1c	20.3		7.2
% missing all Key Care processes except HbA1c	70.4		
% with HbA1c < 7.5%	11.1		15.7
Mean HbA1c	8.5	9	8.9
Median HbA1c	8.3	8.7	8.7

Source: National Paediatric Diabetes Audit 2010/11

A key reason for the poor results for Bromley in the 2010/11 audit was a shortage of specialist Paediatric Diabetic Nurses to support children with diabetes. There have been 0.8 FTE Paediatric Diabetic Nurses in Bromley although this will shortly increase to 1.6 FTE, which will bring it in line with similar size units.

Until recently, newly-diagnosed children with Type 1 DM had to go to King's College Hospital to be started on an insulin pump (the treatment of choice for newly-diagnosed children). The increase in support by the Paediatric Diabetic Nurses should mean that this can be offered in Bromley in the future.

Other support for diabetic children in PRUH including Psychology support and Dietician support is also due to be increased in the near future.

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

Rates of Type 1 Diabetes in the children of Bromley are slightly lower than predicted rates based on national data.

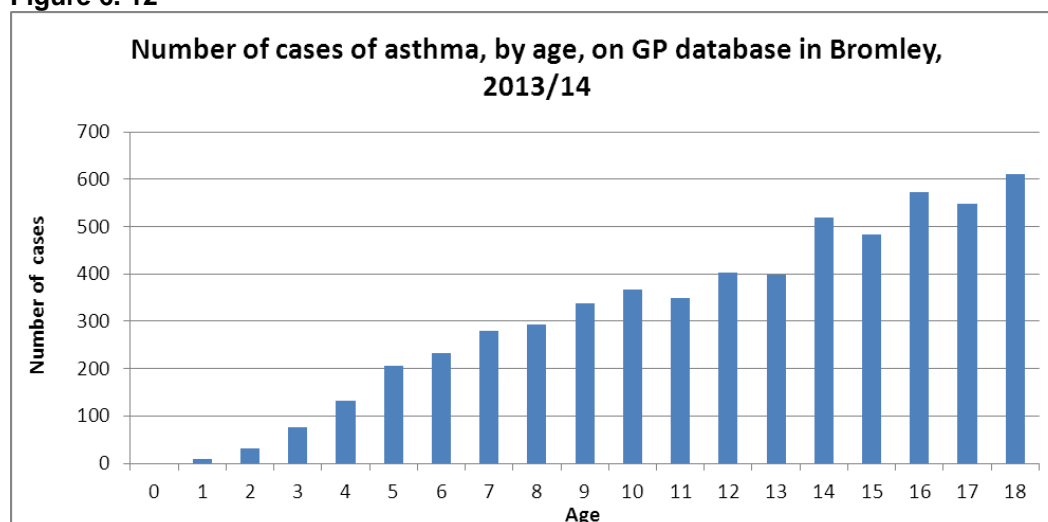
Rates of Type 2 Diabetes (obesity-related) in Bromley are in line with predicted rates based on national data.

Although admissions to hospital for diabetic children are relatively low they could be lower if pro-active specialist support were in place. This specialist support is being increased in Bromley and future measures of both process measures and outcomes in Bromley's diabetic children are expected to improve.

Asthma

There are 5846 children aged 18 and under with a diagnosis of asthma on the GP database in Bromley. This shows a steady increase of numbers diagnosed with asthma throughout childhood.

Figure 6. 12



Source: *Bromley GP Disease Register, 2013*

Prevalence of asthma in Bromley compared to national data

Based on national rates of 9.09%, we would expect to see 6470 young people aged 18 and under in Bromley with asthma. The recorded rate of 5846 is therefore slightly lower than expected.

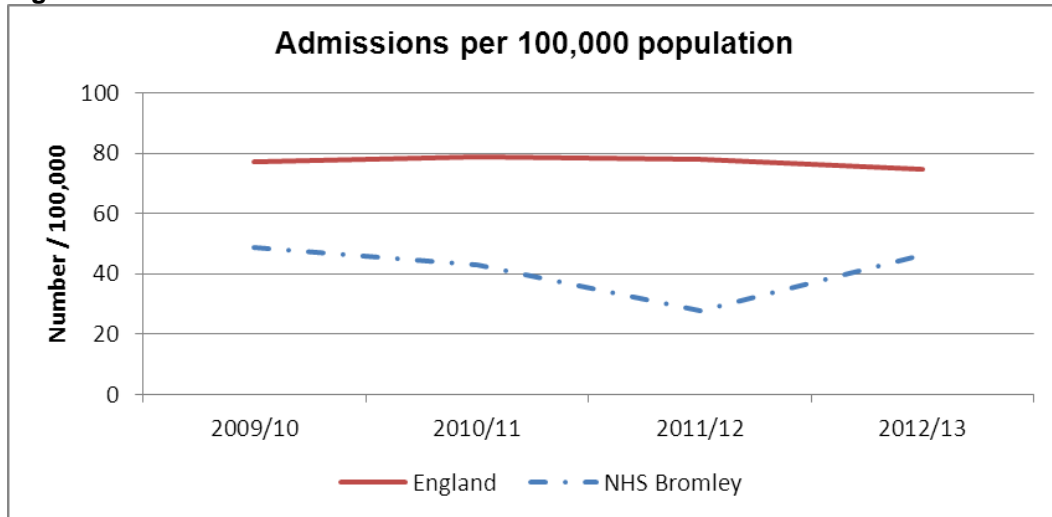
In terms of emergency admissions to hospital and length of in-patient stay, Bromley ranks as 21st out of 221 CCGs in England, where 1st is the best.

Table 6. 24

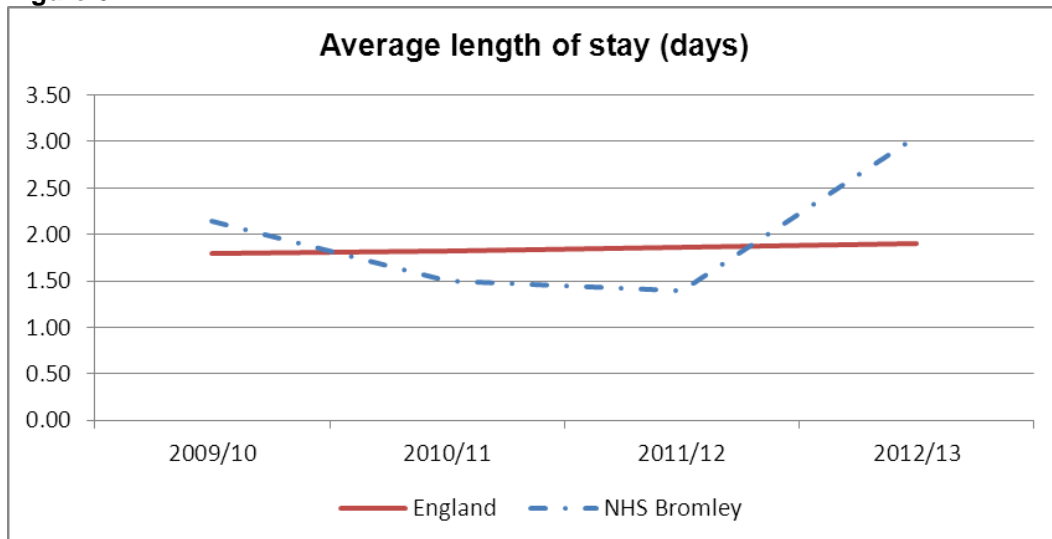
Comparative data for 2012/13	Admissions per 100,000 population	Bed days per 100,000 population	Average length of stay
Bromley	116	112	0.96
London	206	255	1.22
England	219	277	1.25
Top 5% CCGs	90	99	0.79
Top 25% CCGs	121	145	0.92

Source: *CHIMAT*

This indicates that the management of asthma in Bromley is good. The trend tables below indicate that both emergency admissions and length of stay are rising recently.

Figure 6. 13

Source: CHIMAT

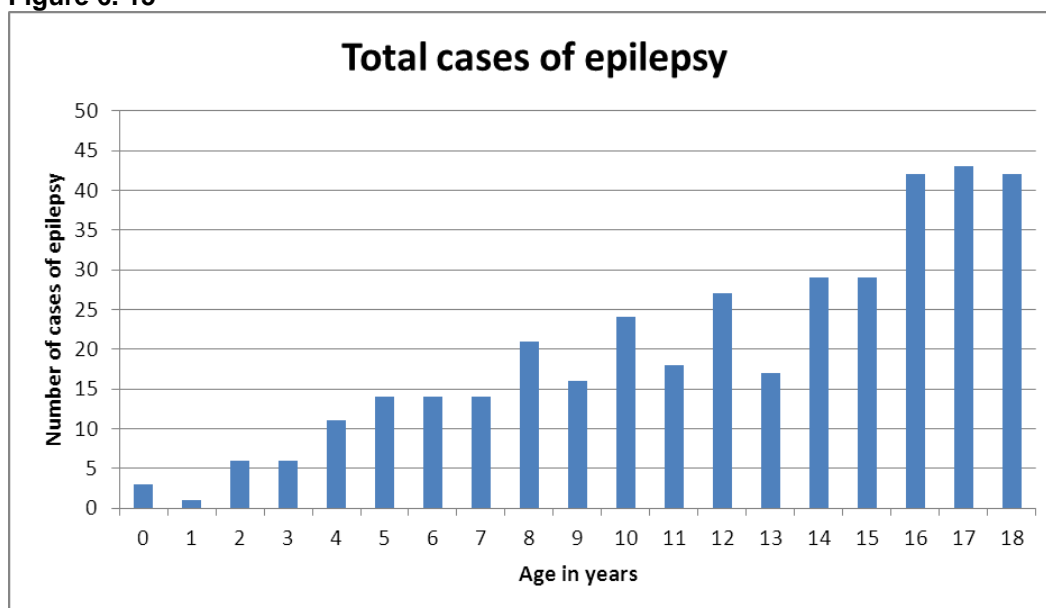
Figure 6. 14

Source: CHIMAT

Epilepsy

Epilepsy syndromes are defined as distinctive disorders identifiable on the basis of a typical age of onset, specific EEG (electroencephalogram) characteristics, seizure types, and other features. A wide range of epilepsy syndromes present throughout infancy, childhood and adolescence from benign self-limiting syndromes to severe epileptic encephalopathies.

Epilepsies are some of the most common chronic neurological conditions of childhood with approximately one in every 200 children affected. In Bromley this would lead us to expect 385 children to have epilepsy. The GP database records 377 children and young people in Bromley with epilepsy.

Figure 6. 15

Source: Bromley GP Disease Register

The child with epilepsy is by definition at risk of epileptic seizures, but may also have a number of associated neurological, educational or psychosocial problems relating to the cause of their epilepsy or associated co-morbidities.

The population of children with epilepsies places significant demands on many different types of health service. Children with epilepsies also place demands on non-health services, both in terms of providing care for a child at risk of seizures and in ensuring that the child can fulfil their potential.

In recent years there has been a focus on improving care for children with epilepsies. Initiatives have largely centred on the implementation of National Institute of Clinical Excellence (NICE) recommendations.

In 2002, the National Sentinel Audit investigated epilepsy-related deaths for the first time, concluding that 59% of child deaths from epilepsy were potentially avoidable.

In 2011 the Royal College of Paediatrics and Child Health (RCPCH) led a national audit of childhood epilepsies and published a comprehensive report outlining quality of care for children across the UK. The audit systematically assessed children presenting with seizures to paediatric services and retrospectively reviewed their first year of care against 12 performance indicators derived from NICE guidelines. The audit revealed significant gaps between national recommendations and care delivered, highlighting variation between providers. For example, the audit showed that 956/1775 (54%) of children diagnosed with epilepsy had no evidence of input from an epilepsy specialist nurse up to 12 months after their first paediatric assessment.

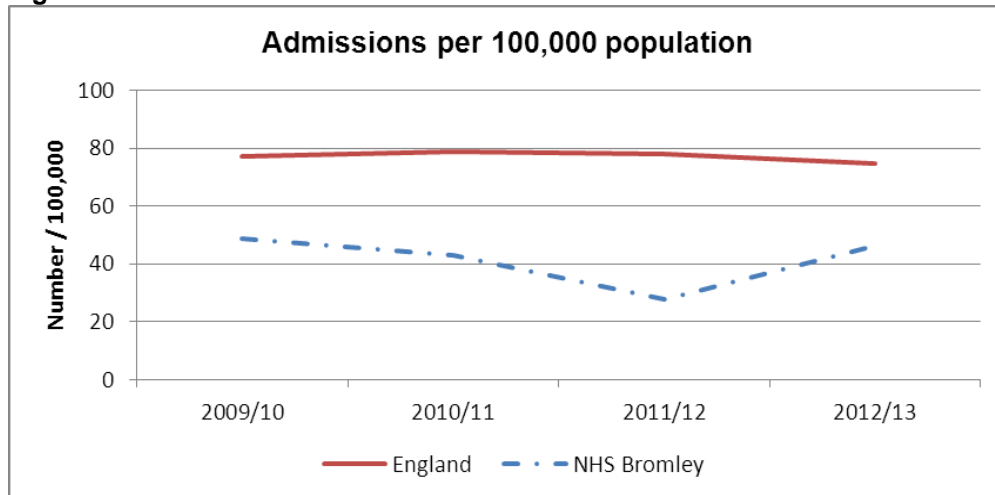
There is no epilepsy specialist nurse for children in Bromley. This may be part of the reason for a relatively high length of stay in hospital of Bromley children admitted with epilepsy, even though emergency admission rates are low.

Table 6. 25

Comparative data for 2012/13	Admissions per 100,000 population	Bed days per 100,000 population	Average length of stay
Bromley	46	146	3.06
London	70	163	2.28
England	75	145	1.91
Top 5% CCGs	27	33	0.58
Top 25% CCGs	45	57	0.86

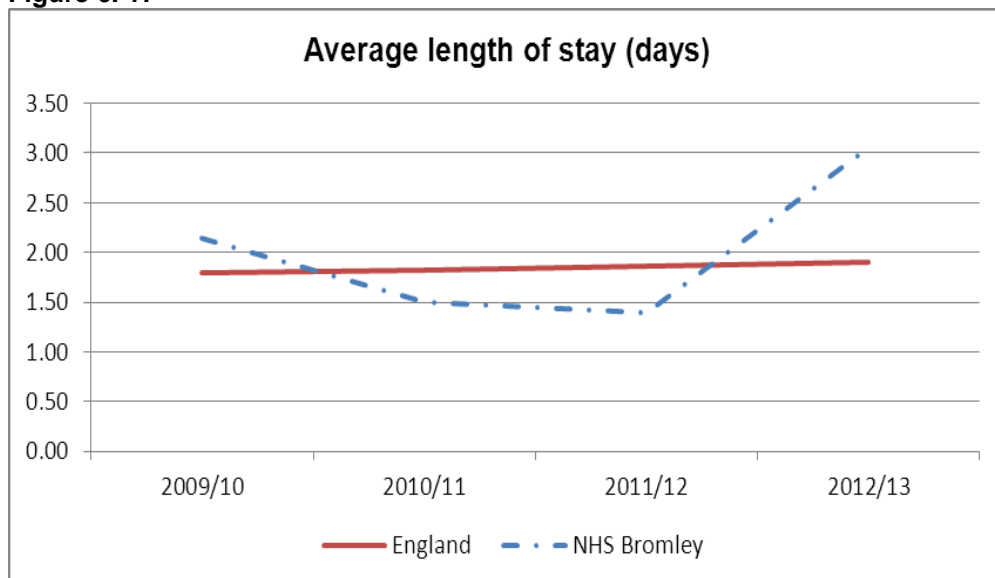
Source: CHIMAT

Figure 6. 16



Source: CHIMAT

Figure 6. 17



Source: CHIMAT

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

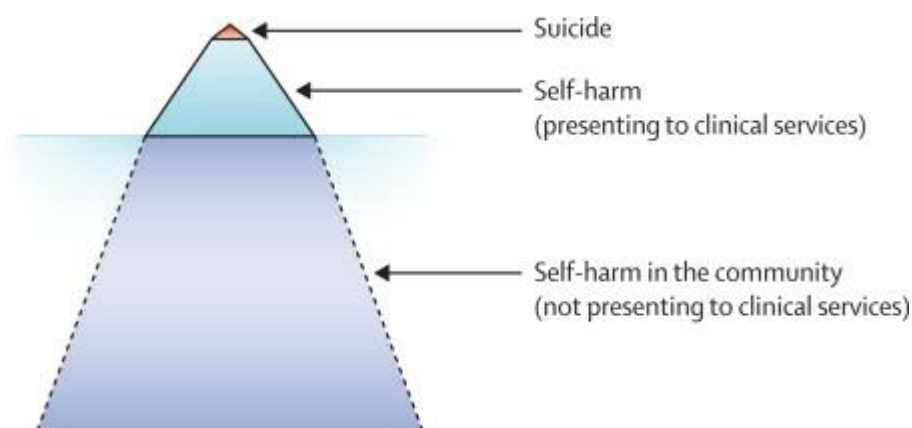
Although admissions to hospital for asthma and epilepsy have been low in Bromley, the most recent data shows an increase in admissions for both conditions. Length of stay in hospital once admitted also tends to be high in Bromley. Arguably Bromley should be matching the best 5% of areas for both admissions and length of stay.

These data indicate that we should be looking to reduce emergency admissions and length of hospital stay for Bromley children with asthma and epilepsy. The provision of specialist paediatric nurses for these conditions may be key to achieving this.

6.7. Self Harm In Young People

Self-harm is defined as 'intentional self-poisoning or self-injury, irrespective of type of motive or the extent of suicidal intent'.¹ Self-harm in children, and in adolescence in particular, is a rising problem in both Bromley and the UK as a whole and therefore a priority for research and intervention.² Approximately 10% of adolescents have reported self-harming behaviours, however, only 1 in 8 of these will present to health services (figure 1).^{3,4} A history of self-harm increases the risk of suicide over the next year by 50-100 fold compared to the general population and the risk may be more significant for those that present to hospital.^{1,5,6} Suicide is the second most common cause of death in young people worldwide.⁷

Figure 6. 18: Representation of the relative prevalence of self-harm and suicide in young people (reproduced from the Lancet)⁸



The female:male ratio of adolescents that self-harm is around 5:1 in early adolescence but this levels off in later years, suggesting that self-harming behaviour is associated with the pubertal stage. Previous UK data showed that self-cutting was the most common method of self-harm in the community, but self-poisoning is the most frequent method of those that present to hospital. Paracetamol has been the most common agent used in self-poisoning. In addition, 15% of patients that present to hospital with self-harm re-present within one year.⁹ On the other hand, adolescents who self-cut are more likely to repeat this behaviour than those who self-poison.⁶ One study also showed that cutting a part of the body other than the arms was associated with more serious psychiatric symptoms and increased risk of suicide.¹⁰

Table 6. 26; Risk factors Associated with self-harm in children and young persons

Sociodemographic factors	Past psychiatric history	Chronic stressors
Female sex ⁹	Previous self-harm ¹³	FH of self-harm or suicide ¹⁷
Low socioeconomic status ¹¹	Depression ¹⁴	FH of mental health disorder ¹⁸
LGBT* sexual orientation ¹²	Anxiety ¹⁴	Parental separation ¹¹
	ADHD ¹⁴	Bullying ⁴
	Personality disorder ¹⁵	Past sexual or physical abuse ³
	Drug and alcohol misuse ^{4,16}	

What can we do to reduce self harm in young people?

Implementing programmes to prevent self-harm and suicide in a population include a whole population approach and a targeted approach to high risk groups.

There is some evidence to support the implementation of a population approach using school-based programmes including psychological well-being programmes and gatekeeper training.¹⁹

In terms of directly addressing targeted (high risk) groups, there is currently a lack of research to show what psychological therapies or social interventions can help to decrease the incidence of self-harm and suicide in these groups.⁸ However, there are encouraging results for multisystemic family-based therapy.²⁰ In addition, diagnosing and treating specific psychiatric disorders has been shown to decrease the incidence of self-harm and is why recognition of these co-morbid disorders in adolescents presenting with self-harm is paramount for health professionals dealing with these patients.²¹ Therefore, competence at dealing with children and young persons who present with self-harm is important for healthcare professionals who work in primary care and the emergency and paediatric departments as well as in CAMHS (Child and Adolescent Mental Health Services).

Results from an American study also show that young persons with thoughts of self-harm were more likely to seek help from school staff, health professionals or a counsellor rather than from friends or family.²²

How much of a problem is self harm in Bromley?

Between 2010 and 2013 Bromley had one of the highest rates of emergency hospital admissions due to self harm in London. The lowest rate in London, in

Southwark, was only a quarter of this rate. Local data also showed an increase in A&E attendances with self harm between 2009 and 2012, although actual numbers are small.

In order to add information to these numbers, the Public Health department conducted a retrospective audit on data on children and young people under the age of 18 years old who presented with deliberate self-harm (DSH) to the Emergency department at Princess Royal University Hospital (PRUH) over a 24 month period, between 1/5/11 and 30/4/13.

This found that there had been 83 attendances in this time by 63 young people (8 young people had attended more than once). Of the 63, 48 were female and 15 male. The average age at the time of attendance was 15 years and 1 month.

Month of presentation

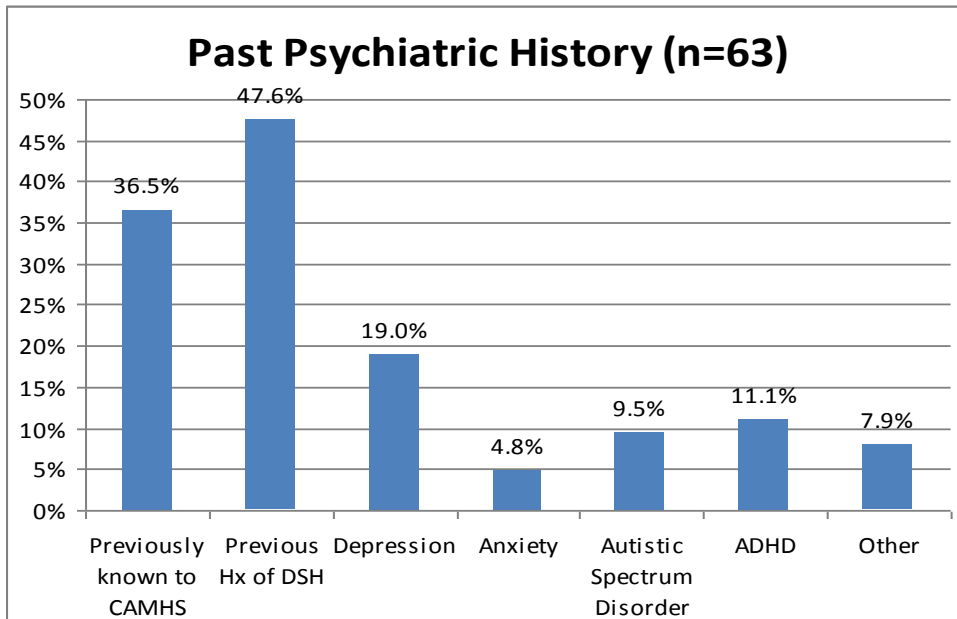
The months with most frequent attendances included January, September, March and April. The higher rates in March and April could be due to stress before exams in May, although the data that was collected on acute stressors (**Figure 6.21**) does not confirm this, as exam stress was not a highly frequent trigger. However, this may not have been asked about or recorded in the notes.

School

Of the 63 patients who attended, data was present from the local and national education databases for 52 patients to cross-reference which school they had been attending. Most of those patients (49) had been at state school compared to 3 from independent schools (5.7%), which shows a slight over-representation from those from state schools. In the Bromley area, 8.1% of children are in independent education. It could be significant that there are single sex girls schools appearing near the top of the list for most attendees.

Past psychiatric history

Figure 6. 19: Past psychiatric history of the 63 patients who attended

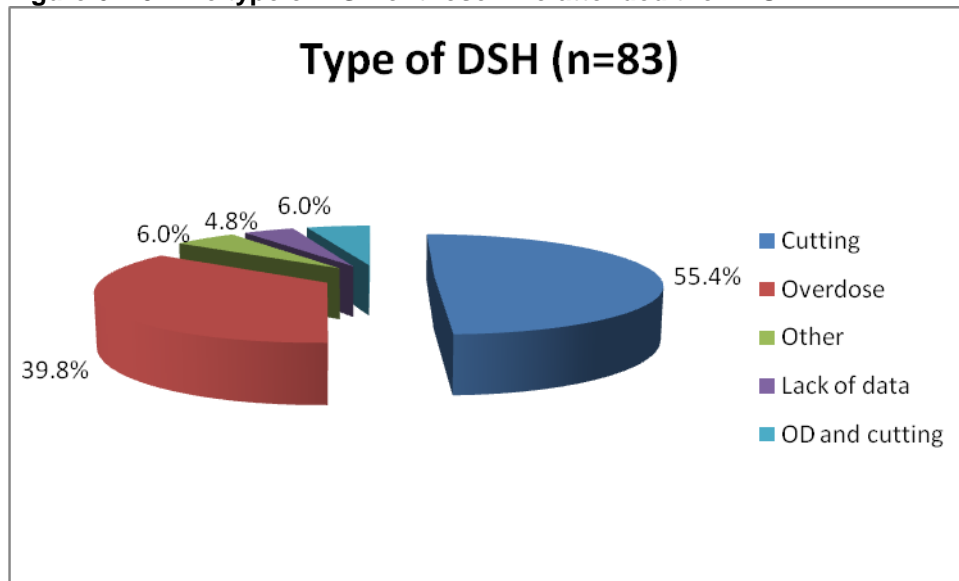


Source: PRUH A&E Self Harm Audit, 2013

The data from **Figure 6.19** concurs with other available research that the conditions of depression, anxiety, ASD (Autistic Spectrum Disorders) and ADHD (Attention Deficit Hyperactivity Disorder) are common in children and young people who self-harm. The number who had reported previous DSH was approximately 50%, but in reality, it is likely that most of the patients who presented would have self-harmed before, particularly the ones who had self-cut. Over a third of patients were already known to CAMHS.

Type of Deliberate Self Harm

Figure 6. 20: The type of DSH of those who attended the PRU



Source: PRUH A&E Self Harm Audit, 2013

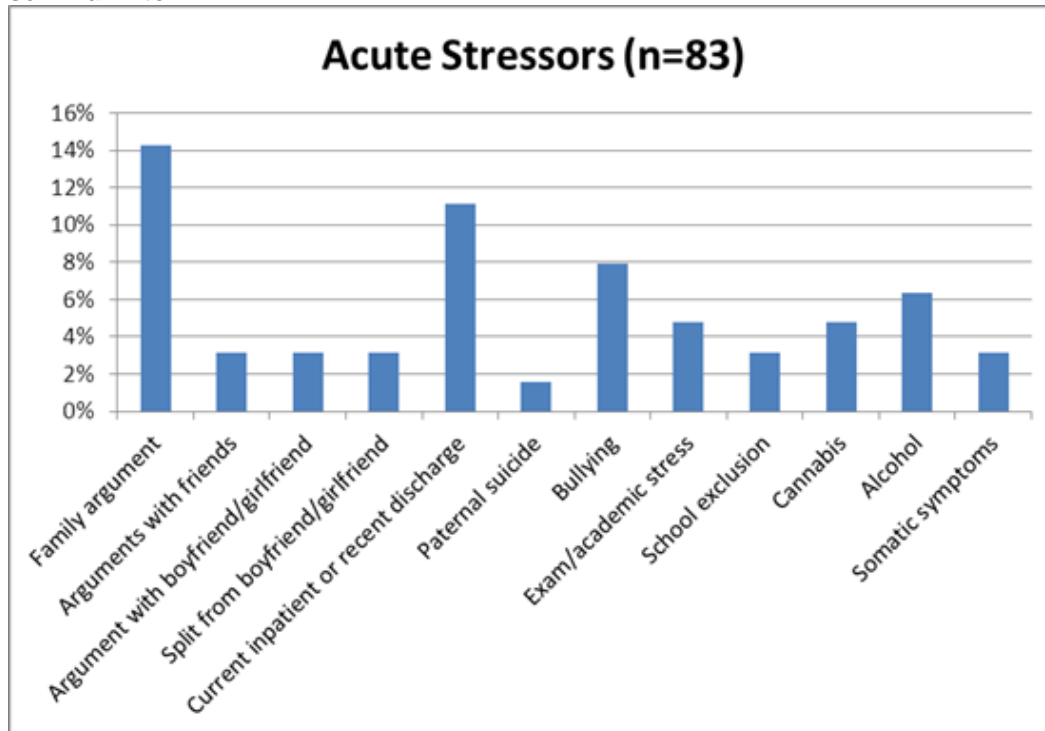
Figure 6.20 illustrates that most of the cases were overdoses and self-cutting episodes. You would expect from past research that overdoses would be most common of cases that attend A&E, but self-cutting is the most frequent from this study. This may reflect that there is a different cohort of patients in the Bromley area or that there is a trend towards self-cutting becoming more prevalent in comparison. This could be significant, as the risk of suicide is in fact higher in those that self-cut than those that overdose.²⁵ Of those that self-cut, the implements most commonly used were a razor or a knife, however, a significant number of records (32.6%) lacked data of what implement was used.

Two thirds of cases which involved cutting were on the arms only.¹⁰

Paracetamol and ibuprofen were the most common agents used in self-poisoning, which is similar to previous research from UK data.⁹

The effects of stressors

Figure 6. 21: Acute stressors or triggers associated with patients who presented with self-harm to ED

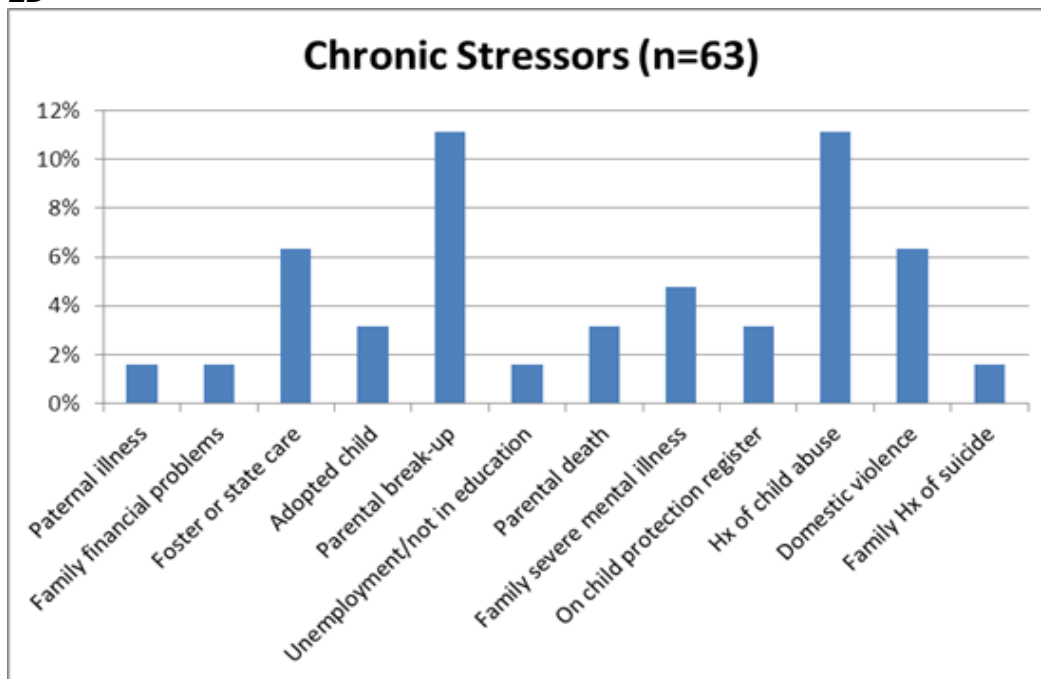


Source: PRUH A&E Self Harm Audit, 2013

Family arguments as well as arguments with friends or a boyfriend/girlfriend were common acute stressors. Cannabis and alcohol consumption also increased the likelihood of attendance. The fairly high frequency of bullying as a trigger is something that can be highlighted for potential intervention in schools. Of particular note, there were a number of cases who were already inpatients on mental health wards.

Analysis of chronic stressors also showed important information (**Figure 6.22**). There were a high number of cases where there was past parental break-up.

A history of child abuse and domestic violence were also common risk factors. There were a significant number of looked after children (four) who attended, one of whom was the most frequent attendee, having attended eight times in the two year period.

Figure 6. 22: Chronic stressors associated with patients who presented with self-harm to ED

Source: PRUH A&E Self Harm Audit, 2013

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

Self harm appears to be an increasing issue for young people in Bromley, and there is some evidence that rates of presentation to services with self harm are higher in Bromley than in most London boroughs.

In Bromley, most of the attendees presented due to self-cutting as opposed to self-poisoning suggesting a possible shift in self-harming behaviours. Of particular note were the common 'triggers' of a new episode of self-harm that presented to A&E, which included family arguments, bullying and already being an inpatient on a mental health unit.

The most frequent chronic stressors of having separated parents, adoption, being a looked after child, having experienced domestic violence in the family or having been a victim of physical or sexual abuse highlights the significant psychological impact these can have on a child.

The evidence that self harm may be reduced by psychological well-being programmes for young people and gatekeeper training for those who they may present to is being taken forward in secondary schools, A&E at the PRUH and CAMHs services in the borough.

For more information on Child Health please contact

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7. Older People

Introduction

This section focuses on the needs of the Borough's older people. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- Introduction of new legislation and focus on community based support
- Bromley demographics
- Support for older people and people living with dementia

Current Context

Care Bill

In May 2013, the Government published the Care Bill, which represents the most significant changes to adult social care in recent times. The Bill proposes fundamental reforms to how the law on Adult Social Care will work, prioritising wellbeing, highlighting the importance of prevention and postponement of the need for care and support, and putting people in control of their care and support, all of which are in line with the Council's Building a Better Bromley aim of supporting independence. The Bill is based on the principles of:

- People's wellbeing at the heart of every decision
- Carers rights on the same footing as the people they care for
- Preventing and delaying need for care and support
- Personal budgets giving people greater control over their care
- Information and advice about the care and support system
- Promoting the diversity and quality of the local care market, shaping care and support around what people want
- New guarantees to ensure continuity of care
- Equity of funding

For services users of state pension age, a cap of £72,000 will be set on the costs they will have to pay to meet their eligible needs. More people will be eligible for financial support. Over the coming year, work will be undertaken to assess the full impact on both the individual and the local authority.

Better Care Fund (shift from hospital to community)

The London Borough of Bromley serves a population of over a third of a million in partnership with a co-terminous Clinical Commissioning Group and two community health providers. Together, we have agreed to refocus services on the needs of residents, not for the convenience of providers or commissioners, but reflecting the principles outlined in the Better Care Fund.

The Department of Health has published seven key areas against which improved outcomes are to be delivered with 'Increasing the proportion of older people living independently at home following discharge from hospital' being key for this section of the JSNA.

Resources will be more targeted towards early identification, prevention and intervention to support local residents in better understanding and managing their long term conditions. Starting with our older and often our more complex patients, they will progressively see a single care manager and co-produce a single care plan over which they feel a real sense of ownership, served by integrated teams focused on maintaining them in their homes safely and for as long as possible.

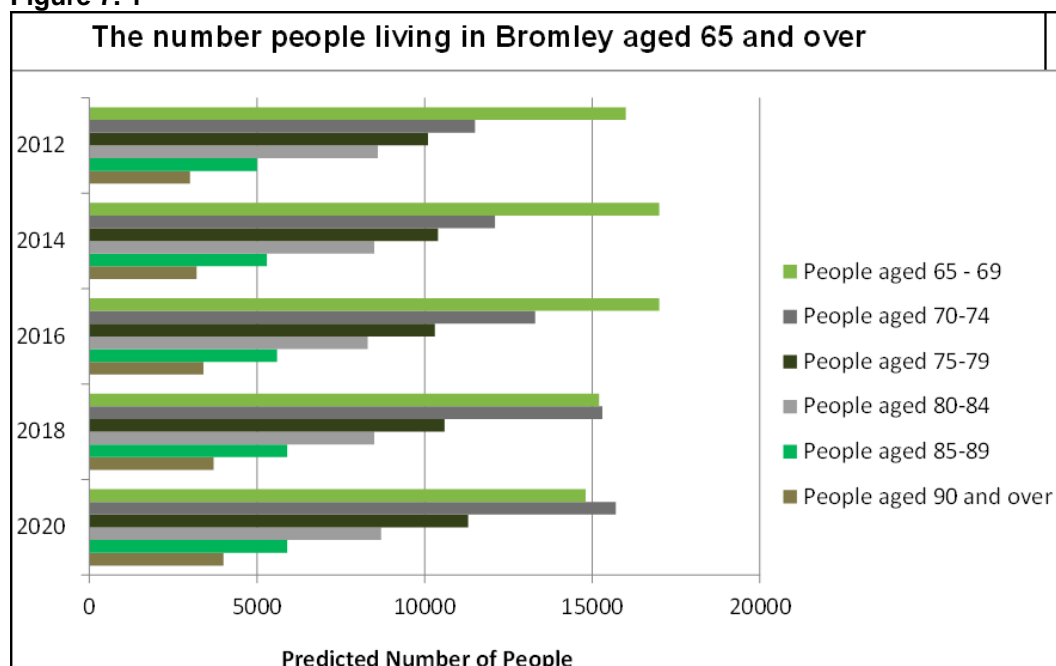
We are already seeing reduced referrals to residential care and reduced levels of hospital care as well as high levels of satisfaction and increased confidence in our pilot admissions avoidance programme for our older, complex patients (locally called the ProMISE programme) and we will be extending the principles of this programme to all our residents throughout the pilot year.

Demographic Information

The changing older people population

Bromley has an ageing population – the largest in London, with 54,200 people aged 65+ years in Bromley at 2014 (POPPI). It is expected that this will increase to 57,900 by 2016 (7% increase) and 60,400 (11% increase) by 2020. Of this cohort, as at 31st March 2013, 2,693 received LBB commissioned or funded services.

Table 7.1 illustrates the predicted changes in the number people living in Bromley aged 65 and over:

Figure 7. 1

Source: *Projecting Older People Population Information System, January 2014*

Table 7. 1

	2012	2014	2016	2018	2020
People aged 65-69	16,000	17,000	17,000	15,200	14,800
People aged 70-74	11,500	12,100	13,300	15,300	15,700
People aged 75-79	10,100	10,400	10,300	10,600	11,300
People aged 80-84	8,600	8,500	8,300	8,500	8,700
People aged 85-89	5,000	5,300	5,600	5,900	5,900
People aged 90 and over	3,000	3,200	3,400	3,700	4,000
Total population 65 and over	54,200	56,500	57,900	59,200	60,400

Source: *Projecting Older People Population Information System, January 2014*

People living in Bromley with dementia

There are currently over 4,000 people living in Bromley with dementia, and with the ageing population the incidence of dementia is set to rise by 308 people by 2016 and will continue to increase by 680 people by 2020.

- Approximately 1,800 people were identified as being on the dementia registers of Bromley GP practices in 2013/14 (Quality and Outcomes Framework).
- In 2012/13, a total of 715 people received social care services for dementia, approximately half of these were supported in the community,

a third in residential homes and a sixth in nursing homes.¹⁶

In November 2013, the following comparisons of Bromley with other areas of England were published as part of the State of the Nation report based on 2012/13 data. Bromley is rated as below average or not good in the following areas:

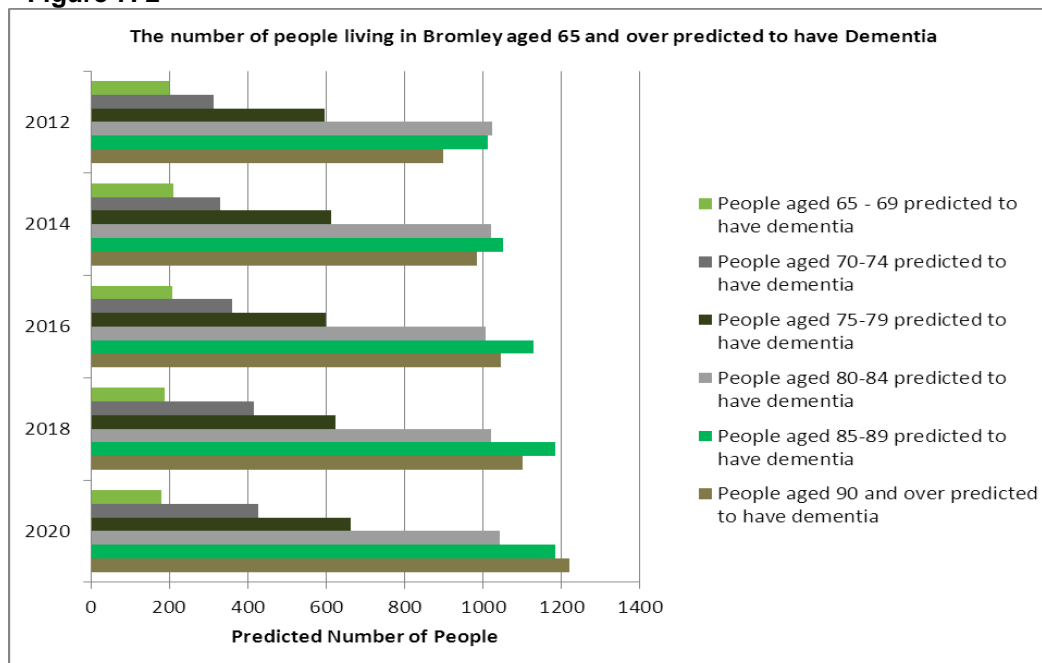
- Having a diagnosis of their condition
- Patients with dementia have to stay in hospital longer, are more likely to be readmitted and more likely to die in hospital than similar patients without dementia.
- Bromley was not registered as working towards being a dementia friendly community.

More positively, Bromley rated as good or average to good for the following:

- Waiting times for the Memory Clinic
- Waiting times for results of tests from the Memory Clinic
- Appropriate use of anti-psychotic drugs
- For over 75s going to hospital as an emergency, looking for signs of dementia, making an assessment and undertaking further tests

The table overleaf illustrates the predicted changes in the number people living in Bromley with dementia:

¹⁶ RAP Table P1, 2012/13

Figure 7. 2

Source: Projecting Older People Population Information System, January 2014

Table 7. 2

	2012	2014	2016	2018	2020
People aged 65-69 predicted to have dementia	198	210	209	187	181
People aged 70-74 predicted to have dementia	312	330	360	417	427
People aged 75-79 predicted to have dementia	595	612	600	623	663
People aged 80-84 predicted to have dementia	1,022	1,019	1,006	1,019	1,042
People aged 85-89 predicted to have dementia	1,011	1,050	1,128	1,183	1,183
People aged 90 and over predicted to have dementia	899	985	1,044	1,102	1,220
Total population aged 65 and over predicted to have dementia	4,037	4,205	4,345	4,532	4,717

Source: Projecting Older People Population Information System, January 2014

Impact of increasing populations

The implication of this growing demographic situation is the increased demand for social care services from people who desire to stay and are living at home longer.

As people's needs become more complex it may be the case that support packages will become increasingly expensive to deliver and will put pressure on already constrained budgets. This is compounded by the fact that many of Bromley's older population are 'asset rich but cash poor' and unable to contribute to the cost of their care packages as their money is tied up with their properties.

People's expectations are also increasing with the introduction of more self directed support and less reliance on residential care. For people with dementia this is leading to:

- Increased demand for complex need care packages
- Referrals to Oxleas Memory Service for assessment, diagnosis and treatment for people who are experiencing difficulties with their memory
- A doubling of specialist dementia residential care since 2006/7
- The need to explore alternative models of accommodation and support to reduce need for residential and nursing care.

Support for older people and people living with dementia

There is an increasing move, both within Bromley and across England, for older people to maintain their independence by being supported either within their own home, or for families to arrange or support their own care. Although the Council provides services to only a relatively small number of people with dementia, the expected significant increase in the population will have a direct impact on the number of older people eligible to receive support from the Council.

CCG ProMISE programme (Proactive Management of Integrated Services for the Elderly)

In 2012, Bromley Clinical Commissioning Group (BCCG) developed a three year Integrated Commissioning Plan outlining the priority areas for shaping and delivering healthcare to Bromley residents. Improving services for older people was established as one of six strategic programmes. The ProMISE initiative, which also seeks to improve services for people with long term conditions, is one these strategic objectives.

The primary aim of the ProMISE programme is to shift the need for unplanned, reactive care delivered in an acute/secondary care setting by adopting a more proactive approach, forecasting individual patient needs for care and support which can be delivered in primary/community care or the patient's home environment.

The key to success for this programme lies in its ability to:

- Prevent this cohort of patients deteriorating due to their co-morbidities
- Maintain and promote high standards of living and independence
- Identify patients at risk before their year of need
- Identify and respond to issues (before the point of crisis), with appropriate services and support, following an in depth assessment and care plan being developed.

A summary of the pilot showed that:

- The average ProMISE patient is 82 and supported by a carer. Few had social services intervention and most were managed by primary care. Whilst the majority were referred for medical deterioration, most were deemed to be able to cope with their conditions with some support. The top four other issues identified by the Care Managers were: falls, carer stress, polypharmacy and cognitive impairment. Only 18 of the cohort of 440 were referred for reasons of cognitive impairment or loneliness, but almost double that number were found to have such issues on assessment
- 54% of patients felt that they were now more likely to stay at home than go to hospital as a result of the Care Manager's assessment.

As part of the ProMISE programme, a training scheme was developed for formal and informal carers (in nursing homes and residents' own homes) to identify Urinary Tract Infection (UTI) symptoms, perform urinalysis, read the results and subsequently fast track the information to the GP, facilitating the earlier detection and treatment of UTIs. It also taught carers the importance of hydration and improved toileting to reduce the overall incidence of UTIs.

The key aims for the project were:-

- Reducing the number of unplanned admissions for UTI in the over 65 patient demographic
- Deliver a comprehensive and useful training package for formal and informal carers
- Establish and deliver a standard operational and service pathway for UTI detection
- Improve quality by assuring the right care in the right place at the right time

- Improve health outcomes through avoiding unnecessary hospital admissions and ensuring UTIs are detected earlier, thus avoiding complications

Key outcomes are:-

- A total of 62 UTI cases were reported (by carers) as avoided between September 2013 and February 2014
- A year on year reduction of 45 UTI hospital admissions
- 216 carers from the following organisations were trained in UTI recognition
 - Informal Carers
 - Day Centres/Charities
 - Extra Care Housing
 - Domiciliary Care Agencies
 - Residential and Nursing Care Homes

Integrated/ locality teams

The NHS community provider is reorganising its teams to operate as six, co-located locality teams comprising a dedicated team leader and team co-ordinator, community matron, district nurses, physiotherapists, occupational therapists, nurse rehabilitation assistants, healthcare assistants and physiotherapy assistants. In one of the six localities, the team has already been joined by a co-located social care manager and community psychiatric nurse to support joint assessment via a single point of entry. The allocation of a lead professional is based on prevailing/overriding need and the improved coordination of care and care planning. The evaluation of the pilot is expected to lead to integrated health and social care teams across each of the six community localities during 2014/15.

Signposting/Referrals

Over the period April 2013 to March 2014, there were 27,517 visits to Bromley MyLife seeking information, advice and guidance, compared to 15,586 for April 2012 to March 2013.

For the year 2013/14, there were 9,826 referrals into Adult Social Care of which 60% were received via Bromley Social Services Direct (BSSD) and 40% from the Hospital. Of these, some 55.6% (5,461) were for new clients i.e. those not in receipt of services when the contact was made.

Of the referrals received:-

- 3,022 (30.8%) had an outcome of No Further Action

- 2,174 (22.1%) were referred to Reablement
- 1,005 (10.2%) were provided with Information, Advice and Guidance
- 155 (1.6%) were referred to Safeguarding

This is leading to a reduction in placements by the London Borough of Bromley in care homes (however, recent unpublished data is suggesting that this may have changed) and an increase in the number of older people who chose to manage their support through a Direct Payment.

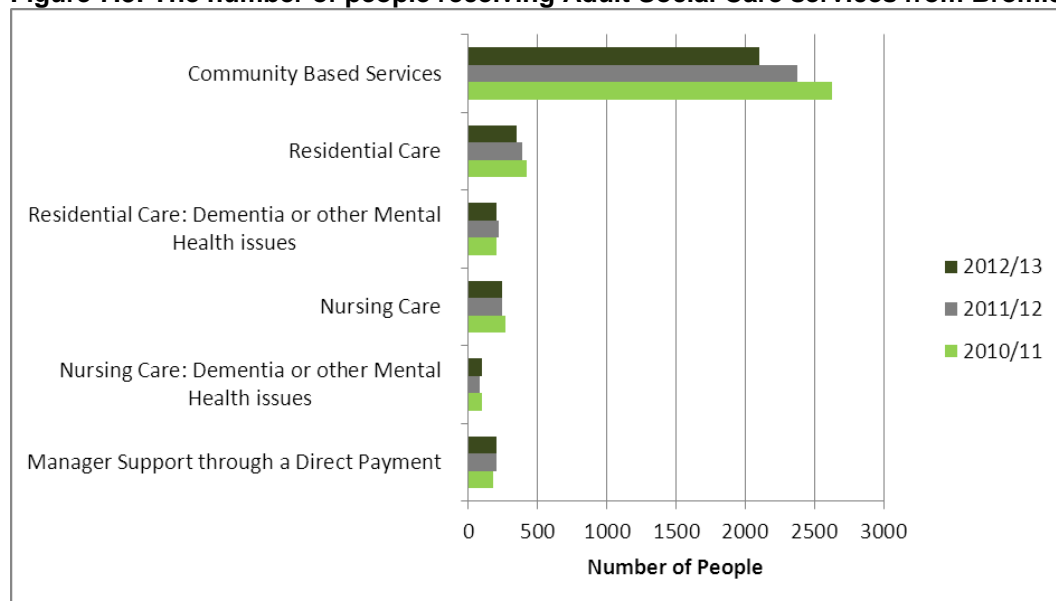
Learning from the Dementia 'Invest to Save' project has demonstrated that the model of a Senior Care Manager leading a team of professionals is effective in providing a coordinated case management approach supporting individuals and their carers affected by dementia. The project has led to four emergency placements in residential homes being avoided and a small saving in domiciliary care achieved.

Work with health colleagues, particularly Community Psychiatric Nurses at the Oxleas Memory Clinic has enabled an appropriate care pathway to be developed, tested and embedded.

Direct working with the care staff at an Extra Care Housing (ECH) development has enhanced understanding of service user admissions from ECH to EMI care homes and to prevent unnecessary moves.

Table 7.3 illustrates the changes in the number of people receiving Adult Social Care services from the London Borough of Bromley between 2010/11 and 2012/13:

Figure 7.3: The number of people receiving Adult Social Care services from Bromley LA



Source: London Borough of Bromley

Table 7. 3

	2010/11	2011/12	2012/13
Older people receiving community based services	2,622	2,374	2,103
Older people receiving residential care	421	392	349
Older people receiving residential care who have dementia or other mental health issues	204	218	203
Older people receiving nursing care	271	244	241
Older people receiving nursing care who have dementia or other mental health issues	96	79	95
Older people who chose to manage their support through a Direct Payment	175	200	205

Source: London Borough of Bromley

What service users are telling us

A survey of 1,690 service users receiving adult social care was carried out between January and March 2013 to establish how these services have affected and/or improved users' quality of life as part of the national adult social care survey.

The survey told us that, of the 690 [41%] people who responded:

- 73% [506] had control over their daily life
- 56% [386] found it easy to find information
- 92% [635] stated that they feel safe

The Public Health Outcomes Framework (PHOF) reflected that in 2012/13, 40.60% of adult social care users had as much social contact as they would like. This is on a par with the London and England percentages of 39.80 and 41.90 respectively.

Table 7. 2: Older People Related PHOF Indicators

Indicator	Time Period	Sex	Age	Bromley	London	England
2.24i - Injuries due to falls in people aged 65 and over	2010/11	Persons	65+ yrs	1895.85	2194.11	2029.50
2.24i - Injuries due to falls in people aged 65 and over	2011/12	Persons	65+ yrs	1806.07	2281.44	2035.18
2.24i - Injuries due to falls in people aged 65 and over	2012/13	Persons	65+ yrs	1623.05	2241.54	2011.01
2.24i - Injuries due to falls in people aged 65 and over	2010/11	Male	65+ yrs	1431.55	1804.31	1587.61
2.24i - Injuries due to falls in people aged 65 and over	2011/12	Male	65+ yrs	1491.49	1891.92	1604.54
2.24i - Injuries due to falls in people aged 65 and over	2012/13	Male	65+ yrs	1239.83	1872.60	1602.08
2.24i - Injuries due to falls in people aged 65 and over	2010/11	Female	65+ yrs	2360.16	2583.91	2471.40
2.24i - Injuries due to falls in people aged 65 and over	2011/12	Female	65+ yrs	2120.65	2670.95	2465.81
2.24i - Injuries due to falls in people aged 65 and over	2012/13	Female	65+ yrs	2006.26	2610.48	2419.93
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	2010/11	Persons	65-79 yrs	879.53	1124.20	1021.42
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)			Aug 2009 - Jul 2012			
	Persons	85+ yrs		28.01	25.58	22.59
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	Persons	18+ yrs	2010/11	38.00	38.50	41.90
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	Persons	18+ yrs	2011/12	40.60	39.10	42.30
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	Persons	18+ yrs	2012/13	40.60	39.80	43.20

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

What does this mean for the residents of Bromley?

- Care Bill changes will:
 - require some changes to how we deliver assessment services in Bromley
 - mean that potentially the Local Authority could be required to fund an increase in packages from 2016
 - potentially raise expectations about the support that the Local Authority should be providing in partnership with Health
- An increasing number of older people are being supported within their own home which will have an increasing impact on community based services by all organisations that are required
- The increasing complexity of needs of the older people in residential care will impact on the services required to be provided by care homes, and the cost to the Council
- Community based services need to continue to support people with complex needs within their own homes – including trained workforce
- Integrated approach to the commissioning and provision of services for people with dementia and their carers

For more information on Older People please contact
Catriona.Ellis@Bromley.gov.uk

8. Learning Disability

Introduction

This section focuses on the needs of the Borough's adults with learning disabilities. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- Demographic information
- Issues and impact
 - Health
 - People supported by adult social care
 - Employment and social inclusion
 - Disability hate crime

Demographic Information

National Information

It is estimated that 1.14 million people in England in 2012 have learning disabilities. This included 908,000 adults aged 18+ of whom 199,000 (22%) were known to GPs and 404,000 who were receiving Disability Living Allowance¹⁷.

Local Information

The projected figure for the number of adults up to the age of 64 with learning disability in Bromley in 2012 is 4,637; this is predicted to increase by 9.2% over the next 8 years¹⁸. One area of growth is the number of children making the transition to adult services. Medical advances mean that more young people with profound and multiple disabilities are surviving to adulthood. The numbers of people aged 65 years and over with learning disability is not known.

Table 8. 1

	Bromley		National	
	2012	2020	2012	2020
Learning Disability (18 to 64y)	4,637	5,065	806,979	836,150
Moderate/Severe Learning Disability	1,043	1,156	180,908	190,175
Autistic Spectrum Disorder	1,857	2,030	330,100	342,917

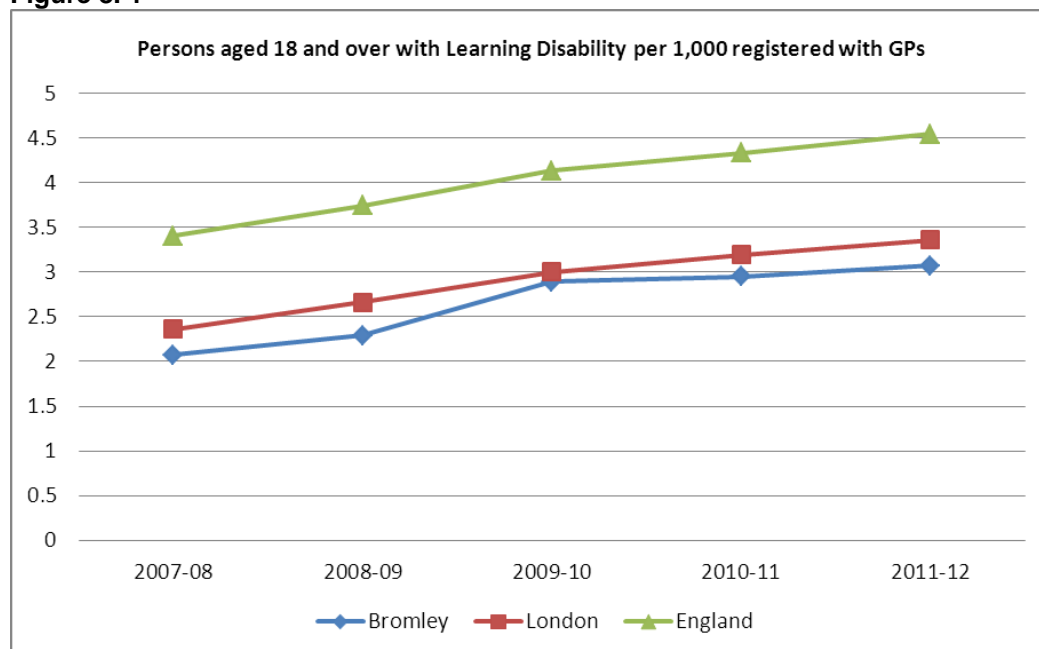
Source: PANSI

¹⁷ People with Learning Disabilities 2012 – Learning Disabilities Observatory PHE report 2012

¹⁸ Projecting Adult Needs and Service Information System January 2014

Of those adults with LD, 1,043 have moderate or severe LD and 1,857 have autistic spectrum disorder¹⁹. Bromley identification rates are significantly lower than the England average.

Figure 8. 1



Source: Learning Disability Profile, 2013

Local Authority data gives a higher figure than GP disease registers for adults with LD aged 18 to 64 years at 955 (2010-11), but this is still lower than the projected figure for moderate and severe LD.

This discrepancy in identification of adults with LD has implications for the health care provision to this patient group. Some of which are explored in the next section.

Issues and Impact

Health

Nationally, GPs are recognising more people with learning disabilities on their practice lists - 4.5 in every thousand in 2011/12. Marked progress has been made between 2008/09 and 2011/12 in the delivery of health checks to people with learning disabilities, with just over half (53%) of eligible adults receiving a health check in 2011/12. In Bromley, however, only 26 of 48 practices opted to participate in the Directed Enhanced Service (DES), so not all people with learning disability known to GPs are covered by this scheme. However, it is

¹⁹ Projecting Adult Needs and Service Information System January 2014

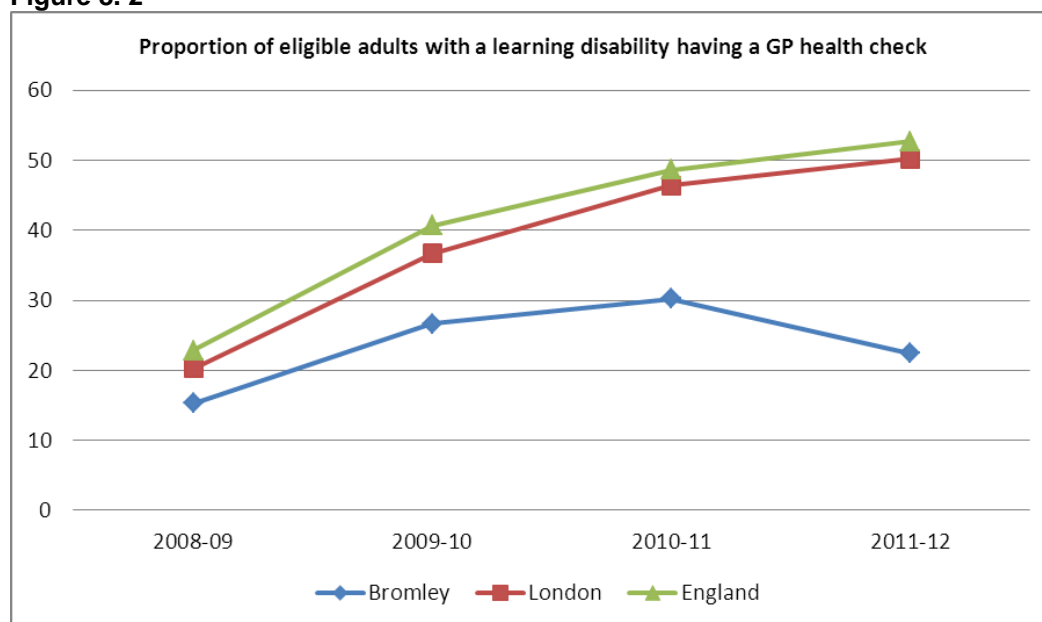
likely that some GPs offer health checks outside the DES scheme as well. Figures for 2013/14 indicate, that of the 402 eligible cohort, 229 checks were carried out in nine months which would equate to a full year figure of 305, an increase on the 2012/13 figure of 269.

Some health conditions associated with learning disability increase the risk of premature death, for example, people with Down's syndrome have higher rates of congenital heart disease. People with learning disabilities have a higher prevalence of certain health problems such as epilepsy, dementia, gastro-oesophageal reflux disease and gastrointestinal cancer. They also have more difficulty than others in recognising health problems and getting treatment for them, therefore, it is advisable for GPs to offer regular health checks to make sure that important health problems are identified and treated. The Confidential Enquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) found that the most common underlying causes of death were heart and circulatory disorders (22%) and cancer (20%) although they were less prevalent than the general population (29% and 30% respectively). The final event leading to death was most frequently a respiratory infection.²⁰

As well as these problems, people with learning disability are susceptible to the same health risks as the rest of the population, for example obesity and physical inactivity. Both of these are exacerbated by a sedentary lifestyle and a restricted range of opportunities to exercise or eat healthily.

Nationally, the median age at death for people with Learning Disabilities is approximately 24 years (30%) younger than for those who do not have learning disabilities. The population pyramid for people with learning disabilities shows a sharp reduction in numbers above the age of 49 years due to reduced life expectancy as well as a suggestion of a sharp increase in numbers for males under the age of 20 years, which may reflect increased survival rates amongst more severely disabled children. The findings into the Confidential Enquiry into Premature Deaths of People with Learning Disabilities (CIPOLD), published in 2012, reported a slightly higher median age at death (65 years for men and 63 years for women).

²⁰ See also 'Health Inequalities & People with Learning Disabilities in the UK: 2011'

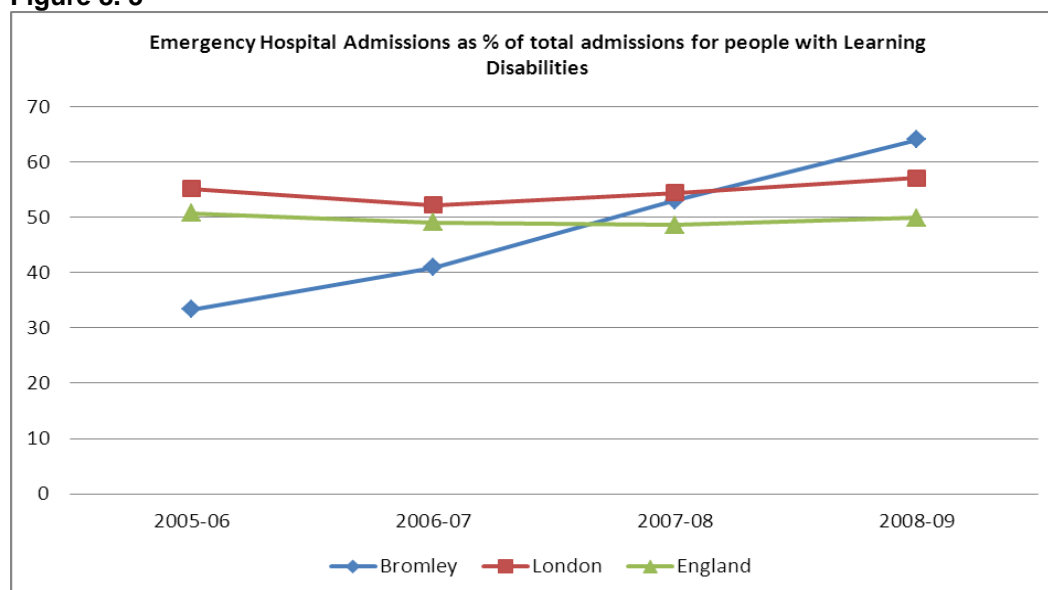
Figure 8. 2

Source: Learning Disabilities Profiles, 2013

A further consequence of low levels of identification of adults with LD is reflected in admission rates to hospital.

Bromley has significantly higher rates of emergency admissions for adults with learning disability (64.05%) than the England average (49.96%). The trend shows a year on year rise in these emergency admissions. However, it should be noted that this data only covers the period to 2009, so may not be representative of the current position.

A high level of emergency admissions can be an indication that earlier opportunities to manage a condition out of hospital have been missed. Emergency admissions do not allow for advance planning to accommodate the needs of people with learning disabilities in hospital.

Figure 8. 3

Source: Learning Disabilities Profiles, 2013

People Supported by Adult Social Care

During 2012/13,

- 867 adults with a learning disability received community based services²¹. 75 of these chose to manage their support package through a direct payment
- 155 received residential care, with seven new placements made this year
- 11 received nursing care, with one new placement made this year

Employment and Social Inclusion

In 2011/12, 7.1% of adults with learning disabilities were reported to be in some form of paid employment. The majority of these worked full time, with men more likely to be working 30+ hours per week than women (0.7% v 0.2%)²².

Nationally, the Public Health Outcomes Framework (PHOF) estimates that in 2011/12, the gap between the employment rate of those with a learning disability and the overall employment rate is 58.70%, and in Bromley 56.20%.

During 2013/14, the Bromley Mencap Jobmatch service received 83 referrals; supported 29 candidates to enter paid employment, and six candidates to secure voluntary work positions. A further 37 candidates were on the waiting list to receive Jobmatch support.

Living in settled accommodation is deemed to improve safety and reduce the risk of social exclusion. Maintaining settled accommodation and providing social

²¹ Community based services include:- Home care, day care, short term residential (not respite), direct payments and professional support

²² People with Learning Disabilities 2012 – Learning Disabilities Observatory PHE

care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care. The Public Health Outcomes Framework (PHOF) reflects that in Bromley, 68.10% of adults with a learning disability live in stable and appropriate accommodation compared to 73.50% in London and 58.50% in England.

Disability Hate Crime

The combined 2011/12 and 2012/13 Crime Survey for England and Wales dataset indicates that there were 62,000 disability motivated hate crimes per year on average.

In 2012/13, the police recorded 1,841 disability hate crimes as compared with 1,757 offences the previous year (a 5% increase). Disability hate crimes accounted for four percent of all hate crimes recorded by the police in 2012/13. There was little variation in the proportion recorded by forces with the exception of Norfolk or Suffolk whose disability hate crimes accounted for 19 per cent and 20 per cent respectively of all hate crimes those forces recorded.

A third (32%) of disability hate crimes involved violence against the person; of these offences, 61% involved injury. Public order offences accounted for 30% of disability hate crimes.

In Bromley, the Disability Hate Crime Project is a partnership of disability organisations that has been established by Community Links Bromley in association with the Metropolitan Police, to tackle the issues of disability hate crime throughout the London Borough of Bromley. The aims of the project are:

- To work with the Metropolitan Police to up-skill members of the force in recognising and responding appropriately to disability hate crimes
- To raise awareness across the public sector and voluntary and community sector on what a disability hate crime is and the role that people and organisations can play both at the preventative stage, as well as responding in sensitive and appropriate ways when hate crimes do occur
- To educate disabled people as to their rights when disability hate crimes occur
- To work with schools to raise awareness of disability hate crime

Additional Work

Bromley is working on implementing changes to the Care Act. Through the Travel Training programme, Bromley has supported over 20 pupils with learning

disability to become independent travellers opening up opportunities to participate in further and higher education, work experience/employment opportunities.

Children and Families Bill

For detail on implementation of the Children and Families Bill, which has signalled far reaching reforms for children and young people with special educational needs and disabilities, and their families, as part of a new birth to age 25 Special Educational Needs system, please see Section 6.2

Table 8. 2: Learning Disability Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	Persons	18-64 yrs	2011/12	57.80	65.7	70
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	Persons	18-64 yrs	2012/13	52.40	68.1	73.5
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	Male	18-64 yrs	2012/13	51.00	66.6	73.2
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	Female	18-64 yrs	2012/13	54.60	70.1	74
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	Persons	18-64 yrs	2011/12	56.20	9.0	7.1

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

What does this mean for the residents of Bromley?

- There is a need to improve the identification of people with learning disabilities in primary care
 - promote the use of patient held Health Action Plans and hospital passports where appropriate
 - raise awareness of the liaison nurse role/contact details within the local hospital(s)
- There is a considerable shortfall in the numbers of people identified with learning disability who have had an annual health check
- The NHS Health Check has been adapted for people with a learning disability and is being undertaken by members of the integrated team
- Further work to be undertaken to raise awareness with GPs of Health Checks
- Promoting independence of people with learning disabilities through schemes such as the travel training programme

For more information please contact Catriona.Ellis@Bromley.gov.uk

9. Sensory Impairment and Physical Disability

Introduction

This section focuses on the needs of the Borough's adults with sensory impairment and physical disabilities. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- Hearing impairment
- Sight impairment
- Physical disabilities

Hearing Impairment

Nationally, the Action on Hearing Loss report 'Hearing Matters' states, that in 2011, hearing loss affected more than 10 million people in the UK (one in six of the population). By 2031, it is estimated that this figure will have risen to 14.5 million. The World Health Organisation predicts that by 2030, adult onset hearing loss will be in the top 10 disease burdens in the UK and other high and middle income countries, above cataracts and diabetes.

There are four different levels of hearing loss defined as:-

- **Mild hearing loss** – can sometimes make following speech difficult, particularly in noisy situations
- **Moderate hearing loss** – may have difficulty following speech without hearing aids
- **Severe hearing loss** – usually need to lipread or use sign language, even with hearing aids
- **Profound deafness** – usually need to lipread or use sign language

Hearing loss has significant personal and social costs and can lead to high levels of isolation and consequent mental ill health, more than doubling the risk of depression in older people. People with mild hearing loss also have nearly double the chance of developing dementia and this risk increases significantly for those with moderate and severe hearing loss. People with hearing loss are likely to withdraw from social activities involving large groups of people ²³

A 2005 MORI Poll of more than 2,000 people showed that almost a quarter (22%) are worried that people will think they are getting old if they wear a hearing aid.

Age related damage to the cochlea, or presbycusis, is the single biggest cause of hearing loss. This process occurs naturally as part of the ageing process.

²³ RNID, Hidden Crisis 2009

The vast majority of people with hearing loss are older and the prevalence increases with age²⁴.

People with hearing loss may also have other additional disabilities or long term health conditions that limit their daily activities such as arthritis and mobility problems. This includes half of older people,²⁵ whilst as many as 40% of deaf children will have additional or complex needs²⁶. This often means that barriers to inclusion and feelings of isolation are compounded, so managing hearing loss can be fundamental to effective management of other conditions²⁷.

An estimated 250,000 people will have dual sensory loss and this number is set to grow as the population ages, however this is considered a gross underestimate²⁸. People with hearing loss are also highly likely to have problems such as tinnitus and balance disorders which contribute as risk factors for falls and other accidental injuries²⁹.

There are more than 45,000 deaf children across the UK³⁰ and many more children experience temporary conditions as a result of conditions such as glue ear. Half of all deaf children are born deaf, whilst half acquire deafness during childhood³¹.

In 2009 in England, 71% of deaf children failed to achieve the government benchmark of five GCSEs at grades A* to C, including English and Maths. Research conducted in 2007 found that even at times of low unemployment, people with severe and profound levels of deafness were four times more likely to be unemployed than the general population.

In Bromley, there are over 31,000 adults over the age of 18 years with moderate or severe hearing impairment (predicted to rise to 35,000 by 2020) and a further 698 with profound hearing impairment (predicted to rise to 813 by 2020).

The number of people with moderate or severe hearing impairment increases with age up to the age of 85 years. The number of people with profound hearing impairment also increases with age, but doubles beyond the age of 85 years³².

²⁴ Davis 1995

²⁵ RNID Annual Survey 2010

²⁶ NDCS Policy on Audiology 2010

²⁷ RNID Annual Survey 2008

²⁸ Deafblind UK 2006

²⁹ Davis et al 2007

³⁰ NDCS 2009

³¹ NDCS Technology Appraisal 2007.

³² Projecting Adults Needs and Service Information System. Projecting Older People Population Information System. January 2014

The London Borough of Bromley has one full time equivalent member of staff based with Deaf Access to undertake assessments both for social care and equipment, for residents with a hearing impairment.

Sight Impairment

Nationally, the World Health Assembly views blindness as a public health issue directly linked with lifestyle and demographic factors³³. Currently, almost 2 million people in the UK are living with some degree of sight loss and this number is rapidly increasing. This figure includes around 360,000 people registered as blind or partially sighted, who have severe and irreversible sight loss³⁴. By 2050, it is predicted that four million people will have sight loss.

The UK population is ageing, and it is projected to continue to age over the next few decades, with the fastest population increases in the numbers of those aged 85 and over. This is the age group more at risk of eye disorders causing vision impairment³⁵.

Two thirds of registered blind and partially sighted people of working age are not in paid employment³⁶, and nearly half of blind and partially sighted people feel 'moderately' or 'completely' cut off from people and things around them³⁷.

Sight loss impacts on a community on many different levels: on a personal level it can be a deeply traumatic life event. On an economic level, it is estimated that in 2008, sight loss cost the UK £22 billion.

The Bromley Vision Strategy February 2013 has found that:-

- **Ageing** is a risk factor in many eye conditions and in other health conditions which may lead to sight loss.
- **Smoking** increases the risk of sight loss; smokers are 50% more likely to develop macular degeneration than non-smokers and to do so at an early age. Bromley's smoking prevalence is the 16th highest in London at 18.1% compared to the 20% England average.
- **Obesity** has been shown to be a risk factor in all four major eye diseases, Macular Degeneration, Glaucoma, Diabetic Retinopathy and Cataracts. The 2014 Health Profile gives a modelled estimate for obesity prevalence in Bromley of 21.2% of those aged 16 years and over, representing approximately 54,000 adults.
- There are clear associations between excessive consumption of **alcohol** over a sustained period of time and the development of all four main eye

³³ Bromley Vision Strategy, February 2013

³⁴ Access Economics 2009

³⁵ UK Vision Strategy 2013-2018

³⁶ Douglas et al, Network 1000, 2006

³⁷ Pey, Nzegwu and Dooley, 2006

diseases. In addition, alcohol consumption by women during pregnancy has also been linked to ocular abnormalities in children.

- The restriction of blood to the eye (as occurs with high blood pressure) can cause damage to the retina and result in deterioration of eye health. Heart health and good circulation are therefore essential to maintaining good health. In Bromley, the prevalence of hypertension is higher than the national average. In 2012-13, there were approximately 46,000 people on Bromley GP hypertension registers. This is likely to further strain the provision of local sight loss services.
- **Stroke** is a risk factor in the development of visual impairment and will have an impact on the provision of local visual impairment services.
- **Diabetes** is the leading cause of sight loss in working age people. As such, it could be considered to be one of the most economically damaging factors leading to sight loss. In 2013 there were 13,681 people in Bromley diagnosed with Diabetes. This reflects a continuous rise in the prevalence over the last 11 years from 1.6% to 5.2%. Given that 40% of people with Type 1 Diabetes and 20% of those with Type 2 Diabetes will go on to develop Diabetic Retinopathy, Diabetic related visual impairment will become a major pressure on local low vision and rehabilitation services.

People with Learning Disabilities are ten times more likely to have eye problems than the rest of the population³⁸. A pathway for adults and young people with learning disabilities has been developed by the Local Optical Committee Support Unit (LOCSU) to ensure that it reflects the needs of people with learning disabilities and is based on established successful learning disability services provided by community optometrists in a number of areas in England.

In Bromley, the numbers of adults between the ages of 18 and 64 years of age with a serious visual impairment is 124, predicted to rise to 135 by 2020³⁹.

In the older age groups (over 65 years) there are larger numbers of people with moderate or severe visual impairment, 4,851 (predicted to rise to 5,416 by 2020). Age related macular degeneration is the most common cause of registrable sight loss in older people.

Physical Disabilities

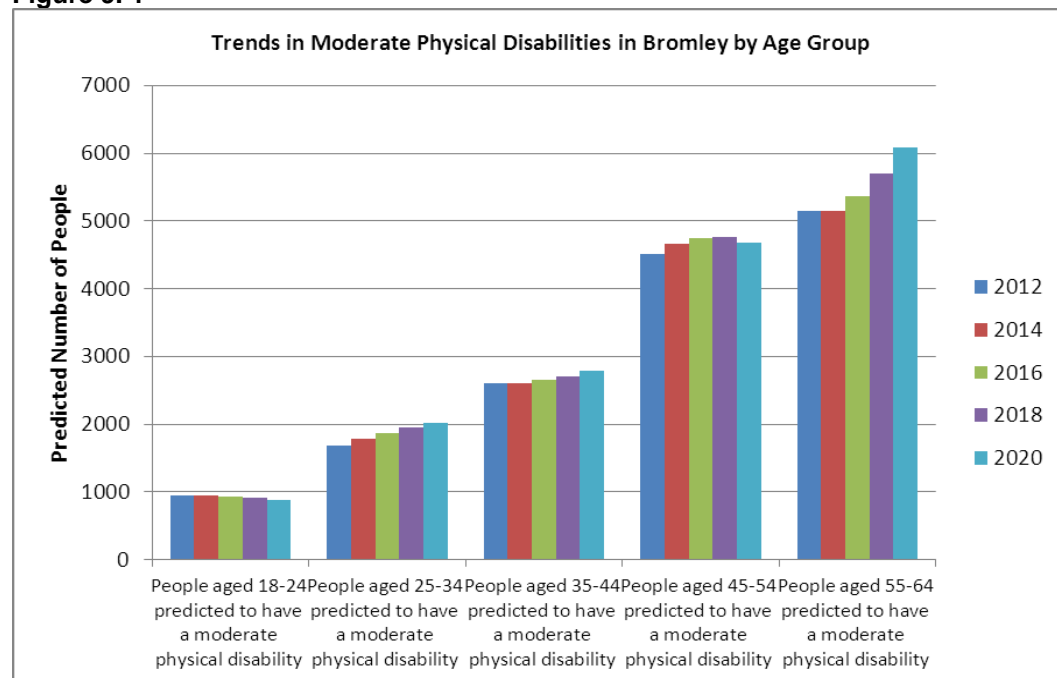
It is estimated that there are 19,316 people of working age in Bromley who have a physical disability or sensory impairment, about 10% of the population aged 18-64. This figure is projected to increase to 21,332 by the year 2020⁴⁰

³⁸ See Ability and RNIB 2011

³⁹ Projecting Older People Population Information System January 2014

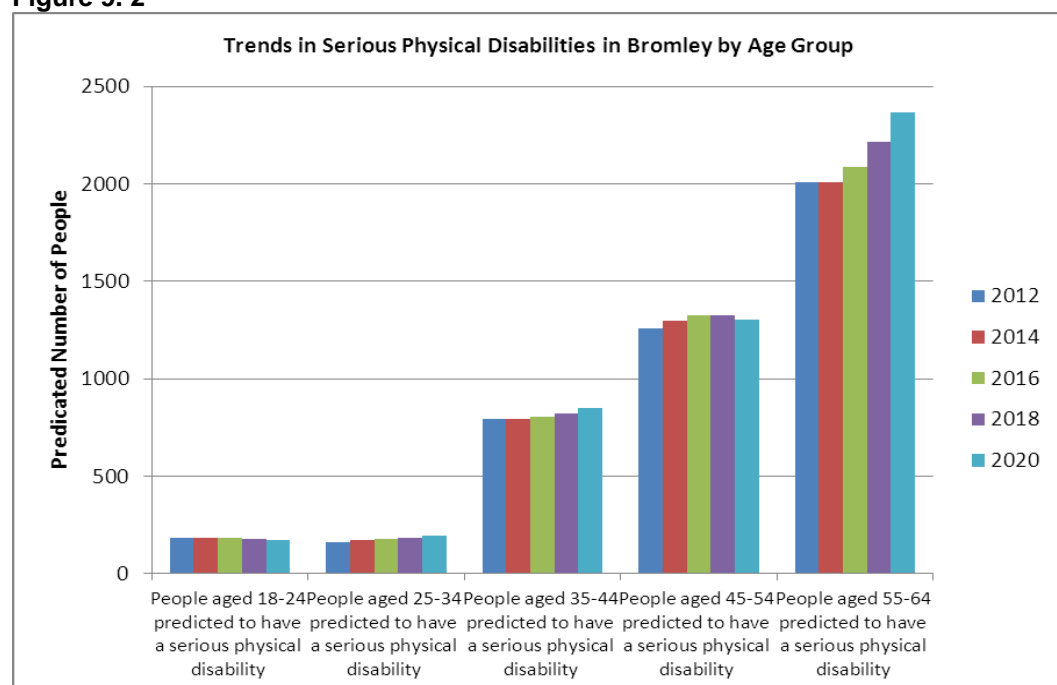
The graphs below show that the numbers of people with physical disability increase markedly with age.

Figure 9. 1



Source: Projecting Older People Population Information System January 2014

Figure 9. 2



Source: Projecting Older People Population Information System January 2014

⁴⁰ Projecting Adult Needs and Service Information January 2014

The Bromley needs assessment for people with Physical Disability and Sensory Impairment (June 2011) identified the following priorities

- Disability awareness among staff and public,
- Empowering people with disabilities
- Accessible public transport to enable independent travel
- Access to services and premises within the borough
- Paid and unpaid employment opportunities.

Progress to date

Staff training is currently being addressed in LBB, and improving accessibility has been made a priority. Transport issues are being addressed by the Mobility Forum, which has contributed extensively to the development of Bromley South station, and is contributing to plans at Bromley North.

A new Vision Strategy group has been set up, with support from external specialist agencies, and a strategy developed. A counselling support group for newly registered people with visual impairment has been set up and early reports say that this is very much appreciated by, and beneficial to, participants.

Disabled Go has performed an annual review of venues in Bromley this year and has reported a number of improvements relating to access, with 24% of venues implementing non-structural changes such as:

- The introduction of disability equality training
- Provision of hearing assistance
- Provision of an email address as an alternative method of contact.

In addition, 5% of venues had some form of structural change to improve access, and encouragingly these premises included GP and dental surgeries, pharmacies and opticians.

The government's Health and Social Care reforms, changes in the way benefits are provided and stricter criteria for access to those benefits, such as mobility allowance, will all have an impact on local disabled people.

For more information please contact Catriona.Ellis@Bromley.gov.uk

10. Mental Health

Introduction

Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential. Moreover good mental health and wellbeing also bring wider social and economic benefits.

Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality and higher levels of social interaction and participation.

Some mental health problems are long lasting and can significantly affect the quality of people's lives, especially if they are not treated. Some people only experience a single episode of mental ill health. Others, who may have longer standing problems, can enjoy a high quality of life and fulfilling careers. However, the personal, social and economic costs of mental ill health can be considerable.

Key Health Issues

Having mental health problems is distressing to individuals, their families, friends and carers, and affects their local communities. It may also impact in all areas of people's lives. People with mental health problems often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation. They are more likely to have poor physical health.

Mental Health can also contribute to perpetuating cycles of inequality through generations. However, early interventions, particularly with vulnerable children and young people, can improve lifetime health and well-being, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. Such interventions not only benefit the individual during their childhood and into adulthood, but also improve their capacity to parent, so their children in turn have a reduced risk of mental health problems and their consequences.

Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16-25 years sooner than the

general population. They have higher rates of respiratory cardiovascular and infectious disease and of obesity, abnormal lipid levels and diabetes. They are also less likely to benefit from mainstream screening and public health programmes.

Increased smoking is responsible for most of the excess mortality of people with severe mental health problems. Adults with mental health problems, including those who misuse alcohol and drugs, smoke 42% of all tobacco used in England. Over 40% of children who have conduct and emotional disorders are smokers.

Mental health problems, such as depression, are also much more common in people with physical illness and having both physical and mental health problems delays recovery from both. Children with a long term physical illness are twice as likely to suffer from emotional or conduct disorder problems. People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven more times more likely to have depression. Adults with both physical and mental health problems are less likely to be in employment.

Adult Mental Health Need in Bromley

Nationally, mental health/psychological symptoms are common in the adult population affecting up to 1 in 3 people. Applied to Bromley, this prevalence would mean that 64,000 people are suffering from one of these symptoms at any one time. About half of those with symptoms, 1 in 6, will suffer from a recognised mental health problem including depression, phobias, obsessive compulsive disorder, panic disorder, generalised anxiety disorder and mixed anxiety and depressive disorder. In Bromley this would equate to about 32,000 people, of whom about 4,000 people will be known to secondary care services such as Oxleas Foundation Mental Health Trust.

Table 10.1 below shows the estimated number of people with a variety of conditions and predicted numbers for future years. It should be noted that the survey upon which the figures are based only included people living in private households. Common mental disorders include different types of depression and anxiety and women are more likely to be affected than men. Those with a common mental disorder are mostly likely to be treated in primary care. Data from GP registers in 2012/13 shows that the prevalence of people with depression over 18 in Bromley is higher (6%) than the average in England (5.8%).

Table 10. 1: Bromley - People aged 18-64 predicted to have a mental health problem projected to 2020

People aged 18-64 predicted to have:	2012	2014	2016	2018	2020
Common mental disorder	30,949	31,581	32,341	33,121	33,837
Borderline personality disorder	868	886	907	929	949
Antisocial personality disorder	652	665	681	698	713
Psychotic disorder	770	785	804	824	841
Two or more psychiatric disorders	13,757	14,038	14,377	14,723	15,040

Source: POPPI Based upon Adult Psychiatric Morbidity in England, 2007 (does not include people in secondary care) and ONS data

Over 2,600 people in Bromley (almost 1% of the adult population) have been identified by GPs as experiencing serious mental illness, as illustrated in **Table 10.2** below.

Table 10. 2: Quality and Outcomes Framework Serious Mental Illness Prevalence

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

Source: HSCIC/ QOF, 2014

Bromley Community Mental Health Profiles, 2013

The Community Mental Health Profiles (CMHP) present a range of mental health information for Local Authorities in England. The CMHP are designed to give an overview of mental health risks, prevalence and services at a local, regional and national level using an interactive mapping tool. The data should be used to inform commissioners of health and social care services in their decision making, leading to the improvement of mental health, and mental health services. In Bromley, the CMHP demonstrates the need to consider the following:

- The rate of homelessness households is significantly worse than the England rate but similar to the regional rate.
- Percentage of adults aged 18+ with depression is significantly higher at (6%) than both England (5.8%) and London (4.4%).

- The ratio of recorded to expected prevalence of dementia, 2010/11 is significantly lower than both England and London rates. This indicates that there is under identification of dementia in Bromley.
- The rate of hospital admissions for unipolar depressive disorders is significantly higher than England rate (39.3/100,000 population and 32.1/100,000 population respectively).
- The rate of people using adult and elderly NHS secondary mental health services is significantly higher than the England rate.
- The rate of in year bed days for mental health is significantly higher than the England rate but lower than the London rate.
- The rate of contacts with Community Psychiatric Nurses were significantly higher than England but similar to regional rates.
- The rate of contacts with mental health services is significantly higher than the England rate but similar to the regional rate.

These findings will be used to inform the development of mental health services provision for Bromley over the next three years.

Mental Health and Older People

Bromley has the highest number of people aged 65+ years and 85+ years in London and is projected to continue to have the highest number in these age groups. People over 65 in Bromley make up approximately 17.74% of the population in 2014.

Population projections indicate that the older population in Bromley is due to rise by 4% that is 2,542 people between 2014 and 2019. The largest rises are expected to be in the 65 - 74 years group.

The number of older people living alone is predicted to increase in line with the general rise in numbers of older people, which may lead to an increase in social isolation.

The second National Psychiatric Morbidity Survey (2007) showed that in this age group there were lower rates of common mental health problems such as worry, irritability and depression compared to the adult population.

Table 10. 3 :Estimated percentage of older people with depressive illness in England and Wales, and estimated numbers for Bromley

Mental Health Condition	% of older adults	Estimated number of people in Bromley aged 65+
Major depression	3-5%	1,561 - 2,602
Minor depression	10-15%	5,204 - 7,806

Census 2011 population

A study carried out by Cambridge University in the same year which focussed on older people showed slightly lower rates for those with depression and severe depression. The overall prevalence of depression was 8.7%, increasing to 9.7% if subjects with concurrent dementia were included. Depression was more common in women (10.4%) than men (6.5%) and was associated with functional disability, co-morbid medical disorder, and social deprivation. Prevalence remained high into old age, but after adjustment for other associated factors, it was lower in the older age groups.

Table 10. 4: Predicted estimates of depression in older people in Bromley from the study by Cambridge University

	2014		2018	
Age breakdown	Depression	Severe depression	Depression	Severe depression
65-69	1,445	425	1300	380
70-74	1,004	194	1269	245
75-79	892	364	909	371
80-84	800	255	800	255
85+	770	332	856	374
65+	4,910	1569	5133	1625

Source: POPPI- data based on ONS population estimates

Dementia

Dementia is clinically defined as an age-related progressive disease associated with cognitive impairment, disorientation, memory loss, change in personality, difficulties with activities of daily living and behaviour that is out of character. (NICE, 2004, Cummings and Jeste, 1999)

A Dementia Needs Assessment carried out in Bromley in 2012 provided information relating to the incidence of dementia in Bromley and included projections of future numbers based on the Dementia UK report of 2007.

It is estimated that there are around 4205 people in Bromley with dementia in 2014. Although the prevalence of dementia is lower in women there are actually more women than men with dementia in Bromley because life expectancy is higher in women. There are more men with dementia in the 65 – 74 age groups, but women outnumber men in the higher age groups. By 2030 the number of people with dementia in Bromley is set to increase to 6,151. Within the next four years there will be an increase of over 300 people with the greatest increase in the over 85 years: as well as dementia this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,400.

Table 10. 5: Predicted estimates of dementia in older people in Bromley

Age breakdown	2014		2018	
	Male	Female	Male	Female
65-69	120	90	105	82
70-74	174	156	220	197
75-79	235	377	240	384
80-85	367	652	367	652
85-89	317	733	384	799
90+	279	706	335	768
65+	1,492	2,713	1,651	2,881
Total Persons (65+ years)	4205		4532	

Source: PANSI data based on ONS population estimates

The Dementia Needs Assessment 2012 also contains information from Healthcare for London which estimated the number of people in Bromley with mild, moderate and severe dementia in the table below. Those with the most severe forms of the condition will have much higher medical, social and mental health needs in comparison to those with mild or moderate disease who may be able to function relatively independently.

Table 10. 6: Estimated number of people with dementia by level of severity in Bromley

Severity of dementia	Number aged 65 and over
Mild	2,008
Moderate	1,190
Severe	482
Total	3,680

Source: POPPI

National, Regional and Local Trends in Suicide Mortality

In London, there were 576 deaths attributed to suicide and undetermined injury in 2012, which equates to a rate of 8.7 per 100,000 population (15+ years) which is lower than the England rate (10.4 per 100,000) and UK rate (11.6/100,000). In 2012, the Bromley rate was 9.5 per 100, 000 population, aged 15+ (PCMD, 2013), an increase from the 2011 rate of 8.45 per 100,000 population aged 15+. The local data should be interpreted with caution as the numbers behind the rates are very small.

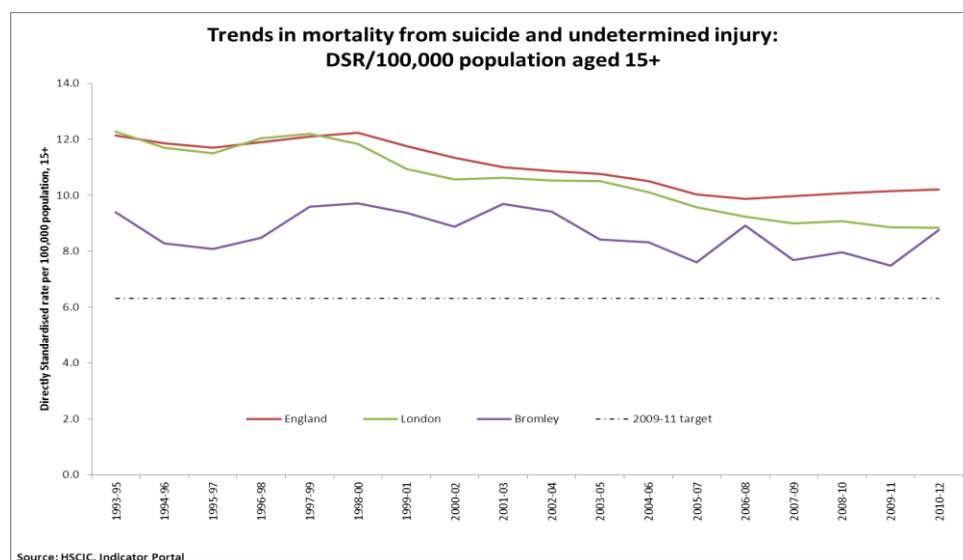
In **figure 10.1**, the mortality rates have been aggregated over three years to increase the number of events to levels which are more statistically meaningful. This shows that mortality rates from suicide and undetermined injury in Bromley have been consistently lower than the London and England rates.

The annual rates will appear to have year to year variability relative to national and London figures because of the small numbers involved locally. **Table 10.7** shows these yearly rates for Bromley.

Table 10. 7 :Annual mortality rates from suicide and injury of undetermined intent

Year	Rate per 100,000
1995	9.98
1996	7.35
1997	6.92
1998	11.18
1999	10.69
2000	7.25
2001	10.19
2002	9.18
2003	9.68
2004	9.37
2005	6.19
2006	9.37
2007	7.24
2008	10.11
2009	5.7
2010	8.3
2011	8.45
2012	9.5

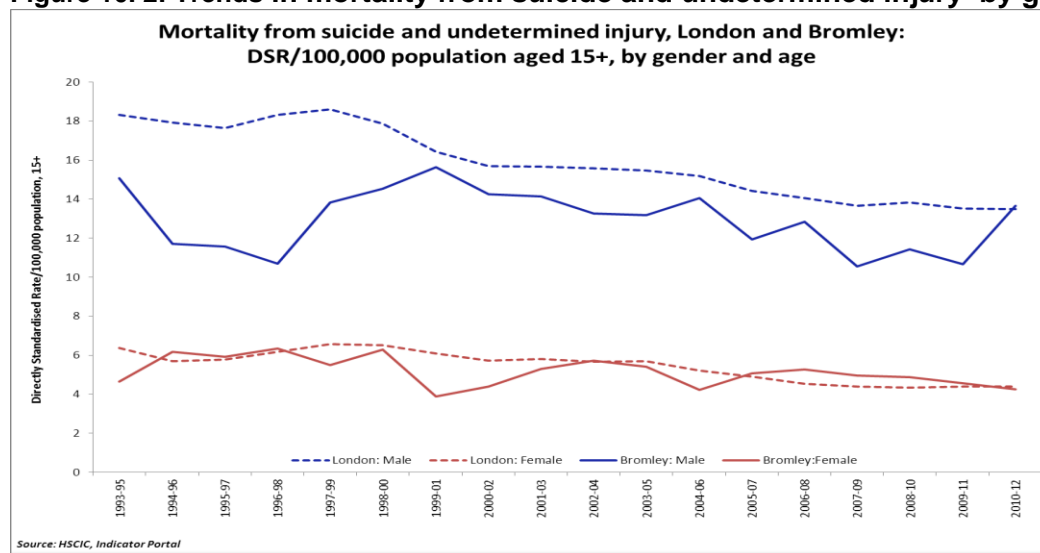
Source: HSCIC, Indicator Portal

Figure 10. 1: Mortality rates from suicide and undetermined intent , all persons-trends

The latest suicide prevention strategy for England [DH, 2014] reiterates the message that suicides are three times more common in males, with middle-aged men continuing to be one of the high-risk groups for suicide prevention

population approaches. A report by the Samaritans suggested that middle-aged men, especially those from poorer socio-economic backgrounds are particularly at risk of suicide due to a combination of factors. These include social and cultural changes (for example, rising female employment and greater solo living) that have particularly impacted on the lives of the cohort of men who are now in mid-life [Samaritans, 2012].

Figure 10. 2: Trends in mortality from suicide and undetermined injury by gender



There are gender differences in mortality rates from suicides and undetermined injury. Overall, suicide rates for men are about three times higher than for women. Whilst the rates in Bromley males are lower than the rates in London males, the female rates show no variation over time.

The majority of suicides in Bromley are aged 35 years and over and are mainly males. Although women are less likely to die from suicide and the numbers behind this data are very small, there is an age and gender divide with young females and older females more likely to die from suicides and undetermined injury than women in middle age.

Of the suicide deaths in Bromley in 2012:

- **41% were aged 55 years and over.**

The majority of deaths within this age group had a history of poor physical health and a mental illness diagnosis.

- **41% of deaths had a documented suicide risk.**
- **36% of all the deaths had a record of an underlying health condition such as cancer, COPD or heart disease.**

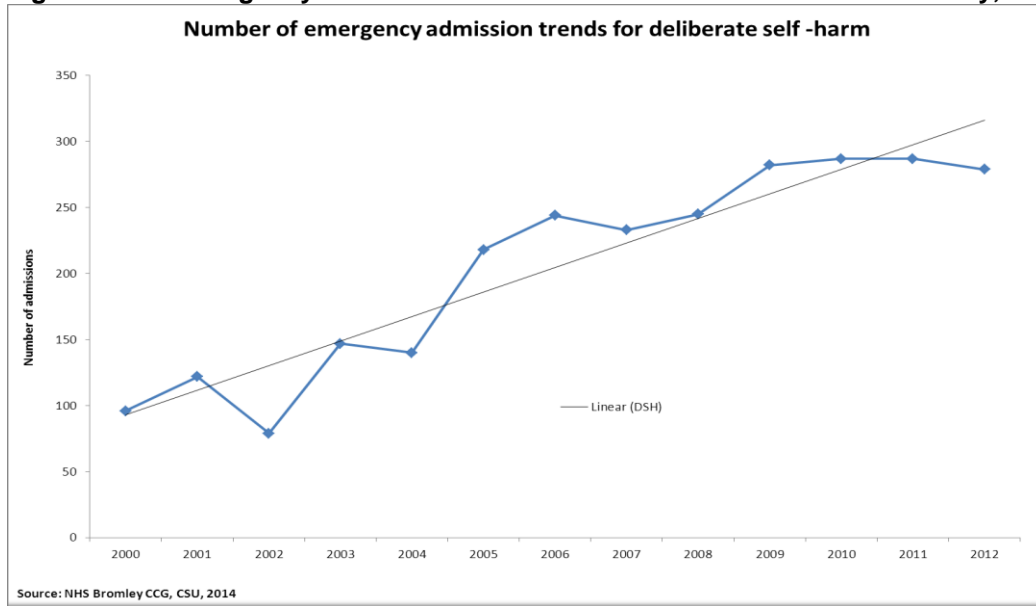
- **32% had a history of self-harm and 1 in 6 had a previous suicide attempt.**
- **55% had had contact with Primary Care within 12 months prior to death.**
- **1 in 2 of all deaths had a previous contact with mental health services.**
- **36% had a diagnosis of mental illness 12 months prior to the death, including depression**
- **9% of all suicides were women**

Deliberate Self Harm

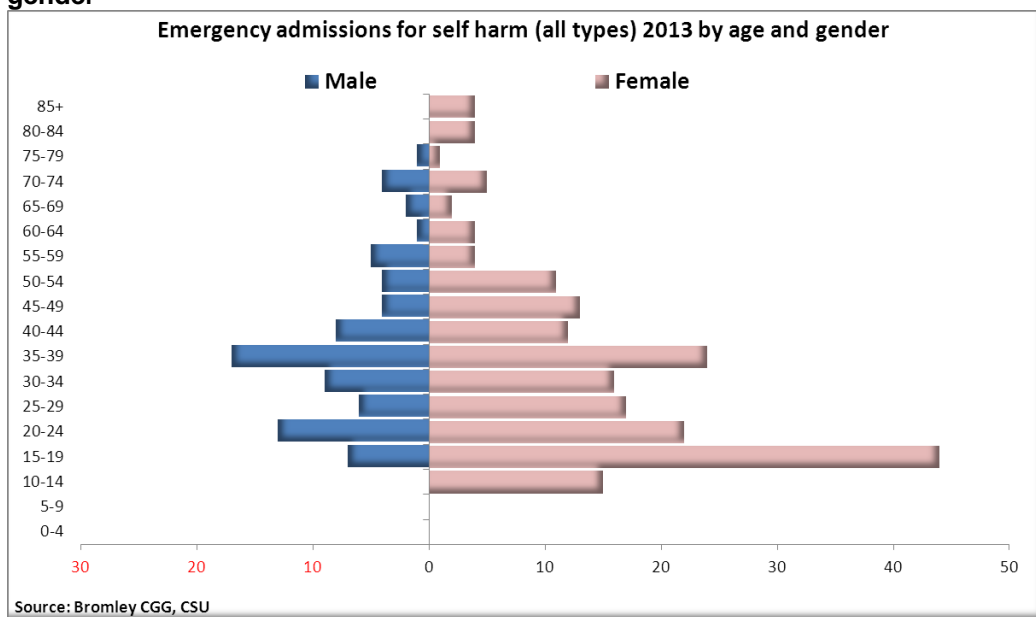
National figures show Deliberate Self Harm (DSH) methods as including overdose, electrocution and wounding, although the most commonly used is self-poisoning, by both men and women. This picture is reflected in Bromley, where self poisoning continues to be the most common method of self-harm across the Borough at 83% of all deliberate self harm in 2012.

Changes within the NHS have led to reduced access to patient identifiable data so it has not been possible to analyse DSH at small area level. National figures demonstrate that DSH acts tend to be concentrated around deprived areas even though the previous data showed, within Bromley, that these acts of self-harm were fairly scattered across the borough. DSH is strongly associated with the manual occupational social groups, the unemployed and socio-economic deprivation.

In 2001 there were 122 hospital admissions for deliberate self-harm in Bromley. In 2012 this number had increased to 279, with a 3% reduction from 2011. Analysis shows an upward trend in the number of emergency admissions for deliberate self-harm.

Figure 10. 3 :Emergency admission trends for deliberate self-harm in Bromley, 2012

There are gender differences in hospital admissions for deliberate self-harm, with more women (71%) being admitted to hospital for self-harm in 2012.

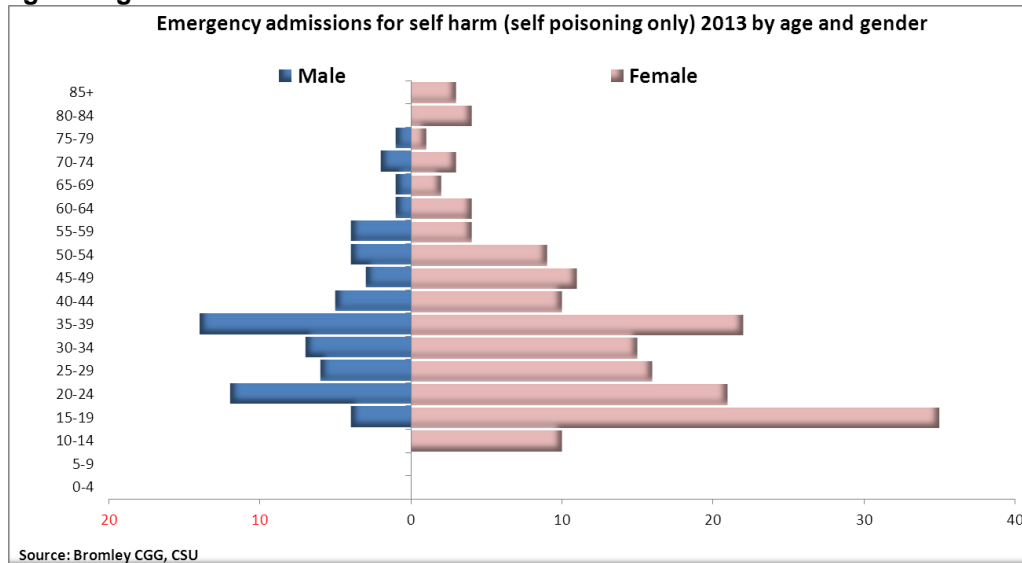
Figure 10. 4: Emergency admissions in Bromley for self-harm (all types), 2012 by age and gender

The 15 -19 year old age band has the highest (18%) percentage of admissions following self-harm, numbers remain high throughout life up to the age of 49 years for women. Deliberate self-harm is a way of coping with life and most commonly starts in teenage years.

There is a link between self-harm and completed suicide reported by the Samaritans (1998), one out of every 100 attempts will result in death within one year.⁹

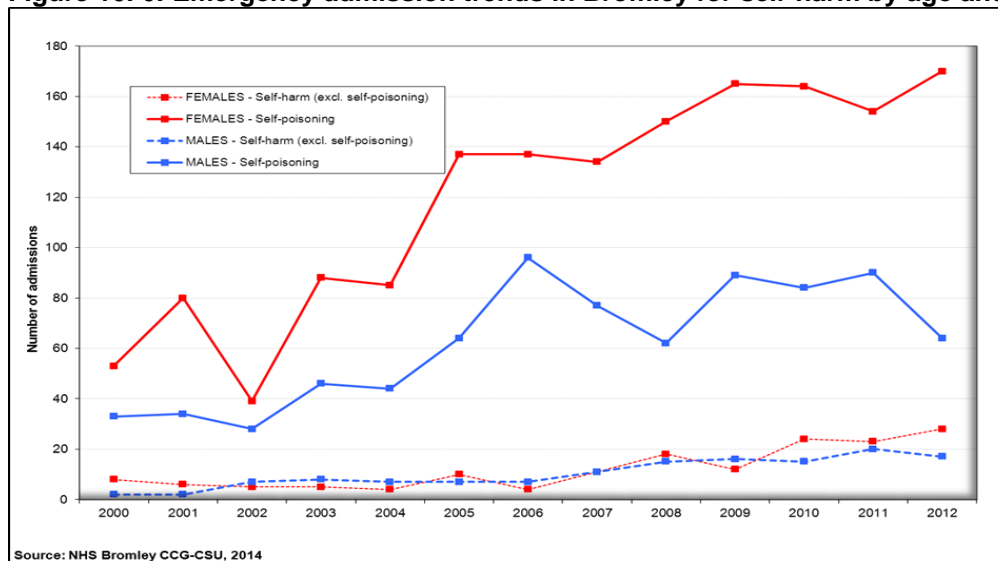
Figure 10.5 shows women of all age groups self-poison more than men, with younger girls more at risk. **Figure 10.6** shows a rising trend of self-harm in Bromley, with self-poisoning as the increasingly preferred method.

Figure 10. 5: Emergency admissions in Bromley for self-harm (self- poisoning only) by age and gender



73% of emergency admissions for self-harm are females following self-poisoning with drugs.

Figure 10. 6: Emergency admission trends in Bromley for self-harm by age and gender



Links between Mental Well-being and Physical Health

Over the last twenty years more evidence has become available on the impact of mental health on physical health.

It may be that poverty, inequality and social exclusion affect physical health via their impact on mental health. It has been found, as a result of studies that explore the impact of mental health on physical health and physical illness, that depression increases the risk of heart disease fourfold. This increased risk is sustained after controlling for other known risk factors e.g. smoking.

Depression also has a significant impact on health outcomes for a wide range of chronic physical illness, including asthma, arthritis and diabetes. Lack of control at work is associated with increased risk of cardiovascular disease. Emotional well-being is also a strong predictor of physical health.

The impact of physical health on mental well being

The management of long term conditions and maintaining individual's mental wellbeing is a key role for all statutory services. The physical wellbeing of people with mental ill health where long term physical health conditions can also lead to lower life expectancy is now recognised as a priority by both Government and professional bodies.

Bromley Mental Health Key Points:

- One person in six has a mental health problem at any one time, and one in four will have a problem during their lifetime.
- In recognition of the burden of mental ill health caused by moderate depression and anxiety disorders, there is a current strategy for improving access to psychological therapies (IAPT) known to be effective in treating these disorders.
- Bromley has a lower than average suicide rate, in 2012 there were 22 deaths from suicide and undetermined injury.
- Since 2002, there has been a significant increase in admissions for self-poisoning. In 2001 there were 122 hospital admissions for Deliberate Self Harm. In 2013 this number had increased to 279 where 83% of these admissions were for self- poisoning.

- Estimates have suggested that the cost of treating mental health problems could double over the next twenty years. More than £2 billion is spent annually on social care for people with mental health problems.
- Mental health problems such as depression are also much more common in people with physical illness, and having both physical and mental health problems delays recovery from both. Children with a long term physical illness are twice as likely to suffer from emotional or conduct disorder problems.
- Having a mental health problem increases the risk of physical ill health. People with mental health problems such as schizophrenia or bipolar disorder die on average 16-25 years sooner than the general population.
- People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven more times more likely to have depression. Adults with both physical and mental health problems are less likely to be in employment.
- In total, it is estimated that there are over 4,200 people in Bromley with dementia in 2014. By 2030 the number of people with dementia in Bromley is set to increase to 6,151. Within the next four years there will be an increase of over 300 people with the greatest increase in the over 85 year age group: as well as dementia this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,400.

Table 10. 8: Mental Health Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	Persons	18-69 yrs	2012/13	73.30	79.40	58.50
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	Persons	18-69 yrs	2012/13	67.40	62.60	62.30
2.23i - Self-reported well-being - people with a low satisfaction score	Persons	16+ yrs	2011/12	6.74	6.93	6.65
2.23i - Self-reported well-being - people with a low satisfaction score	Persons	16+ yrs	2012/13	5.97	6.26	5.77
2.23ii - Self-reported well-being - people with a low worthwhile score	Persons	16+ yrs	2011/12	4.78	5.15	4.87
2.23ii - Self-reported well-being - people with a low worthwhile score	Persons	16+ yrs	2012/13	4.08	4.19	4.36
2.23iii - Self-reported well-being - people with a low happiness score	Persons	16+ yrs	2011/12	8.04	11.17	10.84
2.23iii - Self-reported well-being - people with a low happiness score	Persons	16+ yrs	2012/13	7.59	10.33	10.36
2.23iv - Self-reported well-being - people with a high anxiety score	Persons	16+ yrs	2011/12	22.59	23.94	21.82
2.23iv - Self-reported well-being - people with a high anxiety score	Persons	16+ yrs	2012/13	23.59	22.37	20.98
4.10 - Suicide rate	Persons	All ages	2001 - 03	9.09	11.02	10.53
4.10 - Suicide rate	Persons	All ages	2002 - 04	9.16	11.13	10.45
4.10 - Suicide rate	Persons	All ages	2003 - 05	8.38	11.11	10.36
4.10 - Suicide rate	Persons	All ages	2004 - 06	8.27	10.65	10.09
4.10 - Suicide rate	Persons	All ages	2005 - 07	7.37	9.42	9.20
4.10 - Suicide rate	Persons	All ages	2006 - 08	8.05	8.44	8.63
4.10 - Suicide rate	Persons	All ages	2007 - 09	6.66	7.60	8.31
4.10 - Suicide rate	Persons	All ages	2008 - 10	6.85	7.62	8.39
4.10 - Suicide rate	Persons	All ages	2009 - 11	6.29	7.55	8.48
4.10 - Suicide rate	Persons	All ages	2010 - 12	7.49	7.49	8.49
4.10 - Suicide rate	Male	All ages	2001 - 03	12.54	16.22	16.12
4.10 - Suicide rate	Male	All ages	2002 - 04	12.38	16.48	15.88
4.10 - Suicide rate	Male	All ages	2003 - 05	11.90	16.42	15.74
4.10 - Suicide rate	Male	All ages	2004 - 06	13.69	16.20	15.40
4.10 - Suicide rate	Male	All ages	2005 - 07	11.27	14.31	14.19
4.10 - Suicide rate	Male	All ages	2006 - 08	11.63	13.04	13.43
4.10 - Suicide rate	Male	All ages	2007 - 09	8.75	11.66	12.98
4.10 - Suicide rate	Male	All ages	2008 - 10	9.70	11.85	13.07
4.10 - Suicide rate	Male	All ages	2009 - 11	8.95	11.55	13.18
4.10 - Suicide rate	Male	All ages	2010 - 12	11.59	11.48	13.27
4.10 - Suicide rate	Female	All ages	2001 - 03	5.52	6.14	5.34
4.10 - Suicide rate	Female	All ages	2002 - 04	6.05	6.10	5.41
4.10 - Suicide rate	Female	All ages	2003 - 05		6.14	5.39
4.10 - Suicide rate	Female	All ages	2004 - 06		5.53	5.18
4.10 - Suicide rate	Female	All ages	2005 - 07		4.89	4.56
4.10 - Suicide rate	Female	All ages	2006 - 08		4.15	4.13
4.10 - Suicide rate	Female	All ages	2007 - 09		3.78	3.92
4.10 - Suicide rate	Female	All ages	2008 - 10		3.69	4.00
4.10 - Suicide rate	Female	All ages	2009 - 11		3.82	4.05
4.10 - Suicide rate	Female	All ages	2010 - 12		3.79	3.98

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

- **What does this mean for residents and for children in Bromley**
 - The percentage of over 18s with depression is significantly higher in Bromley than the percentages for both England and London.
 - Overall, suicide rates for men in Bromley are about three times higher than for women.
 - In 2012, 91% of all people dying by suicide were men, of which the 45 years and over age group had the highest number of male deaths.
 - In 2012 there were 279 hospital admissions for deliberate self-harm (a significant increase from the 122 in 2001). 83% of these admissions were for self-poisoning.
 - The 15 -19 year old age group have the highest number of admissions following self-harm, numbers remain high for women throughout life up to the age of 49.
 - Within the next four years there will be an increase of nearly 300 people with dementia, with the greatest increase in the over 85 year age group. As well as suffering from dementia, this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,400.
 - The ratio of recorded to expected prevalence of Dementia is significantly lower in Bromley than both the England rate and the London rate thus the implementation of the Prime Minister's challenge on Dementia is important to improve this position.
 - Implementation of the Mental Health Strategy and CCG Mental Health Programme are key tasks over the next few years, in particular the development of Primary Mental Health Care Services.
-
- ***Substance and Alcohol Misuse are dealt with in section 13 and 14 respectively of the JSNA***
 - ***Deliberate Self Harm in children has been discussed in detail in the Children and Young People section of the JSNA.***

11. End of Life Care

Introduction

It is recognised that good quality end of life care is critically important in giving the individual patient and their family a positive experience of care at what can be a difficult time in their lives.

Therefore it is recognised that there is value in identifying this group of patients correctly and in raising awareness of good end of life care through education particularly for health and social care professionals.

The Gold Standards Framework is the nationally recognised framework which guides health and social care professionals at this time of care. Good end of life care should occur in partnership with individual patients and their families allowing them to make well informed decisions and choices.

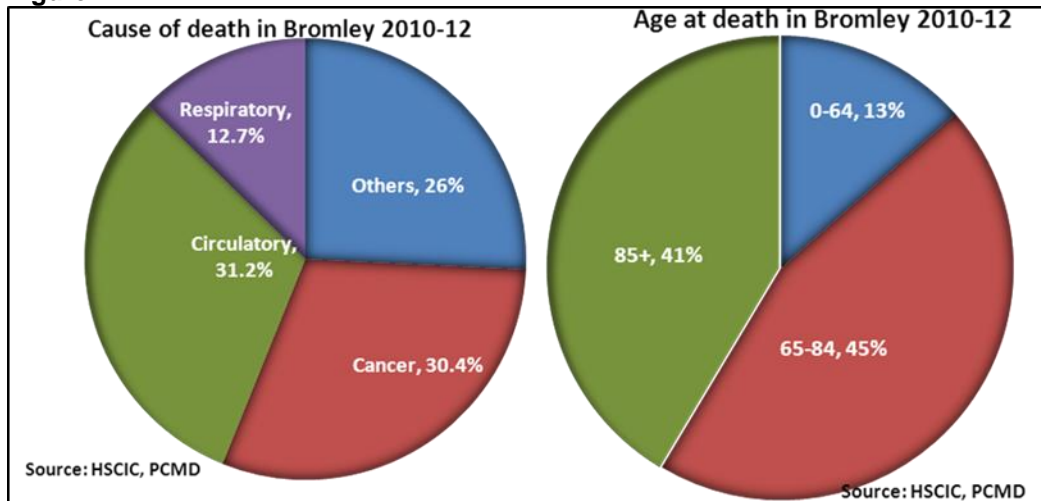
Evidence suggests that the majority of people (between 57%-74%) express a preference to die at home. The proportion of deaths at home is used as a proxy indicator for provision of end of life care and a higher proportion of deaths at home is considered desirable.

The previous JSNA showed little change in trends in Bromley in recent years between those people dying at home versus those dying hospital, but an increase in trend of these people dying in care homes. It also showed progress in implementing the Gold Standards Framework in care homes and primary care, part of which encourages patients to consider an advanced care plan.

It is further recognised that many services of both the health and social care sectors may be involved in an individual's care at this time in their lives. How services are co-ordinated around a patient and communicate together for a common goal will affect the patient's experience of care.

Statistical Analysis

In the period between 2010 and 2012, there were 7658 deaths in Bromley. The majority of these deaths were in those aged over 65 years, and were due to non-cancer causes.

Figure 11. 1

Place of death

Between 2010 and 2012, over half of deaths in Bromley occurred in hospital (53%). This represents a slight decrease in the proportion of deaths occurring in hospital since the 2009-11 period (55% vs. 53%). In terms of home and care home deaths, there has been a small increase in the proportion of people dying in each place between the 2009-11 and 2010-12 periods (20% vs. 21%) and (16% vs. 17%) respectively. There has been no change in the proportion of people dying in a hospice between the 2009-11 and 2010-12 periods in Bromley.

There has been a consistent decrease in proportion of hospital deaths and subsequent increase in deaths in homes, hospices and elsewhere but particularly in care homes. The reduction in hospital deaths is in line with the national end of life care strategy.

Trends in place of death in Bromley 2006-2012

Figure 11. 2

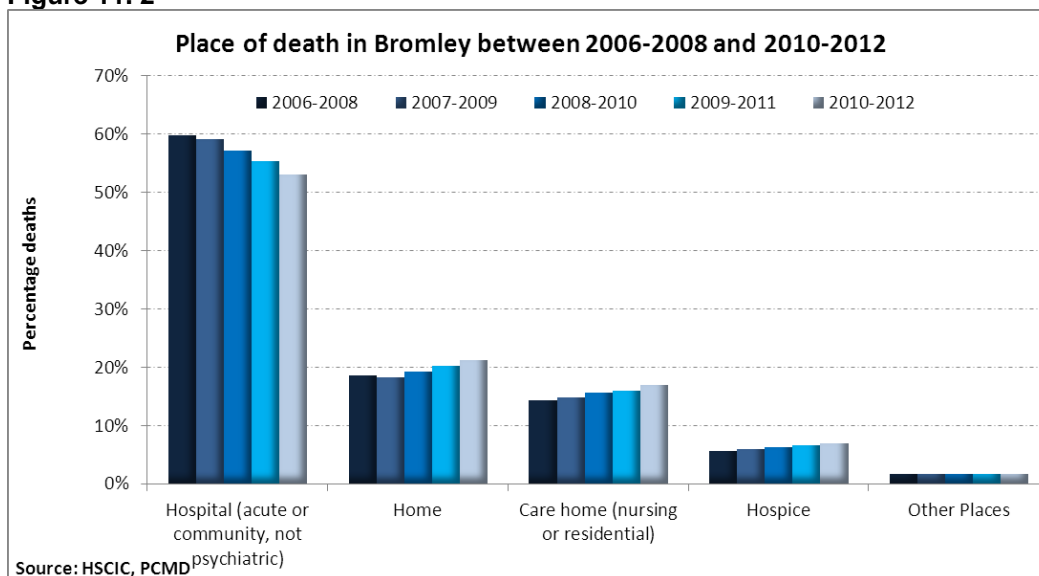
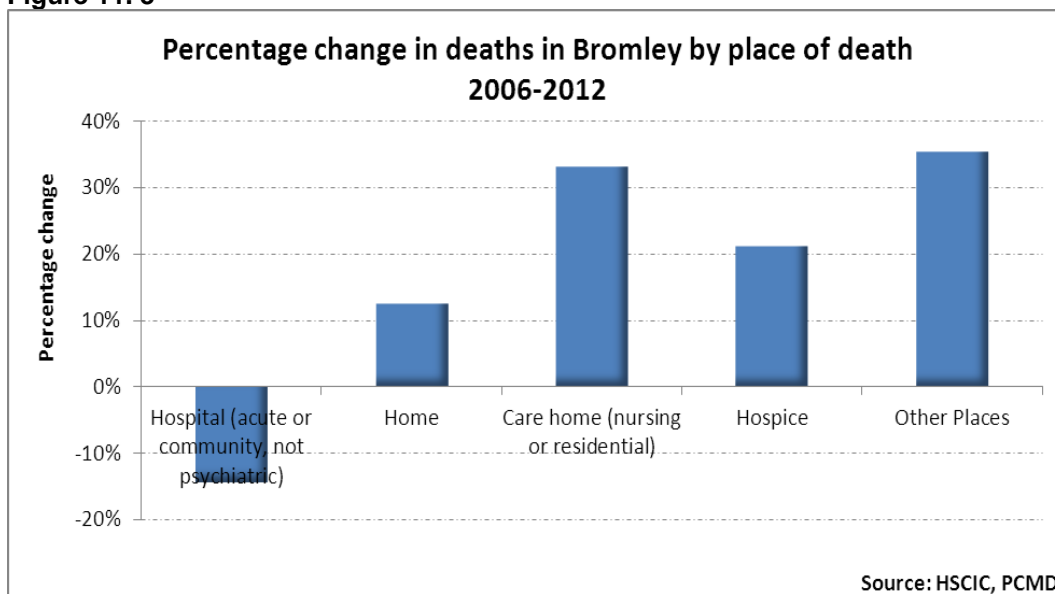
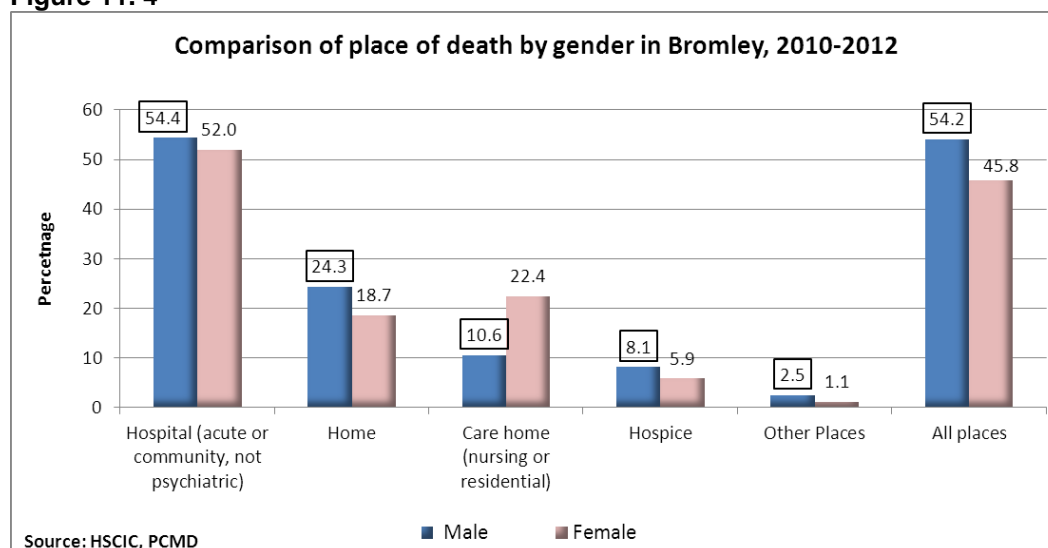


Figure 11. 3



Place of death by gender

Similar to the 2009-11 analysis, there are continued gender variations in place of death in Bromley in 2010-2012. Higher proportions of female deaths continue to occur in care homes than for male deaths (22% vs. 10%). Higher proportions of male deaths also continue to occur in hospital, at home and in hospices in comparison to female deaths. The higher proportion of care home deaths in females reflects the lower life expectancy in men.

Figure 11. 4

Place of death by underlying cause of death

When considering place of death by underlying cause of death, the majority of both cancer and non-cancer deaths occurred in hospital. A significantly higher proportion of cancer deaths occurred in hospices in comparison to non-cancer deaths, as was shown in the 2010-2012 analysis below. A higher proportion of non-cancer deaths occurred in hospital or in care homes than cancer deaths.

Figure 11.6 shows this split by circulatory and respiratory disease.

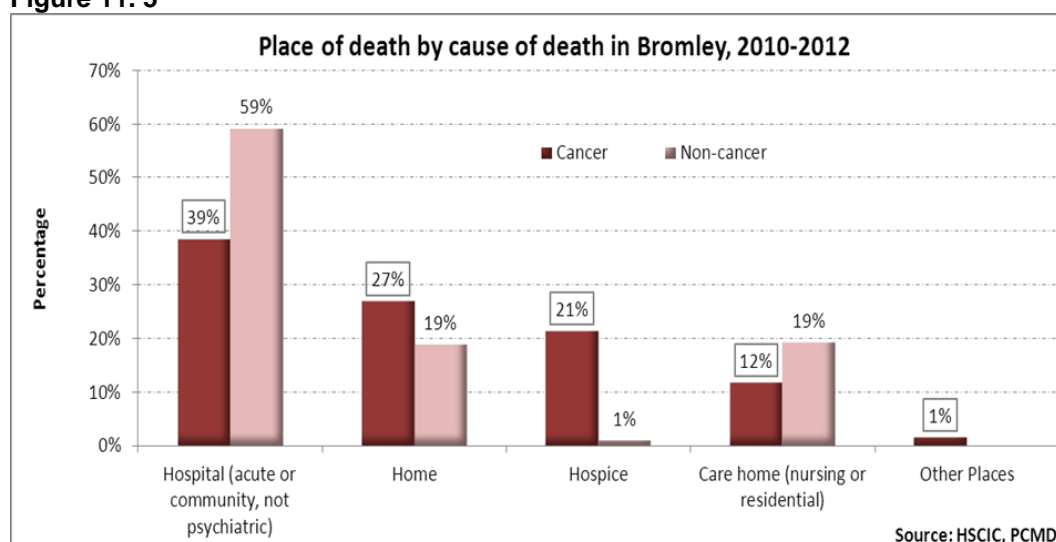
Figure 11. 5

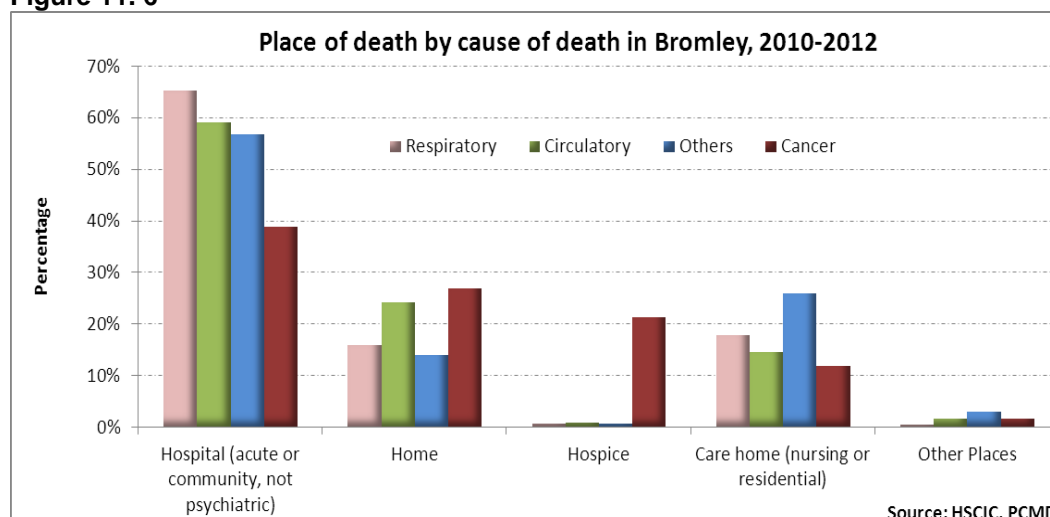
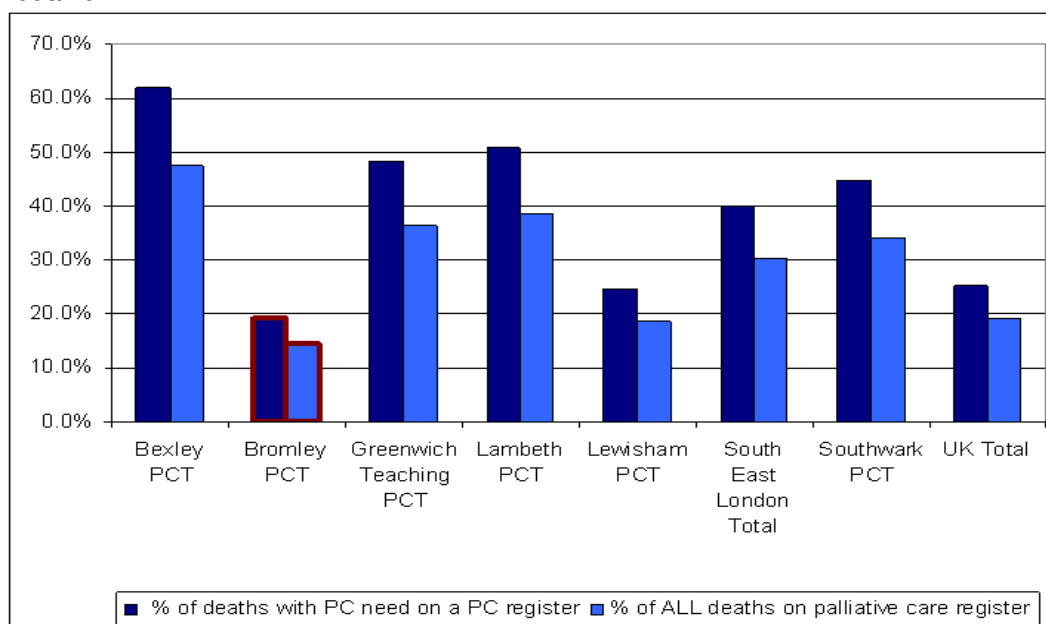
Figure 11. 6

Figure 11.7 suggests that Bromley identifies a lower percentage of patients with a palliative care need than its immediate neighbouring boroughs. It follows therefore that a larger number of patients will not have a palliative care plan in place and are more likely to die in hospital.

Figure 11. 7: Percentage of deaths with palliative care need on a palliative care register, 2008/10



Source: *Marie Curie End of Life Atlas*

Quality in End of Life Care

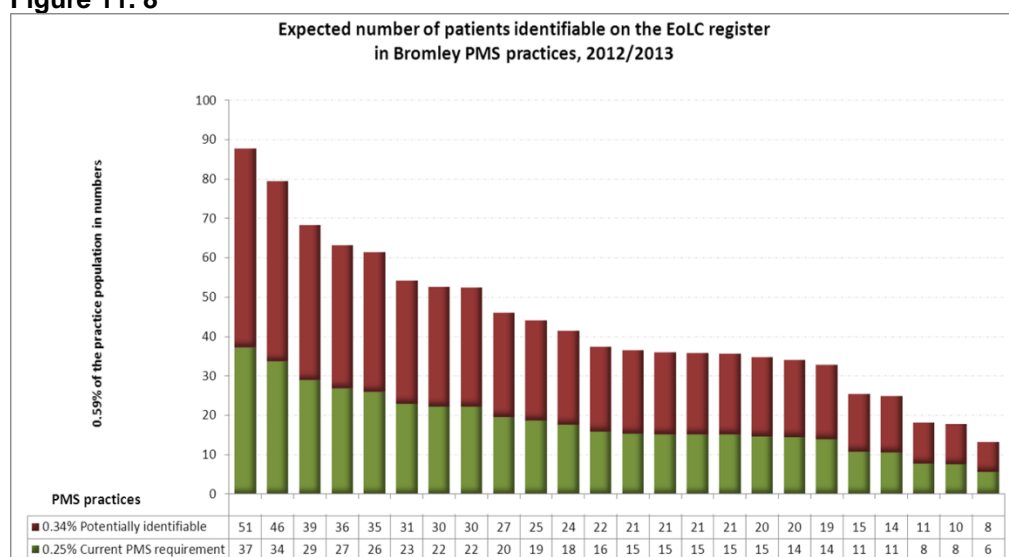
Coordinate My Care (CMC) is a clinical service that coordinates the care of patients nearing the end of life, giving them choice and an improved quality of care. CMC is now fully operational across London.

Over 11,000 personalised patient care plan records have been created (650 in Bromley). The CMC statistics show that 82% died in a place outside the acute sector and 80% died in their preferred place of death. Where patients have a CMC record, 18% die hospital, compared to 54% of those without.

Co-ordinate My Care (CMC) research indicates that at any one time, 0.59% (London) or approximately 1% (elsewhere) of the population would be identifiable by healthcare professionals as likely to die within the next 12 months. **Figure 11.8** shows that a further 597 people in Bromley are potentially identifiable – shown in red.

Twenty four General Practices with a Personalised Medical Services (PMS) contract in Bromley are commissioned to recognise 0.25% of their practice population as appropriate for End of Life care and identify them for their practice End of Life Care Register.

Figure 11. 8



Source: PMS audit, 2014

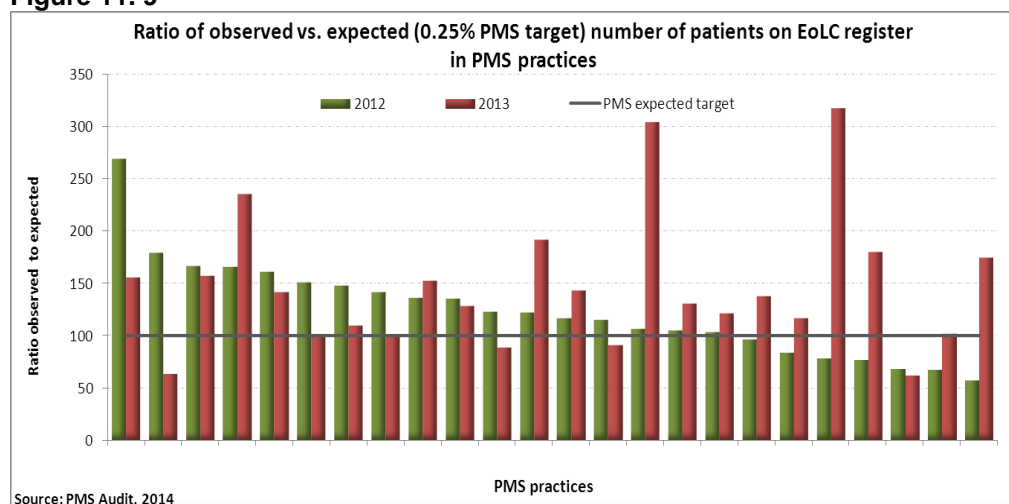
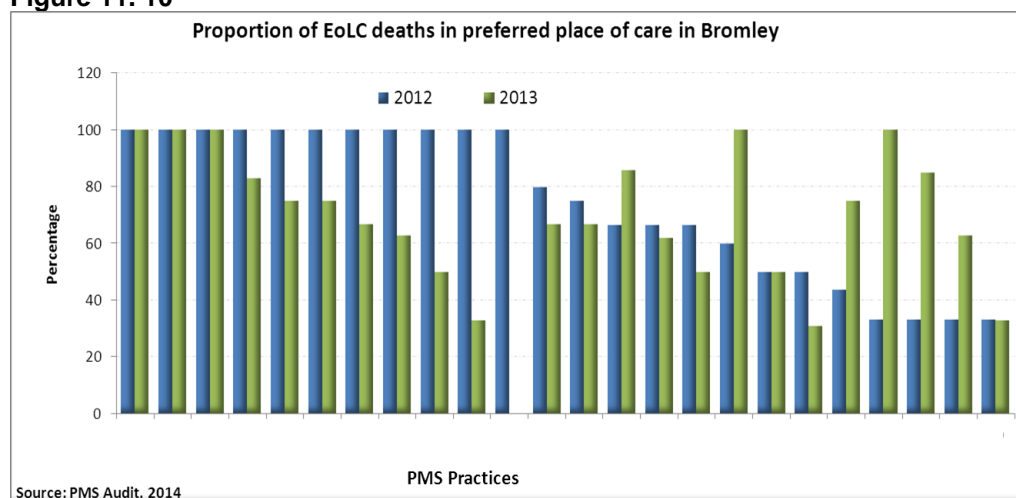
Figure 11. 9

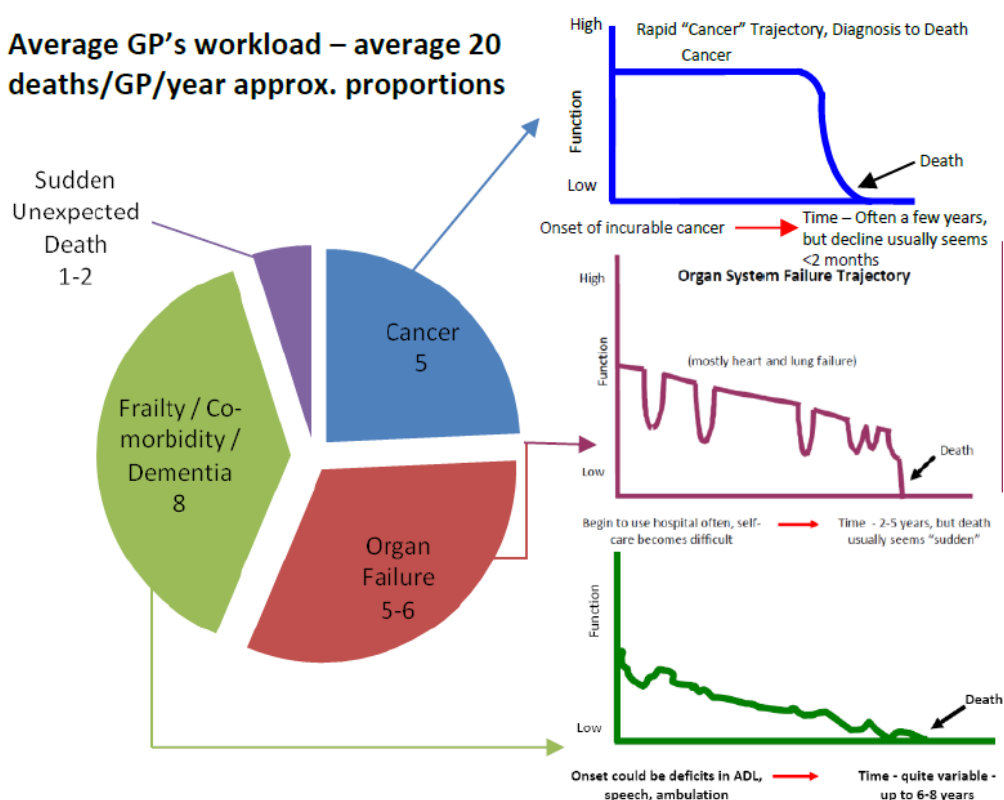
Figure 11.10 shows that although there is very good identification of people at their end of life not all people are dying in their preferred place of care.

Figure 11. 10

It is recognised that there are more patients on the End of Life Care Register with cancer than non-cancer whilst there are more non cancer deaths. The disease trajectory of cancer (**Figure. 11.11** blue graph) shows a rapid decline at the end of life phase. The disease trajectory for heart and lung conditions (red graph) shows a more erratic trend of decline and recovery. This makes it more difficult to predict the end of life phase.

Figure 11. 11

Average GP's workload – average 20 deaths/GP/year approx. proportions



Continuity of care for these patients can be achieved with the allocation of a keyworker able to proactively plan their care in partnership with the patient. Examples of key workers are a District Nurse, Community Matron or Clinical Nurse Specialist. At the moment 50% of patients managed by St Christopher's have a key worker. The aim is to develop a system whereby every patient has a key worker.

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

The majority of deaths in Bromley are due to non-cancer causes (i.e. circulatory and respiratory) in the over 65 years.

From 2006 to 2012 there has been a decrease in the proportion of deaths in hospital with an increase in the proportion of deaths at home, hospice and care homes. This trend is most noticeable from 2008 to 2012.

There are higher proportions of female deaths occurring in care homes than males, likely linked to higher life expectancy in females.

A higher proportion of non-cancer deaths occur in hospital as it may be more difficult to predict the end of life phase in non-cancer patients. So, to improve this we need to focus on end of life services for non-cancer patients.

The PMS audit suggests that PMS practices are successful in identifying patients who are at the end of their life, however this scheme is not applied to General Medical Services (GMS) practices and we have no measure of progress in GMS practices.

In addition, despite the improved identification of patients at their end of life in PMS practices, not all patients are dying in their preferred place of care.

For more information on End of Life Care please contact
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12. Carers

Introduction

This section focuses on the needs of the Borough's carers. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- Introduction of new legislation
- Adult carers
 - Bromley demographics
 - Census and local survey findings
- Young carers
 - Bromley demographics
 - Census and local survey findings

Current Context

The Care Bill places emphasis on the important role carers play and gives them an equal right in law to assessment and support as people with care needs. The Children and Families Bill recognises the need to assess and support young carers and also to work in a whole family way to reduce inappropriate caring roles undertaken by children. These provisions will come into force in 2015. The London Borough of Bromley will work in partnership with carers, Carers Bromley and others towards ensuring that they are effectively implemented.

As a result of the revised partnership framework, arrangements for engaging with service users and carers were amended, revised or revamped. As part of the new framework, the independent Carers Forum has been re-established with robust governance arrangements and a core group of carers under the facilitation of Carers Bromley. The Forum has considered a range of different topics, including: the questions for, and the findings from, the adult carers survey; issues regarding health care support for both carers and the people they care for; and transport concerns.

Planning is currently underway between the Council and Bromley CCG for the development of a Task and Finish Project Group – including representatives from the Carers Forum - to lead the development of a revised Carers Strategy for the Borough, which will be shaped by the learning from the 2013 carers survey and the findings from the 2011 Census.

Adult Carers

Definition

A carer is defined as: **“someone who spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems”**

Carers do not include people who volunteer, or paid workers, as they are referred to as ‘care workers’⁴¹.

Carers play a huge, unpaid role in supporting people with their health and social care needs. Without this support, there would be far greater pressure on both health and local authority services. However, carers often experience significant health difficulties of their own, loneliness and isolation, and may struggle financially or with work commitments. Carers therefore may need support in order to be able to retain choices in their own lives and to stay well.

Demographic Information – Census

The 2011 Census indicates that:

- around 5.4 million people (10.3%) of the population in England were unpaid carers
- Approx. 31,000 people (10%) of the population in Bromley were unpaid carers. This is comparable to the national average but is higher than the London average of 8.5%
 - 6,299 carers stated that they provided more than 50 hours of unpaid care per week
 - 3,439 carers stated that they provided between 20 and 49 hours of unpaid care per week
 - 21,274 carers stated that they provide between 1 and 19 hours of care per week

Local Survey Information

An online survey of adult carers in Bromley was undertaken between September and October 2013 as part of the new virtual service user panel. Questions within the survey were formulated with officers from Bromley Council, Bromley CCG and Carers Bromley together with other key partners. These questions were agreed by members of the Carers Forum as targeting issues that are of great concern to carers in Bromley.

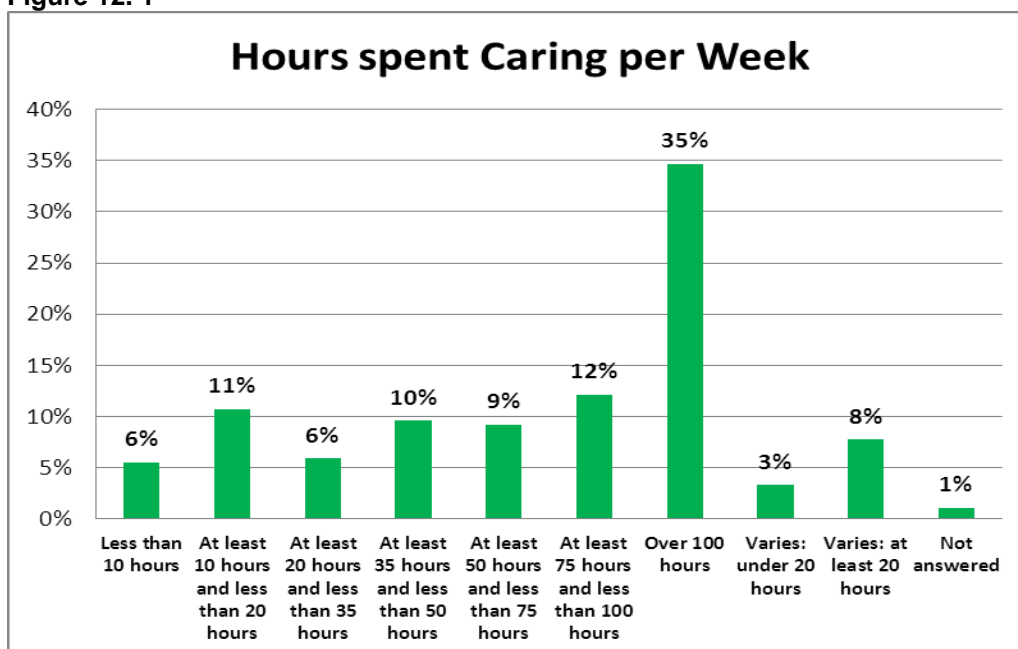
⁴¹ Source: Department of Health, 2008

The Carers Survey directly reached approximately 1,400 known carers through e-mail distribution lists held by a number of our key partners, including Bromley Clinical Commissioning Group, Carers Bromley, Bromley Mencap, Bromley Healthwatch, Bromley Mind and Alzheimer's Society. It was also sent via e-mail to a number of unknown carers, including e-mails to all staff of the Council, local websites, news items, newsletters, publicity in Bromley Libraries, and other publicity. Some of the Council's partner agencies also circulated the survey to their staff.

The Carers Survey⁴² received 271 responses directly from carers in the Borough. The headline results were:

- 45% had had a Carers Assessment, which means that 55% had not had a Carers Assessment
- 72% stated that their GP knows that they are a carer
- 1 in 3 spend over 100 hours per week in their caring role
- 27% care for more than one person
- 1 in 4 have postponed or refused medical treatment due to their caring responsibilities
- 4 in 10 carers have been abused verbally by the person they care for
- 45% receive no support from family, friends or their community
- 87% were worried about the future of the person they care for

Figure 12. 1



Source: Carers Survey, 2014

⁴² The full results from the Carers Survey can be found at <http://www.bromleypartnerships.org/documents/Report%20of%20Carers%20Survey%202013.pdf>

Looking more closely at the 94 carers who are providing over 100 hours caring each week shows the following:

- 17 of the carers are 45-54 years, 20 are 55-64 years and 26 are 65-74 years.
- 12 carers are over 75 years
- 20 carers are the child of the person cared for, 34 are the spouse/partner and 36 are a parent
- 26 carers are caring for someone under 25 years of age whilst 40 are caring for someone 75 years or over

The number of hours that respondents to the Carers Survey state that they spend caring can be compared with the time that Bromley carers said they spend caring in the 2011 Census.

Table 12. 1

Number of hours spent caring per week	2011 Census (Bromley)	2013 Carers Survey Bromley
1 – 19 hours	69%	20%
20 – 49 hours*	11%	23%
50 hours and over	20%	56%

*2013 Carers Survey includes all 'Varies: at least 20 hours' respondents

Source: Bromley Carer's Survey, 2014

This shows that the Carers Survey was completed by a higher percentage of carers who spend 50 hours or more a week caring than there are overall in Bromley. Therefore the answers that have been given come from those who are at the most time-consuming end of the carers spectrum and will be in most need of support.

Impact of being a carer

Many carers feel that their contribution to society goes unrecognised and instead of being supported, they often find that their needs are overlooked, they have to fight to get support and that the support available is insufficient or poor quality. As the number of older people and children with complex needs rises and their life expectancy increases, so the number of carers in Bromley and the number of years they spend caring increases. The age of carers is likely to increase as spouses/partners and children need to care for longer.

Only a small proportion of carers receive any support in their caring role and a significant number of carers are themselves over 65 years. One survey found that 65% of carers aged over 60 have a long term condition or disability themselves, that nearly 70% said caring had a negative impact on their mental health, and one third said they had cancelled treatment for themselves due to their caring responsibilities⁴³.

Carers providing high levels of care are twice as likely to be permanently sick or disabled. Carers also experience difficulties in staying in work. One in five carers gives up employment to care and, on average, carers retire eight years earlier than the rest of the population⁴⁴.

A potential increase in the number of people who can no longer be supported by their carer could lead to increasing pressure on an already stretched health and social care budget.

Social care that delivers early, preventative, personalised support to families to promote the independence of older and disabled people will indirectly support carers too. Care services, employers, the tax and benefit system all have a part to play to ensure carers are properly supported to manage care and to have a life of their own.

Support to Carers

The London Borough of Bromley and Bromley Clinical Commissioning Group have jointly commissioned a 'strategic partnership' contract with Carers Bromley. As a strategic partner, Carers Bromley is funded to be the first port of call for all carers requiring information, advice and guidance. Indeed, the Bromley Carers Survey of 2013 told us that 70% of the 271 respondents felt that Carers Bromley was the best place for new carers to get information about caring. Carers Bromley meets the needs of the majority of the carers requiring support, and only refers carers on to statutory organisations when they are likely to meet the eligibility criteria.

In addition to the strategic partnership with Carers Bromley, the Local Authority and Bromley Clinical Commissioning Group also commission respite services and other support services to carers which may be wholly subsidised or which may be subject to a contribution from the service user. Some of the services provide support both to the service-user and carer, for example day services which provide social stimulation to the service-user during the day as well as a break for the carer.

⁴³ The Princess Royal Trust for Carers (2011), Always on Call, Always Concerned

⁴⁴ ('Real Change, Not Short change: Time to Deliver for Carers' (2007). Carers UK. Buckner, L, Yeandle, S (2007a), 'Carers and Caring in EU Member States'. Eurocarers.

Young Carers

Definition

There is currently no standard definition of the term "young carer"; however, the London Borough of Bromley defines young carers as:

“young people between 4 and 18 years whose lives are in some way restricted because of the need to take responsibility or care for someone in their family with long-term illness, disability, mental health issues, an alcohol/substance misuse problem or HIV.”⁴⁵

It is acknowledged that only small numbers of young carers are currently being identified or assessed for support. The reasons for this include:

- blurred boundaries of responsibility between adult and children's services
- a lack of awareness among many professional groups of young carers' needs and concerns
- young carers' own lack of awareness of their entitlements, and their reluctance to seek formal help.

Demographic Information

National research has also shown that:

- 19% of young carers are living with someone with a mental health issue
- 29% of young carers are living with someone with a physical disability
- 26% of young carers are living with someone with a learning disability
- 40% care for a parent and 41% care for a sibling
- 16% care for more than 1 person in their family

Many national research studies have also examined the experiences of young carers who are in touch with Young Carer Projects. These studies have identified that the Projects do not tend to report the views of the "hard to reach" young carers who are not in touch with either services or projects, or perhaps do not see themselves as young carers at all.

⁴⁵ London Borough of Bromley 2013

Census Information

The 2011 census indicated that of the approx. 5.4 million carers in England, 166,000 are young carers. The 2011 census indicates that 11% of identified young carers care for more than 20 hours a week and a further 9% care for more than 50 hours per week.

As young carers grow older, they become more heavily involved in caring, particularly with regard to personal and intimate care and there are gender differences in the roles they typically undertake. One third of young women who are carers in the 16 to 28 year age group undertake intimate care, compared with 17% of young men who are carers⁴⁶. Support needs to be provided to whole families to ensure that young carers are not required to undertake caring roles which impact negatively on their health, education, or personal development.

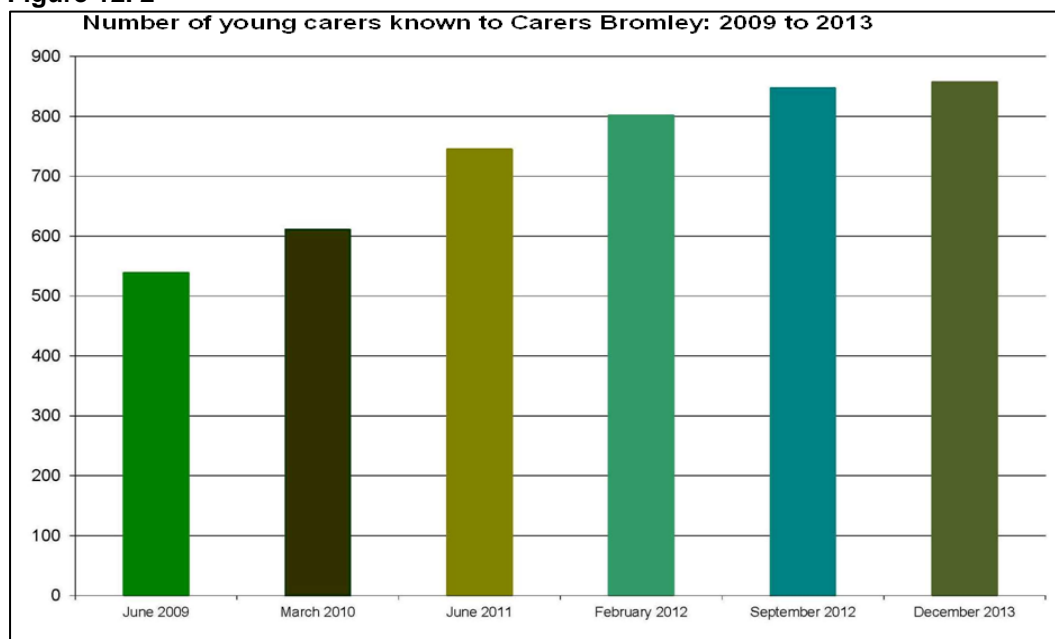
Local Information

The number of young carers identified and supported by Carers Bromley has increased significantly over the past few years; however, it should be noted that from national research it is expected that these are only a portion of the actual number of young carers within the Borough.

In December 2013, a total of 857 young carers were known to Carers Bromley compared to 539 in June 2009, showing an increase of 59%.

This also reflects an increase of 22% between June 2011 [693] and September 2012, and an increase of 7% since February 2012 [802], as illustrated in the following table:

⁴⁶ Becker, F, Becker, S (2008), 'Young Adult Carers in the UK: Experiences, Needs and Services for Carers aged 16–24'. The Princess Royal Trust for Carers (secondary analysis of UK Census 2001)

Figure 12. 2

Source: Carers Bromley

Table 12. 2

	June 2009	March 2010	June 2011	February 2012	September 2012	December 2013
Number of young carers	539	611	745	802	847	857
Difference	-	13%	22%	8%	6%	1%

Source: Carers Bromley

A recent Department of Health report 'Carers in the region – a profile of London' shows that the region in the 2001 Census had 30,574 young carers under the age of 20 (of these 2,661, provided 50 or more hours of care per week), that young carers were more likely than other young people to live in workless households, be in lone parent families and have a limiting long term illness themselves.

55% of all young carers were aged 16-19 years, girls are more likely to be carers than boys, and young people in the Asian ethnic groups are considerably more likely than other young people to be carers.

Whilst there may be areas of affluence in Bromley, there are also areas of deprivation e.g. the Crays, Penge and Mottingham. The Trust for London Poverty File shows that Bromley, in comparison to London Boroughs, offers lower rates of payment to its residents.

The Princess Royal Trust for Carers School Resource Pack 2010 says that there may be up to 30 young carers in an average sized secondary school and that 27% of young carers of secondary school age experience educational difficulties.

This rises to 40% where young people are caring for someone who misuses drugs or alcohol.

Over 39% of young carers were surveyed and they said their schools were not aware that they were young carers. Statistically, 35% of young carers in secondary schools experience educational difficulty and 70% of young carers report being the target of bullying. Also, 45% report feeling tired at school, 55% experience disturbed sleep and 12% are caring for more than one person.

Impact of being a young carer

- many young carers experience bullying: having caring responsibilities is one of the most common characteristics of young people between 14 and 16 who have been bullied. (Characteristics of bullying victims in schools DFE 2010 July 2010 <http://www.natcen.ac.uk/study/the-characteristics-of-bullying-victims-in-schools-our-findings#hotlink3>)
- young carers between 16 and 18 are twice as likely not to be in education, employment or training (NEET) as their peers. ('Against the Odds', Audit Commission, p19, July 2010)
- being a young carer, especially where personal and practical support is lacking, can affect elements of a child's transition to adulthood
- young carers can experience substantial physical, emotional or social problems, and encounter difficulties in school and elsewhere
- 30% of young carers support parents with mental health problems

Table 12. 3: Carers Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
Loneliness and Isolation in adult carers	Persons	All ages	2012/13	36.00	36.50	42.30

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

What does this mean for the residents of Bromley?

- There continues to be insufficient local data/ joint identification of carers and young carers
- Bromley has a similar percentage of carers compared to the England total; however, the Borough has a significantly higher percentage than across London
- The 2013 Carers Survey Bromley indicates that 56% of the 271 Carers responding to the survey provide intensive care of more than 50 hours per week
- Although it is difficult to identify the actual number of young carers in the borough, the number of young carers known to Carers Bromley has increased 59% since June 2009
- The Carers Strategy, including the Young Carers Strategy, is being refreshed during 2014
- Carers assessments have a low take up and how they are presented to carers needs to be revisited in terms of the benefits

For more information please contact Catriona.Ellis@Bromley.gov.uk

13. Substance Misuse

Introduction

Substance misuse is the harmful use of substances (such as drugs and alcohol) for non-medical purposes.

The term “substance misuse” often refers to illegal drugs, but, some legal drugs such as caffeine, alcohol and cigarettes can still cause harm.

NB Alcohol misuse is dealt with in a separate section of the JSNA.

A drug is a chemical substance that acts on the brain and nervous system, changing a person's mood, emotion or state of consciousness.

Misusing drugs damages mental and physical health and harms families and communities. It costs the national economy £15.4bn every year.

Commonly Misused Illegal Drugs

Under the Misuse of Drugs Act 1971, illegal drugs are placed into one of three classes – A, B or C. This is broadly based on the harms they cause either to the user or society when they are misused. Class A drugs are considered likely to cause the most serious harm

Table 13. 1: Commonly misused Illegal drugs

Name/Category	Name/Class	Effects
Cannabinoids (Tetrahydrocannabinol – THC)	<ul style="list-style-type: none"> Cannabis - Weed, skunk, sinsemilla, sensi, resin, puff, pot, marijuana, herb, hashish, hash, grass, ganja, draw, dope, bud, bhang. Class B 	<p>Acute Effects - Euphoria; relaxation; slowed reaction time; distorted sensory perception; impaired balance and coordination; increased heart rate and appetite; impaired learning, memory; anxiety; panic attacks; psychosis</p> <p>Health Risks - Cough, frequent respiratory infections; possible mental health decline; addiction</p>
Opioids	<ul style="list-style-type: none"> Heroin (diacetylmorphine) - Smack, skag, horse, H, gear, brown. Class A Opium. Class A 	<p>Acute Effects - Euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feeling of heaviness in the body; slowed or arrested breathing</p> <p>Health Risks - Constipation; heart infection; hepatitis; HIV; addiction; fatal overdose</p>
Stimulants	<ul style="list-style-type: none"> Cocaine - White, Wash, Toot, Stones, Snow, Rocks, Percy, Pebbles, Freebase, Crack, Coke, Ching, Charlie, Chang, C. Class A Amphetamine Class B. Methamphetamine Class A 	<p>Acute Effects - Increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental alertness; tremors; reduced appetite; irritability; anxiety; panic; paranoia; violent behaviour; psychosis</p> <p>Health Risks - Weight loss, insomnia; cardiac or cardiovascular complications; stroke; seizures; addiction</p> <p>Cocaine – Nasal damage from snorting. Methamphetamine – Severe dental problems.</p>
Club Drugs	<ul style="list-style-type: none"> MDMA (methylene-dioxy-methamphetamine) Class A Flunitrazepam – associated with sexual assault Class C GHB (Gamma hydroxybutyrate) - Liquid Ecstasy, geebs, GBL, GBH, 4-BD, 1. Class C 	<p>Acute Effects, for MDMA - Mild hallucinogenic effects; increased tactile sensitivity; empathic feelings; lowered inhibition; anxiety; chills; sweating; teeth clenching; muscle cramping</p> <p>Flunitrazepam - Sedation; muscle relaxation; confusion; memory loss; dizziness; impaired coordination; addiction. GHB - Drowsiness; nausea; headache; disorientation; loss of coordination; memory loss; Unconsciousness; seizures; coma. Health Risks, for MDMA - Sleep disturbances; depression; impaired memory; hyperthermia; addiction</p>

Prevalence of Substance Misuse

The Crime Survey for England and Wales (CSEW) for 2012/13⁴⁷ reported that 8.2% or 2.7 million adults had taken an illicit drug (excluding mephedrone) in the last year. If applied to Bromley this would represent approximately 15,000 residents reporting illicit use of drugs over the same time period.

The annual Glasgow Prevalence Estimation includes national and regional estimates of the number of opiate, crack and injecting drug users in the UK⁴⁸

Table 13.2 shows the rates of illicit drug use in Bromley as compared with London and England.

Table 13. 2

	Number of Drug Users (Rate per 1000 Adult Population)			
	Opiate & Crack User	Opiate User	Crack User	Injecting
Bromley	1,117 (5.55)	814 (4.05)	750 (3.73)	119 (0.59)
London	54,985 (9.55)	43,918 (7.63)	40,080 (6.96)	11,351 (1.97)
England	293,879 (8.4)	256,163 (7.32)	166,640 (4.76)	87,302 (2.49)

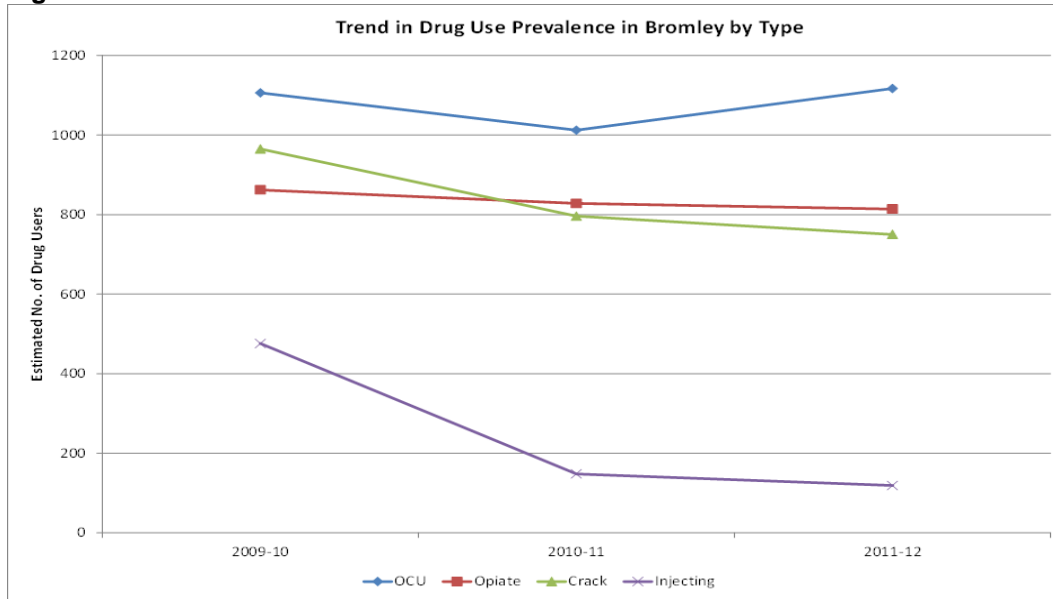
Source: *Glasgow Prevalence Estimates (2011/12)*

Bromley has lower rates of drug use in all the key categories than London and England.

Numbers of drug users in Bromley have been falling in all the key categories over the last two years, with the exception of opiate and crack users (OCU), where numbers have increased (**Figure 13.1**). Across England as a whole, numbers have been decreasing in all categories, however, London has seen an increase in OCU and opiate users over the same time period.

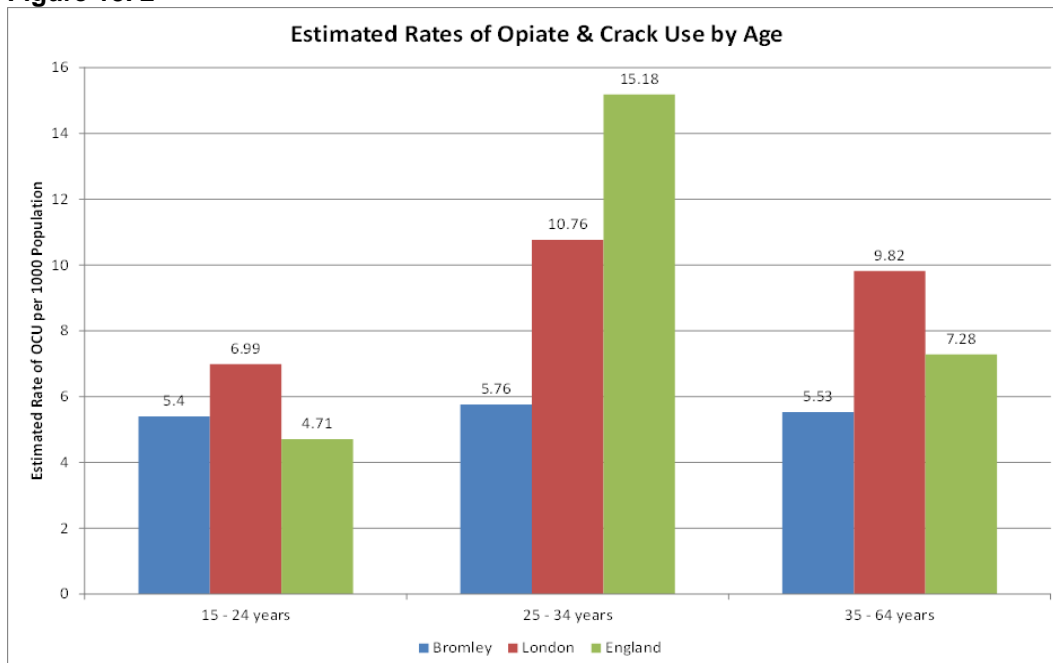
⁴⁷ Home Office. Drug Misuse: Findings from the 2012/13 Crime Survey for England and Wales. 2013

⁴⁸ Hay G et al Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11.

Figure 13. 1

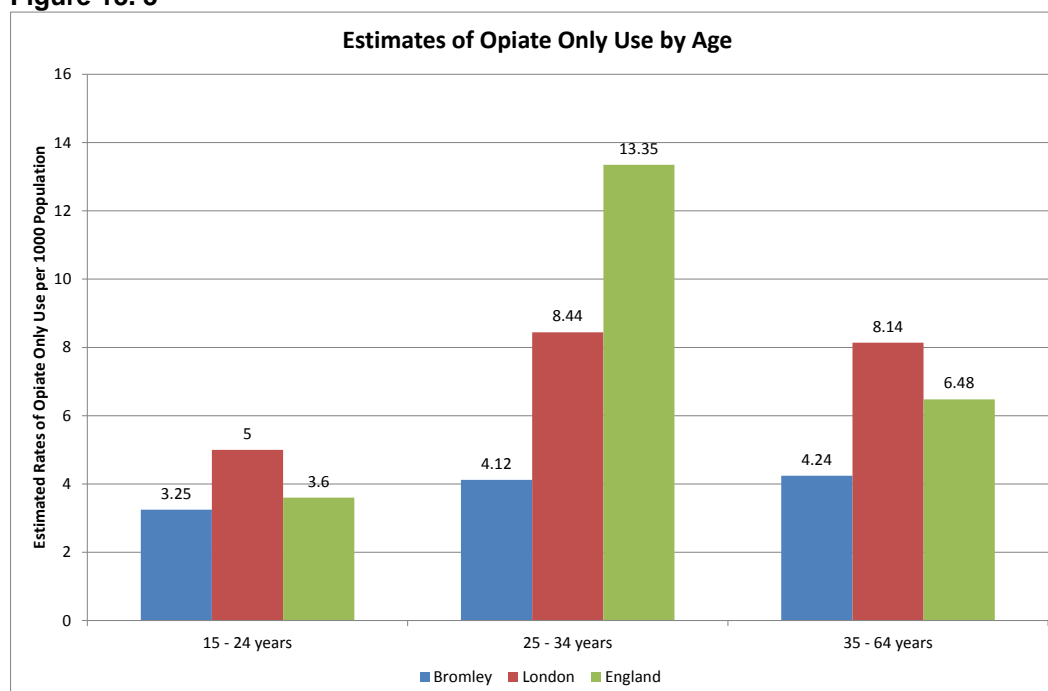
Source: Glasgow Prevalence Estimates 2011-12

The prevalence of opiate & crack use does not vary much with age in Bromley, although in London and nationally, rates are highest in the 25 to 34 year age group (**Figure 13.2**).

Figure 13. 2

Source: Glasgow Prevalence Estimates 2011-12

The picture is similar for opiate only use (Figure 13.3)

Figure 13. 3

Source: Glasgow Prevalence Estimates 2011-12

National data compiled from a range of surveys⁴⁹ describes the characteristics of drug users in England:

- Since 1996 levels of any illicit drug and any Class A drug use during the last year were higher among men than women.
- Single adults were more likely to have taken any drugs or any Class A drug in the last year than any other marital status.
- Adults from a White ethnic group generally had higher levels of any drug use (9.5%) than those from non-White background (5.4%).
- Adults living in a household in the lowest income group (£10,000 or less) had the highest levels of drug use in the last year (11.9%) and Class A drug use in the last year (3.6%) compared with all other income groups. For example 6.8% and 2.8% respectively of adults living in a household with an income of £50,000 or more took drugs and Class A drugs in the last year respectively).
- Since 2001, there has been an overall decline in the prevalence of drug use among pupils. The proportion of pupils who reported ever having taken drugs decreased from 29% in 2001 to 17% in 2012.
- Some young people have shown to be vulnerable to problematic drug use. These include those who truant or have been excluded from school.

⁴⁹ HSCIC Statistics on Drug Misuse: England 2013

Effects of Drug Misuse

Health

Individuals who take illicit drugs face potential health risks, as the drugs are not controlled or supervised by medical professionals. As well as health risks, drugs can become addictive and lead to long term damage to the body. Illicit drug users are also at risk of being poisoned by drugs and overdosing which can lead to a fatality.

In particular, injecting drug users may be exposed to blood borne infections through the sharing of infected needles/syringes, and through the sharing of other injecting paraphernalia. Consequently, those accessing treatment for substance misuse, who meet certain criteria (i.e. previous or current injectors in the case of Hepatitis C) are tested for, and if appropriate, vaccinated against Hepatitis B and C. In 2012/13, 34% of eligible new presenters to drug services in Bromley accepted Hepatitis B vaccinations, compared with the national average of 47%. During the same period, 91% of previously or currently injecting clients in treatment in Bromley received a Hepatitis C test, as compared with the national average of 72.5%.

Research shows that substance use, and misuse may lead to or worsen psychiatric or psychological symptoms or syndromes⁵⁰. The most common associations for substance misuse are with depression, anxiety and schizophrenia.

In 2012-13, there were 318 NHS hospital admissions where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders. In addition there were 43 NHS hospital admissions where there was a primary diagnosis of poisoning by illicit drugs⁵¹.

Mortality rates from substance misuse are fairly low. In 2012, there were just under 1500 deaths related to drug misuse across England and Wales.

A detailed analysis of drug and alcohol related deaths in Bromley over a 10 year period (2002-12) showed that there were fewer drug related than alcohol related deaths, and the rate has fallen over the time period. Of the 447 cases reported, 331 (74%) were directly related to alcohol. One percent were unknown, where no drug or alcoholic substance was implicated in the cause of death record, however there could be a history of drug and/or alcohol abuse. The principal substances implicated in the drug-related only deaths were: opiates (6%) and paracetamol (3%).

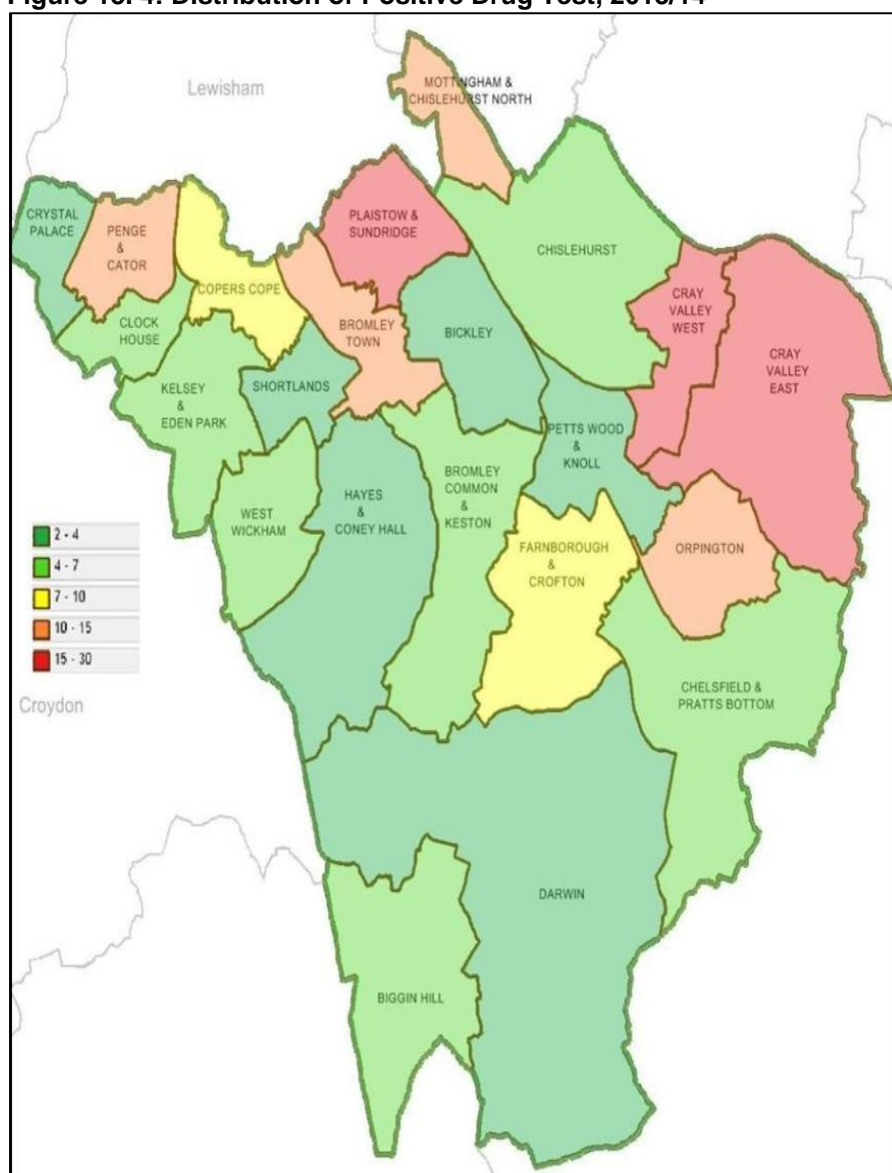
⁵⁰ Crome I. B. (2006) An epidemiological perspective of psychiatric comorbidity and substance misuse: The UK experience/example, in Baldacchino, A. and Corkery, J. (Eds.) Comorbidity: Perspectives Across Europe (ECCAS Monograph No. 4) pp.45–60.

⁵¹ The Health and Social Care Information Centre, Lifestyle Statistics 2013

Crime

There is a strong link between acquisitive crime and addiction to crack cocaine and opiates. The Metropolitan Police Service extended drug testing across all 32 boroughs in London, including Bromley from January 2013 to increase opportunities for diverting drug misusing offenders out of crime and into treatment and reduce associated criminality. A positive drug test on arrest means that a person has to attend a drug assessment, regardless of whether convicted of the offence. Failure to attend is arrestable. These assessments can result in individuals being persuaded into drug treatment. Between January and June 2013 approximately 39% of people who tested positive were referred into treatment. The Police work closely with Arrest Referral workers, who are part of the Bromley drug and alcohol service. **Figure 13.4** shows the distribution of positive tests across Bromley in 2013-14.

Figure 13. 4: Distribution of Positive Drug Test, 2013/14



Source: Metropolitan Police Drug Intervention Program

Drug Dependence

“Drug dependency” is defined as a cluster of behavioural, cognitive, and physiological phenomena, such as a sense of need or dependence, impaired capacity to control substance-taking behaviour and persistent use despite evidence of harm.

The prevalence of drug dependence is lower than the prevalence of any drug use.

The prevalence of drug dependence in 2007 was 3.4% (4.5% of men and 2.3% of women). Most dependence was on cannabis only (2.5%), rather than on other drugs (0.9%). Symptoms of drug dependence were most commonly reported by adults aged between 16 and 24 (13.3% of men and 7.0% of women in this age group).

As regards ethnicity; Black men were most likely (12.4%) and South Asian men were least likely (1.5%) to report symptoms of dependence, whilst dependence ranged from 4.8% of Black women to 0.2% of South Asian women.

Prevalence of drug dependence tends to increase as equalised household income decreases.

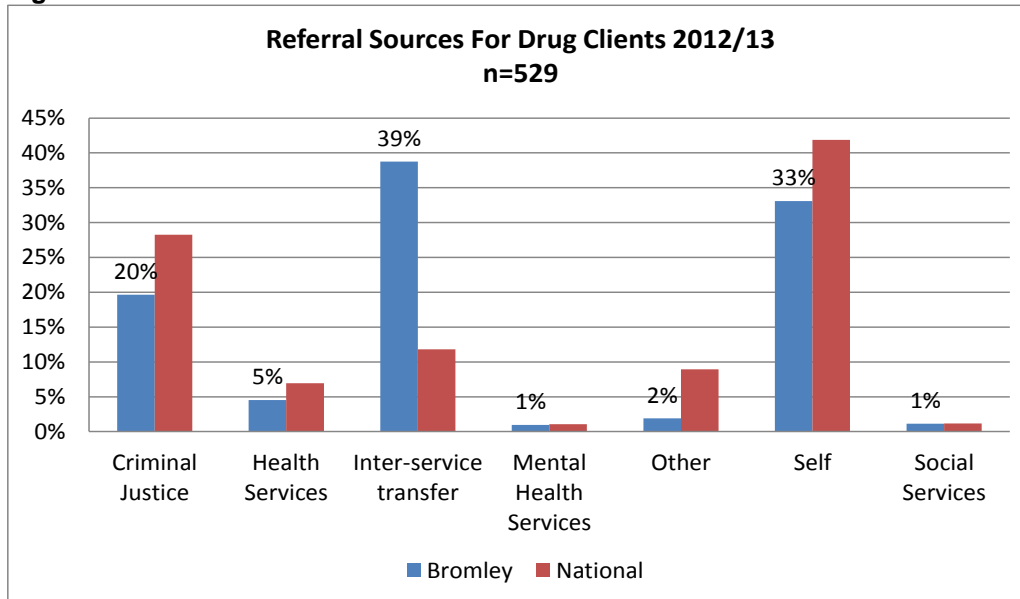
Treatment for Substance Misuse

Adults who are effectively engaged in treatment for substance misuse, use fewer illegal drugs, commit less crime, improve their health and manage their lives better.

In 2012-13, there were 529 treatment episodes in Bromley. The number of treatment episodes is usually slightly higher than the number of people receiving treatment, as a few people may have a break in treatment, or complete and then relapse, generating a second treatment episode.

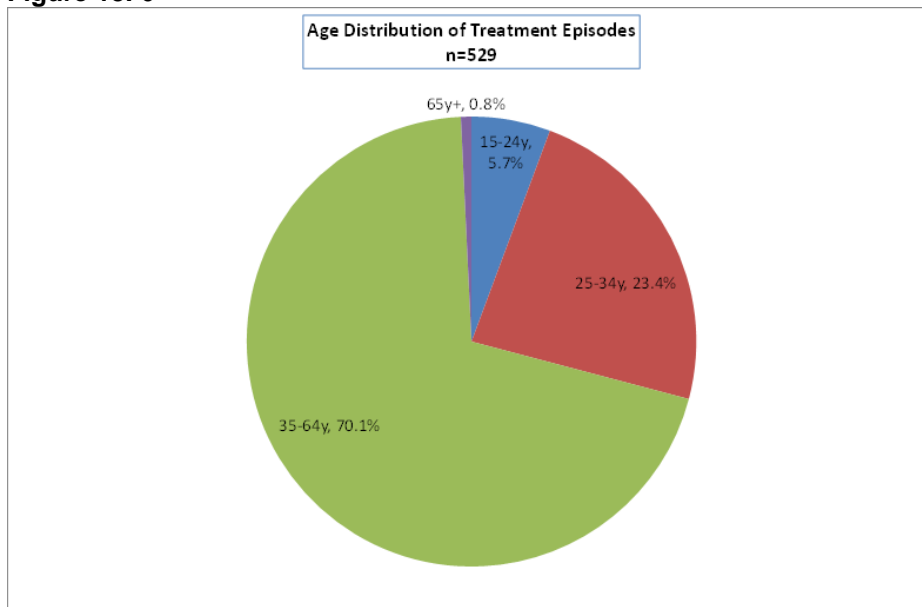
Substance misuse services treat users from a variety of referral sources, including the criminal justice system, GPs, A&E, schools and self-referrals.

Referrals in Bromley from the criminal justice system (police, prison, probation) and self-referrals form a lower proportion of the total referrals than nationally.

Figure 13. 5

Source: National Drug Treatment and Monitoring Service (NDTMS)

The majority of people in treatment are in the 35 to 64 year old age group, which is consistent with the prevalence data, as this is the largest age group in terms of size. Males represent 73% of the treatment episodes.

Figure 13. 6

Source: National Drug Treatment and Monitoring Service (NDTMS)

Bromley has a slightly higher proportion (5%) of people in treatment over the age of 60 years, as compared with the national figure of 3%.

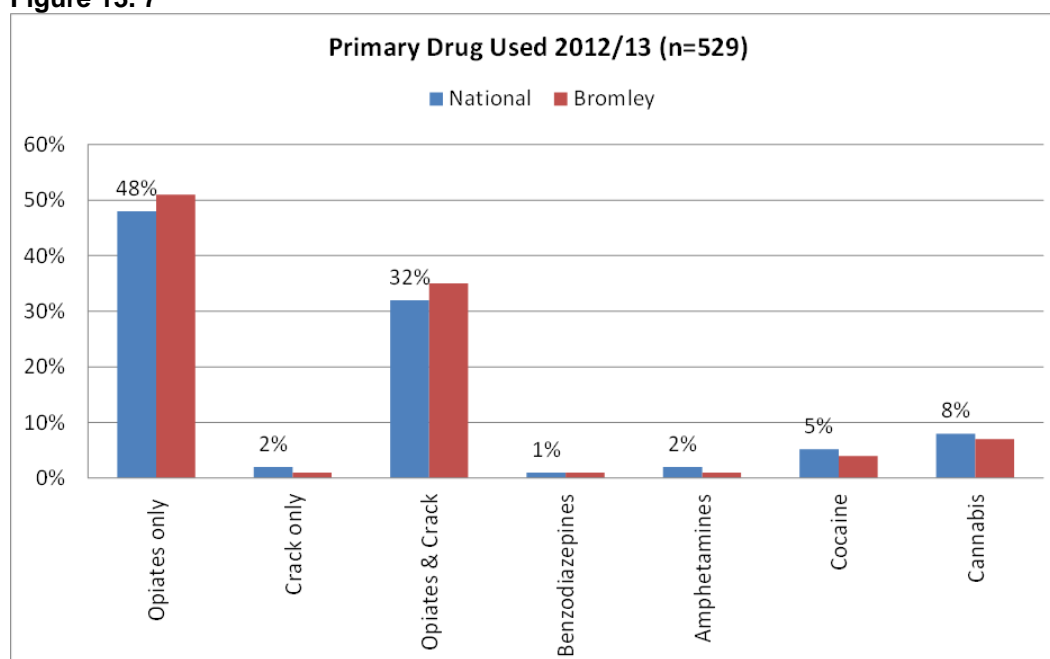
The ethnicity of those in treatment is predominantly White British (84%), which is consistent with the proportion of White British in the borough as a whole (85%).

The wards generating the highest number of treatment episodes are:

- Plaistow & Sundridge – 58
- Cray Valley West – 50
- Crystal Palace – 51

The majority of people in treatment (82%) use either opiates, crack or both as the primary drug, with opiates alone (48%) forming the largest subgroup.

Figure 13. 7



Source: National Drug Treatment and Monitoring Service (NDTMS)

In Bromley there has been a small reduction in the number of people misusing drugs receiving treatment. In 2011/12 there were 555 people in treatment; in 2012/13 there were 520 who were using drugs as a primary substance. This reflects the national downward trend.

There has been an overall increase in the number of opiate users successfully completing treatment (the definition of this is free of drug(s) of dependence who do not then re-present to treatment again within 6 months). Between 1st April 2012 and 31st March 2013, 10.3% (38/370) of opiate clients completed treatment successfully in comparison with 6.6% in 2011/12.

However, there has been a slight reduction in the number of non-opiate users successfully completing treatment, 41.3% (62/150) compared to 48.9% (64/131) in 2011/12.

Individuals successfully completing treatment demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.

Evidence suggests that clients who stop using opiates in the first 6 months of treatment are 4.3 times more likely to complete successfully than those that continue to use. Bromley continues to ensure that individuals move through the treatment system in a timely manner and whilst there are 20.6% of opiate users who have been in treatment for over 6 years this figure is below the national average.

Of the individuals completing their drug treatment 93% of individuals have no housing issues and 38% are in employment.

To continue to improve the number of individuals who complete treatment successfully the services are working to:

- identify why users are leaving treatment,
- managing users' anxiety about stopping substitute prescribing,
- further improving the treatment pathway and care coordination,
- increasing the number of satellite provision sessions,
- providing opportunities for non-opiate users to receive treatment separately from opiate users
- increasing the numbers accessing the service by producing information on services targeted to various locations such as A&E and GP surgeries.

Table 13. 1: Substance Misuse Related PHOF Indicators

Indicator	Sex	Age	Time Period	Bromley	London	England
Successful completion of drug treatment - opiate users	Persons	18-75 yrs	2010	5.90	8.27	6.64
Successful completion of drug treatment - opiate users	Persons	18-75 yrs	2011	7.04	9.91	8.62
Successful completion of drug treatment - opiate users	Persons	18-75 yrs	2012	9.55	9.57	8.24
Successful completion of drug treatment - non-opiate users	Persons	18-75 yrs	2010	43.72	34.48	37.50
Successful completion of drug treatment - non-opiate users	Persons	18-75 yrs	2011	50.67	36.15	39.50
Successful completion of drug treatment - non-opiate users	Persons	18-75 yrs	2012	35.83	34.72	40.20

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

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

Drug misuse is decreasing in Bromley and nationally.

There is a higher proportion of older (60 years+) people being treated for substance misuse in Bromley. This age group often present with more complex problems which will impact on health and social care services.

For more information on Substance Misuse please contact
Claire.Lynn@Bromley.gov.uk

14. Alcohol

In moderation, alcohol can have a positive impact on adults' wellbeing. However, although the majority of people who drink do so in an entirely responsible way, too many people drink alcohol to excess.

Alcohol is one of the three biggest lifestyle risk factors for disease and death in the UK after smoking and obesity.

There are a number of ways in which alcohol can be misused resulting in detrimental effects:

- Chronic heavy drinking
- Binge drinking⁵²
- Moderate drinking in inappropriate circumstances e.g. operating machinery, on medication

These not only pose a threat to the health and wellbeing of the drinker, but also to family, friends, communities and wider society through such problems as crime, anti-social behaviour and loss of productivity.

Alcohol misuse is also directly linked to a range of health issues such as high blood pressure, mental ill-health, accidental injury, violence, liver disease and sexually transmitted infection.

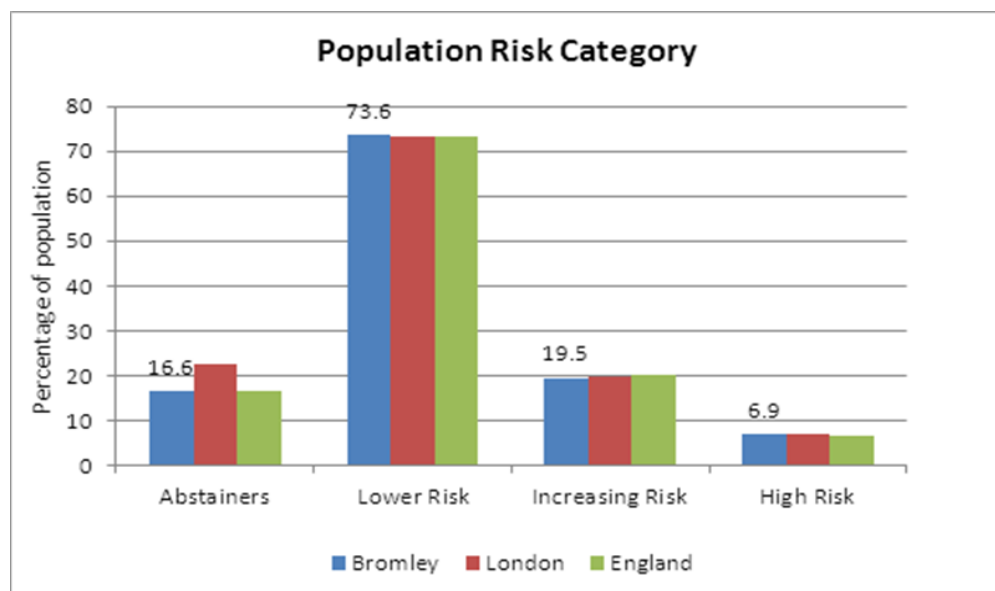
Three levels of risk associated with alcohol consumption have been defined in **Table 14.1:**

⁵² Binge drinking usually refers to drinking lots of alcohol in a short space of time or drinking to get drunk. Researchers define binge drinking as consuming eight or more units in a single session for men and six or more for women. However, this definition does not apply to everyone because the tolerance and the speed of drinking in a session varies from person to person.

Table 14. 1

Risk	Men	Women	Common Effects
Lower risk	No more than 3-4 units per day on a regular basis	No more than 2-3 units per day on a regular basis	<ul style="list-style-type: none"> Increased relaxation Sociability Reduced risk of heart disease (for men over 40 and post-menopausal women)
Increasing risk	More than 3-4 units per day on a regular basis	More than 2-3 units per day on a regular basis	Progressively increasing risk of:
Higher risk	More than 8 units per day on a regular basis or more than 50 units per week	More than 6 units per day on a regular basis or more than 35 units per week	<ul style="list-style-type: none"> Low energy, memory loss, relationship problems, depression, insomnia, impotence, injury, alcohol dependence, high blood pressure, liver disease, cancer

In Bromley, the proportion of people in each of the risk groups is similar to the national picture, however, this should not be reassuring as the national trend has been towards an increasing proportion of people in higher risk groups.

Figure 14. 1

Source: Local Alcohol Profile for England 2014

The estimated level of binge drinking in Bromley is 13.8%, and this is lower than both the London level (14.3%) and the national level (20.1%).

A review of GP Practice databases in Bromley in 2013, showed that approximately 38% of patients registered with Bromley practices had a record

of weekly alcohol consumption in the five year period to 2013. As alcohol misuse is a growing public health issue, it is important that we identify the level of need. The NHS Health Check now includes questions about alcohol consumption.

The Health Impacts of Alcohol Misuse

The Local Alcohol Profiles for England (LAPE) provide data on a number of alcohol related indicators at national and local level.

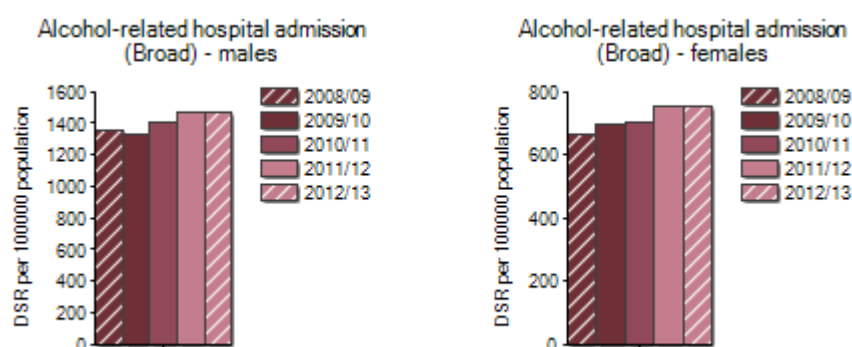
The profiles distinguish between:

- Alcohol-specific outcomes, which include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis
- and
- Alcohol-related conditions, which include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls.

Hospital admission rates for alcohol related conditions for both men and women have been increasing since 2008 to a peak in 2010-11, with the rate unchanged in 2012-13. These rates are significantly lower than those for London and for England.

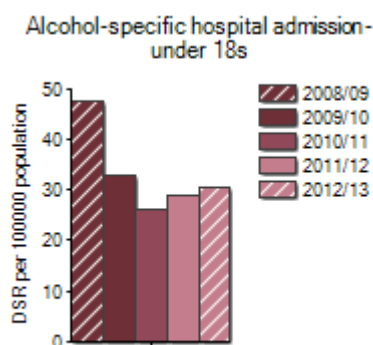
The hospital admission rate for males is almost twice the rate for females in Bromley.

Figure 14. 2: Trend in Bromley Alcohol-related Hospital Admissions



Source: Local Alcohol Profile for England 2014

The alcohol-specific admission rate for under 18 year olds in Bromley has been gradually increasing in the last two years, and is comparable with the rate for London, but significantly lower than the rate for England.

Figure 14. 3 Trend in Bromley Alcohol-specific Hospital Admissions for Under 18s

Source: *Local Alcohol Profile for England 2014*

Whilst alcohol-related mortality in Bromley has been fairly stable in males between 2009 and 2012, there was been a rise in alcohol-related mortality in females in 2012. The mortality rate for males is significantly lower than the England rate, but not significantly different for females. The mortality rate for males is almost twice that for females in Bromley.

Figure 14. 4 Trend in Alcohol-related Mortality in Bromley

Source: *Local Alcohol Profile for England 2014*

Societal Impact of Alcohol Misuse

The key measurable societal impact of alcohol misuse, is alcohol-related crime. The alcohol-related recorded crimes data were calculated based on the proportion of people arrested and who tested positive for urinary alcohol (using an arrestee survey) under the Home Office's former 'key offence' categories, which are:

- Violence against the person

- Sexual offences
- Robbery
- Burglary of dwelling
- Theft of a motor vehicle
- Theft from a motor vehicle

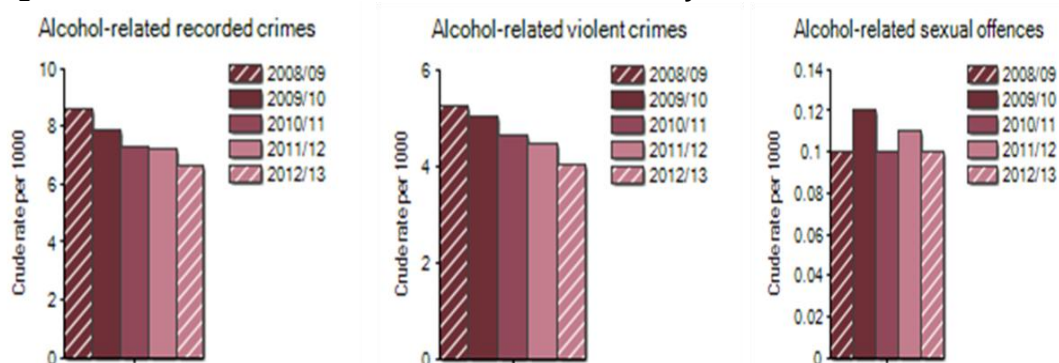
It is important to note that drunkenness offences are not included in these data due to the fact that intoxicated arrestees are not interviewed. Hence, these data may underestimate the true extent of alcohol-related crime.

It is also important to note that this data represents crimes committed in Bromley, but not necessarily by Bromley residents.

In Bromley, there is a continued reduction in alcohol related crimes compared to previous years. Between 2012/13, the crude rate for alcohol-related recorded crime was 6.6 per 1000 population compared to 8 per 1000 population in 2011/12. The rates for alcohol-related violent and sexual crimes also showed continued reduction, which were 4.05 per 1000 population and 0.10 per 1000 population respectively.

Compared to the national rates, Bromley had a lower alcohol-related crime rate across all three categories. Bromley was ranked 260 for recorded crimes, 212 for violent crimes and 137 for sexual crimes. (National average: 9.02 per 1000 for recorded crimes; 5.67 per 1000 for violent crimes; and 0.15 for sexual crimes).

Figure 14. 5 Trend in Alcohol-related Crimes in Bromley



Source: Local Alcohol Profile for England 2014

Alcohol does not cause domestic violence, but there is evidence that where the domestic violence exists, alcohol is often present. There are currently no national figures on the prevalence of alcohol-related domestic violence in the UK.

Profile of people in specialist alcohol treatment

Specialist alcohol treatment services provide treatment to people whose drinking is harmful or people who are alcohol dependent.

Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer.

Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Alcohol dependence is also associated with increased criminal activity and domestic violence, and an increased rate of significant mental and physical disorders.

The prevalence of alcohol dependence was 5.9 % (8.7% of men, 3.3% of women). For men, the highest levels of dependence were identified in 25 – 34 year olds (16.8%), for women in 16 – 24 year olds (9.8%). Among the 14% of alcohol dependent adults who were currently receiving treatment for a mental or emotional problem, women (26%) were more likely than men (9%) to be receiving treatment. This may be because men feel that there is a stigma attached to seeking help; portraying signs of 'vulnerability'; whereas women traditionally feel more able to ask for help.

In 2012/13 Bromley had 380 adults in alcohol treatment. Of all the adults in alcohol treatment, 69% (262) were new clients starting treatment during the year. The proportion of new clients was the same as that for England.

Table 14. 2

	Bromley	National
Number (%) of adults leaving alcohol treatment in 2012-13	252 (66%)	69,989 (64%)
Clients completing treatment successfully in 2012-13	141 (56%) of all exits (37%) of all in treatment	44314 (63%) of all exits 40% of all in treatment
Clients completing treatment successfully (between 1st January 2012 and 31st December 2012) and not returning within 6 months	131 (34%)	39800 (36%)

Source: JSNA Alcohol Profile for Bromley, 2013

People who need alcohol treatment need prompt help if they are to recover from dependency. In Bromley, approximately 71% of adults of all clients in alcohol treatment are able to access treatment within 3 weeks compared to 62% for the rest of England.

There were 150 (29%) adult clients in drug treatment in Bromley who cited additional problematic use of alcohol compared to 22% for England. The average age of those in treatment was 43 years compared to 42 years for England. Cannabis is the most commonly cited substance used together with alcohol. Some may use one or more other substances in addition to alcohol. **Table 14.3** shows the number of clients in specialist treatment services who use other substances.

Table 14.3

Substance used in addition to alcohol	Local	National
Opiates or crack	10 (3%)	4738 (4%)
Cannabis	36 (9%)	10526 (10%)
Other drugs (not opiates or crack)	35 (9%)	9857 (9%)

Source: JSNA Support Pack 2013.

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

Alcohol misuse is a significant public health issue, with over 26% of the population regularly consuming quantities of alcohol sufficient to damage their health.

Despite the extent of this problem, recording of alcohol consumption in primary care is low and needs to be improved.

Of concern is the trend of increasing alcohol specific hospital admission rates in under 18 year olds in Bromley.

Although alcohol-related crime rates in Bromley are lower than the national average, and have been falling, there is a gap in information relating to alcohol-related domestic violence as there are currently no national figures on prevalence.

For more information on Alcohol please contact
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Table14. 4: Alcohol Related PHOF Indicators

Indicator	Sex	Time Period	Bromley	London	England
4.06i - Under 75 mortality rate from liver disease	Persons	2001 - 03	13.12	20.82	78.93
4.06i - Under 75 mortality rate from liver disease	Persons	2002 - 04	13.70	21.00	77.87
4.06i - Under 75 mortality rate from liver disease	Persons	2003 - 05	15.92	20.62	15.85
4.06i - Under 75 mortality rate from liver disease	Persons	2004 - 06	14.43	20.38	16.40
4.06i - Under 75 mortality rate from liver disease	Persons	2005 - 07	13.85	20.17	16.78
4.06i - Under 75 mortality rate from liver disease	Persons	2006 - 08	12.66	19.93	17.14
4.06i - Under 75 mortality rate from liver disease	Persons	2007 - 09	13.45	19.27	17.53
4.06i - Under 75 mortality rate from liver disease	Persons	2008 - 10	13.89	19.51	17.93
4.06i - Under 75 mortality rate from liver disease	Persons	2009 - 11	13.39	19.24	17.87
4.06i - Under 75 mortality rate from liver disease	Persons	2010 - 12	14.56	18.94	17.91
4.06i - Under 75 mortality rate from liver disease	Male	2001 - 03	17.16	28.93	18.00
4.06i - Under 75 mortality rate from liver disease	Male	2002 - 04	19.04	29.52	18.04
4.06i - Under 75 mortality rate from liver disease	Male	2003 - 05	20.03	29.49	20.90
4.06i - Under 75 mortality rate from liver disease	Male	2004 - 06	18.78	29.52	21.65
4.06i - Under 75 mortality rate from liver disease	Male	2005 - 07	17.60	28.99	22.32
4.06i - Under 75 mortality rate from liver disease	Male	2006 - 08	17.35	28.46	22.70
4.06i - Under 75 mortality rate from liver disease	Male	2007 - 09	16.27	27.11	23.26
4.06i - Under 75 mortality rate from liver disease	Male	2008 - 10	17.27	27.28	23.80
4.06i - Under 75 mortality rate from liver disease	Male	2009 - 11	16.81	26.79	23.68
4.06i - Under 75 mortality rate from liver disease	Male	2010 - 12	18.63	26.37	23.81
4.06i - Under 75 mortality rate from liver disease	Female	2001 - 03	9.48	13.23	23.76
4.06i - Under 75 mortality rate from liver disease	Female	2002 - 04	8.85	13.01	23.69
4.06i - Under 75 mortality rate from liver disease	Female	2003 - 05	12.20	12.34	11.01
4.06i - Under 75 mortality rate from liver disease	Female	2004 - 06	10.39	11.82	11.37
4.06i - Under 75 mortality rate from liver disease	Female	2005 - 07	10.38	11.91	11.48
4.06i - Under 75 mortality rate from liver disease	Female	2006 - 08	8.37	11.91	11.82
4.06i - Under 75 mortality rate from liver disease	Female	2007 - 09	10.78	11.90	12.03
4.06i - Under 75 mortality rate from liver disease	Female	2008 - 10	10.79	12.17	12.30
4.06i - Under 75 mortality rate from liver disease	Female	2009 - 11	10.20	12.13	12.29
4.06i - Under 75 mortality rate from liver disease	Female	2010 - 12	10.89	11.95	12.24
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2001 - 03	10.44	17.41	12.46
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2002 - 04	11.09	17.63	12.61
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2003 - 05	13.44	17.55	13.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2004 - 06	12.53	17.39	14.26
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2005 - 07	12.18	17.13	14.63
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2006 - 08	11.22	16.80	14.98
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2007 - 09	11.54	16.12	15.36
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2008 - 10	11.96	16.52	15.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2009 - 11	11.35	16.52	15.73
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	2010 - 12	12.78	16.55	15.73
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2001 - 03	13.98	24.55	15.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2002 - 04	15.78	25.13	15.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2003 - 05	16.79	25.35	18.59
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2004 - 06	16.23	25.68	19.25
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2005 - 07	15.44	25.04	19.88
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2006 - 08	15.96	24.62	20.27
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2007 - 09	14.86	23.13	20.77
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2008 - 10	16.22	23.54	21.34
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2009 - 11	15.77	23.33	21.19
4.06ii - Under 75 mortality rate from liver disease considered preventable	Male	2010 - 12	17.42	23.34	21.29
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2001 - 03	7.26	10.72	21.23
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2002 - 04	6.85	10.60	21.14
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2003 - 05	10.39	10.27	9.16
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2004 - 06	9.10	9.64	9.49
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2005 - 07	9.16	9.73	9.61
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2006 - 08	6.89	9.46	9.92
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2007 - 09	8.43	9.56	10.17
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2008 - 10	8.10	9.91	10.43
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2009 - 11	7.30	10.13	10.47
4.06ii - Under 75 mortality rate from liver disease considered preventable	Female	2010 - 12	8.62	10.18	10.39

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

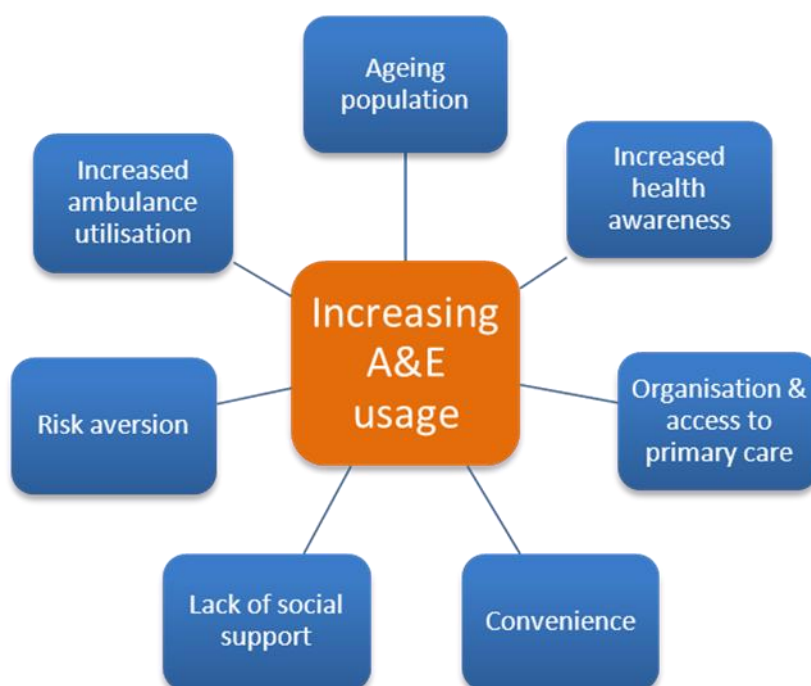
15. Frequent Attenders to Unscheduled Care

The current picture and why does it matter to us?

Increasing pressure has been put on accident & emergency departments (A&E) across the country in recent years with rising numbers of attendances. In 2013 – 2014, 21.7 million attendances were recorded at major A&E departments, single A&E departments, walk-in centres and minor injury units in England, compared to 19.1 million attendances in 2007 – 2008.¹

Numerous studies have looked at factors associated with A&E usage.²⁻⁴ Some suggest that factors such as ageing population, access to primary care, health awareness and convenience, have contributed to the rising A&E attendance rate. (**Figure 15.1**)

Figure 15. 1



These factors can be categorised into population factors, e.g. demographics, health state and socioeconomic status; and provider factors, e.g. access to primary care and continuity of care.

Evidence has been clear and consistent over the years in terms of population factors. For example, increasing age is found to be associated with increased A&E attendances. The same effect is observed in patients with lower socioeconomic status, social isolation and lack of social support. In addition,

having a chronic disease or co-morbidities, such as cardiovascular disease, respiratory disease and terminal illness, is also linked with A&E attendances.

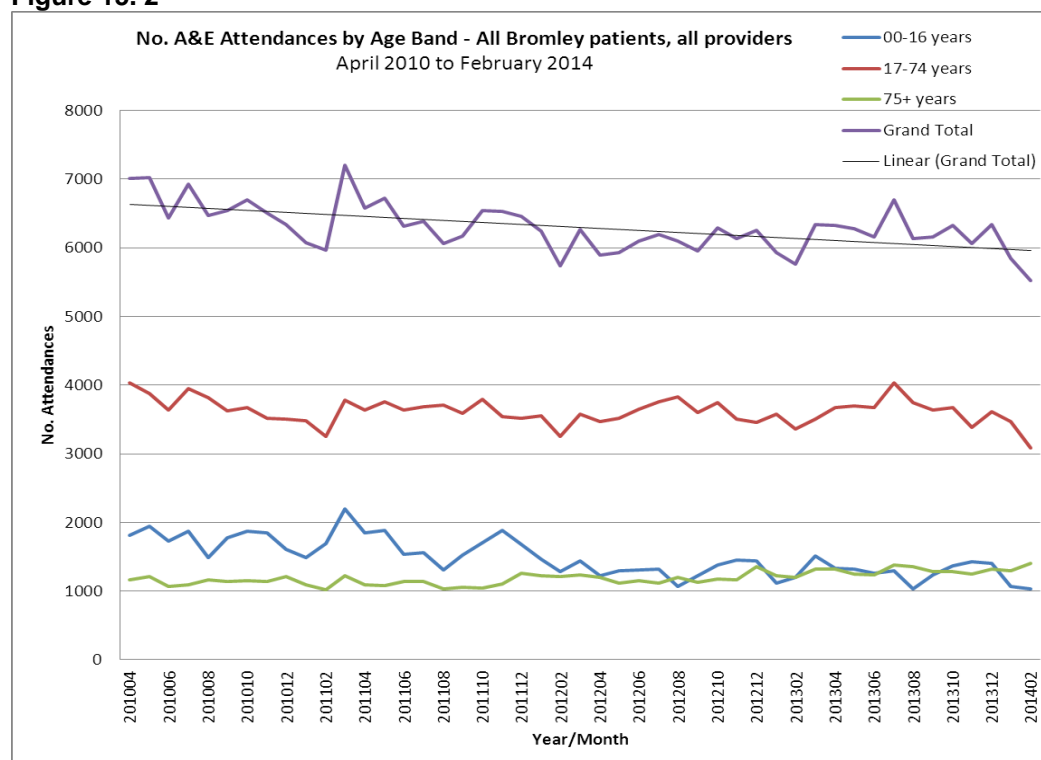
The evidence for provider factors, however, is less clear and consistent. Some suggest that increased access to primary care in terms of longer opening hours and more appointment slots would reduce A&E attendances. The changes to the delivery of the out-of-hour primary care service in 2004 have also been suggested to have led to an increase in attendances. However, this is contradicted by the fact that most people go to A&E during working hours, meaning some people may choose to go to A&E or walk-in centres in terms of preference or they think they will not be able to get an appointment with their GP.

Proximity to a primary health care practice and continuity of care in terms of seeing the same GP have been suggested to influence A&E attendances. However, fewer clear associations are found for these factors.

A recent King's Fund report on transforming the health care system highlights some of the current problems that contribute to the burden of emergency care:⁵

- Highly fragmented urgent care services generate confusion among patient about how and where to access care.
- Lack of alternative options have led to admission of patients even when it is not clinically justified.
- Poor sharing of information as patients move between providers causes failures of care.

In Bromley, the major A&E unit is located at the Princess Royal University Hospital, alongside a GP-led Urgent Care Centre (UCC). However, as Bromley is one of the largest boroughs in London, some residents may find A&E departments in neighbouring boroughs more accessible, such as Queen Elizabeth Hospital in Greenwich, University Lewisham Hospital in Lewisham, King's College Hospital in Lambeth and Croydon University Hospital in Croydon.

Figure 15. 2

Source: South London Commissioning Support Unit, 2014

Figure 15. 2 shows the total number of A&E attendances by Bromley registered patients in recent years. Fluctuations in the number of attendances can be observed throughout. The apparent reduction in A&E attendances can possibly be explained by the opening of UCCs in Bromley, Bexley and Greenwich. In particular for the 0-16 years age group, there has been a change in clinical protocol, where this cohort of patients could be seen directly in the UCC without A&E triage. Nevertheless, the number of A&E attendances remains high and the pressure on resources and staff are still being felt across the emergency care sector.

Recently, an increase in A&E waiting times has been noticed by clinicians and commissioners in Bromley. It is difficult to determine the extent to which this is attributable to the number of attendances. However, this may reflect problems with the flow of patients within the hospital, e.g. admission delay due to bed shortage; investigation delay due to imaging waiting time, specialist review; and discharge delay due to social care and specialist care arrangements. The latter further highlights potential problems with patient flow in the community. For example, delay in community care provision set up, access to primary care, which may potentially lead to the deterioration of clinical symptoms and A&E attendances.

It is important to remember that healthcare resources are limited, and each A&E attendance would carry not just monetary costs. For example:

- Cost of investigations and treatment
- Cost of time of patient/carer, e.g. time off school/work
- Cost and time of transport
- Time of healthcare professionals
- Health implications to other patients due to waiting time

For each attendance, even if the patient does not wait to be seen, some of these costs still apply and a charge is incurred to the commissioners.

Among all A&E users, some patients are found to be attending A&E frequently, which adds further pressure to the already stretched resources. This group of patients are often referred to as '*A&E frequent attenders*'. Although there is no standard definition for an A&E frequent attender, generally it is considered to be someone who attends A&E three or more times in a year. Some studies have already tried to profile these A&E frequent attenders, looking at their demographics, presenting complaint and outcomes, to better understand this group.^{6,7}

The issue with A&E frequent attenders highlights the question of whether the healthcare needs of these patients are being met by the current service provision, and if these needs should be met by the emergency services or other alternative care pathways. Although these frequent attenders do not represent all the service users, we could see that a significant amount of resource could be saved if the number of frequent attendances could be reduced. By understanding the profile and health seeking behaviour of this particular group of patients, policy makers will be able to tailor their approach towards this group to help relieve the immense pressure on the emergency services

Understanding the Bromley picture

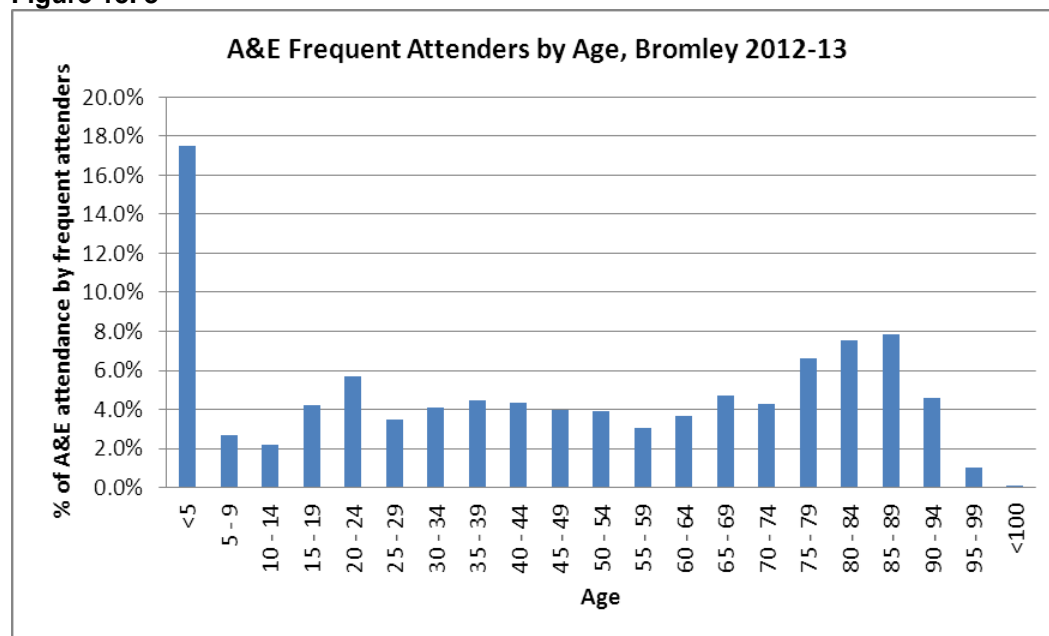
We looked at patients registered with a Bromley GP who attended any A&E department on three or more occasions between April 2012 and March 2013, examining their demographics, presenting complaints and outcomes of their visits.

Between 2012-2013, there was a total of 100,967 A&E attendances recorded for patients registered with Bromley GP practices. Out of these, 22,598 attendances (22.4%) were recorded from 5362 patients who are classified as A&E frequent attenders.

The frequency of attendances ranged from 3 to 135 times, with an average of 4

visits per year. Most of these attendances were visits to A&E at the South London Healthcare Trust (79%) – which includes Princess Royal Hospital and Queen Elizabeth Hospital. This was followed by University Lewisham Hospital (9%), King’s College Hospital (4%) and Croydon University Hospital (3%).

Figure 15. 3



Source: South London Commissioning Support Unit, 2014

Out of 5362 patients, 2834 were female (52.9%) and 2528 were male (47.1%), with a male to female ratio of 1 to 1.12. **Figure 15.3** demonstrates the age distribution of the frequent attenders, which shows a particularly high number of frequent attenders under 5 years of age (17.5%), with a significant proportion of these being <1 year of age (41%).

Top 10 Presenting Complaints for A&E Frequent Attenders

Table 15.1 shows the top 10 presenting complaints found among the A&E frequent attenders, which represents 63% of the attendances. Due to limits in data sharing from providers, presenting complaints for patients attending hospitals other than the South London Healthcare Trust were not known, which accounts for 4792 attendances (21.2%) of the total frequent attendances.

Table 15. 1 Ten commonest presenting complaints among A&E frequent attenders, Bromley 2012-13

<i>Presenting Complaint Category</i>	<i>Frequency</i>	<i>% of total attendances</i>
1. Unknown	4792	21.2%
2. Respiratory illness	2002	8.9%
3. Unwell	1528	6.8%
4. Abdominal Pain	1203	5.3%
5. Injury	966	4.3%
6. Fall	934	4.1%
7. Chest Pain	880	3.9%
8. Gastrointestinal disease	782	3.5%
9. Musculoskeletal problems	584	2.6%
10. Febrile illness	547	2.4%

Source: South London Commissioning Support Unit, 2014

Apart from the 'unknown' category, respiratory illness was the commonest presenting complaint, which included symptoms such as cough, shortness of breath, chest infection and asthma attack. This was followed by the 'unwell' and 'abdominal pain' categories.

Among the frequent attenders, 4.9% presented with complaints that were neither accident nor emergency, or could have been easily be dealt with by primary care or other appropriate care pathways. (**Table 15.2**)

Table 15. 2

<i>Presenting Complaint Category</i>	<i>Frequency</i>	<i>% of attendances by freq. attenders</i>
Intravenous/Intramuscular injection	529	2.3%
Catheter problem	223	1.0%
Blood test	112	0.5%
Asked to return/review	107	0.5%
Feeding tube problem	47	0.2%
Dressing change	44	0.2%
Radiology request	18	0.1%
Cannula or other access problem	17	0.1%
Antibiotics	8	0.0%
Removal of stitches	3	0.0%
Total	1108	4.9%

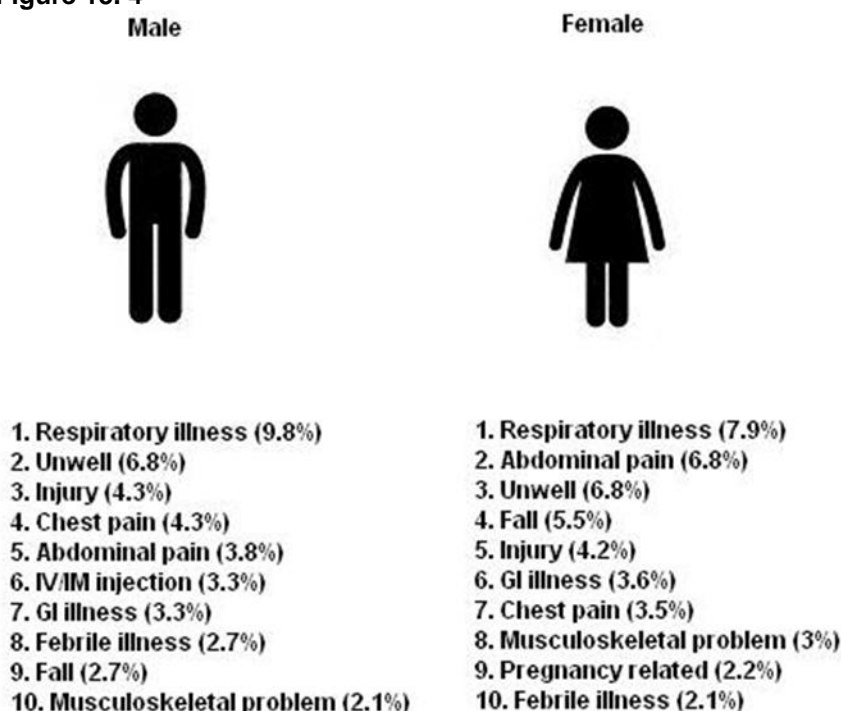
Source: South London Commissioning Support Unit, 2014

Presenting Complaint by Age & Sex

We further looked at presenting complaints by age and sex, where variations could be seen between different age groups and sex. This could be due to differences in health seeking behaviour between different sexes and age groups, as well as variations in common illness associated with age and gender.

Excluding the unknown category, respiratory illness was the commonest presenting complaint for both female and male. However, some variations in presenting complaint were observed between male and female. For example, abdominal pain was the third commonest presenting complaint among women, but it was the sixth for men; Chest pain was the fifth commonest presenting complaint among men, but it was the eighth for women. (**Figure 15.4**)

Figure 15. 4



Source: South London Commissioning Support Unit, 2014

Apart from the 'unknown' presenting complaint, variations in presentation complaints were also observed between age groups. (**Figure 15.5**)

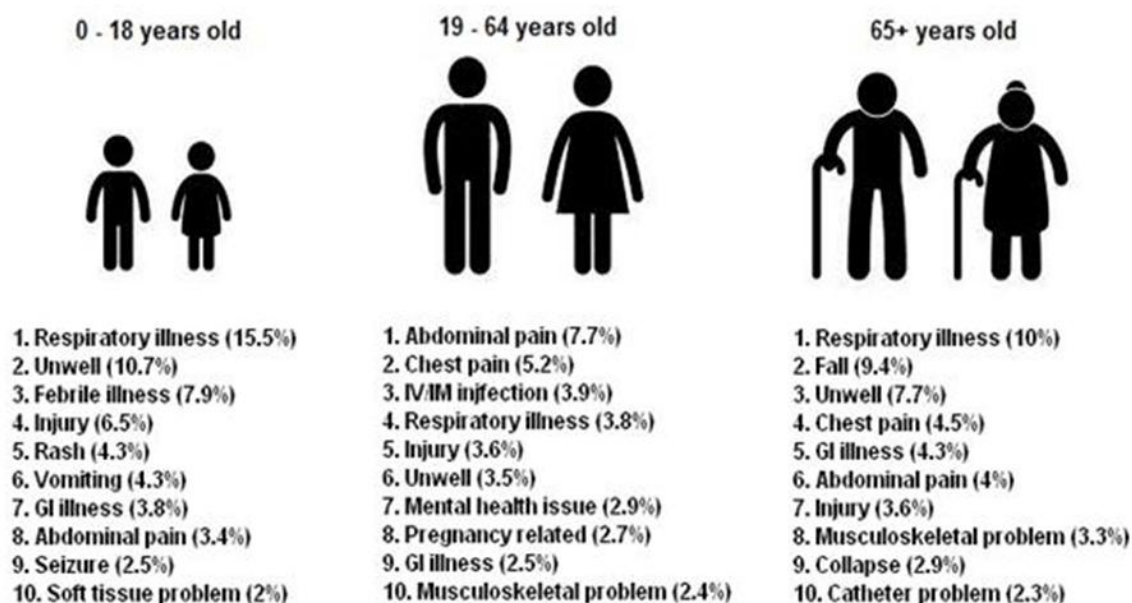
Among the 0 – 18 year age group, common presenting complaints were similar to those seen in primary care for this age group, e.g. 'respiratory illness', 'unwell', 'febrile illness' and 'injury' and 'rash'.

For the 19-64 year age group, the commonest presenting complaint had changed to 'abdominal pain', followed by 'chest pain'. There was also a higher

proportion (2.9%) of patients who presented with mental health issues, which was only a minority for 0-18 years old (0.28%) and 65+ years old groups (0.42%).

In the 65+ year age group, 'respiratory illness' was the commonest presenting complaint, followed by 'fall', which was almost exclusive to this age group.

Figure 15. 5: Common A&E presenting complaints by age groups, Bromley 2012-13



Source: South London Commissioning Support Unit, 2014

Patient Outcomes

We are also interested in what happened to the patients who attended the A&E. (**Table 15.3**)

We found that the majority of attendances were discharged (49%), with over half of them not requiring any follow up at all and some with follow up by GP. A large proportion of attendances also resulted in admission into hospital, with an admission rate of 34.9%.

It is important to note that just under 1000 attendances had patients leaving the department before being treated, which is almost the same as the number of referrals to out-patient clinic.

Table 15. 3: Outcomes of A&E attendance, Bromley 2012-13

Patient outcome	Frequency	%
1. Admitted to a hospital bed	7898	34.9%
2. Discharged - no follow up	6232	27.6%
3. Discharged - follow up by GP	4825	21.4%
4. Referred to other out-patient clinic	986	4.4%
5. Left department before being treated	985	4.4%
6. Transferred to other health care provider	828	3.7%
7. Referred to other health care professional	297	1.3%
8. Referred to fracture clinic	177	0.8%
9. Refused treatment	174	0.8%
10. Referred to A&E clinic	93	0.4%
11. Other	80	0.4%
12. Died in department	22	0.1%
13. Unknown	1	0.0%

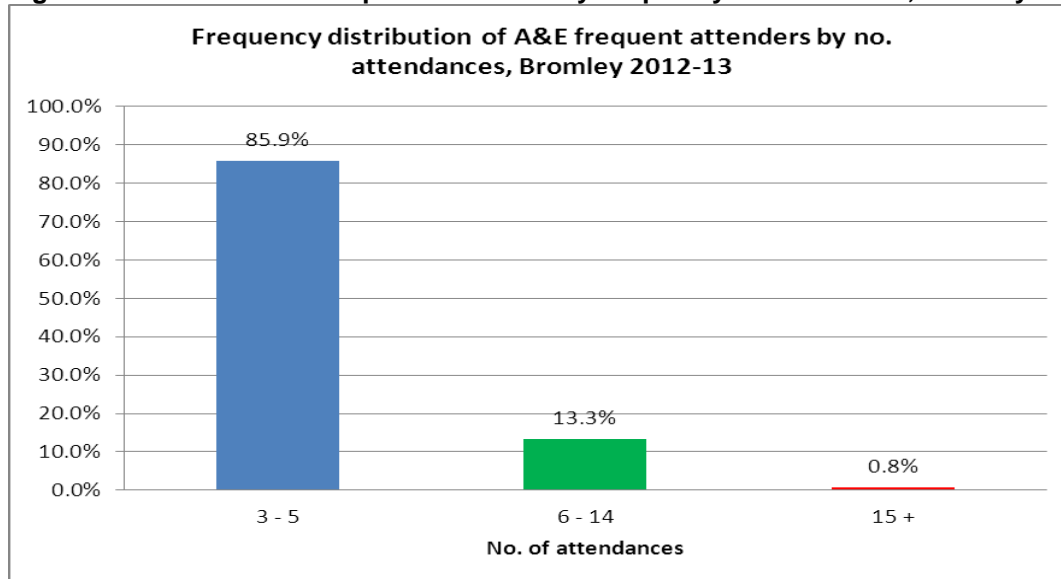
Source: *South London Commissioning Support Unit, 2014*

Presenting Complaint in different frequent attenders

We further classified the patients in three different categories:

- Patients attending A&E 3 – 5 times per year (low frequency attender)
- Patients attending A&E 6 – 14 times per year (medium frequency attender)
- Patients attending A&E 15+ times per year (high frequency attender)

Figure 15.6 shows the frequency distribution of attenders by number of attendances, with majority of frequent attenders visiting A&E between 3 – 5 times per year (85.9%).

Figure 15. 6: No. of A&E frequent attenders by frequency of attendance, Bromley 2012-13

Source: South London Commissioning Support Unit, 2014

Variations in presenting complaint were also observed between patients in these three categories. (**Table 15.4**)

Excluding the 'unknown' category, 'respiratory illness', 'unwell', and 'abdominal pain' were the top three commonest presenting complaints for both low and medium frequency attender groups, which accounted for similar proportions in both groups.

Among the high frequency attender group, 'Unknown' presenting complaint was accountable for nearly half of the attendances. However, there were a relatively higher number of attendances related to intravenous/intramuscular injection, as well as alcohol and mental health issues compared to the low and medium frequency attender groups.

Table 15. 4: Top 10 A&E presenting complaints by frequency of attendance, Bromley 2012-13

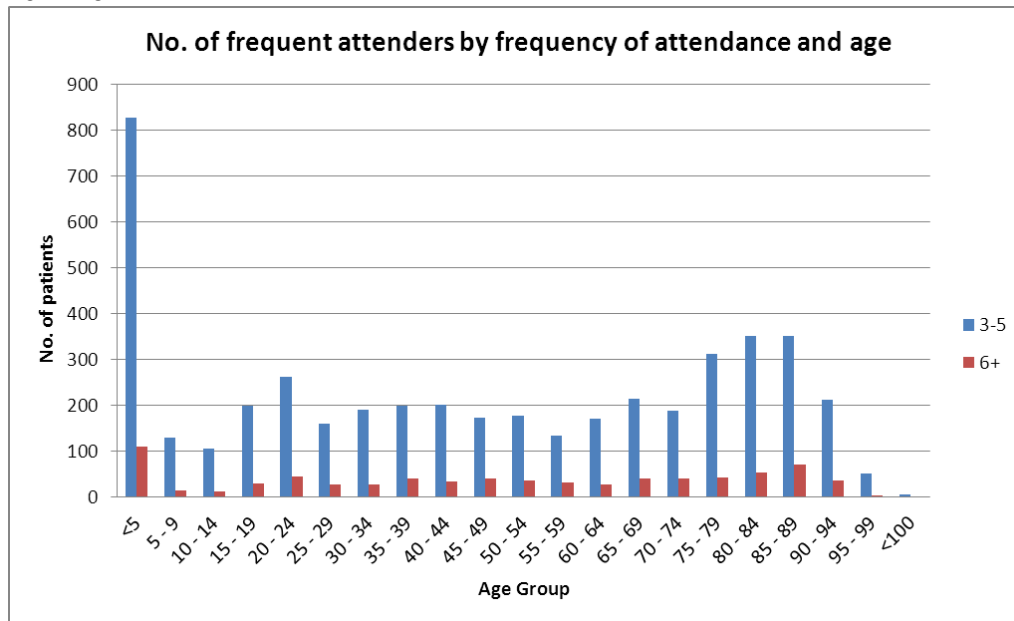
<i>Low frequency attender (3-5)</i>	<i>No. of attendances (%)</i>	<i>Medium frequency attender (6-14)</i>	<i>No. of attendances (%)</i>	<i>High frequency attender (15+)</i>	<i>No. of attendances (%)</i>
1. Unknown	3185 (19.7%)	1. Unknown	1063 (19.9%)	1. Unknown	541 (49.6%)
2. Respiratory illness	1521 (9.4%)	2. Respiratory illness	423 (7.9%)	2. IV/IM	62 (5.7%)
3. Unwell	1100 (6.8%)	3. Unwell	403 (7.5%)	3. Respiratory illness	56 (5.1%)
4. Abdominal Pain	890 (5.5%)	4. Abdominal Pain	281 (5.3%)	4. Chest Pain	52 (4.8%)
5. Injury	767 (4.7%)	5. IV/IM	250 (4.7%)	5. Fitting	41 (3.8%)
6. Fall	708 (4.4%)	6. Fall	213 (4.0%)	6. Alcohol	37 (3.4%)
7. Chest Pain	623 (3.9%)	7. Chest Pain	205 (3.8%)	7. Mental Health	33 (3.0%)
8. Gastrointestinal disease	583 (3.6%)	8. Gastrointestinal disease	190 (3.6%)	8. Abdominal Pain	32 (2.9%)
9. Musculoskeletal	436 (2.7%)	9. Injury	178 (3.3%)	9. Unwell	24 (2.2%)
10. Febrile	433 (2.7%)	10. Musculoskeletal	137 (2.6%)	10. Collapse	22 (2.0%)

Source: South London Commissioning Support Unit, 2014

The majority of low and medium frequency attenders were under the age of 10 (20.8% and 17% respectively). Whereas for the high frequency attenders, the majority were of working age: 40-49 years old (23.3%), 30-35 years old (20.9%), and 50-59 years old – 14%. (**Figure 15.7**)

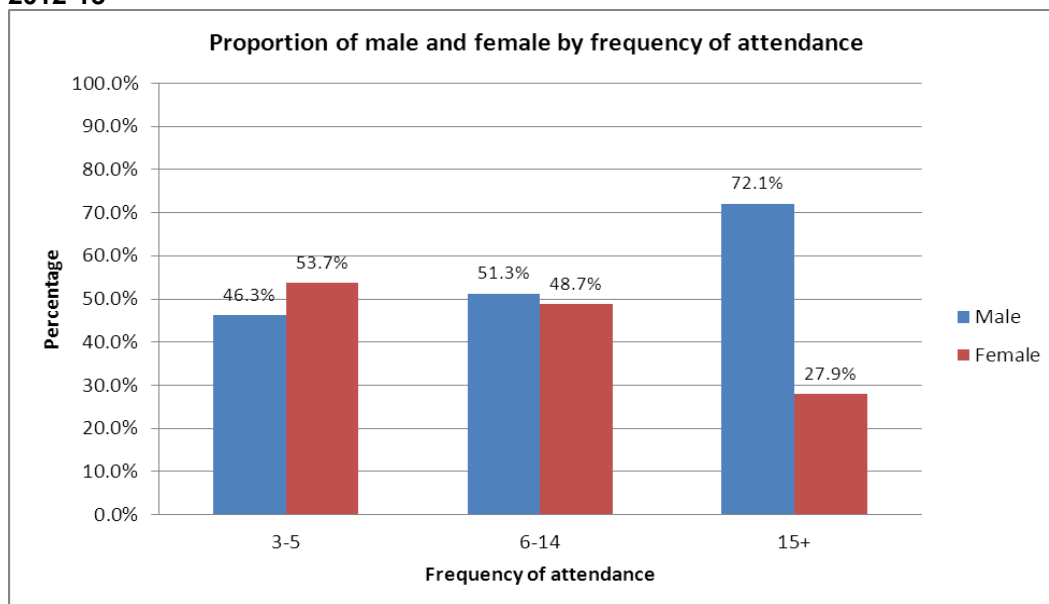
The female to male ratio also changes as the frequency of attendance increases, with a shift from more female than male in the low frequency group (53.7% vs 46.3%) to more male than female in the high frequency group (72.1% vs 27.9%). (**Figure 15.8**)

Figure 15. 7: No. of A&E frequent attenders by frequency of attendance and age, Bromley 2012-13



Source: South London Commissioning Support Unit, 2014

Figure 15. 8: Proportion of male and female by frequency of A&E attendance, Bromley 2012-13

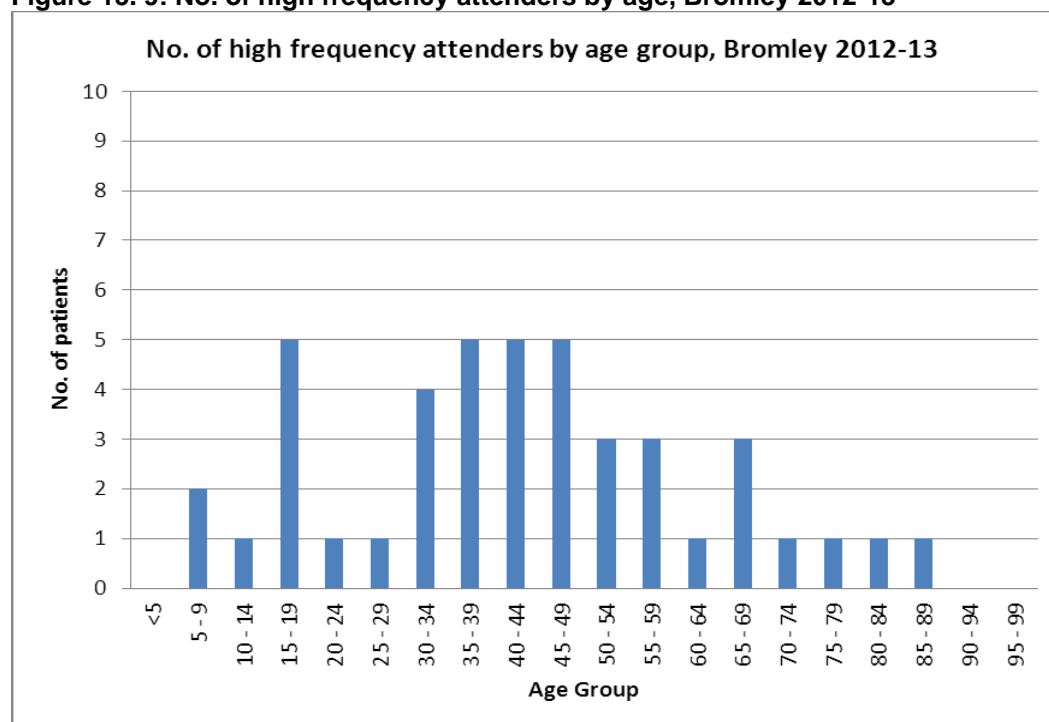


Source: South London Commissioning Support Unit, 2014

High Frequency Attenders (15+ attendances)

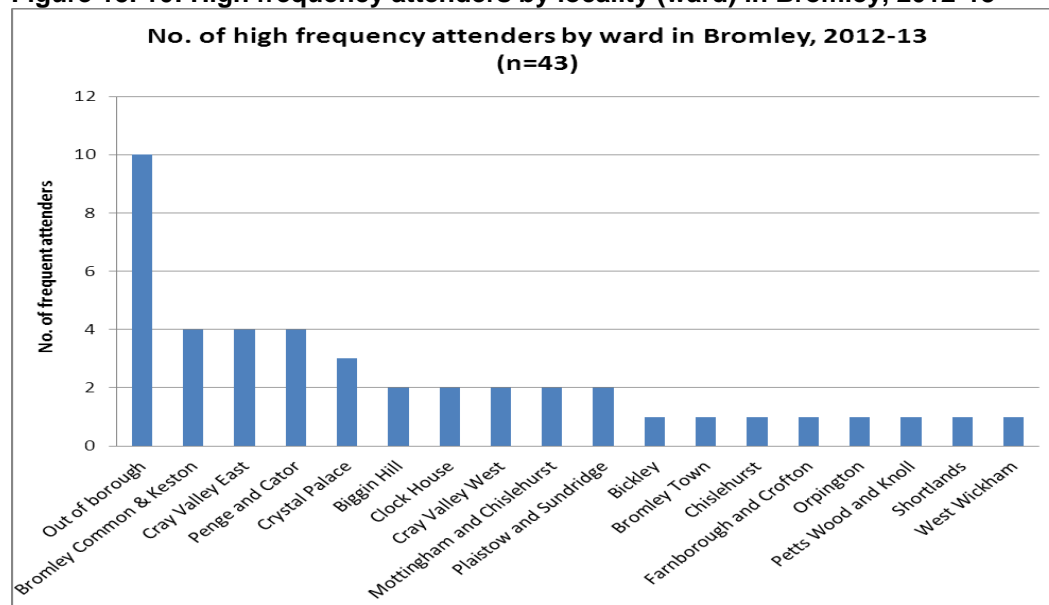
A total of 1090 attendances were attributed to 43 patients who had 15 or more visits to the A&E department in 2012 – 2013, with a much higher proportion of male (72%) than female (28%). The average age of this group of patients was 42.5 years old, with the highest number of patients between 40 – 49 years old. (**Figure 15.9**)

Figure 15. 9: No. of high frequency attenders by age, Bromley 2012-13



Source: South London Commissioning Support Unit, 2014

Looking at these high frequency attenders by locality, a relatively high number of them were resident out of borough and registered with a Bromley practice (n=10, 23%), and of those resident in Bromley, the highest numbers were from Bromley Common & Keston (n=4, 9.3%), Cray Valley East (n=4, 9.3%) and Penge & Cator (n=4, 9.3%). (**Figure 15.10**) Although these numbers are relatively small to detect any obvious trend, it should be noted that Cray Valley East (IMD score=25.10), Penge & Cator (IMD score=25.78) and Crystal Palace (IMD score=33.47) have higher levels of deprivation than the Bromley average (IMD score=14.29), which suggests there is potential association between frequent attenders and deprivation. It is not possible to draw any conclusions about the significance of the high proportion of out of borough residents in this category from the available data.

Figure 15. 10: High frequency attenders by locality (ward) in Bromley, 2012-13

Source: South London Commissioning Support Unit, 2014

As described previously, apart from the 'unknown' category, the commonest presenting complaint for this group was 'intravenous/intramuscular injection', followed by 'respiratory illness' and 'chest pain'. (**Table 15.4**)

However, when we looked at the top three presenting complaints of these 43 patients individually, we found that 'chest pain' was the commonest presenting complaint for ten patients. This was followed by 'alcohol-related problem', 'mental health issue', 'respiratory illness', and 'abdominal pain'. (**Table 15.5**).

Table 15. 5: Common A&E presenting complaint for high frequency attenders, Bromley 2012-13

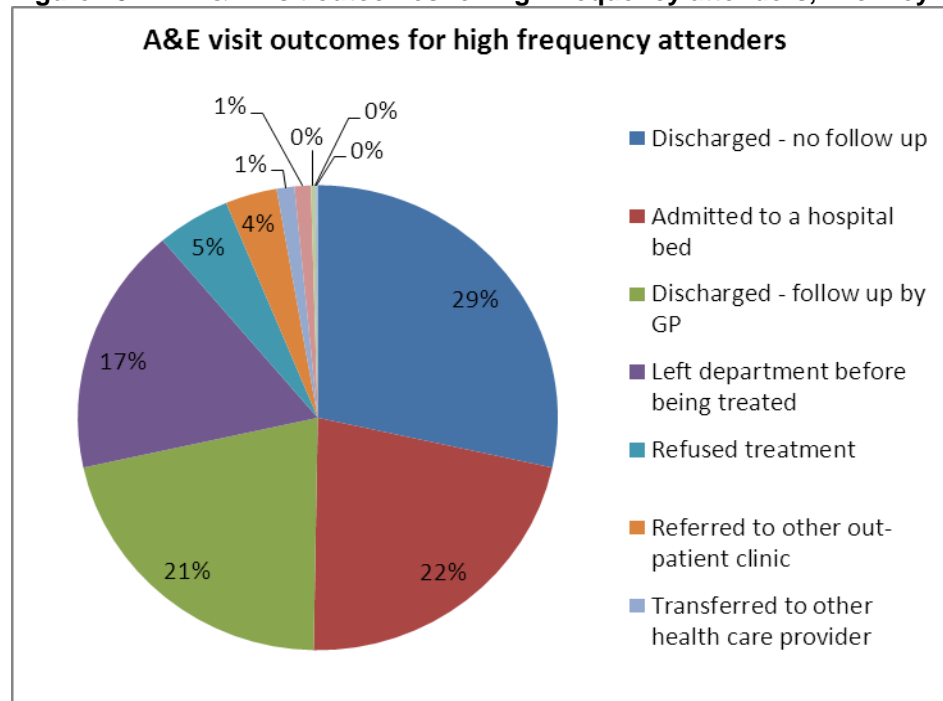
Presenting complaint	Frequency
1. Unknown	27
2. Chest Pain	10
3. Alcohol-related problem	8
4. Mental health issue	8
5. Respiratory illness	7
6. Abdominal pain	5
7. Seizure	4
8. IV/IM injection	4
9. Fall	3
10. Sickle Cell	3

Source: South London Commissioning Support Unit, 2014

Similar to the figures for all A&E attenders, the majority of high frequency attenders were discharged (49.7%), some with no follow-up and some with the advice to be followed up by their GP. However, there is a lower admission rate

for this group of patients, with only 21.8% compared to the overall admission rate of 34.9% described previously. There is also a much higher proportion of attendances with patients leaving the department before being treated (17.2%) compared to the overall proportion (4.4%). (**Figure 15.11**)

Figure 15. 11: A&E visit outcomes for high frequency attenders, Bromley 2012-13

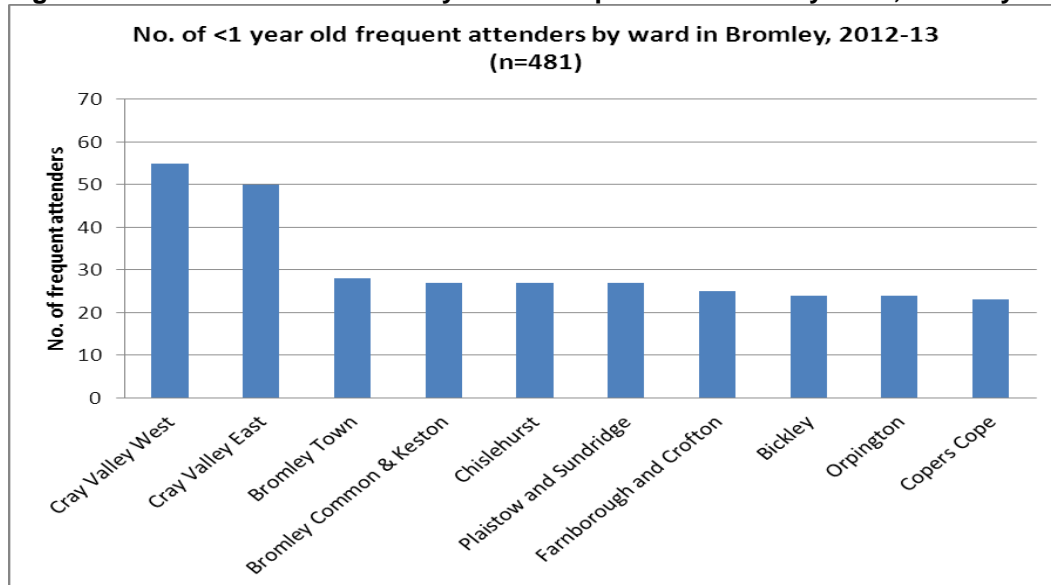


Source: South London Commissioning Support Unit, 2014

The under 1 year-old group

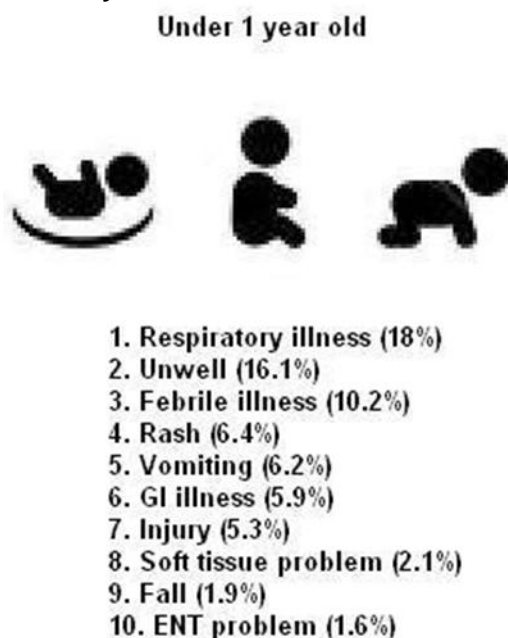
We could see from previous figures that the under 5 years old group contributed to the highest number of A&E attendances, and among this group the biggest single age group was <1 year old (42%).

A total of 2011 attendances were by patients of under 1 year of age (<1 year group), contributed by 481 patients. There were more male (60%) than female (40%). We further looked at the locality of these frequent attenders and found that approximately 64% of these attenders were from the 10 wards outlined below, where Cray Valley West and Cray Valley East have the highest number of frequent attenders (n=55 and n=50) compared to other wards. (**Figure 15.12**) This again, has highlighted the possible association between deprivation and frequent attendances as these two wards have higher levels of deprivation (IMD score= 27.12 and 25.10 respectively) than the Bromley average (IMD score=14.29).

Figure 15. 12: Location of under 1 year old frequent attenders by ward, Bromley 2012-13

Source: South London Commissioning Support Unit, 2014

The commonest presenting complaint was 'respiratory illness', followed by 'unwell'. (**Figure 15.13**) Compared to the overall attendances by patients under 5 years of age, the <1 year group contributed to over half of the attendances with complaints of 'febrile illness' and 'rash' (51% and 59% respectively).

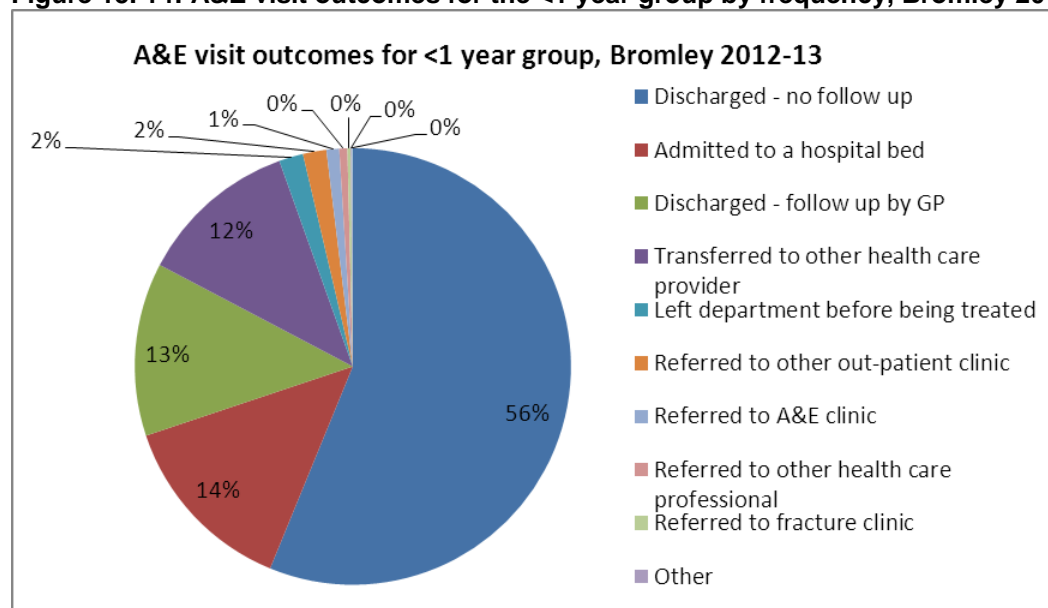
Figure 15. 13: Common A&E presenting complaints for the <1 year group, Bromley 2012-13

Source: South London Commissioning Support Unit, 2014

Figure 15.14 shows the outcomes of the A&E visits. Compared to other age groups, the <1 year group had a much larger proportion of attendances being discharged, either with no follow-up or with GP follow-up (69% compared to

49% of the overall rate). A much lower admission rate was also noted for the <1 year group (13.7% compared to 34.9% of the overall rate).

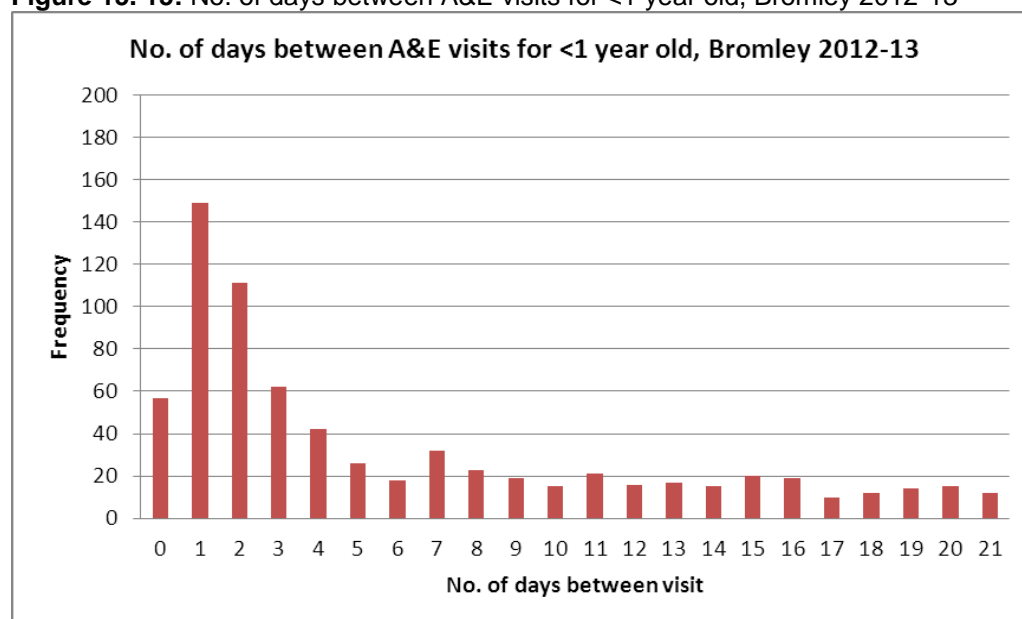
Figure 15. 14: A&E visit outcomes for the <1 year group by frequency, Bromley 2012-13



Source: South London Commissioning Support Unit, 2014

Further analysis was performed to look at the number of days between each visit for the <1 year frequent attenders, which ranged from same day re-attendance to 352 days since the previous visit. A relatively high number of these attendances were 1- 2 days after the previous visit (n=260). (**Figure 15.15**)

Figure 15. 15: No. of days between A&E visits for <1 year old, Bromley 2012-13



Source: South London Commissioning Support Unit, 2014

What does all this data mean?

From the data collected, we know that for every five A&E attendances, one of them was by a user who had attended the A&E three or more times a year, and the majority of these had visited the A&E between 3-5 times per year. A significant proportion of patients were under 5 years of age. This leads us to query the possible causes for this trend:

- Were the visits of a genuine medical nature? (i.e. could have been resolved without recourse to a healthcare professional)
- Was the original medical complaint dealt with fully in the first visit?
- Were there issues with access to primary care services?
- Were there issues with the health seeking behaviour? (i.e. healthcare options other than A&E were not taken into consideration).
- Were there gaps in service provision?

It is difficult from this dataset to judge the extent to which the above reasons contributed to these attendances, especially when a large proportion of presenting complaints was 'unknown' due to limitations in data collection.

Nonetheless, from the data of high frequency attenders, we see that some of them presented to A&E with complaints that could possibly be prevented or dealt with in the community or other health services or pathways, e.g. alcohol related issues, mental health, IV/IM injection. It is also worth noting that there was much a higher proportion of male than female among this group of attenders. The majority of patients were of working age.

Furthermore, we can see that a large number of high frequency attenders were discharged, as well as a relatively high percentage of patients leaving the department without being seen. This brings out the question of whether there are other possible pathways that can meet the health needs of this group of patients, and if methods with the aim to change their health seeking behaviour may alter their attendance pattern.

The question of unmet health needs is supported by a recent survey carried out by the College of Emergency Medicine which found that only 15% of the patients attending A&E surveyed could have been treated in the community. This means that although some of these patients do not require hospital admission or follow up, they do require medical attention. However, whether these unmet health needs should be catered for by A&E is questionable.

In addition, it raises the question of whether these frequent attenders could have been identified at an earlier stage, especially when some of them are attending A&E repeatedly with the same presenting complaint. Potentially, if these frequent attenders are identified early and their health problems are either dealt with or referred to other possible care pathways, it may reduce the number of

A&E attendances. For example, management of alcohol-related problem, recurrent falls, mental health issues, and intravenous/intramuscular injection.

We know that in Bromley, there have been several contractual changes in recent years to help relieve the pressure on emergency services, for example:

- Incentives for GP to look for frequent attenders, patients at risk of falls or recurrent falls, and carers who are struggling to cope
- Increase end of life care capacity
- Introduction of community matron for proactive care
- Quality/Productivity review of GP
- IV pathway for cellulitis treatment
- Medical response team (step-up)
- Rehabilitation in home/intermediate care (step-down)

Work is currently underway with integrated teams (primary, community and social care) in Bromley, and this may have an impact on A&E attendance rates as a wide range of services are provided close to patients home.

For the very young attenders (<1 year of age), they presented to A&E with illnesses that were often managed by primary care services as well, which means many of these attendances could have been managed in the primary care sector. This is further supported by the fact that a large proportion of patients from these visits were discharged with no further follow up required, implying that these attendances were not of significant illnesses.

However, it is important to note that for Princess Royal Hospital, children under 1 year of age are seen directly by the paediatric team instead of the A&E team, which may potentially explain some of the differences seen in the outcomes of the visit. It is because the paediatric team may have more confidence in diagnosis and management of the very young, and therefore, be able to either monitor or treat the children in the community instead of admitting them.

Furthermore, a relatively high number of these attendances took place between 1-2 days since the previous visits, which highlighted the question of whether these visits were due to the nature of disease in the very young children and required repeat assessment, or due to clinical needs not satisfied in the previous visit.

To target this group of young attenders, we would need to look at how parents interact with health services, and the reasons for them bringing their children to A&E departments. There may also be a role for health visitors to influence their behaviour as well.

However, the data analysed in this report does not provide a comprehensive picture of the overall situation with frequent attenders. In order to better

understand the situation, we would also need to look at the attendance pattern of the urgent care centre, utilisation of Emdoc (GP out-of-hour service) as well as background data for frequent attenders of primary care services. These data, however, are not included in this report.

Nevertheless, this report has presented a snapshot view of some of the issues with A&E frequent attenders and highlighted further questions that need to be addressed in the current set up of the emergency services.

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

Rising A&E attendance is influenced by multiple factors, such as ageing population, burden from chronic diseases and socio-economic issues.

1 in 5 A&E attendances are by frequent attenders.

A significant proportion of frequent attenders are under the age of 5 years, in particular the under 1 year age group.

Only a third of the visits by frequent attenders resulted in hospital admissions.

There are indications that improving/ developing primary and community care services could reduce the number of frequent attenders.

There is scope for further work to assess the needs of A&E frequent attenders.

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

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16. Asset Based Community Development

Background

JSNAs are assessments of the current and future health and social care needs of the local community. – these are needs that could be met by the local authority, CCGs, or NHS England. JSNAs are produced by Health and Wellbeing Boards, and are unique to each local area. The policy intention is for Health and Wellbeing Boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities.

Traditionally, JSNAs have been developed using a deficit approach by focusing on problems, needs and deficiencies in communities, such as deprivation and illness. The information provided meant that commissioners were likely to design services to fill the gaps and fix the problems. This can lead to individuals and communities feeling disempowered and dependent, becoming passive recipients of services rather than active agents in their own and their families' lives⁵³.

The asset approach doesn't only see the problems that need fixing and the gaps that need filling. It values the capacity, skills, knowledge, connections and potential in a community. In an asset approach, the glass is half-full rather than half empty.

The asset based approach provides a new way of challenging health inequalities, valuing resilience, strengthening community networks and recognising local expertise. Using an asset based approach can allow commissioners to re-evaluate how services are delivered in a locality and to build upon the strengths that already exist.

The Asset Based Approach

The asset approach is a set of values and principles and a way of thinking about the world. It:

- identifies and makes visible the health-enhancing assets in a community
- sees citizens and communities as the co-producers of health and well-being, rather than the recipients of services
- promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment

⁵³ A Glass Half Full – How an Asset Based Approach Can Improve Community Health and Wellbeing. IDeA 2010

- values what works well in an area
- identifies what has the potential to improve health and well-being
- supports individuals' health and well-being through self esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources
- empowers communities to control their futures and create tangible resources such as services, funds and buildings.
- communities can drive development and change themselves by identifying and mobilising existing (but often unrecognized) assets, thereby responding to and creating local opportunity for positive changes.

While these principles will lead to new kinds of community based working, they could also be used to refocus many existing council and health service programmes.

Why is it Important to Consider an Asset Based Approach to the JSNA?

There are a number of national and local policy contexts which are putting public sector organisations under pressure to re-examine their traditional approaches. These include:

- A failure to significantly shift **health inequalities** nationally, despite investment in both primary and secondary care, and disproportionate investment in the most deprived communities.
- Heavy investment in a **traditionally needs/deficit led model**, which has contributed to over dependence by many of our poorest communities on a heavy state support structure, and has also impacted on a reduction in empowerment and confidence in those communities.
- The findings of '**The Marmot Review**', which strongly evidenced the links between poor health and broader social disadvantage and challenged those addressing health inequalities to contribute to sustainable solutions for communities that also addressed work, economic status and educational issues. It also called strongly for individuals and communities to be more actively involved in local decision making as part of a broader empowerment agenda.
- A radical shift in national political ideology, with a challenge to those involved with communities to help enable '**The Big Society**', with its emphases on co-production, community commissioning, transfer of power away from statutory providers and into the hands of the voluntary/community sector – with a heavy emphasis on unpaid and

voluntary delivery. The new emphasis on the development of ‘**Localism**’ is also a challenge to disaggregate services and delivery down to neighbourhood level wherever possible.

- A new climate of rapid and aggressive **efficiency savings**, with the effects of reductions in service about to be felt most keenly by our poorest and most currently dependent communities.
- An increasing emphasis on the need for Health & Wellbeing Boards to deliver rich and vibrant JSNAs which can be used as the basis for the development of all **Health and Wellbeing Strategy** work, and which can support the moves towards modernising commissioning processes across the board. The JSNA needs to offer a strong picture of the needs and strengths of the communities it serves –which the inclusion of asset based approaches can strongly contribute to.
- The changes to the way in which health services are commissioned with commissioning decisions being made by Clinical Commissioning Groups. **Health and Wellbeing Boards** will enable consortia, alongside other partners, to contribute to effective joint action to promote the health and wellbeing of local communities. and to ensuring that Clinical Commissioning Groups and other partners commission service delivery based on an assessment of population based needs and assets rather than individual needs.
- A shift towards enabling more older people and people with long-term conditions to live independently in their own homes, ensuring that they get the support that they need to do so. A JSNA that looks at community assets and community capacity to support **independent living** as well as population needs will enable the development of a commissioning framework that embraces co-production. This will ultimately identify how people can help themselves and each other as well as the professional services that are required.

The Practicalities

An asset is considered to be any of the following:

- ***the practical skills, capacity and knowledge of local residents***
- ***the passions and interests of local residents that give them energy for change***
- ***the networks and connections – known as ‘social capital’ – in a community, including friendships and neighbourliness***
- ***the effectiveness of local community and voluntary associations***

- ***the resources of public, private and third sector organisations that are available to support a community***
- ***the physical and economic resources of a place that enhance well-being.***

An asset based approach starts by asking questions and reflecting on what is already present:

- ***What makes us strong?***
- ***What makes us healthy?***
- ***What factors make us more able to cope in times of stress?***
- ***What makes this a good place to be?***
- ***What does the community do to improve health?***

A recommended approach is to:

- ***find out what is already working and generate more of it***
- ***promote the project based on what it is trying to achieve, not what the problems are e.g. ‘Salford: a smoke free city’ rather than ‘reduce the high number of smokers in the city’.***
- ***cherish the assets – as soon as people are talking to each other they are working on the solutions***
- ***actively build capacity and confidence among communities and staff***
- ***involve the ‘whole system’ from the beginning – those left out will be left behind***
- ***design in what is needed to achieve the desired future, design out the structures, processes and systems that are stopping this future being achieved, ensure the long-term sustainability of the solutions and the project.***

An Asset Based Approach in Bromley

We already have an example of the first steps towards an asset based approach in Bromley, with a mapping of assets in the Cray Valley community.

In Spring 2013, the Council⁵⁴ began a project within the Cray Valley community to develop and implement a website which details the local assets within, and around, the Cray Valley community. The plan was for this website, the Cray

⁵⁴ The Planning and Development Team within the Council's Education, Care and Health Services department, in partnership with the Council's Environment division, the Cray Valley Initiative Panel and a local Councillor.

Valley Information Portal, to support local residents and businesses to make their community better by:

- Improving the knowledge and use of the facilities and services in the local community
- increasing pride and wellbeing in the local community by raising awareness of the opportunities within the area and offering opportunities for people to help make their local community better
- supporting local businesses to thrive in the local community by raising their profile
- enhancing the role of the 'active citizen' in the local community by promoting the opportunities for people to help join local groups

The project was led by the Planning and Development Team within the Council's Education, Health and Care Services department, in partnership with the Council's Environment division, the Cray Valley Initiative Panel and a local Councillor.

The project was delivered by one member of staff. The project worker began by meeting with a number of key organisations, individuals and community representatives to identify what services and resources there were within the local area. This initially started with a list of the known services and it grew as more services/individuals were identified and recommended by people within the community.

It was identified early on within the project that the understanding of what constitutes the 'Cray Valley community' varied, and that key local landmarks and environmental features impacted significantly on the different services that people knew about and accessed. Therefore, whilst the project focused predominantly on the two wards within the community – Cray Valley East and Cray Valley West – it also captured some key services that are outside that area – such as the local hospitals.

A key area of learning for the Council was the significant impact that key local landmarks and environmental features have on influencing how people access services.

For example, the A224 is major arterial road within the local area, and feedback indicates that this can stop some local residents from accessing services which are located on the opposite side of the road.

It was also apparent that many people only knew about some services due to word of mouth, and this was particularly true for some groups within the community.

It was important, therefore, that the project worker spent a large amount of time building up a network of contacts within the community and seeking referrals from key community representatives.

The structure and content of the website was also dictated by representatives of the local community. For example, there was significant interest in developing sections on 'Local history and Gypsy Traveller project' to showcase the positive history of the area. Representatives were also keen to highlight the increasing number of people who are buying homes and moving into the area.

Through the work of the project, a number of local assets were identified of which there had previously been little awareness.

For example, a number of volunteering opportunities were identified to help people to gain the skills, knowledge and confidence to seek and gain employment.

A further group of 'active citizens' were identified who look after a local park by clearing up rubbish, basic maintenance such as hedge clearing, repainting apparatus in the children's park, dealing with anti-social behaviour, and encouraging the local community to use the park and woods as much as possible.

The project worker was also able to link some groups and individuals together where one could benefit the other or they could benefit each other.

For example, the project worker was able to inform one small group about the Cray Valley Initiative Panel as a possible source of funding for a particular project that they wanted to develop for a specific vulnerable group within the area.

The pages on the Bromley MyLife website were launched in November 2013 and promoted to the key organisations, individuals and key community representatives. There have been over 3,000 page views of the Cray Valley Information Portal between the start of November 2013 and end of March 2014.

Engagement with the key organisations, individuals and key community representatives continues, in order to keep the information up to date, enhance sections where new activities are being created and promote the Cray Valley Information Portal in the local area.

What does it mean for Bromley residents and children?

Using an asset based approach can allow commissioners to re-evaluate how services are delivered in a locality and to build upon the strengths that already exist.

In Bromley we have seen some success with the first area-specific project developed using an asset based approach.

It would be useful to consider extending the scope of asset based work in Bromley.

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

17. Updates on Progress from Last Year's JSNA

3. The Health of People in Bromley

NHS Health Checks

The previous JSNA reported that 35 (0.5%) patients were identified through NHS Health Checks with non-diabetic hyperglycaemia. The numbers were lower than the expected prevalence of pre-diabetes. Further investigation led to the conclusion that there is variation in clinical coding in General Practice. For instance in 2013/14, 58 patients were coded with non-diabetic hyperglycaemia but 581 (6.5%) had blood tests indicating they were at high risk of developing diabetes. There is further work to understand underlying issues and streamline practice.

There is on-going targeted work to improve the identification and management of people at high risk of developing diabetes with the aim of preventing or delaying progression to diabetes.

An in-depth audit is underway investigating follow on management of these patients. The results of the audit will inform further pathway development work. In addition, opportunities for interventions for those identified at risk have been expanded borough wide through the roll out of the successful pilot - "Walking Away from Diabetes"

Sexual Health

Given the increase in HIV prevalence rate, two pilot projects of HIV Rapid Point of Care Testing (POCT) in primary care and community settings were set up in 2012 and continued into 2013. The evaluation of these pilots found that:

- both the use of POCT testing and the settings/venues in which HIV testing was offered (i.e. general practices, pharmacies and in community venues) were acceptable by all demographics.
- success or failure of HIV testing in primary care depends on the support and enthusiasm of the clinical staff and education of GPs and practice nurses is needed to expand HIV testing

Based on the findings and recommendations of the evaluation, HIV Rapid Testing was commissioned as part of the integrated sexual health services from approved general practices and pharmacies, targeting the demographics of MSM and Black Africans in high prevalence areas such as Crystal Palace and Penge & Anerley.

In addition, a training programme, SHIP (Sexual Health in Primary Care) was commissioned. It is tailored to develop primary care staff confidence and support them to promote HIV awareness and testing when appropriate.

Health Protection

A campaign to vaccinate pregnant mothers against Pertussis was implemented in 2012 to reduce the risks to the newborn in response to the national outbreak of pertussis declared following a marked increase in cases.

In Bromley, the reported incidence rate of confirmed pertussis was 6.5 per 100,000 in 2012 compared to 0.3 in 2011. In 2013, there were 19 reported cases of pertussis (of which 14 were laboratory confirmed)

Early indications suggest the programme has been successful in reducing the number of cases in young infants and, as such, immunisation of pregnant women will continue in England until further notice.

Modifiable Risk Factors- Physical Activity

24.1% of Bromley residents are achieving less than 30 minutes of exercise per week compared with 27.5% London average and 28.5% England average. Getting this group active is likely to produce the greatest reduction in chronic disease. Work is being undertaken to target physically inactive adults:

- An independent Sport and Physical Activity Network (Pro-Active Bromley) has been set up to develop and progress physical activity in the borough. The Adult's and Older People subgroup refreshed their annual action plan and, in 2013/14, the network attracted over £244,000 in external funding with an additional in kind partnership contribution of £131,000 (total £375,000). The Children and Young People's subgroup has been re-established and is working on an annual action plan sharing resources and knowledge nationally and locally.
- A new Exercise Referral Hub was launched in May 2014 to accommodate walking, cycling and older adults activities for those residents with an existing medical condition to prescribe exercise depending on their medical condition and preference.

Modifiable Risk Factors – Smoking

There continues to be a rising prevalence of smoking in Bromley, particularly within routine and manual worker groups where prevalence is 8% higher than the general population in Bromley and continues to increase (prevalence was

24.3% in 2011-12, rising to 26.1% in 2012-13). A review of the Stop Smoking Service has taken place and a renewed action plan is now in place including a new outreach mobile clinic with a focus on routine and manual worker groups and wards with a high prevalence of smokers within Bromley.

2013/14 saw a focused programme to gain feedback on smoking status over time, recording the number of quitters recorded at 3, 6 and 12 months, measuring the long term effectiveness of Stop Smoking Services.

In addition, work continues to be undertaken with the local acute trust with hospital staff being trained to deliver brief advice and make referrals to local stop smoking services.

Modifiable Risk Factors – Obesity

A multifactorial and multiagency approach is needed to decrease the prevalence of obesity. Improvements are needed across prevention, identification and weight management interventions, involving a range of partners.

Prevention: A Healthy Weight working group is due to be established to ensure a co-ordinated approach is used to tackle this increasing problem. Partners with the potential to impact on the obesogenic environment include; public health, environment, planning, transport, the food industry, the active environment, acute trusts and those that deliver weight management interventions.

Identification: The aim is to improve the recording of BMI and identification of obesity to 70% of GP practice populations. In 2009, 29% of the practice population had a measured BMI. From 2010-2013, 55% of the practice population had a measured BMI. There is still a 15% improvement in recording required.

Intervention: Increase the capacity of the weight management service to cover 3% of the obese population. In 2012/13, 2.6% of the population was covered.

6.Children and Young People

Educational attainment

- Narrowed the gap from 2012 between the percentage of pupils who receive Free Schools Meals and those pupils who do not at Key Stage 2 and Key Stage 4
- Improved the educational attainment of pupils with a Statement at Key Stage 2 and Key Stage 4
- Reduced the average time between a child entering care and moving in with its adoptive family

- Increased the percentage of young people aged 19 who were looked after aged 16 who were in education, employment or training, and those who were in suitable accommodation

7. Older People

- Increased the number of older people managing their own care through a Direct Payment
- Reduced the number of older people in placements supported by the London Borough of Bromley in care homes – both residential and nursing
- Opened 2 new Extra Care Housing schemes as an alternative to residential care
- Undertook a survey of over 1,200 service users known to the London Borough of Bromley to better understand their needs and views

8&9. Learning Disabilities and People with Physical Disabilities & Sensory Impairment

Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life.

Transitional arrangements were identified as an issue in last year's JSNA. Bromley was successful in being awarded pathfinder status for the Government's Special Educational Needs and Disabilities Green Paper in September 2011. In recognition of the work already being done on transition the Department of Education had agreed that Bromley's Pathfinder could be designated a Preparing for Adulthood (PfA) pathfinder.

As a result, a Transition Workstream had been set up to take forward both the testing of the Green Paper proposals as well as the wider issues identified in the Transition. Therefore, no further work would be undertaken on the Transition Strategy pending further reforms by the government.

10. Mental Health

There has been increased investment in Improving Access to Psychological Therapies (IAPT) to reach 15% of the Bromley population in recognition of the burden of mental health caused by moderate depression and anxiety disorders.

A psychiatric liaison team has been set up at the PRUH to enable better assessment and care management of people with mental illness admitted to a general hospital.

There has been increased funding and capacity development in the memory clinics in Bromley to assist in the earlier diagnosis of dementia.

There has been continued implementation of the Mental Health Strategy for Bromley and a clinical redesign of the Care Pathway for Mental Health is now underway.

11. End of Life Care

Bromley Care Partnership delivered by St Christopher's Bromley has been recently commissioned. This service should increase the number of palliative patients supported to die at home if that is their choice.

Given the continued increase in the proportion of those dying in care homes, further work needs to be done to analyse how many patients in each nursing home in Bromley are identified as being on an end of life register using gold standard framework criteria- and therefore deliver adequate capacity of services for these homes as well as training for staff.

Further work is planned, starting with data collation, to analyse the source of terminal admissions to hospital in order to attempt to understand some of the factors that contribute to high proportions of terminal hospital admissions that present as emergencies at Bromley.

12. Carers and Young Carers

- Published a revised Strategy for Carers for 2012-13
- Undertook a survey of over 400 carers known to the London Borough of Bromley to better understand the needs and views of carers.

13. Substance Misuse

A Drug Death Review Panel was established in 2012 critically looking at drug related deaths to generate understanding and learning towards preventing drug related deaths.

In line with national guidance, a Drug and Alcohol Related Deaths review was carried out in 2012, looking at trends from 2002-2012. This review is a baseline for driving drugs and alcohol mortality prevention in Bromley and will be produced annually.

There has been an in-depth analysis of local data from Bromley Drugs and Alcohol Service to understand service use and needs within Bromley. The findings of the report have informed part of the Substance Misuse section.

In order to improve service user access;

- Supervised Administration of Methadone (SAM) and Needle Exchange (NEX) services have been transferred to participating local pharmacies.
- Delivery points for NEX & SAM services for substance misuse safer injecting/harm minimisation have been increased from 14 to 34

This new approach will significantly improve access through wider coverage across the borough and also promote harm reduction in the community.

In addition, there has been an increase in the number of GP Substance Misuse Shared Care partnership from 5 surgeries to 7. Shared Care partnership improves management of patients with a drug misuse problem.

14. Alcohol

A Public Health Needs Assessment is underway to establish trends and possible preventative approaches in the future.

Introduced Brief alcohol advice and measurement tool to the Accident and Emergency department at the Princess Royal University Hospital.

Introduced Every Contact Counts Brief Advice in alcohol to health improvement services and the audit C brief advice and measurement tool has been introduced in the NHS Health Checks Programme for residents aged 40-70 years.

A social norms study on young people called R U different has taken place in four schools in Bromley. The findings will inform health promotion approaches for young people going forward.

18. Useful References

Alcohol

The Government's Alcohol Strategy. Home Office. (2012)

<http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary>

Local Alcohol Profiles for England 2014

<http://www.lape.org.uk/>

NICE Quality Standard 11: *Alcohol dependence and harmful alcohol use* (August 2011)

<http://publications.nice.org.uk/alcohol-dependence-and-harmful-alcohol-use-quality-standard-qs11>

NICE Public Health Guidance 24: *Alcohol use disorders – preventing harmful drinking* (June 2010)

<http://publications.nice.org.uk/alcohol-use-disorders-preventing-harmful-drinking-ph24>

NICE Public Health Guidance 7: *School-based interventions on alcohol* (Nov 2007)

<http://publications.nice.org.uk/school-based-interventions-on-alcohol-ph7>

NICE Clinical Guideline 100: *Alcohol use disorders – physical complications* (June 2010)

<http://publications.nice.org.uk/alcohol-use-disorders-diagnosis-and-clinical-management-of-alcohol-related-physical-complications-cg100>

NICE Clinical Guideline 115 *Alcohol use disorders – diagnosis, assessment and management of harmful drinking and alcohol dependence* (February 2011)

<http://publications.nice.org.uk/alcohol-use-disorders-diagnosis-assessment-and-management-of-harmful-drinking-and-alcohol-cg115>

Cardiovascular Disease

NICE Quality Standard - *Stroke* (June 2010)

<http://www.nice.org.uk/guidance/qualitystandards/stroke/strokequalitystandard.jsp>

NICE Quality Standard 28: *Hypertension* (Mar 2013)

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Appendix

Ward Profile Indicator Definitions 2014

POPULATION

Ward population

Units:	Count
Description:	The number of all residents in this ward
Source:	GLA, Round Population (December 2013)
Population:	All residents
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 316,000 (total)

Population density

Units:	Square Kilometre
Description:	The number of people per unit area
Source:	2012, (GLA Round population, 2013)
Population:	All residents
Interpretation:	A high value may reflect greater need for services
Comparators:	Bromley= 2,108

OLDER PEOPLE

People aged 75 years and over

Units:	Percentage
Description:	The percentage of residents aged 75 years and over.
Source:	GLA (November 2013)
Population:	All residents
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 8.6

Lone pensioner households

Units:	Percentage
Description:	The percentage of households that consist of a lone pensioner.
Source:	2011 Census, ONS
Population:	All households
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 12.9

FAMILIES

Patients aged under 5 years

Units:	Percentage
Description:	The percentage of residents aged 0-4 years
Source:	GLA (November 2013)
Population:	All residents
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 6.3

Lone parent households

Units:	Percentage
Description:	The percentage of households that consist of a lone parent family
Source:	2011 Census data.
Population:	All households
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 7.3

ETHNICITY

BAME Groups

Units:	Percentage
Description:	The percentage of Black Asian and minority ethnic groups
Source:	2011 Census data.
Population:	All residents
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 16.9

Born outside the UK

Units:	Percentage
Description:	The percentage of people born in a country outside the United Kingdom
Source:	2011 Census
Population:	All residents
Interpretation:	A high value may reflect greater need for services
Comparators:	Bromley = 14.5

DEPRIVATION

Index of Multiple Deprivation 2010 (IMD)

Units:	Mean score
Description:	The Index of Multiple Deprivation 2010 (IMD 2010) is a measure of multiple deprivation at small area level. To construct the single index, seven domains of deprivation, defined by the Office of the Deputy Prime Minister, were weighted as follows: Income deprivation 22.5%; Employment deprivation 22.5%; Health deprivation and disability 13.5%; Education, skills and training 13.5%; Barriers to housing and services 9.3%; Crime 9.3%; Living environment deprivation 9.3%.
Source:	Indices of Deprivation 2010.
Population:	All residents
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 14.1

Income Deprivation Affecting Children Index 2010 (IDACI)

Units:	Score
Description:	The Income Deprivation Affecting Children Index 2010 (IDACI 2010) is a measure of the proportion of children under the age of 16 in an area living in low income households. IDACI is a supplementary index to the Indices of Multiple Deprivation.
Source:	Income Deprivation Affecting Children Index 2010.
Population:	All residents
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 0.2

Funded social care

Units:	Percentage
Description:	The percentage of current local authority funded adult social care service users aged 18+.
Source:	LBB, 2014
Population:	Residents 18 +
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 5.2

EMPLOYMENT AND EDUCATION

No qualification

Units:	Percentage
Description:	The 2011 Census question asked people to indicate all types of qualifications held including foreign qualifications. For this indicator the percentage of those who answered 'no qualification' is presented.
Source:	2011 Census.
Population:	All residents
Interpretation:	A high value may reflect greater need for services
Comparators:	Bromley = 17.9

Average workless benefit claimants

Units:	Percentage
Description:	The rate of workless benefit claimants at a point in time. The indicator combines Job Seekers Allowance, Incapacity Benefit, Employment Support Allowance, Income Support and other income related benefits as at May 2012- May 2013.
Source:	Department for Work and Pensions
Population:	Residents aged 16-64 years.
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 13.9

Never worked or Long term unemployed

Units:	Percentage
Description:	This is an indicator measuring economic inactivity in the working age population. A person is defined long term unemployed at the time of the 2011 Census, if they were unemployed and the year they last worked was 2009 or earlier.
Source:	2011 Census.
Population:	Residents aged 16+.
Interpretation:	A high value may reflect greater need for services
Comparators:	Bromley = 4.3

Routine and Semi routine workers

Units:	Percentage
Description:	The percentage of people aged 16-74 who are employed full-time, part-time or self-employed in routine and semi routine occupations. Excludes full-time students who are economically active.
Source:	2011 Census data.
Population:	Residents aged 16-74 years.
Interpretation:	A low value may reflect greater need for services
Comparators:	Bromley = 16.1

Good level of development at age 5

Units:	Percentage
Description:	The percentage of children aged 5 years achieving a 'good level' of overall development in the Early Years Foundation Stage profile. Figures are based on residents in Bromley maintained schools and discounts residents in out of borough schools.
Source:	LBB, 2013
Population:	Residents aged 5 years.
Interpretation:	A low value may reflect greater need for services
Comparators:	Bromley = 61

Key stage 2: Level 4 and above achievement

Units:	Percentage
Description:	The percentage of pupils achieving level 4 and above in Reading, writing and Maths by pupils ward of residence. Figures are based on residents in Bromley maintained schools and discounts residents in out of borough schools and independent schools.
Source:	LBB, 2013
Population:	Residents aged 11 years.
Interpretation:	A low value may reflect greater need for services

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Comparators: Bromley = 80

General Certificate of Secondary Education (GCSE): 5+ A*-C achievement

Units: Percentage

Description: The percentage of pupils achieving 5 A* to C grades or equivalent including GCSE English and Maths taken at the end of Key Stage 4. Figures are based on residents in Bromley maintained schools and discounts residents in out of borough schools and independent schools.

Source: LBB, 2013

Population: Residents 14-16 years

Interpretation: A low value may reflect greater need for services

Comparators: Bromley = 65.8

HOUSING AND THE NEIGHBOURHOOD

Overcrowded households

Units: Percentage

Description: The percentage of households where the number of rooms is less than the number of rooms 'required' by the household, assuming every household, including one person households, requires a minimum of two common rooms (excluding bathrooms).

Source: 2011 Census

Population: All residents

Interpretation: A high value may reflect greater need for services.

Comparators: Bromley = 8.0

Social rented Households

Units: Percentage

Description: The percentage of households where the accommodation is rented from a Local Authority or Housing Association/Registered Social Landlord.

Source: 2011 Census

Population: All Residents

Interpretation: A high value may reflect greater need for services.

Comparators: Bromley = 14.1

Mortgage repossession orders

Units: Count

Description: The count of mortgage possession claims leading to orders- Not seasonally adjusted. The date reflects the latest figures as of 9th February 2012. Data includes all claims in which the first order, whether outright or suspended, is made during this period.

Source: Ministry of Justice (GLA, 2013)

Population: All claims

Interpretation: A high value may reflect greater need for services.

Comparators: Bromley and Chislehurst constituency = 75

Landlord repossession orders

Units: Count

Description: The count of landlord possession claims leading to orders- Not seasonally adjusted. The date reflects the latest figures as of 9th February 2012. Data includes all claims in which the first order, whether outright or suspended, is made during this period.

Source: Ministry of Justice (GLA, 2013)

Population: All claims

Interpretation: A high value may reflect greater need for services.

Comparators: Bromley and Chislehurst constituency = 160

Crime

Units: Rate per 1000 population

Description: The rate of all crime recorded in an area.

Source: Metropolitan Police Service, 2013

Population: All residents

Interpretation: A high value may reflect greater need for services

Comparators: Bromley = 64.9

	Average Public Transport Accessibility
Units:	Score
Description:	The Index score of accessibility of a point to the public transport network
Source:	TFL, (GLA,2013)
Interpretation:	A low value may reflect greater need for services

WELLBEING AND LIFESTYLE

	General health status (reporting bad and very bad health)
Units:	Percentage (%)
Description:	The 2011 Census question asked people to rate their health as good, fairly good or not good. For this indicator the percentage of those who answered 'bad and very bad' is recorded.
Source:	2011 Census data.
Population:	All residents
Interpretation:	A high value may reflect greater need for services.
Comparators:	Bromley = 14.2

	Overall wellbeing probability
Units:	Score
Description:	The wellbeing scores present a combined measure of well-being indicators of the resident population. Scores over 0 indicate a higher probability that the population on average will experience better well-being according to these measures.
Source:	GLA, 2013
Population:	All residents
Interpretation:	A low value may indicate greater need for services
Comparators:	Bromley = 2

	Smoking prevalence
Units:	Percentage
Description:	The percentage of residents registered with a Bromley GP with a current smoking status recorded as smoking for patients aged 16 and over.
Source:	Quality Outcomes Framework (QOF) 2012/13
Population:	All patients 16 and over
Interpretation:	A low value may indicate under recording.
Comparators:	Bromley = 22.6, Bromley Modelled Estimate = 18.1 (Source: Health Profile 2011)

	Substance misuse
Units:	Rate per 1000 population
Description:	The rate per 1000 of people in treatment for drugs and alcohol abuse
Source:	LBB, 2013
Population:	All residents
Interpretation:	A low value may indicate under detection.
Comparators:	Bromley = 2.26

	Teenage pregnancy
Units:	Rate per 1000 women
Description:	The rate of teenage conceptions per 1000 women
Source:	ONS, TPU
Population:	Women 15-17 years
Interpretation:	A high value may indicate greater service need and poor health outcomes.
Comparators:	Bromley = 31

	Obese children in reception
Units:	Percentage
Description:	The percentage prevalence of obese children in reception
Source:	NCMP,2012/13
Population:	4-5 year olds BMI \geq 95 th Percentile ranking

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Interpretation: A high value may indicate greater service need and poor health outcomes
Comparators: Bromley = 7.8

Obese children in year 6

Units: Percentage
Description: The percentage prevalence of obese children in Year 6
Source: NCMP, 2012/13
Population: 10- 11 year olds, BMI= \geq 95th Percentile ranking
Interpretation: A high value may indicate greater service need and poor health outcomes.
Comparators: Bromley = 16.6

Obesity prevalence

Units: Percentage
Description: The percentage prevalence of obesity in residents registered with a Bromley GP
Source: Quality Outcomes Framework (QOF) 2012/13
Population: All residents 16+ with BMI \geq 30
Interpretation: A low value may indicate under recording.
Comparators: Bromley = 9.5, Bromley Modelled Estimate = 21.8 (Source: Health Profile 2012)

Healthy eating

Units: Percentage
Description: The estimated percentage of the population that eat healthily (consuming 5 or more portions of fruit and vegetables per day). The indicator is a measure of protective lifestyle.
Source: PHE: Local Health, 2013
Population: All residents 16 +
Interpretation: A high value may indicate greater service need and poor health outcomes.
Comparators: Bromley = 36.0

Binge drinking

Units: Percentage
Description: The estimated percentage of the population that binge drink (8 or more units for men and 6 or more units for women)
Source: PHE: Local Health, 2013
Population: All residents 16+
Interpretation: A high value may indicate greater service need and poor health outcomes.
Comparators: Bromley = 13.8

HEALTH OUTCOMES

Female Life Expectancy

Units: Years
Description: Point estimate of life expectancy at birth
Source: PHE: Local Health, 2013
Population: All patients
Interpretation: A low value may indicate greater service need and poor health outcomes.
Comparators: Bromley = 84

Male Life Expectancy

Units: Years
 Description: Point estimate of life expectancy at birth
 Source: PHE: Local Health, 2013
 Population: All patients
 Interpretation: A low value may indicate greater service need and poor health outcomes.
 Comparators: Bromley = 80

Diabetes prevalence

Units: Percentage
 Description: The percentage prevalence of diabetes
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients aged 17+
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 5.2, Bromley Modelled Estimate = 7.0 (Source: APHO)

Stroke prevalence

Units: Percentage
 Description: The percentage prevalence of stroke
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 1.6, Bromley Modelled Estimate = 2.5 (Source: ERPHO)

Serious Mental Illness prevalence

Units: Percentage
 Description: The percentage prevalence of mental health disorders
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 0.8

Chronic Obstructive Pulmonary disease prevalence

Units: Percentage
 Description: The percentage prevalence of chronic obstructive pulmonary disease
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 1.3, Bromley Modelled Estimate = 4.2 (Source: ERPHO)

Asthma prevalence

Units: Percentage
 Description: The percentage prevalence of asthma
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 5.3

Epilepsy prevalence

Units: Percentage
 Description: The percentage prevalence of epilepsy
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients aged 18+
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 0.5

Learning disabilities prevalence

Units: Percentage
 Description: The percentage prevalence of learning disabilities
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients aged 18+
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 0.3

Dementia prevalence

Units: Percentage
 Description: The percentage prevalence of dementia
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 0.5

Coronary heart disease prevalence

Units: Percentage
 Description: The percentage prevalence of coronary heart disease,
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 3.1, Bromley Modelled Estimate =5.5 (Source: ERPHO)

Chronic kidney disease prevalence

Units: Percentage
 Description: The percentage prevalence of chronic kidney disease
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients aged 18+
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 3.9, Bromley Modelled Estimate = 9.4 (Source: NEOERICA)

Heart failure prevalence

Units: Percentage
 Description: The percentage prevalence of heart failure
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 0.7

Atrial fibrillation prevalence

Units: Percentage
 Description: The percentage prevalence of atrial fibrillation

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Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 1.6

Hypertension prevalence

Units: Percentage
 Description: The percentage prevalence of hypertension
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 14.0 Bromley Modelled Estimate = 31.4 (Source: ERPHO)

Cancer prevalence

Units: Percentage
 Description: The percentage prevalence of cancer.
 Source: Quality Outcomes Framework (QOF) 2012/13
 Population: All patients
 Interpretation: A low value may indicate under recording.
 Comparators: Bromley = 2.1

Profile label:

Ward Rank is position of ward score out of 22 wards in the borough where 1 is lowest score- not necessarily good or bad.
 Percentile rank has been colour coded against low, moderate or high need or health outcomes.

	Low
	Moderate
	High