Health and Well-being strategy supporting information (Kensington & Chelsea)

Gayan Perera
Senior Analyst,
Tri-borough Public Health,
Westminster City Council
gperera@Westminster.gov.uk

Background

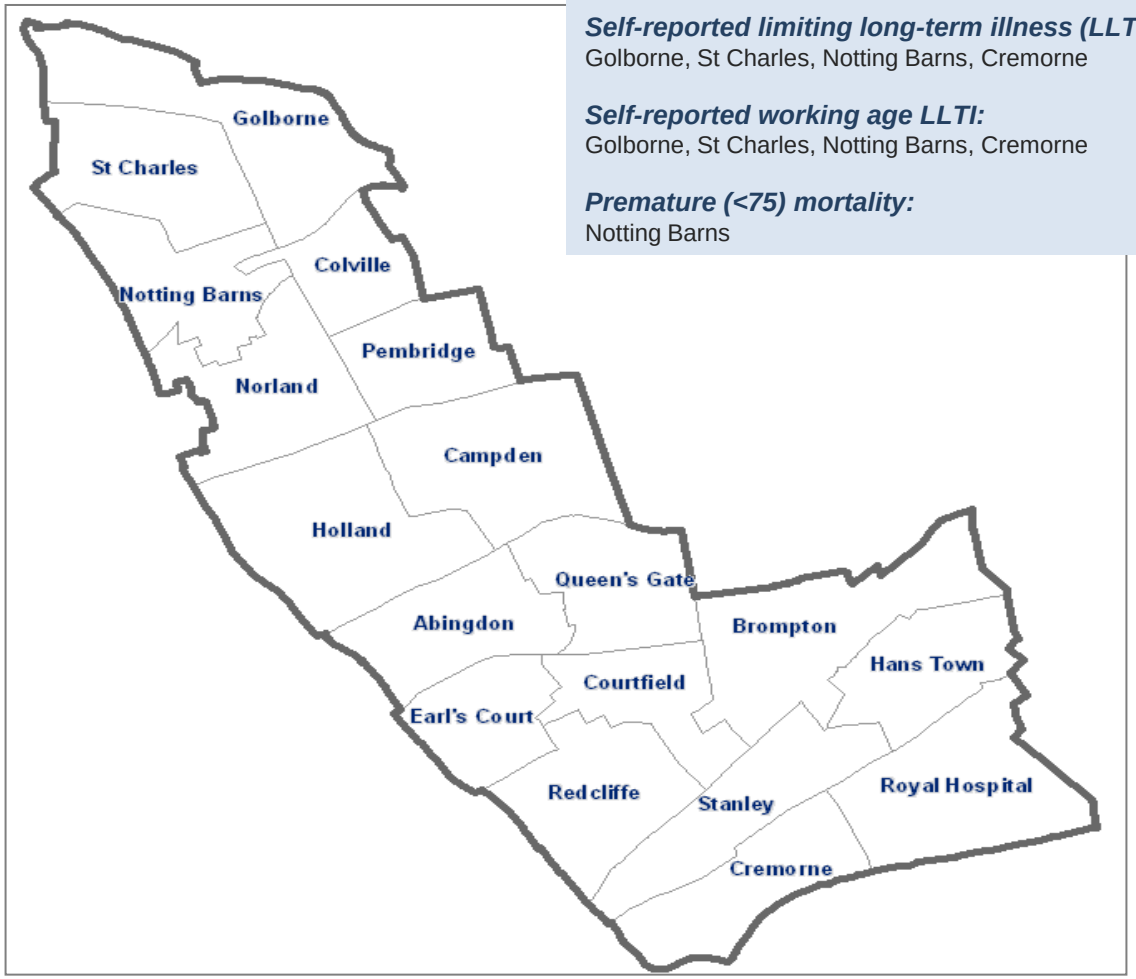
Wards falling into the **worst 20% in London** for:

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



Among the most densely populated areas in country: 159,000 residents and 189,000 registered patients in just 6 square miles

Huge variation in wealth and cultural background.

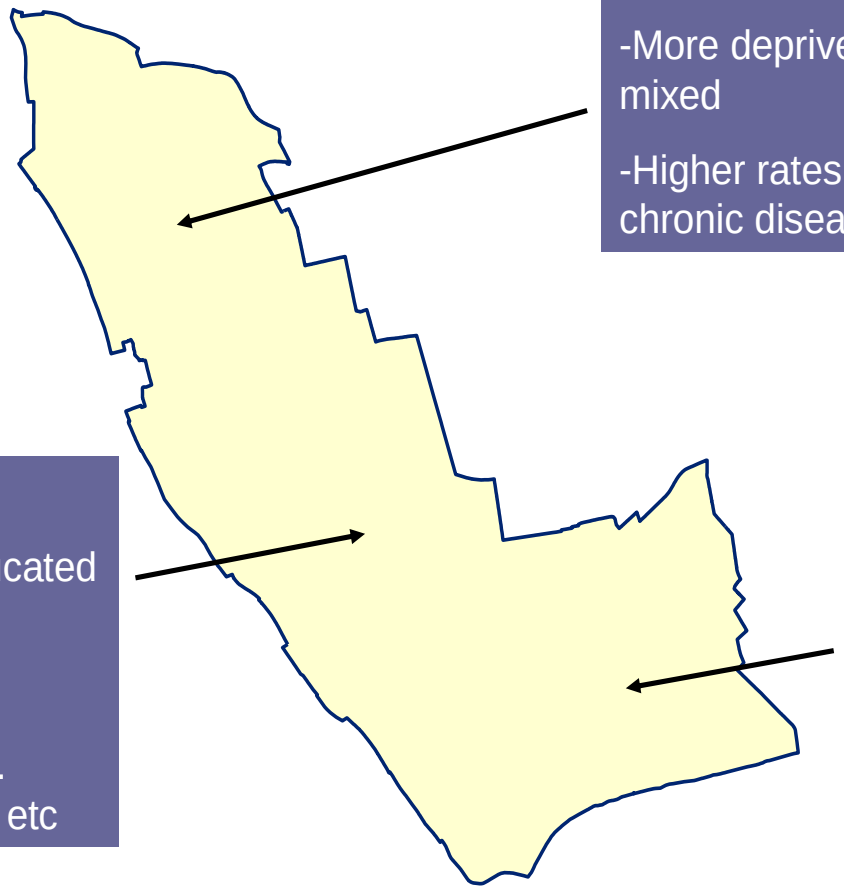
High number of older people living alone.

Most deprived parts of the borough located in the north with pockets of deprived areas in the south.

An Overview of different characteristics of local population

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		

Differing needs of the population



North Kensington

-More deprived and ethnically mixed

-Higher rates of lifestyle-related chronic diseases

South Kensington

-Young, affluent, educated and healthy

-Highly mobile

-Culturally mixed e.g. European, American etc

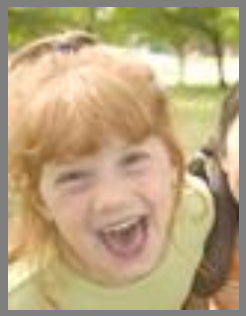
Chelsea

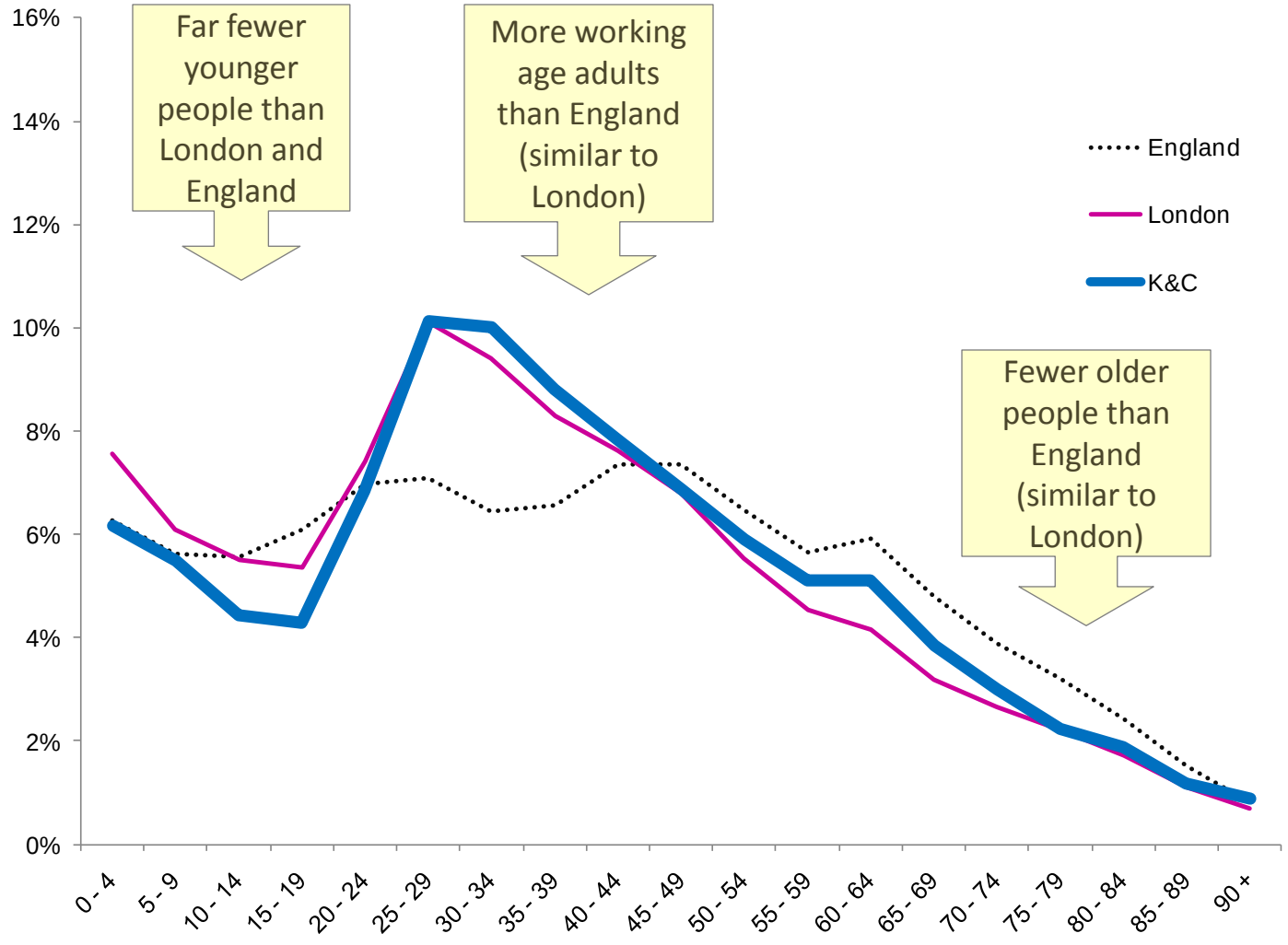
-Older

-Less ethnically diverse

-Very affluent, but with some deprived pockets

Age



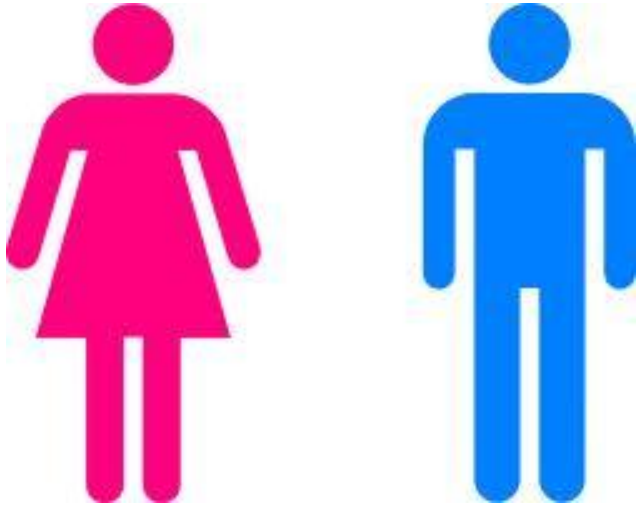


Area dominated by working age population (people in their twenties to forties)

Date of birth and age collected universally across all services

Age	Health status	Healthcare access & quality
What do we know nationally?	• Poorer health and chronic disease with age • Greater levels of disability with age • Around a third of 80+ year olds likely to have dementia • Social isolation among older people • Increasing depression among older people	• Poorer dignity & respect in hospital for some older people • Instances of lower operation rates for cardiac procedures among older population • Younger people more likely to use A&E, not GP • Lower cervical screening uptake for younger women
What do we know in K&C?	• Poorer health and chronic disease with age • Greater levels of disability with age • High numbers of older people living alone – potential for social isolation • Increasing depression among older people	•Younger people more likely to use A&E, not GP • Lower cervical screening uptake for younger women • Older people have less success quitting smoking through local services •Slightly worse access to psychological therapies

Gender



ALL ages	52%	48%
Aged 75+	59%	41%

K&C has a similar gender split to elsewhere

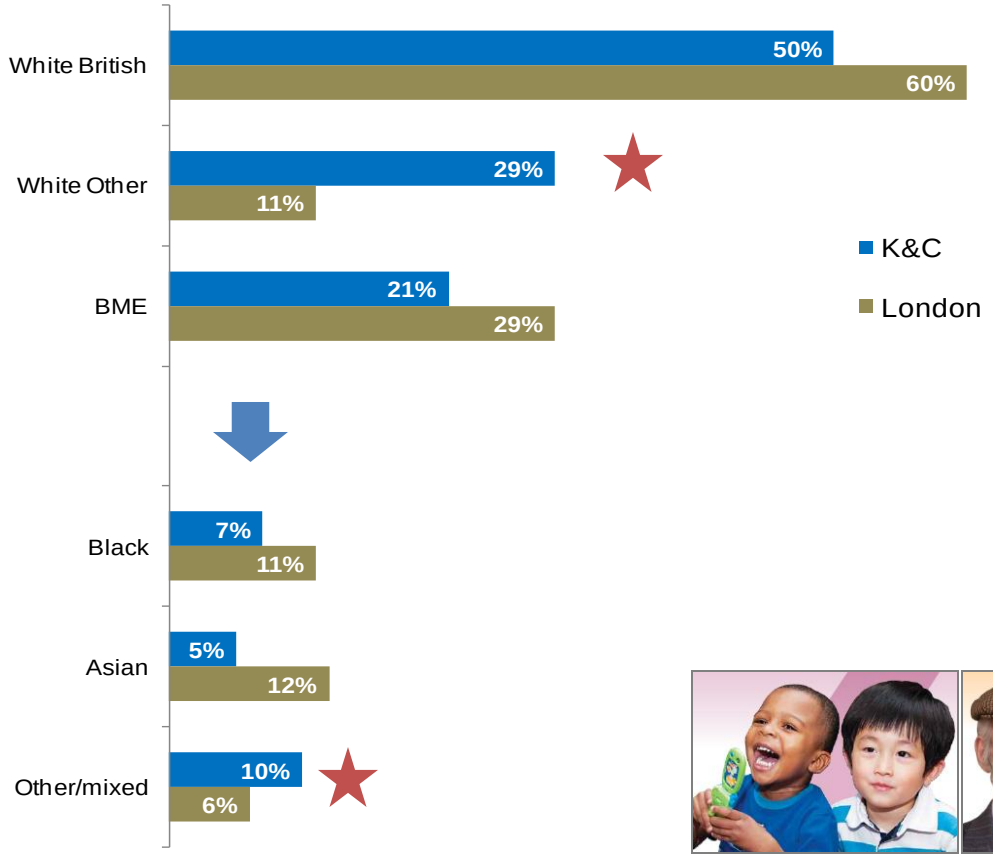
Because women live longer than men, there are a greater proportion of older women than older men in K&C

Information on gender collected universally across all services

Numbers for transgender and gender reassignment not known

Gender	Health status	Healthcare access & quality
What do we know nationally ?	• Shorter life expectancy for men • Higher levels of smoking and low fruit & vegetable consumption among men • Higher suicide rate among men • Higher levels of substance abuse for men, including alcohol • Higher common mental illness for women • Lower levels of physical activity for women • Violence against women • Autism/ADHT higher among boys	• Lower use of GP services by men • Late presentation and diagnosis of cancer for men
What do we know in K&C?	•Same as above, although little information around lifestyles (outside Westminster) and violence against women	•Smoking cessation low among deprived areas •Late presentation for cancer

Race, ethnicity and nationality



'White Other' and 'Other/mixed' groups are large in K&C

Borough is home to some **affluent** groups:
e.g. America, Western Europe, Australia/NZ

...and some more **vulnerable:**
e.g. Middle East and N Africa, Philippines

There is also a 30 pitch Travellers Site between K&C and H&F, under the Westway Motorway

Population by ethnicity 2001 and 2011 census, all ages (Data source: ONS census 2001 and 2011)

	Kensington & Chelsea		London		England	
	2001	2011	2001	2011	2001	2011
White British	50%	39%	60%	45%	87%	80%
White Other	29%	31%	11%	15%	4%	6%
Black	7%	7%	11%	13%	5%	3%
Asian	5%	10%	12%	18%	2%	8%
Other/ Mixed	10%	13%	6%	8%	2%	3%
White	79%	71%	71%	60%	91%	86%
BME	21%	29%	29%	40%	9%	15%

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

- Some ethnic groups have high prevalence of diseases and access to healthcare
  - Prevalence of diabetes is high among South Asians
  - Those HIV patients from Black and African gorups have high rates of late diagnosis of HIV

Race/ ethnicity	Health status	Healthcare access & quality
What do we know nationally?	• Poorer life expectancy for Pakistani/ Bangladeshi groups • Greater susceptibility to diseases such as diabetes for Asian and Black groups • Issues around refugee/asylum seeker health • Low birth weight babies among some groups e.g. Asians • Low physical activity/ high smoking for some groups e.g. Asians	• BME groups disproportionately using emergency services over routine/ GP services and some experience of challenges communicating with health professionals • Gypsies & travellers more likely to use emergency services over routine services • Black groups more likely to be detained under mental health act
What do we know in K&C	• Poorer health among certain ethnic groups, from 2001 Census (e.g. Black group in K&C) • Smoking rates high for Eastern European groups in Westminster • Issues around female genital mutilation for some Somali and Sudanese women • Speech and language therapy more common among BME children	• Conflicting evidence around breast and cervical screening uptake – lower uptake in some groups • Gaps in local knowledge around gypsies & travellers • High 'did not attend' rates among some ethnic groups for hospital services

Sexual orientation

Little is gathered around sexual orientation in K&C.
The Lesbian and gay population in the country may be in the region of 5-7% of the population , according to Stonewall.

K&C has among the highest rates in the country for HIV transmitted through sex between men, with very high rates in Earl's Court in particular, suggesting the **gay population may be larger than elsewhere**.

Sexual orientation	Health status	Healthcare access & quality
What do we know nationally?	• LGBT groups more likely to experience mental health problems and self-harm • More likely to engage in lifestyles harmful to health (e.g. drinking, smoking, drug use)	• Issues around lack of trust/understanding between LGBT groups and health professionals
What do we know in K&C	• Very high levels of HIV acquired through sex between men • High levels of sexually transmitted diseases	• Good access to HIV clinics locally

Disability

Limiting long-term illness: (2011 Census):

25,000 stated they had a LLTI

Visual impairment:

940 registered blind or partially sighted. Likely to be huge undercount

Learning disabilities:

304 on GP learning disability registers

Working age disability (2011 Census):

7,000 stated they couldn't work due to a disability

Mobility impairment:

Estimated **3,400** aged 65 or over

Hearing impairment:

295 registered deaf or hard of hearing. Likely to be huge undercount

Those of working age with a disability more likely to be living in areas of social housing.

Disability among older people likely dramatically in future to rise due to improved life expectancy and ageing of post war baby boom.

Improved life expectancy at birth and better hospital care means increase in numbers with complex needs living into adulthood.

Limited information collected on patient disability

Disability	Health status	Healthcare access & quality
What do we know nationally?	• Low life expectancy and high rates of obesity, heart conditions for those with learning disabilities • Mental health one of the primary causes of disability • Those with chronic diseases more likely to have a common mental illness • Working age disabled people twice as likely to be out of work and claiming benefits as non-disabled people	• Low rates of screening for learning disability population and 'diagnostic overshadowing'
What do we know in K&C	• High rates of incapacity benefit for mental health reasons in deprived parts • Working age disability more likely in areas of social housing and deprivation (according to 2011 Census)	• Some evidence of low rates of screening and health checks for learning disability population • Limitations around accessibility of home care, given restrictions on adaptations to some housing (due to conservation area planning rules) • Challenges around accessibility and DDA compliance of primary care estate and restrictions to adapting premises • Low numbers on hearing and sight registers, compared to likely number in local population

Other protected characteristics

Pregnancy and maternity

K&C has a higher proportion of older mothers and fewer young mothers. Private births are very common. NHS contact with expectant and new mothers is generally through health visiting services, and hospital abortion and maternity services.

There is good information around births and maternal health, but pregnant mothers are not identified routinely in service information

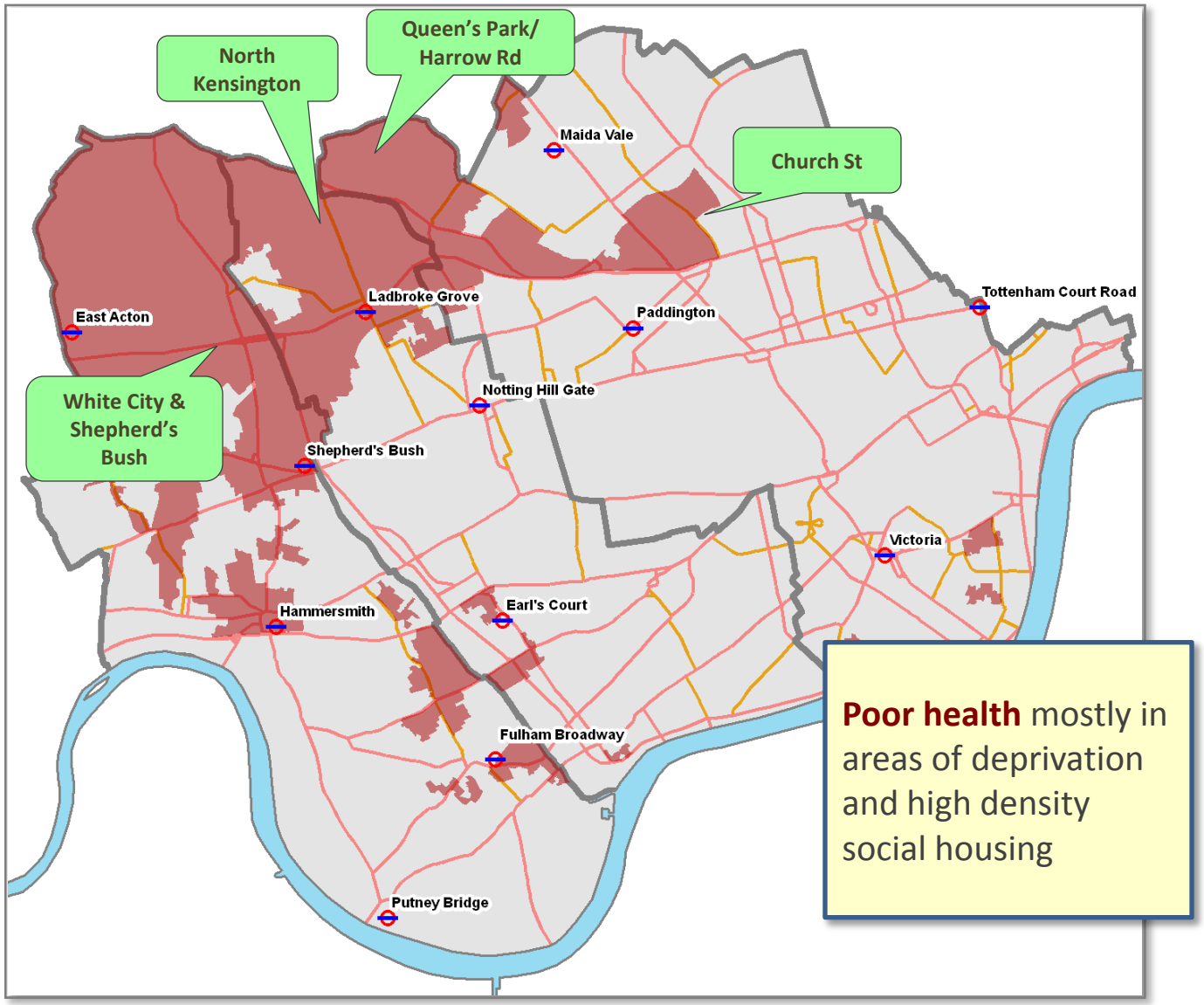
Marriage and civil partnership

In 2011, 37% of all K&C households were populated by married or cohabiting couples, which is lower than average.

In many cases (e.g. mental health), married men have a more favourable health status than men not married.

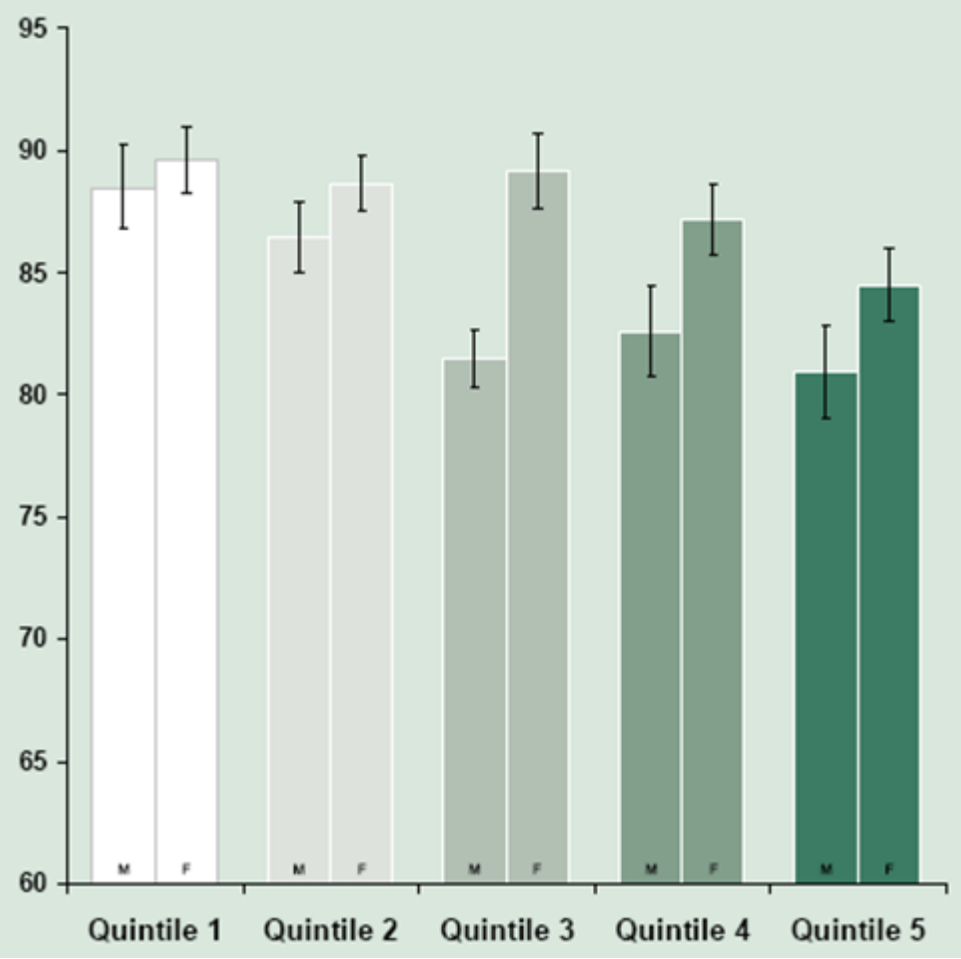
Marital status is not routinely collected by services, nor is civil partnership. In the past, prioritisation has been given to those in more **vulnerable family structures**, such as lone parents with dependent children.

Poverty and social inequality - deprivation



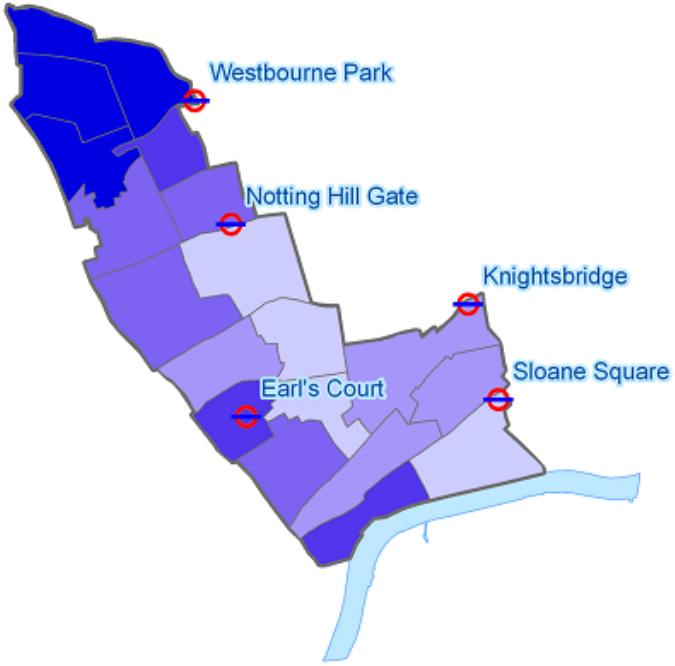
Local Authority	Deprivation
Hackney	1
Tower Hamlets	2
Newham	3
Islington	4
Haringey	5
Lambeth	6
Barking and Dagenham	7
Greenwich	8
Southwark	9
Waltham Forest	10
Lewisham	11
Brent	12
Camden	13
Hammersmith and Fulham	14
Westminster	15
Enfield	16
Ealing	17
Kensington and Chelsea	18
Hounslow	19
Croydon	20
Barnet	21
Redbridge	22
Wandsworth	23
Hillingdon	24
Bexley	25
Havering	26
Harrow	27
Merton	28
Bromley	29
Sutton	30
Kingston upon Thames	31
City of London	32
Richmond upon Thames	33

Poverty and social inequality – life expectancy



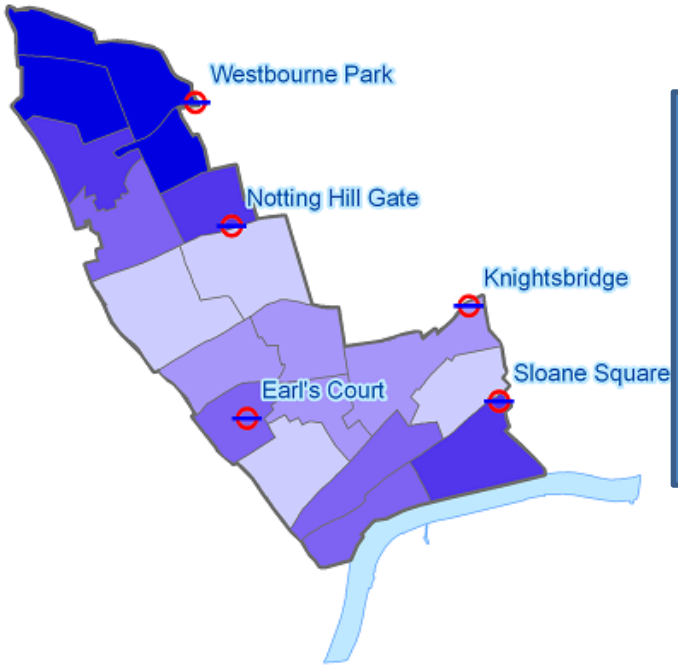
- 16 year for men: Worst life expectancy difference between most deprived part and least deprived part in K&C compared with other local authorities in England.
- Worst 20% in London for St Charles for women
- Linked to lifestyle choices: e.g. smoking, but also poor diet and physical inactivity

Deprivation and premature mortality (under 75)



Average ward level deprivation (IMD 2010)

- Least deprived quintile
- Second least deprived quintile
- Third most deprived quintile
- Second least deprived quintile
- Least deprived quintile



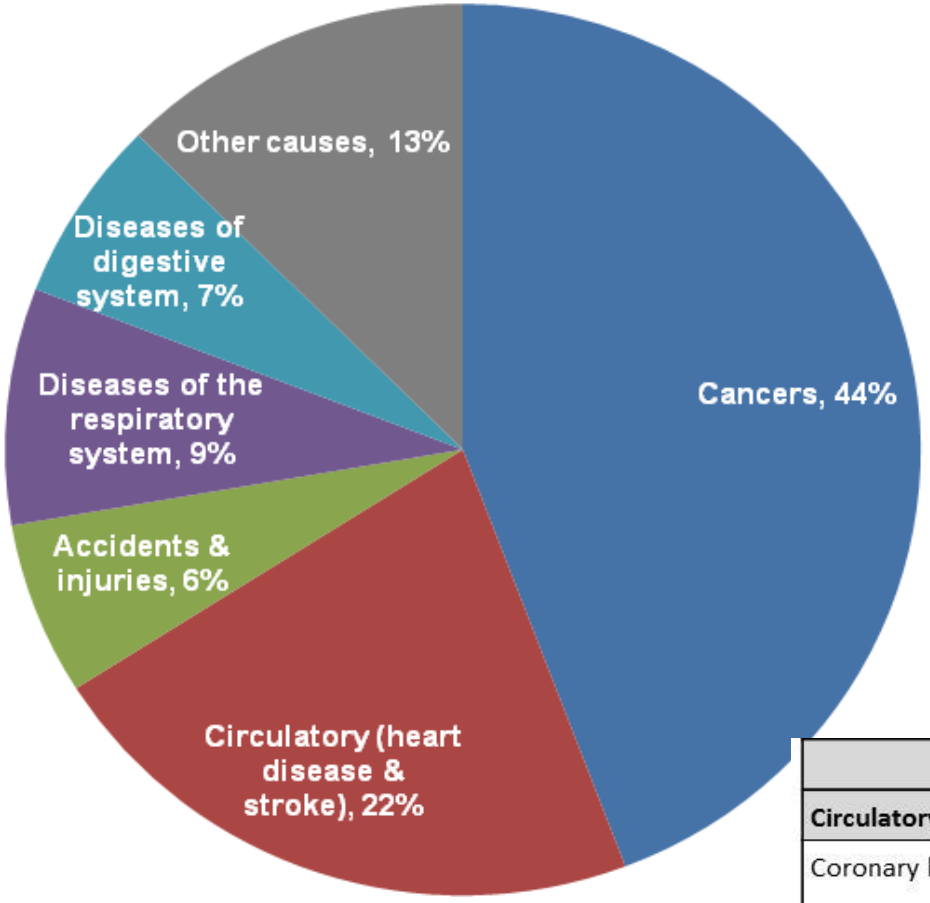
Under 75 Standardised Mortality ratio (year 2012)

- 41.6- 55.1
- 55.2- 73.6
- 73.7- 91.0
- 91.1- 101.5
- 101.5- 130.4

The most deprived wards of Kensington and Chelsea also have the highest rates of Standard mortality ratio (under 75)

Socio-economic status	Health status	Healthcare access & quality
What do we know nationally?	For lower socioeconomic status: •Inequality in terms of life expectancy. • Much greater burden of chronic disease • More likely to smoke and less likely to eat fruit & vegetables or take regular exercise • Higher levels of common mental illness	• More frequent use of healthcare services (partly due to poorer health) • More likely to use A&E over GP, compared to more affluent groups • Greater 'did not attend' rates
What do we know in K&C?	• Large inequality in terms of life expectancy. See previous chart • Much greater burden of chronic disease • More likely to smoke and less likely to eat fruit & vegetables or take regular exercise (based on Major Health Campaign in Westminster)	• Evidence of 'inverse care law' in the past, where poorer quality services are located in poorer areas. No longer necessarily an issue • Greater 'did not attend' rates

Premature deaths by cause, 2013



- 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.

Major causes of death		
Circulatory mortalities	**Cancer mortalities**	**Respiratory mortalities**
Coronary heart disease	Lung	Pneumonia
Heart disease complications	Breast	COPD
Acute MI	Prostate	
Stroke	Pancreas	

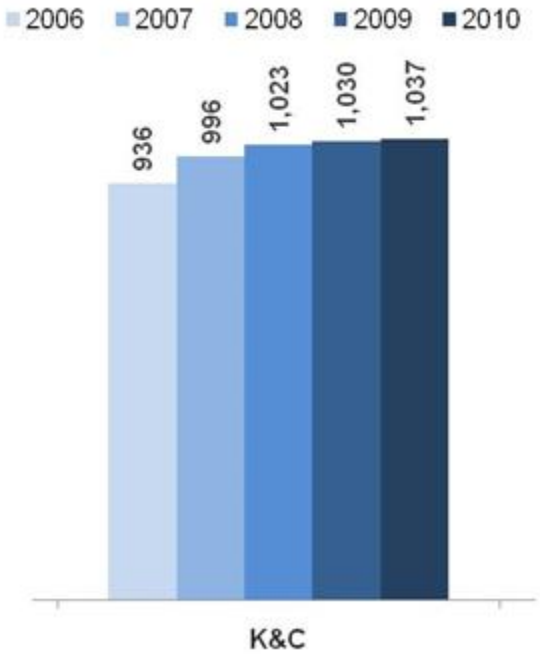
STIs and HIV resident patients in K&C (2006-2010)

HIV prevalence in the K&C area is **amongst the highest in the country** (based on 15-59 population)

Since 2006, there has been an increase in **11%**

The rise in K&C is across **all transmission types** (but females rising faster)

Number of HIV/ AIDS patients over time
(Source: SOPHID)

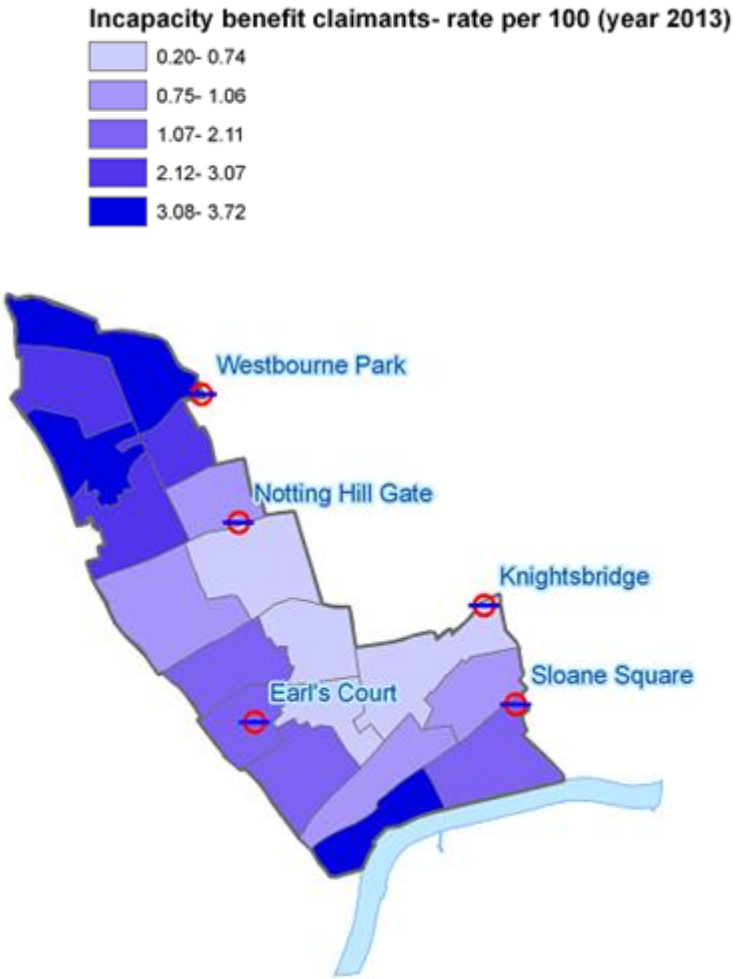


4th highest rate in England 2010
(of which 74% were MSM)

- 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.

Mental health

- High prevalence of Common and severe & enduring mental health problems in K&C
- The WL CCG area already contains 4 of the 5 highest wards for incapacity benefit claimants in London.



Child health

- In Year 6, 21.3% (187) of children are classified as obese.
- The rate of alcohol-specific hospital stays among those under 18 was 30.9 per 100,00 population. This represents 8 stays per year.
- Levels of GCSE attainment, breastfeeding and smoking at time of delivery are better than the England average.
- 30% of local 5 year old school children still suffer from decayed, missing or filled teeth.
- Uptake of the **HPV vaccination**, which protects teenage girls from cervical cancer, is much lower than London and England.

Adult health

- Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are worse than average.
- Rates of statutory homelessness, violent crime and drug misuse are worse than average.

People with co-morbidities

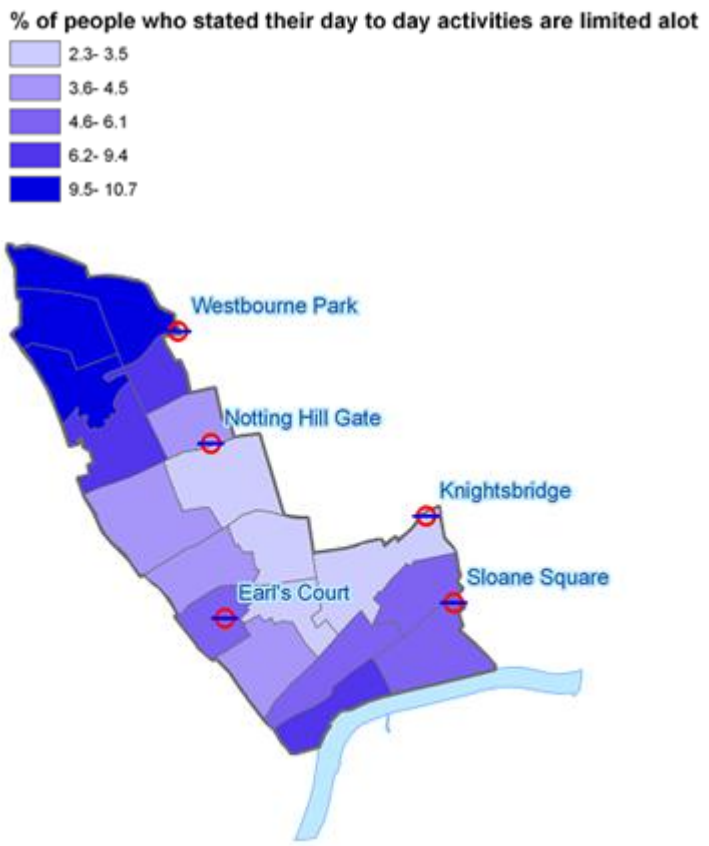
- Around 1 in 5 (38,000) patients in WLCCGG suffer from at least one long term condition. Of these, more than a quarter (10,000) have co-morbidities (two or more conditions).

vulnerable groups

- Around 4,800 children, focused particularly in the north of the borough, particularly in lone parent households are living in poverty
- Furthermore, there are around 380 households where housing benefit has been capped, 257 of which are with children
- Around 336 local **troubled families** experience poor life chances and poor education attainment and cost statutory services significant sums of money

Changing Population

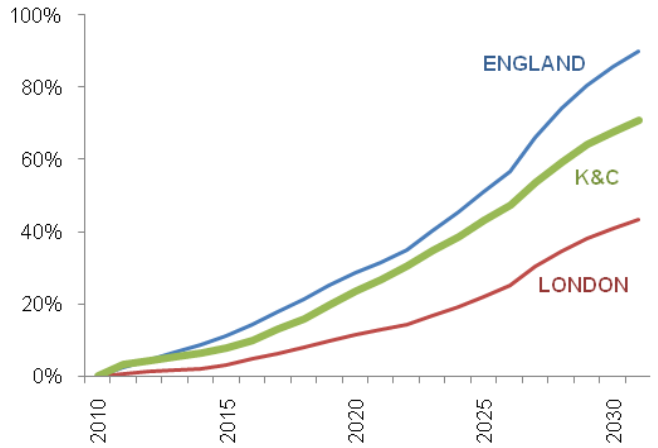
- Illnesses such as dementia, primarily prevalent among very old populations, will become increasingly commonplace. Currently, there are likely to be around 1,700 patients in Kensington and Chelsea with dementia. By 2025, there are likely to be in the region of 2,250 patients. Earlier diagnosis of dementia is associated with delayed admission to nursing care.
- Nearly 10% of the population in northern deprived wards of Kensington and Chelsea stated that their day to day activities are limited due to ill health. It is important to provide care for those people.



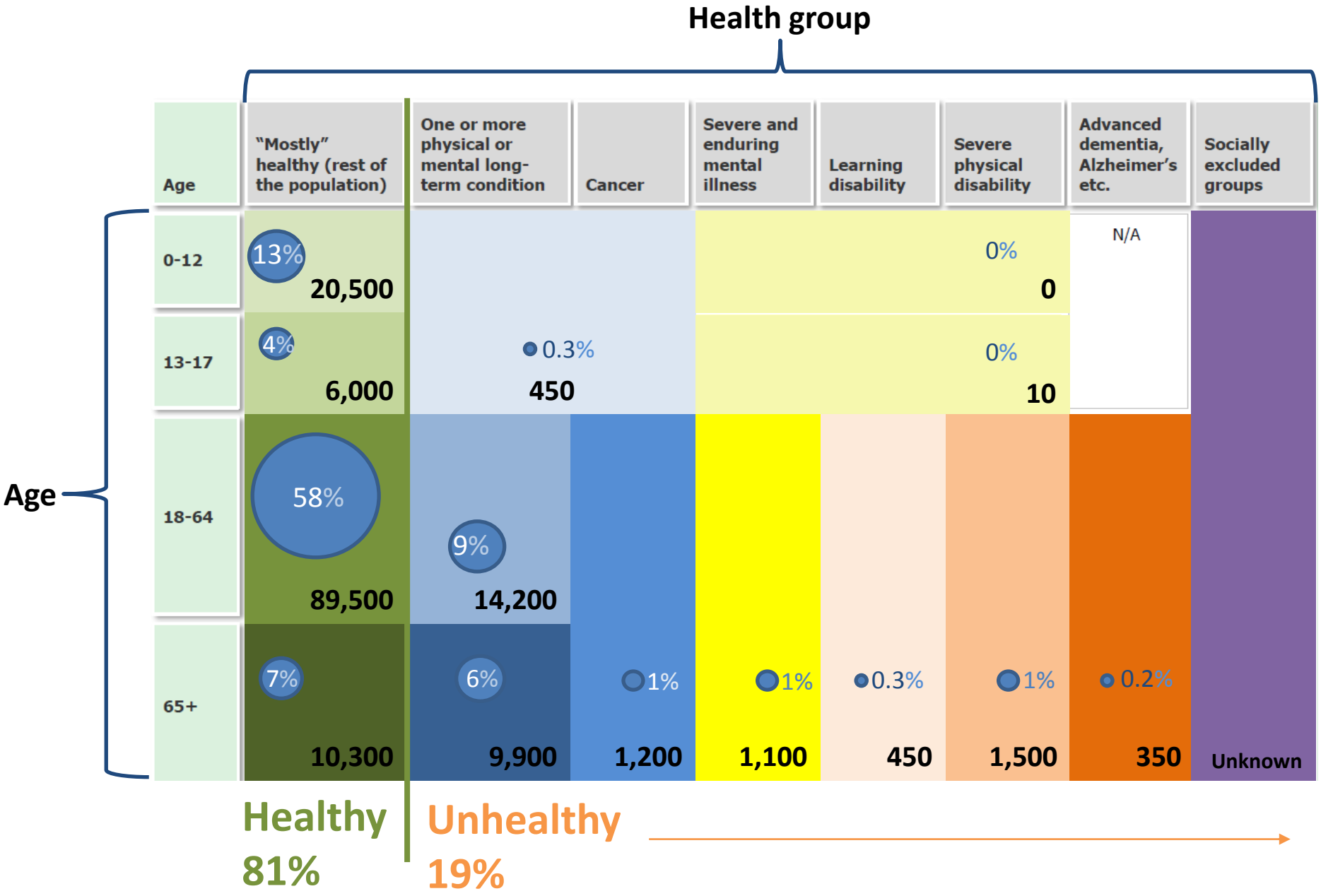
Changing Population: Older people

- 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. It is projected that 80+ Kensington and Chelsea population will grow nearly 40% by 2030

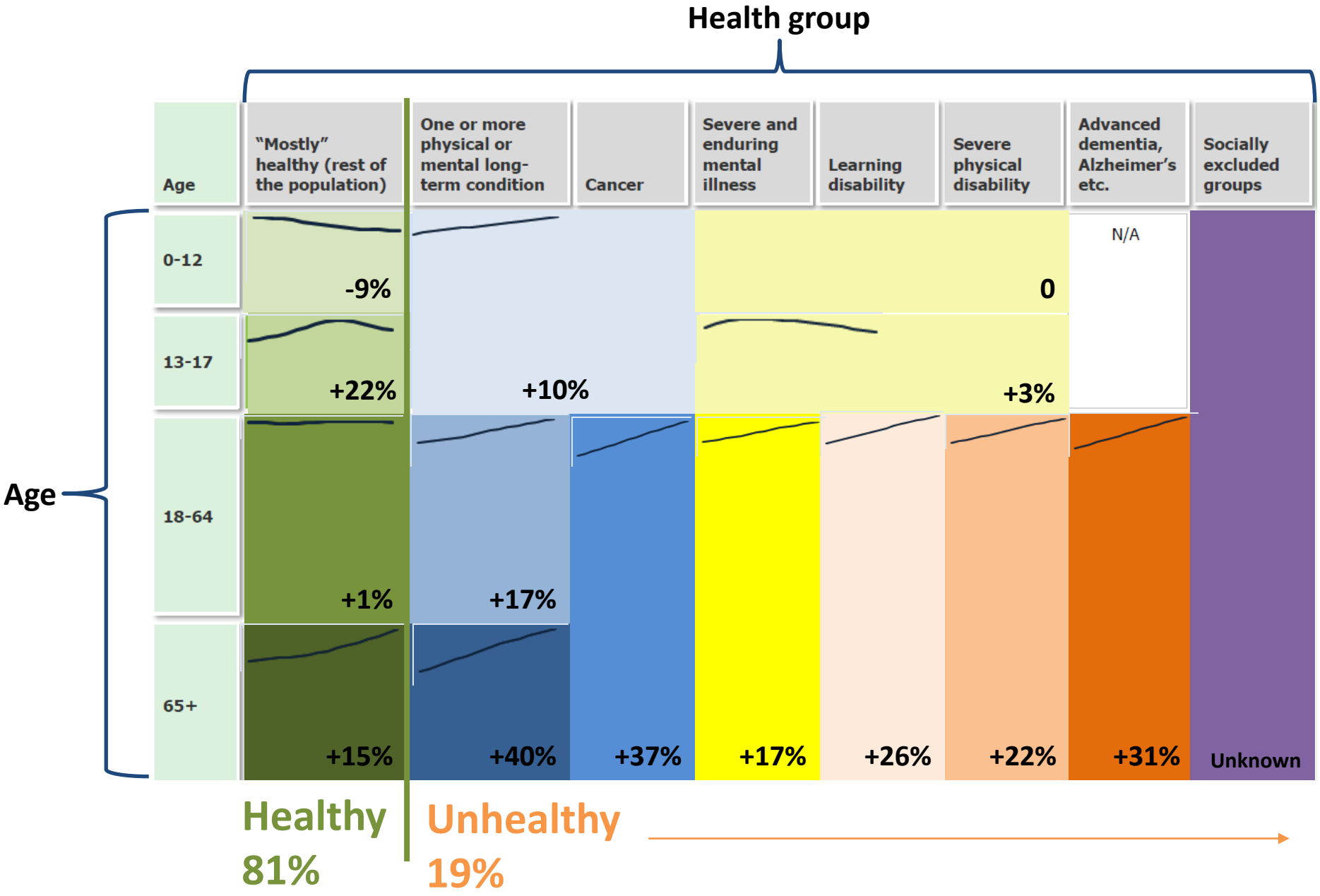
- Projected growth population age 80+



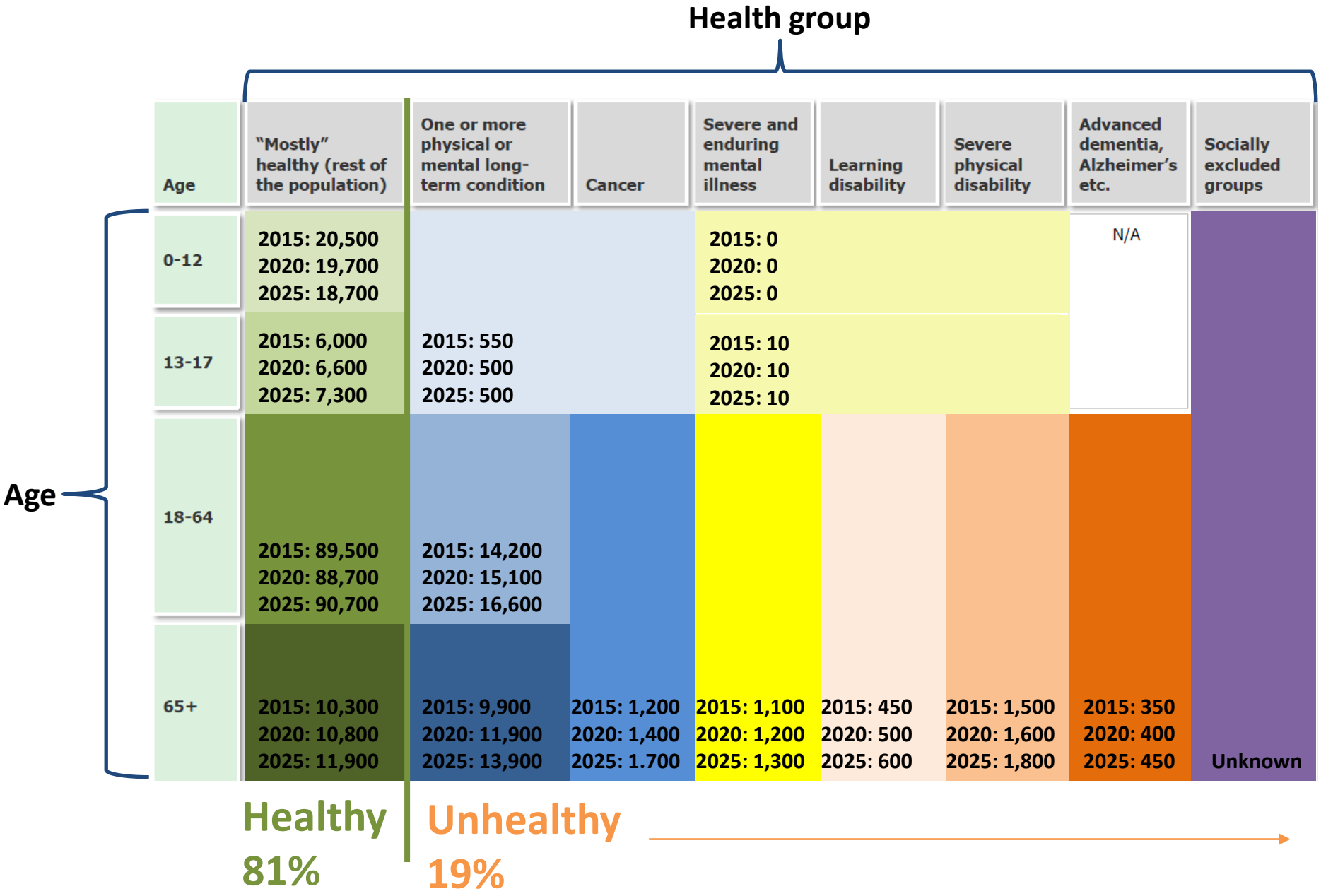
Number and percentage of the population in each group, RBKC 2015



Percentage change in the number in each group and trend, RBKC 2015 - 2025



Number in each group, RBKC 2015 - 2025



Summary - Local Characteristics

Predominantly low death rate from **cancer and CVD compared with England**
...but over half of all deaths from these diseases

Health inequalities: K&C area have the highest variation in life expectancy among men

Also...

One of the largest **HIV** populations in the country

Mostly transmission via sex between men

Very large numbers on GP registers with **Severe and Enduring Mental Illness (SMI)**

Large numbers on incapacity benefit for mental health reasons

State Primary School Children with high levels of **obesity** and poor **oral health**

High proportions living in poverty and overcrowded households