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DATE: 20 January 2011

To: Members of the
GENERAL PURPOSES AND LICENSING COMMITTEE

Councillor Tony Owen (Chairman)
Councillor Stephen Wells (Vice-Chairman)
Councillors Nicholas Bennett J.P., John Canvin, Roger Charsley, Roxy Fawthrop,
John Getgood, Will Harmer, Ian F. Payne, Charles Rideout, Diane Smith,
Tim Stevens, Harry Stranger, Pauline Tunnicliffe and Michael Turner

A joint meeting of the General Purposes and Licensing Committee with the Public Protection and Safety PDS Committee will be held at Bromley Civic Centre on
TUESDAY 1 FEBRUARY 2011 AT 7.00 PM

MARK BOWEN
Director of Legal, Democratic and
Customer Services.

Copies of the documents referred to below can be obtained from
www.bromley.gov.uk/meetings

A G E N D A

1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF ALTERNATE MEMBERS

2 DECLARATIONS OF INTEREST

3 QUESTIONS FROM MEMBERS OF THE PUBLIC ATTENDING THE MEETING

To hear questions received in writing by the Director of Legal, Democratic and Customer Services by 5pm on Wednesday 26th January 2011 and to respond.

4 SCRUTINY SESSION ON ALCOHOL AND VIOLENT CRIME (Pages 3 - 62)

This item will be considered jointly with the Public Protection and Safety PDS Committee.

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Report No.
ES11012

London Borough of Bromley

Agenda
Item No.

PART 1 - PUBLIC

Decision Maker: **Public Protection and Safety Policy Development and Scrutiny Committee and the General Purposes and Licensing Committee**

Date: **1 February 2011**

Decision Type: Non-Urgent Executive Non-Key

TITLE: SCRUTINY SESSION ON ALCOHOL AND VIOLENT CRIME

Contact Officer: Colin Newman, Head of Community Safety
Tel: 020 8461 7915 E-mail: colin.newman@bromley.gov.uk

Chief Officer: Nigel Davies, Director, Environmental Services

Ward: All borough

1. Reason for report

At the Meeting of the Public Protection and Safety Policy Development and Scrutiny Committee on 1 February 2011, Members will receive a presentation relating to alcohol and community safety issues. In support of the presentation and to provide background reading to assist discussion, this report contains a copy of the Alcohol Needs Assessment for the borough and a document outlining details of alcohol related admissions at Accident and Emergency Departments.

2. **RECOMMENDATIONS**

Members of the Public Protection and Safety Policy Development and Scrutiny Committee and the General Purposes and Licensing Committee are asked to note the information contained within the attached documents and delivered as part of the supporting presentation.

Corporate Policy

1. Policy Status: Building a Better Bromley, Local Area Agreement, Community Safety Strategy 2008 – 2011, Public Protection and Safety Portoflio Plan 2010/2011
 2. BBB Priority: Safer Bromley
-

Financial

1. Cost of proposal: N/A
 2. Ongoing costs: N/A
 3. Budget head/performance centre: Public Protection and Safety
 4. Total current budget for this head: £4.1 million
 5. Source of funding:
-

Staff

1. Number of staff (current and additional) – N/A
 2. If from existing staff resources, number of staff hours – N/A
-

Legal

1. Legal Requirement: Statutory Requirement
 2. Call in: Call in is applicable
-

Customer Impact

1. Estimated number of users/beneficiaries (current and projected) - Borough wide
-

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No
2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

- 3.1 Members will receive a presentation that addresses the issues faced in the field of alcohol and community safety. In order to support the detail of the presentations, two documents have been attached to this report, the Alcohol Health Needs Assessment for Bromley and a report relating to Alcohol Attributable Admissions in London.
- 3.2 The Alcohol Health Needs Assessment has been developed in order to identify key issues relating to problematic use of alcohol, assess the health and social impact of alcohol misuse and identify gaps in services. The document will be used by the borough's Drug Action Team to inform commissioning decisions and action planning for addressing the gaps identified. The document relating to alcohol attributable admissions was commissioned by the Regional Public Health Group and sets out the detail of hospital admissions for alcohol attributable conditions. The extent of alcohol attributable admissions is considerable and it is also noted that the number of hospital admissions for conditions wholly or partially caused by alcohol continues to rise, with an average increase between 2003/2004 and 2008/2009 of 8% per year.

4. POLICY IMPLICATIONS

- 4.1 Reducing crime and disorder and the harm caused by drugs and alcohol in Bromley are key elements of both Building a Better Bromley and the Safer Bromley Partnership's Community Safety Strategy 2008 – 2011.
- 4.2 The Public Protection and Safety (PPS) Portfolio provides the lead for the delivery of the Council's activity to meet the vision of making Bromley a safer place. Unlike other Portfolios, the activities overseen by the PPS Portfolio Holder are the responsibility of several departments across the Council and of multiple partner organisations.

Non-Applicable Sections:	Legal Implications, Personnel Implications, Financial Implications
Background Documents: (Access via Contact Officer)	Alcohol health needs assessment for Bromley Alcohol Attributable Admissions in London

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London Health Observatory



Commissioning Support for London

ALCOHOL ATTRIBUTABLE ADMISSIONS IN LONDON

July 2010

Robel Feleke, London Health Observatory

John Hamm, London Regional Public Health Group (RPHG)

Paul De Ponte, London Health Observatory

Commissioned by the Regional Public Health Group, London

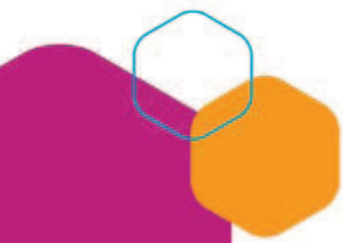
About the LHO

The London Health Observatory (LHO) provides information, data, and intelligence on Londoners' health and health care for practitioners, policy makers and the public. We are one of a network of 12 Public Health Observatories, known as the Association of Public Health Observatories (APHO), set up across five nations of England, Wales, Scotland, Northern Ireland and the Republic of Ireland. The LHO takes the national lead in monitoring health inequalities, ethnicity and health, and tobacco.

From 1 April 2009, LHO became part of Commissioning Support for London (CSL) which has been established to provide clinical and business support to NHS commissioners across London. For further information on our work please visit these websites: www.lho.org.uk www.csl.nhs.uk.

Acknowledgements

The authors are grateful for the contributions made by, Matthew Andrews, Regional Alcohol Manager at RPHG, and Justine Fitzpatrick Deputy Director at LHO.



Summary of findings

- The number of hospital admissions for conditions wholly or partially caused by alcohol (alcohol attributable conditions) continues to rise; between 2003/04 and 2008/09 there was an average increase in admission rates of 8% a year.
- The extent of alcohol attributable admissions is considerable. In 2007/08 there were 102,000 alcohol attributable admissions in London, roughly 1.4 admissions per every 100 persons in London.

How do admission rates vary across London?

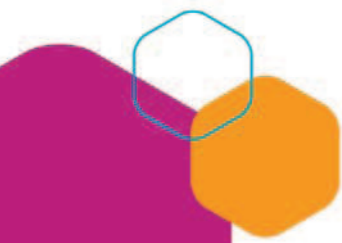
- There are wide inequalities in admission rates for alcohol attributable conditions. There was a two fold difference between the Local Authority with the highest admission rate and the Local Authority with the lowest admission rate. High rates were found in Newham, Ealing and Islington, and low rates in Barnet, Bexley and Enfield. However, admission rates for conditions solely caused by alcohol (alcohol-specific conditions) were highest in Bromley, Newham and Havering.
- The demand that alcohol attributable conditions place on NHS inpatient services varies by day of the week and type of admission. Elective admissions were more likely to be during the week (94% of admissions) compared with emergency admissions (74%).
- More than two thirds (68%) of alcohol attributable admissions were for just three conditions: 35% were for hypertensive diseases, 19% for mental and behavioural disorders, and 15% for cardiac arrhythmias.

Who was admitted?

- One fifth of patients who had an admission for an alcohol-specific condition in 2007/08 had more than one admission for the same condition in that year. Of those people who were admitted for alcoholic liver disease, over a third (34%) had more than one admission that year.
- There were wide ethnic inequalities in admission rates for alcohol attributable conditions, particularly for alcohol-related admissions (those conditions where only a fraction would be due to alcohol). Most ethnic minority groups had higher admission rates than the White group. This is contrary to survey information which suggests that ethnic minority groups consume less alcohol than the White British population. A review of the evidence would be useful to understand these findings.

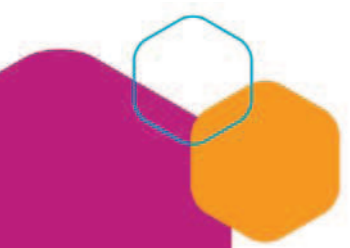
Next steps

- A second phase of analysis will be agreed with the London Regional Public Health Group based on stakeholder feedback. Suggestions for further analysis have been identified in section 6 of this report.



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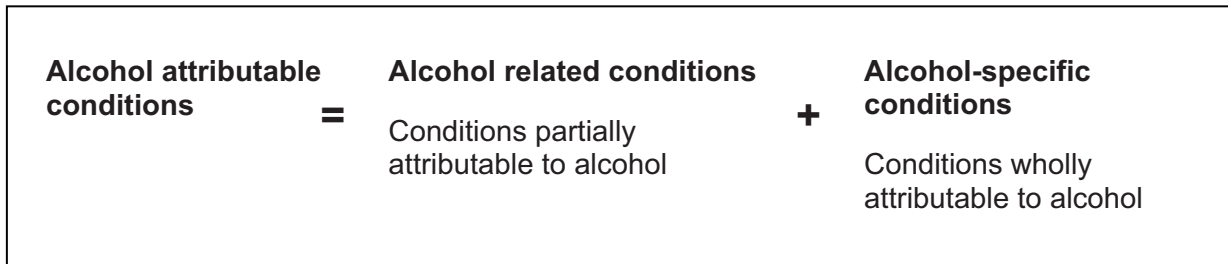


1. Introduction

It is estimated that in England the NHS spends £2.7 billion each year on health problems caused by alcohol¹. Reducing the harm caused by alcohol was therefore identified in the national Public Services Agreements (PSA 25).

Hospital admissions for alcohol attributable conditions are a combination of those conditions that are wholly attributable to alcohol (alcohol-specific conditions) and those conditions that are partially attributable to alcohol (alcohol-related conditions) (see Box 1). Admissions for these conditions, aggregated and directly age standardised have been used for the National Indicator (NI39), Vital Signs VSC 23, and for Local Authorities (LA) and Primary Care Trusts (PCTs) to monitor and track progress in reducing harm from alcohol. In London, 16 PCTs / LAs have selected the indicator in Operating Plans and Local Area Agreements.

Box 1 – Definition of alcohol attributable conditions



While admission rates due to alcohol consumption in London have been consistently lower than the national average, they have risen considerably over recent years (see Figure 1). In 2008/09 the admission rate in London was 66% higher than in 2003/04.

¹ Department of Health (July 2008) *The cost of alcohol harm to the NHS in England An update to the Cabinet Office (2003) study.*

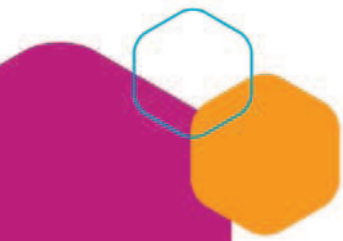
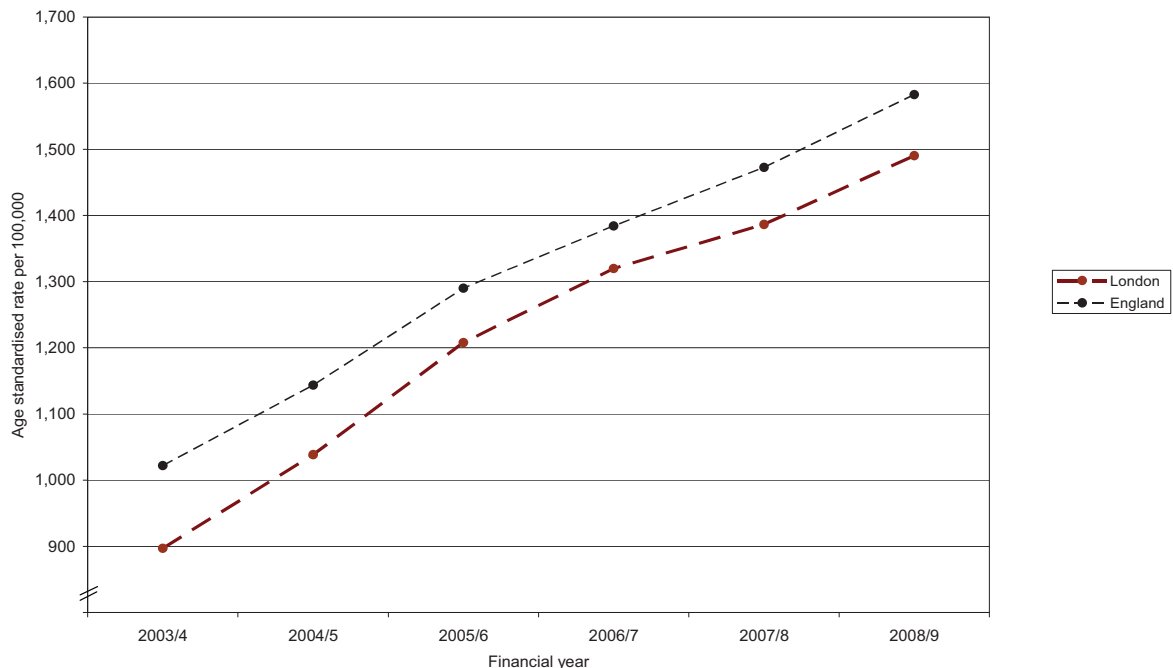


Figure 1 - Directly Age-standardised alcohol attributable admission rates, London and England 2003/04 – 2008/09.



Data source: NI39 HES dataset, LAPE: <http://www.nwph.net/alcohol/lape/download.htm>

The objective of this report is to help local partners understand the nature of the population presenting to hospital with alcohol attributable conditions by providing analysis for each Local Authority. Analysis by sex, diagnosis, admission type and ethnicity are presented together with an exploration of frequency of admission. This will firstly help local partners to better understand measures of alcohol attributable admissions and secondly assist in targeting interventions.

The results have been presented as a London wide report, accompanied by a data pack of tables at Local Authority level. The data pack can be accessed here:

<http://www.lho.org.uk/viewResource.aspx?id=16115>

This report was produced by the London Health Observatory on behalf of the London Regional Public Health Group, Department of Health.

1.1 About the data

This report uses extracts of the Hospital Episode Statistics (HES), which contains all episodes of care in inpatient settings in England. For the 2007/08 analysis a NI39 specific subset of the HES data was used. The NI39 dataset contains all alcohol-specific and related Finished Consultant Episodes (FCEs) based on the dominant alcohol diagnosis, i.e. the diagnosis for which the attributable fraction (AF) is the highest. The AF represents the proportion of admissions for each diagnosis that are estimated to be attributable to harm caused by alcohol. For example, it is estimated that 32% of admissions for hypertension in males aged 35-44 are attributable to alcohol. Therefore the attributable fraction for admissions for hypertension in this age and sex group is 0.32. For alcohol-specific conditions i.e. alcoholic liver disease, the AF is 1. For alcohol related conditions the AF is less than 1.

Annex 1 contains a list of diagnoses and their attributable fractions.

2. Overview of admissions in London by diagnosis and admission type

2.1 Alcohol attributable admissions by diagnosis

In total there were 102,023 admissions for all alcohol attributable conditions in 2007/08 (see Table 1).

- Alcohol-specific admissions made up only about a quarter of all alcohol attributable admissions (26%), with the remaining admissions being due to alcohol-related conditions.
- Males accounted for almost three quarters (73%) of alcohol-specific admissions, and 60% of alcohol-related admissions.
- Three conditions represented 68% of all alcohol attributable admissions. The diagnosis with the highest number of admissions was hypertensive diseases, which accounted for 35% of all admissions. Mental and behavioural disorders due to alcohol were the second highest cause of admissions, amounting to about 20% of all admissions, and cardiac arrhythmias accounted for 15%.
- 62% of admissions were for chronic conditions, i.e. long-term conditions (Table 2). Management or preventative strategies may be possible for some of these conditions. Acute conditions represented 38% of admissions.
- 19,520 patients accounted for the 27,208 alcohol-specific admissions, therefore there were on average 1.4 admissions per patient. A further analysis of multiple admissions can be found in section 5.

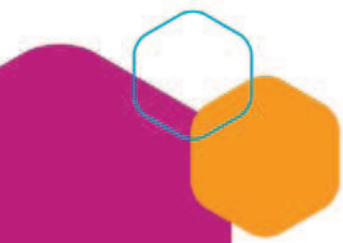


Table 1 - Number of alcohol attributable admissions by diagnosis and sex, 2007/08

	Dominant alcohol diagnosis	Nature of condition	No of admissions attributable by alcohol			No. of patients	Average attributable fraction	
			Male	Female	All			
Alcohol-specific admissions (AF=1)	Mental and behavioural disorders due to use alcohol	Acute	14,386	4,782	19,168	13,924	1	
	Alcoholic liver disease	Chronic	3,618	1,238	4,856	2,772	1	
	Ethanol poisoning	Acute	727	876	1,603	1,481	1	
	Chronic pancreatitis (alcohol induced)	Chronic	527	92	619	466	1	
	Toxic effect of alcohol	Acute	247	227	474	464	1	
	All other alcohol-specific diagnoses	Acute	405	83	488	413	1	
	Total alcohol-specific admissions			19,910	7,298	27,208	19,520	1
Alcohol-related admissions (AF<1)	Hypertensive diseases	Chronic	23,357	12,004	35,362	124,762	0.20	
	Cardiac arrhythmias	Chronic	8,869	6,343	15,212	35,915	0.29	
	Epilepsy and Status epilepticus	Acute	3,902	3,856	7,758	9,818	0.54	
	Fall injuries	Acute	1,592	939	2,531	20,871	0.11	
	Intentional self-harm/Event of undetermined intent	Acute	826	1,314	2,140	5,587	0.34	
	Chronic hepatitis/Liver cirrhosis	Chronic	1,045	591	1,636	1,725	0.64	
	Spontaneous abortion	Acute	0	1,596	1,596	6,842	0.22	
	Assault	Acute	1,273	228	1,501	5,285	0.27	
	Malignant neoplasm of breast	Chronic	0	1,224	1,224	5,655	0.08	
	Malignant neoplasm of lip, oral cavity and pharynx	Chronic	727	204	931	984	0.43	
	Oesophageal varices	Chronic	672	246	918	952	0.68	
	Other cancers	Chronic	1,068	284	1,352	5,301	0.09	
	Other accidents and injuries	Acute	910	220	1,131	6,330	0.17	
	All other alcohol-related diagnoses	Chronic	985	539	1,524	5,871	0.21	
	Total alcohol-specific admissions			45,226	29,589	74,815	235,898	0.22
	Total alcohol attributable admissions			65,136	36,887	102,023	255,418	0.28

Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory.

Table 2 - Number of admissions for acute and chronic conditions attributable to alcohol, 2007/08

	Number of admissions attributable to alcohol			No of patients	Average attributable fraction
	Male	Female	All		
Acute conditions	24,268	14,121	38,389	71,015	0.45
Chronic conditions	40,868	22,766	63,634	184,403	0.23
All conditions	65,136	36,887	102,023	255,418	0.28

Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory.

2.2 Alcohol attributable admissions by admission method

Table 3 shows the number of admissions by method of admission and diagnosis.

- The majority of alcohol attributable admissions were emergency admissions (68%) with elective admissions (i.e. planned admissions) representing 30% of admissions.
- For alcohol-specific conditions, 90% were emergency and only 9% were elective admissions.
- For all diagnoses, the number of emergency admissions was higher than elective admissions with the exception of liver cirrhosis and cancers.

Table 3 - Number of admissions for alcohol-specific and alcohol-related diagnoses by method of admissions, 2007-08

	Reason for admissions	Elective	Emergency	Other types of admissions	Total no of admissions
Alcohol-specific admissions (AF=1)	Mental and behavioural disorders due to use alcohol	1,322	17,629	217	19,168
	Alcoholic liver disease	986	3,769	101	4,856
	Ethanol poisoning**	*	*	*	1,603
	Chronic pancreatitis (alcohol induced)	67	546	6	619
	Toxic effect of alcohol**	*	*	*	474
	All other alcohol-specific diagnoses	64	411	13	488
	Total alcohol-specific admissions	2,442	24,423	343	27,208
Alcohol-related admissions (AF<1)	Hypertensive diseases	16,302	18,146	913	35,362
	Cardiac arrhythmias	4,216	10,524	471	15,212
	Epilepsy and Status epilepticus	1,981	5,455	321	7,758
	Fall injuries	188	2,262	82	2,531
	Intentional self-harm/Event of undetermined intent	30	2,091	18	2,140
	Chronic hepatitis/Liver cirrhosis	873	728	35	1,636
	Spontaneous abortion	375	1,128	93	1,596
	Assault	190	1,270	40	1,501
	Malignant neoplasm of breast	1,030	*	*	1,224
	Malignant neoplasm of lip, oral cavity and pharynx	644	271	17	931
	Oesophageal varices	713	*	*	918
	Other cancers	943	395	14	1,352
	Other accidents and injuries	83	1,006	42	1,131
	All other alcohol-related diagnoses	375	1,055	95	1,524
	Total alcohol-related admissions	27,943	44,716	2,156	74,815
Total	30,385	69,139	2,499	102,023	

Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory.

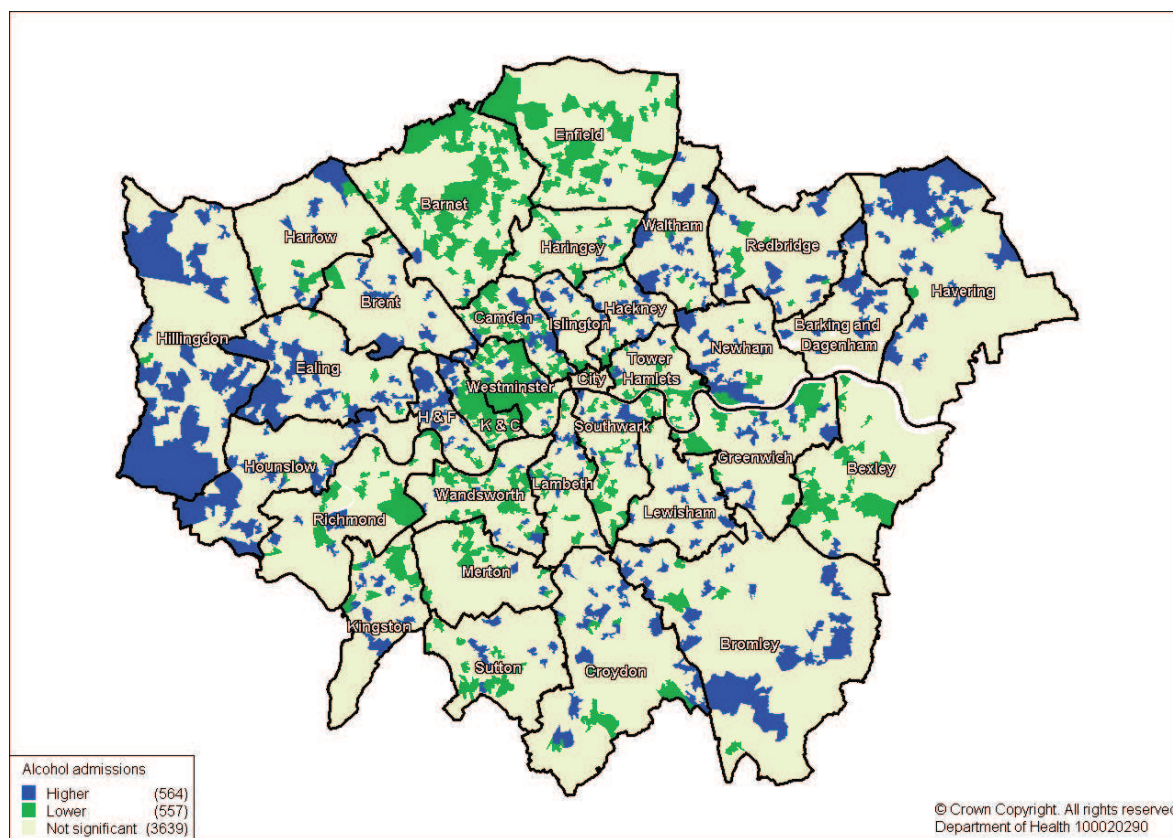
* Numbers below 6 have been suppressed.

**99% of admissions for ethanol poisoning and toxic effect of were emergency, but due to small elective and other types of admissions, numbers have been suppressed.

2.3 Variations in alcohol attributable admission rates across London

There were large variations in alcohol attributable admission rates across London. Map1 shows those areas where there were significantly higher crude rates of alcohol admissions compared to the London average. Overall the higher crude rates were found in Lower Super Output areas in outer London, with a few patches of elevated admission rates in inner London. However, as age has not been adjusted for in this analysis, it may be that the variations in admission rates are due to differences in age profiles across the capital.

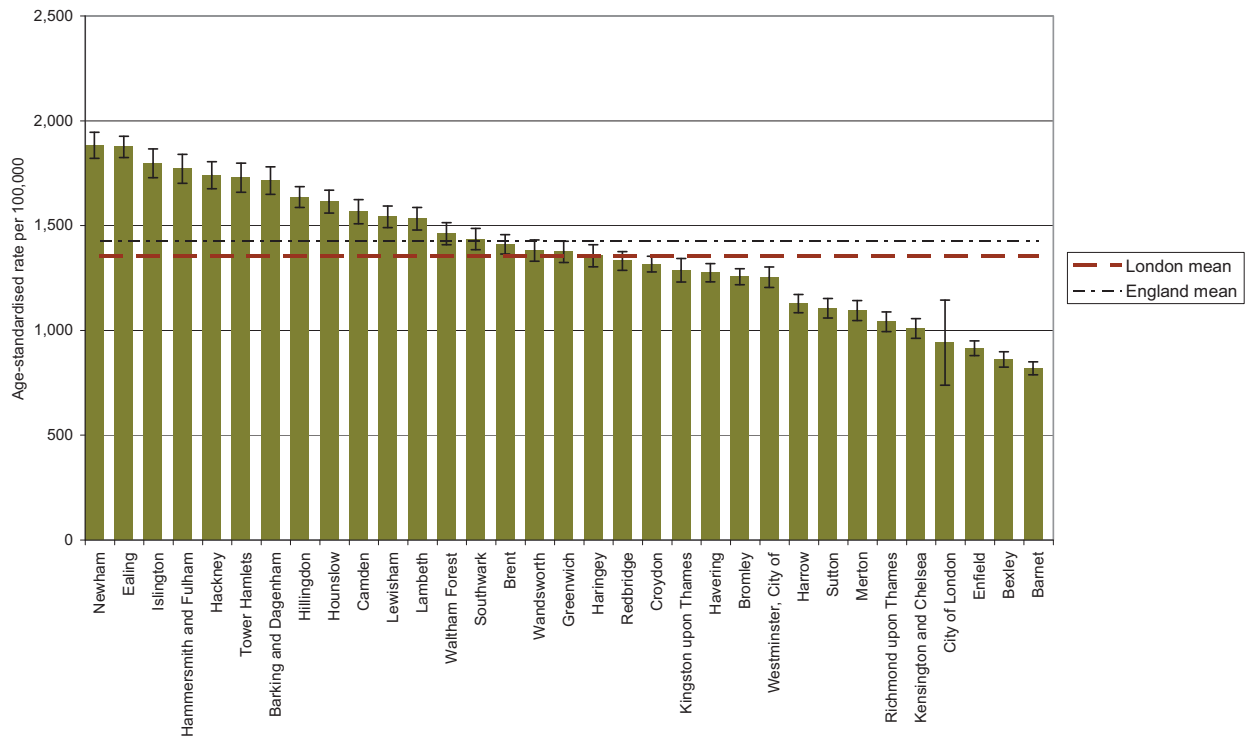
Map 1 Differences in crude rates for Lower Super Output Area (LSOA) per 100,000 population, 2007/08.



Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory. Populations: ONS mid-year population estimates by lower super output area, 2007.

Age-standardised admission rates, by Local Authority also show large variations. Figure 2 shows that the highest admission rates were in Newham, Ealing and Islington and the lowest rates were in Barnet, Bexley and Enfield. Twenty PCTs had significantly higher rates than the England average and the difference in rates between Newham and Barnet was two fold.

Figure 2 – Directly age standardised rates for alcohol attributable admissions, 2007/08.



Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory. Populations: ONS mid-year estimates, 2007.

Local Authorities have also experienced different rates of change over the last few years. Table 4 shows the age-standardised rates for London Local Authorities in 2003/04 and 2007/08. Overall the rate in London was 55% higher in 2007/08 than it was in 2003/04, and the admission rate in Harrow had more than doubled in this time period. The Compound Annual Growth Rate represents the average year-on-year growth, if growth was consistent across all years. Whilst on average there has been an 8% increase in admission rates each year in London, some Local Authorities have experienced growth rates over 10% per year.

Table 4 - Change in directly age standardised rates of admissions due to alcohol, London Local Authorities, 2003/04-2008/09

Local Authority	Age standardised admission		Overall increase in admission rates (%)	Compound Annual Growth Rate (%)
	2003/04	2007/08		
City of London	691	887	28	4
Barking and Dagenham	1,041	1,755	69	9
Barnet	541	846	57	8
Bexley	598	884	48	7
Brent	728	1,443	98	12
Bromley	772	1,293	68	9
Camden	1,048	1,602	53	7
Croydon	976	1,345	38	5
Ealing	1,271	1,906	50	7
Enfield	572	934	63	9
Greenwich	979	1,416	45	6
Hackney	963	1,774	84	11
Hammersmith and Fulham	1,268	1,816	43	6
Haringey	805	1,404	75	10
Harrow	565	1,164	106	13
Havering	899	1,314	46	7
Hillingdon	953	1,676	76	10
Hounslow	1,053	1,639	56	8
Islington	1,158	1,843	59	8
Kensington and Chelsea	743	1,043	40	6
Kingston upon Thames	934	1,318	41	6
Lambeth	1,110	1,562	41	6
Lewisham	982	1,590	62	8
Merton	680	1,122	65	9
Newham	1,338	1,906	42	6
Redbridge	859	1,358	58	8
Richmond upon Thames	797	1,073	35	5
Southwark	1,048	1,460	39	6
Sutton	620	1,136	83	11
Tower Hamlets	1,148	1,732	51	7
Waltham Forest	1,166	1,501	29	4
Wandsworth	875	1,432	64	9
Westminster	923	1,273	38	6
London	897	1,386	55	8

Data source: NI39 HES dataset, LAPE: <http://www.nwph.net/alcohol/lape/download.htm>.
Compound Annual Growth Rate calculated by the London Health Observatory.

Table 5 shows directly age-standardised admission rates for alcohol-specific and alcohol-related conditions by Local Authority.

- The highest rate of admissions for alcohol-specific conditions was in Camden at 707 admissions per 100,000 population. This is four times the rate of Barnet, which was 163 per 100,000.
- For alcohol-related conditions, the rate varied from 1,505 per 100,000 population in Newham to 672 per 100,000 in Kensington and Chelsea.
- The overall alcohol attributable admission rates for Local Authorities can hide variations in rates for alcohol-specific and alcohol-related admission rates across the capital. For example:
 - Westminster had a lower alcohol attributable admission rate than the London average (see Figure 2) but a higher than average alcohol-specific admission rate;
 - Havering also had a lower alcohol attributable admission rate overall but a higher than average alcohol-related admission rate;
 - Southwark and Camden had higher overall alcohol attributable admission rates but these were due to higher alcohol-specific admission rates. Alcohol-related admissions rates in these Local Authorities were lower than the London average.
- Therefore it is necessary for Local Authorities to consider alcohol-specific and alcohol-related conditions separately when identifying their priorities for reducing alcohol attributable harm.

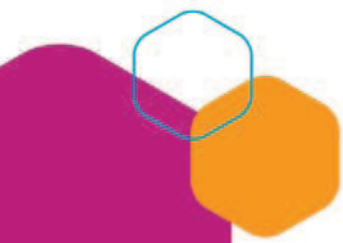


Table 5 - Directly Age standardised rates of admissions for alcohol-specific and alcohol-related conditions, London Local Authorities, 2007/08.

Local authority	Alcohol-specific admissions			Alcohol-related admissions		
	Observed	DSR	Difference to London	Observed	DSR	Difference to London
City of London	39	429	-	49	513	Lower
Barking & Dagenham	629	397	-	2,196	1,317	Higher
Barnet	539	163	Lower	2,424	656	Lower
Bexley	469	206	Lower	1,785	655	Lower
Brent	864	336	Lower	2,874	1,074	Higher
Bromley	829	267	Lower	3,824	990	-
Camden	1,387	707	Higher	1,701	859	Lower
Croydon	1,070	312	Lower	3,739	1,004	-
Ealing	1,430	483	Higher	4,151	1,392	Higher
Enfield	467	163	Lower	2,295	752	Lower
Greenwich	895	421	Higher	2,133	954	-
Hackney	1,118	629	Higher	1,913	1,112	Higher
Hammersmith & Fulham	1,080	703	Higher	1,669	1,068	Higher
Haringey	762	367	-	1,965	989	-
Harrow	481	222	Lower	2,251	906	Lower
Havering	565	242	Lower	3,145	1,034	Higher
Hillingdon	1,034	412	Higher	3,373	1,224	Higher
Hounslow	1,023	478	Higher	2,420	1,137	Higher
Islington	1,008	623	Higher	1,900	1,174	Higher
Kensington & Chelsea	609	338	Lower	1,284	672	Lower
Kingston upon Thames	556	352	-	1,610	936	-
Lambeth	1,344	557	Higher	2,195	976	-
Lewisham	1,066	444	Higher	2,572	1,098	Higher
Merton	508	258	Lower	1,716	838	Lower
Newham	840	378	-	3,002	1,505	Higher
Redbridge	795	315	Lower	2,786	1,017	-
Richmond upon	520	287	Lower	1,564	755	Lower
Southwark	1,255	542	Higher	2,127	894	Lower
Sutton	519	275	Lower	1,770	831	Lower
Tower Hamlets	845	519	Higher	1,867	1,210	Higher
Waltham Forest	836	388	-	2,280	1,073	Higher
Wandsworth	928	389	-	2,380	992	-
Westminster	898	429	Higher	1,854	825	Lower
London	27,208	372	-	74,815	983	-
England	215,221	411	Higher	635,641	1,014	Higher

Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory. Populations: ONS mid-year population estimates, 2007

Figure 3 shows the variation in the admission method for alcohol attributable admissions by Local Authority.

- In Hammersmith and Fulham 78% of alcohol attributable admissions were emergency admissions whilst in Bromley only 57% were emergency admissions; in Bromley 41% of alcohol admissions were elective, and only 20% were elective in Hammersmith and Fulham.
- There were eight London Local Authorities where only 25% or less alcohol attributable admissions were elective, and seven of these were in Inner London.

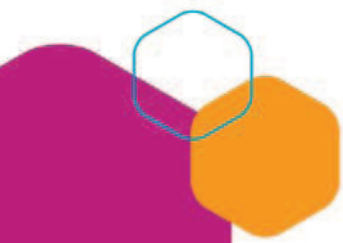
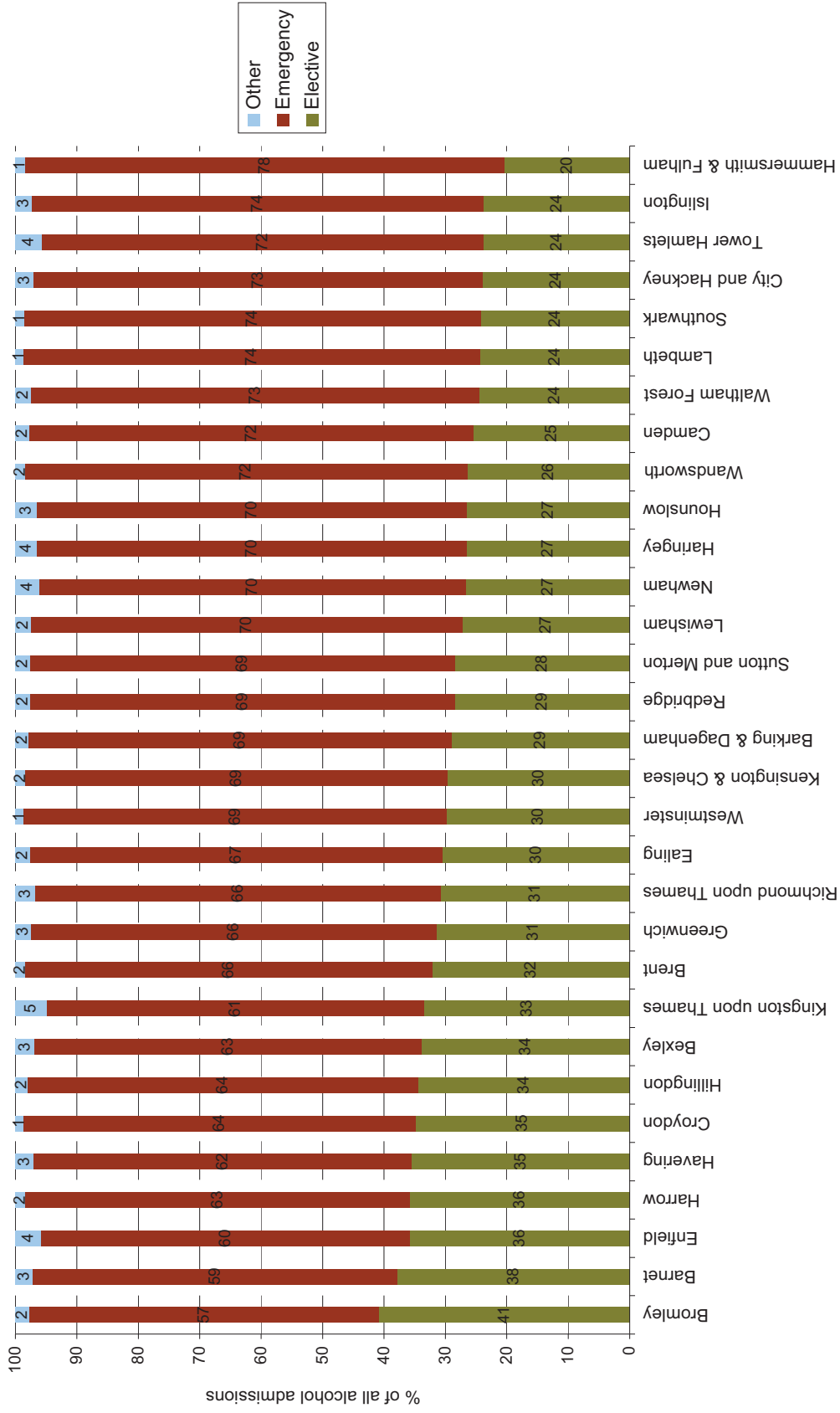


Figure 3 Percentage of alcohol attributable admissions by admission method and Local Authority, London 2007/08



Data Source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory.

3. Alcohol attributable admissions by day of the week

To assess the impact on service provision and to target interventions it is useful to look at the pattern of admissions during the week.

- Overall 80% of admissions attributable to alcohol occurred Monday to Friday, and only 20% of admissions on Saturday and Sunday (Table 6).
- As expected, 94% of the elective admissions were during the week, compared with 74% of the emergency admissions.
- However weekend days had fewer emergency and elective alcohol attributable admissions than any of the week days, although emergency admissions did not vary as much by day of the week.

Table 6 - Breakdown of alcohol attributable admissions by day of the week and admission method, London, 2007/08

Day of week	Elective	Emergency	Other types of admission*	No of admissions	Percentage
Monday	6,202	10,330	385	16,917	17%
Tuesday	6,121	10,107	387	16,615	16%
Wednesday	5,847	10,061	393	16,301	16%
Thursday	5,866	10,218	426	16,510	16%
Friday	4,631	10,347	438	15,417	15%
Saturday	640	9,231	251	10,122	10%
Sunday	1,080	8,843	218	10,141	10%
Total	30,385	69,139	2,499	102,023	100%

Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory.

*Other types of admissions include transfers between hospitals, not known or maternity related admissions.

3.1 Alcohol-specific admissions

- The number of elective admissions per day was roughly constant between Monday to Friday but the number was considerably reduced on weekends; only 6 percent of admissions were during the weekend.
- The number of emergency admissions per day was roughly the same throughout the week with a slight peak on Saturdays: 29% of emergency admissions occurred during the weekend.

Table 7 - Breakdown of alcohol-specific admissions by day of the week and admission method, London, 2007/08

Day of week	Elective	Emergency	Other types of admission	No of admissions	Percentage
Monday	485	3,474	51	4,010	15%
Tuesday	502	3,464	45	4,011	15%
Wednesday	423	3,433	44	3,900	14%
Thursday	534	3,517	60	4,111	15%
Friday	347	3,473	62	3,882	14%
Saturday	64	3,616	37	3,717	14%
Sunday	87	3,446	44	3,577	13%
Total	2,442	24,423	343	27,208	100%

Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory.

3.2 Alcohol-related admissions

- The number of elective admissions per day was roughly constant Monday to Friday but admissions at the weekend were considerably fewer compared to weekday admissions; 6% of elective admissions were at the weekend.
- The number of emergency alcohol-related admissions per day was roughly the same throughout Monday to Friday with a slight decline on weekends; 25% of emergency admissions were during the weekend.

Table 8 - Breakdown of alcohol-related admissions by day of the week and admission method, London, 2007/08

Day of week	Elective	Emergency	Other types of admission	No of admissions	Percentage
Monday	5,717	6,856	334	12,907	17%
Tuesday	5,619	6,643	342	12,604	17%
Wednesda	5,424	6,628	349	12,401	17%
Thursday	5,332	6,701	366	12,399	17%
Friday	4,284	6,874	376	11,535	15%
Saturday	576	5,615	214	6,405	9%
Sunday	993	5,397	174	6,564	9%
Total	27,943	44,716	2,156	74,815	100%

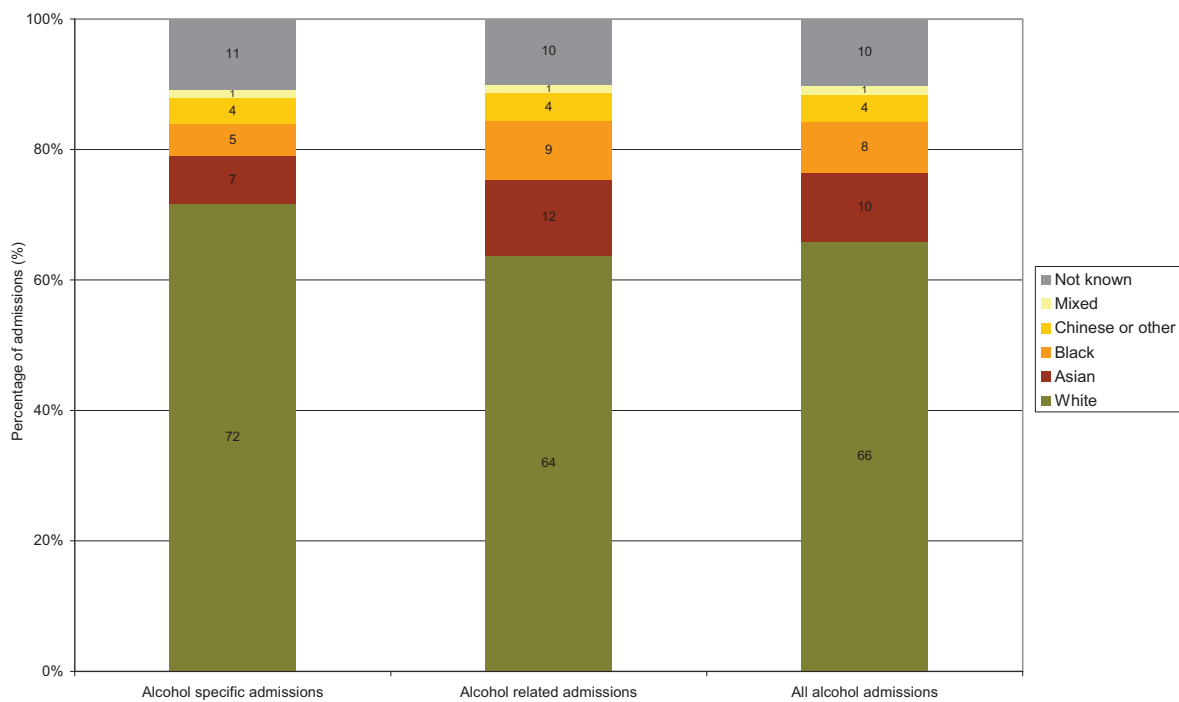
Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved.. Analysed by the London Health Observatory.

There were no apparent variations in terms of day of admission between Local Authorities and the London average. Generally, all Local Authorities had a similar percentage of admission throughout the week as London (see the data pack).

4. Breakdown of alcohol attributable admissions by ethnicity

Overall, 66% of alcohol attributable admissions were among the White ethnic group, and only 24% were among Black, Mixed, Asian and 'Chinese and other' ethnic groups (Figure 4). However there are differences in ethnic breakdown between alcohol-specific and alcohol-related admissions. The White ethnic group represented 64% of alcohol-related admissions compared to 72% of alcohol-specific admissions.

Figure 4 Percentage of alcohol-specific and alcohol-related admissions by ethnic group, London, 2007/08



Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory.

Table 9 shows that crude rates for alcohol-specific admissions for adults from ethnic minority groups were significantly lower than the White group, except for 'Chinese and other'. However for alcohol-related admissions, all ethnic groups except Mixed had a higher rate than the White ethnic group.

Table 9 - Number and crude rate of alcohol-specific and alcohol-related admissions by ethnic group, ages 15-64 years, London 2007/08

Ethnicity	Alcohol-specific admissions				Alcohol-related admissions			
	N	Crude	LCI	UCI	N	Crude	LCI	UCI
Asian	1,753	237	226	249	5,331	721	702	741
Black	1,139	204	193	217	4,403	790	767	814
Chinese or other	963	444	417	473	2,144	990	948	1,032
Mixed	321	216	193	241	658	443	410	478
White	16,301	448	441	455	21,789	598	590	606
Not known	2,567				4,533			
All Groups	23,044	435	429	440	38,858	733	725	740

Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory. Populations: ONS mid-year population estimates, 2007.

Directly age standardised rates (see table 10) follow a similar pattern to crude rates for alcohol-specific admissions; all ethnic minority groups had lower rates than the White group except for 'Chinese and other'. The age-standardised rates for alcohol-specific admissions in the 'Chinese or other' group was higher than for the White group in this case. For alcohol-related conditions, all ethnic groups had higher rates than the White ethnic group. The age-standardised rate among the Mixed ethnic group is higher than the crude rate, possibly due to the Mixed ethnic group having a younger age profile compared to the White group.

Table 10 - Number of alcohol admissions and directly age standardised rates by ethnic group all ages, London

Ethnicity	Alcohol-specific admissions				Alcohol-related admissions			
	N	DSR	LCI	UCI	N	DSR	LCI	UCI
Asian	1,961	222	212	232	8,734	1,229	1,202	1,255
Black	1,366	184	174	195	6,745	1,136	1,107	1,166
Chinese or other	1,062	440	410	470	3,163	1,911	1,834	1,987
Mixed	350	233	204	262	971	874	812	936
White	19,515	371	365	376	47,676	785	778	793
Not known	2,954				7,527			
All Groups	27,208	372	368	377	74,815	983	976	990

Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved.. Analysed by the London Health Observatory. Populations: ONS mid-year population estimates, 2007

Note: Where a valid ethnicity or age is not recorded then the observation has not been included in this analysis.

These findings are interesting in that generally, all ethnic minority groups, except the White Irish group, consume less alcohol than the general population^b. In terms of alcohol-related admissions, whilst the Asian and Black ethnic groups represented only 21% of these admissions, for some conditions they made up a higher percentage. For example, Asian and Black ethnic groups represented 27% of admissions due to hypertensive disorders, which was the most common primary diagnosis for alcohol attributable admissions. One hypothesis could be that the increased rates of alcohol-related admissions in some ethnic minority groups may be due to increased prevalence of diseases such as hypertensive disorder which, in these ethnic groups, might not be caused by alcohol. Further analysis and a review of the evidence is required to understand the findings in this report.

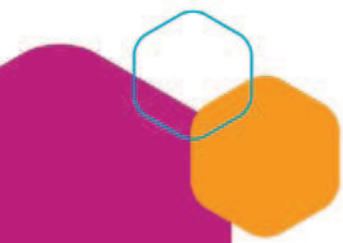
5. Frequent users of inpatient services for alcohol attributable conditions

Some groups of people requiring inpatient treatment for alcohol attributed health problems are more likely to require repeated inpatient episodes of care than others. It is therefore useful to begin to identify the characteristics and the care needs of these groups so that alternative service and treatment options can be developed for these groups and individuals, and thus reduce the need for inpatient services.

Table 11 shows the number of admissions and patients for each primary diagnosis and the number of those patients who were readmitted for the same condition. For example, if an individual was admitted for liver disease and then had a subsequent admission for the same cause in the same financial year, the second admission was counted as one readmission. If however, an individual was first admitted for liver disease then readmitted for hypertensive disease, this was not considered a readmission for this analysis. However, this individual was counted in the totals for both liver disease and hypertensive diseases.

- 20% of patients admitted for an alcohol-specific condition were readmitted for the same condition. The highest percentage of readmitted patients was for alcoholic liver disease, where 34% had more than one admission in the same financial year.
- 23% of patients admitted for an alcohol-related condition were readmitted, with as many as 46% and 48% of patients admitted for malignant neoplasm of the breast and other cancers, respectively, having more than one admission in the same financial year. It is important to understand that these are conditions that would generally require more than one admission and that for many patients their conditions would not be due to alcohol; for example, only 8% of cases of malignant neoplasm of the breast are thought to be due to alcohol. We therefore cannot say how many of those patients with malignant neoplasm of the breast caused by

^b Joint Health Surveys Unit, National Centre for Social Research and University College Medical School (2006) *Health Survey for England 2004: The health of minority ethnic groups*, The Information Centre.



alcohol were readmitted, compared to those patients with the condition but which was not caused by alcohol.

- The percentage of patients who were readmitted due to alcohol-specific and related conditions was likely to be higher than reported here as this analysis focuses only on one financial year.

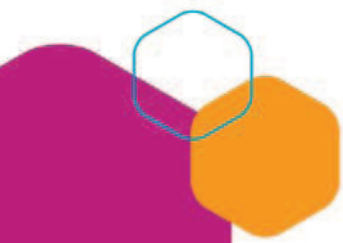
Table 11 - Number of admission, patients and readmissions due to alcohol by primary diagnosis, London 2007/08

Alcohol-specific diagnoses	No. of admissions	No. of patients	No of patients re-admitted	% of patients re-admitted
Mental and behavioural disorders due to	19,168	13,924	2,748	19.7%
Alcoholic liver disease	4,856	2,772	931	33.6%
Ethanol poisoning	1,603	1,481	97	6.5%
Chronic pancreatitis (alcohol induced)	619	466	90	19.3%
Toxic effect of alcohol	474	464	10	2.2%
Other alcohol-specific diagnoses	488	413	52	12.6%
All alcohol-specific diagnoses	27,208	19,520	3,928	20.1%
Alcohol-related diagnoses				
Hypertensive diseases	35,632	124,762	32,050	25.7%
Cardiac arrhythmias	15,212	35,915	10,335	28.8%
Fall injuries	2,531	20,871	1,488	7.1%
Intentional self-harm/Event of	2,140	5,587	491	8.8%
Epilepsy and Status epilepticus	7,758	9,818	2,594	26.4%
Malignant neoplasm of breast	5,655	5,655	2,593	45.9%
Other cancers	1,352	6,285	3,005	47.8%
All alcohol-related diagnoses	74,815	235,898	55,035	23.3%
All admissions due to alcohol	363,424	255,418	58,963	23.1%

Data source: NI39 Hospital Episodes Statistics (HES) extract, 2007/08. Copyright © 2010: The NHS Information Centre for Health and Social Care. All rights reserved. Analysed by the London Health Observatory.

6. Suggestions for further work

- The number of admissions reported in this report only gives a partial picture of the resource demands of conditions caused by alcohol on inpatient services. Calculating the number of bed-days required for alcohol problems and their unit costs would be helpful for planning services across the capital
- It would be useful to look across financial years to gain a more accurate estimate of the number and characteristics of those patients that require more than one admission in a year
- There is a need to better understand what appears to be disproportionate admission rates in some ethnic minority groups and to what extent these are caused by alcohol or by other factors
- Use of geo-demographic segmentation tools may provide some insight into which social groups are most likely to be admitted, or readmitted for alcohol attributable conditions
- It would be helpful for Local Authorities to share their experiences of using alcohol attributable admission data in their strategies to reduce the harmful effects of alcohol, and the need for inpatient services
- Ways of obtaining more routine and up-to-date information on alcohol attributable admissions, via the Secondary Uses Service (SUS) data, for the whole of London, should be explored.



Annex 1

List of ICD10 codes for diagnoses relating to alcohol and their attributable fractions

Category	ICD code	ICD name	Alcohol Attributable Fraction															
			0-15		16-24		25-34		35-44		45-54		55-64		65-74		75+	
			M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Alcohol-specific (Chronic)	E24.4	Alcohol-induced pseudo-Cushing's syndrome	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	G31.2	Degeneration of nervous system due to alcohol	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	G62.1	Alcoholic polyneuropathy	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	G72.1	Alcoholic myopathy	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	I42.6	Alcoholic cardiomyopathy	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	K29.2	Alcoholic gastritis	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	K70	Alcoholic liver disease	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	K86.0	Chronic pancreatitis (alcohol induced)	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	F10	Mental and behavioural disorders due to use of alcohol	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Alcohol-specific (Acute)	T51.0	Ethanol poisoning	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
T51.1		Methanol poisoning	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
T51.9		Toxic effect of alcohol, unspecified	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
X45		Accidental poisoning by and exposure to alcohol	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Accidents & Injury (Acute)	W00-W19	Fall injuries	0.00	0.00	0.22	0.14	0.22	0.14	0.22	0.14	0.22	0.14	0.22	0.14	0.22	0.14	0.22	0.04
	W24-W31	Work/machine injuries	0.00	0.00	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07

Category	ICD code	ICD name	Alcohol Attributable Fraction																
			0-15		16-24		25-34		35-44		45-54		55-64		65-74		75+		
			M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Accidents & Injury (Acute) (cont.)	W32-W34	Firearm injuries	0.00	0.00	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	
	W65-W74	Drowning	0.00	0.00	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	
Accidents & Injury (Acute) (cont.)	W78-W79	Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract	0.00	0.00	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	
	X00-X09	Fire injuries	0.00	0.00	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	
Violence (Acute)	X31	Accidental excessive cold	0.00	0.00	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	
	X60-X84, Y10-Y33	Intentional self-harm/Event of undetermined intent	0.00	0.00	0.34	0.35	0.34	0.33	0.35	0.34	0.35	0.34	0.37	0.34	0.36	0.31	0.25	0.27	0.20
Transport accidents (Acute)	X85-Y09	Assault	0.00	0.00	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27
	§§	Pedestrian traffic accidents	0.00	0.00	0.35	0.16	0.45	0.19	0.46	0.21	0.46	0.21	0.46	0.21	0.23	0.03	0.23	0.03	0.23
Spontaneous	§	Road traffic accidents (driver/rider)	0.00	0.00	0.21	0.09	0.33	0.15	0.24	0.12	0.24	0.12	0.24	0.12	0.09	0.03	0.09	0.03	0.09
	V90-V94	Water transport accidents	0.00	0.00	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20
Digestive (Chronic)	V95-V97	Air/space transport accidents	0.00	0.00	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16
	O03	Spontaneous abortion	0.00	0.00	0.00	0.23	0.00	0.21	0.00	0.22	0.00	0.22	0.00	0.20	0.00	0.20	0.15	0.00	0.12
Cancer (Chronic)	K22.6	Gastro-oesophageal laceration-haemorrhage syndrome	0.00	0.00	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47
	K73, K74	Chronic hepatitis, not elsewhere classified and Fibrosis and cirrhosis of liver	0.00	0.00	0.77	0.67	0.76	0.59	0.74	0.60	0.79	0.59	0.77	0.57	0.71	0.48	0.61	0.38	0.38
Cancer (Chronic)	K85, K86.1	Acute and chronic pancreatitis	0.00	0.00	0.27	0.19	0.27	0.16	0.26	0.16	0.30	0.16	0.27	0.14	0.22	0.10	0.16	0.16	0.07
	I85	Oesophageal varices	0.00	0.00	0.77	0.67	0.76	0.59	0.74	0.60	0.79	0.59	0.77	0.57	0.71	0.48	0.61	0.38	0.38
Cancer (Chronic)	C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	0.00	0.00	0.50	0.40	0.50	0.35	0.49	0.36	0.53	0.35	0.50	0.33	0.44	0.26	0.36	0.20	0.20
	C15	Malignant neoplasm of oesophagus	0.00	0.00	0.32	0.23	0.31	0.20	0.30	0.20	0.34	0.20	0.32	0.18	0.26	0.14	0.20	0.10	0.10
	C32	Malignant neoplasm of larynx	0.00	0.00	0.34	0.25	0.33	0.21	0.32	0.22	0.36	0.21	0.34	0.20	0.28	0.15	0.22	0.11	0.11

Other chronic diseases (low AF)	C18	Malignant neoplasm of colon	0.00	0.00	0.05	0.03	0.04	0.03	0.05	0.03	0.05	0.03	0.04	0.02	0.03	0.03	0.01
	C20	Malignant neoplasm of rectum	0.00	0.00	0.08	0.06	0.08	0.05	0.09	0.09	0.05	0.09	0.05	0.07	0.03	0.05	0.03
	C22	Malignant neoplasm of liver and	0.00	0.00	0.08	0.06	0.08	0.05	0.09	0.09	0.05	0.08	0.05	0.07	0.03	0.05	0.03
	C50	Malignant neoplasm of breast	0.00	0.00	0.16	0.11	0.15	0.10	0.17	0.17	0.10	0.16	0.09	0.13	0.07	0.10	0.05
	I10-I15	Hypertensive diseases	0.00	0.00	0.00	0.09	0.00	0.08	0.00	0.00	0.09	0.00	0.08	0.00	0.06	0.00	0.04
I47-I48	Cardiac arrhythmias	0.00	0.00	0.34	0.24	0.33	0.19	0.37	0.37	0.20	0.34	0.18	0.27	0.13	0.20	0.09	
I50-I51	Heart failure	0.00	0.00	0.35	0.36	0.36	0.35	0.38	0.38	0.35	0.37	0.33	0.34	0.27	0.30	0.22	
G40-G41	Epilepsy and Status epilepticus	0.00	0.00	0.56	0.64	0.58	0.59	0.61	0.61	0.61	0.61	0.57	0.51	0.45	0.42	0.35	
Other diseases (low AF)	I60-I62,	Haemorrhagic stroke	0.00	0.00	0.31	0.20	0.30	0.15	0.34	0.15	0.30	0.13	0.24	0.10	0.16	0.06	
	I63-I66,	Ischaemic stroke	0.00	0.00	0.16	0.03	0.13	0.00	0.18	0.00	0.12	0.00	0.06	0.00	0.00	0.00	
	L40	Psoriasis	0.00	0.00	0.34	0.33	0.34	0.33	0.36	0.32	0.35	0.31	0.33	0.26	0.30	0.22	
§ V12-V14 (.3 -.9), V19.4-V19.6, V19.9, V20-V28 (.3 -.9), V29-V79 (.4 -.9), V80.3-V80.5, V81.1, V82.1, V82.9, V83.0-V86 (.0 -.3), V87.0-V87.9, V89.2, V89.3, V89.9																	
§§ V02-V04 (.1, .9), V06.1, V09.2, V09.3																	

Source: Department of Health communication.



Alcohol health needs assessment for Bromley

September 2010

- 1 Introduction**
- 2. Policy context**
- 3. Epidemiology of alcohol misuse and the impact**
- 4. Services available in Bromley**
- 5. Gaps and priorities for Bromley**

1 INTRODUCTION

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

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

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

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

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

A vision for treatment in Bromley has been developed identifying the priorities for Bromley:

- The misuse of illicit drugs and alcohol is damaging to the individual, to the community in which they live and work and a direct contributor to crime, anti-social behaviour, poor health and detrimental to life opportunities.
- A key priority in Bromley is to counter the spread of drugs and to take rigorous enforcement actions both against dealers and drug users through focused action on disrupting drug markets and tackling all drug and alcohol related crime to ensure Bromley continues to be a safer, stronger and vibrant community.
- Drug users will be identified and directed into appropriate treatment to break the cycle of addiction and appropriate harm minimisation interventions will be provided for people where complete abstinence is not yet possible.
- We will also ensure that particularly young people understand the health, social and legal consequences of drug and alcohol misuse.
- We will deliver these services efficiently and effectively through robust monitoring delivering value for money.

Stakeholders including service user's views about perceived gaps and priorities for alcohol misuse service were sought through two stakeholder consultation meetings. Other key stakeholders were followed up by phone or individual meetings. Stakeholders say children receive mixed messages to their children. Stakeholders also identify that aftercare is neglected for alcohol users who have been detoxified. Detailed feedback is contained in Appendix One

2. NATIONAL POLICY CONTEXT

The Government advises that, adult women should not regularly drink more than 2–3 units of alcohol a day; adult men should not regularly drink more than 3–4 units of alcohol a day; and pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby they should not drink more than 1–2 units of alcohol once or twice a week and should not get drunk. Children under 16 years are encouraged not to drink alcohol.

The Chief Medical Officer issued guidance on alcohol consumption in children and young people in 2009, advising that an alcohol-free childhood is the healthiest and best option. Children should not drink alcohol until at least the age of 15 years. When 15 to 17 year olds consume alcohol, it should always be in a supervised environment. If 15 to 17 year olds do consume alcohol, they should do so infrequently no more than one day a week. The importance of parental influences on children's alcohol use should be communicated to parents, carers and professionals.

The term 'alcohol use disorders' encompasses a range of physical, mental and behavioural conditions associated with alcohol use. The World Health Organization identifies three primary categories of alcohol use disorder:

- Hazardous drinking: individuals drinking above the recognised "sensible" levels but not yet experiencing harm; (22-50 units per week for men and 15-35 units per week for women)
- Harmful drinking: individuals drinking above recommended levels for sensible drinking and experiencing physical and / or mental harm (> 50 unit for men per week and > 35 units for women per week)
- Alcohol dependence: individuals drinking above sensible levels, experiencing an increased drive to use alcohol and difficulty in controlling its use

Binge drinking is defined in the General Household Survey as drinking more than eight units in one day in the past week, for men, and six units or more for women. Different definitions are used in different contexts however. Binge drinking is also harmful to health, and can be associated with accidents, crime and alcohol dependence in later life.

In November 2005, the Department of Health published a report *Alcohol Needs Assessment Research Project (ANARP): the 2004 national alcohol needs assessment for England* highlighted the range of alcohol use disorders in the population and the range of services that were available to offer treatment for alcohol problems. It also identified gaps in services and the regional variations in access to treatment.

In 2004 the Department of Health also published the *Alcohol Harm Reduction Strategy*, whose four key themes were improved education and communication, better identification and treatment of alcohol use disorders, reducing alcohol related crime and disorder, and supply and industry responsibilities. *Choosing Health (2004)* also highlighted sensible drinking and the reduction of alcohol-related harm as one of six priorities, and built upon the Alcohol Harm Reduction Strategy. PCTs were delegated a statutory responsibility to participate with other agencies in the *Crime and Disorder Partnership* to tackle crime and disorder, under an amendment to the *Crime and Disorder Act (1998)*. In 2004 the Tackling Violent Crime Programme was set up by the Home Office, to target initiatives to areas of high violent crime including alcohol-related violence.

In 2007 the *National Alcohol Strategy* was updated in *Safe Sensible Social. The next steps in the National Alcohol Strategy*. This was an eight point strategy for reducing alcohol-related crime, tougher enforcement on underage alcohol sales, more help for people who want to drink less, trusted guidance for parents and young people, information campaigns, a review of NHS spending on alcohol, public consultation on alcohol pricing and promotion, and the development of local alcohol strategies to be developed by April 2008.

The government relaxed the licensing laws in 2000 and reduced the tax on alcohol in real terms. Alcohol is 65 per cent more affordable now than in 1980, and accounts for only 5.2 per cent of household spending compared with 7.5 per cent in 1980 (Office for National Statistics, 2007).

Commissioning intentions identified in *Signs for improvement- commissioning interventions to reduce alcohol-related harm (2010)* include high impact changes. These are interventions likely to have the greatest impact for tackling alcohol-related harm. They include:

- Working in partnership
- Developing activities to control the impact of alcohol misuse in the community
- Influencing change through advocacy
- Improving the effectiveness and capacity of specialist treatment
- Appointing an Alcohol Health Worker
- Providing more help to encourage people to drink less
- Amplifying national social marketing priorities

Alcohol use amongst young people was identified as a key priority in the updated *National Alcohol Strategy: Safe, Sensible, Social (2007)*. The overall proportion of young people that drink has decreased; but those who do drink are consuming more alcohol, more often. Young people who drink are drinking twice the amount they were in 1990 and alcohol consumption was increasing amongst adolescents aged 11-13. An increased level of alcohol consumption by young people is linked to high risk behaviours including unprotected sex and offending. The strategy proposes a focus on the significant minority of drinkers who are at greatest risk. These fall into three main groups:

- Harmful drinkers whose patterns of drinking damage their physical or mental health and who may be causing substantial harm to others
- Young people, particularly those between 11-15 when most young people start to drink
- Young adults, 18-24 year old binge drinkers who are responsible for a disproportionate amount of anti social behaviour and crime

The new Government are reviewing the strategies in relation to drug and alcohol misuse and the commissioning of health services which may have an impact on drug and alcohol services.

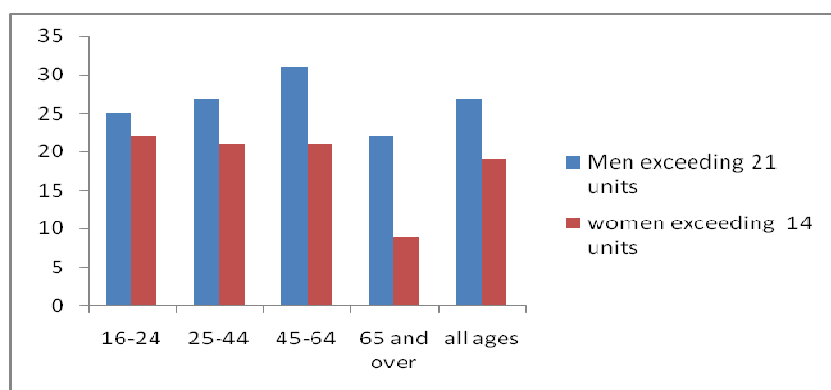
4. EPIDEMIOLOGY OF ALCOHOL MISUSE AND THE IMPACT IN BROMLEY

The demographic profile for Bromley which underpins the data on the epidemiology and the impact on Bromley can be found in Appendix Two

Patterns of alcohol consumption

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

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



Source: GHS 2008

In England the prevalence of hazardous drinking identified in the Adult Psychiatric Morbidity Survey (2007) shows the following:

- **Hazardous drinking:** 24.2% (33.2% of men, 15.7% of women). In men, the highest prevalence of both hazardous and harmful drinking was in 25 to 34 year olds, in women in 16 to 24 year olds.
- **Harmful drinking:** 3.8% of adults (5.8% of men, 1.9% of women)
- **Alcohol dependence** 4% are dependent drinkers. The prevalence of alcohol dependence was 5.9% (8.7% of men, 3.3% of women). For men, the highest levels of dependence were identified in 25 – 34 year olds (16.8%), for women in 16 – 24 year olds (9.8%). Among the 14% of alcohol dependent adults who were currently receiving treatment for a mental or emotional problem, women (26%) were more likely than men (9%) to be receiving treatment. This may be because men feel that there is a stigma attached to seeking help-portraying signs of 'vulnerability'; whereas women traditionally feel more able to ask for help.

The actual prevalence may be higher since the APMS 2007 surveyed private households, and homeless adults and those in an institutional setting will have been under-

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

- **Hazardous drinking:** *individuals drinking above the recognised "sensible" levels but not yet experiencing harm; (22-50 units per week for men and 15-35 units per week for women)* In Bromley 32,008 men and 25,944 women over 16 are hazardous drinkers
- **Harmful drinking:** *individuals drinking above recommended levels for sensible drinking and experiencing physical and / or mental harm (> 50 unit for men per week and > 35 units for women per week).* In Bromley the percentage of people with harmful drinking habits (synthetic estimate 2005) 4.3% which equates to 13,207
- **Alcohol dependence:** *individuals drinking above sensible levels, experiencing an increased drive to use alcohol and difficulty in controlling its use.* In Bromley the percentage of people who are alcohol dependent (estimate based on national APMS 2007 survey) is 6% equates to 14,359
- **Binge drinking:** Percentage binge drinking (over 16 years) (synthetic estimate 2003-5) is 10.7% which equates to 32,191

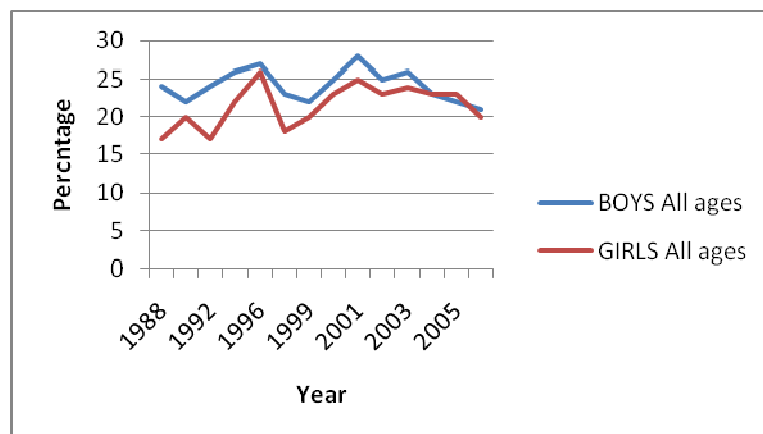
What this means for Bromley

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

Patterns of alcohol consumption in young people

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

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



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

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

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

What this means for Bromley

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

Patterns of alcohol consumption in black and ethnic minority groups

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

What this means for Bromley

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

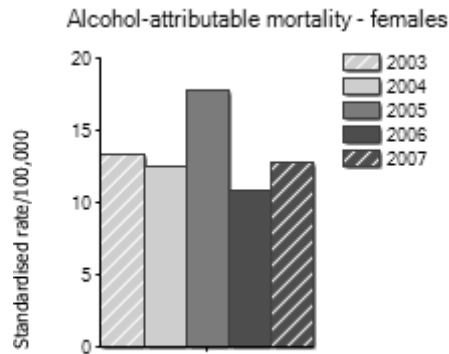
The effects of alcohol

The effects of alcohol on health can be identified in the areas of mortality, effects on physical health and the effects on mental health and well being. The societal effects of alcohol on individuals also have an effect on crime and anti social behaviour.

The effects of alcohol on mortality

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

Alcohol-attributable mortality in Bromley 2003 – 2007



Source: LAPE: Local Alcohol Profiles for England

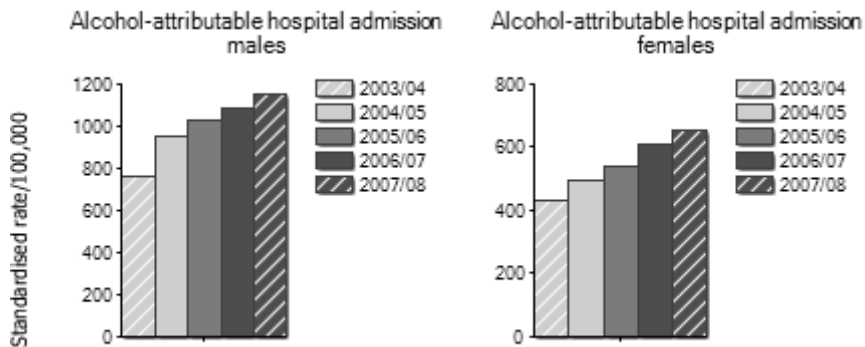
What this means for Bromley

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

The effects of alcohol on physical health

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

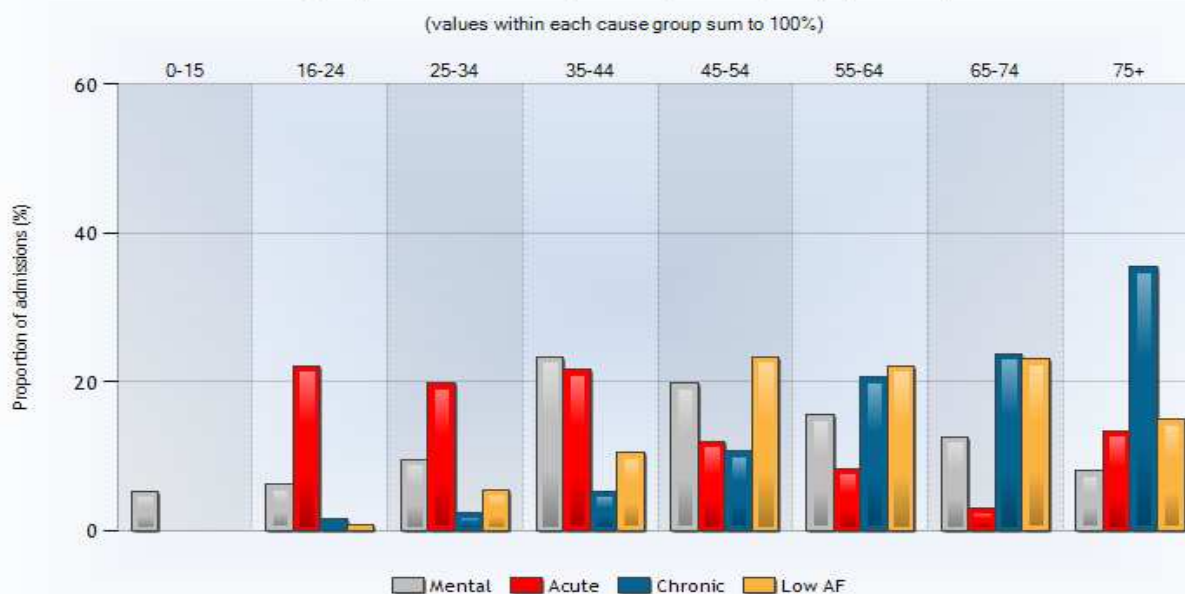
Alcohol-attributable hospital admissions in Bromley 2003 – 2007



Source: LAPE: Local Alcohol Profiles for England

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

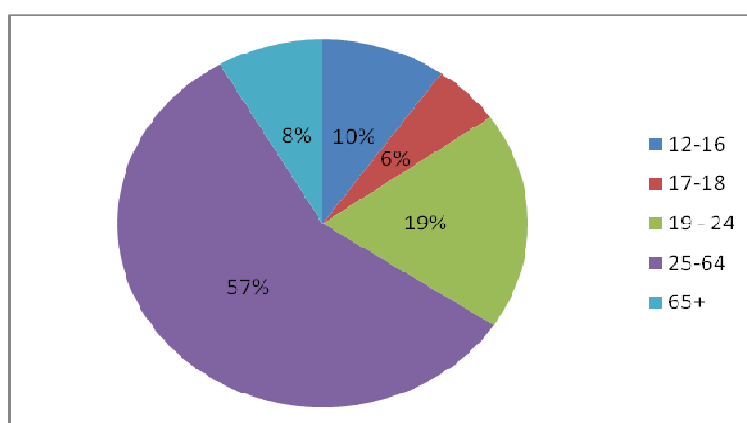
Age-specific admission profile by cause group (2006/07)



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

Admissions to Accident and Emergency services are also an indicator of the impact of alcohol related conditions: In 2009/10 the South London Healthcare Trust had 204 Accident and Emergency attendances for alcohol-related conditions (0.02% of all attendances) of which 31% led to a hospital admission. The youngest attendees were aged 12 years. The breakdown by age is shown below.

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



Source: South London Healthcare Trust

What this means for Bromley

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

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

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

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

Source: APMS 2007

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

What this means for Bromley

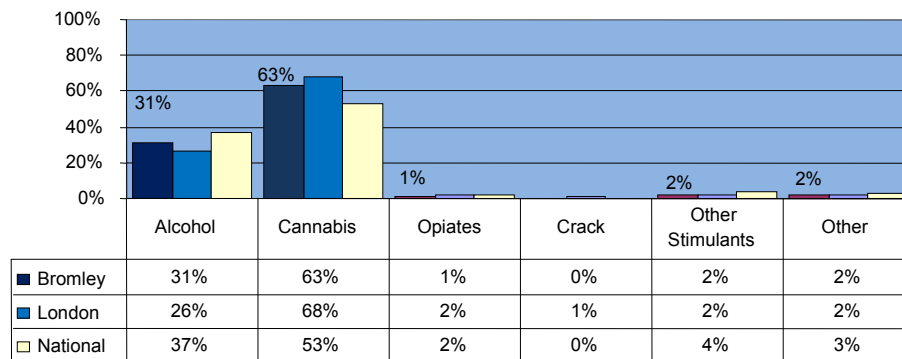
- There is a need to ensure that the acute admission unit for mental health has direct access to detoxification beds with appropriate gate keeping protocols to ensure that individuals are treated appropriately and to reduce the pressure on the in-patient beds

Alcohol and the misuse of other substances

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

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

Primary Drugs of choice for young people 2008/09



The effect of alcohol on sexual health

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

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

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

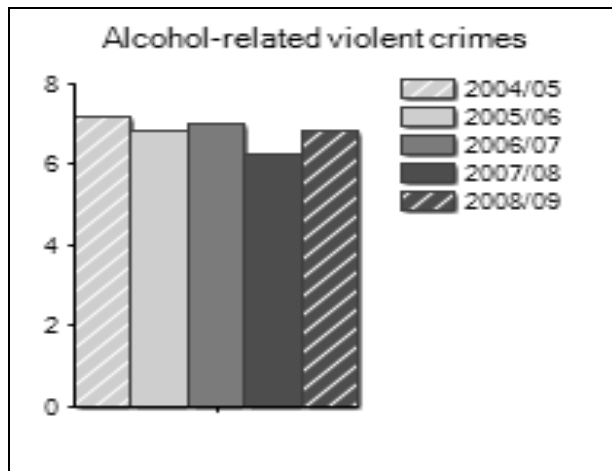
What this means for Bromley

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

The effects of alcohol on Crime

The Local Alcohol profile for Bromley shows that the borough does significantly worse than average, for all alcohol-related crime, and for violent crime. Bromley is ranked 256 for Alcohol-attributable recorded crimes out of 326 local authorities in England, significantly higher than most of Bromley's comparable boroughs except for Barking and Dagenham & Hillingdon. The total estimated number of alcohol attributed crimes (2008/9) was 3067; of these 2060 were estimated for violent crimes attributable to alcohol and 293 estimated sexual crimes attributed to alcohol (2008/9). There has been a slight decrease in alcohol related violent crime between 2004/5 – 2008/9, assuming that reporting and recording of such crime has remained the same. However whilst a potentially valuable indicator the Local Alcohol Profiles for England uses percentage of

crime being alcohol attributable based on the % of people arrested for a particular type of crime who test positive for alcohol in an arrestee survey (1999-2001). This formula is then applied to crime data. This may result in an understatement the role of alcohol in offending. Also a proportion of the crimes counted as alcohol related may also be counted as drug-related if arrestees had tested positive for both alcohol and drug use.



Source: LAPE: Local Alcohol Profiles for England

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

Arrest data 2008/09

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

Source: Bromley metropolitan police 2008/09

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

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

Safe: Sensible: Social- the next steps in the *National Alcohol Strategy (2004)* highlights that drinking among young people under the age of 18, especially frequent drinking, is associated with criminal and disorderly behaviour. Nearly half of all 10-17 year olds who drink once a week or more

admitted to some sort criminal behaviour or disorderly behaviour; approximately two-fifths reported getting into an argument and about a fifth stated they had got into a fight during or after drinking. In September 2009, it was identified that an increasing number of young people were being arrested for offences which involved drugs or alcohol. Statistics provided by the Drug Intervention Programme (DIP) within Bromley estimated that 83 young people were arrested between January and June 2009 for drug/alcohol related offences.

What this means for Bromley

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

6. SERVICES AVAILABLE IN BROMLEY

Prevention

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

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

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

Treatment services

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

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

risen to 23 in 09/10 with more expressing interest to participate in 2010/11. Apart from screening and brief advice, the surgeries have been signposting those considered at risk for Tier 2 support. In 2009/10 there were 1350 prescription items, for an unknown number of individuals, prescribed for alcoholic relapse prevention by GPs. It is difficult to interpret this other than those GPs are prescribing at Tier 3 but not recording their activity with people with alcohol problems.

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

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

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

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

- Individuals with more complex needs are referred via the Bromley Advice and Information Service to Bethnal Addiction Services currently provided by South London & Maudsley NHS Trust. The service currently operates three units for specific interventions depending on need.
- Individuals who require stabilisation or crisis intervention can also self refer to City Road crisis centre. In 2009/10 there was an increase in referrals to City Roads crisis center. As a result of this trend, improvements have been made to improve access to beds for individuals who may be more chaotic.
- Placement in a residential rehabilitation centre. During 2008/09 30 service users have been through the residential rehabilitation. The analysis below breaks down the 30 service users who entered residential treatment Average placement prices ranged from £500 - £740, now average first placement price ranges have reduced from £550 to £400 making it more cost effective. This is due to increased emphasis on negotiation with the service providers without compromising service delivered. The average weekly charge for Residential rehabilitation in 2008/09 was £482.00; this was reduced in 2009/10 to £457.00 (5% reduction).
- Individuals following detoxification have a number of options for services to meet their needs which may include utilising Bromley community services to undertake a structured treatment intervention, attending a structured day program outside of Bromley or being placed in a residential rehabilitation centre.

Numbers of people in treatment by Treatment Type 2009/10

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

Source: NDTMS

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

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

Treatment Type Provision in Bromley compared nationally

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

Source: NDTMS data, 2009/10

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

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

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

Source; NTDMs 2009/10 and NATMS 2010

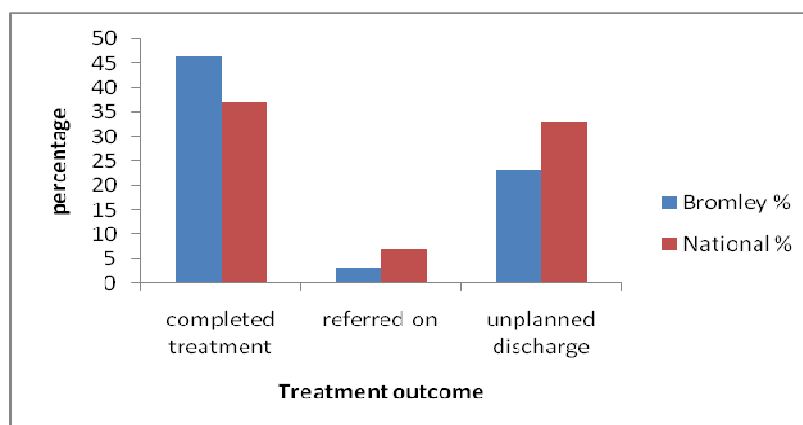
What this means for Bromley

- Bromley is very similar to national rates except that people aged 18-24 years appear to be accessing services less, work needs to undertaken to understand what the obstacles may be and to ensure if necessary this age is targeted for treatment provision
- Bromley appears to treat more people as in- patients, which will have an impact on costs, the use of in-patient residential facilities will be reviewed as aprt of the review of the model of service provision.

Treatment outcomes

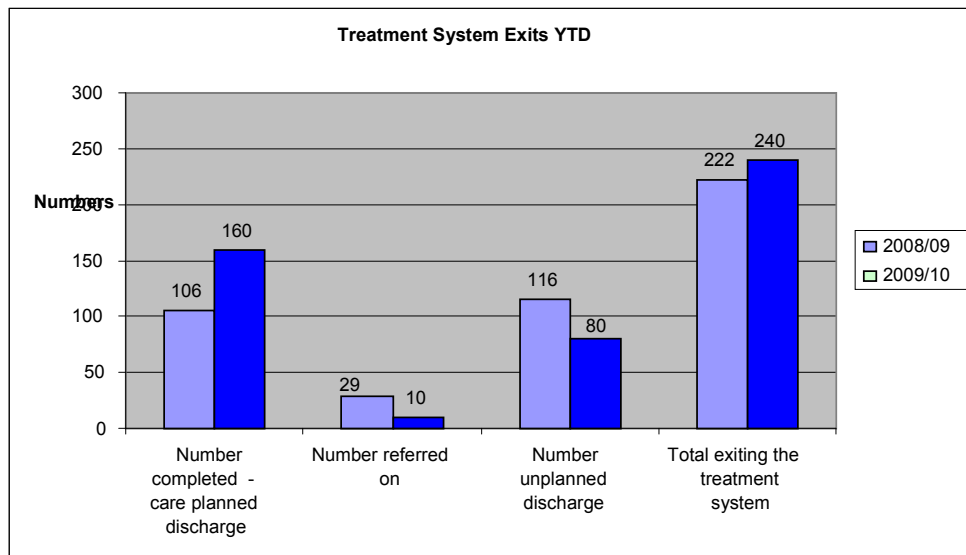
In 2009/10 160/435 (37%) clients completed treatment. Compared to national rates Bromley had a higher percentage of people completing treatment and a lower percentage having an unplanned discharge in 2009/10. Ten clients were referred on for in- patient detoxification /dual diagnosis/complex problems,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

Treatment Outcome in Bromley and England 2009/10



Source; NTDMs 2009/10 and NATMS 2010

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



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

Expenditure on Alcohol Services

The budget for substance misuse- which includes funding for alcohol services is made up of a number of funding streams:

- Primary care provision is funded by the PCT outside of the funding for substance misuse
 - The Pooled Treatment Budget, a government grant is ring-fenced for drug services and is used to support individuals with substance misuse meaningful structured treatment, this budget does not fund for the community based alcohol services in Bromley.
 - Main steam funding for BCAS IS from the PCT mains steam funding.
 - Funding for in patient treatment is from PCT core funding
 - Residential Rehab expenditure is funded from by social care area
- Expenditure on Alcohol Services (excluding GP and Accident and Emergency) in 2009/10

Tier	Provider	Funding stream	Budget
Tier 1 & 2	Bromley Community Alcohol Service	PCT	£393,632
Tier 3	Bromley Community Alcohol Service	PCT	£121,235
Tier 4	Drugs & Alcohol Rehab	LBB	£118,000
Tier 4	In patient detox (drugs and alcohol)	Pooled budget	£102,107 –

Source: Bromley DAT

7. GAPS AND PRIORITIES FOR BROMLEY

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

Community Safety

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

- more work around prevention of driving whilst under the influence of drugs and/or alcohol

- Continued to enforce controlled access to alcohol especially at the points of sale with rigorous vetting of age before sale. A national Home Office led campaign *Tackling Underage Sales of Alcohol Campaign (TUSAC)* used to target worst offending off-licenses known to Trading Standards and the Police.
- Continued to enforce reduction of drinking in public places like parks by young people using Community Police to confiscate drinks from under 18 drinkers.
- To continue to work with drug and alcohol agencies to ensure that contracts are sufficiently flexible to enable agencies to support local borough and police initiatives which promote access into treatment.
- Drug Intervention Programme workers are not currently contracted to provide advice and support to young people under 18 years of age however are able to signpost to the appropriate service. Further work will need to be done to appropriately address this gap in provision

Prevention

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

- In line with the Chief Medical Officer's guidance; agencies in Bromley need to continue to communicate with parents, carers and professionals the message of strict abstinence for under 15s and supervised drinking if at all for the 15-17 age group to minimise alcohol harm both in the short term and in the long term
- Frontline services need to be more visible and welcoming in a non stigmatising way to increase access to support for young people and families with alcohol related issues
- Need for increased alcohol awareness and education amongst young people especially within the educational establishments highlighting the importance of accurate and consistent messages in relation to harm reduction, safer drinking limits, and prevention, including high visibility campaigns in the community to sensitize young people to the dangers of alcohol (similar to "Talk to Frank").

Primary care

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

- Expand the Alcohol-Direct Enhanced Scheme to further increase the number of practices offering Alcohol health checks.
- To address the assertion of under-recording of alcohol consumption in primary care by auditing the recording of alcohol on GP registration and ongoing care
- To continue to provide by direct contact with GP's and by continued participation in GP training information on the services and treatments available in Bromley.

Access to treatment services

Services in Bromley continue to meet the demands of people accessing services although there are a number of issues which need to be addressed, firstly that people aged 18-24 years appear to be accessing services less, work needs to be undertaken to understand what the obstacles may be and to ensure if necessary this age is targeted for treatment provision. Secondly that Bromley

appears to treat more people as in-patients, which will have an impact on costs, the use of in-patient residential facilities will be reviewed as part of the review of the model of service provision. Further work will also be undertaken in the following areas:

- Increase the numbers of points of access to treatment for problematic drinkers, including expanding outreach services.
- To support NICE guidance regarding school based initiatives providing support to schools identified as needing, or requesting additional support from the Healthy Communities Team and to inform schools of the referral pathway into specialist young people's drug and alcohol services.
- To increase access to services for those who are currently underrepresented within local provision including working with local agencies to target those under 24 years of age.
- Protocols are being explored to ensure access to the appropriate detoxification services for individuals from the acute mental health services.
- To explore further the needs of older people in relation to harmful alcohol consumption and access to services
- There is a need to address the increase in hospital admissions in Bromley to reduce the pressure on hospital services and ensure that individual needs are met to reduce harmful alcohol consumption
- To undertake a review of the care pathway for alcohol services with a focus on the A&E department, In-patient services in mental health and aftercare provision.

Information and data

- There is limited data on the effects of alcohol on the elderly – most data sources available suggest that alcohol problems are an issue for young people and up to age 65 and not so much for the over 65+ but this may reflect a lack of awareness and recording issue.
- To develop an alcohol data to monitoring across partnership agencies.
- There is a need to understand and address the increase in female mortality in Bromley due to alcohol which contrasts with the decreasing rates of mortality for men
- Data on alcohol consumption is not routinely collected in Genitourinary Medicine (GUM) clinics, and is not reported on. Furthermore, because of the confidential nature of GUM services, data about sexually transmitted diseases is not collected on a geographical basis, only on a clinic basis, so to get a true Bromley figure is difficult.

Appendix One

Stakeholders key issues

Issue	Providers	Users
Access to alcohol services	<p>Staff training to help users approach their employers re alcohol problems</p> <p>Alcohol prices should be raised – lobbying government</p> <p>Venue for alcohol services should be non stigmatizing yet one stop shop for all substances misused.. Different client groups need different access. REACH is drug –orientated and middle class people won't attend there</p> <p>Alcohol workers needed in A & E</p> <p>Lack of Tier 2 (brief interventions) drop in</p> <p>No self referral to BCAS must be via GP or arrest referral etc.</p> <p>Lack of dual diagnosis services e.g. for alcohol dependent people with suicidal intent, and chronic. Mental health services will only accept if alcohol abstinent for 6 months.</p> <p>Young people, young women, older people and people with physical disability are least likely to access services.</p> <p>People with alcohol problems and related cognitive problems do not have services to access.</p> <p>Training is needed to encourage staff working in learning disability services to refer PLD, because they don't understand health risks or addiction service models</p> <p>Those who arrive intoxicated in A &E are not supported.</p>	<ul style="list-style-type: none"> • Better access to BCAS needed • GPs patchy awareness and identification of alcohol problems • 24 hour Crisis helpline needed ask Samaritans
Access to Prevention and earlier intervention	<p>More GP screening needed.</p> <p>Alcohol can't be separated from other problems a YP has- must be holistic</p> <p>High proportions of people in youth justice system are alcohol users. Tackle in YOT and before this e.g. Neighbourhood teams should recognize.</p> <p>Poly drug and alcohol use is common in YP.</p> <p>Need to educate people earlier before alcohol related harm set in</p> <p>Arrest referral can pick up alcohol users and refer on</p> <p>There is no access to services through custody</p> <p>Reach Works with Housing Associations to pick up dependent users but they are extreme by then</p>	<ul style="list-style-type: none"> • Re-engagement services should be for alcohol not just drugs • Alcohol is very easy to get at 8am in the morning if needed • Most drinking is at home in working age people • Young people drinking in pubs are poly substance users
Access to Relapse prevention	<p>Reach is drug –orientated not alcohol orientated</p> <p>There is not enough psychosocial support post detoxification (revolving door scenario)</p> <p>Outreach team can only do assessments not treatments (no funding)for alcohol problems</p> <p>Women in shared care (mental health + alcohol) remain isolated.</p>	<ul style="list-style-type: none"> • More support via outreach and face: face contact needed post treatment to prevent relapse • Alcoholics Anonymous and SMART are useful
Access to Aftercare	<p>Aftercare is only funded for drug mis users. Methadone users with continued alcohol use are excluded from aftercare.</p>	
Education	<p>The public lack awareness of what a unit of alcohol is and how much they can drink safely.</p> <p>People need education about harm to self and links to crime and sexually transmitted infections unwanted pregnancy etc</p> <p>Young people need education to enable access to services.</p> <p>Stop the “normalization” of alcohol in families and societies</p> <p>Seeing patterns of alcohol use in 13 year olds that used to see in 16 year olds</p> <p>Work with parents needed so messages not mixed</p> <p>Work in schools not enough</p>	<ul style="list-style-type: none"> • People worried about labeling as an alcoholic and hide their need.
Reducing alcohol related harm and crime	<p>More could be made of 3 yearly License Reviews. New Licenses outnumber those revoked (rarely done) Licensing and promoting the night time economy conflicts with community safety, health etc,</p>	
Multiagency working	<p>There is no multiagency panel that brings licensing, trading standards, health, social care together unlike drugs. DAT is perceived as drugs only.</p>	
Monitoring of alcohol abuse	<p>There is at present no collation of data collected by A & E, primary care, probation, local ambulance service -</p>	

Stakeholders suggested solutions

Issue	Providers	Users
Enforcement of licensed organizations serving alcohol to drunk people	<p>Undertake a study in A & E to find out where the attendee had their last alcoholic drink, so this can be used in warnings /revoking licenses</p> <p>Review the "Saturation" Policies in order to reduce the number of licensed premises in the city centre hot spots for alcohol related crime.</p> <p>Institute a "Best Bar "scheme to encourage responsible landlords.</p>	
Mental health /dual diagnosis	Services need to be improved for this group.	
Education	<p>Ask supermarkets and off- licenses to distribute leaflets about alcohol related harm</p> <p>Educate parents and general public</p>	
Alcohol taxation	Lobby for the price of alcohol to be increased	
Treatment	<p>Pilot a triage system (the Cardiff model) between LAS, police and primary care in the city centre on Friday and Saturday nights in order to reduce A & E visits.</p> <p>Train more GPs in brief interventions</p> <p>Put in place more satellite services in A&E, CMHT, GPs, social services ie alcohol workers</p>	
Increased funding	Use crime reduction funding	
Unwanted pregnancy	Link Alcohol strategy with Teenage Pregnancy Strategy	
Relapse prevention	Ask the Samaritans to be a crisis line.	
Management	Revised Alcohol Strategy Action plan and data monitoring towards targets needed	

BROMLEY IN CONTEXT

Bromley is geographically the largest of the all London Boroughs, covering more than 58 square miles, stretching from the highly urbanised areas of Anerley, Penge and Crystal Palace in the northwest to the more rural areas of Biggin Hill in the southeast.

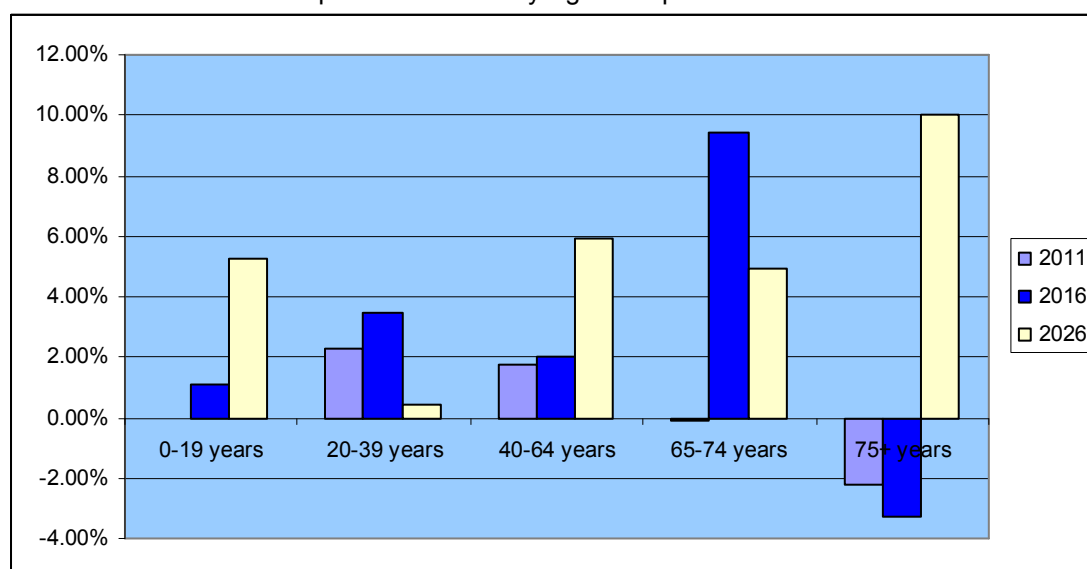
The Borough is a relatively prosperous community, which is reflected in the high level of home ownership (75%) and the highest level of car ownership in London (77% of households own one or more cars). A key change between 1991 and 2001 has been a 245% rise in Lone Parent Households, reaching a current figure of 8224 households.

The population of Bromley is currently just under 300,000. The overall population of Bromley is projected to rise to 299,791 in 2011, and to 303,100 by 2026. This represents a rise of 0.8% between 2006 and 2011, and a rise of 1.92% between 2011 and 2026. Over the last 10 years there have been rises in the number of people aged 75 or above and children aged 15 or below.

Age profile

Bromley has one of the highest proportions of older people within its population of all London Boroughs; particularly those aged over 85 years. The population of pensionable age stands at 57,300 people and is the highest in London. This age group forms 19.3% of the total population. Around 39,000 people in Bromley live within a single person household and almost half of these are 65 or older. The number of older people living on their own within Bromley is higher than the London average. Bromley also has a higher than average number of children compared to its neighbouring boroughs and with a total of 66,680, is placed second behind Croydon with 80,685.

% Population Growth by Age Group 2006 to 2026



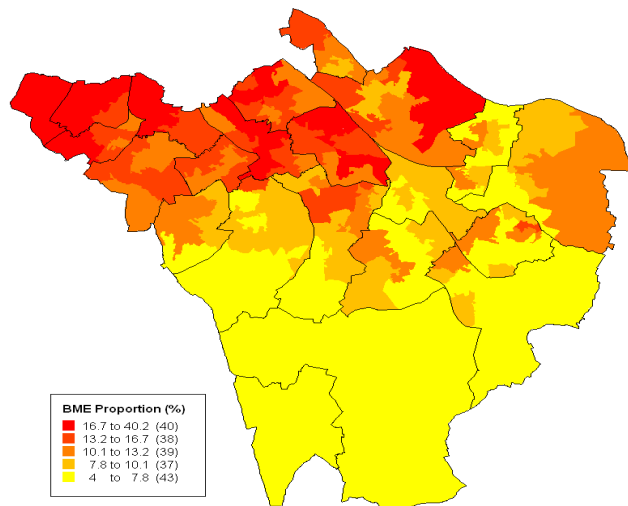
Source: GLA 2009 Round Demographic Projections

Black and Ethnic communities' profile

Bromley's ethnic make up is mostly formed of white British residents. This reflects higher than the London average but slightly less than the national profile of 90%. It is anticipated that representation from ethnic groups in Bromley is going to increase over the next 20 years. The Black Caribbean ethnic group were the largest ethnic group in 2006 but in 2026, the Black African ethnic group will be the largest single ethnic group in Bromley. Bromley has the largest group of settled Gypsies and Travellers in England, which is estimated to be around 1,000 families. Some of the travellers are settled on caravan sites but the majority live in social housing in The Crays, Penge, Bromley and Biggin Hill wards. Furthermore, it is estimated that there are between 2200 - 2400 refugee households.

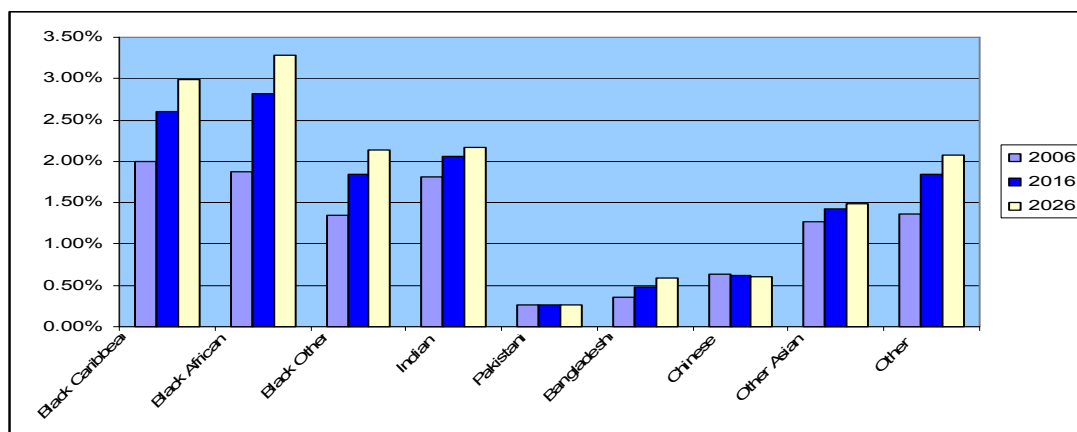
The ethnic minority population is mainly concentrated in the northwest of the Borough with the wards of Crystal Palace and Penge being the only wards where the BME population exceeded 16% of the total. These areas are also notable for relatively high unemployment and the presence of greater health concerns than the rest of the borough. The settled traveller population is in the East of the Borough, particularly in the Crays.

Distribution of the black and ethnic population in Bromley



Approximately 12.3% of Bromley's total population identify themselves as members of minority ethnic groups. This is a figure well below the London average which stands at 29% and 25% for outer London Boroughs and is a significant increase from the 4% of the population recorded in 1991. With around 10% of children and young people having an ethnic minority background, the figure is expected to rise further still to around 10% of the Borough's total population by 2011.

Ethnic group representation in Bromley 2006 – 2026



Source: GLA 2009 Round Demographic Projections

Gender profile

In Bromley, the gender split reflects the wider London and National trends with a slightly higher number of women than men. The gender representation in treatment services also reflects local and national trends with a 29% (women) / 71% (men) split in treatment.

Bromley and comparator populations by age groups and gender (000s)

Age	Bromley		London		ENGLAND	
	Males	Females	Males	Females	Males	Females
0-9	19.400	18.700	514.600	495.000	3,100.000	2,959.200
10-14	9.700	9.100	207.400	200.800	1,543.800	1,472.700
15-19	9.200	8.900	217.800	208.700	1,700.900	1,610.900
20-24	7.800	7.900	279.700	283.800	1,817.200	1,737.100
25-34	19.200	20.400	761.700	740.200	3,436.000	3,338.600
35-44	24.200	25.600	680.900	625.500	3,787.400	3,823.400
45-59	29.800	31.100	648.500	668.300	4,907.000	5,034.200
60+	29.900	39.200	540.500	680.000	5,222.100	6,318.900
Total	149.200	160.900	3,851.100	3,902.300	25,514.400	26,295.000

Source: ONS Mid-2009 Population Estimates, June 2010

Health profile

Bromley scores well in national health indices, coming ninth overall within London based on combination of four key health indicators. The headlines for Bromley are:

- The health of people in Bromley is significantly better than the England and London average. Deprivation, people diagnosed with diabetes and deaths from smoking are all lower in Bromley than the England average, while adults who eat healthily and life expectancy generally in both males and females is higher.
- There are differences in people's health within Bromley by location, gender, income and ethnicity. For example, wards such as Pratts Bottom are among the least deprived in England while areas of Cray Valley East and Biggin Hill are among the most deprived
- Over the last ten years, the rate of deaths from all causes for both men and women has remained below that for England and has fallen every year. Early deaths from heart disease and stroke have fallen from over 100 deaths per 100,000 of population in 1996 to around 60 deaths per 100,000 of population in 2005.
- Rates for physically active children and life expectancy in both males and females are significantly better in Bromley than in England.
- The 2008 Local Area Agreement has prioritised tackling adult participation in sport, obesity among primary school-aged children in reception year, and under 18s conception rate

Crime

The level of crime in Bromley is low compared with neighbouring boroughs and is showing a downwards trend

Crime figures for Bromley 2008 -2010

Number of Offences	12 months to August 10 (year)		12 months to August 09 (year)	
	Bromley	Met Total	Bromley	Met Total
Total Crimes	22,496	827,132	26,058	841,202
Homicide	2	126	4	123
Violence Against the Person (Total)	5,158	174,454	5,507	173,874
Rape	59	3,120	51	2,270
Other Sexual	219	7,192	202	6,608
Robbery (Total)	596	34,001	671	32,910
Robbery (Person)	529	30,858	582	29,604
Robbery (Business)	67	3,143	89	3,306
Burglary (Total)	3,070	89,579	3,994	95,817
Burglary Residential	1,899	58,614	2,215	60,972
Burglary Non-Residential	1,171	30,965	1,779	34,845
Gun Crime	74	3,274	73	3,239
Motor Vehicle Crime	2,875	98,222	3,840	104,479
Domestic Crime	1,765	50,922	2,066	53,098
Racist & Religious Hate Crime	332	9,532	407	9,854
Homophobic Crime	52	1,309	60	1,240

Source: Metropolitan Police Crime figures

As important as the numbers of actual crime is residents perception of crime and their feelings of safety. A survey by MORI *Bromley in 2008/09 Findings of the Place Survey* conducted every two years analyses resident's perceptions of the place in which they live which includes perceptions on crime. In Bromley the findings included:

- Increasing numbers say Bromley and Beckenham town centres are safe and pleasant, with residents thinking there had been the most improvement in Bromley town centre and the least in Orpington
- Crime is still a priority for residents but markedly lower than in 2003, 2006 and 2007
- In 2008 residents feel safer in Bromley than at any other time with 87% feeling safe and 13% feeling unsafe, people feel safer in daylight than the average for outer London as they also do after dark with some of the lowest perceived problems with crime and anti social behaviour
- Concerns about drugs is near the bottom as are worries about drunkenness but all areas of concern have remained static since 2006/07

Bromley resident's perception of issues in the borough

Perceived problem	% in Bromley 2008/09	% across all London Boroughs 2008/09	% in Bromley 2006/07	% across all London Boroughs 2006/07
People using or dealing in drugs	23	37	23	36
People being drunk or rowdy in public places	27	36	27	37
Noisy neighbours or loud parties	11	20	11	13
Teenagers hanging around on streets	44	49	44	69
Rubbish or litter lying around	34	46	34	41
Vandalism, graffiti and other deliberate damage	33	39	33	53
Abandoned or burnt out cars	10	12	10	13

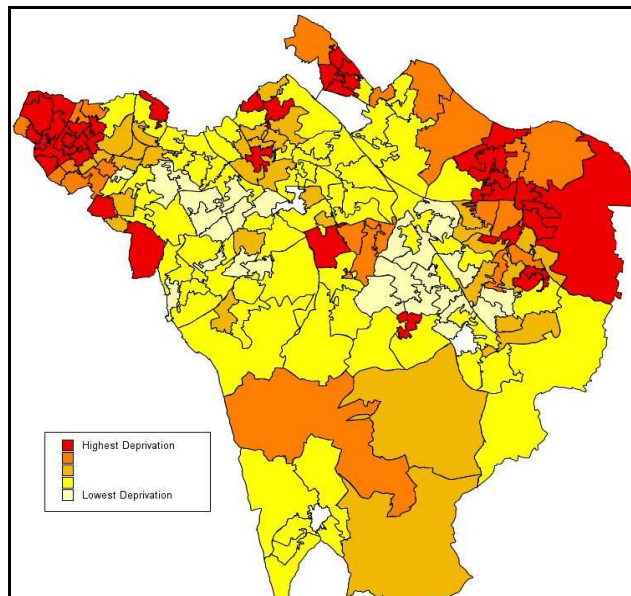
Source Bromley in 2008/09 Findings of the Place Survey MORI

Economic profile

In spite of the higher than average index of economic activity rate, some areas in Bromley present relatively high levels of deprivation. These areas include the West, East and North of the Borough

and include Crystal palace, Penge, Cator, Clock house, Cray Valley East, Cray Valley West, Mottingham, Chislehurst, Plaistow, Biggin Hill and Sundridge.

Bromley index of multiple deprivation



Unemployment in the Borough is lower than the Greater London average at 2.7% compared with a London average of 4.4% and an outer London average of 3.6%. Only Crystal Palace and Penge & Cator have above the London average of unemployment at 5.75% and 5.04% respectively.

Bromley has the fourth highest economy in South London, with a large economically active population compared to other South London Boroughs. Nearly a quarter of Bromley's jobs are located in Bromley Town Centre, and nearly two thirds (62%) of the jobs in the borough are taken by residents of the borough. 55% of the working population work outside the borough.

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