BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT

2012

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Foreword

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Executive Summary

1. Introduction

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

2. Demography

This year, the initial findings of the 2011 Census are included in the JSNA, although the population projections are still based on the 2001 Census data.

The population of Bromley is rising and is predicted to continue to rise. The 2012 estimate of the resident population is 316,647; this is expected to increase to 326,217 by 2017 and 332,956 by 2022.

The number of births has risen considerably in recent years (an increase of 29.1% in 2011 compared to 2002) and is likely to continue to do so. This has resulted in a concomitant increase in the numbers of 0 to 4 year olds.

The number of older people in Bromley is increasing in line with the rise in the overall population, so the proportion of older people is predicted to remain fairly stable at 15.6% over the next 10 years.

There has been an increase in the proportion of the ethnic minority population in Bromley from 13.5% in the 2001 Census to 22.6% in the 2011 Census. For the first time, the 2011 Census has included Gypsy/Irish Travellers as an ethnic category, with 0.2% of Bromley's population stating that they belong to this category.

The 2011 Census shows that although there has been a significant increase in the proportion of people working in higher professional occupations, there has also been a marked increase in the proportion of "never worked" and "long term unemployed" in Bromley.

What this means for the JSNA

Services need to cater for an increasing number of people in Bromley.

Consideration needs to be given to the increasing numbers of older people and young children who are higher users of health and social care services.

The increase in numbers of children will impact on requirements for primary and secondary school places.

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

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, and the latest figures (2007-09) report a life expectancy of 79.9 years for men and 83.8 years for women.

However, life expectancy is 7.8 years lower for men and 6.2 years lower for women in the most deprived areas of Bromley compared with the least deprived areas.

The infant mortality rate in Bromley (3.0 per 1000 live births) is lower than in England as a whole (4.4 per 1000 live births), and has been fairly steady over the last 4 years.

The key causes of death in Bromley remain circulatory disease, cancer and respiratory disease.

The prevalence of heart disease has been stable over the last four years and mortality rates continue to decrease.

The NHS Health Checks Programme is identifying a high risk of CVD in the next 10 years in 8% of screened individuals.

The prevalence of stroke has increased in the last year, but the mortality rate continues to decrease.

The prevalence of hypertension remains above 17% (with over 46,000 cases), despite evidence of under identification of cases. Control of hypertension in Bromley is less effective than across London and England.

The numbers of people in Bromley with diabetes continues to rise, with 13,335 cases on the disease register in 2011-12.

The incidence of all cancers in Bromley has been rising over the last 28 years, but mortality has been falling and survival has been improving. The number of cancer registrations per year has increased since 2002, but has been fairly stable since 2006.

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

About 13% of deaths in Bromley are caused by respiratory disease. This includes influenza and COPD. Chronic Obstructive Pulmonary Disease (COPD) is mainly caused by smoking. Although the prevalence of smoking in Bromley is lower than the London and England averages, smoking prevalence is higher in routine and manual workers.

Mental health problems affect a large proportion of the population, with approximately 158 people per 1,000 of the Bromley population aged 16 to 74 years suffering from a mild to moderate disorder (i.e. anxiety and/or depression).

In 2012 it was estimated that there were 4102 people with dementia in Bromley. GP registers identify 1,703 patients with dementia, suggesting that some cases are not known to clinical services. By 2030 the number of people with dementia in Bromley is estimated to increase to 6047.

In 2010 there were 143 conceptions in females aged between 15 and 17 years. This represents a rate of 26.4 per 1000 female population aged 15 to 17 years, which is lower than both the London rate (37.1) and the England rate (35.4). There has been a 17.8% reduction in the under 18 conception rate since 1998.

Of the 143 under 18 conceptions in 2010, 93 (65%) resulted in a termination of pregnancy. This is significantly higher than the England rate (50.3%), and slightly higher than the London rate (62.5%).

The rate of sexually transmitted infections (STIs) in Bromley is significantly lower than the London rate and the England rate.

Bromley has a high rate of hospital admissions with any mention of pelvic inflammatory disease in women aged 15 to 44 years (564 per 100,000 population) as compared with the London rate (240.3) and the England rate (247.9). This high rate in Bromley merits further investigation.

The prevalence of HIV in people aged 15 to 59 years in Bromley is significantly higher than the prevalence across England, but is lower than the prevalence for London. The number of people living with HIV in Bromley has increased by 68% in the last five years, with the highest rates in the North West of the borough.

Of concern is the increase in the number of cases of whooping cough (Pertussis) in 2012. This is in line with the national trend. In Bromley, most cases have occurred in adults aged over 25 years.

Coverage rates for immunisation have been improving over the past four years, but remain lower than the World Health Organisation (WHO) recommendation of 95%. Rates of immunisation uptake of the preschool booster and 2nd MMR are especially low.

Smoking is a major risk factor for circulatory disease, cancer and respiratory disease. Smoking prevalence in Bromley is estimated to be 18.1% and prevalence has been rising since 2009.

A survey in Bromley last year found that a significant proportion of people asked had been offered and bought illicit tobacco products in the last year.

Obesity is a key risk factor for circulatory disease and cancer, and also for diabetes, which is a precursor to circulatory disease.

The modelled estimate for obesity prevalence in Bromley of 21.8% of those aged 16 years and over represents approximately 54,163 adults in Bromley.

Data collected for Bromley as part of the National Child Measurement Programme (NCMP) shows rising trends in the prevalence of overweight in children in Reception Year and Year 6 with a slight drop in the prevalence of obesity in the same age groups.

There is scope to increase levels of physical participation in Bromley. Current levels for adults are below the national average.

Cycle segmentation data suggests that certain areas within the borough have greater propensity to take up cycling. Households broadly within Bromley North, Shortlands, Copers Cope, Beckenham and around Crystal Palace have the greatest propensity and should be areas in which cycling promotion and activity should be targeted to generate the greatest return.

What this means for the JSNA

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

Prevention, identification and good management of long term conditions (in particular obesity, diabetes, hypertension and HIV) continue to be a priority for Bromley.

Improving immunisation uptake remains a priority in the face of recent outbreaks of infectious diseases such as pertussis.

Smoking prevalence is rising and there is evidence of illicit tobacco trading.

The prevalence of obesity is still a matter for concern.

There is scope to increase levels of physical activity participation in Bromley.

4. Renewal Areas

Action on health inequalities requires action across all the social determinants of health. Although deprivation scores for Bromley are low overall, there is considerable variation across different areas in the borough, resulting in about 5% of Bromley's population living in the most deprived quintiles of the country. In order to improve deprivation scores, action is needed across all of the domains used in establishing the Index of Multiple Deprivation: income, employment, health deprivation and disability, education, skills and training, barriers to housing, living environment and crime.

In response to the London Plan Regeneration Areas Policy, six of the Bromley "Places" are being identified in the evolving Local Plan as five Renewal Areas: "Crystal Palace, Penge & Anerley", "Bromley Common", "The Cray Valley", (combining "Cray Valley, St Paul's Cray & St Mary Cray" with "Orpington, Goddington & Knoll", "Mottingham" (abutting Lewisham and Greenwich regeneration areas) and "Ravensbourne Plaistow & Sundridge" (abutting a Lewisham regeneration area).

5. Housing

The 2011 Census found that there were 130,862 households in Bromley and this figure is predicted to rise together with a reduction in average household size. Approximately 71% of dwellings are owner occupied; this figure is falling and there has been a growth in the private rental sector.

A Housing Condition Survey (2005) indicated that approximately 33% of private sector dwellings in the borough fail the Government's Decent Homes Standard. Vulnerable households are four times more likely to occupy non-decent dwellings if they live in certain wards within the borough.

The main cause in Bromley of homes not meeting the Decent Homes Standard is lack of thermal insulation.

Bromley continues to experience a significant increase (over 150%) in the number of households presenting faced with homelessness. This has resulted in a significant rise in the number of households having to be placed in temporary accommodation.

What this means for the JSNA

- Managing expectations of people who are not in priority need
- Increasing demand for housing
- Increasing numbers of repossessions
- Decreasing supply of affordable housing and temporary accommodation further exacerbates the gap between supply and demand

6. Children & Young People

Educational Attainment

Approximately 20% of the borough's school intake is from neighbouring boroughs (mainly Lewisham and Croydon).

Early Years Foundation Stage (EYFS) performance has been improving year on year since 2008, with 68% of Bromley pupils attaining the expected level of performance in 2012. In addition, the gap between the highest performing pupils and the lowest 20% at EYFS has been reducing (33% in 2010 and 29.2% in 2012).

Bromley's performance at Key Stage 1 is consistently at or 1-2 percentage points higher in all areas than performance nationally. However, the gap in performance at Key Stage 1 between pupils eligible for Free School Meals (FSM) and non-eligible is not narrowing. Pupils not eligible for FSM consistently perform better than those eligible.

Bromley's performance at Key Stage 2 is also consistently above performance achieved nationally. At Key Stage 2, the gap in attainment in combined English and mathematics between those pupils eligible for Free School Meals and those who are not has decreased year on year, from a gap of 29% in 2008 to 22% in 2012.

Girls tend to out-perform boys in most subject areas across all key stages.

A higher percentage of pupils in Bromley schools made the expected amount of progress between the Key Stage 1 and Key Stage 2 assessments in 2012 than nationally.

At GCSE (Key Stage 4), Bromley pupils also achieve higher that the national average, with 68% of pupils gaining 5+ A*-C grades (including English and mathematics) in 2012, compared with 58% nationally.

At Key Stage 4, the Free School Meal/Non Free School Meal gap has fluctuated over the last 3 years when looking at attainment of 5+ A*-C grades, and 5+ A*-C grades including English and mathematics. In 2011 the gap was 21% for the former and 26% for the latter.

What this means for the JSNA

- Continue to develop and sustain relationships with schools which convert to Academies to achieve jointly agreed outcomes to improve the lives of children and young people in the Borough.

- The number of five year olds achieving the expected level for the Early Years Foundation Stage Profile is in line with that of national attainment and it is an area where performance is improving, however the rate of improvement is not at the same high level as the other key stages. A focus is therefore provided on improving attainment at the Foundation Stage as studies, such as the Marmot and Field Reviews, clearly identified the importance of intervention in the early years.

- The attainment gap at Key Stage 2 and Key Stage 4 is a particular area of focus for the LA and for the Department for Education. The priority is addressing the gap between those with Free School Meals/ Non Free School Meals in particular, but there are also gaps in performance across the genders.

Young People in Secondary School

- Young people in Bromley are generally faring well. They have high levels of self-reported health and life satisfaction, they achieve well at school, and they are generally optimistic about their futures.
- These high levels, however, are unevenly spread - by age, sex and affluence. Girls, in particular, have significantly lower levels of reported health and life satisfaction, and higher perceived school pressure, than boys. Well-being and healthy behaviours decrease significantly with age.
- Interventions that have been found effective in improving well-being in young people include parenting programmes and whole school approaches to improving social behaviours and reducing bullying.
- While some interventions are in place in Bromley, implementation and knowledge about what is actually happening is, respectively, variable and incomplete.

What this means for the JSNA

- Whole school approaches are needed to improve well-being of both young people and staff, and through this to reduce exclusions, truancy and crime, improve behaviour at school, increase educational attainment, and reduce risky behaviours.
- Special attention should be given to supporting all parents, not just those whose children already have problems.

Children with Special Educational Needs (SEN) and Disabilities

During the past decade Bromley has experienced a significant increase in volumes of children with Special Educational Needs (SEN) and Disabilities.

In 2012 there were 9,205 pupils in Bromley schools with Special Educational Needs, an increase of 1,193 since 2008.

The number of pupils in Bromley with Statements of Special Educational Needs has also increased, from 1,585 in 2008 to 1,779 in 2012.

Pupils who have a significant degree of Special Educational Needs and Disability perform less well than their peers at all Key Stages and subjects.

In 2012, 30.8% of the 117 Statemented pupils in Bromley achieved the required level in reading at Key Stage 1 compared to 96.4% of pupils who have no SEN. This shows a decline on 2011 where 38.9% of 95 children with a Statement achieved the required level in reading compared to 95.9% of pupils who have no SEN. There is a similar pattern across all subjects.

The results are similar for subjects at Key Stage 2.

Performance at Key Stage 4 shows that 78.3% of pupils who have no special needs achieve the expected level of 5+ GCSEs A*-C including English and maths compared to 20.8% of the 68 pupils who have a full Statement. This shows an improvement on 2011 where 16.8% of 68 children with a Statement achieved the expected level of 5+ GCSEs A*-C including English and maths compared to 79.5% of pupils who have no SEN.

The number of referrals of children to the Specialist Support and Disability Panel has increased by 19% between 2010-11 and 2011-12 – an increase of 38 children to 240.

The Borough's Supporting Inclusion in Pre-School (SIPS) programme supported 8% more pre-school children with severe and complex needs within their local community pre-school setting.

In addition, 22 children with complex health needs, including some requiring airway support, Hickman lines, support for complex diabetes and gastrostomy tube feeding have been supported across 18 mainstream primary and secondary schools in the Borough without requiring a full Statement.

What this means for the JSNA

- Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life.
- The increase in numbers and complexity of needs of children with learning difficulties and/or disabilities has required more specialist and high cost provision to be made available.

Children's Safeguarding and Social Care Referrals

Within Bromley, initial contacts increased by almost 300% from 2008 to 2012 (from 3,425 in 2007/8 to 10,132 in 2011/12). This figure has now levelled off but is not a s low as the 2007-08 level. There was also an increase in the safeguarding referrals which have increased by 85% (from 1,441 in 2007/8 to 2,679 in 2010/11). This placed considerable pressure on children's social care services.
In July 2011, a multiagency support hub (MASH) service was introduced to address the pressures and by forming an effective triage service, have resulted in a decrease in the number of referrals (the 2012-13 cumulative figure was 1526 at November 2012).

What this means for the JSNA

- Initial contacts to, and Assessments by, Children's Social Care Services have significantly increased creating considerable pressures on the Council's staffing and budgets. These have, however, stabilised over the last two years.
- There does appear to be a trend for decreasing numbers of Referrals to Children's Social Care Services thanks to the effective use of MASH.

Children in Care

The numbers of Children in Care in Bromley have increased by 18% (46) between 2007/08 and November 2012/13 to 301.

During the three year period from 2009 to 2012 the average time between a child entering care and moving in with its adoptive family within Bromley is 689 days. This shows a significant decrease compared with the average time between 2008 and 2011 which was 804 days. However, this average is longer than both the average for England (636 days) and the average of the Borough's 'statistical neighbours' (580 days).

Within Bromley, the percentage of young people aged 19 who were looked after at age 16 who were in education, employment or training has increased by 18% between 2010 (31%) and 2012 (49%). This is now above the national average of 36% in 2012.

The percentage of young people aged 19 who were looked after at age 16 who were in suitable accommodation has increased by 7% between 2010 (84%) and 2012 (91%). This is now above the national average of 88% in 2012.

Whilst being in the care of the Council it is acknowledged that it is important for children and young people to have stability in their placements. This means keeping movements between care placements to a minimum. Bromley has been above the England average for the percentage of children in care with three or more placements during the year since 2010.

What this means for the JSNA

- There has been a significant increase in the number of children in care over the last 5 years.
- The average time between a child entering care and moving in with its adoptive family within Bromley is below both the average for England and the average of the Borough's 'statistical neighbours'.
- The percentage of children in care who have more than 3 placement moves a year in Bromley is above that of national average.

7. Older People

Bromley has an ageing population – the largest in London with approximately 54,000 people aged 65+ years in Bromley at 2012. It is expected that this will increase to 57,000 (5%) by 2015 and will continue to increase to 74,100 (37%) by 2030.

There are currently over 4,100 people living in Bromley with dementia, and with the ageing population the incidence of dementia is set to rise by 4% (159 people) by 2015 and will continue to increase by 47% (1,945 people) by 2030.

The numbers of older people supported by Adult Social Care Services has decreased over the last four years. The largest decrease in services has been a 23% decrease in the number of people in nursing care from 320 in 2007/08 to 244 users in 2011/12. However, the number of people using Direct Payments over the last four years has increased by 94% from 103 in 2007/08 to 200 users in 2011/12.

For people with dementia, the introduction of more self-directed support and less reliance on residential care is leading to an increased demand for complex need care packages, increasing referrals to Oxleas Memory Service, a doubling of specialist dementia residential care since 2006/7 and the need to explore alternative models of accommodation and support to reduce need for residential and nursing care.

What this means for the JSNA

- An increasing number of older people are being supported within their own home which will have an increasing impact on community based services by all organisations that are required.
- The increase in older people who chose to manage their own support through direct payments are likely to change both the way in which services are provided and the types of services that are provided across the Borough.
- The increasing complexity of needs of the older people in residential care will impact on the services required to be provided by care homes, and the cost to the Council.

8. Learning Disability

The number of adults up to the age of 64 years with learning disability in Bromley is predicted to increase by 7.3% over the next 8 years.

Identification of adults with LD is significantly lower in Bromley than the England average. In addition, the proportion of adults known to GPs who have had a health check is already significantly lower in Bromley than the England average. This is important because people with learning disabilities have a higher prevalence of certain health problems and also have more difficulty than others in recognising health problems and getting treatment for them.

Bromley has significantly higher rates of emergency admissions for adults with learning disability than the England average.

The proportion of people with learning disability in Bromley living in non-settled accommodation is 24.08%, which is significantly higher than the England average and has been rising over the last two years.

What this means for the JSNA

There is a need to improve the identification of people with learning disabilities in primary care.

There is a considerable shortfall in the numbers of people identified with learning disability who have had an annual health check.

9. Physical Disability and Sensory Impairment

It is estimated that there are around 20,000 people of working age in Bromley who have a physical disability or sensory impairment, about 10% of the population aged 16-64. This figure is projected to increase to 21,750 by the year 2020.

10. Mental Health

The percentage of over 18s with depression is significantly higher in Bromley than the percentages for both England and London.

Overall, suicide rates for men in Bromley are about three times higher than for women.

In 2010, 69.2% of all people dying by suicide were men, of which the 65 years and over age group had the highest number of male deaths.

In 2010 there were 287 hospital admissions for deliberate self-harm (a significant increase from the 122 in 2001). 86% of these admissions were for self-poisoning.

The 15 -19 year old age group have the highest number of admissions following self-harm, numbers remain high and throughout life up to the age of 49 for women.

Within the next four years there will be an increase of nearly 300 people with dementia, with the greatest increase in the over 85 year age group. As well as suffering from dementia, this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,400.

Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16-25 years sooner than the general population.

The measure of overall emotional well-being in Bromley children and young people is lower than would be expected and changes to services locally have resulted in difficulty accessing Child and Adolescent Mental Health Services (CAMHs) by front-line services.

Local Special Educational Needs and Disabilities (SEND) data from schools shows higher rates than would be expected of children with learning disabilities and children on the autistic spectrum.

What this means for the JSNA

Implementation of the Mental Health Strategy and Clinical Commissioning Group Mental Health Programme are key tasks over the next few years.

11. End of Life Care

Between 2008 and 2010, the majority of deaths in Bromley occurred in hospital (56%).

There has been no change in the proportion of people dying at home between the 2005-09 and 2008-10 periods in Bromley. However, there has been an increase in the proportion of people dying in care homes between the two time periods.

Of the deaths that occurred in hospital in Bromley during 2010, 90% of these terminal hospital admissions were emergency admissions.

Considerable progress has been made in implementing the Gold standards Framework in Care Homes and improving End of Life Care services in General Practice.

What this means for the JSNA

Since there has been little change in the numbers of those dying at home in Bromley between 2005-09 and 2008-10, new approaches to increase the number of those able to die at home may need to be considered.

Given the increase in proportion of those dying in care homes in comparison to their own homes, closer examination of what is happening in care homes in Bromley to achieve this in comparison to people's own homes may be required.

An analysis of the source of terminal admissions to hospital may be useful in order to ascertain some of the factors that contribute to the high proportion of terminal hospital admissions that present as emergencies in Bromley.

12. Carers

Bromley has a similar percentage of carers (10%) compared to the England total (10.3%); however, the Borough has a significantly higher percentage than across London (8.4%).

A higher proportion of carers in Bromley provide a lower level of care of under 19 hours per week (6.9%) than both London (5.3%) and England (6.5%).

Fewer carers provide intensive care of more than 50 hours per week in Bromley (2%) than England (2.4%); however, the figure for Bromley is higher than that for London (1.8%).

The number of young carers identified and supported by Carers Bromley has increased significantly over the past few years; however, it should be noted that from national research it is expected that these are only a portion of the actual number of young carers within the Borough.

In September 2012, a total of 847 young carers were known to Carers Bromley compared to 539 in June 2009. This is an increase of 57%. This also reflects an increase of 22% between June 2011 [693] and September 2012, and an increase of 6% since February 2012 [802].

Young carers are less likely to be happy at school and more likely to be bullied than young people with no caring responsibilities. Furthermore, carers are more likely to experience poor health with people providing high levels of care twice as likely to be permanently sick or disabled.

Within the next three to four years the number of people needing care will outstrip the number of people able to provide that care.

As the number of carers increase this will also have an impact on businesses as most carers fall into the 45-64 age brackets at the peak of their careers.

During 2012 the London Borough of Bromley and the Bromley Clinical Commissioning Group published a revised Strategy for Carers for 2012/13. This will be reviewed and revised again during 2013.

What does this mean for our JSNA?

There continues to be insufficient local data/ joint identification of carers and young carers

Bromley has a similar percentage of carers compared to the England total; however, the Borough has a significantly higher percentage than across London

The 2011 Census indicates that a higher proportion of carers in Bromley provide a lower level of care of under 19 hours per week than both the London and England averages

It also indicates that fewer carers provide intensive care of more than 50 hours per week in Bromley than the England averages; however, this is higher than the London average

Although it is difficult to identify the actual number of young carers in the borough, the number of young carers known to Carers Bromley has increased 57% since June 2009

The Carers Strategy, including the Young Carers Strategy, is being refreshed during 2013

Carers assessments have a low take up and how they are presented to carers needs to be revisited in terms of the benefits

The carers survey undertaken during Winter 2012 will provide valuable information on the needs of identified carers

13. Substance Misuse

In Bromley the rate of adults estimated to currently be using an illicit drug is 5.4 per 1,000 population (or 1,106 people).

During 2010/11 there were 1,085 adults treated for drugs misuse in Bromley, of these the highest proportion was aged between 35 and 44 years.

In Bromley, 6% of the population in treatment present for cannabis misuse, nearly 10% for cocaine misuse and less than 1% for amphetamine and ecstasy use. Adults treated for opiates and crack make up the largest proportion of those in treatment (80%).

The emerging AACCE (Alcohol, Amphetamine, Cannabis, Cocaine, Ecstasy) substances are more popular with those aged between 16 and 24 years and there is little information about the long term effects or of patterns of misuse.

During 2010/11 there were a total of 274 people in Bromley who exited from drug treatment services. Three quarters of them were male and over 85% were white. Those aged between 25 and 44 years made up two thirds of treatment exits. Nearly half of those that exited treatment (45%) planned to do so. One quarter were referred on, and another quarter dropped out. Under 5% had unplanned exits from treatment.

What this means for the JSNA

The patterns of substance misuse in Bromley are not high.

The available data looks mainly at those receiving treatment for substance misuse related to opiates and crack. The emerging AACCE substances are more popular with those aged between 16 and 24 years and there is little information about the long term effects or of patterns of misuse.

Prevention work on substance misuse should be done early and in conjunction with other risk taking behaviours such as smoking and alcohol consumption.

14. Alcohol

Overall, data published in 2012 shows that Bromley is significantly better than the average for England for many alcohol-specific and alcohol-attributable indicators. These include binge drinking, alcohol-specific and alcohol-attributable hospital admission (in both males and females), and alcohol-specific mortality. However, indicators relating to alcohol and crime were significantly worse in Bromley, compared to the England average.

Rates for alcohol-attributable hospital admissions in both males and females have been increasing year on year between 2006/07 and 2010/11 in Bromley.

What this means for the JSNA

More preventive work is needed to reduce the levels of alcohol-related crime in Bromley.

An increased understanding of the impact of alcohol on domestic violence is needed.

The levels of alcohol-related hospital attendance and admissions to reduce pressure on secondary care services.

More work is needed to raise awareness of the risks of alcohol misuse in Bromley, particularly in young people.

1. Introduction

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

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

Much of the information in the JSNA is based on information from routine data sources and from health profiles which allow us to benchmark our position in Bromley against London and England. However, in the production of this year's JSNA the editorial team has invited input from stakeholders in the form of Partnership Groups with a special interest in specific groups of the population.

These have included:

- Mental Health Partnership Group
- Older People's Partnership Group
- Learning Disability Partnership Group
- Physical Disability & Sensory Impairment Partnership Group
- Children & Young People's Partnership Group
- Carers Partnership Group
- End of Life Care Strategy Group
- Drug Action Team.

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

2. The Population of Bromley: Demography

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

Key Points

- The latest (2012) estimate of the resident population of Bromley is 316,647, having risen by 21,072 since 2001.
- This is expected to increase to 326,217 by 2017 and 332,956 by 2022.
- The number of 0 to 4 year olds will increase in 2017 to 23,115 and then to 22,563 in 2031.
- The proportion of older people in Bromley (aged 65 and over) is expected to remain fairly stable at 15.6% of the population in 2012, 15.6% by 2017 and 15.5% by 2022.
- The pattern of population change in the different age groups is variable between wards, with some wards such as Bromley Town experiencing a large rise in the proportion of young people and Biggin Hill experiencing a large rise in the proportion of over 75s.
- The number of births has risen considerably in recent years (an increase of 29.1% in 2011 compared to 2002) and is likely to continue to do so.
- The latest (2012) GLA population projection estimates show that 13.3% of the population is made up of Black and minority ethnic (BME) groups; an increase from 8.4% in 2001.
- The BME group experiencing the greatest increase within Bromley's population is the Black African community, from 1.1% of the population in 2001 to 3.2% of the population in 2022.

What this means for the JSNA

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

Current Picture

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

Overall Description of Bromley

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

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

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

Figure 2.1 Nature sites

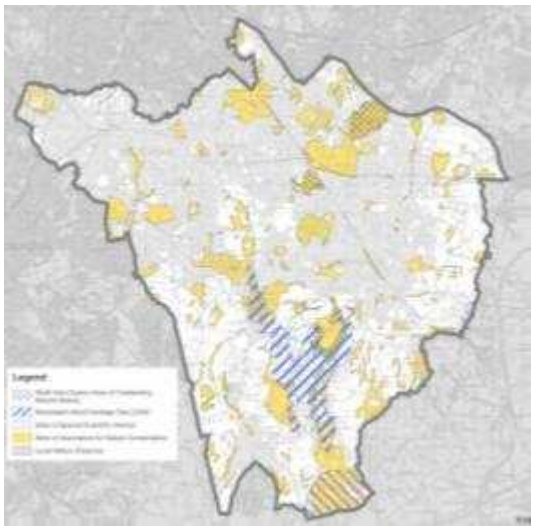
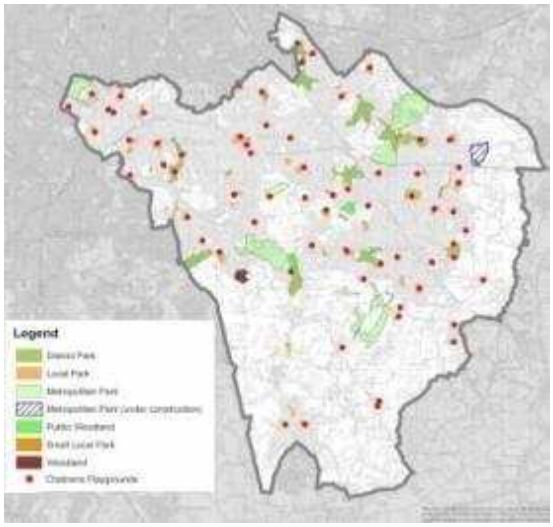


Figure 2.2 Public Parks & Open Spaces



Total Population

The latest (2012) estimate of the resident population is 316,647[1]. This compares with 339,167 registered with GPs in the borough (June 2012)[2]. The borough council is responsible for providing services to its residents. While local health commissioners are responsible for providing services to all of those who are registered with a Bromley GP regardless of where they live, they also have a responsibility for the health of the borough's residents at a population level. This chapter has used the Greater London Authority (GLA) resident population as its basis.

The population rose by 21,000 (7.1%) between 2001 and 2012. The main reasons for this increase are due to the increase of the number of births within the borough as well as migration of new entrants into the borough from Eastern Europe.

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

[1] Source: GLA 2011 Round SHLAA Population Projections SYA

[2] Primary Care Information System (PCIS), Open Exeter

Table 2.1 Age structure across the wards in Bromley, 2012

	Percentage aged 0 to 19 yrs	Percentage aged >75 yrs
Bickley	23.6%	10.6%
Biggin Hill	25.6%	6.2%
Bromley Common and Keston	24.7%	8.1%
Bromley Town	21.2%	6.2%
Chelsfield and Pratts Bottom	24.3%	8.6%
Chislehurst	22.5%	11.6%
Clock House	23.4%	5.8%
Copers Cope	13.9%	7.8%
Cray Valley East	23.3%	7.3%
Cray Valley West	29.1%	8.3%
Crystal Palace	25.4%	4.7%
Darwin	21.0%	7.6%
Farnborough and Crofton	20.5%	11.1%
Hayes and Coney Hall	23.3%	10.6%
Kelsey and Eden Park	23.8%	8.3%
Mottingham and Chislehurst North	27.5%	6.8%
Orpington	24.3%	9.8%
Penge and Cator	25.7%	4.1%
Petts Wood and Knoll	23.4%	10.2%
Plaistow and Sundridge	22.8%	7.0%
Shortlands	19.4%	10.5%
West Wickham	25.5%	11.4%

Source: GLA 2011 Round SHLAA Population Projections

The age distribution of people in Bromley is very similar to that for England as a whole, as illustrated in the population pyramids (Figures 2.3 and 2.4).

Figure 2.3

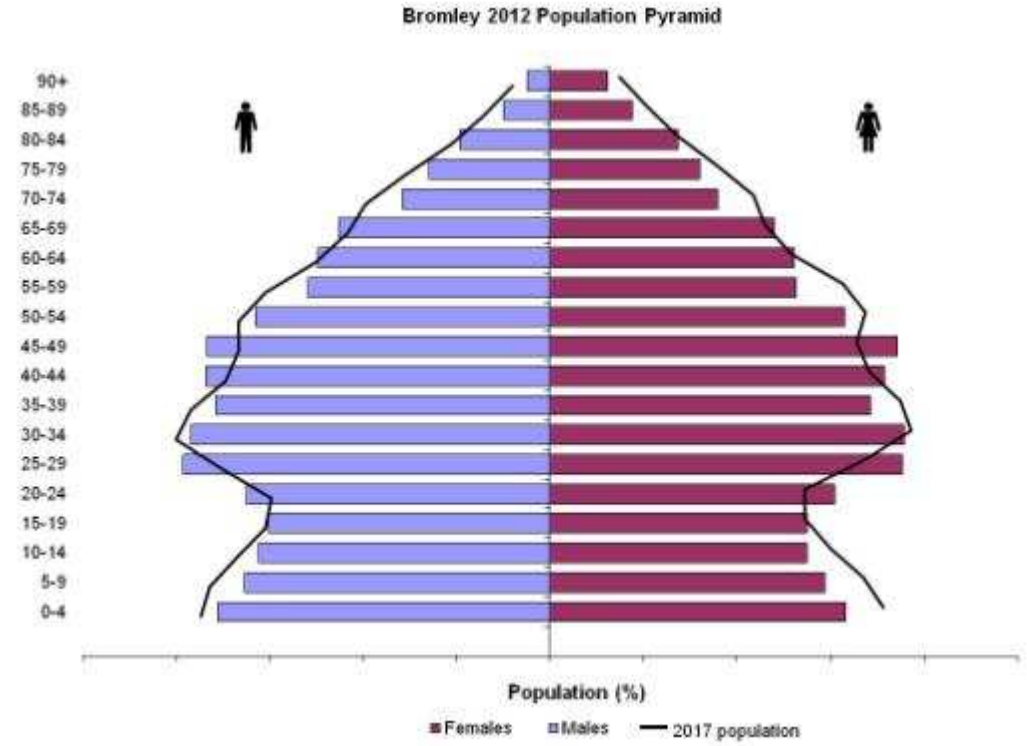
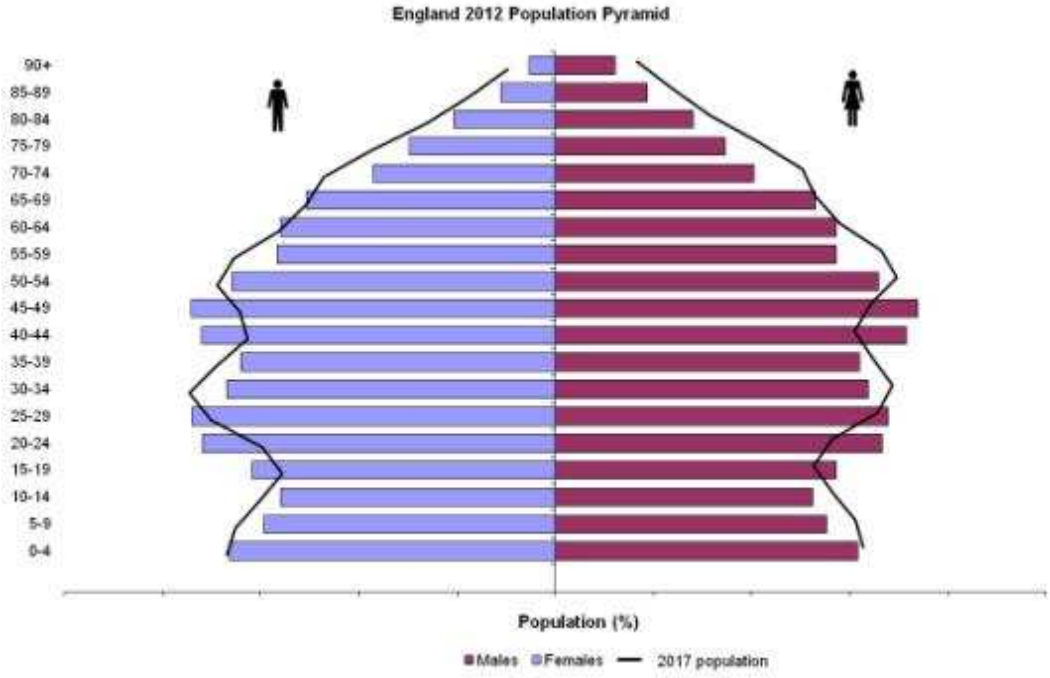


Figure 2.4



Source: ONS 2010-based Sub national Population Projections

Population Projections

The population of Bromley is just over 316,000, and is projected to rise by 1.8% over the next 5 years. (Table 2.2).

Table 2.2

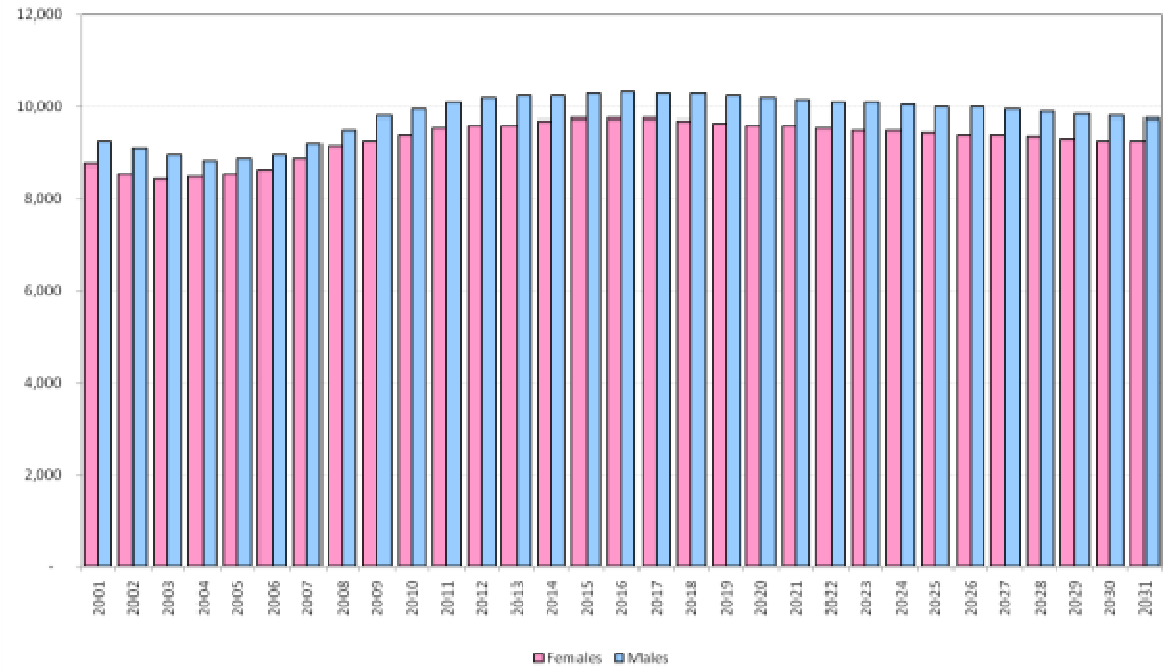
	2012	2017	2022
Total population	316,647	326,217	332,956
0 to 4y (%)	6.7%	7.1%	6.9%
5 to 10y (%)	7.3%	8.0%	8.4%
11 to 18y (%)	9.4%	9.3%	9.9%
Working Age (%)*	64.5%	63.0%	62.1%
Post Retirement (%)¥	15.6%	15.8%	15.0%
80y and over (%)	4.6%	4.5%	4.5%

Source: GLA 2011 Round SHLAA Population Projections

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

The number of 0 to 4 year olds has gradually been increasing since 2005 and will peak in 2016 (20,100) but will then begin to decrease again, dropping by 5.5% in 2031.

Figure 2.5 Population projections of Bromley children aged 0-4 years



Source: GLA 2011 Round SHLAA Population Projections

The pattern of population change in the different age groups is not consistent between wards, with some wards experiencing a large rise in the proportion of young people (Bromley Town is projected to have a 21.7% rise in this age group), and others experiencing a large rise in the population of over 75s (Biggin Hill is projected to have a 69.2% increase in over 75s).

In contrast, the largest reduction in the under 20 year age group will be seen in Chelsfield and Pratts Bottom (4.1%). For over 75s, the largest reduction will be in Mottingham and Chislehurst North (7.1%) (Figures 2.6 and 2.7).

Figure 2.6

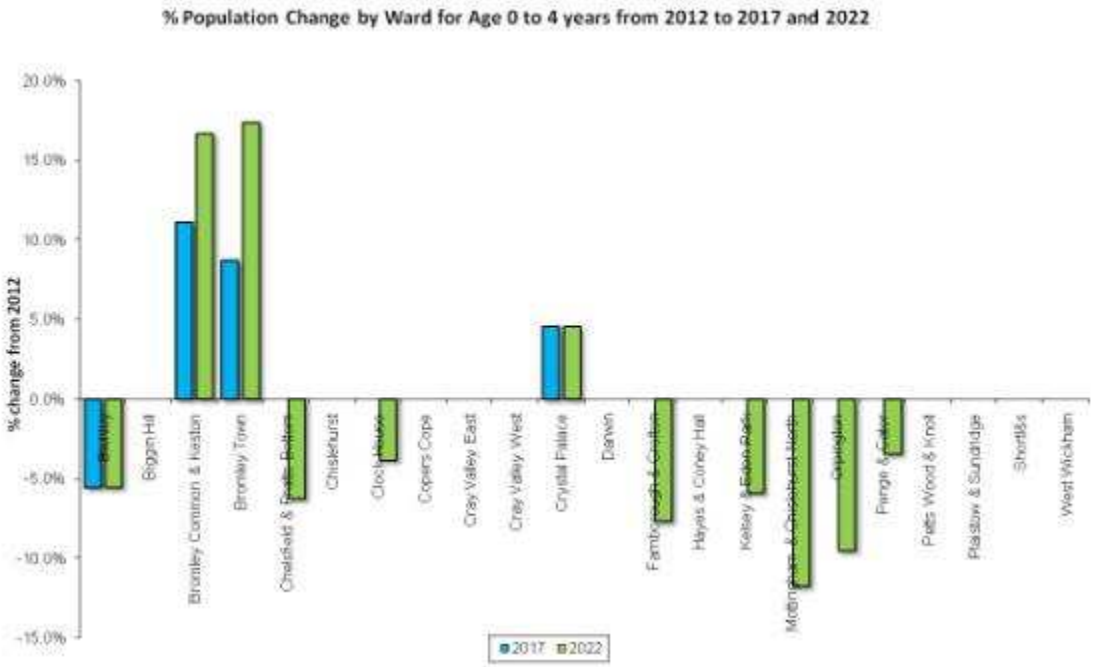
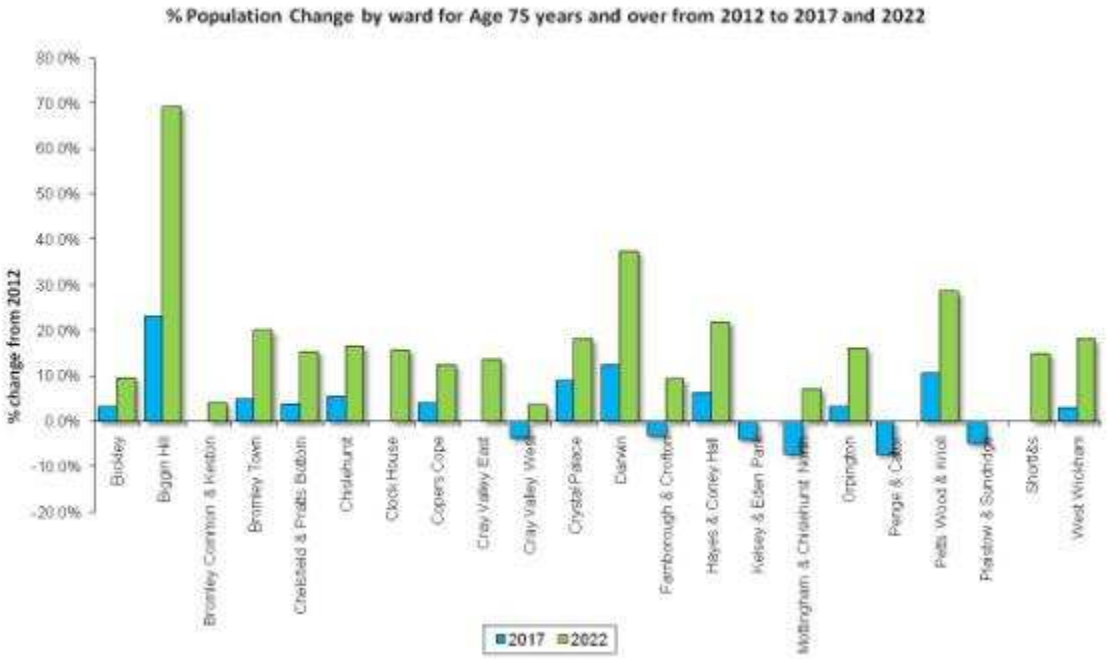


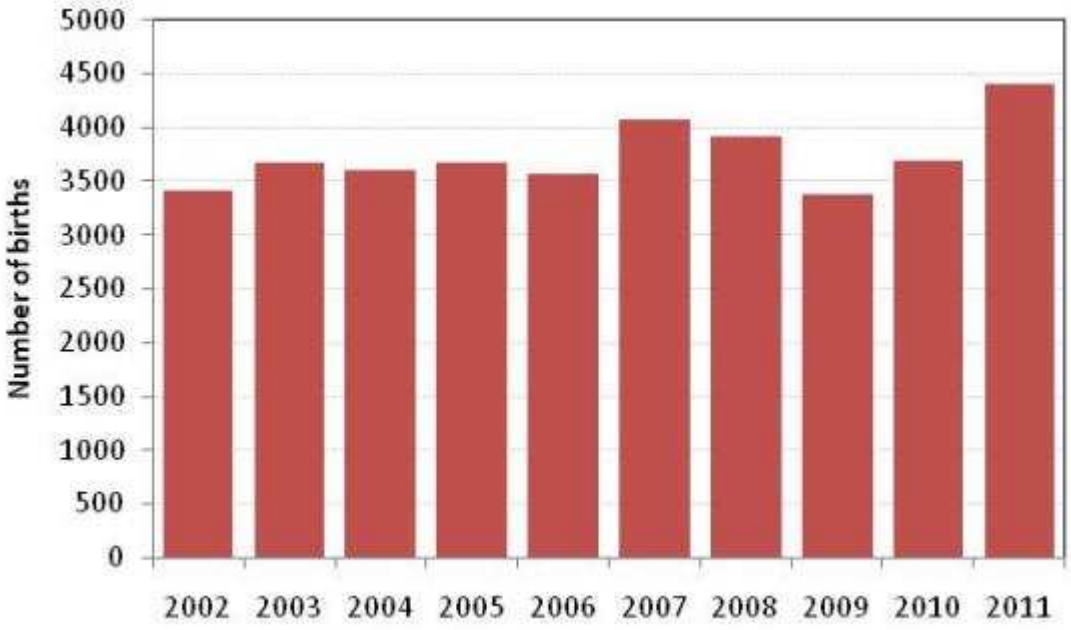
Figure 2.7



Source: GLA 2010 Round SHLAA Population Projections

The number of live births in Bromley has been increasing over the last few years. In 2002 there were 3,400 births in Bromley, which rose to nearly 4,500 in 2011.

Figure 2.8 Number of live births in Bromley



Source: ONS Vital Statistics

What this means for the JSNA

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

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

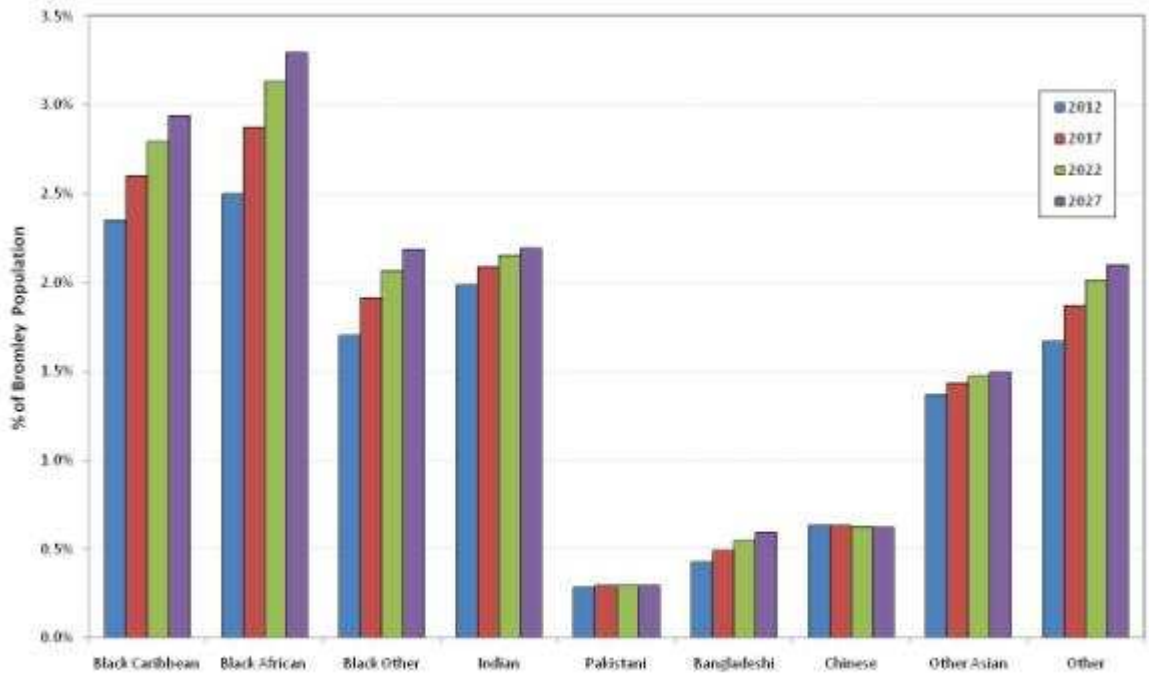
Future situation: The rise in the number of 0 to 4 year olds in the next few years will have an impact on the provision of primary and secondary school places in the near future, and will also affect the usage of health services.

Ethnic groups

There is a discrepancy between the Census results and GLA population projections for the proportion of the population represented by ethnic minority groups. The 2011 Census recorded 22.6% of the Bromley population as ethnic minorities. In contrast, the GLA 2011 Round Ethnic Group Projections estimate that, in 2012, the ethnic minority population of Bromley is 13.3%, and this is projected to rise to 15.9% by 2022. The Black African group is seeing the greatest proportional rise, from 1.1% of the population in 2001, to 3.2% of the population in 2022.

The GLA estimates may be lower because they are still based on 2001 Census data.

Figure 2.9 Percentage of the Population by Ethnic Group



Source: GLA 2011 Ethnic Group Projections Round SHLAA Borough

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

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

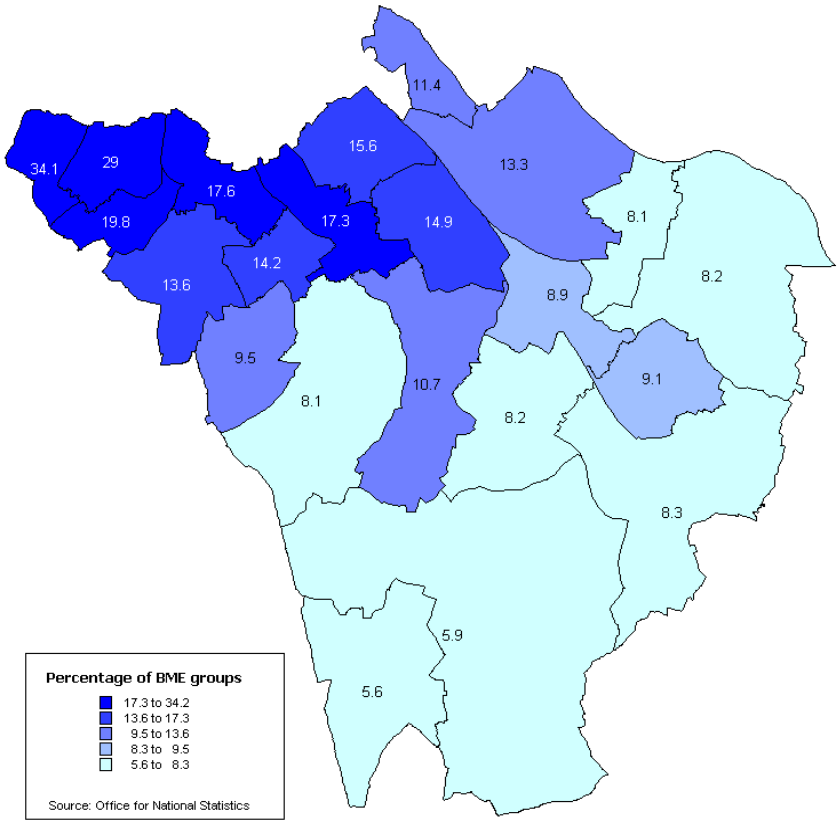
Among ethnic minority groups, Black Africans comprise the largest proportion of those seen for HIV care in all regions. Along with the 'Other' ethnic group, Black Africans also have the highest rates of tuberculosis.

Table 2.3

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

Data from the 2001 census shows that the North-West of Bromley has the highest proportion of ethnic minority population (Figure 2.10). We do not have projections for changes in population by ethnicity at ward level.

Figure 2.10 Percentages of BME Groups by Ward



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

There is a large settled, housed population within the borough, estimated to be in the region of 1,000 families. If accurate these figures would represent the largest settled Gypsy Traveller population in the UK. The borough also contains two authorised sites, Star Lane with 22 pitches and Old Maidstone Road with 12 pitches, both of which are owned and managed by the Local Authority. There are also unauthorised sites at Walden's Farm, Biggin Hill and Bromley Common. The Gypsy Traveller population is considerable in size and is estimated to represent the largest ethnic minority within the borough.

There is evidence that Gypsies and Travellers are the most excluded ethnic minority in this country[3].

What this means for the JSNA

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

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

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

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

The 2011 Census

In 2011 the country experienced the decennial collection of the census. This large survey is conducted across the whole country and provides information on housing and population that is then used to develop policies and to plan public services such as health and education.

The 2011 census was the twenty-first full national census of the population, which marked 210 years.

There are some differences between the 2001 and 2011 datasets which stem from changes to some of the questions that were asked on the census questionnaires.

2011 Census Key Findings for Bromley

- The usually resident population of Bromley on Census Day 2011 (27 March) was 309,392. This compares to 295,532 at Census Day 2001, an increase of 13,860 or 4.5 per cent over the ten year period.

- In comparison the population of London increased by 1 million (14 per cent) between 2001 and 2011 hence the 2011 resident population on Census Day was 8.17 million.

- The median age of Bromley increased by 2 years from 38 years to 40 years. The population also saw a larger increase in the number of females which rose by over 7000 over the ten year period.

- The Bromley Census population estimate is 8,500 lower than the ONS 2010-based sub-national population projection for 2011.

		2011		2001	
	Census Item	**Count**	**%**	**Count**	**%**
Population	Usual Residents	309,392	-	295,532	-
	Population density (persons per hectare)	20.60	-	19.68	-
	Males	148,588	48.0%	141,785	47.98%
	Females	160,804	52.0%	153,747	52.02%
	Mean age	39.90	-	39.35	-
	Median age	40	-	38	-
Households	Lone parent households	9,631	7.4%	7,568	6.01%
	Lone pensioner households	16,856	12.9%	18,760	14.90%

- Average household size in Bromley increased from 2.33 persons in 2001 to 2.4 persons in 2011. Average household size increased in every London borough bar Havering.

- There were two additional ethnic groups added in the ethnicity category of the 2011 census. These were the groups 'White: Gypsy / Irish Traveller' and 'Other: Arab'.

- Bromley's Black African population had increased by 6,446 in 2011.

		2011		2001	
	Census Item	**Count**	**%**	**Count**	**%**
Ethnicity	White	239,478	77.4%	255,618	86.49%
	White Irish	4,463	1.4%	4,652	1.57%
	White (Gypsy / Irish Travellers)	580	0.2%	not collected	
	White other	16,349	5.3%	10,396	3.52%
	Mixed: White & Black Caribbean	3,897	1.3%	1,887	0.64%
	Mixed: White & Black African	1,335	0.4%	577	0.20%
	Mixed: White & Asian	3,016	1.0%	1,716	0.58%
	Mixed: Other	2,649	0.9%	1,336	0.45%
	Asian: Indian	6,215	2.0%	4,458	1.51%
	Asian: Pakistani	1,014	0.3%	691	0.23%
	Asian: Bangladeshi	1,265	0.4%	868	0.29%
	Asian: Chinese	2,768	0.9%	1,799	0.61%
	Asian: Other	4,805	1.6%	1,533	0.52%
	Black: African	9,819	3.2%	3,373	1.14%
	Black: Caribbean	6,609	2.1%	4,637	1.57%
	Black: Other Black	2,258	0.7%	604	0.20%
	Other: Arab	870	0.3%	not collected	
	Other	2,002	0.6%	1,387	0.47%

- The 'general health' question was recorded differently in the 2011 census. The 2001 census asked if a person's general health was 'good', 'fairly good' or 'not good'. The question that was asked in the 2011 census asked if a person's general health was 'very good', 'good', 'fair', 'bad', or 'very bad.

		2011		2001	
	Census Item	**Count**	**%**	**Count**	**%**
Health & Care	Good Health& Very Good Health*	260,572	34.1%	214,103	72.45%
	Fair Health*	36,098	11.7%	60,846	20.59%
	Unpaid Care (50+ hours per week)	6,299	20.3%	4,865	17.14%

*'Good health' and 'very good health' from the 2011 census have been compared with 'good health' from the 2001 census 'Fair health' from the 2011 census has been compared with 'fairly good health' from the 2001 census.

- The National Statistics Socio-economic Classifications (NS-SeC) are used as a standard grouping of occupations of the population across the country. Bromley had the greatest increase in the number of 'higher professional occupations', which rose by 4.3 per cent from the 2001 percentage.
- There has been a marked increase in the proportion of never worked and long term unemployed, increasing from 2.58% in 2001 to 4.3% in 2011.

		2011		2001	
	Census Item	**Count**	**%**	**Count**	**%**
NS-SeC	1. Higher managerial, administrative and professional occupations	32,187	14.5%	25,331	11.93%
	1.1 Large employers & higher managerial & administrative occupations	7,066	3.2%	10,476	4.93%
	1.2 Higher professional occupations	25,121	11.3%	14,855	6.99%
	2. Lower managerial, administrative and professional occupations	58,487	26.3%	52,073	24.52%
	3. Intermediate occupations	36,633	16.5%	26,493	12.48%
	4. Small employers and own account workers	23,195	10.4%	16,516	7.78%
	5. Lower supervisory and technical occupations	11,273	5.1%	10318	4.86%
	6. Semi-routine occupations	22,592	10.2%	17930	8.44%
	7. Routine occupations	13,091	5.9%	9557	4.50%
	8. Never worked and long-term unemployed	9,481	4.3%	5488	2.58%

- There was an additional option added in the tenure question of the 2011 census. This additional item recorded the number of people 'living rent free'.

- There were 4,651 less people in Bromley who owned a house with a mortgage or a loan in 2011 compared to 2001. There was a 4.6 per cent increase of the number of people who rented privately (either from a private landlord or a letting agency) compared to the proportion recorded in 2001.

		2011		2001	
	Census Item	**Count**	**%**	**Count**	**%**
Tenure	Owned: Owned outright	43649	33.4%	40949	32.53%
	Owned: Owned with a mortgage or loan	49136	37.5%	53787	42.73%
	Shared ownership (part owned and part rented)	1036	0.8%	1070	0.85%
	Social rented: Rented from council (Local Authority)	1987	1.5%	1785	1.42%
	Social rented: Other	16438	12.6%	16030	12.74%
	Private rented: Private landlord or letting agency	16229	12.4%	9815	7.80%
	Private rented: Other	1164	0.9%	2430	1.93%
	Living rent free	1223	0.9%	not collected	

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

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

This section will report on:

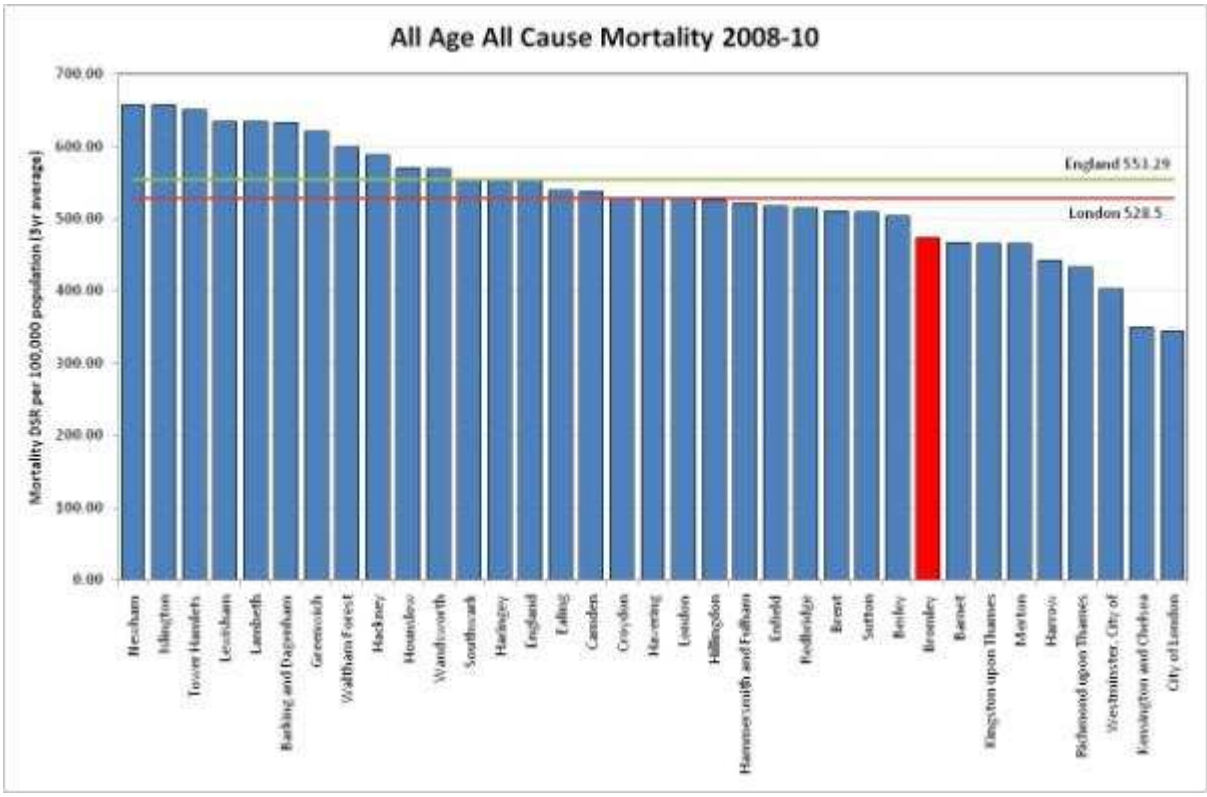
- All Cause Mortality
- Life Expectancy
- Infant Mortality
- Health Inequalities
- Key Causes of Mortality
- Major Health Issues
- Lifestyle Risk Factors for Disease

Mortality & Life Expectancy

All Cause Mortality

The all cause mortality rate (SMR) for Bromley is lower than both the London and England average rates. Bromley has the ninth lowest all cause mortality rate in London.

Figure 3.1

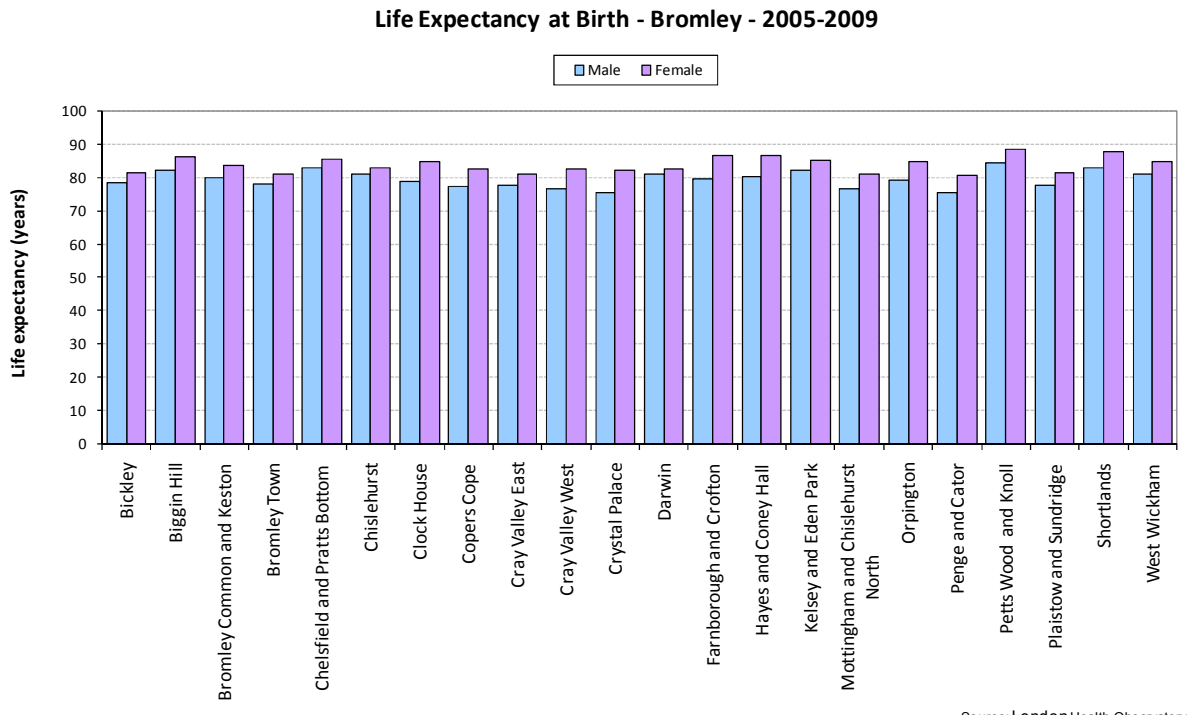


Source: Public Health Mortality Files

Life Expectancy

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, and the latest figures (2007-09) report a life expectancy of 79.9 years for men and 83.8 years for women. Whilst these averages rank 74th and 55th respectively in the national order, there are areas of Bromley with lower life expectancy. The gap between wards with the highest and lowest life expectancy for the years 2005-09 were 8.7 years for men and 7.9 years for women.

Figure 3.2

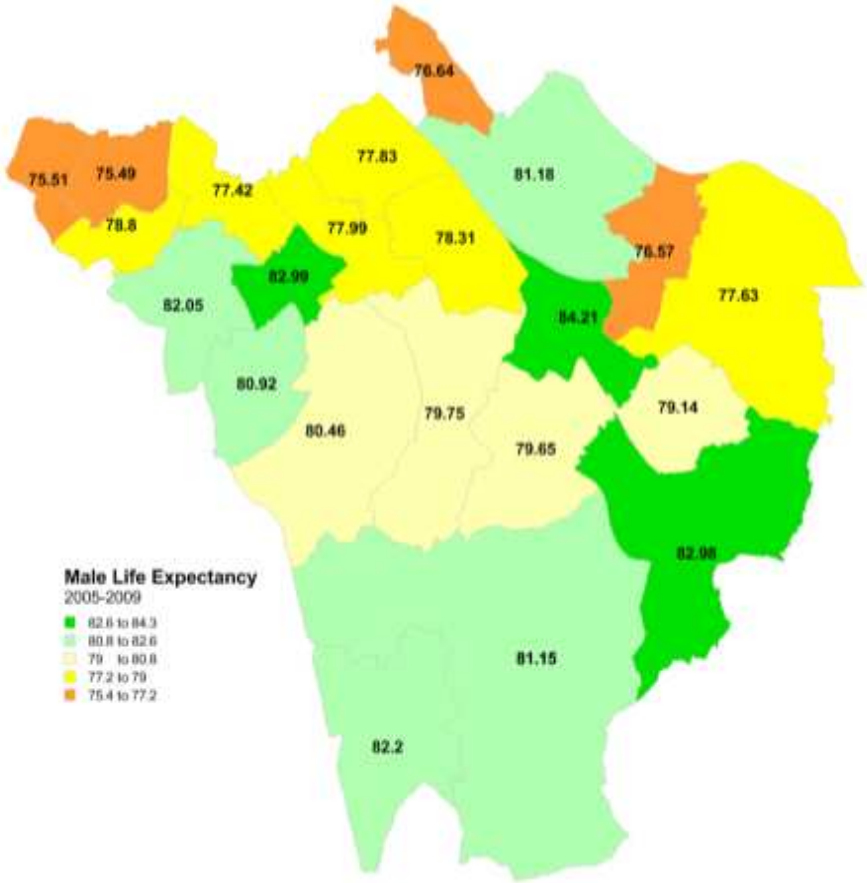


Source: London Health Observatory

Life expectancy is lowest for men in Penge & Cator (75.5y) and in Crystal Palace (75.5y), and for women in Penge & Cator (80.6y) and in Bromley Town (81.1y).

The 2012 Health Profile for Bromley reports that life expectancy is 7.8 years lower for men and 6.2 years lower for women in the most deprived areas of Bromley than in the least deprived areas (based on the Slope Index of Inequality).

Lower levels of life expectancy represent higher numbers of deaths at younger ages. Even with the high life expectancy across Bromley, a number of people do not survive into retirement.



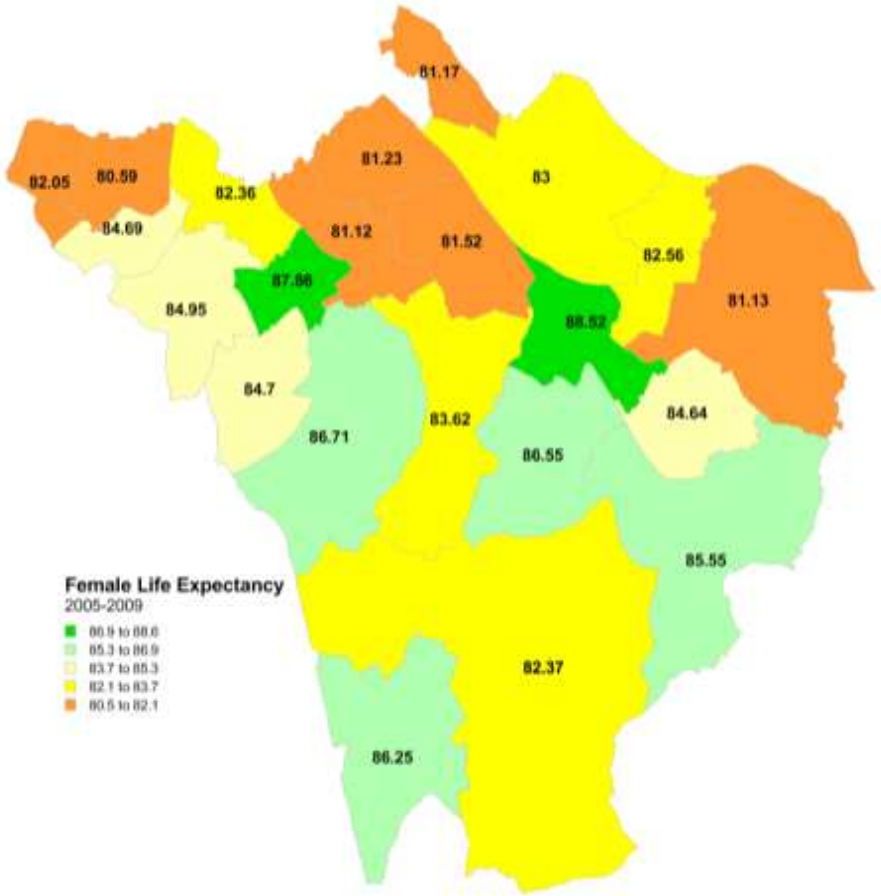


Figure 3.3: Life Expectancy at Birth in Bromley

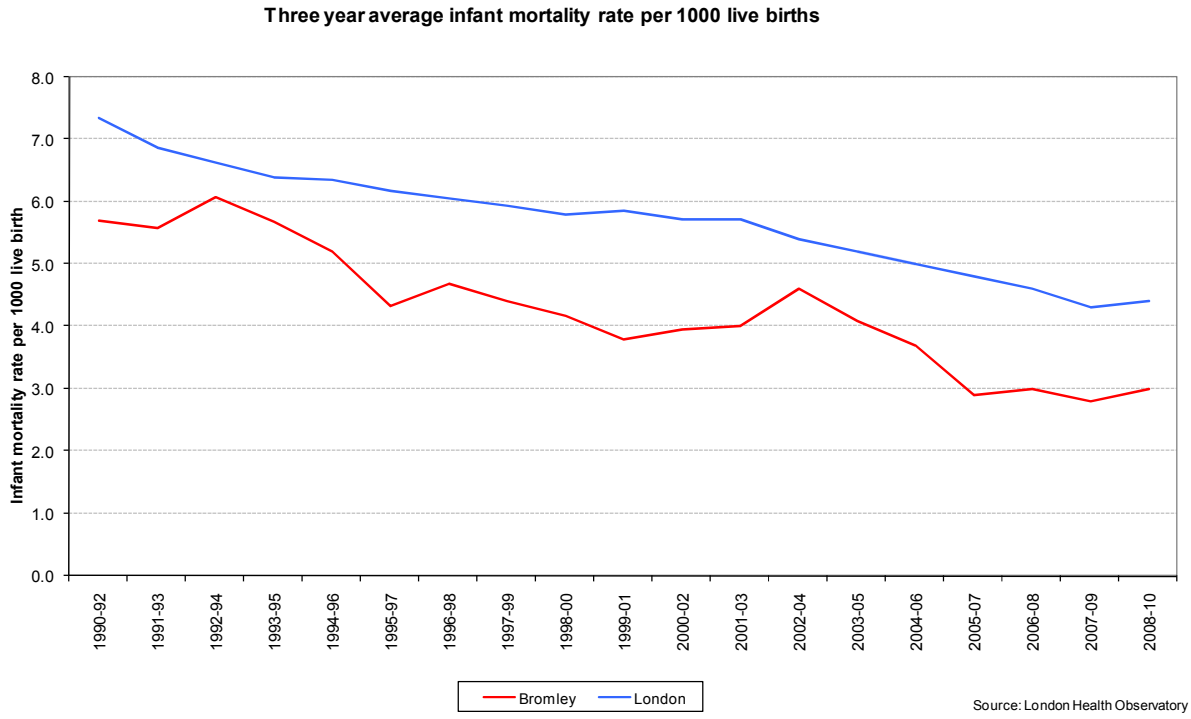
Infant Mortality

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

The infant mortality rate in Bromley (3.0 per 1000 live births) is lower than in England as a whole (4.4 per 1000 live births), and has been fairly steady over the last 4 years. The rate is now almost half the 1990-92 rate of 5.7 per 1000 live births.

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

Figure 3.4



Health Inequalities

Health inequalities are differences in the health status of groups and individuals that are both avoidable and unjust.
Health inequalities arise from social inequalities, themselves the result of unequal distribution of factors influencing health (e.g. housing, environment, social background, income, employment and education).
Michael Marmot's *Strategic Review of Health Inequalities in England post-2010* highlighted an unambiguous social gradient in health i.e. a direct correlation between socioeconomic status and health outcomes.

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

For the period 2006 to 2010, the SII for men in Bromley was 7.8, and for women, 6.2. This can be interpreted as a 7.8 year difference in life expectancy at birth between the most and least deprived males within Bromley, and 6.2 years for females.

The level of inequality is below the England average for men, but above the England average for women (Figures 3.5 and 3.6).

Figure 3.5

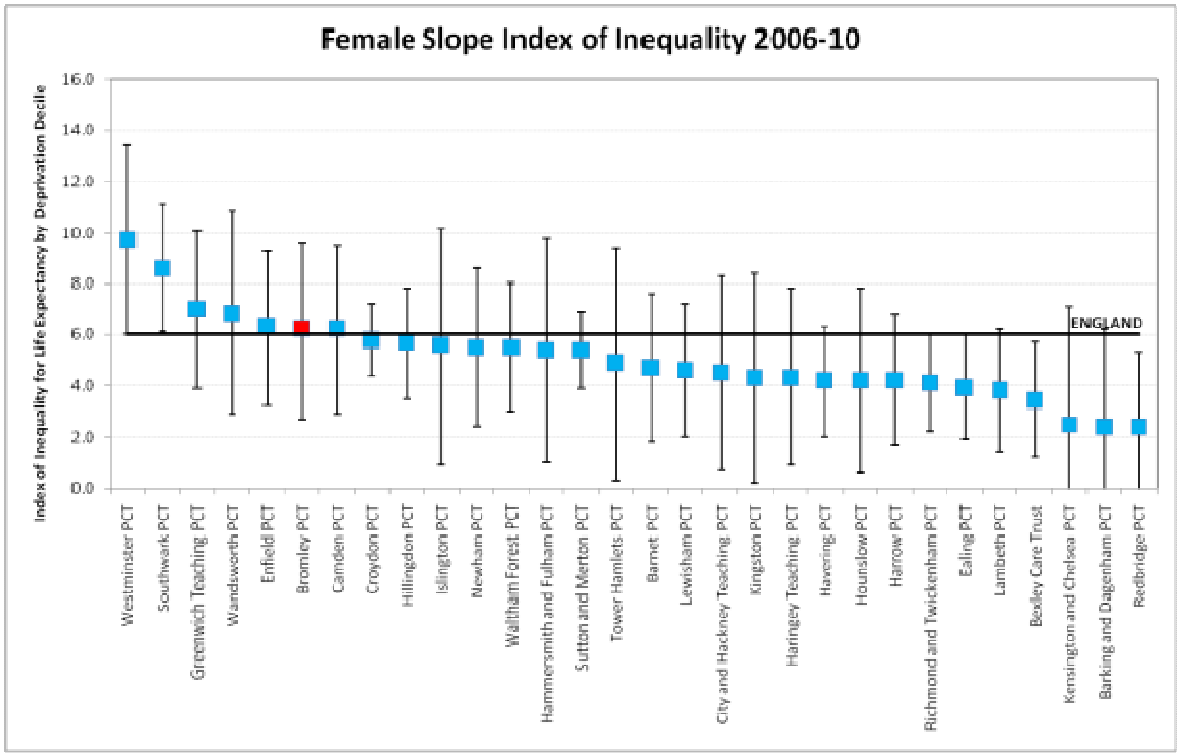


Figure 3.6

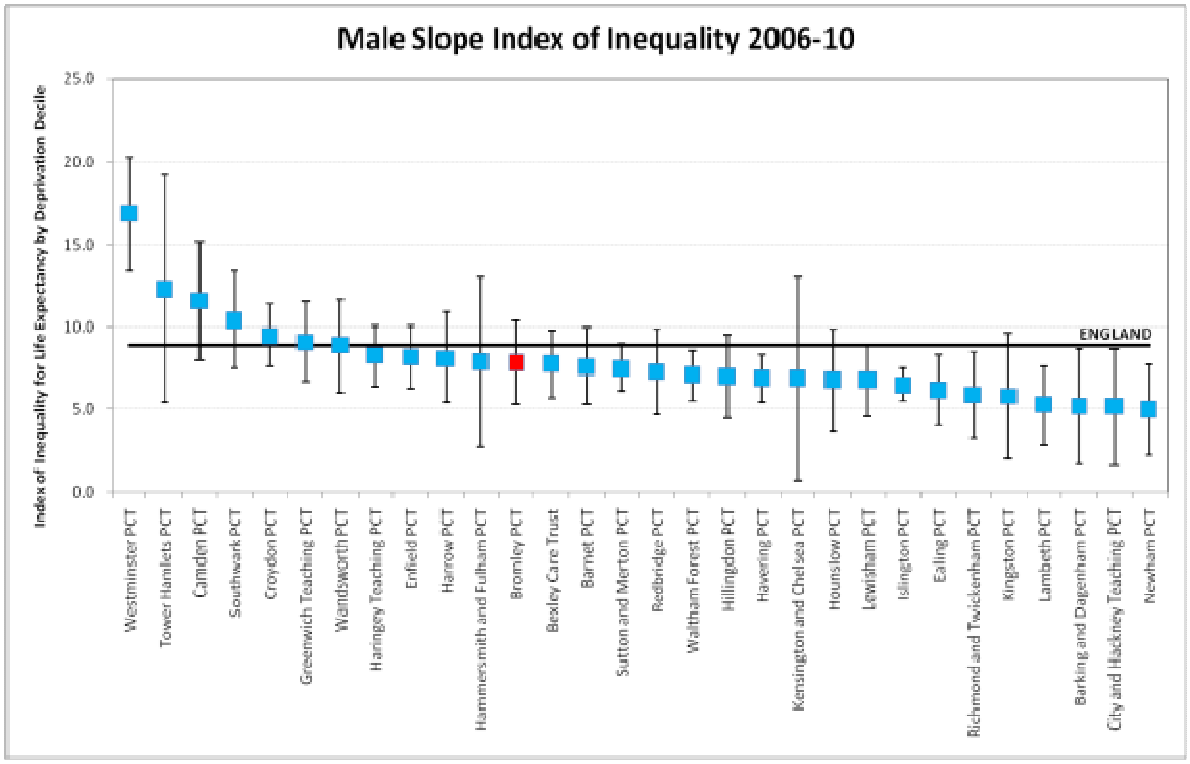
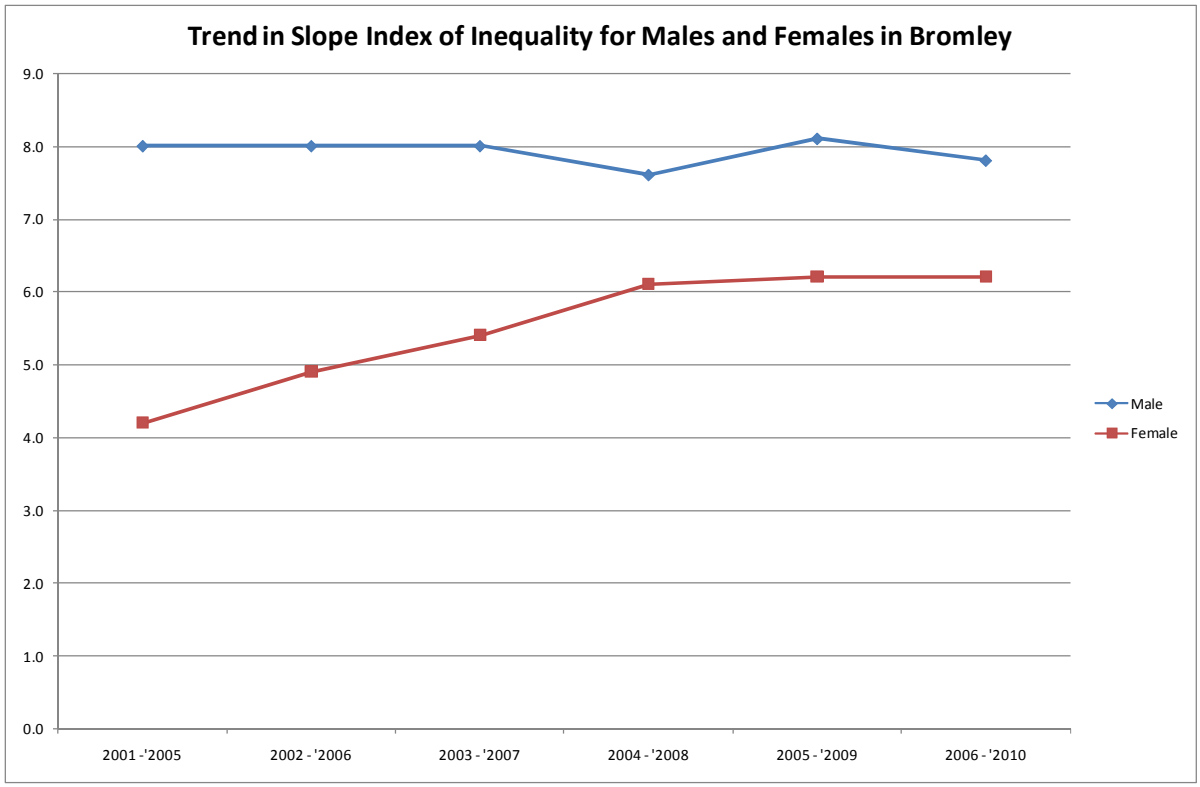


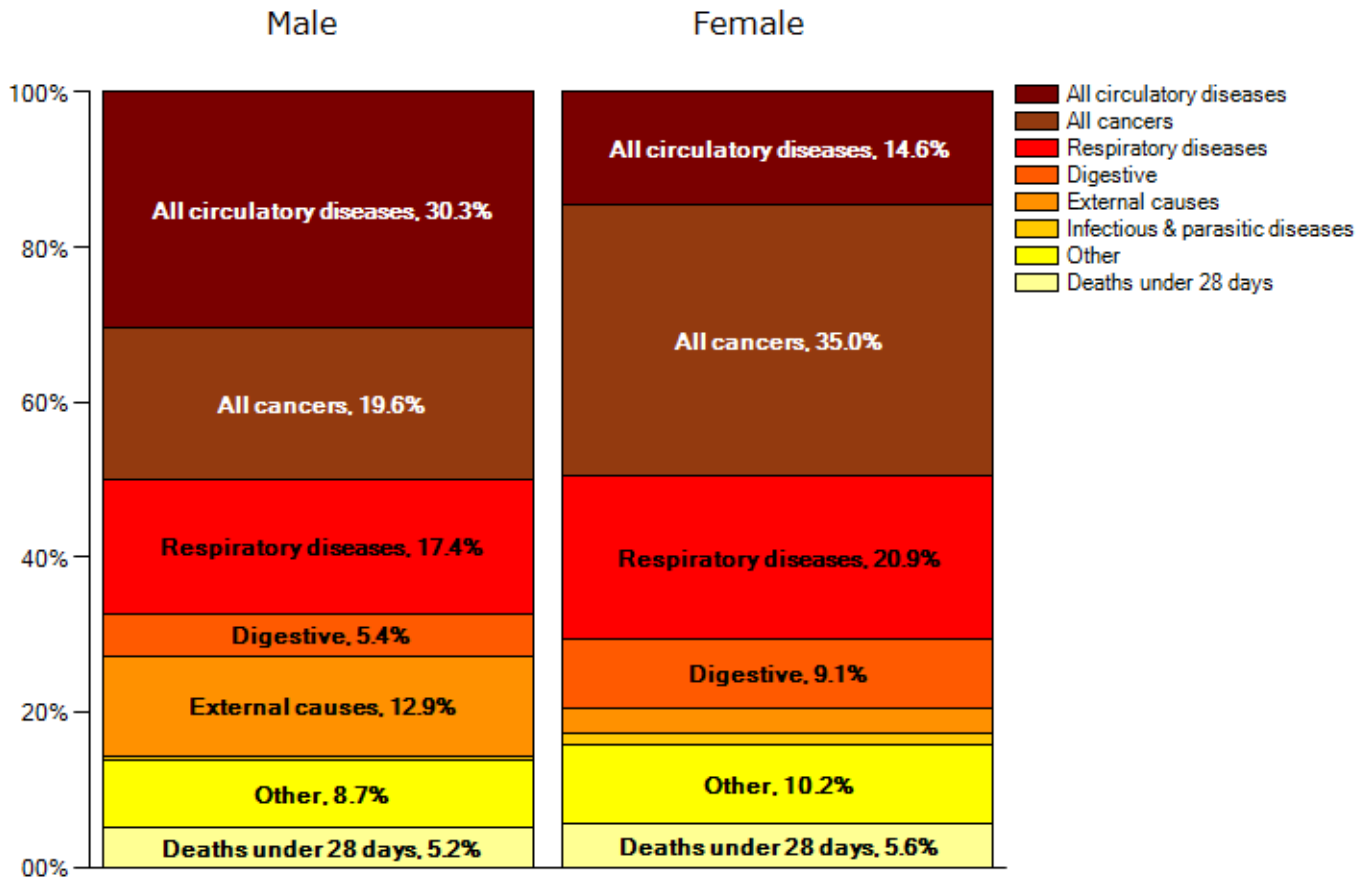
Figure 3.7



The Public Health Observatories' Health Inequalities Intervention Tool can be used to ascertain the relative contribution to the life expectancy gap of specific disease groups. For Bromley, the inequalities are chiefly related to circulatory disease, cancer and respiratory disease. The main contribution being from circulatory disease (30.3%) for men and from cancers (35.0%) for women (*Figure 3.8*).

Figure 3.8

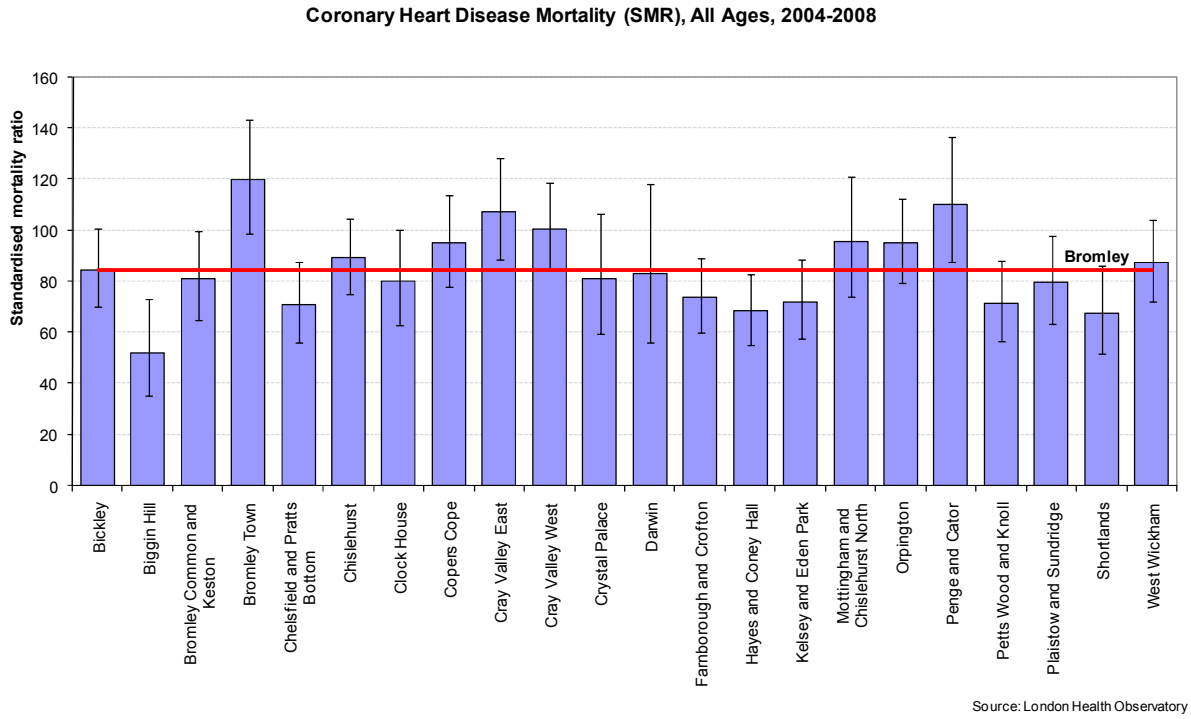
Breakdown of life expectancy gap between the Most Deprived Quintile (MDQ) of Bromley LB and the local authority average by cause of death



Source: LHO

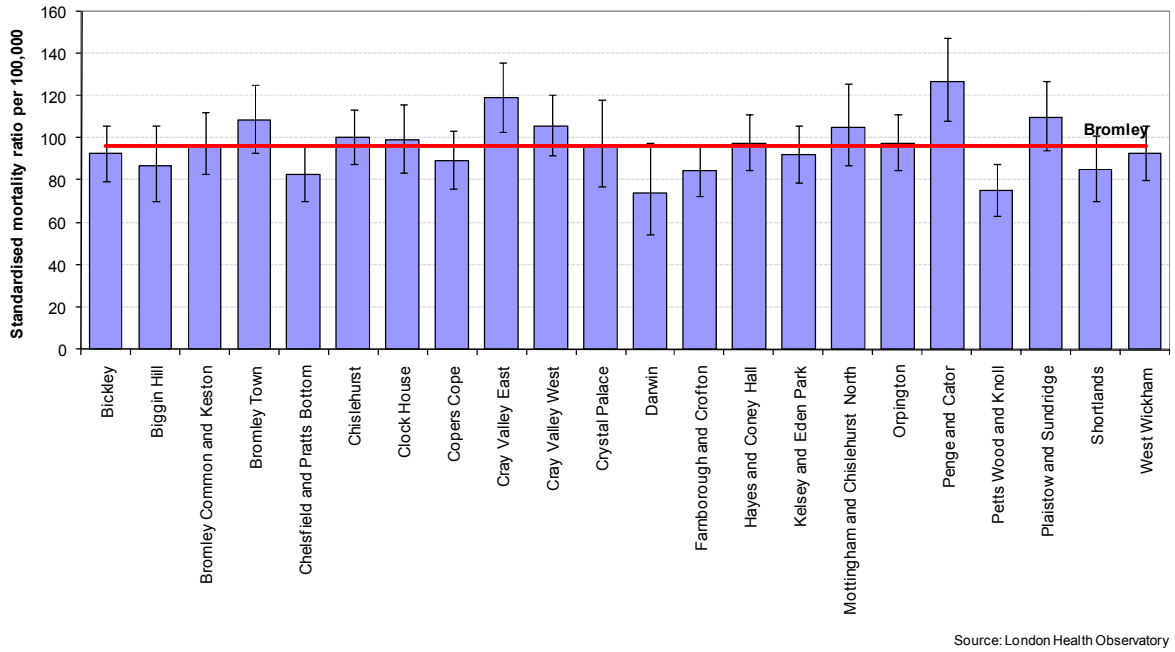
Looking at the relative mortality rates for heart disease and cancer between Bromley wards, it is clear that there are wards with significantly higher than average mortality rates (Figures 3.9 and 3.10). Cray Valley East and Penge & Cator wards have significantly higher than average mortality rates for both heart disease and cancer, and Bromley Town for heart disease.

Figure 3.9



Source: London Health Observatory

Figure 3.10



Source: London Health Observatory

What this means for the JSNA?

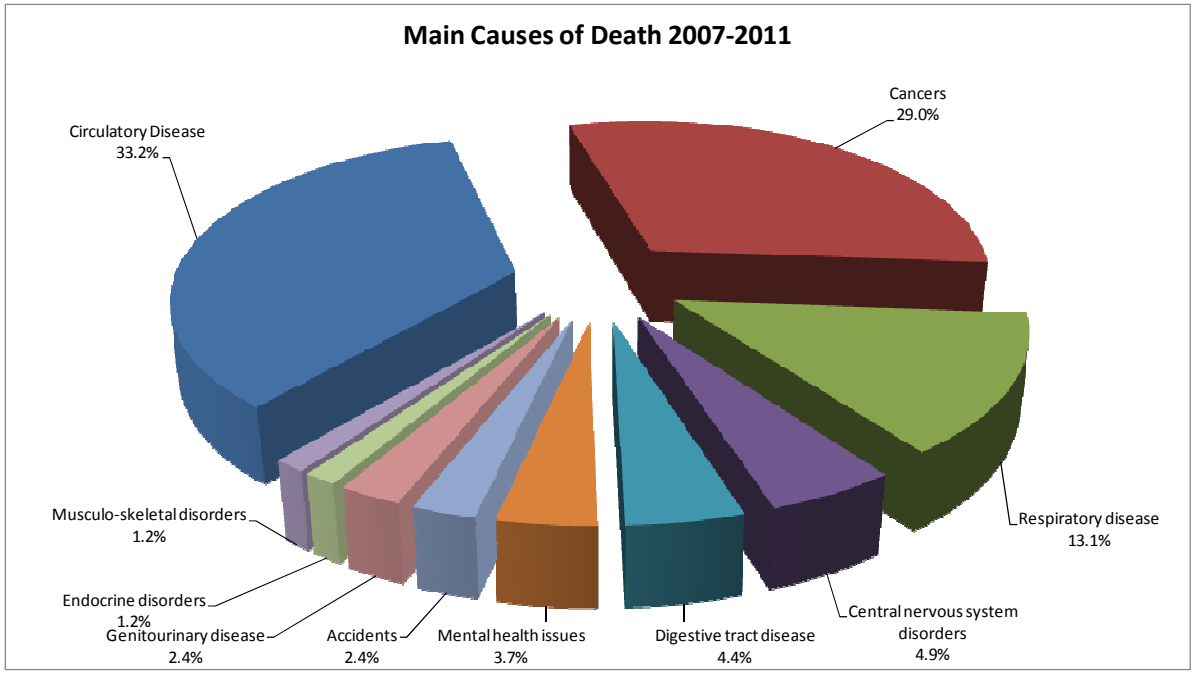
There is a need for continued action to address health inequalities with the disparity in life expectancy between the most and least deprived areas of the Borough.

Key Causes of Mortality & Major Health Issues

The key causes of death in Bromley remain:

- Circulatory disease
- Cancer
- Respiratory disease

Figure 3.11



Source: Public Health Mortality Files

Circulatory Disease

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

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

In addition the difference in CVD mortality rates between the most and least deprived areas in Bromley (the absolute gap) has reduced by 37.3% between 2001 and 2009. However, the relative gap in CVD mortality rates between the most and least deprived areas in Bromley has risen from 120.8% to 156.7%.

<u>Coronary Heart Disease (CHD)</u>

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

Figure 3.12

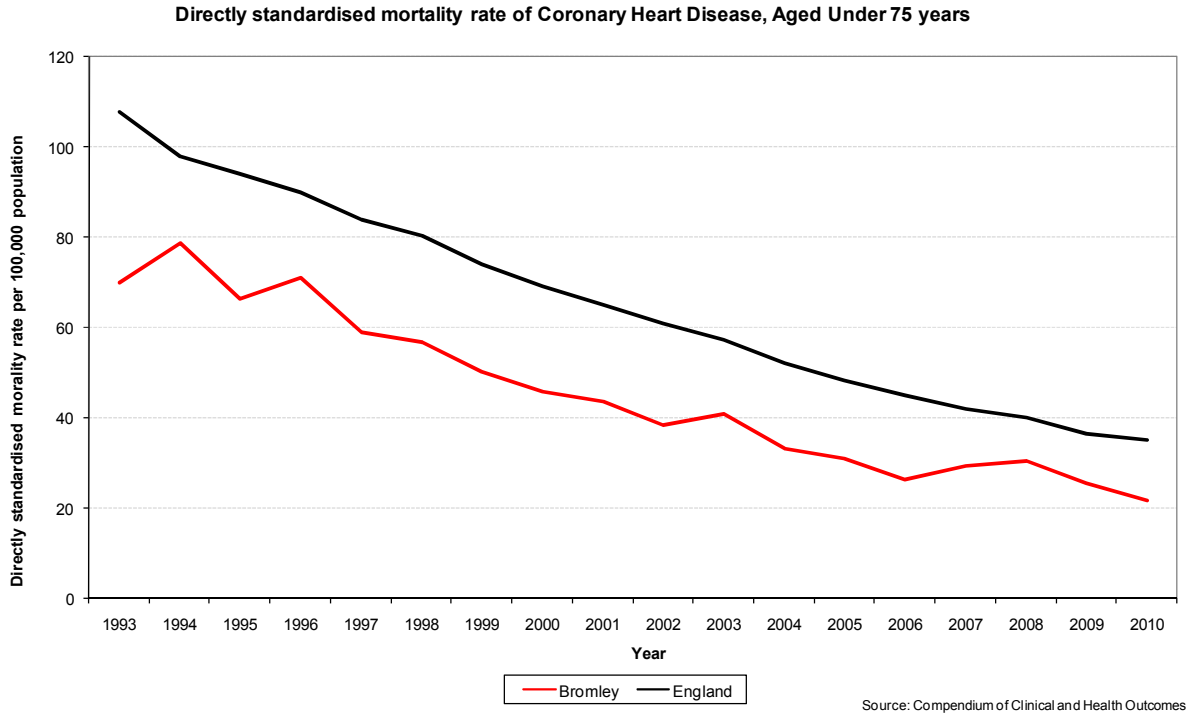


Table 3.1 Prevalence of Coronary Heart Disease

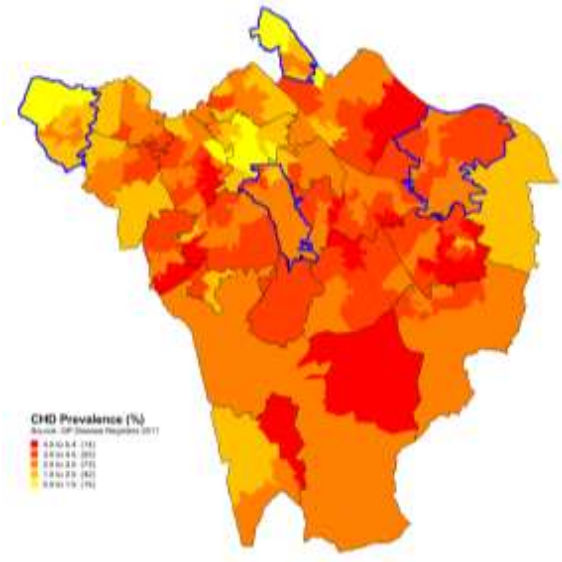
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
CHD Register Size	9798	9717	9790	9859	9984	10253	10177
CHD Prevalence	2.98%	3.76%	3.58%	3.75%	3.79%	3.79%	3.75%

Source: QMAS

In 2009-10 the emergency admission rate for CHD was 160.1 per 100,000 (685 admissions). This is significantly lower than England (205.3 per 100,000) and significantly lower than London (216.1 per 100,000). The emergency admission rate for CHD in Bromley reduced by 29.6% between 2003-4 and 2009-10 (as compared with a fall of 24.2% for England and 21,5% for London).

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

The emergency admission rates for CHD are 1.5 times greater for people who live in the most deprived areas of Bromley as compared with those living in the least deprived areas.



The wards with the highest rates of reported coronary heart disease are:

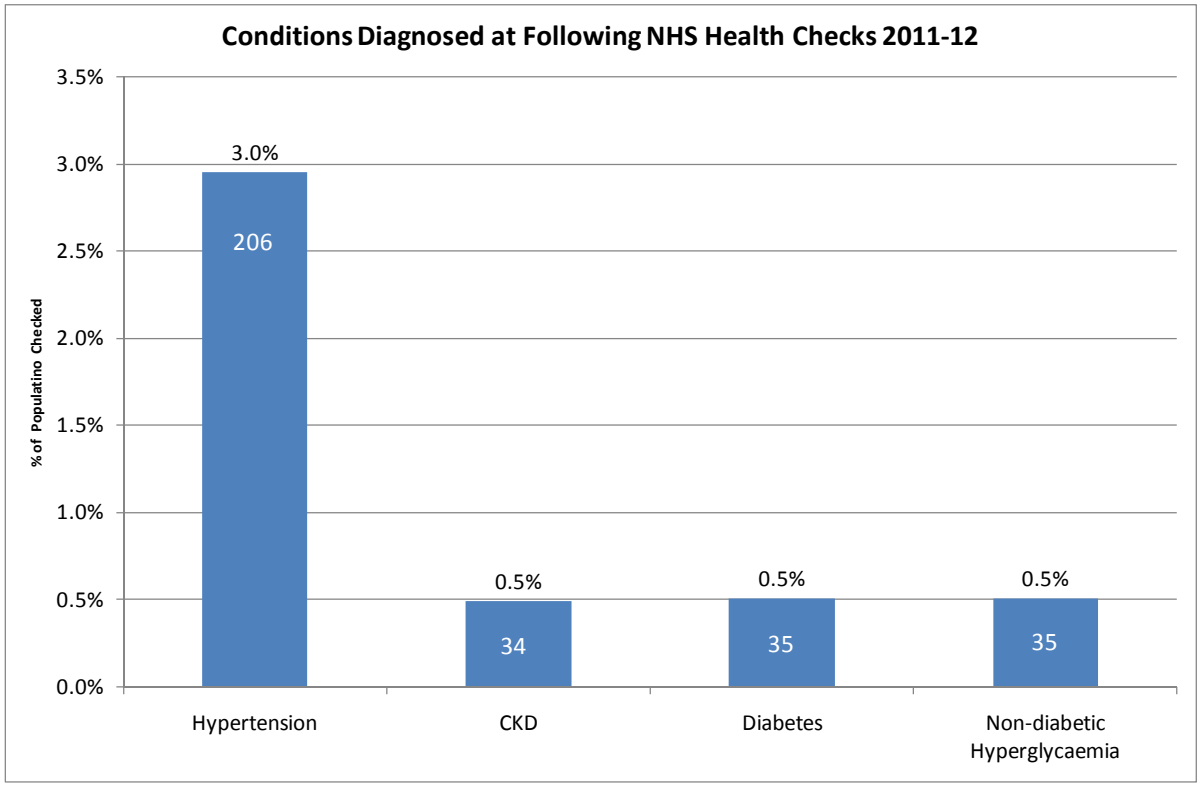
- Farnborough & Crofton
- Cray Valley West
- Shortlands.

The NHS Health Checks Programme aims to prevent heart disease and stroke. Individuals aged between 40 and 74 years without established cardiovascular disease are invited to attend for a health check to assess and manage their risk of developing cardiovascular disease. This programme runs over a five year period, so 20% of the eligible population should be invited each year.

In 2011-12, of the 95,871 eligible individuals, 21,279 (22.2%) were invited for a check and 7595 (7.9%) had completed checks. Of those attending for checks, 40% were male.

Cardiovascular Disease (CVD) risk for the next 10 years was found to be high (greater than 20%) in 557 (8%) individuals. The NHS Health Check identifies individuals eligible for further screening for diabetes, hypertension and chronic kidney disease (CKD). Not all of those eligible for such further screening have received it, and this is an area for further work with primary care, nevertheless, a number of individuals were diagnosed with conditions for which they can now receive treatment to try to reduce cardiovascular risk and prevent disease progression.

Figure 3.13


Conditions Diagnosed at Following NHS Health Checks 2011-12
% of Populatino Checked
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
3.0%
206
0.5%
34
0.5%
35
0.5%
35
Hypertension
CKD
Diabetes
Non-diabetic Hyperglycaemia

Stroke

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

Figure 3.14

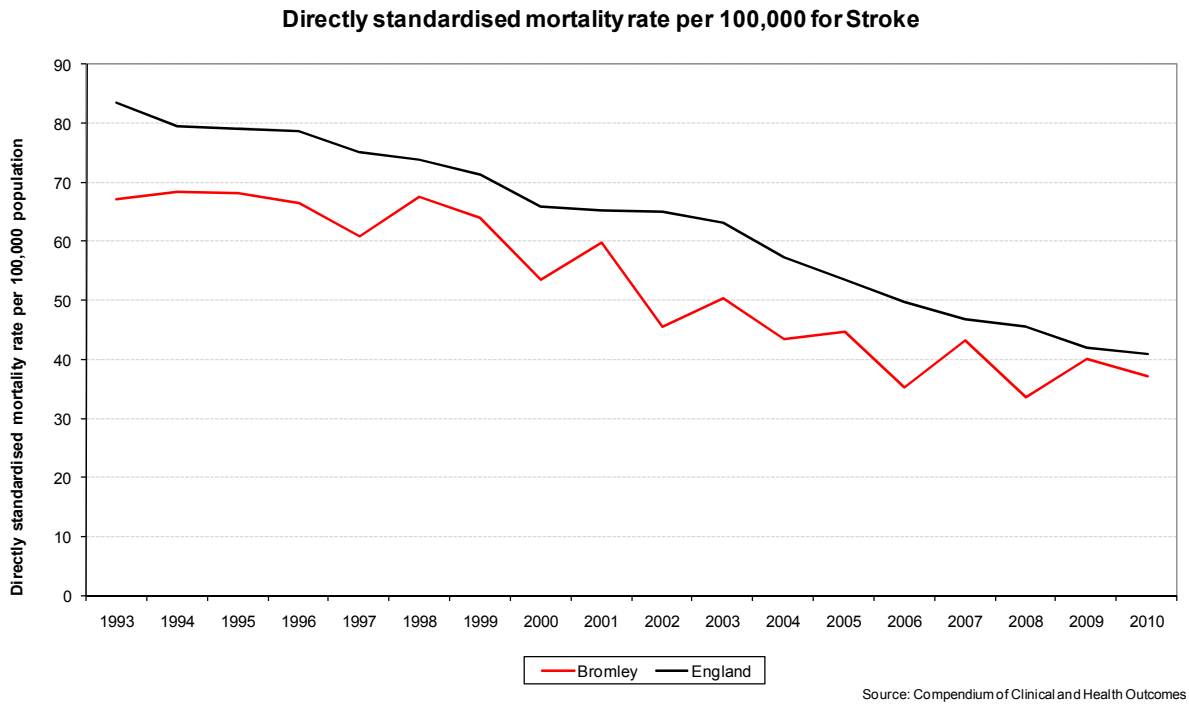


Table 3.2 Prevalence of Stroke

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

Source: QMAS

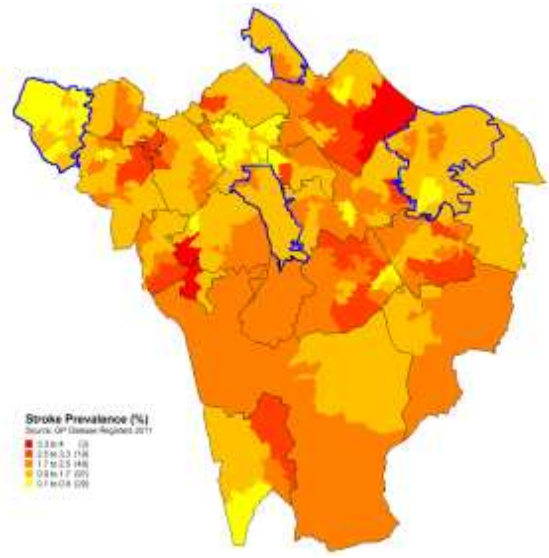
The prevalence of stroke has risen over the last year from 1.61% to 1.94%, this may reflect better identification of stroke on GP disease registers since in 2009-10 observed prevalence for stroke was only 66.6% of the estimated prevalence.

Hospital stroke admission rates in Bromley are similar to the national average overall, and significantly lower for people aged under 75 years; however, residents in Bromley are still two times as likely as residents in the local authority with the lowest admission rate to be admitted to hospital for a stroke before the age of 75.

The average admission rate is coupled with a low number of premature and overall deaths from stroke; Bromley residents are 1.6 times less likely than people living in the England local authority with the highest stroke death rate to die from a stroke; despite this, inequalities in stroke mortality exist. Men in more deprived areas are

significantly more likely to die of stroke than those in the least deprived areas of Bromley.

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



The wards with the highest rates of stroke are:

- Farnborough & Crofton
- Chislehurst
- Orpington

Hypertension

The prevalence of hypertension rose between 2005 to 2011 over the last 6 years, but more slowly in the last 3 years.

The prevalence of recorded hypertension is higher in Bromley than the national average. However, recorded prevalence of hypertension in Bromley is only 47.8% of the estimated prevalence (this figure is 43.9% for England and 41.1% for London).

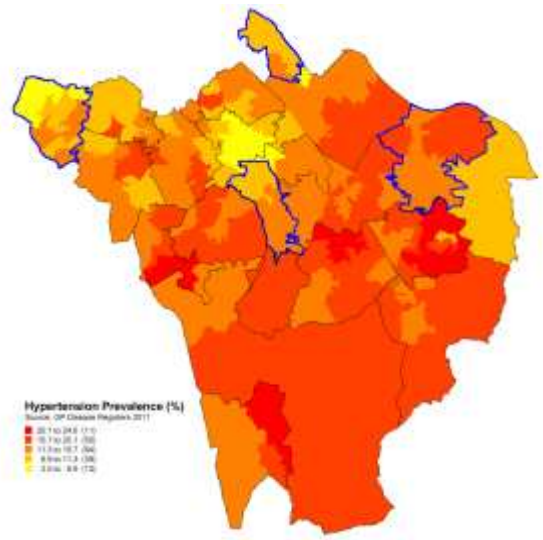
A recent survey in Bromley revealed a low level of awareness of hypertension amongst the public and a false perception that it is a benign condition.

Table 3.3 QOF Hypertension Prevalence

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
No. on practice hypertension register	40,333	41,570	42,651	43,924	45,209	47,088	46,376
Hypertension Prevalence	12.4%	16.3%	15.8%	17.0%	17.5%	17.9%	17.1%

Source: QMAS

Alongside the under detection of hypertension, the proportion of cases who have had their blood pressure checked in the last 9 months (89%) and who achieve the QOF standard of 150/99 mmHg (76%) is lower than the London and England averages. This is particularly significant given that NICE Guidelines recommend a stricter blood pressure control target (140/90 mmHg).

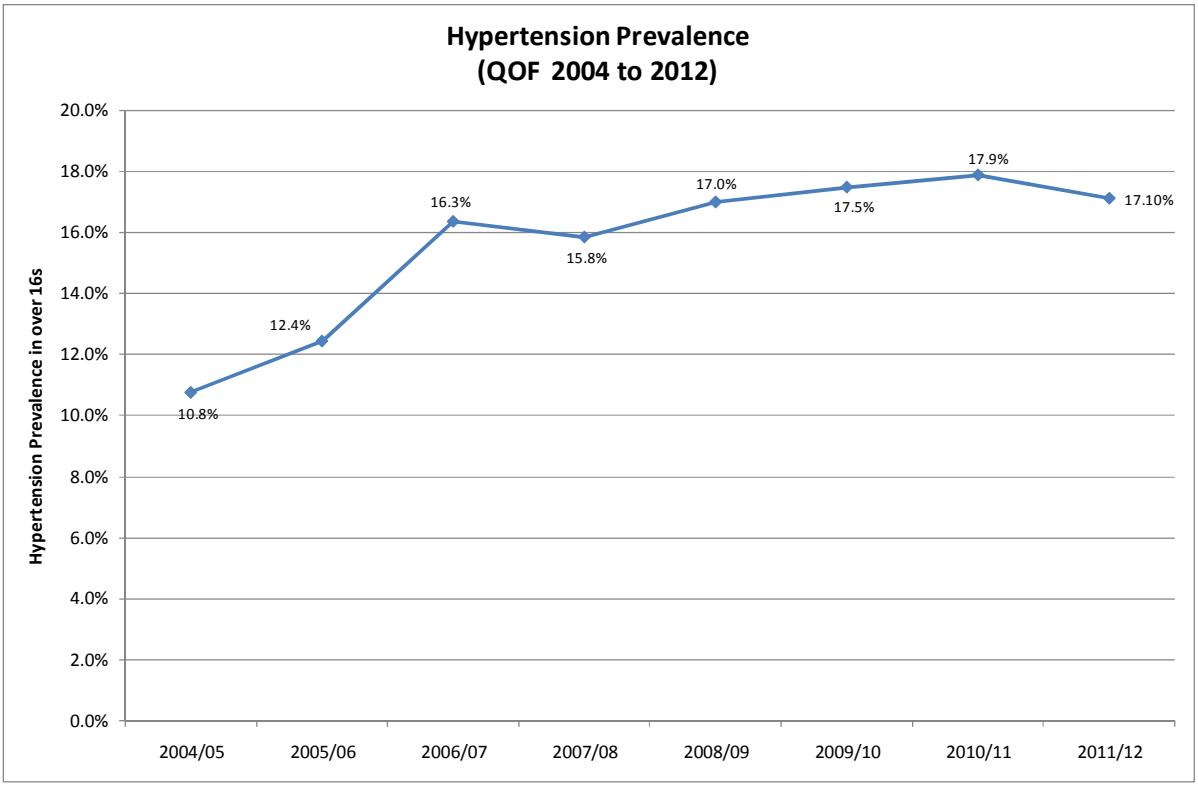


The wards with the highest rates of hypertension are:

- Orpington
- Farnborough & Crofton
- Cray Valley East
- Petts Wood & Knoll
- Darwin

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

Figure 3.15



Source: QMAS

Diabetes

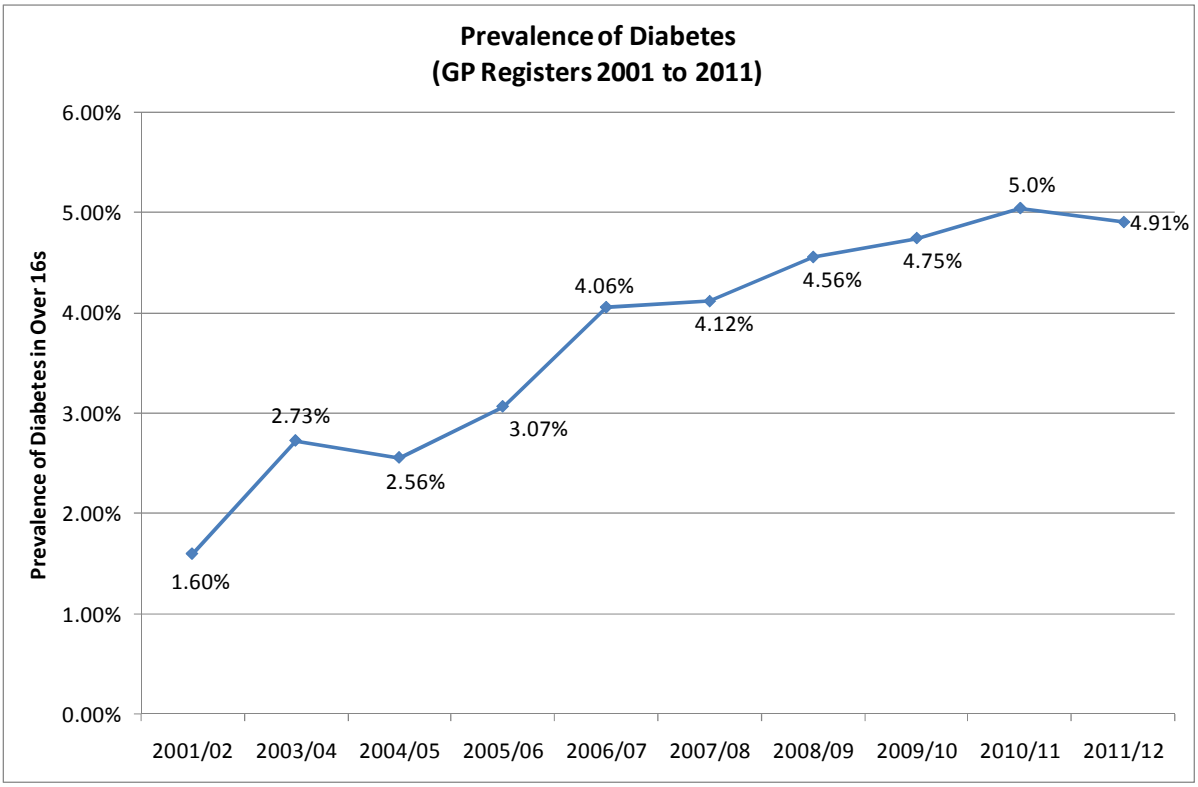
The number of people with diabetes has increased over time. There were 4,846 people on the diabetes register in 2002, as compared with 13,335 in 2011. This reflects a significant rise in prevalence over the last 8 years from 1.6% to 5.0% (Table 3.4). This rise has particular significance because diabetes is classed as a vascular disease which is often a precursor to heart disease or stroke.

Table 3.4 QOF Diabetes Prevalence

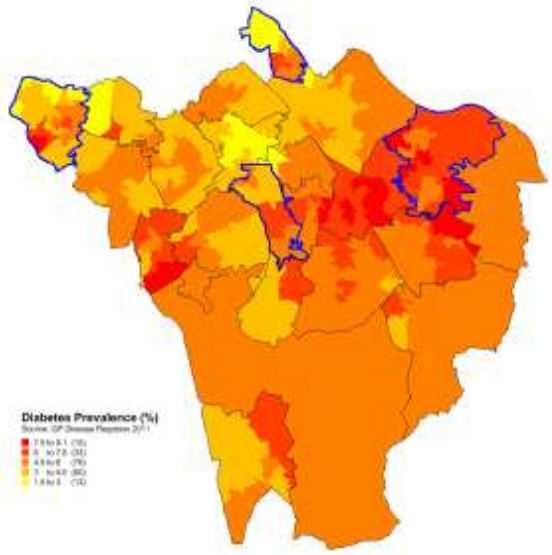
	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
No. on practice diabetic register	8661	9244	10084	10504	11261	11979	12509	13307	13335
Diabetes Prevalence	2.73	2.56%	3.07%	4.06%	4.12%	4.56%	4.75%	5.0%	4.91%

Source: QCI & QMAS

Figure 3.16



Source: QMAS



The wards with the highest rates of diabetes are:

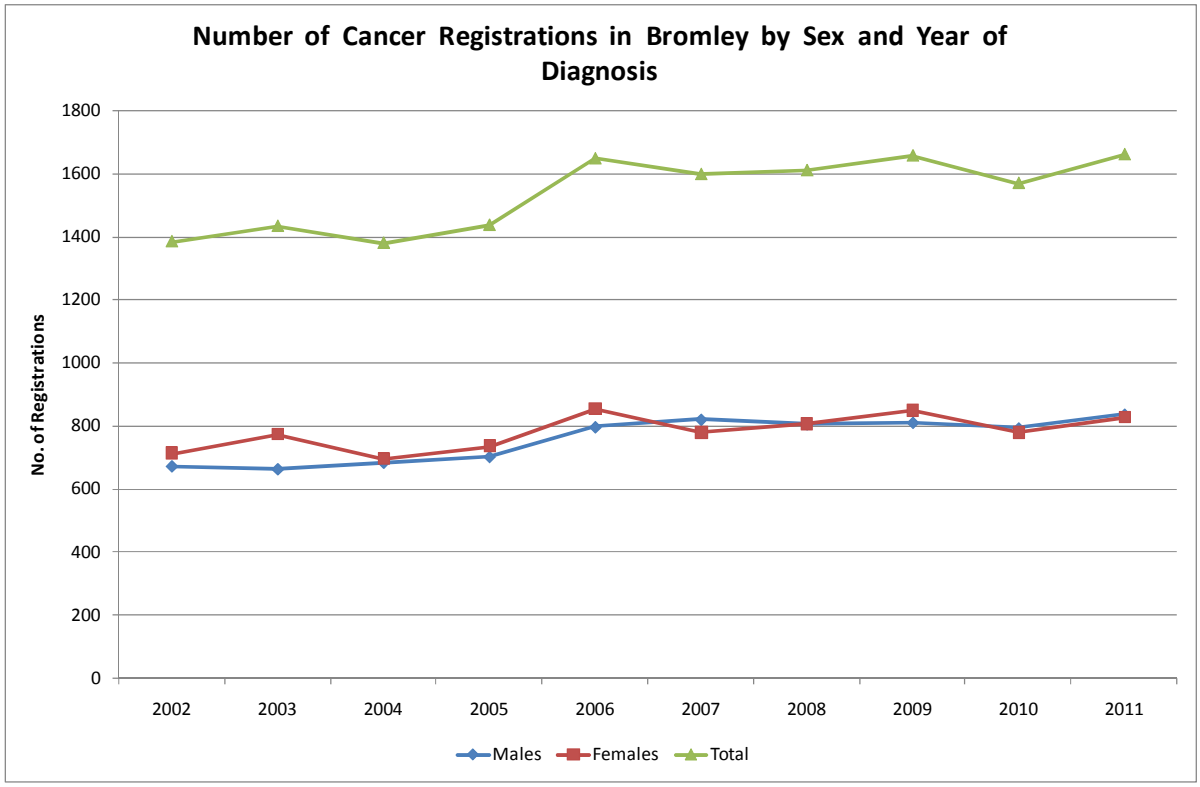
- Petts Wood & Knoll
- Cray Valley East
- Cray Valley West
- Orpington
- Farnborough & Crofton

Cancer

There were 6296 patients recorded with a diagnosis of cancer on GP registers in 2011-12, although the Thames Cancer Registry reported 11,262 registered cancer patients registered in Bromley alive at 31st December 2011. There were over 10,000 cancer deaths in the last 10 years.

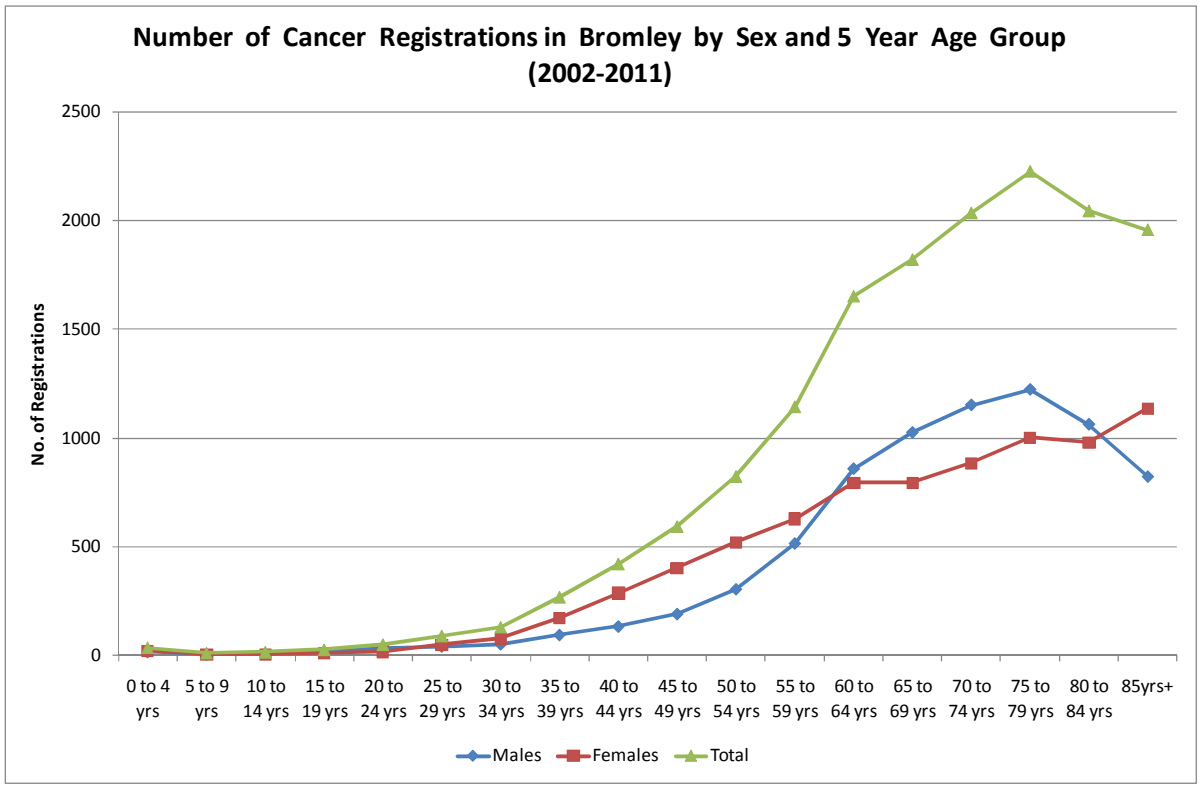
The number of cancer registrations per year has increased since 2002, but been fairly stable since 2006, the numbers of people diagnosed with cancer increases with age, to a peak in the 75 to 79 year age group.

Figure 3.17



Source: Thames Cancer Registry

Figure 3.18



Source: Thames Cancer Registry

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

Table 3.5 Number of Cancer Registrations by Site in Bromley 2002-2011

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

Source: Thames Cancer Registry

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

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

Figure 3.19

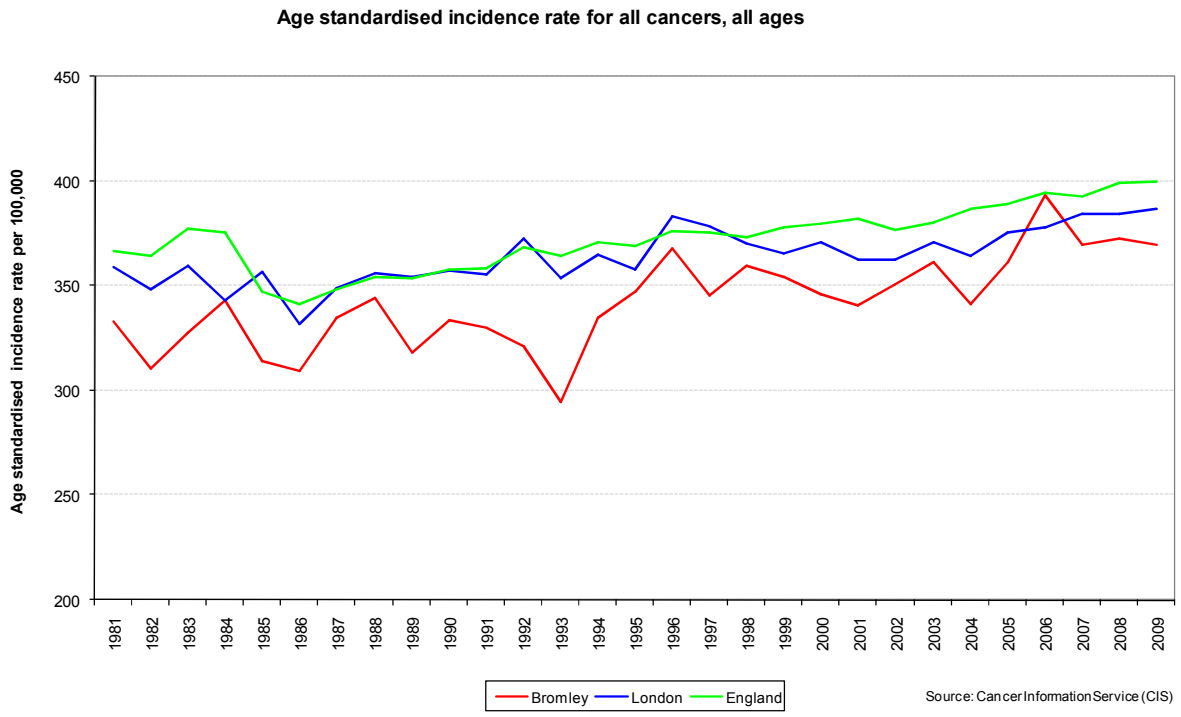


Figure 3.20

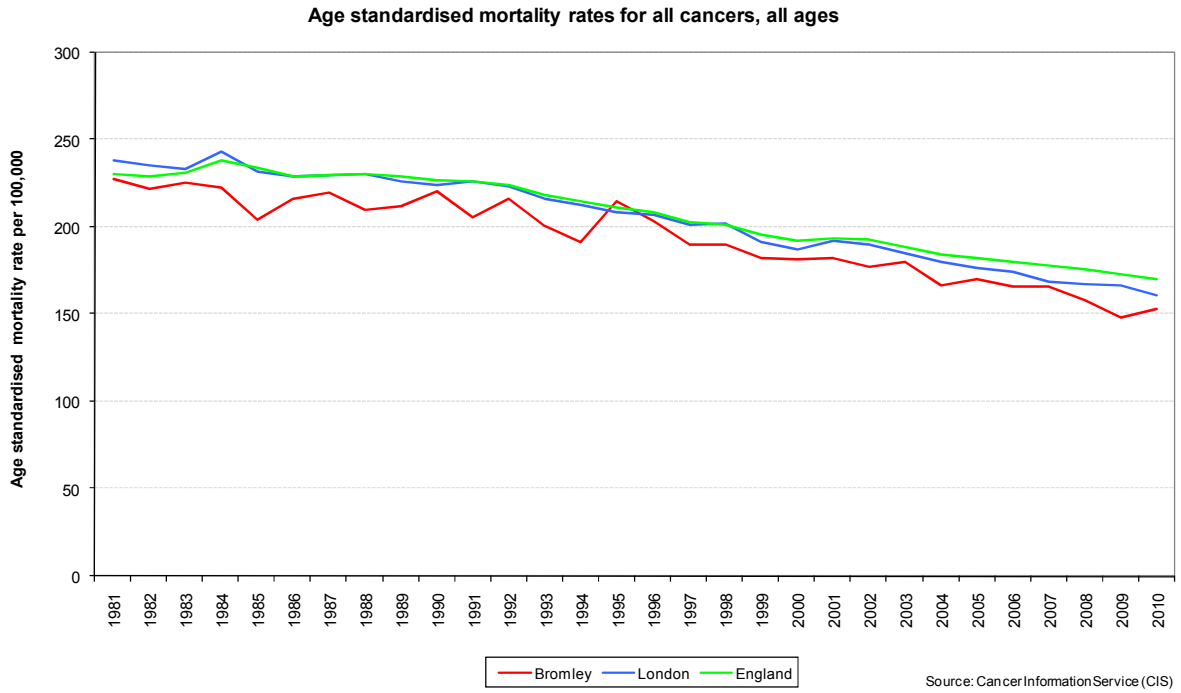
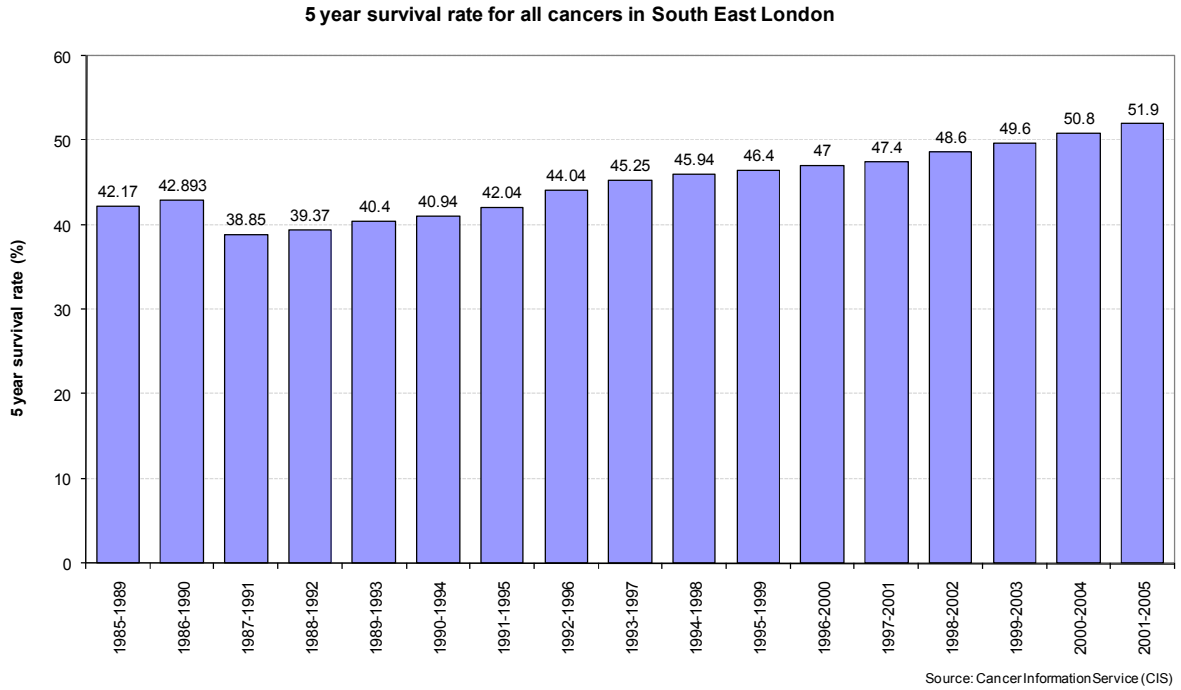
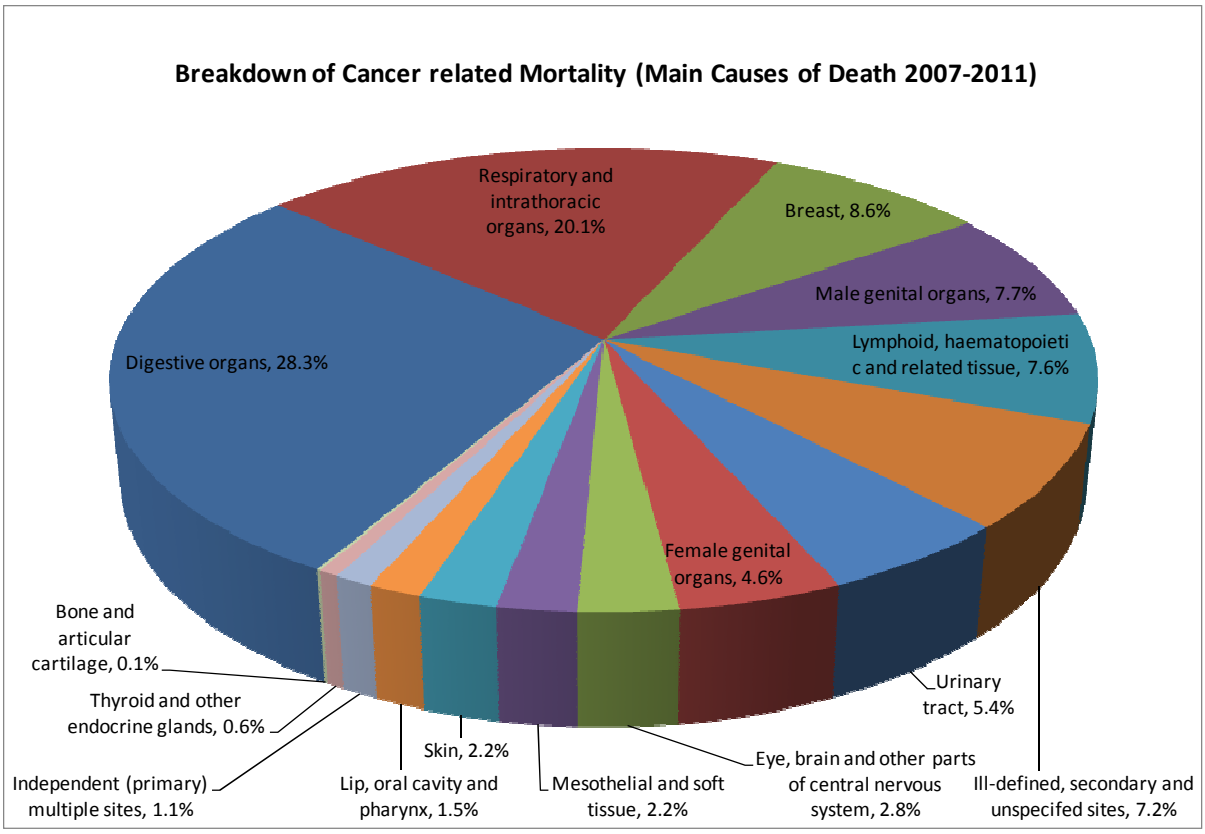


Figure 3.21



The highest proportion of deaths (28.3%) are related to cancer of the digestive organs.



Respiratory Disease

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

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is mainly caused by smoking. The prevalence of smoking in Bromley is 18.1%, lower than the England average (20.0%). However, smoking prevalence is higher in routine and manual workers at 24.3%.

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

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

Table 3.6 QOF COPD Prevalence

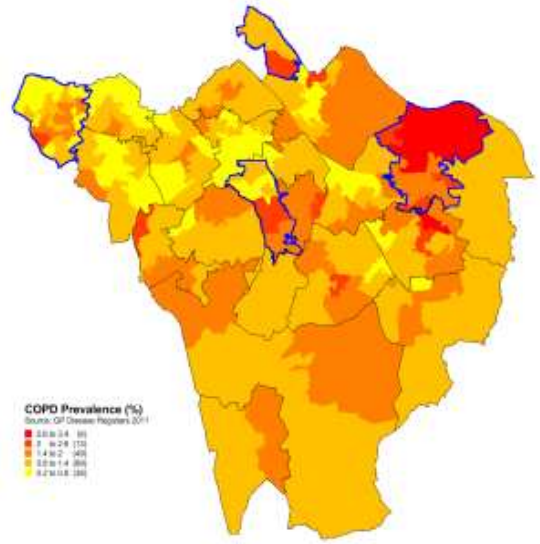
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
COPD Register Size	3342	3509	3735	4006	4143	4296	4247
COPD prevalence	1.02%	1.36%	1.37%	1.52%	1.57%	1.57%	1.56%

Source: QMAS

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

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

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



The wards with the highest rates of COPD are:

- Cray Valley East
- Bickley

Mental Illness

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

Table 3.7 QOF Serious Mental Illness Prevalence

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

Source: QMAS

Dementia

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

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

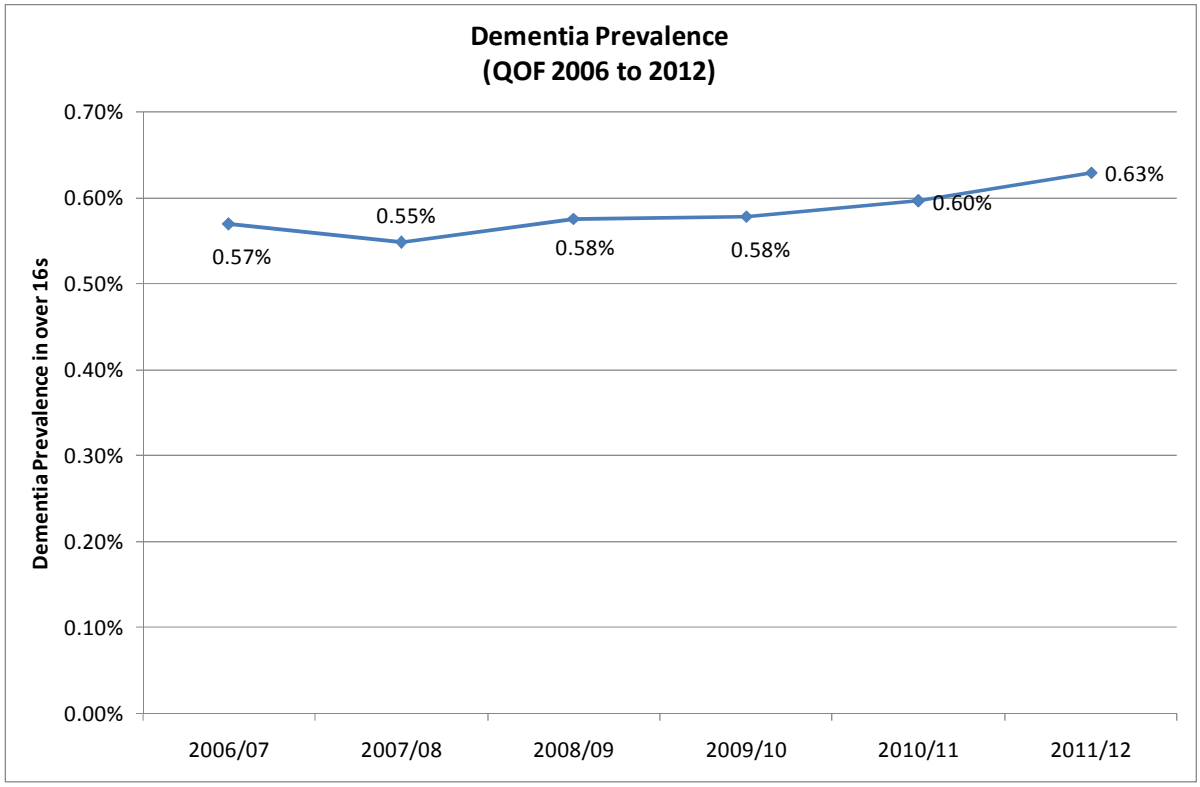
GP registers identify 1,703 patients with dementia, suggesting that some cases are not known to clinical services.

Table 3.8 QOF Dementia Prevalence

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

Source: QMAS

Figure 3.22



Source: QMAS

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

Sexual Health

Teenage Pregnancy

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

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

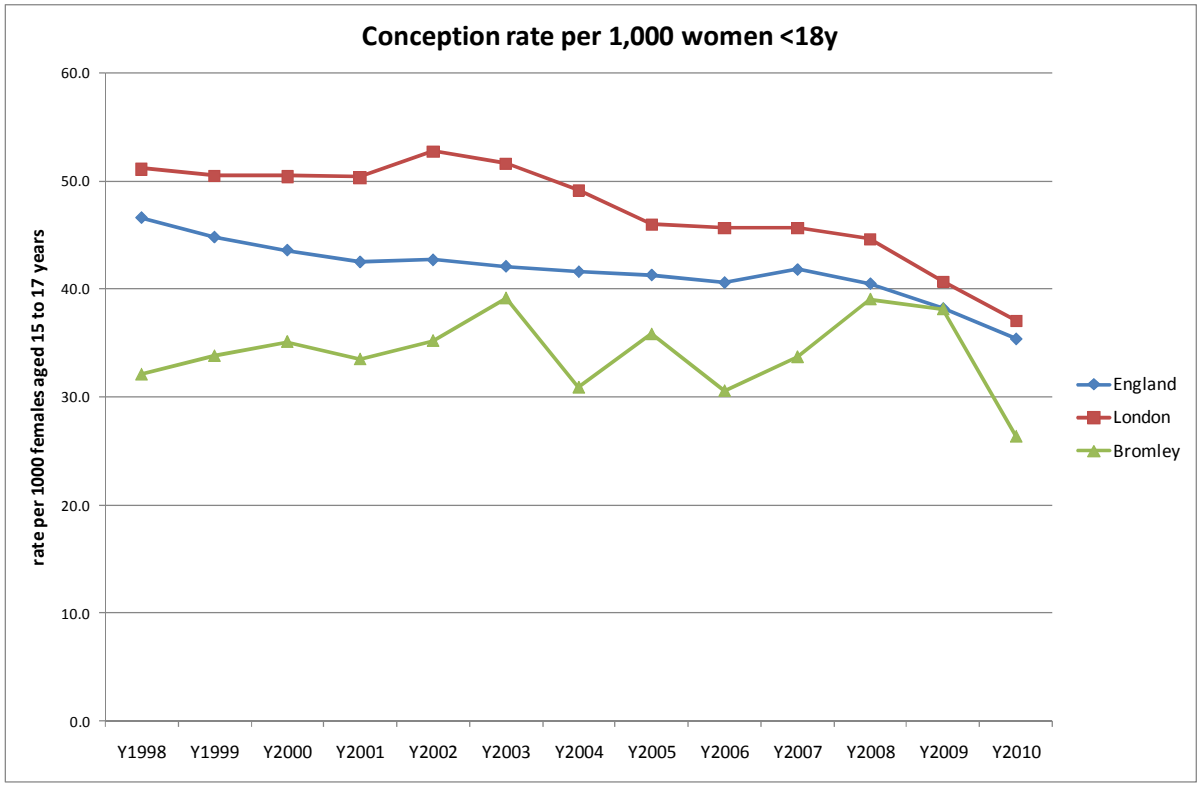
In the longer term, children of teenage mothers experience lower educational attainment and are at higher risk of economic inactivity as adults.

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

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

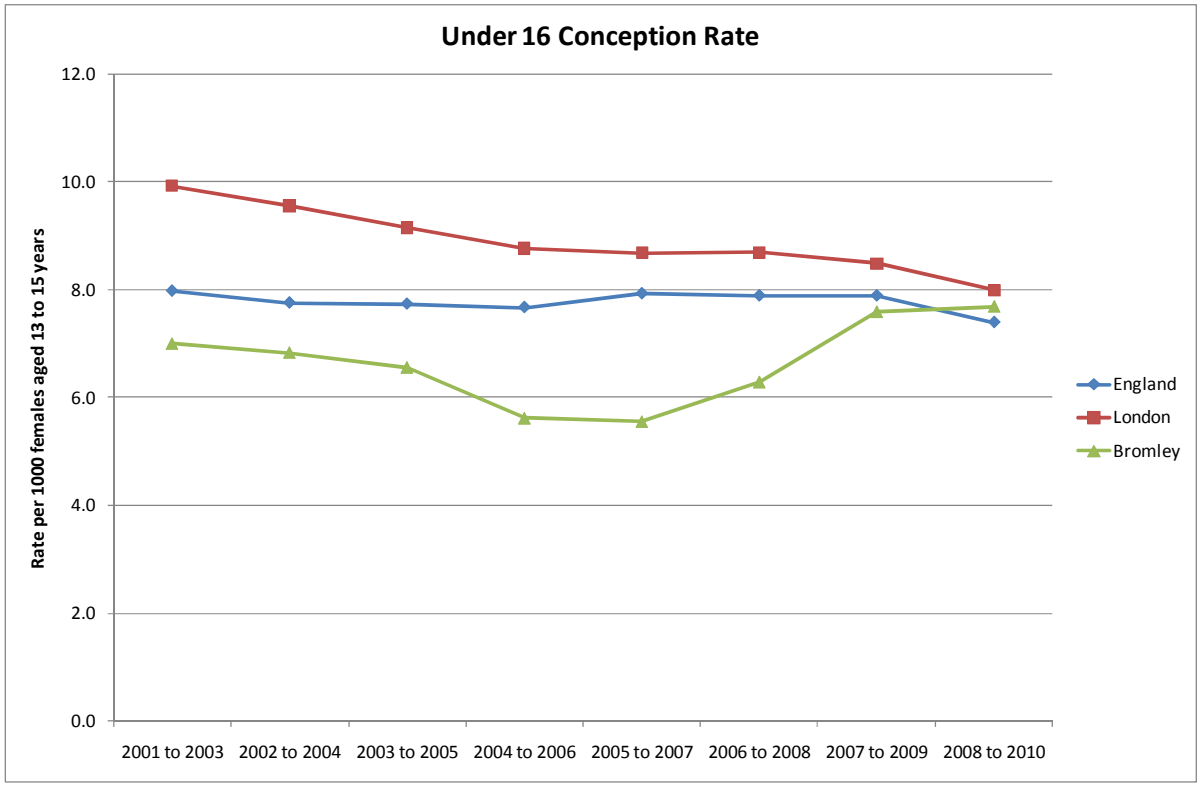
In 2010 there were 143 conceptions in females aged between 15 and 17 years. This represents a rate of 26.4 per 1000 female population aged 15 to 17 years, which is lower than both the London rate (37.1) and the England rate (35.4). There has been a 17.8% reduction in the under 18 conception rate since 1998.

Figure 3.23



Over the three years between 2008 and 2010, there were 125 conceptions in females aged 13 to 15 years, which represents a rate of 7.7 per 1000 female population aged 13 to 15 years. The Bromley rate is lower than the London rate (8.0), but higher than the England rate (7.4). In recent years the under 16 conception rate in Bromley has been increasing.

Figure 3.24



The maternity rate in women under the age of 18 years has been falling since 2008.

Of the 143 under 18 conceptions in 2010, 93 (65%) resulted in a termination of pregnancy. This is significantly higher than the England rate (50.3%), and slightly higher than the London rate (62.5%). However the overall percentage of abortions in under 18s has been falling over recent years.

Figure 3.25

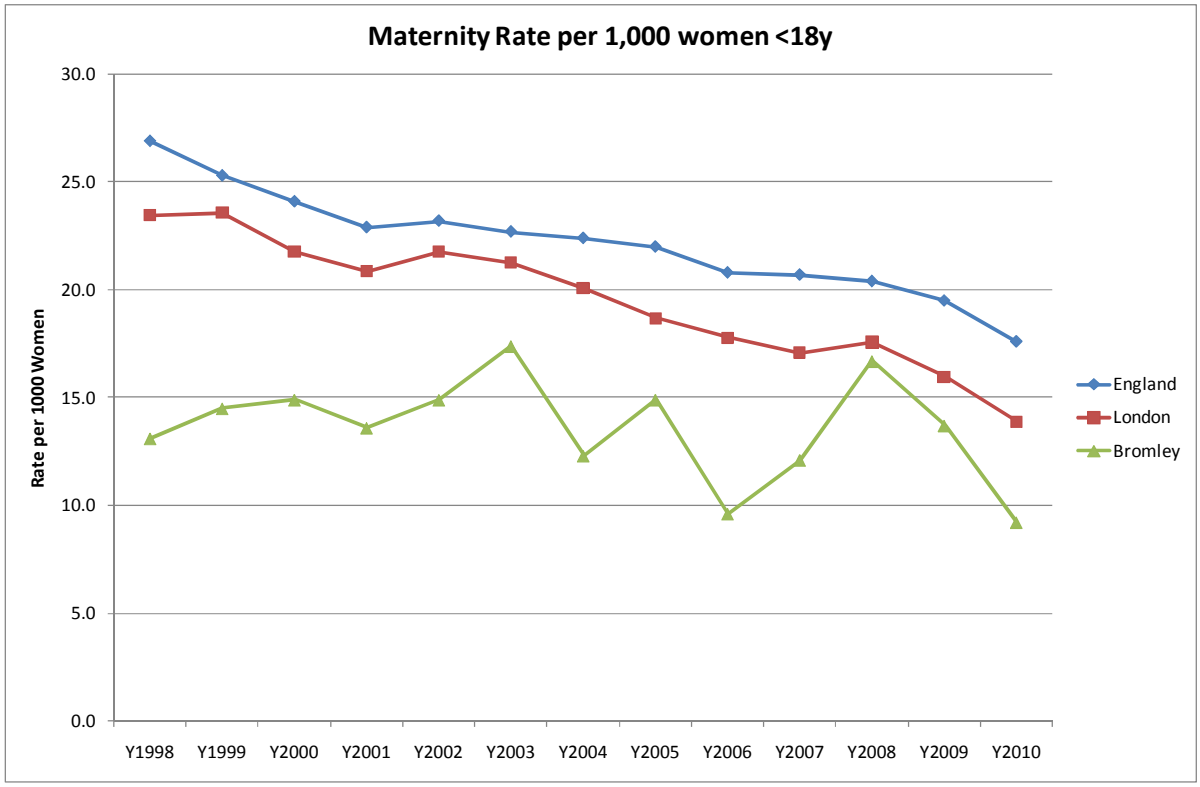


Figure 3.26

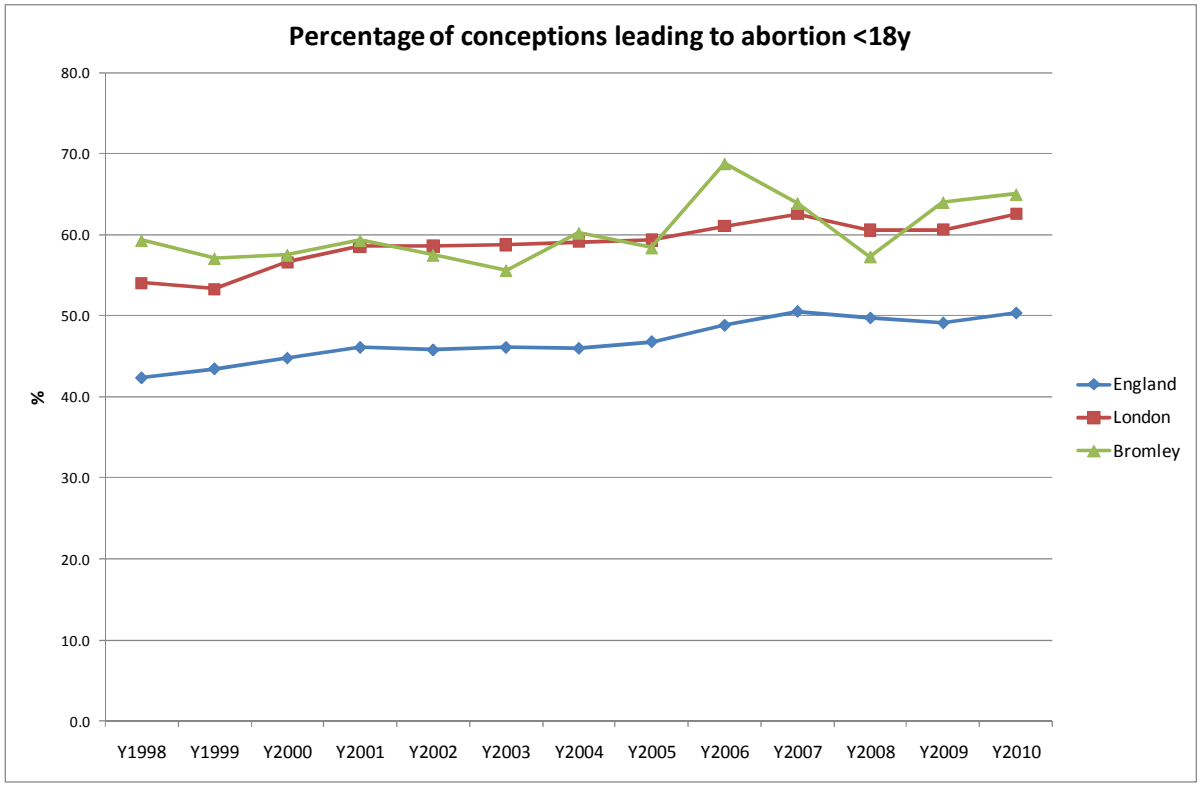


Figure 3.27

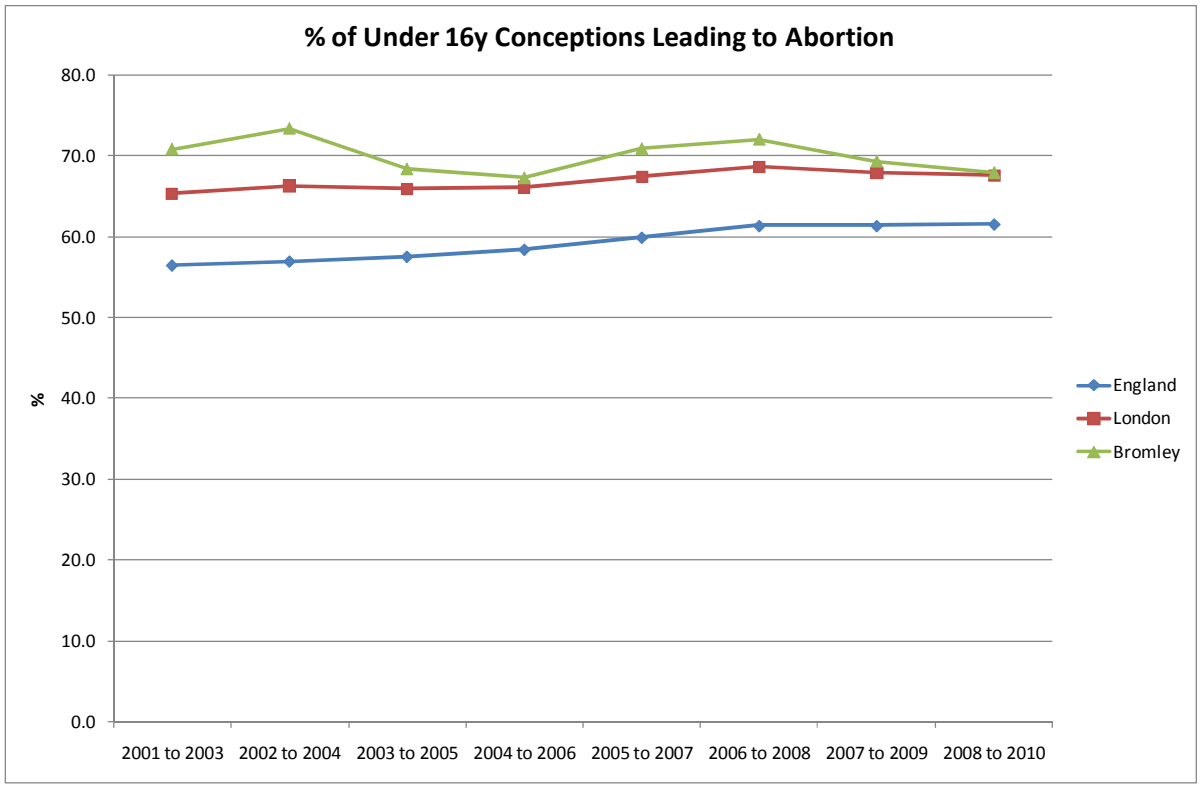
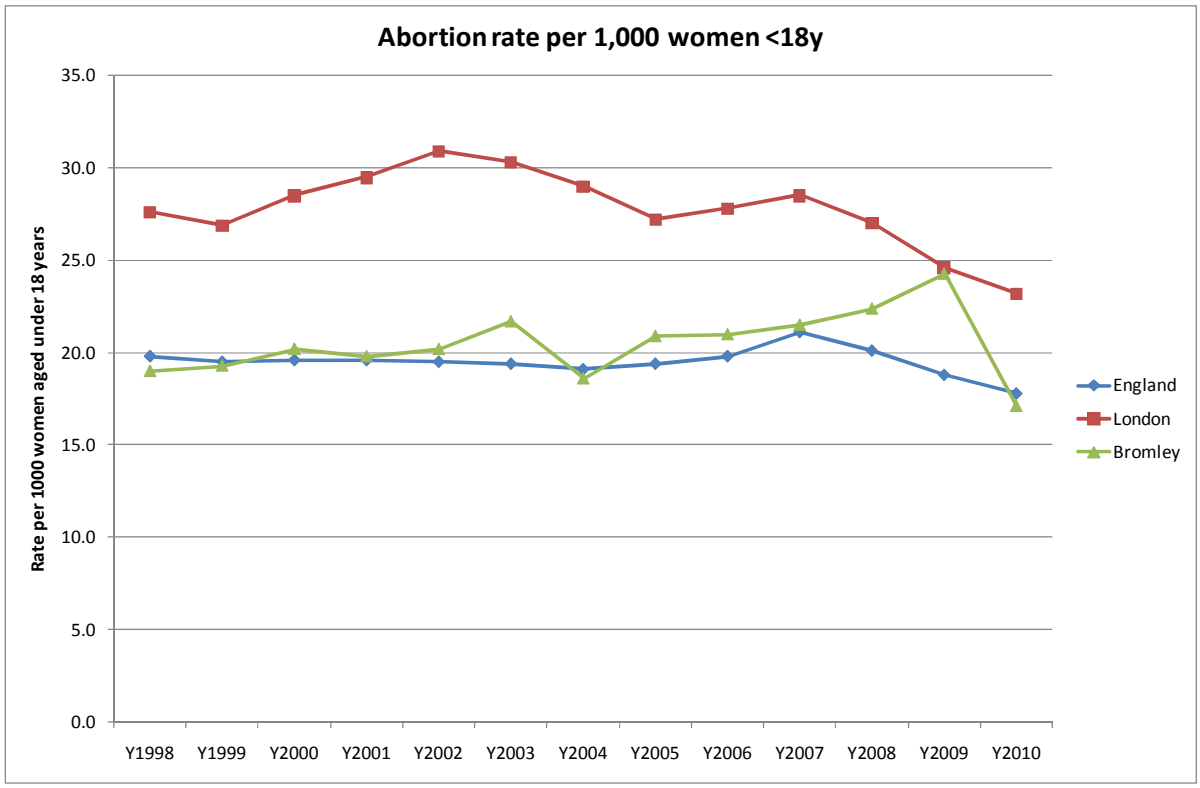


Figure 3.28



Sexually Transmitted Infections

The rate of sexually transmitted infections (STIs) in Bromley (597.7 per 100,000 population) is significantly lower than the London rate (1297.9) and the England rate (792.1).

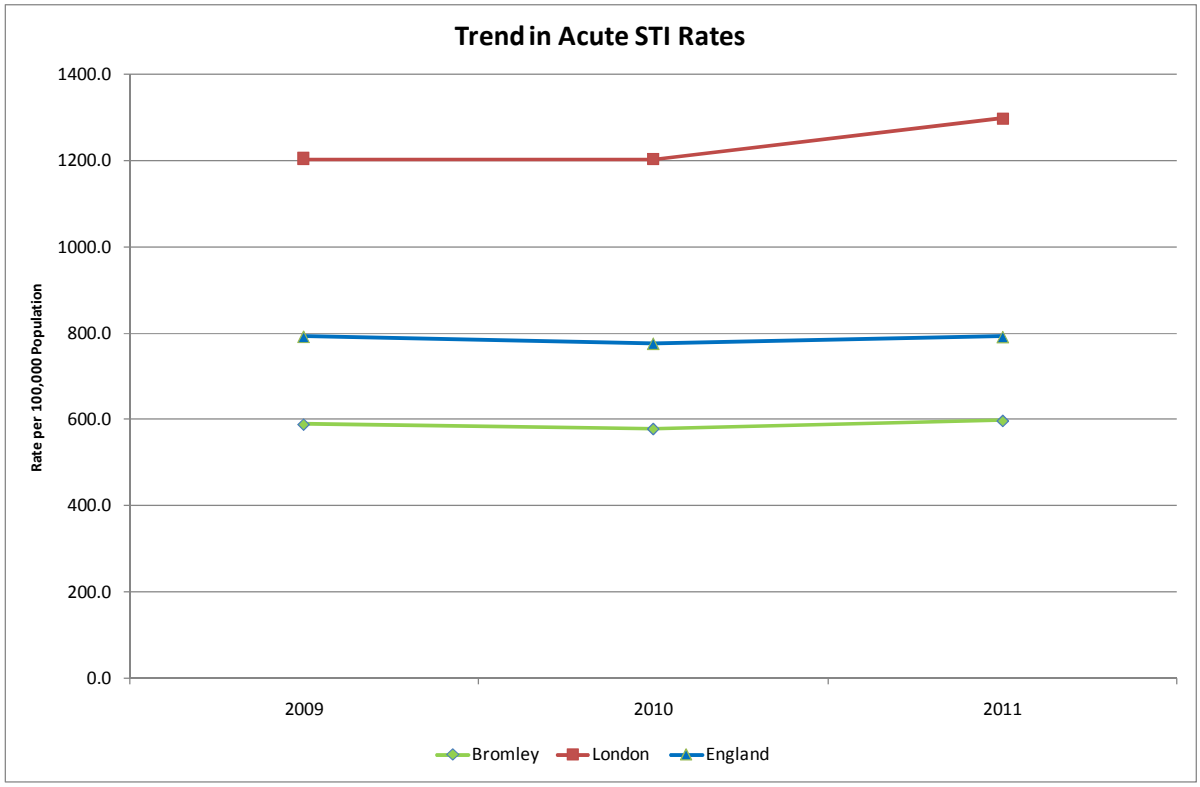
Table 3.9 Rates of Incidence of Specific STIs.

Sexually Transmitted Infection	**Rate of Diagnoses per 100,000 Population 2011**		
	Bromley	**London**	**England**
Gonorrhoea (GUM Clinics)	29.5	109.2	39.1
Syphilis (GUM Clinics)	2.6	17.5	5.4
Chlamydia (15 to 24 yr olds in all settings)	1778.8	2496.2	2124.6

Source: Sexual Health Scorecard

Rates of STIs overall have been increasing slightly over the last three years, although they remain lower than the rates for London and England. Rates of incidence of syphilis and genital warts have been reducing.

Figure 3.29



Chlamydia

The Chlamydia Screening programme is operating well with 21% of 15 to 24 year olds tested for Chlamydia in 2011-12. This rate is significantly higher than the rate for London (20.6%) and for England (20.5%). However, the percentage of positive tests for Chlamydia outside GUM clinics in Bromley (4.9%) is significantly lower than for London (5.7%) and England (5.9%). This corresponds to the significantly lower rate of diagnosed Chlamydia in all settings in Bromley (1778.8 per 100,000 population) as compared with London (2496.2) and England (2124.6).

Pelvic Inflammatory Disease

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

Bromley has a high rate of hospital admissions with any mention of pelvic inflammatory disease in women aged 15 to 44 years (564 per 100,000 population) as

compared with the London rate (240.3) and the England rate (247.9). This high rate in Bromley merits further investigation.

HIV

The prevalence of HIV in people aged 15 to 59 years in Bromley (2.1 per 1000 population) is significantly higher than the prevalence across England (1.89), but is lower than the prevalence for London (5.42).

The number of people living with HIV in Bromley has increased by 68% in the last five years (compared with 48% for England) and by 7% from 2009 to 2010 (compared to 6% for England).

In 2010, the prevalence of HIV in pregnant women in Bromley was 0.3%, across London it was 0.4%.

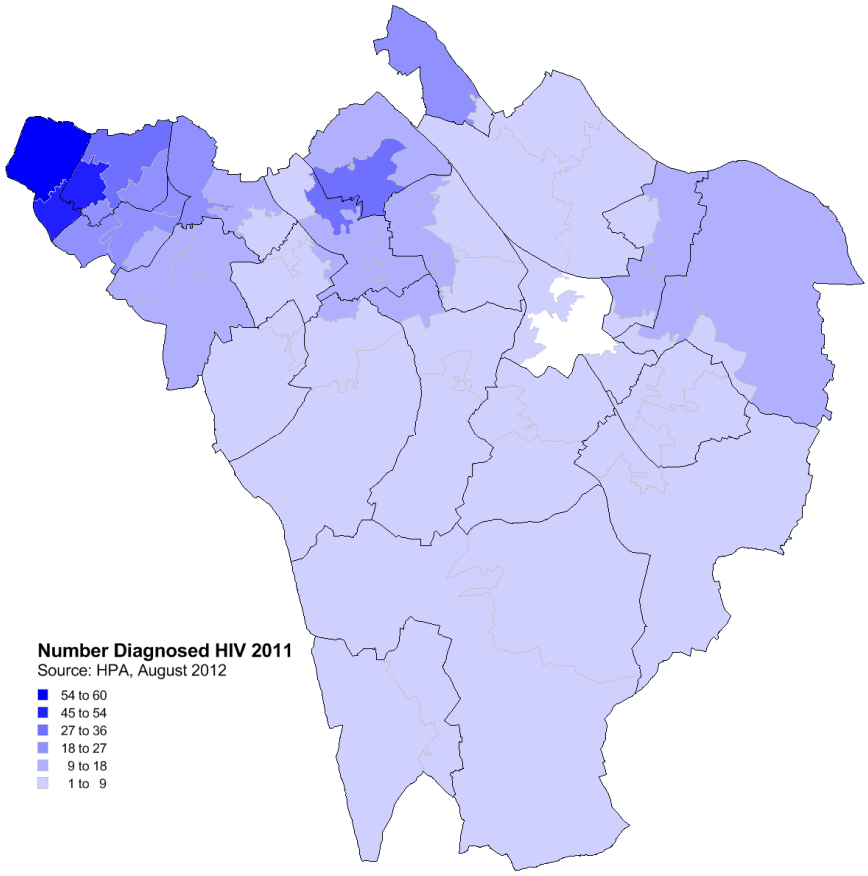
The median age of those accessing care for HIV was 41 years. The greatest numbers of patients accessing care were in the white (48%) and Black African (36%) ethnic groups.

The largest proportion of HIV patients resident in Bromley were infected through sex between men and women (53%). Infection via sex between men accounted for the next largest group (42%).

Uptake of HIV testing in GUM clinics in Bromley (79.2%) is comparable to the level for England (80.3%), but lower than the rate for London (85.4%). The proportion of late diagnoses of HIV for the period 2008-10 is lower in Bromley (44.2%) than for London (50.0%) and for England (52.3%). This is important as people living with diagnosed HIV can expect a near-normal life expectancy, provided they are diagnosed early in the course of their infection. Late presenters (those diagnosed with a CD4 <350 – below the threshold at which treatment should have begun) carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed promptly. Remaining undiagnosed also carries a greater risk of onward transmission.

The highest rates of HIV in Bromley are found in the North-West of the borough. Prevalence rates of higher than 2 per 1000 occur in 33% of middle layer super output areas (MSOAs) in Bromley.

Figure 3.30 Map of HIV Distribution in Bromley 2011



Source: HPA, August 2012

The British HIV Association (BHIVA), the British Association for Sexual Health and HIV (BASHH) and the British Infection Society (BIS) (2008) all advise that testing is recommended when patients present with clinical symptoms suggestive of HIV. They also advocate the routine offer of an HIV test to all adults registering in general practice and all general medical admissions where the local diagnosed HIV prevalence is greater than two per thousand among 15-59 years old. The National Institute for Health and Clinical Excellence (NICE) also recommends HIV testing in primary care in certain risk groups (Black Africans and men who have sex with men (MSM)). Normalising HIV testing will help to break down barriers and improve testing uptake.

As the prevalence of HIV in Bromley has now reached the level of 2 per 1000 population, a pilot project of HIV testing in the GP practices in the north of Bromley i.e. Penge, Anerley and North Beckenham was set up early in 2012. This pilot involves the offer of point of care (rapid) testing to:

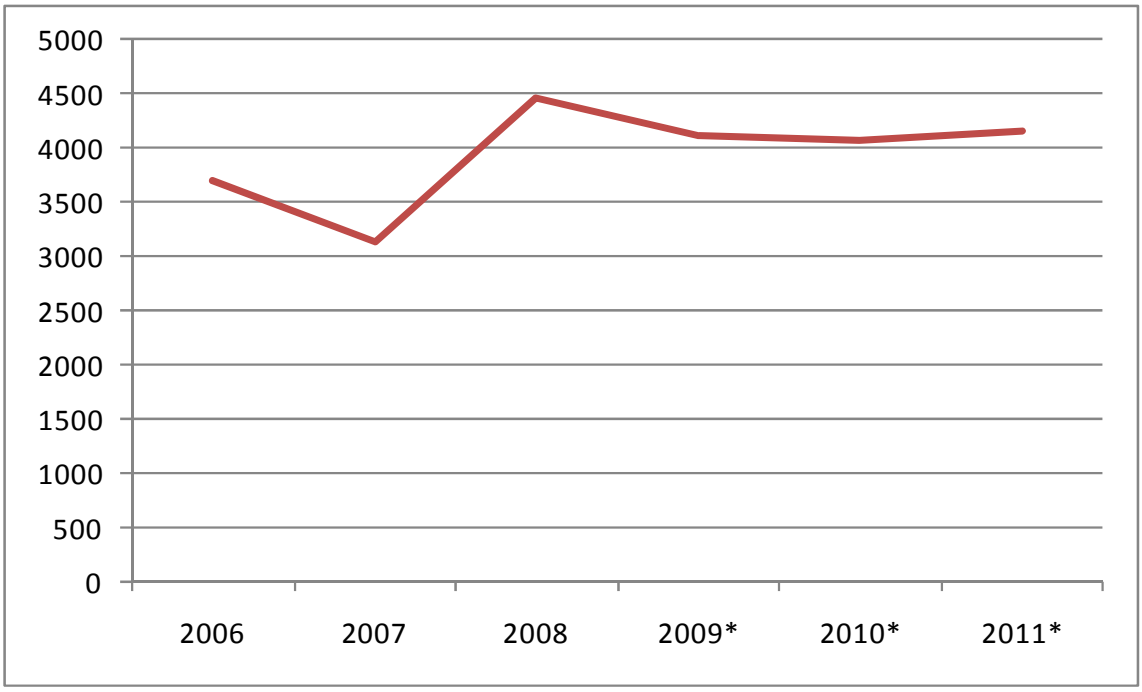
- new patients (aged 15 – 59 in line with the national HIV testing guidelines) at registration
- patients in at risk groups (Black Africans and MSM)
- patients with possible HIV-related symptoms
- patients who request a test

This project will be evaluated to assess whether rates of testing and HIV diagnosis increase. Early findings suggest that this style of testing is acceptable to patients.

Pregnancy and Maternity

The number of live births in Bromley has remained steady over the last three years, at approximately 4,000 births per year.

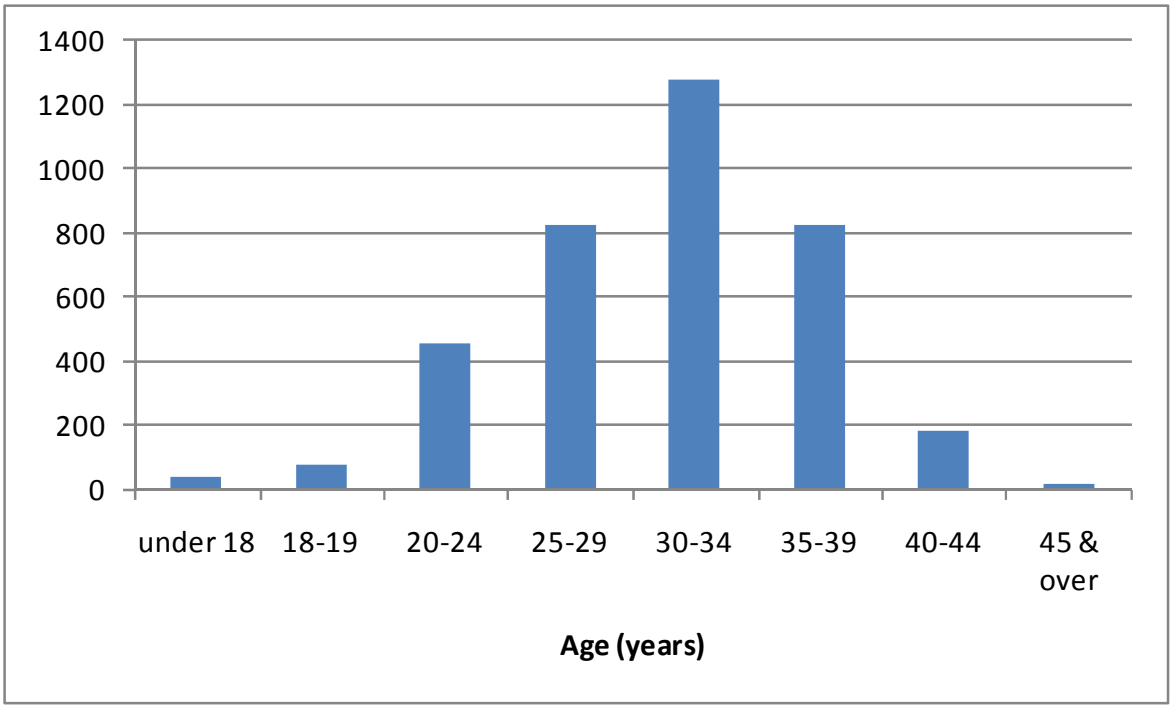
Figure 3.31 Number of live births in Bromley between 2006 and 2011



**ONS data*

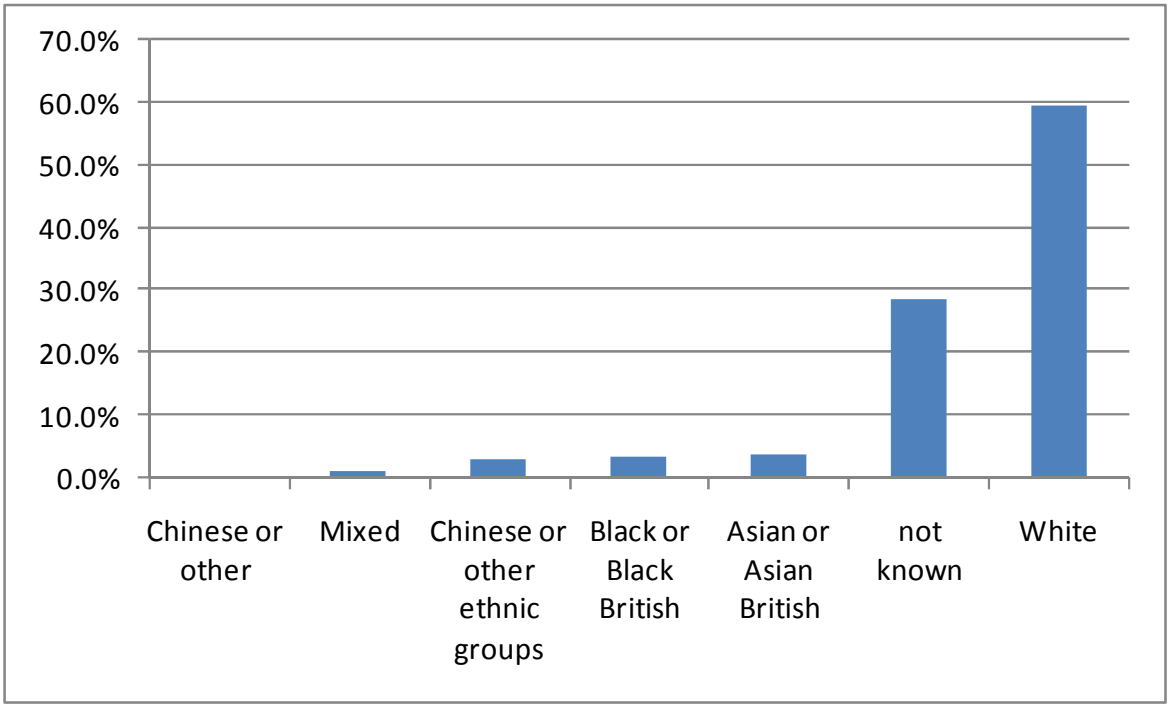
Approximately one third of mothers who gave birth in Bromley between 2011 and 2012 were aged between 30 and 34 years. Nearly 80% of all mothers who gave birth in Bromley in 2011/2012 were aged between 25 and 39 years.

Figure 3.32 Age group of Bromley mothers giving birth between April 2011 and March 2012



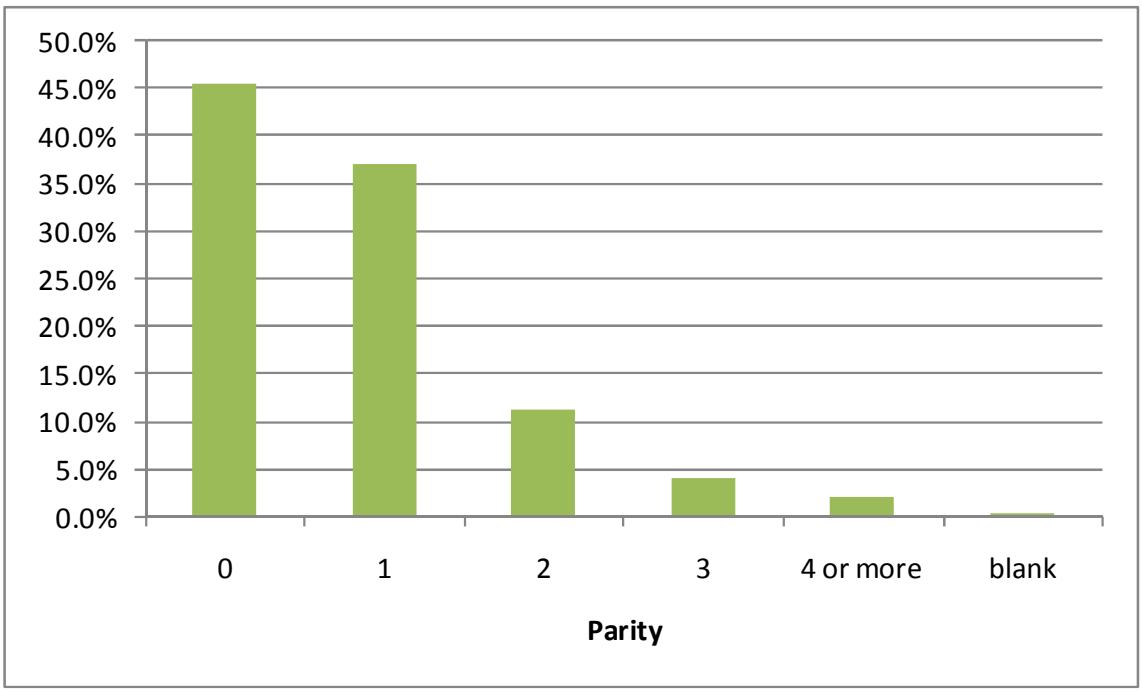
The majority of mothers who gave birth between 2011 and 2012 were from a white ethnic background. Approximately one in ten women was from a minority ethnic group.

Figure 3.33 Ethnicity of Bromley mothers giving birth between April 2011 and March 2012



Nearly a half of all women who gave birth between April 2011 and March 2012 were first time mothers. Another third already had one more child. Approximately 15% of mothers had two or more children.

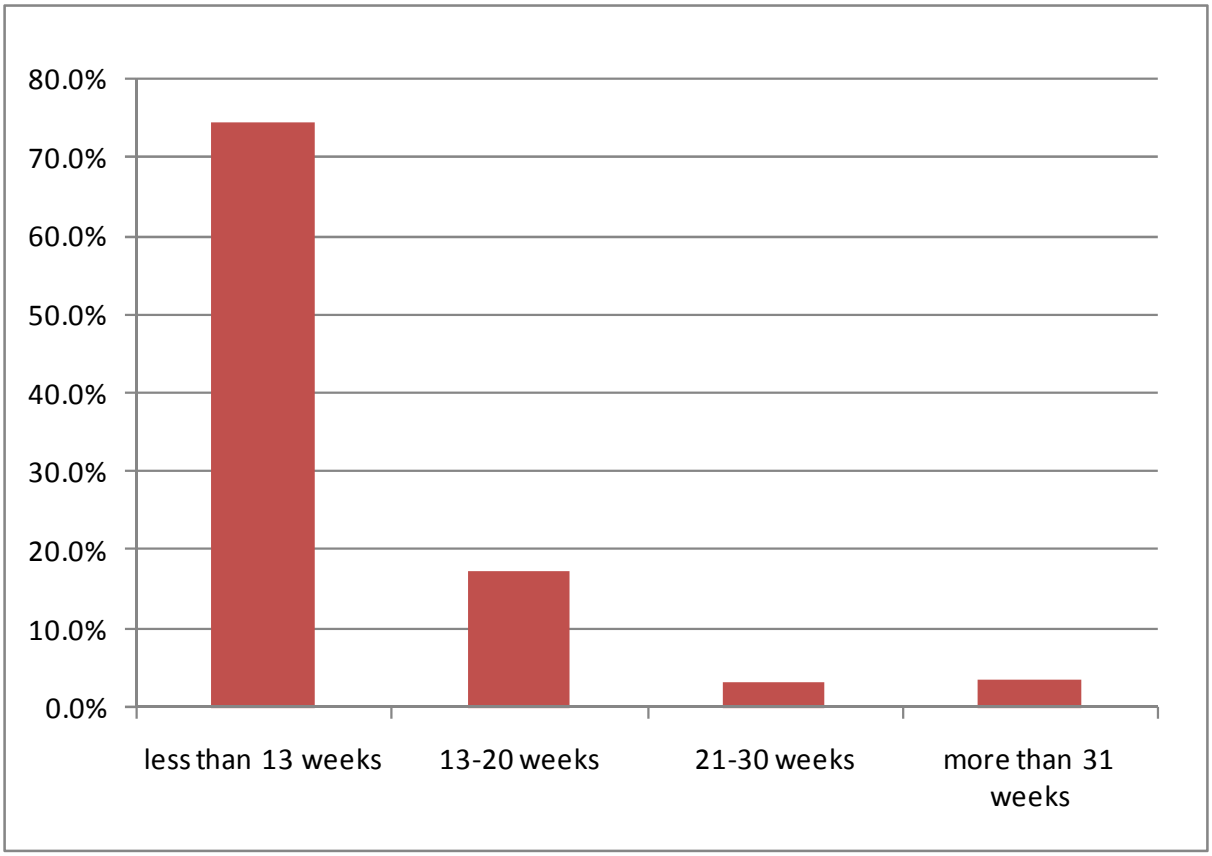
Figure 3.34 Parity of Bromley mothers at booking, April 2011 to March 2012



Early booking to antenatal care, that is a woman booking with a midwife before 13 weeks (12 weeks plus 6 days) gestation, ensures that essential information about the woman's pregnancy and health are collected so that maternity and health services may detect, predict, prevent and manage problems with the mother and unborn child.

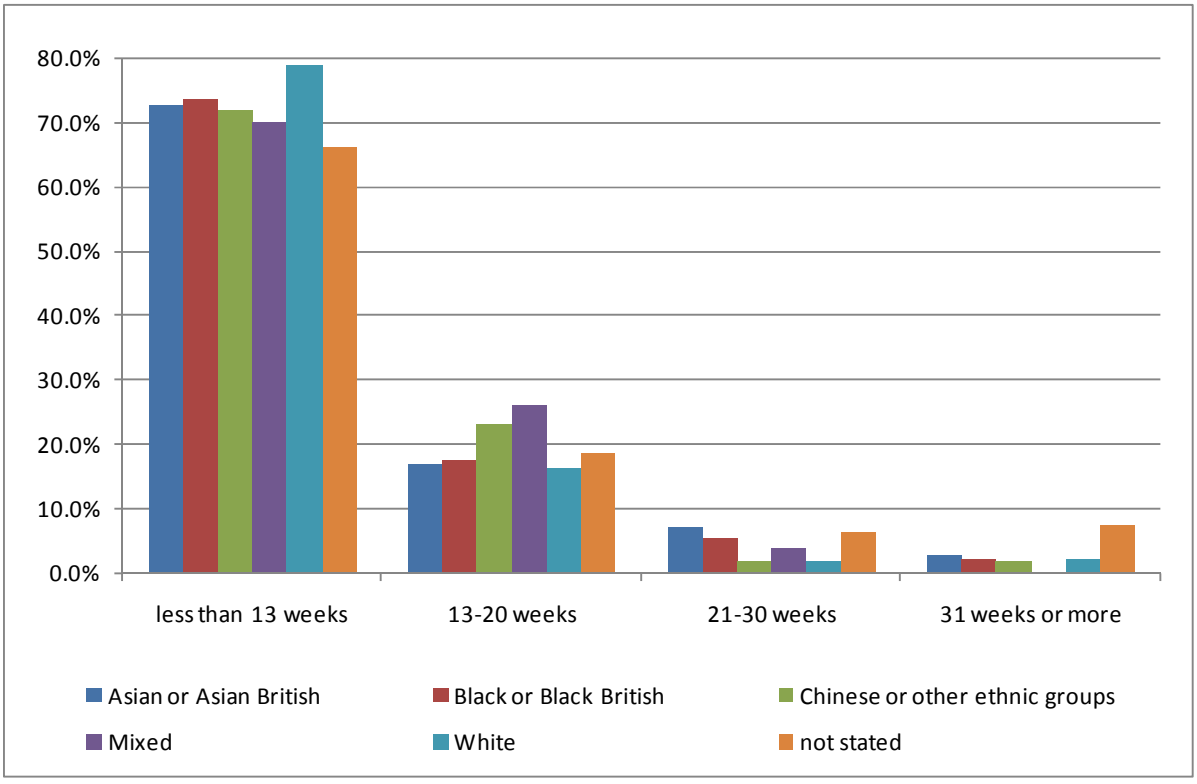
Between April 2011 and March 2012 over 70% of women booked their pregnancy before they were 13 weeks pregnant. Only 7% of mothers booked late (that is after 20 weeks gestation).

Figure 3.35 Gestation of baby for Bromley mothers at time of booking, April 2011 to March 2012



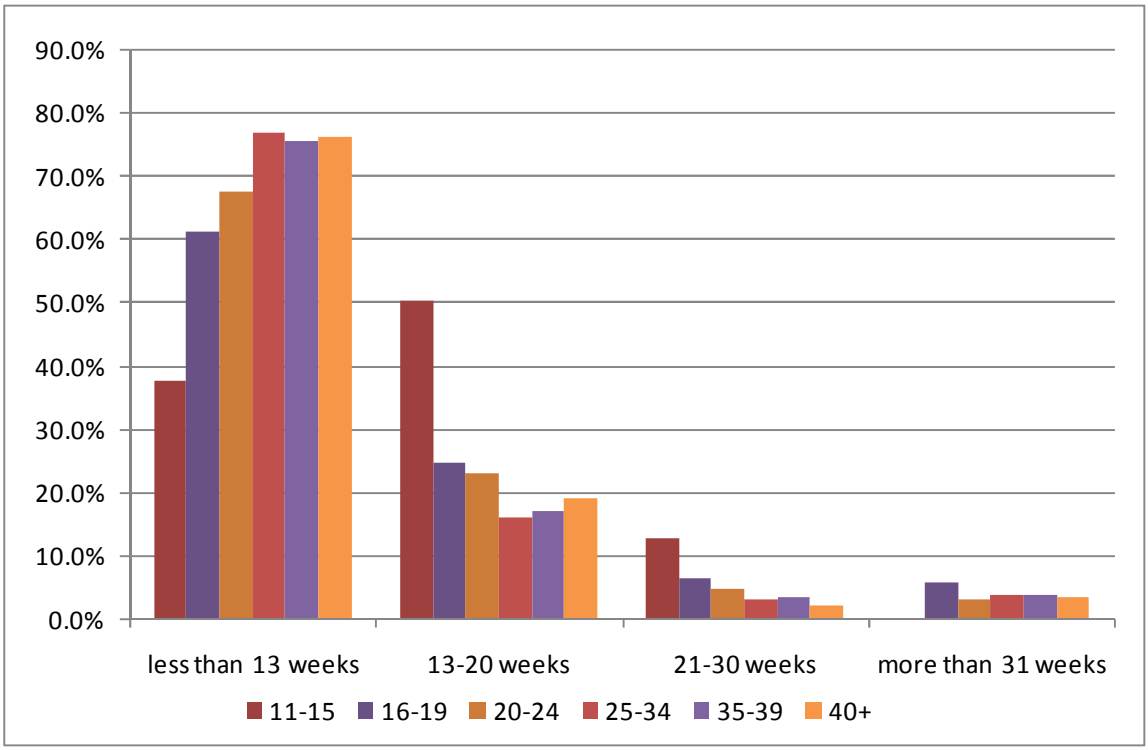
Approximately one in ten women who state their ethnicity as Asian or Asian British book after they are 20 weeks pregnant. Fifteen percent of late bookers have not stated their ethnicity.

Figure 3.36 Gestation of baby at mother's time of booking, by ethnicity, April 2011 to March 2012



The age of the mother seems to influence the time of booking. Younger mothers tend to book their pregnancy later than 13 weeks. Nearly two thirds (62.5%) of mothers aged 11 to 15 years book after 13 weeks gestation. Over three quarters of women aged over 25 years book before their 13th week of gestation.

Figure 3.37 Gestation of Bromley babies at mother's time of booking, by age group, April 2011 to March 2012

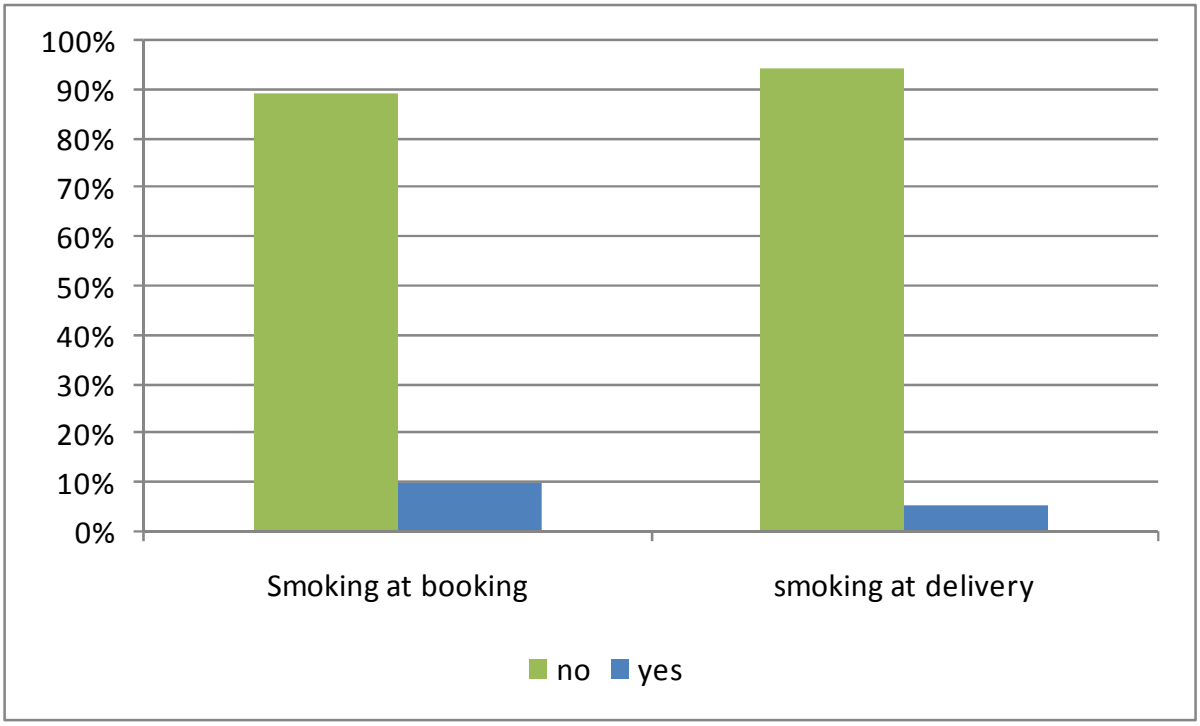


Maternal smoking can result in the increased risk of miscarriage, preterm birth, low birth weight and stillbirth. It has been linked to sudden infant death syndrome,

childhood respiratory illness and behavioural problems. Infants and children of parents who smoke are twice as likely to suffer from a serious respiratory infection and asthma as the children of non-smokers. Pregnant women who smoke are offered help and support to stop smoking.

Ninety percent of women reported not smoking at booking or delivery in Bromley between April 2011 and March 2012.

Figure 3.38 Mother's smoking status at booking and delivery, April 2011 to March 2012



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

In Bromley, approximately one in twenty babies are born weighing less than 2,500 grams. Slightly more than one in ten babies is classified as large for gestational age (LGA) at more than 4,000grams. These are similar to the rates for England. The main reasons for LGA include maternal gestational diabetes and excessive weight gain in pregnancy.

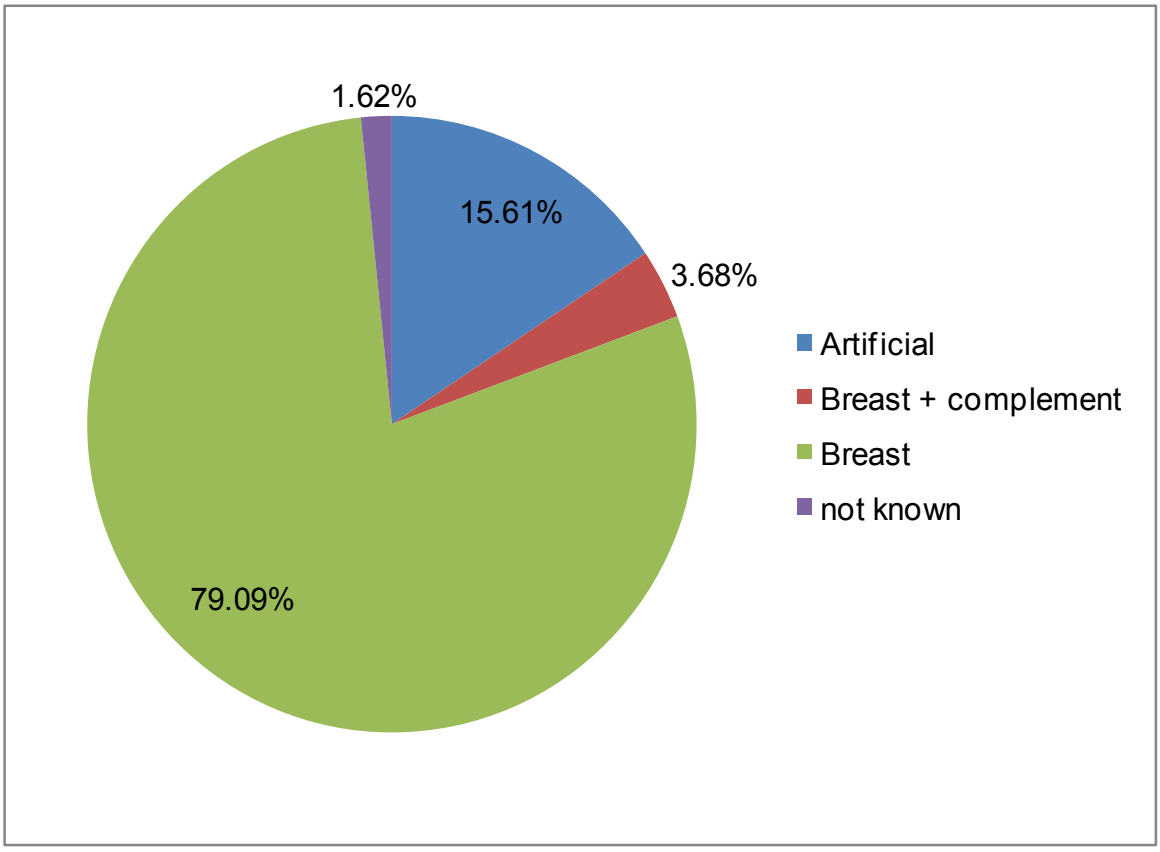
Table 3.10 Birth weight of babies born in Bromley between April 2011 and March 2012

	Bromley		**England**	
Birth weight (grams)	**Number**	**Percentage**	**Number**	**Percentage**
Less than 1,500 g	61	1.65%	5,707	0.96%
1,500 to 2,499 g	164	4.44%	31,008	5.24%
2,500 to 3,499 g	1,829	49.49%	309,292	52.22%
3,500 to 3,999 g	1,184	32.03%	177,059	29.90%
More than 4,000 g	458	12.39%	69,203	11.68%

Breastfeeding, as the earliest nutritional intervention is recognised as promoting health and preventing ill health in the short and long-term for both baby and mother. For baby these include protection against gastroenteritis, respiratory infection, otitis media (inflammation of the ear), urinary tract infections and diabetes mellitus. Studies looking at the long term benefits of breastfeeding for infants suggest lower blood pressure and protection against obesity in childhood (and into adulthood). For the mother, there is a level of protection against pre-menopausal breast, ovarian and endometrial cancers. Breastfeeding can lay the foundations of a close bond between the mother and her child in the early years of life, offering hours of closeness and nurturing everyday.

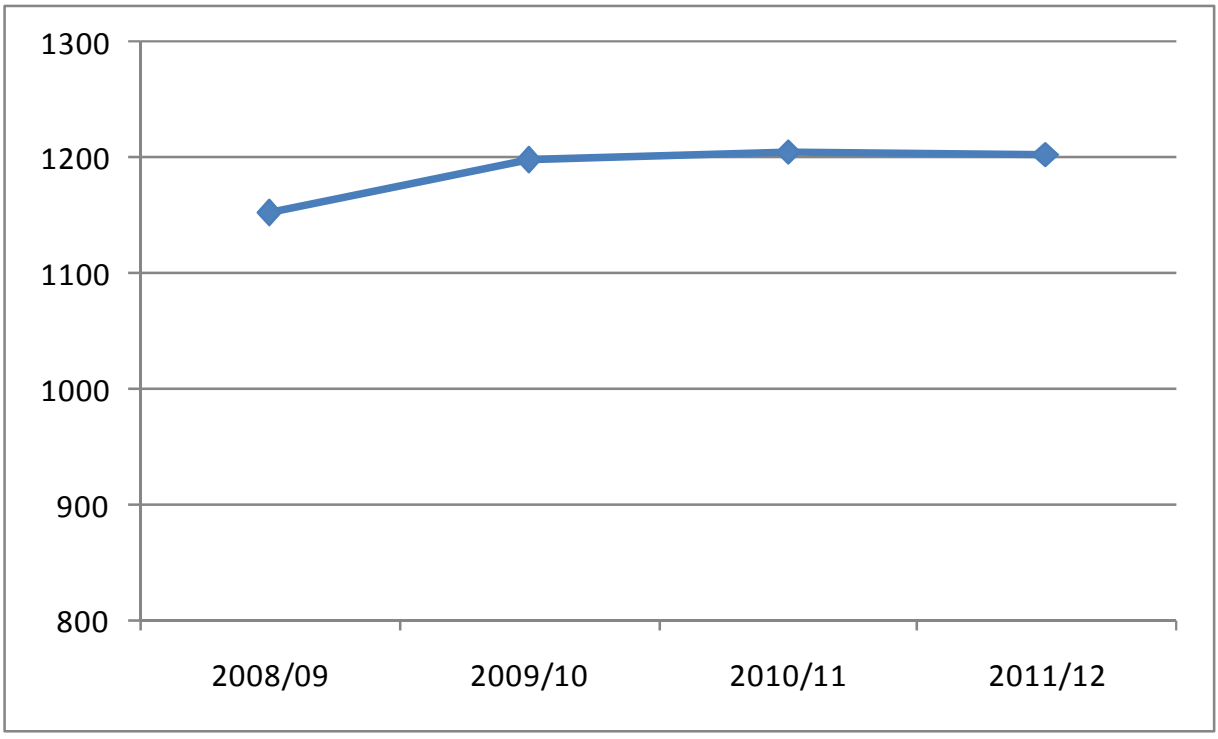
Over 80% of women intended to breast feed at birth in Bromley, either exclusively or with complement.

Figure 3.39 Feeding intention at birth of Bromley women, April 2011 to March 2012



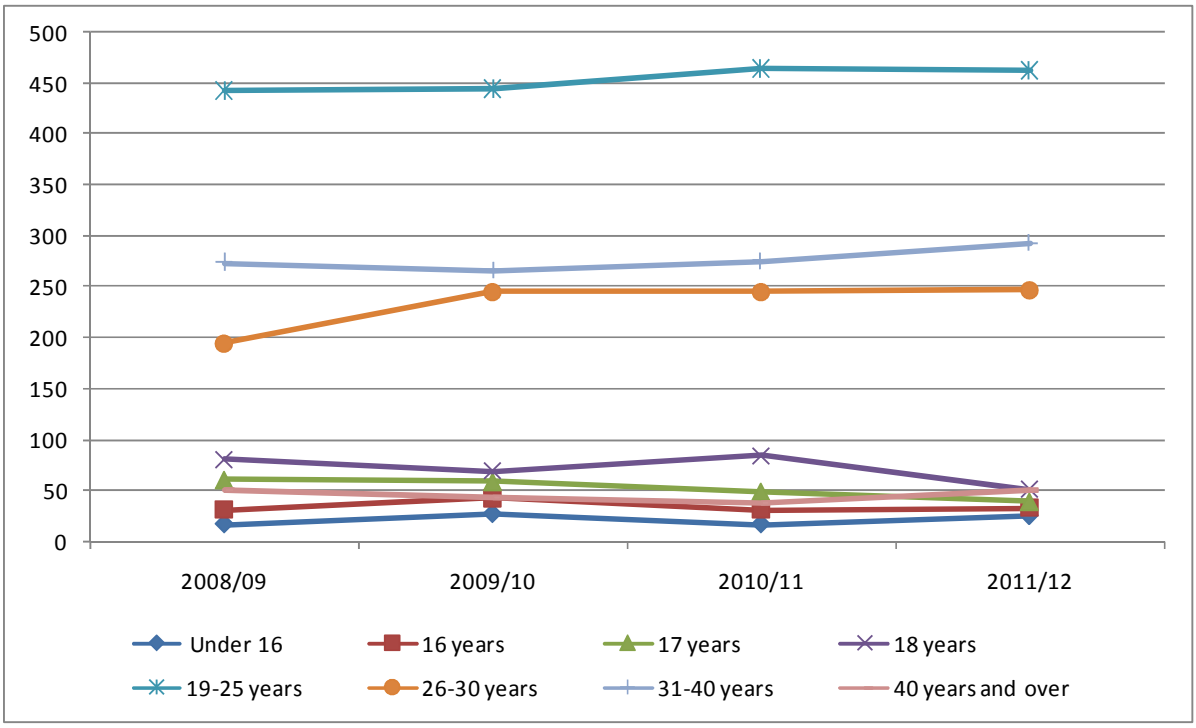
The number of terminations of pregnancies in Bromley has remained steady at approximately 1,200 terminations per year for the last three years.

Figure 3.40 Number of terminations of pregnancies in Bromley women between 2008 and 2012



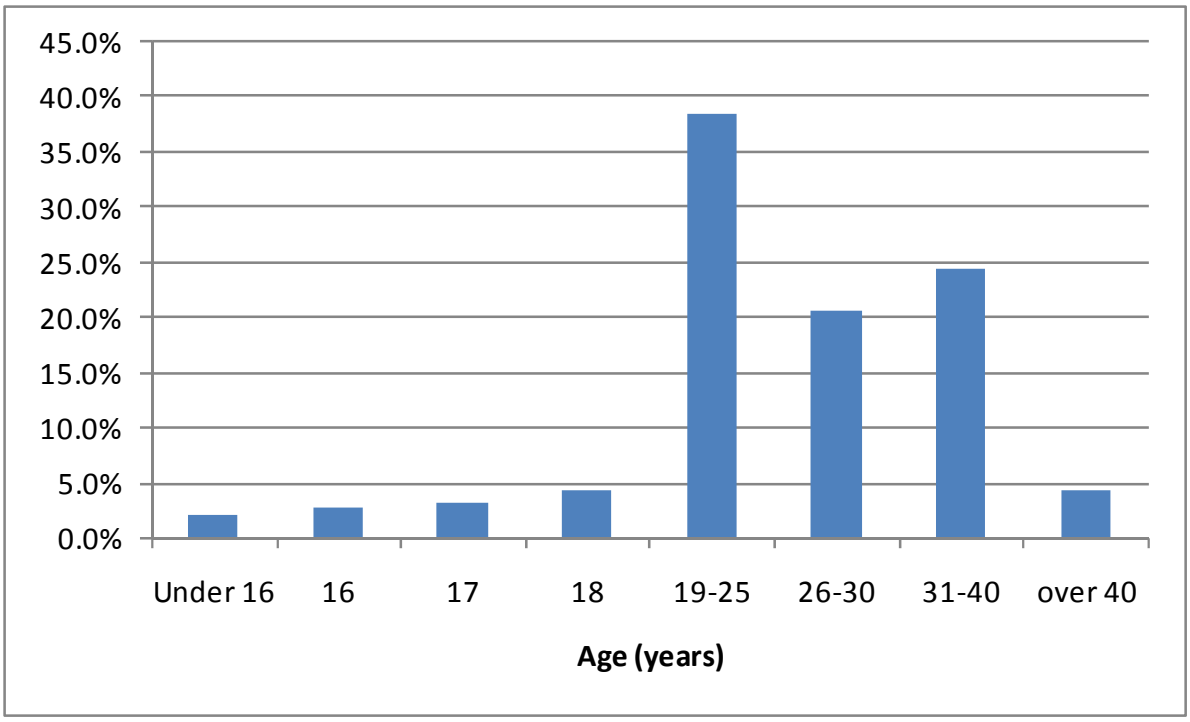
Women aged between 19 and 25 years have consistently had the highest number of terminations over four years (between 2008 and 2012). The number of terminations in women aged between 31 and 40 years has increased slightly over the same time period.

Figure 3.41 Number of terminations of pregnancies in Bromley, by age of female, between 2008 and 2012



During 2011/12, the highest proportions of terminations can be found in women aged 19-25 years. Over 80% of terminations were in women aged between 19 and 40 years old.

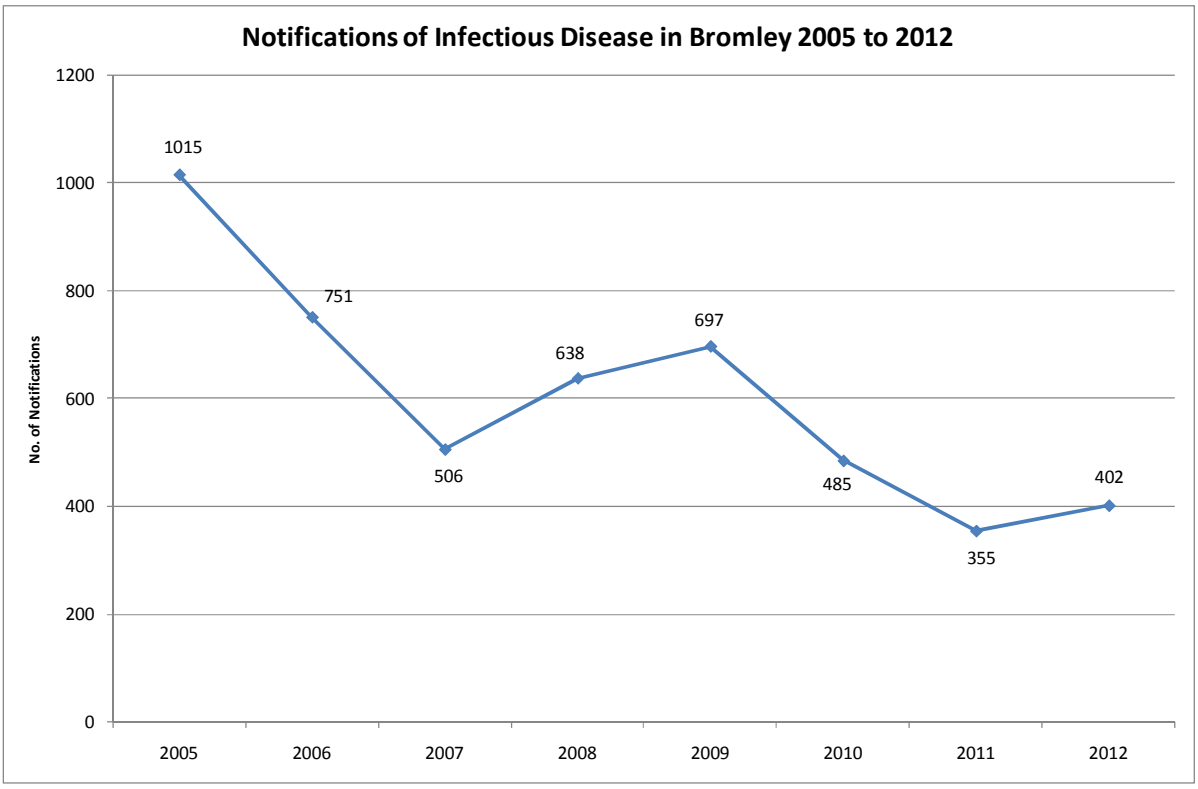
Figure 3.42 Proportion of terminations in Bromley women in 2011/12, by age


45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Under 16
16
17
18
19-25
26-30
31-40
over 40
Age (years)

Infectious Disease

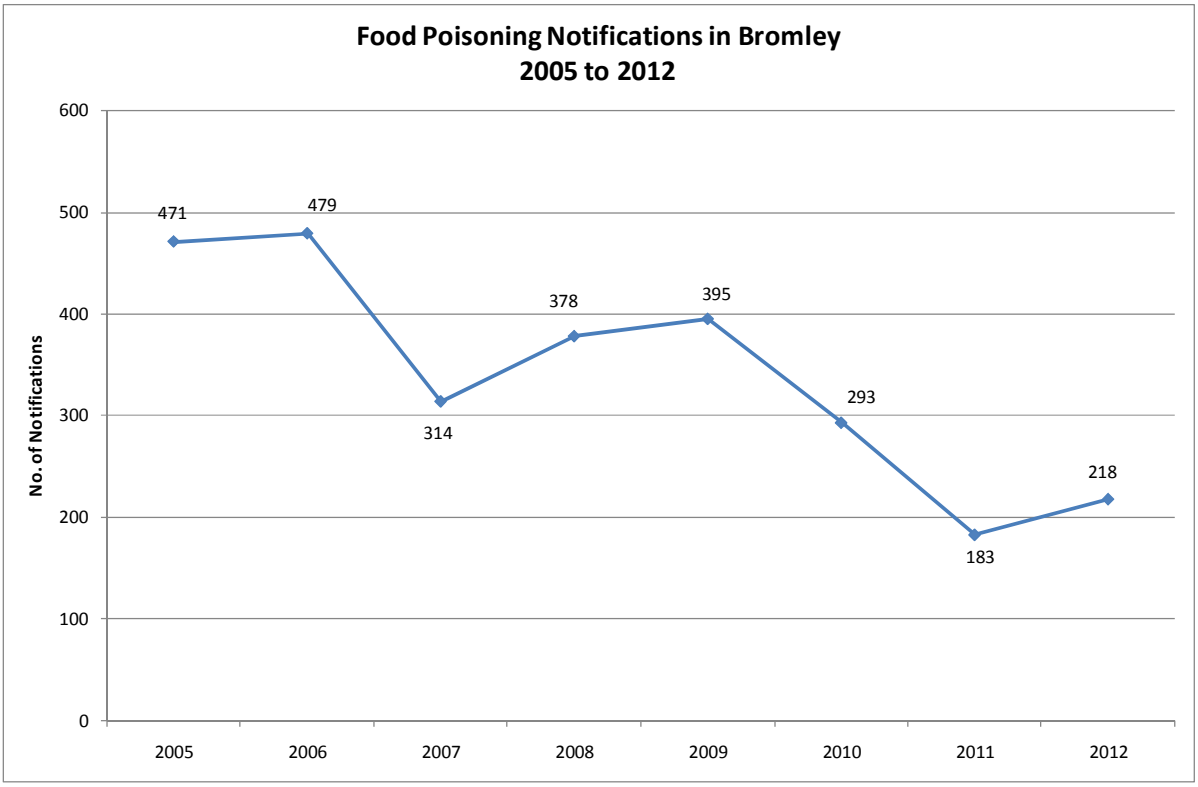
Notifications of infectious disease in Bromley have fallen to less than half the 2005 level. Food poisoning remains the most frequently notified infectious disease, although levels have more than halved since 2005.

Figure 3.43



Source: SELHPU

Figure 3.44



Source: SELHPU

The numbers of notifications of measles and mumps have subsided since the peaks in 2008 and 2009.

Of concern is the increase in the number of cases of whooping cough (Pertussis) in 2012. This is in line with the national trend. In Bromley, most cases have occurred in adults aged over 25 years. Babies under the age of three months are at particular risk, as they have not yet had the opportunity to be vaccinated. Therefore a campaign to vaccinate pregnant mothers against Pertussis has been implemented to reduce the risks to the newborn.

Tuberculosis rates have remained stable, and so awareness is important to facilitate early identification, so that screening and treatment can be instituted to prevent spread.

Table 3.11 Infectious Disease Notifications for Bromley

Disease	2005	2006	2007	2008	2009	2010	2011	2012 (weeks 1 to 49)
Dysentery	0	6	2	1	1	0	2	4
Food Poisoning	471	479	314	378	395	293	183	218
Malaria	2	2	13	2	4	2	3	3
Measles	21	56	50	148	86	34	31	27
Meningitis	0	7	11	6	5	2	1	1
Meningococcal Septicaemia	1	3	4	0	5	0	0	0
Mumps	464	97	49	56	109	96	66	67
Enteric Fever (Typhoid/Paratyphoid fever)	1	4	3	0	0	0	1	1
Rubella	5	8	5	3	8	3	6	3
Scarlet Fever	9	44	12	14	45	18	14	22
Tuberculosis	29	40	36	18	32	34	47	34
Viral Hepatitis	6	2	5	5	3	0	1	3
Whooping Cough	6	3	2	7	4	3	0	19
Total	**1015**	**751**	**506**	**638**	**697**	**485**	**355**	**402**

Source: SELHPU

Immunisation

Coverage rates for immunisation have been improving over the past four years, but remain lower than the WHO recommendation of 95%. Rates of immunisation uptake of the preschool booster and 2nd MMR are especially low.

Table 3.12 Immunisation Uptake Rates for Bromley

Immunisation	2008-09	2009-10	2010-11	2011-12
Immunisation rate for children aged 1 who have completed immunisation for diphtheria, tetanus, polio, pertussis, Haemophilus influenzae type b (Hib) - (i.e. all 3 doses of DTaP/IPV/Hib)	75.5%	86.4%	90.6%	95.1%
Immunisation rate for children aged 2 who have completed immunisation for pneumococcal infection (i.e. received Pneumococcal booster) (PCV)	75.4%	79.4%	82.7%	90.0%
Immunisation rate for children aged 2 who have completed immunisation for Haemophilus influenzae type b (Hib), meningitis C (MenC) - (ie received Hib/MenC booster)	82.2%	83.0%	85.7%	91.9%
Immunisation rate for children aged 2 who have completed immunisation for measles, mumps and rubella (MMR) - (i.e. 1 doses of MMR)	82.2%	81.3%	83.6%	91.5%
Immunisation rate for children aged 5 who have completed immunisation for diphtheria, tetanus, polio, pertussis (DTaP/IPV) (i.e. all 4 doses)	74.3%	73.1%	75.7%	87.6%
Immunisation rate for children aged 5 who have completed immunisation for measles, mumps and rubella (MMR) (i.e. 2 doses)	71.1%	70.8%	77.0%	88.5%

Source: COVER

What this means for the JSNA

Prevention, identification and good management of long term conditions (in particular obesity, diabetes, hypertension and HIV) continue to be a priority for Bromley.

Improving immunisation uptake remains a priority in the face of recent outbreaks of infectious diseases such as pertussis.

Lifestyle Risk Factors

Smoking

Smoking is a major risk factor for circulatory disease, cancer and respiratory disease.

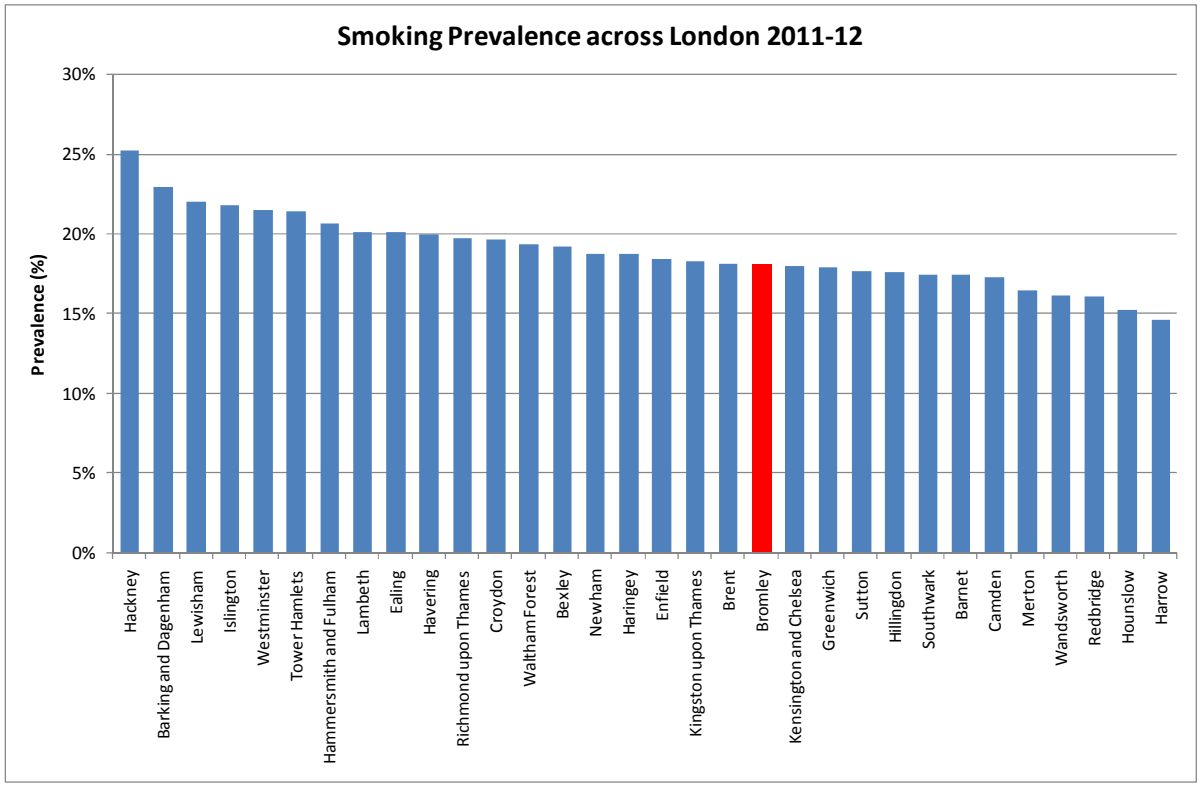
Smoking prevalence in Bromley is estimated to be 18.1% (2011-12) in people aged 18 years and over, as compared with 20.0% for England. Smoking prevalence has been rising since 2009. Bromley has the thirteenth lowest smoking prevalence in London; this is a worsening position. Smoking prevalence in routine and manual occupational groups in Bromley is higher than the general population at 24.3% (2011-12).

Table 3.13 Smoking Prevalence Trend in Bromley

Year	Smoking Prevalence
2009-10	15.5%
2010-11	16.5%
2011-12	18.1%

Source: LHO

Figure 3.45



Source: LHO

Illicit and Niche Tobacco

Over the last few years there has been increasing use of niche tobacco products such as shisha and smokeless tobacco products. Although many people consider shisha to be safe, regular shisha smokers are susceptible to the full range of smoking related diseases. In addition, shisha smoking in enclosed spaces will produce extremely high levels of toxic secondhand smoke and is against the law. Tobacco-free shisha is not safe since it generates dangerous levels of carbon monoxide. Most types of smokeless tobacco contain at least 28 different carcinogenic chemicals. Young people who use smokeless tobacco are more likely to become cigarette smokers.

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

The prevalence of illicit tobacco use (which includes counterfeit or smuggled tobacco) is estimated by HMRC (Her Majesty's Revenue and Customs) to be between 11 and 13% across the country. Illicit tobacco trade is not a harmless activity; it is associated with organised crime, and counterfeit cigarettes regularly contain much higher levels of nicotine than genuine brands, and produce more harmful carbon monoxide. They could also incorporate a seriously unhealthy mix of cancer-causing chemicals including arsenic, cadmium, benzene and formaldehyde – far greater than genuine cigarettes. In addition, the availability of cheap tobacco reduces the economic incentive that some people might have to stop smoking.

A survey was carried out in South East London this year asking 250 smokers in Bromley whether they have been offered cheap cigarettes or hand rolling tobacco in the last year[4].

The results showed that 32.8% of those asked had been offered and 22% had bought cheap tobacco products in the last year. Of those who bought these products, 10.8% said that these represented more than half of their total consumption.

Although neighbouring boroughs such as Greenwich and Lewisham have higher levels of illicit tobacco use, it is also a significant issue in Bromley.

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

Obesity

Obesity is a key risk factor for circulatory disease and cancer, and also for diabetes, which is a precursor to circulatory disease.

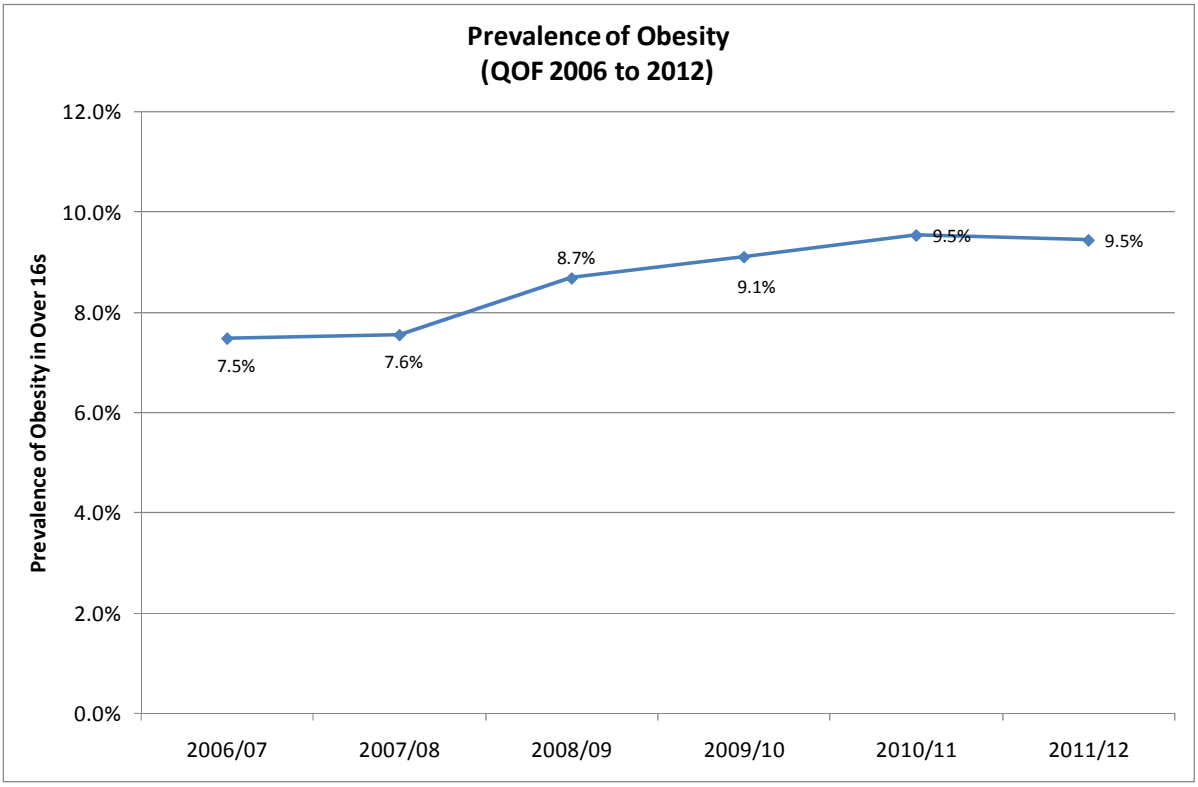
Obesity has an attributable risk for Type 2 diabetes of 24%. Therefore, any changes in the prevalence of obesity will have significant impact on the prevalence of diabetes.

The 2012 Health Profile gives a modelled estimate for obesity prevalence in Bromley of 21.8% of those aged 16 years and over. This represents approximately 54,163 adults in Bromley.

Currently, GP registers have identified 25,663 (approximately 10% of the registered adult population) people over 16 years in Bromley with a BMI >30, indicating obesity. This figure is an underestimate of the true burden of obesity in Bromley.

Levels of obesity recorded in practices have been rising over the past few years, but there was little change since last year.

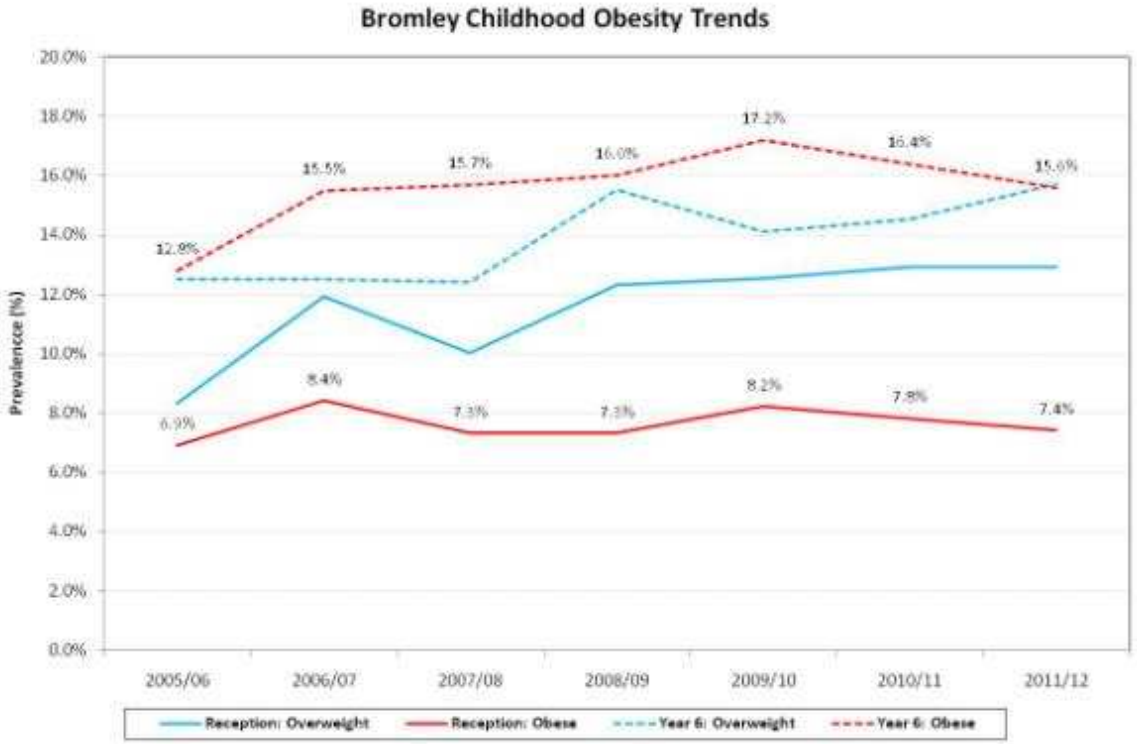
Figure 3.46



Source: QMAS

Data collected for Bromley as part of the National Child Measurement Programme (NCMP) show rising trends in the prevalence of overweight in children in Reception Year and Year 6 with a slight drop in the prevalence of obesity in the same age groups. Childhood obesity levels are below the London and national level.

Figure 3.47



Source: NCMP, NHS IC

Table 3.14

Year Group	2011 – 2012		
	Bromley	**London**	**National**
Reception: Overweight	12.9%	12.4%	13.1%
Reception: Obese	7.4%	11.0%	9.5%
Year 6: Overweight	15.7%	15.0%	14.7%
Year 6:Obese	15.6%	22.5%	19.2%

Source: NCMP, NHS IC

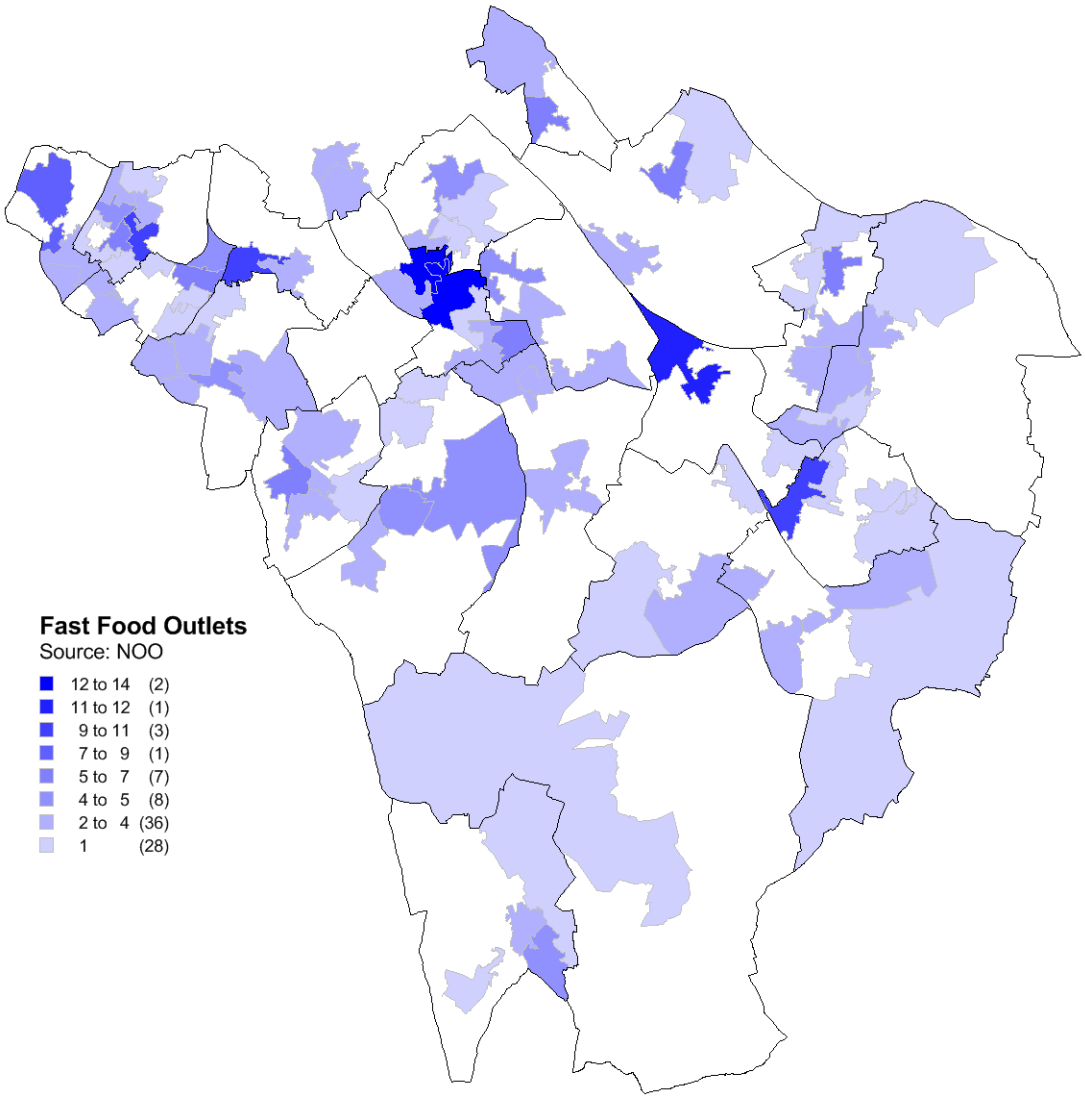
Fast Food Outlets

Nowadays people generally have easy access to cheap, highly palatable and energy-dense food frequently lacking in nutritional value - such as fast food. Research into the link between food availability and obesity is still relatively undeveloped.[5]. Evidence from the USA has identified higher rates of obesity in local communities with high concentrations of fast food outlets[2].

In Bromley, the highest concentrations of fast food outlets are in the town centres – Bromley, Orpington, Petts Wood and Beckenham.

1. Townshend T, Lake A. Obesogenic urban form: theory, policy and practice. Health & Place 2009 Dec;15(4):909–16.
2. Zenk, S. N., Schulz, A.J., &Odoms-Young, A. M. (2009). How neighbourhood environments contribute to obesity. Am J Nurs, 109 (7), 61-64.

Figure 3.48 Numbers of Fast Food Outlets



Physical Activity

Physical inactivity is a leading risk factor for mortality, accounting for 6% of deaths globally.

Physical activity is important throughout the life course:

- It is central to optimal growth and development in the under 5s, in relation to developing motor skills, promoting healthy weight, enhancing bone and muscular development and for the learning of social skills.
- For 5 to 18 year olds, regular physical activity results in reduced body fat, promotes healthy weight and enhances bone and cardio-metabolic health, as well as enhancing psychological wellbeing.
- For adults aged 19 to 64 years, regular physical activity reduces the risk of all-cause mortality, coronary heart disease, stroke, type 2 diabetes, osteoporosis,

some cancers and depression, as well as bringing many positive benefits for psychological health and well-being.

- Evidence shows that increasing physical activity in older adults, over the age of 65 years, improves cardiovascular fitness, strength and physical function, reduces aspects of cognitive decline and susceptibility to falls, and can improve self-esteem and mood.

Physical activity includes all forms of activity, such as everyday walking and cycling, active play, work related activity, active recreation, dancing, gardening or playing active games as well as organised and competitive sport.

There is scope to increase levels of physical participation in Bromley. Current levels for adults are below the national average.

Recommended physical activity guidelines are available at:
http://www.nhs.uk/Livewell/fitness/Pages/physical-activity-guidelines-for-adults.aspx

Table 3.15

	Bromley	England Average	England Best
Physically Active Adults	9.6%	11.2%	18.2%

Source: 2012 Health Profile

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

Based on 2008/09 to 2010/11 data, cycling trips[6] in Bromley accounted for 1.2% of all journeys originating in the Borough. The size of the Borough and its outer rural terrain create barriers to cycling. That said, Bromley does have a higher percentage of trips by bicycle than neighbouring boroughs, Bexley (0.4%) and Croydon (1.0%) but is below the outer London average of 1.5% and that of the south sub region of 2.3%.

London Travel Demand Survey data from 2008/09 to 2010/11 shows that approximately 8200 cycle trips are made by Bromley residents on an average weekday (1.2% of all journeys).

The Cycle Potential Analysis tool provided by TfL helps to identify potential cycling trips that are currently made by mechanised mode (car, van or public transport). For Bromley, this analysis concludes that up to 32% of all trips currently made by motorised modes are potentially cyclable by bike. This was calculated on the total number of trips made within Bromley that were no more than 8km, did not include

[6]A **Trip** is a complete door-to-door movement by an individual to achieve a specific purpose (eg to go from home to work).

those made overnight (8pm – 6am), carrying heavy/bulk load, nor any trips involving those under 5 or over 64 years of age or those with a disability.

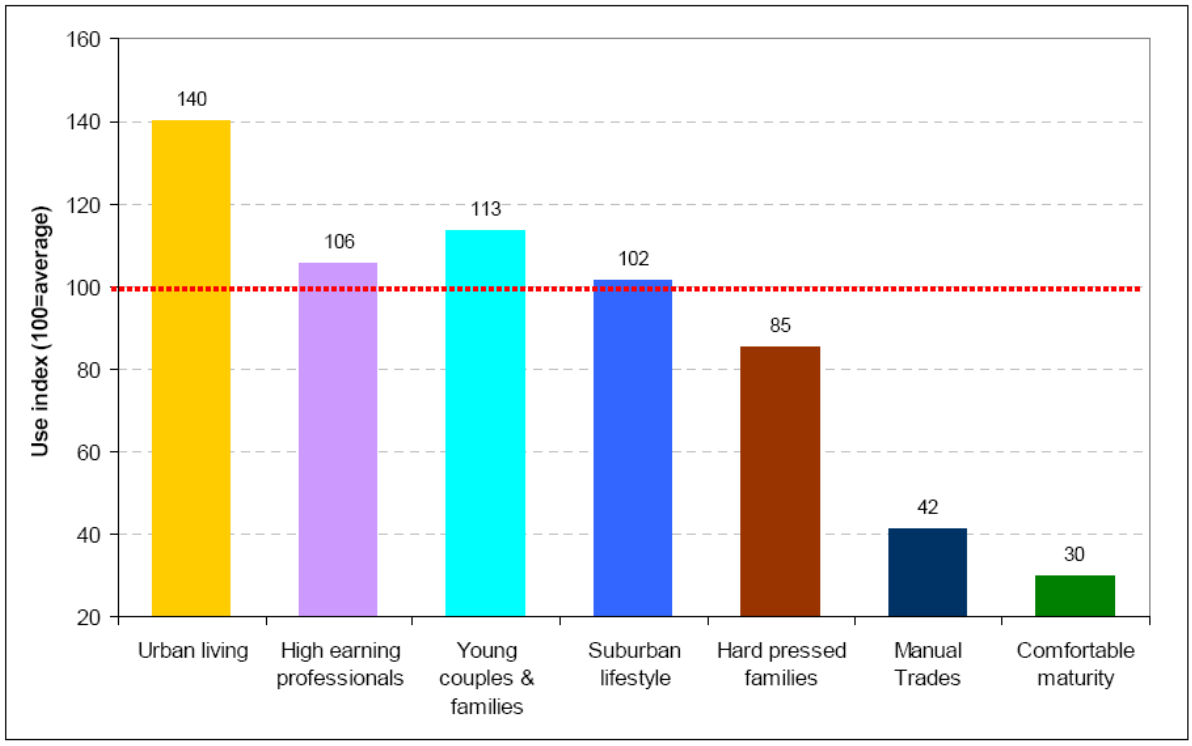
32% of all motorised trips equates to over 210,000 trips a day that could be otherwise made by bicycle. It is important not to assume, however, that because a trip is potentially cyclable and the trip maker is amenable to cycling that the trip would be cycled –there are many things not known about the trip. Largely it depends on what package of measures would be necessary to overcome the barriers to mode shift to cycling.

The Cycle Market Segmentation tool provided by TfL provides boroughs with an insight into population groups most likely to cycle at present and most amenable to cycling in the future.

The 'Cycle Market Segmentation' tool provides data which classifies the population of London into seven segments, each with a different propensity to cycle – see below.

Figure 3.49

PROPENSITY TO CYCLE BY SEGMENT



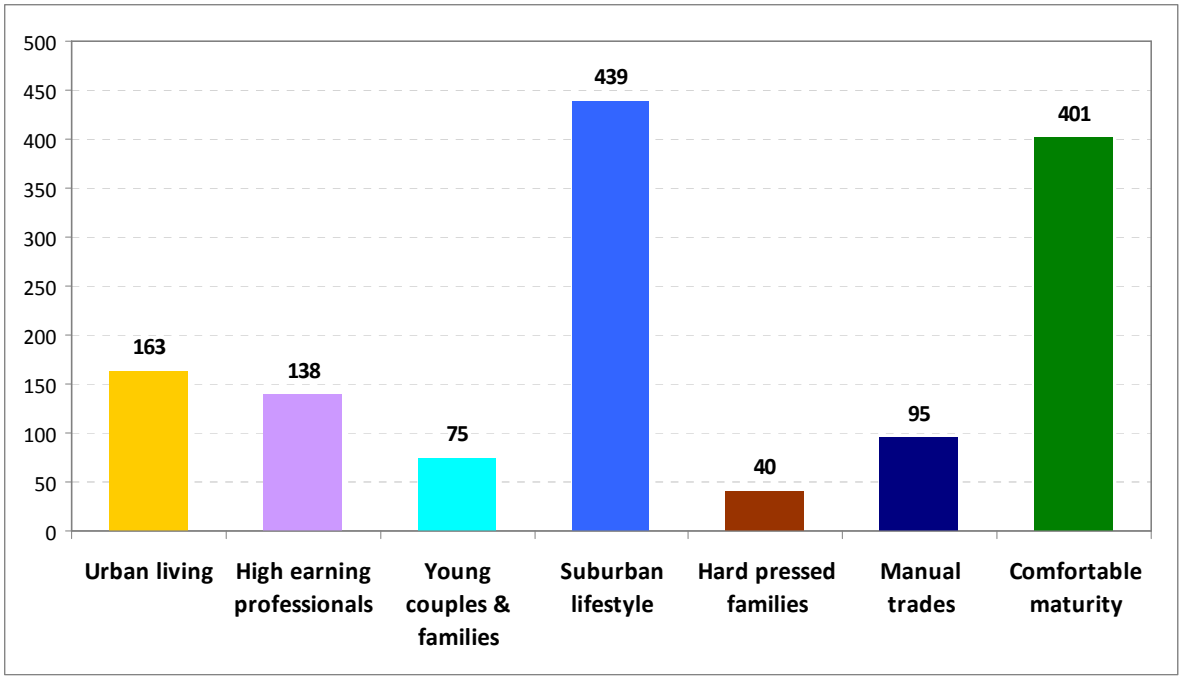
This means that, for example, someone in the *Urban living* segment is 4.6 times as likely to be a cyclist as someone in the *Comfortable maturity* segment. It also means that a Postcode classified as *Urban living* can be expected to generate 4.6 times as many cycling trips as a *Comfortable maturity* Postcode of comparative population.

Applying market segmentation to Bromley

Taking the above segmentation information and applying it to the demographics of Bromley allows for more detailed analysis of the borough. In turn, the analysis should help to identify which geographical areas of the borough have the greatest potential for propensity to cycle to be influenced.

Bromley's population is largely made up of *Suburban lifestyle* and *Comfortable maturity* segments. The following graph illustrates the number (surveyed postcodes) of each segment in Bromley.

Figure 3.50 Bromley Cycle Segments (surveyed postcodes)



- *Urban living* households have the greatest propensity to cycle; only 12.1% of the Bromley population fall within this segment.
- *High earning professionals*, *Young couples & families* and *Suburban lifestyle* are segments that all have a higher than average propensity to cycle; in Bromley these represent 10.2%, 5.6% and 32.5% of residents respectively, a total of 48.5% across the Borough.
- Bromley's highest proportion of *Urban living* households reside in the wards of Crystal Palace, Copers Cope, Plaistow & Sundridge and Bromley Town.
- Bromley's highest proportion of *Young couples & families* households reside in the wards of Penge & Cator, Clock House and Crystal Palace.

The cycle segmentation data suggests that certain areas within the borough have greater propensity to take up cycling. Households broadly within Bromley North, Shortlands, Copers Cope, Beckenham and around Crystal Palace have the greatest

propensity and should be areas in which cycling promotion and activity should be targeted to generate the greatest return.

Households in Orpington, Penge and The Crays are predominantly *Suburban Lifestyles* and therefore also have a higher than average propensity to cycle.

What this means for the JSNA

Smoking prevalence is rising and there is evidence of illicit tobacco trading.

The prevalence of obesity is still a matter for concern.

There is scope to increase levels of physical activity participation in Bromley.

The Places where People Live

4. Renewal Areas

Background : Inequalities Highlighted in the JSNA 2011

Last year the JSNA began exploring the implications of the Marmot Review (2010) which recommended that action on health inequalities would require action across all the social determinants of health, specifically setting out six policy objectives, one of which was to create and develop healthy and sustainable places and communities.

Although deprivation scores for Bromley are low overall, there is considerable variation across different areas in the borough, resulting in about 5% of Bromley's population living in the most deprived quintiles of the country.

The deprivation indices highlighted in the Bromley JSNA 2011 demonstrated concentrations of poorer scores to the north west of the Borough in Crystal Palace, Penge and Anerley, to the north in Mottingham, and to the east in the Cray Valley, as well as centrally at Bromley Common.

In order to improve deprivation scores, action is needed across all of the domains used in establishing the Index of Multiple Deprivation (IMD):

- income,
- employment,
- health deprivation and disability,
- education, skills and training,
- barriers to housing,
- living environment.
- Crime.

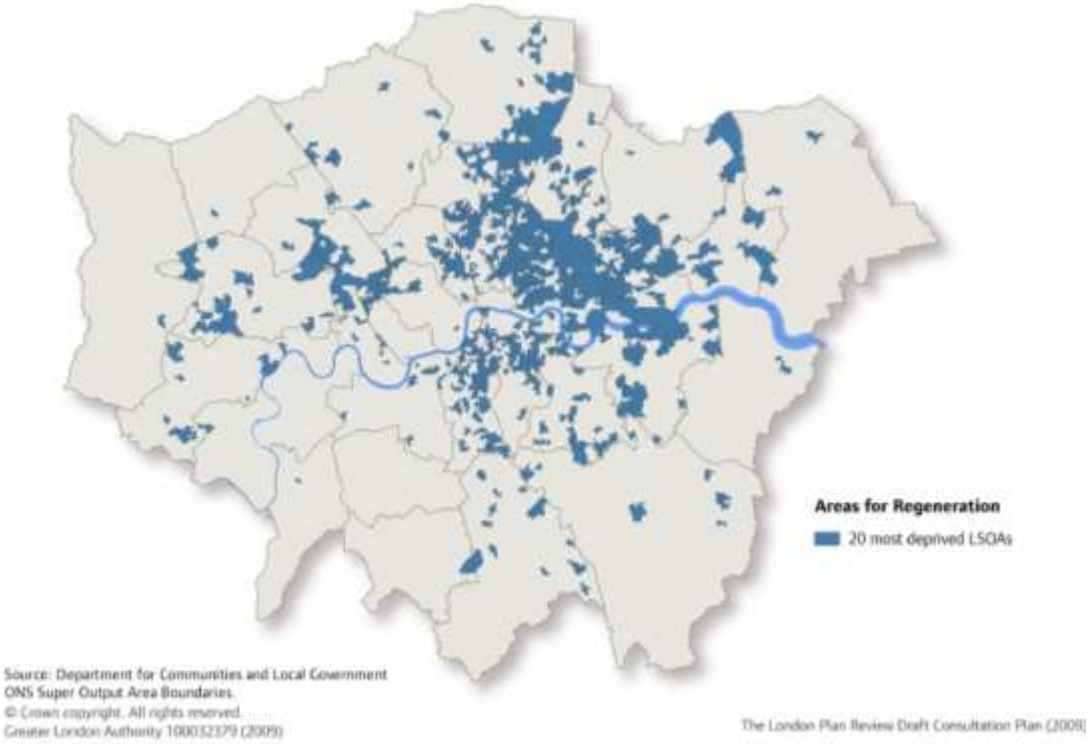
The London Plan Regeneration Areas

The London Plan stresses the Mayor's commitment to addressing social exclusion across London and to tackling spatial concentrations of deprivation (para 2.63).

Regeneration areas are identified in the London Plan based on the domains used in the IMD as above.

London Plan Policy 2.14 states that boroughs should set out integrated spatial policies that bring together regeneration, development and transport proposals with improvements in learning and skills, health, safety, access, employment, environment and housing, in locally-based plans, strategies and policy instruments. These would include Local Plans and Health and Wellbeing Strategies.

Figure 4.1 The Mayors Regeneration Areas (London Plan Map 2.5)



The London Plan Map 2.5 (Figure 4.1) identifies six areas in Bromley as Regeneration Areas, namely:

- Betts Park area
- Maple Rd, Franklin Rd area
- Turpington Lane area
- Cotmandene Cres, Whippendell Way area
- Blacksmith Lane, Wooten Green, Rookery Gardens area
- Quilter Road, Ramsden area

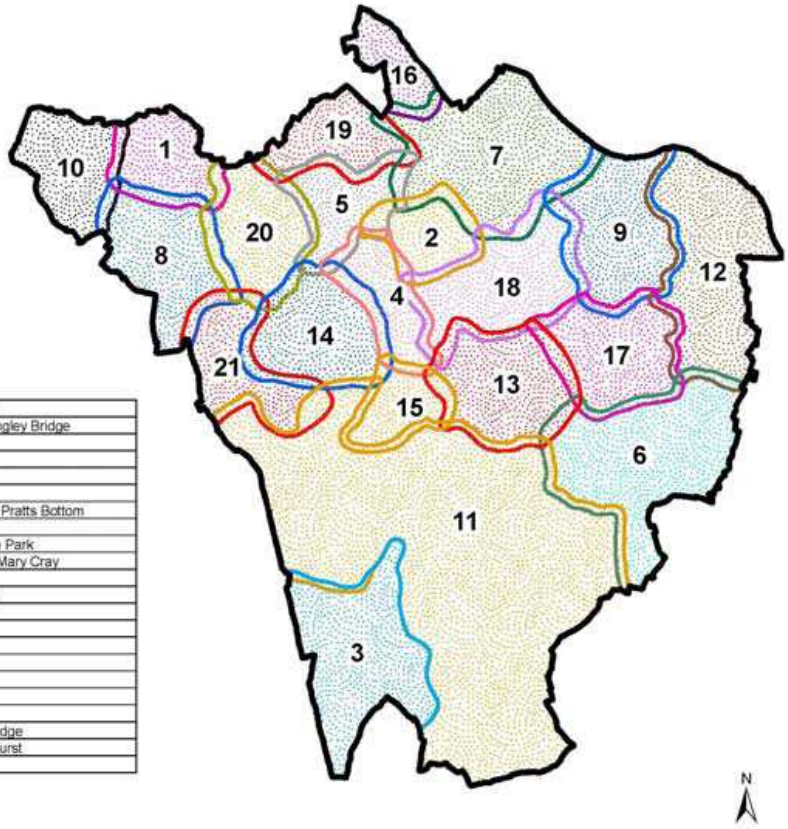
The London Plan also highlights regeneration areas in adjacent boroughs notably in Mottingham.

The areas identified in London Plan map 2.5 are a snapshot in time and relate to very tightly drawn artificial electoral districts. They do not take account of changes taking place over time, the picture in the wider area or other areas where the Council and partner organisations are already seeking to address issues of renewal, notably other parts of Crystal Palace, Penge & Anerley, the Cray Valley and Mottingham.

Bromley's Renewal Areas

Bromley Council is currently preparing its Local Plan which seeks to steer development to appropriate locations over the next 15 – 20 years. In order to understand the various places within the Borough and to anticipate how future development can be best directed in the interests of people locally and across the borough as a whole, the Core Strategy Issues Document has loosely defined 21 distinct local places.

Figure 4.2

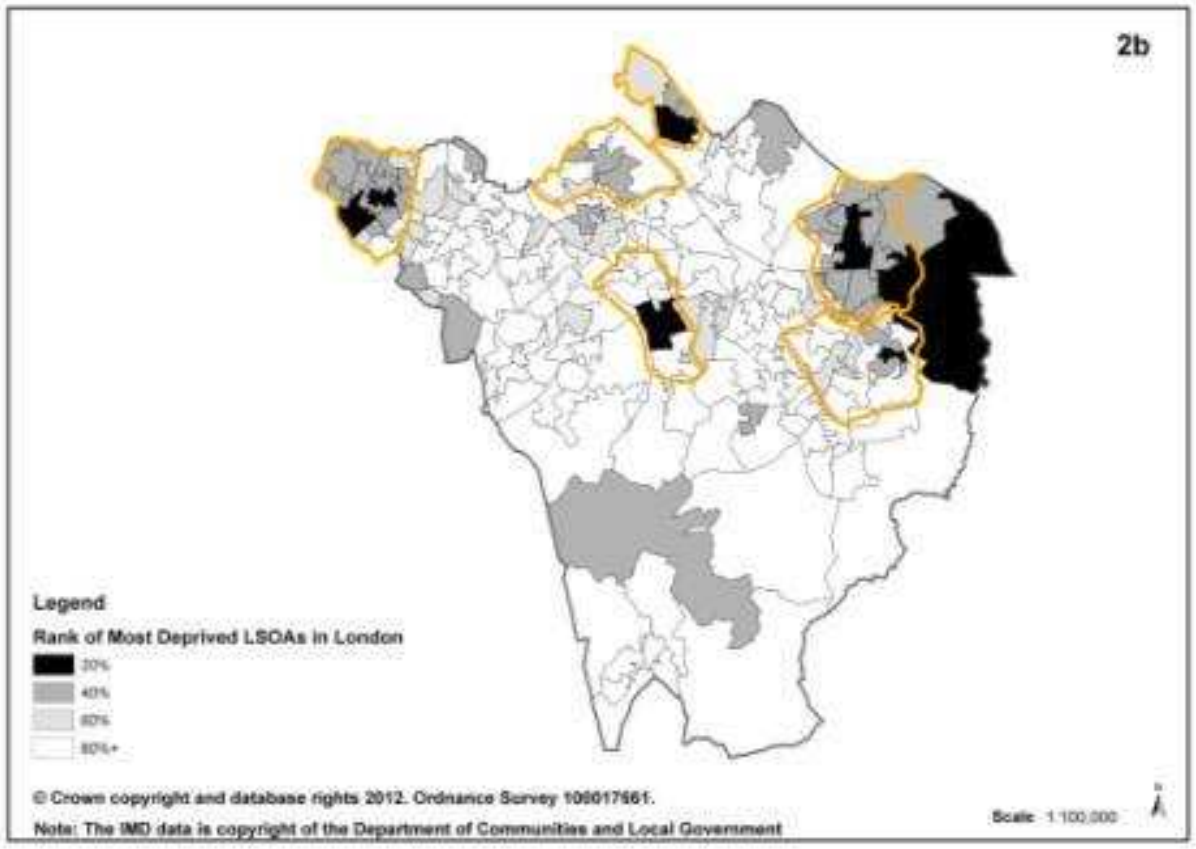


Number	Place Name
1	Beckenham Coppers Cope & Kangley Bridge
2	Bickley
3	Biggin Hill
4	Bromley Common
5	Bromley Town
6	Chelsfield, Green Street Green & Pratts Bottom
7	Chislehurst
8	Clock House, Elmers End & Eden Park
9	Cray Valley, St Paul's Cray & St. Mary Cray
10	Crystal Palace Penge & Anerley
11	Darwin & Green Belt Settlements
12	Eastern Green Belt
13	Farnborough & Crofton
14	Hayes
15	Keston
16	Mottingham
17	Orpington, Goddington & Knoll
18	Petts Wood & Surrounds
19	Ravensbourne, Plaistow & Sundridge
20	Shortlands, Park Langley & Pickhurst
21	West Wickham & Coney Hall

In response to the London Plan Regeneration Areas Policy (Policy 2.14), six of the Bromley "Places" are being identified in the evolving Local Plan as five Renewal Areas (two adjacent places comprising a single "Cray Valley" Renewal Area). These designations are proposed, in order that development within the Renewal Areas can assist in supporting the regeneration of the deprived lower super output areas identified by the Mayor

- "Crystal Palace, Penge & Anerley"
- "Bromley Common"
- "The Cray Valley", (combining "Cray Valley, St Paul's Cray & St Mary Cray" with "Orpington, Goddington & Knoll"
- "Mottingham" (abutting Lewisham and Greenwich regeneration areas)
- "Ravensbourne Plaistow & Sundridge" (abutting a Lewisham regeneration area)

Figure 4.3



The Mayor's Regeneration Areas can benefit from development within the Borough's wider Renewal Areas. Whilst the "Places" within the Renewal Areas contain or abut regeneration areas highlighted by the Mayor, they do not necessarily all exhibit significant levels of deprivation throughout. Notably, "Orpington, Goddington & Knoll" and "Ravensbourne Plaistow & Sundridge".

For the purposes of the JSNA it is appropriate to focus on four "Places" within Bromley's proposed renewal areas where the deprivation indices demonstrate particular needs, namely

- "Crystal Palace, Penge & Anerley"
- "Bromley Common"
- "Cray Valley, St Paul's Cray & St Mary Cray"
- "Mottingham"

In this section, we describe indicators of the wider determinants of health and health outcomes for each of the renewal areas.

The Indicators

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

Air Quality

Air pollution increases the risk of respiratory and heart disease in the population. Both short and long term exposure to air pollutants have been associated to health impacts. More severe impacts affect people who are already ill. Children, the elderly and poor people are more susceptible.

In the UK national air quality objectives have been put in place to protect people's health and the environment. If a local authority finds any places where the objectives are not likely to be achieved, it must declare an Air Quality Management Area (AQMA) there.

The UK Air Quality Objective for nitrogen dioxide sets an annual mean limit of 40µg/m^3.

Childhood Obesity

Being overweight or obese in childhood has consequences for health in both the short term and the longer term. Once established, obesity is notoriously difficult to treat, so prevention and early intervention are very important.

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

Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity – for example, raised blood pressure, fatty changes to the arterial linings and hormonal and chemical changes such as raised cholesterol and metabolic syndrome – can be identified in obese children and adolescents.

Some obesity-related conditions can develop during childhood. Type 2 diabetes, previously considered an adult disease, has increased dramatically in overweight children as young as five, and has been dubbed ‘diabesity’.

Crime

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

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

Cycling

There is a strong body of evidence supporting the link between physical activity and benefits to health. Cycling is ideally placed to contribute to overall activity levels as it is one of the few activities that can be carried out as part of daily life.

Transport for London have developed a Cycle Market Segmentation Tool which provides boroughs with an insight into the population groups most likely to cycle at present and most amenable to cycling in the future. *Urban Living* households have the greatest propensity to cycle, *High Earning Professionals, Young Couples & Families,* and *Suburban Lifestyle* are segments that have a higher than average propensity to cycle.

Demography

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

Disease Burden

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

therefore, consideration should be given to addressing the wider determinants of health.

Education

People with more education (years and qualifications) are likely to live longer, to experience better health outcomes, and to practice health-promoting behaviours such as exercising regularly, refraining from smoking, and obtaining timely health care check-ups and screenings

Two indicators of educational attainment are included: the percentage achieving Level 4+ in English and Maths at Key Stage 2, and the % achieving 5+A*-C including English and maths at GCSE. In addition, school absence is included as an indicator, measuring the percentage of overall absence in a school.

Employment

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

Fuel Poverty

Fuel poverty means being unable to afford to keep warm. A household is considered to be in fuel poverty if it needs to spend more than 10 percent of its income on fuel for adequate heating (usually 21 degrees for the main living area, and 18 degrees for other occupied rooms).

Living in cold homes can damage people's health and affect their quality of life. The elderly, children, and those with a disability or long-term illness are especially vulnerable. It is estimated that fuel poverty is the cause of 10% of excess winter deaths. Children living in cold homes are twice as likely to suffer from chest problems, asthma and bronchitis.

There are three main causes of fuel poverty:

- Poor energy efficiency in the home
- High energy prices
- Low household income

Green Spaces

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

and absorb airborne pollutants. Shading needs to be provided to reduce the risk of people over heating and sunburn.

Housing

Housing conditions affect people's health. Inadequate housing causes or contributes to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer. There is some evidence that overcrowded housing has a negative impact on health[2].

Income

Individual incomes matter to health because of their link with both material deprivation (absence of clean water, good sanitation, adequate nutrition, adequate housing and warmth) and restriction on social participation and opportunity to exercise control over one's life. Above a threshold of material deprivation, income may be more important because of its link with these social factors related to social conditions[1].

Life Expectancy

Life expectancy at birth is defined as the average number of years that a newborn could expect to live, if he or she were subject to the age-specific mortality rates of a given period. In Bromley the average life expectancy for males is 80.3 years and for females 84.3 years. Lower levels of life expectancy represent higher numbers of deaths at younger ages.

Public Transport Accessibility levels (PTAL)

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

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

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

Teenage Pregnancy

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

These include: higher rates of infant mortality than for children born to older mothers, babies are more likely to be born prematurely, which has serious implications for the baby's long-term health and children have higher rates of admissions to A&E.
In the longer term, children of teenage mothers experience lower educational attainment and are at higher risk of economic inactivity as adults.

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

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

Wellbeing Scores

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

The 12 measures included are shown in the table below:

Category	**Indicator**
Health	Life and Expectancy
	Incapacity Benefits claimant rate
Economic security	Unemployment rate
	Income Support claimant rate
Safety	Crime rate
	Deliberate Fires
Education	GCSE point scores
Children	Unauthorised Pupil Absence

Families	Children in out-of-work families
Transport	Public Transport Accessibility Scores
Environment	Access to public open space & nature
Community	Elections Turnout

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

1. *The Impact of Overcrowding on Health and Education: A Review of Evidence and Literature ODPM, May 2004.*
2. *The Influence of Income on Health: Views of an Epidemiologist, Michael Marmot. Health Affairs, March/April 2002.*

Crystal Palace, Penge & Anerley

Demography
Total Population: 32,584
Older People: 8.1% (Bromley: 15.5%)
Children: 8.2% (Bromley: 6.3%)
Young People: 23.9% (Bromley: 23.2%)
BME: 31.8% (Bromley: 13.5%)
Deprivation: 27.71 (Bromley: 14.95)
Lone Parent Households:16.2% (Bromley: 6.2%)
Lone Pensioner Households: 5.1% (Bromley: 14.6%)

Crime (rate per 1000 population)
Violence:24.4 (Bromley: 14.3)
Sexual Offences: 1.8 (Bromley: 0.7)
Robbery: 6.2 (Bromley: 2.0)
Burglary: 15.5 (Bromley: 11.9)
Theft & Handling: 25 (Bromley: 25)
Fraud or Forgery: 4.0 (Bromley: 4.3)
Criminal Damage: 10.3 (Bromley: 7.9)
Drugs: 7.5 (Bromley: 3.3)

Life Expectancy
Males: 75.5 years (Bromley: 79.4yrs)
Females: 81.3 years (Bromley: 83.5yrs)

Wellbeing Score:
Crystal Palace= -10
Penge & Cator = -6
(Bromley wards range: 11 to -11)

Air Quality
This area is part of the Air Quality Management Area (AQMA).
Annual Mean of NO2: 31.2µgm^3
(Target: <40µgm^3)

Public Transport Accessibility
PTAL: 4.2 (Bromley range: 1 to 6)

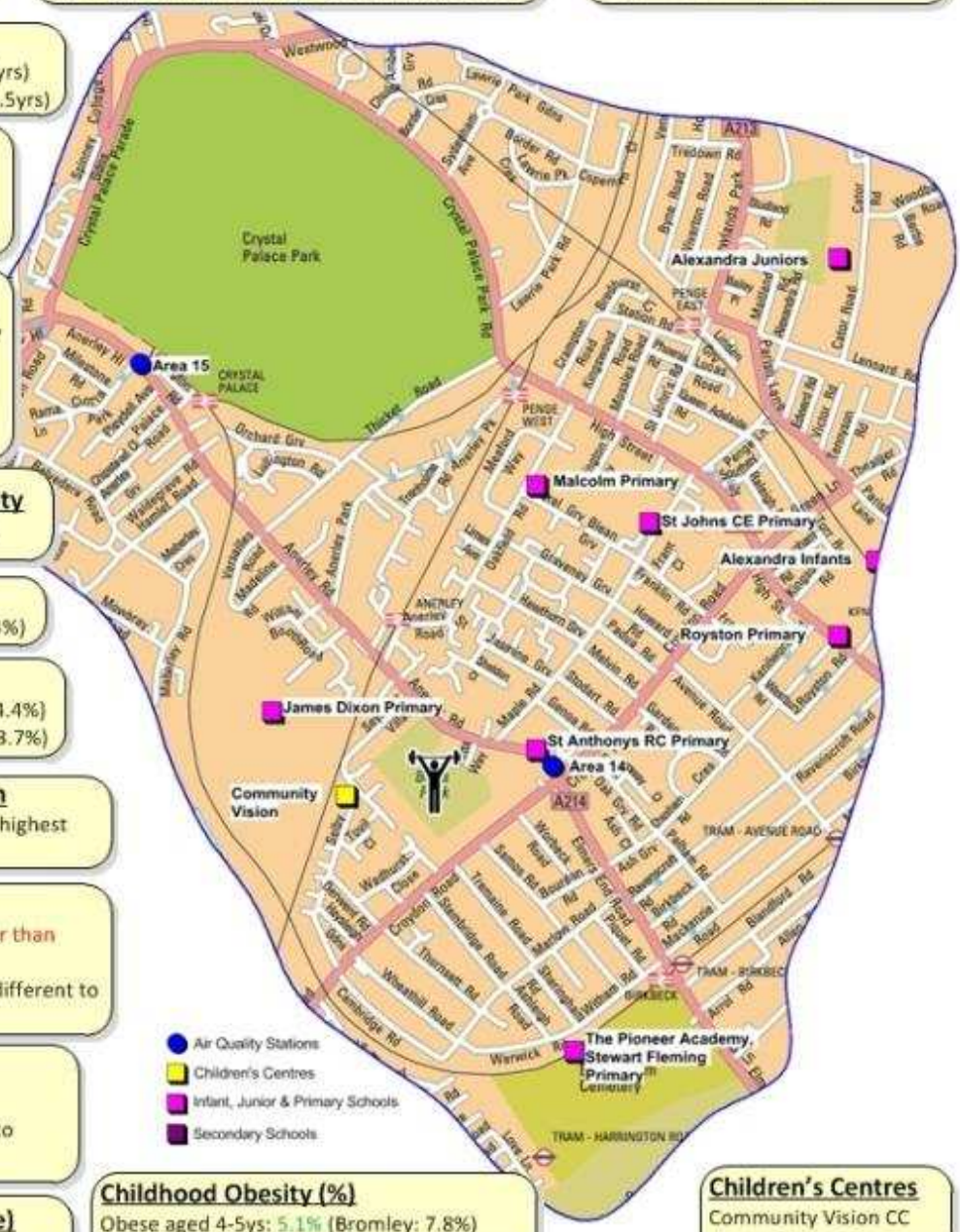
Housing
Overcrowding: 4.3% (Bromley 6.4%)

Income
Employment: 70.2% (Bromley: 74.4%)
Claimant Count: 7.8% (Bromley: 3.7%)

Cycle Market Segmentation
Households in this area have the highest propensity to cycle.

Teenage Pregnancy
Crystal Palace: Significantly higher than England average
Penge & Cator: Not significantly different to England average

Green Spaces
Green space area: 37.3%
Homes with deficiency in access to nature: 19.2%



Childhood Obesity (%)
Obese aged 4-5ys: 5.1% (Bromley: 7.8%)
Obese aged 10-11ys: 16.7% (Bromley: 16.5%)

Children's Centres
Community Vision CC
James Dixon CC

Disease Burden (Prevalence)
Atrial Fibrillation : 0.6% (Bromley: 1.5%)
CHD : 1.8% (Bromley: 3.1%)
CKD : 1.9% (Bromley: 3.3%)
COPD : 1.1% (Bromley: 1.3%)
Diabetes : 4.3% (Bromley: 5.0%)
Heart Failure : 0.4% (Bromley: 0.7%)
Hypertension : 9.0% (Bromley: 14.2%)
Mental Health : 1.2% (Bromley: 0.8%)
Obesity : 9.6% (Bromley: 9.4%)
Smoking : 17.8% (Bromley: 14.4%)

Educational Attainment:

Alexandra Junior: KS2: 78% (Bromley: 83%)	Absence: 4.2% (Bromley: 4.2%)
James Dixon Primary: KS2: 85% (Bromley: 83%)	Absence: 3.9% (Bromley: 4.2%)
Malcolm Primary: KS2: 67% (Bromley: 83%)	Absence: 4.6% (Bromley: 4.2%)
Royston Primary: KS2: 66% (Bromley: 83%)	Absence: 5.4% (Bromley: 4.2%)
St Anthony's Primary: KS2: 62% (Bromley: 83%)	Absence: 5.5% (Bromley: 4.2%)
St John's Primary: KS2: 62% (Bromley: 83%)	Absence: 3.7% (Bromley: 4.2%)
Stewart Fleming: KS2: 94% (Bromley: 83%)	Absence: 4.4% (Bromley: 4.2%)

3.

Summary of Key Issues

Crystal Palace, Penge and Anerley

This is an area with high levels of deprivation, a young population and a high proportion of people from BME groups. Life expectancy is lower than the Bromley average. Wellbeing scores are lower than average.

Health is negatively impacted by low levels of employment, high smoking prevalence, high crime rate and low educational attainment with higher than average school absence.

Although the overall health burden is low, this reflects the young age of this population. Aside from serious mental illness, for which the prevalence is high in this area, the other long term conditions present later in life and have not yet become apparent, despite the presence of many risk factors for disease, including obesity and smoking.

Teenage pregnancy levels are high.

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Bromley Common

Demography
Total Population: 9,878
Older People: 13.1% (Bromley: 15.5%)
Children: 7.3% (Bromley: 6.3%)
Young People: 24.6% (Bromley: 23.2%)
BME: 12.0% (Bromley: 13.5%)
Deprivation: 15.97 (Bromley: 14.95)
Lone Parent Households: 16.4% (Bromley:6.2%)
Lone Pensioner Households: 6.5% (Bromley: 14.6%)

Crime (rate per 1000 population)
Violence: 13.5 (Bromley: 14.3)
Sexual Offences: 0.7 (Bromley: 0.7)
Robbery: 1.3 (Bromley: 2.0)
Burglary: 8.1 (Bromley: 11.9)
Theft & Handling: 14.9 (Bromley: 25)
Fraud or Forgery: 3.7 (Bromley: 4.3)
Criminal Damage: 7.7 (Bromley: 7.9)
Drugs: 2.8 (Bromley: 3.3)

Life Expectancy
Males: 79.8 years (Bromley: 79.4yrs)
Females: 83.6 years (Bromley: 83.5yrs)

Wellbeing Score:
Bromley Common = 3
(Bromley wards range: 11 to -11)

Public Transport Accessibility
PTAL: 2.3 (Bromley range: 1 to 6)

Housing
Overcrowding: 0.95% (Bromley: 6.4%)

Teenage Pregnancy
Not significant different to England average

Air Quality
Annual Mean NO2:26.4µgm^3 (Target: <40µgm^3)

Income
Employment: 73.5% (Bromley: 74.4%)
Claimant Count: 4.3% (Bromley: 3.7%)

Green Spaces
Green space area: 59.3%
Homes with deficiency in access to nature: 11.5%

Disease Burden (Prevalence)
Atrial Fibrillation : 1.3% (Bromley: 1.5%)
CHD : 3.0% (Bromley: 3.1%)
CKD : 4.6% (Bromley: 3.3%)
COPD : 1.3% (Bromley: 1.3%)
Diabetes : 4.5% (Bromley: 5.0%)
Heart Failure : 0.6% (Bromley: 0.7%)
Hypertension : 11.4% (Bromley: 14.2%)
Mental Health : 0.8% (Bromley: 0.8%)
Obesity : 8.9% (Bromley: 9.4%)
Smoking : 17.7% (Bromley: 14.4%)

Childhood Obesity
Obese aged 4-5ys: 2.6% (Bromley: 7.8%)
Obese aged 10-11ys: 4.4% (Bromley: 16.5%)

Children's Centres
Phoenix Centre

Educational Attainment:

Princes Plain Primary: KS2: 60% (Bromley: 83%)	Absence: 5.1% (Bromley: 4.2%)
Raglan Primary: KS2: 84% (Bromley: 83%)	Absence: 3.7% (Bromley: 4.2%)
The Ravensbourne: GCSE: 60.5% (Bromley: 68%)	Absence: 5.8% (Bromley: 5.4%)
Bishop Justice: GCSE: 63.3% (Bromley: 68%)	Absence: 6.1% (Bromley: 5.4%)

Summary of Key Issues

Bromley Common

This is an area of high levels of deprivation and a high proportion of lone parent households.

Employment levels are lower than the Bromley average. Educational attainment is lower than average, with higher than average levels of school absence.

The disease burden is average for Bromley, but smoking prevalence is high.

Mottingham

Demography
Total Population: 8,886
Older People: 13.5% (Bromley: 15.5%)
Children: 7.9% (Bromley: 6.3%)
Young People: 26.7% (Bromley: 23.2%)
BME: 11.3% (Bromley: 13.5%)
Deprivation: 32.09 (Bromley: 14.95)
Lone Parent Households:11.7% (Bromley: 6.2%)
Lone Pensioner Households: 7.41% (Bromley: 14.6%)

Crime (rate per 1000 population)
Violence: 20.6 (Bromley: 14.3)
Sexual Offences: 0.7 (Bromley: 0.7)
Robbery: 1.4 (Bromley: 2)
Burglary: 11.3 (Bromley: 11.9)
Theft & Handling: 28.9 (Bromley: 25)
Fraud or Forgery: 10.6 (Bromley: 4.0)
Criminal Damage: 12.8 (Bromley: 10.3)
Drugs: 3.8 (Bromley: 3.3)

Wellbeing Score:
Mottingham & Chislehurst North = -11
"Worsening year on year"
(Bromley wards range: 11 to -11)

Life Expectancy
Males: 76.6 years (Bromley: 79.4yrs)
Females: 81.2 years (Bromley: 83.5yrs)

Public Transport Accessibility
PTAL: 2.6 (Bromley range: 1 to 6)

Housing
Overcrowding: 1.72% (Bromley: 6.4%)

Teenage Pregnancy
U18: Significantly higher than England average

Air Quality
Annual Mean NO2: 29.1µgm^3 (Target: <40µgm^3)

Income
Employment: 67.5% (Bromley: 74.4%)
Claimant Count: 7.3% (Bromley: 6.4%)

Green Spaces
Green space area: 44.4%
Homes with deficiency in access to nature: 0%

Disease Burden (Prevalence)
Atrial Fibrillation : 1.0% (Bromley: 1.5%)
CHD : 2.1% (Bromley: 3.1%)
CKD : 3.6% (Bromley: 3.3%)
COPD : 1.6% (Bromley: 1.3%)
Diabetes : 4.2% (Bromley: 5.0%)
Heart Failure : 0.6% (Bromley: 0.7%)
Hypertension : 10.2% (Bromley: 14.2%)
Mental Health : 0.9% (Bromley: 0.8%)
Obesity : 8.8% (Bromley: 9.4%)
Smoking : 17.4% (Bromley: 14.4%)

Childhood Obesity
Obese aged 4-5ys: 11.0% (Bromley: 7.8%)
Obese aged 10-11ys: 12.0% (Bromley: 16.5%)

Children's Centres
Castlecombe

Educational Attainment:

Castlecombe Primary: KS2: 90% (Bromley: 83%)	Absence: 5.6% (Bromley: 4.2%)
Mottingham Primary: KS2: 83% (Bromley: 83%)	Absence: 5.2% (Bromley: 4.2%)
St Vincents RC Primary: KS2: 88% (Bromley: 83%)	Absence: 4.1% (Bromley: 4.2%)

Summary of Key Issues

Mottingham

This area has very high levels of deprivation and a high proportion of lone parent households. Life expectancy is below the Bromley average. There are high rates of crime and low levels of employment. Although levels of school absence are higher than average, there is above average educational attainment. Wellbeing scores are not only low, but worsening year on year. There is an above average prevalence of respiratory disease and smoking as well as serious mental illness. Public transport accessibility in this area is low.

Cray Valley, St Pauls Cray & St Marys Cray

Demography
Total Population: 22,916
Older People: 14.5% (Bromley: 15.5%)
Children: 7.7% (Bromley: 6.3%)
Young People: 27.4% (Bromley: 23.2%)
BME: 8.2% (Bromley: 13.5%)
Deprivation: 31.91 (Bromley: 14.95)
Lone Parent Households:14.3% (Bromley: 6.2%)
Lone Pensioner Households: 6.9% (Bromley: 14.6%)

Crime (rate per 1000 population)
Violence: 21.8 (Bromley: 14.3)
Sexual Offences: 1.0 (Bromley: 0.7)
Robbery: 1.8 (Bromley: 2)
Burglary: 17.1 (Bromley: 11.9)
Theft & Handling: 30.9 (Bromley: 25)
Fraud or Forgery: 6.0 (Bromley: 4.3)
Criminal Damage: 17.1 (Bromley: 7.9)
Drugs: 3.7 (Bromley: 3.3)

Wellbeing Score:
Cray Valley East & West = -9
(Bromley wards range: 11 to -11)

Life Expectancy
Males: 77.1 yrs (Bromley: 79.4yrs)
Females: 81.8 yrs (Bromley: 83.5yrs)

Public Transport Accessibility
PTAL: 2.3 (Bromley range: 1 to 6)

Children's Centres
Cotmandene

Housing
Overcrowding: 1.5% (Bromley: 6.4%)

Air Quality
Annual Mean NO2: 26.2µgm^3 (Target: <40µgm^3)

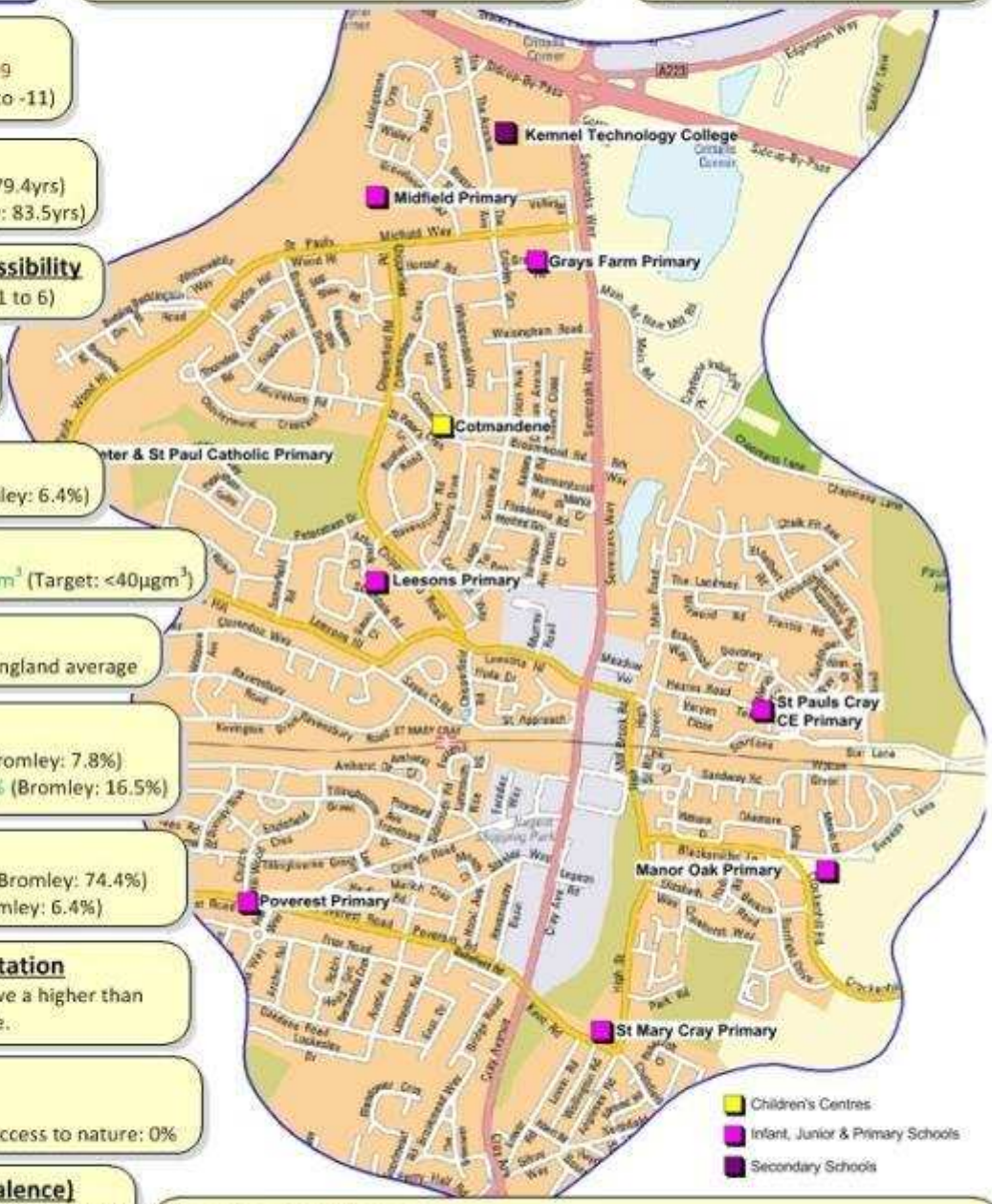
Teenage Pregnancy
U18: Not significant than England average

Childhood Obesity
Obese aged 4-5ys: 6.7% (Bromley: 7.8%)
Obese aged 10-11ys: 14.3% (Bromley: 16.5%)

Income
Employment: CVE: 70.5% (Bromley: 74.4%)
Claimant Count: 6.6% (Bromley: 6.4%)

Cycle Market Segmentation
Households in this area have a higher than average propensity to cycle.

Green Spaces
Green space area: 50.3%
Homes with deficiency in access to nature: 0%



Disease Burden (Prevalence)
Atrial Fibrillation : 1.4% (Bromley: 1.5%)
CHD : 3.4% (Bromley: 3.1%)
CKD : 4.6% (Bromley: 3.3%)
COPD : 2.4% (Bromley: 1.3%)
Diabetes : 6.7% (Bromley: 5.0%)
Heart Failure : 0.8% (Bromley: 0.7%)
Hypertension : 14.7% (Bromley: 14.2%)
Mental Health : 0.9% (Bromley: 0.8%)
Obesity : 15.1% (Bromley: 9.4%)
Smoking : 22.3% (Bromley: 14.4%)

Educational Attainment:

Gray's Farm Primary: KS2: 76% (Bromley: 83%)	Absence: 6.5% (Bromley: 4.2%)
Leesons Primary: KS2: 76% (Bromley: 83%)	Absence: 7.0% (Bromley: 4.2%)
Manor Oak Primary: KS2: 71% (Bromley: 83%)	Absence: 4.7% (Bromley: 4.2%)
Midfield Primary: KS2: 85% (Bromley: 83%)	Absence: 5.5% (Bromley: 4.2%)
Poverest Primary: KS2: 63% (Bromley: 83%)	Absence: 5.8% (Bromley: 4.2%)
St Mary Cray Primary: KS2: 53% (Bromley: 83%)	Absence: 7.4% (Bromley: 4.2%)
St Pauls Cray Primary: KS2: 76% (Bromley: 83%)	Absence: 5.5% (Bromley: 4.2%)
St Peter & St Paul RC Primary: KS2: 82% (Bromley: 83%)	Absence: 5.0% (Bromley: 4.2%)
Kemnal Technology College: GCSE: 59.5% (Bromley: 68%)	Absence: 6.7% (Bromley: 5.4%)

Summary of Key Issues

Cray Valley, St Paul's Cray and St Mary Cray

This area has very high levels of deprivation, with a higher than average proportion of children and young people, and of lone parent households. The Cray's has one of the largest groups of Gypsy Travellers in England; this group is known to have poorer health outcomes than the general population. Crime levels are high, employment levels are low, and the sense of wellbeing is low. Educational attainment is below average and school absence is higher than average. There is poor public transport accessibility. There is a high chronic disease burden which reflects the high levels of adult obesity and smoking. Life expectancy is below the Bromley average.

5. Housing

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

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

The Local Housing Market

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

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

in demand for private rental sector housing is unlikely to increase housing standards within this lower quartile. What is clearer is that the increase in demand has driven a significant rise in rental prices, estimated to be on average 5% over the last year within the Borough (based on SELHP Housing Market Bulletin average rental price for a two bed flat), whilst average household income is believed to have stagnated. The average earnings by residence for full time workers living in Bromley in 2010, was estimated to be £652 per week[7]. These trends are even more extreme in the adjoining South-East London boroughs, such as LB Greenwich where the private rental sector has doubled from approximately 10% to 20% of dwellings over the same 10 year period.

Table 5.1 London Borough of Bromley; Household Tenure

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

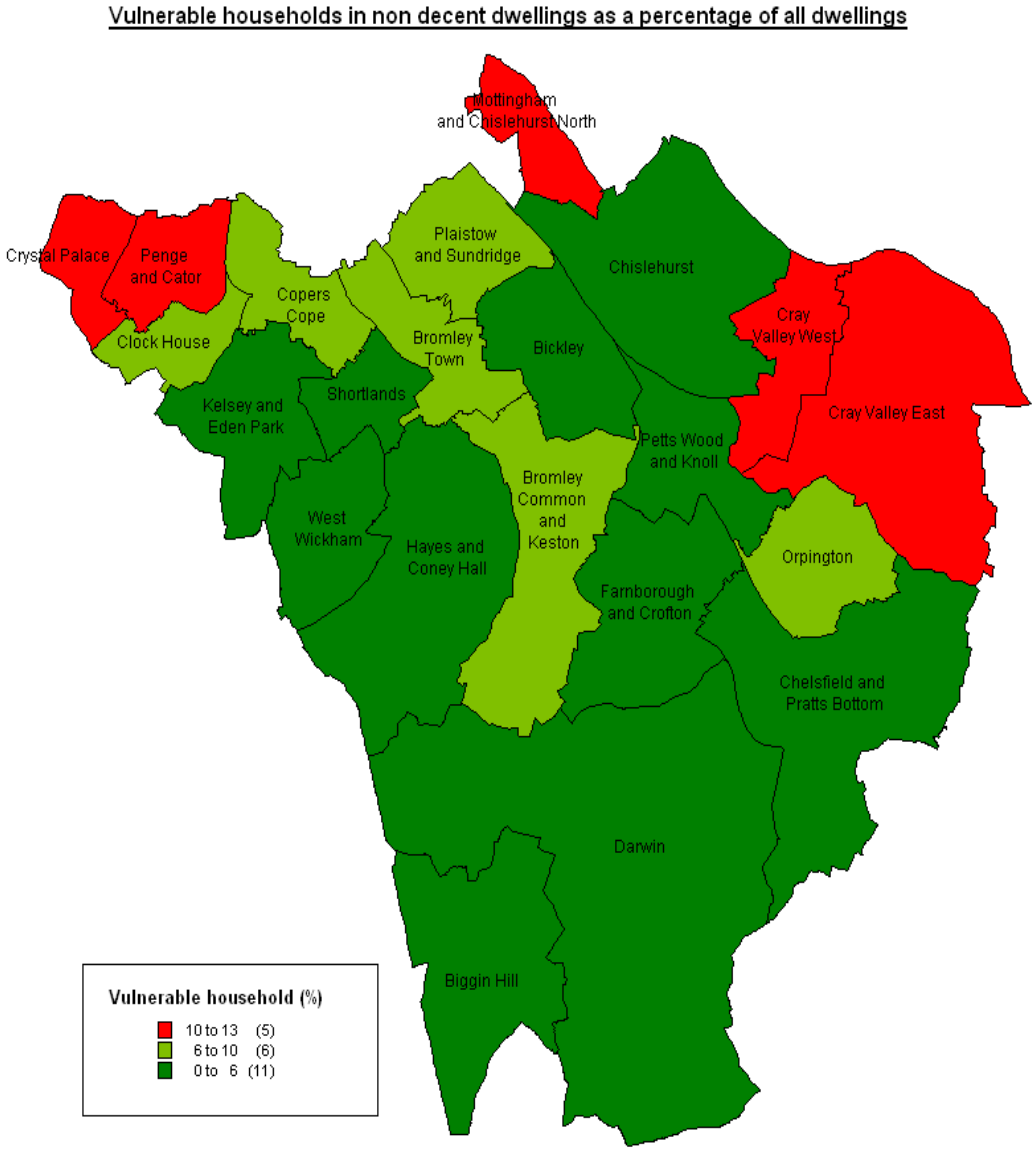
Source: 2011 Census

A Housing Condition Survey (conducted in 2005) indicated that approximately 33% of private sector dwellings in the Borough fail the Government's Decent Homes Standard. The properties in poorest condition are, unsurprisingly, often within the lower quartile of rental prices, and are therefore more likely to be occupied by those on low household incomes. A disproportionate number of vulnerable people, particularly older people, fall within this category.

The number of vulnerable households occupying non-decent dwellings highlights inequalities across the borough. Vulnerable households are four times more likely to occupy non-decent dwellings if they live in certain wards within the borough, illustrated below:

[7] Source: Nomis

Figure 5.1



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

Health Effects of Poor Housing

A recent study in the British Medical Journal reported that insulating existing houses led to a significantly warmer, drier indoor environment and resulted in improved self-rated health, self-reported wheezing, days off school and work, and visits to GPs as well as a trend for fewer hospital admissions for respiratory conditions.

Falls

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

Cold Housing

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

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

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

Housing design and environment

Housing types, such as housing quality, high rise, or floor level, have all been linked to mental ill health. High rise living can be associated with poorer mental health impact on children and mothers because of lack of play space and social isolation.

Young mothers are particularly at risk and studies have shown that women in their early 20s are 3 times more likely to consult a GP for mental health problems if they live in flats. The general design of a neighbourhood, access to communal areas and especially access to natural spaces have also been found to affect mental health and well-being.

Children with ADHD have fewer behavioural problems when they spend more time in natural settings, low income housing areas in London with less access to private gardens have higher prevalence of depression.

Inaccessible public spaces both indoors and outdoors can discourage physical activity and social participation, and may impair mental health and access to services and amenities.

The Need for Affordable Housing

Increased homeless prevention and housing options work have achieved a year on year reduction in homeless acceptances and temporary accommodation use, achieving more than a 50% reduction by 2009/10

However since the onset of the recession, like all London Boroughs, Bromley continues to experience a significant increase (over 150%) in the number of households presenting faced with homelessness. The most significant areas of increase continue to be as a result if mortgage or rent arrears and loss of private rented accommodation, together now accounting for more than one third of all homeless acceptances. This has resulted in a significant rise in the number of households having to be placed in temporary accommodation.

During this period the number of people included on the housing register dramatically increased and the number of properties available for them to move into has continued to fall.

At its peak there were approximately 8,000 households on the housing register and less than 650 properties to which the Council had nomination rights over a 12 month period. This means that only around 8% of applicants were gaining a move via Bromley Homeseekers and those who were successful had to wait many years to secure suitable accommodation.

Having reviewed the service and undertaken extensive consultation it was recognised that practices must change in order to best meet the needs of those with a high level of housing need in Bromley as well as making best use of the resources available to us.

A new allocations scheme was therefore launched in December 2011. The new scheme recognises that the Council cannot assist everyone that approaches for assistance. The threshold for inclusion has therefore been increased to focus on those applicants who have a reasonable chance of securing a move through Bromley Homeseekers. This has reduced the overall number of applicants on the housing register to less than 2,500. For those applicants who do not meet the threshold for inclusion, greater emphasis is placed on offering housing advice and assistance to enable them to pursue alternative housing options to resolve their current housing situation.

Table 5.2

	2008/09	2009/10	2010/11	2011/12	2012/13 half year
Housing register	4,140	5,901	7,638	8,034*	
Total approaching	1,843	2,057	2,869	3,948	2,017
Homeless applicants	755	625	766	1,161	814
Homelessness acceptances	489	414	426	634	286
Temporary accommodation	641	477	427	612	673

* at peak before the old register closed and the new allocations scheme was launched.

Supply has dropped across all sectors of the housing market as churn and new supply slows down. Access to home ownership and social housing has become more restricted and private rents are high and rising, effectively pricing many out of the housing market.

The recent changes to local housing allowance have further increased the difficulty in private rented and leasing scheme acquisition. Thus the bulk of the increase in temporary accommodation use has been through costly nightly paid accommodation arrangements. This position is reflected across London as a whole, with recent reports confirming more than a 50% increase across London in temporary accommodation use for statutory homeless households.
A further reduction in the overall supply of housing association lettings has been witnessed during the first half of 2012/13, with the number of lettings reducing by about 40% compared to the same period for 2009/10.

The welfare reform changes being implemented over the next few years will have a significant impact on private and social housing tenants and landlords in addition to the impacts already being witnessed as a result of the recent housing benefit changes. Recent research suggest that the changes will not only impact housing affordability, but will in turn impact significantly upon household finances in general, leading to increased approaches to statutory services (including housing, social care and education), requesting not only assistance with housing but also essential daily living costs.
There could also be demographic swings across London which may also impact upon service pressures and housing affordability and available supply. Initial analysis has identified in the region of 500 families who will be affected by the total benefit cap and around 2,000 households affected by the extension of the size criteria on social housing.

The above factors mean that, despite the continued focus on homeless prevention and housing options work, the sheer level of increased demand continue to increase homeless acceptances and temporary accommodation placements. This position seems set to continue in the short to medium term, with further increases anticipated as a result of welfare reform.

Housing Development & Supply

The recession has continued to affect the pace of new developments, both when schemes commence and complete. The number of new planning applications being submitted has fallen considerably and continues to remain lower than in the years prior to the economic downturn. Whilst the Borough is meeting its target of residential completions, there remain some 700 residential units permitted on large sites (10 or more units) which have not been started, a number of new developments have been put on hold by private developers hence the delivery of affordable units secured on those sites is delayed. Furthermore, some owners of sites with existing planning permission have sought to reduce the proportion of affordable housing and/or increase its price or reduce/remove the amounts of Payments in Lieu (PiL), arguing that it is no longer financially viable to meet the planning permission requirements. In some cases the developer's arguments have been won on appeal.

Meanwhile, the whole process and methodology whereby the Greater London Authority (GLA) / Homes and Communities Agency (HCA) funds new affordable housing development changed from April 2011. Under the adopted Affordable Rent regime Registered Providers (RP) are able to charge up to 80% of local market rent in order to help fund new development and counter the lower levels of public subsidy being invested into new build affordable housing. The rent level changes have particularly affected London and, slightly less, the South. In many parts of the country RP rents are already near or the same as market rents so the capacity to generate extra income from increasing rents is mainly all in London and the South.

The economic downturn and changes in affordable housing policy takes time to fully impact upon new supply. In 2009/10, the bulk of starts on site and completion were already in the development pipeline before the economic downturn hit and changes to affordable housing policy took effect. During 2011/12 and 2012/13 the impact on starts on site has been more obvious with only 53 affordable housing units starting on site during 2011/12 in comparison with the 373 units starting onsite in 2009/10.

The number of new sites coming forward has fallen and those already with planning consent are delayed until grant or sufficient funding is available. In addition, even as the economy starts to re-stabilise, the effects will continue to be

felt for some time, given the lead in period for new planning applications and then development to start on site, factors that will also be affected by availability of mortgage lending and deposits to enable people to purchase.
The reduction in planning applications, coupled with the marked reduction in new building, also significantly increases the difficulty in finding opportunities for the specialist accommodation supply required to meet the range of needs with groups such as those with learning disabilities, physical disabilities, older people etc.

The supply of affordable social housing available to let has steadily declined over the last few years and has contributed to the reported unmet homeless demand figures. Homelessness derives both from an inadequate supply of social housing but often reflects wider issues, for example, when people face inherent or complex social and financial problems that make it difficult for them to sustain their accommodation.

Housing Need and Supply for People with Support Needs

Housing provision is insufficient for a number of groups with support needs. These include people with mental health problems, people with a physical disability or sensory impairment, people with drug and alcohol problems, ex offenders and young people.

Older People

Bromley has an adequate supply of sheltered accommodation. Extra care housing is a type of sheltered housing that can offer care and support on site and is ideal for people who are less able to manage on their own. Extra care housing offers people aged over 55 years the opportunity to live in a home of their own, even when they have high level care and support needs. It provides a range of housing and care/support services tailored to meet individual needs available 24 hours a day, 7 days a week. The amount of care provided at any time can be flexible to accommodate fluctuating needs, and can be supported by in-built "smart technology" or "telecare" (for example call alarms or sensors to alert staff to particular circumstances). Schemes may be specifically designed to cater for specialist needs, such as for people with dementia. Living within the wider community can help people to maintain and build up the skills needed to retain their independence.

Extra Care Housing is provided by Bromley Education and Care Services in partnership with a number of housing associations. It provides bedsit, studio and one and two-bedroom accommodation for people who are no longer able to live in their own home even with support and who do not need the level of help given by a care home.

The Extra Care Housing schemes some of which have been in existence for many years are located in various parts of the Borough. Over recent years LBB has been working in partnership with a number of organisations to build three new extra care housing developments, the first Crown Meadow Court being located at Bromley Common which opened in April 2011. The second Regency Court (the second phase in Bromley Common), which opened in September 2012, and the third Ann Sutherland Court in Penge due to open imminently.

People with Mental Health Needs

Supported housing for people with mental health problems is provided in a variety of forms, from hostel accommodation with shared facilities, to self contained units offering more privacy and flexibility. Housing support is delivered to tenants in both supported housing and general needs accommodation through the Council's Assessment & Resettlement Team and through floating support workers.

The Assessment and Resettlement Service provides a co-ordinated and holistic approach to meeting the housing needs of people with mental health problems and we recently extended this service to a range of new clients, including homeless people with learning disabilities and 16 and 17 year olds.

People with Learning Disabilities

The Council has successfully completed the programme to relocate 90 adults with learning disabilities from NHS campus provision into the community. The majority of these people now live locally and benefit from having their own tenancies and have flourished in their new homes. All ex - campus clients have their own support plans with their needs met by a variety of providers.

The number of young adults with learning disabilities continues to increase whilst the availability of suitable living accommodation is in decline. There is an increasing requirement to meet people's needs with alternative solutions such as Shared Lives placements and possibly, family purchases as well as supporting parents to look after their sons and daughters in the family home.

Bromley has been able to allocate a limited number of accessible properties from new developments to people with the greatest need and it is intended that this will continue for the foreseeable future.

People with Physical Disability or Sensory Impairment (PDSI)

There are 4 rehab flats for people with PDSI but currently no units of accommodation with support on site or floating support for this group.

The provision of aids and adaptations is one of the means by which the Council promotes independence for people with disabilities. The aids and adaptations service is provided jointly by Occupational Therapists, the Bromley Home Improvement Agency (part of Environmental Health), the Housing Division and local housing associations.

Other Special Needs Groups

There are other groups with support needs who are sometimes missed in the provision of housing and housing support such as ex offenders, people with drug and alcohol problems, and care leavers.

What does this mean for our JSNA?

Managing expectations of people who are not in priority need

Increasing demand for housing

Increasing numbers of repossessions

Decreasing supply of affordable housing and temporary accommodation further exacerbates the gap between supply and demand

Populations of Interest

6. Children & Young People

This section focuses on the needs of particular groups of the Borough's children and young people:

a) Educational attainment and attendance

b) Young people at secondary school

c) Children with Special Educational Needs (SEN) and Disabilities

d) Children's Safeguarding and Social Care

e) Children in Care

The information regarding the emotional and mental health needs of children and young people in the Borough is contained within the Mental Health section of this Joint Strategic Needs Assessment.

6.1. Educational attainment and attendance

Introduction

The overall pupil population within maintained and academy schools, and the Pupil Referral Service provision in Bromley is 47,242 pupils - including post-16 years [January pupil census 2012].

About 20% of the borough's school intake comes from neighbouring boroughs – predominantly Lewisham and Croydon. This has a significant impact on the profile of the children and young people in Bromley schools. For example, the ethnic composition of Bromley's schools varies greatly from the resident ethnic composition. Bromley's schools have an average Black and Minority Ethnic profile of 28.6% compared to the resident children and young people population of 18%.

Attainment of Pupils in Bromley Schools

The national curriculum consists of assessments (both informal and formal tests) at varying stages of a child's school life.

Table 6.1

Assessment	Stage of School Life	Comments
Early Years Foundation Stage	Reception age – aged 5	This is an informal assessment made by the class teacher
Key Stage 1	Year 2 – aged 7	This comprises a set of teacher assessments which assess ability in reading, writing and maths
Key Stage 2	Year 6 – aged 11	This comprises tests and teacher assessments in English maths and science
Key Stage 4	Year 11 – aged 16	GCSE and equivalent tests

Narrowing the gap has been a common phrase used by Government over recent years it recognises that certain vulnerable groups such as pupils who are in receipt of Free School Meals (FSM), Special Educational Needs (SEN), and Children in Care tend to perform less well than their peers. Local authorities and schools have been charged with looking at the gap in performance between these groups and the main cohort of pupils, with a view to raising attainment of vulnerable groups and narrowing the gap in performance over time.

FSM is used as a proxy measure for poverty and in order to assess outcomes for children from low income families. However it is only a proxy measure as many children from these backgrounds do not always take up their entitlement to free meals.

Foundation Stage Profile

Progress of pupils in the Early Years Foundation Stage (EYFS) is measured by grouping elements of the 13 assessments; the expected level of performance is for a pupil to score at least 6 points in each of the 13 assessments.

In 2012, 68% of Bromley pupils attained the expected level of performance compared to 64% nationally. Attainment in the EYFS has been increasing steadily year on year since it began in 2008.

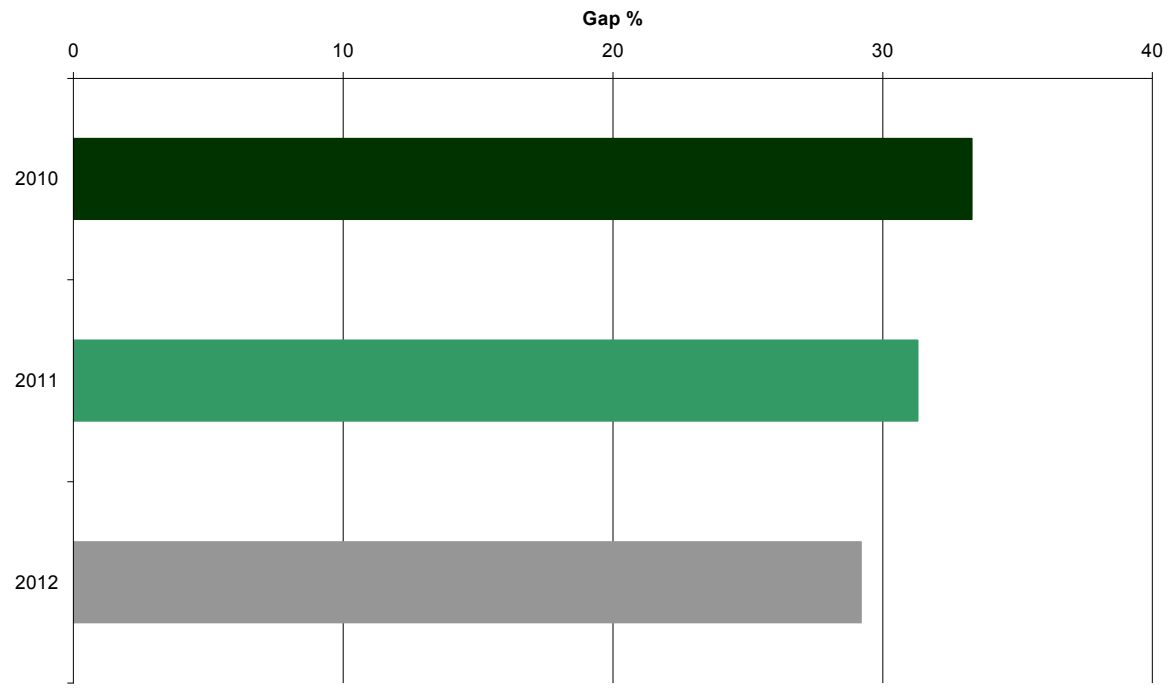
The EYFS gap is an area which Bromley is focusing on. This gap isn't concerned specifically with the performance of vulnerable groups rather the bottom 20% of all pupils. As EYFS has a low baseline in general any under achievement in this area needs urgent attention.

During the last few years, the Borough has successfully reduced the gap as illustrated in the following table and graph:

Figure 6.1

EYFS: Gap between the highest performing pupils and the lowest 20%

[Source: London Borough of Bromley]



	2010	2011	2012
Gap between the highest performing pupils and the lowest 20% at EYFS	33.3%	31.3%	29.2%

Key Stage 1

At age 7 (end of Key Stage 1) pupils are expected to achieve a level 2 in each subject in the Key Stage 1 assessments. The 2012 results show that 88% of pupils achieved Level 2+ in reading, 84% in writing and 91% in maths.

Bromley's performance at Key Stage 1 is consistently at or 1-2 percentage points higher in all areas that performance nationally.

However, the gap in performance at Key Stage 1 between pupils eligible for Free School Meals (FSM) and non eligible is not narrowing. Pupils not eligible for FSM consistently perform better than those eligible. The gap in reading in 2012 is 18% compared to 14% nationally, in writing the gap is 22% compared to 16% nationally and in maths is 13% compared to 11% nationally.

Key Stage 2

At age 11 (end of Key Stage 2) pupils are expected to achieve a Level 4 in each subject in the Key Stage 2 assessments. The 2012 results show that 88% of pupils achieved this in English (from 86% in 2011) and 86% in mathematics (from 84% in 2011), compared with the national averages of 85% for English and 84% for mathematics.

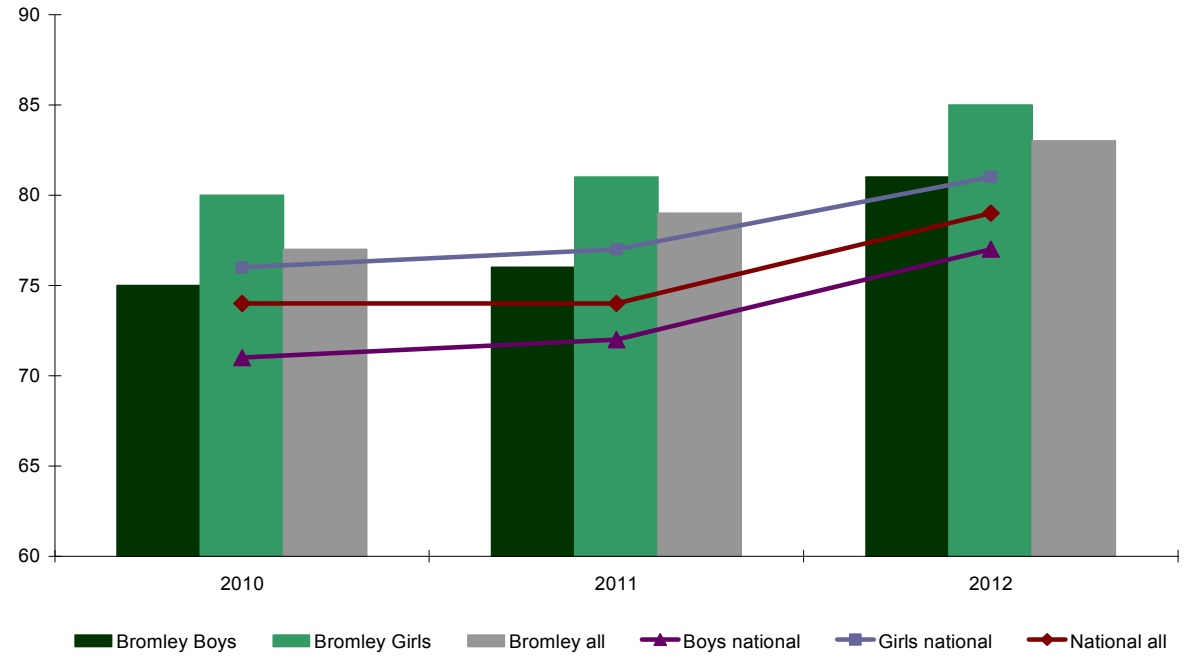
This continues the trend of previous years where pupils in Bromley schools attain above the national average.

Attainment at Level 4 and above in combined English and mathematics has increased from 75% in 2008 to 83% in 2012, against the national attainment of 72% in 2008 and 80% in 2012. The graph below illustrates the attainment in this measure, including a gender breakdown. This graph clearly illustrates that girls tend to out perform boys in most subject areas across all key stages.

Figure 6.2

Key Stage 2 English and Mathematics - % of Pupils at Level 4 or above, by gender

[Source: London Borough of Bromley]



	2010	2011	2012
Bromley – boys	75	76	81
Bromley - girls	80	81	85
Bromley – all	**77**	**79**	**83**
National – boys	77	79	83
National – girls	71	72	77
National – all	**76**	**77**	**81**

At Key Stage 2, the gap in attainment in combined English and mathematics between those pupils eligible for Free School Meals and those who are not has decreased year on year, from a gap of 29% in 2008 to 22% in 2012. This compares to the national gap which reduced from 22% in 2008 to 20% in 2011.

Primary Value added – how a pupil progresses through the school

Value added is designed to measure a child's progress through the school in order to assess the 'added value' the school has made to the outcomes of each child. It looks at prior attainment (the pupil's performance in tests/assessments already undertaken) and plots this against the expected level that a child is likely to achieve

in the next set of assessments. The model used for value added in primary schools is KS1-KS2 and each child is expected to make two levels of progress between KS1 and KS2.

A higher percentage of pupils in Bromley schools made the expected amount of progress between the Key Stage 1 and Key Stage 2 assessments in 2012 than nationally, with 93% in English (compared with 89% nationally) and 89% in mathematics (compared with 87% nationally).

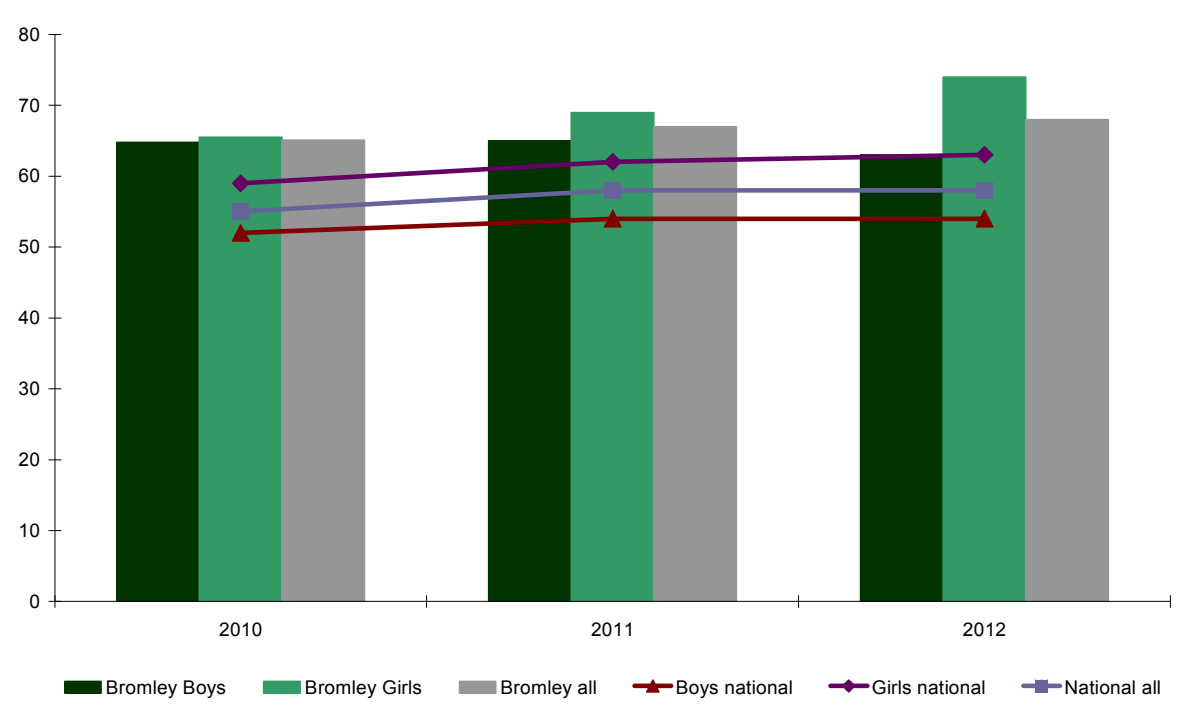
Key Stage 4

At GCSE, Bromley pupils also achieve higher that the national average, with 68% of pupils gaining 5+ A*-C grades (including English and mathematics) in 2012, compared with 58% nationally. The graph below shows the trend for Bromley and nationally.

Figure 6.3

Key Stage 4 - % achieving 5 A*-C including English and Mathematics, by gender

[Source: London Borough of Bromley]



	2010	2011	2012
Bromley – boys	65	65	63
Bromley – girls	66	69	74
Bromley – all	**65**	**67**	**68**
National – boys	52	54	54
National – girls	59	62	63

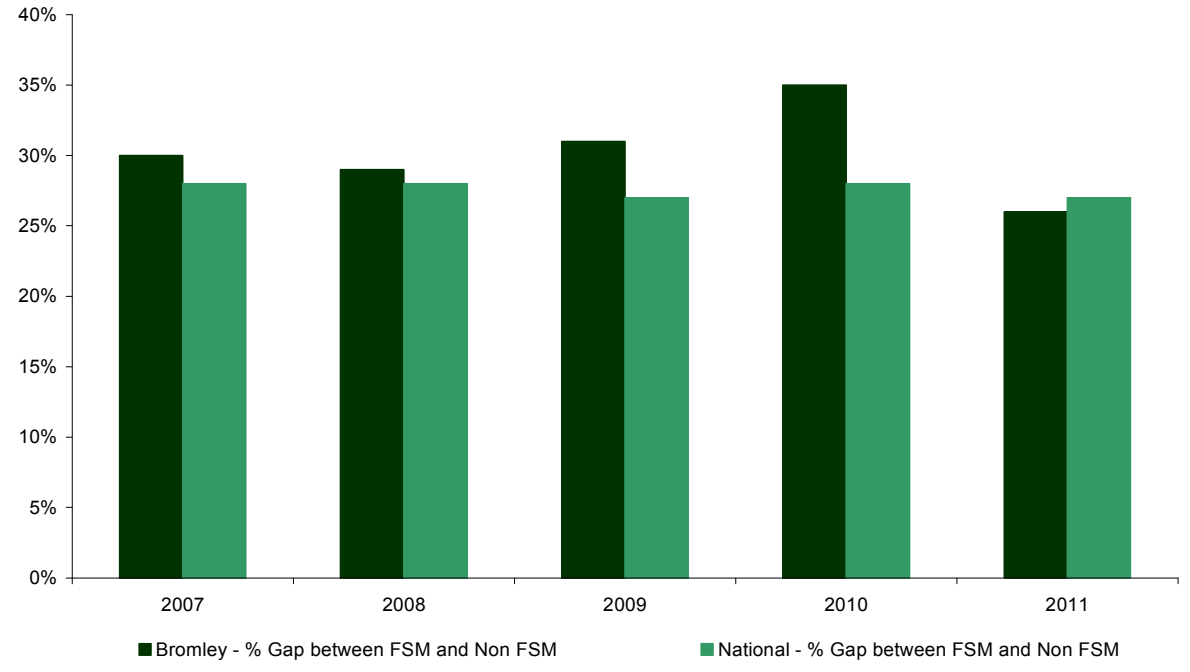
National – all	**55**	**58**	**58**

At Key Stage 4, the Free School Meal/Non Free School Meal gap has fluctuated over the last 3 years when looking at attainment of 5+ A*-C grades, and 5+ A*-C grades including English and mathematics. The former shows a gap of 25% in 2009, reducing to 20% in 2010 but rising slightly to 21% in 2011. The 5+ A*-C including English and mathematics gap was 30% in 2009 rising to 32% in 2010 and falling to 26% in 2011.

Figure 6.4

Key Stage 4 - % of pupils achieving 5 A*-C including English and Mathematics, by Free School Meals eligibility

[Source: London Borough of Bromley]



	2007	2008	2009	2010	2011
Bromley - % Gap between FSM and Non FSM	30%	29%	31%	35%	26%
National - % Gap between FSM and Non FSM	28%	28%	27%	28%	27%

What does this mean for our JSNA?

- Continue to develop and sustain relationships with schools which convert to Academies to achieve jointly agreed outcomes to improve the lives of children and young people in the Borough.

- The number of five year olds achieving the expected level for the Early Years Foundation Stage Profile is in line with that of national attainment and it is an area where performance is improving, however the rate of improvement is not at the same high level as the other key stages. A focus is therefore needed on improving attainment at the Foundation Stage as studies, such as the Marmot and Field Reviews, clearly identified the importance of intervention in the early years.

- The attainment gap at Key Stage 2 and Key Stage 4 is a particular area of focus for the LA and for the Department for Education. The priority is addressing the gap between those with Free School Meals/ Non Free School Meals in particular, but there are also gaps in performance across the genders.

6.2 Young people in secondary school.

This section gives a brief summary of the Annual Public Health Report 2012, which focussed on this group.

- Young people in Bromley are generally faring well. They have high levels of self-reported health and life satisfaction, they achieve well at school, and they are generally optimistic about their futures.
- These high levels, however, are unevenly spread - by age, sex and affluence. Girls, in particular, have significantly lower levels of reported health and life satisfaction, and higher perceived school pressure, than boys. Well-being and healthy behaviours decrease significantly with age.
- Emotional upheaval and the high need for peer approval at this age can lead to anxiety and distorted beliefs about appearance, and increased risk-taking.
- Decisions about health behaviours depend to a large extent on a young person's general well-being, high well-being being associated with low risk-taking, and vice versa.
- The most important determinants of well-being are the quality of family, school and neighbourhood life.
- Interventions that have been found effective in improving well-being in young people include parenting programmes and whole school approaches to improving social behaviours and reducing bullying.
- While some interventions are in place in Bromley, implementation and knowledge about what is actually happening is, respectively, variable and incomplete.

What does this mean for our JSNA?

- Whole school approaches are needed to improve well-being of both young people and staff, and through this to reduce exclusions, truancy and crime, improve behaviour at school, increase educational attainment, and reduce risky behaviours.
- Special attention should be given to supporting all parents, not just those whose children already have problems.

6.3. Children with Special Educational Needs (SEN) and Disabilities

Introduction

During the past decade Bromley has experienced a significant increase in volumes of children with Special Educational Needs (SEN) and Disabilities. Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life.

The increase in numbers and complexity of needs of children with learning difficulties and/or disabilities has required more specialist and high cost provision to be made available.

This section provides a range of information for children with Special Educational Needs (SEN) and Disabilities within the following sections:

- Educational needs
- Health needs

Educational needs

The main cost pressure in the Schools' Budget continues to be in SEN placements, which is volume driven and for which the Council has a statutory duty to make provision.

The number of pupils in Bromley schools with Special Educational Needs has increased by 1,193 children since 2008 - as illustrated in the following table:

Table 6.2

Pupils in Bromley schools with Special Educational Needs

[Source: Department for Education]

	2008	2009	2010	2011	2012
Number of pupils in Bromley schools with SEN	8,012	8,340	8,837	9,465	9,205
Difference	-	328	497	628	-260
% of pupils in Bromley schools with SEN	17.3%	17.9%	17.8%	18.4%	17.8%
Difference	-	0.6%	-0.1%	0.6%	-0.6%

The number of pupils in Bromley with Statements of Special Educational Needs has increased from 1,585 in 2008 to 1,779 in 2012 – a rise of 194 children - as illustrated in the following table:

Table 6.3

Pupils in Bromley with Statements of Special Educational Needs

[Source: Department for Education]

	2008	2009	2010	2011	2012
Number of pupils in Bromley with Statements of SEN	1,585	1,645	1,704	1,786	1,779
Difference	-	60	59	82	-7

Educational attainment

Pupils who have a significant degree of Special Educational Needs and Disability perform less well than their peers at all Key Stages and subjects. This makes narrowing the attainment gap for children with SEN difficult, as the severity of SEN and disabilities in some pupils means that some pupils will never reach the expected level of attainment.

The following tables provide the performance of pupils with Special Educational Needs at the following levels Statemented, School Action, and School Action Plus, compared to pupils who have no SEN.

Table 6.4

Performance at Key Stage 1 2012: % Achieving Level 2+

[Source: London Borough of Bromley]

Level of SEN	No. of Pupils	% of Pupils	Reading	Writing	Maths
No Special Needs	2,816	81.0%	96.4%	93.1%	97.6%
School Action	328	9.4%	61.9%	47.6%	73.2%
School Action Plus	214	6.2%	52.3%	43.5%	62.6%
Statement	117	3.4%	30.8%	25.6%	30.8%

What does this tell us?

- In 2012, 30.8% of the 117 Statemented pupils in Bromley achieved the required level in reading compared to 96.4% of pupils who have no SEN.
- This shows a decline on 2011 where 38.9% of 95 children with a Statement achieved the required level in reading compared to 95.9% of pupils who have no SEN.
- There is a similar pattern across all subjects.

Table 6.5

Performance at Key Stage 2 2012: % Achieving Level 4+

[Source: London Borough of Bromley]

Level of SEN	No. of Pupils	% of Pupils	English	Maths	Science	E&M
No Special Needs	2,420	77.9%	97%	94%	98%	93%
School Action	312	10.1%	72%	63%	75%	54%
School Action Plus	232	7.5%	52%	59%	64%	43%
Statement	139	4.5%	29%	35%	35%	23%

What does this tell us?

- In 2012, 29% of the 139 Statemented pupils in Bromley achieved the required level in English compared to 97% of pupils who have no SEN.
- This shows an improvement on 2011 where 23.8% of 147 children with a Statement achieved the required level in English compared to 95.8% of pupils who have no SEN.
- There is a similar pattern across all subjects.

Table 6.6

Performance at Key Stage 4 2012

[Source: London Borough of Bromley]

Level of SEN	5+ A*-C		5+ A*-C inc English and maths		A*/A grades		No. of pupils
	No.	%	No.	%	No.	%	
No Special Needs	2,547	96.3%	2,072	78.3%	1,869	70.7%	2,645
School Action	287	89.7%	126	39.4%	116	36.3%	320
School Action Plus	195	79.9%	66	27.0%	66	27.0%	244
Statement	68	88.3%	16	20.8%	19	24.7%	77

What does this tell us?

- Performance at Key Stage 4 shows that 78.3% of pupils who have no special needs achieve the expected level of 5+ GCSEs A*-C including English and maths compared to 20.8% of the 68 pupils who have a full Statement.
- This shows an improvement on 2011 where 16.8% of 68 children with a Statement achieved the expected level of 5+ GCSEs A*-C including English and maths compared to 79.5% of pupils who have no SEN.

Health needs

The increase in numbers and complexity of needs of children with learning difficulties and/or disabilities is leading to significant increases in the number of children requiring support from specialist services.

The number of **referrals of children to the Specialist Support and Disability Panel** has increased by 19% between 2010-11 and 2011-12 – an increase of 38 children - as illustrated in the following table:

Table 6.7

Referrals of children to the Specialist Support and Disability Panel

[Source: London Borough of Bromley]

	2010-11	2011-12
% of pupils in Bromley schools with SEN	202	240
Difference	-	38

The Borough's Supporting Inclusion in Pre-School (SIPS) programme supported 8% more pre-school children with severe and complex needs within their local community pre-school setting - as illustrated in the following table:

Table 6.8

Pre-School Children supported by the SIPS Programme

[Source: London Borough of Bromley]

	2010-11	2011-12
No. of Pre-School Children supported by the SIPS Programme	168	183
Difference	-	14

In addition, 22 **children with complex health needs**, including some requiring airway support, Hickman lines, support for complex diabetes and gastrostomy tube feeding have been supported across 18 mainstream primary and secondary schools in the Borough without requiring a full Statement.

What does this mean for our JSNA?

- Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life.

- The increase in numbers and complexity of needs of children with learning difficulties and/or disabilities has required more specialist and high cost provision to be made available.

6.4. Children's Safeguarding and Social Care Referrals

Keeping children and young people safe has always been a key priority, but in the light of the 2007 Peter Connelly case, has become a growing pressure on all Local Authorities with an increase in the number of safeguarding referrals made.

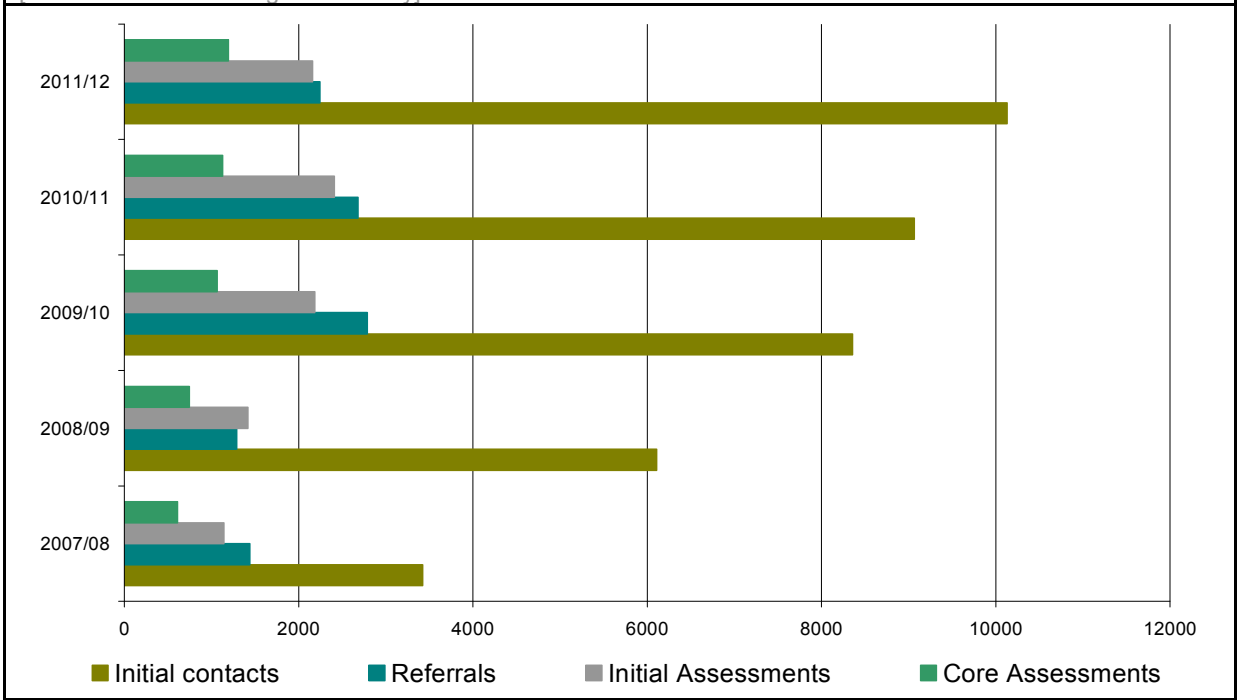
Within Bromley, initial contacts increased by almost 300% from 2008 to 2012 (from 3,425 in 2007/8 to 10,132 in 2011/12). This figure has now levelled off but is not a s low as the 2007-08 level. There was also an increase in the safeguarding referrals which have increased by 85% (from 1,441 in 2007/8 to 2,679 in 2010/11).

This is illustrated in the following graph and table:

Figure 6.5

Safeguarding Referrals to the London Borough of Bromley

[Source: London Borough of Bromley]



	2007/08	2008/09	2009/10	2010/11	2011/12
Initial contacts	3,425	6,109	8,356	9,064	10,132
Difference	-	2,684	2,247	708	1,068
Referrals	1,441	1,289	2,788	2,679	2,244
Difference	-	-152	1,499	-109	-435
Initial Assessments	1,140	1,416	2,188	2,410	2,161
Difference	-	276	772	222	-249
Core Assessments	610	744	1,064	1,130	1,192
Difference	-	134	320	66	62

The graph and table illustrates that the number of both Initial Contacts to the Council and Core Assessments have continued to rise every year since 2007/08.

The number of Referrals and Initial Assessments increased significantly between 2007/08 and 2010/11, before decreasing slightly in 2011/12.

In July 2011, a multiagency support hub (MASH) service was introduced to address the pressures and by forming an effective triage service, have resulted in a decrease in the number of referrals (the 2012-13 cumulative figure was 1526 at November 2012).

What does this mean for our JSNA?

- Initial contacts to, and Assessments by, Children's Social Care Services have significantly increased creating considerable pressures on the Council's staffing and budgets, these have, however, stabilised over the last two years.

- There does appear to be a trend for decreasing numbers of Referrals to Children's Social Care Services thanks to the effective use of MASH.

6.5. Children in Care

Introduction

Children in Care are some of the most vulnerable children in society; living away from their families because their parents faced difficulties and pressures in providing for their care or because the children have suffered abuse or neglect whilst in the care of their families.

Children in Care are provided with care and accommodation which meet their needs. Most often this will be with foster carers but young people may also be placed in residential schools, care homes or units. Most children spend a short time in the care of the Council, either returning to their families or moving to permanent arrangements such as adoption; but for others, their stay may be for several years lasting through to adulthood.

As highlighted in the previous section, in recent years there has been an increase in the volume of children and young people being referred to Children's Social Care Services. This has resulted in an increase in the number of children becoming in the care of the Council.

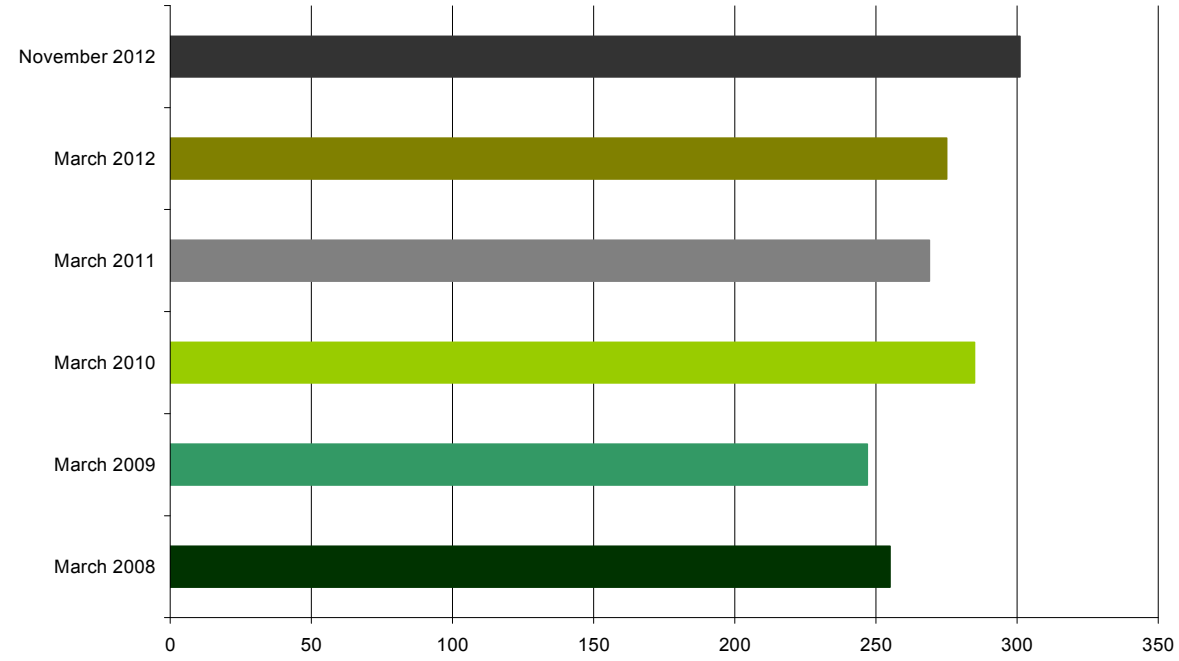
Numbers of Children in Care

The numbers of Children in Care in Bromley have increased by 18% (46) between 2007/08 and November 2012/13. Although there was a decrease in both 2008/09 and 2010/11, the graph below illustrates that there has been an upward trajectory over the five year period.

Figure 6.6

Number of Children in Care

[Source: London Borough of Bromley]



	March 2008	March 2009	March 2010	March 2011	March 2012	November 2012
Number of children	255	247	285	269	275	301
Difference	-	-8	38	-16	6	26

Supporting children through the adoption process

Over the last 12-24 months, the Government have been increasing focusing on the performance of local authorities for supporting children through the adoption process.

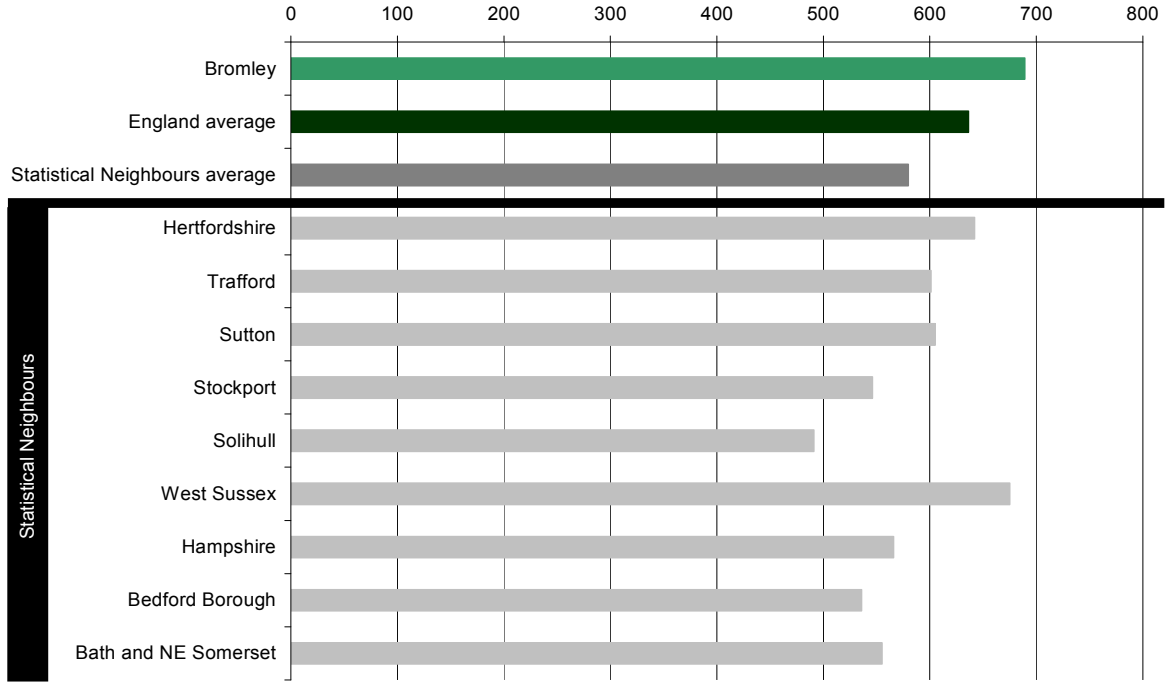
During the three year period from 2009 to 2012 the average time between a child entering care and moving in with its adoptive family within Bromley is 689 days. This shows a significant decrease than the average time between 2008 and 2011 which was 804 days.

However, this average is longer than both the average for England and the average of the Borough's 'statistical neighbours', as illustrated in the following table:

Figure 6.7

The average time between a child entering care and moving in with its adoptive family (the three year period from 2009 to 2012)

[Source: London Borough of Bromley]



	Average length of time
Bromley	689 days
England Average	636 days
Statistical Neighbours Average	580 days

Educational needs

Primary Phase

The data for Key Stage 2 focuses on children who had been continuously looked after for at least 12 months (to 31 March). For 2012 this was 9 young people.

Table 6.9

Performance at Key Stage 2 2012: % Achieving Level 4+

[Source: London Borough of Bromley]

	2009	2010	2011	2012
Percentage of children in care reaching level 4 in English at Key Stage 2	40%	100%	50%	28%
Percentage of children in care reaching level 4 in Maths at Key Stage 2	20%	80%	40%	28%

What does this tell us?

-
- Performance at Key Stage 2 shows that 28% of children in care achieved level 4 in English at Key Stage 2 in 2012 compared to 40% in 2009.
- Performance at Key Stage 2 shows that 28% of children in care achieved level 4 in Maths at Key Stage 2 in 2012 compared to 20% in 2009.

It should be noted that due to the small cohorts of this group, the percentages can fluctuate significantly. Also, 6 (67%) pupils of the 2012 reporting cohort have an identified Special Educational Need (SEN).

It should also be noted that of the 2012 cohort:

- 5 (56%) pupils made 2 levels of progress or more in English.
- 4 (44%) pupils made 2 levels of progress or more in Maths.

Secondary Phase

The data for Key Stage 4 focuses on the children who had been continuously looked after for at least 12 months (to 31 March). For 2012 this was 18 young people.

Table 6.10

Performance at Key Stage 4 2012

[Source: London Borough of Bromley]

	2008	2009	2010	2011	2012
5 A* - C including English and Maths	3%	10%	25%	8.6%	11%
5 A* - C	9.4%	29%	43%	25.7%	16%
5 A*-G	31.25%	47.6%	63%	48.6%	55%
1 A*-G	56.2%	71.4%	75%	74.3%	83%
Sat GCSE or equivalent	Not reported	Not reported	75%	77%	83%

What does this tell us?

- Performance at Key Stage 4 shows that 11% of children in care achieved 5 A* - C including English and Maths in 2012 compared to 3% in 2008.

It should be noted that due to the small cohorts of this group, the percentages can fluctuate significantly. Also, 10 (55%) pupils of the 2012 reporting cohort have an identified Special Educational Need (SEN).

Supporting young people leaving care

The Council has an essential duty in supporting and preparing young people as they leave care and move into adulthood, and supporting them as they leave school.

Education, employment or training

Within Bromley, the percentage of young people aged 19 who were looked after aged 16 who were in education, employment or training has increased by 18% between 2010 (31%) and 2012 (49%). This is now above the national average of 36% in 2012.

Suitable Accommodation

The percentage of young people aged 19 who were looked after aged 16 who were in suitable accommodation has increased by 7% between 2010 (84%) and 2012 (91%). This is now above the national average of 88% in 2012.

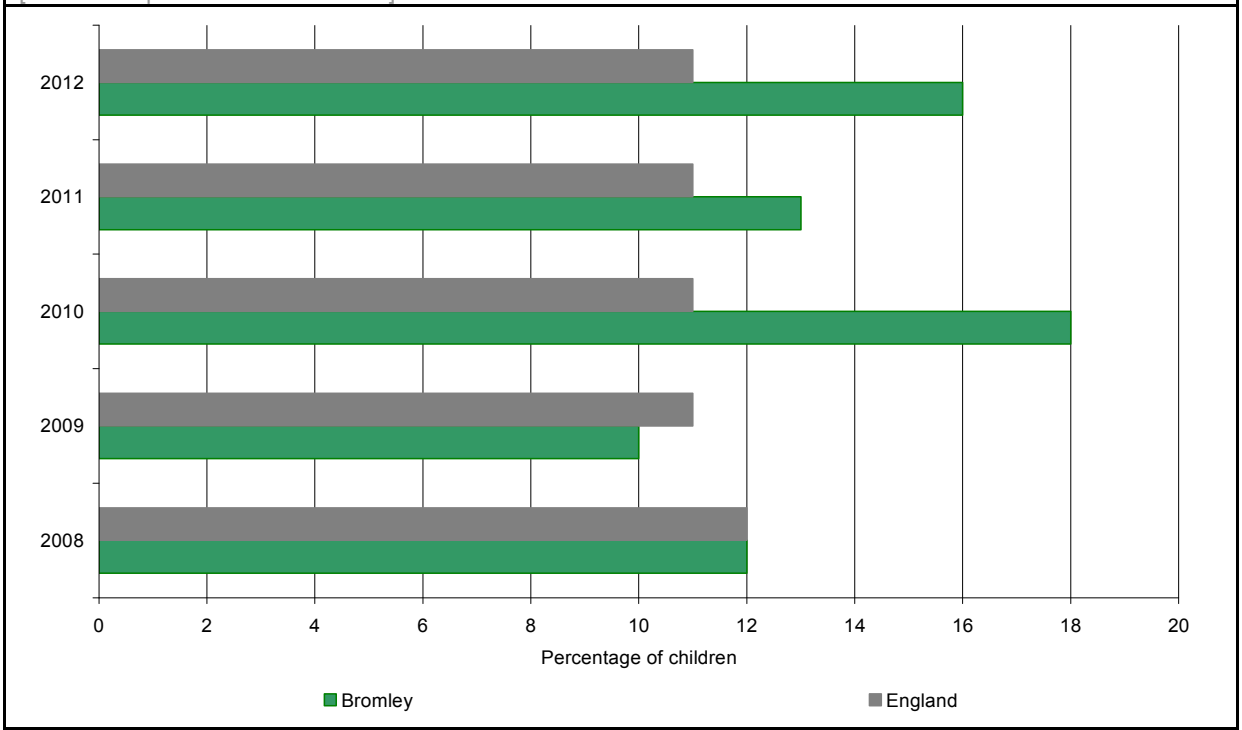
Placement Stability

Whilst being in the care of the Council it is acknowledged that it is important for children and young people to have stability in their placements. This means keeping movements between care placements to a minimum. The graph and table below illustrate that Bromley has been above the England average for the percentage of children in care with three or more placements during the year since 2010.

Figure 6.8

The percentage of children in care with three or more placements during the year

[Source: Department for Education]



	2008	2009	2010	2011	2012
Bromley	12%	10%	18%	13%	16%
England Average	12%	11%	11%	11%	11%

What does this mean for our JSNA?

- There has been a significant increase in the number of children in care over the last 5 years.
- The average time between a child entering care and moving in with its adoptive family within Bromley is below both the average for England and the average of the Borough's 'statistical neighbours'.
- The percentage of children in care who have more than 3 placement moves a year in Bromley is above that of national average.

7. Older People

This section focuses on the needs of the Borough's older people. For this Joint Strategic Needs Assessment it particularly focuses on the following areas:

- The changing older people population
- People living in Bromley with dementia
- Adult social care and support
- Trends
- Impact
- The user voice

7.1 The changing older people population

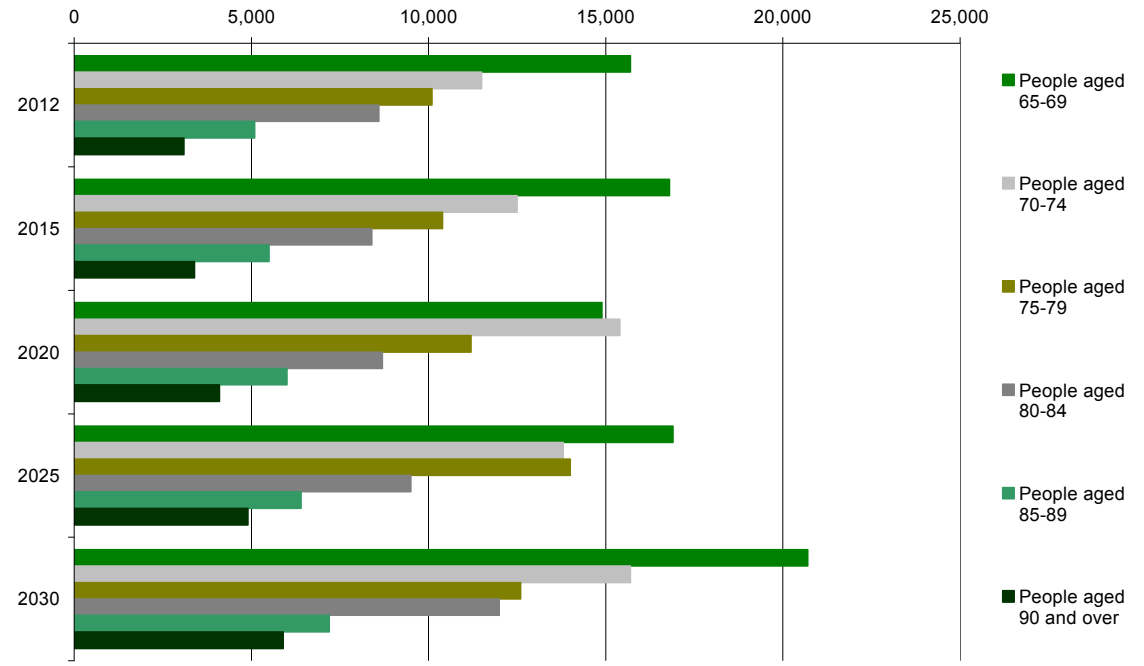
Bromley has an ageing population – the largest in London with approximately 54,000 people aged 65+ years in Bromley at 2012 (Source: Projecting Older People Population Information System, December 2012). It is expected that this will increase to 57,000 (5%) by 2015 and will continue to increase to 74,100 (37%) by 2030.

The following table illustrates the predicted changes in the number people living in Bromley aged 65 and over:

Figure 7.1

The number people living in Bromley aged 65 and over

[Source: Projecting Older People Population Information System, December 2012]



	2012	2015	2020	2025	2030
People aged 65-69	15,700	16,800	14,900	16,900	20,700
People aged 70-74	11,500	12,500	15,400	13,800	15,700
People aged 75-79	10,100	10,400	11,200	14,000	12,600
People aged 80-84	8,600	8,400	8,700	9,500	12,000
People aged 85-89	5,100	5,500	6,000	6,400	7,200
People aged 90 and over	3,100	3,400	4,100	4,900	5,900
Total population 65 and over	**54,100**	**57,000**	**60,300**	**65,500**	**74,100**

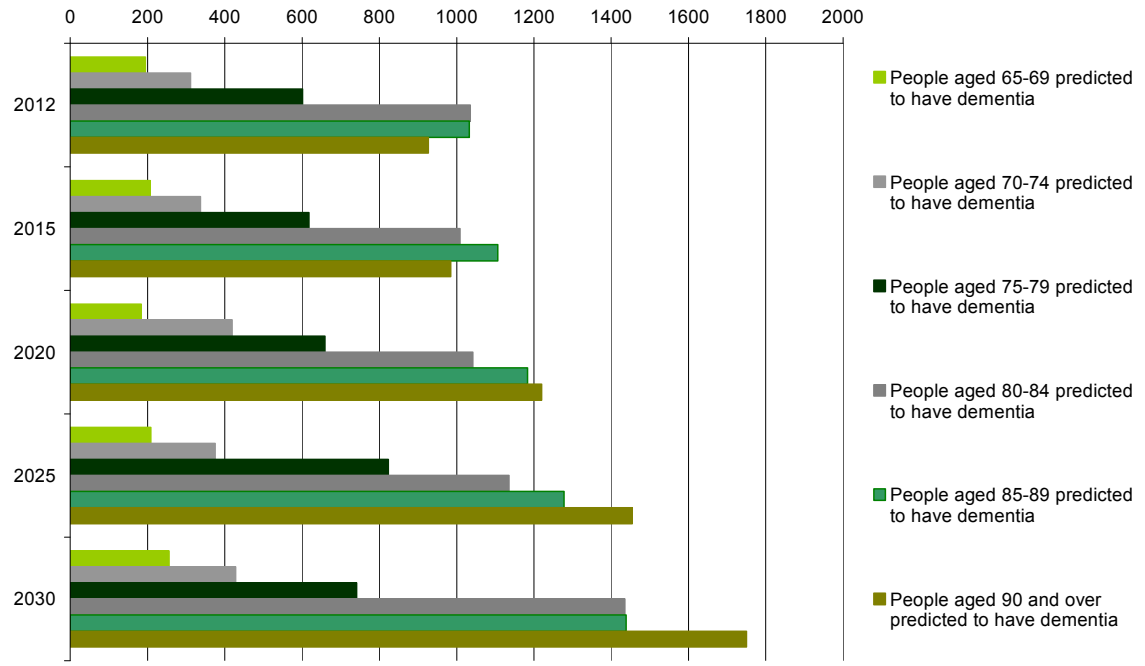
7.2. People living in Bromley with dementia

There are currently over 4,100 people living in Bromley with dementia, and with the ageing population the incidence of dementia is set to rise by 4% (159 people) by 2015 and will continue to increase by 47% (1,945 people) by 2030. The following table illustrates the predicted changes in the number people living in Bromley with dementia:

Figure 7.2

The number of people living in Bromley with dementia

[Source: Projecting Older People Population Information System, December 2012]



	2012	2015	2020	2025	2030
People aged 65-69 predicted to have dementia	194	207	184	209	256
People aged 70-74 predicted to have dementia	312	337	419	375	428
People aged 75-79 predicted to have dementia	601	618	659	823	741
People aged 80-84 predicted to have dementia	1,035	1,009	1,042	1,136	1,435
People aged 85-89 predicted to have dementia	1,033	1,106	1,183	1,278	1,439
People aged 90 and over predicted to have dementia	927	985	1,220	1,454	1,750
Total population aged 65 and over predicted to have dementia	**4,102**	**4,262**	**4,707**	**5,275**	**6,049**

7.3 Adult social care and support

There is an increasing move both within Bromley and across England for older people to maintain their independence by being supported either within their own home, or for families to arrange or support their own care.

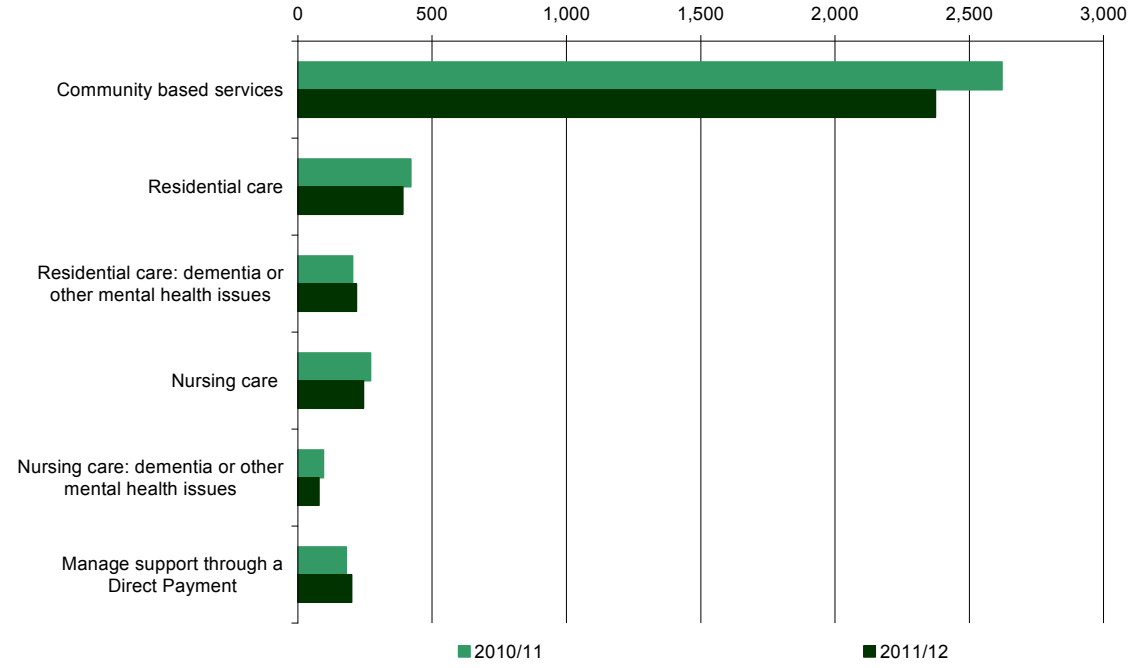
This is leading to a reduction in placements by the London Borough of Bromley in care homes – both residential and nursing – and an increase in the number of older people who chose to manage their support through a Direct Payment.

The following table illustrates the changes in the number of people receiving Adult Social Care services from the London Borough of Bromley between 2010/11 and 2011/12:

Figure 7.3

The number of people receiving Adult Social Care services from the London Borough of Bromley

[Source: London Borough of Bromley]



	2010/11	2011/12
Older people receiving community based services	2,622	2,374
Older people receiving residential care	421	392
Older people receiving residential care who have dementia or other mental health issues	204	218
Older people receiving nursing care	271	244
Older people receiving nursing care who have dementia or other mental health issues	96	79
Older people who chose to manage their support through a Direct Payment	180	200

7.4. Trends

The numbers of older people supported by Adult Social Care Services has decreased over the last four years. The largest decrease in services has been a 23% decrease in the number of people in nursing care from 320 in 2007/08 to 244 users in 2011/12.

However, the number of people using Direct Payments over the last four years has increased by 94% from 103 in 2007/08 to 200 users in 2011/12.

The number of older people with dementia or other mental health issues increased between 2010/11 and 2011/12 which illustrates the increasingly challenging and complex need of those receiving care and support from the Council.

7.5. Impact

The implication of this growing demographic situation is the increased demand for social care services from people who desire to stay and are living at home longer.

As people's needs become more complex it may be the case that support packages will become increasingly expensive to deliver and will put pressure on already constrained budgets. This is compounded by the fact that a lot of Bromley's older population are 'asset rich but cash poor' and unable to contribute to the cost of their care packages as their money is tied up with their properties.

People's expectations are also increasing with the introduction of more self directed support and less reliance on residential care. For people with dementia this is leading to:

- Increased demand for complex need care packages
- Increasing referrals to Oxleas Memory Service
- A doubling of specialist dementia residential care since 2006/7
- The need to explore alternative models of accommodation and support to reduce need for residential and nursing care

7.6. The user voice

A survey of 1,218 service users receiving adult social care was carried out between January and March 2012 to establish how these services have affected and/or improved users' quality of life as part of the national adult social care survey.

The survey told us that, of the 551 [45%] people who responded:

- 92% [502] were satisfied with the care and support services they receive, with 65% [356] very or extremely satisfied
- 64% [348] felt that their quality of life was good, with 34% [187] rating their quality of life as very good or better
- 69% [378] stated that they feel safe
- 58% [322] found it easy to locate information about services

What does this mean for our JSNA?

- An increasing number of older people are being supported within their own home which will have an increasing impact on community based services by all organisations that are required.
- The increase in older people who chose to manage their own support through direct payments are likely to change both the way in which services are provided and the types of services that are provided across the Borough.
- The increasing complexity of needs of the older people in residential care will impact on the services required to be provided by care homes, and the cost to the Council.

8. Learning Disability

The health of people with learning disabilities has steadily improved over the last 30 years. However, they still have higher levels of health needs than their non learning-disabled peers. Although people with learning disabilities live longer than they did decades ago they still have higher mortality rates than people without learning disabilities. People with more severe learning disabilities, and people with Down's syndrome, have the shortest life expectancy of the learning disability population. The highest causes of death for people with learning disabilities are respiratory disease and cardiovascular disease (this tends to be congenital rather than ischaemic).

Some health conditions associated with learning disability increase the risk of premature death, for example people with Down's syndrome have higher rates of congenital heart disease, Alzheimer's disease and cancer than the general population. In addition, learning disability may be associated with cerebral palsy, resulting in postural deformities, eating and swallowing problems which impact on health. Epilepsy is more common in people with learning disability.

As well as these problems, people with learning disability are susceptible to the same health risks as the rest of the population, for example obesity and physical inactivity. Both of these are exacerbated by a sedentary lifestyle and a restricted range of opportunities to exercise or eat healthily.

The projected figure for the number of adults up to the age of 64 years with learning disability in Bromley in 2012 is 4,767; this is predicted to increase by 7.3% over the next 8 years (PANSI). One area of growth is the number of children making the transition to adult services. Medical advances mean that more young people with profound and multiple disabilities are surviving to adulthood. The numbers of people aged 65 years and over with learning disability is not known.

Table 8.1 Projected Figures for Bromley

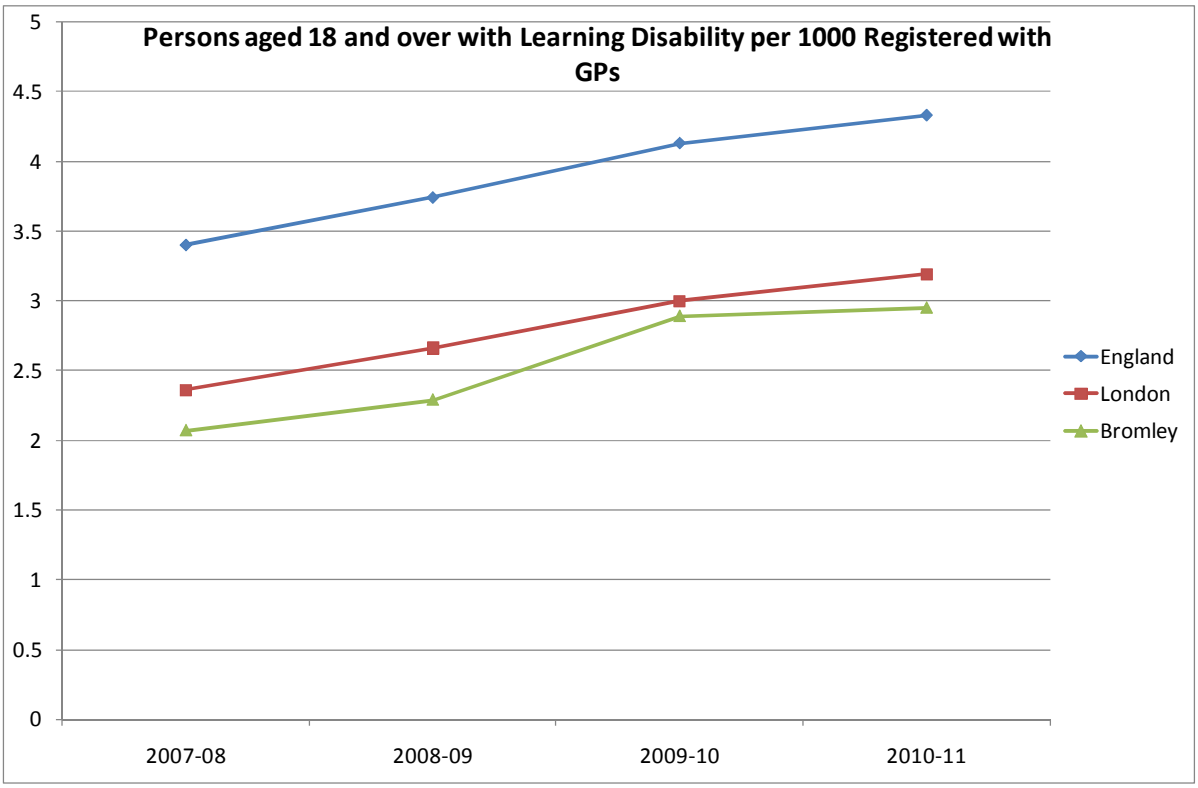
	2012	**2020**	**2030**
Learning Disability (18 to 64y)	4767	5115	5467
Moderate/Severe Learning Disability	1072	1168	1279
Autistic Spectrum Disorder	1927	2068	2206

Data Source: PANSI

Of those adults with LD, 1,072 have moderate or severe LD and 1,927 have autistic spectrum disorder (PANSI). It appears that a significant proportion of those even with moderate or severe LD have not been identified in general practice. GP disease

registers identified 793 patients with LD in 2011-12 (QMAS). Identification of adults with LD is significantly lower in Bromley than the England average.

Figure 8.1



Data Source: Learning Disabilities Profile 2012

Local Authority data gives a higher figure than GP disease registers for adults with LD aged 18 to 64 years at 955 (2010-11), but this is still lower than the projected figure for moderate and severe LD.

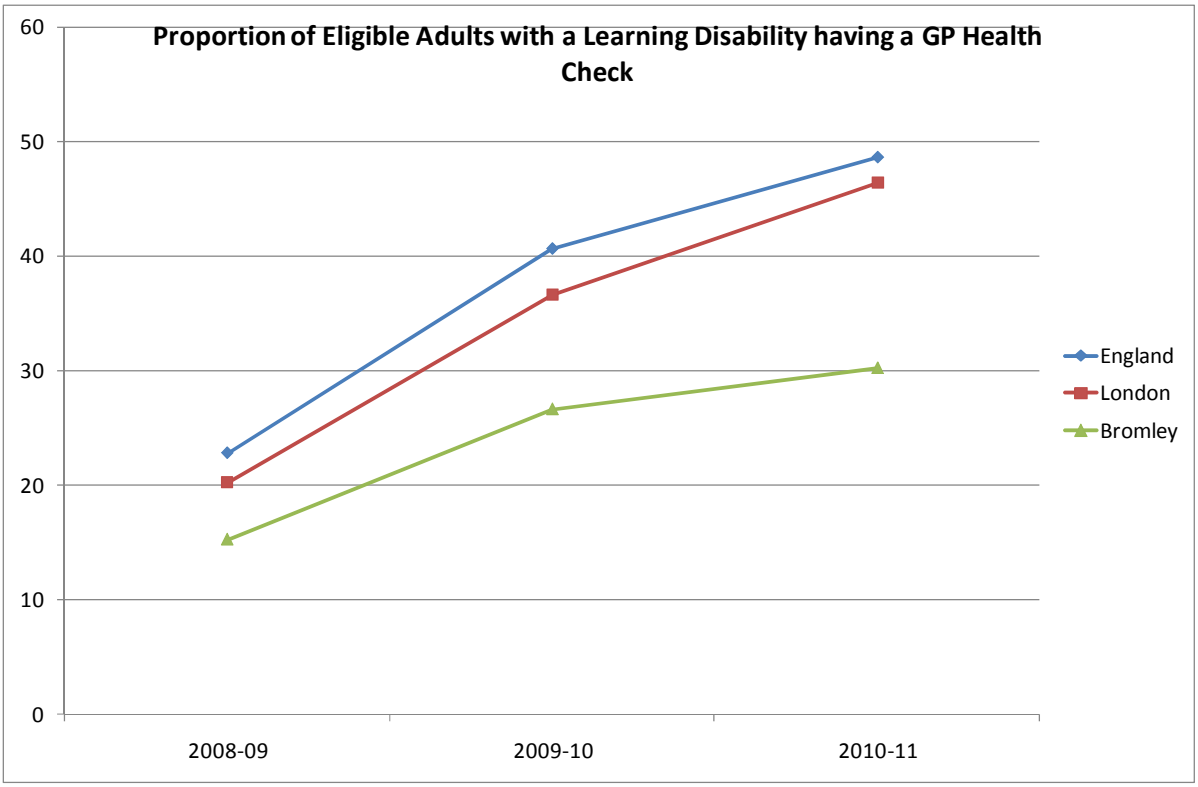
This discrepancy in identification of adults with LD has implications for the health care provision to this patient group.

People with learning disabilities have a higher prevalence of certain health problems such as epilepsy, dementia, gastro-oesophageal reflux disease and gastrointestinal cancer and have lower life expectancy. They also have more difficulty than others in recognising health problems and getting treatment for them, therefore, it is advisable for GPs to offer regular health checks to make sure that important health problems are identified and treated. If people are not known to have learning disability, they may not be offered a health check. In addition, the proportion of adults known to GPs who have had a health check is already significantly lower in Bromley than the England average.

In February 2009 directions were published by the Department of Health that required Primary Care Trusts (PCTs) to offer GP practices in their area the opportunity to provide health checks for adults with learning disabilities as part of a

Directed Enhanced Service. The DES was originally agreed for two years (2008-9 and 2009-10) and was then extended for at least another two years (2010-11 and 2011-12). In Bromley only 25 of 47 practices opted to participate in this DES, so not all people with learning disability known to GPs are covered by this scheme. However, it is likely that some GPs offer health checks outside the DES scheme as well. In addition, there has been a programme of awareness raising with people with learning disabilities, GPs and indeed hospitals, led by the Learning Disability Partnership Board supported by voluntary sector organisations including Advocacy for All and Bromley Mencap.

Figure 8.2



Data Source: Learning Disabilities Profile 2012

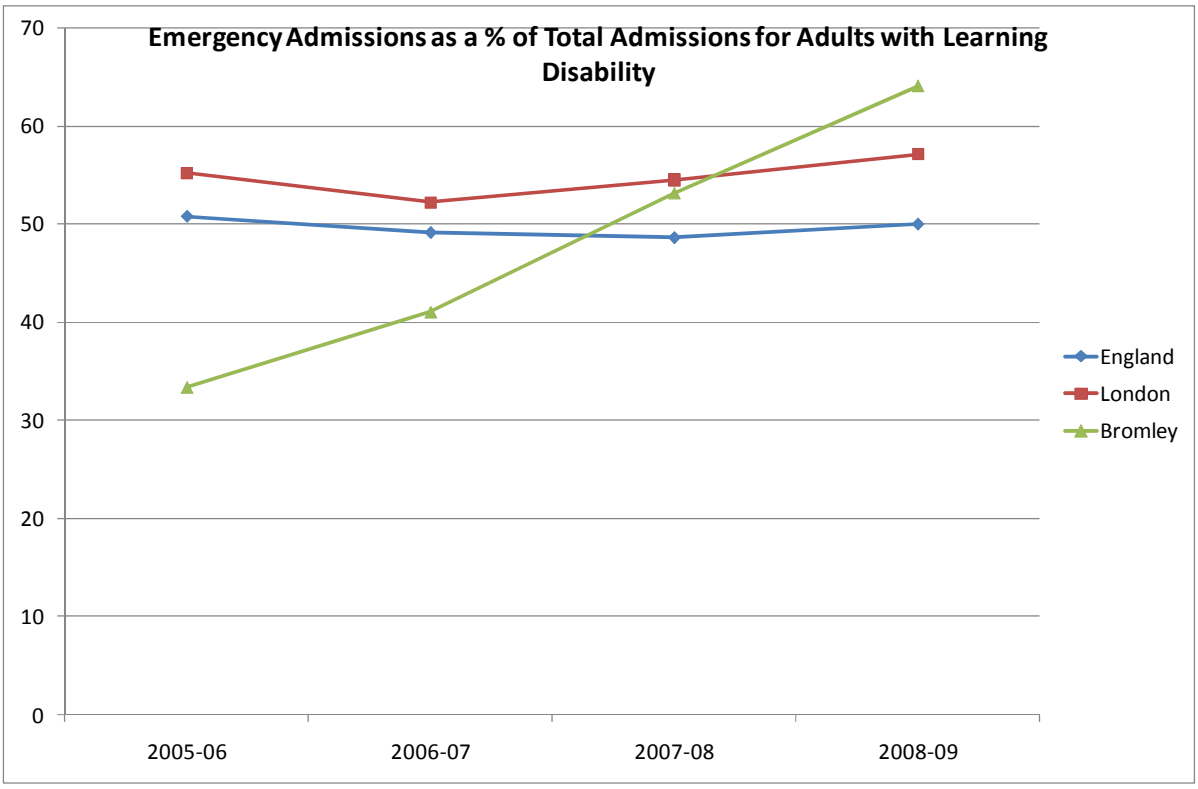
A further consequence of low levels of identification of adults with LD is reflected in admission rates to hospital.

People with learning disabilities have a higher proportion of emergency admissions to hospital than people who do not have learning disabilities (50.0% vs 31.1%). A high level of emergency admissions can be an indication that earlier opportunities to manage a condition out of hospital have been missed. Emergency admissions do not allow for advance planning to accommodate the needs of people with learning disabilities in hospital.

Bromley has significantly higher rates of emergency admissions for adults with learning disability than the England average. The trend shows a year on year rise in

these emergency admissions. However, it should be noted that this data only covers the period to 2009, so may not be representative of the current position.

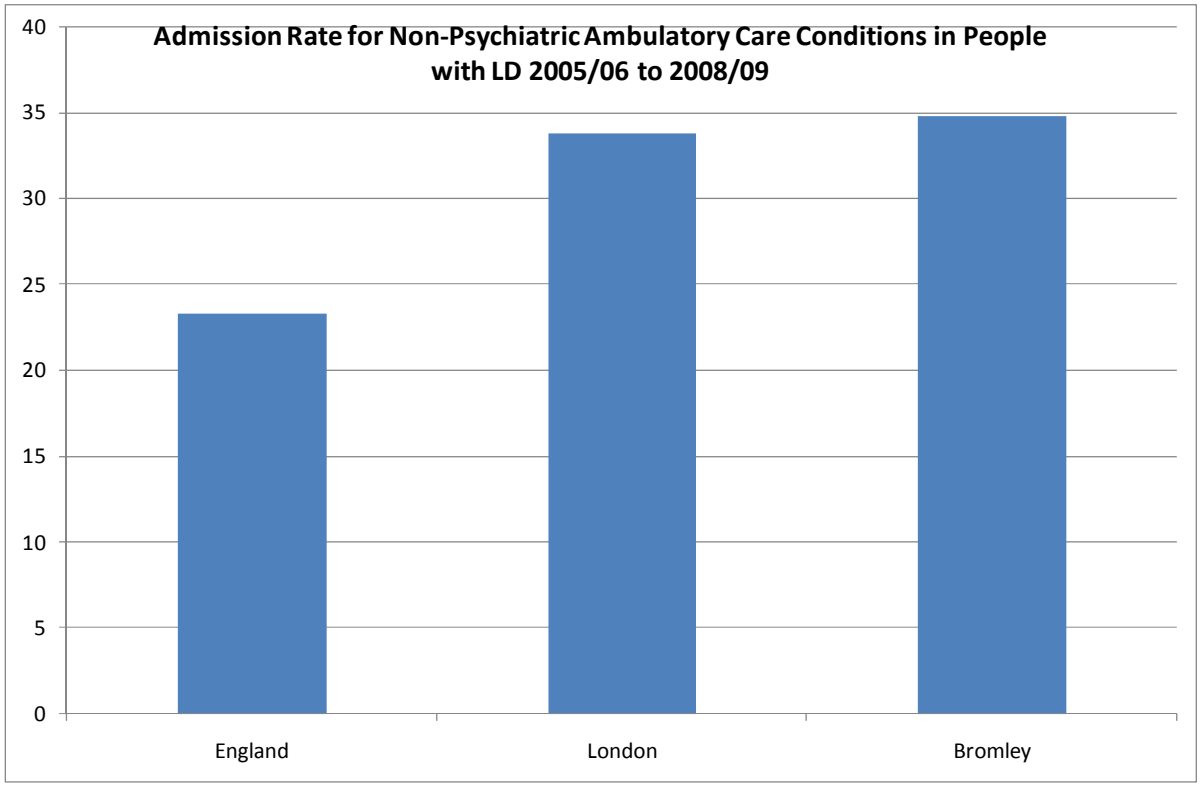
Figure 8.3



Data Source: Learning Disabilities Profile 2012

There are three types of physical health condition common in people with learning disabilities which are more likely to cause admission to hospital if ordinary care is not provided well. These are gastro-oesophageal reflux disorder, epilepsy and constipation. Hospital admission rates for these conditions provide some measure of the quality of community care. Rates of admission for these conditions are significantly higher in Bromley than the England average, but similar to the London rate.

Figure 8.4



Data Source: Learning Disabilities Profile 2012

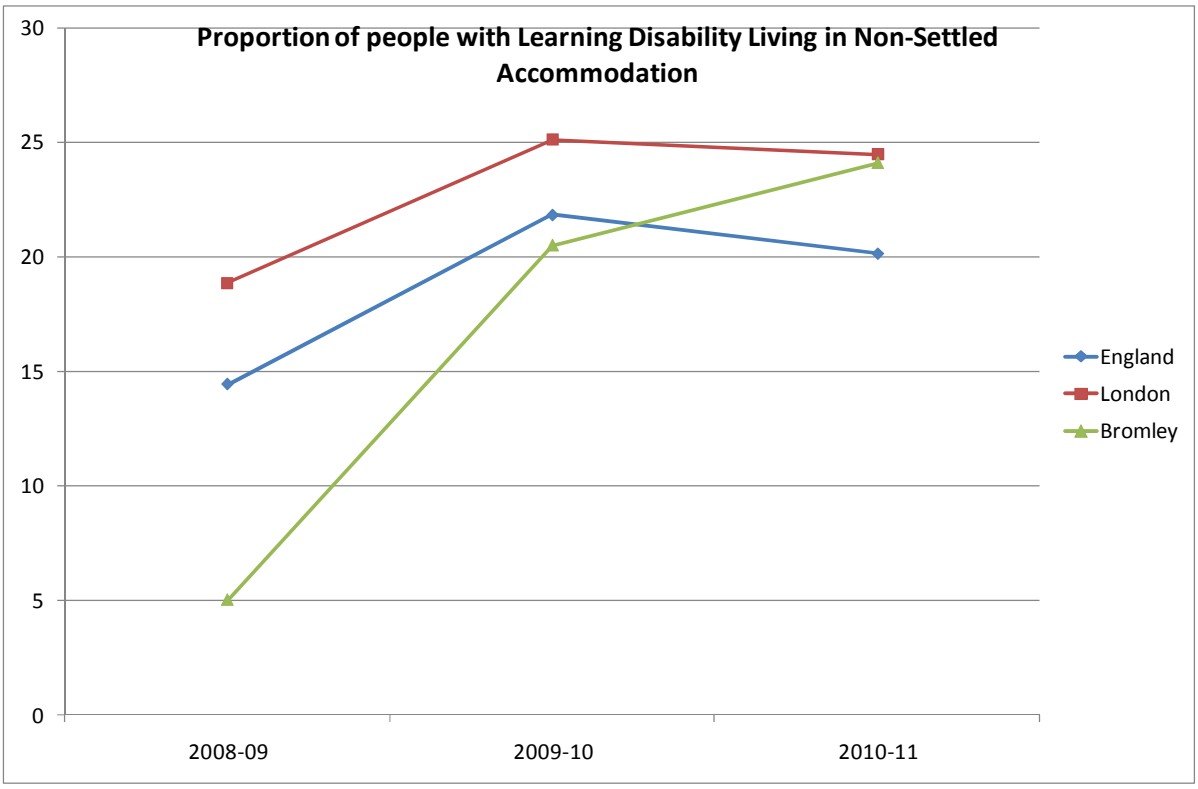
Healthcare for all; report of the independent inquiry into access to healthcare for people with learning disabilities, highlighted that hospitals do need to make appropriate reasonable adjustments so patients with learning disability understand, to the best of their capacity, what is happening and so that healthcare staff take their learning disability into account in assessing symptoms and progress and making decisions about healthcare. A measure of whether this happening is the specific recording of learning disability for episodes of hospital in-patient care. Additionally, family and other carers should be involved as a matter of course as partners in the provision of care, unless good reason is given.

In Bromley, identification of people with learning disability in general hospital statistics is significantly better than the England average. However, for psychiatric in-patient statistics, the identification rate is significantly worse than the England average (24.74% vs 55.61%).

Living arrangements pose difficulties for many people with learning disability. Local Authority Social Service Departments commonly help with this. Accommodation can be divided into settled accommodation, where the person can reasonably expect to stay as long as they want, and unsettled accommodation which is either unsatisfactory or, where, like in residential care homes, residents do not have security of tenure.

In Bromley, the proportion of people with learning disability living in settled accommodation is 57.07% and is not significantly different to the England average. However, the proportion of people with learning disability in Bromley living in non-settled accommodation is 24.08%, which is significantly higher than the England average and has been rising over the last two years. There remain a number of people with learning disability whose accommodation status is unknown to the Local Authority (180 people in Bromley, 18.85%). There are no people with learning disability known to be living in severely unsatisfactory accommodation.

Figure 8.5



Data Source: Learning Disability Profile 2012

The proportion of adults with learning disabilities receiving direct payments is significantly lower than the England average (11.72% vs 24.01%).

Gross expenditure for residential personal social services per 1000 people known to LAs with LD is significantly higher than the England average (25.49% vs 16.21%).

What does this mean for our JSNA?

There is a need to improve the identification of people with learning disabilities in primary care.

There is a considerable shortfall in the numbers of people identified with learning disability who have had an annual health check.

9. Physical Disability & Sensory Impairment

It is estimated that there are around 20,000 people of working age in Bromley who have a physical disability or sensory impairment, about 10% of the population aged 16-64. This figure is projected to increase to 21,750 by the year 2020.

Figures 9.1 and 9.2 show that the numbers of people with physical disability increase markedly with age.

Figure 9.1

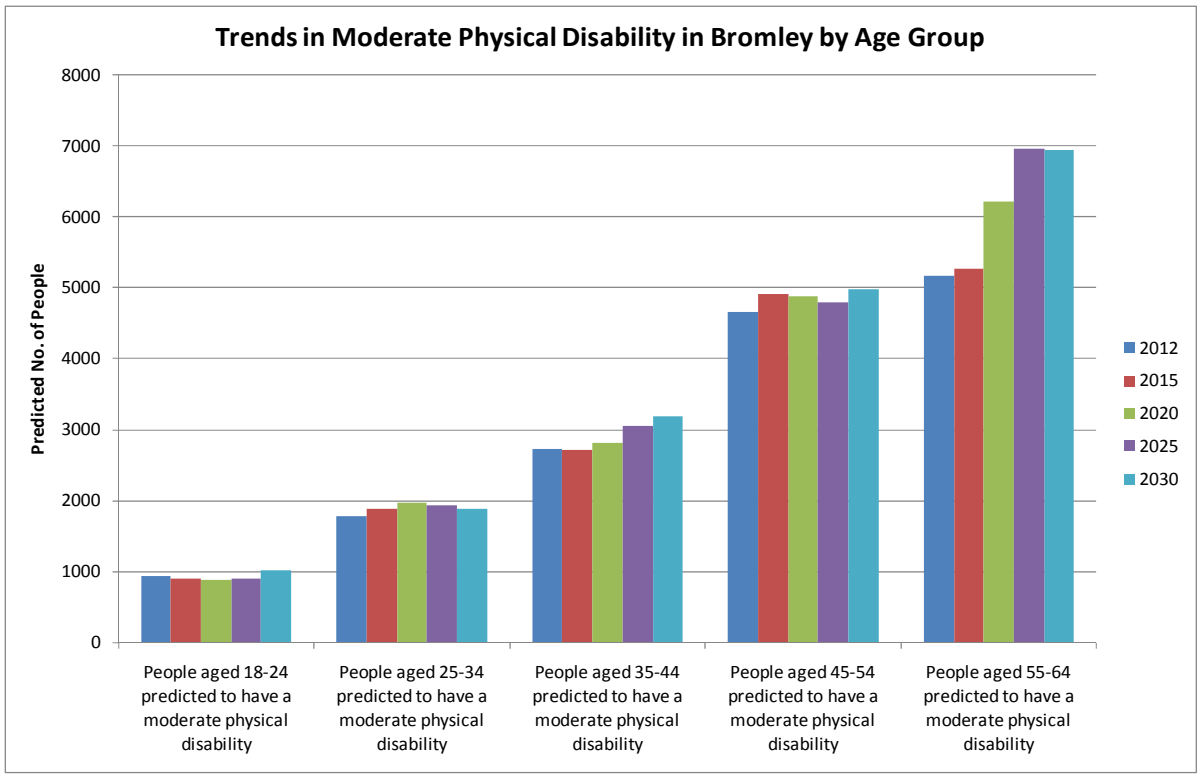
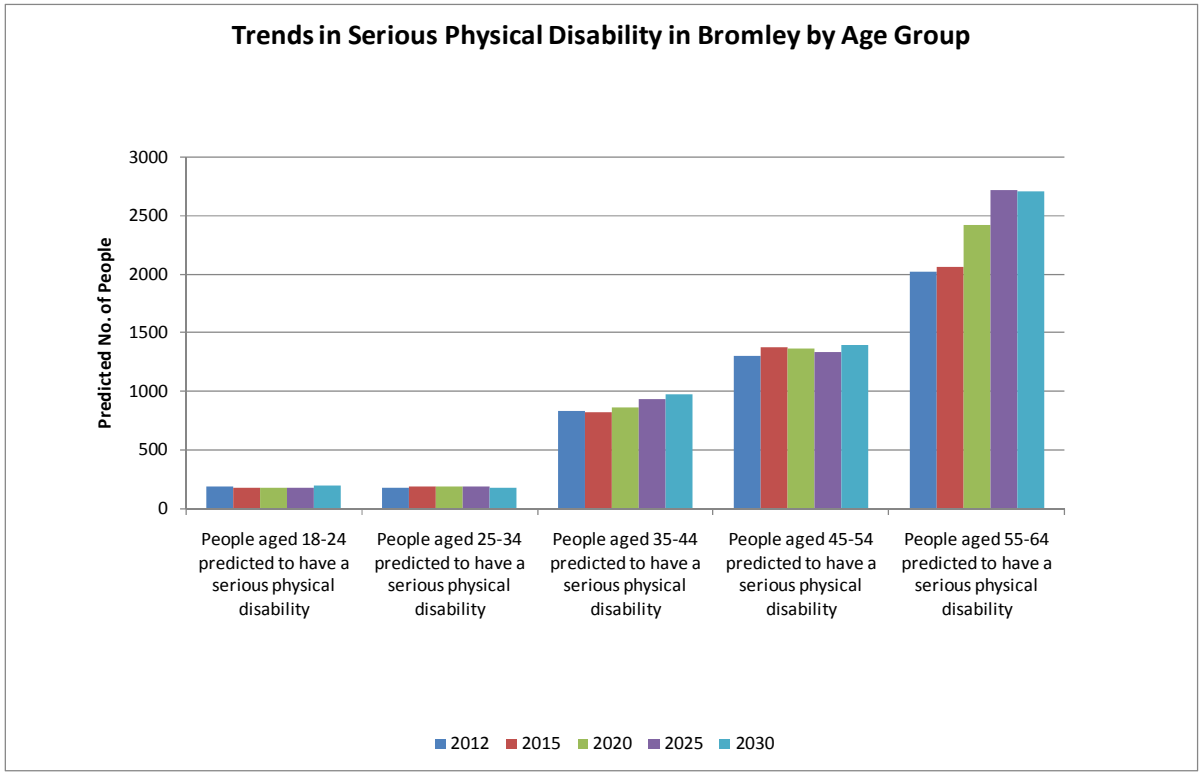


Figure 9.2



There are also over 31,000 adults over the age of 18 years with moderate or severe hearing impairment (predicted to rise to 35,000 by 2020) and a further 700 with profound hearing impairment (predicted to rise to 815 by 2020).

Figures 9.3 and 9.4 show that the number of people with moderate or severe hearing impairment increases with age up to the age of 85 years. The number of people with profound hearing impairment also increases with age, but doubles beyond the age of 85 years. Of the 720 people with hearing impairment who are registered with Deaf Access in Bromley, 23% have been profoundly deaf since birth and most of these will use sign language as their main mode of communication. These people have very different needs to those with acquired hearing loss, and consume a greater proportion of resources.

Figure 9.3

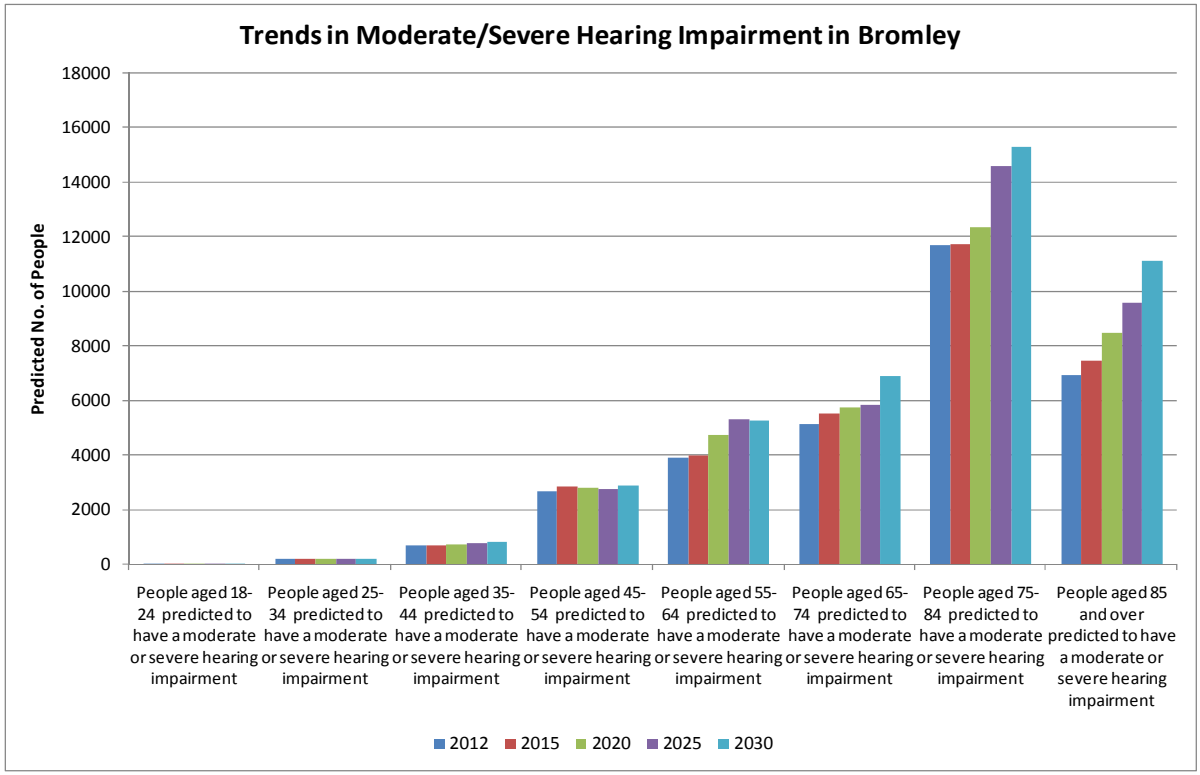
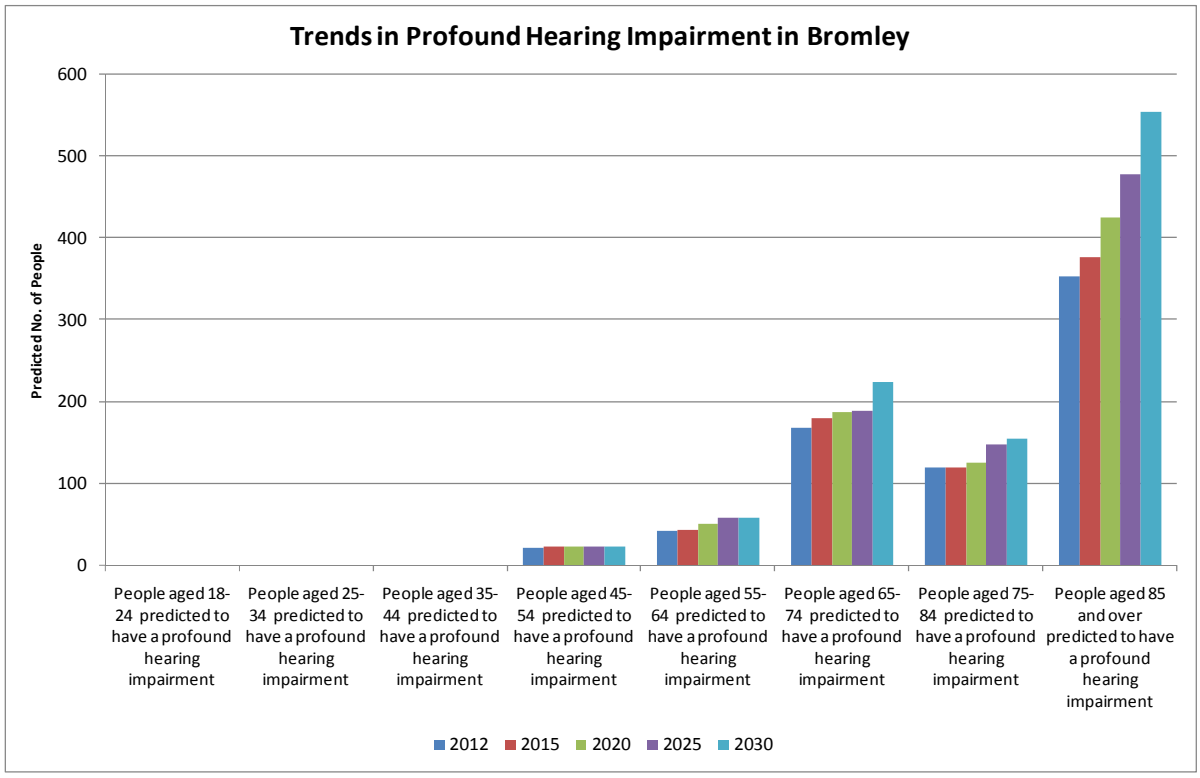


Figure 9.4



The numbers of adults between the ages of 18 and 64 years of age with a serious visual impairment is 129, predicted to rise to 138 by 2020.

In the older age groups (over 65 years) there are larger numbers of people with moderate or severe visual impairment, 4859 (predicted to rise to 5417 by 2020). Age related macular degeneration is the most common cause of registrable sight loss in older people.

Why is it important to address the needs of disabled people?
About half of disabled people are on benefits and less than half are employed. Given the right kind of support and the right kind of attitudes among non-disabled people, all of these people have the potential to contribute to our society – whether it is by work, volunteering, supporting others, educating, consuming and spending, paying taxes, or simply being present and engaged in the community. Without the right kind of support, disabled people can consume considerable resources – whether it is because they are unemployed, require special adaptations and services, depend on support from families and carers who, in turn, are prevented from fully engaging in society, or purely because of the guilt and discomfort that more fortunate people in society experience in their presence. There are therefore compelling economic, social and psychological reasons for ensuring that disabled people can play a full role in our community.

Furthermore, it is now illegal not to do so. The Equality Act 2010 brought together all anti-discrimination legislation relating to people with protected characteristics, of which disability is one. Public organisations with 150 employees or more are obliged by law to publish evidence of what steps they are taking to ensure that disabled people have access to services and facilities that non-disabled people take for granted. They must demonstrate that they have engaged with disabled people, assessed their needs, put in place measures to meet those needs, and gathered evidence as to the success of those measures.

The needs of disabled people in Bromley
Last year, a needs assessment of disabled people in Bromley was conducted jointly by public health and social care. The scope of the work was decided through consultation with local disabled people, whose main concerns were around the ability of disabled people to live normal lives. Following an extensive investigation, in which disabled people and those who care from them were interviewed and surveyed, the following priorities were agreed:

- ***Disability awareness among staff and public***. Because the way that disabled people are treated has such an enormous impact on the quality of their lives, and their ability and willingness to access services and facilities, raising awareness and improving attitudes among staff and public has the potential to have a large positive impact, not just on their experience, but on all the other areas of concern.

- ***Empowering people with disabilities***. There are many services available to people with disabilities but they are not always used. Many people do not register as disabled, they do not always know about available services, and may feel deterred from accessing them. In addition, disabled people themselves are a source of support that is currently under utilised. Thought needs to be given as to what kind of support is needed, both informal and professional, in order to prevent and alleviate mental ill health, and to increase motivation, empowerment and sense of well-being.
- ***Transport***. For people who are blind, or who use a wheelchair, to be able to travel on public transport independently would make a huge difference to their lives. While the railway system is relatively accessible, buses currently are not. Some of the solution may lie in increasing practical help provided by bus drivers. Recruitment of volunteer private drivers would help people who currently are dependent on a companion in order to get out of the house, but who don't have a regular carer.
- ***Access***. Accessibility varies widely in the borough. Accessibility audits need to be conducted routinely, and action plans need to be developed on the basis of the results. Ways of bringing more services and premises up to the standards of the best, and the kind of guidance that could be provided to facilitate this, need to be explored.
- ***Paid and unpaid employment***. Less than half of all disabled people are employed, and expectations of paid work appear to be low. There are already services in place to support disabled people to find work and advise organisations on adaptations. What needs to be explored is why such a low proportion of disabled people are employed.

Progress to date

These findings have been circulated and presented widely; to user groups, partnership boards, and to individuals in LBB and local NHS organisations who have responsibility for access and training.

Staff training is currently being addressed in LBB, and improving accessibility has been made a priority. Transport issues are being addressed by the Mobility Forum, which has contributed extensively to the development of Bromley South station, and are contributing to plans at Bromley North.

A new Vision Strategy group has been set up, with support from external specialist agencies, and a strategy developed. A counselling support group for newly registered people with visual impairment has been set up and early reports say that this is very much appreciated by, and beneficial to, participants.

Disabled Go has performed an annual review of venues in Bromley this year and have reported a number of improvements relating to access with 24% of venues implementing non-structural changes such as:

- The introduction of disability equality training
- Provision of hearing assistance
- Provision of an email address as an alternative method of contact.

In addition, 5% of venues had some form of structural change to improve access, and encouragingly these premises included GP and dental surgeries, pharmacies and opticians.

The government's Health and Social Care reforms, changes in the way benefits are provided and stricter criteria for access to those benefits, such as mobility allowance, will all have an impact on local disabled people.

10. Mental Health

Introduction

Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential. Moreover good mental health and wellbeing also bring wider social and economic benefits. Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality and higher levels of social interaction and participation.

Some mental health problems are long lasting and can significantly affect the quality of people's lives, especially if they are not treated. Some people only experience a single episode of mental ill health. Others, who may have longer standing problems, can enjoy a high quality of life and fulfilling careers. However, the personal, social and economic costs of mental ill health can be considerable.

Key Health Issues

Having mental health problems is distressing to individuals, their families, friends and carers, and affects their local communities. It may also impact in all areas of people's lives. People with mental health problems often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation. They are more likely to have poor physical health.

Mental Health can also contribute to perpetuating cycles of inequality through generations. However, early interventions, particularly with vulnerable children and young people, can improve lifetime health and well being, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. Such interventions not only benefit the individual during their childhood and into adulthood, but also improve their capacity to parent, so their children in turn have a reduced risk of mental health problems and their consequences.

Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as

schizophrenia or bipolar disorder die on average 16-25 years sooner than the general population. They have higher rates of respiratory cardiovascular and infectious disease and of obesity, abnormal lipid levels and diabetes. They are also less likely to benefit from mainstream screening and public health programmes.

Increased smoking is responsible for most of the excess mortality of people with severe mental health problems. Adults with mental health problems, including those who misuse alcohol and drugs, smoke 42% of all tobacco used in England. Over 40% of children who have conduct and emotional disorders are smokers.

Mental health problems such as depression are also much more common in people with physical illness and having both physical and mental health problems delays recovery from both. Children with a long term physical illness are twice as likely to suffer from emotional or conduct disorder problems. People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven more times more likely to have depression. Adults with both physical and mental health problems are less likely to be in employment.

Adult Mental Health Need in Bromley

Mental health/psychological symptoms are common in the adult population affecting up to 1 in 3 people. Applied to Bromley, this prevalence would mean that 64,000 people are suffering from one of these symptoms at any one time. About half of those with symptoms, 1 in 6, will suffer from a recognised mental health problem including depression, phobias, obsessive compulsive disorder, panic disorder, generalised anxiety disorder and mixed anxiety and depressive disorder. In Bromley this would equate to about 32,000 people, of whom about 4,000 people will be known to secondary services.

The table below shows the estimated number of people with a variety of conditions and predicted numbers for future years. It should be noted that the survey upon which the figures are based only included people living in private households. Common mental disorders include different types of depression and anxiety and women are 7% more likely to be affected than men. Those with a common mental disorder are mostly likely to be treated in primary care. Data from GP registers in 2009/10 show that the number of people with depression over 18 in Bromley is significantly worse than the average in England.

Table 10.1 - Bromley - People aged 18-64 predicted to have a mental health problem projected to 2014

Mental Health – 18 – 64 years	**2010**	**2011**	**2012**	**2013**	**2014**
People aged 18-64 predicted to have a common mental disorder	31,112	31,337	31,441	31,595	31,835
People aged 18-64 predicted to have a borderline personality disorder	872	878	881	886	893
People aged 18-64 predicted to have an antisocial personality disorder	660	665	666	670	674
People aged 18-64 predicted to have psychotic disorder	774	779	782	786	792
People aged 18-64 predicted to have two or more psychiatric disorders	13,847	13,947	13,991	14,063	14,165

Based upon Adult Psychiatric Morbidity in England, 2007 (does not include people in secondary care) and ONS data

Over 2,500 people in Bromley (1% of the adult population) have been identified by GPs as experiencing serious mental illness, as illustrated below.

Table 10.2 – Quality and Outcomes Framework Serious Mental Illness Prevalence

	2008/09	**2009/10**	**2010/11**
Number of people registered by GPs as having severe mental ill-health	2,351	2,389	2,511
Serious mental illness prevalence	0.9%	0.9%	1.0%

Source: Quality Management and Analysis System

Bromley Community Mental Health Profiles

- Homelessness households rate per 1000 population significantly worse than England rate but similar to Regional rate.
- Percentage of 18+ with depression significantly worse than both England and Regional rates.
- Directly standardization rate for emergency hospital admissions for unipolar depressive disorders is lower than England Rate.
- Numbers of people using adult and elderly NHS secondary mental health services, rate per 1000 population is significantly higher than the England rate (where no perceived polarity).
- In year bed days for mental health, rate per 1000 population is significantly higher than England Rate but higher than Regional Rate.
- Number of contacts with Community Psychiatric Nurse, rate per 1000 population were significantly higher than England but similar to Regional rates (where no perceived polarity).
- Number of total contacts with mental health services, rate per 1000 population is significantly higher than the England rate but similar to Regional Rate. (where no perceived polarity)

These findings will be used to inform the development of mental health provision for Bromley over the next three years.

Mental Health and Older People

Bromley has the highest number of people over 65 years and over 85 years in London and is projected to continue to have the highest number in these age groups. People over 65 in Bromley make up approximately 15.5% of the population.

Population projections indicate that the older population in Bromley is due to rise between 4.3% – 8.2%, up to 4,300 people between 2011 and 2015. The largest rises are expected to be in the 65 - 74 years group.

The number of older people living alone is predicted to increase in line with the general rise in numbers of older people.

The second National Psychiatric Morbidity Survey (2007) showed that in this age group there were lower rates of common mental health problems such as worry, irritability and depression compared to the adult population.

Table 10.3. - Estimated percentage of older people with depressive illness in England and Wales, and estimated numbers for Bromley

Mental Health Condition	% of older adults	Estimated number of people in Bromley aged 65+
Major depression	3-5%	1,450 – 2,600
Minor depression	10-15%	4,800 – 7,800

A study carried out by Cambridge University in the same year which focussed on older people showed slightly lower rates for those with depression and severe depression. The overall prevalence of depression was 8.7%, increasing to 9.7% if subjects with concurrent dementia were included. Depression was more common in women (10.4%) than men (6.5%) and was associated with functional disability, co-morbid medical disorder, and social deprivation. Prevalence remained high into old age, but after adjustment for other associated factors, it was lower in the older age groups.

Table 10.4 - Predicted estimates of depression in older people in Bromley from the study by Cambridge University

Age	2011		2015	
	Depression	Severe Depression	Depression	Severe Depression
65 – 69	1,205	353	1,405	408
70 – 74	957	184	1,016	197
75 – 79	880	357	903	368
80 – 85	800	252	800	255
85+	748	320	818	355
Total	**4,591**	**1,465**	**4,941**	**1,582**

POPPI data based on ONS population estimates

Dementia

Dementia is clinically defined as an age-related progressive disease associated with cognitive impairment, disorientation, memory loss, change in personality, difficulties with activities of daily living and behaviour that is out of character. (NICE, 2004, Cummings and Jeste, 1999)

One third of people over 95 have dementia and two thirds of people with dementia are women (Dementia UK). Dementia currently affects 800,000 people in the UK, one person in twenty aged over 65 years and one person in five over 80 years of age.

A Dementia Needs Assessment has recently been carried out in Bromley. This provides information relating to the incidence of dementia in Bromley and includes projections of future numbers based on the Dementia UK report of 2007. In total it is estimated that there are just over 4,000 people in Bromley with dementia in 2011. Although the prevalence of dementia is lower in women there are actually more women than men with dementia in Bromley because life expectancy is higher in women. There are more men with dementia in the 65 – 74 age groups, but women outnumber men in the higher age groups. By 2030 the number of people with dementia in Bromley is set to increase to 6,151. Within the next four years there will be an increase of nearly 300 people with the greatest increase in the over 85 years: as well as dementia this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,400.

Table 10.5 - Predicted estimates of dementia in older people in Bromley

Age	2011	2015
65 – 69	174	202
70 – 74	312	331
75 – 79	601	618
80 – 85	1,022	1,022
85 - 89	1,050	1,144
90+	899	1,016
Total	**4,058**	**4,333**

PANSI data based on ONS population estimates

The Dementia Needs Assessment also contains information from Healthcare for London which estimated the number of people in Bromley with mild, moderate and severe dementia in the table below. Those with the most severe forms of the condition will have much higher medical, social and mental health needs in comparison to those with mild or moderate disease who may be able to function relatively independently.

Table 10.6 - Estimated number with late onset of dementia by level of severity in Bromley

Severity of dementia	Number aged 65 and over
Mild	2,008
Moderate	1,190
Severe	482
Total	**3,680**

National and Regional Trends in Suicide Mortality

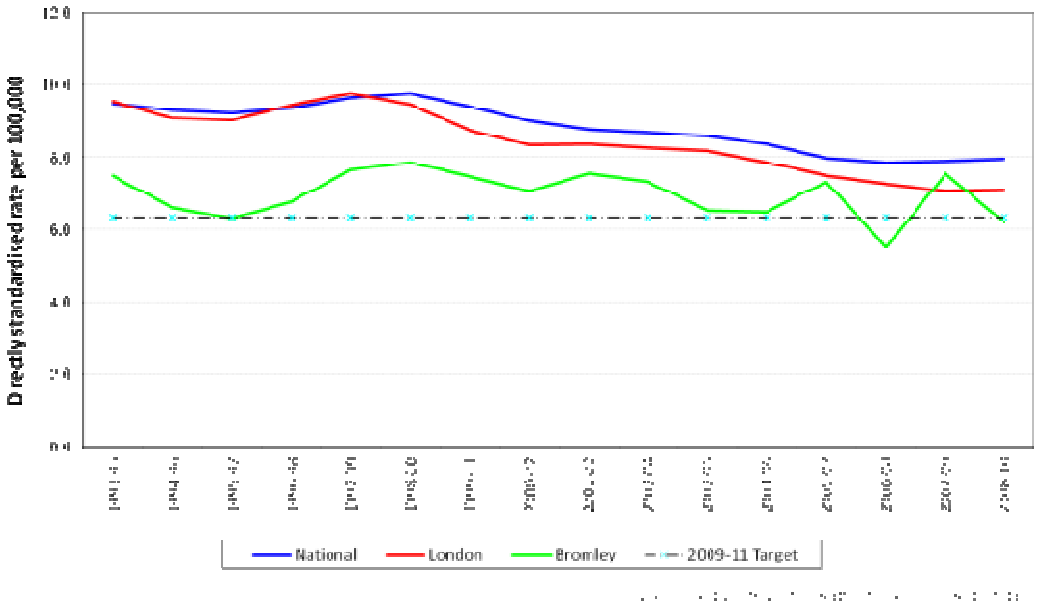
In London, there are approximately 600 deaths attributed to suicide and undetermined injury each year, which equates to a rate of around 8.3 per 100,000 people which is similar to the National rate. In 2010 in Bromley, there were 13 deaths from suicide and undetermined injury (4.3 per 100,000, population), a decrease from the 2009 figure of 22 deaths and a rate of 7.3 per 100,000.

In Figure 10.1, the mortality rates have been aggregated over three years to increase the number of events to levels which are more statistically meaningful.

There will appear to be year to year variability in relation to national and London figures because of the small numbers involved locally.

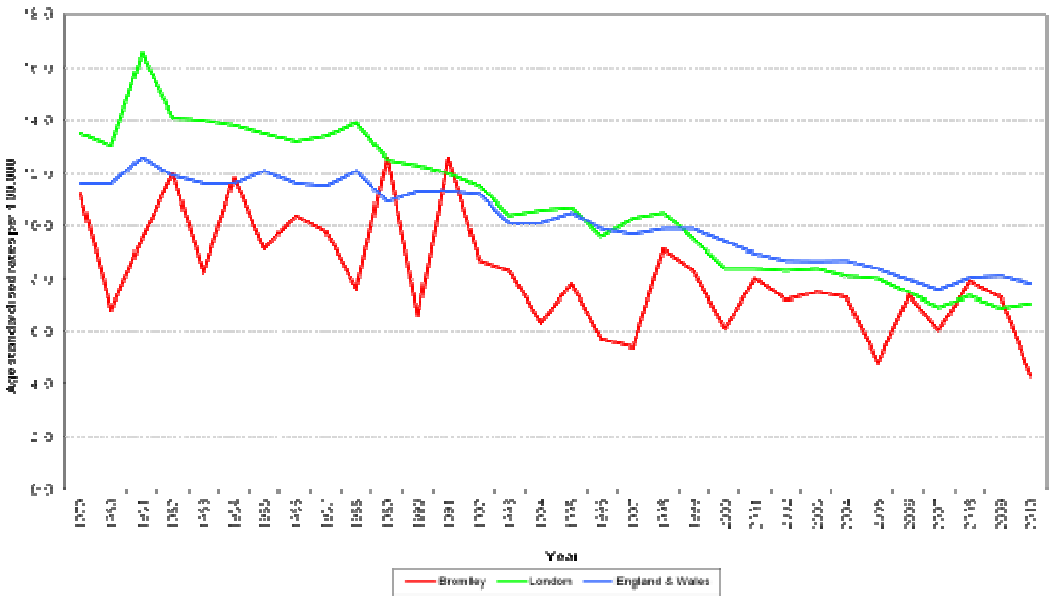
In Figure 10.1, the three year average mortality rates show a more ‘smoothed’ trend line. In 2008-2010, for example, the mortality rate for Bromley had achieved the 2009-2011 target.

Figure 10.1 - Mortality rates from suicide and injury of undetermined intent in Bromley compared with London, England and the 2010 target for Bromley (all persons, all ages)



In Figure 10.2 we can see that overall the trend of suicide rates in Bromley has decreased despite fluctuation from year to year.

Figure 10.2 - Annual trends in mortality from suicide and undetermined injury

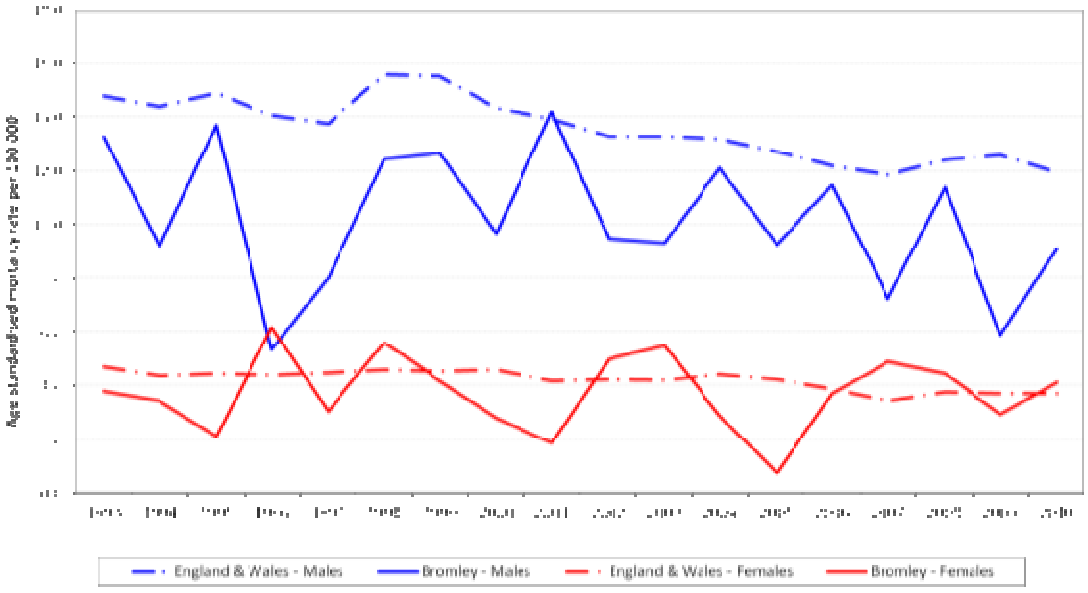


Patterns in suicide mortality by age and gender

Nationally, there has continued to be an encouraging and sustained fall in the rate of suicide amongst young men under the age of 35. However, the death rate from suicide amongst this high-risk group is still high in comparison with the general population (NIHME 2007). The majority of suicides continue to occur in young adult males, that is, those under 50 years. In comparison to women of the same age, younger men are more likely to take their own lives. The peak difference is the 30-39 age group as there are four male suicides to each female. The average ratio between men and women of all ages is almost three male suicides to each female. Once people pass 50 years of age, the ratio gradually reduces, to around 2.1 male suicides to each female suicide in the 80 and over age group (NIHME 2007).

Figure 10.3 shows the age standardised mortality rate for males and females in Bromley compared to England & Wales.

Figure 10.3 - Trends in mortality from suicide and undetermined injury, 1993 to 2010 annually, all ages

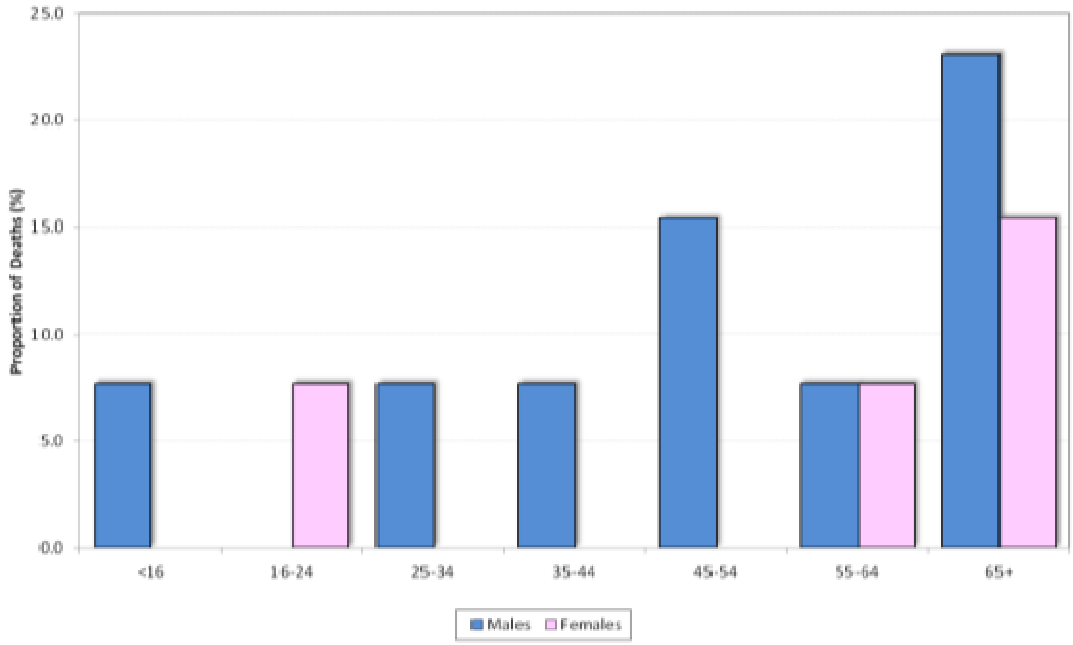


From the figure above we can see that there is a difference in the number of suicides between the sexes. Overall, suicide rates for men in Bromley are about three times higher than for women.

In 2010, 69.2% of all people dying by suicide were men, of which the 65 years and over age group had the most number of male deaths.

Figure 10.4 illustrates that the majority of suicides in Bromley are aged 45 years and over.

Figure 10.4 - Age and sex breakdown of suicides in Bromley 2010



Source: Public Health Mortality Files, Vital Statistics Branch - Office for National Statistics

In Bromley 2010:

- **69.2% were aged 45 years and over.**
  The majority of deaths within this age group had a history of depression and poor physical health. The reasons for depression ranged from having to deal with poor health to work related stress and financial difficulties.

- **38.5% were 65 years and over**.
  Where the information was recorded, it was found that these deaths had records where terminal cancer and depression were present.

- **30.8% of all suicides were women.**
  A 19.2% decrease compared to 2009.

- **15% were experiencing financial difficulties.**
  A number of deaths in 2010 had recorded information about these people experiencing serious financial difficulties and/or work related problems.

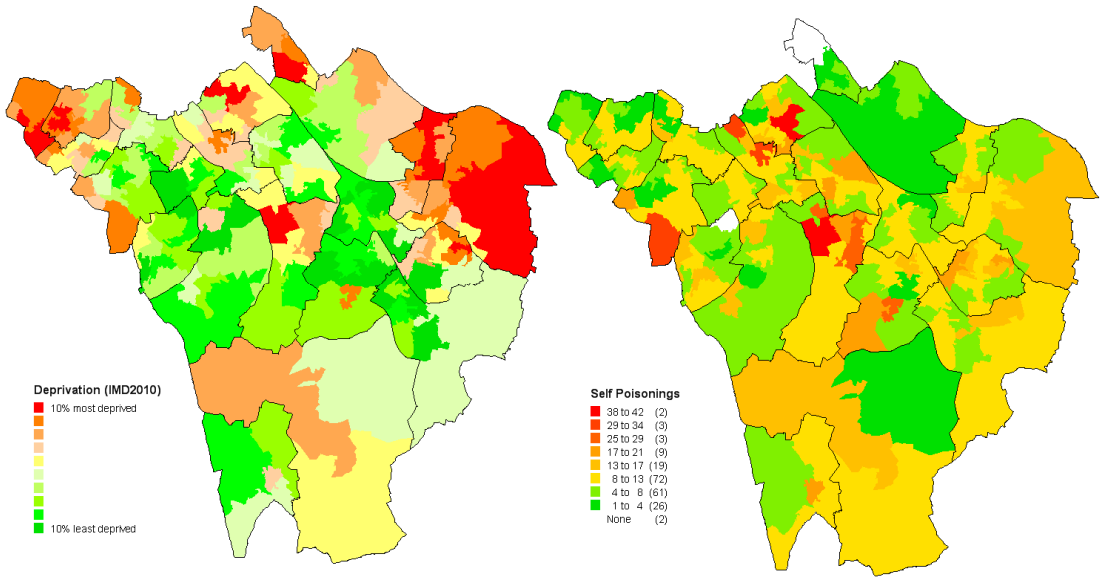
- **23% of deaths were aged 25 years and under.**

Deliberate Self Harm

National figures show Deliberate Self Harm (DSH) methods as including overdose, electrocution and wounding although the most commonly used is self-poisoning, by both men and women.

This picture is reflected in Bromley (2010) where drug overdose was the most common method across the Borough. National figures demonstrate that DSH acts tend to be concentrated around deprived areas but within Bromley these acts of self-harm are fairly scattered across the borough.

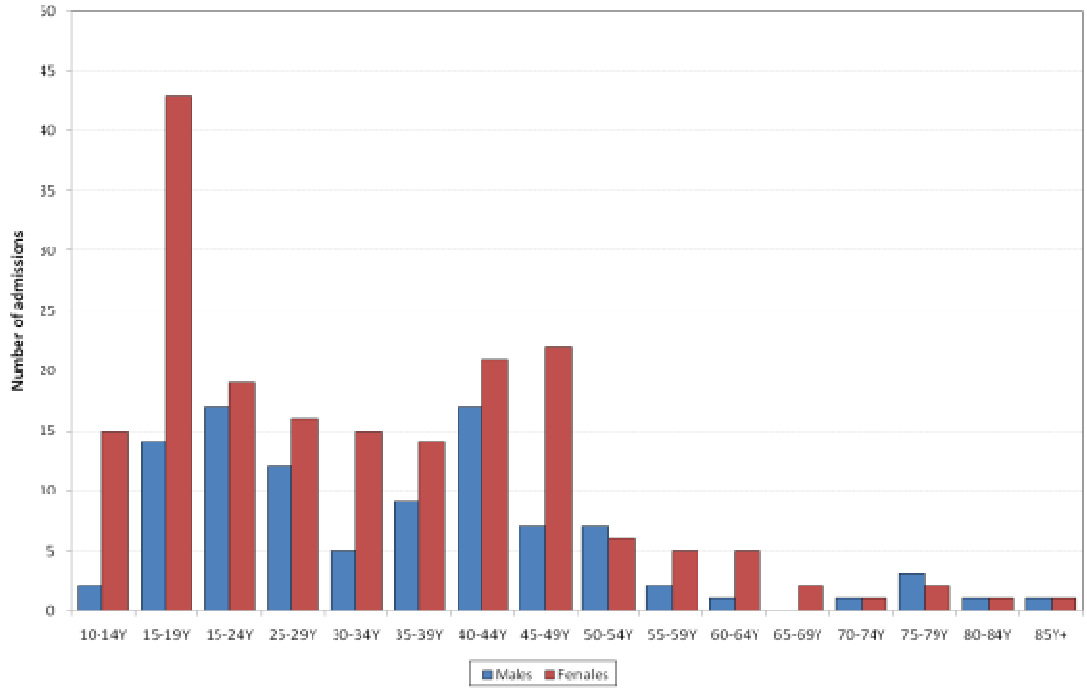
Figure 10.5 - Index of multiple deprivation 2010 compared with the number of self-poisoning admissions in 2010 across Bromley



DSH is strongly associated with the manual occupational social groups, the unemployed and socio-economic deprivation.

In 2001 there were 122 hospital admissions for deliberate self-harm. In 2010 this number had increased to 287 an increase from previous year of 277 (where 86% of these admissions were for self-poisonings).

Figure 10.6 - Emergency admission for self-harm (all types) 2010 by age and gender

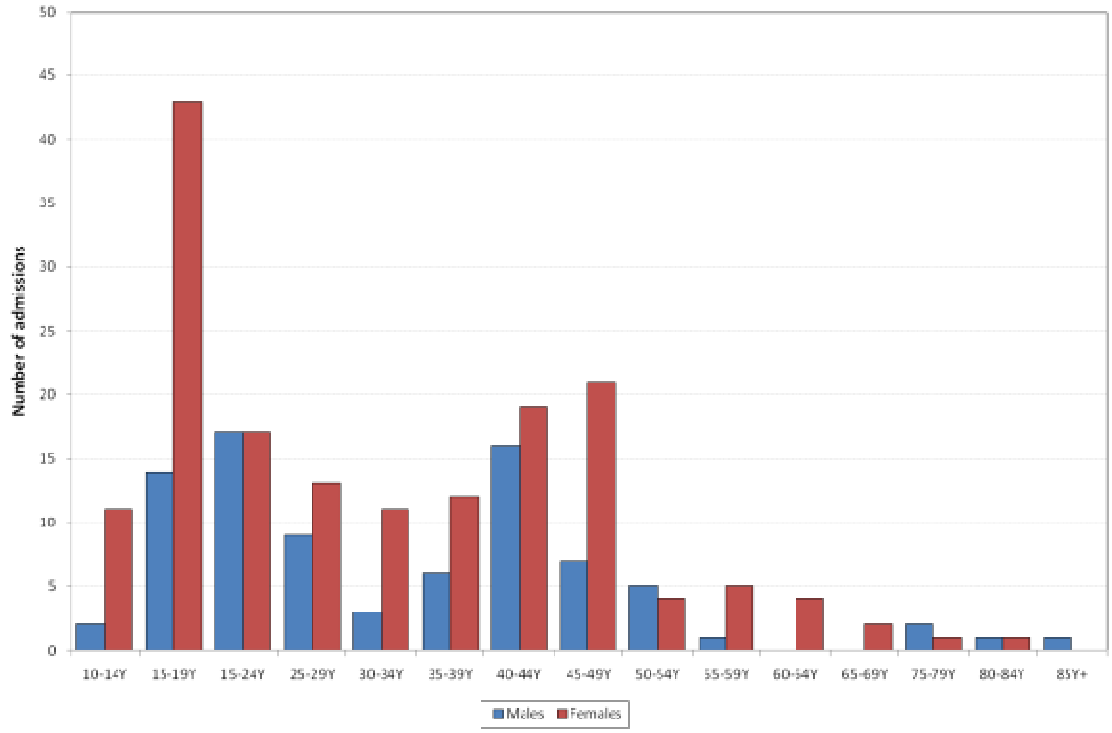


Source: NWCS CDS/SUS, NHS Bromley

The 15 -19 year old age band feature the highest number of admissions following self-harm, numbers remain high and throughout life up to the age of 49 for women. Deliberate self-harm is a way of coping with life and most commonly starts in teenage years.

There is a link between self-harm and completed suicide reported by the Samaritans (1998), one out of every 100 attempts will result in death within one year.

Figure 10.7 - Emergency admission for self-harm (self-poisoning) 2010 by age and gender

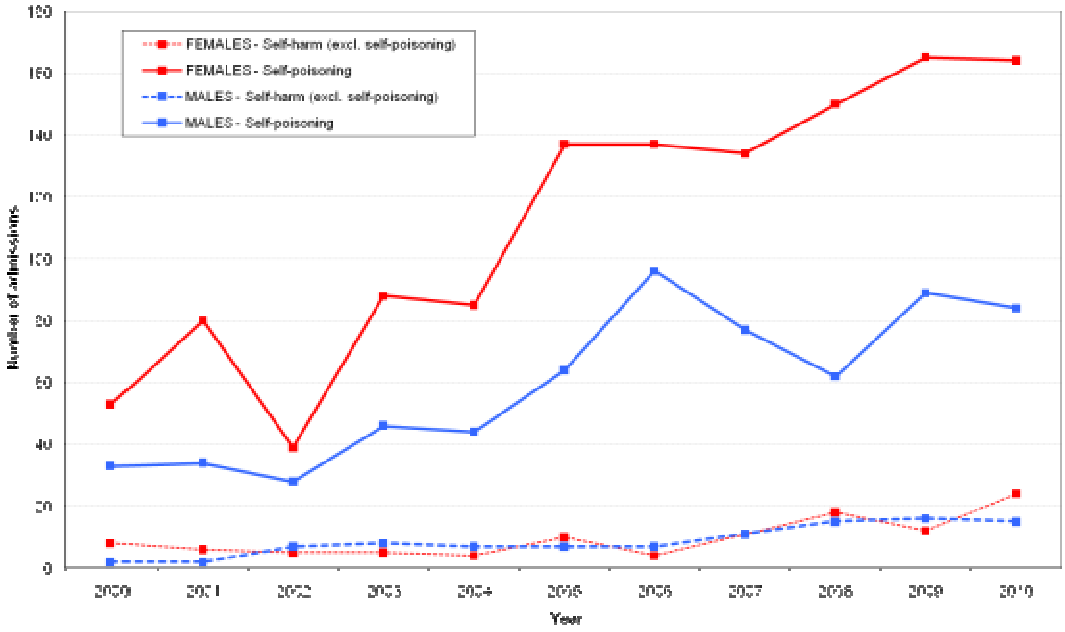


Source: NWCS CDS/SUS, NHS Bromley

66.1% of emergency admissions for self-harm are females following self-poisoning with drugs.

The Samaritans (1998) state that the more a person self-harms the greater the risk that they will eventually die by suicide. Therefore implementation of the Royal College of Psychiatry guidelines on self-harm in Bromley has been important and necessary.

Figure 10.8 - Emergency admission trends for self-harm by age and gender



Source: NWCS CDS/SUS, NHS Bromley

Links between Mental Well-being and Physical Health

Over the last twenty years more evidence has become available on the impact of mental health on physical health.

It may be that poverty, inequality and social exclusion affect physical health via their impact on mental health. It has been found as a result of studies that explore the impact of mental health on physical health and physical illness that depression increases the risk of heart disease fourfold. This increased risk is sustained after controlling for other known risk factors e.g. smoking.

Depression also has a significant impact on health outcomes for a wide range of chronic physical illness, including asthma, arthritis and diabetes. Lack of control at work is associated with increased risk of cardiovascular disease. Emotional well-being is also a strong predictor of physical health.

The impact of physical health on mental well being

The management of long term conditions and maintaining individual's mental wellbeing is a key role for all statutory services. The physical wellbeing of people with mental ill health where long term physical health conditions can also lead to lower life expectancy is now recognised as a priority by both Government and professional bodies.

Bromley Mental Health Key Points:

- One person in six has a mental health problem at any one time, and one in four will have a problem during their lifetime.
- In recognition of the burden of mental health caused by moderate depression and anxiety disorders, there is a current strategy for improving access to psychological therapies (IAPT) known to be effective in treating these disorders.
- Bromley has a lower than average suicide rate, in 2010 there were 13 deaths from suicide and undetermined injury (4.3 per 100,000 population), a decrease from the 2009 figure of 22 deaths and a rate of 7.3 per 100,000, population.
- Since 2002, there has been a significant increase in admissions for self poisoning. In 2001 there were 122 hospital admissions for Deliberate Self Harm. In 2010 this number had increased to 287 where 86% of these admissions were for self poisoning.

- Estimates have suggested that the cost of treating mental health problems could double over the next twenty years. More than £2 billion is spent annually on social care for people with mental health problems.
- Mental health problems such as depression are also much more common in people with physical illness and having both physical and mental health problems delays recovery from both. Children with a long term physical illness are twice as likely to suffer from emotional or conduct disorder problems.
- Having a mental health problem increases the risk of physical ill health. People with mental health problems such as schizophrenia or bipolar disorder die on average 16-25 years sooner than the general population.
- People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven more times more likely to have depression. Adults with both physical and mental health problems are less likely to be in employment.

- In total it is estimated that there are just over 4,000 people in Bromley with dementia in 2011. By 2030 the number of people with dementia in Bromley is set to increase to 6,151. Within the next four years there will be an increase of nearly 300 people with the greatest increase in the over 85 years: as well as dementia this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,400.

Drug and Alcohol Misuse are dealt with in a separate section of the JSNA

What this means for the JSNA

The percentage of over 18s with depression is significantly higher in Bromley than the percentages for both England and London.

Overall, suicide rates for men in Bromley are about three times higher than for women.

In 2010, 69.2% of all people dying by suicide were men, of which the 65 years and over age group had the highest number of male deaths.

In 2010 there were 287 hospital admissions for deliberate self-harm (a significant increase from the 122 in 2001). 86% of these admissions were for self-poisoning.

The 15 -19 year old age group have the highest number of admissions following self-harm, numbers remain high and throughout life up to the age of 49 for women.

Within the next four years there will be an increase of nearly 300 people with dementia, with the greatest increase in the over 85 year age group. As well as suffering from dementia, this group of people are also likely to be the most frail and have other long term conditions. By 2030, this group will have risen by 1,400.

Emotional well-being is a strong predictor of physical health. Men and women who scored highest in a survey on emotional health were twice as likely to be alive by the end of the study. Improving the mental health of the population is expected to decrease the prevalence of a variety of physical health problems, amongst others, cardiovascular disease.

Implementation of the Mental Health Strategy and CCG Mental Health Programme are key tasks over the next few years.

Mental Health in Children and Young People

This section summarises the key findings of the CAMHs Needs Assessment 2012.

This needs assessment looked at a range of local information, including surveys of children and young people (CYP). Where possible, findings were compared to national surveys or similar London boroughs. Although many indicators were positive, some highlighted possible local issues.

Concerning findings include that the measure of overall emotional well-being in Bromley CYP is lower than would be expected. Also, there is some indication that children and young people in Bromley are not able to talk to their parents, family or friends when they are worried.

The surveys indicated that schools may like to consider how they may address bullying better, provide more help on handling feelings and planning for the future, and ensure young people feel listened to.

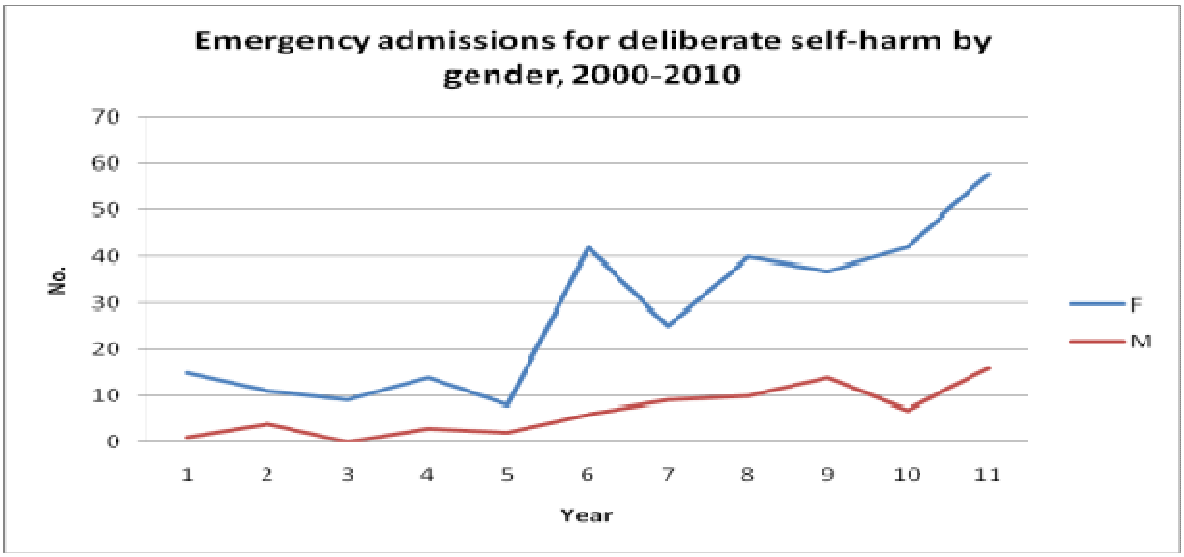
Other local issues, although not directly about emotional health, are likely to impact on overall well-being. These include concerns about safety on public transport for children, relatively low levels of physical activity within and outside school, relatively low participation of children and young people in church or other community group and low engagement of children and young people with adults outside the home. One factor may be the cost of out-of-school activities for children and young people in Bromley.

Findings on specific conditions

Local Special Educational Needs and Disabilities (SEND) data from schools shows higher rates than would be expected of children with learning disabilities and children on the autistic spectrum.

Suicide rates are fairly low but there is a clear rise in recorded self harm in young people in Bromley. The increase in self-harm is seen in both sexes, but it is particularly apparent in adolescent girls, where it is increased from 15 in 2000 to 58 in 2010. (Figure 10.9).

Figure 10.9 No. of emergency admissions for deliberate self-harm for 10-19 years old, 2000-2010



Data on mental health issues in CYP are incomplete, making the views of local stakeholders very important. The stakeholder views give a sense of the pressures and concerns experienced by those working with children and young people in Bromley. Taken together they paint a concerning picture of increasing need, particularly emotional need, and services which are getting harder to access due to changing thresholds or long waiting lists.

Local groups of professionals identified particular problems in Bromley with:

- Increase in emotional problems
- Increase in self harm
- Drug and alcohol issues
- ASD (Autistic Spectrum Disorder)

Overall, changes to services locally have resulted in difficulty accessing CAMHs services by front-line services.

On a more positive note, the IAPT[8] programme in Bromley is being extended into children's services. Oxleas NHS Foundation Trust and Bromley Y were successful in a joint bid in 2012 which will train staff from both agencies to deliver IAPT to children and young people in Bromley.

[8] IAPT – Improving Access to Psychological Therapies

The net result of the changes is that children with emerging mental health needs are less likely to have their needs met at an early stage. Some of these needs will be addressed by the IAPT programme (although this is not in place at the moment), but some will go on to develop much more severe needs.

What this means for the JSNA

A whole community approach to enhancing protective factors and minimising risk factors should be a key part of improving mental health in children in Bromley.

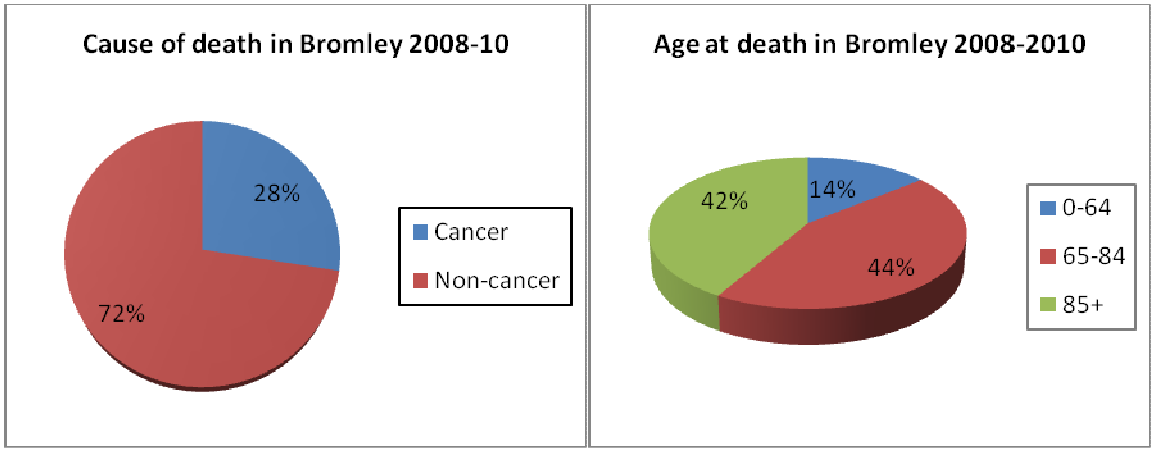
Developing capacity within preschools, schools, Children & Family Centres and primary care is a cost effective way to address emerging mental health needs. This should involve both short-term support for the majority of children with transient problems and long term “holding” for children with more complex issues.

Care pathways should be developed to ensure mental health needs identified are managed at the right level.

11. End of Life Care

In the period between 2008 and 2010, there were 7,810 deaths in Bromley. The majority of these deaths were in those aged over 65 years, and were due to non-cancer causes.

Figure 11.1: Cause of death and Age at death in Bromley 2008-2010



(Source: National End of Life Care Intelligence Network)

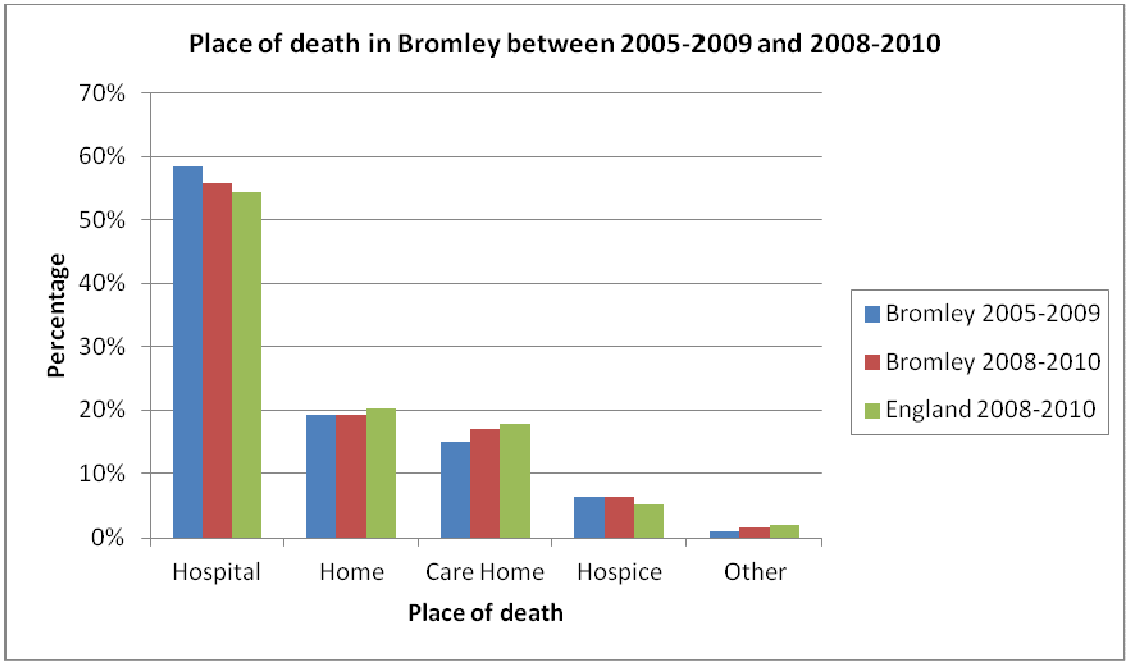
Place of death

Between 2008 and 2010, the majority of deaths in Bromley occurred in hospital (56%). This represents a slight decrease in the proportion of deaths occurring in hospital since the 2005-09 period (59% vs. 56%). However, this proportion for 2008-10 continues to be higher than the national average for the same time period (see Figure 2).

In terms of home deaths, there has been no change in the proportion of people dying at home between the 2005-09 and 2008-10 periods in Bromley. However, there has been an increase in the proportion of people dying in care homes between the two time periods, which means that when using the new 'usual place of residence' indicator, there has been an overall increase in the proportion of people dying in their usual place of residence between the two time periods (see Figures 11.2 and 11.3).

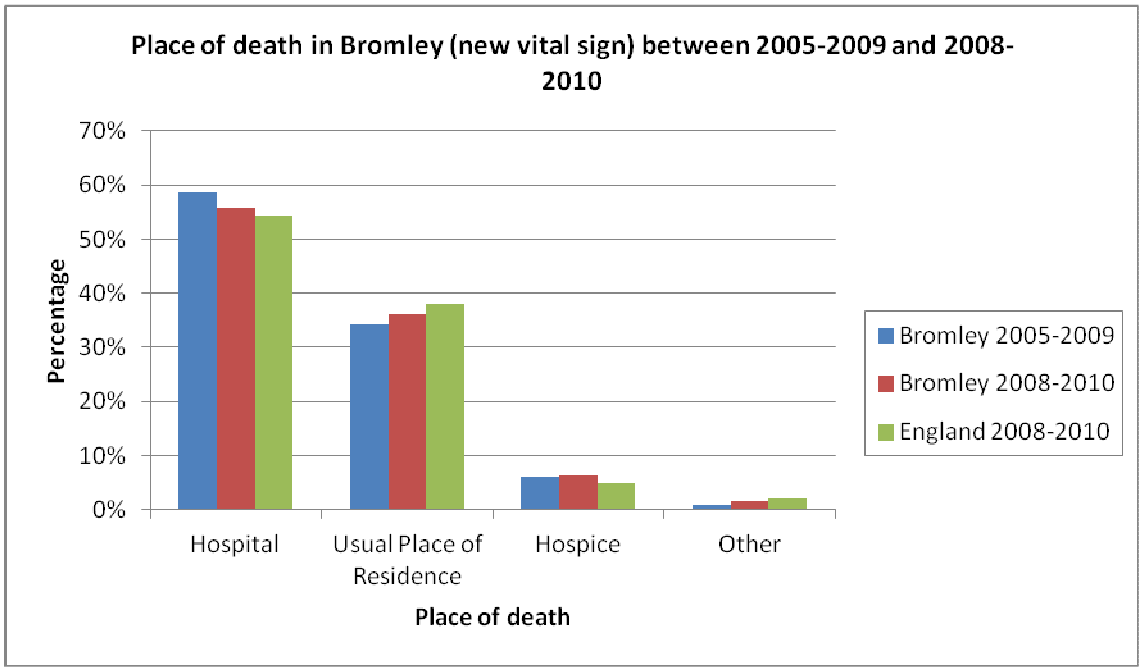
There has been very little change in the proportion of people dying in a hospice between the 2005-09 and 2008-10 periods in Bromley.

Figure 11.2: Place of death in Bromley between 2005-2009 and 2008-2010



(Source: National End of Life Care Intelligence Network)

Figure 11.3: Place of death in Bromley between 2005-2009 and 2008-2010, using the usual place of residence category



(Source: National End of Life Care Intelligence Network)

Place of death by age and gender

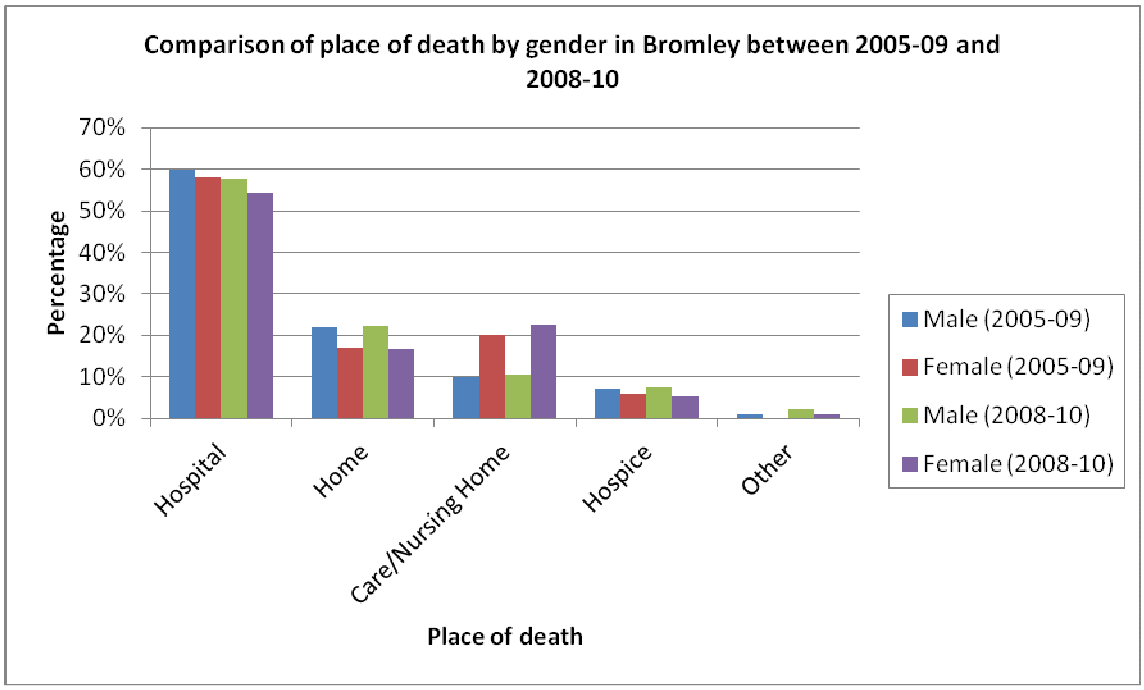
Similarly to the findings of the 2005-09 analysis, there are continued variations in place of death between men and women in Bromley. Higher proportions of female deaths continue to occur in care homes than for male deaths (23% vs. 11%). Higher proportions of male deaths also continue to occur in hospital, at home and in hospices in comparison to female deaths (see Figure 11.4 below).

There is also continued variation in place of death by age group in Bromley. There continue to be higher proportions of those under 65 years of age dying at home or in hospices than those in older age groups. Higher proportions of those over the age of 85 also continue to die in care homes and in hospital in comparison to those in younger age groups.

Place of death by underlying cause of death

When considering place of death by underlying cause of death, the majority of both cancer and non-cancer deaths occurred in hospital. A significantly higher proportion of cancer deaths occurred in hospices in comparison to non-cancer deaths, as was shown in the 2005-09 analysis (see Figure 11.6). A higher proportion of non-cancer deaths occurred in hospital or in care homes than cancer deaths. This too remains unchanged since the 2005-09 analysis.

Figure 11.4: Comparison of place of death by gender in Bromley between 2005-09 and 2008-10

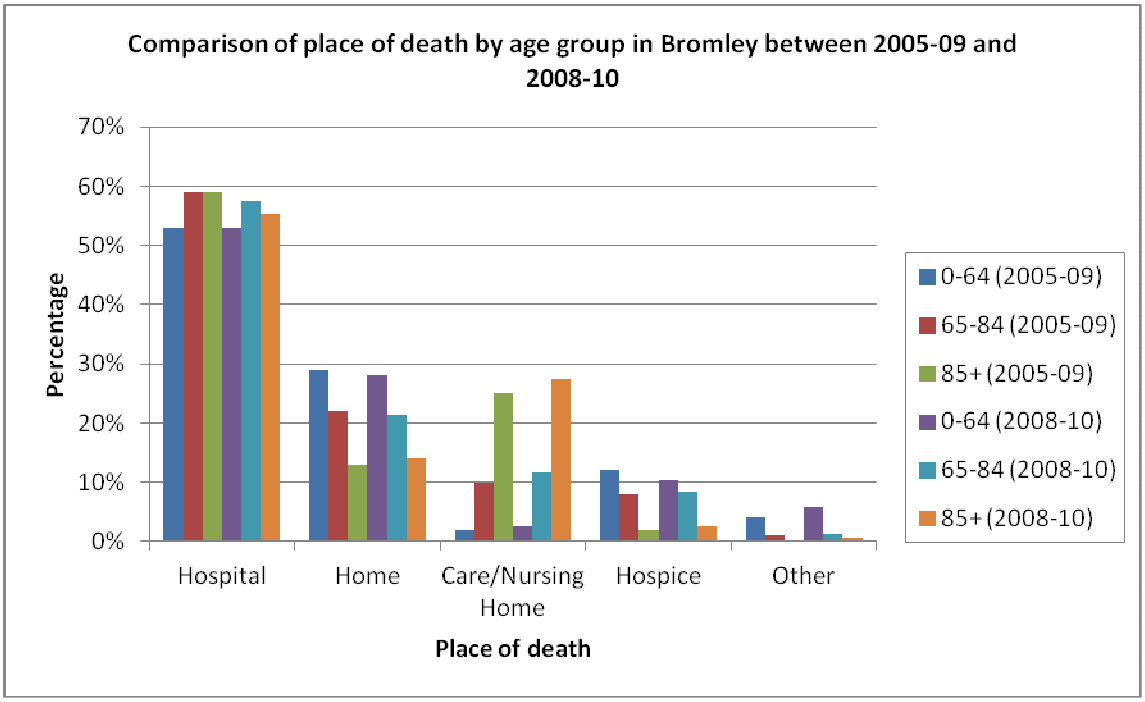


(Source: National End of Life Care Intelligence Network)

Deaths in hospital

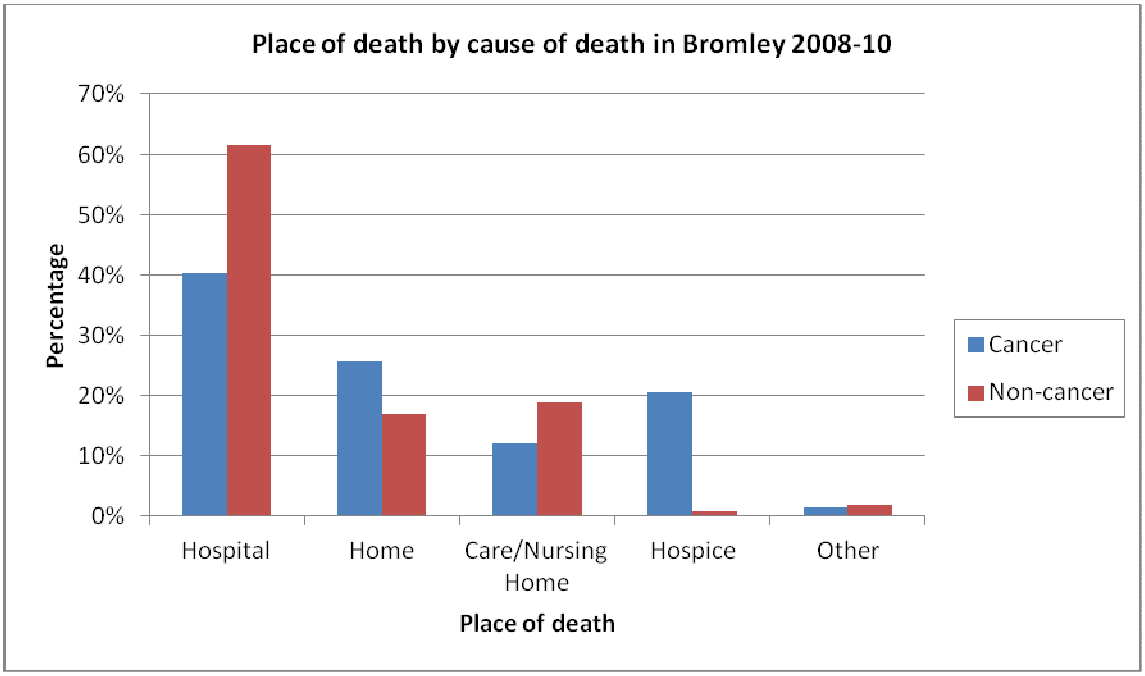
Of the deaths that occurred in hospital in Bromley during 2010, 90% of these terminal hospital admissions were emergency admissions. This is in line with the national average for the same time period. Additionally, over 40% of terminal hospital admissions in Bromley were in the over 85 age group, which is slightly higher than the proportion in over 85s nationally. However, this may be due to the slightly higher proportion of hospital deaths occurring in those aged over 85 in Bromley in comparison to those in England overall (55.3% vs. 52.5%).

Figure 11.5: Comparison of place of death by age group in Bromley between 2005-09 and 2008-10



(Source: National End of Life Care Intelligence Network)

Figure 11.6: Cause of Death in Bromley 2008-2010



(Source: National End of Life Care Intelligence Network)

Table 11.1: Deaths in hospital analyses for Bromley 2010

	Bromley	England
Percentage of terminal admissions that are emergencies	90.2%	89.7%
Terminal admissions that are aged over 85 years	43.3%	37.8%

(Source: National End of Life Care Intelligence Network)

Deaths in care homes

At the start of this year there were 73 care homes in Bromley (this includes residential and nursing homes), of which 11% had achieved the Gold Standards Framework. The Gold Standards Framework Training Programme (GSFTP) for care homes is 'a three stage quality assurance programme that enables care homes to provide quality care for all residents nearing the end of life' (3). To be Gold Standards Framework accredited, care homes have to undertake a three stage process which involves a preparation process, training followed by consolidation of that training, and then eventual accreditation (3). A higher proportion of care homes achieved this accreditation in Bromley than in England overall.

Table 11.2: Care Home analyses from Bromley 2012

	Bromley	England
Number of care homes	73	17,967
Number of care homes per 1,000 population aged 75 or over	2.8	4.4
Number of care homes achieving the Gold Standards Framework	8	291
Percentage of care homes achieving the Gold Standards Framework	11.0	1.6

(Source: National End of Life Care Intelligence Network)

Local data collected from Bromley care homes with nursing (NHs), echo this national data. For the 2011/12 period 19 of the 21 NHs in Bromley have submitted data concerning 4 locally collected outcomes concerning end of life care:

- percentage of NH deaths
- percentage of Do Not Attempt Cardiopulmonary Resuscitation (DNaCPR) orders
- percentage of residents with advanced care plans
- percentage of residents on the Liverpool Care Pathway (LCP/MP) (4).

Table 11.3 below shows year on year improvement in three of these outcomes, suggesting that NHs are making good progress in the implementation of end of life care measures.

Table 11.3: End of Life Care in Nursing Homes in Bromley

Year	NH deaths (%)	DNaCPR (%)	ACP (%)	LCP/MP (%)
2009/10	81% (n=271)	54%	51%	17%
2010/11	86% (n=397)	71%	63%	37%
2011/12	85% (n=336)	77%	79%	60%

(St. Christopher's Hospice, 2012)

End of Life Care in General Practice

Following the previous place of death analysis in 2010, an added value service for End of Life Care for Personal Medical Services (PMS) practices in Bromley was introduced. This service, which started in 2011, rewards participating practices for providing appropriate End of Life Care to a specified proportion of their patients. The provision of appropriate End of Life Care has been outlined as participating practices having to:

- Establish and maintain an End of Life Care Register (EoLCR) of patients whose death is anticipated within 6 months.
- Offer an Advanced Care Plan to all patients on the EoLCR.

- Hold formal meetings at least quarterly about these patients.
- Complete or update a Structured Care Review 1 (SCR1) form for each patient on the EoLCR at every formal meeting.

One year on from the start of this service, which all 26 PMS practices signed up to in 2011, 60% of PMS practices are now achieving the required number of patients on their EoLCR. Data has also been gathered on the number of patients dying in their preferred place of care. This data shows that between 33% and 100% of EoLC patients were able to pass away in their preferred place of care, with values of 75% and above being achieved by almost half of the practices . In moving forward on End of Life Care in general practice, it has been recommended that the findings from PMS practices be compared to those of General Medical Services (GMS) practices in order to ascertain whether the extra service provided by PMS practices has impacted on the care provided to patients nearing the end of life.

What this means for the JSNA

Considerable progress has been made in implementing the Gold standards Framework in Care Homes and improving End of Life Care services in General Practice.

Since there has been little change in the numbers of those dying at home in Bromley between 2005-09 and 2008-10, new approaches to increase the number of those dying at home may need to be considered.

Given the increase in proportion of those dying in care homes in comparison to their own homes, closer examination of what is happening in care homes in Bromley to achieve this in comparison to people's own homes may be required.

An analysis of the source of terminal admissions to hospital may be useful in order to ascertain some of the factors that contribute to the high proportion of terminal hospital admissions that present as emergencies in Bromley.

12. Carers

What is a carer?

A carer is defined as:

> **"someone who spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems"**
> [Source: Department of Health, 2008]

Carers do not include people who volunteer or paid workers as they are referred to as 'care workers'.

Carers play a huge, unpaid role in supporting people with their health and social care needs. Without this support, there would be far greater pressure on both health and local authority services.

What is a young carer?

There is currently no standard definition of the term "young carer"; however, the London Borough of Bromley define young carers as:

> **"young people between 4 and 18 years whose lives are in some way restricted because of the need to take responsibility or care for someone in their family with long-term illness, disability, mental health issues, an alcohol/substance misuse problem or HIV."**
> [Source: London Borough of Bromley, 2013]

It is acknowledged that only small numbers of young carers are currently being identified or assessed for support. The reasons for this include:

- blurred boundaries of responsibility between adults and children's services
- a lack of awareness among many professional groups of young carers' needs and concerns
- young carers' own lack of awareness of their entitlements, and their reluctance to seek formal help.

National research has also found that:

- young carers can experience substantial physical, emotional or social problems, and encounter difficulties in school and elsewhere

- 30% of young carers support parents with mental health problems

- being a young carer, especially where personal and practical support is lacking, can affect elements of a child's transition to adulthood

Many national research studies have also examined the experiences of young carers who are in touch with Young Carer Projects. These studies have identified that the Projects do not tend to report the views of the "hard to reach" young carers who are not in touch with either services or projects, or perhaps do not see themselves as young carers at all.

The numbers of carers

The initial findings from the 2011 Census [Source: Office for National Statistics, 2012] indicate that:

- around 5.4 million people (10.3%) of the population in England were unpaid carers

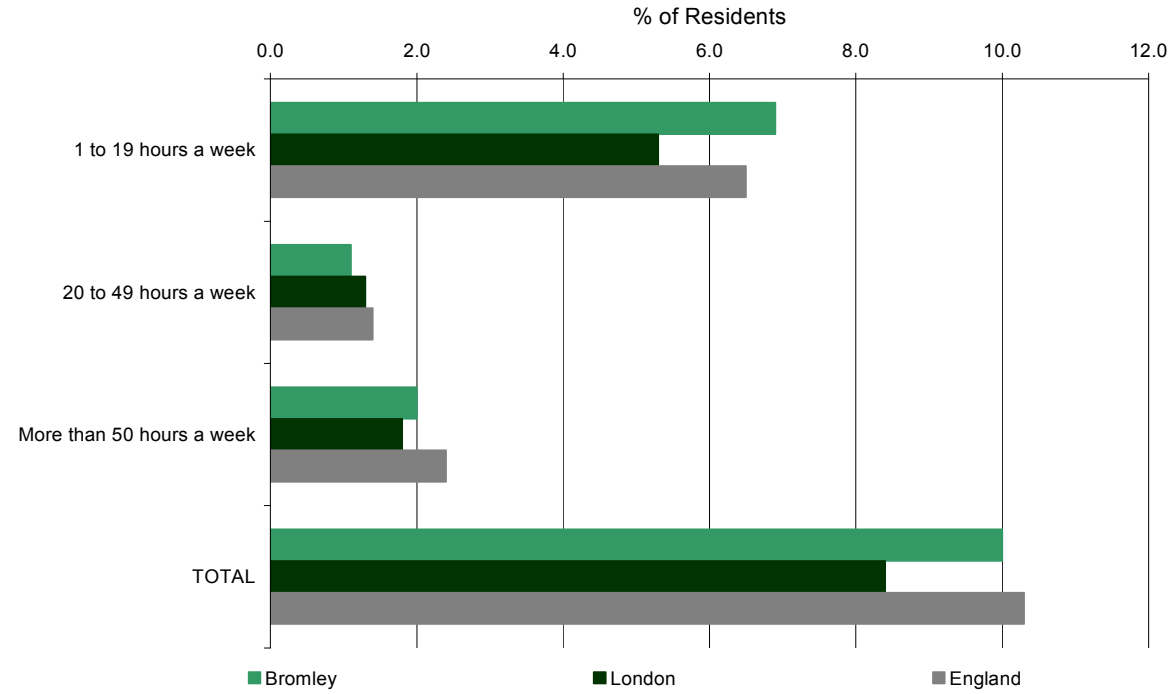
- around 31,000 people (10%) of the population in Bromley were unpaid carers

The following table and graph illustrate the initial findings from the 2011 Census for the percentage of residents who state that they provide unpaid care:

Figure 12.1

Percentage of residents who state that they provide unpaid care: 2011 Census

[Source: Office for National Statistics, 2012]



	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides more than 50 hours unpaid care a week	Totals
Bromley	6.9%	1.1%	2.0%	**10.0%**
London	5.3%	1.3%	1.8%	**8.4%**
England	6.5%	1.4%	2.4%	**10.3%**

The table and graph indicate that Bromley has a similar percentage of carers (10%) compared to the England total (10.3%); however, the Borough has a significantly higher percentage than across London (8.4%).

Interestingly, the figures also seem to indicate that a higher proportion of carers in Bromley provide a lower level of care of under 19 hours per week (6.9%) than both the London (5.3%) and England (6.5%) responses. This also indicates that fewer carers provide intensive care of more than 50 hours per week in Bromley (2%) than the England (2.4%) responses; however, this is higher than the London (1.8%) responses.

The numbers of young carers

The number of young carers identified and supported by Carers Bromley has increased significantly over the past few years; however, it should be noted that from national research it is expected that these are only a portion of the actual number of young carers within the Borough.

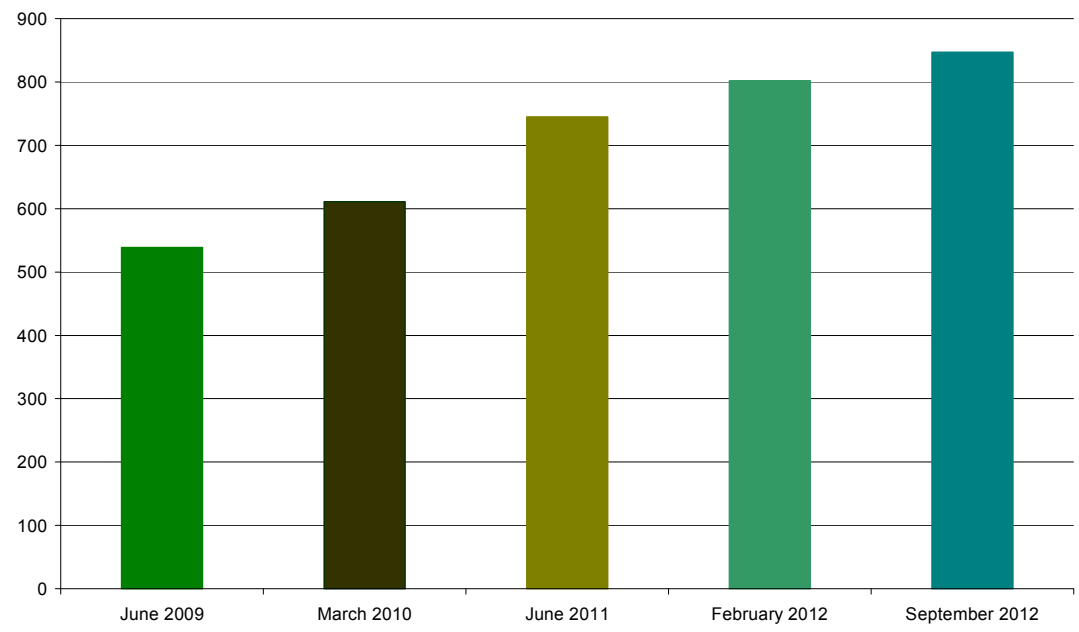
In September 2012, a total of 847 young carers were known to Carers Bromley compared to 539 in June 2009. This is increase of 57%.

This also reflects an increase of 22% between June 2011 [693] and September 2012, and an increase of 6% since February 2012 [802], as illustrated in the following table:

Figure 12.2

Number of young carers known to Carers Bromley: 2009 to 2012

[Source: London Borough of Bromley and Carers Bromley]



	June 2009	March 2010	June 2011	February 2012	September 2012
Number of young carers	**539**	**611**	**745**	**802**	**847**
Difference	-	13%	22%	8%	6%

Supporting carers

Many carers feel that their contribution to society goes unrecognised and instead of being supported, they often find that their needs are overlooked, they have to fight to get support and that the support available is insufficient or poor quality.

Only a small proportion of carers receive any support in their caring role and a significant number of carers are themselves over 65 years.

Young carers are less likely to be happy at school and more likely to be bullied than young people with no caring responsibilities. Furthermore, carers are more likely to experience poor health with people providing high levels of care twice as likely to be permanently sick or disabled.

Within the next three to four years the number of people needing care will outstrip the number of people able to provide that care. An ageing population, smaller family size and geographic mobility have all contributed to what is a growing crisis for national and local government, the NHS and employers.

Impact

Nationally, carers providing high levels of care are twice as likely to report poor health compared with those who did not have any caring responsibilities. This has implications for health and adult social care as it will increase demand for treatment, respite and social care packages. Those who are already over 65 years and those who live in single households are also at risk from requiring care for themselves.

As this increased need for care clashes with cuts in services inevitably resources will be targeted at the most vulnerable leaving the majority to take care of themselves. Age UK examined the impact of a 7% real terms cut to local authority funding. They estimated this would lead to 250,000 fewer older people receiving care in their own home (a 38% decline); a 25% rise in the hours of personal care provided by carers and an estimated £8 billion funding gap for local authorities.

As the number of carers increase this will also have an impact on businesses as most carers fall into the 45-64 age brackets at the peak of their careers. Their experience may be difficult to replace and their economic contribution will also be greatly reduced.

Young carers experience bullying and tend to do less well at school than their peers who have no care responsibilities. This has implications on their future.

National research has also shown that:

- 19% of young carers are living with someone with a mental health issue
- 29% of young carers are living with someone with a physical disability
- 26% of young carers are living with someone with a learning disability
- 40% care for a parent and 41% care for a sibling
- 16% care for more than 1 person in their family

Social care that delivers early, preventative, personalised support to families to promote the independence of older and disabled people will indirectly support carers too. Care services, employers, the tax and benefit system all have a part to play to ensure carers are properly supported to manage care and to have a life of their own.

Current situation

The London Borough of Bromley and Bromley Clinical Commissioning Group have jointly commissioned a 'strategic partnership' contract with Carers Bromley. As a strategic partner, Carers Bromley is funded to be the first port of call for all carers requiring information, advice and guidance. Carers Bromley meets the needs of the majority of the carers requiring support, and only refers carers on to statutory organisations when they are likely to meet the eligibility criteria.

In addition to the strategic partnership with Carers Bromley, the Local Authority and Bromley Clinical Commissioning Group also commission respite services and other support services to carers which may be wholly subsidised or which may be subject to a contribution from the service user. Some of the services provide support both to the service-user and carer, for example day services which provide social stimulation to the service-user during the day as well as a break for the carer. These services have historically been commissioned separately by the Local Authority and Primary Care Trust.

During 2012 the London Borough of Bromley and the Bromley Clinical Commissioning Group published a revised Strategy for Carers for 2012/13. This will be reviewed and revised again during 2013.

An increasing understanding of carers needs

During Winter 2012 the London Borough of Bromley has undertaken a survey of more than 400 carers known by the Council. The Council will be completing a detailed analysis of the responses during Spring 2013. The results from this will then shape service planning, development and review.

What does this mean for our JSNA?

- There continues to be insufficient local data/ joint identification of carers and young carers
- Bromley has a similar percentage of carers compared to the England total; however, the Borough has a significantly higher percentage than across London
- The 2011 Census indicates that a higher proportion of carers in Bromley provide a lower level of care of under 19 hours per week than both the London and England averages
- It also indicates that fewer carers provide intensive care of more than 50 hours per week in Bromley than the England averages; however, this is higher than the London average
- Although it is difficult to identify the actual number of young carers in the borough, the number of young carers known to Carers Bromley has increased 57% since June 2009
- The Carers Strategy, including the Young Carers Strategy, is being refreshed during 2013
- Carers assessments have a low take up and how they are presented to carers needs to be revisited in terms of the benefits
- The carers survey undertaken during Winter 2012 will provide valuable information on the needs of identified carers

13. Substance Misuse

Introduction

A range of factors are important in creating conditions where people are more likely to misuse drugs[9].. Deprivation, unemployment, social exclusion, and poor educational status can all contribute and when combined, risk factors are more significant in determining substance misuse than just one alone. Young people in particular are more likely to give in to family or peer group influences and start experimenting with drugs, sometimes moving on to develop an addiction[10].

Prevalence of drug misuse and the characteristics of those who misuse substances

Substance misuse is an important and far reaching public health issue. Substance misuse affects users, their friends, family, neighbourhood and the wider society. Drugs can play a part in crime, violence and mental illness; it can affect educational attainment, has adverse effects on health, and parental drug use can impact on a child's development and welfare. It is estimated that there are between 250,000 and 350,000 children of problem drug users in the UK[11]. Locally in Bromley there were 175 adults in treatment during 2010-11 who lived with children[12].

The Crime Survey for England and Wales (CSEW)[13] 2011/12 found that nationally, 8.9% of adults (nearly three million people) reported using an illicit drug in the last year. In Bromley this means that approximately 28,000 people used an illicit drug sometime during 2011/12.

The Universities of Glasgow and Manchester publish annual national and regional estimates of the number of opiate, crack and injecting drug users in the UK[14]. The estimated rates of those currently using an illicit drug in Bromley are listed in the table below.

[9] Gaskell. Drug Dilemmas and Choice. 2000
[10] Donaldson and Donalson.Essential Public Health. 2003
[11] Hidden Harm report
[12] Bromley JSNA Support Pack 2011-12
[13] Home Office.Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales (2nd Edition) July 2012. Crown Copyright 2012

[14] Hays et al

Table 13.1

	Drug Use (Rate per 1,000 adult population)				Drug Use (Numbers of adult population)			
	Opiate and Crack User (OCU)	**Opiate User**	**Crack User**	**Injecting**	**Opiate and Crack User (OCU)**	**Opiate User**	**Crack User**	**Injecting**
Bromley	5.47	4.27	4.78	2.36	1,106	862	965	476
Bexley	4.25	3.44	3.26	1.41	628	508	481	208
Havering	5.31	3.83	4.87	1.27	806	582	741	193
Sutton	8.93	7.06	5.84	4.21	1,160	917	759	547
London	9.45	7.81	7.79	2.4	51,445	42,511	42,422	13,056
England	8.93	7.7	5.37	3.01	306,150	264,072	184,247	103,185

In Bromley the rate of adults estimated to currently be using an illicit drug is 5.4 per 1,000 population (or 1,106 people). This is lower than the rates for England (8.9 per 1,000) and London (9.4 per 1,000). This against a backdrop of the lowest levels nationally for over a decade.

For comparison, the rates of our statistical neighbours – Bexley, Havering and Sutton – have also been included. The rate for opiate and crack users in Bromley is similar to the rates in Bexley and Havering, and lower than in Sutton. However, the injecting rate in Bromley is higher than the rates in Bexley and Havering, similar to London and England rates, and approximately half the rate in Sutton. Overall, this suggests we have a higher number of opiate and crack users who inject than some of our neighbouring boroughs.

These estimates do not include those who use cocaine in a powder form, use amphetamine, ecstasy or cannabis, or the injecting of drugs by people who do not use opiates or cocaine[15]. Therefore, the real number of those who are using illicit substances in Bromley will be higher.

Nationally, class A drug use was highest among 20 to 29 year olds (7.2% of 20 to 24 year olds and 5.9% of 25 to 29 year olds). The estimated number of users by age

[15] Hay G et al. Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2009/10: Sweep 6 report. The Centre for Drug Misuse Research, University of Glasgow

group for opiates and opiates & crack in Bromley in 2009/10 are shown in the table below. The highest number of users are seen in the 35 and 64 year age group. This differs from the national pattern of drug use, where the highest drug use was seen in 20-29 year olds.

Table 13.2

	Estimated number of class A drug users in Bromley, by age group (2009/10)		
Drug	**15-24**	**25-34**	**35-64**
Opiate and Crack	272	294	540
Opiate	159	223	480

Source: NDTMS Partnership report

Characteristics of adults who misuse substances

During 2010/11 there were 1,085 adults treated for drugs misuse in Bromley. Over two thirds of those in treatment were male (70.2%), and over three quarters were categorised as white (88.8%). Over a quarter (30%) of those in treatment were parents.

Gender

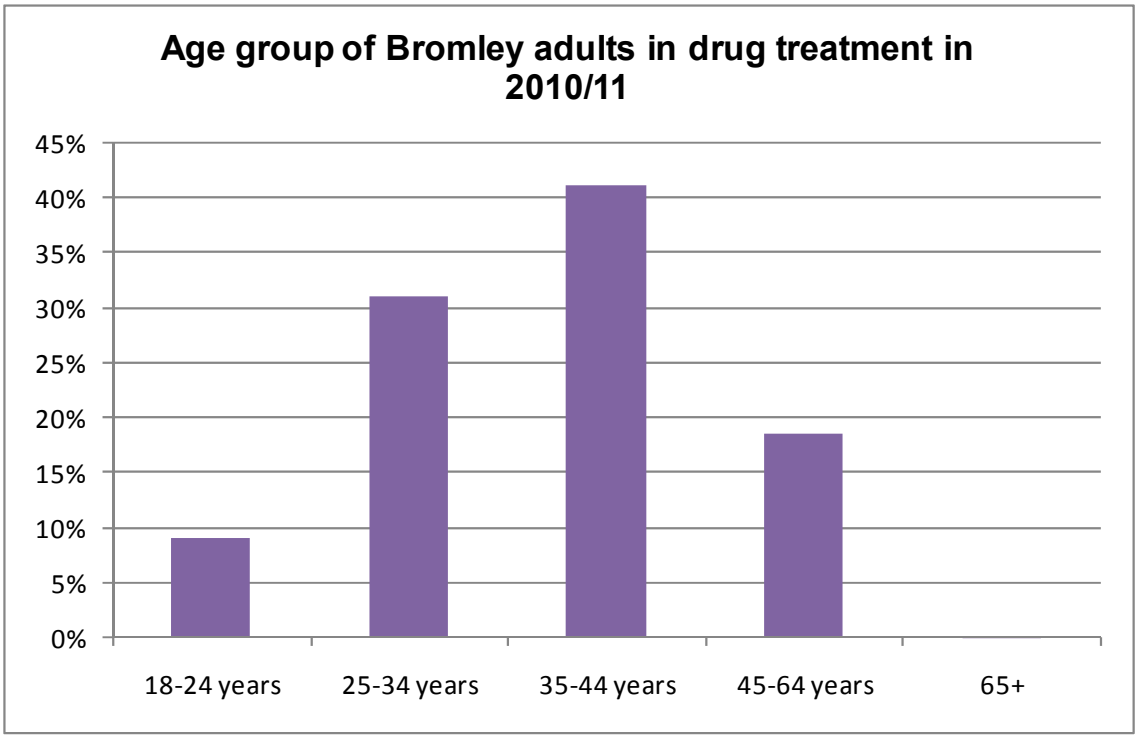
In Bromley during 2010/11 there was more than double the proportion of males in treatment than females (70% versus 30%). This is reflective of the national estimates of drug use amongst adults, where men are more than twice as likely as women to have used any drug in the last year.

Nationally, men had higher levels of any last year drug use, Class A drug use, or use of individual drugs than women in 2011/12. Men were more than twice as likely as women to have used any drug (12.4% of men and 5.5% of women) and any Class A drug (4.4% of men and 1.6% of women) in the last year.

Age

Of the 1,085 adults who were treated for substance misuse in Bromley during 2010/11, the highest proportion was aged between 35 and 44 years. Only one adult over the age of 65 years was treated during the year.

Figure 13.1



Presenting substance

National drug-using trends among under-30s have been changing for several years. There is epidemiological evidence that the number of new heroin starters is falling rapidly. This means fewer young heroin users whilst the established heroin-crack user population is getting older. Younger drug users see this 'smackhead' and 'crackhead' population as "dirty scum".

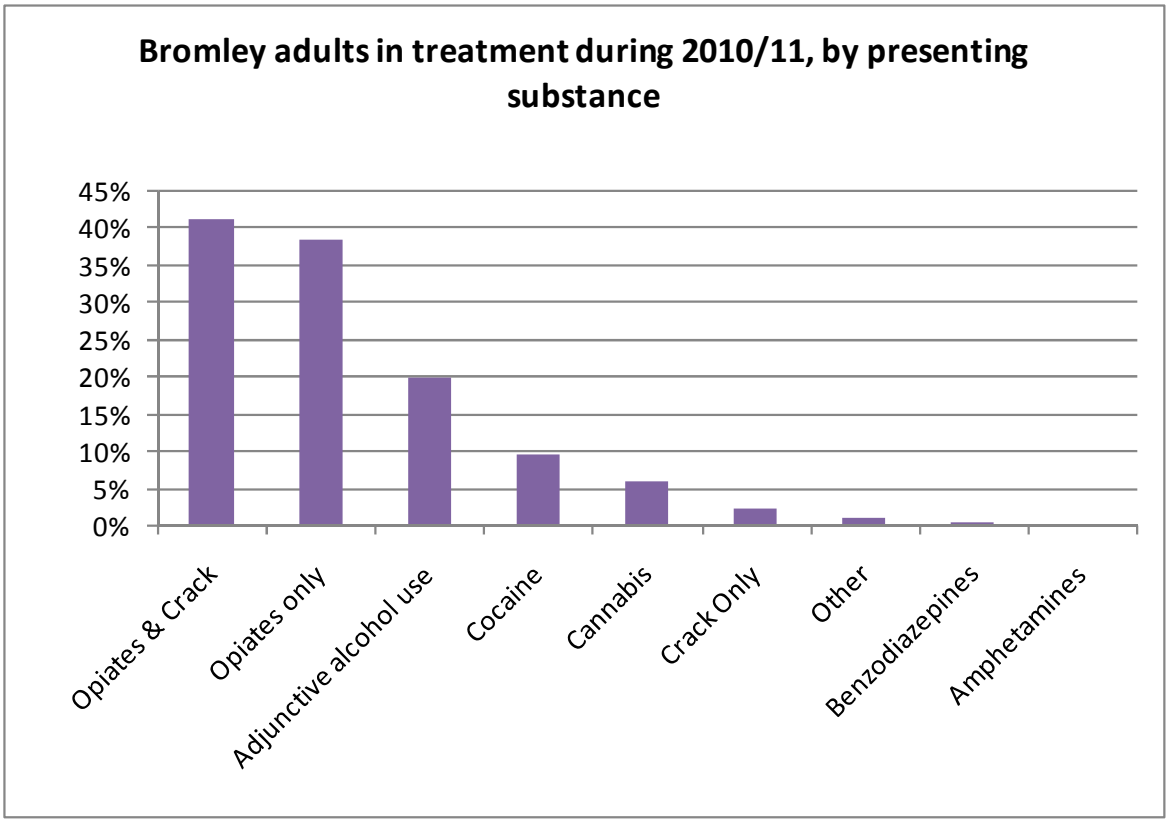
But this attitude may be a protective factor as far fewer vulnerable young people, who would previously have turned to heroin, will now not even try it. They now use and misuse different substances; legal highs, party drugs or AACCE (Alcohol, Amphetamine, Cannabis, Cocaine, Ecstasy)[16]. The short term effects of the AACCE substances include: sleep disorder, loss of appetite, hallucinations, raised blood pressure and in the case of cocaine and ecstasy, could lead to heart attack or stroke. In the longer term they can all lead to addiction, anxiety, depression, fatigue.

Legal highs can carry serious health risks though the short and long term effects on health aren't known. The chemicals they contain have in most cases never been used in drugs for human consumption before, so haven't been tested to show that they are safe. Users can never be certain of what they are taking and what the effects might be.

[16] Parker H. Drug Strategy Loses its Way. Drink and Drugs News, May 2007.

In Bromley, 6% of the population in treatment present for cannabis misuse, nearly 10% for cocaine misuse and less than 1% for amphetamine and ecstasy use. Adults treated for opiates and crack make up the largest proportion of those in treatment, more than three quarters (80%). The low numbers for treatment in the AACCE drugs categories compared to the higher numbers in treatment for opiate and crack could be representative of a social pattern of use and an impression that users are controlling their drug use.

Figure 13.2



Geographical Location

Different factors affect the prevalence of substance misuse problems, with socioeconomic factors and deprivation playing a significant part. Bromley is the largest London borough in the city. It is 30% larger than the next largest borough. The borough is relatively prosperous, but with higher deprivation and disease prevalence in the North-East and North-West of the borough.

People from all backgrounds and classes take drugs for many reasons: for pleasure, to treat physical or emotional pain, for stress or anxiety, or because their friends do.

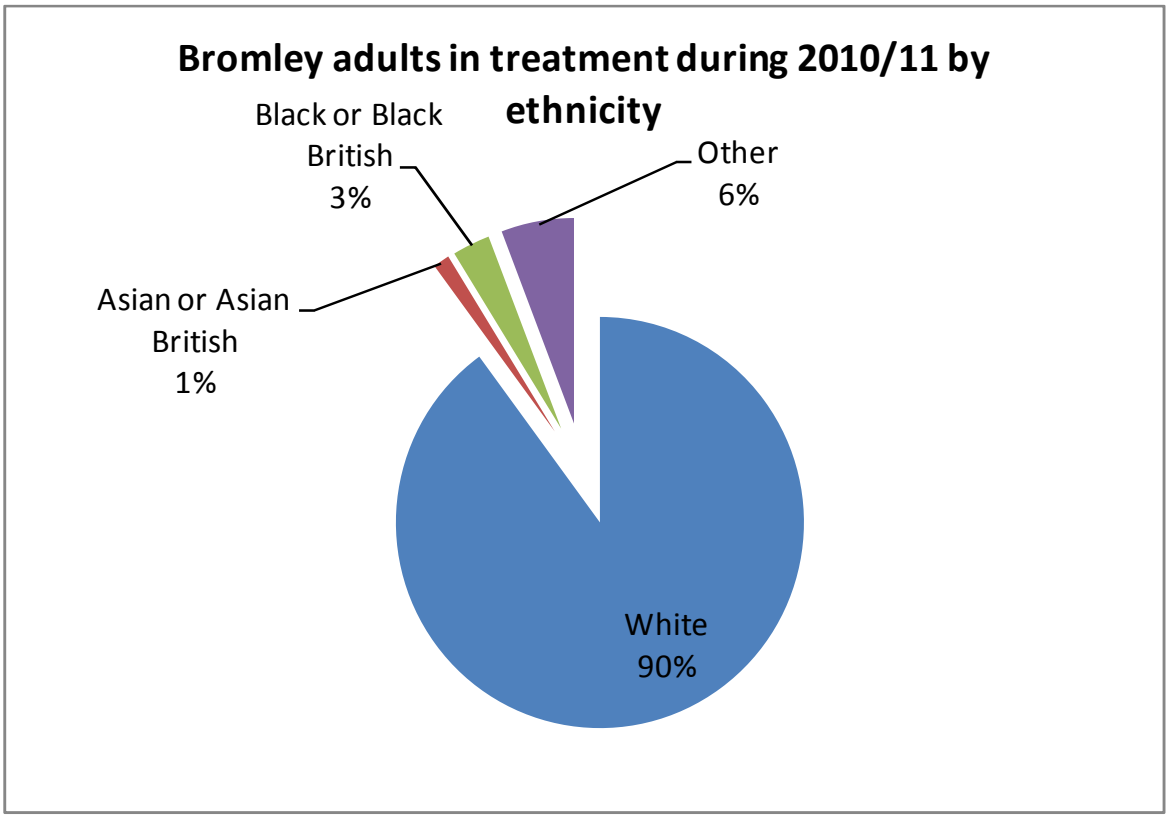
But the pattern of who develops a drug problem and encounters other problems shows a close link between drug misuse, deprivation and social exclusion[17].

BME Groups

Nationally, reported drug use prevalence is highest among the mixed race minority ethnic group and lowest among the Asian group. However, as noted in a 2010 Home Office analysis of British Crime Survey data, the higher level of drug use among people from a mixed race background may be driven by the younger age profile of this population. Differences between Black and White groups are less clearly defined and vary across subgroups, drug types, gender and age[18].

In Bromley, the numbers of adults in treatment for drug use are mainly white in ethnicity. This may be due, in part, to the predominantly white resident population (86%). However, those from minority ethnic groups appear to be under-represented in treatment given the national pattern of drug use in ethnic groups. This could be due to a number of reasons, including stigma or lack of access.

Figure 13.3



[17] Shaw A, Egan J, Gillespie M. Drugs and poverty: A literature review A report produced by the Scottish Drugs Forum (SDF) on behalf of the Scottish Association of Alcohol and Drug Action Teams. March 2007

[18] Beddoes D, Sheikh s, Khanna M and Francis R. The Impact Of Drugs on Different Minority Groups: A Review Of The UK Literature.UK Drug Policy Commission, Office for Public Management. July 2010.

In general there has been a decrease in the proportion of adults who have taken any drug in the last year. In 1996 11.1% of adults claimed to have taken any drug in the last year. This had gone down to 8.9% in 2011/12. Statistically significant reductions in the use of hallucinogens, amphetamines and cannabis can be seen across all age groups between 1996 and 2011/12. The proportions taking powder cocaine are increasing, as are the number of adults reported to have taken GBL[19]/GHB[20].

Mental Health

Research has found that 31% of adults receiving mental health services reported problem drug use in the past year, and between 75% and 86% of adults receiving drug and alcohol services treatments, respectively, were found to have at least one mental health problem.[21] Bromley has lower admission rates to mental health services for substance misuse than the London average.

Table 13.3

	Period	PCT value	Target	% change	London value
Age-standardised admission rates for substance misuse	**2006/07**	**8.7**	**-**	**-45.2**	**14.1**
Age-standardised admission rate for substance misuse, **per 100,000 population**	**2008/09**	**69.1**		**-3.7**	**95.7**

Source: London Mental Health and Wellbeing Scorecard, 2011

Wider Impacts, Risks, and Harms associated with Substance Misuse

Results from a Swiss study have found that drug users who were not in treatment tended to use drugs less frequently, were less likely to inject drugs, had a more social pattern of use and more often had the impression of controlling their drug use. They had less contact with the legal system and the police, were in a better social situation and more often perceived themselves to be in good health. Those whose main drug of use is heroin generally had a more problematic pattern of use than those who use mainly cocaine[22]. These are the users that continue to function well in

[19]Gamma-butyrolactone or 'coma in a bottle'. It is a chemical that should be used as a paint stripper and rust remover for garages or industrial cleaning firms.
[20]*Gamma*-Hydroxybutyric acid or date rape drug. GHB has been used in a medical setting as a general anesthetic, to treat conditions such as insomnia, clinical depression, narcolepsy, and alcoholism, and to improve athletic performance
[21] London Health Observatory, 2008
[22]Hausser D.,KublerD.,Dubois-Arber F. Characteristics of heroin and cocaine users unknown to treatment agencies, results from the Swiss Hidden Population Study. Sozial- und Praventivmedizin, 1999, vol./is. 44/5(222-232),

society whilst managing their drug habit, and may not seek treatment for their addiction until it begins to affect their lives.

Substance and alcohol misuse

There is a clear link in adults between the level of drug use and visits to a nightclub or pub. Levels of drug use in adults increase with increasing frequency of visits to a nightclub or pub. However, this link is not as strongly associated with increasing alcohol consumption. The 2011/12 CSEW showed that almost a third (30.7%) of 16 to 59 year olds who visited a nightclub four or more times in the past month had used any drug in the last year compared with 6.5 per cent of those who had not visited a nightclub. Around a quarter (23.9%) of adults who visited a pub nine or more times in the last month had taken any drug in the last year compared with 5.2 per cent of those who had not visited a pub.

Stigma

Stigmatisation occurs when a person possesses an attribute or status that makes them less desirable or acceptable in other people's eyes. This can affect their interactions with others. People who are seen to be responsible for their own stigma tend to be more greatly stigmatised, as are those that are perceived to be dangerous.

Problem drug use is a status that takes centre stage at the expense of the rest of the person's identity. The general public perceives problem drug users to be dangerous, deceitful, unreliable, unpredictable, hard to talk with, and to blame for their predicament. Health professionals can also have similar and judgmental views in dealing with problem drug users. The families of users are also stigmatised, seen as partly responsible for their relative's addiction. However, family members and carers may also carry the burden of costs linked with the drug use of a relative, which may be forced upon them[23].

Users of drugs report that the attitudes of others can impact on their lives, leading to feelings of low self-esteem and the avoidance of contact with those who don't use drugs. The way help is provided can contribute or exacerbate the stigmatisation around problem drug use. The supervised consumption of methadone in pharmacies provides a unique context in which users' status as problem drug users can be made public. In 2011-12, 5,877 methadone prescription items were given out from 19 venues in Bromley. Those in receipt of these items may feel stigmatised by the attitudes of pharmacy staff and other customers. Some users can feel that the very act of seeking treatment serves to cement an 'addict' or 'junkie' identity, which can

[23]Copello A, Templeton L, Powell J. Adult Family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses. UK Drug Policy Commission, November 2009.

lead to further rejection from family and friends. This may prevent users from seeking treatment[24].

Employment

A recent study in the United States found, among ages 18 and older, unemployment was significantly related to illicit drug use, heavy alcohol use, tobacco use and alcohol/drug disorders. Past month illicit drug use was prevalent among 8.0% in full time employment, 11.5% in part-time employment and 17.0% in unemployed. Although the numbers of unemployed increased markedly in times of economic downturn, the relationship of unemployment to substance misuse and disorders remained generally consistent across sex, race/ethnicity, geographic region and age subgroups[25].

In Bromley in 2011-12, 40% of adults who successfully completed treatment were working ten or more days in the month before they completed. This compares favourably to the national figure of 25%. Keeping people in employment is protective against further drug misuse.

Housing

Housing is not just another "social need": Settled housing is essential if people are to address their substance misuse and other physical, mental and emotional health needs as well as to be free from dependence as outlined in the latest drug strategy.

If someone's housing and support needs are not addressed they are much less likely to enter or remain in treatment. It may also be difficult for them to address their other needs, such as training, education, work, relationships and other aspects of emotional health.

Substance users with a housing need can be[26]:

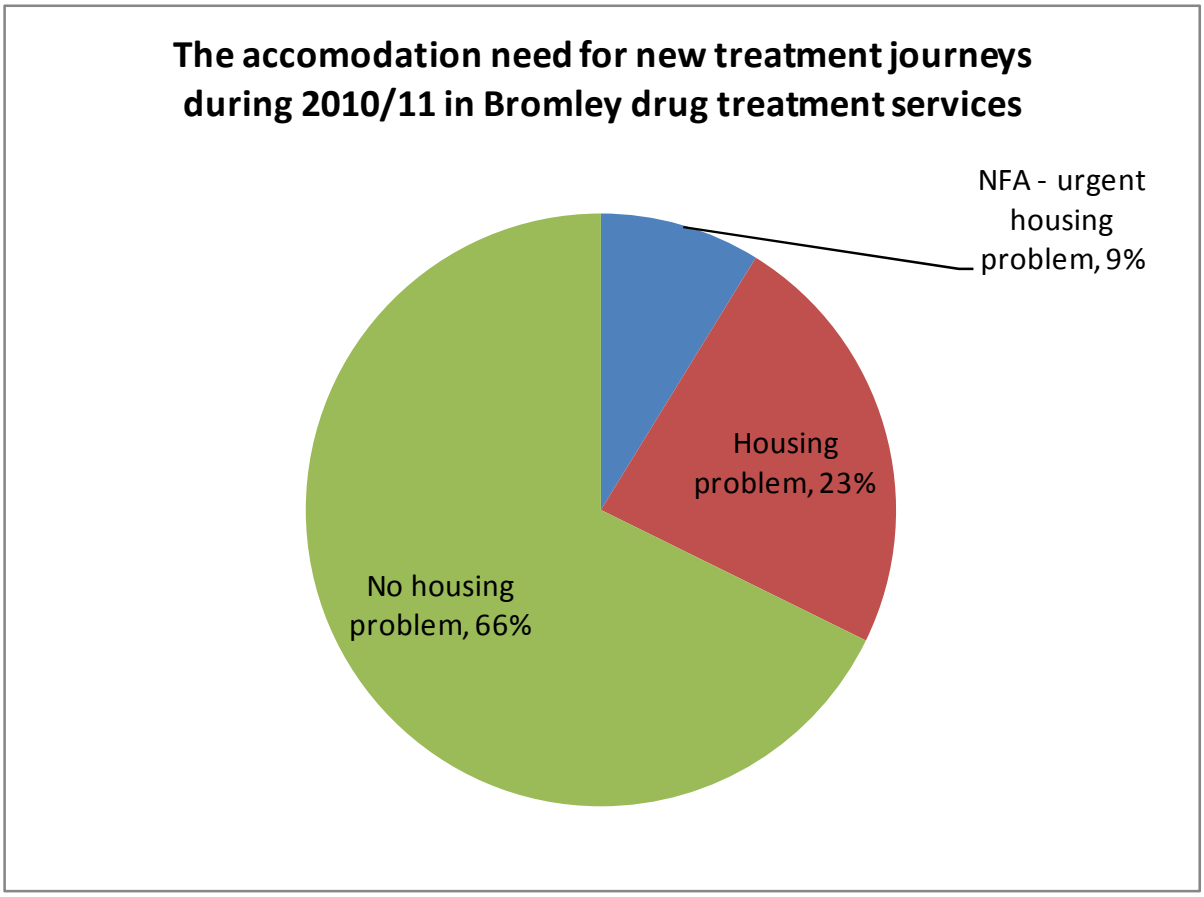
- at risk of losing their existing housing and becoming homeless because of their substance misuse
- street homeless
- in insecure housing (such as "sofa-hopping" between friends)
- in hostels, but still at the stage where staff need to work with them to start to address their substance misuse and other needs

[24]Lloyd C (2010) *Sinning and Sinned Against:The Stigmatisation of Problem Drug Users*. UKDPC
[25] Compton W.,GfroererJ.,Conway K. Unemployment and substance misuse and disorder in the united states during economic recession Neuropsychopharmacology, December 2011, vol./is. 36/(S368-S369),
[26]Jenny Pannell (2007) Substance Users and Supported Housing: What's the Score? Care Services Improvement Partnership

- in hostels and supported housing, but ready to move on because their substance misuse has been stabilised through harm minimisation approaches
- motivated to attempt the abstinence route but needing to access residential rehab or similar structured supported housing provision
- leaving detoxification and rehabilitation (community, hospital, residential or prison-based) and needing settled housing to remain abstinent.

In 2010-11, there were 294 individuals starting new treatment journeys in Bromley. Of these, 9% reported an urgent housing problem and were classified as No Fixed Abode (NFA), a further 23% reported having a housing problem.

Figure 13.4



During 2011-12, 83% of adults who successfully completed treatment in Bromley no longer reported a housing need. This compares to 85% adults nationally.

Health

Injecting drug users may be exposed to blood borne infections through the sharing of infected drug paraphernalia. Several sexual behaviours, including penetration without condom use, also increase the risk of viral exposure. Injecting drug use is a major risk factor for the acquisition and transmission of HIV, hepatitis B and hepatitis C. A study in a London NHS clinic found that 86% of injecting drug users were positive for hepatitis C and 55% were positive for hepatitis B[27]. In Bromley in 2011-12 87% of previous or current injectors in treatment received a hepatitis C test.

Crime and antisocial behaviour

There are longstanding links between drug use and social and economic deprivation. Some people will become involved in crime to support their dependence[28], for others it is part of their lifestyle. Those who take part in criminal behaviour are more likely to come into contact with others who use, sell and distribute drugs[29].

In Bromley the level of crime is average compared with London, a rate of 5.9 crimes per 1,000 population. Local research has suggested that there are high levels of fear of crime associated with some residential areas and town centres[30].

Bromley has a drug intervention programme (DIP) whose function is to identify problem drug users at time of arrest and provide them with support, assessment and engage them with local treatment services. Between March 2010 and February 2011, 170 people were assessed as part of the DIP. Forty per cent of referrals were triaged within six weeks, and all of them started treatment. Just over one fifth (21%) of referrals made via the DIP were already in treatment and did not need referral. A further 8% of referrals had previously been in treatment and were not referred again.

When compared with London, the DIP referrals referred within six weeks for Bromley is significantly lower. On average 55% of DIP clients are referred within six weeks of identification. In Bromley, only 40% of clients are referred within six weeks.

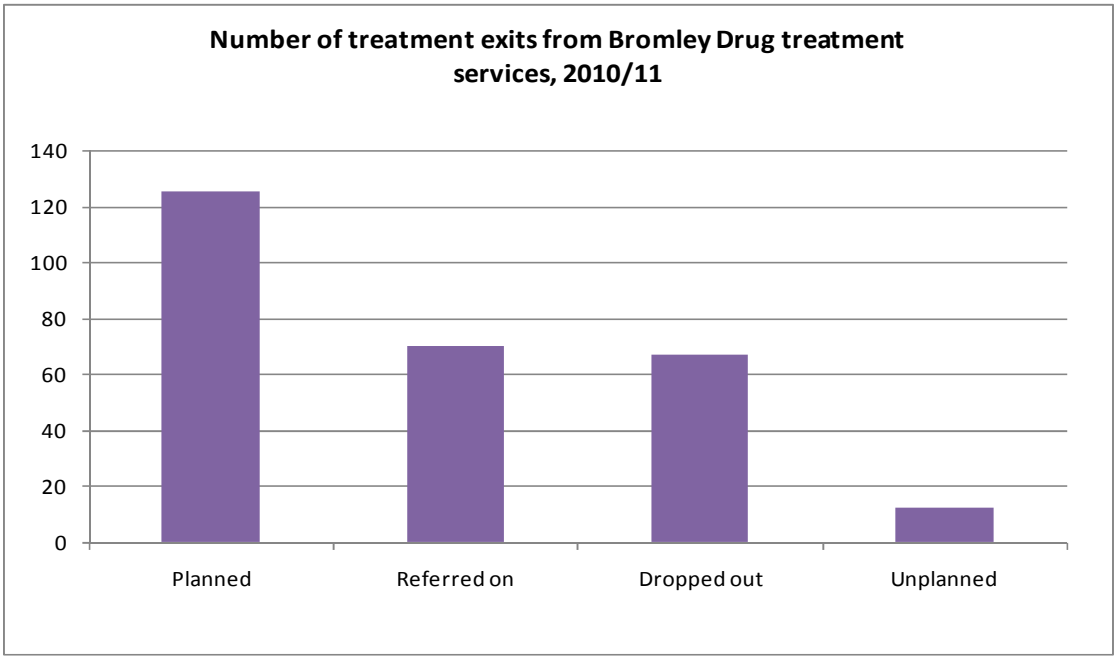
Drug Treatment in Bromley

Adults who are effectively engaged in treatment use fewer illegal drugs, commit less crime, improve their health and manage their lives better. During 2011-12, 515 adults aged over 18 years were engaged in treatment for more than three months. This equates to approximately 92% of the treatment population.

[27]Marsden J and Strang J (2004). Drug Misuse in Stevens A, Raftery J, Mant J and Simpson S (eds) Health care needs assessment. Volume 2.Radcliffe Oxford.
[28]Hammersley R, Forsyth A, Morrison V, Davies J,.The relationship between crime and opioid use. Br J Addiction 1989; 84:1029-43
[29]Marsden J and Strang J (2004). Drug Misuse in Stevens A, Raftery J, Mant J and Simpson S (eds) Health care needs assessment. Volume 2.Radcliffe Oxford.
[30]Bromley Drug Action Team. Adult Needs Assessment Substance Misuse 2009/10

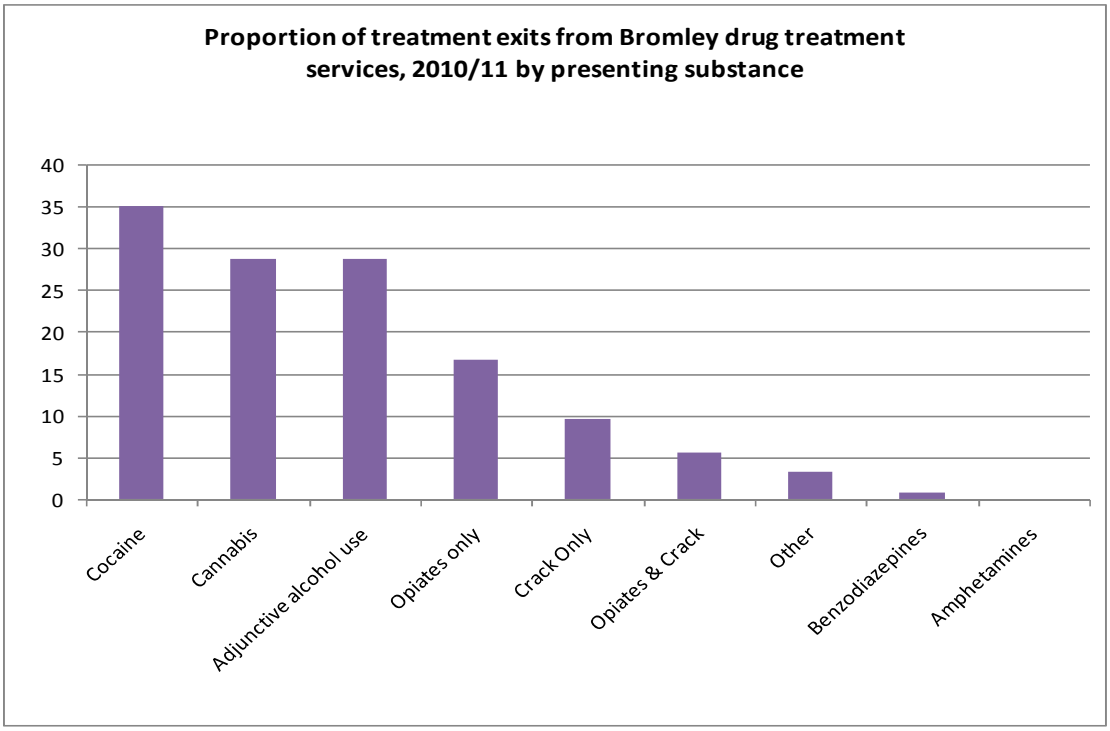
During 2010/11 there were a total of 274 people in Bromley who exited from drug treatment services. Three quarters of them were male and over 85% were white. Those aged between 25 and 44 years made up two thirds of treatment exits. Eighty percent were not parents when they left treatment. Nearly half of those that exited treatment (45%) planned to do so. One quarter were referred on, and another quarter dropped out. Under 5% had unplanned exits from treatment.

Figure 13.5



The CSEW found the most commonly used substance nationally last year was cannabis (6.9%), followed by powder cocaine (2.2%). This is similar to the situation seen in Bromley where over one third of those exiting treatment in 2010/11 had been treated for cocaine use. Over a quarter had been treated for cannabis use and another quarter for adjunctive alcohol use.

Figure 13.6



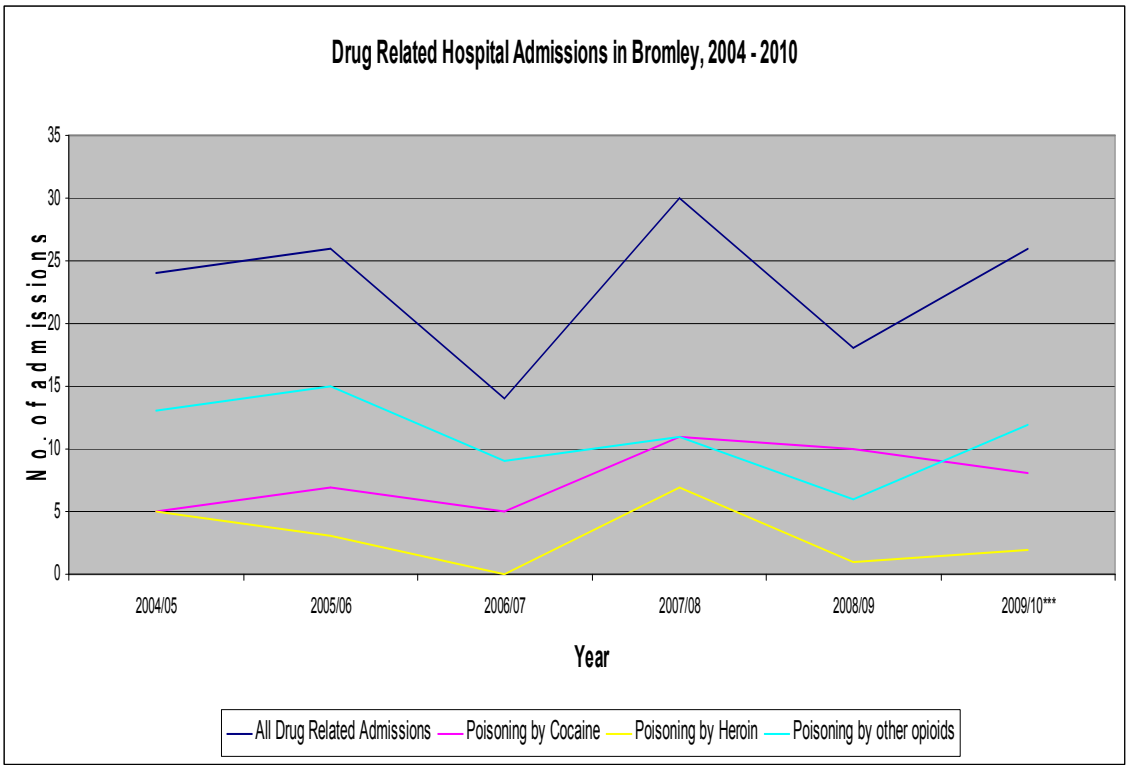
Drug related disease and deaths

Drug use and drug dependence are known causes of premature mortality, with drug poisoning accounting for nearly one in seven deaths among people in their twenties in 2010 in the UK. Over half (58 percent) of all deaths related to drug poisoning involved an opiate drug[31]. Approximately a third of all drug-related poisoning deaths also contain a mention of alcohol or long-term alcohol abuse (for example cirrhosis) in addition to a drug.

Between 2004 and 2010 there have been a total of 138 drug-related hospital admissions in Bromley. This compares with 1,005 alcohol-related admissions during the same period, more than seven times as many. The main reasons for drug-related admission are poisoning by cocaine (33%), heroin (13%) and other opioids (13%).

[31]Age-specific mortality rates for deaths related to drug misuse: by sex, 2006–10 accessed at http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2010/stb-deaths-related-to-drug-poisoning-2010.html#tab-Results on 23 October 2012

Figure 13.7



Source: SUS, as of 17 November 2009

Services Currently Provided in Bromley

There is a well established range of treatment services across the statutory and voluntary sectors to help those affected by drug misuse, including the individual suffering, family members and the wider community.

In Bromley there are a range of services open to those seeking treatment for substance misuse. There is an open access service that allows those with substance misuse to walk in, without seeing another health care professional previously. There are a range of referral routes into treatment services, via another healthcare professional, for example a GP. The care plans for those receiving treatment for substance misuse can range from inpatient stays at specialist units to minimal support and therapies for those requiring less intensive treatment. An aftercare programme was re-launched in 2009-10. It offers four supportive sessions run on a weekly basis. They are open to previous users of the service and continue to offer follow on care to help maintain the success achieved whilst in treatment for substance misuse.

Cost Effectiveness and Expenditure on drug treatment

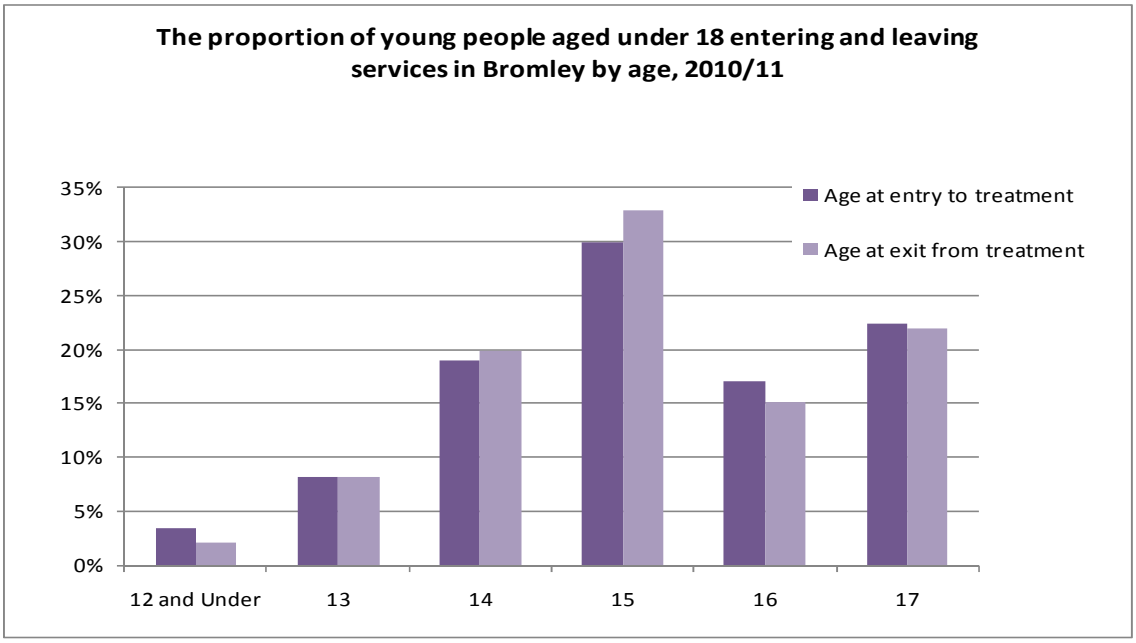
A cost benefit analysis by Frontier Economics in 2011[32] found immediate and long-term benefits of young people's treatment. The immediate benefits of treatment are lower levels of drug and alcohol-related crime, and fewer drug and alcohol-related inpatient admissions and deaths. The long-term benefits of treatment are a lower likelihood (and therefore lower expected cost) of young people developing substance misuse problems as adults, and improved educational attainment and labour market outcomes. For every £1 spent on young people's treatment services, there is a return of up to almost £2 over a two-year period and up to £8 over the long term.

Children and Young People's substance misuse services

Drug use in childhood and adolescence is by far the best predictor of use later in life[33].

The CSEW showed that levels of any drug use in the last year were highest among the 16 to 24 age groups (19.3%), with cannabis being the most commonly used type of drug. During 2010/11 Bromley had a total of 147 people under the age of 18 entering drug treatment services and 146 exiting services. Approximately 80% of those entering and exiting treatment were white. The most common age for those entering and exiting drug treatment services is 15 years.

Figure 13.8

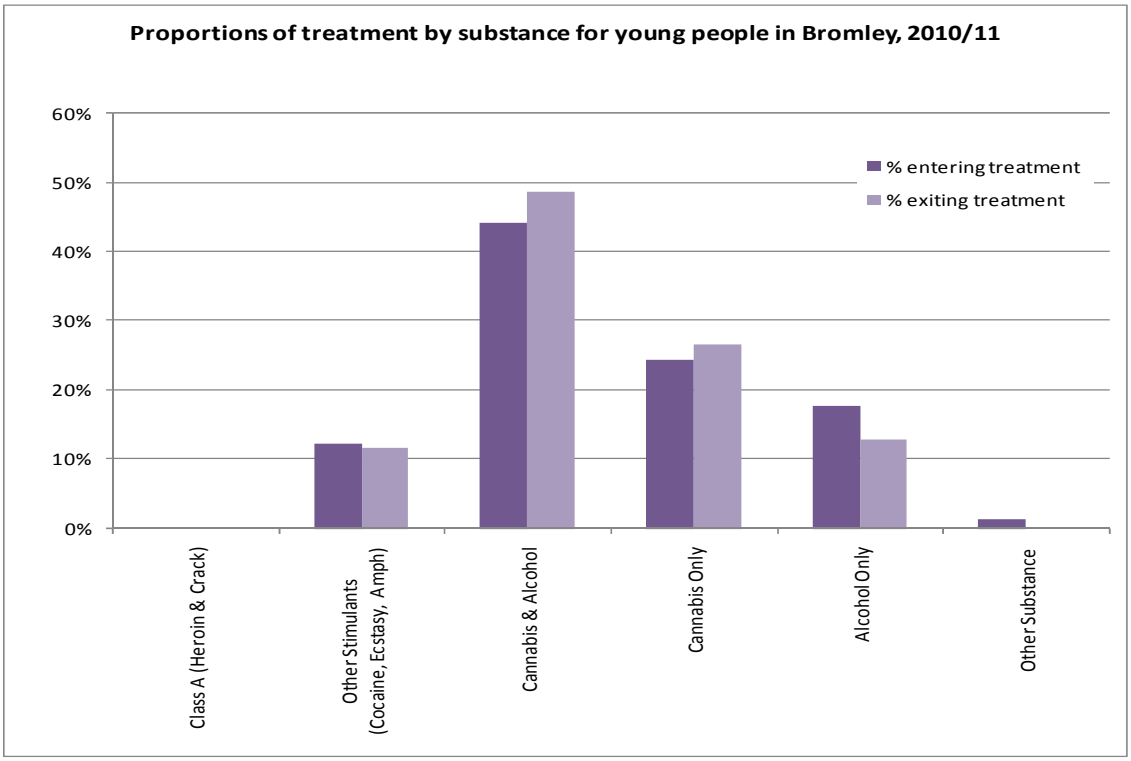


[32]Frontier Economics .Specialist drug and alcohol services for young people – a cost benefit analysis. Department for Education, February 2011

[33] Pathways to Problems

The pattern of substance misuse in adults differs to the pattern seen in the substances treated in those aged under 18. For adults, the majority of those in treatment are treated for crack, crack and heroin and cocaine. In those aged under 18 and in treatment, the most commonly treated substances are cannabis and alcohol, with approximately 10% being treated for 'other stimulants'. In adults, less than 1% are treated for amphetamines or benzodiazepines.

Figure 13.9



What does this mean for Bromley?

The patterns of substance misuse in Bromley are not high. They are in line with our statistical neighbours and lower than London in general. However, the available data looks mainly at those receiving treatment for substance misuse related to opiates and crack. The emerging AACCE substances are more popular with those aged between 16 and 24 years. The long term effects of these drugs are unknown and their implication on the long term health of users is yet to be discovered. Little data is available (other than via the Crime Survey for England and Wales) on the true extent of misuse of these substances.

Those who misuse substances and are functioning well in society are unlikely to appear in any dataset. They will not seek help for their addiction as they do not see it as a problem and may not yet suffer any ill health associated with misuse. However, provision needs to be in place to offer help and support at a time when needed.

There is little data on prevention work done locally with vulnerable young people to raise the awareness and dangers of misusing substances. Prevention work on substance misuse should be done early and in conjunction with other risk taking behaviours such as smoking and alcohol consumption.

What does this mean for the JSNA?

The patterns of substance misuse in Bromley are not high.

The available data looks mainly at those receiving treatment for substance misuse related to opiates and crack. The emerging AACCE substances are more popular with those aged between 16 and 24 years and there is little information about the long term effects or of patterns of misuse.

Prevention work on substance misuse should be done early and in conjunction with other risk taking behaviours such as smoking and alcohol consumption.

14. Alcohol

Introduction

Alcohol misuse is associated with significant risks to health and well-being. In the short-term, it can increase the risk of unintentional injuries, violence and risky sexual behaviour. In the long-term, chronic misuse is associated with increased risks of developing dementia, stroke, cardiovascular disease, cancer and liver disease (e.g. alcoholic hepatitis and cirrhosis) as well as psychosocial problems such as depression and family breakdown. The socio-economic costs of alcohol misuse are also considerable. In 2010/11 alone, there were one million cases (44%) of violent crime and 1.2 million hospital admissions related to alcohol in the UK (Chaplin, 2011, cited in Government Alcohol Strategy, 2012), resulting in an estimated cost to society of £21 billion.

Policy context

In recognition of and in response to the scale of the challenge in tackling alcohol misuse, the Home Office launched the *Government Alcohol Strategy* in 2012, setting out proposals for cracking down on the culture of 'binge drinking' and alcohol fuelled violence and to reduce the number of people engaging in hazardous and harmful drinking. Other goals of the Strategy included: a change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others; a reduction in the number of alcohol-related deaths and a sustained reduction in the numbers of 11-15 year olds drinking alcohol.

Alcohol consumption

Recommended daily intake

The high levels of alcohol consumption in the UK are associated with the increasing availability and affordability of alcohol, as well as the social acceptability of drinking - one study showed that of those who drink regularly above the recommended amounts described above, the vast majority (83%) do not consider drinking as a risk to their long term health (Government Alcohol Strategy, 2012).

The Department of Health provides recommendations on the daily intake of alcohol. This should not exceed 2-3 units of alcohol for women and 3-4 units for men; women who are pregnant or are trying to conceive should avoid drinking alcohol; children under 16 years are encouraged not to drink alcohol because those who start drinking from an early age are more likely to develop alcohol problems in adulthood.

Alcohol misuse categories

The categories of alcohol misuse and their definitions are described in the table below.

Table 14.1. Government definitions of drinking categories

Drinking category	Government definition
Lower risk	Men who regularly drink no more than 3 to 4 units per day and women who regularly drink no more than 2 to 3 units per day.
Increasing risk	Men who regularly drink over 3 to 4 units per day and women who regularly drink over 2 to 3 units per day.
Higher risk	Men who regularly drink over 8 units per day or over 50 units per week and women who regularly drink over 6 units per day and 35 units per week

Source: Safe, Sensible, Social – Consultation on further action, Department of Health (2008)

Alcohol misuse in Bromley

Table 14.2 shows estimates of the proportion of the drinking population aged 16+ in each of the alcohol misuse categories defined above. It can be seen that the proportions in Bromley for all categories is similar to those for England. However, the proportion of the drinking population in Bromley who binge drink is significantly lower than that for England (13.8% vs 20.1%).

Table 14.2 Synthetic estimates of existing drinkers in Bromley and England

	Bromley LB (00AF)			England		
	% of Total Population aged 16+	Lower 95% CI	Upper 95% CI	% of Total Population aged 16+	Lower 95% CI	Upper 95% CI
Abstainers	16.6	11.2	20.6	16.5	11.1	20.6
	% of Drinking Populaion aged 16+	Lower 95% CI	Upper 95% CI	% of Drinking Populaion aged 16+	Lower 95% CI	Upper 95% CI
Lower risk Drinkers	73.6	51.8	86.4	73.3	51.1	86.4
Increasing Risk Drinking	19.5	10.6	37.1	20.0	10.8	38.5
Higher Risk Drinking	6.9	2.5	22.2	6.7	2.4	21.8
Binge Drinking	13.8	12.5	15.2	20.1	19.4	20.8

Source: Local Alcohol Profiles for England (2012)

Local Alcohol Profiles in England

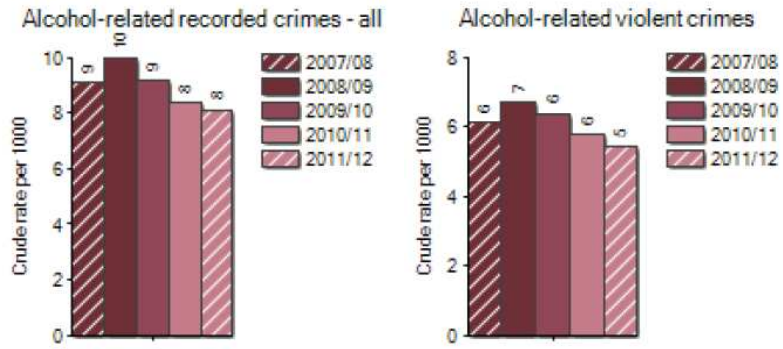
The Local Alcohol Profiles in England (LAPE) provide data on a number of alcohol-related indicators at national and local level. The profiles distinguish between alcohol-specific and alcohol-attributable indicators - the former for conditions wholly related to alcohol e.g. alcohol overdose or alcohol liver disease, the latter for conditions caused by alcohol in some, but not all cases e.g. stomach cancer.

Overall, LAPE data published in 2012 shows that Bromley is significantly better than the average for England for many alcohol-specific and alcohol-attributable indicators. These include binge drinking, alcohol-specific and alcohol-attributable hospital admission (in both males and females), and alcohol-specific mortality. However, indicators relating to alcohol and crime were significantly worse in Bromley, compared to the England average, suggesting more attention is needed to address this issue locally.

Crime

In 2011/12, the crude rate of alcohol-related recorded crimes was 8 per 1000 population, a slight reduction compared to previous years, assuming that reporting and recording of such crime has remained the same (see Figure 14.1 below). For alcohol-related violent crimes, the crude rate in 2011/12 was 5 per 1000 population, again a slight decrease compared to previous years. Despite the reduction in trends, Bromley is ranked 101 for alcohol-related recorded crimes and 97 for alcohol-related violent crimes out of the 151 primary care organisations in England. The LAPE base their calculations on the proportion of people arrested for a particular type of crime who test positive for alcohol (using an arrestee survey) and apply this to available crime data. This method probably underestimates the role of alcohol in offending because, for example, a proportion of the crimes may be classified as drug-related if arrestees had tested positive for both alcohol and drug use.

Figure 14.1. Alcohol-related crimes (recorded or violent), in Bromley 2007-2012



Source: LAPE (2012)

Of the 11,982 arrests in Bromley for a variety of offences in 2008/09, 7012 (58%) were resident in Bromley. Out of these, 322 (4.6%) were attributed to road traffic

accidents in which the individual tested positive for alcohol on breath test (Bromley Metropolitan Police 2008/09). Also of note was that a significant proportion of offences (587 out of 7012) were related to criminal damage in which the individual tested positive for alcohol on breath test. Overall, over a quarter (27%) of individuals tested positive for alcohol following arrest. This reinforces the significance of alcohol in offending and highlights the need to reduce its impact on the level of crime in the Borough.

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.

What this means for Bromley: more preventive work is needed to explore how levels of alcohol-related crime can be reduced in Bromley. Developing ways to assess the impact of alcohol on domestic violence is also important.

What this means for the JSNA

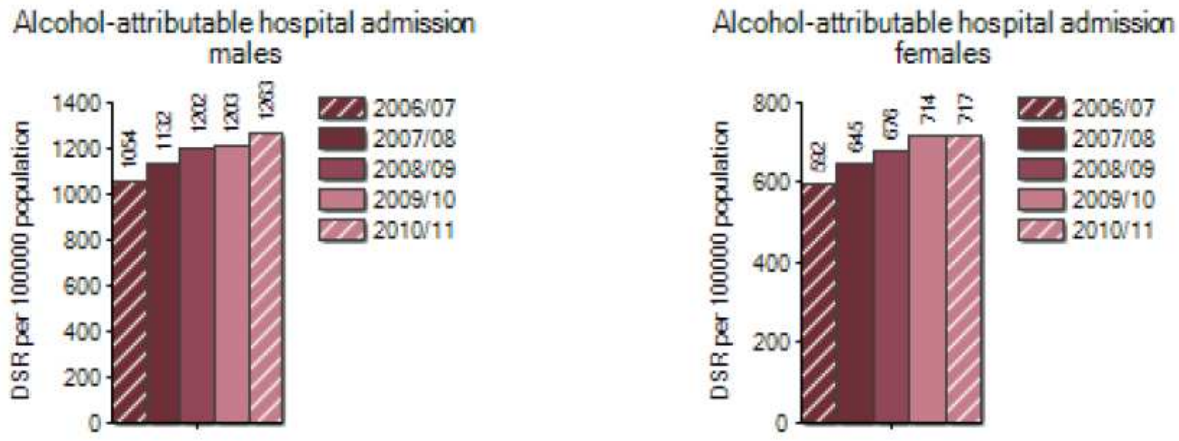
More preventive work is needed to reduce the levels of alcohol-related crime in Bromley.

An increased understanding of the impact of alcohol on domestic violence is needed.

Alcohol and hospital attendance

Trend charts from the LAPE show that directly-standardised rates for alcohol-attributable hospital admissions in both males and females have been increasing year on year between 2006/07 and 2010/11 in Bromley.

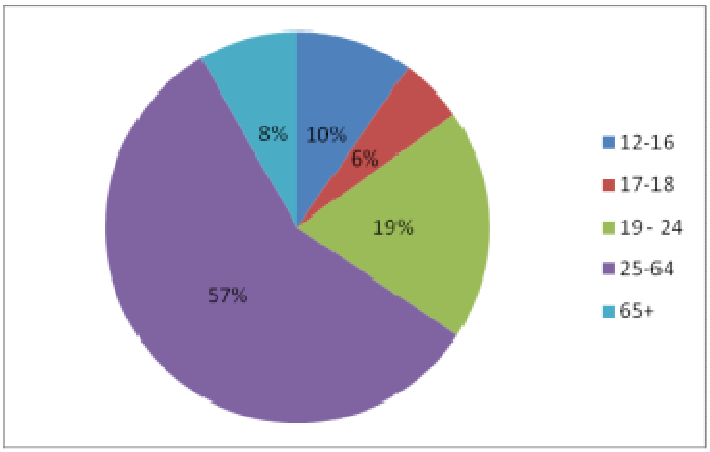
Figure 14.2. Alcohol-attributable hospital admissions in both males and females



Source: LAPE (2012)

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. Whilst the majority of attendances involved 25-64 year old adults, a notable proportion (10%) involved 12-16 year olds. The Chief Medical Officer's 2009 guidance that young people under 15 should not drink alcohol at all is based on findings that those drinking from an early age are more likely to develop alcohol problems in later life. Given that a significant proportion of 12-16 year olds are attending Accident and Emergency services for alcohol-related conditions, more needs to be done to increase awareness of the risks and consequences associated with drinking in young people.

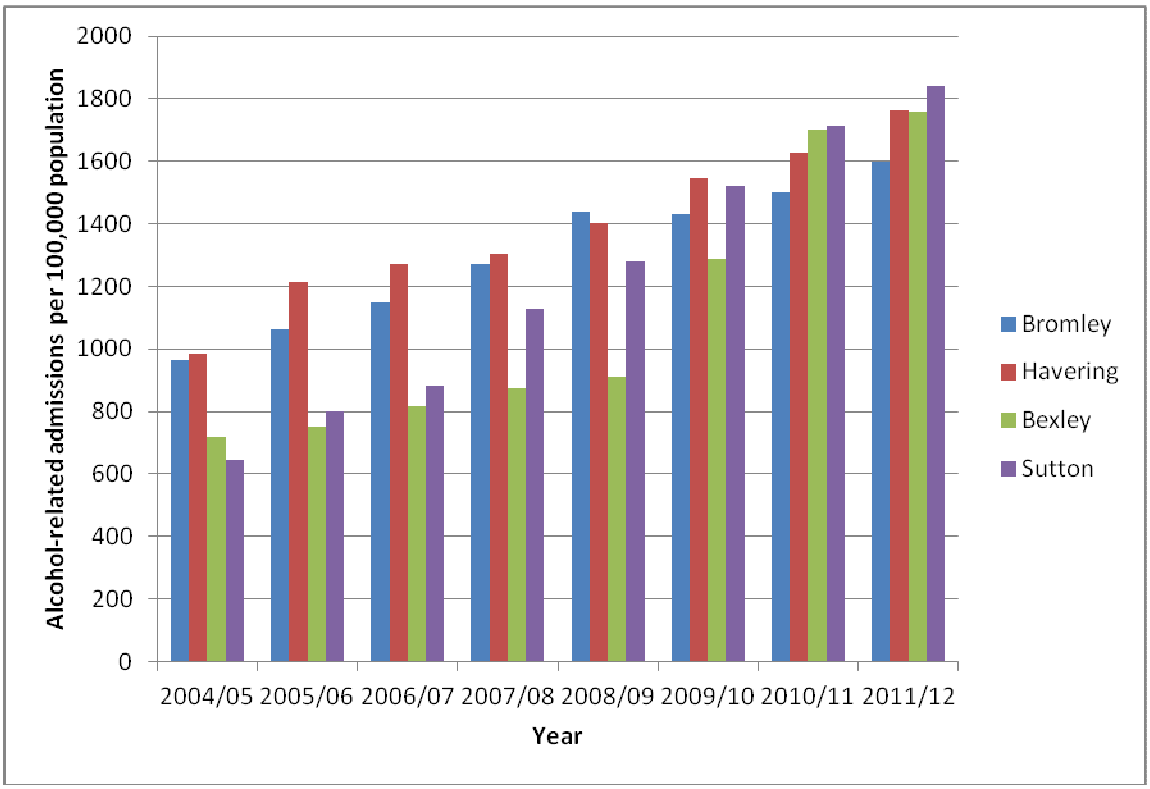
Figure 14.3 South London Healthcare Trust Accident and Emergency attendances 2009/10 by age



Source: South London Healthcare Trust, 2009/10

Age standardised rates of alcohol-related admissions per 100,000 population in Bromley have increased steadily between 2004 and 2012 (see Figure 14.4). Between 2004/05 and 2010, the rates in Bromley were higher than the comparable boroughs of Bexley and Sutton. However, in the last two years, rates in Bromley have been lower than its comparators.

Figure 14.4. Age standardised rates of alcohol-related admissions per 100,000 population, 2004/05 to 2011/12, for Bromley and comparable boroughs



Source: LAPE (2012)

What this means for the JSNA

The levels of alcohol-related hospital attendance and admissions to reduce pressure on secondary care services.

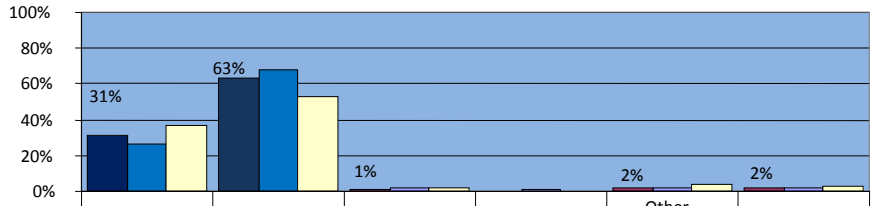
More work is needed to raise awareness of the risks of alcohol misuse in Bromley, particularly in young people.

Alcohol misuse with 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 (NDTMS 2008/09).

Nationally, alcohol and cannabis are by far the most prevalent drugs of choice in the 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 2007/08 to 31% in 2008/09. As a secondary drug, alcohol has increased from 29% to 34% in the same period (NDTMS 2008/09).

Figure 14.5. Primary drugs of choice for young people in Bromley 2008/09



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

Source: NDTMS 2008/09

Treatment services in Bromley

In Bromley, alcohol is discussed as part of substance misuse in school personal health and social education classes. 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.

Tier 1 services are mainly delivered by GPs. 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 and this has risen to 23 in 2009/10 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.

People with acute alcohol-related problems may also come into contact with Emergency departments where they are seen by general physicians and/or psychiatrists. People with chronic alcohol problems may come into contact with community alcohol and drug services, psychiatrists and social care, domestic violence and housing teams.

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 with 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 stabilise 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%).

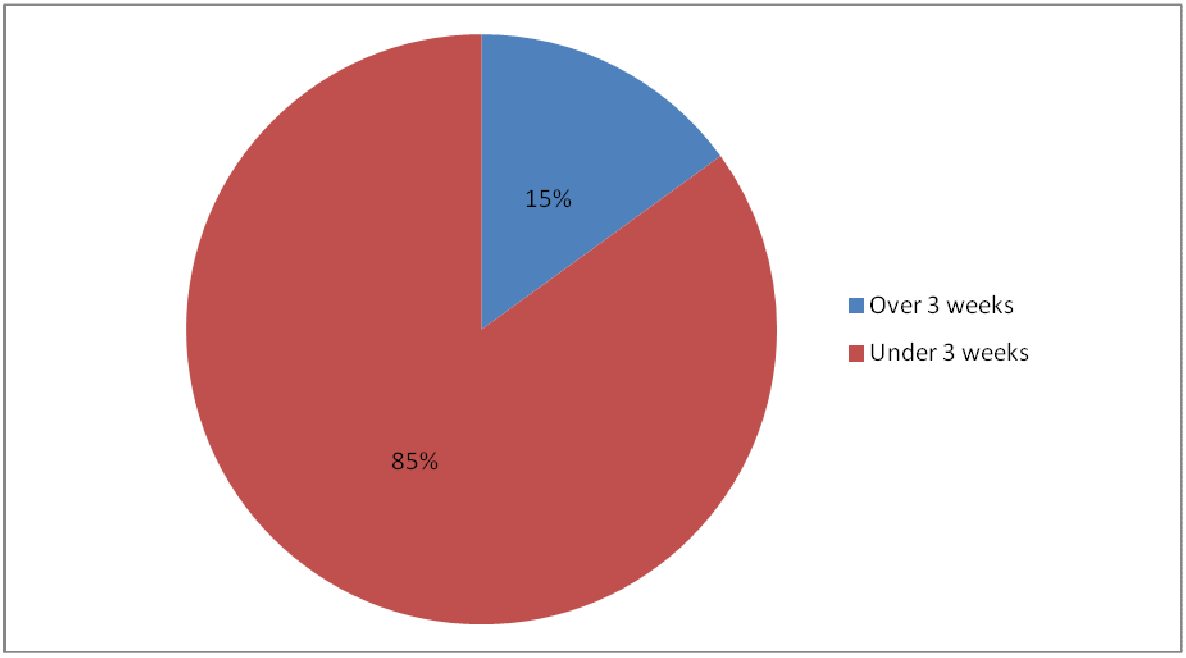
Tier 4 services provide in-patient or residential detoxification. There are a range of services to meet individual needs which include:

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

Treatment waiting times

Figure 14.6 shows the waiting times for first intervention for patients using alcohol treatment services in 2011/12. It can be seen that for the vast majority of patients (85%), waiting times were less than 3 weeks. In the last few years, waiting times for first intervention in Bromley compare favourably with national ones; for example, in the last quarter of 2009/10, 88% of patients experienced waiting times of less than 3 weeks (compared to 81% nationally), for 2010/11, this was 93% (compared to 85% nationally).

Figure 14.6 Waiting times for first intervention for patients using alcohol treatment services in Bromley, 2011/12.



Source: data from NTA (2011/12)

Treatment type

The following table shows differences between Bromley and national alcohol services in the treatment type provided. The size of the difference could be due to coding issues and/or the small numbers involved. What is striking though is that Bromley appears to treat considerably more people as in-patients. This would have important implications for costs.

Table 14.3. Treatment type provision in Bromley compared nationally, 2009/10

Treatment Type Provision	Bromley (2009/10)	Percentage for each treatment type	National percentage 2008/9 (covers adults aged 18+ only)	Difference (%) 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: Taken from NDTMS data, 2009/10

Conclusion

Alcohol misuse is associated with significant health and socio-economic burdens. This chapter shows that, in Bromley, more can be done to reduce the negative impact of alcohol misuse, specifically:

- Tackling the high levels of alcohol-related crime
- Raising awareness of the risks of alcohol misuse in younger people to reduce the pressure on secondary care services and prevent alcohol-related morbidity in later life.
- Reducing rates of alcohol-related in-patient stay by providing more primary care support to reduce costs of secondary care and improve management of alcohol misuse in the community.

15. Updates on Progress from Last Year's JSNA

3. The Health of People in Bromley

Hypertension

Last year's JSNA highlighted that the prevalence of hypertension had been rising in Bromley for the previous 6 years. This rise in prevalence was for two main reasons, earlier identification and a greater number of people developing hypertension to be identified.

In 2011/12 we saw the first dip in the prevalence.

Hypertension has been identified as a priority in the Health & Wellbeing Strategy and a Hypertension Action Plan has been developed and is being implemented. This is being driven through the CVD Strategy Group where the focus is to improve the identification and management of hypertension by all stakeholders through:

- Making hypertension everyone's business
- Increased awareness of the implications of hypertension
- Driving the implementation of NICE Hypertension guidelines

Alongside this there is a widespread initiative that is being considered as a pilot across 22 GP practices looking at the implementation of the NICE Hypertension Guidelines. Evaluation of this will help underpin key elements of the Hypertension Action Plan and will support the development of guidance to roll out across the other practices.

Teenage Conceptions

Last year it was noted that teenage pregnancy rates appear to be falling, but remain highest in the most deprived sections of the borough.

Bromley Sexual Health Strategy Group is currently targeting initiatives in these areas of identified need, including:

- a sexual health specific website [following consultation with local young people]
- a fit for purpose condom scheme [on-line]
- wide availability of EHC [Emergency Hormonal Contraception].

Once these strategies have been fully implemented in the coming months, they will be widely promoted in these areas.

HIV

As the prevalence of HIV in Bromley has now reached the level of 2 per 1000 population, a pilot project of HIV testing in the GP practices in the north of Bromley i.e. Penge, Anerley and North Beckenham was set up early in 2012. This pilot involves the offer of point of care (rapid) testing to:

- new patients (aged 15 – 59 in line with the national HIV testing guidelines) at registration
- patients in at risk groups (Black Africans and MSM)
- patients with possible HIV-related symptoms
- patients who request a test

This project will be evaluated to assess whether rates of testing and HIV diagnosis increase. Early findings suggest that this style of testing is acceptable to patients. This is an important pilot, as if successful, it will improve levels of early diagnosis of HIV. People living with diagnosed HIV can expect a near-normal life expectancy, provided they are diagnosed early in the course of their infection.

Immunisation

Immunisation rates have continued to improve, and for vaccinations given by the first birthday, are now above the WHO's recommendation of 95% uptake.

Work continues to address data quality issues.

In addition, a new pathway has been developed to identify children not registered with a General Practice who have missing immunisations. This pathway involves work by Health Visitors to encourage immunisation as well as registration with a practice for further medical support for these children who may be particularly vulnerable.

4. Environment

Progress has been made in a range of fields, including the following:

1. The Local Plan consultation (proposed Spring 2013)
    - Sets out "Health and Wellbeing" Vision, Objectives and Options to ensure that the impact of developments on health is acknowledged throughout the Local Plan and that developments produce environments which support health and wellbeing.
    - Identifies "Renewal Areas" reflecting "Areas of Regeneration" highlighted by the Mayor. The health challenges in three Renewal Areas are examined in this JSNA.

2. The adult social care services website, "My Life", was launched in October 2011 to enable people to access up to date on-line information and advice on services and support options.

3. Increasing participation in sport and physical activity and improving infrastructure, through Pro Active Bromley.

4. A new skateboard and BMX installation was provided in Tubbenden Recreation Ground.

5. 2 outdoor gyms to be located within the borough's green spaces, in Betts Park www.bromley.gov.uk/directory_record/320095/betts_park and Anerley and Farnborough Recreation Ground www.bromley.gov.uk/directory_record/320128/farnborough_recreation_ground__tugmutton_common in Farnborough.

6. The Crystal Palace Park Management Board was created to deliver small infrastructure improvements to the park and investigate options that will ensure the park's future

7. 170 Snow Friends groups were set up, involving over 3,500 residents.

6. Children and Young People

- Reduced the gap between the highest performing pupils and the lowest 20% at Early Years Foundation Stage
- Narrowed the gap between the percentage of pupils who receive Free Schools Meals and those pupils who do not at Key Stage 2 and Key Stage 4
- Improved the educational attainment of pupils with a Statement at Key Stage 2 and Key Stage 4
- Reduced the average time between a child entering care and moving in with its adoptive family
- Increased the percentage of young people aged 19 who were looked after aged 16 who were in education, employment or training, and those who were in suitable accommodation

7. Older People

- Increased the number of older people managing their own care through a Direct Payment
- Reduced the number of older people in placements supported by the London Borough of Bromley in care homes – both residential and nursing
- Opened 2 new Extra Care Housing schemes as an alternative to residential care
- Undertaken a survey of over 1,200 service users known to the London Borough of Bromley to better understand their needs and views

8 & 9. Learning Disabilities and People with Physical Disabilities & Sensory Impairment

Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life.

Transitional arrangements were identified as an issue in last year's JSNA.

Bromley was successful in being awarded pathfinder status for the Government's Special Educational Needs and Disabilities Green Paper in September 2011. In recognition of the work already being done on transition the Department of Education had agreed that Bromley's Pathfinder could be designated a Preparing for Adulthood (PfA) pathfinder.

As a result, a Transition Workstream had been set up to take forward both the testing of the Green Paper proposals as well as the wider issues identified in the Transition. Therefore, no further work would be undertaken on the Transition Strategy pending further reforms by the government.

10. Mental Health

Adult Mental Health

A Mental Health Needs Assessment was carried out and identified poor physical health in people with mental health problems as a priority for the Bromley Mental Health Strategy. A number of work streams are now underway which include Quality Improvement programmes with Oxleas NHS Foundation Trust and the establishment of long term condition work with the Bromley working for Wellbeing Service.

There has been significant investment in the National Improving Access to Psychological Therapies programme in Bromley which has demonstrated good clinical outcomes which are higher than the London rate.

There has also been significant investment in dementia memory services for Bromley and the establishment of a Liaison Psychiatric team at the PRUH.

CAMHS

Last year the JSNA identified increasing numbers of referrals to CAMHS over previous years. This trend has continued, with particular increases in self harm. A healthcare needs assessment is feeding into a major review of CAMHS services.

12. Carers and Young Carers

- Published a revised Strategy for Carers for 2012-13
- Undertaken a survey of over 400 carers known to the London Borough of Bromley to better understand the needs and views of carers.

13. Substance Misuse

There have been a number of progress areas since last year's JSNA:

- A new integrated Drug and Alcohol service has been in place from December 2011 providing an integrated drug and alcohol service
- The National Treatment Agency has placed Bromley as a nudge partnership meaning that improvement in performance is required
- The overall number of people in treatment has reduced from last year, and there is an increase in the number of those successfully completing their treatment
- Work continues to increase the numbers accessing the service
- Bromley's Drug Intervention Programme performance continues to be good across all areas.

16. Useful References

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NICE Clinical Guidance – *Hypertension CG127* (August 2011)

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UK National Screening Committee – UPDATED The Handbook for Vascular Risk Assessment, Risk Reduction and Risk Management (2012)

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