Bromley Clinical Commissioning Group

BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT

2016

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Contents

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Executive Summary

1. The Population

The population of Bromley continues to grow, to a size of over 326,000 in 2016, and is predicted to expand still further over the next ten years.
The number of 0 to 4 year olds is projected to decrease by the year 2021 to 20,754 and then to 20,169 by 2026.

The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17.7% of the population in 2016 to 18.2% by 2021 and 19.1% by 2026.
Health and social care planning should take account for this rise in the numbers of older people particularly in the South of the Borough which will see the largest increase in numbers of over 75s.

The latest (2016) GLA population projection estimates show that 19% of the population is made up of Black and minority ethnic (BME) groups[^].
The BME group experiencing the greatest increase within Bromley's population is the Black African community, from 4.5% of the population in 2016 to 6.6% of the population in 2031[^].
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.

The employment rate in Bromley is higher than the national and also the London average.

The proportion of mortality attributable to particulate air pollution in Bromley is higher than the UK average, although it is also the lowest in London.

2. Life Expectancy and the Burden of Disease

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, currently at 81.4 years for men and 84.9 years for women. However, there is a gap of 9.7 years for men and 6.7 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 (29.1%) and cancer (29.0%) 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 as inequalities between areas in Bromley have been increasing since 2009.
One avenue to reduce health inequalities is to improve early identification of increased circulatory disease risk through the NHS Health Checks Programme.
There is a need to improve the low uptake of NHS Health Checks across most wards in the borough particularly in the Clock House, Penge and Cator and Crystal Palace wards.
Of concern is the falling number of invitations to the NHS Health Check in the last 2 years. It is anticipated with a reduced number of Providers in 2016- 2017 this may continue to drop further.
In order to maximise the NHS Health Checks outcomes in the prevention and early diagnosis of risk and high risk conditions, appropriate use of pathways is required. Evaluation, monitoring, feedback and service improvements are ongoing to maintain and enhance the effectiveness of the programme.
Where conditions are identified and managed early, people are less likely to progress onto more severe cardiovascular disease of stroke, heart attack or vascular dementia. Of particular importance is the need to maintain and continue improvements in the identification of people who have Pre-Diabetes (non-diabetic hyperglycaemia) and ensure they are offered intensive programmes of lifestyle intervention to prevent the progression onto development of diabetes.
In addition the need to identify people with undiagnosed hypertension and atrial fibrillation and for these to be managed effectively to prevent stroke are of high importance.
Implementing new guidance to provide interventions for those at moderate risk in addition to high risk of CVD is a challenge for Bromley in terms of increased workload.

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

Diabetes represents a continuing challenge in Bromley. The number of people affected has been rising since 2002, and for those diagnosed, control of the associated risk factors for circulatory disease is less effective than nationally. New prevalence modelling has estimated that there are almost 30 thousand people in Bromley at high risk of developing diabetes. Following a successful Diabetes Prevention Pilot in Bromley, we are now a first wave site for the National Diabetes

Prevention programme together with the other South London boroughs. Of the 166 patients referred to the pilot diabetes prevention programme, 117 attended sessions, and of these, 44 (38%) achieved normal blood sugar levels at 12 months, and a further 18 (15%) reduced their risk of developing 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 only in the later stages, which will adversely impact survival rates, as will the low cancer screening uptake in the more deprived parts of the borough.

Mental health problems affect a large proportion of the population, with approximately 10.7% of people completing the GP patient survey reporting that they feel moderately or extremely anxious or depressed. At the more severe end of the spectrum, over 2,500 people in Bromley (0.81% of the adult population) have been identified by GPs as suffering from serious mental illness.
The prevalence of dementia is predicted to rise, and although recording of dementia has increased in Bromley over the last two years, it is likely that there are still many cases not known to clinical services.

Further work is needed to encourage the uptake of childhood immunisations as vaccination rates for several categories, such as MMR, PCV, Hib/MenC, DTaP/IPV (pre-school), remain below the national recommendation of 95% coverage.
There remains a potential for measles outbreaks, particularly in older children and young adults due to poor immunisation uptake. There were 10 confirmed cases of measles in Bromley during 2015.
There has been a rise in the number of cases of Scarlet Fever.
There have been high numbers (277) of confirmed cases of pertussis (whooping cough) in South London in 2015, highlighting the importance of immunisation against pertussis, in particular the uptake of maternal pertussis vaccination programme.

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

Bromley's smoking prevalence decreased from 18.1% in 2012-13 to 14.2% in 2014-15. However, one in seven residents still smoke and smoking prevalence in routine and manual (R&M) occupational groups is consistently higher than the general population.
Smoking continues to have a negative impact on Bromley's morbidity and mortality rates, local economy, health inequalities, local environment, hospital admission, re-admission and post-operative complication rates. Stopping smoking is a priority within Bromley for routine and manual workers, pregnant women, those with a

mental health condition and patients in secondary care (hospital admission, re-admission and post-operative complications).

Bromley has the sixth highest levels of adult overweight and obesity in London, 63.8% are either overweight or obese and the prevalence is rising. In contrast, Bromley has the 2nd lowest childhood obesity rate for children in school year 6 in London at 16.0%. However, the percentage of children who are obese in their first year in primary school doubles by the time they reach their final year in primary school. The prevalence of obesity is far more apparent in deprived wards in the borough. Obesity is significantly higher in the lowest income group than in the highest.
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 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. Just under a quarter of the Bromley population were not participating in even 30 minutes of activity a week (23.8%) in 2015, which is a decrease from 25.6% in 2014.
The percentage of 15 year olds physically active for at least one hour per day seven days a week is only 12.1%, however, this in line with the average rates across London. 69.9% of 15 year olds in Bromley have a mean daily sedentary time in the last week of over seven hours per day.

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

3. Domestic Violence

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

Between June 2015 and June 2016 there were 2480 reported domestic violence offences in Bromley. However, it is known that only 35% of domestic violence incidents are reported to the police. In Bromley the majority of domestic violence

cases are identified and referred to the IDSVA service by the police and over 60% of all reported incidents relate to physical offences.

Women are more commonly affected by domestic violence than men with an estimated 1 in 4 women in England and Wales experiencing domestic violence in their lifetime. Two women are killed every week in England and Wales by a current or former partner as reported by the Crime Survey of England and Wales for the year 2013/2014.
All age groups are affected by domestic violence including children and older people, although the highest percentage of victims is in the 21-30 year age group. In Bromley, the highest percentage of perpetrator suspects is also in the 21–30 year age group.
Information from the Bromley Children's Group Work Programme (which supports children who have witnessed domestic violence and abuse against their mother) shows that, since September 2014, there have been 545 attendances at the Children's Group Work Programme relating to 81 individuals. 343 of these attendances related to 52 individual children. Of the 29 mothers that have attended the Children's Group Work Programme, 72% felt that their child's behaviour had improved.

There is a need for increased education and awareness of domestic violence and the domestic violence services available in Bromley

4. Housing & Homelessness

Homeless people experience some of the worst health outcomes in society. Bromley has a lower number of homeless people compared to most other London boroughs but a rate that is higher than the England average. Numbers have also been increasing over the past few years particularly in terms of the number of homeless people in temporary housing. The majority of people in temporary housing are families with young children.
The most common reasons people cite for becoming homeless are often as a result of a relationship breakdown, end of a short hold tenancy agreement or financial shortfall. The current housing market is making it very challenging for people to access affordable and long term accommodation. More people are being housed in the private rental sector but there is little up to date information on the condition of this housing stock, particularly the accommodation likely to be occupied by people on lower incomes. Housing conditions have an impact on health and well-being.
Bromley provides specialist support and accommodation for high need groups, such as young people, people with clinical mental health conditions, people with dual diagnosis (poor mental health and challenges around substance misuse) and older people. In addition it is supporting households experiencing a reduction in income as a result of benefit caps. The need for this type of support is likely to increase over the next few years.

For the first time in recent years, Bromley has carried out a health needs audit for its single homeless population. Results from the audit show a population group with high physical and mental health needs and with complex backgrounds, for example a history of local authority care or having spent time in prison. Health behaviours of survey respondents indicate the impact of poverty and the challenges this creates in terms of healthy living. For example, poor access to healthy food and lack of opportunities for physical activity. They are also high users of healthcare services.
The Health Needs Assessment identified challenges around the take up of preventative healthcare by Bromley's homeless population, such as flu vaccination programmes and issues relating to improving hospital discharge for people without fixed accommodation.

5. Sexual Health

Although the rate of sexually transmitted infections (STIs) overall is lower in Bromley than nationally, Bromley now has a slightly higher rate than England for Gonorrhoea and Syphilis (though a lower rate for these infections compared to the London average). The majority of new cases of Syphilis and Gonorrhoea occur in men who have sex with men (MSM), indicating that MSM are a high risk group in Bromley.

Young people between the ages of 15 and 24 years in Bromley continue to have the highest rates of new STIs. A high proportion of new STIs are also occurring amongst MSM. The greatest number of STIs occur in the white ethnic group, though new STIs in the black or minority ethnic population make up a greater proportion than would be expected bearing in mind the size of the black and ethnic minority population in Bromley. Geographically there are higher STI rates in the North West of the borough.

The HIV prevalence rate in Bromley continues to rise, currently at a 2.65 per 1,000 population aged 15-59 years which is higher than the England average. Bromley remains one of the lowest high prevalence boroughs in London, but has rates in certain areas that match higher prevalence London boroughs. These are areas in the North West of the borough.

There are now greater numbers of HIV men receiving care with a probable HIV transmission via MSM than via heterosexual intercourse. This is a change from previous years' recordings. There has been a decrease in late diagnosis of HIV, with Bromley performing better than the England average and at a similar level to the London average.

Teenage conception rates have continued to fall in Bromley. Bromley's abortion rate is above the England average but lower than the London average. However, repeat abortions are higher than the London and England average for under 25 year olds.

Women between 18 and 24 years of age are most likely to be accessing contraception services. The main methods of contraception are user dependent methods, such as pills or condoms. However Bromley is keen to encourage greater use of Long Acting Reversible Contraception (LARC) which is more effective, this includes injections, implants and inter-uterine systems. Bromley shows a lower level of LARC usage compared to other London boroughs, particularly in terms of LARC prescriptions by Sexual and Reproductive Health Services.

Bromley has a similar fertility rate to England and a higher rate than the London average. Only a small rise in live births has been seen in the past year. 29% of births are to women born outside of the UK and the greatest number of births occur in the 30 to 34 year age group. More women at 40 years of age and over are now giving birth, showing a rising trend towards older motherhood.

The greatest proportion of births in Bromley takes place in the less deprived areas of the borough. However certain wards experience a large proportion of births in areas of high deprivation. This information helps target interventions to support health and help counteract impacts of deprivation.

Bromley is below the England average in terms of percentage of women smoking at time of delivery and higher than the England average for babies being breastfed 6-8 weeks after birth, though these statistics are currently provisional. Improvements in data collection are required around early booking to antenatal care, which is an important indicator in terms of early access to advice and support around pregnancy.

6. Alcohol Use

Estimates suggest that the level of drinking in people in Bromley is similar to that for London and England, with 17% of people in the increasing and high risk categories.
Local GP data suggests that 21% of men and 6% of women drink above the recommended levels of alcohol each week and this is most prevalent in those aged between 40 and 69 years.

In 2014 there were 121 alcohol-related deaths in Bromley. The mortality rate from alcohol-related causes in Bromley appears to be on a rising trend for women whilst remaining level for men in the period between 2009 and 2013. The alcohol-related mortality rate for men in Bromley is approximately twice that for women.
The rate of alcohol-related hospital admissions has been increasing at national, regional and local levels, but remains lower in Bromley than for London and England. The hospital admission rate for males (2,396 per 100,000 population) is almost twice the rate for females (1,361 per 100,000 population) in Bromley.
The alcohol-specific admission rate for under 18 year olds in Bromley (22.7 per 100,000 population) has been gradually decreasing over the last two years, and is

comparable with the rate for London, but significantly lower than the rate for England.

Availability of alcohol in Bromley is controlled through the Licensing Policy and the work of Trading Standards. There is also a programme of education on alcohol for 13 to 15 year olds.
Screening and advice on alcohol use are delivered in both primary care (for new patients and at NHS Health Checks) and secondary care (PRUH).

During 2015-16, there were 238 adults engaged in structured alcohol treatment services in Bromley, of these 58% were men and 42% women.
The average age of adults in alcohol treatment is 45 years, and the age distribution for both genders is very similar.
Of the 158 new presentations to treatment in Bromley in 2015-16, 5% were pregnant, as compared with 1% nationally.
The new presentation cohort also included 16% who were currently receiving care from mental health services for reasons other than substance misuse.
In addition to the 238 adults in structured treatment for alcohol only, there were additionally 132 adults who were in treatment for alcohol and drug use.
In Bromley, many of those requiring structured treatment for alcohol misuse are in regular employment, 37%, as compared with 29% nationally.
In Bromley, a much higher proportion of adults starting treatment (20%) report a housing problem compared with nationally (11%), although the proportion with an urgent housing problem is the same as the national figure.

Bromley had a lower proportion of successful treatment completers in 2015 than the national value. 28% of individuals left alcohol treatment successfully and did not return within 6 months as compared with 38% nationally.

Fewer than expected young people have accessed the Young Person's Substance Misuse Service in the last year. Of those who access the service, the majority are cannabis users, with 66% additionally using alcohol.

A strategic review of alcohol services is currently underway. Prevention, early identification and intervention will be the focus, particularly in the highest risk group (aged 40 to 69 years). There will also be an emphasis on strengthening the referral pathways.

7. Children and Young People

Child health outcomes show a slight improvement on last year, with only two indicators rated "red", and significant improvements in teenage pregnancy – an indicator which was rated "red" last year.

Performance data for Children's Social Care shows a fairly stable pattern in terms of number of children subject to a Child Protection Plan and Children Looked After, and for both groups the rates are considerably lower than statistical neighbours and nationally.

Health indicators of Children Looked After are good except for the "Strengths and Difficulties" questionnaire (emotional health) scores which are slightly higher than comparators. Educational outcomes for this group are higher than national averages, although the numbers in each cohort are small. Only two of the indicators relating to Children Looked After are of concern – persistent absence from school, and suitable accommodation.

Educational attainment of children and young people in Bromley continues to be good at all stages, even allowing for a new curriculum and assessments. The outcomes of two vulnerable groups – children eligible for Free School Meals (FSM), and children with Special Educational Needs (SEN), merit further mention.
Children eligible for FSM continue to perform less well at every Key Stage than the rest of the population, and this gap increases as they move through the education system. At every stage the gap is greater than the national average, and at Key Stage 4 this gap is increasing over time.

The proportion of Bromley pupils with Special Educational Needs has reduced and is now in line with national levels and statistical neighbours. Bromley continues to have a relatively high number of children with speech, language and communication disorders and on the Autistic Spectrum, and a significant proportion of both of these groups are placed in independent non-maintained special schools. Overall, the educational attainment of Bromley pupils with SEN is higher than the national average at all key stages.

8. Physical Disability and Sensory Impairment

The prevalence of eye conditions as a whole will continue to increase in Bromley, due to an ageing population and increase in factors such as diabetes and obesity, which are associated with eye disease. The three most common eye conditions in Bromley, based on epidemiological models, are likely to be early AMD, background diabetic retinopathy and glaucoma.
In Bromley, 665 people were registered severely sight impaired (blind) and 615 registered sight impaired (partially sighted) as of 31st March 2014. Although the number of people on the register of sight impairment is around 1300, a far greater number of people, almost 10,000, have sight loss that impacts on daily life.
Two thirds of registered blind and partially sighted people of working age are not in paid employment, and nearly half of blind and partially sighted people feel 'moderately' or 'completely' cut off from people and things around them.

In Bromley, there are over 32,000 adults over the age of 18 years with moderate or severe hearing impairment (predicted to rise to 43,000 by 2030) (Figure 8.2) and a further 757 with profound hearing impairment (predicted to rise to 1,010 by 2030).
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.
It is estimated that there are 19,771 people of working age in Bromley who have a physical disability, about 10% of the population aged 18-64. This figure is projected to increase to 22,900 by the year 2030. Of these, approximately 4,500 currently have a serious physical disability, and by 2030, this number is predicted to rise to over 5300.
Employment rates in disabled people aged 16–64 years in Bromley are far lower than employment rates in the general population.

9. 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, hospital is the most common place of death, and the next most frequent place of death is at home for both women and men.
Since 2008, there has been a consistent reduction in the proportion of hospital deaths and a consequent increase in deaths at home.
The proportion of deaths occurring in usual place of residence in Bromley has been consistently lower than the England average over the last two years.
There are differences in place of death between cancer and non-cancer deaths. Both cancer and non-cancer deaths are more likely to occur in hospital, however, a there is a far higher proportion of cancer deaths (18%) in a hospice than non-cancer deaths (1%).
Of the non-cancer deaths, a higher proportion of circulatory deaths occur at home than those from other causes.

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.

The Health & Wellbeing Board has agreed that the JSNA will be delivered over a two year period, and this is the first part of the two year JSNA.

A few key areas have been the subject of in-depth focus:

- Domestic Violence
- Housing and Homelessness
- Sexual Health
- Alcohol Use

In addition, there are updates on a few populations of interest.

Next year, it is planned that the Integrated Care Networks will be the focus of the JSNA, and there will be updates on further populations of interest. There will be a separate detailed JSNA on Children and Young People.

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

1. 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 (2016) estimate of the resident population of Bromley is 326,560*, having risen by 28,235* since 2001.
- The resident population is expected to increase to 333,608* by 2021 and 341,204* by 2026.
- The number of 0 to 4 year olds is projected to decrease by the year 2021 to 20,754* and then to 20,169* by 2026.
- The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17.7% of the population in 2016 to 18.2% by 2021 and 19.1% by 2026.
- 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 (2016) GLA population projection estimates show that 19% of the population is made up of Black and minority ethnic (BME) groups^.
- The BME group experiencing the greatest increase within Bromley's population is the Black African community, from 4.5% of the population in 2016 to 6.6% of the population in 2031^.

* GLA 2015 round SHLAA-based population projections: Capped Household Size Model, Released May 2016

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

What this means 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 (Figures 1 and 2).

Total Population

The latest (2016) estimate of the resident population of Bromley is 326,560. This compares with 340,091 registered with GPs in the borough (Oct 2015). The borough council is responsible for providing services to its residents. While local health commissioners are responsible for providing services to all of those who are registered with a Bromley GP regardless of where they live, they also have a responsibility for the health of the borough's residents at a population level. Whilst population figures are available from a number of sources, chiefly the Office for National Statistics (ONS) and the Greater London Authority (GLA), this chapter has used the Greater London Authority (GLA) resident population as its basis. There is some variation in the population structure between the wards. Cray Valley West has the highest proportion of young people and Copers Cope the lowest. Farnborough & Crofton has the highest proportion of over 75s and Crystal Palace the lowest (see Figures 1.3 and 1.4).

Figure 1.1

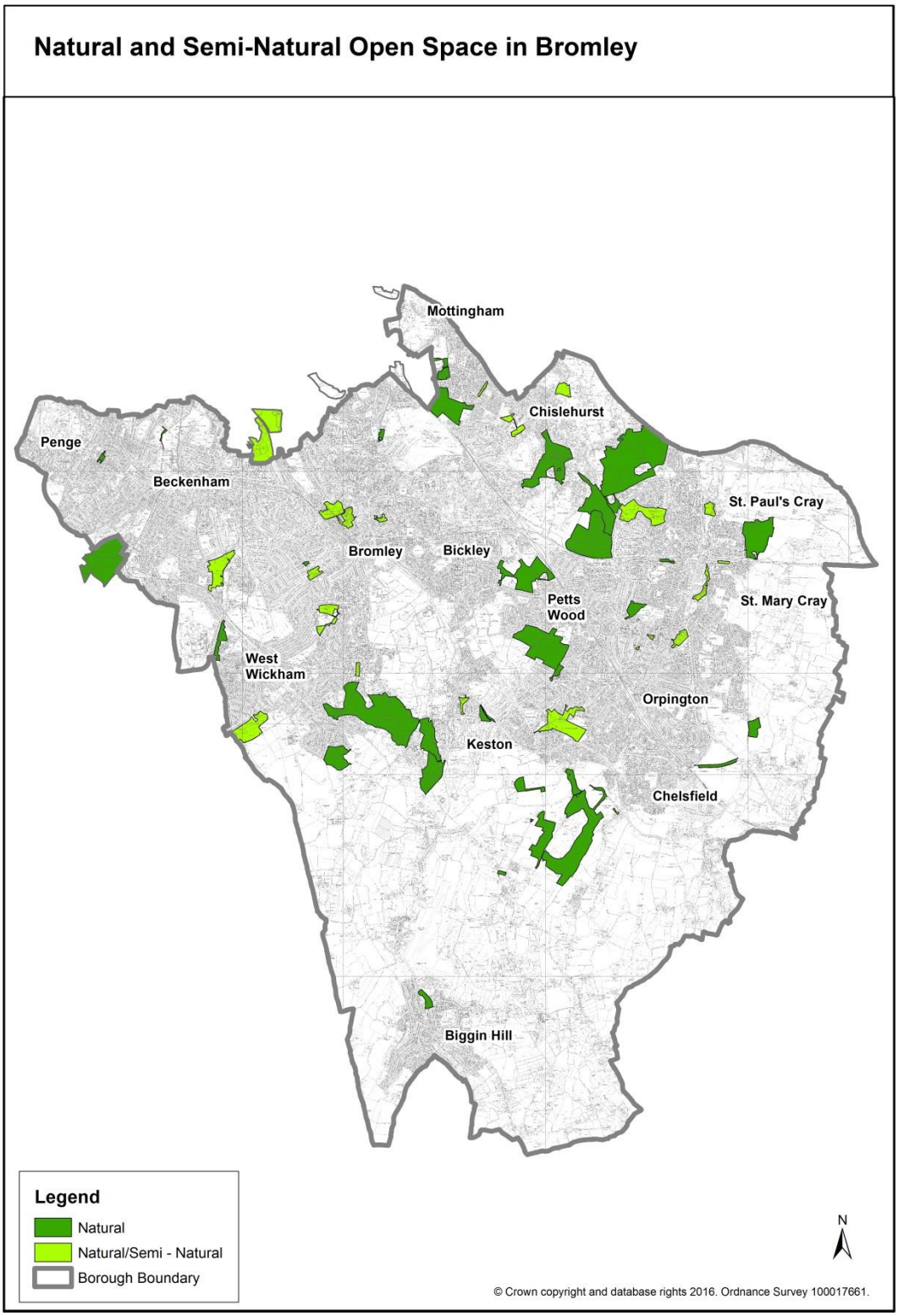
Natural and Semi-Natural Open Space in Bromley
Mottingham
Chislehurst
Penge
Beckenham
St. Paul's Cray
Bromley
Bickley
Petts Wood
St. Mary Cray
West Wickham
Orpington
Keston
Chelsfield
Biggin Hill
Legend
Natural
Natural/Semi - Natural
Borough Boundary
N
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Figure 1.2

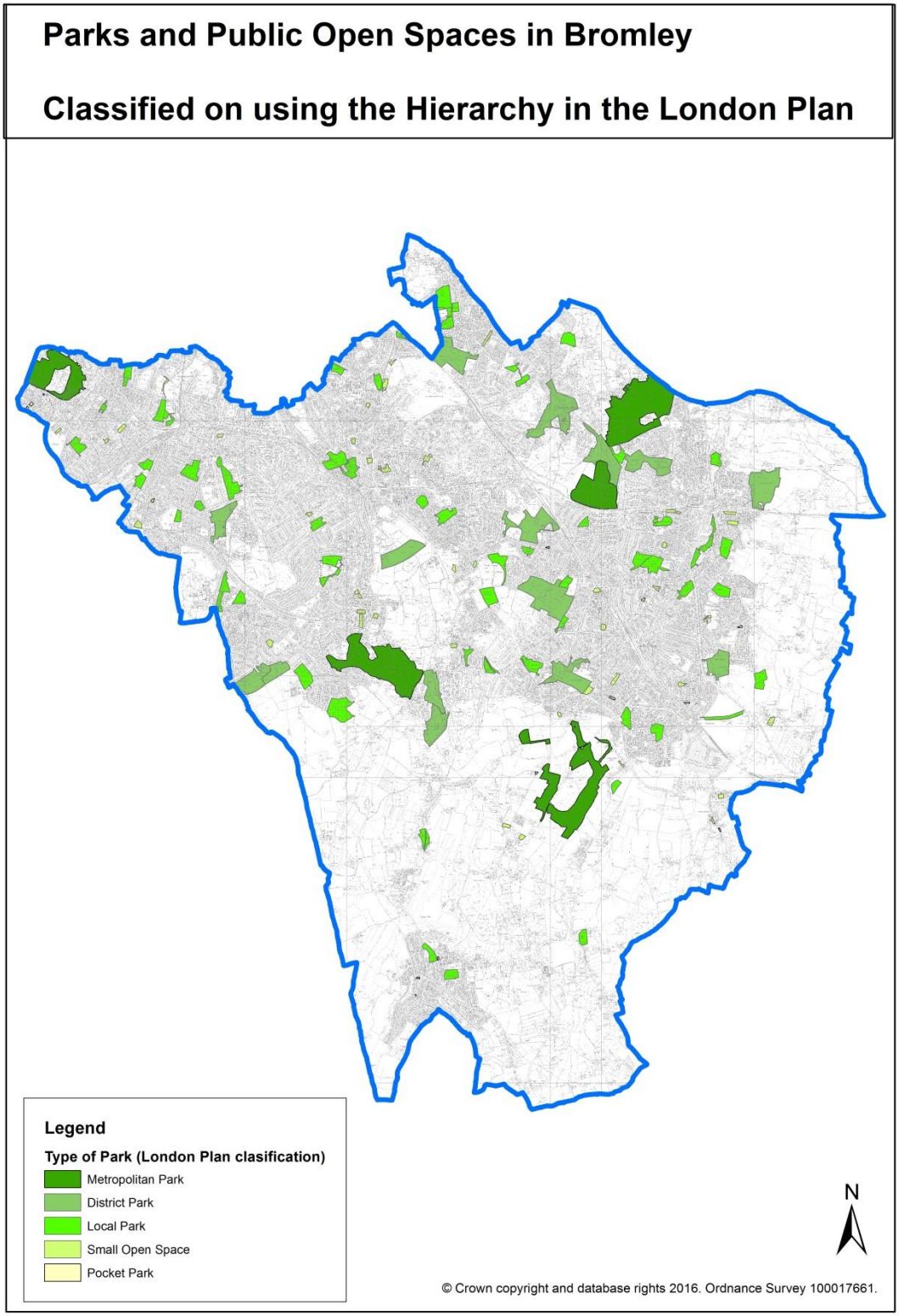
Parks and Public Open Spaces in Bromley
Classified on using the Hierarchy in the London Plan
Legend
Type of Park (London Plan clasification)
Metropolitan Park
District Park
Local Park
Small Open Space
Pocket Park
N
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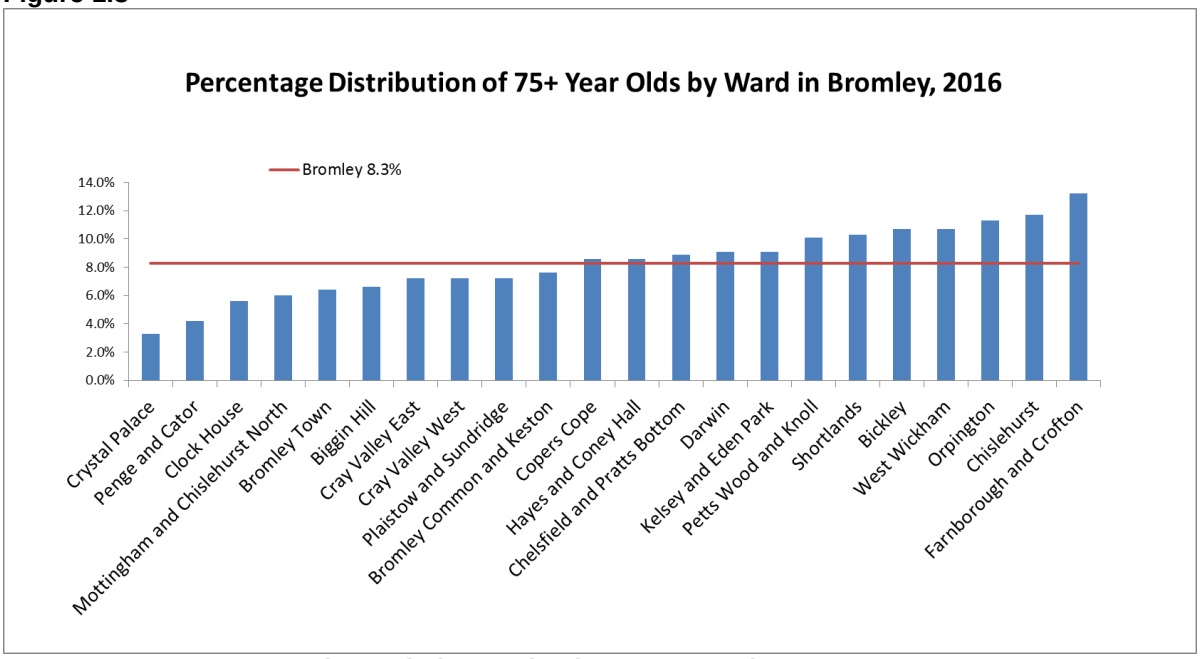
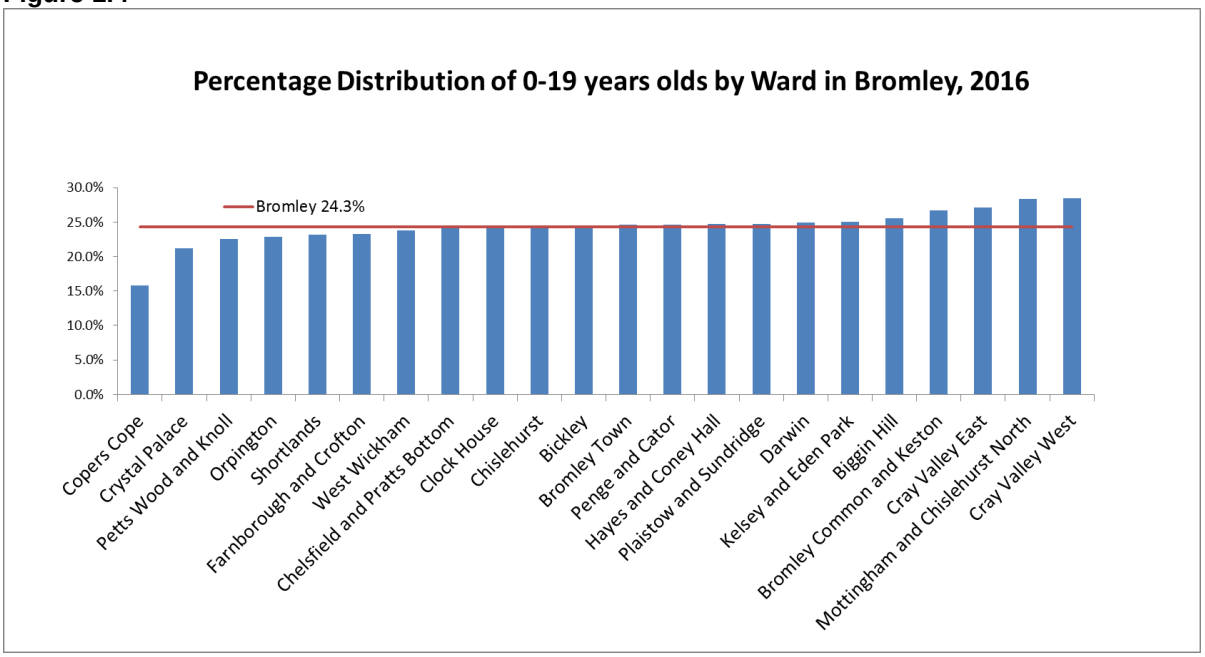
Figure 1.3



Source: GLA 2016, Round Population Projections accessed August 2016

Figure 1.4



Source: GLA 2016, Round Population Projections accessed August 2016

Table 1. 1 Age structure across the wards in Bromley, 2016

	0-19 Years		75+ Years	
	No	%	No	%
Bickley	3911	24.5%	1708	10.7%
Biggin Hill	2691	25.5%	696	6.6%
Bromley Common and Keston	4642	26.7%	1323	7.6%
Bromley Town	4555	24.6%	1193	6.4%
Chelsfield and Pratts Bottom	3652	24.2%	1340	8.9%
Chislehurst	4005	24.4%	1918	11.7%
Clock House	4014	24.3%	926	5.6%
Copers Cope	2581	15.8%	1414	8.6%
Cray Valley East	4407	27.1%	1177	7.2%
Cray Valley West	4925	28.5%	1246	7.2%
Crystal Palace	2804	21.2%	435	3.3%
Darwin	1407	24.9%	516	9.1%
Farnborough and Crofton	3470	23.3%	1963	13.2%
Hayes and Coney Hall	4054	24.7%	1417	8.6%
Kelsey and Eden Park	4131	25.0%	1510	9.1%
Mottingham and Chislehurst North	2981	28.4%	634	6.0%
Orpington	3523	22.9%	1735	11.3%
Penge and Cator	4426	24.6%	759	4.2%
Petts Wood and Knoll	3194	22.5%	1430	10.1%
Plaistow and Sundridge	3948	24.7%	1151	7.2%
Shortlands	2374	23.2%	1055	10.3%
West Wickham	3593	23.8%	1613	10.7%
Bromley	**79288**	**24.3%**	**27159**	**8.3%**

Source: GLA 2015 round ward population projections - SHLAA-based; Capped Household Size model, Released May 2016

The age distribution of people in Bromley is very similar to that for England as a whole, as illustrated in the population pyramids (Figures 1.5 and 1.6).

Figure 1.5

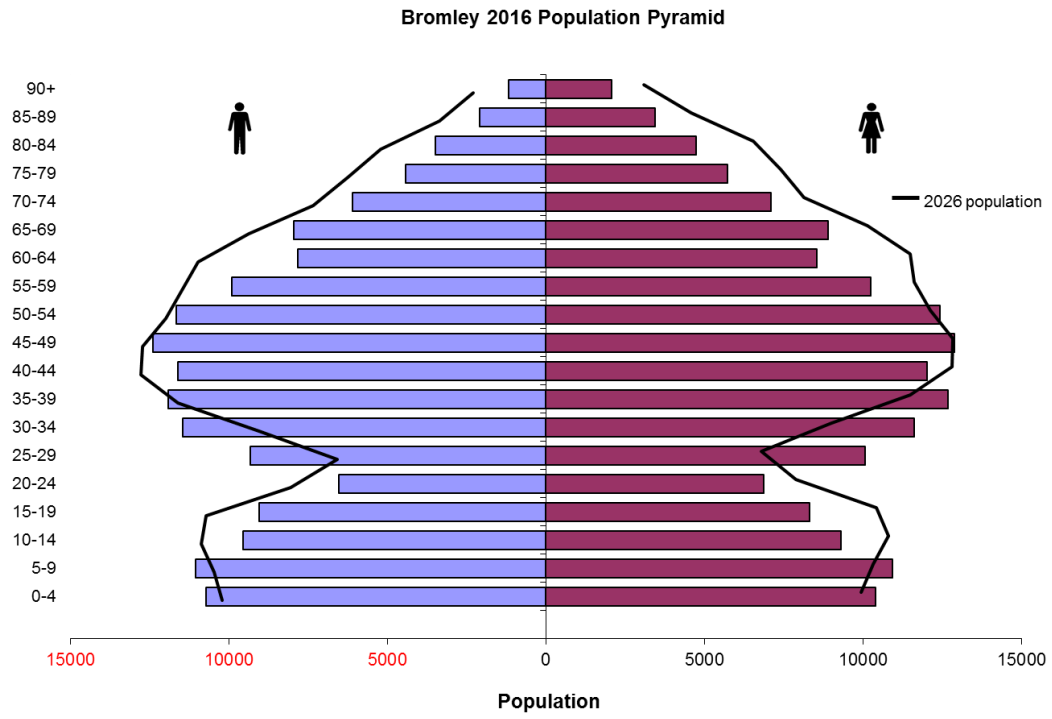
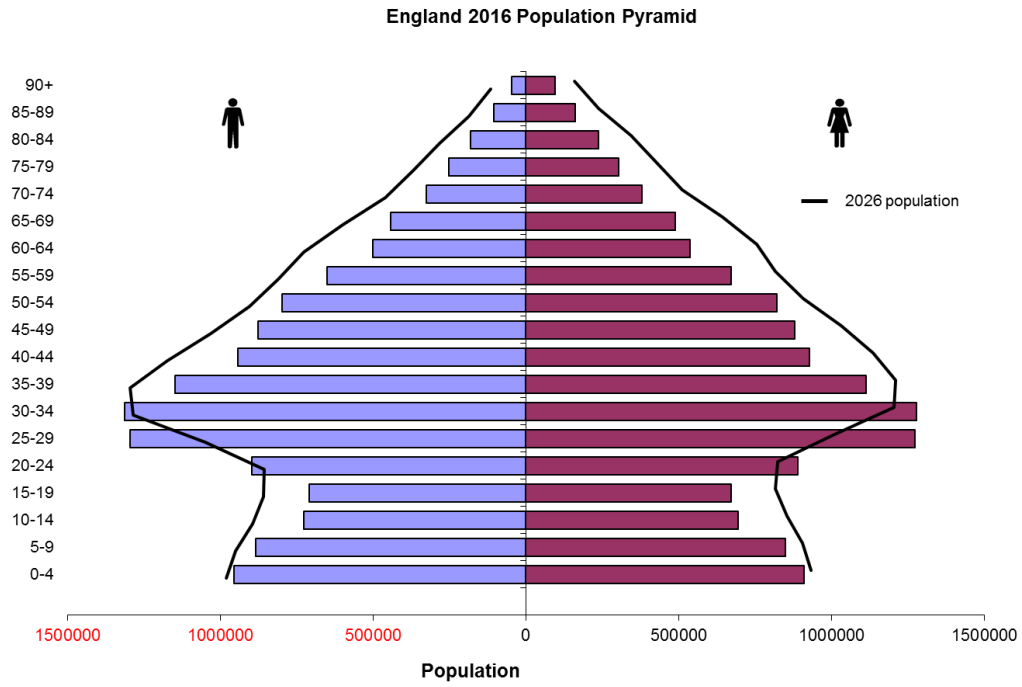


Figure 1.6



Population Projections

The population of Bromley is over 326,000, and is projected to rise by 2.1% over the next 5 years (Table 1.2).

Table 1.2

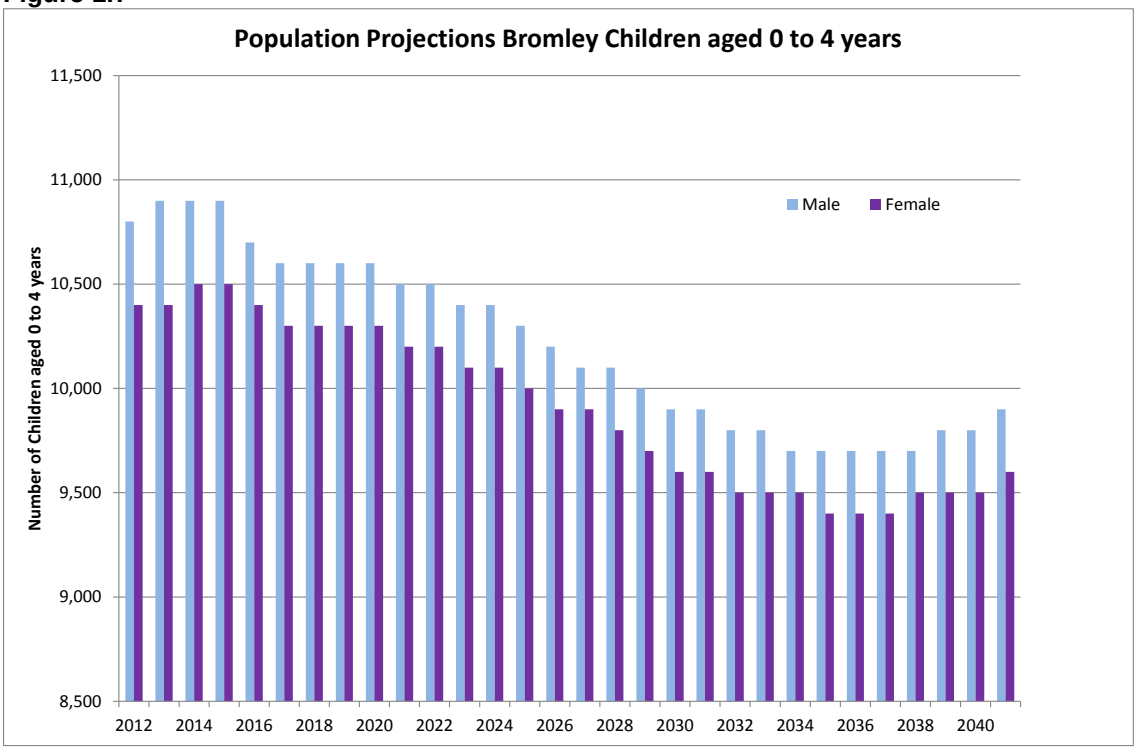
	2016		2021		2026		2031	
Total Population	326,600		333,600		341,200		346,800	
0 - 4 yrs (%)	21,100	6%	20,700	6%	20,100	6%	19,200	6%
5 - 10 yrs (%)	25,900	8%	26,200	8%	25,700	8%	24,100	7%
11 - 18 yrs (%)	29,500	9%	32,700	10%	35,200	10%	33,500	10%
Working age (%)*	203,700	62%	205,000	61%	207,700	61%	208,000	60%
Post Retirement (%)¥	57,200	18%	59,800	18%	65,200	19%	82,500	24%
80+ (%)	17,000	5%	18,000	5%	20,600	6%	28,200	8%

Source: GLA 2015, Round Population Projections accessed August 2016

* Working age =16 to 64y for males and females
¥ Post retirement = Over 64y males and females

The number of 0 to 4 year olds has gradually been increasing since 2011 and peaked in 2014 (21,472) but is then projected to decrease again to a minimum of 19,162 in 2036.

Figure 1.7



Source: GLA 2015 Round SHLAA-based Capped Household Size Model Population Projections (July 2016)

Ward Population Projections

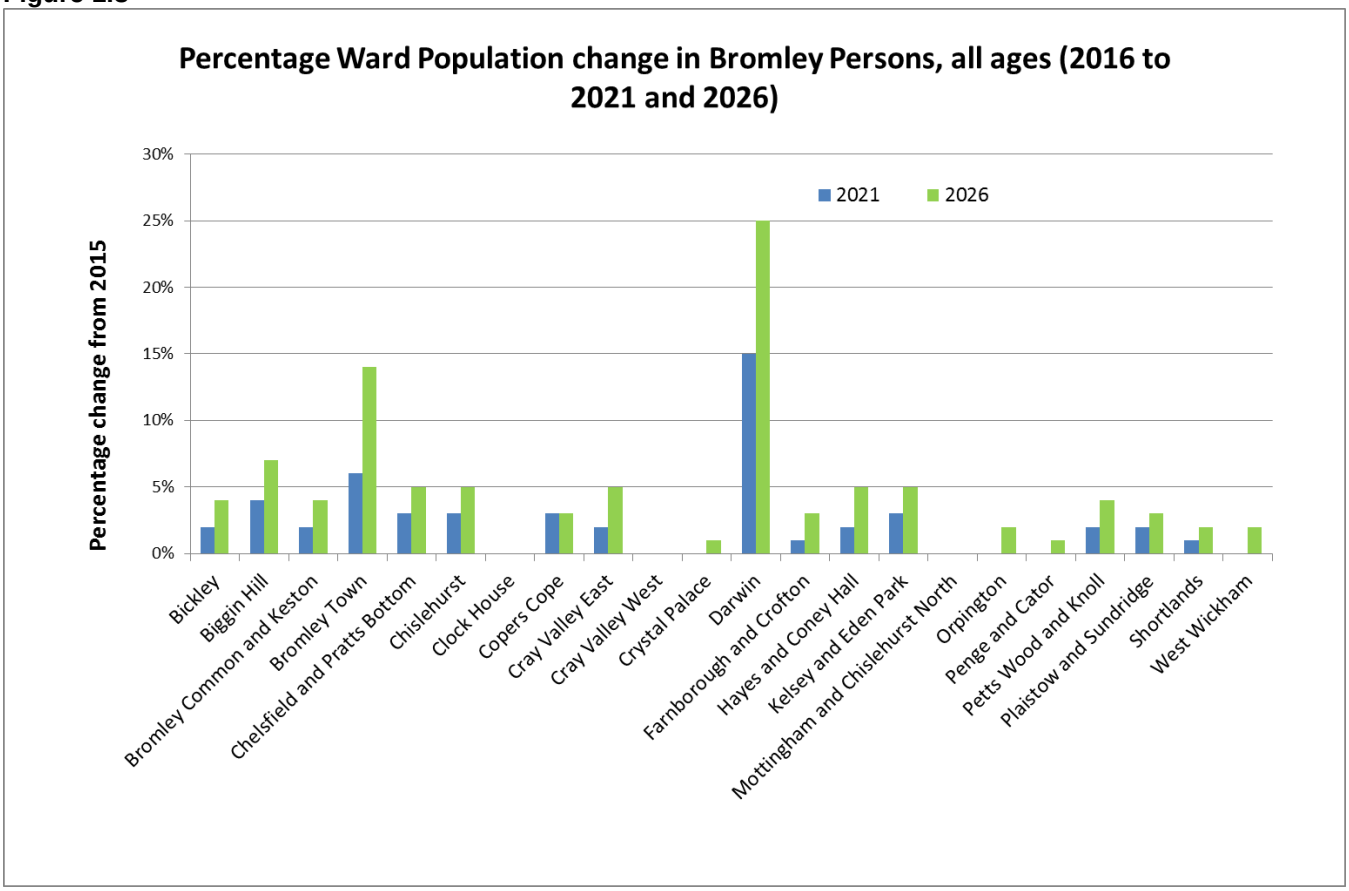
Overall, there is a projected increase in residents across all wards in Bromley. Bromley Town and Darwin are expected to have the highest percentage increase in all wards in 2021 and 2026.

Table 1.3

Ward Population Projections; Persons all ages					
	Population Projections			Change in Numbers	
Ward	**2016**	**2021**	**2026**	**2021**	**2026**
Bickley	15941	16279	16546	338	605
Biggin Hill	10573	11014	11347	441	774
Bromley Common and Keston	17413	17816	18064	403	651
Bromley Town	18539	19716	21679	1177	3140
Chelsfield and Pratts Bottom	15066	15541	15906	475	840
Chislehurst	16428	16986	17334	558	906
Clock House	16527	16554	16553	27	26
Copers Cope	16378	16814	16945	436	567
Cray Valley East	16254	16654	17070	400	816
Cray Valley West	17285	17251	17309	-34	24
Crystal Palace	13256	13207	13418	-49	162
Darwin	5647	6648	7563	1001	1916
Farnborough and Crofton	14919	15069	15323	150	404
Hayes and Coney Hall	16403	16819	17276	416	873
Kelsey and Eden Park	16553	16998	17362	445	809
Mottingham and Chislehurst North	10504	10471	10543	-33	39
Orpington	15389	15450	15690	61	301
Penge and Cator	18000	18025	18264	25	264
Petts Wood and Knoll	14180	14468	14723	288	543
Plaistow and Sundridge	15972	16362	16497	390	525
Shortlands	10238	10335	10420	97	182
West Wickham	15078	15126	15367	48	289
Bromley	**328559**	**335624**	**343225**	**7065**	**14666**

Source: GLA 2015, Round Population Projections accessed August 2016

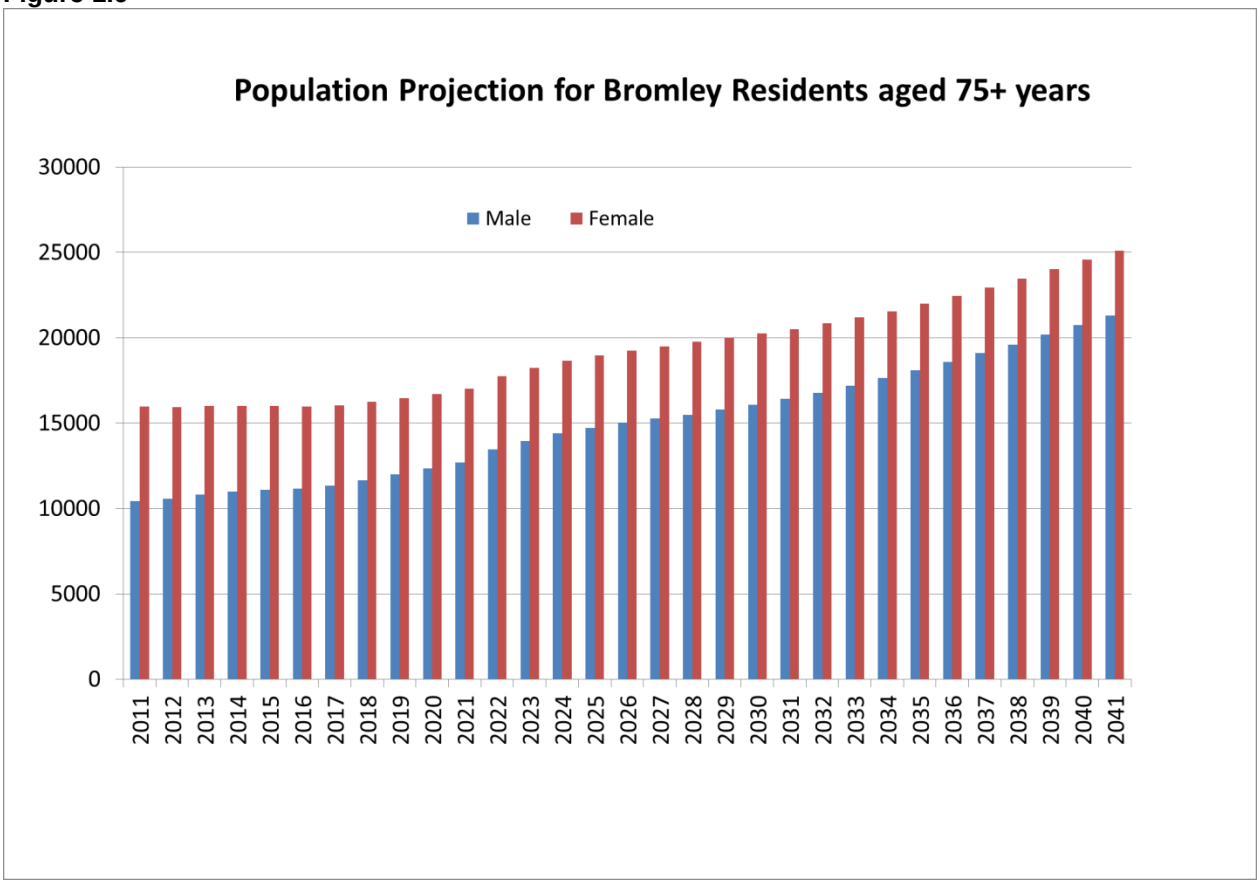
Figure 1.8



Source: GLA 2015, Round Population Projections accessed August 2016

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

Figure 1.9

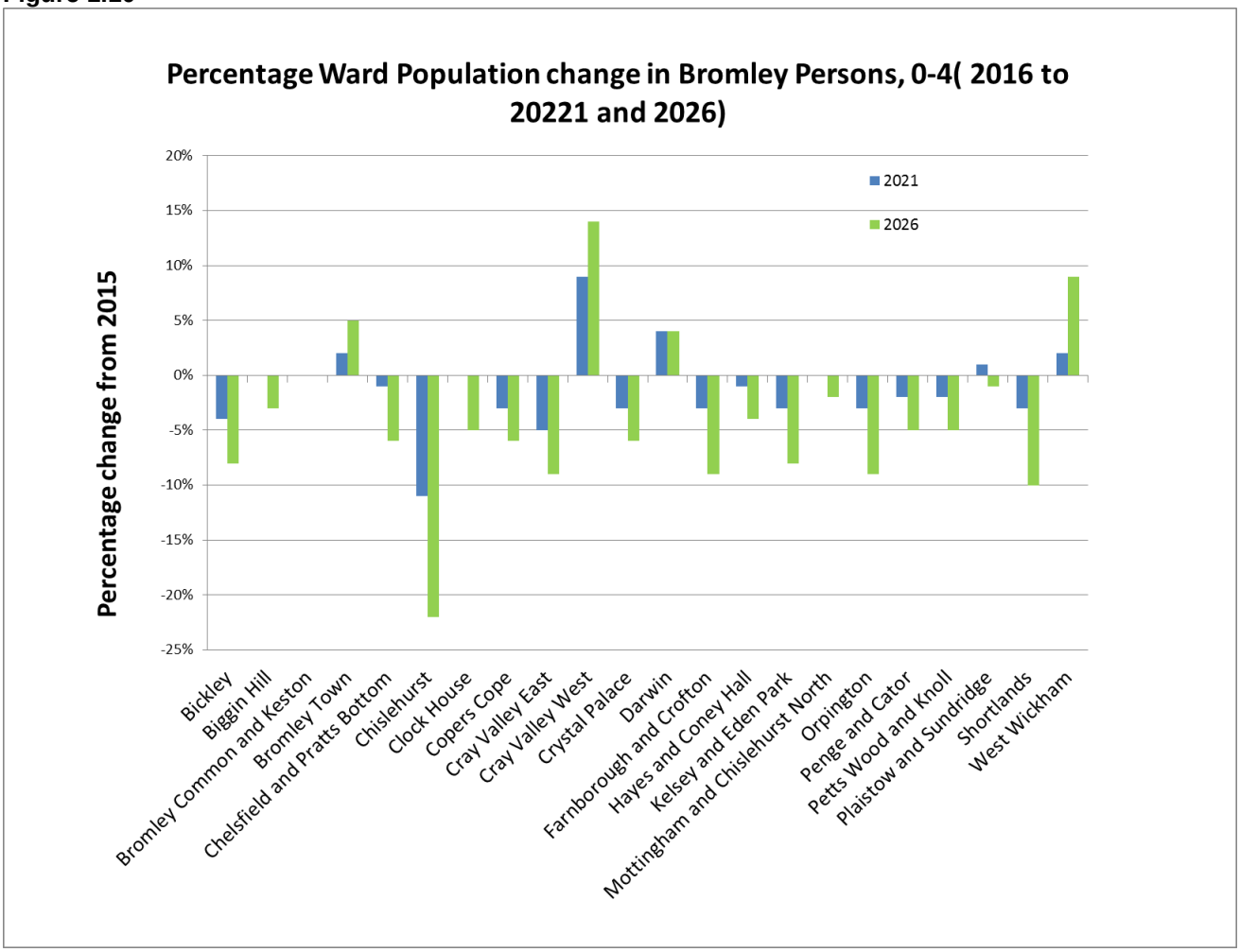


Source: GLA 2015, Round Population Projections accessed August 2016

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

The largest reduction in the 0-4 year age group will be seen in Clock House (18%). For over 75s, the population is projected to increase and the largest increase will be in Biggin Hill (21%), Darwin (15%) and Petts Wood & Knoll (15%), as seen in Figures 1.10 and 1.11.

Figure 1.10



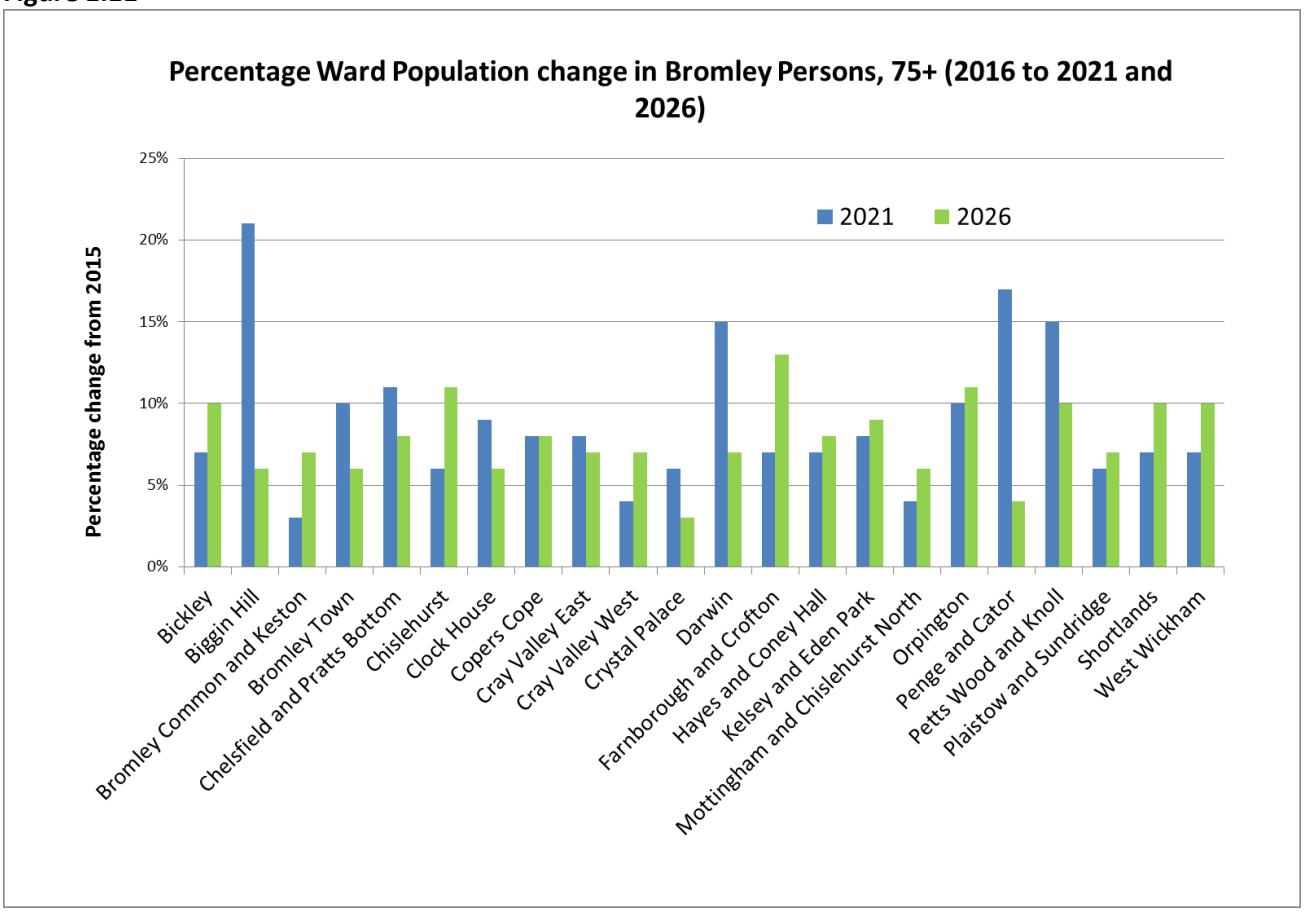
Source: GLA 2015, Round Population Projections accessed August 2016

Table 1.4

Population Aged 0-4 years in Bromley					
	Population in projections			Change in numbers	
Ward	2016	2021	2026	2021	2026
Bickley	892	856	827	-36	-65
Biggin Hill	646	660	650	14	4
Bromley Common and Keston	1243	1215	1135	-28	-108
Bromley Town	1484	1525	1648	41	164
Chelsfield and Pratts Bottom	927	920	891	-7	-36
Chislehurst	975	965	919	-10	-56
Clock House	1366	1231	1123	-135	-243
Copers Cope	1052	1058	994	6	-58
Cray Valley East	1179	1152	1125	-27	-54
Cray Valley West	1156	1117	1074	-39	-82
Crystal Palace	966	936	905	-30	-61
Darwin	299	362	401	63	102
Farnborough and Crofton	718	696	676	-22	-42
Hayes and Coney Hall	859	901	911	42	52
Kelsey and Eden Park	918	904	871	-14	-47
Mottingham and Chislehurst North	863	812	760	-51	-103
Orpington	882	890	881	8	-1
Penge and Cator	1346	1265	1205	-81	-141
Petts Wood and Knoll	912	913	889	1	-23
Plaistow and Sundridge	1160	1128	1057	-32	-103
Shortlands	571	552	528	-19	-43
West Wickham	704	698	699	-6	-5
Bromley	21118	20756	20169	-362	-949

Source: GLA 2015, Round projections SHLAA-based; Accessed February 2017

Figure 1.11



Source: GLA 2016, Round Population Projections accessed August 2016

Table 1.5

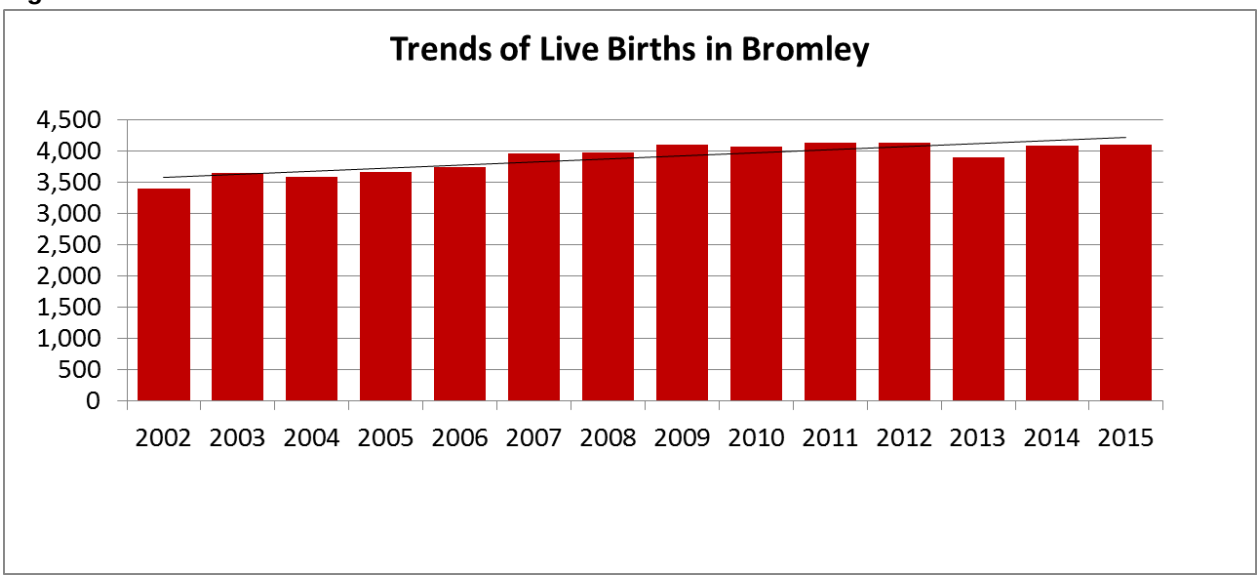
Ward Population Projections; Persons 75+

	Population Projections			Change in Numbers	
	2016	**2021**	**2026**	**2021**	**2026**
Bickley	1708	1838	2023	130	315
Biggin Hill	696	879	1114	183	418
Bromley Common and Keston	1323	1361	1604	38	281
Bromley Town	1193	1324	1505	131	312
Chelsfield and Pratts Bottom	1340	1500	1738	160	398
Chislehurst	1918	2049	2171	131	253
Clock House	926	1016	1253	90	327
Copers Cope	1414	1533	1794	119	380
Cray Valley East	1177	1284	1508	107	331
Cray Valley West	1246	1304	1482	58	236
Crystal Palace	435	463	545	28	110
Darwin	516	610	727	94	211
Farnborough and Crofton	1963	2107	2397	144	434
Hayes and Coney Hall	1417	1520	1816	103	399
Kelsey and Eden Park	1510	1648	1960	138	450
Mottingham and Chislehurst North	634	662	756	28	122
Orpington	1735	1932	2169	197	434
Penge and Cator	759	914	1121	155	362
Petts Wood and Knoll	1430	1682	1906	252	476
Plaistow and Sundridge	1151	1225	1405	74	254
Shortlands	1055	1136	1316	81	261
West Wickham	1613	1742	1971	129	358
Bromley	**27159**	**29729**	**34281**	**2570**	**7122**

Source: GLA 2016, Round Population Projections accessed August 2016

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 4,098 in 2015.

Figure 1.12

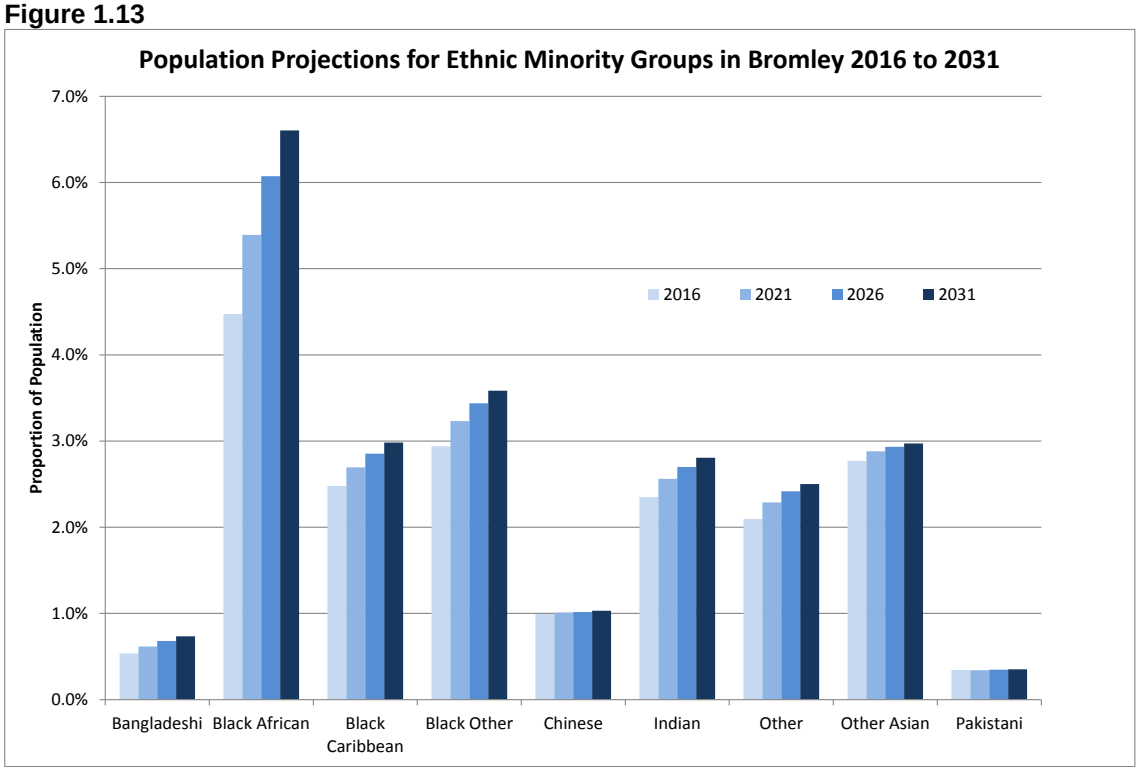


Source: ONS 2016, Live births by local authority of usual residence of mother, Accessed August 2016

Ethnic groups

The GLA 2014 Round Ethnic Group Projections estimate that, in 2016, the ethnic minority population of Bromley is 19.0%, and this is projected to rise to 22.5% by 2026. The greatest proportional rise is in the Black African group.

Figure 1.13



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

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.

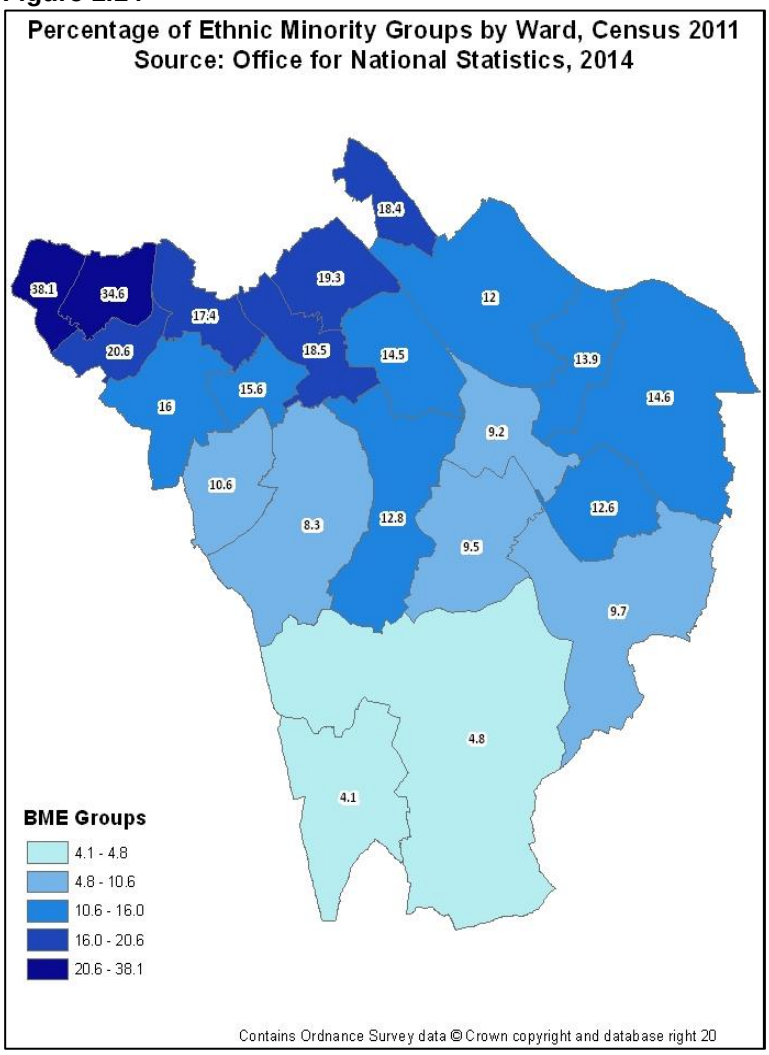
Among ethnic minority groups, Black Africans comprise the largest proportion of those seen for HIV care in all regions. Along with the 'Other' ethnic group, Black Africans also have the highest rates of tuberculosis.

Table 1.6

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 1.14). We do not have projections for changes in population by ethnicity at ward level.

Figure 1.14



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

The borough 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.

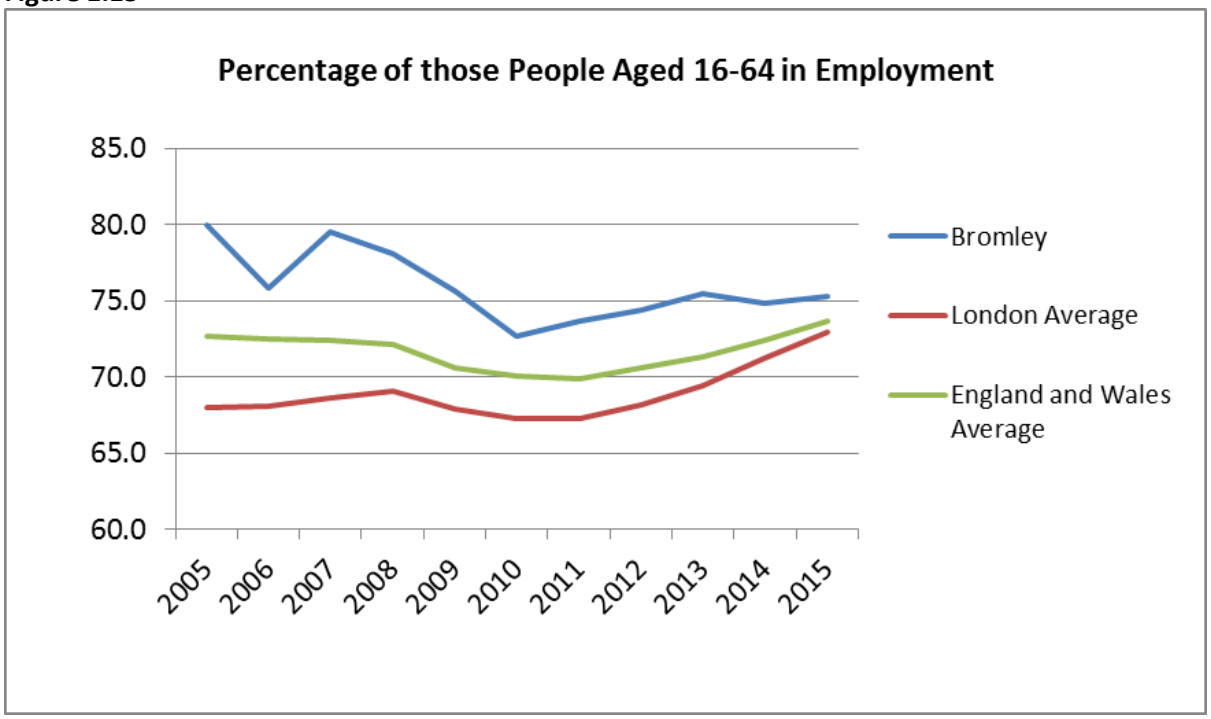
There is evidence that Gypsies and Travellers are the most excluded ethnic minority in this country[1].

[1] Communities and Local Government, *Facts about Gypsies and Travelers*

Employment

The employment rate in Bromley is higher than the national and also the London average, with a 75% employment rate for people aged 16 – 64 in compared to 73% in London during 2015.

Figure 1.15



Source: ONS, Annual Population Survey 2016

Air Quality

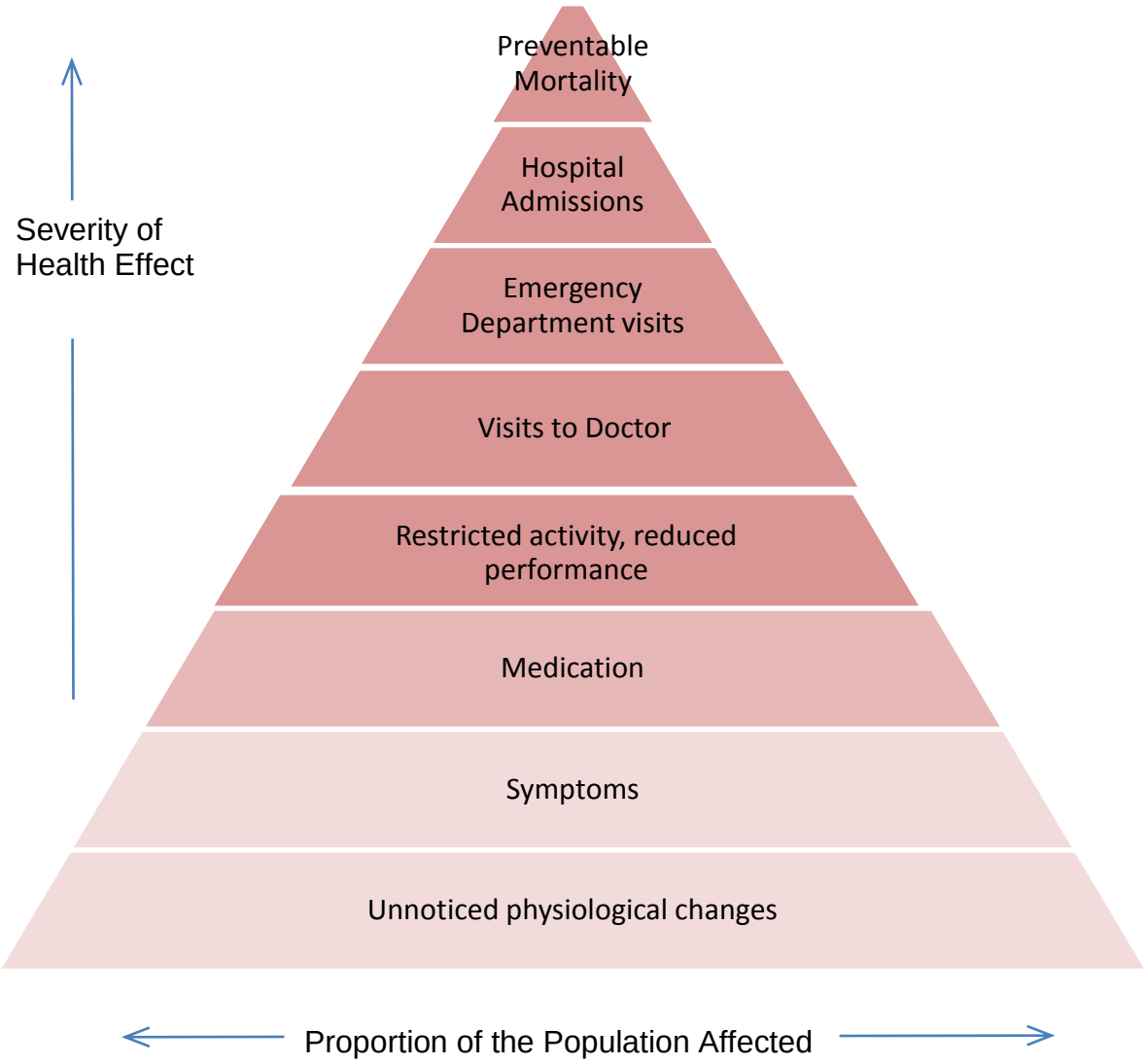
Air pollution refers to substances in the air that harm human health, welfare, plant or animal life. Most pollution in London is caused by road transport and domestic and commercial heating systems.

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

The long term impacts upon health of air pollution can be represented by a pyramid structure, as shown in Figure 1.16 below. For the majority of the population the effects of air pollution are not usually immediately obvious, although some individuals may notice symptoms such as irritation to eyes and throats when pollution levels are elevated.

However, smaller numbers of the population are more vulnerable to the effects of air pollution, as exposure to pollution can exacerbate existing health conditions including cardiovascular and respiratory disease. This can lead to restricted activity, hospital admissions and even premature mortality.

Figure 1.16: Impact of Air Pollution on Health

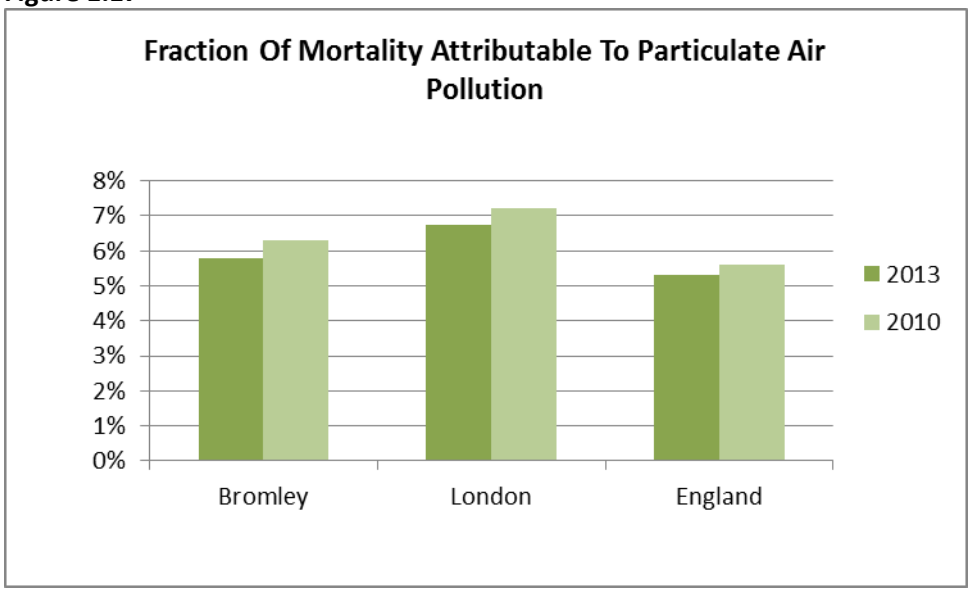


WHO, 2005

The Public Health Outcomes Framework includes a benchmark tool, which enables the comparison of the fraction (%) of mortality attributable to long term exposure to PM2.5 (Particulate Matter (less than 2.5 micrometers diameter) in each local authority in the UK. This can be compared to the UK average which is 5.6% of mortality attributable to long term exposure to PM2.5.

The figure for Bromley in 2013 was 6.3%, which is 13% higher than the UK average and was the best in London.

Figure 1.17



Source: Public Health Outcomes Framework, Accessed August 2016

What this means for Bromley residents and for children in Bromley.

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

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

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

The proportion of mortality attributable to particulate air pollution in Bromley is higher than the UK average, although it is also the lowest in London.

2. 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

2.1 Mortality & Life Expectancy

All Cause Mortality

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

Figure 2.1.1

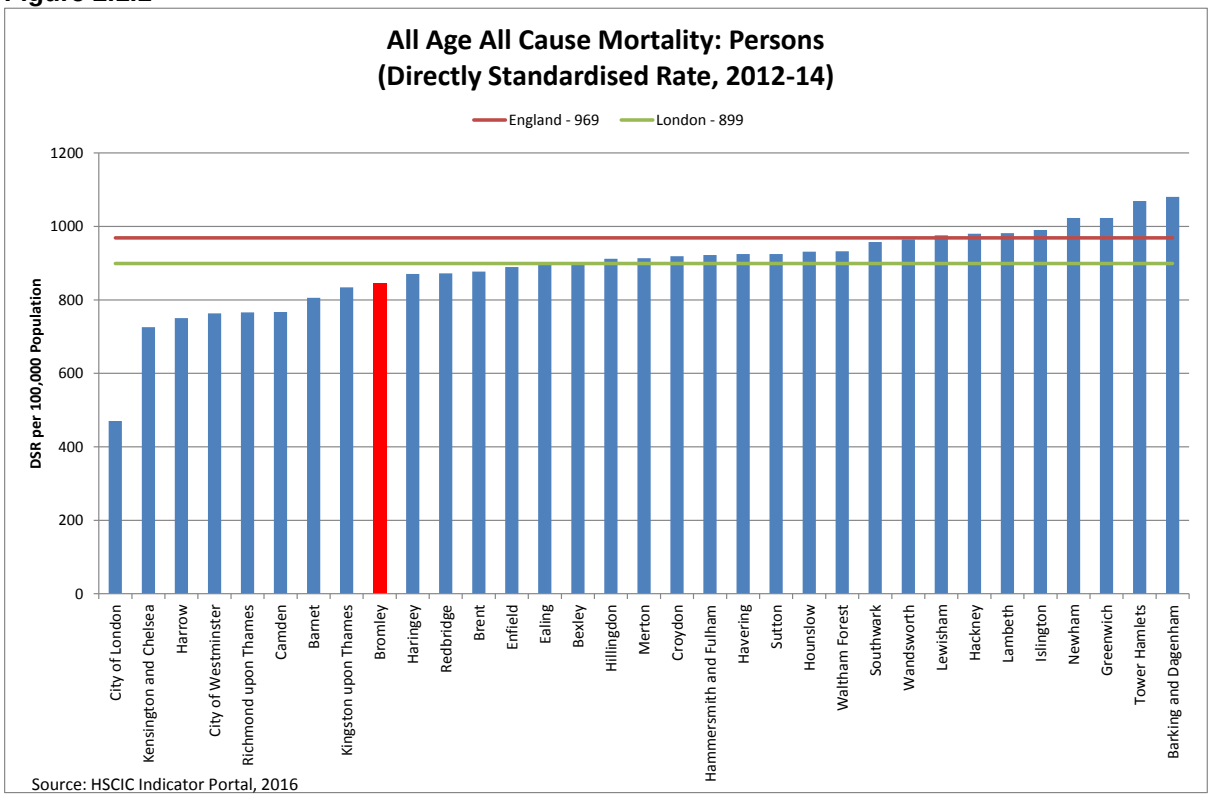
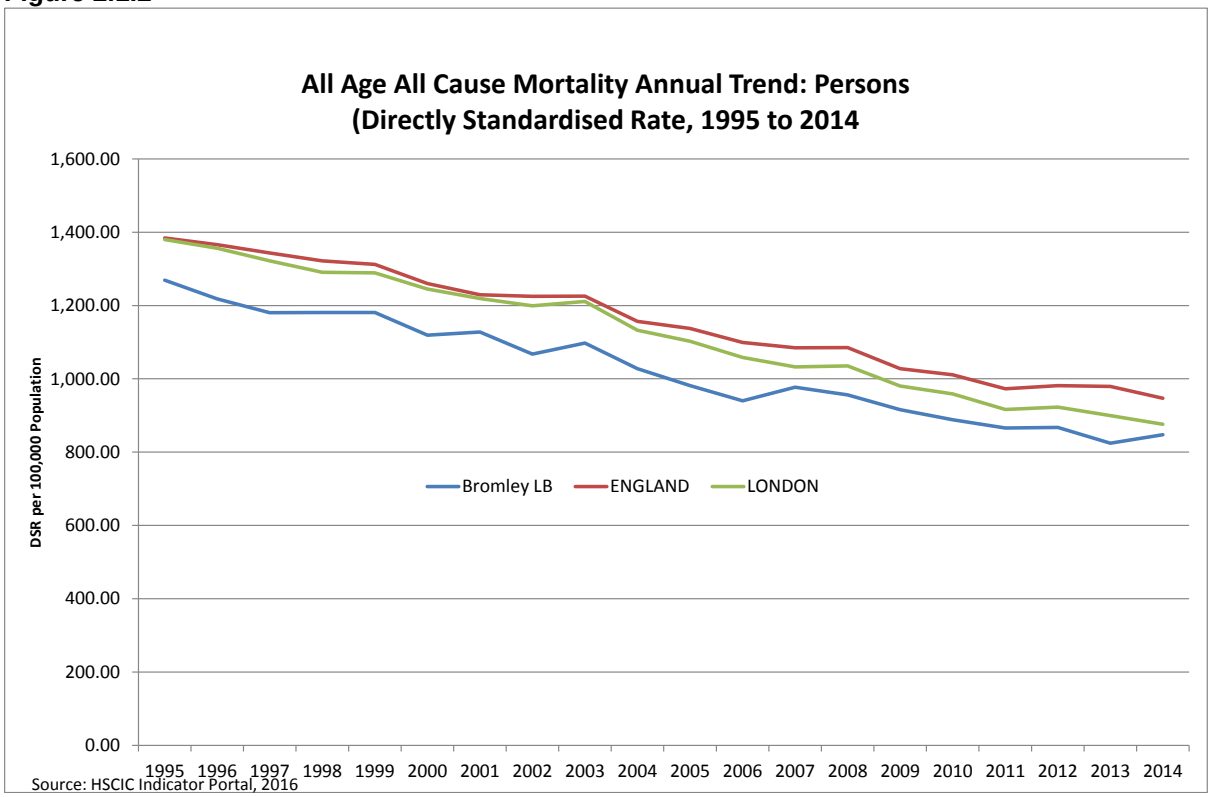


Figure 2.1.2

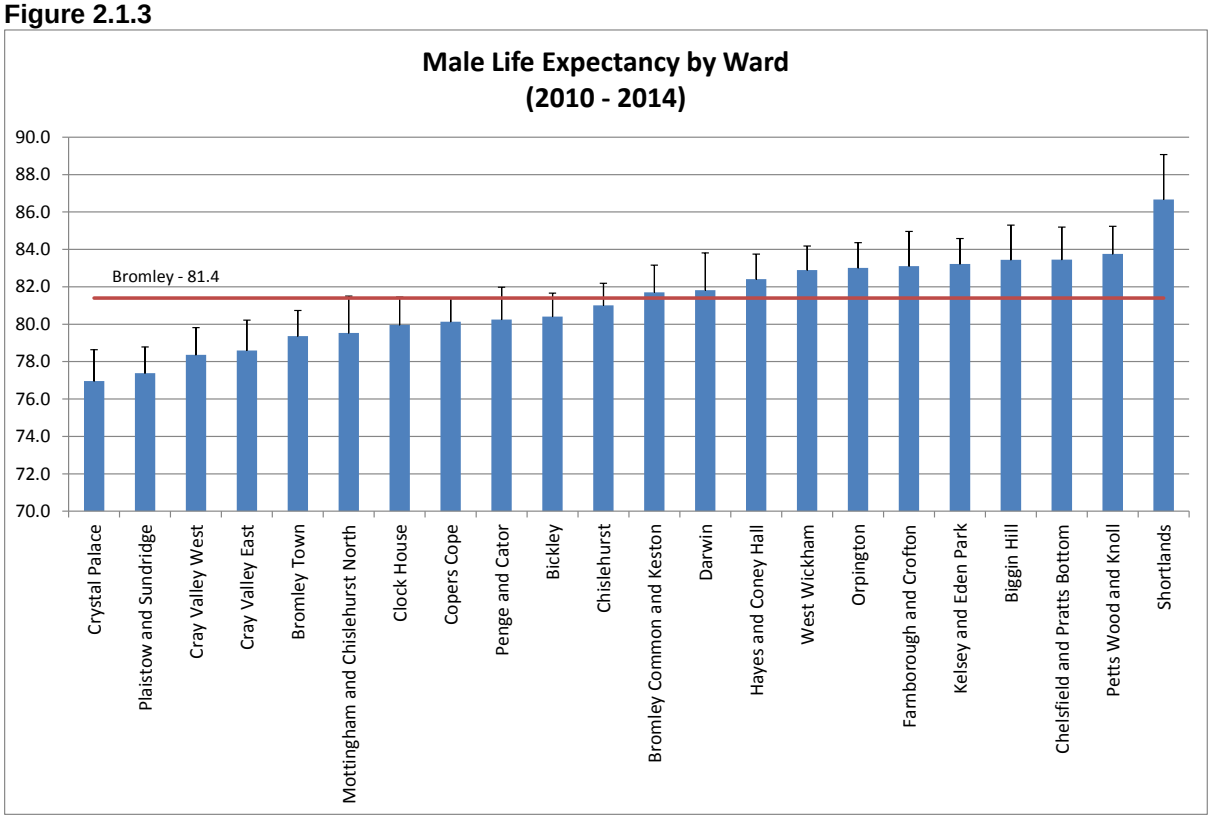

All Age All Cause Mortality Annual Trend: Persons
(Directly Standardised Rate, 1995 to 2014
DSR per 100,000 Population
1,600.00
1,400.00
1,200.00
1,000.00
800.00
600.00
400.00
200.00
0.00
Bromley LB
ENGLAND
LONDON
1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014
Source: HSCIC Indicator Portal, 2016

Life Expectancy

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, and the latest figures (2012-14) report a life expectancy of 81.4 years for men and 84.9 years for women. These averages rank 57th and 44th respectively in the national order. However, life expectancy across Bromley is not uniform. The gap between wards with the highest and lowest life expectancy for the years 2010-14 was 9.7 years for men and 6.7 years for women.

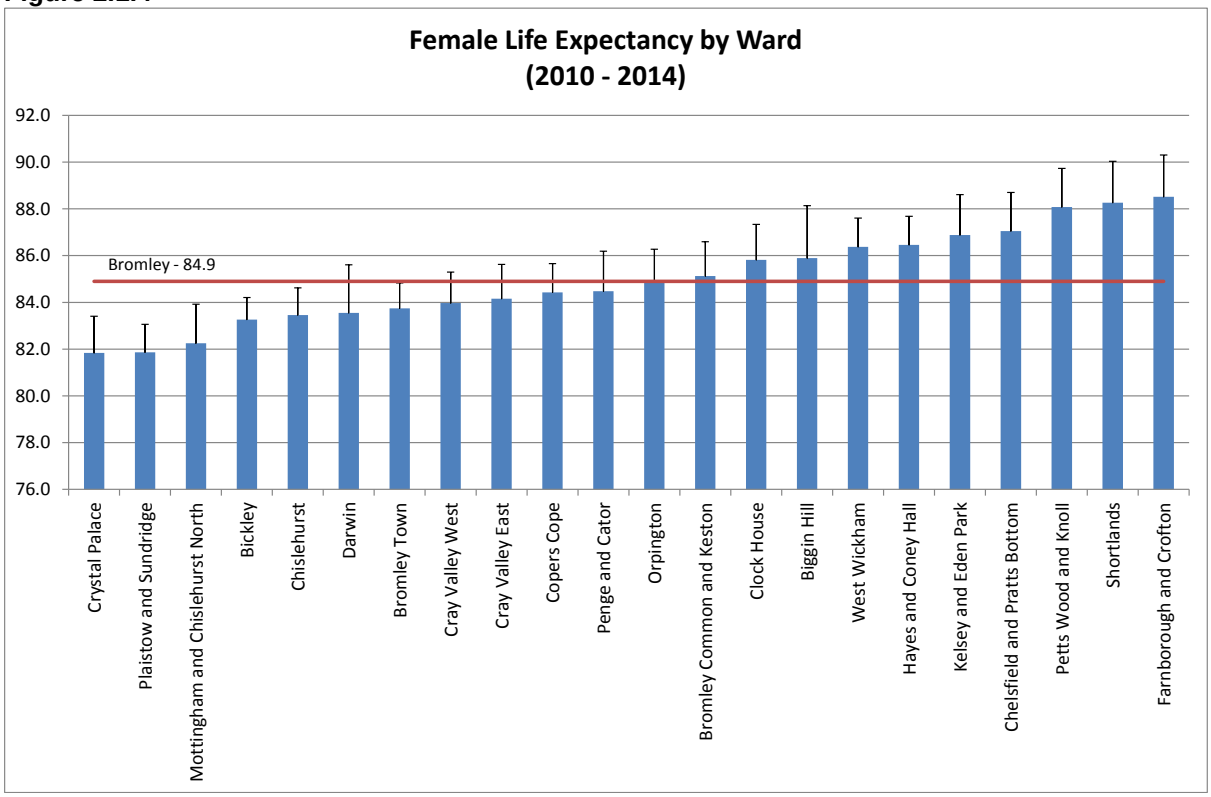
Life expectancy is lowest for men and for women in Bromley in Crystal Palace (77 years and 81.8 years) and Plaistow & Sundridge (77.4 years and 81.9 years) wards.

Figure 2.1.3



Source: London Datastore 2016

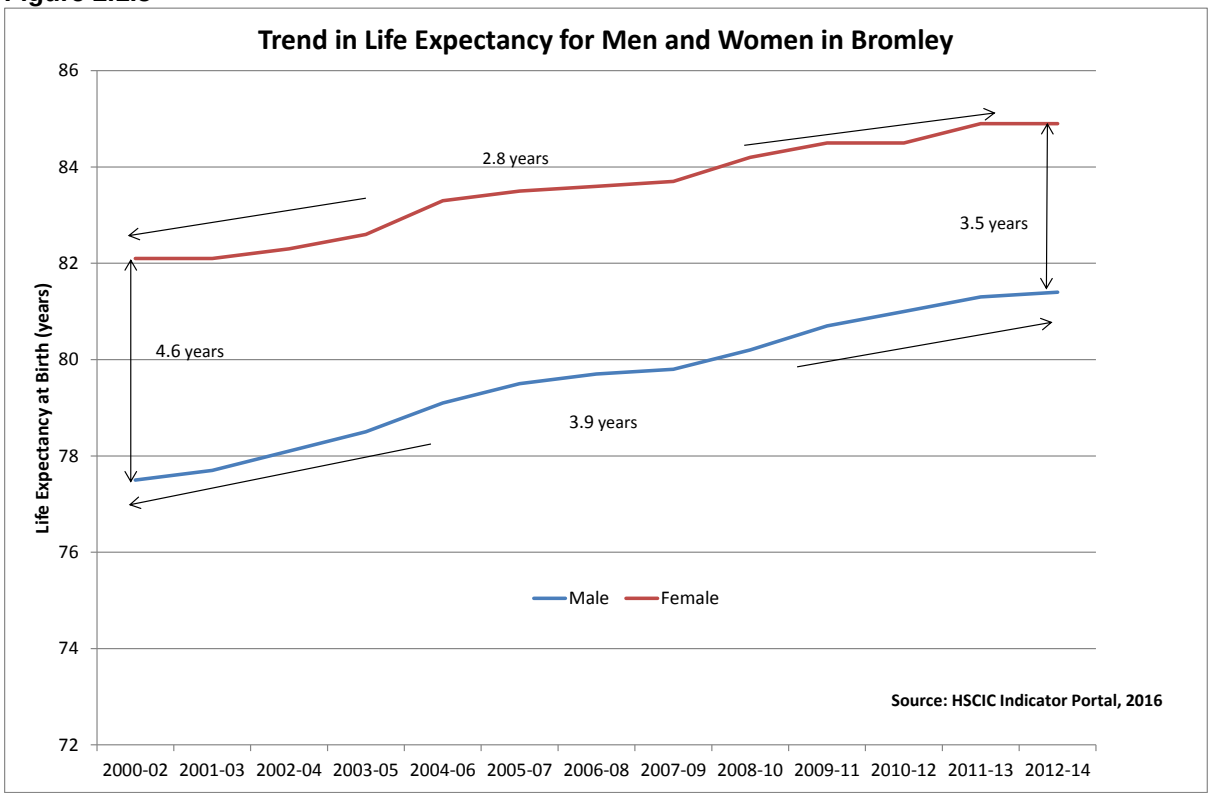
Figure 2.1.4



Source: London Datastore 2016

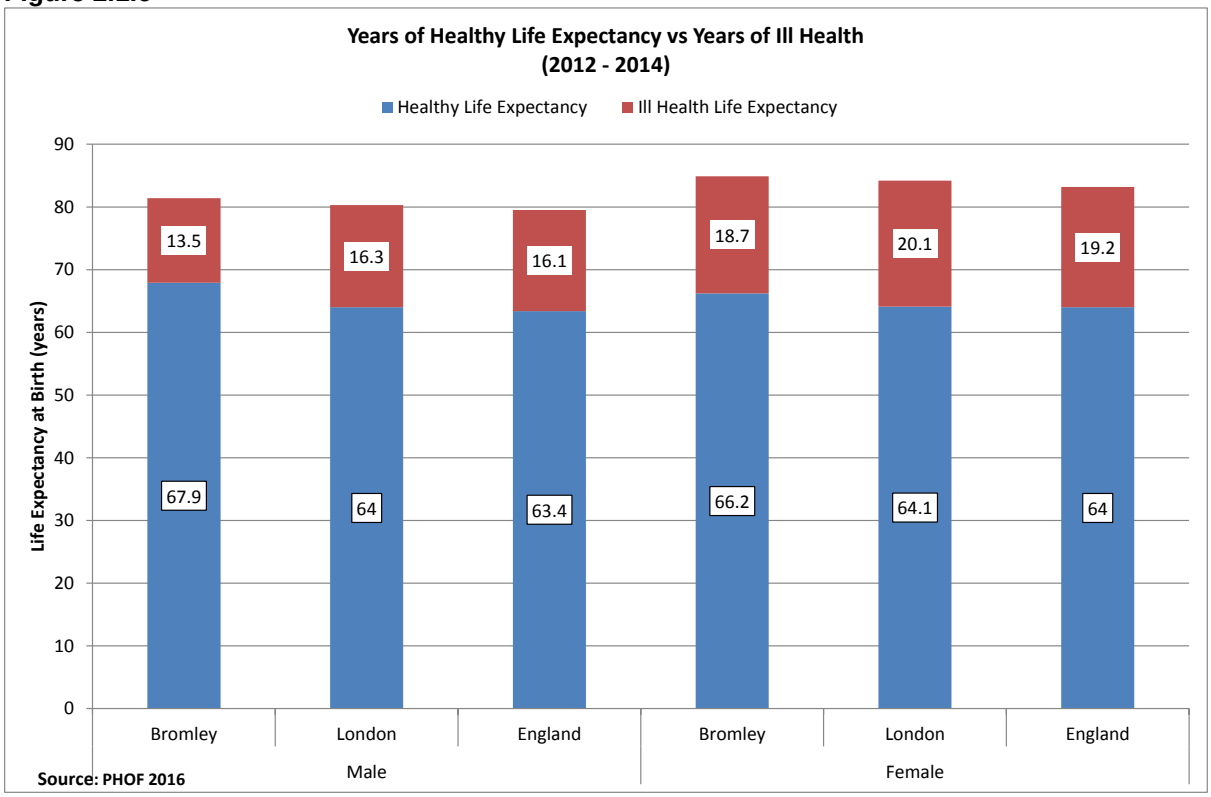
Men have a lower life expectancy than women, but over the last fourteen years, there has been a reduction in the life expectancy gap between men and women from 4.6 years to 3.5 years, with life expectancy increasing for both men and women over the same period.

Figure 2.1.5



It is not just longevity that is important, but healthy life expectancy. Figure 2.1.6 shows that people in Bromley can expect to live more years without illness than the England and London average.

Figure 2.1.6

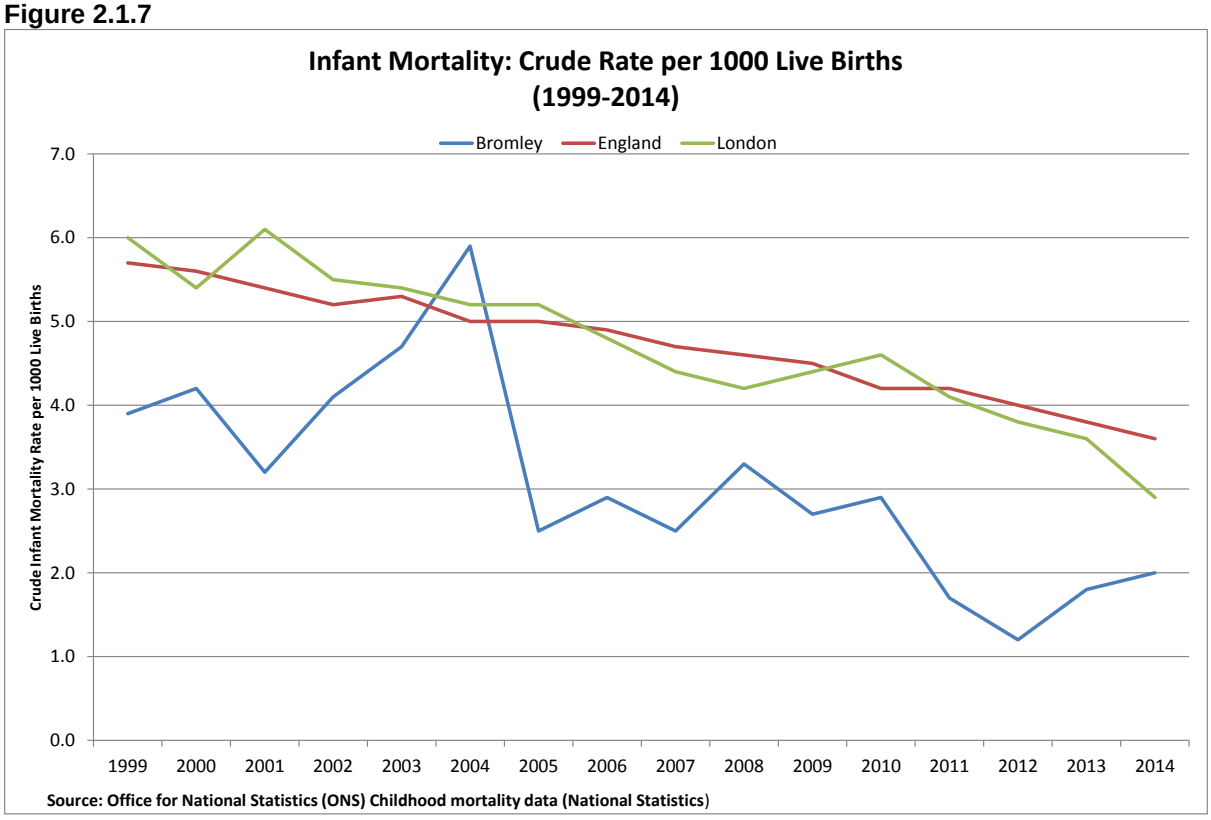


Another important measure of life expectancy is Disability-Free Life Expectancy (DFLE). This is assessed by asking respondents whether they have any health problems or disabilities that you expect will last for more than a year, and whether these health problems or disabilities, when taken singly or together, substantially limit their ability to carry out normal day-to-day activities.
Bromley is ranked 30th in the country for DFLE at birth for men (at 65.7 years) and 6th in the country for women (at 68.7 years).

Infant Mortality

The infant mortality rate looks at deaths under the age of 1 year and is an indicator of the overall health of a population.
The infant mortality rate in Bromley (2.0 per 1000 live births) is lower than in England as a whole (3.6 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. The graph shows some fluctuation, which reflects the small numbers involved.
Individual causes are not described as numbers are small (fewer than 5 deaths a year).

Figure 2.1.7



2.2. Health Inequalities

Health inequalities are differences in the health status of groups and individuals that are both avoidable and unjust.
Health inequalities arise from social inequalities, themselves the result of unequal distribution of factors influencing health (e.g. housing, environment, social background, income, employment and education).

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

For the period 2012 to 2014, the SII for men in Bromley was 8.6, and for women, 6.2. This can be interpreted as an 8.6 year difference in life expectancy at birth between males living in the most and least deprived areas of Bromley, and 6.2 years for females.
Although there is less difference in the level of life expectancy inequalities seen between males and females in Bromley, in the last eleven years, there has been an increase in inequalities in life expectancy within gender (Figure 2.2.3).

Figure 2.2.1

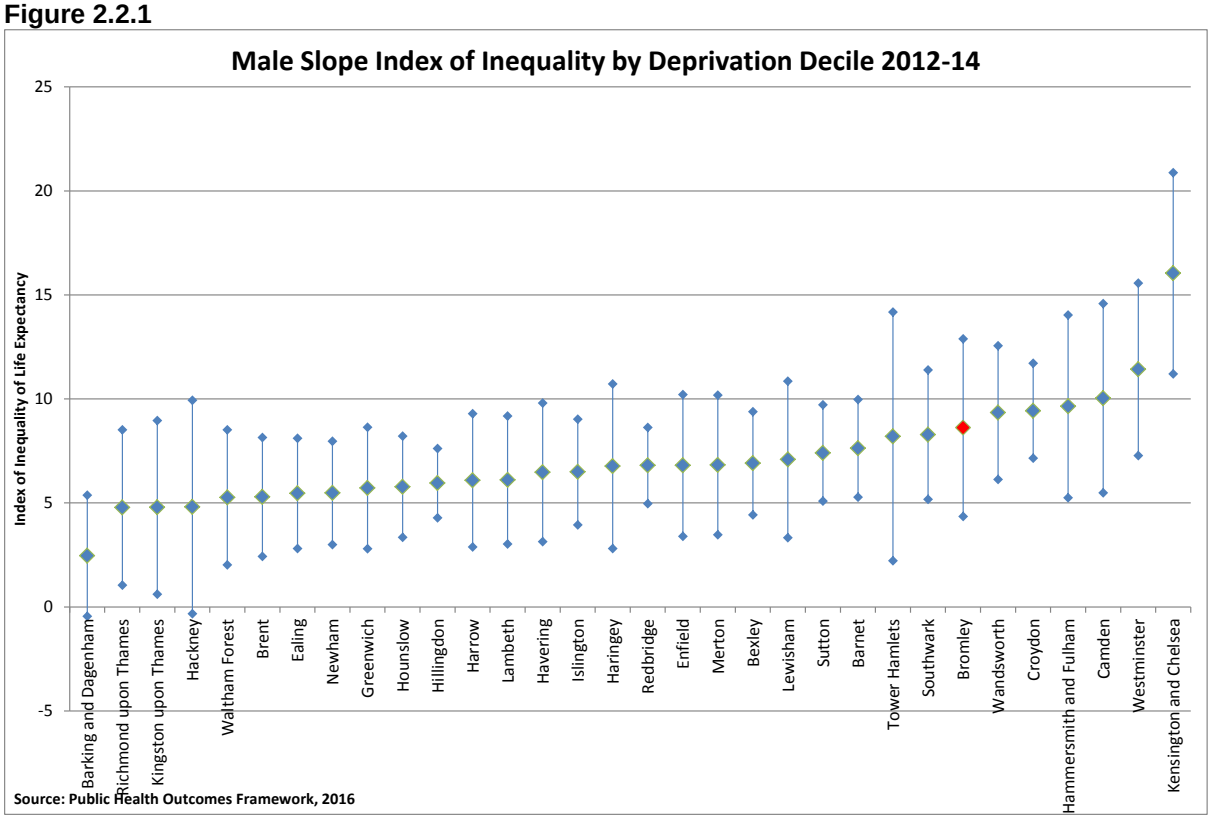


Figure 2.2.2

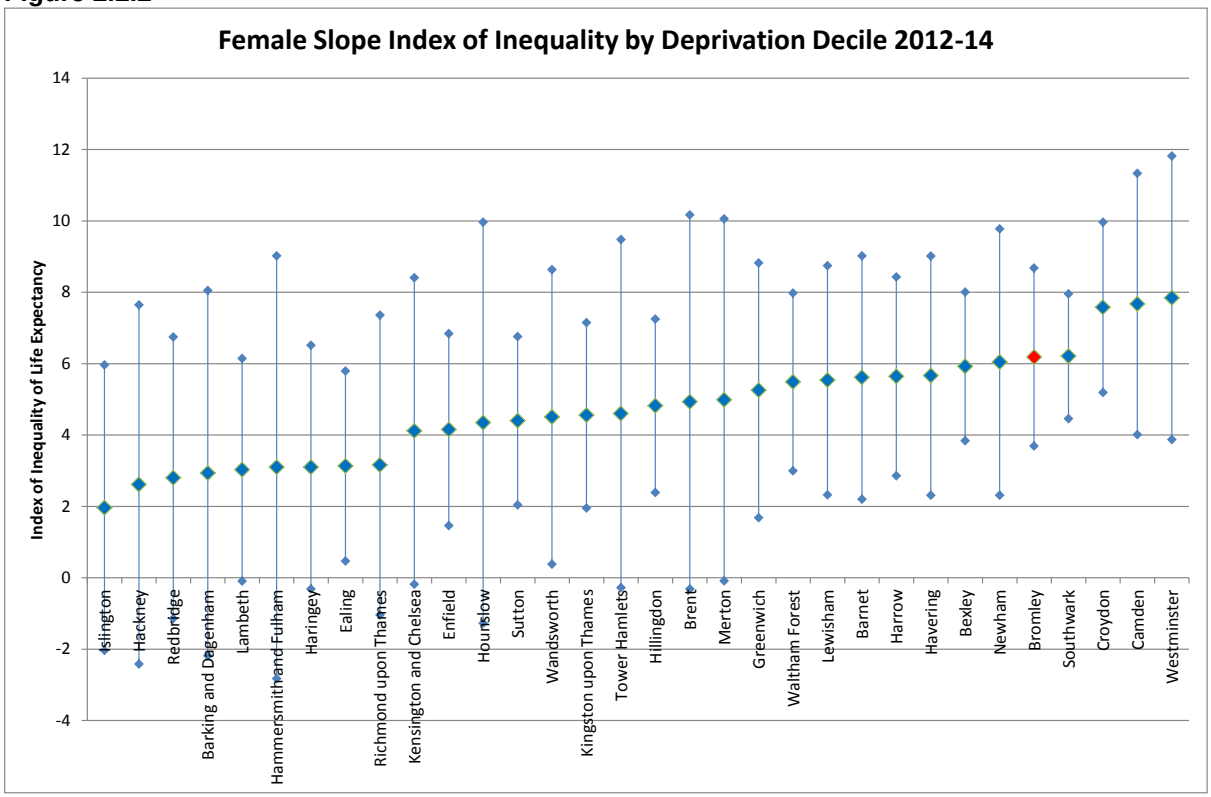
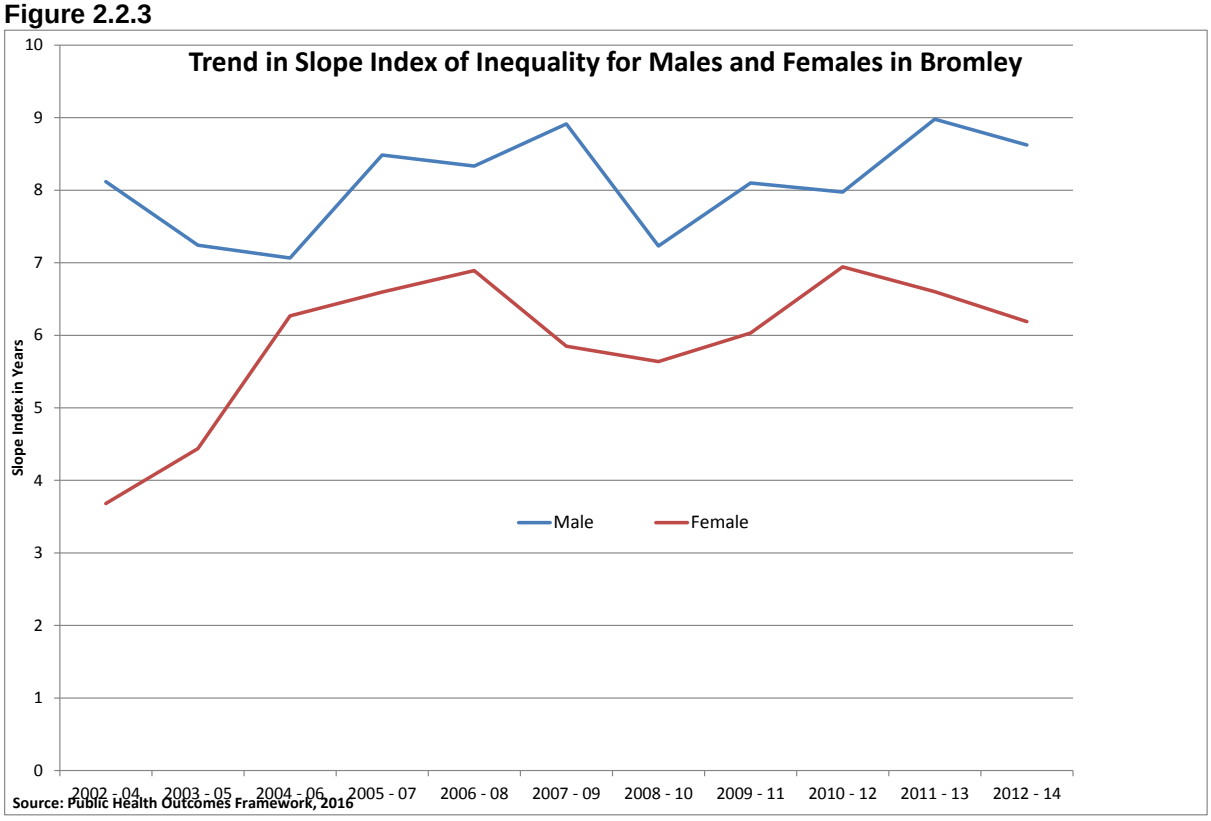


Figure 2.2.3



There is significant variation in mortality rates for coronary heart disease and cancer between wards in Bromley (Figures 2.2.4 and 2.2.5). Crystal Palace ward has significantly higher than average premature mortality rates for both heart disease and cancer, Penge & Cator and Cray Valley East wards for heart disease, and Plaistow & Sundridge and Cray Valley West wards for cancer.

Figure 2.2.4

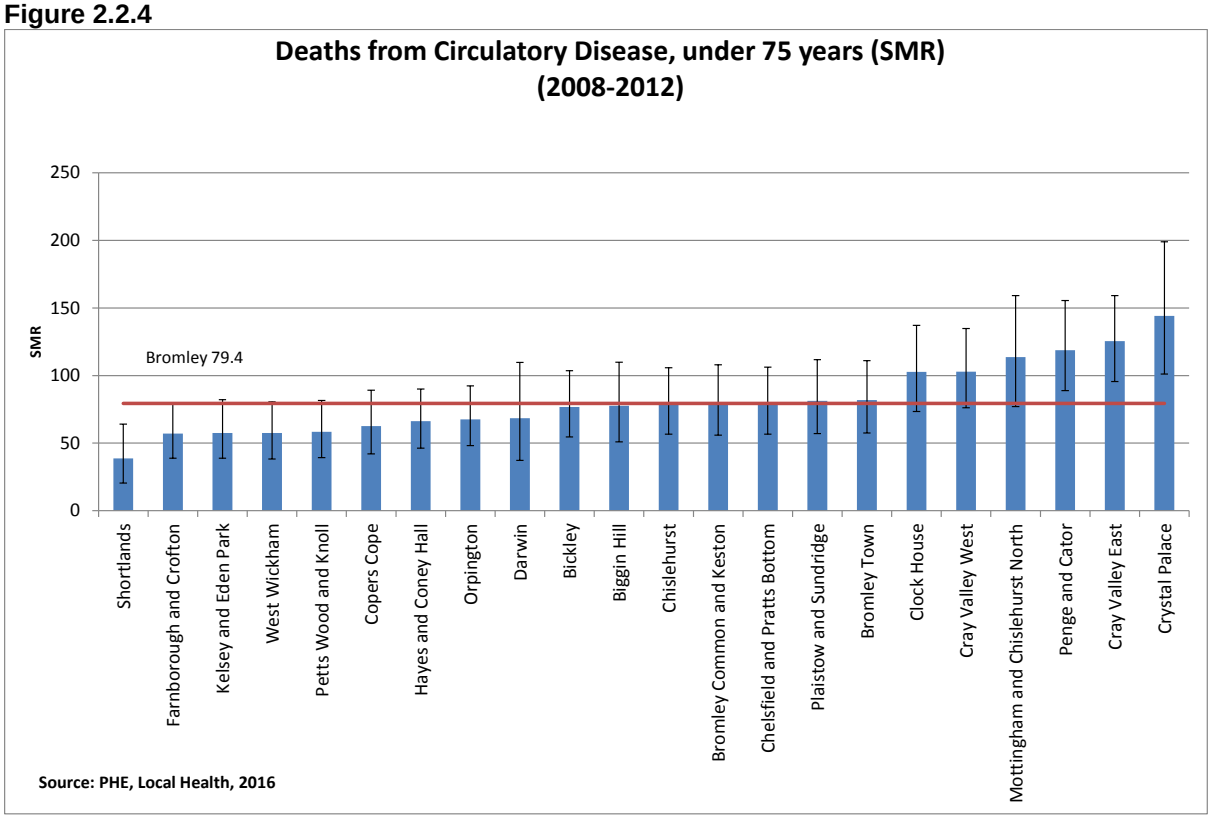
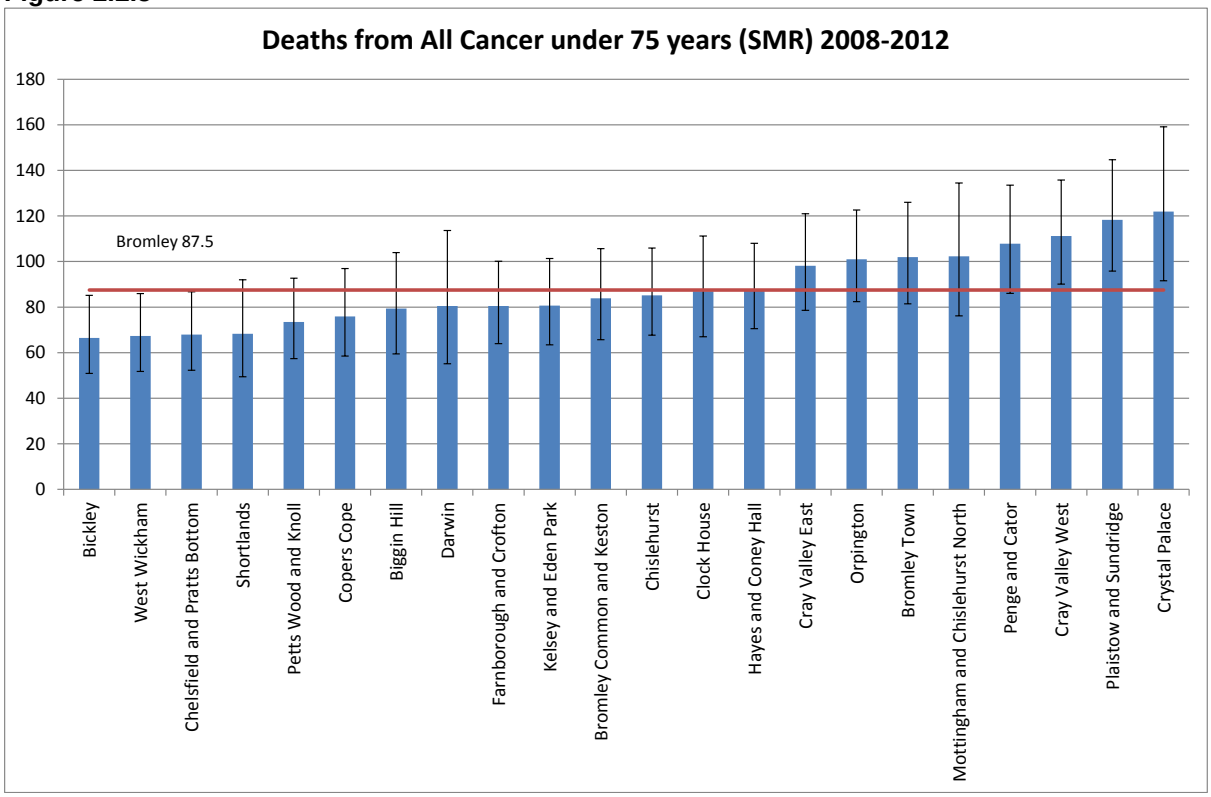


Figure 2.2.5



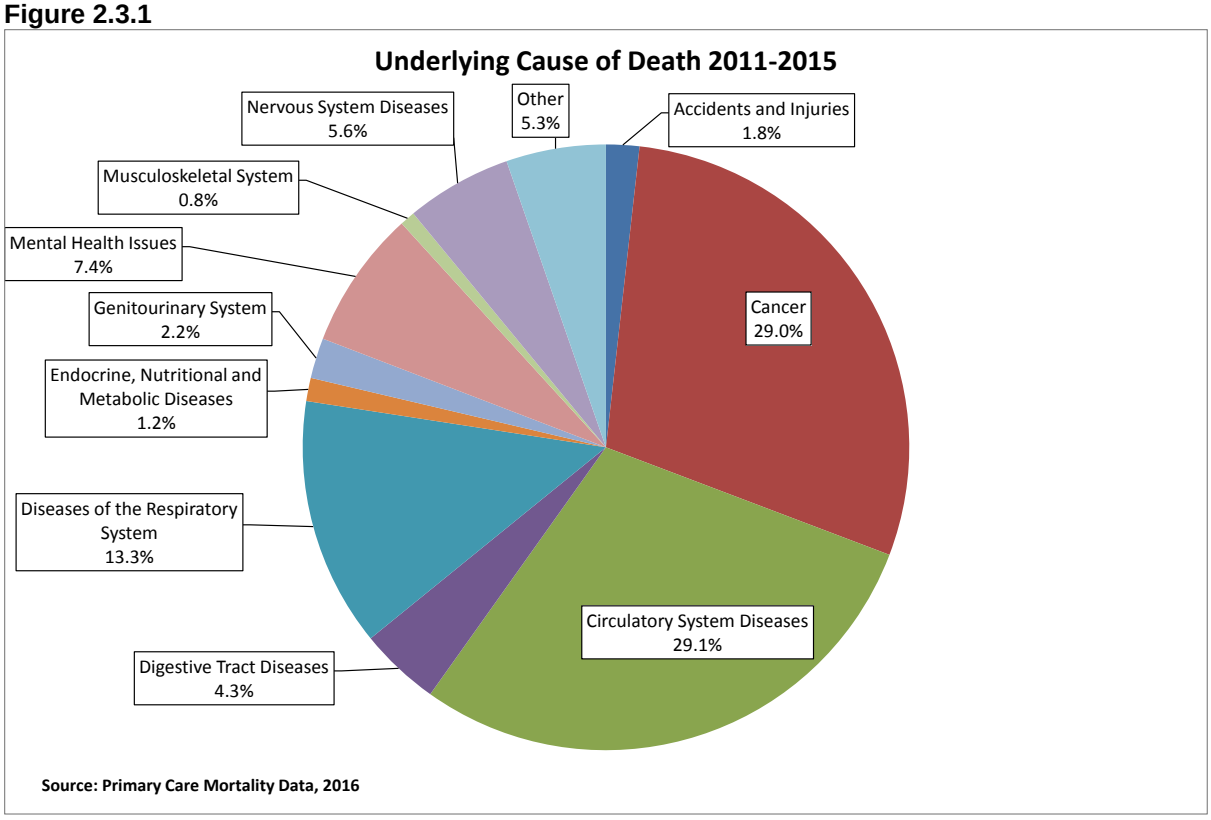
Source: PHE, Local Health, 2016

2.3. Key Causes of Mortality & Major Health Issues

The key causes of death in Bromley remain:

- Cardiovascular disease
- Cancer
- Respiratory disease

Figure 2.3.1



Cardiovascular Disease

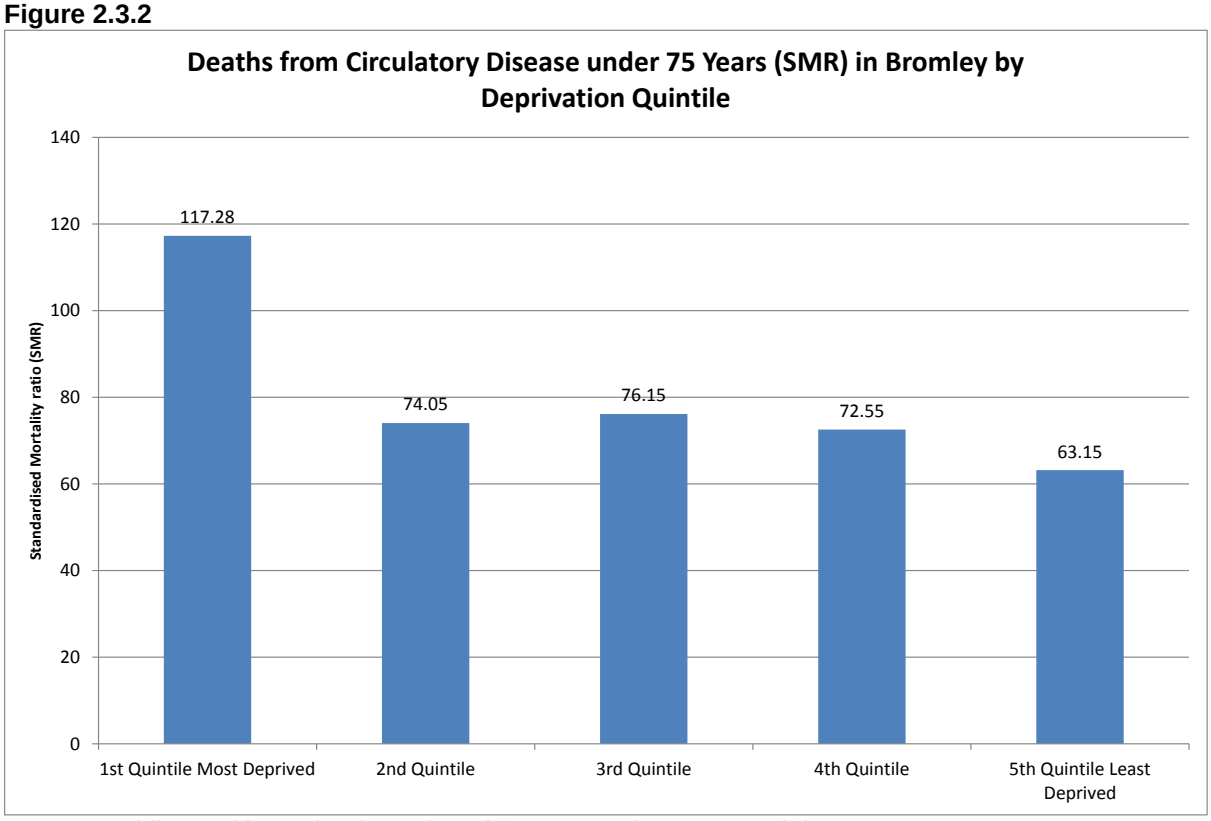
The term cardiovascular disease (CVD) describes a family of diseases (including heart disease, stroke and peripheral vascular disease) sharing a common set of risk factors. Chronic kidney disease and diabetes are also included in the CVD family of diseases as they have similar risk factors and are associated with a greater risk of CVD. Hypertension is a predisposing condition for CVD.
It is important to reduce the number of people living with ill health and dying prematurely, while reducing the gap between communities. A key indicator for this objective is early mortality from cardiovascular disease.

Between 2012 and 2014, the under 75 mortality rate in Bromley from cardiovascular disease considered preventable was 39.6 per 100,000 population (as compared with 49.2 for England and 49.6 for London).
The early mortality rate for cardiovascular disease (CVD) in Bromley is lower than the rate for England, and has been falling steadily since 1995.

Although the CVD mortality rate in Bromley for the period 2012-14 was (at 63.2 per 100,000) lower than England (75.7) and London (78.7), there are differences within the borough. *(PHOF*)

- Male CVD mortality rates are significantly higher than female CVD mortality rates (87.3 and 41.6 respectively). (*PHOF)*
- CVD mortality rates are higher in wards in the most deprived areas of the borough, compared with wards in the least deprived quintile.

Figure 2.3.2



Source: Public Health England, produced from ONS data © Copyright 2013

Coronary Heart Disease (CHD)

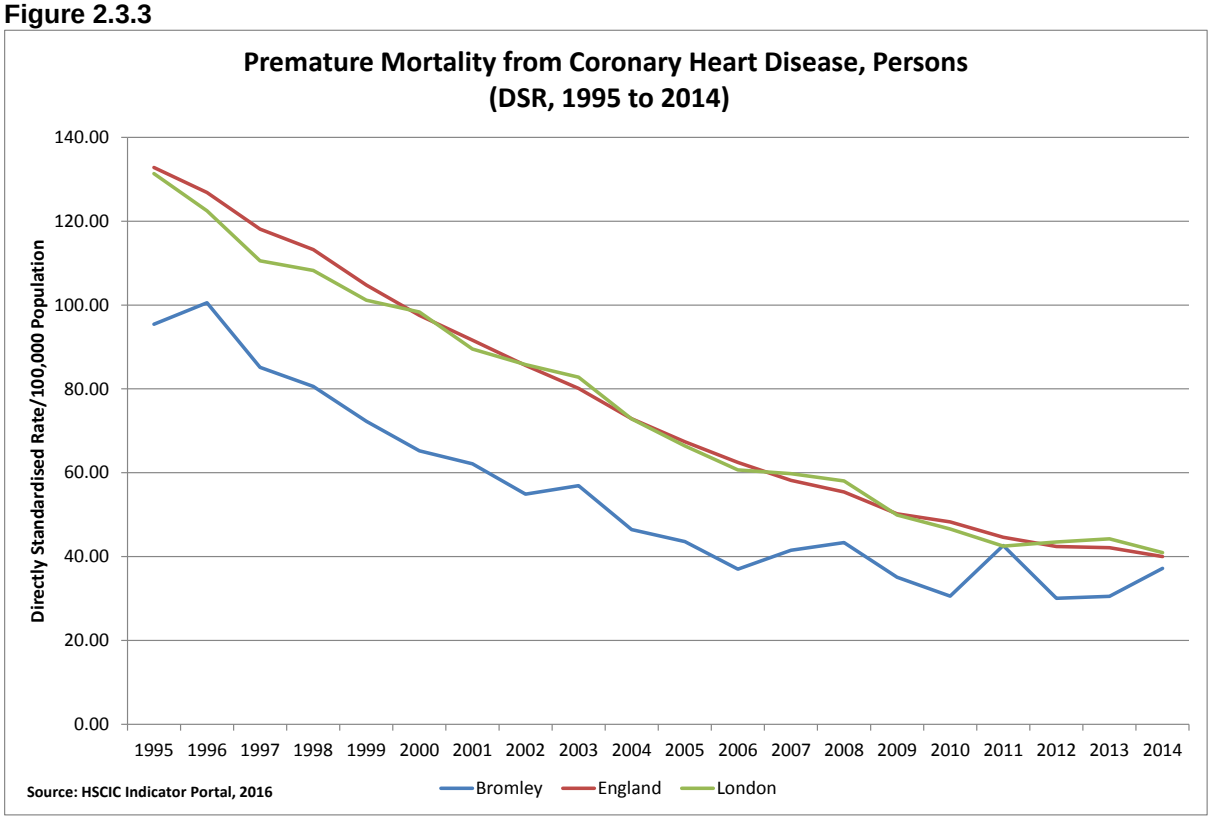
In 2014-15 there were 9,898 people who had been diagnosed with CHD in Bromley. However, based upon Health Survey for England results applied to Bromley, the total number of expected CHD cases is likely to be around 14,200. The prevalence of heart disease based on identified cases in Bromley has been declining over the last 4 years.

Table 2.3.1: Prevalence of Coronary Heart Disease

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
CHD Register Size	9798	9624	9753	9859	9984	9931	10109	10165	10065	9898
CHD Prevalence	3.10%	3.00%	3.00%	3.00%	3.10%	3.10%	3.10%	3.10%	3.00%	2.93%
Source: HSCIC/QOF 2016										

The Public Health Outcomes Framework includes an objective for reducing numbers of people dying prematurely. One of the indicators for this objective is mortality under 75 from cardiovascular disease and CHD is the largest contributor for cardiovascular disease (45%). In the three year period 2012-14, the early mortality rate for CHD in NHS Bromley CCG was 32.6 per 100,000. This is a decrease of 23% since 2004-06. In England, the mortality rate has decreased by 39% over this time period and the rate in the London strategic clinical network has decreased by 36%.

Figure 2.3.3



Management of blood pressure levels in patients with CHD in Bromley is less effective than the national average, with 86.3% achieving optimal blood pressure management (as compared with 88.4% for England).

In contrast, patients with CHD in Bromley are more likely than the national average to be receiving treatment with aspirin or equivalent (92.6% vs 91.7%) and appropriate drug treatment post heart attack (74.5% vs 69.1%).

In 2014-15 the admission rate for CHD was 536.4 per 100,000 (1,567 admissions). This is lower than England (539.7 per 100,000).

NHS Health Checks

Overview of the NHS Health Checks Programme

The NHS Health Checks Programme is a national public health programme aimed at preventing heart disease, stroke, diabetes, chronic kidney disease and vascular dementia. Individuals aged between 40 and 74 years without established cardiovascular disease are eligible to receive an NHS Health Check. This programme runs over a five year period, so 20% of the eligible population should be invited each year.

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

It is recommended that local programmes aim to increase their percentage uptake each year. The aspiration from Public Health England is to achieve an uptake of 75%. The England average uptake was 47.9% for 2015-16.

The programme in Bromley commenced in 2010 with gradual implementation progressing to full rollout of the 20% invitation target achieved in 2011-12 and achieved each subsequent year. Bromley increased its percentage uptake to 43.3% in 2015-16. NHS Health Check numbers achieved to date are shown in Table 2.3.2.

Table 2.3.2: Number of NHS Health Checks Offered and delivered 2011-2016

Year	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% per year)	Number of people who had an NHS Health Check completed	Percentage of people that received an NHS Health Check of those offered
2011-12	99,949	20,995	21%	7,617	**36%**
2012-13	100,037	23,033	23%	8,958	**39%**
2013-14	92,080	23,867	26%	9,028	**38%**
2014-15	93,215	21,206	23%	8,533	**40%**
2015-16	94,312	18,748	20%	8,119	**43%**
TOTAL		**107,849**		**42,255**	

Source: London Borough of Bromley

The population eligible for an NHS Health Check continuously changes as people age, or develop conditions which exclude them, or move in or out of the borough. Therefore, in addition to looking at each year's performance it is important to assess the invitations, checks received and uptake cumulatively. This is reflected in an

adjustment of the Public Health Outcome Framework measures which assess progress since April 2013. The Public Health Outcome Framework Indicators comparing Bromley performance against England and London is shown in Table 2.3.3.

Table 2.3.3: NHS Health Checks Public health outcome framework indicators 2013-14 – 2015-16

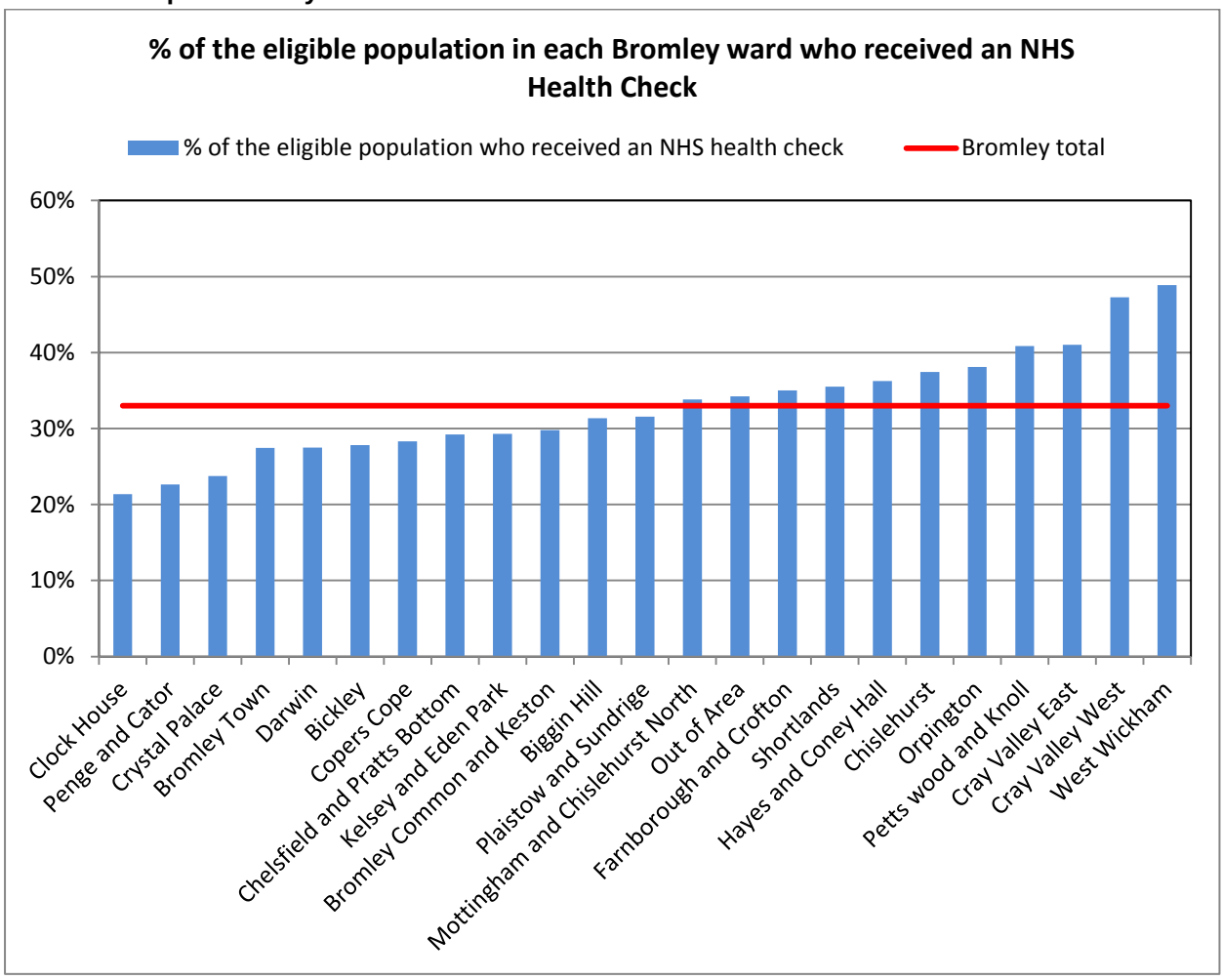
2.22	Take up of NHS Health Check by those eligible	Time period	Bromley	London	England
2.22iii	Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	2013/14 - 2015/16	67.9	67.2	56.4
2.22iv	Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14 - 2015/16	40.1	47.1	48.6
2.22v	Cumulative percentage of the eligible population aged 40-74 who received an NHS Health Check	2013/14 - 2015/16	27.2	31.6	27.4

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

When examining the cumulative coverage of the programme from April 2013, Bromley has a similar performance to the national figure, when comparing uptake of eligible population receiving an NHS Health Check. However, Bromley has a higher percentage of offers and therefore uptake against offers is lower than the England percentage.

In Bromley, the programme has now completed a five year cycle, therefore we are able to assess the cumulative effect of the programme on the population eligible, from April 2011. Coverage of the eligible population over the last five years is shown in Figure 2.3.4 by ward.

Fig 2.3.4 Percentage of eligible population at March 2016 who have received an NHS Health Check in the previous 5 years



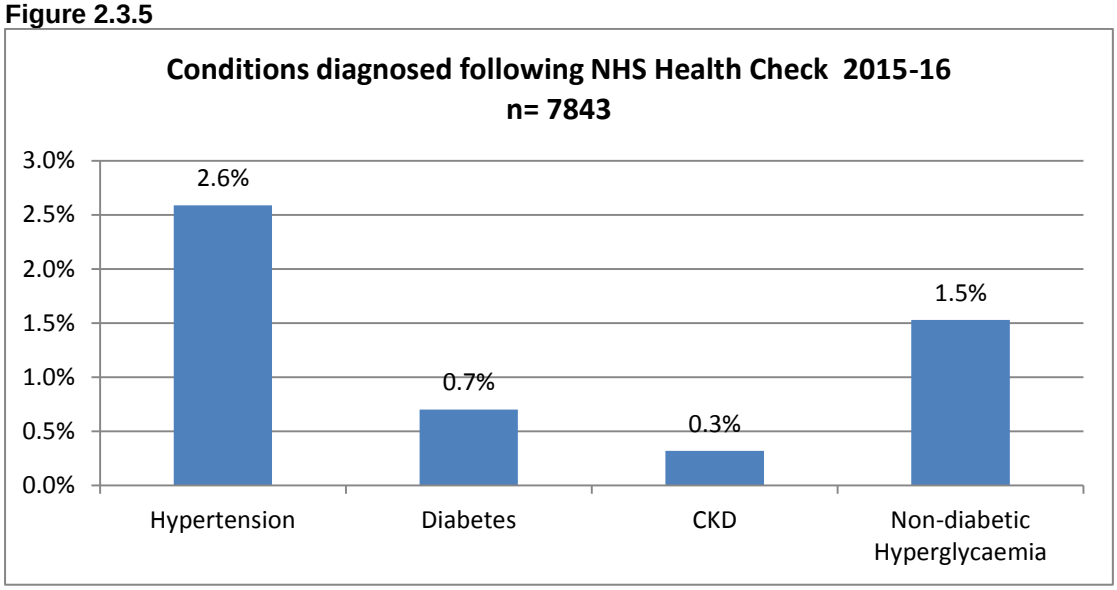
Source: Bromley NHS Health Check Programme 2016

Coverage of NHS Health Checks across the borough remains variable. Coverage in the north of the borough continues to be lower than in the east. Coverage is highest in West Wickham ward and lowest in Clock House ward.

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 2015-16, 334 (4.3%) individuals were found to have a high cardiovascular risk score. This is lower than the national expectation of 9.7%. These individuals will have been offered interventions to try and reduce their risk of developing cardiovascular disease in addition to being offered annual reviews at the GP Practice. NICE lipid modification guidelines published in 2014 recommended intervention also for those with a moderate cardiovascular risk score between 10-19%. This adds an additional 1,360 people to be followed up for intervention to reduce their risk, totalling 1,694 (22%).

The NHS Health Check also identifies individuals eligible for further screening for diabetes, hypertension and chronic kidney disease (CKD). Early diagnosis of these conditions is beneficial in reducing progression to more severe cardiovascular disease such as heart attacks, stroke and vascular dementia. There is an on-going area of work with primary care to ensure people who have been identified as requiring further investigation and follow up are managed according to the relevant pathway of care. A number of individuals were diagnosed with conditions for which they can now receive treatment to try to reduce cardiovascular risk and prevent disease progression. These levels are shown in Figure 2.3.5.

Figure 2.3.5



Source: Bromley GP Practice Data 2016

These figures are likely to be an underestimation as there can be a time delay between having an NHS Health Check and making the linked diagnoses as these require further investigation. At the time of the NHS Health Check, 17% (1,343) of participants had a raised blood pressure, although not all would be expected to have a diagnosis of hypertension. These individuals would all have required follow up investigation and assessment.

A key priority of the NHS Health Check is to identify people at high risk of developing diabetes who can be targeted for interventions to reduce their risk and prevent progression to Type 2 Diabetes. The NHS Health Check programme uses a diabetes filter to identify which patients to test for diabetes risk; those with high blood pressure or a body mass index in the obese category are tested. The NHS Health Check results from 2015-16 for assessment of diabetes risk found 120 (1.5%) of individuals had a diagnostic code indicating this increased risk, however 429 (5.5%) of individuals were found to have an HbA1c blood test in the pre-diabetic range.

Work is being done to improve utilisation of the diabetes filter for those who met the criteria at the time of their NHS Health Check. In 2013-14 only 58% who met the diabetes filter were tested, this increased to 79% in 2014-15 and to 87% in 2015-16.

The NHS Health Check will be contributing towards the prevention of stroke in Bromley, by including a mandatory pulse rhythm check for 2016-17. People found to have an irregular pulse at their NHS Health Check require further testing to see if they have a heart rhythm disorder - atrial fibrillation. People diagnosed with atrial fibrillation are at high risk of stroke and are offered medication to prevent this.

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 the Clock House, Penge and Cator and Crystal Palace wards.
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.

Of concern is the falling number of invitations to the NHS Health Check in the last 2 years. It is anticipated with a reduced number of Providers in 2016- 2017 this may continue to drop further.

In order to maximise the NHS Health Checks outcomes in the prevention and early diagnosis of risk and high risk conditions, appropriate use of pathways is required. Evaluation, monitoring, feedback and service improvements are ongoing to maintain and enhance the effectiveness of the programme.
Where conditions are identified and managed early, people are less likely to progress onto more severe cardiovascular disease of stroke, heart attack or vascular dementia. Of particular importance is the need to maintain and continue improvements in the identification of people who have Pre-Diabetes (non-diabetic hyperglycaemia) and ensure they are offered intensive programmes of lifestyle intervention to prevent the progression onto development of diabetes.
In addition the need to identify people with undiagnosed hypertension and atrial fibrillation and for these to be managed effectively to prevent stroke are of high importance.

Implementing new guidance to provide interventions for those at moderate risk in addition to high risk of CVD is a challenge for Bromley in terms of increased workload. However, it is very important that this is achieved if we are to maximise the effectiveness of the programme.

Stroke

The recorded prevalence of stroke has been stable at about 1.5% over the last 3 years. In 2014/15 there were 5,086 people who had been diagnosed with a stroke in NHS Bromley CCG. In the same period there were 349 admissions recorded on the Sentinel Stroke National Audit Programme.

Table 2.1.4: Prevalence of Stroke

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Stroke Register Size	4825	4884	4979	5125	5184	5181	5246	5122	5121	5086
Stroke Prevalence	1.50%	1.50%	1.50%	1.60%	1.60%	1.60%	1.60%	1.50%	1.53%	1.51%
Source: HSCIC/QOF 2016										

Of those people diagnosed with stroke, a lower proportion achieves optimal control of blood pressure (82.2%) in Bromley than the England average (84.3%). (Source CVD profiles).

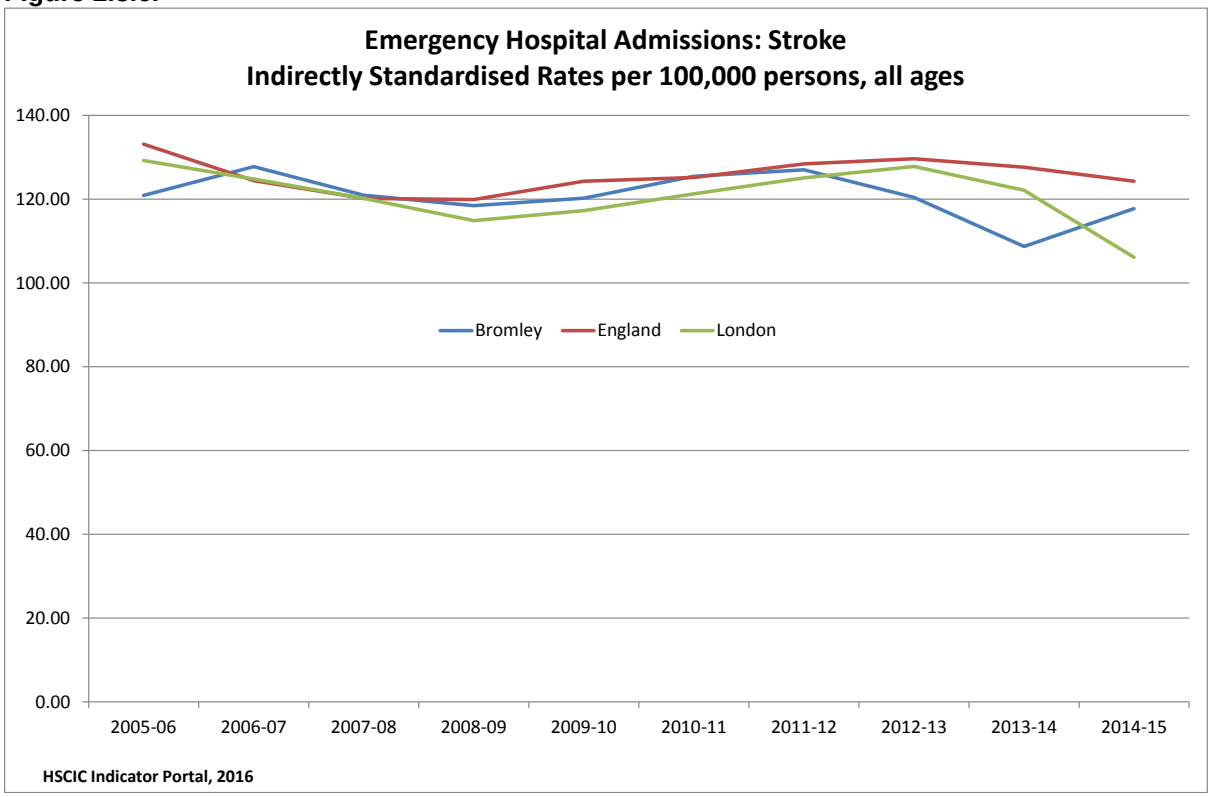
The proportion of patients with a non-haemorrhagic stroke who have a record of anti-platelet or anti-coagulant therapy (90.9%) is also lower than the national average (91.7%).

Atrial fibrillation (AF) is a known risk factor for stroke. The diagnosed prevalence of AF in Bromley is 1.7%, and the estimated prevalence is 2.5%, indicating that there could be an additional 2800 people with undiagnosed AF in the Bromley registered population.

Treating appropriate patients with atrial fibrillation with anticoagulants lowers the risk of stroke. In Bromley, 44.0% of stroke patients admitted who had a history of atrial fibrillation were prescribed anticoagulation prior to their stroke. This is similar to the England rate (44.4%).

In 2014-15, the admission rate for stroke in Bromley was 141.2 per 100,000 (429 admissions). This is significantly lower than England (171.9). The admission rate for stroke in Bromley decreased by 5.7% between 2004-05 and 2014-15.

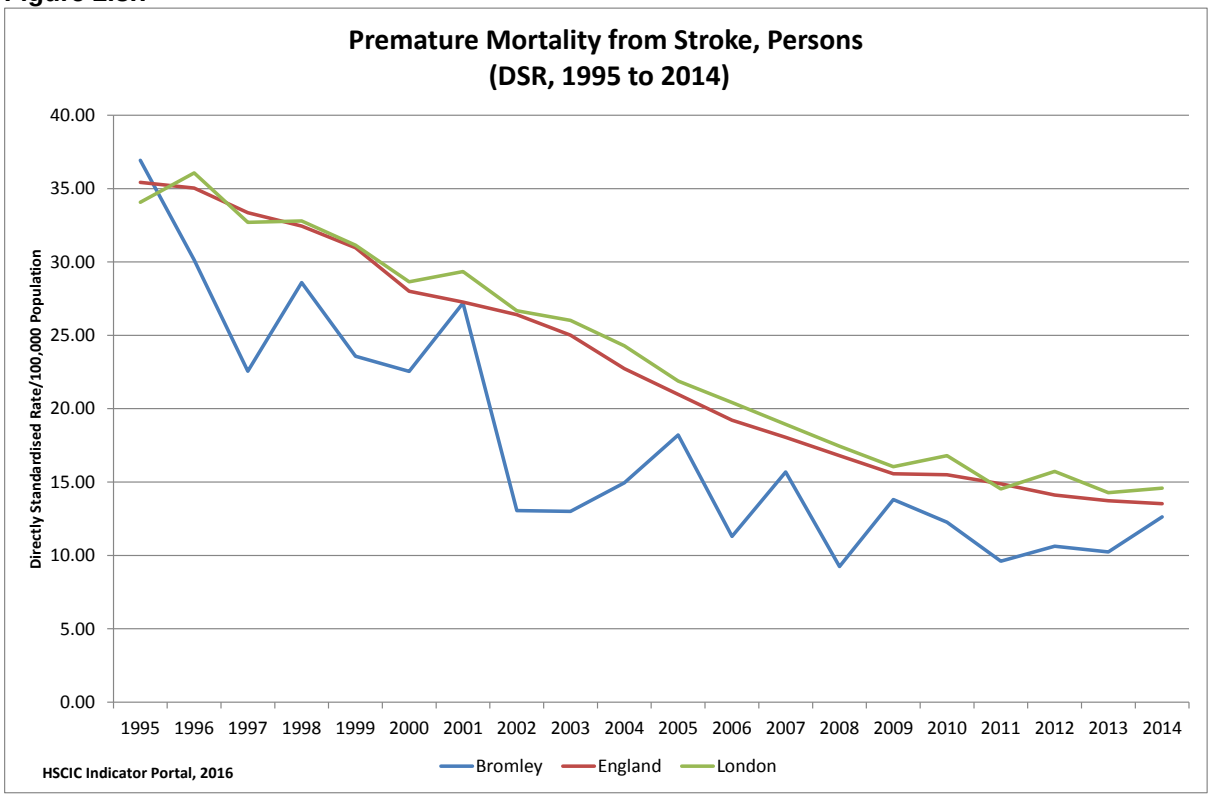
Figure 2.3.6.



It is a requirement of the National Stroke Strategy in England that all eligible patients receive a six month assessment after their discharge from hospital following a stroke. This is key to assessing the outcomes of stroke care. In 2014-15, Bromley assessed 8.2% of eligible patients at six months, which is lower than in 2013-14 when it was 32.1%. The level nationally was 24.5%.

The stroke mortality rate in Bromley has reduced significantly since 1995, and is currently similar to the rate for England. The early mortality rate (under 75 years) due to stroke was 11.2 per 100,000 in 2013. Later mortality (over 75 years of age) rate from stroke in Bromley was 565.6 per 100,000 people. This was similar to the England rate (616.4).

Figure 2.3.7



Hypertension

The prevalence of hypertension has been reducing slightly since 2010.

The prevalence of recorded hypertension in Bromley (13.7%) is similar to the national average (13.8%). However, the expected prevalence of hypertension in Bromley is higher at 24.4%, indicating under-identification. There could be 36,000 undiagnosed hypertensives in Bromley. In Bromley, the percentage of patients aged 45 years and over who have a record of blood pressure in the preceding 5 years, is (91%), which is similar to the national percentage of 90.6%).

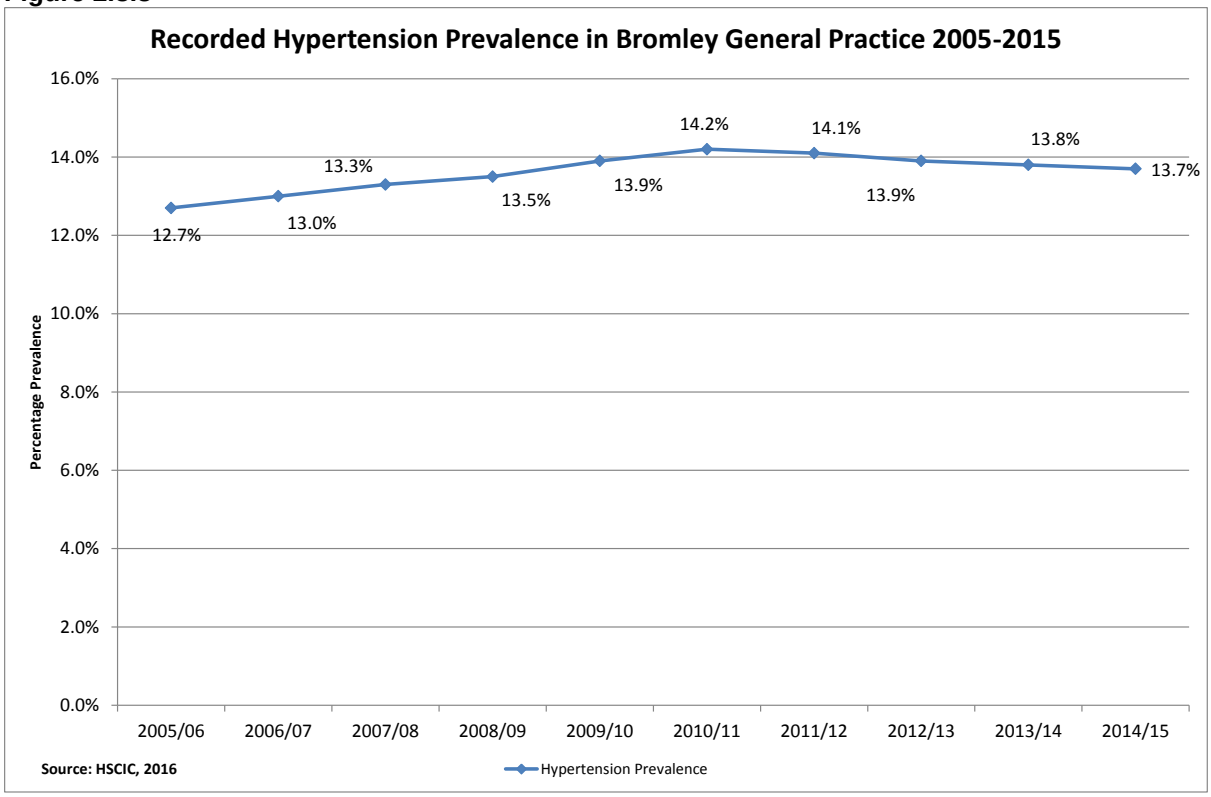
Table 2.3.5: Hypertension Prevalence

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

Optimal management of hypertension reduces the risk of developing cardiovascular disease. In Bromley, optimal management is achieved in a lower proportion of hypertensives than the national average. 77.4% of patients with hypertension have their blood pressure controlled to 150/90 or less, as compared with 80.4% nationally.

The risk of developing cardiovascular disease can be reduced in patients with hypertension by careful management of blood pressure and other cardiovascular risk factors such as physical inactivity and smoking. In Bromley, 84.4% of patients aged 15 years and over who were recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months, as compared with 85.8% nationally.

Figure 2.3.8



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 undiagnosed atrial fibrillation, as well as a number of people with known hypertension which has not been adequately controlled. These people are at a higher risk of stroke, kidney disease, heart disease and other conditions.

Chronic Kidney Disease

In 2014-15 there were 9779 people aged 18 years and over who had been diagnosed with Chronic Kidney Disease (CKD) in Bromley. This represents 3.69% of the registered population aged 18 years and over.

Table 2.3.6

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

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

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

Table 2.3.7

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

Patients with CKD benefit from early treatment which is proven to reduce mortality and slow progressive decline in kidney function.
Blood pressure control is important in CKD, and in Bromley 70.8% of CKD patients have good blood pressure control as compared with 74.4% nationally.
A lower proportion of CKD patients in Bromley have had a urine albumin:creatinine ratio test in the previous 15 months than the national average (69.5% vs 75.4%).
There were 288 Bromley residents receiving renal replacement therapy (RRT) in 2014. The number receiving RRT has increased by 19.5% between 2009 and 2014.
In Bromley in 2014, the percentage of people receiving RRT who have had a renal transplant was 60.4%, a further 9.7% received home dialysis and 29.9% received hospital dialysis.

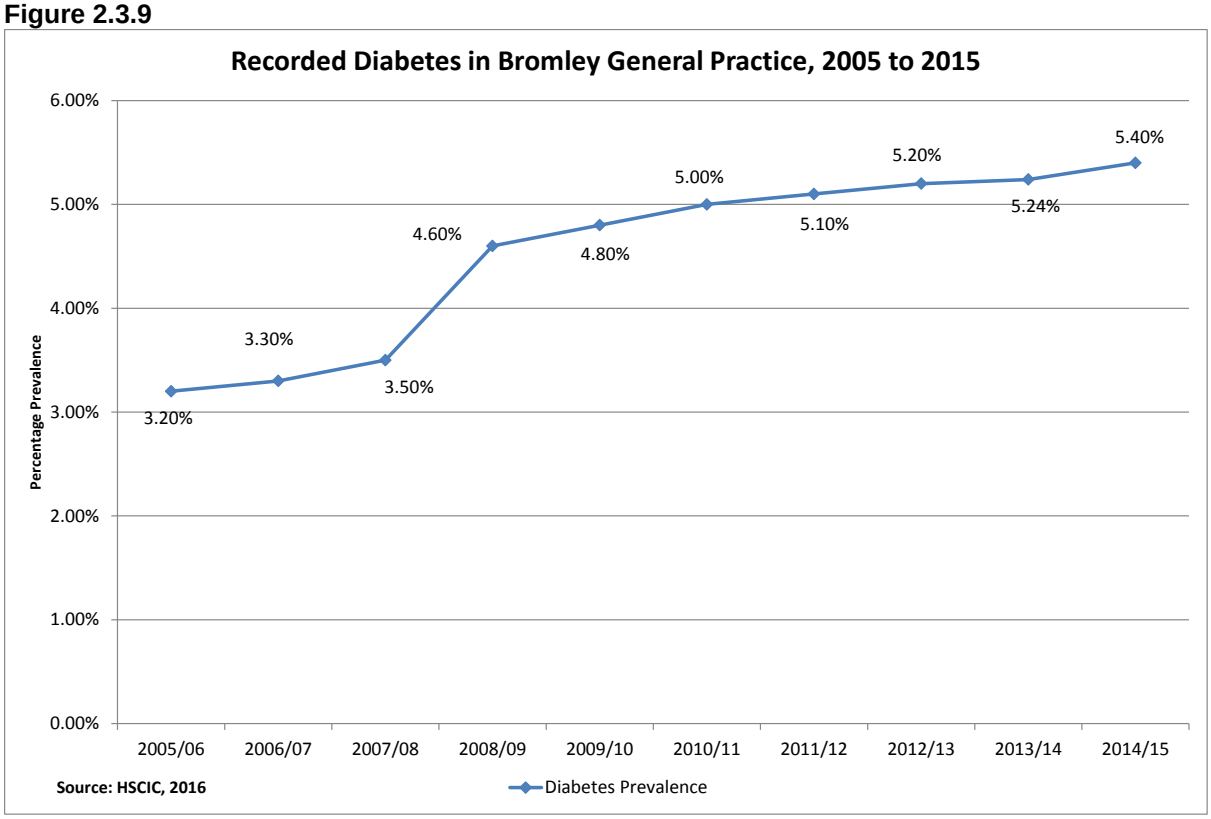
Diabetes

The number of people with diabetes has increased over time. There were 4,846 people on the diabetes register in 2002, as compared with 14,493 in 2014-15 (**Table 3.5**). The prevalence of diabetes in Bromley is 5.4%, as compared with 6.4% for England as a whole. This rise has particular significance because diabetes is classed as a vascular disease which is often a precursor to heart disease or stroke.

Table 2.3.8: Diabetes Prevalence

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Diabetes Register Size	10084	10520	11293	11979	12509	12947	13269	13681	14013	14493
Diabetes Prevalence	3.20%	3.30%	3.50%	4.60%	4.80%	5.00%	5.10%	5.20%	5.24%	5.40%
Source: HSCIC/QOF 2016										

Figure 2.3.9



In addition, there are a large number of people with non-diabetic hyperglycaemia (NDHG) who are at high risk of developing diabetes. National prevalence modelling predicts that there are 29, 800 people with NDHG currently in Bromley. A search of GP systems in 2016 found that approximately 15,419 people have blood test results indicating that they have NDHG, indicating that many have not been identified.

Bromley is part of a South London Partnership first wave site for the New National NHS Diabetes Prevention Programme, which started in late summer of 2016. Patients at high risk of diabetes are referred to a nine month intensive lifestyle intervention involving 18 face to face group sessions.
This follows on from Bromley's pilot diabetes prevention programme, which was a one year intensive lifestyle intervention for 120 people with NDHG. Of the 166 patients referred to the pilot diabetes prevention programme, 117 attended sessions, and of these, 44 (38%) achieved normal blood sugar levels at 12 months, and a further 18 (15%) reduced their risk of developing diabetes.

Control of diabetes, as measured by an HbA1c of =<59mmol/mol is similar in Bromley (60.0%) to England as a whole (60.4%). However, there is a range of variation between practices. (QOF 2014-15).

Control of blood pressure (to <+140/80 mmHg) in diabetic patients in Bromley is lower than the England average, 68.5% vs 71.2% while cholesterol control is similar 69.7% vs 70.8% for both Bromley and England respectively. Again, there is a range of variation between practices. (QOF 2014-15).

At GP practice level in Bromley, the percentage of patients receiving all eight care processes ranged from 7.4% to 77.4%. For three treatment targets, the percentage ranged from 28.7% to 58.3%.

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

People with diabetes rarely die as a direct result of diabetes. Most die from complications such as heart disease, stroke and kidney failure. People with diabetes are more likely to die than their peers of the same age and sex in the general population. The additional risk of mortality for people with diabetes was 38.1% in Bromley, for England the additional risk was 39.2% (from the combined National Diabetes Audit of 2009-10, 2010-11, and 2011-12).

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.

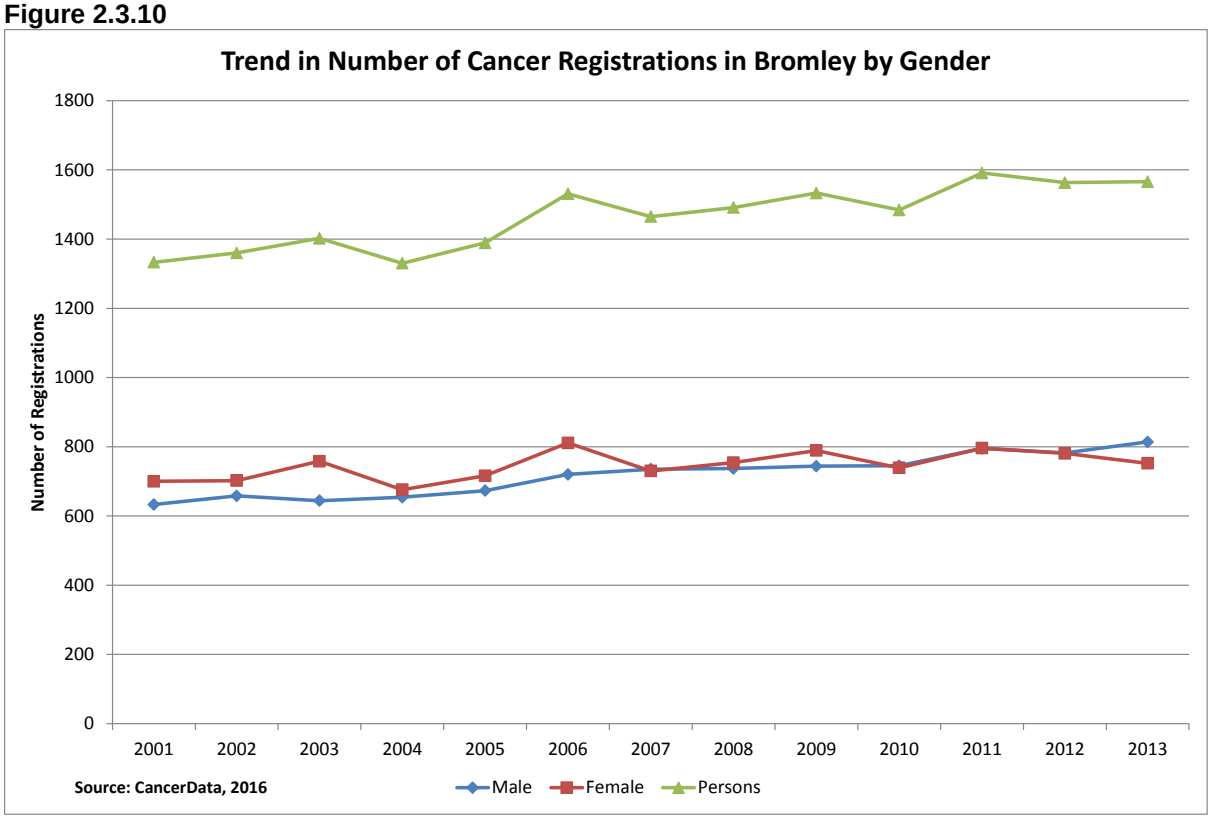
Following a successful Diabetes Prevention Pilot in Bromley, we are now a first wave site for the National Diabetes Prevention programme together with the other South London boroughs.

Of the 166 patients referred to the pilot diabetes prevention programme, 117 attended sessions, and of these, 44 (38%) achieved normal blood sugar levels at 12 months, and a further 18 (15%) reduced their risk of developing diabetes.

Cancer

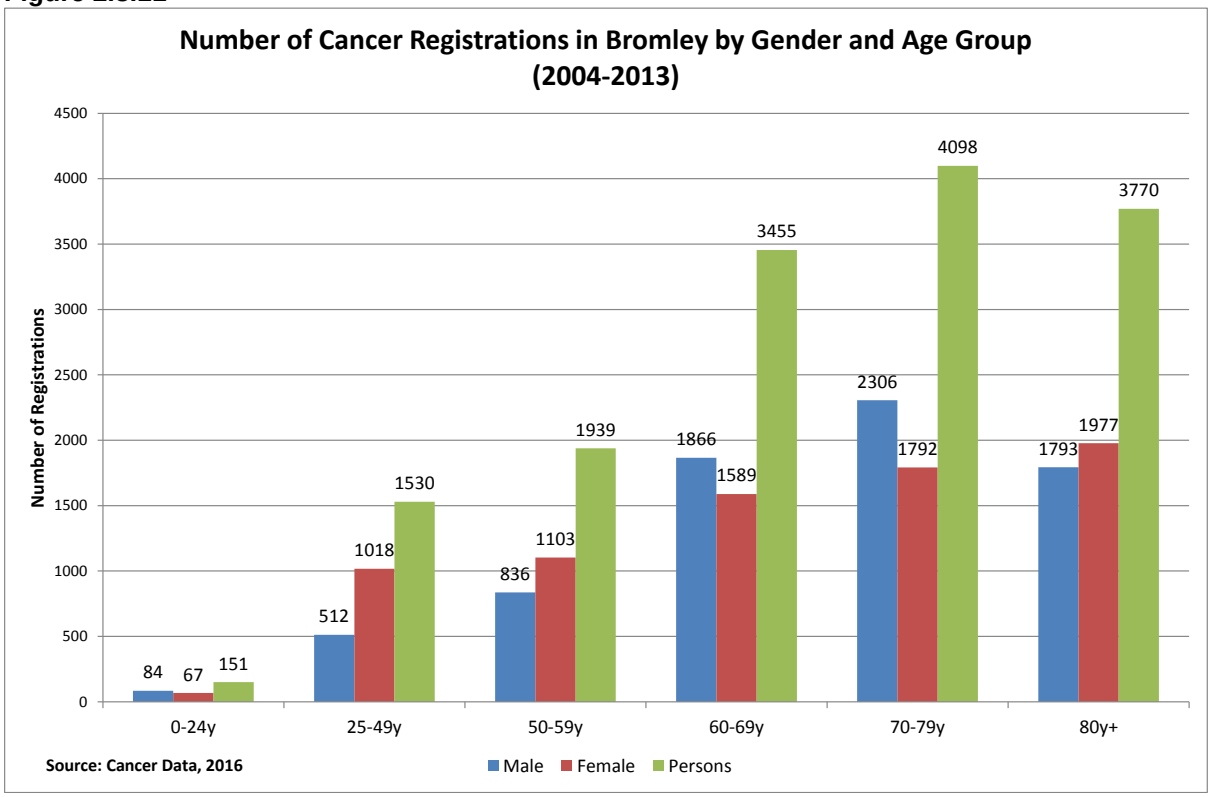
There were 7,802 patients recorded with a diagnosis of cancer on GP registers in 2014-15. There were over 10,000 cancer deaths in the last 10 years.
The number of cancer registrations per year has increased as shown in Figure 2.3.10.

Figure 2.3.10



The number of people diagnosed with cancer increases with age, to a peak in the 75 to 79 year age group (Figure 2.3.11).

Figure 2.3.11



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

Table 2.3.9: Number of Cancer Registrations by Site in Bromley, 2004-2013

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

** Excluding non-melanoma skin cancer*

Source: Cancer Data, 2016

Table 2.3.10 Incidence Rates for Cancer at Different Tumour Sites in 2013

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

Figure 2.3.12

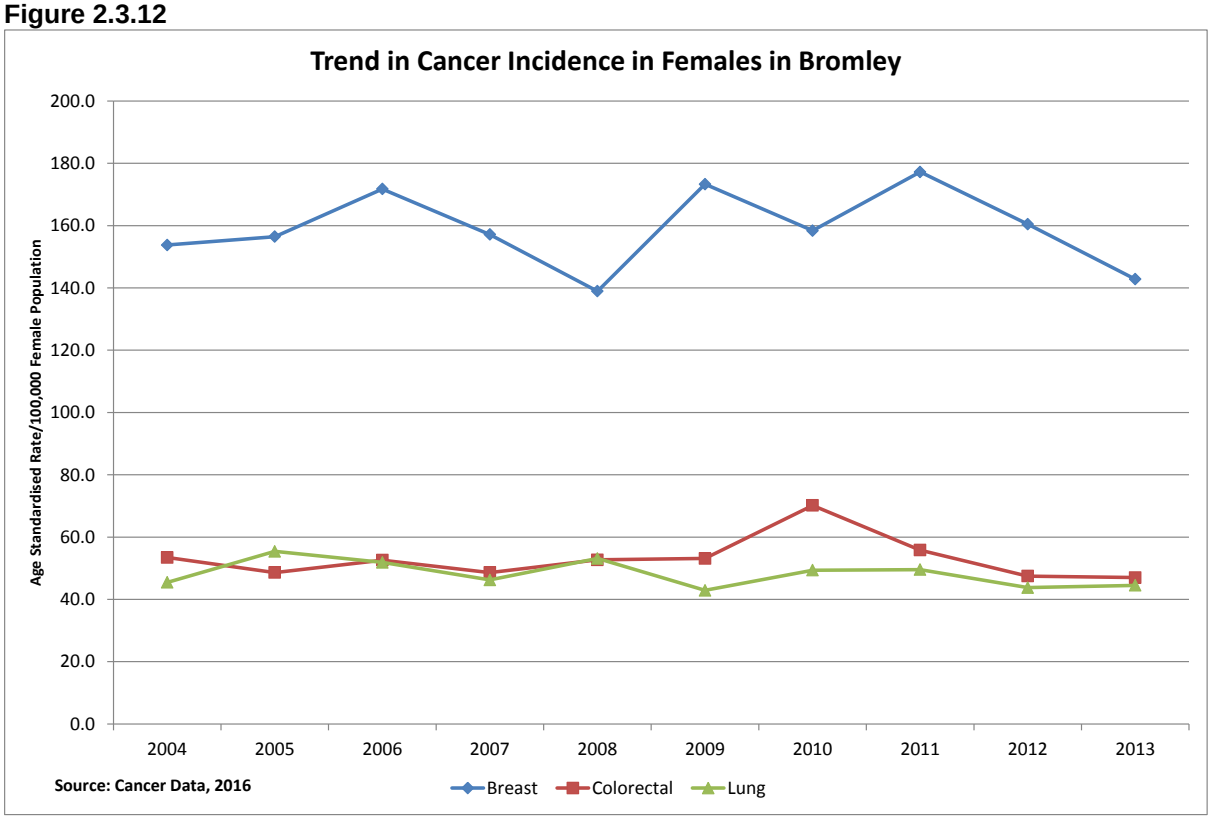
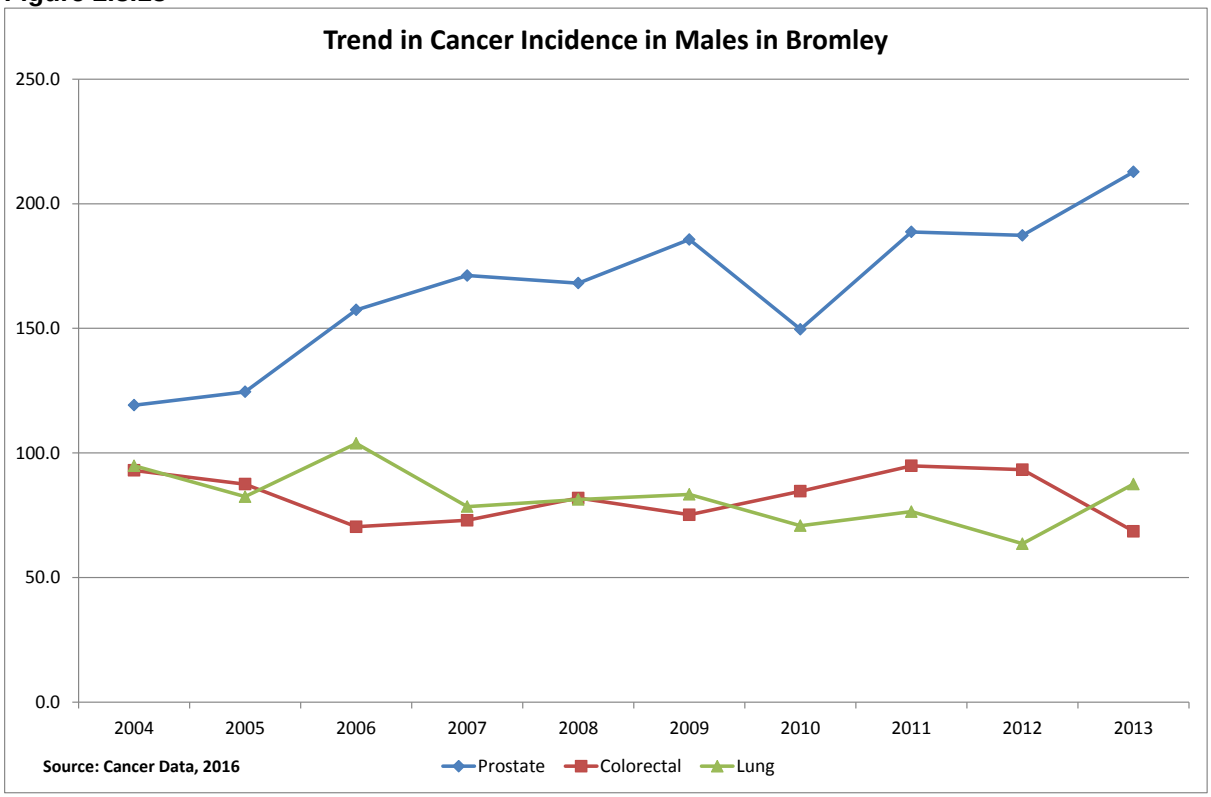


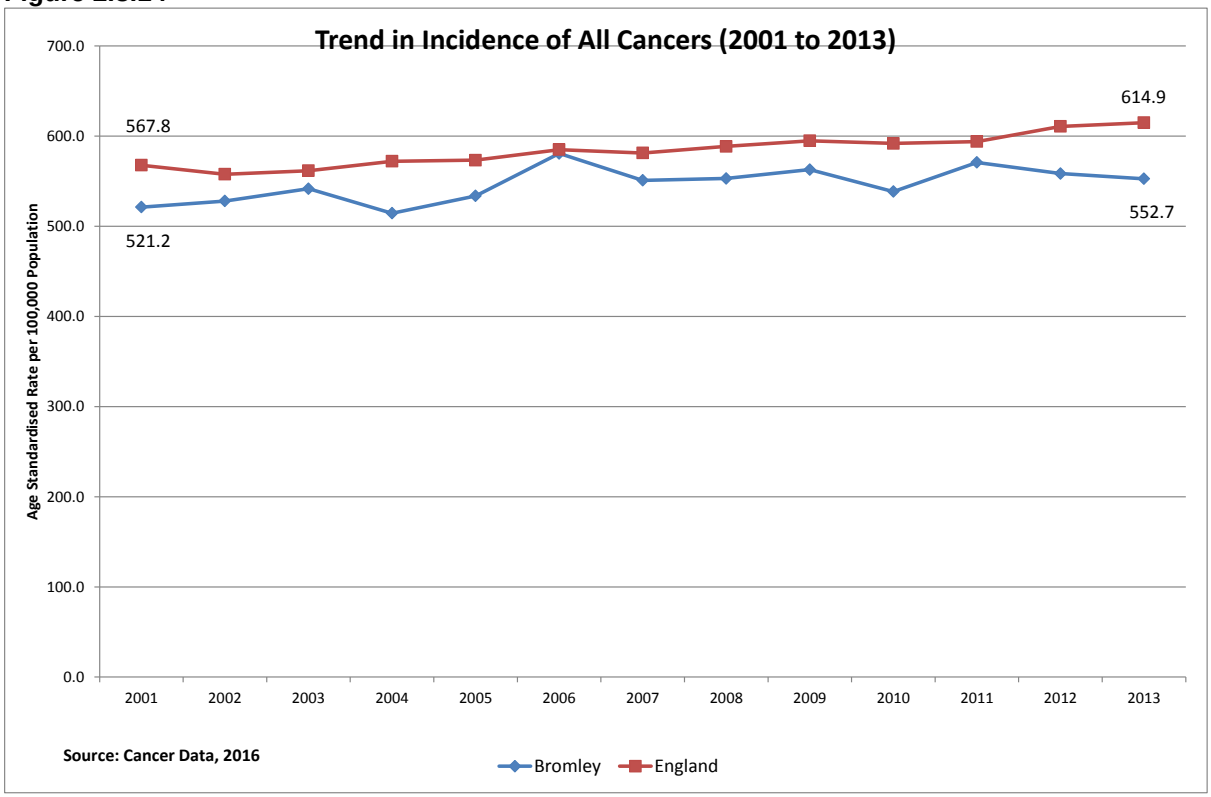
Figure 2.3.13



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

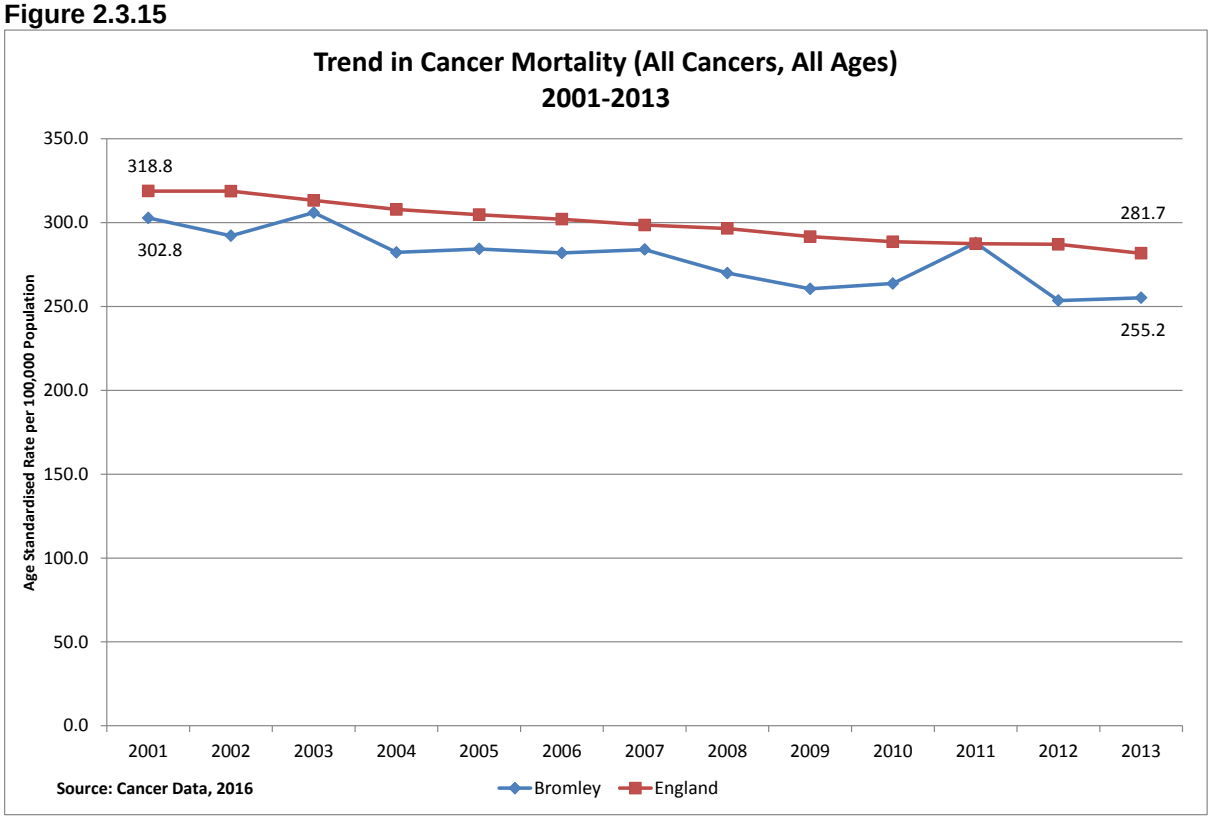
The incidence of lung, colorectal (in both men and women) and breast cancer (in women) in Bromley has fallen over the last ten years. In contrast, the incidence of prostate cancer in men in Bromley has increased (from 119 to 213 per 100,000).

Figure 2.3.14



Overall cancer mortality has been falling over the last 13 years as shown in Figure 2.3.15.

Figure 2.3.15



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

Nevertheless, Only just over a third of cancers in Bromley were detected early in 2012 and 2013 as shown in Figure 2.3.16 below**.** This is lower than for England as a whole.

Figure 2.3.16

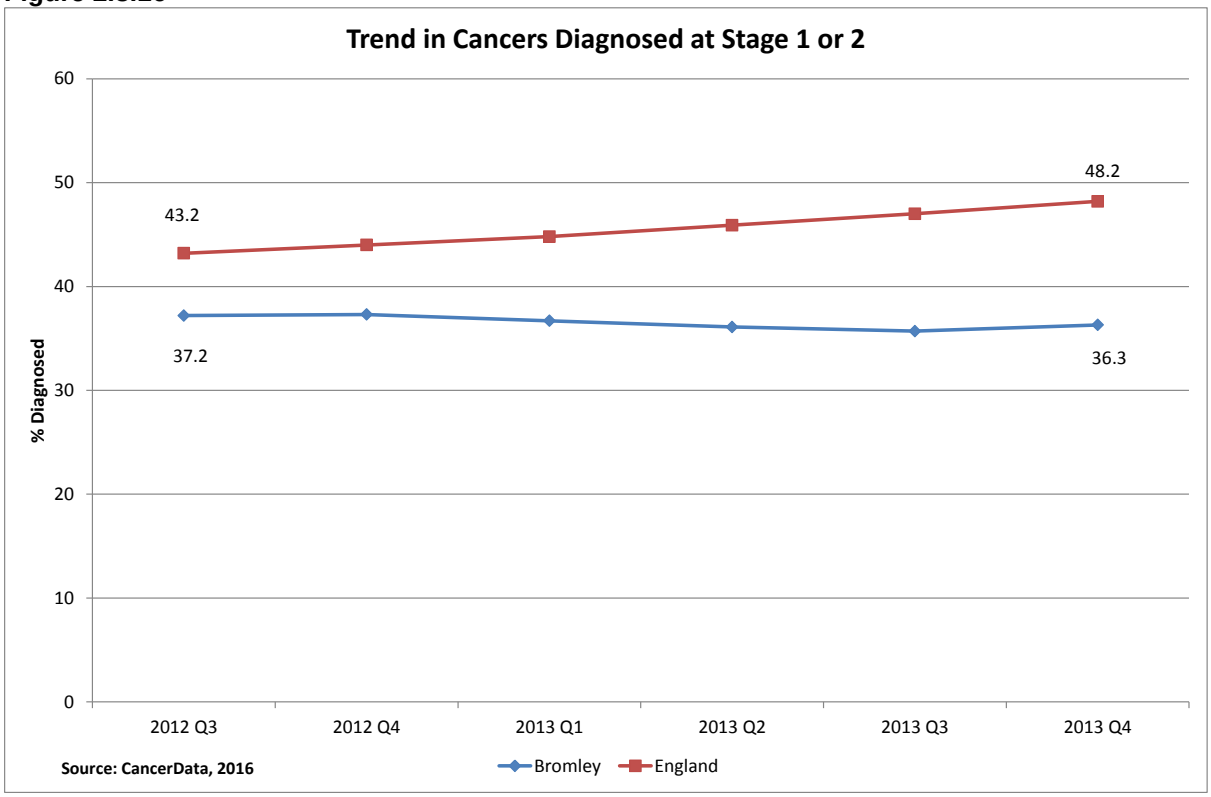
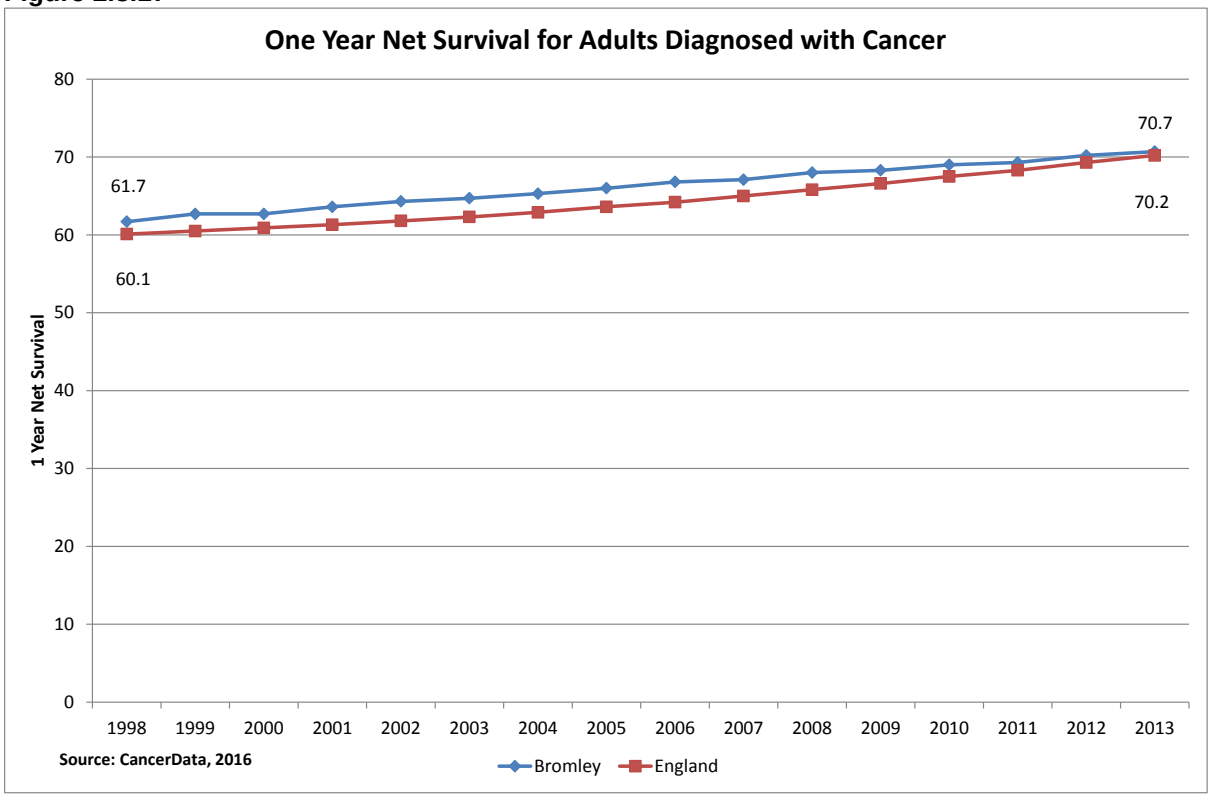


Figure 2.3.17

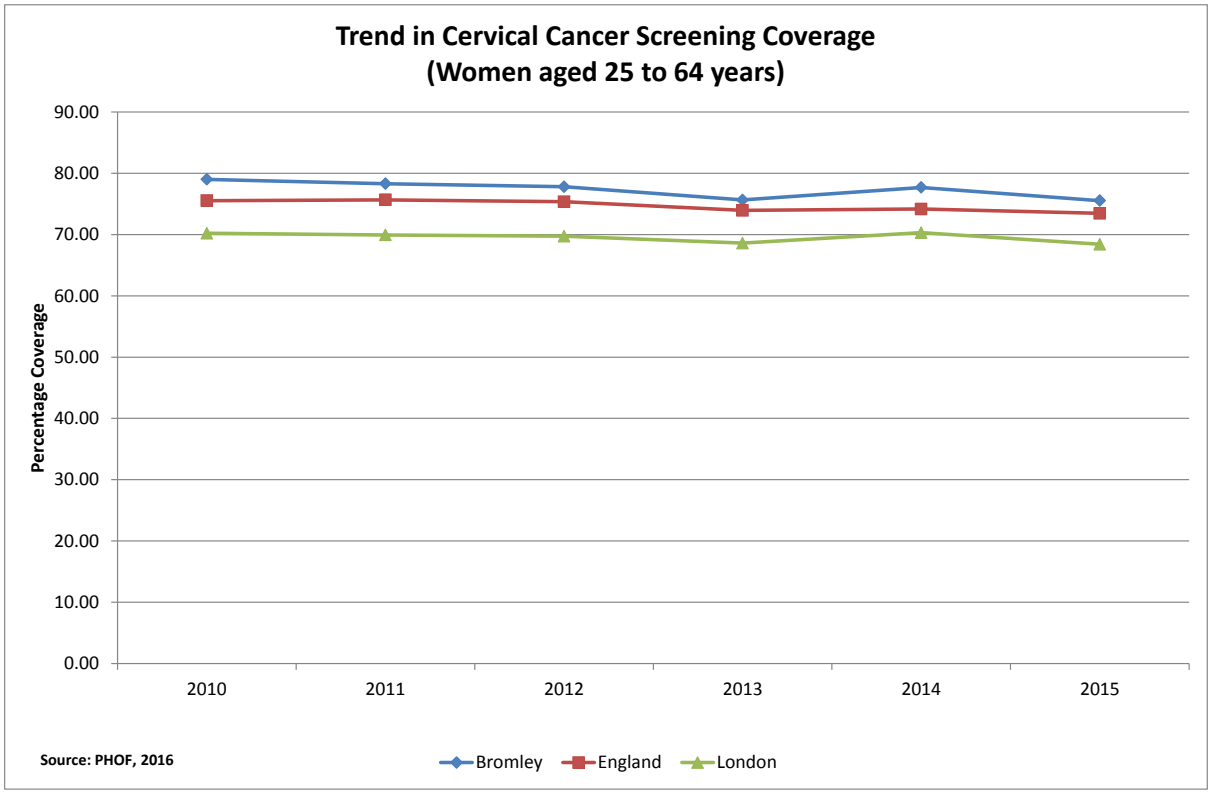


One year survival for cancers in adults has been above the England average since 1998. Five year survival figures are not available for Bromley, but have been increasing over the last 10 years for England as a whole.

Cancer Screening

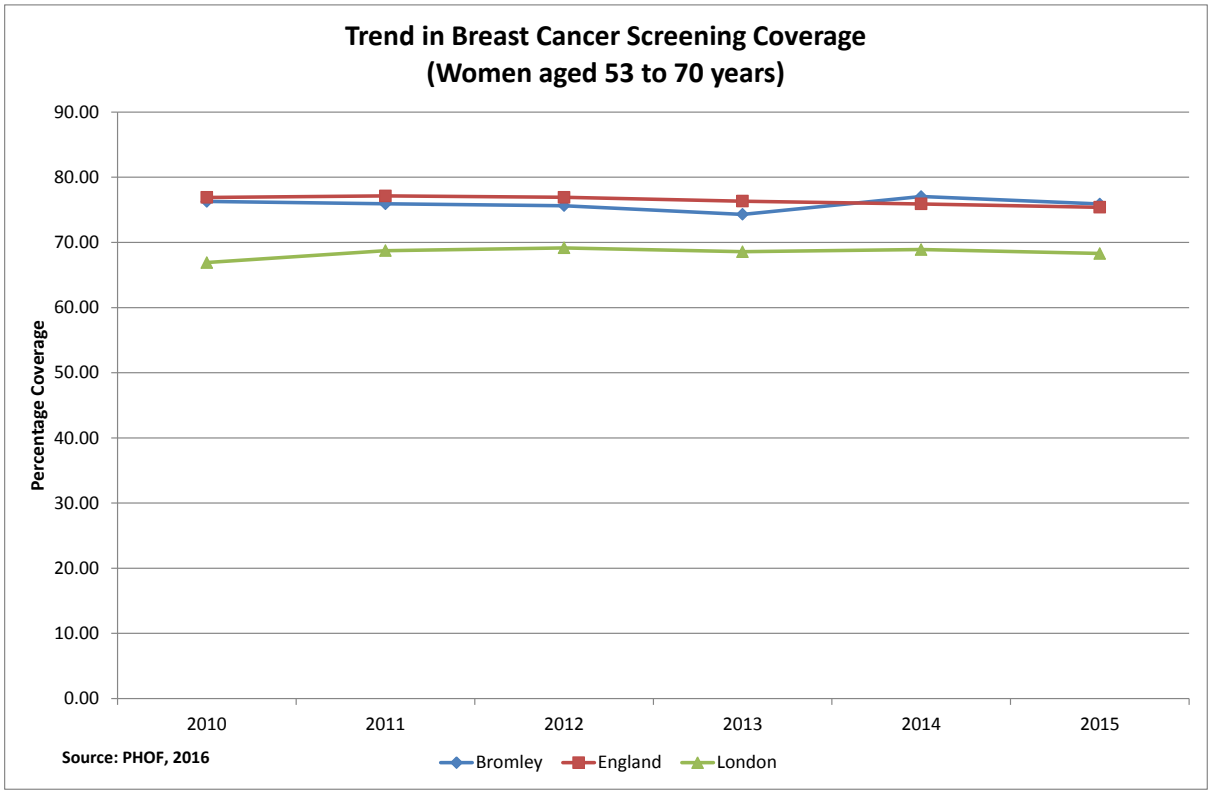
Cervical cancer screening uptake in women aged 26 to 64 years in Bromley has been consistently better than the London and National average over the last five years (Fig 2.3.18). However, it is worth noting that the cervical cancer screening uptake in Bromley has fallen by about 3% in the last 5 years.

Figure 2.3.18



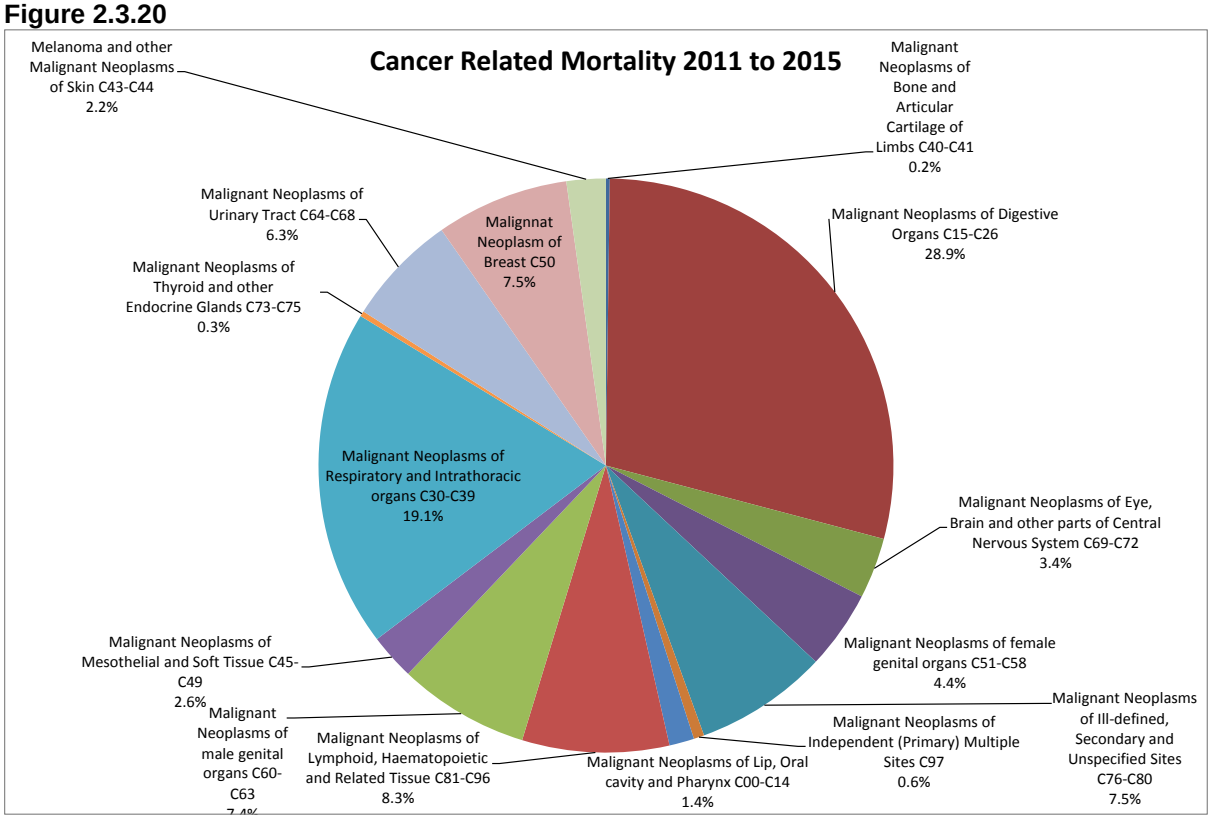
Breast cancer screening uptake in Bromley has improved. It has remained on par with the National average, and has consistently performed over 7% better than London (Figure 2.3.19).

Figure 2.3.19



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

Figure 2.3.20



Source: Primary Care Mortality Database, 2016

What this means for Bromley residents and children in Bromley

Cancer remains one of the key causes of mortality in Bromley, and although survival rates have been improving, incidence of all cancers is rising, indicating the need for good prevention strategies.
A significant proportion of cancers are diagnosed only in the later stages, which will adversely impact survival rates, as will the low cancer screening uptake in the more deprived parts of the borough.

Respiratory Disease

About 13% of deaths in Bromley are caused by respiratory disease. This includes influenza and COPD. The under 75 years mortality rate from respiratory disease is lower in Bromley (24.3 per 100,000) than for England (32.6 per 100,000).

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is mainly caused by smoking. The prevalence of smoking in Bromley is 14%, lower than the England average (18%).

However, smoking prevalence is higher in routine and manual workers in Bromley at 16.3%.
There are 4520 people in Bromley diagnosed with COPD, giving a prevalence of 1.34%.
The recorded prevalence of COPD in Bromley is lower than the value for England (1.8%).

Table 2.3.11: COPD Prevalence

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
COPD Register Size	3342	3525	3747	4006	4143	4178	4232	4371	4455	4520
COPD Prevalence	1.10%	1.10%	1.20%	1.20%	1.30%	1.30%	1.30%	1.30%	1.33%	1.34%
Source: HSCIC/QOF 2016										

Asthma

The prevalence of recorded asthma in Bromley is 5.3% (17,740 people), which is slightly lower than the value for England (6.0%).

Mental Illness

Mental health problems affect a large proportion of the population, with approximately 10.7% of people completing the GP patient survey reporting that they feel moderately or extremely anxious or depressed.
GP recorded levels of depression in Bromley are lower at 6.85% (18,140 people), as compared with 7.3% in England.

Table 2.3.12: Depression Prevalence

	2012/13	2013/14	2014/15
Depression Register Size	15645	16789	18140
Depression Prevalence	6.00%	6.38%	6.85%
Source: HSCIC/QOF 2016			

Of those people completing the GP patient survey in Bromley, 4.7% reported suffering from a long term mental problem, as compared with 5.1% across England.

At the more severe end of the spectrum, over 2,500 people in Bromley (0.81% of the adult population) have been identified by GPs as suffering from serious mental illness. This is lower than the recorded rate for England of 1.07%.

Table 2.3.13: Serious Mental Illness Prevalence (QOF)

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Serious Mental Illness Register Size	1667	2165	2265	2351	2389	2447	2544	2616	2667	2738
Serious Mental Ilness Prevalence	0.50%	0.70%	0.70%	0.70%	0.70%	0.80%	0.80%	0.80%	0.79%	0.81%
Source: HSCIC/QOF 2016										

Dementia

The incidence of dementia has risen nationally over the last seven years.
In 2012, it was estimated that there were 4,102 people with dementia in Bromley; a relatively small population of these from black and minority ethnic groups.
By 2030 the number of people with dementia in Bromley is estimated to increase to 6047.

Table 2.3.14 Predicted changes in the number of people living in Bromley with Dementia

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

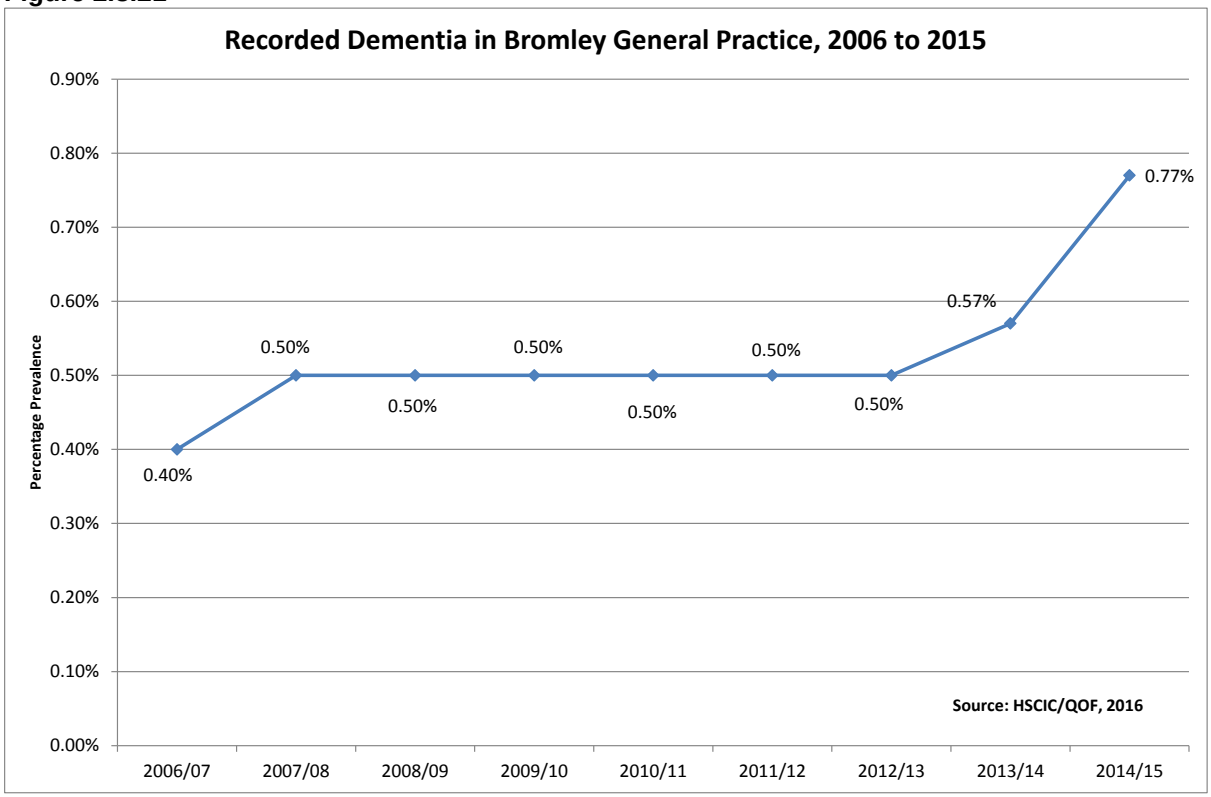
Source: Projecting Older People Population Information System, August 2016

GP registers identify 2615 patients with dementia, suggesting that some cases are not known to clinical services. Recording has increased significantly over the last two years following case finding initiatives.

Table 2.3.15: Dementia Prevalence (QOF)

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Dementia Register Size	1423	1452	1489	1499	1542	1690	1794	1902	2615
Dementia Prevalence	0.40%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.57%	0.77%
Source: HSCIC/QOF 2016									

Figure 2.3.21



What this means for Bromley residents and children in Bromley

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

2.4 Health Protection in Bromley

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

In Bromley, the South London Health Protection Team (SLHPT) 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. SLHPT 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 2.4.1 shows the number of individual cases formally notified to SLHPT for Bromley residents in 2015 and also for the previous years, 2006-2014. 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. Despite this, there are still a larger number of suspected cases not formally notified, but identified through telephone advice contact with the SLHPT and recorded on their case management database. Table 2.4.2 shows the difference between the numbers of formally notified and less formally identified suspected cases for 2015.

Table 2.4.1 : Infectious disease notifications for Bromley, 2006-2015

Disease	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Acute Meningitis	7	11	6	5	2	1	1	1	-	1
Food poisoning	479	314	378	395	293	183	230	220	244	154
Infectious bloody diarrhoea	6	2	1	1	0	2	4	3	7	11
Invasive group A streptococcal disease	-	-	-	-	-	-	1	4	1	1
Legionnaires' Disease	-	-	-	-	-	-	0	1	1	1
Measles	56	50	148	86	34	31	27	49	32	27
Mumps	97	49	56	109	96	66	68	66	78	62
Rubella	8	5	3	8	3	6	3	3	2	3
Scarlet fever	44	12	14	45	18	14	22	20	127	214
Tuberculosis	40	36	18	32	34	47	37	32	18	25
Whooping cough	3	2	7	4	3	0	20	19	13	19
Other	-	-	-	-	-	-	6	3	8	26
Total	**751**	**506**	**638**	**697**	**485**	**355**	**425**	**425**	**536**	**544**

Source: South London Health Protection Team, 2014 & Centre for Infection and Disease Control via SLHPT 2016.

Table 2.4.2 Comparison of Formal Notifications with Cases Dealt with by SLHPT

Disease	Formally Notified	Case Management Database
Acute Meningitis	1	17
Food poisoning	154	422
Infectious bloody diarrhoea	11	7
Invasive group A streptococcal disease	1	6
Legionnaires' Disease	1	3
Measles	27	38
Mumps	62	66
Rubella	3	6
Scarlet fever	214	242
Tuberculosis	25	3
Whooping cough	19	50
Pneumonia	-	1
Viral Hepatitis	-	14
Malaria	-	2
Other	26	
Total	**544**	**877**

Source: South London Health Protection Team, 2014 & Centre for Infection and Disease Control via SLHPT 2016.

Scarlet Fever

Scarlet fever notifications were elevated in most areas in England in 2015-16 compared with the year before, although London has had lower notification rates than other parts of the country. The majority of cases were reported in children under 10 years of age, with the peak in 1- 4 year olds. Levels in Bromley were significantly higher in 2015 than in 2014.

Mumps

Mumps cases continue to be identified nationally, predominantly in young adults aged between 15 and 30 years of age.

In 2015, there were 258 confirmed and probable mumps cases in South London residents, with confirmed cases accounting for 31 of this total. This included 1 laboratory confirmed case and 32 suspected cases, resident in Bromley.

Adults aged 25+ years continued to account for the majority of confirmed South London cases in both 2015 and the years from 2011-14, though the proportion of cases in this group increased from just over a half (51%: median) to almost three-quarters in this period (74%).

National data suggest that over a third of recently reported cases have received at least one dose of MMR vaccination in childhood suggesting that transmission may in part be due to some waning of immunity (Health Protection Report Vol 9 No.18. May 2015 and Vaccine Preventable diseases/COVER report: South London Area Team PHE).

Measles

Thirty-eight confirmed and probable measles cases were reported among South London residents in 2015, with confirmed cases accounting for over three-quarters (30) of this total. This was the highest proportion of confirmed cases over the past five years.

The LAs in South London reporting by far the highest number of confirmed measles cases during 2015 were Bromley (10), followed by Southwark (7) and Bexley (6), accounting for over three-quarters of all confirmed cases.

Whooping Cough (Pertussis)

In 2015, 389 confirmed and probable cases of pertussis were reported among South London residents, with confirmed cases accounting for 71% (277) of these.

Confirmed cases increased slightly in South London (by 8%) between 2014 and 2015 (from 253 to 277) and accounted for over half of confirmed cases (495) reported in London during this period.

Over the past five years (2011-15) the rate of pertussis in South London has remained consistently higher than the London rate. In 2015, the rate in South London was 8.7/100,000 inhabitants compared to 5.8/100,000 in London.

Adults aged 25+ years continued to account for the large majority of South London cases, both in 2015 (71.5%) and 2011-14 (median: 69%).
In Bromley there were 23 confirmed cases of pertussis in 2015.

Immunisation against Infectious Disease

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

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

Rotavirus is a common cause of diarrhoea and sickness particularly affecting babies and young children. Whilst most children recover at home within a few days, about one in ten require admission to hospital as a result of dehydration. Rotavirus vaccine was introduced in 2013, and is given orally at the ages of 8 and 12 weeks. Since its introduction, the rotavirus vaccine has prevented more than 70% of cases. 94.5% of children in Bromley were immunised against Rotavirus by their 1st birthday in 2015-16.

Table 2.4.3 shows the annual data for the latest available year (2016-16) for Bromley[2].

Table 2.4.3: Percentage of children immunised by birthday, Bromley, London and England, 2015 – 16

	Bromley (%)	London (%)	England (%)
By 1st Birthday			
DTaP/IPV/Hib (Primary)	92.5	89.2	93.6
PCV (primary)	92.4	90.0	93.5
By 2nd Birthday			
DTaP/IPV/Hib (Primary)	95.4	92.2	95.2
MMR (1st dose)	90.8	86.4	91.9
Hib/MenC (booster)	90.4	85.9	91.6
PCV (booster)	90.3	85.6	91.5
By 5th Birthday			
DTaP/IPV/Hib (Primary)	95.6	92.4	95.6
DTaP/IPV (booster)	81.0	78.3	86.3
MMR (1st dose)	94.6	91.1	94.8
MMR (1st and 2nd dose)	84.1	81.7	88.2
Hib/MenC (booster)	92.3	88.7	92.6

Source: Cover of vaccination evaluated rapidly (COVER) programme: annual data. PHE 2016

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

[2] Full data can be found at: https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-annual-data

Routine Human Papilloma Virus (HPV) immunisation is given to girls in England in School Year 8. Coverage reports show the percentage of girls who had completed their course of three HPV immunisations by the end of the school year (Table 2.4.5). The vaccination has proved to be very effective and so since September 2014 it has been possible to move to 2 doses of vaccine in the routine HPV programme in the UK.

Table 2.4.5: HPV coverage data of first, and second doses for the routine cohort at 31 August 2014. (Doses given 1st September 2014 to 31st August 2015)

	Bromley (Local Authority)	London (Area Team)	England
Dose 1	90.2	83.8	89.4
Dose 1 and 2	84.5	79.2	

Source: PHE https://www.gov.uk/government/statistics/annual-hpv-vaccine-coverage-2014-to-2015-by-local-authority-and-area-team

COVER figures are higher in Bromley than London as a whole, but lower than the rest of England, so there is still more work to be done.
Other than immunisations for the primary course of DTaP/IPV/Hib by age two and five years, Bromley's vaccination coverage in children falls short of the WHO recommendation of 95%. HPV vaccination coverage is higher than London and England for the first dose.

Pertussis (whooping cough)

In April 2012 a national outbreak of pertussis was declared. Pertussis activity increased beyond levels reported in the previous 20 years and extended into all age groups, including infants less than three months of age. In response the Department of Health announced that pertussis immunisation would be offered to pregnant women from 1 October 2012. This programme aims to passively protect infants from birth, through intra-uterine transfer of maternal antibodies, until they can be actively protected with the first dose of pertussis vaccine scheduled at eight weeks of age. In June 2014 the Joint Committee on Vaccination and Immunisation (JCVI) considered available data relating to the coverage, effectiveness and safety of the programme, its impact on disease and current epidemiology. The programme has been highly successful and so it has advised that it should continue for a further five years.
Uptake of the maternal pertussis vaccination programme in South London was 60.0% in Quarter 4 of 2015-16. This is lower than the England average of 61.0% in the same period. It is important for Public Health England, NHS England, primary care and maternity services to work together to improve maternal vaccination uptake to prevent unnecessary illness and mortality from pertussis in infants.

Influenza

Seasonal influenza is a major cause of morbidity and mortality. Analysis of Health Protection Agency data (England 2010-11) allowed estimates of the increased risk of

death associated with flu. Death in 'at risk' groups is 11 times higher and this rises to 47 times higher for some groups such as those with immunosuppression. Flu vaccination remains a safe and effective way to protect those vulnerable in the population. In 2014/15 the following people were eligible for flu vaccination:

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

Data for influenza vaccinations given from 1 September 2015 to 31 January 2016 shows that vaccine uptake levels in Bromley are lower than England for every at risk group. Compared to London Bromley performing better in all groups except at risk patients aged 6 months to 65 years. More work is needed in Bromley to match the England average. Other area teams nationally have shown it is possible to exceed the national average.

Table 2.4.6 shows the uptake of seasonal flu vaccine in at risk groups in Bromley.

Table 2.4.6 Final cumulative uptake data for England on influenza vaccinations given from 1 September 2015 to 31 January 2016

	Bromley	London	England
>65 years	67.1	66.4	71
< 65 years At Risk	42.2	43.7	45.1
Pregnant Women	38.7	38.6	42.3
Age 2 yrs	33	26.6	35.4
Age 3 yrs	33.6	28.8	37.7
Age 4 yrs	26	21.7	30

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

Vaccines for Older People

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

Table 2.4.7: Shingles vaccine coverage report, Bromley and England, September 2015 to February 2016

	% Coverage in Routine Cohort 70 years	% Coverage in Catch-up Cohort 78 years
ENGLAND	48.7	50.3
NHS BROMLEY CCG	46.2	46.5

Source: Shingles Immunisation Vaccine Uptake Monitoring Programme, Public Health England (PHE) 2016

It is important to ensure high uptake of pneumococcal vaccine to prevent clusters of cases particularly in vulnerable settings such as care homes. Table 2.4.8 gives the uptake of pneumococcal (PPV) vaccination in over 65s in Bromley. Coverage is lower in Bromley than London and England.

Table 2.4.8: Percentage of 65 years and older receiving the pneumococcal vaccine anytime up until the 31st March 2016

	Bromley (Local Authority)	London (Area Team)	England
PPV in adults aged 65 years and over	63.4	65.3	70.1

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

Vaccine Indicators in Public Health Outcomes Framework

Indicator 3.03 of the PHOF reports population vaccination coverage of various vaccines over the four most recent years of data. Results for Bromley, London and England are shown in Table 2.4.9. Bromley's performance against the national goal for coverage is shown in red where it falls below the goal and green where it meets the goal. This highlights Bromley not meeting goals for 2 doses of MMR at age 5, PPV and flu.

Table 2.4.9: Population Vaccine Coverage PHOF Indicators

Indicator	Time Period	Sex	Age	Bromley	London	England	Bromley Comparison to Benchmark (Goal)
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2010/11	Persons	1 yr	81.25			
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2011/12	Persons	1 yr	100.00			
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2012/13	Persons	1 yr	100.00			
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2013/14	Persons	1 yr	87.50			
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2014/15	Persons	1 yr	100.00			
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2010/11	Persons	2 yrs	85.71			
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2011/12	Persons	2 yrs	75.00			
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2012/13	Persons	2 yrs	100.00			
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2013/14	Persons	2 yrs	100.00			
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2014/15	Persons	2 yrs	93.33			
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2010/11	Persons	1 yr	90.64	90.73	94.15	Above 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2011/12	Persons	1 yr	95.13	91.27	94.67	Above 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2012/13	Persons	1 yr	95.01	91.10	94.74	Above 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2013/14	Persons	1 yr	94.47	89.76	94.34	Above 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2014/15	Persons	1 yr	94.59	90.55	94.23	Above 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2010/11	Persons	2 yrs	93.42	92.85	95.98	Above 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2011/12	Persons	2 yrs	96.40	93.33	96.14	Above 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2012/13	Persons	2 yrs	95.96	93.58	96.30	Above 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2013/14	Persons	2 yrs	96.07	93.08	96.14	Above 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2014/15	Persons	2 yrs	96.47	92.52	95.74	Above 90%
3.03iv - Population vaccination coverage - MenC	2010/11	Persons	1 yr	90.09	89.27	93.39	Above 90%
3.03iv - Population vaccination coverage - MenC	2011/12	Persons	1 yr	94.06	89.95	93.89	Above 90%
3.03iv - Population vaccination coverage - MenC	2012/13	Persons	1 yr	94.90	89.94	93.89	Above 90%
3.03v - Population vaccination coverage - PCV	2010/11	Persons	1 yr	90.15	89.58	93.58	Above 90%
3.03v - Population vaccination coverage - PCV	2011/12	Persons	1 yr	94.46	90.40	94.22	Above 90%
3.03v - Population vaccination coverage - PCV	2012/13	Persons	1 yr	94.51	90.83	94.43	Above 90%
3.03v - Population vaccination coverage - PCV	2013/14	Persons	1 yr	93.52	89.72	94.07	Above 90%
3.03v - Population vaccination coverage - PCV	2014/15	Persons	1 yr	94.23	90.32	93.88	Above 90%
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2010/11	Persons	2 yrs	85.72	84.88	91.59	Below 90%
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2011/12	Persons	2 yrs	91.86	86.78	92.34	Above 90%
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2012/13	Persons	2 yrs	90.45	87.35	92.66	Above 90%
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2013/14	Persons	2 yrs	90.56	86.81	92.51	Above 90%
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2014/15	Persons	2 yrs	90.69	86.75	92.13	Above 90%
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	2011/12	Persons	5 yrs	92.09	80.14	88.63	Above 90%
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	2012/13	Persons	5 yrs	91.60	86.92	91.49	Above 90%
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	2013/14	Persons	5 yrs	92.13	87.16	91.93	Above 90%
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	2014/15	Persons	5 yrs	93.91	87.32	92.39	Above 90%
3.03vii - Population vaccination coverage - PCV booster	2010/11	Persons	2 yrs	82.71	82.40	89.34	Below 90%
3.03vii - Population vaccination coverage - PCV booster	2011/12	Persons	2 yrs	91.66	85.28	91.49	Above 90%
3.03vii - Population vaccination coverage - PCV booster	2012/13	Persons	2 yrs	90.27	86.58	92.47	Above 90%
3.03vii - Population vaccination coverage - PCV booster	2013/14	Persons	2 yrs	90.05	86.31	92.44	Above 90%
3.03vii - Population vaccination coverage - PCV booster	2014/15	Persons	2 yrs	89.98	86.37	92.20	Below 90%
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2010/11	Persons	2 yrs	83.56	83.75	89.13	Below 90%
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2011/12	Persons	2 yrs	91.49	86.08	91.25	Above 90%
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2012/13	Persons	2 yrs	90.59	87.14	92.32	Above 90%
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2013/14	Persons	2 yrs	91.16	87.46	92.66	Above 90%
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2014/15	Persons	2 yrs	90.71	87.29	92.29	Above 90%
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2010/11	Persons	5 yrs	88.92	88.17	91.92	Below 90%
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2011/12	Persons	5 yrs	95.16	89.70	92.90	Above 90%
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2012/13	Persons	5 yrs	94.04	90.58	93.87	Above 90%
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2013/14	Persons	5 yrs	94.30	90.64	94.11	Above 90%
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2014/15	Persons	5 yrs	95.20	90.70	94.37	Above 90%
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2010/11	Persons	5 yrs	77.01	76.62	84.21	Below 90%
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2011/12	Persons	5 yrs	88.49	80.21	86.02	Below 90%
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2012/13	Persons	5 yrs	87.52	80.77	87.72	Below 90%
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2013/14	Persons	5 yrs	88.42	80.70	88.32	Below 90%
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2014/15	Persons	5 yrs	88.40	81.10	88.62	Below 90%
3.03xii - Population vaccination coverage – HPV vaccination coverage for one dose (females 12-13 years old)	2014/15	Female	12-13 yrs	90.20	83.81	89.43	
3.03xiii - Population vaccination coverage - PPV	2010/11	Persons	65+ yrs	65.82	64.97	70.46	
3.03xiii - Population vaccination coverage - PPV	2011/12	Persons	65+ yrs	56.69	62.61	68.34	<previous year's England value
3.03xiii - Population vaccination coverage - PPV	2012/13	Persons	65+ yrs	61.68	64.24	69.09	<previous year's England value
3.03xiii - Population vaccination coverage - PPV	2013/14	Persons	65+ yrs	61.58	63.57	68.94	<previous year's England value
3.03xiii - Population vaccination coverage - PPV	2014/15	Persons	65+ yrs	62.53	64.94	69.79	<previous year's England value
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2010/11	Persons	65+ yrs	72.01	71.44	72.84	Below target 75%
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2011/12	Persons	65+ yrs	73.67	72.24	74.02	Below target 75%
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2012/13	Persons	65+ yrs	73.48	71.24	73.38	Below target 75%
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2013/14	Persons	65+ yrs	69.90	70.02	73.21	Below target 75%
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2014/15	Persons	65+ yrs	69.24	69.24	72.74	Below target 75%
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2015/16	Persons	65+ yrs	67.15	66.41	70.99	Below target 75%
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2010/11	Persons	6 months-	46.05	48.92	50.39	
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2011/12	Persons	6 months-	47.68	51.43	51.62	
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2012/13	Persons	6 months-	45.49	50.94	51.29	
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2013/14	Persons	6 months-	46.46	51.97	52.26	
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2014/15	Persons	6 months-	45.81	49.75	50.27	
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2015/16	Persons	6 months-	42.20	43.73	45.14	
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old)	2014/15	Persons	70	52.47	48.73	59.05	
3.03xviii - Population vaccination coverage - Flu (2-4 years old)	2014/15	Persons	2-4 yrs	31.50	28.89	37.59	
3.03xviii - Population vaccination coverage - Flu (2-4 years old)	2015/16	Persons	2-4 yrs	30.82	25.71	34.36	

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

Tuberculosis

TB incidence in Bromley remains very low compared to the average London rate (figure 2.4.10). There were a total of 26 TB cases in Bromley in 2015-16. Young males aged 20 to 39 years old were the most common age group notified as cases of TB. Almost a third of Bromley TB patients were born in the UK: a higher proportion than usually seen in London but numbers are low and so should be interpreted with caution. The most common ethnic group was Indian followed by black African, but again numbers were very small. Social risk factors, such as homelessness, imprisonment, drug or alcohol misuse, were above the London average, particularly among those with pulmonary disease.

Figure 2.4.10: Annual TB incidence rate 2002 – 2013

Source: PHE Bromley TB profile (2013)

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

Healthcare associated infections

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

Mandatory and voluntary surveillance schemes are in place to monitor blood stream infections caused by meticillin-resistant and meticillin-sensitive *Staphylococcus aureus*, *E coli* and glycopeptide-resistant organisms, carbepenem resistant organisms, *Clostridium difficile* infections and surgical site infections. PHE publishes data quarterly and annually for acute trusts and clinical commissioning groups. Bromley CCG had between 2 and 10 cases of *C. difficile* in patients over 2 years of age each month between June 2015 and June 2016 (total 72 cases) and only one case of Meticillin Resistant *Staphylococcus aureus* bacteraemia in the same period. Full HCAI data for the acute trusts in SE London can be found by following the appropriate links from https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis#management-of-healthcare-associated-infections-hcai

Other selected Health Protection Indicators in Public Health Outcomes Framework

Table 2.4.11 shows other selected health protection indicators included in the PHOF. Over recent years Bromley has been similar or better than England in terms of TB treatment completion, TB incidence, and mortality from communicable disease.

Table 2.4.11: Health Protection Related PHOF Indicators

Indicator	Time Period	Sex	Age	Bromley	London	England	Bromley Comparison to England Benchmark
3.05i - Treatment completion for TB	2001	Persons	All ages		74.51	63.67	Similar
	2002	Persons	All ages	73.08	74.07	67.38	Similar
	2003	Persons	All ages	69.23	76.46	69.58	Similar
	2004	Persons	All ages	61.54	78.32	70.09	Similar
	2005	Persons	All ages	69.23	78.82	70.28	Similar
	2006	Persons	All ages	76.32	81.86	75.53	Similar
	2007	Persons	All ages	81.48	82.82	78.09	Similar
	2008	Persons	All ages		85.34	79.90	
	2009	Persons	All ages	83.87	86.40	81.82	Similar
	2010	Persons	All ages	83.33	85.99	82.64	Similar
	2011	Persons	All ages	92.50	85.49	81.81	Similar
	2012	Persons	All ages	79.31	86.09	83.59	Similar
	2013	Persons	All ages	75.86	86.14	84.79	Similar
3.05ii - Incidence of TB	2000 - 02	Persons	All ages	7.43	37.66	12.73	Better
	2001 - 03	Persons	All ages	8.31	39.34	13.07	Better
	2002 - 04	Persons	All ages	9.76	41.56	13.51	Better
	2003 - 05	Persons	All ages	9.96	43.06	14.08	Better
	2004 - 06	Persons	All ages	11.03	43.85	14.67	Better
	2005 - 07	Persons	All ages	11.41	43.89	14.98	Better
	2006 - 08	Persons	All ages	10.24	42.95	14.96	Better
	2007 - 09	Persons	All ages	9.19	42.64	15.12	Better
	2008 - 10	Persons	All ages	9.23	42.01	15.06	Better
	2009 - 11	Persons	All ages	11.66	41.86	15.24	Better
	2010 - 12	Persons	All ages	11.25	41.23	15.10	Better
	2011 - 13	Persons	All ages	10.72	39.54	14.72	Better
	2012 - 14	Persons	All ages	8.08	35.38	13.52	Better
4.08 - Mortality rate from a range of	2001 - 03	Persons	All ages	9.13	14.75	10.95	Similar
	2002 - 04	Persons	All ages	7.94	14.86	11.49	Similar
	2003 - 05	Persons	All ages	9.25	16.31	12.98	Similar
	2004 - 06	Persons	All ages	11.08	18.56	15.31	Better
	2005 - 07	Persons	All ages	17.40	21.91	17.74	Better
	2006 - 08	Persons	All ages	16.52	20.97	17.70	Similar
	2007 - 09	Persons	All ages	13.63	18.17	15.82	Similar
	2008 - 10	Persons	All ages	8.07	13.86	13.04	Better
	2009 - 11	Persons	All ages	7.86	12.16	11.87	Better
	2010 - 12	Persons	All ages	8.21	10.77	10.87	Better
	2011 - 13	Persons	All ages	8.14	10.34	10.67	Better
	2012 - 14	Persons	All ages	7.43	10.35	10.16	Better
	2001 - 03	Male	All ages	9.10	16.42	12.35	Similar
	2002 - 04	Male	All ages	9.65	16.24	12.72	Similar
	2003 - 05	Male	All ages	10.66	17.41	13.92	Similar
	2004 - 06	Male	All ages	11.82	19.12	16.13	Similar
	2005 - 07	Male	All ages	15.93	22.30	18.61	Similar
	2006 - 08	Male	All ages	14.48	22.06	18.65	Similar
	2007 - 09	Male	All ages	12.70	19.90	16.67	Similar
	2008 - 10	Male	All ages	8.82	15.78	13.76	Similar
	2009 - 11	Male	All ages	10.39	13.54	12.79	Better
	2010 - 12	Male	All ages	9.26	12.26	11.92	Better
	2011 - 13	Male	All ages	9.13	11.59	11.91	Better
	2012 - 14	Male	All ages		11.42	11.20	
	2001 - 03	Female	All ages	8.67	13.24	9.99	Similar
	2002 - 04	Female	All ages	6.77	13.54	10.62	Similar
	2003 - 05	Female	All ages	8.24	15.14	12.27	Similar
	2004 - 06	Female	All ages	10.61	17.61	14.65	Better
	2005 - 07	Female	All ages	17.65	20.93	17.05	Similar
	2006 - 08	Female	All ages	17.29	19.73	16.96	Similar
	2007 - 09	Female	All ages	13.81	16.67	15.11	Similar
	2008 - 10	Female	All ages	7.57	12.24	12.36	Better
	2009 - 11	Female	All ages	6.47	10.90	11.10	Better
	2010 - 12	Female	All ages	7.73	9.49	10.03	Better
	2011 - 13	Female	All ages	7.67	9.31	9.72	Similar

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

What this means 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 and mumps outbreaks, particularly in older children and young adults due to poor immunisation uptake, as seen in the 38 confirmed measles cases and 31 confirmed mumps cases in South London in 2015.

There has been a rise in the number of cases of Scarlet Fever.

There were 277 confirmed cases of pertussis in South London in 2015, highlighting the ongoing importance of immunisation against pertussis, in particular of ensuring good uptake of maternal pertussis vaccination.

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

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

2.5 Modifiable Lifestyle Risk Factors

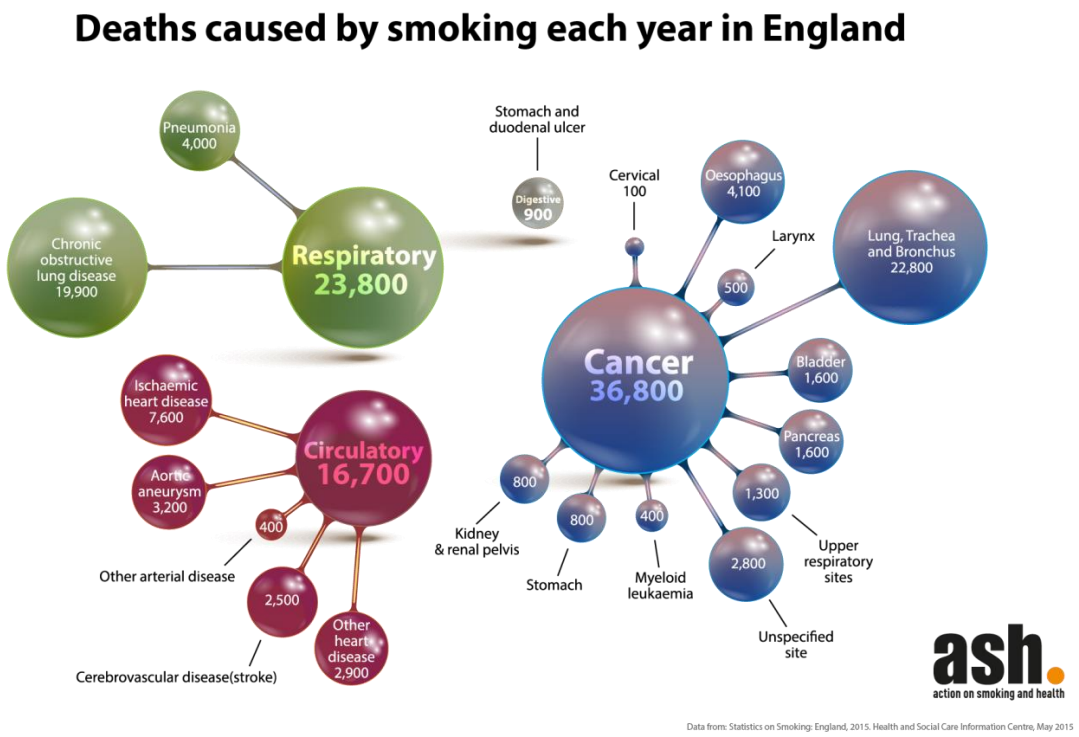
Unhealthy lifestyles are a major contributor to the key causes of morbidity and mortality in Bromley. Smoking, excess weight and physical inactivity are all independent modifiable risk factors.

Smoking

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

Smoking is a major risk factor for cardiovascular disease (heart disease and stroke), Chronic Obstructive Pulmonary Disease (emphysema, bronchitis and asthma) and many cancers (in particular lung, bowel and breast cancer). Smoking causes approximately 96,000 deaths a year in the United Kingdom, smokers are much more likely to die prematurely (up to 16 years of lost life expectancy). 1 in 2 long-term smokers die from a smoking related illness[1].

Figure 2.5.1



Source: Action on Smoking and Health, 2015[2].

Smoking prevalence

The total population of adult smokers (18+) is decreasing in the UK. Bromley's smoking prevalence (14.2%) is below the England (16.9%) and London (16.3%) smoking prevalence. In Bromley, the current adult smoker population is approximately 43,934 residents. Bromley's smoking prevalence decreased by

2.2% (6,807 residents) between 2014 and 2015, which is reflective of the decreasing trend nationally[3].

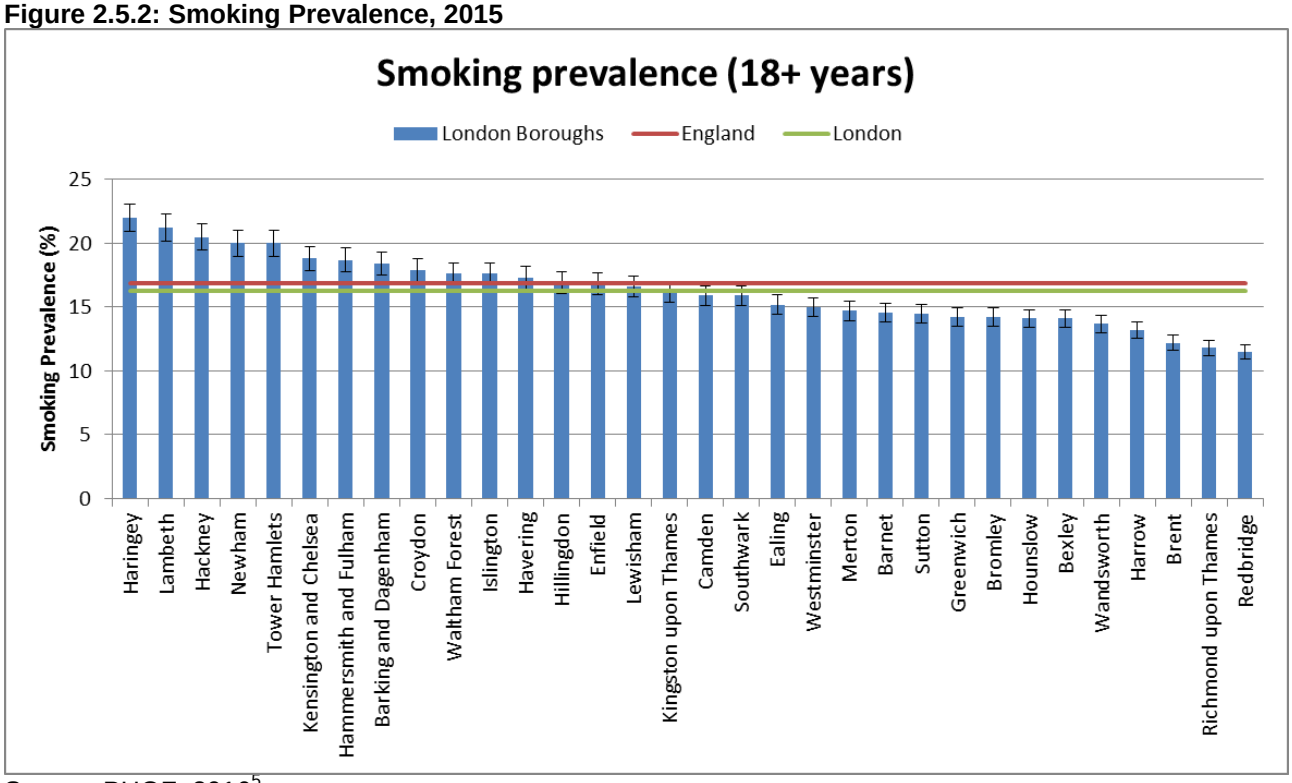
Table 2.5.1 Smoking Prevalence Trend in Bromley

Year	Smoking Prevalence
2009-10*	15.5%
2010-11*	16.5%
2011-12*	17.8%
2012-13	18.1%
2013-14	16.0%
2014-15	14.2%

Source: *LHO* and Tobacco Control Profiles 2016*[4]

Bromley is ranked 25th highest in order of smoking prevalence across London out of 32 London boroughs. However, one in seven residents still smoke, which has a major impact on their health and the wellbeing and that of those around them.

Figure 2.5.2: Smoking Prevalence, 2015

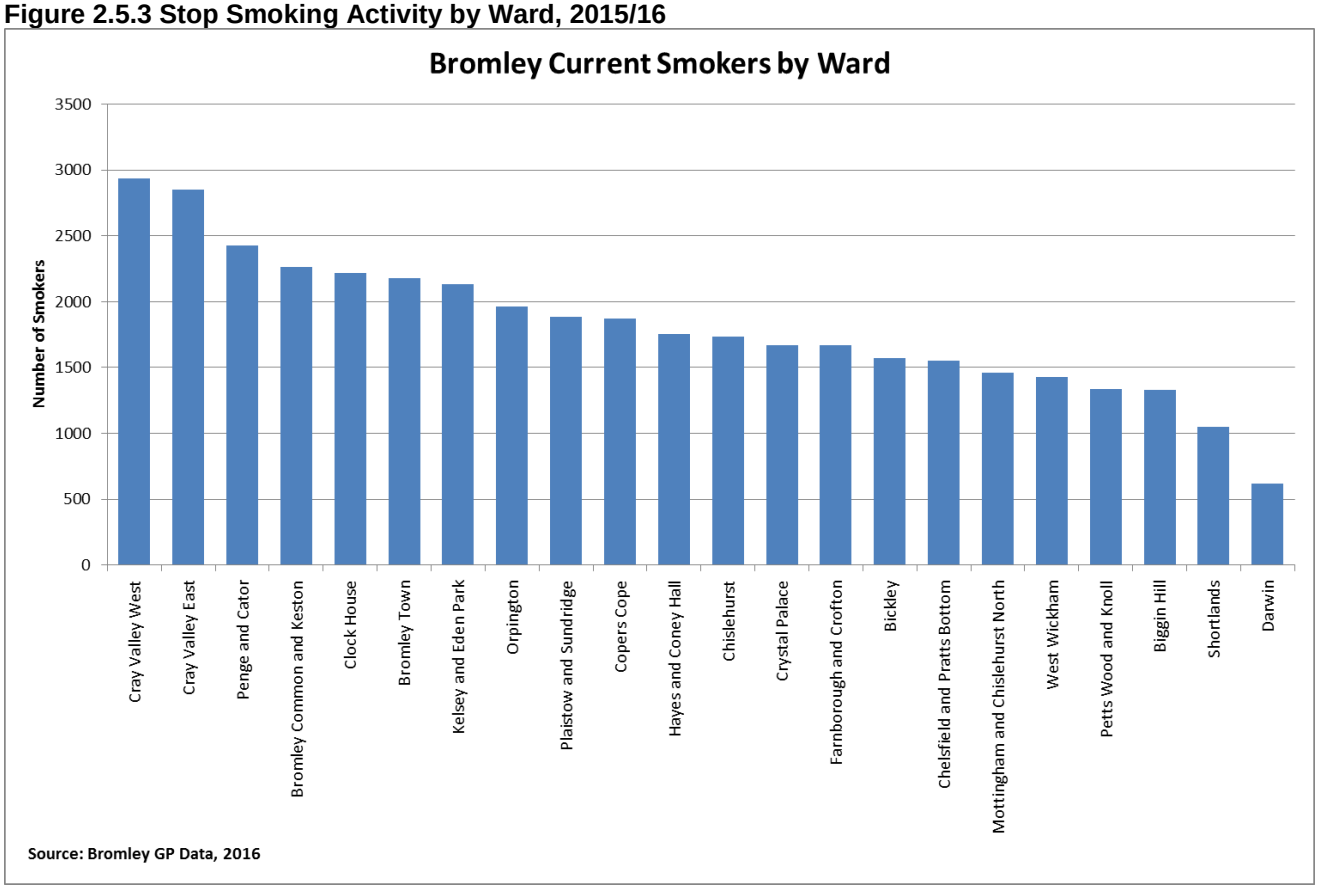


Source: PHOF, 2016[5]

Smoking Prevalence by Ward in Bromley, 2015/16.

In 2015-16, the wards with the highest smoking prevalence were; Cray Valley West (5,968 smokers), Cray Valley East (2,851 smokers), Penge & Cator (2,428) and Bromley Common & Keston (2,266)[6].

Figure 2.5.3 Stop Smoking Activity by Ward, 2015/16



The current burden of smoking in Bromley

Impact of smoking – The impact of smoking on health has reduced as the prevalence of smoking has reduced, but there are still significant negative health implications in Bromley[7].

Smoking attributable mortality – The age-standardised mortality rate for smoking attributable causes was lower in Bromley during 2012-14 (237.2 per 100,000 population) than the overall London and England rate (261.4 compared to 274.8 per 100,000 population, respectively).

Smoking attributable deaths from heart disease –The age-standardised rate for smoking attributable deaths from heart disease was lower in Bromley during 2012-14 (28.4 per 100,000 population) than in London and England (27.7 compared to 29.7 per 100,000 population, respectively).

Smoking attributable deaths from stroke – The age-standardised mortality rate for these deaths was 8.0 in Bromley, 9.4 in London compared with 9.3 per 100,000 population in England as a whole.

Smoking attributable hospital admissions – The age-standardised rate for smoking attributable hospital admissions in Bromley was 1,287 per 100,000

population aged 35 years and over, as compared with 1,517 in London and 1,671 in England in 2014/15.

There is strong evidence of higher risks and worse surgical outcomes when a patient continues to smoke. Smokers are 38% more likely to die after surgery than non-smokers. 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

It is estimated that, in London, savings of approximately £2.6 million a year could be made if between 8% and 17% of smokers quit before having surgery. These savings are derived from reducing the length of stay and the cost of treating post-operative complications[8].

Secondary Prevention

Secondary prevention includes screening of individuals to detect whether they smoke, and to give brief advice. This takes place in Primary Care as part of the NHS Health Checks for people aged between 40 and 74 years, and also at the Princess Royal University Hospital (PRUH) as part of the Health Promoting Hospital Local Incentive Scheme commissioned by the CCG.

All patients admitted to participating wards at the PRUH are asked whether they smoke, offered a brief intervention and referral to the Bromley Stop Smoking Service if they wish. This scheme started in 2014-15, each year more wards are enrolled onto the scheme, currently 10 wards are participating.

Table 2.5.2 Smoking Screening Results at the PRUH

Time Period	No. of Admissions	No. patients Screened	No. patients who smoke	Brief Advice
Q1 2015-16	4092	88%	832	92%
Q2 2015-16	6582	70%	919	89%
Q3 2015-16	7641	65%	995	88%
Q4 2015-16	5712	70%	801	92%
Q1 2016-17	7043	68%	976	90%
Q2 2016-17	6646	74%	575	46%

Source: Kings College Hospital NHS Foundation Trust - PRU Hospital data 2016[9].

Bromley's population smoking prevalence is 14.2% and within this hospital population self- reported smoking status is 14.8%, which is lower than expected. Work is ongoing to support this initiative, performance is affected by staff turnover and training. From 2018-19, smoking screening in hospitals will be part of a National CQUIN.

Inequalities

Smoking rates are much higher within certain groups and deprived communities. Smoking is around twice as common among people with mental disorders. Lesbian, gay and bisexual communities are also significantly more likely to smoke, as are the long-term unemployed, and some minority ethnic groups, which also have gender disparities. Helping disadvantaged smokers quit is the best way to reduce health inequalities[10].

Routine and Manual

Smoking prevalence in routine and manual occupational groups in Bromley (15.8%) is lower than the London (24.2%) and England (26.5%) prevalence. Smoking continues to be higher in the most deprived wards in Bromley, undermining the health of the most disadvantaged communities. Smoking has been identified as the single biggest cause of inequality in death rates between social classes in the UK.

Smokers are more likely to live in poverty; a twenty-a-day smoker will spend more than £3,000 a year on cigarettes. There are approximately 25,774 households in Bromley with at least one smoker. Approximately 5,077 people would not be below the poverty line if the cost of smoking were returned to the household[11].

Pregnant Smokers

The smoking rate at time of delivery in 2014-15 in Bromley (4.7%) is slightly below the London average (4.8%) and decreased by 1.2% compared to 2013/14 figures. This is the 12th highest prevalence in London. It is considerably lower than the England average of 11.4%. It is worth noting that statistics on women who smoke during their pregnancy rely on self-reporting and can be subject to

under reporting. In 2015, there were 4,098 births in Bromley, equating to approx. 193 women smoking at time of delivery[12].

- Pregnant mothers are an identified priority group nationally. Smoking during pregnancy can cause serious health problems and is associated with complications during labour, increased risk of miscarriage, premature birth, still-birth, low birth weight, respiratory conditions, attention and hyperactivity difficulties, learning difficulties and sudden unexpected death in infancy. Infants born to smokers are much more likely to become smokers themselves.
- National statistics highlight maternal smoking is associated with various factors including age and socio-economic position. For example, teenage mothers are twice as likely to smoke before and during pregnancy and three times as likely to throughout.
- Mothers in routine and manual occupations are more than four times as likely to smoke throughout pregnancy – compared to those in managerial and professional occupations (29% and 7% respectively).
- Exposure to second hand smoke (SHS) leads to exposure to toxins which contributes to: asthma, middle-ear infections, Sudden Infant Death Syndrome (SIDS), pneumonia and bronchitis.
- 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.

Smoking prevalence in young people.

Smoking status at age 15 years has now been recorded in 2014/15, which shows that Bromley has a greater number of current, regular and occasional smokers at this age than London and England. This is of concern as 90% of smokers started before the age of 19 years.

Table 2.5.3

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

Source: PHOF, 2015[13]

Children from low income families are more likely to be exposed to second hand smoke in the home. Household smoking increases rates of childhood asthma by as much as 50%. Children with a parent who smokes are also up to three times more likely to go on to smoke themselves.

Mental Health

Smoking is around twice as common among people with mental disorders, and almost three times as common in those with more severe mental illnesses in Bromley. The smoking prevalence in adults with serious mental illness in Bromley is 36.4% which is below the England (40.5%) and London (38.9%) prevalence. This difference in the prevalence of smoking has significant consequences: people with mental health conditions die on average 10 to 20 years earlier than the general population and smoking is the single largest factor in this difference[14].

Smokers with mental disorders are just as likely to want to quit as those without, but are more likely to be heavily addicted to smoking, to anticipate difficulty quitting smoking, and are historically much less likely to succeed in any attempt to quit. This is a priority group for Bromley.

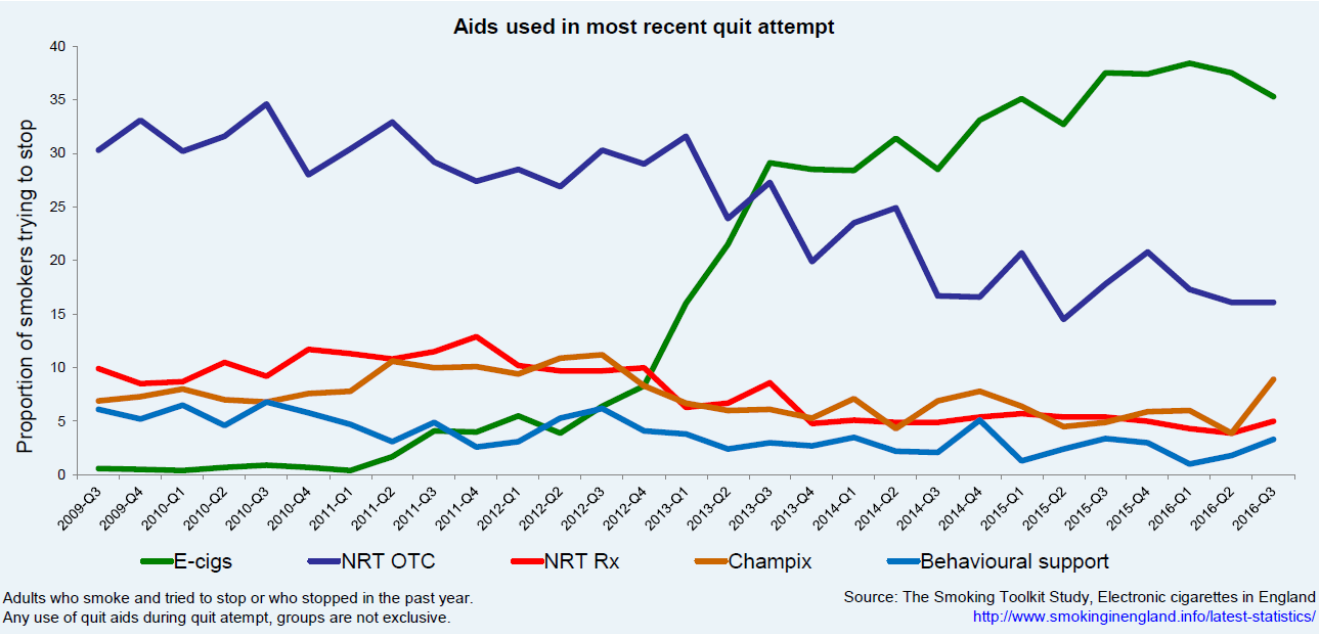
Bromley Stop Smoking Services

Evidence has shown that a smoker is four times more likely to quit if they are supported to do so by a trained stop smoking advisor. However, the number of smokers accessing stop smoking services has decreased. The Bromley Stop Smoking Service records the number of people who have quit smoking and are abstinent at 4-weeks in line with national guidance. In 2015-16, the Stop Smoking Service achieved 2245 attempts to quit and 1056 quitters (47% efficacy rate). The England success quit rate was just over half at 53% efficacy[15].

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

A consistent message to all smokers remains that they should stop completely, immediately and permanently. However, those who are unable or unwilling to stop smoking should be encouraged to adopt a 'Harm Minimisation' approach to move them closer to becoming smokefree. Although existing evidence is not clear about the health benefits of smoking reduction, those who reduce the amount they smoke are more likely to stop smoking eventually, particularly if they are using licensed nicotine-containing products (NICE PH45)[16]. E-cigarettes are now the most popular support when quitting.

Figure 2.5.4: Frequency of smoking aids used when attempting to quit smoking in England.



Source: Action on Smoking and Health, 2016[17]

How much is smoking costing in Bromley?

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

The total annual cost of smoking in Bromley is £66.9m*, which can be broken down as: Costs to businesses: £4.55m and 27.0m (productivity losses – smoking related sick days and smoking breaks respectively), Lost productivity (early deaths) 19.4m, NHS Costs: £8.7m, Social Care Costs: 5.4m (this equates to approximately 4,977 individuals requiring additional social care support), plus passive smoking costs, accidental fires ignited by smoking related materials and street litter[18].

What this means for Bromley residents and the children of Bromley

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

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

Bromley's smoking prevalence decreased from 18.1% in 2012-13 to 14.2% in 2014-15. However, one in seven residents still smoke. Stopping smoking should be targeted within Bromley to prioritise routine and manual workers, pregnant women, those with a mental health condition and patients in secondary care (hospital admission, re-admission and post-operative complications).

A whole system approach is needed to reduce smoking prevalence at a population level. This includes central government legislation such as expanding the smoking ban to include smokefree cars, making best use of national initiatives such as Stoptober and No Smoking day, and mobilising local healthcare providers and community services to implement 'Making Every Contact Count' principles to ensure everyone who comes into contact with members of the public and has the opportunity to have a conversation to improve health offers Very Brief Advice (VBA) on the benefits of stopping smoking and making referrals to stop smoking services.

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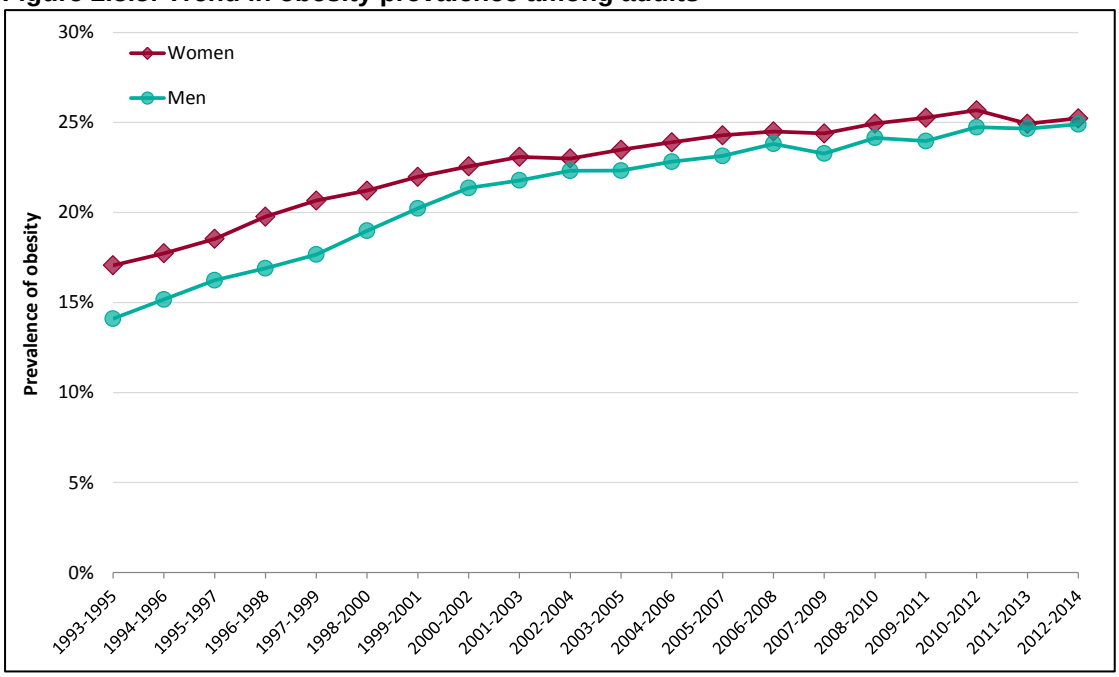
Adult Obesity

Prevalence of obesity and overweight

Obesity presents one of the major health challenges globally, nationally and locally. In 1980, eight per cent of adult women and six per cent of adult men were classified as obese. In a little over 35 years, the majority of people are now overweight or obese; In England 64.6%, and in London 58.4% of adults and 33.2% and 37.2% of children aged between 2 and 15 respectively are either overweight or obese. Overweight and obesity in adults is predicted to reach 70% by 2034[1].

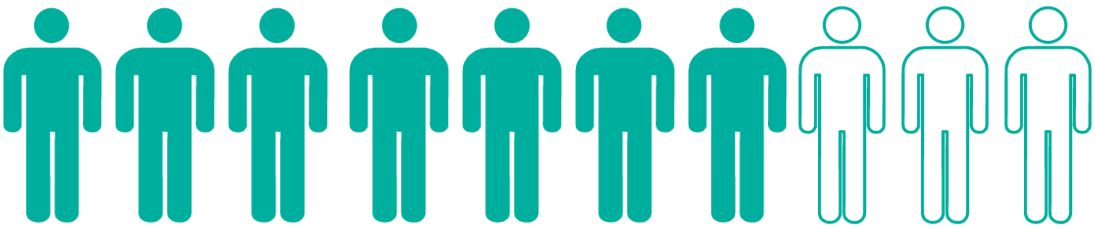
Figure 2.5.5: Trend in obesity prevalence among adults



Source: Health Survey for England 1993-2014

Figure 2.5.6

More than 7 out of 10 men are overweight or obese (66.4%)



More than 6 out of 10 women are overweight or obese (57.5%)

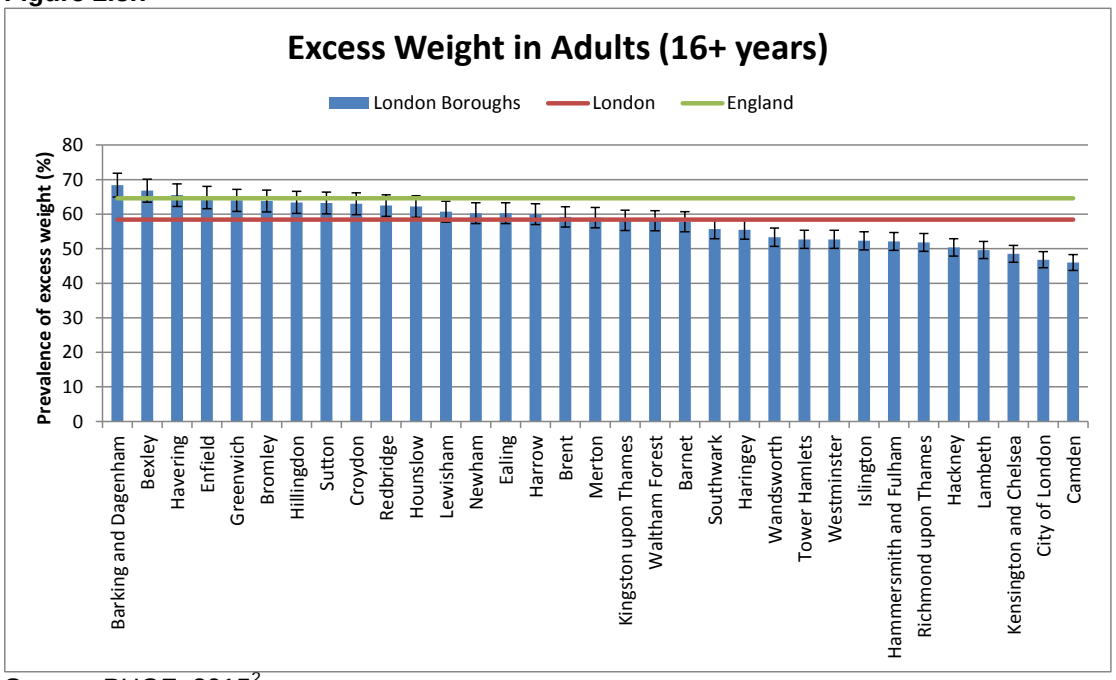
Adult (aged 16+) overweight and obesity: BMI ≥ 25kg/m^2
Source: Health Survey for England 2012 to 2014 (three-year average)

Nationally, one in four men (24.9%) and women (25.2%) are classified as obese (BMI ≥ 30kg/m^2).

The current burden of obesity in Bromley

The public health outcomes framework 2016[2] reported that 63.8% of Bromley's population are either overweight or obese, which represents approximately 197,392 adults. Bromley is ranked as the sixth highest prevalence of excess weight in London, higher than populations with similar populations such as Richmond upon Thames and Kensington and Chelsea who feature as the sixth and third lowest respectively.

Figure 2.5.7



Source: PHOF, 2015[2]

Health implications of obesity.

Obesity is the second leading cause of preventable death behind smoking. Obesity reduces life expectancy by an average of 3 years and severe obesity reduces it by 8-10 years and has a considerable impact on quality of life. Those who are severely obese are 3 times more likely to need social care than those who are a healthy weight[3].

Obesity is a key risk factor for circulatory disease and cancer, which were accountable for 58.1% of the deaths in Bromley between 2011 and 2015. In addition, obesity has an attributable risk for Type 2 diabetes of 24%. In tandem with the rising levels of obesity in Bromley, there has been a significant increase in the prevalence of diabetes and residents at risk of diabetes [4] (see diabetes section).

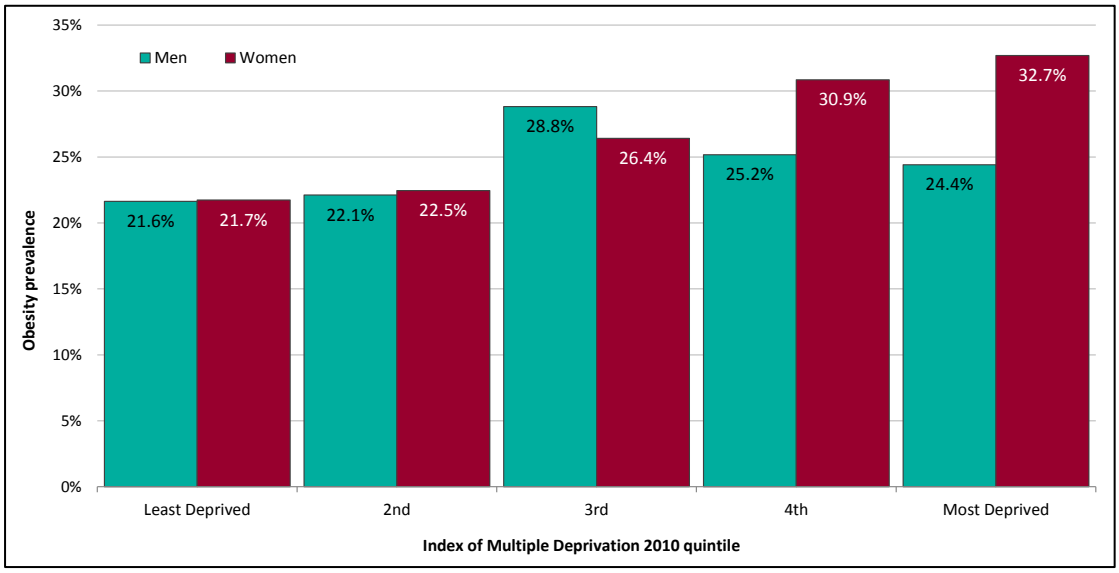
Table 2.5.4: The benefits of a 10 kilogramme weight loss

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

Inequalities

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

Figure 2.5.8: Adult obesity prevalence by deprivation in England



Source: Health Survey for England 2007-2011[6]

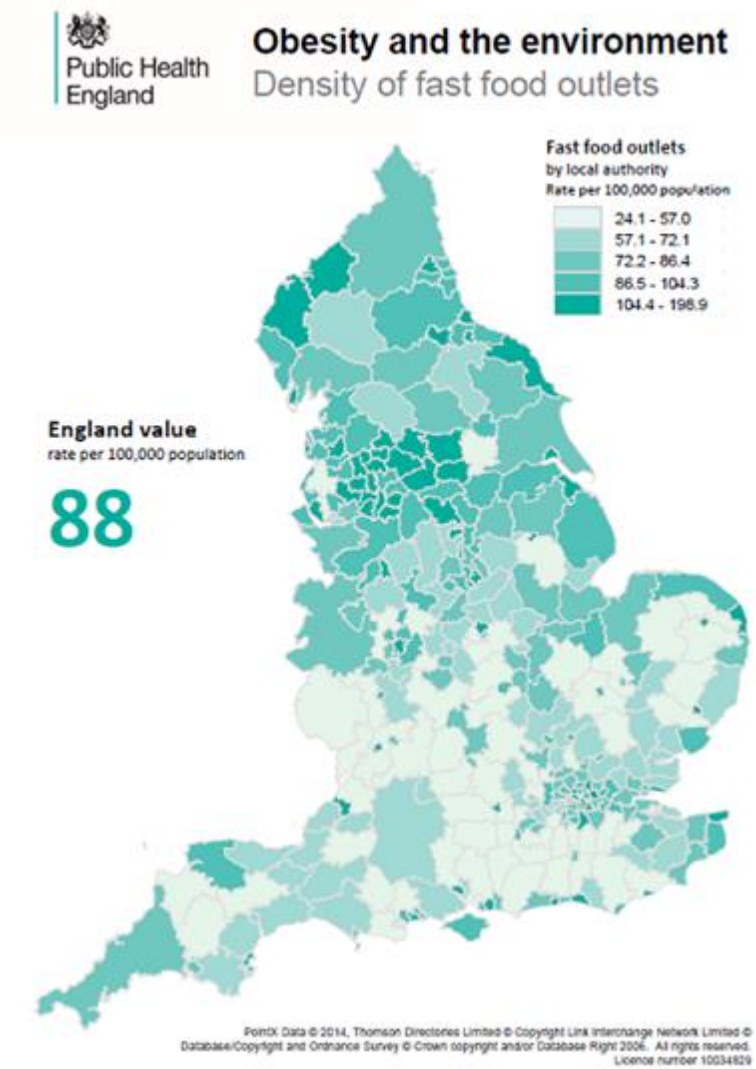
Food Accessibility

Fast food outlets (FFO) are by no means solely responsible for the obesity crisis, the problem is multifaceted and complex. However, FFOs provide a source of some of the unhealthiest food that is available within our communities. People generally have easy access to cheap, highly palatable and energy-dense food frequently lacking in nutritional value. Food purchased from fast-food outlets and restaurants is up to 65% more 'energy-dense' than the average diet. Energy dense, nutritionally imbalanced diets can contribute to the risk of disease. High levels of salt contribute to increased blood pressure, a risk factor for stroke. Saturated fats can increase levels of cholesterol in the blood, which is a risk factor for coronary heart disease (CHD). Trans fats can also raise cholesterol.

Deprivation and Fast Food Outlet Proliferation

The density of FFO by local authority is shown in Figure 2.5.9. The model shows there are 79.4 FFOs per 100,000 population in Bromley, compared to 88 FFOs per 100,000 population in England. Prevalence is highest in inner city boroughs but outer boroughs are fast increasing.

Figure 2.5.9: Density of Fast Food Outlets by Local Authority in England



Source: Public Health England 2014[7].

Fast food outlets in Bromley.

- In 2012, Bromley had 217 FFOs, in 2015 there were 255 FFOs. An increase of 38 FFOs within 3 years.
- This represents an increase of 6% FFOs per year. In the next ten years Bromley could have an additional 150 FFOs if there is no ability to manage proliferation.
- 156 out of the 217 FFOs in 2012 are still open in 2015 under the same name, 99 new suppliers have taken over existing FFOs or created new ones.
- The highest prevalence of FFOs are within Penge and Cator (35 outlets), Bromley Town (33 outlets) and Orpington (16 outlets) wards. FFOs are predominately clustered around town centres but there is a higher prevalence in areas of deprivation towards the far east and west of the borough.
- The ability of the planning system to address the health impact of fast food is limited in that it can only control new fast food takeaways and cannot deal with the problems of existing takeaways and other fast food outlets. Therefore, planning controls should be seen as part of a strategic response, in preparing for the future.

Table 2.5.5: Fast Food Outlets per Ward in Bromley, 2015.

Bromley Ward 2015	Fast Food Outlet Count
Bickley	8
Biggin Hill	7
Bromley Common and Keston	10
Bromley Town	33
Chelsfield and Pratts Bottom	7
Chislehurst	7
Clock House	11
Copers Cope	11
Cray Valley East	10
Cray Valley West	13
Crystal Palace	12
Darwin	1
Farnborough and Crofton	5
Hayes and Coney Hall	8
Kelsey and Eden Park	13
Mottingham and Chislehurst North	12
Orpington	16
Penge and Cator	35
Petts Wood and Knoll	15
Plaistow and Sundridge	7
West Wickham	14

Evidence suggests there is a relationship between the accessibility of fast food and obesity. Therefore, limiting the availability of the worst examples of this food, especially to vulnerable communities such as children and deprived neighbourhoods is recommended. Accessibility, particularly proximity and opening hours of fast-food outlets are factors that influence use. Davis and Carpenter (2009) found that fast food restaurants within 160 metres of a school (0.1 miles) are associated with a 5% increase in obesity[8].

Consumption of food and drink

The constitution of a diet is important and a major contributor to chronic disease and premature death. Average intakes of saturated fat, sugar and salt are above the recommended daily allowance in the UK whilst fruit and vegetable, fibre and some vitamins and minerals are below recommendations. There is a higher proportion of the adult population meeting the recommended '5-a-day' intake of fruit and vegetables on a 'usual day' (adults) in Bromley (53.8%) than in England (52.3%) and London 49.4%.

The National Diet and Nutrition Survey (2008/09 - 2011/12) measured food consumption and nutrient intakes from a 4-day food diary[9] and found nationally;

- Mean consumption of oily fish in all age groups was well below the recommended one portion (140g) per week. For example, mean consumption in adults aged 19 to 64 years was 53g per week.
- Mean intake of saturated fat exceeded the recommended level (no more than 11 per cent food energy) in all age/sex groups. For example, mean saturated fat intake for adults aged 19 to 64 years was 12.6 per cent food energy.
- On average, adults aged 19 to 64 years obtained 8.4 per cent of energy intake from alcohol and those aged 65 and over obtained 6.4 per cent.

How much is Obesity costing in Bromley?

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

Annual Cost of Obesity:

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

Source: Public Health England, February 2015[10].

For every participant who undertakes a 12 session commercial weight management programme, the NHS stands to save £230 over their lifetime[11].

What this means for Bromley residents and the children in Bromley

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

Excess weight contributes significantly to the incidence and progression of diseases such as circulatory disease, cancer and type 2 diabetes. A significant proportion of Bromley's residents (63.8%) are at higher risk of these conditions and of premature death.

Education and personal responsibility are critical elements of any program to reduce obesity, but not sufficient on their own. Additional interventions are needed that rely less on conscious choices by individuals and more on changes to the environment and societal norms.

No single solution creates sufficient impact to reverse obesity: only a comprehensive, systemic program of multiple interventions is likely to be effective. However, adult and childhood obesity are directly related to deprivation so targeted interventions are likely to be effective.

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Physical Activity in Adults

Physical inactivity is known to be the fourth leading cause of global mortality. If everyone in England met Chief Medical Officer (CMO) guidelines for activity, nearly 37,000 deaths a year could be prevented[1]. Many of the leading causes of ill health in today's society, such as coronary heart disease, cancer and type 2 diabetes, could be prevented if more inactive people were to become active.

Table 2.5.6: Physical Activity contribution to reduction in risk of mortality and long term conditions

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

Source: Department of Health. Start Active, Stay Active (2011)[2].

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

Prevalence of Physical Activity

National guidance for physical activity

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

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

CMO Physical Activity Guidelines[3];

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

Figure 2.5.9: Adult Physical Activity Levels

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

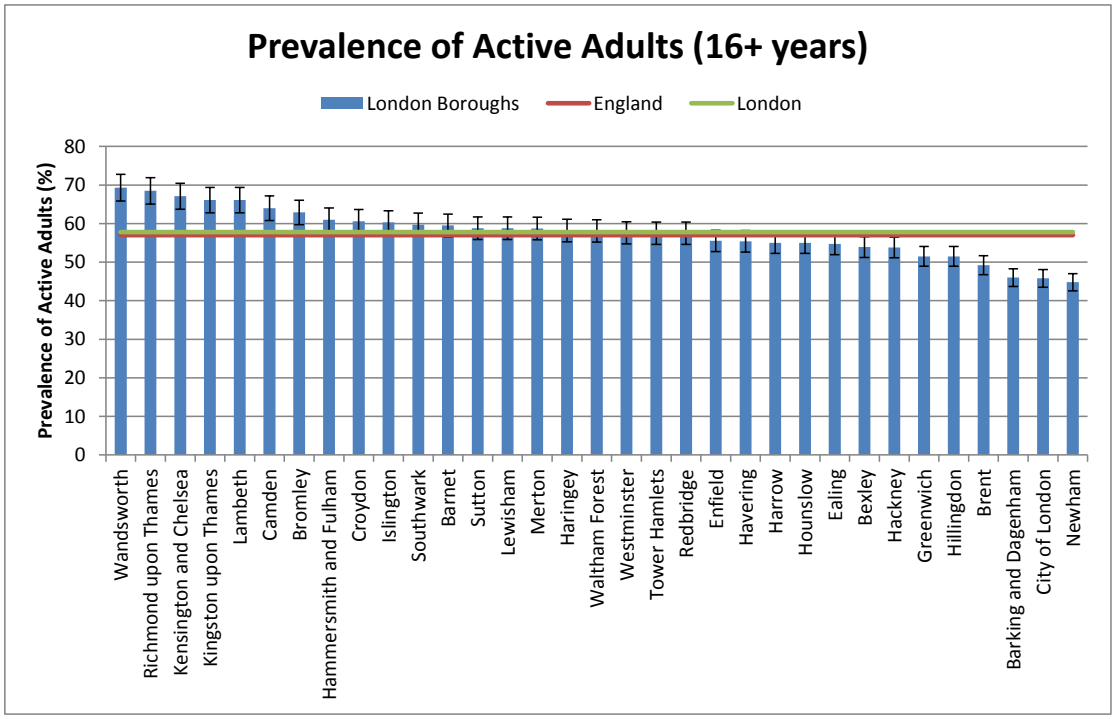
Around half of women meet national physical activity recommendations* (55%)

*150 minutes of moderate intensity physical activity per week

Source: Health Survey for England 2012 (base aged 16 and over)[4]

Adherence rates to physical activity in Bromley are above the London (57.8%) and England (57.0%) participation rates. 62.9% of Bromley population meet the recommended physical activity guidelines of 150 minutes in 2015, which increased from 58.1% in 2014. Despite activity being above the average, there is scope to increase levels of physical activity participation above the minimum requirement for health benefits, particularly within inactive populations in Bromley.

Figure 2.5.10

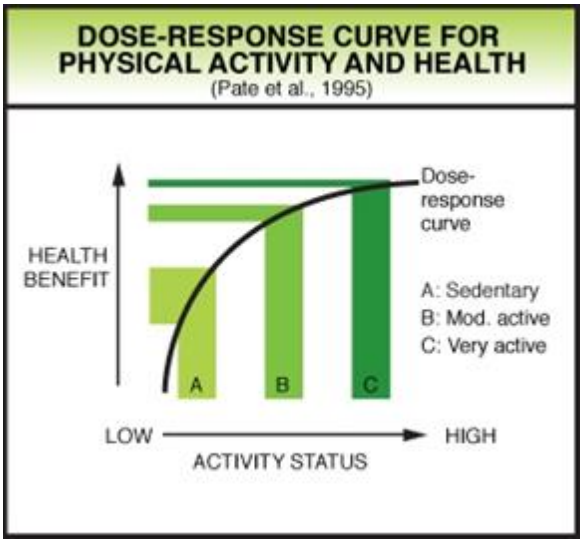


Source: PHOF, 2015

Inactive populations

Although activity rates are high, just under a quarter of the Bromley population were not participating in even 30 minutes of activity a week (23.8%) in 2015, which decreased from 25.6% in 2014. This is less than the London (28.1%) and England (28.7%) number of recorded sedentary individuals[5]. Targeting those adults who are significantly inactive (that is, engaging in less than 30 minutes of activity per week) will produce the greatest health benefits and reductions in chronic disease. On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual[6].

Figure 2.5.11



Source: Department of Health 2011

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 inactivity[7].

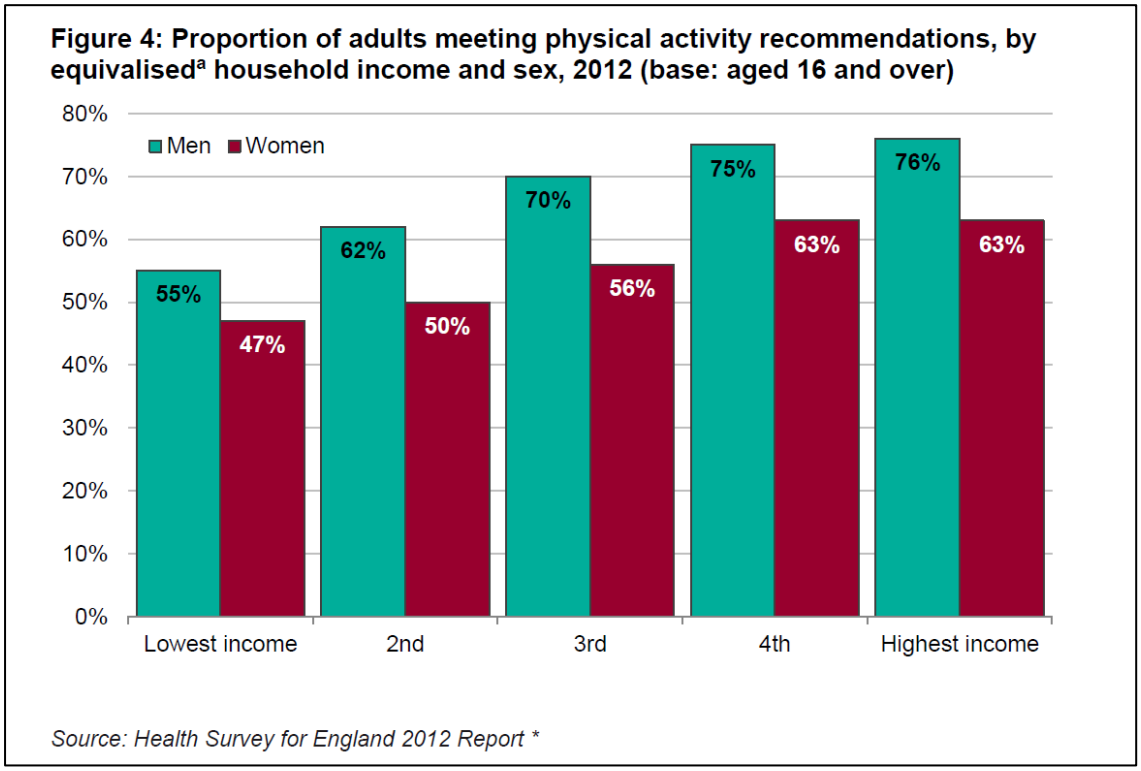
There are additional economic and social benefits of being active, for example a reduction in absenteeism, reduced health and social care costs.

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 year[8].

Inequalities and inactivity

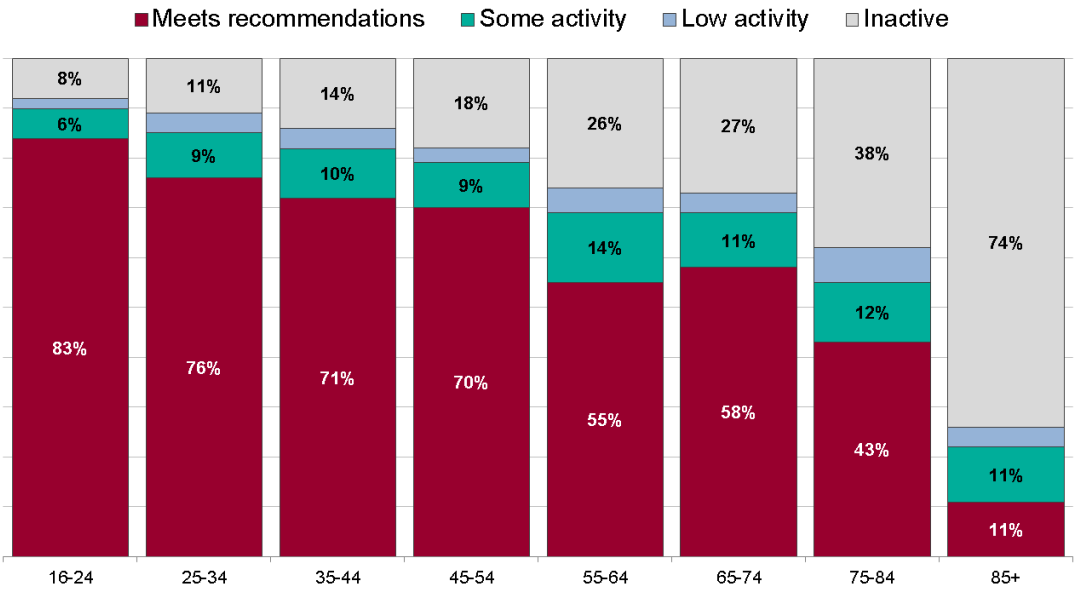
Physical activity levels are related to household income. Areas of high socio-economic deprivation are more likely to have higher levels of inactivity[9]. Supporting inactive groups provides the maximum financial return on investment and is the most effective means of narrowing health inequalities.

Figure 2.5.12



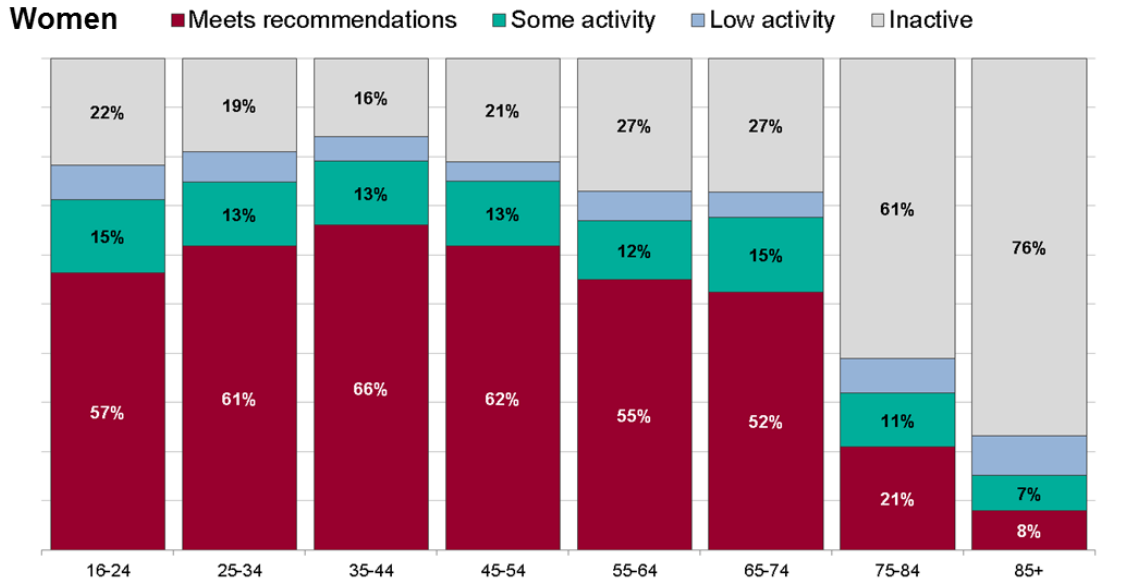
Participation declines with age.

Figure 2.5.13: Adult physical activity levels by age in males.



Meets recommendations: 150 minutes of MVPA per week **Some activity**: 60-149 minutes of MVPA per week
Low activity: 30-59 minutes of MVPA per week **Inactive**: less than 30 minutes of MVPA per week
MVPA is calculated as minutes of moderate intensity activity or double the minutes of vigorous intensity activity
Source: Health Survey for England 2012 (base aged 16 and over)

Figure 2.5.14: Adult physical activity levels by age in females.



Meets recommendations: 150 minutes of MVPA per week
Some activity: 60-149 minutes of MVPA per week
Low activity: 30-59 minutes of MVPA per week
Inactive: less than 30 minutes of MVPA per week

MVPA is calculated as minutes of moderate intensity activity or double the minutes of vigorous intensity activity

Source: Health Survey for England 2012 (base aged 16 and over)[11]

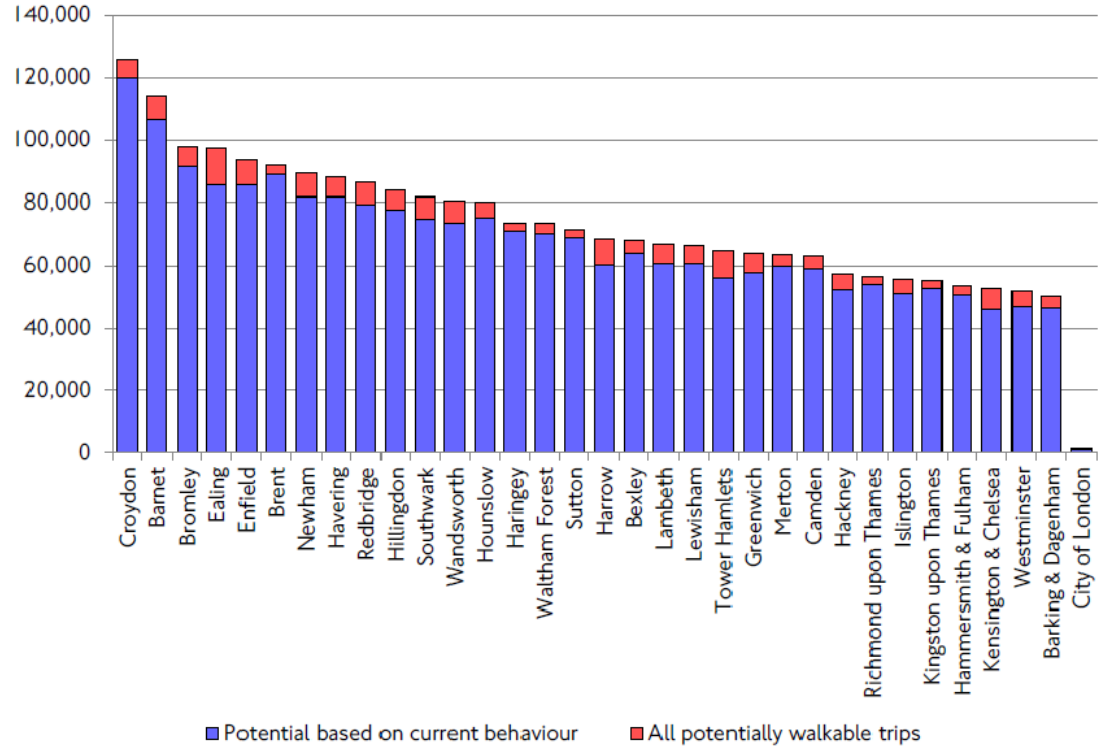
Some groups in society such as disabled people, older people and some ethnic minority groups are less likely to be active than others. Attracting the hardest to reach groups is challenging and requires specific, attractive, targeted interventions for these groups.

Active Environments

Walking is the most accessible form of activity and is the most likely way all adults can achieve the recommended levels of physical activity[10]. 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. In Bromley, walking accounted for 26.5% of all transport trips[11] 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 activity.

In 2015, Bromley residents made 184,600 walkable trips per day, plus there were an additional 97,800 trips that could have been reasonably walked but were made by car instead. Bromley have the third highest amount of trips currently driven that could have been walked[12].

Figure 2.5.15: Potential walkable trips per day per London borough in addition to daily walkable trips made



Source: LTDS 2012/13 – 2014/15

Car ownership is the strongest determinant of inactivity in London[13]. In outer London non-car owners are three times more likely to do 30 minutes of active travel per day than car owners. Bromley has the fifth highest percentage of households in London with access to a car (53%). Bromley has the fourth lowest public transport access level in London. So it is important to encourage active transport.

Environments must feel safe, attractive and engaging enough to entice people to walk. Transport for London's health policy research[14] sets out the 10 evidence-based indicators known to influence whether people choose to walk and cycle. Research evidences that streets need to:

- Have other people choosing to walk or cycle
- Have a diverse range of people out on the street
- Have shade and shelter
- Have places to stop and rest
- Have air that is perceived to be clean
- Have things to see and do
- Not be too noisy
- Be easy to cross
- Make people feel safe and relaxed

Across a town of 150,000 people, if everyone walked an extra 10 minutes a day, the HEAT model estimates. 31 lives could be saved, current value of £30m per year (Health economic assessment tools for walking and cycling).

Bromley's green and active environment contributes significantly to the active population. Bromley has the 2nd highest number of sports facilities per head, behind only Richmond which has a 50% smaller population and very low levels of deprivation. Bromley has the highest number of sports clubs per head in comparison to all other boroughs. Club membership is higher than the London average. 42.8% of residents are playing sport for 30 minutes at least once per week and 21.3% at least 3 times a week for a period of 30 minutes. This places Bromley in the top 10 boroughs for sports participation. Bromley is in the top 10 boroughs for the percentage of residents that participate in sport in the outside environment (31.6%). The percentage of residents using outdoor space for exercise or health reasons has increased from 4% in 2011 to 19% in 2015. Bromley currently has the 6th highest rate of outdoor participation amongst all London boroughs, with one of the fastest growing rates.

What this means for Bromley residents

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

Active transport has been cited as the most effective way to increase physical activity across the population and to help people who are inactive become active. Walking and cycling are important means of transport as well as recreational and sporting activities. Walking and cycling for everyday travel purposes enable people to build physical activity into their routine so they stay active every day without having to make a conscious effort to 'get fit'. Planning and infrastructure are the biggest determinants of encouraging people to undertake walking and cycling.

With one the highest number of sports clubs and facilities per person, Bromley must utilise this strength and concentrate supporting third sector organisations and community groups to deliver effective local programmes. Bromley has a network of 600 voluntary organisations, recruitment and retention of volunteers is imperative.

There is a need to.

- Encourage active transport in the borough ahead of car usage.
- Consider the impact of physical inactivity in regeneration and planning regulations.
- Prioritise and resource physical inactivity programmes to the same level as other top tier public health risks.

- Invest in evidence-based programmes that engage inactive groups.
- Deliver physical inactivity strategies independently of obesity and weight management.
- Support third section organisations and community groups to deliver effective local programmes. Continue to gather the evidence base for physical activity interventions as per the national standard evaluation framework[12].

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Children and Young People Healthy Weight and Physical Activity

Introduction

Primary prevention aims to prevent a problem before it occurs. Supporting families within the local population to keep children healthy is a fundamental objective for the London Borough Bromley.

The Chief Medical Officer illustrates a strong case for a shift to prevention in her Annual Report 'Our Children Deserve Better: Prevention Pays' (2012). Early intervention and preventive measures have a significant impact on health outcomes. Furthermore, improving the lives of children and young people brings significant economic benefits.

The evidence presented to date highlights that the life course approach matters (Marmot 2012). Evidence for the life course approach is strong; each stage of life affects the next. In particular, events in the early period of life have a profound effect on the future health and wellbeing of children and young people (CMO 2012). For example, we know that 79% of teenagers who are obese will go on to become obese adults.

Healthy Weight

The pattern of increase in obesity in England between 1995 and 2005 was similar among both younger and older children (aged 2-10 and 11-15 respectively). Since then, the proportions of older children who are obese have remained broadly steady. Among younger children, there was a slight dip in the proportion who were obese in 2012, but this has not been sustained.

Figure 2.5.15: Trend in the prevalence of obesity
Children aged 2-10 and 11-15 years, Health Survey for England 1995-2014

The National Child Measurement Programme (NCMP) measures the weight and

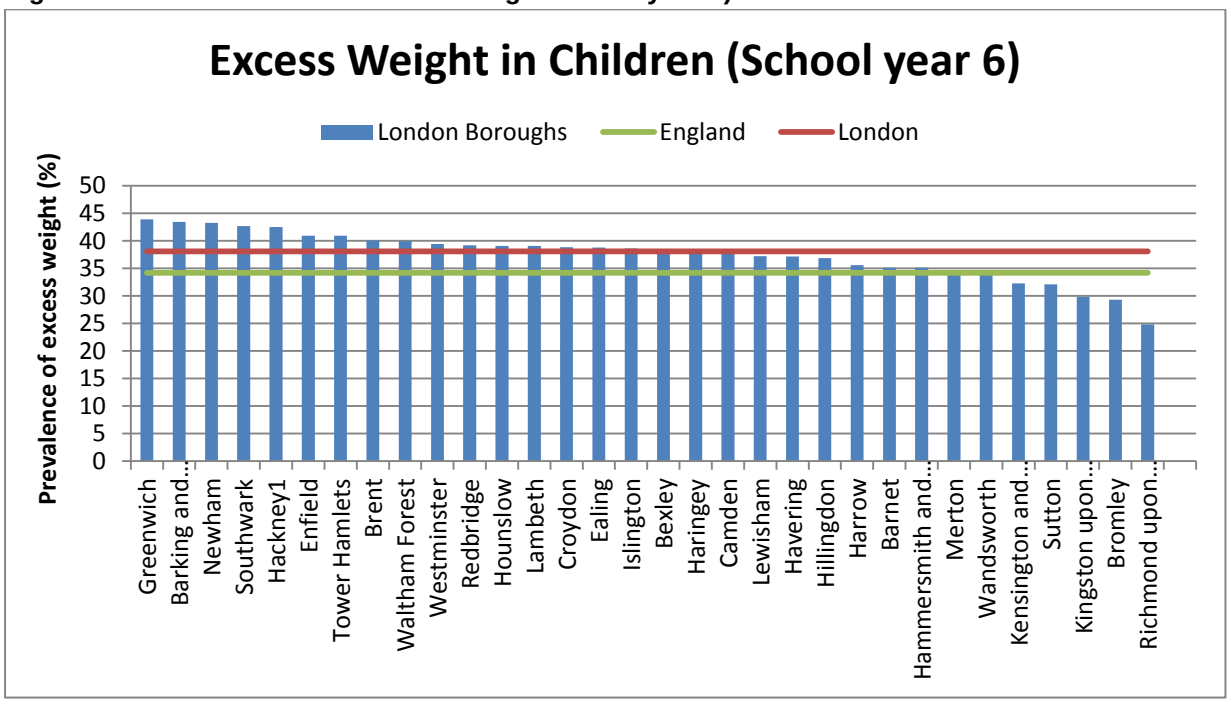
height of children in Reception class (aged 4 to 5 years) and Year 6 (aged 10 to 11 years). The programme has two key purposes:

1. To provide robust public health surveillance data on child weight status, to understand obesity prevalence and trends at local and national levels, to inform obesity planning and commissioning and underpin the Public Health Outcomes Framework (PHOF) indicator on excess weight in 4-5 and 10-11 year olds.

2. To provide parents with feedback on their child's weight status: to help them understand their child's health status, support and encourage behaviour change and provide a mechanism for direct engagement with families with overweight, underweight and obese children.

The PHOF indicators illustrate that obesity rates vary considerably across London. In the 2015-16 school year, for children in school year 6, the range was from 12.6% in Richmond upon Thames, to 28.5% in Barking and Dagenham. Bromley has the 2nd lowest childhood obesity rate in London at 16.0%.

Figure 2.5.16: Prevalence of excess weight school year 6)



Source: https://fingertips.phe.org.uk/profile/national-child-measurement-programme

Across London, and similarly in Bromley, the percentage of children who are obese

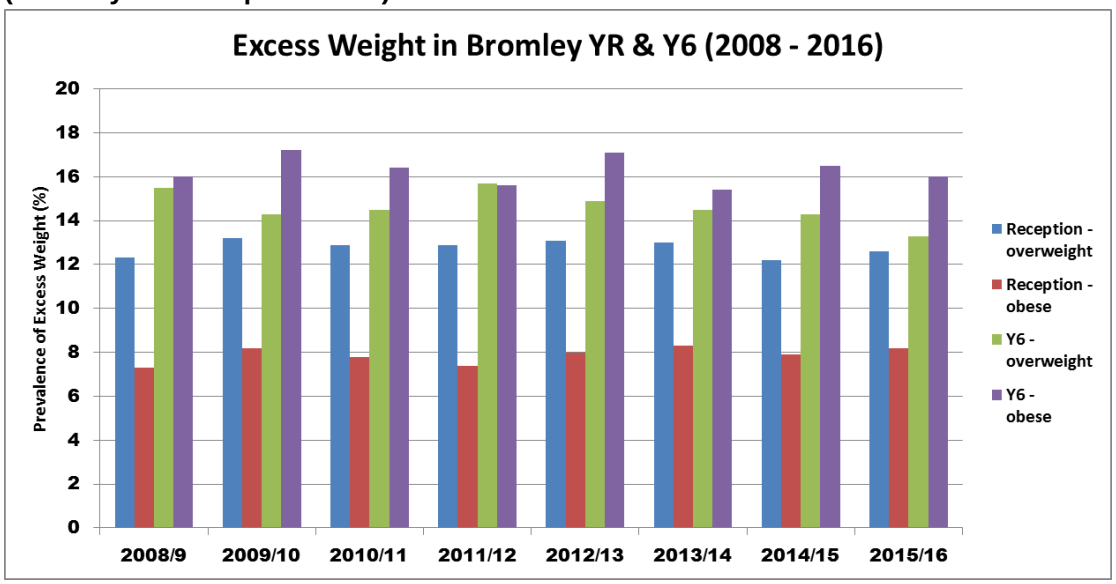
in their first year in primary school, doubles by the time they reach their final year in primary school. In the latest cohort in Bromley, 8.2% were obese in Reception, this increased to 16% by the time these children were in Year 6. In the last academic year, almost 21% of children in Reception and over 29% in Year 6 were either overweight or obese. This equates to 1,736 children in one year from Bromley schools.

Table 2.5.7 : NCMP data for overweight and obese children in Bromley

Year Group	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Reception: Overweight	12.3%	13.2%	12.9%	12.9%	13.1%	13%	12.2%	12.6%
Reception: Obese	7.3%	8.2%	7.8%	7.4%	8%	8.3%	7.9%	8.2%
Year 6: Overweight	15.5%	14.3%	14.5%	15.7%	14.9%	14.5%	14.3%	13.3%
Year 6: Obese	16.0%	17.2%	16.4%	15.6%	17.1%	15.4%	16.5%	16.0%

Source: https://fingertips.phe.org.uk/profile/national-child-measurement-programme

Figure 2.5.17: Trend in the prevalence of excess weight in Bromley (School year: Reception to Y6)



Source: https://fingertips.phe.org.uk/profile/national-child-measurement-programme

The prevalence of obesity is far more apparent in deprived wards in the borough. Household income data illustrates child obesity prevalence rises as household income falls, and is significantly higher in the lowest income group than in the highest.

Although the national trend in increasing childhood obesity appears to have halted, the current levels of childhood obesity represent serious long-term risks to health, in particular, childhood obesity poses a significant health inequality issue.

Breastfeeding

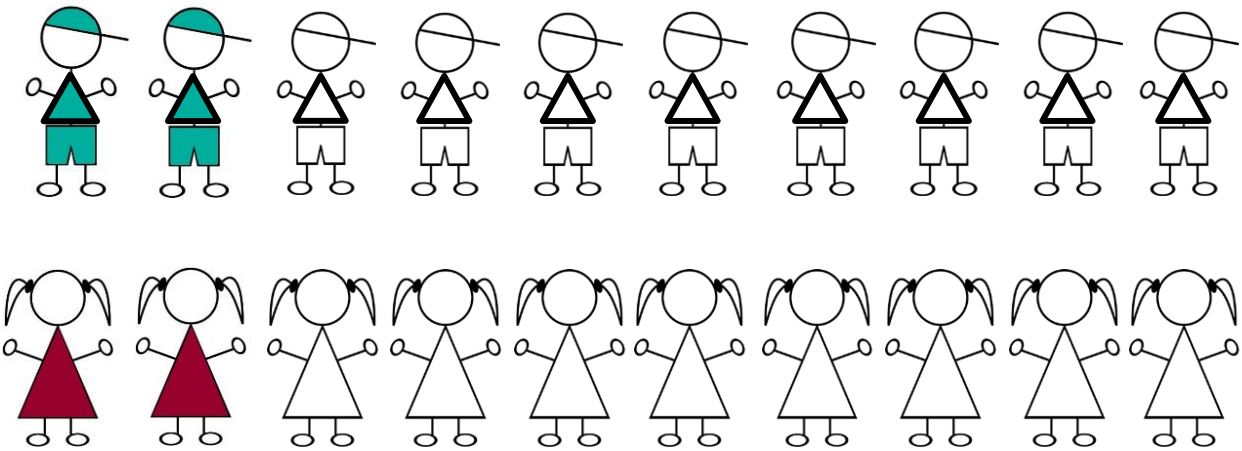
Increasing evidence points to the possible impact of interventions targeting early life, such as in utero and infancy, including breastfeeding (CMO 2012).

The benefits of breastfeeding are well documented. One important health benefit of breastfeeding is prevention of obesity. Experimental statistics about breastfeeding prevalence at 6-8 weeks, Q1 (April to June) 2016/17 were recently published. The feeding status of 86% of Bromley infants aged six to eight weeks was known, 52% either partially or fully breastfed at 6 – 8 weeks.

Physical Activity

Figure 2.5.18. : Physical activity among children - Health Survey for England 2012

Around two in ten children aged 5-15 years meet the government recommendations* for physical activity (boys 21%, girls 16%)



*HSE reports at least 60 minutes of moderate to vigorous activity on all seven days in the last week. Though it is stated specifically that this is a minimum and that children and young people should engage in moderate to vigorous physical activity for up to several hours each day and undertake vigorous intensity activity, including muscle- and bone-strengthening activities, at least three days each week.

Physical activity rates amongst children and young people in Bromley

- The percentage of 15 year olds physically active for at least one hour per day seven days a week is 12.1%. This in line with the average rates across London

- 69.9% of 15 year olds in Bromley have a mean daily sedentary time in the last week of over seven hours per day.

Active Travel

Active travel supports a whole system approach, recognising that opportunities for everyday physical activity for young people and families are key to tackling obesity. Adult and family cycle training ('Bikeability') is facilitated by Bromley's Road Safety Team. Support is offered to absolute beginners who have never ridden a bike before to people that need to build bike-handling skills appropriate to their level of experience. Cycle training is offered through the schools too, various modules are available based on children's skill level and their age.

Table 2.5.8. : Active Travel Bromley - summary of activity

Initiative	**Participating numbers**
STARS Travel Plan (Sustainable Travel: Active, Responsible, Safe), includes cycle & scooter training	88 schools
Junior & Youth Travel Ambassadors	43 (110 pupils trained as Junior travel Advisors) 12 (79 trained Youth Travel Ambassadors).
Cycle Training – trained to Bikeability Level 1, 2 & 3	1,600 pupils from primary and secondary schools
Smart Movers - children who travel in a 'smart' way 10 times per month (scooter, walking, cycling, park/walk) receive a badge each month	20 schools participating, approximately 5,500 children per month
Other events include: • Walk to school week, promoting walking • Cyclist of the year • Biking breakfast, students that cycle are rewarded with a free healthy breakfast	

Healthy Schools

In Bromley, 80% of schools are currently participating in the Healthy Schools Scheme. HSL is an awards programme that all London schools can choose to participate in to improve children and young people's health and well-being. Bromley has one of the highest participation rates in the programme of all London boroughs.

Since 2013, twenty eight Satellite Sports Clubs have been established in Bromley secondary schools, this number is above the London average. Satellite Clubs are extensions of community sports clubs that link with a secondary school and aim to offer opportunities to underrepresented groups to participate in physical activity.

Since 2012, the aim of Bromley's School Games Organisers is to harness the legacy of the Olympic and Paralympic Games and use the Bromley's School Games as a vehicle to inspire more young people to participate in competitive school sport across the borough. Participation of Bromley schools in the School Games is above average.

Table 2.5.9: Bromley School Games Participation Spring & Summer 2016

	Bromley	Average for London
Number of Schools competing (Level 2 & Level 3)	109	87
Number of Schools eligible to compete	111	84
Number of Participants at Level 2	3684	3206
Number of Teams at Level 2	386	356

What this means for Bromley residents and the children in Bromley

The percentage of children who are obese in their first year in primary school, doubles by the time they reach their final year in primary school. Obese young people are more likely to become obese adults, excess weight contributes significantly to the incidence and progression of diseases.

The prevalence of obesity is far more apparent in deprived wards in the borough. Obesity is significantly higher in the lowest income group than in the highest. So targeted outreach work should prioritise those areas most at risk.

3. Domestic Violence

Introduction

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

The reported Domestic Abuse and Sexual Violence incident rate in Bromley from July 2015 to June 2016 was 15 victims per 1000 of the local population, this equates to roughly 4800 victims of these 2480 were domestic abuse offences. A high number of domestic violence incidents remain unreported and nationally 1 in 4 women will experience domestic violence in their lifetime.

This section has a focus on the needs of women and girls due to the disproportionate impact of VAWG crimes on women and girls. A 2009 study based on police reports, which looked at the dynamics of domestic violence, found that only 5% of domestic violence incidents were perpetrated by women in heterosexual relationships. This does not mean that men are never victims of domestic violence, rape or forced marriage nor that women are not occasionally the perpetrator.

Forms and Definitions of Violence Against Women and Girls

The UN defines violence against women as "any act of gender-based violence that is directed at a woman because she is a woman or acts of violence which are suffered disproportionately by women." This includes physical, sexual and psychological/emotional violence, economic abuse and sexual exploitation. VAWG can take place at home, work or in public places such as on the street or public transport.

The following are all forms of violence against women and girls:

- Domestic violence and abuse
- Female Genital Mutilation (FGM)
- Forced marriage
- 'Honour'-based violence
- Prostitution and trafficking
- Sexual violence including rape

- Sexual exploitation
- Sexual harassment
- Stalking
- Faith-based abuse

Domestic Violence/Abuse - Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

The introduction of the Serious Crime Act 2015 section 76 recognised the offence of controlling or coercive behaviour in intimate or familial relationships and as such is now a criminal offence that can carry a custodial sentence.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten the victim.

Female genital mutilation (FGM) - FGM involves the complete or partial removal or alteration of external genitalia for non-medical reasons. It is mostly carried out on young girls at some time between infancy and the age of 15. Unlike male circumcision, which is legal in many countries, it is now illegal across much of the globe, and its extensive harmful health consequences are widely recognised.

Forced marriage - A marriage conducted without valid consent of one or both parties, where duress is a factor.

'Honour'-based violence - HBV is violence committed to protect or defend the 'honour' of a family and/or community. Women, especially young women, are the most common targets, often where they have acted outside community boundaries of perceived acceptable feminine/sexual behaviour. In extreme cases, the woman may be killed.

Prostitution and trafficking - Women and girls are forced, coerced or deceived to enter into prostitution and/or to keep them there. Trafficking involves the recruitment, transportation and exploitation of women and children for the purposes of prostitution and domestic servitude across international borders and within countries 'internal trafficking'.

Sexual violence including rape - Sexual contact without the consent of the woman/girl. Perpetrators range from total strangers to relatives and intimate partners, but most are known in some way. It can happen anywhere – in the family/household, workplace, public spaces, social settings, during war/conflict situations.

Sexual exploitation - Involves exploitative situations, contexts and relationships where someone receives 'something' (e.g. food, drugs, alcohol, cigarettes, affection, protection money) as a result of them performing, and/or another or others performing on them, sexual activities. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the person's limited availability of choice resulting from their social/economic and/or emotional vulnerability. Girls involved in or connected to gangs are at risk of sexual exploitation by gang members.

Sexual harassment - Is unwanted verbal or physical conduct of a sexual nature. It can take place anywhere, including the workplace, schools, streets, public transport and social situations. It includes flashing, obscene and threatening calls and online harassment.

Stalking - Repeated (i.e. on at least two occasions) harassment causing fear, alarm or distress. It can include threatening phone calls, texts or letters; damaging property; spying on and following the victim.

Faith-based abuse - Child abuse linked to faith or belief. This includes a belief in concepts of witchcraft and spirit possession, demons or the devil acting through children or leading them astray (traditionally seen in some Christian beliefs), the evil eye or djinns (traditionally known in some Islamic faith contexts) and dakini (in the Hindu context); ritual or muti-murders where the killing of children is believed to bring supernatural benefits or the use of their body parts is believed to produce potent magical remedies; and use of belief in magic or witchcraft to create fear in children to make them more compliant when they are being trafficked for domestic slavery or sexual exploitation.

Domestic Violence – A National Profile

Information about domestic violence and violence against women and girls is largely focused on domestic violence and mostly linked to Police reporting.

Domestic Violence and abuse are experienced by adults and children from all backgrounds, and many domestic incidents remain unreported and often result in devastating consequences for long-term mental and physical health. Domestic Violence/Abuse crosses all ethnicities, sexual orientations, class and age, with the impact of abuse on the elderly and those with complex and multiple needs often poorly reported. Nationally, violent crime figures show that despite a long downward trend in violent crime, domestic abuse remains a widespread problem which affects more than 8.5% of women and 4.5% of men every year. Two women are killed every week in England and Wales by a current or former partner.

Domestic Abuse costs society an estimated £15.7 billion per year. Domestic abuse has a significant impact on a wide range of services including housing, criminal justice and social services provision. In England the estimated total costs of domestic violence are £5.419bn which comprises:

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

The Office of National Statistics 2013/2014 states that:

- There were 8.5% of women and 4.5% of men who reported having experienced any type of domestic abuse in the year 2013/2014 (that is, partner / ex-partner abuse(non-sexual), family abuse (non-sexual) and sexual assault or stalking carried out by a current or former partner or other family member). This is equivalent to an estimated 1.4 million female victims and 700,000 male victims.
- There were 6.8% of women and 3.0% of men who reported having experienced any type of partner abuse in the last year, equivalent to an estimated 1.1 million female victims and 500,000 male victims.

- Overall, 28.3% of women and 14.7% of men had experienced any domestic abuse since the age of 16 years old, equivalent to an estimated 4.6 million female victims and 2.4 million male victims.
- Among both men and women intimate violence was higher for younger age groups. Women aged between 16 and 19 years and between 20 and 24 years were more likely to be victims of domestic abuse (11.3% and 12.5% of the respective population) compared with those aged

between 45 and 54 years and between 55 and 59 years (4.7% and 2.7% respectively).

- Women were more likely than men to have experienced intimate violence across all headline types of abuse asked about. For example, 2.2% of women and 0.7% of men experienced some form of sexual assault (including attempts) in the last year.

Research by the NSPCC highlights the impact of domestic abuse on children living in the family, with 1 in 5 children witnessing domestic abuse. A third of children witnessing domestic abuse also experience another form of abuse. SafeLives estimate that 62% of children living with domestic abuse are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others. There is a growing amount of research that highlights the long term effects of domestic abuse on children, this includes aggressive, anti-social, fearful and/or inhibited behaviour. As a result, young people that witness abuse in the home are more likely to develop long term problems such as depression, trauma related symptoms and be violent in their own adolescent and adult relationships.

The abuse of children often starts prior to them even being born. The Department of Health in 2004 reported that, in 30% of cases, domestic violence either starts or will intensify during pregnancy. Domestic abuse has been identified as a prime cause of miscarriage or still birth.

In March 2013 the Home Office introduced a new official definition of domestic violence, this was expanded to include 16 to 17-year-olds.

Older victims of domestic violence experience abuse for twice as long as those aged 61 years and under. Nearly half have a disability yet older victims are hugely under represented among domestic abuse services. In research conducted by SafeLives they found that older victims are less likely to attempt to leave in the year before accessing help and more likely to be living with the perpetrator after getting support. Research shows that:

- Only 27% of older victims will attempt to leave in the year before accessing help compared to the 68% of those under 60 years of age.
- 32% of older victims will continue to live with the perpetrator after getting support compared to 9% of those under 60 years of age.
- 48% of older victims also have a disability for a third of those, this is a physical disability.
- Victims aged 61 years and over are far more likely to experience abuse from an adult family member (44%) than those under the age of 60 years (6%).

Statistics from the Crown Prosecution Service provided the number of domestic violence cases referred to the CPS by the Police, the number of prosecutions and the number of convictions. The latest statistics show:

- Over 88,000 cases were referred to the CPS by Police, Around 65% were charged
- 93% of defendants were men
- Domestic abuse-related crime forms 8% of total crime, and 11% of all sexual offences, 33% of all recorded assaults with injury, and 49% of all recorded harassment crimes in England and Wales
- In 2013-14, there were 78,000 prosecutions for domestic abuse offences. The conviction rate for domestic violence offences in England and Wales was 75%
- 64% of all harassment and stalking prosecutions and 77% of all restraining order breaches in England and Wales in 2013-14 were domestic violence related

(*Source: CPS, Violence against Women and Girls crime report 2012-2013, July 2014*)

Multi Agency Risk Assessment Conference

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

Data from the pan London domestic violence needs assessment Report 2016 shows that, across London, the number of referrals to MARAC has risen annually since 2014, from 6,995 referrals to 9,919 in December 2015. In 2015 all 33 local authorities held at least one MARAC meeting per month with an average of 310 cases discussed per borough indicating a rise in MARAC referrals. Referrals to MARAC are an indication of the need across London for high risk support.

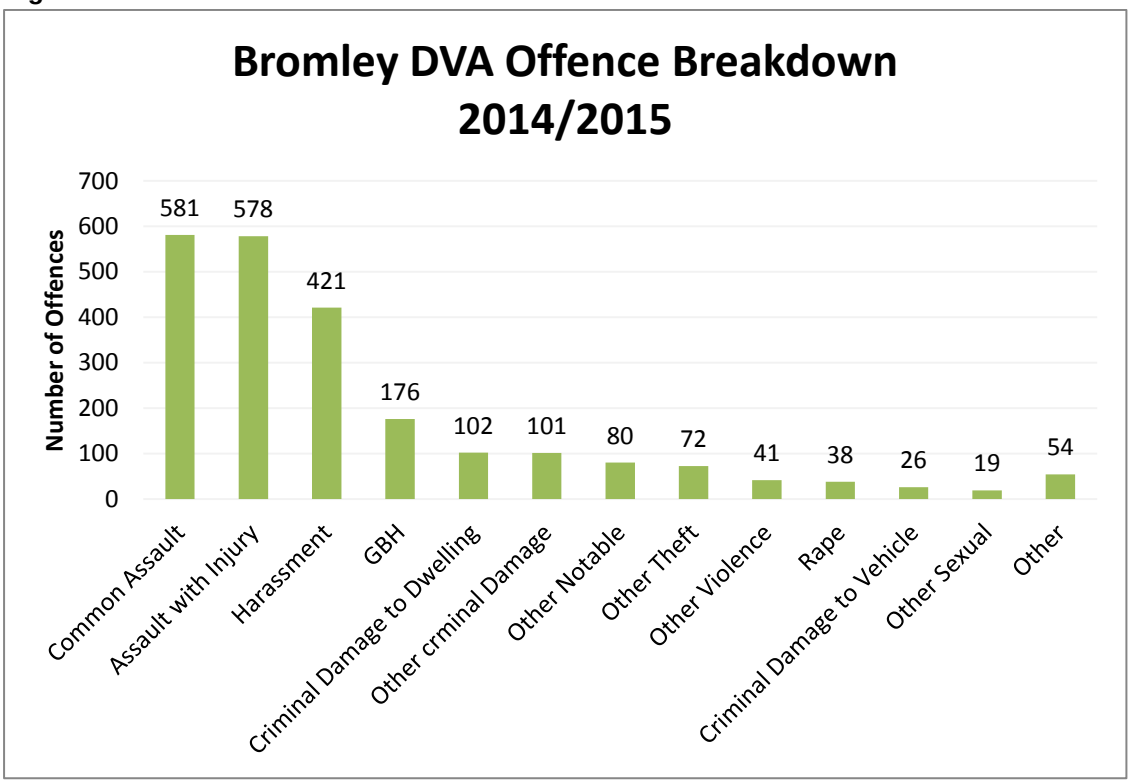
Bromley Offences, Victim and Suspect Profiles

Our statistics and data on the wider issues of violence against women and girls in Bromley is very limited at this time and one of our recent key actions was to ensure that we had robust mechanisms in place to capture a wide range of data to enable accurate mapping of the prevalence of VAWG in Bromley and implement modifications to our VAWG services if needed.

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

The tables below provide basic demographic information on domestic violence/abuse offences and victim and perpetrator information.

Figure 3.1



Source: Metropolitan Police Service 2014/15

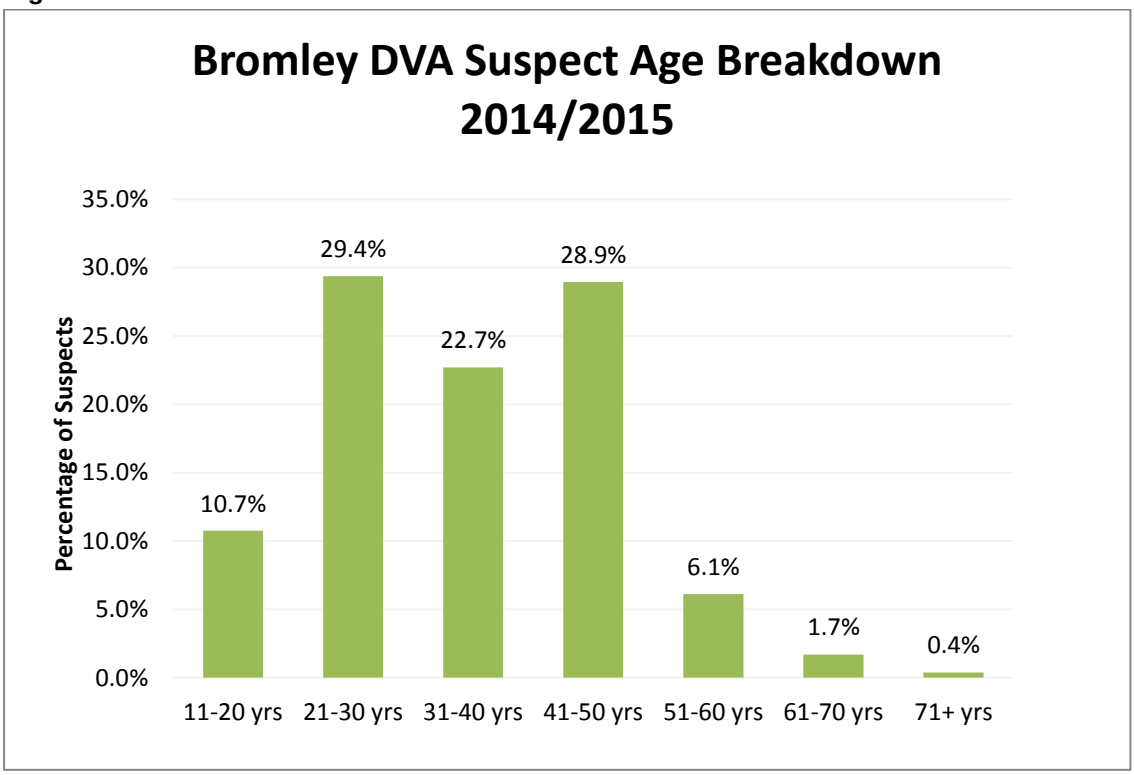
Data supplied by Bromley Metropolitan Police Service (MPS) for the year 2014/2015 shows that of the 2,289 reported offences:

- 581 offences were Common Assault
- 578 offences were Assault with injury
- 176 of grievous bodily harm
- 41 Offences recorded as other violence

Over 60% of all offences recorded by the MPS in Bromley were physical offences with 12.7% of those being of the more serious offence of grievous bodily harm.

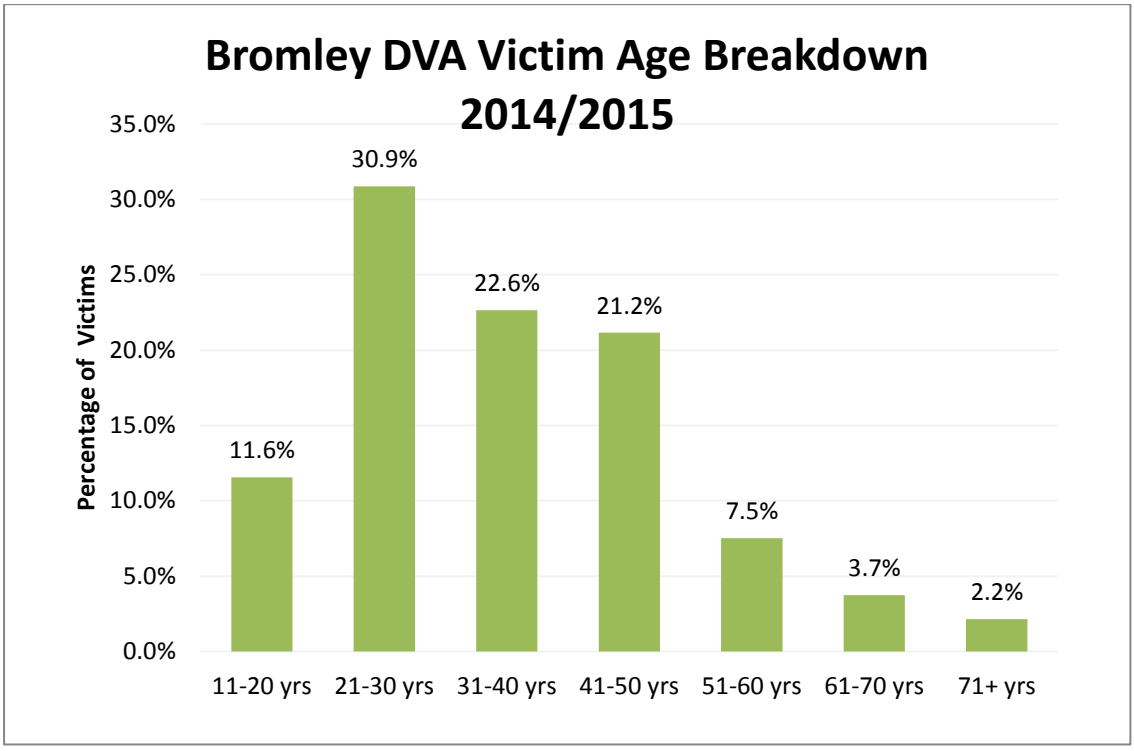
There were 421 cases of harassment recorded in the year 2014/2015 and account for just over 18% of the recorded domestic violence/abuse cases for Bromley MPS.

Figure 3.2



Source: Metropolitan Police Service 2014/15

Figure 3.3



Source: Metropolitan Police Service 2014/15

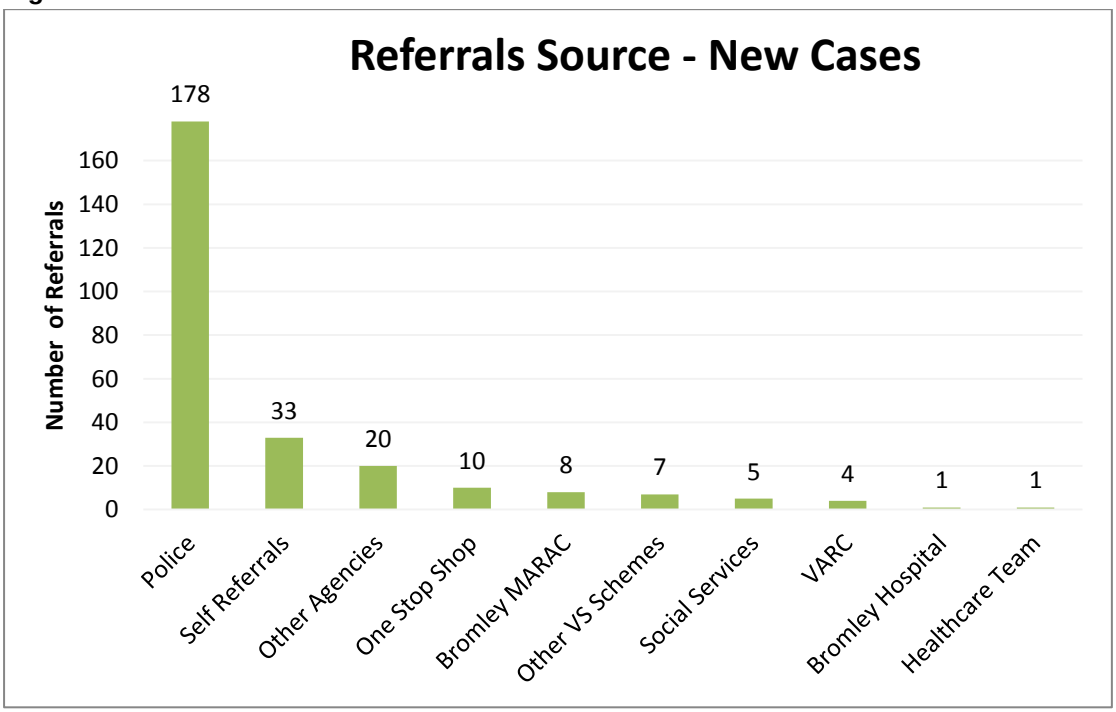
Data supplied by Bromley Metropolitan Police shows that the highest numbers of suspects are in the age range of between 21 and 30 years old (32%) this mirrors the highest victim age range of between 21 and 30 years old (30.7%). This trend follows through from age 11 years to age 60 years.

The Independent Domestic Abuse Advocacy Project has 2 full time Independent Domestic and Sexual Violence Advisors (IDSVAs) placed within the Bromley Metropolitan Police Community Safety Unit and 1 full time Community IDSVA. The Domestic Abuse Advocacy Project increases victim safety and works to improve conviction rates for domestic abuse crimes by providing dedicated support, advocacy and advice to victims from their first point of contact with the police and to victims in the community. Data supplied by the Domestic Abuse Advocacy Project for the period 2015/2016 shows that:

- The Bromley Domestic Abuse Advocacy Project received 297 new referrals of whom a total of 267 engaged with the service.
- 89% were identified as medium risk and 11% were defined as at high risk and were eligible for the multi agencies risk assessment conference (MARAC).
- 97% of service users accessing the service were female.

The IDSVA service received referrals from 14 different organisations. The majority of referrals were from Bromley Police, which reflects the fact that two of the three IDSVAs in Bromley currently deliver the service from Bromley Police Station.

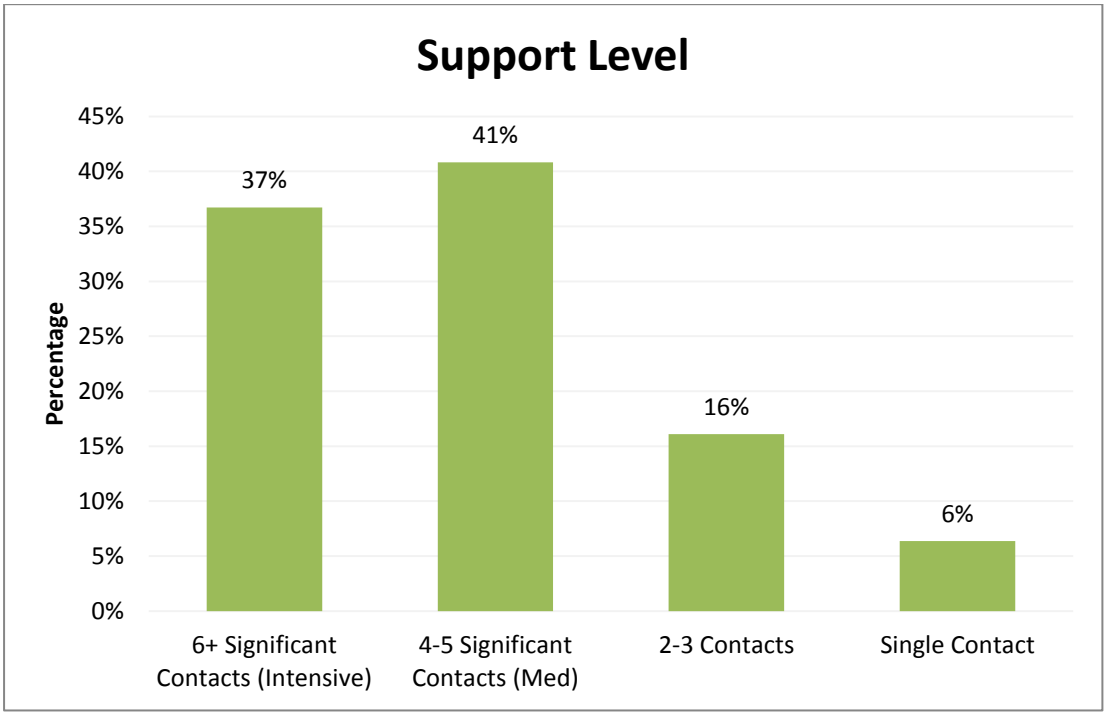
Figure 3.4



Source: Victim Support Bromley Domestic Violence Annual Report 2015-16

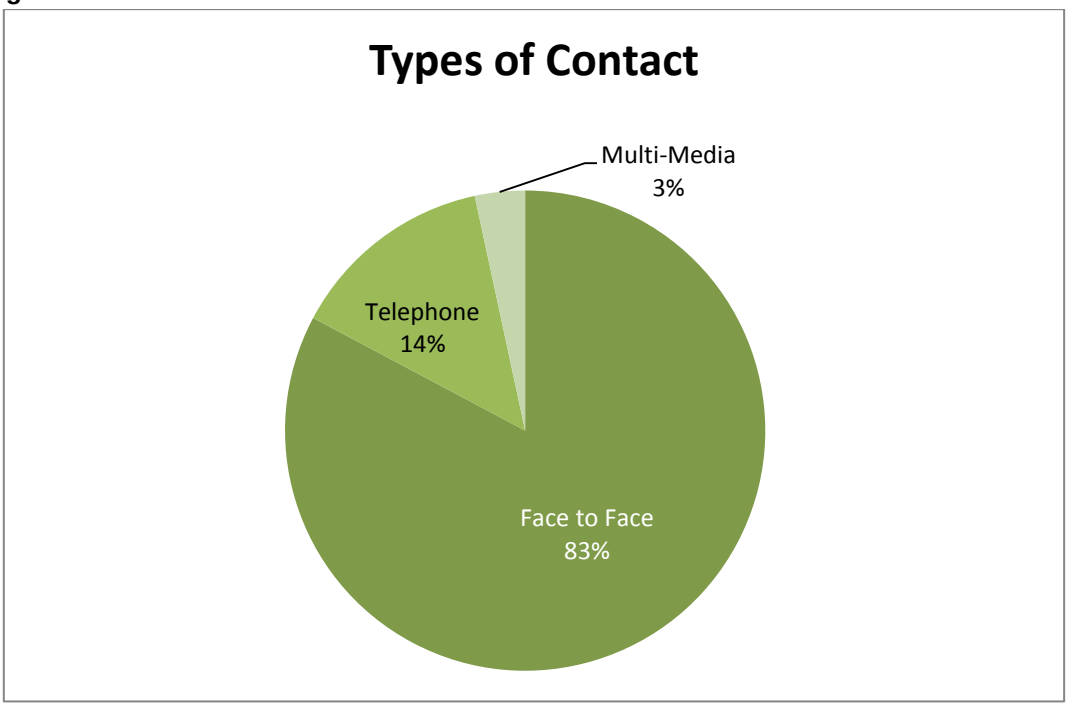
The three IDSVAs in Bromley have supported 267 victims, including 5 men. 78% of victims required more than 4 sessions of support and 37% required even more intensive support. The chart below details the type of contact for all 267 clients and the majority of contacts were face to face support (83%).

Figure 3.5



Source: Victim Support Bromley Domestic Violence Annual Report 2015-16

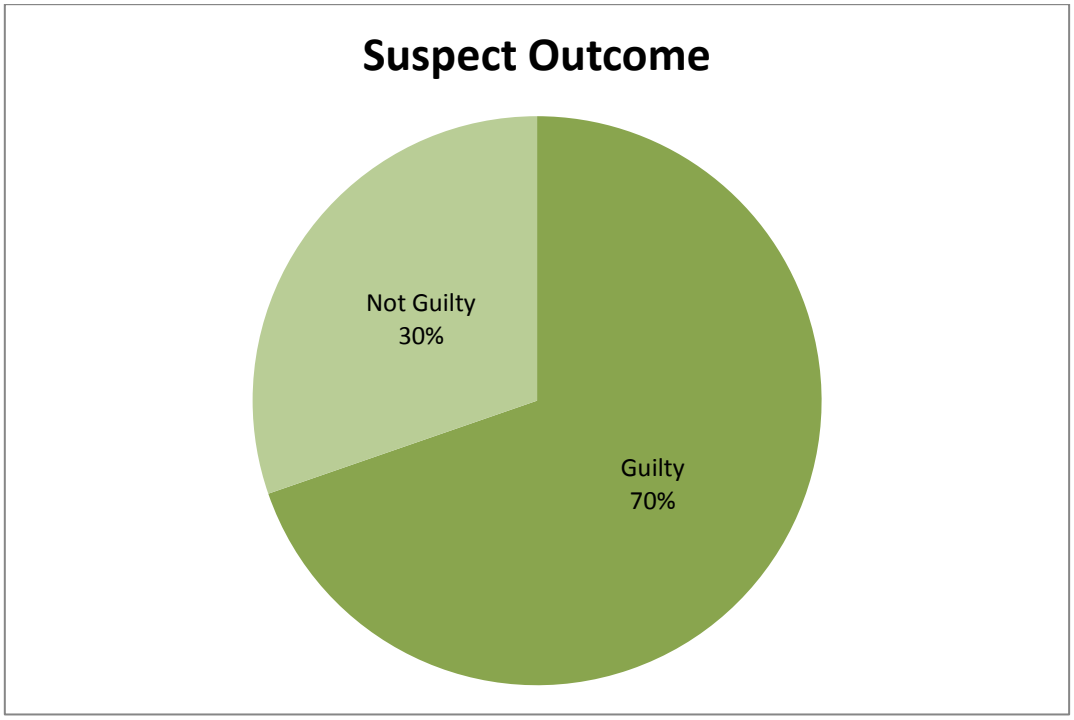
Figure 3.6



Source: Victim Support Bromley Domestic Violence Annual Report 2015-16

During the period April 2015 to March 2016 the IDSVA project supported 33 victims in court. Of the total cases that went to court 23 were found guilty and 10 not guilty. The project therefore contributed to achieving a 70% guilty rate.

Figure 3.7



Source: Victim Support Bromley Domestic Violence Annual Report 2015-16

The IDSVAs are also present at the Bromley One Stop Shop. The One Stop Shop (OSS) is a project that is run by Bromley Women's Aid and is a free and confidential service for victims and survivors of domestic abuse. In the year 2015-16 the One Stop Shop provided access to multi agency advice for 315 female and male victims of domestic abuse. The OSS has now made it possible for clients unable to attend in person to access support and advice via telephone and email. The OSS has proved to be a crucial as a first point of contact to accessing further support and advocacy.

Support for Children and Young People

The Bromley Children's Group Work Programme has been supporting children who have witnessed domestic violence and abuse against their mother in the London Borough of Bromley since September 2014. Specific groups are offered based on the ages of the children requiring support. Groups are also offered to mothers who have experienced domestic violence and abuse.

Since September 2014 there have been 545 attendances at the Children's Group Work Programme relating to 81 individuals. 343 of these attendances related to 52 individual children.

Table 3.1

Year and Calendar Quarter	Number of Attendances
2014 Q3	20
2014 Q4	53
2015 Q1	160
2015 Q2	95
2015 Q3	55
2015 Q4	95
2016 Q1	67
Total	**545**

Of the 29 mothers that have attended the Children's Group Work Programme, 72% felt that their child's behaviour had improved.

DVIP Perpetrator Programme

The Domestic Violence Intervention Project (DVIP) is a 26 session group work programme for perpetrators delivered in various boroughs across London and the Home Counties. The programme is not an anger management or counselling group. It is specifically designed to address intimate partner violence, drawing upon a wide range of approaches. DVIP's facilitators work to create a safe but challenging environment whilst offering support for personal change. They address issues of masculinity, sexual respect, the instrumental and systematic nature of intimate partner violence, and intimacy to name but a few.

The DVIP perpetrator programme has been operating in Bromley since May 2015. Due to the length of the programme data will need to be collected over a long period of time to evaluate the projects impact in Bromley.

DVIP's primary aim is to increase the safety and well-being of women and children affected by domestic abuse. Therefore they will not work with perpetrators unless DVIP have the opportunity to support the relevant partners or ex-partners of those individuals.

The Mirabal research project, a five year study led by Professors Liz Kelly and Nicole Westmoreland carried out the most extensive investigation undertaken in the UK into the efficiency of domestic violence perpetrator programmes. Their research concluded that most men who complete Respect accredited perpetrator programs:

- stopped using physical and sexual violence,
- strongly decreased use of coercion, control and other forms of abuse,
- take responsibility for the abuse and its impact,
- learn how to be non-abusive in intimate relationships,
- Understand the impact of their abuse on their children.

Statistics provided by DVIP perpetrator programme for the year 2015 showed that:

- There had been a 50% increase in referrals across London and the Home Counties.
- 89% of men said that the programme had been very useful in making positive relationship changes.
- 93% of women experienced no further physical violence since their partner started the programme
- 77% of women reported that they and their children were much safer.

What this means for adults and children in Bromley

Data from MOPAC (the Mayor's Office for Police and Crime) show that between June 2015 to June 2016 there were 2480 reported domestic violence offences in Bromley.

Women are more commonly affected by domestic violence than men with an estimated 1 in 4 women in England and Wales experiencing domestic violence in their lifetime. Two women are killed every week in England and Wales by a current or former partner as reported by the Crime Survey of England and Wales for the year 2013/2014.

Only 35% of domestic violence incidents are reported to the police (Stanko, 2000 & Home Office, 2002).

All age groups are affected by domestic violence including children and older people, although the highest percentage of victims is in the 21-30 year age group.

In Bromley the majority of domestic violence cases are identified and referred to the IDSVA service by the police and over 60% of all reported incidents relate to physical offences.

There is a need for increased education and awareness of domestic violence and the domestic violence services available in Bromley. Community engagement and public awareness campaigns will delivered as part of the Bromley VAWG strategy.

4. Housing and Homelessness

Introduction

Homelessness affects many different types of people and groups, from single adults to children and families. It can be caused through personal circumstance, such as a relationship breakdown, domestic violence, accumulation of debt or child abuse. Homelessness can also be attributed to external environmental factors such as a lack of affordable housing, difficult housing market conditions and a strained economic climate with related effects on welfare, poverty and unemployment. These personal and environmental factors are often interlinked[3].

This section looks at:

- The importance of including homelessness in the JSNA.
- What homelessness looks like in Bromley
- The relationship between homelessness and the housing market
- Key findings from Bromley's homeless health needs audit of single homeless people in the borough.

4.1 What is homelessness?

In England, homelessness is legally defined as a person who has no home in the UK or anywhere else to occupy. This includes people living in temporary accommodation, those housed in property that could be damaging to their health, those who cannot afford their current accommodation, people facing eviction and rough sleepers[4].

Homelessness tends to be considered in two ways: 'statutory' and 'non statutory'. Statutory homelessness refers to homeless people for whom the local authority has a duty to find accommodation. These are described as households deemed to be homeless, eligible and in 'priority need'. Most often 'priority need' refers to adults with dependent children and/ or households with a vulnerable member, such as someone with a disability or someone who has recently left prison.

'Non statutory homelessness' is often referred to as the single homeless i.e. people who find themselves with no stable accommodation but also have no dependents. They are legally entitled to advice rather than accommodation

[3] *Preventing homelessness to improve health and well-being (Homeless Link, 2015)*
[4] *Preventing homelessness to improve health and well-being (Homeless Link, 2015)*

support. This definition also includes non-UK nationals whose immigration status renders them ineligible for acceptance as statutorily homeless[5].

Rough sleepers may fall into either category. Rough sleepers are often the most visible form of homelessness, but can also be difficult to identify as they may not present themselves to the borough for support. They could be sleeping in the open or in other areas not designed for habitation.

Why include homelessness in the JSNA?

The JSNA describes the health and well-being of the local community to help consider how best their needs can be met through the commissioning of services. People who are or are at risk of experiencing homelessness are very important to include in this assessment for a number of reasons as set out below:

a) Health inequalities

Understanding the size and needs of Bromley's homeless population supports the JSNA to meet its duty under the Health and Social Care Act 2012 to describe the health inequalities that exist in its local area, which then inform relevant action[6].

Homeless people experience some of the worst health outcomes in our society. The life expectancy of someone who sleeps rough can be as low as 42 years compared to an average life expectancy of 83 years in Bromley. In terms of health and well-being, homeless people have far greater physical and mental health needs than the general population[7]. A Homeless Link health audit of 2,500 homeless people found that 41% of homeless people have a long term physical health problem and 45% a diagnosed mental health problem. This compares with 28% and 25% respectively for the general population. A recent study on the respiratory health needs of homeless people cited that 64% of participants who had slept rough reported chest infections, 11% had suffered from pneumonia and, for all conditions surveyed, the longer a participant had spent homeless or in unstable accommodation the higher the likelihood they had a diagnosed condition[8]. Homeless people

[5] Mayor of London Health Inequality Strategy Delivery Plan 2015-2018 Indicator Report (GLA, 2015) https://www.london.gov.uk/sites/default/files/mayors_his_delivery_plan_indicator_report_final.pdf

[6] Mayor of London Health Inequality Strategy Delivery Plan 2015-2018 Indicator Report (GLA, 2015) https://www.london.gov.uk/sites/default/files/london_health_inequalities_strategy_delivery_plan_2015-2018.pdf

[7] Alcott, L Albanese, F and Hutchinson, S (2014) *Needs to Know: Including single homelessness in Joint Strategic Needs Assessments* Homeless Link and St Mungo's Broadway http://www.mungosbroadway.org.uk/homelessness/publications/latest_publications_and_research

[8] *Room to Breathe* (Groundswell, 2016) http://groundswell.org.uk/room-to-breathe/

are also likely to have a dual diagnosis, for example a mental health condition as well as being HIV positive.

In terms of lifestyle behaviours, there are very high smoking rates amongst the homeless population in addition to high levels of alcohol consumption and regular drug use[9]. Homeless people are also likely to have a poor level of nutrition.

Communicable diseases such as TB and hepatitis are of significant concern amongst this population group, particularly among those living in hostels or on the streets. It is often harder to screen and treat homeless people for TB and hepatitis owing to a lack of fixed abode, chaotic lifestyle and a mistrust of statutory services. This poses particular challenges for identifying and treating Multi-Drug Resistant TB that requires careful monitoring of patients to ensure completion of treatment.

b) Access to services

As a result of poor health and well-being and lack of stability or social support, homeless people are high users of acute health services, such as Accident and Emergency. This has significant cost implications for the NHS, with the Department of Health estimating the homeless population's use of health care at £85m per year[10]. Greater use of primary care and community services could reduce these costs. However homeless people are also forty times less likely to be registered with a GP than the general population[11].

Evidence suggests that tailored healthcare support could be a more effective way of meeting the needs of the homeless population, both in terms of cost and outcomes[12]. Understanding the size and needs of Bromley's homeless population can help the borough assess how best to support this population through existing services or consider more effective ways, both in terms of access and cost. For example, by considering partnership working between the housing and health sector to target interventions such as health screening.

The homeless population will also be high users of other services, such as accommodation advice and employment support. Addressing homeless people's needs and ultimately supporting them into stable accommodation could free up the capacity of other borough services.

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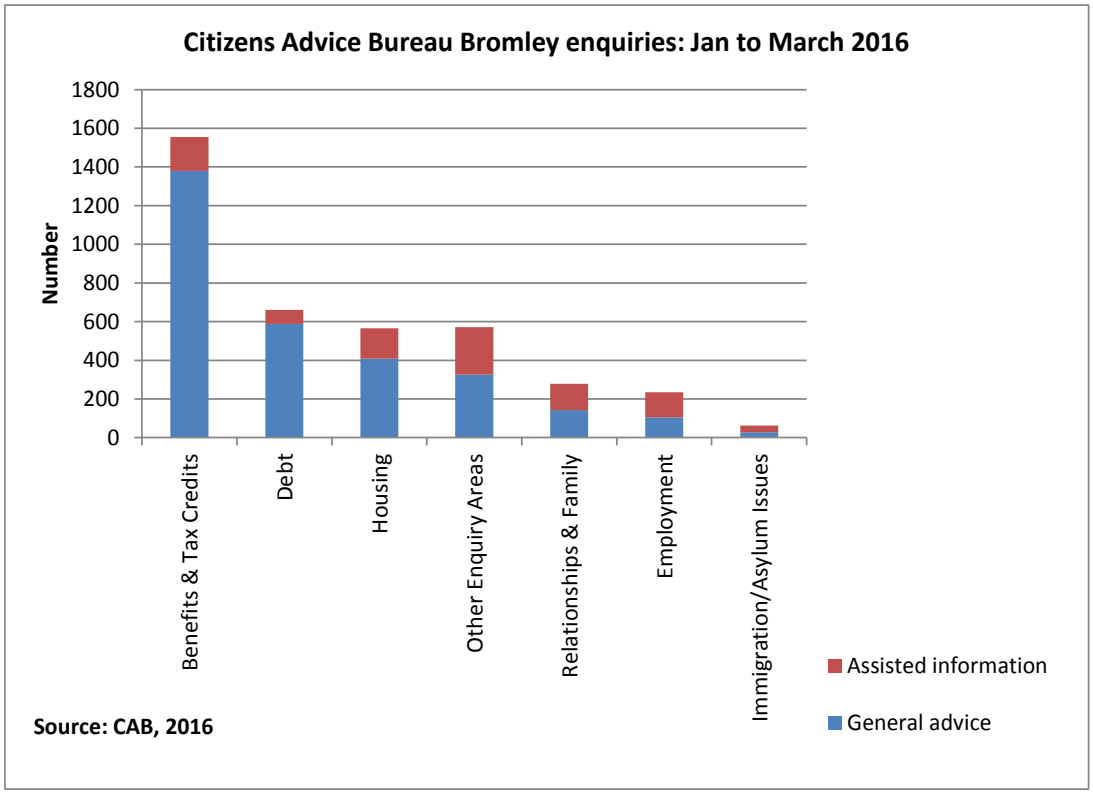
[9] *The unhealthy state of homelessness: Health audit results* (Homeless Link, 2014)
[10] *The unhealthy state of homelessness: Health audit results* (Homeless Link, 2014)
[11] Healthy London Partnership website https://www.myhealth.london.nhs.uk/healthy-london/about
[12] *No going back: Breaking the cycle of rough sleeping and homelessness (*London Assembly, 2014)

Figure 4.1.1 shows usage of Bromley's Citizens Advice Bureau (CAB) for the first quarter of this year. 1,717 cases were seen in total, with 14% of these relating to housing. However a client's housing situation will also be impacted by their income, relationships, employment and immigration status (all other categories listed by CAB for that quarter).

Figure 4.1.1



c) Good housing supports health

Housing is a wider determinant of health where providing decent, secure housing supports people to move on from homelessness, improves mental and physical well-being and can often lead to other opportunities to participate in society, for example through education, volunteering or employment. Early intervention by providing housing related support when required can prevent loss of accommodation and reduce the impact such experiences may have on people's health, such as increased anxiety and depression and reduced self-reliance.

Poor housing often has a detrimental impact on health. This not only affects the individuals involved, but also local services in terms of treatment and support. Recent research calculates that if £10 million could be invested in improving sub-standard housing in England the NHS would save £1.4 billion in first year treatment costs alone[13]. Additional research by the King's Fund

[13] Nicol, S, Roys, M, Garett, H *The cost of poor housing to the NHS* (BRE, 2015)

and the new NHS alliance highlights the role housing associations can play in reducing NHS costs by supporting people's well-being[14]. For example domestic violence prevention work and drop in support for older residents.

Table 4.1.1 summarises some of the housing hazards and their potential health impact.

Table 4.1.1: Summary of housing hazards and potential health impact

Housing hazard	Description	What is the health impact?	Who is affected?
Accidents	Caused by internal environmental hazards.	Falls	Older people and very young children, especially in low income households.
Cold housing, including dampness and condensation.	Main cause in Bromley of homes not meeting the Decent Homes Standard is lack of thermal insulation, which can lead to cold homes.	Hypothermia, asthma attacks, heart attacks, strokes or deep vein thrombosis, respiratory illness, arthritis, accidents and mobility problems, mental health conditions, sickle cell related problems.	Damp homes and condensation cause respiratory problems particularly for young children, older people and allergy sufferers.
Design and outdoor space	Housing design includes building type (such as a flat or detached property) and general design of the neighbourhood such as access to outdoor space.	High rise living is associated with poorer mental health. Access to natural spaces improves mental health and inaccessibility discourages physical activity and social participation.	Children and mothers are particularly affected.

The JSNA informs all commissioning decisions which might impact on health and care in Bromley. The evidence in this section therefore supports decisions on how best to meet the needs of Bromley's homeless population.

4.1.2 What does homelessness look like in Bromley?

There is a large variation in statutory homelessness rates in London, with higher rates in central London such as Westminster. In addition, certain outer London boroughs such as Brent, Newham and Haringey have relatively high

[14] *The economic case of housing and health: The role of housing associations* (The King's Fund/ new NHS alliance, 2016)

rates of statutory homelessness, potentially reflecting levels of high deprivation[15]. Bromley has a lower prevalence of homelessness than most London boroughs, but it has seen a change in recent years.

The Public Health Outcomes Framework (PHOF) includes two indicators for homelessness:

1. Eligible homeless people not in priority need per thousand households

This indicator represents the number of households that have presented themselves to their local authority but under homelessness legislation have been deemed to be not in priority need. The majority of the people that fall under this cohort are single homeless people.

Bromley figures for 2014/2015 for this indicator are 1.1 per 1,000 households (overall count 147) which is worse than the England average (0.9 per 1,000). Compared to other London boroughs, Bromley has the 13th highest rate for single homeless people. When looking at trend data the rate has worsened since 2010/11 and improved slightly over the past year (see **Figure 4.1.2**).

2. The number of households in temporary accommodation

The indicator for households in temporary accommodation counts the numbers of statutory homeless, i.e. the population deemed to be in priority need.

Bromley's current rate is 7.5 per 1,000 households (overall count 1,010) a value that has been increasing since 2010. It is lower than the overall London rate (14.0 per 1,000 households) and is the twelfth lowest in London though higher than the England average. Bromley's rate has also seen a rise in the past year (see **Figure 4.1.3**).

[15] Mayor of London Health Inequality Strategy Delivery Plan 2015-2018 Indicator Report (GLA, 2015)

Figure 4.1.2

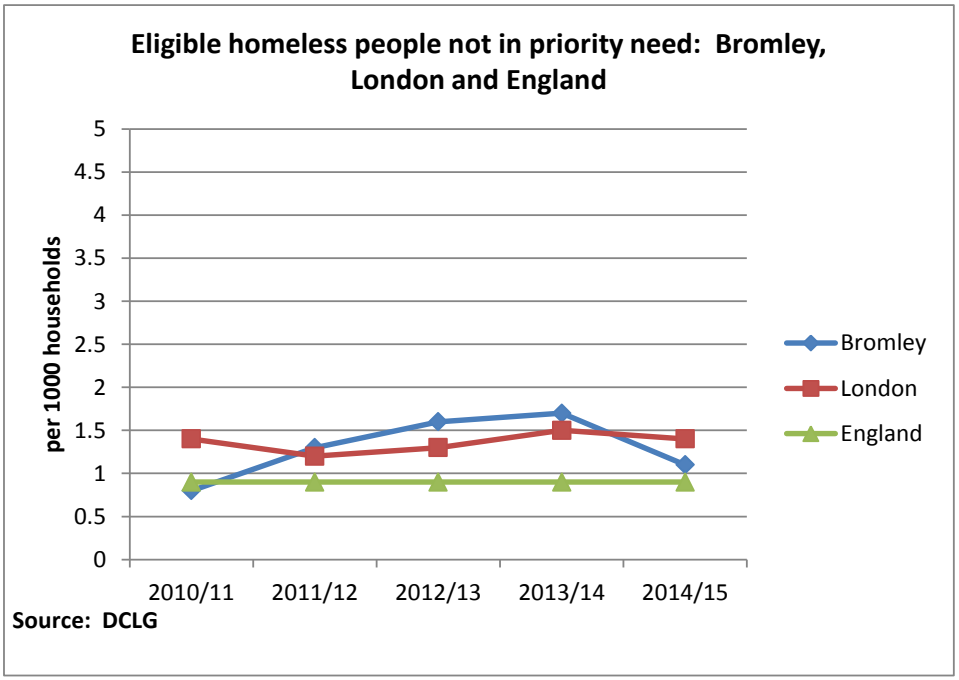
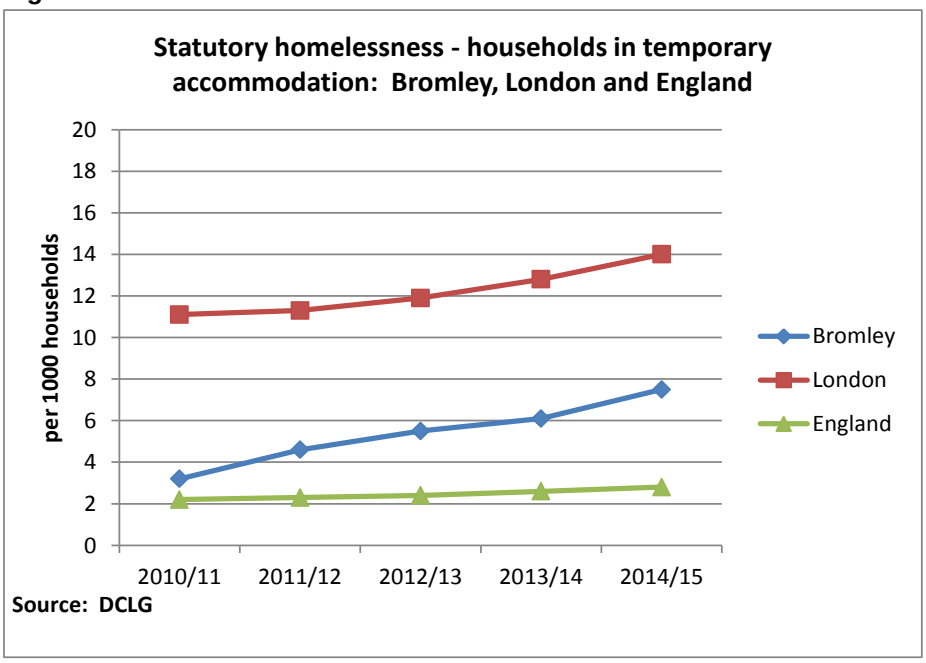


Figure 4.1.3



In addition, Bromley has data on the number of homeless applications received each year and the decisions on each application. **Figure 4.1.4** and **Table 4.1.2** show that there has been a decrease in the number of homeless applications in the past year (1,492 to 1,014, a decrease of 32%). However there is also a 46% increase in the number of people accepted as statutory homeless, from 406 in 2010-11 to 591 in 2015-2016. Please note that the table of decisions regarding homeless applications does not include applications that have since been withdrawn or prevented from becoming homeless following application, hence the difference in totals between the two figures.

Figure 4.1.4

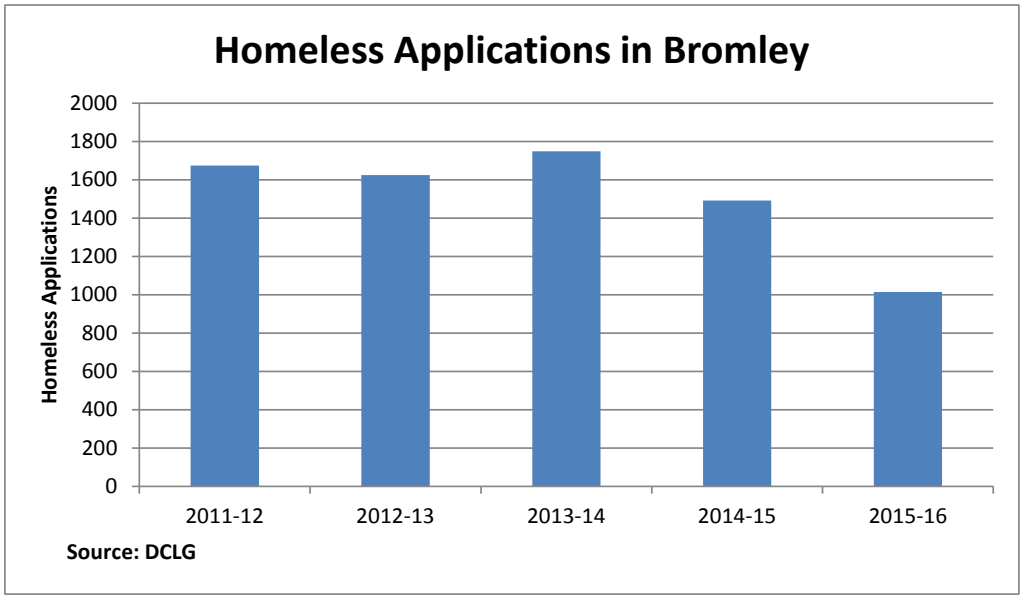


Table 4.1.2: Decisions regarding homeless applications in Bromley, 2010-16

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Accepted Homeless	406	586	518	461	428	591
Accepted Homeless out of area	16	12	11	14	7	6
Accepted No Local Connection	13	36	37	28	16	11
Intentionally Homeless	31	55	60	68	31	25
Not Eligible	20	17	30	32	17	9
Not Homeless	190	283	264	313	256	313
Not in Priority Need	109	172	214	230	147	41
Total	785	1161	1134	1146	902	996

Source: DCLG

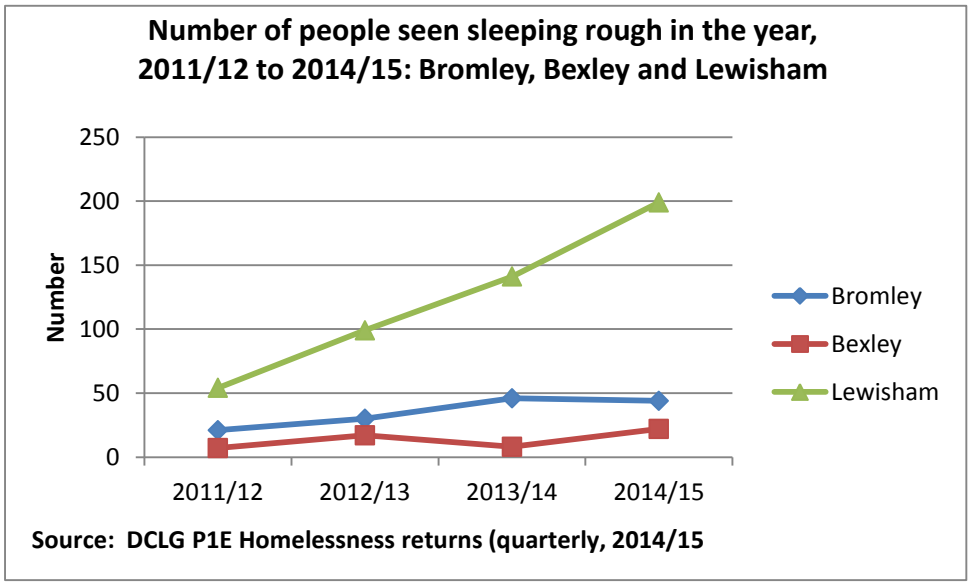
The other data source to help understand the size of Bromley's homeless population is the numbers of rough sleepers counted in the borough. Current estimates over the year place this number at 44, a decrease of two since 2013/14[16]. The latest CHAIN report, which counts new rough sleepers cited in each quarter (April to June 2016), puts the Bromley figure at 19. Rough sleepers are often intermittent, returning to the streets on and off which makes numbers difficult to track[17].

Figure 4.1.5 compares Bromley's number of rough sleepers to two other South East London boroughs across the past four years. The rates across London vary considerably (for example, Westminster had 2,570 rough

[16] Mayor of London Health Inequality Strategy Delivery Plan 2015-2018 Indicator Report (GLA, 2015)
[17] *No going back: Breaking the cycle of rough sleeping and homelessness* (London Assembly, 2014)

sleepers in 2014/15) which would distort the overall London average. When comparing three South East London boroughs, Bromley has a higher rate than its neighbouring borough Bexley but a lower rate than its inner London neighbour Lewisham, which also shows a steep increase over the last year.

Figure 4.1.5



b) Who makes up Bromley's homeless population?

Data on who is applying and being accepted as homeless in Bromley is collected by the Department for Communities and Local Government (DCLG). This provides a detailed picture on why applicants are deemed eligible, indicating their specific needs.

1014 applications were made in Bromley in 2015/16 to be accepted as statutory homeless, with 591 accepted as in priority need. 72% (438) of applicants were accepted owing to dependent children. A number of other categories also include children and young people, including pregnancy, people aged 16/17 years of age and people formerly in care. The last category is an important group in terms of supporting the needs of vulnerable young people and the services they might require, including health, education and social support. **Figures 4.1.6** and **4.1.7** describe accepted applications by household type and reason for decision.

Figure 4.1.6

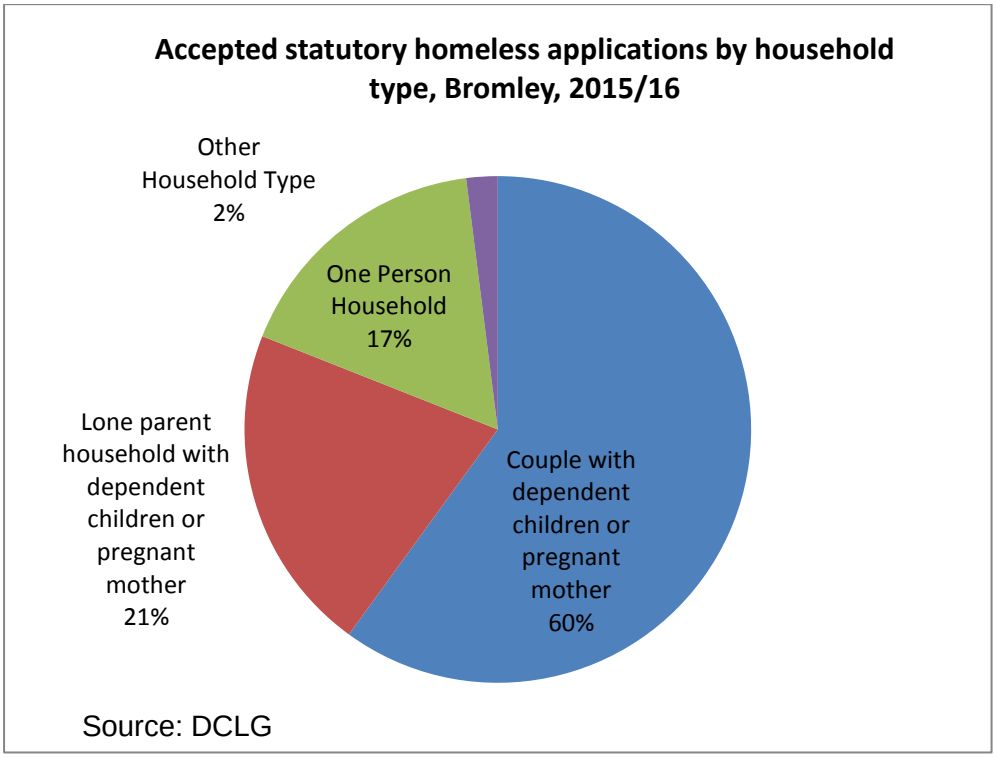
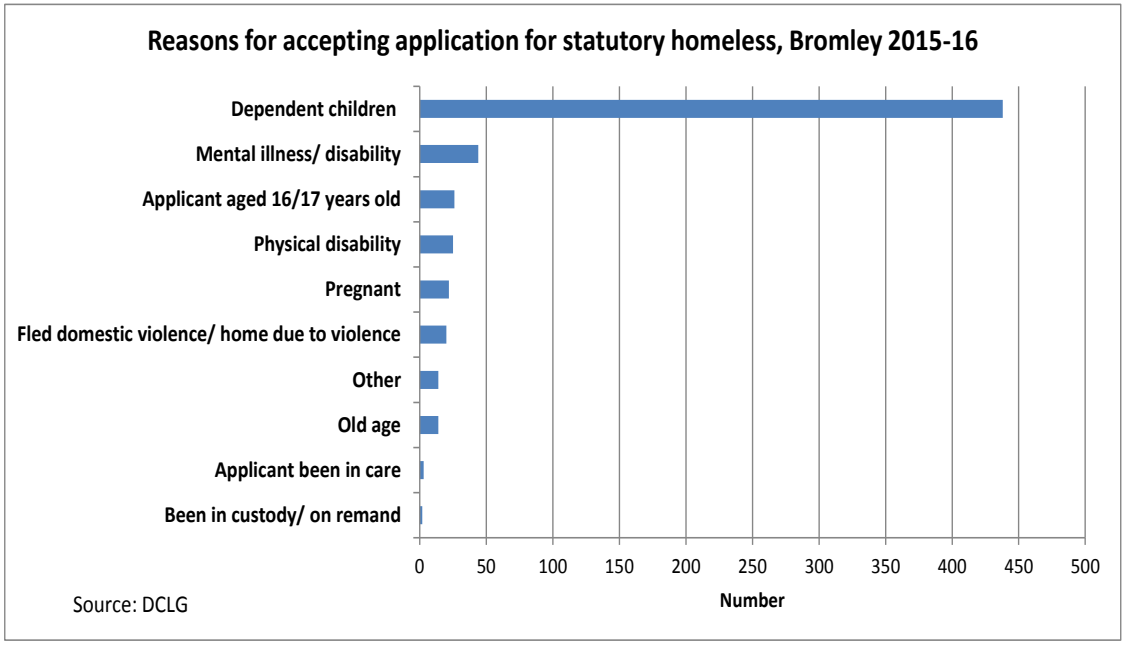


Figure 4.1.7



The following points can also be drawn from the homeless application data:

- 11% of applicants were accepted for poor mental and physical health/ disability (44 and 25 of the applicants respectively). Fleeing violence/ domestic violence represented 3% (20) of applicants which is likely to also be associated with health needs.
- The greatest number of people who apply and are accepted are aged between 25 and 44 years of age. 49 applicants were over 60 years,

though only 11 applicants were accepted as priority need (see **Figure 4.1.8).**

- By ethnic group, the largest number of applications were classified as white, with the second largest group Black/ African/ Caribbean/ Black British at 21%. The Black/ African/ Caribbean/ Black British group make up 10% of Bromley's general population. (See **Figure 4.1.9**).
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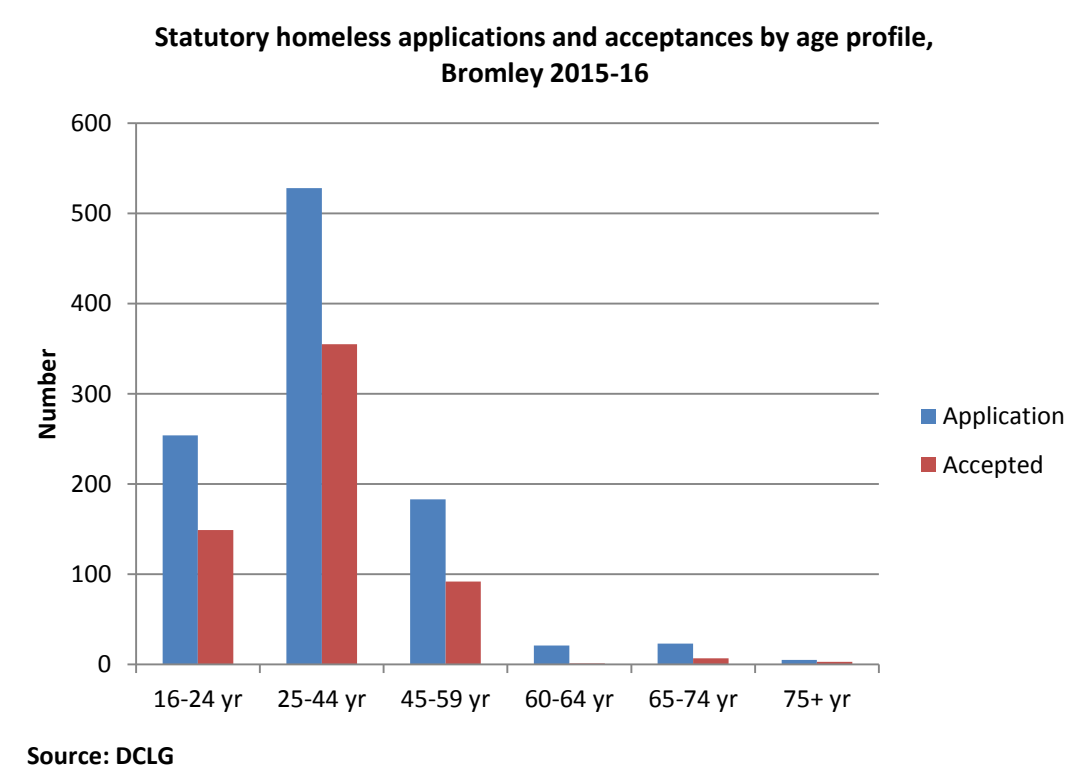
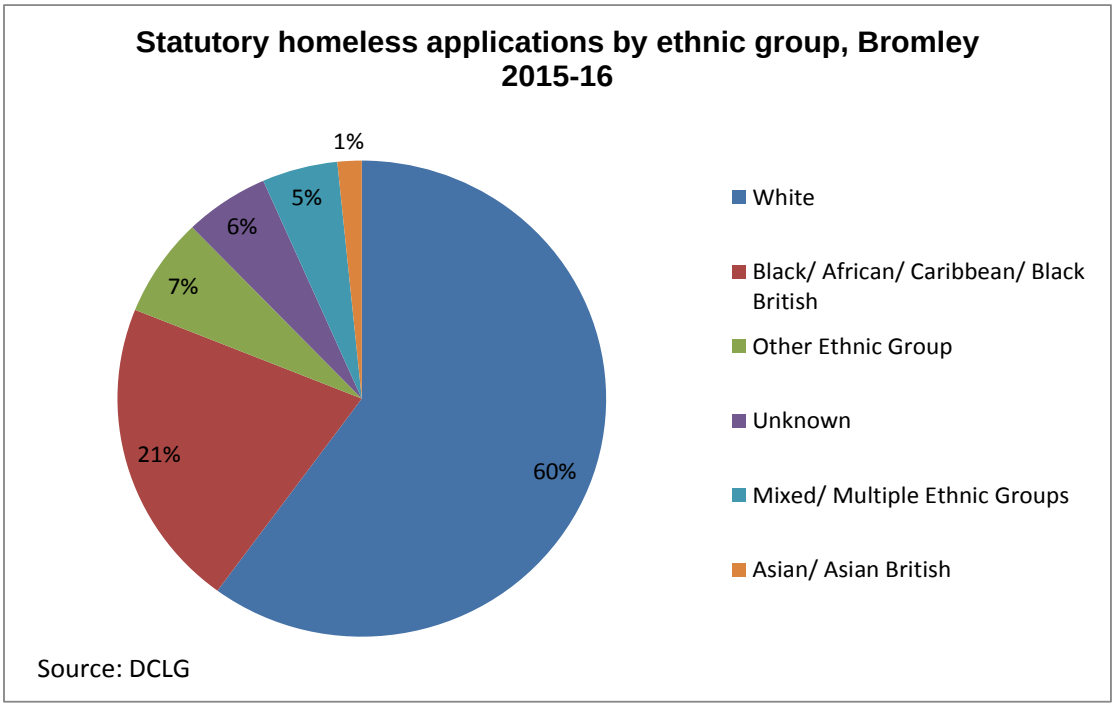
Figure 4.1.8



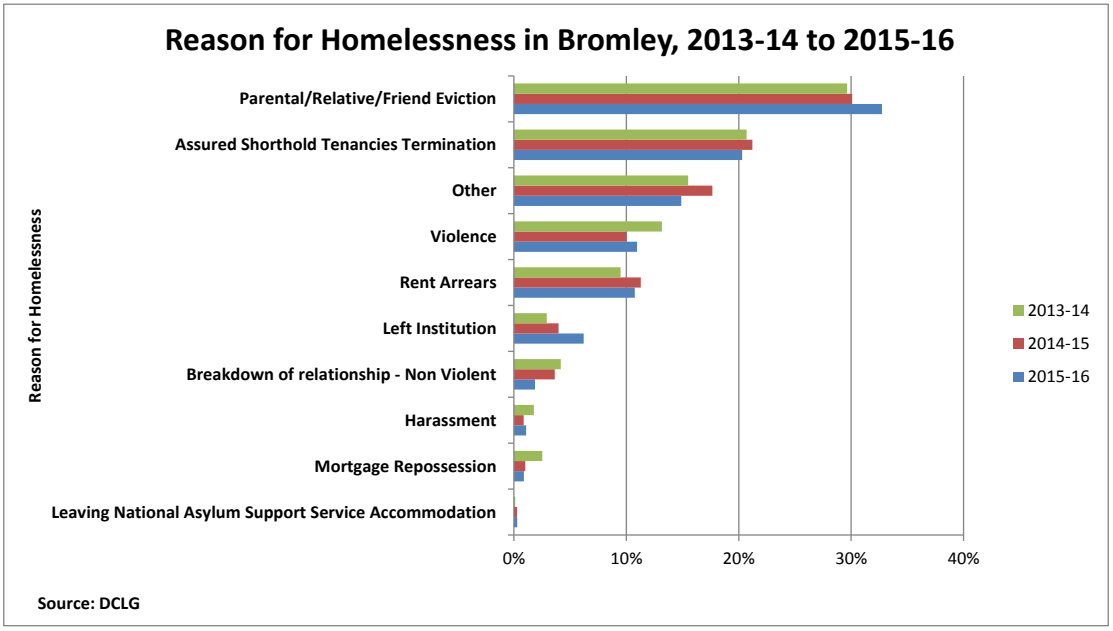
Source: DCLG

Figure 4.1.9



Reasons for becoming homeless in Bromley are set out in **Figure 4.1.10**. There has been little change in the main reasons for becoming homeless across the past three years, though a higher proportion cite parent/ care giver/ friend eviction compared to the previous year. The second main reason is the termination of an assured shorthold tenancy.

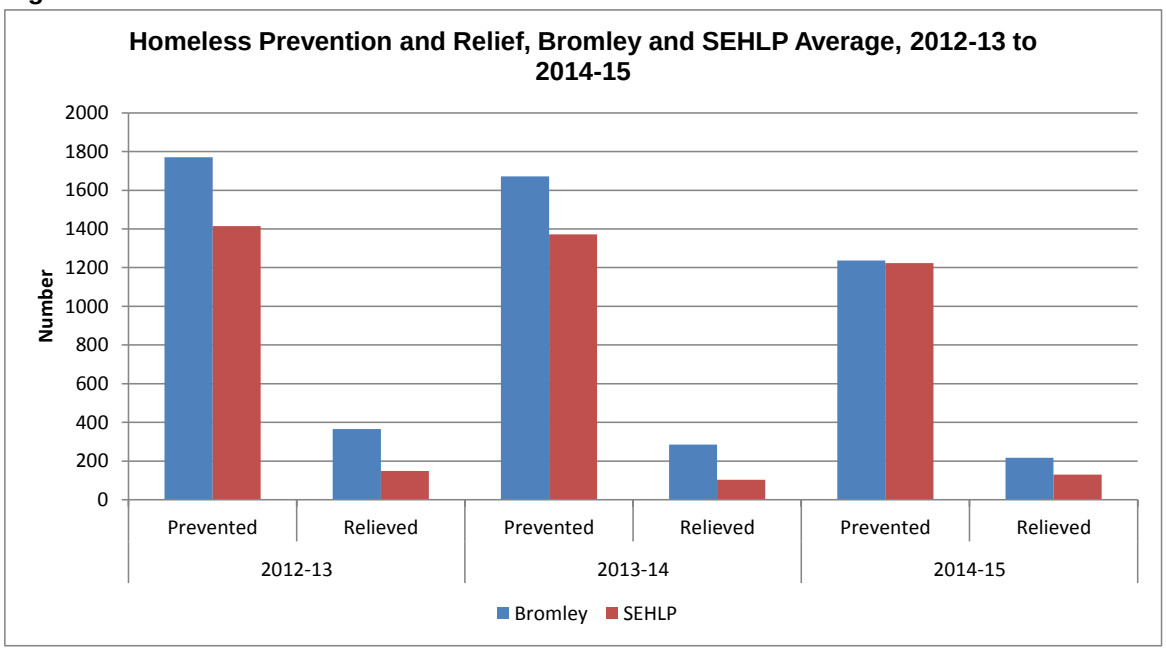
Figure 4.1.10



Homeless prevention refers to the ability of a borough to either obtain alternative accommodation for the family or individual at the point at which the person/ people would be vulnerable to homelessness, or be assisted to remain in their existing home through such interventions as help with rent or legal negotiations. This data captures a large proportion of the work of local government on homelessness which may address needs of people who do or do not fit statutory criteria before they are offered temporary accommodation. The people prevented from becoming homeless would have been eligible for statutory support. The relief is offered to the single homeless population.

A number of factors influence this data, such as the size of the homeless problem being reported to the borough, prioritisation of the prevention service by the borough and the effectiveness of the service and housing stock availability[18]. Bromley services prevent more homelessness on average than South East London as a whole, however the number of cases prevented has reduced over the last two years. This is likely to be due to difficulty in accessing affordable private sector accommodation for this group.

Figure 4.1.11



What this means for Bromley residents and their children

Bromley has a lower prevalence of homelessness than most London boroughs though its numbers of statutory and single homeless are higher than the England average. The number of households in temporary accommodation (an indicator for the statutory homeless) has increased over the past four years from 3 per 1,000 households to 7 per 1,000 households.

[18] Mayor of London Health Inequality Strategy Delivery Plan 2015-2018 Indicator Report (GLA, 2015)

The number of homeless applications has fallen in the past year but the number accepted as statutory homeless has increased. The majority of these households have children under 16 years old. In addition, 11% of applicants were accepted owing to health needs.

The greatest number of applicants and acceptances are between 25 and 44 years of age and the largest ethnic group represented is white followed by Black/ African/ Caribbean/ Black British. This group is overrepresented compared to Bromley's overall population.

Bromley will continue to focus efforts on early intervention support by providing, where possible, alternative accommodation and advice. In addition, it will seek to relieve pressure on the current housing market by making the case for more affordable housing supply.

4.2 Housing and its relationship with homelessness

Affordable and decent housing is a concern across London and is impacting a high number of population groups. This section looks at Bromley's housing market, supply of temporary accommodation, and welfare reform in addition to housing supply for people with support needs.

i) The Local Housing Market

Based on GLA population projections there are 137,858 households in Bromley in 2016, a 5.4% increase since 2011. The Census calculated that approximately 31% are single person households, which is likely to rise before the next Census.

Approximately 71% of households are in owner occupation and approximately 13% are in the private rented sector. The Council no longer owns any housing stock and all social rented housing is supplied through Housing Associations (Registered Providers) which accounts for around 14% of the Borough's dwellings.

Table 4.2.1 shows the change in tenure mix between 2001 and 2011. The falling level of owner occupation is likely to be a result of fewer first time buyers entering the market.

Table 4.2.1: Percentage Household Tenure in Bromley

	2001	2011
Owns outright (%)	32.5	33.4
Owns 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

The growth of the private rental sector (8.5% to 13.3% of dwellings) reflects the fall in home ownership. Housing standards are largely unregulated within the private rented sector (unlike the social rented sector) so the health effect of this shift is largely unknown. A study of private sector housing conditions in 2009 indicated that approximately 36% of private sector dwellings in the Borough failed the Government's Decent Homes Standard. The properties in the poorest condition are 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.

In terms of the homeless or formerly homeless population, a recent study involving a follow up survey of 297 participants in England (including London) indicates that homeless people re-housed in to private rented accommodation have poorer housing outcomes than those who move into social housing. For example, 13% in the private rental sector had moved four times during a five year period and 58% had become homeless again at least once. This compares to 22% becoming homeless again who were re-housed in local authority accommodation and 18% who were re-housed in a housing association. In addition people in the private rental sector were also less likely than those in social housing to receive support from services[19]. A high rate of turnover in the private rental sector is also seen across London's population as a whole[20].

Other housing market issues that affect more vulnerable communities in Bromley include:

[19] Crane,M, Joly, L, Manthorpe, J,. "Rebuilding Lives Formerly homeless people's experiences of independent living and their longer-term outcomes"; Kings College London; January 2016 https://www.kcl.ac.uk/sspp/policyinstitute/publications/RebuildingLives-FULL.pdf

[20] Strategic Market Housing Assessment South East London https://www.lewisham.gov.uk/myservices/planning/policy/LDF/evidence-base/Documents/SELondonSHMA2014.pdf

Housing need and supply

The South-East London sub region commissioned a Strategic Housing Market Assessment (SHMA) 2014 which highlights a number of key challenges and issues related to housing provision. It estimated that a total of 7,188 housing units per annum are required across the sub region and an estimate of net annual affordable housing need of 5,000 units per annum. With regard to the size of units the SHMA (2014) highlights the greatest need for one bedroom units (53%) followed by 2 bedroom (21%) and 3 bedroom (20%) units up to 2031. Currently, the highest level of need for affordable housing in Bromley is for two bedroom units, as reflected on the Council's Housing Register.

The London Plan sets out a minimum housing supply target for Bromley of 641 dwellings per annum[21]. The draft Local Plan identifies key sites and broad locations to deliver this housing target for the next 15 years (the length of the Local Plan period).

The London Plan also encourages the building of affordable housing which it defines as 'social rented, affordable rented and intermediate housing provided to eligible households whose needs are not met by the market.[22]' Definitions of these terms are provided in **Table 4.2.2** below. London boroughs are required to provide affordable housing on sites with capacity to provide 10 or more homes. Bromley seeks 35% provision of affordable housing on these sites. The number of affordable dwellings provided is influenced by the number of larger housing developments and therefore fluctuates. In recent years Bromley has produced around 150 affordable dwellings per year.

[21] Five year supply of deliverable land for housing (June 2015) http://www.bromley.gov.uk/downloads/download/73/annual_monitoring_reports

[22] https://www.london.gov.uk/what-we-do/planning/london-plan/current-london-plan/london-plan-chapter-3/policy-310-definition

Table 4.2.2: Definitions of affordable housing

Term	Description
Social-rented housing	Housing provided by a landlord where access is on the basis of housing need and rents no higher than target rents set by the Government for housing association and local authority rents.
Affordable rented housing	Rented housing let by registered providers to eligible households. Affordable rent is not subject to the national rent regime but is subject to other rent controls that require a rent of no more than 80 per cent of the local market rent where this does not exceed Local Housing Allowance levels.
Intermediate housing	Sub-market housing available to people on moderate incomes who cannot afford to buy or rent housing generally available on the open market. Intermediate housing may take the form of shared ownership, low cost home ownership or sub market rented housing.

The preferred approach for controlling the occupancy of social/affordable rented housing is for the ownership of this housing to be transferred to a Registered Provider (RP) nominated or agreed by the Council. Government guidance also makes reference to "Starter homes" in the affordable home category. Further guidance will follow in terms of the starter homes policy and the implications of this policy for other types of affordable housing.

In general, in terms of housing supply Bromley has a range of land constraints, not least the Green Belt designation covering much of the Borough, which limits its capacity to meet need. However the Strategic Housing Land Availability Assessment (SHLAA) 2013 indicates that there is capacity across the sub-region to achieve the overall annual targets.

Increase in rental prices for lower quartile rents

The increase in demand for private rental accommodation has driven a significant rise in rental prices for lower quartile rents. These are estimated to have risen about 4% over the last year within the Borough[23]. This reflects a year on year rise (rental prices rising at 5% over 2014/15). In comparison

[23] SELHP Housing Market Bulletin 15/16 average lower quartile rental price for a two bed flat www.selondonhousing.org

household income has risen by 4.5% over a five year period (2010-2015) averaging a less than 1% increase per year[24]. The rent increase in Bromley is similar to the rest of London, with the ONS index of private sector rents indicating that average rents grew by 4.1% in London in the year to September 2015, compared to 1.9% in the rest of England[25]. Average private sector rents in London are more than twice the national average for all property sizes[26].

Occupation of non-decent dwellings

In general vulnerable households are more likely to occupy non-decent dwellings. There is currently no up to date data on non-decent dwellings in the borough and the ward they come under. Further work needs to take place to identify this.

ii) Temporary accommodation

The demand for, and supply of housing that is affordable has been impacted by the current housing market and welfare reforms. As a result the number of homeless households in temporary accommodation year on year is increasing with many families being placed outside the borough boundaries. The level of demand from London Boroughs has also seen a rise in the number of households having to be placed into emergency shared facility accommodation.

Currently, there are 1,219 families in temporary accommodation. This is the highest level for five years. The table below shows that almost half of these households (49%) are based outside Bromley. The length of time households remain in temporary accommodation is increasing as move-on options become more limited with an average length of stay of 57 weeks. Currently the number of households in temporary accommodation is increasing by 12 to 15 households per month. There is an observed impact on families as a result of unstable accommodation, for example behavioural issues among children.

The impact of temporary housing goes beyond the uncertainty and unsettledness that results from feeling displaced and can impact both physically and mentally on homeless households. Co-ordination of services to these groups is critical to enable them to exercise decisions or choice over their situation and access health and support services. This can be particularly challenging for households based outside of the borough.

[24] Nomis https://www.nomisweb.co.uk/
[25] ONS experimental index of private rents
[26] Valuation Office Agency private rental market statistics

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 often in excess of housing benefit, and reduced affordable housing nominations through re-lets and new build development.

Table 4.2.3: Households living in temporary accommodation, 2011 to Q1 2016

	2011	2012	2013	2014	2015	2016*
No of Households in Temporary Accommodation (TA)	429	612	764	824	1010	1219
No of placements In Borough	360	431	505	485	590	617
No of Placements out of Borough	69	181	259	339	420	602
No of placements in Nightly Paid Accommodation (NPA)	121	258	333	420	590	744
No of Placements in Long Term Temporary Accommodation	308	354	431	404	420	475
Average length of Stay in TA (days)	392	316	383	428	398	398

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

*Data up to end of June 2016.

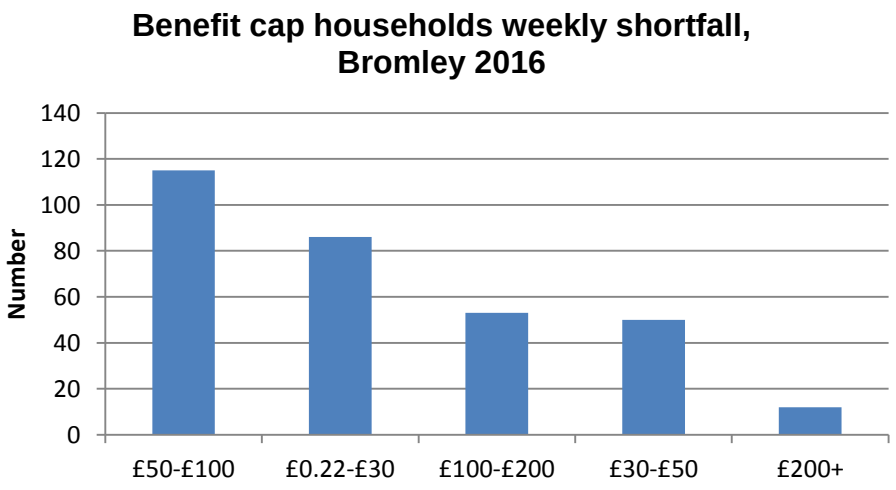
iii) Welfare reforms

The benefit cap is a limit on the total amount of income from certain benefits a household can receive, introduced via the Welfare Reform Act in 2012. A household is benefit capped if they receive more than £26,000 per annum (£500 per week) in out of work benefits (including housing benefit). This will be reduced from 7 November to £23,000 (£442.30 per week). If you receive more than the benefit cap allows then your Housing Benefit or Universal Credit will be reduced until you are brought back within the cap.

Bromley is aware of 316 households affected by the benefit cap. 307 of these are families with children. 230 of these cases have a weekly shortfall of more than £30, indicating an inability to meet the housing costs of the borough.

The average shortfall is £71.04 per week, with 65 cases with a shortfall of over £100 a week.

Figure 4.2.1



Source: Bromley Council Housing team

The Bromley Council housing team are currently working with approximately 100 benefit cap households. The response by a number of clients to the reduction in income has resulted in debt, rent arrears, use of food banks or going without meals, rather than moving into employment or finding a cheaper home. Service responses for this group are likely to include increased support through home visits, debt advice/ budgeting support, joint working with other agencies (such as Jobcentre plus, the Bromley Children's Project) and assistance with moves to more affordable accommodation and employment support.

From autumn 2016 the benefit cap is going to be reduced and will be set at a different level depending on whether you live inside or outside London. This is likely to increase the number of benefit cap cases in Bromley. Intensive work is taking place with the households affected by the benefit cap to look at how they can be supported into employment or alternative housing. This includes resilience building to improve coping skills around hardship, identifying childcare options and access to discretionary payments where appropriate.

iv) Housing supply for people with support needs

The provision of specialist and supported housing is critical for vulnerable people. This section considers Bromley's housing support for young people, people with mental health needs and dual diagnosis and older people.

Young people

This year Bromley has seen an increase in the number of homeless accepted cases for 16 – 24 years from 23% to 25%. The needs of this group are often complex and challenging, including issues around drugs and alcohol misuse, gang involvement, relationship breakdown etc.

There is a dedicated Senior Practitioner for young people based within the Housing department. They undertake joint assessment with housing options officers for every 16 – 17 year old who approaches the department as homeless or threatened with homelessness. This approach ensures a holistic and multi-disciplinary approach to identifying the housing and care needs of the Young Person (YP) and formulating a clear pathway to meet these needs. Practical interventions include joint meeting with parents and YP when appropriate, referral for mediation services or step down services and adopting a reflective interview approach with the YP to enable them to gain a better understanding of their behaviour and the likely impact on their families. This approach has seen 8 YP return to their parental home this year.

The housing needs for this group are mainly met through the provision of supported accommodation where they are supported to access education, training and employment amongst other needs. There are 40 units of such placements in the borough.

With indications of increasing numbers of young people being accepted as homeless, future plans need to consider other move-on pathways as Social Housing providers may refuse to offer longer term accommodation as a result of the reduction of Local Housing Allowance. This affects those who have not been accommodated through the Social Care pathway.

Last year, the JSNA highlighted the increased prevalence of domestic and associated violence amongst young people. Although the number of incidents reported has reduced, it is still an area Bromley continues to monitor.

Recent research by King's College found that homeless young people are most likely to experience difficulties after being resettled into accommodation compared to other age groups but are least likely to receive support. They are also more likely than any other age group to become homeless again and to accumulate significant debt (55% of 20 to 24 year olds surveyed had debts of over £6,000 or more at 60 months of being resettled)[27].

People with mental health needs and dual diagnosis

[27] Crane,M, Joly, L, Manthorpe, J,. "Rebuilding Lives Formerly homeless people's experiences of independent living and their longer-term outcomes"; Kings College London; January 2016 https://www.kcl.ac.uk/sspp/policyinstitute/publications/RebuildingLives-FULL.pdf

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.

Currently there are 48 mental health specific units in the borough and all clients are provided with floating support to enable them to maintain their tenancies.

In terms of mental health needs, it is important to note that there are a number of people without a clinical diagnosis where poor mental health may be impacting on their ability to maintain their tenancy. This group are likely to benefit from additional support to prevent the loss of their tenancy.

Public Health England includes two indicators on housing for people with specific support needs. This includes:

- Learning disability - Percentage of adults known to the council recorded as living in their own home of with their family
- Secondary mental health services - percentage of adults (aged 18-69) who are receiving secondary mental health services on the Care Programme Approach and recorded as living independently, with or without support.

Bromley is performing at a worse level than London and England in terms of the percentage of adults with a learning disability living in stable and appropriate accommodation. This is the same for males and females but is particularly low for males at 20% worse than the England average (overall count of population affected is 160). For adults in contact with secondary mental health services, Bromley performs better than England and close to London on both scores.

Table 4.2.4: Accommodation support for adults with learning disabilities and in contact with secondary mental health services: Bromley, 2014/15

Public Health Outcome Framework Indicator		Bromley	London	England
1.06i Percentage of adults with a learning disability who live in stable and appropriate accommodation	Male	53.3%	67%	73.2%
	Female	61%	70.7%	73.1%
1.06ii Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation	Male	74.4%	75.9%	58.4%
	Female	79.7%	80.5%	61.3%

Source: Health and Social Care Information Centre

Older people

Within the social rented sector, Bromley has an adequate supply of older person's accommodation including sheltered accommodation. However there is a shortfall of private specialist older people provision and, to a lesser extent, for shared ownership. This need is set out in The London Plan (2015) Annex 5 which gives an indicative annualised strategic benchmark of 140 private sale units per year and 65 units per year for "intermediate sale". Population projections suggest that this demand is likely to continue. The draft Bromley Local Plan supports the provision of specialist housing across all tenures and encourages the maximisation of existing sites providing specialist accommodation in addition to resisting loss.

The spectrum of older person's accommodation is described by a range of terminology. The London Plan uses the term 'Specialist Accommodation for Older People' and this is broken down into three categories:

1. Sheltered accommodation – self-contained accommodation specifically designed and managed for older people in need of no or low level support.
2. Extra care accommodation – self-contained accommodation that meets the needs of people with an existing or foreseeable physical or mental health impairment. Extra care provision can be provided round the clock.
3. Residential/ nursing care (including end of life/ hospice care and dementia care).

Appropriate accommodation for older people can help reduce hospital stays by providing safe and supported accommodation. This is particularly important to reduce the risk of falls for older people, which cause a high

amount of morbidity and mortality in older people in addition to early admissions to residential homes. Specialist accommodation can also be easier to heat[28]. Supportive accommodation can help older people improve their mental health, for example by improving cognitive function and reducing depression and anxiety[29].

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

It is predicted that there will be ongoing pressure on Bromley's housing supply as the average household size decreases and rental and property purchases increase at a greater rate than income. Up to date data is required on the condition of Bromley's housing stock, in particular the private sector which is likely to be occupied by those on lower incomes and relied on in terms of supporting people out of homelessness.

The number of families in temporary housing is the highest for five years. This is likely to have a negative impact on the population's health, including children's well-being, and creates challenges in terms of ongoing access to services.

The benefit cap is continuing to affect a high number of families, with this number expected to increase from autumn 2016 when the cap is reduced. Evidence suggests that households are cutting back on food or going into debt rather than moving into employment or finding cheaper accommodation.

Bromley provides specialist support and accommodation for high need groups, such as young people, people with clinical mental health conditions, people with dual diagnosis (poor mental health and challenges around substance misuse) and older people. Further investigation is required into what specialist support is available for adults with learning disabilities in the borough and how this can be improved.

Key areas of activity for Bromley include:
1. Increasing the supply of affordable and decent housing which will help reduce the number of families in temporary accommodation and provide alternatives for families experiencing the benefit cap.
2. Monitor the longer term impact of welfare reform for clients aged less than 35 years old and the wider impact on young people leaving supported accommodation.

[28] *Homes for Older Londoners: Building healthy homes for a comfortable and independent retirement* (London Assembly Housing Committee, 2013)
[29] *The economic case of housing and health: The role of housing associations* (The King's Fund/ new NHS alliance, 2016)

4.3 Bromley Single Homeless Health Needs Audit

a) Background and approach

Bromley participated in a South East London Homeless Health Needs Audit at the end of 2015 to early 2016, specifically focusing on the single homeless population in the borough. The Homeless Health Needs Audit is a tool designed by Homeless Link to help local areas understand, plan for and improve the health of the homeless population in their local area. In addition Homeless Link has pooled data from across England to allow local comparisons with national data.

Healthwatch Bromley played a major part in this survey by identifying members of Bromley's single homeless population in partnership with Living Well Bromley. Participants were also identified by Bromley Food Bank and Evolve Housing and Support. Volunteers who carried-out the interviews underwent training at Healthwatch in addition to the launch training provided by the council.

The survey was available online, but it was agreed a more practical approach was to complete hard copies and enter the data afterwards. Participants were either currently homeless or had been homeless in the past two years.

Sample size

The survey was live for 10 weeks between 14/12/15 and 15/02/16. The target number of responses was 50 in line with the minimum sample size recommended by Homeless Link's Health Needs Audit Tool Kit.

In total 47 responses were received. Not all answers were completed and therefore the numbers of responses per question were taken into account in the analysis of the survey. Comparisons have been made where possible with the national Homeless Link Health Needs Audit (pooling data from 27 different areas), the general England population (for example through the ONS General Lifestyle Survey) and with Bromley population data, helping to show patterns and differences in terms of survey response.

b) Who responded to the survey?

The table below provides a demographic breakdown of the survey participants, comparing this data where appropriate with national, regional and local comparisons.

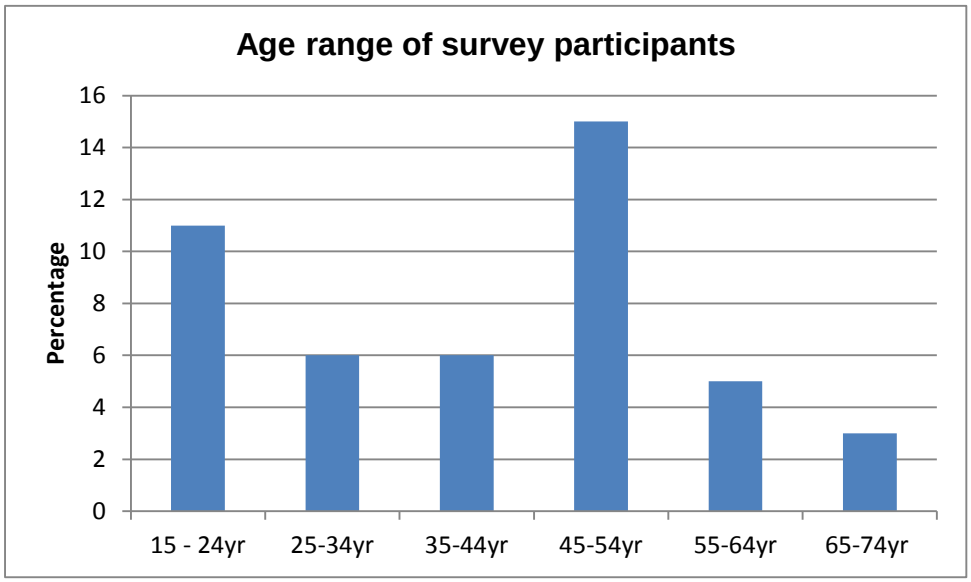
It is important to note that participants were identified by support services and therefore are the people likely to be engaged with some sort of support, which might influence some of the findings.

Table 4.3.1: Demographic characteristics of survey participants

Characteristic	Survey demographic	Comparison with national/ regional and local data
Age	A broad range of ages responded to the survey, from 16 to 74 years of age. The greatest proportion of responses were between 45 to 55 years of age. In addition there were a high number of responders aged between 16 and 24 years (24%, 11).	6.7% of Bromley respondents were over 65 years of age which compares with 2% of the Homeless Link national homeless health audit[30].
Gender	All responders indicated their gender, with 13 female (28%) and 34 male (72%).	The over representation of men amongst the single homeless population is consistent with the national picture, with the national audit being 71% male[31].
Ethnicity	46 responders indicated their ethnicity. The majority identified as white (78%) and 15% identified as Black/ African/ Caribbean/ Black British.	Bromley's local population is largely white (81.5%). The Black/ African/ Caribbean/ Black British ethnic category make up 10% of Bromley's overall population[32].
Sexual orientation	All participants responded to this question with the vast majority identifying as heterosexual (41, 87%), 4% as Gay or lesbian and 7% as bisexual.	This broadly is similar to the London population, which estimates the proportion of the LGBT community at 10%[33].
Disability	46 participants responded to the question regarding long standing illnesses or disability, with only one non-response. 57% (27) reported having a longstanding illness or disability.	32% of the general population of England report a longstanding illness or disability[34].

Figure 4.3.1

[30] Homeless link health needs audit up to July 2015 http://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data
[31] Homeless link health needs audit up to July 2015 http://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data
[32] GLA population projections 2015 http://data.london.gov.uk/dataset/gla-population-projections-custom-age-tables
[33] Transport for London Sexual Orientation Equalities Scheme 2008-11 http://content.tfl.gov.uk/sexual-orientation-equality-scheme-2008-2011.pdf
[34] The Office of National Statistics, Chapter 7 – General health (General Lifestyle Survey Overview – a report on the 2011 General Lifestyle Survey) http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-7.html

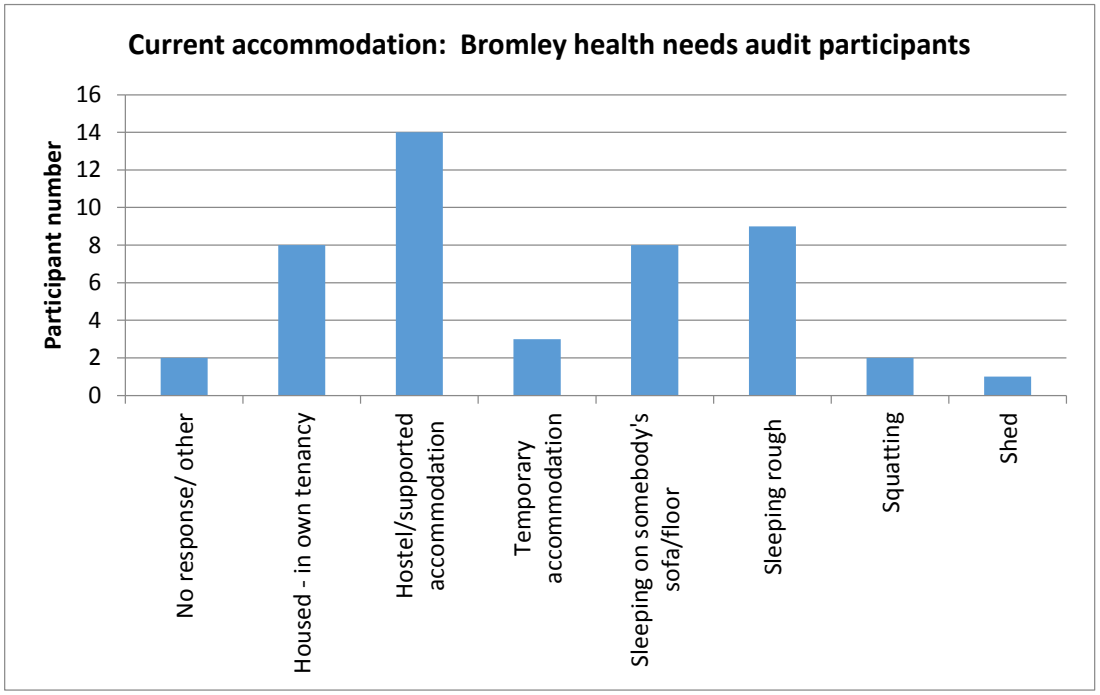


Accommodation and background

46 participants gave a response to the question regarding current accommodation. Only 30% (14) were in a hostel or other temporary accommodation with 8 participants housed in their own tenancy. A fairly high number were rough sleeping (19.6%) or sleeping on somebody's sofa/ floor (17.4%).

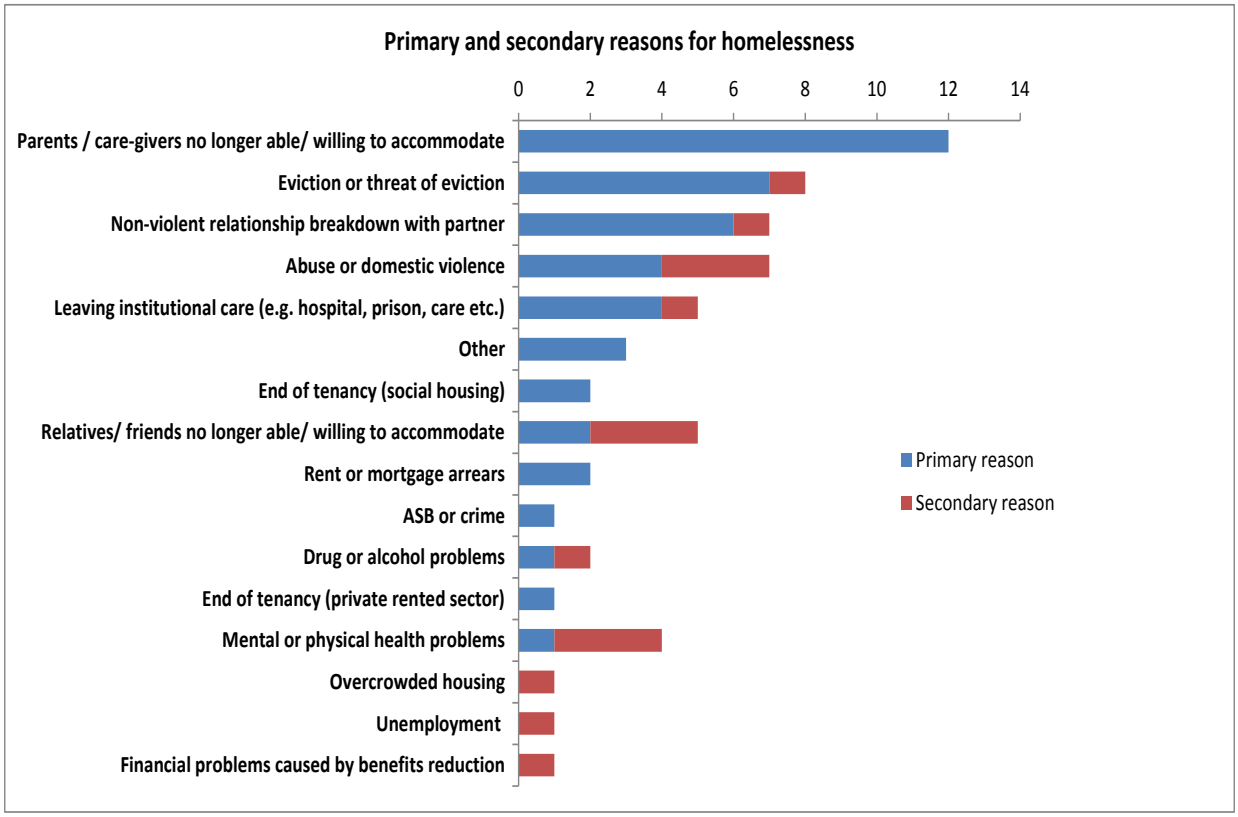
Historically, 25 of the participants stated they had sofa surfed, 25 slept rough and 59% had applied to the council as homeless. The age range of those having ever slept rough spans from 14 to 53 years of age.

Figure 4.3.2



Forty-six participants stated a main reason for homelessness, with 16 also listing secondary reasons. The most frequently cited reason was parent/ care-giver no longer able or willing to accommodate them, with the second most cited reason eviction or threat of eviction. These are the same frequent reasons recorded by the population applying for statutory homeless status in Bromley, which provides an insight into how homeless people determine their own status. Seven participants cited abuse or domestic violence as a primary or secondary reason and seven cited non-violent relationship breakdown with partner. Mental and physical health problems and drug or alcohol problems featured less commonly as reasons for homelessness.

Figure 4.3.3



Personal history/ additional vulnerability

Nineteen participants had spent time in prison (40%) and 12 (26%) had been a victim of domestic violence. Four of these responses were from men and eight from women. Eight participants had experience of local authority care and five had been admitted to hospital for mental health reasons.

Regarding current education, employment and training status, 54 responses were provided suggesting participants felt that more than one category described their circumstance. The most frequent response (9 participants) was unable to work owing to long term sickness or disability. An additional 8 responses indicated unemployment and not looking for work. However 5 responses stated unpaid/ voluntary work, two attending full time education, two employed or self-employed and 7 looking for paid work or a Government training scheme (sixteen participants in total either engaged in employment or training or actively looking). The age range of participants looking for paid work is from 17 to 54 years.

Education, training and employment (ETE) is associated with better health outcomes for homeless people, with a King's College study on resettled homeless populations noting that participants involved in education or

employment were less likely to feel depressed and be more optimistic about the future[35].

Homeless health needs audit summary: what does this mean?

Respondents to the survey showed demographic similarities with the national homeless health link audit, and therefore consistency with larger samples of single homeless participants. An exception is a larger representation of older people in Bromley's survey response. As with Bromley's statutory homeless population, there is an overrepresentation of Black/ African/ Caribbean/ Black British ethnic group compared to Bromley's general population. Having a long standing illness or disability is considerably higher than in the general population at 57%.

Primary reasons for homeless status amongst participants relate to relationship breakdown with parents, carers or partners in addition to eviction or threat of eviction (indicating financial difficulties). These are similar to reasons stated by applicants to Bromley council for statutory homeless status. Health problems are generally seen as a secondary reason.

Participants' background information indicates vulnerability as a population group, having previously experienced violence, local authority care, time in prison or admission to hospital for mental health reasons. Current accommodation also indicates high needs for this group, including rough sleeping, squatting and sleeping on someone else's sofa.

Many participants feel unable to work owing to health/ disability. However a high number are also looking for employment or are engaged in an employment related activity such as volunteering or training. This is across a broad age range, which is useful to note for employment intervention support.

Physical health needs

Participants were asked if they suffered from a physical health problem and for each problem, whether they had suffered with it for less or more than 12 months.

The audit showed the following:

- Only 26% (12) reported no physical health conditions in the past 12 months or more.

[35] Crane,M, Joly, L, Manthorpe, J,. "Rebuilding Lives Formerly homeless people's experiences of independent living and their longer-term outcomes"; Kings College London; January 2016 https://www.kcl.ac.uk/sspp/policyinstitute/publications/RebuildingLives-FULL.pdf

- 74% (35) cited a physical health problem either within the past 12 months or more than a year ago.
- 13% (6) had experienced health problems more than twelve months ago, with three of these participants citing two or more physical health conditions.
- In terms of number of conditions experienced, 38% (18) participants cited one to three conditions, 17% (8) participants four to six conditions and 6% (3) participants over seven conditions.

The most common physical health problems reported by participants were hypertension and joint aches/ problems with bones (26% each). The majority had experienced these physical health conditions in the past 12 months.

Other frequent physical conditions experienced over the past twelve months include fainting/ blackouts, sight problems and circulation problems. Asthma had the highest response for a condition experienced more than 12 months ago, whilst chronic breathing problems was cited 6 times as a condition experienced in the last 12 months and twice as one more than 12 months ago.
Many of these physical health conditions are associated with homelessness, for example being brought about through a poor living and sleeping environment.

Figure 4.3.4

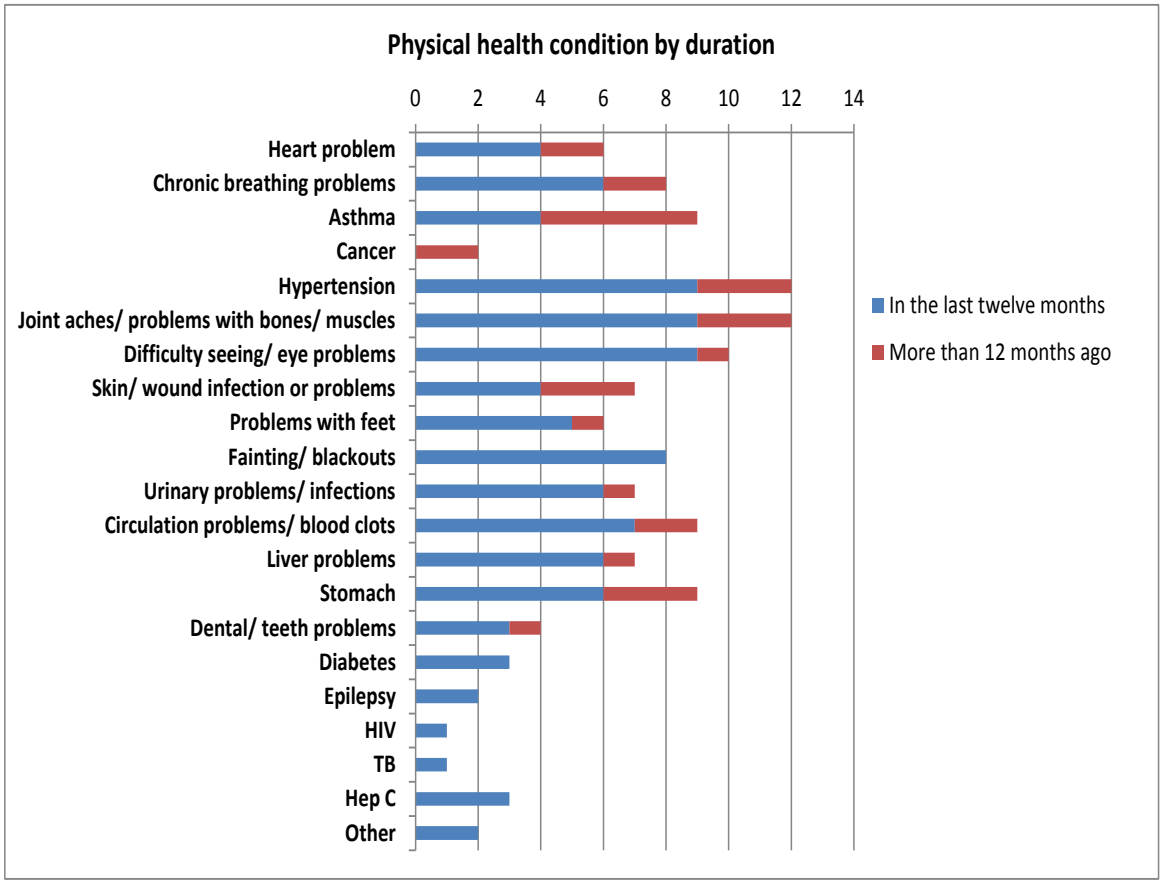
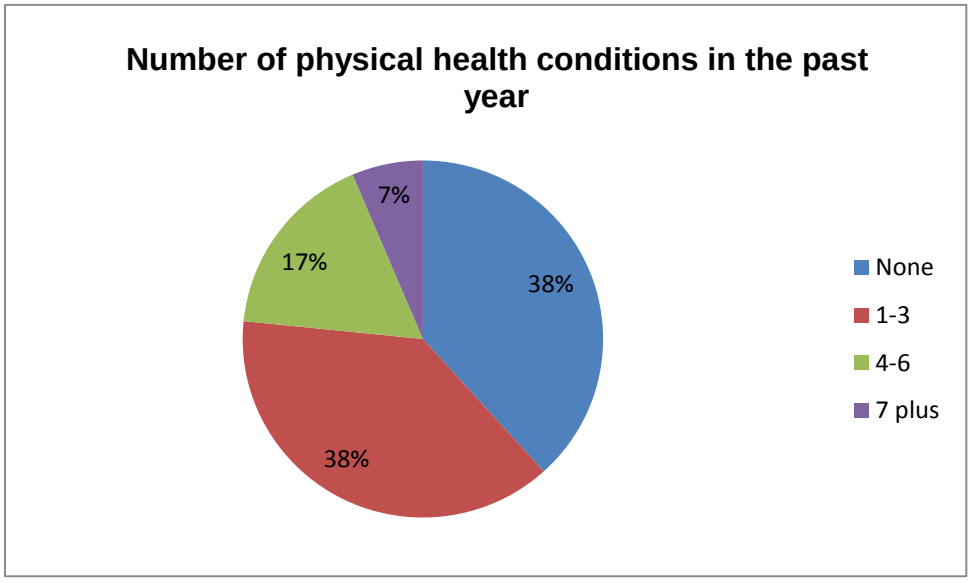

Physical health condition by duration
0
2
4
6
8
10
12
14
Heart problem
Chronic breathing problems
Asthma
Cancer
Hypertension
Joint aches/ problems with bones/ muscles
Difficulty seeing/ eye problems
Skin/ wound infection or problems
Problems with feet
Fainting/ blackouts
Urinary problems/ infections
Circulation problems/ blood clots
Liver problems
Stomach
Dental/ teeth problems
Diabetes
Epilepsy
HIV
TB
Hep C
Other
In the last twelve months
More than 12 months ago

Figure 4.3.5



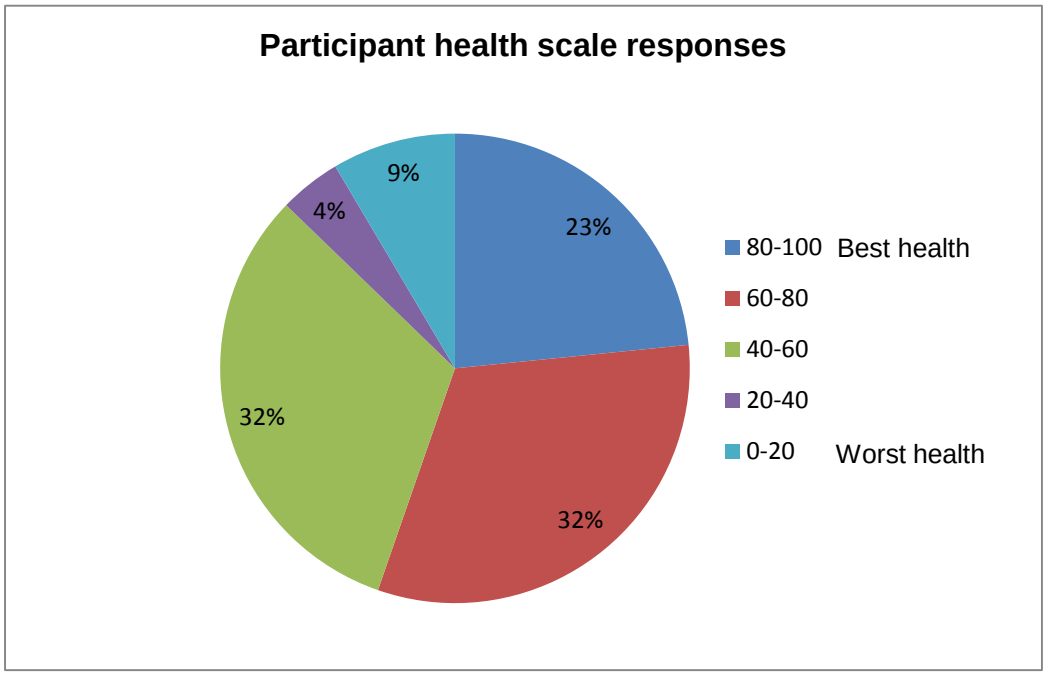
Participants were asked about their mobility, vision, hearing, pain, ability to do usual activities and their self-caring abilities on the day they completed the homeless health needs survey. From the responses, 43% of participants had problems walking about and the same number were in moderate pain/ discomfort. 34% cited problems with vision and around a quarter of respondents had some problems with self-care and performing usual activities. This provides information on some of the challenges homeless people have in terms of looking after themselves in addition to engaging with the environment and services around them, from public transport to attending hospital appointments. A detailed breakdown is set out in **Table 4.3.2**.

Participants were also asked to rate their current health on a scale of 0 to 100, 0 being the worst state you could imagine and 100 being the best. 23% (11) of participants rated their current health as being good with a rating of 80 or more. 64% of respondents reported a score between 40 and 80 and 13% (6) reported that their health was poor with a score lower than 40, including 4 scores cited between 9 to 10 indicating a very poor state of overall health. This indicates that a small but important number of participants have a very low assessment of their overall health.

Table 4.3.2: Current health experience

Health and care	Number (percentage) of participants	Current experience
Mobility	20 (43%)	Problems walking about
Self-care	1 (2%)	Unable to wash or dress myself
	9 (19%)	Some problems washing or dressing myself
Usual activities	9 (19%)	Unable to perform my usual activities
	11 (24%)	Some problems performing usual activities
Pain/ discomfort	6 (13%)	In extreme pain or discomfort
	20 (43%)	In moderate pain or discomfort
Vision	13 (28%)	Some problems seeing things clearly
	3 (6%)	Unable to see things clearly
Hearing	1 (2%)	Extreme difficulty hearing
	5 (11%)	Moderate difficulty hearing

Figure 4.3.6



Mental health needs

Slightly more respondents cited mental health problems to physical health conditions, with 36 participants (77%) reporting having at least one mental health need within the past 12 months or more than a year ago. This is in line with the Homeless Link national health needs audit which reported 80% of respondents having a mental health need.

Participants were asked about 12 different types of mental health conditions with an additional 'Other' category. The majority of respondents cited one or two mental health conditions (25 participants) and 11 participants reported having three or more mental health needs, with three of these indicating a very high level of need (seven, nine and thirteen conditions marked).

The mental health needs most commonly cited were depression, anxiety, personality disorder and dual diagnosis (mental health and substance misuse issue). Participants were asked to indicate how anxious or depressed they felt on the day they completed the Bromley Homeless Health Needs Survey. 45 participants responded to the question, with 14 citing they were extremely anxious or depressed and 15 moderately anxious or depressed (64% of participants in total).

Both the Bromley and National homeless health needs audit show that long term mental health problems are more prevalent in people experiencing homelessness than in the general population. For example:

- 57% participants of the Bromley health needs audit reported suffering from depression compared to 6.38% in Bromley[36].
- 40% reported suffering from anxiety compared to 4.6% of the London population[37].
- 9% reported suffering from schizophrenia compared to 1-3% of the general population[38].

It is important to note that people experiencing a physical health condition are also more likely to suffer mental ill health, with the presence of a long-term physical health condition increasing the risk of mental ill health by two to three times over that of the general population[39]. In turn, mental ill health increases the risk of physical illness. Challenges around dealing with mental illness can lead to engagement with riskier behaviours or being less able to look after yourself as a result of illness. There is therefore a two to four times risk of

[36] Bromley Council JSNA 2015 https://bromley.mylifeportal.co.uk/uploadedFiles/Bromley/Bromley_Homepage/QuicklinkContent/Health_and_Wellbeing/Publications/Bromley_JSNA_2015.pdf

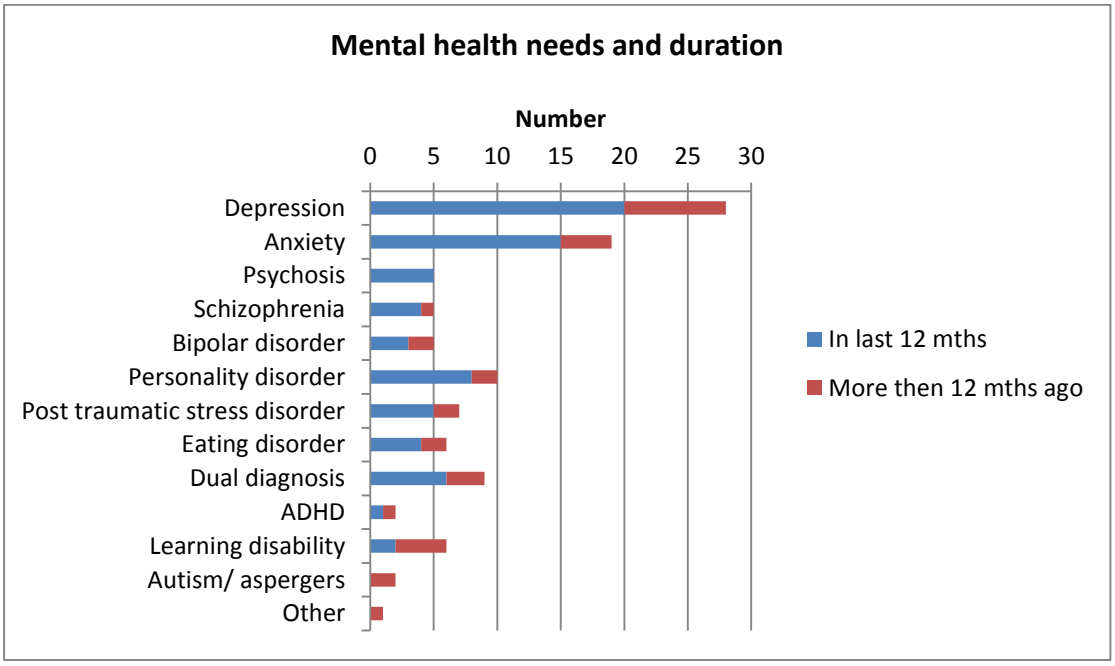
[37] *London Mental Health: The invisible costs of mental ill health* (GLA, 2014)

[38] Adult psychiatric morbidity in England, 2007: Results of a household survey (HSIC, 2009)

[39] *London Mental Health: The invisible costs of mental ill health* (GLA, 2014)

people with mental health conditions dying prematurely compared to the general population, mainly from physical causes like cardiovascular disease[40].

Figure 4.3.7



Drug use

Participants were asked if they had used drugs in the past twelve months. 32% (15) reported using drugs of some sort, with seven using more than one substance. The commonly used drugs were cannabis (8) heroin (5), cocaine (5) and tranquilisers (3). Heroin and cannabis were highest in terms of regular use. However, for all these questions nearly half of participants did not respond.

Alcohol use

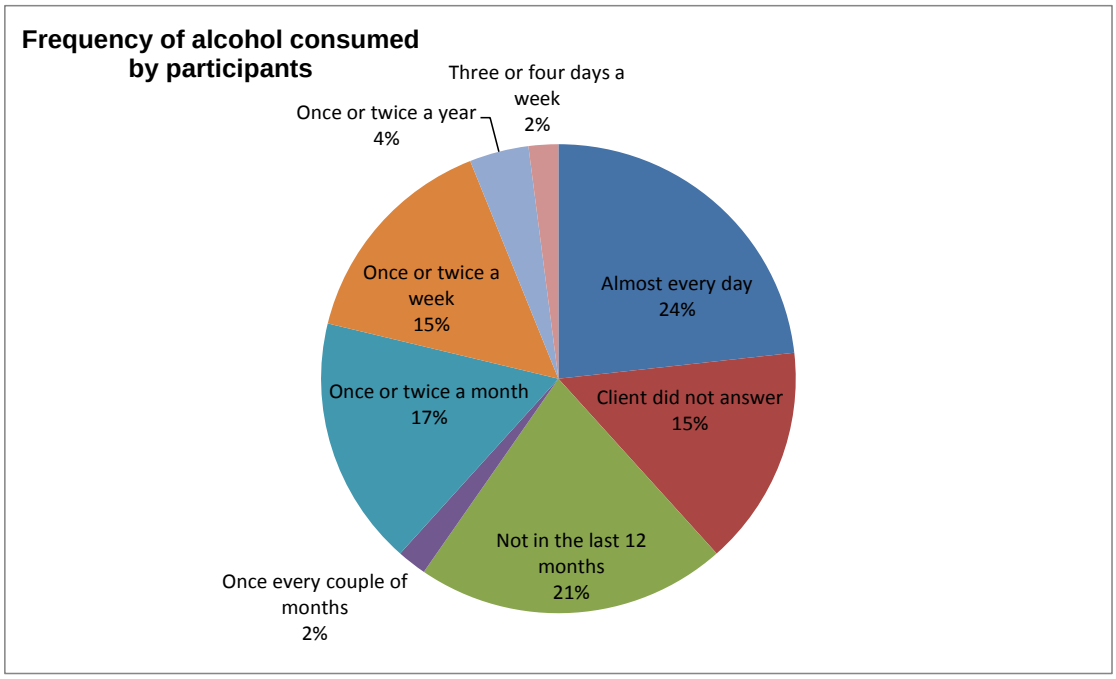
37 participants responded to the question on how many units they drink on a typical day. 8 (17%) participants indicated that on a typical day drinking they engage in harmful drinking behaviour by consuming 10 or more units of alcohol. 41% (15) of respondents drink more than Department of Health recommended levels of more than 3-4 units on a regular basis, compared to 13% of the Bromley general population. 27% (10) of surveyed participants were abstinent, which is lower than the Bromley general population at around

[40] 'Long-term conditions and mental health: The cost of co-morbidities.' The King's Fund and Centre for Mental Health 2012 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-healthcost-comorbidities-naylor-feb12.pdf

25 Adult psychiatric morbidity in England, 2007: Results of a household survey (HSIC, 2009)

33%. Abstainers include people who may have had harmful or dependent drinking patterns in the past but may have stopped drinking since.

Figure 4.3.8



Twelve participants cited they have an alcohol problem, with six out of this 12 stating they were in recovery. Three participants cited that they were receiving treatment and it met their needs, three that they were not receiving treatment but it would help and six stating they did not need treatment. As with drug treatment, the numbers were low in terms of understanding the most favourable treatment interventions, with numbers fairly well spread for advice/ information, peer support and mutual aid groups as meeting needs. Advice and information was the most commonly received support.

Health behaviours

Smoking

Participants were asked whether or not they smoked. 45 participants responded with 64% (29) stating they are a current smoker. This compares with around 20% of the general population. Over half of the current smokers (52%, 15) would like to give up. 16 participants have been offered help to give up by a health professional, with seven of these taking this up. Four participants smoke e cigarettes.

The smoking rates were lower than the National Homeless Health Needs Audit where 77% of those surveyed were a current smokers. The proportion who would like to quit smoking is higher than the National Homeless Health Needs Audit at 52% compared to 41%.

Diet

Participants were asked how many meals on average they had per day. 43 participants responded to this question, with the majority stating one (42%), followed by two (37%). Three participants stated none and six participants three meals or more.

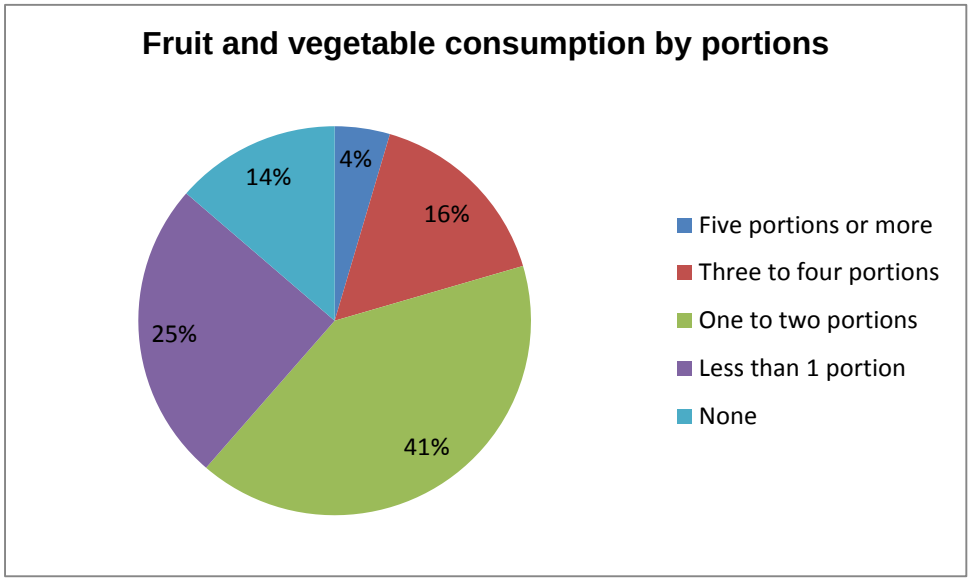
Participants were also asked if they had ever accessed a local food bank. 27 out of 41 responses stated yes. This is likely to be connected to the fact that a large proportion of participants were identified in partnership with Living Well Bromley which provides a food bank.

The audit also included questions on participants fruit and vegetable consumption. The average number of fruit and vegetables consumed daily by the general public according to the Food Statistics Pocket Book 2013[41] is 4.1 portions for adults, which reduced to 2.9 for the poorest 10% of the population. 41% of Bromley respondents (18) stated that they ate one to two portions of fruit and vegetables a day, with the next highest category less than one at 25% (11). Six stated no consumption of fruit and vegetables and nine over three portions (20%) with only 4.6% meeting the Department of Health guidelines of five portions. This compares to 27% of the general population[42].

[41] The Food Statistic Pocket Book 2013, DEFRA https://www.gov.uk/government/statistics/food-statistics-pocketbook-2013

[42] The Food Statistic Pocket Book 2015, DEFRA https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526395/foodpocketbook-2015update-26may16.pdf

Figure 4.3.9



Physical activity

43 respondents replied to how often per week they exercised for 30 minutes of more. 26% (11) responded that they engaged in exercise five times or more a week (the recommended level) with 9% (4) three to four times. However 33% (14) stated that they never engaged in any form of physical activity. Overall 74% (32) of participants do less than the recommended form of activity.

Homeless health needs audit summary: what does this mean?

The survey respondents expressed a high level of physical health needs, with the survey findings supporting studies on the number of physical health conditions experienced by the homeless population, particularly regarding respiratory health conditions. Many of these physical health conditions are likely to be the result of being homeless and the impact this has in terms of a poor living environment and not being able to take care of yourself. A high number of participants cited challenges in day to day activities as a result of poor physical health, such as mobility issues or experiencing moderate pain or discomfort.

There is a high prevalence of mental health conditions in this population group, from common mental health disorders to severe clinical conditions. Responses to questions around mental health needs in addition to respondents assessments of their overall health indicates that some of the participants have a very low sense of well-being and urgently require support.

Health behaviours of respondents indicate the impact of poverty and the challenges this creates in terms of healthy living. For example, poor access to healthy food and lack of opportunities for physical activity. Physical and mental health conditions are also likely to have a negative impact on take up of healthy behaviours.

Accessing health services

a) Registration and usage

The most frequently used health service by participants over the past 12 months was the GP (68%) which is slightly lower than the general population (71% of people are estimated to have seen or spoken to their GP in the last 6 months[43]). The GP service is also the most frequently used health contact with 16 participants using it more than three times in the past year.

The table below summarises proportions of participants accessing services and the barriers around access where cited. A recent Healthwatch Bromley report focusing on the health needs of those who are at risk economically or identify as vulnerable includes a case study of a homeless individual unable to access a GP owing to lack of permanent address[44].

Table 4.3.3: Summary participant registration to health services and barriers

Service type	Participant registration by percentage	Barriers to registration
GP	77	Unable to complete a form. Unable to provide an address.
Homeless health care service	53	None cited.
Dentist	49	Unable to provide an address

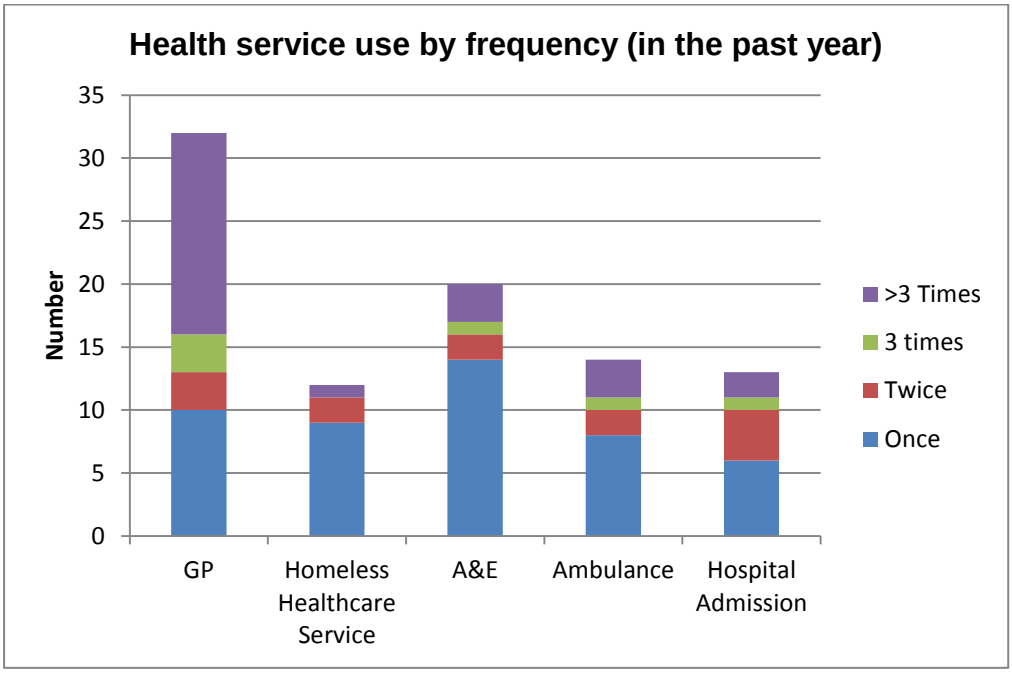
43% (20) of participants cited using A&E services in the past year. This is higher than the Homeless Link National Health Needs Audit figure (35%). The three most common reasons given for A&E use include accidents, a physical health problem/ condition and self-harm/ suicide. 14 participants used the ambulance in the past year, with reasons similar to that for A&E. For hospital admission, the most common reason was relating to a physical health problem or condition. Hospital Episode Statistics research states that around

[43] GP Patient Survey National Summary Report January 2015

[44] *Banking on a Meal* (Healthwatch Bromley, 2016) http://www.healthwatchbromley.co.uk/sites/default/files/uploads/Banking_on_a_Meal_... HWBL_-_FINAL_2016.pdf

twice the number of A&E attendances are from people living in the 10% most deprived areas compared to those living in the least deprived 10%. In addition users of mental health services are more than twice as likely to attend A&E than non-users[45]. Homeless Link has also calculated that homeless people report on average 1.66 A&E visits a year compared with 0.38 per year for the general public[46].

Figure 4.3.10



Hospital discharge

The thirteen respondents who had been admitted to hospital in the past year were asked if staff in the hospital made sure they had somewhere safe to stay. All participants responded, with five stating they were asked, five that they were not and three could not remember. In terms of discharge location, seven were discharged into accommodation suitable to their needs. Four stated that they were discharged onto the streets.

Three of the participants stated that they were readmitted into hospital within 30 days of discharge.

a) Uptake of treatment and support

The table below summarises uptake of treatment and support for physical and mental health needs. It shows a higher proportion feeling that their needs were met in terms of physical health than for mental health. Just over a

[45] Accident and Emergency focus report (Health and Social Care Information Centre, 2013) http://digital.nhs.uk/catalogue/PUB13040/acci-emer-focu-on-2013-rep-V2.pd

[46] *The unhealthy state of homelessness: Health audit results* (Homeless Link, 2014)

quarter in both categories felt that they would benefit from more support, and a slightly lower level did not receive help but would like some. A fairly high proportion felt that they did not need any support for their mental health condition (24%).

Table 4.3.4: Summary of support received for physical or mental health need

	Physical health need	Mental health need
Received help which met need	40%	26%
Received support but would like more	27%	26%
Did not receive help but would like some	23%	24%
Do not need any support	10%	24%

The one participant with TB had received treatment. Of the three with Hep C, two had received treatment with one citing they had not been offered any. Twenty-eight (60%) of participants were on prescribed medication for a physical or mental health problem.

Talking therapy, medication and training/ skills for employment were the mental health interventions that participants reported most met their health needs. However the numbers of responses are low owing to the sample size so it is difficult to draw anything conclusive from this data.

Participants were asked if there had been a time in the last 12 months when they had felt they needed an assessment or treatment for a mental health problem but did not receive it. All participants responded to this question with 34% (16) citing that there was at least one occasion. A variety of reasons were given for not receiving an assessment, including challenges getting an appointment, being refused treatment, the waiting list and distance to travel.

b) Health protection

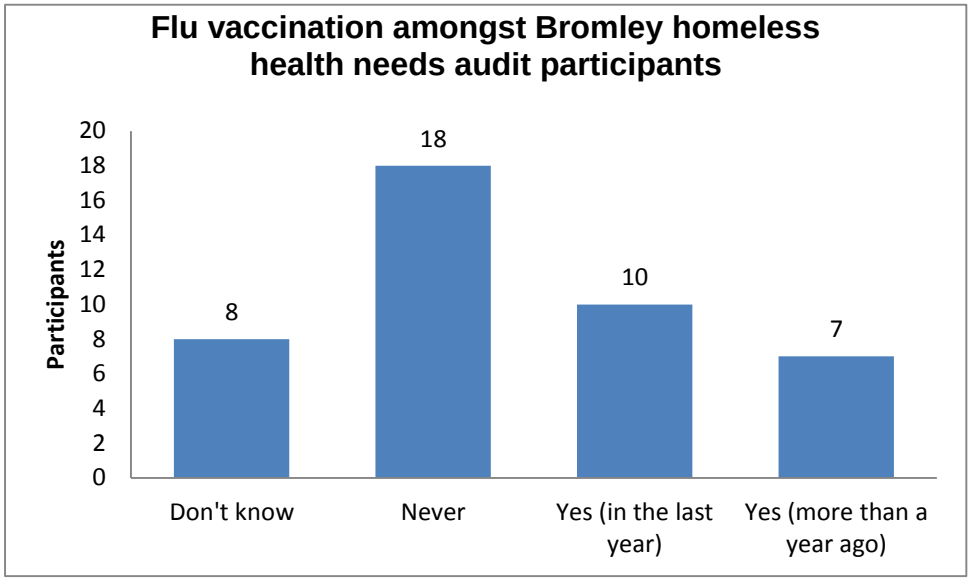
Vaccination

There was a low level of awareness regarding hepatitis B vaccination with 45% (21) participants stating they did not know if they had received the vaccine. Five participants stated that they had received the full course (three vaccinations) and six just the one vaccination. People who have spent time in prison are considered at risk of hepatitis B and vaccination is recommended. Three of the five participants who had received the full course and three of the participants who received one dose had spent time in prison. However 13

participants who spent time in prison out of 19 in total were either unsure of their vaccination status or had not received the hepatitis B vaccine.

It is recommended that those with long term or underlying health conditions are vaccinated against the flu. In terms of flu vaccination, 43 participants responded and only 10 (23%) cited that they had had a flu vaccination in the past year. A further 7 (16%) had had a flu vaccination more than a year ago. Research has demonstrated that homeless people's eligibility for flu vaccination due to clinical risk factors was 38.9% compared with 13%, but only 23.7% of those eligible were vaccinated compared to national levels of 52%[47].

Figure 4.3.11



Female health

Female respondents over 25 were asked if they had a cervical smear test in the past 3 years. Four responded yes, including a female of 18 years of age and one with no stated age. No women asked had received a breast examination in the past three years. This was directed at women over 50, with four participants meeting the criteria.

Sexual health

Participants were asked if they have had a sexual health check in the past 12 months. 39 responded to the question with 18% (7) stating yes and 74% (29) no. Five of the yes responses were female, with four between 16 and 24

[47] Story A, Aldridge RW, Gray T, *et al.* Influenza vaccination, inverse care and homelessness: cross-sectional survey of eligibility and uptake during the 2011/12 season in London. *BMC Public Health* 2014; **14**: 44. Doi:10.1186/1471-2458-14-44

years old and one with age not stated. The two other responses were males between 35 and 55 years old.

57% (27) of participants stated that they would know where to access free contraception, with 26% (12) responding no and 8 stating not applicable. The majority of responders who knew where to access free contraception also knew how to get information and advice on sexual health (20 out of 27). The GUM or sexual health clinic was the most common place cited to get advice (13 responses), followed by GP or nurse (8 responses) the homeless/ housing staff (3 responses).

Homeless health needs audit summary: what does this mean?

Access to GPs for Bromley's single homeless population is fairly similar to the general Bromley population according to the survey results. However this needs to take into account the small sample size and the likely bias of survey participants being the single homeless who are to some extent engaged with services. In addition, barriers for this population were cited, such as lack of permanent address, which should not prevent GP registration.

Survey respondents are using emergency care, such as A&E and ambulances, at a higher rate than the general population. This might be associated with mental illness or attributed to a deprived living environment, such as an increased risk of accidents.

There was less satisfaction with the support received to treat mental health conditions compared to physical health conditions. Both areas indicated need for greater support. In terms of health protection, flu and Hepatitis B vaccination have a poor uptake amongst survey participants and could provide a high benefit owing to the risks associated with this population group. Female respondents were more likely than male to have received a sexual health check in the past twelve months.

6. Implications

This chapter includes an important analysis of the needs of single homeless people in Bromley. Although the numbers involved in the homeless health needs audit are small, responses show similarities with both regional and national data on the needs and experiences of the homeless population. This substantiates the findings of this research.

Its implications can be considered around three areas in terms of informing future work:

1. Addressing areas of need around preventative health care and hospital discharge

The audit showed a number of actions that can take place to support the health and well-being of the homeless population via health services. For example improving take up of annual flu vaccinations or increasing awareness around sexual health. This might require GPs to use appointments with homeless people to also check that they are aware and know how to access other types of health and well-being support, plus that their client details are up to date (for example address and mobile phone number).

London's Find and Treat service, a specialist outreach team for homeless people primarily focused around tackling TB, also provides influenza vaccination in addition to testing for other diseases such as Hepatitis C and B[48]. Homeless related services and organisations might want to maximise contacts with homeless people when this service is in the borough.

In addition to preventative healthcare, the audit flagged up a need for consistency in terms of hospital discharge. Although the majority of respondents were discharged into suitable accommodation, four stated returning to rough sleeping. In 2013 the Government invested in a Homeless Hospital Discharge Fund to improve services for people leaving hospital who are homeless. The pilot projects as a result of this investment were evaluated by Homeless Link, with recommendations including[49]:

- Development of homeless hospital discharge protocols to provide a clear referral route and single point of contact for clients.
- Training of medical staff in terms of definitions of homelessness and awareness of key housing and homelessness support organisations.
- Set of monitoring data on outcomes for homeless patients, for example length of stay and accommodation status on admission.

Bromley will explore the provision provided by Green Parks House, which supports housing resettlement of adults with mental health needs, to see if this service can advise a homeless patient attending any part of the Princess Royal University Hospital. In addition Bromley's new homeless prevention scheme will contact hospitals alongside GP surgeries and mental health teams. This will help health sector organisations identify other organisations that can support homeless people or people at risk of homelessness, such as housing benefit teams.

[48] Information on Find and Treat at https://www.uclh.nhs.uk/ourservices/servicea-z/htd/pages/mxu.aspx

[49] Evaluation of the Homeless Hospital Discharge Fund (Homeless Link, 2015) http://www.homeless.org.uk/sites/default/files/site-attachments/Evaluation%20of%20the%20Homeless%20Hospital%20Discharge%20Fund%20FINAL.pdf

The homeless health needs audit was carried out at a time when homeless health needs are being looked at in detail at a pan London level as a result of the report *Better Health for London* (London Health Commission, 2014). This has led to a London Homeless Health Programme which has developed:

- A CCG Toolkit to brief commissioners on their local homelessness needs and services
- A 'Best Practice Guide' for CCGs on 'what works' in improving health services for the homeless

Analysis of Bromley's homeless health needs audit should be considered in light of these tools once published, potentially in discussion with other South East London boroughs who carried out similar audits in their areas.

2. Working with the Private Rental Sector to support resettlement

An ongoing area of concern is the availability of affordable housing in the borough that is of a known decent condition and supports households with specific needs, whether that is young children, people with disabilities or families facing challenges around income, such as debt and benefit uptake. A report referred to in this chapter by King's College states ***"***Given the mounting pressure to rehouse homeless people and the growing shortage of social housing, resettlement into the PRS [Private Rental Sector] is now unavoidable and will continue for the foreseeable future. This raises questions about how formerly homeless people can better be supported to manage in this type of accommodation, to negotiate with landlords about repairs, and to cope with conflicts that may arise with other tenants."

The charity, Crisis has carried out work on private rented sector access schemes that support clients who are homeless, at risk of homelessness or vulnerably housed to create and sustain tenancies[50]. These schemes support landlords who are letting to a tenant with experience of homelessness in addition to supporting tenants with any structural barriers they are facing to accessing private rental accommodation.

Bromley provides support to private landlords through partnership work between the Housing Acquisition team and the Support and Resettlement team. This work needs to continue in addition to expanding support to people facing hardship in terms of coping skills and resilience building.

3) Survey for Homeless Families

Over the next year Bromley will carry out a survey for homeless families. This will build on the data for single homeless people by considering the statutory

[50] Gousy, H, Home. *No less will do: Improving access to private renting for single homeless people* (Crisis 2016)

homeless adult population in addition to the health needs of children in temporary housing.

It will be important to compare the Homeless Families survey results with the single homeless population audit in terms of common themes in addition to considering the specific needs of this growing population group. For example, this chapter highlighted challenges in terms of the growing number of families in temporary housing. The survey will help explain what this looks like from a health needs perspective.

What does this mean for Bromley residents and for children in Bromley?
Bromley has a substantial homeless population. This can be considered in two groups: the single homeless population and the statutory homeless population, which can also be counted by households in temporary accommodation.

There has been a rise in recent years of the number of households in temporary accommodation. A very high proportion of these households include children and some are placed outside of the borough. Households are also remaining in temporary accommodation for an increasing length of time.

For the first time in recent years Bromley has undertaken an audit of its single homeless population. This has allowed it as a borough to perform a detailed analysis of a small sample of one of the borough's most vulnerable communities to poor health outcomes.

Results of the survey show a population group with high physical and mental health needs who are frequent users of emergency health services. Improvements in access to preventative health care and mental health support in addition to potentially a more consistent approach around hospital discharge needs to be considered for this population group.

Bromley in the next year will carry out a homeless health needs audit on homeless families in the borough. Data from this survey can be compared to the single homeless audit and help consider the health needs of people in temporary housing in addition to specific needs of homeless parents and children.

Accessible, affordable and supportive housing is key to supporting the single homeless and statutory homeless population in Bromley. Areas highlighted in this chapter include:

- Up to date understanding of the condition of existing private rental housing stock, particularly in the lower rent quartile.
- An analysis of the private rental sector in terms of how it can provide supportive accommodation for vulnerable community groups.
- Continuing to provide advice to families on low incomes regarding building resilience in the face of financial hardship, for example by accessing community support and taking up advice on avoiding accumulation of debt.

5. Sexual Health and Pregnancy and Maternity Care

Introduction

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

This section explores:

- The current rate, trends and demographic patterns of five important STIs: Chlamydia, Gonorrhoea, Syphilis, Genital Warts and Genital Herpes.
- Incidence of Pelvic Inflammatory Disease (PID).
- An in depth look at HIV in the borough.
- Teenage pregnancy, terminations and contraception use.
- Cervical cancer incidence and vaccination.

Sexually Transmitted Infections (STIs)

2,087 new STIs were diagnosed in residents of Bromley in 2015. This compares with 2,188 in 2014, showing a small decline of 4.8% which follows a similar pattern to London and England.

Rates of STIs overall in Bromley have been increasing since 2009, though there is a small decrease in 2015 of 4.6%. A similar decrease (3.5%) is also seen in England though London overall increased its rate by 1.8%. The fall in Genital Warts is likely to contribute to this decrease. Previous years increases in STIs is partly due to improved testing and reporting but also due to increased risk taking behaviours, especially among MSM individuals of all ages and young people under the age of 25 years. The prevalence of STIs in Bromley is the third lowest among London Boroughs.

Table 5.1 sets out the diagnostic rate per 100,000 population for Bromley over a three year period for five important STIs: Chlamydia, Gonorrhoea, Syphilis, Genital Warts and Genital Herpes. The diagnostic rates for London and England for 2015 are also included in addition to Bromley's rank position compared to local authorities across England (with 1 indicating the highest rate of disease). Bromley has a lower rate than London for all five listed STIs. It also has a lower rate than England for Chlamydia, Genital Warts, Genital Herpes and new STIs including and excluding Chlamydia. It has a higher rate

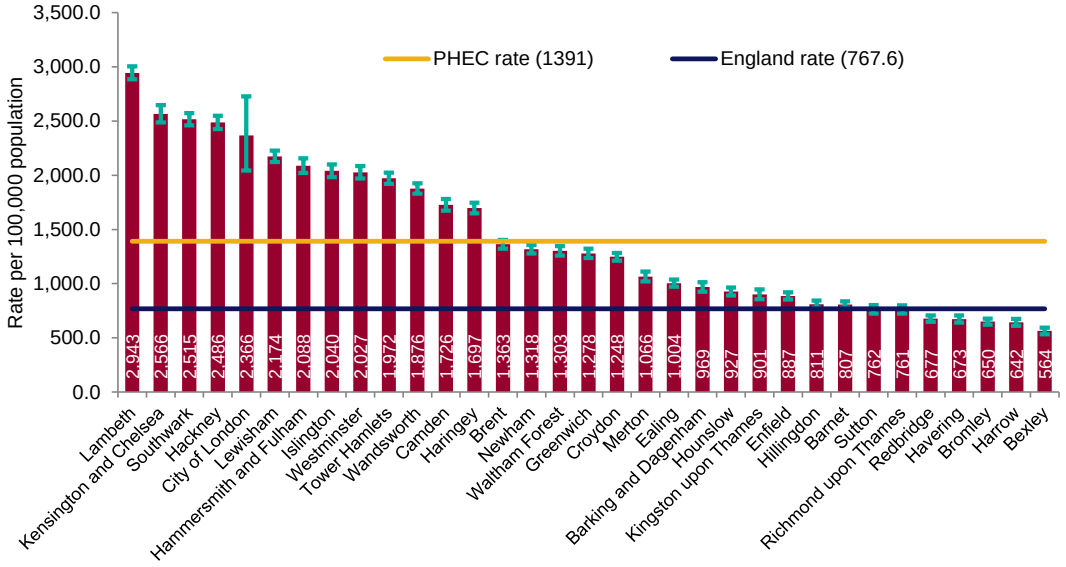
than England for Gonorrhoea and slightly higher for Syphilis. This is reflected in its rank status in England for Gonorrhoea and Syphilis at 40 and 31 respectively.

Table 5.1: Diagnostic rates for STIs in Bromley 2013 to 2015

Diagnosis	**Rate 2013**	**Rate 2014**	**Rate 2015**	**% change 2014-2015**	**Rank England, 2015** (1 = highest)	**Rate England Residents 2015**	**Rate London residents 2015**
New STIs	715	681	650	-4.6	85	768	1,391
New STIs (Excluding Chlamydia aged >25)	768	759	736	-3	-	815	1,606
Chlamydia	276.1	261.0	268.0	2.7	110	361	554
Gonorrhoea	52.8	64.4	76.3	18.5	40	70.7	221.9
Syphilis	5.0	7.2	10.6	47.2	31	9.3	32.9
Genital Warts	118.0	118.6	104.3	-12	105	118.9	159.3
Genital Herpes	*55*	*52*	57	10	75	57.6	93.8

Source: Sexual and Reproductive Health Profiles, 2016; GUMCAD, CTAD, ONS

Figure 5.1: Rate of new STI diagnoses per 100,000 population among London residents by local authority of residence: 2015



Source: Public Health England, GUMCAD (level 3 services) and CTAD

Chlamydia

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

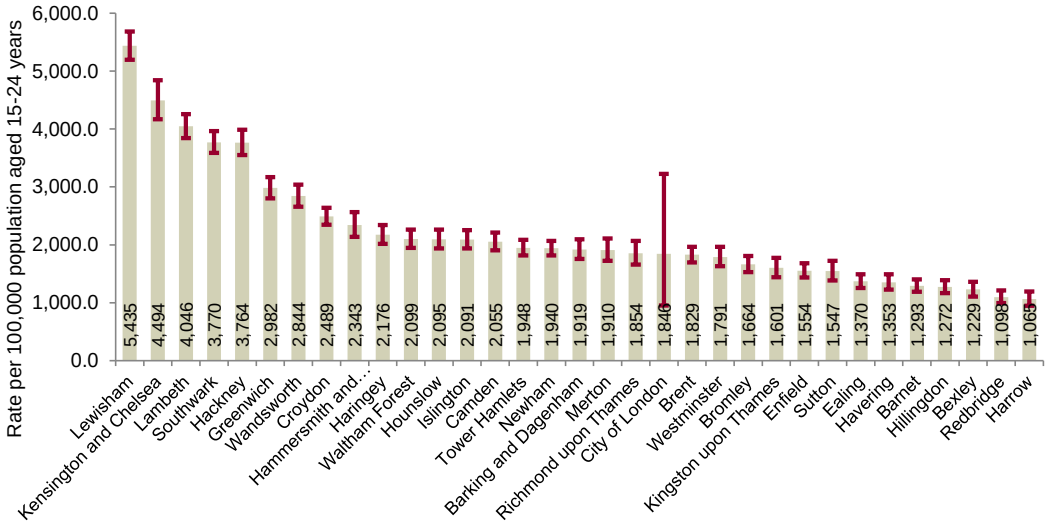
The prevalence rate of Chlamydia in Bromley is below the national average. This is in accordance with its low prevalence of all STIs compared to other London boroughs. Bromley is committed to ensuring that 20 to 25% of 15 to 24 year olds are screened for Chlamydia, prioritising testing and awareness raising in its population groups at most risk.

Chlamydia detection rates and screening proportion

Four years of data is now available in the Chlamydia Testing Activity Dataset (CTAD). National trends show a decline in detection rate over the past three years, with the biggest change in detection rate from 2014-2015 (-7.3%). This trend is reflected in Bromley's data with a decline of 9.6% in 2014-2015, owing potentially to a decline in testing coverage with fewer tests in non-

specialist sexual health clinics and community venues[51] with the exception of contraception clinics. In addition the low detection rate is related to the borough's low prevalence rate.

Figure 5.2: Chlamydia detection rate per 100,000 population aged 15-24 years in London by upper tier local authority of residence: 2015



Source: Public Health England, GUMCAD (level 3 services) and CTAD

Table 5.2: Chlamydia proportion aged 15-24 screened (Sexual and Reproductive Health Profiles, 2015)

Bromley	London	England
21.5	27.4	22.5

[51] Health Protection Report, Infection Report Volume 10, Number 22 (PHE, 2016)

Figure 5.3

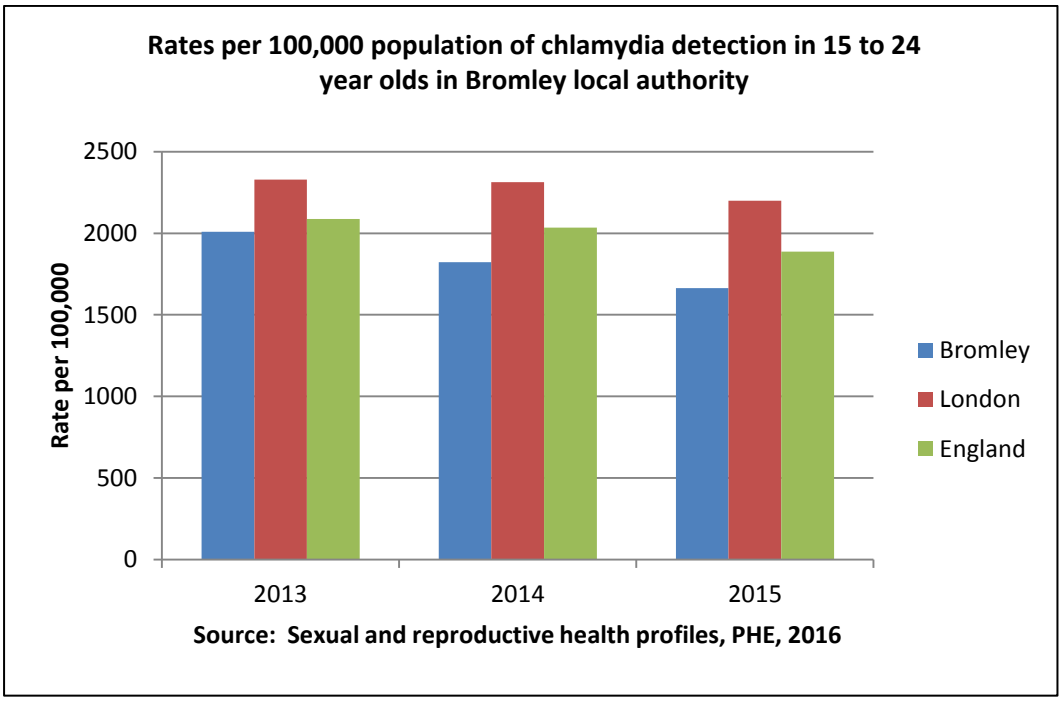


Table 5.2 shows 2015 data for the proportion of 15 to 24 year olds screened in Bromley for Chlamydia. Bromley's proportion of 21.5% is similar to England's but lower than London's overall rate, reflecting the lower prevalence of Chlamydia in the borough.

2014 Chlamydia testing data shows the split in Bromley between tests in GUM clinics and community settings, with the majority taking place in the latter (see **Table 5.3**). From this data, 7.3% of tests are positive. This proportion of positives is lower than the England 2015 average of 8.4% across all testing venues[52].

Table 5.3: Chlamydia testing data in 15-24 year olds in Bromley: 2014

Number of chlamydia tests in GUM	Number of chlamydia tests in other settings	Total number of tests	Number of positives (all settings)	Percentage of population tested (all settings)*
3042	5377	8419	617	24.6

*Repeat tests are not excluded

Source: Data from Genitourinary Medicine Clinics and community settings

[52] Health Protection Report, Infection Report Volume 10, Number 22 (PHE, 2016)

Re-testing also takes place to check treatment success. Although recommended, only a low percentage of people attend re-testing. For example, 12% of young people diagnosed with Chlamydia in Bromley in quarter 3 of 2014 attended for re-testing. Out of that proportion 10% were positive. Sexual health clinics and community-based settings need to encourage re-testing after a positive diagnosis as well as annual screening and on change of sexual partner[53].

Gonorrhoea

Rates of Gonorrhoea and Syphilis in Bromley are now above the national average, though below the London average. The increases in Bromley seen in the last year reflect the national pattern, with the largest proportional increases in diagnoses in England between 2014 and 2015 reported for Syphilis (20%) and Gonorrhoea (11%)[54]. Bromley's percentage change between 2014 and 2015 for these two infections are 47.2% and 18.5% respectively. It is important to note that there are small numbers (for example for Syphilis <50 people) with infection in the borough, explaining in part the high percentage increase.

Improved test sensitivity and uptake may have contributed to the increase in Gonorrhoea infections but increased transmission is also likely to play a major role. A particular concern nationally is the rapid rise in Syphilis and Gonorrhoea among MSM which strongly suggests high levels of condomless sex[55]. There is a spread of resistance to frontline antimicrobials for Gonorrhoea which is reducing treatment options.

A recent paper looking at the spatial modelling of Gonorrhoea in London confirmed the presence of 'core areas' of high incidence, and identified 'core' high-risk groups, in particular young adults (16-29 years), males, Black Caribbeans and more deprived areas[56]. Bromley will continue to take forward targeted and focused prevention programmes, such as promotion of condom use and early detection through frequent testing, to minimize onward transmission of STIs.

[53] Annual Epidemiological Spotlight on Sexually Transmitted Infections in London: 2015 data (PHE, 2016)
[54] Health Protection Report, Infection Report Volume 10, Number 22 (PHE, 2016)
[55] Health Protection Report, Infection Report Volume 10, Number 22 (PHE, 2016)
[56] Le Polain De Waroux O[1], Harris RJ, Hughes G, Crook PD, The epidemiology of gonorrhoea in London: a Bayesian spatial modelling approach Epidemiol Infect. 2014 Jan;142(1):211-20

Figure 5.4

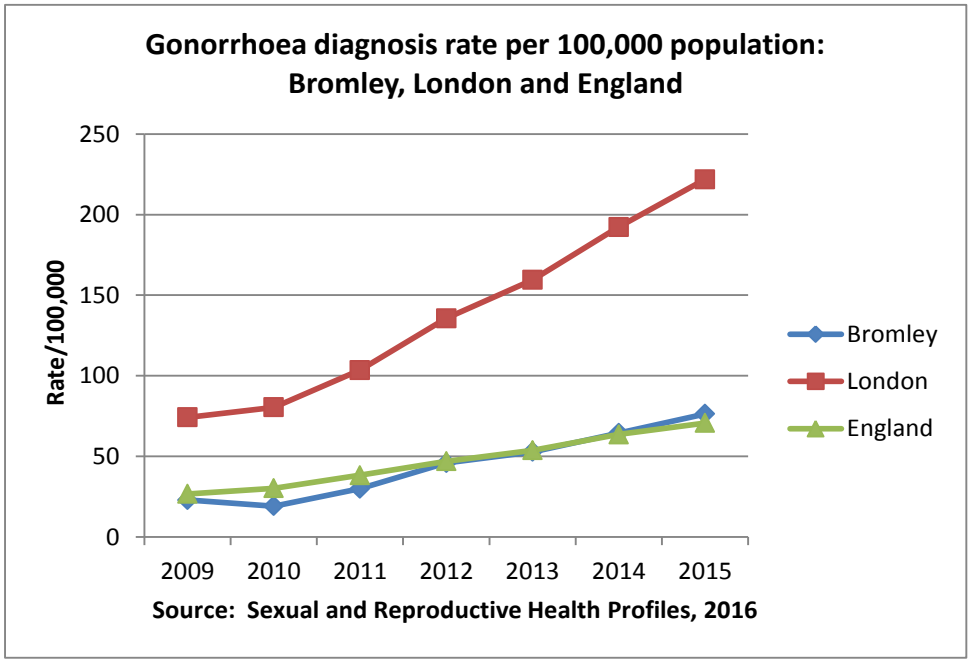
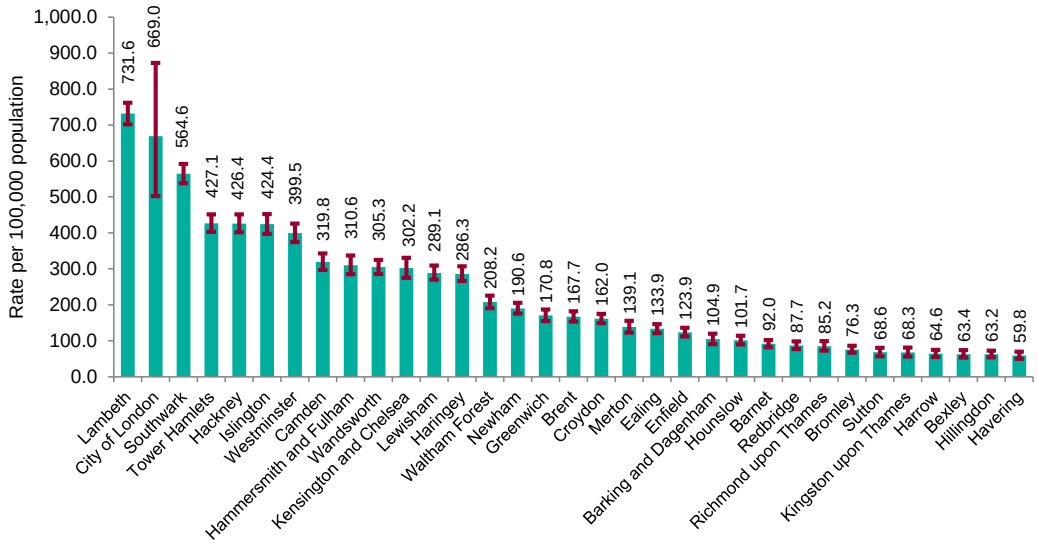


Figure 5.5: Rate of Gonorrhoea diagnoses per 100,000 population in London by upper tier local authority of residence: 2015



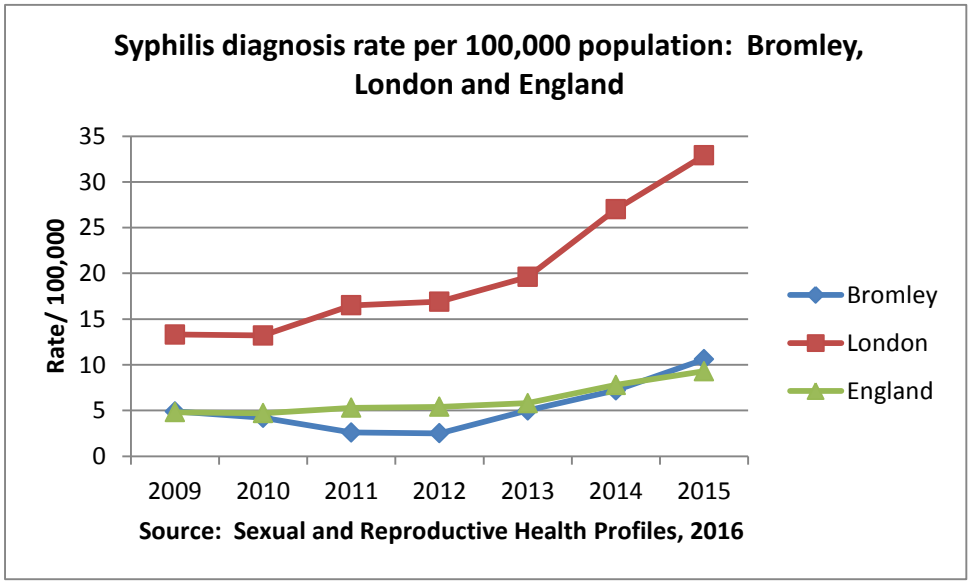
Source: Public Health England, GUMCAD (level 3 services)

Syphilis

There is very high prevalence of Syphilis in London compared to nationally. Although Bromley rates are similar to England as a whole (see **Figure 5.6**) the level of infection is increasing which requires targeted action in terms of awareness raising, testing, treatment and contact tracing. Syphilis infection increases likelihood of HIV transmission and if the infection reaches its tertiary phase can be fatal, though this is rare owing to the use of antibiotics[57].

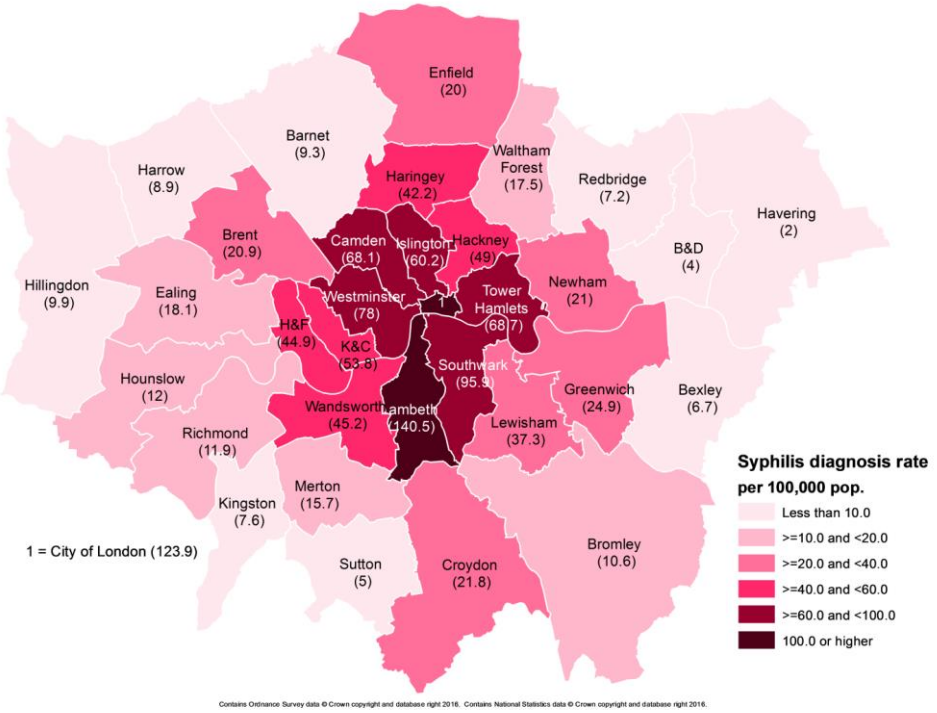
Public Health England data indicates that men who have sex with men (MSM) account for a high number of new Syphilis infections, with high risk sexual behaviours likely to be driving transmission rates. The median age of MSM diagnosed with Syphilis in 2015 was 36 years, the majority were white (74%) and 44% were born in the UK[58]. Owing to the small numbers of Syphilis cases it is not possible to break this number down by sexual orientation for Bromley.

Figure 5.6



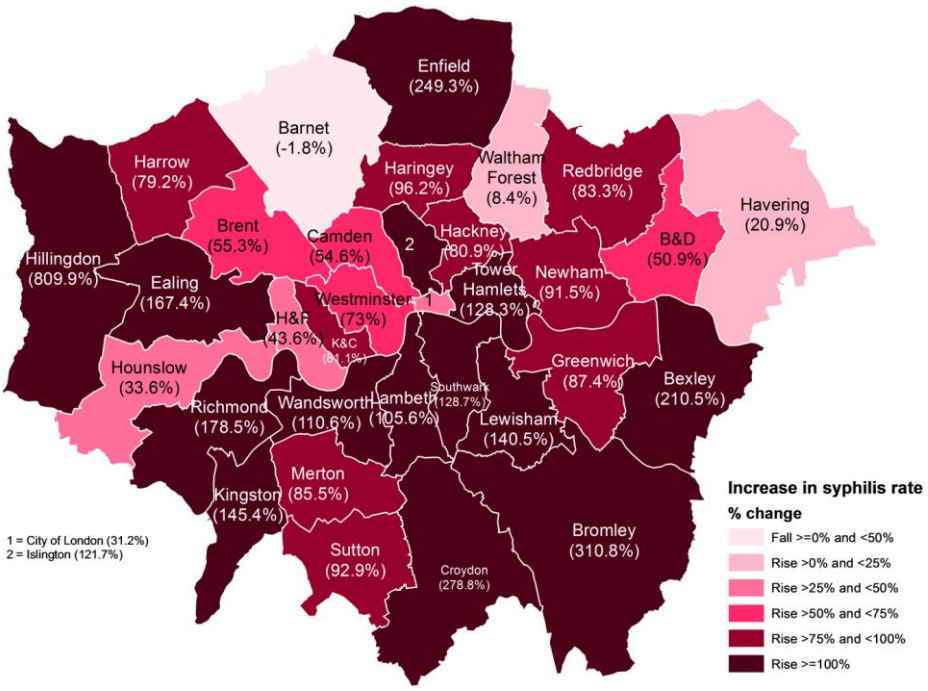
[57] Syphilis epidemiology in London: Sustained high numbers of cases in men who have sex with men (PHE, 2016)
[58] Syphilis epidemiology in London: Sustained high numbers of cases in men who have sex with men (PHE, 2016)

Figure 5.7: Map of Syphilis rates per 100,000 residents by local authority in London, 2015.



Data source: GUMCAD

Figure 5.8: Map of percentage increase in rates of Syphilis per 100,000 residents by local authority in London, from 2011 to 2015.



Data source: GUMCAD

Genital warts and genital herpes

Bromley has seen a 12% decrease in diagnoses of genital warts, which follows a national trend (7% decrease). A decrease amongst women is associated with the Human Papilloma Virus (HPV) vaccination[59].

There has been a small increase in the diagnosis of genital herpes that follows national trends. Patterns of both infections over the past six years in Bromley are set out in Figures 5.9 and 5.10.

Figure 5.9

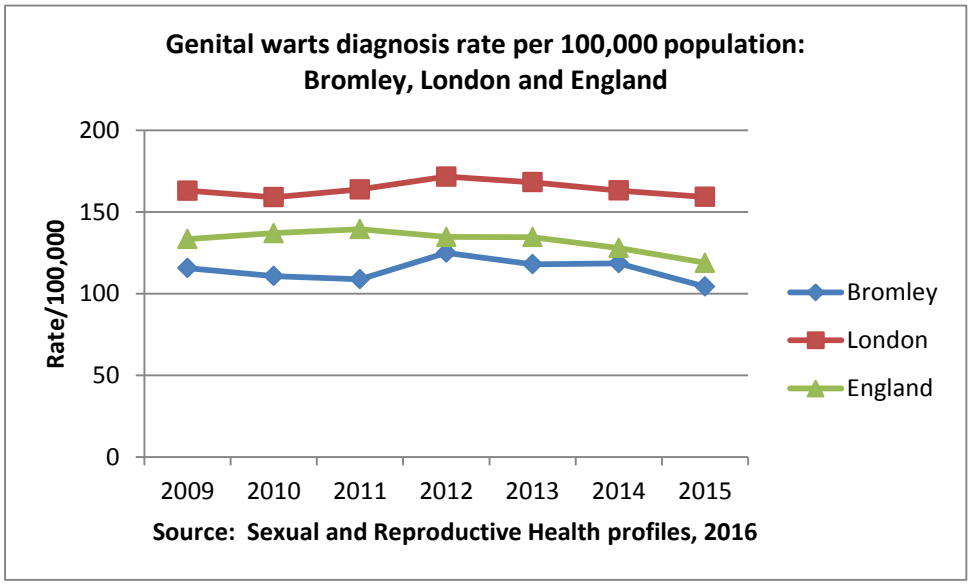
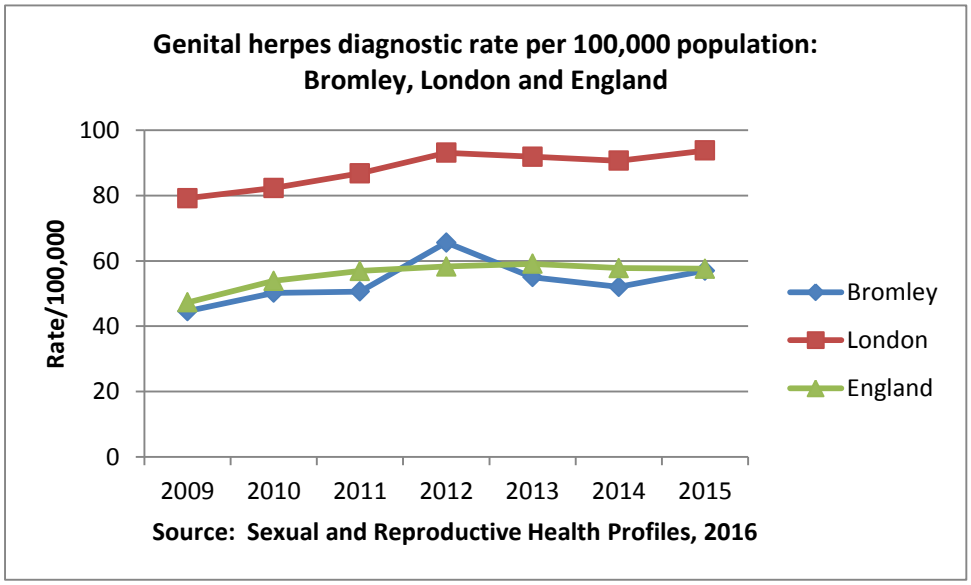


Figure 5.10



[59] Health Protection Report, Infection Report Volume 10, Number 22 (PHE, 2016)

Distribution of STIs and Deprivation

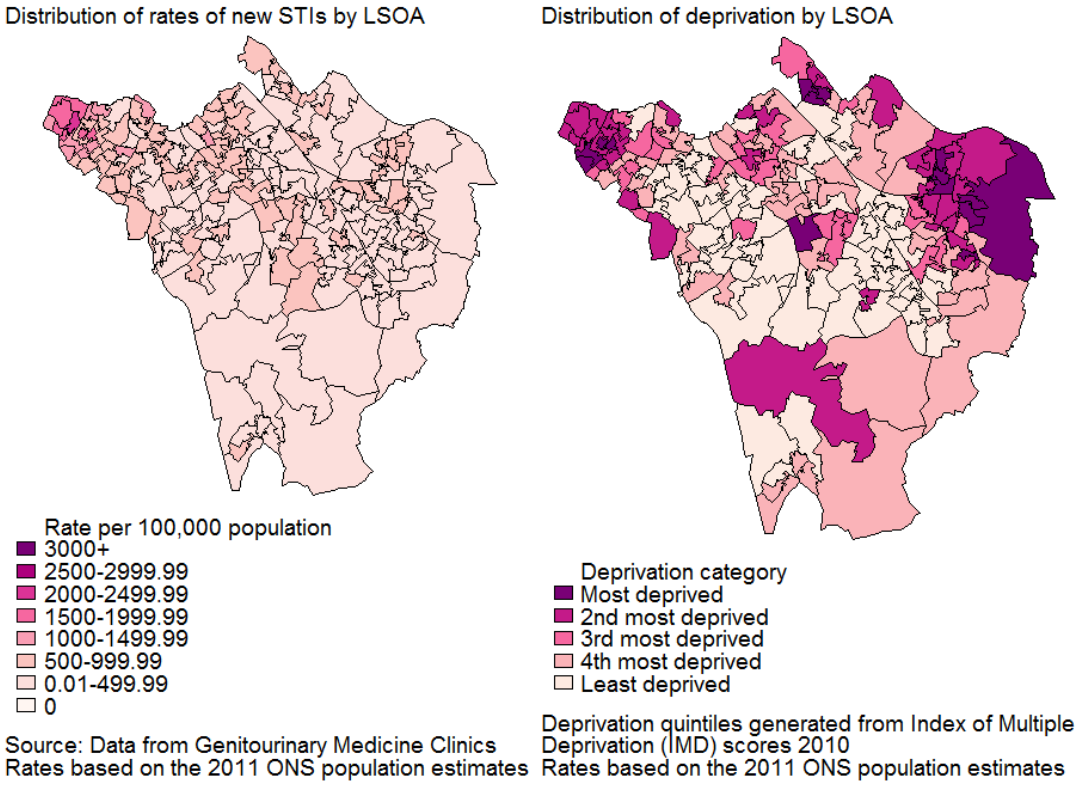
The overall low prevalence of STIs in Bromley compared to other London boroughs hides wide variations across the borough. There is considerable geographic variation in the distribution of STIs, which is shown in **Figure 5.11** below. This shows the highest rates in the North West of the borough, particularly the wards of Crystal Palace, Penge & Cator and Clockhouse.

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

2015 English Indices of Deprivation places Bromley as 220 out of 326 local authorities in terms of English areas for deprivation (first in the rank has the highest rates). However when local concentration of deprivation in Lower Super Output Areas is included Bromley's rank is 154. This reflects the high areas of deprivation that exist in the borough.

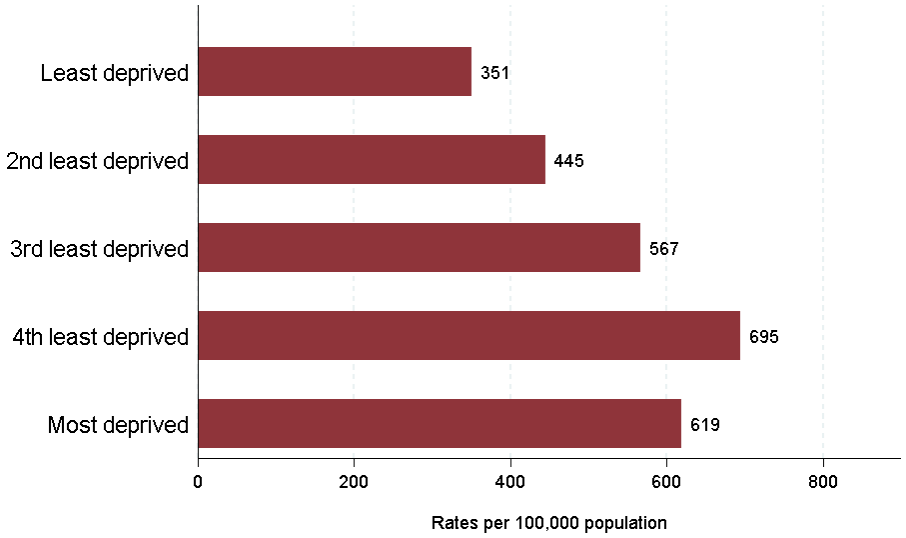
The relationship between deprivation level and STI rate is not aways consistent in Bromley. For example, a high STI rate is seen in the North West area of the borough, corresponding with higher than average levels of deprivation. However, there is a low STI rate in Cray Valley East despite high levels of deprivation. In addition **Figure 5.12** below shows that the highest STI rates are in the 4th least deprived category, which suggests a number of different population factors at play when considering STI rates in Bromley.

Figure 5.11: Rates of new STIs (2014) and deprivation by LSOA* in Bromley (GUM diagnoses only)



* Lower Layer Super Output Areas (LSOA) are built from groups of contiguous Output Areas and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The minimum population is 1,000 and the mean is 1,500.

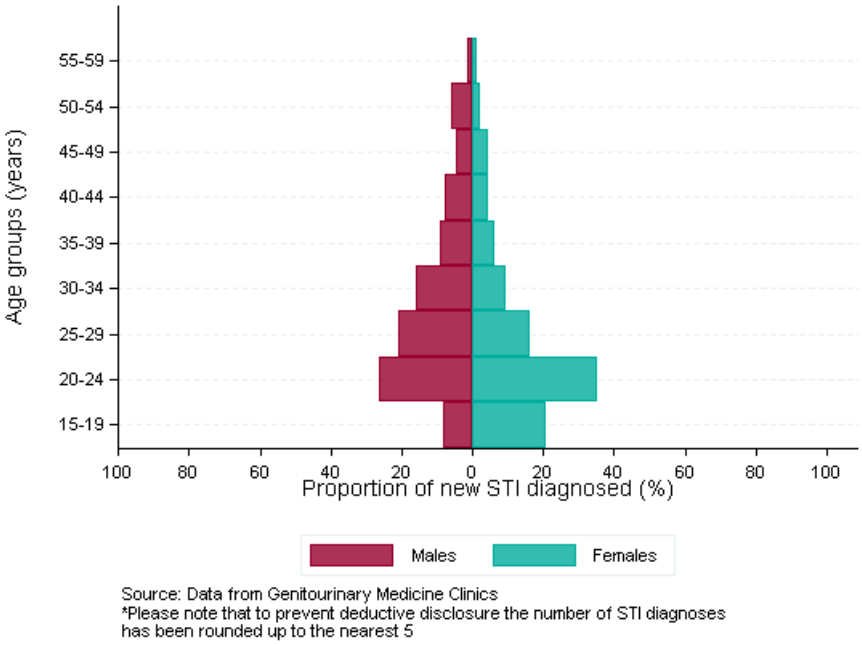
Figure 5.12. Rates* of new STIs by deprivation category in Bromley (GUM diagnoses only): 2014



Source: Data from Genitourinary Medicine Clinics
Rates based on the 2011 ONS population estimates
Excludes chlamydia diagnoses made outside GUM
*Please note that to prevent deductive disclosure the underlying number of STI diagnose used to calculate the rates in this figure has been rounded up to the nearest 5

Young people aged between 15 and 24 years' experience the highest rates of new STIs. In Bromley in 2014, 43% of diagnoses of new STIs were in young people aged 15-24 years, a decrease of 9% compared to 52% in the previous year (2014 GUM clinic data). The age profile for new STI infections is shown in **Figure 5.13** below.

Figure 5.13. Proportion of new STIs by age group and gender in Bromley: 2014



Further information about the STI rate amongst the 15-24 year age group is required to understand whether the decrease in STI in the past year is a trend and how best to target interventions to reduce the rate overall. The table below shows where Bromley's population between the ages of 15 to 29 years of age live, using mid-year population estimates. The three wards with the highest number of people aged 15 to 19 years old are Cray Valley West, Bromley Common & Keston and Chislehurst and for 20 to 24 years of age Cray Valley West, Penge & Cator and Cray Valley East.

Bromley will also take forward work with schools to integrate Sex and Relationship Education (SRE) into the PSHE curriculum. This includes the borough's community early intervention sexual health check service working closely with schools to support teachers to deliver SRE in addition to working with non-school based settings attended by under 16 year olds.

Table 5.4: GLA 2015 round ward population projections, Bromley

Ward	Number of people aged 15 to 19	Number of people aged 20 to 24	Number of people aged 25 to 29
Bickley	795	513	715
Biggin Hill	663	486	557
Bromley Common and Keston	1069	681	934
Bromley Town	786	648	1442
Chelsfield and Pratts Bottom	786	447	647
Chislehurst	1014	509	816
Clock House	696	627	1045
Coopers Cope	406	546	1545
Cray Valley East	941	817	1021
Cray Valley West	1215	980	1126
Crystal Palace	502	681	1337
Darwin	314	187	186
Farnborough and Crofton	957	538	535
Hayes and Coney Hall	1005	765	787
Kelsey and Eden Park	944	671	809
Mottingham and Chislehurst North	690	462	735
Orpington	858	764	813
Penge and Cator	888	882	1400
Petts Wood and Knoll	578	544	680
Plaistow and Sundridge	751	607	1034
Shortlands	518	311	583
West Wickham	983	736	674

Source: GLA datastore, 2016

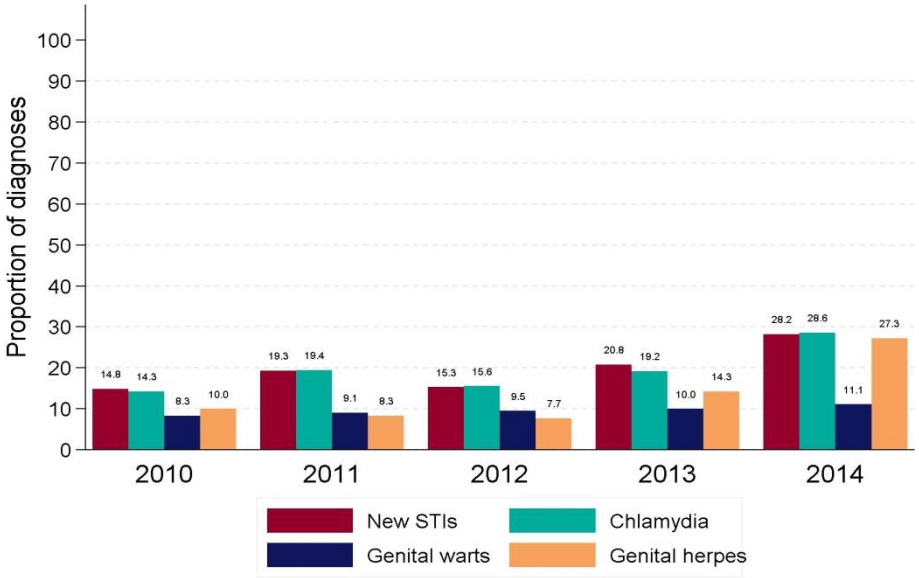
Men who have sex with men (MSM)

In Bromley in 2015, for cases in men where sexual orientation was known, 28.1% (n=295) of new STIs were among MSM. This is similar to the London average of 30%[60]. In 2010, the proportion of new STIs among MSM was 14.8% (n=115). This shows a more than doubling of the number of STIs amongst MSM in Bromley over the past five years, possibly a result of changing demographics of the area in addition to Londoners putting

[60] Annual Epidemiological Spotlight on Sexually Transmitted Infections in London: 2015 data (PHE, 2016)

themselves at risk through unsafe sex. Please note the numbers for MSM presented in this report include homosexual and bisexual men.

Figure 5.14: Proportion* of new STIs, chlamydia, genital warts and genital herpes in MSM among men in Bromley (GUM diagnoses only): 2010-2014



Source: Data from Genitourinary Medicine clinics
Excludes chlamydia diagnoses made outside GUM
For cases in men with known information on sexual orientation
See Figure 5 for denominator
*Please note that to prevent deductive disclosure the number of STI diagnoses in this figure has been rounded up to the nearest 5

National evidence[61] suggests an increase in STI rates in MSM are due to:

- Better detection, specifically for Gonorrhoea and Chlamydia diagnoses
- Condomless sex associated with HIV sero-adaptive behaviour (selection of partners perceived to be of the same HIV sero-status). The rate of acute bacterial STIs in HIV-positive MSM is up to four times that of MSM who were HIV-negative or of unknown HIV status.
- Chemsex, which refers to sex that occurs under the influence of drugs.

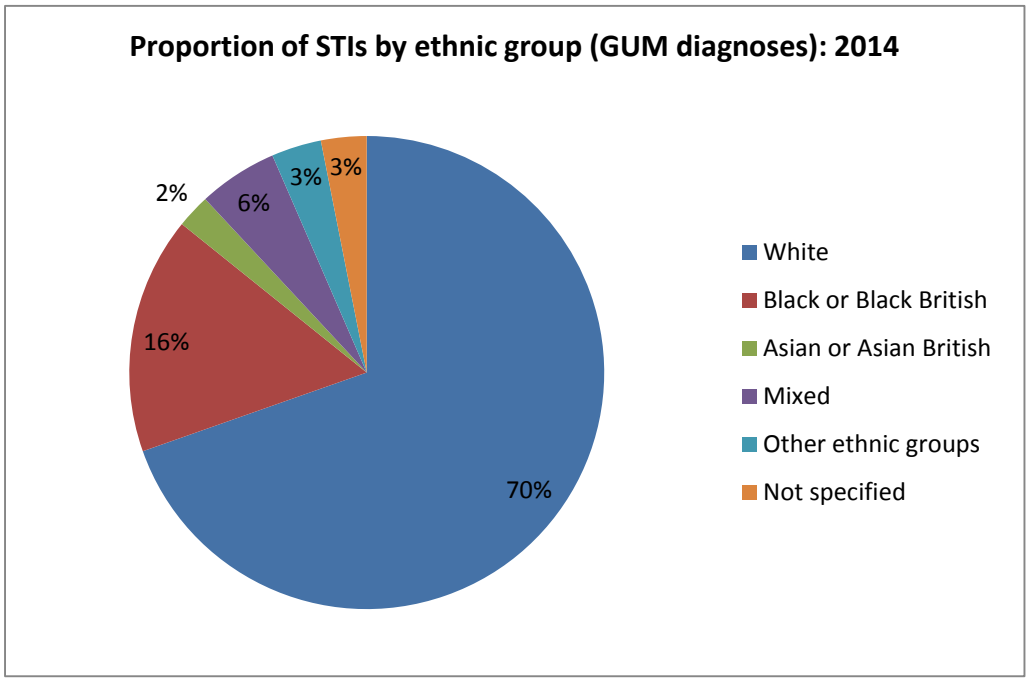
STI by ethnic group and country of birth

27.3% of new STIs diagnosed in GUM clinics in 2014 were in individuals from a black or minority ethnic background, which compares to 19% which make up Bromley's population. 16.2% of this number were Black or Black British. These proportions are rounded up and presented in the figure below. Please note, to prevent deductive disclosure STI diagnoses figures for each group have been rounded up to the nearest five (1,760 cases in total).

[61] Annual Epidemiological Spotlight on Sexually Transmitted Infections in London: 2015 data (PHE, 2016)

Where recorded, 18.0% of new STIs diagnosed in Bromley were in people born overseas.

Figure 5.15



Reinfection of STIs

Reinfection with an STI is a marker of persistent risky behaviour. In Bromley, an estimated 4.6% of women and 8.9% of men presenting with a new STI at a GUM (Sexual Health) clinic during the five year period from 2010 to 2014 became re-infected with a new STI within twelve months. Nationally, during the same period of time, an estimated 7% of women and 9% of men presenting with a new STI at a GUM clinic became re-infected with a new STI within twelve months

In Bromley, an estimated 4.8% of women and 8.2% of men diagnosed with Gonorrhoea at a GUM clinic between 2010 and 2014 became re-infected with Gonorrhoea within twelve months, an increase of 1% for both groups when compared to data from 2009 to 2013. Nationally, an estimated 3.7% of women and 8.0% of men became re-infected with Gonorrhoea within twelve months.

Young people are more likely to become reinfected with STIs. In Bromley, an estimated 8.5% of 15-19 year old women and 12.3% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2010-2014 became reinfected with an STI within twelve months[62]. Young

[62] Bromley Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2014 (PHE, 2015)

people may require more confidence and resilience in negotiating safer sex. In addition there is a need to make greater efforts at encouraging condom use amongst young people and at risk groups, in addition to promoting early testing as a prevention method.

What this means for Bromley residents

The latest data indicates a decrease in new STI infections in Bromley, changing a previous trend of year on year increases. This is likely to be partly due to a decrease in the infection rate of genital warts, associated with the Human Papilloma Virus vaccination.

Despite an overall decrease, Bromley continues to see increases in infection rates of the following STIs:

- Chlamydia
- Syphilis
- Gonorrhoea
- Genital herpes

STIs are also geographically concentrated with the highest rates in the North West of the borough, particularly the wards of Crystal Palace, Penge & Cator and Clockhouse.

Bromley needs to continue its targeted prevention and treatment programme for communities it knows are at increased risk, specifically:

- Young people (aged 15 to 24 years)
- MSM
- Certain ethnic groups, particularly Black and Black African.

This will include the rolling out of an online STI home testing service in addition to including a requirement for a community provider to work closely with schools and non-school based settings to help deliver sex education.

Pelvic Inflammatory Disease

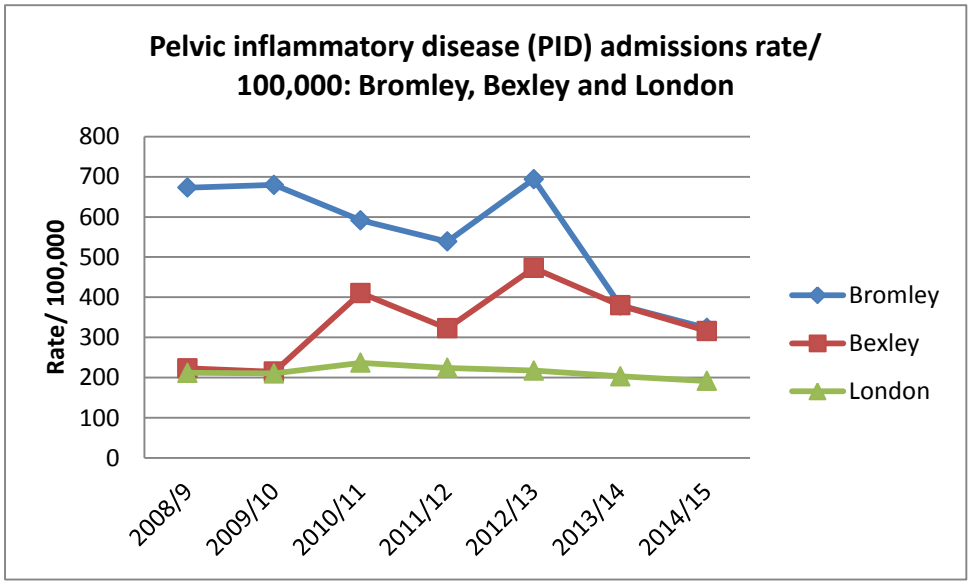
Pelvic inflammatory disease (PID) is a generic term for inflammation of the female uterus, fallopian tubes and/or uterus which progresses to scar formation with adhesions to nearby tissues and organs. PID can result in infertility, ectopic pregnancy and chronic pain. Although there are many possible 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.

For the past few years, Bromley and its neighbouring borough Bexley have observed a high PID admission rate in comparison to London's overall

prevalence, despite an overall lower number of STIs. The South East London Health Protection Team investigated these rates in 2015 but were unable to conclude if the high rates were a result of data anomaly. A potential factor could be challenges around ascertainment of PID cases as there is no reliable diagnostic test. However no conclusion can be drawn at this stage[63].

Current data shows a decline in PID admissions over the past two years in both Bexley and Bromley though they remain at a higher rate than London (see **Figure 5.16**).

Figure 5.16



What this means for Bromley residents

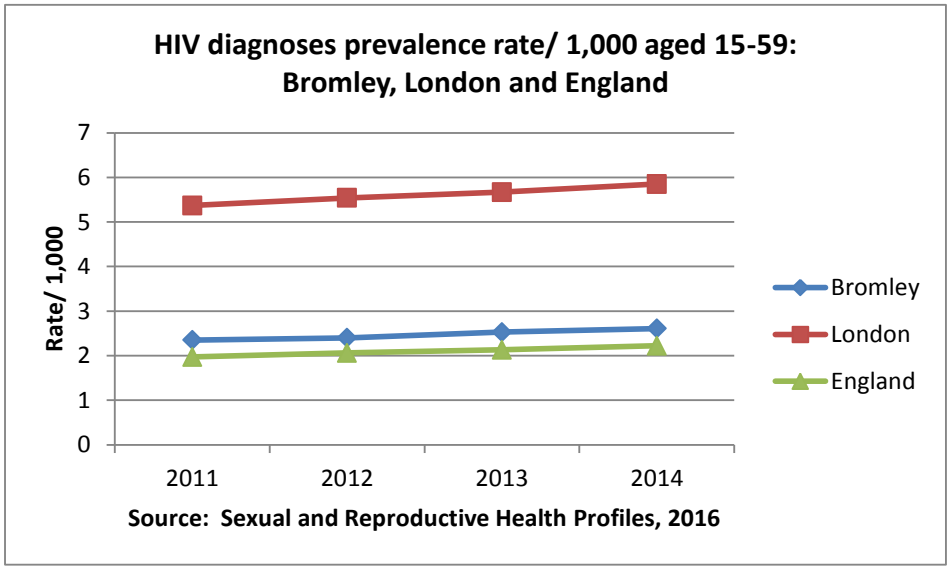
Investigative work so far has not been able to ascertain why Bromley saw high admission rates for PID. The rates have been decreasing since a peak in 2012/13. Careful monitoring of the downward trend will continue to help identify the cause of the historical high rate.

HIV

The number of Bromley residents living with diagnosed HIV continues to rise. The diagnosed HIV prevalence rate has now risen to 2.65 per 1,000 population aged 15-59 years, compared to 2.2 per 1,000 in England. A prevalence rate of 2 per 1,000 population (aged 15-59) or higher denotes a high prevalence area and routine HIV testing to detect the infection is recommended.

[63] Marr, R, *Investigation into High Rates of Pelvic Inflammatory Disease in Bexley and Bromley* (South East London Health Protection Team, 2015)

Figure 5.17

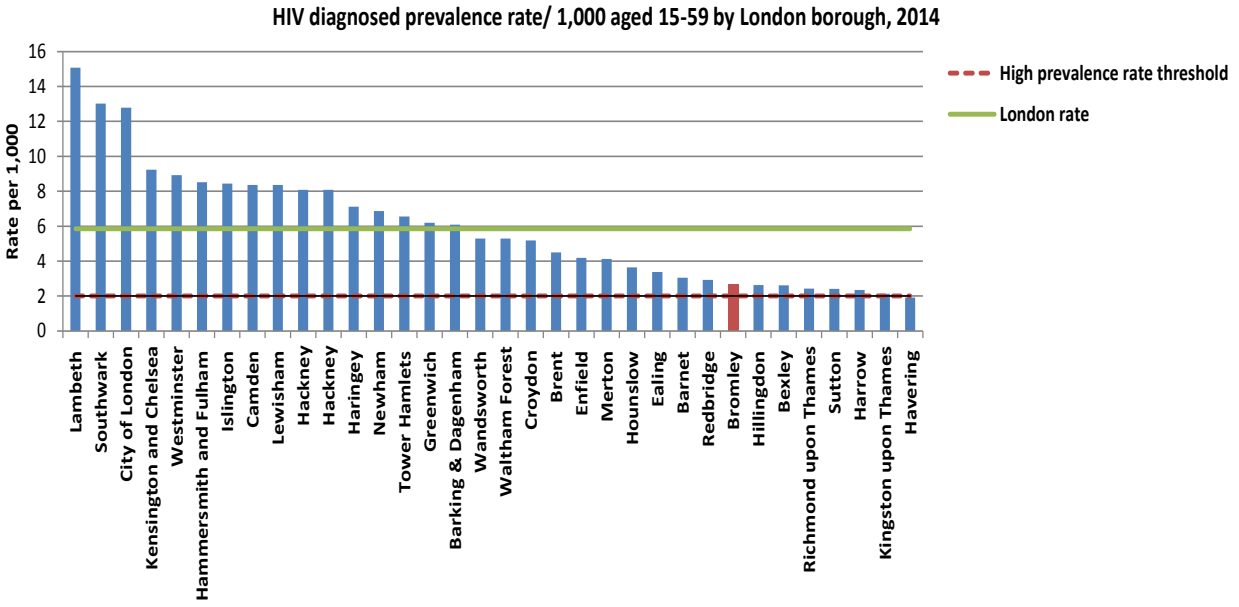


Bromley remains one of the lowest 'high prevalence' areas in London (eighth lowest, with London prevalence average of 5.85). This overall prevalence masks local variation.

The highest rates of HIV in Bromley (20 plus, 10-19.9 and 6-9.9 per 1000) continue to be found in the North-West spur of the borough. Prevalence rates of higher than 2 per 1000 occur in approximately half of Middle layer Super Output Areas (MSOAs) in Bromley as shown in **Figure 5.19**.

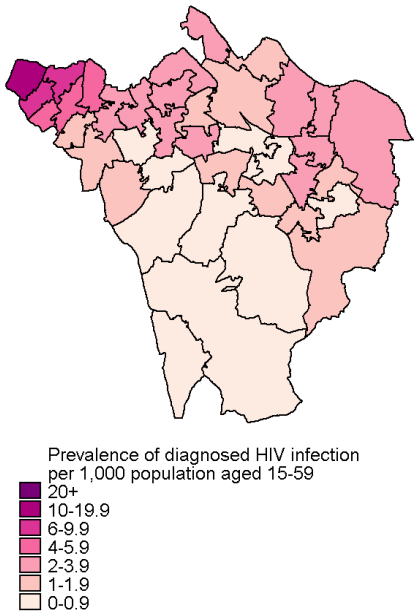
The pattern of HIV prevalence in Bromley is not linked to deprivation. Prevalence in the 2nd most deprived quintile remains higher than any other quintile in the borough with the most deprived quintile having the lowest prevalence rate.

Figure 5.18



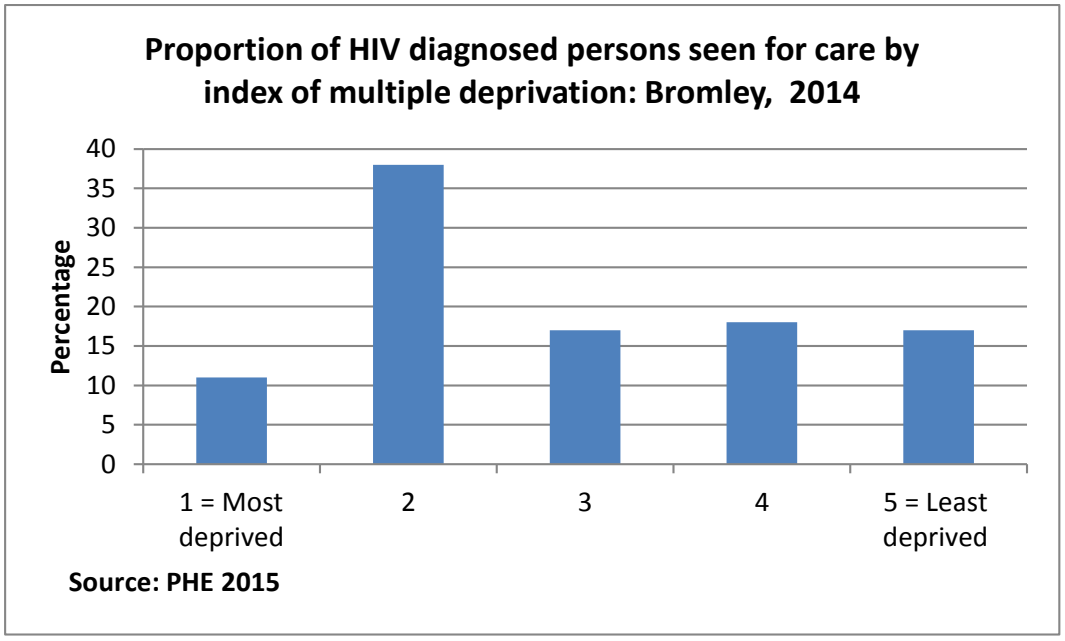
Source: Sexual and Reproductive Health Profiles, 2016

Figure 5.19. Prevalence of diagnosed HIV in 15 to 59 year olds (per 1,000) by MSOA in Bromley: 2014



Source: The Survey of Prevalent HIV Infections Diagnosed (SOPHID)

Figure 5.20

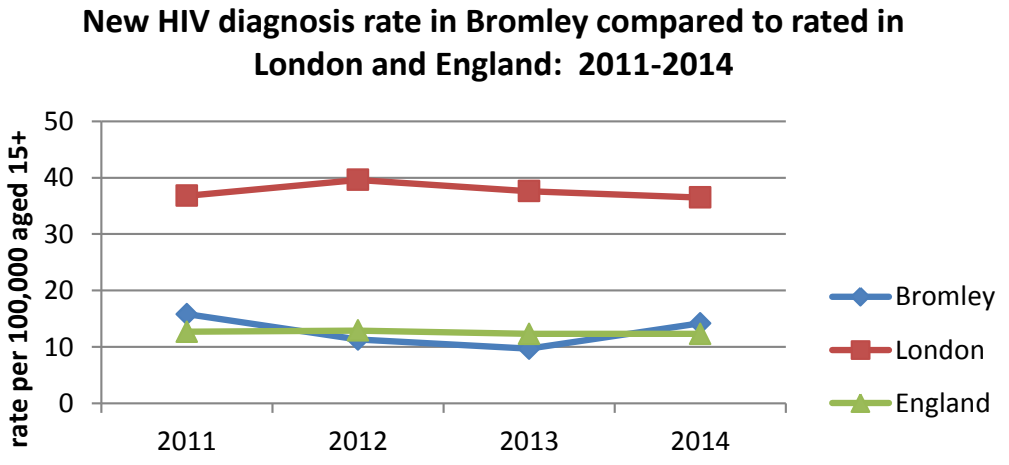


New diagnoses

In 2014 there were 37 new HIV diagnoses in Bromley (Sexual and Reproductive Health profile, 2016). The rate of new HIV diagnosis per 100,000 population among people aged 15 or above in Bromley was 14.2 compared to 12.3 in England[64]. This is a 46% rate increase from 2013 data (9.7 per 100,000) following a decline in rate since 2011 (see **Figure 5.21**).

Owing to the small numbers involved it is not possible to present a breakdown of new diagnoses by route of transmission. In England in 2014, 51% of new HIV diagnoses were in MSM, 16% in male heterosexuals and 20% in female heterosexuals. By ethnicity, 55% of new HIV diagnoses were in white and 21% in black African populations[65].

Figure 5.21



Source: Survey of Prevalent HIS Infections Diagnosed (SOPHID); HIV and AIDS New Diagnoses Database (HANDD), The new HIS and AIDs reporting system (HARS)

HIV diagnosed persons seen for care

Data for 2015 is now available regarding HIV persons seen for care in the borough. This provides interesting analysis compared to previous years and is described by route of transmission, age and gender and ethnic group.

Route of transmission

Data from 2015 shows a change from past data with the most common probable route of HIV transmission being men who have sex with men (MSM) compared to heterosexual intercourse (49% compared to 47%). The

[64] Bromley Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2014 (PHE, 2015)

[65] Bromley Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2014 (PHE, 2015)

comparison of 2014 and 2015 data is shown in **Figure 5.22** below. This might suggest a change in Bromley's population demographic.

Figure 5.22

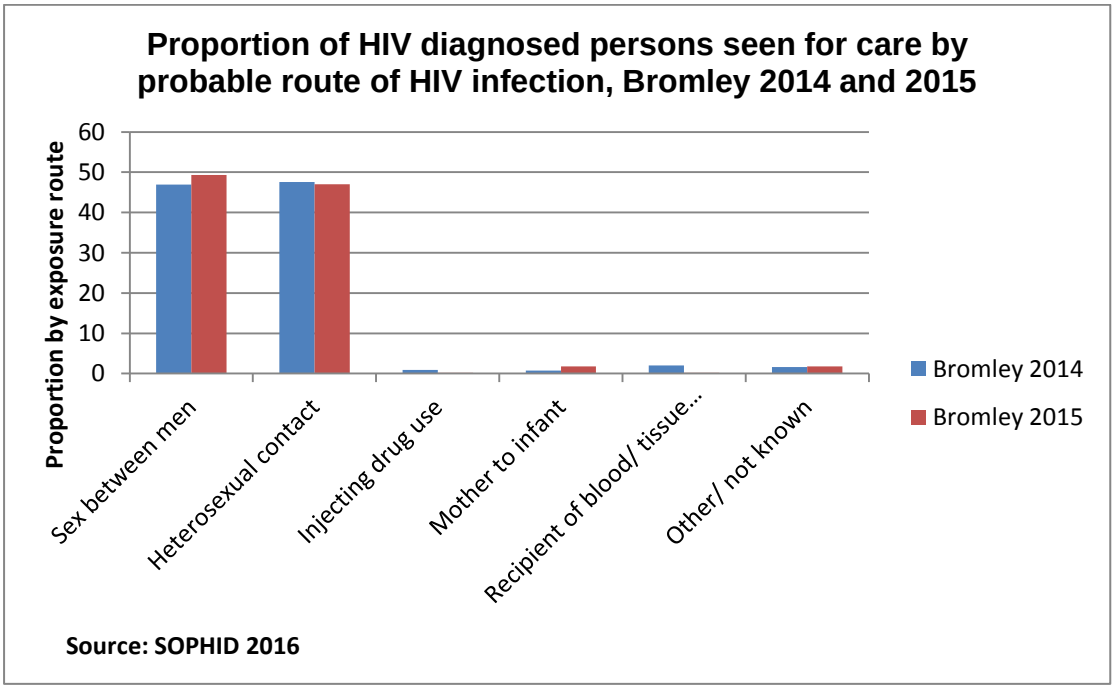


Table 5.5 shows the number of HIV diagnosed person for care by exposure category across a four year period. This shows a steady increase in numbers for MSM transmission since 2011, and at the same time a steady increase in probable route of HIV transmission by heterosexual contact. Therefore it is the numbers for MSM transmission that seem to be going up at a faster rate compared to heterosexual transmission. The upward trend in numbers receiving care is likely to be due to a combination of factors including increased testing, improved recording and increasing incidence.

Table 5.5: Number of HIV diagnosed persons seen for care by probable route of HIV infection: Bromley, 2011-2015

Exposure Category	2011	2012	2013	2014	2015
Sex between men	201	209	225	260	276
Heterosexual contact	233	239	254	263	262
Mother to Infant	10	11	11	13	10
Total HIV diagnosed persons seen for care	**457**	**473**	**504**	**548**	**560**

Source: SOPHID 2016

Heterosexual men, the highest proportion of whom are Black African, remain

a concern as they have a higher change of being unaware of their HIV status and continue to carry the risk of onward transmission. This highlights the importance of targeting efforts on raising HIV infection awareness, early diagnosis and early access to HIV care among heterosexuals especially among Black Africans.

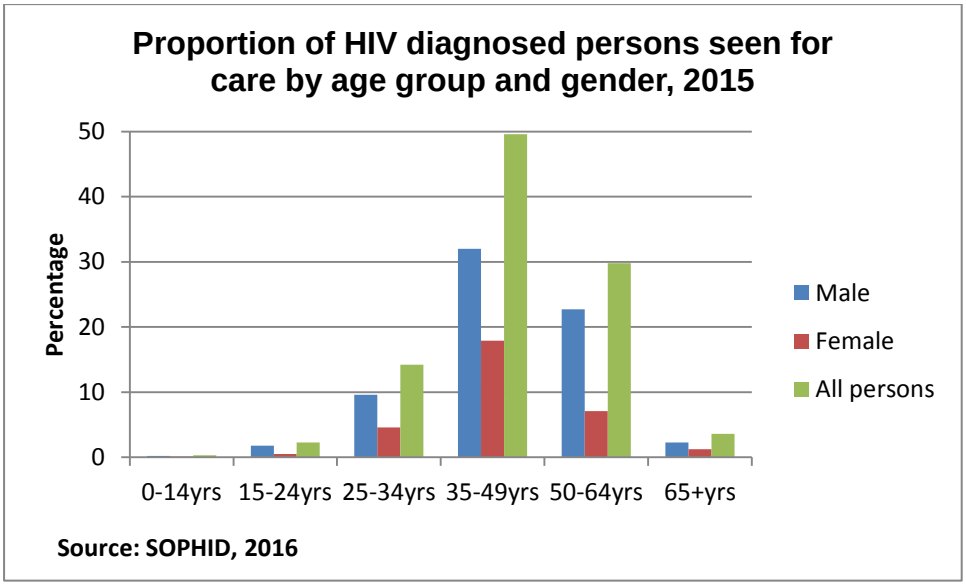
HIV transmission from mother to child makes up only a small proportion (1.8%) of all transmissions in Bromley. It remains the third highest transmission route despite a slight reduction from the previous year. It therefore remains important to encourage early antenatal booking (which includes HIV testing) for all women, particularly amongst Black African women in areas where the prevalence is high.

HIV care by age and gender

Men continue to be the majority seen for care. The largest age range for care is for people between 35 and 49 years of age, with the second highest 50 to 64 years. The population diagnosed with HIV in Bromley therefore seem to be part of Bromley's ageing demographic. It is also useful to note that 3.6% of persons requiring HIV care are 65 plus (a higher proportion than in the 15-24 years age range).

The pattern presented can be understood by continued transmission of HIV infection and improved survival. Services need to evolve appropriately in terms of targeting sexual health awareness and testing and treatment services.

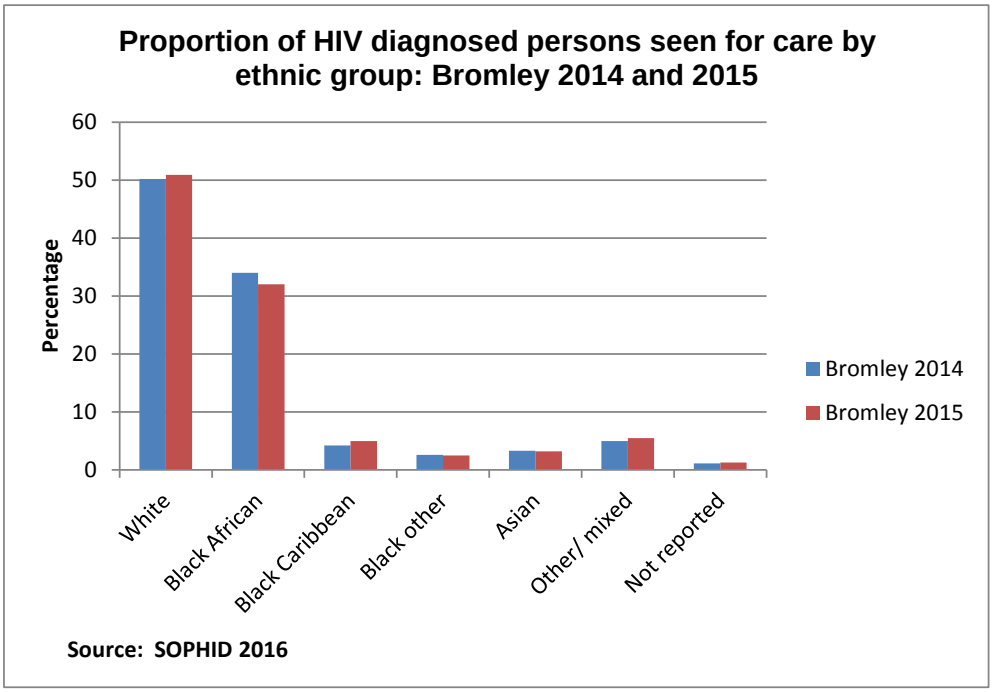
Figure 5.23



HIV care by ethnic group

The two ethnic groups that contribute the majority of known HIV infections diagnosed in Bromley are White (50.9%) and Black African (32%). Men represent more than 10 times the cases in the white ethnic group compared to women and approximately double in the Black African group. This breakdown by gender reflects the probable route of infection with men who have sex with men (MSM) more likely to be white and those acquiring HIV through heterosexual contact most likely to be from the Black African ethnic group.

Figure 5.24



HIV late diagnoses

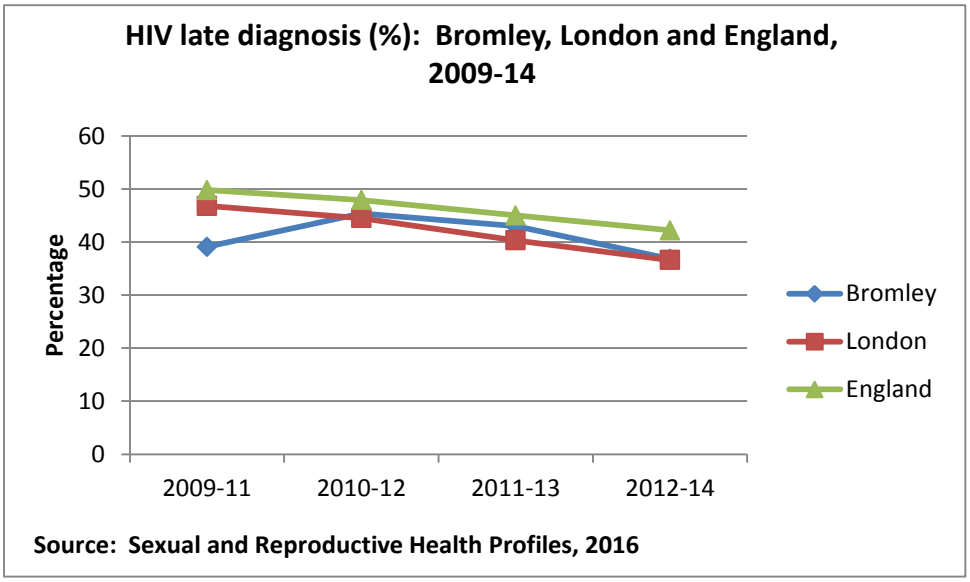
Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. This is important as people living with diagnosed HIV can expect a near-normal life expectancy, provided they are diagnosed early in the course of their infection. Late presenters (those diagnosed with a CD4 <35, 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.

Between 2012 and 2014, 37% (95% CI 27-48) of Bromley HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm^3 within 3 months of diagnosis) compared to 42% (95% CI 41-43) in England. This is a 7% decrease from 2011-2013 data and is only slightly higher than the London overall figure (36.6%). 31.1% (95% CI 18.2-46.6) of men who have sex with men (MSM) and 40.5% (95% CI 38-68) of heterosexuals were diagnosed late.

There has been a decrease in late diagnoses amongst heterosexuals compared to the 2011 and 2013 data range, where the proportion was 53% of heterosexuals diagnosed late.

HIV testing has been expanded in primary and community settings since 2013 as a proven way of tackling late diagnosis and onward transmission of this infection. The downward trend in late diagnoses will continue to be monitored to understand if this expansion has made an impact. However, continuing to promote HIV awareness and access to testing and treatment is required for all at risk groups.

Figure 5.25



Bromley's HIV testing uptake is below the London and England rates and approximately the same as England for testing coverage but below the London rate. Testing coverage represents the number of persons tested for HIV and not the number of tests reported, whilst testing uptake can include multiple episodes of HIV test offer per individual within a year. This can explain the differences in data between these two figures.

Figure 5.26

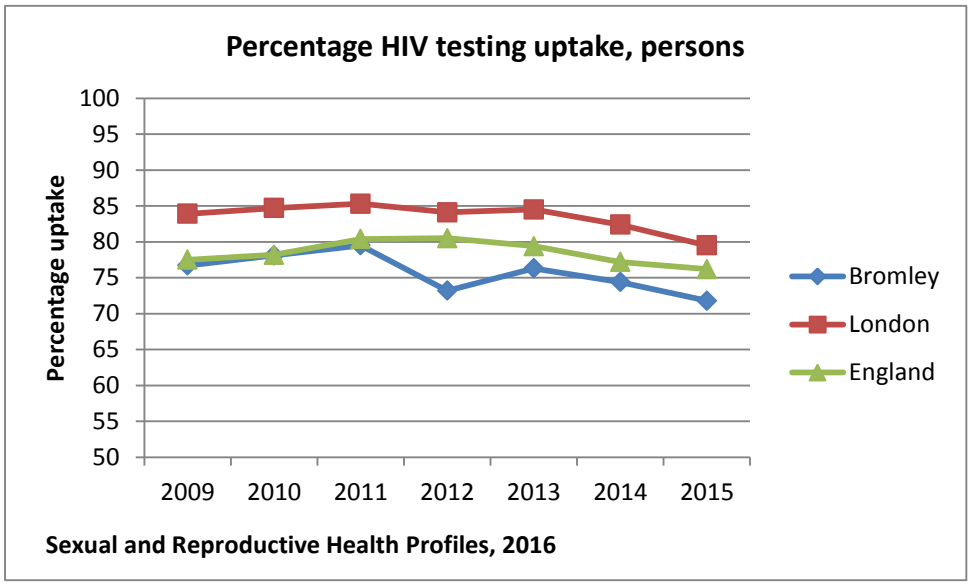
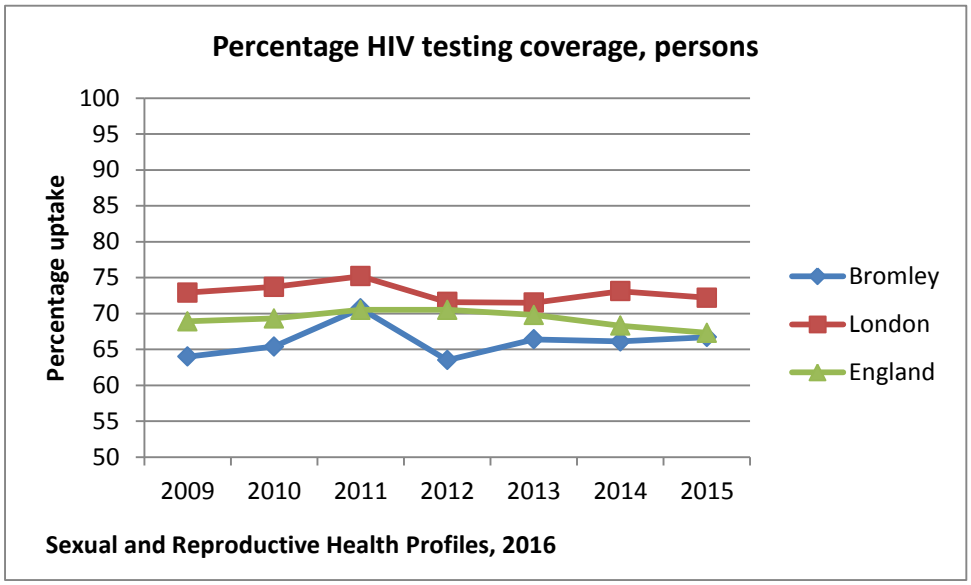
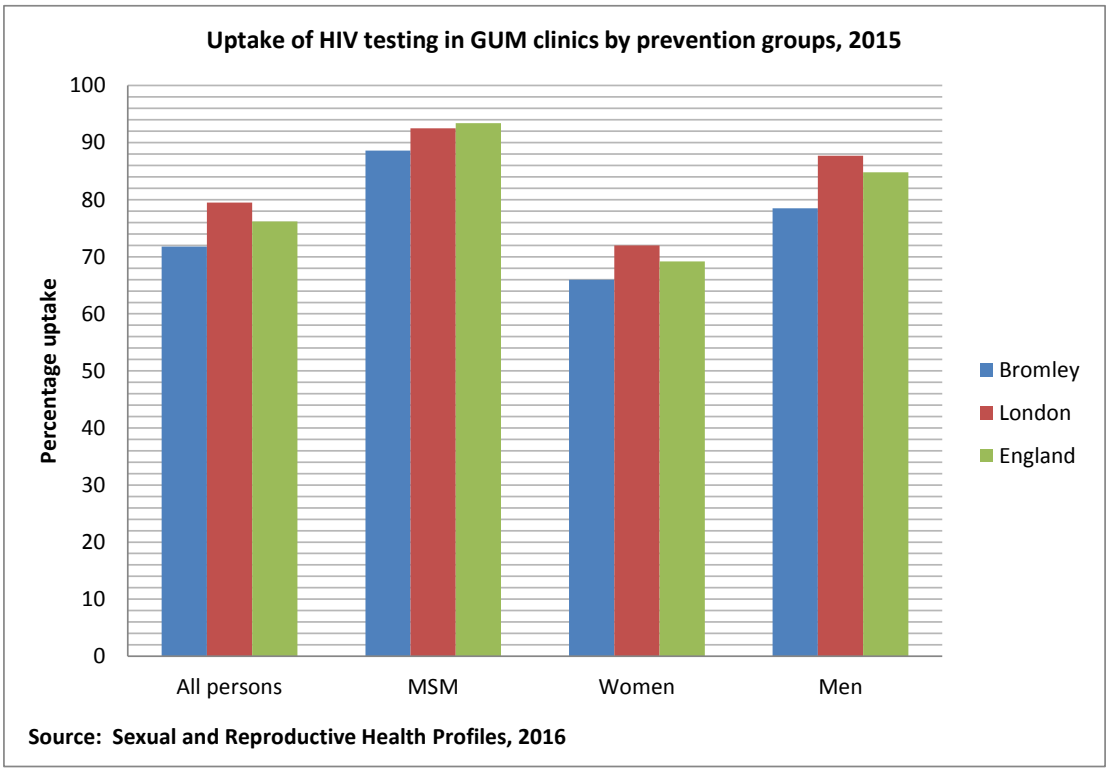


Figure 5.27



The 2015 data on uptake rates of HIV testing in GUM clinics by prevention groups (MSM, women and men) indicate that uptake in Bromley is slightly lower for all groups compared to London and England (**Figure 5.28)**. As mentioned above, uptake is measured by comparing where an HIV test was accepted as a proportion to those where an HIV test was offered. Therefore multiple episodes of HIV test and offer are included per individual within a year.

Figure 5.28



A pilot HIV testing project took place in 2014 to assess the acceptability and effectiveness of offering drop-in rapid HIV testing clinics in high prevalence postal areas of Bromley. This research found that the most significant barrier to testing is individuals not seeing themselves at risk of HIV infection, even when they belong to high risk groups such as Black Africans. Recommendations from the report included for Bromley to target high risk population groups in the borough in addition to young people, to normalise HIV testing as part of routine primary care in addition to offering confidential community testing[66].

In addition Bromley is working with South East London partners to provide an online home sampling (testing) service for STIs to offer a more accessible and responsive service, targeting MSM and Black African and Black Caribbean groups.

What this means for Bromley residents

The HIV prevalence rate in Bromley is now higher than the average England rate and there is marked variation within the borough, with pockets of very high prevalence. The diagnosis rate has increased from 2013 to 2014. However there has been a reduction in HIV late diagnosis, with Bromley

[66] Jeffrey, A, *Bromley HIV Testing Project*: *Final report* (Metro, 2014)

performing better than the England average and at a similar level to the London average.

Heterosexual residents are the highest group diagnosed with HIV closely followed by MSM cases. White is the largest ethnic group followed by Black African. However recent data for people receiving HIV care in the borough show a shift in numbers with probable transmission of infection by sex between men compared to heterosexual contact. The most likely age group receiving care is between 35 and 49 years of age, with the second highest 50 to 64 years. In addition, 3.6% of people receiving care for HIV are over 65 years old.

Attention should continue on improving:
- HIV infection awareness
- Early diagnosis and
- Early access to HIV care.

This is particularly important for population groups which fall under the most common routes of transmission (MSM and Black African men and women) and the older age group. Health prevention and promotion work will include the rolling out of an online home testing service.

Teenage Pregnancy

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

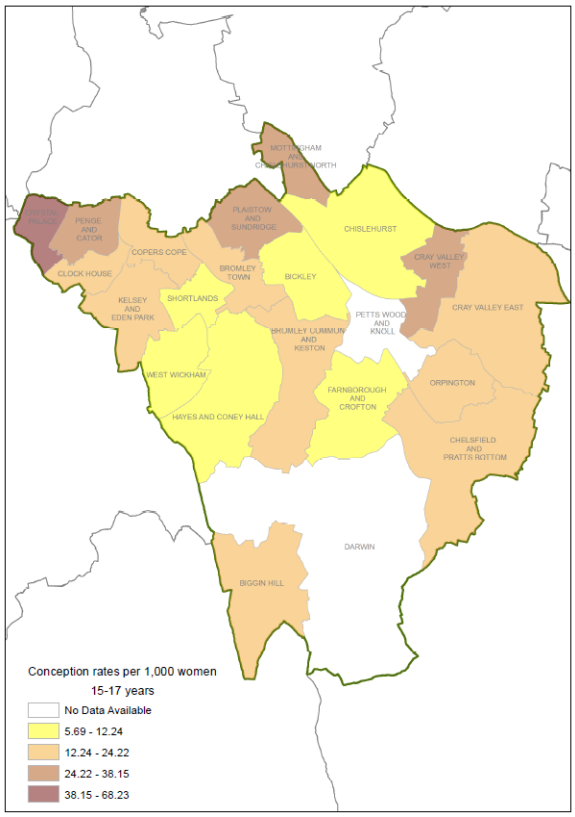
- A higher rate of child poverty for children born to women under 20 years old.
- Higher risk of low birth weight and infant mortality.
- Greater risk of adult poverty for both parents.
- Poorer mental health for young mothers up to three years after birth[67].

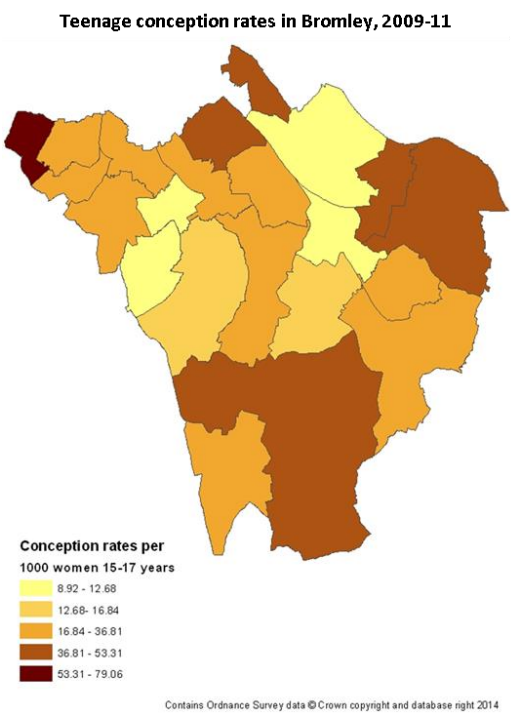
The picture of teenage pregnancy in Bromley is directly linked to deprivation**.** Where data is available, the highest teenage conception rates are in Crystal Palace, Cray Valley West, Mottingham & Chislehurst North, Plaistow & Sundridge and Penge & Cator (**Figure 5.29**). This is useful for targeting special services for mothers and young women and identifying areas for health promotion and/ or education services. These are all areas of high deprivation in the borough.

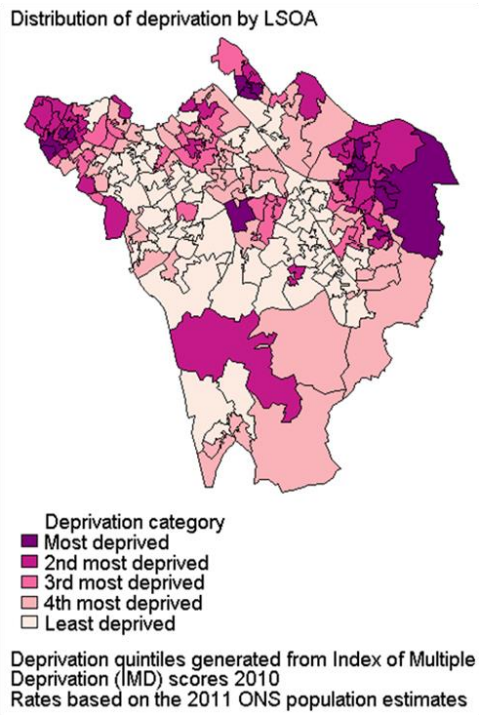
[67] *Good progress but more to do: Teenage pregnancy and young parents* (Local Government Association: Public Health England, 2016)

No data is provided for Darwin and Petts Wood & Knoll wards, potentially owing to the small number of conceptions of under 18s over this time period. Further investigation is needed of this data to understand the changes in rates between the two periods, particularly for Darwin which showed a high rate between 2009-11.

Figure 5.29: Teenage conception rates in Bromley, 2012-2014, compared to 2009-11 and distribution of deprivation



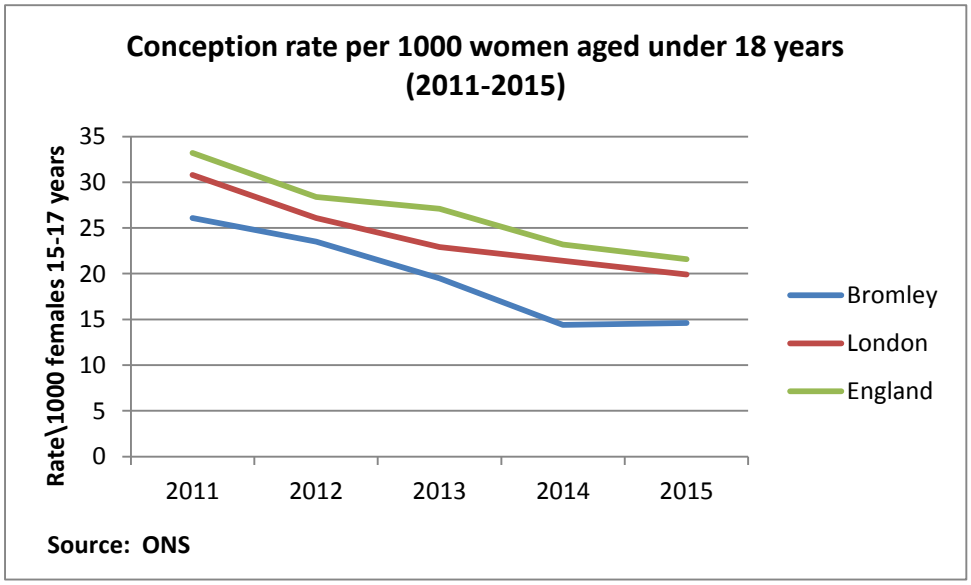




Under 18s conception

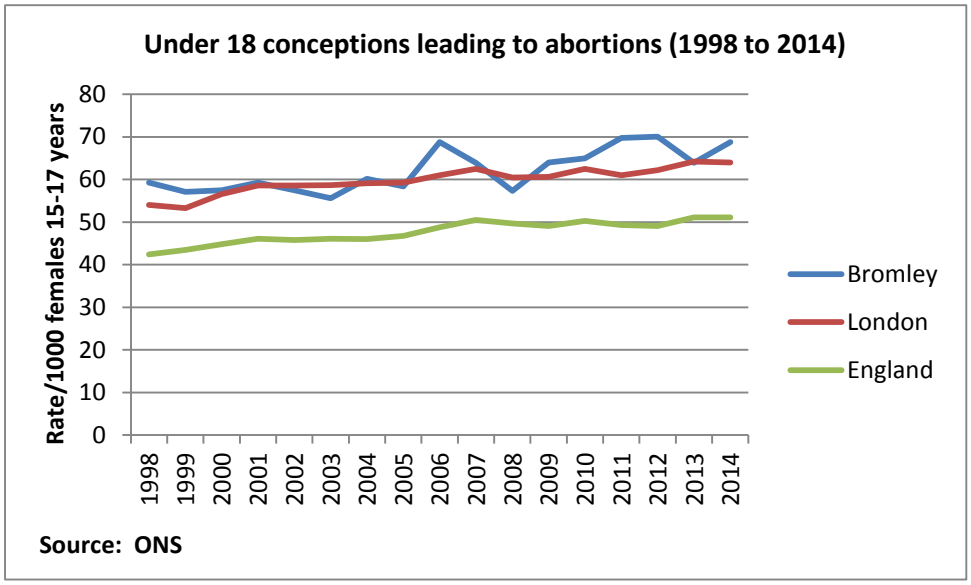
Bromley has seen a sustained drop in teenage pregnancy, with a lower rate than the England and London average. The latest 2015 provisional data shows a plateau in Bromley's rate from 2014 to 2015 at around 14.5 conceptions per 1000 women aged 15 to 17 years old. This compares to a national rate of 21.6 and a London rate of 19.9. **Figure 5.30** presents the latest data over five years, using the rate for June in each year.

Figure 5.30



The rate of teenage conceptions resulting in abortions in Bromley has risen to 68.8% in 2014 compared to 2013 data of 63.9%. The London average is 64% with the England value 51.1%. More information on abortion rates is included later in this chapter.

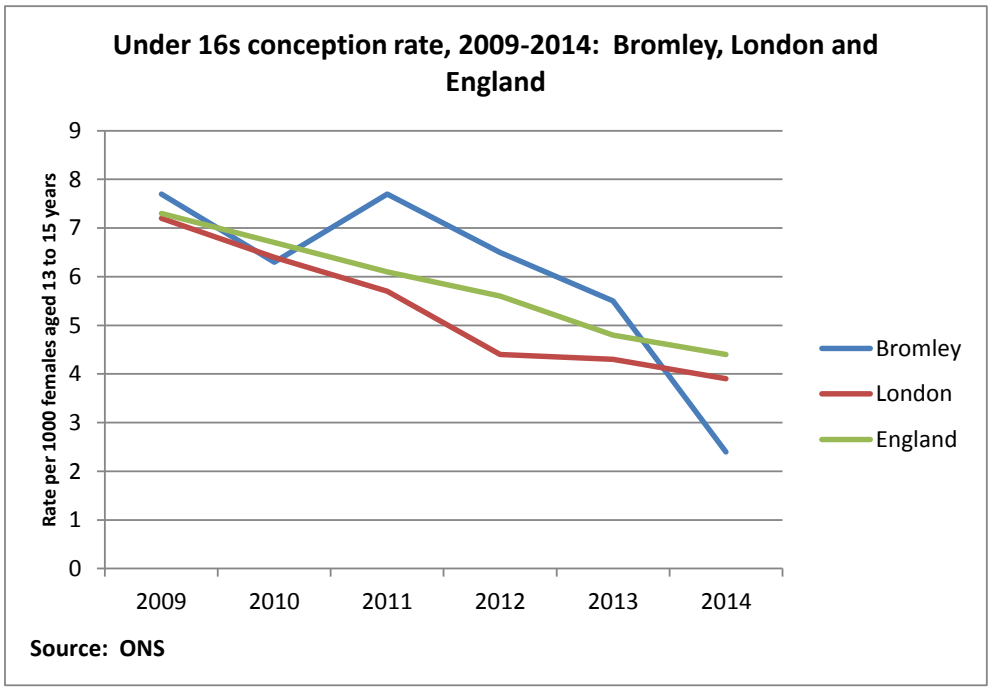
Figure 5.31



Under 16s conception

14% of all teenage pregnancies in Bromley are under the age of 16 years (2014 data). This compares to 27% in 2013. This is lower than the national and London average.

Figure 5.32



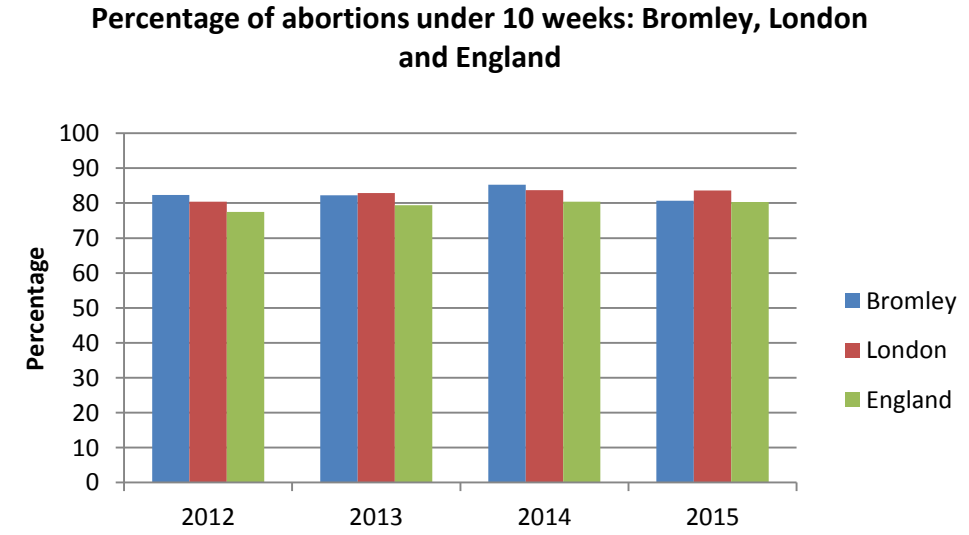
Abortions

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

Terminations of pregnancy below 10 weeks

In 2015, Bromley achieved 80.7% of abortions under 10 weeks. This is similar to the England average (80.3%) and lower than the London average (83.6%). Terminations that take place under 10 weeks gestation can minimise complications and can indicate service quality in terms of access and response. Provider data (Marie Stopes International) for the year to date (April to August 16/17) shows an 89% average in terminations taking place under 10 weeks.

Figure 5.33



Source: Sexual and Reproductive Health Profiles, 2016

Terminations of pregnancy – all ages

According to national figures, in 2015 there were 1,206 terminations performed on Bromley residents. The termination rate in Bromley in 2015 was 19.1 per 1,000 women aged 15-44 which was higher than the national rate (16.7 per 1000 population), but lower than London (21.6 per 1000 population) (see **Figure 5.34**).

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. 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 contribute to Bromley's pregnancy termination rate.

Figure 5.35 shows abortion rates by age in Bromley. The rates highest is in women aged 20-24 years with the second two highest rates in women between 18-19 and 25-29 years of age. Bromley has higher rates than England across all ages with the exception of under 18s. It also has higher rates compared to London for 20 to 24 year olds and 25 to 29 year olds though it is lower for all other age ranges.

Figure 5.34

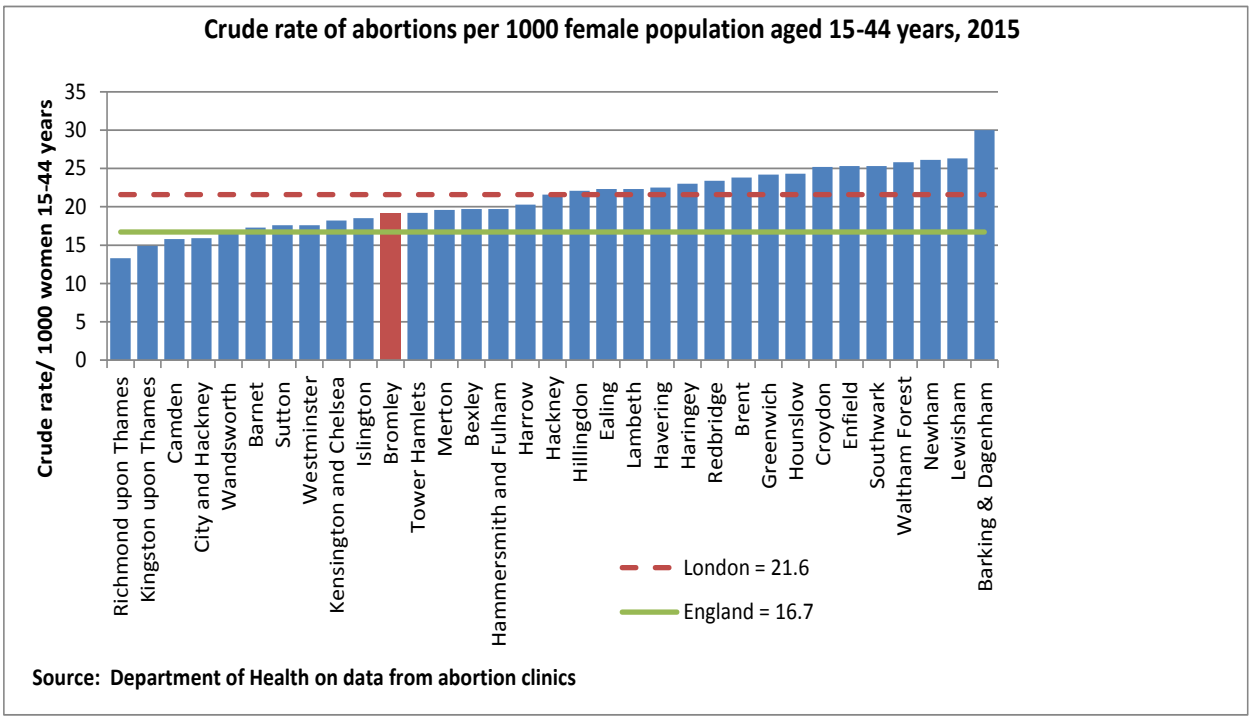
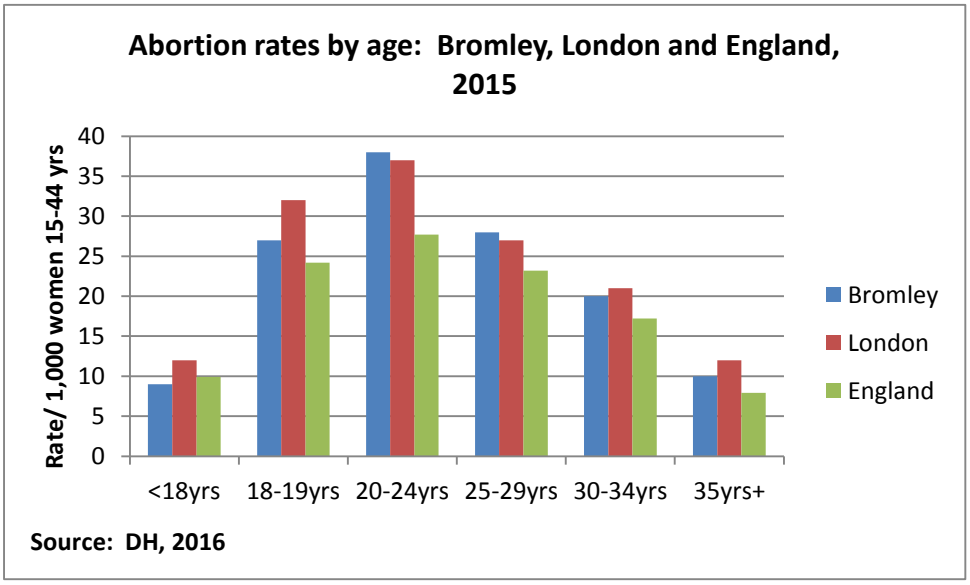


Figure 5.35

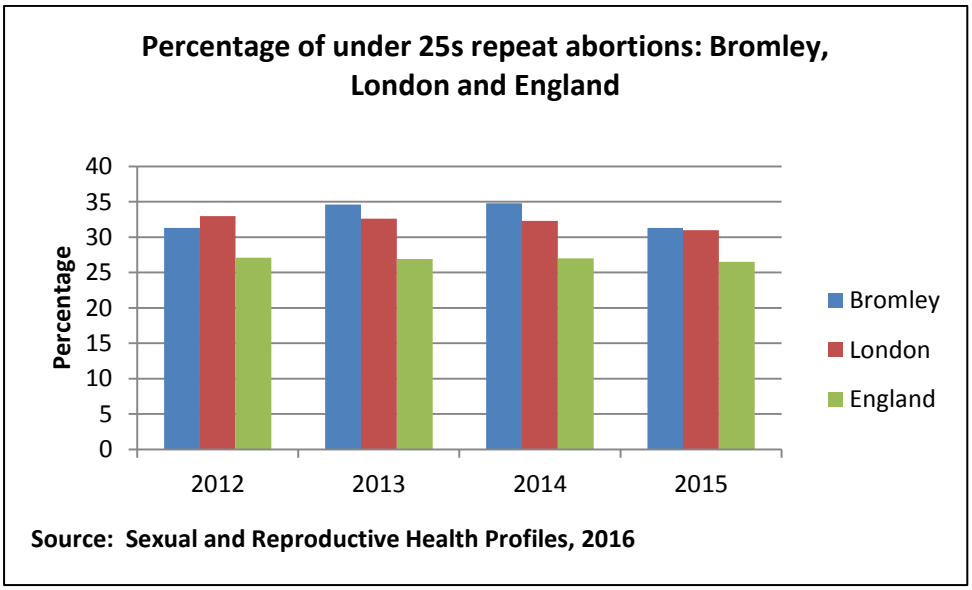


Repeat abortions for women aged under 25 years

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 challenges around access to contraception and sex education as well as other more complex social factors especially in women under the age of 25 years.

Bromley's under 25 repeat abortion figures (see **Figure 5.36**) are higher than the England average (31.3% and 26.5% respectively) but are very close to the London average (31%). It should 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.

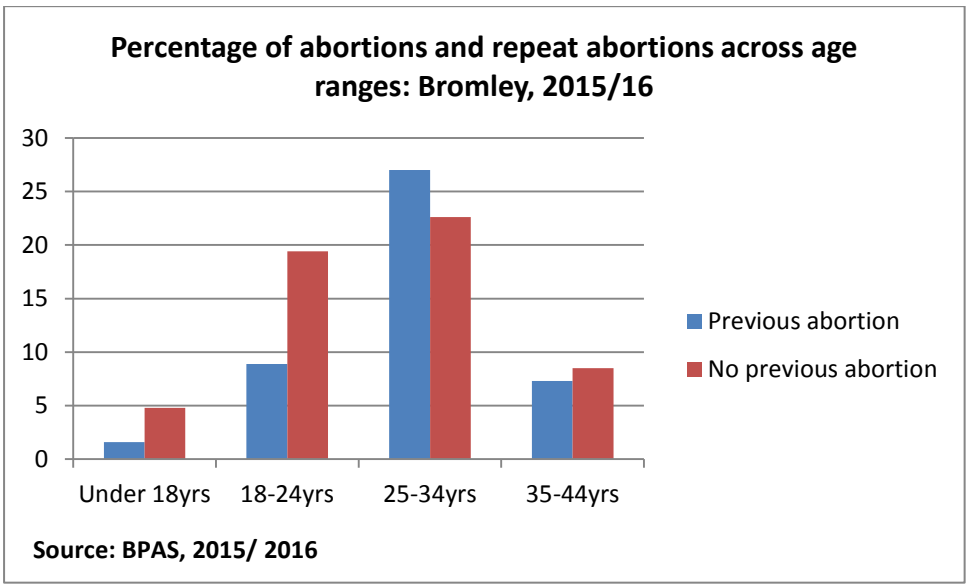
Figure 5.36



Local data collected by the pregnancy advisory service (BPAS) shows the breakdown of repeat abortions by age group compared to no previous abortion for the year 2015/16. The year to date show 8.9% of abortions were repeat abortions in the 18-24 years age range and 1.6% in the under 18s. The greatest majority of repeat abortions in Bromley take place in the 25 to 34 years age range (27% of all abortions), with repeat abortions being more common than first abortions in this age group. Please note this does not include all numbers for the borough.

Further exploration work is required to understand the social and economic factors that influence repeat abortions in Bromley.

Figure 5.37



What this means for Bromley residents and for children in Bromley

The teenage conception rate has continued to fall in Bromley for both under 18s and under 16s. Data between the two reporting periods needs to be explored to help explain changes for wards Darwin and Petts Wood & Knoll.

Bromley's abortion rate is above the England average but lower than the London average. Repeat abortions are higher than the London and England average for under 25 year olds. For all age groups, local provider data shows the greatest number of repeat abortions taking place in the 25 to 34 year age range. Further investigation is required to understand this pattern.

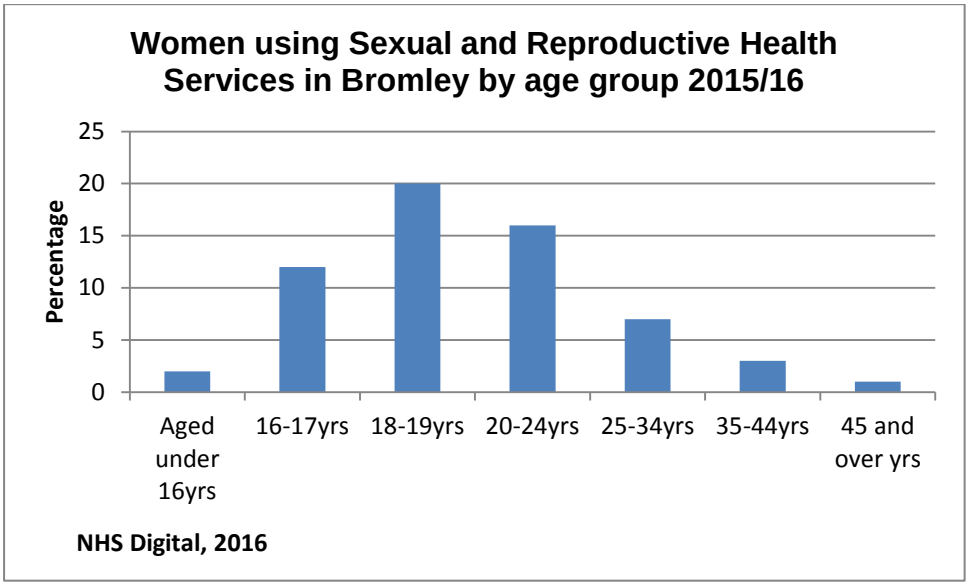
Contraception use in Bromley

In 2015/16 there were 5,170 contacts with Bromley women using Sexual and Reproductive Health (SRH) services[68]. Of this number 4,285 were using these services for contraceptive reasons. This is a decrease in number since previously recorded data in 2013/14 (6,700 contacts overall and 5,300 for contraception related reasons). However it is important to note that this data does not cover all the ways in which a person may access reproductive health services. For example, it excludes services provided in out-patient clinics and those provided by General Practitioners as well as contraceptives purchased over the counter at a pharmacy or in other retail settings. Therefore, changes over time presented in this report may be due to changes in the way people access contraceptive health services rather than changes in contraceptive use.

The greatest age range likely to use a SRH service in Bromley is 18 to 19 years old (20%). This is similar percentage to the England average (19%). The next most common use is amongst the 20-24 years age range.

[68] Sexual and Reproductive Health Services England 2015-16 (NHS Digital) http://www.content.digital.nhs.uk/catalogue/PUB21969

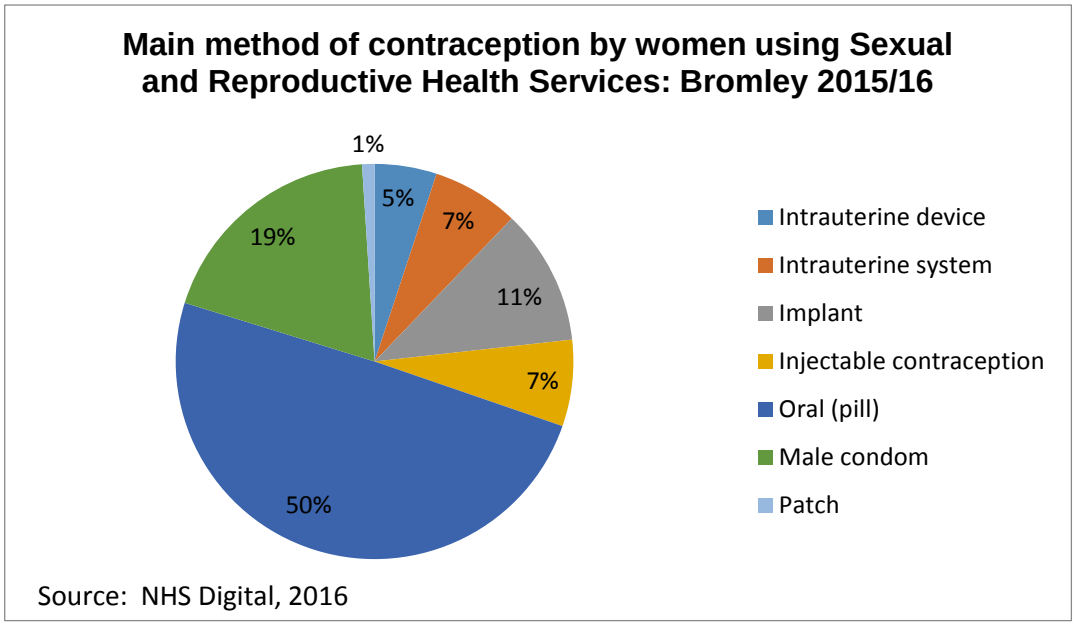
Figure 5.38



SRHs data has not been age standardised so it is difficult to compare against other London boroughs, for example usage of services by women below 20 years. For this age range Bromley's percentage is the same as the London average but lower than the England average (38%) at 34%.

Preferred contraception method by women in Bromley is set out in **Figure 5.39**.

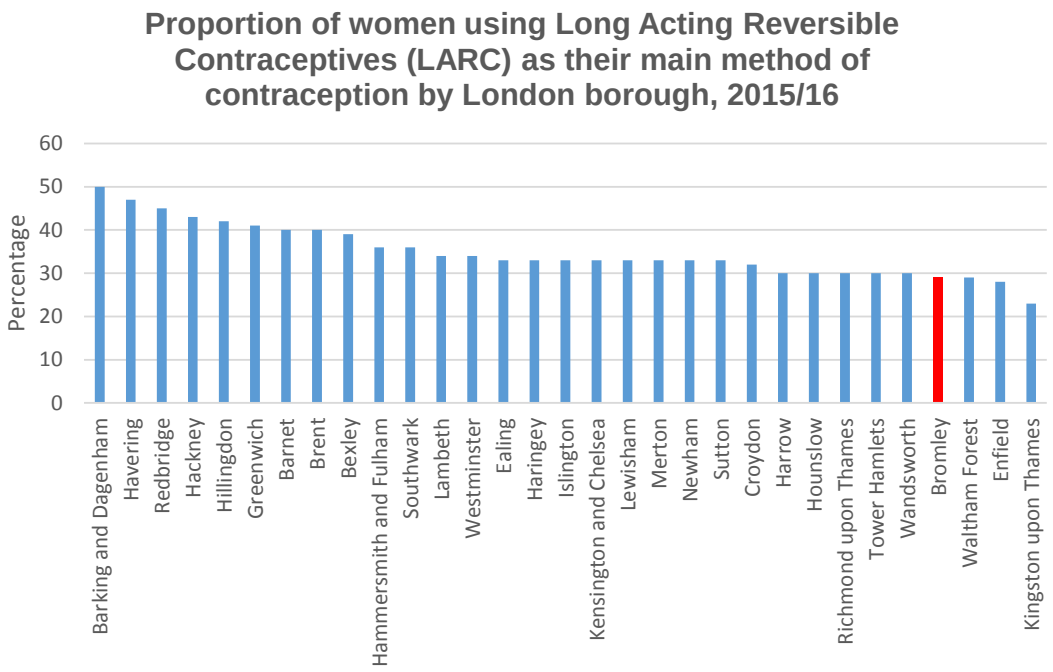
Figure 5.39



Of the 4,285 contacts with SRHs for contraception reasons, the majority (71%) preferred user dependent methods such as pills and condoms. Only

29% preferred LARC. This is below the England average at 38%. Bromley is the fourth lowest London borough for LARC usage according to 2015/16 data. This is considered in more detail below when analysing LARC prescription data.

Figure 5.40



Source: NHS Digital, 2016

LARC in General Practice

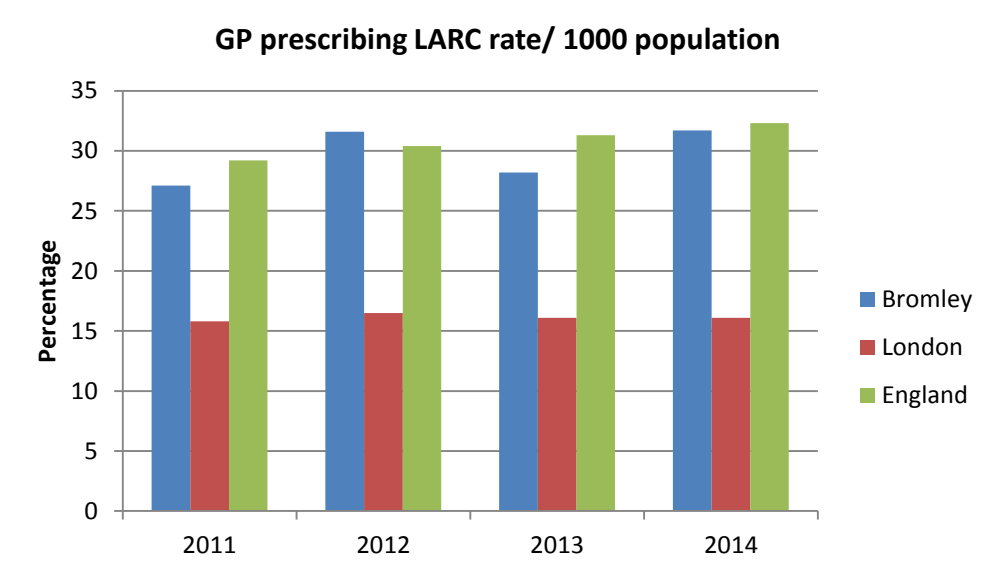
LARC methods [Long Acting Reversible Contraception] such as contraceptive injections, implants and intra-uterine systems [IUS] are more effective methods of contraception as they do not depend on daily actions by individuals and tend to be cost effective compared to other methods if used for over a year.

In 2014, Bromley was the second highest borough for GP prescriptions of LARC, at 31.7 per 1000 resident female population aged 15-44 years. This is very close to the England rate of 32.3 and is much higher than the overall London rate of 16.1. It indicates the success of strengthening the Service Level Agreement with Bromley's 33 GP practices to increase provision of this service.

The rate of LARC prescriptions in Sexual and Reproductive Health (SRH) services is, however, lower than the London average at 11.2 per 1000 female residents (aged 15 – 44 years) compared to 19.2 in London and 17.8 in England. At the SRH services, 12.5% of women under 25 years old are

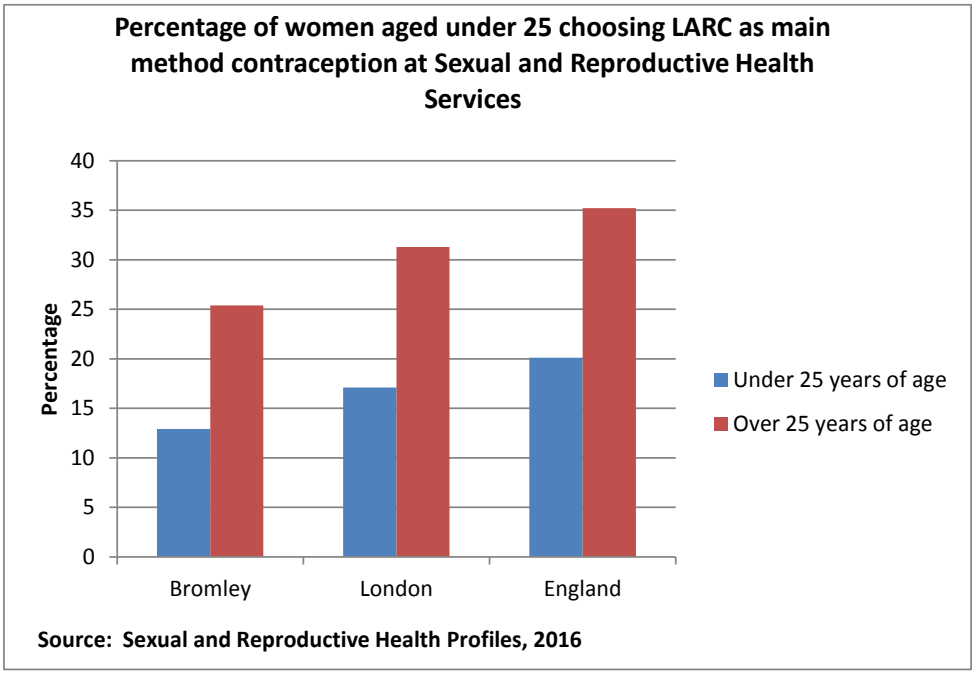
choosing it as their main method of contraception compared to 25.4% over 25 years. Slightly more in both age ranges are choosing LARC as their main contraception across London (17.1% and 31.3% respectively) and again higher values are seen in England (20.1% and 35.2%).

Figure 5.41



Source: Sexual and Reproductive Health Profiles, 2016

Figure 5.42



There are a number of potential issues to note regarding the above data which include:

1. LARC removal rates are not currently available, which needs to be seen alongside prescription rates.
2. The above indicators of prescribed LARC excludes injections, replacing an earlier indicator which included injections. This is owing to:

- The higher failure rate of injections
- Injections are outside local authority contracts
- Injections are relatively easier to give through primary care compared to the time and resource of other LARC methods[69].

3. LARC may also be prescribed in other services not included in the data, such as termination of pregnancy (TOP) services.

In addition, the Sexual and Reproductive Health service is relatively small in Bromley which has the potential to skew figures.

Bromley is keen to encourage greater prescriptions of LARC in the borough, both through GPs and Sexual and Reproductive Health services. Discussions will take place with the Clinical Commissioning Group regarding greater use of injections, including potential counselling for women on the possible side effects associated with LARC methods to reduce removal rates. The Sexual and Reproductive Health Services will also be encouraged to work more closely with the GP practices regarding LARC prescriptions.

Cervical Cancer

[69] Bromley Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2014 (PHE, 2015)

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 do not.

Cervical cancer can take many years to fully develop. The HPV vaccination consists of three injections over 12 months which is given to 12-13 year old girls, largely through secondary schools. Research has shown that the HPV vaccine provides effective protection for at least 20 years which should cover the irregularity of the HPV incubation period. The vaccination has proved to be very effective and as a result since September 2014 it has been possible to move to two doses of vaccine in the routine HPV programme in the UK.

The data in the table below show the percentage of girls who had completed their course of the HPV immunisations by the end of the school year (**Table 5.6**). Bromley has a high coverage of HPV vaccination, with dose 1 and 2 at 84% compared to 79.2% as a London average.

Table 5.6: HPV coverage data of first and second doses for the routine cohort at 31 August 2014. (Doses given 1st September 2014 to 31st August 2015)

	Bromley (Local Authority)	London (Area Team)	England
Dose 1	90.2	83.8	89.4
Dose 1 and 2	84.5	79.2	-

Source: PHE **https://www.gov.uk/government/statistics/annual-hpv-vaccine-coverage-2014-to-2015-by-local-authority-and-area-team**

The rate of cervical cancer registration in Bromley is 7.6 per 100,000 per population (2011-2013 data) which is slightly lower than London at 8.0 and lower than the England rate of 9.6.

What this means for Bromley residents and for children in Bromley

Women between 18 and 24 years of age are most likely to be accessing contraception services. The main method of contraception is user dependent methods, such as pills or condoms. However, long acting reversible contraceptives (LARCS) are considered a preferred method in terms effectiveness.

Current data shows high prescription rates in GP settings but lower in Sexual and Reproductive Health Services. More work needs to take place to encourage LARC take up in both service settings.

Bromley has a high rate of HPV vaccination coverage for girls and a lower rate of cervical cancer registrations compared to London and England. This suggests a successful programme in cervical cancer prevention in the borough.

Table 5.7: Sexual Health Related PHOF Indicators, 2016

Indicator	Time period	Sex	Bromley	London	England
2.04 Under 18 conceptions	2014	Female	16.7	21.5	22.8
2.04 Under 16 conception rate	2014	Female	2.4	3.9	4.4
3.02 Chlamydia detection rate (15 to 24 year olds)	2015	Persons	1,663	2,200	1,887
3.02 Chlamydia detection rate (15 to 24 year olds)	2015	Male	1,202	1,593	1,276
3.02 Chlamydia detection rate (15 to 24 year olds)	2015	Female	2,117	2,738	2,492
3.04 People presenting with HIV at a late stage of infection	2012-2014	Persons	36.8%	36.6%	42.2%

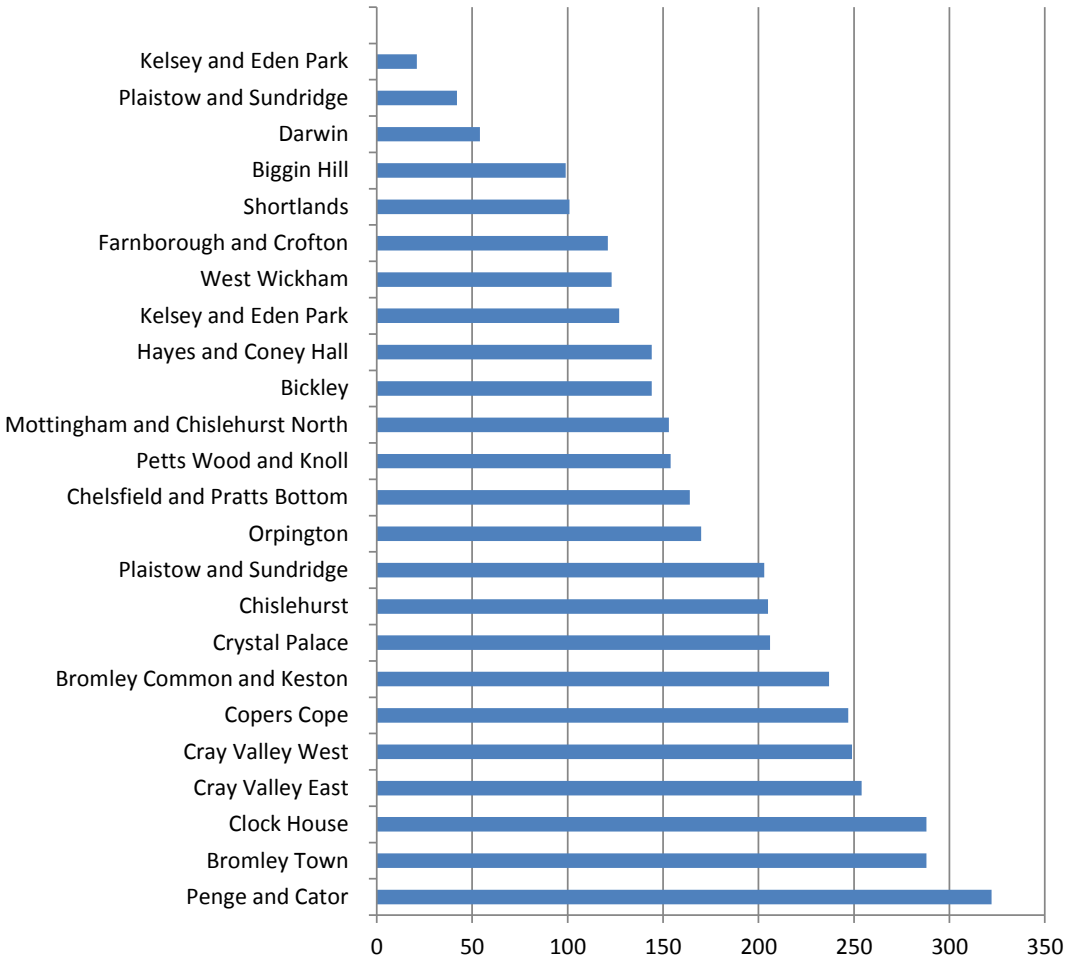
For more information please contact Mimi.Morris-Cotterill@Bromley.gov.uk

Pregnancy and Maternity

Birth and fertility rates

The number of live births in Bromley in 2015 shows a very small increase from 2014 data, at 4,098 compared to the previous year figure of 4,086[70]. The highest number of births according to the latest ward level data (ONS, 2015) are in Penge & Cator, Bromley Town and Clock House wards (**Figure 5.43**).

Figure 5.43



Source: ONS, 2016

Bromley has a General Fertility Rate (GFR) of 64.3, representing the number of live births per 1,000 women aged between 15 to 44 years. This is slightly higher than the London average and higher than the England average.

[70] ONS https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsbyareaofusualresidenceofmotheruk

Bromley, London and England all experienced a fall in GFR between 2012-13 and then a subsequent rise over the past two years (**Figure 5.44**).

The GFR does not take into account the structure of the population, for example how many women there are of child bearing age. This is better taken into account by the Total Fertility Rate (TFR), used to describe the total number of children the average woman in a population is likely to have based on current birth rates throughout her life. Bromley's TFR is 1.84 compared to the London rate of 1.72. This figure gives an indication of population growth (for example, the necessary population replacement rate is calculated at about 2.1). However it does not indicate the numbers of people who may move into the borough, for example from other London boroughs, other parts of England or other countries. Using TFR, Bromley has a similar rate to England and a higher rate than London (**Figure 5.45**).

Figure 5.44

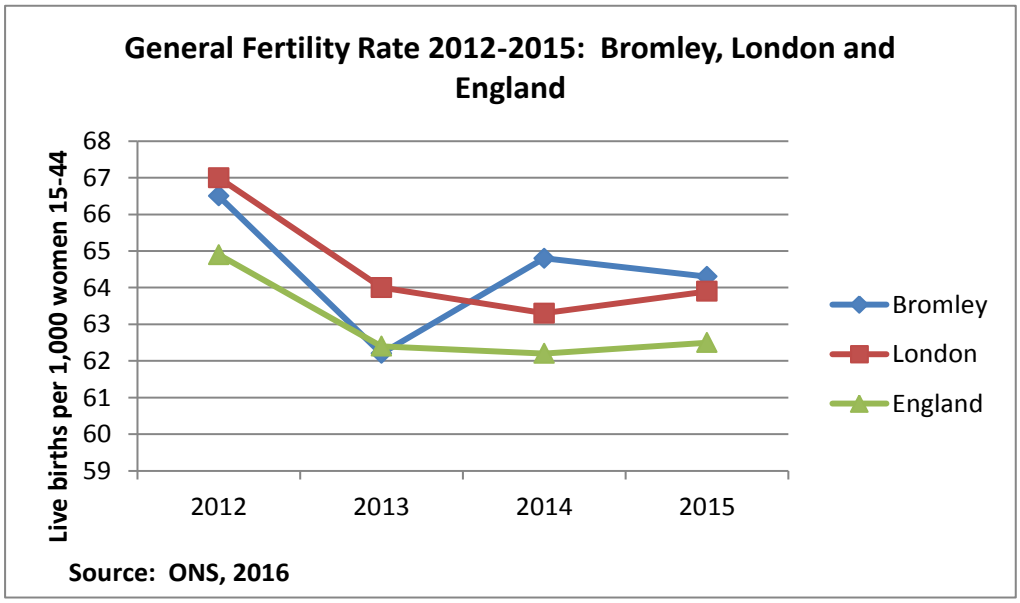
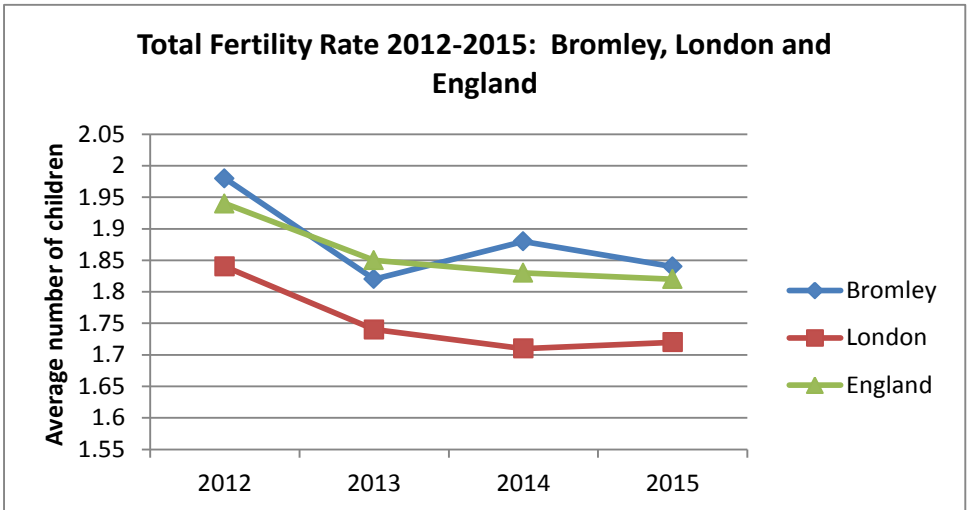


Figure 5.45



Source: ONS, 2016

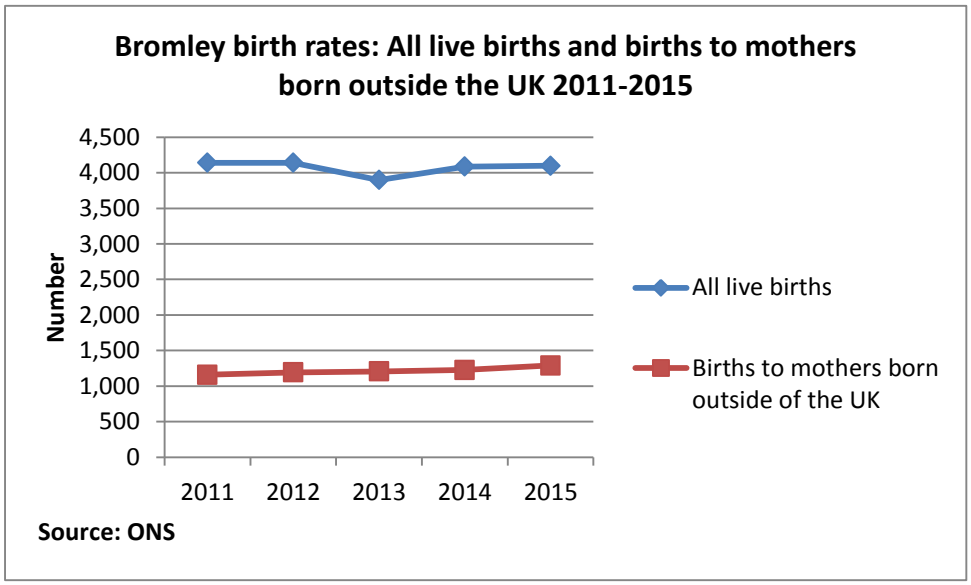
Births to mothers born outside the UK

UK women make the largest contribution to Bromley's birth rate, making up 71% of all births in 2015. The number of births to mothers born outside the UK is increasing very slightly, with an additional 12 births between 2014 and 2015. **Figure 5.46** sets out the trend of all live births and births to mothers born outside of the UK in Bromley which shows a fairly constant rate, with a small increase in births to mothers outside of the UK each year (from 1,159 in 2011 to 1,289 in 2015).

The country of birth of the mother is useful to know in terms of maternity service planning. For example, there may be unknown medical conditions for people born outside of the UK or differences in terms of cultural preferences around birth. In addition nationally there is a higher infant mortality rate for babies of mothers born outside the UK (3.8 deaths per 1,000 live births compared to 3.5 deaths per 1,000 live births). The highest infant mortality rates are for babies of mothers born in Pakistan or Western Africa. Differences in rates are likely to reflect underlying factors such as the mother's age and socio-demographic characteristics[71].

Figure 5.46

[71] Childhood mortality in England and Wales: 2014, Statistical bulletin (ONS, 2016) http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2014#mothers-country-of-birth



The most common country of birth for non-UK mothers in Bromley is Poland, followed by India and Nigeria (**Table 5.8**). Knowledge of country of birth is also important for identification of FGM and HIV testing, both often identified under maternity care. Somalia where a third of FGM cases are from is the 26th most common country of birth for non-UK born mothers in Bromley. To note, country of birth is collected at birth registration, which is different to ethnicity or migration history. Therefore not all women born outside the UK will be recent in-migrants (and similarly the UK born will include the children of earlier migrants)[72].

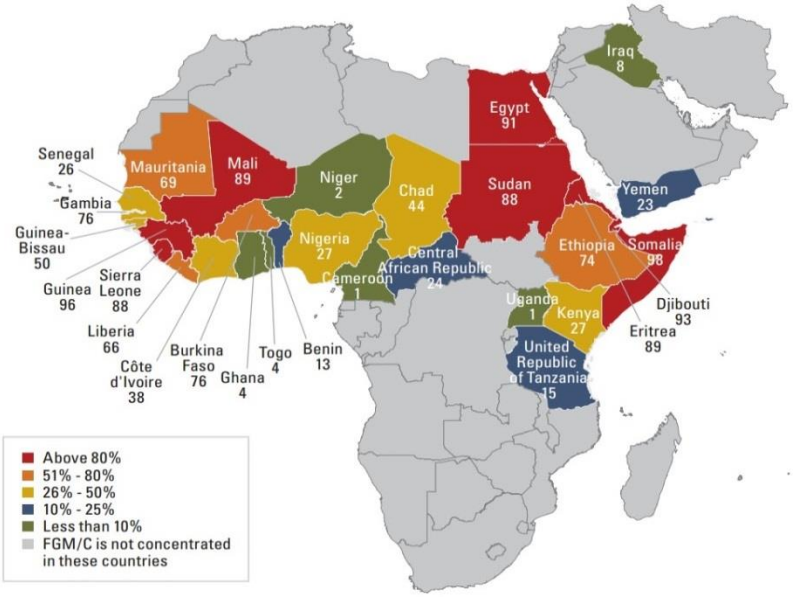
[72] Parents' country of birth, England and Wales: 2015, statistical bulletin (ONS, 2016)

Table 5.8: Twenty most common countries of birth for non-UK born mothers in Bromley, 2015

Rank	Country of birth of mother	Number of births	Percentage of all births	Top ten UK rank
1	Poland	105	2.5	1
2	India	88	2.3	3
3	Nigeria	85	2	6
4	South Africa	57	1.4	10
5	Romania	50	1.2	4
6	China	40	1	-
7	Ireland	36	0.9	-
8	France	34	0.8	-
9	Jamaica	30	0.7	-
10	Germany	29	0.7	8
11	Brazil	28	0.7	-
12	Sri Lanka	26	0.6	-
13	Albania	25	0.6	-
14	Lithuania	25	0.6	-
15	Ghana	24	0.6	-
16	Bulgaria	23	0.6	-
17	Italy	22	0.5	-
18	Russia	21	0.5	-
19	Bangladesh	20	0.5	5
20	Pakistan	20	0.5	2
	Outside the UK	1,289	31	

Source: ONS, 2016

Figure 5.47: Map of FGM prevalence



Source: UNICEF (July 2013), Global databases on data from multiple indicator cluster survey, Demographic and Health Survey and other national surveys, 1997 – 2012

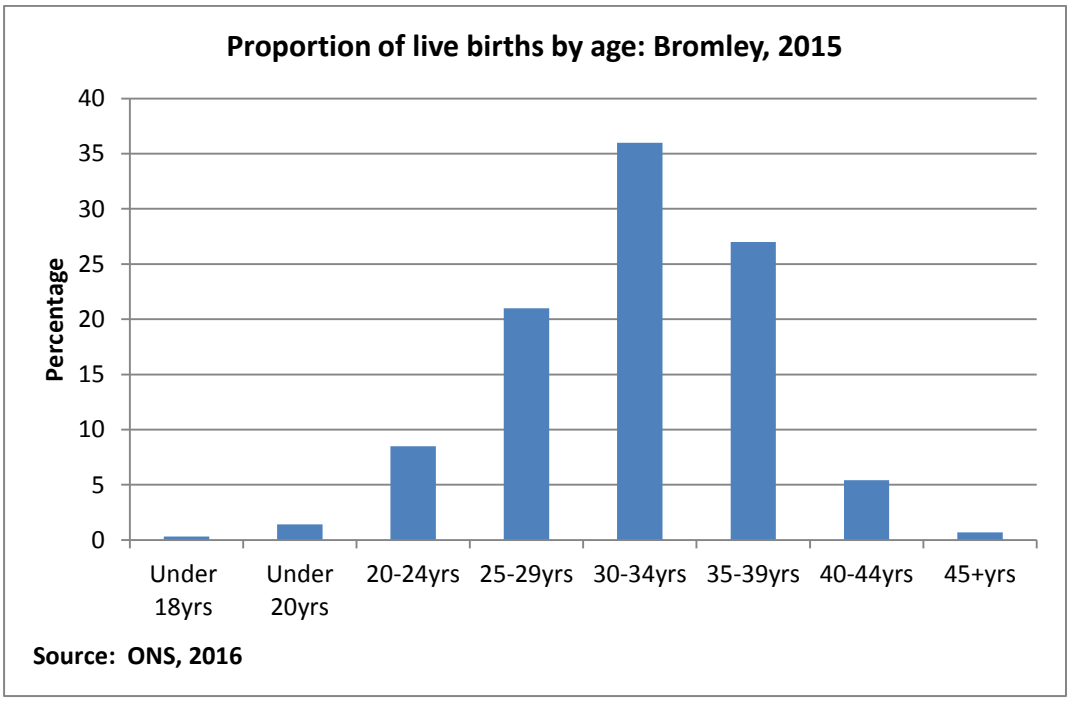
Births by Mother's Age

Proportion of births by age range show a high proportion of births in the 30 to 34 year age group in Bromley (36%, 1473). The second highest group of births takes place in the 35-39 age range (27%, 1121). More women over 45 years of age are giving birth than women under 18 years of age (0.7% compared to 0.3%). This follows national trends where the largest percentage increase in fertility rates from 2014 to 2015 were for women aged 40 years and over (3.4%).

It is important that reproductive healthcare services (contraception, termination and maternity care) address the needs associated with this trend towards older motherhood. This can include complications in pregnancy and birth, for example hypertension, plus the fact that women becoming pregnancy later in life are more likely to experience general age-related health conditions, such as diabetes and obesity[73]. However this needs to take account of other factors that can affect pregnancy or birth complications, such as socioeconomic status.

[73] What's the problem with older mothers? British Pregnancy Advisory Service https://www.bpas.org/get-involved/advocacy/briefings/older-mothers/

Figure 5.48



Births by Index of Multiple Deprivation

Children raised in disadvantaged environments are on average less likely to succeed in school and suffer poorer health outcomes as adults. Therefore understanding the proportion of births by areas of deprivation supports health organisations make informed decisions about the level of intensity with which preventive actions designed to improve health should be focused[74]. For example, focusing on registration at GP surgeries, children and family centres and breastfeeding support.

Figure 5.49 below shows the distribution of births in Bromley by Index of Multiple Deprivation. It shows a spread of births across all five ranges, but with a greater percentage in the least deprived quintile. Ward level data shows which areas have the greatest proportion of births in areas of multiple deprivation. This information is set out in **Table 5.9** and **Table 5.10**, looking at the most deprived and second most deprived quintile. This shows that the greatest proportion of births in areas of deprivation take place in Mottingham & Chislehurst, Cray Valley West and Cray Valley East, and when looking at the second most deprived quintile Crystal Palace, Penge & Cator and Cray Valley East. 81% of births and 77% of births respectively in Cray Valley East and Cray Valley West are either in the most deprived or second most deprived quintile.

[74] Institute of Health Equity (2010) Key Messages of 'Fair Society Healthy Lives', 'Fair Society Healthy Lives' (Marmot Review). UCL Institute of Health Equity.

Strong informal support networks can mitigate the effects of deprivation. Healthcare workers in Bromley have noted greater evidence of support networks in certain wards, such as Crystal Palace and Penge & Cator, compared to others such as Cray Valley East and Cray Valley West. There is a strong evidence base on other ways to support children in early life, for example targeted programmes based on early signs of risk such as insecure attachment between parent and child[75].

Figure 5.49

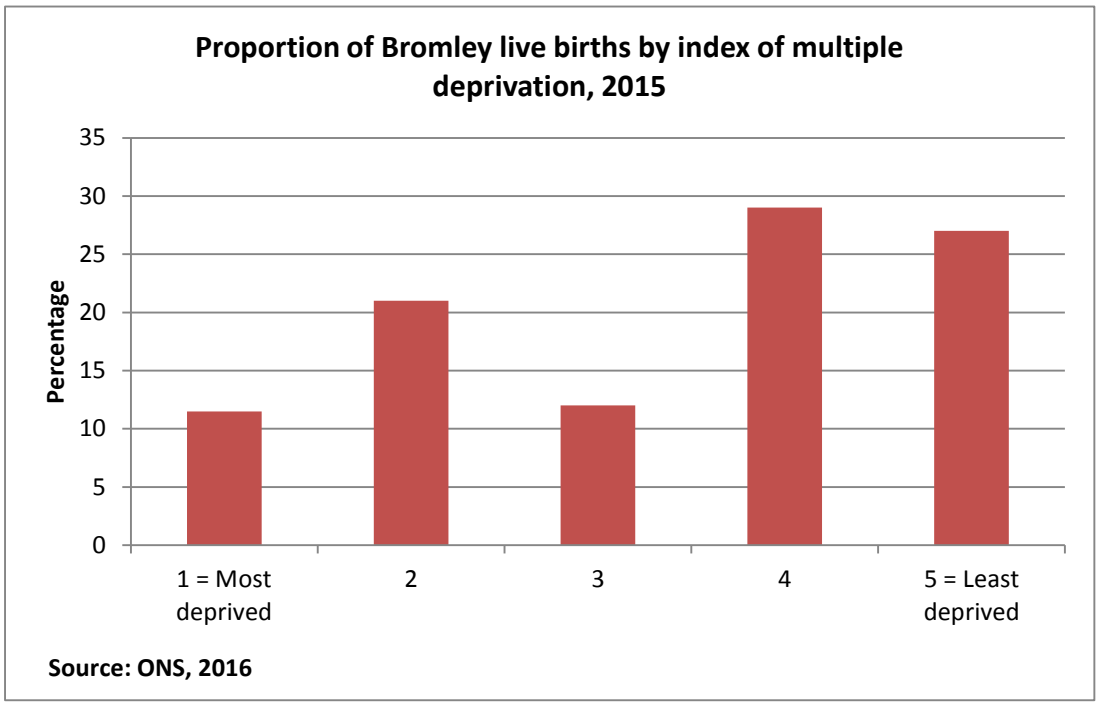


Table 5.9: Top five wards with the greatest proportion of births in the most deprived quintile Lower Super Output Area (LSOA): Bromley, 2015

Number	Ward	Percentage of births	Number of births
1	Mottingham & Chislehurst	56	86
2	Cray Valley West	36	90
3	Cray Valley East	32	82
4	Bromley Common & Keston	28	67
5	Crystal Palace	23	47

[75] Foundations for Life: What works to Support Parent Child Interaction in the Early Years (Early Intervention Foundation, 2016) http://www.eif.org.uk/publication/foundations-for-life-what-works-to-support-parent-child-interaction-in-the-early-years/

Table 5.10: Top five wards with the greatest proportion of births in the second most deprived quintile Lower Super Output Area (LSOA): Bromley, 2015

Number	Ward	Percentage of births	Number of births
1	Crystal Palace	77	159
2	Penge & Cator	61	197
3	Cray Valley East	49	124
4	Cray Valley West	41	103
5	Orpington	31	52

Early booking to antenatal care

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. Certain population groups, such as young pregnant women, have a higher likelihood of late booking for pregnancy care, for example owing to concern about being judged by health care providers. Late booking may lead to less access to advice and support on areas that support better health outcomes for the unborn child, for example around nutrition in pregnancy, smoking cessation and early access to and information about screening programmes[76].

There are two targets for women to have a full health and social risk assessment as part of their first antenatal care appointment:

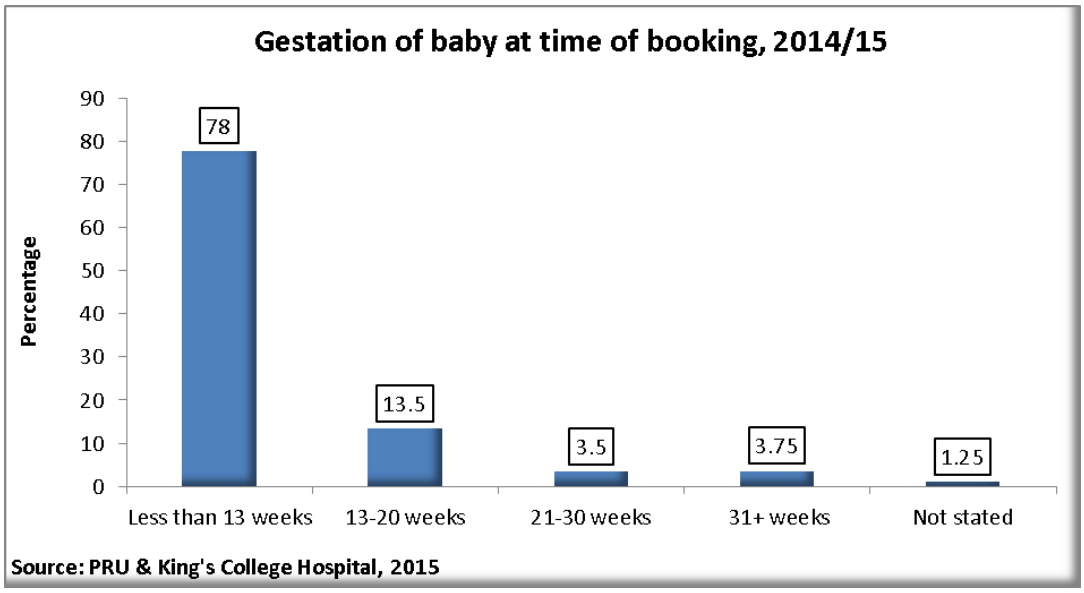
1. At least 50% of pregnant women to be seen by 10 weeks of pregnancy.
2. At least 90% of women to be seen by 12 weeks and 6 days of pregnancy.

Data from 2014/15 indicates that 78% of Bromley women booked for antenatal care before 13 weeks of pregnancy in 2014/15 which is below the 90% national target (**Figure 5.50**). This is an improvement on the 58.9% achievement in 2013/14. Unfortunately, Bromley's data for 2015/16 does not meet the NHS England validation criteria so it is not published. Data from the local provider, adjusted by Bromley's CCG, indicates that between June 2015 and June 2016 the range of ante-natal bookings within 12 weeks is from

[76] Annual Report of the Chief Medical Officer 2012 *Our Children Deserve Better: Prevention Pays* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255237/2901304_CMO_complete_low_res_accessible.pdf

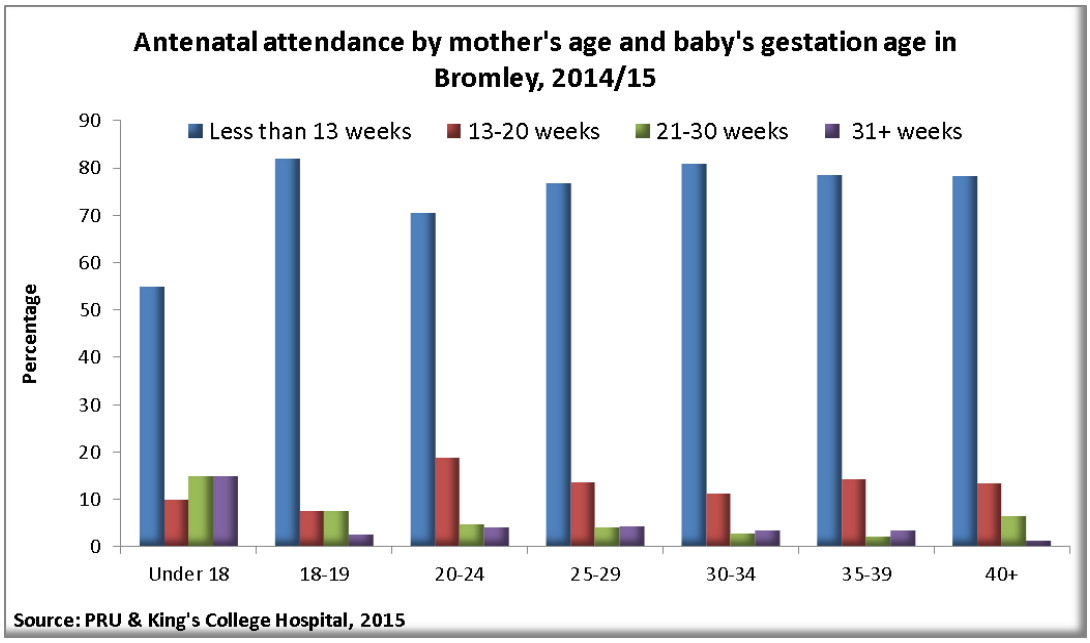
71.5% to 84.2%, with an average of 80%. This suggests further improvement since 2014/15 but performance is still under the goal of 90%. The local provider data is from King's College Hospital which covers around 85% of Bromley's antenatal bookings.

Figure 5.50



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

Figure 5.51



Smoking in pregnancy

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

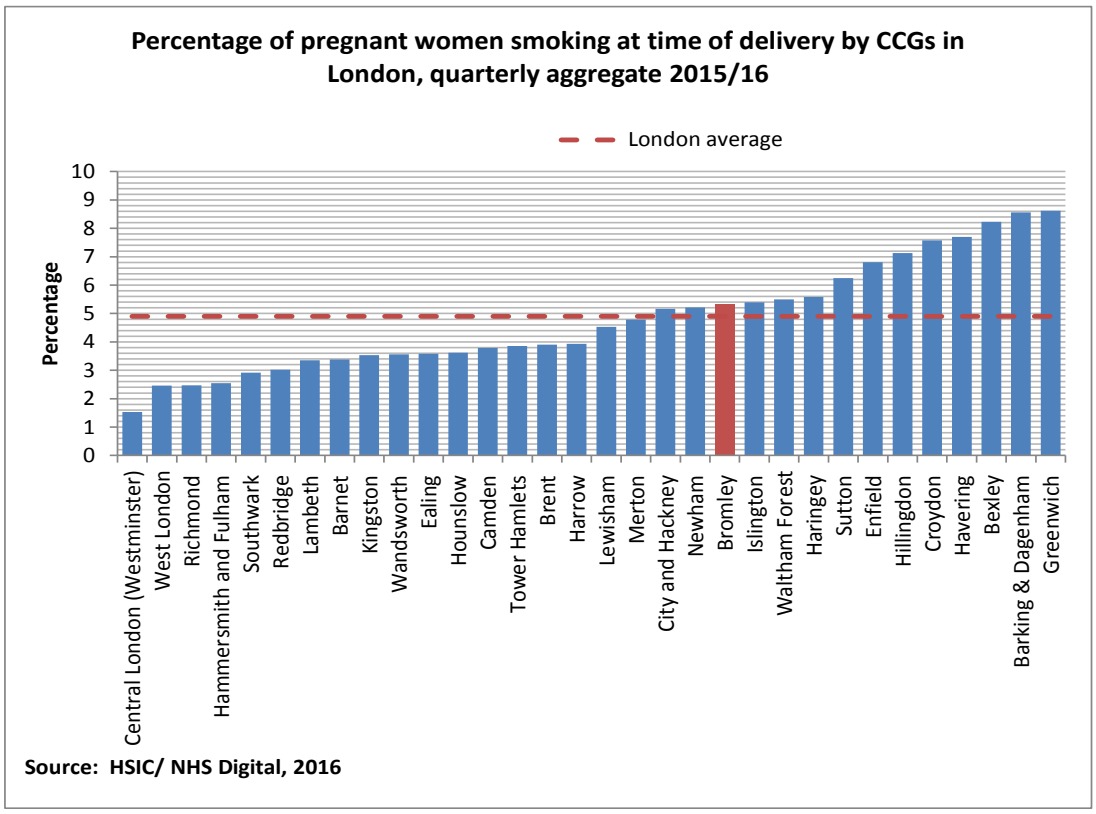
Supporting pregnant women to stop smoking may help them to quit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant. It is worth noting that statistics on women who smoke during their pregnancy rely on self-reporting and can be subject to some under reporting. National statistics highlight maternal smoking is associated with various factors including age and socio-economic position. For example, teenage mothers are twice as likely to smoke before and during pregnancy and three times as likely to throughout[77]. Information from the Bromley and Bexley Family Nurse Partnership shows higher smoking rates for these two boroughs for young parents compared to any other London borough at 71%[78].

[77] A framework for supporting teenage mothers and father (Public Health England/ Local Government Association, 2016) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524506/PHE_LGA_Framework_for_supporting_teenage_mothers_and_young_fathers.pdf

[78] Data for January 2016.

National benchmarking data shows the smoking rate at time of delivery in Bromley (5.3%) slightly above the London average (4.9%) but have decreased by 0.6% compared to 2013/14 figures. It is considerably lower than the England average of 10.6%. Although the proportions are low, work is needed to further drive down the rates in line with other London boroughs.

Figure 5.51

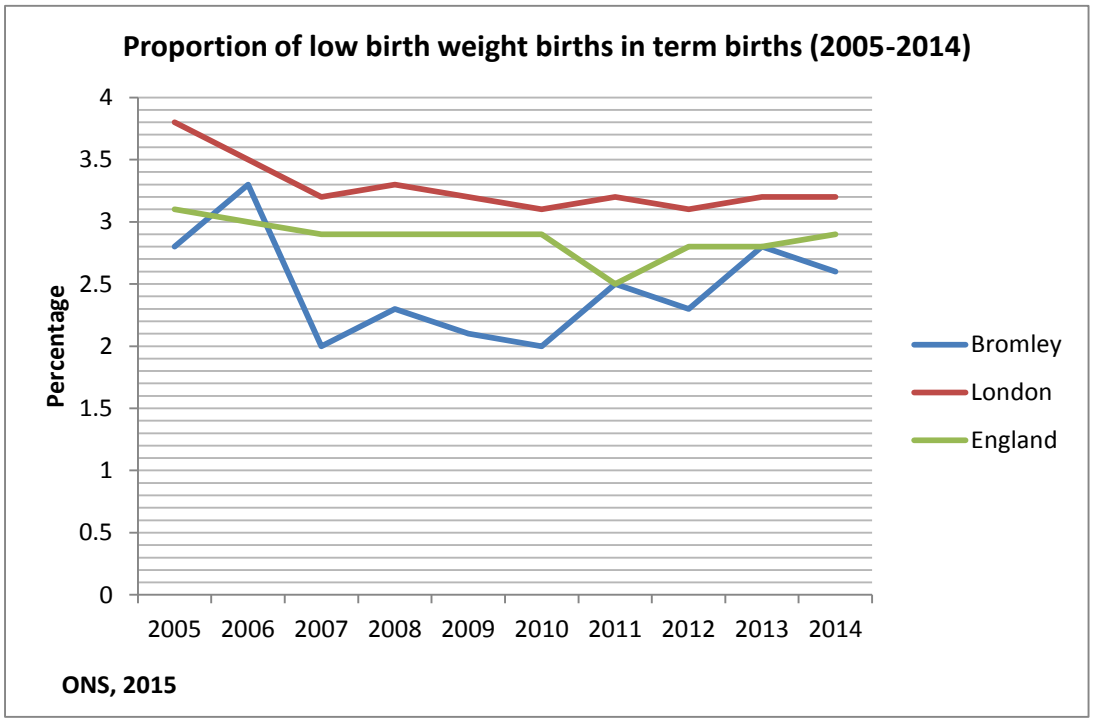


Birth weight

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, defined as live births with a recorded birth weight under 2500g born after 37 weeks. 2.6% (106) of full term babies born in Bromley in 2014 weighed less than 2,500 grams. This rate is lower than London (3.2) and England (2.9).

Figure 5.52



Analysis of ONS data for 2015[79] shows that 11% of babies are classified as large for gestational age (LGA) at more than 4,000 grams. LGA babies are at greater risk of perinatal morbidity and mortality. One of the risk factors for LGA is poorly controlled diabetes particularly gestational diabetes, pre-existing diabetes mellitus and excessive weight gain in pregnancy. This data requires further validation but shows a drop from the previous year in babies classified as large for gestational year by 1.6%.

Stillbirths

There were 18 stillbirths in Bromley in 2015. Ten stillbirths were UK born mothers and two were unidentified in terms of country of mother's birth. Six were non-UK born mothers. This is a slightly higher proportion than the percentage of births for non UK born mothers (33% compared to 31%) and with such a small sample size it is difficult to interpret any increase in risk.

Nationally there is a downward trend in the stillbirth rate since 2005 with a decrease of 18.5% over the last 10 years[80]. However the UK still has one of the highest stillbirth rates amongst high income countries. In addition there

[79] To note, this is drawn from data for all births for 2015.

[80] Births in England and Wales, 2015: statistical bulletin (ONS, 2016) http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2015#the-number-of-stillbirths-decreased-in-2015

has been little improvement in overall rates nationally since 2014[81]. Evidence based actions to reduce stillbirths include reducing smoking in pregnancy, monitoring of fetal growth and movement and effective fetal monitoring during labour.

Breastfeeding rates

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

For babies the 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.

A new interim reporting system is in place to monitor prevalence of breastfeeding at 6 to 8 weeks via health visitors. 2015-16 is the first reporting period for this data and unfortunately most London local authorities data has yet to meet the validation criteria. However, there are statistics for Bromley, stating that 61.4% of babies are being breastfed 6-8 weeks after birth[82]. This is a total of 535 out of 971. Within this number, 390 are totally breastfed (44.8%). It is useful to note that the breastfeeding status is unknown for 868 babies in Bromley.

It is difficult to make comparisons using a new dataset that is still undergoing evaluation. Of London boroughs that passed the validation criteria, Croydon had a rate of 66.7% and Kingston upon Thames of 73%. It is not possible to cite a London average owing to data quality, but the reported England average is 43.7%.

What this means for Bromley residents and for children in Bromley

[81] Saving Babies' Lives: A care bundle for reducing stillbirths (NHS England, 2016) https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf

[82] ONS Breastfeeding at 6 to 8 weeks after birth: 2015 to 2016 quarterly data (Experimental statistics) https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-after-birth-2015-to-2016-quarterly-data

The number of live births is rising slowly, with the greatest number of births in Penge & Cator, Bromley Town and Clock House wards. Bromley has higher birth rates than the London average. This has implications for Bromley primary schools and children services in the borough.

UK women make the largest contribution to Bromley's birth rate (71%). Poland, India and Nigeria are the most common countries of birth for non-UK born mothers in Bromley. In terms of age, the greatest number of births occur in the 30-34 years age group. More women at 40 years of age and over are now giving birth than women under 18 years of age. This shows a rising trend towards older motherhood, with reproductive healthcare services needing to reflect the population changes.

The greatest proportions of births in Bromley take place in the less deprived areas of the borough. However certain wards experience a large proportion of births in areas of high deprivation. The top three wards with the greater proportion of births in the most deprived Lower Super Output Area are Mottingham & Chislehurst, Cray Valley West and Cray Valley East. This information helps target interventions to support health and help counteract the impacts of deprivation.

Bromley is below the England average in terms of percentage of women smoking at time of delivery and higher than the England average for babies being breastfed 6-8 weeks after birth.

Improvements in data collection are required around early booking to antenatal care and breastfeeding status.

Table 5.11: Pregnancy and Maternity Related PHOF Indicators, 2016

Indicator	Time period	Sex	Bromley	London	England
2.01 Low birth weight of term babies	2010	Persons	2.0	3.1	2.9
2.01 Low birth weight of term babies	2011	Persons	2.5	3.2	2.8
2.01 Low birth weight of term babies	2012	Persons	2.3	3.1	2.8
2.01 Low birth weight of term babies	2013	Persons	2.8	3.2	2.8
2.01 Low birth weight of term babies	2014	Persons	2.6	3.2	2.9
2.02i Breastfeeding initiation	2011/12	Female	83.6	87.0	74.0
2.02i Breastfeeding initiation	2012/13	Female	84.7	86.8	73.9
2.02i Breastfeeding initiation	2013/14	Female	-	-	74.0
2.02i Breastfeeding initiation	2014/15	Female	-	86.1	74.3
2.02ii- Breastfeeding prevalence at 6-8 weeks after birth	2011/12	Female	57.2	67.5	47.2
2.02ii- Breastfeeding prevalence at 6-8 weeks after birth	2012/13	Female	59	68.5	47.2
2.02ii- Breastfeeding prevalence at 6-8 weeks after birth	2013/14	Female	-	-	45.8
2.02ii- Breastfeeding prevalence at 6-8 weeks after birth	2014/15	Female	-	-	45.8
2.03 Smoking status at time of delivery	2011/12	Persons	6.1	6.0	13.2

Indicator	Time period	Sex	Bromley	London	England
2.03 Smoking status at time of delivery	2012/13	Persons	5.2	5.7	12.7
2.03 Smoking status at time of delivery	2013/14	Persons	5.9	5.1	12.0
2.03 Smoking status at time of delivery	2014/15	Persons	4.7	4.8	11.4

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

For more information please contact Dr Jenny.Selway@Bromley.gov.uk

6. Alcohol Use in Bromley

Introduction

In many parts of the world, drinking alcoholic beverages is a common feature of social gatherings. Nevertheless, the consumption of alcohol carries a risk of adverse health and social consequences related to its intoxicating, toxic and dependence-producing properties.

In addition to the chronic diseases that may develop in those who drink large amounts of alcohol over a number of years, alcohol use is also associated with an increased risk of acute health conditions, such as injuries, including from traffic accidents.

According to the World Health Organisation[83]:

- Worldwide, 3.3 million deaths every year result from harmful use of alcohol, this represent 5.9% of all deaths.
- The harmful use of alcohol is a causal factor in more than 200 disease and injury conditions.
- Overall 5.1% of the global burden of disease and injury is attributable to alcohol, as measured in disability- adjusted life years (DALYs).
- Alcohol consumption causes death and disability relatively early in life. In the age group 20 – 39 years approximately 25% of the total deaths are alcohol-attributable.
- There is a causal relationship between harmful use of alcohol and a range of mental and behavioural disorders, other non-communicable conditions as well as injuries.
- Causal relationships have been established between harmful drinking and incidence of infectious diseases such as tuberculosis as well as the course of HIV/AIDS.
- Beyond health consequences, the harmful use of alcohol brings significant social and economic losses to individuals and society at large.

Epidemiology of Alcohol Misuse[1]

Alcohol is a psychoactive substance with dependence-producing properties.

Alcohol consumption can have an impact not only on the incidence of diseases, injuries and other health conditions, but also on the course of disorders and their outcomes in individuals. Alcohol-related harm is determined, apart from environmental factors, by three related dimensions of drinking:

- the volume of alcohol consumed
- the pattern of drinking

[83] World Health Organisation Global Status Report on Alcohol and Health, 2014.

- and, on rare occasions also the quality of alcohol consumed

Alcohol Consumption has been identified as a component cause for more than 200 diseases, injuries and other health conditions.
A component cause may be one among a number of components, none of which alone is sufficient to cause the disease. When all the components are present, the sufficient cause is formed.
For most diseases and injuries causally impacted by alcohol, there is a dose–response relationship. For example, for all alcohol-attributable cancers, the higher the consumption of alcohol, the larger the risk for these cancers.

Pattern of Drinking also affects the risk of harm. For example, a pattern of drinking while eating seems to be associated with less harm from chronic diseases than the same pattern of drinking at other times.
The cardio protective effect of low-risk patterns of alcohol consumption disappears completely in the presence of heavy episodic drinking (HED).
HED is the consumption of 60 or more grams of alcohol (7.5 units) on at least one single occasion at least monthly. The volume of alcohol consumed on a single occasion is important for many acute consequences of drinking such as alcohol poisoning, injury and violence, and is also important wherever intoxication is socially disapproved of. HED is associated with detrimental consequences even if the average level of alcohol consumption of the person concerned is relatively low.

Quality of Alcohol Consumed may impact on health and mortality for instance when home-made or illegally produced alcoholic beverages are contaminated with methanol or other very toxic substances, such as disinfectants.

Mechanisms of Harm in an Individual
There are three main direct mechanisms of harm caused by alcohol consumption in an individual. These three mechanisms are:

- toxic effects on organs and tissues;
- intoxication, leading to impairment of physical coordination, consciousness, cognition, perception, affect or behaviour;
- dependence, whereby the drinker's self-control over his or her drinking behaviour is impaired

Factors Affecting Alcohol Consumption and Alcohol-Related Harm[1]
A variety of factors have been identified at individual and societal levels, which affect the magnitude and patterns of consumption and can increase the risk of alcohol use disorders and other alcohol-related problems in drinkers and others.
Environmental factors such as economic development, culture, availability of alcohol and the level and effectiveness of alcohol policies are relevant factors in explaining

differences in vulnerability between societies, historical trends in alcohol consumption and alcohol-related harm.

Age

Children, adolescents and elderly people are typically more vulnerable to alcohol-related harm from a given volume of alcohol than other age groups.

Early initiation of alcohol use (before 14 years of age) is a predictor of impaired health status because it is associated with increased risk of alcohol dependence and abuse at later ages, alcohol-related motor vehicle accidents, and other unintentional injuries. At least part of the excess risk among young people is related to the fact that, typically, a greater proportion of the total alcohol is consumed during heavy drinking episodes. Also, young people appear to be less risk-averse and may engage in more reckless behaviour while drunk.

While alcohol consumption generally declines with age, older drinkers typically consume alcohol more frequently than other age groups. Also, as people grow older, their bodies are typically less able to handle the same levels and patterns of alcohol consumption when they were younger, leading to a high burden from unintentional injuries, such as alcohol-related falls.

Gender

Harmful use of alcohol is the leading risk factor for death in males aged 15–59 years, yet there is evidence that women may be more vulnerable to alcohol-related harm from a given level of alcohol use or a particular drinking pattern. The vulnerability of females to alcohol-related harm is a major public health concern because alcohol use among women has been increasing steadily in line with economic development and changing gender roles and because it can have severe health and social consequences for newborns.

There is a higher burden of alcohol-related disease among men than women because men are less often abstainers, drink more frequently and in larger quantities.

However, the same level of alcohol consumption leads to more pronounced outcomes for women because women typically have lower bodyweight, smaller liver capacity to metabolise alcohol and a higher proportion of body fat, so achieve higher blood alcohol concentrations than men.

Women are also affected by interpersonal violence and risky sexual behaviour as a result of the drinking problems and drinking behaviour of male partners.

Women who drink during pregnancy may increase the risk of fetal alcohol spectrum disorder and other preventable health conditions in their newborns.

Familial Risk Factors

A family history of alcohol use disorders is considered a major vulnerability factor for both genetic and environmental reasons.

Multiple genes influence alcohol use initiation, metabolism and reinforcing properties in different ways, contributing to the increased susceptibility to toxic, psychoactive and dependence-producing properties of alcohol in some vulnerable groups and individuals.

Parental alcohol use disorders have been found to negatively affect the family situation during childhood. Parents with alcohol use disorders display particular patterns of alcohol consumption and thereby increase the likelihood that their children will develop drinking patterns associated with high risk of alcohol use disorders when they are introduced to alcohol. Heavy drinking by parents affects family functioning, the parent–child relationship and parenting practices, which in turn affects child development adversely. The mistreatment of children, including sexual abuse, physical abuse and neglect, may also lead to childhood psychopathology and later to problem drinking.

Socioeconomic Status[1]

Surveys and mortality studies, particularly from the developed world, suggest that there are more drinkers, more drinking occasions and more drinkers with low-risk drinking patterns in higher socioeconomic groups, while abstainers are more common in the poorest social groups. However, people with lower socioeconomic status (SES) appear to be more vulnerable to tangible problems and consequences of alcohol consumption. For example, manual workers seem more vulnerable to severe alcohol-related health outcomes, including mortality, than non-manual workers for a given pattern of drinking.

One explanation for the potentially greater vulnerability among lower SES groups is that they are less able to avoid adverse consequences of their behaviour due to a lack of resources. For example, individuals with higher SES may be more able to choose safer environments in which to drink, purchase social or spatial buffering of their behaviour and have better access to high-quality health care services.

A second explanation could be that individuals in lower SES groups have a less extensive support network, i.e., fewer factors or persons to motivate them to address alcohol problems before severe consequences occur.

A third, contested, explanation that has been proposed in the past is that of an “all or nothing” pattern of behaviour in lower SES groups, i.e. poor people drink less often, but when they drink, they drink a lot.

Guidelines on Alcohol Use

In August 2016, the UK Chief Medical Officers issued guidelines and recommendations on regular drinking, single episodes of drinking and on pregnancy and drinking[84].

Weekly Drinking Guideline

This applies to adults who drink regularly or frequently i.e. most weeks

The Chief Medical Officers' guideline for both men and women is that:

- To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis.
- If you regularly drink as much as 14 units per week, it is best to spread your drinking evenly over 3 or more days. If you have one or two heavy drinking episodes a week, you increase your risks of death from long term illness and from accidents and injuries.
- The risk of developing a range of health problems (including cancers of the mouth, throat and breast) increases the more you drink on a regular basis.
- If you wish to cut down the amount you drink, a good way to help achieve this is to have several drink-free days each week.

Single Occasion Drinking Episodes

This applies to drinking on any single occasion (not regular drinking, which is covered by the weekly guideline)

The Chief Medical Officers' advice for men and women who wish to keep their short term health risks from single occasion drinking episodes to a low level is to reduce them by:

- limiting the total amount of alcohol you drink on any single occasion
- drinking more slowly, drinking with food, and alternating with water
- planning ahead to avoid problems e.g. by making sure you can get home safely or that you have people you trust with you.

The sorts of things that are more likely to happen if you do not understand and judge correctly the risks of drinking too much on a single occasion can include:

- accidents resulting in injury, causing death in some cases
- misjudging risky situations, and
- losing self-control (e.g. engaging in unprotected sex).

Some groups of people are more likely to be affected by alcohol and should be more careful of their level of drinking on any one occasion for example those at risk of falls, those on medication that may interact with alcohol or where it may exacerbate pre-existing physical and mental health problems.

[84] UK Chief Medical Officers' Low Risk Drinking Guidelines, August 2016

If you are a regular weekly drinker and you wish to keep both your short- and long term health risks from drinking low, this single episode drinking advice is also relevant for you.

Pregnancy and drinking

The Chief Medical Officers' guideline is that:

If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.

Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

The risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy.

If you find out you are pregnant after you have drunk alcohol during early pregnancy, you should avoid further drinking. You should be aware that it is unlikely in most cases that your baby has been affected. If you are worried about alcohol use during pregnancy do talk to your doctor or midwife.

Classification of drinking behaviours

The most common classifications of alcohol consumption are based on quantity. The World Health Organisation and the National Institute of Health & Care Excellence (NICE) refer to classifications as follows:

Table 6.1: Classification of Drinking Behaviours[85]

RISK			Men	Women
1	**Lower risk** This level of drinking means that in most circumstances you have a low risk of causing yourself future harm.	**Sensible drinking** Drinking within the recommended limits.	No more than 3-4 units a day on a regular* basis	No more than 2-3 units a day on a regular* basis
2	**Increasing risk** Drinking at a level that increases the risk of damaging your health and could lead to serious medical conditions.	**Hazardous drinking** A pattern of alcohol consumption that increases risk of harm.	More than 3-4 units a day on a regular* basis	More than 2-3 units a day on a regular* basis
3	**Higher risk** This level of drinking has the greatest risk of health problems.	**Harmful drinking** A pattern of alcohol consumption that is causing mental and physical damage.	More than 50 units per week (or more than 8 units per day) on a regular* basis	More than 35 units per week (or more than 6 units per day) on a regular* basis

*Regular in this context means drinking at this sort of level every day or most days of the week; whilst for weekly drinking, it refers to the amounts drunk most weeks of the year.

[85] Adapted from Gravesham County NHS. http://www.gravesham.gov.uk/__data/assets/pdf_file/0007/62359/Units_Poster.pdf last accessed 16/09/14

Binge drinking

The new guidelines allow estimates to be made of the amounts of alcohol likely to be harmful when consumed on a single drinking day.

Table 6.2 Risks in a Single Drinking Day

Amount of Alcohol in One Day	Risk
Up to 4.67 units	This value is a third of the recommended weekly limit. This is the value you would drink if you drank 14 units spread evenly over three days.
More than 4.67 and up to 7 units	Evidence in the new guidelines suggests that the risk of accident or injury increases when drinking this amount of units over 3 to 6 hours.
More than 7 and up to 14 units	Up to the level that men and women are advised not to regularly drink in a week.
More than 14 units	The equivalent of drinking more than the low risk guidelines recommend for regular drinking in a week, in one day.

Source: Opinions & Lifestyle Survey 2016

Dependence

Drinkers can also be classified by their addiction to alcohol, known as dependence. Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations.

- **Mild dependence:**
  May crave an alcoholic drink when it is not available or find it difficult to stop drinking.
- **Moderate dependence:**
  Likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking.
- **Severe dependence:**
  May have withdrawal fits (delirium tremens: e.g. confusion or hallucinations usually starting between two or three days after the last drink); may drink to escape from or avoid these symptoms.

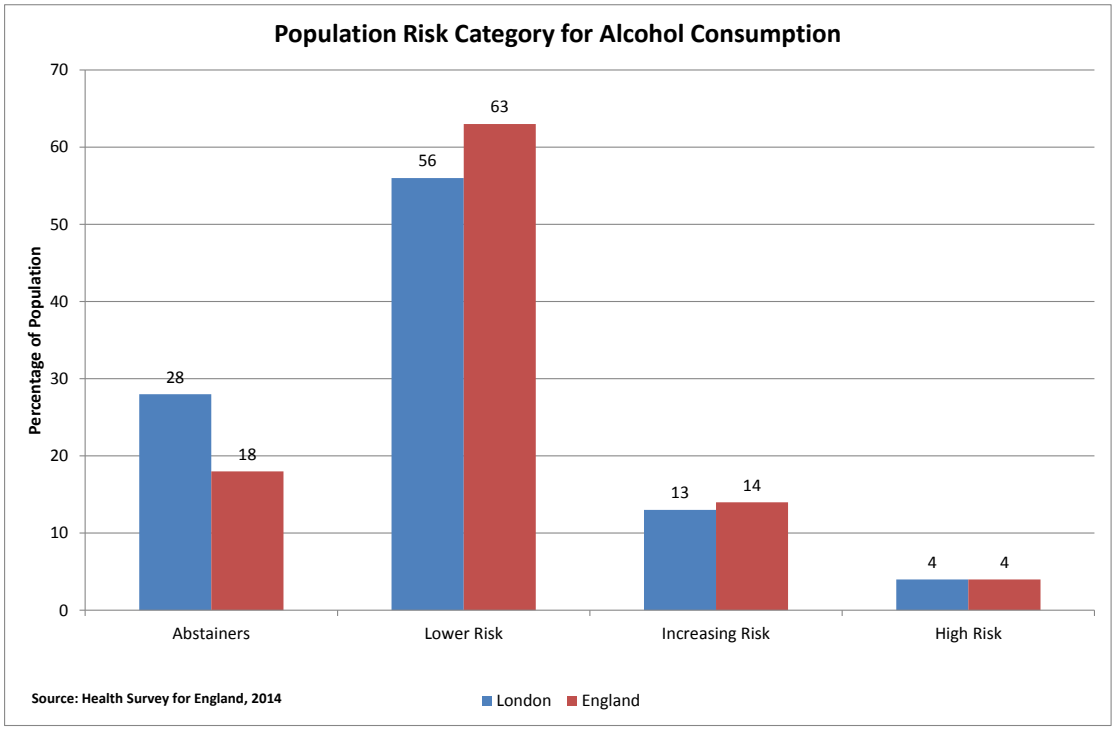
Abstainers are considered to be people who have reported not consuming alcohol in the previous 12 months. This may include people who have once been dependent on alcohol but are no longer consuming it.

Alcohol Consumption in Bromley

Obtaining reliable information about drinking behaviour is difficult, and social surveys consistently record lower levels of consumption than would be expected from the data on alcohol sales. However, a range of data sources which are available locally were extracted and analysed to understand patterns and trends in alcohol consumption in the Bromley population.

People in Bromley are not thought to drink any more than the average for London or England. In 2012 an estimated 73.6% of all drinkers in Bromley were in the lower risk category and drinking within the recommended levels, compared to 73.4% for London. There were 19.5% of drinkers at increasing risk, and a further 6.9% at high risk, which was no different to the London average. Figure 1 shows the most recent estimates of people consuming alcohol regionally and nationally.

Figure 6.1: Health Survey for England Estimates of Alcohol Consumption 2014



* Abstainers include people who may have had harmful or dependent drinking patterns in the past but may have stopped drinking since. They are not included in the estimation of lower risk drinkers.

Data collected from GP systems in June 2016 shows that of the 274,935 people aged 16 years and over registered with Bromley GPs, 42.2% have been asked about their alcohol consumption within the last three years. As this proportion is quite low, it is not possible to draw definite conclusions about alcohol consumption in the population. It should also be noted that information on the volume of alcohol consumption alone will not identify all those at risk, as some patterns of consumption e.g. heavy episodic drinking cause harm at lower levels of consumption.

The following data relates to those who have a record of their alcohol consumption within the last three years:
Almost 13% of people in Bromley reported drinking above the recommended weekly limit, with more men than women exceeding the recommendations (21.3% vs 6.3%). This is lower than Health Survey for England estimates for London.

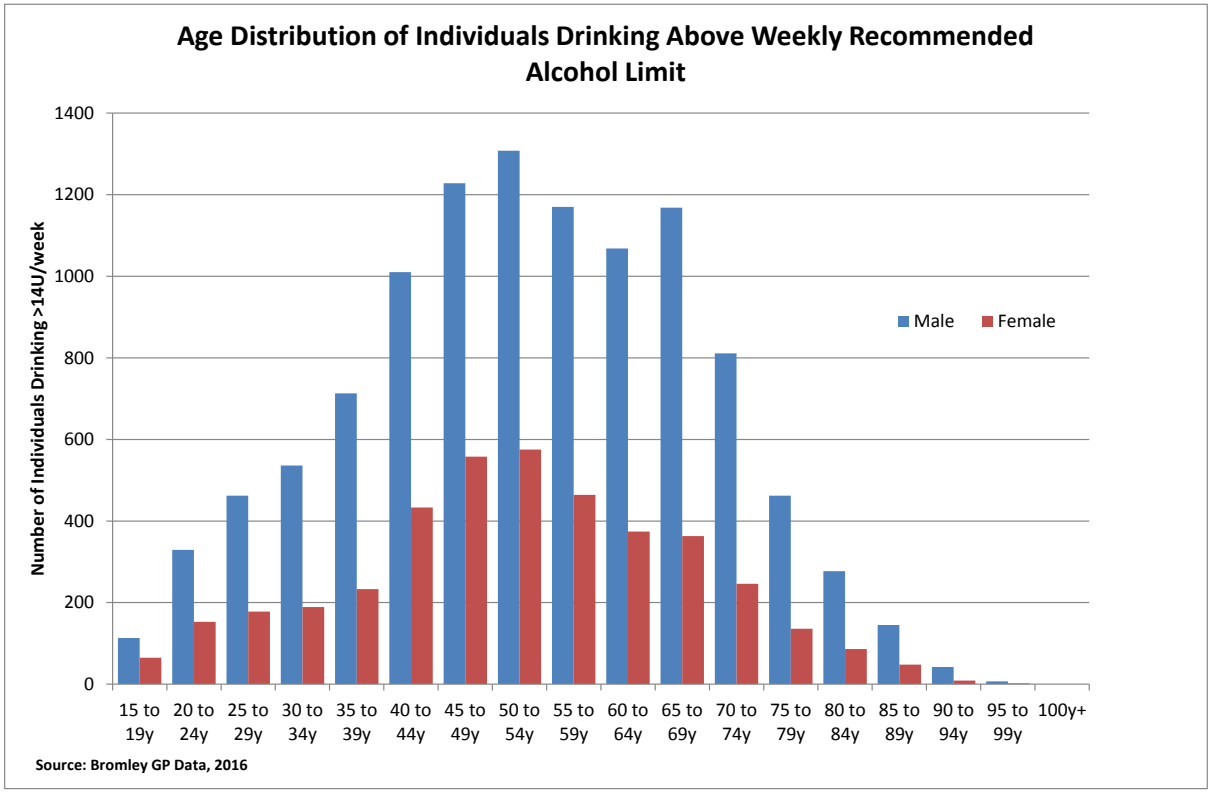
Table 6.3 Alcohol Consumption in Bromley

No. of Units Weekly	Persons	Male	Female
Zero	33%	25.1%	39.7%
Up to 14 units	53.9%	53.7%	54%
Over 14 units	12.9%	21.3%	6.3%

Source: Bromley GP Data, 2016

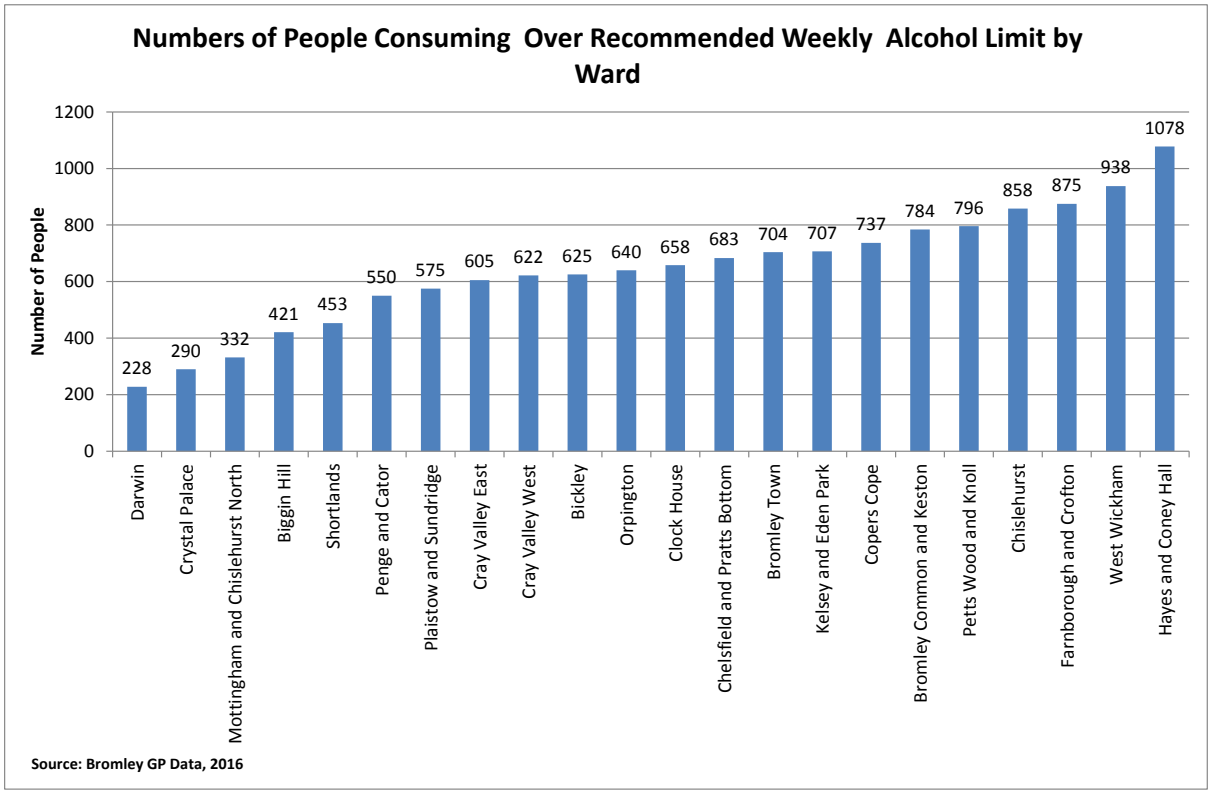
The numbers of men and women drinking above the recommended limit of 14 units per week rises with age to a peak at age 50 to 54 years, and declines again thereafter.

Figure 6.2 Age Distribution of Alcohol Consumption in Bromley, 2016



The numbers of people drinking above the recommended weekly limits varies with ward of residence, Hayes & Coney Hall ward having the highest number, and Darwin having the lowest number.

Figure 6.3: Harmful Alcohol Consumption in Bromley by Ward, 2016



Patients registered with Bromley GPs who are aged between 40 and 74 years and do not have existing cardiovascular disease are eligible for an NHS Health Check every five years. As part of the NHS Health Check, patients complete a short questionnaire relating to their alcohol consumption, the Audit C questionnaire (https://www.alcohollearningcentre.org.uk/Topics/Latest/AUDIT-C/).

In 2015-16, of the 6,868 people who had an NHS Health Check, 95% completed the Audit C questionnaire. 736 of these (10.7%) had a score of 8 or more, indicating an increasing risk from their volume and pattern of alcohol consumption (16.1% of men and 7.1% of women). This level is slightly lower overall and particularly for men than that expected for this age group compared to the reported consumption in the GP data.

Prevalence of binge drinking

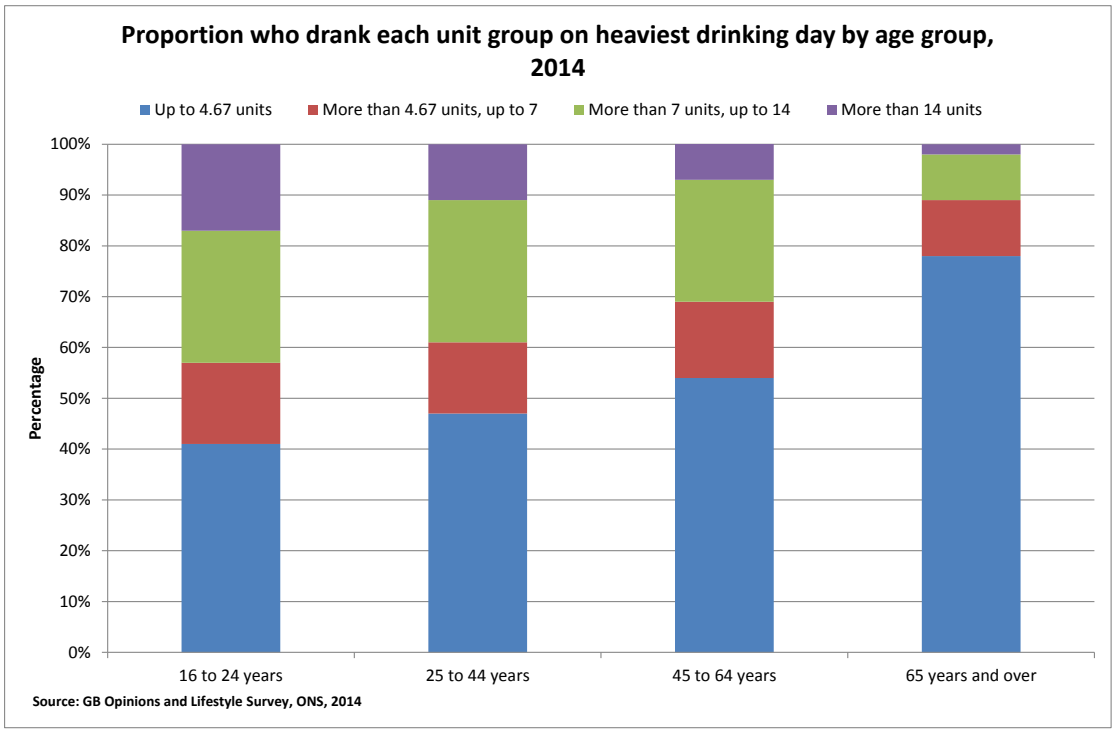
In 2014, the GB Opinions and Lifestyle Survey found that 58% of the population had drunk alcohol in the week before being interviewed.

Of these, 45% drank more than 4.67 units on their heaviest drinking day (i.e. over a third of the weekly limit) and 9% drank more than the recommended weekly amount of 14 units in one day.

Although young people were less likely to have consumed alcohol (48% of those aged 16 to 24 years as compared with 66% of those aged 45 to 64 years), they were more likely to consume more than the recommended weekly limit in one day (17% of 16 to 24 year olds as compared with 2% of those aged 65 years and over).

There are no recent local Bromley estimates for the level of binge drinking available.

Figure 6.4 National Estimates for Alcohol Consumption on a Single Drinking Day



Impact on Health & Wellbeing

The Chief Medical Officer's Alcohol Guidelines published in 2016 state that drinking any level of alcohol regularly carries a health risk for everyone.
An analysis of 67 risk factors and risk factor clusters for death and disability found that alcohol is the 3rd leading risk factor for death and disability after smoking and obesity.

Among the conditions for which alcohol is a causal factor are:

- Mouth, throat, stomach, liver and breast cancers
- Cirrhosis of the liver
- Heart disease
- Depression
- Stroke
- Pancreatitis

The lifetime risk of cancer increases with increasing alcohol consumption, as illustrated in the table below:

Table 6.4 Alcohol Consumption and Cancer Risk

Weekly Alcohol Consumption (Units)	Lifetime Risk (per 1000)	
	Breast Cancer	Bowel Cancer
35+	206	115
14	126	64
0	109	64

Alcohol misuse is also associated with mental health problems. A number of large epidemiological surveys demonstrate the high prevalence of co-morbidity in those attending mental health services and both drug and alcohol treatment services.
An estimated 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year.
There is a strong association between alcohol misuse and suicide. The National confidential inquiry into suicide and homicide by people with mental illness found that there was a history of alcohol misuse in 45% of suicides among the patient population during period 2002 to 2011.

Alcohol Related Mortality

Excessive alcohol consumption is a major cause of preventable premature death.
Liver disease is one of the leading causes of death in England and people are dying from it at younger ages. Alcohol accounts for over a third of all cases of liver disease. Most liver disease is preventable.
Liver disease has more than doubled since 1980 and is the only major killer disease on the increase during that period in the UK [86].

National

In England, in 2014 there were 22,966 alcohol-related deaths. Males accounted for a larger proportion of all alcohol-related deaths than women in England (66% in 2014). Between 2012 and 2014, the rate of deaths related to chronic liver disease in England was 15.21 per 100,000 population, and the rate of alcohol-related cancer deaths was 38.04 per 100,000 population.

Local

In 2014 there were 121 alcohol-related deaths in Bromley. The mortality rate from alcohol-related causes in Bromley appears to be on a rising trend for women whilst remaining level for men in the period between 2009 and 2013.
The alcohol-related mortality rate for men and women in Bromley is lower than the national levels, but the rate for women is slightly higher than the London regional

[86] PHE, Health Matters: harmful drinking and alcohol dependence, January 2016

rate. The alcohol-related mortality rate for men in Bromley is approximately twice that for women.

Between 2012 and 2014, the rate of deaths related to chronic liver disease in Bromley was 10.00 per 100,000 population, and the rate of alcohol-related cancer deaths was 34.3 per 100,000 population.

Figures 5 and 6 show the trend in alcohol-related deaths in Bromley, London and England by gender.

Figure 6.5: Alcohol-related deaths. Directly Standardised Rate - Males

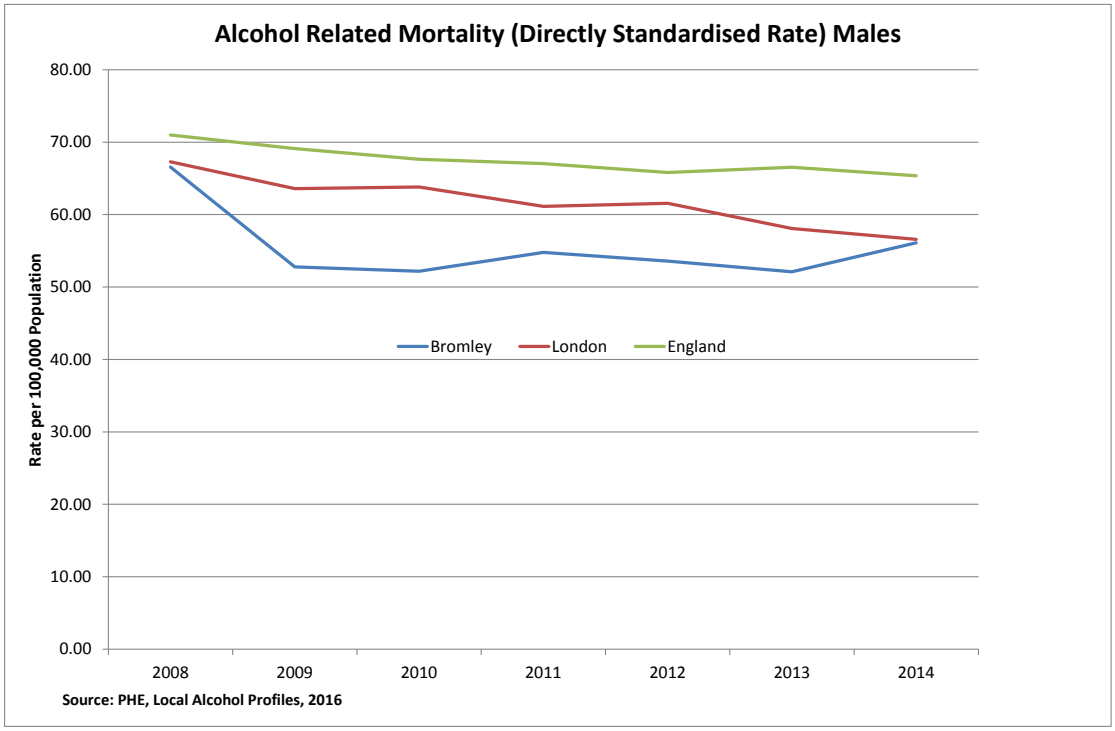
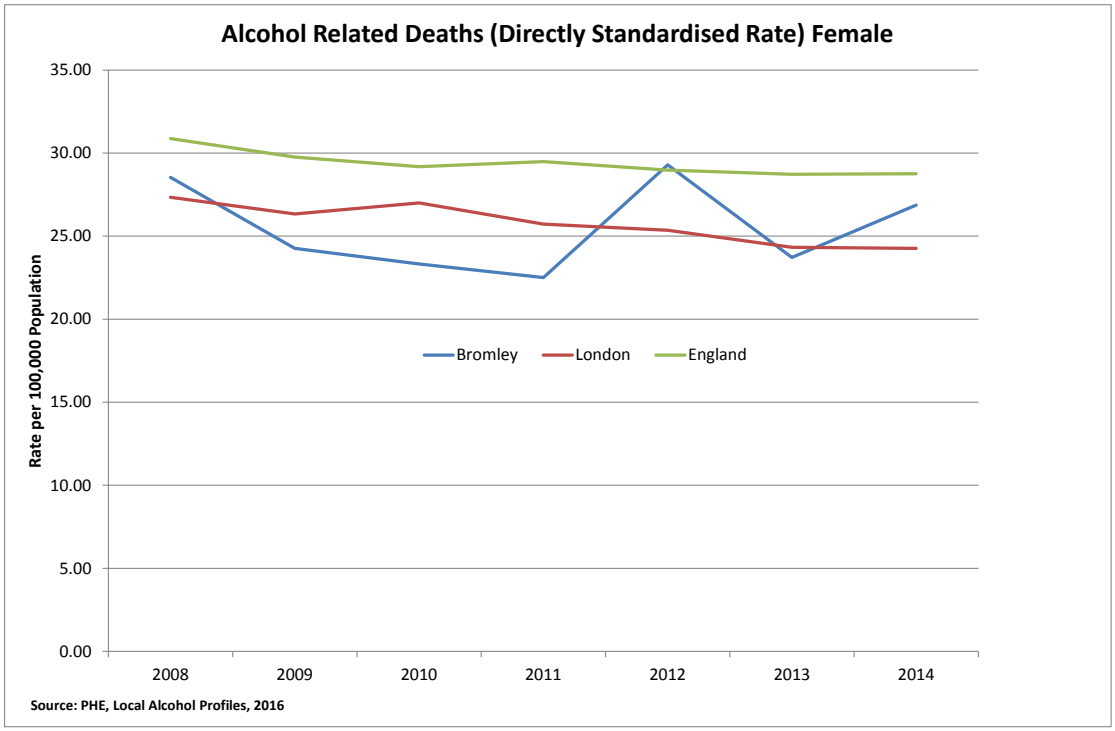


Figure 6.6: Alcohol-related deaths. Directly Standardised Rated - Females



Hospital Admissions - burden of ill-health due to alcohol[87]

Alcohol-related hospital admissions can be due to regular alcohol use that is above lower-risk levels and are most likely to involve increasing-risk drinkers, dependent drinkers and binge drinkers.

Alcohol dependence can be a long-term condition, which may involve relapses even after good quality treatment. Dependent individuals also experience many health problems and are frequent users of health services.

Health conditions in which alcohol plays a causative role can be classified as either "alcohol-specific" or "alcohol-related". For alcohol-specific conditions, alcohol is causally implicated in all cases e.g. alcohol poisoning or alcoholic liver disease.

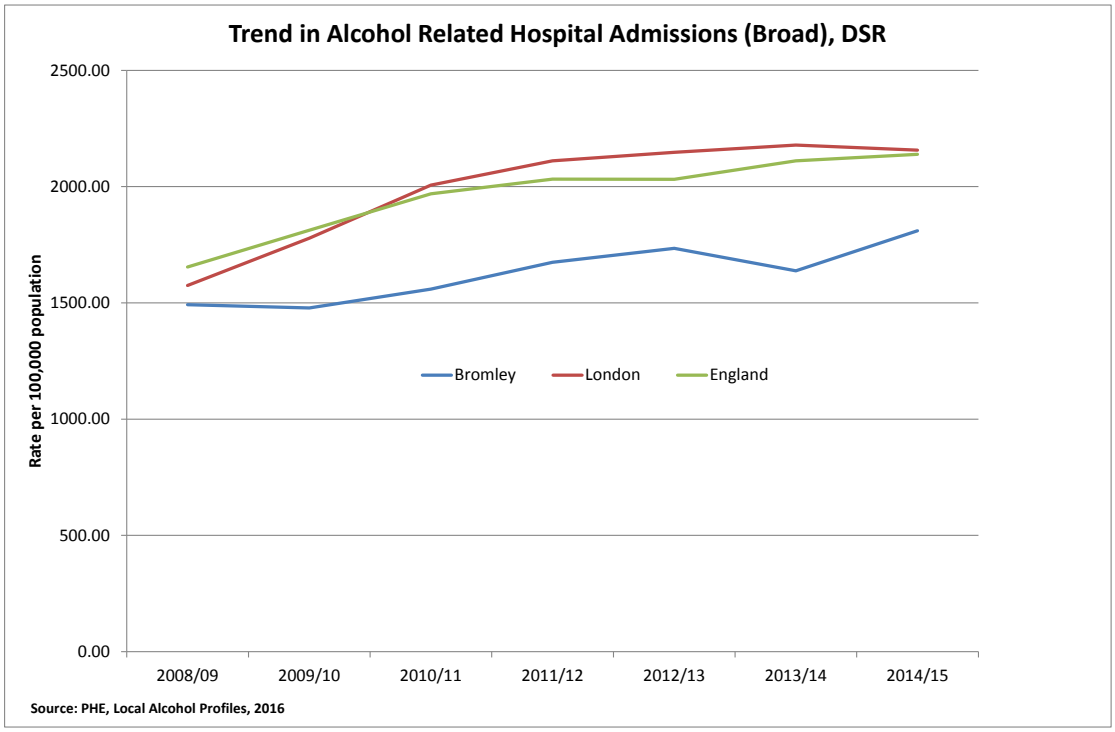
Alcohol-related conditions include all alcohol-specific conditions plus those where alcohol is causally implicated in some, but not all cases, e.g. high blood pressure, various cancers and falls.

There are two types of measure for alcohol-related admissions. The broad measure is an indication of the totality of alcohol health harm in the local adult population. The narrow measure shows the number of admissions where an alcohol-related illness was the main reason for admission or was identified as an external cause. The narrow measure is more responsive to change resulting from local action on alcohol.

[87] PHE, JSNA Support Pack 2016

The rate of alcohol-related hospital admissions whilst increasing at national, regional and local levels, remains lower in Bromley than for London and England as shown in figure 7 below.

Figure 6.7: Alcohol-related NHS hospital admissions 2008/09 to 2014/15



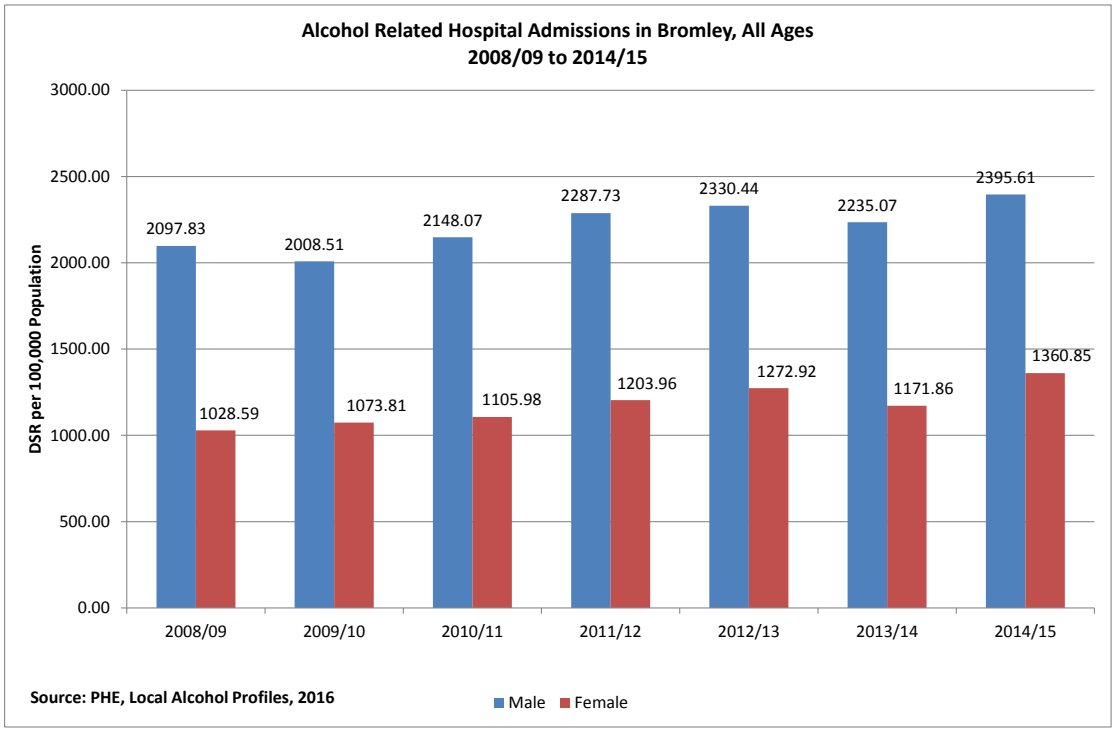
In 2014/15, there were an estimated 1,085,830 hospital admissions in England where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code (the broad measure).

Nationally, more males than females are admitted to hospital with alcohol-related conditions.

The hospital admission rate for males is almost twice the rate for females in Bromley. The rates are shown in Figure 8.

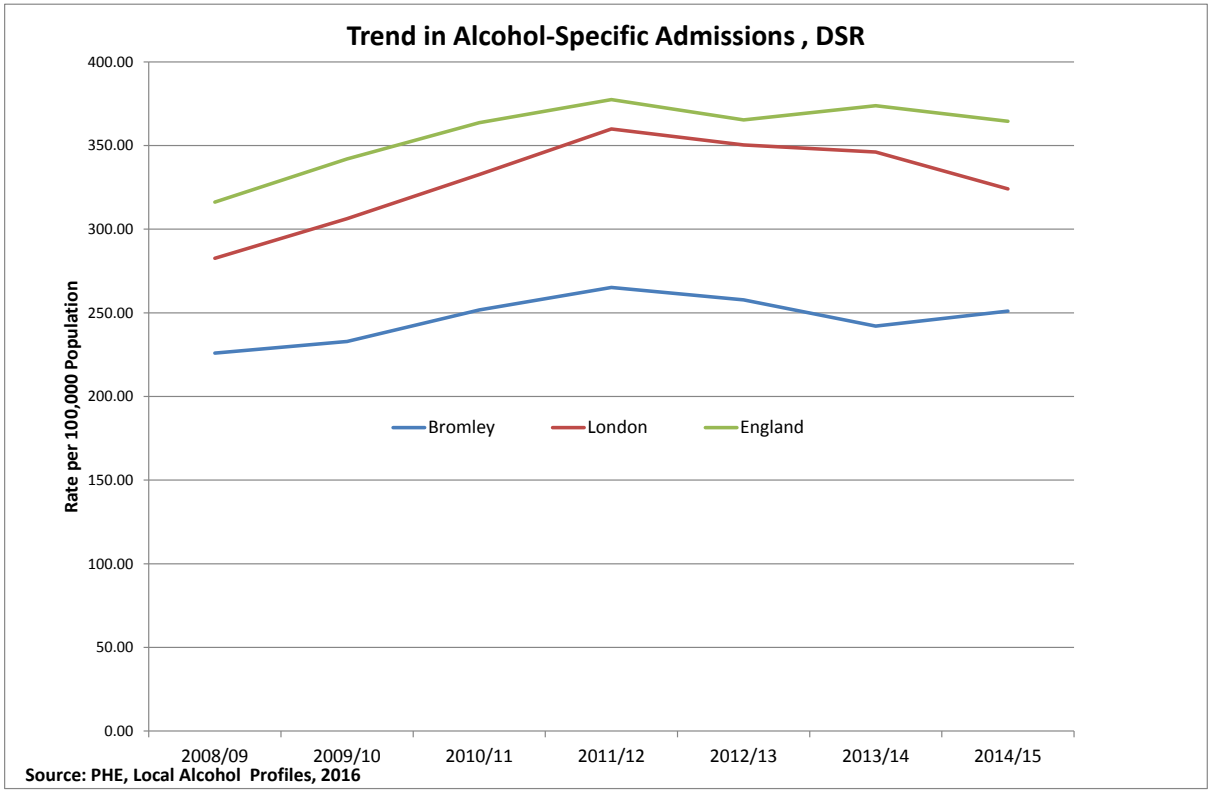
In 2014-15, nearly half of the alcohol-related hospital admissions nationally were for cardiovascular disease, and 19% were for mental and behavioural disorders due to alcohol.

Figure 6.8: Alcohol-related hospital admissions for men and women in Bromley 2008/09 - 2014/15



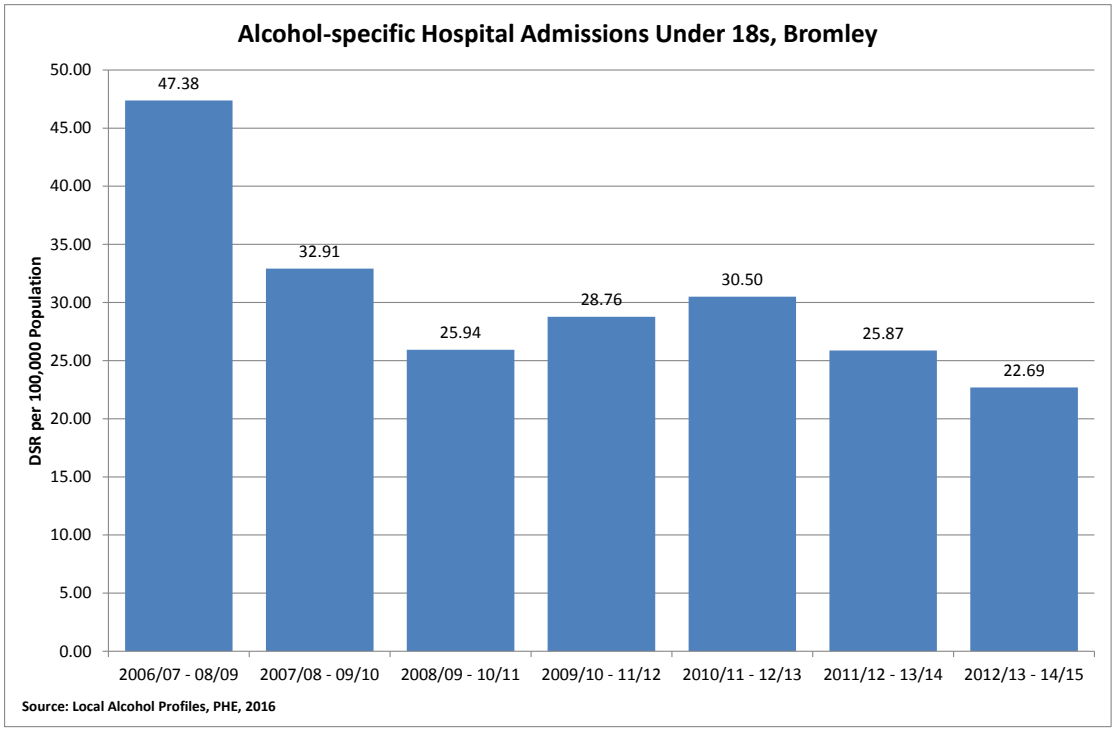
Alcohol-specific hospital admissions have been lower in Bromley than in London and England over the last seven years, but overall, there has been an increase in the rate of admissions over this period.

Figure 6.9 Trend in Alcohol Specific Admissions



The alcohol-specific admission rate for under 18 year olds in Bromley has been gradually decreasing over the last two years, and is comparable with the rate for London (23.73 per 100,000), but significantly lower than the rate for England (36.61 per 100,000 population).

Figure 6.10: Alcohol-specific hospital admissions for young people in Bromley 2006/07 to 2014/15



Socioeconomic Impact[1]

In addition to harm to the physical (e.g., liver disease) and/or mental health (e.g., episodes of depressive disorder) of the drinkers, alcohol consumption is often associated with socioeconomic consequences.

Alcohol is typically a valued commodity, which means that drinking usually uses resources which would otherwise be available for other purposes. Where earnings are low, heavy drinking may further impoverish the drinker, the drinker's family, or a whole community, thus increasing health or social harm.

Intoxication, dependence or alcohol withdrawal states can result in poor performance in major social roles – in functioning at work, in parenting, in relationship and friendship roles. Both the drinker and others may be affected by the consequences, such as job or productivity loss, break-up and dysfunction in family life, including domestic violence. This in turn can result in harm to physical or mental health.

The reputational drinking history of an individual, i.e., how the pattern of drinking is interpreted by others, is crucial in social judgements, both those made in the moment

and in the longer term. There is a clear tendency in many cultures to marginalize and socially exclude habitually intoxicated persons and their families, even more so than "dirty or unkempt" persons.

Marginalisation related to alcohol use can affect health status through diminished access to good health care. Studies on health services show that the care given is likely to be inferior, or the access to health care worsened, if the patient is seen as a run-down drinker or a similarly degraded status.

Harm to Other Individuals

In addition to harm to the drinker from their alcohol consumption, there are also harms to others by various means:

- **Injury** to other individuals can be intentional, e.g., assault or homicide, or unintentional, e.g., a traffic crash, workplace accident or scalding of a child.
- **Neglect or abuse** can affect, for example, a child, a partner or a person in the drinker's care.
- **Default on social role** can involve the drinker's role as a family member, as a friend and/or as a worker.
- **Property damage** can involve damage, for example, to clothing, a car or a building.
- **Toxic effects** on other individuals include most notably fetal alcohol syndrome (FAS) and preterm birth complications.
- **Loss of amenity or peace of mind** can influence family members (including children), friends, co-workers and strangers, who may, for example, be kept awake or frightened by the actions of the drinker.

Harm to Society at Large

The harmful use of alcohol results in a significant health, social and economic burden on society at large through:

- The increased burden of disease
- Social and economic costs

5.9% of all deaths and 5.1 % of the global burden of disease and injury in 2012, as measured in DALYs (Disability Adjusted Life Years), is attributable to alcohol. Beyond the population-level burden of diseases and injuries, it is important to note that harmful use of alcohol kills or disables people at a relatively young age, resulting in the loss of many years of life to death and disability.

There are three major categories of alcohol-attributable social and economic costs.

1. Direct economic costs of alcohol consumption. Direct costs encompass costs for multiple types of health-care services, such as hospitalisations, ambulatory care, nursing home care, prescription medicines or home health care. Direct

costs also include significant costs in the justice sector caused, for example, by damage to property from vehicle crashes and arrests for being “drunk and disorderly” as well as increased crime. Depending on the society, many of the direct costs are borne by governments.

2. Indirect costs. Indirect costs result, for example, from lost productivity due to absenteeism, unemployment, decreased output, reduced earnings potential and lost working years due to premature pension or death. These indirect costs are typically borne by society at large, because the alcohol-attributable loss in workforce productivity can affect the economic viability of an entire community.
3. Intangible costs. Intangible costs are the costs assigned to pain and suffering, and more generally to a diminished quality of life. Such intangible costs are borne by the drinkers, as well as their families and potentially by other individuals linked to the drinker.

Treatment and Management of Alcohol Misuse

The management of alcohol misuse at a population level falls into three categories:

- **Primary Prevention** which seeks to prevent the onset of disease. This takes place when the individual is still in good health, before there are any signs and symptoms of disease. It is chiefly concerned with maintaining a healthy lifestyle and avoiding adverse environmental influences. In this case primary prevention is concerned with preventing harmful alcohol use.

- **Secondary Prevention** aims to halt the progression of a disease once it is established. It takes place when the individual has developed early indicators of the development of disease. Lifestyle changes can still have a beneficial effect at this stage. In this case secondary prevention is concerned with identifying harmful alcohol use and harm reduction in individuals who are not yet alcohol dependent.

- **Tertiary Prevention** is concerned with the rehabilitation of people with an established disease to minimise residual disabilities and complications. In this case, tertiary prevention is concerned with managing individuals who are dependent on alcohol.

Management of the physical consequences of harmful alcohol use is not considered here, as this is in the NHS domain and management is not specifically related to alcohol.

Primary Prevention

Population approaches help reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol related harm.
Population approaches can help by creating an environment that supports lower risk drinking. Examples of population approaches include those that seek to control the availability of alcohol through pricing, licensing controls, and preventing under age sales.
International evidence suggests that making it less easy to buy alcohol, (by reducing the number of outlets selling it in a given area and the days and hours when it can be sold), is an effective way of reducing alcohol related harm. The research base also supports the use of local crime and related trauma data to map the extent of alcohol related problems before developing or reviewing a licensing policy. The Council is responsible under the Licensing Act 2003 for granting licences for the retail sale / supply of alcohol in the borough. If an area is saturated with licensed premises, and the evidence suggests that additional premises may affect the licensing objectives, the Council can adopt a cumulative impact policy which can be used to limit the number of new premises. The Council has identified two Cumulative Impact Areas (Bromley and Beckenham town centres), however the policy can only be considered where there are relevant representations made against an application. If no one objects to an application then the Council must grant it.

In addition, effective interventions on preventing under age sales, sales to people who are intoxicated or proxy sales (that is, illegal purchases for someone who is under-age or intoxicated) have been effective in reducing harm, in particular to young people. Ensuring that action is taken against premises that regularly sell alcohol to people who are under age, intoxicated or making illegal purchases for others is important in reducing harm. NICE and other studies support undertaking test purchases (using mystery shoppers) to ensure compliance with the law on under age sales.

Supporting people in understanding how much alcohol they are drinking is key to promoting sensible drinking as the social norm.

Primary prevention strategies include national programmes such as Change for Life, which highlight safe levels of alcohol consumption, the harms of drinking and suggest alternatives and tracking devices.
More locally, Bromley Changes (the Young Person's Substance Misuse Service) offers an annual session at each of Bromley's secondary schools for 13 to 15 year olds talking about safe levels of drinking, the journey of alcohol through the body, and the effects of alcohol.
For nine secondary schools, there is also a monthly drop in session, where pupils can ask for information about issues relating to alcohol.
During the week of 17th to 23rd November – Alcohol Awareness Week, assemblies are offered at schools for pupils aged 14 to 16 years.

The Licensing Act 2003 covers retail sales and the supply of alcohol, the provision of various forms of entertainment and the provision of late night refreshment.
There are four statutory objectives which must be addressed when any licensing functions are undertaken. The licensing objectives are:

- the prevention of crime and disorder
- public safety
- the prevention of public nuisance and
- the protection of children from harm.

There is currently no public health objective in the Act, but since April 2013, the Director of Public Health has been designated a Responsible Authority and as such is entitled to make representations to the licensing authority. Within Bromley's Statement of Licensing Policy, there is a section on Public Health. However, at present, the role of Public Health information in relation to licensing decisions in Bromley is unclear.

Table 6.5 Licenced Premises in Bromley

Year	Number of licenced premises	Number of licenced Clubs	No of 24hr licences
2009	815	90	4
2012	839	81	5
2013	731	81	5
2014	712	97	5
2016	774	77	10

Source: Bromley DCMS/Home Office Returns

In Bromley three alcohol exclusion zones have been established, in Beckenham Town Centre, Bromley Town Centre and in Penge. Within an alcohol exclusion zone it is an offence under the Criminal Justice and Police Act 2001 to consume alcohol in 'public' - any open space other than that which forms part of licensed premises. These zones have been established primarily to reduce problems relating to alcohol crime and disorder, but also serve a primary prevention function.
The police collect information about violent crime/drunkenness incidents related to the night-time economy (between 8 pm and 5 am) on Beckenham and Bromley High Streets and on East Street in Bromley.
There is quite a lot of variation in the incident figures from month to month (Figures 11 to 13) because of the small numbers involved, however, these stay largely within the control limits (set at +/- 2 standard deviations).

Figure 6.11

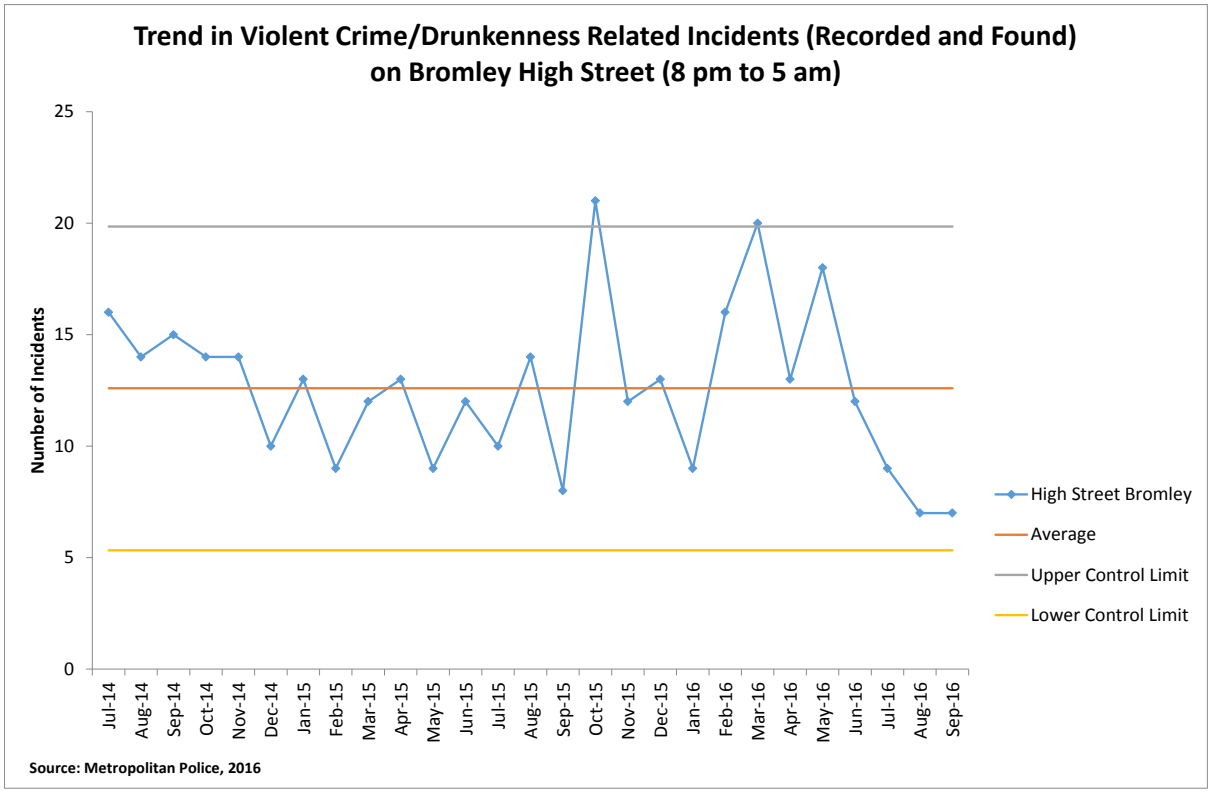


Figure 6.12

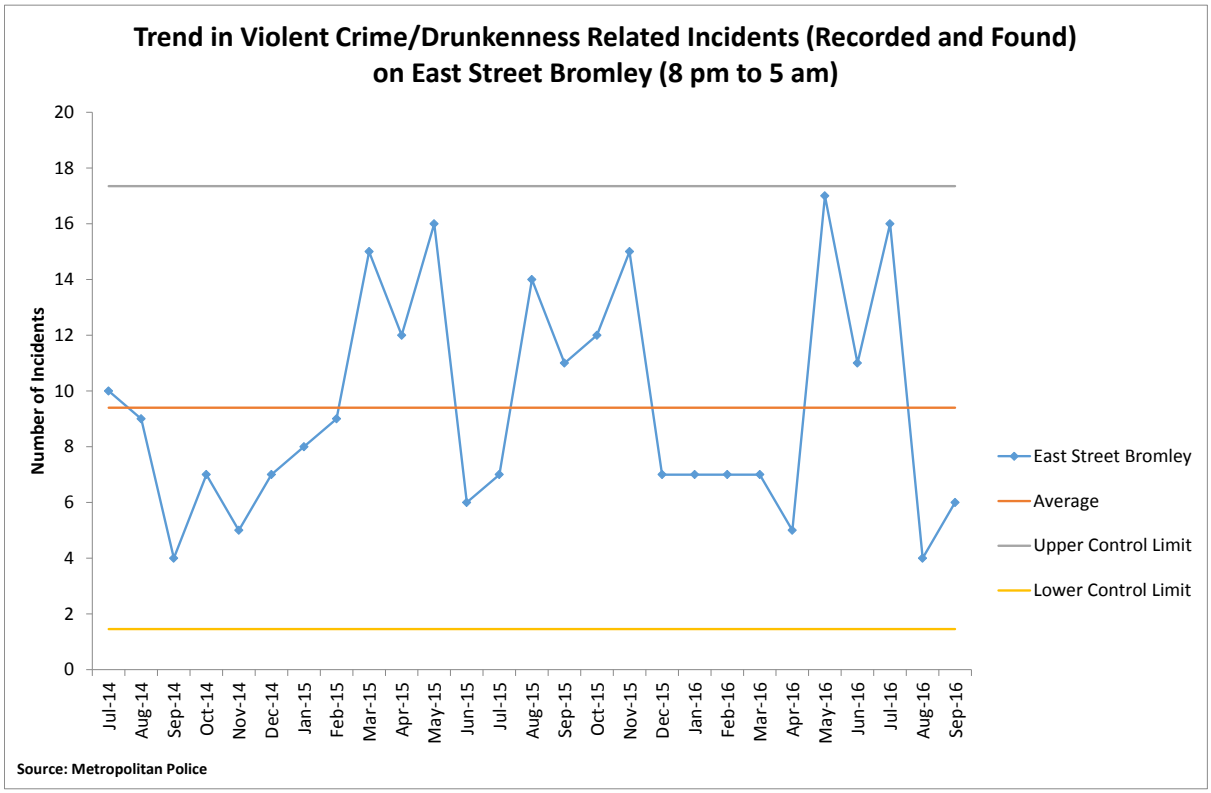
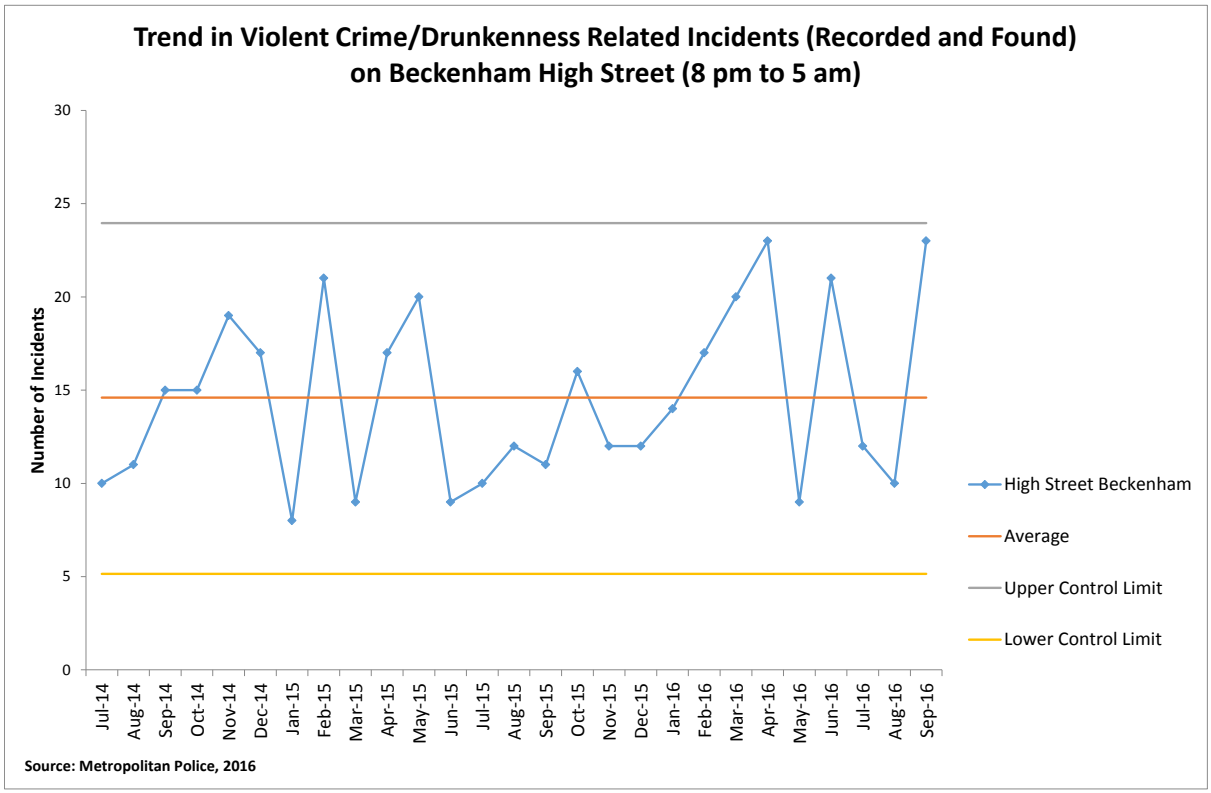


Figure 6.13



Trading Standards have a role to play in the primary prevention of alcohol misuse by enforcing the law and restricting alcohol sales.
It is against the law:

- To sell alcohol to someone under 18 anywhere.
- For an adult to buy or attempt to buy alcohol on behalf of someone under 18.
- For someone under 18 to buy alcohol, attempt to buy alcohol or to be sold alcohol.

Trading Standards carry out test purchases using under age volunteers, often police cadets. Premises targeted are those where we have received an allegation of under age sales, or as a result of visits by officers who have carried out a risk assessment of the management of the business. In some cases, a previous visit with an 18 year old volunteer would have been conducted to test whether or not the business was complying with voluntary age verification systems, for example Challenge 25, where we would expect the business to ask for proof of age.
Compliance levels for alcohol test purchasing are as follows:

In 2015-16 the % of premises who refused the sale was 85%. This compares to previous years where the compliance level was 88% in 2014-15, 70% in 2013-14 and 77% in 2012-13.

Secondary Prevention

Secondary prevention includes screening of individuals to detect whether their consumption of alcohol is at a harmful level, and giving brief advice.
This takes place in Primary Care as part of the NHS Health Checks for people aged between 40 and 74 years, and also at the Princess Royal University Hospital (PRUH) as part of the Health Promoting Hospital Local Incentive Scheme commissioned by the CCG.
All patients admitted to participating wards at the PRUH should be screened using the FAST Questionnaire (https://www.alcohollearningcentre.org.uk/Topics/Latest/Fast-Alcohol-Screening-Test-FAST/) offered a brief intervention and referral to the Bromley Drug and Alcohol Service as appropriate. This scheme (part of the Health Promoting Hospital Incentive Scheme commissioned by the CCG) started in 2014-15 and each year more wards are enrolled onto the scheme, and currently 10 wards are participating.

Table 6.6 Alcohol Screening Results at the PRUH

Time Period	No. of Admissions	Screened	FAST Score >3	Brief Advice
Q1 2015-16	2736	82.7%	4.7%	99.1%
Q2 2015-16	3713	81.1%	4.9%	99.3%
Q3 2015-16	3923	86.2%	6.3%	90.6%
Q4 2015-16	3909	85.8%	5.0%	78.7%
Q1 2016-17	3986	90.5%	5.5%	76.0%
Q2 2016-17	3780	84.0%	6.3%	37.7%

The level of screening is high, but there are a lower than expected proportion of FAST scores above 3 (compared to alcohol consumption levels in the general population). Work is ongoing to support this initiative, as performance is affected by staff turnover. From 2018-19, alcohol screening in hospitals will be part of a National CQUIN.

Harm reduction interventions by the Specialist Substance Misuse Service for both adults and young people are considered in the section on tertiary prevention.

Tertiary Prevention

Tertiary prevention is the management of individuals who are dependent on alcohol. This management is delivered by the specialist substance misuse provider.
Included in this section is information on harm reduction for non-dependent drinkers, as this is also delivered by the specialist service.

The main aim of treatment is to move a client from a position of problematic drugs and/or alcohol misuse, with possible poor physical health status, chaotic lifestyle and criminality to a position of stability, improved health and well-being, employment and positive engagement with the community.
This may be achieved through:

- harm reduction – reducing the alcohol consumption to achieve “controlled drinking” i.e. reducing alcohol consumption to a moderate level.
- Abstinence oriented treatments using a range of interventions including community or inpatient detoxification, medication, psychosocial interventions and residential rehabilitation.

Treatments are more effective if given in combination. However, it should be understood that dependency is a chronic illness for which there is no cure. Abstinence is a lifelong battle.

Treatment in Bromley

Bromley Drug and Alcohol Service provides services at different levels based on the level of dependency determined at initial assessment, as shown in the Alcohol Model Pathway diagram.

Beyond brief intervention, each level includes:

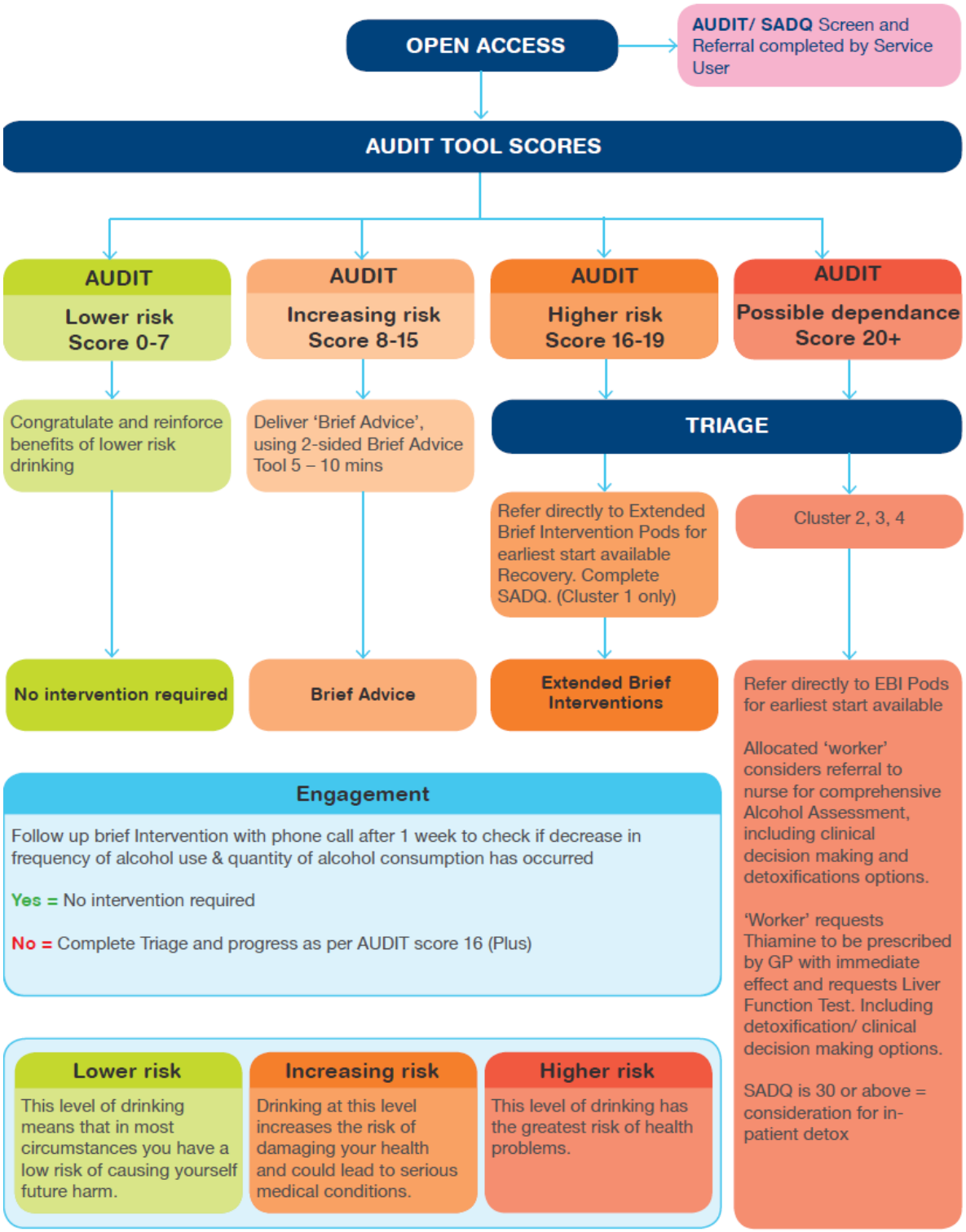
- Assessment/Engagement
- Extended Brief Intervention Pods (groups)
- Care Planning/Care Co-ordination and case management
- Withdrawal management
- Psychosocial interventions
- Pharmacotherapy
- Aftercare/Reintegration/Recovery

The length of treatment is determined by the level of dependency:

- Harmful/Mild Dependence 12 weeks
- Moderate Dependence 24 weeks
- Severe Dependence (without complex needs) approx. 12 months
- Moderate/Severe Dependence (with complex needs) at least 12 months

In addition, for complex patients who require it, there is spot purchasing from specialist providers for inpatient detoxification (for patients for whom there are medical risks) and for residential rehabilitation (where there is a need for complete separation from established patterns of behaviour and social networks).

CGL Alcohol Model Pathway

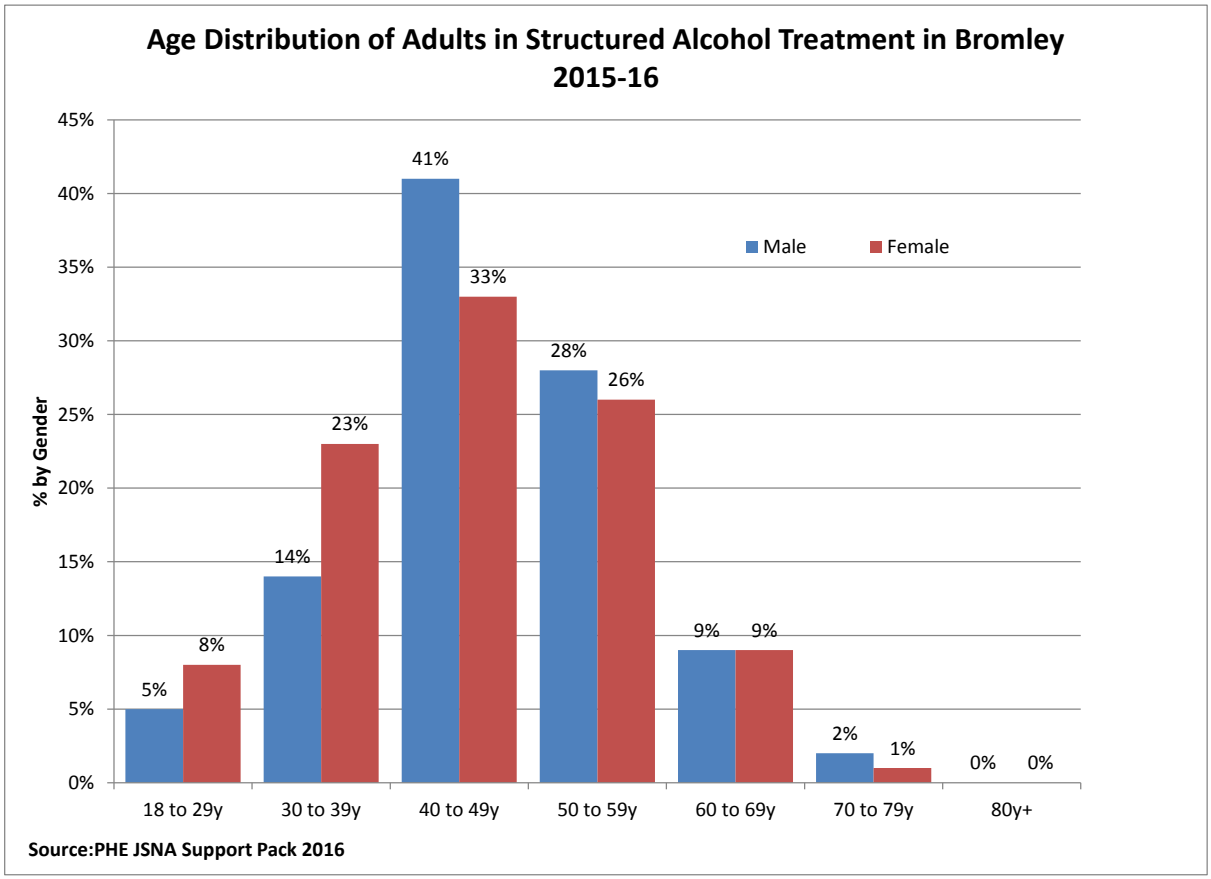


Adults Attending Structured Alcohol Treatment Services in Bromley

Evidence shows that, when individuals are engaged in treatment, they consume less alcohol, improve their health, manage their lives better and cause less harm to themselves, those close to them and to the wider community.

During 2015-16, 238 adults were engaged in structured alcohol treatment services in Bromley, of these 58% were men and 42% women.

Figure 6.14 Age of Individuals Receiving Alcohol Treatment



The average age of adults in alcohol treatment is 45 years, and the age distribution for both genders is very similar, although more females than males under the age of 40 years present for alcohol treatment.

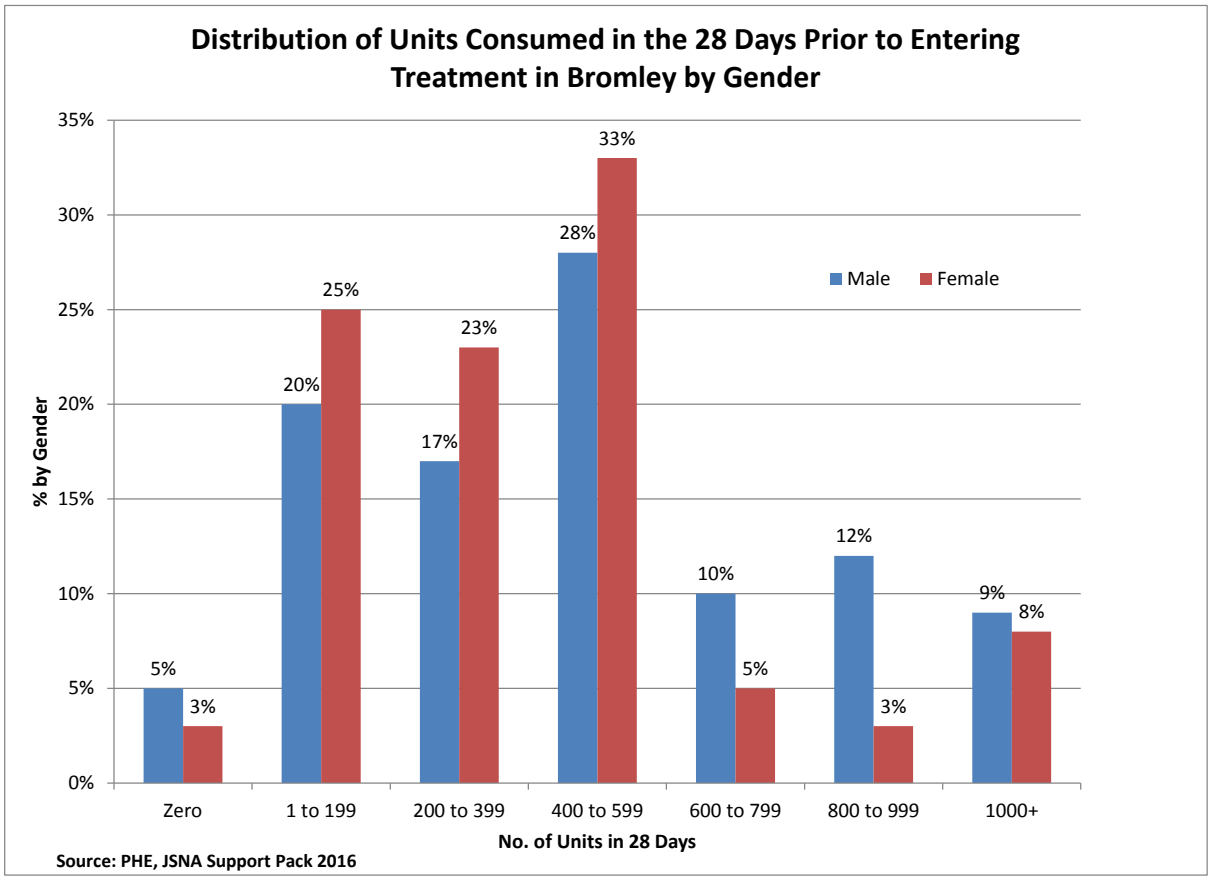
Of the 158 new presentations to treatment in Bromley in 2015-16, 5% were pregnant, as compared with 1% nationally.

The new presentation cohort also included 16% who were currently receiving care from mental health services for reasons other than substance misuse, this is lower than the national figure of 20%.

Most people who require structured treatment for alcohol dependence will be drinking at higher risk levels. There is no direct correlation between regular consumption levels and dependence, but the levels of alcohol consumed by individuals in the 28 days prior to entering treatment may give some indication of the severity of dependency and potential harm among the treatment population.

Although the majority of adults cite using alcohol in the month prior to treatment, 7% nationally (and 5% locally) cite no alcohol use. This may be because they have been referred to treatment directly from the criminal justice system or they may be in treatment to maintain abstinence and prevent relapse.

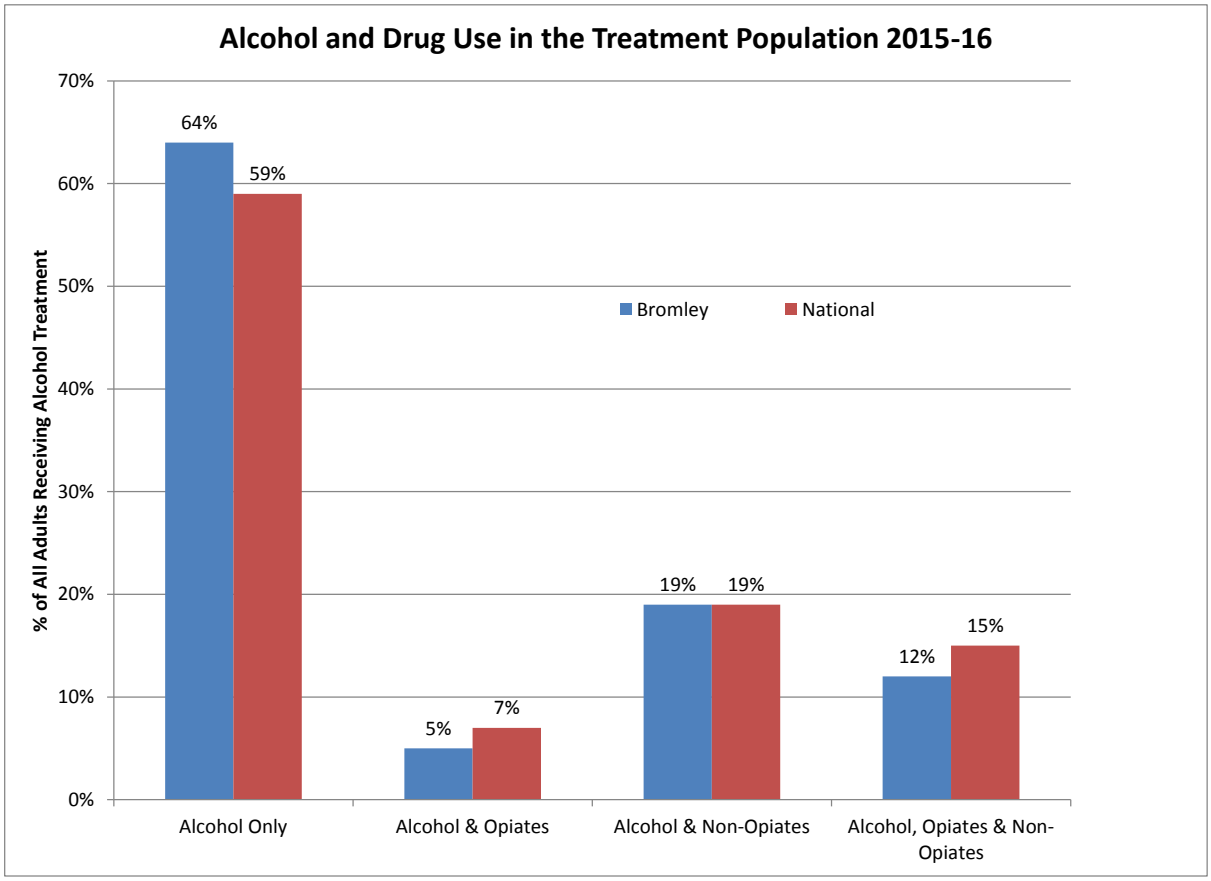
Figure 6.15 Alcohol Consumption Levels Prior to Treatment



In the chart above, it can be seen that a greater proportion of men than women were consuming above 600 units in the 28 day period, however, it should be remembered that women suffer harm at lower alcohol consumption levels than men.

In addition to the 238 adults in structured treatment for alcohol only, there were additionally 132 adults who were in treatment for alcohol and drug use.
The proportion of adults in alcohol treatment also using opiates is lower for Bromley than nationally. The most commonly cited additional drugs were crack (12%), cocaine (15%) and cannabis (11%).

Figure 6.16 Additional Substance Use

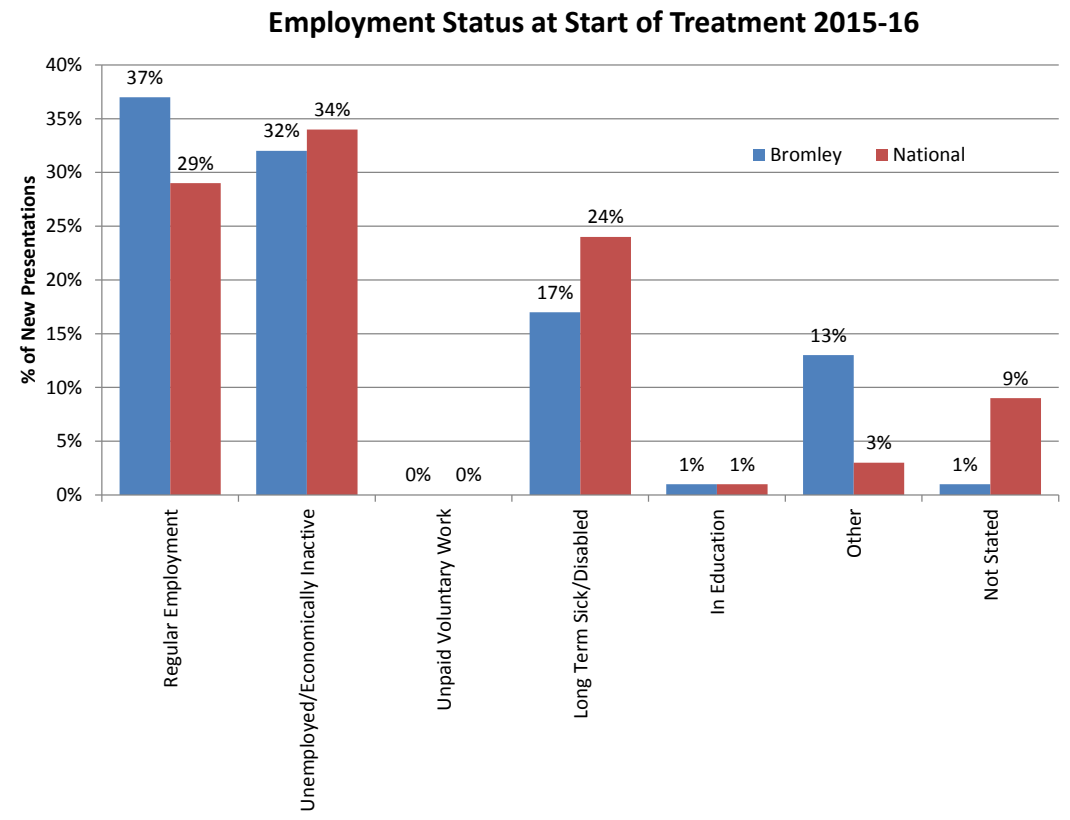


Recovery from alcohol dependence relies to some extent on the social, physical and financial assets of the individual; so called recovery capital.

Improving job outcomes is key to sustaining recovery. In Bromley, many of those requiring structured treatment for alcohol misuse are in regular employment, 37%, as compared with 29% nationally.

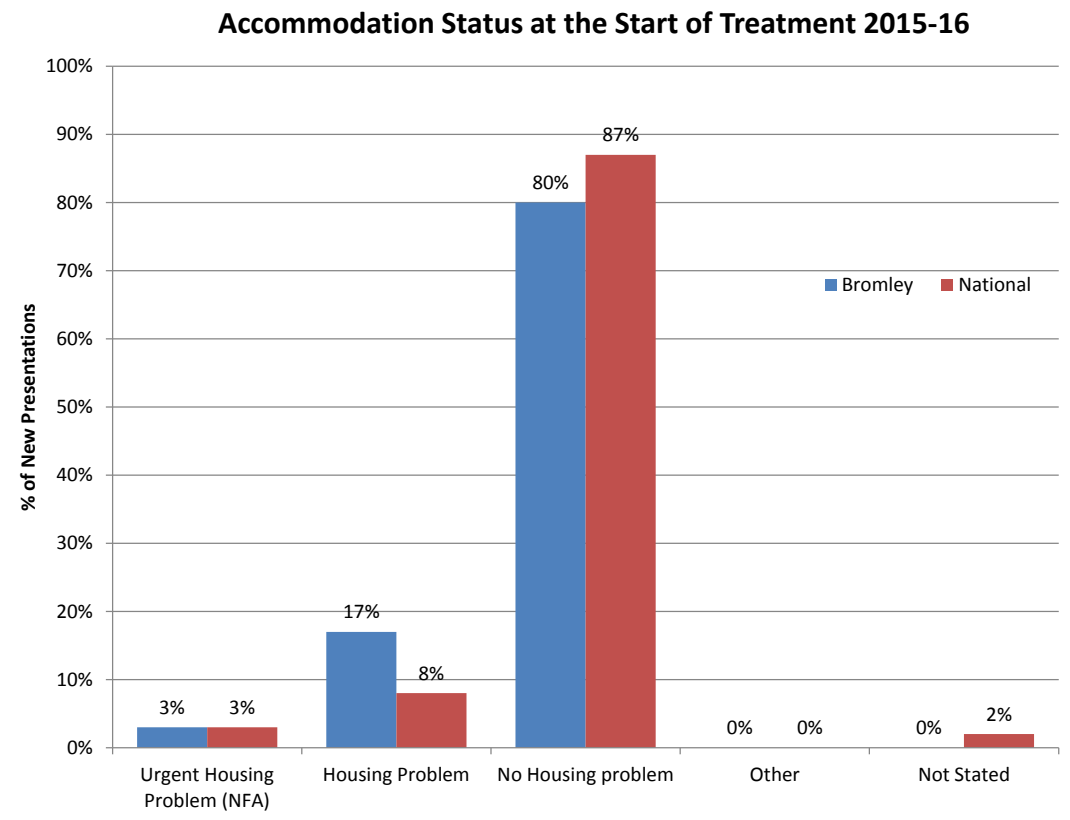
A safe, stable home environment also enables people to sustain their recovery. In Bromley, a much higher proportion of adults starting treatment (20%) report a housing problem compared with nationally (11%), although the proportion with an urgent housing problem is the same as the national figure.

Figure 6.17: Employment Status



Source: PHE, JSNA Support Pack, 2016

Figure 6.18: Housing Status



Source: PHE, JSNA Support Pack 2016

Adults in Non-Structured Treatment

The alcohol treatment service provides support not only for those who are dependent on alcohol, but also for individuals who have harmful levels of drinking and need support to reduce their alcohol consumption (i.e. harm reduction).

Those whose level of drinking places them at higher risk are offered an extended brief intervention over a course of twelve weeks.

Between July 2015 and June 2016, there were 74 individuals drinking at higher risk levels who received support from the service.

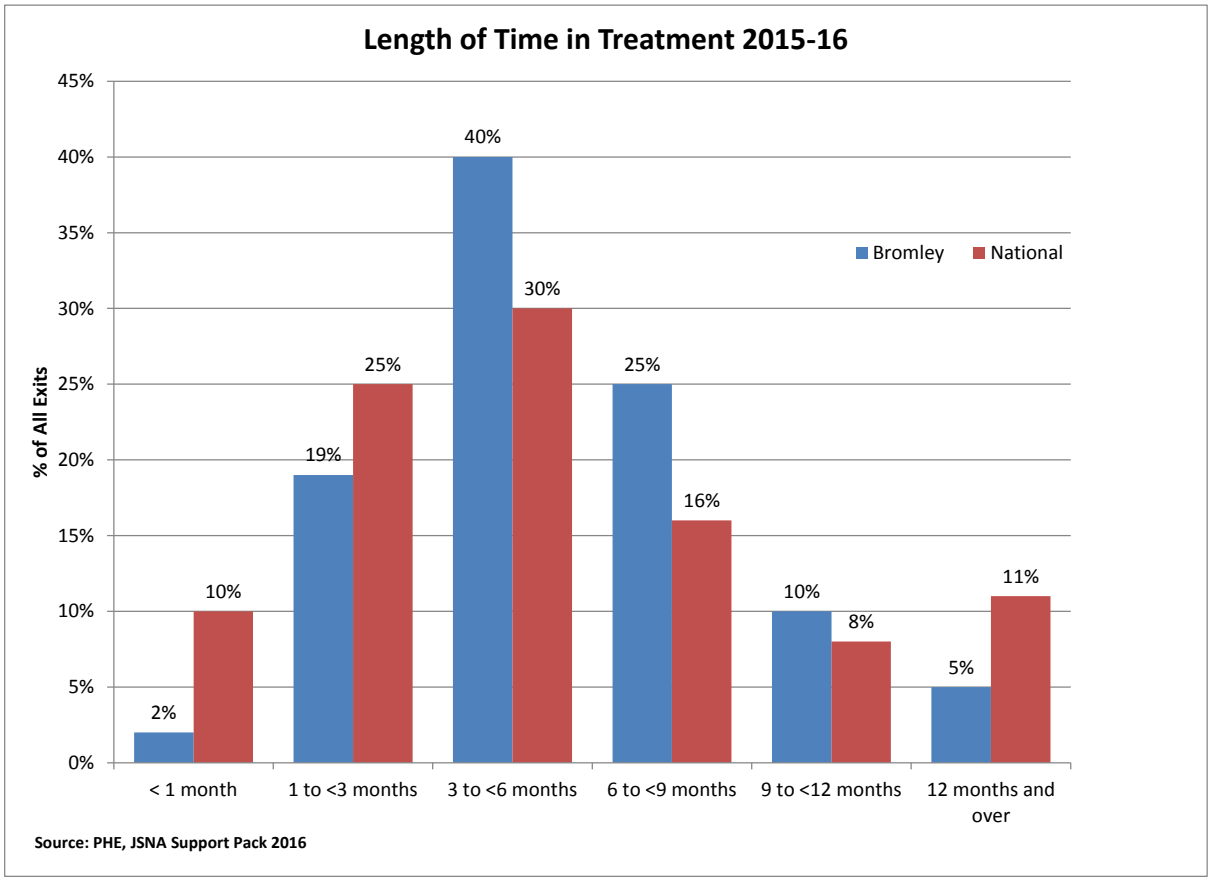
Of these 64.9% were male and two thirds were between 35 and 54 years of age.
Many of this group have stable backgrounds, i.e. stable housing (75.7%), a stable employment situation (44.6%), and no identified safeguarding issues (51.4%).
Referrals are mainly from the GP (37.8%) or self-referrals (31.1%).

Treatment Outcomes in Adults

NICE Guidelines suggest that harmful drinkers and those with mild alcohol dependence might benefit from a package of care lasting three months, while those with moderate dependence might need a six month package and those with severe dependence or those with complex needs may need a package of care lasting up to a year.
The length of a typical treatment period is around six months, although nationally 11% of clients remained in treatment for at least a year. Retaining individuals for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of individuals in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.

In Bromley, a higher proportion of individuals than nationally are retained in treatment for over three months, and a lower proportion are retained beyond 12 months.

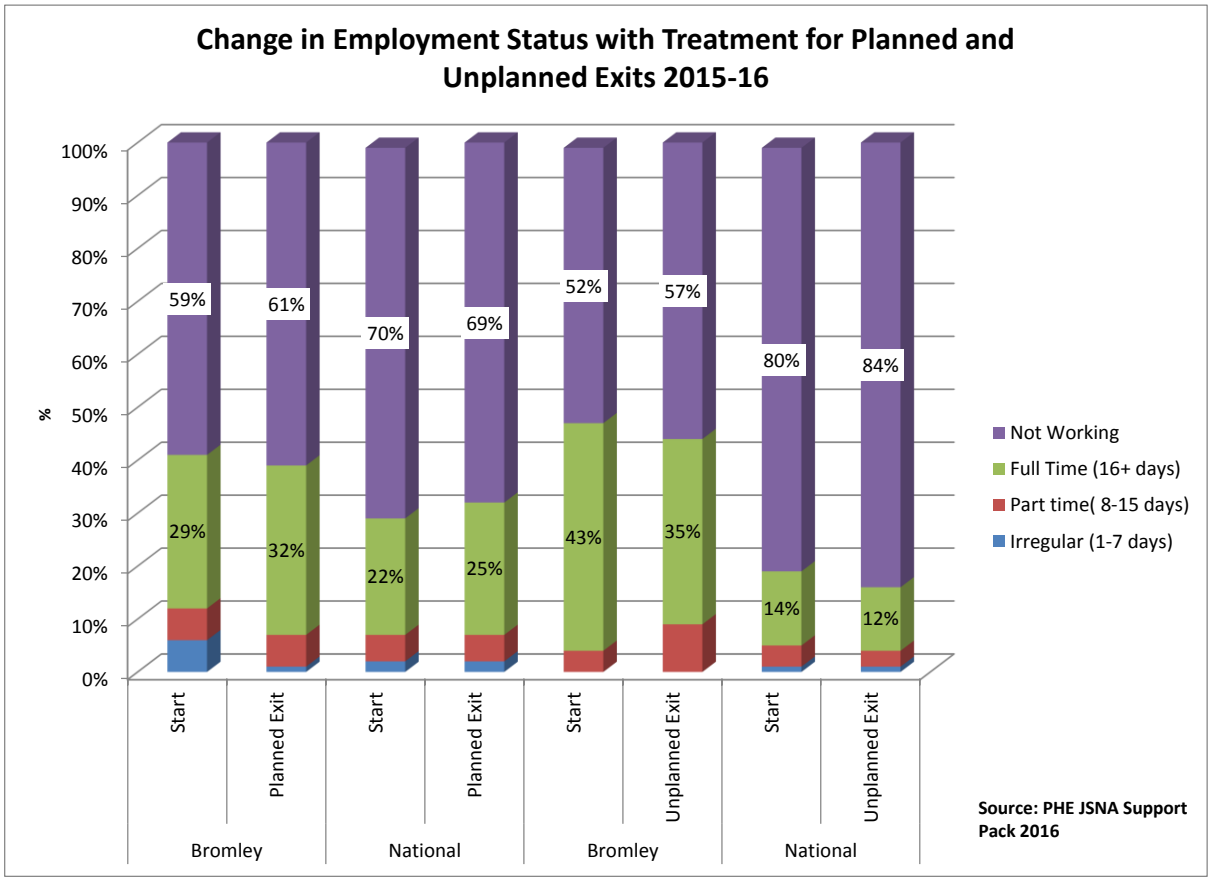
Figure 6.19 Length of Time in Treatment



The key measure of successful treatment is the proportion of people who successfully completed treatment and did not return within six months.
In the calendar year 2015, 28% of individuals left alcohol treatment successfully and did not return within 6 months as compared with 38% nationally.

For those still in treatment, there are a number of indicators at six month review which are predictors of continued recovery. These are rates of abstinence from alcohol, and changes in average days use, secure housing at planned exit and employment status at planned and unplanned exit.
In 2015-16, 65% of individuals reported abstinence at planned exit, as compared with 48% nationally.
There was a reduction in average drinking days from 21.7 days to 11.7 days in Bromley, compared with from 20.6 days to 12.4 days nationally.
A lower proportion of individuals (78%) no longer reported a housing need in Bromley than nationally (84%).
Although there was an improvement in the proportion of individuals working fulltime at planned treatment exit as compared with at start of treatment, there was also an increase in the percentage not working at all in Bromley. For unplanned exits, the employment status worsened between start and exit both in Bromley and nationally.

Figure 6.20: Change in Employment Status



Young People

Young people are more prone to harmful health effects from alcohol use, and misuse of alcohol can have a major impact on their education, and their long-term chances in life.

Official data for the year 2015-16 relating to alcohol and substance misuse treatment in young people is not yet available, although the numbers appear to be much lower than would be expected.

Of the 35 young people aged between 13 and 17 years treated in the Young People's Substance Misuse Service during 2015-16, 23 (65.7%) reported alcohol use in combination with other substances (34 of the 35 reported cannabis use).

Strategic Review

Bromley has been identified by Public Health England as a priority partnership which would benefit from support to address alcohol harm.

It was agreed at a meeting with the Head of the London Alcohol and Drugs Team that Bromley would complete Public Health England's Alcohol CLeaR Assessment Tool.

CLeaR is an evidence-based improvement model which stimulates discussion among partners about local opportunities for improving outcomes through effective

collaborative working. It allows partnerships to **C**hallenge services, provide **Lea**dership and examine **R**esults (CLeaR).
The areas to be considered are summarised in Table 7.

Table 6.7 CLeaR Domains

	Domain	Content of Sub-sections
1	Setting the Context	Defining local priorities
2.	Leadership	Vision and governance
		Planning and commissioning
		Partnership
3.	Challenge services	Communications and social marketing
		Primary prevention (reducing availability)
		Secondary prevention (targeting those at risk)
		Tertiary prevention (treatment provision)
4.	Results	Nationally reported data
		Locally collected intelligence
		Progress against local alcohol objectives

The CLeaR tool was launched on 16th September; therefore this strategic review is just starting. It will involve discussions with all the partners involved in the prevention and management of alcohol misuse: community safety partnership representatives, licensing, trading standards, planning, housing, the clinical commissioning group, the substance misuse treatment provider, an elected member with responsibility for the alcohol, licensing, and/or community safety portfolios, representatives from primary care and the Kings College Hospital NHS Foundation trust and Oxleas NHS Foundation trust. The process will include a wider consultation with adult and children's social care, Jobcentre Plus, third sector agencies working with vulnerable groups, housing providers, schools and colleges and service users.

What this means for residents and children in Bromley

Estimates suggest that the level of drinking in people in Bromley is similar to that for London and England, with 17% of people in the increasing and high risk categories. Local GP data suggests that 21% of men and 6% of women drink above the recommended levels of alcohol each week and this is most prevalent in those aged between 40 and 69 years.

In 2014 there were 121 alcohol-related deaths in Bromley. The mortality rate from alcohol-related causes in Bromley appears to be on a rising trend for women whilst remaining level for men in the period between 2009 and 2013. The alcohol-related mortality rate for men in Bromley is approximately twice that for women.

The rate of alcohol-related hospital admissions has been increasing at national, regional and local levels, but remains lower in Bromley than for London and England.

The hospital admission rate for males (2,396 per 100,000 population) is almost twice the rate for females (1,361 per 100,000 population) in Bromley.
The alcohol-specific admission rate for under 18 year olds in Bromley (22.7 per 100,000 population) has been gradually decreasing over the last two years, and is comparable with the rate for London, but significantly lower than the rate for England.

Availability of alcohol in Bromley is controlled through the Licensing Act 2003 and the Councils Licensing Policy, however this is only relevant where objections to an application are made. If no objections are made the Council must grant the licence. Trading Standards work to ensure that alcohol is not sold or available to under 18 year olds. There is also a programme of education on alcohol for 13 to 15 year olds.

Screening and advice on alcohol use are delivered in both primary care (for new patients and at NHS Health Checks) and secondary care (PRUH).

During 2015-16, there were 238 adults engaged in structured alcohol treatment services in Bromley, of these 58% were men and 42% women.
The average age of adults in alcohol treatment is 45 years, and the age distribution for both genders is very similar.
Of the 158 new presentations to treatment in Bromley in 2015-16, 5% were pregnant, as compared with 1% nationally.
The new presentation cohort also included 16% who were currently receiving care from mental health services for reasons other than substance misuse.
In addition to the 238 adults in structured treatment for alcohol only, there were additionally 132 adults who were in treatment for alcohol and drug use.

In Bromley, many of those requiring structured treatment for alcohol misuse are in regular employment, 37%, as compared with 29% nationally.
In Bromley, a much higher proportion of adults starting treatment (20%) report a housing problem compared with nationally (11%), although the proportion with an urgent housing problem is the same as the national figure.

Bromley had a lower proportion of successful treatment completers in 2015 than the national value. 28% of individuals left alcohol treatment successfully and did not return within 6 months as compared with 38% nationally.

Fewer than expected young people have accessed the Young person's Substance Misuse Service in the last year. Of those who access the service, the majority are cannabis users, with 66% additionally using alcohol.

A strategic review of alcohol services is currently underway. Prevention, early identification and intervention will be the focus, particularly in the highest risk group

(aged 40 to 69 years). There will also be an emphasis on strengthening the referral pathways.

Updates on Populations of Interest

7. Children and Young People

This section focuses on the needs of particular groups of the Borough's children and young people:

- An Overview of the Health of Children in Bromley
- Children's Safeguarding and Social Care
- Educational attainment

7.1. Overview of Child Health in Bromley

Table 7.1 presents a summary of almost all available child health data which is available at borough, region (London) and national level. Alongside the health indicators for Bromley, England and London is presented the data from other London boroughs which are similar to Bromley in health terms. The information is presented using Public Health England RAG ratings as well as the value of each indicator and a definition of each indicator.

Those indicators marked green are where the indicator is better than the national rate. 28 of the 45 indicators in Bromley are green. Even when compared to the boroughs with similar health profiles (Bexley, Havering and Sutton), Bromley children and young people are rated higher in many health indicators.

Only 2 indicators for Bromley are rated "red": One of these was rated "red" last year: family homelessness. This indicator is red for almost every London borough. The other "red" indicator which was also red last year is "Hospital admissions due to substance misuse: Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse". This is being addressed locally.

Some of the indicators have improved. The rate of conceptions in girls aged under 16 is now lower than both the London and national rates and rated green, and the child mortality rate is now just below the national and London rate.

Although the rate of childhood obesity in children aged 4-5 years is one of lowest rates in London, the rate of overweight children at this age is 19.9% (down from 21.3% last year) and is still rated amber.

Table 7.1

Indicator	Period	England	London	Bromley	Bexley	Havering
1. Healthy Life Expectancy at birth (Male)	2012-14	63.4	64.0	67.9	65.9	64.0
2. Healthy Life Expectancy at birth (Female)	2012-14	64.0	64.1	66.2	6.1	65.8
3. Life Expectancy at birth (Male)	2012-14	79.5	80.3	81.4	80.4	80.2
4. Life Expectancy at birth (Female)	2012-14	83.2	84.2	84.9	84.4	83.9
5. Children in poverty (under 16s)	2014	19.2	23.7	16.2	18.4	18.4
6. School Readiness: The percentage of children achieving a good level of development at the end of reception	2014/15	66.3	68.1	73.7	76.2	68.5
7. School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2014/15	51.2	58.6	52.8	65.2	52.7
8. Obese children (4-5 years)	2014/15	9.1	10.1	7.9	10.4	9.5
9. Obese children (10-11 years)	2014/15	19.1	22.6	16.5	22.1	20.5
10. Excess weight in 4-5 year olds	2014/15	21.9	22.2	19.9	25.6	23.7
11. Excess weight in 10-11 year olds	2014/15	33.2	37.2	31.1	36.9	35.9
12. Pupil absence	2014/15	4.62	4.48	4.28	4.17	4.90
13. Family homelessness	2014/15	1.8	3.9	2.6	4.2	1.7
14. First time entrants to the Youth Justice System	2014	409	426	317	300	235
15. 16-18 year olds not in education employment or training	2015	4.2	3.1	3.4	2.7	3.4

Indicator	Period	England	London	Bromley	Bexley	Havering
16. Low birth weight of term babies	2014	2.9	3.2	2.6	2.9	2.5
17. Low birth weight all babies	2013	7.4	7.9	7.1	6.4	7.0
18. Children in out of work households (%)	2014/15	16.0	16.4	16.6		
19. Children aged 11-15 in low income families (%)	2012			12.9		
20. Smoking status at time of delivery	2014/15	11.4	4.8	4.7	7.9	10.4
21. Under 18 conceptions	2014	22.8	21.5	16.7	19.5	22.8
22. Conceptions in those aged under 16	2014	4.4	3.9	2.4	4.6	6.1
23. Teenage mothers	2014/15	0.9	0.5	0.6	0.5	0.8
24. New Sexually Transmitted Diseases including Chlamydia	2013	3433	4039	3075	2697	3228
25. A&E attendances	2014/15	540.5	681.9	468.1	511.8	653.4
27. Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2014/15	109.6	83.3	63.7	88.2	89.2
28. Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2014/15	131.7	98.6	107.3	92.5	82.4
29. Children killed or seriously injured in road traffic accidents	2012-14	17.9	12.2	11.2	9.6	16.7
30. Children in care	2015	60	52	37	50	45

Indicator	Period	England	London	Bromley	Bexley	Havering
32. Children in care with up to date immunisations	2015	87.8	85.3	94.1	93.9	87.5
33. Infant mortality	2012-14	4.0	3.6	1.6	2.8	3.2
34. Child mortality rate	2012-14	12.0	12.0	11.9	10.0	8.0
35. Tooth decay in children aged 5	2011/12	0.94	1.23	0.52	*	0.54
36. Children with 1 or more decayed, missing, filled teeth	2011/12	27.9	32.9	21.5	*	19.8
37. Hospital admissions due to alcohol specific conditions	2012/13 - 2014/15	40.1	26.6	25.9	15.9	20.7
38. Hospital admissions due to substance misuse	2012/13 - 2014/15	88.8	70.3	168.1	123.1	73.8
39. Hospital admissions for asthma (<19 years)	2014/15	216.1	211.2	133.1	177.1	138.3
40. Hospital admissions for mental health conditions	2014/15	87.4	94.2	102.1	109.8	54.5
41. Hospital admissions as a result of self harm	2014/15	398.8	203.8	267.5	180.7	161.3
42. Emotional wellbeing LAC (Av difficulties score)	2014/15	13.9	13.2	14.1	15.4	15.2
43. Smoking prevalence age 15 (WAY survey) – current smokers	2014/15	8.2	6.1	9.9	9	5.8
44. Smoking prevalence age 15 (WAY survey) – regular smokers	2014/15	5.5	3.4	6.6	4.9	3.5
45. Smoking prevalence age 15 (WAY survey) – occasional smokers	2014/15	2.7	2.7	3.3	4.1	2.2

Source: PHOF, 2015 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. 42-45

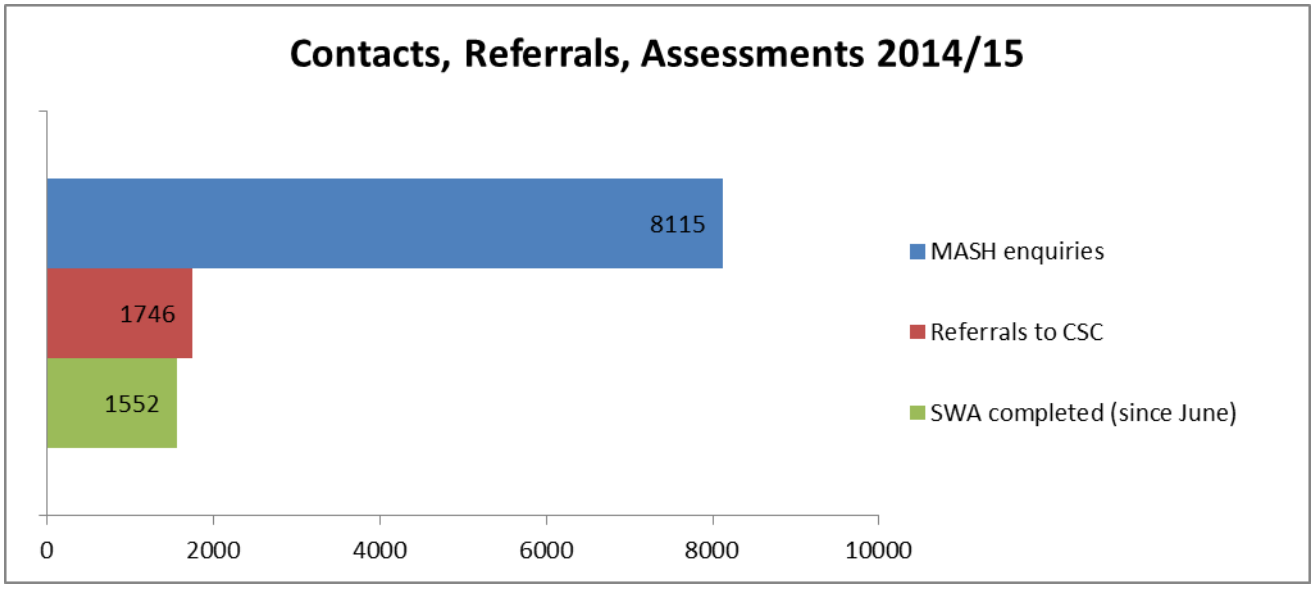
7.2 Children's Social Care

Referral and Assessment

Children's Social Care services have a duty to safeguard and promote the welfare of children. Last year over 10,000 initial contacts were made to Children's Social Care services. Over 8,000 of these contacts were processed by the Multi Agency Safeguarding Hub (MASH) where contact information is triaged by colleagues from social care, health, the police, education, early help and an independent domestic abuse advisor. 29% of contacts to the MASH progressed to Children's Social Care.

Since June 2014, initial and core assessments have ceased to exist and following a referral, children are assessed under a single continuous assessment known locally in Bromley as a Social Work Assessment (SWA). This change has been made nationally following the recommendations of Munro. This assessment should be completed within 45 days and in Bromley assessments are reviewed by a manager after 10 days. In 2014/15 84% of SWA's were completed within 45 days, just above the national average of 82%.

Figure 7.2.1

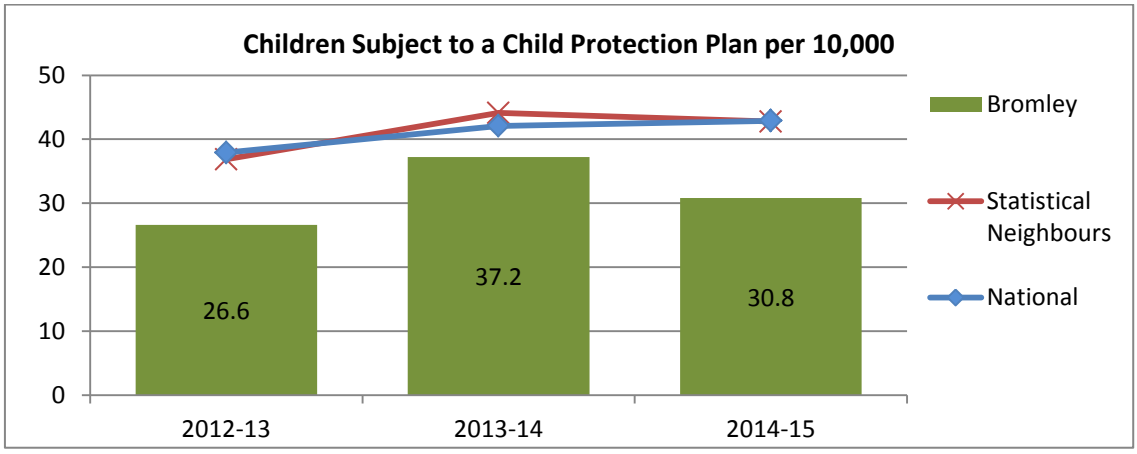


Source: London Borough of Bromley

Children Subject to a Child Protection Plan

In 2014/15 there were 220 children subject to a child protection plan which is 30.8 per 10,000 population. This is significantly lower than our comparators and the national average at 43.

Figure 7.2.2



Source: London Borough of Bromley

The largest category of abuse to children subject to a child protection plan is Neglect, closely followed by Emotional abuse. 30% of children subject to a child protection plan were from black and minority ethnic groups.

The following have been identified as areas of possible need, however there is not currently enough evidence to include any detail here. These will be developed and feature as part of the 2016/17 JSNA report if need is identified:

- Children known to early help services and children's social care as a result of parental domestic abuse, mental health and substance misuse
- Children in Need
- Child Sexual Exploitation and missing Children Looked After
- Violence Against Women and Girls
- Young people's homelessness
- Health needs of children, including specifically children at risk from missing, CSE, trafficking and gangs

What this means for Bromley residents and for children in Bromley

Initial contacts are being processed by the MASH to ensure appropriate referrals are reaching Children's Social Care. Social Work Assessments are being completed in a timely way. The proportion of Bromley children subject to a child protection plan in low compared to other boroughs.

Children Looked After

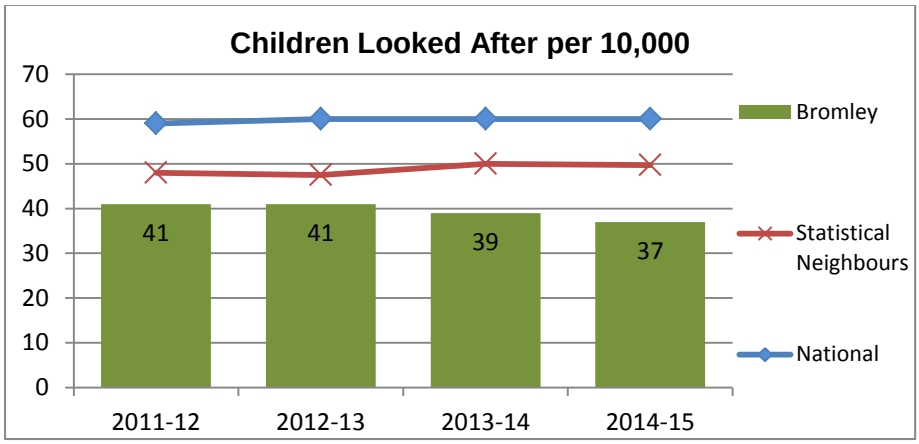
Children Looked After are some of the most vulnerable children in society; living away from their families because their parents faced difficulties and pressure in providing for their care or because the children have suffered abuse or neglect whilst in the care of their families.

Children Looked After are provided with care and accommodation which meet their needs. Most often this will be with foster carers but young people may also be placed in residential schools, care homes, or units. Most children spend a short time in the care of the council either returning to their families or moving to permanent arrangements such as adoption, but for others their stay may be for several years lasting to adulthood.

General Profile of Children Looked After (CLA) in Bromley

- The number of Children Looked After as at the end of each financial year has remained relatively stable, ranging between 250 - 286 over the last seven years.
- The rate of 37 Children Looked After per 10,000 population under 18 is significantly lower than comparator groups. The rate is 50 for statistical neighbours and 60 nationally.

Figure 7.2.3



Source: London Borough of Bromley

- 32% of Children Looked After are from black and minority ethnic (BME) groups, a slight increase from last year and higher than the BME population of Bromley children which is 27%. Nationally, 22% of CLA are BME but in London this rises to 57%
- Bromley has a relatively high proportion of older children. 25% of CLA are aged 16-17 and 40% are aged 10-15. This reflects a similar trend across the statistical

neighbours, London and England.

- 58% of CLA are male
- A high proportion of Children Looked After (61%) have special educational needs, and 35% of CLA have a Statement of Special Educational Needs or an Education, Health and Care Plan.
- The number of unaccompanied asylum seeking children in Bromley is low but starting to rise.

Placements and Stability

- 73% of Children Looked After are in foster placements, of these 69% are placed with in-house foster carers and 8% are placed with a relative or friends.
- Placement stability – the percentage of children in long term placements (over 2 years) is in line with the national average.
- The percentage of children with 3 or more placements in a year is 10.6%. This has improved year on year and is in line with the national average.
- The percentage of Children Looked After placed out of the borough and more than 20 miles from where they used to live is 21% compared to 12% nationally.

Adoption and Permanence

In 2014/15, 20 children and young people were adopted, up from 14 the previous year. This is 13% of the children who ceased to be looked after in the year compared to 16% nationally. Timeliness of adoption is poor. As measured by the Adoption Scorecard, the number of days between a child entering care and moving in with their adoptive family has increased, so has the time between receiving court authority for adoption and matching with an adoptive family. We are not meeting the thresholds set by the government to address the delay in the adoption process. This is true of many other local authorities too.

A further 15% of children ceasing to be looked after are achieving permanence through Special Guardianship Orders to family or friends. In some cases this is ruled by the courts as the preferred option to adoption.

The average length for care proceedings in Bromley is 33 weeks which is just over the national average of 30

Health of Children Looked After

Bromley is successful in making sure that immunisations and health assessments are up to date. 94% of immunisations were up to date compared to 88% nationally, and 89% of health assessments; just below the national average of 90%. The proportion of young people attending dental checks each year is higher than nationally.

Table 7.2.1: Health Checks completed on time

	Children looked after for at least 12 months	Immunisations were up to date		Teeth checked by a dentist		Annual health assessment	
		Number	%	Number	%	Number	%
Bromley 2014/15	170	160	94.1%	160	94.7%	150	88.8%
Bromley 2013/14	180	170	94.4%	150	83.3%	160	88.8%
Bromley 2012/13	175	165	94.2%	140	80.0%	155	88.5%
Statistical Neighbours	*3,225*	*2,765*	*85.7%*	*2,645*	*82.0%*	*2,805*	*87.0%*
London	*6,410*	*5,470*	*85.3%*	*5,720*	*89.2%*	*5,800*	*90.5%*
England	*48,090*	*42,240*	*87.8%*	*41,250*	*85.8%*	*43,140*	*89.7%*

Source: Department for Education

"Strength and difficulties questionnaires" (SDQs) are required annually to assess the emotional health of CLA aged 4 to 16 who have been looked after continuously for at least twelve months. The questionnaire is completed by the carer. A higher score on the SDQ indicates more emotional difficulties. A score of 0-13 is considered normal, 14-16 is considered borderline cause for concern and a score of 17 and over is a cause for concern. Bromley's average score in 2014/15 was 14.1

Bromley has the same proportion of normal scores as its statistical neighbours and a higher proportion of scores causing concern.

Table 7.2.2: Emotional health SDQ analysis 2014/15

	Average score per child	Eligible children with an SDQ score considered:		
		Normal	Borderline	Concern
Bromley	14.1	50%	11%	39%
Statistical Neighbours	*13.9*	*50%*	*14%*	*37%*
London	*13.2*	*54%*	*12%*	*34%*
England	*13.9*	*50%*	*13%*	*37%*

Source: Department for Education

Educational Attainment of CLA

When looking at the attainment of Children Looked After the key factor worth noting are the very small numbers in each cohort.

Key Stage 1

In the 2014/15 Key Stage 1 assessments 7 pupils formed the reporting cohort. From this 29% of children achieved Level 2+ (the expected level for KS1) in Reading and Maths, and 43% achieved a level 2+ in Writing. This is lower than comparators and nationally. The small numbers in the cohort each year does mean that performance fluctuates. 4 of the 7 children in the cohort have a Statement of Special Educational Needs.

Table 7.2.3: Percentage of children achieving level 2+ at Key Stage 1

	Eligible children	Reading	Writing	Maths
Bromley 2014/15	7	29%	43%	29%
Bromley 2013/14	11	56%	56%	56%
Bromley 2012/13	5	60%	60%	60%
London		*73.0%*	*70.0%*	*77.0%*
England		*71.0%*	*63.0%*	*73.0%*

Source: Department for Education

Key Stage 2

There were 12 looked after children in the 2014/15 reporting cohort. 3 children have SEN. 50% of the cohort achieved Level 4 and above in reading, writing and maths combined. This was down from 63% the previous year and is below the percentage achieved by our comparators

In terms of levels of expected progress, all but one of the children made 2 levels of progress or more in English and Maths. This compares favourably to progress in previous years.

Table 7.2.4: Percentage of children achieving level 4+ at Key Stage 2

	Eligible children	Maths	Reading	Writing	Grammar, punctuation and spelling	Reading, writing and mathematics
Bromley 2014/15	12	75%	67%	58%	50%	50%
Statistical Neighbours		*74%*	*70%*	*64%*	*61%*	*56%*
London		*70%*	*75%*	*65%*	*61%*	*58%*
England		*64%*	*71%*	*61%*	*54%*	*52%*

Source: Department for Education

GCSE

The issues faced at KS2 are also factors at KS4; small cohort numbers and high levels of SEN. This means that performance in the national indicator of 5^{+} A*-C including English and Maths does fluctuate.

25% of children achieved at least 5 A*-C's including English and Maths. This is excellent, higher than in past years for Bromley and higher than comparators. All of these highest achieving children were attending Bromley schools and they have all experienced a period of long term stable care in foster placements.

Table 7.2.5: A summary of GCSE performance

	Eligible children	5+ GCSEs at grades A*-C	5+ GCSEs at grades A*-C including English & Maths	1+ GCSEs at grades A*-E
Bromley 2014/15	19	35%	25%	90%
Bromley 2013/14	28	25%	14%	74%
Bromley 2012/13	19	21%	16%	26%
Statistical Neighbours		*14%*	*10%*	
London		*22%*	*17%*	
England		*18%*	*14%*	

Source: Department for Education

Exclusions and School Attendance

There have been no Bromley Children Looked After permanently excluded from school in the last 7 years. Bromley's fixed term exclusion rate had been decreasing since 2009 to 8.2% in 2014/15. This is lower than statistical neighbours and nationally (10.3%).

2.9% of Children Looked After were absent from school in 2014/15. This has been decreasing over the last 8 years and is lower than our statistical neighbours (4.2%) and national (4%) comparators. However persistent absence is higher at 7.2% compared to 5.25%.

Care Leavers

A young person qualifies for care leaver support if they are looked after for more than 13 weeks and are looked after on their 16th birthday. The care leaver cohort that we report on is expanding and covers 19 to 21 year olds (previously just 19 year olds).

75% of care leavers were in suitable accommodation at their last birthday, this is lower than the 81% reported nationally and 83% by our statistical neighbours.

In 2014/15, 48% of care leavers were in education employment and training (EET). This is in line with comparators and the national average. 16% of care leavers were not in touch and so their EET status is unknown. 36% are NEET

Youth Offending and Substance Misuse

Less than 5 young people who had been CLA for longer than 12 months were identified as having a substance misuse problem. This is down from the previous year

In 2014/15, 8.3% of 10-17 year old CLA young people in Bromley were convicted or subject to a final warning or reprimand during the year, a slight reduction from last year and higher than our statistical neighbours and England. There are small numbers in the cohort however so the percentage can vary widely.

Table 7.2.6: The number and percentage of looked after young people who received a warning or conviction during the year

	CLA for at least 12 month aged 10 or older	Convicted or subject to a final warning or reprimand during the year	
		Number	%
Bromley	120	10	7%
Statistical Neighbours	*2,150*	*95*	*4%*
London	*4,840*	*280*	*6%*
England	*31,820*	*1650*	*5%*

Source: Department for Education

What this means for Bromley residents and for children in Bromley

The data on Children Looked After shows a variable picture.
The measures of health tend to be measures of processes (for example number of health checks or dental checks) rather than information on actual levels of health. Where this information is available, for example offending behaviour, the findings are concerning. Some of the findings may be related to the relatively high rates of CLA with Special Educational Needs in Bromley.
The time taken for children to be adopted from care needs to be shorter to help ensure good outcomes. All of this data is monitored closely and appropriate interventions such as CAMHS support are available when required.

For more information on Children's Safeguarding and Social Care please contact Tracey.Beeson@Bromley.gov.uk

7.3. Educational Attainment

Introduction

The overall pupil population, including post-16 years, within LA maintained and academy schools, and the Pupil Referral Service provision in Bromley is at its highest known level at 49,215 pupils (January pupil census 2016).

Table 7.3.1

Pupils in Bromley Schools [Source: Department for Education]						
	2011	2012	2013	2014	2015	2016
Number of pupils in Bromley schools	47,079	47,242	47,663	48,208	48,627	49,215
Difference		163	421	545	419	588

About 20% of the borough's secondary school intake comes from neighbouring boroughs – predominantly Lewisham and Croydon. This has a significant impact on the profile of the children and young people in Bromley schools. For example, Bromley's schools have an average Black and Minority Ethnic (BME) profile of 35% compared to the resident BME children and young people population of 17%.

Attainment of Pupils in Bromley Schools

The national curriculum includes assessments at varying stages of a child's school life as detailed in Table 7.3.2.

Table 7.3.2

Assessment	Stage of School Life	Comments
Early Years Foundation Stage	Reception (age 5)	This is a set of teacher assessments
Phonics	Year 1 (age 6)	Children undertake a check of 40 words to confirm whether they have learnt phonics decoding. There is also a re-check in year 2 if the expected standard is not met in year 1, or the child did not take the check in year 1.
Key Stage 1	Year 2 (age 7)	This comprises a set of teacher assessments in reading, writing, mathematics and science. Tests in reading and mathematics are also taken to confirm/inform the teacher assessments
Key Stage 2	Year 6 (age 11)	This comprises a set of tests in grammar, reading and mathematics and teacher assessments in reading, writing, mathematics and science.
Key Stage 4	Year 11 (age 16)	GCSE and equivalent tests

Source: London Borough of Bromley

Evidence shows that many vulnerable groups such as pupils who are in receipt of Free School Meals (FSM), Special Educational Needs (SEN), and Looked After

Children tend to perform less well than their peers. The Government has charged local authorities and schools with closing the gap in performance between these groups and the main cohort of pupils, with a view to raising attainment of vulnerable groups and closing the gap in performance over time.

FSM is used as a proxy measure for poverty and used to assess outcomes for children from low income families. However it is only a proxy measure as many children from these backgrounds do not always take up their entitlement to free school meals (FSM).

Within this section FSM gap results are reported due to their significance in relation to children's well-being and life chances

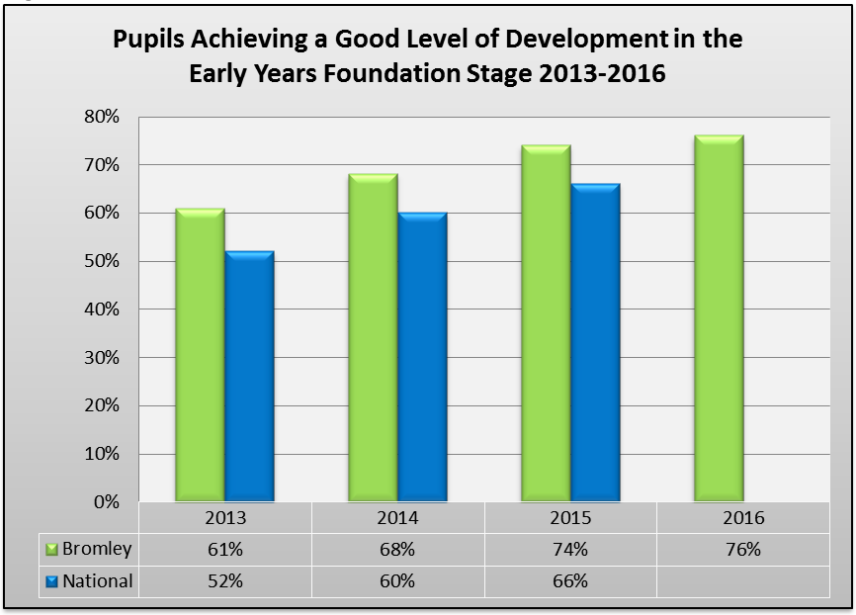
Foundation Stage Profile

The current Early Years Foundation Stage (EYFS) Framework was introduced in September 2013, with the progress of children in the EYFS measured against 17 learning goals. Children are assessed as 'Emerging', 'Expected' or 'Exceeding'. A pupil is considered to have achieved a 'Good Level of Development' if they reach 'Expected' or 'Exceeding' in Communication and Language, Physical Development, Personal, Social and Emotional Development, Literacy and Mathematics.

Pupils are also given a total points score for their achievements, where emerging has a score of 1, expected has a score of 2 and exceeding has a score of 3. These are added for each of the 17 early learning goals to give the overall score. The total points score for Bromley in 2016 was 35.5, compared with 35.3 in 2015 and 34.5 in 2014.

In 2016, 76% of Bromley pupils attained a good level of development, compared with 74% in 2015 and 68% in 2014. The 2015 national result was 66% (2016 national data is not available until October 2016).

Figure 7.3.1



Source: London Borough Of Bromley

In 2016 the performance at the Early Years Foundation Stage (Good Level of Development) for pupils eligible for Free School Meals (FSM) was 56% compared with 76% of those not eligible for FSM. The gap therefore was 22%, a slight drop from 2015 where the gap was 23%. The national figure for both 2014 and 2015 was 19%. 2016 national figures are not yet published. This level of gap requires attention.

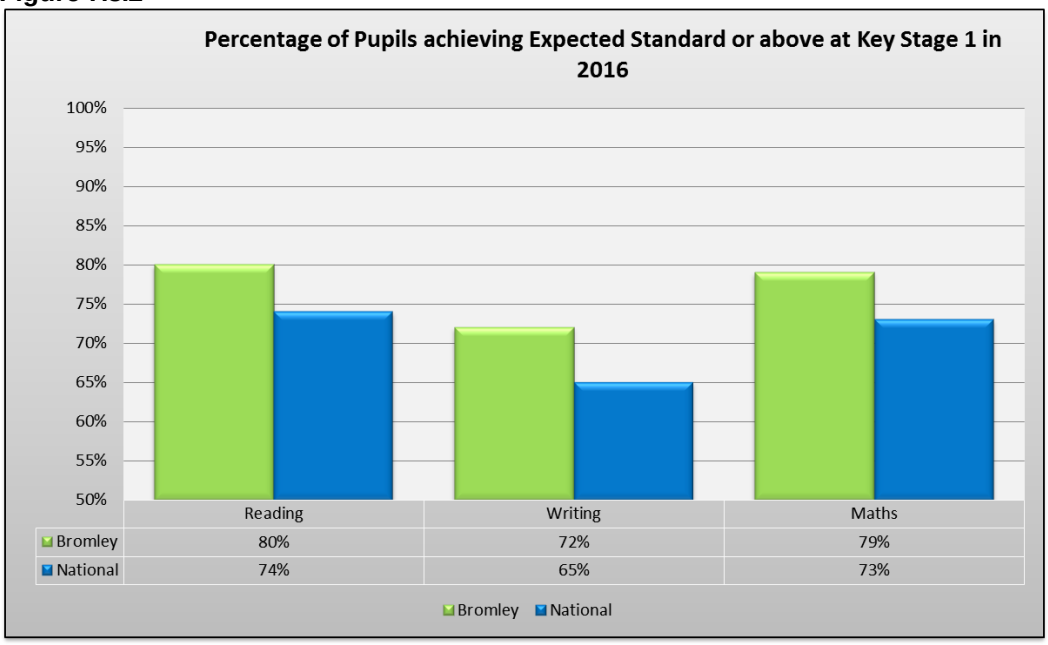
Key Stage 1

Following the introduction of the new national curriculum, the summer of 2016 saw pupils undertake the new assessments for the new curriculum. Whereas in previous years, pupils were expected to reach a certain level of the national curriculum, this has now been removed. The national standard is based upon the proportion of children who are working at the Expected Standard or at Greater Depth within the Expected Standard.

The 2016 results for Bromley show that 80% of pupils achieved the expected standard in reading, 72% in writing and 79% in maths. This compares to the 2016 national figures, where 74% reached the expected standard in reading, 65% in writing and 73% in maths, showing Bromley to be around 6 percentage points higher.

The gap in performance at Key Stage 1 between pupils eligible for Free School Meals (FSM) and non-eligible has shown a significant change following the new assessments. Pupils not eligible for FSM still consistently perform better than those eligible, but nationally the gap has increased across all subjects by between 5 and 10 percentage points. The gap in reading for Bromley in 2016 was 18% compared to 17% nationally, in writing the gap was 16% in Bromley compared to 18% nationally and in maths was 18% in Bromley compared to 18% nationally.

Figure 7.3.2



Source: London Borough of Bromley and Department for Education

Key Stage 2

At age 11 (end of Key Stage 2) the introduction of the new national curriculum is also reflected in new assessment outcomes. Similarly to Key Stage 1, pupils are assessed against whether they have met the expected standard or not in each subject.

Children undertake externally marked tests in grammar, reading and mathematics, and are teacher assessed in reading, writing, mathematics and science.

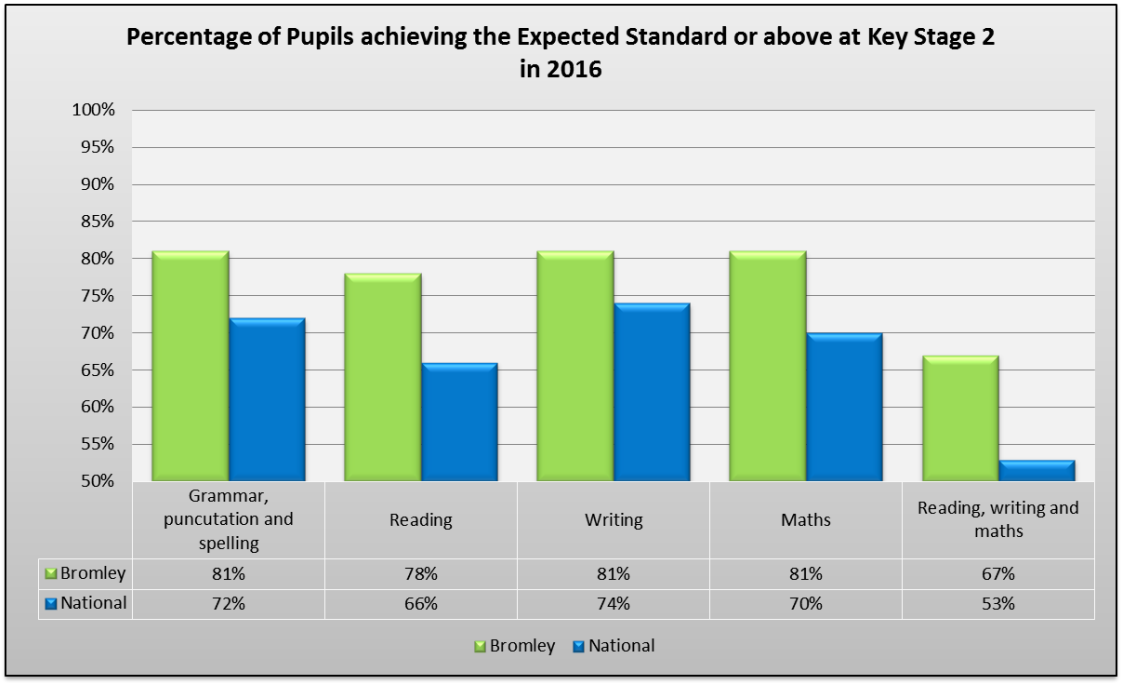
The national standard looks at whether children meet the expected standard in the grammar, reading and maths tests, and in writing teacher assessment, and what proportion of children meet the standard across all of reading, writing and maths.

The 2016 results are provisional at this stage but show that in Bromley, 81% of pupils achieved the expected standard or above in the grammar, punctuation and spelling test, 78% in the reading test, 81% in writing teacher assessment and 81% in the mathematics test. The provisional national averages for 2016 show 72% achieved the expected standard or above in the grammar, punctuation and spelling test, 66% in reading, 74% for writing teacher assessment and 70% for mathematics.

Despite the change in assessments, this continues the trend of previous years where overall pupils in Bromley schools attain above the national average.

Provisional results for the percentage reaching the expected standard in the combined reading, writing and mathematics measure shows 67% in Bromley compared with the national figure of 53% (see figure 7.3.3).

Figure 7.3.3



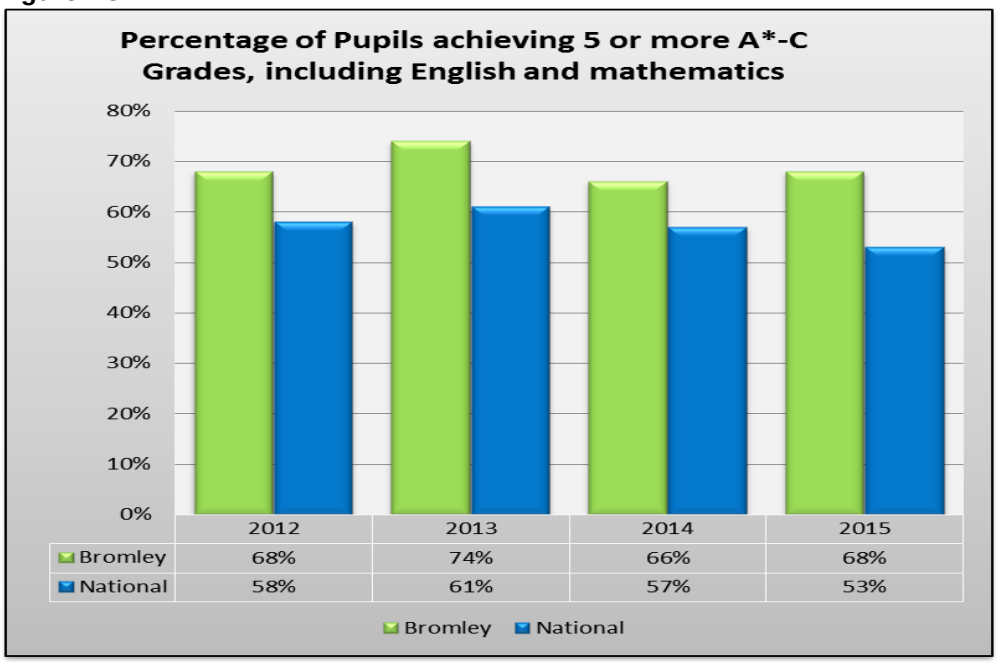
Source: London Borough of Bromley and Department for Education

At Key Stage 2, similarly to Key Stage 1, the gap in attainment between those pupils eligible for Free School Meals and those who are not has increased significantly in Bromley. At Key Stage 2, the provisional gap for the combined reading, writing and mathematics measure for 2016 is 25% compared to 15% in 2015. The national figure for 2016 has not yet been published but in 2015 it was 17%.

Key Stage 4

At GCSE, Bromley pupils also achieve higher that the national average, with 68% of pupils gaining 5+ A*-C grades (including GCSE English and mathematics) in 2015, compared with 53% nationally as shown in Figure 5.1.5. The 2016 results have yet to be published. The apparent dip in the 2014 results, both in Bromley and nationally reflects the changes in policy relating to the Wolf Report into the Reform of Vocational Education and the introduction of a new early entry policy, both of which affect the 5 A*-C including English and mathematics measure. These changes can be viewed in more detail at *http://www.education.gov.uk/schools/performance/secondary_14/s3-1.html*.

Figure 7.3.4



Source: London Borough of Bromley and Department for Education

At Key Stage 4, the Free School Meal/Non Free School Meal gap has increased over the last 3 years when looking at the percentage of 5+ A*-C grades including English and mathematics. The gap was 28% in 2013 rising to 31% in 2014 and to 33% in 2015. The national gap in 2015 was 28%.

What this means for Bromley residents and for children in Bromley

Although attainment in Bromley schools is generally above the national average, certain groups of children, in particular those in receipt of Free School Meals do not make the desired rate of progress.

There is a small but significant number of schools where sustainable improvement is not yet achieved. Improvements in these areas need to remain a priority for Bromley schools.

Children with Special Educational Needs and Disabilities (SEND)

This section provides a range of information for children with Special Educational Needs and Disabilities in Bromley.

The number of pupils in Bromley schools with Special Educational Needs is currently at 6,940 pupils (based on the January 2016 school census), which continues the year-on-year decrease seen since 2011, as shown in Table 7.3.3.

Table 7.3.3

Pupils in Bromley Schools with Special Educational Needs
[Source: Department for Education]

	2009	2010	2011	2012	2013	2014	2015	2016
Number of pupils in Bromley schools with SEN	8,340	8,337	9,465	9,205	8,885	7,956	7,084	6,490
Difference	328	497	628	-260	-320	-929	-872	-594
% of pupils in Bromley schools with SEN	17.9%	17.8%	18.4%	17.8%	16.9%	16.5%	14.6%	13.2%
Difference	0.6%	-0.1%	0.6%	-0.6%	-0.9%	-0.4%	-1.9%	-1.4%

Source: Department for Education

Following the SEND reforms introduced by the Government from September 2014, children are now given an Education, Health and Care (EHC) Plan rather than a Statement. In the current transition period, children will be shown as having either an EHC plan or the old-style Statement of SEN. Not all children with a Statement will necessarily move on to an EHC plan. In Bromley the number of pupils with either an EHC Plan or Statement of Special Educational Needs increased from 1,645 in 2009 to 1,901 in 2013, followed by a decrease of 210 to 1,621 in 2016.

Table 7.3.4

Pupils in Bromley Schools with a Statement of Special Educational Needs or Education, Health and Care Plan
[Source: Department for Education]

	2009	2010	2011	2012	2013	2014	2015	2016
Number of pupils in Bromley schools with a Statement of SEN or EHC Plan	1,645	1,704	1,786	1,779	1,901	1,818	1,726	1,621
Difference		59	82	-7	122	-83	-92	-105

Source: Department for Education

However the above table does not include all pupils with statements or EHC plans maintained by London Borough of Bromley. As shown below, whilst the figure decreased from 2013 to 2015, it has showed a small increase to 2016 of +45.

Table 7.3.5: Numbers of pupils with statements or EHC Plans maintained by Bromley

	2010	2011	2012	2013	2014	2015	2016
	1,885	1,940	1,975	1,975	1,915	1,825	1,870
Difference:		+55	+35	0	-60	-90	+45

Source: London Borough of Bromley

The percentage of pupils with statements or EHC plans in Bromley schools remains above the national and London averages.

Table 7.3.6: Percentage of pupils with statements or EHC Plans based on where they attend school

	2010	2011	2012	2013	2014	2015	2016
England	2.8	2.8	2.8	2.8	2.8	2.8	2.8
London	2.7	2.7	2.7	2.7	2.7	2.8	2.8
Bromley	3.3	3.5	3.4	3.6	3.4	3.2	3.0
Hertfordshire	2.0	2.0	2.0	1.9	1.9	1.9	1.9
Trafford	2.9	3.0	3.2	3.3	3.5	3.4	3.3
Sutton	3.1	3.2	3.2	3.1	3.0	2.9	3.0

Source: Department for Education

In Bromley, pupils with Statements or EHC plans are placed in varying provisions, dependent on their need. The table below shows where these pupils are placed.

Table 7.3.7: Statements/EHC Plans maintained by Bromley by type of school (%)

	2016
Maintained Mainstream Schools (including Academies)	46.5%
Maintained Special Schools (including Academies)	28.5%
Independent Non-maintained Special schools	12.8%
SEN Units in Mainstream Schools (including Academies)	3.7%
Other	8.5%
Total	100%

Source: London Borough of Bromley

Every child with a Statement or EHC plan will have a primary need identified according to a set of defined (by the Department for Education) needs. The table below shows the numbers of pupils as at the 31st March 2016 by need and type of provision (excluding those in FE provision). Bromley has a high number of pupils with Speech and Language needs, and also those with Autistic Spectrum Disorder. Whilst the 2016 benchmarking data is not yet published, based on previous year's data, Bromley has higher numbers of these needs than its neighbouring boroughs.

Table 7.3.8 Type of Need by Provision Type

Need / Provision Type	Maintained Mainstream	SEN Units in Mainstream	Maintained Special School	Other Provision	Independent and Non-Maintained Special Schools	Total Pupils
Specific Learning Difficulty	41	0	4	2	7	**54**
Moderate Learning Difficulty	38	6	44	5	13	**106**
Severe Learning Difficulty	17	0	47	1	12	**77**
Profound and Multiple Learning Difficulty	3	0	18	1	2	**24**
Social, Emotional and Mental Health	53	2	38	11	35	**139**
Speech, Language and Communication Needs	364	28	144	20	69	**625**
Autistic Spectrum Disorder	184	16	131	11	61	**403**
Visual Impairment	9	0	6	1	1	**17**
Hearing Impairment	24	14	3	1	4	**46**
Multi-Sensory Impairment	0	0	3	0	1	**4**
Physical Disability	47	1	52	3	9	**112**
Other difficulty/disorder	24	0	18	3	5	**50**
Total	**804**	**67**	**508**	**59**	**219**	**1657**

Source: London Borough of Bromley

Educational attainment of pupils with Special Education Needs and Disabilities

Pupils who have a significant degree of Special Educational Needs and Disability perform less well than their peers at all Key Stages and subjects. This makes closing the attainment gap for children with SEND difficult, as the severity of SEN and disabilities in some pupils means that some pupils will never reach the expected level of attainment.

The following tables provide the performance of pupils in 2015 at Key Stage 1, Key Stage 2 and Key Stage 4 with Special Educational Needs at the following levels of SEN Support (replacing School Action and School Action Plus), or EHC Plan or Statement, compared to pupils who have no SEN. The 2016 results are not yet published.

Table 7.3.9

Key Stage 1 2015 - Level 2+	No SEN		SEN Support		Education, Health and Care Plan or Statement	
	Bromley	National	Bromley	National	Bromley	National
Number of Pupils	*3322*		*453*		*79*	
Reading	98%	96%	69%	64%	34%	27%
Writing	96%	95%	57%	55%	25%	21%
Maths	99%	98%	75%	73%	35%	29%

Source: Department for Education

Table 7.3.10

Key Stage 2 2015 - Level 4+	No SEN		SEN Support		Education, Health and Care Plan or Statement	
	Bromley	National	Bromley	National	Bromley	National
Number of Pupils	*2787*		*475*		*103*	
Grammar	*93%*	90%	*57%*	45%	*34%*	20%
Reading	98%	96%	77%	69%	40%	30%
Writing	97%	96%	64%	58%	33%	21%
Maths	97%	94%	73%	64%	38%	26%
Reading, Writing and Maths	94%	90%	53%	43%	25%	16%

Source: Department for Education

Table 7.3.11

Key Stage 4 2015	No SEN		SEN Support		Education, Health and Care Plan or Statement	
	Bromley	National	Bromley	National	Bromley	National
Number of Pupils	*2744*		*377*		*143*	
5+ A*-C Grades	*82%*	74%	*47%*	32%	*18%*	12%
5+ A*-C Grades, including English and Maths	76%	65%	37%	24%	17%	9%
5+ A*-G Grades	99%	98%	92%	86%	57%	43%
English Baccalaureate	39%	28%	11%	6%	4%	2%

Source: Department for Education

What does this tell us?

The 2015 results again show the difference in attainment for those pupils with and without SEN, with in general, the higher the SEN need of the pupil, the lower their attainment. The Bromley results overall are above the national comparator figures in each SEN category and for each subject.

What this means for Bromley residents and for children in Bromley

Compared to similar areas there are higher rates in Bromley of children with speech, language and communication needs, children with severe, profound and multiple learning difficulties, and pupils on the autistic spectrum. Pupils with behavioural, emotional or mental health needs are more likely to attend independent schools than in neighbouring boroughs. Children with SEN have lower attainment than their peers without SEN, but attainment is above the national averages at all key stages.

For more information on Children with Special Educational Needs and Disabilities please contact Georgina.Sanger@Bromley.gov.uk

8. Physical Disability and Sensory Impairment

Introduction

This section focuses on the needs of the Borough's adults with sensory impairment and physical disabilities. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- Sight impairment
- Hearing impairment
- Physical disabilities

Sight Impairment

Nationally, the World Health Assembly views blindness as a public health issue directly linked with lifestyle and demographic factors. Currently, almost two million people in the UK are living with some degree of sight loss and this number is rapidly increasing. This figure includes around 360,000 people registered as blind or partially sighted, who have severe and irreversible sight loss. It is predicted that by 2020 the number of people with sight loss will rise to over 2,250,000. And by 2050, the numbers of people with sight loss in the UK will double to nearly four million.

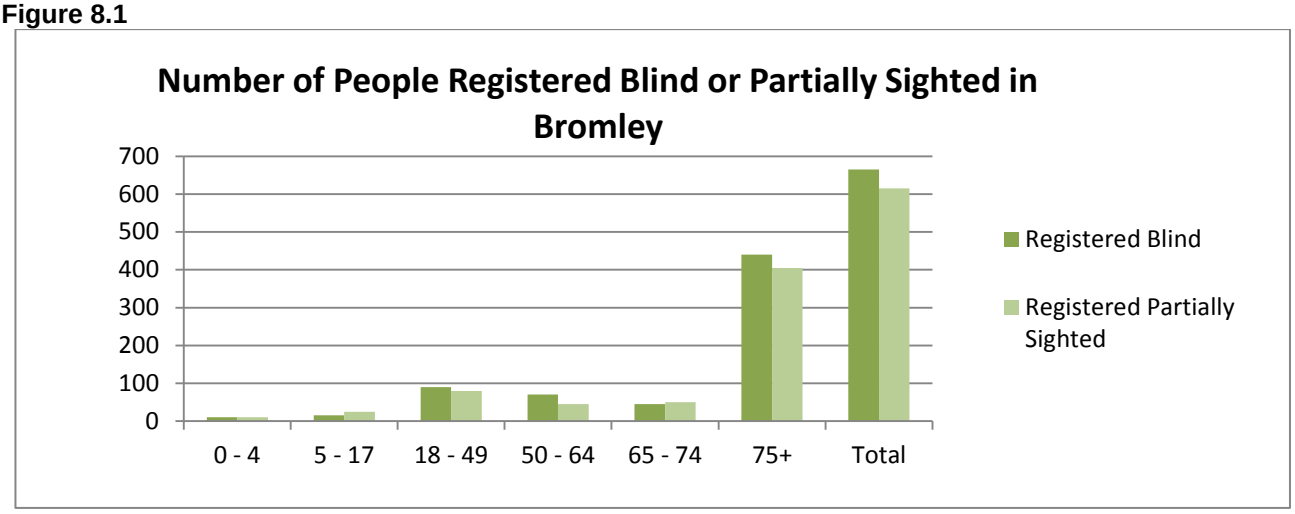
The UK population is ageing, and it is projected to continue to age over the next few decades, with the fastest population increases in the numbers of those aged 85 and over. This is the age group more at risk of eye disorders causing visual impairment.

Two thirds of registered blind and partially sighted people of working age are not in paid employment, and nearly half of blind and partially sighted people feel 'moderately' or 'completely' cut off from people and things around them.

Sight loss impacts on a community on many different levels: on a personal level it can be a deeply traumatic life event. On an economic level, it is estimated that in 2008, sight loss cost the UK £22 billion.

In Bromley, 665 people were registered severely sight impaired (blind) and 615 registered sight impaired (partially sighted) as of 31st March 2014 (figure 8.1 and Table 8.1). Registration statistics are on a three yearly basis; therefore these are the most recent data.

Figure 8.1



Source: Registered Blind and Partially Sighted People year ending 31 March 2014 England, NHS Digital

Table 8.1: Registration of people with sight impairment in Bromley as at 31st March 2014

	0 – 4y	5 – 17y	18 – 49y	50 – 64y	65 – 74y	75y+	Total
Number of People in Bromley registered Blind	10	15	90	70	45	440	665
Number of People in Bromley registered Partially Sighted	10	25	80	45	50	405	615

Note: Numbers may not sum up due to rounding
Source: Registered Blind and Partially Sighted People year ending 31 March 2014 England, NHS Digital

There is a difference in the numbers of people registered as sight impaired and those who are predicted to have sight impairment using epidemiological models. The estimated number of people with sight impairment is higher in some of the estimates below, underlining the fact that Certification of Vision Impairment data used for registration does not capture the full extent of sight loss experienced by a population.

Projecting Older People Population Information (POPPI) estimates in 2015 there were just over 5000 people in Bromley aged over 65 with moderate or severe visual impairment. This is estimated to rise to almost 5,500 in 2020 and over 6,800 in 2030 (table 8.2).

The POPPI estimate of 1754, for those aged 75 and over with registrable eye conditions in 2015 (table 8.2), is far higher than the 845 people aged 75 and over actually registered in 2014 (table 8.1).

Table 8.2: POPPI estimates for people aged 65 or over with moderate or severe visual impairment and people aged 75 or over with registrable eye conditions in Bromley, projected to 2030

	2015	2020	2025	2030
People aged 65-74 predicted to have a moderate or severe visual impairment	1669	1736	1758	2072
People aged 75 and over predicted to have a moderate or severe visual impairment	3398	3683	4352	4749
People aged 75 and over predicted to have registrable eye conditions	1754	1901	2246	2451

Source: www.poppi.org.uk version 9.0 produced on 03/10/16

Projecting Adult Needs and Service Information (PANSI) estimated in 2015 in Bromley, the number of adults between the ages of 18 and 64 years of age with a serious visual impairment was 127, predicted to rise to 132 by 2020 and 141 by 2030 (table 8.3). This is a relatively small number compared to older adults.

Table 8.3: PANSI estimates for people aged 18 – 64 with serious visual impairment in Bromley, by age, projected to 2030

	2015	2020	2025	2030
People aged 18-24 predicted to have a serious visual impairment	14	14	14	16
People aged 25-34 predicted to have a serious visual impairment	27	29	28	27
People aged 35-44 predicted to have a serious visual impairment	30	32	34	35
People aged 45-54 predicted to have a serious visual impairment	32	32	32	33
People aged 55-64 predicted to have a serious visual impairment	23	27	30	30
Total population aged 18-64 predicted to have a serious visual impairment	127	132	137	141

Source: www.pansi.org.uk version 8.0 produced on 03/10/16

The RNIB uses a wider definition of sight loss that includes people with lower levels of sight loss, but which still impacts on daily life. The RNIB sight loss tool indicates a greater impact of sight loss on the Bromley population, with an estimated 10,390 people living with sight loss in 2015 (Table 8.4). Of these 6,570 are living with mild sight loss, 2,540 are living with moderate sight loss (partial sight) and 1,270 are living with severe sight loss sight (blindness). RNIB estimates by 2030, there will be 14,140 people in Bromley living with sight loss, an increase of 36.1%. By 2030, the number of people living with severe sight loss is estimated to be 1,790, an increase of 40.9%.

Table 8.4 RNIB estimates of number living with sight loss in Bromley

	2015	2020	2025	2030
Mild	6,570	7,160	7,920	8,920
Moderate sight loss	2,540	2,770	3,060	3,440
Severe sight loss	1,270	1,390	1,570	1,790
Total	10,390	11,330	12,560	14,140

Source: RNIB Sight Loss Data Tool Version 3.1, June 2016. Accessed 3rd October 2016.

Sight threatening eye conditions

The burden of sight threatening eye conditions, which are; age related macular degeneration (AMD), cataract, glaucoma and diabetic retinopathy, are all projected to increase in Bromley (table 8.5).

In Bromley, between 2015 and 2030 it is estimated by the RNIB sight loss tool (version 3.1, 2016) there will be:

- 33% increase in the number of people living with early stage AMD (compared to 35% across England)
- 38% increase in the number of people living with late stage dry AMD and a 39% increase in the number of people living with late stage AMD (compared to 48% and 50% across England)
- 41% increase in the number of people living with cataract (compared to 51% across England)
- 19% increase in the number of people living with glaucoma (compared to 14% across England)
- 16% increase in the number of people living with diabetic retinopathy (compared to 11% across England)
- 16% increase in people living with severe diabetic retinopathy (compared to 11% across England)
- 22% increase in the estimated number of adults living with diabetes (compared to 18% across England).

Table 8.5: Projected number of people living with sight threatening eye conditions in Bromley

	2015	2020	2025	2030
Early stage AMD	13200	14460	15840	17490
Late stage dry AMD	1030	1120	1250	1420
Late stage wet AMD	2140	2500	2580	2980
Cataract	3250	3600	3960	4570
Glaucoma	3080	3280	3480	3670
Diabetic retinopathy	6290	6600	6960	7320
Severe diabetic retinopathy	580	610	640	670

Source: RNIB Sight Loss Data Tool Version 3.1, June 2016. Accessed 3rd October 2016.

Underlying causes of eye conditions

The Bromley Vision Strategy February 2013 and the 2015 Public Health Needs Assessment on Eye Health have found that:-

- **Ageing** is a risk factor in many eye conditions and in other health conditions which may lead to sight loss. Age related Macular Degeneration (AMD), Cataract, Glaucoma and to an extent Diabetic Retinopathy (i.e. duration or diagnosis) all show a positive association with age.
- **Smoking** increases the risk of sight loss; Research has shown that cessation programmes which link sight loss and smoking provide a motivation for people to reduce or give up smoking.
- **Obesity** has been shown to be a risk factor in all four major eye diseases, Macular Degeneration, Glaucoma, Diabetic Retinopathy and Cataracts. The 2016 Health Profile gives a modelled estimate for prevalence of excess weight in Bromley of 63.8% of those aged 16 years and over, representing approximately 197,392 adults.
- There are clear associations between excessive consumption of **alcohol** over a sustained period of time and the development of all four main eye diseases. In addition, alcohol consumption by women during pregnancy has also been linked to ocular abnormalities in children.
- The restriction of blood to the eye (as occurs with **high blood pressure**) can cause damage to the retina and result in deterioration of eye health. Heart health and good circulation are therefore essential to maintaining good health. In Bromley, the prevalence of hypertension is similar to the national average. In 2014-15, there were approximately 46,370 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 2014/15, there were 14,493 people in Bromley diagnosed with Diabetes. This reflects a continuous rise in the prevalence over the last 12 years. Given that 40% of people with Type 1 Diabetes and 20% of those with Type 2 Diabetes will go on to develop Diabetic Retinopathy, diabetes related visual impairment will become a major pressure on local low vision and rehabilitation services. It is estimated that there are 29,800 people in Bromley at high risk of diabetes.

People with Learning Disabilities are ten times more likely to have eye problems than the rest of the population. 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.

Associated Impacts of Eye Disease

There are significant adverse health impacts associated with sight loss, such as an increased risk of depression and falls. People with sight problems are also likely to have additional disabilities and to live alone, indicating that those affected by sight loss are among the most vulnerable and isolated. A study by Frick and Kymes (2006) argues that these findings rank the absolute economic burden of sight loss with that of cancer, dementia and arthritis.

Additional impairments

In Bromley, of the 615 people registered with partial sight, 39% (240) have an additional impairment or a mental health problem (table 8.6). Of the 665 people registered blind, 43% (285), have an additional impairment or a mental health problem (table 8.7). These additional issues increase the health and social care need people may have and highlights how vulnerable people with sight impairment could potentially be.

Table 8.6 Registered Partially Sighted People with an Additional Disability by Category

Registered Partially sighted people with / who are								
		Total with additional disability	Mental Health Problems	Learning disability	Physical disability	Deaf with speech	Deaf without speech	Hard of hearing
Bromley	Number	240	15	0	210	0	0	10
	Percentage	100%	6%	0%	88%	0%	0%	4%

Note: Numbers may not sum up due to rounding
Source: NHS Information Centre, 2016 (downloaded from London Datastore)

Table 8.7 Registered Blind People with an Additional Disability by Category

Registered Blind people with / who are								
		Total with additional disability	Mental Health Problems	Learning disability	Physical disability	Deaf with speech	Deaf without speech	Hard of hearing
Bromley	Number	285	10	0	240	20	0	15
	Percentage	100%	4%	0%	84%	7%	0%	5%

Note: Numbers may not sum up due to rounding
Source: NHS Information Centre, 2016 (downloaded from London Datastore)

Access

The needs of people with sight impairment are often not taken into account by designers or planners. For example, the design of transport systems, signage, labelling, public buildings and shared space environments often fail to take into account the needs of people with sight loss. Half of people with sight loss say they experience difficulty getting into and moving around buildings.

Falls

A review of evidence on the link between falls and sight loss found that almost half of all falls sustained by blind and partially sighted people were directly attributable to their sight loss. On average, the estimated medical cost of falls nationally is £269 million. Of the total cost of treating all accidental falls in the UK, 21% was spent on the population with visual impairment. A number of studies have demonstrated the cost benefits of cataract surgery in improving life quality and reducing the number of falls.

In Bromley, as of 2015, RNIB estimates that

- 9,847 people with sight loss aged over 65 experience a fall per year.
- Of these falls, 4,654 are directly attributable to sight loss.
- 97 people aged over 65 with sight loss experience a severe fall per year (defined as a fall that results in hospital admission through A&E).
- Of these severe falls, 46 are directly attributable to sight loss.

(source: RNIB sight loss tool version 3.1, 2016)

Quality of Life and Emotional Wellbeing

Evidence suggests a strong link between sight loss and reduced psychological wellbeing, particularly amongst older people who develop sight loss later in life. People living with sight loss report lower feelings of wellbeing, reduced self-confidence and lower satisfaction with their health.

Older people with sight loss are almost three times more likely to experience depression than people with good vision. Patients with bilateral neovascular age related Macular Degeneration report a substantially lower quality of life, poorer vision-related functioning, greater anxiety and depression, more frequent falls and fractures, and greater dependency on carers.

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 lip read or use sign language, even with hearing aids
- **Profound deafness** – usually need to lip read or use sign language

Hearing loss has significant personal and social costs and can lead to high levels of isolation and consequent mental ill health, more than doubling the risk of depression in older people. People with mild hearing loss also have nearly double the chance of developing dementia and this risk increases significantly for those with moderate and severe hearing loss. People with hearing loss are likely to withdraw from social activities involving large groups of people.

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. The vast majority of people with hearing loss are older and the prevalence increases with age.

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 whilst as many as 40% of deaf children will have additional or complex needs. 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 conditions.

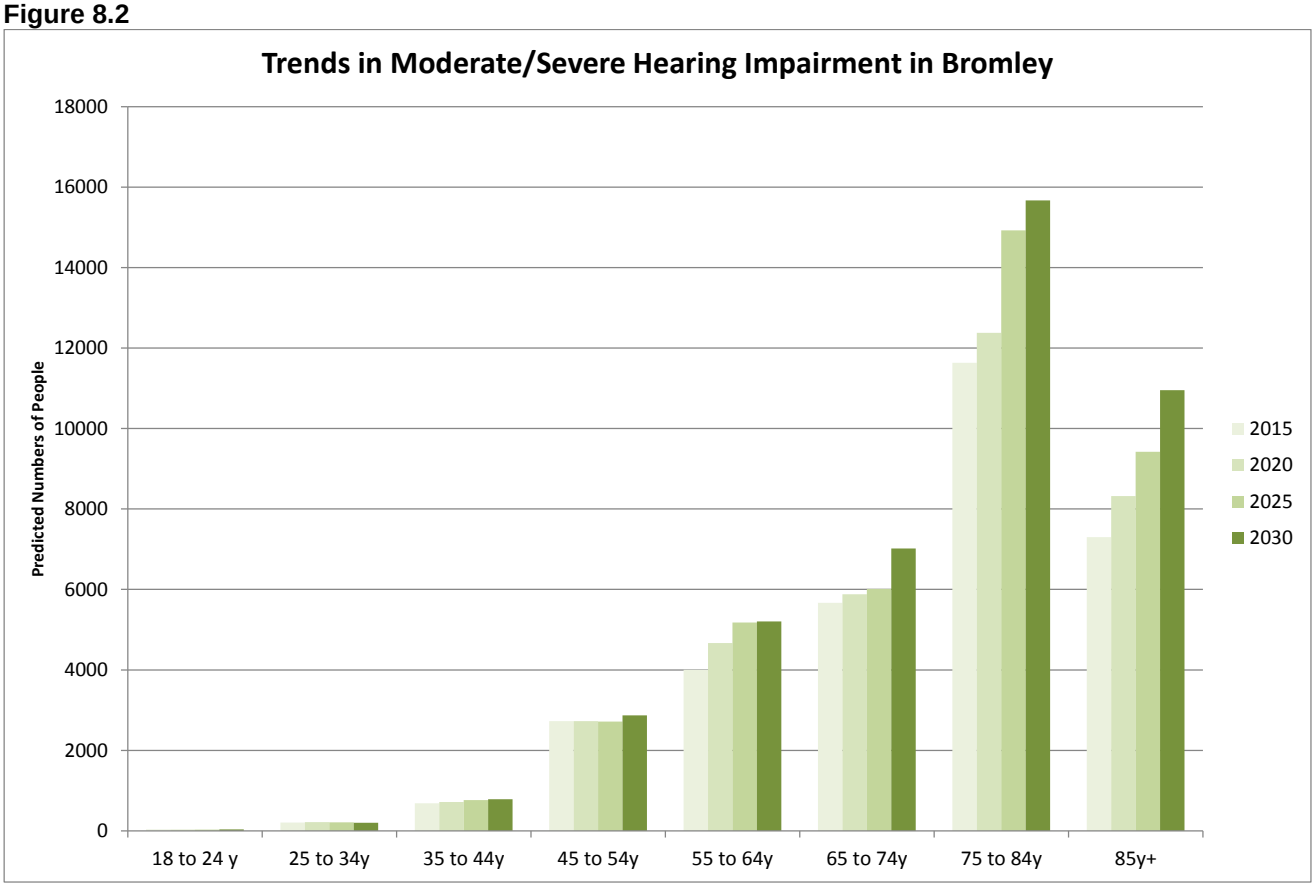
An estimated 250,000 people will have dual sensory loss and this number is set to grow as the population ages, however this is considered a gross underestimate. People with hearing loss are also highly likely to have problems such as tinnitus and balance disorders which contribute as risk factors for falls and other accidental injuries.

There are more than 45,000 deaf children across the UK 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 childhood.

In 2015 in England, 58.9% of deaf children failed to achieve the government benchmark of five GCSEs at grades A* to C, including English and Maths. Research conducted in 2007 found that even at times of low unemployment, people with severe and profound levels of deafness were four times more likely to be unemployed than the general population.

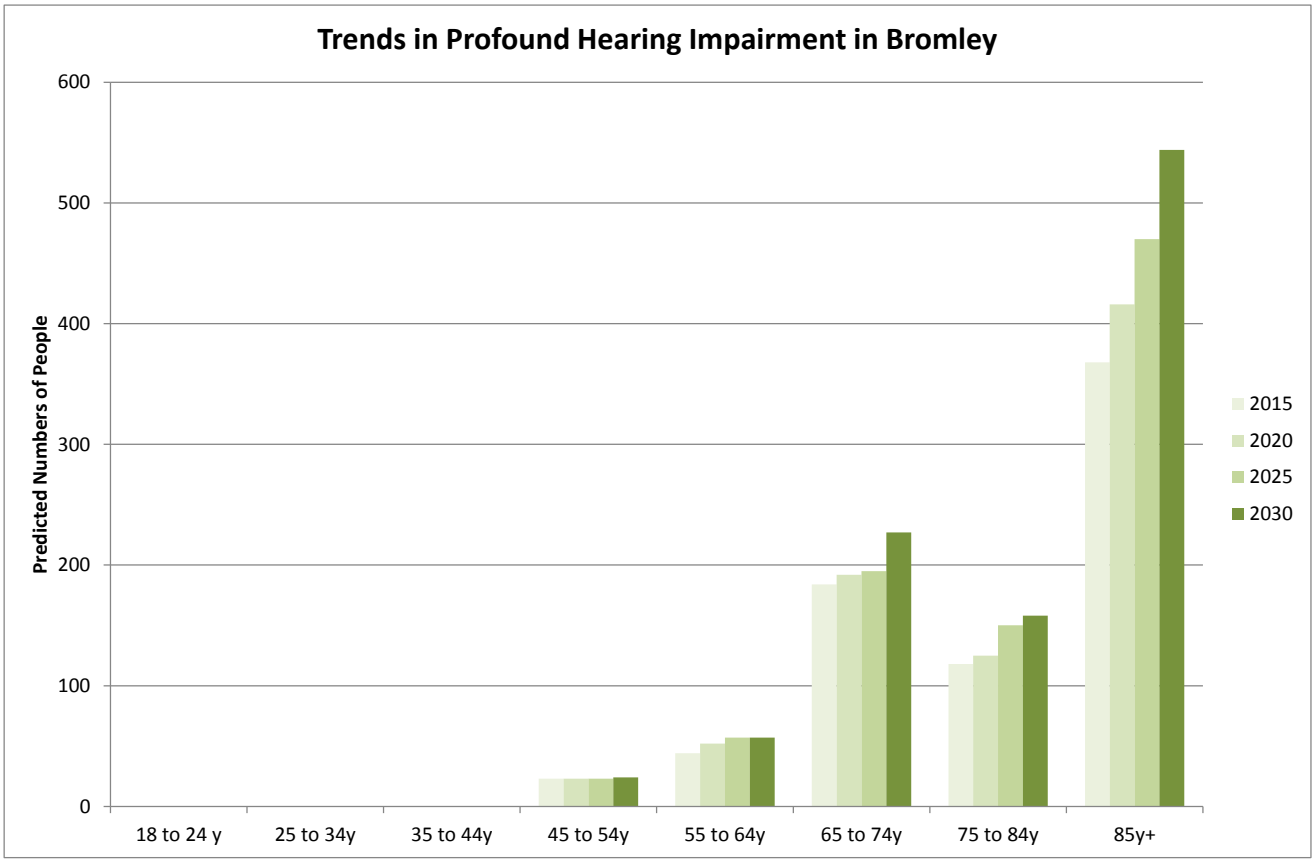
In Bromley, there are over 32,000 adults over the age of 18 years with moderate or severe hearing impairment (predicted to rise to 43,000 by 2030) (Figure 8.2) and a further 737 with profound hearing impairment (predicted to rise to 1,010 by 2030) (Figure 8.3).

Figure 8.2



Source: Projecting Adult Needs and Service Information and Projecting Older People Population Information System October 2016

Figure 8.3

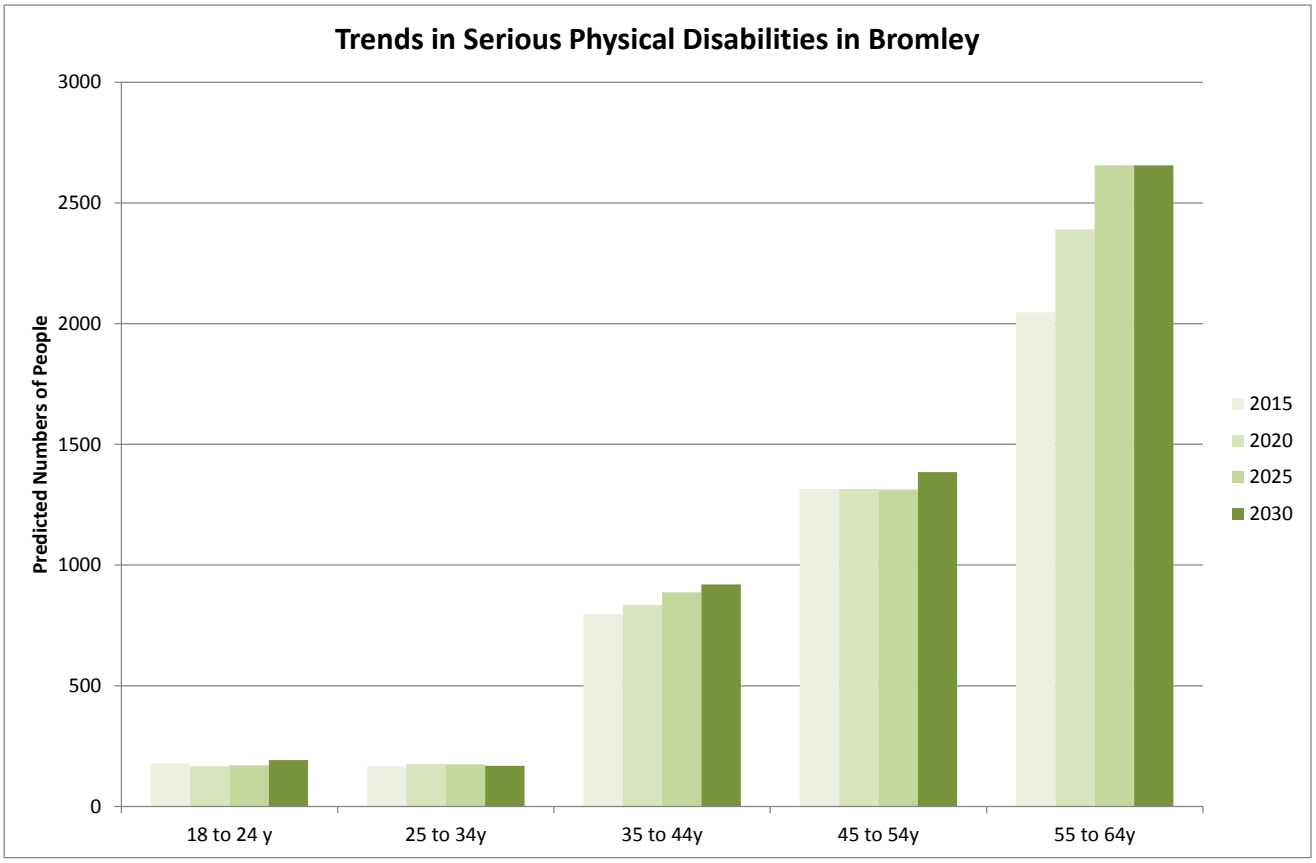


Source Projecting Adult Needs and Service Information and Projecting Older People Population Information System October 2016

Physical Disabilities

It is estimated that there are 19,771 people of working age in Bromley who have a physical disability, about 10% of the population aged 18-64. This figure is projected to increase to 22,900 by the year 2030. Of these, approximately 4,500 currently have a serious physical disability, and by 2030, this number is predicted to rise to over 5300 (Figure 8.4).

Figure 8.4



Source Projecting Adult Needs and Service Information October 2016

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

Employment rates in disabled people aged 16–64 years in Bromley are 49%, compared to 81% in people without a disability in Bromley (table 8.8).

Table 8.8 Employment rates in people with and without disabilities, 2015

Employment Rate in Disabled people 2015		
	Disabled 16-64 (Equality Act core or Work Limiting)	Non-Disabled 16-64
Bromley	49%	81%
Inner London	49%	77%
Outer London	51%	78%

Source: London Datastore, Accessed August 2016

What this means for Bromley residents and for children in Bromley.

The prevalence of eye conditions as a whole will continue to increase in Bromley, due to an ageing population and increase in factors such as diabetes and obesity, which are associated with eye disease. The three most common eye conditions in Bromley, based on epidemiological models, are likely to be early AMD, background diabetic retinopathy and glaucoma.

In Bromley, 665 people were registered severely sight impaired (blind) and 615 registered sight impaired (partially sighted) as of 31st March 2014. Although the number of people on the register of sight impairment is around 1300, a far greater number of people, almost 10,000, have sight loss that impacts on daily life.

Two thirds of registered blind and partially sighted people of working age are not in paid employment, and nearly half of blind and partially sighted people feel 'moderately' or 'completely' cut off from people and things around them.

In Bromley, there are over 32,000 adults over the age of 18 years with moderate or severe hearing impairment (predicted to rise to 43,000 by 2030) and a further 757 with profound hearing impairment (predicted to rise to 1,010 by 2030).

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.

It is estimated that there are 19,771 people of working age in Bromley who have a physical disability, about 10% of the population aged 18-64. This figure is projected to increase to 22,900 by the year 2030. Of these, approximately 4,500 currently have a serious physical disability, and by 2030, this number is predicted to rise to over 5300.

Employment rates in disabled people aged 16–64 years in Bromley are far lower than

employment rates in the general population.

9. End of Life Care

Introduction

It is recognised that good quality end of life care is critically important in giving the individual patient and their family a positive experience of care at what can be a difficult time in their lives.

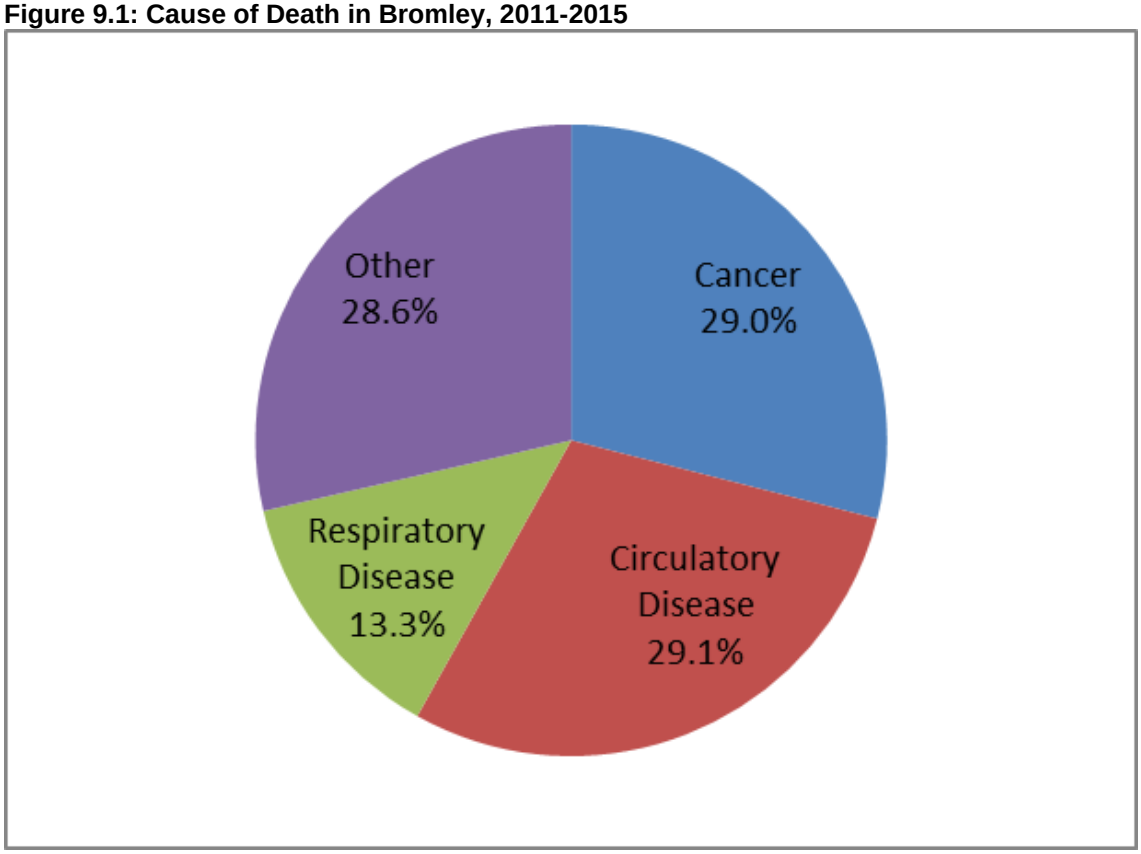
Therefore, there is value in identifying this group of patients correctly and in raising awareness of good end of life care through education particularly for health and social care professionals.

Good end of life care is about predicting and meeting need at the right time rather than giving defined timescales. There is good evidence that people are more likely to receive well-co-ordinated, high quality care if improvements are made in predicting people at the end of life whatever their diagnosis and including them on a register.

Deaths in Bromley

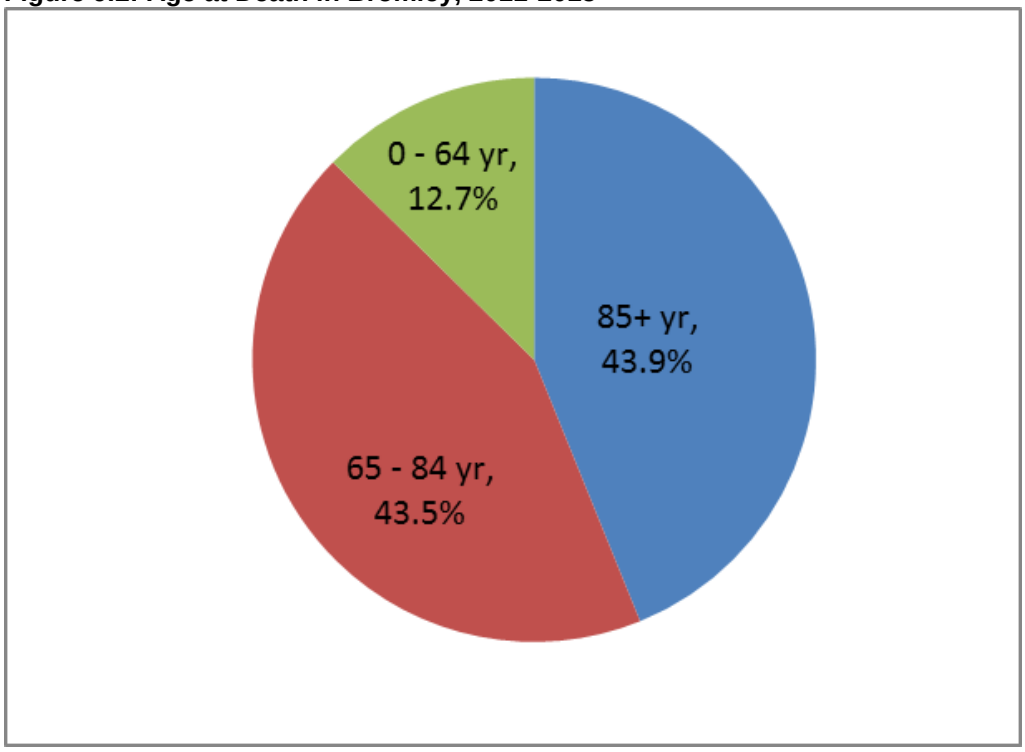
Between January 2015 and December 2015 there were 2,463 deaths in Bromley.

Figure 9.1: Cause of Death in Bromley, 2011-2015



Source: PCMD, 2016

Figure 9.2: Age at Death in Bromley, 2011-2015



Source: PCMD, 2016

Place of Death

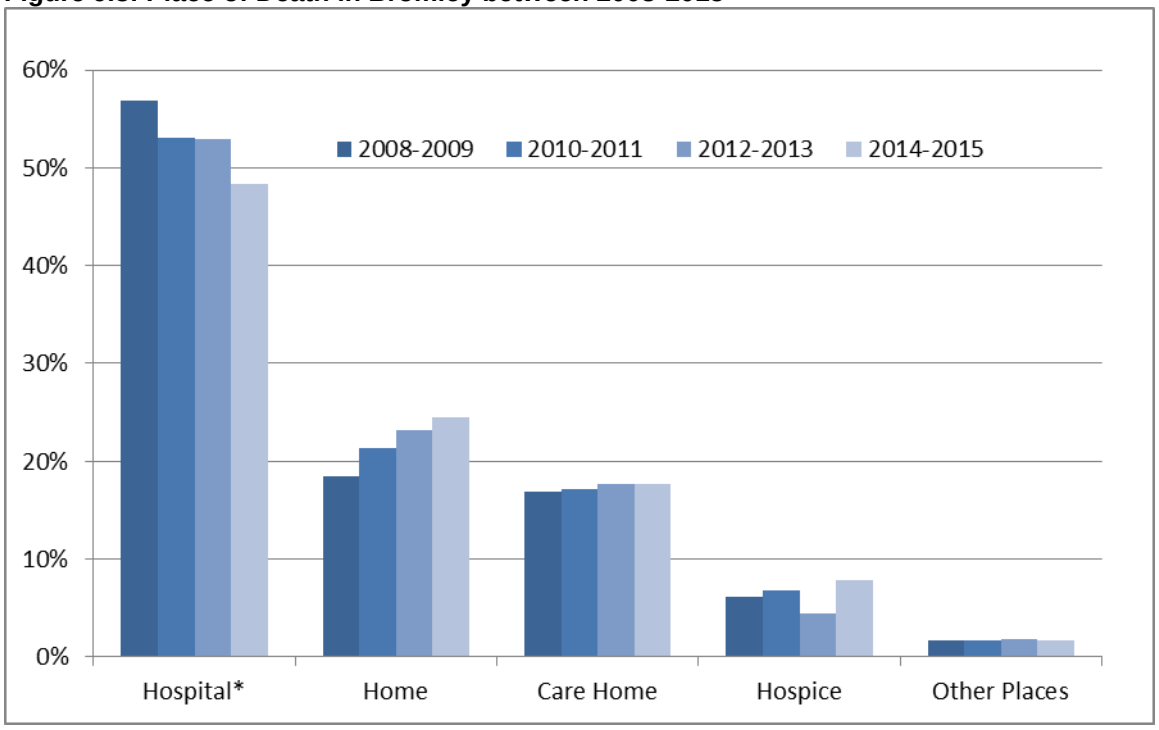
The period 2014-15 saw a small reduction in hospital deaths and an increase in deaths occurring in hospices compared with the period 2012-13.

Table 9.1 Place of Death

Place of Death	2012-2013	2014-2015
Hospital	53%	48%
Home	23%	24%
Care Home	18%	18%
Hospice	4%	8%
Other Places	2%	2%

Source: HSCIC/PCMD, Accessed 2016

Figure 9.3: Place of Death in Bromley between 2008-2015

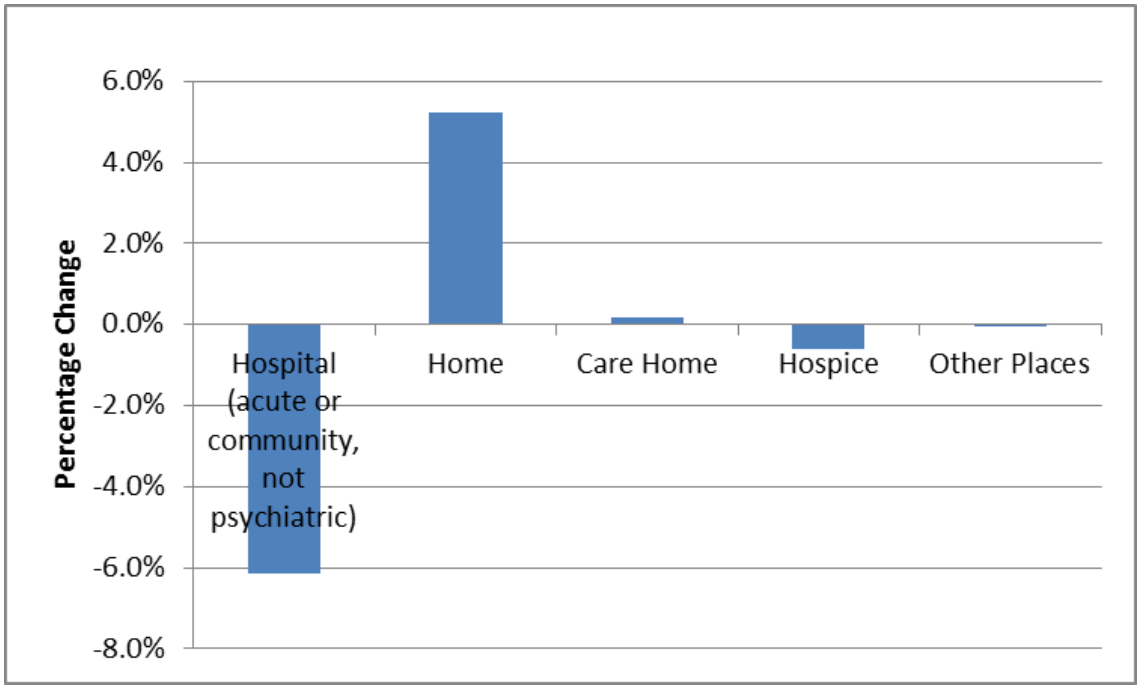


Source: PCMD, 2016

* Acute or Community, not Psychiatric

Since 2008, there has been a consistent reduction in the proportion of hospital deaths and a consequent increase in deaths at home. Deaths in care homes have not increased as much since 2008, however, they remain above 2008 levels.

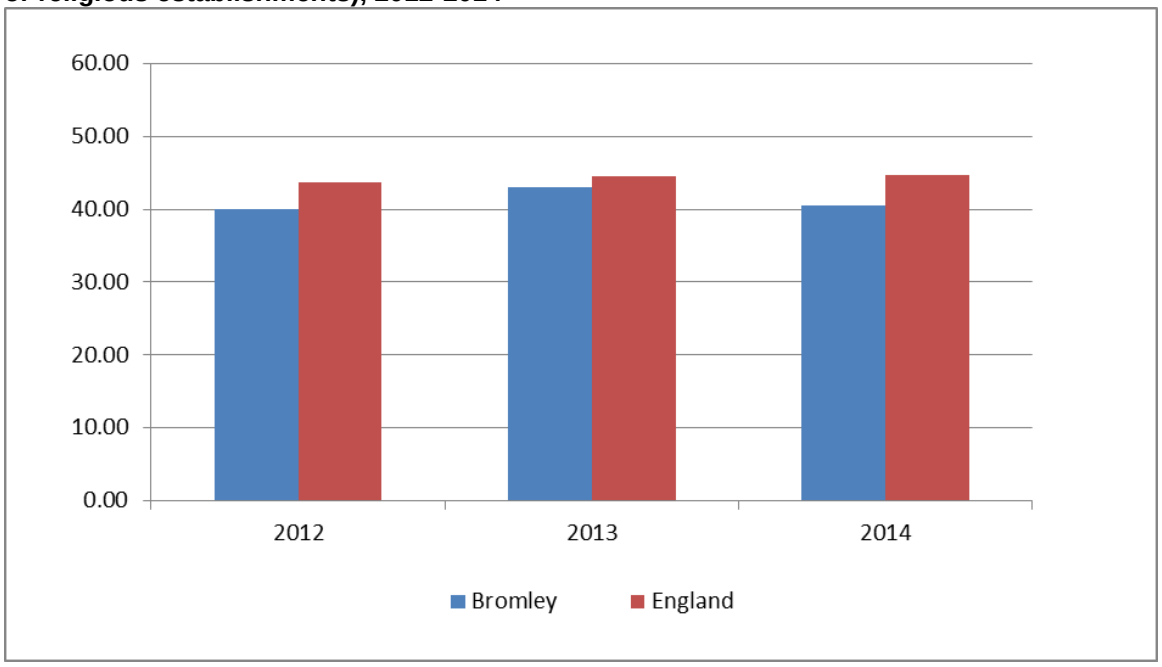
Figure 9.4: Percentage Change in Deaths in Bromley by Place of Death between 2008-2010 and 2013-2015



Source: PCMD, 2016

Although the number has increased, the proportion of deaths occurring in usual place of residence in Bromley has been consistently lower than the England average over the last two years.

Figure 9.5 Percentage of all registered deaths occurring in usual residence (home, care home or religious establishments), 2012-2014

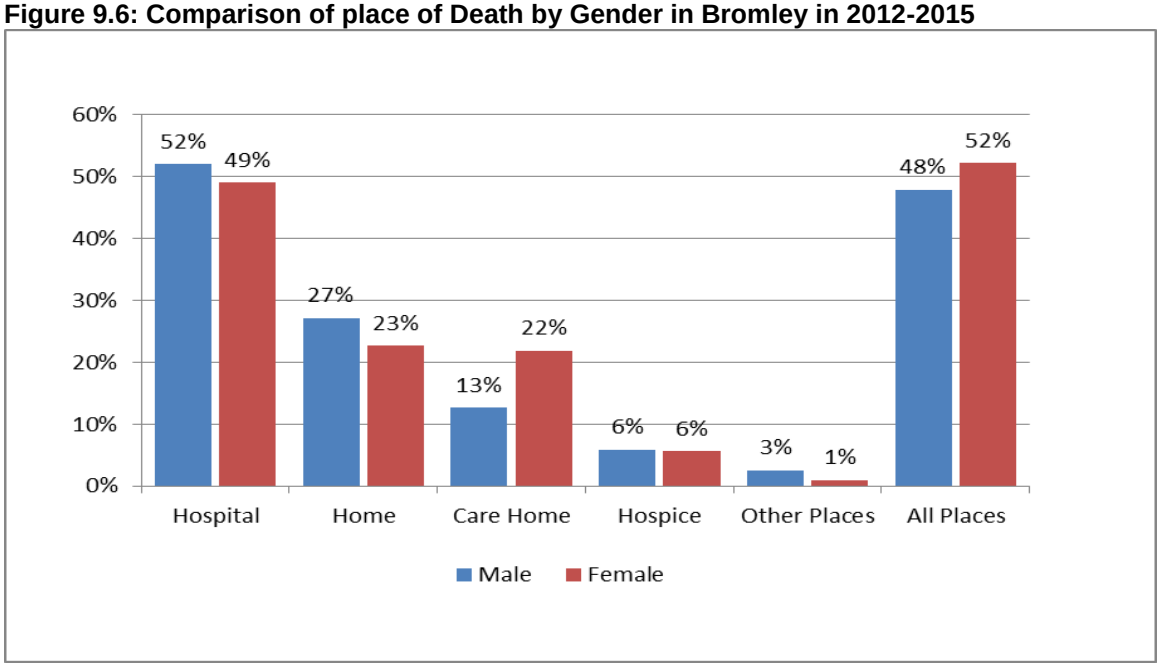


Source: End of Life Care Profiles, 2016

Place of death by gender

Hospital is still the most common place of death for both men and women, but the next most frequent place of death is at home for women and also men. Only 13% of men die in care homes as compared with 22% of women, which is reflective of the higher proportion of women residing in care homes due to their longer life expectancy.

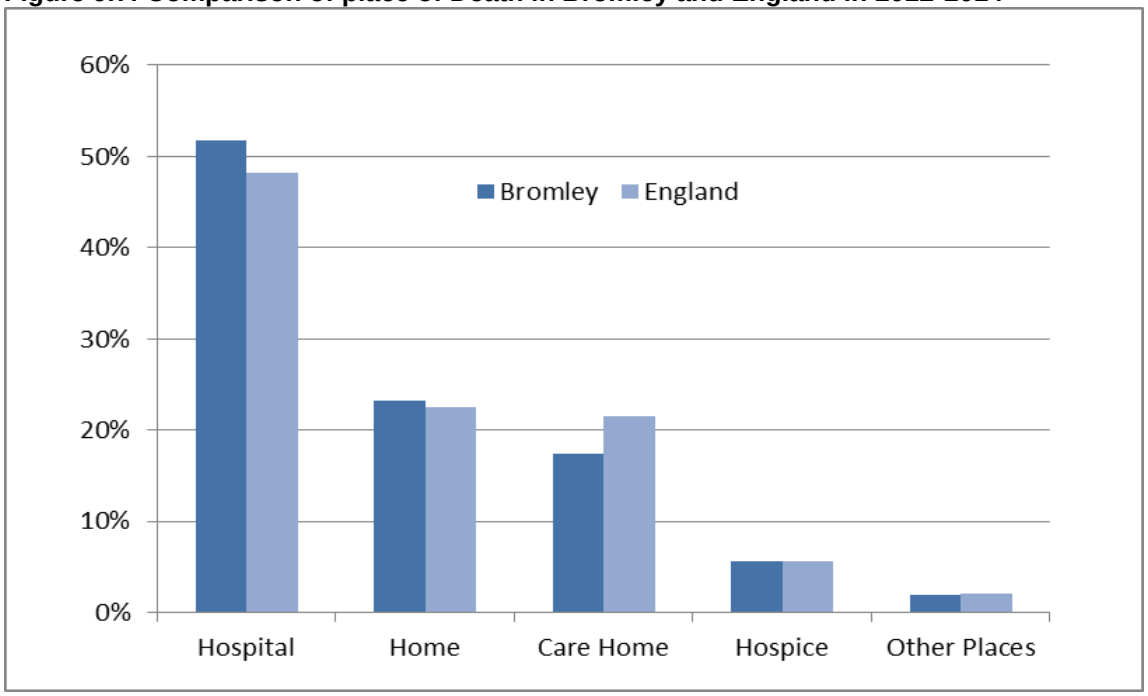
Figure 9.6: Comparison of place of Death by Gender in Bromley in 2012-2015



Source: PCMD, Accessed 2016

Compared to the national average, people in Bromley are more likely to die in hospital. Additionally to this, a significantly higher proportion of people die in care homes nationally than in Bromley.

Figure 9.7: Comparison of place of Death in Bromley and England in 2012-2014



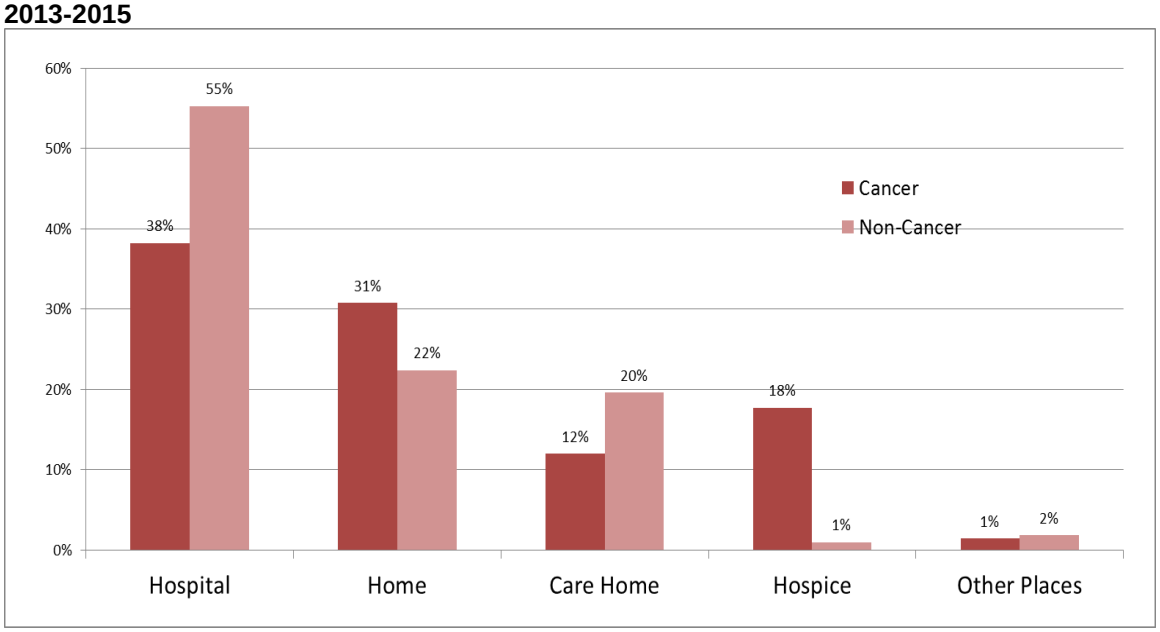
Source: End of Life Care Profiles, 2016

Place of death by underlying cause of death

During 2013-15, there were differences in place of death between cancer and non-cancer deaths. Both cancer and non-cancer deaths were more likely to occur in hospital, at 38% and 55% respectively. The most striking difference is the far higher proportion of cancer deaths (18%) in a hospice than non-cancer deaths (1%).

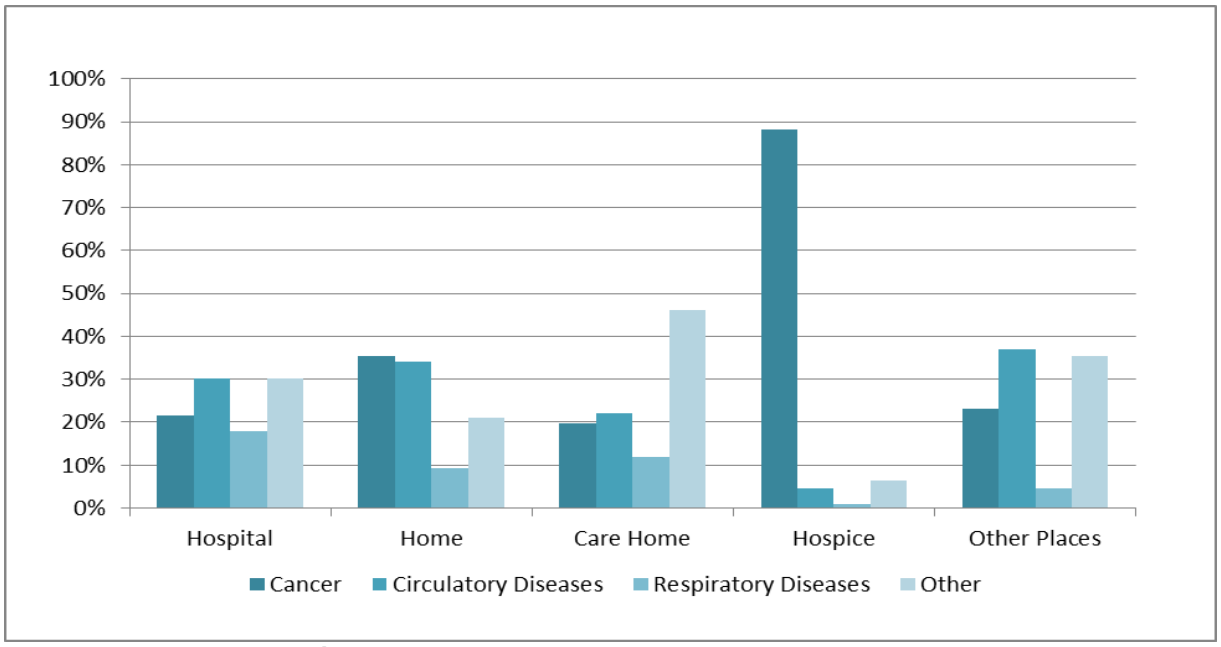
Of the non-cancer deaths, a higher proportion of circulatory deaths occur at home than those from other causes (Figure 9.8 and Figure 9.9).

Figure 9.8: Comparison of Place of Death by Cause of Death in Bromley 2013-2015



Source: PCMD, Accessed 2016

Figure 9.9: Comparison of Place of Death by Cause of Death in Bromley 2013-2015



Source: PCMD, Accessed 2016

Differences in place of death also occur with age. Hospital remains the most common site for all age groups. In addition to this, as age increases the number of deaths occurring in a care home also increases.

Table 9.2: Place of Death by Age, Annual Average 2012-2014

Place of Death	Bromley (Percentage)				England (Percentage)			
	<65 yrs	65-84 yrs	85+ yrs	All Ages	<65 yrs	65-84 yrs	85+ yrs	All Ages
Hospital	49.29	53.62	50.59	51.76	46.26	51.15	45.49	48.18
Home	7.32	1.26	0.94	1.90	6.94	1.53	1.00	2.15
Care Home	2.44	11.53	27.96	17.44	2.83	14.79	36.61	21.47
Hospice	10.37	7.41	2.44	5.65	10.55	7.20	1.96	5.67
Other Places	30.59	26.18	18.07	23.25	33.42	25.33	14.95	22.52

What this means for residents of Bromley

- Despite a decrease in the number of deaths at hospital and an increase of deaths at home, there is scope to improve the proportion of deaths in the preferred place of death in Bromley.
- Bromley has a lower than national average proportion of deaths in the usual place of residence.
- Deaths are overall more likely to occur in hospital than elsewhere.
- Deaths occurring in a hospice are far more likely to be related to cancer than non-cancer causes.

10. Useful References

All Topic Areas

The following two references provide links to sites with guidelines and profiles for many of the areas considered in the JSNA.

Public Health England Data and Analysis Tools:

https://www.gov.uk/guidance/phe-data-and-analysis-tools

National Institute for Health and Care Excellence (NICE):

https://www.nice.org.uk/

Alcohol

The Government's Alcohol Strategy, Home Office. (2012)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf

UK Chief Medical Officers' Low Risk Drinking Guidelines, August 2016
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

Domestic Violence

HM Government ending violence against women and girls strategy 2016-2020

Pan London Domestic Violence Needs Assessment Report 2016

Office of National Statistics – Intimate personal violence and serious sexual assault.

Mayor's office for Police and Crime – Domestic and sexual violence dashboard:
https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-research/crime%20/domestic-and-sexual

Further reading into Mirabal intimate partner abuse research
https://www.dur.ac.uk/criva/projectmirabal/

CPS Violence Against Women and Girls Report 2013/2014

End of Life Care

End of Life Care Strategy, 2014

http://www.ncpc.org.uk/sites/default/files/End%20of%20Life%20Care%20Strategy%20New%20Ambitions%20Report_WEB.pdf

Actions for End of Life Care: 2014-16

http://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf

End of Life Care Profiles

http://fingertips.phe.org.uk/profile/end-of-life

Health & Wellbeing Strategy

Bromley Health and Wellbeing Strategy 2012 -2015

http://bromley.mylifeportal.co.uk/content/doc.aspx?id=3077

Obesity – Adults and Children

NHS London Healthy Urban Development Unit . Using the planning system to control hot food takeaways: A good practice guide. 2013.
http://www.healthyurbandevelopment.nhs.uk/wp-content/uploads/2013/12/HUDU-Control-of-Hot-Food-Takeaways-Feb-2013-Final.pdf

NICE Quality Standard 6 - *Diabetes in adults* (March 2011)
http://www.nice.org.uk/guidance/qualitystandards/diabetesinadults/diabetesinadultsqualitystandard.jsp

NICE Public Health Guidance 11 - *Maternal and child nutrition* (November 2014)
http://guidance.nice.org.uk/PH11

NICE Public Health Guidance 27 – *Weight management before, during and after pregnancy* (July 2010)
http://guidance.nice.org.uk/PH27

NICE Public Health Guidance 35 – *Type 2 Diabetes Prevention: Population and community-level interventions* (May 2011)

http://guidance.nice.org.uk/PH35

NICE Public Health Guidance 38 – *Type 2 Diabetes: Prevention in people at high risk* (July 2012)
http://guidance.nice.org.uk/PH38

NICE Public Health guidance 42: *Obesity - working with local communities* (November 2012)
http://publications.nice.org.uk/obesity-working-with-local-communities-ph42

NICE Public Health guidance 46: *BMI: Preventing ill health and premature death in black, Asian and other minority ethnic groups* (July 2013)
http://guidance.nice.org.uk/PH46

NICE Public Health guidance 47 – Weight Management: lifestyle services for overweight or obese children and young people (October 2013)
http://publications.nice.org.uk/managing-overweight-and-obesity-among-children-and-young-people-lifestyle-weight-management-ph47

NICE Clinical Guideline 43 – *Obesity prevention* (March 2015)
https://www.nice.org.uk/guidance/CG43

Public Health England. Making the case for tackling obesity, 2015.
https://www.noo.org.uk/slide_sets

Public Health England. Adult obesity and type two diabetes. July 2014.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338934/Adult_obesity_and_type_2_diabetes_.pdf

Public Health England. Density of Fast Food Outlets by local authority in England, 2014
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/296248/Obesity_and_environment_March2014.pdf

The Information Centre - *National Child Measurement Programme - England, Publications*
http://content.digital.nhs.uk/article/2021/Website-Search?q=NCMP&go=Go&area=both

The Royal College of Physicians – *Action on obesity: comprehensive care for all* (September 2015)
http://www.rcplondon.ac.uk/sites/default/files/action-on-obesity.pdf

The School Food Plan – a series of actions to improve food in schools
http://www.schoolfoodplan.com/

Statistics on Obesity, Physical Activity and Diet: England 2016.
http://content.digital.nhs.uk/catalogue/PUB20562/obes-phys-acti-diet-eng-2016-rep.pdf

Physical activity

British Heart Foundation. Economic Costs of Physical Inactivity (2013)
http://www.bhfactive.org.uk/userfiles/Documents/eonomiccosts.pdf

Health Economics Assessment Tool. World Health Organisation (2014)
http://www.heatwalkingcycling.org/

Department of Health. Start Active, Stay Active. A report on physical activity for health from the four home countries' Chief Medical Officers, 2011.
http://www.bhfactive.org.uk/userfiles/Documents/startactivestayactive.pdf

Department of Health. UK physical activity guidelines, 2011.
https://www.gov.uk/government/publications/uk-physical-activity-guidelines

NICE Public Health Guidance 2 – *Four commonly used methods to increase physical activity* (March 2015)
https://www.nice.org.uk/guidance/PH2

NICE Public Health Guidance 8 – *Physical activity and the environment* (January 2008)
http://guidance.nice.org.uk/PH8

NICE Public Health Guidance 13 – *Promoting physical activity in the workplace* (May 2008)
http://guidance.nice.org.uk/PH13

NICE Public Health Guidance 17 – *Physical activity for children and young people* (January 2009)
http://guidance.nice.org.uk/PH17

NICE Public Health guidance 41: *Physical activity: Walking and cycling* (November 2012)
http://guidance.nice.org.uk/PH41

NICE Public Health guidance 44: *Physical activity - brief advice for adults in primary care* (May 2013)

http://guidance.nice.org.uk/PH44

NICE Public Health guidance 54: *Physical activity: exercise referral schemes* (September 2014)
https://www.nice.org.uk/guidance/ph54

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11. Glossary

Acronym	Definition
A&E	Accident & Emergency
AF	Atrial Fibrillation
AIDS	Acquired Immune Deficiency Syndrome
AMD	Age related Macular Degeneration
BPAS	British Pregnancy Advisory Service
CAB	Citizens Advice Bureau
CCG	Clinical Commissioning Group
CD4	Cluster of Differentiation 4 (Type of White Blood Cell)
CHAIN	Combined Homelessness and Information Network
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
CLA	Children Looked After
CLeaR	**C**hallenge services, provide **Lea**dership and examine **R**esults
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
COVER	Cover of Vaccination Evaluated Rapidly
CPS	Crown Prosecution Service
CQUIN	Commissioning for Quality and Innovation
CSE	Child Sexual Exploitation
CVD	Cardiovascular Disease
DALY	Disability Adjusted Life Year
DCLG	Department for Communities and Local Government
DFLE	Disability-Free Life Expectancy
DSR	Directly Standardised Rate
DTaP	Diphtheria, Tetanus and Pertussis Vaccine
DV	Domestic Violence
DVA	Domestic Violence/Abuse
DVIP	Domestic Violence Intervention Programme
EHC	Education, Health and Care
EoLC	End of Life Care
ETE	Education, Training and Employment
EYFS	Early Years Foundation Stage
FAST	Fast Alcohol Screening Test
FFO	Fast Food Outlet
FGM	Female Genital Mutilation

Acronym	Definition
FSM	Free School Meals
GCSE	General Certificate of Secondary Education
GFR	General Fertility Rate
GLA	Greater London Authority
GP	General Practitioner
GUM	Genitourinary Medicine
HbA1C	Glycosylated Haemoglobin
HBV	Honour Based Violence
HCAI	Healthcare Associated Infection
HEAT	Health Economic Assessment Tool
HED	Heavy Episodic Drinking
Hib	Haemophilus influenza type b
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSL	Healthy Schools London
IDSVA	Independent Domestic & Sexual Violence Advisor
IPV	Inactivated Polio Vaccine
IUS	Intra-uterine system
JCVI	Joint Committee on Vaccination and Immunisation
JSNA	Joint Strategic Needs Assessment
KS 1-4	Key Stage 1-4
KS1	Key Stage 1
LARC	Long Acting Reversible Contraception
LBB	London Borough of Bromley
LGA	Large for Gestational Age
LGBT	Lesbian Gay Bisexual Transgender
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Support Hub
MenC	Meningitis C
MMR	Measles Mumps and Rubella vaccine
MOPAC	Mayor's Office for Policing and Crime
MPS	Metropolitan Police Service
MRSA	Multi Resistant Staphylococcus aureus
MSI	Marie Stopes International
MSM	Men who have Sex with Men
MSOA	Middle Layer Superoutput Area
NCMP	National Child Measurement Programme
NDHG	Non-Diabetic Hyperglycaemia
NEET	Not in Employment, Education or Training
NHS	National Health Service

Acronym	Definition
NICE	National Institute for Health and Care Excellence
NOIDS	Notification of Infectious Diseases
NPA	Nightly Paid Accommodation
ONS	Office for National Statistics
OSS	One Stop Shop
PANSI	Projecting Adult Needs and Service Information
PCMD	Primary Care Mortality Data
PCV	Pneumococcal Conjugate vaccine
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PID	Pelvic Inflammatory Disease
PM2.5	Particulate Matter (less than 2.5 micrometers diameter)
POPPI	Projecting Older People Population Information System
PPV	Pneumococcal Vaccine
PRS	Private Rental Sector
PRUH	Princess Royal University Hospital
PSHE	Personal, Social and Health Education
RAG	Red Amber Green (Traffic Light Rating)
RNIB	Royal National Institute for the Blind
RP	Registered Providers
RRT	Renal Replacement Therapy
SDQ	Strengths and Difficulties Questionnaire
SED	Socioeconomic Deprivation
SELHP	South East London Housing Partnership
SEN	Special Educational Needs
SEND	Special Educational Needs and Disability
SES	Socioeconomic Status
SHLAA	Strategic Housing Land Availability Assessment
SHMA	Strategic Housing Market Assessment
SHS	Second Hand Smoke
SIDS	Sudden Infant Death Syndrome
SII	Slope Index of Inequality
SLHPT	South London Health Protection Team
SRE	Sex and Relationship Education
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWA	Social Work Assessment
TA	Temporary Accommodation

Acronym	Definition
TB	Tuberculosis
TFR	Total Fertility Rate
TOP	Termination of Pregnancy
VARC	Victim Assessment and Referral Centre (Victim Support)
VAWG	Violence Against Women and Girls
VTEC	Vero cytotoxin-producing Escherichia coli
WHO	World Health Organisation
YP	Young Person