BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2025

Adult Mortality and Morbidity

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Executive summary

This Mortality and Morbidity Joint Strategic Needs Assessment (JSNA) provides an analysis of health outcomes within the London Borough of Bromley, focusing on mortality and morbidity trends, key health challenges, and disparities across different populations. The purpose of this report is to inform public health planning, resource allocation, and the development of targeted interventions aimed at improving health outcomes, reducing inequalities, and addressing the key health issues affecting Bromley residents.

Key findings:

- **Mortality trends**: Bromley has seen a consistent decline in overall mortality rates over the past two decades, with the borough generally reporting lower rates than the regional and national averages. However, a slight increase in 2023, influenced by the COVID-19 pandemic, has been observed. Males have a higher mortality rate than females, though both genders have experienced a decline over time.
- **Life expectancy**: Life expectancy in Bromley has increased steadily since 2001, with males seeing an increase from 77.2 to 81.8 years and females from 81.9 to 85.9 years. These figures remain higher than national and regional averages. However, life expectancy inequality has increased slightly, with a gap between the most and least deprived areas, indicating a need for targeted health interventions in more deprived areas.
- **Leading causes of mortality and morbidity**: Cancer (27%), cardiovascular diseases (23%), and respiratory infections (20%) are the leading causes of death in Bromley.
    - Diabetes, obesity, and alcohol-related prevalence are also rising concerns, reflecting the growing burden of lifestyle-related diseases.
    - Respiratory diseases and cardiovascular health remain significant challenges, although mortality rates from these conditions have declined over the past two decades.
    - Emergency hospital admissions for coronary heart disease, stroke and myocardial infarction are significantly lower in most Bromley wards compared to England's levels, with very few wards having similar ratios. COPD admissions in Crystal Palace (192.3) are nearly double the national average and there are 30% more admissions due to COPD in Penge and Cator (standardised admission ratio of 130), when compared to England.
- **Health inequalities**: Significant health disparities exist between Bromley's most and least deprived areas, particularly in relation to chronic diseases such as cardiovascular conditions, cancer, and respiratory diseases. Addressing these inequalities through focused interventions in socioeconomically disadvantaged areas is critical to improving overall health outcomes.
- **Risk factors**: The top three risk factors contributing to early death and disability are high systolic blood pressure, high LDL cholesterol and dietary risks such as low intake of fruits, vegetables, and fibre, and high intake of sodium, processed meat, and trans-fatty acids. Other key lifestyle risk factors include high fasting plasma glucose, high body mass index and tobacco use. These factors are contributing to increased morbidity and mortality, particularly among adults.

- **Age-specific trends**: Cancer, cardiovascular diseases and respiratory diseases dominate mortality in older age groups (65+).

1.Introduction

The London Borough of Bromley, located in the Southeastern part of Greater London, is one of the largest boroughs by area and has a diverse population with varied socioeconomic backgrounds. Understanding the mortality and morbidity rates in Bromley is crucial for public health planning, resource allocation, and the development of targeted interventions to improve the health and well-being of its residents.

Bromley's overall mortality rate is a key indicator of the health status of the population. This measure provides insights into the effectiveness of the healthcare system, living conditions, and the prevalence of chronic diseases. It is essential to compare Bromley's mortality rate with regional and national averages to identify areas requiring attention. Chronic diseases such as diabetes, hypertension, and mental health disorders significantly impact the morbidity in Bromley. Monitoring the prevalence and managing these conditions effectively can improve the quality of life and reduce healthcare costs.

1.1 Purpose of the report

The purpose of this Mortality and Morbidity Joint Strategic Needs Assessment (JSNA) report is to provide a comprehensive analysis of mortality and morbidity within the London Borough of Bromley. This report aims to identify key health challenges and disparities affecting the local population, thereby informing strategic planning and policy development to improve health outcomes and reduce inequalities.

1.2 Scope and methodology

This report covers a detailed examination of mortality and morbidity data, including the leading causes of death and the prevalence of major diseases and conditions. The analysis is based on the latest available data from national and local health databases, such as OHID Fingertips, the Primary Care Mortality Database, and data from the 2013 Global Burden of Disease study, providing modelled estimates of the burden of poor health and disability. See Appendix 1 for more detail on the data sources.

1.3 Definitions of mortality and morbidity

The Office for National Statistics (ONS) defines mortality as the number of deaths in a population over a period[1]. This report examines overall mortality rates, age-specific mortality, and the leading causes of death in Bromley. The Department of Health and Social Care (DHSC) defines morbidity as the state of being diseased or unhealthy within a population[2]. It includes the prevalence and incidence of diseases and health conditions, reflecting the overall level of ill health in a population. Morbidity data is crucial for understanding the burden of diseases, identifying health trends, and

[1] Office for National Statistics. (2024). *Mortality statistics in England and Wales QMI*. Retrieved January 20, 2025, from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/mortalitystatisticsinenglandandwalesqmi#:~:text=Mortality%20statistics%20in%20England%20and%20Wales%20are%20based%20on%20the,and%20users%20of%20mortality%20data

[2] Department of Health and Social Care. (2017). Chapter 3: Trends in morbidity and behavioural risk factors. Retrieved January 20, 2025, from https://www.gov.uk/government/publications/health-profile-for-england/chapter-3-trends-in-morbidity-and-behavioural-risk-factors#definitions

informing public health interventions. See Appendix 2 for definitions of key mortality and morbidity terms.

1.4 National context

National strategies to address mortality and morbidity, focus on prevention, early diagnosis, and effective management of chronic diseases. These strategies are designed to improve overall public health outcomes and reduce health inequalities across different population groups. For decades, the UK healthcare system has focused on treating illness. The Green Paper "Advancing Our Health: Prevention in the 2020s" emphasises a shift from treatment to prevention, targeting lifestyle factors such as smoking, obesity, and physical inactivity. It prioritises how long people live in good health, rather than just how long they live. The green paper also addresses the social determinants of health, aiming to reduce preventable diseases and improve life expectancy. By focusing on prevention, the strategy seeks to lower the incidence of chronic conditions, thereby reducing morbidity and mortality[3].

A major part of the national strategy is the 2022 Health and Care Bill, which sets out policies for integrating care services, improving health outcomes, and addressing health inequalities[4]. The bill aims to improve collaboration between the NHS, local authorities, and other public services. This collaborative approach aims to target the root causes of morbidity and mortality, such as socioeconomic deprivation, poor housing, and limited access to healthcare.

The NHS Long Term Plan is a comprehensive strategy aimed at improving health outcomes through prevention, early detection, and management of chronic diseases such as cancer, cardiovascular disease, and diabetes. The plan focuses on enhancing clinical services, promoting early diagnosis, and expanding access to mental health services. A key goal is to increase cancer early detection rates and improve outcomes for heart and respiratory diseases, with an aim to significantly reduce mortality rates by 2028[5].

The Department of Health and Social Care has developed numerous public health campaigns targeting specific health conditions such as smoking, alcohol consumption, and obesity. The "Tackling obesity: empowering adults and children to live healthier lives" campaign, for instance, is part of the government's effort to reduce the rising levels of obesity in the UK, which is a key risk factor for several chronic conditions that contribute to premature mortality, including heart disease, type 2 diabetes, and certain cancers[6]. This initiative emphasises the importance of community-based interventions, healthy school programs, and advertising restrictions on unhealthy foods. By enhancing local public health efforts, it is expected that a more tailored response to regional disparities in health will occur.

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[3] Department of Health & Social Care. (2019.). Advancing our health: Prevention in the 2020s. Retrieved January 20, 2025, from https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/713af73f-5588-4757-b643-ed940dcbc930

[4] UK Parliament. (2022). Health and Care Bill 2021-22. Retrieved January 20, 2025, from https://bills.parliament.uk/bills/3022

[5] NHS England. (2019.). The NHS Long Term Plan. Retrieved January 20, 2025, from https://www.england.nhs.uk/wp-content/uploads/2022/07/nhs-long-term-plan-version-1.2.pdf

[6] Department of Health & Social Care. (2020.). Tackling obesity: empowering adults and children to live healthier lives. Retrieved January 20, 2025, from https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/713af73f-5588-4757-b643-ed940dcbc930

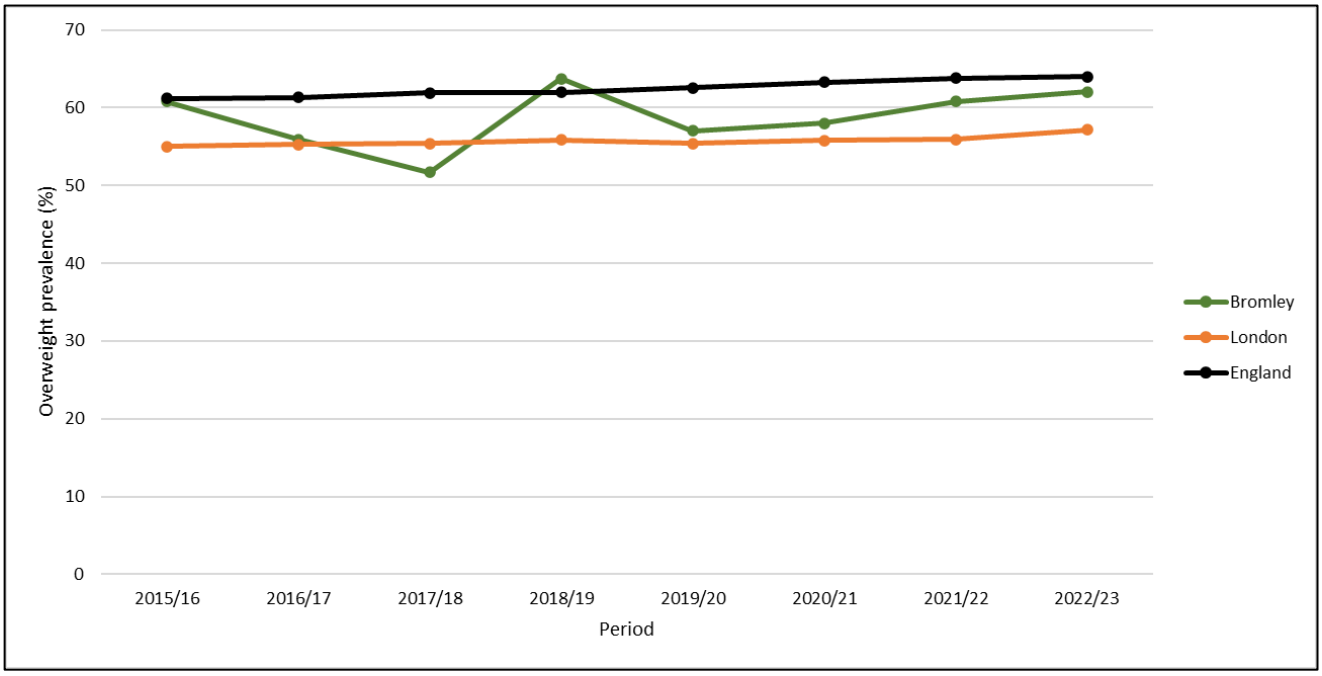
The "Core20PLUS5" framework is a targeted approach to address health inequalities, focusing on the most deprived 20% of the population. It prioritises five clinical areas: cardiovascular disease, cancer, chronic respiratory disease, maternity, and mental health. The strategy aims to improve healthcare access and outcomes for disadvantaged groups, narrowing the gap in mortality and morbidity rates between different socioeconomic groups[7].

[7] NHS England. (2021). Core20PLUS5: National healthcare inequalities improvement programme. Retrieved January 20, 2025, from https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

2. Behavioural risk factors

Understanding behavioural risk factors is crucial because they significantly influence the development and progression of many diseases and health conditions. Behaviours such as smoking, poor diet, drug misuse and excessive alcohol consumption can lead to chronic diseases like heart disease, diabetes, and cancer. By identifying and addressing these risk factors, public health initiatives can target interventions to promote healthier lifestyles, prevent disease, and improve overall health outcomes.

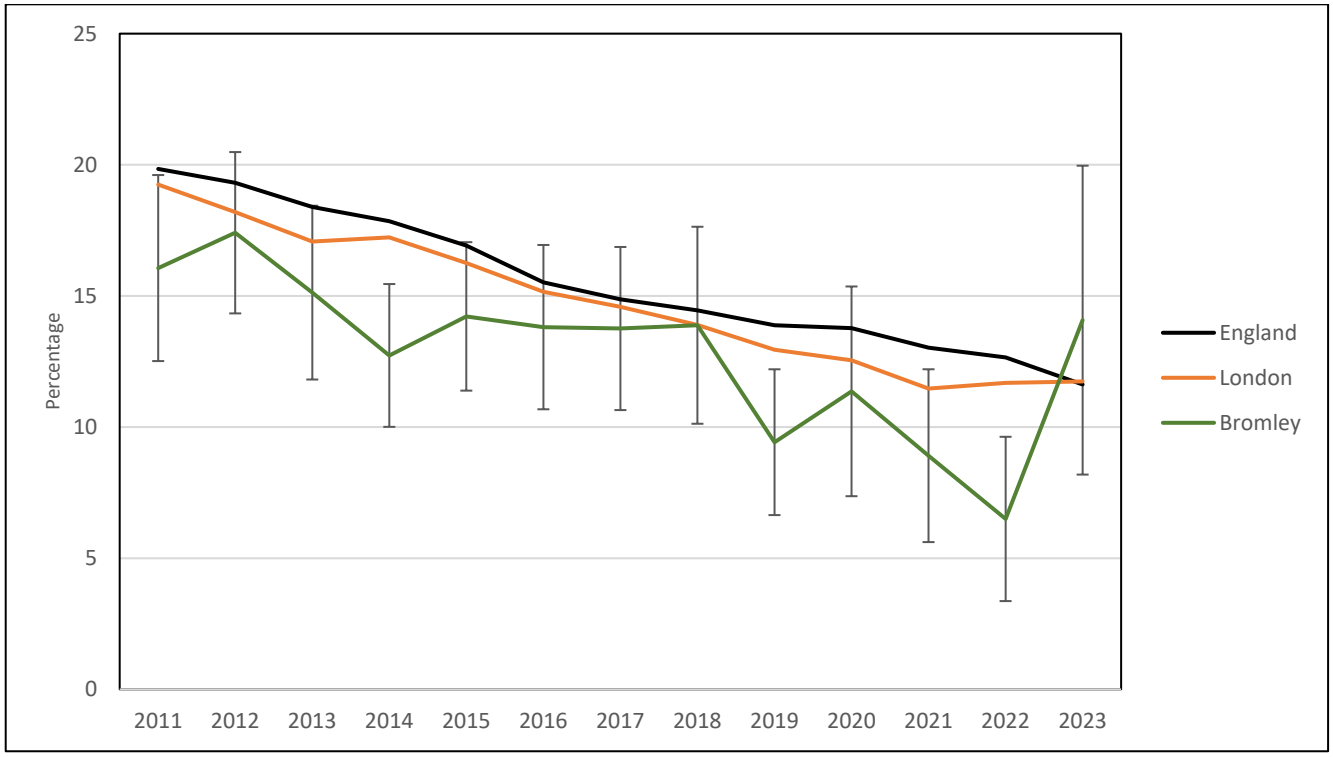
Figure 1: Trend in overweight (including obesity) prevalence in adults (18+ years), Bromley, London and England, 2015/16 – 2022/23.



Source: OHID Fingertips, 2024

In Bromley, the prevalence of overweight and obesity in adults has steadily increased from 60.8% in 2015/16 to 62.1% in 2022/23, showing a rise of 1.3% (Figure 1). While this upward trend mirrors the national pattern, Bromley's rate of increase is slower than that of England, which saw a 2.8% rise over the same period, and slightly faster than London, which experienced a 2.2% increase. Despite Bromley's prevalence being lower than England's, it has seen more fluctuation in its yearly values, suggesting a moderately rising trend in comparison to the more stable but slower growth observed in London.

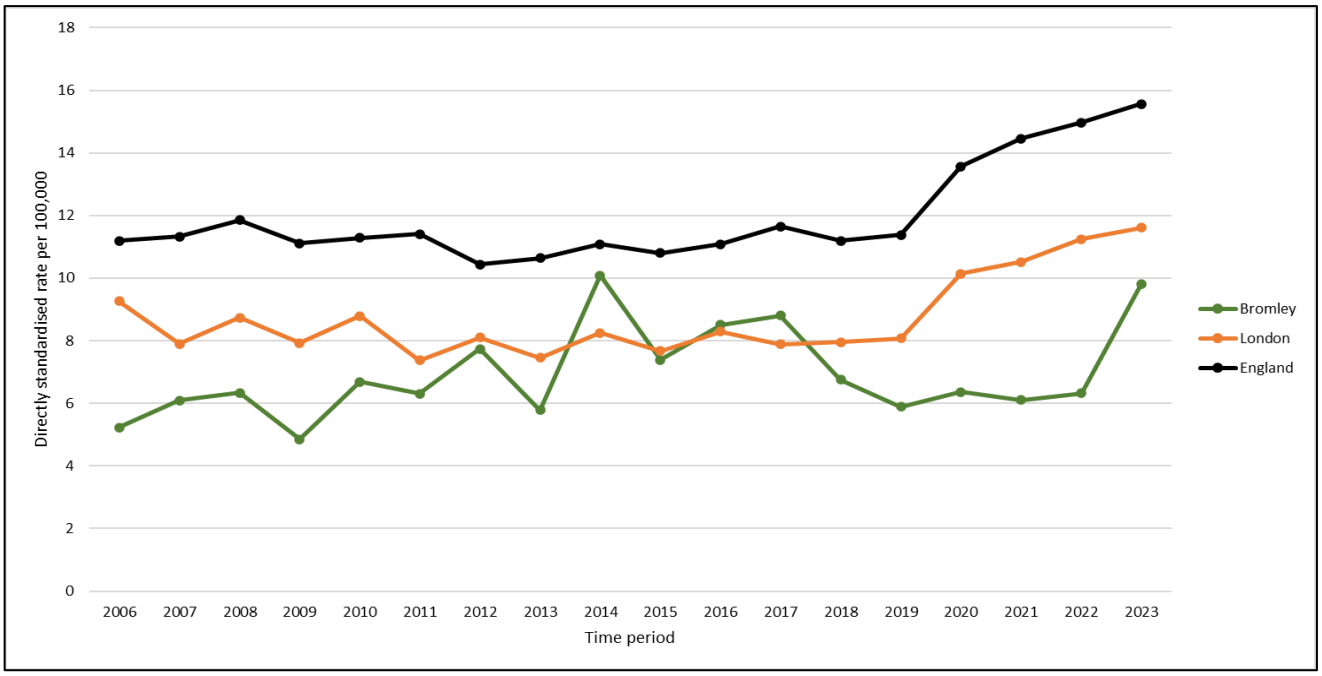
Figure 2: Smoking prevalence in adults (18+ years) - current smokers (APS)



Source: OHID Fingertips, 2024

In Bromley, smoking rates have declined, consistent with national figures (Figure 2). From 2022 to 2023, the prevalence of current smokers has increased from 6.5% to 14.1%, meanwhile national rates have mildly decreased. This rise may have been influenced by potential survey data errors, particularly considering the wide confidence intervals around the estimates. Such fluctuations may suggest uncertainty in the data rather than a genuine increase in smoking rates.

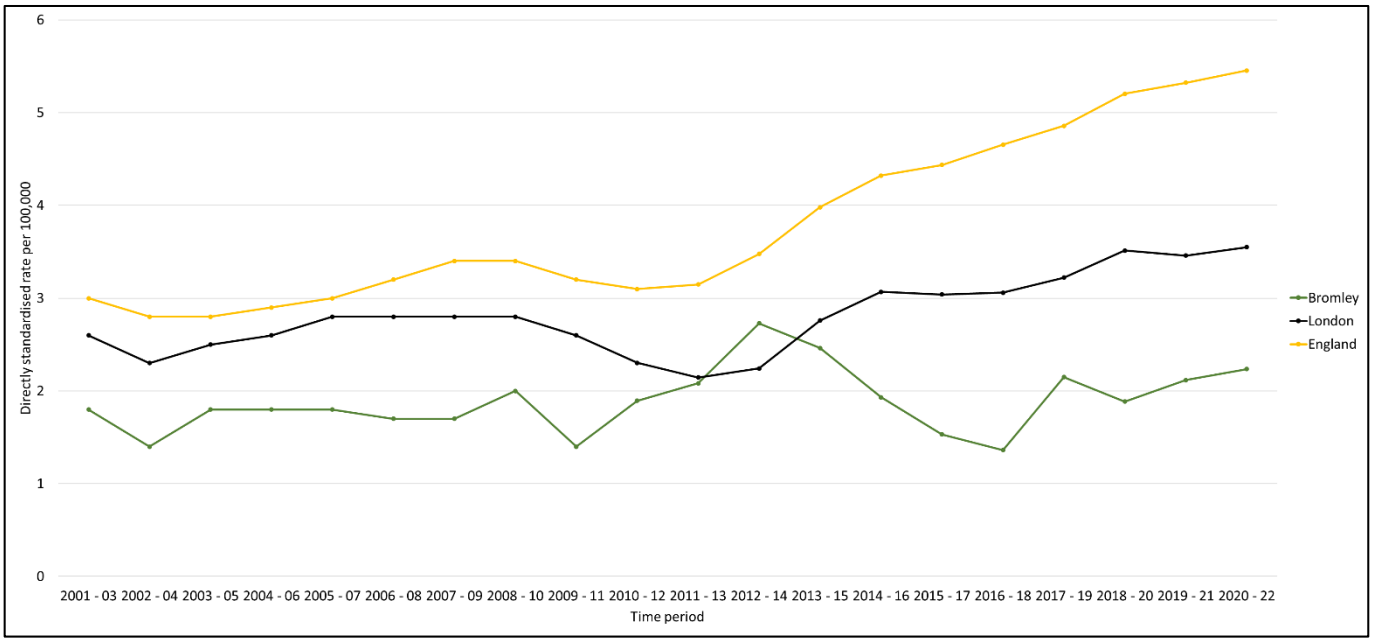
Figure 3: Alcohol-specific mortality, Bromley, London and England, 2006 - 2023



Source: OHID Fingertips, 2024

There has been an increasing trend in alcohol-specific mortality between 2016 and 2023 (Figure 3). Bromley's alcohol-specific mortality rates have fluctuated over the years, with a significant rise observed in the most recent years. While historically lower than both London and England, Bromley's rate has increased notably from 6.4 per 100,000 in 2020 to 9.8 in 2023, marking a rise of approximately 54%. In comparison, London and England also saw increases during the same period, with London rising from 10.15 to 11.60, and England from 13.6 to 15.6. Despite its historically lower rates, Bromley's alcohol-related mortality is now approaching regional levels, highlighting a shift in local health trends.

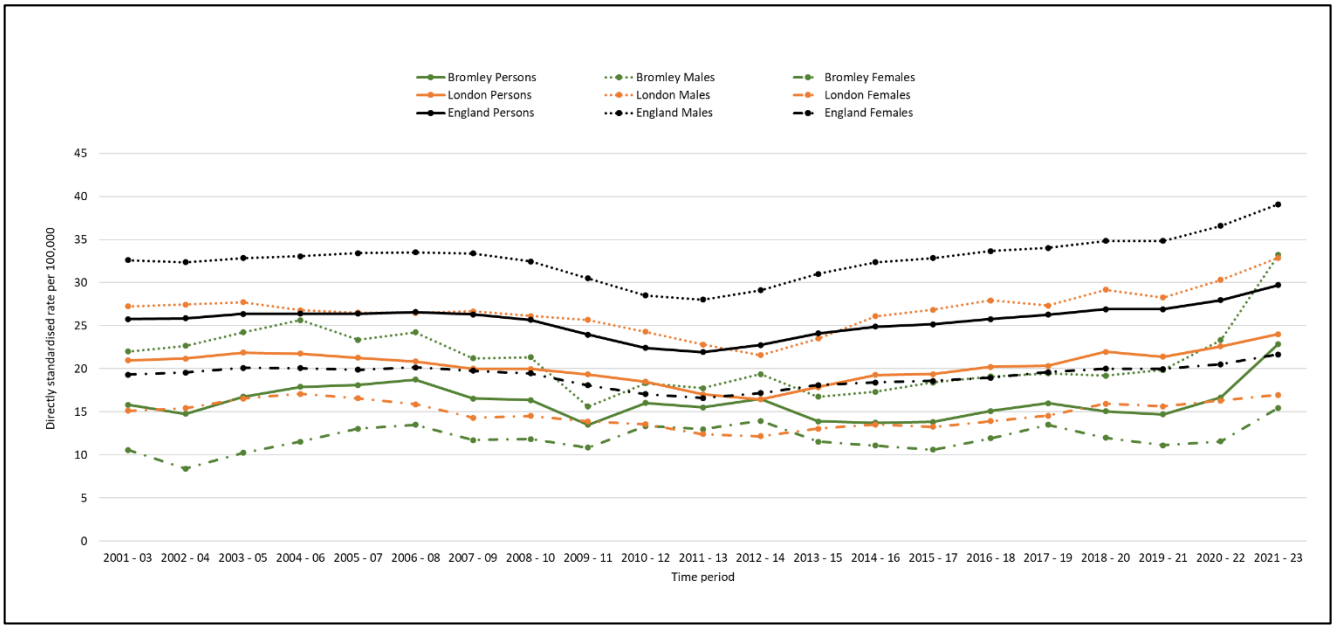
Figure 4: Deaths from drug misuse, Bromley, London and England, 2001 – 2022



Source: OHID Fingertips, 2024

Bromley's drug misuse mortality rates have historically been lower than both London and England, but recent years show an upward trend, increasing from 1.9 per 100,000 in 2018-20 to 2.2 in 2020-22. While this remains below the rates for London (3.6 per 100,000) and England (5.5 per 100,000), the increase suggests a growing concern. In contrast, London's rates have remained relatively stable, and England's rates continue to rise, highlighting a more significant national issue.

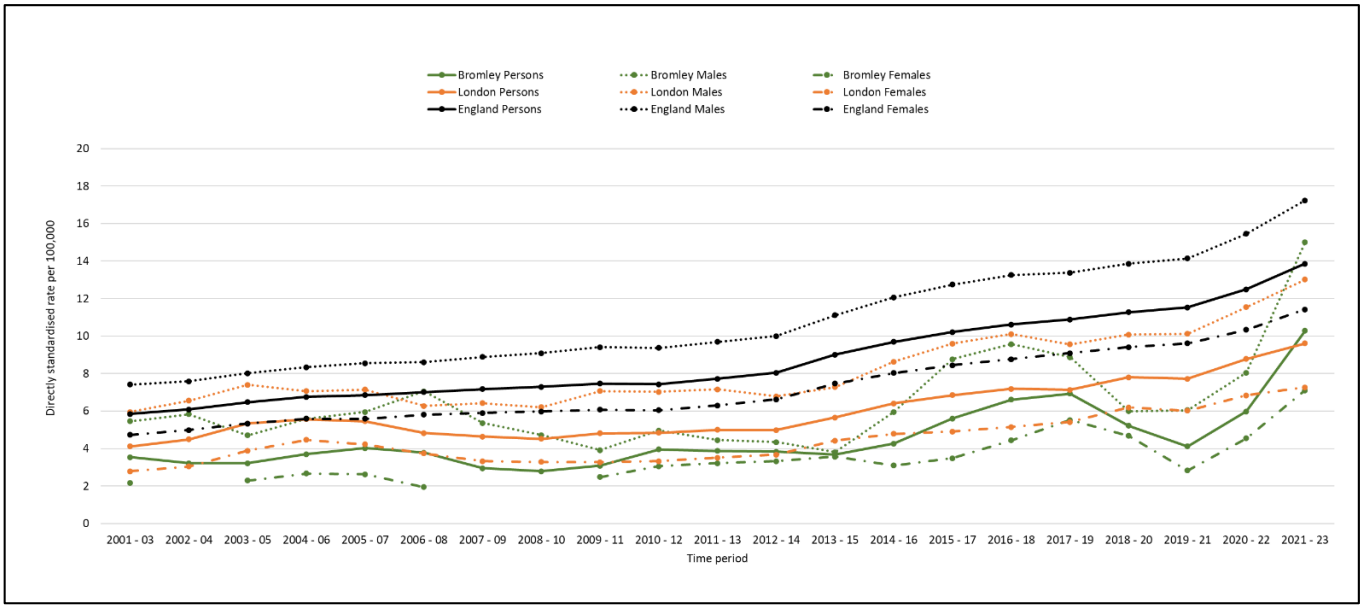
Figure 5: Mortality rate from accidents, Bromley, London and England, 2001 – 2023



Source: OHID Fingertips, 2024

Bromley's mortality rate from accidents has historically been lower than both London and England. However, 2021-23 saw a sharp increase to 22.86 per 100,000, up from 16.66 in 2020-22 (+37%), outpacing regional and national increases. The rise was especially pronounced among males, whose rates increased from 19.2 (2018-20) to 33.2 (2021-23) (+73%), while female rates also increased but to a lesser extent. In comparison, London and England saw much smaller increases in the same period.

Figure 6: Mortality rate from accidental falls, Bromley, London and England, 2001 – 2023



Source: OHID Fingertips, 2024

Bromley's mortality rate from accidental falls has historically been lower than both London and England, but 2021-23 saw a significant surge to 10.3 per 100,000, surpassing London for the first time. This increase was particularly driven by males, whose rate rose from 8.1 (2020-22) to 15.0 (2021-23) (+86%), while female rates remained stable at 7.1 per 100,000. Compared to London

and England, Bromley's recent rise (+72%) far exceeded the national (+11%) and regional (+9.6%) increases.

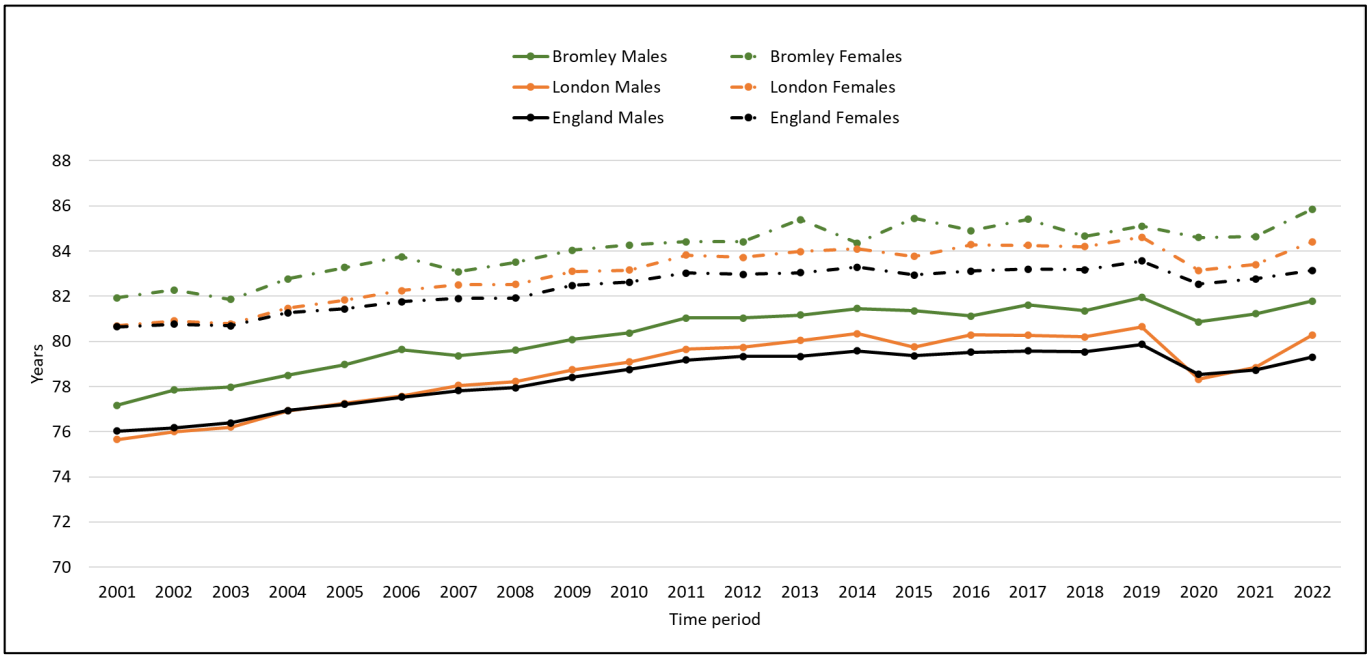
3. Life expectancy

3.1 Life expectancy at birth

Life expectancy at birth is a crucial summary measure of mortality and morbidity, as it informs us on the estimated length of life. This helps local authorities assess other indicators and identify factors influencing life expectancy and healthy life expectancy. Life expectancy at birth estimates the average number of years a person would live based on current mortality rates. For the context of this report, it predicts how long a newborn would live if throughout their life, they experienced the age-specific mortality rates of the Bromley area, from 2001 to 2023.

Following the 2021 Census, the Office for National Statistics (ONS) updated the mid-year population estimates (MYE) it produces, a process done every 10 years. The official population estimates for mid-2012 to mid-2020 have been revised using data from the 2021 Census. The data for life expectancy has been updated to use these revised population estimates from 2012 onwards.

Figure 7: Life expectancy at birth for males and females in Bromley, London and England



Source: OHID Fingertips 2024

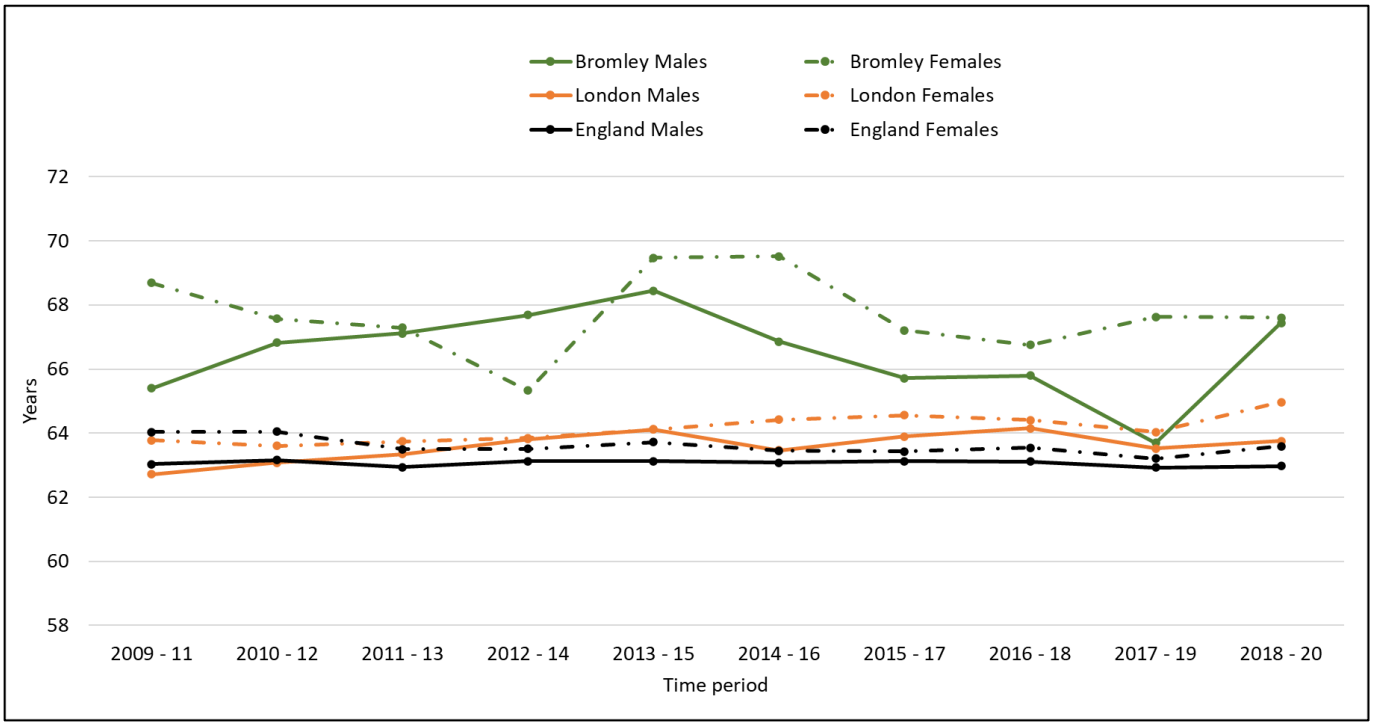
Figure 7 shows life expectancy at birth for Bromley, London and England between the years of 2001 and 2022. There has been an overall increase for both males and females in Bromley, London and England, from 2001 to 2022, the female life expectancy at birth being consistently higher than males' life expectancy (Figure 9). The average number of years a male resident in Bromley would expect to live based on contemporary mortality rates has gone from 77.2 years in 2001 to 81.8 years in 2022, whereas the average number of years a female resident in Bromley would expect to live based on contemporary mortality rates has gone from 81.9 years in 2001 to 85.9 years in 2022. The life expectancy at birth for both male and female residents of Bromley has consistently remained above both regional and national averages. The drop observed around 2019-2020 was likely influenced by the COVID-19 pandemic and affected all three areas. Bromley

demonstrated an increase in life expectancy at birth, from 80.9 years in 2020 to 81.8 years in 2022 in males and an increase from 84.6 years in 2020 to 85.9 years in 2022 in females.

3.2 Healthy life expectancy at birth

Another vital measure of mortality and morbidity is healthy life expectancy at birth, showing the years a person can expect to live in good health rather than with a disability or in poor health. It highlights overall trends in population health, aiding local authorities in assessing and identifying factors influencing healthy life expectancy. The measure estimates the average years a person would live in good health based on current mortality rates and self-reported health status, using data from deaths, mid-year population estimates, and health surveys aggregated over three years. These figures reflect the health and mortality of Bromley residents during each period.

Figure 8: Healthy life expectancy at birth for males and females in Bromley, London and England



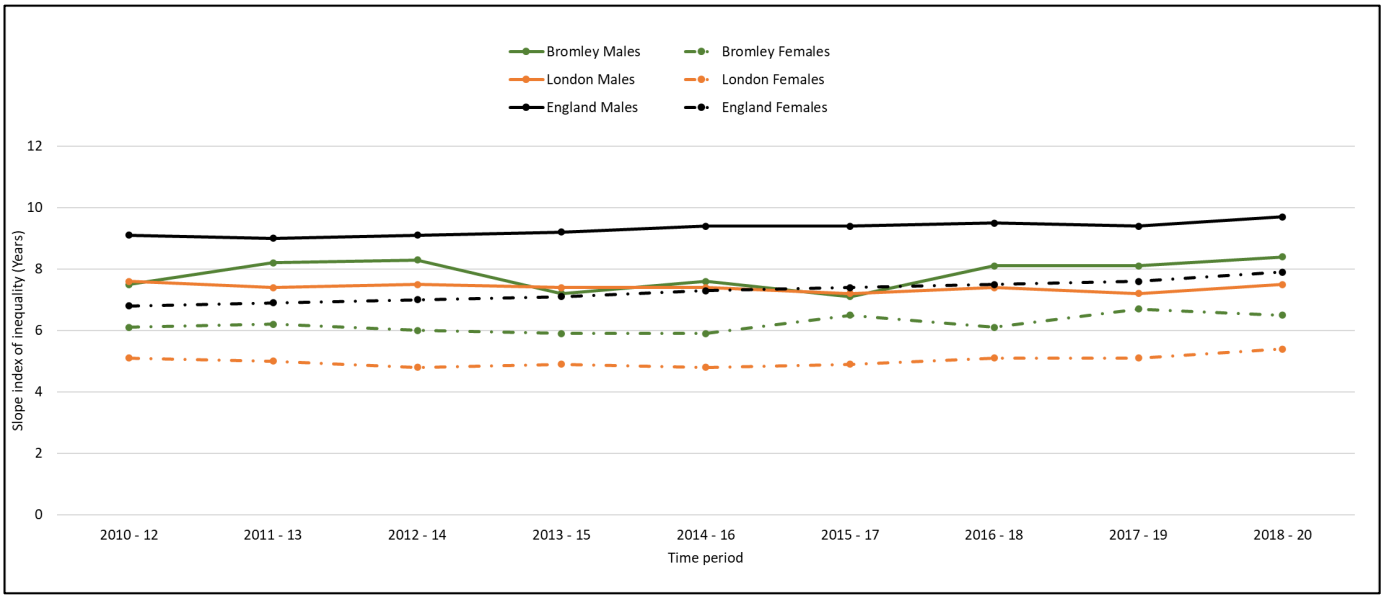
Source: OHID Fingertips 2022

Figure 8 shows a variable trend in the average number of years in good health for both male and female residents in Bromley. Healthy life expectancy at birth for males and females in Bromley is consistently higher than regional and national levels.

3.3 Inequality in life expectancy at birth

Inequality in life expectancy at birth is a crucial high-level health inequalities outcome, central to the Department of Health's goals. It highlights inequalities across England and within local areas, focusing on deprivation at a small area level. By emphasising area-based inequalities, it provides context for local areas to assess other indicators, set priorities, and identify factors affecting life expectancy, particularly in regions with low life expectancy. See Appendix 2 for a full definition of inequality of life expectancy.

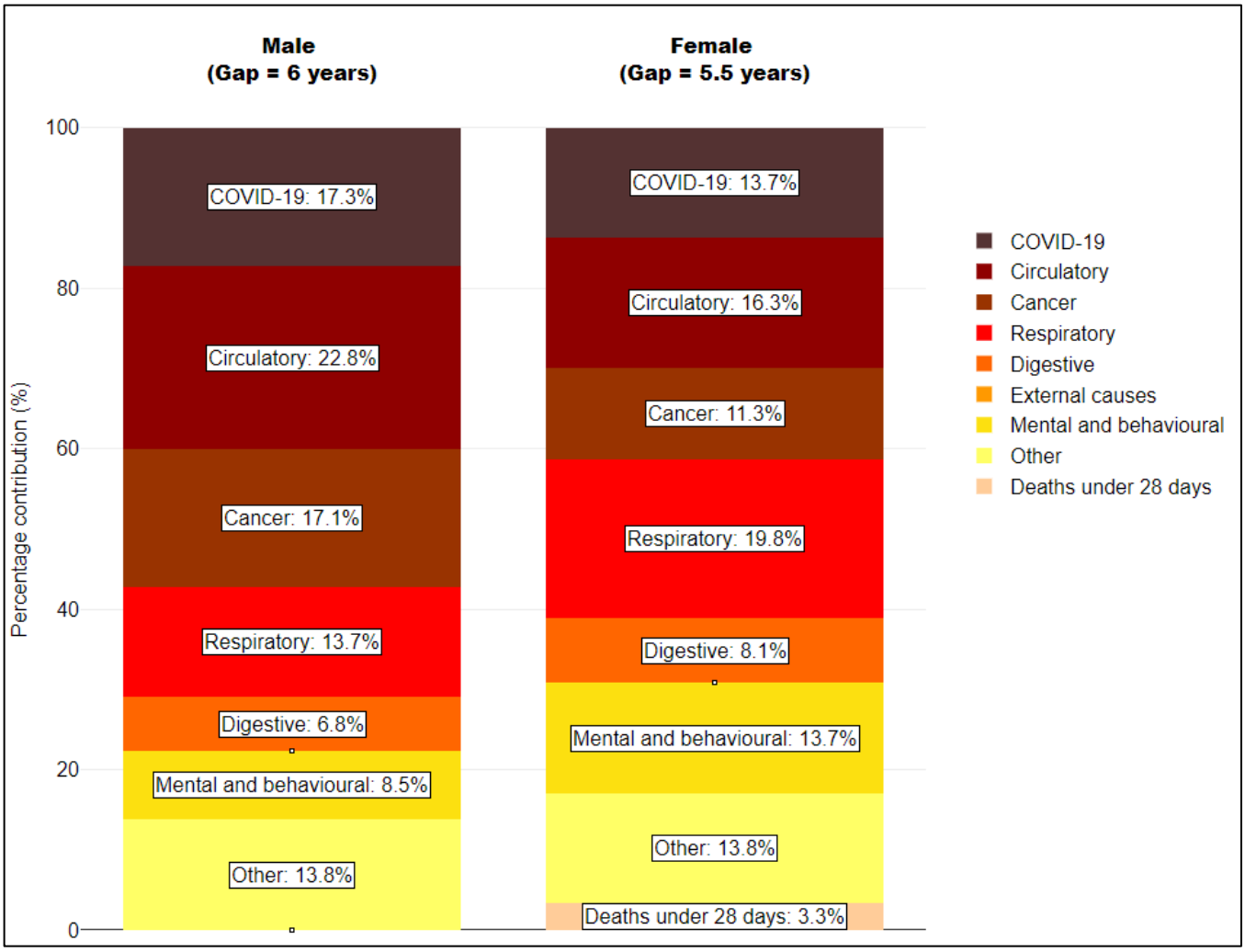
Figure 9: Inequality in life expectancy at birth for males and females in Bromley, London and England



Source: OHID Fingertips, 2022

Both males and females in Bromley show a relatively stable trend in the slope index of inequality, with a minor increase from 2010-12 to 2018-20; 7.5 to 8.4 years in male residents and 6.1 to 6.5 years in female residents (Figure 9). However, Bromley's inequality of life expectancy at birth for both males and females are higher than London levels but lower than England levels. Addressing these differences through targeted healthcare support and community initiatives can help reduce disparities and promote overall well-being.

Figure 10: Breakdown of the life expectancy gap between the most and least deprived quintiles of Bromley by cause of death, 2020 to 2021



Source: OHID Segment tool, 2022

The life expectancy gap between the most and least deprived quintiles in Bromley (6 years for males, 5.5 years for females) is driven by disparities in key causes of death (Figure 10). Circulatory diseases are the largest contributor for males (22.8%) and a significant factor for females (16.3%), followed by COVID-19 (17.3% males, 13.7% females) and cancer (17.1% males, 11.3% females). Covid-19 is seen as prominent because the data was recorded during the COVID-19 pandemic period but the inequality of the life expectancy gap is expected to be more impacted by other causes. Respiratory diseases contribute more to the female gap (19.8%) than males (13.7%), while mental and behavioral disorders disproportionately affect females (13.7%) compared to males (8.5%). Digestive diseases (6.8% males, 8.1% females) and infant deaths (3.3% in females) further highlight socio-economic health disparities. These findings emphasise the need for targeted interventions in cardiovascular and respiratory health, cancer screening, mental health support, and maternal care to reduce inequalities and improve life expectancy in deprived populations.

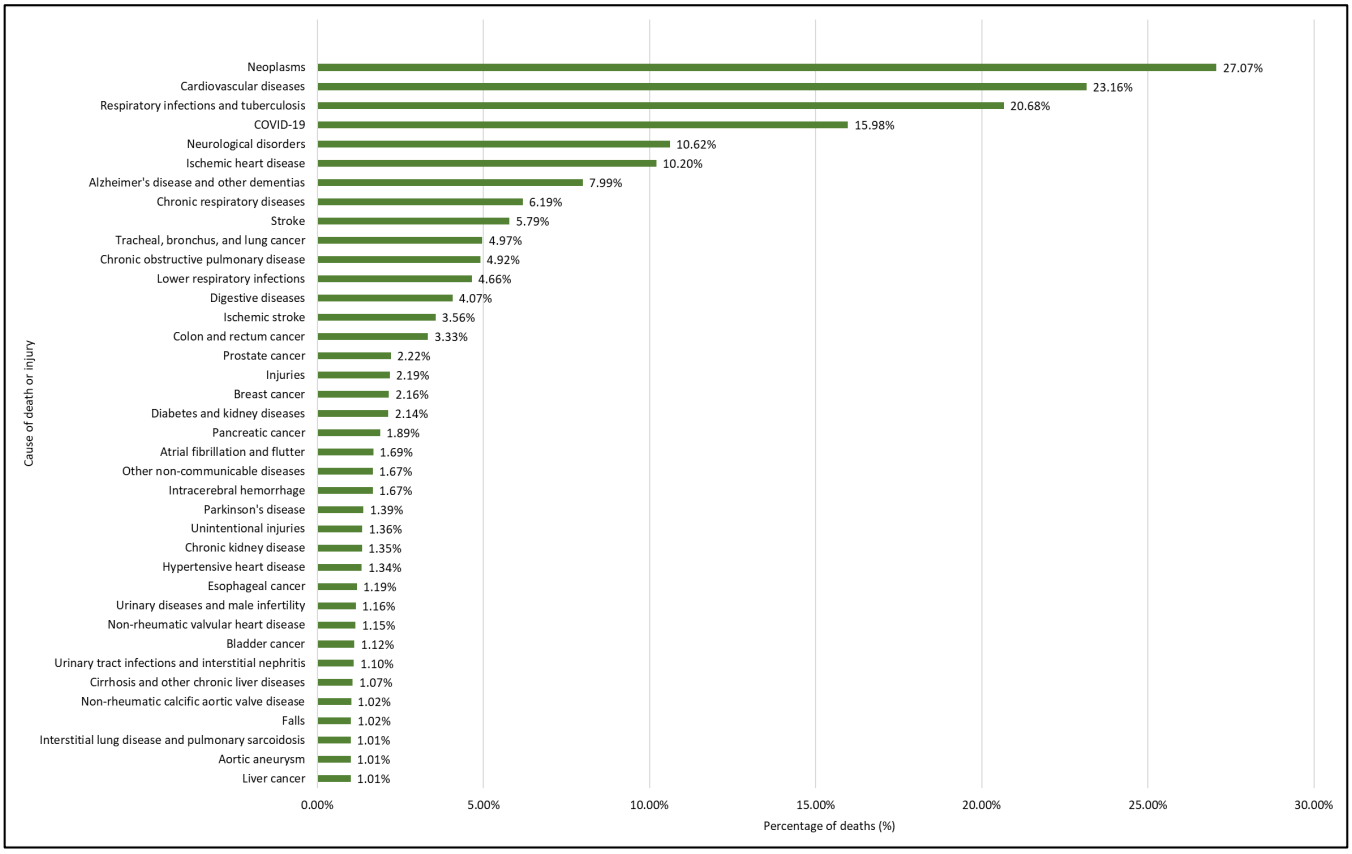
4. Morbidity

4.1 The Global Burden of Disease

The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) is an international research initiative that assesses the impact of various diseases and risk factors. It quantifies the burden of disease by combining years of life lost due to premature death with years lived in less-than-optimal health. Disability Adjusted Life Years (DALYs) are calculated by adding the years lived with disability (YLD) and the years of life lost (YLL). YLD represents the time spent in suboptimal health, whether the condition is temporary or lifelong, while YLL accounts for the years lost due to deaths occurring before the expected lifespan.

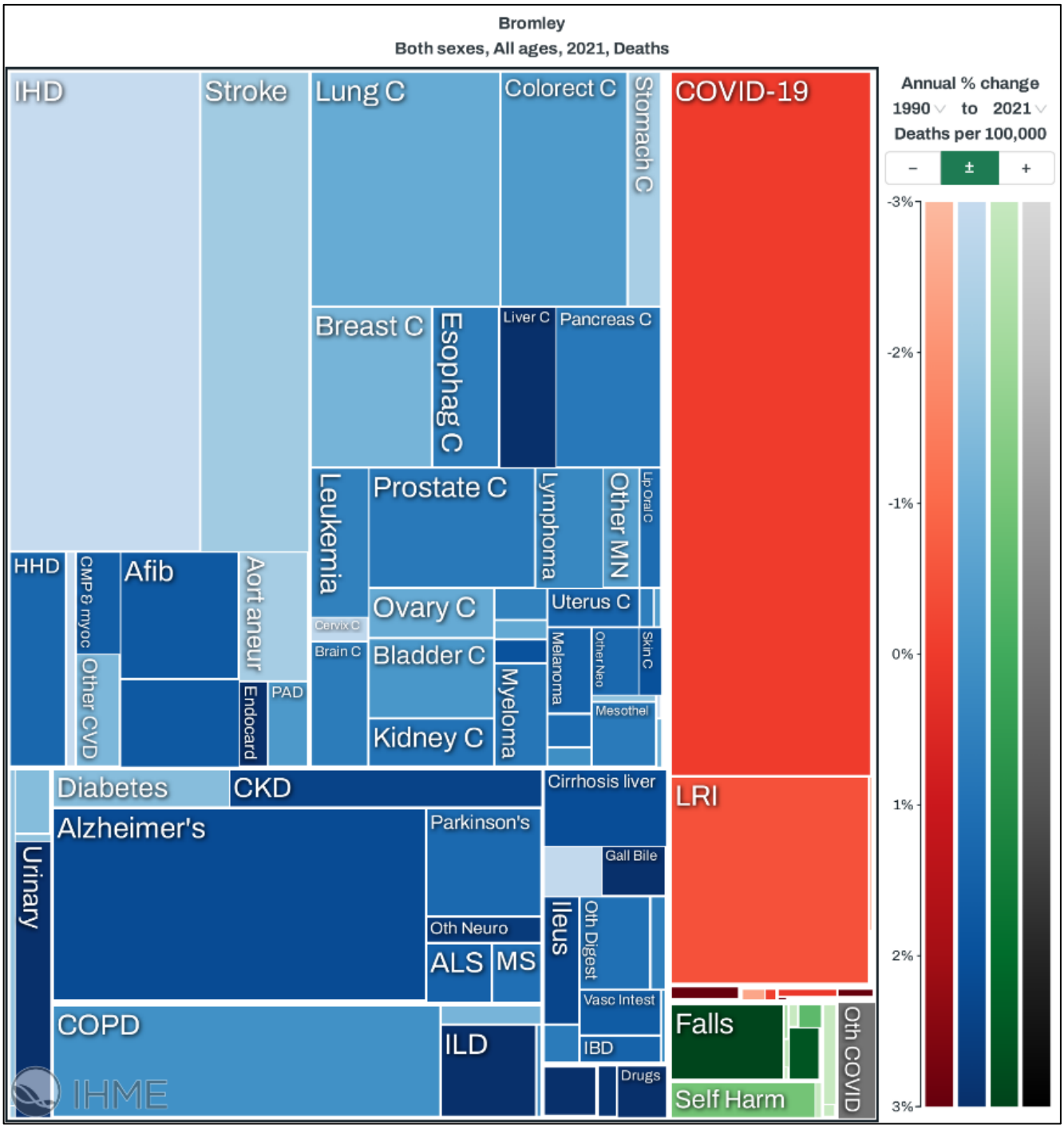
The latest GBD study for 2021 (published in May 2024) includes data on mortality and morbidity across 204 countries and territories, covering 371 diseases and injuries, and 87 risk factors. The study estimates that in Bromley, the highest burden of disease across all age groups is from cancers (neoplasms), responsible for 27.1% of all deaths, followed by cardiovascular diseases (CVD) at 23.1%, and respiratory infections at 20.7%, with COVID-19 accounting for 16.0% of deaths (Figures 11 and 12). Covid-19 has had a significant impact upon the GBD study for 2021, was the highest cause of death in England in 2021 and was the leading cause of DALY's globally. In terms of DALYs, the leading causes are cardiovascular disease, followed by neoplasms, diabetes and kidney disorders, and substance misuse disorders. High systolic blood pressure remains the highest risk factor in Bromley that leads to early death and disability (Figure 15).

Figure 11: Percentage of deaths by cause of death or injury, Bromley, 2021



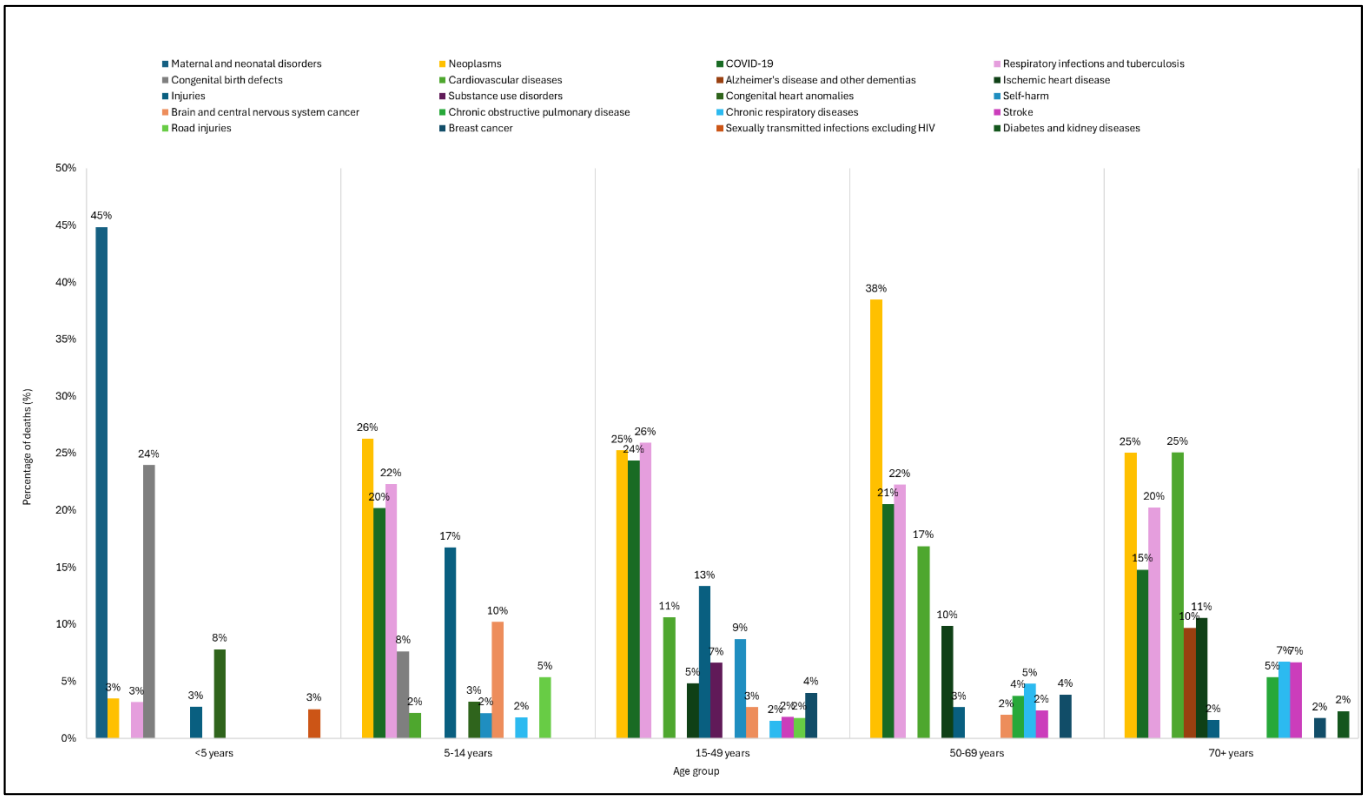
Source: Institute for Health Metrics and Evaluation, 2024

Figure 12: GBD Cause of death in Bromley, 2021.



Source: Institute for Health Metrics and Evaluation, 2024

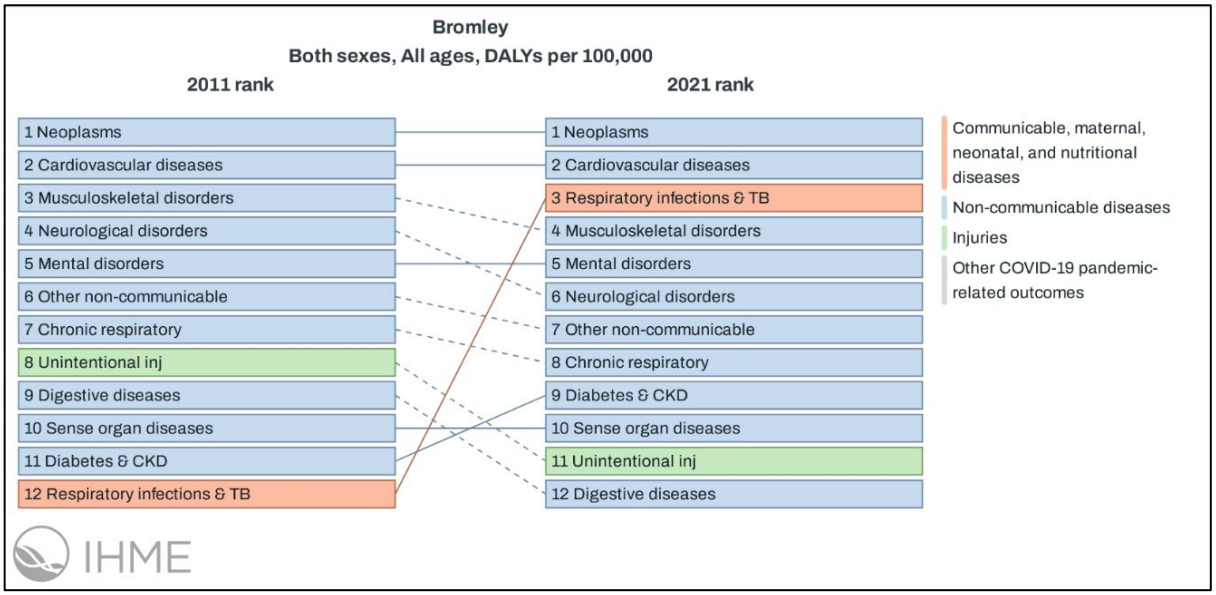
Figure 13: Percentage of deaths by age group and cause of death, Bromley, 2021



Source: Institute for Health Metrics and Evaluation, 2024

The leading causes of death in Bromley varied by age group in 2021. Neoplasms were the leading cause of death in people aged 5-14 (26%), 15-49 (25%), 50-69 (38%), and 70+ (25%) years. Cardiovascular diseases ranked second in people aged 15-49 (25%), 50-69 (22%), and 70+ (25%). Maternal/neonatal disorders (45%) and congenital birth defects (24%) were dominant in children under 5 years. Respiratory diseases were prevalent in people aged 50-69 (21%) and 70+ years (20%), while Alzheimer's/dementia (15%) those 70+. Substance use disorders (13%) and self-harm (11%) were notable in the 15-49 age group.

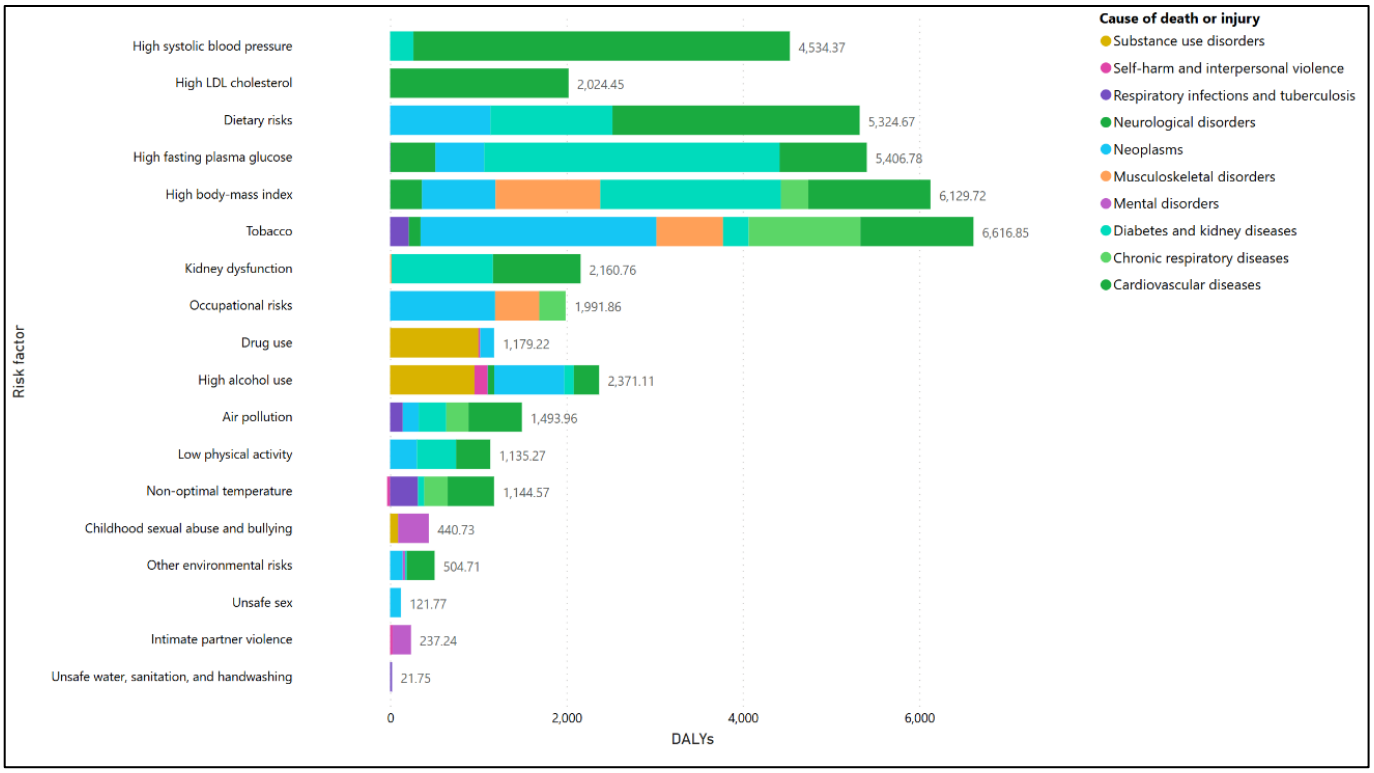
Figure 14: Ranking of diseases and injuries, Bromley, 2011 and 2021.



Source: Institute for Health Metrics and Evaluation, 2024

Figure 14 compares the leading causes of disease burden (DALYs per 100,000) in Bromley between 2011 and 2021. While neoplasms and cardiovascular diseases remained the top two causes, respiratory infections and TB changed from rank 12 to 3, likely due to COVID-19's impact. Most non-communicable diseases remained dominant, though slight rank shifts occurred. The rise in infectious diseases highlights the pandemic's effect, emphasising the need for strengthened public health measures and chronic disease management.

Figure 15: No of DALYs (Disability Adjusted Life Years) by risk factor (level 2) and cause of death and disability (level 2), Bromley, 2021



Source: Institute for Health Metrics and Evaluation, Global Burden of Disease Study, 2024

Figure 15 illustrates the number of Disability Adjusted Life Years (DALYs) by risk factor and cause of death and disability in Bromley. The top three risk factors contributing to early death and disability are high systolic blood pressure, high LDL cholesterol and dietary risks such as low intake of fruits, vegetables, and fibre, and high intake of sodium, processed meat, and trans-fatty acids. are also prominent risk factors. Additional key lifestyle risk factors include high fasting plasma glucose, high body mass index and tobacco use. High systolic blood pressure remains the leading risk factor. Cardiovascular diseases account for a large portion of DALYs, particularly linked to high blood pressure, cholesterol, and tobacco use. Diabetes and kidney diseases are heavily influenced by high fasting plasma glucose and obesity, while chronic respiratory diseases are strongly associated with tobacco use and air pollution. Aside from CVD and diabetic and kidney diseases, mental health and musculoskeletal disorders also appear across multiple risk factors, highlighting the need for integrated healthcare approaches.

While lifestyle-related risks dominate, occupational hazards, air pollution, and alcohol use also contribute significantly. Lower-impact factors, such as unsafe sex and intimate partner violence, still warrant attention but contribute relatively fewer DALYs. These findings emphasise the need for targeted public health interventions, including dietary improvements, obesity prevention,

smoking cessation programs and air quality regulations, to reduce the disease burden and improve population health in Bromley.

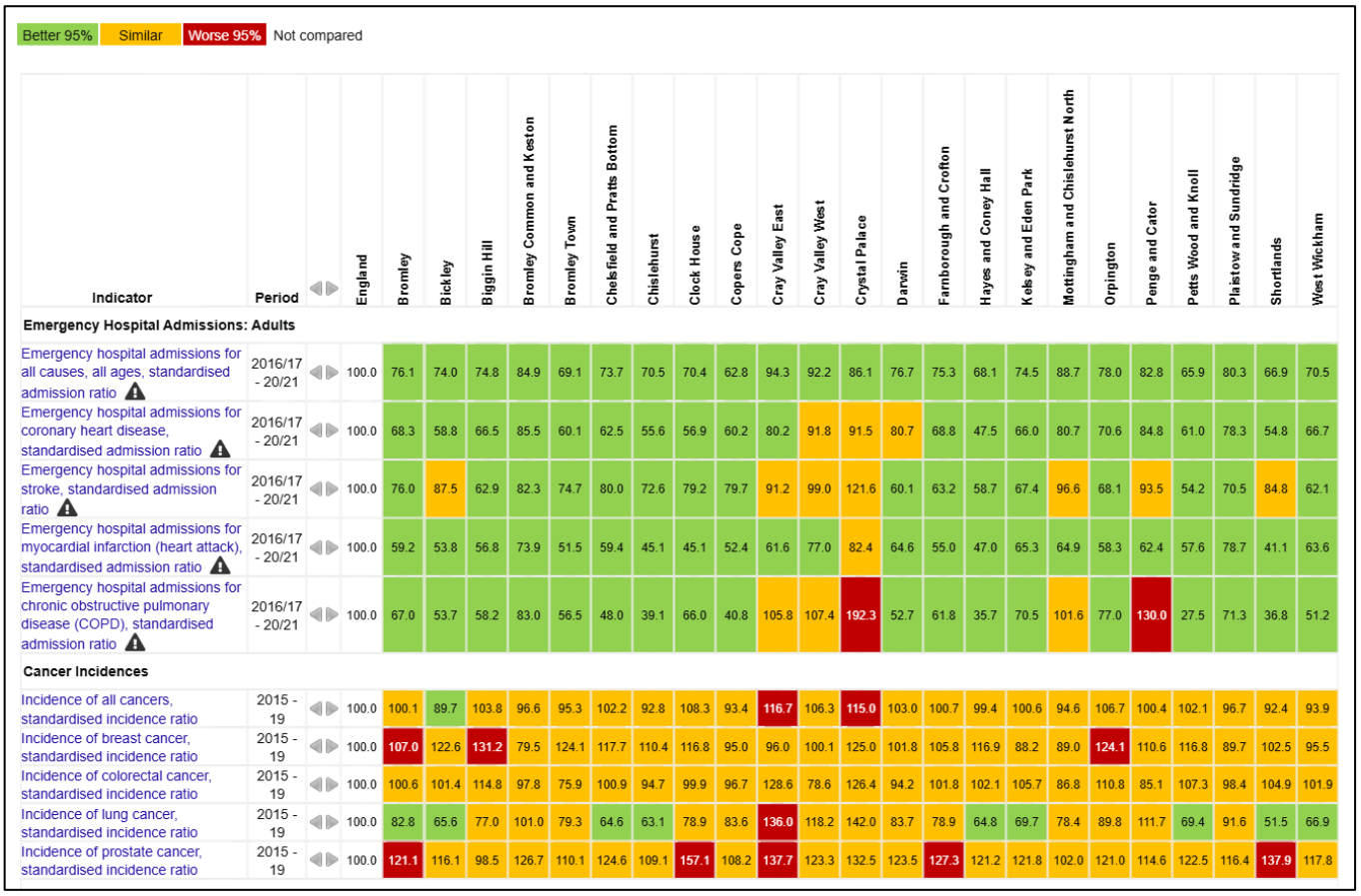
4.2 Hospital admissions

The NHS Data Model and Dictionary define emergency hospital admissions as ‘unpredictable’ or ‘short notice’, requiring immediate attention due to medical necessity. Local emergency admission rates will be compared with expected levels based on the age demographics of the population. High emergency admission ratios may be due to several factors, including high injury rates within a population or challenging management of chronic conditions in primary care. It serves as a measure of unplanned secondary care usage within a population, and caution is advised when interpreting these findings.

Age-specific admission rates for England were derived from all admission episodes with valid electoral ward and age coding. The unadjusted expected admissions for each electoral ward were calculated by applying these age-specific rates to the population of each ward. Adjustments were made to account for missing age codes in the national data, if the age distribution of the missing data matches the national level. Electoral ward admissions include all admissions for that area, regardless of age coding validity.

The ⚠ symbol indicates that there are some concerns regarding the reliability of the data for the metric. NHS Digital has reported a data quality issue with Hospital Episode Statistics (HES) data for some hospitals during the 2016-2017 financial year. A proportion of records lacked a valid geography of residence. OHID has flagged the affected areas, advising that the data should be interpreted with caution.

Figure 16: Change in emergency hospital admissions and cancer incidence in England and Bromley electoral wards



Better 95% | Similar | Worse 95% | Not compared

Indicator	Period	England	Bromley	Bickley	Biggin Hill	Bromley Common and Keston	Bromley Town	Chelsfield and Pratts Bottom	Chislehurst	Clock House	Copers Cope	Cray Valley East	Cray Valley West	Crystal Palace	Darwin	Farnborough and Crofton	Hayes and Coney Hall	Kelsey and Eden Park	Mottingham and Chislehurst North	Orpington	Penge and Cator	Petts Wood and Knoll	Plaistow and Sundridge	Shortlands	West Wickham
Emergency Hospital Admissions: Adults																									
Emergency hospital admissions for all causes, all ages, standardised admission ratio ⚠	2016/17 - 20/21	100.0	76.1	74.0	74.8	84.9	69.1	73.7	70.5	70.4	62.8	94.3	92.2	86.1	76.7	75.3	68.1	74.5	88.7	78.0	82.8	65.9	80.3	66.9	70.5
Emergency hospital admissions for coronary heart disease, standardised admission ratio ⚠	2016/17 - 20/21	100.0	68.3	58.8	66.5	85.5	60.1	62.5	55.6	56.9	60.2	80.2	91.8	91.5	80.7	68.8	47.5	66.0	80.7	70.6	84.8	61.0	78.3	54.8	66.7
Emergency hospital admissions for stroke, standardised admission ratio ⚠	2016/17 - 20/21	100.0	76.0	87.5	62.9	82.3	74.7	80.0	72.6	79.2	79.7	91.2	99.0	121.6	60.1	63.2	58.7	67.4	96.6	68.1	93.5	54.2	70.5	84.8	62.1
Emergency hospital admissions for myocardial infarction (heart attack), standardised admission ratio ⚠	2016/17 - 20/21	100.0	59.2	53.8	56.8	73.9	51.5	59.4	45.1	45.1	52.4	61.6	77.0	82.4	64.6	55.0	47.0	65.3	64.9	58.3	62.4	57.6	78.7	41.1	63.6
Emergency hospital admissions for chronic obstructive pulmonary disease (COPD), standardised admission ratio ⚠	2016/17 - 20/21	100.0	67.0	53.7	58.2	83.0	56.5	48.0	39.1	66.0	40.8	105.8	107.4	192.3	52.7	61.8	35.7	70.5	101.6	77.0	130.0	27.5	71.3	36.8	51.2
Cancer Incidences																									
Incidence of all cancers, standardised incidence ratio	2015 - 19	100.0	100.1	89.7	103.8	96.6	95.3	102.2	92.8	108.3	93.4	116.7	106.3	115.0	103.0	100.7	99.4	100.6	94.6	106.7	100.4	102.1	96.7	92.4	93.9
Incidence of breast cancer, standardised incidence ratio	2015 - 19	100.0	107.0	122.6	131.2	79.5	124.1	117.7	110.4	116.8	95.0	96.0	100.1	125.0	101.8	105.8	116.9	88.2	89.0	124.1	110.6	116.8	89.7	102.5	95.5
Incidence of colorectal cancer, standardised incidence ratio	2015 - 19	100.0	100.6	101.4	114.8	97.8	75.9	100.9	94.7	99.9	96.7	128.6	78.6	126.4	94.2	101.8	102.1	105.7	86.8	110.8	85.1	107.3	98.4	104.9	101.9
Incidence of lung cancer, standardised incidence ratio	2015 - 19	100.0	82.8	65.6	77.0	101.0	79.3	64.6	63.1	78.9	83.6	136.0	118.2	142.0	83.7	78.9	64.8	69.7	78.4	89.8	111.7	69.4	91.6	51.5	66.9
Incidence of prostate cancer, standardised incidence ratio	2015 - 19	100.0	121.1	116.1	98.5	126.7	110.1	124.6	109.1	157.1	108.2	137.7	123.3	132.5	123.5	127.3	121.2	121.8	102.0	121.0	114.6	122.5	116.4	137.9	117.8

Source: OHID, 2025

Figure 16 shows that the latest data we have on emergency hospital admissions for coronary heart disease, stroke and myocardial infarction are significantly lower in most Bromley wards compared to England's levels, with a few wards having similar ratios. However, there are a few areas where hospital admissions and cancer incidence are significantly higher than the national average (100). Chronic Obstructive Pulmonary Disease (COPD) admissions in Crystal Palace (192.3) are nearly double the national average and there are 30% more admissions due to COPD in Penge and Cator (standardised admission ratio of 130), when compared to England. For most wards in Bromley, cancer incidence has similar levels to England. The incidence of all cancers is about 17% higher in Cray Valley East (116.7) and 15% higher in Crystal Palace (115.0) between 2015 and 2019. Bromley's breast cancer and prostate cancer incidence ratios are significantly higher than England's (107.0 and 121.1 respectively). Biggin Hill and Orpington have higher breast cancer incidence ratios than England (131.2 and 124.1 respectively). Lung cancer incidence in Cray Valley East is 38% higher in Cray Valley East when compared to England. Prostate cancer incidence is about 57% in Clock House, 38% higher in Cray Valley East and Shortlands, and 27% higher in Farnborough and Coney Hall.

The variation in emergency hospital admissions and cancer incidence across different wards may be influenced by several factors, including demographics, socioeconomic conditions, lifestyle behaviours, and data recording differences. Areas with older populations may have higher breast and prostate cancer incidence due to age-related risk. Differences in screening uptake and healthcare engagement could contribute to higher recorded cancer incidence, reflecting better detection rather than a true increase in cases. Socioeconomic factors may also play a role, as

higher lung cancer incidence may be impacted by smoking prevalence or environmental exposure. Similarly, higher COPD admissions may be influenced by smoking, air pollution, or occupational hazards. Differences in hospital admissions may reflect differences in referral patterns, or local health initiatives rather than true disparities in disease prevalence.

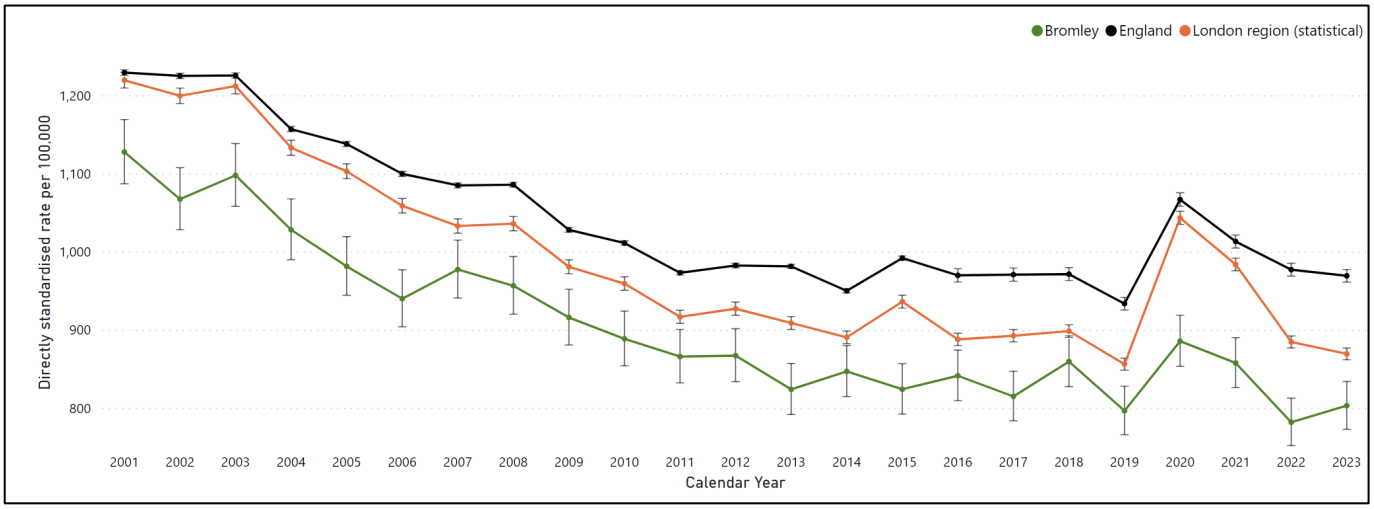
5. Mortality

Mortality rates are crucial indicators of public health. These rates are influenced by a wide range of factors, including living conditions, environmental aspects, health behaviours, and access to and quality of healthcare. See Appendix 2 for mortality rate definition.

All-cause mortality is a fundamental measure of the health status of a population. It represents the cumulative effect of the prevalence of risk factors, the prevalence and severity of disease, and the effectiveness of interventions and treatment. Differences in levels of all-cause mortality reflect health inequalities between different population groups, e.g. between genders, social classes, and ethnic groups.

5.1 Mortality from all causes

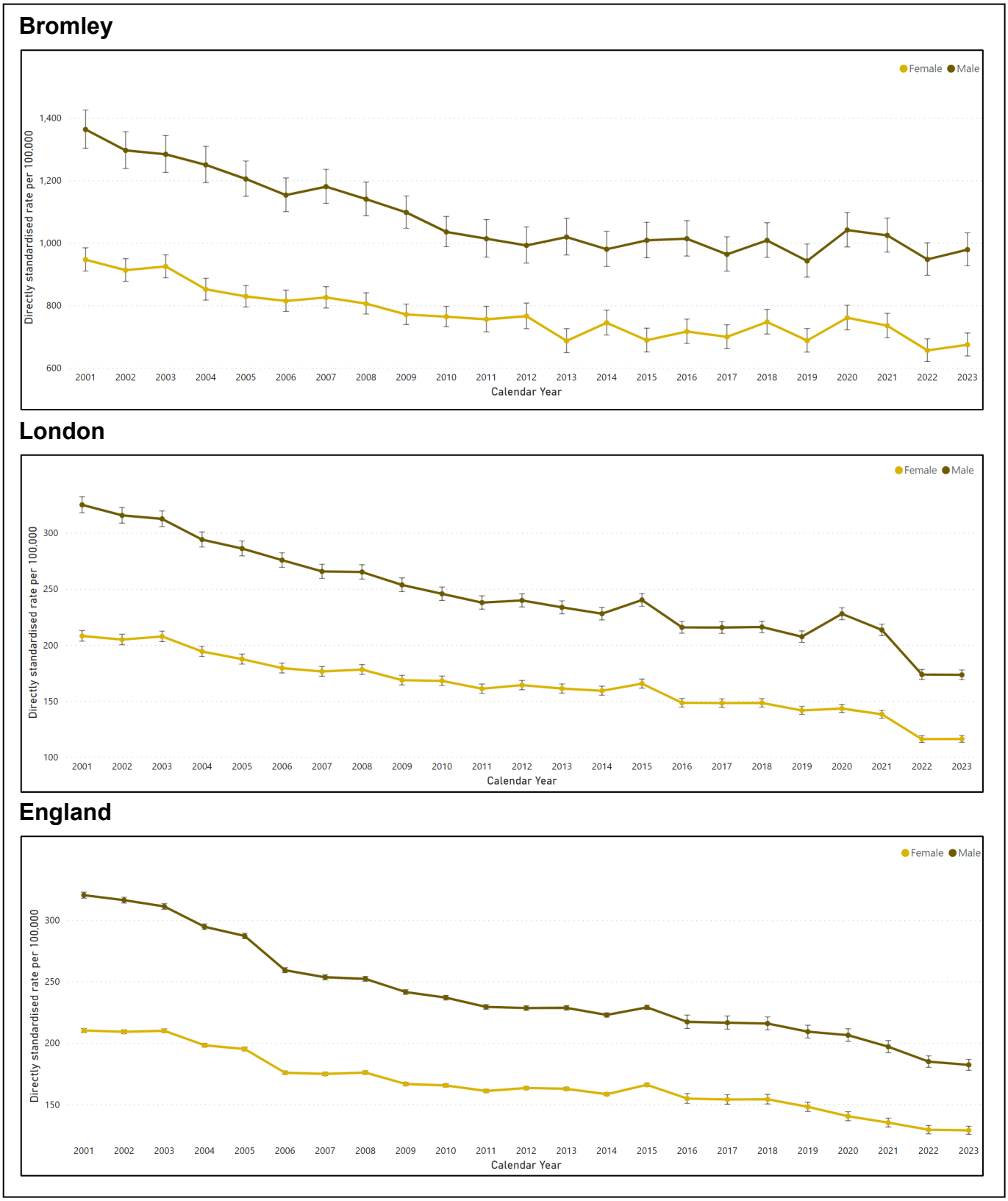
Figure 17: Mortality rates from all causes for persons in Bromley, London and England



Source: OHID Fingertips 2024

Figure 17 shows the rate of deaths registered in the respective calendar years, in persons of all ages in Bromley, London and England. There has been an overall decline in mortality rates from all causes in Bromley, London and England, over the past two decades. All-cause mortality rates in Bromley have gone from 1,127 deaths per 100,000 in 2001 to 803 deaths per 100,000 in 2023. Bromley's directly standardised rate per 100,000 consistently remained below both regional and national averages. The spike observed around 2019-2020 was likely influenced by the COVID-19 pandemic and affected all three areas.

Figure 18: Mortality rates from all causes for males and females in Bromley, London, and England



Source: OHID Fingertips 2024

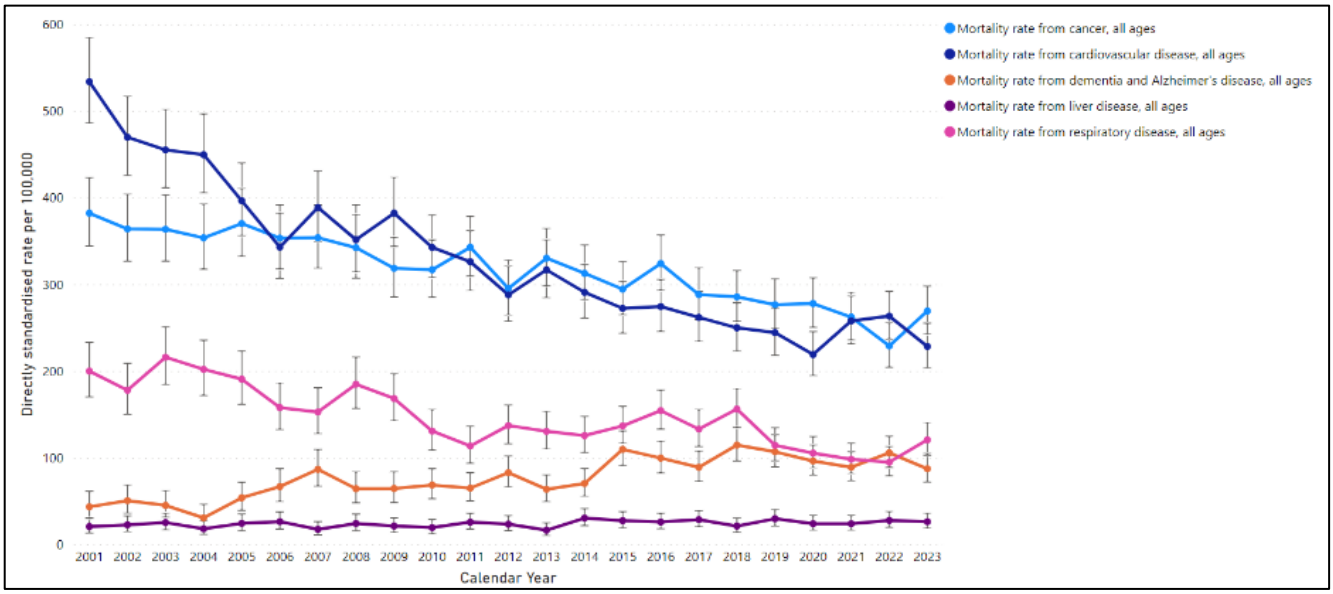
Figure 18 shows a decline in directly standardised rates in both Bromley males and females. All-cause mortality rates are consistently higher in males, when compared to females. In Bromley males, the rates declined from 1,319 deaths per 100,000 in 2001 to 978 deaths per 100,000 in

2023. In Bromley females, the rates declined from 951 deaths per 100,000 in 2001 to 674 deaths per 100,000 in 2023. These observed trends are consistent with both regional and national levels.

5.2 Principal causes of death

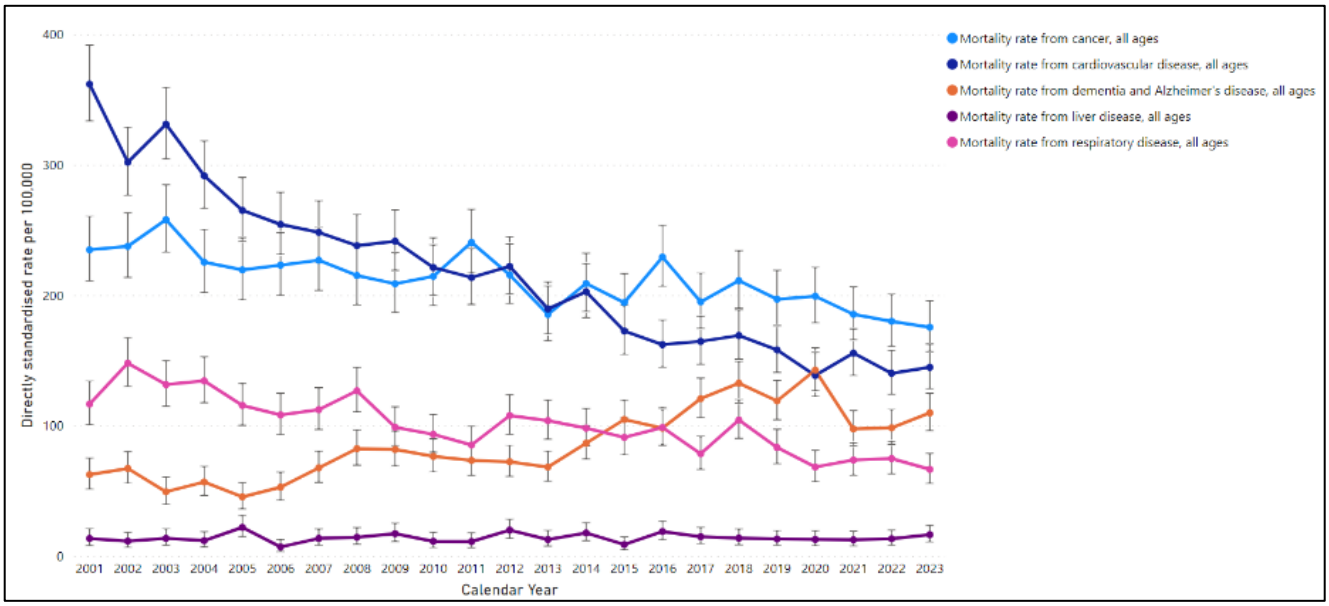
This section presents mortality rates for selected chapters of the International Classification of Diseases, Tenth Revision (ICD-10), as well as specific causes within those chapters. The section focuses on the leading causes of death and those of significant public health interest.

Figure 19: Mortality rates for principal causes of death in males, Bromley, 2001 to 2023



Source: OHID Fingertips 2024

Figure 20: Mortality rates for principal causes of death in females, Bromley, 2001 to 2023



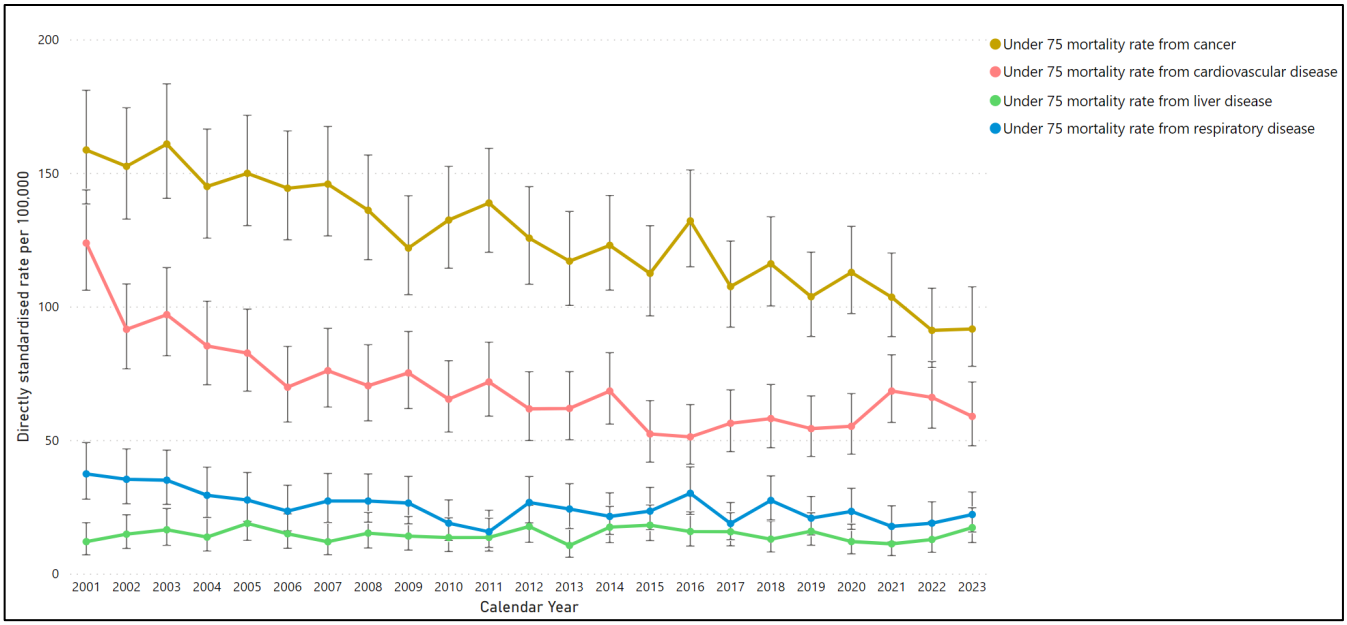
Source: OHID Fingertips 2024

Between 2001 and 2023, mortality rates from cardiovascular disease in Bromley fell by 57% for males and 60% for females (Figures 19 and 20). This is bigger than the decrease for cancer (30% for males and 25% for females) but the rate increased between 2019 and 2022. Mortality rates for Alzheimer's disease and dementia increased steadily between 2001 and 2023, (by 102% for

males and 75% for females), but rates for respiratory disease fell over this period, by 40% for males and 43% for females. Mortality rates for liver disease slightly increased by 22%.

“Under 75 mortality rates” show the death rates among individuals younger than 75 years old. Understanding death rates in under 75-year-olds is crucial for highlighting premature deaths, which are often preventable and significantly impact public health. Premature mortality provides a strong indication of a population’s overall health, correlating with various other health measures. To continue reducing premature mortality rates and address inequalities between areas, a concerted effort in both prevention and treatment is essential, as it reflects on the effectiveness of healthcare systems and guide policy and resource allocation.

Figure 21: Mortality rates for principal causes of death, under 75s, Bromley, 2001 to 2023.



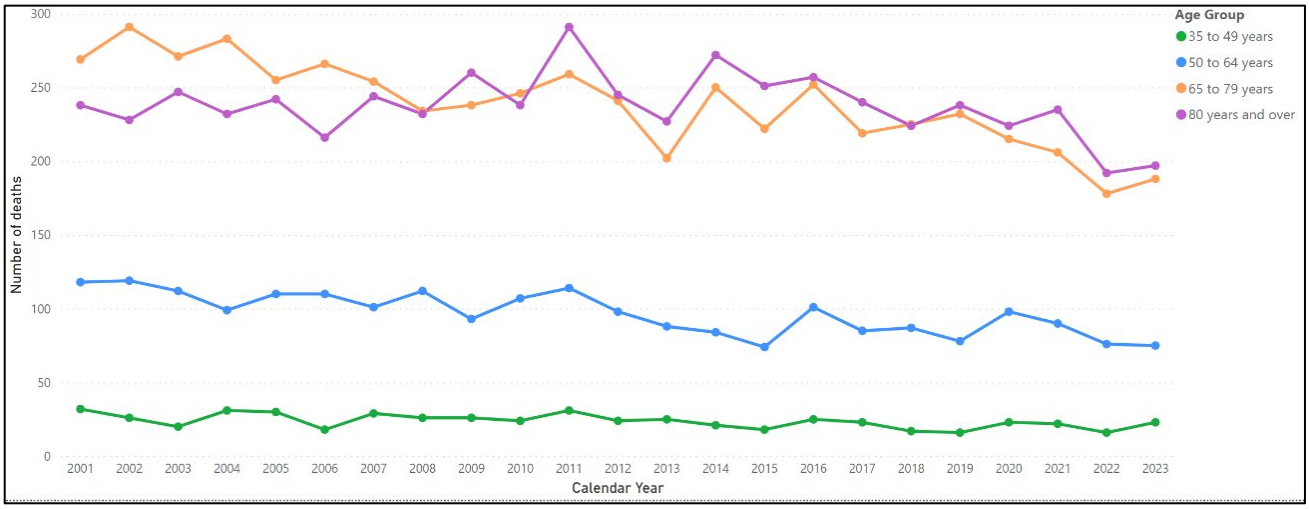
Source: OHID Fingertips 2024

Since 2001, cancer has been the leading cause of death in the under 75-year-olds in Bromley (91.6 deaths per 100,000 people in 2023), followed by cardiovascular disease (58.9 deaths per 100,000 people in 2023; Figure 21). Between 2001 and 2023, mortality rates from cardiovascular disease fell by 52%. This is bigger than the decrease for cancer (42%) and respiratory disease (19%). Over this period, mortality rates from liver disease also increased by 44%.

5.3 Cancer

Cancer is the leading cause of death in Bromley and England, with half of the population expected to develop some form of it during their lifetime. To continue reducing cancer mortality rates, focused efforts in both prevention and treatment are essential.

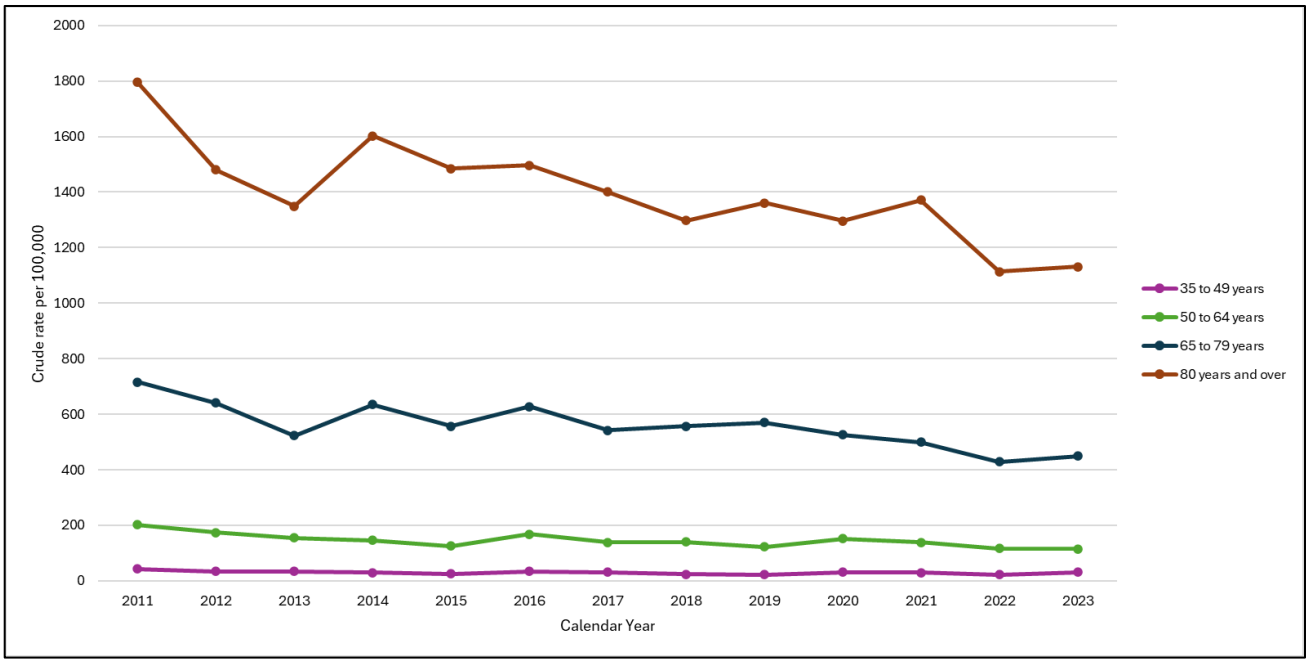
Figure 22: Number of deaths from cancer by age category in persons aged 35 years and over, Bromley, 2001 to 2023



Source: PCMD, 2024

People aged 65+ showed the highest number of deaths from cancer from 2001 to 2023 (Figure 22). People aged 65 to 79 years showed the highest decline (30%) in the total number of deaths from neoplasms, going from 269 deaths in 2001 to 188 deaths in 2023, followed by those 80 years and over with 238 deaths in 2001 to 197 deaths in 2023 (17% decrease). People aged 50 to 64 years have a higher number of deaths from cancer than those aged 35 to 49 years.

Figure 23: Crude mortality rate from cancer by age category in persons aged 35 years and over, Bromley, 2011 to 2023

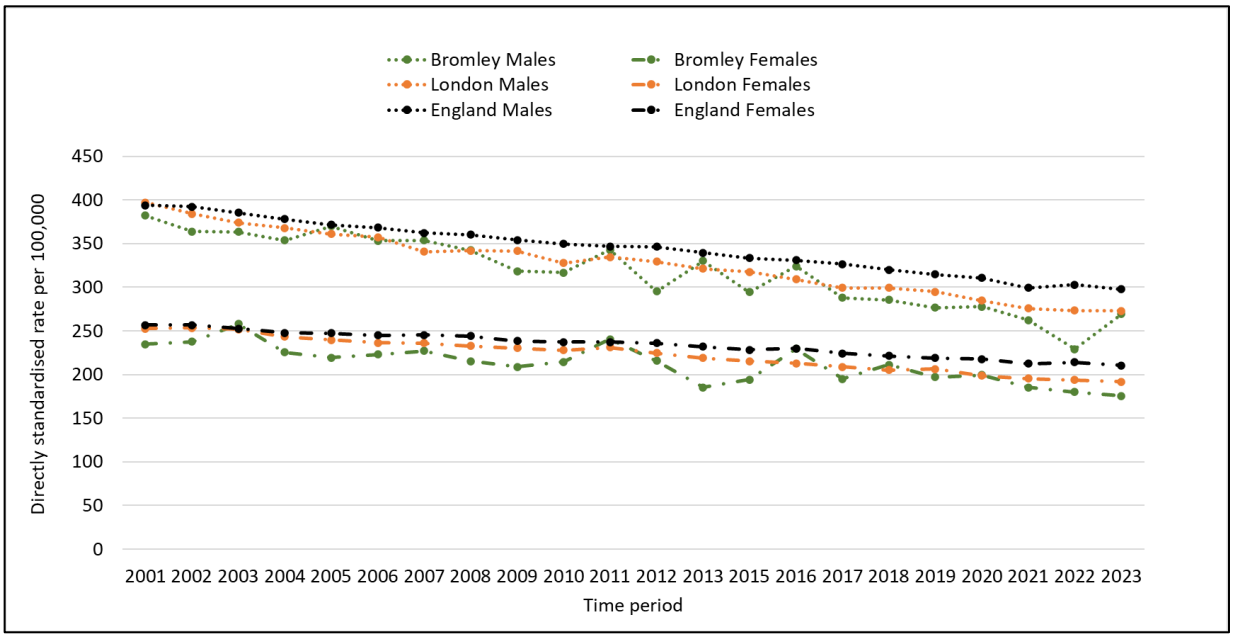


Source: PCMD and ONS, 2024

From 2011 to 2023, mortality rates from cancer increased by age category (Figure 23). People aged 80 years and over showed the highest crude mortality rate from cancer from 2011 to 2023. Mortality rates in people aged 80 years and over declined from 1,796 deaths per 100,000 in 2011 to 1,131 deaths per 100,000 in 2023. People aged 65 years and over showed the highest decline

(37%) in mortality rates from neoplasms. People aged 50 to 64 years have a higher number of deaths from cancer than those aged 35 to 49 years.

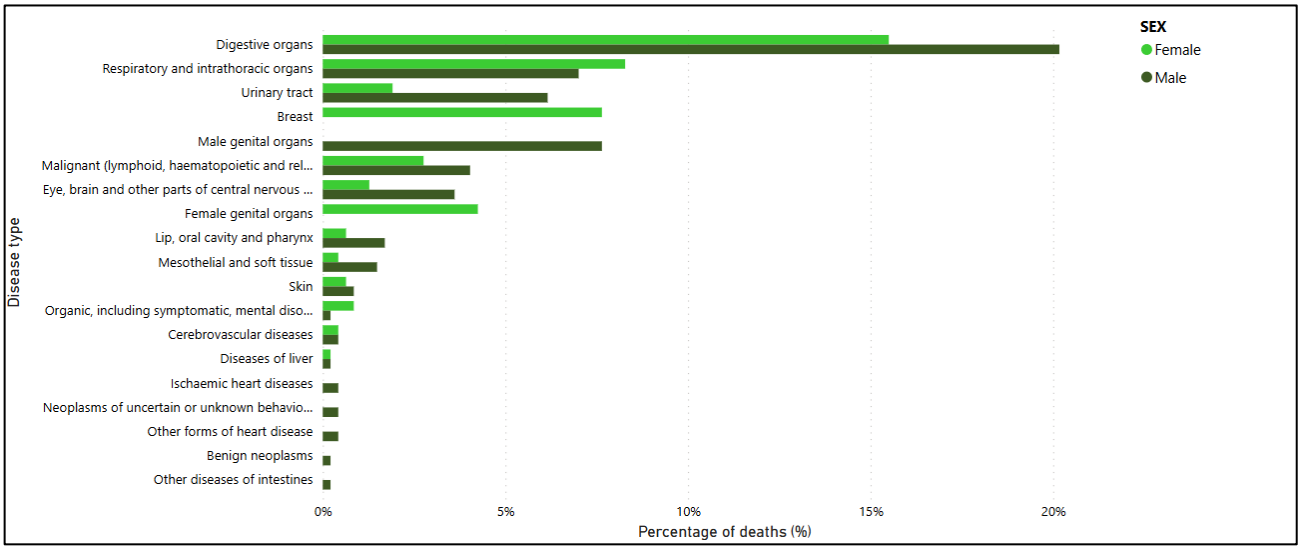
Figure 24: Mortality rate from cancer, all ages, Bromley, London and England



Source: OHID Fingertips, 2024

In Bromley, mortality rates from cancer are higher in males when compared to females between 2001 and 2023, consistent with regional and national levels. There were peaks in 2011 and 2016, when mortality from cancer in Bromley exceeded the London mortality rates. These variations are likely due to natural statistical fluctuations associated with smaller population sizes, like Bromley, where annual changes can appear more pronounced. Despite a trough in recent years, cancer mortality rates among Bromley males have increased from 228.9 to 269.2 per 100,000 in 2023, highlighting the need for continued monitoring and targeted interventions (Figure 24).

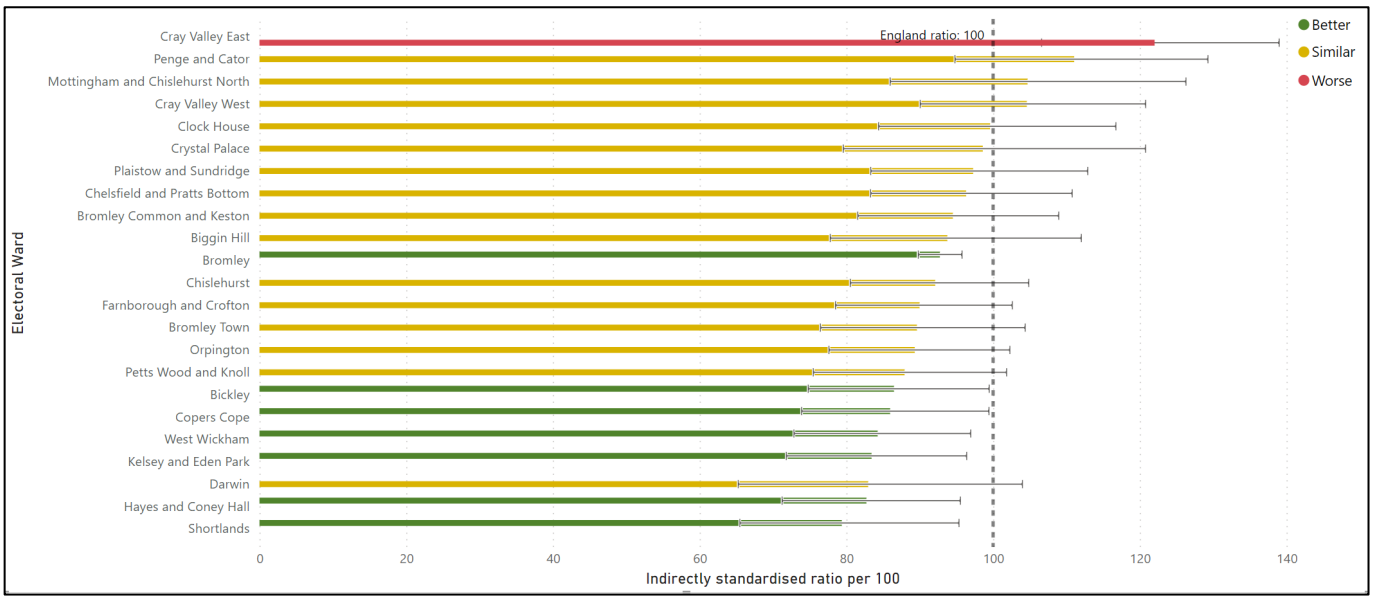
Figure 25: Most prevalent types of cancer deaths in Bromley males and females, 2023



Source: Primary Care Mortality Database, 2024

The most common type of cancer deaths in Bromley in 2023, were attributed to the digestive organs, accounting for 36.5% in males and 34.6% in females (Figure 25). This is followed by cancers of the male genital organs (accounting for 13.9%) in males and cancers of respiratory and intrathoracic organs (18.28) in females. The third most common types of cancer deaths in males are attributed to respiratory and intrathoracic organs (12.7), whereas in females, it is breast cancer (17.1%).

Figure 26: Deaths from all cancer, by Bromley wards, standardised mortality ratio, 2016 to 2020.



Source: OHID Fingertips 2024

*These calculations were made before the change in electoral ward boundaries and names in March 2021.

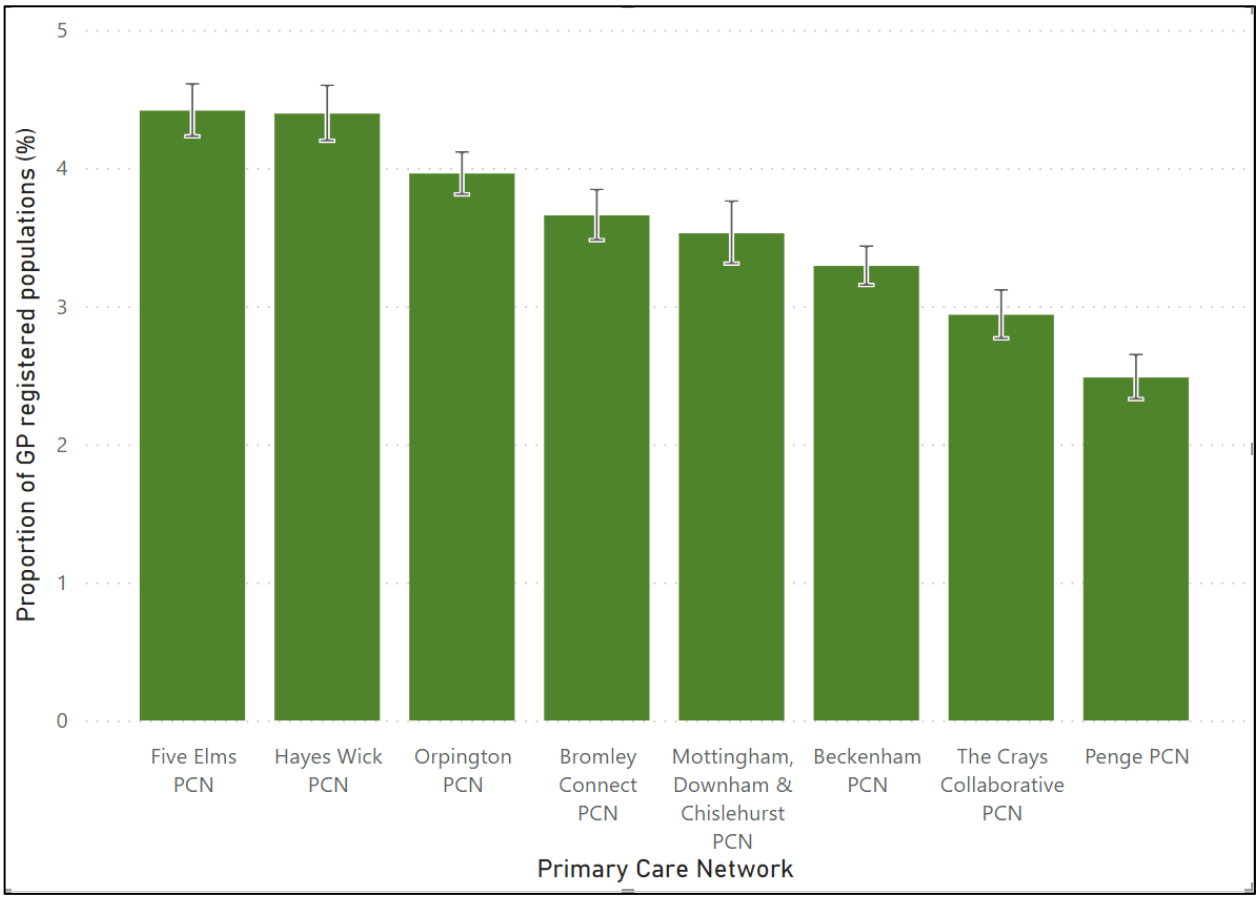
Figure 26 shows the ratio of deaths from all cancer in Bromley wards, in proportion to the age-specific mortality rates in England between 2016 and 2020. The standardised mortality ratio is highest in Cray Valley East, which has a significantly higher standardised mortality ratio than England, at 122 deaths per 100. Shortlands has the lowest standardised mortality ratio of 79.4 deaths per 100, which is significantly lower than the England ratio of 100. Of the 22 wards in Bromley, six have a significantly lower standardised mortality ratio than England. These are Bickley, Copers Cope, West Wickham, Kelsey and Eden Pak, Hayes and Coney Hall and Shortlands.

Cancer is a clinical priority across the UK. While the main management of cancer happens in secondary care, general practice plays a crucial role in referring and supporting cancer patients and ensuring coordinated care. Bromley Primary Care Networks (PCNs) are groups of general practices working together to improve healthcare services in the Bromley area[8]. They aim to provide more coordinated and comprehensive care by sharing resources and expertise. Bromley has eight PCNs. Each PCN supports its member practices with extended hours, social prescribers, and clinical pharmacists to enhance patient care. Figure 18 shows the percentage of

[8] Bromley GP Alliance. (2015.). Primary care networks (PCNs). Retrieved January 20, 2025, from https://bromleygpalliance.org/primary-care-networks-pcns/

patients with cancer, as recorded on practice disease registers (register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1st April 2003).

Figure 27: Cancer prevalence by Bromley's Primary Care Networks, 2022/23



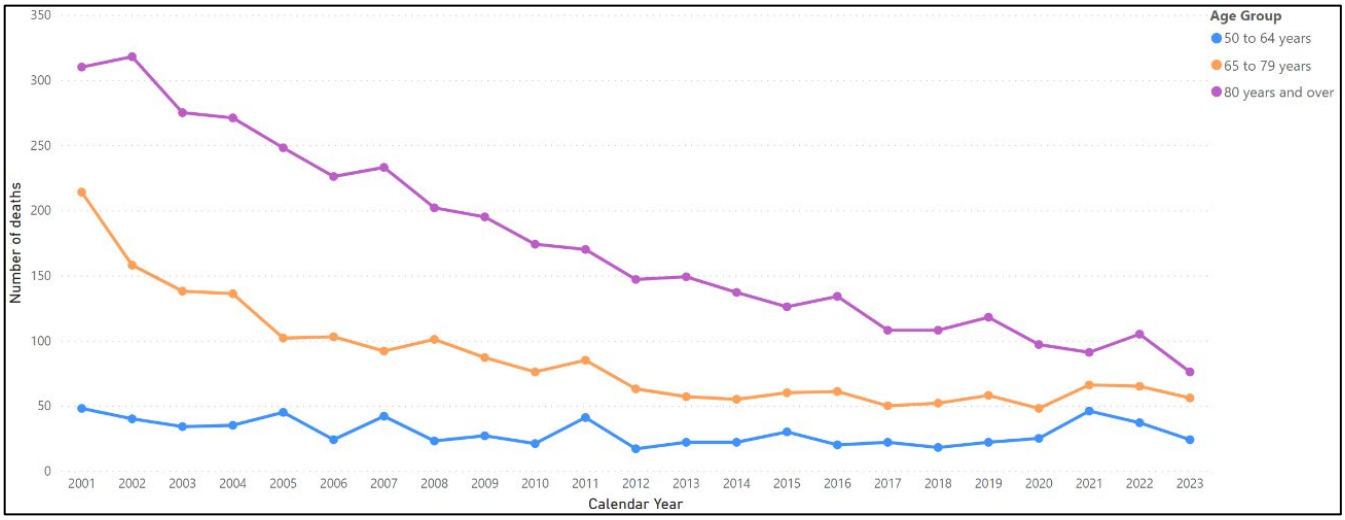
Source: Quality Outcomes Framework, NHS England, 2024

Five Elms and Hayes Wick PCNs had the highest percentage of GP registered patients with cancer diagnosis, at 4.4% for both PCNs. (Figure 18). They were over 77% higher than Penge PCN, which had the lowest percentage of GP registered patients with cancer at 2.5%. Across all eight PCNs, the percentage of GP registered patients with cancer ranged from 2.5% to 4.4%. This variation might be due to considerations such as differences in local demography, population behaviours or access to services.

5.4 Cardiovascular diseases

Cardiovascular disease remains a common cause of death in England. Significant progress has been made in recent decades with better treatments and lifestyle improvements. However, continued efforts in both prevention and treatment are essential to further reduce mortality rates from cardiovascular disease.

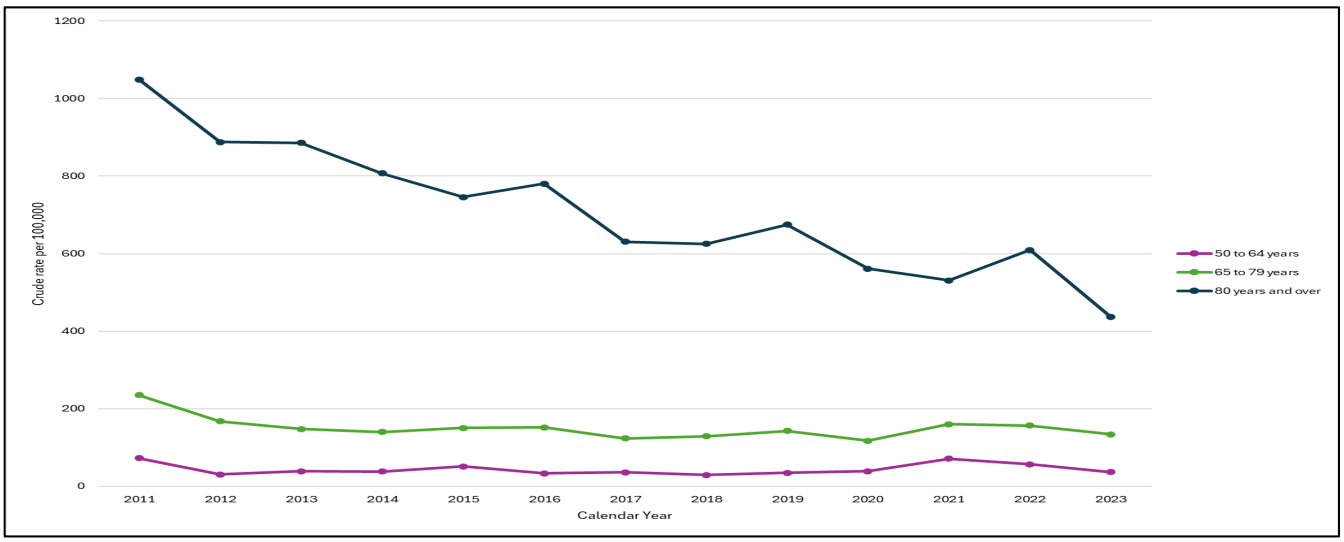
Figure 28: Number of deaths from diseases of the circulatory system in persons aged 50 years and over, Bromley, 2001 to 2023



Source: PCMD, 2024

Between 2001 and 2023, there has been an overall decline in the number of deaths due to diseases of the circulatory system among adults aged over 50 years in Bromley (Figure 28). People aged 80+ years showed the highest number of deaths due to diseases of the circulatory system from 2001 to 2023, and the highest decline of 75.5% within this period. This is followed by those aged 65 to 79 years who showed a 73.8% decline in the total number of deaths due to diseases of the circulatory system, going from 214 deaths in 2001 to 56 deaths in 2023.

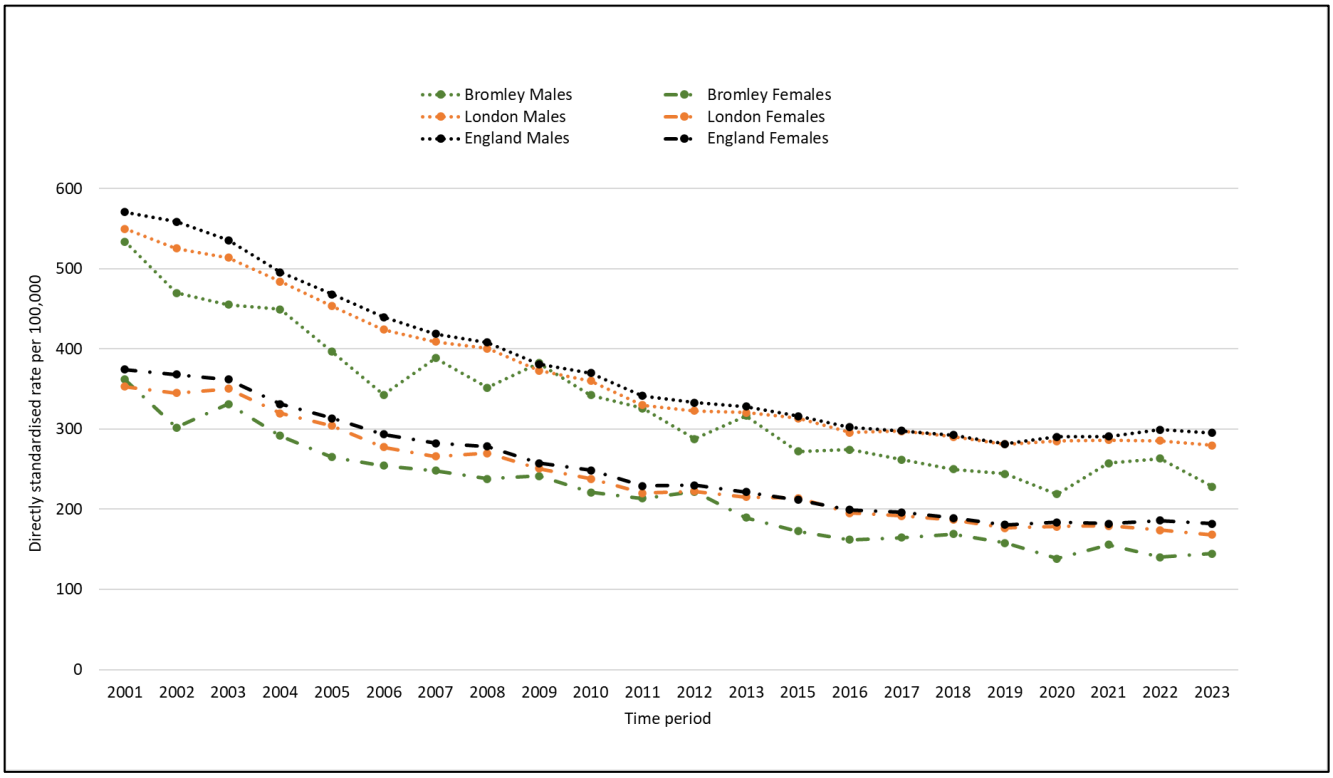
Figure 29: Mortality rate from diseases of the circulatory system in persons aged 50 years and over, Bromley, 2011 to 2023



Source: PCMD and ONS, 2024

From 2011 to 2023, the crude mortality rate from circulatory diseases decreased among adults aged over 50 years in Bromley (Figure 29). People aged 80+ years showed the highest death rates, and the highest decline from 1,049 to 437 deaths per 100,000 from 2011 to 2023. This is followed by those aged 65 to 79 years who showed a smaller decline in deaths, going from 235 deaths per 100,000 in 2001 to 134 deaths per 100,000 in 2023.

Figure 30: Mortality rate from cardiovascular disease, all ages, Bromley, London and England

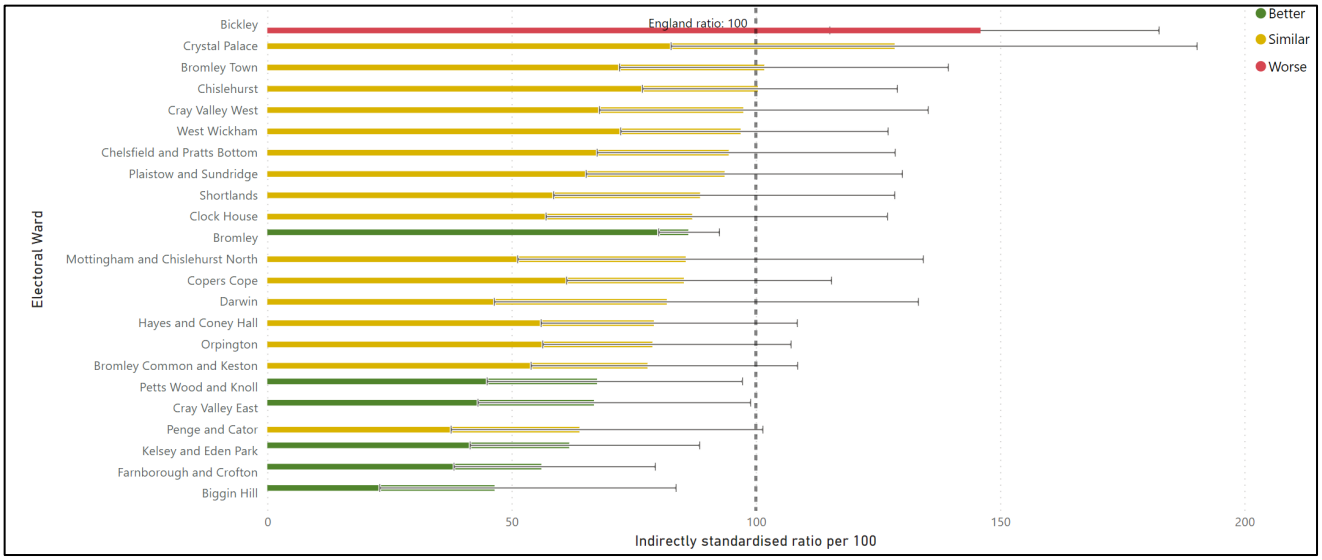


Source: OHID Fingertips, 2024

In Bromley, there is an overall downward trend in mortality rates from cardiovascular disease between 2001 and 2023, with males showing higher rates in comparison to females, consistent with regional and national levels (Figure 30). While mortality among Bromley males dropped from 263.3 to 228.3 deaths per 100,000 between 2022 and 2023, female mortality rates saw a slight increase from 140.1 to 144.7 deaths per 100,000. These fluctuations may reflect natural variation due to small numbers rather than a sustained trend. However, the rise in female mortality warrants continued monitoring to assess whether it indicates emerging health disparities or differences in risk factors and healthcare access.

Stroke is the third most common cause of death in the developed world, with one-quarter of stroke deaths occurring in individuals under 65. Evidence shows that proper diagnosis and management can significantly improve outcomes.

Figure 31: Deaths from stroke, by Bromley wards, standardised mortality ratio, 2016 to 2020.



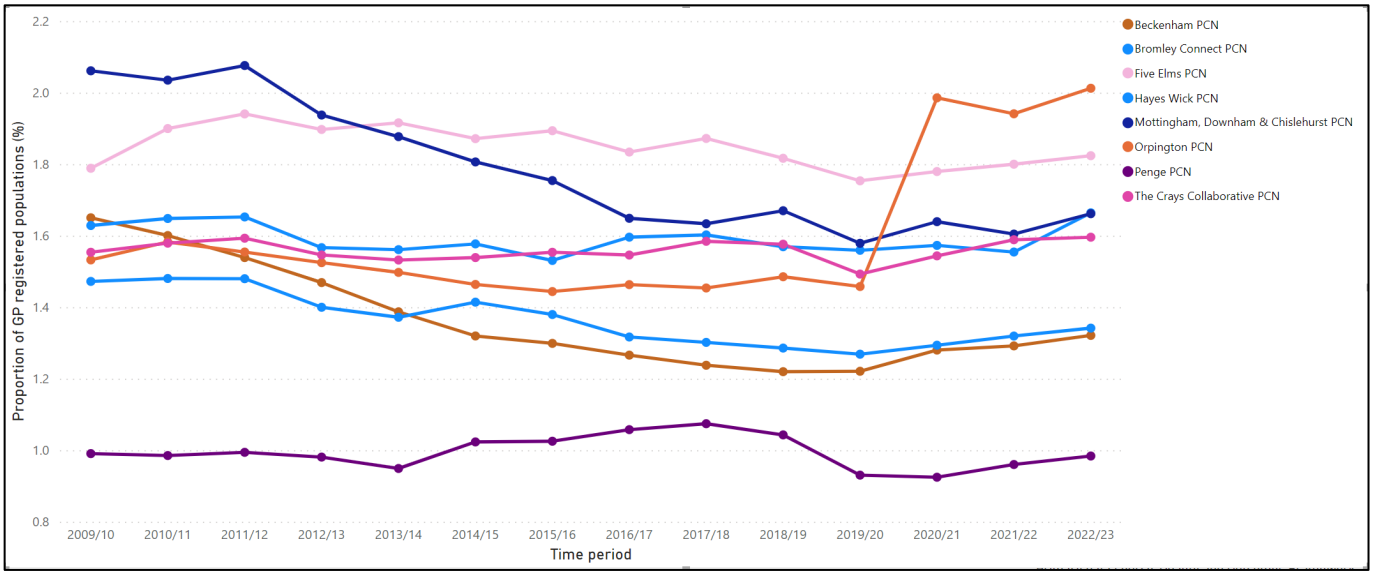
Source: OHID Fingertips 2024

*Please note that these calculations were made before the change in electoral ward boundaries and names in March 2021.

Figure 31 shows the ratio of deaths from stroke in Bromley wards, in proportion to the age-specific mortality rates in England between 2016 and 2020. The standardised mortality ratio is highest in Bickley, which has a significantly higher standardised mortality ratio than England, at 146 deaths per 100. Biggin Hill has the lowest standardised mortality ratio for stroke at 46.5 deaths per 100, which is significantly lower than the England ratio of 100. Of the 22 wards in Bromley, five have a significantly lower standardised mortality ratio than England. These are Petts Wood and Knoll, Cray Valley East, Penge and Cator, Kelsey and Eden Park, Farnborough and Crofton and Biggin Hill.

Wards with higher proportions of older populations, such as Bickley and Farnborough & Crofton, tend to have higher SMRs due to the increased vulnerability of elderly residents to stroke. Please refer to page 14 of the latest Demography JSNA chapter for age-specific population projections by Bromley wards. However, wards like Petts Wood & Knoll, Kelsey & Eden Park, and Biggin Hill, which also have significant older populations, show lower SMRs, suggesting that factors such as healthier lifestyles, better healthcare access, effective stroke prevention programs, and community health initiatives may be mitigating the stroke risks. Wards with a younger population, like Cray Valley East, benefit from a generally healthier community, which could lower overall stroke mortality despite having older residents. Therefore, while age is a primary factor, healthcare services, local health initiatives, and lifestyle also significantly influence stroke mortality rates across the wards.

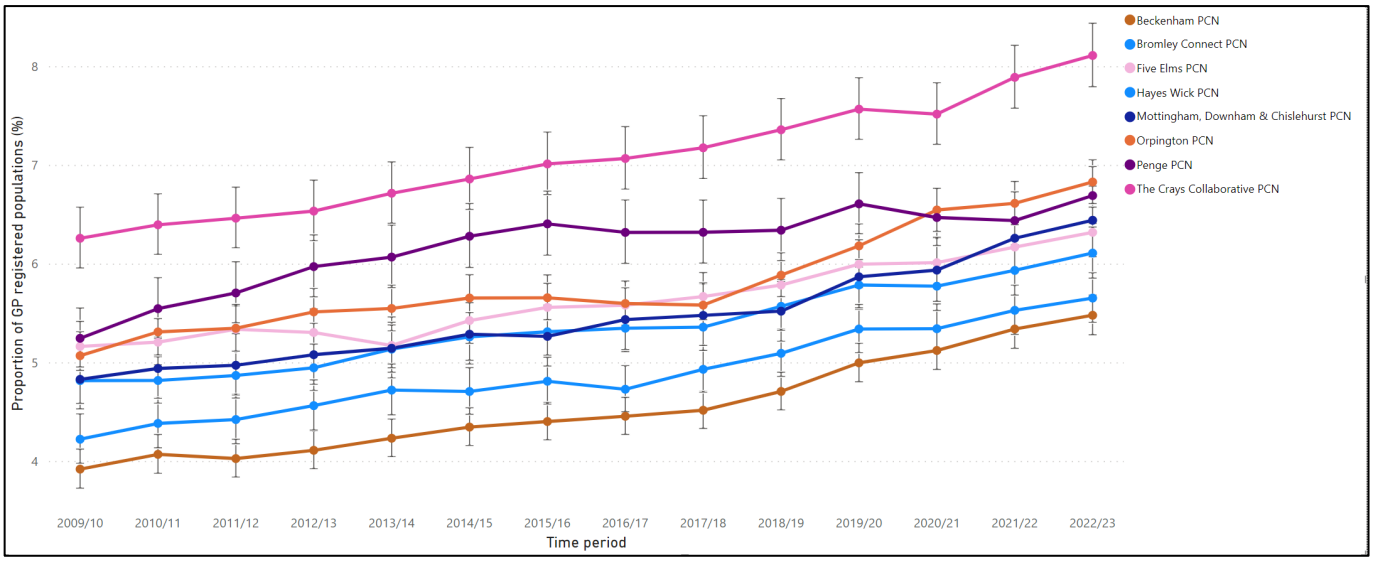
Figure 32: Trend in stroke prevalence by Bromley Primary Care Network



Source: Quality Outcomes Framework, NHS England, 2024

The trend in stroke prevalence varies by PCN. Orpington became the PCN with the highest percentage of GP registered patients with a stroke, rising from 1.5% in 2009/10 to 2.0% in 2022/23 (Figure 32). Orpington PCN's stroke prevalence exceeded that of Five Elms, during the pandemic years of 2019/20 and 2020/21. This increase in prevalence likely reflects the cumulation of people living with stroke, as well as the aging population. Between 2019/20 and 2022/23, Penge PCN, consistently had the lowest percentage change in the number of GP registered patients diagnosed with a stroke, which may reflect fewer new diagnoses, or a stable population of GP registered patients diagnosed with a stroke, possibly influenced by mortality or reduced monitoring during the pandemic years.

Figure 33: Diabetes prevalence by Bromley Primary Care Network

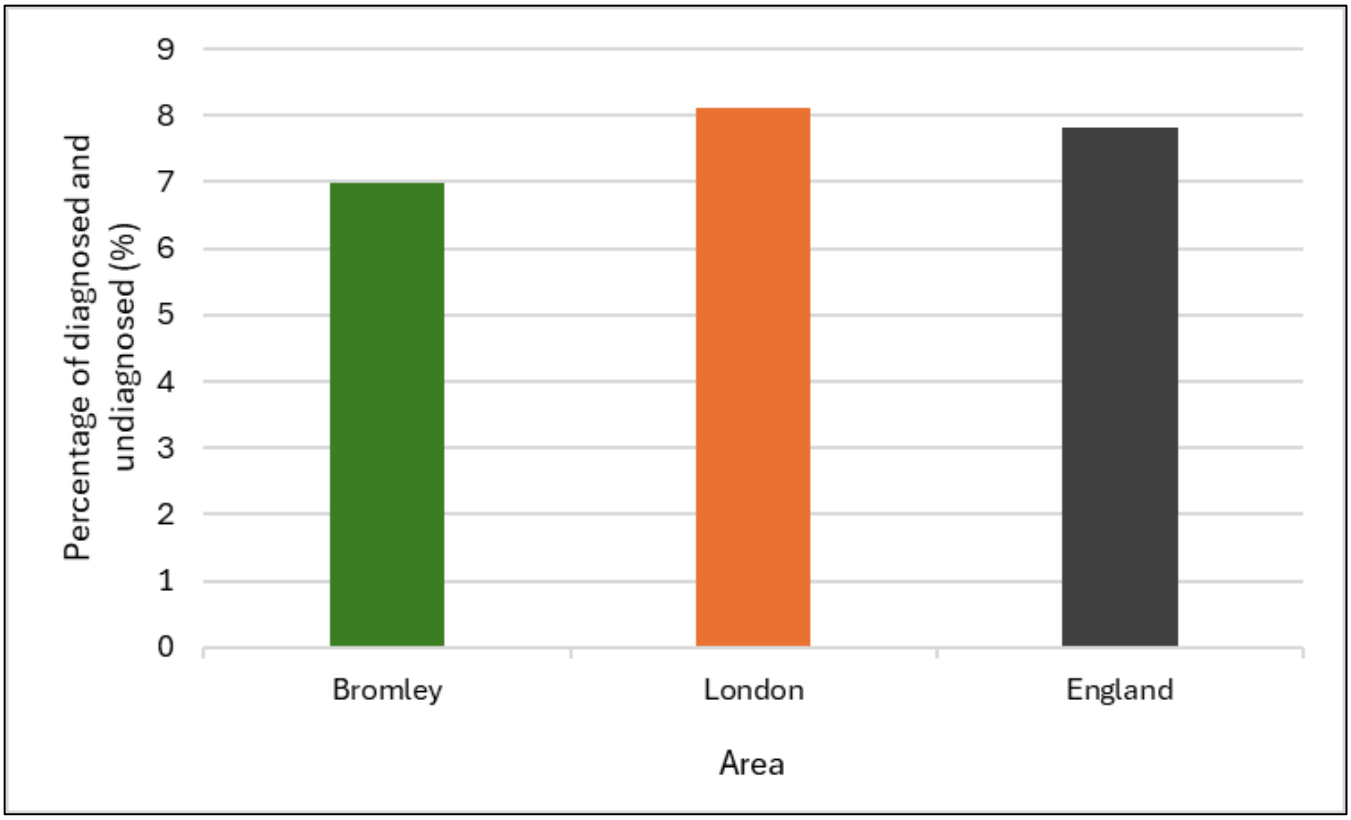


Source: Quality Outcomes Framework, NHS England, 2024

The prevalence of diabetes has increased across all PCNs in One Bromley. The Crays Collective is the PCN with the highest percentage of GP registered patients with a diabetes diagnosis, ranging from 6.3% in 2009/10 to 8.1% in 2022/23 (Figure 33). Between 2009/10 and 2022/23,

Beckenham PCN, consistently had the lowest percentage of GP registered patients diagnosed with diabetes, ranging from 4.0 % to 5.5%.

Figure 34: Estimated prevalence of diagnosed and undiagnosed type 2 diabetes in people aged 16 and over, 2021



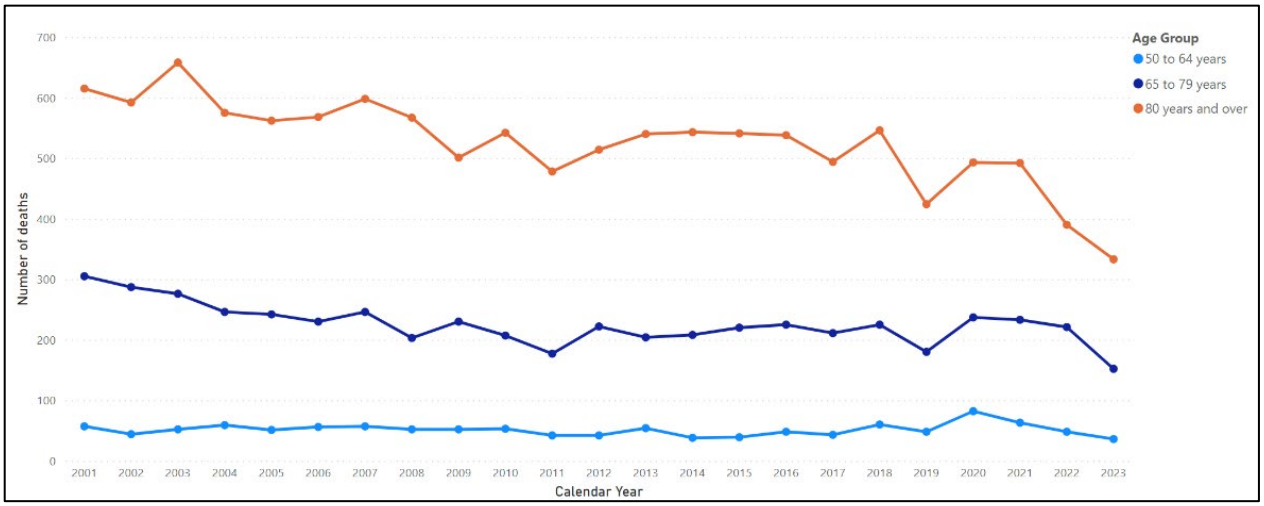
Source: OHID Fingertips, 2025

In 2021, the estimated prevalence of diagnosed and undiagnosed type 2 diabetes in Bromley was lower than in London and England, at just under 7%. London has the highest prevalence, exceeding 8%. The prevalence in England is slightly lower than London but remains notably higher than Bromley. This suggests that Bromley has a lower overall burden of type 2 diabetes compared to regional and national averages.

5.5 Respiratory disease

Respiratory disease is a common cause of death in England, with smoking being the primary cause of chronic obstructive pulmonary disease (COPD), a major respiratory condition. This section aims to direct public health efforts towards preventing smoking and addressing other environmental factors that contribute to respiratory diseases. Mortality rates directly measure healthcare needs, indicating the overall burden of respiratory diseases on the population.

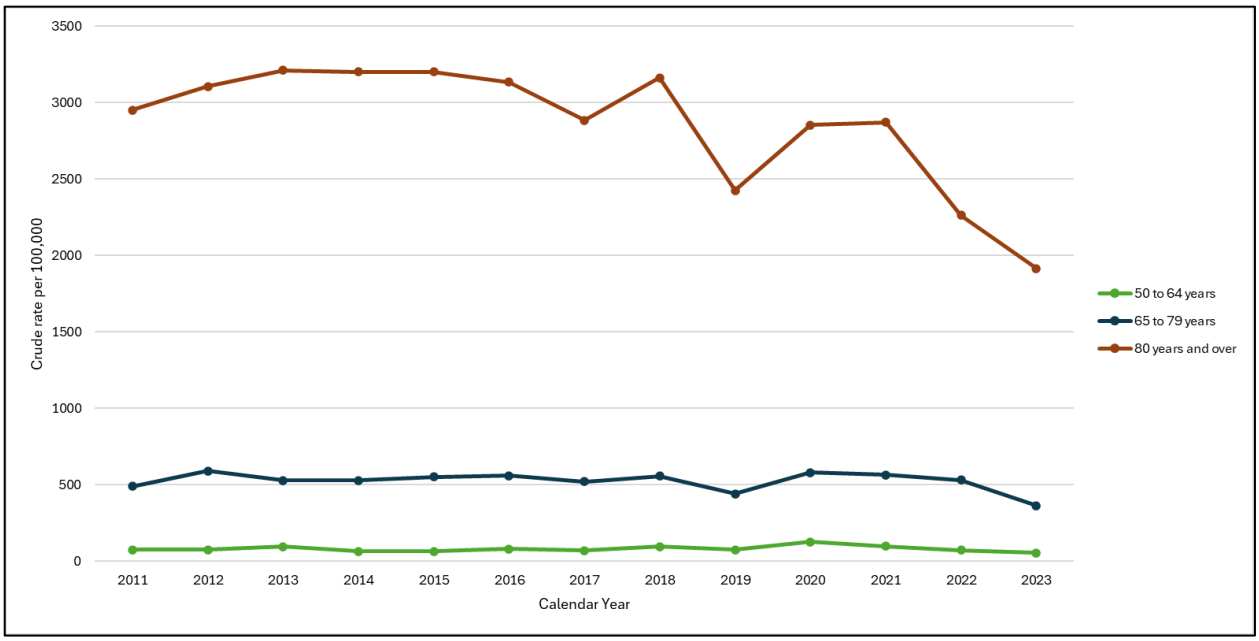
Figure 35: Number of deaths due to diseases of the respiratory system in persons aged 50 years and over, Bromley, 2001 to 2023



Source: PCMD, 2024

Between 2001 and 2023, there has been an overall decline in the number of deaths due to diseases of the respiratory system among adults over 50 years in Bromley (Figure 35). People aged 80+ years showed the highest number of deaths due to diseases of the respiratory system from 2001 to 2023, followed by those aged 65 to 79 years. People aged 65 to 79 years showed the highest decline (50%) in the total number of deaths due to diseases of the respiratory system, going from 305 deaths in 2001 to 152 deaths in 2023, followed by those 80 years and over with 615 deaths in 2001 to 333 deaths in 2023 (45% decrease).

Figure 36: Crude mortality rates from diseases of the respiratory system in persons aged 50 years and over, Bromley, 2011 to 2023

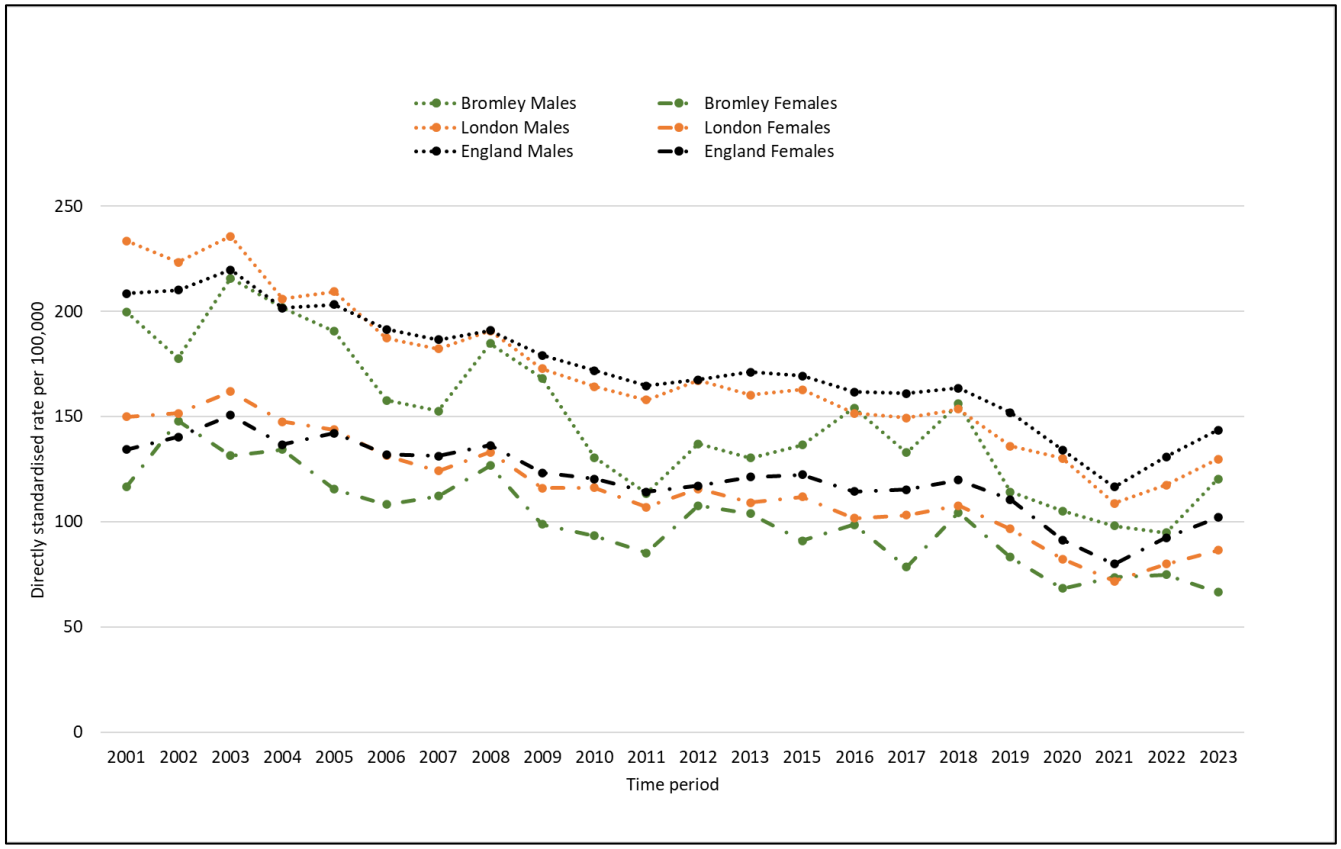


Source: PCMD and ONS, 2024

Between 2011 and 2023, there has been an overall decline in the crude mortality rate from diseases of the respiratory system among adults over 50 years in Bromley (Figure 36). People aged 80+ years showed the highest death rate from diseases of the respiratory system, followed

by those aged 65 to 79 years. People aged 80 years and over showed the highest decline (35%) in the mortality rate from diseases of the respiratory system, going from 2,949 deaths per 100,000 in 2011 to 1,913 deaths in 2023.

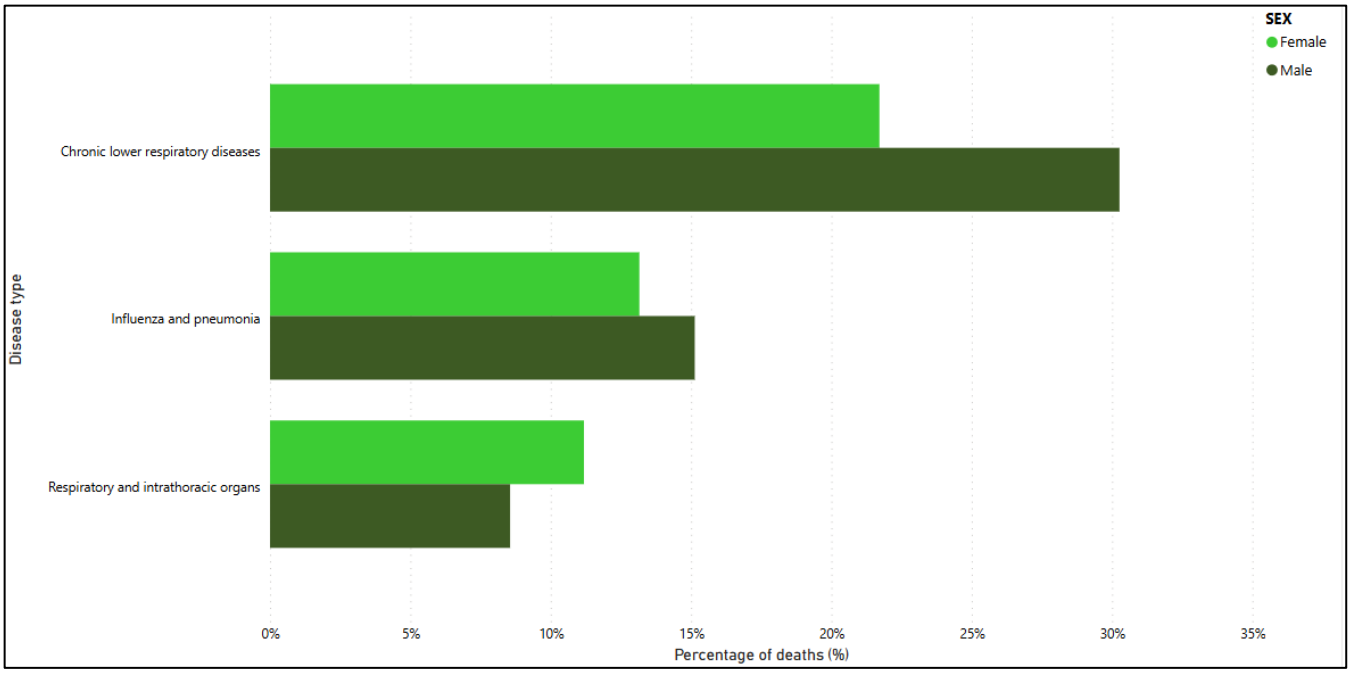
Figure 37: Mortality rate from respiratory disease, all ages, Bromley, London and England



Source: OHID Fingertips, 2024

In Bromley, there is an overall downward trend in mortality rates from respiratory disease between 2001 and 2023, with males showing higher rates in comparison to females, consistent with regional and national levels.

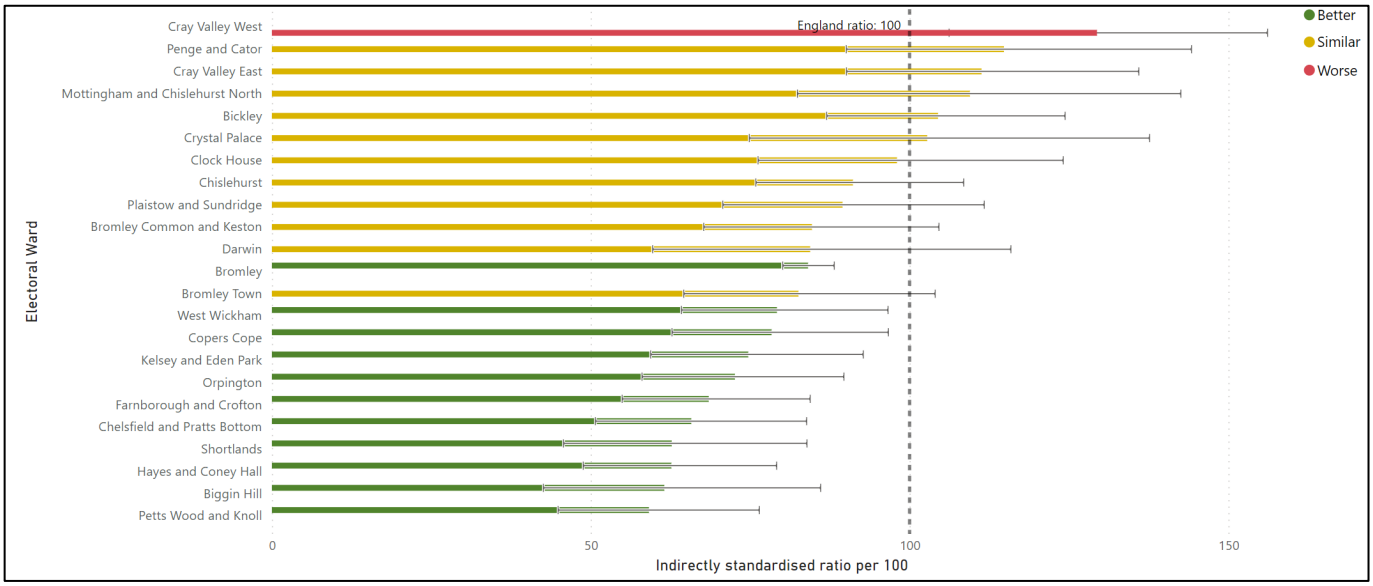
Figure 38: Most prevalent types of deaths from diseases of the respiratory system, Bromley, 2023



Source: PCMD, 2024

The most prevalent underlying cause of deaths from respiratory diseases in Bromley in 2023, were attributed to chronic lower respiratory diseases, accounting for 35.4% in males and 27.7% in females (Figure 38). This is followed by influenza and pneumonia (accounting for 18.0%) in males and 16.8 in females. The third most common type of deaths from diseases of the respiratory system in males is attributed to cerebrovascular diseases (13.3%), whereas in females, it is diseases of the respiratory and intrathoracic organs (14.3%).

Figure 39: Deaths from respiratory disease, by Bromley wards, standardised mortality ratio, 2016 to 2020.

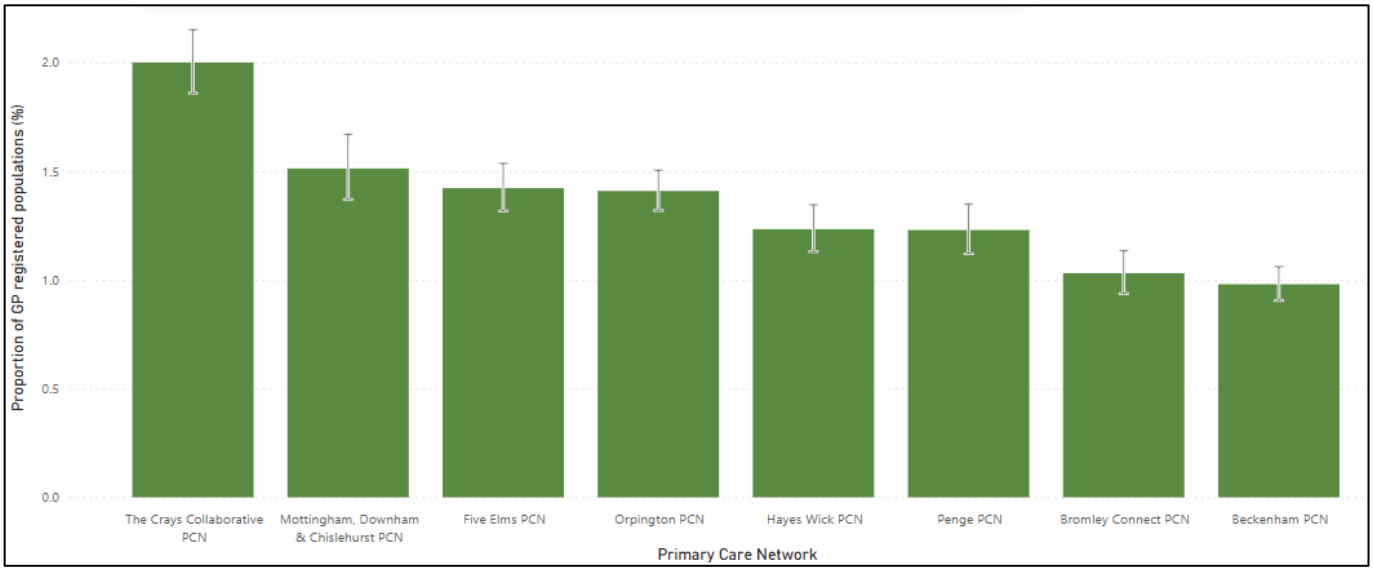


Source: OHID Fingertips 2024

Figure 39 shows the ratio of deaths from respiratory disease in Bromley wards, in proportion to the age-specific mortality rates in England between 2016 and 2020. The standardised mortality ratio is highest in Cray Valley West, which has a significantly higher standardised mortality ratio than England, at 129.4 deaths per 100. Petts Wood and Knoll has the lowest standardised mortality ratio of 59.1 deaths per 100, which is significantly lower than the England ratio of 100. Of the 22 wards in Bromley, ten have a significantly lower standardised mortality ratio than England. These are Bickley, West Wickham, Copers Cope, Kelsey and Eden Pak, Orpington, Farnborough and Crofton, Chelsfield and Pratts Bottom, Shortlands, Hayes and Coney Hall, Biggin Hill and Petts Wood and Knoll.

COPD is a prevalent and disabling condition with high mortality. The most effective treatment is quitting smoking. Oxygen therapy can extend life in the later stages and improve exercise capacity and mental state. Some patients benefit from inhaled steroids, while many respond to inhaled beta agonists and anti-cholinergics. Pulmonary rehabilitation has been shown to enhance quality of life. Most COPD patients are managed by GPs and primary healthcare teams, with referrals to secondary care as needed.

Figure 40: Chronic Obstructive Pulmonary Disease (COPD) prevalence by Bromley Primary Care Network, 2022/23

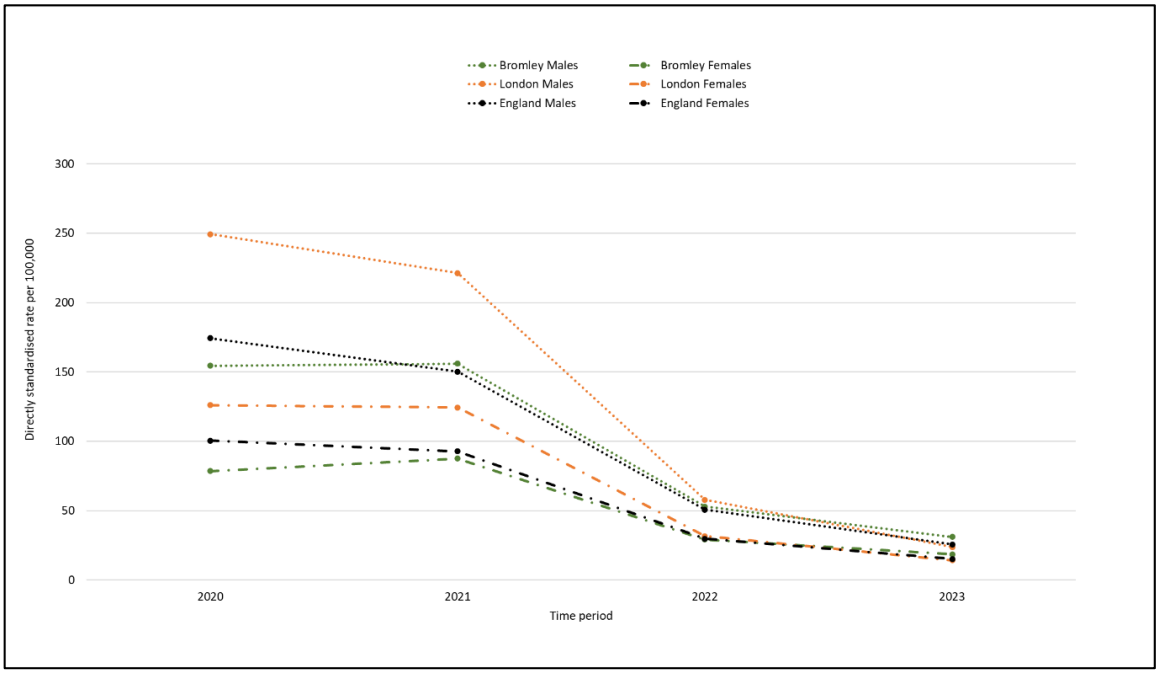


Source: Quality Outcomes Framework, NHS England, 2024

The Crays Collective is the PCN with the highest percentage of GP registered patients with a COPD diagnosis of 2% in 2022/23 (Figure 40). Beckenham PCN had the lowest percentage of GP registered patients diagnosed with COPD at 1.0%.

COVID-19 was the most common cause of death in England in 2020, with its impact on mortality varying significantly across different areas. Figure 41 shows mortality rates where COVID-19 was the underlying cause.

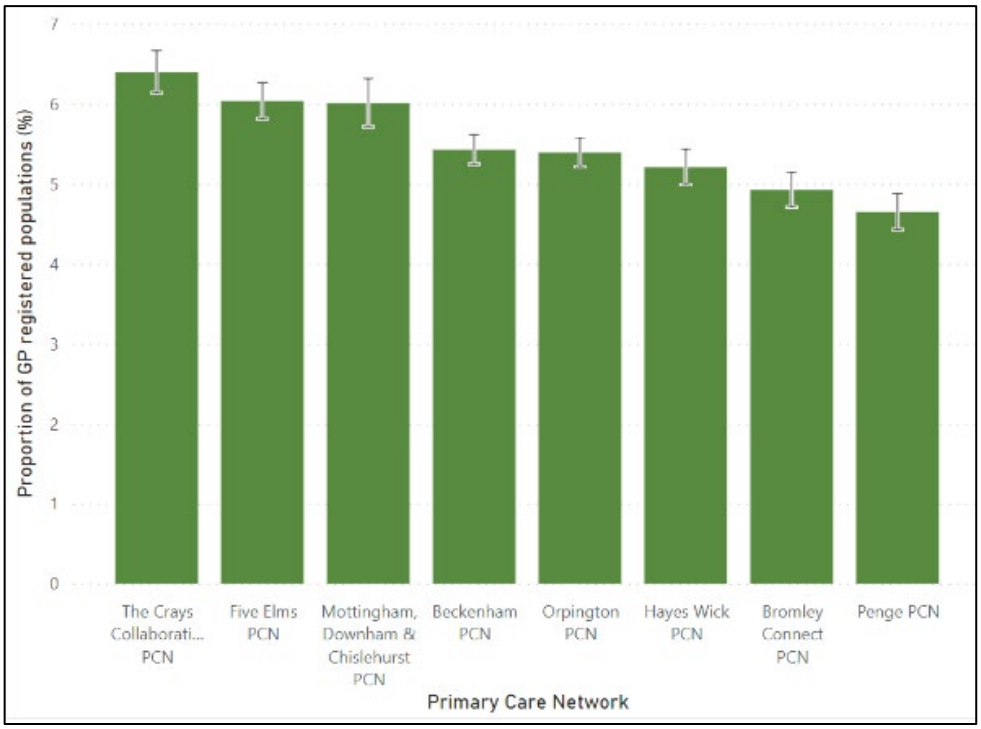
Figure 41: Mortality rate for deaths due to COVID-19, Bromley, London and England



Source: OHID Fingertips, 2024

In Bromley, there is an overall downward trend in mortality rates for deaths due to COVID-19 between 2020 and 2023, with males showing higher rates in comparison to females, consistent with regional and national levels (Figure 41). All three areas showed peaks in 2021, notably seen among Bromley males that exceeded England males by 3.9%. Mortality rates due to COVID-19 have further decreased as the pandemic has waned.

Figure 42: Prevalence of Asthma in GP registered persons aged 6 years and over by Bromley Primary Care Network, 2022/23



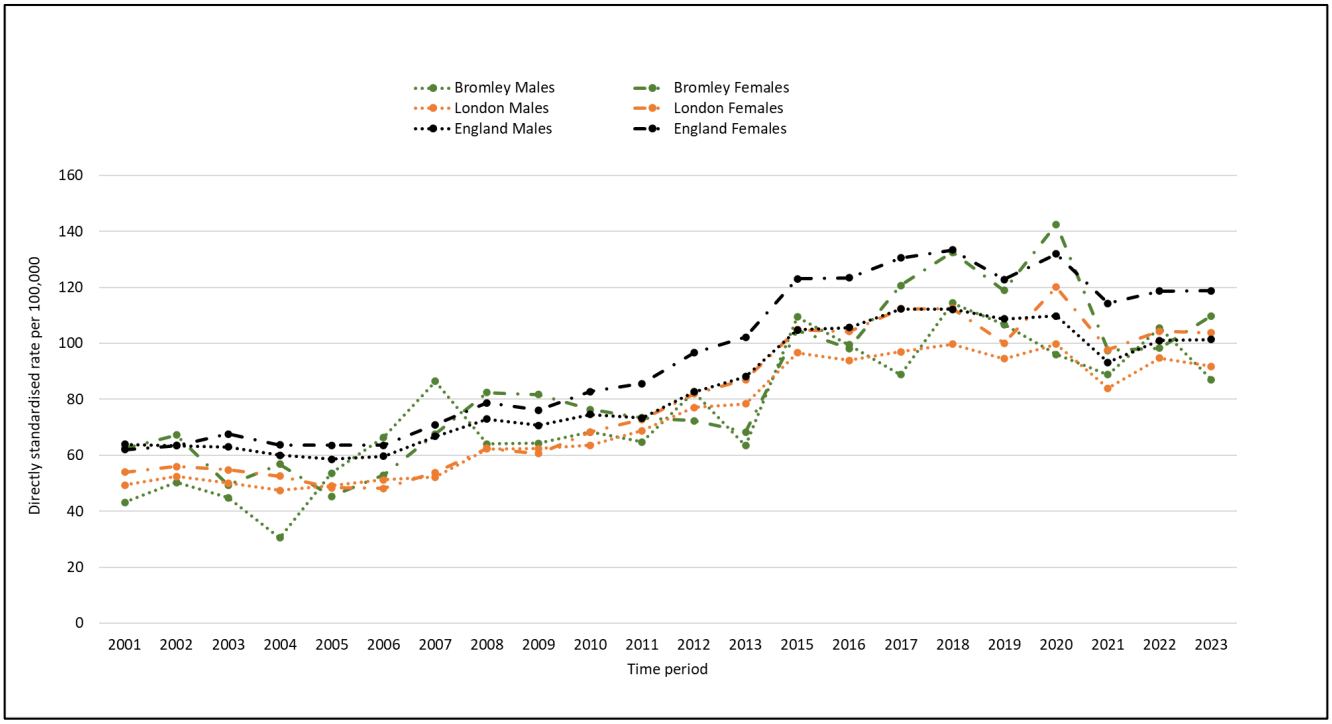
Source: Quality Outcomes Framework, NHS England, 2024

The Crays Collaborative and Five Elms PCNs had the highest percentage of GP registered patients with an asthma diagnosis, at 6.40%, and 6.04%, respectively (Figure 42). They were over 37% higher than Penge PCN, which had the lowest percentage of GP registered patients with asthma at 4.7%. Across all 8 One Bromley PCNs, the percentage of GP registered patients with cancer ranged from 4.7% to 6.4%.

5.6 Dementia and Alzheimer's disease

Recognising the specific type of dementia a person has can be advantageous for patients, their families, general practitioners, hospitals, social care staff, and others. It aids in understanding how to prevent or delay the onset of certain dementias, anticipate the condition's progression, and plan for the patient's future and future dementia services. Additionally, it assists in managing symptoms, accessing suitable support services, understanding genetic risks, and contributes to future research.

Figure 43: Mortality rate from dementia and Alzheimer's disease, all ages, Bromley, London and England



Source: OHID Fingertips, 2024

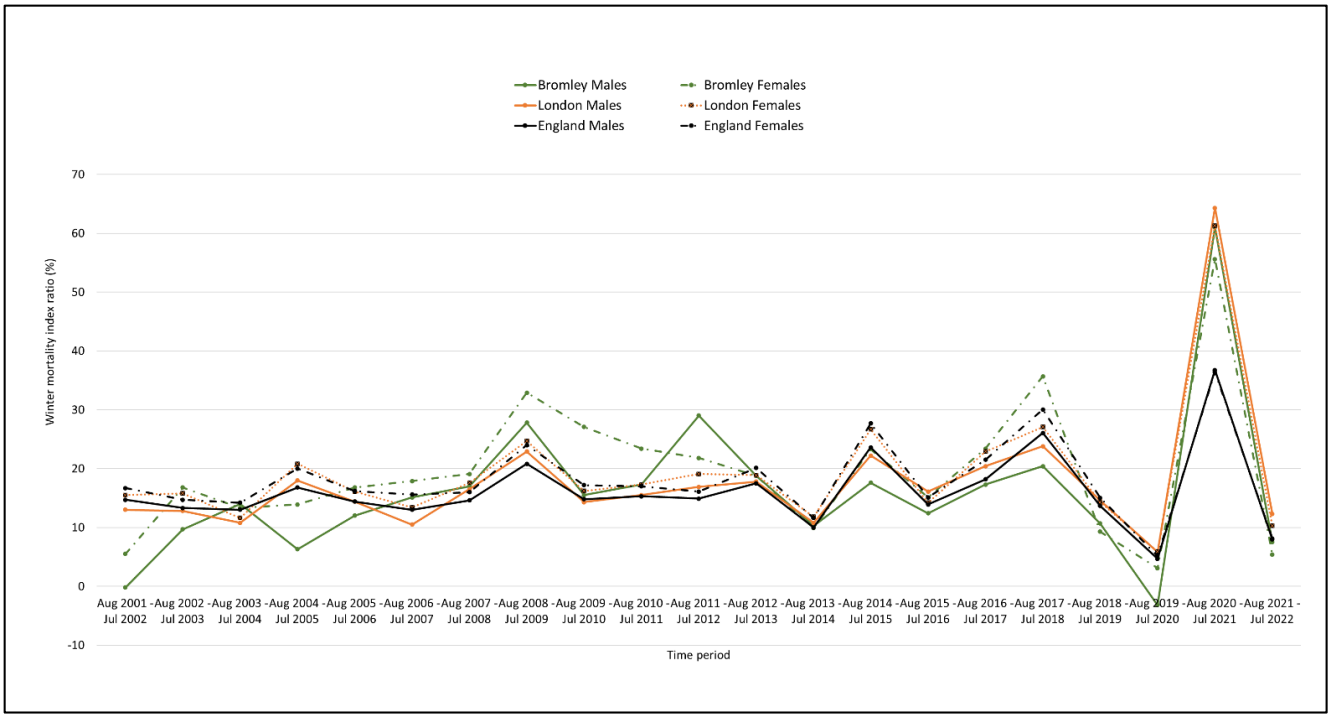
Mortality rates from dementia and Alzheimer's disease have risen significantly across Bromley, London, and England since 2001, with a notable increase from 2011 onwards (Figure 43). One reason for this could be changes in the awareness and diagnosis of the condition. There does seem to have been a recent plateau of the mortality rate with rates falling more recently perhaps due to the consequences of the pandemic. In recent years (2018–2023), Bromley's rates for women have consistently been higher than London's but have fluctuated around the national average. Women tend to have higher mortality rates with an underlying cause of Alzheimer's compared to men.

5.7 Winter mortality

The purpose of the winter mortality measure is to compare the number of deaths that occurred in the winter period (December to March) with the average of the non-winter periods (August to November and April to July). Winter mortality is not solely a reflection of temperature, but of other factors, such as fuel poverty. These include respiratory diseases and pressure on services, which have been more intense than usual during and following the height of the pandemic.

It is an important measure as it allows users to assess whether policies are having an impact on mortality risks during the winter period.

Figure 44: Winter mortality index in persons, males and females in Bromley, London, and England



Source: OHID Fingertips 2024

In the most recent years, Bromley's Winter Mortality Index (WMI) has followed national and regional trends, with a significant peak in 2020–2021, likely due to the impact of COVID-19. During this period, Bromley's WMI was higher than England's. This highlights the importance of continued monitoring and support for vulnerable groups during winter months.

6. Conclusions and main findings

- The top three risk factors contributing to early death and disability are high systolic blood pressure, high LDL cholesterol and dietary risks such as low intake of fruits, vegetables, and fibre, and high intake of sodium, processed meat, and trans-fatty acids. Between 2015 and 2023, the prevalence of overweight and obesity in Bromley adults rose by 1.3%, going from 60.8% to 62.1%. This is slower than the national rise but faster than London's.
- Mortality rates from all causes have generally decreased in Bromley, London, and England over the past two decades. As of 2023, Bromley's mortality rate was 803 deaths per 100,000, which is still lower than both the regional and national averages. A temporary spike in mortality was observed in 2019-2020 due to COVID-19, but Bromley demonstrated a faster decline in mortality rates after 2020.
- Mortality rates in Bromley are consistently higher in males than in females. In 2023, male mortality was 978 deaths per 100,000, compared to 674 deaths per 100,000 for females. Both groups have seen a decline in mortality rates over time, but the gender gap remains significant.
- Life expectancy at birth has shown a steady increase in Bromley from 2001 to 2022. Males' life expectancy rose from 77.2 years in 2001 to 81.8 years in 2022, while females' life expectancy increased from 81.9 years in 2001 to 85.9 years in 2022. Bromley's life expectancy remains higher than regional and national averages, despite a temporary drop during the COVID-19 pandemic in 2019-2020.
- Bromley's healthy life expectancy is higher than London and England. Female healthy life expectancy has remained higher than that of males.
- A growing disparity in life expectancy between the most and least deprived areas of Bromley was noted, with a 6-year gap for males and a 5.5-year gap for females. This inequality is explained primarily by differences in circulatory diseases, cancer, respiratory diseases, and mental health issues. There is a need for targeted interventions, particularly in deprived areas, to address these health disparities.
- Emergency hospital admissions for coronary heart disease, stroke and myocardial infarction are significantly lower in most Bromley wards compared to England's levels, with very few wards having similar ratios. COPD admissions in Crystal Palace (192.3) are nearly double the national average and there are 30% more admissions due to COPD in Penge and Cator (standardised admission ratio of 130), when compared to England.
- In 2021, cancer remained the leading cause of death, accounting for 27% of all deaths in Bromley, followed by cardiovascular diseases (23%) and respiratory infections (20%). COVID-19 was responsible for nearly 16% of all deaths in Bromley in 2021. Although cancer mortality has decreased in older age groups, deaths have increased among younger populations. Cardiovascular diseases, cancer, and respiratory diseases remain the primary contributors to both mortality and morbidity in Bromley.
- People aged 80 years and over showed the highest crude mortality rate from cancer from 2001 to 2023. Cray Valley East and Cray Valley West have been particularly affected by cancer and respiratory diseases, with Cray Valley West having the highest mortality rates for respiratory diseases.
- Bickley is notably affected by stroke-related mortality, while Biggin Hill has lower stroke prevalence.

- Penge PCN has the lowest cancer prevalence, possibly due to differences in local demography, population behaviours or access to services.

In conclusion, Bromley has seen overall improvements in life expectancy and reductions in mortality rates, with some positive trends in healthy life expectancy. Despite these improvements, significant health inequalities persisted between 2020 and 2021, particularly in more deprived areas, where life expectancy and mortality are disproportionately affected by conditions such as cancer, cardiovascular diseases and respiratory diseases.

7. Appendices

7.1 Appendix 1: Data sources

To understand mortality and morbidity in Bromley, the following data sources were used:

1. The Primary Care Mortality Database (PCMD): NHS Digital provides PCMD, which includes a list of all deaths recorded in Bromley residents.
2. OHID Fingertips Public Health Profiles. For a full list of profiles, see the fingertips website.
    a. Mortality Profile: Trends in mortality rates for various causes of death, allowing comparisons between different areas.
    b. Local Authority Health Profiles: Overview of health for each local authority in England, highlighting local health issues and aiding in planning to improve health and reduce inequalities.
    c. Local Health: Public health data for small geographic areas within local authorities, enabling detailed local level analysis.
    d. Smoking Profile: Data on smoking prevalence, related health outcomes, and the impact of smoking on public health.
    e. Alcohol Profile: Information on alcohol consumption, alcohol-related health issues, and the impact of alcohol on public health.
    f. Public Health Outcomes Framework: A set of indicators to measure public health outcomes and track progress in improving health and reducing inequalities.
    g. National General Practice Profiles: Data on the quality and outcomes of general practice services, including patient demographics and health conditions.
    h. Child and Maternal Health: Indicators related to the health of children and mothers, including birth outcomes, child development, and maternal health.
    i. Health Protection: Data on infectious diseases, environmental hazards, and other factors affecting public health protection.
3. OHID Segment tool: This tool provides detailed information on the causes of death and age groups contributing to inequalities in life expectancy at the local area level. It helps identify the main factors driving the life expectancy gap between different areas and within areas, particularly between the most and least deprived quintiles. By targeting these causes, the tool aims to support efforts to reduce health inequalities.
4. The Global Burden of Disease study: This comprehensive research program assesses mortality and disability from major diseases, injuries, and risk factors globally and regionally. It quantifies health loss across different populations and over time, providing valuable insights into global health trends and challenges. The study helps inform health policy and resource allocation by highlighting the most significant health issues and their impact on populations.

The Primary Care Mortality Database (PCMD):

PCMD collates deaths by place of death, CCG of residence and date of death. The fields include Age, Gender, NHS Number, Usual Address, Postcode, Ward, Occupation, Cause(s) of Death with ICD10 codes and descriptions, Location of Death, etc. Geographically, the Bromley PCMD dataset records deaths of Bromley residents (regardless of where the death occurred) and deaths occurring in Bromley for non-residents.

The underlying cause of death is recorded for all deaths in the PCMD using the World Health Organisation's (WHO) International Classifications of Diseases version 10 (ICD 10. It is worth noting the changes in coding deaths over the time. From 1998-2000 deaths in England were coded using the Ninth Revision of the ICD (ICD-9), since 2001, the Tenth Revision of the ICD (ICD-10) has been in use. The PCMD data is filtered to include only Bromley residents and date of death from January 2001 to December 2023. Due to various organisation and regulation changes access to datasets (Coroner records and GP clinical records) that complement the PCMD extract is no longer possible. The absence of those datasets eliminates the soft intelligence around mortality which is vital in prevention strategies. The report specifically looks at profiling the population of registered deaths in the region.

OHID Fingertips Public Health Profiles:

Data for the OHID Fingertips Public Health Profiles is collected from various sources, including national surveys like the Health Survey for England, administrative data from health services (e.g., hospital admissions, general practice records), and mortality records from the Office for National Statistics (ONS). Many indicators are sourced from the Public Health Outcomes Framework (PHOF), which tracks public health outcomes and measures progress in improving health and reducing inequalities. Additionally, local data from authorities and health services provide insights into smaller geographic areas, while specialised databases contribute specific information for profiles like smoking and alcohol. This comprehensive approach ensures detailed and accurate public health assessments across different regions and populations. Most of the data from this report was obtained from the Mortality and Local Authority Health Profiles.

Mortality Profile:

The Mortality profile's indicators cover ten topics, including mortality rates for leading causes of death such as cancer and cardiovascular disease, specific cancers (lung, breast, prostate), cardiovascular diseases (ischaemic heart disease, stroke), COVID-19, dementia and Alzheimer's disease, liver disease, respiratory diseases (influenza, pneumonia, chronic lower respiratory disease), preventable mortality, mentions of causes on death certificates (diabetes, hypertensive disease), child mortality by age groups, and other mortality indicators related to risk factors like smoking, drug misuse, air pollution, and various causes such as accidents, infectious diseases, suicides, and road casualties in England. The Mortality Profile presents mortality rates for various chapters of the International Classification of Diseases, Tenth Revision (ICD-10), as well as for specific causes within those chapters. The selection focuses on the leading causes of death with the highest mortality rates and those of significant public health concern. For full details on each indicator, see the definitions tab of the Mortality Profile online tool.

Local Authority Health Profiles:

The local authority health profiles aim to assist local governments and health services in planning to improve local population health and reduce health inequalities. While the 'Health Profile for England' addresses national health trends, Local Health provides detailed health information for smaller areas within local authorities, allowing users to examine local-level differences. Unless otherwise noted, indicators are sourced from the Public Health Outcomes Framework (PHOF).

7.2 Appendix 2: Key definitions

Mortality rate: The number of deaths in a population during a specific period, usually expressed per 1,000 or 100,000 individuals, allowing for comparisons between areas of different sizes and tracking changes over time within a single area as its population size changes. These comparisons can be misleading if the age structure of the populations varies. Where possible, age- standardisation was carried out to adjust for differences in the age structure of populations, enabling fair comparisons between areas and over time. Without this adjustment, areas with older populations, like rural regions, would appear to have higher mortality rates than younger, urban areas, leading to unfair comparisons.

Life expectancy: The average number of years a person can expect to live, based on current mortality rates.

Inequality of life expectancy: The difference in the average number of years people is expected to live, influenced by various socioeconomic factors such as income, education, and geographic location. To measure inequality of life expectancy, life expectancy is determined for each deprivation decile within lower super output areas, and the slope index of inequality (SII) is then calculated. The SII quantifies the social gradient in life expectancy, indicating how life expectancy varies with deprivation. It represents the range in life expectancy from the most to the least deprived, based on a statistical analysis of the relationship between life expectancy and across all deprivation deciles.

Premature mortality: Deaths that occur before a person reaches an expected age, often defined as deaths before age 75.

The Standardised Admission Ratio (SAR): Observed admissions in an MSOA divided by the adjusted expected admissions for that MSOA, then multiplying the result by 100.

Standardised Mortality Ratio (SMR): A ratio of observed deaths in a study population to the number of deaths expected, based on age-specific rates in a standard population.

Incidence: The number of new cases of a disease or condition in a specific population during a defined period.

Prevalence: The proportion of cases of a disease or condition in a specific population at a given time.

Cause of death: The disease or injury that initiated the sequence of events leading directly to death.

Underlying cause of death: The disease or injury that started the train of morbid events leading directly to death, or the circumstances of the accident or violence that produced the fatal injury.

Comorbidity: The presence of one or more additional diseases or conditions co-occurring with a primary disease or condition.

Age-standardised rate: A rate that has been adjusted to a standard age distribution to allow comparisons between populations with different age structures.

Age-specific rate: The frequency with which the event occurs relative to the number of people in a defined age group. The rate is limited to a particular age group compared to age-standardised rates which use the age- specific rates and adjust for population differences.

Health inequality: Differences in health status or in the distribution of health determinants between different population groups.

Preventable mortality: Deaths that could be avoided through effective public health and primary prevention interventions.

Quality-Adjusted Life Year (QALY): A measure of the value of health outcomes, which combines the quantity and quality of life lived.

Disability-Adjusted Life Year (DALY): A measure used to quantify the overall burden of disease. One DALY represents the loss of the equivalent of one year of full health. It combines two components: Years of Life Lost (YLL) – the number of years lost due to premature death. Years Lived with Disability (YLD)- the number of years lived with a disability or health condition.

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