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  or telephoning 020 8339 8000
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Contributors

A report like this can only be produced with the help and dedication of the many people who are listed below.

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Editorial Committee

Jonathan Hildebrand, Iona Lidington, Helen Raison
Introduction

This is my third report on the health of people in Kingston. The 2007 report contained recommendations for actions to improve the health of local people and this report starts with an update on progress against these.

The focus for this year’s report is the way aspects of housing can impact on people’s health. Homelessness has a major impact on people’s health which is compounded by the fact that many homeless people have health issues. The chapter dealing with this highlights a needs assessment that was undertaken locally, as a result of which a series of recommendations have been made.

People who are unable to afford to heat their homes are said to be suffering from ‘fuel poverty’. They are at higher risk of dying from a range of conditions in the winter months. The effects of fuel poverty are highlighted in chapter four. Poor housing also has a negative effect on health, and this is discussed in detail in chapter three.

Refugees and asylum seekers may experience difficulties in accessing a range of services, including housing. Chapter six describes the findings from a needs assessment carried out in Kingston, and also makes recommendations for the future.

A range of other topics are also dealt with in the report. I am confident that the section on swine flu (in the emergency planning and preparedness section) will be out of date by the time you read this report; it is a snapshot of a rapidly changing situation. The advice contained within it regarding the importance of basic hygiene measures will however still be very much worth following.

The uptake of a range of childhood immunisations, whilst higher in Kingston than the London average, still gives cause for concern as, to take one example, we are at risk of a measles outbreak locally.

Both NHS Kingston (formerly known as Kingston Primary Care Trust) and the Royal Borough of Kingston continue to show their commitment to prevention by investing in a range of initiatives which will improve the health of the population in the future. This is now even more important given the economic situation, which is likely to have a negative effect on some people’s health.

I would like to thank everyone involved in the production of this document. Special thanks go to Helen Raison for her excellent work in co-ordinating the report.

If you require additional information on any of the areas described in the chapters, I would encourage you to e-mail the authors whose addresses are listed with the chapter title. In addition I would welcome comments on the report which can be sent to me at jonathan.hildebrand@kpct.nhs.uk

Dr Jonathan Hildebrand
Joint Director of Public Health
## Chapter 1

**Update on Progress against the Recommendations in the Joint Annual Public Health Report 2007**

Helen Raison, Specialty Registrar in Public Health, NHS Kingston (helen.raison@kpct.nhs.uk) and Iona Lidington, Joint Associate Director of Public Health, NHS Kingston / Royal Borough of Kingston (iona.lidington@kpct.nhs.uk)

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<td><strong>Ethnicity and inequalities</strong></td>
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<tr>
<td>1</td>
<td>To continue the recruitment and development of Community Development Workers to work with communities for improved health outcomes and experiences.</td>
<td>Equalities and Community Engagement Manager</td>
</tr>
<tr>
<td>2</td>
<td>To improve access to opportunities to learn English for vulnerable people and those with health problems.</td>
<td>Equalities and Community Engagement Manager and Health Education Officer</td>
</tr>
<tr>
<td>3</td>
<td>To continue to carry out consultation work with communities and identify local needs, issues and concerns.</td>
<td>Community Development Worker for Refugees, Asylum Seekers, Gypsies and Travellers and Equalities and Community Engagement Manager</td>
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**Update on Progress against the Recommendations in the Joint Annual Public Health Report 2007**

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<tr>
<td>4</td>
<td>Equalities and Community Engagement Manager with partner organisations</td>
<td>A Black and minority ethnic community needs assessment has been commissioned and is currently being carried out.</td>
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To continue to work in partnership with the Mental Health Trust, NHS Kingston, Council and local Voluntary Organisations on improving the health of Black and minority ethnic communities.

NHS Kingston has commissioned Royal Borough of Kingston Community Care to provide an Equalities and Community Engagement Team - a team of community development workers and programmed work to tackle inequalities in health that exist. This team has now been established and forms part of the wider Joint Public Health Team.

Voluntary organisations have been commissioned to provide projects that reduce health inequalities. Voluntary organisations commissioned for work during 2008/9 include The Tamil Information Centre for their health media project, Refugee Action Kingston for their health and wellbeing centre, information and advice service and their database management, and Learn English at Home for their English for Health project.

Korean Access to Mental Health Services group has been commissioned to work with Korean youths, improving their knowledge and understanding of mental health and where to go for help. A telephone advice service hosted by MIND has been set up for Koreans experiencing mental distress. A youth film is being produced on Korean’s concepts of mental health and short films are being shown in the Odeon cinema. A series of mental health articles have appeared in the Korean press.

The Dementia Project continues to run and one event was provided in September 2008 specifically targeting the Tamil community.
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<td><strong>People with Learning Disabilities</strong></td>
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<td><strong>Health</strong></td>
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<td>5</td>
<td>NHS Kingston and the Council will develop a detailed specification for community health services for people with a learning disability.</td>
<td>The specification for community health services has been agreed.</td>
</tr>
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<td>6</td>
<td>NHS Kingston and the Council will work with GP services to ensure the experience of people with a learning disability who access these services is improved.</td>
<td>The Learning Disabilities Parliament is working with a GP practice to establish a GP champion role.</td>
</tr>
<tr>
<td>7</td>
<td>NHS Kingston and the Council will work to ensure that people have access to a health facilitator, a health action plan, and regular health checks.</td>
<td>The business case for the provider ‘Your Healthcare’ will take account of these recommendations. The Learning Disability Parliament completed a piece of work involving health professionals, family members, staff, and people with a learning disability. A report went to the Partnership Board, with recommendations. The Action Group is setting up a Health sub-group to ensure the recommendations are actioned.</td>
</tr>
<tr>
<td>8</td>
<td>NHS Kingston and the Council will ensure adequate provision exists to support people with a learning disability who have additional mental health issues or who have challenging needs in the community.</td>
<td>The business case for the provider ‘Your Healthcare’ will take account of these recommendations. The Learning Disability Parliament completed a piece of work involving health professionals, family members, staff, and people with learning disability. A report went to the Partnership Board, with recommendations. The Action Group is setting up a Health sub-group to ensure the recommendations are actioned.</td>
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## Update on Progress against the Recommendations in the Joint Annual Public Health Report 2007

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<td>Involvement and Information</td>
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<td>9</td>
<td>The Council will increase resources dedicated to supporting the development of the User Parliament, so that the capacity of the Parliament to represent people with learning disability is increased.</td>
<td>Head of Learning Disabilities (RBK)</td>
</tr>
<tr>
<td>10</td>
<td>The Council will commission a self-advocacy service, to support user involvement across services, which will feed into the Parliament, and will support people with learning disability to be involved in service development.</td>
<td>Head of Learning Disabilities (RBK)</td>
</tr>
<tr>
<td>11</td>
<td>The Council will develop a Communication Strategy, in conjunction with people with learning disability, families, and other partners, so that all stakeholders are aware of developments, and how to input into decision-making processes.</td>
<td>Head of Learning Disabilities (RBK)</td>
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<td><strong>Inclusion</strong></td>
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<tr>
<td>12 The Council will continue to work with local services and organisations to ensure that people with a learning disability are seen as valued members of their communities.</td>
<td>Head of Learning Disabilities (RBK)</td>
<td>Being developed through a learning disabilities commissioning strategy.</td>
</tr>
<tr>
<td>13 The council will ensure the development of an increasing range of activities for people with a learning disability to access in the community.</td>
<td>Head of Learning Disabilities (RBK)</td>
<td>Leisure opportunities in the community are being developed. A draft day service change plan is out for consultation, due to be finalised in June 2009.</td>
</tr>
<tr>
<td>14 The Council will continue to promote the employment of people with learning disabilities through Kingston Workstart, and will develop social enterprises.</td>
<td>Head of Learning Disabilities (RBK)</td>
<td>Employment opportunities in the community are being developed. A draft day service change plan is out for consultation, due to be finalised in June 2009.</td>
</tr>
<tr>
<td><strong>Children</strong></td>
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<tr>
<td>15 Ensure the Children and Adolescent Mental Health Strategy (CAMHS) addresses the needs of children with a learning disability.</td>
<td>Manager of Integrated Service for Disabled Children</td>
<td>The needs of children with a learning disability are in the draft CAMHS strategy.</td>
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### Update on Progress against the Recommendations in the Joint Annual Public Health Report 2007

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<tr>
<td>16 Develop children specific continuing care policy in line with national guidance when published.</td>
<td>Manager of Integrated Service for Disabled Children</td>
<td>The National Continuing Care policy for children is currently under consultation.</td>
</tr>
<tr>
<td>17 Ensure a planned parenting strategy addresses the needs of parents with learning disabilities and parents of children with learning disabilities.</td>
<td>Manager of Integrated Service for Disabled Children</td>
<td>A new Parent Participation Officer has been employed. They will take forward a parenting strategy, ensuring the needs of children with disabilities are used to inform the development of parenting support services.</td>
</tr>
<tr>
<td>18 The Council will commission specialist services that meet the needs of older people with a learning disability, providing suitable accommodation and support for people who are becoming increasingly frail, have nursing needs, or who suffer from dementia.</td>
<td>Head of Learning Disabilities (RBK)</td>
<td>Discussions are on-going with two potential providers. The service is being developed through a learning disabilities commissioning strategy.</td>
</tr>
<tr>
<td>19 Drop-in sessions for carers of service users in transition services will be run on a twice monthly basis, in the evening and during the day, by the adult transition care managers.</td>
<td>Head of Learning Disabilities (RBK)</td>
<td>Regular meetings for transition families are on-going. This is being developed through a learning disabilities commissioning strategy.</td>
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<td>20</td>
<td>A comprehensive transition leaflet containing information for parents/carers will be published.</td>
<td>Head of Learning Disabilities (RBK)</td>
</tr>
<tr>
<td>21</td>
<td>This leaflet will also be distributed during a twice yearly adult services open evening for parent/carers and children who are moving into learning disability adult services.</td>
<td>Head of Learning Disabilities (RBK)</td>
</tr>
<tr>
<td>22</td>
<td>Outreach to be undertaken with community groups to establish a means of improving access and take-up of services, to ensure that services available are known, and that RBK is in contact with and accessible to all people with a learning disability in the Borough.</td>
<td>Head of Learning Disabilities (RBK)</td>
</tr>
<tr>
<td>23</td>
<td>The council will identify young people who have been through the education system but who do not present to adult services, to ensure their needs are being met.</td>
<td>Head of Learning Disabilities (RBK)</td>
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### The Mental Health of Older People

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<td>24</td>
<td>Improve the capacity and skill level of local residential and nursing homes to meet the needs of older people with complex mental health needs and challenging behaviour through the provision of training and advice and support by a multidisciplinary group of professionals that are specifically trained to work with people with varying degrees of mental illness and or challenging complex mental health issues.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
</tr>
<tr>
<td>25</td>
<td>Enhance the support provided to older people with mental health needs in the community to maximise their independence and avoid unnecessary hospital admissions, e.g. by developing a specialist intensive mental health rapid response team.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
</tr>
<tr>
<td>26</td>
<td>Develop the role of primary care in the early identification, diagnosis and support of older people with mental health needs in the community.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
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<td>Recommendation</td>
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<tr>
<td>27 Enhance the skills and capacity of Kingston Hospital staff to meet the needs of older people with mental health needs, particularly those diagnosed with dementia.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>Being developed through forthcoming Older People’s Mental Health Strategy and implementation of national Dementia Strategy.</td>
</tr>
<tr>
<td>28 Enhance the skills of all staff working in generic, non-specialist areas in the detection and management of mental illness.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>This has been identified as a training need which will be addressed through the implementation of the Older People’s Mental Health Strategy.</td>
</tr>
<tr>
<td>29 Review the current model of care for older people with mental health needs provided in Kingston Hospital, and consider other options for providing a more suitable environment which promotes responsive and holistic services for this group of patients.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>This will need to be audited against the national Dementia Strategy.</td>
</tr>
<tr>
<td>30 Review the capacity and joint working arrangements between South West London &amp; St. George's Mental Health Trust, Kingston Hospital Trust, Tolworth Hospital.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>Being developed through forthcoming Older People’s Mental Health Strategy and implementation of national Dementia Strategy.</td>
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### Update on Progress against the Recommendations in the Joint Annual Public Health Report 2007

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<tr>
<td>31 Improve the ability of older people with mental health needs to access general health care e.g. optical, podiatry, dental care in appropriate settings and a timely manner.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>Being developed through forthcoming Older People’s Mental Health Strategy and implementation of national Dementia Strategy.</td>
</tr>
<tr>
<td>32 Review the information, advice and support provided to carers especially in early stages of mental illness diagnosis.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>Being developed through forthcoming Older People’s Mental Health Strategy and implementation of national Dementia Strategy.</td>
</tr>
<tr>
<td>33 Raise public awareness about recognising the early signs of depression and dementia and provide information and advice about services that promote the well-being of those affected and their carers.</td>
<td>Healthier Communities Manager and Healthier Communities Officer, Active Ageing</td>
<td>Focus groups held in March 2009 with older people to identify best approaches to providing information. Being developed through forthcoming Older People’s Mental Health Strategy.</td>
</tr>
<tr>
<td>34 Raise awareness of the usefulness of Telecare services in maintaining the independence and safety of older people with mental health needs.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>Being developed through forthcoming Older People’s Mental Health Strategy and implementation of national Dementia Strategy.</td>
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<td>35 Engage with older people from BME communities to ensure that their needs are met by local mental health services.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>Being developed through forthcoming Older People's Mental Health Strategy and implementation of national Dementia Strategy.</td>
</tr>
<tr>
<td>36 Ensure appropriate support for older people with learning disabilities with dementia.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>Being developed through forthcoming Older People's Mental Health Strategy and implementation of national Dementia Strategy.</td>
</tr>
<tr>
<td>37 Develop and monitor a dignity code on which services will be commissioned.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>Being developed through forthcoming Older People's Mental Health Strategy and implementation of national Dementia Strategy.</td>
</tr>
<tr>
<td>38 Increase the involvement of older people with mental health needs in evaluating, monitoring and planning services and facilitate older people's involvement in developing mental health promotion services.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>Being developed through forthcoming Older People's Mental Health Strategy and implementation of national Dementia Strategy.</td>
</tr>
<tr>
<td>39 Further develop mental well-being and early support services including the provision of emotional and social support, befriending and peer support and improving access to counselling.</td>
<td>Healthier Communities Manager and Healthier Communities Officer, Active Ageing</td>
<td>Focus groups held in March 2009 with older people to identify best approaches to providing support. Older people action group being set up to build capacity of older people to lead support services.</td>
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<tr>
<td>40 Review the availability and accessibility of services and support for older people with substance misuse needs.</td>
<td>Mental Health Commissioner, NHS Kingston</td>
<td>This will be developed jointly with the Strategic Partnership for Alcohol and Drugs.</td>
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**Oral Health**

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<tr>
<td>41 Produce an Oral Health Promotion Strategy for Kingston with a focus on health promotion and prevention and the resources to implement the recommendations.</td>
<td>Dental Public Health with Clinical Director of Special Care Dentistry for Kingston +/- Oral Health Promotion lead</td>
<td>To make progress on all the dental health recommendations, NHS Kingston is working with the Dental Public Health Consultant to devise a plan for implementation.</td>
</tr>
<tr>
<td>42 Through targeted Oral Health Promotion interventions, reduce the level of dental decay in primary teeth measured by the dmft Index and reduce the inequalities in decay experience across Kingston, ensuring that the dental decay experienced in young children’s primary teeth is not repeated in their permanent teeth as they become older. A major component will be optimising children’s exposure to fluorides in line with ‘Choosing Better Oral Health’.</td>
<td>Oral Health Promotion Lead commissioned through Special Care Dental Services</td>
<td>An oral health promotion scheme targeted at families with three year old children, ‘Brushing for Life’, is on hold until a dental redesign has been undertaken.</td>
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<td>43 Through improved access to appropriate treatment and active individual prevention services, reduce the proportion of all children with active and untreated disease by attracting into regular dental care those with poorer oral health who are currently not accessing dental services. A particular focus needs to be on pre-school and primary school aged children.</td>
<td>Primary Care Commissioners advised by Dental Public Health and Dental Practice Advisor</td>
<td>An oral health promotion scheme targeted at families with three year old children, ‘Brushing for Life’, is on hold until a dental redesign has been undertaken. NHS Kingston has commissioned three new dental contracts since 2007 to help increase access to dentistry. NHS Kingston has run a successful advertising campaign, changing the perception of availability of NHS dentists and has commissioned above and beyond the allocations from the Department of Health.</td>
</tr>
<tr>
<td>44 Through Oral Health Promotion continue to maintain the improved levels of dental decay in older children becoming adults and provide evidence based preventative advice to reduce the incidence of oro-facial trauma and tooth surface loss.</td>
<td>Oral Health Promotion lead commissioned through Special Care Dental Services</td>
<td>NHS Kingston has provided dental practice information to patients at all local events and road shows, through other primary care providers, and partner organisations, and held a National Smile Month event.</td>
</tr>
<tr>
<td>45 Through commissioning processes ensure that the future increased specialist dental needs of adults are met locally.</td>
<td>Primary (and Secondary) Care Commissioners advised by Dental Public Health and Dental Practice Advisor</td>
<td>NHS Kingston has commissioned three new dental contracts since 2007 to help increase access to dentistry. NHS Kingston’s Professional Executive Committee (PEC) has now agreed a Dental Commissioning Strategy that will help to address the needs of this client group.</td>
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<td>46</td>
<td>Continue to develop further services for patients who require 'Special Care' Dentistry and those who suffer from phobias.</td>
<td>Primary Care Commissioners advised by Dental Public Health and Dental Practice Advisor</td>
</tr>
<tr>
<td>47</td>
<td>Improve access to NHS Dentistry.</td>
<td>Primary Care Commissioners advised by Dental Public Health and Dental Practice Advisor</td>
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**Sexual Health**

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<td>48</td>
<td>To develop, consult on, tender and launch an integrated sexual health service.</td>
<td>Sexual Health Consultant</td>
</tr>
<tr>
<td>49</td>
<td>To implement the 48-hour action plan for GUM.</td>
<td>Sexual Health programme Lead</td>
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<tr>
<td>50</td>
<td>To monitor access to contraception services.</td>
<td>Sexual Health programme Lead</td>
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<td>Lead responsibility</td>
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<td>The new long-acting reversible contraception (LARC) clinic has been monitored since September 2008 and will continue to be monitored until September 2009.</td>
</tr>
<tr>
<td>51</td>
<td>To decide the future provision of contraception services across NHS Kingston.</td>
<td>Sexual Health Programme Lead</td>
</tr>
<tr>
<td></td>
<td>Future provision of these services is influenced by progress made with the integrated sexual health service, reported on above. In addition, EHC is about to be offered consistently from community pharmacies across the borough. A wider range of LARC will be offered from GPs, KU19, Hawks Road contraception clinic, and The Point staff at The Wolverton.</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>To publicise contraception services widely.</td>
<td>Sexual Health Promotion Specialist and Sexual Health Programme Lead</td>
</tr>
<tr>
<td></td>
<td>A Sexual Health Promotion Specialist is now (17/11/08) in place and is leading on the identification of gaps in publicity of contraception services in relevant settings. Publicity developments include relaunched new Condom Distribution Scheme (September 2009), LARC clinics, EHC from community pharmacies, and Chlamydia screening cards to promote access to 15-24 year olds accessing General Practice.</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>To develop and implement an action plan to ensure the Healthcare Commission target for access to reproductive health is met.</td>
<td>Sexual Health Programme Lead</td>
</tr>
<tr>
<td></td>
<td>Long acting reversible contraception (LARC) training is offered to GPs as well as staff working at KU19, Hawks Road, and the Wolverton. Intention to include a full range of LARC to NHS Kingston women post-termination of pregnancy at the BPAS site (2009/2010).</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>To continue to implement the Teenage Pregnancy action plan.</td>
<td>Teenage Pregnancy Co-ordinator (RBK), Sexual Health Promotion Specialist and Sexual Health Programme Lead (NHS Kingston)</td>
</tr>
<tr>
<td></td>
<td>A Teenage Pregnancy Co-ordinator has been in post since February 2008. The Sexual Health Promotion Specialist is leading on the delivery of comprehensive sexual health training to School Health and RBK staff (training will run from November 2008 to April 2009). Plans are in place to develop a school based level one sexual health service as part of a general health drop-in.</td>
<td></td>
</tr>
</tbody>
</table>
The resident population of Kingston was 157,923 in mid-2007. Table 2.0 shows the estimated resident population as calculated by the Office for National Statistics (ONS). The Greater London Authority (GLA) population projections estimate that the resident population of Kingston was 152,353 in 2007. GLA population estimates, which are used later in this chapter, are usually lower than ONS estimates.

Table 2.0
The estimated resident population of Kingston, by age group and sex, 2007

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>All Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>5,057</td>
<td>4,879</td>
<td>9,936</td>
</tr>
<tr>
<td>5-9</td>
<td>4,389</td>
<td>4,331</td>
<td>8,720</td>
</tr>
<tr>
<td>10-14</td>
<td>4,142</td>
<td>4,161</td>
<td>8,303</td>
</tr>
<tr>
<td>15-19</td>
<td>4,693</td>
<td>4,837</td>
<td>9,530</td>
</tr>
<tr>
<td>20-24</td>
<td>6,450</td>
<td>6,641</td>
<td>13,091</td>
</tr>
<tr>
<td>25-29</td>
<td>6,839</td>
<td>6,571</td>
<td>13,410</td>
</tr>
<tr>
<td>30-34</td>
<td>7,508</td>
<td>6,647</td>
<td>14,155</td>
</tr>
<tr>
<td>35-39</td>
<td>7,121</td>
<td>6,408</td>
<td>13,529</td>
</tr>
<tr>
<td>40-44</td>
<td>6,466</td>
<td>6,385</td>
<td>12,851</td>
</tr>
<tr>
<td>45-49</td>
<td>5,385</td>
<td>5,179</td>
<td>10,564</td>
</tr>
<tr>
<td>50-54</td>
<td>4,368</td>
<td>4,657</td>
<td>9,025</td>
</tr>
<tr>
<td>55-59</td>
<td>4,129</td>
<td>4,512</td>
<td>8,641</td>
</tr>
<tr>
<td>60-64</td>
<td>3,507</td>
<td>3,545</td>
<td>7,052</td>
</tr>
<tr>
<td>65-69</td>
<td>2,361</td>
<td>2,510</td>
<td>4,871</td>
</tr>
<tr>
<td>70-74</td>
<td>1,965</td>
<td>2,343</td>
<td>4,308</td>
</tr>
<tr>
<td>75-79</td>
<td>1,618</td>
<td>2,190</td>
<td>3,808</td>
</tr>
<tr>
<td>80-84</td>
<td>1,129</td>
<td>1,869</td>
<td>2,998</td>
</tr>
<tr>
<td>85-89</td>
<td>672</td>
<td>1,381</td>
<td>2,053</td>
</tr>
<tr>
<td>90+</td>
<td>354</td>
<td>724</td>
<td>1,078</td>
</tr>
<tr>
<td>Total</td>
<td>78,153</td>
<td>79,770</td>
<td>157,923</td>
</tr>
</tbody>
</table>

Source: ONS, Mid-Year Population Estimates, 2007
The Population of Kingston

Figure 2.0 shows that the number of men and women under 75 years of age is roughly balanced. Women outnumber men in the over 75 year old population, reflecting their longer life expectancy.

**Figure 2.0** Estimated age structure of Kingston’s resident population, 2007

Between 2006 and 2007, the estimated resident population of Kingston grew by 1.3% (2,006 people) from 155,917 in mid-2006 to 157,923 in mid-2007. The proportion of children aged 0-14 grew by 2.2% (585). The proportion of 15-24 year olds grew by 1.7% (377) and the proportion of adults aged 25-64 years and 85 years and over grew by 1.2% (1,017) and 3.3% (100) respectively. In contrast, the proportion of people aged 65-84 decreased by 0.5% (73) (Table 2.1).

Between 2006 and 2007, the Kingston population grew by a much larger proportion (1.3%) compared to London (0.6%). The rise in children aged under 15 years was much greater in Kingston (2.2%) compared to London (0.8%). In both Kingston and London, the 65-84 year old age group contracted.
The Population of Kingston

Table 2.1 Number and percentage change in the resident population of Kingston between 2006 and 2007, compared to London.

<table>
<thead>
<tr>
<th></th>
<th>Under 15</th>
<th>15-24</th>
<th>25-64</th>
<th>65-84</th>
<th>85+</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston 2006</td>
<td>26,374</td>
<td>22,244</td>
<td>88,210</td>
<td>16,058</td>
<td>3,031</td>
<td>155,917</td>
</tr>
<tr>
<td>Kingston 2007</td>
<td>26,959</td>
<td>22,621</td>
<td>89,227</td>
<td>15,985</td>
<td>3,131</td>
<td>157,923</td>
</tr>
<tr>
<td>Change</td>
<td>585</td>
<td>377</td>
<td>1,017</td>
<td>-73</td>
<td>100</td>
<td>2,006</td>
</tr>
<tr>
<td>Kingston % change</td>
<td>2.2%</td>
<td>1.7%</td>
<td>1.2%</td>
<td>-0.5%</td>
<td>3.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>London % change</td>
<td>0.8%</td>
<td>1.0%</td>
<td>0.6%</td>
<td>-0.7%</td>
<td>3.7%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

Source: ONS, Mid-Year Population Estimates, 2007

Over the six-year period between 2007 and 2013 both Kingston and London resident populations are predicted to grow. The growth rate in Kingston’s population (2.7%, 4,626) is expected to be lower than that of London’s population (4.6%, 342,798) (Table 2.2).

In Kingston, between 2007 and 2013, the number of people in most age groups is expected to increase. It is important to note that although the population estimates for Kingston during 2006 and 2007 show that the proportion of people in the 65-84 age group is declining (Table 2.1), the longer-term estimate predicts a 7.2% rise in this age group between 2007 and 2013 (Table 2.2). Whilst the estimates in Table 2.2 indicate that the over 85’s population may stabilise, other estimates show this age group will continuously grow. The increasing numbers of older people will have a large impact on local health and social care services if proved to be accurate.

Similarly, across London, between 2007 and 2013, most age groups are expected to increase, except for the 15-24 age group which is expected to decrease by 0.2% (Table 2.2).

Table 2.2 Predicted change in the populations of Kingston and London between 2007 and 2013

<table>
<thead>
<tr>
<th></th>
<th>Under 15</th>
<th>15-24</th>
<th>25-64</th>
<th>65-84</th>
<th>85+</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston</td>
<td>2.8%</td>
<td>0.3%</td>
<td>2.5%</td>
<td>7.2%</td>
<td>0.0%</td>
<td>2.7%</td>
</tr>
<tr>
<td>London</td>
<td>5.5%</td>
<td>-0.2%</td>
<td>5.5%</td>
<td>2.5%</td>
<td>8.4%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

Source: © GLA 2007 Round Population Projections (Low)
The Ethnic Population of Kingston

The latest ethnic population projections published by the Greater London Authority (GLA) show that the largest ethnic category in Kingston is 'Other Ethnic Groups' followed by 'Indian' and 'Other Asian' communities. Table 2.3 shows the estimated ethnic composition of the population of Kingston in 2007, 2013 and 2026.

According to these estimates, the population of Kingston (all ethnic groups) is expected to grow by 2.7% between 2007 and 2013 and 4.4% between 2007 and 2026. The proportion of White people is expected to decline by 1.2% between 2007 and 2013 and by 3.9% between 2007 and 2026. The proportions of all other ethnic groups are expected to increase over time with the largest increase shown between 2007 and 2026 by the small 'Bangladeshi' community (58.6%), followed by the 'Chinese' community (53.9%) and by the 'Other Ethnic Groups' which is expected to grow by 48.5% (Tables 2.3 and 2.4 and Figures 2.1, 2.2 and 2.3).

Kingston has a large Korean population that reside mainly in New Malden. However, it is difficult to estimate the size of this population as it is not separately identified by the ethnicity definitions used in the census. It is likely that they will form part of the 'Other Asians' and 'Others' ethnic categories.

Table 2.3
The estimated ethnic composition of the population of Kingston in 2007, 2013 and 2026

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>2007</th>
<th>2013</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ethnic Groups</td>
<td>152,353</td>
<td>156,481</td>
<td>159,085</td>
</tr>
<tr>
<td>White</td>
<td>120,999</td>
<td>119,577</td>
<td>116,272</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1,000</td>
<td>1,182</td>
<td>1,353</td>
</tr>
<tr>
<td>Black African</td>
<td>1,979</td>
<td>2,386</td>
<td>2,720</td>
</tr>
<tr>
<td>Black Other</td>
<td>1,267</td>
<td>1,382</td>
<td>1,453</td>
</tr>
<tr>
<td>Indian</td>
<td>6,673</td>
<td>7,607</td>
<td>8,710</td>
</tr>
<tr>
<td>Pakistani</td>
<td>2,458</td>
<td>2,836</td>
<td>3,139</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>498</td>
<td>617</td>
<td>790</td>
</tr>
<tr>
<td>Chinese</td>
<td>2,753</td>
<td>3,370</td>
<td>4,238</td>
</tr>
<tr>
<td>Other Asian</td>
<td>6,313</td>
<td>7,079</td>
<td>7,916</td>
</tr>
<tr>
<td>Others</td>
<td>8,414</td>
<td>10,445</td>
<td>12,494</td>
</tr>
</tbody>
</table>

Source: © GLA 2007 Round Ethnic Group Projections (Low)
Table 2.4
Projected change in the ethnic groups of the population of Kingston, 2007, 2013 and 2026

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>2007 - 2013 Difference</th>
<th>% change</th>
<th>2007 - 2026 Difference</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ethnic Groups</td>
<td>4,128</td>
<td>2.7%</td>
<td>6,732</td>
<td>4.4%</td>
</tr>
<tr>
<td>White</td>
<td>-1,421</td>
<td>-1.2%</td>
<td>-4,727</td>
<td>-3.9%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>182</td>
<td>18.2%</td>
<td>354</td>
<td>35.4%</td>
</tr>
<tr>
<td>Black African</td>
<td>407</td>
<td>20.5%</td>
<td>741</td>
<td>37.4%</td>
</tr>
<tr>
<td>Black Other</td>
<td>116</td>
<td>9.1%</td>
<td>186</td>
<td>14.7%</td>
</tr>
<tr>
<td>Indian</td>
<td>934</td>
<td>14.0%</td>
<td>2,037</td>
<td>30.5%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>378</td>
<td>15.4%</td>
<td>682</td>
<td>27.7%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>119</td>
<td>23.9%</td>
<td>292</td>
<td>58.6%</td>
</tr>
<tr>
<td>Chinese</td>
<td>617</td>
<td>22.4%</td>
<td>1,485</td>
<td>53.9%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>766</td>
<td>12.1%</td>
<td>1,603</td>
<td>25.4%</td>
</tr>
<tr>
<td>Others</td>
<td>2,031</td>
<td>24.1%</td>
<td>4,080</td>
<td>48.5%</td>
</tr>
</tbody>
</table>

Source: © GLA 2007 Round Ethnic Group Projections (Low)

Figure 2.1 Projected change in the population of Kingston, by ethnic group 2007 to 2013

Source: © GLA 2007 Round Ethnic Group Projections (Low)
The Population of Kingston

Figure 2.2 Projected change in the population of Kingston, by ethnic group, 2007 - 2026

Figure 2.3 Projected growth (numbers) in the Kingston population, by ethnic group 2007 to 2026. White ethnic group not shown.

Source: © GLA 2007 Round Ethnic Group Projections (Low)
The Electoral Ward Populations of Kingston

Figures 2.4 and 2.5 show the projected change in the electoral ward populations of Kingston, and indicates that the populations of the majority of electoral wards are expected to grow over the next 20 years.

Over the six-year period between 2007 & 2013, the highest population growth is estimated in Grove (17.3%), Tolworth & Hook Rise (8.8%), Norbiton (5.2%) and Canbury (5.2%) while the largest population decline is expected to be in Chessington North & Hook (0.3%), Chessington South (0.1%) and Coombe Vale (0.1%) (Figure 2.4).

Over the 20-year period from 2007 to 2026, the highest population growth is expected to be in Norbiton (29%), Chessington South (23.4%) and Tolworth & Hook Rise (18.4%). The largest population contraction is expected in Grove (14.4%), St Mark’s (9.8%) and Coombe Hill (7.1%) (Figure 2.5).

It is important to be aware that because electoral ward populations are small, unforeseen factors can disproportionately affect their size. This makes long term predictions imprecise, and such uncertainty must be taken into account in the local planning process.

Figure 2.4 Projected changes in the electoral ward populations over six years from 2007 to 2013

Source: © GLA 2007 Round Ward Population Projections (Low)
General Practice Registered Population in Kingston

A total of 189,789 people were registered with Kingston general practices in March 2009 (Table 2.5 and Figure 2.6). More men, compared to women, are registered with a GP between birth to 14 years of age and 30 to 69 years of age, whilst women outnumber men between 15 to 30 years of age and 70 years and over.

The registered population is more than 20% greater than the resident population. It is therefore very important to be aware of which population estimate is being used when services are being planned, especially given that NHS Kingston is responsible for the registered, rather than resident, population.

Comparison of the registered GP population with that of the resident population of Kingston shows that people from all age groups are joining Kingston practices from other boroughs but the highest difference is among men aged 30 to 64 and among women 20 to 49 years of age (Table 2.5).
Table 2.5 Comparison of estimated resident population (2007) and GP registered population (31st March 2009)

<table>
<thead>
<tr>
<th>Age</th>
<th>Resident</th>
<th>Male</th>
<th>Registered</th>
<th>Difference</th>
<th>Resident</th>
<th>Female</th>
<th>Registered</th>
<th>Difference</th>
<th>Resident</th>
<th>Registered</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>5,057</td>
<td>5,869</td>
<td>812</td>
<td></td>
<td>4,879</td>
<td>5,705</td>
<td>826</td>
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<td>9,936</td>
<td>11,574</td>
<td>1,638</td>
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<td>5-9</td>
<td>4,389</td>
<td>5,116</td>
<td>727</td>
<td></td>
<td>4,331</td>
<td>4,981</td>
<td>650</td>
<td></td>
<td>8,720</td>
<td>10,097</td>
<td>1,377</td>
</tr>
<tr>
<td>10-14</td>
<td>4,142</td>
<td>5,153</td>
<td>1,011</td>
<td></td>
<td>4,161</td>
<td>5,021</td>
<td>860</td>
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<td>8,303</td>
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<td>15-19</td>
<td>4,693</td>
<td>5,548</td>
<td>855</td>
<td></td>
<td>4,837</td>
<td>5,767</td>
<td>930</td>
<td></td>
<td>9,530</td>
<td>11,315</td>
<td>1,785</td>
</tr>
<tr>
<td>20-24</td>
<td>6,450</td>
<td>7,100</td>
<td>650</td>
<td></td>
<td>6,641</td>
<td>8,191</td>
<td>1,550</td>
<td></td>
<td>13,091</td>
<td>15,291</td>
<td>2,200</td>
</tr>
<tr>
<td>25-29</td>
<td>6,839</td>
<td>7,497</td>
<td>658</td>
<td></td>
<td>6,571</td>
<td>8,010</td>
<td>1,439</td>
<td></td>
<td>13,410</td>
<td>15,507</td>
<td>2,097</td>
</tr>
<tr>
<td>30-34</td>
<td>7,508</td>
<td>8,923</td>
<td>1,415</td>
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<td>6,647</td>
<td>8,291</td>
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<td>14,155</td>
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<td>35-39</td>
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<td>2,096</td>
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<td>7,989</td>
<td>1,581</td>
<td></td>
<td>13,529</td>
<td>17,206</td>
<td>3,677</td>
</tr>
<tr>
<td>40-44</td>
<td>6,466</td>
<td>8,601</td>
<td>2,135</td>
<td></td>
<td>6,385</td>
<td>7,159</td>
<td>774</td>
<td></td>
<td>12,851</td>
<td>15,760</td>
<td>2,909</td>
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<tr>
<td>45-49</td>
<td>5,385</td>
<td>7,148</td>
<td>1,763</td>
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<td>5,179</td>
<td>6,370</td>
<td>1,191</td>
<td></td>
<td>10,564</td>
<td>13,518</td>
<td>2,954</td>
</tr>
<tr>
<td>50-54</td>
<td>4,368</td>
<td>5,771</td>
<td>1,403</td>
<td></td>
<td>4,657</td>
<td>5,174</td>
<td>517</td>
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<td>9,025</td>
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<td>1,920</td>
</tr>
<tr>
<td>55-59</td>
<td>4,129</td>
<td>5,106</td>
<td>977</td>
<td></td>
<td>4,512</td>
<td>4,569</td>
<td>57</td>
<td></td>
<td>8,641</td>
<td>9,675</td>
<td>1,034</td>
</tr>
<tr>
<td>60-64</td>
<td>3,507</td>
<td>4,649</td>
<td>1,142</td>
<td></td>
<td>3,545</td>
<td>4,403</td>
<td>858</td>
<td></td>
<td>7,052</td>
<td>9,052</td>
<td>2,000</td>
</tr>
<tr>
<td>65-69</td>
<td>2,361</td>
<td>3,189</td>
<td>828</td>
<td></td>
<td>2,510</td>
<td>3,042</td>
<td>532</td>
<td></td>
<td>4,871</td>
<td>6,231</td>
<td>1,360</td>
</tr>
<tr>
<td>70-74</td>
<td>1,965</td>
<td>2,369</td>
<td>404</td>
<td></td>
<td>2,343</td>
<td>2,671</td>
<td>328</td>
<td></td>
<td>4,308</td>
<td>5,040</td>
<td>732</td>
</tr>
<tr>
<td>75-79</td>
<td>1,618</td>
<td>1,933</td>
<td>315</td>
<td></td>
<td>2,190</td>
<td>2,409</td>
<td>219</td>
<td></td>
<td>3,808</td>
<td>4,342</td>
<td>534</td>
</tr>
<tr>
<td>80-84</td>
<td>1,129</td>
<td>1,305</td>
<td>176</td>
<td></td>
<td>1,869</td>
<td>2,029</td>
<td>160</td>
<td></td>
<td>2,998</td>
<td>3,334</td>
<td>336</td>
</tr>
<tr>
<td>85-89</td>
<td>672</td>
<td>765</td>
<td>93</td>
<td></td>
<td>1,381</td>
<td>1,601</td>
<td>220</td>
<td></td>
<td>2,053</td>
<td>2,366</td>
<td>313</td>
</tr>
<tr>
<td>90+</td>
<td>354</td>
<td>315</td>
<td>-39</td>
<td></td>
<td>724</td>
<td>833</td>
<td>109</td>
<td></td>
<td>1,078</td>
<td>1,148</td>
<td>70</td>
</tr>
<tr>
<td>Total</td>
<td>78,153</td>
<td>95,574</td>
<td>17,421</td>
<td></td>
<td>79,770</td>
<td>94,215</td>
<td>14,445</td>
<td></td>
<td>157,923</td>
<td>189,789</td>
<td>31,866</td>
</tr>
</tbody>
</table>

Source: Primary Care Support Services, March 2009
Births

There were 2,197 births in Kingston in 2007, which is 151 more births than the previous year. Accordingly, the General Fertility Rate (GFR) in 2007 was 58.6 live births per 1000 women aged 15-44 years, which is slightly higher than the GFR of 56.5 in 2006.

Low birth weight is associated with lower socio-economic status as well as smoking during pregnancy. In 2007, the percentage of live and still births less than 2,500 grams remained lower in Kingston (6.9%) than the regional and the national percentages at 7.9% & 7.5% respectively.

The Total Period Fertility Rate (TPFR) is the average number of live births that would occur per women resident in an area, if women experienced the area’s current age-specific fertility rates throughout their childbearing life span. The local TPFR rose slightly from 1.6 in 2006 to 1.7 in 2007. The regional TPFR also rose from 1.8 in 2006 to 1.9 in 2007, while the national rate remained unchanged at 1.9.

The percentage of mothers under 20 years of age decreased in Kingston from 2.6% in 2006 to 2.4% in 2007, while the percentage of mothers 40 years of age and over increased from
4.6% to 5.6%. During the same period, the London-wide percentage of mothers under 20 years of age declined from 4.2% to 4.0% and the national percentage also decreased from 6.9% to 6.5%. For women over 40 years of age the London-wide percentage increased from 4.7% in 2006 to 5.0% and the national percentage increased from 3.5% to 3.7% (Table 2.6).

**Table 2.6**
Key Birth Statistics, 2007

<table>
<thead>
<tr>
<th>Area</th>
<th>Female Population aged 15-44</th>
<th>Number of live births</th>
<th>General Fertility Rate</th>
<th>Total Period Fertility Rate</th>
<th>% Mothers under 20 Years</th>
<th>% Mothers 40 Years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston</td>
<td>37,489</td>
<td>2,197</td>
<td>58.6</td>
<td>1.7</td>
<td>2.4%</td>
<td>5.6%</td>
</tr>
<tr>
<td>London</td>
<td>1,840,073</td>
<td>125,505</td>
<td>68.2</td>
<td>1.9</td>
<td>4.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>11,127,216</td>
<td>689,771</td>
<td>62.0</td>
<td>1.9</td>
<td>6.5%</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

Source: ONS VS1 & VS2 Tables 2007 and Clinical and Health Outcomes Knowledge Base 2009

**Infant mortality**

Death rates in infants can be a useful indicator of the health of the overall population and the quality of local health services. However, caution must be exercised when interpreting these figures as rates are based on a very small number of deaths that will vary year on year.

There were five infant deaths in Kingston during 2007, a decrease of two infant deaths from 2006. This lowers the mortality rate from 3.4 to 2.3/1000 live births. Figure 2.7 shows the three year rolling average infant mortality rate for Kingston and England & Wales and indicates a declining rate of infant mortality both locally and nationally. The infant mortality rate in Kingston is lower than the rate in England and Wales.
Morbidity

Diagnoses recorded in primary care will increasingly present a more accurate picture of the level of ill health within the population. Table 2.7 shows the average prevalence of the main conditions encountered in primary care together with the number of people captured on the disease registers of Kingston’s 28 General Practices.

Prevalence is a measure of the amount of a disease in the population at a particular point in time. For comparisons with the estimated national prevalence for the conditions shown in Table 2.7 please see the 2006 Joint Annual Public Health Report (pages 121-126). It should be noted that prevalence is affected by other factors such as:

- Diagnostic practice: it is impossible to completely standardise the methods clinicians use to make diagnoses.
- Data recording: there may be variations in the completeness and accuracy of practice records.
### Table 2.7
Number of people on disease registers and prevalence of main conditions recorded in general practice, April 2009

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of people on disease register</th>
<th>Prevalence in April 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>32,684</td>
<td>17.2%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>19,531</td>
<td>10.3%</td>
</tr>
<tr>
<td>Obesity</td>
<td>11,082</td>
<td>5.8%</td>
</tr>
<tr>
<td>Depression</td>
<td>9,397</td>
<td>5.0%</td>
</tr>
<tr>
<td>Asthma</td>
<td>8,687</td>
<td>4.6%</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>6,085</td>
<td>3.2%</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>4,380</td>
<td>2.3%</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>4,101</td>
<td>2.2%</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>3,736</td>
<td>2.0%</td>
</tr>
<tr>
<td>Stroke</td>
<td>1,925</td>
<td>1.0%</td>
</tr>
<tr>
<td>Cancer</td>
<td>1,915</td>
<td>1.0%</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>1,851</td>
<td>1.0%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>1,717</td>
<td>0.9%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>1,247</td>
<td>0.7%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>849</td>
<td>0.4%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>801</td>
<td>0.4%</td>
</tr>
<tr>
<td>Dementia</td>
<td>556</td>
<td>0.3%</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>342</td>
<td>0.2%</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>120</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Source: Quality & Outcomes Framework (QOF), QMAS database - April 2009
The Population of Kingston

Life expectancy in Kingston

Life expectancy is a good measure of the overall health of the population. People in Kingston continue to have better health experience than the national average and this is reflected in their life expectancy. Table 2.8 shows the life expectancies of Kingston's men and women to be higher than the regional and national estimates. Kingston is among the 25% of local authorities and among the 15% of Primary Care Trusts with the highest life expectancy at birth (for men and women).

**Table 2.8**
Life expectancy (in years) at birth for Kingston, London and England & Wales, 2005 to 2007

<table>
<thead>
<tr>
<th>Area</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Life expectancy at birth (years)</td>
<td>Rank order</td>
</tr>
<tr>
<td>England and Wales</td>
<td>77.5</td>
<td>81.7</td>
</tr>
<tr>
<td>London</td>
<td>77.9</td>
<td>82.4</td>
</tr>
<tr>
<td>Kingston upon Thames</td>
<td>79.3</td>
<td>83.0</td>
</tr>
<tr>
<td></td>
<td>74(^1)</td>
<td>86(^1)</td>
</tr>
<tr>
<td>NHS Kingston</td>
<td>79.3</td>
<td>83.0</td>
</tr>
<tr>
<td></td>
<td>15(^1)</td>
<td>23(^1)</td>
</tr>
</tbody>
</table>

\(^1\) Rank order is the relative position of local authorities in England where 1 = highest and 352 = lowest.
\(^2\) Rank order is the relative position of PCTs in England where 1 = highest and 152 = lowest.

Mortality in Kingston

There were 1,116 deaths in Kingston in 2007. Kingston's death rates continue to be lower than the regional and national rates. The 2005-07 pooled all ages standardised mortality ratio (SMR) was 91 for Kingston, 96 for London and 100 for England and Wales. Deaths under 75 years of age are known as premature deaths. The 2005-07 pooled SMR for all causes premature deaths in Kingston was 84, while London and England and Wales SMRs were 100 and 101 respectively. The SMRs in Kingston for both men and women were 84.

Local all causes death rates have been declining steadily in line with the regional and national rates. Figures 2.8 and 2.9 demonstrate the decline in premature death rates in Kingston in comparison with regional and national rates.
Figure 2.8 Premature (deaths under 75 years) all causes mortality rates in men in Kingston, London and England and Wales, 1993 - 2007

Figure 2.9 Premature (deaths under 75 years) all causes mortality rates in women in Kingston, London and England and Wales, 1993 - 2007

Source: 2009 Clinical and Health Outcomes Knowledge Base, nww.nchod.nhs.uk
The commonest causes of death in Kingston reflect the national picture (Table 2.9). Of the 1,116 deaths that occurred in 2007:

- 372 (33.5%) were due to diseases of the circulatory system
- 288 (26%) were due to cancer
- 171 (15.4%) were due to diseases of the respiratory system
- The commonest single cause of all age deaths in men was ischaemic heart disease (16.5% in men) followed by cerebrovascular disease (mainly strokes) (7.8%) and lung cancer (6.4%).
- The largest single cause of all age deaths in women was cerebrovascular disease (mainly strokes) (12.7%) followed by ischaemic heart disease (12.5%) and pneumonia (8%).

Of the 331 people who died prematurely, the commonest causes of these deaths were:

- Among men, ischaemic heart disease (16.8%) followed by lung cancer (9.4%) and cerebrovascular disease (4.7%).
- Among women, lung cancer (11.4%) followed by ischaemic heart disease (8.6%) and breast cancer (7.9%).
### Table 2.9 Main causes of all ages and premature deaths in Kingston, 2007

<table>
<thead>
<tr>
<th>Condition</th>
<th>Male</th>
<th>% of all causes deaths</th>
<th>Female</th>
<th>% of all causes deaths</th>
<th>Male</th>
<th>% of all causes deaths</th>
<th>Female</th>
<th>% of all causes deaths</th>
<th>Male</th>
<th>% of all causes deaths</th>
<th>Female</th>
<th>% of all causes deaths</th>
<th>All deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the circulatory system (ICD10 I00-I99)</td>
<td>50</td>
<td>26.2%</td>
<td>27</td>
<td>19.3%</td>
<td>156</td>
<td>31.1%</td>
<td>216</td>
<td>35.2%</td>
<td>372</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ischaemic heart disease (ICD10 I20-I25)</td>
<td>32</td>
<td>16.8%</td>
<td>12</td>
<td>8.6%</td>
<td>83</td>
<td>16.5%</td>
<td>77</td>
<td>12.5%</td>
<td>160</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebrovascular disease (ICD10 I60-I69)</td>
<td>9</td>
<td>4.7%</td>
<td>9</td>
<td>6.4%</td>
<td>39</td>
<td>7.8%</td>
<td>78</td>
<td>12.7%</td>
<td>117</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasms (ICD10 C00-C97)</td>
<td>72</td>
<td>37.7%</td>
<td>68</td>
<td>48.6%</td>
<td>143</td>
<td>28.5%</td>
<td>145</td>
<td>23.6%</td>
<td>288</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung cancer (ICD10 C33-C34)</td>
<td>18</td>
<td>9.4%</td>
<td>16</td>
<td>11.4%</td>
<td>32</td>
<td>6.4%</td>
<td>27</td>
<td>4.4%</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast cancer (ICD10 C50)</td>
<td>0</td>
<td>0.0%</td>
<td>11</td>
<td>7.9%</td>
<td>1</td>
<td>0.2%</td>
<td>22</td>
<td>3.6%</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diseases of the respiratory system (ICD 10 J00-J99)</td>
<td>18</td>
<td>9.4%</td>
<td>14</td>
<td>10.0%</td>
<td>73</td>
<td>14.5%</td>
<td>98</td>
<td>16.0%</td>
<td>171</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia (ICD10 J12-J18)</td>
<td>5</td>
<td>2.6%</td>
<td>3</td>
<td>2.1%</td>
<td>33</td>
<td>6.6%</td>
<td>49</td>
<td>8.0%</td>
<td>82</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidents (ICD10 V01-X59)</td>
<td>7</td>
<td>3.7%</td>
<td>4</td>
<td>2.9%</td>
<td>11</td>
<td>2.2%</td>
<td>10</td>
<td>1.6%</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide and undetermined injuries (ICD10 X60-X84, Y10-Y34 exc. Y33.9)</td>
<td>5</td>
<td>2.6%</td>
<td>1</td>
<td>0.7%</td>
<td>5</td>
<td>1.0%</td>
<td>1</td>
<td>0.2%</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total of main conditions of deaths</td>
<td>152</td>
<td>79.6%</td>
<td>114</td>
<td>81.4%</td>
<td>388</td>
<td>77.3%</td>
<td>470</td>
<td>76.5%</td>
<td>858</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other conditions</td>
<td>39</td>
<td>20.4%</td>
<td>26</td>
<td>18.6%</td>
<td>114</td>
<td>22.7%</td>
<td>144</td>
<td>23.5%</td>
<td>258</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All causes</td>
<td>191</td>
<td>100.0%</td>
<td>140</td>
<td>100.0%</td>
<td>502</td>
<td>100.00%</td>
<td>614</td>
<td>100.0%</td>
<td>1116</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: ONS 2007 VS3 Tables
Coronary heart disease mortality

Coronary heart disease (CHD) accounted for 160 deaths in 2007 (14% of all deaths). 44 deaths were in people under 75 years of age (13% of all premature deaths).

CHD mortality, however, has been steadily falling both in Kingston, regionally and nationally. The SMR for premature deaths from CHD in Kingston has halved during the last 10 years, from 161 in 1996 to 79 in 2007 (Figure 2.10). A similar rate of decline was achieved in London (210 to 102) and in England & Wales (221 to 101).

Figure 2.10  Premature CHD mortality in Kingston, London and England and Wales, 1993 to 2007

Stroke mortality

Stroke accounted for 117 deaths in 2007 (10.5% of all deaths in Kingston). However only 18 of these were in people aged under 75, making up just 5% of premature deaths. This indicates that stroke mainly causes deaths in people aged 75 and over.

Stroke death rates have declined steadily in Kingston, but at a slightly lower pace than that of CHD.

During the last 10 years, premature stroke mortality in Kingston has fallen by nearly 30% from an SMR of 134 in 1996 to 97 in 2007. In London it fell from 200 to 106 and nationally from 195 to 101. (Figure 2.11).
Cancer mortality

Cancer mortality accounted for over 26% of all deaths in Kingston in 2007 (288 people). Deaths from cancer in people aged under 75 made up 42% of the total number of deaths in this age group in 2007, showing that death from cancer often affects younger people.

Overall, premature deaths from cancer declined during the last 10 years by 8% in Kingston (from an SMR of 100 in 1996 to 92 in 2007), and by 27% (126 to 92) in London and 19% nationally (125 to 101).
The Population of Kingston

Figure 2.12  Premature mortality from cancer in Kingston, London and England and Wales

Chapter 3
Housing and Health

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Introduction
The association between housing conditions and physical and mental ill health has long been recognised. The relationship is complex because the home, the neighbourhood, and wider housing policy can all affect the health of the population. Poor housing conditions often co-exist with other forms of deprivation, such as unemployment, poor education, and social isolation. The government’s priorities include improving the health of the worst off in society. One of the ways in which this can be done is by addressing housing issues.

Why is this an important public health problem?
A range of specific housing related factors are known to adversely affect health. They are:
- Housing policy issues. These include housing allocation, lack of housing (homeless people, whether without a home or housed in temporary accommodation, experience negative health effects), housing tenure, housing investment and urban planning.
- The broader social aspects of the built environment, including overcrowding, neighbourhood quality, infrastructure deprivation (such as the lack of access to health services, parks, and stores selling healthy food), neighbourhood safety and social cohesion.
- Cold and damp housing (which may be linked to fuel poverty).
- The quality of the indoor environment, including infestations, internal hazards (that increase the likelihood of accidents), noise, asbestos, carbon monoxide, lead and moulds.

Housing can affect an individual’s health whilst, conversely, health can affect an individual’s housing opportunities. Sustained experience of housing deprivation over time further increases the probability of ill health.

During a recession, as unemployment rises, some household incomes will drop. Reduced income may affect the ability to pay rent, keep up mortgage repayments, and maintain the home in a decent state. In the longer term a recession may impact on the local authority’s ability to support local housing need.

This chapter considers housing issues in the context of all these factors. There are separate chapters on Fuel Poverty (Chapter 4) and the Health Needs of Homeless People (Chapter 5).

Housing and Health

Housing tenure

Home ownership can provide a degree of security and control and, in the majority of cases, has a positive effect on people’s lives. In some circumstances though, ownership can have a negative relationship with health. Studies have found that people who experience difficulties in meeting mortgage repayments also suffer increased insecurity and poorer mental health\(^2\).

Owner occupation is the main form of housing tenure in Kingston and is increasing. In April 2007, three quarters (74.5%) of the housing stock in Kingston was owner-occupied, compared to 70% in 2001 (according to census data). Private rented housing accounts for 14.2% of the housing stock. (Figure 3.0)

**Figure 3.0** Housing tenure in Kingston, April 2007. Percentages rounded.

![Pie chart showing housing tenure in Kingston](image)

Source: Royal Borough of Kingston Housing Strategy 2007-2010

Affordability of housing in Kingston

Affordability is a measure of whether households can access and sustain the cost of private sector housing. Poor affordability can result in loss of local employees, an increase in poverty and a high number of households requiring assistance with their housing, either via social rented property or through housing benefit. This can result in a loss of mix and balance in the population within the area.

---

The 2009 Strategic Housing Market Assessment\(^3\) estimates that the shortfall of affordable housing in Kingston is 1,738 homes per year over the next 5 years.

Kingston has high house prices and private rents making it difficult for people on low or modest incomes to find housing. According to the Land Registry, the mean house price in Kingston in quarter 4 of 2008 was £328,495. This is higher than the national average of £208,310 but slightly lower than the Greater London average of £344,521. House prices vary considerably across Kingston as shown in Figure 3.1.

**Figure 3.1** Variation in property price by postcode in Kingston in Quarter 2, 2008

![Variation in property price by postcode in Kingston in Quarter 2, 2008](image)

Source: Land Registry

The costs of social-rented or private-rented properties in Kingston are shown in Table 3.0. There is a large gap between the cost of social and private rentals. Intermediate housing priced within the social rent/private rent gap could potentially be useful for a number of households in Kingston.

\(^3\) Strategic Housing Market Assessment, Fordhams on behalf of RBK, First draft April 2009
Housing and Health

Table 3.0 The monthly cost of social rented and private rented housing in Kingston upon Thames, by size of dwelling

<table>
<thead>
<tr>
<th>Bedrooms</th>
<th>Social</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Authority Rent</td>
<td>Housing Association Rent</td>
</tr>
<tr>
<td>1 bed</td>
<td>£329</td>
<td>£338</td>
</tr>
<tr>
<td>2 bed</td>
<td>£377</td>
<td>£381</td>
</tr>
<tr>
<td>3 bed</td>
<td>£399</td>
<td>£446</td>
</tr>
<tr>
<td>4 bed</td>
<td>£420</td>
<td>£511</td>
</tr>
</tbody>
</table>

Source: Social housing data: CORE. Private Rental data: Online Letting Agents Survey. Published in Strategic Housing Market Assessment, Fordhams, 2009

An analysis of affordability of market housing in Kingston (as at January 2009) found that:

- 83.9% of lone parents would be unable to afford market housing.
- Single person households are also relatively unlikely to be able to afford to buy property.
- Households that contain two or more adults and no children are most likely to be able to afford market housing in Kingston.
- 32% of households headed by someone employed in Kingston would not be able to afford market housing within the Borough (compared to 13% of households headed by someone employed outside of Kingston). There is potential for some households employed within Kingston to be marginalised from the market, which may impact on the local economy and the population mix. (Figure 3.2)
Housing and Health

Figure 3.2 Theoretical affordability of market housing in Kingston upon Thames

Source: Fordham Research household survey 2009

Housing affordability in a recession

Affordability in a recession is affected by changes in house prices and rents, changes to the rate of building new homes, and importantly by the loss of, or reduction in, income of some households.

The local unemployment rate in Kingston (measured by Jobseekers allowance recipients as a percentage of the economically active population) was 2.2% in January 2009 (1,670). This represents a 50.5% increase in the unemployed since July 2008⁴. Norbiton ward consistently has the highest unemployment rate in the Borough (4.1%), which is close to the London average.

The volume of planning applications is decreasing, with a decline of 45% between December 2007 and December 2008. This includes those larger residential sites where social housing was due to be delivered, most significantly on the site of the Skerne Road power station.

Currently the recession is not impacting on rent arrears or applications for housing at Royal Borough of Kingston (RBK), although if it continues it is forecast to have an effect in the future.

⁴ “Local Economy Monitor” March 2009, Royal Borough of Kingston
Housing and Health

**Local Authority Housing**

The Borough has a relatively small social housing sector, with 8% of housing being council-owned and less than 4% available via registered social landlords. Social housing stock is sited both on estates and individual streets.

The number of people on the Common Housing Register (a register of people applying to rent property from the council-owned stock and from Housing Associations) continues to rise; as at 31st March 2009 it was 7,700 individuals, reflecting the local shortage of affordable housing.

Although RBK is committed to reaching targets for new homes, the lack of larger, more strategic sites capable of delivering the number of new homes required means that the private sector will increasingly be used to meet this housing need. There are currently around 700 households living in temporary accommodation in the private sector waiting for a settled home and some of these will opt to remain longer term where agreement can be reached with landlords. In the current market, with a reduced level of demand, this is achievable and provides more choice for tenants.

**Inequalities: Barriers to Housing and Services**

The inequality in access to housing and local services across Kingston is measured as part of the Index of Multiple Deprivation (IMD). The domain for ‘barriers to housing and services’ has two sub-parts: 1) the measure of wider barriers which estimates household overcrowding, the percentage of households having decisions made by the council for homeless status, and a measure of housing affordability; 2) the measure of geographical barriers which includes road distance to services such as GP surgeries, shops, schools and post offices. For full details see Appendix 1.

Figure 3.3 shows a complex picture, and should be interpreted with care. Some areas such as Chessington (including the Garrison Lane area), parts of Norbiton (including the Cambridge Road Estates), and Old Malden (including Sheeprhouse Way), are more deprived in terms of barriers to housing and services. However, areas such as Coombe Hill appear as highly deprived on the map, but this is mainly because high house prices in these areas make housing unaffordable for the majority of the population (Coombe Hill is one of the least deprived wards at multiple deprivation level).

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Inequalities: Well-being and housing issues of people living in social housing

NHS Kingston and the Royal Borough of Kingston are committed to a process of better understanding the needs of local people, and are focusing work on areas of disadvantage in the borough where people tend to suffer from poorer health, barriers to housing and services, higher levels of unemployment and higher rates of crime.

One of the areas in Kingston identified as disadvantaged is the Cambridge Road Estates and Cambridge Gardens. In 2007 residents were surveyed as part of the evaluation of a community development project that had been running on the estates for three years. The survey identified that many residents felt they had good neighbours and the community was
Housing and Health

Residents cited antisocial behaviour, particularly at night, as their main concern. Few people described dissatisfaction with repairs and maintenance of housing, but this may have been because the survey did not ask specifically about repairs.

Another area in Kingston identified as disadvantaged is York Way, Garrison Lane and Green Lane Estates in Chessington. Much of the housing in this area is rented from the Local Authority (also known as 'social housing').

A participatory needs assessment was carried out in 2008 to gather a range of views from residents. Concerns included delays or failure to carry out repairs and maintenance on rented properties, the isolation of people with disabilities, the general degradation of the area, the inability to afford rising fuel prices (fuel poverty), the allocation of council housing, and the perception that the Council spends money on entertainment and other ventures, rather than on social housing. See Box 3.0.

In order to address the housing issues raised by residents, the participatory needs assessment recommends that:

• RBK Housing Department, the Resident Participation Manager, the Neighbourhood Manager and Community Development Worker should set up a joint working review between housing department staff, the community group and representatives of tenants, to agree protocols for improved communication.
• RBK Housing Department, the Resident Participation Manager and the Neighbourhood Manager to feedback to residents on the Housing Investment Review.

In the long term, the Royal Borough of Kingston believes that one option for ensuring social housing is owned and managed by an organisation that has better access to money for repairs and maintenance, is to transfer council-owned rental properties to a Housing Association. A housing stock transfer such as this could only proceed if residents voted in favour of this process. A separate consultation with residents regarding the options for stock transfer is ongoing.

Kingston rarely qualifies for any regeneration funding, and so there is a lack of investment available for any environmental improvements. However, the Play Strategy is looking to provide or refurbish outdoor play areas in parts of Kingston, including social housing areas.
Main findings from the Participatory Needs Assessment with residents living in York Way, Garrison Lane and Green Lane Estates

**Condition of housing**

Quality of social housing was a priority for the majority of residents on the estates, and related to both maintenance and essential modernisation. These included the need for double glazing, upgrading of insulation and heating systems, asbestos removal, and repairs to guttering, door entry systems, lighting, doors, windows, garden fences and walls. There was general agreement about the need for more frequent and improved estate inspections, including inspections which take account of the specific circumstances of people with disabilities.

**Communication with the Housing Department**

Some residents would like to improve communications to and from the Housing Department. Accessibility of information about the area and services available was also raised.

**Disabled people**

In addition to the common experience of residents described above there was an added dimension of the loneliness and isolation experienced by disabled people who live in supported housing. Opportunities to engage in activities outside their homes can be extremely limited and thus their contact with the outside world is minimal.

**General degradation of the area**

Long term residents described a noticeable decline in the overall quality of housing in the area. This was considered to be the result of a build up of large and minor repairs not being attended to and the poor quality of repairs undertaken.

**Fuel poverty**

Many residents had anxieties about the rising price of fuel and this exacerbated the need for homes that are energy efficient. It was noted that residents in poorer quality housing consequently paid more to heat their homes.

**Allocation of council housing**

Some residents were unhappy with the size of their accommodation and did not feel that their needs for more space were likely to be met. Others mentioned their concerns about the allocations policy including a perceived lack of provision for young people and a perceived lack of priority to longer standing residents of the borough.
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Perception of allocation of funding

Many residents expressed beliefs that money is being spent in Kingston on large scale projects that benefit well-off residents in the borough, such as developments in central Kingston. Residents on these estates in Chessington found it hard to understand why priority is apparently given to entertainment over the necessity of decent housing. There was also a belief that some residences were improved while others were not.

Neighbourhood safety

The fear of crime can alter people’s lifestyle and affect their health. Whilst the level of crime in Kingston is relatively low, the fear of crime reported by residents is often disproportional to the actual threat/risk.

A Safer Kingston Partnership survey conducted in October 2008 concluded that residents felt the borough to be a safe place to live with relatively low levels of crime. The priority level for alcohol misuse has reduced, but was still felt to be an issue that needed addressing.

Condition (quality) of homes

Homes in good condition (decent homes) are important for the health and well-being of those living in them. Poor housing helps an area to get a bad reputation. That makes it an unpopular place to live, which in turn may lead to the breakdown of communities. The links between the condition of housing and public health are complex (Figure 3.4)
The condition of a home can be assessed against a Decent Homes Standard, which is the minimum standard that homes should meet in order to be acceptable. A decent home meets the following four criteria:

- It meets the current statutory minimum standard for housing.
- It is in a reasonable state of repair.
- It has reasonably modern facilities and services.
- It provides a reasonable degree of thermal comfort.

Since 2006, local authorities have used a tool called the Housing Health and Safety Rating System (HHSRS) to assess the fitness of homes (Box 3.1).

Note: Progress along the arrows is not inevitable. XCOLD = excess cold.
Source: Good Housing Leads to Good Health: A toolkit for environmental health practitioners. Chartered Institute of Environmental Health and Building Research Establishment

6 Chartered Institute of Environmental Health (2008) Good Housing Leads to Good Health: A toolkit for environmental health practitioners. www.cieh.org
Box 3.1

The Housing Health and Safety Rating System (HHSRS)

The HHSRS has been developed to identify and evaluate the potential risks to health and safety from deficiencies identified in dwellings. A home can be assessed for each of 29 hazards, but the most common hazards are

- Damp and mould growth
- Excess cold
- Crowding and space
- Entry by intruders
- Falling on level surfaces
- Falling on stairs

Fire safety is also included in the HHSRS. Radon is not a hazard in Kingston.

A dwelling is given a rating for each of the potential 29 hazards based on the risk it poses to the occupant. Scores fit into 10 bands, and those that fall in the worst 3 bands are called category 1 hazards. A judgement is made on the likelihood of an occurrence over the next twelve months which could result in harm to a member of the relevant vulnerable group e.g. the vulnerable group for excess cold is all persons 65 years and over. The Council has a duty to take action when a category 1 hazard is found, and has the power to act against a category 2 hazard.

A study by the Building Research Establishment found that in Kingston:

- 43% of private sector homes (24,078) failed the decent homes standard against at least one element. This was 7% worse than the national average of 36% failure.
- 23% (13,122) had a category 1 hazard under the HHSRS (Box 3.1)
- 32% of council-owned homes do not meet the Decent Home standard

Local action on decent homes

The overall aim of the Royal Borough of Kingston (RBK) is to improve the condition of property of all tenures in the borough.

Most people in Kingston live in the private sector and most of these people are well housed. However, a substantial minority live in unsatisfactory conditions and many people find it difficult to maintain their home. Substantial investment is needed in private sector homes in the borough. The overall strategy is to reduce the number of non-decent homes, particularly
those occupied by vulnerable people, with a focus on energy efficiency, fuel poverty and bringing empty homes back in to use.

Around 32% of council-owned homes do not meet the Decent Homes standard and the Council is faced with a critical lack of investment available to improve these properties. There have been many improvements in the areas of energy efficiency, gas, electrical and heating installations. However, major investment needs remain including bathroom and kitchen modernisation, window improvements and increased security measures. RBK is currently exploring options to address this investment need.

In Kingston help to improve the quality and safety of homes is offered in the form of

- Home repair grants
- Schemes such as 'Houseproud' - that can release equity to the asset rich-cash poor to improve their homes
- Disabled Facilities Grants
- Coldbuster Grants
- Empty Property Grants.

**Savings to the NHS if housing repair and remedial work is carried out**

The costs of repair work to housing compared to the costs to the NHS of the harm caused, has been modelled by the Buildings Research Establishment (Table 3.1).

The most cost effective interventions, in terms of savings to the NHS if harm is prevented by remedial work on a dwelling, are those to address excess cold (see Fuel Poverty, Chapter 4) and falls in the home (see later in this chapter).

This model is a useful tool for estimating the impact of housing improvements on health, and is a useful way of setting out potential reduction in ill health and cost savings to the NHS in business cases.
Housing and Health

Table 3.1 Estimated number of hazards in private dwellings in Kingston, with the cost of repairs and cost savings to the NHS

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Expected number of harms</th>
<th>Cost of remedial works</th>
<th>Annual cost to NHS</th>
<th>Ratio of remedial work to NHS annual cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Damp</td>
<td>100</td>
<td>£1,107,500</td>
<td>£43,900</td>
<td>25.23</td>
</tr>
<tr>
<td>Excess cold</td>
<td>175</td>
<td>£873,775</td>
<td>£2,974,400</td>
<td>0.29</td>
</tr>
<tr>
<td>Crowding</td>
<td>10</td>
<td>£165,230</td>
<td>£124,900</td>
<td>1.32</td>
</tr>
<tr>
<td>Entry by intruders</td>
<td>1,754</td>
<td>£1,834,684</td>
<td>£778,600</td>
<td>2.36</td>
</tr>
<tr>
<td>Falling on level surfaces</td>
<td>311</td>
<td>£119,766</td>
<td>£786,700</td>
<td>0.15</td>
</tr>
<tr>
<td>Falling on stairs</td>
<td>175</td>
<td>£59,150</td>
<td>£429,600</td>
<td>0.14</td>
</tr>
</tbody>
</table>

Note: These estimates are based on UK averages and actual incidence of harm relating to each hazard. The associated costs to NHS and cost of remedial work may vary from these estimates. Further work to refine these estimates is recommended. Based on 56,140 private dwellings in the borough. Ratios> 1 need more than one year for payback.

Source of model: HHSRS cost calculator7 Buildings Research Establishment

Individual hazards in the home

There are a number of individual hazards in the home that can have a negative impact on health. They are:

- Overcrowding
- Cold and damp (please see Fuel Poverty Chapter 4)
- Indoor pollutants and infestations
- Accidents in children and young people
- Falls in older people
- Fires

There are no significant problems with indoor pollutants and infestations in Kingston, and so these are not covered in this chapter.

Overcrowding

Overcrowding is where the number of persons sleeping in the dwelling contravenes the specified bedroom standard or the specified space standard. It takes into account the number of people living at the dwelling, as well as their ages and gender.

Overcrowding is associated with poorer mental health. Flat dwelling is associated with social isolation, crime, reduced privacy and fewer opportunities for safe play for children8. Houses of multiple occupation (HMO) are defined as dwellings or converted residential buildings

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7 Housing Health and Safety Rating System Cost calculator (HHSRS) http://www.cieh.org/policy/good_housing_good_health.html

58 Health Begins at Home
which are occupied by persons who do not form a single household. Evidence suggests that those living in HMO are four times more likely to suffer injury and twice as likely to die in a fire as those in single dwellings\(^9\). Overcrowding can affect children and young people in a number of ways, for example making it difficult to complete their homework. Overcrowding is also thought to increase vulnerability to infections such as TB and gastrointestinal illnesses.

Overcrowding is a problem in both the private and public sector housing in Kingston. In the social housing sector of Kingston 1,058 households were registered as 'overcrowded' on the common housing register at 1st April 2008.

In Kingston, to overcome the effects of overcrowding, and because the supply of affordable homes is unable to match the demand, a number of initiatives are being used. They include:

- The promotion of incentives to households under-occupying their accommodation to help them to re-house in more suitably sized homes, releasing their larger properties into the local market.
- A preferred dwelling mix for new developments which includes 42% of new dwellings having 3 or more bedrooms
- Extension of existing homes
- An innovative ‘Breathing Space’ scheme which uses large private sector properties as an interim measure for some council tenants and families, while they bid for permanent social housing. Thirty-six tenants were re-housed in this way during the first period, to 31st December 2008.
- A home-visiting Mitigation and Well-Being Officer who offers creative solutions for changes to the home and people’s lifestyles which allows families to remain within their current home.
- The possibility of the Council acquiring private sector dwellings on the open market being considered.

Accidents at home in children and young adults

Each year 4,000 people die in the UK following an injury at home and about one million children and young people under 25 years old attend Accident and Emergency departments as a result of an injury at home\(^{10}\).

Home visits to parents in disadvantaged socioeconomic areas to give advice on home hazards, together with campaigns, has been shown to be effective in making parents change physical aspects of houses to make them safer. There is also evidence that free or discounted home safety equipment e.g. window guards, leads to behavioural change which may reduce accidents.

\(^{10}\) BMA (2003) Housing and Health Building the future. London: British Medical Association
Housing and Health

In Kingston there are some initiatives which contribute to reducing childhood accidents in the home, although there are also some gaps. Locally:

- Home Repair Grants are provided via RBK, subject to an assessment under the Housing Health & Safety Rating System.
- Health visitors provide advice on home safety when visiting parents of newborn children, and in particular at the one year* review. A review in 2007\(^\text{11}\) found that this advice was not offered consistently across the borough. There is no systematic process for offering this to families with older children.
- There is currently no safety equipment loan scheme or discount scheme available. This could be provided through the RBK Handyperson Scheme, or as a new service.

Falls at home in older people

There are approximately 1,500 deaths a year in the UK, in people aged over 65 years following a fall in the home\(^\text{12}\).

Removing and repairing trip and fall hazards such as torn carpets and dangerous stairs is effective in reducing falls. The effect is strongest for people with a history of falling (prior to safety improvements to their home), and for men aged 75 years or over\(^\text{13}\).

Taking action to reduce falls in the home is cost effective for the NHS. For every £10 spent on reducing trip and fall hazards in the home, £60 is saved by the NHS not needing to treat older people who have fallen (See Table 3.1 for potential savings).

In Kingston there are some initiatives which contribute to reducing falls at home, although there are also significant gaps.

Locally:

- Social Services provide a Handyperson Scheme that can carry out repairs.
- An enhanced and expanded falls prevention service is needed. Funding has been now received to review the falls care pathway in 2009 and prepare a detailed plan for future local falls care and prevention. The review will include looking at the use of validated home fall hazard assessments in Kingston. In 2010 it is planned that a dedicated Falls Coordinator for Kingston will be appointed to oversee and coordinate the Kingston Falls Service, including coordinating specialist falls management training for staff.
- Some sheltered housing for older people provided by RBK requires modernisation, which would reduce trip and fall hazards.

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* The 8 month check carried out by health visitors has been replaced by the one-year review
Fires in the home

Domestic fires are more prevalent in areas of low income, in households with children and in households in which adults smoke. Those living in houses of multiple occupation and temporary accommodation are also at higher risk of injury due to fire, burns or scalds\textsuperscript{14}.

Research has shown that providing free smoke alarms (with or without installation) may be effective in reducing fire-related injury\textsuperscript{14}. It is not known if community-based injury or burn education programmes are effective.

Locally:

- The London Fire Brigade provides home safety visiting to vulnerable people.
- The London Fire Brigade promotes fire safety to members of the public.
- RBK has a policy to install hard wired smoke/heat detectors to all social housing stock. As an interim measure a partnership agreement is in place whereby Kingston Fire Service (KFS) trains RBK contractors to assess those properties requiring a smoke detector. KFS provide smoke detectors where needed.
- RBK ensures that large houses in multiple-occupation meet fire safety standards, via the enforcement of licensing provisions under the Housing Act 2004.

Housing and Health

Recommendations

1. The Royal Borough of Kingston (RBK), NHS Kingston and partners should work together to mitigate the effects of the recession on local housing needs and housing-related ill health.

2. RBK and NHS Kingston should improve data-sharing on housing and health, through the Joint Public Health Information Team.

3. RBK Housing Department, the Resident Participation Manager and Neighbourhood Manager should set up a joint working review between housing department staff, the community group and representatives of tenants in the York Way, Garrison Lane and Green Lane area of Chessington. They should agree protocols for improved communication.

4. RBK Housing Department, Resident Participation Manager and Neighbourhood Manager should feedback the findings of the Housing Investment Review to residents in the York Way, Garrison Lane and Green Lane area of Chessington.

5. Further participatory needs assessments in Kingston should take account of housing issues and should be fed back to the Housing Department at RBK.

6. NHS Kingston should support the RBK Play Strategy which includes providing or refurbishing outdoor play areas in parts of Kingston, including in some social housing areas.

7. RBK should continue with its strategy to reduce the number of non-decent homes, particularly those occupied by vulnerable people, with a focus on energy efficiency, fuel poverty and bringing empty homes back in to use.

8. RBK should continue to explore ways to meet the major investment needs for social housing, in particular bathroom, kitchen modernisation, windows and increased security measures.

9. The Building Research Establishment calculator, for estimating the impact of housing improvements on cost savings for the NHS, should be provided as evidence for business cases.

10. NHS Kingston and RBK should explore effective ways of spending budgets on interventions to improve the quality of people’s homes, in particular in relation to falls and excess cold.

11. NHS Kingston and RBK should put in place an enhanced and expanded falls prevention service which incorporates validated home falls hazard assessments.

12. The local health visiting service, in partnership with others, should work towards offering advice on home safety to all parents and carers of children living in all areas of the borough.

13. The provision of a children’s safety equipment loan scheme should be explored, either through an existing channel such as the RBK Handyperson loan scheme, or as a new service.
**Chapter 4**

**Fuel Poverty**

Laura MacLehose, Specialty Registrar in Public Health, Acting Healthier Communities Manager, NHS Kingston / Royal Borough of Kingston (laura.maclehose@kpct.nhs.uk)

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**Introduction**

A household is said to be in ‘fuel poverty’ if it needs to spend more than 10% of its income on fuel (including heating, hot water, lighting and cooking) to maintain a ‘satisfactory’ heat in the home\(^1\). Satisfactory heat is defined as 21 degrees centigrade for the main living area and 18 degrees centigrade for any other occupied rooms. Households in fuel poverty face the stark choices of spending their resources on basics such as food and clothing, or heating their homes.

A cold home has been shown to be linked to excess deaths in winter, particularly from heart attacks, strokes, respiratory infections and falls. In Kingston just over 8% of private households, or about 4,200 dwellings, are thought to be in fuel poverty\(^2\).

**Causes of fuel poverty**

There are three main factors that can influence whether a household may suffer fuel poverty:

1. the energy efficiency status of the property
2. the cost of energy
3. household income.

In addition, two other factors play a role:

4. energy using behaviour, for example, correctly using the boiler
5. extended need for warmth, for example, if someone is confined to the home due to illness, disability or age.

**Energy efficiency**

The energy status or energy efficiency of a property is determined by a measure called the ‘Standard Assessment Procedure’ or SAP (Box 4.0)

**Box 4.0**

<table>
<thead>
<tr>
<th><strong>SAP Scores</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A Standard Assessment Procedure or SAP measures the energy efficiency of a building. Factors such as double glazing, insulation and an efficient boiler all increase a building’s energy efficiency. Under the 2001 methodology, a SAP score of 1 is the worst while a score of over 100 means that a building produces more energy than it needs (for example, by a wind turbine or solar panels). A home with a SAP score of 65 is considered to be energy efficient. SAP scores can be used to help determine where investments for improvements may be made.</td>
</tr>
</tbody>
</table>

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\(^2\) Building Research Establishment (BRE) estimates produced on behalf of RBK. June 2008.
Fuel Poverty

In 2007, the average SAP score for all English housing stock was 50\(^3\). As building regulations have focused more on energy efficiency, so the SAP scores have improved\(^4\). The lower the SAP or energy efficiency score, the more a building costs to heat. While newer buildings show encouraging improvements in energy efficiency, the low energy efficiency of average housing shows that there is much need for further measures in some of the older housing. On a low income, it may be impossible to adequately keep an energy inefficient house warm enough for good health. Table 4.0 shows the typical energy efficiency of houses built in the UK over different decades.

Table 4.0 Energy efficiency of homes in the UK, by age of building

<table>
<thead>
<tr>
<th>Dwelling age</th>
<th>Typical construction</th>
<th>Average SAP rating</th>
<th>% of total housing stock*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-1919</td>
<td>Workers’ cottages, brick built, slate/tile roof, rarely with cavity</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>1919-1944</td>
<td>Standard designs started to emerge, cavities became common in the 1930s, some local attempts at planning regulations (local building codes)</td>
<td>43</td>
<td>58%</td>
</tr>
<tr>
<td>1945-1964</td>
<td>Post-war building boom, prefab housing, local authorities set spatial and health standards, cavities now predominant</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>1965-1980</td>
<td>First attempts by central government to control building regulations, first thermal regulations</td>
<td>51</td>
<td>23%</td>
</tr>
<tr>
<td>Post-1980</td>
<td>Building Regulations now continually reviewed and improved, tightening thermal, acoustic and health and safety standards</td>
<td>61</td>
<td>19%</td>
</tr>
<tr>
<td>The future?</td>
<td>Energy Efficient Home</td>
<td>65 or higher</td>
<td></td>
</tr>
</tbody>
</table>

* in UK in 2005

Cost of energy

The cost of energy will play a role in determining how much heating a household can afford. For particular groups, such as pensioners on fixed incomes, fluctuations and increases in price can put adequate heating out of reach. Data shows that while energy prices remained fairly stable or even decreased from 1990 to around 2004, they have generally increased since then, with a large peak in mid-2008.


Household income

Household income will determine how much money is available for a home to be heated. Pensioners and people on low incomes (particularly those confined to the home throughout the day through illness or disability, people with very young children or very old people) may have to make difficult choices in deciding how income is allocated. The decreasing rates of interest on savings, which started towards the end of 2008, may directly affect the amount of income available to many pensioners in Kingston. When more than 10% of the household income is allocated to purchase of fuel to maintain a satisfactory heating regime, the household is said to be in fuel poverty.

Consequences for health

Britain has an estimated 40,000 excess winter deaths* each year. Between 2000 and 2007, in Kingston in the winter months 540 more people died than was expected. This is equivalent to around 77 people a year recorded as excess winter deaths. Studies have now shown that about 60% of these excess deaths are linked to the cold with others associated with influenza and other seasonal illnesses. Other countries with much more severe winters, such as the Scandinavian countries, have very few excess winter deaths. It has been suggested that housing in Scandinavian countries is better insulated against the cold and this may, in part, explain some of the mortality difference.

Low indoor temperatures of people’s homes are associated with increased vulnerability due to cardiovascular disease. Studies have shown that a lowering of temperature by just 1 degree can result in a rise of blood pressure of 1.3 mm Hg, increasing risk of strokes and heart attacks. Cold air also affects the normal protective function of the respiratory tract, leading to increased vulnerability to respiratory infections. Dampness in the home can increase mould growth, which can cause asthma and respiratory infections. Falls and injuries, particularly in the elderly through worsened symptoms of arthritis and decreased dexterity, are found to increase in cold homes. Increased mental health problems are also linked to cold, damp housing. Studies have shown that mental health improves when the heat inside

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* The estimated number of excess winter deaths is the difference between the number of deaths during the four winter months (December to March) and the average number of deaths during the preceding four months (August to November) and the following four months (April to July). Figures are rounded to the nearest 10.
Fuel Poverty

A home is increased by improving insulation of the building\textsuperscript{9,10}. In an extreme cold snap, people in poor housing or without adequate heating may also be at risk of hypothermia, although deaths from this are very rare in the UK.

Local issues: How much fuel poverty is there in Kingston?

Just over 8\% of Kingston households (data only includes private households), around 4,200 dwellings, were thought to be in fuel poverty in June 2008\textsuperscript{11}. There is some variation between areas within Kingston with the highest levels of fuel poverty found in Alexandra (11\%) and the lowest in Grove (5\%) (Table 4.1).

<table>
<thead>
<tr>
<th>Ward</th>
<th>SAP less than 35</th>
<th>Fuel poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandra</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Berrylands</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Beverley</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>Canbury</td>
<td>21%</td>
<td>6%</td>
</tr>
<tr>
<td>Cheshington North and Hook</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Cheshington South</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Coombe Hill</td>
<td>16%</td>
<td>6%</td>
</tr>
<tr>
<td>Coombe Vale</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Grove</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Norbiton</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Old Malden</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>St James</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>St Mark’s</td>
<td>15%</td>
<td>9%</td>
</tr>
<tr>
<td>Surbiton Hill</td>
<td>16%</td>
<td>7%</td>
</tr>
<tr>
<td>Tolworth and Hook Rise</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Tudor</td>
<td>14%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Building Research Establishment (bre) estimates produced on behalf of RBK. June 2008

\textsuperscript{9} Gilbertson J, Stevens M, Stell B, Thorogood N. Home is where the hearth is: Grant recipients’ views of England’s Home Energy Efficiency Scheme (Warm Front). Social Science and Medicine. Vol 63, Issue 4, August 2006: 946-956


\textsuperscript{11} Building Research Establishment estimates produced on behalf of RBK, June 2008
In Kingston, most fuel poverty is thought to be concentrated in the private rented households. In addition, ‘property rich-fuel poor’ type households are thought to be an issue in Kingston. Data from England as a whole shows that those suffering fuel poverty are often single person households aged over 60 years on low incomes.

Figure 4.0 shows fuel poverty estimates across west London, using a combined measure from 2001 and 2003. This measure does not take full account of social housing; nevertheless it shows that households in some more affluent parts of the borough suffer fuel poverty, probably due to a high number of property rich - fuel poor households.

Fuel poverty is not easy to measure at the population level. However, a new indicator, ‘National Indicator 187’ has been developed, which aims to estimate fuel poverty at the local area and national level. This monitors, through surveys, the proportion of households containing someone on income-related benefits that occupies a low energy efficient home.

Fuel Poverty

(a dwelling with a SAP less than 35), or occupies an energy efficient home (a dwelling of SAP of 65 or greater). All Local Authorities, including the Royal Borough of Kingston, are now required to report on fuel poverty by this measure. While not all people who suffer fuel poverty are on income related benefits, it is thought that about 60% of fuel poor households are, and therefore this indicator will capture a picture of much of the fuel poverty in England. The first surveys collecting data for this indicator were scheduled to be completed by the end of 2008.

Other sources of data include the ‘Fuel Poverty Indicator’, which used data from the 2003 English House Condition Survey (EHCS) and 2001 Census to estimate fuel poverty for different household types at the local area level. In addition, the English Housing Survey (EHS), which was launched in 2008, is a continuous national survey of housing which includes physical inspections (including energy efficiency assessments) and will provide data from 2010. This survey is commissioned by the branch of government called Communities and Local Government.

What can be done about fuel poverty?

Fuel poverty is best tackled by the joint working of councils, primary care trusts, landlords, and community groups that work with the affected populations. Central government also has a major role to play. Key interventions include:

- **Improving energy efficiency of buildings.** In the medium and long term, house building regulations need to be further tightened to ensure that new buildings take on board new developments in energy efficiency technology. In the immediate term, improvements in existing households energy efficiency can be made (including installing adequate insulation, efficient boilers and other measures).

- **Increasing income** of those in fuel poverty, for example by targeted payments for fuel, by increasing the minimum wage, increasing pensions, and by ensuring receipt of benefits.

- **Price of fuel.** Studies have shown that some poor people in the UK are paying more for their electricity and gas than the wealthy. This is because some of the big fuel suppliers charge more per fuel unit for customers paying by prepayment meters than those paying by direct debit or other measures. The poorest in the UK pay by prepayment meters more often than higher income customers. In addition, past debts to the fuel companies may also be collected through the meters. This higher fuel tariff directly increases the risk of fuel poverty in the poorest in this country. Campaign groups have called for this disparity in fuel tariffs to be abolished.

- **Information.** Educating people on how to best use energy efficiently, and how to access available grants or best fuel deals can also play a role in helping householders avoid or alleviate fuel poverty.

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Targeting these interventions appropriately is a key issue for local agencies. Although data is available on those receiving benefits, people living just above the benefits threshold in fuel inefficient accommodation may not be known to the council or health services, yet may be in great need. In Kingston, in particular, concern has been raised for the ‘property rich-fuel poor’ category, in particular, the elderly on a low pension. It is important to ensure that interventions, such as increased insulation of a house do not result in a worsening of other health risk factors (such as increased mould growth, a risk factor for asthma and other respiratory conditions, if household ventilation is restricted). The interventions can play a dual role in both reducing fuel poverty and also help the UK in its quest to meet its global carbon emission reduction obligations.

What is happening in Kingston?

The Royal Borough of Kingston has recognised the importance of addressing fuel poverty in the borough. It has joined together with a group of neighbouring and nearby London boroughs to run several schemes to try and address local fuel poverty. In addition, population groups, such as pensioners, are able to access national schemes, such as the Winter Fuel Payment (an annual payment made to households with someone aged 60 or over to help with heating costs) and the Cold Weather Payment (extra payments to people over 60 years who are receiving Pension Credit when the local weather has been very cold). The local schemes include the following:

**Coldbusters** is a scheme to provide free grants for items such as central heating, new boilers, upgrade of heating controls, cavity wall and loft insulation and draught proofing. The eligibility criteria include whether or not a household receives certain benefits and the age of the householder. The scheme is run jointly with a number of London boroughs in south-west London, including Richmond and Croydon (more information is available via telephone 0800 358 6668).

**Warmfront** is a national government-funded organisation that offers grants to make homes warmer and more energy efficient through providing grants up to the value of £3,500 (or £6,000 if oil central heating) for central heating installation and a number of other heating measures. Eligibility is determined by whether a household receives certain benefits. Tenants of social landlords are not eligible as the local authorities are directly responsible for maintaining these properties to an adequate standard. Further information is available via www.warmfront.co.uk or telephone 0800 316 2805.

**Houseproud** is a partnership scheme run by the Home Improvement Trust that provides assistance to homeowners aged 60 and over, or who are disabled, or who have a disabled person living with them. The scheme arranges loan financing for repairs, adaptations and improvements to housing in Kingston and nearby boroughs.
CEN (Creative Environmental Networks) is working with The Royal Borough of Kingston, other boroughs and NHS Kingston, to help older people and vulnerable households to access the grants available through Cold Busters and other schemes. Kingston has had a successful working partnership with CEN since 1999 and the partnership has included the operation and delivery of the Coldbusters and Home Visiting scheme. Home visiting teams from CEN provide assessments for households and help them complete the necessary paperwork to obtain grants or arrange for work to be carried out. The home visiting teams also provide education on energy saving measures directly to households and to community groups. (Box 4.1)

Box 4.1

**Case study: a CEN home visitor working in Royal Borough of Kingston and NHS Kingston**

I visited Mr H at his semi-detached two-storey Kingston home in February 2009 and found that he had no central heating, and was using only electric on-peak heaters to keep warm. Coupled with this, Mr H also had unfilled cavity walls and only two inches of loft insulation, so any warmth produced from his expensive heaters went straight out the walls and roof. Being aged over 80 and living off only a small pension he was finding the exceptionally cold winter and increased fuel prices difficult to bear. As he receives attendance allowance I informed him about the Coldbusters and Warm Front grants that could provide insulation and a central heating system for his home. Although Mr H was delighted to be put forward for cavity wall and loft insulation he had had a bad experience with a gas leak in the past which was his reason for avoiding central heating and wasn’t keen on having the system installed. Instead, I put him forward for off-peak electric storage heaters and made an application for a 15% discount on his fuel through his supplier’s social tariff which he was unaware he was eligible for. Although the measures are yet to be implemented, Mr H stands to save up to 50% of the heat loss in his home through his roof and walls (up to £435 off his current bills based on data from the Energy Saving Trust) and will save even more once his heating system is changed and his bills reduced by a further 15% through his new social tariff. Mr H said he hoped that these measures would make his home affordable to heat and give him the peace of mind to use his heating next winter.

**Other winter warmth and winter health activities.** A range of other activities are supported by NHS Kingston and other partners to help keep the local population healthy in the colder winter months. These include supporting the nationally led ‘Keep Warm Keep Well’ information campaign, providing influenza vaccinations to target groups and helping people give up smoking, to improve circulation and reduce chances of heart attacks and other conditions.
Addressing fuel poverty in Kingston will help prevent premature mortality in many older and vulnerable people. It can also improve the quality of life for currently fuel poor households. By making changes to improve household insulation and installing other energy efficiency measures, Kingston will also contribute to the global campaign for reducing carbon emissions.
Fuel Poverty

Recommendations

1. NHS Kingston and the Royal Borough of Kingston should maintain financial support for interventions shown to be effective in alleviating fuel poverty and should continue to leverage support and measures from national schemes where possible.

2. NHS Kingston and the Royal Borough of Kingston should evaluate interventions being used locally to alleviate fuel poverty.

3. The Royal Borough of Kingston should use all available data methods for identifying homes at risk of fuel poverty.

4. NHS Kingston should set up a referral network of allied health professionals (including health visitors and social services staff) to refer vulnerable householders for fuel poverty alleviation measures.

5. NHS Kingston and Royal Borough of Kingston should further develop its partnerships with community organisations to promote fuel poverty alleviation measures and encourage energy efficiency.

A CEN Home visitor gives energy efficiency advice to a south London resident during a home visit.
Chapter 5
Health needs of homeless people

Jo Carr, Public Health Lead for Homelessness, NHS Kingston (jo.carr@kpct.nhs.uk), Jane Scarlett, Consultant in Public Health, NHS Kingston (jane.scarlett@kpct.nhs.uk), Natasha Thandrayen, GP Registrar

Introduction

Although Kingston is a relatively affluent borough compared with London as a whole, there are marked pockets of deprivation with the phenomenon of ‘sofa surfing’ giving cause for concern. Sofa surfers are homeless people who live temporarily in their friend’s or relative’s houses and their numbers are very difficult to estimate. Often they live in very crowded and unsanitary conditions, which will impact on their health.

Rough sleepers are homeless people who live on the streets, and they almost always have significant health problems. The exact numbers of rough sleepers is not known because historically the numbers have been so low that the Royal Borough of Kingston has not been required to undertake formal counts.

From the local authority’s viewpoint, homeless people are categorised into those who are ‘statutorily homeless’ (i.e. are provided with temporary accommodation), those who are ‘homeless but not in priority need’, those who are intentionally homeless, and those who are not homeless.

The Royal Borough of Kingston Homelessness Review and Strategy for 2008 - 2011 includes a work plan for a Health and Homelessness Sub-Group. It is intended that this group will be reconvened in autumn 2009 in order to tackle health issues for the homeless population of Kingston highlighted by both the strategy and a recent survey1 undertaken by NHS Kingston.

Current evidence suggests that the impact of the economic downturn has not resulted in an increase in homelessness in Kingston as would be expected. This is a picture replicated across England, however most authorities consider that an increase is likely in due course given the experience of previous recessions.

Why is this an important Public Health Issue?

People who are homeless have highly specific health needs (described in detail later in this chapter), compounded by difficulties in accessing healthcare and other services. Key groups of homeless people are those with mental health problems, substance misusers, refugees and asylum seekers, and young families. Some of these factors may have a negative impact on their eligibility for housing.

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# Health needs of homeless people

## Homelessness in Kingston - Jason Carey, Homelessness Manager, RBK

The Royal Borough of Kingston (RBK) receives applications from people throughout the year requesting help for ‘homelessness’. Applicants are categorised into:

- Statutorily homeless i.e. ‘a priority’ - RBK provides temporary accommodation
- Homeless but ‘not in priority need’ - RBK and Kingston Churches Action on Homelessness (KCAH) provide housing advice and assistance
- Not homeless, or intentionally homeless

The number of applications from households for assessment as ‘homeless’ has halved from 1,212 in 2004/2005 to 625 in 2008/2009. This reduction is reflected across many parts of England and is thought to be for a combination of reasons, such as improved homelessness prevention work by councils and voluntary organisations, a preference for private sector dwellings, and a greater awareness of the scarcity of social housing leading to people deciding not to apply. Over the same time period, the percentage of households applying where RBK has accepted a duty to provide temporary accommodation has remained at around 30%. The current economic recession has not yet caused an increase in applications.

### Number of applications for statutory homeless, number accepted, and number classified as homeless but not in priority need

<table>
<thead>
<tr>
<th>Year</th>
<th>Applications</th>
<th>Statutorily homeless</th>
<th>Homeless but not in ‘priority need’</th>
<th>Not homeless, or intentionally homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004/05</td>
<td>1212</td>
<td>329</td>
<td>325</td>
<td>558</td>
</tr>
<tr>
<td>2005/06</td>
<td>1165</td>
<td>288</td>
<td>360</td>
<td>517</td>
</tr>
<tr>
<td>2006/07</td>
<td>1001</td>
<td>230</td>
<td>355</td>
<td>416</td>
</tr>
<tr>
<td>2007/08</td>
<td>944</td>
<td>207</td>
<td>265</td>
<td>472</td>
</tr>
<tr>
<td>2008/09</td>
<td>625</td>
<td>218</td>
<td>169</td>
<td>238</td>
</tr>
</tbody>
</table>

## Health as part of the assessment for housing need

The criteria applied include assessing whether someone is in priority need - this may include a decision on whether they are ‘vulnerable’. Vulnerability in this context is defined as

*A person who is less able to fend for himself than an ordinary homeless person so that injury or detriment to him will result where a less vulnerable man will be able to cope without harmful effects*.

It is important that there is a common understanding of these criteria between the council and health professionals, especially GPs. In particular, the meaning of
vulnerability in a housing application context where a person has a medical condition that can be interpreted in different ways by different people.

Drugs and alcohol use do not render someone automatically vulnerable. This means there is a group of individuals who may not qualify for temporary accommodation, and may have to rely on housing advice services.

People with mental illness being discharged from in-patient healthcare may qualify for temporary accommodation. The Mental Health and Housing Protocol has recently been re-drafted, and training put in place to remind staff about early referral to housing services to prevent delayed discharge.

Local Issues

A survey of health needs in the local homeless population was carried out using a standard questionnaire at a number of organisations that are in contact with homeless people.

The survey captured the needs of rough sleepers, sofa surfers, statutorily homeless, and others in housing need. For simplicity, the survey respondents are referred to as ‘homeless’ in this chapter, but this does not necessarily mean that they were all statutorily homeless.

A total of 113 questionnaires were completed by service users during October and November 2008. Of these:

- 76 were from Kingston Churches Action on Homelessness
- 14 from YMCA
- 9 from Eagle Chambers
- 6 from RBK Homeless Persons Unit
- 5 from Hestia housing
- 3 from Kaleidoscope

This gives a total of only 15 from statutory services.

The majority (60%) classed themselves as homeless as opposed to being in temporary accommodation (40%), although it was not possible to ascertain how many were street homeless.

Most were relatively young, with 50% aged under 30 and only 8% aged over 50.
Health needs of homeless people

Figure 5.0 Age of homeless people in Kingston


Figure 5.1 shows that the majority (62%) of those surveyed were White British, whilst 16% were of African or Caribbean ethnic origin. This is a larger proportion of African and Caribbean people than is found in the total population of Kingston.

Figure 5.1 Ethnic origin of homeless people in Kingston

Health Service Use

Ninety-one homeless people (83%) were registered with a GP practice, whilst 17% were not. Of those registered, only 41 were registered with practices within the borough of Kingston and 16 were registered outside London.

Thirty-five (34%) were registered with a dentist and 68 (69%) were not. 78% said they had no problem accessing dental care, however only 27% had seen a dentist within the last two years.

A&E attendance rates were high, with 44 people (40%) having attended A&E in the past year. Twenty-two of these (50% of those who attended, 21% of the total sample) had been admitted to hospital. Sixteen people reported that they had had difficulties on discharge from hospital. This pattern of hospital use suggests poor access to community based services, resulting in inappropriate attendance at A&E.

Medical Problems

The prevalence of medical problems was high given the young age of the population. Twenty nine percent of people reported mental health problems, which was the commonest medical problem reported. This highlights the importance of having well coordinated mental health services for this vulnerable group. Respiratory, gastro-intestinal and musculo-skeletal problems were also common.

Figure 5.2 Medical problems reported by homeless people

Health needs of homeless people

Access to Services

Over a third of homeless people reported problems with knowing how to access sexual health, smoking cessation and drug and alcohol services. A large proportion (43%) reported not knowing how to access counselling services.

Figure 5.3 Numbers of homeless people surveyed who know how to access different health services


Local Services

In addition to the survey, a mapping exercise and stakeholder analysis of local services was carried out using semi-structured interviews with service providers. This gave a complex picture of services, with varying eligibility criteria and services provided. Mapping a clear pathway through these services was not possible because of their complexity. Gaps identified included:

- Poor co-ordination of services, including both poor communication between services and a lack of understanding by individual services of the remit of other services. Particular difficulties which should be addressed include understanding between the Community Mental Health Teams (CMHTs) and Housing Services.
- No outreach mental health services for homeless people to prevent service users being lost to follow-up.
- Both statutory and voluntary housing sectors would like to see a decrease in the amount of time between referral to CMHT and the patient being seen.
- Dual diagnosis services (for people who have both mental health and substance misuse
problems) were felt to be particularly poorly co-ordinated, and there is no clear arrangement for who has lead responsibility for their care to ensure that they are not lost between services.

- Major need for improved access to counselling services, both for young people and for adults.
- Need for further training for several staff groups was raised.

**Recommendations**

**General**
1. Improvement to the coordination of services for health and homelessness is needed, with better understanding of the role of each service, scope and benefits of services available and clear referral pathways.
2. Better access to community mental health services is needed, together with better understanding of the range of mental health conditions which can be appropriately treated in primary care without recourse to the CMHT.
3. Improved training to a range of professionals is needed. This should cover the roles of all services involved with homeless people, but in particular mental health services.
4. Improved information is needed on service provision both for service users and for professionals. An accessible information resource should be provided e.g. a “Homelessness Health Pack” that contains details of clinic location and times, general advice on healthcare, health promotion, blood borne viruses and so on. This should be available at GP surgeries, hospitals including A&E and housing services so that homeless people know where to go as a first port of call.
5. Improved access to counselling services for homeless people is needed.

**Dual Diagnosis Services**
6. A review of the currently commissioned dual diagnosis service run by the Community Drug and Alcohol Team (CDAT) is needed. This service appears not to be meeting the needs identified by the survey, and vulnerable patients are falling between drug and alcohol and mental health services, despite a specific dual diagnosis service being in place.
7. Patients suffering from dual diagnosis problems need active follow-up care after discharge from hospital. Extended outreach work may be needed to ensure this can be provided.
Health needs of homeless people

Homelessness link worker
8 Consideration should be given to establishing a specific homelessness health worker role. This could include:

• Acting as a point of contact between services for homeless people and developing sustainable communication routes between services.
• Following up patients after discharge from hospital, supporting attendance at GP and outpatient appointments, following up patients on detoxification programmes and providing outreach work.
• Advocating on behalf of patients with services such as housing to confirm their current health status.
• Compiling and distributing the ‘Homelessness Health Pack’ or equivalent.
• Participating in training for those working with homeless people.

Drop-in health service
9 A drop-in health service should be piloted, to increase access to community services and so reduce the very high use of A&E. The service could also give access to health promotion services.

10 It is suggested that the pilot should run two half-day sessions per week as a pilot scheme for one year, and that uptake and success rates are monitored between months 3 and 9, with data collated for screening, referrals and ‘did not attend’ (DNA) rates. Months 9 to 12 would be used to evaluate the data and make the case, if justified by the evidence, for a permanent service.

11 If the pilot is successful, a longer term service could be part of a Local Enhanced Service at a GP practice, or based at a voluntary organisation which has clinic facilities.
Introduction

Refugees and asylum seekers have particular health needs and often experience multiple disadvantages. They are not one homogenous group, but instead are people with extraordinary experiences, from many different countries and who have diverse languages and cultures.

Most people who come to the UK as asylum seekers do so for a variety of reasons including fleeing war, ethnic cleansing, political persecution, rape or torture in their home country. A recent Home Office report concluded that the main reasons people seek asylum in the UK are their country of origin’s colonial links with Britain, the presence of family and friends, and the fact that English is a global language.
An asylum seeker only becomes a refugee when their application for asylum has been successful, following proof that they face persecution in their home country.

Definitions of refugees and asylum seekers can be found in Box 6.0. This chapter considers the needs of refugees and asylum seekers. It does not cover failed asylum seekers, economic migrants or illegal immigrants.

**Box 6.0**

A **Refugee** is someone who has successfully applied for asylum and is allowed to stay in the country having proved they would face persecution in their home country.

An **Asylum Seeker** is someone who has left their country of origin and formally applied for asylum in another country, but whose application has not been dealt with yet.

A **‘Failed’ Asylum Seeker** is someone who has been unsuccessful in their appeal for asylum and has exhausted all appeal routes.

They are not economic migrants (someone who has moved to another country to work) or illegal immigrants (someone whose entry into or presence in the country contravenes immigration laws)

This chapter will cover the following in relation to refugee and asylum work in Kingston:

- The Refugee and Asylum Seekers Needs Assessment carried out in 2008
- A conference held in March 2009 that brought stakeholders and service providers together to inform them about the needs assessment and to agree action plans
- Community development work with refugees and asylum seekers
- New management information systems for Refugee Action Kingston
- The Health and Wellbeing Centre and refugee health events

**Why this is an important Public Health Issue?**

There are approximately 2,000 refugees and asylum seekers currently being supported by Refugee Action Kingston, the only organisation in the Royal Borough of Kingston entirely devoted to supporting refugees and asylum seekers. However, there may be many more refugees who have settled in to the community who are not using this support service, and other asylum seekers who are not aware of Refugee Action Kingston or the services it offers.

Some of the traumatic experiences that refugees and asylum seekers face, and the fact that they have to resettle into a new country (often leaving friends, family, jobs and everything they know in their home country), mean that they experience health problems including depression and anxiety as well as physical health concerns. They experience multiple
problems in accessing health services, housing, education and jobs in the UK. This is due to a lack of understanding of the systems in the UK, language barriers, low income or minimal benefits, and also because many experience discrimination or racism.

Local Issues identified by a needs assessment

A needs assessment was carried out over the past year on the needs of refugees and asylum seekers in Kingston. This included a literature review highlighting some key research about the health needs of refugees nationally, mapping of existing local information, an analysis of local data, focus groups and one-to-one interviews with over 80 refugees and asylum seekers.

The needs assessment found that there are approximately 2,000 people living in 764 households who are known to Refugee Action Kingston. The main countries of origin are North Korea, Afghanistan, Iraq and Sri Lanka. In Kingston there are currently 81 unaccompanied children from 22 countries who are known to Social Services at the Royal Borough of Kingston, most children coming from Iran.

Further details from the needs assessment are available on request from Martha Earley, Equalities and Community Engagement Manager.

Six main themes emerged in the needs assessment. They were:

- Housing problems
- Problems with English language, interpreting and communication
- Difficulties getting jobs
- Experiences of discrimination
- Problems accessing health services
- Variation in accessibility of information and advice.

A summary of some of the main issues under these categories is set out below.

Housing

Over half (58%) of refugees and asylum seekers described problems and obstacles accessing housing. Of all groups, Somalis had most housing problems. Some housing needs were related to health, and others to overcrowding, the type and location of housing. Some refugees and asylum seekers described how repairs to property were not carried out by landlords. Noise disturbance was a problem for some. Some refugees and asylum seekers had difficulty understanding letters sent from the Council and others did not understand the method that was used to decide the level of an individual’s housing needs. Estate Agents were felt, in general, to treat refugees and asylum seekers on benefits poorly.
Bringing about Change for Refugees and Asylum Seekers

“My main problem is housing, I have 7 people in a 2 bedroom flat. I have been once to complain they didn’t give me an answer. My husband acts as an interpreter, but as he works he doesn’t have time to chase up [Iraqi User]”

English language, interpreting and communication
Over half of the people (53%) who took part in the focus groups stated that language was the main barrier to settling into the area and accessing services. One in seven people (14%) who took part in the focus groups described how they made their own arrangements for interpreting. There were many consequences of lack of English and poor interpreting support, often resulting in wasted appointments and inappropriate use of services. Such failings can have a life-changing impact for refugees and asylum seekers.

Difficulties in using phone-based services were due to language and cost, and prevented the forging of relationships with services such as those provided by the Council and primary care. Many of these services do not, or are not aware of how to, provide interpreting services. Language barriers often make a consultation or meeting impossible, and exacerbate the dependency on community and voluntary organisations to provide an interpreting or messaging function.

About 12% of people (10 people) described communication problems they or their children had with schools. Not being able to communicate in English prevented some parents helping their children.

A third of people (33%) complained about the paucity and rigidity of ESOL (English for Speakers of Other Languages) provision at Kingston College, and the process required in order to access this provision.

Some quotes from the interviewees on their experiences:

“I cannot communicate with my GP - I have asked for an interpreter, but they say that they haven’t got an interpreter [Afghan User]”

“I am really motivated to learn English on a full time basis, but can’t find one I can afford. Fees are £240 for courses at the college [Arabic speaking User]”
Jobs and education
A third (33%) of people described finding jobs and work as a key challenge. Many have qualifications from abroad which are not recognised in the UK. The Job Centre was not able to deal with refugees and asylum seekers who could not speak English, instead sending clients to use Refugee Action Kingston phones in order to be able to get a phone-based interpreter to help communication, even though RAK do not have capacity or facilities to provide telephones or telephone support to clients.

“My problem is with work - I am a civil engineering graduate with many years experience - here though what you do abroad it is not counted as experience and age discrimination also happens - I can’t do other manual jobs as have back problems [Iraqi User]”

Experiences of discrimination
A number of refugees and asylum seekers, particularly those who were practising Muslims, had experienced discrimination. For young people, the discrimination they faced was mostly in the form of bullying. This was compounded by the fact that there are few places to socialise and meet in Kingston.

“We have come across bullying - we have lots of Korean people [at our school] and they throw paper at you and imitate the way we talk…then sometimes they hit you and run away. My friend told the teacher but the teacher doesn’t do anything… I just tell people that I don’t want to talk to them anymore [Korean User]”

Barriers to accessing health services
Many refugees and asylum seekers did not understand how the healthcare system works. Numerous problems registering with a GP were reported. These included misunderstanding of status or documentation by reception staff, or unwillingness to take the time to use an interpreter to assist with registration. One young woman, who came as an unaccompanied asylum seeker, described difficulties registering with a GP in Kingston even with a social worker as an advocate. Just under half (43%) have registered with certain local GPs because they speak their language. Two thirds (66%) of people who were registered with GPs who spoke their own language stated that they were not happy with the service from their GP.

“When I changed GPs it was very difficult for them to accept me - they asked me if I had refugee status, proof of address, I already had registered with two GPs and they made it very difficult. Why this GP say no, I can’t understand, then I got my status, then they accepted me, my key worker Lou was with me all the time, even then they would not accept me and register me [African User]”
Advice and information

Refugees and asylum seekers in Kingston felt there is a need to expand Refugee Action Kingston’s services to provide more information and advice to individuals. Most respondents said they do not complain, as they are fearful of the consequences if they did. A number of users are very aware that they were not always treated as equal to others. Refugees and asylum seekers have difficulty understanding systems in the UK and would benefit from a better understanding of the council, the school system, housing department decision-making and the healthcare system.

“...in my country doesn’t have a GP, so when I feel sick I don’t know where to go, whether to go to the hospital or the GP - very different system. When I feel sick, just go to hospital and pay money, here you have to go to the GP first and talk about why you feel sick...so now have to go through someone first who decides whether you are sick enough to go to hospital [Korean User]”

Conference on refugees and asylum seekers

In March 2009, a conference was held entitled ‘Ordinary People in Extraordinary Circumstances: Bringing About Change for Refugees and Asylum Seekers Living in Royal Borough Kingston’.

Jonathan Hildebrand, Joint Director of Public Health chairs the conference session on the brick wall faced by refugees and asylum seekers

Martha Earley leads a breakout group considering issues in more detail
The conference was held for stakeholders and service providers who have influence over the lives of, and services experienced by, refugees and asylum seekers living in the borough. The conference had two aims; to inform local service providers of the needs of refugees and asylum seekers and to make plans for action for future work to address inequalities. Staff from health, social care, housing, education, employment, the Police and the voluntary sector attended the conference and took part in the action planning sessions. The key recommendations agreed are in Box 6.1.

**Box 6.1**

**Key Stakeholder Recommendations from the Conference**

**Improving Access to Healthcare**
- Develop clearer guidance on who is entitled to what.
- Consider bi-lingual advocacy model of interpreting.

**Discrimination and Employment**
- Raise awareness with the Job Centre. Issues include providing more support to refugees and asylum seekers, dispelling myths about refugees having no qualifications, pay discrimination and gender issues.

**Developing Strategic Thinking and Joint Working**
- Develop a joint strategy which addresses the key areas identified in the report.
- Agree joint strategy group membership at a senior management level to drive strategy forward.

**Service Provision**
- Develop a centrally co-ordinated information database of services and resources.

**Communication and Interpreting**
- Identify funding for additional ESOL provision (for lower levels which do not necessitate taking exams) for asylum seekers and refugees.
- Identify more accessible places where such provision could be offered, such as primary schools, Children’s Centres and locations which have existing childcare provision.
- Improve access to interpreting in the statutory and voluntary sector. Provide training for managers and reception staff.
Community development work with refugees and asylum seekers

Phil Murwill (Community Development Worker for Refugees and Asylum Seekers) and a mother and her daughter at a local health event, jointly run with Refugee Action Kingston.
In January 2009, a Community Development Worker (CDW) for Refugees and Asylum Seekers was appointed. Working across Public Health, Social Services and in close partnership with Refugee Action Kingston, the CDW’s role is to promote the health of refugees and asylum seekers living in the Royal Borough of Kingston. The CDW’s role is also to address barriers associated with refugees and asylum seekers when accessing health and social care services and to influence how services are delivered to this minority group.

The management of information by Refugee Action Kingston

Refugee Action Kingston (RAK) has spent almost two years improving their database systems so that information can be easily and accessibly understood about refugees living locally. The new database can report how many refugees and asylum seekers are being served by RAK, how many of them are older people, have disabilities, or require benefit support services. This means that Public Health at NHS Kingston, and other service providers, can better understand the needs of refugees and asylum seekers. RAK now uses this database as the basis of a triage service referring on for specialist advice, advocacy and support services.

Raghad Al-Ugaily is the front line of the Crisis, Support and Advice service provided by Refugee Action Kingston. This service acts as a triage service to access support and services for vulnerable refugees and asylum seekers.
The Health and Wellbeing Centre and Health Day

Refugee Action Kingston runs a Health and Wellbeing Centre which was part-funded by NHS Kingston in 2007/8. The centre has a wide variety of health and wellbeing courses and support services that refugees and asylum seekers are able to freely access two days a week. This is a front line service that provides information and support, helps to prevent isolation, and assists with learning English.

For the third year in a row, and again in collaboration with Refugee Action Kingston’s Health and Wellbeing Centre service, a Health Day for refugees and asylum seekers was held at Piper Hall on the Cambridge Road Estate. A wide variety of health topics were discussed and 48 refugees and asylum seekers attended, demonstrating yet again how keen people are to educate themselves about health issues, and to learn about the different services available.

There were six different language groups represented: Arabic, Korean, Tamil, Farsi, Kurdish and Punjabi. Each group was provided with an interpreter. The different language groups were visited by health experts who spoke for 25 minutes on their particular topic as well as taking questions. The topics covered included: recognising and dealing with stress; TB awareness; immunisations; cancer screening; smoking cessation; interpreting services; physical fitness and healthy eating.

The importance of these health days can be demonstrated by the fact that a lady who attended a previous talk on cancer screening attended a breast screening clinic as a result, and was then diagnosed and treated for cancer.
Recommendations

1. The Royal Borough of Kingston’s Equalities and Community Engagement Team and NHS Kingston’s Public Health Team to support partners to take forward recommendations made at the Stakeholder’s Conference held in March 2009.

2. The Equalities and Community Engagement Manager to co-ordinate and lead on the development of a joint five year strategy on refugees and asylum seekers to be produced by February 2010. The Joint Strategy to include partners within Royal Borough Kingston’s Housing department, Education, Learning and Children’s Services, Community Care Services and Adult Education. Partners will also include NHS Kingston, Refugee Action Kingston, and other statutory partners including the Job Centre and the Metropolitan Police Service.

3. The Equalities and Community Engagement Team should arrange a follow up strategic event to provide an update on progress against the recommendations set out in the needs assessment and conference findings.

4. The Community Development Worker for Refugees and Asylum Seekers, working within the Equalities and Community Engagement Team to continue to build links with refugee and asylum seeking communities and their representing organisations and work with communities to identify health concerns and to provide health promotion outreach.

5. Equalities and Community Engagement Team to support funding initiatives and bids for future projects to build on the successful partnership work with service providers such as Refugee Action Kingston and the Royal Borough of Kingston.

6. NHS Kingston should support the Refugee Crisis Support and Advice Service provided by Refugee Action Kingston.

7. Refugee Action Kingston to continue to report findings from service users.
Introduction

Health in childhood and early life is crucially important, both for current and future health. Most children in Kingston are healthy, and there is good support for children, parents and families. However, there are some persistent inequalities in health, with some children living in poverty and having a start in life which is more likely to lead to poorer health as they get older. Health in childhood was considered in the 2006 annual report, and in this update we consider some aspects of child health and wellbeing in more detail.

This chapter covers:
1. Maternity
2. Children’s Speech and Language Services
3. Play
4. Child and Adolescent Mental Health
5. Drug and alcohol misuse by children and young people

Local issues

1. Maternity

Health in childhood, and in later life, is influenced by health before birth, and so any consideration of childhood has to start with care before birth. There were 2,197 babies born in Kingston in 2007, and the number of births has been increasing over the past few years (Figure 7.0)
The total period fertility rate (TPFR) is the average number of live births per woman resident in an area, if women experienced the area’s current age-specific fertility rates throughout their childbearing lifespan. The level at which a population replaces itself is a TPFR of 2.1 births per woman. In Kingston the TPFR is below the replacement level (being between 1.5 and 1.6, see Figure 7.1) but although it had been dropping for a number of years, it rose to 1.7 in 2007.

Source: VS Tables, Office for National Statistics 1980 to 2005

Figure 7.0 Total births per year in Kingston (non zero axis) with three year rolling average
Figure 7.1 Total Period Fertility Rate in Kingston compared to London, and England and Wales (non-zero axis)

The increased number of births is due to an increase in the number of women in Kingston, in particular women in the 25-44 age group (Figure 7.2)

Figure 7.2 Female resident population by age in Royal Borough of Kingston, 1995 to 2017

Source: VS Tables, Office for National Statistics, 1980 - 2005

Note. The graph shows population estimates up until 2006 and population projections thereafter.
This rise in the young female population may partly be due to changes in available accommodation in Kingston. In the five years from April 2003 to March 2008 there were 2168 housing units built in Kingston, and 63% of these were in the Kingston Town neighbourhood (1359 units). The largest number of units was completed in 2004/5. 47% of the units were two bedded, and 34% one bedded. There are a further 564 units under construction at present, which suggests a further increase in the young population is likely in the relatively near future, although the recession may have some impact on the completion of such property.

Kingston has a higher proportion of births to older mothers than either London or England and Wales as a whole. Teenage pregnancy rates are low and are currently on course to meet the 2010 target (Figure 7.3).

**Figure 7.3** Births by maternal age to residents of Royal Borough of Kingston, 2006

There is an ongoing trend towards child-bearing at an older age in Kingston. From 2000 to 2006 there was a 50% increase in the number of births to women aged over 40 (from 61 to 94) and a 14% increase in the number of births to women over 35 (from 409 to 465).

Most births take place in NHS hospitals. Home births comprised 2.7% of births nationally, 2.2% in London and 1.9% in Kingston. In 2006/7, 88% of births to NHS Kingston patients took place in Kingston Hospital (2064 of 2337), a further 8% in Epsom and St Helier Hospital (193 births) and 2% in St George’s Hospital.
Pregnancy Outcomes
Outcomes are good in Kingston compared to other areas. Stillbirth rates, peri-natal mortality rates, infant mortality rates and the proportion of low birth weight babies are all below both national and London averages.

Twelve weeks booking target
Early booking of pregnant women with the local maternity services is important to improve all maternity outcomes, and also to facilitate the delivery of the Down’s syndrome, sickle cell disease and thalassaemia screening targets set by the National Screening Committee. Early booking has been identified by the London Health Observatory (LHO) as a good precursor of better health for the mother and child. The booking appointment is a key point for assessment of risks in the mother.

A target has now been set that 80% of women should have their booking appointment before 12 weeks gestation. In 2006, 7.1% of bookings for delivery at Kingston Hospital were within 12 weeks gestation. The latest data from quarter 1 of 2008/09 shows an improvement with 14% of bookings with Kingston Hospital before 12 weeks (203/1507 bookings).

Information on gestation at booking has not been coded in routine data in Kingston Hospital in the past, and systems to collect this data routinely are now being set up.

The Healthcare Commission review of maternity services 2007 found that the average time between making first contact and the booking appointment for Kingston Hospital was 5.1 weeks. This was one of the longest times taken of all units in England.

Risk factors for poor birth outcomes
A recent study from LHO looking at risk factors for infant deaths found that the strongest predictors were not very prevalent in Kingston1. However the proportion of mothers in Kingston who continue to smoke through pregnancy appears to be high, although this may in part be due to incomplete data recording elsewhere. (Table 7.0).

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1 Born Equal, London Health Observatory, 2007
Antenatal screening
Ante-natal screening is an important component of maternity care. Ante-natal screening is a way of assessing whether an unborn baby could develop, or has developed, an abnormality during pregnancy. It measures how likely a baby is to have a particular condition, and if the risk of a complication is found to be high the mother may be offered a diagnostic test before the baby is born.

Ante-natal screening can detect the likelihood of a range of genetic or chromosomal conditions or infectious diseases, including Down’s syndrome, spina bifida, sickle cell anaemia, thalassaemia, HIV, Hepatitis B, syphilis, and rubella. These tests are carried out at different times in pregnancy, from 10 weeks gestation to around 20-22 weeks. Screening coverage in Kingston is high, with very close to 100% uptake of the tests.

Method of delivery
Caesarean section rates in Kingston are the third highest in South West London, Surrey and Sussex (SWLSS) for 2006. Rates are high both for planned and emergency caesarean sections. Since 2002, the rate of sections in Kingston has risen slightly, which is a similar picture to the rest of SWLSS².

Induction of labour is also an important issue, and Kingston Hospital was the fourth highest out of eleven units for induction of labour, with around 20% of women induced. Kingston Hospital was the third highest for inductions for “post-dates” at around 7.5%, which is nearly twice the rate for St George’s Hospital. Over the past three years the percentage of women induced has reduced very slightly, but further reduction is still needed. Induction rates in SWLSS as a whole are higher than those for England.

² Perinatal Outcomes in South West London, Surrey and West Sussex, 2002-2006, South West London, Surrey and Sussex Perinatal Audit Group

Table 7.0 Risk factors for poor pregnancy outcomes in Southwest London

<table>
<thead>
<tr>
<th></th>
<th>% mothers smoking in pregnancy</th>
<th>% smoking in pregnancy unknown</th>
<th>% mothers initiating breastfeeding</th>
<th>% mothers where feeding method unknown</th>
<th>% early book (less than 12 weeks) 2005/6</th>
<th>% deliveries coded with gestational age at first antenatal 2005/6</th>
<th>% deliveries coded with ethnicity 2005/6</th>
</tr>
</thead>
<tbody>
<tr>
<td>W/Work</td>
<td>6.5</td>
<td>2.7</td>
<td>80.9</td>
<td>0.9</td>
<td>24.0</td>
<td>28.4</td>
<td>83.7</td>
</tr>
<tr>
<td>Sutton &amp; Merton</td>
<td>5.2</td>
<td>29.5</td>
<td>71.4</td>
<td>19</td>
<td>25.3</td>
<td>1.7</td>
<td>82.2</td>
</tr>
<tr>
<td>Kingston</td>
<td>6.5</td>
<td>0</td>
<td>89.5</td>
<td>0</td>
<td>8.6</td>
<td>1.6</td>
<td>95.6</td>
</tr>
<tr>
<td>Richmond</td>
<td>5.3</td>
<td>0</td>
<td>91</td>
<td>0</td>
<td>23.1</td>
<td>13.5</td>
<td>94.1</td>
</tr>
<tr>
<td>Croydon</td>
<td>9</td>
<td>3.5</td>
<td>80.6</td>
<td>3.2</td>
<td>14.3</td>
<td>0.6</td>
<td>91.9</td>
</tr>
</tbody>
</table>

Source: London Health Observatory, Born Equal, 2007
Note. The zeros in the table indicate where there is complete data i.e. no unknowns
Quality of maternity care

The quality of maternity care is of national importance, and a commitment to improve maternity services is set out in Maternity Matters. In Kingston, improvement to aspects of quality at Kingston Hospital maternity services are set out in a Commissioning for Quality and Innovation Scheme (CQUIN) agreed in the contract between NHS Kingston and Kingston Hospital for 2009/2010.

2. Speech and Language Therapy for Children

The role of a Speech and Language Therapist (S&LT) is to assess and treat speech, language and communication problems in people of all ages to enable them to communicate to the best of their ability. They may also work with people who have eating and swallowing problems. In the UK around 5% of children enter school with difficulties in speech and language.

In previous years, the capacity of the S&LT service in Kingston has been very limited, which has led to long waiting times before children can be assessed and treatment started. There is good evidence that early diagnosis and treatment, including speech and language therapies, for some conditions such as Autistic Spectrum Disorder can lead to better outcomes and an overall reduction in disability.

The Children’s Speech & Language Therapy Team (CSLTT) has been involved in extensive redesign work during 2008 and has achieved a large reduction in waiting times for initial assessment of 2-5 year olds, an increase in the range of interventions available including a service for children who stammer, and improved support for junior therapists and assistants.

The CSLTT received 276 new referrals during 2008. Over a third of these children were diagnosed with a problem with sound development, whilst nearly a quarter had a problem with language development. Other disorders were less common. See Figure 7.4. There were a total of 780 children (new and ongoing cases) aged 3–16 years being treated by the CSLTT as at February 2009.

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The specialist Speech and Language Department at the Maple Centre received 87 new referrals during 2008. A high proportion of these children will have long-term complex conditions. Most of these children are transferred to the CSLTT for long-term speech and language therapy.

The CSLTT has seen an increasing demand for its services for a number of reasons. Firstly, there is an increasing birth rate in Kingston, which has lead to an increase in children requiring S&LT (10% could be expected to have persistent long term speech, language and communication needs, and up to 50% of children may have a transient problem with speech, language or communication development). Secondly, there has been an increase in the number of children diagnosed with autistic spectrum disorders (although it is not clear if the increase is caused by a real increase in the incidence of ASD or a result of better diagnosis or registration). In addition, the introduction of Children Centres facilitates the development of a pre-referral /prevention S&LT service which would be well-placed to appropriately manage referrals and support parents in improving their management of their child’s condition.
Children and Young People

The current gaps in the service are:

- More S&LT provision is needed to cover the increased number of mainstream school places (300 extra in Kingston) and the increased number of places in Specialist settings, and a pre-referral/prevention service to the Children’s Centres.
- The development of a transition S&LT service for children moving to adult services.
- Further improvement to the S&LT service for children with complex needs in order to ensure safe swallowing and communication development.

3. Play

Play is a crucial aspect of children’s lives. Kingston Play Partnership carried out a consultation in 2008 with nearly 500 children, parents and stakeholders, to start developing a new Play Strategy. There was a high level of consensus on the main themes as shown in Table 7.1. The new play strategy will be published in summer 2009.

Table 7.1 The most popular themes for play. Shown as percentage of people agreeing with each theme (out of 500 surveyed)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Percentage agreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involve children, young people, parents and the local community in plans for their local area</td>
<td>92%</td>
</tr>
<tr>
<td>Promoting ways to make play safer</td>
<td>87%</td>
</tr>
<tr>
<td>Promoting better understanding and respect between children, young people and adults</td>
<td>94%</td>
</tr>
<tr>
<td>Promote the importance of play for all children and young people</td>
<td>92%</td>
</tr>
<tr>
<td>Improve facilities for disabled children</td>
<td>96%</td>
</tr>
<tr>
<td>Improve play areas for 8-13 year olds</td>
<td>90%</td>
</tr>
<tr>
<td>Open up play areas outside of normal hours. For example, allow children to use school play grounds at the weekend</td>
<td>62%</td>
</tr>
<tr>
<td>More support for people to obtain play work qualifications</td>
<td>79%</td>
</tr>
<tr>
<td>Make sure plans for new residential areas include provision of good play spaces</td>
<td>89%</td>
</tr>
</tbody>
</table>

Kingston is the top performing authority in London for participation in physical activity in school (85% of children and young people participating in at least 120 minutes of curriculum PE in 2007/8).

There is a recognised need to improve play space for children, particularly natural outdoor play areas. Kingston has been successful in bidding for funding and will receive a capital grant in excess of £1.1 million to improve or build 22 play areas in the borough. This programme will be carried out in line with local needs as indicated through an extensive process of community engagement. A priority for the building programme will be to improve play facilities for children and young people with disabilities.
4. Child and Adolescent Mental Health Services (CAMHS)

The emotional well-being of children and young people is of crucial importance in making sure that they achieve their full potential in life. Emotional difficulties and mental health problems at an early age are associated with educational failure, family disruption, self harm, offending and anti-social behaviour. Untreated emotional difficulties and mental health problems create distress, not only in children and young people, but also for their families, carers and the wider community. This can continue into adult life and affect the next generation.

A comprehensive needs assessment of the mental health of children and adolescents in Kingston was undertaken in November 2007. It found that there is an estimated prevalence of 7% of children with a mental disorder in Kingston, which is lower than the national average. However there is a 50% difference in estimated prevalence between the lowest and the highest rates in the wards across Kingston, with the highest prevalence of 9% in Norbiton, Chessington South and Tolworth South and East.

This means an estimated 1,191 children aged 5-15 in Kingston have a mental health disorder. There are no estimates for younger children, but prevalence of mental disorders seems to increase with age, so for children aged 16-19 at least another 500 could be expected.

Children in special circumstances (including those who are homeless, those who misuse substances, asylum seekers, young offenders, looked after children) may have a higher prevalence of mental health problems, and need more support.

Overall the analysis shows that Kingston is performing well in the following areas:

Mental health promotion and early intervention. Multi agency training was provided to all frontline staff and the SEAL (Social and Emotional Aspects of Learning) programme is provided in schools.

Partnership Working. Targeted services offer considerable support to children and young people with significant behavioural difficulties (‘conduct disorder’), who are at risk of exclusion from school. CAMHS support and individual counsellors are provided for Pupil Referral Units. The targeted services have all been designed to meet specific needs seen as high priority. They take account of Youth Justice Board targets, the mental health needs of children who are looked after (promoting placement stability) and the high levels of need in families with ill and disabled children.

Measuring outcomes. A range of outcome measures are currently used across all services.

Developing multi-disciplinary specialist services: The Kingston specialist (tier 3) service, FACT, redesigned their service in 2007. There are no waiting lists, interventions are offered in line with NICE guidance and assessments use validated and well respected tools. The team has a
strong record of minimising hospital admissions particularly with a high quality Eating Disorder Clinic including a dietician.

*Services for Young People of Sixteen and Seventeen Years of Age*: Children and young people are very rarely admitted to adult wards. Good transition protocols are in place for most conditions.

There were however some gaps where the need for further work was identified. These were:

- A lack of sustainable and robust structures for user involvement.
- Some gaps in training of frontline staff in mental health awareness, in particular teachers and GPs, and follow up support after training.
- No mapping of the various counselling services provided in schools, inadequate information on uptake and no protocols to co-ordinate these with other services.
- Not enough engagement with black and minority ethnic groups including asylum seekers.
- Incomplete support for young carers and people witnessing domestic violence.
- Substance misuse not seen as a core part of role by all CAMHS staff.
- Mental health services being hard to access and perceived as stigmatising by some young people and families.
- Poorly co-ordinated support for children with learning disabilities.
- Inadequate support for foster carers to enable them to promote children's mental health.
- Inconsistent multi-agency approach to meet the needs of children and young people with complex, severe and persistent behavioural and mental health needs.
- Inconsistency in meeting the wider needs e.g. educational needs of children and young people with mental health problems.
- Collaborative arrangements with Kingston hospital paediatric unit.
- There is inadequate provision of social work support in all in-patient settings.
- No child specific continuing care protocol.
- Different outcome measures are being used by different services.
- Limited capacity in the Youth Offending Service to continue to meet screening, assessment and referral target timescales and to provide a fully integrated response to young offenders with emerging or significant mental health needs.

These findings have formed the basis for a CAMHS strategy being developed by Kingston's Children's and Young Peoples Trust (CYPT). In addition, a pilot CAMHS Service User Group was started at the end of 2008. The aim of the group was to bring together young people who have used children's mental health services in Kingston and gather their opinions on the services. The pilot is being evaluated, and if successful, may be run on an ongoing basis from 2009 onwards.
5. Drug and alcohol misuse by children and young people

In 2008, a needs assessment of young people’s alcohol and drug misuse services was undertaken jointly between NHS Kingston and the Royal Borough of Kingston in order to determine whether the provision of services are meeting the local need.

The drugs and alcohol habits of children in Kingston were gathered through two different routes with two overlapping age groups:

1) School pupils aged 8 to 16 years surveyed via a national initiative and
2) Children and young people aged 11 to 18 years identified via youth settings including higher risk children identified primarily via the Youth Offending Service.

The survey findings are presented separately.

Smoking, drugs and alcohol use among school pupils in Kingston

A national survey was carried out among children and young people aged 8 to 16 years across England in 2008. 885 young people in Kingston completed the survey. Their responses were weighted to ensure the results were representative of Kingston’s population with regard to gender, eligibility for free school meals and type of school.

- Tobacco smoking
  Three quarters (75%) of 8-16 year old pupils in Kingston had never smoked a cigarette and this was the same as the national average. The proportion of children and young people who smoked every day was lower in Kingston (2%) compared with the national average (4%).

- Alcohol consumption
  In Kingston, 30% of 8-16 year old pupils reported never having had an alcoholic drink and this was higher than the national average of 25% in England. Eleven percent of pupils reported they had been drunk in the last month, with 7% reporting they had been drunk three or more times in the last four weeks.

- Substance misuse
  In Kingston, 11% of young people aged 12 to 16 years reported ever having taken drugs and this was comparable to the national average. The proportion of young people reporting using cannabis, solvents and other drugs in the last four weeks was higher in Kingston than for England but this finding was not statistically significant (Figure 7.5).

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Smoking, drugs and alcohol use among young people, including 'higher risk' young people, in Kingston

A local detailed survey was carried out among young people aged 11 to 18 years with help from the Youth Offending Service, Youth Service and other youth settings. A total of 76 questionnaires were returned, including 36 from young people in contact with targeted and specialist services providing us with the views of those at potentially higher risk. The majority of respondents were male (63%), aged 14 to 16 years (65%) and of white ethnicity (82%).

- Tobacco smoking
  Only 19% of young people (11 to 18 years) surveyed reported they had never smoked a cigarette with 53% reporting they smoked every day. Over half of regular smokers (smoking once a week or more) reported they would like to give up smoking.

- Alcohol consumption
  Only 4% of young people surveyed reported never having had an alcoholic drink. Two thirds (64%) reported they had been drunk in the last month, with 30% reporting they had been drunk three or more times in the last four weeks. The main sources of alcohol for people aged less than 18 years were newsagents and corner shops (Figure 7.6). Alcohol was the main drug of use reported by half of all referrals to the young people’s specialist substance misuse services in Kingston, highlighting the importance of addressing the need for alcohol prevention and treatment among young people in Kingston.

Figure 7.5 Percentage of school pupils aged 12 to 16 years reporting ever using each substance in the past four weeks (Tell Us 3 data) 2008. (*other includes cocaine, LSD, ecstasy, heroin, crack, speed and magic mushrooms)
Substance misuse
Seventy five percent of young people who completed the questionnaire reported ever taking drugs and this increased with increasing age. Of those who had ever tried drugs, the most common substance used was cannabis, followed by poppers and ecstasy. Forty three percent of young people reported current (in the last month) drug use and the most common substance was cannabis, followed by ecstasy and crack or cocaine.

Where do young people go to seek information and help?
A quarter of school pupils aged 8 to 16 years in Kingston felt they needed better information and advice on alcohol and drugs. Youth clubs, websites and specialist drugs services were the three most commonly reported places to go for information, highlighting the importance of making information accessible to young people through local websites such as www.younglivin.org.uk and www.sorted4.info.

Current provision of young people’s substance misuse services
There are a range of young people’s services available at the universal, targeted and specialist levels in Kingston (Figure 7.7). However, a key recommendation from the needs assessment was the necessity for greater clarity of the roles and responsibilities of each service with regards to substance misuse (including alcohol) prevention and treatment.

National surveillance data\(^5\) suggests that the Kingston specialist substance misuse services are
achieving the National Treatment Agency (NTA) treatment quality measure\(^6\) that at least 90% of young people requiring specialist substance misuse treatment should be catered for in a young person’s service (2007/08 Kingston: 98%). However, the proportion of referrals from Children and Family Services in Kingston was lower than the NTA treatment quality measure (2007/08 Kingston: 14%; NTA target: 20%) and this needs to be addressed. A review of the public health work of Health Visitors and School Nurses in 2007 identified that staff in the Children’s and Family Services needed training on the options for referral of children with drugs and alcohol problems\(^7\).

The key recommendations from the needs assessment were:

- Promotion of smoking cessation services to young people in contact with targeted and specialist services should be encouraged.
- The provision of services to address the prevention of alcohol use among young people in addition to the treatment of alcohol misuse in young people should be prioritised.
- Local collaboration by partners to prevent under-age sales of cigarettes and alcohol in the Borough needs to continue.
- Websites (both national and local) providing information on drugs and alcohol for young people should be widely publicised.
- Greater clarity on roles and responsibilities of each service should be shared across the PCT, RBK and other organisations.
- Ensure the increasing number of young people referred from Learning and Children’s Services is maintained.

The findings from the needs assessment on drugs and alcohol use by young people have been presented to the Young People’s Substance Misuse Joint Commissioning Group and improvements are being lead by RBK.

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\(^7\) Public Health Workstream - Report to the Children’s and Families Steering Group, Helen Raison 28th August 2007, KPCT Public Health Department.
Figure 7.7 Universal, targeted and specialist substance misuse services for young people in the Royal Borough of Kingston.

Referred from the following to enter at any point on the service pyramid:

- Criminal justice/YOT
- Education
- Social services
- LAC
- A&E
- General hospital
- Mental health (CAMHS)
- GP
- Self/parent
- Youth Offending service
- Specialist drug worker
- CAMHS specialist
- Team/psychiatrist
- Youth Offending Service
- Youth Inclusion and Support Panels (YISP)
- Teenage pregnancy
- ASCA (counselling)
- Woodroffe FACT/ Positive Futures
- Kingston CAMHS
- Pupil Referral Unit
- Targeted Youth Support Team
- Positive Futures
- Youth Clubs
- Schools
- Police
- Oxygen

*also referred to as “Eagle Chambers Drugs worker”
Recommendations

Maternity
1 NHS Kingston, Kingston Hospital and partners should ensure all women are able to have a full social and health assessment in early pregnancy, and that 80% are assessed by 12 weeks gestation.
2 NHS Kingston, Your Healthcare, Kingston Hospital and partners should continue to work to reduce mothers smoking, both during pregnancy and after birth to ensure children live in smoke free environments.
3 Kingston Hospital should work towards reducing caesarean section rates and induction of labour rates.
4 NHS Kingston will monitor the maternity CQUIN agreed with Kingston Hospital.

Play
5 The Royal Borough of Kingston should finalise and publish Kingston’s Play Strategy, and build or improve 22 play areas within the borough.
6 Inequalities should be reduced through ensuring that these areas are easily accessible by marginalised groups, including disabled children.

Children’s Speech and Language Services
7 NHS Kingston should review the need for S&LT provision in the light of demand from the increased number of children in mainstream and special schools.
8 The S&LT service and partners should further develop the transition between the children’s S&LT service and adult services.
9 The S&LT service for children with complex needs should be further improved in order to ensure safe swallowing and communication development.

Child and Adolescent Mental Health
10 NHS Kingston, the Royal Borough of Kingston and partners should work towards addressing the gaps in CAHMS provision identified by the CAHMS needs assessment.
11 The CAHMS strategy should be finalised and implemented.

Drugs and Alcohol use by Young People
12 NHS Kingston, the Royal Borough of Kingston and partners should work towards implementing the recommendations set out in the needs assessment on drug and alcohol use by the young people of Kingston.
Chapter 8
Health Protection and Emergency Planning

Childhood Immunisation

Nicola Pratelli, Senior Public Health Nurse-Immunisation, NHS Kingston (nicola.pratelli@kpct.nhs.uk)

Primary Immunisations
Primary immunisations are the group of vaccinations offered to children, which protect against infection with diphtheria, tetanus, pertussis, polio, Haemophilus influenza B, measles, mumps and rubella.

Uptake of primary immunisations in Kingston
NHS Kingston continues to have high recorded uptake in all primary immunisations compared with other primary care trusts in South West London. Uptake in Kingston is good compared to London, achieving on average 5 - 7% higher uptake rates compared to London as a whole. However, not all immunisation rates are high enough to achieve herd immunity. During 2007, the reported uptake of all vaccinations fell gradually and then rose slightly in 2008. This may be explained by adjustment of the denominator population and problems experienced with new systems of data collection and recording during 2007.

DTaP/IPV/Hib vaccine
This vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib). It is scheduled for all children at two, three, and four months of age. The uptake at 12 months of DTaP/IPV/Hib vaccine (Pedicel!), also known as the '5 in 1', has remained fairly consistent with Kingston showing a very slight decline in 2007 (Figure 8.0) but since the middle of 2008 uptake has remained around 90%. The latest data shows that in March 2009 uptake was 90.5%.
Figure 8.0 DtaP IPV Hib Vaccine uptake at 12 months of age.

Pneumococcal vaccine (PCV) uptake and Meningitis C (Hib/MenC) uptake at 24 months

At the age of two years, the target is for 95% of children to be immunised against pneumococcal infection (the PCV vaccine). Throughout 2008 and into early 2009 this target has been missed, with rates fluctuating around 85%, until March 2009 when the rate rose to 91.6%.

At the age of two years, 95% of children should be immunised with MenC/Hib vaccine. Whilst this target was exceeded in the first quarter of 2008, it has not been met since, although it has remained consistently above 90%.

Measles Mumps Rubella (MMR) uptake

Measles was a significant problem nationally in 2007. London was particularly affected with over 1,200 suspected cases, of which over 420 were confirmed. South West London was significantly affected with 209 suspected measles cases during 2007.
Kingston’s immunisation rate for MMR remains below the national targets although local uptake of the vaccine is 85% at two years (Figure 8.1) and 81% at five years. These levels fall short of those needed to reach the herd immunity threshold for measles at 92-95%.

**Figure 8.1** MMR first dose at 24 months

In August 2008, the Department of Health announced a national MMR catch-up campaign to vaccinate every child under the age of 18 years. As part of the catch-up campaign in Kingston, since September 2008, children and young people have been invited to attend their GP practice to receive MMR if they have not previously received any vaccine or have only received one dose of the vaccine. This catch-up programme ran until March 2009.

**Haemophilus influenzae Type b (Hib) catch-up campaign**

Haemophilus influenza B (Hib) is an infection that can cause a number of major illnesses, such as blood poisoning, pneumonia and meningitis. A Hib catch-up campaign was launched in September 2007 and was due to end in March 2009. The eligible group for this campaign were children born between 13th March 2003 and 3rd September 2005. This campaign ensures that children who were too young to participate in the 2003 catch-up campaign...
(those born between 2nd April 1999 and 12th March 2003), and are too old to have received a routine Hib/MenC vaccine at 12 months (those born 4th September 2005 onwards) receive a Hib booster over the age of one year. Thus all children born after 1st April 1999 should have received a dose of Hib vaccine over the age of one year.

Human Papilloma Virus (HPV) Vaccination for Girls in Kingston

Genital infection with Human Papilloma Virus (HPV) is linked to virtually all cervical cancer cases and is the most common viral infection of the reproductive tract. The objective of the HPV immunisation programme is to provide the three required doses of HPV vaccine to females before they reach an age when the risk of HPV infection through sexual contact increases, and they are at subsequent risk of cervical cancer. It should be emphasised that all women, whether vaccinated or not, will continue to be encouraged to attend for cervical screening because current vaccines do not protect against all the types of HPV that are linked to cervical cancer. The cervical screening programme will also provide the means to monitor the long term effectiveness of the vaccine.

The HPV immunisation programme to routinely vaccinate girls aged 12-13 was introduced in September 2008 following advice from the Joint Committee on Vaccination and Immunisation. A two-year catch-up programme will commence in Autumn 2009 for girls up to the current year 13, to ensure all girls aged 14 to 18 years are offered the vaccine.

During 2008/2009 there was a specific catch up programme for 17 to 18 year olds which was mainly carried out via general practice as a significant number of young women within this identified group may have left education.

Future immunisation issues

In London, the quality of immunisation data declined following introduction of a new Child Health System - Child Health Interim Application (CHIA) - in 2005. NHS Kingston was no exception. It is planned that NHS Kingston’s child health system will be moved over to the RiO system at the end of 2008 and beginning of 2009. The data is currently under review and is being validated prior to migration. It is anticipated that this will bring improvements to Kingston’s immunisation recall and reporting system, including improved quality and accuracy of data.

A Senior Public Health Nurse who leads on immunisation commenced working for NHS Kingston in September 2008. Two school nurses have been employed to support the HPV campaign. In addition, as part of the Choosing Health priorities, three school nurses have been employed to assist the immunisation programme for 0 to 19 year olds.
In the coming year, NHS Kingston plans to reduce inequalities in childhood vaccination, with the support of the South West London Health Protection Unit, to ensure that all children are protected against the most common childhood infections and vaccine preventable diseases. Improving uptake of childhood immunisations, particularly the MMR vaccine, has been identified as a priority for London. NHS Kingston recognises that sustained investment is essential in this area in order to meet national targets and local trajectories for the future.

**Recommendations**

1. The capacity of the immunisation coordinator should be increased.
2. All local healthcare staff should promote the benefits of immunisation to local people.
3. NHS Kingston should consider campaigns aimed at populations in Kingston where there is a low uptake of childhood vaccinations.
4. NHS Kingston should use the local media to highlight the importance of childhood vaccinations.
Tuberculosis

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Tuberculosis (TB) is a serious but treatable infectious disease and an important public health issue both in London and globally. It is controlled by prompt diagnosis and ensuring that each person completes their treatment course. Treatment of cases is accompanied by the tracing of their close contacts to identify if anyone else also needs treatment for TB. Specialist TB nurses provide rapid access for assessment and treatment, and undertake the contact tracing.

TB is a local priority in London. The pan-London group called ‘Stopping TB in London’ has developed a number of measures which aim to define and set standards for TB services in London (see Box 8.0). These metrics are being further developed across London.

**Box 8.0**

**NHS London Standards for TB Care: TB metrics 2008***

- Prompt diagnosis: All TB samples should be processed using liquid culture technology.
- Prompt diagnosis: all results on sputum smears should be available within 1 working day of the sample reaching the laboratory.
- Identification of those with complex needs: a risk assessment, as defined by National Surveillance Standard, is carried out on each TB patient to identify those at risk of not completing their TB treatment.
- Treatment completion to achieve, as a minimum, 85% treatment completion rate at 12 months after commencing therapy (national target) using WHO equation \% = (C/T) x 100 \% (percentage TB patients completed treatment) = C (number of TB patients (notifications) completing treatment/T (total number of TB notifications minus de-notifications) x 100.
- Prevention of further infection: all defined contacts of a TB case should be identified and screened as per NICE Guidelines. Services are able to report contact tracing details - specifically numbers seen, numbers offered chemoprophylaxis, numbers offered BCG and numbers diagnosed with TB.
- Workforce: there should be a minimum of 1 specialist TB nurse for every 40 TB notifications per year and full clinic administrative support in place.
- HIV: all TB patients to be offered an HIV test.

* these metrics will be revised for 2009/10
During 2008, the ‘Stopping TB in London’ group was reorganised into the London TB Commissioning Board and the London TB Clinical Reference Group, with the changes being completed in November 2008.

In the last five years the number of cases of TB in people living in the Royal Borough of Kingston has fluctuated from 22 cases in 2004 to 29 cases in 2007. Table 8.0 shows the number and rate of TB by local authority of residence since 2003.

Kingston residents have a lower rate of TB (18.4 cases per 100,000 people) compared to Croydon, Wandsworth and Merton in South West London. Whilst the Kingston rate is lower than the overall London rate of 43.2 cases per 100,000 people, it is higher than the rate for England of 15.2 cases per 100,000 people.

### Table 8.0 Number of TB cases in South West London minus de-notifications from 2004 to 2008* by local authority of residence, and the rate per 100,000 for 2008

<table>
<thead>
<tr>
<th>Local authority</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>Rate per 100,000 in 2008*</th>
</tr>
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<tbody>
<tr>
<td>Croydon</td>
<td>120</td>
<td>113</td>
<td>102</td>
<td>117</td>
<td>112</td>
<td>33.0</td>
</tr>
<tr>
<td><strong>Kingston upon Thames</strong></td>
<td>22</td>
<td>29</td>
<td>25</td>
<td>28</td>
<td>29</td>
<td><strong>18.4</strong></td>
</tr>
<tr>
<td>Merton</td>
<td>62</td>
<td>61</td>
<td>66</td>
<td>57</td>
<td>64</td>
<td>32.1</td>
</tr>
<tr>
<td>Richmond upon Thames</td>
<td>12</td>
<td>19</td>
<td>20</td>
<td>14</td>
<td>13</td>
<td>7.2</td>
</tr>
<tr>
<td>Sutton</td>
<td>24</td>
<td>25</td>
<td>27</td>
<td>33</td>
<td>14</td>
<td>7.5</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>94</td>
<td>125</td>
<td>82</td>
<td>115</td>
<td>110</td>
<td>39.0</td>
</tr>
<tr>
<td>South West London</td>
<td>334</td>
<td>372</td>
<td>322</td>
<td>364</td>
<td>342</td>
<td>25.4</td>
</tr>
<tr>
<td>London</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>43.2**</td>
</tr>
<tr>
<td>England</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15.2**</td>
</tr>
</tbody>
</table>

*Rates use ONS mid year population estimates for 2004 to 2007, except 2008 which is based on 2007 population data.

Source (Southwest London numbers and rates): London TB Register

**Source (London and England rates) 2007 data, Health Protection Agency

### BCG vaccination in Kingston

The current policy in Kingston is to offer BCG vaccination selectively to newborns at high risk of contracting TB, for example to children whose parents come from a country with endemic TB. This policy is based on the rate of TB in the Kingston population being below a threshold of 40 cases per 100,000 population. However, TB rates in Wandsworth have been close to 40 per 100,000 in the last 2 years, which represents high endemicity. The South West London Health Protection Unit is closely monitoring these rates to ensure that appropriate action is taken if the rate exceeds the threshold in one of Kingston’s neighbouring PCTs.
Treating TB and treatment targets

All clinics treat patients using guidelines developed by the National Institute for Health and Clinical Excellence (NICE). Tracing of people who are close contacts is undertaken for all cases. Wider screening, if required, is supported or led by the South West London Health Protection Unit in settings such as schools and hospitals.

The London TB standard for treatment completed is for 85% of patients to have completed treatment one year from their treatment start date. NHS London will be monitoring treatment completion by PCT. The overall treatment completion rate for patients from South West London PCTs who were notified in 2007 was 78%, although the rate in Kingston was 57%. Low treatment completion rates in Kingston could be attributed to a transition phase when a new Lead TB Nurse was being recruited to post. Monitoring of activity since 2007 has shown a marked improvement in TB completion rates at the chest clinic. Low treatment completion rates in Kingston may also be affected by deaths during a single year, but may also be related to the smaller numbers of cases, the disproportionate affect of small variations in cases lost to follow-up, patients transferred out to other hospitals without feedback of data on their treatment completion (although this is now being addressed by the London TB Register team), and the fact that some patients may require longer treatment regimens.

Further work is needed to deduce whether there is a problem with the commissioned TB service that is resulting in low treatment completion rates, or whether it is due to incomplete data. Incomplete data can be improved by following up patients whose care has been transferred out to ensure treatment completed elsewhere is captured, and through a robust local process ensuring cases lost to follow-up are kept to a minimum.

A TB network manager has recently been recruited to develop TB services in the region. In partnership with stakeholders, the TB network manager will work towards developing key performance indicators at agreed intervals to deliver on the London TB metrics (Box 8.0).

Improving the diagnosis and referral of TB

An innovative TB assessment tool has been developed by the Lead TB Nurse at Kingston Hospital. The tool will help health care professionals to assess people at high risk of TB and identify those that should be referred on to the TB clinic. The tool is being supported by the South West London Health Protection Unit and will be given to GPs, practice nurses, occupational health professionals, prisons, housing officers and homeless units, drug projects and staff in other settings where people at high risk of TB come into contact with services.
Joint Working and Training
The Kingston TB service has been working jointly with other services such as Kaleidoscope and Housing Services at RBK to ensure people with TB are fully treated and cared for, and able to complete their treatment course with minimal disruption. Jointly agreed activities include offering TB medication in settings other than at the TB Clinic.

The Kingston TB service continues to provide training on TB to a range of professionals working in the Kingston locality.

Recommendations
1. The TB clinic team at Kingston Hospital, the TB Network Manager, Health Protection Unit and NHS Kingston should work collaboratively to improve care pathways and data collection on current services provided through the clinic.
2. The TB Clinic Team at Kingston Hospital and partners should work towards minimising patients lost to follow up by providing an outreach worker resource to link between the chest clinic and the community.
3. The TB assessment tool should be adopted across the borough to enhance the identification and referral of people with TB.
Improving Sexual Health

Julia Waters, Sexual Health Programme Lead, NHS Kingston (julia.waters@kpct.nhs.uk)

Introduction

Sexual health is a key national priority for the NHS, and is also a priority for London and Kingston. London has the highest prevalence of sexual ill health in the UK and this has a disproportionate impact on inequalities, public health and use of health services.

A recent London sexual health needs assessment and service mapping project ‘Sex and Our City’ was published in 2008 to assist the NHS in London in developing and delivering high quality sexual health services. For the first time, the NHS in London has a baseline mapping of sexual health services and needs. The Sex and Our City report made many recommendations. This chapter looks in more details at the recommendation that “PCTs should prioritise interventions with the greatest potential for cost effectiveness and impact on health outcomes, including:

- Improving access to Long Acting Reversible Contraception (LARC) prescribing
- Offering Chlamydia screening more widely
- Making HIV testing more accessible to avoid late diagnosis”

Why is this an important public health issue?

For nearly two decades there have been changes in sexual behaviour in the UK, with increasing numbers of heterosexual partners, lower age at first sexual intercourse, increase in number of concurrent partnerships, increase in heterosexual anal sex, and payment for sex. These behaviours have contributed to the increase in number of diagnoses of sexually transmitted diseases and to 30% of pregnancies being unplanned. This has been reflected in increasing GUM clinic throughput as well as rising disease prevalence and high teenage pregnancy rates in the community.

Such increases in demand for sexual health services mean it is no longer sensible or economic to deliver sexual health care only in hospital-based specialist services. Kingston is developing an integrated sexual health specification which is due to be implemented from 2010/11.

**Local Issues**

This section looks in more detail at:

- Contraception - long acting reversible contraceptives
- Chlamydia - Widening access to screening
- HIV - ensuring early diagnosis

**Contraception: A move towards long acting reversible contraceptives**

Contraceptive failure may result in unwanted pregnancies, abortion, miscarriage, maternity (live births) and medical conditions such as ectopic pregnancy. In 2005/06 the average cost of a contraceptive failure was estimated to be £1,500.

The abortion rate for NHS Kingston is slightly higher than the national average: 20 per 1,000 women aged 15-44 compared with the national average of 18.5. Furthermore, a quarter of all abortions are to young women under 25 reporting a previous abortion.

In 2007, long-acting reversible contraceptive (LARC) methods made up only 10% of contraceptive prescriptions in Kingston (Figure 8.2), which is significantly lower than the figures for England of 21% and for London of 19%. The group of long acting reversible contraceptives comprises intrauterine devices, the intrauterine system, injectable contraceptives and implants.

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6 NICE (2007). One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups, National Institute for Health and Clinical Excellence
These data demonstrates the high use of traditional user-dependent methods such as the pill, compared to the more cost effective non user-dependent LARC methods which have lower failure rates. The National Institute for Health and Clinical Excellence (NICE) recommends that women should have the choice of, and access to, a range of contraceptive methods including LARC, and encourages PCTs to shift to offering LARC methods more widely.

In September 2008 Kingston Hospital Trust’s genitourinary medicine department worked with NHS Kingston to start a weekly LARC training clinic. To date, referrals from GPs have been limited and there have been lower numbers than expected of GPs attending the training clinic. Despite this, the number of attendees appropriately attending the LARC clinic has risen, so that clinics soon became booked up and the 16-19 age group is well-represented.

There has also been a relevant change to the Quality and Outcomes Framework (QOF) for GPs. From 2009/10 GPs will be rewarded for giving advice on contraception, particularly long acting methods. It is hoped this will improve access to the full range of contraceptive methods and result in a reduction in unintended pregnancies, particularly teenage pregnancy and abortions. Work will be required to ensure the advice provided in general practice is consistent and of high quality, and to ensure care pathways are in place.

**Local action to improve contraceptive choice**

The aim in Kingston is to offer convenient access to a range of contraception services (including LARC) from a range of community-based and primary care settings (with under 24
year olds accessing community pharmacies for emergency hormonal contraception), a 5 year target of 100% of sexually active under 24 year olds accessing condom services and a 7% shift from oral contraception to LARC use by 2012 / 2013.

This will be achieved by:

- Re-launching and rolling out the condom distribution scheme in line with pan-London plans (procurement and distribution).
- Ensuring consistent emergency hormonal contraception provision from community pharmacies.
- Expanding school general health drop-ins to include sexual health services.
- Arranging with British Pregnancy Advisory Service (as Kingston’s main abortion provider) to provide immediate advice about, and initial supply of, the full range of reversible contraceptive methods, including condoms, and access to permanent methods. This is in line with the Recommended Standards for Sexual Health Services, MedFASH, 2005.
- Enabling ongoing provision of LARC training for general practice staff and contraception service providers as well as genitourinary medicine (GUM) staff.
- Enabling clinical support of provision of LARC from general practice settings.
- Supporting a comprehensive choice of contraception (including LARC) from community contraception sites and termination of pregnancy providers.
- Engaging non-clinical settings to provide clinical sexual health support (through the sexual health promotion nurse post which commenced in January 2008).
- Increasing the capability of school health, local authority, and primary care staff in primary prevention. This will be led by the new sexual health promotion specialist who joined in November 2008.
- Ensuring the sexual health promotion specialist is actively involved with promoting sexual health services and any related media / publicity developments.
- Making services acceptable and accessible to young people through the use of the ‘You’re Welcome’ criteria (a set of criteria designed for all health services which aim to improve the acceptability, accessibility, quality and choice of services for young people).
Chlamydia

Untreated Chlamydia infection may result in pelvic inflammatory disease (PID), ectopic pregnancies or infertility. These complications are all preventable if the infection is diagnosed and promptly treated. Complications are extremely distressing for women, and cost an estimated £100 million to the NHS every year.

Young people in Kingston aged 15-19 years and 20-24 years have the highest rates of Chlamydia, based on the numbers seen at the Wolverton Centre (Figure 8.3).

**Figure 8.3** Age-specific diagnosis rates for Chlamydia at the Wolverton Centre for NHS Kingston patients

![Graph showing age-specific diagnosis rates for Chlamydia](#)

Source: K60 GUM data

Notes. The age groups used in this graph are based on available data from the Health Protection Agency and may not represent equal ranges.

The Vital Sign target for 2009/10 is that 25% of 15-24 year olds will be screened for Chlamydia within the South West London screening programme. An integrated approach will be required to utilise outreach and core service providers to achieve this.

Since the South West London Chlamydia Screening Programme commenced in January 2008, Kingston’s screening rates improved throughout 2008/09. This increase is mainly due to the commissioning of the Metro outreach organisation. Although outreach screening did well in covering young men, positivity rates remained low because the more vulnerable groups were
not well-targeted. This was highlighted in the Chlamydia Screening Office and National Chlamydia Screening Programme reports.

**Local action to improve Chlamydia screening**

Screening will be made more available, with particular attention to the 15-24 year age group. This will be achieved by:

- Developing contracting/procurement strategies based on the priorities in the 2008 sexual health needs assessment and best practice service models e.g. for outreach. Collaboration will be considered with neighbouring PCTs to optimise contracts with sites which serve residents from more than one PCT.
- Commissioning to exceed the target to gain maximum value for money (35 - 50% screening coverage being cost-effective in a population with 10% positivity rate).
- Continuing commissioning of primary care through local enhanced services (LES), with Community Pharmacy also providing partner notification and treatment as part of the programme. Screening LES to be based on return rate only with targets for GPs.
- Commissioning provider services to engage in increased outreach work to benefit from the effective model used by existing outreach organisation e.g. engaging schools and youth services.
- Collaborating with RBK on joint planning to ensure Chlamydia screening is prioritised in the Local Strategic Partnership (LSP), the Joint Strategic Needs Assessment (JSNA), and the Local Area Agreement (LAA).
- Improving public awareness of the Chlamydia screening programme by commissioning effective social marketing to ensure the vulnerable sub-groups of the population can access screening.
- Commissioning outreach workers and a new sexual health promotion nurse to specifically undertake screening in areas of vulnerable young people - thus identifying and screening populations with potentially higher positivity rates.
- Developing links between youth services, education and outreach to core services to increase access to existing clinical provision. To be lead by the new sexual health promotion specialist nurse and outreach workforce.
- Improving capability and identifying gaps in provision and training. Resourcing and prioritising the training for staff within core services, especially in relation to treatment and partner notification (by the new sexual health promotion specialist post).
- Seeking young persons' views in developing local publicity (by the new sexual health promotion specialist post).
- Undertaking a capacity analysis of existing services to support service planning for Chlamydia screening.
• Continuing to foster strong links between NHS Kingston and local surveillance services e.g. local laboratories.
• Ensuring that contraception services contribute substantially to the target by offering Chlamydia screening on a routine opt-out basis only.
• Engaging and commissioning abortion services to provide Chlamydia screening as routine care prior to abortions in all under-25 year olds.

**HIV**

Early diagnosis of HIV means treatment can begin at an earlier stage, which gives each person with HIV the chance of a better prognosis. Early diagnosis can also prevent onward transmission of HIV to others.

The 2007-2008 NHS London Business Plan made HIV prevention a priority for London PCTs and set a new HIV prevention performance indicator to reduce late diagnoses of HIV on the basis that earlier diagnosis will:
• Reduce the level of undiagnosed HIV in the population
• Enable people to be supported to make behavioural changes to avoid infecting others
• Some people may have their infectivity reduced due to earlier treatment with antiretroviral drugs (ART)
• Reduce lengthy inpatient stays
• Reduce the risk of AIDS/symptomatic HIV (it is estimated that 25% of all HIV related deaths are in patients who presented late)

In Kingston just under a third of all cases are diagnosed late. Late diagnosis is defined as a CD4 count less than 200 cells / mm³ indicating an average of 8 years of infection prior to diagnosis.

Overall, comparing 2007 data with the baseline 2004/05 data, NHS Kingston ranks 18th best out of 31 of the London PCTs in its proportion of late HIV diagnoses in the whole population. Using the same data comparisons, NHS Kingston ranks 5th best for late diagnoses in Men having Sex with Men (MSM), but is the second worst out of 31 PCTs for new diagnoses being made late in the heterosexual population. (Figure 8.4)
Across SW London, most people infected heterosexually were Black African (70%) and most people infected through sex between men were White (76%).

The sexual health needs assessment revealed that in 2006 approximately half of all new diagnoses in Kingston were in Black Africans. The highest rate was in Black African females.

Late diagnoses continue to occur as a result of health care agencies failing to identify symptoms of HIV infection. Many agencies are not adequately aware of the appropriate procedures for pre- and post-test discussion. Symptoms can be identified by taking a risk history and by an up to date awareness of HIV and AIDS related symptoms. Post-test discussion involves providing results, following up and referring people appropriately to medical and social care support.

The sexual health needs assessment (2008) revealed that in Kingston

- there is limited HIV outreach work from African Positive Outlook and with Black Africans, with MSM and with young people.
- HIV testing is offered in only 11 out of the 24 responding GP practices.
- There is very limited access to condoms in GP surgeries.
- GPs and other agencies were not facilitating the early diagnosis of HIV in people of Black African background.
Local action to improve early diagnosis of HIV

In Kingston, the aim is to increase ease of access to HIV testing in the acute sector, primary care, and community settings and to provide better primary and secondary prevention through community organisations so that by 2010/11 only 15% of people receiving new HIV diagnoses have a ‘late’ diagnosis.

This will be achieved by rolling out the ‘You’re Welcome’ framework and involving young people (including the most socially excluded), MSM, Black African populations, service user groups and expert patient groups in the development of services and related publicity. The main actions will be:

- Strengthen collaborative commissioning to ensure effective support of HIV prevention services from community based voluntary black and ethnic minorities and men who have sex with men (MSM) groups.
- Training general practice staff in HIV testing.
- GP local enhanced service (LES) costs to include HIV testing.

Conclusion

Kingston’s plans are compatible with the recent sexual health intelligence gained from the pan-London ‘Sex and the City’ survey which highlights improving access to long acting reversible contraceptives, offering Chlamydia screening more widely, and making HIV testing more accessible to avoid late diagnosis.

Effective commissioning of a responsive and innovative sexual health service is essential if the vision of an effective and personalised world class service is to be realised.

Recommendations

1. NHS Kingston and partner organisations should work together to implement the recommendations set out by the sexual health needs assessment.

2. NHS Kingston and partners should work together to commission effectively to address further improvements to LARC provision, the Chlamydia Screening Programme, and the identification and care of people with HIV.
Emergency Planning and Preparedness

Noel James, Emergency Planning Manager, NHS Kingston (noel.james@kpct.nhs.uk)

Introduction

The Civil Contingencies Act 2004 requires NHS Kingston to prepare for major incidents and other civil emergencies which may affect the borough and its population. NHS Kingston is classified as a Category 1 responder, which places a number of statutory duties on the Trust. Other Category 1 responders include NHS Acute Trusts, Local Authorities and the Emergency Services.

NHS Kingston is required to:
- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and to maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other responders to enhance co-ordination and efficiency

This year, the emergence of swine flu has tested local emergency planning and has led to a strengthening of planning for, and response to, a pandemic. Other than this, Kingston has been fortunate in the low number of incidents in the borough this year.

This chapter considers the current situation with swine flu, the frameworks for emergency planning and preparedness, and briefly reviews the main non-flu incidents and risks to the population of Kingston.

Swine flu H1N1

Swine flu is a respiratory illness caused by the type A influenza (H1N1) virus, which emerged in Mexico in April 2009. Transmission of this virus is thought to occur in the same way as seasonal flu. The infection can be treated with antiviral medication. To date, most reported cases outside of Mexico have been mild and people have recovered fully after treatment.
What is the national picture?

Swine flu is a pandemic influenza. A pandemic influenza is a type of influenza that occurs every few decades and which spreads rapidly across the world. The symptoms of pandemic flu are similar to those of ‘ordinary’ flu but are usually, but not always, more severe. Groups at particular risk will not be known until the disease has been in circulation for many months, but it is likely that at least a quarter of the population may be affected by the end of a pandemic.

Due to the significant impact of a flu pandemic the Government, led by the Department of Health, has produced a national influenza pandemic plan. Each PCT across the country has developed local plans in accordance with national guidance.

The World Health Organization (WHO) raised its pandemic alert level to Phase 6 on Thursday 11th June 2009, having been at Phase 5 since Tuesday 29 April 2009. The Director-General of WHO is the decision-maker in terms of elevating the global stages of pandemic alert. Experts from around the world are working in close collaboration with WHO to help determine what risk this situation poses to global public health.

Phase 6 is characterised by ‘human-to-human spread of the virus into at least two countries in one WHO region plus at least one country in a different WHO region’. The declaration of Phase 6 is a signal to be ready to operationalise plans if and when the pandemic reaches Kingston.

What is the local picture?

The Health Protection Agency is monitoring this situation closely. Testing has shown that human swine influenza H1N1 can be treated with the anti-virals oseltamivir (Tamiflu) and zanamivir (Relenza). However, earlier reported swine influenza cases recovered fully from the disease without requiring antiviral medication.

The confirmed cases (to date) within South West London sector have mainly been connected to outbreaks in schools, but this is likely to change during the coming months.

Comprehensive advice on swine flu is published on the Health Protection Agency website www.hpa.org.uk.
Local response

Since the beginning of the swine flu outbreak in April 2009, the local Health Protection Unit has been working closely with NHS Kingston, primary care colleagues and patients to collect samples, conduct testing and provide advice on medication and other public health activities.

Following revised Department of Health guidance, NHS Kingston has been finalising operational plans in anticipation of the situation potentially escalating in the near future.

Advice for the public on swine flu is shown in Box 8.1. The virus spreads through the air when people cough and sneeze. Basic hygiene measures, including good hand hygiene, will help reduce the chance of infection.

Lessons learnt to date

A number of issues and recommendations have been raised since the start of the swine flu outbreak. New procedures for dealing with suspected cases have been agreed and original Department of Health guidance has been updated. As a result local plans have been revised to incorporate new procedures and recommendations.

One of the key aspects to the response has been good communication links with both staff and key stakeholders. Regular updates provide individuals with the reassurance and knowledge for dealing with patients and the general public.
CATCH IT

Germs spread easily. Always carry tissues and use them to catch your cough or sneeze.

BIN IT

Germs can live for several hours on tissues. Dispose of your tissue as soon as possible.

KILL IT

Hands can transfer germs to every surface you touch. Clean your hands as soon as you can.
Current advice to the public about Swine Flu
(June 2009)

Patients with flu-like symptoms should follow these steps:

• Stay at home
• Visit the NHS Choices website (www.nhs.uk) for information and frequently asked questions about Swine Flu. Use the online flu symptom checker on www.nhs.uk or the NHS Direct website www.nhsdirect.nhs.uk
• If people living in Kingston do not have access to the internet, they can call the Swine Flu Information line on 0800 1 513 513 to hear the latest advice.
• If people with flu-like symptoms have taken these steps and are still concerned, they can call the NHS Direct Telephone Service 0845 46 47 or they should call their GP. They will be able to discuss their symptoms and agree the next steps to take.
• People should not go into their GP surgery or local Accident and Emergency department unless advised to do so or if they are seriously ill, because they might spread the illness to others. They should ask their ‘flu friend’ to go out for them.

General infection control practices and good respiratory hand hygiene can help to reduce transmission of all viruses, including the human swine influenza. This advice is:

• Cover your nose and mouth when coughing or sneezing, using a tissue when possible.
• Dispose of dirty tissues promptly and carefully.
• Maintain good basic hygiene, for example washing hands frequently with soap and water to reduce the spread of the virus from your hands to face, or to other people.
• Clean hard surfaces (e.g. door handles) frequently using a normal cleaning product.
• Make sure your children follow this advice.

Ensuring NHS Kingston is compliant with its emergency planning and preparedness duties

The duties of NHS Kingston under the Civil Contingencies Act are encompassed within the NHS Emergency Planning Guidance (2005) and reinforced by the Standards for Better Health (Public Health Core Standard C24) which states that:

“Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which affect the provision of normal services”
The five main areas of work that have been undertaken to achieve and maintain compliance are:

1) Risk assessments
The Local Resilience Forum has in place a robust system for the identification of risks and has created a local risk register. To date, the risk register* identifies pandemic flu, flooding, and terrorism as the highest risks to the South West London sector.

2) Planning and Preparedness - Major Incident Plan
NHS Kingston has a Major Incident Plan which is the overarching plan that is intended to support and guide staff in the event of a major incident. It is supported by a number of specific emergency plans such as a heat wave plan, a mass vaccination plan and a mass casualty plan. In addition, NHS Kingston has a separate pandemic flu plan.

These plans are reviewed regularly and updated as required. In the past year, NHS Kingston has assessed the impact of the separation from NHS Kingston of a group of staff (comprising district nurses, health visitors and related staff) to form a social enterprise organisation ‘Your Healthcare’. These staff will form an important part of the response team in a major incident. NHS Kingston has considered what needs to be put in place to retain an effective response capacity.

3) Command and Control Structure in an Emergency
In the event of an emergency NHS Kingston has a nominated emergency control room which provides a single focal point for managing the response to an incident. To ensure the incident is managed efficiently NHS Kingston has agreed a Strategic (Gold), Tactical (Silver) and Operational (Bronze) level of command to any response. (Figure 8.5)

* The public version of the risk register can be accessed at http://www.london-fire.gov.uk/Documents/local-resilience-forum-southwest-london.pdf
NHS Kingston continues to maintain a senior manager on call rota, which ensures the organisation can be alerted of an incident 24 hours a day. The on call manager (silver) will notify the director (gold) on call of any incidents that occur within the borough.

4) Business Continuity Planning
The NHS Kingston business continuity plan is now in place and the resilience of a number of systems is due to be tested. Depending on the nature of the incident, the recovery phase may be managed by normal procedures, or if the incident has a major impact on services then the continuity plans will also provide guidance on returning to business to normal.

NHS Kingston will support GPs and other independent contractors to develop their own continuity plans.

5) Training and Exercise
The NHS Emergency Planning Guidance 2005 requires NHS organisations to participate in a live exercise every three years, a tabletop exercise every year and a six monthly communications test. During the period April 2008 to March 2009 NHS Kingston participated in:
- Two communication exercises
- Two table top exercises and
- Participated and umpired in a number of external multi-agency exercises.

In addition to the exercises, the emergence of swine flu in April 2009 has tested many aspects of the emergency plans in a real situation.

The Emergency Planning Committee
The Joint Director of Public Health (DPH) is the NHS Kingston lead for emergency planning supported by the dedicated emergency planning manager. The DPH chairs the multi-agency emergency planning and influenza pandemic committee. The emergency planning team liaises with all the relevant agencies in the borough which includes representatives from the London Borough of Kingston, Kingston Hospital Trust, Police, London Ambulance Service, Health Protection Unit and South West London & St Georges Mental Health Trust, to ensure the effective co-ordination of NHS Kingston plans. In addition, the team is responsible for ensuring NHS Kingston is aware of, and implements, any changes in emergency planning guidance or standards.
NHS Kingston specific planning

Over the last year NHS Kingston has finalised a number of specific emergency plans. The pandemic flu and mass vaccination plan have been completed which involved consultation with a number of different agencies. Both plans will continue to be updated following the publication of national guidance and lessons learnt from future exercises.

Non-flu incidents and the main risks to the Kingston population

The recent emergence of swine flu, and the declaration of a pandemic, has been the most important incident in the last year. Otherwise, in recent years the borough has been fortunate with the small number and low severity of incidents that have occurred. The most significant non-flu events within the borough have involved fluvial flooding and severe weather (Box 8.2), but these have only resulted in a moderate impact on services.

Risk of Terrorism

The London Bombings was the most recent terrorism attack experienced in the UK. Hundreds of people were directly injured by the attacks but many more were affected by their experiences that day and in the days that followed.

Whilst much is being done to minimise the risk of future attacks on the country, if one was to be successful, the impact may be catastrophic. Lessons identified in the investigations following the London Bombings allowed all organisations to improve their emergency preparedness and cohesion. Some of the keys areas identified for improvement included better support to the bereaved and survivors, providing timely information to the public and keeping London moving safely. It is important these lessons are incorporated into plans to improve the response to future major incidents.

Risk of Flooding

The likelihood of tidal flooding in Kingston is very low but the impact on the community and infrastructure would be catastrophic. As a result, the local authority in partnership with all Category 1 responders is developing local plans. The flood plans will list roles and responsibilities for each organisation to ensure a coordinated response. The local authority will take into consideration the river flooding incidents that have occurred recently in Kingston.
The greatest health risks with flooding are drowning, accidents and injuries due to moving water and concealed hazards, and carbon monoxide poisoning. The main area of concern for NHS Kingston is to ensure patients continue to have access to health services in their time of need.

The Environment Agency provides further details on flood warnings and offers practical advice on preparing your home or business for flooding.
Health Protection
and Emergency
Planning

Box 8.2

**Severe Weather Incident: Snow**

Heavy snow fell throughout the Sunday night and settled across South East England on the morning of the 2nd February 2009. The conditions caused major disruption to public transport and road traffic. This resulted in large numbers of NHS staff being unable to attend work which increased the pressures on health services. Those who were able to make it to work found it increasingly difficult to travel to see patients at home.

The severe weather affected the whole of London therefore the difficulties faced by individual primary care trusts were very similar. In particular, staff shortages, reduction in public transport and poor communications between organisations were the main issues faced by services. The snow incident did not warrant the declaration of a major incident but most organisations within the borough invoked their business continuity plans which helped prioritise their response.

Since the severe weather incident the South West London emergency planning sector has developed a list of actions following lessons learnt. These will all be incorporated into local emergency and business continuity plans.

During any local incident the best advice for the general public is to 'stay-in' and 'tune-in' to either local radio and television or visit the NHS Kingston and NHS Direct websites for accurate and timely information.
Future priorities

The priorities for the next year for emergency planning are to focus on responding to and recovering from the swine flu pandemic, and to develop specific emergency plans which will include ‘flooding’ and ‘mass casualties’. In addition, NHS Kingston will focus resources towards the training and exercising of staff to help improve NHS Kingston’s response and cohesion to all future incidents. Training is key to the successful implementation of emergency plans and is an essential part of NHS Kingston’s emergency planning process.

Recommendations

1. NHS Kingston, Royal Borough of Kingston and partners should continue to develop and adjust plans for responding to an influenza pandemic, using lessons learnt from the ongoing swine flu outbreak.
2. NHS Kingston should deliver comprehensive emergency planning training to all staff on a rolling basis.
3. NHS Kingston and Royal Borough of Kingston should develop severe weather plans taking into account the recent lessons from recent flooding and severe weather incidents.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APHR</td>
<td>Annual Public Health Report</td>
</tr>
<tr>
<td>ASCA</td>
<td>Addiction Support and Care Agency</td>
</tr>
<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorder</td>
</tr>
<tr>
<td>ART</td>
<td>Anti Retroviral Therapies</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacille Calmette Guérin (TB Vaccination)</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>BPAS</td>
<td>British Pregnancy Advisory Service</td>
</tr>
<tr>
<td>Bre</td>
<td>Building Research Establishment</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CD4</td>
<td>Cluster of Differentiation 4</td>
</tr>
<tr>
<td>CDAT</td>
<td>Community Drugs and Alcohol Team</td>
</tr>
<tr>
<td>CDRP</td>
<td>Crime and Disorder Reduction Partnership</td>
</tr>
<tr>
<td>CDW</td>
<td>Community Development Worker</td>
</tr>
<tr>
<td>CEN</td>
<td>Creative Environmental Networks</td>
</tr>
<tr>
<td>CfI</td>
<td>Centre for Infections, Health Protection Agency, Colindale</td>
</tr>
<tr>
<td>CHIA</td>
<td>Child Health Interim Application</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CHS</td>
<td>Child Health Computer System</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence Interval</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
</tr>
<tr>
<td>COVER</td>
<td>Coverage of Vaccination Evaluated Rapidly</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation Scheme</td>
</tr>
<tr>
<td>CRE</td>
<td>Cambridge Road Estates</td>
</tr>
<tr>
<td>CSCI</td>
<td>Commission for Social Care Inspection</td>
</tr>
<tr>
<td>CSLTT</td>
<td>Children’s Speech and Language Therapy Team</td>
</tr>
<tr>
<td>CSPAN</td>
<td>Community Sport and Physical Activity Network</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and Young People</td>
</tr>
<tr>
<td>CYPT</td>
<td>Children and Young Peoples Trust</td>
</tr>
<tr>
<td>DAAT</td>
<td>Drug and Alcohol Action Team</td>
</tr>
<tr>
<td>DCLG</td>
<td>Department for Communities and Local Government</td>
</tr>
<tr>
<td>DNA</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>DPH</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>DTP</td>
<td>Diphtheria, Tetanus and Pertussis</td>
</tr>
<tr>
<td>ECM</td>
<td>Every Child Matters</td>
</tr>
</tbody>
</table>
EHC Emergency Hormonal Contraception
EHCS English House Condition Survey
EHS English Housing Survey
ePACT Electronic Prescribing Analysis and Cost Data
ESOL English for Speakers of Other Languages
GDP General Dental Practitioner
GFR General Fertility Rate
GLA Greater London Authority
GP General Practitioner
GUM Genito-Urinary Medicine
HHSRS Housing Health and Safety Rating System
Hib Haemophilus influenza B
HIV Human Immunodeficiency Virus
HMO Houses of Multiple Occupation
HPA Health Protection Agency
HPU Health Protection Unit
HPV Human Papilloma Virus
IAPT Improved Access to Psychological Therapies
IDU Injecting Drug User
ILI Influenza like Illness
IMD Index of Multiple Deprivation
IT Information Technology
JSNA Joint Strategic Needs Assessment
KCN Kingston Carers’ Network
KFS Kingston Fire Service
LAA Local Area Agreement
LARC Long Acting Reversible Contraception
LBW Low Birth Weight
LD Learning Disability
LDP Local Delivery Plan
LEAH Learn English At Home
LES Local Enhanced Service
LFB London Fire Brigade
LHO London Health Observatory
LSP Local Strategic Partnership
LTBR London Tuberculosis Register
MedFASH Medical Foundation for AIDS and Sexual Health
Men C Meningitis C
MMR Measles, Mumps and Rubella
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMRV</td>
<td>Measles, Mumps and Rubella Vaccination</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NCAT</td>
<td>National Clinical Advisory Team</td>
</tr>
<tr>
<td>NCSP</td>
<td>National Chlamydia Screening Programme</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NHSK</td>
<td>NHS Kingston</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NSC</td>
<td>National Screening Committee</td>
</tr>
<tr>
<td>NSF</td>
<td>National Service Framework</td>
</tr>
<tr>
<td>NTA</td>
<td>National Treatment Agency for Substance Misuse</td>
</tr>
<tr>
<td>OCs</td>
<td>Oral Contraceptives</td>
</tr>
<tr>
<td>Ofsted</td>
<td>Office for Standards in Education</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>OPMH</td>
<td>Older Peoples Mental Health</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PCV</td>
<td>Pneumococcal vaccine</td>
</tr>
<tr>
<td>PEC</td>
<td>Professional Executive Committee</td>
</tr>
<tr>
<td>PGD</td>
<td>Patient Group Direction</td>
</tr>
<tr>
<td>PHAR</td>
<td>Public Health Annual Report</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
</tr>
<tr>
<td>PSHE</td>
<td>Personal, Social and Health Education</td>
</tr>
<tr>
<td>PTiPC</td>
<td>Psychological Therapies in Primary Care team</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
</tr>
<tr>
<td>RAK</td>
<td>Refugee Action Kingston</td>
</tr>
<tr>
<td>RBK</td>
<td>Royal Borough of Kingston</td>
</tr>
<tr>
<td>SAP</td>
<td>Standard Assessment Procedure</td>
</tr>
<tr>
<td>SEAL</td>
<td>Social and Emotional Aspects of Learning</td>
</tr>
<tr>
<td>SLT, S&amp;LT</td>
<td>Speech and Language Therapy</td>
</tr>
<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
</tr>
<tr>
<td>SPAD</td>
<td>Strategic Partnership for Alcohol and Drugs</td>
</tr>
<tr>
<td>SMR</td>
<td>Standardised Mortality Ratio</td>
</tr>
<tr>
<td>SOA</td>
<td>Super Output Area</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SWL</td>
<td>South West London</td>
</tr>
<tr>
<td>SLWSS</td>
<td>South West London Surrey and Sussex</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TPFR</td>
<td>Total Period Fertility Rate</td>
</tr>
<tr>
<td>VS</td>
<td>Vital Statistics</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Glossary

Asylum seeker
Someone who has left their country of origin and formally applied for asylum in another country, but whose application has not been dealt with yet.

ASCA
ASCA (Addiction Support and Care Agency) offers a range of interventions including counselling, group work and holistic therapies in Kingston and Richmond.

CD4
CD4 (cluster of differentiation 4) is a glycoprotein expressed on the surface of cells involved in the immune response including T helper cells, regulatory T cells, monocytes, macrophages, and dendritic cells. CD4 is the primary receptor used by HIV to gain entry into host T cells.

Children's Centre
Children's Centres bring together a variety of services, such as antenatal and post natal care, child health preventative services, parental outreach and day care provision in one location.

Connexions
Connexions is an organisation that offers advice to 13 to 19 year olds on education, careers, housing, money and health.

Decent Home
A 'decent home' is a dwelling that meets the following four criteria:-
1. It meets the current statutory minimum standard for housing
2. It is in a reasonable state of repair.
3. It has reasonably modern facilities and services.
4. It provides a reasonable degree of thermal comfort.

dmft index
An indicator of dental disease calculated as the proportion of the number of teeth decayed, missing of filled to the total number of teeth examined among 5 year old children.

Fuel Poverty
A household is in fuel poverty if it needs to spend more than 10% of its income on fuel (including heating, hot water, lighting and cooking).
Herd immunity
Herd immunity occurs when the vaccination of a portion of a population (or ‘herd’) provides protection to unvaccinated individuals. When large number of the population are immune it is more difficult for infection to pass from person to person.

Index of Multiple Deprivation (IMD)
IMD is a composite measure made up of seven domains, which when combined give a score indicating the estimated deprivation experienced by the population in any given area. Further information on IMD can be found in Appendix 1 and in last years Annual Public Health Report 2007- The Road Less Travelled.

KU19
‘KU19’ offers a confidential sexual health and contraceptive service to young people. It is an open access service (no appointment is necessary) and has services at the Wolverton Centre at Kingston Hospital (known as ‘The Point’), the YMCA in Surbiton and Siddeley House in central Kingston.

Low Birth Weight
Babies born weighing less than 2500g are classified as being of low birth weight.

Neonatal
The period between birth and the first month of life.

National Institute for Health and Clinical Excellence (NICE)
The independent organisation responsible for providing national guidance on the promotion of good health and the treatment of ill health (www.nice.org.uk).

Overcrowding
Overcrowding is where the number of persons sleeping in a dwelling contravenes the specified bedroom standard or specified space standard.

Oxygen
Oxygen is a local project for young people started by local churches that works in partnership with a range of local agencies.

Participatory Needs Assessment
An assessment of the needs of a population or group of people, based on detailed work to canvas their wishes and demands. This type of assessment uses methods such as surveys, focus groups and one-to-one interviews.
**Perinatal**
The period from 24 weeks gestation to 7 days after birth.

**Positive Futures**
Positive Futures is a national social inclusion programme using sport and leisure activities to engage with disadvantaged and socially marginalised young people.

**Premature death**
Death in someone under 75 years old.

**Pupil Referral Unit**
A Pupil Referral Unit is a type of school set up and run by local authorities to provide education for children who cannot attend school.

**Quality and Outcomes Framework (QOF)**
The annual reward and incentive programme detailing GP practice achievement results. It is a voluntary process for all surgeries in England and was produced as part of the GP contract in 2004.

**Refugee**
Someone who has successfully applied for asylum and is allowed to stay in the country having proved they would face persecution in their home country.

**Rough sleepers**
Homeless people who live on the street.

**Social housing**
Properties owned by and rented from councils or landlords providing dwellings to people known to the council, or Housing Associations (in contrast to the private market).

**Sofa surfers**
Homeless people who live temporarily in their friends or relatives houses.

**Standardised Mortality Ratio (SMR)**
A measure for comparing observed deaths compared to expected deaths, that can be used across subpopulations in the same year or across different years. A value of 100 indicates that the actual (observed) number is the same as the expected number. A value higher than 100 indicates that the actual number is higher than expected.
Statutorily Homeless
A designation given to people who apply to the council for assessment for homelessness, and who fulfil a set of criteria categorising them as in a priority group for housing. The Council has a duty to provide temporary accommodation to a person who is statutorily homeless.

Super Output Areas (SOAs)
SOAs are a new geography of the 2001 census designed to improve the reporting of small area statistics in England and Wales. SOAs are more similar in size than wards. They are intended to be stable and to allow comparison and monitoring of policy over time.

Swine Flu H1N1
Swine flu H1N1 is a novel influenza virus that emerged in Mexico in April 2009 and is causing a worldwide pandemic.

Your Healthcare
Your Healthcare is the name of the new service providing district nursing, health visiting, speech and language therapies and associated services.
Appendix 1: Index of Multiple Deprivation 2007: Barriers to Housing and Services Domain

The Index of Multiple Deprivation (IMD) is based on the idea of distinct dimensions of deprivation which can be categorised and measured separately. They are experienced by individuals living in an area. People may be counted as being deprived in one of more of the domains, depending on the number and types of deprivation that they experience.

The first IMD was published in 2000, updated in 2004 and updated most recently in 2007. Further details can be found in last year’s Joint Annual Public Health Report 2007 ‘The Road Less Travelled’. The domains are:

- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services
- Crime
- Living environment deprivation

The IMD 2007 is a Lower layer Super Output Area (LSOA) level measure. Kingston has 97 LSOAs.

Barriers to Housing and Services Domain

The purpose of this domain is to measure barriers to housing and key local services. The indicators are structured into two sub-domains: ‘geographical barriers’, and ‘wider barriers’ which includes issues relating to access to housing, such as affordability.

Sub Domain: Wider Barriers

- Household overcrowding (Source: 2001 Census)
- LA level percentage of households for whom a decision on their application for assistance under the homeless provisions of housing legislation has been made, assigned to the constituent SOAs (Source: Communities and Local Government, 2005)
- Difficulty of Access to owner-occupation (Source: modelled estimates produced by Heriot-Watt University, 2005)

Sub Domain: Geographical Barriers

- Road distance to a GP surgery (Source: National Administrative Codes Service, 2005)
- Road distance to a general stores or supermarket (Source: MapInfo Ltd, 2005)
- Road distance to a primary school (Source: DCFS, 2004-05)
- Road distance to a Post Office or sub post office (Source: Post Office Ltd, 2005)
# Statistical Annex

## Table SA-1

Population Age Structure in Kingston, 2007 (numbers)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Gender</th>
<th>0-4</th>
<th>5-14</th>
<th>15-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>All Ages</th>
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<tr>
<td>Kingston M</td>
<td>5,057</td>
<td>8,531</td>
<td>11,143</td>
<td>27,934</td>
<td>17,389</td>
<td>4,326</td>
<td>2,747</td>
<td>1,026</td>
<td>78,153</td>
<td></td>
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<tr>
<td>upon F</td>
<td>4,879</td>
<td>8,492</td>
<td>11,478</td>
<td>26,011</td>
<td>17,893</td>
<td>4,853</td>
<td>4,059</td>
<td>2,105</td>
<td>79,770</td>
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<tr>
<td>Thames P</td>
<td>9,936</td>
<td>17,023</td>
<td>22,621</td>
<td>53,945</td>
<td>35,282</td>
<td>9,179</td>
<td>6,806</td>
<td>3,131</td>
<td>157,923</td>
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<td>London M</td>
<td>271,329</td>
<td>427,680</td>
<td>498,068</td>
<td>1,398,886</td>
<td>761,644</td>
<td>210,636</td>
<td>129,332</td>
<td>40,151</td>
<td>3,737,726</td>
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<td>F</td>
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<td>412,629</td>
<td>491,405</td>
<td>1,348,668</td>
<td>804,801</td>
<td>240,200</td>
<td>180,357</td>
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<td>3,819,204</td>
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<td>989,473</td>
<td>2,747,554</td>
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<tr>
<td>England M</td>
<td>1,640,539</td>
<td>3,231,491</td>
<td>3,714,783</td>
<td>7,584,911</td>
<td>6,621,395</td>
<td>2,126,788</td>
<td>1,282,566</td>
<td>366,035</td>
<td>26,568,508</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>1,561,550</td>
<td>3,082,011</td>
<td>3,504,612</td>
<td>7,622,604</td>
<td>6,817,953</td>
<td>2,341,705</td>
<td>1,766,918</td>
<td>806,146</td>
<td>27,503,499</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>3,202,089</td>
<td>6,313,502</td>
<td>7,219,395</td>
<td>15,207,515</td>
<td>13,439,348</td>
<td>4,468,493</td>
<td>3,049,484</td>
<td>1,172,181</td>
<td>54,072,007</td>
<td></td>
</tr>
</tbody>
</table>


## Table SA-2

Kingston & Greater London Authority Six Year Population Projections, 2013 (numbers)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Gender</th>
<th>0-4</th>
<th>5-14</th>
<th>15-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston M</td>
<td>5,134</td>
<td>9,155</td>
<td>8,793</td>
<td>27,929</td>
<td>18,490</td>
<td>4,982</td>
<td>2,668</td>
<td>1,049</td>
<td>78,201</td>
<td></td>
</tr>
<tr>
<td>upon F</td>
<td>4,858</td>
<td>8,669</td>
<td>8,725</td>
<td>28,051</td>
<td>19,527</td>
<td>5,498</td>
<td>3,564</td>
<td>1,933</td>
<td>80,824</td>
<td></td>
</tr>
<tr>
<td>Thames P</td>
<td>9,992</td>
<td>17,824</td>
<td>17,518</td>
<td>55,980</td>
<td>38,017</td>
<td>10,480</td>
<td>6,232</td>
<td>2,983</td>
<td>159,025</td>
<td></td>
</tr>
<tr>
<td>Greater M</td>
<td>268,729</td>
<td>439,108</td>
<td>423,637</td>
<td>1,403,138</td>
<td>755,701</td>
<td>206,914</td>
<td>125,608</td>
<td>37,612</td>
<td>3,670,446</td>
<td></td>
</tr>
<tr>
<td>London F</td>
<td>258,066</td>
<td>423,457</td>
<td>448,225</td>
<td>1,410,243</td>
<td>802,833</td>
<td>234,923</td>
<td>177,428</td>
<td>79,325</td>
<td>3,834,499</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>526,795</td>
<td>862,565</td>
<td>881,862</td>
<td>2,813,380</td>
<td>1,558,534</td>
<td>441,837</td>
<td>303,036</td>
<td>116,937</td>
<td>7,504,945</td>
<td></td>
</tr>
</tbody>
</table>

Source: 2007 Round of GLA Demographic Projections (Low)
### Table SA-3

<table>
<thead>
<tr>
<th>Area</th>
<th>2007</th>
<th>2013</th>
<th>2016</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston upon Thames</td>
<td>157,600</td>
<td>170,100</td>
<td>175,600</td>
<td>184,200</td>
</tr>
<tr>
<td>Greater London</td>
<td>7,556,100</td>
<td>7,939,400</td>
<td>8,114,300</td>
<td>8,390,100</td>
</tr>
</tbody>
</table>


### Table SA-4
Key Birth Statistics, 2007

<table>
<thead>
<tr>
<th>Area</th>
<th>Female Population aged 15-44</th>
<th>Number of live births</th>
<th>General Fertility Rate*</th>
<th>Total Period Fertility Rate</th>
<th>% Mothers under 20 Years</th>
<th>% Mothers 40 Years &amp; over</th>
<th>% Live Births in NHS Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston upon Thames</td>
<td>37,489</td>
<td>2,197</td>
<td>58.6</td>
<td>1.69</td>
<td>2.4%</td>
<td>5.6%</td>
<td>97.2%</td>
</tr>
<tr>
<td>London</td>
<td>1,840,073</td>
<td>125,505</td>
<td>68.2</td>
<td>1.92</td>
<td>4.0%</td>
<td>5.0%</td>
<td>95.9%</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>11,127,216</td>
<td>689,771</td>
<td>62.0</td>
<td>1.91</td>
<td>6.5%</td>
<td>3.7%</td>
<td>96.5%</td>
</tr>
</tbody>
</table>

* Birth Rate per 1000 Female aged 15-44

Source: 2009 Clinical and Health Outcomes Knowledge-Base
## Table SA-5
### Key Abortion Statistics, 2007

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Abortions for women Aged 15–44</th>
<th>Total Period Abortion Rates TPAR – Aged 11–49**</th>
<th>Rate per 1000 Women Aged 15–44 ASR*</th>
<th>Number of abortions to women under 18 years of age</th>
<th>Abortion rate/1000 to women under 18 years of age</th>
<th>% Abortions to women under 18 years of age</th>
<th>% Abortions 13 weeks gestation &amp; over</th>
<th>% Total NHS Funded Abortions**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston upon Thames</td>
<td>712</td>
<td>0.57</td>
<td>19</td>
<td>31</td>
<td>11.6</td>
<td>4.4%</td>
<td>8.1%</td>
<td>85.7</td>
</tr>
<tr>
<td>London</td>
<td>50,213</td>
<td>0.85</td>
<td>27.3</td>
<td>3,386</td>
<td>27.2</td>
<td>6.7%</td>
<td>10.2%</td>
<td>79.8</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>198,499</td>
<td>0.56</td>
<td>17.8</td>
<td>20,289</td>
<td>19.8</td>
<td>10.2%</td>
<td>10.3%</td>
<td>88.5</td>
</tr>
</tbody>
</table>

* Rates for all ages are based on populations aged 11–49 and include cases with age not stated  
** includes NHS hospitals and agencies  

Source: 2009 Clinical and Health Outcomes Knowledge Base

## Table SA-6
### Infant mortality statistics, 2007

<table>
<thead>
<tr>
<th>Area</th>
<th>Stillbirths</th>
<th>Perinatal Mortality</th>
<th>Early Neonatal Mortality</th>
<th>Neonatal Mortality</th>
<th>Post-Neonatal Mortality</th>
<th>Infant Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston upon Thames</td>
<td>Number</td>
<td>8</td>
<td>12</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>3.6</td>
<td>5.4</td>
<td>1.8</td>
<td>2.3</td>
<td>0.0</td>
</tr>
<tr>
<td>London</td>
<td>Number</td>
<td>781</td>
<td>1,067</td>
<td>286</td>
<td>387</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>6.2</td>
<td>8.4</td>
<td>2.3</td>
<td>3.1</td>
<td>3.7</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>Number</td>
<td>3,598</td>
<td>5,360</td>
<td>1,762</td>
<td>2,269</td>
<td>1,040</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>5.2</td>
<td>7.7</td>
<td>2.6</td>
<td>3.3</td>
<td>5.2</td>
</tr>
</tbody>
</table>

*Stillbirths:* Fetal deaths occurring after 24 weeks gestation.  Rate per 1,000 total live and still births  
*Perinatal Mortality:* Stillbirths and deaths of infants at ages under 7 days.  Rate per 1,000 total live & still births  
*Early Neonatal Mortality:* Deaths of infants at ages under 7 days.  Rate per 1000 live births.  
*Neonatal Mortality:* Deaths occurring under 28 days.  Rate per 1000 live births.  
*Post-neonatal Mortality:* Deaths of infants at ages 28 days to 1 year.  Rate per 1000 live births.  
*Infant mortality:* Deaths to infants at various ages: (<7 days, <28 days & 28 days to 1 year) under 1 year.  Rate per 1000 live births.  

Table SA-7
All cause mortality rates “all ages”, 2007

<table>
<thead>
<tr>
<th>Area</th>
<th>Gender</th>
<th>Number of Deaths</th>
<th>Crude Death Rate</th>
<th>Directly Standardised Death Rate*</th>
<th>All Cause SMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston upon Thames</td>
<td>M</td>
<td>500</td>
<td>642</td>
<td>635</td>
<td>89 (85 to 93)</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>611</td>
<td>770</td>
<td>452</td>
<td>93 (89 to 98)</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>1,111</td>
<td>707</td>
<td>535</td>
<td>91 (88 to 94)</td>
</tr>
<tr>
<td>London</td>
<td>M</td>
<td>24,458</td>
<td>663</td>
<td>698</td>
<td>97 (96 to 98)</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>25,236</td>
<td>667</td>
<td>476</td>
<td>94 (94 to 95)</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>49,694</td>
<td>666</td>
<td>577</td>
<td>96 (95 to 96)</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>M</td>
<td>238,185</td>
<td>904</td>
<td>713</td>
<td>100 (100 to 101)</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>261,375</td>
<td>956</td>
<td>502</td>
<td>100 (100 to 101)</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>499,560</td>
<td>930</td>
<td>597</td>
<td>100 (100 to 100)</td>
</tr>
</tbody>
</table>

*Rate per 100,000 population
*Rate per 100,000 and use the European Standard Population as the standard population.
PCO level data use 2004 mid-year population estimates


Table SA-8
All Causes Mortality, Indirectly Standardised Mortality Ratios (SMRs), all ages, all persons, 1993-2007

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston upon Thames</td>
<td>All</td>
<td>119</td>
<td>121</td>
<td>123</td>
<td>119</td>
<td>114</td>
<td>121</td>
<td>114</td>
<td>111</td>
<td>112</td>
<td>109</td>
<td>112</td>
<td>97</td>
<td>97</td>
<td>93</td>
</tr>
<tr>
<td>London</td>
<td>All</td>
<td>134</td>
<td>129</td>
<td>130</td>
<td>128</td>
<td>124</td>
<td>121</td>
<td>121</td>
<td>117</td>
<td>114</td>
<td>112</td>
<td>113</td>
<td>106</td>
<td>102</td>
<td>98</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>All</td>
<td>137</td>
<td>130</td>
<td>131</td>
<td>129</td>
<td>127</td>
<td>124</td>
<td>123</td>
<td>118</td>
<td>116</td>
<td>115</td>
<td>115</td>
<td>109</td>
<td>107</td>
<td>102</td>
</tr>
</tbody>
</table>

### Table 9: Main Causes of death in Kingston during 2006 & 2007, age 15 and over

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>2006</th>
<th>2007</th>
<th>Difference in death numbers since 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>% of All Cause Mortality</td>
</tr>
<tr>
<td>Diseases of the circulatory system (ICD10 I00-I99)</td>
<td>184</td>
<td>200</td>
<td>35.6%</td>
</tr>
<tr>
<td>Ischaemic heart disease (ICD10 I20-I25)</td>
<td>96</td>
<td>72</td>
<td>19.2%</td>
</tr>
<tr>
<td>Hypertensive disease (ICD10 I10-I15)</td>
<td>5</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>Cerebrovascular disease (ICD10 I60-I69)</td>
<td>40</td>
<td>76</td>
<td>8.0%</td>
</tr>
<tr>
<td>Malignant neoplasms (ICD10 C00-C97)</td>
<td>159</td>
<td>142</td>
<td>31.8%</td>
</tr>
<tr>
<td>Stomach Cancer (ICD10 C16)</td>
<td>6</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Colorectal Cancer (ICD10 C17-C21)</td>
<td>18</td>
<td>18</td>
<td>3.6%</td>
</tr>
<tr>
<td>Lung Cancer (ICD10 C33-C34)</td>
<td>24</td>
<td>30</td>
<td>4.8%</td>
</tr>
<tr>
<td>Malignant melanoma of skin (ICD10 C43)</td>
<td>2</td>
<td>4</td>
<td>0.4%</td>
</tr>
<tr>
<td>Female breast (ICD10 C50)</td>
<td>20</td>
<td>20</td>
<td>3.3%</td>
</tr>
<tr>
<td>Cervix uteri (ICD10 C53)</td>
<td>3</td>
<td>3</td>
<td>0.5%</td>
</tr>
<tr>
<td>Prostate Cancer (ICD10 C61)</td>
<td>27</td>
<td>27</td>
<td>5.4%</td>
</tr>
<tr>
<td>Leukaemia (ICD10 C91-C95)</td>
<td>7</td>
<td>14</td>
<td>1.6%</td>
</tr>
<tr>
<td>Diseases of the respiratory system (ICD 10 J00-J99)</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Bronchitis and emphysema (ICD10 J40-J44)</td>
<td>20</td>
<td>21</td>
<td>4.0%</td>
</tr>
<tr>
<td>Pneumonia (ICD10 J12-J18)</td>
<td>35</td>
<td>61</td>
<td>7.0%</td>
</tr>
<tr>
<td>Accidents (ICD10 V01-V59)</td>
<td>9</td>
<td>14</td>
<td>1.8%</td>
</tr>
<tr>
<td>Motor vehicle traffic accidents (ICD10 V01-V89)</td>
<td>4</td>
<td>0</td>
<td>0.8%</td>
</tr>
<tr>
<td>Suicide and undetermined injuries (ICD10 X60-X84, Y10-Y34 excl. Y33.9)</td>
<td>12</td>
<td>16</td>
<td>2.4%</td>
</tr>
<tr>
<td>Suicide and self-inflicted injury (ICD10 X60-X64)</td>
<td>8</td>
<td>12</td>
<td>1.6%</td>
</tr>
<tr>
<td>All causes, age 15 and over</td>
<td>534</td>
<td>611</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table SA-10
Indirectly Standardised Mortality Ratios (SMRs) for selected causes of deaths for Kingston residents, All ages, males & females, average 2005-2007 and the change since 2004-2006 average

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>2004-2006 SMR</th>
<th>95% Confidence Interval</th>
<th>2005-2007 SMR</th>
<th>95% Confidence Interval</th>
<th>% Change in SMR</th>
<th>2004-2006 SMR</th>
<th>95% Confidence Interval</th>
<th>2005-2007 SMR</th>
<th>95% Confidence Interval</th>
<th>% Change in SMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Causes (ICD10 A00-Y99)</td>
<td>88</td>
<td>84 to 93</td>
<td>89</td>
<td>85 to 93</td>
<td>-1</td>
<td>93</td>
<td>89 to 97</td>
<td>93</td>
<td>89 to 98</td>
<td>0</td>
</tr>
<tr>
<td>All Circulatory Disease (ICD10 I00-I99)</td>
<td>90</td>
<td>83 to 98</td>
<td>88</td>
<td>81 to 96</td>
<td>2</td>
<td>88</td>
<td>81 to 95</td>
<td>91</td>
<td>84 to 99</td>
<td>-3</td>
</tr>
<tr>
<td>Hypertensive Disease (ICD10 I10-I15)</td>
<td>96</td>
<td>48 to 172</td>
<td>75</td>
<td>34 to 143</td>
<td>11</td>
<td>94</td>
<td>52 to 154</td>
<td>86</td>
<td>48 to 142</td>
<td>8</td>
</tr>
<tr>
<td>Coronary Heart Disease (ICD10 I20-I25)</td>
<td>86</td>
<td>77 to 96</td>
<td>84</td>
<td>74 to 94</td>
<td>2</td>
<td>77</td>
<td>67 to 87</td>
<td>80</td>
<td>70 to 92</td>
<td>-3</td>
</tr>
<tr>
<td>Stroke (ICD10 I60-I69)</td>
<td>51</td>
<td>76 to 108</td>
<td>88</td>
<td>73 to 106</td>
<td>3</td>
<td>97</td>
<td>85 to 110</td>
<td>98</td>
<td>85 to 112</td>
<td>-1</td>
</tr>
<tr>
<td>All Malignant Neoplasms (ICD10 C00-C97)</td>
<td>92</td>
<td>84 to 101</td>
<td>94</td>
<td>86 to 103</td>
<td>-2</td>
<td>90</td>
<td>81 to 99</td>
<td>92</td>
<td>83 to 101</td>
<td>-2</td>
</tr>
<tr>
<td>Stomach Cancer (ICD10 C16)</td>
<td>87</td>
<td>51 to 137</td>
<td>89</td>
<td>53 to 141</td>
<td>-2</td>
<td>38</td>
<td>12 to 88</td>
<td>56</td>
<td>22 to 114</td>
<td>-18</td>
</tr>
<tr>
<td>Colorectal Cancer (ICD10 C17-C21)</td>
<td>101</td>
<td>76 to 132</td>
<td>87</td>
<td>64 to 116</td>
<td>14</td>
<td>107</td>
<td>83 to 143</td>
<td>104</td>
<td>77 to 137</td>
<td>3</td>
</tr>
<tr>
<td>Lung Cancer (ICD10 C33-C34)</td>
<td>89</td>
<td>73 to 108</td>
<td>84</td>
<td>68 to 103</td>
<td>5</td>
<td>86</td>
<td>67 to 108</td>
<td>89</td>
<td>70 to 111</td>
<td>-3</td>
</tr>
<tr>
<td>Malignant Melanoma (ICD10 C43)</td>
<td>106</td>
<td>43 to 219</td>
<td>102</td>
<td>41 to 211</td>
<td>4</td>
<td>74</td>
<td>20 to 191</td>
<td>105</td>
<td>39 to 229</td>
<td>-31</td>
</tr>
<tr>
<td>Breast Cancer (ICD10 C50)</td>
<td></td>
<td></td>
<td>0</td>
<td>82 to 104</td>
<td>-2</td>
<td>84</td>
<td>65 to 106</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer (ICD10 C53)</td>
<td></td>
<td></td>
<td>0</td>
<td>73 to 170</td>
<td>92</td>
<td>34 to 200</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer (ICD10 C61)</td>
<td>108</td>
<td>84 to 136</td>
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<td>113</td>
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<td>74 to 210</td>
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<td>Accidents (ICD10 V01-X59)</td>
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<td>37 to 78</td>
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<td>17 to 56</td>
<td>45</td>
<td>27 to 72</td>
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<td>65 to 137</td>
<td>72</td>
<td>45 to 109</td>
<td>24</td>
<td>107</td>
<td>53 to 191</td>
<td>73</td>
<td>29 to 151</td>
<td>34</td>
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<tr>
<td>Suicide (ICD10 X60-X84)</td>
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<td>64 to 152</td>
<td>67</td>
<td>38 to 111</td>
<td>35</td>
<td>149</td>
<td>71 to 274</td>
<td>110</td>
<td>44 to 227</td>
<td>39</td>
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Health Begins At Home
Joint Annual Public Health Report
for Kingston 2008

Dr Jonathan Hildebrand
Joint Director of Public Health