Kensington and Chelsea Joint Strategic Needs Assessment

Highlights Report 2013-14



A summary of public health challenges and opportunities for the population living in, working or visiting the borough of Kensington and Chelsea

Further detail on the areas identified in this report can be found in the detailed report on www.jsna.info

About this report

This is a summary of the public health challenges but also public health opportunities for those living in, working or visiting Kensington and Chelsea. It is not designed to cover all aspects of the local population in detail. Instead, it builds on the existing programme of Joint Strategic Needs Assessment (JSNA) work and puts it into context to encourage local services for public health priority setting.

The purpose of the report

Those reading this report will get an understanding of these aspects:

- The **make-up** and **healthiness** of the local population
- The factors that **influence health** locally
- The population groups, disease types or areas we may want to **focus on** to improve health
- The **Public Health Outcomes Framework** indicators we perform well or poorly on compared to London

How this report relates to the Health and Wellbeing Board and Strategy

Annual reporting of the key public health challenges and opportunities locally are used by the Health and Wellbeing Boards to develop their Health and Wellbeing Strategies, along with other key sources of information such as JSNA 'deep dive' documents on specialist areas, other strategic plans, assessments and policy, and views from service users and the public.

Other more detailed JSNA findings can be found on the website www.jsna.info

The Kensington and Chelsea Health and Wellbeing Strategy themes

1. Making better use of resources to achieve improved outcomes
2. Improving partnership working for sexual health services
3. Improving partnership working in Early Years Services (to ensure the best start in life)
4. Ensuring safe and timely discharge from hospital
5. Achieving and maintaining a healthy weight in children
6. Accessible and flexible mental health/ substance use services

Our Community

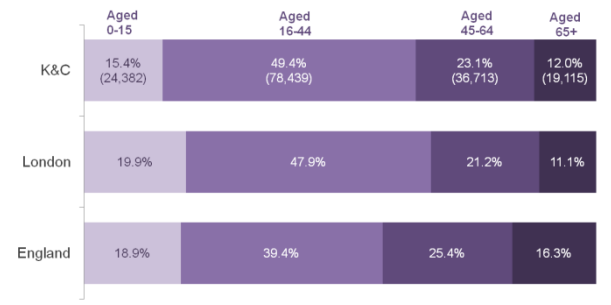
Kensington and Chelsea is a small, but densely populated and vibrant Central London borough. The population is unusual in that it has a large proportion of older working age residents and very few children, as well as high levels of international migration and cultural diversity. Rich and poor live side by side, particularly in the north of the borough.

Age and gender

Kensington and Chelsea is a small Inner London borough. The **age profile** of the borough is common to other inner city areas in that it has a very large working age population and smaller proportions of children in particular, (the 2nd smallest in London). Those aged 65+ form a slightly larger proportion of the total population than London, but smaller than England. Compared to London, the borough has the 12th highest proportion of younger working age residents, the 8th highest of older working age residents and 12th highest of retirement age.

The **gender** split is broadly similar, but with more women in the older age groups due to their longer life expectancy.

Age structure

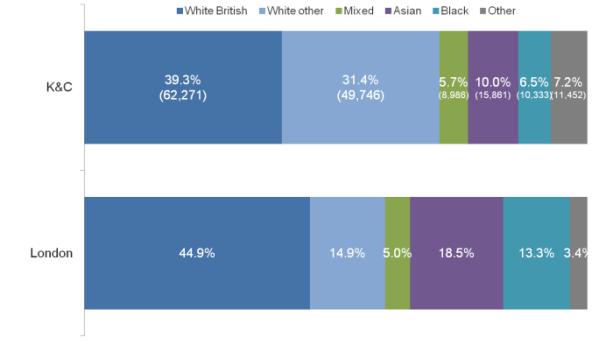


Diversity

Half the borough's population were **born abroad**. There are a smaller proportion from White British groups (accounting for 4 in 10 of the population), and the highest proportion nationally from 'other white' backgrounds (31%), with American and European groups (particularly French, Italians, and Spanish) among the more prominent communities living in the borough.

Nearly a third (29%) of the population is from **Black, Asian and minority ethnic (BAME) groups**, up from 21% in 2001. Kensington and Chelsea has a smaller Black population and much smaller Asian population than the London average, but the 9th largest proportion nationally from 'Mixed' groups and 2nd highest from the 'Arab' group, after Westminster.

Broad ethnic group, 2011



The borough at a glance…			
78,500	Households	**6**	Live births each day
£795,000	Median house price	**2**	Deaths each day
158,700	Residents	**12,300**	Local businesses
29%	From BAME groups	**£36,000**	Annual pay
50%	Born abroad (2011 Census)	**2.1%**	Unemployment rate (JSA) *(London 3.1%)*
28%	Main language not English	**17%**	Local jobs in Public Sector
53%	State school pupils whose main language not English	**Ranked 103rd**	Most deprived borough in England *(out of 326)* (18th in London)
10k/13k	Annual flows in and out of the borough	**24%**	Children <16 in poverty, 2011 *(HMRC)*
179,118	Registered with local GPs	**Ranked 2nd**	Highest carbon emissions in London *(not including City of London)*
280,000	Daytime population in an average weekday		

Over a quarter of the borough's residents state their **main language is not English** and, of these, 1 in 10 state they are not able to speak English well; this is around 2% of the borough's population. French, Arabic, Spanish and Italian are the most common languages other than English.

The local population is very **mobile:** 10,300 people moved in and 12,600 moved out in the year to June 2012. Turnover of population can create significant challenges in providing public health services as well as accurately recording the population size.

Housing

Eighty six per cent of the borough's **housing stock** is made up of flats, compared to half in London. Many of these flats have limited outdoor space and nearly half have no entrance at ground floor level and some have no lifts, potentially making access difficult for some people with mobility issues.

A third of people (34%) live in **private rented** housing – the 4th highest in London – and a similar proportion (37%) are **owner occupiers** – the 10th lowest in London. One quarter (25%) live in **social housing**, which is similar to London.

Forty seven per cent of households are **one person households**, the highest in the country. One in 10 households (10.5%) is a lone pensioner household, higher than London (9.6%) but lower than England. Almost half (43%) of older people live alone, carrying a risk of social isolation.

Pressure on social housing stock and property prices in London has resulted in **overcrowding**, particularly among families. Across all tenures, a smaller proportion of households (9%) are considered to be overcrowded, compared to London (12%).

Social factors

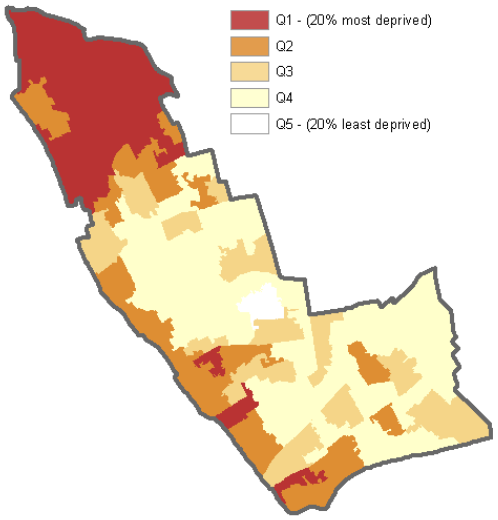
Despite the highest house prices in the country, parts of the borough are still deprived, with the borough being the 103rd most deprived in the country in 2010 according to the index of multiple **deprivation**, which is based on a range of economic, social and housing indicators. Pockets of deprivation are particularly focussed in the north of the borough, although there are pockets elsewhere. These areas usually correspond to areas of social housing and poorer than average health.

A quarter of children under 16 (24%) live in **poverty** according to official definitions, which is lower than London but higher than England. The **Job Seekers Allowance** rate (2.1%) is very low, but rates are twice this in Golborne, Notting Barns and St Charles.

Most common languages spoken (2011 Census) and countries of birth (GP registrations)

English	72%	UK	56%
French	4.9%	USA	3.7%
Arabic	2.9%	France	3.1%
Spanish	2.7%	Italy	2.5%
Italian	2.4%	Australia	2.0%
Portuguese	1.4%	Spain	1.8%
German	1.4%	Former USSR	1.7%
Tagalog/ Filipino	0.9%	Philippines	1.5%
Persian/ Farsi	0.9%	Iran	1.3%
Russian	0.7%	Germany	1.3%

Deprivation, 2010



Deprivation focused in the north of the borough in Golborne, Notting Barns and St Charles

Men living in Kensington and Chelsea have the 5th highest life expectancy in the country, and for women it is the 6th highest. Whilst many residents are very affluent, there are also residents with poorer health in the areas of social housing, predominantly in the north of the borough; they experience large health inequalities compared to the rest of the borough.

Levels of healthiness

Life expectancy for men in Kensington and Chelsea is among the highest nationally and more than two years higher than London. The new population numbers taken from the 2011 Census resulted in a drop in ranking from highest nationally to the current position of 5th highest, due to a smaller than expected population size in the 2011 Census. The difference in life expectancy between affluent and deprived areas in the borough – 6.9 years – is slightly less than nationally, but the lack of consistent trend means this may be unreliable.

Life expectancy for women in the borough is 2-3 years above the London and England averages. As with male life expectancy, adjustments in the population size as a result of the 2011 Census resulted in a drop in rank from highest to 6th highest nationally. Differences in life expectancy between affluent and deprived areas is less than nationally, at 2.5 years, and may have improved.

Most people in Kensington and Chelsea consider their **health** to be good – the 15th highest in the country. The minority of people who consider their health to be **bad or very bad** are more likely to have long term conditions that limit their ability to lead normal lives and are much more likely to be older. They also tend to be clustered around areas of deprivation/ social housing.

Those living in areas of high density **social housing** are 2-3 times as likely to report bad/very bad health compared to those in areas with low density, depending on age. This can make targeting of support easier, as areas of social housing in the borough are usually well defined.

Wards falling into the **worst 20% in London** for:

Self-reported bad/very bad health:
Golborne, St Charles, Notting Barns, Cremorne, Colville

Self-reported limiting long-term illness (LLTI):
Golborne, St Charles, Notting Barns, Cremorne

Self-reported working age LLTI:
Golborne, St Charles, Notting Barns, Cremorne

Premature (<75) mortality:
Notting Barns

Health facts, 2011 Census

86% The proportion of people saying their health is good/very good
In London it is 84%

7,200 The number of people in the borough who say their health is bad. A third of these are 65+

1 in 21 People of working age whose daily activities are limited a lot by long term illness *similar to London*

Life expectancy at birth, 2010-12

Males: 82.1 years ranked 5/324
London: 79.7; England: 79.2

Females: 85.8 years ranked 6/324
London: 83.8; England: 83.0

K&C is ranked among the highest in the country for both men and women

Difference in life expectancy within borough

Men: 6.9 years

Women: 2.5 years

The difference in life expectancy between deprived and affluent areas in the borough is lower than the national average, and data suggests the gap has narrowed for women. However, there is no consistent trend in the data, and early death rates do show huge variation between affluent and deprived wards

Causes of early death

The principle **cause** of premature (<75) death in Kensington and Chelsea is cancer, followed by cardiovascular disease (which includes heart disease and stroke). A significant number of people also die from COPD. This is pattern is broadly similar to the rest of the country. Accidents and injuries are most common among younger residents and comprise a large proportion of total avoidable deaths (see chart),.

Tackling chronic diseases using a range of interventions, including support for **lifestyle change** and **improved support** for those already with chronic disease. Compared to a decade ago, around 95 fewer people die before the age of 75 each year, with differing levels of success across disease types.

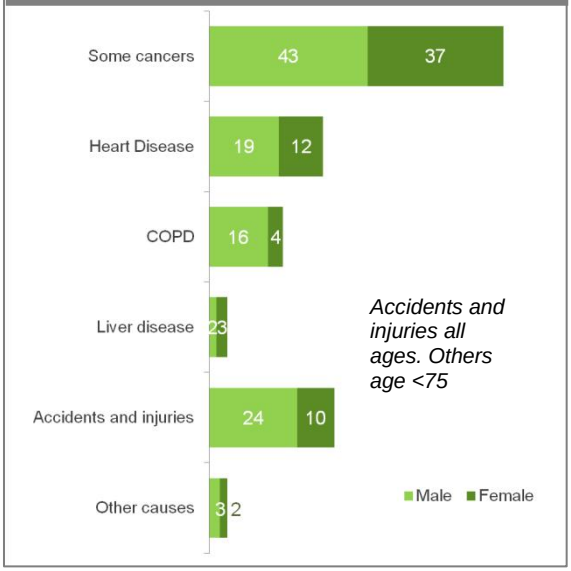
The impact of disability on quality of life

Although improvements in health often focus on reducing years of life lost through early death, the growing **burden of disability** also requires a co-ordinated response, with **mental disorders**, **substance use**, **musculoskeletal** disorders and **falls** all having a significant impact on the ability to lead a fulfilling life and contribute to society through stable employment up to retirement. Locally, mental health is the most common reason for long term sickness absence, and several of the wards in the deprived parts of the borough fall into the 20% highest in London for incapacity benefit/ ESA claimant rates for mental health reasons.

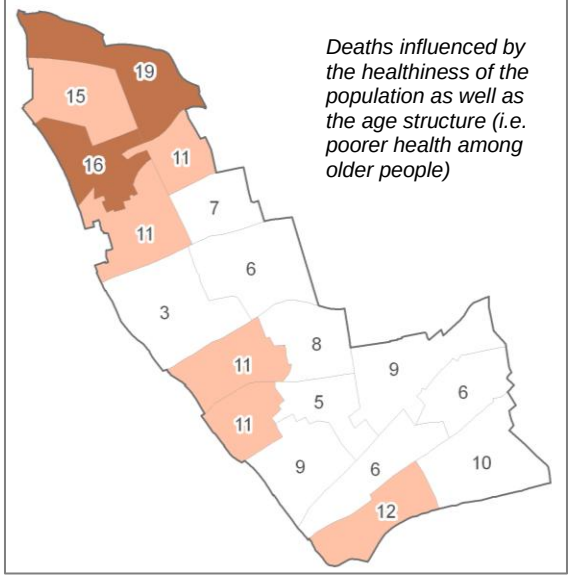
Tackling the 'wider determinants'

Although some of the causes of poor health and long-term conditions are easily identified – tobacco use, high blood pressure, being overweight, poor diet, and physical inactivity in particular – the public health challenge remains facilitating behaviour change amongst populations who may not be ready to change. Understanding and tackling the factors which prevent healthy choices include tackling underlying issues around housing, the urban landscape, employment, and education.

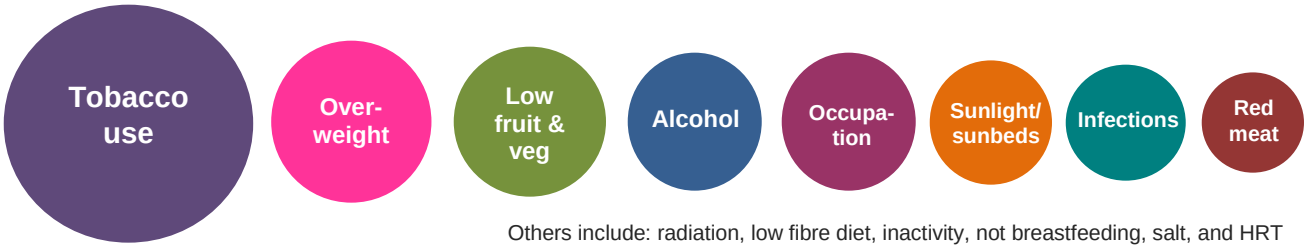
Potentially avoidable deaths, 2012



Potentially avoidable deaths by ward



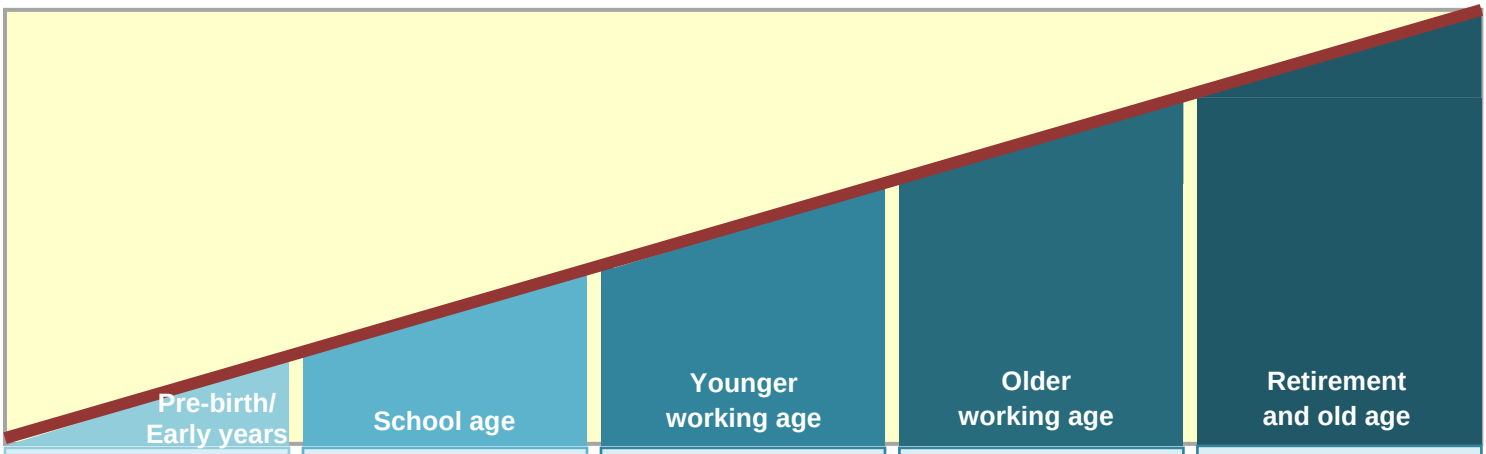
Cancer Research UK *How many cancers can be prevented?:* Factors influencing cancer incidence



Others include: radiation, low fibre diet, inactivity, not breastfeeding, salt, and HRT

MAXIMISING POTENTIAL FOR GOOD HEALTH OVER THE LIFE COURSE

The diagram below shows how individuals and organisations play a part in improving health from before birth up until death:



Pre-birth/ Early years

Planned pregnancy (SRE in school, contraception etc)

Vulnerable families (e.g. teen pregnancy, homelessness, domestic violence) known to services and supported through pregnancy/ early years

Access maternity services early. Supporting a healthy pregnancy e.g. smoking, alcohol, weight gain, folic acid

Prepared for birth: antenatal education/ maternity care

Parents supported through the healthy child programme e.g. health visiting, breastfed to 6 months, immunised, support for post-natal depression

Early help support for families to ensure readiness for school e.g. development reviews, speech/ language, physical, and emotional health

School age

All children supported to achieve good educational attainment and qualifications, including vulnerable groups e.g. healthcare plans for children with additional needs

Reduce detrimental effects of poverty on educational outcomes

Good oral health: healthy diet, brushing teeth, & visiting dentist

Discouraged from starting habits detrimental to health e.g. smoking, drug use

Maintaining healthy weight e.g. school environment, being physically active

Supported in building mental health resilience e.g. education, school nursing, anti-bullying

Intensive support for families facing multiple difficulties where this is resulting in poor outcomes, high costs, or safety issues

Younger working age

Received screening and advice around STIs and conception

Where appropriate, received additional training or support to get into paid work

Help giving up smoking through a stop smoking service

Received support for low-level mental illness via IAPT programme, if needed

Support managing any hazardous alcohol or drug use through statutory services

Registered with GP and women attending cervical screening

Older working age

Retain an active lifestyle to prevent overweight and the risk of long-term conditions

Undiagnosed long term conditions (e.g. high blood pressure, diabetes) picked up via health checks, to be offered in a range of settings

Effective self-management of these conditions, through information, training, and a change in habits

Women attending cervical and breast screening

Support for those on long-term sickness to return to work

Received support for low-level mental illness via IAPT programme, if needed

Retirement and old age

Further undiagnosed conditions picked up and self-managed or managed through GP/ community services, rather than through emergency care

Avoiding social isolation through the active engagement in activities and pastimes. In particular, partaking in gentle physical activity (e.g. walking, gardening) to lower risk of cancer, heart disease, mental ill-health and weak bone strength

Screening for signs of dementia

Receiving high quality health and social care designed around the person, not the condition, in convenient settings and at convenient times

On reaching end of life, support in dying in preferred place of death

VULNERABLE GROUPS Giving all groups the chance to thrive across the life course

Sleeping rough	With severe & enduring mental illness	With learning/ physical disabilities		Prison population
At risk of suicide	Experiencing impact of welfare reform or poverty	HIV/AIDS	Carers	Troubled families

HEALTHY AND SUSTAINABLE COMMUNITIES

High quality general practice and hospitals	Living in housing conducive to good health	Safe and healthy neighbourhoods
High quality and inclusive education	Open space, clean air and good local amenities	A sense of community

GIVING CHILDREN THE BEST START IN LIFE

Studies have shown that foundations for virtually every aspect of physical, intellectual and emotional development are laid in early childhood. What happens during pregnancy and the early years of life has lifelong effects on many aspects of health and well-being– from obesity, heart disease and mental health, to educational achievement and economic status.

Investment in early years is likely to have more impact than later on in life, as it works over the life course.

Pre-birth and pregnancy

Some **vulnerable young people and families** in the borough may need additional support to reduce the risk of slipping into a cycle of poor health or increased service use later on in life. Those with mental ill-health or substance use problems or long term unemployed are particularly vulnerable. All first-time teen mothers are offered the Family Nurse Partnership service, which has been shown to result in improved child and maternal attachment, healthy child development, and longer-term improved economic outcomes for young mothers. Teenage conception is low in the borough relative to elsewhere in London and England, with around 38 conceptions and 14 births a year.

Some pregnant women are more prone to **Vitamin D and Folate (Folic acid) deficiency**, which can have an impact on their bone health and the health of the unborn child. National data suggests those from some ethnic minority groups and deprived backgrounds are particularly at risk. The Healthy Start Scheme addresses this through free provision of vitamins, milk, fruit and vegetables to parents on low incomes. Distribution of vitamins is cost-effective, but uptake locally is low relative to the need.

Obesity holds considerable risks for women during pregnancy and child birth, such as gestational diabetes, miscarriage, and complications during birth. Increased health risks for a child being born to an obese mother are similar to those from smoking in pregnancy, and include still birth, future obesity and its associated health risks. No local data exists on obesity prior to pregnancy but nationally, around half of women of childbearing age are overweight or obese, with rates rising over time. NICE guidance on weight management during pregnancy identifies that community and environmental approaches and making healthy lifestyle changes, are likely to be most effective.

Domestic violence often starts in pregnancy and poses an additional risk to the unborn child. Domestic violence can be identified during pregnancy through contact with midwives, which represents a unique opportunity to provide support to those affected and to safeguard the unborn child.

Although illegal in this country, **female genital mutilation** (FGM) still occurs among residents in the borough, particularly those who originate from countries such as Egypt, Ethiopia, Eritrea and Somalia. FGM is heavily under-reported so true numbers are not known locally, but are likely to be highest in Golborne ward. FGM often occurs in the country of origin and can cause serious complications later, especially during pregnancy and childbirth. Work to prevent FGM focuses around awareness of the illegality and child protection, as well as reversal/ reconstructive surgery.

Late booking for initial pregnancy care planning has previously been an issue in the borough but has improved with the introduction of better appointment systems and service access. Late booking is more common among BAME groups and those with English as a second language. Improvement of access to interpreting services and the provision of midwifery in community settings such as children's centres will support women to access maternity services earlier.

Early years

Immunisation is the most effective way of protecting children against many infectious diseases. Child immunisation uptake has generally declined in the borough since two years ago. Two in ten children in the borough have not been fully immunised by the age of two, rising to nearly 3 in 10 by the age of five. This is much lower than the population level of immunity needed to prevent outbreaks or epidemics of diseases such as measles, particularly amongst those who missed out on the MMR vaccine a decade ago. Keeping immunisation uptake to a high level in an area with high national and international migration is very challenging and requires co-ordinated health promotion and provision from a range of agencies.

The borough has very high rates of **breastfeeding at 6-8 weeks** (82.3%) compared to London (68.5%), and a continued focus on maintaining high rates of exclusive breastfeeding, particularly in areas of deprivation, will continue to have a strong positive impact on health of mother and child.

Children in Kensington and Chelsea **attend A&E and other urgent care** much more frequently than is typical for London or England. Data from 2010/11 identifies over 7,000 attendances in a year in the borough among under 5s, around 20 a day, in many cases for conditions that could be managed in primary care. High A&E attendance may relate to the proximity of local A&E services, low levels of registration with GP practices due to population 'churn', and lack of availability of high quality primary care services.

Treatment for some common conditions (e.g. allergies and asthma) is often managed in a hospital outpatient setting but can be **managed in a GP/ community setting** at a similar or lower cost, and potentially at a greater convenience to patients. The NHS agenda to provide more services in an 'out of hospital' setting supports this move. A new Connected Care pilot initiative is being implemented which provides specialist advice and support from paediatricians working closely with GPs, nurses, school nurses and health visitors to improve identification and management of common conditions to prevent escalation and the need for hospital services.

Anecdotally, head teachers and other professionals have reported a deterioration of **children's motor, language, and social skills**. This may be a result of less physical activity and more 'screen time'. The reasons for this will need to be investigated further.

School age

Educational attainment has consistently been found to have significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health. Eighty per cent of those attending schools in the borough achieved 5 GCSEs grades A* to C including English and Maths, in 2012/13, compared to 64% in London and 59% in England. Families have been found to have the most influence on levels of attainment, so closer links between schools, the family, and the local community may be most effective.

Overweight and obesity remain high for children in the borough, with nearly a third of children of school age either overweight or obese, around 4,500-5,500 children locally. The potential impact and cost of being overweight in adulthood is well known: nearly half of diabetes and a quarter of heart disease can be attributed to excess weight, and it is also a significant risk factor for many cancers; it can also be highly stigmatising. Successful programmes to tackle child obesity take more than one approach, work across a whole community, and involve a range of organisations. School-based interventions have been shown to work in a number of settings but require considerable commitment from children and parents. The local 'Healthy Schools' partnership - which works to create a health-promoting environment - is achieving good engagement but relies on all schools signing up. Services tackling child obesity locally are currently being re-commissioned.

Tooth decay is preventable, yet it is the most common cause of hospital admission for children and young people. The rate of tooth decay amongst school children has historically been high in the borough, but most recent data has shown improvement to the level of London and England. However, 30% of local 5 year old school children still suffer from decayed, missing or filled teeth. Embedding healthy habits as early as possible in children's lives has been shown to have the biggest impact over the life course. Healthy weaning, lower sugar intake, correct brushing twice a day with fluoride toothpaste, and fluoride varnishing all help to prevent decay. Targeted work in primary schools and community health promotion activities appear to have been effective locally.

In order for children and young people to avoid unhealthy behaviour late in life, there are huge opportunities for schools and other agencies to **reinforce healthy lifestyles** through a prevention agenda, such as helping to avoid starting smoking (rather than giving up later in life), continuing an active lifestyle (which tends to drop for girls as they get older) and building resilience with regard to alcohol and drug use, sexual health and mental health. The recently introduced school survey will identify particular local issues for young people and promotion of participation in the survey and using its findings will benefit local decision-making about appropriate initiatives. Local initiatives have included educational approaches in local schools.

Uptake of the **HPV vaccination**, which protects teenage girls from cervical cancer, is much lower than London and England. The challenge has been around completing all three doses, with the 3rd dose sometimes missed due to absence from school when children travel abroad to visit families.

Supporting vulnerable groups

Around a quarter (26%) of children in Kensington and Chelsea were classified as **living in poverty** in 2010/11, similar to London (28%) and higher than England (21%). This amounts to around 4,800 children, focused particularly in the north of the borough, particularly in lone parent households. Furthermore, there are around 380 households where housing benefit has been capped, 257 of which are with children (with 634 children affected). Furthermore, 152 households with children are currently affected by the 'bedroom tax'. The numbers of homeless families living in temporary accommodation in the borough has also been higher than London and England. The routes out of poverty are generally considered to focus around employment and skills of parents, and alleviating some of the impact by supporting children within education in particular, to improve life chances and break the cycle.

Local **troubled families** experience poor life chances and poor education attainment, and cost statutory services significant sums of money, but can be helped via intensive 1:1 or family support for a short periods of time. Locally, 336 families have been identified. Kensington and Chelsea has a higher rate of first time entrants to the Youth Justice System than London and England and the emotional well-being of looked after children is low, although the number in care is lower than the London average. Evidence suggests that schemes such as Multisystemic Therapy (MST), which has been introduced in pilot form in the tri-borough area, may be able to avoid care and custody among adolescents and may be cost effective to statutory services, particularly through avoiding care, which can cost as much as £50,000-100,000 a year.

Children with complex needs are increasingly likely to survive into adulthood and old age. The life expectancy of children with complex physical and learning disabilities (e.g. cerebral palsy and Downs syndrome) has been improving over time and is likely to lead to an increasing number of children 'transitioning' into adult services over the next decade. There are increases forecast for learning disabilities services for the next two years, although these are most apparent in Westminster. The likely rises over time may put increasing pressure on budgets for health and social care, particularly as local services have been seeing people with an increasingly complex range of conditions such as autism and challenging behaviour.

PROMOTING AND PROTECTING GOOD HEALTH

The message around maintaining good health and avoiding disease is a simple one: taking regular physical activity, avoiding smoking, drinking sensibly and having 'good' work all play a huge part in reducing most chronic disease. However, the factors that influence lifestyle choices are complex, and facilitating change is one of the fundamental public health challenges faced today.

People will of course still develop diseases. Once they do, catching it early and managing it well can have a huge impact on quality of life.

Staying healthy

Smoking is the largest avoidable cause of death and the biggest cause of inequalities, nationally and locally, and is responsible for around 151 deaths in the borough each year. This is 34 fewer than typical of England, and less people smoke in Kensington and Chelsea (18%) than average for London (19%) and England (20%); however, rates are much higher in deprived areas. Nationally, the majority of smokers state they want to give up the habit, and supporting people to give up smoking and stopping people starting is the business of councils, GPs, hospitals, schools, the workplace, friends and family. The local cost associated with smoking is estimated to be £31 million, and around £700,000 is spent in the borough on schemes to support stopping smoking. Stop smoking services have been found to be among the most cost effective ways to quit. Enforcement and control of sales, along with prevention messages, have also been effective locally.

The use of **other forms of tobacco consumption** (such as Khat and Shisha) tend to be a particular issue in the inner London area, and yet use of these substances has a substantial impact on health. Data suggests use of Khat has been growing in the young adult population. Local surveys are being carried out to understand the scale of the issue.

Indications from national estimates and GP data suggest that Kensington and Chelsea has a very low rate of adult **obesity** (14%) compared to London (21%), but with almost double the rate likely in deprived areas compared to affluent areas. Nevertheless, 20,000 nearly residents may be obese.

Around 1 in 5 people in the borough (21%) are **physically inactive**, doing less than 30 minutes activity per week. Two thirds (65%) do the recommended 150 minutes a week, high for London. Rates of inactivity for BAME groups are typically around one quarter higher than average, and people over 55 are around twice as inactive. Inactivity is one of the major causes of disease such as diabetes, cardiovascular disease, cancer and musculoskeletal problems and a cause of obesity. Being active on average reduces the chance of getting diabetes by one fifth. Even relatively small increases in physical activity are associated with protection from disease, improved quality of life, cost savings for health and social care services, and improve work productivity. Activity doesn't necessarily mean sport, with moderate activities such as walking having positive health impacts. NICE obesity guidance recommends local authorities promote active travel and affordable leisure facilities. Brief chats with GPs and other health professionals are also cost-effective.

Having a diet rich in **fruit and vegetables** is one of the most vital factors in preventing cancer and heart disease, and is the third most influential factor for avoiding cancer. Estimates suggest half (48%) of the local population eats five portions of fruit and vegetables a day. Maintaining a high intake in a time of rising food costs is challenging and requires innovative ideas, particularly in poor areas. NICE suggests that local authorities could have a role in encouraging local retailers to promote affordable fruit and vegetables.

Hazardous or dependent consumption of **alcohol** can result in significant harm to individuals. Alcohol has significant costs to the NHS (around £10 million per year locally), loss of productivity (around £20 million locally), impact on crime (around £30 million locally), as well as domestic violence and relationship breakdown. Kensington and Chelsea has the 4th lowest rate in London for death from chronic liver disease, with around 6 men and 5 women dying every year. Deaths have dropped since a decade ago, but alcohol-related admissions have more than doubled.

Hotspots for alcohol-related admissions include the Golborne, St Charles and Cremorne areas. Tackling alcohol use demands a range of approaches, from specialist support for alcohol addiction, to advice in GP surgeries, to liaison support in Hospital A&Es. Given the borough is a destination for night-time visitors, licensing issues are critical in the control of establishments, and alcohol-related crime is significantly higher than nationally.

Identifying and managing disease

The impact of **undiagnosed disease** is huge, with an estimated 30% of people locally with diabetes undiagnosed by their GP, rising to over half for those with hypertension. Estimates based on national modelling on the introduction of the Health Checks programme suggest that carrying out health checks in the borough would identify around 60-70 new cases of diabetes and kidney disease annually. However, public awareness of Health Checks is low. Locally, 'Diabetes Champions' build awareness of the risks of the disease via peer messaging, predominantly in areas with high BAME populations. Health trainers also work in housing estates supporting healthy lifestyles.

Common mental illness such as anxiety and depression affects around 1 in 6 people at any one point in time and is one of the leading causes of disability nationally. Levels of funding for the evidence-based IAPT programme have been increasing to meet a target of 15% of prevalence annually. Success of the programme relies on referrals into the service from a number of sources to ensure the service is meeting fair access for all. In neighbouring Hammersmith and Fulham, local mental health 'champions' are trained to identify people suffering from mental ill-health and offer them support in accessing mental health services as well as providing ongoing support after treatment.

In 2012, Kensington and Chelsea had the 12th highest reported **acute Sexually Transmitted Infections (STI) rate** in England. Good access to a range of STI screening services locally is likely to contribute to effective detection and diagnosis. However, the rate highlights that there are significant challenges to be addressed in reducing the impact of poor sexual health locally. Around a third of acute STIs diagnosed were seen in young people aged 15-24. Gay men and African communities are also disproportionately affected. Investment in sexual health promotion activities including effective models of Sex and Relationships Education is likely to build the resilience of young people locally. Further integration and expansion of sexual health and contraception services is essential to maximise opportunities for detection and diagnosing STIs. This must include early and effective treatment to break cycles of onward transmission and re-infection.

Coverage of **breast screening** in the borough is currently the lowest in the country, with close to 4 in 10 women (5,700 women) not having had an NHS screening within the last three years. There are significant challenges locally around achieving high screening rates, given high population movement and high private and overseas use (which cannot be counted). GPs play a critical role in ensuring screening call/recall lists are up to date, and that people are called when they are not abroad.

Cervical screening coverage is the 3rd lowest in the country for younger women and the lowest for older women. Cervical screening also suffers from similar challenges to breast screening around population movement and overseas use. Around 22,000 women have not received cervical screening in the eligible time period. In the past, improvements in rates have been achieved in particular through comprehensive GP list cleaning, and a range of other approaches have been tried, such as text reminders.

The incidence of **Tuberculosis** (TB) is lower than London, but is high compared to England – there have been an average of 33 cases a year for the last 3 years. Kensington and Chelsea is at risk as it is bordered by high prevalence boroughs such as Brent. The bulk of TB cases are acquired abroad, although the homeless population is also prone to TB. The condition is easily treated in the majority of cases, although treatment is expensive, particularly for multi-drug resistant TB. Changes to structures and responsibilities for TB services means strong levels of coordination may be needed to maintain a low rate.

Supporting vulnerable groups

Not everyone has an **equal chance** to thrive in life. Some are born with disability, whilst others experience poorer outcomes from adverse life circumstances which may occur at difference stages in their life. As a result, people from these groups often suffer from ill-health and disease which could have been avoided with the appropriate support. In some cases, giving these groups resilience and a chance to thrive means they are then better able to 'help themselves' later in life, rather than reinforcing dependency over time.

There is an opportunity for those **out of work** in the borough for health reasons to benefit from swift and intensive support to return to work. There are 9,400 people in the borough on long term benefits (6+ months). Of these, 1,275 claim Job Seekers Allowance and 4,800 Employment Support Allowance/ Incapacity Benefit/SDA. The estimated savings to benefits, health and crime of getting all those on out of work benefits into work for one year is around £70 million.

People with **learning disabilities** often suffer poor quality of life and die on average around 23 years earlier than the general population, often from potentially avoidable conditions. There is substantial scope to improve detection of illness through individual NHS health checks with this population, and to improve quality of life using a range of approaches, such as shifting accommodation from residential care to a stable community environment and supporting paid work. Numbers with learning disabilities are expected to grow too, due to better life expectancy into old age. This means services need to plan for greater numbers experiencing the conditions of old age such as dementia, and more children transitioning into adulthood.

West London CCG had the highest population with **severe and enduring mental illness** known to GPs in the country in 2012/13 (2,588 people registered with Kensington and Chelsea Practices). There continue to be challenges supporting those with SMI in maintaining good mental and physical health (e.g. through health checks), being in employment, and being in secure housing. In some cases, patients are being treated in secondary care, when they could be treated in a community setting more efficiently.

Estimates from 2009/10 suggest that the borough has the 3rd highest rate of **problem drug users** in London, or 1,750 people (although local data suggests this estimate may be unrealistically high). Crimes associated with drug use cost around £70 million locally according to estimates based on Home Office figures. Structured drug treatment programmes have been shown to be effective not only in improving health and reducing virus transmission but also a significant reduction in offending. One of the main challenges around moving people out of the treatment system drug-free is to ensure they have stable housing, good mental and physical health care, meaningful activities (e.g. education, employment) and positive social networks.

Suicide has a devastating effect on all those involved is the most common cause of death for men under 35. Rates of suicide and undetermined injury are lower than London and England, with around 10 a year. The cost of a completed suicide is in the region of £1.7 million, due to costs to statutory services, lost output, and intangible costs such as pain and suffering of relatives. Evidence suggests case-finding of those at risk of suicide could be improved via GP training, which has been found to be cost-effective to the NHS and hugely cost-saving to wider society.

Those **sleeping rough** in the borough have been found to have very high levels of emergency health care use and poor levels of health which could be avoided with better coordination and support. A recent JSNA has highlighted gaps in service provision for rough sleepers in primary care resulting in excessive use of secondary care.

In 2011, the borough had the 4th highest **HIV prevalence** rate in England. A quarter of people with HIV in England remain undiagnosed. However, between 2011 and 2013, Kensington and Chelsea had the 6th lowest rate of late diagnosis in London. Gay men and African communities remain the populations most disproportionately affected by HIV locally. Effective treatment means that the number of people living with HIV is increasing annually, with an increasing proportion aged over 50 years. The high local rate of HIV requires ongoing investment to maximise testing opportunities across a range of key delivery settings and support HIV prevention programmes. Consideration needs to be given to better linkage of HIV prevention services with both mental health and substance misuse services.

Welfare reform is affecting a number of families in the borough. Those who have been unable to negotiate down their rent will have to move home, but in some cases may move to overcrowded households or drift into debt. Currently, 380 households have been capped, of which 257 are households with children (with a total of 634 children), with 152 households with children affected by the 'bedroom tax'. Supporting those affected by Welfare Reform by lifting families out of unemployment, supporting them with discretionary housing payments where appropriate, or ensuring safe passage to a more affordable home, may help alleviate some of the impacts of the change.

Food schemes in the borough have reported growing numbers in **food poverty** as a result of welfare reform, which has also been claimed nationally. Work is being carried out in local boroughs to systematically establish the impact work with local agencies to alleviate the effects.

SUPPORTING GOOD HEALTH INTO OLDER AGE

Older people are the greatest users of health and social care services across the life stage and are also the most complex to treat, often needing support with multiple conditions. By old age, the management and treatment of chronic disease is paramount, and maintaining quality of life and providing joined up, high quality services are crucial. Given their caring responsibilities and levels of volunteering, older people are likely to contribute more to the UK economy than they receive.

Therefore, ensuring that older people maintain their independence is crucial, which includes avoiding unnecessary hospital stays and prolonging admission to care homes.

Older people are often negatively viewed as a drain on resources due to their use of hospital and social care. However, some studies suggest older people are actually a net **asset** to the economy, in terms of time and money they pay back. Of particular relevance are their commitment to volunteering (highest among people aged 65-74) and the large number of hours older people provide in unpaid care. There is therefore a strong economic argument around ensuring older people maintain good health and support, and using the knowledge and experience gained though their lifetime in positive ways.

Improved life expectancy and the ageing of the baby boom generation will result in an expected **increase in number of older people** (65+) in London by 16% (and 85+ by 35%) over the next decade. Locally, the growth is harder to predict: a rise of 23% is predicted (and 46% in 85+). The expected increase in demand from this, coupled with the gradual shift towards longer periods of time spent with chronic and disabling conditions, means services are shifting from hospital settings into a more coordinated, community-based approach covering both health and social care. This may impact positively on the hospital re-admission rate for Kensington and Chelsea patients back into hospital care at 30 days (the 8th highest in London in 10/11).

Schemes which improve **self management** and self-care for those with conditions like diabetes (e.g. Xpert) will complement the new model of care and have been found to be cost-effective nationally for improving outcomes and saving costs. However, locally they have tended to suffer from poor rates of attendance. Fresh approaches such as more community-based models with more flexible timings (e.g. like for the Expert Patient Programme) are associated with better uptake.

Local older people and organisations representing them have identified that services which take a **holistic approach** to their health (rather than just services based around conditions) suit them better. Concerns raised have been around ensuring that GP appointments are available easily and that older people have enough time to discuss their conditions.

Given the ageing population and people living for longer in ill-health, there will be an increasing need for the **provision of care** among our older population, possibly an increase of 1,000 carers over the next decade. Currently, provision of unpaid care is the 4th lowest nationally (11,000 people). If there are an insufficient number of unpaid carers locally, or lack of support (e.g. through respite care or health checks), caring responsibilities are more likely to fall on statutory services. This could cost £135 million a year.

Social isolation and **loneliness** among older people is more common among older and vulnerable people in the borough, often alone, sometimes those providing care, or who are in poor health themselves. Isolation may be exacerbated locally due to the nature of the housing stock (small units, above ground level, without lifts), as well as fear of crime and people's attitude towards their neighbourhood.

Published research has found those socially isolated are more likely to be admitted to residential or nursing care, although locally the breakdown of informal care arrangements appears to be instrumental. The borough has a larger proportion of the population aged 65+ compared to London (but lower than England), and around 4 in 10 live alone. Schemes to tackle loneliness and isolation are usually carried out via befriending and 'Community Navigator' schemes.

The number of people with **dementia** in the borough could rise by as much as 40% in the next decade, due to the ageing of the baby boom population and improved life expectancy and survival from other chronic disease. Early diagnosis of the disease appears to improve outcomes for those with the condition later in life. Levels of diagnosis of dementia for West London CCG (51%) are higher than nationally (42%). There is scope to improve this further, particularly through more awareness of the disease, and referral to memory clinics.

Improving life expectancy and greater expectations for vulnerable older people (including those with learning disabilities) creates further demand for a range of **supported accommodation** types (e.g. extra care housing) that enable residents to spend more time living independently rather than in residential or nursing care settings. Development of appropriate housing is challenging, given demand for new development in the borough and relies on close working with developers.

Preventing **sight loss** is crucial for maintaining independence among the older population. The Royal National Institute of Blind People suggests that half of blindness and serious sight loss could be prevented by timely detection and treatment. The provision of sight tests, which contribute to detection of sight loss, was slightly lower in the borough than nationally in 2011/12.

BUILDING HEALTHY AND SUSTAINABLE COMMUNITIES

Health is determined by the lifestyles we lead, the opportunities we experience and the care we receive, which in turn depends on a wider set of factors – education, employment, work and social status.

Local institutions such as schools, hospitals, parks, roads, housing developments, and cultural institutions can all have huge positive or negative impacts on how we live our lives and provide opportunities for us to reach our potential for a full and healthy life. Many of these come under the responsibility of councils, allowing opportunities for change.

The local area

Kensington and Chelsea's town centres, such as Knightsbridge, are often major international destinations, but are also the local hub for most of the borough's residents. Creating '**healthy high streets**' can improve residents and visitors' health, through working with fast food outlets, 'designing out' crime hotspots, and sensitive approaches to licensing. However, changes to high streets need to be balanced against supporting commercial opportunities in the borough.

Many of London's strategic road networks cut through the borough, filtering traffic onto minor roads that experience increasingly high traffic volumes. Carbon emissions are the 2nd highest in London and the proportion of deaths attributable to **air pollution** is estimated to be the 2nd highest nationally (excluding City of London), primarily through cardiovascular disease. Three of the 187 GLA Air Quality Focus Areas in the capital are in the borough, where NO2 levels are exceeded and human exposure is high (Cromwell Road, Knightsbridge and Notting Hill Gate). Measures can be taken to offset increases in air pollution including: investment in green infrastructure; early warning of poor air quality via text for those with COPD; encouraging sustainable transport and promotion of cycling to discourage car use; to adoption of school travel plans for children travelling to school.

Adoption of some of these solutions such as school travel plans and cycle initiatives may also contribute to a reduction to the high rate of **road traffic accidents** locally. On average, there are 85 people injured or killed on the borough's roads each year. The majority of these are non-residents and injuries rather than deaths. In 2011, three borough residents were killed in land transport accidents, including two pedestrians.

There are a number of existing and new **urban regeneration** sites in the borough, which will have a significant effect on population size and the make-up of the borough, particularly Earls Court, and Canal Way (Sainsbury's) in the far north of the borough. These sites offer huge opportunities for 'designing in' good health to developments and identifying premises that can be used to provide primary care services, supporting the 'out of hospital' agenda. The introduction of the Community Infrastructure Levy (CIL) will increase opportunities to improve the physical and social infrastructure of both new development areas and existing neighbourhoods.

Although the amount of **open space** in Kensington and Chelsea is less than average for London, there are still numerous parks and open spaces, considering its residential density, such as Holland Park and Kensington Gardens. Utilisation of outdoor space for exercise and health reasons is higher than London and England levels. Increasing collaboration with developers has resulted in more open spaces and quality public realm. Open spaces and playgrounds existing within the borough's housing estates have the potential to cultivate community empowerment social cohesion, reduce crime and improve health.

Poor quality housing has been calculated as costing the NHS at least £600 million a year nationally (probably over £1 million locally) with a cost to wider society of more than £1.5 billion. Cold housing impacts on cardiovascular, respiratory and rheumatoid disease and mental illness. There are around 47 excess winter deaths each year. Damp and mould is associated with respiratory disease, and overcrowding with mental ill-health. Prioritising renovation work on housing stock to those most at risk, designing out risk of falls and providing support with winter fuel payments may help alleviate some of these issues. Effective identification of those most at risk remains a big challenge and often existing services who have contact with residents can be used to 'signpost' to other services.

There are increasing concerns about the social impact of licensed **gambling** premises on those who frequent them, their families, and the surrounding community, with betting shops tend to be located in areas of relative poverty and deprivation. Licensing authorities are required to protect children and other vulnerable persons from being harmed or exploited by gambling, and a number of local authorities are striving to identify what action they might successfully take which aligns with the legislative framework and the interests of local residents and businesses.

Local services

The gradual shift towards longer periods of time spent with chronic conditions, and the decreasing need to spend long periods of time in hospital means services need to adapt away from hospital settings into a more coordinated, **community-based care** approach covering both health and social care. Given this rise in often complex co-morbidities, services focusing on the person not the disease appear most popular from a patient point of view. There have been a range of approaches introduced to tackle this challenge, such as integrated care between health and social care, and the *Shaping a Healthier Future* agenda.

Regular **patient surveys** are carried out on all **healthcare providers**. The quality of community mental health services (2013) was considered 'about the same' as nationally, as were local A&E departments (2012), inpatient departments (2012), and outpatient departments (2011). For the maternity care survey (2010), antenatal care was ranked worse than nationally in Imperial College Trust.

Around half of people (47%) rate their **experience with their GP** as 'very good'. Levels of satisfaction of people with Kensington and Chelsea GP practices is better than London (38%) and England (45%). Satisfaction with opening hours and confidence and trust in the GP are both similar to England, but confidence and trust in the practice nurse has tended to be lower than England (and similar to London).

Data from the Quality and Outcomes Framework on **quality of GP care in 2012/13** identifies West London CCG as having the 12th lowest average clinical score of any of the 211 CCGs in England, relating to care for patients with long term conditions. On average, the CCG's GP practices achieved 92.0% of all clinical points available, compared to 94.0% in London and 95.4% in England. The smoking clinical domain had a much lower number of points achieved than London and England (which relates to recording of smoking status and an offer of support and treatment). This highlights scope for further improvement in the quality of general practice care for those with long term conditions.

Around 6 out of 10 people using **adult social care** in the borough said they were extremely or very satisfied with adult social care services. Like London as a whole, satisfaction in Kensington and Chelsea has been rated lower than the England average (K&C: 61.8%; London 58.2%; England 63.7%), suggesting scope for further improvement.

Worse than London and England | Between London and England | Better than London and England

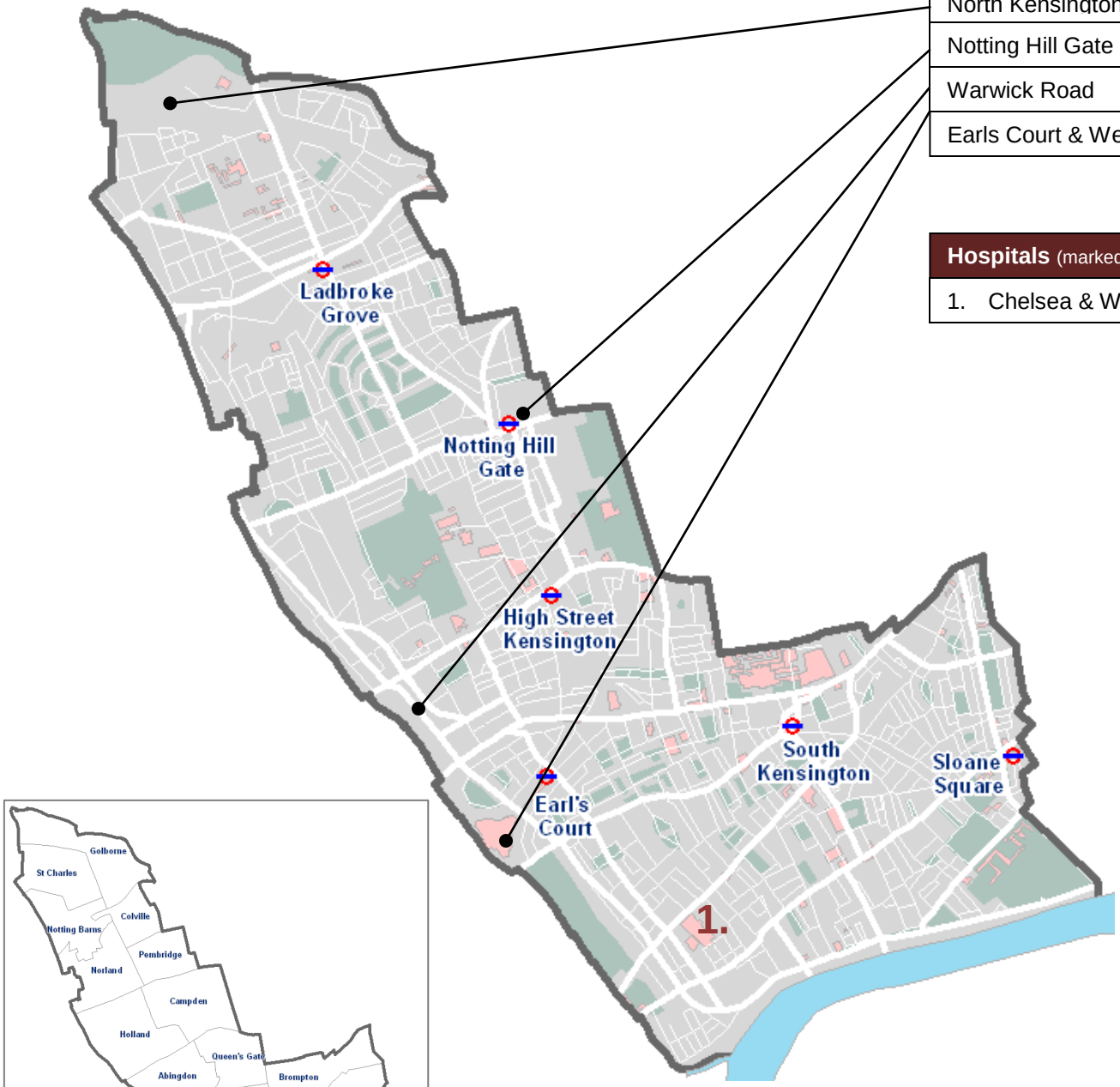
Bold *Significantly worse*

Indicator	K&C	London	England	Time Period
Overarching				
0.1i - Healthy life expectancy, male	66.9 years	63.0 years	63.2 years	2009 - 11
0.1i - Healthy life expectancy, female	67.8 years	63.8 years	64.2 years	2009 - 11
0.1ii - Life expectancy at birth, male	81.6 years	79.3 years	78.9 years	2009 - 11
0.1ii - Life expectancy at birth, female	86.1 years	83.6 years	82.9 years	2009 - 11
0.2iii - Slope index of inequality in life expectancy, male	11.8 years		9.7 years	2009 - 11
0.2iii - Slope index of inequality in life expectancy, female	6.5 years		7.2 years	2009 - 11
0.2iv - Gap in life expectancy - local authority to England, male	+2.7 years	+0.4 years		2009 - 11
0.2iv - Gap in life expectancy - local authority to England, female	+3.2 years	+0.7 years		2009 - 11
Wider determinants				
1.01ii - Children in poverty (under 16s)	23.8%	27%	21%	2011
1.03 - Pupil absence	4.7%	4.8%	5.1%	2011/12
1.04i - First time entrants to the youth justice system	659.4	584.7	537.0	2012
1.05 - 16-18 year olds not in education employment or training (NEET)	8.6%	4.7%	5.8%	2012
1.06i - Adults with a learning disability in stable and appropriate accom	67.3%	65.7%	70.0%	2011/12
1.06ii - Adults in secondary mental health in stable and appropriate accommodation	68.3%	72.6%	66.8%	2010/11
1.08i - Gap in the employment rate between long-term health condition and the overall	2.0	9.0	7.1	2012
1.08ii - Gap in the employment rate between learning disability and overall	54.1	58.7	63.2	2011/12
1.09i - Sickness absence - % of employees with at least one day off in previous week	1.8%	2.2%	2.2%	2009 - 11
1.09ii - Sickness absence - The percent of working days lost due to sickness absence	1.1%	1.2%	1.5%	2009 - 11
1.10 - Killed and seriously injured casualties on England's roads	53.9	35.4	40.5	2010 - 12
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	55.8	71.9	67.7	09/10-11/12
1.12ii - Violent crime (including sexual violence) - violence offences	13.8	15.3	10.6	2012/13
1.13i - Re-offending levels - percentage of offenders who re-offend	26.2%	26.6%	26.8%	2010
1.13ii - Re-offending levels - average number of re-offences per offender	.70	.73	.77	2010
1.14i - The percentage of the population affected by noise - Number of complaints about noise	31.1%	16.4%	7.5%	2011/12
1.14ii - % of population exposed to road, rail and air transport noise of 65dB(A)+ (daytime)	26.4%	12.5%	5.4%	2006/07
1.14iii - % of population exposed to road, rail and air transport noise of 55 dB(A)+ (night-time)	33.6%	18.9%	12.8%	2006/07
1.15i - Statutory homelessness - homelessness acceptances	6.3	3.9	2.3	2011/12
1.15ii - Statutory homelessness - households in temporary accommodation	16.1	11.3	2.3	2011/12
1.16 - Utilisation of outdoor space for exercise/health reasons	17.6%	10.5%	15.3%	Mar 12-Feb 13
1.17 - Fuel Poverty	10.1%	9.9%	10.9%	2011
1.18i - Social Isolation: % of adult social care users with as much social contact as would like	38.7%	39.1%	42.3%	2011/12
Health improvement				
2.01 - Low birth weight of term babies	2.3%	3.2%	2.8%	2011
2.02i - Breastfeeding - Breastfeeding initiation		87.0%	74.0%	2011/12
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth			47.2%	2011/12
2.03 - Smoking status at time of delivery		6.0%	13.2%	2011/12
2.04 - Under 18 conceptions	24.7	28.7	30.7	2011
2.06i - Excess weight in 4-5 year olds	21.3%	23.3%	22.6%	2011/12
2.06ii - Excess weight in 10-11 year olds	38.3%	37.5%	33.9%	2011/12
2.07i - Hospital admissions caused by injuries in children (aged 0-14 years)	79.4	93.3	118.2	2011/12
2.07ii - Hospital admissions caused by injuries in young people (aged 15-24)	106.2	111.1	144.7	2011/12
2.08 - Emotional well-being of looked after children	13.8	13.5	13.8	2011/12
2.13i - Percentage of physically active and inactive adults - active adults	65.3%	57.2%	56.0%	2012
2.13ii - Percentage of active and inactive adults - inactive adults	20.7%	27.5%	28.5%	2012
2.14 - Smoking prevalence - adults (over 18s)	18.1%	18.9%	20.0%	2011/12
2.15i - Successful completion of drug treatment - opiate users	9.5	9.6	8.2	2012
2.15ii - Successful completion of drug treatment - non-opiate users	27.6	34.7	40.2	2012
2.17 - Recorded diabetes	3.9%	5.6%	5.8%	2011/12
2.20i - Cancer screening coverage - breast cancer	58.2%	68.6%	76.3%	2013
2.20ii - Cancer screening coverage - cervical cancer	59.1%	68.6%	73.9%	2013
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	80.3%	78.7%	80.9%	2011/12
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	15.2%	20.6%	16.5%	2012/13
2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	7.7%	45.2%	49.1%	2012/13
2.23i - Self-reported well-being - people with a low satisfaction score	27.6%	27.2%	24.3%	2011/12
2.23ii - Self-reported well-being - people with a low worthwhile score	24.2%	22.6%	20.1%	2011/12
2.23iii - Self-reported well-being - people with a low happiness score	31.3%	30.6%	29.0%	2011/12
2.23iv - Self-reported well-being - people with a high anxiety score	46.0%	44.5%	40.1%	2011/12
2.24i - Injuries due to falls in people aged 65+ persons	2085.1	1871.8	1664.8	2011/12
2.24i - Injuries due to falls in people aged 65+, male	1696.5	1555.0	1301.6	2011/12
2.24i - Injuries due to falls in people aged 65+, female	2473.7	2188.6	2027.9	2011/12
2.24ii - Injuries due to falls in people aged 65-79	1377.7	1071.8	940.5	2011/12
2.24iii - Injuries due to falls in people aged 80+	5268.2	5471.8	4923.9	2011/12

Indicator	K&C	London	England	Time Period
Health protection				
3.01 - Fraction of mortality attributable to particulate air pollution	8.3%	7.2%	5.4%	2011
3.02i - Chlamydia diagnoses (15-24 year olds) - Old NCSP data	2031.1	2496.21	2124.64	2011
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD, male	1222.7		1367.68	2012
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD, female	2144.2		2568.39	2012
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD, persons	1681.7		1979.05	2012
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	85.1%	91.3%	94.7%	2011/12
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	89.3%	93.3%	96.1%	2011/12
3.03iv - Population vaccination coverage - MenC	81.6%	89.9%	93.9%	2011/12
3.03v - Population vaccination coverage - PCV	85.1%	90.4%	94.2%	2011/12
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	80.5%	86.8%	92.3%	2011/12
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years)		80.1%	88.6%	2011/12
3.03vii - Population vaccination coverage - PCV booster	80.5%	85.3%	91.5%	2011/12
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	82.9%	86.1%	91.2%	2011/12
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	86.7%	89.7%	92.9%	2011/12
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	75.4%	80.2%	86.0%	2011/12
3.03xii - Population vaccination coverage - HPV	80.0%	78.9%	86.8%	2011/12
3.03xiii - Population vaccination coverage - PPV	57.6%	62.6%	68.3%	2011/12
3.03xiv - Population vaccination coverage - Flu (aged 65+)	70.3%	72.2%	74.0%	2011/12
3.03xv - Population vaccination coverage - Flu (at risk individuals)	48.4%	51.4%	51.6%	2011/12
3.04 - People presenting with HIV at a late stage of infection	39.1	46.9	50.0	2009 - 11
3.05i - Treatment completion for TB	89.4%	85.8%	82.8%	2012
3.05ii - Incidence of TB	24.0%	41.4%	15.1%	2010 - 12
3.06 - Public sector orgs with a board approved sustainable development management plan	66.7	75.1	84.1	2011/12
Healthcare and premature mortality				
4.01 - Infant mortality	4.07	4.3	4.3	2009 - 11
4.02 - Tooth decay in children aged 5	1.26	1.23	.94	2011/12
4.03 - Mortality rate from causes considered preventable	116.6	137.6	146.1	2009 - 11
4.04i - Under 75 mortality rate from all cardiovascular diseases	45.0	62.7	60.9	2009 - 11
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	23.0	39.3	40.6	2009 - 11
4.05i - Under 75 mortality rate from cancer	89.9	103.3	108.1	2009 - 11
4.05ii - Under 75 mortality rate from cancer considered preventable	58.6	59.3	61.9	2009 - 11
4.06i - Under 75 mortality rate from liver disease	17.5	15.1	14.4	2009 - 11
4.06ii - Under 75 mortality rate from liver disease considered preventable	14.8	12.9	12.7	2009 - 11
4.07i - Under 75 mortality rate from respiratory disease	13.8	21.9	23.4	2009 - 11
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	6.4	10.8	11.6	2009 - 11
4.08 - Mortality from communicable diseases	22.6	31.7	29.9	2009 - 11
4.10 - Suicide rate	6.0	6.8	7.9	2009 - 11
4.11 - Emergency readmissions within 30 days of discharge from hospital, persons	12.5%	12.0%	11.8%	2010/11
4.11 - Emergency readmissions within 30 days of discharge from hospital, male	13.6%	12.5%	12.1%	2010/11
4.11 - Emergency readmissions within 30 days of discharge from hospital, female	11.6%	11.4%	11.4%	2010/11
4.12i - Preventable sight loss - age related macular degeneration (AMD)	124.2		110.5	2011/12
4.12ii - Preventable sight loss - glaucoma			12.8	2011/12
4.12iii - Preventable sight loss - diabetic eye disease			3.8	2011/12
4.12iv - Preventable sight loss - sight loss certifications	34.8		44.5	2011/12
4.14i - Hip fractures in people aged 65 and over	337.9	434.0	457.2	2011/12
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	192.3	217.5	222.2	2011/12
4.14iii - Hip fractures in people aged 65 and over - aged 80+	993.3	1408.1	1514.6	2011/12
4.15i - Excess Winter Deaths Index (Single year, all ages)	18.8	17.3	17.0	Aug 10-Jul 11
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	37.0	22.2	21.2	Aug 10-Jul 11

New development areas
North Kensington
Notting Hill Gate
Warwick Road
Earls Court & West Kens

Hospitals (marked on map)
1. Chelsea & Westminster



Work produced by the Tri-borough Public Health Intelligence Team:

Topic	Location
Reports published by the Tri-borough Public Health Intelligence Team are disseminated via the JSNA website. For further information please visit www.jsna.info. Below are direct links to some of the most recent and relevant reports.	
Carers Evidence Packs	http://www.jsna.info/reports-and-data/population-and-vulnerable-groups.html
Child & Adolescent Mental Health Joint Strategic Needs Assessment	http://www.jsna.info/download/get/camhs-jsna-2013/44.html
Prison Health Needs Assessment	http://www.jsna.info/download/get/prison-health-needs-assessment-2013/44.html
Rough Sleepers: Health and Healthcare Summary	http://www.jsna.info/download/get/rough-sleepers-health-and-healthcare-summary/44.html
Rough Sleepers: Health and Healthcare Annex	http://www.jsna.info/download/get/rough-sleepers-health-and-healthcare-annex/44.html
Sexual Health Joint Strategic Needs Assessment	http://www.jsna.info/download/get/sexual-health-jsna-2013/39.html
Shisha Evidence Briefing	http://www.jsna.info/download/get/shisha-evidence-briefing/32.html
Suicide Prevention Joint Strategic Needs Assessment	http://www.jsna.info/download/get/suicide-prevention-jsna/39.html
Tobacco Control Joint Strategic Needs Assessment	http://www.jsna.info/download/get/tobacco-control-jsna-2013/39.html
2012 JSNA summary report	http://www.jsna.info/download/get/kensington-and-chelsea-jsna-highlight-report-2012/15.html

Current NICE Public Health Guidance and information for local authorities:

Topic	Location
NICE support for local government	http://www.nice.org.uk/localgovernment/Localgovernment.jsp
Alcohol	http://publications.nice.org.uk/alcohol-lgb6
Obesity	http://publications.nice.org.uk/preventing-obesity-and-helping-people-to-manage-their-weight-lgb9
Physical Activity	http://publications.nice.org.uk/physical-activity-lgb3
Tobacco	http://publications.nice.org.uk/tobacco-lgb1
Walking and cycling	http://publications.nice.org.uk/walking-and-cycling-lgb8

Other relevant websites:

Topic	Location
Department of Health	https://www.gov.uk/government/organisations/department-of-health
Evidence Search	https://www.evidence.nhs.uk/
Kings Fund	http://www.kingsfund.org.uk/publications
Public Health England	https://www.gov.uk/government/organisations/public-health-england
Public Health Outcomes Framework	http://www.phoutcomes.info/
Social Care Institute for Excellence	http://www.scie.org.uk/

For more information, please contact info@jsna.info