Bexley Covid Impact Assessment 2022

Vital-5 Health Inequalities Assessment

Draft version 0.2 not for public sharing

1. Executive Summary and Key Findings

This review of health inqualties in Bexley was commissioned by the Director of Public Health, Dr Anjan Gosh, as part of a larger Covid Impact Assessment. The report has been prepared by PHAST, a social enterprise working closley with the Bexley Public Health Team.

The report focuses on five key measures identified by King's Health Partners and established as priorities at South East London level:

- Hypertension
- Smoking
- Alcohol
- Obesity
- Mental health

These "Vital 5" have a major impact on the burden of disease, therefore the management of this relatively small number of behaviours and conditions should impact on a much broader range of outcomes. We also include sections on people with a learning disability and adults with learning difficulties, because these are important domains of inequality that would otherwise have been lost.

This report is based on analyses of quantitative data available from national agencies and government departments, including the Office for National Statistics (ONS), Office for Health Improvement and Disparities (OHID), UK Health Security Agency (UKHSA) and data provided by public health services, health services, and other council departments. This was supplemented by information and insights provided by stakeholders representing commissioners, providers, the voluntary sector and subject experts.

The project was overseen by a joint steering group and supported by a working group.

The report first decribes national evidence and current focus on health inequalities, then presents high level indicators of health inequalities in Bexley, followed by a section on each of the Vital 5.

Introduction, national perspective, and high level indicators

The introduction describes what we know from national studies of health inequalities. There are three key themes that emerge from the national studies:

- Health outcomes are associated with deprivation, with those in the most deprived areas experiencing the worst outcomes. Moreover the studies show that there is a clear social gradient, with a linear relationship between deprivation and health outcomes.
- Most of the ethnic differences in observed health outcomes can be explained by

> deprivation. A higher proportion of people from ethnic minorities live in the more deprived areas, and living in these areas influences their health outcomes.

- There was a social gradient in mortality from COVID-19, and deprivation explained most of the higher mortality in Black and Asian minority communities. This further exposed the existing inequalities in the prevalence of comorbidities such as obesity and hypertension that are highly associated with higher mortality from COVID-19.

How does this evidence from national studies translate to health inequalities in Bexley?

Bexley as a borough is within the 20% least deprived areas nationally, and the 9th least deprived borough in London. Deprivation varies by ward within Bexley. Four wards in the North (Slade Green & Northend, Thamesmead East, Belvedere and Erith) are more deprived than the England median, whilst Crook Log, a ward in central Bexley, and Blackfen & Lamorbey and Blendon & Penhill, wards in the South of Bexley, are half as deprived as the England average. Within Bexley, the North of the borough is 2.5 to 3 times more deprived than some of the wards in the central and South of the borough. 1 in 4 of Bexley's residents live in the most deprived wards in the North of Bexley.

In Bexley the Black and Asian minority (BAME) population makes up less than 1 in 5 of the overall population. However, wards in the North have a different profile. In Thamesmead 1 in 2 residents are from the BAME community, and in Erith, Belvedere and Slade Green & Northend about 1 in 3 are from the BAME community. Around 1 in 2 of the BAME community in Bexley lives in the North.

In view of this, extrapolating data and findings from national studies to Bexley would suggest that inhabitants of the wards in north Bexley are likely to face worse health outcomes.

High level indicators of health inequalities in Bexley

Life expectancy is a high level indicator of health inequality. People living in Bexley on average live longer than the average for London or England, as described by life expectancy at birth. However, there are significant inequalities in life expectancy within Bexley associated with deprivation. The wards in the North of the borough have lower life expectancy compared with less deprived wards. The wards of Slade Green & Northend and Thamesmead East have significantly lower female life expectancy than the England average, and Erith and Slade Green have significantly lower male life expectancy than the England average. The least deprived wards have significantly higher life expectancy than the England average.

There is a similar gradient in life expectancy between GP practice registered populations. The life expectancy for the registered populations of practices located in the North, such as Slade Green Medical Centre, Lakeside Medical and Riverside Surgery, is significantly lower than the registered populations of practices located in

less deprived wards.

The gap in the life expectancy between the most and least deprived quintiles has remained constant for males but has increased over the last decade for females in Bexley.

The difference in life expectancy at ward level indicates that there are excess deaths in deprived wards at a younger age compared with the less deprived wards. Excess deaths in the 40-59 age group explain 25% of the difference in life expectancy in men and 20% in women. Excess deaths in the 60-79 age group explain 55% of the difference for men and 42% in women. For women, excess deaths in the 20-39 age group explain about 8% of the difference in life expectancy.

For men, circulatory conditions (30%) and respiratory conditions (25%) drive the gap in life expectancy in Bexley. For women, the most important causes are cancer (33%) and circulatory disease (25%).

Mental heath

The other persistant inequality revealed by the national evidence is the premature mortality gap between people living with serious mental illness (SMI) and those without SMI. We found similar inequalities in Bexley where premature mortality (under 75 years) in people with SMI was about 5 times greater than that in people without SMI. It should be noted that Bexley is not an outlier when compared with similar boroughs, but it remains a signficant inequality. In line with national evidence, excess premature mortality in people with SMI is due to cardivascular, liver and respiratory diseases.

These deaths are avoidable, in that they can be prevented through promotion of healthy behaviours, through early detection and treatment of cardiovascular, liver and respiratory conditions. Smoking, alcohol, obesity, and hypertension are key factors that can be addressed to avoid excess deaths.

In this report we describe health inequalities related to these key causes known as the Vital 5.

Smoking

Smoking rates have been decreasing in Bexley as they have across England and London, but mortality and hospital admissions contributable to smoking are significantly higher in Bexley than the London average. There are significant differences in smoking rates within Bexley, with six GP practices having a higher proportion of their adult registered population recorded as smokers compared to the England average.

Data provided by NHS South East London CCG show that there is a higher rate of smoking in men, people in middle age, and White British, White Irish and Gypsy, Roma and Traveller communities.

Trends in smoking prevalence have been decreasing in people with SMI, however the current rate is nearly twice that of the rate in the general population. There are higher rates of smoking in people with anxiety and depression in North Bexley PCN. People in the 18-39 age group make up the highest proportion of all recorded smokers with anxiety and depression.

Obesity

The adult obesity rate in Bexley is significantly higher than the England average. There are large differences in the proportion of registered patients recorded with obesity at GP practices in the North, with significantly higher rates at Bellegrove Surgery, Riverside Surgery, Slade Green Medical Centre and Lakeside Medical. Recorded levels ranged from 10% to 25%, with North Bexley PCN and Clocktower PCN having significantly higher obesity levels than the England average.

Data from GP practices shows that women, people aged 40+, and people from Black African/Caribbean, Gypsy and Roma Traveller community, and Eastern European backgrounds had higher levels of obesity.

Bexley has the second highest obesity level in pregnant women in London, and a significantly higher level than England. This data is based on assessment at first booking and provides a true picture reflective of the general population. Data from the local maternity unit shows that rates are highest in pregnant women aged 30-34.

Hypertension

Hypertension as recorded by GP practice registers is higher in all four PCNs in Bexley compared with South East London CCG. The rates are dependent on the age profile of the practice and North Bexley PCN has the lowest proportion of people aged 65+. Currently APL and Clocktower PCN have significantly higher recorded rates of hypertension. North Bexley has the lowest rates, although these are increasing. The rates reflect recorded prevalence and therefore underestimate true underlying prevalence as there will be undetected hypertension in the population. There is a higher proportion of recorded hypertension in North Bexley in younger age groups compared with other PCNs.

Rates of hypertension are highest in White British, Black African/Caribbean, and Gypsy Roma Traveller communities..

Mental Health

Crude rates of depression recorded within GP practices vary between practices. These variations are also reflected in referrals and admission rates. The highest rates are seen in Slade Green & Northend, Erith, Sidcup, and Cray Meadows. Over half of admissions are from the five most deprived areas.

The rates were higher in the 18-39 age group. Ethnicity recording was not complete

with 16% not stated. Of those with ethnicity recorded, 74% are White British and 5% from Black African communities. The referral rates are higher in females.

What works well in Bexley?

We spoke to stakeholders to find out about works well in Bexley to support residents that were smokers, had unhealthy weights, misuse alcohol, and people living with mental health conditions.

Smoking

Bexley has an in-house smoking cessation team. From the stakeholder engagement, we heard that the service has formed good relations with primary care. This is evidenced by the quantitative referral data. The uptake and success rate of the service is good across the social classes, gender, and age. Based on the total uptake figures, 22% were from routine and manual occupations, 17% from intermediate and managerial and professional (14%), 14% were retired, and 12% had never worked or were long term unemployed. 8% were unable to work due to sickness or disability, and 9% were carers. The success rate was good among people in the routine and manual and intermediate occupation class, with 60% successfully quitting. From a subsample of the clients that took up the service and had a medical condition, mental health and COPD were the main co-existing conditions. These clients also had a variety of other co-morbidities. The success rate among these clients was good.

The service has successfully implemented an E-Cig provision pilot scheme in partnership with local vaping shops. This was featured as a case study in the newly published NCSCT E-cig Guidance for Stop Smoking Services.

What can be improved?
Lessons learnt during COVID when the service switched to telephone support and coped well with an increased demand means that the service will continue with a hybrid model. The success rate was higher as people were easily contactable and because of the fear of the virus being a respiratory illness.

There is now better recording of smoking status of all adult patients and increasing referrals from GP practices. There are also more referrals from secondary care – for example from the "waiting well" programme where patients on waiting lists can be referred and embedding it as part of care pathways.

In addition to supporting people who smoke to give up smoking, preventing take up of smoking through Tobacco control partnership/alliance should be prioritised by the Council.

Obesity

In 2018, the adult weight management programme 'Slimming World' was commissioned. Data shows that overall, the service has been successful in achieving weight loss and encouraging participants to complete the intervention, with a 73% completion rate, 68% achieving weight loss of 3%, and 46% achieving 5% weight loss. There is a good spread of groups across the borough.

What can be improved?

Referrals and uptake of the service among men, ethnic minority groups and people with long term conditions. Two new weight management services have been commissioned to target these groups. Lessons learnt during COVID suggest that in Bexley clients prefer in person service rather than virtual. This warrants further understanding since results from other services show that access to virtual services have resulted in higher uptake in groups that previously did not routinely engage.

Alcohol

South London and Maudsley NHS Foundation Trust provides an adults' substance misuse treatment service. The service offers structured treatment to all adults experiencing issues with drugs and/or alcohol; support to carers; and wraparound support i.e. access to training/CV development/job opportunities, housing support etc. It plays a significant role in developing partnerships with other local agencies to ensure a joint approach to substance misuse. As an integrated service, it works well, and outcomes are good. The service is well run and links in with partner organisations.

What can be improved?

Lessons learnt from COVID when the service had to retain clients for longer, indicate that substance misuse requires a broader approach rather than relying on one treatment service alone to address all issues. Improvements to identification and referral are required in all frontline services across Bexley, along with consideration of rolling out IBA/other prevention activities.

Mental Health

A range of Mental Health and Wellbeing support services are jointly funded by Council and CCG including:
- Prevention and Early Intervention Grants
- Bexley Voluntary Services Council (BVSC)
- Social Prescribing (Community Connect)
- Recovery, Wellbeing and Employment Support
- Mental Health Rehabilitation and Community Support

The CCG commissions:
- Improving Access to Psychological Therapies (IAPT)
- Secondary Mental Health Services
- Specialist Mental Health Services

Mental health is an umbrella term to encompass a variety of health issues. Health needs are complex and this is further exacerbated by health inequalities related to physical health comorbidities and deprivation, and employment . Badging mental health as one condition does not do justice to people living with different mental health conditions, single or comorbid.

Conclusions

This review found that there are signficant health inequalities in life expectancy in Bexley. Bexley residents enjoy better health outcomes than the average for England and Bexley has many assets including its open and green spaces. However, similarly to every borough in England, it has internal inequalities that need addressing now as the focus moves from the pandemic response to recovery. These inequalities are largely linked to derprivation. The North of the borough has higher levels of deprivation which is a key driver of health inequalities.

As demonstrated, health outcomes are poorer in areas of higher deprivation, all policies and plans should consider the impact of health.This report further found health inqualities exist in the prevalence of modifiable risk factors: obesity, smoking, alcohol and hypertension. The inequalities faced by people living with mental health problems has shown that Bexley system leaders will need to take bold steps to address this. The aim if for all babies born in Bexley to live longer and healthier lives as well as supporting residents to live healthier lives. This cannot be a step change approach as it is not dependent on one factor or one partner. A whole system approach, embeding ways of reducing health inequalities will need to be developed.

Recommendations

The Health and Wellbeing Board and its constiuent member organisations have a statutory duty to improve the health and wellbeing of the local population and address inequalities. Covid has highlighted that the above statutory duty is the right thing to do for the people we serve. Based on the findings of this report we suggest the folowing:

1. Aspire to embed health and health inequalities in all polices and plans so that every part of the Bexley system is working towards the same goals:

   - Reduce the gap in life expectancy between communities.

   - Improve health status and disability free life expectancies.

   - As part of this public health to offer masterclasses in population approaches such as health in all polices and explain how different non health services can incorporate health in what they deliver.

- Support services to understand the social model of health and ways to implement this model in their work.
- Support local primary care networks to develop health improvement plans.

2. Refresh and adopt the place based health and wellbeing strategy

- Public health with partners to develop an action plan and monitoring metrics for the strategy.
- HWB to ensure quarterly progress reports.

3. The ICS develoment plans to ensure place based plans and resources are supported adequately

- Local inequalities are not lost in the overall scheme.
- Population health management systems use data from other partners to draw a wider picture to support practices to understand the wider determinants of their population's health.

4. The role of the voluntary sector is considered as part of all plans

- The voluntary sector is resourced well to deliver the role it can play in health improvement and tackling health inequalities.
- Enable training for communities for health literacy and championing health.

2. Background

Statement of the Problem

The Covid-19 pandemic has once again brought to the fore the inequalities in health outcomes that have existed in our society. Higher rates of illness and deaths in people living in more deprived communities compared with people living in less deprived communities is not new information.. The pandemic has revealed an even more urgent need to address the root causes of these inequalities.

Deprivation and Inequalities in COVID-19 related deaths

During the pandemic, diagnosis and death rates in people living in deprived areas were higher than those living in less deprived areas. The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females[1]. The inequality was greater in the younger population. COVID-19 mortality rates for people younger than 65 years were 3.7 times higher in the most deprived areas than the least deprived areas in England between March 2020 and March 2021[2]. The Marmot report [3] on the socioeconomic and health inequalities during the pandemic highlighted that there was a social gradient in mortality rates in COVID-19 similar to that for non-COVID-19 deaths.

Figure 1: Age-standardised mortality rates in males from all causes, COVID-19 and other causes (per 100,000), and deprivation deciles in England, for deaths occurring between March and July 2020.
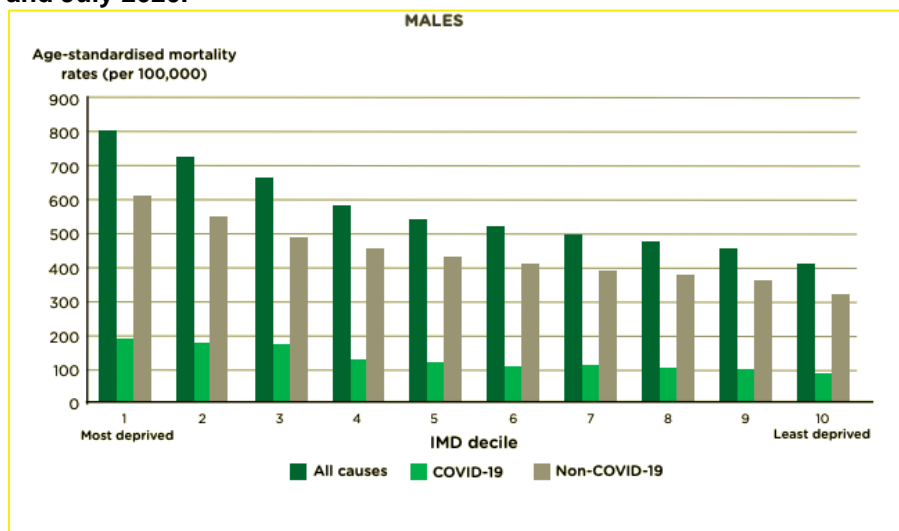
Source: Institute of Health Equity, Build Back Fairer: The Covid-19 Marmot Review, build-back-fairer-the-covid-19-marmot-review-full-report.pdf (instituteofhealthequity.org)

---

[1] PHE Disparities in the risk and outcomes of Covid-19 August 2020
https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes
[2] The Health Foundation; The Covid-19 impact enquiry report -Unequal impact fairer,recovery
https://www.health.org.uk/publications/reports/unequal-pandemic-fairer-recovery
[3] Institute of Health Inequity and the Health Foundation Build Back Fairer: The Covid-19 Mamot Review
https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-the-covid-19-marmot-review

Ethnicity and inequalities in COVID 19 mortality

People from BAME communities experienced disproportionate mortality from Covid 19 compared with White British Communities.[4] Figure 3 compares the age-adjusted and adjusted for socioeconomic demographics hazard ratios[5] for males and females using white British ethnic group as reference[6]. This analysis suggests that socioeconomic factors explain a substantial part of the raised rate of death experienced by ethnic groups compared with the White ethnic group.

Among males, these factors explain about two-thirds of the raised risk for Bangladeshi or Pakistani ethnic background, more than half for Black and about 40% for Indian ethnic backgrounds respectively. Among females these factors explain about 70% of the raised risk for Black females and 80% for Indian females.

Figure 2: Male and female rate of deaths (per 100,000) involving COVID-19 compared to the white ethnic group by ethnic groups in England and Wales, 2020 .
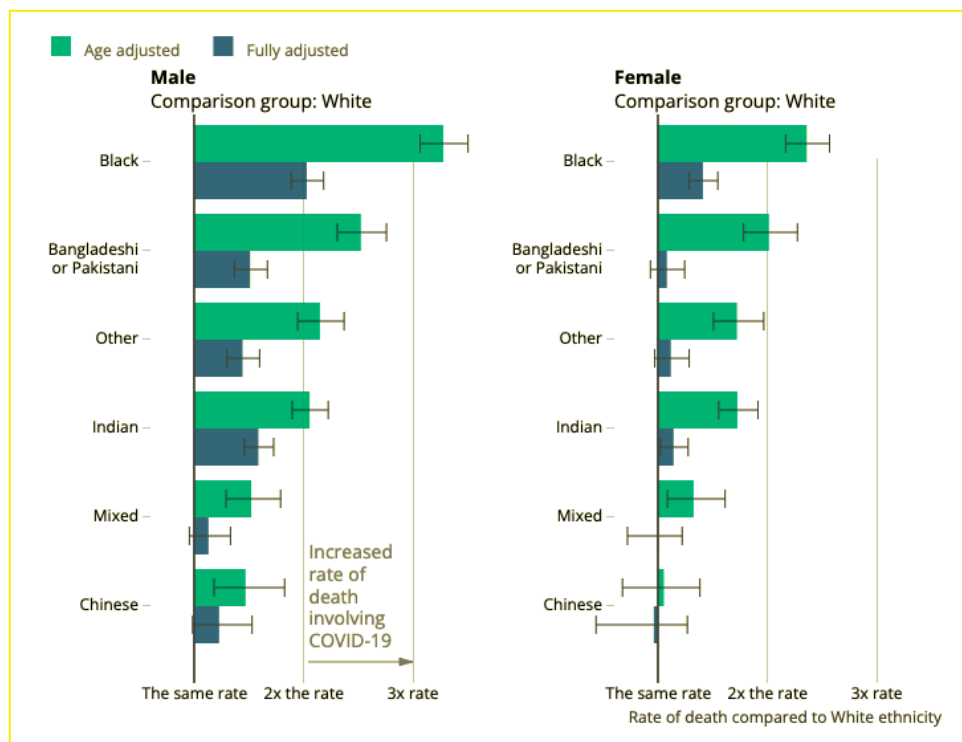
Source: Office for National Statistics, Coronavirus (COVID 19) related deaths by ethnic group; England and Wales, https://www.ethnicity-facts-figures.service.gov.uk/covid-19

---

[4] Williamson, E.J., Walker, A.J., Bhaskaran, K. *et al.* Factors associated with COVID-19-related death using OpenSAFELY. *Nature* **584,** 430–436 (2020). https://doi.org/10.1038/s41586-020-2521-4

[5] A measure of how often a particular event happens in one group compared to how often it happens in another group, over time.

[6] ONS Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020 https://www.ethnicity-facts-figures.service.gov.uk/covid-19

Ethnicity and deprivation

A higher proportion of BAME communities live in more deprived areas[7] , as described by the index of multiple deprivation[8] (IMD). IMD is a composite index which includes deprivation across several domains such income, crime, access to housing and services and living conditions.

Figure 3: Percentage of people living in the most deprived 10% of neighbourhoods by ethnicity, England, 2019
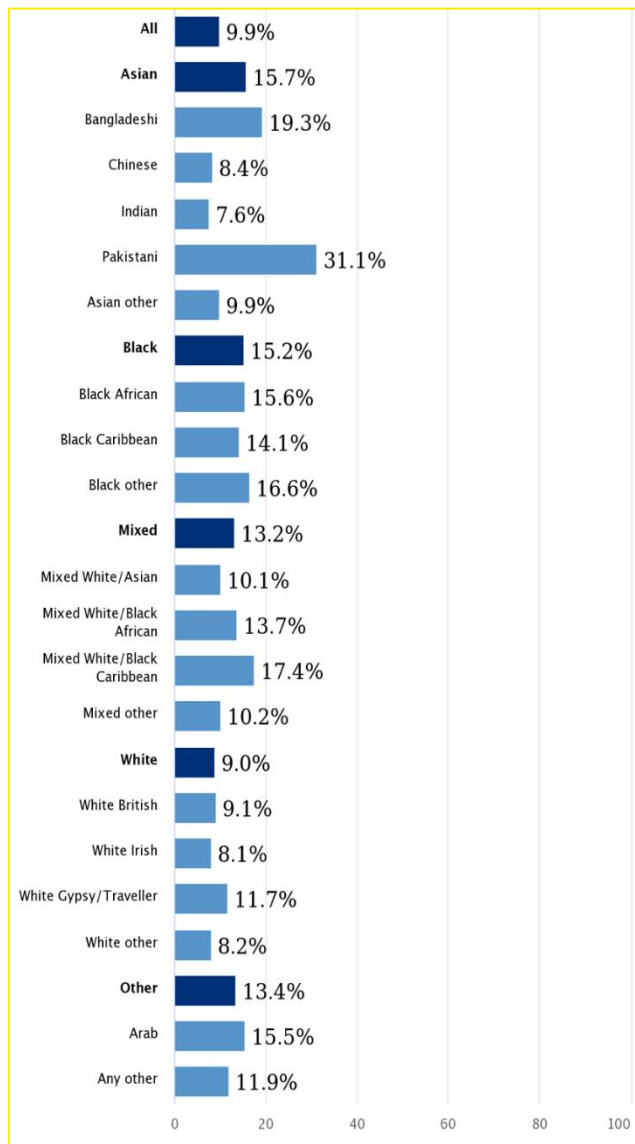
Source: Ministry of Housing, Communities and Local Government, English Indices of Deprivation (National Statistics), English indices of deprivation 2019 - GOV.UK (www.gov.uk)

The data for the most deprived 10% of neighbourhoods shows that:

---

[7] MHCLG Sept 2020 People living in deprived neighbourhoods: https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest

[8] English indices of deprivation https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Black ethnic groups (19.8%) were the most likely to live deprived neighbourhoods, and the white ethnic groups were the least likely to (8.7%).

Out of the 18 individual ethnic groups, people from the Pakistani (30.7%) and Bangladeshi (26.3%) groups were the most likely to live in the most income-deprived neighbourhoods.

People from the White British, White Irish and White Other ethnic groups were the least likely to live in the most income-deprived neighbourhoods (8.7% of each ethnic group).

Black communities (31%) were more likely to live in areas with barriers to housing and services compared with Asian (18.7%) and White British (8.7%)[9].

Comorbidities and risk of COVID 19 mortality

A systematic review[10] found that hypertension, obesity, and diabetes mellitus were identified to be the most prevalent comorbidities in COVID-19 patients. Comorbidities including chronic cardiac disease, non-asthmatic chronic pulmonary disease, chronic kidney disease, liver disease and obesity were associated with higher mortality from COVID-19 in hospital.

Social gradients in morbidities such as cardiovascular disease, diabetes , cancer and obesity are known to exist and COVID 19 has focused attention to addressing health inequalities that exist in the prevalence and outcomes of these preventable diseases[11].

---

[9] The Barriers to Housing and Services indicator in IMD measures the physical and financial accessibility of housing and local services. The indicators fall into two sub-domains: 'geographical barriers', which relate to the physical proximity of local services, and 'wider barriers' which includes issues relating to access to housing such as affordability and homelessness.

[10] Ng WH, Tipih T, Makoah et al Comorbidities in SARS-CoV-2 Patients: a Systematic Review and Meta-Analysis ASM Journals mBio Vol. 12, No. 1 https://journals.asm.org/doi/10.1128/mBio.03647-20

[11] Docherty AB, Harrison EM, Green CA, et al. Features of 20 133 UK patients in hospital with covid-19 using the ISARIC WHO Clinical Characterisation Protocol: prospective observational cohort study. *BMJ*. 2020;369:m1985. Published 2020 May 22. https://www.bmj.com/content/369/bmj.m1985

3. Policy context

National priorities

The priorities for the newly formed Office for Health Improvement and Disparities (OHID)[12] are to:

- identify and address health disparities, focusing on those groups and areas where health inequalities have greatest effect.
- act on the biggest preventable risk factors for ill health and premature death including tobacco, obesity and harmful use of alcohol and drugs.
- work with the NHS and local government to improve access to the services which detect and act on health risks and conditions as early as possible.
- develop strong partnerships across government, communities, industry and employers, to act on the wider factors that contribute to people's health, such as work, housing and education.
- drive innovation in health improvement, harnessing the best of technology, analytics, and innovations in policy and delivery, to help deliver change where it is needed most.

In response to the COVID 19 highlighted inequalities, the department of housing and communities is committed to levelling up across the whole of the United Kingdom to ensure that no community is left behind, particularly as we recover from the COVID-19 pandemic. Areas of change would be to:

- Boost productivity, pay, jobs and living standards by growing the private sector, especially in those places where they are lagging.
- Spread opportunities and improve public services, especially in those places where they are weakest.
- Restore a sense of community, local pride and belonging, especially in those places where they have been lost.
- Empower local leaders and communities, especially in those places lacking local agency.

NHS action to reduce inequalities

The NHS[13] has stated that a central part of responding to COVID-19 and restoring services must be to increase the scale and pace of NHS action to tackle health inequalities to protect those at greatest risk. Eight urgent actions were identified by the advisory group building on the NHS Long term plan to address health inequalities:

---

[12] OHID https://www.gov.uk/government/organisations/office-for-health-improvement-and-disparities/about#priorities
[13] NHS https://www.england.nhs.uk/about/equality/equality-hub/action-required-to-tackle-health-inequalities-in-latest-phase-of-covid-19-response-and-recovery/

- Protect the most vulnerable from COVID-19
- Restore NHS services inclusively
- Develop digitally enabled care pathways in ways which increase inclusion
- Accelerate preventative programmes which proactively engage those at risk of poor health outcomes
- Particularly support those who suffer mental ill-health
- Strengthen leadership and accountability
- Ensure datasets are complete and timely
- Collaborate locally in planning and delivering action

Local ICS priorities

Vital 5- an initiative by the King's Health Partners[14], advocates for people, communities and organisations to make improvements into five factors that have a major impact on health at an individual and population level. These are priority areas for the local Integrated Care system -Our Healthier South East London:

- Hypertension
- Smoking
- Obesity
- Alcohol intake
- Mental health

By reducing obesity and harmful drinking, stopping smoking, controlling blood pressure, and identifying and improving poor mental health will help prevent ill health, promote good health, and improve detection, management and treatment of existing conditions.

Local authorities' duty on health inequalities

Local authorities have a statutory duty to improve health and reduce health inequalities in their local area.

Bexley published a its system wide prevention strategy[15] which aims *to create and maximise by 2025, the circumstances that enable Bexley residents to live longer and enjoy better health for more of their lives, and give our younger residents the best start in life and help them to achieve their full potential.*

The prevention strategy is structured on six themes grouped under the three domains of People, Policies and Practices and Places.

---

[14] https://www.kingshealthpartners.org/our-work/value/vital-5

[15] https://www.bexley.gov.uk/services/health-and-social-care/bexleys-public-health/our-plans-help-us-live-better

Theme 2 of the strategy aims to improve the outcome for adults and older people.

One of the priorities under theme 2 is:

To effectively reduce health inequalities and achieve the best possible outcomes for people within available resources, this means addressing the 'Vital 5': reducing obesity; smoking; harmful drinking; controlling blood pressure; and identifying and improving poor mental health. Identifying, recording and sharing data on these will strengthen care pathways, improve outcomes and make a large contribution to increasing value and sustainability within the health and care system.

The London Borough of Bexley's Director of Public Health commissioned this independent health inequalities review of the topics covered by the five vital 5 initiative.

Purpose of the health inequalities review

The aims of the review are to:

- Identify what health inequalities exist in Bexley and where in the borough the highest health inequalities are seen.
- Review current health needs among Bexley residents according to the Vital 5 namely hypertension, obesity, mental health, smoking and alcohol consumption. (Diabetes and other conditions such as atrial fibrillation are outside the scope of this work).
- Make recommendations to address inequalities within Bexley.

4. Methodology

This work was conducted as per the scope and service specification of the commission. Details of the service specification can be obtained from the commissioner, namely the Bexley Director of Public Health. This work was part of a larger COVID 19 impact assessment project. The scope of this workstream was therefore limited to the service specification of the commission.

Governance and Oversight

The governance and oversight of the work was through a steering group. The terms of reference and membership is attached in Appendix 1. The membership included decision makers from all partners organisations that are key players in the system. A working group was established, the terms of reference and membership is attached in Appendix 2.

Key Lines of Enquiry (KLOE)

The original key lines of enquiry (KLOE) was an exhaustive list in order to undertake a detailed analyses of all public health indicators by age, gender, ethnicity, and small area with five-year trends. This was refined together with members of the working group and was signed off by the DPH. The key reasons for refining the KLOE were unavailability of data at that granular level for an indicator or the indicator did not fit within the scope, e.g. HIV late diagnosis.

Data sets

Publicly available data

Data available from validated sources is available publicly. This data was provided by local commissioners and providers. Publicly available data was sourced from Office for National Statistics (ONS); Public Health England (now split between UK Health and Security Agency, UKHSA and Office for Health improvement and Disparities, OHID). The list of the datasets and metadata (indicator definitions) are provided in Appendix 3.

Two types of data were available:

- those that were based on data collections where local data is returned to the appropriate body,
- data based on national validated surveys that include representative samples from each local authority.

Locally collected data

Local data sets that were available were discussed with internal council directorates

and NHS commissioners and providers. The list of the data suppliers, data specification and and any limitations are provided in Appendix 4.

Limitation of data

The survey based on smaller samples may be modelled to the whole population and is the best estimate that is available. On the other hand, the data collected such as mortality (deaths) and morbidity (illness) are more robust as they are based on occurrence of an event during a time period.

Similarly, uptake of service provides a good estimate on the cohort that enters the service and not those who may not access the service.

However, by looking at the prevalence (modelled) and uptake of service by geography or ethnicity, age can provide insights on those areas where populations that would benefit from an intervention reside.

Data Access

Data access was an immediate challenge at the start. Principally, the lack of a data sharing agreement between the public health team and data owners meant that there was difficulty in accessing relevant data by Bexley Public Health Team.

This was a complex issue as data suppliers (those who don't own data but have authority to extract the data) could only supply data once the data owners had agreed to the data request. For instance,, the Clinical Commissioning Group (CCG) could supply data as they have access to the data, however the GP are the owners of the data, hence data specification for the GP owned data required permission from GP practices. Similarly, internally business analysts (suppliers) did not own the data, so the specification had to be agreed with the data owner.

The Bexley Public Health Team and all partners worked with support from PHAST team to address this issue and put in place appropriate data sharing agreements that met the GDPR regulations. Whilst it delayed the project, this now allows the public health team to work collaboratively with analysts across the system for future work.

Data Extraction

Once the data agreements and permissions were in place data extractions were done by suppliers from October to December 2021.

Data Analyses

Descriptive analyses were undertaken, and data is presented based on the availability by age, ethnicity or geography. Where confidence intervals were available, significant inference was made. Where valid denominators were available , rates were calculated. Comparators were agreed and are provided in Appendix 5.

Stakeholder Engagement
Stakeholder mapping and engagement

The following stakeholder engagement activities/mapping were initiated:

- Met with local team to agree approach
- Co-produced stakeholder map
- Steering group members (oversight and governance)
- Working group members (area expertise)
- Wider stakeholder group (lived experiences and perceived needs)

The stakeholder mapping is attached in appendix 6.

We conducted semi-structured interviews with those stakeholders involved in Vital 5 from December to February 2022. Questionnaires for semi structured interviews were agreed with working and steering group and list of invitees are attached in Appendix 7.

We held 18 semi-structured interviews with key stakeholders via Microsoft Teams. There were also participants who completed questionnaires and were not interviewed. The interviews provided an opportunity to ask further questions as part of the exploratory methods used to conduct the engagement activities. This style enabled stakeholders to offer further insight that they may have overlooked or not considered as relevant in the first instance. Stakeholders were also encouraged to send any additional information after their interview if needed.

Each interview lasted 45 minutes to 1 hour and was preceded by the participants completing a questionnaire (see appendix 1) specific to their role. Some participants completed more than one questionnaire to reflect the multiple roles they played within the system.

Limitations

Due to the delay in data access, analyses and timing, some of the intended work with the other COVID Impact assessment engagement to be led by internal community engagement was not feasible. However, the Bexley Public Health Team is continuing to use the reports and the analyses to engage through existing forums and meetings.

We undertook a thematic analysis of the findings of the interviews and submitted questionnaires to identify the main findings from the review and help develop recommendations. This qualitative research methodology involved the researchers and participants collaborating to understand local issues and support local decision makers in identifying key actions to take to bring about social change. It is hoped that this review will enable evidence based and informed decision making. There were local

stakeholder fora and workshops which the team have attended. However, due to time constraints and some of these workshops scheduled for outside the period of the engagement timeline, the key stakeholders were encouraged to complete the questionnaires and attend an interview as an alternative. Some stakeholders such as the education subject experts took up this offer. It was a useful way to garner the breadth of information required to achieve the objectives of the engagement activities.

5. Findings on Health inequalities in Bexley

Where in the borough are the highest inequalities?

As deprivation and income poverty are key drivers of health status and inequality, we explored deprivation and income poverty differences within Bexley.

Chapter Summary

Key messages

- Within Bexley, areas of deprivation vary from the highest level seen in London to the lowest level. There is a clear North -South divide although there are small pockets of deprivation in the south.
- Poverty, a key driver of health inequalities ranges from 20% to 5.6%.
- The areas of highest deprivation and income poverty have the most diverse communities with 50-30% residents are from BAME communities.
- GP practices in these areas therefore service a population with multiple disadvantages.

Key recommendations

- The resources and growth overview and scrutiny committee should be requested to plan a scrutiny of the North-South divide in 2022/2023 and recommend actions to level up the North to reduce the divide.
- The South East ICS should develop a costed plan by December 2022 to support the practices in the more deprived areas of Bexley to enable them to co-produce health improvement plans with their practice populations.

Disparity in deprivation within Bexley

With an IMD score of 16.5 Bexley falls in the second lowest deprived quintile nationally. As shown in Figure 4 which compares deprivation score for all London boroughs, Bexley can be ranked as 9th lowest deprived borough in London. However, within Bexley there are wards which have IMD scores which are similar to the most deprived boroughs in London as shown in Figure 5. England and London are highlighted in yellow and grey, and Bexley is highlighted in purple in the chart.

Figure 5 shows IMD deprivation scores for Bexley wards.

The ward of Slade Green and Northend has the greatest level of deprivation with a score of 31.6 which may be comparable to Barking and Dagenham (32.8) Hackney (32.5) and Newham (29.6). At the lowest end of deprivation, the wards of Crook Log

(9.9), Blackfen & Lamorbey (9.6) and Blendon & Penhill (9.4) are comparable with Richmond upon Thames (9.4).

This illustrates the disparities in the socioeconomic and living environments of populations living in Bexley.

Figure 4: London boroughs by Index of Multiple Deprivation (IMD), London, 2019
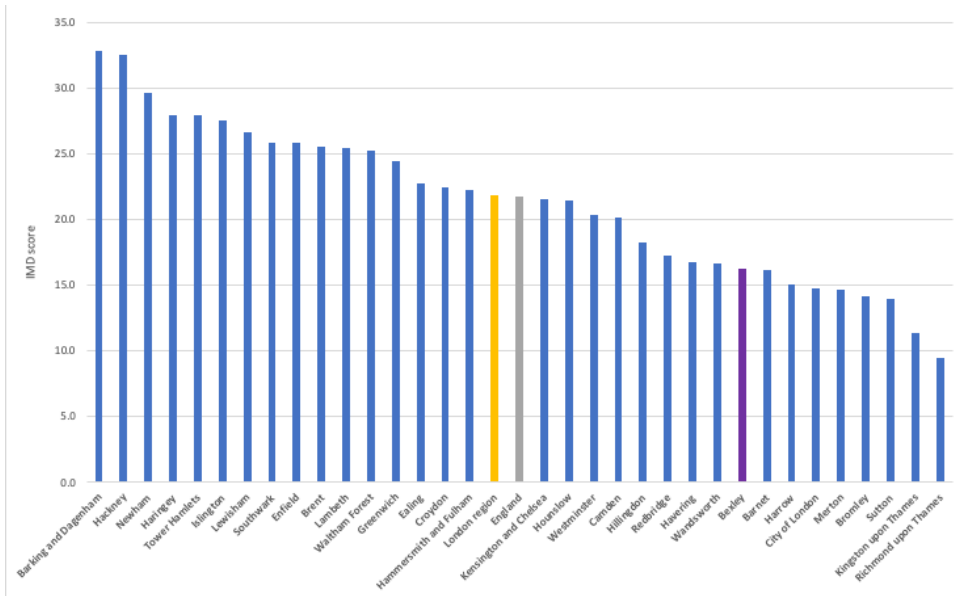
Data Source: Office for Health Improvement and Disparities, Public Health Profiles, Public health profiles - OHID (phe.org.uk)

Figure 5: Index of Multiple Deprivation (IMD) scores by Bexley wards, Bexley, 2019
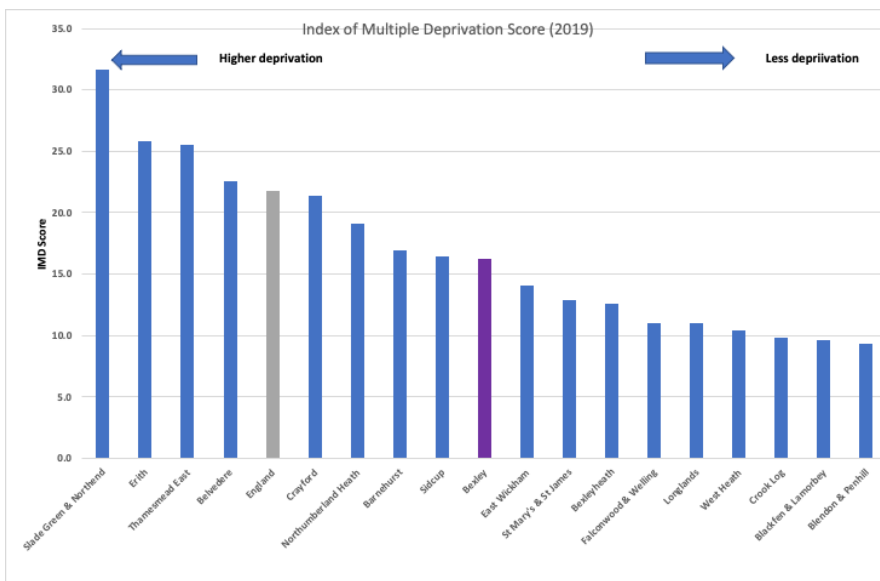
**Data Source: Office for Health, Improvement and Disparities, Wider Determinants of health, Public health profiles - OHID (phe.org.uk)**

Disparities in Income in Bexley

Figure 6 shows the income deprivation domain of IMD 2019 by ward. The income deprivation domain describes the disparities in income at population level.

Overall, in Bexley 10.6% of the population are described as income poor but within Bexley this ranges from over 20% in Slade Green and Northend (twice as high than Bexley) to as low as 5.6% in Blendon & Penhill (half that of Bexley).

The four wards highlighted in red (Slade Green and Northend, Thamesmead east, Erith and Belvedere) have significantly higher rates of income poverty compared with the England and Bexley averages.

The wards highlighted in green (East Wickham, St Mary's and St James, Bexleyheath, Longlands, Crook Log, Falconwood & Welling, West Heath, Blackfen & Lamorbey, and Blendon & Penhill) had significantly lower income poverty.

Figure 6: Bexley wards by Income deprivation as part of Index of Multiple Deprivation, Bexley, 2019
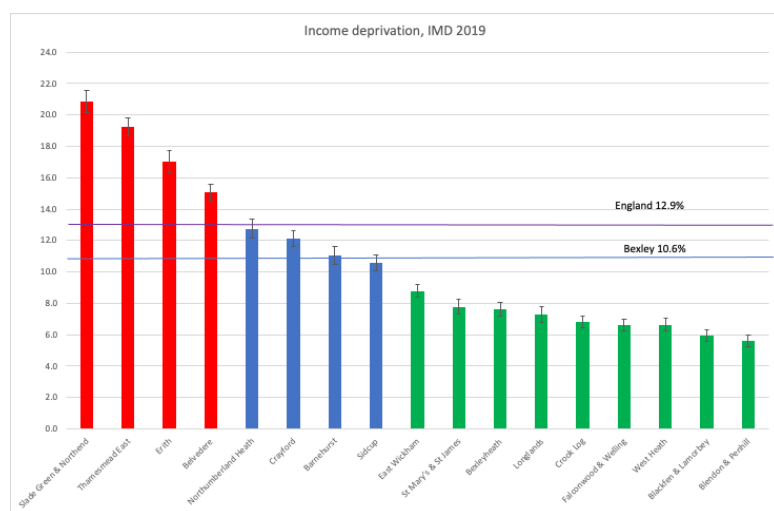
Data Source: Office for Health, Improvement and Disparities, Wider Determinants of health, Public health profiles - OHID (phe.org.uk)

Income poverty affecting older people

Figure 7 shows small areas in Bexley by decile of the income deprivation affecting older people indicator. This indicator is based on the proportion of people aged 60+ years that are income poor in that area.

**Figure 7: Income deprivation affecting older people by Bexley Wards, Bexley, 2019**
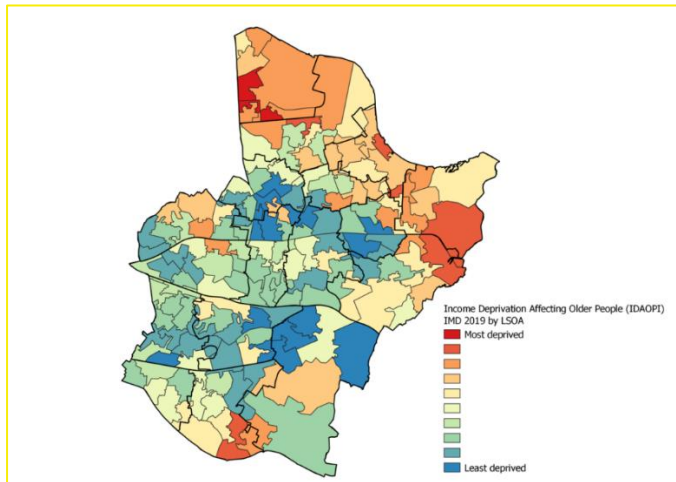
Source: Ministry of Housing, Communities & Local Government, English Indices of Deprivation 2019, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019.

A similar pattern is seen when exploring income deprivation affecting children as shown in the 5-19 joint strategic needs assessment for Bexley.

Disparities in deprivation by GP practice

Figure 8 shows the IMD deprivation scores of Bexley GP practices. GP deprivation is measured as the proportion of registered patients living in the most deprived areas, according to the NHS Digital Patients registered at a GP practice dataset. Three practices highlighted in red: Lakeside practice, Slade Green Medical Centre and Riverside surgery, are in the 2nd highest deprivation quintile of practices compared with England whilst six practices highlighted in green are in the lowest (least deprived) quintile.

Figure 8: Deprivation scores and quintiles by GP practices in Bexley, Bexley, 2019
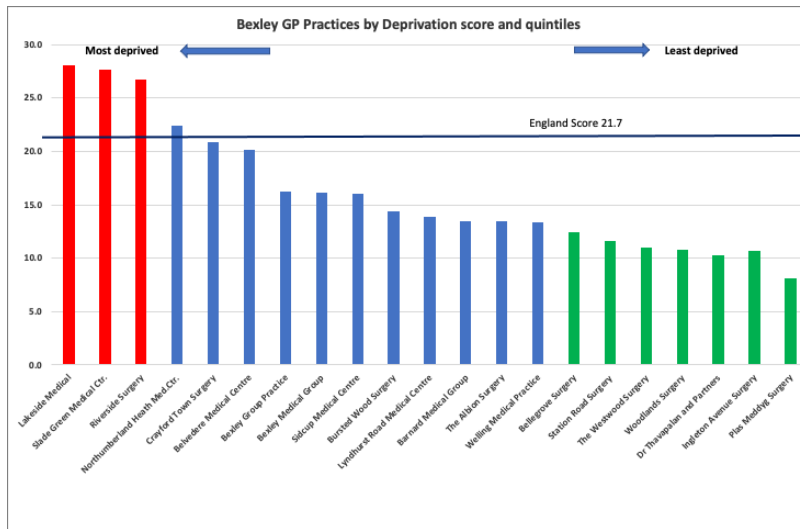
Data source; Office for Health Improvement and Disparities, National General Practice Profiles,
National General Practice Profiles - Data - OHID (phe.org.uk)

Figure 9 is a map of Bexley with location of practices shown as small circles . The map shows the small area deprivation by IMD 2019 with red as the most deprived and darkest green as the least deprived. The practices ae also colour coded by quintiles of deprivation with red circles for practices in the most deprived quintile and darkest green circle for practices in the least deprived quintile. The quintiles are based on the proportion of practice population living in the most deprived area compared to national average.

GP practices located in different areas of Bexley are serving local populations living within their neighbourhoods. These disparities in the practice population deprivation needs to be taken into consideration in any ICS strategy for health improvement and tacking health inequalities. (full list of names and location map is provided in Appendix X).

Figure 9: GP Practices in Bexley wards by quintile of deprivation coding with small area deprivation, Bexley, 2019
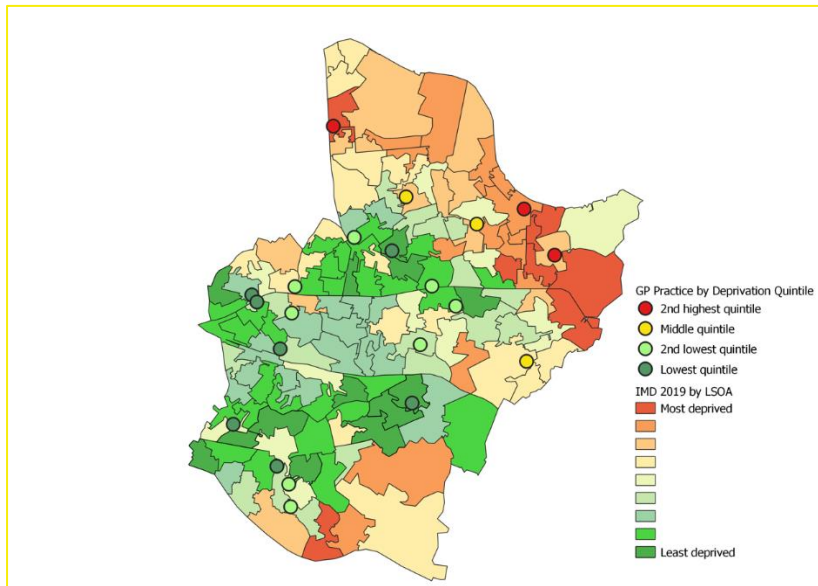
Source: Ministry of Housing, Communities & Local Government, The English Indices of Deprivation 2019 - Statistical Release, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019.

Differences in ethnic population by deprivation within Bexley

To explore if within Bexley there is a similar picture as evidenced nationally that a higher proportion of BAME communities live in more deprived are this section decribes ethnic population profile by deprivation .

Figure 10 shows the percentage of the ward population that are from BAME communities as per 2011 Census.

The four wards of Thamesmead East, Erith, Belvedere and Slade Green & Northend shown in red in the chart have a significantly higher proportion of the population from BAME communities compared with England and London. In Thamesmead East just above half the population are from BAME communities. In Erith and Belvedere about 30% are BAME and in Slade Green & Northend about 27%. These wards as described above are more deprived with income deprivation in Thamesmead East and Slade Green and Northend twice that of Bexley average. These findings mirror the national picture with a high proportion of BAME communities living in more income deprived areas.

Wards highlighted in green (Crayford, Bexleyheath, Barnehurst, Sidcup, St Mary's & St James, Blendon & Penhill, Longlands, Blackfen & Lamorbey) have a significantly lower proportion of BAME communities. Less than 10% of the population of wards such as St Mary's and St James, Blenden and Penhill, Longlands, Blackfen and Lamorbey are from

BAME communities. The proportion of the population that is income poor in these wards is less than 10%.

Figure 10: Percentage of people from BAME communities by Bexley wards, Bexley, 2011
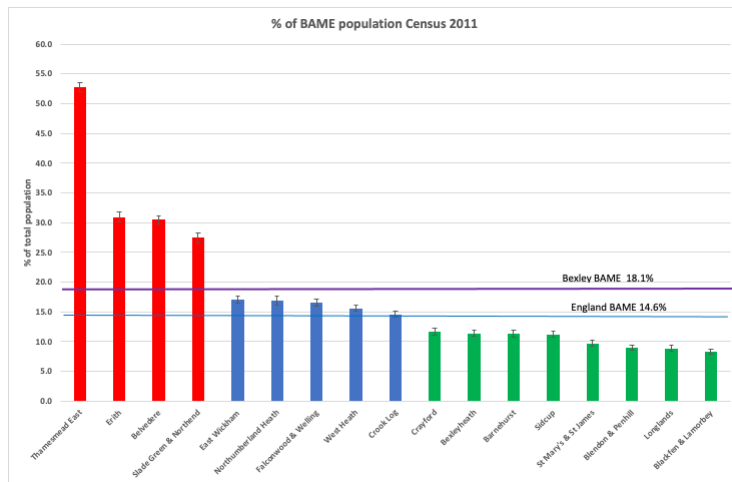
Data Source: Office for Health Improvement and Disparities, Public Health Profiles, Public health profiles - OHID (phe.org.uk)

Differences in ethnicity by GP practices

Figure 11 shows ethnicity as recorded on the GP registers. The ethnic coding is not standardised, with over 231 different ethnic codes compared to the 20-ethnicity classification applied in the Census. This data hence should be interpreted with caution in particular with the mixed communities where coding is the least consistent. Some communities defined as mixed, may belong to Asian or Black communities as there were codes which were mixed Black or Mixed Asian which were not well defined. The White British ethnic group is well defined. Although the ward and practice recorded ethnicities are not comparable, the coding in GP practices allows for finer segmentation by ethnicity including Eastern European and Gypsy Roma and Traveller populations.

Overall, 90% of the practice population has an ethnicity code recorded. Westwood Surgery (Clocktower PCN) Woodland Primary Care (Frognal PCN), and Crayford Town Surgery (North Bexley PCN) had only 3% practice population without a recorded ethnicity. Two surgeries Plas Meddyg Surgery and The Albion Surgery, both in APL PCN had over 20% of the population without a coded ethnicity. Overall, North Bexley PCN had 8%, Clocktower 7%, Frognal PCN 10% and APL 18% of their registered population not coded for ethnicity.

Lakeside Medical Practice (37%), Riverside Surgery (36%) and Slade Green Medical Centre (35%) have the highest proportion of the registered population from Black and Asian communities.

Barnard Medical Centre (6%) and Woodlands Primary Care (8%) have the lowest proportion of BAME registered population. Albion and Plas Meddyg Surgery has 8% registered population coded BAME, however about 1 in 5 patients do not have an ethnic code recorded.

Black African communities are the largest BAME community in Bexley borough. Lakeside Surgery (30%) Slade Green (28%) and Riverside (22%) have the largest Black African/Black Caribbean registered population. Comparing the White British proportion of the registered population at GP practices, Woodlands has 79% coded as British White and Lakeside has 13% White British. Lakeside Surgery (2%), Bexley Medical Practice (2%), The Westwood Surgery (2.5%) and Lyndhurst Medical Centre (2%) are practices with over 2% population with Eastern European ethnicity.

Figure 11: Percentage of registered ethnic groups by Bexley GP practices, Bexley, 2022
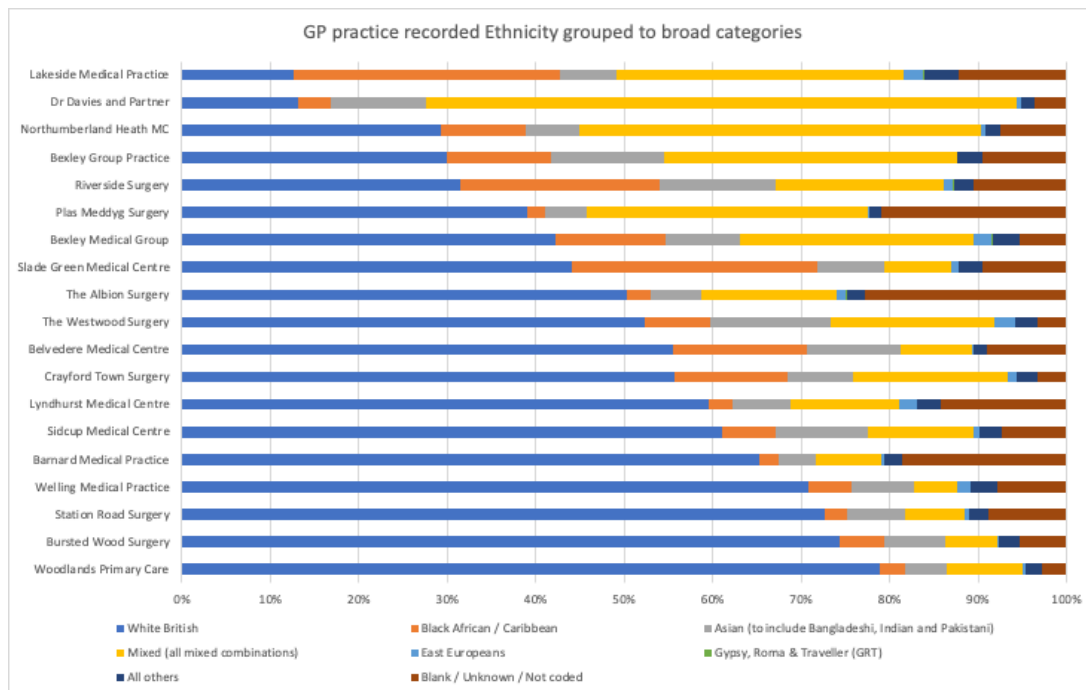
Data Source: South East London CCG

6. Inequalities in life expectancy at birth

Chapter summary

Key messages

- Men have lower life expectancy at birth compared with women, but women have lower healthy, and disability free life expectancy compared with men.
- Both men and women living in North of the Borough have a lower life expectancy compared with their fellow residents living in the South of the Borough.
- The gap between life expectancy of women living in deprived areas and less deprived areas has increased over the years.
- Cardiovascular disease is a key cause of inequalities in life expectancies in both men and women.
- In men respiratory diseases and in women cancer are also key causes of inequalities in life expectancy.

Key recommendations

- The Director of Public Health and the Chief Medical Officer of the ICS should jointly develop an action plan by March 2023 to reduce the gap inequalities in life expectancies in Bexley

To explore this, we used the public health outcomes framework (PHOF) which has a set of indicators that are used to compare and monitor progress on improving health and reducing health inequalities at local area. Life expectancies are overarching indicators within PHOF which allow monitoring health inequalities between and within local authorities.

Life expectancy is a measure of how long people can expect to live in a particular population. It is a measurable indicator that can be used to describe the health outcomes in different populations. Life expectancy is based on rates of death at different ages in different populations with more deaths at a younger age resulting in lower life expectancies. Hence, it reflects the mortality rates at a particular time period in an area or population. By comparing life expectancies of people living in different areas or between different populations allows goal setting for reducing health inequalities by addressing the underlying conditions of preventable deaths at younger age.

Gender inequalities in life expectancy

Figure 12 illustrates the trends in three-year combined life expectancy at birth in Bexley compared with the national (England) and regional (London) trends for both males and females from 2001 to 2020.

Men have shorter life expectancy at birth compared with women however women's healthy life expectancy at birth is worse compared with men. The gender inequalities in life expectancies have remained throughout the years with life expectancies in men remaining less than women nationally, regionally and in Bexley. Reductions in the gap between males and females were larger for London and England by 2018-2020 compared with Bexley. In Bexley the gap remained similar, from 4.2 years at baseline to 4.0 years in 2018-2020. It reduced from 4.8 to 4.0 years and 4.5 to 3.7 years in London and England, respectively.

Figure 12: Life expectancies in years by gender, location (Bexley, London and England) and year, 2001-2020
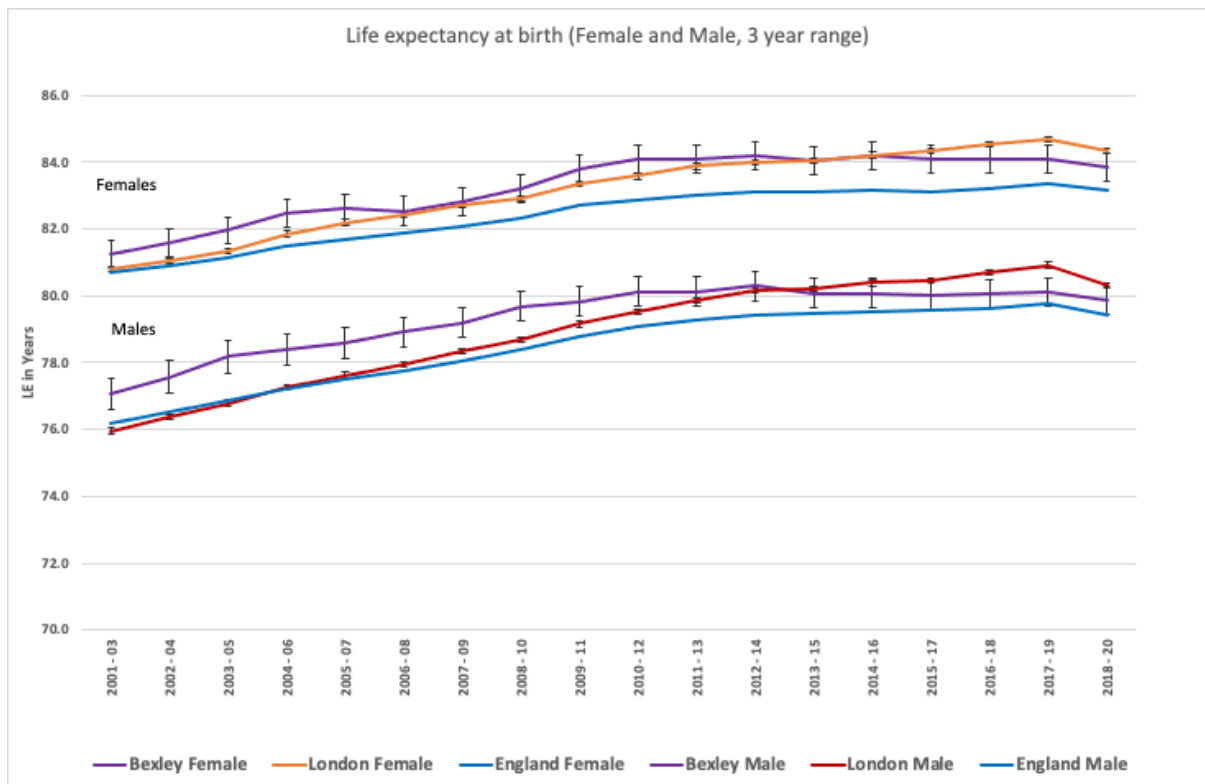
Data source: Office for Health Improvement and Disparities, Public Health Outcomes Framework
Public Health Outcomes Framework - Data - OHID (phe.org.uk)

Life expectancies have increased both for males and females, the increase in Bexley has been smaller (2.8 years) compared with London (4.8 years) and England (3.2 years) for men. For women, the increase has been smaller (2.6 years) than London (3.5 years) but similar to England (2.4 years).

At the baseline, female life expectancy was similar with London and England, but over the years it has become better than England. At baseline, male life expectancy in Bexley was significantly better than London and England but over the years it has become similar to England and lower than London. The reason for this is the lower rate of increase in male life expectancy in Bexley compared with London and England.

Figure 13 shows life expectancies for men and women in Bexley compared with similar boroughs. Green bars denote values that are significantly higher than the national (England) life expectancy and red bars indicate values that are significantly lower than the national Life expectancy. Blue bars are similar to national values. Male life expectancy in Bexley was similar to Sutton but lower than Bromley and higher than Havering, Thurrock and Medway. Thurrock and Medway have significantly lower life expectancies for males and females compared to England and the rest of the boroughs in the comparator group. Bromley has significantly higher male and female life expectancies compared with all the comparator boroughs.

The gender gap of 4 years in Bexley is higher than the London comparator boroughs of Bromley (3.5 years), Sutton (3.6 years) and Havering (3.8 years).

Figure 13: Life expectancies by gender and nearby boroughs from 2018-2020
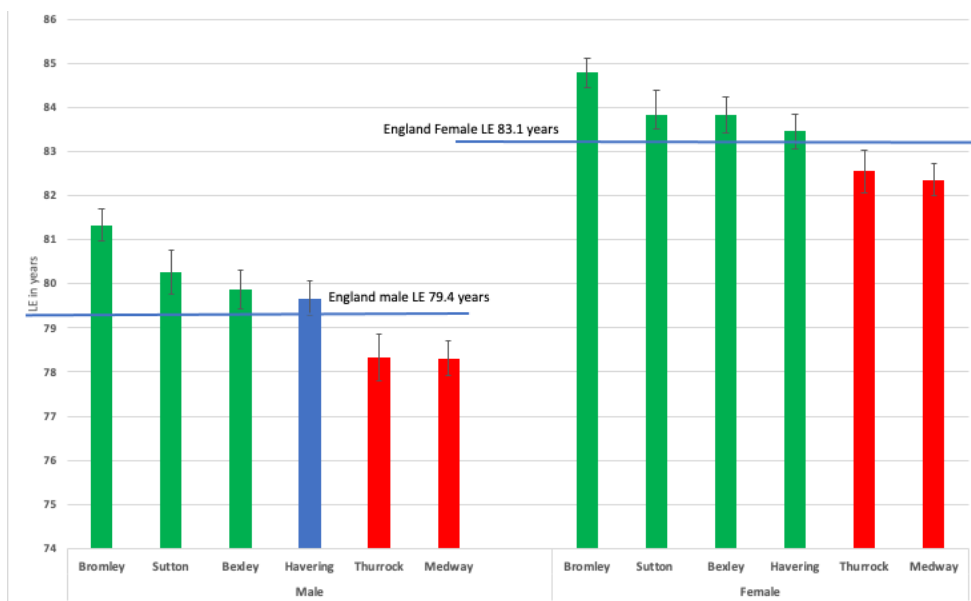
Data Source: Office for Health Improvement and Disparities, Public Health Outcomes Framework
Public Health Outcomes Framework - Data - OHID (phe.org.uk)

Geographic inequalities in life expectancy at birth

Figure 14 and Figure 15 shows female and male life expectancies by ward.

Compared with England, female life expectancy in five wards which are in the south and central areas of Bexley have better life expectancy and two (Thamesmead East
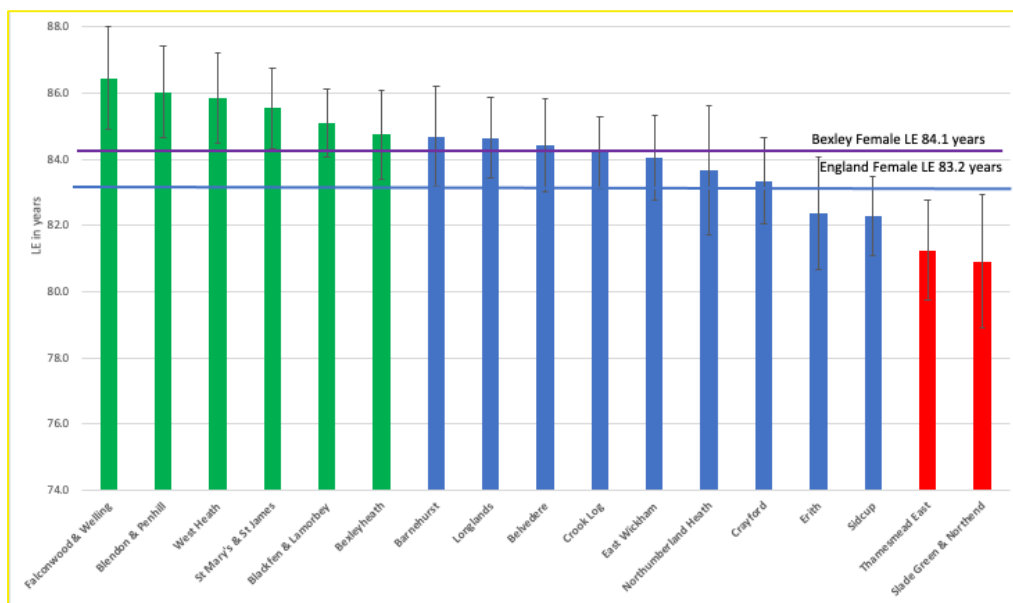
and Slade Green and Northend) which are in the North have lower life expectancy than England.

Compared with Bexley female life expectancy for the same period, the wards of Falconwood & Welling, Blendon & Penhill, West Heath, St Mary's & St James, and Blackfen & Lamorbey have significantly higher life expectancies, and the wards of Erith, Sidcup, Thamesmead East and Slade Green & Northend have significantly lower life expectancies.

There is a gap of 5.5 years between the ward with the highest life expectancy (Falconwood and Welling LE 86.4 years; 95% CI 84.9-88.0 years) and the ward with the lowest life expectancy (Slade Green and Northend, LE 80.9 years; 95% CI 78.9-82.9 years)

Figure 14: Female life expectancy by Bexley wards, Bexley, 2015-2019

Date source: Office for Health Improvement and Disparities, Local Authority Health Profiles, Local Authority Health Profiles - Data - OHID (phe.org.uk)

For males, a similar pattern of inequalities is observed with four wards that have life expectancies higher compared with England, and two in the North (Erith and Slade Green and Northend) with values significantly lower compared with England and Bexley.

Compared with Bexley male life expectancy for the same period, the wards of West Heath and Blendon & Penhill have significantly higher life expectancies and the wards of Erith and Slade Green & Northend have lower life expectancies.

There is a gap of 5.6 years between the ward with the highest life expectancy (West Heath, LE 83.4 95% CI 82.1-84.7 years) and the ward with the lowest life expectancy (Slade Green and Northend, LE 76.6; 95% CI 74.9 -78.4 years)

Figure 15: Male life expectancy by Bexley wards, Bexley, 2015-2019
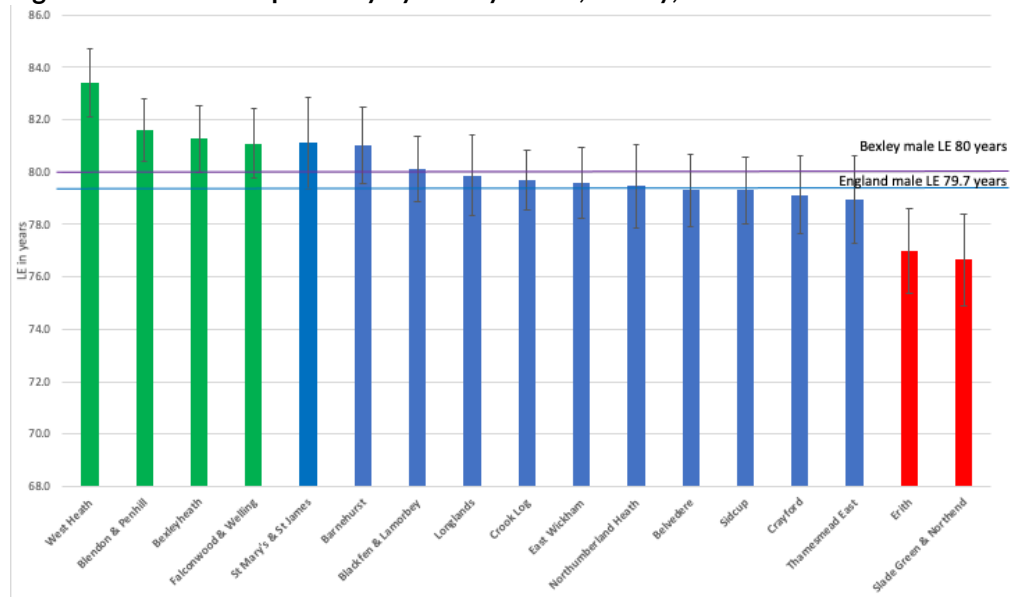
Date source: Office for Health Improvement and Disparities, Local Authority Health Profiles, **Local Authority Health Profiles - Data - OHID (phe.org.uk)**

Inequalities in life expectancy by GP practice

Figures 16 and Figure 17 show the variation in female and male life expectancy[16] by GP practice.

Five practices, namely Plas Meddyg Surgery, Ingleton Avenue Surgery, Dr Thavapalan and Partners, The Westwood Surgery, Bellegrove Surgery are in the top quintile (nationally compared) for female life expectancy whilst Lakeside Medical is in the lowest quintile and Slade Green Medical Centre is in the second lowest.

There is a gap of 4.4 years between the practice with the highest female life expectancy (Plas Meddyg Surgery, LE 85.8 years) and the practice with the lowest life expectancy (Lakeside medical practice LE 81.4 years).

For males, Dr Thavapalan and Partners and Plas Meddyg Surgery practices have the highest life expectancy (top quintile) and Lakeside Medical, Riverside Surgery and Slade Green Medical Centre have the lowest life expectancy (2nd lowest quintile).

There is a gap of 4.2 years between the practice with the highest male life expectancy (Dr Thavapalan, LE 81.8) and the practice with the lowest life expectancy (Lakeside Medical Practice, LE 77.6 years).

---

[16] The life expectancy for the MSOAs where the practice population lives has been proportionally applied to build a population weighted average life expectancy for the practice.

Figure 16: Female Life expectancy by Bexley GP practices, Bexley, 2015-2019
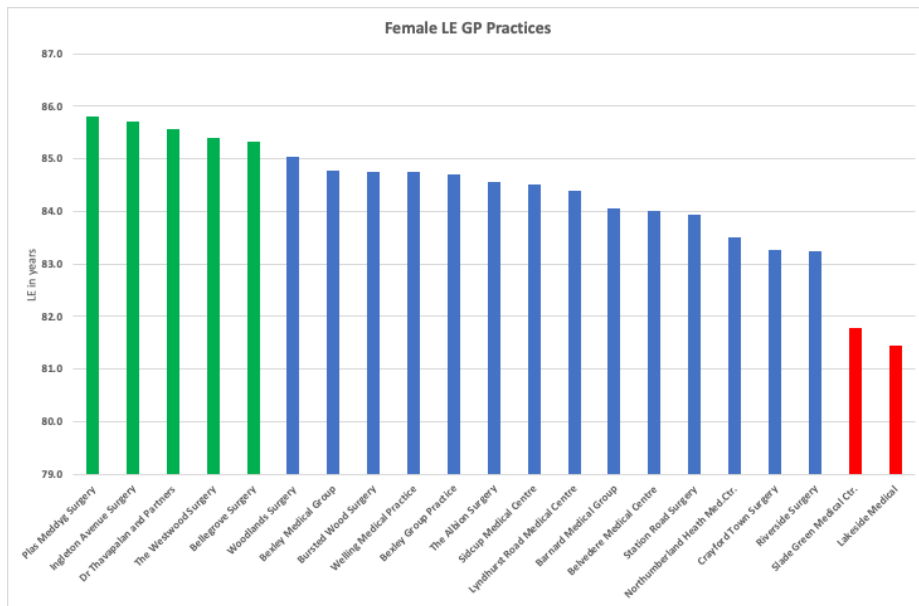
Data Source: Office for Health Improvement and Disparities, Local Authority Health Profiles Public health profiles - OHID (phe.org.uk)

Figure 17: Male Life expectancy by Bexley GP practices, Bexley, 2015-2019
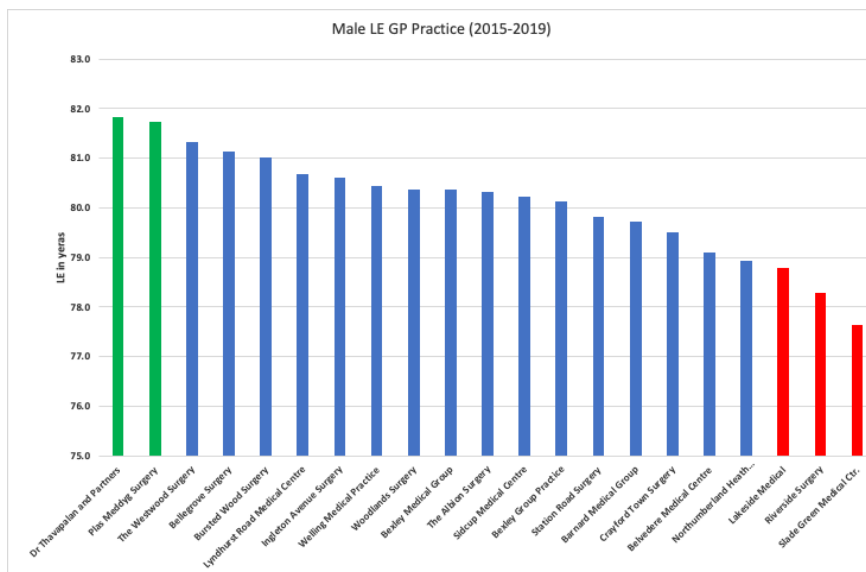
Date source: Office for Health Improvement and Disparities, Local Authority Health Profiles Public health profiles - OHID (phe.org.uk)

Health inequalities gap by deprivation

Figure 18 shows the trend in the inequalities gap (absolute[17]) between the least deprived and most deprived areas of Bexley for women. The gap in the female life expectancy has increased over the years. Women in the more deprived wards have

---

[17] Whereas the Slope Index of Inequality uses a linear regression line of best fit, here we report the absolute difference between the point estimates for life expectancy in the least and most depivated areas of Bexley.

seen a decrease in life expectancy from the baseline of 2010-2012 from 84.1 (95% CI 82.5-85.7) years to 80.5 (95% CI 79.0-82.1) years in 2017-2019. In men, the gap has remained constant over the years.

Figure 18: Comparing years from 2010 to 2019 by female life expectancy of the most and least deprived areas in Bexley, 2019
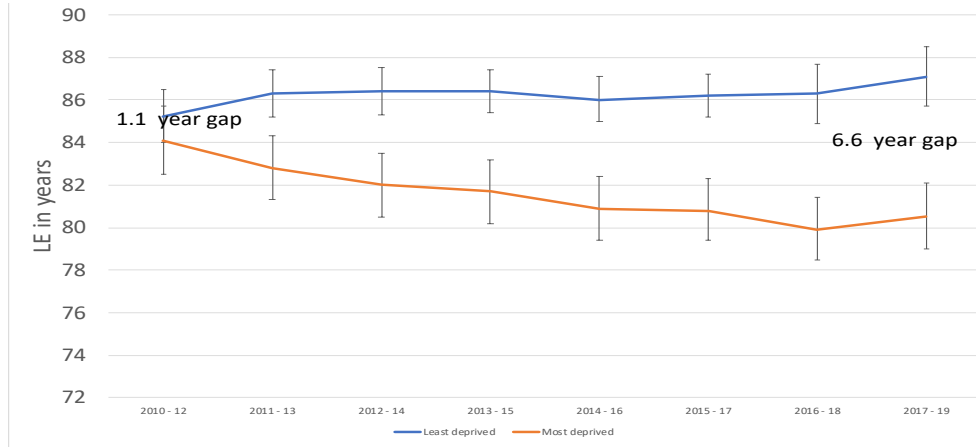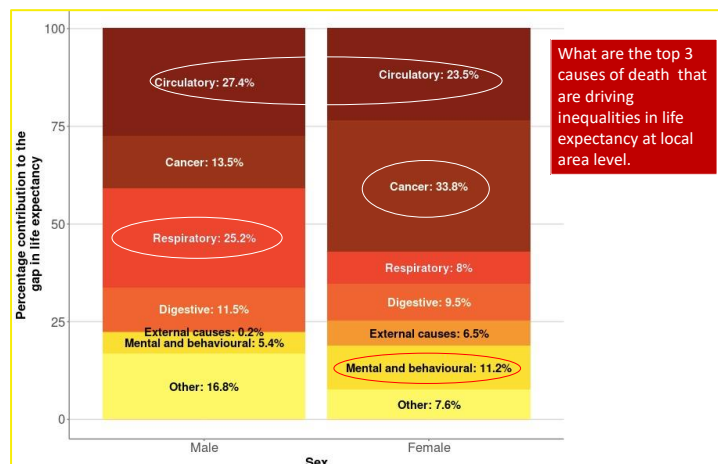

Data Source: Office for Health Improvement and Disparities, Health Inequalities Dashboard
https://analytics.phe.gov.uk/apps/health-inequalities-dashboard/

Main causes of mortality by deprivation

Figure 19 shows the main causes of mortality that drive the health inequalities in Bexley as described by life expectancy. This suggests that men and women living in the more deprived wards on average (at population level) die at a younger age of cardiovascular disease compared with men and women living in the least deprived wards.

For men, respiratory conditions are the second largest drivers of inequalities. For women, cancers are the largest drivers of inequalities. Mental health and behavioural conditions contribute to just over 10% of the inequalities in life expectancy.

Figure 19: Percentage contribution of cause of death by gap in life expectancy and gender, Bexley, 2015-2017
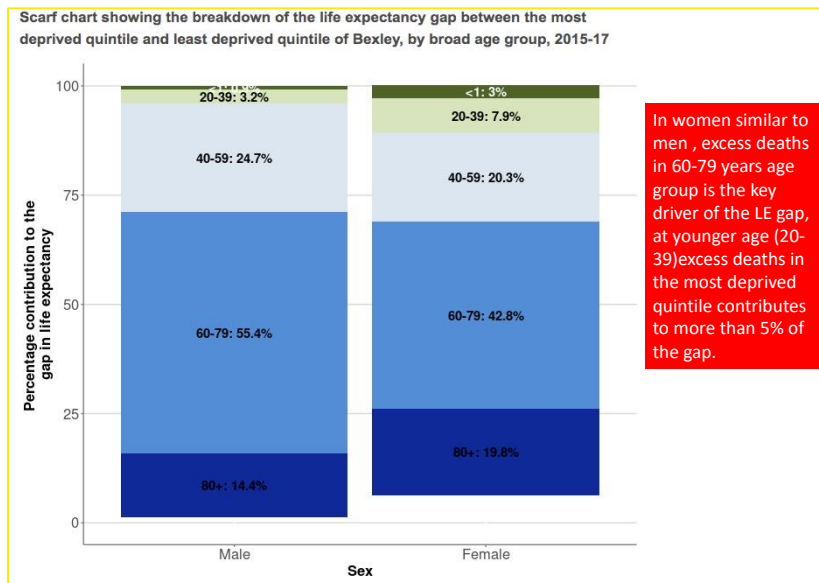
Data Source: Office for Health Improvement and Disparities OHID Health inequalities dashboard tool

Differences in mortality by broad age groups

Figure 20 shows that in men just about a quarter of the excess deaths in the more deprived quintile occur in the 40-59 age group whilst for women around one fifth of the excess deaths occur in this age group in the most deprived quintile.

Figure 20: Life expectancy gap between the most deprived quintile and least deprived quintile, Bexley, 2015-2017

Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Bexley, by broad age group, 2015-17

In women similar to men, excess deaths in 60-79 years age group is the key driver of the LE gap, at younger age (20-39)excess deaths in the most deprived quintile contributes to more than 5% of the gap.

Data Source: Office for Health Improvement and Disparities, OHID Health inequalities dashboard tool

Health Status and Disability Free Life Expectancy (measure of morbidity and good health)

Life expectancy tells us how long on average people can be expected to live given the current death rates at different ages in the population. It does not tell us how many of these years can be expected to be lived without disability (free from disability) or in good health. Table 1 provides the different life expectancies for Bexley and the related health inequalities within Bexley.

On average, both males and females have significantly lower good health status and disability free life expectancy compared with life expectancy. Women are more likely to live with disability or with poor health as there is over 20 years gap between life expectancy and health and disability related life expectancies. For men, the difference between life expectancy and good health and disability related health life expectancies is about 14 years.

Hence, whilst women have higher life expectancy than men, the gap is reversed for

health and disability related life expectancies. For example, for men the disability free life expectancy is 66.1 years (95% CI 63.9-68.3 years) compared with 59.8 years (95% CI 56.8-62.8 years) for women.

Table 1: Different measures of life expectancies for Bexley (2017-2019)

Measure	Gender	Value	95% CI (Lower Limit)	95% CL Upper Limit)
Life Expectancy at birth	Male	80.1	79.7	80.5
	Female	84.1	83.7	84.5
Healthy life expectancy at birth	Male	66.5	64.3	68.6
	Female	61.8	58.8	64.8
Disability-free life expectancy at birth	Male	66.1	63.9	68.3
	Female	59.8	56.8	62.8
Life Expectancy at 65 years	Male	10.2	8.5	11.9
	Female	22	21.6	22.3
Healthy life expectancy at 65	Male	10.2	8.5	11.9
	Female	8.9	6.4	11.3
Disability-free life expectancy at 65	Male	10.5	8.9	12.2
	Female	9.6	7.3	11.8

Data Source: OHID

7. Smoking

Chapter Summary

Key messages

- The cost of smoking to Bexley System in estimated to be £81.2 million per year.
- The Bexley mortality rate (198.1/100,000) attributable to smoking and the hospital admissions rate (1267/100,000) are both significantly higher compared with London.
- Inequalities in smoking prevalence are evident in Bexley with a gap of eleven percentage points in recorded prevalence in GP practices and four percentage in population prevalence of smoking between general population and population with routine and manual occupation.
- The smoking cessation service has a good record of contributing to reducing the inequalities as the uptake (25% of all service users) and quit rates (60% success) for smokers from routine and manual occupations are high.

Key recommendations

- The tobacco control group in Bexley should review its terms of reference by Sept 2022 with a remit to implement the full recommendations of NICE guidance and the Royal College of Physicians (RCP) report.
- The tobacco control group should have an approved costed action plan for implementing the NICE guidance and the ambitions in the NHS Long Term plan by December 2022 so that commissioners and providers across the system can build these into their 2023 plans.

Smoking related health inequalities national context

The Health Survey for England (2019) shows that the inequalities in smoking rates have remained persistent. The rates in lower occupational bands (routine and manual occupations) at 25% are significantly higher compared with rates of 10.5% in higher occupational bands (managerial and professional occupations).[18] The rate of smoking in people living in social housing is 28% compared with about 6% in people owning their house with mortgage.

---

[18] NHS https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2019

National plan

The national plan on smoking[19] vision is to create a smoke-free generation. This is achieved when smoking prevalence falls below 5%.

Economic costs of smoking to Bexley

The costs to of smoking to Bexley are estimated[20] to be about £81.2million. The costs to the different sectors are estimated as below:

- £66.5 million due to loss of productivity (£20 million due to smoking related lost earnings, £30 million due to smoking related unemployment and £6.5 million due to early deaths)
- £9.3 million to healthcare (£5.3 million to primary care and £3.9 million to secondary care)
- £4.6 million to the social care (2.21 to residential care and 2.3 million to domiciliary care)
- £ 1.0 million to fire

A smoker spends just about £2K per year on average based on sale of tobacco.

Impact of smoking on mortality and morbidity in Bexley

Smoking continues to contribute to mortality and hospital admissions although rates have decreased overall. The prevalence of smoking in Bexley was estimated to be 12.9% and in 2017-2019 there were about 800 estimated deaths due to smoking and in 2019/20 1,670 hospital admissions attributable to smoking[21]. The Bexley mortality rate (198.1/100,000) attributable to smoking and the hospital admissions rate (1267/100,000) are both significantly higher compared with London.

---

[19] Department of Health and Social Care; Smoke-free genenration: tobacco control plan for England: https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england

[20] Action on Smoking https://ash.org.uk/ash-local-toolkit/ash-ready-reckoner-2022/
[21] OHID Local Tobacco Control Profiles

Prevalence of smoking in Bexley

Current prevalence

The definition of current smokers from the Annual Population Survey (APS) has changed in 2020. Based on the new definition, 12.9% of adults (18+ years) were estimated to be current smokers in 2020. Smoking rates in adults in manual and routine occupations is 16.6%.

Trends

Based on the previous definition used in APS the rates for current smokers (18+) was 20.2% (95% CI 16.5 -23.9%) in 2011 and 14.2% (95% CI 10.5 -17.9%) in 2019. Because of the smaller sample sizes at borough level the confidence intervals are larger. It should be noted that the sample sizes are small, but they are representative.

It can be observed that Bexley had a significant decrease till 2018. The regional and national data shows a significant decrease from baseline. At baseline local, regional and national rates were 20% and dropped to 14% locally and nationally and to 13% in London, respectively.

Figure 21: Estimated smoking rates by percentages of the population between Bexley, London and England from 2011 to 2019
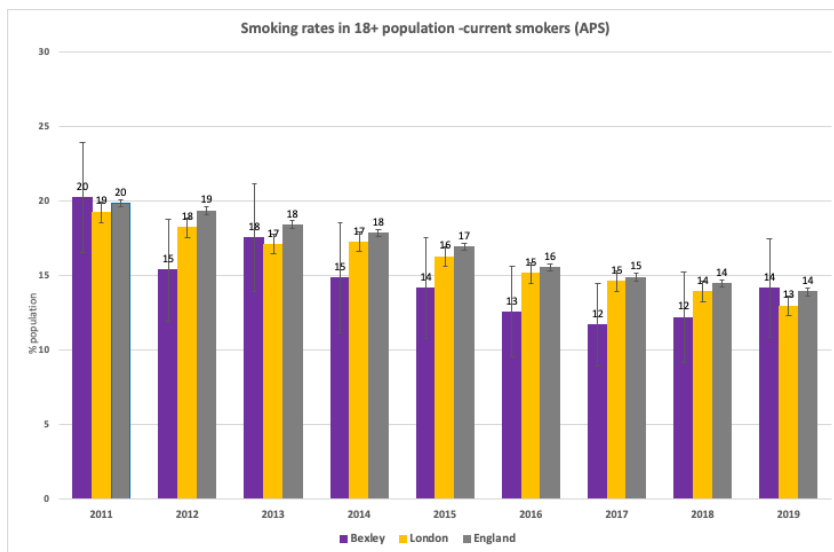
Data Source: Office for Health Improvement and Disparities, Local Tobacco Control Profiles, Local Tobacco Control Profiles - Data - OHID (phe.org.uk)

Differences in recorded smoking rates

Figure 22 shows recorded crude smoking rates in GP adult (18+ years) practice populations. This is based on anyone who has a record of smoking. There may be smokers who have not been asked or not declared their smoking status. Whilst this

may not be a true reflection of the data, it remains the best estimate of smokers registered to GP practices.

Six practices (Northumberland Heath Medical Centre, Bexley Medical Group, Belvedere Medical Centre, Lakeside Medical and Riverside Surgery and Bexley Group Practice) mainly located in the north of the borough have significantly higher smoking rates than the England average of 15.9%. The difference between the highest rates and lowest smoking rates are about 11% points.

From the four primary care networks (PCNs), North Bexley PCN has a significantly higher smoking rate, Clocktower PCN has similar rates and Frognal and Apl PCNs have significantly lower smoking rates compared with the England average.

Figure 22: Estimated smoking prevalence across GP practices in Bexley, 2020-2021
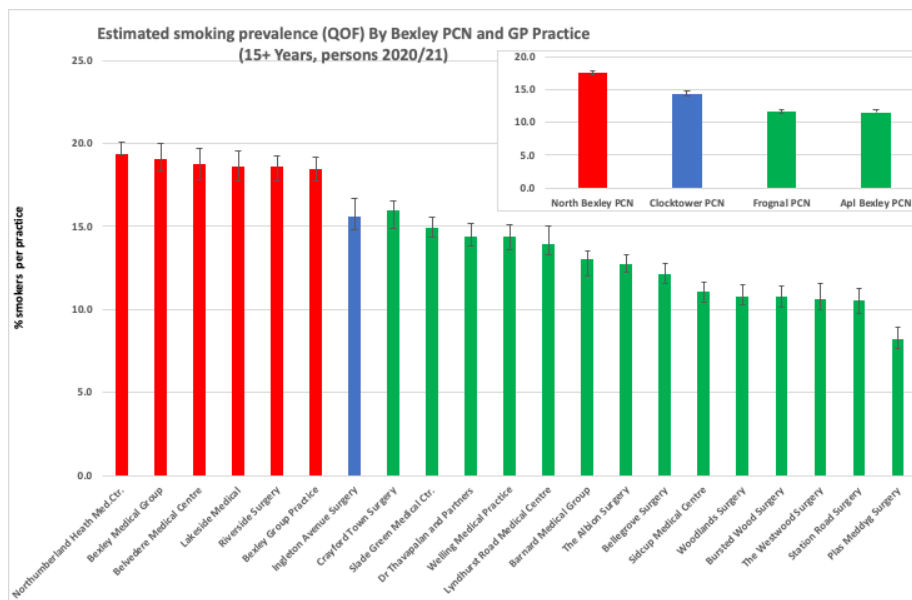
Data source: Office for Health Improvement and Disparities, National GP Profiles, OHID National GP profiles

Smoking related inequalities by ethnicity

Figure 23 shows crude smoking rates by ethnicity as recorded on GP practice lists. Whilst the Gypsy, Roma, Traveller (GRT) coded population is small (107) smoking rates are the highest in this community. Eastern Europeans have the second highest smoking rates.

Overall, both communities are minor communities in the Bexley resident and registered populations. Smoking rates were lowest in the Black and Asian communities. These rates are similar to the national picture based on the Annual

Population Survey (APS 2019)[22] which found rates of 19% in mixed race communities, 14% in White British, 9.7% in Black and 8.3% in Asian communities, respectively. The national APS did not survey adequate numbers of GRT or Eastern European communities.

Figure 23: Smoking rates by ethnic groups, Bexley, 2022
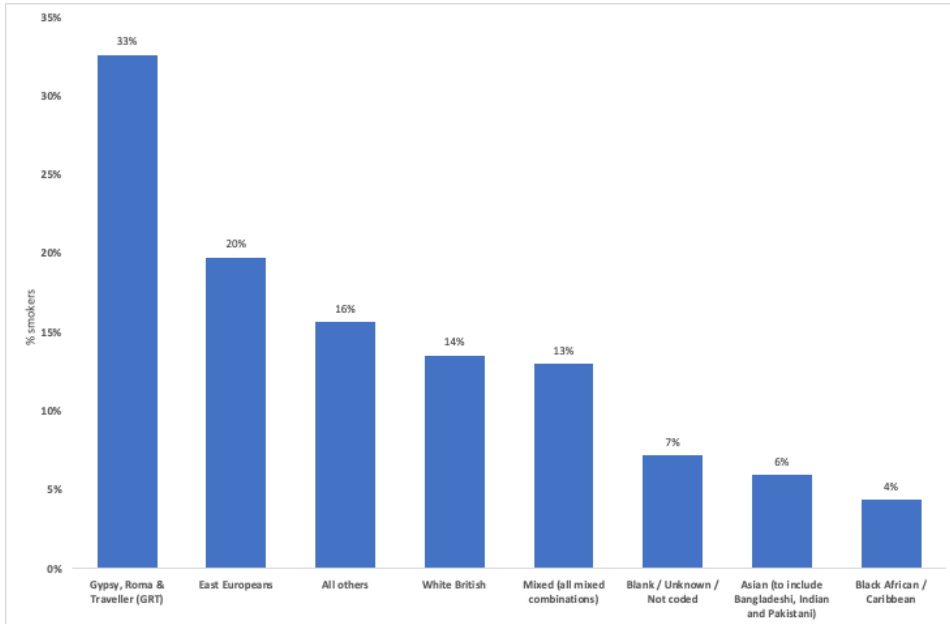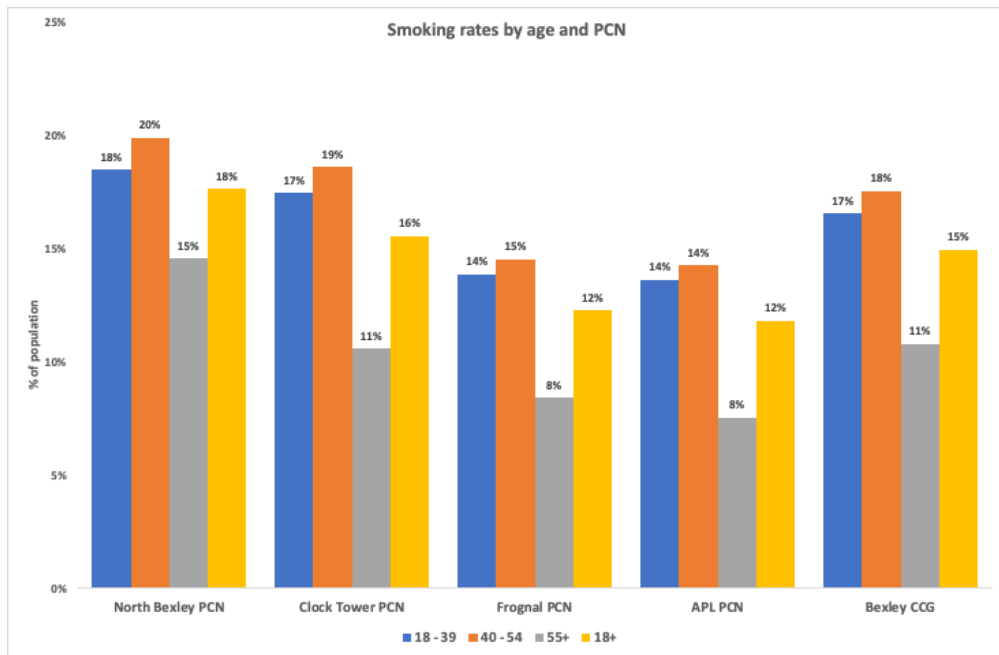

Data Source: South East London CCG

Smoking related inequalities by broad age group

Smoking Figure 24 shows recorded smoking rates by broad age groups by PCN. The smoking rates in the 18-39 and 40-49 years age are highest. The lowest rates (8%) were in the 55+ age group in Frognal and APL PCN and the highest rates (20%) were in the 40-54 group in North Bexley.The highest smoking rates are in the North Bexley PCN and lowest in the APL PCN.

Figure 25 shows smoking rates by gender. Men had higher smoking rates compared with women in all the PCN. The diference between men and women was higher in Frognal PCN (7%) compared to other PCNs. Overall men make up 56% of total recorded smokers.The gender rates in Bexley are similar to that reported nationally from the APS survey.

---

[22]Office of National Statistics; Annual Population Survey 2019: https://www.ethnicity-facts-figures.service.gov.uk/health

Figure 24: Smoking rates by age and PCN as recorded on GP practice lists, Bexley PCNs

Data Source: South East London CCG

Smoking related inequalities by gender

Figure 25: Smoking rates by gender across Bexley Primary Care Networks
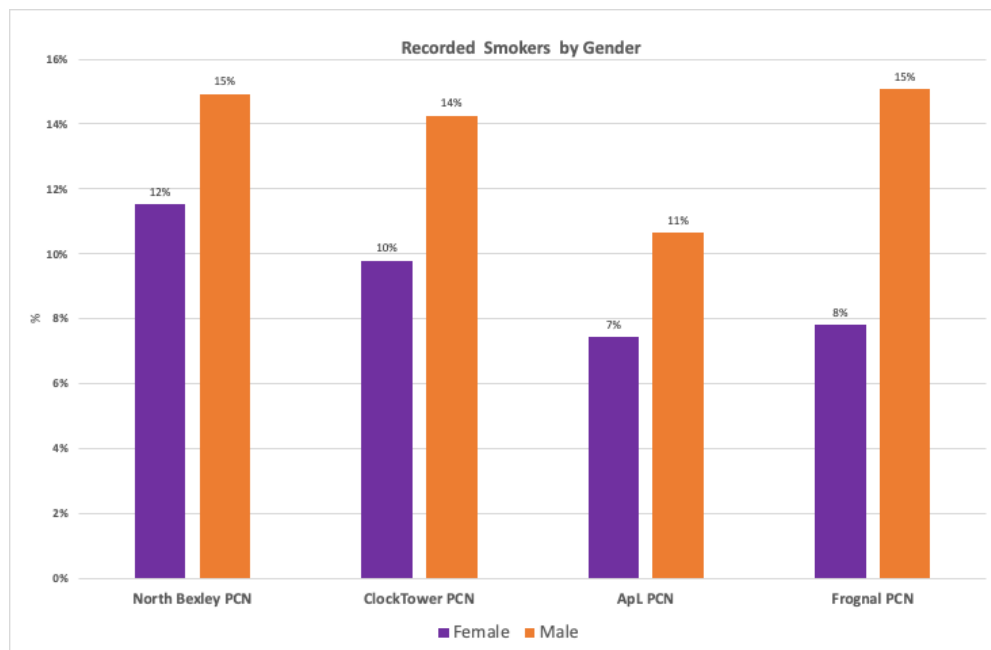

Data Source: South East London CCG

Smoking in pregnancy

Women are asked for smoking status at booking appointments and encouraged to stop smoking duing preganacy. Two indicators – smoking at time of booking appointment (smoking in early pregnancy) and smoking status at time of delivery provide insights

into the successful referals and smoking quitters in pregnancy.

Figure 26 shows the trends in smoking status (smokers) at time of delivery. At baseline Bexley rates (12.5%) were similar to England (13.6%) but higher than London (6.5%) as has been the case with smoking in the general population in Bexley. However, the rate of decrease in Bexley has been greater than England. In 2020/21 the rates in Bexley (4.5%) were similar to London (4.6%) and half of the England rate (9.6%). However due to pandemic there may have been limitations on recording. But overall from baseline, Bexley has consistently lower rates than England wit the gap between London average and Bexley reducing over time.This may suggest that London maternity units focused efforts to reduce smoking in pregnancy to achieve the national target of less than 6%, as the rates in Bexley comparators outside London such as Medway remain higher than England, and Thurrock similar to London, although both have seen reductions from baseline.

Figure 26: Comparing the percentage of mothers in Bexley, London and England that were smokers at time of delivery by year, 2010-2021
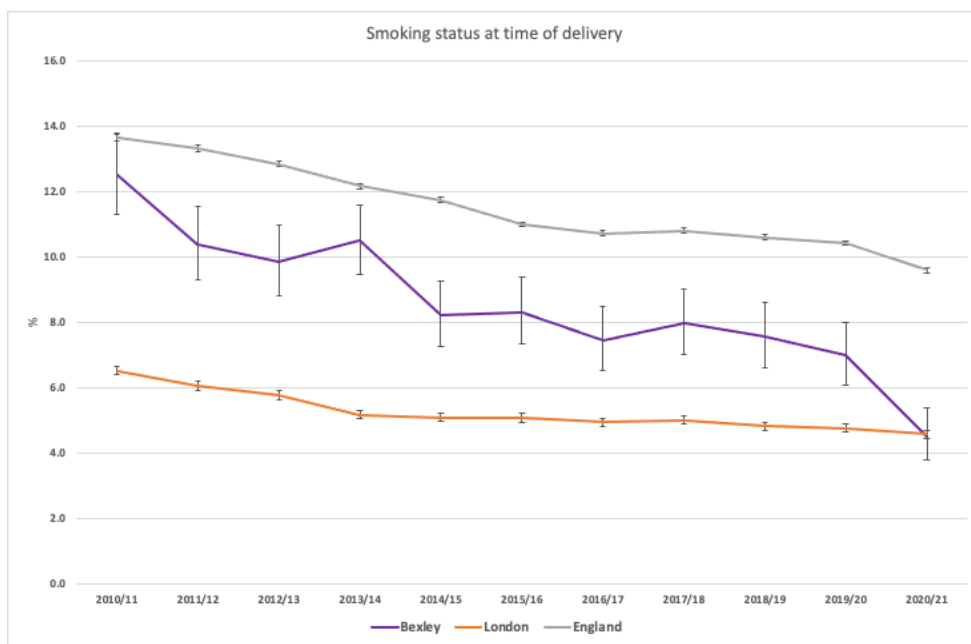
Data Source: Office for Health Improvement and Disparirites, Public Health Profiles, Public health profiles - OHID (phe.org.uk)

Figure 27 shows smoking in early pregnancy (status at time of booking) in London boroughs with London as the comparator. Although all London boroughs have significantly lower rates of women presenting as smokers in early pregnancy, compared to England (12.8%), Barking and Dagenham (10%), Havering (9.5%) and Bexley (9%) have the highest rates of women presenting as smokers at the time of booking in London.

The lowest rates in London were in Kensington and Chelsea (2.1%).

Comparing the rates at the time of booking with rates of smoking status at the time of delivery gives an indication of women giving up smoking to protect harm to their unborn babies. This is a good time to educate mothers-to-be of healthy behaviours: healthy eating, physical activity, mental health and the impact of these on the heallth of unborn babies at birth and into adulthood.
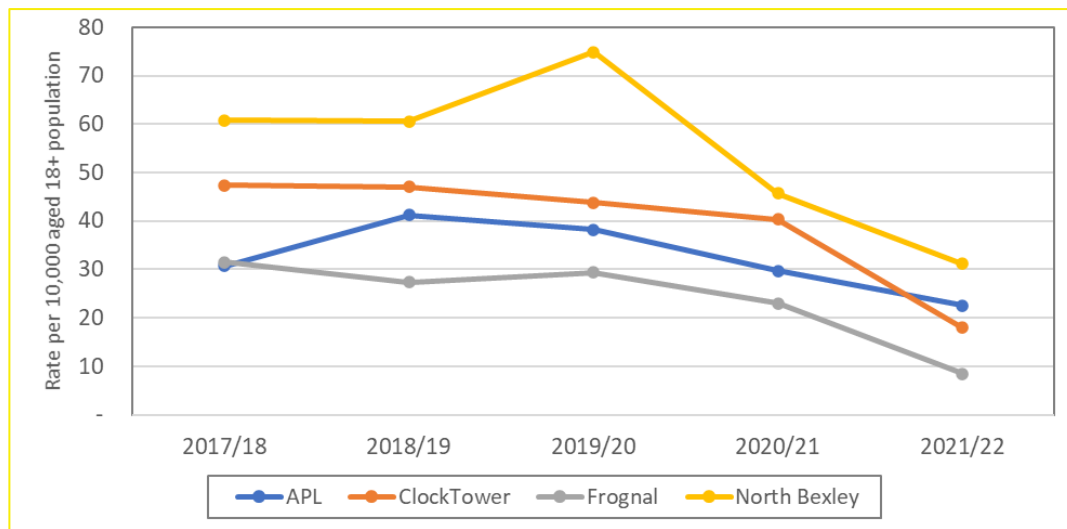
Figure 27: Smoking rates in early pregnancy by London boroughs and England, 2018/2019
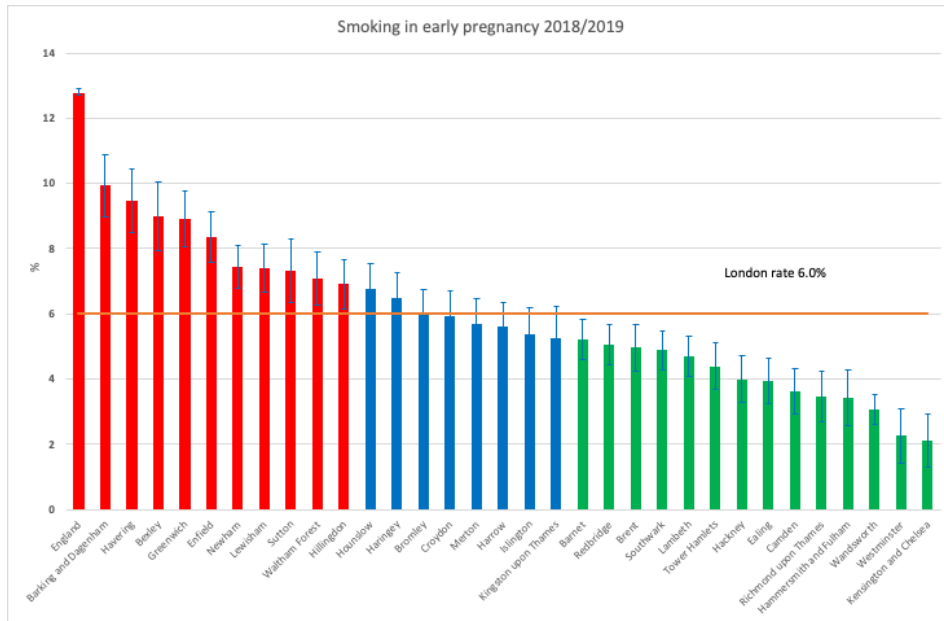
Data Source: Office for Health Improvement and Disparirites, Public Health Profiles, Public health profiles - OHID (phe.org.uk)

Smokers with anxiety and depression

Figure 28: Smokers with anxiety or depression (aged 18+) by Bexley PCN and year, 2017/18 to 2021/22

Data Source: Provided by NHS South East London CCG Data

In 2017/18 to 2021/22, North Bexley PCN has experienced a higher rate of smokers who have anxiety or depression when compared to the other Bexley PCNs. All PCNs have experienced a decrease in their rate since 2019/20.

Figure 29 Smokers with anxiety or depression (aged 18+) by age group and Bexley PCN, 2021/2020
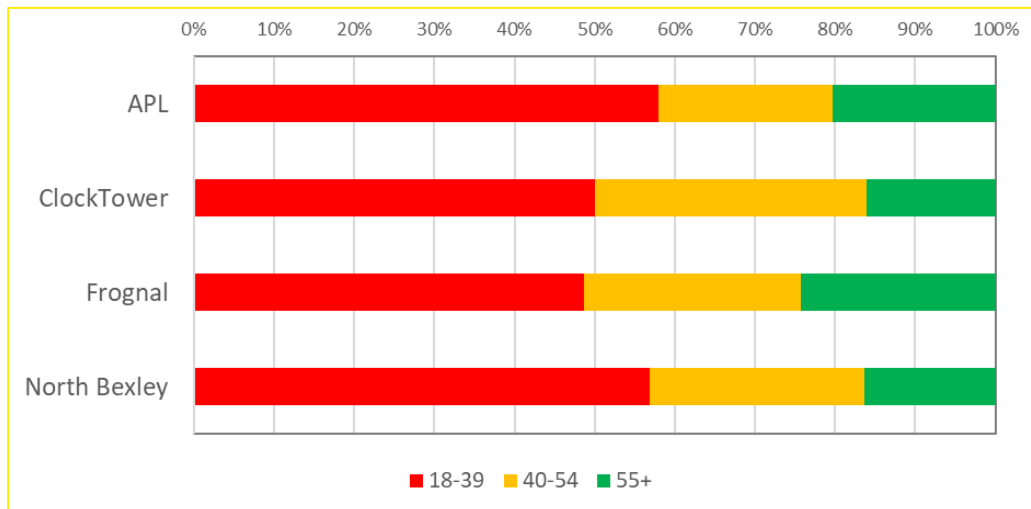
Source: NHS South East London CCG Data

Interventions to reduce smoking

Evidence based guidance

NICE guidance[23] recommends three key approaches to reduce smoking in the population with seventeen recommendations as shown in below. NICE also recommends three recommendations on policy, commissining and training.

Prevent taking up of smoking including preventing children, young people and young adults aged 24 through:

1.1 Organising and planning national, regional or local mass-media campaigns

1.2 Campaign strategies to prevent uptake and denormalise tobacco use

1.3 Helping retailers avoid illegal tobacco sales

1.4 Coordinated approach to school-based interventions

1.5 Whole-school or organisation-wide smokefree policies

1.6 Adult-led interventions in schools

1.7 Peer-led interventions in schools

Promoting quitting and raising awareness:

1.8 Using medicinally licensed nicotine-containing products

1.9 Promoting stop-smoking support

1.10 Promoting support for people to stop using smokeless tobacco

Treating dependence and reducing harm:

1.11 Identifying and quantifying people's smoking

1.12 Stop-smoking interventions

1.13 Support to stop smoking in primary care and community settings

1.14 Support to stop smoking in secondary care services

1.15 Supporting people who do not want, or are not ready, to stop smoking in one go to reduce their harm from smoking

1.16 Stopping use of smokeless tobacco

1.17 Adherence and relapse prevention

Recommendations on policy, commissioning and training:

1.21 Policy

---

[23] NICE guideline [NG209] Tobacco: preventing uptake, promoting quitting and treating dependence Published: 30 November 2021 https://www.nice.org.uk/guidance/ng209

Duty of care in the NHS

A 2018 report conducted by The Royal College of Physicians "Hiding in plain sight:[24] Treating tobacco dependency in the NHS", reviewed the harms and costs arising from smoking in the patients we see every day and suggested a new approach to treating addiction. It showed that clinicians working in almost all areas of medicine will see their patient's problems improved by quitting smoking. Furthermore, it outlined that systematic intervention is a cost-effective means of both improving health and reducing demand on NHS services. Smoking cessation is not just about prevention of illness but can also serve as a form of treatment for other conditions.

The report highlights the importance of smoking cessation in patients with tobacco dependence. Smoking cessation should be incorporated in a systematic manner and advises that it is an opt-out intervention due to:

- The principle of autonomy requires that patients who smoke and who are in contact with health services have their smoking ascertained, and information and treatment offered, to enable autonomous decisions on future smoking.

- The principle of justice requires that we offer smokers help to quit smoking; failure to so implies that smokers' health is less important than that of other patients.

- Failing to provide help to quit smoking while delivering other similarly or less cost-effective interventions to smokers represents distributive injustice which both perpetuates and exacerbates health inequalities. Opt-out models of treatment help to sustain autonomy and justice in treating smoking, and should be the norm.

- It is at least as important to address smoking in patients using secondary care as those in primary care.

- Treating the physical health of patients is also no less important than treating mental health. Treating smoking improves both.

- Since most people would prefer to avoid being ill than to go through illness and treatment, prevention should be given a proper place in the allocation of health service resources.

- Proper use of health service resources also requires that more cost-effective treatments are used in preference to less cost-effective treatments.

- Smoke-free NHS estates protect the health of patients and staff, signals that smoking is a crucial health issue, and supports smokers who are trying to quit.

---

[24] Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS.London: RCP, 2018.2020   https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs

- Heath service commissioners and practitioners have a responsibility to ensure that cost-effective smoking interventions are provided and properly implemented. Failure to identify and treat smokers is no less negligent than failure to identify and treat patients with cancer. Systems failure is no less negligent in this respect than individual failure.

- Smoking cessation should be incorporated, as a priority, as a systematic and opt-out component of all NHS services as a complement to local authority service and delivered in smoke-free settings. It is unethical to do otherwise.

The NHS Long term plan smoking ambitions

The NHS Long Term Plan [25]has accepted the RCPH report and adopted the Ottawa Model for Smoking Cessation in 120 hospitals across Canada identifies the smoking status of all admitted patients, followed by brief advice, personalised bedside counselling, timely nicotine replacement therapy and/or pharmacotherapy, and follow-up after discharge.

- By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.

- Second, the model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.

- Third, a new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services. On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings.

The Bexley tobacco control plan:

- The Tobacco Control Plan for Bexley is currently in development, with delivery and oversight by the Tobacco Control Delivery Group, which meets quarterly. The agreed priorities of the Tobacco Control Plan are to:

- De-normalise smoking and reduce exposure to second hand smoke

- Drive more smokers to quit

- Ensure effective and consistent messaging around tobacco control.

- Actions to achieve these priorities include:

- Promoting vaping and providing free vapes for smokers

- Working with the Council's Place Directorate and Registered Social Housing Providers to explore ways to help social tenants to quit smoking and increase smokefree homes in these communities.

- Work with Maternity Providers for Bexley to improve uptake of smoking

---

[25] NHS Long Term Plan (online): https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/smoking/

cessation treatment and support in pregnant smokers

- Work with the 0-19 service to screen and refer smoking new mother for support to quit, and to encourage households with babies and young children to be smokefree.

- Revisit previous proposals for voluntary smokefree zones within the borough including outside schools, public buildings and in town centres.

Stop smoking services in Bexley

This is a service provided directly by Public Health staff and therefore, no contract is in place. Pre-2017, Bexley Stop Smoking Service was a fully universal service delivered by level 2 advisors located in nine GP surgeries across the borough. This became a fully in-house specialist service provided by the council from April 2017 and funded by local authority public health with medication funded by the GP prescription budget.

Stop smoking services are a 12-week programme consisting of an initial 30 minute consulation followed by weekly 10 minute follow-up consulations. Services run Monday to Friday including late evenings.

Figure 30 shows rate[26] of successful quitters at 4-weeks per 100,000 smokers in Bexley compared with London and England. Because of large 95% confidence intervels for local authority services it is difficult to make an inference except that it is moving in the same direction as the national and regional figures. The rates have halved from 2013/14 to 2019/20.

Figure 30: Successful smoking quitters at 4 weeks per 100,000 smokers in Bexley, London and England by year, 2013-2020

---

[26] OHID defintion: The quit rate was calculated by dividing the number of smoking quits by smoking population, multiplied by 100,000. The numerator was from NHS digital and the denominator is Population who currently smoke. Smoking prevalence estimates at local authority level for those aged 18+ (calculated from the Annual Population Survey) were multiplied by the corresponding ONS mid-year population estimates for age 16+ to calculate the smoking population.
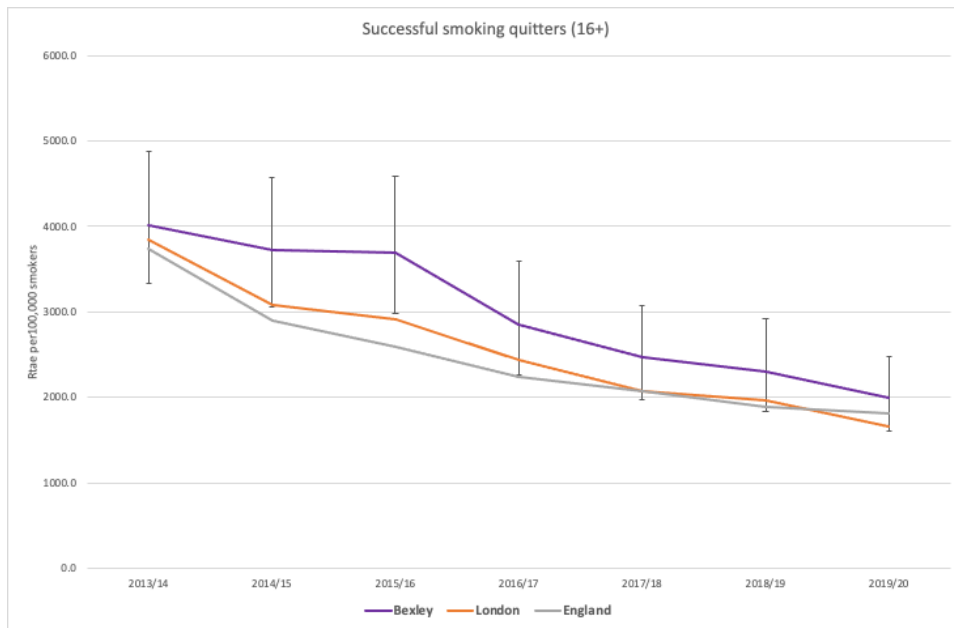
Data source: Office for Health Improvement and Disparities, Local Tobacco Control Profile,
Local Tobacco Control Profiles - OHID (phe.org.uk)

A joint report by Action on Smoking and Health (ASH) and Cancer Research UK (CRUK) report[27], 'A changing landscape: stop smoking services and tobacco control in England', which surveyed tobacco control leads responsible for 107 local authorities, found that between 2014/15 and 2017/18 local authority spending on tobacco control and stop smoking services in England fell by 30% and 36% of authorities had reduced their smoking cessation budgets in 2018, compared with only 4% that had increased them.

During this time frame, the budget for the stop smoking service in Bexley was reduced by 50%. This included the removal of the prescription budget, which reimbursed the CCG for the cost of stop smoking medications prescribed by GP's. It was only through agreement with the CCG to fund these medication costs in the future, as well as the refocusing of the service into a fully in-house specialist service, that made provision of stop smoking services in Bexley sustainable.

Impact of COVID 19 on services

A study of stop smoking services[28] and vaping shops during early COVID 19 suggested that 98% of the stop smoking services in the sample adapted by providing telephone or video calls. This provided support to the vulnerable population who smoke to quit smoking. It is estimated since the start of the pandemic that over one million people

---

[27] Interview insights from Service Manager
[28] Cox, S., Ward, E., Ross, L. et al. How a sample of English stop smoking services and vape shops adapted during the early COVID-19 pandemic: a mixed-methods cross-sectional survey. Harm Reduct J 18, 95 (2021). https://doi.org/10.1186/s12954-021-00541-0

who smoke have made a quit attempt (an estimated additional 440,000, compared to pre-pandemic levels) in Great Britain[29].

The stop service in Bexley was able to immediately transition to telephone support ensuring that the support was able to continue. All team members had access to effectively work remotely.

The strong partnership working with Bexley GP practices already existed and this helped ensure that service users continued to have direct access to their treatment medications.

The pathway for medications was already in place (via request letter from the service to the patients GP). The medication request letter was usually issued to the patient to submit to the surgery. With the implementation of telephone support, the service was able to switch to emailing these request letters direct to the surgery.

The demand and acceptance of service pre pandemic, during the peak waves of cases during the pandemic and as we move into recovery are described below.

Performance of Bexley stop smoking services pre and post COVID

Further analyses was done by PHAST on data extracted from local service by the Bexley Public Health Team.

Figure 31 shows the actual number of referrals to the stop smoking services from 2017 to 2021. Prior to 2017, all referrals were not recorded. The referrals into the service inceased from pre-Covid and remained stable with a slight drop in 2020.

There were a number of factors that played into the demand and access to service during COVID 19. Initial increase in demand of services when extra clinics were started to meet the demand.This was in part due to initial COVID fears of the fact it was a respiratory illness. The Quit for COVID campaign and pro-active re-engagement calls made by the team also helped to increase activity through the service.

- This was followed by a decrease in demand primarily due to decreased referrals from GP practices which was partly compensated by increase in referrals from maternity and acute services.

- On the whole patients were less likely to DNA during lockdowns as there was a stronger likelihood that they were at home and able to accept the call.

- The engagment and quit rate of referrals had also improved in particular among maternity referrals due to telephone call even if missed could be resceduled easily.

[29] "A million people have stopped smoking since the COVID pandemic hit Britain"; Action on smoking and health; 2020: https://ash.org.uk/media-and-news/press-releases-media-and-news/pandemicmillion/

Figure 31: Smoking referrals to the Bexley Stop Smoking Service Team by year, 2017 to 2020
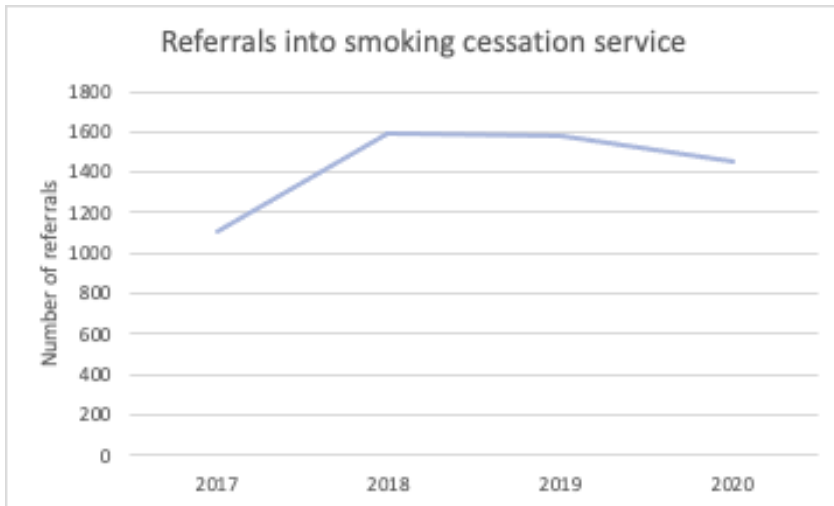
Data Source: Provided by local stop smoking services from Quit Manager

Figure 32 provides information on the acceptance of service by people referred by year as a proportion of referrals recorded. Since 2017 when the service was changed, acceptance has increased with about 70% accepting the service.

Figure 32: Clients responding to service by percentage of recorded referrals by year, Bexley, 2016-2020
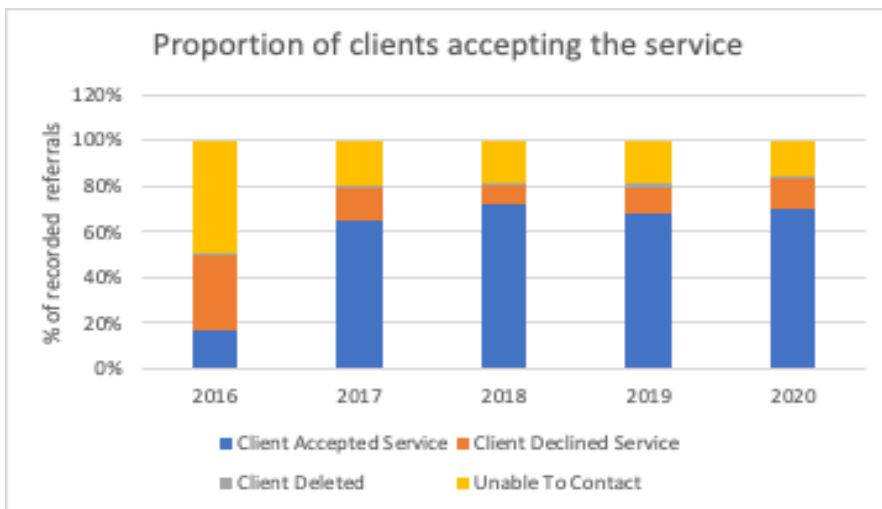
Data Source: Provided by local stop smoking services from Quit Manager

Who refers to the stop smoking service?

Figure 32 provides information on source of the referrals. Just over 51% of the referals were from GP practices followed by referrals from maternity (13%) and referrals from web 12%.

Figure 33: Source of referrals to the stop smoking service (combined 2016-2021)

Referring source (Combined 2017-2021)
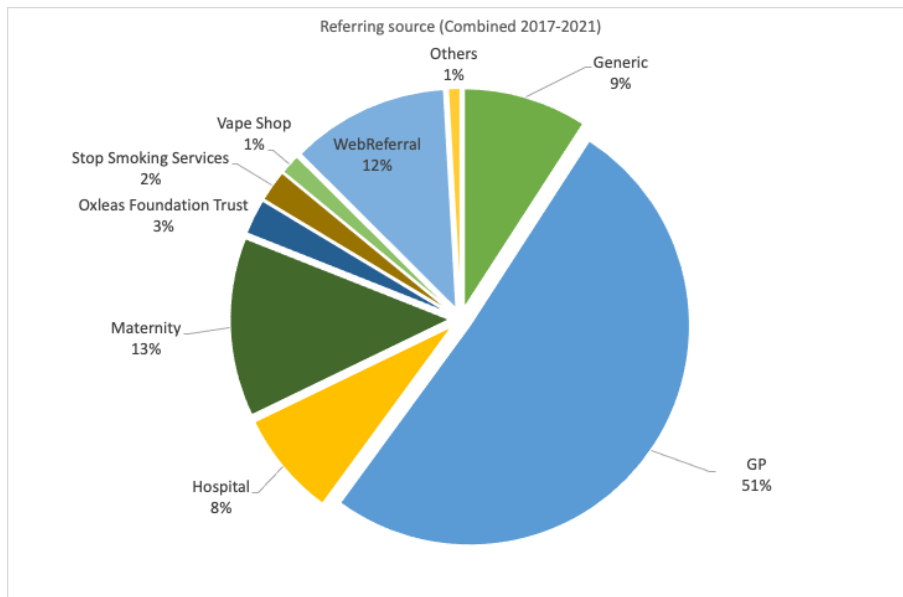
Data Source: Provided by local stop smoking services from Quit Manager

Sociodemographic profile of service users

To explore the uptake of service by age, gender, ethnicity and occupational status, combined data (2016-2021) from the local smoking service was analysed that had a gender code and were registered with a Bexley GP practice. This gave a sample of 3724 service users.

Uptake of service by gender and GP practice

Figure 34 shows the number of people who accepted the service (through any channels) by GP practices by gender. The number from each practice varied from over 371 for Norththumberland Medical Centre to 76 for Dr Thavapalan and Partners. There were more women (58% of the total) compared with men.

Figure 34: Number of smokers accepting smoking cessation service by gender and practice, Bexley

Uptake of smoking cssation service by gender and practice
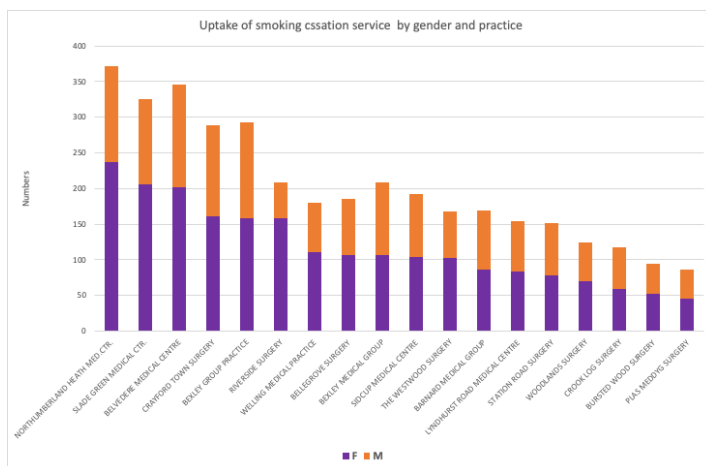
Data Source: Provided by local stop smoking services from Quit Manager

Figure 35 shows the quit rate by practice and gender among those who take up the service. 57% of women and 62% of men recorded as 4 week quitters approved by DH validation. The success rate by practice ranged from 85% to 28% in men and 72% to 47% for women.

Figure 35: Percentage successful quitters by practice and gender, Bexley
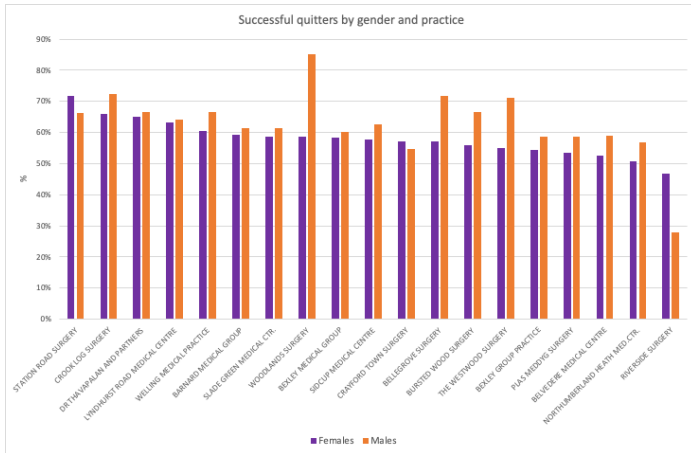
Data Source: Provided from the local stop smoking service from quit manager

Uptake by occupation

Figure 36 shows smoking quitters by occupation as proportion of total quitters. The highest proportion of uptake was from routine and manual occupations (22%) followed by intermediate (17%) and managerial and profesional (14%). 14% were retired and 12% had never worked or were long term unemployed. 8% were unable to work due to sickness or disability and 9% were carers.

Smoking rates are higher in people from routine and manual occupations. More should be referred to the service as the local data provides evidence that the uptake and quit rate is also high in these populations.

Figure 36: percentage of total quitters by occupation
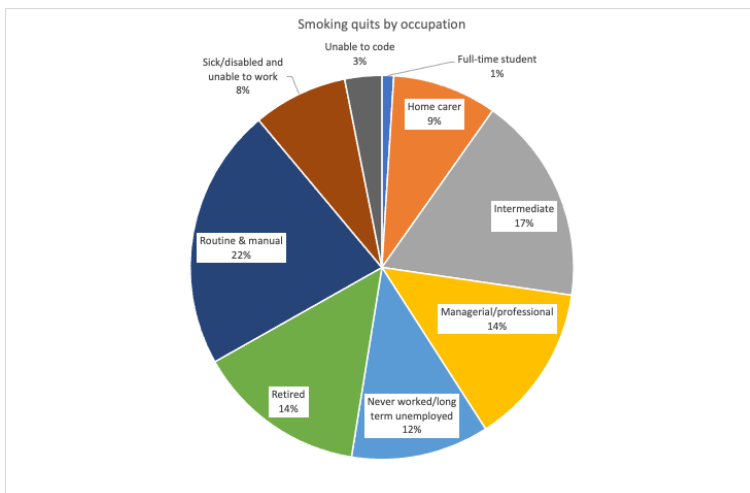
Data Source: Provided from the local stop smoking service from quit manager

Figure 37 shows the success rate by occupation class. The success rate was highest in the highest socioeconomic classification of occupation at 68%; the lowest at 46% was in people who were unable to work due to sickness or disability.

The success rate in manual and routine occupations and intermedate occupations was 61%. Applying this rate to the sample, this means about 41% (around 900) were quitters from routine and manual and intermediate occupations.

This indicates that referring people from the manual and routine occupations can help address inequalities in smoking rates and smoking related morbidity and mortality.

Figure 37: Success rate of quitting smoking by occupation, Bexley
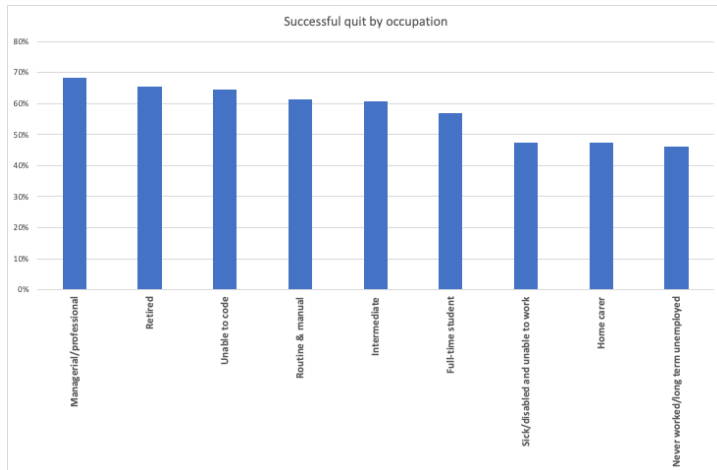
Data Source: Provided from the local stop smoking service from quit manager

Uptake by ethnicity

Figure 38 shows that the highest proporton of people entering the service were from White British population.

Figure 38: Uptake of smoking cessation service by ethnicty, Bexley
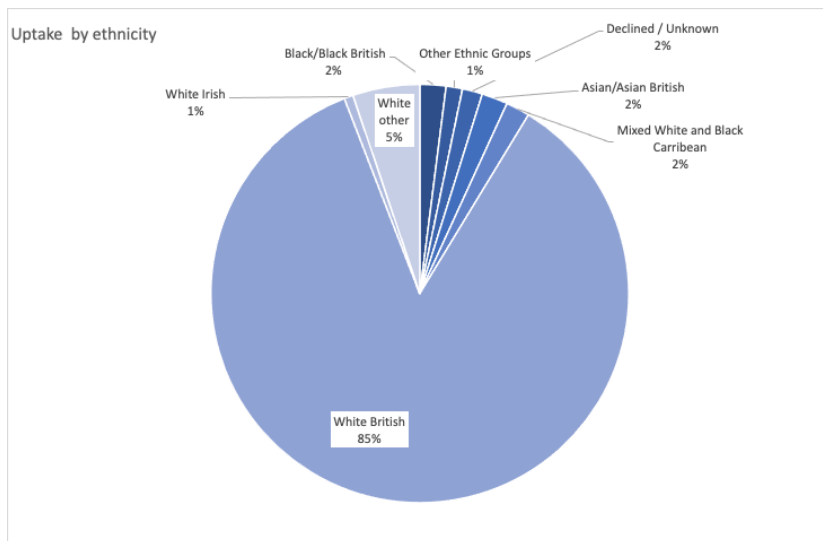
Data Source: Provided from the local stop smoking service from quit manager

Figure 39 shows the success rate for quits by ethncity. The highest rates were in those that had declined to give their ethnicity or unknown, All communites had a success rate of around 60% or just above, while Black communities and White Irish had less than a 50% success rate.

Figure 39: Percentage of successful smoking cessation at 4 weeks by ethnicity, Bexley
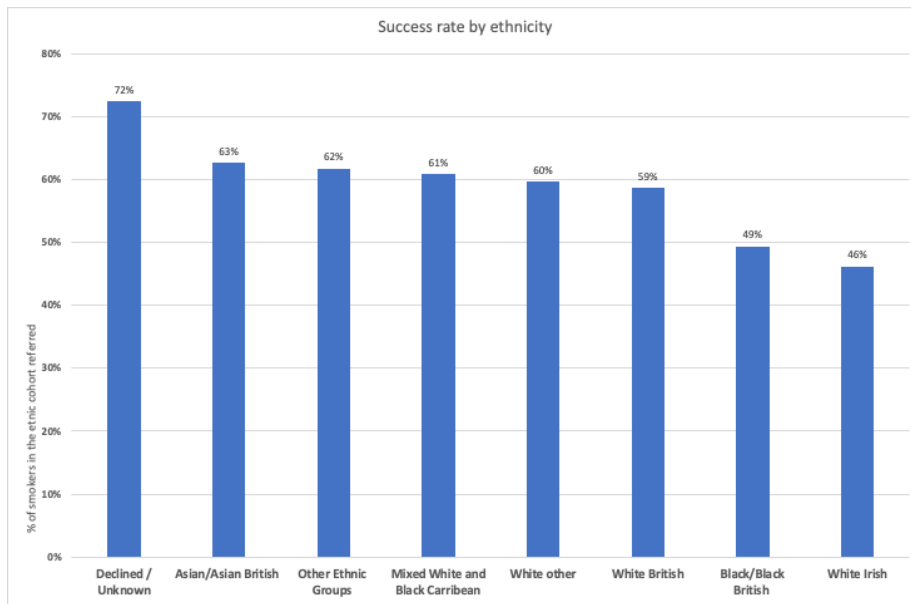
Data Source: Provided from the local stop smoking service from quit manager

Uptake by broad age group

 Figure 40 shows breakdown of the sample by broad age groups. The highest proportion of clients were from the 18-39 years age group, with a similar proportion of one third being from the 40-54 years age group and the 54-74 years age group.The under 18 group was very small.

Figure 40: Referrals to smoking cessation services by age group, Bexley
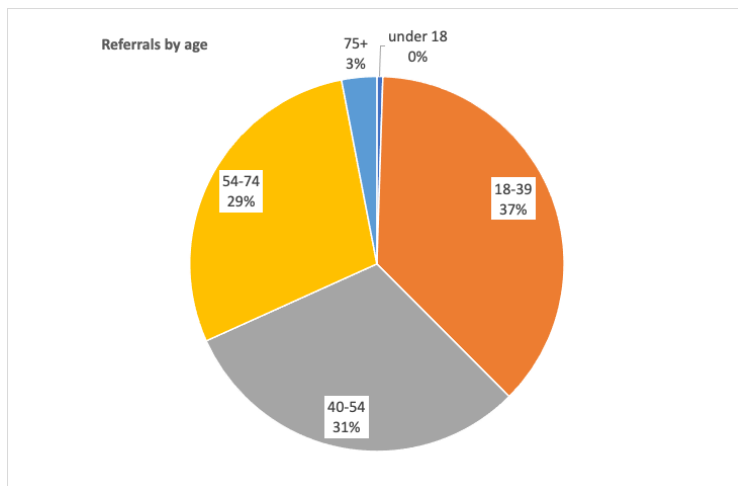
Data Source: Provided from the local stop smoking service from quit manager

Figure 41 shows the success rate by the broad age groups in the sample. All the age groups have a success rate above 50%, with ages 54-74 years having the highest rates (64%) and ages 18-39 years having the lowest (54%).

Figure 41: Success rate of smoking cessation by age groups in the local service, Bexley
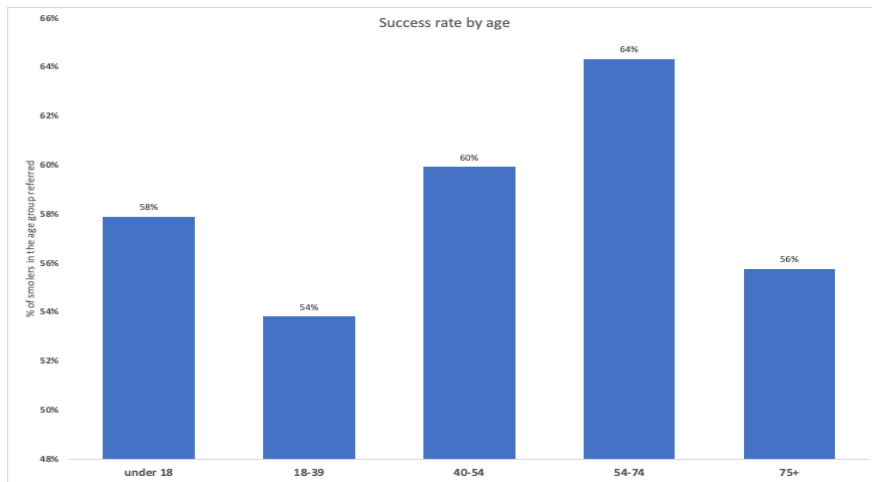

Data Source: Provided from the local stop smoking service from quit manager

Existing medical conditions of service users

Many of the clients that are are take up the service have an underlying medical condition. From the sample of 3,793 clients that had a gender recorded, not all had a health status recorded, so the data was analysed using 40% of the sample.

Figure 42 shows clients that had a single medical condition and Figure 43 shows the rates for clients with comorbidites with the main underlying condition. Mental health was the main issue and when comorbidites are included Mental Health and COPD are of a similar proportion to diabetes and asthma. Hence, many clients have conditons for which smoking is a contributory factor in adverse outcomes.

Figure 42: Clients with single medical conditions
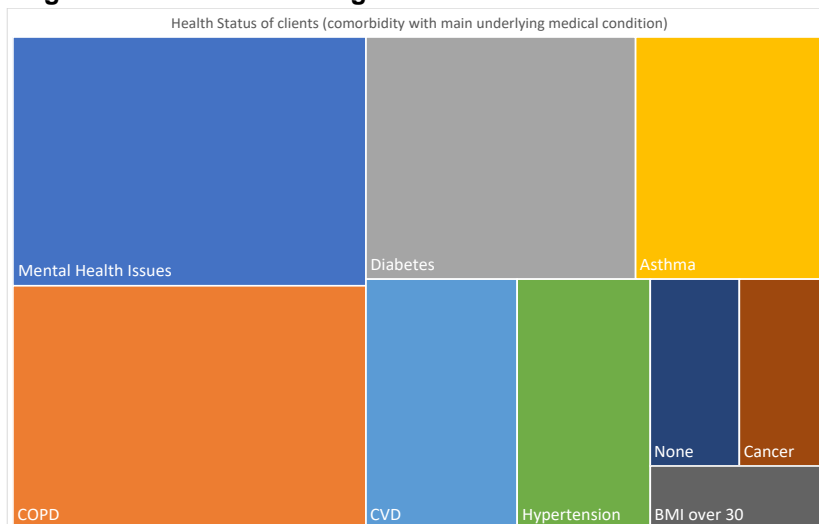
Data source:

Figure 43 : Clients with medical conditions including comorbidites

Health Status of clients (comorbidity with main underlying medical condition)
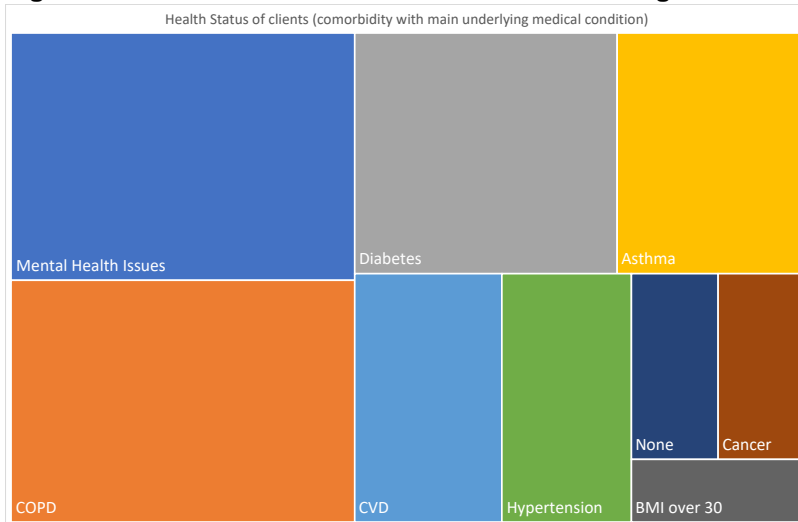
Data source

Figure 44 shows the success rate of clients based on the underlying mental health condition and when the client has co-morbidities with the main health condition.

The success rates are higher in clients that have comorbidities compared with an underlying single condition. For example, clients with single COPD, CVD and diabetes have around 32-39% success rate whilst clients with comorbidities have above 55% success rate.

Figure 44: Percentage of smoking cessation by medical condition as single comorbidity and with comorbidities, Bexley, ?year

Success quits by medical condition of client
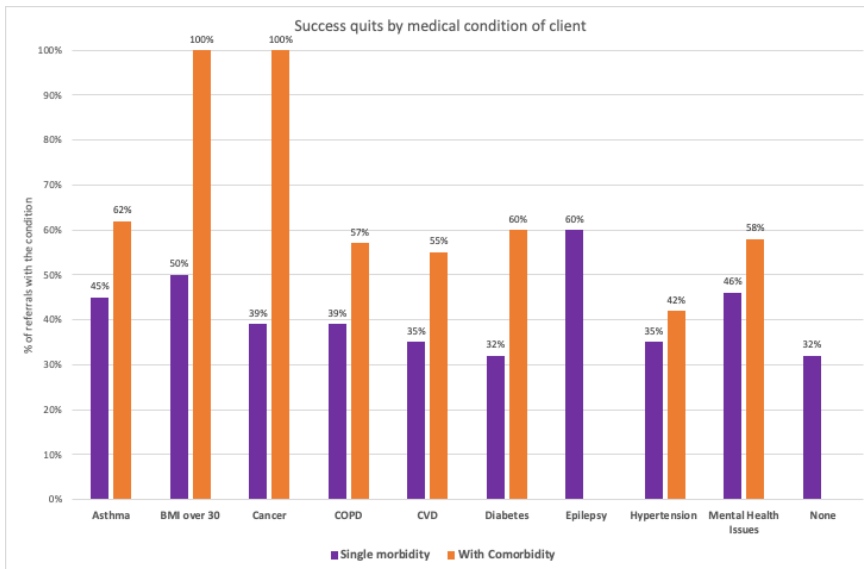
Data Source: Provided from the local stop smoking service from quit manager

## Recording of smoking status for patients with medical conditions in GP practices

Figure 45 shows smoking status reviewed by GP practices in the last 12 months for people with certain medical conditions. Figure 46 shows the offer of support for

smoking cessation.

The percentage of patients with any or any combination of the following conditions: coronary heart disease, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months.

Some practices have significantly lower smoking status recorded in these patients who would benefit from referral to local stop smoking services.

Figure 45: Percentage of smokers in patients with CHD, PAD, stroke, TIA, hypertension, COPD, CKD, asthma, schizophrenia, BPAD, other psychosis in last 12 months by GP Practice, Bexley, 2020/21
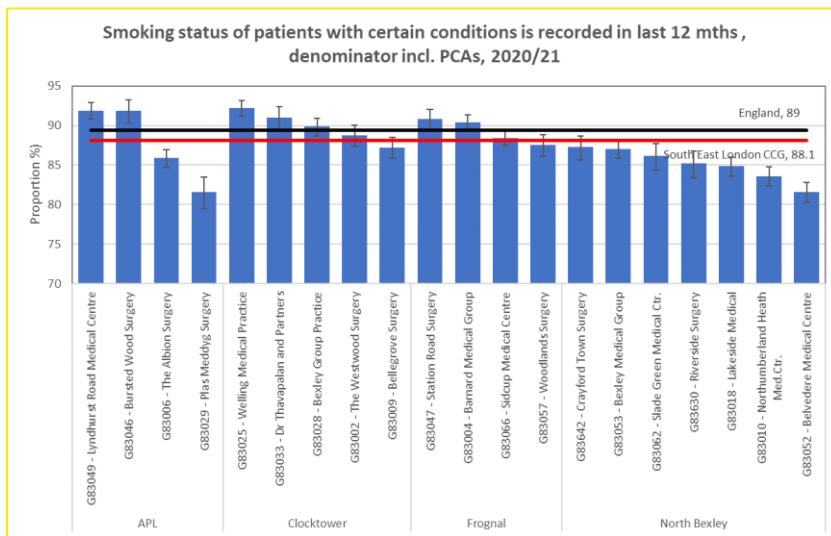
Source: Office for Health Improvement and Disparities, National General Practice Profiles, National General Practice Profiles - OHID (phe.org.uk)

Figure 46: Percentage of smokers offered support and smoking cessation by General Practice, Bexley, 2020/21
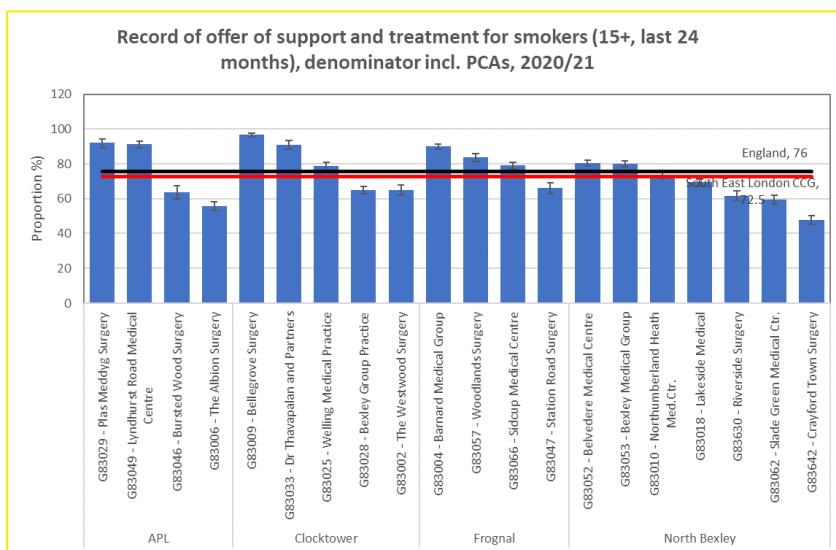
Source: **Office for Health Improvement and Disparities, National General Practice Profiles,** National General Practice Profiles - OHID (phe.org.uk)

8. Alcohol

Chapter Summary

<div style="border: 1px solid black; padding: 10px;">

Key messages

- Alcohol related admissions in Bexley show an increasing trend with the admission episodes of male under 40 years, alcohol related cardiovascular admissions in males and alcohol related mental health and behavioural disorders higher than the London average.
- Crude rates from GP recorded alcohol dependency indicate differences by PCN and age.

Key recommendations

- Public health and ICS should agree a plan by to estimate and monitor alcohol dependency in Bexley population by December 2022 as part of the COVID recovery using validated tools such as Alcohol Use Disorders Identification Test (AUDIT) or shortened versions (such as AUDIT-C and Fast Alcohol Screening Test (FAST).
- Public health should have a evidence based project implemented starting April 2023 to work with schools and colleges and employers to prevent harmful drinking in the 16+ age group.
- Substance misuse commissioners should implement the Blue Light Project as an alternative pathway for resistant and/or people with complex need who do not engage with services as part of commissioned service from April 2023.

</div>

Public health burden of alcohol -national context

PHE (now OHID) published a report on the public health burden of alcohol.[30] Alcohol misuse is the biggest risk factor for death, ill-health and disability among 15-49 year olds in the UK, and the fifth biggest risk factor across all ages. Alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers, high blood pressure, cirrhosis of the liver, and depression.

Alcohol consumption is a contributing factor to hospital admissions and deaths from a

---

[30] "The public health burden of alcohol: evidence review"; Public Health England; 2016; https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review

diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually.

Alcohol related health inequalities national context

The alcohol-specific mortality rate in males is more than twice the rate in females. In 2020, there were 17.5 deaths per 100,000 males compared with 8.7 deaths per 100,000 females - a 17% increase in males and a 24% increase in females from 2019[31].

There is a bigger difference in the rates of alcohol-specific mortality between the most and least deprived deciles of the population. In 2020, alcohol-specific mortality was 18.9 per 100,000 population in the most deprived decile, compared with 7.8 per 100,000 population in the least deprived decile - a 25% increase in the most deprived decile and a 5% increase in the least deprived decile from 2019.

Alcohol related harm to others

The adverse consequences of alcohol consumption include the negative consequences of drinking on individuals other than the drinkers themselves, both health and social problems[32]. Alcohol's harm to others (HTO) is an interactional occurrence at the level of individuals and their relationships and is determined from the perspective of those affected by the drinker rather than from the perspective of the drinker or the society.

A study by Public Health England (PHE) in England on HTO found that factors associated with experiencing harm were:

- younger age (p<0.001),
- drinking harmfully/hazardously (p<0.001),
- white British (p<0.001 compared to other white groups and Asian groups and p=0.017 compared to black groups),
- having a disability (p<0.001),
- being educated (p<0.001 compared to no education) and
- living in private rented accommodation (p=0.004 compared with owned outright).

Factors associated with lower odds were

- Being in the family stage of life (defined as having children in the household) had significantly lower odds of harm (p=0.006 compared to being single),
- being retired (p<0.001 compared to being employed).

Guidelines for low risk drinking for UK

---

[31] "Alcohol related harm and drinking behaviour"; The Nuffield Trust;2022; https://www.nuffieldtrust.org.uk/resource/alcohol-related-harm-and-drinking-behaviour-1#background

[32] "Harm to others from drinking: patterns in nine societies"; World Health Organisation; 2019; https://www.who.int/publications/i/item/9789241515368

The Chief Medical Officers considered evidence on harmful drinking and produced guidelines[33] for low risk drinking which applies to adults who drink regularly or frequently i.e. most weeks. The Chief Medical Officers' guideline for both men and women is that:

- To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis.

- If you regularly drink as much as 14 units per week, it is best to spread your drinking evenly over 3 or more days.

- If you have one or two heavy drinking episodes a week, you increase your risks of death from long term illness and from accidents and injuries.

- The risk of developing a range of health problems (including cancers of the mouth, throat and breast) increases the more you drink on a regular basis.

- If you wish to cut down the amount you drink, a good way to help achieve this is to have several drink-free days each week.

Impact of alcohol in Bexley

Data from the local alcohol profiles [34] for 2020/21 published by OHID provide the following burden from alcohol in Bexley:

- There were 62 alcohol related deaths (broad)[35] in Bexley. Directly standardised rates for Bexley (27.1/100,000 95 CI 20.9 -31.1) were lower than London and England. Bexley was one of the boroughs with the lowest alcohol related mortality in London compared with England along with Bromley, Harrow, Barnet, Westminster, Richmond upon Thames and City of London.

- However, trends in alcohol related admissions are showing an increasing trend with 2020/21 were similar to London with 3312 alcohol related admission episodes. The directly standardised rates of 1458/100,000 (95% CI 1408-1508) were similar to London and England along with Newham, Haringey, Barking and Dagenham.

- The 2020/21 hospital admissions data from OHID suggests that there the burden of alcohol is increasing in Bexley and has an impact on both cadiovascular health and mental health.
    - Admissions for alcohol related cardiovascular disease in Bexley are higher than London average 697/100,000 (95% CI 693 -733) with 1553

---

[33] "Alcohol consumption: advice on low risk drinking"; Department of Health and Social Care; 2016; https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking

[34] OHID Local alochol profiles https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data

[35] A measure of hospital admissions where either the primary diagnosis (main reason for admission) or one of the secondary (contributory) diagnoses is an alcohol-related condition. This represents a Broad measure of alcohol-related admissions but is sensitive to changes in coding practice over time. We have used this to demonstrate the full burden of alocohol consumption.

episodes. This was primarily due to male admissions (1321 episodes) and rates for males are higher compared with London average.

- o Admissions for mental health and behavioural disorders due to alcohol in Bexley are lower than London average but are showing an increasing trend. Whilst the male episodes are higher, rates for females are higher compared with London average.

- o Admissions for population aged below 40 years and 65+ in Bexley was higher than London average for males. For females, admissions were higher for 40-64 years compared with London average.

- The data on treatment shows that the completion rate for those in treatment has been decreasing with only 30% completion rate in 20/21.

Recorded prevalence of alcohol dependency by PCN in Bexley

Alcohol misuse is when the levels of alcohol consumed are considered harmful (above 14 units a week) or when someone is dependent on alcohol. Population level data for Bexley is not available as with many other local authorities unless they participated in the PHE survey.

Hence we have used a proxy indicator of recorded data on GP practice which may not give a true estimate but is the only data that was available. . The limitations of this data is mentioned in the methodology section and in particular that it does not include data from one practice. Data extracted from the GP EMIS system was provided by the South London CCG.

All four PCNs experienced a drop in the recorded rate of alcohol dependency in 2020/21. This could be explained by the COVID-19 pandemic and the temporary closure of bars and restaurants as well as the restrictions on shopping. In addition, the face to face appointments were replaced by virtual or telephone appointments. In 2021/22 the rates have increased. Within London, Bexley had higher admission episodes for people aged under 40 years.

Figure 47: Alcohol dependency (aged 18+) by Bexley PCN, Bexley, 2017/18 to 2021/22
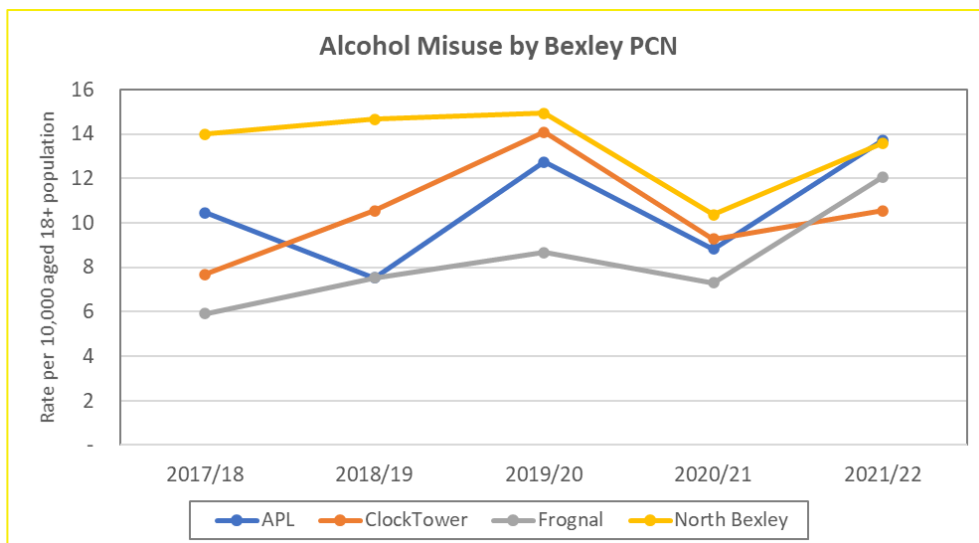
Source: NHS South East London CCG data based on extract from EMIS

Figure 48: Alcohol misuse by age group and by Bexley PCN, Bexley, 2021/22
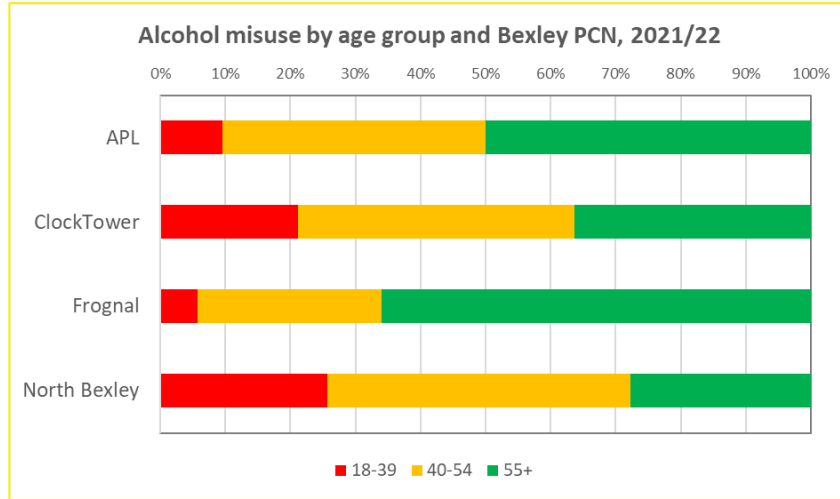
Source: NHS South East London CCG data extracted from EMIS

Similarly to the alcohol and drug misuse chart, practices in the Frognal PCN had higher levels of alcohol misuse in those aged over 55. APL, ClockTower and North Bexley all experience higher levels of alcohol misuse in those aged 40-54.
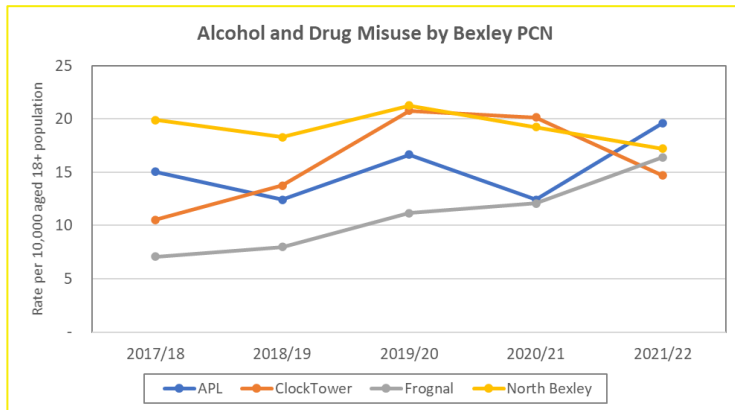
Alcohol and drug misuse by PCN

Frognal's rate has continued to increase from 7 per 10,000 in 2017/18 to 16.4 in 2021/22. APL PCN's rate of alcohol and drug misuse has increased from 15 per 10,000 population in 2017/18 to 19.6 in 2021/22. ClockTower rate of misuse increased intially starting with a rate of 10.5 per 10,000 rising to a high of 20.8 in 2019/20 but dropped to 14.7 in 2021/22. North Bexley has also seen a slight decrease in the last 2 years. This may be reflective of improved identification intially with COVID impacting on some of the routine process or actual reduction.

Alcohol and drug use by broad age group

Figure 50 shows the recorded alcohol and drug misuse by broad age group. Frognal PCN has a different profile with more users in the 55+ age group. North Bexley and Clock Tower PCN have both got a higher proportion of users in the younger age group.

Figure 49: Alcohol and drug misuse (aged 18+) by Bexley PCN, Bexley, 2017/18 to 2021/22

Source: NHS South East London CCG data extracted from EMIS

Figure 50: Alcohol and drug misuse by age group and by Bexley PCN, Bexley, 2021/22
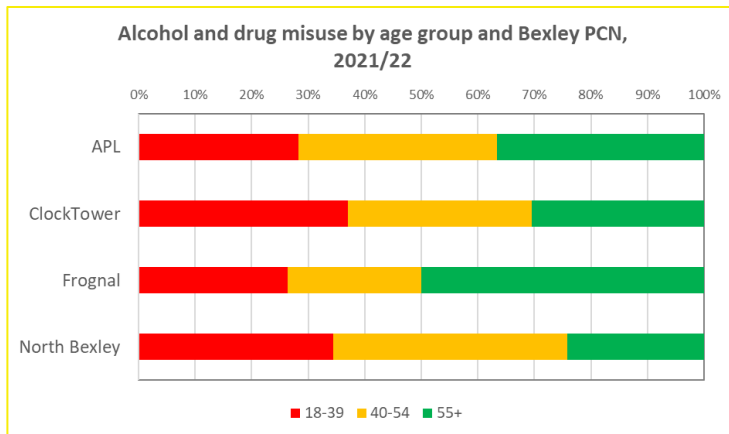
Source: NHS South East London CCG data extracted from EMIS

Interventions for reducing risk of harmful drinking

Evidence based guidance

NICE has six evidence based guidance on alcohol misuse

Public Health Guidance

Alcohol-use disorders: prevention (PH24)
Key recommendations for local areas are on:

- o licensing and
- o resources for screening and brief interventions

Alcohol interventions in secondary and further education (NG135):

This guideline covers interventions in secondary and further education to prevent and reduce alcohol use among children and young people aged 11 up to and including 18. It also covers people aged 11 to 25 with special educational needs or disabilities in full-time education. It will also be relevant to children aged 11 in year 6 of primary school. This guideline includes recommendations on:

- o planning alcohol education
- o delivering universal alcohol education
- o targeted interventions

Clinical Guidance

- Alcohol-use disorders: diagnosis and management of physical complications (CG100)
- Nalmefene for reducing alcohol consumption in people with alcohol dependence (TA325)
- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (CG120)
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115)

Sheffield alcohol model for minimum pricing for local authority

A recent modelling study[36] found that it is feasible to apply the Shefield alcohol policy

---

[36] Brennan A, Angus C, Pryce R, Buykx P, Henney M, Gillespie D, Holmes J, Meier PS. Potential effects of minimum unit pricing at local authority level on alcohol-attributed harms in North West and North East England: a modelling study. Southampton (UK): NIHR Journals Library; 2021 Mar. https://pubmed.ncbi.nlm.nih.gov/33764725/

framework to local authorities and the estimates suggest that minimum unit pricing for alcohol at local authority level could be effective in reducing alcohol-attributable deaths, hospitalisations, NHS costs and crime. Health inequalities were estimated to reduce with greater health gains in the deprived areas, where more cheap alcohol is purchased and where there are higher baseline harms.

Good practice model- reducing harm in people with complex needs

Anywhere between 75% and 92% of dependent drinkers are not in treatment at any one time[37].This "treatment gap" – the difference between those identified with a problem and those accepting help for it – is the largest for any identifiable condition. It is also the big challenge for the alcohol treatment field

The Blue Light project[38] is Alcohol Change UK's national initiative to develop alternative approaches and care pathways for change resistant drinkers who place a huge burden on public services. These include the frequent hospital attenders, the repeat offenders and those committing anti-social behaviour. In an area with a population of 250,000, the Blue Light project estimated that there are around 250 Blue Light clients who cost at least £12–13 million each year across a range of agencies.

Blue Light began as a co-production involving 23 local authorities. Local staff and service users in each area contributed expertise to the development. In partnership with Public Health England it is now implemented in over 60 local authorities across England and Wales.

Adult Substance Misuse Services in Bexley

This is a dedicated service for Bexley commissioned by Bexley Public Health Team and delivered by South London and Maudsley NHS Foundation Trust. Trained staff who have the expertise and knowledge provide structured treatment to all adults experiencing issues with drugs and/or alcohol; support to carers; wraparound support for their social and practical needs including access to training, CV development and job opportunities, housing support.

The team play a significant role in developing partnerships with other local agencies to ensure a holistic approach to substance misuse support and treatment. There is a long term contract and funding is managed by Bexley Public Health.

The National Drug Treatment Monitoring System (NDTMS) data helps drug and alcohol treatment demonstrate the outcomes it achieves for the people it treats, and in

---

[37] "The Blue Light Project"; Ward M; Institute of Alcohol studies; 2019; https://www.ias.org.uk/2019/10/03/the-blue-light-project/

[38] The Blue Light Project; Alcohol Change; https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project

doing so aids accountability. The National Drug Treatment Monitoring System (NDTMS) data is used to monitor the quality and performance of the services and helps the local commissioners demonstrate the outcomes achieved for the residents. Adult substance misuse performance targets are generally achieved and outcomes have been benchmarked and are in line with neighbouring boroughs.

Impact of COVID on services

Adult substance misuse services had to adapt by retaining service users in treatment for longer than normal and group sessions moved online for those service users who had internet access. More complex service users were retained in the community due to closure of inpatient units. Large proportions of staff working from home undertaking mainly one to one sessions since group sessions have stopped for the substance misuse. The services implemented many changes required to move to virtual and telephone working patterns with clients. Coffee mornings also ceased. Some staff had been allocated to the pandemic response and levels of referrals increased particularly professional referrals. Many clients especially those working found the telephone service helpful.

People in Treatment for alcohol/drug misuse (data from NDTMS)

There were 4,283 Bexley patients who were in treatment between 2016 and 2020. The trend chart below shows that for all drug groups collected in the NDTMS data, the number of patients in treatment has been increasing.

Figure 51: Number of patients in treatment by year and alcohol, opiates and non opiates, Bexley, 2016-2020
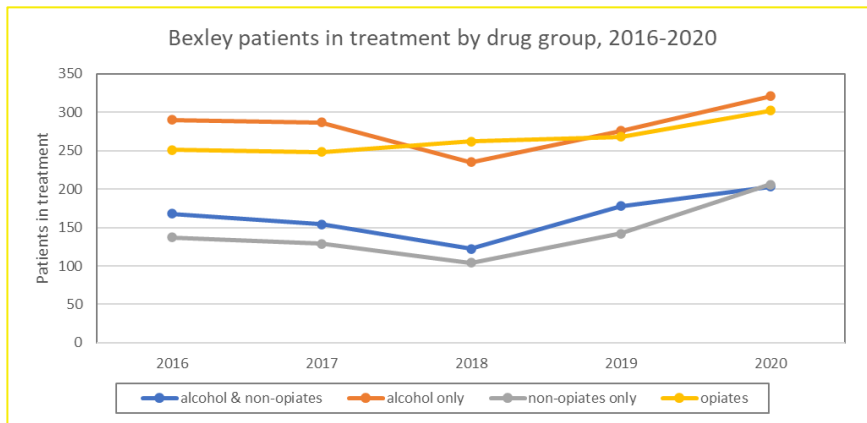
**Figure 52: Percentage of patients in treatment for substance misuse by gender and age, Bexley, 2010-2020**
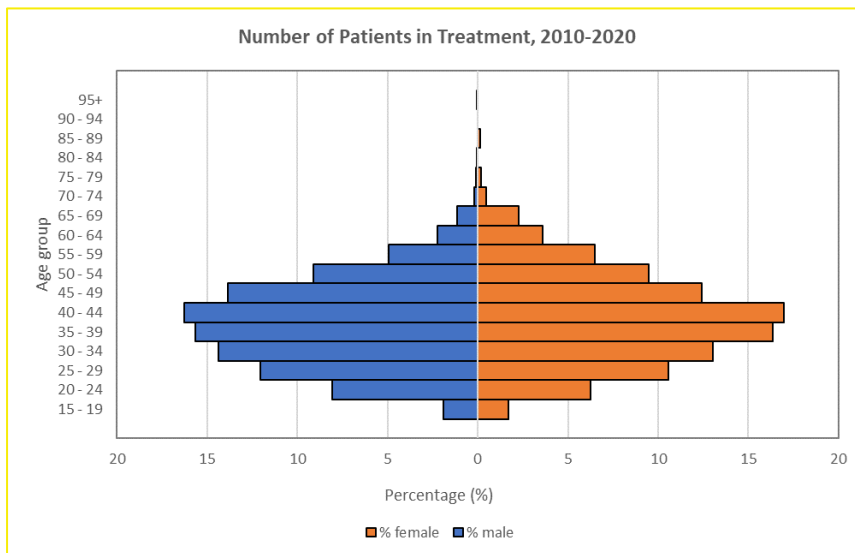
The proportion of Bexley residents completing treatment between 2010 and 2020 fluctuated between 5.7% in 2013 to its highest of 19.6% in 2016. The latest figures show that around 10% of patients who were in treatment successfully completed in 2020.

Figure 53: Percentage of Bexley residents successfully completing treatment for substance misuse by year, Bexley, 2010-2020
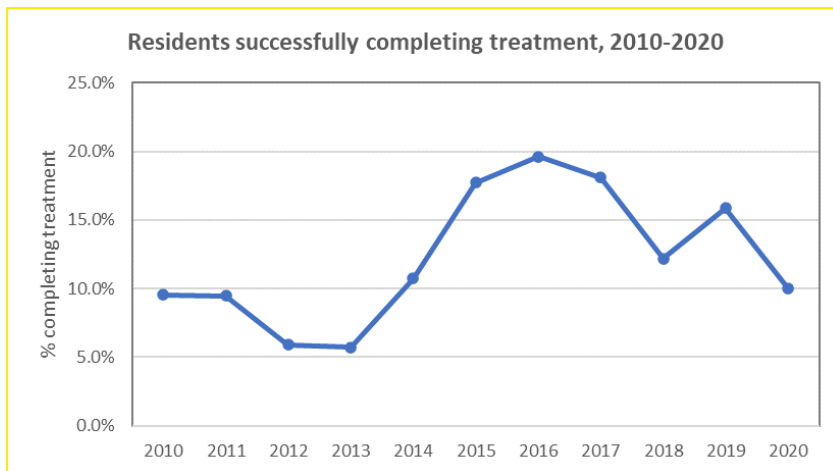
Source: NDTMS – SlaM extract

The NDTMS data collected by SLaM showed that across the five year period (2016-2020), that 16.2% of Bexley residents known to the service had either housing problems (11.7%) or urgent housing problems (4.5%).

Of those Bexley residents who were in treatment across 2016-2020, 43% were due to alcohol, compared to 26% who were in treatment to misuse of non-opiates and 31% of opiates.

Figure 54: Percentage of adult drinkers drinking more than 14 units per week by year, Bexley, 2016-2021
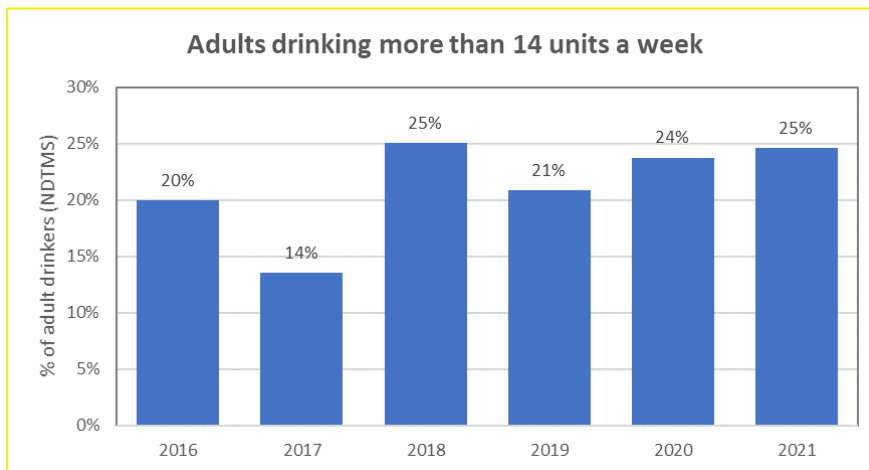
Source: NDTMS – SlaM extract

The percentage of adults drinking more than 14 units a week out of all adults presented to SLaM for alcohol treatment was 21% (2016-2020 combined).

Adult alcohol related acute inpatient admissions

There is variation across the borough when looking at the rate of alcohol related inpatient admissions for 2016-2020. The areas with the darker colours show higher levels of alcohol related admissions, whereas the lighter areas have lower rates of admissions. The wards with the highest rates are East Wickham (1,392 per 10,000),

Christchurch (1,244), Danson Park (1,219), and Lesnes Abbey (1,180).

Alcohol related inpatient admissions across the borough are seen more often in those aged 55 and over. Longlands ward has the biggest proportion of older inpatient admissions whereas North End has the least – showing a larger proportion of those aged 40-54 when compared to the other wards in the borough.

Figure 55: Adult alcohol related inpatient admissions (aged 18+) by ward, Bexley, 2016-2020
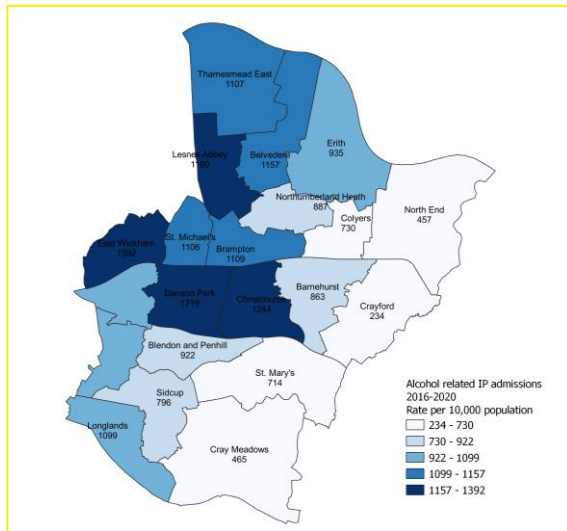
Source: LGT data, Office for National Statistics licensed under the Open Government Licence v.3.0.

*Data from Princess Royal University Hospital (PRUH) and Darenth Valley Hospital (DVH) have not been included

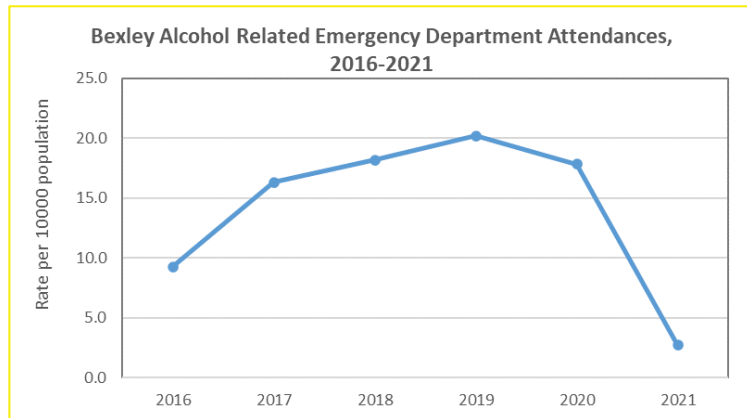**Figure 56: Alcohol related inpatient admissions by age group and ward, Bexley, 2016-2021**
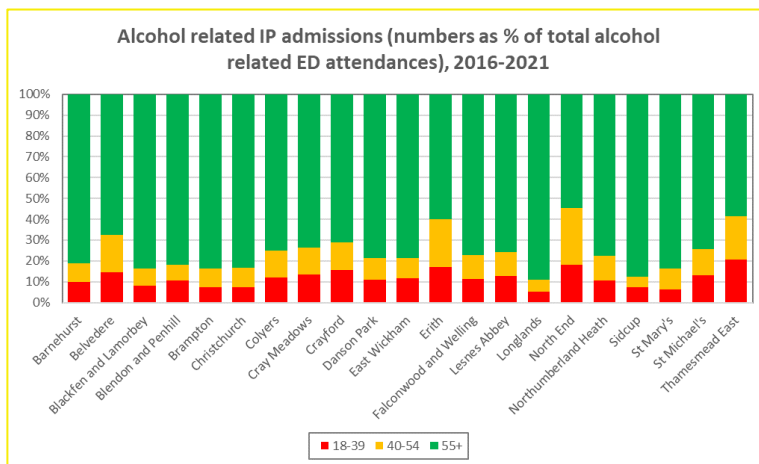
Source: LGT data
*Data from Princess Royal University Hospital (PRUH) and Darenth Valley Hospital (DVH) have not been included

Adult alcohol related emergency department attendances

The number of alcohol related emergency department attendances amongst Bexley adults was at its highest in 2019 (387 per 10,000 population). Since 2019 it has been decreasing through 2020 and 2021. National evidence suggests that during the pandemic homeless people were less likely to attend ED due to alcohol intake and this maybe because they were housed.
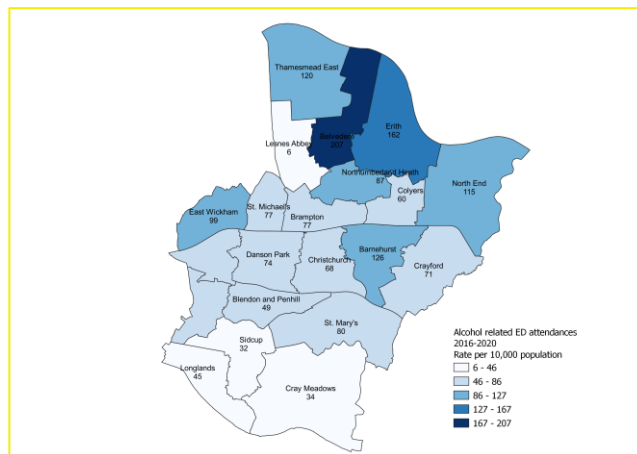
Figure 57: Adult alcohol related emergency department attendances per 100,000 by year. Bexley, 2016-2020

Source: LGT data
*Data from Princess Royal University Hospital (PRUH) and Darenth Valley Hospital (DVH) have not been included

**Figure 58: Adult alcohol related emergency department attendances by Bexley ward, Bexley, 2016-2020**

Source: LGT data, Office for National Statistics licensed under the Open Government Licence v.3.0
*Data from Princess Royal University Hospital (PRUH) and Darenth Valley Hospital (DVH) have not been included

Belvedere had the highest rate of alcohol related emergency department attendances in 2016 to 2020. Overall, the north of the borough experience the higher rates in these hospital attendances than the south of the borough.

Figure 59: Adult alcohol related emergency department attendances (aged 18+) by age group and ward, 2016-2021
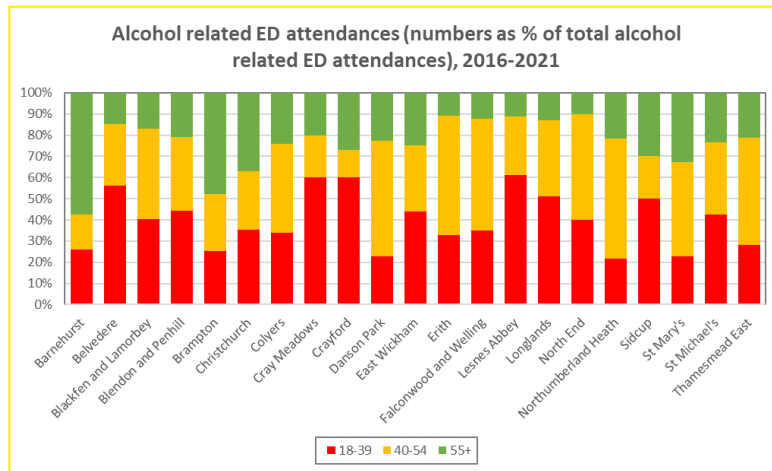
Source: LGT data
*Data from Princess Royal University Hospital (PRUH) and Darenth Valley Hospital (DVH) have not been included

There is a lot of variation across Bexley's wards when looking at the age groups of those patients presenting themselves to emergency departments for alcohol related issues. Belvedere, Cray Meadows, Crayford, Lesnes Abbey and Sidcup had higher proportions of patients aged 18-39 which reflects the younger population resident within these areas.

Barnhurst and Brampton had the highest proportion of patients aged 55 and over, whereas Danson Park, Erith, Falconwood and Welling, North End and Northumberland Heath had higher proportions of 40-54 year olds.

9. Obesity

Chapter Summary

Key messages

- Bexley has one of the highest estimated prevalence of obesity in London with 69% of adults classified as overweight or obese.

- The recording of obesity in GP practices in not consistent with population data which indicates a lost opportunity to offer advice and refer to weight management services.

- PCN in the most deprived areas have high rates of obesity compared with the other PCNs.

Key recommendations

- The obesity strategy group should develop an implementation plan for the seven themes by December 2022.

- The HWB board should request annual progress report on implementation of the obesity strategy.

Obesity a silent pandemic and its impact on COVID 19 -national context

Obesity, a crisis that has been developing insidiously for decades, is an ongoing pandemic that had considerable interactions with the COVID 19 pandemic[39]. Obesity was quickly found to be associated with worse COVID-19 clinical outcomes. Conversely, there are suggestions the COVID-19 pandemic has led to a worsening of diets, inactivity, and weight-loss treatment interruptions, particularly in deprived sectors of society.

Public Health England[40] (now OHID) reported new evidence that suggested excess weight was associated with an increased risk of the following for COVID-19: a positive test, hospitalisation, advanced levels of treatment (including mechanical ventilation or admission to intensive or critical care) and death. The risks seemed to increase

---

[39] Editorial, Obesity: another ongoing pandemic The Lancet Gastroenterology & Hepatology | Volume 6, Issue 6, June 2021 https://www.thelancet.com/journals/langas/article/PIIS2468-1253(21)00143-6/fulltext
[40] PHE Excess Weight and COVID-19 Insights from new evidence July 2020 https://www.gov.uk/government/publications/excess-weight-and-covid-19-insights-from-new-evidence

progressively with increasing BMI above the healthy weight range, even after adjustment for potential confounding factors, including demographic and socio-economic factors. It further suggested that there was some evidence to suggest that disparities in excess weight may explain some of the observed differences in outcomes linked to COVID-19 for older adults and some BAME groups.

Obesity is an established risk factor for many chronic conditions and mild obesity was associated with the loss of one in ten, and severe obesity the loss of one in four potential disease-free years during middle and later adulthood. This increasing loss of disease-free years as obesity becomes more severe occurred in both sexes, among smokers and non-smokers, the physically active and inactive, and across the socioeconomic hierarchy[41].

Prevalence of obesity in Bexley

The estimated prevalence[42] of adults in 2019/2020 who are classified as overweight or obese was 69.0% (95 % CI 64.5% to 73.3%) which is higher than the London average (55.7%) and national average (62.8%). Within London there were only three boroughs with higher rates, Bexley, Havering (67.3% 95% CI 62.8 to 72.0) and Newham (68.2%; 95 CI 63.2%-73.0%)

Figure 60 shows the estimated rates of obesity and overweight over time in Bexley compared with England and London based on the Active Lives Survey (ALS).

At baseline, rates in Bexley were comparable to London and England. In London, rates have remained stable, but increased in Bexley resulting in significantly higher rates. The most recent data as shown in Figure 61 suggests that Bexley has the highest rates of adult overweight including obesity (BMI ^{3} 25 kg/m^2) in London.

---

[41] Nyberg SS, Batty GD, Pentt J et al Obesity and loss of disease-free years owing to major non-communicable diseases: a multicohort study The Lancet Public Health Oct 2018 Volume 3Number 10 https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30139-7/fulltext

[42] PHOF indicator based on Active Lives Survey

Figure 60: Percentage adults overweight and obese by location (Bexley, London, England) and year, 2015-2020
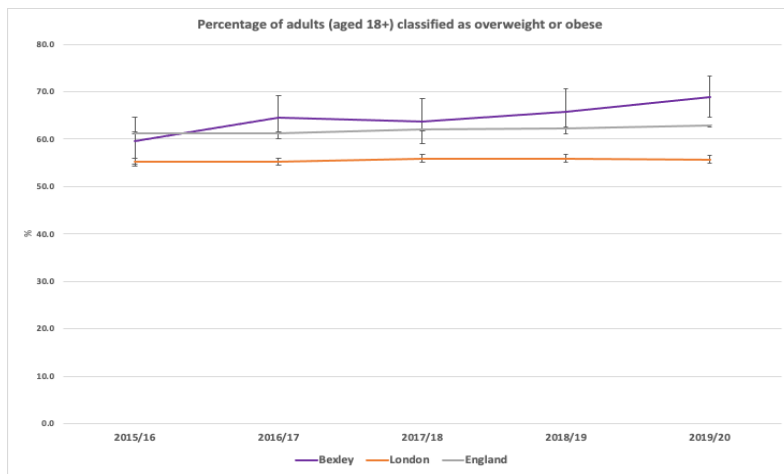
Data Source: Office for Health Improvement and Disparities, Public Health Outcomes Framework, Public Health Outcomes Framework - Data - OHID (phe.org.uk)

Figure 61: Percentage of overwight and obese adults (18+) by London boroughs (2019/2020)
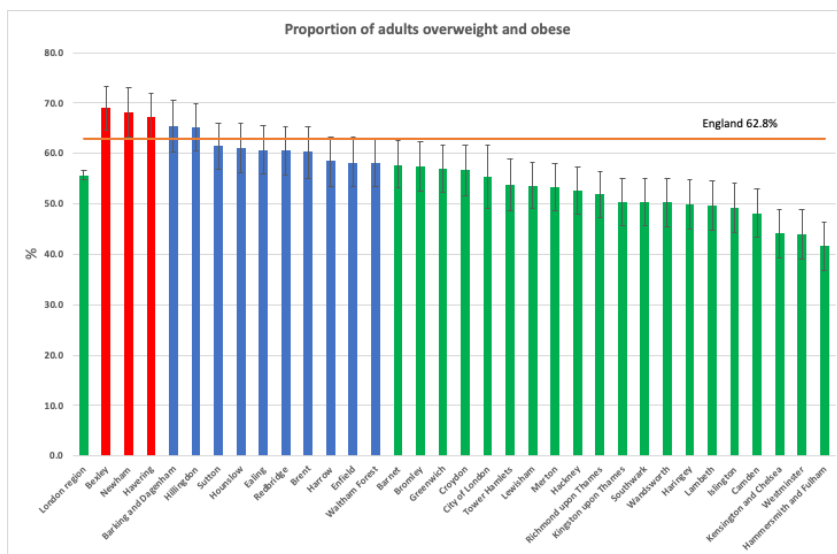
Data Source: Office for Health Improvement and Disparities, Public Health Outcomes Framework, Public Health Outcomes Framework - Data - OHID (phe.org.uk)

## Recorded crude obesity rates in GP practice

Figure 62 shows the proportion of adults on obesity (BMI ^{3} 30 kg/m^2) register by GP practice. This ranges from 1.4% to 11.8%. The practices with a very low proportion may also have issues with coding and recording as current obesity rates in the general population are higher. The quality outcomes frameworks (QOF) data do not give the true picture of obesity levels. From what is known through the Health Survey of

England[43], that 35% of men and 37% of women living in the most deprived areas were obese compared with 20% of men and 21% of women in the least deprived areas. The recorded rates in registered population may therefore be underestimates of true obesity levels.

Data extracted by South East London CCG in March 2022 showed a range of levels of obesity from 7.9% to 25%.

North Bexley and Clocktower PCN have significantly higher proportions compared with England whilst API and Frognal have significantly lower values. Frognal PCN has the lowest proportion.

Figure 62: Obesity in adults (18+ years, QoF) by GP practices in Bexley, 2020/21
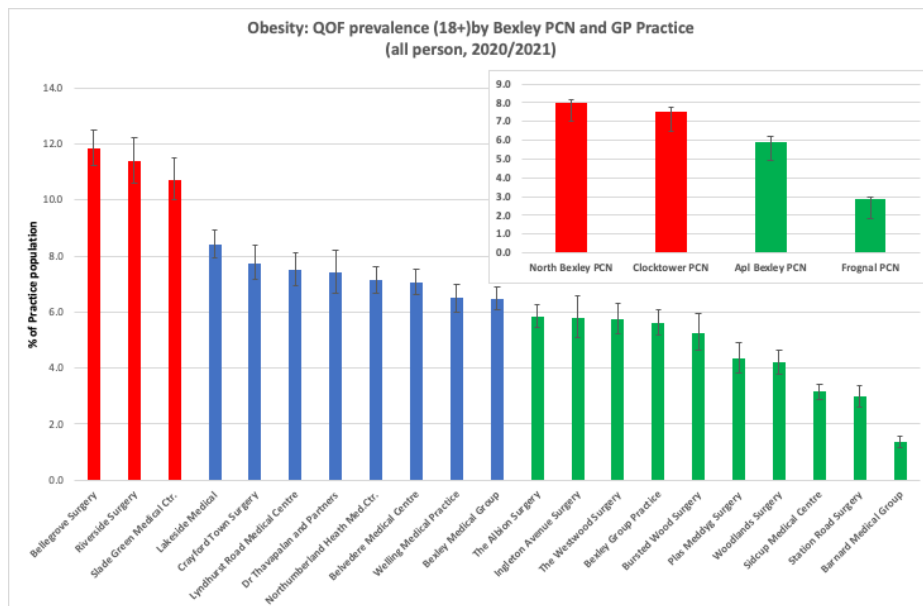
Data Source: Office for Health Improvement and Disparities, Public Health Outcomes Framework, Public Health Outcomes Framework - Data - OHID (phe.org.uk)

Recorded obesity by ethnicity

Figure 63 shows recorded obesity (BMI $\geq$ 30 kg/m^2) levels for the 18+year age group by ethnicity in the Bexley registered population. Black African/Caribbean communities had the highest obesity level whereas British White and Asian and mixed communities are lower. This is similar to the national overweight and obesity levels by ethnicity.

Figure 63: Recorded obesity rates (%) by ethnicity in Bexley GP practices, Bexley

---

[43] NHS Health Survey of England 2018 http://healthsurvey.hscic.gov.uk/support-guidance/public-health/health-survey-for-england-2019.aspx
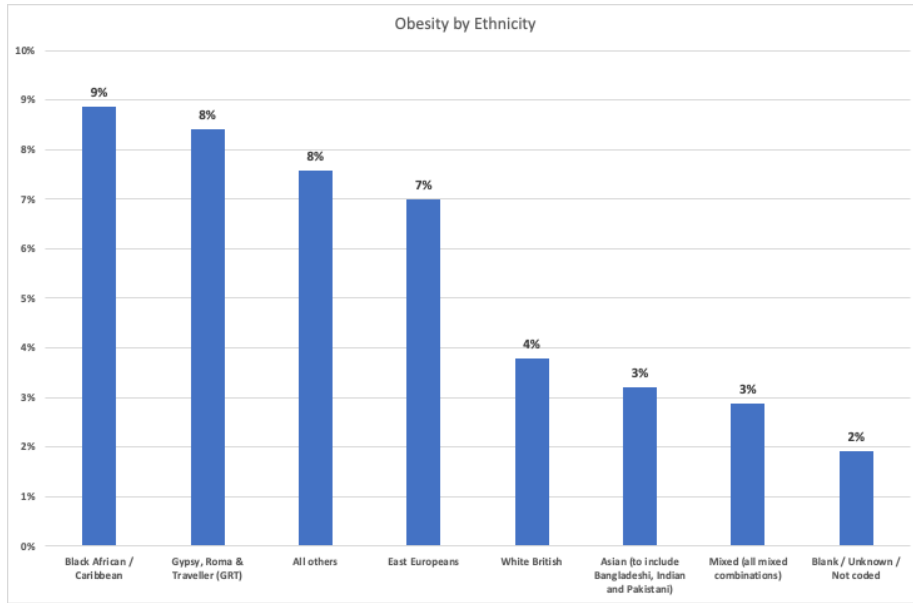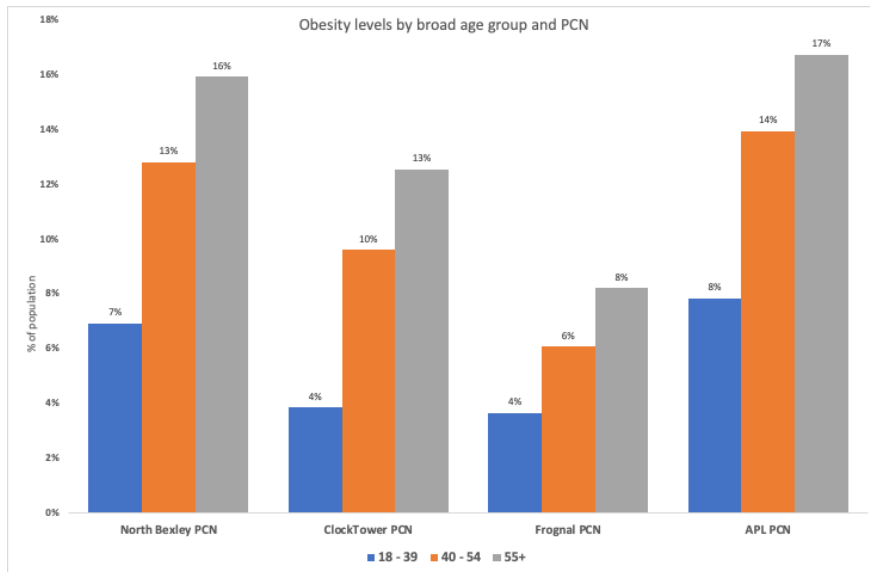
Data Source: South East London CCG

Figure 64 shows that the recorded obesity levels are higher in the 55+ years group. The Health Survey of England found overweight rates were highest in the 55-64 and 65 -74 year age group for men and women, respectively. Obesity rates were highest in the 45-55 age group for men and 55-64 years in men.
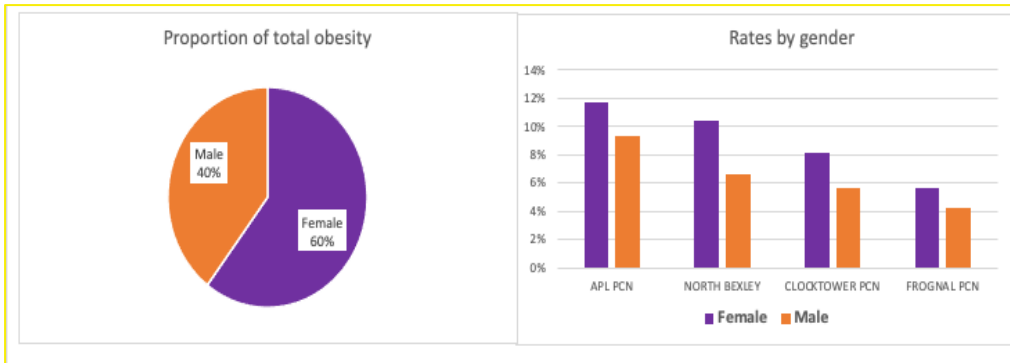
Figure 64: Recorded obesity levels by age groups and PCN, Bexley

Data Source: South East London CCG

Figure 65 shows the recorded levels of obesity by gender. 60% of the obesity records were for women. The rates by gender by PCN shows all PCNs had higher rates in women compared with men.

**Figure 65: Recorded obesity by gender and PCN, Bexley**

Data Source: South East London CCG

Obesity in early pregnancy

Mothers who are overweight or obese have increased risk of complications during pregnancy and birth including diabetes, thromboembolism, miscarriage and maternal death. Babies born to obese women have a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity. Figure 66 shows obesity in early pregnancy assessed at time of booking in London boroughs. London had significantly lower rates (17%) compared to national rates (22%). The rates in Bexley were similar to national rates but significantly higher than London.

**Figure 66: Percentage obese in early pregnancy by London borough, 2018/2019**
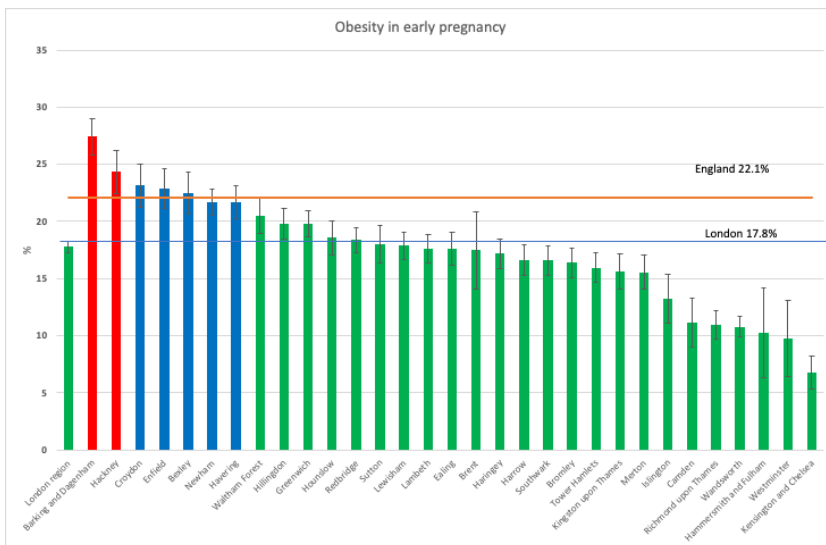
Data source: Office for Health Improvement and Disparities, Public Health Outcomes Framework, Public health profiles - OHID (phe.org.uk)

Figure 67 shows the rates by recorded ethnicity in data from the Lewisham maternity unit for women resident in Bexley that were assessed as obese at maternity booking. Most of the ethnicity recorded in this data was "Other". The largest proportion of adult maternity bookings who had a BMI greater than 30 were aged between 25 and 34 years. For those aged between 25 and 29, 29% were Asian, whereas in those mothers

aged 30-34, 36% identified as of black ethnic origin.

Figure 67: Adult maternity (aged 18+) bookings with a BMI greater than 30 by ethnicity and age group, Lewisham Maternity Unit, 2020

Adult maternity bookings with a BMI >30 by ethnicity and age group, 2020
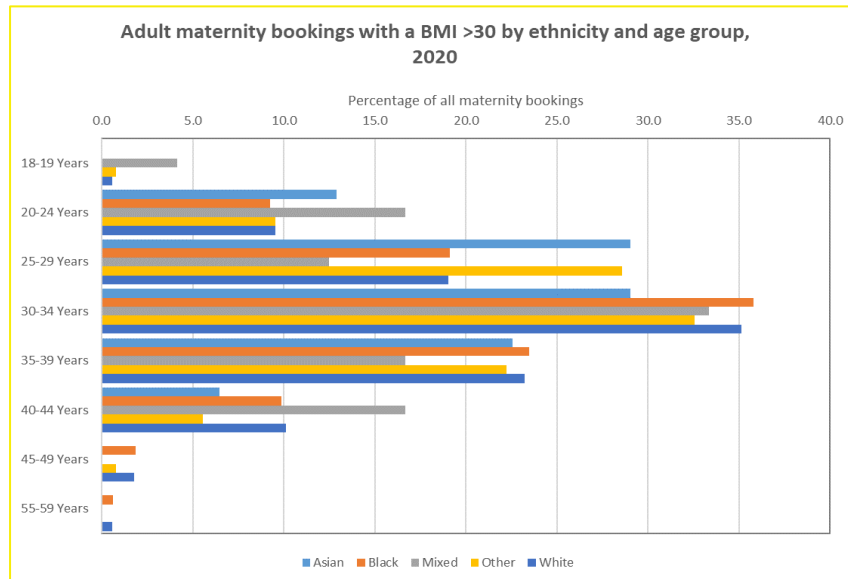
Source: Data provided by LGT

Evidence based interventions

NICE has 11 published guidance on obesity covering topics from prevention to treatment of severe obesity.

Public Health Guidance

Obesity: working with local communities (PH42)

- Weight management: lifestyle services for overweight or obese adults (PH53)
- Weight management: lifestyle services for overweight or obese children and young people (PH47)
- BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (PH46)
- Obesity prevention (CG43)
- Preventing excess weight gain (NG7)
- Maternal and child nutrition (PH11)
- Weight management before, during and after pregnancy (PH27)

Clinical guidance for NHS clinicians

- Obesity prevention (CG43)
- Preventing excess weight gain (NG7)
- Obesity: identification, assessment and management (CG189)

- Naltrexone–bupropion for managing overweight and obesity (TA494)
- Single-anastomosis duodeno-ileal bypass with sleeve gastrectomy for treating morbid obesity (IPG569)
- Implantation of a duodenal–jejunal bypass sleeve for managing obesity (IPG471)
- Laparoscopic gastric plication for the treatment of severe obesity (IPG432)

Obesity strategy for Bexley (2020-2025)

Bexley obesity prevention strategy's vision [44] is to create a local environment that supports everyone to have a healthy weight, to halt the rise of excess weight among children and adults and create a downward trajectory by 2025. It aims to develop and implement a whole system which:

- reduces the rate of excess weight in children by a minimum of 2%, with a stretch target of 5%
- reduces the level of excess weight in adults by a minimum of 2%, with a stretch target of 5%
- creates healthy environments at school, in workplaces and throughout the Borough

It plans to deliver this through:

- Increasing the availability of healthier foods
- Creating an environment that inspires physical activity
- Recognising the links between Obesity and Mental Health
- Supporting a healthy lifestyle through good livelihoods
- Equipping the workforce to contribute to the Obesity agenda
- Embedding Healthy Lifestyles across agendas
- Providing quality services that support weight management
- Communicating core and targeted Healthy Lifestyles messages

Service provision in Bexley

There are three Tier 2 Adult weight management services. The Slimming World service funded through the public health grant since 2018 until 30th Sept 2022. In 2021, two additional services have been funded through an Office of Health Improvement and Disparities (OHID) grant as twelve-month pilots delivered by Counterweight and Momenta Newcastle. The two pilots are commissioned to offer targeted interventions towards certain groups.

---

[44] Bexley Obesity Strategy "Creating a whole systems approach to tackle obesity 2020-2025"; Bexley Clinical Commissioning Group; https://www.bexley.gov.uk/services/health-and-social-care/bexleys-public-health/bexley-obesity-strategy

Impact of COVID on the services

Slimming World were relatively quick to respond during the pandemic, regularly communicating with the commissioner and their members about progress. Self-referral was introduced in January 2021 in response to the low uptake and to ease pressure off primary care. This has resulted in an increase in referrals and making it as easy as possible for people to self-refer has helped. There are gaps and areas for improvements in relation to male uptake, people from non-white groups and deprived areas.

Slimming World service has been successful in achieving weight loss and encouraging participants to complete the intervention with a 73% completetion rate, 68% achieving weight loss of 3% and 46% achieving 5% weight loss. There is a good spread of groups across the borough. Between April to June 2020, the Slimming World service had to close face-to-face groups and moved to setting up virtual groups. During this period there were no new referrals. Once virtual groups commenced there was a decline in referrals compared to the same time last year and overall referrals were slow to increase, even once some groups returned to face-to-face. It was reported that some of the challenges during COVID were due to some people waiting for face-to-face groups to resume, adapting to changes to service delivery, COVID-related issues and requiring GP referral.

## Slimming World Weight Management Programme

Slimming World groups are available to all people up and down the country who are looking for a weekly weight management club to attend. These are run by trained Slimming World Consultants and meetings happen a weekly basis, supporting members with their weight goals.

There are 26 Slimming World groups held across Bexley, in 14 different areas of the Borough.

The number of attendances to Bexley Slimming World groups was at its highest in 2016/17 (n=1,678), before it dropped to a low of 502 in 2018//19. Since the pandemic restrictions have been lifted, we can see an increase in the number attendances to 1,603 in 2021/22.

Profile of service users

Figure 68: Bexley Slimming World Attendances by year, 2016-2022

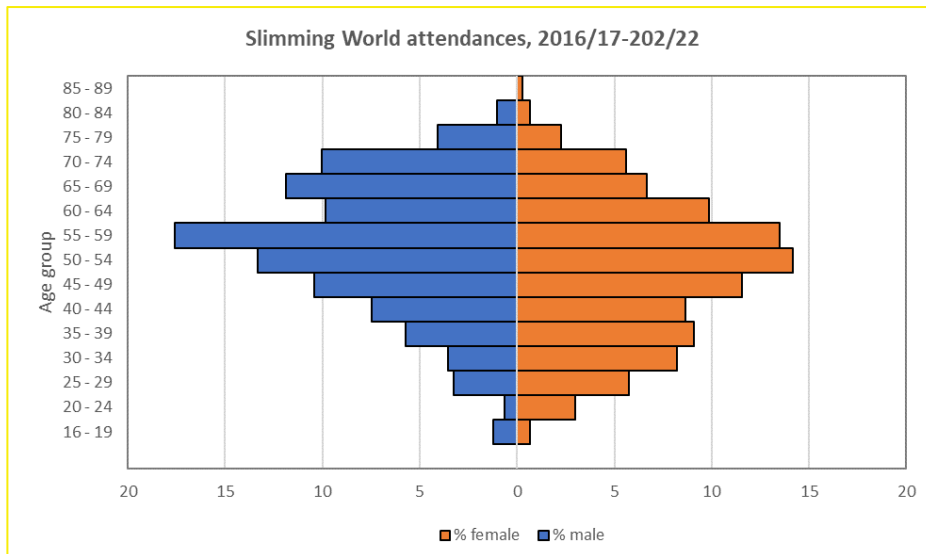**Bexley Slimming World Attendances**
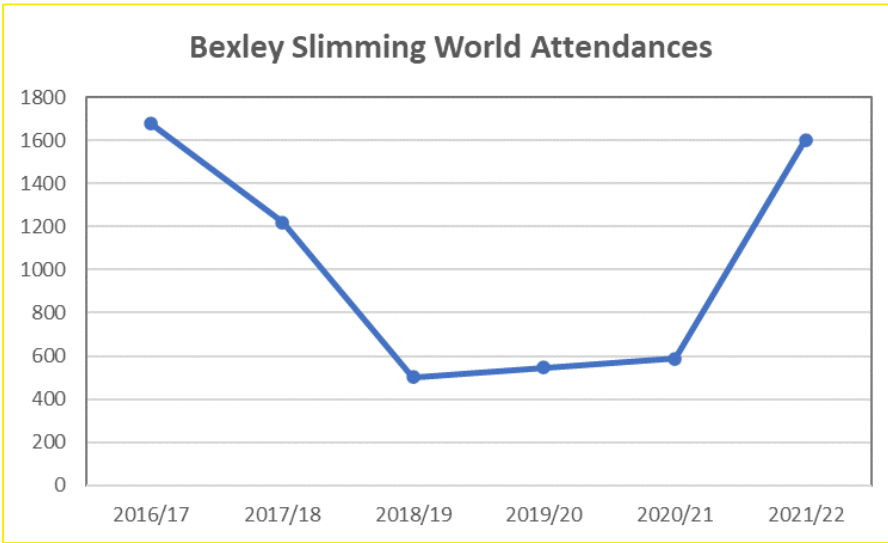
Source: Slimming World

Attendance by age for males and females

The population pyramid below shows the split of male and female slimming world members and by age group. The data is first split by gender and then the percentages reflect each age group for that gender. Hence age pyramids for each gender should be read separtaely for example males aged 55-59 are the highest attenders from males whilst for females 50-54 age group. Wihin males more males aged 65-79 years are attending compared with 30-39 years. Within females more females aged 30-44 years are atending compared with 65-74 years females.

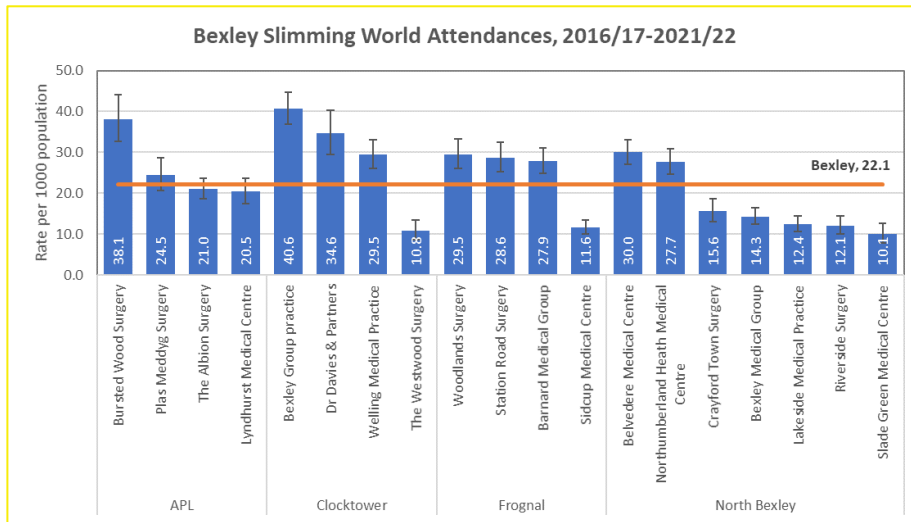**Figure 69: Bexley Slimming World Attendances by age and gender, 2016-2022**

Slimming World attendances, 2016/17-202/22

Source: Slimming World

Attendance by gender

87% of all Slimming World group attendances have been made by women (13% men). Women members tend to range from their 30s with more women in their 50s and early 60s whereas compared to the men, there is a higher propotion of 55-59 year olds and more older males.

Figure 70: Bexley Slimming World Attendances per 100,000 by GP Practice, Bexley, 2016-2022

Source: Slimming World

Attendance by ethnicity

85% of Bexley's Slimming World members were recorded as White British with 3.1% recorded as Black or Black British African and 2.3% recorded as any other white background. The rest of the cohort were very small proportions of less than 1%.

Physical activity in adults

Physical activity and health

Physical activity benefits healtl, improves sleep, maintains healthy weight, manages stress, improves quality of life.

Physical activity reduces your chance of:

- type 2 diabetes by up to 40%
- cardiovascular disease by up to 35%
- falls and depression by up to 30%
- joint and back pain by up to 25%
- cancers (colon and breast) by up to 20%

How much physical activity?

Type and duration of physical activity impacts the health benefits offered. Physical activites can be broken down to the following core aspects:

Be active – at least 150 minutes of moderate intensity per week (increased breathing and able to talk) or at least 75 minutes of vigorous intensity per week (breathing fast and difficulty talking), or a combination of both.

Examples of moderate intensity activity are swimming, brisk walking, cycling

Examples of vigorous intensity activity are running, climbing stairs, sport

Build strength-To keep muscles, bones and joints strong, build strength on at least 2 days a week. Examples of bone and muscle strengthening activities are carrying heavy bags, gym, yoga

Minimise sedentary time by breaking up periods of inactivity.

Balance activities for older adults

For older adults, to reduce the chance of frailty and falls, improve balance 2 days a week. Examples of balance activities are dancing, bowls and Tai Chi

Physical activity in adults in Bexley

Figure 71 shows the percentage of adults who were physcally active (self-reported). At baseline Bexley had similar levels to regional and national levels. which then increased to 72% in 2018/2019 which was the highest year. In the most recent year it has decreased below the national and regional levels.

Figure 72 shows percentage of adults that are physically active in London boroughs. Bexley, along with Havering, is within the ten boroughs which have significantly lower levels of adults that are physically active.
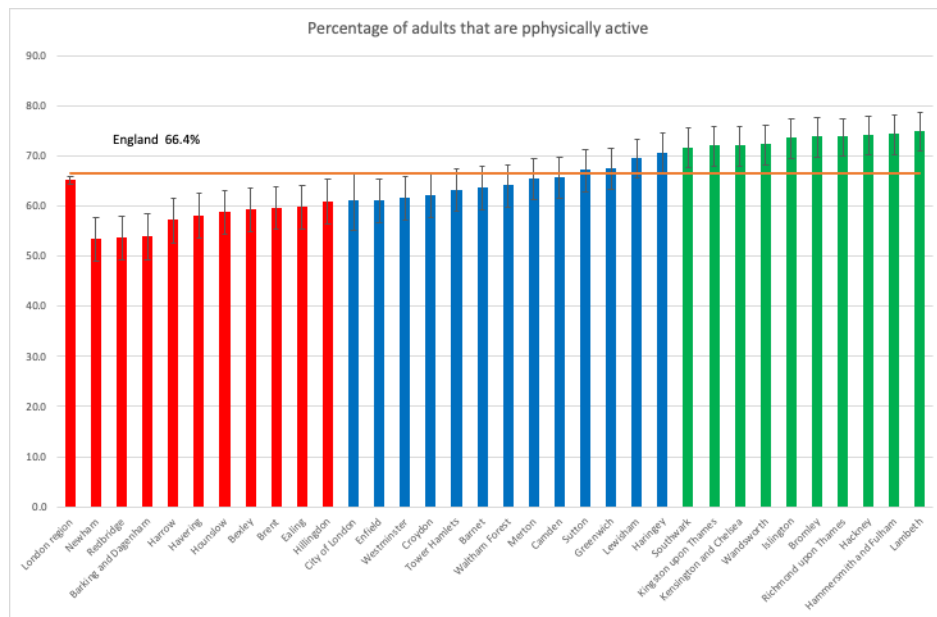
Figure 71 Percentage of adults reporting being physically active by year and location (Bexley, London, England), 2015-2020
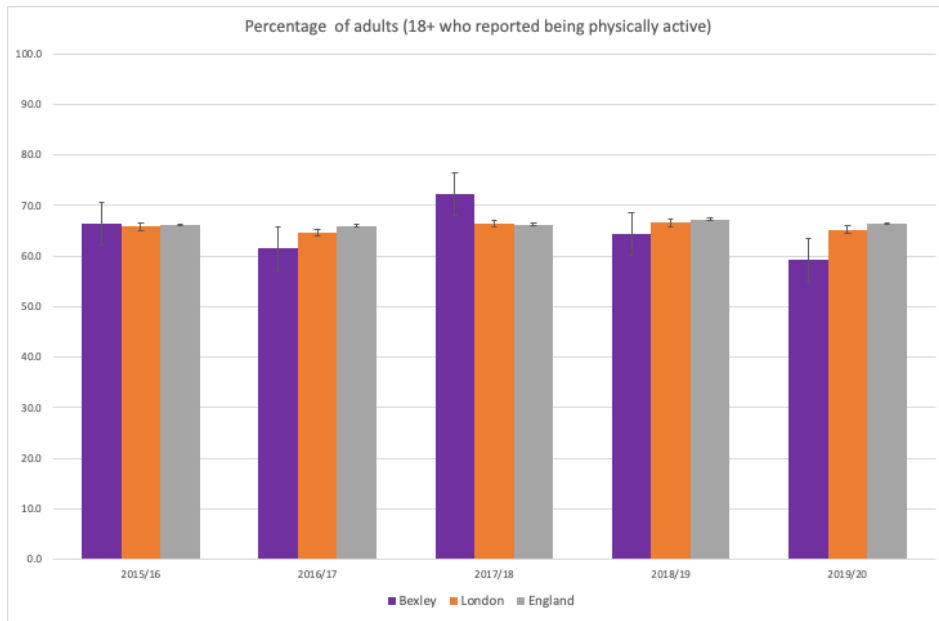
Data source : Office for Heatlh Improvement and Disparities, Public Health Outcomes Framework, Public Health Outcomes Framework - Data - OHID (phe.org.uk)

Figure 72: Percentage of adults that are physically active by London boroughs

Data source : Office for Heatlh Improvement and Disparities, Public Health Outcomes Framework, Public Health Outcomes Framework - Data - OHID (phe.org.uk)

Only about half of the adults in Bexley meet the 'five a day' fruit and vegetable recommendation. This is similar to the England average and most of the London boroughs.

Comparing Bexley to the comparators outside London, Bexley is similar to Thurrock for both adults that are physically active and for the five a day recommendation.

Medway has a higher proportion of adults meeting the 'five a day' recommendation.

Evidence based interventions for increasing physical activity

NICE guidance on physical activity includes recommendations to increase physical activity

- Physical activity and the environment (NG90)
- Physical activity: exercise referral schemes (PH54)
- Physical activity: brief advice for adults in primary care (PH44)
- Physical activity: walking and cycling (PH41)

Provision of sports and fitness, parks and green and open space in Bexley

Sports and fitness

There is good provision of parks and open space, sports and fitness services[45] in Bexley which aim to support the population to keep active with sport and fitness activities and achieve a positive impact on population physical health and wellbeing.

Mind in Bexley[46] also provide advice and links to help support physical and mental health.

The 2008 Local development framework recognised the importance of green and open spaces to population health and wellbeing. The technical analyses for the LDF drew the following conclusions:

Parks and gardens

- Parks in Bexley are multifaceted and provide a range of opportunities for residents. Their diverse nature is integral to the character of the Borough and larger parks have received significant investment in recent years and are of award-winning quality. Local parks are important to residents in the Borough and are perceived to be of lower quality, providing a poor range of facilities and are less well maintained. Future efforts should focus on qualitative enhancements to smaller sites.
- Parks provide opportunities to participate in moderate exercise and physical activity. Shortfalls in these areas also raise the importance of increasing access to the marshes in order to ensure that residents have access to informal

---

[45] "Sport and Fitness around Bexley"; https://www.bexley.gov.uk/services/parks-leisure-and-libraries/sport-and-fitness

[46] "Top tips and links to help support your physical and mental health"; MIND in Bexley; https://mindinbexley.org.uk/physical-activity

recreational opportunities.

- Many parks in the Borough are surrounded by housing development and therefore lack connectivity to other open spaces and to the wider area that they serve. Linkages to other areas would maximise the benefits of these sites and facilitate the effective management and marketing of parks. The draft Public Rights of Way Access and Improvement Plan also seeks to address these issues.

- New parks should be designed to maximise the integration of the facility with the local community and other open spaces and landlocking should be avoided.

Natural and semi-natural open space

- Despite the urban character of the Borough, Bexley has significant quantities of natural and semi-natural open space. This is enhanced by the presence of seminatural areas within many of the Borough's larger parks. Large natural areas such as the Crayford and Erith Marshes provide a variety of habitats for wildlife as well as opportunities for recreation.

- Maintaining a balance between recreation and biodiversity is seen as a key challenge going forward. Facilitating access to existing natural and semi-natural open spaces and developing links between current sites is as important as providing local natural and semi-natural open spaces. Green corridors are therefore of significant importance, even where there is no public access as plants and animals still need to move from site to site to maintain genetic diversity.

- Maximising access to natural open space in Welling, Bexleyheath and Sidcup is seen as a key challenge over the LDF period and the provision of semi-natural areas within parks is encouraged. The draft Public Rights of Way Access and Improvement Plan also seeks to address these issues.

10. Hypertension

Chapter Summary

<div style="border:1px solid black; padding:10px;">

Key messages

- **Recognising and treating hypertension significantly improves cardiovascular outcomes**
- **Black ethnic communities have a higher-than-average incidence of mortality from hypertension and stroke.**
- **Black ethnic communities with hypertension are also noted to have strokes at a younger age.**
- **To address significant health consequences due to uncontrolled hypertension, there are several hypertension related indicators in GP contracts.**

</div>

London priorities on hypertension

Prevention of cardiovascular disease is a key priority in London[47]. However, many adults living with Atrial Fibrillation (AF), hypertension (HTN) and Familial Hypercholesterolaemia (FH) remain undiagnosed. Without detection and medicine management, these conditions can increase the risk of having a stroke or heart attack, leading to higher mortality rates or greater disability. Ambitions for improving the detection and treatment of the 3 high risk conditions have been set nationally.

The Cardiovascular Disease (CVD) vision for London has been drafted by local system partners. Our regional data has been used to make sure the CVD ambition for London is aspirational but also achievable and clinically credible.

The proposed CVD vision and ambition for London state that by 2023 we would:

- Save an additional 400 lives each year by reducing the number of heart attacks and strokes.

- Empower Londoners to take control of their circulatory health.

- Work together with all our system partners to find and optimally treat Londoners with any of the three high risk conditions (high blood pressure, high cholesterol and atrial fibrillation).

---

[47] Cardiovascular Disease Prevention Partnership Resource Pack; NHS England and NHS Improvement London; https://www.england.nhs.uk/london/london-clinical-networks/our-networks/cardiac/cardiovascular-disease-prevention-partnership-resource-pack/

Pan London ambitions are to:

- Detect 80% of expected population with hypertension.

- Protect 80 % of all people with known hypertension by controlling BP to 140/90mmHg.

NICE clinical guidelines for hypertension

NICE guideline [NG136] Hypertension in adults: diagnosis and management recommends:

- diagnosing hypertension
- starting antihypertensive drug treatment
- monitoring treatment and blood pressure targets
- choosing antihypertensive drug treatment (treatment steps 1 to 4)
- measuring blood pressure
- assessing cardiovascular risk and target organ damage
- lifestyle interventions

Hypertension and GP contracts

Hypertension is a common medical condition which is largely managed in primary care and represents a significant workload for GPs and the primary care team. Trials of anti-hypertensive treatment have confirmed a significant reduction in the incidence of stroke and chronic heart disease (CHD) in patients with treated hypertension. Quality and Outcomes Framework (QOF) of the General Medical Services (GMS) contract has a number of hypertension related indicators.

A review[48] of QoF registers at GP practice found that hypertension ranges between 18.8% and 31%, excluding the highest and lowest 10% of practices. It also suggested that approximately 68% of the estimated number of people with hypertension are recorded on GP QOF hypertension registers.

Trends in hypertension by PCN

Figure 73 shows the trends in QoF registers of hypertension in Bexley PCNs compared with South East London CCG. APL, ClockTower and Frognal PCN all have higher rates (crude rates). Frognal PCN has seen a decrease in the register whilst North Bexley PCN an increase.

Figure 74 shows the hypertension QoF risk register for GP practices and the PCNs. There is similar variation with seven practices having registers that have higher

---

[48] "Hypertension prevalence estimates in England, 2017"; Public Health England; Hypertension prevalence estimates in England, 2017 (publishing.service.gov.uk)

proportions compared with England. It is important to note that these are crude rates so will also depend on the age profile of the practice population. However, the population aged 65 years and above are 12.5% in North Bexley PCN; 17.1% in Clocktower PCN ; 20% in Frognal PCN and 20.8% in Apl Bexley PCN. From national data we know that Black ethnic communities have higher-than-average incidence of and mortality from hypertension and stroke, and they have strokes at a younger age.

Figure 73: Trends in QoF registers of Hypertension
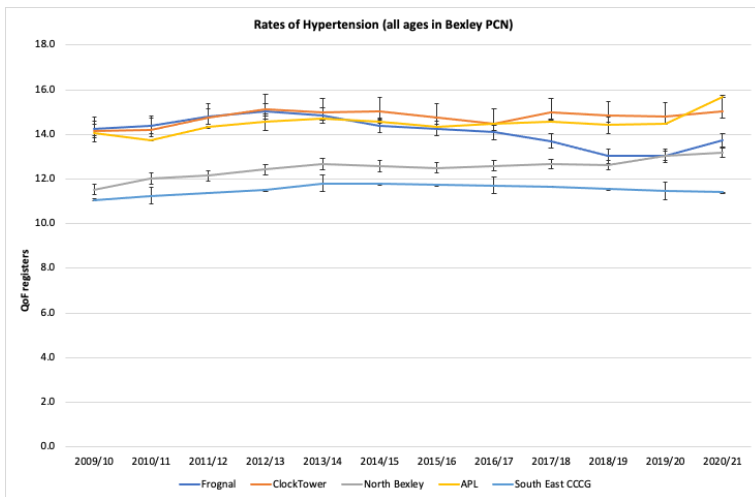
Data Source: Office for Health Improvement and Disparities, Public Health Outcomes Framework
Public health profiles - OHID (phe.org.uk)

Figure 74: QOF prevalence of registered patients with hypertension by Bexley GP Practices, Bexley, 2020/21
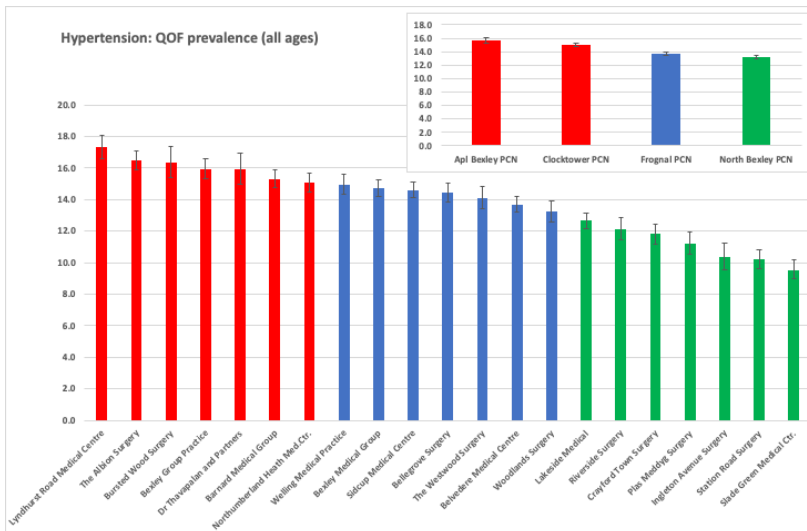
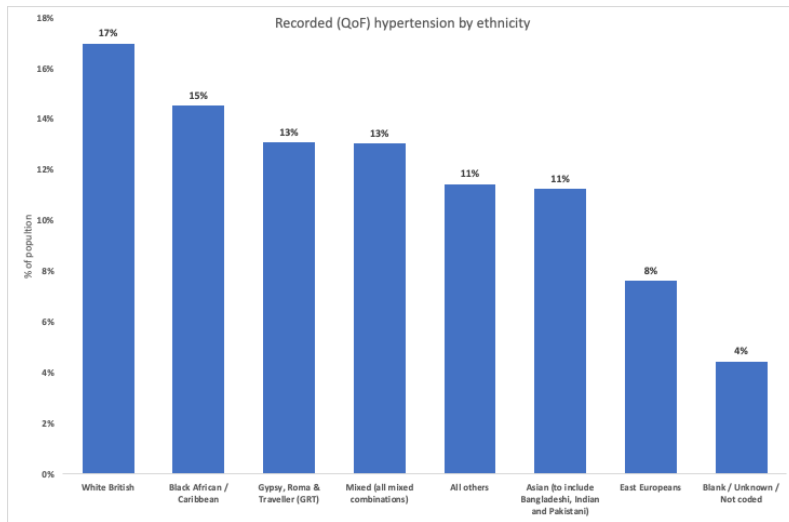**Data Source: Office for Health Improvement and Disparities, Public Health Outcomes Framework**
Public health profiles - OHID (phe.org.uk)

Hypertension records by ethnicity

Figure 75 shows the recorded crude levels of hypertension by ethnicity. White British

had the highest hypertension. The hypertension levels were similar in all PCNs.

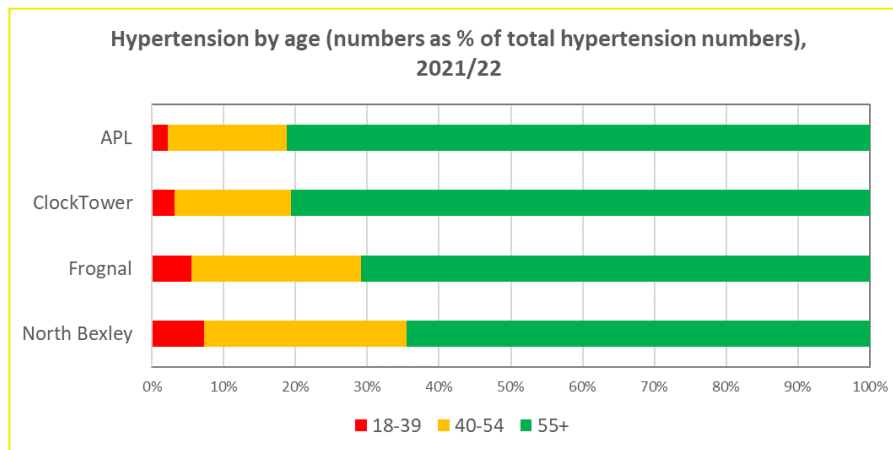**Figure 75: Recorded hypertension by ethnicity for registered population in Bexley**

Data Source: South East London CCG

Hypertension records by age

Across all four PCNs, the proportion of 55-year-olds and older with hypertension is higher than those aged 18-39 and 40-54.

Figure 76: Hypertension by age group (aged 18+) by Bexley PCN, 2021-2022

Source: NHS South East London CCG

Figure 77: Percentage of patients (<80 years of age with hypertension) in the last 12 months with blood pressure<=140/90mmHg by Bexley PCNs, 2020-2021
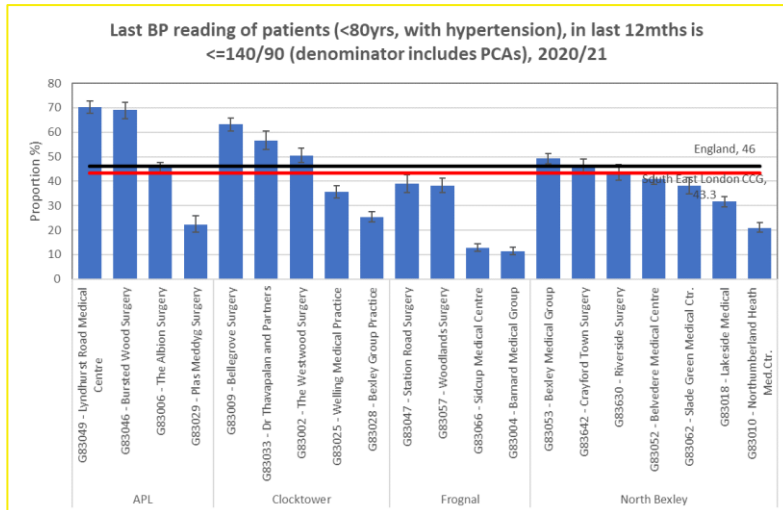
Source: Office for Health Improvement and Disparities, Public Health Profiles, Public health profiles - OHID (phe.org.uk)

This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years and under. It aims to promote the primary and secondary prevention of cardiovascular disease through satisfactory blood pressure control. The intermediate outcome can be achieved through lifestyle advice or drug therapy.

11. Mental health and health inequalities

Chapter Summary

<div>

Key messages

- About 16% of the Bexley adult population were estimated to common mental health problem in 2017.
- Recorded prevalence in GP practices was about 11% with a variation ranging from 15% to low of 2%.
- Excess percentage mortality rate n people with serious mental illness has increased from baseline of 400 of 2015-2017 to 500 in 2018-2019.
- The main causes for excess mortality are liver diseases, respiratory disease and cardiovascular disease.
- Smoking prevalence in people with mental health problems is estimated to be 5%.
- Referrals to the IAPT services were highest in 2018/19 after which there was a decrease with lowest referrals in 2020/21.
- More than half of the referrals (56%) were in the age group 18-39 age group of which 72% were females.
- 19% of referrals had disability with the largest proportion having learning disability and mobility issues.
- Patients requiring specialist care has been steadily increasing although inpatient admissions have been decreasing. Proportion of females is higher than males.
- A higher proportion of clients accessing specialist services are from the more deprived areas of North. Highest proportion are in the older age group.

Key recommendation

- A three-year action plan to reduce health inequalities in people with mental illness should be developed by March 2023 by public health working with providers and service users.

</div>

People with mental health conditions have poor health outcomes. Whilst nationally investment in mental health services is increasing, the reasons for much of the health inequalities faced by people with mental health conditions can be explained by the wider determinants of health and inequity to access to health care.

Impact of COVID on mental health -national data

The report[49] on COVID 19 mental health and wellbeing surveillance concluded that multiple studies found:

- deteriorations in mental health and wellbeing between March and May 2020,
- improvement through July, August and September 2020 to a point where levels were comparable to before the pandemic.
- second deterioration in population mental health and wellbeing between October 2020 and February 2021,
- improved back to pre-pandemic levels through August, September and October 2021.
- some evidence of deterioration in the population mental health and wellbeing around the Christmas period in 2021.

Evidence shows that the mental health and wellbeing impact of the COVID-19 pandemic has been different for different groups of people. The groups that were more affected were:

- women,
- young adults (aged between 18 and 34),
- adults with pre-existing mental or physical health conditions,
- adults experiencing loss of income or employment,
- adults in deprived neighbourhoods,
- some ethnic minority populations,

Prevalence of mental health illness in Bexley

The OHID mental health and wellbeing JSNA[50] for Bexley provides the following estimates for mental illness in adults

- In 2017, there were an estimated 31250 people with common mental health disorders which is 16.0% of 16+ population
- In 2017, the estimated prevalence of common mental health disorders in 65+ population was 9.6% (3900 people)
- In 2020/21 the incidence of depression in 18+ population according to QoF data was 1.4% which is about 2600 new cases
- In 2020/21, the prevalence of depression in 18+ population according to QoF was 11.1% which is about 21130 cases

---

[49] "COVID 19 Mental Health and Welbeing surveillance: report"; Office for Health Improvement and Disparities; (April 2022) https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report

[50] "Mental Health and Welbeing JSNA"; Office for Health Improvement and Disparities; https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna

Variation in recorded depression by GP practice

Figure 78 provides the crude prevalence of depression by GP practice compared with England. All PCNs have overall lower rates compared with England.
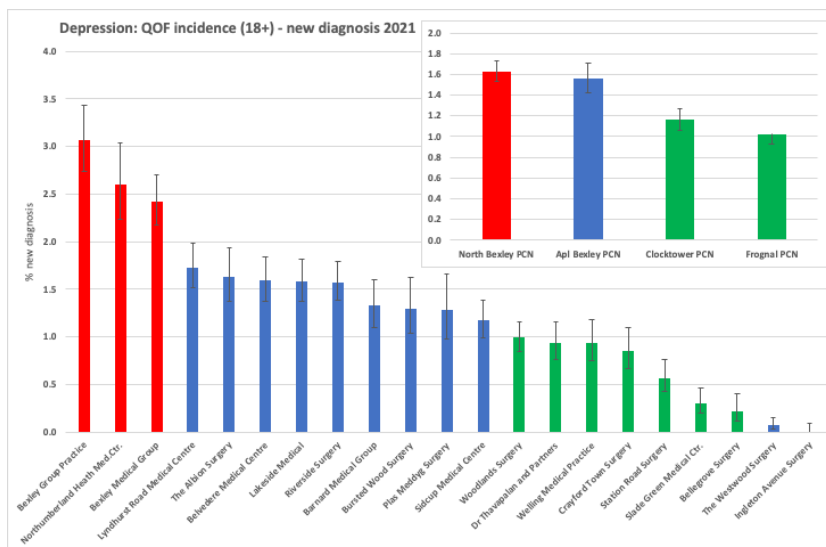
Figure 78: Prevalence of depression by Bexley GP Practices, Bexley, 2020-2021
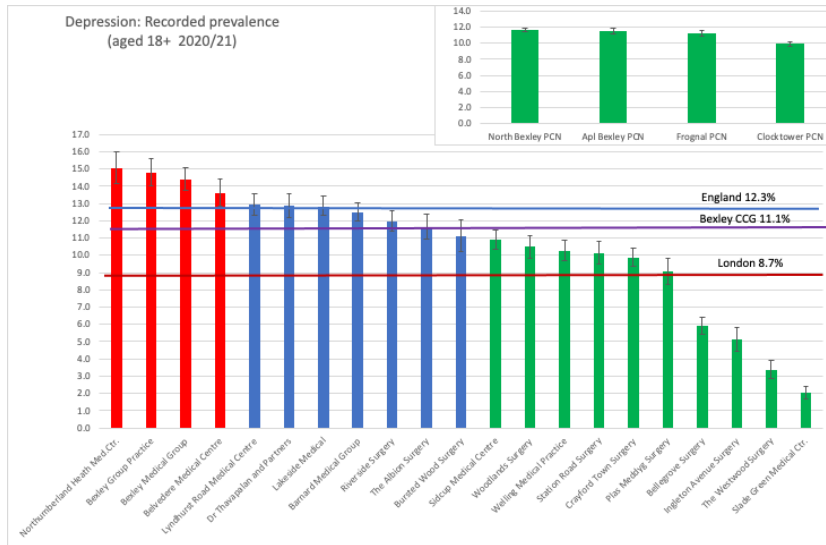
Data Source: Office for Health Improvement and Disparities, Public Health Profiles Public health profiles - OHID (phe.org.uk)

Figure 79 shows that incidence in North Bexley PCN is higher than the national rate.

Figure 79: Percentages of newly diagnosed depression by GP Practices in Bexley, 2021
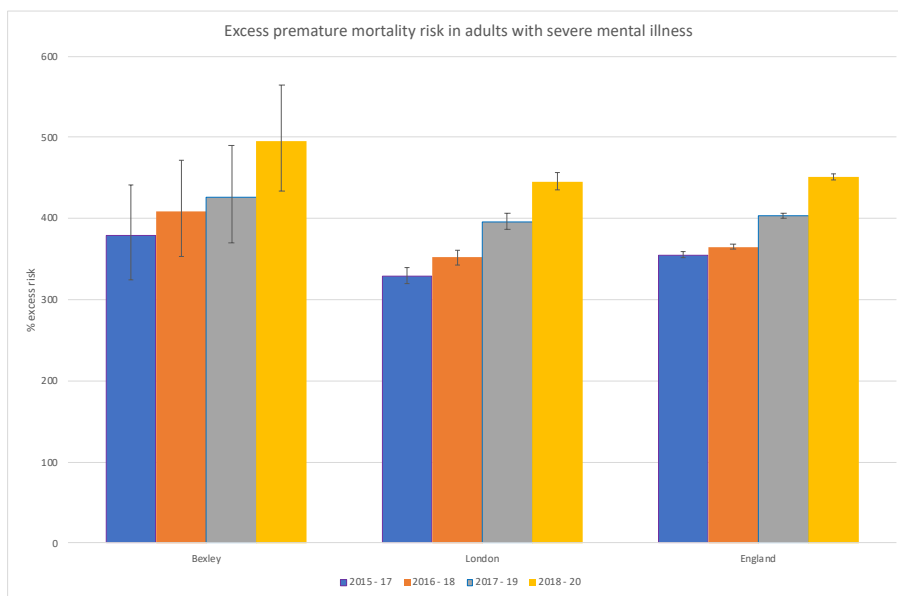

Data Source: Office for Health Improvement and Disparities, Public Health Profiles Public health profiles - OHID (phe.org.uk)

Mental health inequalities in Bexley

Figure 80 shows the trend in excess risk[51] (%) for people under 75 years of age with severe mental illness in Bexley, London and England. Because of smaller numbers at borough level, 95% confidence intervals for Bexley are larger. However, regional and national data indicate that increased risk of premature mortality in people with severe mental illness has increased significantly from 2017. In Bexley in 2018-2020, the risk was 495 (433-565). In other words, the premature mortality in people with SMI is five times higher in people with SMI compared with people without SMI.

Figure 80: Percentage excess all cause mortality in adults (<75) with severe mental illness by location and year, 2015-2020
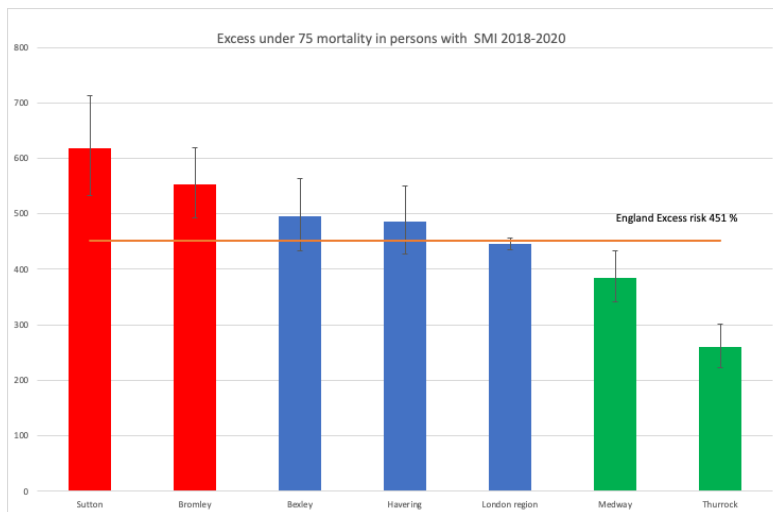

Data Source: Office for Health Improvement and Disparities, OHID Mental Health Inequalities Dashboard

Figure 81 shows the excess risk for under 75 mortality in Bexley comparator boroughs. In Bexley and Havering the risk is similar to the regional and national risk, but in Sutton and Bromley it is higher and in Medway and Thurrock it is significantly lower.

---

[51] This is a measure of excess premature mortality experienced by adults with SMI over adults without SMI. SMI is defined as having a referral to secondary mental health services in the five years preceding death.it is a ratio of directly standardised (DSR) premature mortality in people aged 18-75 years with SMI and DSR of premature mortality in people without SMI expressed as percentage.

Figure 81: Excess risk of under 75 mortality in people with severe mental illness by comparator London boroughs (2018-2020)

Data Source: Office for Health Improvement and Disparities, OHID Mental Health Inequalities Dashboard

Table 2 shows key causes of excess mortality in people with mental illness in Bexley. These are: liver disease (similar to England but higher than London), respiratory disease and cardiovascular disease which are similar to London and England.

Table 2: Excess under 75 mortality risk (%) by cause of death in people with SMI

Excess mortality by cause	Bexley	London	England
Excess under 75 mortality rate in adults with severe mental illness (SMI) (2018-2020)	494.9	445.0	451
Excess under 75 mortality rate due to cancer in adults with severe mental illness (SMI) (2016-2018)	109.4	119.7	112.6
Excess under 75 mortality rate due to cardiovascular disease in adults with severe mental illness (SMI) (2016-2018)	385.0	318.8	318.8
Excess under 75 mortality rate due to liver disease in adults with severe mental illness (SMI) (2016-2018)	657.8	474.1	541.1
Excess under 75 mortality rate due to respiratory disease in adults with severe mental illness (SMI) (2016-2018)	553.8	530.0	520

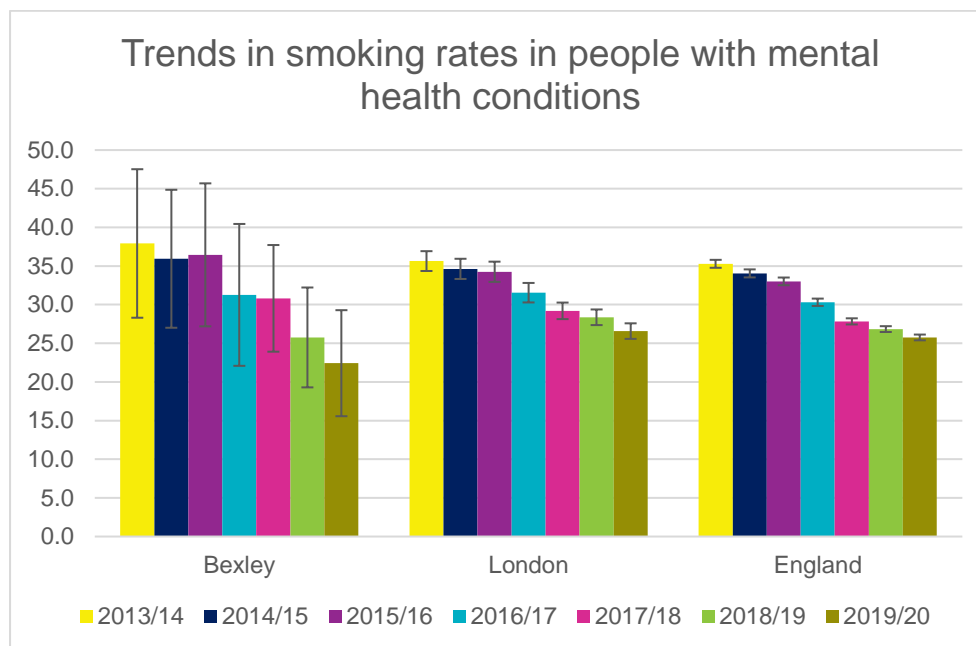Date source: Office for Health Improvement and Disparities, OHID Mental Health Inequalities Dashboard

Modifiable risk factors in people living with mental illness

Smoking, alcohol and obesity are all modifiable risk factors for the three causes which are the key causes of under 75 years excess deaths in people with mental health

conditions. CVD and respiratory diseases are all a cause of deprivation related health inequalities described previously.

Figure 82 shows smoking rates in people with long term mental health conditions reported through the GP population survey. The 95% CI for local areas are larger but the trend is similar to that observed regionally and nationally. However, the rates are nearly twice that in the general population (which includes people with mental health conditions).

Figure 82: Smoking prevalence in adults with a long term mental health condition by Bexley, London, England populations and year, 2013-2020

Data Source: Office for Health Improvement and Disparities, OHID Mental Health Inequalities Dashboard

Inequalities in wider determinants and mental health

People with mental health problems face inequalities in housing, employment and education. Figure 83 shows number of people with long term mental health problems in stable accomodation.[52] There was a drop in 2016/17 but the proportion of people living in stable accommodation is increasing in Bexley and is significantly above regional and national levels.

At baseline 2011/12 the proportion in Bexley was 68% which was lower than the London rate of 71% but higher than England percentage of 55%. By 2020/21 Bexley had 79% living in stable accomodation where as in London it decreased to 61% and in England increased to 58%.

Figure 84 shows the trends in the gap in employment between those with long term

---

[52] Potentially data quality issues have been identified with the Adult Social Care Outcomes Framework. Future analysis will aim to utilise local data.

mental health problems and general population. In Bexley this gap has remained above the baseline of 64%. In London and England the gap increased from a baseline of about 60% to 68%.

Figure 83: Percentage of people in contact with mental health services living in stable accomodation by location and year. Bexley, London, England, 2011-2021
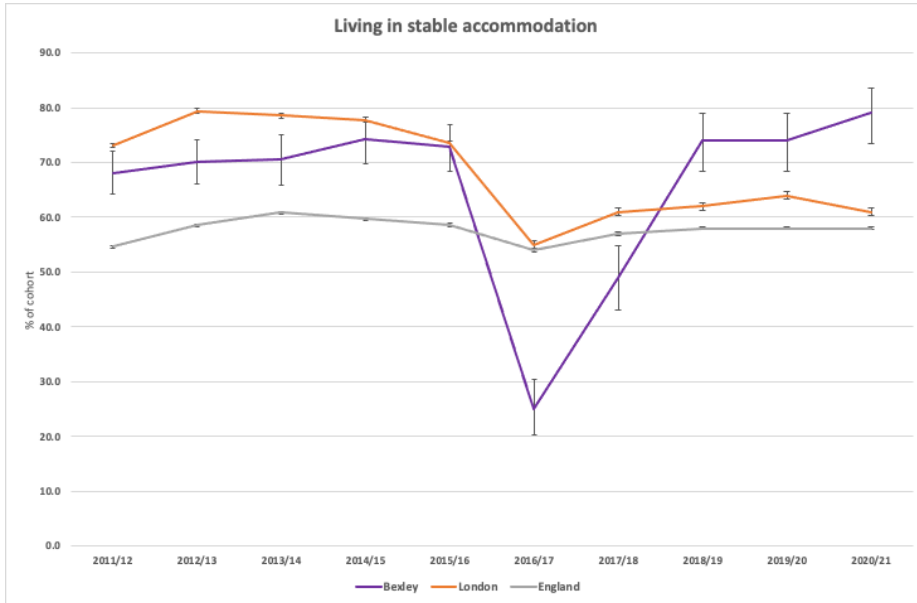
Data Source: Office for Health Improvement and Disparities, OHID Mental Health Inequalities Dashboard

Figure 84: Percentage difference in employment gap between people in contact with mental health services and overall employment rates by location and year. Bexley, London, England, 2011-2020
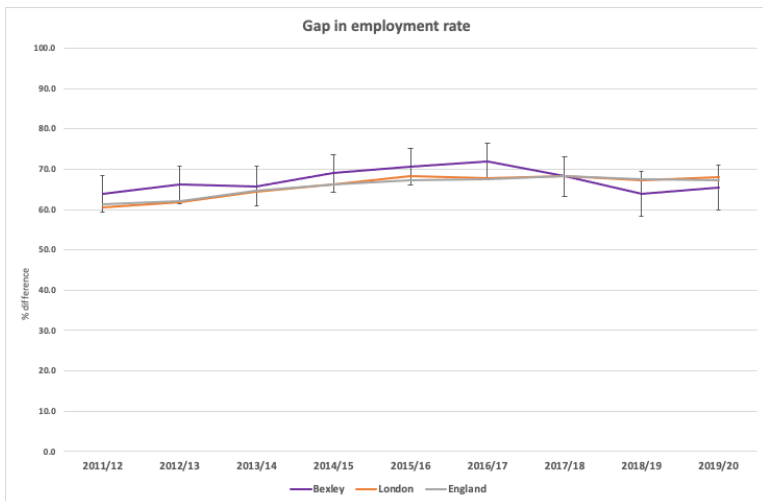
Data Source: Office for Health Improvement and Disparities OHID Mental Health Inequalities Dashboard

Evidence based Intervention

The Chief Medical Officer Annual Report for public mental health[53] called for focus on evidence-based interventions using the framework of:

- mental health promotion, which is primarily concerned with the determinants of mental health mental illness prevention, which is concerned with the causes of disease.
- treatment and recovery.

NICE guidance -some examples

- Mental wellbeing at work (NG212)
- Eating disorders: recognition and treatment (NG69)
- Antenatal and postnatal mental health: clinical management and service guidance (CG192)
- Decision-making and mental capacity (NG108)
- Mental health of adults in contact with the criminal justice system (NG66)
- Transition between inpatient mental health settings and community or care home settings (NG53)
- Workplace health: management practices (NG13)
- Older people: independence and mental wellbeing (NG32)
- Mental wellbeing in over 65s: occupational therapy and physical activity interventions (PH16)
- Common mental health problems: identification and pathways to care (CG123)
- Depression in adults: recognition and management (CG90)
- Depression in adults with a chronic physical health problem: recognition and management (CG91)

Service Provision in Bexley

Local residents are offered a range of mental Health and Wellbeing support services which are offered across the borough and are based on the need using GP population registers. There are some services that are shared with neighbouring boroughs too. The involvement of the voluntary sector to deliver services where appropriate has increased capacity as demand as grown and supported prevention to reduce the demand on secondary care and minimise the risk of people falling into crisis or requiring urgent referrals.

These services include:

- Prevention and Early Intervention Grants jointly funded by the council and CCG under the Better Care Fund. The Bexley Voluntary Services Council (BVSC) offers support services to all charities, community groups and social enterprise,

---

[53] Chief Medical Officer Annual Report for public mental health; Department of Health and Social Care; 2014 https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health

commissioned by the SELCCG and Bexley Council which runs until March 2025. This service is accessible to all residents and continues to offer vital help as community led interventions which enable early help and self-care to be promoted across the borough. These services also encourage peer support which has been beneficial during the pandemic when statutory services were running remotely or were limited.

- The Social Prescribing (Community Connect) commissioned by the SELCCG and Bexley Council is also delivered through BVSC from May 2017 to Sep 2022. This is open to all residents not just those requireing mental health services.

- Mind in Bexley runs the Improving Access to Psychological Therapies (IAPT) service offering evidence-based psychological therapies to all residents with depression and anxiety disorders, and comorbidities such as long-term physical health conditions (LTCs) or medically unexplained symptoms (MUS). It is NHS based, delivered under supervision by trained staff and integrated into clinical pathways as part of a national initiative and has run from Apr 17 to March 22 commissioned by SEL CCG.

- Oxleas NHS Foundation Trust (FT) delivers Secondary Mental Health Services to those who are referred from Tier 1 services. In addition, South London and Maudsley NHS FT also offer Specialist Mental Health Services. Both of these are commissioned by SEL CCG and Oxleas also receives funding from the council mental health social work grant.

- Recovery, Wellbeing and Employment Support is delivered through Mind in Bexley and the current two-year contract has run since April 2021 jointly commissioned by SEL CCG and the council.

- Mental Health Rehabilitation and Community Support is available from Choice Support since April 2020 and has been granted a 2 year extension beyond March 2023 and jointly funded by the council and SEL CCG.
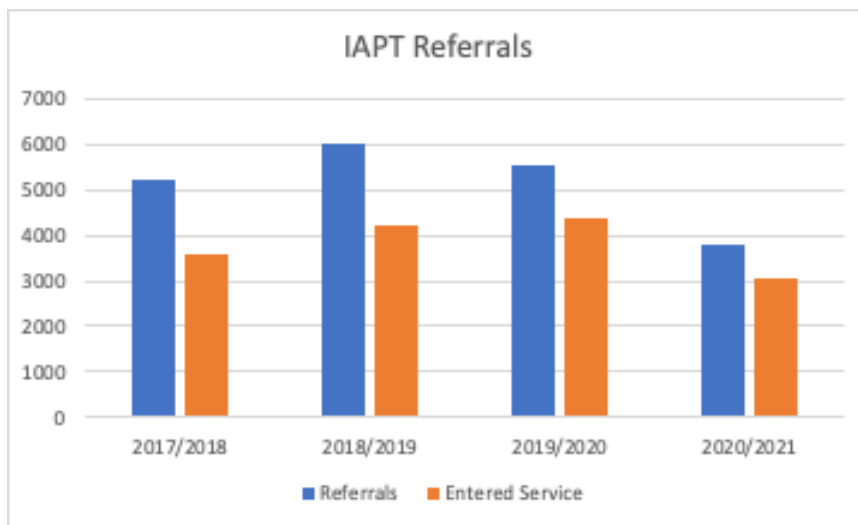
Services are monitored using national targets and local discretionary standards where applicable. Quality outcomes are also monitored including service user experiences. The Better Mental Health Fund is being reviewed as part of an evaluation to assess if these service offer value for money and reduce pressures on secondary care

Psychological Therapies

Trend in referrals to IAPT service

Figure 85 shows the referrals received (18+) in the last four years and persons entering the service. The highest number of referrals (5,980) were received the year prior to COVID (April 2018-March 2019). During the following two years of pandemic there were less referrals received, with 3,765 referrals received from April 2020-March 2021. The number of persons entering the service was highest in 2019/2020 at 4,350 and lowest in 2020/21 at 3,060.

Figure 85: Referrals to Improving Access to Psychological Therapies (IAPT) services by year, Bexley, 2017-2021

Data Source: NHS Digital, IAPT Annual report, https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services
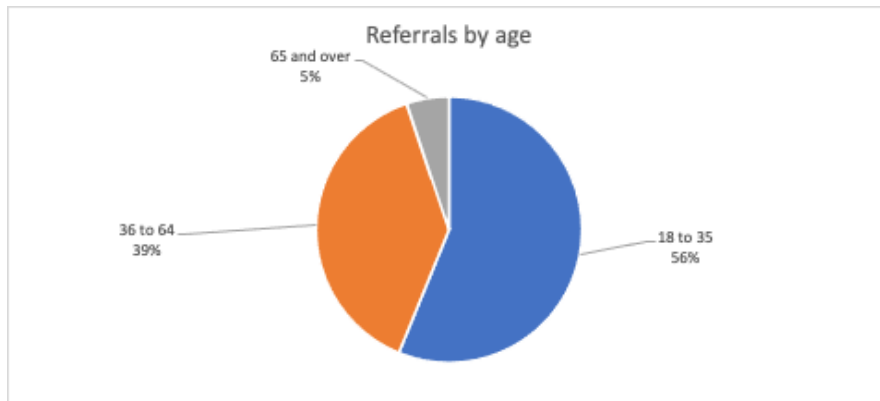
The decrease in IAPT referrals received between April 2020-March 2021 is in line with a decrease observed nationally, with an average decrease of 14% reported by NHS Digital for the same time period.[54] Nationally validated data are not yet available for 2021/22, but pre-validated data from NHS South East London CCG show levels of referrals returning to roughly pre-pandemic level, at around 5,000.

---

[54] NHS Digital, IAPT Annual report, https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services

Referals by age

56% of the referrals were from 18-35 years of age, 39% aged 36-64 years and 5% 65+ year. Overall, in the last 4 years of the 20485 referrals received, 51% were in the 18-35 age group, 43% were in the 36-64 years age group and 6% were in the 65+ years.

Figure 86: Referrals to IAPT services by age group, Bexley, 2020-2021
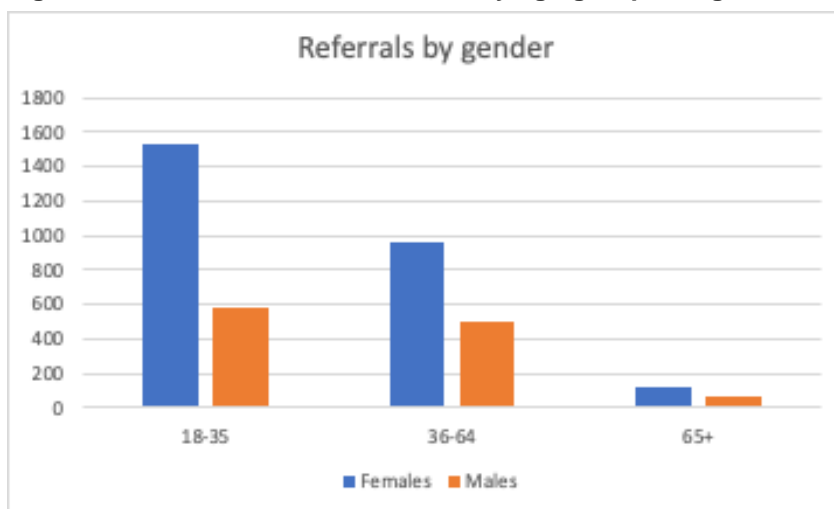

Data Source: NHS Digital, IAPT Annual report, https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services

Referrals by gender

69% of the referrals were females and this was highest in the 18-35 age group. In the 18-35 age group 72% of referrals were female and in the 65+ age group 64% were female.

Figure 86: Referrals to IAPT services by age group and gender, Bexley, 2020-2021
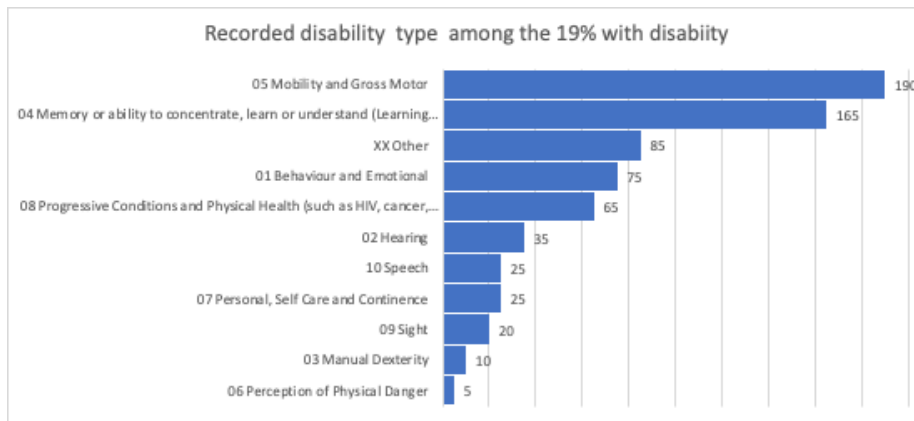

Data Source: NHS Digital, IAPT Annual reports, https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services

Referrals by disability

About 19% of all referrals in 2020/21 had disability. Figure 87 shows the type of disability recorded for the clients. Highest referrals among those with disability were those with mobility problems and learning disability.

Figure 87: Referrals to IAPT services by recorded disability

Recorded disability type among the 19% with disabiity

Disability type	Count
05 Mobility and Gross Motor	190
04 Memory or ability to concentrate, learn or understand (Learning...	165
XX Other	85
01 Behaviour and Emotional	75
08 Progressive Conditions and Physical Health (such as HIV, cancer,...	65
02 Hearing	35
10 Speech	25
07 Personal, Self Care and Continence	25
09 Sight	20
03 Manual Dexterity	10
06 Perception of Physical Danger	5

Data Source: NHS Digital IAPT, Annual reports, https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services

Referrals by ethnicity

The data indicated that 72% of referrals were White British, and 26% BME. 8% were Black or Black British and 5% were Asian or Asian British.

Secondary mental health services- Oxleas Mental Health

This dataset consists of all patients that were referred between 1st April 2016 and 31st March 2021. The dataset contains at least one attended appointment with a Mental Health team excluding adults with learning difficulties (ALD), the patient residing within South East London CCG at the time of referral/admission and be linked to a Bexley Primary Care Network GP Practice.

Any referral with a discharge reason of entered in error or Inappropriate referral are excluded from this dataset.

Figure 88: Total number of Bexley referrals seen by Oxleas Mental Health excluding adults with learning difficulties (ALD) by year, Bexley, 2016/17 to 2020/21
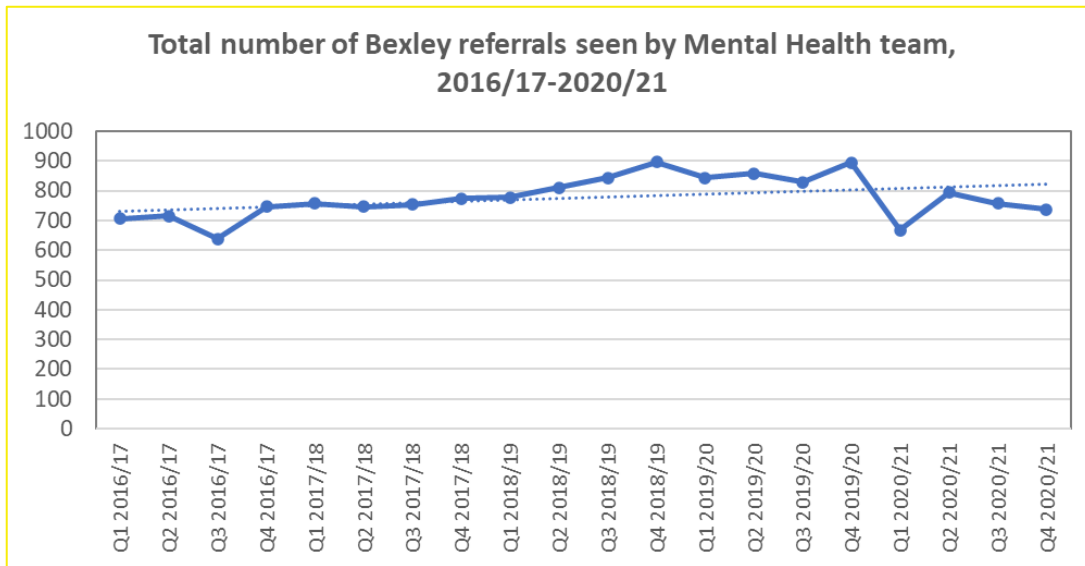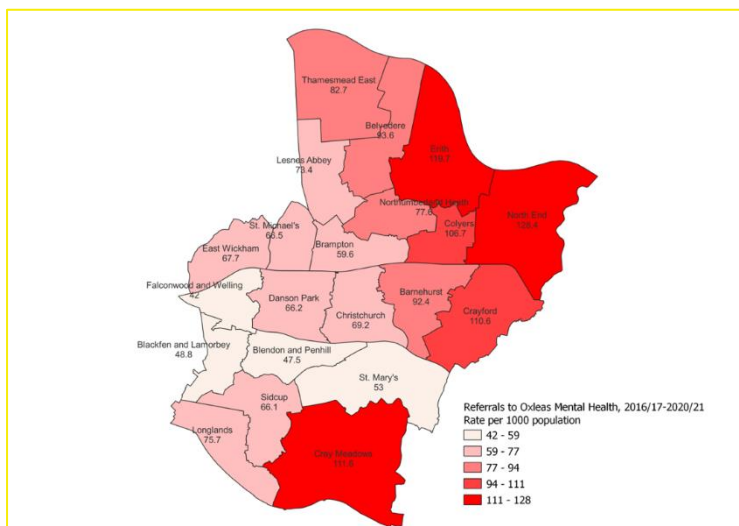

Source: Oxleas data

The number of Bexley registered patients being referred to the Mental Health team has been increasing since 2016/17. Over the period of 2016/17 to 2020/21 there has been a total of 15,550 referrals which equates to 6% of the registered population in Bexley. 57% of all referrals are female compared to 43% that are male. There are higher rates of referrals to the Oxleas Mental Health team in North End (128.4 per 1000 population) ,Erith (119.7) and Cray Meadows (111.6).

Over 56% of mental health referrals to the Oxleas team between 2016/17 and 2020/21 were made by Bexley residents who reside within the top five most deprived areas of the borough.

Figure 89: Rate of Bexley referrals per 100,000 seen by Oxleas Mental Health excluding ALD by Bexley ward, 2016/17 to 2020/21

The top ten primary diagnoses of Bexley residents who had been referred to the Oxleas MH team were:

- Emotionally unstable personality disorder
- Adjustment disorders
- Mixed anxiety and depressive disorder
- Paranoid schizophrenia
- Moderate depressive episode
- Recurrent depressive disorder, current episode moderate
- Acute stress reaction
- Depressive episode, unspecified
- Post-traumatic stress disorder
- Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances| Harmful use

Inpatient admissions by Oxleas Mental Health 2016/27 to 2020/21

The number of admissions made by the Oxleas Mental Health team has fluctuated across the last five years but overall, it has steadily decreased. In Q1 2016/17 there were 219 admissions compared to Q1 2020/21 which was 145. 56% of all admissions are female compared to 44% which are male.

Over 56% of admission reasons were recorded as blank. Of those that were categorised, many of the referrals were for the assessment and treatment of mental health problems. A small proportion of referrals (1.3%) were detained under the MHA.

Figure 90: Admissions to Oxleas Mental Health units by year, Bexley, 2016/17 to 2020/21
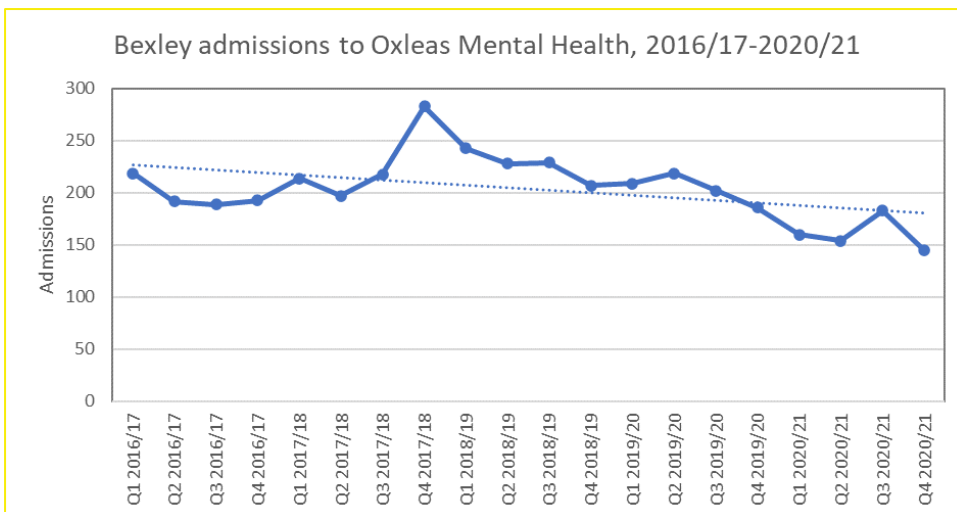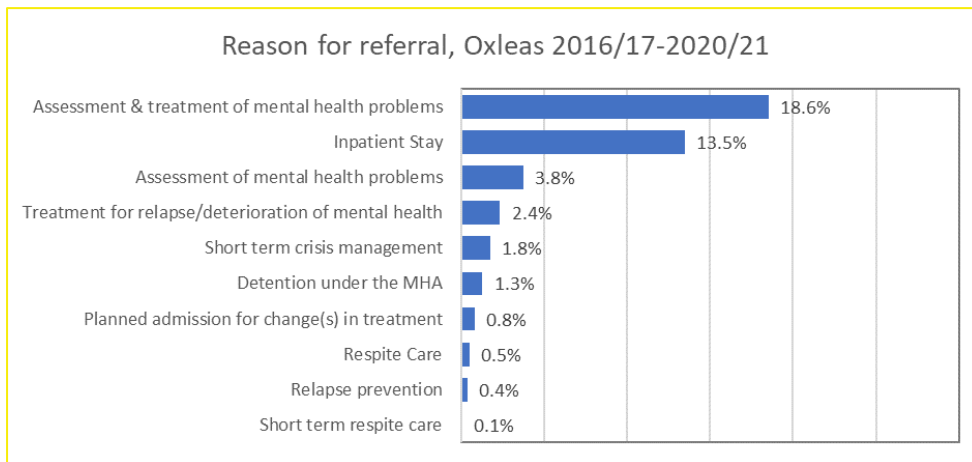
Data Source: Provided by Oxleas Mental health Trust

Figure 91: Admissions by Oxleas Mental Health team by age and gender, Bexley, 2016/17 to 2020/21

Mental health admmissions by Oxleas MH team, 2016/17-2020/21
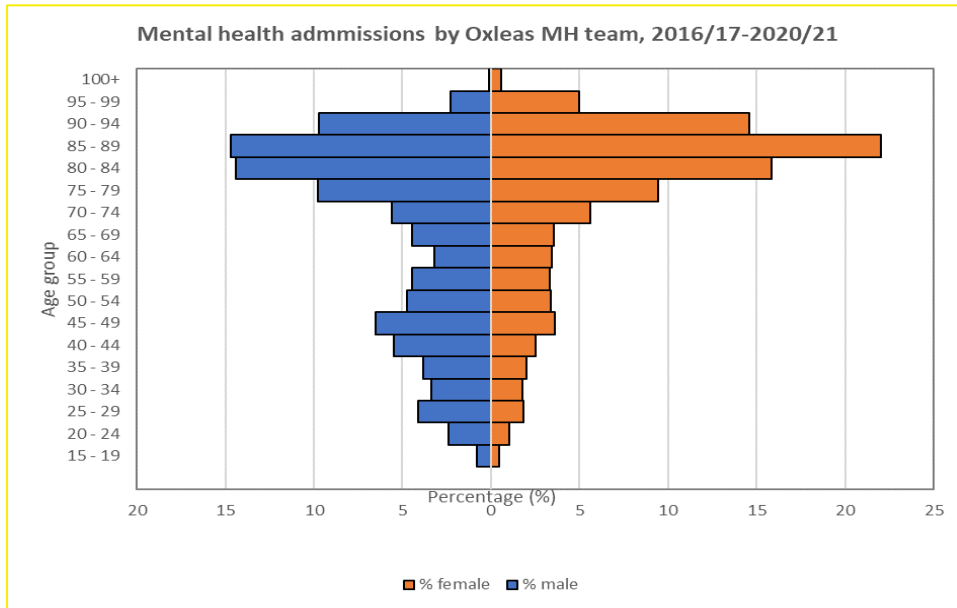
Data Source: Provided by Oxleas mental health trust

Figure 92: Reason for referral to admission to Oxleas mental health services, Bexley, 2016/17 to 2020/21

Reason for referral, Oxleas 2016/17-2020/21

Assessment & treatment of mental health problems	18.6%
Inpatient Stay	13.5%
Assessment of mental health problems	3.8%
Treatment for relapse/deterioration of mental health	2.4%
Short term crisis management	1.8%
Detention under the MHA	1.3%
Planned admission for change(s) in treatment	0.8%
Respite Care	0.5%
Relapse prevention	0.4%
Short term respite care	0.1%

Source: Oxleas data

Figure 93: Rate of admissions per 100,000 by Oxleas Mental Health team excluding ALD by Bexley ward, 2016/17 to 2020/21
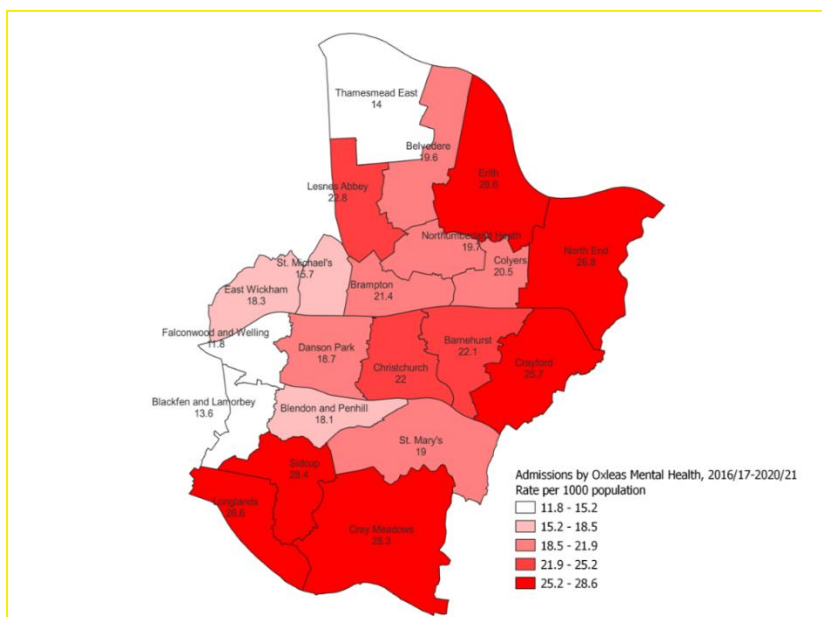

Source: Oxleas data, Office for National Statistics licensed under the Open Government Licence v.3.0

Erith, Sidcup and Cray Meadows have the highest rates of admissions made by the Oxleas mental health team (28.6, 28.4 and 28.3 respectively) during the period 2016/17 and 2020/21.

Figure 87: Bexley referrals seen by Oxleas Mental Health excluding ALD by IMD decile, Bexley, 2016/17 to 2020/21
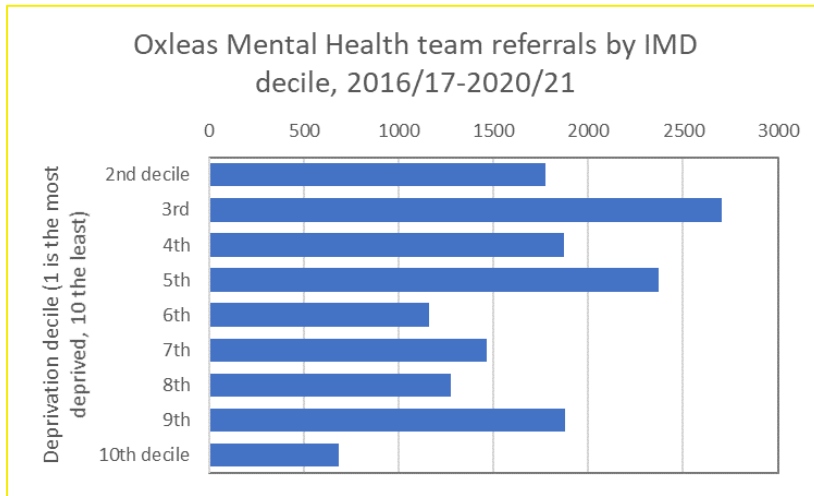

Source: Oxleas data

Hospital admissions for people with mental health conditions

Admissions by age and gender

Across Bexley, there is an approximate even split between females and males being admitted to hospital with mental health conditions. For the five year period, 2016/17 to 2020/21, 52% of males were admitted compared to 48% of females. Bexley residents aged less than 50 years account for 62% of the total number of hospital admissions for mental health conditions.

Figure 95: Hospital admissions for people with mental health conditions by age group and gender, Bexley, 2016/17 to 2020/21
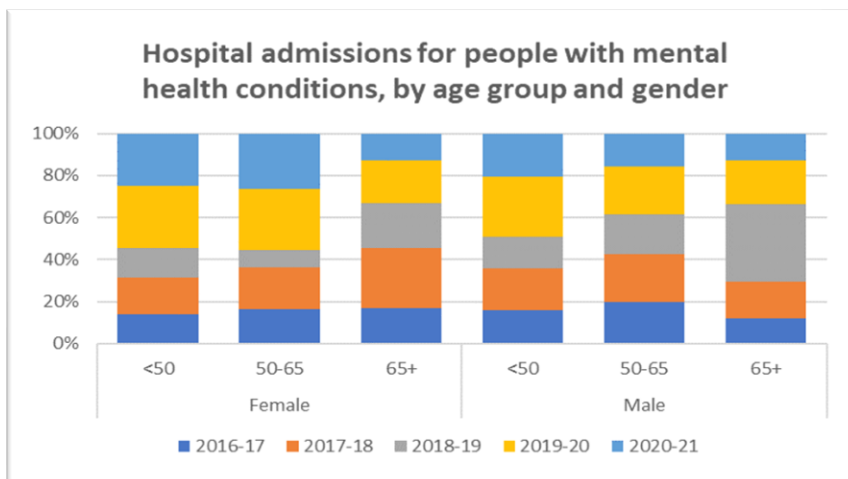
Source: Inpatient MHSDS data

When looking at the trends of admissions in Bexley, the rate of male admissions has been above that of females apart from in 2020/21.

Figure 96: Hospital admissions for people with mental health conditions Bexley by gender, 2017/18 to 2021/22
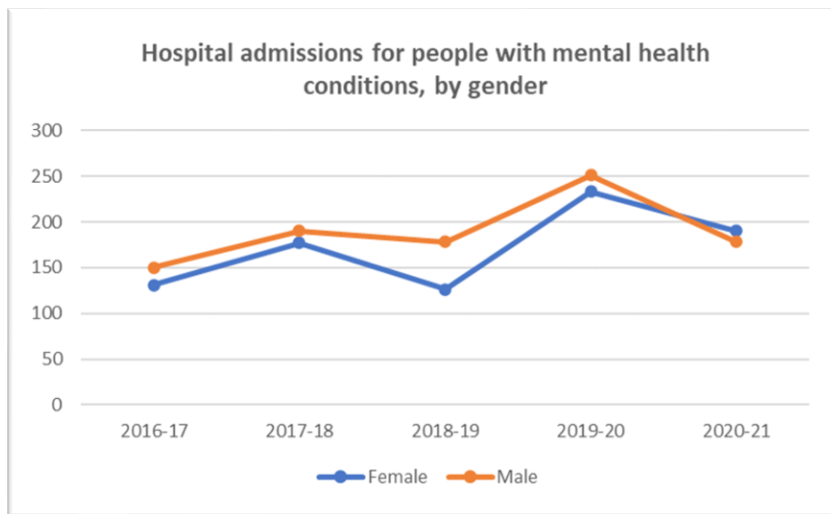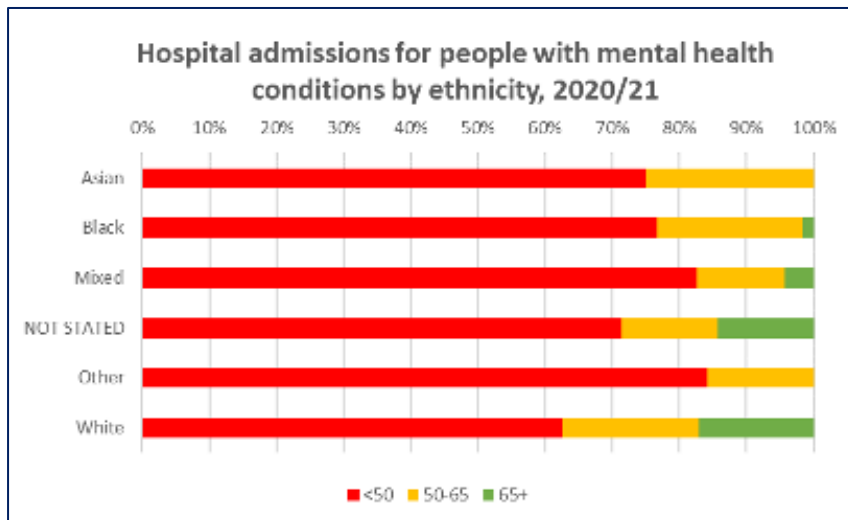

Source: Inpatient MHSDS data

Admissions by ethncity

There was a higher proportion of Bexley residents with a recorded ethnicity of white (60%) over the five year period. 16% of admissions were recorded as from a black ethnic background.

Figure 97: Hospital admissions for people with mental health conditions by ethnicity and age group, Bexley, 2021/22

Source: NHS South East London CCG

When comparing ethnicity and age groups across this cohort, there are lower proportion of admissions from White community in under 50 years compared to all proportion of the communities. There was no recording of any Asians in the 65+ category.

Figure 98: Primary ICD group diagnosis of hospital admissions for people with mental health conditions by age, Bexley 2016-2020

Primary diagnosis of hospital admissions for people with mental health conditions by age group , Bexley 2016-2020
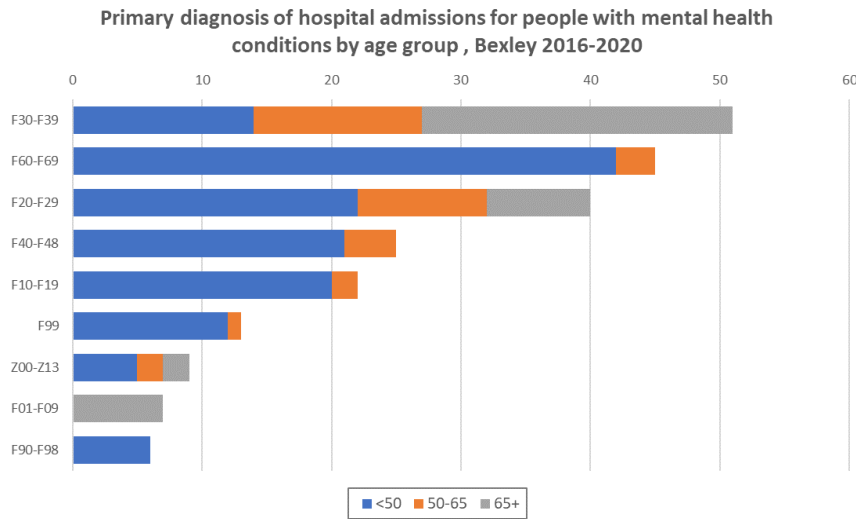
Source: NHS South East London CCG

Table 3: Supporting table of ICD-10 groupings for mental health conditions

| ICD grouping	Description
F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioural disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30-F39	Mood [affective] disorders
F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behaviour
F70-F79	Intellectual disabilities
F80-F89	Pervasive and specific developmental disorders
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Source: NHS South East London CCG

Admissions by diagnosis

The most common primary diagnosis of Bexley patients that were being admitted to hospital was for mood (affective) disorders (ICD-10: F30-F39).   Of these hospital admissions, 47% of patients who presented with mood disorders were aged over 65 years.

Disorders of adult personality and behaviour accounted for 93% of patients aged less than 50.

Figure 99: People referred to mental health services and are overweight by select GP PCNs, Bexley, 2021/22
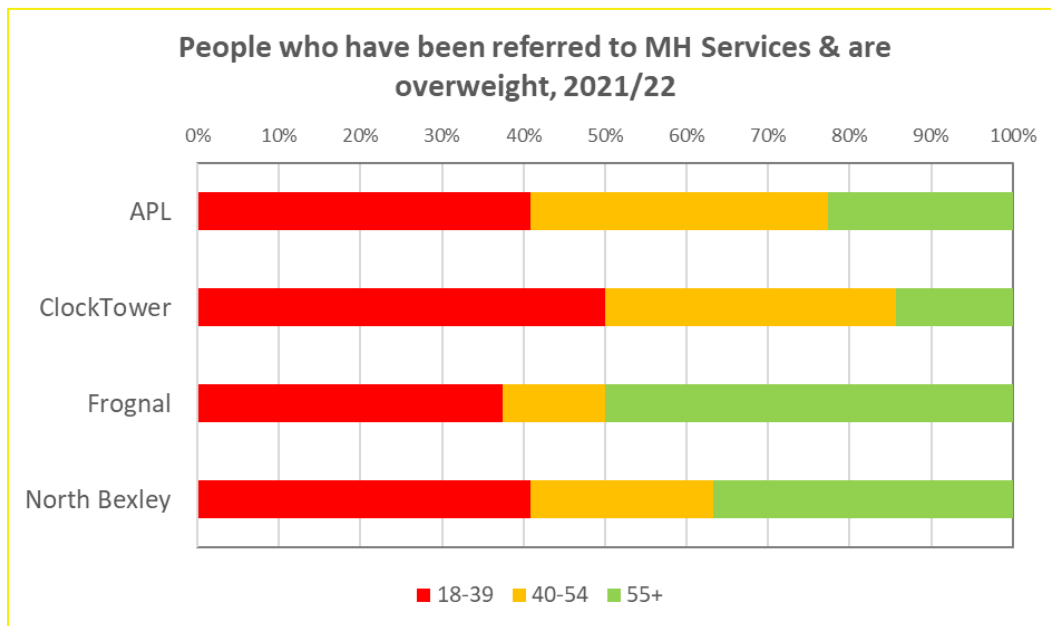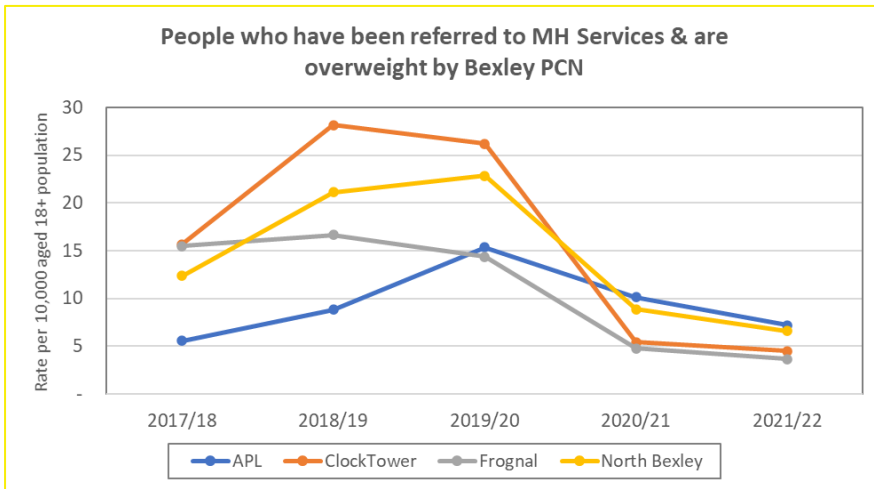

Data Source: South East London CCG

Admissions by unhealthy weights

Data collected at Bexley GP practice level shows that for those patients who were referred to mental health services and who are overweight were more commonly in the 18–39-year-old category. Frognal however had a large proportion of older patients, aged 55+.

Figure 100: Rate of people referred (per 100,000) to mental health services and are overweight by Bexley PCN and year, Bexley, 2017/18 to 2021/22


Bexley Source: South East London CCG

Over the last five years the rate of people being referred to mental health services and who are overweight have mainly been from the ClockTower PCN. However, over the last two years the rate has dropped below that of APL and North Bexley.

Dual diagnosis

Figure 101: Adults who are in contact with mental health services and are involved with substance misuse by Bexley PCN and gender, Bexley, 2017/18 to 2021/22
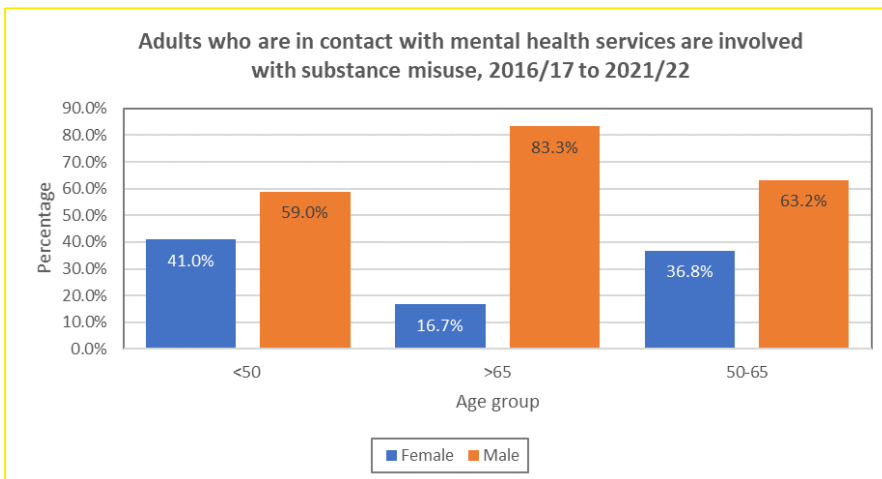
Source: Lewisham and Greenwich Trust Data

Bexley adults who were in contact with mental health services and were involved with substance misuse were analysed into three age groups. It was reported that more males were using the service between the five year period, of which 83.3% of those aged over 65 were males.
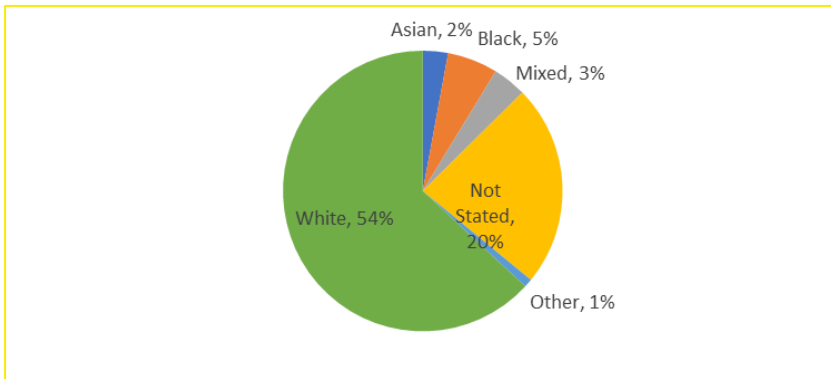
Figure 102: Adults who are in contact with mental health services and are involved with substance misuse by ethnicity, Bexley, 2016/17 to 2021/22


Source: Lewisham and Greenwich Trust Data

The collection of mental health service users and their resident wards is poorly collected. During 2016/17 and 2021/22 86% of service users had no ward recorded therefore no insights can be drawn on a geographical basis.

Eating disorders or disordered eating services

The number of eating disorder referrals recorded by South London and Maudsley has declined over time, seeing an all-time low in 2021.

Figure 103: Eating disorder referrals to South London and Maudsley (SLaM) by year, Bexley, 2016 to 2021
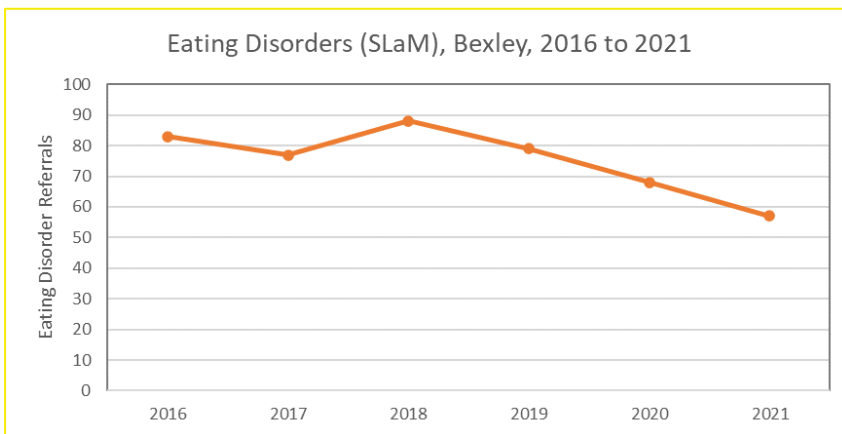
Data source: South London and Maudsley NHS Trust

90% of eating disorder referrals were female compared to 10% that were male. Those aged 20-24 years had more referrals in both genders when compared to other age groups. No patients aged over 75 were referred for any eating disorder to SLaM during 2016 and 2021.
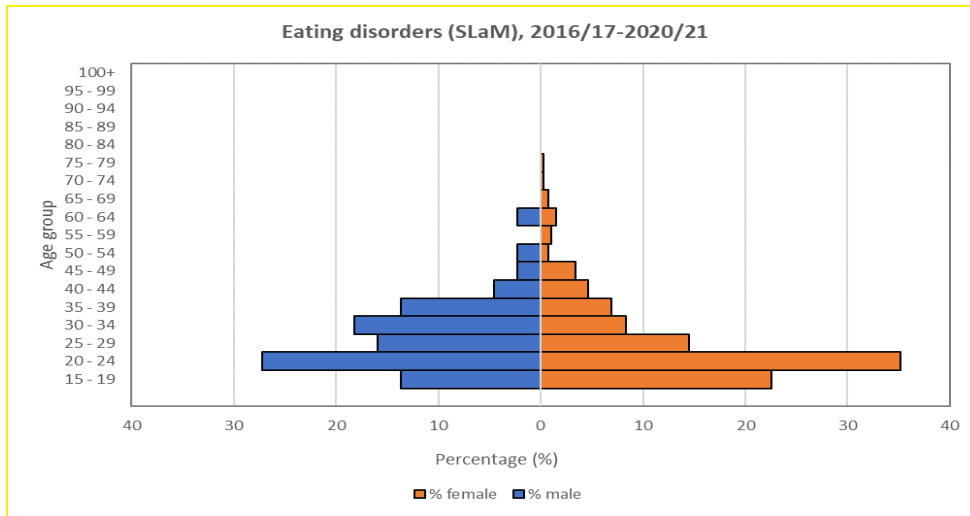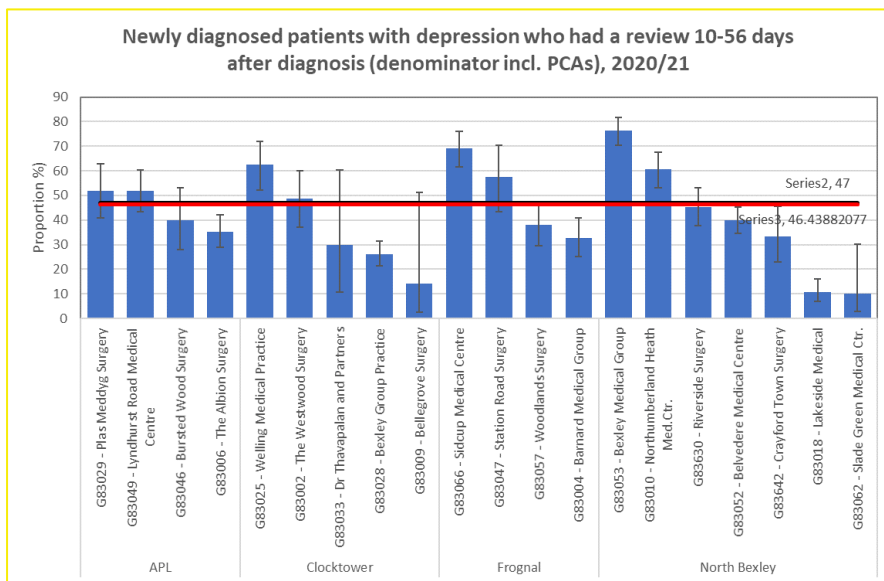
Figure 104: Eating disorder referrals to South London and Maudsley (SLaM) by age and gender, Bexley, 2016 to 2021

Data source: South London and Maudsley NHS Trust

Figure 105: Percentage of newly diagnosed patients with depression who had a review 10-56 days after diagnosis by GP Practice, Bexley, 2020/21

Data Source: Office for Health Improvement and Disparities, Public Health Profiles Public health profiles - OHID (phe.org.uk)

Three practices in Bexley had significantly higher proportions of newly diagnosed patients with depression having a review within 10-56 days of diagnosis; these were Welling Medical Practice, Sidcup Medical Practice and Bexley Medical Group.

Dementia by GP Practice

The face-to-face review should focus on support needs of the patient and their carer. In particular, the review should address four key issues:

- an appropriate physical and mental health review for the patient
- if applicable, the carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs
- if applicable, the impact of caring on the caregiver
- communication and co-ordination arrangements with secondary care (if applicable).

A series of well-designed cohort and case control studies have demonstrated that patients with Alzheimer-type dementia do not complain of common physical symptoms but experience them to the same degree as the general population.

Patient assessments should therefore include the assessment of any behavioural changes caused by:

- concurrent physical conditions (e.g. joint pain or intercurrent infections)
- new appearance of features intrinsic to the disorder (e.g. wandering) and delusions or hallucinations due to the dementia or as a result of caring behaviour (e.g. being dressed by a carer)

Depression should also be considered since it is more common in patients with dementia than those without.

Figure 106: Percentage of patient that had a dementia care plan reviewed in the last 12months by Bexley GP Practice, 2020/21
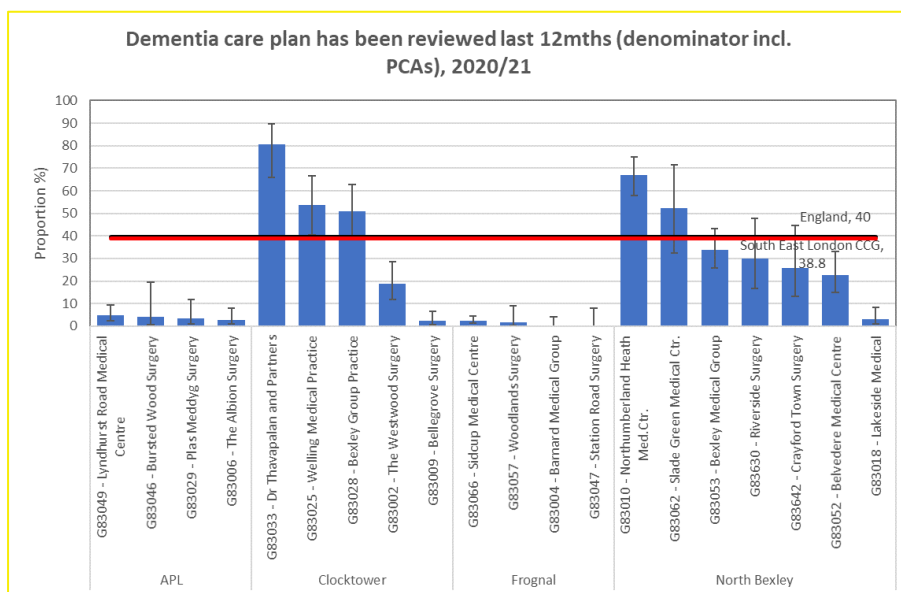
Welling Medical Centre and Northumberland Medical Centre have both significantly high proportions of dementia care plan reviews that have been conducted in the last 12 months compared to other practices across the borough.

Self-harm

At Borough level, Bexley experiences significantly lower age-adjusted admission rates for hospital stays for self-harm than the England average. The rate of admission in Bexley is 55 per cent lower than would be expected if Bexley experienced the same age-specific rates as England as a whole. However, there is wide variation at ward level, ranging from 20.1 per cent (95% CI: 13.8-28. 2) in Falconwood & Welling, to 94 (78.2-112.0) in Slade Green & Northend.

Figure 107. Admission ratio for hospital stays due to self-harm by Bexley ward, Bexley, 2015/16 – 2019/20
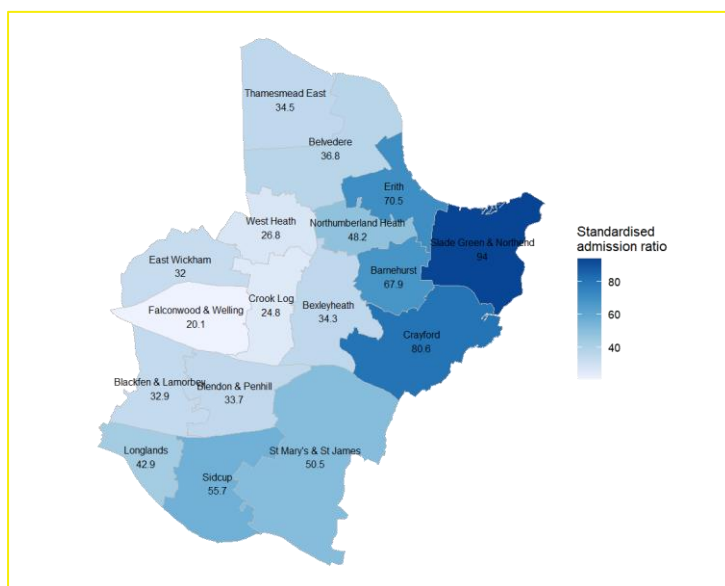
Suicide

Numbers are too small and/or too disclosive to report on the on the suicide rate for females in Bexley. For males and persons ages 10+, the suicide rate in Bexley is higher than London but lower than the England average, however the small underlying numbers render the significance of this difference undetermined. For males ages 65+ the suicide rate is lower than both the London and England averages, but again the significance of this difference is undetermined.

Figure 108. Suicide rate per 100,000, ages 10+ 2018-20; ages 65+ 2013-17

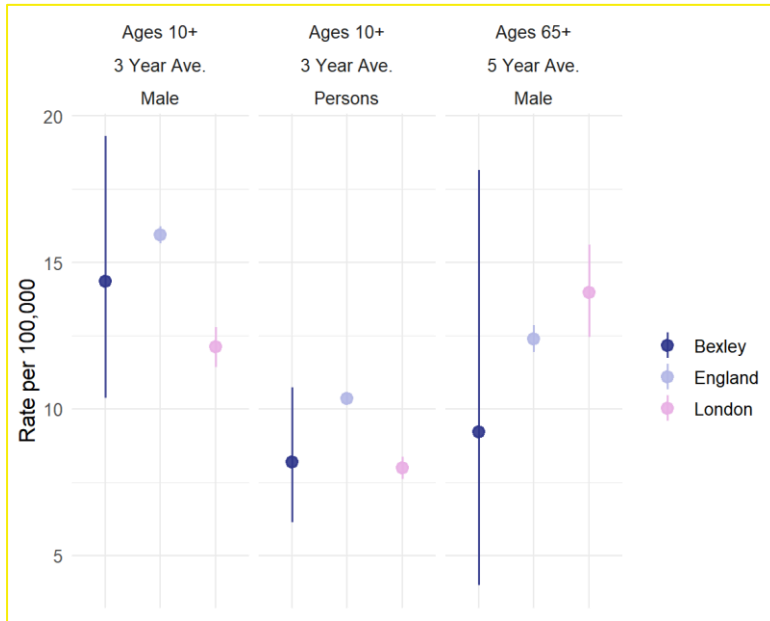

Source: **Office for Health Improvement and Disparities, Public Health Profiles, Public health profiles - OHID (phe.org.uk)**

12. Learning disability and health inequalities

Prevalence (GP registrations)

The number of people on Bexley's GP's learning disability registers increased from 989 in 2020, to 1,138 in 2021, an increase of 15%. The overall proportion of people on Bexley's GP's learning disability registers was 0.46% in 2021 – higher than the London average (0.41%) but lower than the England average (0.53%).

In 2019 a subset of Bexley GP practices reported their registers by age and sex. Of the 783 registered patients represented, 64% were male:

Figure 109: People on the QOF learning disability register by age and sex, 2018-19
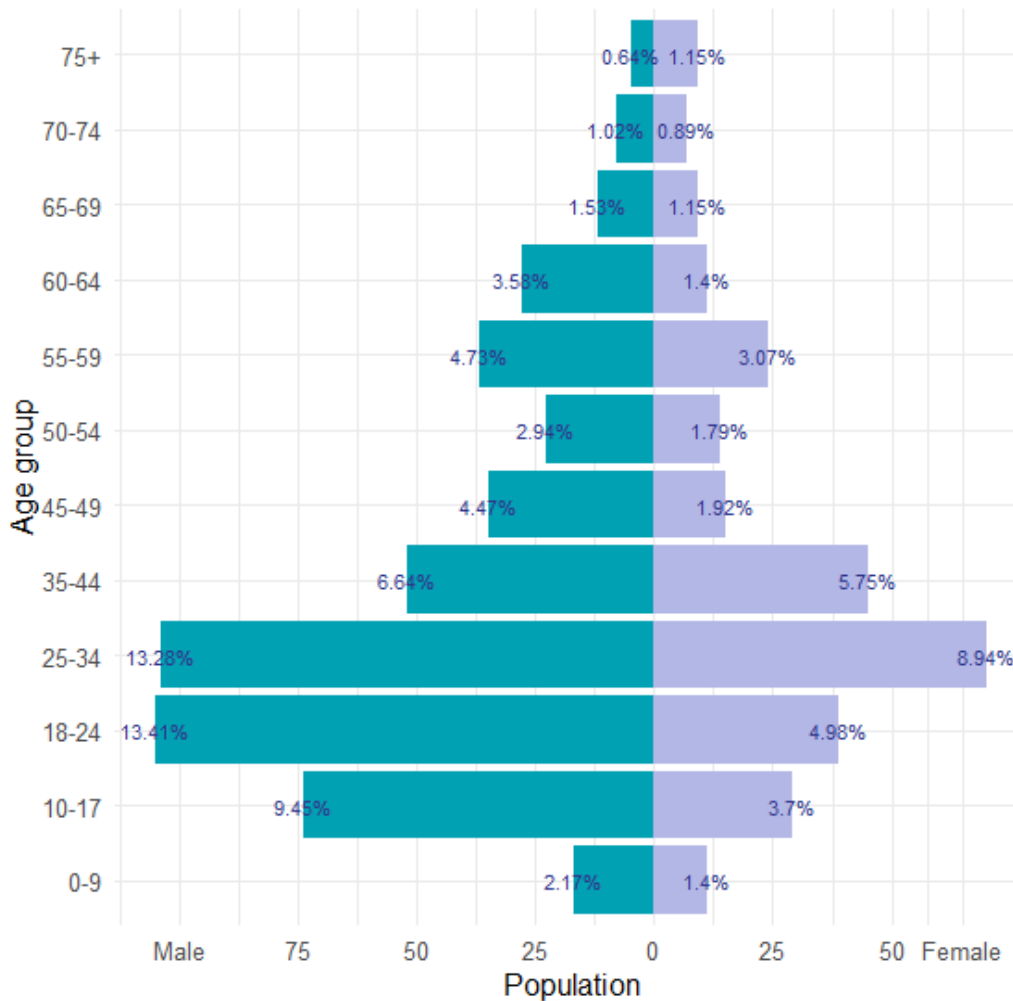
Source: NHS Digital: Health and care of people with Learning Disabilities, https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2018-to-2019

The age and sex structure of this population is different from the general population of Bexley, but mirrors similar findings in national studies. A spike in teenage and young adult males is thought to reflect over-diagnosis due to higher exposure to services. The smaller proportion of

older people is thought to reflect both health inequalities and indeed inequity in the care of people with learning disabilities,[55] as well as the reduced life expectancy for associated conditions such as Down's syndrome.[56]

Long Term Support

In 2020/21, 545 people were receiving long term adult social care support where the primary support reason was "learning disability". Over the last five years this figure has remained almost constant. On average, 64% of these people are male, compared to 36% female – exactly mirroring overall GP registered prevalence. In 2020/21, 81% were White British, with 4% Black African and 3% of Indian background. Numbers in other ethnic categories were too small numbers to report.

Figure 10 shows there is no association between residential deprivation and receipt of long term adult social care support for learning disability:

Figure 110: People Receiving Long Term Adult Social Care Support Where the Primary Support Reason was "Learning Disability" by IMD 2019 decile (%), Bexley, 2016/17 to 2020/21
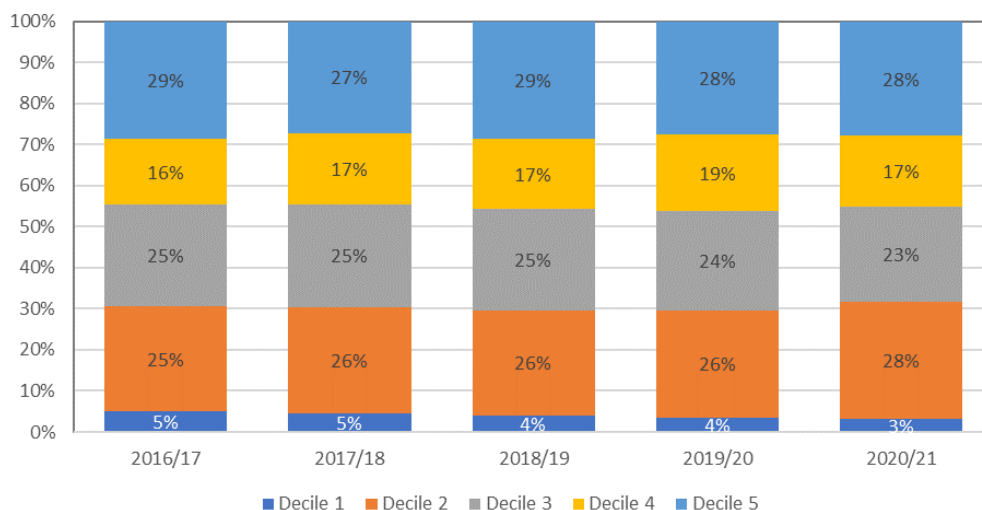
Source: SALT statutory return – Long Term in the year (LTS001a), London Borough of Bexley

Of the 545 people in receipt of the service in 2020/21, 67% were in settled accommodation and 20% were in non-settled accommodation. The accommodation status of the remaining 13% is unknown. 79% were in unpaid employment compared to only 14% that were in paid. The remaining 7% were of unknown employment status.

---

[55] P Heslop, P Blair, P Fleming, M Hoghton, A Marriott, L Russ, *Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD)*, Bristol University, 2013

[56] G Glover, M Ayub, *How People with Learning Disabilities Die*, Department of Health, IHAL 2010-06

Adult Learning Disability (ALD) referrals or clients seen by Oxleas ALD teams, 2016/27 to 2020/21

Over the last five year the rate of referrals seen by Adult Learning Disability (ALD) teams across Bexley has decreased. In Q1 2016/17 there were 38 referrals in total, compared to only 19 in Q4 of 2020/21.

Of all of the referrals during this 5 year period to this team, 60% of them are male compared to 40% who are female.

Figure 110: Total number of referrals seen by ALD teams by calendar quarter, Bexley, 2016/17 to 2020/21
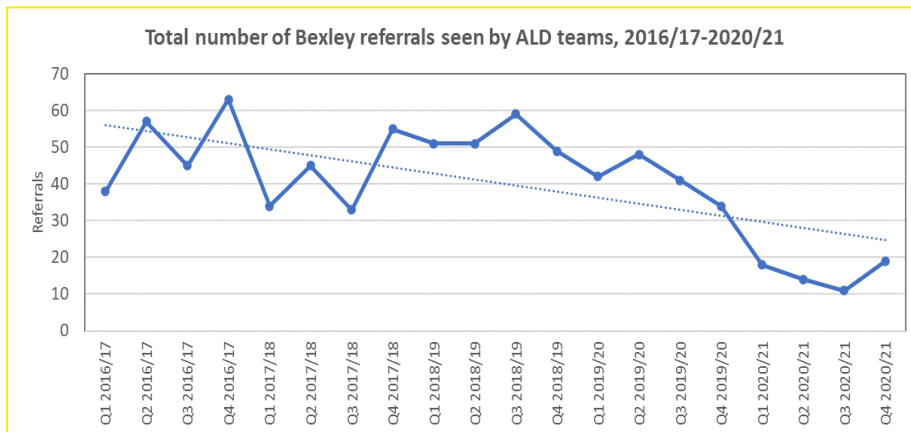
Data Source: Oxleas

Figure 111: Referrals or clients seen by ALD teams by age and gender, Bexley, 2016/17 to 2020/21
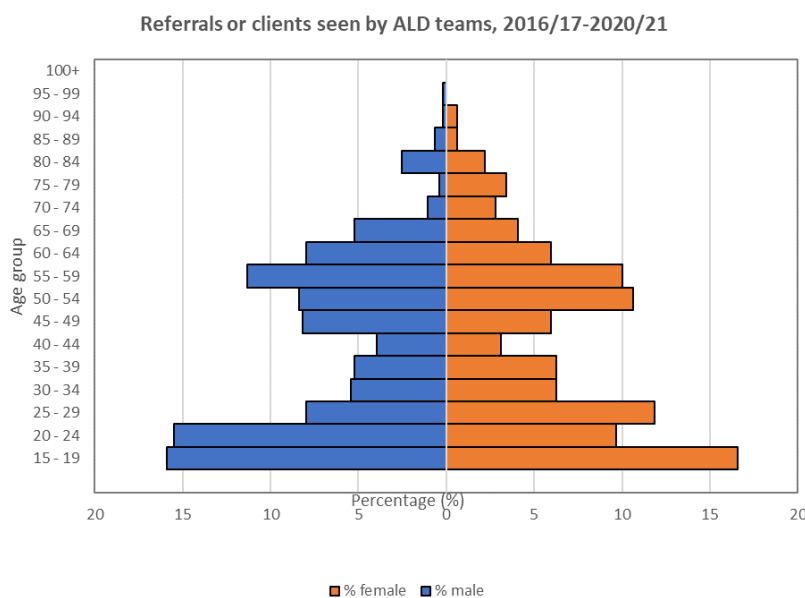
Data Source: Oxleas

Figure 112: Referrals or clients seen by ALD teams by Bexley ward, Bexley, 2016/17 to 2020/21
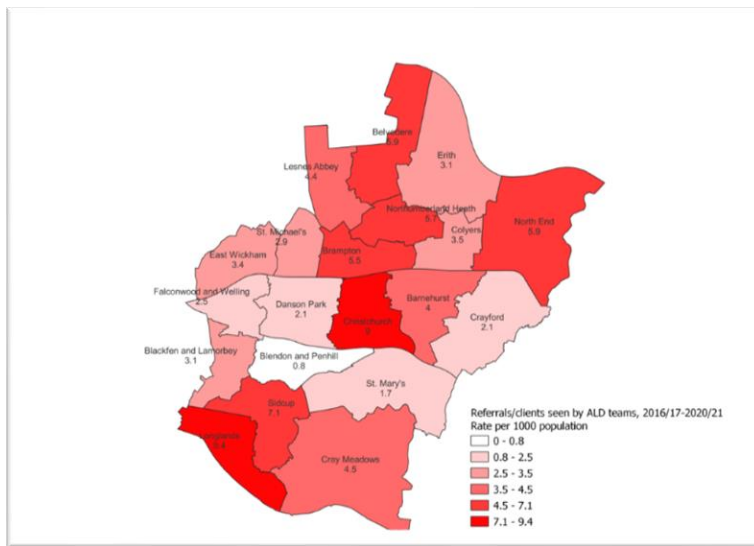
Data Source: Oxleas, Office for National Statistics licensed under the Open Government Licence v.3.0

Longlands and Christchurch were the wards with the highest rates of referrals seen by ALD teams throughout 2016/17 to2020/21 (9.4 per 1000 population and 9 respectively).

13. Insights from stakeholder engagement

Bexley is experiencing the twin challenges of an ageing population toward the south and a relatively younger, ethnically diverse and deprived population towards the north. Increasing population size and diversity has made the needs more varied and health priorities have widened with key areas including obesity (adults and children), diabetes, dementia, addiction - smoking, substance misuse (including alcohol), frailty, mental health and children and young people's emotional wellbeing. There are other linked strategies mentioned within the strategy including Family Wellbeing Strategy, Obesity Prevention Strategy, Preparing for Adulthood Strategy, Looked After Children and Leaving Care Strategy, Transformation Plan for Children and Young Peoples' Mental Health and Emotional Wellbeing – Refresh, Domestic Abuse Strategy.

The Bexley Prevention System-wide Strategy[57] (2021 to 2025) has an overarching People domain focussing on prevention across the life course 'from cradle to grave'. Theme two relates to 'Healthy Adults' and has two priorities. Firstly, around creating an environment where people can be healthy. Secondly, make decisions about their future, and engage in meaningful life roles in the community at all stages and secondly, supporting people through key life changes and events.

There are local services commissioned based on local need and through the course of the COVID-19 pandemic, service delivery became intermittent due to the restrictions resulting in constant disruptions over a period of nearly two years.

Most services evolved due to the restrictions and as commissioners and providers worked in partnership with the service users and various local stakeholders, services were adapted to ensure service continuity particularly with a focus on harm reduction and minimising the risk of spreading COVID-19. This led to majority of services moving from physical face-to-face delivery to online virtual appointments and sessions. The impact of this model on service users is yet to be fully understood, however initial indications are mixed.

There are local services commissioned based on local need and through the course of the COVID-19 pandemic, service delivery became intermittent due to the restrictions resulting in constant disruptions over a period of nearly two years.

Most services evolved due to the restrictions and as commissioners and providers worked in partnership with the service users and various local stakeholders, services were adapted to ensure service continuity particularly with a focus on harm reduction and minimising the risk of spreading COVID-19. This led to majority of services moving from physical face-to-face delivery to online virtual appointments and sessions. The impact of this model on service users is yet to be fully understood, however initial indications are mixed.

---

[57] Bexley Prevention System-wide Strategy; London Borough of Bexley; https://www.bexley.gov.uk/sites/default/files/2021-10/Bexley-Prevention-Strategy.pdf

What works well in Bexley?

Partnership working is an asset

The system-wide obesity prevention strategy[58] provides the local health and social care organisations, voluntary and community groups with the vision for addressing inequalities relating to long term conditions and lifestyle. Adult substance misuse works well as an integrated service where outcomes are good, service is effectively run and well developed links in with partner organisations.

Effective use of limited resources

Sexual and reproductive health services are mostly clinical interventions and services are commissioned to nationally set quality standards and prices negotiated on London footprint to maximise value for money. Contracts are reviewed on a pan-London for ISHSs and local contracts are bench-marked against other LAs to ascertain market comparison.

Local Communication and engagement channels

A dedicated space where experts can come together from a wide range of disciplines to make plans and operationally deliver outreach and community development exists. This became a virtual operational 'corporate team' to disseminate information and problem solve; rather than the senior corporate group. These have helped to deliver consistent messaging across the local area particularly during the pandemic. There is sustained energy to build trust in the community by going to places where underserved communities reside and holding meaningful conversations with them about how they want to be engaged, understanding the types of support, information and guidance that would be helpful and appropriate. These have helped to create more opportunities through the CCG small grants scheme which offers communities the ability to develop community led solutions to some of the issues they face.

Proactive voluntary sector involvement

There is dedication and leadership from the voluntary organisations who are involved with little or no financial reward and who take a proactive altruistic approach to supporting local communities. Many of their volunteers are directly impacted and may use services themselves and therefore have direct experience and insight which enables them to be empathetic in their support and delivery of their offer to those in need particularly the most vulnerable and marginalised.

"Voluntary sector is now being recognised for what it can bring to the table."

Challenges Pre-COVID

---

58 Bexley Obesity Strategy; London Borough of Bexley; https://www.bexley.gov.uk/services/health-and-social-care/bexleys-public-health/bexley-obesity-strategy

Standalone services

Substance misuse requires a holistic approach and opportunities for partnership working rather than relying on one treatment service to address all issues. The need for more integration between services including employment and housing have also been identified for mental health and smoking cessation services to ensure holistic delivery.

Resource allocation

The sexual and reproductive health prevention services had very little resource to devote to the local area. These are mostly a test and treat service; ability to book ISHS services and greater links to the CCG Termination services or for contraception. There were indications that staff changes and flux had occurred during the pandemic since many moved to remote working staff working in temporary or interim roles moved to other local areas who could offer a more competitive wage. This trend is not unique to Bexley. The council community engagement team was disbanded with two staff progressed into a joint arrangement with South East London CCG to allow some continued engagement and community development work. Mental health services have remained inadequate for the need in Bexley and remain underfunded compared to neighbouring local authorities. As the demography of Bexley has changed, the demand for dementia services for the elderly has increased mainly in the South, however North Bexley, areas such as Thamesmead, have a younger population with different needs.

Mental health referrals have increased and this has led to longer waiting lists. This has raised concerns about the use of the voluntary sector for IAPT services. IAPT is meant to reduce the need for referrals. Some have highlighted the limited staffing resources as a possible barrier.

Impact of Covid restrictions on the population

Stakeholders spoke about the potential impact of Covid restrictions on local population based on national reports. There are early indications that many residents were unable to maintain the required levels of physical activity during periods of lockdown. Furthermore stakeholders reported lower motivation due to the isolation and anxiety from the pandemic and ensuing uncertainty.

Mental health conditions increased during the pandemic and there is a risk of a latent demand as many people during lockdown consumed disturbing information and experienced uncertainty which led to increased anxiety and stress with limited access to their social networks for support. People have coped during these periods in various ways.

There are reports from national data of an increase in take up of more risks factors such as smoking, alcohol and diets that are high in sugar and fat. There is an urgent need to focus on these modifiable risk factors associated with the risk of developing cardiovascular disease such as hypertension.

Stakholders spoke about the need to make the services more accessible.

Targeting of high-risk groups such as males and those from BAME groups needs to be improved as current male uptake is only 8% and there is poor uptake across all minority ethnic groups. Adult weight management service data shows that most referrals are people with no reported long-term condition. This suggests that those with more complex obesity and other issues may not be coming forward for support. Self-referral options increased cases and motivation to join the service however this hinders the focus on offering a targeted service, for example slimming world which may not require a GP referral.

There is also an indication that coordination and communication between services needs to improve and offer more flexibility for residents by fitting the service delivery models around the services users' needs thereby making them more person-centred.GP practices have not seen as many patients in person, making it less likely to have routine consultations such as blood pressure checks and reviews, informed discussions about smoking with a subsequent offer of a referral. These are reported to have been less likely to happen during telephone GP or nurse consultations.

Opportunities during COVID

Partnership working with community organisations

More voluntary sector involvement in supporting residents' mental health across the borough. These need to be evaluated to consider whether they were well distributed to areas of need such as Thamesmead and Slade Green. Community involvement has helped to reduce the stigma associated with mental health conditions.

Strengthened Partnership working with between organisations

The smoking cessation service had existing strong partnership working with Bexley GP practices which helped ensure that service users continued to have direct access to their treatment medications. The pathway for medications was already via request letter from the service to the patients GP and while this was usually issued to the patient to hand into the surgery, with the implementation of telephone support, the service was able to switch to emailing these request letters direct to the surgery. GP practices were able to electronically send prescriptions direct to pharmacy also meant that patients only needed to attend the pharmacy to collect prescriptions rather than collecting paper prescriptions from the GP practice first. The experience and professionalism of the advisors assisted with having effective conversations and support for service users despite consultations occurring remotely by phone.

Use of technology and innovation

Many services were offered remotely in response to the COVID-19 restrictions which helped service continuity and enabled many patients to continue to access much needed care. Some were blended offers which indicated adaptability and flexibility of these services.

However, an over reliance on online access to services during the lockdown and subsequently when restriction were partially lifted may have created inequalities which continue as some patients are less likely to engage with services as effectively as they would in person. IAPT services including talking therapies which worked effectively face-to-face have moved online. The smoking services provided a high standard of care to services users and learning from the pandemic will maintain a hybrid of telephone and face to face consultations as the future delivery model. This will make it easier for patients that struggle to attend every session in person, as well as give those patients that struggle with telephone support a return to the opportunity to be seen in person. Moving clinics back to face-to-face locations will also help to resume carbon monoxide validation of quits as part of monitoring outcomes. The smoking cessation service was able to immediately transition to telephone support ensuring that the support was able to continue. All team members had access to effectively work remotely.

14. Discussion and conclusions

Defining health is more than the absence or presence of disease. Furthermore, it is clear that health is influenced by where we live, study, work and play, how we live our lives, our social connections, the jobs we do and the type and quality of health and care services to which we have access.

The COVID 19 pandemic and the restrictions that were required to control the pandemic have had an impact on all of these factors. The pandemic brought to life the harsh realities of how these factors have been driving inequalities in health outcomes, resulting in the higher burden of infections and deaths in some poplations that are known to suffer inequalties, in particular people living in more deprived areas, people with existing mental health conditions and people from BAME communities. Additionally people in jobs that are normally paid less such as the hospiitality industry and those on zero hour contracts had to face uncertainity and income loss.

Bexley residents enjoy better health outcomes than the average for England and it has many assets including its open and green spaces. However, similarly to every borough in England it has inequalties that need addressing now as the focus moves from the pandemic response to recovery.

This report on health inequalties and the modifiable risk factors -obesity, smoking, alcohol and hypertension and the inequalties faced by people living with mental health problems has shown that Bexley system leaders will need to take some bold steps to address these inequalties so that all babies born in Bexley can expect to live longer and healthier lives and all people can be enabled to live healthier lives. This cannot be a step change approach as it is not dependent on one factor or one partner. A whole system approch embeding ways of reducing health inequalities in all we do will need to be developed. As demonstrated health outcomes are poorer in areas of higher deprivation ,all policies and plans would need to consider the impact of health.

To illustrate this, areas with higher deprivation have a higher number of people from BAME communities, and the GP practices in those areas have a practice population with lower life expectancy. The populations they serve also have lower incomes and and hence more efforts and resources are required to enable these populations to prioritise health amongst all the other aspects of their lives. This cannot be done by the GP practice alone but in partnership with other players including the local communities. North Bexley PCN has the highest number of practices and largest population with many of the communities described as facing inequalties living in their catchment areas.

Mental health and improving the lives of people with existing mental illness needs greater focus as highlighted by the stark inequalties as described by the excess mortality at younger age.

This report found that the outcomes from services such as smoking cessation are postive for people from lower socioeconomic class, people with mental health conditions and every effort through programmes such as Making Every Contact

Count should be used as standard to refer and enable people to access health improvement services. This is imprtant for all communities as demontrated by the gap in life expectancy and health status and disbabilty free life expectancies.

The NHS is undergoing another restructure with Integrated Care Systems replacing STPs from July 2022. Whist this aims to bring all the health and care partnerships together, the balance between centralised system and place will need to be maintained. This is particularly important as local authorities are place based and local drivers of inequalties need to be addressed through local partnerships.

The pandemic has been an opportunity by local partners to drive forward joint working and as found through the stakeholder engagement, these local relationships and partnerships became crucial in keeping residents safe, taking action where and as appropraite and the role that many communities played in looking after their friends, family and neighbours. These local networks will be key and how these are resourced and given the freedom to prioritise local actions will be a challenge when top-down restructure is ongoing and other areas within the ICS may have larger inequalties or deprivation.

There is strong desire to improve the health and wellbeing of people who live in Bexley judging by the responses and intense motivation expressed by those key stakeholders who participated in the Vital 5 Health Inequalities Audit (HIA) engagement.

Bexley has a draft Health and Wellbeing Strategy which is place based – which is the preferred approach as shown by this report that place dictates health. Primary Care Networks are required as part of the conditions of their current funding to each produce Health Improvement Plans but these as decribed above need to be done in partnership with local partners , communities adressing local inequalties and using local assets.

The Council is developing a new Corporate Plan, to be endorsed by the administration to be elected in May 2022 and no doubt health and health inequalties at local level will feature highly in this plan.

15. Recommendations

The Health and Wellbeing Board and its constiuent member organisations have a statutory duty to improve the health and wellbeing of the local population and adress inequalities. The pandemic and the knock on effects from measured needed to contain the spread has highlighted that the above statutory duty our responsibility to the people we serve. Based on the findings of this report we suggest the following:

Aspire to embed health and health inequalities in all polices and plans so that every part of the Bexley system is working towards the same goals:

- Reduce the gap in life expectancy between communities

- Improve health status and disability free life expectancies

- As part of this public health to offer masterclasses in population approaches such as health in all polices and explain how different non health services can incorporate health in what they deliver.

- Support services to understand the social model of health and ways to implement this model in their work

- Support local primary care networks to develop health improvement plans

Refresh and adopt the place based health and wellbeing strategy:

- o Public health with partners to develop an action plan and monitoring metrics for the strategy

- o HWB to ensure quarterly progress reports

The ICS develoment plans to ensure place based plans and resources are supported adequately:

- o Local inequalties are not lost in the overall scheme

- o Population health management systems use data from other partners to draw a wider picture to support pactices to understand the wider determinants of their population

The role of voluntary sector is considered as part of all plans:

- o Voluntary sector is resourced well to deliver the role it can play in health improvement and tackling health inequalties

- o Enable training for communities for health literacy and championing health