



# Planning for the future

The Kensington and Chelsea  
Joint Strategic Needs Assessment

Summary Report  
May 2009

**NHS**  
**Kensington and Chelsea**



THE ROYAL BOROUGH OF  
KENSINGTON  
AND CHELSEA



# Contents

1. Introduction.....	4-9
2. Health and well-being .....	10-13
3. Disease trends .....	14-19
4. Healthcare services .....	20-29
5. Children and young people .....	30-37
6. Older people .....	38-43
7. Mental health .....	44-49
8. Disability.....	50-59
9. Substance misuse.....	60-67
10. Next steps .....	68-69





# 1. Introduction

## Kensington and Chelsea's first Joint Strategic Needs Assessment

This report summarises the findings of Kensington and Chelsea's first Joint Strategic Needs Assessment (JSNA).

It identifies the current and future health and social care needs of the borough's population and analyses whether needs are being met locally. It has been carried out jointly by Kensington and Chelsea Council and NHS Kensington and Chelsea.

The JSNA process is designed to create a framework which guides the development and delivery of all health and adult social care services. We want to ensure we are providing relevant, responsive and well coordinated services to the right people in the right way, both now and in the future.

## Outputs from this year's Joint Strategic Needs Assessment

Three outputs have been produced:

- **Joint Strategic Needs Assessment – Summary Report:** this document contains all the key findings.
- **Joint Strategic Needs Assessment – Analysis Supplement:** covers the same areas as the summary report but in much greater detail, with web links to data factsheets. It will be updated regularly as new research and data emerge. It is located at the following internet address: [www.rbkc.gov.uk/partnerships/healthwellbeing/analysis\\_supplement.asp](http://www.rbkc.gov.uk/partnerships/healthwellbeing/analysis_supplement.asp)
- **Data Factsheets:** over 100 easy to print factsheets on a range of demographic, health and services-related topic areas, with rates and numbers both for now and in the future. Available through the Analysis Supplement, or at the following location: [www.rbkc.gov.uk/partnerships/healthwellbeing](http://www.rbkc.gov.uk/partnerships/healthwellbeing)

## A note about population figures

The data used in the documents comes from a range of sources: the Office for National Statistics (ONS), GP systems, the Council, hospitals, the Greater London Authority (GLA), the Department of Health, and many other bodies. Within the report, different data is used for different purposes; selection is based upon actual local experience and expertise relevant to the topic to ensure the most appropriate data is used for planning purposes.

In many cases the data is presented as rates. It is important to remember that the population projections that underpin these rates are an informed estimate of population. Annually revised figures will mean our understanding of needs may change over time. We will therefore continue to routinely monitor data for changes and update the JSNA accordingly.

For a more detailed discussion about population, please see the Kensington and Chelsea Partnership's **Community Strategy 2008 to 2018** and **Picture of our Community**. This can be found at [www.rbkc.gov.uk/kcpartnership/general](http://www.rbkc.gov.uk/kcpartnership/general)

## The ongoing process of assessing need

Producing the Joint Strategic Needs Assessment has been a learning experience. For future assessments, we will be examining certain key issues in further depth and will be involving the voluntary sector and residents more fully in identifying needs and preferences.

We also recognise the need to feed back findings on a continual basis to those making decisions about health and social care. The JSNA should therefore be seen as a 'cycle', rather than a one-off activity.

The three duty holders responsible for the JSNA are:



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## Our population

### Kensington and Chelsea is a small inner London borough...

- The Royal Borough of Kensington and Chelsea has a small population relative to other local authority areas – various sources on population offer a range between 167,000 and 175,000 people – yet it is the most densely populated of any borough in the UK.

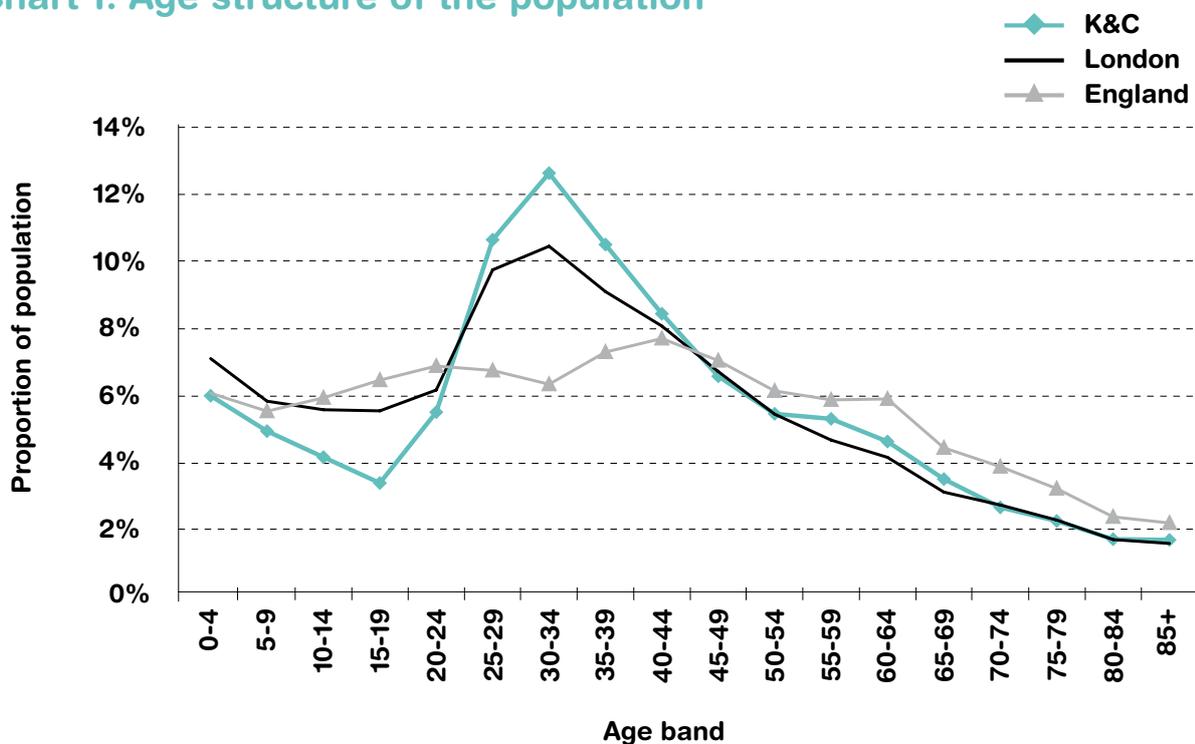
### It is home to a large working age population...

- Nearly half (48 per cent) of our residents are aged between 20 and 44, compared to 44 per cent in London and 35 per cent in England. Compared to the rest of England, Kensington and Chelsea has a smaller proportion of children and older people. (See Chart 1 below).

### The composition of the population is very influenced by migration...

- Large numbers of people move in and out of the borough, with an annual turnover of up to 30 per cent moving in or out in some areas. There are large movements of students and young working age adults into the borough. This is partly fuelled by the very high proportion of private rented housing, most notably in the south of the borough.
- There is more movement out of the borough than movement in from age 30 onwards, and those with young families are more likely to move out. This results in a smaller school age population than in other areas.

Chart 1: Age structure of the population



Source: GLA population projections 2007 (Low), ONS 2006 sub national population projections

### The population is generally highly affluent although large inequalities do exist...

- Residential house prices are the highest in the country, meaning many of the borough's residents are affluent and highly educated. However, more than half of all housing in the four most northerly wards is social housing, with most of this area falling into the 20 per cent most deprived in the country.
- Deprived communities in the north of the borough generally have higher levels of unemployment and worklessness. There are also higher proportions of children and young people, with close to half living in poverty and over half living in overcrowded situations. Inward and outward migration in this area is far less pronounced.

### The borough is home to a wide range of different communities, particularly from Western Europe, North America, the Middle East and North Africa...

- Close to half the Kensington and Chelsea population (43 per cent) were born abroad. The borough has the largest proportion for people classifying themselves as 'White other' of anywhere in the country. The largest Black and minority ethnic (BME) numbers are found in the north of the borough, in areas of relative deprivation (see Map 1).
- The borough has the largest numbers of Americans (6,000), French (5,000) and Italians (4,000) of any borough in London. These communities are most concentrated in the centre and south of the borough (see Map 2).
- After English, Arabic is the most commonly spoken language, with over 5,000 speakers. Two thirds of these were born in Iraq, Lebanon and Morocco. North African and Middle Eastern communities are generally more common in the north of the borough, although the Iranian (Farsi speaking) population is most

concentrated in the centre of the borough. The Portuguese speaking community is split between Brazilians and Portuguese, the latter more common in the north.

- Over half of the borough's residents classify themselves as Christian and one in ten Muslim, (rising to one in five in Golborne ward in the far north).

### Kensington and Chelsea can expect modest population growth in the future, with a smaller rise in the number of older people than nationally...

- The borough's population is predicted to increase by 4,000 to 5,000 residents over the next five years, or roughly 0.5 per cent per year. Over the next 20 years, there is likely to be an increase in the proportion of children and older working age adults (see Chart 2). The rise in numbers of people aged 65 and above is predicted to be nine per cent, four to five times less than the growth nationally.

For further information on population, please see the relevant chapters in this document.

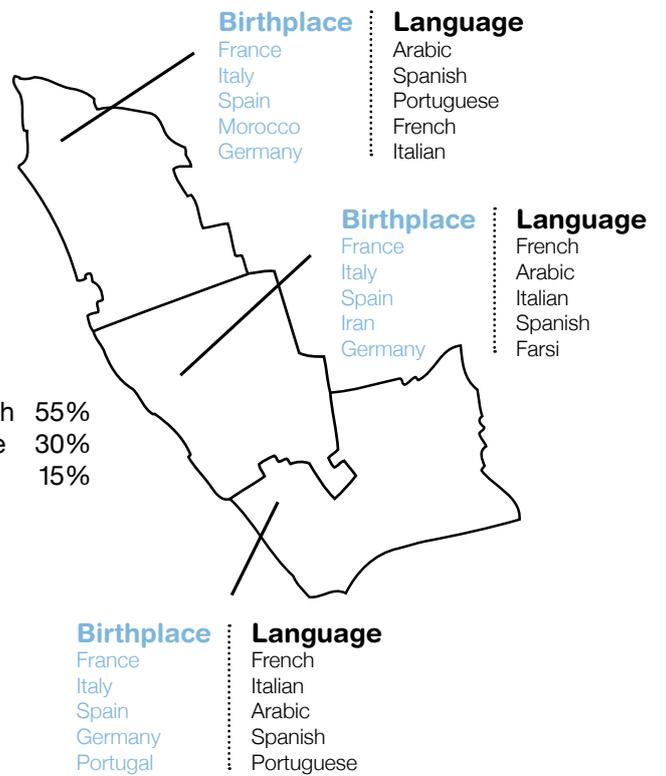
Suggested further reading: ***A Picture of our Community 2008, Community, Equality and Inclusivity***. This can be found at [www.rbkc.gov.uk/kcpartnership/general/](http://www.rbkc.gov.uk/kcpartnership/general/)

## Map 1: Ethnicity in Kensington and Chelsea



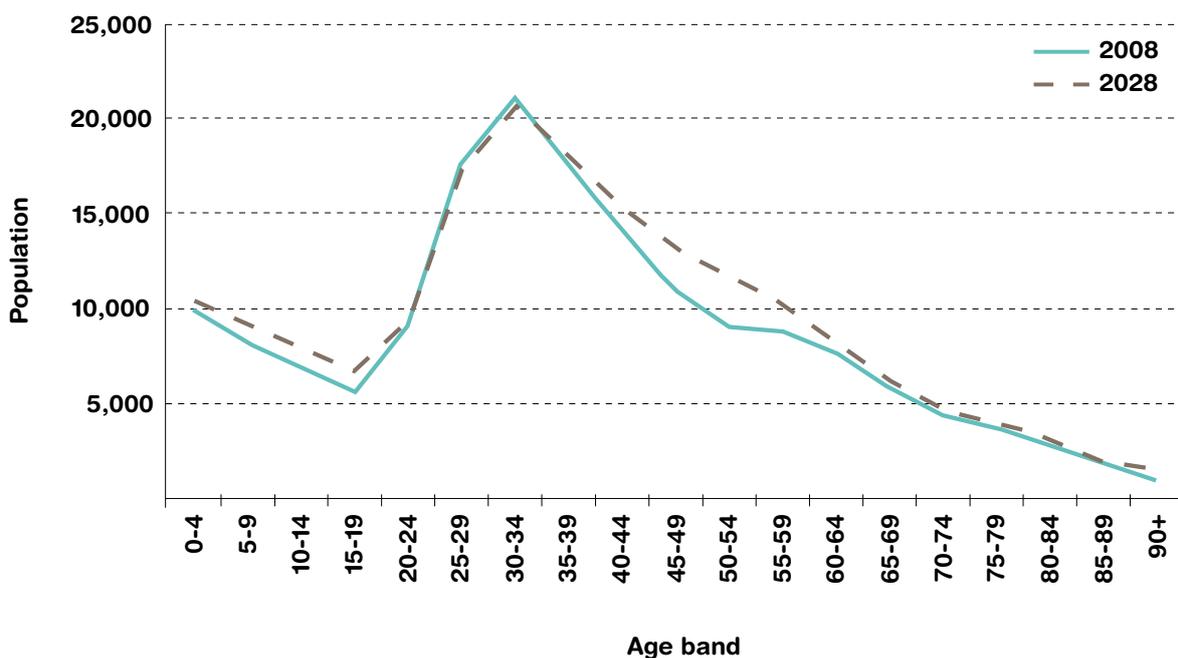
Source: ONS 2001 Census

## Map 2: Most common non-English speaking countries of birth and languages spoken - Based on GP registrations



Source: Derived from 'Place of birth' field, Exeter 2008

## Chart 2: 20 year population change in Kensington and Chelsea



Source: GLA population projections 2007 (Low)



# 2. Health and well-being

## Key messages

- Health is excellent in the borough as a whole, but this masks significant variation between deprived and affluent areas.
- The gap appears to be widening as the rate of premature death in affluent parts of the borough is decreasing faster than the London average.
- Residents from the Black ethnic group generally suffer poorer health than average, partly because they are more likely to be living in positions of material disadvantage.
- Even though less people smoke in Kensington and Chelsea, smoking is a significant and preventable cause of health inequalities.
- Generally, the borough's residents are more likely to take regular exercise, eat fruit and vegetables, and are much less likely to be obese than the rest of London. However, inequalities exist; in the four northerly wards, the rate of obesity is 50 per cent higher than the rest of the borough.
- Binge drinking appears more common among residents in the south and less common in the north, although alcohol-related admissions and deaths are generally more common in the north.

## Levels of health and well-being

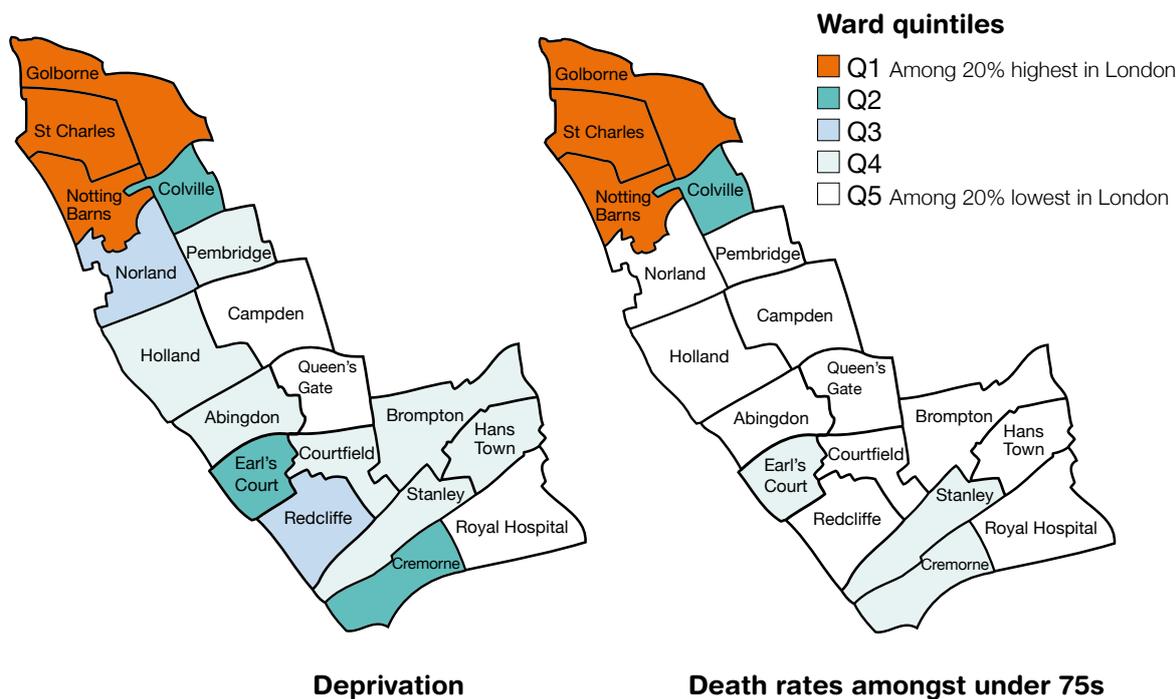
### Overall, health and well-being is excellent in Kensington and Chelsea...

- Overall, Kensington and Chelsea residents have excellent health; life expectancy is the highest in the country for both men and women, five years higher than the national average. The borough has very high levels of self-reported good health and very low levels of limiting long-term illness.
- Satisfaction with the borough as a place to live is also high; a recent survey found it to be the third highest in London. The factors that appear to impact most on residents' satisfaction are traffic congestion, street cleanliness, community safety and fear of crime.

### But health varies dramatically within the borough...

- Areas of poor health in Kensington and Chelsea match areas of deprivation and social housing (see Map 3). Not surprisingly, there is a huge difference in life expectancy across the borough: ten years between the most healthy and least healthy ward.
- Those in the four most northerly wards are also twice as likely to die before 75 as those in the rest of the borough – an age when death is generally considered to be preventable. Golborne, St Charles and Notting Barns wards would all need to reduce the number of premature deaths by five to six a year to be in line with the London ward average of 25 to 26 deaths.

### Map 3: Comparison of multiple deprivation with under 75 mortality rates



Source: IMD (2007), LHO (2002-2006)

#### The health ‘divide’ may be getting wider...

- Data suggests that premature (under the age of 75) death rates in the four most northerly wards are improving at a similar rate to London, but the more affluent areas are improving much faster.

#### The borough’s communities have different levels of health...

- Residents from the Black ethnic group in Kensington and Chelsea experience the poorest health in the borough. This differs from London as a whole, where health among the Asian ethnic group is worst.
- This variation can probably be explained by the socio-economic status of Black residents in the borough, three quarters of whom live in social housing, compared with just a third of the Asian group.

- Among the borough’s migrant population groups, those from Iraq, Iran and Egypt all have a greater proportion of older people than average, and are likely to have poorer than average health too (see Map 4). Those from the Indian ethnic group have the largest number of older people of the migrant communities, but their health is likely to be better than average.

### Lifestyle and behaviour

#### Lifestyle and behaviour, such as smoking, diet, exercise, alcohol consumption and substance misuse, can dramatically affect health and well-being...

- In particular, smoking is the single largest preventable cause of death and one of the principal causes of health inequalities. Whilst one in six adults smoke, which is lower than London, around 12 to 16 per cent of all deaths in the borough are likely to be directly caused by smoking each year, or 100 to 130 people.

**Overall, residents have very healthy lifestyles, but there are big differences within the borough...**

- While levels of regular physical activity in Kensington and Chelsea are among the highest for adults in London, in the north of the borough they are a third lower than the borough average. Take-up of exercise is a third lower among BME groups than White groups, indicating a need to promote and facilitate exercise and activity among these groups.
- While adults in Kensington and Chelsea are estimated to have the highest rate of fruit and vegetable consumption and the second lowest rate of obesity in the country (half the national rate), there are likely to be about 18,000 obese adults in the borough, with rates in the four northerly wards 50 per cent higher than in the rest of the borough.

- Although Kensington and Chelsea performs well compared with the national average across a range of alcohol indicators, levels of hazardous and harmful drinking are higher than nationally, and the borough has a significantly higher number of alcohol-related recorded crimes.
- Binge drinking is likely to be most common in the South Kensington area, which has a young age profile; it is less common in the north, where a significant proportion do not drink for religious reasons. However, while admissions for alcoholic liver disease are spread relatively evenly, death is more likely to occur in those from deprived areas. There are also high levels of drug misuse in the borough and, in response to this need, a higher than average number of people are in contact with structured drug treatment services when compared to London as a whole.

**Map 4: Countries of origin with significant poor health and/or older people**



The pale green areas show a population that is slightly higher than the Kensington and Chelsea average (which is white). The wards with blue shading indicate the population is more than 50 per cent higher than the borough average.

Source: ONS (2001), Exeter (2008)



# 3. Disease trends

## Key messages

- Death rates are low and vary within the borough, with most people dying of the national 'big killers': heart disease, cancer, stroke and respiratory disease.
- Some diseases are likely to become more common, such as melanoma, breast and prostate cancers, diabetes and HIV. In some cases, better identification of diseases is also contributing to the number of people known to services.
- Some conditions are likely to become more common simply as a result of the increase in the number of older people, like dementia.
- However, change as a result of an increase in the older population will mostly occur at a slower rate than nationally, and predominantly in 15 to 20 years time when the 'baby boom' generation become very old.
- Epidemiological models are not very precise in working out the levels of under-diagnosis of disease locally (as Kensington and Chelsea is atypical compared to England), but it is likely to be high. Diseases likely to be under-diagnosed are diabetes, coronary heart disease, high blood pressure and common mental illnesses like anxiety and depression.

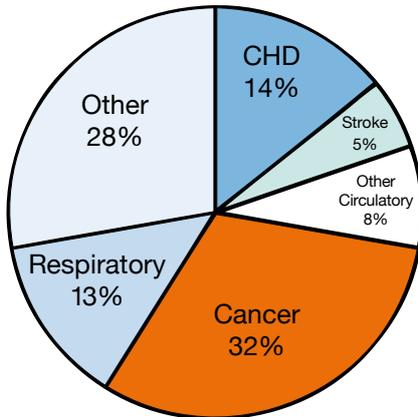
## Causes of illness and death

**Irrespective of the inequalities in health, cardiovascular disease, cancer, diabetes and respiratory diseases remain the big challenges...**

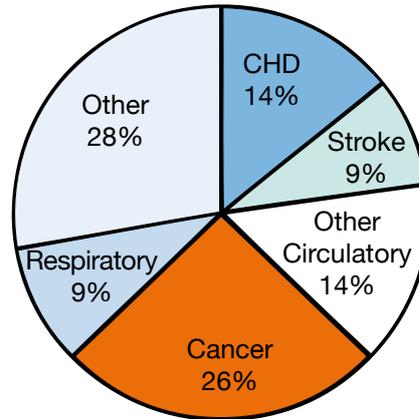
- Chronic diseases are the predominant cause of death for all wards in the borough, irrespective of whether they are deprived or affluent. Cancer accounts for 28 per cent of all deaths in Kensington and Chelsea, with cardiovascular disease accounting for 32 per cent (see Chart 3).
- These two big killers have been dropping over time, faster than nationally, due to better diet and a falling number of smokers, more effective prescribing, and quicker and more effective treatment. They are likely to continue dropping in the future, though the rate of decline will slow.
- In 15 to 20 years time, there may even be rises in the number of deaths from some diseases (even though the rate per population will continue to drop). This is because of the ageing of the post-war 'baby boom' generation, which means a larger number of very old people.

**Chart 3: Causes of death in Kensington and Chelsea, 2007**

**Males**



**Females**



Source: ONS VS (2007)

**Increases in disease prevalence**

Even though we are getting healthier and living longer, a number of diseases are becoming more common...

- Although the overall number of cancer cases has been dropping slightly in the borough, breast, melanoma and prostate cancers appear to be increasing in the London area; bowel cancer cases are remaining stable. However the small numbers make it difficult to identify consistent trends locally. None the less, the death rates from these diseases are likely to continue to drop.
- Diabetes is increasing on GP registers and a rise of at least four per cent a year or more is expected over the next few years. Some of this is due to increased rates in the population, fuelled by rising obesity. However, a proportion of this is also likely to be a result of improved rates of diagnosis by GPs.
- HIV has also been growing at around five per cent a year and will probably continue at this rate, resulting in significant cost implications in the future. The increase in the numbers with

HIV continues to be the result of increased survival rates and continued transmission of infection. Around one third of all people with HIV are likely to be undiagnosed.

- Although the number on coronary heart disease (CHD) registers has not been changing, the elective (planned) admissions associated with CHD have been rising consistently at over six per cent a year, possibly reflecting more accurate treatment of CHD.
- Although Kensington and Chelsea has only half the new cases of tuberculosis compared to the London average, the borough is surrounded by high incidence areas according to definitions from the World Health Organisation. We need to ensure there is sufficient capacity to manage outbreaks, provide support to communities and trace contacts should an outbreak occur, as well as ensuring effective neonatal and childhood BCG vaccination programmes.
- There has been a 15 per cent increase of sexually transmitted infections (STIs) reported at genitourinary medicine (GUM) clinics in the last five years, and a sharp increase in new cases of Chlamydia in recent years. This may be due in part to increases in screening, but also to the spread of infection.

### Some changes are driven by the changing population structure...

- In the short-term, there will be a growth in the number of very old residents as a result of increases in life expectancy. This will lead to a small increase in dementia cases, probably one to two per cent increase in the next five years (between ten and 30 extra people). This is far lower than nationally.
- In 15 to 20 years time, the post war 'baby boom' generation will reach old age. The impact of this will be 'softer' locally than elsewhere in the country due to the strong influence of inward and outward migration on our population. However, the number of very old residents with dementia is expected to rise by around 15 per cent in the next 20 years. This will have a significant impact on service costs, as dementia has a very high cost per case. In England, the number of people with dementia is set to rise by 66 per cent.

## Better diagnosis of disease by services

### We don't know the exact numbers of people likely to have undiagnosed chronic diseases...

- Epidemiological models that calculate the likely number with chronic diseases in the population can be compared to numbers known to GP practices. Comparisons of expected levels of diseases in the population, such as hypertension, CHD and diabetes, consistently place Kensington and Chelsea GPs among the highest in the country for levels of under-diagnosis for these diseases. However, the models are relatively crude and do not pick up the idiosyncrasies of our local population with its affluence and overall good health.

### But we can be fairly certain that there is significant undiagnosed disease in the local population...

- Given the mobile nature of the population, any argument about precise levels of under-diagnosis is probably academic. What is more important is to recognise that there is under-diagnosis, as well as a proactive approach to tackling the issue by using evidence-based methods of finding new cases.
- To raise the numbers of people on GP chronic disease registers to meet the level of diagnosis currently found in London would, according to models, require an increase of around: 1,500 to 2,000 people on diabetes registers; 3,000 to 4,000 people on hypertension registers; and 300 to 400 people on CHD registers.
- Diagnosis in general practice does seem to be improving over time and there is upward growth in numbers with hypertension, diabetes and Chronic Obstructive Pulmonary Disease (COPD) known to services. The numbers on GP lists for these conditions is likely to continue to grow at around four per cent a year. In the case of diabetes, this is also likely to be due to the disease becoming more common (see Table 1).

### Some improvements in diagnosis are being fuelled by increased capacity in services...

- With growth in primary care counselling services for common mental illness, such as depression and anxiety, the level of diagnosis and treatment is likely to rise. At present, the growth in new cases of depression recorded is not rising significantly, but this probably reflects recording in practices rather than clinical change.

**Table 1: Expected change in GP recorded prevalence and hospital admissions in next five years, based on past trends**

	Register size	Elective admissions	Emergency admissions
COPD	↑	↑	–
CHD	–	↑	–
Stroke/TIA	–	–	–
Heart failure	–	–	–
Diabetes	↑	–	–
Asthma	–	–	–
HIV/AIDS	↑	–	↑
Hypertension	↑	–	–
Severe and Enduring Mental Illness	–	n/a	n/a

– means no significant change expected.

Source: QMAS, Dr Foster, SOPHID (2003-2008)

- Evidence suggests that neither common, nor severe and enduring, mental illness is actually becoming more prevalent in the population. There is some evidence to show that a significant number of people in the London area are treated privately, which may drop with improved NHS access.
- The predictions about changes in patterns of chronic disease recorded prevalence and admissions have been summarised above in Table 1. The predictions are based on past activity in primary care or hospital, and therefore reflect past behaviour in diagnosis and case management of people with diseases. Any changes in clinical practice, such as changes in treatment thresholds or a shift of activity into a community setting, would impact on the accuracy of these predictions.





# 4. Healthcare services

## Key messages

- GP practices are well situated, but issues exist around opening times - especially according to younger adults.
- Practices in the borough are achieving a high quality of service for many major disease areas. However, there is still scope for improvement, particularly for smaller care groups such as people with atrial fibrillation (heart condition causing fast or erratic heartbeat), or for those with learning disabilities, or those in need of palliative care.
- The borough has the lowest uptake of NHS dental services in the country for both adults and children. Local research has shown a resistance to using dentistry, particularly in high need areas.
- Stop Smoking services are reaching the right people, but not in the right numbers. Pharmacies have been the most successful referrers and providers in the past.
- Breast and cervical screening uptake is very low. This contrasts with very low mortality rates for breast and cervical cancer. Uptake of breast screening is lowest in high income areas.
- Planned and emergency care has been rising much faster than population growth, but the number of bed days is down.

- Satisfaction with the hospital experience is variable, but generally more favourable in Chelsea and Westminster than St Mary's.
- Four fifths of all A&E attendance occurs between 9am and 10pm. A significant proportion attends between 6pm and 9pm, when many GP surgeries are closed. Chelsea and Westminster A&E has very high attendance rates for families with very young children.
- Case management programmes are very sensitive to cost per patient; patients costing more than £500 a head per year, and who are less than 50 per cent likely to be admitted in that year, will probably cost more to case manage than will be saved.

## Overall perceptions of health services

**A major piece of work was commissioned by the PCT to examine people's perceptions of the local NHS...**

- The studies were carried out in 2008 by external organisations and consisted of a range of interviews, analysis and focus groups. A range of service themes were covered, including maternity care, emergency care, planned care and general practice.

**Table 2: Perception of health services**

Belief drivers	What do they currently believe?	What do we want them to say?
Clinical excellence	Treatment is generally good, but instructions and guidance are poor and patients do not know what to do if they have questions.	“They get it right at every step.”
Accessibility	People struggle to get the support they need when they need it.	“They are always there to help whenever and however I need.”
Proactive	The NHS is there for when something is wrong.	“They are very active in promoting health.”
Efficiency	They experience a lot of frustration and difficulty getting what they need. They cannot get through, they have to wait, and the smallest task can be so complicated.	“It’s always so reliable and easy. It’s clear.”
Personalisation	They don’t see the NHS as flexible and accommodating to their specific needs or issues.	“They give me a sense of control over my own health and my family’s health.”
Humanity	They often feel that they are treated rudely and rushed through the process. They feel processed rather than cared for.	“They seem to really care about people.”

**The study found an overall belief in the NHS and the excellent quality of care provided, but gaps around humanity and efficiency...**

- Although the experience of service users varied by service, the overarching theme was that people had experienced a very high standard of clinical care, but sometimes a lack of humanity, see Table 2 above. It was often felt that the ‘before and after’ elements were missing. People say they want a greater sense of control over their health, better choice and access, and a better process of responding when things do go wrong. Cleanliness was also a concern.

## General practice

**GP practices are geographically close to most local residents...**

- The average distance ‘as the crow flies’ for patients to their GP’s practice is under 0.6km. A recent PCT survey found three quarters of people currently travel less than ten minutes and at least three quarters of older residents and working age residents walk to their surgery.

**But some younger adults still find surgery times inconvenient...**

- The proportion of practices in Kensington and Chelsea offering extended opening hours is higher than the London and England averages, but a third of under 35s still find GP surgery times inconvenient; almost no over 65s do.

**Table 3: Kensington and Chelsea QOF scores for clinical areas compared to London**

Better	Similar	Worse
Stroke	Chronic kidney disease	Atrial fibrillation
Diabetes	Hypothyroid	Palliative care
COPD	CHD	Learning disabilities
Cancer	Epilepsy	
Dementia	Heart failure	
Smoking	Mental health	
	Asthma	
	Hypertension	
	Depression	

Source: QMAS 2007/08

**What people want from services varies by age...**

- Roughly half of all older residents (aged over 65) would not travel ten minutes more than they currently do to receive additional GP services, regardless of what that service is. Maintaining a short journey time is probably more important to this group than having a wide range of services or more convenient times.
- Younger people are much more willing to travel an extra ten minutes to receive additional services – the most popular being simple procedures (x-rays, for example), simple tests and seeing a GP without an appointment.

**Patient satisfaction is similar to London but worse than England...**

- Patients in Kensington and Chelsea consistently report similar levels of overall satisfaction with their GP across a range of indicators when compared to London. However, as with London, satisfaction is lower compared to England as a whole. Consistent

issues of concern relate to cleanliness, attitude of doctors and quality of care from other health professionals, particularly practice nurses.

- Older people are much more satisfied than younger people: 74 per cent of under 35 year olds felt their health issue was dealt with satisfactorily compared to 90 per cent for over 65 year olds. This may relate as much to expectations as to actual experience.

**Quality of care is often better than the London average...**

- Part of the GP contract rewards practices for achieving targets on a range of quality indicators, known as the Quality and Outcomes Framework, or QOF scores. Using this as a measure of quality of service, Kensington and Chelsea practices perform better than London on many of the major chronic disease areas such as stroke, diabetes and COPD. However, with London consistently performing below the national average across most disease areas, there is still scope for improvement (see Table 3 above).

**But there are areas where quality of care could be improved if we aspire to perform better than the London average...**

- Kensington and Chelsea practices perform similarly to London for major diseases such as CHD, heart failure, asthma, hypertension and severe and enduring mental illness. However, practices perform more poorly than London for learning disabilities, where six practices do not have practice registers, and atrial fibrillation (a heart condition causing fast and erratic heartbeat) diagnosed using ECG, and for the proportion of patients treated with anti-coagulation drugs or anti-platelet therapy (to reduce blood clotting). Performance is also worse for palliative care, where one practice does not have a register and 18 practices do not have regular multi-disciplinary meetings to discuss patients (see Table 3).

**And a north/south gap in quality standards may be re-appearing...**

- Using the same approach to measure quality, there have been overall improvements over time. In particular, there has been a levelling up of quality across the borough. However in the most recent year the more deprived north of the borough achieved lower scores than the south. This may relate to the significant challenges in providing care and managing chronic disease in an area with significant poor health and deprivation.

**But there is good evidence that the incentive structure created for the new GP contract has narrowed inequalities nationally...**

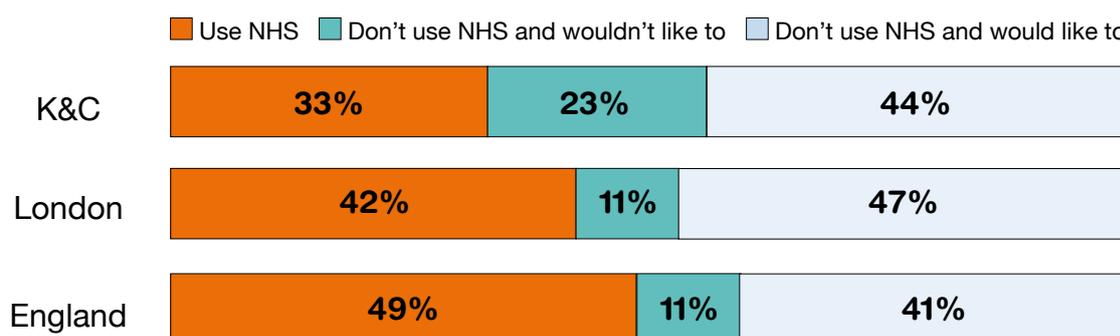
- Published research recently demonstrated that the introduction of the Quality and Outcomes Framework (QOF) has significantly narrowed health inequalities nationally.

**NHS dentistry**

**Some of the local population rely on private dentistry, but a significant proportion say they would prefer to be using an NHS dentist...**

- Four out of ten residents visit a private dentist regularly (at least every two years) in Kensington and Chelsea, among the highest rates in the country; a third of residents visit an NHS dentist, which is the third lowest in the country.
- A proportion of those using private care or not visiting any dentist would like to be using NHS dentistry; in Kensington and Chelsea, this proportion is 44 per cent: lower than average compared to London, but slightly higher than England (see Chart 4 below). This may reflect perceived problems with finding NHS dentists in London, or the quality of available services.

**Chart 4: Comparison in proportion wanting to use NHS dentistry**



Healthcare Commission (2008)

### The number of people visiting NHS dentists in the borough over time has been dropping fast...

- NHS dentistry in Kensington and Chelsea has reduced faster than most other PCTs and the number of children and adults visiting an NHS dentist in the borough is the lowest in the country.

### But the NHS is offering dental services in the borough that are not being taken up...

- Most dental practices had spare capacity at the end of 2008, not using all their commissioned units of dental activity at the end of last year.

### Those using NHS dentistry are much more likely to be from deprived areas, possibly only using the service in a crisis...

- Three quarters of all adult activity in NHS dentistry in the borough is for patients who are exempt from treatment (much higher than London or England), reinforcing the notion that, on a local level, the service caters for the more deprived population. There is a higher proportion of complex dentistry compared to London and England, suggesting that those who use the service are doing so out of necessity rather than for preventive treatment.

### We have gained an understanding of why some people don't use local NHS dentists...

- Several research studies have been carried out locally, mainly in deprived areas, to identify behaviour and attitudes towards local dentistry; this is part of a social marketing campaign designed to increase local uptake. The research found that some people believe they cannot use an NHS dentist; some think NHS dentistry will be of poorer quality; and some people simply do not think they need to see a dentist unless they have specific problems with their teeth.

## Other primary care services

### Stop Smoking services are targeting the right people, but not in the right numbers...

- In 2007/08, the Stop Smoking service was more effective at encouraging smokers in the most deprived areas in the borough to set quit dates, but less effective in the more transient, affluent areas such as South Kensington and East Chelsea (Royal Hospital). However, just five per cent of all smokers living in the borough set a quit date last year and two per cent quit.
- The proportion of smokers setting a quit date who had been referred to the service through pharmacy was two thirds, compared to just a quarter from general practice. Those referred through a pharmacy had a higher quit rate than those through general practice and group courses; the service overall has a low quit rate compared to other areas.

### The Sexual Health Needs Assessment found good practice but some gaps in provision among services which need to be addressed...

- The PCT commissioned Sexual Health Needs Assessment identified gaps in service provision.
- Recommendations included that: services need to address the previously unidentified needs of people over the age of 35; services need to increase early diagnosis of HIV and plan for big increases in older people with the infection; and that services need to prioritise culturally sensitive and appropriate sex education, advice and treatment.
- The needs assessment found GP prescribing of long-acting reversible contraceptives (LARCs) to be extremely variable, but low as a whole and therefore in need of promotion.
- Uptake in the Chlamydia screening programme at the time of study was low. This is now improving, but uptake needs to continue to improve.

### Continence and Falls Services are only capturing a small segment of the population likely to be affected...

- Patients known to the PCT Continence Service are twice as common as the average in the north, and half as common in the south. This suggests that the service is mostly reaching those in deprived areas within close proximity and may be missing other population groups, or even patients, in deprived pockets in the south. Overall, the numbers in contact with the service are around one tenth of the 5,000 people in the borough likely to experience moderate or severe incontinence.
- The average of 350 referrals a year to the Falls Service is substantially below the predicted number of 6,000 falls a year, based on national rates.

### We need to be able to monitor patients' views more routinely...

- Many of the primary care services run by, or commissioned by the PCT, have not routinely monitored patient satisfaction. A plan is in place to implement this and this is recommended as a routine procedure.

## Screening services

### Breast screening uptake is very low, but is showing signs of improvement...

- Breast screening uptake is the sixth lowest in London and the eighth lowest in the country. The lowest rates are within highest income areas, with roughly five per cent lower uptake than the PCT average. This suggests that factors such as population mobility (see outward migration Chart 6 in Children and Young People's section) and private use may partly explain the low uptake. Based on an analysis of surnames, the lowest uptake appears to be among Black African women, suggesting the need for a targeted approach.

### Cervical screening uptake is consistently low...

- Kensington and Chelsea has the second lowest cervical screening coverage rate in the country; the borough's neighbours – Hammersmith and Fulham, and Westminster – were the lowest and third lowest respectively. Practices with a more frequent turnover of women of screening age generally (see outward migration Chart 6 in Children's section) and small practices were both more likely to have poorer uptake.

## Hospital services

### Planned admission rates match what we know about health in the borough...

- The rate of planned (or elective) admissions in Kensington and Chelsea is much lower than in London and England, although it is higher than London in areas of the borough with significant deprivation. Over the last five years, there has been a three per cent growth per year in the number of elective admissions above population growth. Although the number of admissions has risen, the total number of bed days has decreased year on year.

### Clinical care in local hospitals is felt to be good but satisfaction rated by patients is variable...

- The Healthcare Commission rated the quality of services at Chelsea and Westminster and Imperial (including St Mary's and Hammersmith hospitals) as 'good' in 2007/8.
- In the 2007 Healthcare Commission survey of inpatients, Chelsea and Westminster achieved a better than average overall rating of care, almost within the top 20 per cent of trusts nationally; St Mary's achieved slightly worse than average.

- Both trusts scored poorly for doctors and nurses talking in front of patients as if they were not there. St Mary's in particular, had poor scores for explanations and support with patients' operations and procedures. Chelsea and Westminster scored particularly well for aspects around leaving the hospital, with the exception of delays in discharge.

## Emergency care

### The standard of out-of-hours care is good locally...

- A recent assessment from the Healthcare Commission of out-of-hours provision found Kensington and Chelsea PCT to be among the 31 per cent best performing nationally on a range of different indicators.

### Use of hospital Accident and Emergency (A&E) services is particularly common for families with very young children...

- Of those attending A&E, three quarters attend no more than once a year, whereas the four per cent most frequent attendees accounted for 14 to 15 per cent of the total activity. Young children are very likely to attend A&E and are also more likely to attend

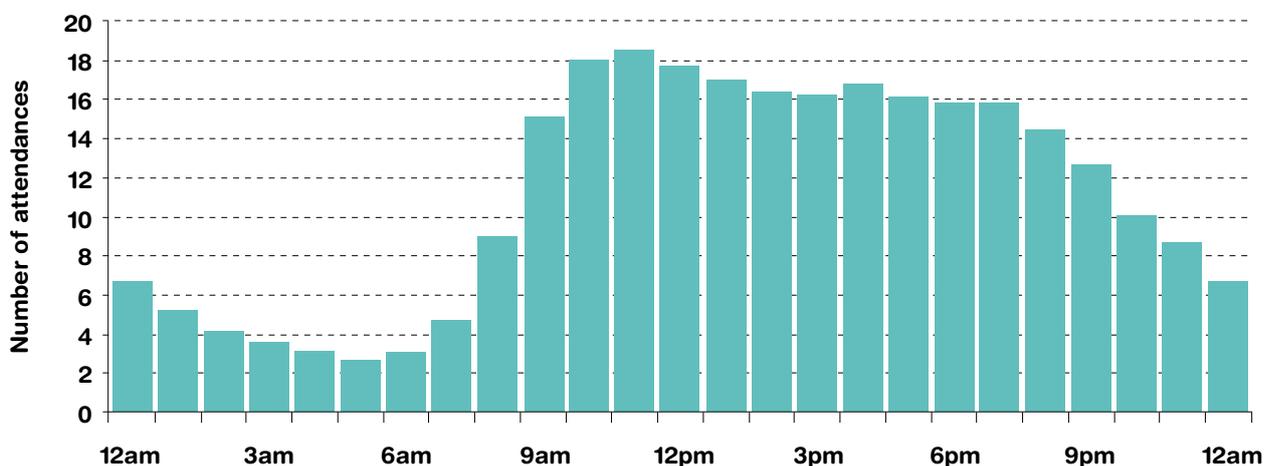
more frequently than other groups. This is particularly true in Chelsea and Westminster, where a third of children under five locally attend at least once.

- There is evidence of higher attendance rates for people living in areas of deprivation and social housing; this may relate to poorer health and/or greater likelihood for this group to use A&E over other forms of healthcare.
- There are no reliable figures locally on changes in activity levels in A&E departments, but the number of emergency admissions through A&E has been rising.

### The bulk of attendance in A&E occurs in daytime...

- Peak flow into A&E occurs between the hours of 9am and 5pm, but there is also a considerable volume of activity in the evening period (6pm to 11pm) – a time when many GP practices have tended to be closed. Overall, four fifths of activity occurs between 9am and 10pm (see Chart 5), with peak periods in both local trusts tending to be Saturday, Sunday and Monday lunchtimes.
- Those in their twenties who attend are by far the most likely to not have a GP code; some of these will not be registered with a GP.

**Chart 5: Average number of attendances by hour of day in Chelsea and Westminster A&E**



Source: Requested from trust (2008)

### Emergency admissions to hospital are more common in deprived areas and are rising year on year...

- The emergency admission rate in Kensington and Chelsea is much lower than in London and England, although it is higher in our deprived wards than the London average. After accounting for population growth, figures suggest that there has been a four to five per cent growth per year in the number of emergency admissions over the last five years.
- Emergency admissions for chronic diseases account for roughly 15 per cent of all emergency admissions. Within this, the highest volume of admissions is for diabetic-related and COPD admissions, which are also higher cost than average.

### Like planned hospital care, satisfaction rated by patients is variable...

- A 2004/5 review of satisfaction among patients using A&E departments found patient satisfaction of Chelsea and Westminster either better than, or similar to, the national average on all but one indicator: the cleanliness of the toilets. St Mary's fell into the worst 20 per cent nationally for 11 indicators, including overall satisfaction, overall rating of care, and dignity and respect.

## Avoiding emergency admission

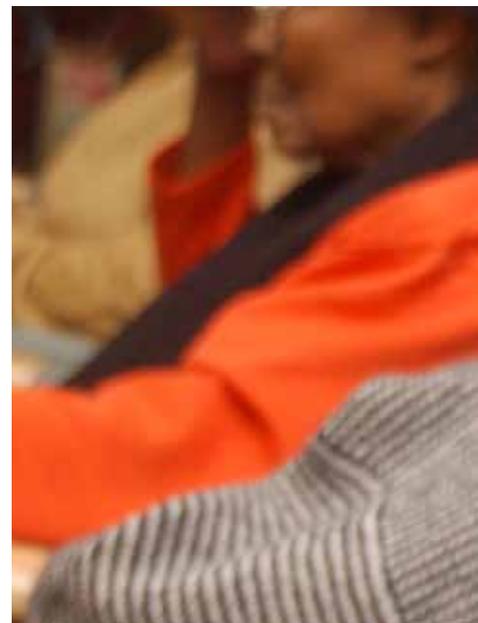
### The management of chronic disease patients in a primary care setting can be facilitated by predicting emergency hospital admission for previous attendees...

- The King's Fund PARR tool identifies people at high risk of admission to hospital. Some of these predicted admissions can be avoided by case management: improved coordination of their (usually) multiple conditions in primary care.

- In January 2008, 230 patients in the PCT had a 50 per cent risk of emergency admission over the following 12 months, including 80 people with a 75 per cent risk, based on admission patterns in the past. However, this number fluctuates and probably decreases once very young patients and deaths are removed.

### Identifying who should be 'case-managed' in this way is crucial to the success of these programmes...

- The likelihood of people being admitted in the future is three times higher in the four most northerly wards compared to the rest of the borough; it is recommended that any case management programme with health professionals reflects this variation. King's Fund analysis found many of those identified had multiple conditions, meaning support for high intensity users of healthcare services should not necessarily be disease specific.
- The cost of the management of people in primary care is crucial to the cost effectiveness of these programmes. King's Fund modelling has suggested that for case management programmes costing £500 per person per year, a risk score of 50 or above for likelihood of admission in the following 12 months would be needed for most interventions to break even. For interventions costing £750 a person, a risk score of 75 or above and a reduction in admissions of 15 to 20 per cent would be needed to just to break even. Including those with risk scores below 75 would result in a net loss.





# 5. Children and young people

## Key messages

- Kensington and Chelsea has a small proportion of children compared to other local authorities, particularly older children, but this pattern is typical of inner London.
- This is largely due to outward migration; the number of births is actually quite typical of other areas.
- Outward migration is concentrated in the more affluent areas, with the remaining younger population being more deprived than average, causing specific geographical challenges to services.
- Since 2000, the number of births has been rising. Although the rise is smaller than London and England, there will be some impact on demand for a range of child and adolescent services in the near future.
- Services for children are rated by Ofsted as outstanding in all outcome areas. Only two other councils are rated as good.
- School children are more likely to eat fruit and vegetables and take exercise, and are less likely to smoke or take drugs when compared to national rates. However, children's lifestyles get less healthy as they get older.

- Childhood obesity among state school children varies widely, with twice the rates in the most income deprived areas compared with the least, and higher rates than the national average.
- The number of Looked After Children has been declining over time, which is in line with national trends.
- Five year olds at maintained (state) schools in the borough have much worse oral health than the London average.
- Maternity services need to be improved; Kensington and Chelsea has the highest Caesarean section rate in London, a very low home birth rate, and women's experience of local services is poor.

## Profile of children and young people

### We have fewer children and young people in the borough compared to many others...

- Kensington and Chelsea has a smaller proportion of children compared to other boroughs in London and England; this is particularly true for older children and young people. Sources of population figures estimate there are between 30,000-34,000 children and young people (aged 0-19) in the borough. However, numbers are growing slowly and strong geographic differences exist, which impacts on the scale and specification of services required.

## Migration patterns of children and young people

### Movement out of the borough often depends on the type of housing young families are living in...

- Even though the fertility rate – the likelihood of women having children – is low in Kensington and Chelsea, the high number of women of child-bearing age living here means that the numbers of new births in the population is high compared to the national level. However, there is considerable movement out of the borough following childbirth.
- Families with young children living in privately rented and owned housing (mostly in the South Kensington and Chelsea area) are very likely to move out of the borough (see Chart 6). This results in half the number of resident older children in these areas compared to London, or the north of the borough. As children get older, families move out due to the cost and size of accommodation available. A shortage of high quality secondary school places across London may also be a factor.
- In contrast, those living in social housing are far less likely to move out, and these areas therefore have more children than the London average. The Holland Park area also has significant numbers of children, possibly due to the housing types and size.

### This movement contributes to a more ethnically diverse and deprived child population in the north of the borough...

- The population of children and young people is more diverse than the population as a whole. Two fifths of under fives in North Kensington are from BME groups and more than half of the children in voluntary and maintained schools speak English as an additional language.

- In 2006, two thirds of births were to mothers born abroad – the fifth highest rate in London. This is a mixture of births to mothers from prosperous and less prosperous countries. For example, one in ten mothers of new births is from the United States; four out of ten babies are classified as being from BME groups.

## Changes in the number of children and young people

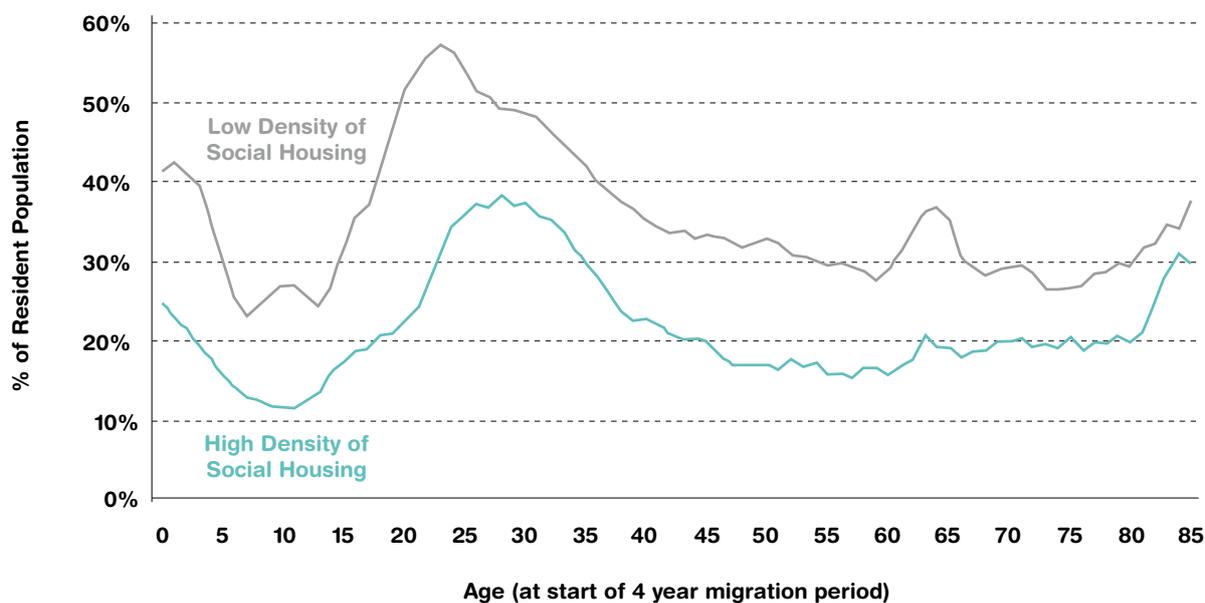
### We have a gradually rising child population...

- Since 2000, there has been a gradual growth in the number of new births each year, with occasional fluctuations. Analysis suggests that the rise in numbers is mostly due to an increase in numbers of women of child-bearing age, rather than the increase in likelihood of women to have children (the latter being the case in London and nationally). Annual growth is less than London and England.
- Over time, the increased number of births is translating into an increased number of younger children; there has been an annual growth of one per cent in the GP registered population aged birth to four. This ‘bubble’ will follow through to older age bands over the next few years (see Table 4).

### This is likely to result in a slight increase in demand for child and adolescent services in the near future...

- Demand for all services at a primary school entrant stage (age five) is therefore likely to rise gradually, possibly levelling from 2011 onwards, but having an impact on older age groups over time.
- The rise in births over the last few years will probably also translate into a small increase in children with complex needs.

**Chart 6: Migration out of Kensington and Chelsea over a four year period**



Exeter (2004-08)

**Table 4: Projected changes in child population in Kensington and Chelsea**

	2003	2008	2013	2018
Live births	2,240	2,280	2,340	2,360
Residents Age 5	1,600	1,780	1,840	1,870
Residents Age 11	1,360	1,420	1,520	1,610

Source: ONS VS (2001-07), GLA Low Projections (2007)

## The influence of poverty on health need

Levels of child poverty are among the highest nationally in areas of deprivation, but among the lowest in other parts of the borough...

- The varying social make-up of the borough points towards varying need in different parts of Kensington and Chelsea. Nearly half (45 per

cent) of all children in the four most northerly wards are classified as living in poverty, compared to just 14 per cent in the rest of the borough.

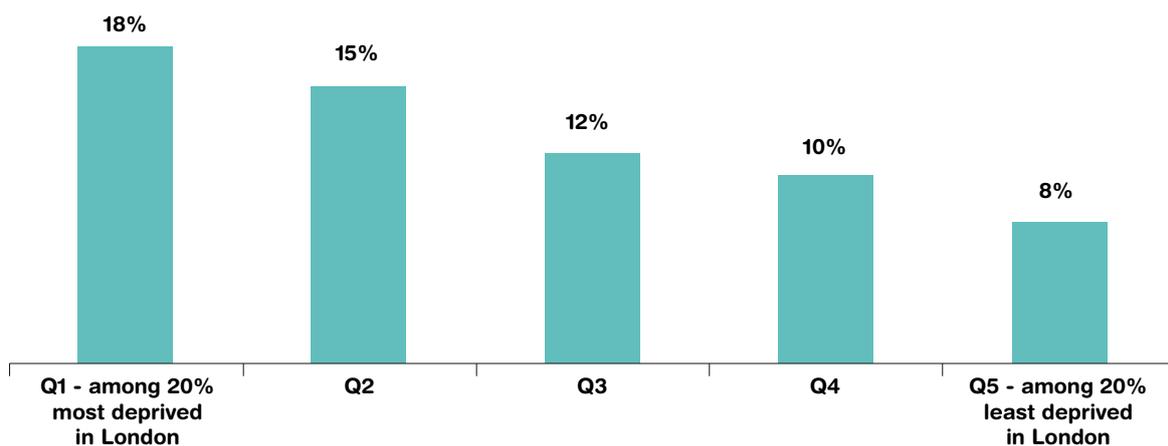
- Whilst overcrowding is generally a problem for children in the borough, levels vary. Almost two thirds of children in Golborne ward live in overcrowded conditions, compared to just one in six in Campden ward in the centre of the borough.

### Poverty in parts of the borough impacts on healthiness and the need for support...

- Children living in poverty are more likely to be admitted for accidents and injuries, with 40 to 50 per cent higher rates among under fives in the four northerly wards compared to the rest of the borough. Children in poverty are more likely to use hospital Accident and Emergency departments. Birth weights for singleton births are generally lower in the more deprived parts of the borough, although this is not such a significant issue in Kensington and Chelsea as it is elsewhere.

- Poverty and deprivation have a substantial impact on levels of child oral health; pupils at the borough's maintained schools have significantly worse teeth than the London average.
- Levels of obesity are consistently higher than the England average in Reception and Year 6 (age ten). For Kensington and Chelsea school children in Reception and Year 6 combined, those living in the 20 per cent most income deprived areas in London were twice as likely to be obese as those in the least deprived areas in 2006/7 (see below Chart 7).

**Chart 7: Kensington and Chelsea obesity by quintiles of deprivation affecting children (Reception/Year 6)**



Source: Local data collection (2006-07), IDACI (2007)

## Vulnerable children

We have significant challenges around vulnerable children, but numbers are generally dropping...

- Children in Need, under the Children Act 1989, encompasses children with complex health needs, physical, sensory or learning disabilities or emotional and behavioural difficulties. Assessments to provide services take into account parenting capacity and the family environment.

- In 2005, the Children in Need (CIN) Census estimated that there were 2,290 Children in Need in touch with Kensington and Chelsea Children's Social Services at that time. Two thirds (1,525) of the children received a service during the census week. The vast majority of CIN (2,010 children, or 87 per cent) were supported in their families.
- In 2009, there are up to 900 active Children in Need cases in social work teams.

## The number of children requiring Child Protection Plans remains constant...

- The total number of children subject to a Child Protection Plan in Kensington and Chelsea has remained between 50 and 70 over the past decade. This is low in relation to the total child population when compared to the national average.

## The number of Looked After Children is falling...

- At the end of 2007/2008, 178 children were Looked After by the Council. Proportionally this is above the national average, but well below that for inner London and has been steadily decreasing for some time.
- The demographic and housing profile of Kensington and Chelsea make the borough a difficult place to recruit foster carers. As a result, many Looked After Children are placed outside the borough, although the vast majority of them within greater London.

## Looked After Children are far more likely to be from a Black or minority ethnic group...

- Excluding unaccompanied asylum seeking children, nearly three quarters of Looked After Children are of BME origin. This is disproportionate, but in line with national trends.

## Mental health

### A quarter of all children requiring mental health support are likely to experience some type of mental disorder...

- It is thought that 7000 to 8000 children and young people would benefit from mental health support at any one time in Kensington and Chelsea. Of these, approximately 1900 children aged five to 16 are likely to experience some type of mental disorder with less than 100

having a severe mental health problem. These figures are in line with inner London.

- About 900 pupils in (maintained) primary schools and 600 in secondary schools are likely to be in need of mental health information and support. Of these, 150 pupils are likely to require support from specialist CAMH services.

## School children

### A large proportion of the borough's children attend independent schools...

- Close to half the borough's school age children attend independent schools and there are relatively large proportions of children either travelling in or out of the borough to attend schools. Children attending maintained (state) schools in the borough are more likely to live in an area of deprivation, receive a free school meal, or have Special Educational Needs than is average for England.

### And children attending the borough's state schools are ethnically very diverse...

- The ethnic profile of the borough's state school children has not changed significantly in recent years, but the percentage speaking English as an additional language (52 per cent in 2008) has been rising consistently for the last two decades. The most common language spoken in state schools after English is Arabic.

### Academic attainment in the borough's schools is very high...

- Levels of attainment in Kensington and Chelsea schools are very high: Kensington and Chelsea has been first or second nationally for three years for the contextual value added (CVA) score, measuring progress between Key Stage 1 and Key Stage 2.

## Lifestyles

### Our maintained (state) school children have healthier than average lifestyles...

- The 'Tell Us' survey suggests healthier lifestyles for children compared to nationally, with lower rates of smoking and alcohol use, and similar rates of fruit and vegetable consumption.
- Substance misuse related admissions to hospital for under 20 year olds is also much lower than nationally (30 admissions in Kensington and Chelsea during the period 2003 to 2006, compared to an England average of 100).
- The Health Survey 2008 covering young people who live, work or use services in the borough found just two per cent had five or more portions of fruit and vegetables in the previous day, with 40 per cent having three to four portions. In addition, 68 per cent said they had never smoked a cigarette; 68 per cent had never had an alcoholic drink; and 74 per cent of pupils had never taken any drugs.

### But there are clear challenges around supporting healthy lifestyles for older children in particular...

- Consumption of fruit and vegetables and involvement in physical activity both drop with age in the borough, and the proportion of children that have ever smoked rises quickly with age, from a quarter of 13 year olds to nearly two thirds of 17 year olds.
- There is, therefore, a need to support children and young people around making healthy choices.

### Support from services is generally good, but with room for improvement...

- Pupils taking part in the survey in Kensington and Chelsea also rated the information and

advice they received on alcohol, smoking and drugs to be as good as or better than pupils nationally.

- Knowledge and awareness of sexually transmitted infections and safer sex was found to be high, although many young people did not know of the full range of available contraception – particularly long-acting reversible contraceptives.

## Developing services for children and young people

### The high standard of services for children and young people in the borough has been recognised...

- The 2009 Annual Performance Assessment of Family and Children's Services stated that it is outstanding in all aspects.

### But services around maternity could be improved further...

- A third of the borough's mothers giving birth in NHS hospitals have a Caesarean section – the highest proportion in London. This can only be partially explained by the older age profile of mothers in the borough and should be explored in more detail with an audit of hospital clinical notes.
- The recent Healthcare Commission Maternity Review also placed Chelsea and Westminster, St Mary's, and Hammersmith as the three worst hospitals in the country for offering choice of a home birth (only a quarter were offered the option, compared to more than half nationally).
- The review also found that 37 per cent of women were not receiving the NICE recommended number of antenatal checks at Chelsea and Westminster hospital, which is being addressed.

### **We need to make sure support is ‘joined up’, which can sometimes be challenging given the high number of women using the private sector...**

- Close to one in five mothers (18 per cent) living in the borough gives birth in a private hospital. This can cause challenges around support for breastfeeding, immunisation, identification of post-natal depression and other services, where mothers are often hard to engage.
- A recent PCT health visiting survey found women wanted more support with breastfeeding, particularly in the hospital in the initial days after childbirth.

### **There have been huge improvements in immunisation uptake for Measles, Mumps and Rubella (MMR) among two year olds, but there is a need for improvement around pre-school boosters...**

- Whilst immunisation rates for MMR have traditionally been very poor in the borough, Kensington and Chelsea has now improved dramatically, with an uptake of 86 per cent for under two year olds last year – the highest percentage in London. However, uptake of the pre-school booster is still very poor. Many children and young people are therefore not immune to measles and an epidemic is a real risk. A catch-up MMR programme seeks to address this risk. Uptake for other childhood immunisation for under two year olds is similar to London, but considerably below the national trend.

### **Even though we know oral health among state primary school children is poorer than London, we have low uptake of NHS dentistry for children...**

- Capacity within NHS dentistry in Kensington and Chelsea has contracted faster than most other London PCTs since the new dental contract was introduced. The number

of children accessing the NHS service is currently the lowest in the country, even though there were unused units of dental activity at the end of the last two years, and NHS dentistry is available to local people but is not being used.

### **There are particular concerns about mental health services for children and adolescents...**

- The Child and Adolescent Mental Health Service (CAMHS) case load is higher than the London average, which suggests that children and young people are well served in the borough. However, there is a lack of knowledge about unmet CAMHS need in less recognised vulnerable groups.
- In addition, population trends indicate that there is likely to be a greater demand for CAMH services in the future, particularly in the south of the borough.
- Transitions from CAMHS to Adult Mental Health Services are problematic, as vulnerable young people easily fall between the gaps.
- Kensington and Chelsea was awarded Beacon status for its flexible, accessible and well-coordinated CAMH services. However, there is still scope for improving the commissioning process for services across the full spectrum of CAMHS needs. A three year CAMHS Commissioning Strategy 2009 to 2012 has recently been published.

### **Specific pieces of work are already underway to improve some areas...**

- For people with disabilities the ‘transition’ from Children’s Services to Adult Services is being improved.
- Young carers are a particularly vulnerable group and support for them is being increased through the new Young Carers’ Strategy.



# 6. Older people

## Key messages

- The size of the older population in Kensington and Chelsea is small, as it is for other boroughs in London.
- Chelsea has the highest numbers of older people, but parts of the north of the borough have the highest numbers in poverty.
- Hence uptake of social care services is generally higher in the north, matching 'need' well in most cases. The exception to this is day care services and, to a certain extent, the meals service.
- Better life expectancy and the ageing of the postwar 'baby boom' generation means a future rise in numbers of older people. However, the big rise will not be felt until 15 to 20 years time and is likely to be about four times smaller than nationally.
- The rise in numbers of very old people will mean a rise in conditions such as dementia, arthritis and mobility problems.
- There is likely to be malnutrition among a significant proportion of older people and this should be investigated further.
- Kensington and Chelsea has a very low rate of residential/nursing care and is moving more towards the provision of community care.

- While this model is generally preferred by residents, there are challenges. This includes the high numbers living alone and in rented property, which impacts on mobility, isolation and the ability to self-fund.
- There is a shortage of extra care housing, particularly in the south of the borough, and of sheltered and extra care housing for sale.
- There are very few carers in the borough and they need to be supported further as their role becomes more crucial.
- The ageing older population from countries such as India, Iraq, Iran and Egypt will have a growing need for culturally appropriate services.

## Profile of older people

**Kensington and Chelsea has a small older population compared to nationally, with the highest numbers in the far south but the highest need in the north...**

- Kensington and Chelsea has a small older population compared to nationally, although compared to London it is quite similar. The highest concentration of older people is in Chelsea, though the wards of St Charles and Norland in the north of the borough also have high numbers.

- Levels of ‘need’ are reflected in uptake of social care services, with much higher uptake in the northern wards where there is significant deprivation and poverty among older people. The average age of older people (aged 65 or over) accessing community care in Norland, St Charles, Notting Barns, Golborne and Cremorne wards is three years younger than in the rest of the borough, reflecting the levels of poor health and chronic disease in these areas.
- Conversely, Hans Town and Royal Hospital wards, which have the highest proportion of older people, are less likely to be using social care services.

**There will be a big increase in the number of older people, but not until 15 to 20 years time, giving us time to plan appropriately for the change...**

- Better life expectancy means that the numbers of older people in Kensington and Chelsea will rise gradually, with small increases in the next five years. However, there will be noticeable increases in 15 to 20 years time resulting from the ageing of the ‘baby boom’ generation (see Chart 8).

**But the increase is likely to be nothing like the rise experienced nationally...**

- The over 65 population is likely to grow roughly four times more slowly in Kensington and Chelsea than nationally. This more gradual rise is because our population is governed more by inward and outward migration than by natural changes of births and deaths, with more people moving out of the borough than moving in from the age of 30 onwards (see Chart 6 in the Children’s section of this document).

**Longevity brings its own challenges, with rises in a range of illnesses and disabling conditions...**

- As people live longer, they are more likely to acquire disabling conditions, particularly arthritis, dementia and visual impairment. These will have a direct impact on their well-being and ability to live independently. The predicted rise in numbers with these conditions in the next five years is just one to two per cent, but is likely to rise by 15 per cent in 20 years time, when the postwar ‘baby boom’ generation become very old.

**But there are probably a number of residents with disabling disorders who are currently not known to services...**

- Population models suggest that there are about 1,400 people with dementia in the population, yet general practice registers are aware of less than 500. While there may be some inaccuracies in population predictions, there is likely to be a significant under-diagnosis of dementia. National estimates suggest two thirds of dementia is undiagnosed and this may be the case locally. This is also likely to be the case with sensory impairment.

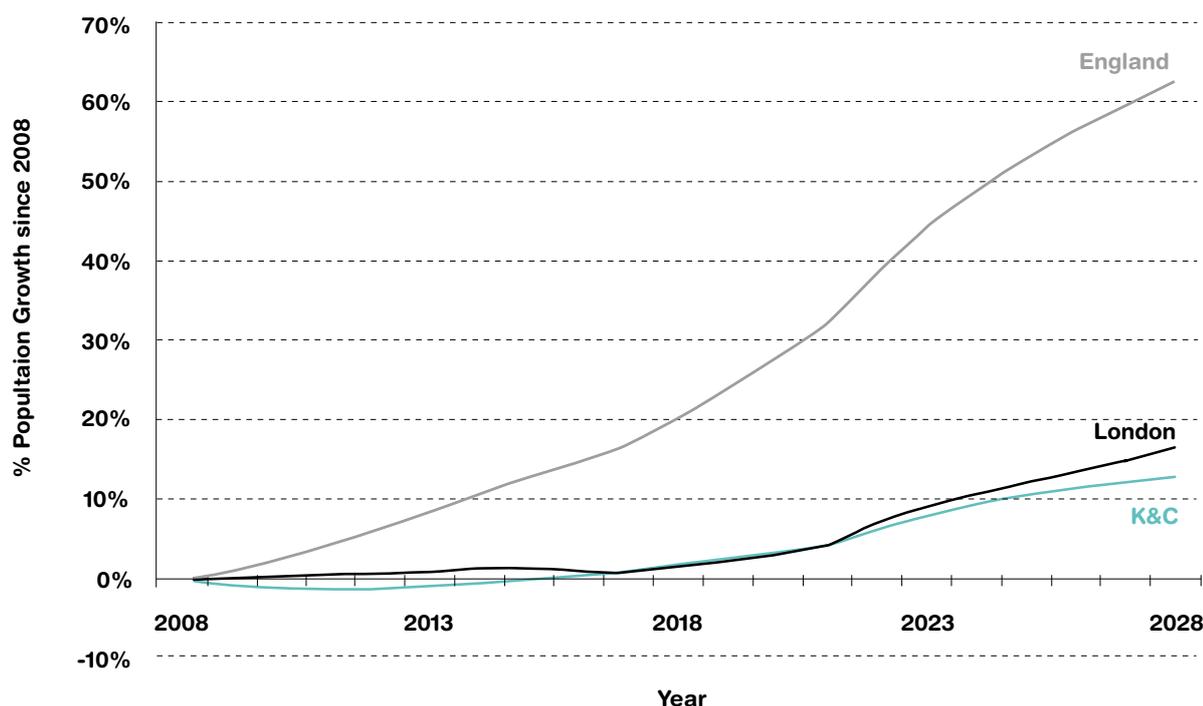
**And there may be high levels of malnutrition among older people...**

- A recent study found potentially high levels of malnutrition among older people receiving care at home, and a lack of awareness among older people of their nutritional needs. It is recommended that a clear nutritional policy is used across all community services and community screening for malnutrition introduced.

**And the numbers of some ‘at risk’ older people are likely to grow...**

- People with learning disabilities are living longer and may require specialist housing and support when their carers (usually parents) are no longer able to look after them.

## Chart 8: Projected Older Population Change (aged 80+)



Source: GLA Low Population Projections (2007)

## Provision of care

**Kensington and Chelsea has moved more towards community care and away from residential/nursing care as a means of supporting vulnerable older people...**

- Kensington and Chelsea has the second lowest rate of admission to residential/nursing home care in London, with a larger focus on community care for older vulnerable people in the borough. This corresponds with the wishes of many older people in the borough, who express a desire to remain at home for as long as practically possible.

**Uptake of social care services generally meets the needs of vulnerable and less affluent older people very well...**

- The provision of social care services matches expected levels of need very closely, with a strong association between the level of older people in poverty and the take-up of services (see Map 5 overleaf).

**But day care in particular is focused in the north, with very low take-up in the south...**

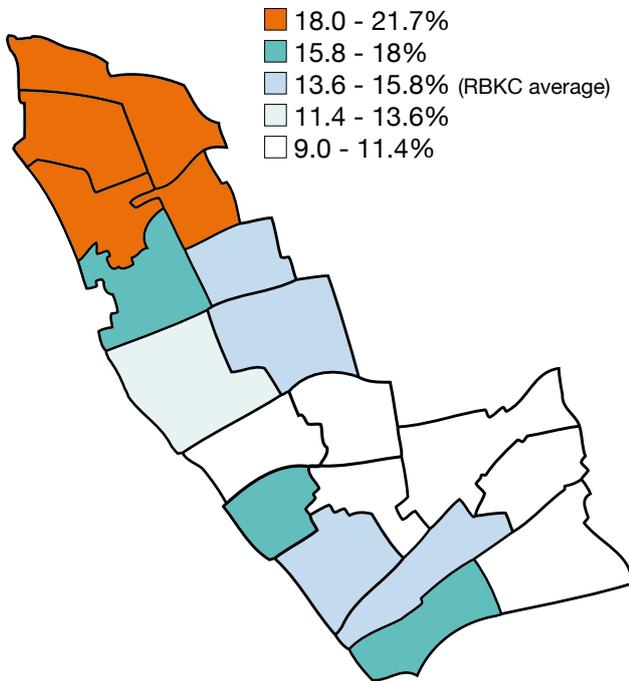
- Use of day care services are more than four times higher in the north of the borough compared to in the south, possibly relating to the location of available services (see Map 5 overleaf). It is recommended that the current structures are reviewed. The meals service also does not match need very closely and should be explored further.

**We know that not all people who want to die at home are being given the opportunity...**

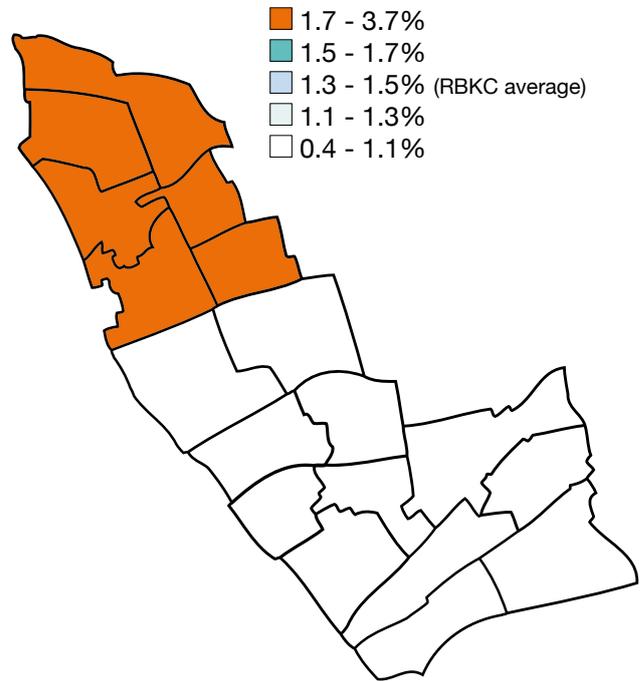
- A PCT consultation on end of life services told us that 63 per cent of participants would choose their home as their preferred place of care at the end of life. Currently, 20 per cent of all deaths occur at home; this proportion has remained constant over a number of years and is similar to other parts of the country.

## Map 5: Proportion of residents aged 65 and over known to Adult Social Care receiving community and day care services

### Community care



### Day care



Source: Royal Borough Social Services (2008), GLA Low (2007)

### The low level of home ownership in Kensington and Chelsea continues to influence the ability to self-fund social care in old age...

- Just one in four pensioner households in the borough are owner occupied, compared with nearly one in seven in England. Those without the asset of a home are less likely to be able to make a significant contribution to the cost of their own care. It is not possible to accurately predict how this will change in the future.

### And the move towards community care may exacerbate problems around isolation and loneliness among the large numbers of pensioners living alone...

- Six out of ten pensioners live alone in the borough – the highest proportion in London. There is a clear link between living alone and higher levels of depression, loneliness and unhappiness, which may affect older people's ability to maintain their independence. If the move away from residential care towards home care continues, the need for care and support to maintain independence will create additional pressure on services.

## Supporting older people to live in their own homes creates challenges...

- Half of all older people in Kensington and Chelsea with a limiting long-term illness live above ground floor level. Generally, a third of people aged 85 and above need help with stairs, so accessibility will become increasingly important if the move towards home-based care continues.
- The borough is above the national average for the proportion of older people with no central heating in their home.
- A shortage of extra care housing has been identified, particularly in the south of the borough, and also of sheltered and extra care housing for sale.

## Informal care in the borough is scarce and support for carers will become critical in the future...

- The borough falls among the lowest in the country for the provision of informal care. High house prices, the limited supply of social housing, and the general trend of geographical mobility for families mean this challenge will remain.
- The changing age profile means there are likely to be more very old people living in the community over time, possibly with fewer people to care for them. This indicates an increasing need for effective support for carers. Identifying and supporting older and other vulnerable carers is necessary to enable frail older people to live in the community.

## The Black and minority ethnic population

### The ageing of the ethnic population will result in a modest rise in demand for services due to poorer health in this group...

- The Black and minority ethnic (BME) population in Kensington and Chelsea has poorer health than the white population. Compared to the White population, those from BME groups receiving community care are on average four years younger, and those in residential and nursing care three years younger. This reflects the greater need for support for the older BME community.
- The poorer health among BME groups means there is likely to be an increase in demand for services as this group ages. However, this growth in demand is likely to be relatively small and can probably be contained within existing structures.

### But we need to think about how services can become increasingly culturally appropriate in what they provide...

- There will also be a gradual increase in demand for culturally appropriate services, particularly in diverse areas such as the north of the borough. Those from Iran, Iraq and Egypt have an older age profile than average for the borough and are likely to be in poorer health. Older residents from India form the largest group of ethnic minority elders, but are generally in better health than average.



# 7. Mental health

## Key messages

- The borough ranks fourth highest in the country for the proportion of people known by practices to have severe and enduring mental illness. It is more common in the north.
- Kensington and Chelsea probably has more people with common mental illnesses than the London average, and a similar proportion to England. Those known to practices are spread evenly in the borough, but other sources of data suggest higher numbers in the north.
- About a third of depression and a half of anxiety goes undiagnosed nationally and this is likely to be true locally as well.
- Those using inpatient services are twice as likely to be from the Black ethnic group, even after accounting for the ethnic profile of the areas where they live.
- In Golborne, St Charles and Notting Barns, one in 18 of the working age population claim incapacity benefit/ severe disablement allowance for mental health reasons – all within the worst five per cent of London wards.
- Severe and common mental illnesses are probably not becoming more prevalent, but more and more people will be diagnosed due to better case finding and more primary care counselling capacity.
- Secondary care services match need quite well, although Cremorne ward has

more people known to services than expected, pointing to better access for residents or under diagnosis by GPs.

- Day hospital services do not appear to meet need in the north of the borough.

## Prevalence and ‘under-diagnosis’

**Kensington and Chelsea has among the highest numbers of people known by practices to have severe and enduring mental illness...**

- Kensington and Chelsea GPs have three times the proportion of people on severe and enduring mental illness (SMI) registers compared to nationally, or just over 2,200 people, which is the fourth highest GP practice prevalence in the whole country. SMI includes schizophrenia and bipolar disorder.
- The high numbers are likely to reflect a high level of need in the local population, but also good local systems for diagnosing and recording. Levels of under-diagnosis are usually considered to be low for this disease area.

**The number of people with common mental illnesses is harder to quantify, but we know it is probably higher than the London average...**

- Levels of common mental illness in the borough are harder to identify and are usually estimated (see Table 5). There are likely to be in the region of 4,000 to 5,000 people at any

one time with depression, 7,000 to 8,000 with anxiety, and a significant number with other disorders. This includes mixed anxiety and depression, which is not listed below. The vast majority of people with common mental illness (probably about 90 per cent) are seen within a primary care setting.

- GP registers, which capture numbers of new depression cases over a year, place Kensington and Chelsea as the third highest in London, and slightly higher than England as a whole.

### There is likely to be significant under-diagnosis of common mental illness...

- National data suggests significant under-diagnosis of common mental illness in primary care, either because people do not visit their GP with the problem, or it is not identified. Nationally, about a third of all people experiencing a depressive episode and a half of all people experiencing anxiety are not diagnosed by their GP to have the illness.

## Factors influencing levels of mental illness

### Local levels of severe and enduring mental illness follow patterns of deprivation, with more in the north...

- The proportion of patients with severe and enduring mental illness known to GP practices is 50 per cent higher in North Kensington than in South Kensington and Chelsea; North Kensington has a higher concentration of social housing and services.

### Those in contact with inpatient services are less typical of the general borough population than those using outpatient or community services...

- Of those known to local inpatient services, 57 per cent are men and 43 per cent women. Those using inpatient services also have a younger age profile than other services.
- After accounting for the ethnic structure of the areas where the patients live, the Black ethnic

**Table 5: Estimated numbers of people with mental disorders and likely change due to shifts in the age structure of the population**

Disorder	Current	Future				% growth	
	2008	2013	2018	2023	2028	5 year	20 year
Schizophrenia	668	684	698	713	728	2	9
Bipolar/related	2,082	2,127	2,156	2,181	2,204	2	6
Depression	4,123	4,238	4,325	4,401	4,477	3	9
Anxiety	7,903	8,123	8,300	8,457	8,588	3	9
Personality	8,106	8,323	8,465	8,586	8,698	3	7
Eating	224	224	225	227	229	0	2
Child and adolescent	1,370	1,434	1,500	1,528	1,537	5	12

Source: King's Fund (2008), GLA Low (2007)

group is still two times over-represented in inpatient services, but by smaller amounts in other settings. A local audit found that over one third of BME inpatient admissions occurred via the police, while White people are more likely to be brought in by their families.

### **There are mixed messages about how the level of common mental illness varies within the borough...**

- The number of people newly diagnosed with depression is similar across the borough according to practice recording. However, prescribing for anti-depressants is nearly 50 per cent higher in the north, which may reflect more severe cases of the disease, or less access to 'talking therapies'.

### **In our deprived wards, worklessness caused by mental ill-health is among the highest in all London...**

- Golborne, St Charles and Notting Barns fall into the worst five per cent of all wards in London for the number of working age population claiming incapacity benefit or severe disablement allowance for mental health problems. This is more than one in 18 of the working age population (see Map 6).

## **Future rises and implications**

### **Mental illness probably isn't becoming more common over time, but the number of diagnosed people will grow...**

- Evidence suggests that adult mental illness will not become more common. However, there are likely to be more people diagnosed with a mental illness in the future for several reasons: better diagnosis of diseases; more comprehensive treatment capacity in primary care, such as a growth in funding for counselling services; and changing demographic patterns, meaning more older people with depression in particular. The

changes resulting from demographic shifts have been illustrated in Table 5.

- The likely rise in the child and adolescent population, driven by the rising number of births since 2000, may put pressure on existing Child and Adolescent Mental Health Services (CAMHS). Estimates suggest a rise in demand of five per cent in the next five years, and 12 per cent in the next 20 years.

## **Use of inpatient services**

### **Levels of secondary care service use in the borough are low...**

- Kensington and Chelsea's use of inpatient services is low for London and has dropped. This may reflect the local investment in community services.

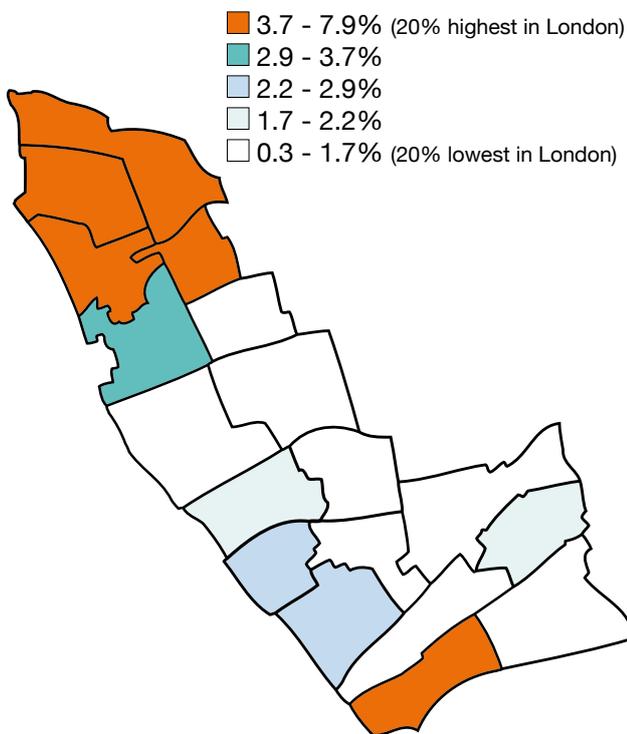
### **And uptake of secondary care services mostly matches needs well...**

- Secondary care (inpatient, outpatient and community) services for people with mental health problems match need well, with greater uptake in areas known to have greater mental illness. Need is measured through GP practice registers for severe and enduring mental illness.

### **But Cremorne ward in the south has a higher level of service use than expected, which may mean there is more need there than we thought or residents there are getting better access to services...**

- Cremorne ward has roughly one and a half times the number of patients in contact with services than expected. The higher number of patients was not accompanied by a significantly higher level of contact per patient.
- This may either point towards better access/ lower entry criteria to services for people in this geographical area compared to other areas, or an under-recording on GP registers.

## Map 6: Residents receiving incapacity benefit for mental health reasons



Source: DWP (2008)

### Day hospital services do not appear to match levels of need...

- The day hospital for the north of the borough is based in North Westminster and has low usage. The equivalent service in the south (the South Kensington and Chelsea Mental Health Centre) is in the same building as the inpatient wards and use is high – which includes use by inpatients. Therefore, it is difficult to accurately assess the level of provision of day hospital services.

### And the uptake of day hospital services is very sensitive to distance from the patient...

- The numbers attending the South Kensington and Chelsea Mental Health Centre drop off substantially for wards in the centre of the borough, with patients in those areas far less likely to attend day hospital, or use statutory mental health services generally.

## Use of primary care and other services

### Quality of care from GP practices is similar to other areas in London...

- Part of the GP contract rewards practices for achieving targets on a range of quality indicators, known as QOF scores. Using this as a measure of quality of service, Kensington and Chelsea practices perform to a similar standard as the London average for severe and enduring mental illness and depression patients.
- However, the proportion of non-attendees to annual reviews for severe and enduring mental illness who are followed up in 14 days is slightly worse than London. In addition, the proportion on lithium therapy with a record of serum creatinine is among the worst in London.

### Access to primary care counselling has been limited in the past, but is going through a process of improvement...

- The PCT is working closely with practice-based commissioners in order to redesign and strengthen the counselling service, with an increase in counselling capacity.

### Patients and services have both recognised the need for more focus on employment and vocational activities...

- There is a recognised high level of incapacity benefit take-up for mental health reasons in the three most northerly wards (see Map 6). There is therefore a need for the PCT/local authority and other organisations to work together more to provide better employment and vocational activities for those out of work.

### Access to supported and move-on housing to resettle people experiencing mental illness is limited...

- The Supporting People Strategy identified a lack of provision at high support end. The PCT and Council have responded by developing further space, with ten commissioned and proposed units if a building can be found. Ensuring people move through the system and that high support accommodation is available for those who need it on leaving hospital, is a major challenge for the PCT and Council.

### **There are particular concerns about GP referrals for Children and Adolescents Mental Health Services...**

- A recent needs analysis for the Child and Adolescent Mental Health Service (CAMHS) showed that GPs are the main referrers (18 per cent), although there is great variation between surgery referral rates. Over a seven month period, 16 GP surgeries in the south of the borough made 24 referrals, whilst 12 made none. It also showed that GPs were more likely to make referrals where CAMHS had established an outreach service to families.

## **Physical health issues**

### **The inter-relationship between poor mental health and poor physical health is well established...**

- Nationally, psychiatric outpatients are nearly twice as likely to die prematurely as the general population from a range of often preventable physical conditions, such as coronary and respiratory disease, and are also prone to diabetes, infections and greater levels of obesity.
- In a recent review of health inequalities, mental health service users expressed a desire for a clearer range of options and better advertising of leisure and physical activity pursuits in the borough. They also expressed a desire for better access to dentistry, dietary advice and support to stop smoking.

## **Service user involvement**

### **Users of outpatient and community services in London are less happy with care compared to nationally, and users of local services are no exception...**

- In 2008 the Healthcare Commission surveyed users of outpatient and community services run by CNWL Mental Health Trust. The trust scored the same as the London average for the overall rating of care, but within the worst 20 per cent nationally because most other London mental health trusts were also rated poorly. Twenty-one per cent rated care as excellent, compared to 27 per cent in England.

### **There is a strong culture of involving service users in decisions and gathering feedback on satisfaction with services...**

- There is significant information on patient experience of services, through Healthcare Commission reports, internal processes in CNWL and through user-focused monitoring (UFM), where trained users interview those using services and collate information on service experience.

### **Service users want a more holistic view of their needs...**

- The Joint Mental Health and Well-being Strategy includes seven priorities identified with service users and carers, using national and local policy and data. One of these was for joined-up services, based on joint commissioning; this does not just include medical care, but also housing, employment and leisure. Work to identify pathways for service delivery will be a key part of achieving a more holistic approach to mental health delivery.



# 8. Disability

## Key messages – Physical disabilities

- The most deprived wards in the borough are among the 20 per cent highest in London for: limiting long-term illness among those of working age; economic inactivity from disability; and receipt of incapacity benefit. Golborne ward has particularly high rates for these indicators.
- Women and those from deprived areas are more likely to be in contact with social care services for a physical disability.
- Mobility impairment is the most common of all impairments. This is likely to create challenges in the borough where the age and preservation status of buildings severely restricts opportunities for adaptation.
- The number of people reporting with a hearing impairment appears to be low compared to the London average.
- Better life expectancy and the ageing of the 'baby boom' generation means the numbers with various impairments will probably grow by around 12 to 15 per cent in the next 20 years. This includes around 300 additional people with a mobility impairment.
- Local surveys have highlighted that people feel that more progress needs to be made to improve access to shops, cinemas and restaurants.

## Key messages – Learning disabilities

- The number of people with learning disabilities known to services is lower than expected.
- Forty per cent of those known to services live outside the borough, which is partly due to the location of supported housing and residential homes. These clients remain the responsibility of the local authority.
- There is currently not enough local accommodation for people with complex needs.
- There will probably be very small increases in the number of children born with a learning disability in the future, similar to increases in the last decade.
- Improving life expectancy among adults also means the number of people over 65 with a learning disability could rise by a quarter (roughly nine people) in the next ten years. Although the number appears small, there may be high costs associated with supporting these people.
- The gradually increasing life expectancy will mean the average age of carers will also increase. Increased support for this group may be necessary in future years.
- Carers and professionals have identified barriers people with learning disabilities face getting certain aspects of healthcare, particularly dentistry requiring general anaesthetic.

## Profile of people with physical disability or sensory impairment

**Nearly half the disabled population are aged over 65, including nearly a third over the age of 75...**

- Nationally, 18 per cent of the adult population report some form of physical disability from mild to severe. Applied locally, around four per cent (6,000) of people are likely to have a severe disability, of whom around 2,200 are aged over 65.

**As well as age, deprivation is a strong factor associated with disability...**

- Nationally, rates of physical disability are twice as high in the 20 per cent most deprived wards compared to the 20 per cent least deprived. Locally, after accounting for age differences, there is more than a twofold difference in levels of limiting long-term illness between Golborne and Queen's Gate; a large part of limiting long-term illness is likely to result from physical disability.

**The proportion of working age adults who cannot work due to permanent sickness or disability is lower than London overall, but very high in the north of the borough – particularly Golborne...**

- The proportion of residents in the borough who are unable to work due to permanent sickness or disability was the twelfth lowest in London in 2001. However, Golborne, St Charles, Notting Barns and Cremorne wards were all within the 20 per cent highest in London and the proportion receiving incapacity or other disability-related benefits in these wards is twice the London average.

- Golborne had the highest rate of self-reported working age limiting long-term illness of any ward in London in 2001.

**The number of working age adults with a physical disability or sensory impairment known to Adult Social Care is lower than expected, in comparison to the number of older people known to services...**

- Adult Social Care is in contact with around 3,550 people with a physical disability or sensory impairment. The number of these aged under 65 is low, which is likely to be due in part to high mobility and a healthier and wealthier population, with more people choosing not to use public services.
- There is greater contact with services among over 65s than under 65s, with twice as many residents with physical disability or sensory impairment in the north of the borough compared to the south, after adjusting for levels of need. The north-south variation reflects the socio-economic divide in the borough.

**Men are less likely to be in contact with Adult Social Care than women...**

- Men aged under 65 account for half the general population, but just 39 per cent of those known to Adult Social Care; for over 65s, men account for 38 per cent of the general population, but 33 per cent of those known to Adult Social Care. The cause of this variation is currently unclear, but nationally figures suggest that fewer older men than women use social care. This is mainly because women live longer; female carers, including wives, provide much informal care for older men and older women are more likely to be widowed and live alone. However, the gap cannot purely be explained by life expectancy.

**Table 6: Levels of disability in Kensington and Chelsea**

Kensington and Chelsea Population	Number of People	%
<b>All age</b>		
Self reporting a limiting long-term illness	23,500	14
Estimated to have a serious physical disability	6,000	4
Receiving Royal Borough Adult Social Care services for a physical disability or sensory impairment (aged 18+)	3,550	2.7
<b>Working age (16 to 64)</b>		
Self reporting a limiting long-term illness	13,300	11
Economically inactive due to a disability or illness	4,500	4
Receiving incapacity benefit/severe disablement allowance	6,000	5

*ONS 2001 Census, Health Survey for England 2001, applied locally by age band, Kensington and Chelsea RAP data 2007 to 2008, ONS 2001 Census, Health Survey for England 2001*

**The most widespread impairment is problems with mobility, which affects three quarters of those with a physical disability...**

- National estimates suggest 8,300 people under 65 and 6,800 people over 65 in the borough are likely to have moderate to severe mobility problems, although the relative good health in the borough suggests actual numbers may well be smaller. This is significant not only because of the demand on social care services, but because the age and preservation status of buildings in the borough severely restricts opportunities for adaptation.

**Travel concessions (disabled parking badges, disabled freedom passes and the Taxicard scheme) are issued to meet the mobility needs of residents who have severe disabilities, in line with statutory definitions and eligibility criteria...**

- Available data suggests that travel concessions are issued across the Royal Borough roughly in line with the prevalence

of severe disabilities and the unemployment and poverty that are associated with those disabilities. The prevalence of disability (and related poverty) varies greatly across the borough, with people applying for different types of travel concession based on their affordability and usefulness.

- Older recipients of disabled parking badges reflect the pattern of need related to age and mobility impairment in different parts of the borough.
- There is some indication that the application rate for the Taxicard scheme (which carries a cost for usage) is somewhat lower in more economically deprived areas of the borough once levels of disability are considered. However, in these areas there is a greater number of people who apply for freedom passes (which are free to use). This variation is related to socio-economic differences between areas of the borough, as well as to patterns of taxi and bus availability, which also vary greatly across the borough.

### The number with a hearing impairment known to services in the borough appears low compared to elsewhere...

- Around 400 residents are likely to have a severe hearing impairment and 270 residents are registered with services as being deaf or hard of hearing. The identification rate in Kensington and Chelsea for hearing impairment is within the bottom third of London boroughs for both under and over 65s. Another 282 people are known to services but are not registered.

### But identification of those with a visual impairment is similar to the London average...

- Approximately 3,500 residents are estimated to have a visual impairment in the borough. Although just 940 residents in Kensington and Chelsea are registered as being blind or partially sighted, Kensington and Chelsea has average or better than average identification rates for visual impairment across ages when compared to other London boroughs.

## Changing patterns of demand for physical disability services

### Better life expectancy and the ageing of the 'baby boom' generation means that the number of over 75s will increase in the borough, leading to an increase in numbers with a disability...

- The increase in numbers is likely to be gradual, with the biggest impact in 15 to 20 years time. However, current estimates suggest much smaller predicted rises in the older population compared to nationally, due to the influence of migration on the local population structure.
- Levels of mobility impairment are likely to rise roughly one per cent in five years time (an

increase of 20 to 40 people), and 11 to 17 per cent by 20 years time (an increase of 300 to 500 people in the population). The facility to house and maintain independence in the borough is very constrained.

- Applying current levels of Taxicard usage to future population estimates suggests 50 more people using the service in five years time, and 400 more in 20 years time (based on current utilisation rates). Demand for disabled parking badges is likely to rise by 50 people in five years time and 330 people in 20 years.
- Visual impairment among those aged 75 and over is unlikely to change dramatically in the next five years, but will rise by between 13 and 20 per cent by 20 years time (an increase of 250 to 350 people in the population, or 70 to 110 known to services).

## Creating opportunities and support for adults with physical disabilities

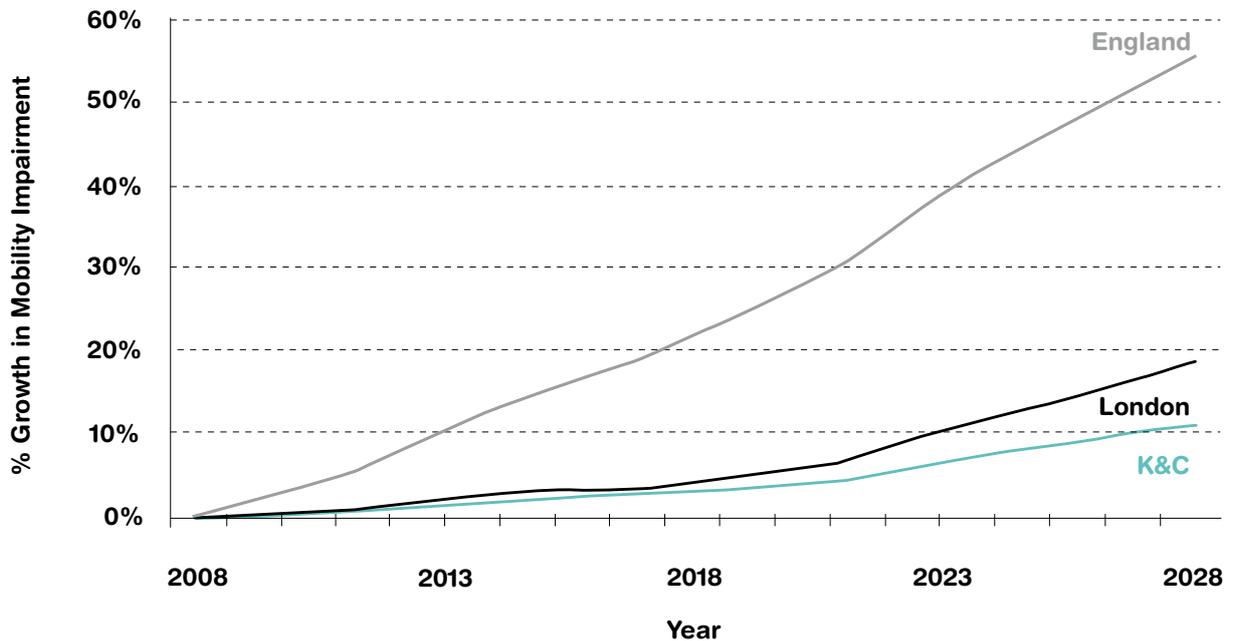
### The number of adults with physical disabilities helped to live at home has been increasing over time...

- Services are being developed to support people with disabilities to live independently. There are currently low levels of admissions to residential care, with growing numbers of people receiving self-directed care and support to live in the community. Around 590 people with physical disabilities in Kensington and Chelsea receive help from social care services to live at home, which has risen from 485 two years ago.

### Many public and residential buildings present access problems for disabled people...

- The views of local disabled people suggest that progress in recent years on making

## Chart 9: Projected growth of mobility impairment in 65+ year olds



GLA population projections (2007 - low), ONS 2006 subnational population projections (for England), POPPI

public buildings accessible has been slow in the venues where they most want improved access, such as shops, restaurants and cinemas. Many GP surgeries are in converted residential premises and one third of all premises-assessed surgeries are not fully accessible to disabled people. There is work underway to develop new premises.

- The Council is carrying out a project to assess all social housing properties within the borough to establish whether they would meet the needs of disabled people. This has led to the creation of an Accessible Housing Register.

**Nationally, disabled people are more likely to live in poverty and less likely to be in work compared to the general population, so there may be a need to ensure we have sufficient vocational rehabilitation services...**

- The proportion of economically active disabled residents in Kensington and Chelsea is

within the lowest 25 per cent nationally, so developing services is a priority.

**‘Personalisation’ aims to enable people to devise and purchase their own care in a way tailored to their own personal requirements...**

- At the end of March 2009, over 350 people had received some form of direct payment. Twenty-one payments went to people with learning disabilities and 108 went to people with physical disabilities (this includes payments to carers of people in these groups). Individual budgets will fundamentally transform the organisation of services for people with physical and sensory impairments, but they may reduce demand for local authority-provided care services, as people seek alternative provision.

## Profile of people with learning disabilities

The number of people known to learning disability services in Kensington and Chelsea is low compared to national prevalence rates...

- Applying national prevalence rates to the local population suggests that 650 to 700 people have a severe learning disability in Kensington and Chelsea. However, the number known to Kensington and Chelsea Adult Social Care is about half this figure (302 people). Also, Kensington and Chelsea GPs have the lowest identified learning disability prevalence of any PCT in the country.

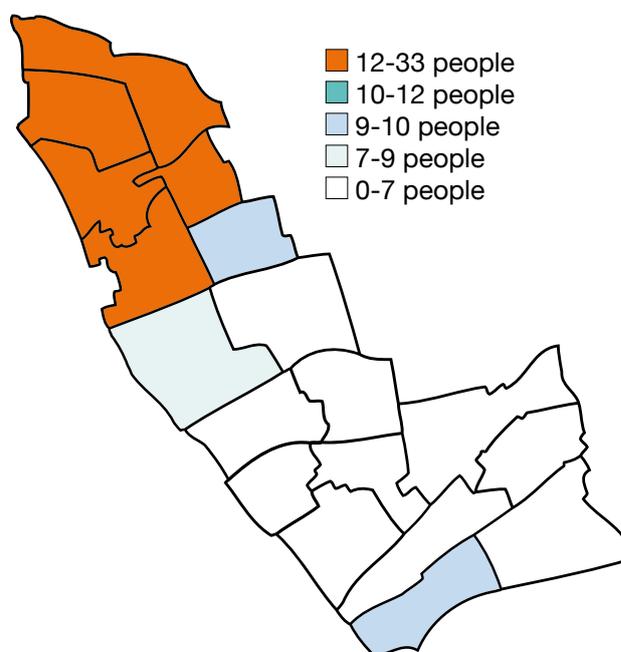
But this is more likely to be due to social and demographic reasons than from poor identification ...

- While this appears to indicate considerable unmet need in the borough, the inspection body the Commission for Social Care Inspection was satisfied in 2007 that: “there are...very few cases who do not actually receive services”. Learning disability services have been proactive in outreach work, and thresholds for Kensington and Chelsea services are for ‘moderate’ ‘rather than just ‘substantial’ need’ cases, unlike most other London boroughs.
- The low numbers are more likely to indicate the smaller number of people with learning disabilities living in the local community who want support from social care services. This is due to the expected high uptake of private services from affluent clients and the high proportion living in residential care outside the borough.

A significant number of people with learning disabilities live outside the borough, but remain the financial responsibility of the local authority....

- Roughly 40 per cent of people known to learning disability services live outside the borough. Of those who are resident in Kensington and Chelsea, three quarters live in the four most northerly wards (see Map 7). The pattern of residence is due in part to the location of supported housing and residential homes.

Map 7: Uptake of Royal Borough Learning Disability Services



<b>All service users:</b>	302
<b>Residents in borough:</b>	179
<b>Residents elsewhere:</b>	123

Source: GLA population projections (2007 - low), ONS 2006 subnational population projections (for England), POPPI

### Compared to the general population, those known to services are slightly younger and more likely to be from BME groups...

- Compared to the local population generally, the structure of the learning disabilities population is broadly similar, although the proportion of older people is slightly smaller. Nationally, people with learning disabilities die between five and ten years earlier than the general population.
- Twenty-seven per cent of people with learning disabilities known to Kensington and Chelsea are from BME communities, compared to 21 per cent in the general Kensington and Chelsea population. This could be because those from the more affluent white ethnic group are seeking private support rather than social care services. Although the difference is not large, it is being investigated further.

## Changing patterns of demand for learning disability services

### The likelihood of a child being born with a learning disability will probably increase by a small amount in the near future...

- Significant improvements in medical science for very low birth weight babies has resulted in a modest rise in numbers with learning disabilities over the last few decades. The impact of this recently has been very small, as very low birth weight babies form just one per cent of all births. There may be some impact from increasing numbers of children born with foetal alcohol syndrome.

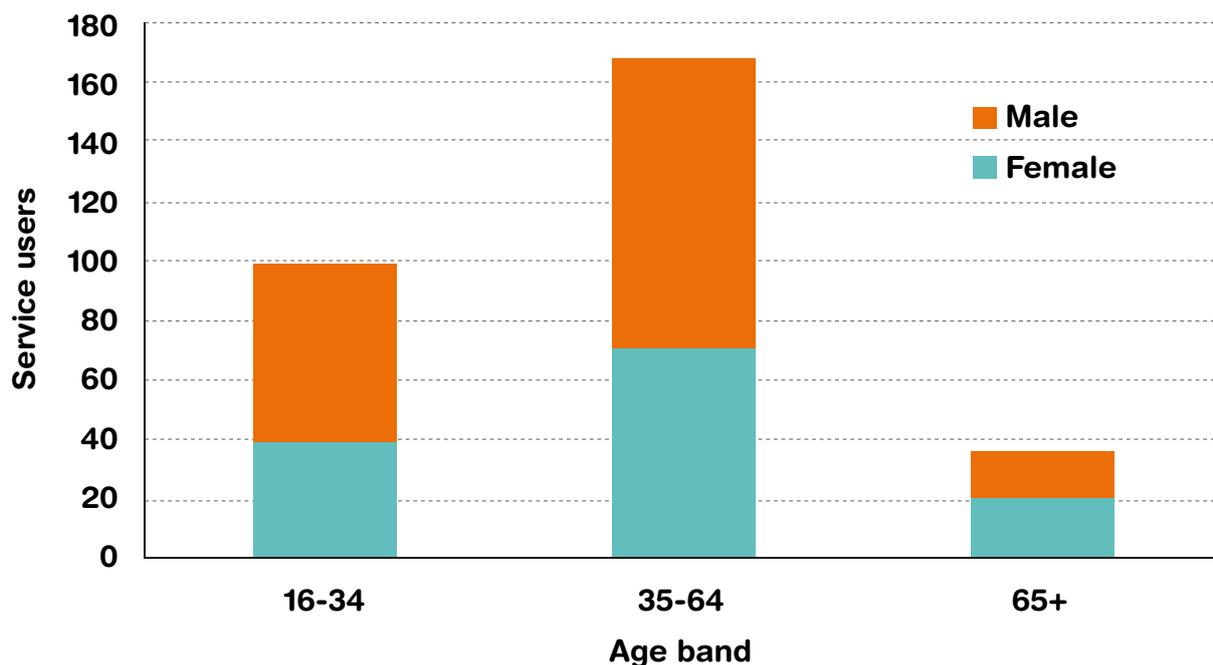
### But the increasing total number of births in the borough will probably result in small increases in babies born with learning disabilities...

- The small predicted increase in all births will probably result in marginal increases in babies born with learning disabilities, around six per cent in total over the next decade (similar to the last decade), which is less than one extra infant a year.

### With more children surviving into adulthood and better life expectancy once in adulthood, there is likely to be a growth in the number of older people requiring services...

- Applying national predictions of change to local service numbers suggests that there could be a rise in the total number of adults known to services over the next ten years – predominantly from a rise in clients over 50, where the figures rise from 103 to around 118. Within this, the number aged 65 and above could rise from 37 to around 46 (a 25 per cent increase), and from 16 to 22 for those aged 75 and above (a 33 per cent increase).
- Numbers in care should be monitored rigorously during the upcoming years to ascertain the impact on services, particularly from diseases associated with ageing such as dementia. At present, there may be an increase in the total numbers with dementia by about two to three people over the next ten years.
- The proportion of service users of Pakistani or Bangladeshi ethnicity are at a similar level to the general population, unlike nationally, where they are three times more common.

**Chart 10: Kensington and Chelsea learning disability service users by age and gender**



Source: Kensington and Chelsea Social Care Services, 2008, GLA Projections (2007 – low) for 2008

## Learning disability services

**An increasing number of people with complex health needs are now being supported in their own homes...**

- A shift in investment in learning disability services – from shared housing, to a wider range of housing options with support to enable people with learning disabilities to live independently in their local communities – has been identified as needing to increase. Because so much accommodation is out-of-borough, and not available in borough, Kensington and Chelsea has a higher proportion of people in residential care and among the lowest proportion helped to live at home when compared to London and England.
- However, the main element of the learning disability service is out-of-borough residential care for people with complex needs and challenging behaviour, and there is currently a lack of local accommodation for people with high or complex needs.

## Physical health and well-being

**People with learning disabilities are more likely to experience major illnesses, develop them younger, and die from them sooner than the general population...**

- Poor health among those with learning disabilities can relate to congenital problems, poor socio-economic circumstances, and lifestyle issues particular to those with learning disabilities. The most common problems affecting people with learning disabilities are obesity, diabetes and respiratory disease. This is followed by epilepsy, hearing and visual impairments and, for some groups, osteoporosis and urinary tract infections. One in three people with learning disabilities is also likely to have problems with their sight or hearing, though there may be cases where they experience both.

### **The health needs of people with learning disabilities are also more likely to go unnoticed by services...**

- A need to reduce diagnostic overshadowing – where physical health issues are attributed to a patient's mental state – has been identified by carers and professionals. Work is underway to train and improve awareness among healthcare staff. There are also efforts being made to introduce better health screening schemes.

### **Some people with learning disabilities have difficulties getting the healthcare they need...**

- Carers have expressed concern over the length of waiting times for hospital bed-based dentistry, and longer sessions for people with learning disabilities are not routinely available. Some people with learning disabilities have also experienced difficulties in getting help with sight problems.

### **Less than one in five people with a learning disability are in work, which is likely to impact on mental and physical well-being...**

- A need has been identified to provide and widen support, with access to education and employment for young people with learning disabilities, and clear pathways during the transition phase from children's into adult learning disability services.
- Consultation with residents indicates that there is not always enough encouragement and support for disabled people to use leisure and sports facilities.

## **Support for people with learning disabilities and their carers**

### **An ageing learning disability population means more support from services, for both users and carers...**

- Nationally, it is estimated that nearly a third of carers of people with learning disabilities are over 70. With an ageing learning disability population, increasing care and support will be needed for carers. The increase in survival into adulthood also means more support is necessary for adults with learning disabilities who are parents.



# 9. Substance misuse

## Key messages

- Kensington and Chelsea is estimated to have a high rate of problematic drug use, with approximately one and a half per cent of the population resident in the borough having a crack or opiate problem.
- There are a high proportion of older heroin and methadone users known to services, with close to three quarters over the age of 35. Local services are also concerned about the level of cannabis and stimulant use in the borough.
- North Kensington (W10) has the highest rate of contact with services for all types of drugs, although Earl's Court (SW5) and South West Chelsea (SW10) are also high for problematic drug use.
- Kensington and Chelsea is estimated to have higher levels of alcohol consumption than London, similar to nationally. However, the rate of hospital admissions for alcohol-related harm is low compared to elsewhere.
- Admissions resulting from alcohol are focused in the north of the borough, generally in areas of deprivation.
- While deaths from alcohol have remained constant, admissions have been steadily climbing (in common with

elsewhere). Some of this may be from better coding of data in hospitals.

- Particular vulnerable groups for substance misuse in the borough are homeless and hostel residents and people with mental illness.
- There are more from the Black ethnic group in treatment than expected, given the postcode areas they come from.
- The Kensington and Chelsea substance misuse service has been rated as 'good' and 'excellent' over the last two years; 12 week retention rates are currently higher than for London and England.

## Problematic drug use

**The level of problematic drug users in the borough is not known with accuracy, but is estimated to be about one and a half per cent...**

- In 2006 to 2007 there were an estimated 2,350 problematic drug users in the borough (defined as crack or opiate users), aged 15 or above.
- Estimates suggest a high level of crack use – typical of London – as well as high levels of drug injectors.
- There has been some question over the accuracy of the problematic drug use estimates; local services believe they may be an overestimate of real problematic drug use.

## Kensington and Chelsea appears to have a higher proportion of older problematic drug users than many other areas...

- Estimates suggest more than two thirds of all problematic users are over the age of 35. Although the age profile of all users in treatment is similar to London, 71 per cent of heroin and methadone users in treatment are over 35. Older drug users are likely to have more significant health needs.

## Types of drugs used

More people are in treatment for heroin than any other drug; however, the proportion is small when compared to national figures, with a higher proportion of crack cocaine and methadone users...

- Heroin was identified as the main problem drug for one third (29 per cent) of clients in drug treatment, compared to 61 per cent nationally. Cannabis (16 per cent) forms a slightly larger proportion than nationally, and crack cocaine (14 per cent) and methadone (12 per cent) are both twice as common (see Table 7).

The number in contact with services who are known to use cannabis has been growing and is of concern to local services...

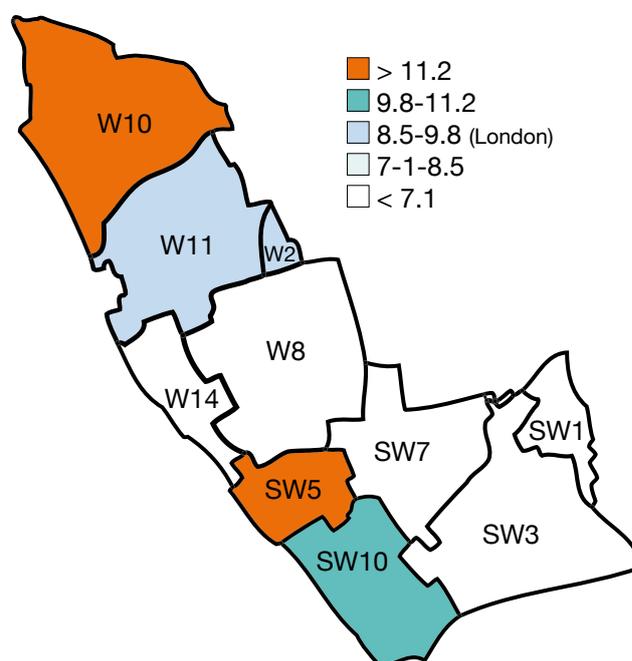
- Local service data, the Cannabis Action Group Cannabis Survey 2007, and anecdotal information from a number of agencies highlights that young people in Kensington and Chelsea seem more likely to use cannabis than other drugs.
- Cannabis users have a much younger age profile than other drug users, and are also more likely to be male and from a Black and minority ethnic group.

## Patterns of drug use

The pattern of drug users in treatment generally follows the pattern of deprivation, with larger numbers in the North Kensington area...

- Nationally, manual and routine groups are more likely to use drugs than managerial and professional groups. Local treatment data shows a similar pattern, with the deprived North Kensington (W10) area having a considerably higher rate of known drug users than other postcode areas in the borough; this area has the highest prevalence in the borough for all main types of drugs (see below).

### Map 8: Drug users receiving treatment per 1,000 15+ year old population



Source: RBKC data request from NTA (2007/08)

**Table 7: Drug user profile of those in treatment by drug group**

Drug (first choice)	Average age	% Male	% BME K&C population 21%	Proportion of total known to services (07/08)
Heroin	38	72%	22%	29%
Cannabis	24	81%	61%	16%
Crack	35	65%	54%	14%
Methadone	42	66%	17%	12%
Cocaine	31	51%	32%	10%
All other opiates	39	59%	24%	6%
Prescription drugs	40	55%	25%	4%
Other drugs	32	80%	47%	8%
All drugs	35	69%	36%	100%

Source: Kensington and Chelsea data request from NTA, 2007/08

- In addition, the Earl’s Court (SW5) and South West Chelsea (SW10) areas also have high numbers in treatment for problematic drug use. Those problem drug users resident within Kensington and Chelsea who have sufficient resources to fund their drug use without committing crime, and receive their treatment through private healthcare, are not reflected in the data.

**Drug-related crime also varies significantly across the borough...**

- Golborne ward has over four times the London average for drugs offences and nearly three times the borough average; Colville and Pembridge wards have three times the London average and twice borough average. It is important to note that a significant proportion of drug offences in the borough are committed by non-residents.

**Estimated alcohol use**

**Overall, estimated levels of alcohol consumption in Kensington and Chelsea are not significantly different to nationally...**

- Although alcohol consumption is not known with any degree of accuracy, estimates suggest around 15 per cent of residents in the borough (23,000 people) are likely to binge drink. In addition, six per cent (9,000 people) are likely to engage in ‘harmful’ drinking, consuming 50 or more units a week for men and 35 or more for women. These proportions are not significantly different to England.
- Extrapolating from population estimates and known prevalence rates, it is predicted that there are nearly 600 people in Kensington and Chelsea with moderate or severe alcohol dependence.

**The harm related to alcohol is substantial, but generally Kensington and Chelsea has smaller burden than nationally...**

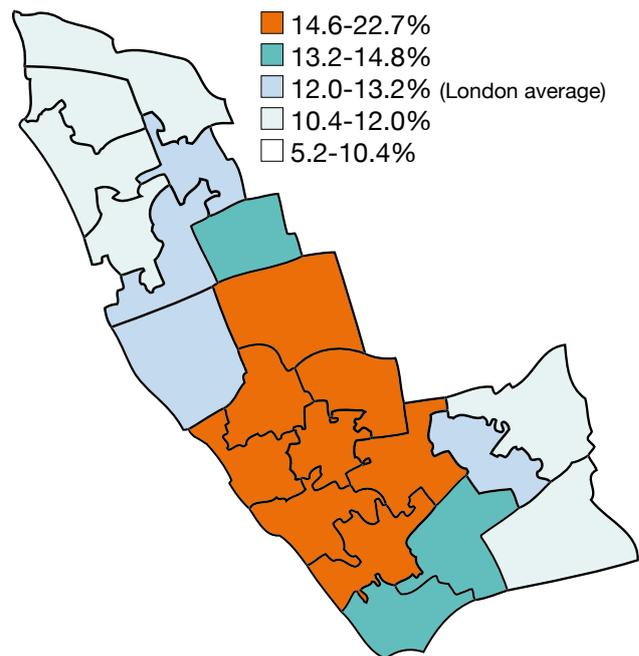
- Alcohol can be responsible for ill health and death. Roughly 18 men and seven women die each year in the borough from causes specific to alcohol; the rate is significantly lower than England and lower than London. The number of hospital admissions a year (50 for men, 25 for women) is a similar rate to London and England for men, and significantly lower than England for women.
- There are also a range of conditions for which alcohol is a significant cause, such as suicide and undetermined injury, cancer of the oesophagus, breast cancer, stroke and hypertensive diseases. In addition to deaths directly specific to alcohol, eight men and five women die from alcohol-attributable causes each year, as well as there being 750 male admissions and 450 female admissions.

**Patterns of alcohol use**

**There are significant variations in alcohol-related harm within the borough, with a strong deprivation bias...**

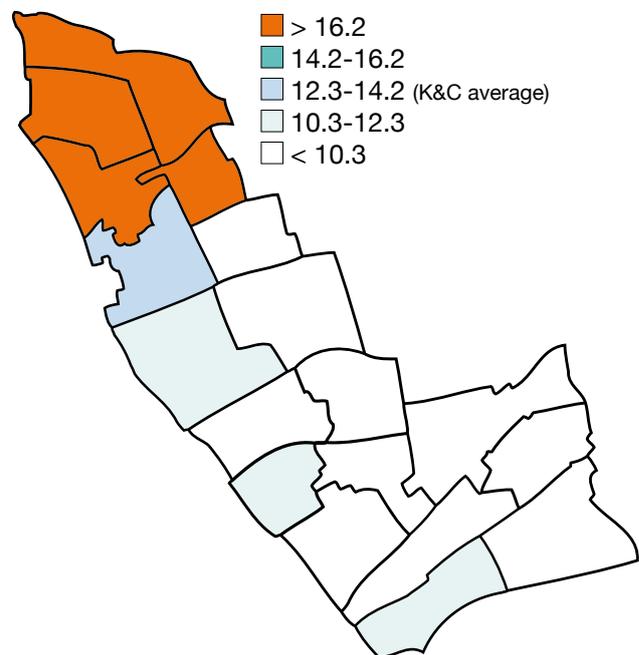
- Estimates of consumption suggest binge drinking is most common in the South Kensington area, which has a young age profile; it is less common in the north, where a significant proportion do not drink for religious reasons (see Map 9).
- However, the areas displaying the highest levels of harm display a deprivation bias, with the four most northerly wards, as well as Earl's Court and Cremorne, accounting for over half of all admissions for mental and behavioral disorders from alcohol and alcoholic liver disease (see Map 10).

**Map 9: Binge drinking**



Source: ONS Synthetic Estimates (2003-2005)

**Map 10: Alcohol-related admissions, per 10,000 population**



Source: Dr Foster Intelligence, GLA Low population estimates (2007/08)

### **We still need more data to be able to understand the needs of our local population better...**

- There is a lack of accurate data on binge drinkers and people who drink at home, particularly older residents in the borough. There is also a lack of information on those who only use GP services and may not present as having a substance misuse problem. More information is also needed about those accessing private healthcare.

## **Changes in substance use over time**

### **National surveys show a decline in drug use for both adults and children over the last few years, with a few exceptions in some groups...**

- The British Crime Survey has shown falling drug use nationally in recent years. However, the proportion of 16 to 24 year olds using cocaine powder on a monthly basis has doubled between 2000 and 2007; this trend may well continue. The use of cannabis has also risen and is of concern.
- There has been no change in the estimated number of problematic drug users nationally, but there appears to have been a decrease in the number injecting drugs.

### **There has been no rise in the number admitted or dying from alcoholic liver disease in the borough over the last decade...**

- Roughly 18 men and seven women die each year in the borough from causes specific to alcohol; of these, there are around seven deaths from alcoholic liver disease. There are in the region of 40 emergency admissions a year for alcoholic liver disease, with very little change over time.

### **The number of hospital admissions for alcohol-related harm has been rising over time and is likely to continue to rise...**

- The number of admissions for alcohol-related harm in the borough has consistently risen, from 1,200 in the year 2002 to 2003, to 1,800 four years later. This represents an annual rise of nearly 15 per cent, which is slightly below the annual rise in London and England. It is unclear what proportion of this rise is a result of better coding of admission data, but real growth is likely to impact on illness in future years. For example, about 11 per cent of dementia is related to alcohol use.

## **Use of substance misuse services**

### **Substance misuse services are generally rated highly in reviews of service quality...**

- The Healthcare Commission and National Treatment Agency for Substance Misuse rated Kensington and Chelsea as 'Good' in their 2007/2008 review of diversity and Tier four (inpatient and residential rehabilitation) review; we achieved 'Excellent' on three of the 11 criteria and 'Fair' on two criteria.
- At 82 per cent, Kensington and Chelsea drug treatment services had the seventh equal highest 12 week retention rate of clients in London during 2007/08. This is higher than England, where the figure is 78 per cent.

### **The substance misuse service caters for a number of vulnerable groups, particularly homeless and hostel residents, and those with mental health problems...**

- Homeless and hostel residents are mostly located in Earl's Court and Redcliffe wards. A large number of these residents have drug and alcohol problems and are unlikely to self-refer to specialist services. Satellite services go into hostels to ensure those in need of drug and alcohol treatment are able to access services.

- There is considerable overlap between severe mental health problems and substance misuse; identification of those with problematic drug use and severe mental health issues requires consistent screening tools with an agreed definition of 'dual diagnosis'. The extent of the problem of substance misuse within mental health services needs further exploration.

**Compared to the areas where they live, there are proportionately more drug users in treatment from the Black ethnic groups than those represented in the general population...**

- When compared to the ethnic profile of the areas they live in, there is some over-representation - particularly from the Black ethnic group (16 per cent in treatment, compared to 11 per cent in the population where users live), with similar representation from the Asian ethnic group (five per cent in both). The same figures also suggest under-representation from the White ethnic group (64 per cent compared to 73 per cent).

**General practice and A&E departments are crucial for screening and delivering drug treatment services...**

- There is a long established 'shared care' service offered to drug users within Kensington and Chelsea from GP practices and the CNWL NHS Foundation Trust. Forty per cent of GPs are involved in the scheme and a significant proportion of pharmacies are also involved in delivering services to drug users. The scheme is currently under review.
- There is now a specialist substance use liaison nurse in post in place at Chelsea and Westminster Hospital Accident and Emergency Department, who supports staff to screen, signpost and refer to specialist services.

- A local enhanced service has been introduced to support GPs in screening for alcohol problems, offering brief interventions and referring to Tier Three treatment services (drug and alcohol treatment in the community with regular sessions). Around 80 per cent of practices provide this service.

## Service user involvement

**There are established systems in place for gathering users' views of substance misuse services, and users have input into shaping services...**

- A service user satisfaction survey in 2006 found that 70 per cent of respondents in Kensington and Chelsea agreed that: "This service is good at taking users' views into account". Service user involvement through the Service User Drug Reference Group (SUDRG) is held up as an example of best practice by the National Treatment Agency; the group is involved in the planning and development of drug and alcohol services at a local and regional level.
- Service users have identified the lack of access to substance use services over the weekend and in the evenings as an issue - especially for those who work. Although some evening provision is in place and some peer-led services are available at weekends, there is a need to increase out of hours services to meet the expressed need for prescribing and therapeutic services.
- A national survey by the National Drug Treatment and Monitoring Service found more support could be provided to family members, partners and friends. We have invested in a family service, but more needs to be done to ensure we are accessing the most vulnerable.

## Education, training and employment

**With the link between social and economic well-being and good health, substance users need support to re-establish themselves within their communities...**

- Targeted services have been developed, providing access to a range of opportunities which enable substance users to re-enter formal education, volunteering or employment, or to improve self-esteem and confidence. Ongoing investment and development in this service is critical in moving people from specialist services to universal services.



# 10. Next steps

## The JSNA is an ongoing process...

This is a summary of the first JSNA that the Council and PCT have produced. It is rich in data, which is important when planning services. Perhaps more important though, is the process of preparing, refreshing and refining the JSNA. It is through this process that all interested parties – the Council, health and voluntary sector – can achieve a common understanding of what exactly the data means.

It should be remembered that the JSNA is not static. The detailed internet-based chapters will be updated regularly as a result of growing experience and new evidence. Gaps in it will be identified as the use of JSNA as a tool matures.

From your feedback, the JSNA Coordinator will produce an action plan for 2009 to 2010 which will list all identified gaps and research needs. Work to fill the gaps will be overseen by the Health and Well-being Partnership Board, and guided by the new Joint Commissioning Board.

An updated report will be produced annually, summarising JSNA-related work that has taken place in the year and the impact this has had.

## The role of the JSNA for commissioners...

The JSNA provides a framework for understanding the overlap across different commissioning activities and agendas. You should also be able to use this tool to identify joint commissioning opportunities across business groups, organisations and sectors. It offers a singular opportunity to focus on inequality issues which are starkly exposed in the data. It must become the authoritative source for commissioning activities.

## What now?

We want you to tell us what priorities future JSNAs should include. If there is a particular piece of analysis that would assist your decision-making process, please email [JSNA@rbkc.gov.uk](mailto:JSNA@rbkc.gov.uk).

Also, please notify [JSNA@rbkc.gov.uk](mailto:JSNA@rbkc.gov.uk) whenever you carry out consultation work or produce a new strategy. We want the JSNA to be as up-to-date as possible and need your help to do this.

## English

Information from this document can be made available in alternative formats and in different languages. If you require further assistance please use the contact details below.

## Arabic

يمكن توفير المعلومات التي وردت في هذا المستند بصيغ بديلة ولغات أخرى. إذا كنت في حاجة إلى مزيد من المساعدة، الرجاء استخدام بيانات الاتصال الواردة أدناه.

## Farsi

اطلاعات حاوی در این مدارک به صورتهای دیگر و به زبانهای مختلف در دسترس می باشد. در صورت نیاز به کمک بیشتر لطفاً از جزئیات تماس ذکر شده در ذیل استفاده کنید.

## French

Les informations présentées dans ce document peuvent vous être fournies dans d'autres formats et d'autres langues. Si vous avez besoin d'une aide complémentaire, veuillez utiliser les coordonnées ci-dessous.

## Portuguese

A informação presente neste documento pode ser disponibilizada em formatos alternativos e em línguas diferentes. Se desejar mais assistência, use por favor os contactos fornecidos abaixo.

## Somali

Macluumaadka dokumentigan waxaa lagu heli karaa qaabab kale iyo luuqado kala duwan. Haddii aad u baahan tahay caawinaad intaas dhaafsiisan fadlan isticmaal xiriirka faahfaahinta hoose.

## Spanish

La información en este documento puede facilitarse en formatos alternativos y en diferentes idiomas. Si necesita más ayuda por favor utilice la siguiente información de contacto.

**Environmental Healthline  
telephone number  
020 7361 3002**



**Kensington and Chelsea**



THE ROYAL BOROUGH OF  
**KENSINGTON  
AND CHELSEA**