Review of Health Inequalities in Kensington and Chelsea

Report to the Overview and Scrutiny Committee on Health
January 2008
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CHAIRMAN’S FOREWORD

The most welcome information to emerge from this scrutiny exercise is the fact that everybody in Kensington and Chelsea appears to be getting healthier. This means, of course, that the health inequalities gap is not reducing and this demonstrates that greater effort and resources need to be directed towards helping the more vulnerable and deprived residents of the Borough to live healthier lives and obtain easier access to high quality health care services.

Because of this and in view of time constraints, the review group focused its attention on four groups of people whose health outcomes are not as good as those of the rest of the population. The good news is that for three of those groups, children and mothers, users of mental health services and people who live in social housing, the problems are recognised and steps are being taken to improve their situations. The work being done for children and their parents in particular, through Sure Start, the children’s centres and the improvements resulting from the new GP contract, is very encouraging.

The really worrying revelations came when we scrutinised the health experiences, health care services and health outcomes for children and adults with learning disabilities. Parents, carers and service users all told of extended waits for treatment, instances of diagnostic overshadowing, bad experiences in hospital settings, dismissive attitudes when carers tried to explain patients’ circumstances and sometimes a complete lack of understanding of their needs on the part of the health professionals into whose care they had been placed.
Acute dental services delivered in hospital settings stood out as offering particularly bad experiences and these were compounded by extended waits for treatment while patients suffered in silence – in one case for two years, in another for six months. Diagnostic failures caused a boy to be in severe pain for months from a splinter lodged in his leg before an aromatherapist identified the problem. A young woman who was helped to live independently is now about to lose most of her teeth because no one took responsibility for her oral hygiene.

Of great concern to the review group is the fact that improving the health care experiences of those with learning disabilities appears to be an optional extra. For example, the Chelsea and Westminster Hospital’s response to the request for a quiet room for some treatments for children with learning disabilities is that it will depend on space constraints in the paediatric department. The review group believes that this should be a core element of the hospital’s services for children with learning disabilities.

Little, if any, specific training in the needs and care of people with learning disabilities is included in the education of health care professionals; it is left to individuals to seek out the appropriate training for themselves. Disability equality schemes seem to have little focus on this particular care group and the very special and targeted services and environment that they often need.

I believe that there is scope for a further look at the whole range of services for children and adults with learning disabilities. This should include health care, social care and the voluntary sector – and it should also look at the experience of the parents and carers of people with learning disabilities, whose own needs are very often overlooked.

This is not to say that everything is bleak. There are also some excellent examples of good care and good practice within the Borough. The need now is to ensure that they are spread right across the whole spectrum of care.

This report should be seen as complementing the Access to Services for Disabled People that reported to the Council in November 2006 and I will end by quoting Cllr. Christopher Buckmaster’s comment in his foreword to that report: “While we cannot always remove impairment we can ensure that society operates to provide optimum opportunity for disabled people”. This aspiration must surely extend to adults and children with learning disabilities and the members of this review group will ensure that the recommendations in this report are promoted to all service providers. We will monitor their implementation and we will tackle robustly any who seek to evade them.

Cllr. Judith Blakeman
Chairman
1 SUMMARY OF MAIN RECOMMENDATIONS

The Council, together with the PCT, should set up a directory of all leisure and health promotion activities available in the borough from sports and recreation to walking, dancing and other physical and social activities (such as drama and music groups and museum visits). This should be available on-line to GPs as well as to the general public.

The Council, together with the PCT, should co-ordinate messages on healthy living and disease prevention across all agencies engaged in this activity.

Hospital trusts should examine their protocols to ensure that these do not get in the way of information from support workers on the particular needs of patients with learning disabilities getting through to nursing and medical staff.

The PCT and the hospital trusts should set out clearly what steps are being taken to eliminate diagnostic overshadowing, to record and monitor its occurrence and how the training of health care staff is designed to minimise it.

The PCT, together with the local hospital trusts and GPs, should devise a way of flagging up the needs of people with learning disabilities when they are referred from primary to secondary and specialist care and ensure that this information precedes them at all stages of hospital attendance, including at reception, accident and emergency, surgery and medicine.

The PCT, together with the local hospital trusts and GPs, should ensure that the burden of contacting and organising medical treatment and care does not fall disproportionately on the carer or parent. This may require the health services to identify a health facilitator to co-ordinate all aspects of healthcare in support of the patient and carer.

As part of meeting their disability equality duty, hospitals should create environments that provide for privacy, including private waiting and changing areas for children with complex disabilities whose behaviour can be affected by waiting room pressures. This would be of benefit to all patients.

The Council and the PCT should jointly evaluate the GP exercise referral scheme to see if it is achieving its objectives and to identify what more can be done to support it. For example, the PCT should resume its support of the scheme, GPs should be encouraged to follow up their referrals and the Borough should consider how attendees on low income can be supported and encouraged to continue with their exercise programmes.

The PCT should ensure that there is a clear mainstream care pathway to enable people with learning disabilities to access dental services. GPs and hospitals should have systems in place to flag up the specific needs of
patients with learning disabilities attending hospital for acute dental care. The claims by some parents of children with disabilities about extended waiting times for treatment must be investigated. Adults with learning disabilities should be offered an improved choice of hospital for acute dental care.

The PCT should assess the acceptability and cost effectiveness of preventive dentistry intervention for children. Targeted prevention work should be piloted in one area to see how effective it is in bringing down dental problems.

The PCT should consider cost effective ways of collecting information on any specific dental health care needs of black and ethnic minority communities so that appropriate dental health interventions can be made.

The PCT, with the Council where appropriate, should ensure that health checks for people with severe and enduring mental illness are carried out by their GP on an annual basis as detailed in the new GP contract and that the health needs arising out of these checks are incorporated into patients’ action plans.

The Council and the PCT should support and assist the three GP practices in the Borough with large learning disability populations to develop their services, perhaps through a local development scheme along the lines of the one in Westminster. The community learning disability nurses should provide appropriate specialist backup to these enhanced services.

In order to reduce overcrowding in social housing the Council should set targets to monitor the number of moves by under-occupiers and pilot a range of new incentives and schemes to encourage moves. It should carry out an audit of under and over-occupied properties in conjunction with social landlords.

The Council and the PCT should publish a statement of the impact of overcrowding on mental and physical health to improve awareness. The Council should influence developers using Section 106 legislation to ensure that new build properties have sufficient outdoor and green spaces and that there is a good provision of affordable and social rented properties with more than two bedrooms. In all its publicity to those on the Common Housing Register the Borough should make it clear that, given the current shortage of properties with more than two bedrooms, those who are considering enlarging their families should be prepared to be re-housed outside the Borough if their accommodation becomes overcrowded.
2 STRUCTURE OF THE REPORT

2.1 Section 3 of the report introduces the Review, setting out the:
   a) Background to the Review
   a) Terms of Reference of the Review
   b) Membership of the Review Group
   c) Methodology of the Review

2.2 Section 4 of the report sets out the Review’s findings on:
   b) Whether the health inequalities gap identified by the 2004 review, as measured in terms of premature mortality, is changing for better or worse;
   c) What progress has been made by local agencies in tackling health inequalities since 2004.

2.3 Section 5 of the report looks in more detail at the health and health care of four vulnerable or deprived groups in the community (people with learning disabilities; users of mental health services; children under five and their mothers; and people living in social housing) and examines:
   a) The profile of these groups in the Borough;
   d) The differences in health outcomes for these groups compared to the rest of the population;
   e) The barriers to accessing health care and health promotion services in the Borough.

2.4 Section 6 of the report sets out the findings and recommendations of the review in relation to the health of the vulnerable groups.

2.5 A glossary at the end of the report provides an explanation of some of the terms used in this report.

3 INTRODUCTION TO THE REVIEW

3.1 BACKGROUND TO THE REVIEW

3.1.1 In January 2003, Council commissioned a review of health inequalities in the Royal Borough, lead by the (then) Overview and Scrutiny Committee (OSC) for Social Services, Health and Housing. The review report, together with the Cabinet and PCT responses, were presented to Council in December 2004.

3.1.2 In September 2006, the Health OSC set up a review group to consider what progress has been made on health inequalities and what further work should be undertaken to tackle health inequalities in the Royal Borough.
3.2 TERMS OF REFERENCE OF THE REVIEW

The Health OSC agreed the following terms of reference for the health inequalities review 2007:

a. To review and update the baseline information on health inequalities that was produced for the 2004 Review;

b. To investigate what action has been taken by the Royal Borough of Kensington and Chelsea ((RBKC or the Council), the Kensington and Chelsea Primary Care Trust (K&C PCT or the PCT), the Kensington and Chelsea Partnership (KCP) and other local agencies and organisations to tackle health inequalities in the Royal Borough, including examining what progress has been made in pursuing the ideas contained in the 2004 health inequalities report;

c. To identify which strategies and approaches aimed at reducing health inequalities are working and which are not, and the reasons for this;

d. To consider the experience of other parts of the country in tackling health inequalities and draw appropriate lessons for the Royal Borough;

e. To explore, with key stakeholders involved in improving public health and tackling health inequalities, additional effective ways of reducing inequalities in the context of the Royal Borough;

f. To undertake a thematic exploration of the work being done to tackle specific types of health inequalities in the Royal Borough. Four themes were identified: child and maternal health, the health of people with learning disabilities, users of mental health services, and people living in social housing;

g. To link the work of the review group at appropriate points with the work being done by the PCT and the Royal Borough on developing a new Public Health Strategy for Kensington and Chelsea.
3.3 MEMBERSHIP OF THE REVIEW GROUP

Members of the Health Inequalities Review Group were:


3.4 METHODOLOGY OF THE REVIEW

3.4.1 The review group was updated by the PCT on the state of the health inequalities gap in the Borough and a detailed report was received on the progress of work by the Council and the PCT on improving health and reducing health inequalities in the Borough.

3.4.2 The review group decided early on to focus its energies on looking in detail at the experience of a number of vulnerable or disadvantaged groups in the community who have worse health outcomes than the general population. The aim was to understand the factors that impacted on their health, consider what could be done to remove any barriers to better health and make concrete recommendations on what more could be done by the agencies involved to improve the health and health care of these groups.

3.4.3 The Review Group sponsored four workshops between March and June 2007 involving service users and carers from the vulnerable groups, tenants, advocacy groups, service managers and professional staff, parents of children with disabilities and representatives of organisations working in housing, social care and public health. One of these workshops (on Housing and Health) was organised jointly with Council and PCT officers working on the development of the Borough Public Health Strategy and Action Plan. Altogether over 100 people were involved in the discussions or in giving evidence to the review group (a full list of participants is attached as Appendix A).

3.4.4 Two further sessions were held in July and September 2007 to hear evidence from RBKC Leisure Services Department, the RBKC Leisure Services Contractor (Cannons), the Chelsea and Westminster Hospital and Kensington
and Chelsea PCT. Service users and carers from the vulnerable groups, their advocates and representatives from other interested organisations were invited to a meeting with the health care trusts in September to listen to the presentations and ask questions. Following the meeting, the review group asked the PCT and the Chelsea and Westminster Hospital to respond in writing to the issues raised by service users. The trusts’ responses are attached as Appendix K.

4 PROGRESS ON HEALTH INEQUALITIES SINCE 2004

4.1 Update on the health inequalities gap in the Borough

4.1.1 The PCT has recently drafted a report entitled *Is the Health Inequalities “Gap” in Kensington and Chelsea changing?* which looks at whether there have been improvements in the health of people in different parts of the Borough compared to London and England and whether health inequalities are getting better or worse locally. Premature mortality (death under 75 years of age) was used to quantify levels of healthiness. The paper is attached in full as Appendix B.

4.1.2 Premature mortality was chosen as the most appropriate measure of health inequalities as it was considered to represent potentially avoidable deaths, and was not confounded by the location of residential and care homes. The report found that the premature mortality rate in the most deprived parts of the Borough – the four most northerly wards – has improved over the last five years at a similar rate to London and faster than the national rate.

4.1.3 However, the health inequalities “gap” between these wards and the rest of the Borough has widened. This is because premature mortality in the rest of the Borough has improved much faster than the London and national averages. This vast improvement is likely to be due in part to gentrification.

4.1.4 The ranking of the “healthiest” of the wards in the Borough has remained similar:

a) St Charles and Golborne continue to have the worst health, followed by Notting Barns, then Colville and Cremorne;

b) Some of the healthier wards have become more healthy, in particular Queens Gate and Brompton wards in the South Kensington area; and

c) The life expectancy gap between the most and least healthy wards is still in excess of ten years.

4.1.5 In its paper the PCT argues that because of the limited influence of statutory agencies such as the PCT and Council on demographic change in the more affluent areas of the Borough, alternative measures may be needed to benchmark health improvements in the Borough’s most deprived areas. It
proposes to continue monitoring premature mortality locally in comparison to London and England benchmarks.

4.1.6 Progress in tackling health inequalities can be measured in a number of ways. A recent paper by the Health Development Agency entitled *Health Inequalities: concepts, frameworks and policy* argues that there are three dimensions to tackling health inequalities:

1. Improving the health of poor people (a positive change in their social conditions and life chances, in their risk behaviours and as a longer term outcome, in their health and well being);
2. Narrowing the health gaps between the worst off in society and the better off requires improving the health of the poorest faster than for rest of population;
3. Reducing health gradients: the standards of health enjoyed by the best off should be attainable by all.

4.1.7 On the basis of this definition it is clear that while there has been some success in improving the health outcomes of the most disadvantaged (measured in terms of premature mortality rates), there has also been a widening of inequalities between the most and the least healthy wards in the Borough.

4.2 Progress on tackling health inequalities since the 2004 review

4.2.1 The review group received reports on the progress of work in reducing health inequalities from the Kensington and Chelsea PCT and the Royal Borough, which are summarised below. The full reports are attached as Appendix C.

4.2.2 The 2005 Health Equity Audit of General Practice carried out by the PCT showed that out of the 14 access and quality indicators used, seven showed improvement, one no change and six showed a deterioration in health inequalities in the Borough compared with a similar exercise carried out in 2003. The audit also showed that since 2003 there had been improvements in cervical screening and child immunisation.

4.2.3 The PCT has achieved the national target for ‘flu immunisation for the last three years in succession for over 65s. Its Stop Smoking Service has met its 2006/07 target of achieving 1,500 four week quitters for the year. A higher proportion of smokers from deprived areas had set quit dates and quit at four weeks than smokers from affluent areas in the previous three years. Childhood immunisation rates have increased year on year from 49% in 2003/04 to 80% in 2006/07.

4.2.4 The PCT has been engaging communities and individuals in improving their own health through developed a Peer Health Education Programme. Fifteen local residents have completed a course enabling them to deliver “cook and
taste" sessions to their own communities. Two students have been employed as community food workers and more wish to be employed on a sessional basis. 145 residents have attended the seven week ‘Cook and Taste' programmes, 64 of whom have increased their fruit and vegetable portions by two portions (the target set by the Government Office for London).

4.2.5 Progress has been made on improving child and maternal health through:
   a. Establishing two breastfeeding cafes;
   b. Improving breastfeeding initiation rates (from 89% in 2006 to nearly 91% in 2007);
   c. Supporting Healthy Schools initiatives through providing professional advice and support to schools;
   d. Investing in services to improve childhood nutrition through supporting parents around weaning and increasing dietetic advice;
   e. Working to reduce childhood obesity.

4.2.6 The Equity Audit of General Practice in 2005 showed improvement in the quality of care and a reduction in inequity compared to 2003, but the number of practices offering additional services (child surveillance, IUD clinics, and minor surgery) had declined and greater reductions had been in the most deprived areas. Since the re-audit of General Practice in 2005, equity audits have been carried out on the stop smoking service and the district nursing service. An equity audit on the health visiting service is currently being carried out.

4.2.7 Improvements in quality and access have been made since the 2005 Equity Audit. For example: currently, all except one practice is signed up to deliver child health surveillance. GPs have the right to opt in or out of providing enhanced services such as IUD and minor surgery; however, the PCT has strict guidelines around infection control, levels of qualification and minimum activity levels which practices must meet to be able to provide enhanced services. Patients registered at practices not offering IUD fitting are able to go to any family planning clinic; those registered at practices not offering minor surgery attend one of two centres in the Borough commissioned by the PCT to offer this service (one in the north and one in the south).

4.2.8 The PCT dietetics department was involved in drafting the tender specifications for menu planning for the new catering contract for the PCT. Healthier options are now available for PCT staff and patients.

4.2.9 The new GP contract requires GP practices to hold registers of patients with a range of chronic diseases and lifestyle factors such as obesity. Payment relates to targets achieved for these groups and for size of register. The number of registers increased on a two yearly basis and currently covers 19 areas. This incentivised payment structure has helped to drive up quality and continuity of care for those with chronic diseases.
4.2.10 The PCT has been using the national GP contract to get better information to target services. The formation of disease registers for a range of different chronic disease and lifestyle areas has enabled the PCT to improve its understanding of morbidity in the Borough and therefore target its services more appropriately.

4.2.11 The Council's *Community Strategy* identified “health and well being” as one of the two priority areas for a cross-cutting approach. Of the 78 objectives in the *Community Strategy* that contribute to improving health and reducing health inequalities, 53 measurable targets relate to this. These 53 targets appear in the *Community Strategy* monitoring plan, including targets relating to all Local Area Agreement (LAA) projects. The Kensington and Chelsea Partnership produced a progress report against the *Community Strategy* monitoring plan in July 07 which showed that 71% of the 53 targets identified as contributing to improving health and reducing health inequalities were assessed as ‘Green’ for progress.

4.2.12 Progress in reaching the LAA targets aimed at reducing health inequalities has been reported as follows:

(a) Income targets: 902 people received advice and guidance regarding benefits that could increase their income levels (reported in March 07). This was slightly under the anticipated target of 1092 but since then, services have been increased and are accessible in children’s centres due to high demand. The Citizen’s Advice Bureau are leading on this project and anticipate meeting the target for September 07 of 1754 (to be reported at the end of November 2007).

(b) Food and nutrition targets: 64 people have reported to have increased their fruit and vegetable consumption by two portions and the PCT is therefore on track to meet the LAA target.

(c) *Healthy Schools* targets: The number of *Healthy Schools* in the Borough currently stands at 21 of a possible 33 (63.6%). This puts the Borough significantly ahead of the target of 55% for September 2007 and also the target of 60% of schools by March 2008.

(d) Reducing childhood obesity targets: Levels of child obesity in state schools in the Borough in Reception year (age 4-5) and Year 6 (Age 10 – 11) were 14.2% in 2005/06; this rose to 15.3% in 2006/07 and is behind the LAA target. National data have not been published yet, which will establish whether this rise is faster or slower than the national rate. The target was originally designed to be a 'stretch' on the national target, delivering a halt in the rise in obesity two years earlier than the 2010 national target; however, the national target has now
(e) Breastfeeding targets: The PCT met its target for breastfeeding initiation and is ahead of its target of breastfeeding at 6-8 weeks (June 2007: 79.1%; target 69.3%).

(f) Teenage mothers: The percentage of teenage mothers resident in the Borough and known to Connexions who access employment, education and training was reported as 45% in March 07. This was a reduction from 54% reported in September 06 but this is due to the very low actual number of conceptions, causing the figures to fluctuate.

(g) Sports participation targets: The percentage of young people participating in at least two hours of high quality physical activity in week was reported as 74% in September 06. The Sports Development Partnership is confident that the target of 82% for September 07 will be met (results to be reported end of November 07). The number of young people obtaining qualifications as sports coaches was 30 in March 07, well ahead of the target of ten. An update will be reported end of November 07.

4.2.13 Housing Policy: In recognition of the part that overcrowding can play in contributing to people’s poor health, the Royal Borough’s new allocations scheme seeks to tackle health inequality by awarding a higher level of priority to severely overcrowded households than at present. For the first time overcrowded households will be able to compete for properties with statutorily homeless households. Severely overcrowded households will also be on the same points as top level medical priority households. The new scheme was implemented in July 2007. In addition, important health benefits are expected to flow from the Council’s achievement of its Decent Homes programme.

4.2.14 Health Action Plans: All young people with learning disabilities in transition from child to adult and about 74% of learning disability service users have health action plans prepared by their community nurse. These identify health risks and make recommendations about how these should be addressed; for example blood pressure checks, obesity, screening for breast or testicular cancer. Health action plans are reviewed to ensure that they are implemented. The community learning disability team identifies GP practices with high numbers of people with learning disability and discusses their special needs with the GP, the practice nurse and other health professionals.

4.2.15 Other ways in which the health needs of people with learning disability have been supported included:

a. Preparing information in an accessible format, for example, on what an examination may involve, what to expect when going into hospital;
b. Staff try to allay people’s fear of, for example, going for an appointment or having an injection or smear test. They may also accompany them to the appointment;
c. A “communication passport” is prepared for some people going into hospital to help staff understand and communicate with them. The community nurse within the team prepares the communication passport and liaises with the hospital. When used, it is a very effective way of ensuring that the individual’s needs are known by the hospital clinical staff.

4.2.16 Mental Health: Direct payments have been used for the purpose of providing access to regular physical exercise for mental health day service care users and carers. As of November 2007, 37 direct payments are in place for service users and five for carers of people with mental health problems. This compares with just six service users on direct payments for gym membership in October 2006.

4.2.17 In conclusion, the review group noted that:
1. Improving health outcomes is a significant feature of the Council’s Community Strategy and Local Area Agreement
2. 71% of the 53 Community Strategy targets have been assessed as “green” for progress;
3. A number of the LAA targets are on course to being met: food and nutrition, breastfeeding and sports participation by young people;
4. However, between 2005/06 and 2006/7 there has been a rise in childhood obesity in state schools in the Borough;
5. Progress has been made in meeting targets on ‘flu immunisation, smoking cessation and there has been increase in childhood immunisation rates;
6. Some progress has been made in targeting health improvement work at areas of the Borough where health is poorest – for example, through smoking cessation;
7. Take up of the Healthy Schools programme has increased significantly to 21 out of a possible 33 and the Council is to be commended for the effort it has put into this area;
8. Progress has been made on developing joint initiatives and joint targets between the Council and the PCT, though there is scope for much more co-ordination between the two organisations to maximise the impact of existing resources, particularly on health promotion;
9. There is scope for greater use of Section 106 agreements to improve the quality and affordability of housing;
10. The new housing allocations policy gives the same priority to overcrowding as to medical needs and its impact on reducing overcrowding should be monitored.
5 IN-DEPTH FOCUS ON THE HEALTH OF VULNERABLE GROUPS

5.1 Introduction

5.1.1 This review has sought to get a more detailed picture of the health and access to health care of some particularly vulnerable or deprived groups in the community who, research suggests, have poorer health outcomes than the general population. These groups are: (1) people with learning disabilities; (2) users of mental health services; (3) children under five and their mothers; and (4) people living in social housing.

5.1.2 The review has focused on the role that services aimed at preventing ill health and timely and effective health care intervention can play in improving the physical health of these vulnerable groups.

5.1.3 The review has examined specific problems that these groups experience in accessing health promotion, health care and treatment services and what more could be done to improve access to these services.

5.1.4 In depth information on location, health outcomes and barriers to good health for these four groups has been detailed in Appendix D and is summarised briefly below.

5.2 People with learning disabilities

5.2.1 There are 350 people with learning disabilities known to services, half of whom live within the Borough. Three quarters of residents with learning disabilities live in the north of the Borough, due in part to the location of supported housing. A learning disability is different from a learning difficulty (such as dyslexia, ADHD, autism, emotional difficulties) and also excludes conditions such as head trauma, stroke, dementia, Alzheimer’s, mental illness and physical disabilities. It is diagnosed by a care manager or, where it is not clear, by a psychologist using psychometric testing.

5.2.2 People with learning disabilities have significantly poorer health than the general population, with the most common problems being obesity, diabetes and respiratory disease. Poor health among those with learning disabilities can relate to: poor socio-economic circumstances (which are correlated with ill health), congenital problems and lifestyle issues particular to those with learning disabilities.
5.2.3 Common barriers to good health for people with learning disabilities include:

- A lack of information on what support is available, delivered in an appropriate format
- Poor attitudes and communication skills among health and social care professionals
- Diagnostic overshadowing, where individuals’ health problems are attributed to their impairment, even when they are completely unrelated
- Poorly designed buildings,
- A lack of appropriate facilities
- Inappropriate systems
- Poor health education and information in the community

5.3 Users of mental health services

5.3.1 In Kensington and Chelsea, 2,195 patients are known by practices to have a severe and enduring mental illness (1.2% of the population) and nearly 7,000 are known to have had a new diagnosis of depression in the previous twelve months. Levels of severe and enduring mental illness are 50% higher in North Kensington compared to South Kensington and Chelsea.

5.3.2 People with severe and enduring mental illnesses (such as schizophrenia and bipolar disorder) are at increased risk for a range of physical illnesses and conditions, including coronary heart disease, diabetes, infections, respiratory disease and greater levels of obesity. They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease. People with a diagnosis of schizophrenia or bipolar disorder are more than twice as likely to have diabetes than other patients. In many cases, weight gain in people with severe and enduring mental illness is a side effect of medication.

5.3.3 People who use mental health services are much less likely than the general population to be offered blood pressure, cholesterol, urine or weight checks, or to receive opportunistic advice on smoking cessation, alcohol, exercise or diet. Reasons include being unaware of and/or late recognition of symptoms, low expectations of health care services, difficulties in attending a GP surgery and potentially long waiting times, communication problems with health care professionals, and stigma and discrimination on the part of health care professionals, as well as problems with GP registration.
5.4 **Children under five and their mothers**

5.4.1 In Kensington and Chelsea there is a similar proportion of new births compared to London. These tend to be spread fairly evenly throughout the borough. Young families from the more affluent areas of South Kensington and Chelsea are more likely to move away from the Borough than those in the more deprived and ethnically diverse area of North Kensington, leaving concentrations of older children in North Kensington in particular.

5.4.2 Kensington and Chelsea is an affluent borough and performs well on a range of health outcomes. However, inequalities within the Borough do exist; these correlate broadly with deprivation: indicators such as low birthweight, hospital admission, smoking in pregnancy and bottle-feeding are all higher in the more deprived north of the Borough.

5.4.3 Barriers to good health for mothers and young children are complex and far-ranging and include most of the ‘wider determinants’ of health, such as education, housing and income. The structure, location and organisation of care provided to mothers and children are also key to improving their health.

5.5 **People living in social housing**

5.5.1 A quarter (26%) of properties in Kensington and Chelsea are classified as social housing; this is the same as the London average (26%) but higher than nationally (19%). The social housing is focused primarily in the north of the Borough: 57% of households in the four most northerly wards are categorised as social housing, compared to 18% elsewhere in the Borough. Compared to private housing in the Borough, it houses a higher proportion of black and minority ethnic (BME) groups, school age children, older people, and lone parent families with dependent children.

5.5.2 Health inequalities within the Borough are large: there is an absolute difference in life expectancy between the ‘most healthy’ and ‘least healthy’ ward of more than ten years. Those living in areas of high density social housing in the Borough are twice as likely to die before the age of 75 compared to those in other areas. Levels of most chronic diseases are higher in the north of the Borough compared to the south. Residents living in social housing report three times the rate of ‘not good’ health and limiting long-term illness compared to those in private housing.

5.5.3 It is likely that the causal link between housing and health works in both directions, with housing affecting an individual’s health and health also affecting an individual’s housing opportunities. There are direct links with housing quality such as cold and damp, lack of housing or temporary
accommodation, and factors that relate more to the broader social and
dehavioural environment such as overcrowding, sleep deprivation,
neighbourhood quality and infrastructure deprivation. Poor housing conditions
often coexist with other forms of deprivation such as poor education,
unemployment, ill health and social isolation, making it difficult to isolate,
modify and assess the overall health impact of housing conditions. Clearly,
the medical condition of applicants is considered when social housing is
allocated to families, thereby influencing the levels of poor health in areas of
social housing.

6 FINDINGS AND RECOMMENDATIONS OF THE REVIEW

6.1 Access to Information

6.1.1 The availability of information in the right format at the right time plays a
critical role in enabling people to take advantage of health promotion and
treatment opportunities.

6.1.2 On child and maternal health, the review group heard that there was scope for
greater co-ordination between the professionals and agencies that come into
contact with parents and children to deliver a consistent set of messages.
These need to be credible, consistent and culturally appropriate.

6.1.3 The Council and the local NHS have resources invested in health visitors and
home visitors through Sure Start which could be refocused to target and
deliver messages that could impact on behaviour. Home visitors visit families
when the child is eight weeks old and then again at 18 months. These
provide critical opportunities to get messages across which could have a
significant impact on the future health and well-being of children and their
parents. This approach could be reproduced in other parts of the Borough as
home visiting begins to be cascaded to other localities.

6.1.4 Children’s centres could also be used to deliver health messages and health
services more consistently across the Borough. Childcare provision could be
used to attract parents in particularly deprived areas. This contact could then
be used to get across key messages on healthy living and disease prevention,
including immunisation, dental care, child safety and accident prevention,
breastfeeding, advice on quitting smoking, weaning and food preparation for
children and parental mental well-being.

6.1.5 The review group heard that people with learning disabilities and users of
mental health services, as well as the professionals working with them, often
did not know enough about what leisure and sports opportunities are available
to them. There is no one single place for potential users and service providers
to access such information. This information tends to be scattered and insufficiently targeted at the people who could benefit from it. Lack of confidence among service users sometimes also prevented them from taking part in physical activity, particularly in exercise referral schemes (more information on these schemes is included in Section 6.7.3 of the Report).

**Recommendations**

The Council and the PCT should:

R1 Set up a directory of all leisure and health promotion activities available in the Borough from sports and recreation to walking, dancing and other physical and social activities (such as drama and music groups and museum visits). This should be available on-line to GPs as well as to the general public to enable people to mix and match from a menu of options available locally or within a reasonable travelling distance. Once the directory is in place, these activities should be analysed, with input from service users and those not using the services to see if there are gaps and whether activities take account of matters such as cultural preferences. The directory should include information on the availability of direct payments for such activities.

R2 Ensure that all clinicians addressing mental health and learning disability needs are aware of the opportunities for prescribing and promoting leisure and exercise and how they could be funded, particularly for those patients embarking on courses of medication which have an impact on weight management.

R3 Co-ordinate messages on healthy living and disease prevention across all agencies engaged in this activity and particularly to use the childcare provision at Children’s Centres to get across key health messages to parents.

**6.2 Attitudes among health professionals**

6.2.1 The review group heard that awareness of learning disability issues and take-up of appropriate training by primary care providers is low. Although the total number of people with learning disabilities living in the Borough is small (198) there is an argument that there should be a greater emphasis on disability issues in the training programmes of health professionals and carers as part of addressing the wider disability equality duty. In this context, the planned event for all GPs and practice staff in Kensington and Chelsea to look at the needs of people with learning disabilities is welcome.

6.2.2 The review group was told that more should be done to make accessible training tools easily available (for example via the Net) to GPs, to ensure that there is a minimum number of learning disability trained GPs in the Borough.
6.2.3 Similarly there is a need for more education and training on disability issues for acute health care providers. The review group heard concerns about the level of awareness of hospital staff in high contact areas, such as reception, accident and emergency, surgery and medicine on the specific needs of people with learning disabilities. Concerns were raised at the review group that hospital protocols sometimes got in the way of staff understanding the needs of people with learning disabilities – for instance that information from parents and carers on the particular needs of individuals, like support mechanisms to help them to eat them eat, does not always get through to clinicians and nurses.

6.3.4 The review group was told that the lack of awareness and understanding among health care staff of the needs of people with learning disabilities - for example that they prefer images rather than words, don’t understand structures and need time to make decisions - could lead to this group being ignored, isolated and treated inappropriately.

6.2.5 The review group was told about the problem of diagnostic overshadowing, where the health problems of people with learning disabilities and users of mental health services are sometimes attributed to their impairment or mental condition, even when they are completely unrelated. This leads to inappropriate treatment or insufficient choice of appropriate treatments.

**Recommendations**

The PCT should:

R4 Identify a GP with a special interest in learning disabilities to champion the interest of people with learning disabilities across the local health sector;

R5 Enhance learning disability training for all local GPs.

The hospital trusts should:

R6 Examine their protocols to ensure that they do not impede information from support workers, carers and parents on the particular needs of patients with learning disabilities getting through to nursing and medical staff.

The PCT and the hospital trusts should:

R7 Take steps to improve training for all GP and hospital reception staff on dealing with people with learning disabilities. This should include advice on how to make best use of expert resources such as the learning disability community team – not just on effective strategies for health promotion and
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maintenance, but also for pre and post operative support and on preparing hospital teams for the patient.

R8 Set out clearly what steps are being taken to eliminate diagnostic overshadowing; how its occurrence is recorded, monitored and evaluated and how the training of healthcare staff will be tailored to minimise its occurrence.

R9 Ensure that healthcare staff discuss the physical side effects of drugs with their patients.

6.3 Communication and coordination between agencies

6.3.1 The review group heard that professionals don’t always know what support is available for people with learning disabilities in the community, in hospitals and in GP practices. There is a huge amount of information around but not necessarily known to the relevant people. The speed of changes to health services also means that people can’t always keep up.

6.3.2 During discussions at the review group with people with learning disabilities and their carers, it emerged that when patients with learning disabilities are referred to hospital for treatment by GPs there is no system for flagging up their learning disabilities and associated needs. This means that the hospital is not always adequately prepared to deliver the service in an appropriate way. Given the effort that many carers say that they have to put into preparing people for the hospital visit, a bad experience at a hospital can set things back.

6.3.3 The review group was told that from a parent’s or carer’s perspective, there was too much emphasis on the parent or carer to organise or contact all the different people and services that may be involved in providing care or treatment, particularly around general anaesthetics and dental surgery. As one carer commented “I want people to know their job and do it”.

6.3.4 It was reported that there was often a reduction in service or a change to different services once a child reaches adulthood. For example a parent reported that the speech and language support and physiotherapy that her child was receiving while at school had been curtailed when she started attending college. Although issues of statutory entitlement go beyond the terms of this review, there is considerable scope for improving the management of the transition process.

6.3.5 In its evidence to the review, Yarrow Housing praised the valuable liaison role of the learning disability community nurses between GPs and hospitals. Their specialist knowledge and professional credibility enabled them to provide advice to GPs on specific patient needs, for example on conditions such as
complex epilepsy, swallowing, communication and psychological issues. However Yarrow Housing were concerned whether there was sufficient such community nurse capacity to meet existing demand.

6.3.6 The point made in section 6.1.5 on the need for co-ordination between agencies to give a clear set of healthy living and disease prevention messages to target groups is also relevant here.

Recommendations

The PCT and the Royal Borough should:

R10 Consider introducing “Crisis Cards” for people with learning disabilities similar to those carried by mental health patients that carry details of health conditions and medication and other needs.

R11 Ensure that parents of children with learning disabilities are provided with information about the transition arrangements when their children reach adulthood well in advance of the event. Any potential change or reduction in services should be signalled and worked through with parents so that they are not faced with a sudden, unexplained diminution or change in services.

The PCT, the local hospital trusts and GPs should

R12 Devise a way of flagging up the needs of people with learning disabilities when they are referred from primary to secondary and specialist care and ensure that this information precedes them at all stages of hospital attendance, including at reception, accident and emergency, surgery and medicine.

R13 Ensure that the burden of contacting and organising medical treatment and care does not fall disproportionately on the carer or parent. This may require the health services to identify a health facilitator to co-ordinate all aspects of health care in support of the patient and carer.

6.4 Empowerment and self advocacy

6.4.1 There is a need to provide the paid and family carers of people with learning disabilities with information, advice, training and support on health related issues so that they can become health advocates.

6.4.2 The review group was told about the expert patients’ programme (EPP) a patient empowerment programme run by the PCT. This is a training programme that gives people who live with long-term chronic conditions the opportunity to develop new skills to manage their condition better on a day-to-
day basis. The programme emphasises the importance of appropriate exercise, a healthy diet, good communication and partnership working with health professionals. It is based on the premise that people living with chronic illnesses are often in the best position to know what they need to manage their own condition. Provided with the necessary 'self-management' skills, they can make a significant impact on their disease and quality of life.

6.4.3 The review group was informed that the EPP is currently on track to deliver six courses per year – each course having a maximum of 14 participants. In 2006/07, 64 participants signed up to attend five courses. This included generic EPP courses and EPP course for carers with a long-term condition. The carers’ courses were run in partnership with RBKC, which provided the venue and funding for tutors.

6.4.4 The potential pool of participants is difficult to gauge. The course is suitable for anyone living with any self-defined long-term health condition. In order to attend the course people need to be motivated to make changes in their life and to engage in the goal setting and action planning that is an integral part of the programme. The carers’ course is offered currently to carers of adults with long-term health conditions who typically themselves would have one or more long-term health condition. It is open to people with mental as well as physical health issues, although there are some caveats in relation to people with conditions such as psychoses.

6.4.5 Courses in other languages are being developed, with some courses in Arabic planned.

6.4.6 In relation to child and maternal health, the limitations of the role of GPs in improving child health were recognised. The Sure Start programme was commended as a good way to signpost families to what health care, health promotion and prevention are available. The difficulty is not a lack of choice but parents not knowing what is available or not having the confidence to take part.

Recommendations

The Council and the PCT should:

R14 Find additional ways of supporting the paid and family carers of people with learning disabilities with information, advice, training and support on health related issues so that they can become health advocates.

R15 Study the reputed success of buddying systems, including bilingual buddying, and if they are found to be effective, consider rolling them out across more areas.
R16 Where appropriate, consider relocating services currently delivered on GP premises into other venues such as children's centres and schools in order to bring the more isolated parents into contact with other parents.

R17 Identify those dentists with a particular interest in children's dentistry and ensure that this is communicated effectively to the general public.

6.5 A holistic approach

Users of mental health services and their advocates have argued for a strategic approach that takes a holistic view of service users. This would address the whole spectrum of needs, from medical support to housing, training, employment and leisure opportunities.

Social isolation was identified as an important problem for users of mental health services. Helping them to become more aware of the services available and offering them a broader range of opportunities to participate in normal activities were both thought to be important. It was recognised that there was a need to build people's confidence to enable them to take advantage of these opportunities and give them more control over the services provided for them.

Recommendations

The PCT and the Council should:

R18 Identify appropriate ways of supporting people who may be isolated to access the many existing sports and leisure opportunities in the borough – including through buddying projects;

R19 Ensure that GPs, children's centres, day centres and mental health units are fully engaged with the PCT's stop smoking services.

The PCT should:

R20 Highlight in its clinical governance plans the role that primary care providers are expected to play in signposting users of mental health services to appropriate support and personal development networks that could promote their well being.

The Council should:

R21 Ensure that the statutory sector is championing the development of employment opportunities for vulnerable groups generally and specifically to
ensure that the community mental health teams look at the experience of voluntary sector programmes that support employment opportunities in the Borough.

R22 Ensure that day services make action on health and well being an integral part of the personal development plans of their members.

6.6 **Responsiveness to individual needs**

Some people with learning disabilities are not able to use specialist surgery based GP services because of behavioural issues. Parents of children with complex disabilities highlighted the need for care providers to take simple, practical steps such as having a flexible appointments system that allows for double appointments or early or late appointments and, for example, individual cubicles and separate waiting areas in hospitals, which would make their life easier.

**Recommendations**

R23 The PCT should encourage GPs to offer double appointments as well as early and late appointments, perhaps through the locally enhanced scheme referred to earlier.

R24 Hospitals should create more inclusive environments that provide separate spaces, such as private areas for children with complex disabilities whose behaviour is affected by waiting room pressures. This would benefit all patients.

6.7 **Healthy living, leisure and exercise**

6.7.1 The provision of healthy living activities for people with learning disabilities was reasonably good in some parts of the Borough, particularly activities at the Portobello Fitness Centre. However not all activities have a specialist learning disability focus, often due to lack of resources. There is scope for developing more fun activities, such as food shopping to learn about healthy eating and cooking classes.

6.7.2 The review group recognised that a lack of opportunity for physical activity is a major cause of health inequality. Barriers to exercise include a perceived lack of facilities in the Borough, awareness and affordability of facilities, distance from them, fear of crime in open spaces and insufficient encouragement to take part in the activities. The absence of easily accessible information on what is available is another factor, addressed in section 6.1.1 of this report.
6.7.3 The review group was told about the exercise referral scheme which has been running over a number of years at the Kensington Leisure Centre and the Chelsea Sports Centre, operated in partnership between the Council, the contractor, the PCT (until April 2006) and the Westway Development Trust. Individuals are referred by their GP using a referral form but have to make the appointment themselves. At the first appointment the individual's health and lifestyle needs are assessed and an appropriate exercise programme is prescribed – initially over twelve weeks – at subsidised prices (assessment £6.75, Gym session £2.80, swim £1.20). After completing twelve weeks of the programme an individual can continue to use the facilities by applying for a concessionary pass, or for those in full time employment, pay a membership fee of £12 a month.

6.7.4 The leisure services contractor Cannons has been keen to develop the scheme and has invested money in new exercise diaries, promotional material and in training additional instructors. However, they pointed out that there was a missing link between the leisure centres and the GPs in that no reports are made to GPs, or follow up action taken if individuals don't attend, who make up between 30% and 40% of those referred. There has also been no systematic assessment of the effectiveness of the exercise regime. The review group recognised the need for a more systematic approach to helping people attend and complete the programme.

Recommendations

Leisure: the PCT and the Council should

R25 Take account of the needs of people with learning disabilities and users of mental health services when developing ideas on healthy living activities.

R26 Explore the possibility of offering extra concessions for leisure facilities to people from certain geographical areas and at certain times of the year, such as during the school holidays.

R27 Improve the ways that information on leisure activities is disseminated, for example via the Internet and through a maintained database that could be accessed by RSLs, TMO, voluntary groups, councillors and the public. There is scope for using more sophisticated targeted marketing techniques to attract different groups.

Exercise referral scheme: the Council and the PCT should:

R28 Evaluate the scheme to see if it has been achieving its objectives and what more could be done to support it, for example, by encouraging GPs to follow-
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up their referrals, with the probable additional advantage of reducing GP prescription bills;

R29 Consider how attendees on low incomes could be supported and encouraged to continue with their exercise regime where even the subsidised cost of membership is a barrier, for example, through greater use of direct payments;

R30 Resume the PCT’s involvement in the scheme. With its recovered financial position the PCT may consider developing a locally enhanced scheme that overcomes some of the weaknesses identified by this review in section 6.7.4;

R31 Work with Cannons the contractor to experiment with a buddying system to help individuals stay the course;

R32 Use the Borough Newsletter to raise public awareness of the exercise referral scheme.

R33 Make action on health and well being an integral part of the support and development plans of users of the Council’s day services,

R34 Improve the quality of food in day centres.

6.8 Dentistry services

6.8.1 The Community Dental Service (CDS) is reported to be generally good in dealing with people with learning disabilities on routine matters until the situation gets complex and the use of a general anaesthetic becomes necessary. For safety reasons, all work under general anaesthetic has to be carried out at a hospital – and patients and carers feel there is no clearly defined care pathway between the CDS and the hospital. This can lead to extended delays for people with learning disabilities in getting even routine treatment. The review group was told that there was no provision for adults to go to Chelsea and Westminster hospital for dental services even if this were their choice, because the hospital does not provide a service for adults with learning disabilities. As a result, adult dental referrals are usually made to hospitals a considerable distance from the Borough, generally to Northwick Park, even though there are three major local hospitals within easier reach of most Borough residents.

6.8.2 The lack of clear care pathways means that personal relationships become the best way of getting things done - usually with a single point of contact. But when staff leave, it upsets the relationship. Very high turnover of staff also makes training difficult. The answer may be to ensure that mainstream care pathways are in place and that they take into account the needs of people with learning disabilities. If the systems and pathways are in place then the
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impact of high staff turnover and the reliance on individual personalities will become less important.

6.8.3 The PCT took over the management of the community dental service from April 2007. The review group heard that this has led to disruption for some users.

6.8.4 In relation to children’s dental health, it was recognised that more effort needed to be directed in the community at preventing dental problems from occurring in children in the first place. In connection with this issue the impact of the recent Brushing for life and Cool Kids campaign needs to be studied. There is a need for better information on dentistry provision in the Borough, and more opportunities should to be created for dialogue and discussion between dentists and the community. There is a perception that it is difficult to register with dentists who do NHS work in the north of the Borough. There is also not enough information to target appropriate dental health interventions to the needs of specific black and ethnic minority communities.

6.8.5 The review group heard that there was need for all agencies involved in children’s health to work together on a consistent set of messages about achieving and maintaining good dental health, for example, not keeping sweet things in the mouth too long. Such an approach would maximise the impact of existing resources on health promotion.

6.8.6 For users of mental health services, access to dental services can be difficult and off putting. Potential patients report concerns that they may be charged for dental services and they are not always aware of the community dental service at St Charles Hospital.

Recommendations

Dentistry services for people with learning disabilities: the PCT should:

R35 Ensure that there is a clear mainstream care pathway to access dental services;

R36 Ensure that GPs and hospitals have systems in place for flagging up patients with learning disabilities and their associated needs;

R37 Investigate claims by some parents of children with disabilities about the extended waiting times for treatment;

R38 Provide an improved choice of hospitals for adults with learning disabilities, while recognising the need to balance patients’ choice with the availability of appropriate expertise in the hospitals identified;
R39 Inform all service users of any new arrangements at the Community Dental Service following its transfer to the PCT; ensure that the care of individuals does not suffer following changes in personnel at the CDS; and ensure that all service users are aware of the option of home visits and their advantages and disadvantages if they are unable physically to access the CDS premises for whatever reason.

Dental health of children: the PCT should

R40 Assess the acceptability and cost effectiveness of preventive dentistry intervention and pilot increased prevention work in one area to see how effective it is in reducing dental problems;

R41 Ensure that information on dentistry services is more widespread and provided from a variety of venues;

R42 Ensure that more health professionals are involved in promoting dental health messages across the borough;

R43 Ensure that these messages are consistent across all agencies,

R44 Encourage all health professionals to promote annual dental health checks for 2-3 year olds so that dental problems are picked up at the earliest opportunity;

R45 Work with the Council to make dental advice available at the children’s centres;

R46 Establish a forum of people interested in dental health issues to focus on access to dental services in the north of the Borough;

R47 Consider cost effective ways of collecting information on the dental health needs of black and ethnic minority communities so that targeted dental health interventions can be made;

Dentistry for mental health service users: the PCT should:

R48 Improve information of the provision of dental services, where they are located and what charging policies apply.

6.9 Access to GP services

6.9.1 Having access to a surgery within a reasonable distance from home is particularly important for people with learning disabilities and this needs to be reflected in any proposals arising out of the Darzi report.
6.9.2 The community learning disability team (CDLT) currently undertakes health checks, but these do not include the blood and urine tests that are important for diagnosing conditions such as thyroid problems to which people with learning disabilities may be prone. The Westminster PCT local development scheme has led to a significant increase in referral rates for people with learning disabilities from primary to more specialist care. This scheme ensures that all people with learning disabilities are registered with a GP, receive annual health checks, are allocated a health facilitator or co-ordinator of health care and have individual health action plans.

6.9.3 The review group was told that the new GP contract enables GPs to offer health checks to people with severe and enduring mental illness.

**Recommendations**

The PCT and the Council where appropriate, should:

R49 Monitor to ensure that health checks for people with severe and enduring mental illness are carried out by their GP on an annual basis as detailed in the new GP contract and that any health needs arising out of these checks are incorporated into an individual health action plan;

R50 Ensure that GP services are accessible to mental health service users and people with learning disabilities across the Borough;

R51 Encourage GPs practising in the Borough to have a minimum and adequate level of training on mental health and learning disability issues;

R52 Ensure that there are mechanisms to follow-up people with severe mental illness who miss more than one appointment with a health care professional;

R53 Consider what configuration of GP services would provide best for the needs of people with learning disabilities. Options include: some GPs specialising in learning disability; retaining generalist GPs but enhancing their skills, knowledge and understanding of learning disabilities issues;

R54 Study the experience of the Westminster local enhanced scheme for people with learning disabilities with a view to setting up a similar scheme in the Royal Borough;

R55 Encourage the three GP practices in the Borough that have large learning disability populations to develop their services, perhaps through offering a local development scheme and enable the community learning disability team nurses to provide appropriate specialist backup to these enhanced services;
R56 Ensure that there are health action plans for all people with learning disabilities, particularly around dental care and access to healthy living activities and monitor and manage their implementation.

6.10 Access to opticians

The review group was told that some people with learning difficulties have experienced difficulties in getting help with sight problems, since opticians’ tests rely on reading letters. This problem is exacerbated in the case of people whose first language is not English. Reference was made to a practice in Bayswater area which used pictures rather than letters of the alphabet in tests that were provided free of charge.

Recommendation

R57 The PCT should encourage local opticians to use pictures in carrying out eye tests for people with learning disabilities, particularly for those whose first language is not English.

6.11 Impact of overcrowding on health

The Borough has some of the highest levels of overcrowding in the country. Overcrowding has significant effects on mental and physical health and contributes to health inequalities. Many overcrowded households have strong links to the local area and are reluctant to move out, which heightens the problem. Expectations of what the Council and Registered Social Landlords (RSLs) can provide are very high. For example, there is an expectation that tenants will be provided with a larger flat if they have more children.

Housing stock never meets expectations, and education on the limited supply could be of value. It is also essential to make better use of existing social housing stock in the Borough. One way is to increase the number of moves by those tenants currently occupying properties significantly larger than they require. Despite a considerable amount of work to date to identify under-occupiers and make them aware, through advertising, targeted mailings and other publicity, of the incentives available for moving to a smaller property, the number of moves achieved has been relatively small to date. This is an area that needs continued attention and new approaches should be piloted to encourage people to move.

Recommendations

The Council should:
R58 Set targets and monitor the number of moves by under-occupiers

R59 Pilot a range of new incentives and schemes to encourage moves and monitor their success;

R60 Carry out an audit of under and over-occupied properties jointly with the social landlords;

R61 Investigate the extent of illegal subletting in the Borough jointly with the social landlords;

R62 Extend initiatives to alleviate the immediate stresses associated with overcrowding such as after school homework clubs and more welcoming communal spaces on estates.

R63 Influence developers using Section 106 legislation to ensure that new build properties have sufficient outdoor and green spaces and that there is a good provision of affordable and social rented properties with more than two bedrooms.

R64 In all its publicity to those on the Common Housing Register, make it clear that, given the current shortage of properties with more than two bedrooms, those who are considering enlarging their families should be prepared to be re-housed outside the Borough if their accommodation becomes overcrowded.

The Council and the PCT should:

R65 Publish a statement on the impact of overcrowding on mental and physical health to improve awareness.

6.12 Impact of the physical and social environment on health

6.12.1 Fear of crime impacts on mental health, increases social isolation and reduces the likelihood of using open spaces in the evenings. Inadequate lighting can contribute to a fear of crime. Older people in particular are not taking part in physical and social activities, partly due to fear of crime and a lack of confidence that leads to social isolation. Poor transport links to some areas of social housing compounds this issue.

6.12.2 People with disabilities do not always have the means to live independently due to a lack of suitable housing and/or the lack of knowledge by some RSLs about adapted properties. Cold and damp properties are still contributing to ill health among social housing residents. The housing stock is in some cases is antiquated, poorly insulated and served by inadequate heating.
Environmental factors like noise and poor neighbourhood behaviour have been shown to be very detrimental to mental health and well-being.

**Recommendations**

The Council should:

R66 Ensure that there are more police community support officers (PCSOs) on the streets after 7.00 p.m. and during school holidays to reduce the fear of crime;

R67 Ensure that street lighting meets residents’ expectations;

R68 Ensure that new build properties are planned so as to “design out crime”;

R69 Pilot a multi-agency open space regeneration project, led by the voluntary sector and including the RSLs, TMO, PCSOs to reduce the fear of crime through innovative use of green spaces. The Council should advise community groups on how to participate;

R70 Ask the TMO and RSLs to carry out an audit of adapted properties to enable older and disabled people to live independently in their homes;

R71 Ask the TMO and RSLs to roll out ‘friendly neighbour agreements’ for new tenants.

The Council and the PCT should

R72 Provide training for RSL staff on affordable warmth;

R73 Establish a forum to purchase fuel more cheaply.

Recommendations specifically relevant to each vulnerable or disadvantaged group are set out separately in the appendices as follows:

*Appendix E:  Recommendations specifically relevant to learning disabilities*

*Appendix F:  Recommendations specifically relevant to mental health*

*Appendix G:  Recommendations specifically relevant to child and maternal health*

*Appendix H:  Recommendations specifically relevant to social housing*

*Appendix J:  List of all the recommendations*

*Appendix K:  Correspondence between the health inequalities review group and NHS trusts*
GLOSSARY

Health Inequality: Health inequality is the difference in health experiences and health outcomes between different population groups. They can be defined by socio-economic status, geographical area, age disability, gender or ethnic group.

Primary Care Trust: This is the part of the NHS responsible for planning and securing health services and improving the health of a local population. It is responsible for commissioning services from GPs, dentists, pharmacies, hospitals, mental health and learning disability service providers.

The Kensington and Chelsea Partnership was set up in 2002 to bring together local public organisations such as the Council, the Police and Primary Care Trust to work alongside the voluntary sector, business and community groups. It aims to join up services within the Borough, plan locally for the long-term and improve quality of life in the Borough, especially in more deprived neighbourhoods.

Local Area Agreement: Local Area Agreements are three year agreements between a local authority and the government which set out a set of local and national targets for the local authority to achieve. In return the government makes funding available and may agree to changes in particular areas to enable the Council to meet those targets.

Community Strategy: A community strategy sets out a long term vision for a Council-wide area, backed up by action plans to achieve it. It is developed in conjunction with the local community and provides a framework for issue based strategies such as health inequalities, children or the environment.

Connexions: Central London Connexions provides a range of information, advice and support for 13 to 19 year olds in the Royal Borough plus a service for young people with learning needs or disabilities up to the age of 25. It offers advice on a wide range of issues, from careers, work and study through to housing, drugs, money, health and leisure. It is managed locally by a Connexions Partnership that brings together all the key youth support services.

Sure Start: Sure Start is a cross-government programme of support for children and their families living in deprived areas. It aims to give the best start in life for every child by bringing together early education, childcare, health and family support. Sure Start contributes to children’s health and to reducing health inequalities by making health services more accessible to the most disadvantaged children and families. The overall focus of is on prevention and early identification of needs.
Children’s Centres: Sure Start children’s centres are places where children under five years old and their families can receive seamless integrated services and information, and where they can access help from multi-disciplinary teams of professionals.

Expert Patients Programme (EPP) is a training programme run by the PCT aimed at giving people who live with long-term chronic conditions the opportunity to develop new skills to manage their condition better on a day-to-day basis.

Tenant Management Organisation (TMO): Since 1996 The Royal Borough has transferred responsibility for the day to day management of its housing stock to the TMO, which manages the housing stock on the Royal Borough's behalf.

Registered Social Landlord (RSL): This is a voluntary (not for profit) organisation which provides affordable housing to people in housing need and which is registered with the government body called the Housing Corporation.