Prioritising Health and Wellbeing Needs

Kensington and Chelsea
JSNA Highlight Report 2012

JSNA
Joint Strategic Needs Assessment

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Introduction

The Joint Strategic Needs Assessment (JSNA) guides the development and delivery of health and social care services, by focusing on local priorities and enabling partnerships. This JSNA highlight report is a high level summary of the major factors impacting the health and wellbeing of residents of Kensington and Chelsea.

The report has been laid out to aid Health and Wellbeing Boards, Clinical Commissioning Groups and other stakeholders in establishing local priorities.

The report makes reference to *Fair Society, Healthy lives*, the Marmot Review into health inequalities in England, which recommended action *across* the social gradient to improve everyone's health, with a scale and intensity that is proportionate to the level of disadvantage. Some of the factors influencing health inequalities have been highlighted in the diagram below. This report aims to support cost-effective commissioning decisions, and therefore makes reference to relevant public health guidance from the National Institute for Health and Clinical Excellence (NICE).

A wealth of analysis has been carried out by the Public Health Team and Council analysts to inform the JSNA process over the last few years. This document provides a synopsis of current need. In the coming months, a more detailed updated JSNA will be developed which will incorporate findings from the new 2011 Census as they are released, and will introduce an 'asset-based' approach to understanding health and well-being, rather than using the current 'deficit' approach. It will also include detail around health and social care service use by different population groups.

Further details of the JSNA can be found at www.jsna.info

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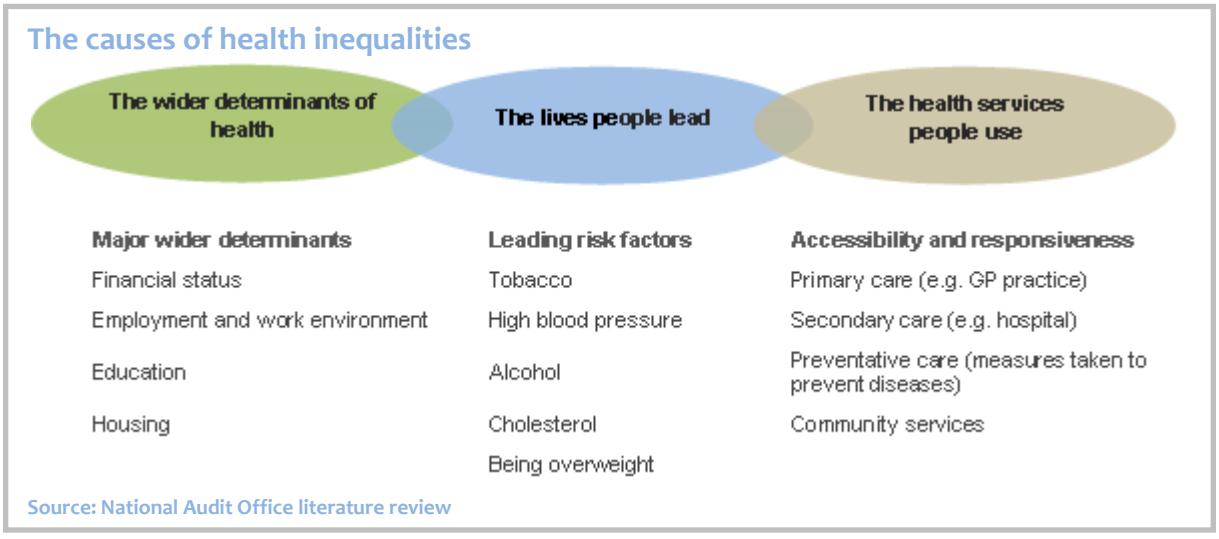
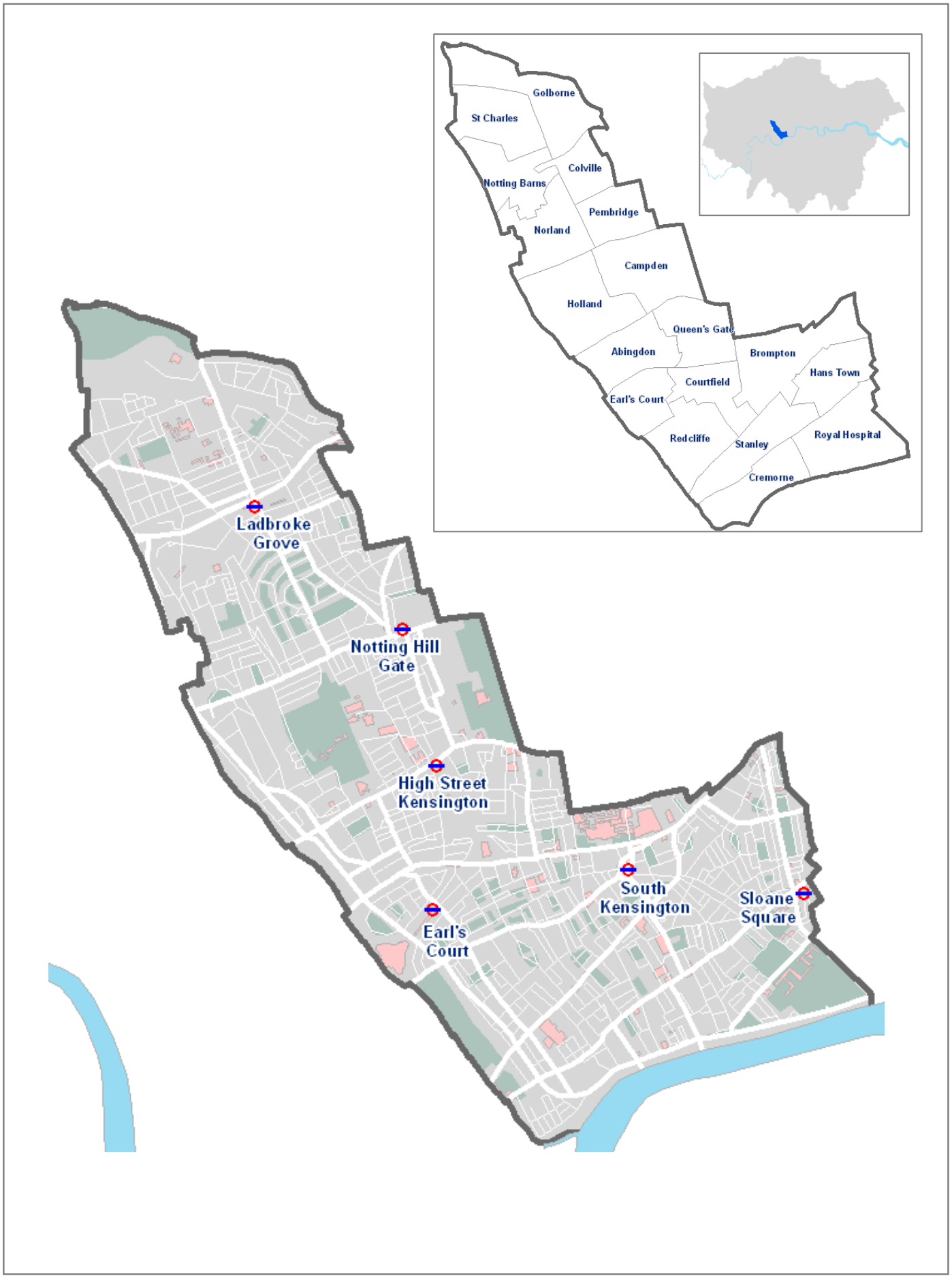


Location and ward maps



The Local Population

Kensington and Chelsea is a small and very densely populated borough situated in the centre of London, bordered by Westminster to the East and Hammersmith and Fulham to the West. The borough is popular for tourism and retail, with areas such as Chelsea, Kensington High Street, Notting Hill, South Kensington and Ladbroke Grove.

The Office for National Statistics estimates the resident population in 2010 to be 169,500 people, with 179,700 patients registered with Kensington and Chelsea GPs. The population is expected to rise in the medium to long term, with a particular focus in development areas such as Canal Way in the far north of the borough, and the Earl's Court/ Warwick Road area.

The population is characterised by a large proportion of young working age residents, high levels of migration in and out the borough, and ethnic and cultural diversity. Although residents have the highest life expectancy in the country, there are significant pockets of poor health in the more deprived areas and therefore large inequalities.

Age

The age profile in Kensington and Chelsea is typical of urban areas in having a high proportion of young working age adults, and a smaller proportion of children. There are a similar proportion of older people to London but far fewer than nationally. The 117,500 residents aged 16 to 64 represent 69.3% of the total population. This population structure impacts on the types and range of service required in the borough.

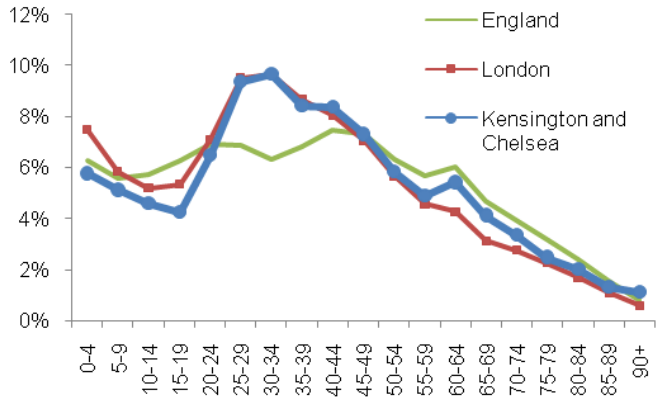
Gender

There are slightly more women than men living in the borough. As with elsewhere, there are a greater number of older women due to longer life expectancy.

Ethnicity

The borough has a smaller proportion of residents from 'White British', 'Black' and 'Asian' ethnic groups in comparison to London. There are more from the 'Other/mixed' category, and three times more from the 'White other' category – the highest in the country. The White other category includes those from Europe,

Population Structure, 2010



Population Ethnicity, 2001

	K&C	London	England
White British	50%	60%	87%
White Other	29%	11%	4%
Black	7%	11%	5%
Asian	5%	12%	2%
Other/Mixed	10%	6%	2%
White	79%	71%	91%
BME	21%	29%	9%

Ireland, the Americas and Australia. 76% of the borough's state school children are from ethnic groups other than White British.

Nationality and language

Analysis of data on patients registered with GPs suggests there are significant populations from the Americas, Western Europe, Australia, the Philippines, the former USSR and Iran. Common minority languages spoken include Arabic, French, Spanish, Italian and Portuguese. English is spoken as an additional language by 54% of the borough's state school children.

Households

There are around 83,500 households in Kensington and Chelsea with an average household size of 2.0 persons. Around half of households in Kensington and Chelsea are single households, one of the highest nationally. Under a fifth of the borough's households are occupied by families, and less than 1 in 10 by lone parents, and single elderly households accounting for 15%. The proportion of private rented housing is very high compared to London and England.

Population mobility

Kensington and Chelsea had the sixth highest population mobility rate in England and Wales in 2001, with one in five residents moving address in the previous year. Population 'churn' can create challenges around effective delivery of public health programmes such as screening and immunisation.

Deprivation

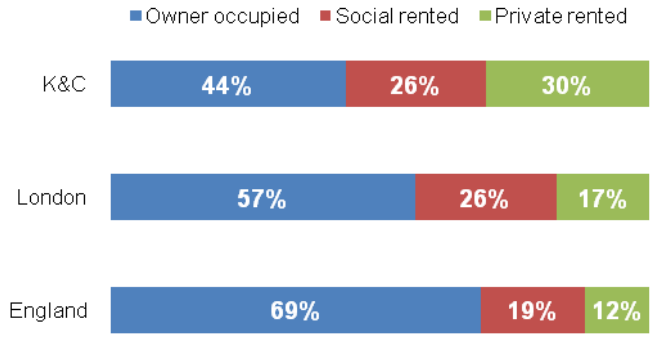
The Index of Multiple Deprivation (IMD) combines economic, social and housing indicators into a single score, allowing the ranking of areas by deprivation. In 2010, Kensington and Chelsea was ranked 103rd most deprived local authority in the country, with significant areas of deprivation in the four northerly electoral wards.

Most common nationalities and languages.

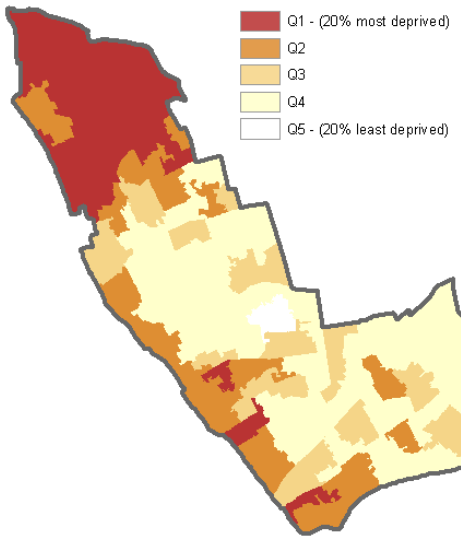
Estimates based on GP registration data (2011)

Most common country of Birth (excl. UK)		Most common first language (excl. English)	
1	USA	1	Arabic
2	France	2	French
3	Italy	3	Spanish
4	Australia	4	Italian
5	Spain	5	Portuguese

Tenure, 2001



Index of Multiple Deprivation 2010



Child wellbeing and child poverty

The Child Wellbeing Index (CWI) is a composite index with seven domains: material well-being; health; education; crime; housing; environment; and children in need. Based on these, the borough is ranked 127th lowest out of 354 in England for wellbeing. Figures from the Index of Multiple Deprivation Affecting Children (IDACI) suggest that 21% of the borough's children live in income-deprived households.

Employment and unemployment

The majority of jobs in the borough fall into the service and retail sectors. The unemployment rate for residents is currently 7.3%, the 7th lowest in London. The Job Seekers Allowance (JSA) claimant rate (2.8%) is below London (4.4%) and Great Britain (4.1%), although the rate for claimants for over 12 months is similar.

Incapacity benefit for mental health

Golborne, St Charles and Notting Barns are in the top ten wards in London with the highest level of working age incapacity benefit claimants for mental health reasons. Colville and Cremorne are also within the top 20% of wards in London with high claim rates.

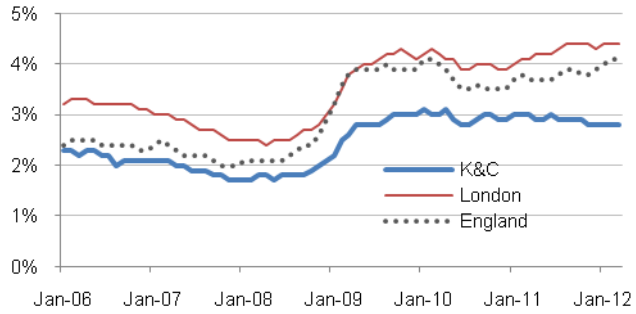
Health and life expectancy

The average life expectancy is 85.1 years for men and 89.8 for women, the highest in the country. Life Expectancy in Kensington and Chelsea was the fastest improving in the country over the last decade, with an increase of 7.8 years for men and 7.5 years for women.

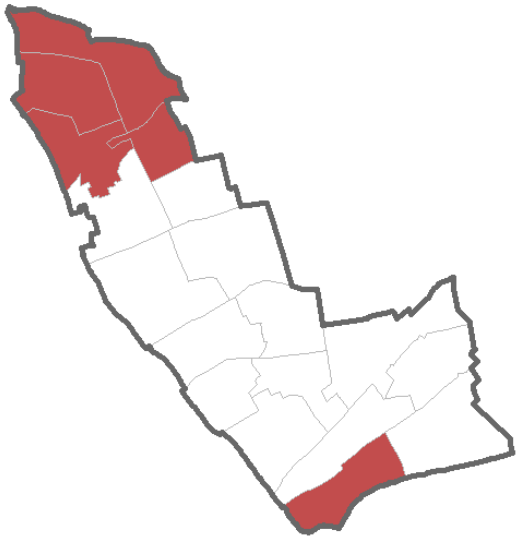
Disability-free life expectancy

Disability-free life expectancy is increasing, but at a slower rate than life expectancy: people are experiencing **longer periods of time living with disability**, resulting from improved survival rates from major diseases

Job Seekers Allowance (JSA) claimant rate over time



Incapacity Benefit claimants - mental health reasons
Areas with the 20% highest claimant rates in London, Aug 2011



such as stroke, heart disease and cancer. National modelling predicts women aged 65 in 2030 will live for four years with a disability, compared to three years today. Given large numbers living alone locally, this is likely to increasingly impact on the level of support required from services and carers.

Health inequality

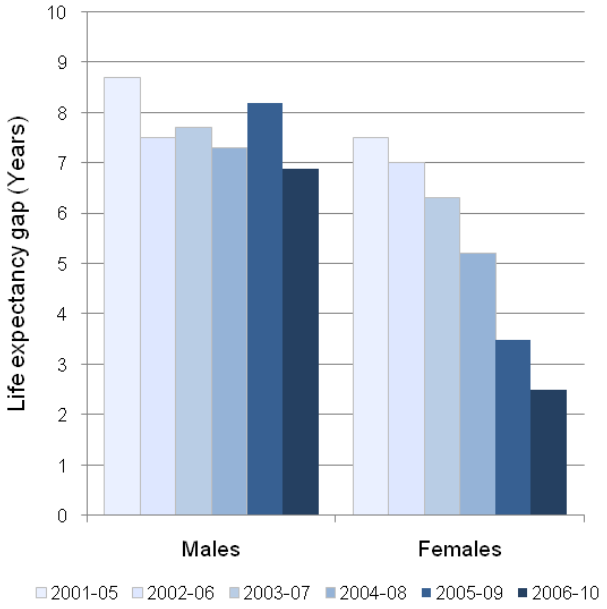
There is variation in life expectancy across the social gradient in Kensington and Chelsea. The Slope Index of Inequality, which measures the absolute difference in life expectancy between the most and least deprived areas, shows a 6.9 year life expectancy gap for men and a 2.5 year gap for women (2006-10). These are lower than the median figures for England (8.9 and 6.0 respectively).

There appears to be a narrowing of the gap among women over the past 5 years, and improvements in life expectancy appear to have been experienced across the social spectrum. However, the lack of a strong trend across areas and over time means confidence in these findings is low.

Health inequality is highlighted by the variation in premature death in the borough: almost twofold between the four northerly wards and the rest of the borough.

Life expectancy gap

Between the most and least deprived areas (2001-05 – 2006-10)



Prioritising the Causes of Early Death in the Borough

Premature mortality refers to people who die before the age of 75. This measure is used to identify deaths usually considered 'avoidable'. Last year, there were 303 premature deaths in Kensington and Chelsea, a lower number than is typical for a borough in London or England. Of these, 9 were aged under 1 and 2 were aged 1-19.

Prioritising action to reduce early death is important because work focused in particular areas or with particular groups has the power to reduce the variation in life expectancy that currently exists in the borough, thereby narrowing health inequalities.

The principal cause of premature death in Kensington and Chelsea is **cancer**, followed by **cardiovascular disease** (CVD) (which includes heart disease and stroke). A significant number of people also die from respiratory diseases. Accidents and injuries are most common among younger residents. This is pattern is broadly similar to the rest of the country.

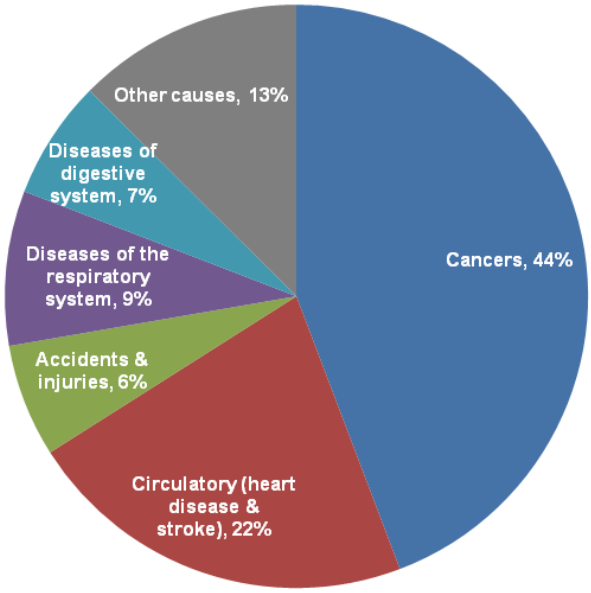
Tackling these chronic diseases using a range of factors, particularly lifestyle change and improved services for those with chronic disease, has resulted in a reduction of around 120 early deaths a year over the last decade, with differing levels of success across disease types.

Cardiovascular disease

There have been marked reductions locally in premature mortality from CVD in the past decade (by 47%), the result of factors such as timely high quality treatment, effective prescribing, and a reduction in the number of smokers. Ten years ago, CVD was the primary cause of early death; it is now the second most common.

Currently 54 residents of the borough die prematurely each year from heart disease and 12 from stroke.

Premature deaths by cause, 2011



Cancer

Improvements in lifestyles, as well as more accessible and high quality care, have resulted in a decline in the early death rate for cancer. The change has been faster than in London and England (27% locally in the last decade, compared to 20% in London and 17% nationally). Nationally, issues still exist around early diagnosis of cancer, with chances of survival much poorer in areas of deprivation.

Currently 134 residents of the borough die prematurely each year from cancer, which is around 40-50 less than a typical London borough.

Lung, breast and bowel cancer account for the greatest number of early deaths in the borough.

What does the evidence say?

NICE guidance PH15 identifies stopping smoking and the appropriate prescribing of statins to reduce cholesterol as being the most cost-effective interventions for making improvements in life expectancy in targeted communities.

Approaches

Two focuses are generally used to tackle early death from chronic disease:

- **Primary prevention** - reducing risk factors for these diseases by promoting and maintaining healthy lifestyles e.g. stopping smoking
- **Secondary prevention** - better identification and treatment of chronic diseases e.g. appropriate prescribing of statins and anti-hypertensive

NICE Guidance

- NICE PH15 Identifying and supporting people most at risk of dying prematurely

Prioritising the Largest Causes of Disability in the Borough

Prioritising health needs based on causes of death is valuable in understanding life years lost, but it does not always capture the impact of disability on day to day living. Conditions that may not result in premature death can nevertheless result in a huge day to day health burden on people's lives. This not only impacts on service use but also employment possibilities and participation in social networks.

The recent Marmot review outlined the economic case for tackling and supporting disability, given the increasing proportion of the future working age population who, in the absence of intervention, would be living with a disability.

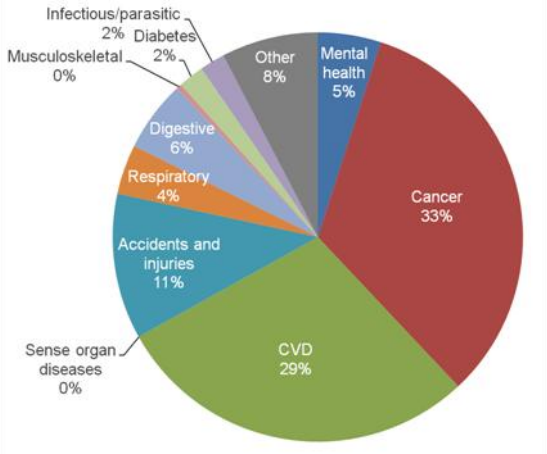
Nationally, **mental ill-health** accounts for the greatest burden of years of life with a disability. Whilst it only accounts for 5% of years of life lost before the age of 75, it is responsible for over 40% of all years of life spent with a disability.

Mental ill-health has been shown to have a strong inter-relationship with other chronic diseases. For example, there is a three times higher likelihood of depression among those with diabetes.

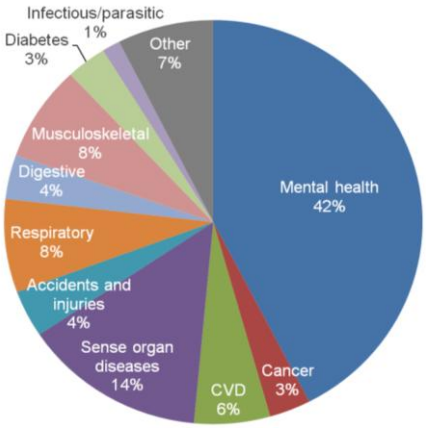
Locally, inpatient admission for chronic disease is 15-30% more common among those on GP depression registers, compared to those who are not.

Other conditions are significant causes of disability: **sense organ diseases** (14%), **respiratory disease** (8%) and **musculoskeletal disorders** (8%) each individually account for a greater burden of disability in lifetime than either CVD (6%) or cancer (3%).

Years of life lost before age 75 by cause, 2004-08



Years of life with a disability by cause, 2004-08



NICE Guidance

- PH16 Mental well-being and older people
- PH22 Promoting mental well-being at work
- PH19 Management of long-term sickness and incapacity for work

Prioritising Where the Borough is an 'Outlier'

Sometimes it may be appropriate to target resources towards population groups, disease types, or geographical areas where the borough is seen to be an 'outlier' compared to elsewhere. In the case of Kensington and Chelsea, indicators often show overall good health, masking pockets of very poor health, meaning within-borough comparisons are usually the most valid.

Being an outlier might mean the borough is performing worse than elsewhere and needs are not being met. It might also be that the borough is home to vulnerable population group not common elsewhere (such as an HIV population) that has very specific health needs to be addressed.

Outliers for harmful behaviour

Child obesity in Kensington and Chelsea state primary schools has been consistently higher than nationally for Year 6 pupils (aged 10-11) over a period of time. Further detail on child obesity can be found in the next section 'Emerging Public Health Issues'.

Levels of **physical activity** and **smoking prevalence** are both favourable compared to London and England, but estimates suggest parts of the north of the borough have among the lowest activity levels in London, with this area also having 50-70% higher smoking prevalence than the rest of the borough. Within the borough, hospital admissions for **childhood injuries** are highest in areas of deprivation, as are **admissions for alcohol**, particularly so in Golborne ward.

Kensington and Chelsea has the 12th highest rate of acute **sexually transmitted infections** in the country, including the 4th highest rate of syphilis. Whilst Chlamydia rates are high among 25+ year olds, the rate for 15-24 year olds is similar to average.

Poor dental health during childhood can result in significant disease and distress in later life through dental decay and gum disease with pain and infection. Dental caries accounts for one fifth of all hospital admissions for 5-9 year olds.

NICE Guidance

- PH2 Four commonly used methods to increase physical activity
- PH1 Brief interventions and referral for smoking cessation
- PH30 Preventing unintentional injuries among under 15s in the home
- PH24 Alcohol-use disorders – preventing harmful drinking
- PH3 Prevention of sexually transmitted infections and under 18 conceptions

37.7% of 5 year olds attending the borough's state schools have **decayed, missing or filled teeth**, the 7th highest in London in 2007/08 and higher than the London average, with highest levels in areas of deprivation (the survey is currently being repeated). The proportion of children who had **seen an NHS dentist** in the previous 24 months at December 2011 (35.8%) was much lower than London (67.0%) and England (70.7%).

Outliers for health and disease

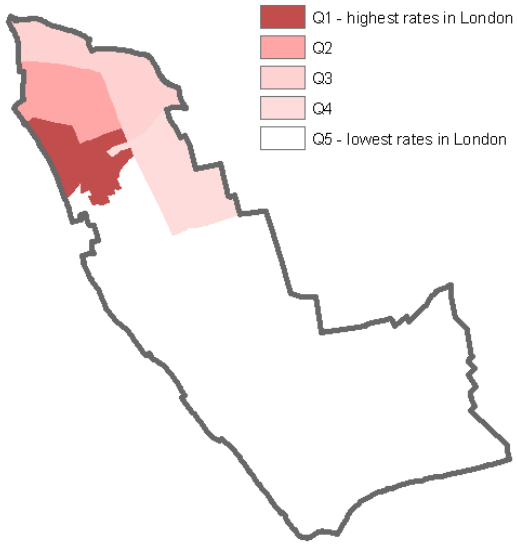
The overall **premature (under 75) death rate** in Kensington and Chelsea is the 4th lowest in the country, but Notting Barns ward falls within the 20% worst wards in London, with around 6 more early deaths a year than is typical for London.

The premature death rate from **cancer** is the lowest in the country, but Notting Barns ward falls within the 20% worst wards in London, with around 3 more early deaths a year than is typical for London. The rate in the area covered by the four northerly wards is more than one and a half times that of the rest of the borough.

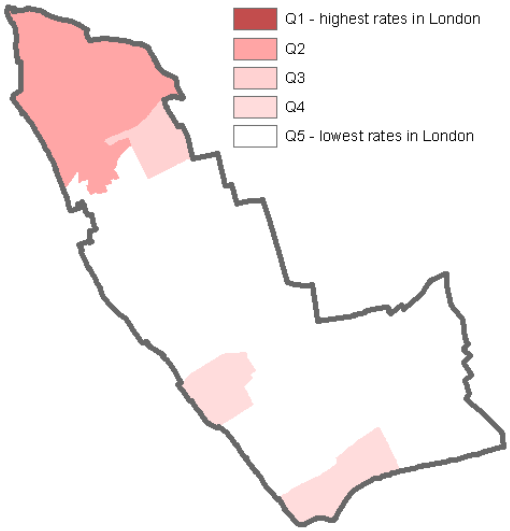
Breast and cervical screening coverage rates continue to be among the lowest in the country, with local evidence of population diversity, migration and high use of private services creating a constant challenge to improvement. Survival from breast and lung cancer is higher in the borough than the London average. There are 1-3 deaths a year from cervical cancer in the borough.

The premature death rate from **cardio-vascular disease** is the lowest in London. Although no electoral wards fall into the worst 20% in London, the four northerly wards are still around one fifth higher than the London average and in total account for around 6 more deaths a year than average.

Cancer - Premature Mortality 2006-10
Mortality rates by London quintile



CVD - Premature Mortality 2006-10
Mortality rates by London quintile



Vulnerable population groups

There are currently 2,531 patients in the borough on a GP register for **severe and enduring mental illness** (e.g. schizophrenia), the 4th highest in the country in 2010/11. These patients are focused in the four northerly wards and West Chelsea.

There are currently 1,031 residents in Kensington and Chelsea diagnosed with **HIV**, the 4th highest rate aged 15-59 in the country, with a higher proportion of cases contracted via sex between men. In 2010, 13% of cases were diagnosed late, compared to the London average of 27%. Late diagnosis carries with it increased risk of poor health and death and increases chances of onward transmission.

There are likely to be in the region of 1,800 families financially affected by **welfare reform** by £25 a week or more, resulting from changes in legislation around housing benefit. There will also be further families affected from the introduction of Universal Credit. Those most affected by changes to housing benefit live in Earl's Court and Abingdon wards. Local services are in the process of ensuring those at risk are supported through the process.

The estimated number of **problem drug users** in Kensington and Chelsea was 1,750 in 2009/10, a rate of 14.6 per 1,000 population aged 15-64, the 3rd highest rate in London (although local data suggests this estimate may be unrealistically high). The cost to society of crimes associated with problem drug use in the borough may be as much as £70 million, (based on national estimates from the Home Office).

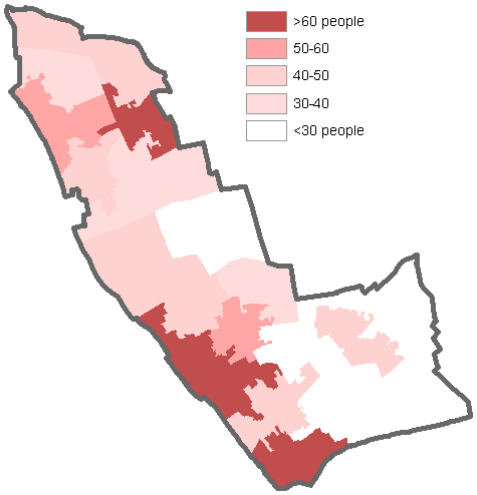
Severe & enduring mental illness patients
2,531 patients on GP registers

HIV/AIDS
1,031 patients known to services
Focused in Earls Court area

Problem drug users
Estimated 1,750
Focused in North and Earl's Court

At risk of Welfare Reform
1,500 households with £25+ gap per week . Worst in Earl's Court & Abingdon

HIV/AIDS – People known to services, 2009



NICE Guidance

- PH34 Increasing the uptake of HIV testing among men who have sex with men
- PH4 Interventions to reduce substance misuse among vulnerable young people
- PH18 Needle and syringe programmes

Prioritising Emerging Public Health Issues

A number of emerging public health issues is likely to have an increasingly significant impact both in the short and long term in Kensington and Chelsea over time. The impacts are likely to be felt within the NHS and local councils, but also much more widely.

Prioritising action around these issues may help alleviate their impact and ensure services are adequately prepared for the future.

Obesity can lead to a greater risk of heart disease, stroke, some cancers, high blood pressure, mental ill-health, and is likely to have contributed to 40% rise over 5 years in GP-recorded numbers with **diabetes** locally.

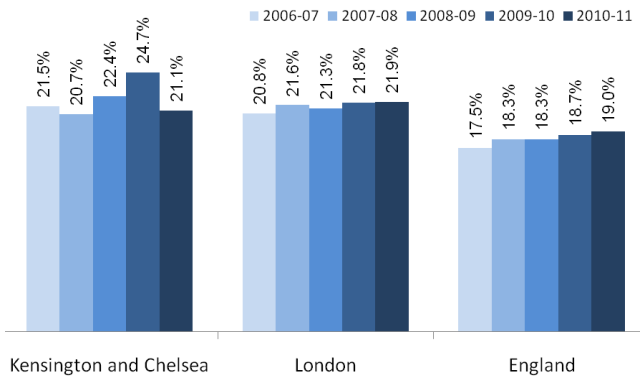
Child obesity in Kensington and Chelsea state primary schools has been consistently higher for Year 6 pupils (aged 10-11) over a period of time. These higher rates may in part be a result of physical inactivity and poor diet, which is also reflected in poorer than average levels of **tooth decay** locally. In 2010/11, 74 children in reception and 178 children in year 6 were found to be at risk of obesity (BMI 95th percentile) and 48 and 119 were classified as clinically obese (BMI 98th percentile). 27% of the borough's primary school children live outside the borough.

It is estimated that 18,500 adults in the borough are obese, 13% of all adults. Levels of adult obesity have been rising nationally. The cost to the NHS from obesity is probably around £10-20 million a year in the borough..

Alcohol-related harm

Although Kensington and Chelsea has significantly lower levels of **alcohol-related harm** compared to elsewhere, it appears to be increasing over time. 'Hotspots' for alcohol-related admissions are generally in areas of deprivation, particularly Golborne ward in the far north. **Alcohol-related crime** in the borough is higher than the national average, but lower than the London average.

Obesity trend in Year 6 children



NICE Guidance

- PH27 Weight management before, after and during pregnancy
- PH17 Promoting physical activity for children and young people
- PH13 Promoting physical activity in the workplace
- PH35 Preventing type 2 diabetes - population and community interventions

Local alcohol facts

80%: the amount that alcohol-related admissions have grown by in the last 8 years (slower than London and England)

£5.5 million: the estimated cost of alcohol-attributable admissions in Kensington and Chelsea, or £32 for each resident

40,000 Days: the estimated working days lost locally from absences caused by drinking

A growing older population

The number of older people is expected to rise considerably over the next two decades. Although the rise experienced locally may not be as substantial as the rise nationally, it will nevertheless have a dramatic impact on demand for services. At the same time, the number of those providing **unpaid care** in Kensington and Chelsea was the 5th lowest in the country in 2001.

This rise is caused by improvements in life expectancy and greater numbers of people born in the post war 'baby boom' who are approaching old age. The latter cause explains the predicted acceleration in numbers of 80+ year olds from around 2025 onwards.

Unless behaviour and services change, people will experience longer periods of time **living with disability**, resulting from improved survival rates from major diseases such as stroke, heart disease and cancer.

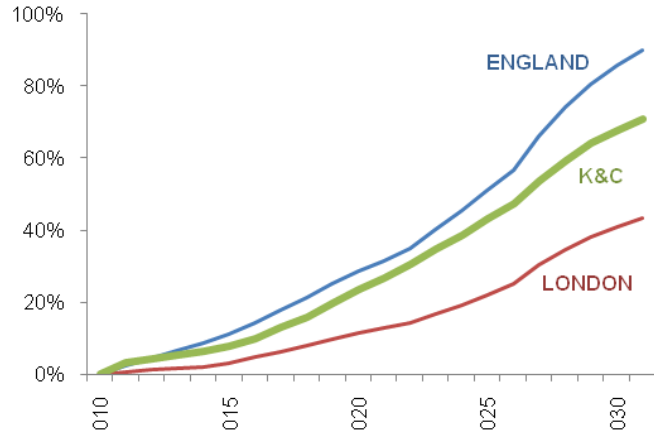
Illnesses such as **dementia**, primarily prevalent among very old populations, will become increasingly commonplace. Currently, there are likely to be around 1,700 patients in Kensington and Chelsea with dementia. By 2025, there are likely to be in the region of 2,250 patients. Earlier diagnosis of dementia is associated with delayed admission to nursing care.

Public health issues for the older population, such as social isolation, physical inactivity, and falls, may become more commonplace, as will levels of disability and mobility issues.

Improved life expectancy for children with complex needs

Medical and social care advances have been leading to significant increases in the life expectancy of children with complex needs. This vulnerable population group may therefore need support over longer periods.

Projected growth population age 80+



NICE recommends:

NICE recommends that memory assessment services should be the single point of referral for all people with a possible diagnosis of dementia.

They also recommend that health and social care managers should coordinate and integrate working across all agencies involved in the treatment and care of people with dementia and their carers.

NICE CG 42: Supporting people with dementia and their carers in health and social care

Prioritising the Social Determinants of Health

Social inequities in health are the unfair and avoidable differences in health across groups in society. In 2010, Michael Marmot published the “Fair Society, Healthy Lives” report, which illustrated the "social gradient in health". He laid out evidence demonstrating that disadvantage starts before birth and accumulates throughout a person’s life, leading to poorer health outcomes later on in life.

Prioritising a ‘life course’ approach is seen as being vital in the process of improving health and well-being and reducing inequalities. The six policy objectives from the report cover a range of national and local recommendations for action.

1) Giving every child the best start in life

The Marmot review advocates focusing resource particularly on the early years, given that “what happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being - from obesity, heart disease and mental health, to educational achievement and economic status.”

More children in Kensington and Chelsea achieve a **good level of development at age 5** than London and England.

The **infant mortality rate** in Kensington and Chelsea has consistently been falling and is far below the London and England average.

Breastfeeding at 6-8 weeks is, at 77.7%, considerably higher than the London and England rates (63.9%; 45.2%).

Last year, 55 women stated that they were **smoking during pregnancy**, or 3.1% of all NHS maternities. This was lower than London (6.5%) and much lower than England (13.5%). Data for this indicator is self-reported by new mothers, collected via hospital discharge summaries.

NICE identifies **child immunisation** as one of the cheapest and most effective public health interventions. The mobile population in Kensington and Chelsea creates challenges around achieving coverage rates

Marmot recommendations *Local action for giving every child the best start in life:*

- Pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
- Routine support to families through parenting programmes, children’s centres and key workers, via outreach to families
- Programmes for the transition to school
- Good quality early years education and childcare proportionately across the gradient, with outreach for disadvantaged children

Child development

Children age 5 achieving a ‘*Good level of development*’, 2011

in line with national targets. For example, the proportion of children who completed both their MMR doses by their 5th birthday was 66.4% in 2010/11 which is lower than the national median of 84.2%.

2) Enabling children and adults to maximise their capabilities and have control over their lives

Maintaining a reduction in inequalities across the social gradient requires "a sustained commitment to children and young people through the years of education".

73% of children at Kensington and Chelsea schools achieved **5 or more GCSEs at Grade A* to C**, including English and Maths, the second highest local authority in the country.

6.0% of people in Kensington and Chelsea aged 16-19 are **not in employment, education, or training**, compared to 5.7% in London and 6.7% in England.

3) Creating fair employment and good work for all

Evidence shows being in good employment is protective of health and being unemployed contributes to poor health. Recent reports have therefore highlighted the importance of early intervention to support those on sickness absence back to work. The Marmot review pointed out that "jobs need to be sustainable and offer a minimum level of quality".

The **unemployment rate** is currently 7.3%, the 7th lowest in London. However, nearly half of all Job Seekers Allowance (JSA) claimants are in long-term unemployment (over 6 months).

Golborne, St Charles and Notting Barns are all within the top ten highest wards in London for working age people claiming incapacity benefits for mental health reasons. Colville and Cremorne are also among the worst 20% in London.

Marmot recommendations *Local action for maximising capabilities and control:*

- Extend the role of schools in supporting families and communities
- Implement extended schools
- Develop the school-based workforce to work across school-home boundaries
- Support for 16–25 year olds on life skills, training and employment opportunities
- Work-based learning, e.g. apprentice-ships for young people
- More availability of non-vocational lifelong learning across the life course

Marmot recommendations *Local action for creating fair employment and good work for all:*

- Ensure public/ private sector employers adhere to equality guidance/ legislation
- Implement guidance on stress management wellbeing promotion and physical and mental health at work
- Prioritise flexibility over retirement age
- Encourage/ incentivise employers to make jobs suitable for lone parents, carers and people with mental and physical health problems

4) Ensuring a healthy standard of living for all

The Marmot review highlighted that having insufficient money to lead a healthy life is a highly significant cause of health inequalities. Income is needed for "adequate nutrition, physical activity, housing, social interactions, transport, medical care and hygiene".

In Kensington and Chelsea, the average gross **household income** is £39,000 per annum which is £6,000 higher than the London average. However, 9% of households depend on less than £15,000 per year.

One in five (21%) of the borough's children live in **income-deprived households** (rising to over half in some parts of the borough). The proportion of the population in receipt of means-tested benefits is lower than London and England.

5) Creating sustainable communities and places that foster health and wellbeing

The physical and social characteristics of communities have been found to impact on inequalities in health. Marmot also found a clear social gradient in 'healthy' community characteristics, with poorer environmental conditions more prevalent among deprived communities than their affluent counterparts.

The introduction of the Community Infrastructure Levy (CIL) will increase opportunities to **improve the physical and social infrastructure** of both new development areas (e.g. Earl's Court and Canal Way) and existing neighbourhoods.

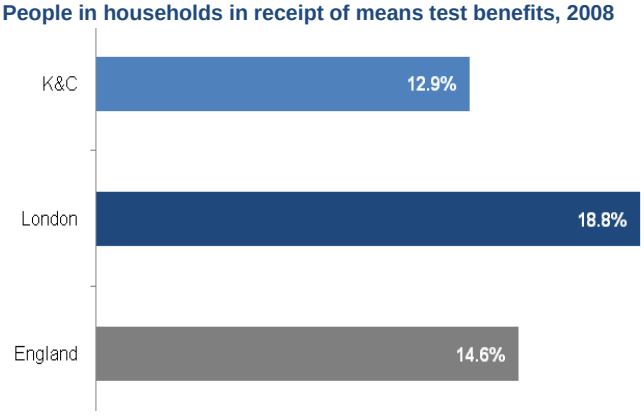
In 2005, 15% of Kensington and Chelsea was classified as **open space**, compared to 22% in Inner London and 38% in London. Not all of this is publicly accessible space.

Marmot recommendations *Local action for healthy standard of living for all:*

All actions listed in the report related to national drivers for change

Benefits

People in households in receipt of means test benefits, 2008



Marmot recommendations *Local action for creating sustainable communities:*

- Improve active travel for all social groups
- Improve the availability of good quality open and green spaces for all
- Improve the food environment in local areas, across the social gradient
- Improve housing energy efficiency
- Remove barriers to community participation and action
- Reduce social isolation
- Integrate planning, transport, housing, environmental and health systems

6) Strengthening the role and impact of prevention

Lifestyle factors that have a significant effect on chronic disease – such as smoking, physical inactivity and poor diet – have a clear social gradient. The Marmot review recommends that prevention roles, sometimes seen as 'NHS', should be the responsibility of a range of local stakeholders and the move of public health to local authorities therefore offers opportunities.

The diverse and highly mobile local population means identifying those with unhealthy behaviour and supporting them to make changes can be challenging.

Kensington and Chelsea residents have very favourable levels of adult obesity and physical activity compared to elsewhere. However, even with this relative advantage, **obesity** still affects around 18,500 adults in the local population (particularly those in deprived areas), and over 110,000 adults in the borough do not participate in 30 minutes of **physical activity** at least three times a week.

Marmot recommendations *Local action for strengthening prevention:*

- Increase/ improve the scale and quality of medical drug treatment programmes
- Focus interventions such as smoking cessation and alcohol reduction on reducing the social gradient
- Programmes to address the causes of obesity across the social gradient
- Focus core efforts of public health departments on interventions related to the social determinants of health proportionately across the gradient

Action in Kensington and Chelsea around lifestyle change:

During 2010/11:

Local **stop smoking services** helped 1,213 people to quit smoking at 4-6 weeks. This was higher than the NHS target set

699 people **drug users** were engaged in effective treatment. This was lower than the target

Appendix: References

The local population

Resident population: ONS 2010 mid-year estimate
GP registered population: PCT extraction from Open Exeter, January 2012
Life expectancy: ONS Life expectancy at birth 2008-10
Migration: ONS 2001 Census, and comparisons between years for GP registration data
Poor health in deprived areas: Premature mortality SMRs 2005-09 by ward, HNA Toolkit website, and slope index of inequalities, London Health Observatory website
Age, gender, and population structure chart: ONS 2010 mid-year estimate
Ethnicity: ONS 2001 Census. School ethnicity from School ethnicity from Department for Education, January 2012
Nationality: Country of birth derived from free text 'place of birth' field in Exeter GP registration data, 2010. Language estimated, based on country of birth. Residents speaking other languages may also speak English. School languages from Department for Education, January 2012
Household size and structure: GLA 2010 SHLAA household projections, ONS 2001 Census for single elderly households
Housing tenure: ONS 2001 Census
Population mobility: ONS 2001 Census
Deprivation: Index of multiple deprivation 2010, Department for Communities and Local Government
Child well-being: Child well-being index 2010, Department for Communities and Local Government
Children in poverty: Index of deprivation affecting children (IDACI) 2010, Department for Communities and Local Government
Employment and unemployment: Model-based unemployment August 2008-Sept 2010, Nomis. Job Seekers Allowance (JSA) March 2012, Nomis
Incapacity benefit for mental health reasons: DWP August 2011
Life expectancy: ONS Life expectancy at birth 2008-10
Disability-free life expectancy: MAP 2030 Modelling Age Populations to 2030 http://www.gro-scotland.gov.uk/files2/stats/seminars/ihac-modelling-ap-to-2030.pdf
Health inequality: slope index of inequalities, London Health Observatory website

Prioritising the causes of early death in the borough

Number of premature deaths: ONS Primary care mortality database 2011 and ONS VS3 2010
Premature deaths by cause: ONS Primary care mortality database 2011
Premature deaths over time: Age standardised premature mortality over time, NCHOD
Premature CVD and cancer deaths over time: Age standardised premature mortality from CVD and cancer over time, NCHOD
Premature CVD and cancer deaths by ward: Under 75 SMRs for CVD and cancer by ward 2005-09, HNA toolkit

Prioritising the largest causes of disability in the borough

The Marmot review: Fair Society, Healthy Lives: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
Years of life lost and years of life with a disability: from the WHO global burden of disease 2004-08 http://www.who.int/healthinfo/global_burden_disease/en/
Mental health and chronic disease: evidence of inter-relationship cited in Quality and Outcomes Framework (QOF) 2011/12 guidance. Local analysis carried out by INWL PCTs using SUS data and GP depression registers in Kensington and Chelsea, and Hammersmith and Fulham, 2011

Prioritising where the borough is an 'outlier'

Child obesity: National Child Measurement Programme (NCMP) data, 2010/11, from NHS Information Centre
Smoking prevalence: Integrated Health Survey July 2010 to June 2011. Extracted from LHO website. Local variation from GP downloads 2009/10
Physical activity: Sport England Active People's Survey, 2009/10. Physical activity variation from estimates, 2003-05, extracted from Neighbourhood Statistics
Accidents and injuries: admissions for accidents and injuries 2010, NCHOD, and INWL PCTs analysis of admission rates by ward, 2008/09 to 2010/11
Alcohol specific and related harm: NCHOD 2010, Northwest Public Health Observatory Alcohol Profiles, including NI39 alcohol related admissions over time, to 2010/11, and INWL PCTs analysis of emergency admissions by ward
Sexually transmitted infection (STI) data: HPA website 2010/11
Oral health: BASCD survey of 5 year olds, 2007/08. Access to dentistry in last 24 months, Dec 2011. From NHS Information Centre website

Premature deaths by ward: under 75 SMRs by ward 2006-10, HNA toolkit. NCHOD for borough data
Premature cancer deaths by ward: under 75 SMRs for cancer by ward 2006-10, HNA toolkit. NCHOD for borough data
Breast and cervical screening: coverage 2010/11, extracted from NHS Information Centre website
Cancer survival rates: 1 year survival from those diagnosed 2004-08. National Cancer Intelligence Network. Extracted from My Health London website
Premature CVD deaths by ward: Under 75 SMRs for CVD by ward 2006-10, HNA toolkit. NCHOD for borough data
Severe and enduring mental illness: GP QOF registers of severe and enduring mental illness, QMAS March 2012. Ranking from QOF 2010/11 pages on NHS Information Centre website
HIV/AIDS: SOPHID 2010 for ranking and 2009 for other detail. HPA late diagnosis figures 2010. Late diagnosis is CD4 count <200 cells/mm3 within 91 days of diagnosis
Welfare reform: provided by RBKC on 23/02/2012
Problem drug users: Estimated number in population 2009/10, NTA website (login required)
Cost to society of drug use: Breaking the Link report, NTA page 7 http://www.nta.nhs.uk/uploads/nta_criminaljustice_0809.pdf

Prioritising emerging public health issues

Child obesity: National Child Measurement Programme (NCMP) data, 2010/11, from NHS Information Centre. Local data provided by CLCH School Nursing Teams
Diabetes prevalence: QOF 2006/07 to 2011/12. Extracted from QMAS
Adult obesity: synthetic estimates of adult obesity, 2003-05, extracted from Neighbourhood Statistics
Estimated cost of obesity: adapted from the Foresight Report, Government Office for Science (national figure £5 billion)
Alcohol specific and related harm: NCHOD 2010, Northwest Public Health Observatory Alcohol Profiles, including NI39 alcohol related admissions over time, to 2010/11, and INWL PCTs analysis of emergency admissions by ward, and *Closing Time: counting the cost of alcohol-attributable hospital admissions in London*, from the LHO website. Working days lost from alcohol estimated from 17 million working days lost nationally (NICE Guidance 24 Alcohol-use disorders: preventing the development of hazardous and harmful drinking
Rising older (80+) population: GLA 2010 SHLAA projections for Hammersmith and Fulham and London. ONS 2008 subnational population projections for England
Dementia growth: estimates produced by INWL PCT, based GLA 2010 SHLAA projections applied to GP registered population
Children with complex needs: estimates produced by INWL PCT, based on findings from Emerson Report and GLA 2010 SHLAA projections http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103201

Prioritising the social determinants of health

The Marmot review: Fair Society, Healthy Lives: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
Development at age 5: Department for Education 2011. From Marmot indicators on LHO website: http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx
Infant mortality: Infant death under 1 year, 2010, NCHOD
Breastfeeding: 6-8 week breastfeeding uptake by PCT 2010/11. Published on Department of Health website
Smoking during pregnancy: Smoking at time of birth by PCT 2010/11. Published on Department of Health website
Child immunisation: First and second doses of MMR by age 5, 2010/11. Extracted from www.ic.nhs.uk
Educational attainment: 5 or more GCSEs at Grade A* to C, including English and Maths Department for Education secondary school league tables, extracted January 2012
Not in employment, education, or training: NEETs aged 16-19, Nov 2010 to Jan 2011. Department for Education. From Marmot indicators on LHO website: http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx
Unemployment: Model-based unemployment August 2008-Sept 2010, Nomis. Job Seekers Allowance (JSA) March 2012, Nomis
Incapacity benefit for mental health reasons: DWP August 2011
Household income: Paycheck 2009. From GLA London Datastore
Child poverty: Index of deprivation affecting children (IDACI) 2010, Department for Communities and Local Government
Open space: GLA London datastore borough profiles. Figure from 2005
Adult obesity: synthetic estimates of adult obesity, 2003-05, extracted from Neighbourhood Statistics
Physical activity: Sport England Active People's Survey, 2010/11
Stop smoking service uptake: Number of smoking quitters at 4-6 weeks for the Hammersmith and Fulham Stop Smoking Service, 2010/11
Drug users in treatment in Hammersmith and Fulham: 2010/11. Provided by INWL PCTs