

Committee Agenda



City of Westminster



THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

Title: **Health & Wellbeing Board (Concurrent Meeting)**

Meeting Date: **Thursday 24th January, 2019**

Time: **4.00 pm**

Venue: **Committee Room 1, The Town Hall, Hornton Street, London, W8 7NX**

Councillor Heather Acton (Chairman)	WCC - Cabinet Member for Family Services and Public Health
Councillor David Lindsay (Chairman)	RBKC - Lead Member for Healthy City Living
Councillor Sarah Addenbrooke	RBKC - Lead Member for Adult Social Care
Councillor Emma Will	RBKC - Lead Member for Families, Children and Schools
Councillor Nafsika Butler-Thalassis	WCC - Minority Group Representative
Dr Neville Purssell	Central London Clinical Commissioning Group
Dr Andrew Steeden	West London Clinical Commissioning Group
Melissa Caslake	Bi-Borough Children's Services
Olivia Clymer	Healthwatch Westminster
Angeleca Silversides	Local Healthwatch RBKC
Dr David Finch	NHS England
Bernie Flaherty	Bi-Borough Adult Social Care
Andrew Howe	Bi-Borough Interim Director of Public Health
Dr Naomi Katz	West London Clinical Commissioning Group
Detective Inspector Iain Keating	Metropolitan Police
Detective Chief Inspector Seb	Metropolitan Police

Adjei-Addoh	Westminster Community Network
Hilary Nightingale	Central and North West London NHS Foundation Trust
Maria O'Brien	Imperial College NHS Trust
Toby Hyde	Central London Community Healthcare NHS Trust
Basirat Sadiq	Housing and Regeneration
Jennifer Travassos	London Fire Brigade
Spencer Sutcliffe	



Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.



An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Gareth Ebenezer, Governance Officer.

**Tel: 020 7361 2947; Email: gareth.ebenezer@rbkc.gov.uk
Corporate Website: www.rbkc.gov.uk**

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Director of Law in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To report any changes to the Membership of the meeting.

2. MINUTES

To agree the Minutes of the meeting held on 28 November 2018.

(Pages 5 - 10)

3. DECLARATIONS OF INTEREST

To receive declarations of interest by Board Members and Officers of any personal or prejudicial interests.

4. PROPOSED MEMORANDUM OF UNDERSTANDING FOR JOINT RB KENSINGTON & CHELSEA AND WESTMINSTER HEALTH & WELLBEING BOARD

(Pages 11 - 22)

Part A – Health and Wellbeing Board Priorities

5. DISCUSSION ABOUT DEMENTIA TO FEED INTO THE BI-BOROUGH DEMENTIA STRATEGY UNDER DEVELOPMENT

(Pages 23 - 32)

- Overview of Dementia in RBKC and Westminster (incl. London Dementia Challenge) – Bi-Borough Officers.
- General discussion about dementia and what action the Board recommends taking to address it. This discussion will feed into the developing Dementia Strategy.

Part B – Other Important Items Sponsored by the Board

6. MENTAL HEALTH & WELLBEING JSNA FIRST DRAFT

(Pages 33 - 224)

(Colin Brodie, Bi-Borough Public Health)

Part C – Monitoring – Statutory Items / Other

7. ADULT SAFEGUARDING FINAL REPORT

(Pages 225 - 260)

(Louise Butler, Bi-Borough Adult Social Care)

8. ANY OTHER BUSINESS

Stuart Love
Chief Executive – City of Westminster

Barry Quirk
Chief Executive - RB Kensington and Chelsea
16 January 2019

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MINUTES



CITY OF WESTMINSTER



THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a concurrent meeting of Westminster City Council's and the Royal Borough of Kensington & Chelsea's **Health & Wellbeing Boards** held at 4pm on **Thursday 29th November 2018**, The LookOut, Hyde Park London, W2 2UH.

Present:

Councillor Heather Acton WCC - (Cabinet Member for Family Services and Public Health)

Councillor David Lindsay (RBKC - Lead Member for Healthy City Living)

Councillor Sarah Addenbrooke (RBKC – Lead Member for Adult Social Care)

Councillor Robert Freeman (RBKC – Chairman of the Adult Social Care and Health Scrutiny Committee)

Councillor Lorraine Dean (WCC – Member of the Family and People Services Policy and Scrutiny Committee)

Councillor Nafsika Butler-Thalassis (WCC - Minority Group Representative)

Andrew Howe (Interim Director of Public Health)

Jackie Rosenberg (Chief Executive, One Westminster)

Bernie Flaherty (Bi-Borough Executive Director of Adult Social Care)

Jennifer Travassos (Head of Prevention)

Angela Spence (Kensington & Chelsea Social Council)

Iain Cassidy (Open Age)

Dr Sarah Elkin (Imperial College NHS Trust)

Dr Naomi Katz (West London CCG)

Sophie Coronini-Cronberg (Chelsea & Westminster NHS Foundation Trust)

Dr Neville Pursell (Clinical Representative from the Central London CCG)

Dr Andrew Steeden (West London CCG)

John Ryan (London Fire Brigade)

Olivia Clymer (Healthwatch Westminster)

Angeleca Silversides (Healthwatch RBKC)

Elizabeth Dunsford (WCC - Public Health)

Colin Brodie (WCC – Public Health)

Melissa Caslake (Bi-Borough Children's Services)

Councillor Heather Acton thanked the Royal Parks' for hosting the meeting and providing an opportunity for the Board to engage further with the local community.

1 MEMBERSHIP

- 1.1 With the approval of both Boards it was agreed for the Westminster City Council Health and Wellbeing Board Chair to lead the meeting.
- 1.1 Apologies for absence were received from, Maria O'Brien (Central and North West London NHS Foundation Trust), Lesley Watts (Chelsea & Westminster NHS Foundation Trust), Clare Robinson (Imperial College NHS Trust), Louise Proctor (Managing Director – NHS West London CCG), Dr David Finch (NHS England) and Detective Inspector Iain Keating (Metropolitan Police).

2 DECLARATIONS OF INTEREST

- 2.1 No declarations were made.

3 LONELINESS IN WESTMINSTER AND RBKC

- 3.1 Andrew Howe, Bi-Borough Interim Director of Public Health, introduced the report, which provided an overview of the issue of loneliness and social isolation across both boroughs. The differences between the two terms was explained and the Board noted how there was significant evidence of the negative impact they had on both physical and mental health. Older people were generally considered at risk, however rates of young adults experiencing loneliness and social isolation were increasing.
- 3.2 Local initiatives to tackle loneliness and social isolation locally were described including community-based initiatives such as 'Sing to Live' and one-to-one interventions, for example befriending and mentoring. There was a need to target the most vulnerable people in the community and the significant role the private sector could play in helping with social isolation was explained.

4 ROYAL PARKS WORK TO TACKLE ISOLATION

- 4.1 Richard Pering (Learning Manager), Laura McMahon (Community Learning Officer) and Tess Pettinger (Volunteer and Programmes Manager) provided the Board with a presentation detailing the work undertaken by Royal Parks' to tackle loneliness. An overview of the learning and voluntary programmes established was provided along with the role they played in helping people connect with each other and nature. The LookOut venue at Hyde Park alone received approximately 12,000 visitors per year consisting of school groups, adults and families.
- 4.2 The Board noted the different community programmes which were in operation including a social group for over 50s, a group for adults with mental health issues and an allotment therapy group for young people with learning disabilities. In the future, it was hoped new programmes could be developed and efforts would be made to increase the diversity of residents participating.

The Board noted that it was intended to build on the work carried out by continuing to widen and deepen the existing engagement already undertaken.

5 SELF CARE (WLCCG)

- 5.1 Dr Andrew Steeden, representing the West London Clinical Commissioning Group, introduced a report on the Self-Care approach within West London CCG and how the programme was intended to increase patient confidence in making informed decisions about their health. It was expected that Self-Care would positively contribute to patients' confidence and motivation, which in turn was expected to contribute towards a long-term reduction in use of primary, secondary and some tertiary care services. The Board was pleased to note that for approximately every £1 spent on the programme £2.80 worth of benefits would be recognised to empower residents and deliver savings.

6 DISCUSSION ABOUT LONELINESS TO FEED INTO THE DRAFT WELLBEING JSNA FOR WESTMINSTER AND RBKC

- 6.1 The Chair introduced the item and explained that Colin Brodie (Bi-Borough Public Health Knowledge Manager) was drafting a Wellbeing JSNA. The Board was invited to make proposals about loneliness across all ages in the Bi-Borough, which would be fed into the JSNA. The Board noted that currently the Royal Parks did not operate any 'Park Runs' and it was felt these well attended events provided an excellent opportunity for residents to improve both their physical and mental health. Mr Pering from the Royal Parks recognised the benefits of 'Park Runs' but explained that due to the number of events held at their parks it was challenging to introduce them. It was agreed for further discussions to take place between members of the Board and the Royal Parks regarding 'Park Runs'.
- 6.2 The Board held a detailed discussion on further aspects of the report and highlighted that areas such as disabilities and English language ability were also potential factors in loneliness and social isolation.
- 6.3 Councillor Acton and Councillor Lindsay explained that they had recently attended a very successful Community Champions event and expressed the Board's thanks to Public Health officers and supporting organisations for helping organise the event along with the Community Champions for attending. The Board recognised the benefits of the programme and how it helped tackle loneliness and social isolation by providing an effective entry into society for individuals. The importance of supporting volunteering programmes was stressed in ensuring they achieved positive outcomes.
- 6.4 The Board provided further comments on the draft Wellbeing JSNA that included expanding the areas around young carers and those people who were housebound as it was recognised that these were groups of people who potentially suffered from loneliness and social isolation.
- 6.5 Colin Brodie thanked the Board for their comments and requested that Members forward on any further relevant information to the steering group

who were drafting the JSNA, with a particular focus on success stories detailing initiatives that were considered to work well.

7 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT: THE HEALTH AND WELLBEING OF YOUNG PEOPLE IN KENSINGTON & CHELSEA AND WESTMINSTER

- 7.1 Andrew Howe, Bi-Borough Interim Director of Public Health, updated the Board on progress on the annual report of the Director of Public Health for 2018/18. It was explained that the report was designed to be a call to action, and to highlight the importance of protecting and promoting the health and wellbeing of young people. The Board noted that young people had heavily inputted into the report through interviews, workshops and case studies to help share their suggestions to improve health and wellbeing for their, and future, generations.
- 7.2 The key issues emerging from the report were detailed and these primarily centred on:
- Crime and safety;
 - Daily pressures and challenges;
 - Social media; and
 - Access to services and information.
- 7.3 An overview of the recommendations contained within the report was provided and the Board also noted that the title of the report was yet to be finalised in consultation with young people. The Board discussed the report and suggested that the key theme of drugs and alcohol be expanded to include parents' usage and the context this had within the home. It was also suggested that more in-depth detail relating to loneliness and social isolation caused by poverty and young people with disabilities be provided.
- 7.4 Colin Brodie informed the Board that the report was scheduled to be signed-off in January 2019 and Members were requested to feed back any further comments before then. The draft report would go out to the different groups for further consultation and the Board would be updated on how the information provided was acted upon.

8 ITEMS FOR OFFLINE REVIEW

- 8.1 The Chair provided an update on the following:
- It was confirmed that the Adults Safeguarding paper would be a discussion item for the January 2019 Health and Wellbeing Board meeting.
 - An update was provided on the recent successful Learning Disabilities Plan event held within Kensington and Chelsea.

- At their previous meeting, the Westminster Health and Wellbeing Board had received an informative presentation on work undertaken to improve the ventilation and insulation of Westminster properties. Disappointment was expressed that due to GDPR issues data detailing the effectiveness of the work undertaken could not be shared, however discussions were ongoing to resolve this issue.

PART 2 (PRIVATE)

RESOLVED:

That under Section 100 (A) (4) and Part 1, paragraph 2 of Schedule 12A to the Local Government Act 1972 (as amended), the public and press be excluded from the meeting for the following item of business because it related to Information which was likely to reveal the identity of an individual, and it was considered that, in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

9 DEMENTIA FRIENDS INFORMATION SESSION

- 9.1 The Board invited Sharon Grant, Head of Personalisation, Bi-Borough Adult Social Care, and David Morris, Dementia Friends Champion, to provide an information session on dementia.

10 ANY OTHER BUSINESS

- 10.1 There was no other business to report.

The Meeting ended at 5.51 pm.

CHAIR: _____

DATE _____

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Westminster Health
& Wellbeing Board



THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA
RBKC Health
& Wellbeing Board

Date: 24 January 2019

Classification: General Release

Title: Proposed MOU for a joint K&C and Westminster Health and Wellbeing Board

Report of: Bernie Flaherty, Bi-Borough Exec. Dir. ASC and Public Health

Report Author and Contact Details: Anne Pollock, Principal Policy Officer (apollock@westminster.gov.uk, x2757)

1. Executive Summary

- 1.1 At the concurrent meeting of the K&C and Westminster Health & Wellbeing Boards in November 2018, the Board discussed creating a joint K&C and Westminster Health and Wellbeing Board.
- 1.2 The sovereign Health and Wellbeing Boards (HWBB) for Kensington & Chelsea (K&C) and Westminster each meet separately six times per year. The Boards are held by the local authorities and the local Clinical Commissioning Groups (CCGs), bringing together stakeholders from across local government, the NHS, and the voluntary and community sector. The aim is to plan strategically to improve the health and wellbeing of residents in K&C and Westminster.
- 1.3 The Boards regularly discuss the same issues and there is significant crossover in Board Membership (see Appendix A). It is proposed that a joint K&C and Westminster HWBB is established to avoid duplication of work. The sovereign HWBBs will continue and will hold any discussions of relevance only to their borough.
- 1.4 This proposed Memorandum of Understanding (MOU) sets out the agreed processes for the joint Board.

2. Key Matters for the Board

- 2.1 That the Westminster and RBKC Boards consider proposals to establish a joint Westminster and RBKC HWBB.

3. Recommendations

- 3.1 That the Westminster Board approves the proposals to establish a joint HWBB with the Royal Borough Kensington and Chelsea.
- 3.2 That the Westminster Board approves the draft constitution of the proposed Joint HWBB (including the membership), as set out in Appendix C.
- 3.3 That the Westminster Board approves the draft meeting schedule, as set out at Appendix D.
- 3.4 That the Kensington and Chelsea Board approves the proposals to establish a joint HWBB with the Westminster Board.
- 3.5 That the RBKC Board approves the draft constitution of the proposed joint HWBB (including the membership), as set out in Appendix C.
- 3.6 That the RBKC Board approves the draft meeting schedule, as set out at Appendix D.

4. Proposal

- 4.1 It is proposed that there are six HWBB board meetings per year for each borough. This will be split into four joint K&C and Westminster HWBB meetings and two meetings of each sovereign-borough HWBB. In this new structure, it is suggested that
- the joint K&C and Westminster HWBB meetings focus on health and wellbeing matters relating to both boroughs
 - one of the sovereign HWBB meetings includes a review of the Boards' progress
 - once per year, a joint K&C and Westminster HWBB meeting includes a dedicated workshop to develop and agree joint priorities and ways of working for the year ahead
 - The sovereign HWBBs may decide to hold a concurrent meeting with the other HWBB, instead of holding a separate, sovereign-borough HWBB meeting
- 4.2 The joint K&C and Westminster HWBB members will ensure the following founding principles of the Health and Wellbeing Boards will be continued across both boroughs
- shared leadership of a strategic approach to the health and wellbeing of communities that reaches across all relevant organisations
 - commitment to driving real action and change to improve services and outcomes
 - openness and transparency in the way that the board carries out its work
 - inclusiveness in the way it engages with patients, service users and the public.

- 4.3 The Royal Borough of Kensington & Chelsea's (RBKC) Lead Member for Healthy City Living and the Westminster City Council (WCC) Cabinet Member for Family Services and Public Health are the respective chairs of their borough's Health and Wellbeing Boards. They will alternately chair the joint HWBB meetings. If neither the WCC Cabinet Member nor the RBKC Lead Member is able to chair the meeting, the Vice-Chairs of the joint Board will do so instead. The Vice-Chairs of the Board will be the Chairs of Central and West London CCGs.
- 4.4 The local authority elected members and Chairs of the CCGs will work closely together to ensure the integrated management of the joint-borough and sovereign-borough HWBBs.
- 4.5 The HWBB will bring together Board Members for strategic health and wellbeing planning. This includes encouraging integrated working between health and social care partners, being accountable for the delivery of the Health and Wellbeing Strategies' Priorities and the K&C and Westminster HWBBs' key issues and producing JSNAs. All board members will have the opportunity to contribute to the board's deliberations, strategies and activities. In addition, all members (with commitment from their nominating organisations) will share ownership of the board and accountability to the communities it serves.
- 4.6 The joint-borough HWBB will only discuss issues relevant to both boroughs. If a sovereign-board issue arises that needs to be discussed at a sovereign-board meeting, the relevant Board will meet directly after the joint HWBB.

5. HWBB priorities

- 5.1 For 2018/19, K&C and Westminster's HWBBs have agreed to focus their work on the following key issues, in line with each borough's local needs:
- Sugar, including in Early Years
 - Loneliness
 - Dementia
- 5.2 The K&C and Westminster Boards will agree joint priorities for the following 12 months when they meet in May 2019.

6. Venue

- 6.1 The Chair, in collaboration with the co- and vice-chairs, will decide where the Board meeting will take place, with the aim being to encourage public attendance at the Board. If no community venue is organised, the Board will alternately meet in RBKC Town Hall and WCC City Hall.

7. Membership

- 7.1 The joint K&C and Westminster Board Membership will be reviewed periodically with partners to ensure it is fit-for-purpose (see board members at Appendix B).

7.2 In terms of roles and responsibilities, members are expected to work together to deliver the statutory functions of the Board in the interests of K&C and Westminster residents. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and clinical commissioning groups (CCGs).
- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under s75 of the NHS Act 2006 (i.e. lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
- A power to encourage close working between commissioners of health-related services and the board itself.
- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.

8. Governance

8.1 To support integrated management of the Board, representatives from RBKC, WCC and CL and WL CCGs will meet six weeks before each meeting to plan the agenda. This will ensure both boroughs and both CCGs have oversight of papers being presented to the joint Board.

8.2 The Chair will approve the final meeting agenda of the Health and Wellbeing Board agenda in consultation with the co-chair, and the vice-chairs.

8.3 Subject to these proposals being approved, WCC's Committee Services and RBKC's Governance Services will consider the appropriate clerking arrangements. The Board papers will be circulated one week ahead of the Board meeting once they have been collated and also published on each website.

9. Legal Implications

9.1 The joint Board must remain compliant with the statutory obligations of Health and Wellbeing Boards.

9.2 The Health and Social Care Act 2012 permits that two or more Health and Wellbeing Boards may make arrangements for –

- (a) any of their functions to be exercisable jointly;
- (b) any of their functions to be exercisable by a joint sub-committee of the Boards;
- (c) a joint sub-committee of the Boards to advise them on any matter related to the exercise of their functions

9.3 The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), a duty of local authorities and Clinical Commissioning Groups (CCGs).
 - A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (i.e. lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
 - A power to encourage close working between commissioners of health-related services and the board itself.
 - A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.
 - Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions. Such delegated functions need not be confined to public health and social care. Where appropriate, they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.
- 9.4 Each borough will maintain sovereign Health and Wellbeing Strategies, which will be discussed during their sovereign meetings, as necessary.
- 9.5 Most JSNAs are produced across K&C and Westminster. They can therefore be included on the agenda of the joint Board. If a sovereign JSNA is required, it will either be discussed during the sovereign meetings, reviewed offline or, if necessary, included on the agenda of the joint Board.
- 9.6 All other statutory functions will be addressed through the sovereign and joint Boards, as relevant.

10. Next Steps

- 10.1 Subject to the K&C and Westminster Boards' approval, the first meeting of the joint HWBB will take place on 9 May 2019. A programme of meetings for both joint and sovereign Health and Wellbeing Boards can be found at Appendix D.

APPENDICES:

Appendix A: Overview of previous Board Agendas

Appendix B: Table Outlining Board Membership

Appendix C: Draft Constitution of the Joint K&C and Westminster Health and Wellbeing Board

Appendix D: Programme of meetings for joint and sovereign Health and Wellbeing Board

Appendix A: Overview of previous Board Agendas

A breakdown of the K&C and Westminster Board agendas from January-July 2018 are detailed below

- There were 12 distinct agenda items across both the K&C and Westminster Boards in this time period
- Of this number, 8 items were brought to both boards; K&C had 1 sovereign item and Westminster had 3 sovereign items
- As such, **two-thirds of agenda items were shared across both boards** (67%), and one third were sovereign (33% total - 8% sovereign K&C and 25% sovereign Westminster)

As both boards have agreed the key issues of sugar in early years, dementia and loneliness, there will be increased crossover in agenda items.

Shared K&C and Westminster HWBB Agenda Items January-July 2018

Shared Item	Date at RBKC HWBB	Date at WCC HWBB
Integrated Care Outcomes Framework/Whole Systems Integrated Care Dashboard Presentation/ North West London Sustainability and Transformation Plan/ Transforming Primary Care in West London	10 January	18 January
BCF Programme 2017-19: Progress Monitoring Report	14 March	20 March
Suicide Prevention Action Plan 2018-2021	14 March	20 March (NB Suicide Prevention Refresh - 18 January)
Pharmaceutical Needs Assessment 2018-21	14 March	20 March
SEND JSNA, Strategy and Commissioning Plans	11 July	Local Area SEND Brief – 20 March JSNA – 24 May Strategy - 12 July
DPH Annual Report	11 July	12 July
Decision on the Selection of Three Key Topics for the Board/Health and Wellbeing Board Workshop Session Notes, 14 March 2018	11 July	12 July
“Big Plan” LD Joint Commissioning Strategy	11 July	13 September (offline review)
Westminster Planning for Integrated Care and the MCP/ Progress Delivering the West London CCG Integrated Care Strategy	12 September	13 September

Overview of K&C and Westminster HWBB Agendas January-July 2018

RBKC		Westminster	
<u>10 Jan 2018</u>	<ul style="list-style-type: none"> • North West London Sustainability and Transformation Plan • Transforming Primary Care in West London • Improving Mental Health Services for Young People • JSNA Work Programme Update 	<u>18 Jan 2018</u>	<ul style="list-style-type: none"> • 2017-18 Progress Update on the Health and Wellbeing Strategy, incl. discussion on the London Health Devolution MOU • Integrated Care Outcomes Framework • Whole Systems Integrated Care Dashboard Presentation • Verbal Update on the work of the Safer Westminster Partnership • Suicide Prevention Strategy Refresh
<u>14 March 2018</u>	<ul style="list-style-type: none"> • Pharmaceutical Needs Assessment • Better Care Fund Programme 2017-19 – Progress Monitoring Report • Suicide Prevention Action Plan 2018-2021 	<u>20 March 2018</u>	<ul style="list-style-type: none"> • Chairman’s Verbal Update • Local Area SEND Brief • BCF Programme 2017-19 – Progress Monitoring Report • Suicide Prevention Action Plan 2018-2021 • Pharmaceutical Needs Assessment 2018-21
		<u>24 May 2018</u>	<ul style="list-style-type: none"> • Patients and their Carers’ Experiences of Living with Long-Term Health Conditions in Westminster • Children & Young People with SEND JSNA
<u>11 July 2018</u>	<ul style="list-style-type: none"> • Children with Special Educational Needs and Disabilities (SEND) - JSNA, SEND Strategy and Joint Commissioning Plan (SEND) WLCCG Primary Care Network Development • Learning Disabilities Big Plan 2018-2021 • Draft DPH Annual Report • Health and Wellbeing Board Workshop Session Notes, 14 March 2018 	<u>12 July 2018</u>	<ul style="list-style-type: none"> • Decision on the Selection of Three Key Topics for the Board • Homelessness Prevention Health Referrals • Draft DPH Annual Report • Children's SEND Strategy • Children’s Joint Commissioning Plan (SEND)

Appendix B: Table Outlining Board Membership*

Name	Position	Organisation
Cllr Heather Acton (Co-Chair)	Cabinet Member for Families & Public Health	WCC
Cllr David Lindsay (Co-Chair)	Lead Member for Healthy City Living	RBKC
Dr Neville Pursell	Chair of the CL CCG	Central London CCG
Dr Andrew Steeden / Dr Naomi Katz	Chair / Vice Chair of the WL CCG	West London CCG
Cllr Sarah Addenbrooke	Lead Member for Adult Social Care	RBKC
Cllr Nafsika Butler-Thalassis	Minority Group representative	WCC
Cllr Emma Will	Lead Member for Families, Children and Schools	RBKC
Jules Martin	Managing Director	Central London CCG
Louise Proctor	Managing Director	West London CCG
Olivia Clymer	CEO	Healthwatch Central West London
Bernie Flaherty	Bi-borough Executive Director of Adult Social Care	WCC/RBKC
Senel Arkut	Bi-borough Director of Health Partnerships	WCC/RBKC
Melissa Caslake	Bi-borough Executive Director of Children's Services	WCC/RBKC
Andrew Howe	Bi-borough Director of Public Health	WCC/RBKC
Dr David Finch	NHS England NW London representative	NHS England
Jennifer Travassos	Housing representative	WCC
Dr Basirat Sadiq	Divisional Director of Operation	Central London Community Healthcare NHS Trust
Clare Robinson	AD of Service Development & Commissioner Relations	Imperial College Healthcare NHS Trust
Maria O'Brien/ Robyn Doran	Managing Director/COO	Central and North West London NHS Trust
Lesley Watts	CEX	Chelsea and Westminster Hospital NHS Foundation Trust
Angela Spence	CEX	K&C Social Council
Hilary Nightingale	Chair of Westminster Community Network	Westminster Community Network
Iain Cassidy	CEO	Open Age
Spencer Sutcliffe and Paul Kavanagh	BC for RBKC and BC for Westminster	London Fire Brigade
DI Iain Keating / DI Seb Adjei-Addoh –	WCC and RBKC Met Board representatives	Metropolitan Police

* Correct at time of writing

Appendix C: Bi-Borough Joint Health and Wellbeing Board Draft Constitution

1. VISION OF THE BOARD

- 1.1 The K&C and Westminster (the Bi-Borough) Health and Wellbeing Board will provide strong and effective leadership across the local authorities and NHS partners by setting a clear direction, across traditional boundaries, to deliver change and fresh thinking. The Bi-Borough Board will work in partnership to address health issues that cannot be tackled by one organisation alone.
- 1.2 The Board will recognise that one size does not fit all and will ensure that services are designed to reflect the changing needs of the individuals and communities they serve and are easy to access. The Board will be accountable to those they serve through elected members, and will act as a champion for the voice of those who live, work and play in K&C and Westminster.
- 1.3 The broad vision for the Board is that it will
 - Promote integrated health and social care, where all parties agree this makes sense, in order to deliver more effective and efficient local services.
 - Agree strategic key issues for the joint board in line with each borough's sovereign Health and Wellbeing Strategies. The joint board will push progress against these priorities further and faster, ensuring 'silo working' and conflict are removed. Organisational boundaries should not be a hindrance to developing effective solutions.
 - Demonstrate clear leadership, championing the work and aims of the Board, and act as the key link between their own organisation or department and the Board, ensuring consistency and effective communications.
 - Work with regional and national partners, where this is identified as the most appropriate way of tackling issues and addressing need.

2. RESPONSIBILITIES

- 2.1 To provide strategic and organisational leadership in developing the vision for health and wellbeing in K&C and Westminster and mobilising, co-ordinating and ensuring health and social care decisions are based on clear evidence for improving outcomes.
- 2.2 To mobilise, coordinate and share resources from its membership, and from others, to deliver agreed priorities and the Board's key issues.
- 2.3 To oversee the delivery of shared Joint Health and Wellbeing Strategy (JHWS) priorities, ensuring that health and social care, as well as the wider determinants, can better address the need of the local population.
- 2.4 To oversee the production and use of a programme of Joint Strategic Needs Assessments (JSNA) by the local authorities and the Clinical Commissioning Groups, and ensure that the needs of the local population are properly assessed and captured. The JSNA should aim to map assets as well as needs for local areas and become embedded across the commissioning process of all systems. To also oversee the production and maintenance of the Pharmaceutical Needs Assessment (PNA).

- 2.5 To ensure that all commissioners (the local authorities, the CCGs and the National Commissioning Board) meet their legal obligations by having regard to the JSNA and the Health and Wellbeing Strategies when commissioning and developing their commissioning plan.
- 2.6 To put in place sub-groups to the Board, as and when required, to support the delivery of its functions.
- 2.7 To promote and encourage integrated working across the wider determinants of health including alignment between organisation and department plan and strategies.
- 2.8 To ensure effective engagement and involvement – staff, provider, public, patient, service user and community – in the work of the Bi-Borough Board, delivering on WCC’s Leader’s commitment to better engagement with residents and the RBKC Leader’s commitment to making RBKC a listening borough.
- 2.9 To develop an annual workplan, as well as short, medium and long term goals that have measurable outcomes aligned to the NHS, Public Health and Social Care outcomes frameworks. This to ensure that the performance of the Board and others with responsibility to deliver RBKC and WCC’s sovereign Health and Wellbeing Strategy can be measured, and is accountable.
- 2.10 To review progress annually, and to consider other reports identifying health and social care needs, such as the Director of Public Health’s annual report.
- 2.11 To ensure, through Board members, that organisation and department plans and strategies are aligned. Also to have sight of and influence the strategies and key policies of the local NHS, the Councils, the Community and Voluntary sector, and other partner agencies.
- 2.12 To respond to any relevant local, regional or national consultations on major service redesigns for health, care and wellbeing related service provided within the boroughs or that affect the boroughs.
- 2.13 To promote and support opportunities for Bi-Borough commissioning of health, care and wellbeing where this is the most appropriate way of addressing issues.

3. MEMBERSHIP:

- 3.1 Meetings of the Board will be alternately chaired by RBKC’s Lead Member for Healthy City Living and Westminster’s Cabinet Member for Family Services & Public Health.
- 3.2 Per s194 of the Health and Social Care Act (2012), the Health and Wellbeing Board is to consist of—
 - (a) at least one councillor of the local authority
 - (b) the director of adult social care for the local authority,
 - (c) the director of children's services for the local authority,
 - (d) the director of public health for the local authority,

- (e) a representative of the Local Healthwatch organisation for the area of the local authority,
- (f) a representative of each relevant clinical commissioning group, and
- (g) such other persons, or representatives of such other persons, as the local authority thinks appropriate.

3.3 After a Health and Wellbeing Board is established, a local authority must consult the Health and Wellbeing Board before appointing another person to be a member of the Board.

Appendix D: Programme of meetings for Joint and sovereign Health and Wellbeing Boards

2018/19 Dates

Joint and sovereign Board meetings in 2018/19 will take place per below

- The K&C sovereign board meeting will be held on 20 March 2019.
- The Westminster sovereign board meeting will be held on 28 March 2019.

2019/20 Dates

Joint and sovereign Board meeting dates in 2019/20 will take place per below

- Joint board meetings will be held on
 - 9 May 2019 (Workshop to develop joint priorities and agree ways of working for 2019/20)
 - 4 July 2019
 - 28 November 2019
 - 6 February 2020
- The sovereign K&C board meetings will be held on
 - 25 September 2019
 - 22 April 2020 (to include a review of progress)
- The sovereign Westminster board meetings will be held on
 - 10 October 2019
 - 2 April 2020 (to include a review of progress)



Westminster Health & Wellbeing Board



RBKC Health & Wellbeing Board

Date:	24 January 2019
Classification:	General Release
Title:	Dementia Overview
Report of:	Bernie Flaherty, Bi-Borough Exec. Dir. ASC and Public Health
Report Author and Contact Details:	Anne Pollock, Principal Policy Officer

1. Executive Summary

- 1.1 This paper aims to provide an overview of the issue of dementia in the two Boroughs, and to encourage a discussion on what actions the Health and Wellbeing Boards, and their constituent organisations, can take to collectively prevent this disease, as well as supporting those with dementia and their carers, friends and families to secure a timely diagnosis, to live well and to die well.
- 1.2 Feedback from the discussions will be used to inform the developing dementia strategy for the Royal Borough of Kensington & Chelsea (RBKC) and the City of Westminster.

2. Key Matters for the Board

- 2.1 The RBKC and Westminster Health and Wellbeing Boards are asked to
 - Consider dementia health and care support in RBKC and Westminster, as set out in this paper
 - Discuss and share feedback using the following guiding questions:
 - What is your experience of supporting people with dementia and their carers, friends and families in your organisations or service areas?
 - Do you know of any local success stories for supporting dementia?

- What global/national/international best practice in whole-systems dementia care and support are you aware of? Can any of these initiatives be implemented in RBKC and Westminster?
- Have you any particular areas or groups of concerns about dementia locally?
- Share an organisational commitment that will support a whole-systems approach to dementia. Examples of commitments could include
 - Rolling out dementia friends training to staff in your organisation
 - Committing to providing a dementia-friendly environment e.g. through clear signposting in buildings.
 - Introducing dementia-related requirements in contract specifications

3. Background Information about Dementia

- 3.1 The word 'dementia' describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. A person with dementia may also experience changes in their mood or behaviour.
- 3.2 Dementia is caused when the brain is damaged by diseases, such as Alzheimer's disease or a series of strokes. Alzheimer's disease is the most common cause of dementia. Other common types of dementia are vascular dementia, mixed dementia, dementia with Lewy bodies and frontotemporal dementia.
- 3.3 Dementia is a progressive condition. As such, these changes are often small to start with, but they can become severe enough to affect daily life for someone with dementia. This progression will vary from person to person and each will experience dementia in a different way – people may often have some of the same general symptoms, but the degree to which these affect each person will vary.
- 3.4 The specific [symptoms](#) that someone with dementia experiences will depend on the parts of the brain that are damaged, the disease that is causing the dementia and how far the disease has progressed. However, common symptoms can include
- day-to-day memory – e.g. difficulty recalling events that happened recently,
 - concentrating, planning or organising – e.g. difficulties making decisions, solving problems or carrying out a sequence of tasks (such as cooking a meal),
 - language – e.g. difficulties following a conversation or finding the right word for something,
 - visuospatial skills – e.g. problems judging distances and seeing objects in three dimensions,
 - orientation – e.g. losing track of the day or date, or becoming confused about where they are.
 - changes in mood – e.g. becoming frustrated or irritable, apathetic or withdrawn, anxious, easily upset or unusually sad.

With some types of dementia, the person may hallucinate or strongly believe things that are not true (delusions).

- 3.5. The Alzheimer's Society report found that in 2013 the total cost of dementia in the UK was estimated to be £26.3 billion. Of this, approximately £4.3 billion consists of health care,

and approximately £10.3 billion consists of social care. The remaining £11.6 billion accounts for estimated unpaid care contributions.

3.6. Dementia mainly affects people over the age of 65 (one in 14 people in the UK in this age group have dementia), and the likelihood of developing dementia increases significantly with age. Dementia can also affect younger people too. There are more than 42,000 people in the UK under 65 with dementia.

3.7. Risk factors for dementia include

- Ageing
- Gender (higher prevalence amongst women)
- Ethnicity (BAME people are more likely than white Europeans to develop dementia)
- Genetics
- Cardiovascular factors (Type 2 Diabetes, high blood pressure/cholesterol levels and obesity)
- Other medical conditions e.g. Parkinson's, Multiple sclerosis, HIV
- People with Down's syndrome and learning disabilities

In addition, the latest research suggests that other factors are also important. These include:

- hearing loss
- untreated depression
- loneliness or social isolation
- a sedentary lifestyle

3.8 Currently there is no certain way to prevent all types of dementia as researchers are still investigating how the disease develops. However, there is good evidence that a healthy lifestyle can help reduce an individual's risk of developing dementia. It can also help prevent cardiovascular diseases, such as stroke and heart attacks, which are themselves risk factors for Alzheimer's disease and vascular dementia. Research indicates that by modifying the risk factors people are able control, our risk of dementia could be reduced by up to 30%.

4. Strategic context

National

4.1 In March 2012, the government launched a national challenge to fight dementia. This programme of action was set up to deliver sustained improvements in health and care, create dementia friendly communities, and boost dementia research.

4.2 The Prime Ministers' Challenge on Dementia 2020 (launched February 2015) sets out the UK Government's strategy for transforming dementia care within the UK. The Challenge aims to build on the previous programme of action, and, by 2020, see England become

- the best country in the world for dementia care and support and for people with dementia, their carers and families to live; and
- the best place in the world to undertake research into dementia and other neurodegenerative diseases.

4.3 This will be achieved by

- Improving diagnosis, assessment and care for people living with dementia
- Ensuring that all people living with dementia have equal access to diagnosis
- Providing all NHS staff with training on dementia appropriate to their role
- Ensuring that every person diagnosed with dementia receives meaningful care

4.4 The government acknowledged that this cannot be achieved alone and the vision is also a call to action for all to show understanding and compassion to those with the disease to transform dementia care, support and research.

4.5 The Care Act 2014 created a new legislative framework for adult social care, and also gives carers a legal right to assessment and support. NICE has produced guidance, quality standards and advice for the health and social care system to drive improvements in quality.

Regional

4.6 The Dementia Friendly London ambition sees Alzheimer's Society, the GLA, London Health Board and other partners working together to achieve the following by 2022:

- 2,000 dementia friendly organisations
- 500,000 Dementia Friends
- Every London borough working to becoming a dementia friendly community
- Meaningful involvement of people affected by dementia

4.7 As part of this London dementia challenge, Alzheimer's Society held its first annual Dementia Friendly London Summit at the GLA in May 2018, as part of Dementia Action Week. Over one hundred delegates from across industries gathered at City Hall to share their plans to bring the Mayor of London's vision of a dementia-friendly capital to life. Key speakers included representatives from ADASS, the NHS, the Met Police, TfL, and London & Thames Valley CBI.

Local

4.8 The 2020 Dementia Challenge is in line with the findings of the North West London Collaboration of CCGs' report *NWL Strategic Review of Dementia 2015*. Details of the report's findings are included later in this report.

4.9 The RBKC Joint Health and Wellbeing Strategy priorities include “Good mental health for all”, with a specific commitment to “[encouraging] awareness and [improving] the quality of local services and support for people living with dementia and their carers.

4.10 The Westminster Joint Health and Wellbeing Strategy priorities include “reducing the risk factors for, and improving the management of, long-term conditions, such as dementia”. Commitments include “[creating] the conditions for dementia friendly communities, where an understanding of dementia supports communities to value the contributions of people experiencing the condition and their carers.

4.11 Westminster’s City for All vision outlines the Council’s commitment to

- A Caring and Fairer City – where caring and supporting the most vulnerable within the community is, and will always remain, the Council’s most important priority.
- A Healthier and Greener City – the Council will work closely with partners including the NHS to encourage individuals and families to enjoy active and healthy lives, while we focus our resources on the support needed for the most vulnerable in our city.

The City for All vision also outlines plans to open a new 84-bed home to provide specialist care for people living with dementia as part of a wider dementia strategy to support those and their families living with this difficult illness.

4.12 The Bi-Borough ASC and Public Health six priorities are

- Personalisation
- Market shaping and development
- Quality Assurance
- Safeguarding
- Prevention
- Integration

5. Dementia in RBKC and Westminster

5.1 Current estimates of the number of people living with dementia in the local population are ca. 1,500 in RBKC and 1,800 in Westminster. Approximately 50% of the population with dementia are aged 85+. (JSNA)

5.2 Through population projections, the number of people living with dementia is estimated to rise by 70% for Kensington & Chelsea; and by 45% for Westminster by 2030. Although the rates are not increasing as much predicted in the 2015 JSNA, they are still rising. Diagnostic, treatment and care service provision may need to expand proportionately to meet this increasing need.

5.3 In March 2015 WL CCG had a diagnosis rate compared with expected prevalence of 73%, and CL CCG 72%. This compared with 66% in London and 65% nationally.

6. Initiatives to support people with dementia and their carers, friends and families in RBKC and Westminster

6.1 Appendix A provides an overview of some of the current commissioned services available for those at risk of developing dementia, those living with dementia and those who care for them. Please note that not all are dementia-targeted services and some are general services that support people with dementia and their carers, friends and families.

6.2 These services are in addition to:

- The input of the Council's social work teams and information and advice team;
- The option of direct payments, when relevant and desired

7. Key Achievements and Upcoming Milestones

Regional

7.1 RBKC and Westminster Officers are working with partners to meet the Mayor's Dementia-Friendly London challenge.

7.2 Bernie Flaherty, Bi-Borough Director of Adult Social Care and Public Health, is the London ADASS Dementia Lead and has been working on improving dementia care and support across the capital. Key elements of the London ADASS work programme include:

- Increasing the number of dementia friends across London
- Enhancing the personalisation of care of those with dementia

7.3 The Mayor has committed the GLA and TfL to work towards becoming dementia friendly organisations and committed to partnership working with the Alzheimer's Society. A Pan London working group has been set up to discuss Dementia Friendly London. The group's successes will be presented at the Dementia Summit in May 2019, following on from the May 2018 Dementia Summit.

7.4 On 18 December 2018, the London Health Board received a progress update from the Alzheimer's Society and the ADASS dementia lead on making London dementia-friendly and creating dementia-friendly communities. Highlights include:

- Recruitment of people with dementia to sit on the Mayoral People's Panel is on-going
- The Mayor has appointed a Dementia Champion for the GLA
- TfL launched a new e-learning Dementia Friends package in December 2018, fronted by CEO Mike Brown
- ADASS's programme to improve dementia awareness and call to action for all Health and Wellbeing Boards and the Dementia Commissioners Network to become dementia friends

7.5 London ADASS also presented the London Health Board with an update on their work to enable championing a personalised approach. This includes

- Working with a specialist IT company to develop a video profiling the virtual character, "Martha's", dementia case. Martha is an animation of a 64-year old woman in the early stages of dementia. The animation aims to show how a personalised approach can empower and enable Martha to live as independently as possible.

- Exploring developing a second virtual male character – Arthur; and
- Launching both Martha and Arthur at GLA’s digital event on the 13 February 2019 and presenting them at the ADASS Dementia Summit in May 2019.

Local

7.6 The table on at Appendix B outlines some recent achievements in progressing dementia care in RBKC and Westminster, as well as upcoming milestones for the New Year.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:

Appendix A – Overview of Some Current Dementia Care Services in RBKC and Westminster

Appendix B – Overview of Some Recent Achievements and Upcoming Milestones in Dementia Services in RBKC and Westminster

Appendix A – Overview of Some Current Dementia Care Services in RBKC and Westminster commissioned by the local authorities*

Preventing Well	
Raising public awareness and understanding of dementia in the wider community.	<p><u>Availability</u></p> <p><u>RBKC and WCC</u></p> <ul style="list-style-type: none"> Community Champions (All Community Champions projects work with older people to support physical activity, healthy eating, wellbeing etc. Although not a targeted dementia service, some projects have Dementia Friends-trained Champions) Communications Channels (e.g. information shared via People First, Westminster Plus etc.) Dementia Friends Staff training in RBKC and Westminster
NHS Health Checks	<p><u>RBKC and WCC</u></p> <p>Dementia is included in as part of the NHS Health Check for people aged 65-74 years.</p>
Reducing the risk of people developing dementia - ASC Commissioned Prevention Services	<p><u>RBKC and WCC</u></p> <p>Public Health commissions a range of healthy lifestyle services that will contribute to lowering the risk of vascular dementia, including smoking cessation service, the cardio-vascular disease prevention programme and the alcohol service</p> <p>ASC commissions a range of preventative services that support in targeting the key modifiable risk factors for dementia in older adults; social isolation, lack of physical activity, depression</p> <p><u>RBKC</u></p> <ul style="list-style-type: none"> Open Age - Second Half Resource Centre; New Horizons Resource Centre; Meet, Eat and Learn; Health Lungs; and Phone Club SPID –Older People Supper Club Octavia – Befriending Age UK –Exercise at Home; Exercise for the Mind; Health Promotion, Community Engagement and Shopping K&C Forum - Health Talks Support Pepperpot – Day and Drop in Centre Everyone Active – Exercise for those with long term conditions <p><u>WCC</u></p> <ul style="list-style-type: none"> Open Age -Osteoblast Bone Health; Churchill Hub; Westbourne Hub; and Queens Park and Harrow Road Hub Bishop Creighton House - Falls Prevention & Keep Active Notting Hill Genesis - Penfold Hub Octavia - Leonora Hub and Outreach
Diagnosing Well	
Information and Advice	<p><u>RBKC</u></p> <ul style="list-style-type: none"> Age UK - Information and Advice CAB – Information and Advice MIND - Peer Support Action Disability Kensington and Chelsea <p><u>WCC</u></p> <ul style="list-style-type: none"> Westminster Advice Services Project
Diagnosis	<p><u>RBKC and WCC</u></p> <p>The Memory Service - Westbourne Park is joint funded by the Local Authority and the NHS. It comprises of a team of health and social care professionals with expertise in working with people with memory difficulties and dementia. They also have close links with the Admiral Nursing Service.</p>
Supporting Well	
Targeted Carers Services	<p><u>RBKC</u></p> <ul style="list-style-type: none"> Carers Network - Hub Age UK - Carers Alliance Open Age – Time for Me Midaye – BME Support for Carers K&C Mental Health Carers Association Everyone Active – Carers CAB – Advice & Information <p><u>WCC</u></p> <ul style="list-style-type: none"> Carers Network – Hub CAB – Advice and Information
Targeted Dementia Services	<p><u>RBKC</u></p> <ul style="list-style-type: none"> Age UK – Dementia Advisor; Dementia Outreach; Dementia volunteer co-ordinator; and Dementia Café Octavia – Reed Dementia Day Centre RBKC – Chamberlain House Day Centre <p><u>WCC</u></p> <ul style="list-style-type: none"> Westbourne Park Dementia Day Centre; and Pullen Day Centre Dementia and Physical Disabilities

Living Well	
Dementia Friendly Communities	<ul style="list-style-type: none"> There are a number of community institutions e.g. museums that run dedicated sessions for attendees with specialist needs and Faith organisations that offer support through various methods.
Accommodation-Based Services	RBKC <ul style="list-style-type: none"> Octavia - Burgess Field Extra Care Home (ECH); James Hill House ECH; Miranda House and High Level ECH Dedicated Dementia Service
	WCC <ul style="list-style-type: none"> Octavia – Leonora House has a dedicated dementia wing within the scheme. Notting Hill Genesis – Penfold has a dedicated dementia wing within the scheme.
Residential & Nursing Care Services <ul style="list-style-type: none"> Resident’s needs resulting from illnesses such as dementia may mean that they are best met by residential and nursing care services. Residential and nursing care services focus on improving physical and mental health, providing improved social activity and mental and physical stimulation. 	RBKC <ul style="list-style-type: none"> Care UK – Ellesmere Housing Nursing/Residential Gold Care Homes – Alan Morkill House Residential Sanctuary Care – Princess Louise Kensington Continuing Health Care Nursing
	WCC <ul style="list-style-type: none"> Sanctuary Care – Westmead Residential; Carlton Dene Residential; Athlone House Continuing Health Care Nursing; Butterworth Specialist Nursing Care; and Garside House Continuing Health Care Nursing
Dying Well	
<p>Most residents with a dementia diagnosis (and their families) wish to receive palliative care their own home.</p> <p>The services that support residents and help them live well also provide palliative care.</p>	RBKC Advice & Support Services <ul style="list-style-type: none"> Age UK – Information & Advice on advance care planning Age UK Dementia Advisor – supports re advance care planning Extra Care Housing Services <ul style="list-style-type: none"> Octavia – Extra Care Housing supports residents to remain in their own home as long as they wish and is viable including end of life plans. Residential and Nursing Care <ul style="list-style-type: none"> Providers work with residents to develop end of life plans to help residents die as they wish. Some residents are very reluctant to engage in this activity. A number of providers are signed up to and accredited with the Gold Standard Framework, an end of life programme to ensure residents received good quality, person-centred care
	WCC Westminster residents are able to use their personal budget to support end of life care. Services can then be tailored to meet their individual needs or circumstances.
	More widely <ul style="list-style-type: none"> Where appropriate, a range of services will encourage residents to engage in advance and end of life planning.

* NB this table details all services provided from 31 March 2019

Appendix B – Overview of Some Recent Achievements and Upcoming Milestones in Dementia Services in RBKC and Westminster

Area of Work	Key Achievements	Upcoming Milestones
Dementia Strategy	<ul style="list-style-type: none"> • Plan and DoT approved by Members • Engagement plan signed off by senior officers 	<ul style="list-style-type: none"> • Engagement events signed off by Members • Officer-level engagement with frontline health & social care officers and LAG • Planning for Dementia Group meeting/Expert Panel
Training & Awareness Raising	<ul style="list-style-type: none"> • RBKC Cabinet and ELT, and RBKC and WCC HWBB trained as Dementia Friends • All Community Champions projects undertook a mental health awareness campaign from May to July supported by the CCGs and linked with Mental Health Awareness Week. • KCTMO committed in principal to training frontline staff as Dementia Friends 	<ul style="list-style-type: none"> • Rollout of Dementia Friends Training across the workforce • Community Champions committed to prioritising dementia in the next financial year and having a programme for upskilling champions in place in the New Year.
Service Commissioning – Well Pathway	<ul style="list-style-type: none"> • Dementia Friends included in new service specifications and encouraged with existing providers; • Provider-led workshops on social isolation (key modifiable risk factor for dementia in Older People); 	<ul style="list-style-type: none"> • Commence tender exercise for Extra Care Houses – staff dementia and dementia friends training and a built environment check list will be included. • New contracts issued and services specs for the 56 services being renewed. • Dementia friends and built environment check lists will be included in the new contracts and service specs.
Dementia Friendly Community Initiatives	<ul style="list-style-type: none"> • Healthy Workplace Charter Businesses now encouraged to become Dementia Friendly too. • Built environment dementia checklist rolled out among building based services <ul style="list-style-type: none"> ○ Dementia Friendly Environment checklists carried out for the new Westminster City Hall and in all Westminster Libraries ○ Libraries Health Information Officer trained as Dementia Champion trainer. ○ Maida Vale Library hosting user group sessions for clients of the memory service and their carers • Dementia Action Alliances 	<ul style="list-style-type: none"> • Libraries meeting with Resonate Arts and the Westminster Memory Service to explore devising and loaning memory boxes to community organisations for members to host memory cafes. • Dementia friends information sessions planned for library staff and customers



Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	24 January 2019
Classification:	General Release
Title:	Mental health and wellbeing JSNA
Report of:	Director of Public Health
Wards Involved:	All
Financial Summary:	There are no financial implications arising directly from this report. Any future financial implications that may be identified as a result of the review and re-commissioning projects will be presented to the appropriate Board and governance channels in a separate report
Report Author and Contact Details:	Colin Brodie, Public Health Knowledge Manager cbrodie@westminster.gov.uk

1. Executive Summary

- 1.1 This paper presents a draft version of the Mental Health and Wellbeing Joint Strategic Needs Assessment (JSNA) for consideration by the Health and Wellbeing Board.

PLEASE NOTE only the Executive Summary to the JSNA report is included with the printed agenda. The 177-page full report is included with the papers for this Board on the RBKC website. A copy is also available on email request to the Clerk.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board are invited to discuss and consider the findings and the recommendations in the report. In particular, the Board are invited to consider the following questions:

- Do you agree with the key recommendation and the six priorities of this JSNA? Are there any priorities that you think need to be included?
- Are there any very important areas of Mental Health and Wellbeing which fall within the scope of this JSNA which have not been included?
- Are there any amendments that need to be made for accuracy?

3. Background

3.1 Good mental health and wellbeing is important for us to lead happy, healthy lives. It has a positive impact on our inter-personal relationships and how we cope and engage with the world around us.

3.2 Research shows that good mental health and wellbeing promotes our overall health, supports recovery from illness, and improves life expectancy. It also has a positive impact on better educational achievement, reducing risky health behaviours, reduced risk of mental illness suicide, improved employment rates, reduced anti-social behaviour and higher levels of social interaction and participation.

4. Purpose and scope of the JSNA

4.1 This JSNA responds to a recommendation in 'The Roads to Wellbeing', the annual report of the Director of Public Health, to undertake a needs assessment of mental health and wellbeing in Kensington and Chelsea, and Westminster. It has been undertaken to inform and support strategy development, commissioning decision making, and action planning to improve mental health and wellbeing and reduce inequalities across the Bi-borough area.

4.2 In July 2018 a workshop was held to identify the key questions that were to be answered by the JSNA. In summary the key questions are:

- What do we mean by mental health and wellbeing?
- What is the local prevalence and characteristics of mental health and wellbeing across the life course?
- What are the local determinants and factors (risk and protective) for poor mental wellbeing and illness across the life course?
- What local services and assets in the community are available to meet these needs?
- What works to promote or protect mental wellbeing across the life course?
- What are the views and experience of both residents and patients accessing services?
- What are the potential gaps or areas of unmet need which require local action?

4.3 The format of the JSNA follows that recommended in the Mental Health JSNA Toolkit published by Public Health England (PHE) in 2017. Data has been drawn from a number of sources including population level data analysis, local service data, national and local research and literature, and service user feedback.

4.4 It is important to note that the potential scope of a JSNA on this topic is considerable as so many factors are a cause and consequence of mental health and wellbeing. We fully acknowledge that there will inevitably be gaps in this JSNA as a consequence.

5. Key findings and recommendations

5.1 Drawing on the evidence and data contained within the JSNA, the Executive Summary (p5-6) contains an analysis of current strengths, areas for future development, opportunities and potential challenges across the two Boroughs.

5.2 Based on this analysis the JSNA makes one key recommendation:

“The Health and Wellbeing Board takes a leadership role in setting the vision to achieve improved mental health and wellbeing in the Bi-borough and to reduce inequalities. The Board should establish a Mental Health and Wellbeing Working Group involving key partners to:

- Reach consensus on a vision for mental health and wellbeing in the Kensington and Chelsea, and Westminster population.
- Agree on a set of priority outcomes to achieve this vision
- Create a Strategic Action Plan and framework to implement and deliver these outcomes
- Monitor progress against the Strategic Action Plan and provide quality assurance for the Health and Wellbeing Board

- Ensure that local strategy and delivery plans address the findings of this JSNA
- To identify innovation and ‘cutting edge’ practices and develop a mechanism to coordinate bids to maximise potential for success”

5.3 In addition, a number of priority areas for this group to consider are highlighted:

- Mobilising local assets, services, and communities
- Pathways
- Funding
- Future demand
- Primary care
- Innovation

6. Next steps

6.1 In January 2019 a consultation on the draft report will be undertaken with key stakeholders, including the Health and Wellbeing Board, which will ask the following three questions:

- Do you agree with the key recommendation and the six priorities of this JSNA? Are there any priorities that you think need to be included? Please include rationale and supporting evidence
- Are there any very important areas of Mental Health and Wellbeing which fall within the scope of this JSNA which have not been included?
- Are there any amendments that need to be made for accuracy?

6.2 Responses will be collated and reviewed by the Mental Health and Wellbeing JSNA Steering Group for incorporation into the JSNA. A final JSNA report will be presented to the Health and Wellbeing Board in March for approval prior to publication

7. Legal Implications

7.1 The JSNA was introduced by the Local Government and Public Involvement in Health Act 2007. Sections 192 and 196 Health and Social Care Act 2012 place the duty to prepare a JSNA equally on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB).

7.2 JSNAs are a key means whereby LAs work with CCGs to identify and plan to meet the care and support needs of the local population, contributing to fulfilment of LA s2 and s3 Care Act duties.

7.3 Implications verified/completed by: TBC

8. Financial Implications

8.1 There are no financial implications arising from this report. Any future financial implications identified as a result of the report will be presented to the appropriate Board(s) and governance channels in a separate report.

Implications verified/completed by: Richard Simpson, Public Health Finance Manager, 02076414073

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:

BACKGROUND PAPERS:

Mental Health and Wellbeing JSNA: Executive Summary

Mental Health and Wellbeing JSNA: Full Report

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Mental health and wellbeing in Kensington and Chelsea, and Westminster

Joint Strategic Needs Assessment (JSNA) Report

Executive Summary

DRAFT report for consultation

1. Introduction

Good mental health and wellbeing is important for us to lead happy, healthy lives. The foundations for good mental health and wellbeing are established in childhood and adolescence. It has a positive impact on our inter-personal relationships and how we cope and engage with the world around us. Research shows that good mental health and wellbeing promotes our overall health, supports recovery from illness, and improves life expectancy. It also has a positive impact on better educational achievement, reducing risky health behaviours, reduced risk of mental illness suicide, improved employment rates, reduced anti-social behaviour and higher levels of social interaction and participation.

Unfortunately, at least one in four people will experience a mental health problem at some point in their lifetime, with one in six adults and one in ten children (aged five to sixteen years) suffering at any one time. Around 75% of mental health conditions are established by the age of 17. This indicates the importance of early intervention and addressing the childhood determinants of mental health and wellbeing. Of these, family relationships are pre-eminent, as positive attachments result in good emotional and social development for children, equipping people with the necessary skills and knowledge to achieve resilience and positive mental wellbeing in adulthood

Mental illness represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability – with estimates suggesting that the cost of mental health problems in England is close to £105 billion per year, including costs of lost productivity and wider impacts on wellbeing and treatment costs. These are expected to double by 2030.

This JSNA seeks to improve our understanding of the mental health and wellbeing landscape within our communities, understand how poor mental health and wellbeing affects our local health and social care economy, and recommend priority areas for action

Definitions

The terms mental health and mental wellbeing are often used interchangeably, and there is often confusion around terminology. For the purpose of this JSNA we have mostly used the term mental health and wellbeing to include the whole spectrum and experience, from positive mental wellbeing through to severe mental illness.

Mental Health

The World Health Organisation defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”

The term covers a “spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health” – *Better Mental Health for All, Faculty of Public Health*.

Mental Wellbeing

Mental wellbeing covers the positive end of mental health covering both the ‘feeling good’ and ‘functioning well’ components. Feeling good is subjective and embraces happiness, life satisfaction and other positive affective states. Functioning well embraces the components of psychological wellbeing (self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and environmental mastery)

Our emotional or mental wellbeing is closely linked with our physical health, and is strongly associated with positive relationships and healthier communities

2. Purpose and Scope

This JSNA report responds to a recommendation in the annual report of the Director of Public Health to undertake a needs assessment of mental health and wellbeing in the boroughs of Kensington and Chelsea and Westminster. It has been undertaken to provide **an evidence base to inform and support strategy development, commissioning decision making and action planning** to improve mental health and wellbeing and reduce inequalities across the Bi-borough.

The key questions for the JSNA were developed at a workshop held with key stakeholders in July 2018. These are;

- a) What do we mean by mental health and wellbeing?
- b) What is the local prevalence and characteristics of mental health and wellbeing across the life course?
- c) What are the local determinants and factors (risk and protective) for poor mental wellbeing and illness across the life course?
- d) What local services and assets in the community are available to meet these needs?
- e) What works to promote or protect mental wellbeing across the life course?
- f) What are the views and experience of both residents and patients accessing services?
- g) What are the potential gaps or areas of unmet need which require local action?

Further questions for the JSNA to consider are included in the Appendices of the full report.

Both national and local strategy and guidance emphasises the benefits of promoting positive mental wellbeing to the individual and society, and the importance of shifting the focus to preventing mental ill-health. An important recent example of investment in prevention is that of the implementation of Mental Health Support Teams in schools and colleges following the green paper on Transforming Children and Young People's Mental Health Provision.

The prevention agenda is a key policy driver for the local authority, Adult Social Care, Public Health, the NHS and other key partners, and has been highlighted in the recent publication of the NHS Long Term Plan. Both the Joint Health and Wellbeing Strategies make a commitment to preventing mental illness and promoting good mental wellbeing across the life course, and align with the ambitions set out in the Like Minded vision for North West London. While much of the data available for this JSNA focusses on mental ill health, it also reports on many of the factors that impact on mental health and wellbeing, and mental wellbeing data is included where available.

3. Key findings at a glance

Key findings are summarised at the beginning of each chapter in the full report. Drawing on these, and from the evidence and data contained within the JSNA, the following analysis of current strengths, areas for future development, opportunities and potential challenges was undertaken by the Mental Health and Wellbeing JSNA Steering Group, and has informed the development of the key themes and recommendations. This provides a strategic overview of the findings of the JSNA.

Mental Health and Wellbeing JSNA - Key findings at a glance

Current strengths	Areas for future development
<ul style="list-style-type: none"> • Thriving community and voluntary sector supporting and promoting mental wellbeing • Specialist clinicians and centres of excellence • Clear perinatal mental health pathway, specialist pathways, suicide strategy, and specialist homelessness services • Strong Healthy Schools Partnership and Healthy Early Years • Development of models such as Primary Care Plus and Community Living Well • Relatively well funded with commitment to mental health and wellbeing • Compared to the London average there are: <ul style="list-style-type: none"> • Higher levels of life satisfaction and happiness, with an upward trend in high life satisfaction, finding life worthwhile and high happiness in Westminster • Higher educational attainment and low youth unemployment • Lower rates of long-term unemployment • Lower rates of looked after children • Higher % of people in touch with mental health services who are in stable appropriate housing • Lower hospital admission rates for self-harm • 100% IAPT referrals resulting in treatment waited less than 18 weeks • Lower rate of smoking among adults in both boroughs • Lower prevalence of residents (children and adults) with a long-term health problem or disability in both boroughs • Lower prevalence of adults and children with a learning disability • Lower prevalence of residents registered deaf or hard of hearing in both boroughs • Lower percentage of unpaid carers in both boroughs 	<ul style="list-style-type: none"> • Develop a strategic vision with clear delivery plan for mental health and wellbeing with clarity on leadership and specific roles • Develop visible care pathways to recovery for children and adults • Build trust and confidence in the capacity and skills within primary care to better manage mental health and wellbeing • Waiting times can be lengthy and exacerbate mental health conditions • Better communication and clarity needed on services and assets, and how to navigate the system • Local issues affecting our population include high numbers of homelessness, population churn, and high number of residents experiencing trauma • Looked after children are placed out of Borough which brings specific challenges • Compared to the London average there are: <ul style="list-style-type: none"> • lower % of service users with a crisis plan • lower % of patients waiting <28 days between first and second treatments • higher numbers of delayed discharges • lower satisfaction with social care support and protection

Mental Health and Wellbeing JSNA - Key findings at a glance

Opportunities	Potential challenges for the future
<ul style="list-style-type: none"> • The JSNA builds on the current national and local conversation on mental health and wellbeing, and could provide a good platform for developing creative and collaborative partnerships of key stakeholders, and setting ambitions for the mental health and wellbeing of our population • Existing and potential work with social housing providers to support residents with mental health conditions and to promote community resilience, address loneliness, and promote mental wellbeing. • Opportunities to identify best practice in developing peer support models • Work with residents and services users to co-produce pathways and services to promote mental health and wellbeing • Build on existing social prescribing models across the two Boroughs, such as My Care My Way to promote mental health and wellbeing • Support the already strong community and voluntary sector to provide services promoting mental health and wellbeing to all local communities, and to address specific barriers (such as language barriers) • Recommissioning and procurement of supported housing services may present opportunities to improve support for residents with poor mental health • Trailblazer funding secured to implement Mental Health Support Teams in schools • Utilising new technologies to deliver services to meet the needs of young people in a way that is engaging for them 	<ul style="list-style-type: none"> • Potential danger of overburdening universal services with mental health referrals • Working within the existing financial envelope, there is a tension between maintaining current investment in treatment services in order to meet needs and the shift required to invest in prevention • This is particularly important when levels of future funding are uncertain and in the context of an increasing demand for mental health services • There is a particular challenge for children & young people with mental health needs who are not accessing education • Compared to the London average there are: <ul style="list-style-type: none"> • downward trends in high life satisfaction, finding life worthwhile and high happiness in Kensington and Chelsea • Higher rates of adult and child poverty • Higher % of children with social, emotional and mental health needs and lower percentage of children 'school ready' • Higher rates of children in need due to parental absence or parental illness/ disability • Higher rates of hospital admissions for mental/ behavioural disorders due to the use of alcohol • Higher rates of opiate and crack use • Higher rates of homelessness and single person households • Higher rates of depression in Kensington and Chelsea • Higher rates of severe mental illness in both boroughs • Suicide rate higher in RBKC, comparable in WCC. Rate in males higher for both boroughs • Mixed life satisfaction results at age 15 years • Higher rates of unemployment • Higher rates of residents registered blind or partially sighted 18 to 75 years in Kensington and Chelsea and 75+ in Westminster

4. Recommendation and priorities

Drawing together the evidence and the analysis above the JSNA has identified one key recommendation to mobilise improvement in mental health and wellbeing in the Bi-borough.

Key recommendation

The Health and Wellbeing Board takes a leadership role in setting the vision to achieve improved mental health and wellbeing in the Bi-borough and to reduce inequalities. The Board should establish a Mental Health and Wellbeing Working Group involving key partners to:

- Reach consensus on a vision for mental health and wellbeing in the Kensington and Chelsea, and Westminster population.
- Agree on a set of priority outcomes to achieve this vision
- Create a Strategic Action Plan and framework to implement and deliver these outcomes
- Monitor progress against the Strategic Action Plan and provide quality assurance for the Health and Wellbeing Board
- Ensure that local strategy and delivery plans address the findings of this JSNA
- To identify innovation and 'cutting edge' practices and develop a mechanism to coordinate bids to maximise potential for success

The mental health and wellbeing 'system' is incredibly complex and broad in scope and we acknowledge that to coordinate this system would be a virtually impossible task. However, this recommendation would ensure there is a responsible body with leadership and oversight of a shared work programme to promote mental health and wellbeing in the population, and reflect the spirit of collaboration and integration that is required.

From the available evidence and analysis the JSNA has highlighted a number of priorities that need to be considered at a strategic level.

Priorities

Mobilising local assets, services, and communities

The Bi-borough benefits from a thriving and vibrant third sector who make a significant contribution to promoting mental wellbeing, as well as the expertise and knowledge of a variety of specialist clinicians and centres of excellence for mental health and wellbeing. We need to ensure that we build capacity across the system and make the most of these assets, services and communities – and ensure that they are sustainable, and work collaboratively to promote and maintain the mental health and wellbeing of our residents and patients

Pathways

There is emerging evidence that the Perinatal Mental Health Service pathway is helping to provide good care for residents and patients using those services. Similarly, clear and well communicated pathways for children and young people, and adults, need to be developed.

Funding

Any future strategies and commissioning plans should consider how we work better in partnership in order to maximise outcomes within existing budgets, and how funding can be sustained across the system into the future.

Future demand

There is evidence of an increase in demand for mental health services, including indications of increasing needs for children and young people. Consideration will need to be given to focusing on prevention as well as early intervention to address demand and future planning to ensure services are equipped to meet this need.

Primary care

Primary care, and GPs in particular, play a key role in enabling a cultural shift towards a recovery based model where patients are discharged in to their care, and their recovery from mental ill-health can continue. Primary care practitioners must have the knowledge and skills to manage mental health conditions and enable these pathways to recovery

Innovation

Work in partnership across local authority, NHS, community and voluntary sector, business and industry, and academia to develop and trial innovative and integrated solutions to promote good mental health and wellbeing across the Bi-borough, with a particular focus on prevention and early intervention. Use academic collaborations to evaluate effectiveness and cost effectiveness of local initiatives and programmes to ensure value for money.

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Mental health and wellbeing in Kensington and Chelsea, and Westminster

Joint Strategic Needs Assessment (JSNA) Report

DRAFT report for consultation

This report

This report responds to a recommendation in 'The Roads to Wellbeing'¹, the annual report of the Director of Public Health, to undertake a needs assessment of mental health and wellbeing in Kensington and Chelsea, and Westminster. It has been undertaken to inform and support strategy development, commissioning decision making, and action planning to improve mental health and wellbeing and reduce inequalities across the Bi-borough area.

It specifically aims to:

- Gather and collate evidence which allows us to obtain a comprehensive understanding of the mental health and wellbeing landscape within our communities
- Understand how poor mental health and wellbeing affects our local health and social care economy
- Identify specific strengths and gaps in our current services, and any particularly 'at-risk' groups
- Identify best practice in this field
- Recommend priority areas for action

Data has been drawn from a number of sources including population level data analysis, local service data, national and local research and literature, and service user feedback.

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Acknowledgements

We would like to thank the many people and organisations who have contributed to this report. Particular thanks are due to the Steering Group for their input and guidance on the development of this JSNA:

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¹ Bi-borough Public Health Department. The Roads to Wellbeing
<https://www.jsna.info/aphr201617>

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DRAFT

1 Recommendations and priorities

1.1 Key Recommendation

The Health and Wellbeing Board takes a leadership role in setting the vision to achieve improved mental health and wellbeing in the Bi-borough and to reduce inequalities. The Board should establish a Mental Health and Wellbeing Working Group involving key partners to:

- Reach consensus on a vision for mental health and wellbeing in the Kensington and Chelsea, and Westminster population.
- Agree on a set of priority outcomes to achieve this vision
- Create a Strategic Action Plan and framework to implement and deliver these outcomes
- Monitor progress against the Strategic Action Plan and provide quality assurance for the Health and Wellbeing Board
- Ensure that local strategy and delivery plans address the findings of this JSNA
- To identify innovation and 'cutting edge' practices and develop a mechanism to coordinate bids to maximise potential for success

1.2 Priorities

The JSNA has highlighted a number of priorities that need to be considered at a strategic level. Other areas for development may need to be considered, and the Working Group will seek to develop their own work programme.

Mobilising local assets, services, and communities

The Bi-borough benefits from a thriving and vibrant third sector who make a significant contribution to promoting mental wellbeing, as well as the expertise and knowledge of a variety of specialist clinicians and centres of excellence for mental health and wellbeing. We need to ensure that we build capacity across the system and make the most of these assets, services and communities – and ensure that they are sustainable, and work collaboratively to promote and maintain the mental health and wellbeing of our residents and patients

Pathways

There is emerging evidence that the Perinatal Mental Health Service pathway is helping to provide good care for residents and patients using those services. Similarly, clear and well communicated pathways for children and young people, and adults, need to be developed.

Funding

Any future strategies and commissioning plans should consider how we work better in partnership in order to maximise outcomes within existing budgets, and how funding can be sustained across the system into the future.

Future demand

There is evidence of an increase in demand for mental health services, including indications of increasing needs for children and young people. Consideration will need to be given to focusing on prevention as well as early intervention to address demand and future planning to ensure services are equipped to meet this need.

Primary care

Primary care, and GPs in particular, play a key role in enabling a cultural shift towards a recovery based model where patients are discharged in to their care, and their recovery from mental ill-health can continue. Primary care practitioners must have the knowledge and skills to manage mental health conditions and enable these pathways to recovery

Innovation

Work in partnership across local authority, NHS, community and voluntary sector, business and industry, and academia to develop and trial innovative and integrated solutions to promote good mental health and wellbeing across the Bi-borough, with a particular focus on prevention and early intervention. Use academic collaborations to evaluate effectiveness and cost effectiveness of local initiatives and programmes to ensure value for money.

2 Introduction

2.1 Background

Good mental health and wellbeing is important for us to lead happy, healthy lives. It has a positive impact on our inter-personal relationships and how we cope and engage with the world around us. Research shows that good mental health and wellbeing promotes our overall health, supports recovery from illness, and improves life expectancy.

Not only that, but there is evidence that good mental health and wellbeing also has a positive impact on better educational achievement, reducing risky health behaviours, reduced risk of mental illness suicide, improved employment rates, reduced anti-social behaviour and higher levels of social interaction and participation (Chevelier & Feinstein, 2006; Meltzer et al., 2006).

Unfortunately, at least one in four people will experience a mental health problem at some point in their lifetime, which can affect their daily life, relationships and physical health, and one in six adults have a mental health problem at any one time (McManus et al., 2009). One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood (Green et al., 2005).

Among adults under 65, nearly half of all ill health is mental illness. In other words, for those of working age, nearly as much ill health is mental illness as all physical illnesses put together (LSE, 2012). Every year in the UK, more than 250,000 people are admitted to psychiatric hospitals and over 4,000 people commit suicide. Mental illness represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability (World Health Organisation, 2008).

Estimates suggest that the cost of mental health problems in England are close to £105 billion per year, which includes costs of lost productivity and wider impacts on wellbeing and treatment costs. These are expected to double by 2030 (Department of Health, 2011).

Positive mental wellbeing is incredibly important to ensure we 'feel good' and 'function well'. 'The Roads to Wellbeing', the 2016/17 annual report of the Director of Public Health for Kensington and Chelsea, and Westminster highlighted how we can take steps to achieve this using the Five Ways to Wellbeing, an evidence-based framework – Connect, Be Active, Keep Learning, Take Notice and Give. The report also noted that we needed to better understand the mental health and wellbeing needs of the local population in order to shape future strategy and commissioning activity. This JSNA aims to address that need.

2.2 Strategy context and policy drivers

Mental health and wellbeing is a priority for both boroughs, the NHS and central government. As a result, there are many local, regional and national strategies on mental health. There is a common consensus about the importance of wellbeing and promoting good mental health, rather than a focus on intervening when an individual becomes mentally unwell. This section summarises some of the more recent strategy and policy drivers.

National

Five Year Forward View for Mental Health

In 2016 the Independent Mental Health Taskforce published the Five Year Forward View for Mental Health for the NHS in England. This strategy brought together health and care leaders, people who use services and experts in the field, and signified the first time a strategic approach had been taken to improve mental health outcomes across the health and care system, in partnership with the health arm's length bodies.

The strategy recognised the importance of creating a shift towards prevention and that mental health should have parity with physical health and wellbeing. The following priorities for action by the NHS were identified in the report:

- A 7 day NHS – right care, right time, right quality
- An integrated mental and physical health approach
- Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens

In July 2016, NHS England published an Implementation Plan to set out the actions required to deliver the Five Year Forward View for Mental Health. The Implementation Plan brings together all the health delivery partners to ensure there is cross-system working to meet the recommendations made by the Taskforce.

Members of the taskforce were responsible for making sure that there was cross-system commitment and alignment when developing actions within the national strategy and that continued partnership, working effectively and meaningfully, enables the strategy to be delivered.

Better Mental Health for All

This report is intended as a call to action to promote a public health approach to mental health and wellbeing, as well as being a useful resource for practitioners in public health and beyond. It focusses on what can be done individually and collectively to enhance the mental health of individuals, families and communities by using a public health approach.

The report describes why public mental health is important, risk and protective factors for mental health and wellbeing, and interventions and approaches to promote good mental health and wellbeing across the life course.

This JSNA has drawn on the evidence contained in the report to inform the relevant sections in this report.

Being mindful of mental health

This report from the Local Government Association outlines the influence that local authorities on the mental wellbeing of their communities and how their services can promote and support the mental wellbeing of the local population. The report summarises this as:

- Councils make a significant contribution to the mental wellbeing of their local communities.
- Councils have key statutory and non-statutory duties that are an integral part of the mental health services landscape. To improve services and the mental health of our communities, a whole-system review that looks at the future of all mental health services, including the voluntary and community sector, is needed.
- Councils need adequate funding to enable them to fully play their essential part in the mental health system.
- There needs to be a re-focus in mental health policy away from medicalisation and mental ill health to prevention, early intervention and mental wellness.

The report articulates what councils should be looking at to enable their residents to live in better mental health, including a number of top tips to create mentally well places:

- Include mental health in all policies.
- Enable people in public and high profile appointments to share stories of mental health experiences, and have a member Mental Health Champion.
- Work closely with the local voluntary and community sector, incorporating their role into local mental health and wellbeing plans.
- Work closely with the NHS and local clinical commissioning groups; consider mental health and mental wellness within health and wellbeing board activities.
- Include design for mental wellness in planning policies and new developments
- Provide mental health training, awareness, protocols and support for the council's staff and councillors.
- Focus on perinatal and early-years mental health and prevention and early intervention in general.
- Work with schools and other children's facilities to raise awareness of mental health and resilience.
- Emphasise the links between physical and mental health; in both treatment of ill health and in promoting the importance of leisure and outdoor facilities.
- Have regard for the impact of home and place on mental health.

Mental Health Act

In October 2017, the Prime Minister announced an independent review of the Mental Health Act 1983 to make improvements following rising detention rates, racial disparities in detention and concerns that the Act is out of step with a modern mental health system. The review team was also asked to consider how to improve practice within the existing legislation.

Following the publication of the review the government will be introducing a new Mental Health Bill to transform mental health care. The government is accepting two of the review's recommendations to modernise the Mental Health Act.

- Those detained under the Act will be allowed to nominate a person of their choice to be involved in decisions about their care. Currently, they have no say on which relative is contacted. This can lead to distant or unknown relatives being called upon to make important decisions about their care when they are at their most vulnerable
- People will also be able to express their preferences for care and treatment and have these listed in statutory 'advance choice' documents.

Local

Joint Health and Wellbeing Strategies

Mental health and wellbeing has been identified as a priority in both local Health and Wellbeing Strategies, and through that process there is already work with colleagues from across the local authority, community and voluntary organisations, schools, businesses and NHS partners to improve the mental wellbeing of our residents. Both strategies align with the Like Minded ambitions for mental health and wellbeing across North West London.

The Westminster strategy highlights the importance of prioritising and embedding prevention, early intervention and a partnership approach to stop and reverse the negative trends of poor mental health. The strategy makes the following commitments:

Working with individuals, communities, professionals and employers in Westminster we will improve mental health for Westminster people by:

- addressing the stigma associated with all types of mental health conditions
- treating and caring for people as individuals and recognising the complex factors that impact mental health
- recognising and addressing the wider determinants of mental health, including housing, employment, education and community interactions
- ensuring that statutory, voluntary and community organisations continue to work closely together to identify people early who might require support
- supporting people in the workplace and tackling barriers into work

- working with communities to develop peer support, resilience and cohesion so that individuals, families and neighbours can support and look out for each other
- providing information through a range of mediums that is tailored for people of all ages and situations to access and use.

The Kensington and Chelsea strategy makes articulates their ambition to prevent, identify and treat mental health across all age groups to:

- Make work a healthy place to be by promoting good workplace mental health and wellbeing and supporting people with mental illness into employment
- Promote better emotional and mental health and early intervention in schools including access to counselling and psychological therapies and work with partners to tackle cyber-bullying
- Provide support for parents and parents-to-be for their own mental health and for the long-term mental health of their families
- Improve access to psychological therapies and children and young people's mental health services.
- Encourage GPs to use 'social prescribing' and non-medical interventions to improve mental health and wellbeing
- Work with professionals to break down the barriers between physical and mental health and ensure both are treated equally
- Encourage awareness and improve the quality of local services and support for people living with dementia and their carers
- Support residents at risk of social isolation including older residents who live alone
- Work with staff in frontline services across the system to build skills and awareness of mental health
- Promote access and signpost to activities that promote wellbeing, volunteering and stronger social networking to improve outcomes
- Provide early support for older people through effective information and advice and signposting to preventative/universal services
- Work with communities to help change attitudes, tackle stigma, and develop understanding of mental health.
- Improve the physical health and lifestyles of people with mental health conditions, with a particular focus on people with serious mental health conditions
- Ensure that crisis support is available for people with serious mental illness

Like Minded

The Like Minded strategy for mental health and wellbeing across North West London highlights the importance of working together and co-production to learn best practice and share innovative approaches. The strategy was co-produced with patients, carers, doctors, voluntary organisations and charities and other experts.

The Like Minded vision is:

By working together, our vision is for North West London to be a place where people say:

- “My wellbeing and happiness is valued”
- “I am supported to stay well”
- “My care is delivered at the place that is right for me”
- “The care and support I receive is joined up”
- “As soon as I am struggling, help is available”

The Roads to Wellbeing

The 2016-17 annual report of the Director of Public Health focused on mental wellbeing in Westminster and Kensington and Chelsea, and the importance of protecting and improving our own mental wellbeing, and that of the people around us – our families, friends, neighbours, and local communities.

The key messages from the report are:

- Poor mental wellbeing can affect us and those around us at any point in our lives. Mental wellbeing can impact on all aspects of our lives and is ‘everyone’s business’
- We can all play a role in improving our own and others’ mental wellbeing: Connect, Be Active, Keep Learning, Take Notice, and Give
- To help build the mental resilience of our local communities we need to better understand residents’ mental wellbeing and what works to improve this.
- We can achieve this by working in partnership with residents and other organisations and considering mental wellbeing when commissioning and evaluating services
- We need to ensure investment is channelled towards prevention and early intervention not just towards treatment

The report makes a number of recommendations for different sectors and agencies, including one for the local Health and Wellbeing Boards to commission this JSNA in order to better understand the mental health and wellbeing needs of our population.

Dementia strategy

A dementia strategy is currently being developed for the Bi-borough by the local authority and key partners, to address the increasing and varied levels of need in the population and to promote dementia friendly communities. This strategy will take into account the local JSNA on dementia published in 2015 as well as more recent data and evidence documented in this report.

2.3 Scope and definitions

Scope

In line with recent national and local strategy the focus of the report will be on promoting positive mental wellbeing and preventing mental illness, rather than treatment aspects of clinical mental *ill*-health, although this is also covered in order to provide an overview of the full range of mental health and wellbeing in the two Boroughs. The JSNA will evidence the benefits of promoting positive mental wellbeing to the individual and society, and the importance of shifting the focus to preventing mental ill-health.

In July 2018 a workshop was held to identify the key questions that were to be answered by the JSNA. A full table outlining these questions is included in Appendix A. In summary the key questions are:

- What do we mean by mental health and wellbeing?
- What is the local prevalence and characteristics of mental health and wellbeing across the life course?
- What are the local determinants and factors (risk and protective) for poor mental wellbeing and illness across the life course?
- What local services and assets in the community are available to meet these needs?
- What works to promote or protect mental wellbeing across the life course?
- What are the views and experience of both residents and patients accessing services?
- What are the potential gaps or areas of unmet need which require local action?

The format of the JSNA follows that as recommended in the Mental Health JSNA Toolkit² published by Public Health England (PHE) in 2017. In addition, it is worth noting that the What Works for Wellbeing Centre has created an indicator set³, intended to help local decision-makers understand the wellbeing of their constituents. This set is composed of seven domains that can inform us about levels of wellbeing in our communities: personal wellbeing, equality, education & childhood, health, social relationships, place and economy. These domains align with the JSNA toolkit and can be identified within the JSNA.

² Public Health England (2017) Better mental health: JSNA toolkit.

<https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit>

³ What Works for Wellbeing. Local Authority Wellbeing Indicator Set.

<https://whatworkswellbeing.org/product/local-authority-wellbeing-indicator-sets-and-guidance-only/>

It is important to note that the potential scope of a JSNA on this topic is considerable as so many factors are a cause and consequence of mental health and wellbeing. We acknowledge that there will inevitably be gaps in this JSNA as a consequence.

Grenfell and North Kensington

The fire at Grenfell Tower on June 14, 2017 had a devastating impact on many people. 71 people lost their lives in the fire and another resident died later. Many others have experienced trauma, loss and, displacement.

Over time this is likely to affect wider mental health, physical health, and in turn cause a range of social challenges including family breakdown, educational and employment challenges. This will have an impact on the mental health and wellbeing of those affected by the fire.

A separate health needs assessment – The Journey to Recovery - has been undertaken which considers the primary impacts on health and wellbeing, including mental health and wellbeing, of those affected by the Grenfell disaster. This JSNA report does not attempt to duplicate that document and should be read in conjunction with The Journey to Recovery needs assessment.

Definitions

Mental health

The World Health Organisation defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community⁴.

The “Better mental health for all” report (Faculty of Public Health, 2016) describes how the term mental health is a “spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health.”

Mental wellbeing

Mental wellbeing covers the positive end of mental health covering both the ‘feeling good’ and ‘functioning well’ components. Feeling good is subjective and embraces happiness, life satisfaction and other positive affective states. Functioning well embraces the components of psychological wellbeing (self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and environmental mastery)

Our emotional or mental wellbeing is closely linked with our physical health, and is strongly associated with positive relationships and healthier communities

⁴ WHO (2014) Mental health: a state of wellbeing.
http://www.who.int/features/factfiles/mental_health/en/

2.4 Relation to commissioning

The overall purpose of the JSNA is to inform strategy development, commissioning decision making, and action planning to improve mental health and wellbeing and reduce inequalities across the Bi-borough area.

DRAFT

3 Understanding people and place

To inform strategy and service planning the JSNA describes the local population, the levels of mental wellbeing, the prevalence and incidence of mental health conditions, and the characteristics of the population of the two Boroughs (for example, size, age and gender) which may drive demand for mental health services now and in the future.

Inequalities exist in the prevalence of mental health problems, access to services and outcomes. There are specific groups of people who are more likely to have poor mental wellbeing and are more at risk of developing mental health problems whose needs must be met.

There are also important causes and consequences of mental health and wellbeing such as health behaviours like smoking and physical activity and misuse of alcohol and drugs. Although not considered in depth in this JSNA, they have been included.

Note: In all comparative analyses utilizing Public Health England published comparative data, Kensington and Chelsea and Westminster indicators are compared to London averages. England rates are also provided for information.

3.1 Key Messages

Key messages: Understanding People and Place

Understanding Place

Wider determinants

- Of the wider determinants of mental ill health, key challenges in the borough are deprivation, poverty and homelessness.
- Employment rates are lower than the London average, however long-term unemployment rates are lower than the London average as are unemployment rates for young people
- Educational outcomes are good with children from both boroughs achieving a higher rates of GCSE A-C passes compared to the London average
 - With the exception of violent crime in Westminster and re-offending rates in Kensington and Chelsea, indicators of crime levels show lower rates than the London average

Well-being

- Over the past 7 years well-being scores for happiness, finding life worthwhile and life satisfaction have increased in Westminster, but declined for Kensington and Chelsea. Scores for anxiety have remained relatively stable.

- In 2017/18 Westminster scored higher than the London average on measures of well-being: happiness, finding life worthwhile and life satisfaction, while Kensington and Chelsea scores were lower
 - Anxiety scores for both boroughs were slightly higher London average

Understanding People

Population demographics

- Both boroughs have a lower percentage of BME residents, but a higher proportion of mixed ethnicity residents compared to the London average

Prevalence

- While rates of depression recorded by GP practices in both boroughs are comparable to the London average, the recorded prevalence of serious mental illness are higher than the London average in both boroughs

Smoking

- Rates of smoking in the general adult population are lower than the London average, but higher than the London average among those with a serious mental illness

Alcohol and Substance Misuse

- Both boroughs have a higher rate of hospital admissions for mental and behavioural disorders due to the use of alcohol. Rates of alcohol dependence in both boroughs are comparable to the London average
 - The estimated prevalence of opiate and/or crack cocaine use is higher than the London average in both boroughs, as is the rate of hospital admissions for substance misuse among young people in Kensington and Chelsea

Suicide and Self-harm

- While the suicide rate is higher than the London average in Kensington and Chelsea and comparable to the London average in Westminster, the suicide rate for men in both boroughs is higher than the London average.
 - The rate of hospital admissions for self-harm, at all ages, is lower than the national average in both boroughs, as are rates of self-harm among young people compared to the London average

3.2 Current

Wellbeing in the Boroughs

Since 2011, the ONS has asked a large sample of UK adults aged 16 and over about their wellbeing. In 2017-18, UK wide, 30.1% of the population had a very high satisfaction with their life overall. Around a third (35.8%) had a very high rating of how worthwhile they feel the things they do are. 34.8% rated their happiness as very high for the day preceding, with 40.5% rating their anxiety for the day preceding as very low. (ONS, 2017-18)

Table 1 shows the latest estimates of personal wellbeing in Kensington and Chelsea (RBKC) and Westminster (WCC), 2017/18. From Table 1, while scores in both boroughs are similar to the London and England averages, RBKC is shown to have lower mean well-being scores –particularly for happiness–and a larger anxiety score compared to the London average. Westminster scores better than the London average on all but anxiety which is higher.

Table 1: 2017/18 Life-satisfaction scores

Indicator	Description	RBKC	WCC	London	England
Happiness	Overall, how happy did you feel yesterday? 0-10 scale where 10 is completely happy	6.82	7.56	7.44	7.52
Life satisfaction	Overall, how satisfied are you with your life nowadays? 0-10 scale where 10 is completely satisfied	7.31	7.58	7.52	7.68
Purpose/meaning	Overall, to what extent do you feel the things you do in your life are worthwhile? 0-10 scale where 10 is completely worthwhile	7.55	7.77	7.73	7.88
Anxiety	Overall, how anxious did you feel yesterday? 0-10 scale where 10 is completely anxious	3.71	3.33	3.13	2.90

Source: ONS 2017/18

Incidence and prevalence of mental illness

This section covers the estimated and recorded prevalence of mental illness in the Kensington and Chelsea and Westminster.

Population prevalence rates of diagnosed and undiagnosed case of mental illness are taken from The Adult Psychiatric Morbidity Study (APMS), while the recorded prevalence, diagnosed prevalence rates are taken from Quality and Outcomes Framework (QoF) registers, the GP Survey and social care data. All of which are publicly available.

Population prevalence

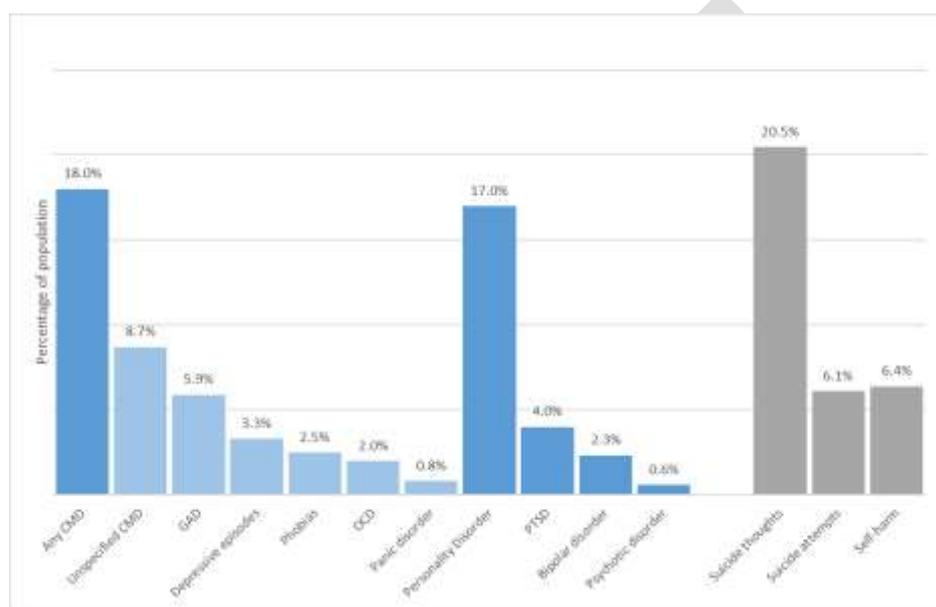
The Adult Psychiatric Morbidity Study (APMS) provides estimates the population level prevalence of mental illness (diagnosed and undiagnosed) and by key sociodemographic characteristics:

- age
- sex
- ethnicity
- household structure
- employment status

- benefit status
- geographic region

While this study does not provide prevalence rates at borough level, adjusted estimates of prevalence are provided for the London region. Chart 1 shows the estimated prevalence of mental illness and self-harm in London. Table 2 shows the estimated number of cases of mental illness, by borough, should London estimates prevail.

Chart 1: The relative prevalence of common mental health conditions and mental illness in the London region.



APMS (2014). Estimates of the prevalence of psychiatric disorders are based APMS 2007 and 2014 data

Table 2: Estimated numbers affected by mental illness by borough, 2018

Illness/ presentation	Borough	Rate	Count	Illness/ presentation	Borough	Rate	Count
Common Mental Disorder	RBKC	18.0%	23,943	Personality Disorders	RBKC	17.0%	22,613
	WCC	18.0%	38,484		WCC	17.0%	36,346
Common Mental Disorder-Unspecified	RBKC	8.7%	11,572	PTSD	RBKC	4.0%	5,321
	WCC	8.7%	18,601	WCC	4.0%	8,552	
Generalised anxiety disorder	RBKC	5.9%	7,848	Bipolar disorder	RBKC	2.3%	3,102
	WCC	5.9%	12,614		WCC	2.3%	4,986
Depressive episode	RBKC	3.3%	4,390	Psychotic disorder	RBKC	0.6%	798
	WCC	3.3%	7,055		WCC	0.6%	1,283
Phobias	RBKC	2.5%	3,325	Self-harm	RBKC	6.4%	8,507
	WCC	2.5%	5,345		WCC	6.4%	13,674
Obsessive compulsive disorder	RBKC	2.0%	2,660	Suicide thoughts	RBKC	20.5%	27,218
	WCC	2.0%	4,276		WCC	20.5%	43,748
Panic disorder	RBKC	0.8%	1,064	Suicide attempts	RBKC	6.1%	8,098
	WCC	0.8%	1,710		WCC	6.1%	13,016

Table 3: Variation in the Population prevalence of mental illness by key demographic characteristics (APMS, 2014)

Illness/ presentation	Prevalence 16+	Relationship to:						
		Age	Sex	Ethnicity	Household type	Employment status	Benefit status	Region
Bipolar disorder	2.0%	Clear gradient - Higher at younger ages: 16-24yrs: 3.4% vs. 65-74yrs: 0.4%	Higher among Males: 2.1% vs. Females, 1.8%	Highest among Black/Black British 3.5% vs. lowest in Asian/Asian British, 1.4%	Highest - Single person household: 5.5% vs. Lowest: 2 adults 60yrs+, no children, 0.4%	Highest among economically inactive: 4.3% lowest in employment, 1.9%	Higher on benefits than not: Highest on ESA: 12.4%	Higher in London, 2.3% vs. England, 2.0%
Personality disorder - Antisocial	3.3%	Clear gradient - Higher at younger ages: 16/18-24yrs: 4.9% vs. 55-64yrs: 2.2%	Higher among Males: 4.9% vs. Females, 1.8%	Highest among Mixed ethnicity 4.8% vs. lowest in Asian/Asian British, 1.4%	Highest - Single person household: 6.6% vs. Lowest: Adults with children, 2.9%	Highest among economically inactive: 4.7% lowest in employment, 2.8%	Personality disorder: Higher on benefits than not: Highest on ESA: (3-48% vs. 12-14%), ESA: 48%	Higher in London, 4.4% vs. England, 3.3%
Personality disorder - Borderline	2.4%	Clear gradient - Higher at younger ages: 16/18-24yrs: 5.7% vs. 55-64yrs: 1.0%	Higher among Females: 2.9% vs. Males, 1.9%	Highest among White British % vs. 2.6% lowest in Black/Black British, 1.4%	Highest - Single person household: 3.9% vs. Lowest: Adults with children, 2.0%	Highest among economically inactive: 5.3% lowest in employment, 1.5%		Lower in London, 2.2% vs. England, 2.4%
PTSD	4.4%	Clear gradient - Higher at younger ages: 16/18-24yrs: 8.0% vs. 55-64yrs: 0.6%	Higher among Females: 5.1% vs. Males, 3.7%	Highest among Black/Black British 8.3% vs. lowest in White Other, 2.2%	Highest - Single person household: 10.8% vs. Lowest: 2 adults 60yrs+, no children, 1.4%	Highest among economically inactive: 10.5% lowest in employment, 2.7%	Higher on benefits than not: Highest on ESA: (16-34% vs. 3.4-4.2%), ESA: 34%	Lower in London, 4.0% vs. England, 4.4%
Common Mental Health Disorders	15.7%	Higher at younger ages peaks at: 35-44yrs 19.3% vs. 75 yrs+: 8.8%	Higher among Females: 19.1% vs. Males, 12.2%	Highest among Mixed ethnicity 19.8% vs. lowest in White Other, 1.4%	Highest - Single person household: 29.4% vs. Lowest: 2 adults 60yrs+, no children, 10.4%	Highest among economically inactive: 33.1% lowest employed full-time, 14.2%	Higher on benefits than not: Highest on ESA: (35-66% vs. 15-17%), ESA: 66%	Higher in London, 18.0% vs. England, 15.7%
Psychotic disorders	0.5%	Parabolic, peaks at: 35-44yrs 1.0% vs. 75 yrs+: 0.1%	Higher among Females: 0.6% vs. Males, 0.5%	Highest among Black/Black British 1.4% vs. lowest in White, 0.5%. No data on Mixed ethnicity	Highest - Single person household: 1.1% vs. Lowest: adults no children, 0.4%	Highest among economically inactive: 2.3% lowest employed full-time, 0.1%	Higher on benefits than not: Highest on ESA: (5-13% vs. 0.2-0.3%), ESA: 13%	Higher in London, 0.6% vs. England, 0.5%
Self-harm	7.3%	Most common at 16-24yrs: 17.5% vs. 75yrs+: 0.3%	Higher among Females: 8.9% vs. Males, 5.7%	Highest among White British 8.1% vs. lowest in White, 5.5%.	Highest - Single person household: 14.9% vs. Lowest: adults no children, 1.5%	Highest among economically inactive: 14.6% lowest employed full-time, 7.6%	Higher on benefits than not: Highest on ESA: (15-34% vs. 7-8%), ESA: 13%	Lower in London, 7.1% vs. England, 7.3%
Suicidal thoughts	20.6%	Most common at 16-24yrs driven female prevalence, men most common at- 55-64yrs	Higher among Females: 22.4% vs. Males, 18.7%	Highest among White British 21.6% vs. lowest in Asian/ Asian British, 13.1%.	Highest - Single person household: 40.2% vs. Lowest: adults no children, 11.4%	Highest among unemployed: 30.5% lowest employed, 20.8%	Higher on benefits than not: Highest on ESA: (37-66% vs. 19-22%), ESA: 66%	Lower in London, 20.6% vs. England, 21.3%
Suicide attempts	6.7%	Most common at younger ages 16-34yrs, peaks at 16-24 yrs, 9.0% driven female prevalence, men - 55-64yrs	Higher among Females: 8.0% vs. Males, 5.4%	Highest among White British 6.9% vs. lowest in Asian/ Asian British, 5.3%.	Highest - Single person household: 16.0% vs. Lowest: adults no children, 2.5%	Highest among economically inactive: 16.1% lowest employed full-time, 5.8%	Higher on benefits than not: Highest on ESA: (5-7% vs. 20-43%), ESA: 43%	Lower in London, 6.4% vs. England, 6.7%

Source: Adult Psychiatric Morbidity Survey, 2014

Other estimates

Public Health England reports the estimated prevalence of long-term mental health problems and of anxiety and depression (in the community and among social care users).

Table X shows that based on these estimates, both boroughs are indicated to have a higher percentage of GP registered patients with long-term mental health problems and depression and anxiety compared to the London average. Table X also shows that in Kensington and Chelsea the percentage of care users with depression and anxiety is higher than the London average, while in Westminster the percentage is lower than the London average

Table 4: Further estimates of long-term mental illness and anxiety and depression

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2016/17	5.6%	6.1%	4.8%	5.7%	141	202
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	14.7%	14.2%	12.4%	13.7%	399	500
Depression and anxiety among social care users: % of social care users	2013/14	56.8%	51.6%	54.4%	52.8%	-	-

Source: Public Health England Fingertips (2018)

Recorded prevalence

Table 5 shows the incidence and prevalence of diagnosed cases of mental illnesses based on GP registers in 2016/17 and claimant data from 2016. The following key points are made:

- The recorded incidence of depression in both boroughs is the same as the London average
- The prevalence of severe mental illness in both boroughs and the prevalence of depression in Kensington and Chelsea, are higher than the respective London averages. Rates of depression recorded in Westminster are lower than the London average
- In 2016/17 the number of new cases of depression were 1,700 and 2,400 for Kensington and Chelsea and Westminster respectively.
- In 2016/17 the number of adults registered with a Serious Mental Illness were 3,000 and 3,600 for Kensington and Chelsea and Westminster respectively
- over 10,000 residents in each borough are recorded on GP registers as having depression
- In both boroughs the rate of Employment Support Allowance (ESA) for mental and behavioural disorders is above the London average.
- Rates of hospital admission for self-harm in young adults are below the London average in both boroughs. There is no comparison of adult admission rates to the London average, however rates in both boroughs are below the England average
- 2014-16 pooled data show suicide rates in Kensington and Chelsea to be higher than the London average, while in Westminster rates are comparable.

However male rates are higher than the London in both borough. By contrast, the female suicide rate is lower in Westminster compared to the London average, however there is no data for Kensington and Chelsea.

Table 5: GP recorded incidence and prevalence of mental illnesses 2016/17 by borough

Indicator	Period	Rate				Count		
		RBKC	WCC	London	England	RBKC	WCC	
Depression incidence (QOF): % of patients 18+	2016/17	1.1%	1.1%	1.1%	1.5%	1,736	2,393	
Depression recorded prevalence (QOF): % of practice register aged 18+	2016/17	8.2%	5.4%	6.6%	9.1%	13,569	11,810	
SMI (QOF): % of patients all ages	2016/17	1.5%	1.4%	1.1%	0.9%	2,937	3,609	
ESA claimants for mental and behavioural disorders per 1,000 working age	2016	26.8	28.1	23.0	27.5	2,930	4,930	
Hospital Admissions for Self-Harm: DSR	2016/17	59.2	67.1	-	185.3	93	164	
Hospital admissions: self harm/ 100,000 15-19	2016/17	-	224.5	305.2	619.9	-	26	
Hospital admissions: self harm/ 100,000 20-24	2016/17	75.4	57.2	188.6	393.2	7	10	
Suicide: rate per 100,000 population (3 year average)	Persons	2014 - 16	9.3	8.7	8.7	9.9	38	51
	Male	2014 - 16	14.8	13.9	13.4	15.3	29	40
	Female	2014 - 16	-	3.5	4.2	4.8	9	11
Excess < 75 mortality rate (adults with SMI) observed / expected	2014/15	256.2%	282.8%	327.2%	370.0%	-	-	

Source: Public Health England Fingertips (2018)

Well-being

Over time, fluctuations are seen in levels of wellbeing. For our boroughs, changes over the last six years have largely been small, as demonstrated in the below charts (the scale is enlarged to show the detail). However it is noticeable that while the trend in scores for life satisfaction (Chart 2), finding life worthwhile (Chart 3) and Happiness (Chart 4) is increasing and the trend for anxiety score (Chart 5) is declining, the converse is observed for Kensington and Chelsea.

Chart 2: Life satisfaction trend

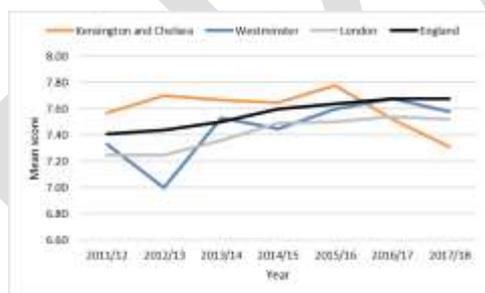


Chart 3: Life worthwhile trend

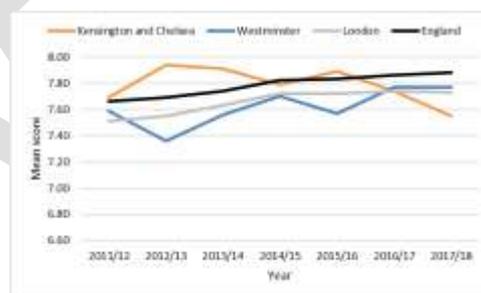


Chart 4: Happiness trend

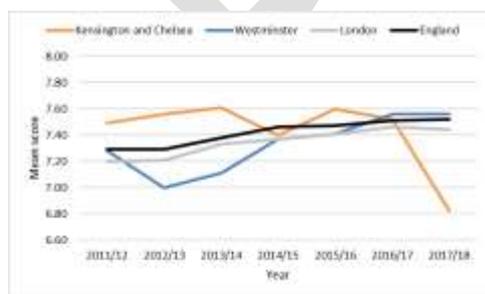
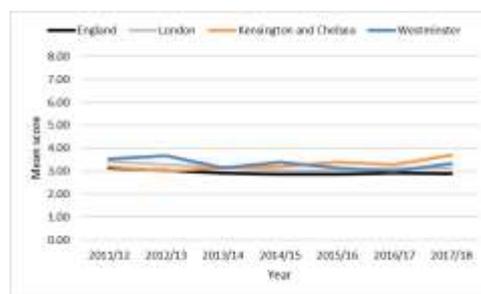


Chart 5: Anxiety trend



Source: ONS 2017

Well-being and age and sex

Borough level data on the association between well-being scores and age and sex are not available therefore Charts 6 to 13 describe the associations for the UK as a whole.

Charts 6, 8 and 10 show life satisfaction, finding life worthwhile and happiness peaks at around 65 and 79 years, while lowest scores are seen between the ages of 40 and 59 years – the same age anxiety scores peak (Chart 12).

Charts 7, 9, 11 and 13 show life satisfaction, finding life worthwhile, happiness peaks and anxiety scores are higher among women compared to men. The biggest gaps in scores by gender are for finding life worthwhile (Chart 9) and anxiety (Chart 13).

The same charts also show scores for both sexes have followed a comparable upward trend for life satisfaction, finding life worthwhile and happiness, and comparable reduction in anxiety scores over the past six years.

Finally, to note from Charts 6, 8, and 10 life satisfaction, finding life worthwhile and happiness scores are typically higher for almost all ages in 2016/17 compared to 2011/12, and anxiety scores lower at almost all ages. Exceptions include lower life satisfaction scores at ages 90 and over (Chart 5) and higher anxiety scores at ages 16 to 24 years (Chart 11) in 2016/17 compared to 2011/12.

Chart 6: Life satisfaction and age

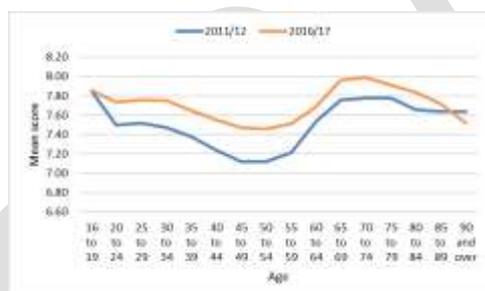


Chart 7: Life satisfaction and sex

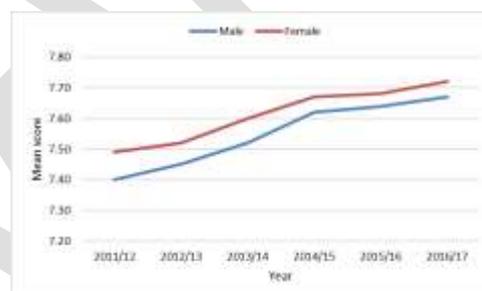


Chart 8: Life worthwhile and age

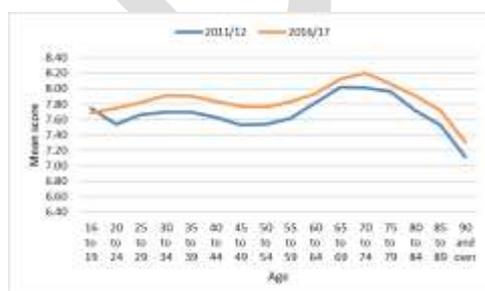


Chart 9: Life worthwhile and sex

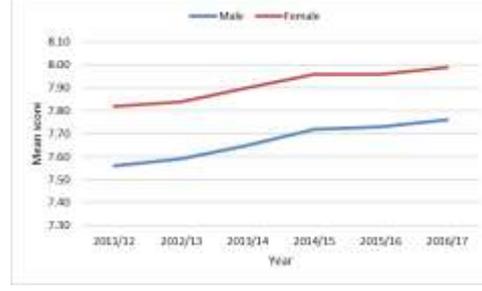


Chart 10: Happiness and age

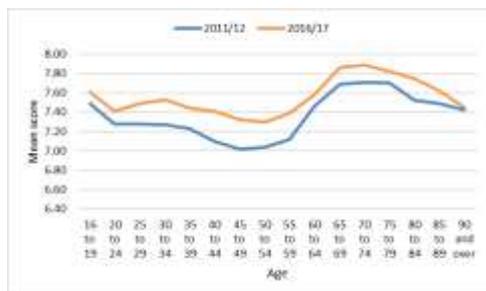


Chart 11: Happiness and sex

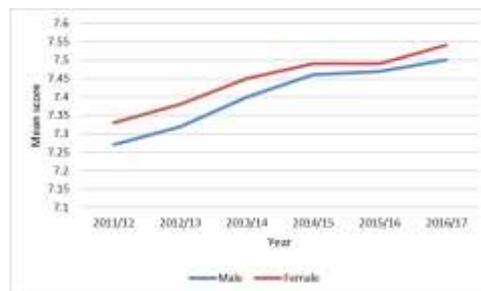


Chart 12: Anxiety and age

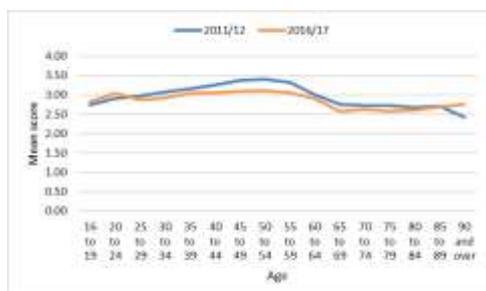
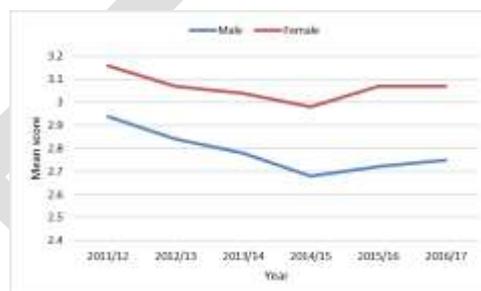


Chart 13: Anxiety and sex



Source: ONS 2018

Mental illness

Table 6 shows the estimated numbers of residents to have a mental illness by type of illness in 2018 and over the next 5 to 10 years. These numbers are calculated by applying the APMS prevalence rates to Office for National Statistics population projections for each borough.

Assuming that prevalence of mental illnesses and rates of diagnosis remain unchanged over the next 5 to 10 years, the following future numbers of residents could be expected to experience mental illness.

Table 6: Estimated cases of mental illness by type and borough 2018, 2023 and 2028

Illness/ presentation	Borough	London	2018	2023	2028	2018-2023	2018-2028
Common Mental Disorder	RBKC	18.0%	23,943	24,805	25,720	862	1,777
	WCC		38,484	40,691	42,123	2,207	3,639
Common Mental Disorder- Unspecified	RBKC	8.7%	11,572	11,989	12,431	417	859
	WCC		18,601	19,668	20,360	1,067	1,759
Generalised anxiety disorder	RBKC	5.9%	7,848	8,131	8,431	283	583
	WCC		12,614	13,338	13,807	724	1,193
Depressive episode	RBKC	3.3%	4,390	4,548	4,715	158	326
	WCC		7,055	7,460	7,723	405	667
Phobias	RBKC	2.5%	3,325	3,445	3,572	120	247
	WCC		5,345	5,652	5,850	307	505
Obsessive compulsive disorder	RBKC	2.0%	2,660	2,756	2,858	96	197
	WCC		4,276	4,521	4,680	245	404
Panic disorder	RBKC	0.8%	1,064	1,102	1,143	38	79
	WCC		1,710	1,809	1,872	98	162
Personality Disorders	RBKC	17.0%	22,613	23,427	24,291	814	1,679
	WCC		36,346	38,431	39,783	2,085	3,437
PTSD	RBKC	4.0%	5,321	5,512	5,716	192	395
	WCC		8,552	9,043	9,361	491	809
Bipolar disorder	RBKC	2.3%	3,102	3,214	3,332	112	230
	WCC		4,986	5,272	5,458	286	472
Psychiatric disorder	RBKC	0.6%	798	827	857	29	59
	WCC		1,283	1,356	1,404	74	121
Self-harm	RBKC	6.4%	8,507	8,813	9,139	306	631
	WCC		13,674	14,458	14,967	784	1,293
Suicide thoughts	RBKC	20.5%	27,218	28,198	29,238	980	2,020
	WCC		43,748	46,258	47,885	2,509	4,137
Suicide attempts	RBKC	6.1%	8,098	8,390	8,699	292	601
	WCC		13,016	13,763	14,247	747	1,231

Source: Adult Psychiatric Morbidity Survey, 2014

3.3 Comparative data on understanding people

This section looks at how Kensington and Chelsea and Westminster compare to the London average on key areas of understanding people.

Table 7 summarises comparative data published by Public Health England.

From Table 7, the following key points are made:

- Both boroughs have a lower percentage of BME residents, but a higher proportion of mixed ethnicity residents compared to the London average
- Rates of both long-term illness (adults and children) and learning disabilities in adults are lower than the London average
- Compared to London, both boroughs have lower rates of first time offenders, first time entrants into the youth justice system and young people in the youth justice system
- The rate of unpaid carers is lower than the London average
- The prevalence of residents registered deaf or hard of hearing is below the London average in both boroughs, while the prevalence residents registered blind or partially sighted is higher than the London average at ages 18-64 years in Kensington and Chelsea and 75 years plus in Westminster
- Compared to the London average, both boroughs have a higher rate of homeless people in temporary accommodation. In addition, Kensington and Chelsea also has a higher rate of people homelessness not in priority need. By contrast rates of family homelessness in both boroughs are lower than the London average.
- While rates of depression recorded by GP practices in both boroughs are comparable to the London average, the recorded prevalence of serious mental illness are higher than the London average in both boroughs
- Rates of smoking in the general adult population are lower than the London average, but higher than the London average among those with a serious mental illness
- Both boroughs have a higher rate of hospital admissions for mental and behavioural disorders due to the use of alcohol. Rates of alcohol dependence in both boroughs are comparable to the London average
- The estimated prevalence of opiate and/or crack cocaine use is higher than the London average in both boroughs, as is the rate of hospital admissions for substance misuse among young people in Kensington and Chelsea
- While the suicide rate is higher than the London average in Kensington and Chelsea and comparable to the London average in Westminster, the suicide rate for men in both boroughs is higher than the London average.
- The rate of hospital admissions for self-harm, at all ages, is lower than the national average in both boroughs, as are rates of self-harm among young people compared to the London average

Table 7: Indicators on 'understanding people'

Indicator	Period	Rate				Count		
		RBKC	WCC	London	England	RBKC	WCC	
Ethnicity: % population	White	2011	70.6%	61.7%	59.8%	85.4%	112,017	135,330
	Mixed	2011	5.7%	5.2%	5.0%	2.3%	8,986	11,395
	Black	2011	6.5%	7.5%	13.3%	3.5%	10,333	16,472
	Asian	2011	10.0%	14.5%	18.5%	7.8%	15,861	31,862
	Other	2011	7.2%	11.1%	3.4%	1.0%	11,452	24,337
GP patient survey: % Long-term health problem		2011	13.1%	13.8%	14.2%	17.6%	28,803	21,645
Learning disabilities known to GPs: % on register		2016/17	0.2%	0.3%	0.4%	0.5%	406	667
15 year olds with a diagnosed long-term illness, disability or medical condition % of 15 yr olds		2014/15	11.3%	11.6%	12.6%	14.1%	-	-
First time offenders: rate per 100,000 population		2017	160.7	158.7	215.3	166.4	252	384
First time entrants to the youth justice system/ 100,000 10-17		2017	231.2	250.3	380.3	292.5	26	43
Children in the youth justice system: rate per 1,000 aged 10 - 18		2016/17	5.2	4.8	6.2	4.8	-	-
Unpaid carers: % of population		2011	1.2%	1.6%	1.8%	2.4%	1,954	3,426
People aged 18-64 registered deaf or hard of hearing per 100,000	18-64	2009/10	120.5	146.4	170.2	172.8	140	275
	65-74	2009/10	204.0	366.0	581.0	620.0	25	50
	75+	2009/10	1104.0	2212.0	2970.0	3089.0	125	285
People aged 18-64 registered blind or partially sighted per 100,000	18-64		261.2	213.8	221.2	214.1	280	345
	65-74		859	732	818.0	569.0	105	105
	75+		4977	6026	5197.0	4255.0	440	725
Statutory homelessness: households in temporary accommodation/1,000 households		2016/17	23.3	21.0	15.1	3.3	1,849	2,503
Statutory homelessness: eligible homeless people not in priority need/1,000 households		2016/17	1.6	0.9	1.1	0.8	123	105
Homelessness applications – total decisions made: rate per 1,000 households		2015/16	14.3	8.2	9.1	5	1,131	956
Family homelessness: rate per 1,000 households		2016/17	3.1	3.1	4.0	1.9	245	372
Smoking Prevalence in adults - current smokers (APS)		2017	13.2%	14.1%	14.6%	14.9%	16,890	27,922
Smoking prevalence in adults with serious mental illness (SMI)		2014/15	43.6%	40.8%	38.9%	40.5%	819	1,110
Estimated percentage of adults with alcohol dependence		2014/15	1.4%	1.4%	1.4%	1.4%	1,738	2,728
Admission to hospital for mental and behavioural disorders due to alcohol/ 100,000 pop.		2016/17	59.8	60.4	55.8	72.3	93	136
Estimated prevalence of opiate and/or crack cocaine use		2014/15	11.3	13.2	8.9	8.6	1,250	2,249
Young people hospital admissions due to substance misuse: rate per 100,000 aged 15 - 24	Young people	14/15 - 16/17	73.2	51.2	67.2	89.8	36	45
Hospital Admissions for Self-Harm: DSR		2016/17	59.2	67.1	-	185.3	93	164
Hospital admissions: self harm/ 100,000	15-19 years	2016/17	-	224.5	305.2	619.9	-	26
	20 - 24 years	2016/17	75.4	57.2	188.6	393.2	7	10
Suicide: age-standardised rate per 100,000 population (3 year average)	Person	2014 - 16	9.3	8.7	8.7	9.9	38	51
	Male	2014 - 16	14.8	13.9	13.4	15.3	29	40
	Female	2014 - 16	-	3.5	4.2	4.8	9	11

Source: Public Health England Fingertips (2018)

3.4 Determinants of mental health and wellbeing

One of the aims of the JSNA is to understand the determinants of health in an area and consider social and contextual factors that affect mental health and wellbeing, such as employment, crime, safety and housing. The mental health and wellbeing of each individual is influenced by their social setting, such as having the ability to earn enough money and feeling part of a community¹. This section considers these determinants which lead to unfair and avoidable differences in health within and between populations.

Understanding these aspects of 'place', or social factors in a local area can help to quantify levels of risk, protection and resilience within a community. It can help to identify vulnerable groups and consider what interventions could help to reduce vulnerability and develop resilient communities. Greater community resilience has the potential to:

- reduce the prevalence of mental health problems

- increase the prevalence of good mental health
- improve recovery and support for individuals who have become unwell

Interventions which affect the social determinants of mental health and wellbeing require joint working and collaboration across a range of partners, for example the education sector working with health and wellbeing boards.

Deprivation

Experiencing disadvantage can increase the risk of poor mental health and wellbeing. People with mental health problems can be affected by a ‘spiral of adversity’¹ where factors such as employment, income and relationships are impacted by their condition.

People who live in deprived areas are more likely to need mental healthcare but less likely to access support and to recover following treatment⁴. This compounds and worsens mental health problems. Data from the European Quality of Life Survey shows material deprivation index to be the single strongest predictor of both life satisfaction and happiness (Understanding Wellbeing Locally, 2017).

The Index of Multiple Deprivation (IMD) is the official measure of deprivation in England. The IMD is a weighted score based on information captured across seven domains (income, employment, education, health and disability, crime, barriers to housing and services and living environment). Scores are calculated at Lower Layer Super Output Level (LLSOA) and presented in quintiles: Quintile 1, LLSOAs within the 20% most deprived LLSOAs in England, through to Quintile 5, LLSOAs within the 20% least deprived LLSOAs in England.

Table 8 shows how Kensington and Chelsea and Westminster compare to the London average. From Table 8 both Kensington and Chelsea and Westminster are shown to have higher rates of deprivation compared to the London average.

Table 8: Percentage and estimated number of residents living in the 20% most deprived areas

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Living in 20% most deprived areas: % (IMD 2015)	2014	23.6%	28.6%	22.9%	20.2%	36,824	66,829

Source: Public Health England Fingertips (2018)

Poverty & financial security

Having a very low income or experiencing economic deprivation is associated with poor wellbeing⁵. Poverty can be both a causal factor and a consequence of poor mental wellbeing and mental ill health. Across the UK, both men and women in the poorest fifth of the population are twice as likely to be at risk of developing mental health problems as those on an average income. The cumulative impacts of poverty are present throughout the life course, starting before birth and continuing into older age.

⁵ Brown H, Abdallah S, Townsley R (2017) Understanding local needs for wellbeing data. Measures and indicators. What Works for Wellbeing

Table 9 provides comparative data on poverty and financial security and, where available, estimates of the numbers affected. The following key points are noted:

- compared to London, Kensington and Chelsea and Westminster have higher rates of children aged under 16 years and children and young people aged under 20 years living in poverty
- rates of fuel poverty are estimated to be lower than the London average in both boroughs
- compared to the national average both boroughs have a higher percentage of people aged 60 years and over living in income deprivation - There is no comparative data on rates of income deprivation affecting older people in London.

Table 9: Indicators of poverty and financial security, comparison to London

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Children under 20 in poverty: %	2015	20.1%	28.5%	19.2%	16.6%	3,820	8,325
Children under 16 in poverty: %	2015	19.4%	27.3%	18.8%	16.8%	3,195	6,875
Fuel poverty: % of households	2015	8.7%	9.4%	10.1%	11.0%	6,975	10,067
Older people (60+) living in poverty: % (IDAOPI)	2015	21.6%	24.9%	-	16.2%	-	-

Source: Public Health England Fingertips (2018)

Housing & homelessness

Stable, good quality housing is critical to positive mental wellbeing, as well as protective factor for mental health and a vital element of recovery. Insecure, poor quality and overcrowded housing causes stress, anxiety, and depression, and exacerbates existing mental health conditions. Homelessness and poor quality housing are risk factors for mental health problems.

Table 10 provides comparative data on housing and homelessness and, where available, estimates of the numbers affected. The following key points are noted:

Compared to London;

- both boroughs have higher rates of households in temporary accommodation, but lower rates of family homelessness
- rates of homelessness – people not in priority need - are higher in Kensington and Chelsea, but lower in Westminster
- rates of decisions on applications for homelessness are higher in Kensington and Chelsea, but lower in Westminster
- both boroughs have a lower rates of estimated fuel poverty
- Both boroughs have higher rates of adult social care clients with mental health conditions living at home
- both boroughs have higher rates of men and women – who are in touch with mental health services – placed in stable and appropriate accommodation
- both boroughs have a higher percentage of single person households

Table 10: Indicators of housing and homelessness, comparison to London

Indicator	Period	Rate				Count		
		RBKC	WCC	London	England	RBKC	WCC	
Statutory homelessness: households in temporary accommodation/1,000 households	2016/17	23.3	21.0	15.1	3.3	1,849	2,503	
Statutory homelessness: eligible homeless people not in priority need/1,000 households	2016/17	1.6	0.9	1.1	0.8	123	105	
Homelessness applications – total decisions made: rate per 1,000 households	2015/16	14.3	8.2	9.1	5	1,131	956	
Family homelessness: rate per 1,000 households	2016/17	3.1	3.1	4.0	1.9	245	372	
Fuel poverty: % of households	2015	8.7%	9.4%	10.1%	11.0%	6,975	10,067	
Social care mental health clients aged 18-64 receiving home care during the year:/ 100,000	2013/14	60.6	133.2	46.1	42.2	65	-	
Stable & appropriate accommodation: % of adults in contact with mental health services	Persons	2016/17	81.0%	77.0%	55.0%	54.0%	-	-
	Male	2016/17	78.0%	74.0%	53.0%	53.0%	-	-
	Female	2016/17	84.0%	83.0%	57.0%	56.0%	-	-
People living alone: % of households occupied by a single person	2011	23.4%	22.5%	12.8%	12.8%	36,524	47,893	

Source: Public Health England Fingertips (2018)

Education & lifelong learning

Education is a key determinant of later health and wellbeing. It improves people's life chances, increases their ability to access health services and enables people to live healthier lives.

Education develops skills that help people to function and make decisions in life. It increases peoples' ability to get a job and avoid living in poverty. It helps people to understand how social and health systems work allowing them to improve their health and wellbeing²⁰.

Schools have an important role in promoting mental wellbeing among children²¹. Pupils with emotional and conduct disorders are more likely to fall behind in their learning²³. Those not in education, employment or training (NEET) after the age of 16 are at increased risk of depression and suicide and the damaging effect of unemployment at this stage of life lasts into later life

Table 11 provides comparative data on indicators of education and life long-learning and, where available, estimates of the numbers affected. The following key points are noted:

- compared to London, both boroughs have higher rates of primary school aged children with social, emotional and mental health needs, however at secondary level, compared to the London average rates of need are higher in Westminster but lower than the London average in Kensington and Chelsea
- compared to the London average both boroughs have lower rates of youth unemployment – 16 to 18 years olds Not in Education, Employment or Training (NEET)
- GCSE achievement is higher than the London average in both boroughs, however comparative data for children in care is not available

Table 11: indicators of education and life-long learning, comparison to London

Indicator	Period	Rate				Count		
		RBKC	WCC	London	England	RBKC	WCC	
% School pupils with social, emotional and mental health needs	Primary	2018	2.3%	2.0%	2.2%	2.2%	169	207
	Secondary	2018	1.9%	4.3%	2.5%	2.3%	103	500
16-18 yrs NEET: %	2015	2.9%	1.6%	3.1%	4.2%	60	60	
5 GCSEs A*-C including English & Maths: %	2015/16	65.0%	63.6%	61.3%	57.8%	362	700	
Children in care % 5 or more GCSEs	2015	-	-	16.8%	13.8%	-	-	

Source: Public Health England Fingertips (2018)

Employment & working conditions

Meaningful, stable and rewarding employment is a protective factor for mental wellbeing and can be a vital element of recovery from mental health problems. Equally, periods of unemployment (particularly long term) and unstable employment are risk factors for mental health problems.

There are strong links between employment and mental health¹. The workplace provides an opportunity to promote well-being and support people to ‘build resilience, develop social networks and develop their own social capital’³⁰. People who are unemployed are between 4 and 10 times more likely to report anxiety and depression and to complete suicide³¹.

The data in Table 12 provides comparative data on employment outcomes. The following key points are noted:

- both boroughs have lower rates of working –age residents in employment, but lower rates of long-term unemployment compared to the London average
- both boroughs have a smaller gap between the employment rate of people in contact with secondary mental health services and the general employment rate
- In London 40% of people with a mental illness or learning disability are in employment

Table 12: indicators of employment and working conditions comparison to London

Indicator	Period	Rate				Count		
		RBKC	WCC	London	England	RBKC	WCC	
Employment: % of population aged 16-64	2016/17	64.5%	68.0%	73.8%	74.4%	69,900	116,800	
Long-term unemployment: % 16-64	Aug-16	0.3%	0.4%	0.4%	0.4%	360	640	
Gap in employment rate -in contact with secondary mental health services vs. overall employment rate	Male	2016/17	65.6	72.1	75.1	73.5	-	-
	Female	2016/17	47.5	49.7	60.4	60.5	-	215
% with a mental illness or learning disability in employment	2016 Q4	-	-	40.0%	43.3%	-	-	

Source: Public Health England Fingertips (2018)

Crime & justice

The relationship between crime and mental health and wellbeing is complex. It can also be controversial, as public perception about the relationship can contribute to stigma, discrimination and social exclusion.

While there is public perception that people with mental health problems are offenders, most crimes are committed by people who do not have mental health problems. People with mental health problems are three times more likely to be a victim of crime than the general population and five times more likely to be a victim of assault (rising to 10 times more likely for women)⁶.

Being a victim of crime, or exposure to violent or unsafe environments can increase have a negative impact on mental wellbeing and increases the risk of developing a mental health problem. The most serious example of this at a young age is child abuse,

⁶

which can have a sustained detrimental impact on mental health through to adulthood.

As the recent annual report of the Director of Public Health has shown, crime and safety (and its impact on wellbeing) is a key issue of concern to young people in our Boroughs.

Addressing the links between mental health and crime requires partnership work between a range of agencies including education, health, public health, police, the judiciary, places of custody and the range of community organisations which help people in contact with justice services

The data in Table 13 provides comparative data on crime among children and adults. The following key points are noted:

- In general rates of crime among adults and young people in both boroughs are lower than the London average.
- Rates of violent crime in Westminster and re-offending rates in Kensington and Chelsea are above the London average

Table 13: Indicators of crime and justice, comparison to London

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
First time offenders: rate per 100,000 population	2017	160.7	158.7	215.3	166.4	252	384
First time entrants to the youth justice system/ 100,000 10-17	2017	231.2	250.3	380.3	292.5	26	43
Children in the youth justice system: rate per 1,000 aged 10 - 18	2016/17	5.2	4.8	6.2	4.8	-	-
Violent crime (including sexual violence) - violence offences: rate per 1,000 population	2016/17	22.1	36.7	22.2	20.0	3,492	8903
Re-offending levels: % of offenders	2014	26.0%	25.2%	25.7%	25.4%	306	568

Source: Public Health England Fingertips (2018)

Domestic Abuse

In 2015-2016, 2023 incidents of domestic abuse were recorded by the Metropolitan Police in Kensington and Chelsea, and 3037 in Westminster. Unfortunately, this is just the tip of the iceberg as only a fraction of domestic abuse incidents are reported to the authorities.

Last year over 2 million adults aged 16-59 experienced domestic abuse across the nation (1.3 million people, 695,000 men) - 8.5% of the population of women and 4.5% population of men.⁷ Applied locally, this means that an estimated 10,953 adults in Westminster and 6,509 adults in Kensington and Chelsea experienced some form of domestic abuse last year. An estimated 28% of women have experienced domestic abuse at some point since the age of 16,⁸ and a quarter of 13-18 year of girls report experiencing physical abuse in their own intimate relationships, and one third sexual abuse.⁹

⁷ ONS Domestic Abuse in England and Wales, March 2018 *Office for National Statistics*

⁸ ONS Domestic Abuse in England and Wales, March 2018 *Office for National Statistics*

⁹ Partner Exploitation and Violence in Teenage Intimate Relationships, NSPCC London, 2011

Those who have experienced or continue to suffer from domestic abuse, either physical, sexual or psychological, are at a greatly increased risk of mental health problems:

- 40% of high-risk domestic abuse victims report having mental health issues.
- 16% of victims have considered or attempted suicide, and 13% of victims report self-harming.
- Victims are at a high risk of Post-Traumatic Stress Disorder, with one study reporting many as two thirds of victims of abuse developing PTSD.
- Between 30% and 60% of psychiatric in-patients have experienced severe domestic abuse¹⁰.

Source: SafeLives Policy & Evidence 2018

Community wellbeing & Social capital

Mental wellbeing is a combination of an individual's experience (such as happiness and satisfaction) and their ability to function as both an individual and as a member of society. It includes a sense of control, resilience, self-efficacy and social connectedness.

The mental wellbeing of individuals is influenced by factors at a community level such as social networks, sense of local identity, levels of trust and reciprocity and civic engagement. The benefit of this "social capital" can be felt at an individual level (for example, through family support) or at a wider collective level (for example, through volunteering). Social capital is associated with values such as tolerance, solidarity or trust. These are said to be beneficial to society and are important for people to be able to cooperate

Community assets improve the health and the quality of the community. They include physical assets such as public green space, play areas and community buildings and social assets such as volunteer and charity groups, social networks and the knowledge and experiences of local residents. These assets have potential to protect and increase community wellbeing and thus strengthen resilience.

The data in Table 14 provides comparative data on measures of community well-being and social capital. The following key points are noted:

- Levels of well-being among young people in Westminster are estimated to be lower than the London average, while levels in Kensington and Chelsea are above.
- Both boroughs score higher than the London average on the Office for National Statistics measure of life-satisfaction and happiness
- In both boroughs a higher percentage of residents are indicated to get enough physical activity and to have sports club membership compared to the London average

¹⁰ Howard L.M et al, Domestic violence and severe psychiatric disorders: prevalence and interventions in 'Psychological Medicine', 2010

- Both boroughs have a higher percentage of older adults living alone compared to the London average

Table 14: Indicators of community well-being and social capital

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Wellbeing in 15 year olds: mean wellbeing (WEMWBS) score age 15	2014/15	48.6	47.4	47.8	47.6	-	-
Self-reported well-being - high satisfaction score: % of respondents	2015/16	83.9%	81.2%	79.6%	81.2%	-	-
Self-reported well-being - high happiness score: % of respondents	2015/16	77.2%	76.3%	74.3%	74.7%	-	-
Enough physical activity: % of population age 19+	2016/17	68.2%	66.7%	64.6%	66.0%	-	-
Sports club membership: % of population 16+	2015/16	30.9%	27.7%	-	22.0%	-	-
Older people living alone: % of households occupied by a single person 65+	2011	5.3%	5.2%	3.9%	5.2%	8,240	11,035

Source: Public Health England Fingertips (2018)

4 Spotlight on Loneliness & Social Isolation

4.1 Introduction

Loneliness and social isolation are harmful to our health and a key public health issue. Research indicates that lacking social connections is as damaging to our health as smoking 15 cigarettes a day and increases the likelihood of early death (Holt-Lunstad, 2015).

There is evidence that loneliness is a significant risk factor for a wide range of physical and mental health problems, including depression (Cacioppo et al, 2006; Green et al, 1992), heart disease and stroke (Valtorta et al, 2016), high blood pressure (Hawkey et al, 2010), sleep problems, reduced immunity and cognition in the elderly (James et al, 2011; Holwerda et al, 2012).

People that are lonely are more likely to visit their GP, use A&E services, have higher medication use, and higher incidence of falls

Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill (Marmot, 2010).

There are some specific life changing events which are significant triggers for loneliness, such as retirement or bereavement, as well as a number of groups who are more likely to be at risk. Areas of material deprivation are more likely to have higher levels of loneliness as can be seen in section 4.3 below, which reflects many of the key risk factors for loneliness and social isolation.

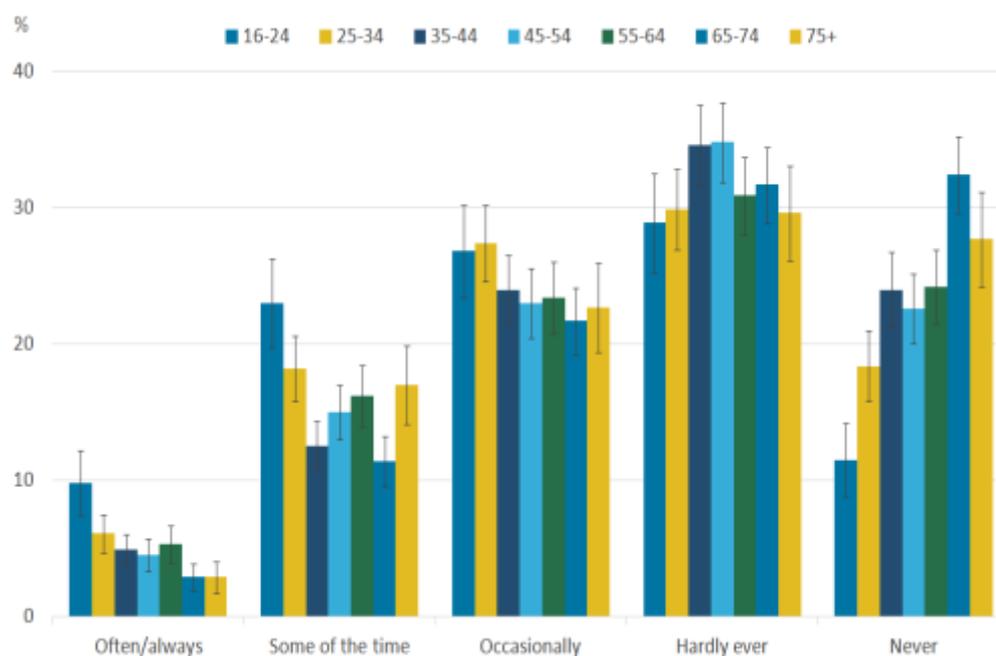
Definitions

Although many of the studies on loneliness and/ or social isolation use these words interchangeably, it is important to note the distinction between the two. Social Isolation is 'A sociological category relating to imposed isolation from normal social networks'. It is objective and based on the amount of people in a person's social network.

'Loneliness' is a subjective feeling occurring when there is a perceptual gap between actual and desired social relationships. Although social isolation can lead to loneliness, loneliness can be experienced by anyone and social isolation is not a pre-requisite.

Prevalence of loneliness and social isolation

Loneliness and social isolation occur across the life course. Although loneliness has traditionally been associated with older people, recent analysis (2016/17) by the Office for National Statistics shows that that levels of loneliness are at least as high if not higher in those aged under 25.

Chart 14: Loneliness levels broken down by age

Who is at an increased risk of loneliness and social isolation?

The following groups or characteristics are identified as being at greater risk of loneliness or social isolation:

- People who are living alone, single, widowed or divorced/ separated
- Those who are economically inactive or unemployed
- Those in debt or a low income
- People who are carers
- People living in rented accommodation
- Children with special needs and young care leavers
- Refugees and homeless people
- Perinatal mothers
- People with poor physical or mental health
- Anyone with poor mobility or sensory impairment
- Ethnic minority communities
- Those who identify as LGBTQ
- People abusing alcohol or drugs

4.2 Strategic Context

National

In October 2018 the government launched their first loneliness strategy. The Government's vision is for the UK to be a place where we can all have strong social relationships and where loneliness is recognised and acted on without stigma or shame.

To achieve this requires a society-wide change. The strategy sets out how government, local authorities, businesses, health, the voluntary sector, communities and individuals can all help to build a more socially connected society.

Three overarching goals guide government's work on loneliness.

- to improve the evidence base to better understand what causes loneliness, its impacts and how best to tackle it.
- to embed loneliness as a consideration across government policy
- to build a national conversation on loneliness, to raise awareness of its impacts and to help tackle stigma.

The strategy builds on previous governmental announcements to tackle loneliness. In June 2018, the Prime Minister announced £20m of funding to support voluntary, community and charitable organisations to tackle loneliness. Since June, the Prime Minister also announced the Ageing Society Grand Challenge, as part of government's Industrial Strategy.

Social prescribing is a cornerstone of the strategy. By 2023, government will support all local health and care systems to implement social prescribing connector schemes across the country, supporting government's aim to have a universal national offer available in GP practices.

The Health Secretary confirmed the government's commitment to tackling loneliness and social isolation in the policy paper "Prevention is better than cure: our vision to help you live well for longer" (on 5 November 2018). The vision for putting prevention at the heart of the nation's health include reducing loneliness and social isolation, and making social prescribing available in every local area by 2023.

Local

Both the Westminster and RBKC's joint Health and Wellbeing Strategies outline commitments to tackle loneliness in each borough.

The Westminster Health and Wellbeing Strategy acknowledges that positive social interactions are crucial to mental and physical health and wellbeing and sustained loneliness and lack of interaction with others can lead to poorer mental and physical health. The strategy commits health and social care services to work closer together with partners and communities to minimise loneliness and isolation.

RBKC Health and Wellbeing Strategy similarly recognises the role of social interaction in supporting good health. The strategy includes the commitment of health and social care partners to encourage partnership working between community and voluntary services, the NHS and local authorities to put in place strategies that will reduce social isolation and loneliness in the community.

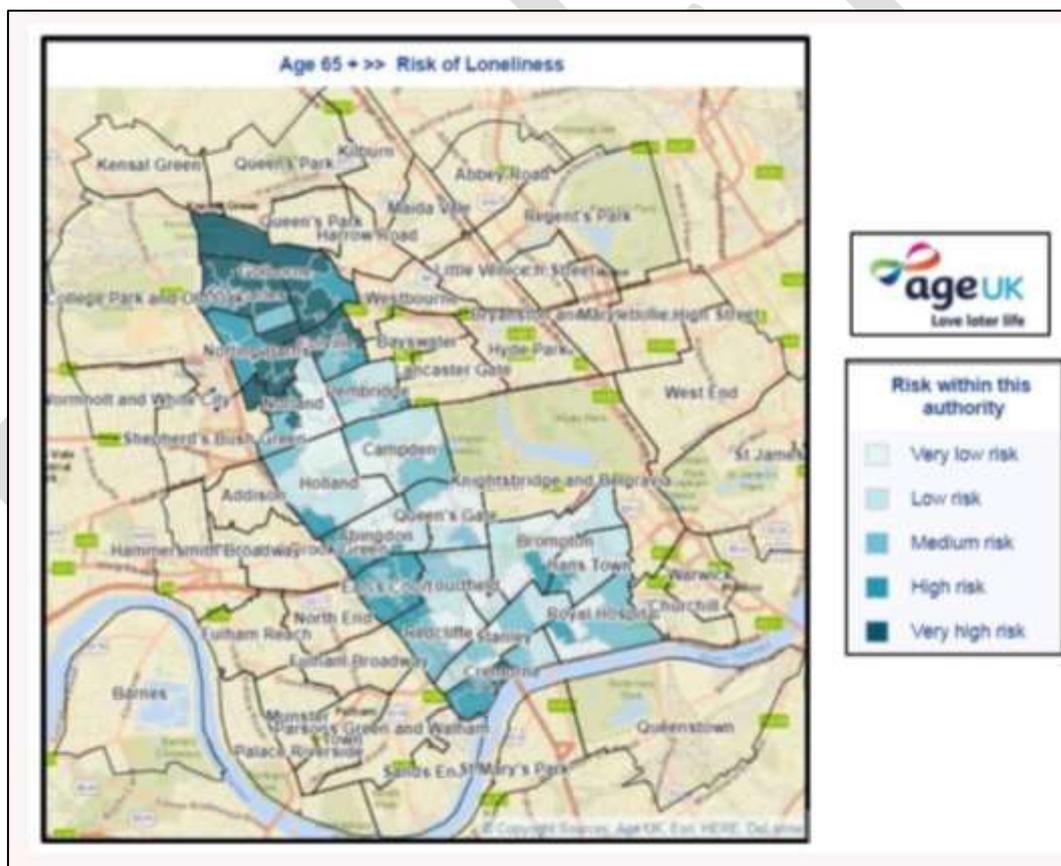
4.3 The Local Picture

People who have good social relationships have higher wellbeing and better mental health (Understanding Wellbeing Locally, 2017).

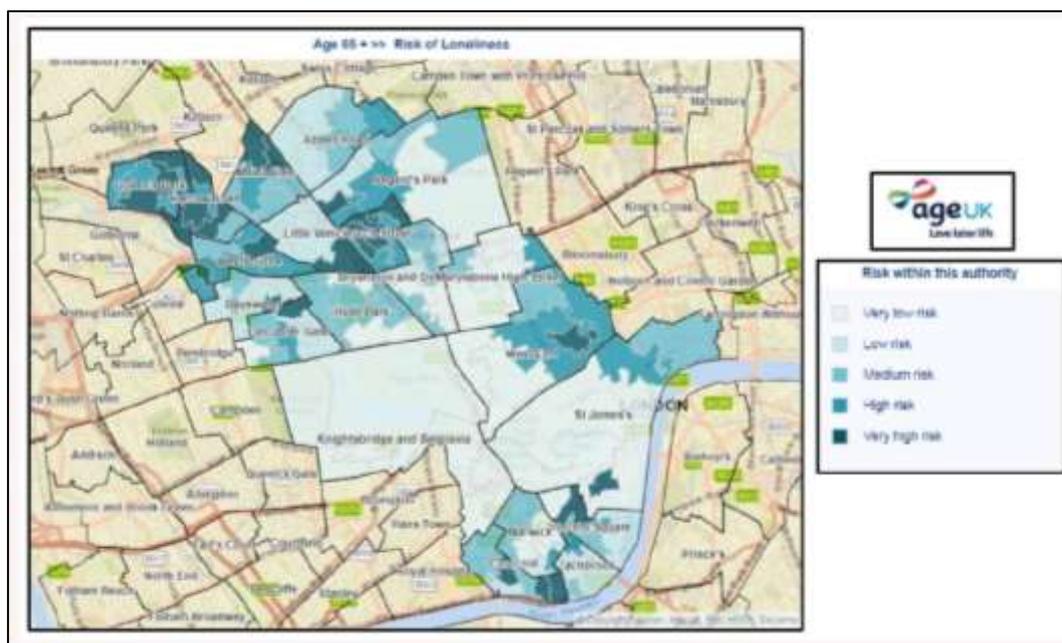
The population of Westminster has one of the highest ‘churn’ rates in London (meaning that people move around a lot). The likelihood of social bonds existing between residents is lower in areas with high churn, increasing the risk that people may be socially isolated. (GLA, 2015). 45% of all households in Westminster and 47% of Kensington and Chelsea households are one person households (Westminster JSNA Highlights Report, 2013-14). Living alone correlates with social isolation.

Nationally, it is estimated that around 10% of the population aged over 65 is lonely. In Kensington and Chelsea, 14% of the population are aged 65 or over. Maps (ii) and (iii) below show the risk of loneliness in those aged over 65 years in Kensington and Chelsea and Westminster (based upon 2011 census figures).

Map 1: Kensington and Chelsea



Source: Age UK <http://data.ageuk.org.uk/loneliness-maps/england-2016/kensington%20and%20chelsea/>

Map 2: Westminster

Source: AgeUK <http://data.ageuk.org.uk/loneliness-maps/england-2016/westminster/>

Less than half of adult social care users in both boroughs have as much social contact as they would like: 39.4% in Kensington and Chelsea and 29.7% in Westminster. This is similar to the rest of London (36.5%) in Kensington Chelsea but worse in Westminster (PHOF, 2012-13).

4.4 What works to prevent and tackle loneliness and social isolation across the life course?

Various schemes have proven effective in preventing and tackling social isolation across the life course. However, to date studies on the effectiveness of interventions to tackle loneliness have largely focused on those aged 55+. There is a lack of knowledge on the effectiveness of interventions in other age groups, although approaches deemed effective in older age participants may also be applicable across different age groups, such as group interventions and befriending.

Many reviews recognise the important role that social networks and community programmes have on improving social integration and tackling loneliness. All reviews note that a holistic approach to intervention is needed, and there is no one-size-fits-all model. This is reflected in the My Care, My Way model developed across West London CCG.

Befriending & Community Navigators

Befriending is the most commonly used type intervention to tackle loneliness and isolation in the elderly and is also used in pregnancy and early years. Many reports into befriending have found that it has a modest to significant positive impact on loneliness.

The Care Connect project in Leeds focussed on re-engaging Irish males with their local communities through volunteer befriending services. Loneliness was reportedly alleviated when people took part in activities that reconnected them with their heritage.

Overall, the evidence suggests slightly more positive outcome levels for one-to-one befriending interventions compared to group based befriending activities.

Evidence suggests that the Community Navigator style services have a positive impact, with users becoming less lonely and socially isolated following such contact.

Group-based interventions

Many creative group interventions report a widespread, positive impact on the feelings of loneliness. These interventions include artistic and inspiring activities, discussions, group exercise, therapeutic writing and group therapy.

Various forms of music therapies have a positive impact on loneliness levels. These included choirs, group music making sessions, music learning and performance. Local examples of this include our community choirs such as the Live to Sing, Sing to Live! programme.

Evidence suggests that group-based interventions with a creative focus have a greater positive impact on loneliness than groups focusing on principles of social integration and friendship.

Additional / Specific Interventions across the Life Course

Pregnancy & Early Years

Family Action Perinatal support service uses volunteer befrienders to visit perinatal pregnancy stage, offering social, emotional and practical support. The scheme is successful in providing support to the mother; improving mother- baby relations; encouraging the mother to use health services, children's centres, parks and other community areas; and signposting and support with matters such as housing and benefits. It is targeted at at-risk mothers, deemed vulnerable or who have mild to moderate mental health problems.

The Birth Companions scheme is an example of an effective intervention targeting vulnerable women in the perinatal stage, in prisons or detention centres. It offers a one-to- one service including antenatal classes, support during labour and birth, practical assistance, breastfeeding support and community visits.

Children & Young People

Effective social isolation prevention programs focus on promoting the rights of others and respecting others in society through education. As well as behaviour- change approaches to reduce bullying, schemes such as peer mentoring, cyber mentoring and creative workshops helped to establish social interactions for at risk children.

Initiatives encouraging outdoor play and activity increase opportunities for social interaction.

Schools and school nursing teams are well placed to identify and support young carers, who are at an increased risk of social isolation and who often go under the radar. The school nursing model 'Getting it Right for Children, Young People and Families' sets out a framework to plan and structure service delivery to support young carers through partnership and effective approaches.

Working Age Adults

The TimeBanks approach is being used increasingly in local areas to build strong and mutually supportive social networks in low income communities. Through the TimeBanks scheme, people can give and receive support from each other by contributing different skills and practical help.

Men in Sheds is an example of an initiative specifically aimed at combatting loneliness and building friendships amongst men, who often find it more difficult to build social connections and discuss health and personal concerns.

Later Life

Homesharing (lodgers providing companionship and low- level care in the home in exchange for affordable rent) has proven effective. Householders reported a reduction in the loneliness and social isolation they previously faced. Companionship was identified as a mechanism for reducing loneliness.

Evidence for Reminiscence Therapy is mixed, with some reports of improvement in loneliness levels (Chiang, 2010). Other programs report no effect on loneliness, however there was no decline in levels of loneliness (Bergman Evans 2004).

A humour based therapy program has been successful in alleviating loneliness through fun and creative group sessions, telling jokes and laughing.

Animal Assisted Therapies (AATs) range from placing caged birds in resident's rooms, to the introduction of actual and robot animal in both 1-2-1 settings and into group environments. AATs were found to be most effective on those reporting the highest levels of loneliness. Evidence on the impact of robot animals is conflicting, with some

studies finding no impact on loneliness, and another finding a positive impact. It should be noted that using robotic animals on mentally impaired elderly people raises moral and ethical concerns. The quality of this evidence is not assured as there is a high risk of bias.

Internet & media

In terms of loneliness, social media and the internet is often seen as a double sided and can arguably contribute to feelings of loneliness as well as being part of the solution (Robbins 2014, LPHO). A recent study has shown that the use of social media sites is only effective in reducing loneliness when it is used with the intention of making new friends (Teppers 2014), or to stay connected to family and friends. It is argued that training more lonely people to use the internet to stay connected with friends and family could have a positive impact on loneliness, however studies on this so far have proved inconclusive.

5 Spotlight on Suicide Prevention

5.1 The importance of suicide prevention

Every day in England around 13 people take their own lives. For every person who dies 10 people are directly effected. The effects can reach into every community and have a devastating impact on families, friends, colleagues and others. Preventing suicide requires the combined actions by local authorities, mental health and health care services, primary care, community based organisations and voluntary agencies, employers, schools, colleges and universities, the police, transport services, prisons and others.

Local Authorities are well placed to prevent suicide because their work on public health addresses many of the risk factors, such as alcohol and drug misuse, and spans efforts to address wider determinants of health such as employment and housing. There are also important and varied opportunities to reach local people who are not in contact with health services through on-line initiatives or working with the third sector.

The second suicide prevention action plan builds on the progress made under the previous strategy. Work to prevent suicide in the boroughs is co-dependent on existing and developing work to promote good mental health, in particular amongst men, young people and minorities. The priorities for the action for 2018 -2021 seek to build on the progress that has been undertaken to date, ensure that those gains are held and concentrate efforts on a limited number of achievable areas.

5.2 Suicide Incidence and Prevalence

2014-16 pooled data show suicide rates in Kensington and Chelsea to be higher than the London average, while in Westminster rates are comparable. However male rates are higher than the London in both borough. By contrast, the female suicide rate is lower in Westminster compared to the London average, however there is no data for Kensington and Chelsea.

The following groups are at higher risk of death by suicide: men (15 to 59 years), looked after children, older people, some minority ethnic communities, people with previous suicide attempts and people in crisis (for example bereaved by suicide, relationship breakdown, loss of employment).

5.3 Suicide Prevention Priorities

Tackling suicide prevention is an iterative process over the long term across many settings. Action needs to take place on a number of levels, working with partners at London Region, at North West London and at borough level. Below are the 2018-21 action plan priority areas.

Borough level priorities areas:

- Reducing risk in high-risk groups
- Tailoring approaches to improve mental health in specific groups

- Provide better information and support to those bereaved or affected by suicide

Promotion of a multiagency approach

- North West London sub-regional priority area:
- Improving data collection and monitoring

London Regional level priority area:

- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

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6 Perinatal mental health and wellbeing

6.1 Key Messages

Key messages: Perinatal Mental Health

Prevalence

- Literature based estimates suggest that perinatal mental illness will occur in 20% of births. In 2018 this would be equate to 335 cases in Kensington and Chelsea and 533 in Westminster.
 - Of perinatal mental illnesses, the most common disorders are adjustment disorders and distress in the perinatal period and mild to moderate depressive illness and anxiety in the perinatal period.

Risk factors

- Key risk factors for perinatal mental ill health include a history of mental health problems, childhood abuse and neglect, domestic violence, unplanned or unwanted pregnancy, still birth and infant death, inadequate support, alcohol and substance misuse, lone parenthood
 - Comparative data show indicate that both boroughs have lower rates of infant mortality, single parenthood and children aged under 18 years on a child protection plan compared to the London average. However, the rate of parents in drug treatment in Westminster and the rate of parents in alcohol treatment in Kensington and Chelsea, the still-birth in Kensington and Chelsea and the percentage of parents that were not born in the UK are all above the London average.

What Works

- There is high quality evidence that the following are effective:
 - Home visiting and peer support interventions for women at high risk of postnatal depression.
 - Home visiting programmes are effective at promoting parenting and infant mental health
- There is moderate quality evidence that the following are effective:
 - Programmes that involved men's active participation with and/or observation of their own children can improve the father-child relationship
 - Antenatal classes can improve parental wellbeing, parent-child attachment and parenting/problem solving skills

- Skin to skin contact can improve attachment and mother-child interaction
- Better Mental Health for All (2016) provides a helpful summary of interventions across the life course and Parenting support is also recommended.
 - See also relevant NICE guidance PH40, QS115, CG158 and CG192

6.2 Background

The physical and mental wellbeing of the mother, and the family environment during pregnancy, infancy and childhood is of fundamental importance to mental health. A parent's ability to bond with and care for their baby, their parenting style and the development of a positive relationship can predict numerous physical, social, emotional and cognitive outcomes through to adulthood⁴.

While the relationship between mother and child is particularly important, the mental health of fathers and other caregivers should also be considered. Paternal and maternal depression is shown to have a negative impact on how parents interact with children⁴ and can have long-term consequences if left untreated⁴.

During pregnancy and the year after birth, many women experience common mild mood changes. Some women can be affected by common mental health problems, including anxiety disorders (13%) and depression (12%)². The risk of developing a severe mental health condition is low, but increases after childbirth. The impact of poor mental health can be greater during this period, particularly if left untreated⁵.

6.3 Prevalence and incidence

Population prevalence

Perinatal mental health problems are estimated to affect 10-20% of women during pregnancy and the first year after birth. Based on Office for National Statistics birth estimates for 2018 (ONS SNPP, 2016 –based birth projections) up to 335 women in Kensington and Chelsea and up to 533 women in Westminster, could be affected by perinatal mental illness.

Table 15 shows the projected numbers of births by borough in 2018 and over the next 5 to 10 years. Table 15 also estimates the cases of perinatal mental illness assuming 20% of women are affected.

Table 15: births by age of mother 2018, 2023 and 2028

	Borough	2018	2023	2028
Births	RBKC	1,673	1,501	1,414
	WCC	2,663	2,515	2,405
Estimated cases of perinatal mental illness	RBKC	335	300	283
	WCC	533	503	481

Source: Office for National Statistics SNPP projections

Other estimates

The Public Health England Perinatal Mental Health Profiles provide estimates of the prevalence of maternal mental illness by Local Authority based on survey data (see Table 16).

From Table 16, adjustment disorders are estimated to be the most common maternity related mental illness (up to 300 cases per 1,000 deliveries), followed by mild-moderate depressive episodes (up to 150 cases per 1,000 deliveries).

Table 16: Estimates cases of perinatal mental illness by borough

Indicator	Period	Rate per 1,000 deliveries		
		RBKC	WCC	
Severe depressive illness in perinatal period	2015/16	30	45	65
PTSD in perinatal period	2015/16	30	45	65
Chronic mental illness in perinatal period	2015/16	2	5	5
Postpartum psychosis	2015/16	2	5	5
Mild-moderate depressive illness and anxiety in perinatal period	2015/16	100 to 150	140 – 210	215 - 325
Adjustment disorders and distress in perinatal period	2015/16	150 to 300	210 to 415	345 to 645

Source: Public Health England Perinatal Mental Health Profiles (2018). * All values rounded to the nearest 5

Recorded prevalence

There are no registers for perinatal mental illness.

6.4 Risk factors

Public Health England have identified the following key risk factors for postpartum depression:

- history of mental health problems
- childhood abuse and neglect
- domestic violence
- interpersonal conflict
- inadequate social support
- alcohol or drug abuse
- unplanned or unwanted pregnancy
- migration status

The risk of developing postpartum psychosis is significantly increased by a family or personal history of bi-polar disorder, while bereavement by miscarriage, stillbirth or neonatal death are risk factors for mental health problems in both parents.

Table 17 summarises the available on the prevalence of identified risk factors locally, while table 18 shows the estimated numbers of men and women of reproductive age estimated to have bi-polar disorder. From Tables 4.2 and 4.3 the following key points are identified:

- At the last measurement 2011/12 the rate of parents in drug treatment were higher than the London average in Westminster and lower in Kensington and Chelsea, while the converse was true for the rate of parents in alcohol treatment: higher in Kensington and Chelsea and lower in Westminster compared to the London average
- In Westminster the rate of still births is higher than the London average, while the rate in Kensington and Chelsea is lower
- Both boroughs perform better than the London average in areas of lone parenthood, infant mortality and children with a child protection plan
- Rates of children born to non-UK parents and rates of children in need are higher than the London average in both boroughs
- Based on the estimates from the Adult Psychiatric morbidity study 2.3% of people (men, 2.7%; women, 2.0%) are estimated to have Bi-polar. Applied to the borough populations of reproductive age, 16 to 45 years, this equates to around 1,700 people in Kensington and Chelsea and 3,000 people in Westminster.

Table 17: Risk factors for maternal mental illness

Indicator	Period	Rate				Count		
		RBKC	WCC	London	England	RBKC	WCC	
Parents in treatment per 100,000 0-15yr olds	Drugs	2011/12	81.6	137.2	104.1	110.4	20	45
	Alcohol	2011/12	134.7	91.5	108.2	147.2	33	30
Stillbirths: Rate per 1,000 births	2014 - 16	4.3	5.0	4.9	4.5	23	40	
Sole registered births: % births	2014	3.9%	3.8%	5.6%	5.4%	71	100	
Lone parent families: % of households	2011	4.9%	5.7%	8.5%	7.1%	3,816	6,002	
Infant mortality: Rate per 1,000 births	2014 - 16	2.4	2.6	3.2	3.9	13	21	
Children on child protection plan per 10,000 <18	2014/15	22.0	27.8	40.6	42.9	61	113	
Children in need per 10,000 children <18	2014/15	894	851	702	674	2,482	3,464	
Looked after children aged <5 per 10,000 pop <5	2016/17	5.6	14.4	-	36.9	5	20	
Births to non-UK parents: % of live births	2015	80.7%	81.6%	66.2%	34.0%	1,457	2,208	

Source: Public Health England Perinatal Mental Health Profiles (2018)

Table 18: Estimated prevalence of bi-polar disorder among men and women of reproductive age, 16-45 years

Borough/ Prevalence	2018		2023		2028	
	Male	Female	Male	Female	Male	Female
Kensington & Chelsea	2.7%	2.0%	2.7%	2.0%	2.7%	2.0%
Westminster	990	687	994	685	1,000	689
	1,904	1,192	1,956	1,210	1,953	1,203

Source: Adult Psychiatric Morbidity Survey 2014, GLA population estimates

6.5 Protective factors

Public Health England has highlighted that understanding people and understanding place are key elements of protecting all people from mental illness. In particular, understanding inequalities/ hard to reach groups and ensuring equality of access to service. Specific to maternal mental health the following are key aspects of protection maternal mental health:

- promoting healthy pregnancies
- promoting healthy lifestyles
- primary and secondary prevention
- early identification
- timely provision of quality specialist care.

6.6 What works

In an evidence review undertaken in 2015 on public mental health in the three Boroughs, Shah reports that the following interventions are supported by good quality evidence:

- Home visiting and peer support interventions for women at high risk of postnatal depression.
- Home visiting programmes are effective at promoting parenting and infant mental health

The review reported that home visiting is dependent on a range of process factors such as the intensity and frequency of visits and skills of the provider. Effect sizes are stronger for interventions that:

- last for more than 6 months and involve at least 12 home visits
- started earlier rather than later in parenthood
- are delivered by professionals rather than paraprofessionals or lay people
- are focussed on a broad range of outcomes

The following had a moderate quality evidence base:

- Programmes that involved men's active participation with and/or observation of their own children can improve the father-child relationship
- Antenatal classes can improve parental wellbeing, parent-child attachment and parenting/problem solving skills
- Skin to skin contact can improve attachment and mother-child interaction

Finally, there is a low quality evidence base for:

- Providing advice on infant capabilities to improve parental stress and prevent sleep related problems
- Mixed method interventions combining home visiting with other support for teenage mother parenting skills

Better Mental Health for All (2016) provides a helpful summary of interventions across the life course. For perinatal support the following are recommended:

- Universal infant programmes, including antenatal care and programmes to help all parents develop sensitivity to their infants, have been shown to be effective in improving parental mental health as well as that of the infant.
- Promotional interviewing, which focuses on the positive and aims to empower and support parents as well as to identify needs, is recommended in the English Child Health Promotion Programme
- Suicide prevention plans developed should address the perinatal period:
 - Identify those at increased risk of developing perinatal conditions;
 - Develop a personalised care plan for each woman at increased risk
 - Ensure that women with a history of serious illness are prepared for pregnancy and receive preventative management when pregnant
- The Maternal Mental Health Pathway sets out guidance for healthcare professionals supporting mothers during pregnancy and after birth
- The Family Nurse Partnership Programme addresses parenting and parental wellbeing from pregnancy to the end of the first year of life in teenage parents.

Parenting support is also recommended:

- Baby Steps is a programme designed to help parents cope with the pressures of a new baby which has been developed by the NSPCC
- Mellow Parenting is a suite of programmes covering different age groups from Mellow Baby to Mellow Teen

What NICE says...

NICE guidelines (PH40) emphasise *'the importance of the child's relationship with their mother or main carer, which is in turn dependent on the carer's social, emotional and economic stability.'*

They also emphasize the greater vulnerability to mental health problems of children from socioeconomically disadvantaged backgrounds.

They report that *'current service provision highlights that exposure to the healthy child programme (estimated only 50% of 2-2.5 y olds in 2010,) perinatal and parenting support varies greatly in provision and quality of implementation (Care Quality Commission 2010; DH 2010b)'*

There is currently no measurement of social and emotional wellbeing in the under 5s.

NICE guidelines (CG158) recommend:

Offer a group parent training programme to the parents of children and young people aged between 3 and 11 years who:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder **or**
- have oppositional defiant disorder or conduct disorder **or**
- are in contact with the criminal justice system because of antisocial behaviour.

6.7 Service Activity

Routine antenatal and postnatal appointments are opportunities for health professionals to discuss emotional wellbeing with women and identify potential mental health problems. Maternity, GP and health visiting services have frequent contact with the mother, baby and family during the perinatal period and are well placed to provide support, make initial assessment and refer onwards if problems are identified. (NICE Quality Standard QS115 -Antenatal and Postnatal Mental Health)

Table 19 summarises local health visiting service performance for the two boroughs. It shows that, with the exceptions of eight week review rates in Kensington and Chelsea and twelve month review rates in Westminster, health visitor review rates are worse than the London average.

Table 19: Percentage of births and children receiving a health visitor review by age and borough

Indicator	Period	RBKC	WCC	London	England	RBKC	WCC
Health Visitor review by 8 weeks: % births	2015/16	65.9%	44.7%	51.6%	80.4%	1,057	1,130
Health Visitor new birth visits <14 days: % births	2015/16	84.6%	87.0%	88.5%	87.0%	1,651	2,099
Health visitor 12 month review: % of children	2015/16	39.1%	57.7%	42.3%	72.6%	792	1,372

Source: Public Health England Perinatal Mental Health Profiles (2018)

According to NICE Clinical guideline CG192 (2014). The most common mental health problems that women in the perinatal period experience are depression and anxiety. It is expected that Improving Access to Psychological Therapy (IAPT) services should be able to meet the needs of both the mother and/or father, and the infant (NHS. IAPT: Perinatal positive practice guide [2009]).

Data on IAPT service performance indicators can be found in Chapter 8.7.

Local data

Data from the interim evaluation of the Central and North West London Foundation Trust (CNWL) Perinatal Mental Health Service reports that between July and December 2017, 294 referrals for community based Perinatal Mental Health Service (PMHS) team.

Table 20 shows the majority of referrals to the Kensington and Chelsea and Westminster service, 55%, were made by primary care clinicians, followed by 22% from hospitals. The evaluation report found 39.5% of referrals to the PMHS were women known to mental health services.

Table 20: Referrals to Kensington and Chelsea and Westminster PMHS July – December 2017

Referral Source	Number of referrals
Primary Health Care	161
Acute Secondary Care	66
Other – Unknown	52
Self-referral	9
Internal referral	<5
Other – Source known	<5
Local Authority Services	<5
Independent or voluntary sector	-
Total	294

Source: CNWL Perinatal Mental Health Interim Report (May-18)

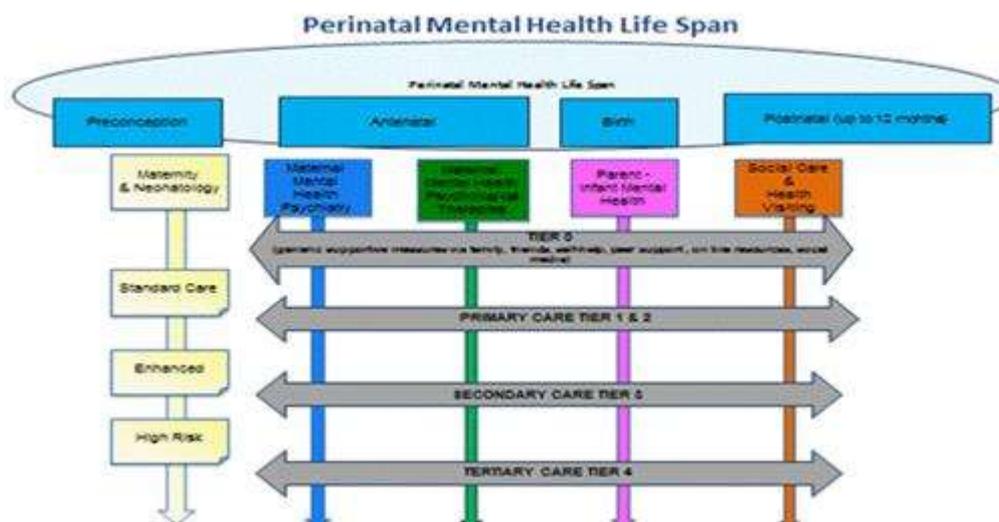
Demand

CNWL report that there has been a 140% increase for Kensington and Chelsea and Westminster in the number of perinatal service contacts between July and December 2017 compared to the pre-launch equivalent 6-month period between Dec 2016 and May 17: New contacts increased by 90%, while follow-up contacts increased by 170%.

6.8 Local services and asset mapping

In 2015, Central & West London CCGs undertook a review of perinatal mental health services with a view to enhancing the existing service and developing a community based model of care that meets the needs of all women who experience perinatal mental health problems. The new perinatal mental health care pathway commenced in April 2018.

The pathway aims to take a holistic approach to addressing the bio- psychosocial wellbeing of mothers, infants, partners and families, drawing on evidence from national guidelines and standards for the treatment and management of perinatal mental illness, including guidance from NICE^[1] and the Royal College of Psychiatrists. The service is based on the Tiered Model of Care (set out below) and operates on a hub and spoke basis, where two core virtual hubs are established, for Inner and Outer North West London respectively. The service for Central & West London CCGs spans the inner hub.



The tiered model of care has an integrated care pathway for each level of need consists of the following:

- Standard Care (low risk) for women who have an established history of mild-moderate disorder or who are experiencing mild common disorders, such as anxiety and depression during the perinatal period for the first time.
- Enhanced Care (medium risk) for women who have an established history of moderate-complex mental disorder, or who are not responding to treatment within the standard clinical pathway.
- Specialist Care (high risk) for women at high risk of relapse of serious and enduring mental illness such as bipolar affective disorder, schizophrenia, schizoaffective disorder, unstable emotional personality disorder or severe depression.

The 'spokes' of the service are established across the community, at Children's Centre's, GP practices, Maternity Units, wherever it is most appropriate for families.

A copy of the full local care pathway is included in Appendix X. as well as the Perinatal Mental Health GP Referral Assessment, Core Processes and Standards.

The newly commissioned service consists of:

- Primary care Increasing Access to Psychological Therapy
- Secondary care mental health service
- Tertiary care mother and baby unit
- Parent and infant psychotherapy service

A training programme over the past 12 months has supported the new service and care pathway. Those who have been trained include GPs, Health Visitors and Midwives.

The outcome for GPs is that they:

- are more aware of mental health issues during the perinatal period,
- know where to refer and are making more referrals

- Know they can also access advice from a psychiatrist as to what action they can take to care for a patient knowing that they will be supported

Outcomes – One year on CNWL are evaluating the impact of this new service, a 6 month review has been done and ND with sent to LD as well as the 1 year review when completed.

The CNWL's findings in the six-month evaluation for Brent, Harrow, Hillingdon, Westminster, Kensington and Chelsea show that from its launch the service has seen a steady increase of the number of referrals. With a 53% increase in new assessment. The feedback from referrers and service users confirm that the PMHS has been successful in initiating partnerships with a variety of statutory and non-statutory healthcare agencies to deliver multidisciplinary, evidence-based care to parents, their babies and their significant others.

“The new service is good at delivering care for women who services are aware of at the start of their pregnancy, may need extra specialist care. However, there is still work to look at ensuring that the mental health needs of others who do not have prior mental health issues are picked up e.g. by the health visiting service.”

Quote from a local GP.

6.9 Quality and outcomes

Public Health England produced comparative quality and outcomes indicators for perinatal mental health are still under development.

Waiting times

- While data on waiting times for perinatal mental health services are not available, analysis of IAPT performance suggests:
- Both CCGs have higher percentages of patients (that have completed treatment) that have been seen for first treatment within 6 weeks and within 18 weeks respectively. This is also true for 'in month referrals' seen in within 6 weeks in West London CCG and seen within 18 weeks in Central London CCG.
 - By contrast, Central London CCG has a lower percentage of 'in month' referrals waiting less than 6 weeks for first treatment and West London CCG has a lower percentage of 'in month' referrals waiting less than 18 weeks for first treatment

In addition, service user feedback from Central and North West London Foundation Trust (CNWL) suggests that 82% of service users find waiting times reasonable (See Table 21).

Table 21: Perinatal Mental Health Services: Patient satisfaction - waiting time to first appointment

Agreed the waiting time for the first appointment was reasonable	82%
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Source: CNWL Perinatal Mental Health Interim Report (May-18)

6.10 Service User Views

These service user views are taken from the Interim Report on CNWL's Perinatal Mental Health Service published in May 2018.

Service user views were gathered at independently run focus groups and through an online questionnaire.

Findings from both the questionnaire and the focus groups are very similar which is predominantly positive. Service users were particularly satisfied with the staff engagement, 100% agreed that staff listened to them and understood their problems and 89% agreed that the staff gave them the care and treatment they needed. 100% agreed that their family and they felt cared for, the service felt friendly and would recommend the service to others.

Survey Results

Percentage	Survey Question
82%	Agreed the waiting time for the first appointment was reasonable
75%	Were satisfied with the venue
93%	Agreed that appointment letters were clear and efficient
100%	Agreed their confidentiality was respected.
96%	Agreed the service administrator was polite and efficient
89%	Agreed that staff gave them the care and treatment they needed
96%	Agreed that staff helped them to understand their difficulties
93%	Agreed they were involved in their care
86%	Agreed that staff also considered their baby's needs
93%	Agreed they were given the opportunity to involve significant others

Service users noted that information about the service was limited both in relation to the availability of information leaflets and the understanding of the service from other professionals, and that knowledge and understanding of the service could be improved.

Whilst the communications between professionals within the PMHS was generally effective, some partnerships were not experienced as being as positive, with

comments about the partnership between the PMHS and the birth centre, midwives and health visitors. There were comments that sometimes they would receive inconsistent quality of the health visitors/midwife service

There was a recommendation for more peer support from previous service users as well as perinatal support groups/coffee mornings.

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7 Children and young people's mental health and wellbeing

7.1 Key Messages

Key messages: Children and young people's mental health and wellbeing

Prevalence

- It is expected that 50% of people who have a lifetime mental illness (not including Dementia) will have experienced symptoms by the age of 14 years
- Estimates from the Mental Health of Children and Young People Survey suggest 12.8% of children and young people aged 5 to 19 years will have a mental, emotional or behavioural disorder. The London prevalence is slightly lower at 9.0%. Based on the London estimate, in 2018, 2,137 children and young people from Kensington and Chelsea and 3,416 children and young people from Westminster were estimated to have a mental, emotional or behavioural disorder.
 - Emotional disorders are the most common, of which anxiety disorders are the most common. Emotional disorders are more common in girls compared to boys while behavioural disorders are more common in boys.

Risk factors

Risk and factors for child mental illness are divided into four areas: child, school, family and community.

Child level

- There is a clear contrast between the child level risk factors between boroughs: in general, children in Kensington and Chelsea demonstrate lower rates of child level risk factors compared to London, while children in Westminster experience higher rates.
- Exceptions include the rate of Learning Disabilities, children aged 15 years with a diagnosed illness, disability or medical condition, GCSE performance and looked after children's average difficulties score – both boroughs perform better than London on these indicators, but both boroughs perform worse than the London average on school readiness.

Family

- Rates of looked after children and children subject to a child protection plan are lower than the London average in both boroughs. However, in Kensington and Chelsea, the percentage of children subject to repeat child protection plan is higher than the London average
- Both boroughs have lower rates of children in need and looked after children for abuse or neglect compared to London. However both boroughs also have higher rates of children in need due to family stress, family

dysfunction or absent parenting and children in need due to parental disability or illness compared to London. Westminster, also has a higher rate of looked after children for family stress, family dysfunction or absent parenting

- Both boroughs have higher rates of children in need due to parental disability or illness, however rates of children and young people providing care were lower than the London average in 2011

School

- Both boroughs have higher rates of secondary school fixed period exclusions and school absences compared to the London average. Westminster also demonstrates higher rates of fixed period exclusions for disruptive behaviour and primary school fixed period exclusions than London, a finding not made in Kensington and Chelsea. In addition, Kensington and Chelsea is shown to have higher rates of bullying at age 15.
- Generally, both boroughs have lower rates of risky behaviour at age 15 compared to the London average. The exception is Kensington and Chelsea which has a higher rate of current smokers at age 15 and higher rates of alcohol specific hospital admissions among under 18's, compared to London
- Rates of children and young people in the youth justice system are lower than the London average in both boroughs

Community

- Both boroughs have a higher percentage of children aged under 16 and under 20 years living in poverty and children receiving free school meals compared to the London average.
- Both boroughs have lower rates of family homelessness

What Works

- Mental health promotion activities can help children develop positive mental wellbeing and prevent mental disorder. Pre-school and early education programmes are highlighted in the Under 5's Healthy Child Programme and result in improvements in cognitive skills, school readiness, academic achievement and family outcomes, including siblings. They are also effective in preventing emotional and conduct disorder.
- Targeted approaches such as home visiting programmes improve child functioning and reduce behavioural problems e.g. the UK's Family Nurse Partnership.

- School-based mental health promotion interventions can improve wellbeing, with resulting benefits for academic performance, social and emotional skills and classroom behaviour (NICE, 2008a). They can also result in reductions in anxiety and depression (NICE, 2009b). Targeted Mental Health Support in Schools (TaMHS) is also effective.
- *Better Mental Health For All* (2016) reports a number of interventions or programmes to promote mental health and wellbeing among children and young people:
- See also relevant NICE guidance PH20 NICE 2008a and NICE 2009b

7.2 Background

Building resilience and promoting good mental wellbeing in children and young people is critical. Research tells us that mental health issues frequently develop in our early and teenage years with half of all mental health problems emerging before the age of 14 and three quarters by age 25².

There are numerous opportunities across the life course to help promote positive mental health and wellbeing and to build resilience of children and young people. Early intervention to address the childhood determinants of mental health and wellbeing is important. Of these, family relationships are pre-eminent, as positive attachments result in good emotional and social development for children, equipping people with the necessary skills and knowledge to achieve resilience and positive mental wellbeing in adulthood.

7.3 Prevalence and incidence

Population prevalence

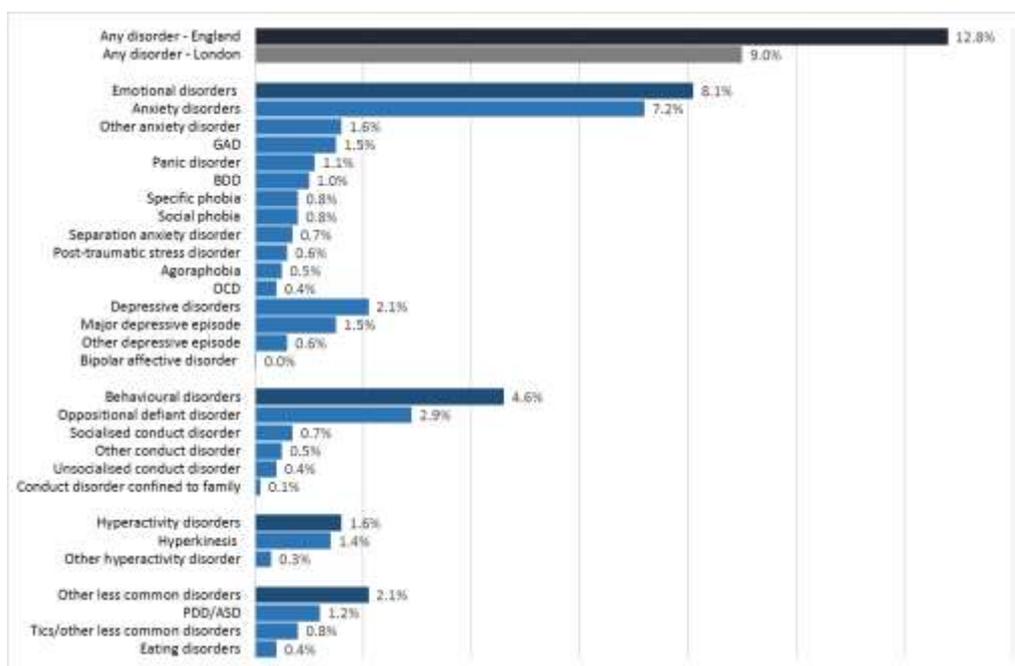
It is expected that 50% of people who have a lifetime mental illness (not including Dementia) will have experienced symptoms by the age of 14 years. This section collates the available estimates of the prevalence of mental illness in children and young people (Chart 15) and translates these into estimated numbers affected across in the Bi-Borough, now and in the future. (See Table 22).

The majority of estimates of the prevalence of mental illnesses in children are taken from the *Mental Health of Children and Young People Survey* (NHS Digital, 2018)

Chart 15 shows the relative prevalence of mental emotional and behavioural disorders in children aged 5 to 19 years as estimated by the Mental Health of Children and Young People Survey for 2017. All except the any disorder – London prevalence rates are based on national rates.

Overall levels of mental ill health in London are expected to be lower than the national average, 9.0% compared to 12.8%. Chart 15 also shows emotional disorders are the most common disorders, of which anxiety disorders have the highest prevalence.

Chart 15: Estimated prevalence of mental, emotional and behavioural disorders in children aged 5 to 19 years, 2017



Source: *Mental Health of Children and Young People Survey, NHS Digital, data published 2018.* ASD – Autism Spectrum Disorder, BDD – Body Dysmorphic Disorder, GAD – Generalised Anxiety Disorder, OCD – Obsessive Compulsive Disorder, PDD – Pervasive Development Disorder

Applied to the population of the bi-boroughs aged 5 to 19 years, Table 22 shows the estimated number of children and young people affected by mental, emotional and behavioural disorders. Estimates are provided for 2018 and for the next five and ten years.

It is assumed that the prevalence of each disorder will not change from 2017 estimates. Therefore, the reduction in numbers in 2028 is due to an expected reduction in the number of young people residing in both boroughs and not an expected reduction in the prevalence of mental, emotional or behavioural disorders.

Table 22: Estimated prevalence of mental, emotional and behavioural disorders in the bi-borough, 2017

Disorder/ presentation	Prevalence 5 - 19 years	Kensington and Chelsea					Westminster				
		2018	2023	2028	Change	Change	2018	2023	2028	Change	Change
					2018 - 2023	2023 - 2028				2018 - 2023	2023 - 2028
Any disorder - England	12.8%	3,039	3,046	2,952	8	- 94	4,859	5,070	5,070	211	- 1
Any disorder - London	9.0%	2,137	2,142	2,076	5	- 66	3,416	3,565	3,565	149	- 0
Emotional disorders	8.1%	1,923	1,928	1,868	5	- 60	3,075	3,209	3,208	134	- 0
Anxiety disorders	7.2%	1,709	1,714	1,661	4	- 53	2,733	2,852	2,852	119	- 0
Other anxiety disorder	1.6%	380	381	369	1	- 12	607	634	634	26	- 0
GAD	1.5%	356	357	346	1	- 11	569	594	594	25	- 0
Panic disorder	1.1%	261	262	254	1	- 8	418	436	436	18	- 0
BDD	1.0%	237	238	231	1	- 7	380	396	396	17	- 0
Specific phobia	0.8%	190	190	185	0	- 6	304	317	317	13	- 0
Social phobia	0.8%	190	190	185	0	- 6	304	317	317	13	- 0
Separation anxiety disorder	0.7%	166	167	161	0	- 5	266	277	277	12	- 0
Post-traumatic stress disorder	0.6%	142	143	138	0	- 4	228	238	238	10	- 0
Agoraphobia	0.5%	119	119	115	0	- 4	190	198	198	8	- 0
OCD	0.4%	95	95	92	0	- 3	152	158	158	7	- 0
Depressive disorders	2.1%	499	500	484	1	- 15	797	832	832	35	- 0
Major depressive episode	1.5%	356	357	346	1	- 11	569	594	594	25	- 0
Other depressive episode	0.6%	142	143	138	0	- 4	228	238	238	10	- 0
Bipolar affective disorder	0.0%	8	8	8	0	- 0	13	14	14	1	- 0
Behavioural disorders	4.6%	1,092	1,095	1,061	3	- 34	1,746	1,822	1,822	76	- 0
Oppositional defiant disorder	2.9%	688	690	669	2	- 21	1,101	1,149	1,149	48	- 0
Socialised conduct disorder	0.7%	166	167	161	0	- 5	266	277	277	12	- 0
Other conduct disorder	0.5%	119	119	115	0	- 4	190	198	198	8	- 0
Unsocialised conduct disorder	0.4%	95	95	92	0	- 3	152	158	158	7	- 0
Conduct disorder confined to family	0.1%	24	24	23	0	- 1	38	40	40	2	- 0
Hyperactivity disorders	1.6%	380	381	369	1	- 12	607	634	634	26	- 0
Hyperkinesis	1.4%	332	333	323	1	- 10	531	555	554	23	- 0
Other hyperactivity disorder	0.3%	71	71	69	0	- 2	114	119	119	5	- 0
Other less common disorders	2.1%	499	500	484	1	- 15	797	832	832	35	- 0
PDD/ASD	1.2%	285	286	277	1	- 9	456	475	475	20	- 0
Tics/other less common disorders	0.8%	190	190	185	0	- 6	304	317	317	13	- 0
Eating disorders	0.4%	95	95	92	0	- 3	152	158	158	7	- 0

Source: Mental Health of Children and Young People Survey, NHS Digital, data published 2018. London rates applied to Bi-Borough population estimates published by the Greater London Authority (GLA). ASD – Autism Spectrum Disorder, Body Dysmorphic Disorder (BDD), GAD – Generalised Anxiety Disorder, OCD – Obsessive Compulsive Disorder, PDD – Pervasive Development Disorder

Prevalence and socio-demographic factors

Results from the Mental Health of Young People Survey 2017 describe the relationship between the prevalence of any mental disorder (mental, emotional, behavioural) among children and young people, and demographic factors and wider determinants.

From Table 23, the prevalence of all mental disorders (mental, emotional and behavioural) among 5 to 19-year-olds is higher:

- at ages 17 to 19 years compared to 5 to 10 years
- among boys at ages 5-10 years and girls at 17 to 19 years
- in the White British population
- among children with special educational needs and children with poor physical health
- where parents have a mental health disorder and where family functioning is unhealthy
- where household income is low, benefits for income or disability are claimed
- in areas of deprivation and in the England

Table 23: Any mental, emotional or behavioural disorder

Any mental, emotional or behavioural disorder						
Illness/ presentation	Prevalence 5 to 19 years	Relationship to:				
		Age	Sex	Ethnicity	Special educational needs	Child/ young person's health
Any disorder	12.8%	Prevalence increases with age 9.5% at ages 5 to 10 years to 16.9% at ages 17 to 19 years	Prevalence is higher in boys aged 5 to 10 years, 12.2% vs. 6.6% similar aged 11 to 16 years, c.14% and higher in girls 17 to 19 years, 23.9% vs 10.3% boys	Highest among White British 14.9%, lowest among Asian/Asian British, 5.2%	Higher among children with special educational needs, 39.1% vs. 9.8% without	Clear gradient: highest where health is fair/poor/very bad, 41.8% compared to very good health, 6.4%

Any mental, emotional or behavioural disorder						
Illness/ presentation	Parental mental health issues	Relationship to:				
		Family functioning	Household income	Benefits status	Deprivation	Region
Any disorder	Higher where parent indicated to have a common mental health disorder, 27.9% vs. 9.4% where no disorder	Higher where unhealthy family functioning, 22.2% vs. 8.9% where healthy functioning	Prevalence increases the lower household income, however 4th lowest income quintile: Highest income (1st quintile), 6.8%, Lowest income, 14.1% (4th quintile 16.2%)	Higher where family receives low income benefits 18.2% vs. 9.8% without and where disability benefits are claimed 31.8% vs. 9.8% without	Unclear: Lowest in least deprived two quintiles (Q1 and Q2), 11.8 -11.9%, highest in Q3, 14.4% and in between for the most deprived (Q4 and Q5), 12.8% to- 13.1%.	Highest in the East of England, 15.6%, Lowest in London 9.0%

Demographics

The Mental Health of Young People Survey reports that, overall, the prevalence of all disorders, behavioural disorders, hyperkinetic disorders and other less common disorders are more prevalent in boys aged 5 to 15 years compared to girls, while the prevalence of emotional disorders is higher in among girls. Table 24 provides a more detailed breakdown of the relationship between specific disorders and age and sex.

Table 24: Relationships between prevalence of mental disorders and age and sex, 2017. London

Emotional disorders

Illness/ presentation	Relationship to:		
	Prevalence 5 to 19 years	Age	Sex
Emotional disorders	8.1%	Prevalence increases with age 4.1% at age 5 to 10 years to 14.9% at ages 17 to 19 years	Higher among boys at 5 to 10 years 4.6% vs. 3.6%, higher among girls otherwise: 11 to 16 years (10.9% vs. 7.1%) and 17 to 19 years (22.4% vs. 7.9%)

Anxiety disorders

Illness/ presentation	Relationship to:		
	Prevalence 5 to 19 years	Age	Sex
Anxiety disorders	7.2%	Prevalence increases with age 3.9% at ages 5 to 10 years and 13.1% at ages 17 to 19 years	Higher for boys aged 5 to 10 years, 4.6% vs. 3.6%, higher for girls otherwise: 11 to 16 years, 10.9% vs. 7.1% and 17 to 19 years 22.4% vs. 7.9%
Separation anxiety	0.7%	Prevalence is highest at 5 to 10 years, 1.0% than 11 to 16 years, 0.6%. Not recorded at 17 to 19 years	Higher for girls aged 5 to 10 years, 1.1% vs. 1.0%, higher for boys otherwise: 11 to 16 years, 0.8% vs. 0.4%
Generalised anxiety disorder	1.5%	Prevalence increases with age 0.7% at ages 5 to 10 years and 3.2% at ages 17 to 19 years	Higher for boys aged 5 to 10 years, 1.2% vs. 0.2%, higher for girls otherwise: 11 to 16 years, 2.2% vs. 1.0% and 17 to 19 years 4.6% vs. 1.9%
Obsessive compulsive disorder	0.4%	Prevalence lowest aged 5 to 10 years, 0.1% and the same at ages 11 to 19 years, 0.7%	Does not vary: at ages 5 to 10 years, 0.1%. Similar at ages 11 to 19, 0.7%
Specific phobia	0.8%	Parabolic: Increasing from ages 5 to 10 years to 11 to 16 years 0.8% to 0.9%, falls at ages 17 to 19 years to 0.6%	

Illness/ presentation	Relationship to:		
	Prevalence 5 to 19 years	Age	Sex
Social phobia	0.8%	Prevalence increases with age 0.2% at 5 to 10 years and 1.8% at 17 to 19 years	Same for boys and girls
Agoraphobia	0.5%	Not recorded at ages 5 to 10 years, Highest at ages 11 to 16 years, 1.7%, vs. 17 to 19 years, 0.8%	Higher for girls
Panic disorder	1.1%	Not recorded at ages 5 to 10 years, Increases with age 11 to 16 years, 1.1%, to 3.4% at ages 17 to 19 years	Higher for girls
Post-traumatic stress disorder	0.6%	Prevalence increases with age 0.2% at ages 5 to 10 years and 1.3% at ages 17 to 19 years	Same for boys and girls
Other anxiety disorders	1.6%	Prevalence increases with age 1.2% at ages 5 to 10 years and 2.3% at ages 17 to 19 years	Higher for girls

Depressive disorders

Illness/ presentation	Relationship to:		
	Prevalence 5 to 19 years	Age	Sex
Depressive disorders	2.1%	Prevalence increases with age 0.3% at age 5 to 10 years to 4.8% at ages 17 to 19 years	Higher in boys aged 5 to 10 years, 0.4% vs. 0.2%, higher in girls at ages 11 to 16 years, 3.8% vs. 1.6% and at 17 to 19 years, 6.5% vs. 3.2%
Major	1.5%	Prevalence increases with age 0.2% at age 5 to 10 years to 3.5% at ages 17 to 19 years	Higher in boys aged 5 to 10 years, 0.2% vs. 0.1%, higher in girls at ages 11 to 16 years, 2.8% vs. 1.0% and at 17 to 19 years, 4.7% vs. 2.4%
Other	0.6%	Prevalence increases with age 0.1% at age 5 to 10 years to 0.8% at ages 17 to 19 years	Same at age 5 to 10 years, 0.1%, higher in girls at ages 11 to 16 years, 1.1% vs. 0.6% and at 17 to 19 years, 1.8% vs. 0.8%

Bipolar affective disorder

Illness/ presentation	Relationship to:		
	Prevalence 5 to 19 years	Age	Sex
Bipolar affective disorder	0.0%	Not recorded at ages 5 to 10 years, Increases from <0.0% at ages 11 to 16 years to 0.1% at ages 17 to 19 years	Higher for girls

Source: *Mental Health of Children and Young People Survey, NHS Digital, data published 2018*

Other estimates

Comparative analysis of the prevalence of mental illness in children aged 5 to 16 years performed by PHE suggests that rates are lower than the London and England average in Kensington and Chelsea 8.2%, but higher than the England average in Westminster, 9.6% (England 9.2%, London 9.3%). Trend analysis is not available.

7.4 Risk factors

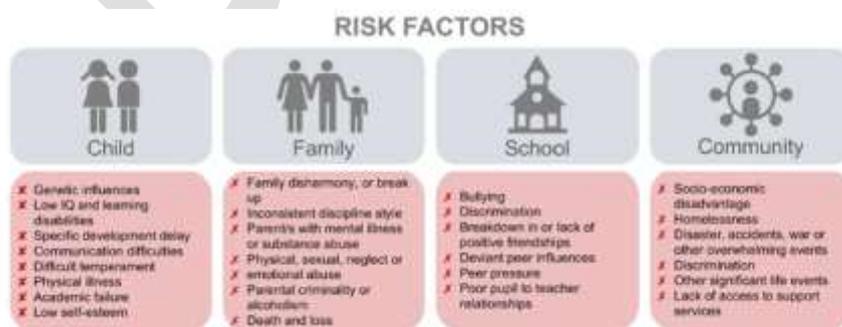
As discussed in Chapter 4, the primary predictor of mental health and wellbeing in children and young people is the quality of the parent-child relationship and parenting more broadly.

Children also spend a high proportion of their waking life in schools and so this is an age where the school environment is key to wellbeing. The school ethos, mental wellbeing of teachers, relationships with peers and prevalence of bullying all matter. The importance of the school environment was also recognised in recent consultation with young people for the annual report of the Director of Public Health.

Recently, attention has been given to adverse childhood experiences (ACE) and the impact these events have on an individual's health and wellbeing into adulthood. The term is used to describe the occurrence of abusive or neglectful parenting, drug and alcohol misuse, parental mental illness, divorce or bereavement. Where risks are identified and problems addressed early, a virtuous cycle of accessing the right support and recovery can be established

Figure 1 summarises the known risk factors associated with children and young people developing mental illness.

Figure 1



Source: *Adapted from the mental health of children and young people in London (PHE, December 2016)*

Comparative data

The following section reviews comparative data from the PHE fingertips profiles relating to children and young people. The indicators are RAG (red, amber, green) rated to indicate where rates are worse, the same or better than the London region.

Child excess weight is not included in Figure 1 however it is included in the PHE JSNA profile as a risk factor and has therefore been included.

Child level risk factors

Table 25 summaries comparative data from the PHE fingertips profiles relating to the child level risk factors identified in Figure 1. The following key points are noted:

- There is a clear contrast between the child level risk factors between boroughs: in general children in Kensington and Chelsea demonstrate lower rates of child level risk factors compared to London, while children in Westminster experience higher rates.
- Exceptions include the rate of Learning Disabilities, children aged 15 years with a diagnosed illness, disability or medical condition, GCSE performance and looked after children's average difficulties score – both boroughs perform better than London on these indicators, but both boroughs perform worse than the London average on school readiness.

Table 25: Comparative data, child level risk factors

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Pupils with Learning Disability: % of pupils	2017	3.8%	4.2%	4.4%	5.6%	476	951
School Readiness: % of all eligible children	2016/17	70.1%	70.7%	73.0%	70.7%	727	1,052
School Readiness - % eligible free school meal	2016/17	58.7%	65.4%	63.6%	56.0%	132	170
GCSEs 5A*-C incl. English & Maths: % pupils	2015/16	65.0%	63.6%	61.3%	57.8%	362	700
5 or more GCSEs % of children in care	2015	-	-	16.8%	13.8%	-	-
Special Educational Needs	% age	2018	13.5%	15.3%	14.4%	1,732	3,427
	% Primary	2018	10.3%	15.0%	12.4%	550	1,730
	% Secondary	2018	14.6%	13.9%	13.9%	1,079	1,471
Children in need due to child disability or illness per 10,000 < 18 yrs	2017	21.4	46.1	36.3	31.2	61	204
15 year olds with a diagnosed long-term illness, disability or medical condition % of 15 yr olds	2014/15	11.3%	11.6%	12.6%	14.1%	-	-
Mental health disorders % pop. 5-16 yrs	2015	8.2%	9.6%	9.3%	9.2%	1,491	2,571
Hyperkinetic disorders: % 5-16 yrs	2015	1.3%	1.6%	1.5%	1.5%	237	423
Conduct disorders: % 5-16 yrs	2015	4.9%	5.9%	5.7%	5.6%	881	1576
Social, emotional and mental health needs	% age	2018	2.1%	3.2%	2.4%	274	713
	% Primary	2018	2.3%	2.0%	2.2%	169	207
	% Secondary	2018	1.9%	4.3%	2.5%	103	500
Looked after children 5-16: average difficulties	2016/17	10.5	12.3	13.7	14.1	-	-
Cause for concern - % of looked after children	2016/17	-	25.0%	35.5%	38.1%	-	20
Children in need -socially unacceptable behaviour per 10,000 < 18yrs	2017	29.4	7.7	10.9	6.7	84	34
Mean wellbeing (WEMWBS) score at 15 yrs	2014/15	48.6	47.4	47.8	47.6	-	-
Positive satisfaction at 15 yrs: % positive	2014/15	62.8%	50.4%	59.9%	63.8%	-	-
Excess weight Reception yr: % 4-5 yr olds	2016/17	21.1%	24.7%	22.3%	22.6%	146	298
Excess weight Year 6: % 10-11 yr olds	2016/17	34.2%	43.1%	38.5%	34.2%	215	518

Source: Public Health England Fingertips (2018)

Family

Table 26 shows that, by contrast to child level risk factors, the boroughs present similarly on familial risk factors when compared to London. The following key points are noted:

- Rates of looked after children and children subject to a child protection plan are lower than the London average in both boroughs. However, in Kensington and Chelsea, the rate of children subject to repeat child protection plan is higher than the London average.
- Both boroughs have lower rates of children in need and looked after children for abuse or neglect compared to London.
- Both boroughs have higher rates of children in need due to family stress, family dysfunction or absent parenting compared to London. In addition, Westminster, also has a higher rate of looked after children for family stress, family dysfunction or absent parenting
- Both boroughs have higher rates of children in need due to parental disability or illness, however rates of children and young people providing care were lower than the London average in 2011

Table 26: Comparative data, family level risk factors

Indicator	Period	RBKC	WCC	London	England	RBKC	WCC	
Domestic abuse-related incidents & crimes per	2016/17	22.9	22.9	22.9	22.5	-	-	
Parents in drug treatment: Rate per 100,000 children	2011/12	81.6	137.2	104.1	110.4	20	45	
Parents in alcohol treatment: Rate per 100,000	2011/12	134.7	91.5	108.2	147.2	33	30	
Children in need: abuse/neglect rate/10,000 < 18	2017	107.5	104.0	166.3	172.9	307	460	
Looked after: due to abuse or neglect rate/10,000 < 18	2017	3.9	10.9	14.3	16.2	11	48	
Children in need: family stress/dysfunction/absent parenting rate/10,000 < 18	2017	163.6	145.0	97.9	93.8	467	641	
Looked after: family stress/dysfunction/absent parenting rate/10,000 < 18	2017	8.8	18.5	11.6	9.3	25	82	
Children in need: parent disability/illness rate/10,000 < 18 yrs	2017	20.7	22.4	14.2	9.2	59	99	
Young people providing care: % 16-24	2011	4.4%	5.1%	5.4%	4.8%	735	1,330	
Children providing care: % <15	2011	0.8%	1.0%	1.1%	1.1%	186	332	
Looked after children: rate/ 10,000 < 18	2015/16	37.1	38.7	50.5	60.3	105	165	
Child protection plan: rate/ 10,000 < 18 yrs	Neglect	2017	14.4	7.9	16.2	20.9	41	35
	Abuse	2017	8.4	10.2	21.1	19.9	24	45
Repeat child protection plan for 2nd/ subsequent time %	2017	27.8%	4.9%	14.8%	18.7%	25	6	

Source: Public Health England Fingertips (2018)

School

The following indicators relate to the influences that can occur through a child's experiences at school. The following key points are noted:

- Kensington and Chelsea is shown to have higher rates of bullying at age 15.
- Both Kensington and Chelsea and Westminster have a higher proportion of residents of mixed and of other ethnicity compared to the London average.
- Both boroughs have higher rates of secondary school fixed period exclusions and school absences compared to the London average, however Westminster also demonstrates higher rates of fixed period exclusions for disruptive behavior and primary school fixed period exclusions than London, a finding not made in Kensington and Chelsea.
- Generally, both boroughs have lower rates of risky behavior at age 15 compared to the London average. The exception is Kensington and Chelsea which has a higher rate of current smokers at age 15 and higher rates of alcohol specific hospital admissions among under 18's, compared to London.

Table 27: Comparative data, school level risk factors

Indicator	Period	Rate				Count		
		RBKC	WCC	London	England	RBKC	WCC	
15 yr olds bullied in the past couple of months: % of	2014/15	50.2%	49.6%	50.0%	55.0%	-	-	
Ethnicity: % population	White	2011	70.6%	61.7%	59.8%	85.4%	112,017	135,330
	Mixed	2011	5.7%	5.2%	5.0%	2.3%	8,986	11,395
	Black	2011	6.5%	7.5%	13.3%	3.5%	10,333	16,472
	Asian	2011	10.0%	14.5%	18.5%	7.8%	15,861	31,862
	Other	2011	7.2%	11.1%	3.4%	1.0%	11,452	24,337
15 yr took drugs (excl. cannabis) in the last month: % of 15 yr olds	2014/15	-	0.6%	1.0%	0.9%	-	-	
15 yr olds regular drinkers: % of 15 yr olds	2014/15	1.8%	1.5%	3.1%	6.2%	-	-	
15 yr olds current smokers: % of 15 yr olds	2014/15	5.3%	6.8%	6.1%	8.2%	-	-	
3 or more risky behaviours: % of 15 yr olds	2014/15	8.2%	7.5%	10.1%	15.9%	-	-	
Hospital admissions -alcohol-specific <18	14/15-16/17	23.6	17.3	19.4	34.2	20	22	
Fixed period exclusion: persistent disruptive behaviour: rate /100 school aged pupils	2015/16	0.5%	0.9%	0.7%	1.2%	62	204	
Secondary school fixed period exclusions: rate/ 100 pupils	2015/16	8.8%	7.6%	6.9%	8.5%	423	846	
Primary school fixed period exclusions: rate /100 pupils	2015/16	0.4%	1.0%	0.8%	1.2%	27	106	
School absence: % of half days missed	2016/17	4.6%	4.6%	4.4%	4.7%	173,033	282,314	

Source: Public Health England Fingertips (2018)

Community

Table 28 shows how the boroughs compare to London on indicators of community level factors that influence the risk of a child developing a mental illness. The following key points are noted:

- Rates of children and young people in the youth justice system are lower than the London average in both boroughs
- Both boroughs have a higher percentage of children aged under 16 and under 20 years living in poverty compared to the London average.
- Westminster has a higher percentage of children living in income deprivation compared to the London average, whereas in Kensington and Chelsea has a lower percentage.
- Both boroughs have a higher percentage of children receiving free school meals compared to the London average.
- Both boroughs have lower rates of family homelessness, care leavers and out of work households compared to the London average

Table 28: Comparative data, community level risk factors

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
First time entrants to the youth justice system: rate per 100,000 population aged 10-17	2017	231.2	250.3	380.3	292.5	26	43
Children in the youth justice system: rate per 1,000	2016/17	5.2	4.8	6.2	4.8	-	-
Child poverty: % of children aged 0-15 (IDAC)	2015	17.4%	28.7%	24.4%	19.9%	4,305	9875
Children under 20 in poverty: % children <20	2015	20.1%	28.5%	19.2%	16.6%	3,820	8,325
Children under 16 in poverty: % of children < 16	2015	19.4%	27.3%	18.8%	16.8%	3,195	6,875
16-18 year olds not in education, employment or training: % of 16-18 year olds	2015	2.9%	1.6%	3.1%	4.2%	60	60
Free school meals: % uptake among all pupils	2017	20.4%	24.3%	16.5%	13.9%	2,598	5,535
Family homelessness: rate per 1,000 households	2016/17	3.1	3.1	4.0	1.9	245	372
Families out of work: % of households with dependent children & no adult in employment	2011	3.6%	5.0%	5.7%	4.2%	2,842	5,251
Children leaving care: rate per 10,000 children aged under 18	2015/16	26.5	25.8	30.7	27.2	75	110

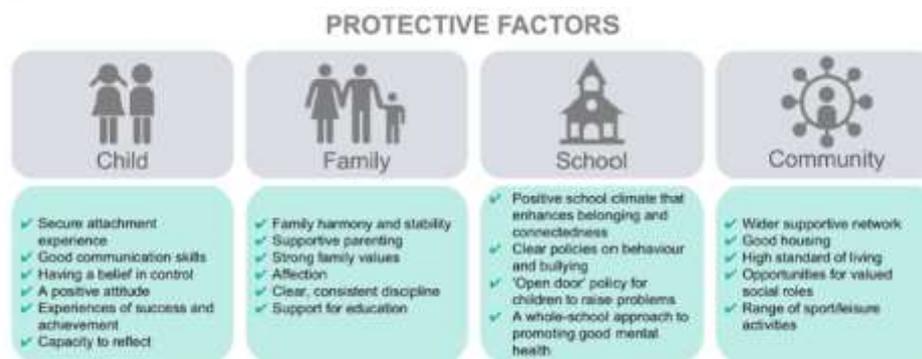
Source: Public Health England Fingertips (2018)

7.5 Protective factors

Figure 2 summarises the known protective factors associated with a reduced likelihood of children and young people developing mental illness.

Comparative quantitative data on protective factors for children as described below is currently not available.

Figure 2



Source: Adapted from *the mental health of children and young people in London* (PHE, December 2016)

7.6 What works

Shah (2015) found that mental health promotion activities can help children develop positive mental wellbeing and prevent mental disorder. Pre-school and early education programmes are highlighted in the Under 5's Healthy Child Programme and result in improvements in cognitive skills, school readiness, academic achievement and family outcomes, including siblings (Woolfenden, Williams & Peat, 2001). They are also effective in preventing emotional and conduct disorder.

More targeted approaches such as home visiting programmes improve child functioning and reduce behavioural problems (Waddell et al., 2007) (being rolled out in the UK as Family Nurse Partnership).

School-based mental health promotion interventions can improve wellbeing, with resulting benefits for academic performance, social and emotional skills and classroom behaviour (NICE, 2008a). They can also result in reductions in anxiety and depression (NICE, 2009b). Targeted Mental Health Support in Schools (TaMHS) is also effective.

Evidence for school-based yoga and mindfulness activities to improve mental health was very low quality.

Better Mental Health For All (2016) reports a number of interventions or programmes to promote mental health and wellbeing among children and young people:

- Parenting under Pressure, a promising programme for supporting parenting in families where parents abuse drugs or alcohol.
- Let's Talk About Children, a manual for a two session discussion with parents who are living with a mental health problem.
- The English Healthy Child Programme (2009) covers five to nineteen-year olds and sets out the recommended framework of universal and progressive services for children and young people in order to promote optimal health and wellbeing.
- A comprehensive 'whole school' approach to promoting the mental wellbeing of children and young people.
- Evidence based bullying prevention programmes in settings in which children and young people learn, live and spend their leisure time.
- Looked after children should have sufficient involvement in decisions to do with their care and have access to nurturing relationships that foster attachment.
- Target wellness services towards clusters of children identified as being at high risk of multiple poor behaviours, rather than providing single issue services only.
- The Early Intervention in Psychosis (EIP) model, which was developed in Melbourne and has been adopted in England and Wales, is an effective intervention.
- A prevention intervention aimed at children at risk of eating disorders is Cognitive Dissonance Activities. This initiative engages young people in conversation on body image.
- The Increasing Access to Psychological Therapies (IAPT) programme

What NICE says...

NICE guidelines (PH20) outline responsibility for all involved professionals to be adequately trained to support children's social and emotional wellbeing through:

- listening and facilitating skills and the ability to be non-judgemental
- how to manage behaviours effectively, based on an understanding of the underlying issues
- identifying and responding to the needs of young people who may be experiencing emotional and behavioural difficulties
- how to access pastoral care based in secondary education or specialist services provided by other agencies, such as child and adolescent mental health services
- the issues in relation to different medical conditions (such as diabetes, asthma and epilepsy) to ensure young people with these conditions are not bullied, inappropriately excluded from school activities or experience any undue emotional distress
- opportunities to reflect upon and develop their own social and emotional skills and awareness.

Their evidence review (2009) concluded:

'This evidence therefore is mixed and it is unclear whether curriculum-based interventions for tackling bullying and disruptive behaviour are effective. However, on balance the evidence suggests that certain interventions can be effective. It is possible that including community elements in these types of interventions may be beneficial'

7.7 Service Activity

Preventative services

Looked after children

Nationally, Public Health England publish comparative data on the services for children. Table 29 below summarises the published indicators on assessment for looked after children and the performance of the boroughs compared to the London average. From this data the following key points are noted:

- In 2014, both boroughs achieved a higher than London average percentage of looked after children receiving their annual assessment and eligible looked after children assessed for emotional and behaviour health.
- Westminster also achieved a higher than the London average percentage of looked after children aged under 5 years with up-to-date development assessments, while data for Kensington and Chelsea were not available.

Table 29: Assessments for looked after children

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
% Looked after children who had an annual assessment	2014	100.0%	100.0%	92.2%	88.4%	55	125
% eligible looked after children assessed for emotional and behavioural health	2014	85.0%	100.0%	78.0%	68.0%	34	95
% looked after children aged <5 with development assessments up-to-date	2014	-	100.0%	93.2%	86.8%	-	20

Source: Public Health England Fingertips (2018)

Health Visiting

As seen in Chapter 6 on perinatal mental health, Table 30 shows that, with the exceptions of 8-week review rates in Kensington and Chelsea and 12-month review rates in Westminster, health visitor review rates are worse than the London average.

Table 30: Percentage of births and children receiving a health visitor review by age and borough

Indicator	Period	RBKC	WCC	London	England	RBKC	WCC
Health Visitor review by 8 weeks: % births	2015/16	65.9%	44.7%	51.6%	80.4%	1,057	1,130
Health Visitor new birth visits <14 days: % births	2015/16	84.6%	87.0%	88.5%	87.0%	1,651	2,099
Health visitor 12 month review: % of children	2015/16	39.1%	57.7%	42.3%	72.6%	792	1,372

Source: Public Health England Perinatal Mental Health Profiles (2018)

Treatment services

Prescribing

Data on the number of children prescribed antidepressants is not available, only the number of items prescribed (packs of medication).

Chart 16 shows that the crude rate of antidepressant items prescribed to children aged 0 to 19 years per 1,000.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

Chart 16 shows rates of prescribing have been typically higher in Westminster compared to Kensington and Chelsea and rates in both boroughs and have been increasing over the past three financial years.

Chart 16: Antidepressant prescribing, items per 1,000 children aged 0 to 19 years



Source: NHS North West London Medicines Management

Table 31 shows annual numbers of items prescribed per financial year and crude rates per 1,000 GP registered population to enable comparison.

From Table 31 in 2017/18 1,045 items were prescribed to children in Kensington and Chelsea and 1,474 items to children from Westminster.

Table 31: Antidepressant prescribing 0 to 19 years inclusive

Metric	Borough	2015/16	2016/17	2017/18
Items/1,000 population	Kensington & Chelsea (WLCCG excl. QPP)	18	23	28
	Westminster (CLCCG + QPP)	28	28	34
Items	Kensington & Chelsea (WLCCG excl. QPP)	701	819	1,045
	Westminster (CLCCG + QPP)	1,105	1,162	1,474

Source: NHS North West London Medicines Management

Specialist mental health services

This section describes the finding from analysis of activity data provided by Central and North West London Foundation Trust (CNWL). In interpreting these findings it should be considered that while CNWL is the largest provider of mental health care

services, there are other mental health services, and therefore the numbers presented are likely to be an underestimate of current demand for treatment services.

Referrals

Chart 17 shows referrals to Central and North West London Foundation Trust’s (CNWL’s) Child and Adolescent Mental Health Services (CAMHS) by Clinical Commissioning Group (CCG).

CCG boundaries map to the Bi-Borough as follows:

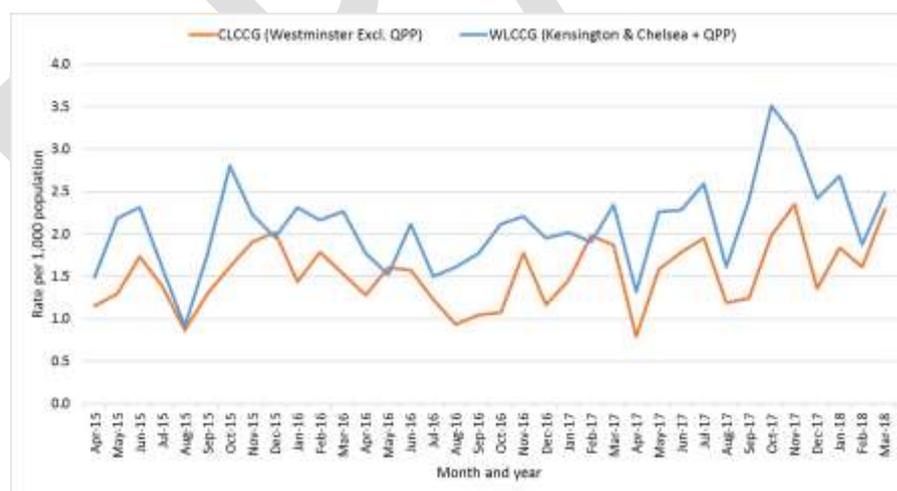
- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen’s Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen’s Park Paddington

In interpreting referrals data, it should be noted that not all referrals are accepted, and that not all accepted referrals lead positive diagnosis and treatment.

Chart 17 shows the trend in referrals from all sources. Tables 32 and 33 show annual numbers by referral source for Central London CCG and West London CCG respectively. They show referral volumes by source in rank order and indicate where annual numbers have increased (dark blue) or decreased (light blue) year on year.

Tables 36 and 37 list the reasons for referral in rank order. Year on year changes are highlighted as increase (dark blue) or decrease (light blue).

Chart 17: CAMHS referrals to CNWL, all sources of referral, monthly trend



Source: CNWL contract monitoring data

From Tables 32 and 33 the following key points are made:

- The most common referral routes into CAMHS are via GP, from the Education Service or from A&E in both CCGs
- For most referral routes 2017/18 volumes have been higher than 2016/17 in both CCGs

- Continual year-on-year increases in volumes have been seen in referrals from A&E departments and carers in CLCCG, and from WLCCG from education services, A&E departments and 'other services or agency'
- Numbers of referrals from 'other secondary care specialities' in CLCCG and social services in WLCCG have been continually declining

Table 32: CAMHS: Source of referral and year on year change in volumes CLCCG
NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

Source of referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
GP	321	319	329	969	52%	99%	103%
Education Service	70	63	127	260	14%	90%	202%
Accident And Emergency Department	30	72	87	189	10%	240%	121%
Other service or agency	35	23	53	111	6%	66%	230%
Social Services	54	27	28	109	6%	50%	104%
Carer	23	30	33	86	5%	130%	110%
Other secondary care specialty	47	19	15	81	4%	40%	79%
Community-based Paediatrics	9	6	9	24	1%	67%	150%
Other Primary Health Care	15	5	<5	20	1%	33%	-
Hospital-based Paediatrics	9	9	<5	18	1%	100%	-
Self	<5	<5	11	11	1%	-	-
Asylum Services	<5	<5	0	0	0%	-	-
Health Visitor	<5	<5	<5	0	0%	-	-
Independent Sector - Low Secure Inpatients		<5	0	0	0%	-	-
NHS Direct	<5	<5	<5	0	0%	-	-
Other Independent Sector Mental Health Services	<5	<5	<5	0	0%	-	-
Out of Area Agency	<5	<5	<5	0	0%	-	-
Probation Service	<5	<5	<5	0	0%	-	-
Permanent transfer from another Mental Health NHS Trust		<5	0	0	0%	-	-
School Nurse	<5	<5	<5	0	0%	-	-

Source: CNWL contract monitoring data

Table 33: CAMHS: Source of referral and year on year change in volumes WLCCG
NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

Source of referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
GP	501	437	510	1448	43%	87%	117%
Education Service	103	126	166	395	12%	122%	132%
Accident And Emergency Department	51	133	156	340	10%	261%	117%
Other service or agency	60	78	184	322	10%	130%	236%
Social Services	114	84	63	261	8%	74%	75%
Other secondary care specialty	100	39	49	188	6%	39%	126%
Carer	43	34	70	147	4%	79%	206%
Community-based Paediatrics	21	17	22	60	2%	81%	129%
Self	9	17	15	41	1%	189%	88%
Hospital-based Paediatrics	13	17	7	37	1%	131%	41%
Other Primary Health Care	31	5	<5	36	1%	16%	-
NHS Direct	<5	<5	19	19	1%	-	-
Health Visitor	16	<5	<5	16	0%	-	-
School Nurse	8	5	<5	13	0%	63%	-
Other Independent Sector Mental Health Services	<5	5	7	12	0%	-	140%
Out of Area Agency	<5	<5	5	5	0%	-	-
Asylum Services	<5	<5	0	0	0%	-	-
Independent Sector - Low Secure Inpatients	0	<5	0	0	0%	-	-
Probation Service	<5	<5	<5	0	0%	-	-
Permanent transfer from another Mental Health NHS Trust	0	<5	0	0	0%	-	-

Source: CNWL contract monitoring data

Emergency non-emergency

From Table 34, the majority of referrals to CAMHS are routine in nature, with over 85% of referrals from each CCG. The remaining 15% are urgent or emergency referrals. In 2017/18 there were 181 urgent or emergency referrals from WLCCG and 81 from CLCCG.

Table 34 Type of referral by CCG

WLCCG (Kensington and Chelsea +QPP)							CLCCG (Westminster Excl. QPP)						
Referral type	Referrals			Percentage of referrals			Referral type	Referrals			Percentage of referrals		
	15/16	16/17	17/18	15/16	16/17	17/18		15/16	16/17	17/18	15/16	16/17	17/18
Emergency	39	83	98	4%	8%	8%	Emergency	19	36	36	3%	6%	5%
Routine	975	856	1097	91%	85%	86%	Routine	582	512	623	93%	88%	88%
Routine Plus	<5	-	-	0%	0%	0%	Routine Plus	<5	-	-	-	0%	0%
Urgent	63	66	83	6%	7%	6%	Urgent	24	35	47	4%	6%	7%

Source: CNWL contract monitoring data

Accepted Referrals

Table 35 shows that the percentage of referrals that are accepted has been increasing in both boroughs over the past three financial years. In 2017/18 the percentage of referrals to CAMHS accepted was 81% for WLCCG registered patients and 88% for CLCCG registered patients.

Table 35 CAMHS: Referrals accepted by CCG

WLCCG (Kensington and Chelsea +QPP)							CLCCG (Westminster Excl. QPP)						
Decision	Referrals			Percentage of referrals			Decision	Referrals			Percentage of referrals		
	15/16	16/17	17/18	15/16	16/17	17/18		15/16	16/17	17/18	15/16	16/17	17/18
Accepted	859	819	1030	80%	82%	81%	Accepted	504	538	618	86%	86%	88%
Not Accepted	217	185	247	20%	18%	19%	Not Accepted	79	86	83	14%	14%	12%
Not Recorded	<5	<5	<5	-	-	-	Not Recorded	<5	<5	<5	-	-	-

Source: CNWL contract monitoring data

Reason for referral

Table 36 and 37 show annual numbers by referral by reason for referral Central London CCG and West London CCG respectively. From these tables the following key points are made:

- Anxiety is the most common reason for referral for both CCGs, followed by 'in crisis'.
- The number of referrals for PTSD for WLCCG have increased over 13 times between 2016/17 and 2017/18. This is expected to be related screening for PTSD following the Grenfell Tower disaster.

- The number of referrals for 'in crisis' in both boroughs and capacity (advice or assessment) in WLCCG have been declining year on year

Table 36 CAMHS: Reason for referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

Reason for referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
Anxiety	76	207	246	529	28%	272%	119%
In crisis	297	132	65	494	26%	44%	49%
Depression	57	51	86	194	10%	89%	169%
Relationship difficulties	64	50	62	176	9%	78%	124%
Conduct disorders	20	15	61	96	5%	75%	407%
Self harm	27	34	30	91	5%	126%	88%
Suspected ADHD	14	27	38	79	4%	193%	141%
Suspected ASD	8	14	28	50	3%	175%	200%
Post-traumatic stress disorder	<5	8	28	36	2%	-	350%
Neurodevelopmental conditions	11	10	14	35	2%	91%	140%
Unexplained physical symptoms	15	5	5	25	1%	33%	100%
Eating disorders	5	11	7	23	1%	220%	64%
Perinatal mental health issues	12	<5	0	12	1%	-	-
Adjustment to Physical Health Condition	<5	<5	11	11	1%	-	-
Obsessive compulsive disorder	<5	6	5	11	1%	-	83%
Capacity (advice/assessment)	7	<5	<5	7	0%	-	-
Drug and alcohol difficulties	<5	<5	<5	0	0%	-	-
Medication Review	<5	<5	<5	0	0%	-	-
Organic brain disorder	<5	0	<5	0	0%	-	-
Personality disorders	<5	<5	<5	0	0%	-	-
Phobias	<5	<5	<5	0	0%	-	-

Source: CNWL contract monitoring data

Table 37 CAMHS: Reason for referral and year on year change in volumes WLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

Reason for referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
Anxiety	193	345	325	863	26%	179%	94%
In crisis	496	171	116	783	24%	34%	68%
Post-traumatic stress disorder	<5	8	272	280	8%	-	3400%
Depression	51	82	117	250	8%	161%	143%
Conduct disorders	34	78	116	228	7%	229%	149%
Self harm	39	67	81	187	6%	172%	121%
Relationship difficulties	53	44	58	155	5%	83%	132%
Suspected ADHD	35	52	53	140	4%	149%	102%
Neurodevelopmental conditions	35	57	41	133	4%	163%	72%
Capacity (advice/assessment)	52	28	8	88	3%	54%	29%
Perinatal mental health issues	48	<5	0	48	1%	-	-
Eating disorders	7	14	19	40	1%	200%	136%
Suspected ASD	7	9	24	40	1%	129%	267%
Unexplained physical symptoms	15	14	9	38	1%	93%	64%
Adjustment to Physical Health Condition	<5	<5	13	13	0%	-	-
Obsessive compulsive disorder	<5	5	7	12	0%	-	140%
Drug and alcohol difficulties	<5	7	<5	7	0%	-	-
Medication Review	<5	<5	<5	0	0%	-	-
Organic brain disorder	<5	0	<5	0	0%	-	-
Personality disorders	<5	<5	<5	0	0%	-	-
Phobias	<5	<5	<5	0	0%	-	-

Source: CNWL contract monitoring data

Caseload

In 2017/18 average caseloads were 663 for WLCCG and 492 for CLCCG. Chart 18 shows the monthly trend in CAMHS caseload by referring CCG. Numbers on caseload are converted into rates per 1,000 population aged 0 to 19 years to enable comparison. From Chart 18 cases per head of population from WLCCG are typically higher compared to CLCCG

Chart 18 CAMHS: children and adolescents on caseload per 1,000 population aged 0 to 19 yrs



Source: CNWL contract monitoring data

Hospital admissions

Table 38 presents comparative Public Health England data on the rates of mental health related hospital admission for children and young people. From this table the following key points are made:

- Rates of hospital admissions for mental illness and self-harm among 10 to 24-year olds are lower than the London average in both boroughs.
 - Rates of self-harm in age groups 10-14 and 15 to 19 years are also lower than the London average in Kensington and Chelsea, however is not possible to report on Westminster due to a lack of data
- Rates of hospital admission for substance misuse among young people in Kensington and Chelsea are higher than the London average, while in Westminster they are lower than the London average

Table38: Mental health related hospital admission rates for children and young people

Indicator	Period	Rate				Count		
		RBKC	WCC	London	England	RBKC	WCC	
Hospital admissions - mental health/ 100,000	<18	2016/17	56.0	47.5	76.8	81.5	16	21
Hospital admissions - self harm per 100,000 population	10-24 yrs	2016/17	98.2	113.7	197.2	404.6	22	43
	10-14yrs	2016/17	-	64.6	102.1	211.6	-	7
	15-19yrs	2016/17	-	224.5	305.2	619.9	-	26
Hospital admissions -substance misuse/100,000	15-24yrs	14/15 - 16/17	73.2	51.2	67.2	89.8	36	45

Source: Public Health England Fingertips (2018)

Local data

Analysis of hospital spells for primary and secondary diagnoses of mental health conditions (International Classification of Diseases 10th edition [ICD 10] Chapter F) and self-harm (codes within ICD 10 Chapter X) produced the findings in Table 39. Data presented where more than 5 spells occurred in the pooled 2015/16 and 2016/17 data and for the top 5 diagnoses

Table 39 presents the findings from local analysis of hospital activity data. As mental health and/ or self-harm diagnoses are most commonly coded as a secondary diagnosis, only pooled data from 2015/16 and 2016/17 could be utilised as the 2017/18 spells data does not include secondary diagnosis field.

Table 39 shows the number of hospital admissions are low, fewer than 20 spells over two years. Of recorded spells:

- the most common primary mental health diagnoses are ‘mental and behavioural disorders due to the use of alcohol’ in Kensington and Chelsea and ‘depressive episodes’ in Westminster
- the most common primary mental health diagnoses are ‘mental and behavioural disorders due to the use of alcohol’ in Kensington and Chelsea and ‘depressive episodes’ in Westminster.

Table 39: Hospital admissions (Spells), children aged 0 to 19 years, with a relevant primary diagnosis Chapter F or X, 2015/16 and 2016/17 pooled data

Primary Diagnosis	Borough	EL	NEL	Secondary Diagnosis	Borough	EL	NEL
Mental and behavioural disorders due to use of alcohol	RBKC	-	5	Mental and behavioural disorders due to use of tobacco	RBKC	7	7
Developmental disorder of speech and language, unspecified	RBKC	5	-	Disturbance of activity and attention	RBKC	8	<5
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics & antirheumatics	RBKC	-	5	Childhood autism	RBKC	8	<5
				Specific (isolated) phobias	RBKC	7	<5
				Developmental disorder of scholastic skills, unspecified	RBKC	6	<5
				Developmental disorder of speech and language, unspecified	RBKC	6	<5
Depressive episode, unspecified	WCC	-	8	Childhood autism	WCC	30	5
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics & antirheumatics	WCC	-	13	Developmental disorder of scholastic skills, unspecified	WCC	17	<5
Exposure to unspecified factor	WCC	-	11	Anxiety disorder, unspecified	WCC	14	<5
Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	WCC	-	7	Depressive episode, unspecified	WCC	-	13
Intentional self-harm by sharp object	WCC	-	5	Specific (isolated) phobias	WCC	12	-
				Mental and behavioural disorders due to use of tobacco	WCC	5	<5

Source: Secondary Uses Service spells data 2015/16 and 2016/17 pooled data. EL – Elective, NEL – Non-elective. n – Number

7.8 Local services and asset mapping

Services for Children, Young People and Families that Support Emotional Health and Wellbeing

A joint review of the Emotional Health and Wellbeing Services was carried out in 2018 with a report published in July 2018. The findings of this report are significantly drawn upon in this section.

The range of services across the Bi-Borough is considered to be good with a variety of activities taking place in schools, in partnership with the Local Authority and Clinical Commissioning Groups. Services include face-to-face and online awareness raising / training in schools and early years settings.

Table 40: Services for Children, Young People and Families that Support Emotional Health and Wellbeing

Type / Age	Westminster	Kensington and Chelsea
0-5	Family Nurse Partnership Health Visiting Attachment project 0-5 / CNWL Healthy Early Years Awards Children's Centres/ Family Hubs	Family Nurse Partnership Health Visiting Attachment project 0-5 / CNWL Healthy Early Years Awards Children's Centres
5-11	Early Help Service LA CNWL Early Intervention Workers (EIWs) MIND Mental Health First Aid (MHFA) Kooth online counselling Healthy Schools Awards Domestic Violence Prevention in Schools School Health Service School investment in Emotional Health and Wellbeing from Pupil Premium Funding.	Early Help Service LA CNWL Early Intervention Workers (EIWs) MIND Mental Health First Aid (MHFA) Kooth online counselling Healthy Schools Awards Gap – no DV School Health Service School investment in Emotional Health and

		Wellbeing from Pupil Premium Funding.
12-16	CNWL Early Intervention Workers MIND MHFA Kooth online counselling Healthy Schools Awards School Health Service	CNWL Early Intervention Workers MIND MHFA Kooth online counselling Healthy Schools Awards School Health Service
16-18	CNWL Early Intervention Workers MIND MHFA Kooth online counselling Adult IAPT Healthy Schools Awards School Health Service	CNWL Early Intervention Workers MIND MHFA Kooth online counselling Adult IAPT Healthy Schools Awards School Health Service
Child Protection Prevention	Early Help - Partners in Practice (social Care systemic working with families)	Early Help -Partners in Practice (social Care systemic working with families)
Looked After Children	LAC Team CNWL (LA commissioned)	Gap – dedicated LAC therapeutic specialist team X1 Clinical Psychologist (LA commissioned) – Focus on Practice / Nick Pembry’s team
Sexual Abuse	NWL CSA Hub	NWL CSA Hub
Children with Disabilities	Gap – therapeutic specialist team	Behaviour Family Support Team (BFST)
Youth Offending Service	CNWL CAMHS Worker	CNWL CAMHS Worker
Transition	NWL Young Minds Project Transition worker – being recruited	NWL Young Minds Project Transition worker – being recruited

Children's Centres/Hubs

Children's Centres in RBKC are a one-stop shop for families living in the boroughs with a child under the age of five. Their aim is to provide families with information, advice, guidance and support to help them be school ready, healthy adults, healthy children, confident parents, and provide skills and opportunities to support them back to work or training.

There are two children's centre hubs in Westminster and one family hub, with plans for the other two to become family hubs. The family hubs provide additional services to children's hubs such as birth registrations on site, housing advice, parenting courses, Child & Adolescent Mental Health Services and are for families with children up to the age of nineteen.

Early Help

Early Help Practitioners use systemic skills to help families identify patterns in how they relate to each other and the problems they are facing and then enables them to take different positions and see other opportunities for action. This process builds new possibilities for change and mobilises the resources within the family to function in a different way, thus reducing or diminishing problematic symptoms (such as poor behaviour, family arguments mental wellbeing, school attendance etc..).

They look at the whole family and work to build on the strengths of that family. They follow a team around the family (TAF) approach so that support is coordinated across a number of agencies and ensure that the voice the child is heard. They provide both support to individual families and also group work in schools. Support available to families includes:

- Parenting Techniques
- Wellbeing support
- Support to increase school attendance
- Support with a child behaviour concern
- Accessing local networks and activities
- Building parent's confidence
- Supporting school transition
- Identifying and supporting young carers

They also offer group work in schools on the above areas to both parents and students as well as topics such as bullying, personal safety and increasing aspirations.

Health Visiting and Family Nurse Partnership (FNP)

Health Visitors are trained and skilled in assessing mental health including the use of assessment tools WHOOLEY and the Edinburgh Postnatal Depression Scale, which are both recommended by NICE. Their role is prevention, early identification of risk and early intervention. The health visiting services have the opportunity to assess maternal mental health at the antenatal contact, the new birth visit and at the 6-8 week visit. These contacts are for all mothers. The 1 year assessment and the two – two-and-a-half year review are key for addressing the development of the child.

FNP is a licensed intensive home visiting service for first time young mothers commencing 16 weeks of pregnancy until child aged two-teenage often have higher rates of poor mental health up to three years post birth. They use perinatal assessment tools and the Ages and Stages Social Emotional questionnaires to assess the parent: child-interaction, attunement, attachment and bonding.

Midwives work closely with both groups to share risk factors.

It is a concern that currently not all mothers and their babies are getting these mandated checks locally and with the potential to miss identifying concerns with maternal or paternal mental health.

Family Hubs with the integration of Health (MWs, HVs, School Health) with Social Care (Social workers, Early Help staff, Children's Centre Staff, housing), 'One Front Door' and 'Tell It Once' - reduce duplication, and may reduce referrals, waiting times and access.

School Health Service

School Health Service work in teams to supervise and lead the delivery of universal and mandated elements of the Healthy Child Programme 5-19 which includes health screening; health needs assessment and the National Child Measurement Programme. In addition, they input into the school health care plans of children with long term conditions and play a key role in safeguarding. The service also incorporates an offer of provision of relationships and sex education. A Registered Mental Health Nurse will provide specialist advice, CAMHS liaison and integrated training based on school needs assessments. School Nurses trained in Tier 1 interventions provide dedicated support for each school and referral to CAMHS.

Healthy Schools and Healthy Early Years

Emotional Health and Wellbeing is one of the four theme areas of the Healthy Schools Awards and Health Early Years Awards. Both programmes support schools and early years settings to put in place:

- Senior leadership team for Emotional Wellbeing and Mental Health.
- Emotional health and wellbeing policy which is reflected in practice and through ethos, culture and the environment and review by consultation at least every three years.
- The curriculum includes emotional wellbeing and mental health including anti-bullying, social and emotional learning and risk. T.
- Playground provision – playgrounds need to be safe, supportive, encourage physical active and include quiet areas
- Pupil voice – the school has mechanisms in place to ensure that the views of all children and young people including those hard to reach are reflected in the school's decision making
- The school provide opportunities for child and young people to build confidence and self-esteem; develop responsibility, independence and resilience and learn how to assess risk and stay safe

- The school has systems to identify and meet the needs of vulnerable children and young people and has arrangements to provide appropriate and relevant support. All children and young people and parent/carers can confidentially, access advice, support and services (within and beyond school)
- The school identifies staff CPD needs for health and wellbeing and provides appropriate training and development opportunities
- The school provide opportunity for parents/carers to access information, support and advice on health and wellbeing

Silver and Gold Awards

All schools or early years setting once they have their Bronze Award are encouraged to work towards a Silver and Gold Award. Whether they choose an explicitly mental health priority or another area, working towards these awards will improve the wellbeing of pupils.

To achieve the Silver the awards the school identifies a health priority for the school by carrying out a needs analysis. They may choose mental health as their priority. They then use this needs analysis to identify at least one universal and one targeted health priority. They then develop planned outcomes and an action plan to achieve these priorities.

To achieve the Gold award they implement their plan over about a year or so and evaluate its impact.

Examples of health priorities in relationship to EWMH:

Secondary School

- Universal: Improve the physical and mental wellbeing of the pupils through an increase in understanding and engagement with physical activity.
- Targeted: Supporting the physical and mental wellbeing of year 11 students in connection with exam stress and body image.

Primary School

1. Universal: To improve resilience, self-regulation and healthy relationships of all pupils across the whole school.
2. Targeted: To improve behaviour for learning and emotional wellbeing in identified group of Year 5 boys

Examples of measurable outcomes include:

- Increase the number of pupils reporting they feel safe in school
- Increase the number of pupils reporting “I know what to do if I feel worried or upset at school”
- Increase the number of pupils reporting the school does enough about bullying
- Increase the number of pupils reporting they are confident to be peer mediators following training

- Increase the number of pupils reporting they know where to access support for their mental wellbeing
- Increase the number of pupils reporting they have strategies in place to deal with exam stress
- Increase the number of pupils reporting they can work well in groups

To support schools working towards the Healthy Schools Awards, there is guidance, advice and training provided by the Health Education Partnership.

Areas for improvement or development

In recent years, Early Intervention Worker capacity has been utilised to deal with perceived capacity challenges within Specialist CAMHS. A shift is needed to an Early Intervention focus out into school.

Behaviour Family Support Team is a highly specialised and resource intensive service commissioned for RBKC residents only. Service could be adapted to incorporate less expensive clinical staff and provider greater coverage for Westminster.

Specialist Community Child and Adolescent Mental Health Services (CAMHS)

The specialist CAMHS contract is part of the adult mental health contract, which is shared with 5 other CCGs. The service is provided by Central and North West London NHS Trust.

Referral to the specialist community CAMHS service can be via the general practitioner (GP) or teacher. A few clinics will also accept self-referrals. Following assessment, the CAMHS service designs a package of care around a child, which links in with the support currently being provided to the family by other agencies and professionals.

Some of the services provided by the community CAMHS are as follows:

Art therapy

Art therapy helps people to express what they are thinking and how they are feeling through the use of art. Art therapy may help you find out more about yourself, which can lead to positive changes. Art therapy is open to all, and does not require being skilled in art.

Child and adolescent psychotherapy

Child and adolescent psychotherapy involves meeting with a specially trained therapist. Seeing a child and adolescent psychotherapist individually can help people to think about their personal difficulties, by exploring how their feelings and thoughts are connected to their relationships and behaviour, and how past experiences can affect their current relationships.

Child psychotherapists work with children and young people on an individual basis, usually in a weekly session, but they also do short-term work with parents or carers and their children together.

Cognitive behavioural therapy (CBT)

CBT is a ‘talking therapy’ that focuses on the links between thoughts, feelings and behaviour. It aims to help the young person to manage your feelings and change any thinking or behaviour patterns which might be unhelpful and/ or making their problems worse.

Family therapy

Family therapy involves working with the CYP and the people who are important to them. The CYP and the people who come with them are encouraged to consider each other’s points of view, experiences and beliefs and find ways to make positive changes that work for everyone involved.

Medication

If CAMHS doctors (psychiatrists) think that you can be helped by medication they will discuss this with you and your parents or carers. They will explain why they think medication could help, any possible side-effects, and your other options.

Eating Disorder’s Service

The specialist Eating Disorders Service though provided by CNWL is contracted for through a separate arrangement.

Crisis and Liaison Service

A CYP 24 hour crisis service is currently being set up. The current arrangement for access to services is via accident and emergency departments.

Performance of Specialist CAMHS

Overall, performance is good for each of the CAMHS providers operating in the bi-borough. This is in accordance with the KPIs agreed with commissioners and reported monthly.

Outcomes – evidencing the difference that makes a difference

CAMHS providers are on the whole achieving their targets for systematic use of clinical outcome measures and reporting the effectiveness of therapeutic interventions.

Table 41: CAMHS Key Performance Indicators

CAMHS KPI measurement for end of year 2017/18	West London	Central London	Target
% of CYPIAPT/ CAMHS Outcome Research Consortium (CORC) measures completed for patients accepted into the service	87.6%	91%	85%

Title

% of appropriate CYPIAPT/ CORC measure completed for patients discharged from the service	81.4%	87.5%	80%
% of young people discharged with CYPIAPT/ CAMHS CORC measure showing improvement between acceptance and discharge	67.5%	72.1%	>60%

Improving access to CAMHS^[2]

In relation to national access targets for NHS consultant led services, both CAMHS services are achieving targets for enabling access within mandatory timescales, and are performing better overall than neighbouring CCG areas in North West London. However, the target is set low at 85% of children and young people seen within 18 weeks. A new access standard of 4 weeks to assessment is anticipated for 19/20 as indicated in the Schools Green Paper.

Table 42: CAMHS: Percentage of CYP seen within 18 weeks

CCG	% CYP seen within 18 weeks	Target
West London	91.9%	85%
Central London	95.1%	85%
NWL Average	88.6%	-

Increasing numbers of children and young people accessing CAMHS

Nationally, CCGs have been set the target of increasing access to support for children and young people to emotional wellbeing mental health services. The ambitious target is to meet 35% of mental health prevalence by 2020/21. The target set for 2018/19 is for each CCG area to support 30% of local prevalence, which is being met successfully by both CCGs in the Bi-borough.

Table 43: Percentage of local prevalence (CYP) accessing CAMHS

CCG	% Access rate (annual) ^[3]	Target
West London	78.1% ^[4]	30%
Central London	31.0%	30%
NWL average	36% ^[5]	30%

Staffing within Specialist CAMHS

During the EWMH review carried out in 2018 by the CAMHS commissioners, CNWL agreed to share staffing numbers and description as well as for the commissioner to meet with service teams to listen to clinicians' assessment of strengths, areas for development^[6].

Table 44: CNWL CAMHS staffing levels in comparison with neighbouring CCGs

CAMHS Service	Total Clinical / Medical	EIW (recommended 25%)	Psychiatry (recommended 15-25%)
Westminster	40.5	36% (inc. CWPs)	20%
RBKC	44	24% (inc. CWPs)	11%

Key points:

- Level of staffing allocated to early intervention in each service is sufficient for an effective primary mental health model in each area of Bi-Borough.
- Level of psychiatry is lower than recommended levels for RBKC. However, there are higher levels of clinical psychology in RBKC capable of some diagnostic work.
- Banding is relatively high for both Westminster and RBKC CAMHS. It is worth reviewing the introduction of lower-banded staff for development as part of a cost effective and sustainable workforce development strategy.

High Level Findings from the Children's Emotional and Mental Wellbeing Report

1. **Early intervention strategy** – to develop an effective Primary Mental Health Worker model with a clear allocated offer for every school and GP Practice in each borough by 1st April 2019. Enhanced development / promotion of guided self-help^[7] online counselling, positive parenting interventions and 0-5 attachment project. Consider PMHW management of Single Point of Access

in each borough. Strategic aim to reduce demand / escalation to Specialist CAMHS by intervening early.

2. **MCP integration and alignment (focus autism and LD)** – consider opportunity for integrated / aligned models to increase quality and achieve efficiencies for families within the context of Managed Care Partnership (MCP) development. The main area of focus to address is pre-diagnostic, diagnostic and post-diagnostic support for CYP with autism. Develop effective **autism strategy** and action plan in each borough (combined with clinician commissioned to deliver **proactive CETRs** for CYP at risk of admission / high need / complex, integration / alignment of CAMHS / Community Paediatrics processes, support for young adults below AMHS threshold).
3. **Behavioural support service** – recommission BFST service to see more clients and value support equitably across RBKC and Westminster. Consider co-locating with special schools or children with disabilities team with Local Authority and behavioural support service with schools. Children with complex / severe physical health needs (including Continuing Health Care patients) require access to a paediatric behaviour specialist, who can carry out assessments for those children and young people with challenging behaviour issues.
4. **Focus productivity assurance** – in recent years, great gains have been made by CAMHS to report on outcomes and improving access in terms of numbers and waiting times. The key focus to sustain these gains is a new focus by commissioners and providers on optimising best use of clinical capacity, which requires significant improvement based on the current data picture.

Early Intervention Psychosis Service (CNWL)

Early Intervention Psychosis Service

Early intervention in psychosis services are multidisciplinary Community Mental Health Teams (see 8.8.5) that assess and treat people with a first episode of psychosis without delay (within 2 weeks). Most patients present between the age of 15 and 25 years. Treating symptoms and preventing symptoms from coming back, helps to reduce the number of people who need to be admitted to hospital.

Referral of the young person to this service can sometimes be delayed due to late recognition by schools and parents that behaviours are outside of what can be explained as “being a difficult teenager”. Referral on from the GP can also be delayed by different clinical judgments by the GP as to what is the best next step due to the potential connotations for the young person of having a diagnosis. Referral can also come via the CAMHS. The main aim of the service is to be welcoming, challenge concerns that the young person and family may

have and get the young person on the way to recovery as soon as possible and return to work/school/university. Support for the parents so that the whole family can support recovery is crucial. Some schools and universities are particularly supportive at re-establishing and supporting students back into education.

Future Challenges

Feedback from the service is that there is still a long journey to be made in the health and social care system to treat those who need treatment but empower those with capacity to manage their own conditions with the support of their family. CNWL's recovery college referred to earlier is one asset to enable this process.

The numbers of young people are coming in to the psychosis service after substance misuse poses a future challenge. Has substance misuse of new drugs become normalised amongst some groups? This is potentially an area for investigation.

Those patients most at risk of poor outcomes are those who do not have intact social networks are at risk of acute loneliness. They need somewhere to go and people to talk to.

Can resident's association and communities be empowered to be more supportive of those living amongst them with a mental health condition?

7.9 Quality and outcomes

Table 45 shows percentage of children referred to Child and Adolescent and Mental Health services (CAMHS) within 18 weeks and to the CAMHS eating disorder service, within 4 weeks. Both services are provided by Central and North West London Foundation Trust (CNWL). The following key points are noted:

- Referrals from West London CCG are less likely to be seen within threshold waiting times than Central London CCG referrals
- From Table 45 eating disorder referral to treatment targets are met more frequently by the eating disorder service

Table 45: monthly waiting times to first treatment, CAMHS, CNWL 2017/18

West London CCG													Av.
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Referrals
CAMHS (18wks)	9.9%	19.2%	23.6%	11.8%	38.6%	26.7%	12.3%	26.0%	36.5%	8.3%	44.0%	10.7%	71
CAMHS Eating Disorders (4wks)			86%			75%	50%	100%	0%	0%	0%	0%	<5

Central London CCG													Av.
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Referrals
CAMHS (18wks)	8%	10%	11%	10%	11%	8%	8%	8%	10%	8%	11%	11%	48
CAMHS Eating Disorders (4wks)			100%			33%	100%	100%	67%	100%	0%	100%	<5

7.10 Service User Views

In 2017/18, the charity Rethink was commissioned by CAMHS commissioners to conduct number of reviews to assess the quality and accessibility of services from the perspective of young people and their parents.

Accessibility report

67% of parents and carers felt that access to appointments needed improvement. Of these 54% (13) responded that the waiting time to be accepted by the service and/or to receive treatment was too long. Many also complained that once inside the service, the time between appointments was too long. 13% specifically thought out-of-hours appointments were needed.

Young people welcomed the possibility to attend via 'drop in' sessions and the possibility to attend sessions in early evening.

63% of users said that the environment and staff made CAMHS offices accessible for them.

"The staff here. I can talk about my feelings. It's a friendly environment" - A young person who took part in the review

Parents and carers were asked 'in your experience, what works well about accessing CAMHS'. 43% said that the staff themselves made the service accessible through their friendly and supportive approach.

"The people we have had contact with have all been amazingly supportive and knowledgeable" - A parent who took part in the review.

Youth Offending Team (YOT) Review:

The review only evaluated the CAMHS delivery service in Westminster YOT, as in RBKC there had not been a CAMHS worker to apply the service model specifically and consistently over the last two years. The report indicated that overall the service is good. 67% of users rated it good, very good or excellent. Both parents/ carers and young people are satisfied with accessibility, time and location of service. The report did however note a need to improve the consistency of the service including coordination between YOT staff and CAMHS staff.

Typical comments given by service users:

"Easy to talk to" – Westminster

"It is good to have a neutral person to talk to" – Westminster

Eating Disorders Service review:

Staff are considered to be compassionate and competent while some points were noted such the environment being unwelcoming, cold and clinical with no waiting room. Another criticism was need for soundproofing of therapeutic spaces required to ensure confidentiality. A prominent concern from the service users was a lack of integration of the dietician and meal plans into the broader scope of their treatment plan.

Out of Hours Service for Under 18s:

Feedback indicated a strong level of support for the service as a highly valuable and important way to meet the mental health needs of young people in times of crisis. However, there was a clear need for the service to improve on its provision of advice/signposting.

There were important differences in the service users and parents/carers experience of dealing with hospital accident and emergency (A&E) staff in contrast with CAMHS staff, with many feeling more listened to and comfortable with CAMHS staff than the former. Particular criticisms of A&E include lack of privacy for support and communication challenges noted with A&E staff. Lastly, long waiting times were repeatedly mentioned by service users and parents as an area for improvement.

Supporting CYP with Disabilities and their Families in Managing Challenging Behaviour

The Behavioural Family Support Team (BFST) seeks to meet the needs of families and children and young people (CYP) with disabilities presenting with challenging behaviour. The service is for children with autism and/or moderate to severe learning disabilities, who have emotional, behavioural or mental health problems and are residents of RBKC.

92% of parents rated the service between seven and ten out of ten, showing high levels of overall satisfaction with respect to their experience, support given and long-term impact. The service was found to be accessible, with most parents being referred in through their social worker or school. Parents also revered the service's specialist knowledge, multi-agency coordination of support and their ability to enhance parents' understanding of diagnoses. For 67% of parents, the service had positively impacted their child's educational placement and 75% felt that the BFST had supported them to cope and manage better as a family, therefore preserving family relationships.

8 Working age adult mental health and wellbeing

8.1 Key Messages

Key messages: Adult mental health and wellbeing

Prevalence

- The estimated prevalence of mental illness in working age adults was taken from the Adult Psychiatric Morbidity Survey (APMS 2014). This survey found common mental disorders to be the most prevalent at 18%. Locally this translates to an estimated 20,529 residents of Kensington and Chelsea and 34,673 residents of Westminster. The most prevalent specified common mental was generalised anxiety disorder, estimated to affect 8.7% of the population.
- Personality disorders were found to be the next most prevalent, affecting an estimated 17.5% of the population
- 20.5% of respondents reported having had suicidal thoughts, while 6.1% had attempted suicide and 6.4% had self-harmed
 - Based on local GP register data, the prevalence of mental illness in both boroughs and depression in Kensington and Chelsea is higher than the London average

Risk factors

- Both boroughs have lower rates of people with a learning disability or long-term health problem or disability compared to the London average
- While the employment rate in both boroughs is below the London average, the long-term unemployment rate is lower than the London average
- Rates of marital break-up and persons living alone are higher than the London average
- Both boroughs have comparable rates of Dementia among GP registered patients to the London average
- Both boroughs are expected to have the same rate of alcohol dependence as the London average, however both boroughs have higher rates of hospital admissions for mental and behavioural disorders due to the use of alcohol
- Kensington and Chelsea has a higher rate of substance misuse among young adults, while Westminster has a lower rate, compared the London average. In addition, the prevalence of opiate and/or crack cocaine use among adults is higher than the London average
 - Both boroughs have higher rates of self-reported high satisfaction and high happiness compared to the London average

Protective factors

- Uptake of physical activity is estimated to be better than the London average in both boroughs, however, social isolation among Adult Social Care service users is indicated to be higher with a lower percentage of clients reporting enough social contact compared to the London average.

What Works

- Meeting the housing needs for at-risk adults is an area that supports mental health outcomes. Housing interventions that result in improved mental health outcomes include re-housing interventions; targeted interventions such as supported housing for high-risk groups (including those with mental disorder); housing support for high-risk families; and interventions that address fuel poverty.
- There is strong evidence that access to green and open spaces directly improves our health and wellbeing.
 - Physical activity is associated with reductions in depression, improved wellbeing (including people with schizophrenia), better cognitive performance in children and better mental health outcomes in older people.
- Positive psychology interventions and mindfulness interventions promote positive thoughts and emotions
- Secure employment, support for unemployed people and work based mental health and stress management interventions
- There is some evidence that neighbourhood enhancement and regeneration, debt advice and financial capability interventions are effective.
 - The Better Mental Health for All (year) report also identifies key interventions
 - See also relevant NICE guidance PH22 and NICE 2009a

8.2 Background

Adulthood is a time of greater independence and control over life, and is a particularly important point in the life course because of the influence adults have on others through their various roles as partner, co-worker, parent and carer.

Many people become parents and the quality of relationships in the home with partners, if present, and children has a very strong influence on parents' mental health.

Family relationships matter to adults as well as children. Being in a stable relationship is more strongly associated with both physical and mental health benefits, including lower morbidity, lower levels of smoking and drinking, and greater life satisfaction than being single. Unhappy relationships are more strongly predictive of mental health problems than not being in a relationship. Not all adults form families and loneliness can be an issue.

Many adults may also be required to take on the role of caring for a spouse or family member who is ill or has a disability. This can have a negative impact on their mental wellbeing, due to feeling increasingly isolated and unsupported.

Experiencing two or more adverse life events in adulthood is associated with mental health problems and for some this can have a cumulative effect following on from adverse life experiences in childhood. Work, or lack of it, matters greatly as well as the quality of the working environment. People in Great Britain who are unemployed are between four and ten times more likely to develop anxiety and depression.

Access to community resources, such as friendship networks, facilities for children, opportunities for exercise, the quality of the environment and social inequity, stigma and discrimination all impact on adult mental health. The neighbourhood environment is an important factor in the health and functioning of adults.

8.3 Prevalence and incidence

Population prevalence

Adult Psychiatric Morbidity Survey (2014)

Table 46 shows the estimated prevalence of mental illness in the working age population are taken from the Adult Psychiatric Morbidity Survey (2014). Estimates are calculated from the **England** age-specific prevalence rates for each illness.

Should the England prevalence of mental illness prevail in the both boroughs and remain constant, and population of each borough grow as projected by the Greater London Authority, the numbers of cases of mental illness shown in Table 46 could be expected.

Table 46. Estimated prevalence of mental illness by borough 2018 to 2028

Illness/ presentation	Borough	2018	2023	2028	Illness/ presentation	Borough	2018	2023	2028
Any CMD	RBKC	20,529	20,837	21,089	Antisocial personality disorder	RBKC	3,577	3,642	3,701
	WCC	34,673	36,192	36,728		WCC	5,690	5,834	5,869
Unspecified CMD	RBKC	9,266	9,412	9,527	Bipolar disorder	RBKC	2,618	2,653	2,689
	WCC	15,686	16,366	16,605		WCC	4,587	4,754	4,804
GAD	RBKC	7,181	7,284	7,370	Borderline personality disorder	RBKC	2,422	2,470	2,535
	WCC	12,042	12,581	12,781		WCC	3,874	3,999	4,074
Depressive episodes	RBKC	4,138	4,198	4,236	Psychotic disorder	RBKC	702	709	713
	WCC	6,853	7,173	7,278		WCC	1,171	1,224	1,234
Phobias	RBKC	3,193	3,235	3,275	Suicide thoughts	RBKC	25,235	25,668	26,033
	WCC	5,471	5,690	5,761		WCC	42,614	44,544	45,321
OCD	RBKC	1,695	1,721	1,745	Suicide attempts	RBKC	8,542	8,673	8,784
	WCC	2,854	2,983	3,035		WCC	14,588	15,204	15,411
Panic disorder	RBKC	595	611	628	Self-harm	RBKC	9,664	9,817	10,000
	WCC	1,023	1,073	1,104		WCC	17,284	17,888	18,110
PTSD	RBKC	5,554	5,644	5,741					
	WCC	9,575	9,972	10,144					

Source: Adult Psychiatric Morbidity Survey (2014). Greater London Authority population projections

Other estimates

Public Health England reports the estimated prevalence of long-term mental health problems and of anxiety and depression (in the community and among social care users).

Table 47 shows that based on these estimates, both boroughs are indicated to have a higher percentage of GP registered patients with long-term mental health problems and depression and anxiety compared to the London average. Table 47 also shows that in Kensington and Chelsea the percentage of care users with depression and anxiety is higher than the London average, while in Westminster the percentage is lower than the London average

Table 47: Further estimates of long-term mental illness and anxiety and depression

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Long-term mental health problems (GP Patient Survey): % of respondents aged 18+	2016/17	5.6%	6.1%	4.8%	5.7%	141	202
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	14.7%	14.2%	12.4%	13.7%	399	500
Depression and anxiety among social care users: % of social care users	2013/14	56.8%	51.6%	54.4%	52.8%	-	-

Source: Public Health England Fingertips (2018)

Recorded prevalence

Table 48 shows the incidence and prevalence of diagnosed cases of mental illnesses based on GP registers in 2016/17 and claimant data from 2016. The following key points are made:

- The recorded incidence of depression in both boroughs is the same as the London average
- The prevalence of severe mental illness in both boroughs and the prevalence of depression in Kensington and Chelsea, are higher than the respective London averages. Rates of depression recorded in Westminster are lower than the London average
- In 2016/17 the number of new cases of depression were 1,700 and 2,400 for Kensington and Chelsea and Westminster respectively.
- In 2016/17 the number of adults registered with a Serious Mental Illness were 3,000 and 3,600 for Kensington and Chelsea and Westminster respectively
- Over 10,000 residents in each borough are recorded on GP registers as having depression
- In both boroughs the rate of Employment Support Allowance (ESA) for mental and behavioural disorders is above the London average.
- Rates of hospital admission for self-harm in young adults are below the London average in both boroughs. There is no comparison of adult admission rates to the London average, however rates in both boroughs are below the England average

Table 48: GP recorded incidence and prevalence of mental illnesses 2016/17 by borough

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Depression incidence (QOF): % of patients 18+	2016/17	1.1%	1.1%	1.1%	1.5%	1,736	2,393
Depression recorded prevalence (QOF): % of practice register aged 18+	2016/17	8.2%	5.4%	6.6%	9.1%	13,569	11,810
SMI (QOF): % of patients all ages	2016/17	1.5%	1.4%	1.1%	0.9%	2,937	3,609
ESA claimants for mental and behavioural disorders per 1,000 working age	2016	26.8	28.1	23.0	27.5	2,930	4,930
Hospital Admissions for Self-Harm: DSR	2016/17	59.2	67.1	-	185.3	93	164
Hospital admissions: self harm/ 100,000 15-19	2016/17	-	224.5	305.2	619.9	-	26
Hospital admissions: self harm/ 100,000 20-24	2016/17	75.4	57.2	188.6	393.2	7	10

Source: Public Health England Fingertips (2018)

8.4 Risk factors

As we grow into adulthood we start to experience additional challenges to our mental wellbeing. We may experience the loss of loved ones, job or housing insecurity, financial worries and the stresses of everyday life. Building close relationships with friends, family and our communities is incredibly important as is looking after our workplace health.

Table 49 shows comparative data on risk factors for mental illness taken from the Public Health England fingertips profiles for each borough. The first indicator is reported for Clinical Commissioning Group (CCG) registered patients. CCG boundaries map to the Bi-Borough as follows:

- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen’s Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen’s Park Paddington

The following key points are identified:

- Both boroughs have lower rates of people with a learning disability or long-term health problem or disability compared to the London average
- The long-term unemployment rate in both boroughs is also lower than the London average
- Rates of marital break-up and persons living alone are higher than the London average
- Both boroughs have comparable rates of Dementia among GP registered patients to the London average
- Both boroughs are expected to have the same rate of alcohol dependence as the London average, however both boroughs have higher rates of hospital admissions for mental and behavioural disorders due to the use of alcohol
- Kensington and Chelsea has a higher rate of substance misuse among young adults, while Westminster has a lower rate, compared the London average. In addition, the prevalence of opiate and/or crack cocaine use among adults is higher than the London average

- 39.5% of Kensington and Chelsea residents and 27.7% of Westminster residents in touch with specialist alcohol services are also in contact with mental health services (London, 28.1%)
- 24.4% of Kensington and Chelsea residents and 28.9% of Westminster residents in touch with specialist drug services are also in contact with mental health services (London, 28.5%)

Table 49 Risk factors for mental illness. Comparative data

Indicator	Period	Rate				Count	
		WLCCG	CLCCG	London	England	RBKC	WCC
Learning disability QOF prevalence: % of people on GP practice registers	2016/17	0.30%	0.20%	0.40%	0.50%	637	451

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
GP patient survey: % Long-term health problem	2011	13.1%	13.8%	14.2%	17.6%	28,803	21,645
Long-term unemployment: rate per 1,000 working age population	2016	3.4	3.7	4.1	3.7	371	650
Marital breakup: % of adults	2011	11.4%	11.4%	10.6%	11.6%	15,248	21,208
People living alone: % of residents in households occupied by a single person	2011	23.4%	22.5%	12.8%	12.8%	36,524	47,893
Adults with dementia known to GPs: % patients	2016/17	0.5%	0.5%	0.5%	0.8%	1,051	1,364
Estimated percentage of adults with alcohol dependence	2014/15	1.4%	1.4%	1.4%	1.4%	1,738	2,728
Admission to hospital for mental and behavioural disorders due to alcohol/ 100,000 pop.	2016/17	59.8	60.4	55.8	72.3	93	136
Young people hospital admissions due to substance misuse: rate per 100,000 aged 15 - 24	Young people 14/15 - 16/17	73.2	51.2	67.2	89.8	36	45
No. in treatment at specialist services	Alcohol	273	505	11,440	80,454	273	505
Contact with mental health & specialist services: % in treatment 18+	Alcohol	39.5%	27.7%	28.1%	22.7%	75	88
Estimated prevalence of opiate and/or crack cocaine use/ 1,000 15-64	2014/15	11.3	13.2	8.9	8.6	1,250	2,249
No. in treatment at specialist services	Drug	779	964	30,200	199,339	779	964
Contact mental health & specialist services % in treatment 18+	Drug	24.4%	28.9%	28.50%	24.3%	76	118

Source: Public Health England Fingertips (2018)

8.5 Protective factors

The most powerful childhood predictor of adult life satisfaction is a child’s emotional health. The most modifiable and important risk factors for mental health problems and the most important determinants of mental wellbeing lie in the family, the environment, the community and the society into which a child is born and raised.

While unemployment is a key risk factor, having stable and secure long term employment can provide feelings of self-worth and efficacy.

Table 50 summarises the available comparative data on protective factors. The following key points are made:

- While Table 49 shows rates of long-term unemployment are lower than the London average, employment rates are lower in both boroughs compared to the London average
- Both boroughs have higher rates of self-reported high satisfaction and high happiness compared to the London average
- In both boroughs a higher percentage residents are estimated to be getting enough exercise compared to the London average
 - sports club membership is also estimated to be higher than the national average in both boroughs
- The estimated percentage of Adult Social Care service users with enough social contact is lower than the London average in both boroughs

Table 50 Comparative data on protective factors, comparison to London

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Employment: % of population aged 16-64	2016/17	64.5%	68.0%	73.8%	74.4%	69,900	116,800
Self-reported well-being - high satisfaction score: %	2015/16	83.9%	81.2%	79.6%	81.2%	-	-
Self-reported well-being - high happiness: %	2015/16	77.2%	76.3%	74.3%	74.7%	-	-
Enough physical activity: % of population age 19+	2016/17	68.2%	66.7%	64.6%	66.0%	-	-
Sports club membership: % of population aged 16+	2015/16	30.9%	27.7%	-	22.0%	-	-
Enough social contact ASC users: % ASC users	2016/17	36.2%	36.2%	41.0%	45.4%	-	-

Public Health England Fingertips (2018)

8.6 What works

For adults, there are a number of interventions that are shown to promote mental wellbeing. Meeting the housing needs for at-risk adults is an area that supports mental health outcomes. Housing interventions that result in improved mental health outcomes include:

- Re-housing interventions (Thomson et al., 2009);
- Targeted interventions such as supported housing for high-risk groups, including those with mental disorder (Nelson, Aubrey & Lafrance, 2007);
- Housing support for high-risk families (family intervention projects) associated with reduced eviction rates and improved neighbourhood (National Centre for Social Research, 2010); and
- Interventions that address fuel poverty and ensure adequate heating are associated with improved mental health (Thomson et al., 2009).

There is some evidence that indicates that neighbourhood enhancement and regeneration results in improved mental health. The evidence mainly relates to physical activity with 'walkable neighbourhood' schemes that increase rates of physical activity and provide more opportunities for social interaction (Killoran et al., 2006).

There is strong evidence that access to green and open spaces directly improves our health and wellbeing. Green spaces are associated with a raft of health benefits such as

- improved mental health and wellbeing
- improved cognitive function and stress reduction
- increased self-esteem and improved sleep quality

Physical activity is associated with reductions in depression (NICE, 2009a), improved wellbeing (including people with schizophrenia) (Holley et al., 2011) better cognitive performance in children and better mental health outcomes in older people (NICE, 2008b). Active leisure programmes are associated with improved mental wellbeing. Active travel can be facilitated by a range of interventions including family/school-based active travel promotion schemes, active travel infrastructure (NICE, 2009a).

There is some evidence that debt advice results in improved mental health (Pleasant & Balmer, 2007). Improved financial capability results in improved mental health as well as reduced anxiety and depression (Taylor, Jenkins & Sacker, 2009).

In addition, positive psychology interventions promote positive thoughts and emotions (Sin & Lyumbomirsky, 2009). Mindfulness interventions have been shown to contribute to positive mood, improved quality of life, self-esteem, empathy, optimism, meaning, reduced anxiety and depressive symptoms (Chiesa & Serretti, 2009).

As employment is one of the key risk factors for mental health and wellbeing among adults, secure employment can provide feelings of self-worth and efficacy:

- Work-based mental health promotion results have been shown to deliver increased performance at work and reduced sickness rates as well as reduced anxiety and depression (Kuoppala, Lamminpaa & Husman, 2008);
- Work-based stress management interventions have been shown to deliver reduced work-related stress/sickness absence (Richardson & Rothstein, 2008); and
- Support for unemployed people results in increased employment and reduced distress (Audhoe et al., 2010).

The *Better Mental Health for All* report (2016) points to the following interventions:

- Provide mental health literacy training to frontline housing and advice workers can help individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes
- Use social media and other avenues to disseminate public mental health messages such as those promoted in the 5 Ways to Wellbeing
- Mindfulness has a rapidly expanding evidence base and is increasingly popular in both people with mental health problems and risk factors and in general populations
- Promote body work that both exercises and stills the mind like Yoga and Tai Chi, which are increasingly popular and have a small evidence base to support their effectiveness
- Promote walking and exercise on prescription schemes, books on prescription schemes, social prescribing and wellbeing pledge programmes in primary care
- Promote the use of volunteering, as a way of linking local people who share their time and skills, and enabling them to live well, improve their health and wellbeing, and link them to their community.
- Increasing people's capacity to use psychological treatment methods (such as CBT) can prevent the development of mental health problems, particularly if used during periods of transition and pressure, such as redundancy, after birth or after a bereavement.
- Provide bereavement counselling and relationship support
- Support unemployed working age adults into high quality work and ensure those who are unable to work have access to a reasonable standard of

resources and are supported to lead fulfilling lives, moving towards employment as appropriate

- Increase mental health literacy, especially for people with limited financial and social resources, including older people, people with long term health conditions, refugees, people from Black and Minority Ethnic communities and people living with disabilities.
- People living with serious mental health problems will benefit from regular general physical health assessments and from signposting to information and support that addresses diet, alcohol consumption, exercise, drug misuse and sleep
- Other important interventions include public health intervention that might otherwise be overlooked such as access to smoking cessation, free dental and optical examinations, and flu vaccinations
- Services, facilities and resources should be inspected to ensure they are accessible. This can be done by assessing in collaboration with the local community and making any necessary adjustments.
- Ensure service navigators are available to people with complex needs and advocate for them to have peer experience and be skilled in negotiating the access barriers experienced by minority groups
- Develop trauma informed care, particularly for those who have witnessed or experienced violence, abuse and/or severe neglect either in childhood or adulthood

What NICE says...

NICE guidelines (PH22) outline responsibilities around workplace mental health:

- Adopt an organisation-wide approach to promoting the mental wellbeing of all employees, working in partnership with them. This approach should integrate the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions.
- Ensure that the approach takes account of the nature of the work, the workforce and the characteristics of the organisation.
- Promote a culture of participation, equality and fairness that is based on open communication and inclusion.
- Create an awareness and understanding of mental wellbeing and reduce the potential for discrimination and stigma related to mental health problems.
- Ensure processes for job design, selection, recruitment, training, development and appraisal promote mental wellbeing and reduce the

potential for stigma and discrimination. Employees should have the necessary skills and support to meet the demands of a job that is worthwhile and offers opportunities for development and progression. Employees should be fully supported throughout organisational change and situations of uncertainty.

- Ensure that groups of employees who might be exposed to stress but might be less likely to be included in the various approaches for promoting mental wellbeing have the equity of opportunity to participate. These groups include part-time workers, shift workers and migrant workers.
- Adopt a structured approach to assessing opportunities for promoting employees' mental wellbeing and managing risks.
- Different approaches may be needed by micro, small and medium-sized businesses and organisations for promoting mental wellbeing and managing risks. Smaller businesses and organisations may need to access the support provided by organisations such as the Federation of Small Business and Chambers of Commerce.

Social prescribing: the evidence

Social prescribing has been a key focus of recent strategy and policy to improve wellbeing. Theresa May recently announced plans for social prescribing to be in place by 2023 when announcing the Government's first loneliness strategy.

Social prescribing is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

Social prescribing is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focussed on improving mental health and physical well-being. Those who could benefit from social prescribing schemes include people with mild or long-term mental health problems, vulnerable groups, people who are socially isolated, and those who frequently attend either primary or secondary health care.

Evaluation of the impact of social prescribing has proved challenging, as much of the data collected for evaluation is subjective feedback from service users and is difficult to quantify and to analyse. Consequently, results are often inconsistent and difficult to compare between different projects.

However, evidence to support the value of social prescribing can be collated by looking at examples of successful schemes where it has been used to improve patient care. Evaluation of a social prescribing pilot scheme in Rotherham (Voluntary Action Rotherham) has shown impact in various different areas:

- reduction in demand for urgent hospital care (reduction in A&E attendances in those under 80y by 23%)
- improvement in well-being for patients with long-term health conditions (82% of service users experience positive change after 3-4 months of social prescribing)
- estimated economic benefits, a return on investment of £1.98 for each £1 invested, based on NHS costs avoided due to reduction in demand for urgent hospital care

A further report on Social Prescribing in Bristol assessed the Social Return on Investment (SROI), reporting a ratio of £2.90 for every £1 spent.

Social prescribing can benefit a wide section of the population: vulnerable and at-risk groups; lonely, isolated, excluded groups; people with mild to moderate depression/anxiety; frequent attenders in Primary Care.

Many of the perceived benefits around social prescribing are related to improvement in mental health outcomes. Research by the Mental Health Foundation in 2005 found that 78% of GPs had prescribed an antidepressant in the previous 3 years, despite believing that an alternative treatment might have been appropriate, with 60% of GPs saying that they would prescribe antidepressants less frequently if other options were available.

As such, the use of guided self-help and support groups is now suggested in NICE guidelines for management of depression, either in parallel with, or as an alternative to antidepressants. Many of these projects have a focus on Mental Health conditions, with some studies showing 'improvements in anxiety levels and in feelings about general health and quality of life', and another study showing statistically significant improvements in PHQ9 scores for depression, GAD7 scores for anxiety, the Friendship Scale, ONS Wellbeing measures and IPAQ items for moderate exercise, only 3 months after taking part in a social prescribing project. Social prescribing can help increase recovery from mental illness, help patient manage their condition and help social inclusion of people with mental health problems.

In particular, 'green activity', or 'ecotherapy' – improving health and wellbeing through contact with nature – has been shown to have many benefits, including improved self-esteem, positive mood and self-efficacy, as well as reduction in physical and mental health symptoms and improvement in quality of life. The charity, Mind, has produced a leaflet on ecotherapy, to educate potential users about the benefits of this, which include increased activity, social contact and sense of wellbeing.

8.7 Service Activity

Treatment services

This section summarises comparative data on adult mental health services from published by Public Health England. Indicators data relate to Clinical Commissioning Group (CCG) registered patients. CCG boundaries map to the Bi-Borough as follows:

- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen's Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen's Park Paddington

General Practice

Table 51 summarises comparative data on General Practitioner (GP) services. The following key points are made:

- Rates of prescribing for psychosis are lower than the London average in WLCCG, while in CLCCG rates are higher
- Both CCGs have lower rates of patients receiving '1st choice' antidepressants
- Of patients diagnosed with depression a higher percentage of patients for WLCCG received bio psychosocial assessment compared to the London average, while in CLCCG the percentage is lower
- Both CCGs have a higher percentage of patients with a Long Term Condition (LTC) who agree they receive enough support from local services compared to the London average
- Both CCGs have a lower percentage of patients on lithium therapy within a therapeutic range within the past 4 months, and a lower percentage of patients on lithium therapy with a record of serum creatinine, compared to the London average
- Both CCGs have a lower percentage of patients with diagnosed depression review within 10-56 days of diagnosis compared to the London average
- Both CCGs have lower than London average percentages of patients with a Serious Mental Illness (SMI) with a comprehensive care plan and/or have had a blood pressure, an alcohol consumption check or cervical screen

Table 51 General practice comparative indicators

	Period	Rate				Count	
		WLCCG	CLCCG	London	England	WLCCG	CLCCG
GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1,000 population	2017/18 Q4	47.2	54.7	53.9	62.4	9,628	10,332
Primary care prescribing of '1st choice' antidepressants: % of prescription items	2016/17	66.5%	63.9%	69.0%	68.7%	70,950	68,799
Assessment of depression: % of adults with a new diagnosis of depression who had a bio-psychosocial assessment on diagnosis	2013/14	76.1%	71.9%	72.5%	75.8%	1,575	796
% of people with long-term conditions visiting GP who feel they have had enough support from local services in last 6 months	2015/16	58.8%	62.0%	57.6%	63.1%	813	700
Patients on lithium therapy with levels in therapeutic range: % within preceding 4 months	2016/17	73.5%	77.5%	78.3%	83.0%	164	107
Patients on lithium therapy with record of serum creatinine and TSH: % with record in the preceding 9 months	2016/17	85.7%	90.6%	92.9%	94.5%	191	125
Review of depression: % of newly diagnosed patients with depression who had a review 10-56 days after diagnosis	2016/17	54.6%	55.0%	63.2%	64.4%	1,224	1,087
People with SMI who have comprehensive care plan: % of people with SMI	2016/17	81.4%	79.3%	83.0%	79.0%	2,533	1,874
Patients with SMI with blood pressure check: % with record in preceding 12 months	2016/17	82.2%	81.9%	84.0%	82.2%	2,557	1,936
Patients with SMI with alcohol consumption check: % with record in preceding 12 months	2016/17	84.5%	83.9%	85.2%	81.4%	2,629	1,983
Female patients with SMI who had cervical screening test: % tested in preceding 5 years	2016/17	68.1%	65.5%	68.9%	70.0%	711	490

Source: Public Health England Fingertips (2018)

Improving Access to Psychological Therapies (IAPT)

IAPT services provide evidence-Based treatments for people with anxiety and depression.

Table 52 provides a summary of IAPT service performance indicators. The data presented relate to Clinical Commissioning Group (CCG) registered patients. CCG boundaries map to the bi-borough as follows:

- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen's Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen's Park Paddington

From Table 52 the following key points are made:

- IAPT referral rates and the percentage of referrals that are from BME patients are higher than the London average
- Treatment rates are also higher than the London average in West London CCG, however lower than the London average in Central London CCG
- Average waiting times for first treatment for West London CCG patients are 13.4 days – shorter than the England average, 17.5 days, while average waiting times are 20.7 days for Central London CCG patients – longer than the England average.
- Both CCGs have higher percentages of patients (that have completed treatment) that have been seen for first treatment within 6 weeks and within 18 weeks respectively. This is also true for 'in month referrals' seen in within 6 weeks in West London CCG and seen within 18 weeks in Central London CCG.
 - By contrast, Central London CCG has a lower percentage of 'in month' referrals waiting less than 6 weeks for first treatment and West

London CCG has a lower percentage of 'in month' referrals waiting less than 18 weeks for first treatment

- Of referrals, a higher percentage of referrals from West London CCG are estimated to have anxiety or depression compared to the London average, while Central CCG referrals have a lower percentage for these illnesses
- The treatment completion rate is higher than the London average for patients of West London CCG, while the completion rate is lower than the London average for Central London CCG patients
- In both CCGs, average treatment durations are above the England average (6.9 attended appointments), 7.5 and 8.2 attended appointments respectively. However maximum durations of treatment are below the England average (89 attended appointments), 21 and 30 attended appointments respectively.
- 53% of patients from West London CCG and 61% of patients from CL CCG are 'moving towards recovery' at the completion of treatment, compared to the London average is 53.4%
- Both CCGs have higher rates of patients completing treatment compared to the London average, 72%, who have achieved 'reliable improvement, 78% and 79.7% for West London CCG and Central London CCG respectively
- Did not attend (DNA) rates in West London CCG are lower than the London average 8.2% vs. 8.6%, while rates are above the London average for Central London CCG patients at 9.4%

Table 52 IAPT comparative data

	Period	Rate				Count	
		WLCCG	CLCCG	London	England	WLCCG	CLCCG
IAPT referrals: rate (quarterly) per 100,000 population aged 18+	2017/18 Q4	1,161	944	868	871	2,135	1,395
Entering IAPT treatment: rate (quarterly) per 100,000 population aged 18+	2017/18 Q4	819	589	625	606	1,505	870
IAPT referrals for BME patients: % of referrals (in quarter)	2017/18 Q4	66.6%	65.8%	53.5%	18.3%	1,105	665
Waiting < 6 weeks for IAPT treatment (standard measure): % of referrals that have finished course of treatment waiting <6 weeks for first treatment	Mar-18	94.0%	95.0%	90.9%	89.2%	240	150
Waiting < 6 weeks to enter IAPT treatment (supporting measure): % of referrals (in month) waiting <6 weeks for first treatment	Mar-18	96.1%	93.3%	94.9%	91.3%	490	280
Waiting < 18 weeks to enter IAPT treatment (supporting measure): % of referrals (in month) waiting <18 weeks for first treatment	Mar-18	99.0%	100.0%	99.3%	99.3%	505	300
Waiting < 18 weeks for IAPT treatment (standard measure): % of referrals that have finished course of treatment waiting <18 weeks for first treatment	Mar-18	100.0%	100.0%	98.3%	98.7%	255	155
Average wait to enter IAPT treatment: mean wait for first treatment (days)	Mar-18	13.4	20.7	-	17.5	13	21
Access to IAPT services: people entering IAPT (in month) as % of those estimated to have anxiety/depression	Mar-18	17.3%	12.4%	17.1%	17.2%	510	300
IAPT paired data completeness: % of completed treatments (in month) with paired PHQ9 and ADSM scores	Mar-18	100.0%	100.0%	99.6%	99.0%	255	155
Completion of IAPT treatment: rate (quarterly) per 100,000 population aged 18+	2017/18 Q4	367	284	286	320	675	420
Average IAPT treatment dosage: mean number of attended treatment appointments for those referrals finishing course of treatment (in month)	Mar-18	7.5	8.2	-	6.9	8	8
Maximum IAPT treatment dosage: maximum number of attended treatment appointments for those referrals finishing course of treatment (in month)	Mar-18	21	30	-	89	21	30
IAPT recovery: % of people (in month) who have completed IAPT treatment who are "moving to recovery"	Mar-18	53.0%	61.0%	53.4%	52.5%	125	85
IAPT reliable improvement: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement"	2017/18 Q4	78.0%	79.7%	72.0%	71.6%	460	295
IAPT DNAs: % of IAPT appointments (in month)	Mar-18	8.2%	9.4%	8.9%	10.3%	270	185
IAPT ethnic group coding completeness: % of referrals (in quarter) with a valid ethnic group code	2017/18 Q4	77.8%	72.4%	84.3%	85.6%	1,660	1,010

Source: Public Health England Fingertips (2018)

Care Programme Approach (CPA)

Table 53 summarises comparative data mental health services users with CPA. The following key points are made:

- The percentage of mental health service users with a CPA is higher than the London average in WLCCG, but lower in CLCCG
- Both CCGs have a higher than London average percentage of people on a CPA in appropriate housing and with a HoNOS assessment
- Of people on a CPA for more than 12 months, WLCCG has a higher than London average percentage who have had a review, while in CLCCG the percentage is lower
- Both CCGs have a higher than London average percentage of people with a CPA followed up after discharge
- Both CCGs have a lower than London average percentage of people with a crisis plan in contact with mental health services

Table 53 CPA comparative data

	Period	Rate				Count	
		WLCCG	CLCCG	London	England	WLCCG	CLCCG
People on Care Programme Approach (CPA): rate per 100,000 population aged 18+ (end of quarter snapshot)	2017/18 Q4	549	409	396	375	1,010	605
Mental health service users on CPA: % of mental health service users (end of quarter snapshot)	2017/18 Q4	25.7%	18.4%	19.9%	16.1%	1,010	605
Stable and appropriate accommodation: % of people on CPA (aged 18-69) (end of quarter snapshot)	2017/18 Q4	85.9%	80.2%	63.1%	58.8%	790	445
CPA users with HoNOS assessment: % of people on CPA with HoNOS recorded (end of quarter snapshot)	2017/18 Q4	90.1%	89.2%	83.7%	67.6%	2,780	1,645
CPA review: % of people on CPA for more than 12 months who have had a review (end of quarter snapshot)	2017/18 Q4	95.2%	92.8%	94.5%	77.8%	795	450
Follow up after discharge: % (quarterly) of patients on CPA	2017/18 Q4	100.0%	98.10%	94.60%	95.50%	73	51
Service users with crisis plans: % of people in contact with mental health services (end of quarter snapshot)	2017/18 Q4	3.5%	2.8%	7.0%	11.3%	500	325

Source: Public Health England Fingertips (2018)

Patient flow

Table 54 summarises comparative data on the patient flows. The following key points are made:

- Both CCGs have a higher than England average percentage of mental health patients waiting less than 28 days between 1st and 2nd treatments, however waiting times are shorter than the England average
- Both CCGs have higher rates of delayed discharges compared to the London average
- Both boroughs have a lower percentage of mental health service users in hospital compared to the London average

Table 54 Patient flow comparative data

Indicator	Period	Rate				Count	
		WLCCG	CLCCG	London	England	WLCCG	CLCCG
Percentage waiting < 28 days between 1st & 2nd treatment (annual)	2015/16	34.4%	41.6%	-	35.6%	1,965	2,000
Average waiting time between 1st & 2nd treatment (annual)	2015/16	28.0	24.4	-	31.6	-	-
Delayed discharges: days of delayed discharges in the quarter: rate per 1,000 bed days	2017/18 Q4	54.5	61.0	51.6	35.8	675	610
Service users in hospital: % of mental health service users (end of quarter snapshot)	2017/18 Q4	1.3%	1.5%	2.6%	2.0%	50	50

Source: Public Health England Fingertips (2018)

Local data

This section presents the findings of analysis of local health and care service data

GP prescribing

Data on the number of adults prescribed antidepressants is not available, only the number of items (packs of medication).

Chart 19 shows that the crude rate of antidepressant items prescribed to adults aged 20 to 64 years per 1,000 population.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

From Chart 19 it can be seen that antidepressant prescribing rates are typically higher in Kensington and Chelsea compared to Westminster. The chart also shows rates in both boroughs and has been increasing slightly over the past three financial years.

Chart 19 Antidepressant prescribing, items per 1,000 adults aged 20 to 64 years



Source: NHS North West London Medicines Management

Table 55 shows annual numbers of items prescribed per financial year and crude rates per 1,000 GP registered population to enable comparison.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

From Table 55 in 2017/18 almost 90,000 antidepressant items were prescribed to working age adults in Kensington and Chelsea and almost 112,000 items in Westminster.

Table 55 Antidepressant prescribing items and rate per 1,000 population aged 20-64 years

Metric	Borough	2015/16	2016/17	2017/18
Items/ 1,000 population	Kensington & Chelsea (WLCCG excl. QPP)	550	615	612
	Westminster (CLCCG + QPP)	546	586	583
Items	Kensington & Chelsea (WLCCG excl. QPP)	81,915	87,256	89,540
	Westminster (CLCCG + QPP)	96,656	106,284	111,847

Source: NHS North West London Medicines Management

Specialist mental health services

This section describes the finding from analysis of activity data provided by Central and North West London Foundation Trust (CNWL). In interpreting these findings it should be considered that while CNWL is the largest provider of mental health care services, there are other mental health services. Therefore, the numbers presented are likely to be an underestimate of current demand for treatment services.

Referrals

Chart 20 shows referrals to Central and North West London Foundation Trust’s (CNWL’s) Adult Mental Health Services by Clinical Commissioning Group (CCG).

CCG boundaries map to the Bi-Borough as follows:

- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen’s Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen’s Park Paddington

In interpreting referrals data it should be noted that of referrals, not all are accepted (see Table 59 below) and of those accepted not all referrals lead to a positive diagnosis and treatment.

Chart 20 shows the trend in referrals from all sources. Table 56 and 57 show annual numbers by referral source for Central London CCG and West London CCG respectively. These show referral volumes by source in rank order and indicate where annual numbers have increased (dark blue) or decreased (light blue) year on year.

Tables 60 and 61 list the reasons for referral in rank order. Year on year changes are highlighted as increase (dark blue) or decrease (light blue).

Chart 20 Adults: Referrals to CNWL, all sources of referral, monthly trend



Source: CNWL contract monitoring data

From Tables 56 and 57 the following key points are made:

- the most common referral route into Adult services is from A&E in both boroughs. GP is the next most common source of referral from WLCCG, while in CLCCG GP is fourth, following 'other service or agency' and other primary health care.
- For most referral routes 2017/18 volumes have been higher than 2016/17 in both CCGs
- Continual year-on-year increases in volumes have been seen in referrals from A&E departments, other primary health care and Court Liaison Diversion Service in both CCGs and from WLCCG from carers, other independent mental health providers and the probation service
- Numbers of referrals from carers and 'out of areas agencies' in CLCCG and 'other secondary care specialities', 'other service or agency' and 'Permanent transfers from another Mental Health Trust' in WLCCG have been continually declining

Table 56 Adults: Source of referral and year on year change in volumes CLCCG
NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

Source of referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
Accident And Emergency Department	895	1027	1296	3218	29%	115%	126%
Other service or agency	639	578	470	1687	15%	90%	81%
Other Primary Health Care	430	530	581	1541	14%	123%	110%
GP	605	330	443	1378	12%	55%	134%
Police	395	473	412	1280	11%	120%	87%
Other secondary care speciality	425	468	353	1246	11%	110%	75%
Self	183	93	104	380	3%	51%	112%
Social Services	84	12	16	112	1%	14%	133%
Court Liaison and Diversion Service	7	29	68	104	1%	414%	234%
Carer	27	24	17	68	1%	89%	71%
Courts	17	26	17	60	1%	153%	65%
Out of Area Agency	27	19	10	56	0%	70%	53%
Other Independent Sector Mental Health Services	16	21	18	55	0%	131%	86%
Permanent transfer from another Mental Health NHS Trust	8	16	9	33	0%	200%	56%
Temporary transfer from another Mental Health NHS Trust	6	13	<5	19	0%	217%	-
NHS Direct	11	<5	7	18	0%	-	-
Drug Action Team / Drug Misuse Agency	10	<5	<5	10	0%	-	-
Health Visitor	<5	<5	8	8	0%	-	-
Prison	8	<5	<5	8	0%	-	-
Voluntary Sector	6	<5	<5	6	0%	-	-
Asylum Services	<5	<5	0	0	0%	-	-
Community-based Paediatrics	<5	<5	<5	0	0%	-	-
Education Service	<5	0	<5	0	0%	-	-
Employer	<5	<5	<5	0	0%	-	-
Improving Access to Psychological therapies Service	0	0	0	0	0%	-	-
Independent Sector - Low Secure Inpatients	<5	<5	<5	0	0%	-	-
Independent sector - Medium Secure Inpatients	<5	<5	<5	0	0%	-	-
Probation Service	<5	<5	<5	0	0%	-	-
School Nurse	<5	<5	0	0	0%	-	-

Source: CNWL contract monitoring data

Table 57 Adults: Source of referral and year on year change in volumes WLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

Source of referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17 to	16/17 to 17/18
Accident And Emergency Department	1691	1721	2129	5541	36%	102%	124%
GP	1113	885	943	2941	19%	80%	107%
Other secondary care specialty	719	636	580	1935	12%	88%	91%
Other service or agency	665	606	545	1816	12%	91%	90%
Police	315	249	303	867	6%	79%	122%
Other Primary Health Care	154	215	256	625	4%	140%	119%
Self	196	169	213	578	4%	86%	126%
Social Services	323	27	39	389	3%	8%	144%
Court Liaison and Diversion Service	17	72	124	213	1%	424%	172%
Courts	80	43	77	200	1%	54%	179%
Out of Area Agency	25	33	33	91	1%	132%	100%
Carer	20	24	28	72	0%	120%	117%
Other Independent Sector Mental Health Services	11	26	27	64	0%	236%	104%
Permanent transfer from another Mental Health NHS Trust	24	19	10	53	0%	79%	53%
NHS Direct	13	7	15	35	0%	54%	214%
Prison	8	13	9	30	0%	163%	69%
Temporary transfer from another Mental Health NHS Trust	17	13	<5	30	0%	76%	-
Health Visitor	5	7	12	24	0%	140%	171%
Probation Service	8	10	6	24	0%	125%	60%
Drug Action Team / Drug Misuse Agency	5	7	5	17	0%	140%	71%
Asylum Services	<5	<5	0	0	0%	-	-
Community-based Paediatrics	<5	<5	<5	0	0%	-	-
Education Service	<5	0	<5	0	0%	-	-
Employer	<5	<5	<5	0	0%	-	-
Improving Access to Psychological therapies Service	0	0	0	0	0%	-	-
Independent Sector - Low Secure Inpatients	<5	<5	<5	0	0%	-	-
Independent sector - Medium Secure Inpatients	<5	<5	<5	0	0%	-	-
School Nurse	<5	<5	0	0	0%	-	-
Voluntary Sector	<5	<5	<5	0	0%	-	-

Source: CNWL contract monitoring data

Referral type

From Table 58, almost of half of referrals to adult mental health services are routine in nature for both CCGs, the remaining half is split almost equally between urgent or emergency referrals. In 2017/18 there were 2,786 urgent or emergency referrals from WLCCG and 1,826 from CLCCG.

Table 58 Adults: Type of referral by CCG

WLCCG (Kensington and Chelsea +QPP)

CLCCG (Westminster Excl. QPP)

Referral type	Referrals			referrals		
	15/16	16/17	17/18	15/16	16/17	17/18
Emergency	1363	1364	1584	25%	28%	30%
Routine	2435	2123	2508	45%	44%	47%
Routine Plus	226	237	71	4%	5%	1%
Urgent	1395	1071	1202	26%	22%	22%

Referral type	Referrals			referrals		
	15/16	16/17	17/18	15/16	16/17	17/18
Emergency	793	788	831	21%	21%	22%
Routine	1939	1823	1909	51%	50%	50%
Routine Plus	238	127	114	6%	3%	3%
Urgent	843	939	995	22%	26%	26%

Source: CNWL contract monitoring data

Accepted

Of referrals, table 59 show that the percentage of referrals that are accepted has increased between 2015/16 and 2017/18 in both CCGs. In 2017/18 the percentage of referrals to adult services accepted was 77% for WLCCG registered patients and 81% for CLCCG registered patients.

Table 59 Adults: Referrals accepted by CCG

WLCCG (Kensington and Chelsea +QPP)							CLCCG (Westminster Excl. QPP)						
Decision	Referrals			referrals			Decision	Referrals			referrals		
	15/16	16/17	17/18	15/16	16/17	17/18		15/16	16/17	17/18	15/16	16/17	17/18
Accepted	3736	3689	4114	69%	77%	77%	Accepted	2850	2708	3102	78%	71%	81%
Not Accepted	1548	904	1225	29%	19%	23%	Not Accepted	584	972	705	16%	25%	18%
Not Recorded	135	202	26	2%	4%	0%	Not Recorded	243	133	42	7%	3%	1%

Source: CNWL contract monitoring data

Reason for referral

Table 60 and 61 show annual numbers by referral by reason for referral Central London CCG and West London CCG respectively. From these tables the following key points are made:

- For both CCGs ‘in crisis’ is the most common reason for referral, followed by Depression in CLCCG and HTT gatekeeping in WLCCG
- Continual year on year increases in referrals for depression, anxiety, HTT gatekeeping, perinatal mental health, ongoing or recurrent psychosis and are observed for both CCGs. CLCCG has seen continual increases in capacity (advice/assessment), suspected first episode psychosis and WLCCG in PTSD, bipolar, medication review, obsessive compulsive disorder
- The number of referrals for ‘unexplained physical symptoms’ in both CCGs have been declining year on year

Table 60 Adults: Reason for referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

Reason for referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
In crisis	2461	1361	1525	5347	47%	55%	112%
Depression	278	373	418	1069	9%	134%	112%
Capacity (advice/assessment)	184	394	462	1040	9%	214%	117%
Anxiety	151	215	238	604	5%	142%	111%
HTT Gate-keeping	154	218	230	602	5%	142%	106%
Perinatal mental health issues	57	147	185	389	3%	258%	126%
Self harm	113	133	123	369	3%	118%	92%
Ongoing or Recurrent Psychosis	55	124	152	331	3%	225%	123%
Suspected ADHD	63	131	124	318	3%	208%	95%
Relationship difficulties	31	120	100	251	2%	387%	83%
Post-traumatic stress disorder	56	114	59	229	2%	204%	52%
Drug and alcohol difficulties	45	69	43	157	1%	153%	62%
Personality disorders	37	58	43	138	1%	157%	74%
Medication Review	31	45	35	111	1%	145%	78%
Bi polar disorder	23	45	19	87	1%	196%	42%
HTT Discharge Facilitation	12	32	14	58	1%	267%	44%
Adjustment to Physical Health Condition	10	28	16	54	0%	280%	57%
Suspected First Episode Psychosis	6	12	23	41	0%	200%	192%
Obsessive compulsive disorder	8	15	9	32	0%	188%	60%
Unexplained physical symptoms	15	10	6	31	0%	67%	60%
Self - care issues	0	14	8	22	0%	-	57%
Conduct disorders	7	7	<5	14	0%	100%	-
Eating disorders	<5	7	0	7	0%	-	0%
Specific Procedure	7	0	<5	7	0%	0%	-
Gambling Difficulties	<5	<5	7	7	0%	-	-
Neurodevelopmental conditions	<5	<5	<5	0	0%	-	-
Organic brain disorder	<5	<5	<5	0	0%	-	-
Phobias	0	<5	0	0	0%	-	-
Service Redesign	<5	0	0	0	0%	-	-
Suspected ASD	<5	<5	0	0	0%	-	-
Suspected Autism Spectrum Disorder	0	0	<5	0	0%	-	-
(Blank)	<5	0	0	0	0%	-	-

Source: CNWL contract monitoring data

Table 61 Adults: Reason for referral and year on year change in volumes WLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

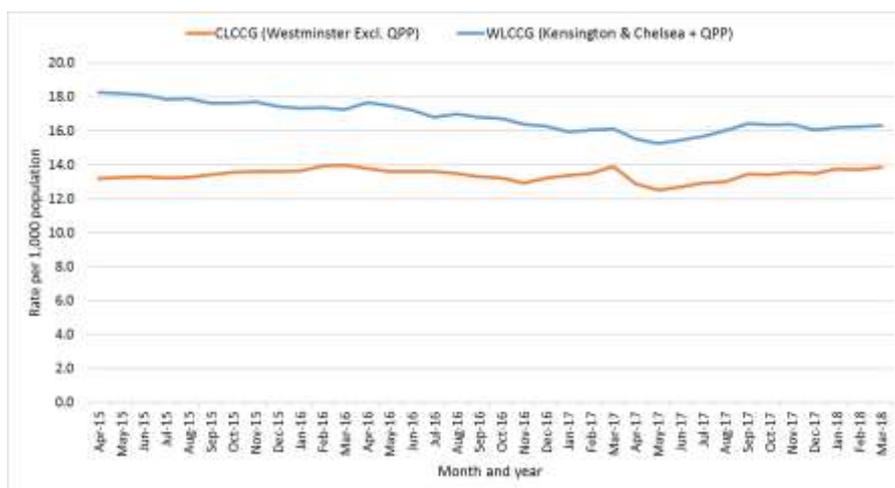
Reason for referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17 to	17/18
In crisis	3254	1642	2079	6975	45%	50%	127%
HTT Gate-keeping	427	457	596	1480	10%	107%	130%
Depression	279	521	619	1419	9%	187%	119%
Capacity (advice/assessment)	519	431	459	1409	9%	83%	106%
Anxiety	138	291	208	637	4%	211%	71%
Self harm	165	231	158	554	4%	140%	68%
Ongoing or Recurrent Psychosis	121	201	228	550	4%	166%	113%
Perinatal mental health issues	59	218	256	533	3%	369%	117%
Suspected ADHD	63	140	137	340	2%	222%	98%
Post-traumatic stress disorder	51	114	142	307	2%	224%	125%
Drug and alcohol difficulties	70	124	93	287	2%	177%	75%
Personality disorders	49	108	77	234	2%	220%	71%
Bi polar disorder	61	73	80	214	1%	120%	110%
Medication Review	22	58	96	176	1%	264%	166%
Adjustment to Physical Health Condition	21	37	36	94	1%	176%	97%
Suspected First Episode Psychosis	26	41	20	87	1%	158%	49%
HTT Discharge Facilitation	18	28	21	67	0%	156%	75%
Unexplained physical symptoms	27	19	13	59	0%	70%	68%
Self - care issues	0	17	15	32	0%	-	88%
Conduct disorders	8	7	11	26	0%	88%	157%
Relationship difficulties	8	16	<5	24	0%	200%	-
Obsessive compulsive disorder	6	7	9	22	0%	117%	129%
Specific Procedure	9	0	0	9	0%	0%	-
Organic brain disorder	<5	<5	<5	0	0%	-	-
Eating disorders	<5	<5	<5	0	0%	-	-
Gambling Difficulties	<5	<5	<5	0	0%	-	-
Neurodevelopmental conditions	<5	<5	<5	0	0%	-	-
Phobias	0	<5	0	0	0%	-	-
Service Redesign	<5	0	0	0	0%	-	-
Suspected ASD	<5	<5	0	0	0%	-	-
Suspected Autism Spectrum Disorder	0	0	<5	0	0%	-	-
(Blank)	<5	0	0	0	0%	-	-

Source: CNWL contract monitoring data

Caseload

In 2017/18 average caseloads were 2,776 for WLCCG and 2,182 for CLCCG. Chart 21 shows the monthly trend in adult caseload by referring CCG. Numbers on caseload are converted into rates per 1,000 population aged 20 to 64 years to enable comparison. Cases per head of population from WLCCG are typically higher than from WLCCG compared to CL CCG.

Chart 21 Adults: adults on caseload per 1,000 population aged 65 year and over



Source: CNWL contract monitoring data

Hospital spells

Analysis of hospital spells for primary and secondary diagnoses of mental health conditions (International Classification of Diseases 10th edition [ICD 10] Chapter F) and self-harm (codes within ICD 10 Chapter X) produced the findings in Table 62. Data presented where more than 5 spells occurred in the pooled 2015/16 and 2016/17 data and for the top 5 diagnoses.

Table 62 presents the findings from local analysis of hospital activity data. As mental health and/ or self-harm diagnoses are most commonly coded as a secondary diagnosis, only pooled data from 2015/16 and 2016/17 could be utilised as the 2017/18 spells data does not include secondary diagnosis field.

Table 62 Hospital admissions (Spells), adults aged 16-64 years, with a relevant primary diagnosis Chapter F or X, 2015/16 and 2016/17 pooled data

Primary Diagnosis	Borough	EL	NEL	Secondary Diagnosis	Borough	EL	NEL
Mental and behavioural disorders due to use of alcohol	RBKC		78	Mental and behavioural disorders due to use of tobacco	RBKC	264	96
Panic disorder [episodic paroxysmal anxiety]	RBKC	-	9	Mental and behavioural disorders due to use of alcohol	RBKC	17	112
Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	RBKC	-	23	Depressive episode, unspecified	RBKC	89	33
Exposure to unspecified factor	RBKC	-	17	Anxiety disorder, unspecified	RBKC	97	17
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics	RBKC	-	13	Specific (isolated) phobias	RBKC	90	<5
Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	RBKC	-	5	Bipolar affective disorder, unspecified	RBKC	14	<5
				Schizophrenia, unspecified	RBKC	9	8
				Mixed anxiety and depressive disorder	RBKC	12	<5
				Developmental disorder of scholastic skills, unspecified	RBKC	10	<5
				Mental and behavioural disorders due to use of opioids	RBKC	<5	11
				Mental and behavioural disorders due to use of cocaine	RBKC	<5	10
				Paranoid schizophrenia	RBKC	5	<5
				Panic disorder [episodic paroxysmal anxiety]	RBKC	<5	6
				Agoraphobia	RBKC	8	-
				Delirium, unspecified	RBKC	-	7
Mental and behavioural disorders due to use of alcohol	WCC	-	158	Mental and behavioural disorders due to use of tobacco	WCC	382	186
Depressive episode, unspecified	WCC	<5	14	Depressive episode, unspecified	WCC	164	85
Unspecified nonorganic psychosis	WCC	-	11	Mental and behavioural disorders due to use of alcohol	WCC	10	205
Anxiety disorder, unspecified	WCC	-	10	Specific (isolated) phobias	WCC	108	<5
Acute and transient psychotic disorder, unspecified	WCC	-	8	Anxiety disorder, unspecified	WCC	46	33
Paranoid schizophrenia	WCC	-	7	Schizophrenia, unspecified	WCC	14	37
Mental and behavioural disorders due to use of opioids	WCC	-	7	Bipolar affective disorder, unspecified	WCC	18	14
Agoraphobia	WCC	6	-	Mental and behavioural disorders due to use of opioids	WCC	<5	20
Mental and behavioural disorders due to use of cannabinoids	WCC	-	5	Developmental disorder of scholastic skills, unspecified	WCC	11	<5
Delusional disorder	WCC	-	5	Paranoid schizophrenia	WCC	<5	12
Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	WCC		41	Mental and behavioural disorders due to use of cannabinoids	WCC	<5	9
Exposure to unspecified factor	WCC		36	Mental and behavioural disorders due to use of cocaine	WCC	<5	9

Table 62 continued

Primary Diagnosis	Borough	EL	NEL	Secondary Diagnosis	Borough	EL	NEL
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics	WCC		35	Post-traumatic stress disorder	WCC	<5	6
Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	WCC		22	Failure of genital response	WCC	8	<5
Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances	WCC		9	Mixed anxiety and depressive disorder	WCC	9	<5
Intentional self-harm by sharp object	WCC		6	Unspecified nonorganic psychosis	WCC	9	-
Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system	WCC		5	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	WCC	<5	5
				Delirium, unspecified	WCC	<5	5
				Obsessive-compulsive disorder, unspecified	WCC	<5	5

Source: Secondary Uses Service spells data 2015/16 and 2016/17 pooled data. EL – Elective, NEL – Non-elective. n - Number

Support Services

Adult social care

Comparative data

Table 63 summarises comparative data on social care indicators for both boroughs. The following key points are noted:

- Both boroughs have higher rates of social care assessment for mental health clients compared to the London average
- Kensington and Chelsea have lower rates of mental health clients in residential or nursing care compared to the London average, while rates in Westminster are higher
- Both boroughs have a lower percentage of social care mental health clients receiving self-direct support and Westminster a lower percentage of clients receiving self-direct payments, compared to the London average. Kensington and Chelsea has a comparable percentage of clients receiving self-directed payments
- Both boroughs are highlighted as having lower rates of satisfaction with care, support and protection compared to the London average, however this indicator is not specific to mental health clients

Table 63 Comparative data on social care services

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Social care assessments for mental health clients: rate per 100,000 population aged 18-64	2013/14	1,917	598	332	265	2,055	965
Social care mental health clients in residential/nursing care: rate per 100,000 population 18-64yrs	2013/14	18.7	108.5	29.7	31.9	20	175
Self-directed support: % of social care mental health clients	2013/14	12.6%	17.7%	34.5%	28.4%	135	195
Self-directed payments: % of social care mental health clients	2013/14	10.7%	9.5%	10.7%	10.7%	115	105
Satisfaction with social care support: % service users extremely satisfied or very satisfied with their care and support	2015/16	58.8%	59.5%	60.3%	64.4%	-	-
Satisfaction with social care protection: % service users	2015/16	70.8%	76.8%	81.7%	85.4%	-	-

Source: Public Health England Fingertips (2018)

Chart 22 shows the quarterly trend in referrals to Adult Social Care services for Mental Health Support between April 2015 and March 2018.

In interpreting these data it is important to note residents can have more than one referral per period and not all referrals result in a support package being implemented– Table 64 shows the relative numbers of referrals to service users referred and the percentage of referrals that led to a support.

Chart 22 Rate of referrals to Adult Social Care services for Mental Health Support



Source: Adult Social Care client data

Table 64 Adult Social Care referrals for mental health support, adults 16-64 years

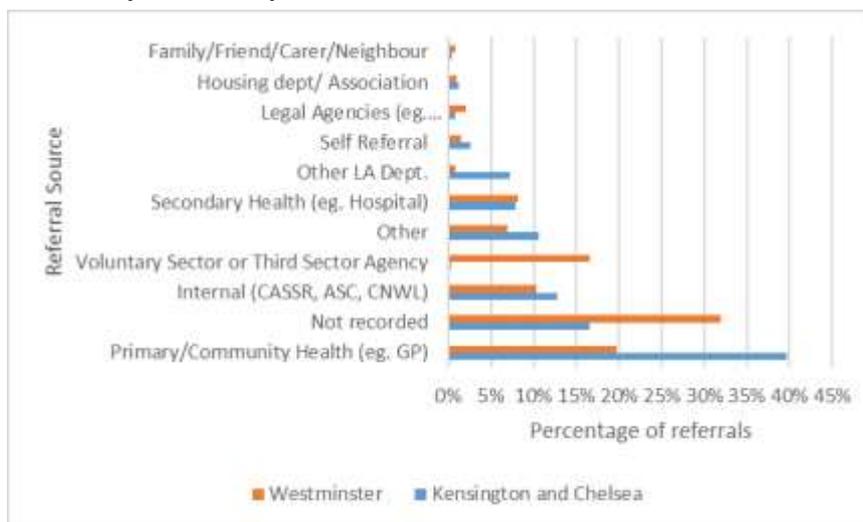
Borough	Mental Health Support	2015/16	2016/17	2017/18
RBKC	Individuals referred	1,252	686	476
WCC	Individuals referred	1,170	759	695
RBKC	% Individuals all ASC referrals	64%	56%	45%
WCC	% Individuals all ASC referrals	49%	56%	49%
RBKC	Referrals	1,321	711	497
WCC	Referrals	1,277	788	758
RBKC	Referrals accepted*	48%	66%	54%
WCC	Referrals accepted*	73%	70%	54%

Source: Adult Social Care client data. *Remaining referrals either requiring further assessment / no assessment or rejected

Referral source

Chart 23 shows the distribution of referrals by source. From chart 23, of referrals with a source recorded, referrals in Kensington and Chelsea are most commonly from Primary/ Community care, while referrals in Westminster a similar percentage of referrals are made by Primary/ Community care and the voluntary/ third sector.

Chart 23 Mental health support referrals percentage by source and borough pooled data 2015/16 to 2017/18



Source: Adult Social Care client data

Table 65 shows the annual numbers of Adult Social Care (ASC) service users receiving care packages for ‘mental health support’. As individuals can have more than one care package in place, numbers of service users and the number of care packages is shown. The following key points are made:

- Westminster has almost three times the number of working age service users receiving mental health support compared to Kensington and Chelsea
- numbers of service users and packages for mental health support have declined over the past three financial years
- the percentage of ASC service users with mental health support has declined over the past three financial years

Table 65 Numbers of Service Users and packages for Mental Health Support (excl. Memory and Sensory support)

Borough	Mental Health Support	2015/16	2016/17	2017/18
RBKC	Service Users	274	243	231
WCC	Service Users	604	603	584
RBKC	% Individuals all ASC referrals	18%	16%	15%
WCC	% Individuals all ASC referrals	28%	27%	25%
RBKC	Packages	780	407	443
WCC	Packages	1,872	1,185	1,244

Source: Adult Social Care client data

8.8 Local Services and asset mapping

8.8.1 Employment Support

Work is good for mental health whether it is paid or unpaid. Once in work our mental health can be helped or harmed by the mental health environment within the workplace.

Westminster Employment (WE) - Westminster Employment specializes in supporting people with significant barriers to find employment. They work with people with moderate to severe learning or/and physical disabilities to support them into mainstream employment. They are specialists in providing the correct support and work with employers to create a job that fits the persons skills and abilities.

They are currently consulting their services on the service, the report is due is in December and will be included in this report if available.

RBKC has a wide employment support service offer from Local Authority, Health and third sector parties. Services specifically able to support those with mental health conditions include:

- Family and Community Employment Service (FACES),
- Department for Work and Pension's Work and Health Programme
- Community Living Well – Employment Service providing employment advice and support to people with mental health issues managed in primary care, regardless of their diagnosis.

CNWL Recovery College

The CNWL Recovery and Wellbeing College is a place where people can learn about recovery and wellbeing in a supportive environment. They provide a range of courses to support people to regain hope, to learn, grow, share and discuss. Included in their offer are courses that are employment and work related.

"I believe that the Recovery and Wellbeing College has played a major part in my own recovery. After I was diagnosed with a mental health condition and detained under the mental health act, I gradually lost everything that had value for me: my career, responsibility for my children; my relationship with my partner, my friends and my sense of identity. It seemed like everyone in my life from then on only focused on what was considered to be wrong with me. It was like everything I had built up in my life before my diagnosis was just wiped away. It was difficult to see myself as anything other than 'a problem'."

"At the Recovery and Wellbeing College I was able to use my lived experience to help develop a course and for the first time,

worked in a truly collaborative way with practitioners and felt that I had something to contribute. “

“I have friends and colleagues and an active role in my community now, and I have gained an understanding of personal recovery and of how to manage my mental health in a positive and effective way. This in turn has enabled me to feel able to return to my previous career and I have just gained a new position as a psychologist.”

“With the Recovery and Wellbeing College I came into contact with people who were hope inspiring, focused on my strengths and helped me to rebuild my life.”

A Service User Experience

The London Healthy Workplace Charter

Both boroughs provide free support to employers to gain the London Healthy Workplace Charter Awards. The London Healthy Workplace Charter, backed by the Mayor of London, provides clear and easy steps for employers to make their workplaces healthier and happier. Organisations self-assess themselves at meeting standards on:

- health and safety
- mental health
- physical activity
- attendance management

8.8.2 West London CCG Mental Health Services

8.8.2.1 Urgent Mental Health Care Pathway

Referrals in to the Urgent Mental Health Care Pathway referrals can come from a wide variety of sources including Police, Ambulance Service, Carers, GPs etc as well as self-referral. Calls are made to the CNWL run single point of access (SPA). Their role is to provide advice, support, triage and booking.

The Single Point of Access (SPA) is the contact and triage service for the mental health services.

Other key elements of the mental health service provision are the Dual Diagnosis Service and the Drugs and Alcohol Services which are commissioned by the local authority.

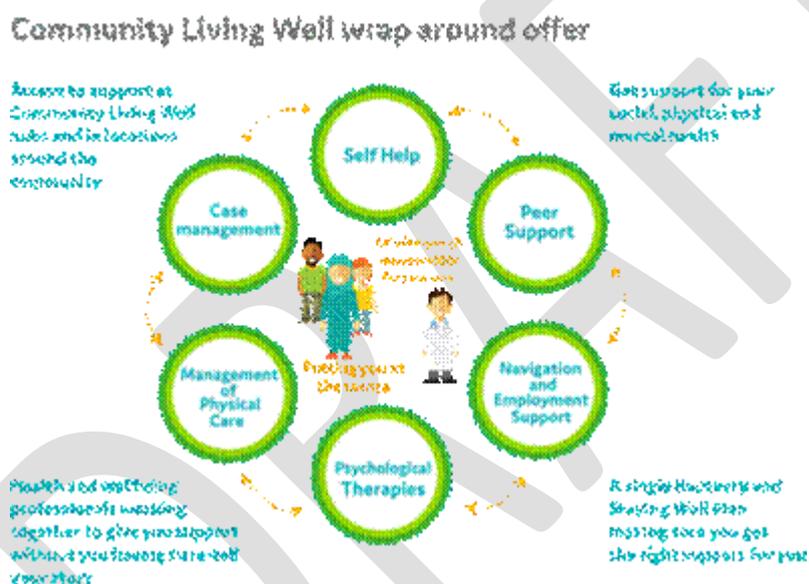
8.8.2.2 Routine Care/Community Living Well

Access to NHS mental health services is via the GP, apart from access to the Improving Access to Psychological Therapy (IAPT) services, to which people can self-refer. Where there is an urgent issue there is the Urgent Mental Health Care Pathway which is included in the Appendix.

GPs complete the SPA standard referral form. For non-complex and low risk patients, GPs are prompted to refer to the Community Living Well service. For Drugs, Alcohol and other Addictions, GPs are prompted to refer to drugs and alcohol services which are commissioned by the local authority.

Community Living Well was co-produced with service users, carers, NHS and voluntary sector organisations. It provides a wraparound service which has individuals at the centre of their care and offers support with social wellbeing, mental and physical health needs

Figure 3. Community Living Well Model of Care



The Community Living Well team is made up of a range of professionals. Depending on what support people need they may see one of the following:

- Employment Support Workers
- Navigators
- Mental Health Nurses
- Psychiatrists
- Psychological Therapists or Counsellors
- Peer Support Workers and Coordinators

Community Living Well brings together a range of clinical and wellbeing services to provide coordinated access to mental, physical care and social wellbeing support. Services include:

8.8.2.2.1 Jobs in Mind

Jobs in Mind, in partnership with SMART (see below) provides [Employment Support](#) for Community Living Well. Jobs in Mind provide specialist employment support and advice for those struggling with work-related issues caused by stress, anxiety or mental health problems.

8.8.2.2.2 [St Mary Abbots Rehabilitation and Training \(SMART\)](#)

SMART, in partnership with Jobs in Mind provides Navigators for Community Living Well. SMART is a charity that promotes mental health through purposeful activity. They offer a range of supported recovery, work and training opportunities in a friendly and enabling environment. People build both practical and personal skills, gaining experience and confidence. Working one-to-one with individuals they help them people find work and training outside SMART and reconnect with their community through a programme of social events and activities. SMART works closely with the providers of statutory services to develop a more holistic approach to supporting people with mental health needs.

8.8.2.2.3 [Kensington and Chelsea Mind](#)

Kensington and Chelsea Mind delivers Peer Support for Community Living Well. Mind offers information, support and training services to support the recovery, growth and wellbeing of people who are experiencing mental health problems to enable them to live full and independent lives.

Central and North West London NHS Foundation Trust (CNWL)

CNWL is the provider for both Psychological Therapy and the Primary Care Liaison Nurse teams within Community Living Well.

Mother Tongue Counselling is delivered Westminster Mind. It aims to integrate Arabic and Farsi (Persian) speaking communities in Kensington and Chelsea, Queen's Park and Paddington into primary care mental health services, by providing effective, accessible and culturally capable one-to-one counselling in their mother tongue languages, along with wellbeing groups and workshops around mental and emotional health, tailored to suit the needs of the group.

8.8.2.2.4 [Kensington and Chelsea Social Council](#)

Kensington and Chelsea Social Council in partnership with SMART and Jobs in Mind delivers the Navigator Service within Community Living Well. The Kensington and Chelsea Social Council is the local voluntary and community sector infrastructure body which counts 370 organisations amongst its active members. The organisation works to improve the quality of life for residents of the borough by supporting locally focused voluntary and community organisations

8.8.3 Central London CCG Mental Health Services Adults

8.8.3.1 Crisis Care

The crisis care pathway is the same at West London CCG, and is via CNWL's Single Point of Access. The SPA process is valued by GPs. Ideally crisis presentation at accident and emergency departments is avoided however there is considered to be a good liaison psychiatry service in place when this does occur.

The Health Based Places of Safety which were established as part of the Crisis Care Concordat. The current site in Westminster is the Gordon Hospital. There is currently a review underway in North West London with the proposal to reduce the number of sites so that the quality of care can be improved.

8.8.3.2 Routine Care

GPs make mental health referrals to the Primary Care Plus Service which has been in place for the last 5 years. Patients can also self-refer. Primary Care Plus provide the triage function for routine care. The mental health practitioner will see the patient at their own GP surgery and carry out a full assessment. This process taking place in the GP surgery has the benefit of reducing stigma and seeing people closer to home.

Care Navigators within the Primary Care Plus Service will help patients access other services for such those provided by Westminster MIND, Abbey Centre, Beethoven Centre and floating housing support.

Primary Care Plus will refer on to Community Mental Health Teams if required.

If patients wish to, they can bypass Primary Care Plus and self-refer to the IAPT service.

The primary IAPT service the provision is considered reasonable with 8 week waits, a choice of service and good recovery rates.

Secondary talking therapies are experiencing high demand with 6-9 month waits

"It is hard to get the right people to have the right therapy at the right time". GP

This is despite a large provision of psychologists, psychotherapy and some unique service such as migration trauma service.

The Primary Care Plus Service is currently being reviewed to look at how transition between services can be improved, providing better continuity of care and reduction of silo working.

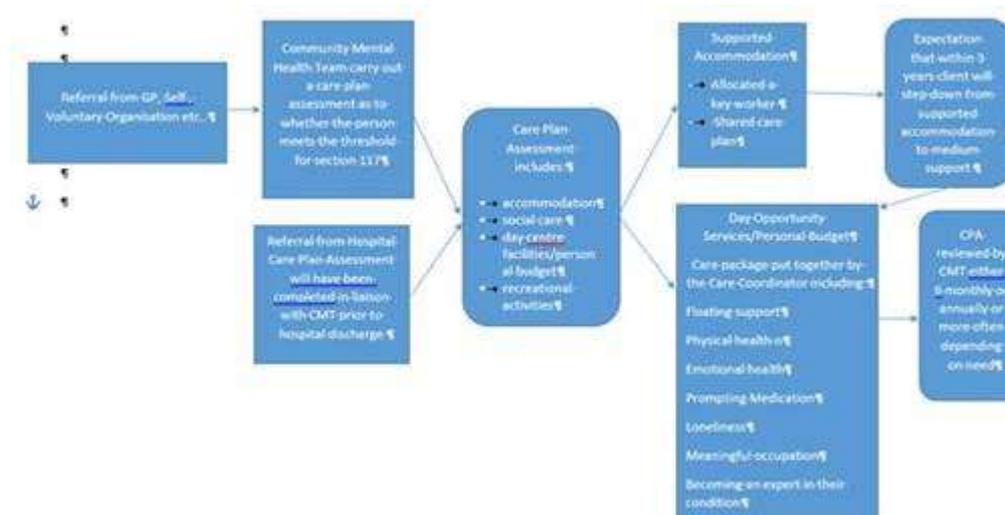
Issues with secondary care are the extended times that people spend there. Some of this may be due to some GPs not be equipped to deliver DEPO injections. Another factor may be that the care of those under a section117 has to be provided by community mental health teams. There is also concern at the length of time people are staying in supported housing for years and not moving on to living independently.

8.8.4 Local Authority Commissioned Services

8.8.4.1 Statutory Provision

The local authority commissions statutory provision which includes supported accommodation; day opportunity services (RBKC only) and spot purchase services for working age adults with severe and enduring mental health conditions.

Figure 4 Adult Mental Health Care Pathway



Section 117 of the Mental Health 2007 requires Health and Local Authorities to provide, in co-operation with relevant voluntary agencies, aftercare services, until they are satisfied that this is no longer necessary, for:

- Service users who are or have been detained under Section 3. Service users who are or have been admitted to a hospital in pursuance of a hospital order made under Section 37 (whether or not with restrictions under Section 41)
- Service users transferred to a hospital in pursuance of a hospital direction made under Section 45A.
- Service users subject to a transfer direction made under Section 47 or 48.
- Service users, as set out above, on leave of absence authorised by the Responsible Clinician

8.8.4.2 Supported Accommodation

Housing related support for people with severe mental illness ranges from floating support to low, medium and high supported housing. Residential and hospital placements are utilised to meet people's needs, support recovery goals and enable move-on where appropriate. Intensive services include NHS acute (inpatient) and Psychiatric Intensive Care Units, independent hospital provision and specialist placements for complex care. Residential and nursing placements are usually out of the local area.

There are a range of registered social landlords providing the supported accommodation. The local authority works closely with both the landlords and those providing the support to ensure that residents are safe and are receiving the right

package of support. Registered Social Landlords (RSL) are also used as one of the resources used as part of the planning for moving on from supported accommodation.

Providers of supported accommodation are required to map the environment around their setting for day opportunities / universal assets. They also need to report on how they are signposting to these.

Though Mental Health Supported Accommodation is associated with a reduction in days spent in hospital and duration of hospital stays with significant improvement (alleviation) of symptoms over time but it does have limiting effectiveness over time. To avoid long-term living in an institutional setting with all its attendant problems (deskilling; social exclusion; limited horizons; lack of personal space; institutionalised behaviours etc.).

A review of supported accommodation is currently underway and due to report in December 2018. A JSNA on Housing Support and Care was published in August 2016. Older people with mental ill-health may also have physical health issues, particularly due to the correlation between alcohol/substance use and mental health. MH supported accommodation provision generally is not accessible for those with mobility issues.

The volume of supported accommodation is high in both boroughs, but demand also remains high in both boroughs. RBKC has limited provision of only 60 mental health specific high support beds. Vacancies are not being created in the accommodation, as people are not moving on to independent living.

8.8.4.3 Spot Purchasing

Spot purchasing from small organisations is managed through care coordinators. All day opportunities services in WCC are spot purchased from personal budgets

Historically services have planned and been maintained on the basis of the provision of block payments. The move to personal budgets for those with severe and enduring mental health conditions has the following challenges:

- Capacity of the person to take control of their personal budget
- The challenge of finding an appropriate person to take responsibility for the personal budget, in many cases people with severe and enduring mental health conditions are no longer in contact with their family
- Market readiness
- Considerable resource required in the form of communication, time, energy and infrastructure

Clients will have a Care Plan Assessment review annually. This should be a multidisciplinary process and cover both mental and physical health. It will include a review as to whether a client is taking their medication.

8.8.4.3 Challenges

The perceived need from people with serious mental illness are very high in both boroughs but it feels like there is limited capacity to get in to the mental health care system.

Particular demand for adult social care supported is generated by:

- levels of rough sleepers in Westminster,
- levels of deprivation and poverty;
- levels of alcohol and substance misuse. – are we picking people up earlier enough?
- Aging population, more complex needs
- Half of those in supported accommodation have substance misuse issues.

There is a perception that high caseloads are resulting in high staff turnover, as staff feel overwhelmed by their caseload.

The expectation is that clients will move on from supported accommodation within 3 years if not sooner. They are stepped down to being supported by floating support. But it is considered unlikely that this cohort of patients, particularly those with a history of substance misuse, will be able to move on to independent living due their complex needs.

However, there is a recovery focused journey expected which providers report in their month returns on progress being made. Data on improvements in the quality of life of individuals in supported accommodation is case study based rather than data of performance against outcomes.

The day opportunity services are asked to report on where they have referred people on to the universal offer e.g. healthy eating, physical activity, social prescribing.

8.8.5 Community Mental Health Service

The organizational structure of the community mental health service provided by CNWL in each borough is unique to each borough (see Figures 5 and 6). The adult mental health contract is shared with 5 other CCGs in North West London.

Figure 5: Kensington and Chelsea Service – CMHT in Blue

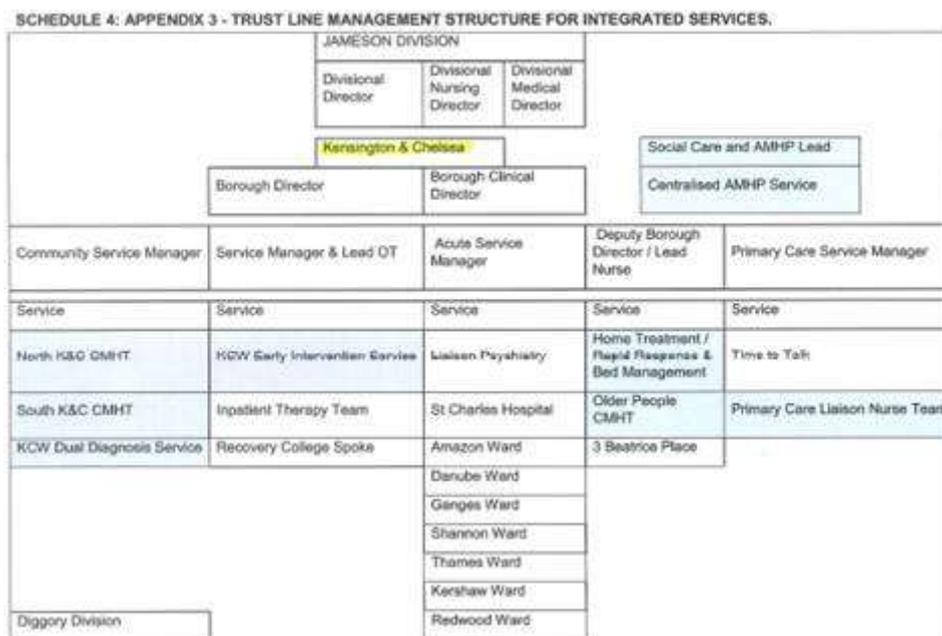
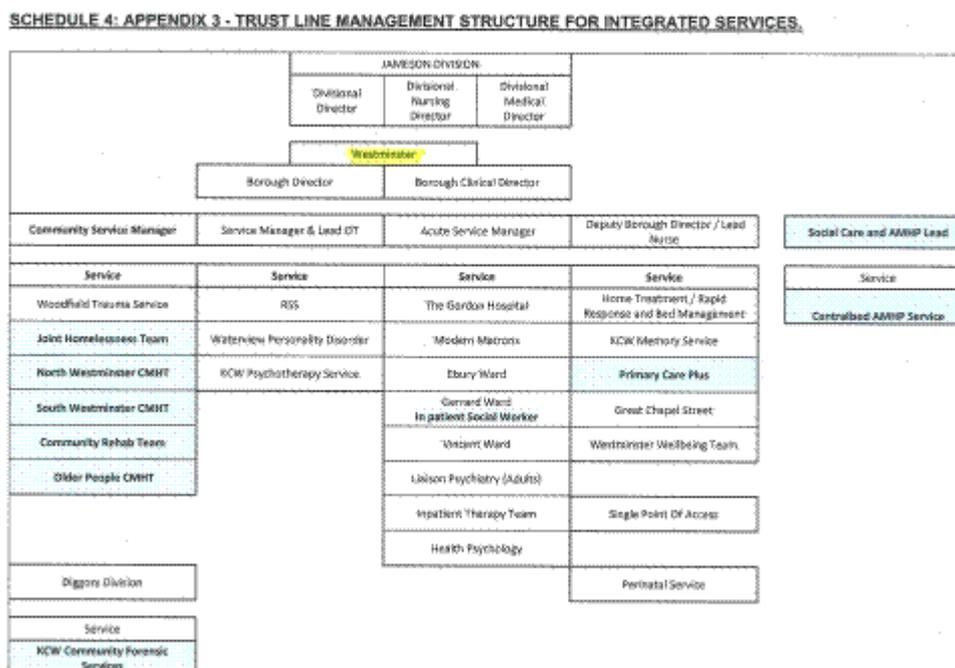


Figure 6: Westminster Service – CMHT in Blue



Community mental health services have recently strengthened their focus on physical health care, ensuring weight gain due to medication is minimised, and referring to smoking cessation services, drugs and alcohol services as well as healthy lifestyle services.

Community mental health teams have recently put in a new process to review their caseloads in workshops to see which patients are ready to move on back to the care of their GP. This development has been supported through a greater understanding by clinicians of the support available in the community and in primary care.

8.8.6. Support for those with a Dual Diagnosis of Mental Illness and Substance Misuse

Dual diagnosis, or co morbidity, is the presence and interaction of two conditions. This can often complicate the treatment of either or both conditions. Treatment frequently requires specialist knowledge in meeting the presenting needs, which can vary depending on the presentation of either or both conditions.

The term dual diagnosis encompasses a broad range of conditions which interact within the mental health and substance use context. People may experience them concurrently or sequentially, with the possible combinations including:

- A primary psychiatric or enduring mental illness which leads to substance use
- Substance use which negatively impacts the presentation of a psychiatric illness
- Intoxication and/or the effects of substance use or dependence which leads to psychological symptoms
- Substance use and/or withdrawals which lead to psychiatric symptoms or illness

(DOH: 2002)

Recent literature and polices, define dual diagnosis more narrowly as a severe and enduring mental illness characterised by features of psychosis. These illnesses are schizophrenic type disorders, bipolar affective disorder and other delusional and affective disorders. These illnesses are experienced alongside substance use which includes the use of legal or illicit drugs, including alcohol, which could be harmful with or without dependence.

The Local Authorities' Dual Diagnosis team is set up to provide a service to service users who are open to secondary mental health, either as Out Patient appointments under Lead Professional Care or care co-ordinated under Care Programme Approach, who also have substance use needs. The team will focus on supporting service users regarding their substance use needs. Team members do not act as Care Co-ordinators, but work in joint partnership.

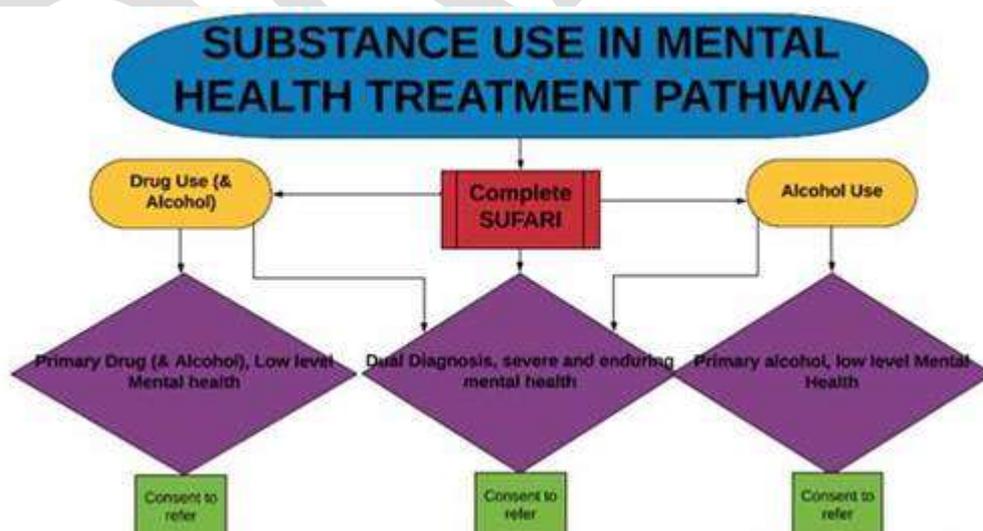
Referrals are screened by the team manager/members and allocated to a dual diagnosis worker within 28 days from the point of referral. Engagement can often be delayed if someone is referred from hospital and still requires treatment. Significant delays in discharge can also occur due to social care needs such as housing.

Ongoing work with the service user may include –

- a) One-to-one sessions either at home or at another suitable venue.
- b) Referral to structured day time activities through mental health services through Personalisation/Personal Budgets
- c) Engagement with Drop In groups run by Substance Use Services
- d) Support to attend for assessment for a detox from alcohol or opiates where appropriate
- e) Referral for a substance use/ dual diagnosis day programme
- f) Referral to a substance use residential rehabilitation programme
- g) Other suitable work to support the service user to make changes to their substance use.
- h) Contributing to the assessment by care co-ordinators for Personal Budgets and other packages of care for the service user.
- i) Motivational Interviewing, psycho-social education, promoting engagement in community activities to promote general well-being.

This will be reviewed with the service user and in professional and clinical supervision.

Figure 7: substance use in mental health treatment pathway



This care pathway is in place concurrently with a draft Bi Borough Dual Diagnosis Joint Working process (K&C & WCC). There are particular complex issues with the care and treatment of this cohort of patients in relation to poor outcomes, particularly social

isolation and housing. These complex issues can impact on levels of engagement with services including the mental health service.

Patients with the dual diagnosis team are linked into drugs and alcohol services successfully. Those who do not meet the dual diagnosis remit can be jointly assessed by mental health services and the dual diagnosis team, access drug or alcohol services directly or seek treatment via primary care mental health workers via their GP. As substance misuse and mental illness can frequently be an interrelated matter, a whole person approach needs to be considered.

The strengths of the existing dual diagnosis service lie in working within an assertive outreach approach, ensuring that they build trusting relationships; safeguard and engage service users with harm minimisation; change talk and explore the impact of substance use on their mental illness and other areas of their lives. The service supports well-being and engagement with mental and physical health care, and access to housing, financial, social and psychological support.

It has been recognised that the treatment of dual diagnosis can be lengthy and once those individuals are closed to mental health services, they are no longer able to access support from dual diagnosis. This leaves a gap in provision, which can create some dependency on services, particularly for individuals who lack social support and vocation. Specific groups that benefit from the input of the dual diagnosis service are:

- Arabic speakers – this group are hard to engage with other services, perhaps due to stigma,
- Women
- LGBTQ

The dual diagnosis team are aiming to strengthen their impact on the overall health improvement of patients and improve community integration to reduce dependency on the service and promote independence.

Mental Health Services working with Patients with Dual Diagnosis

It is essential that dual diagnosis service users are not discharged from services prematurely and that an outreach approach is adopted to prevent them from falling through the gaps, the financial cost for the health and social care system if a patient with dual diagnosis does not continue with treatment are considerable including the cost of crisis admissions.

If a patient with dual diagnosis does not continue with treatment, the financial costs for the health and social care system are considerable including the cost of crisis admissions.

Areas for improvement of care that have been identified for this cohort include:

- Training for inpatient staff on how to deal with substance misuse on the ward
- Training for community mental health staff on working with clients with Dual Diagnosis
- Improve uptake to talking therapies for those with Dual Diagnosis

- Support clients to become experts in managing their condition both mental health and substance misuse
- Improve access/use of the voluntary sector by building relationships with those organisations, give clients more information but also support them when needed when they initially access new activities by taking clients there, and introducing them.
- Develop a Bi-borough Group Programme which is not stigmatising, helps people grow emotionally, have a safe place, (Colleen has funding for this)
- Training Strategy – for drugs and alcohol services and for mental health services so they are better equipped to look after those with dual diagnosis. The recommendation is a condensed version of the 2-day Drugs and alcohol and mental health training; training the needs to challenge the stigma of substance misuse.
- Improve the pathway from Mental Health Services into Substance Misuse Services – mental health staff to complete SUFARI screening tool, increased presence of drug and alcohol workers in mental health services,
- Need to analyse trends on the use of services better by systematic collection of data
- People falling through the cracks – stop disengagement by asking the right questions and meeting their needs
- People stopping their medication
- Address barriers to services and treatment through user engagement

8.8.7 Substance Misuse Services and Wellbeing

The local drug and alcohol treatment system have bedded an asset-based model, where the services are built around people and communities, their needs, aspirations, capacities, skills and to work to build up their autonomy and resilience.

As part of their recovery Service users are to be assisted to develop potential by:

- Working productively and creatively
- Building strong relationships with others
- Contributing to their community
- Strengthening and actively supporting health initiatives within services and recovery communities as well as in the wider community.

Examples of this include:

- Roads to Wellbeing website- The map provided information about regular opportunities in the local areas for activities that were low cost or free.
- Innovation fund to spark new ideas and includes a panel of service users and members of local communities. Successful bids have included:
 1. the creation of a drama piece created and performed by volunteers in the Queens Park area and attended by 100 members of the local community.

- Community gardening and a cooking space is being developed with the Chelsea Physic Gardens with people in recovery and other socially isolated local residents.

Case Study – Billie

The first application to the Big Ideas Fund came from Billie. Billie applied to the fund to run jewellery making and macramé workshops for other service users. Billie has taken these workshops to a variety of service user groups, running stalls at community events and was even featured in the most recent DDN magazine.

8.9 Quality and outcomes

Table 66 summarises comparative data on the quality and outcomes of local services by borough, while table 67 summarises comparative data on the quality and outcomes of local services by CCG.

From Table 66 the following key points are made:

- In both boroughs the employment rate of those in contact with a secondary mental health service is below the London average. However, the gap between this employment rate and the general employment, in both boroughs, is narrower than the London average, for males and females
- There is no local data on the proportion of people with a learning disability or mental illness in employment
- In both boroughs the percentage of social care mental health clients receiving home care is higher than the London average

Table 66 Comparative data on outcomes for adults by borough

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Employment rate those in contact with secondary mental health services vs. overall: %pt difference	2016/17	56.5	62.0	67.8	67.4	-	-
Gap in the employment rate in contact with secondary mental health services vs. overall	Male	65.6	72.1	75.1	73.5	-	-
	Female	47.5	49.7	60.4	60.5	-	215
% of those with a mental illness or learning disability in employment	2016 Q4	-	-	40.0%	43.3%	-	-
Social care mental health clients 18-64 receiving home care during the year/100,000	2013/14	60.6	133.2	46.1	42.2	65	-

Source: Public Health England Fingertips (2018)

Table 67 Comparative data on outcomes for adults by CCG

Indicator	Period	Rate				Count	
		WLCCG	CLCCG	London	England	WLCCG	CLCCG
Smokers on GP registers (certain conditions) offered cessation support and treatment: % within yr	2016/17	96.7%	95.2%	96.5%	95.2%	6,990	5,007
Mental health admissions to hospital: rate per 100,000 population	2017/18 Q4	413.5	365.5	325.7	274.3	190	135
Gate kept admissions: % (quarterly) admissions to acute wards that were gate kept by the CRHT teams	2017/18 Q4	100.0%	100%	98.60%	98.70%	92	79
CPA adults in employment: % of people on CPA (aged 18-69) (end of quarter snapshot)	2017/18 Q4	6.5%	7.2%	6.2%	7.7%	60	40

Source: Public Health England Fingertips (2018)

From Table 67 the following key points are made:

- A higher than London average percentage of WLCCG registered patients are offered smoking cessation support, while the percentage is lower for CLCCG. However the indicator refers to certain condition and not specifically individuals with a mental illness
- Both CCGs have a higher rate of mental health admissions to hospital compared to the London average
- In both CCGs 100% of acute mental health admissions were gate kept by CHRT teams
- Both CCGs have a higher percentage of adults on a CPA in employment compared to the London average

Waiting times

The following section summarises the latest available data on waiting time performance by service. The data presented refer only to the performance of Central and North West London Foundation Trust (CNWL). The following services are covered:

- Psychiatric Liaison services
- Crisis teams (urgent and emergency referrals) and for routine referrals to Community Mental Health Teams (CMHT)
- IAPT
- Early Intervention Service (EIS)

From these tables the following key points are made:

- On average, 71% of patients are seen by Kensington and Chelsea Psychiatric Liaison service within waiting time thresholds. For Westminster Psychiatric Liaison service, the percentage is 81%.
- On average, 93% of West London CCG patients are seen by CNWL Crisis or CMHT teams within waiting time thresholds. For Central London CCG the percentage is 96%.
- IAPT services to both CCGs consistently meet the 18 week target 100% of the time. For 4 week waits the performance is lower but met for over 90% of patients each month. As patients with maternal mental illness may access IAPT, the waiting time performance shown in Table 3 may be considered reflective of waits for access to perinatal support.
- The percentage of patients with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period within 2 weeks of referral. Table 71 shows variable monthly performance for patients of both CCGs.

Table 68 Psychiatric Liaison: Percentage of referrals seen within threshold waiting times, by service

Kensington & Chelsea Psychiatric Liaison													
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Emergency < 1 hour	64%	68%	63%	63%	73%	82%	76%	82%	87%	78%	74%	67%	73%
Routine < 24hours	57%	50%	57%	50%	57%	83%	63%	86%	92%	80%	64%	75%	70%

Westminster Psychiatric Liaison													
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Emergency < 1 hour	81%	82%	71%	70%	82%	82%	75%	80%	85%	84%	87%	86%	80%
Routine < 24hours	81%	56%	78%	77%	78%	89%	93%	94%	93%	77%	86%	84%	83%

Source: CNWL contract monitoring data

Table 69 Crisis Team and CMHT: Percentage of referrals seen within threshold waiting times, by CCG

West London CCG													Av.
	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Referrals
Emergency referrals (4hrs)	100%		100%	100%	50%	100%	100%	100%	100%	100%	100%		<5
Urgent referrals (24 hrs)	100%	95%	95%	96%	89%	96%	97%	100%	94%	86%	79%	86%	29
Routine referrals (4 wks)	85%	89%	90%	93%	95%	95%	97%	94%	92%	95%	90%	96%	75

Central London CCG													Av.
	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Referrals
Emergency referrals (4hrs)	100%		100%	100%	100%	100%		100%	100%	100%	100%		<5
Urgent referrals (24 hrs)	97%	100%	91%	94%	92%	96%	92%	95%	97%	96%	100%	95%	33
Routine referrals (4 wks)	93%	90%	95%	89%	94%	96%	95%	97%	93%	94%	93%	91%	41

Source: CNWL contract monitoring data

Table 70 IAPT: Percentage of referrals seen within threshold waiting times, by CCG

West London CCG													Av.
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Referrals
IAPT (18 wks)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	494
IAPT (6 wks)	95%	95%	95%	96%	95%	96%	95%	95%	95%	91%	96%	97%	470

Central London CCG													Av.
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Referrals
IAPT (18 wks)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	281
IAPT (6 wks)	97%	99%	98%	98%	98%	99%	97%	96%	96%	96%	98%	96%	274

Source: CNWL

Table 71 Early Intervention Service (EIS): Percentage of patients with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period within 2 weeks of referral

West London CCG													Av.
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Referrals
EIS care package (2wks)	33%	er	100%	0%	er	67%	100%	100%	83%	100%	75%	50%	<5

Central London CCG													Av.
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Referrals
EIS care package (2wks)	0%	0%	100%	100%	100%	100%	100%	0%	100%	50%	100%	100%	<5

Source: CNWL

8.10 Voluntary and Third Sector Assets in Mental Health and Wellbeing

The voluntary and third sector play a rich and vital role in providing assets for mental health and wellbeing. Listed below are just a flavour of the organisations that contribute to mental wellbeing, including two based in Camden that our residents are known to use.

Table 72 Examples of community and voluntary sector organisations contributing to mental health and wellbeing

Westminster	Both boroughs	RBKC
ETAT – Encouragement through art and talking	Bump Start	Solidarity Sports – Supporting local families
Abbey Centre	Listening Place	Talking Theatre
Westbourne Park Family Centre	MIND	Pepperpot – older afro-Caribbean activities, day centre
Womens’ Trust	OPEN AGE	Migrants organise
Beethoven Centre	Volunteer Centres	MIDAYE
St Vincent’s Family Project	Community Champions	MUSAWA – BME consortium
Family Lives	Befriending Project	Dalgarno Trust
Neighbourcare- St Johns Wood and Maida Vale	Resonate Arts	Community Centre (
Café Maida Vale Gallery	BME Health Forum	Meanwhile Gardens
PIP- Learning Disability		Men’s Sheds- CAMDEN
SHAK Camden		

The third sector provides opportunities for making friends, to learn, to contribute to society and to be physically active which are key aspects of the five ways to wellbeing as outlined in the Director of Public Health’s Report Roads to Wellbeing.

They provide services across the life course from Bump Start where through a network volunteers they support parents and children who are experiencing difficulties of one kind or another to Age UK providing opportunities to socialise and befriending.

The third sector are also commissioned as providers of services for those with a mental health condition. For example RBKC commissions community mental health day

services from MIND, Hestia and SMART whilst Westminster spot purchases services from personal budgets.

The CCGs as part of their care planning whether as part of their Community Living Well service, My Care My Way Service or as part of the Primary Care Plus service are sign-posting to open access services provided by the third sector as well as paying for particular services. Examples of services funded by the CCGs are that Westminster MIND are an IAPT provider and also provide mother tongue counselling for patients of West London CCG.

Reflections from the community mental health service from working with the third sector after the Grenfell Fire are that the circumstance of dealing with the tragedy meant that relationships were built with the third sector beyond the business and usual ones with SMART, MIND and HESTIA. There was greater recognition of what groups can and wish to contribute to wellbeing of their community both faith groups such as Al Manaar, and the Methodist Church as well as other community organisations such as Rugby Portobello, Harrow Club and Midaye.

At a time of focus on limited budgets there is a complexity of funding streams for the third sector i.e. spot purchasing, social prescribing, commissioned block payments. There is potential risk for the economic sustainability of some services provided by the third sector which may be reliant on a number of these if this is not understood. There may also be a competition for access to services that the third sector may be providing free access to for the general population but are also being drawn upon by the health and social care system for those with an identified mental health need.

There has been a decrease in feeling like people have a choice about who attends their CPA or Care Review meeting with them since 2010 (down 30% in Westminster and down 8% in Kensington and Chelsea).

8.11 Service User Views

What is the national picture?

In August 2018, Healthwatch England produced a service user feedback report on Mental Health Services. Over 34,000 people shared their views and experiences of mental health services over more than 2 years. Six common issues were identified across different adult mental health services;

1) *People struggle to find the information and support they need*, due in turn to difficulties navigating the services, and not wanting to access services via their GP

2) *Physical and Mental health needs are treated in isolation*- Many people have both physical and mental symptoms, so services need to consider the individuals full needs. A lack of co-ordination between hospital services and social care or mental health services results in some patients being discharged without the care they need. This is a particular issue for people with drug or alcohol problems, and those with learning disabilities.

3) *Varying levels of support between areas or services*, along with inconsistent care and lack of communication between different services or areas can prolong recovery. Moving areas can lead to unnecessary reassessments and a change in mental health professional, which can distress people with mental health problems and time and trust must be re-invested to build a relationship with the professional.

4) *Long delays in accessing services and crisis care* results in delays to receiving a diagnosis and treatment. A lack of timely support can result in conditions worsening.

5) *Lack of Mental health training and understanding* in non- MH health and care settings means that concerns go can unaddressed.

6) *Lack of involvement or power over decisions affecting them*- many people are concerned that there is a lack of empathy and respect from professional staff, which further pressured but short appointment slots.

What is the local picture?

A number of surveys have been undertaken locally among services users on particular aspects of the care that they receive. Some of the findings reflect some of the themes highlighted in the national research.

Care planning

A recent (2017) evaluation of 27 adults accessing the community mental health teams at Pall Mall and Woodfield Road found:

- Some people still don't know what care plans are, what format they might take, and state they do not have one. Since 2010 awareness has gone up by 2% to 75% in Westminster and down by 18% to 58% in Kensington and Chelsea.
- Since 2010 there has been a decrease in people feeling like they have a choice about who attends the CPA or care review meeting (down 30% in Westminster; down 8% in RBKC)
- A marked reduction in people reporting they knew when their next CPA/Care Review meeting would take place (down 32% to 13% in Westminster; down 29% in K&C to 21%)
- There was an increase in the percentage of interviewees with a Crisis Plan (up 13% to 63% in Westminster; up 13% to 50% in K&C)

A number of recommendations are made in the report to address these gaps, increase awareness of care plans and how they can support patients to track their recovery.

Community Treatment Orders (CTO)¹¹

A survey of 17 recipients of CTOs identified a number of themes:

Communication – although nearly all had been told what the CTO was and the reason for it, in a way that they could understand there were a very small number of instances where language or literacy were a barrier. Most people (59%) were not told how long a CTO would last, with no clear dates for review.

Involvement – almost half of the interviewees (46%) had not had their care plan changed since the start of the CTO or even knew they had a care plan.

Relationship with professionals – people tended to see their CPN during the course of the CTO and the frequency of appointments met their needs. The nature of the relationship did not usually change because of the CTO, although there were some cases where it did (for better and for worse equally). Interviewees valued having a professional who really listened to them.

Independent Mental Health advocacy – although access to an Independent Mental Health Advocate (IMHA) is a statutory right for people on a CTO 41% (7 people) were not told about the advocacy service or how to access an advocate.

The majority of the interviewees were white British, male and/or in the 36-45 age group. A number of recommendations were highlighted to address these issues.

The Single Point of Access Service (SPA)

A recent User Focused Monitoring project (May 2017) looked at the knowledge of the SPA as a service, and service user feedback.

The majority of Mental Health service users have not heard of the SPA. In community mental health team waiting rooms, 42 of 64 people approached (65%) had not heard of the service. In Gordon and St Charles mental health hospitals, 85% of people asked had not heard of the service.

What can the SPA offer? There was lots of confusion about the remit and abilities of the SPA from both service users interviewed (15 people) and by professionals (4 people). It was felt that the service was not explained clearly enough in the introduction to the service.

¹¹ 'A CTO is the legislative power by which patients with mental health difficulties who are treated involuntarily in hospital can be discharged into the community but still remain subject to compulsory treatment. The CTO thus extends the setting for involuntary treatment from being exclusively confined to the hospital ward to the community.' (Stroud, J., Doughty, K., and Banks, L., School of Applied Social Science, University of Brighton May 2013)

Access to Service. Service user and professionals appreciated the 24 hour availability of the service. Voluntary sector managers found that fast access to information that would help speed up the process of getting support for the client.

14 out of 17 respondents called for help to manage a crisis, though other reasons for calling included signposting to other services and advice.

Half of people interviewed felt that they had not been given enough time to discuss their issues. Participants' suggestions for improvements included lengthening the time available to talk, reducing waiting times, the availability of face to face contact and follow up services, as well as creating alternative routes to access the service.

Primary Care Plus

GPs can refer to the Primary Care Plus service which coordinates referrals into mental health services and offers patients an assessment by a mental health practitioner in their own GP surgery. The service can refer to the community mental health team if required, as well as other local services which support wellbeing. It can also help those discharged from hospital back into the community.

In 2014 an evaluation of the service interviewed 12 services users who had been 'stepped up' into the service found that:

- 50% saw their GP more than once a month, and 75% felt that the amount of times they saw their GP about mental health was enough for their needs
- Although booking appointments with the Primary Care Liaison Nurse was considered easy for most, 2 people mentioned communication as a barrier to making an appointment
- Most (9 out of 12) found the PCLN helpful in some way, for example to be referred, feeling needed and not judged, getting medication or advice, and feeling supported. A small number did not find PCLN appointments helpful with reasons such as finding the PCLN confrontational.
- Just over half (7 out of 12) found that they had their needs met by the PCLN for reasons such as getting quick appointments, helpful to talk to, being referred, and getting medication. However, 5 of the 12 reported that they had not had their needs met, citing reasons such as lack of expertise, having to organise their own care due to lack of knowledge, and not getting on with the PCLN.
- The majority of the interviewees (8) felt that their GP practice did not have the skills or knowledge to manage their mental health condition. While they valued the GP for their physical health, they did not feel the GP understood their mental health issues and that they needed specialist help.
- Respondents did value the proximity of their GP practice and some did have good relationships with their GP.

The report puts forward some recommendations on training for GPs and their staff, communicating information about the role of the PCLN (in ways that tackle language and other communication barriers), and administration of appointments.

It should be noted that the study involved a small sample size, with the majority of interviewees being of a white ethnic background (75%) and within the 26-65 age bracket (10 out of 12).

DRAFT

9 Older adults mental health and wellbeing

9.1 Key Messages

Key messages: Older Adult Mental Health

Prevalence

- The estimated prevalence of mental illness in older adults was taken from the Adult Psychiatric Morbidity Survey (APMS 2014). Not including dementia, national estimates applied to the local population of older adults suggest that 2,527 older adult residents of Kensington and Chelsea and 3,170 older adult residents in Westminster experience a common mental health disorder. The most common of specified disorders was general anxiety disorder, affecting 819 older residents in Kensington and Chelsea, and 1025 in Westminster
- Should the England prevalence of mental illness prevail in the both boroughs and remain constant, and population of each borough grow as projected by the Greater London Authority, the number of cases of mental illness in older adults (not including dementia) in 2028 will grow to 3162 in Kensington and Chelsea and 4071 in Westminster.

Risk factors

- Levels of discrimination, presence of meaningful activities and relationships, physical health condition and poverty are key factors that affect the mental health and wellbeing of older people. In addition factors such as recent bereavement, caring responsibilities, family breakdown, loss of mobility and loss of independence (giving up driving, unemployment, age-related disability) all present risk factors
- Some groups of older people are at increased risk of mental health problems. Those who are lonely have a higher risk of developing dementia and depression and older people in a caring role may struggle to get the support they need

Comparative data on prevalence of risk factors shows

- The rate of diagnosed dementia among the GP registered population is lower than the London average in Kensington and Chelsea, while rates in Westminster are above the London average
- Both boroughs have a higher percentage of residents aged 60 years and over living in income deprivation compared to the national average

- In both boroughs the percentage of older people living alone is above the London average and the percentage of social care users with enough social contact is lower than the London average

What Works

There is evidence that the following interventions can have a beneficial effect on mental health and wellbeing:

- befriending programmes along with psychosocial interventions can promote wellbeing and prevent depression
- volunteering opportunities are associated with improved mental wellbeing, self-reported health and reduced depression
- addressing hearing loss is associated
- physical activity programmes can improve mental wellbeing and reduce mental illness.
- interventions to promote household warmth are associated with improved mental health and reduced depression
- Interventions to prevent social isolation have also been shown to improve wellbeing
- The Better Mental Health for All report highlights the following areas for consideration:
- The Campaign to End Loneliness provides guidance on developing strategies to address loneliness amongst older people in their local populations.
- NICE recommend a range of activities for older people including support sessions to assist with daily routines and self-care, community based physical activity programmes, walking schemes and training for practitioners. (See also relevant NICE guidance PH16)

9.2 Background

Our mental health and wellbeing can be challenged as we grow older by events outside of our control, such as the loss of a loved one and reduced mobility. The Mental Health Foundation and Age Concern said “promoting mental health and well-being in later life will benefit the whole of society by maintaining older people’s social and economic contributions, minimising the costs of care and improving quality of life” (Mental Health Foundation & Age Concern, 2006).

Life satisfaction, the feeling of being worthwhile, and happiness all increase in the years leading up to and during the first few years of retirement, however so do feelings of anxiety. It is in the later years of retirement, 74 and older, that anxiety stays continuously high, but happiness, life satisfaction and feeling worthwhile decrease.

Mental health problems in later life are under-identified by health professionals and by older people themselves⁶, this can be when the impacts of poor mental health and adversity throughout life become evident⁴. To promote mental wellbeing for all it is vital to prevent, identify and effectively treat mental health problems in later life.

Good relationships and connecting with others is important for a mentally healthy later life. Loneliness can lead to deterioration in health and wellbeing and is also a symptom of common mental health conditions. Although recent research has shown us that young people often report being lonely more often than older adults, nearly half of all people over the age of 75 live alone.

Many older adults will suffer from physical ill health and this can lead to mental health problems. The risk of developing depression is over 7 times higher in those with two or more chronic physical problems.

9.3 Prevalence and incidence

Population prevalence

Table 73 shows the estimated prevalence of mental illness excluding dementia in the older age population are taken from the Adult Psychiatric Morbidity Survey (2014). Estimates are calculated from the **England** age-specific prevalence rates for each illness.

Should the England prevalence of mental illness prevail in the both boroughs and remain constant, and population of each borough grow as projected by the Greater London Authority, the numbers of cases of mental illness shown in Table 73 could be expected.

Table 73. Estimated prevalence of mental illness by borough 2018 to 2028

Illness/ presentation	Borough	2018	2023	2028	Illness/ presentation	Borough	2018	2023	2028
Any CMD	RBKC	2,527	2,799	3,162	Antisocial personality disorder	RBKC	-	-	-
	WCC	3,170	3,566	4,071		WCC	-	-	-
Unspecified CMD	RBKC	1,242	1,391	1,577	Bipolar disorder	RBKC	55	55	61
	WCC	1,560	1,764	2,016		WCC	68	73	83
GAD	RBKC	819	897	1,010	Borderline personality disorder	RBKC	-	-	-
	WCC	1,025	1,148	1,310		WCC	-	-	-
Depressive episodes	RBKC	428	469	528	Psychotic disorder	RBKC	41	45	50
	WCC	537	601	685		WCC	52	58	66
Phobias	RBKC	136	152	172	Suicide thoughts	RBKC	2,488	2,738	3,088
	WCC	171	193	220		WCC	3,118	3,499	3,992
OCD	RBKC	74	83	94	Suicide attempts	RBKC	676	730	818
	WCC	92	105	120		WCC	846	941	1,071
Panic disorder	RBKC	161	179	203	Self-harm	RBKC	300	313	346
	WCC	202	228	260		WCC	374	410	465
PTSD	RBKC	289	309	346					
	WCC	361	400	455					

Source: Adult Psychiatric Morbidity Survey (2014). Greater London Authority population projections

9.4 Risk factors

As with other age groups there are many risk factors associated with the mental health of older adults. Levels of discrimination, presence of meaningful activities and

relationships, physical health condition and poverty are key factors that affect the mental health and wellbeing of older people⁷.

Older people who have experienced any of the following are at a greater risk of a decline in their independence and wellbeing⁸ if:

- their partner died in the past 2 years
- they are a carer
- they live alone and have little opportunity to socialise
- recently separated or divorced
- recently retired (particularly if involuntarily)
- unemployed in later life
- on low income
- have recently experienced or developed a health problem
- have had to give up driving
- have an age-related disability
- are aged 80 or older

Some groups of older people are at increased risk of mental health problems. Those who are lonely have a higher risk of developing dementia and depression and older people in a caring role may struggle to get the support they need⁴.

Table 74 shows summarise comparative data on mental health risk factors for older adults. From Table 74 the following key points are made:

- The rate of diagnosed dementia among the GP registered population is lower than the London average in Kensington and Chelsea, while rates in Westminster are above the London average
- Both boroughs have a higher percentage of residents aged 60 years and over living in income deprivation compared to the national average
- In both boroughs the percentage of older people living alone is above the London average and the percentage of social care users with enough social contact is lower than the London average

Table 74 Comparative data on mental health risk factors for older adults

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Dementia recorded prevalence (aged 65+): % of practice register	Sep-17	4.3%	4.9%	4.5%	4.3%	1,050	1,303
Older people living in poverty: % of population aged 60+ (IDAOP)	2015	21.6%	24.9%	-	16.2%	-	-
Older people living alone: % of households occupied by a single person aged 65 & over	2011	5.3%	5.2%	3.9%	5.2%	8,240	11035
Enough social contact in adult social care users: % of adult social care users	2016/17	36.2%	36.2%	41.0%	45.4%	-	-

Source: Public Health England Fingertips (2018)

9.5 Protective factors

There is limited comparative data specifically focused on protective factors in older adults, therefore this section therefore presents the available data. Some data is already included in risk factors and most relate to adults rather than older ages. Table

75 summarises the available comparative data. From Table 75 the following key points are made:

- Levels of life satisfaction and happiness in the boroughs is higher than the London average, as are physical activity levels
- Health related quality of life for residents aged 65 years and over is higher than the London average in Kensington and Chelsea and similar to the London average in Westminster
- Levels of social isolation among carers and care users, as well as care users' and carer's quality of life measures are below the London average.

Table 75 Comparative data on protective factors for mental health for older adults

Indicator	Period	Rate				Count	
		RBKC	WCC	London	England	RBKC	WCC
Self-reported well-being - high satisfaction score: % of respondents	2015/16	83.9%	81.2%	79.6%	81.2%	-	-
Self-reported well-being - high happiness score: % of respondents	2015/16	77.2%	76.3%	74.3%	74.7%	-	-
Health related quality of life for older people (Persons, 65+ yrs)	2016/17	0.764	0.731	0.728	0.735	-	-
Carer-reported quality of life score: people caring for someone with dementia 18+ yrs	2014/15	6.7	7.0	7.6	7.9	-	-
Social care-related quality of life (Persons, 18+ yrs)	2015/16	18.1	18.5	18.6	19.1	-	-
Percentage of physically active adults - current method (Persons, 19+ yrs)	2016/17	68.2%	66.7%	64.6%	66.0%	-	-
Enough physical activity: % of population age 19+	2016/17	68.2%	66.7%	64.6%	66.0%	-	-
Older people living alone: % of households occupied by a single person aged 65 & over	2011	5.3%	5.2%	3.9%	5.2%	8,240	11,035
Social Isolation: percentage of adult social care users who have as much social contact as they would like (Persons, 18+ yrs)	2017/18	35.8%	34.3%	41.4%	46.0%	-	-
Social Isolation: percentage of adult carers who have as much social contact as they would like (Persons, 18+ yrs)	2016/17	30.1%	29.0%	35.6%	35.5%	126	110

Source: Public Health England Fingertips (2018)

9.6 What works

There is evidence that:

- befriending programmes along with psychosocial interventions can promote wellbeing and prevent depression (Cattan et al., 2005).
- volunteering opportunities are associated with improved mental wellbeing, self-reported health and reduced depression.
- addressing hearing loss is associated with improved quality of life.
- physical activity programmes can improve mental wellbeing and reduce mental illness.
- interventions to promote household warmth are associated with improved mental health and reduced depression (Thomson et al., 2009).
- Interventions to prevent social isolation have also been shown to improve wellbeing (Deacon et al., 2009). This is discussed in more depth elsewhere in the JSNA.

The *Better Mental Health for All* report (2016) highlights the following areas for consideration:

- The Campaign to End Loneliness provides guidance on developing strategies to address loneliness amongst older people in their local populations. Their Loneliness Framework set out interventions across the healthcare system and the wider community
- Community approaches to reduce isolation in older people that have been found to be effective include:
 - Befriending and mentoring
 - Social group schemes which incorporate self-help support and peer involvement
- Identifying and supporting carers with a focus on carers aged eighty-five and over.
- Dementia Friendly Communities is an Alzheimer's Society programme which enables the creation of dementia-friendly communities across the UK and ensures everyone understands that they have a shared responsibility for ensuring people with dementia feel understood, valued and able to contribute to their community.
- The Dementia Friends initiative aims to change people's perceptions of dementia and to change the way the nation thinks, talks and acts about the condition
- Peer support groups for people with early stage dementia living in extra care, retirement housing and their families have had promising outcomes in the areas of wellbeing, social support and practical coping strategies, with improvements in communication abilities, managing memory and managing lives all linked to peer support
- Reminiscence therapy for older people has a range of therapeutic and preventative effects, including reduction in symptoms of depression and improved feelings of self-esteem
- NICE recommend a range of activities for older people including support sessions to assist with daily routines and self-care, community based physical activity programmes, walking schemes and training for practitioners.

What NICE says...

NICE Guidelines (PH16) outline recommendations around the wellbeing of older people:

- Involve occupational therapists in the design and development of locally relevant training schemes for those working with [older people](#). Training schemes should include:
 - essential knowledge (and application) of the principles and methods of [occupational therapy](#) and health and wellbeing promotion

- effective communication skills to engage with older people and their carers (including group facilitation skills or a person-centred approach)
- Ensure practitioners have the skills to:
 - communicate effectively with older people to encourage an exchange of ideas and foster peer support
 - encourage older people to identify, construct, rehearse and carry out daily routines and promote activities that help to maintain or improve health and wellbeing
 - improve, maintain and support older people's ability to carry out daily routines and promote independence
- Collect and use regular feedback from participants.
- Advise older people and their carers how to exercise safely for 30 minutes a day (which can be broken down into 10-minute bursts) on 5 days each week or more. Provide useful examples of activities in daily life that would help achieve this (for example, shopping, housework, gardening, cycling).
- Invite regular feedback from participants and use it to inform the content of the service and to gauge levels of motivation.

In collaboration with older people and their carers, offer a range of walking schemes of low to moderate intensity with a choice of local routes to suit different abilities; and tailored physical activity and exercise schemes

9.7 Services

Treatment services

Prescribing

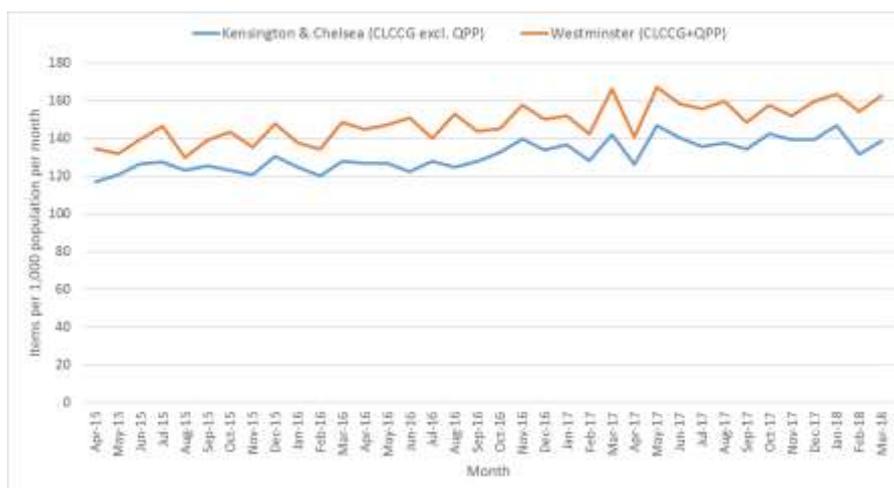
Data on the number of older adults prescribed antidepressants is not available, only the number of items (packs of medication).

Chart 24 shows that the crude rate of antidepressant items prescribed to older adults aged 65 years and over per 1,000 population.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

From Chart 24 it can be seen that antidepressant prescribing rates are typically higher in Westminster compared to Kensington and Chelsea. The chart also shows rates in both boroughs and has been increasing slightly over the past three financial years.

Chart 24 Antidepressant prescribing, items per 1,000 adults aged 65 years and over



Source: NHS North West London Medicines Management

Table 76 shows annual numbers of items prescribed per financial year and crude rates per 1,000 GP registered population to enable comparison.

As local Clinical Commissioning Groups (CCGs) are not co-terminus with borough boundaries, borough level activity has been estimated by attributing GP practices to boroughs based on location.

From Table 76 in 2017/18 around 40,000 antidepressant items were prescribed to older adults in Kensington and Chelsea and almost 50,000 items in Westminster.

Table 76 Antidepressant prescribing items and rate per 1,000 population aged 65 years and over

Metric	Borough	2015/16	2016/17	2017/18
Items/1,000 population	Kensington & Chelsea (WLCCG excl. QPP)	1,487	1,569	1,659
	Westminster (CLCCG + QPP)	1,668	1,793	1,880
Items	Kensington & Chelsea (WLCCG excl. QPP)	36,353	38,530	42,165
	Westminster (CLCCG + QPP)	41,406	45,964	49,698

Source: NHS North West London Medicines Management

Specialist mental health services

This section describes the finding from analysis of activity data provided by Central and North West London Foundation Trust (CNWL). In interpreting these findings it should be considered that, while CNWL is the largest provider of mental health care services, there are other mental health services, therefore the numbers presented are likely to be an underestimate of current demand for treatment services.

Referrals

Chart 25 shows referrals to Central and North West London Foundation Trust’s (CNWL’s) Older Adult Mental Health services for registered patients aged 65 years and over, by Clinical Commissioning Group (CCG).

CCG boundaries map to the Bi-Borough as follows:

- West London CCG (WLCCG) – Kensington and Chelsea borough and Queen’s Park Paddington (Westminster borough)
- Central London CCG (CLCCG) – Westminster borough excluding Queen’s Park Paddington

In interpreting referrals data it should be noted that of referrals, not all are accepted (see Table 80 below) and of those accepted not all referrals lead to a positive diagnosis and treatment.

Chart 25 shows the trend in referrals from all sources. Table 77 and 78 show annual numbers by referral source for Central London CCG and West London CCG respectively. The tables show referral volumes by source in rank order and indicate where annual numbers have increased (dark blue) or decreased (light blue) year on year.

Tables 79 and 80 list the reasons for referral in rank order. Year on year changes are highlighted as increase (dark blue) or decrease (light blue).

Chart 25 shows that monthly referral rates for CCG registered patients have declined in 2017/18. It also shows that prior to 2017/18, monthly rates of referral from both CCGs have been similar, but in 2017/18 rates for WLCCG exceed those from CLCCG.

Chart 25 Older Adults: Referrals to CNWL, all sources of referral, monthly trend



Source: CNWL contract monitoring data

From Tables 77 and 78 the following key points are made:

- the most common referral route into Older Adult services is from GPs followed by 'other secondary care specialty'
- No continual year on year increase in referral volumes from any source is observed for either CCG, but there have been continual year on year reductions in the number of referrals from GPs and 'other service or agency'

Table 77 Older Adults: Source of referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

Source of referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17 to	17/18
GP	680	658	552	1890	66%	97%	84%
Other secondary care specialty	213	178	131	522	18%	84%	74%
Other service or agency	133	34	29	196	7%	26%	85%
Social Services	78	44	24	146	5%	56%	55%
Other Primary Health Care	30	25	<5	55	2%	83%	-
Self	9	12	7	28	1%	133%	58%
Accident And Emergency Department	7	7	10	24	1%	100%	143%
Carer	5	8	5	18	1%	160%	63%
Voluntary Sector	5	<5	0	5	0%	-	-
Drug Action Team / Drug Misuse Agency	<5	0	0	0	0%	-	-
Health Visitor	<5	0	0	0	0%	-	-
Improving Access to Psychological therapies Service	0	0	0	0	0%	-	-
Independent sector - Medium Secure Inpatients	0	0	<5	0	0%	-	-
NHS Direct	<5	0	<5	0	0%	-	-
Other Independent Sector Mental Health Services	<5	<5	<5	0	0%	-	-
Out of Area Agency	<5	<5	<5	0	0%	-	-
Permanent transfer from another Mental Health NHS Trust	<5	<5	<5	0	0%	-	-
Police	<5	<5	<5	0	0%	-	-
Temporary transfer from another Mental Health NHS Trust	<5	<5	0	0	0%	-	-

Source: CNWL contract monitoring data

Table 78 Older Adults: Source of referral and year on year change in volumes WLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

Source of referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17 to	17/18
GP	921	868	815	2604	66%	94%	94%
Other secondary care specialty	311	342	200	853	21%	110%	58%
Other service or agency	132	45	28	205	5%	34%	62%
Social Services	39	31	32	102	3%	79%	103%
Other Primary Health Care	33	31	32	96	2%	94%	103%
Accident And Emergency Department	12	7	16	35	1%	58%	229%
Self	18	7	8	33	1%	39%	114%
Police	7	5	5	17	0%	71%	100%
Carer	5	5	5	15	0%	100%	100%
Voluntary Sector	12	<5	0	12	0%	-	-
Drug Action Team / Drug Misuse Agency	<5	0	0	0	0%	-	-
Health Visitor	<5	0	0	0	0%	-	-
Improving Access to Psychological therapies Service	0	0	0	0	0%	-	-
Independent sector - Medium Secure Inpatients	0	0	<5	0	0%	-	-
NHS Direct	<5	0	<5	0	0%	-	-
Other Independent Sector Mental Health Services	<5	<5	<5	0	0%	-	-
Out of Area Agency	<5	<5	<5	0	0%	-	-
Permanent transfer from another Mental Health NHS Trust	<5	<5	<5	0	0%	-	-
Temporary transfer from another Mental Health NHS Trust	<5	<5	0	0	0%	-	-

Source: CNWL contract monitoring data

Emergency and non-emergency

From Table 79, the majority of referrals to older adult mental health services are routine in nature, over 80% in both CCGs, the remaining are predominantly urgent, but not emergency referrals. In 2017/18 there were 128 urgent referrals from WLCCG and 67 from CLCCG, while numbers of emergency referrals were fewer than 5 per month.

Table 79 Older Adults: Type of referral by CCG

WLCCG (Kensington and Chelsea +QPP)							CLCCG (Westminster Excl. QPP)						
Referral type	Referrals			referrals			Referral type	Referrals			referrals		
	15/16	16/17	17/18	15/16	16/17	17/18		15/16	16/17	17/18	15/16	16/17	17/18
Emergency	<5	6	<5	-	0%	-	Emergency	<5	<5	<5	-	-	-
Routine	1291	1087	965	87%	81%	84%	Routine	1056	889	696	90%	91%	91%
Routine Plus	21	63	52	1%	5%	5%	Routine Plus	<5	6	5	-	1%	1%
Urgent	179	193	128	12%	14%	11%	Urgent	111	80	67	10%	8%	9%

Accepted

Of referrals Table 80 show that the percentage of that are accepted has not changed substantially between 2015/16 and 2017/18 in both CCGs. Around one-third of referrals are not accepted. In 2017/18 the percentage of referrals to adult services accepted was 70% for WLCCG registered patients and 67% for CLCCG registered patients.

Table 80 Older Adults: Referrals accepted by CCG

WLCCG (Kensington and Chelsea +QPP)							CLCCG (Westminster Excl. QPP)						
Decision	Referrals			referrals			Decision	Referrals			referrals		
	15/16	16/17	17/18	15/16	16/17	17/18		15/16	16/17	17/18	15/16	16/17	17/18
Accepted	1051	995	806	70%	74%	70%	Accepted	787	662	519	67%	68%	67%
Not Accepted	438	349	340	29%	26%	30%	Not Accepted	380	314	253	33%	32%	33%
Not Recorded	6	5	<5	0%	0%	-	Not Recorded	<5	<5	<5	-	-	-

Reason for referral

Table 81 and 82 show annual numbers by referral by reason for referral Central London CCG and West London CCG respectively. From these tables the following key points are made:

- For both CCGs 'in crisis' is the most common reason for referral, followed by Capacity (advice/ assessment) in CLCCG and Depression in WLCCG
- Continual year on year increases are only seen in capacity (advice/assessment) referrals from WLCCG
- The number of referrals for 'in crisis' in both CCGs have been declining year on year, as have referrals for 'unexplained physical symptoms' from WLCCG

Table 81 Older Adults: Reason for referral and year on year change in volumes CLCCG

NHS Central London (Westminster Excl. Queen's Park and Paddington) CCG

Reason for referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
In crisis	958	656	545	2159	75%	68%	83%
Capacity (advice/assessment)	48	96	75	219	8%	200%	78%
Depression	49	87	80	216	8%	178%	92%
Anxiety	39	66	48	153	5%	169%	73%
Ongoing or Recurrent Psychosis	9	24	10	43	1%	267%	42%
Unexplained physical symptoms	30	10	0	40	1%	33%	0%
Medication Review	8	11	<5	19	1%	138%	-
Personality disorders	8	<5	<5	8	0%	-	-
Organic brain disorder	7	<5	<5	7	0%	-	-
Self - care issues	0	5	<5	5	0%	-	-
Self harm	<5	5	<5	5	0%	-	-
Adjustment to Physical Health Condition	<5	<5	<5	0	0%	-	-
Bi polar disorder	<5	<5	<5	0	0%	-	-
Conduct disorders	<5	<5	0	0	0%	-	-
Drug and alcohol difficulties	<5	<5	<5	0	0%	-	-
Eating disorders	<5	0	0	0	0%	-	-
Neurodevelopmental conditions	<5	0	0	0	0%	-	-
Obsessive compulsive disorder	<5	0	0	0	0%	-	-
Post-traumatic stress disorder	<5	<5	<5	0	0%	-	-
Relationship difficulties	<5	<5	<5	0	0%	-	-
(blank)	<5	0	0	0	0%	-	-
	<5	0	0	0	0%	-	-

Source: CNWL contract monitoring data

Table 82 Older Adults: Reason for referral and year on year change in volumes CLCCG

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG

Reason for referral	Referrals					Change	
	15/16	16/17	17/18	2015-18	Share	15-16 to 16/17	16/17 to 17/18
In crisis	1235	968	830	3033	77%	78%	86%
Depression	89	180	152	421	11%	202%	84%
Ongoing or Recurrent Psychosis	35	52	33	120	3%	149%	63%
Capacity (advice/assessment)	33	39	41	113	3%	118%	105%
Anxiety	28	41	35	104	3%	146%	85%
Medication Review	24	14	23	61	2%	58%	164%
Bi polar disorder	9	7	11	27	1%	78%	157%
Organic brain disorder	<5	11	8	19	0%	-	73%
Self harm	9	8	<5	17	0%	89%	-
Drug and alcohol difficulties	<5	15	<5	15	0%	-	-
Conduct disorders	13	<5	0	13	0%	-	-
Adjustment to Physical Health Condition	<5	6	<5	6	0%	-	-
Eating disorders	<5	0	0	0	0%	-	-
Neurodevelopmental conditions	<5	0	0	0	0%	-	-
Obsessive compulsive disorder	<5	0	0	0	0%	-	-
Personality disorders	<5	<5	<5	0	0%	-	-
Post-traumatic stress disorder	<5	<5	<5	0	0%	-	-
Relationship difficulties	<5	<5	<5	0	0%	-	-
Self - care issues	0	<5	<5	0	0%	-	-
Unexplained physical symptoms	<5	<5	0	0	0%	-	-
(blank)	<5	0	0	0	0%	-	-
(blank)	<5	0	0	0	0%	-	-

Source: CNWL contract monitoring data

Caseload

In 2017/18 average caseloads were 484 for WLCCG and 331 for CLCCG. Chart 26 shows the monthly trend in older adults caseload by referring CCG. Numbers on caseload are converted into rates per 1,000 population aged 65 years to enable comparison. From Chart 26 cases per head of population from WLCCG are typically higher compared to CLCCG

Chart 26 Older Adults: older adults on caseload per 1,000 population aged 65 years and over



Source: CNWL contract monitoring data

Hospital admissions

Analysis of hospital spells for primary and secondary diagnoses of mental health conditions (International Classification of Diseases 10th edition [ICD 10] Chapter F) produced the findings in Table 81. Data presented where more than 5 spells occurred in the pooled 2015/16 and 2016/17 data and for the top 5 diagnoses

Table 83 presents the findings from local analysis of hospital activity data. As mental health and/ or self harm diagnoses are most commonly coded as a secondary diagnosis, only pooled data from 2015/16 and 2016/17 could be utilised as the 2017/18 spells data does not include secondary diagnosis field.

Table 83 Hospital admissions (Spells), adults aged 65years and over, with a relevant primary diagnosis Chapter F or X, 2015/16 and 2016/17 pooled data

Primary Diagnosis	Borough	EL	NEL	Secondary Diagnosis	Borough	EL	NEL
Mental and behavioural disorders due to use of alcohol	RBKC	-	19	Exposure to unspecified factor	RBKC	-	10
Vascular dementia, unspecified	RBKC	<5	11				
Unspecified dementia	RBKC	-	12				
Delirium, unspecified	RBKC	<5	11				
Severe depressive episode with psychotic symptoms	RBKC	-	9				
Anxiety disorder, unspecified	RBKC	-	7				
Depressive episode, unspecified	RBKC	-	5				
Unspecified dementia	WCC	-	32	Exposure to unspecified factor	WCC	-	19
Delirium, unspecified	WCC	-	25	Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	WCC	-	10
Mental and behavioural disorders due to use of alcohol	WCC	-	17	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics & antirheumatics	WCC	-	6
Anxiety disorder, unspecified	WCC	-	9	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism & psychotropic drugs, not elsewhere classified	WCC	-	5
Vascular dementia, unspecified	WCC	-	9				
Delirium superimposed on dementia	WCC	-	8				

Source: Secondary Uses Service spells data 2015/16 and 2016/17 pooled data. EL – Elective, NEL – Non-elective. n - Number

Support Services

Chart 27 shows the quarterly trend in referrals to Adult Social Care services for Mental Health Support between April 2015 and March 2018.

In interpreting these data it is important to note residents can have more than one referral per period and not all referrals result in a support package being implemented. Table 84 shows the relative numbers of referrals to service users referred and the percentage of referrals that led to a support.

Chart 27 Rate of referrals to Adult Social Care services for Mental Health Support

Source: Adult Social Care client data

Table 84 Referrals to ASC Mental Health Support

Borough	Mental Health Support	2015/16	2016/17	2017/18
RBKC	Individuals referred	462	412	343
WCC	Individuals referred	296	272	351
RBKC	% Individuals all ASC referrals	19%	18%	14%
WCC	% Individuals all ASC referrals	10%	10%	13%
RBKC	Referrals	521	482	418
WCC	Referrals	336	311	412
RBKC	Referrals accepted*	7%	4%	1%
WCC	Referrals accepted*	25%	10%	8%

Source: Adult Social Care client data

Table 84 shows the current numbers of Adult Social Care Clients with 'Mental Health Support' primary reason for support. This table also shows the number packages assigned to ASC clients.

Table 85 Numbers of Service Users and packages for Mental Health Support (excl. Memory and Sensory support)

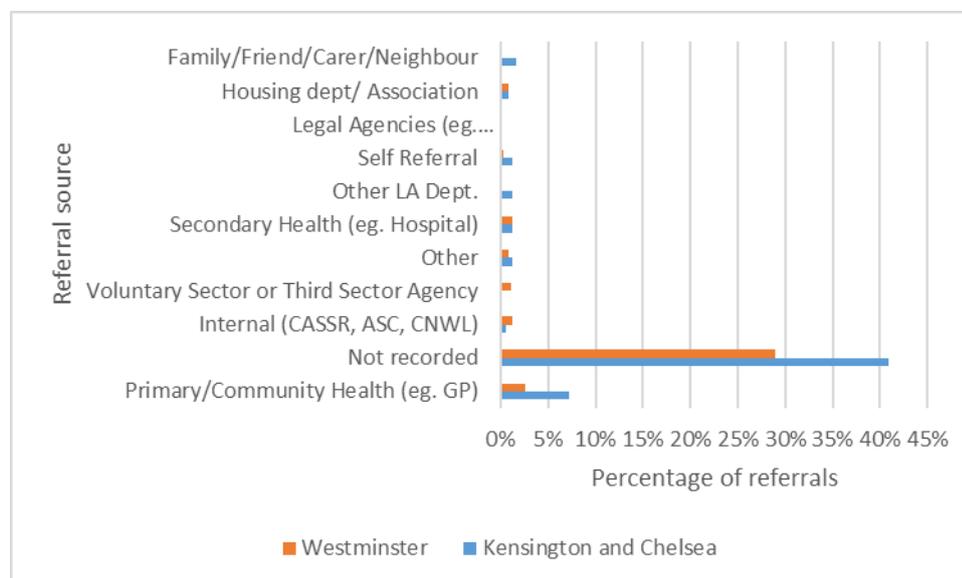
Borough	Mental Health Support	2015/16	2016/17	2017/18
RBKC	Service Users	142	148	141
WCC	Service Users	306	307	328
RBKC	% Individuals all ASC referrals	7%	7%	7%
WCC	% Individuals all ASC referrals	8%	8%	9%
RBKC	Packages	574	321	334
WCC	Packages	1,286	853	874

Source: Adult Social Care client data

Referral source

Chart 28 shows the distribution of referrals by source.

Chart 28: Referrals for mental health support by source and borough, pooled data 2015-18



Source: Adult Social Care client data

9.8 Local services and asset mapping

9.8.1 Central London CCG

Older adults are triaged by Primary Care Plus and then may be referred on to the Older People's Community Mental Health Team, the Home Treatment Team or to the Kensington & Chelsea and Westminster Memory Service.

Wait times for the Memory Service are considered to be too long (insert how long). Options are being considered for more assessments to be carried out by GPs, and make more use of the Primary Care Plus Navigators to provide post diagnosis support and sign-posting to services such as those provided by OpenAge and to ensure integration of mental health care and physical health care.

9.8.2 West London CCG

There are a number of services looking after the health care of older adults.

- The My Care My Way service provides integrated health and social care for those over the age of 65. The organisations included are GP surgeries, NHS hospitals, local community and social care services as well as many local charities and voluntary organisations.
- Memory Service and post diagnostic support

- Older people's community health teams

Like Central London CCG, long waits for the memory service are being addressed by developing proposals for more diagnosis to be done by the GP.

The current structure which keeps mental health services and physical health separate has a potential for some duplication.

9.8.3 Older Adults Wellbeing Services Commissioned by Local Authorities including Dementia Services

9.8.3.1 All Older Adults

Adult Social Care commission a range of services that contribute to the mental wellbeing of older adults which include hubs, carer's services, befriending, residential and nursing.

The Royal Borough of Kensington and Chelsea –Community Hubs

New Horizons

New Horizons offers over 80 sessions per week, including art, keep fit and IT classes, various discussion groups, a 10-week life stories programme and massage/reflexology sessions, amongst others.

Second Half Centre

The centre holds over 60 hours of activities and classes each week: Zumba Classes, Pilates, Yoga, Art, and International Cooking Classes. IT skills, from basic emailing to Excel, are also taught in the dedicated IT room. The centre also has a café onsite, where members can drop by and catch up with friends.

Westbourne Hub

The activities going on at Westbourne Hub include yoga, computer training, chair exercise, knitting, dance, current affairs discussion and sewing. They also have a number of sessions going on in various local locations, covering Tai Chi, ballroom dancing, art classes and a men's monthly lunch club and health talk.

City of Westminster – Community Hubs

Queens Park, Harrow Road

The centre offers a range of activities including: group singing sessions; guitar lessons; training around use of iPads; a 16 week exercise programme; sewing and an Arabic women's group. An outreach service, on the phone, based around creative writing is also available.

Churchill Hub

The Churchill hub offers activities such as a computer drop-in group, sewing and craft sessions, creative writing classes, steady and stable, knitting group and conversational English class. The hub also puts on a current affairs and creative writing phone group for those who are housebound.

Penfold Hub

The Penfold Hub offers dozens of activities per week, including an on-site community cafe, chair based yoga, art, trips out into the community, cook and eat classes and gardening sessions. The hub also runs a number of health and wellbeing classes, including Breathe Easy Westminster, acupuncture sessions and a 'Keep on moving', low impact fitness class.

Leonora Hub

The Leonora group, for people aged 50 and above, meets on Tuesdays and Wednesdays. Members choose which activities they want to take part in during the morning. Examples of activities on offer include bingo, dominoes, word games and reminiscence sessions. In the afternoon, the hub offers chair exercises or gentle yoga classes with a trained instructor. The centre also organise parties to mark special occasions throughout the year.

9.8.3.2 Services for those living with Dementia

The following services are those specifically commissioned by ASC for those with dementia:

- WCC
- London Care - Integrated Dementia Service. This currently consists of a dementia day centre at Westbourne Park, dementia advisor who runs dementia cafes, and dementia nurse.
- London Care - Pullen Day Centre. This is a day centre supporting those with cognitive and physical impairment needs most days and has a day dedicated for those with a dementia diagnosis.
- Carers Network - Carers Hub. They have dedicated support sessions for those caring for someone with a dementia diagnosis.
- Notting Hill Genesis - Penfold Extra Care Housing. Service generally supports residents with physical and or cognitive impairments and has 8 dedicated units for those with dementia.
- Octavia - Leonora Extra Care Housing. Service generally supports residents with physical and or cognitive impairments and has 5 dedicated units for those with dementia.
- RBKC
- Age UK Dementia Services. 1) Dementia advisor who runs the dementia cafes. 2) Volunteer co-ordinator. 3) Dementia one to one support. 4) Exercise for the mind sessions.
- Chamberlain House dementia day centre.

- Octavia – High Lever Extra Care Housing. All the 81 ECH housing units within RBKC supports residents with physical and or cognitive impairments. High Lever is a 5 unit scheme dedicated for those with dementia.

9.8.3.3 Support for Carers

The support for carers is crucial for their own mental health and wellbeing as well as enabling them to continue to care for their loved ones. Support available encompasses information and advice; carers assessments and reviews; outreach and partnership

Information and Advice (4 hours per day, 5 days per week)

The service delivers specialist advice to all carer cohorts in the following priority areas:

- Carers related information, advice, guidance and support;
- Health- maintenance, improvement, self-management and recovery
- Welfare Rights;
- Legal Advice;
- Financial Advice including debt and money advice;
- Community Care – Care Act 2014;
- Education / Employment / Training advice.

Carers Assessments and Reviews (195 per quarter in WCC, 65 per quarter in RBKC)

The service delivers carers assessments, reviews, and support planning, and indicative carers personal budget allocations to the full range of carer cohorts within our communities. This review of the needs of each carer includes the following:

- An individual's caring role and how it affects their life and wellbeing;
- The carer's health and wellbeing – physical, mental and emotional issues;
- The carer's emotional wellbeing and feelings and choices about caring;
- The carer's capacity regarding work, study, training and leisure;
- The relationships, social activities and goals that the carer wants to achieve;
- Housing issues that may be affecting the carer;
- Planning for emergencies (such as a Carer Emergency Scheme) with the carer;
- Eligibility and access to Personal Health Budgets.

Support, Outreach and Partnership

- A dedicated Carers' telephone helpline for Carers' enquiries (8 hours per day, 5 days per week)
- Wrap around service including out of office hours – carers support provision (4 hours per day, 5 days per week)
- Targeted information and advice surgeries within identified community settings throughout the borough (3 co-located sessions x 42 weeks per year in WCC, 1 x 42 weeks in RBKC)

- Work with GP Surgeries, prioritising surgeries who have participated within the Primary Care Carers Navigator Scheme (1 practice per week in both WCC and RBKC)
- Carer identification, accessing new carers via primary care facilities, pharmacies, clinics, primary and community health facilities (1 organisation per week in both WCC and RBKC)
- Generic peer support groups / drop-ins that give Carers across all care groups the chance to meet others in similar situations and offer peer support at venues across the borough (1 per month in WCC)
- Specialist support groups for: Carers of adults with mental health issues, Carers of adults with learning disabilities (including autism) and or physical disabilities, and mental health needs. (1 per month in WCC)
- Home visiting for Carers as necessary (WCC quarterly target: 15, RBKC quarterly target: 5)
- A quarterly carers forum in both WCC and RBKC
- Distribution of a Carers' information pack - produced on an annual basis with the involvement of Carers (ongoing)
- Production and distribution of a quarterly Carers' newsletter and e-bulletin
- Bi-monthly awareness sessions / briefings for social and health care staff
- Bi-monthly education, training and employment sessions / briefings, e.g. CV writing workshops
- Bi-monthly carers support training, e.g. dementia awareness training
- Partnership working with the shared service (3 borough) adult social care website for supporting health and independent living, PeopleFirst, to ensure carers information is accurate and up to date and reflects the needs of all carer cohorts and our communities within each borough
- Quarterly partnership events to promote Carers' rights, assessments and services and identify hidden Carers. These include Carers' Week and Carers' Rights Day, and others as identified
- Partnership working with care management teams, primary care organisations, general practices and voluntary and community sector and faith organisations (60 partnership engagement activities per year developing shared outcomes)

9.8.4 Central London CCG and WCC Adult and Older Adult Mental Health

Purpose/Modality	Description	Spend 2017/18
Placements	Mental Health registered care and nursing care placement , purchase on an individual 'spot' contract based by NHS CCG or Local Authority to meet Section 117 Mental	NHS and LA

Title

	Health Act aftercare duties	
Supported Housing	Accommodation with staff support delivered through Housing	NHS and LA
Adult Acute in Patient	Acute Care in Hospital in-patient provision	NHS
Adult Acute PICU	Psychiatric Intensive Care Unit for the care and treatment of persons whose distress, absconding risk, suicidal and challenging behaviour requires a secure environment.	NHS
Rehabilitation(Residential Open & Secure)	Mental Health rehabilitation beds in an in-patient setting identified as 'mental health rehabilitation', to differentiate it from community based rehabilitation , provided by the NHS and independent hospital sector	NHS
ECRs/NCA	Extra Contractual Referral/ Non-Contract Activity	NHS
Specialist Out of Area in Patient Services	In-patient specialist care and treatment in regional or national centres for specific conditions	NHS
OPMH in Patients(functional & Organic)	Older People's Mental Health for Functional(e.g. depression, psychosis) and Organic (Dementia) conditions	NHS
Mental Health & Dementia Care Homes (Local)	Local provision of Nursing Care for functional and organic conditions.	NHS

9.8.5 West London CCG and WCC Adult and Older Adult Mental Health

Tier 4		
Purpose/Modality	Description	Spend 2017/18
Placements	Mental Health registered care and nursing care placement , purchase on an individual 'spot' contract based by NHS CCG or Local Authority to meet Section 117 Mental Health Act aftercare duties (Include JHT and MH Accommodation Seeker Service and also a percentage of RBKC supported housing contracts for socially excluded group.	NHS and LA
Supported Housing	Accommodation with staff support delivered through Housing	NHS and LA
Supported Living in - borough		NHS and LA
Adult Acute in Patient	Acute Care in Hospital in-patient provision	NHS
Adult Acute PICU	Psychiatric Intensive Care Unit for the care and treatment of persons whose distress, absconding risk, suicidal and challenging behaviour and therefore require a secure environment.	NHS
Rehabilitation(Residential Open & Secure)(CNWL	Mental Health rehabilitation beds in an in-patient setting	NHS

Rehabilitation and Specialist)	identified as 'mental health rehabilitation', to differentiate it from community based rehabilitation , provided by the NHS and independent hospital sector	
ECRs/NCA	Extra Contractual Referral/ Non-Contract Activity	NHS
Specialist Out of Area in Patient Services	In-patient specialist care and treatment in regional or national centres for specific conditions	NHS
OPMH in Patients(functional & Organic)	Older People's Mental Health for Functional(e.g. depression, psychosis) and Organic (Dementia) conditions	NHS
Mental Health & Dementia Care Homes (Local)	Local provision of Nursing Care for functional and organic conditions. (Includes Ellesmere Dementia 20 bedded unit)	NHS and LA

10 Spotlight on Dementia

10.1 Introduction

A JSNA specifically on Dementia was published in 2015 and this JSNA does not propose to duplicate this work. Information in this the older adults section of this report includes updates to data where available and service provision.

Dementia is a term used to describe a range of cognitive and behavioural symptoms that can include memory loss, problems with reasoning and communication and change in personality, and a reduction in a person's ability to carry out daily activities, such as shopping, washing, dressing and cooking. The most common types of dementia are Alzheimer's disease, vascular dementia, mixed dementia, dementia with Lewy bodies and frontotemporal dementia. Dementia is a progressive condition, which means that the symptoms will gradually get worse. This progression will vary from person to person and each will experience dementia in a different way – people may often have some of the same general symptoms, but the degree to which these affect each person will vary (Dementia Gateway, Social Care Institute for Excellence).

Dementia mainly affects people over the age of 65 (one in 14 people in the UK in this age group have dementia), and the likelihood of developing dementia increases significantly with age. However, dementia can also affect younger people too. There are more than 42,000 people in the UK under 65 with dementia.

10.2 National Context

In March 2012, the government launched a national challenge to fight dementia. This programme of action was set up to deliver sustained improvements in health and care, create dementia friendly communities, and boost dementia research.

The Prime Ministers' Challenge on Dementia 2020 (launched February 2015) sets out the UK Government's strategy for transforming dementia care within the UK. The Challenge aims to build on the previous programme of action, and, by 2020, see England become

- the best country in the world for dementia care and support and for people with dementia, their carers and families to live; and
- the best place in the world to undertake research into dementia and other neurodegenerative diseases.

This will be achieved by

- Improving diagnosis, assessment and care for people living with dementia
- Ensuring that all people living with dementia have equal access to diagnosis
- Providing all NHS staff with training on dementia appropriate to their role

- Ensuring that every person diagnosed with dementia receive meaningful care

10.3 Prevalence

Current estimates of the number of people living with dementia in the local population are ca. 1,500 in RBKC and 1,800 in Westminster. Approximately 50% of the population with dementia are aged 85+. (JSNA)

Through population projections, the number of people living with dementia is estimated to rise by 70% for Kensington & Chelsea; and by 45% for Westminster by 2030. Diagnostic, treatment and care service provision may need to expand proportionately to meet this increasing need.

10.4 Current Performance against PHE’s Dementia Pathway on a Page

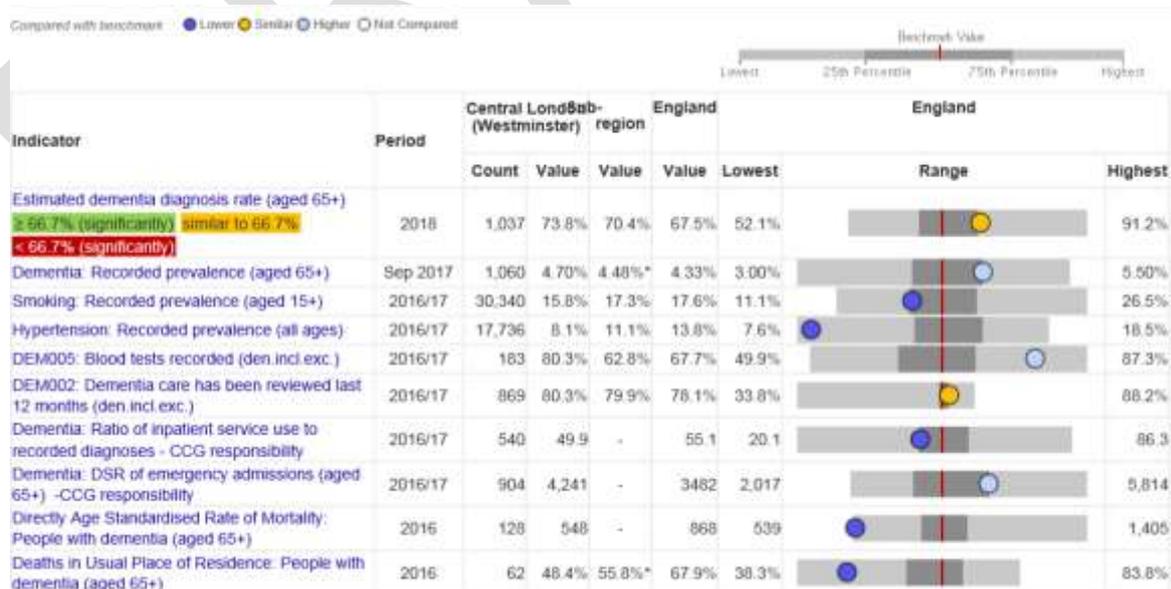
The Dementia Pathway on a Page produced by PHE gives snapshot of how dementia is prevented and diagnosed locally. It also shows data on the care that is provided to people with dementia, including end of life care.

Areas of performance highlighted by the profile for are the higher than the England average rates Dementia DSR Emergency Admissions for both CCG areas and the lower rates of people dying in their usual place of residence.

In March 2018 WL CCG had an estimated diagnosis rate of 75.7%, and CL CCG 73.8%. In comparison to the 70.4% in London and 67.5% nationally rates are better in West London than in London. The diagnosis rate for Central London is similar to London.

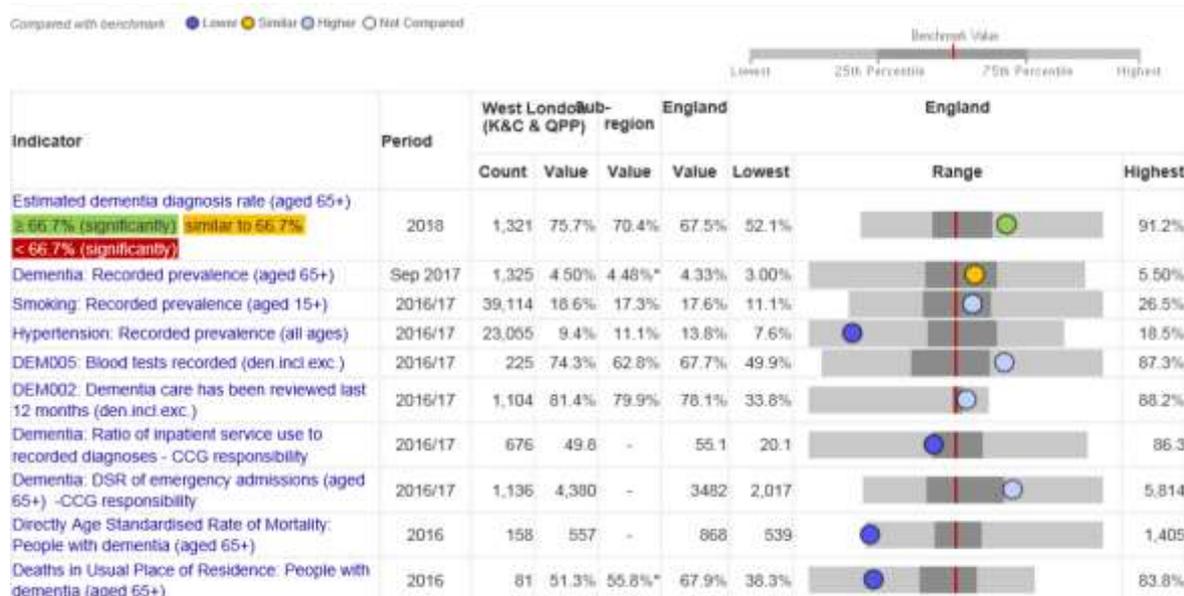
Dementia Pathway on a Page Central London CCG (Westminster)

PHE Fingertips dementia Profile (accessed 15 August 2018)



Dementia Pathway on a Page West London CCG (Kensington and Chelsea & Queens Park & Paddington)

PHE Fingertips dementia Profile (accessed 15 August 2018)



10.5 Dementia Friendly City

Services needed by those living with dementia and those who care from them are both dementia specific and non-dementia specific. For details of current services see the Local Services and Asset Mapping section.

For those living with dementia and their carers to have a good quality of life requires not only NHS and LA commissioned services but also for London to become a dementia friendly city. The Alzheimer’s Society, the GLA, London Health Board and other partners working together to achieve the ambition of a Dementia Friendly London by 2022 with the following priority areas for action.

- 2,000 dementia friendly organisations
- 500,000 Dementia Friends
- Every London borough working to becoming a dementia friendly community
- Meaningful involvement of people affected by dementia

10.6 Development of a Local Dementia Strategy

A dementia strategy for Westminster and Kensington and Chelsea is currently in development informed by the Dementia JSNA 2015, the North West London Strategic Review of Dementia 2015 as well as new developments in national policy guidance and research. Work is also being informed through a programme of engagement with people who are affected by dementia commencing in January 2019.

11 Health Economics

The following tables detail the return on investment results from *Commissioning cost-effective services for promotion of mental health and wellbeing and prevention of mental ill-health* (Public Health England, 2017) for Kensington and Chelsea and Westminster, respectively.

The results suggest the highest cumulative financial value for money is from investing in school-based socio-emotional learning, £5.08 for every £1 spent. However other factors, such as the size of the population impacted, the robustness of the assumptions made in the models, should also be considered when deciding on where to best to prioritise investments.

DRAFT

Kensington and Chelsea

Intervention	Target population	Outcomes	Efficacy	Expected local impact	Time period	Cost 'usual care'	Cost post intervention	Cost of intervention	Savings (net)	Savings (gross)	ROI	Positive ROI in year 1	Savings from	Savings to
Investing in socio-emotional learning: school based resilience	Children aged 11 (n=1,546)	Reduced incidence of depression	41% reduction in the probability of depression	Reduction in children experiencing depression 93 to 70	7 years	£ 245,783	£ 177,900	£ 13,373	£ 67,883	£ 54,510	£5.08:£1	Y	Reduction in hospital care (A&E, inpatient and outpatient), GP services, school nurses/ counsellors, CAMHS/ child psychologists, social workers, other professionals and absenteeism cost to families	NHS, Local Authority, Families, Schools
Whole school anti-bullying programme	Children aged 7 to 8 years (n = 1,637)	Reduction in incidence of intermittent and intense bullying.	18% reduction in the probability of being bullied compared to no intervention	Reduction in intense bullying 35 to 24 and 252 to 209	4 years	£ 196,003	£ 187,511	£ 5,371	£ 8,492	£ 3,121	£1.58:£1	Y	Reduced GP and CAMHS utilisation, reduced ambulance and hospital costs associated with self-harm, and reduced school absence	NHS, Families
Universal workplace well-being programme	Employees (n=500)	Reduction in absenteeism and presentee-ism	303% Increase in the proportion of workers maintaining their well-being	Increase in employees maintaining well-being 165 to 199	1 year	£ 97,245	£ 41,050	£ 41,050	£ 97,245	£ 56,195	£2.37:£1	Y	Absenteeism-related and Presenteeism-related productivity losses avoided, and GP visits avoided	NHS, Employers
Universal programme of CBT for employees identified as being stressed	Employees (n=1000)	Reduction in employees identified as stressed remaining stressed	13% reduction in the probability of remaining stressed	Reduction in employees remaining stressed by 86 per 1,000 employees	2 years	£ 6,985	£ 3,492	£ 3,493	£ 6,985	£ 3,492	£2.00:£1	Y	Avoided GP visits and physical care costs, utilisation of secondary mental health services, medications, occupational health and LA well-being services, reduced productivity losses, presenteeism and increased retention	NHS, Local Authority, Productivity
Support for adults experiencing problematic debt, without mental health problems, attend GP surgeries	Adult population in debt (n=20,701)	Reduction in depression, stress and debt	44% reduction in proportion with unmanageable debt	Increase in the number of people in debt whose debt is manageable: 16,768 to 17,928	5 years	£ 42,610,472	£38,515,638	£ 1,573,506	£4,094,834	£2,521,328	£2.60:£1	N	GP Visits, Depression treatment, Legal and Debt administration, Workplace stress and absence due to debt, Depression productivity losses	NHS, Legal sector, Productivity
Investing in self-harm and suicide prevention	Incidence of suicide * population (n=518)	Reduction in the number of attempted and completed suicides	41% Reduction in the probability of self-harm	At year 10, 7 non-fatal suicide attempts, and 7 completed suicides prevented	10 years	£ 2,128,126	£ 1,985,657	£ 48,675	£ 142,469	£ 93,794	£2.93:£1	N	Ambulance, treatment for suicide and self-harm, ongoing psychological treatment, Productivity losses, Police investigations, Coroner Inquests, Intangible costs	NHS, Local Authority, Police, Productivity losses, Intangible losses
Signposting over 65's to group activities	22,627 of whom 6% (n=1,358) engage with the service	Reduction in loneliness leading to reduction in depression and self-harm	8% Reduction in probability sometimes lonely and 8% reduction in probability sometimes lonely	Reduction in 'always lonely' 502 to 460 and sometimes lonely 786 -720	5 years	£ 1,788,218	£ 1,738,064	£ 39,710	£ 50,154	£ 10,444	£1.26:£1	N	Reduced GP Visits, Depression and Self-harm treatments, and increased volunteering rates through signposting	NHS, Volunteers (local community)
Collaborative care for people with long-term physical health conditions	People with diabetes and coronary heart disease	Reduction in rates of depression in people with diabetes and coronary heart disease	21% Reduction in the probability of depression	Reduction in depressed 116 to 104 in year 1 and 131 to 129 in year 2	2 years	£ 3,070,119	£ 3,026,794	£ 28,561	£ 43,324	£ 14,763	£1.52:£1	Y	Health and Social Care services, Productivity	NHS, Productivity

Westminster

Intervention	Target population	Outcomes	Efficacy	Expected local impact	Time period	Cost 'usual care'	Cost post intervention	Cost of intervention	Savings (net)	Savings (gross)	ROI	Positive ROI in year 1	Savings from	Savings to
Investing in socio-emotional learning: school based resilience	Children aged 11 (n=2,092)	Reduced incidence of depression	41% reduction in the probability of depression	Reduction in children experiencing depression 126 to 95	7 years	£ 332,586	£ 240,729	£ 18,096	-£ 91,858	-£ 73,762	£5.08:£1	Y	Reduction in hospital care (A&E, inpatient and outpatient), GP services, school nurses/ counsellors, CAMHS/ child psychologists, social workers, other professionals and absenteeism cost to families	NHS, Local Authority, Families, Schools
Whole school anti-bullying programme	Children aged 7 to 8 years (n = 2,456)	Reduction in incidence of intermittent and intense bullying.	18% reduction in the probability of being bullied compared to no intervention	Reduction in intense bullying 52 to 35 and 378 to 313	4 years	£ 294,064	£ 281,324	£ 8,058	-£ 12,740	-£ 4,682	£1.58:£1	Y	Reduced GP and CAMHS utilisation, reduced ambulance and hospital costs associated with self-harm, and reduced school absence	NHS, Families
Universal workplace well-being programme	Employees (n=500)	Reduction in absenteeism and presentee-ism	303% Increase in the proportion of workers maintaining their well-being	Increase in employees maintaining well-being 165 to 199	1 year	£ 97,245	£ 41,050	£ 41,050	-£ 97,245	-£ 56,195	£2.37:£1	Y	Absenteeism-related and Presenteeism-related productivity losses avoided, and GP visits avoided	NHS, Employers
Universal programme of CBT for employees identified as being stressed	Employees (n=1000)	Reduction in employees identified as stressed remaining stressed	13% reduction in the probability of remaining stressed	Reduction in employees remaining stressed by 86 per 1,000 employees	2 years	£ 6,985	£ 3,492	£ 3,493	-£ 6,985	-£ 3,492	£2.00:£1	Y	Avoided GP visits and physical care costs, utilisation of secondary mental health services, medications, occupational health and LA well-being services, reduced productivity losses, presenteeisma and increased retention	NHS, Local Authority, Productivity
Support for adults experiencing problematic debt, without mental health problems, attend GP surgeries	Adult population in debt (n=31,950)	Reduction in depression, stress and debt	44% reduction in proportion with unmanageable debt	Increase in the number of people in debt whose debt is manageable: 25,879 to 27,669	5 years	£ 65,766,111	£59,446,038	£ 2,428,590	-£ 6,320,073	-£3,891,483	£2.60:£1	N	GP Visits, Depression treatment, Legal and Debt administration, Workplace stress and absence due to debt, Depression productivity losses	NHS, Legal sector, Productivity
Investing in self-harm and suicide prevention	Incidence of suicide * population (n=779)	Reduction in the number of attempted and completed suicides	41% Reduction in the probability of self-harm	At year 10, 11 non-fatal suicide attempts, and 11 completed suicides prevented	10 years	£ 3,284,605	£ 3,139,842	£ 75,126	-£ 219,889	-£ 144,764	£2.93:£1	N	Ambulance, treatment for suicide and self-harm, ongoing psychological treatment, Productivity losses, Police investigations, Coroner Inquests, Intangible costs	NHS, Local Authority, Police, Productivity losses, Intangible losses
Signposting over 65's to group activities	28,385 of whom 6% (n=1,703) engage with the service	Reduction in loneliness leading to reduction in depression and self-harm	8% Reduction in probability sometimes lonely and 8% reduction in probability sometimes lonely	Reduction in 'always lonely' 630 to 577 and sometimes lonely 986 -903	5 years	£ 2,243,274	£ 2,180,356	£ 49,816	-£ 62,918	-£ 13,102	£1.26:£1	N	Reduced GP Visits, Depression and Self-harm treatments, and increased volunteering rates through signposting	NHS, Volunteers (local community)
Collaborative care for people with long-term physical health conditions	People with diabetes and coronary heart disease	Reduction in rates of depression in people with diabetes and coronary heart disease	21% Reduction in the probability of depression	Reduction in depressed 179 to 160 in year 1 and 203 to 200 in year 2	2 years	£ 4,738,501	£ 4,671,633	£ 44,082	-£ 66,868	-£ 22,786	£1.52:£1	Y	Health and Social Care services, Productivity	NHS, Productivity

12 Appendix A – Scope questions

Questions for the JSNA (following Stakeholder Workshop)								
Key	Place	People	Perinatal	CYP	Adults	Older People	Service Mapping	What Works
<p>Page 218</p> <p>1. What do we mean by mental health and wellbeing?</p> <p>2. What is the local prevalence and characteristics of mental health and wellbeing?</p> <p>3. What are the local determinants and factors</p>	<p>1. What are the community assets that support wellbeing and create a socially inclusive community?</p> <p>2. Who has access to these assets and who does not?</p> <p>3. How do we maximise the</p>	<p>1. What is the prevalence of mental ill-health in our Boroughs?</p> <p>2. What are future projections of need?</p> <p>3. What does the data tell us about wellbeing in the Boroughs?</p>	<p>1. What is the local prevalence of perinatal mental ill-health?</p> <p>2. What are the risk factors for perinatal mental ill-health?</p> <p>3. What is the impact of perinatal mental ill-health?</p>	<p>1. What are the specific mental health and wellbeing issues for this age group?</p> <p>2. What is the pattern of mental health and wellbeing in this age group?</p> <p>3. What are the risk factors for poor mental wellbeing or ill-health among this age group?</p>	<p>1. What are the risk factors for poor mental wellbeing or ill-health among this age group?</p> <p>2. What works to improve workplace health and helps people to access employment ?</p>	<p>1. What are the risk factors for poor mental wellbeing or ill-health among this age group?</p> <p>2. What are the facts about social isolation and loneliness in the boroughs? And what works to tackle this?</p> <p>3. Accessibility: How do we create environments</p>	<p>1. What services and pathways currently exist e.g. primary, secondary care</p> <p>2. What works/best practice to make services more accessible?</p> <p>3. Integration of services and integration of commissioning services and its impact on mental wellbeing, and</p>	<p>1. What works to promote and protect wellbeing at different stages of the life course?</p> <p>2. What works to tackle social isolation and loneliness?</p> <p>3. What does an effective social prescribing model look like?</p>

<p>(risk and protective)?</p> <p>4. What local services and assets in the community are available to meet these needs?</p> <p>5. What works to promote or protect wellbeing across the life course?</p>	<p>potential of these assets?</p> <p>4. What are the key determinants for wellbeing in our boroughs?</p>	<p>4. What is the impact of mental illness on individuals, their community and the health and care economy?</p> <p>5. What are the specific needs at different ages in life?</p>	<p>4. What services are in place for perinatal mental health in the Bi-borough?</p> <p>5. What support or interventions do parents and families need during the perinatal period?</p>	<p>4. What data do we have for mental health and wellbeing in schools?</p> <p>5. What is already happening in schools and education to support wellbeing?</p>	<p>3. How do we support individuals and families with low income and those who use the benefits system?</p> <p>4. How do we reach seldom heard groups?</p>	<p>that are accessible for older people?</p> <p>4. What are the pre-existing assets and how do we make these accessible?</p> <p>5. What are the facts around dementia and how do we prevent it/create dementia friendly communities?</p>	<p>the interface between mental and physical health services</p> <p>4. Can we quantify the number of people who have more than one need that wouldn't be covered by the same service?</p>	<p>4. What interventions are the most cost effective/offer good ROI?</p> <p>5. How do we measure impact of services/interventions on wellbeing?</p>
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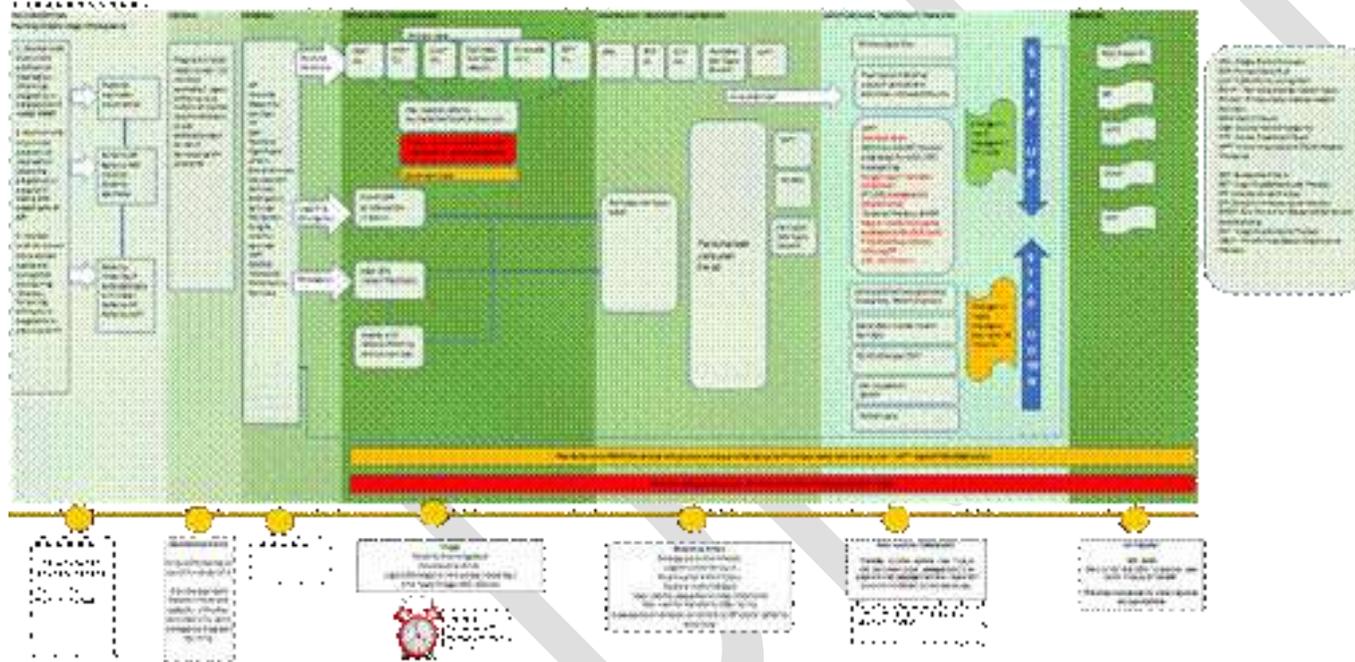
<p>6. What are the views and experience of both residents and patients accessing services?</p> <p>7. What are the potential gaps or areas unmet need which require local action?</p>		<p>6. What do we know about people who act as carers?</p> <p>7. What matters to local people and how do we reach seldom heard people?</p>	<p>6. How do we raise awareness of perinatal mental health among the public, parents, and non-mental health professionals?</p>	<p>6. What works to promote and protect mental wellbeing in early years through to adolescence?</p> <p>7. What role does social media play in mental wellbeing for this age group?</p> <p>8. How can services best engage with and support particular groups, such as BME or children who find it difficult to communicate?</p> <p>9. How can we increase the preventative mental</p>	<p>5. What do we know about the wellbeing of those in the criminal justice system?</p> <p>6. How connected are people living the Boroughs and what works to improve social connectedness?</p>	<p>6. How do we support people to maintain their wellbeing during transitions such as retirement?</p> <p>7. How do we improve access to adult education?</p>		<p>6. What works to increase uptake of personal budgets?</p>
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				<p>wellbeing messages into schools and local communities</p> <p>10. How do we best support CYP to make the transition to adulthood?</p>				
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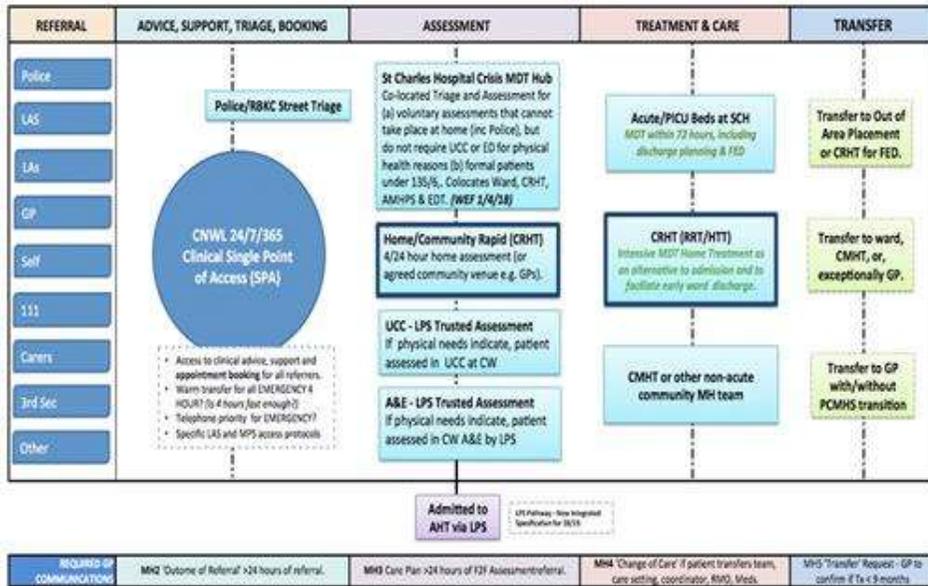
13 Appendix B - Pathways

13.1 Perinatal Mental Health Care Pathway

Page 222



Enhanced Urgent Mental Health Care Pathway for WL & CL CCGs (multi-agency co-design, summer 2017).



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**SAFEGUARDING ADULTS
EXECUTIVE BOARD
ANNUAL REPORT
2017/18**

mistreated?

bullied?

hit?

neglected?

hurt?

silenced?

silenced?

COURAGE
COMPASSION
ACCOUNTABILITY

SAFEGUARDING ADULTS EXECUTIVE BOARD ANNUAL REPORT 2017/18

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FOREWORD



I am pleased to present the fifth annual report of the Safeguarding Adults Executive Board (SAEB) for Westminster, Kensington and Chelsea, and Hammersmith & Fulham. The report explains the role, functions and purpose of a Safeguarding Adults Board which are prescribed by the Care Act 2014. It lists the organisations who are represented on the Board as well as other groups and agencies who contribute to the Board's work streams. Everyone, both jointly and independently, work to ensure the safety of those adult residents who are deemed to be most at risk of harm through the actions of other people.

The report contains examples of this collaborative work. Following the success of the Hoarding event mentioned in last year's report, the Board organised a similar conference which was held during National Hoarding Awareness week. The report describes the increasing emphasis the Board places on financial abuse by giving prominence to the work of the boroughs' Trading Standards Officers. New initiatives include developing a closer working relationship with the London Fire Brigade through more 'person-centred risk assessments' and increasing the involvement of the Community Champions network with the work of the Board.

The Board wants to ensure that all its members' adult safeguarding work is person led, focusses on outcomes that meet the needs of the individual and thereby improves their quality of life, well-being and safety. The work mentioned above, together with other examples, is shown under the headings 'You Said, We Did' and designed to illustrate the Board's Safeguarding Strategy, commonly known as 'The House' in action. The strategy received recognition as 'best practice' by the National Safeguarding Adults Chairs Group, and I was pleased to share it with colleagues from across England.

The Board continues to promote the concept of Making Safeguarding Personal- 'no decision about me without me'. As in previous years, the report contains case studies which show the application of this principle and highlight the difference that a person-centred safeguarding intervention makes to the life of an individual. However, whilst the emphasis of the report is about people, there are some statistics about the safeguarding journey. The purpose is to show the number of concerns, enquiries and cases

resulting in some form of action. It is important to provide context, so the data shows the size of the eligible adult population living in the three boroughs together with those adults who have care and support needs.

Last year, I mentioned a high-profile case involving a death at a care home which led to the commissioning of a Serious Adult Review (SAR) in September 2015. Over the past 3 years, the Board has continually reviewed and considered what we can learn about how placements for people with dementia are commissioned, made and monitored across the three boroughs. This report contains my summary of the reasons for commissioning the SAR, the questions posed to Board members and some of their responses. The inter-dependency of different agencies is evident in making the right placement for a dementia sufferer utilising the skills, knowledge and experience of staff to ensure the best outcome for the individual.

Monitoring dementia care provision, like many areas of safeguarding is ongoing, and it will be the responsibility of the two new Safeguarding Adults Boards to decide upon their priorities and work plans for 2018/19. The new arrangements are a consequence of the disaggregation of the three boroughs and result in a Bi-Borough Board covering Westminster and Kensington and Chelsea with a separate Board for Hammersmith and Fulham.

I have chaired the SAEB since its inception 5 years ago. I have worked with many people over this period, and I would like to express my appreciation to everyone who has contributed to the work of the Board and supported me in my role. One of the key strengths of the Board is the diversity and the seniority of its members and their willingness to get involved in its work. As always, I am particularly grateful to those members to find time to chair one of the Board's workstreams; this breadth of experience and knowledge ensures that adult safeguarding is seen as not just the responsibility of the local authorities.

Thank you,

A handwritten signature in black ink that reads "Mike Howard".

Mike Howard

Independent Chair of the Safeguarding Adults Executive Board

WHAT IS THE SAFEGUARDING ADULTS EXECUTIVE BOARD?

The Board is responsible for overseeing and leading on the protection and promotion of an adult's right to live an independent life, in safety, free from abuse and neglect across The Royal Borough of Kensington and Chelsea, The City of Westminster and the London Borough of Hammersmith and Fulham.

“The Safeguarding Adults Executive Board is the statutory body under the Care Act 2014 that sets the strategic direction for safeguarding. The Board is greater than the sum of the operational duties of its core partners”

The Board is a partnership of organisations working together to prevent abuse and neglect, and where someone experiences abuse or neglect, to respond in a way that supports their choices and promotes their well-being.

The Board believes that adult safeguarding takes **COURAGE** to acknowledge that abuse or neglect is occurring and to overcome our natural reluctance to face the consequences for all concerned of shining a light on it.

The Board promotes **COMPASSION** in our dealings with people who have experienced abuse and neglect, and in our dealings with one another, especially when we make mistakes. The Board promotes a culture of learning rather than blame.

At the same time, as members of the Board, we are clear that we are **ACCOUNTABLE** to each other, and to the people we serve in the three boroughs.

The Care Act 2014 says key members of the Board must be the Local Authority; the Clinical Commissioning Groups; and the Chief Officer of Police. The statutory members of the Safeguarding Adults Executive Board:

- The Bi Borough Executive Director of Adult Social Care and Health
- The Director of Social Care, London Borough of Hammersmith & Fulham

- Deputy Director Quality, Nursing and Patient Safety, North West London Collaboration of Clinical Commissioning Groups
- The Kensington and Chelsea Borough Commander of the Metropolitan Police

The Care Act 2014 states that the Board can appoint other members it considers appropriate with the right skills and experience.

There are senior representatives on the Board, from the following organisations:

- London Fire Brigade
- Imperial College Healthcare NHS Trust
- Chelsea and Westminster Hospital Foundation NHS Trust
- The Royal Marsden NHS Foundation Trust
- Central London Community Healthcare Trust
- Central North West London NHS Foundation Trust
- West London Mental Health Trust
- Community Rehabilitation Company (CRC)
- National London Probation Service
- Children's Services
- Community Safety
- Local Councillors
- Housing (Local Authority)
- Mind
- Genesis Notting Hill Housing
- Trading Standards
- Public Health Community Champions Programme
- HM Prison, Wormwood Scrubs
- Royal Brompton and Harefield HNS Foundation Trust
- Healthwatch
- Adult Social Care

“Board members are the senior ‘go to’ person in each of these organisations with responsibility for adult safeguarding”

They bring their organisation's adult safeguarding issues to the attention of the Board, promote the Board's priorities, and disseminate lessons learned throughout their organisation.

The Board can use its statutory authority also to assist members in addressing barriers to effective safeguarding that may exist in their organisation, and between organisations.

WHAT IS THE SAFEGUARDING ADULTS EXECUTIVE BOARD?

An even wider group of people, including voluntary sector organisations; housing and homelessness agencies; advocacy and carers' groups; and members of the public all contribute to the Board's four work-streams.

The sub-groups of the board are all chaired by either organisations representing health and the police or by voluntary sector organisations

- Community Engagement Group
- Developing Best Practice Group
- Better Outcomes for People Group
- Safeguarding Adults Case Review Group

“The Board recognises that hard-working staff on the front line of all these organisations carry out the challenging and complex work of preventing and responding to abuse and neglect, every day of every year”

The Care Act 2014 says members may make payments for purposes connected with the Board.

Most of the Funding for the Board comes from the Local Authorities and the **Clinical Commissioning Groups**.

Mayor's Office for Policing and Crime provides an annual contribution of £5,000 to local safeguarding adult boards.

Also for the third year running, **The London Fire Brigade** have contributed £1,000 per borough, to be shared between the Safeguarding Adults Board and the Local Safeguarding Children Board.

The Board is using these contributions to fund the independent Chair and a Board Business Manager, to further improve its effectiveness and efficiency.

The Care Act 2014 says that all members of the Board have the right skills and experience necessary for the Board to act effectively and efficiently to safeguard adults in its area.

Attendance is good and members are committed and work hard to progress the Board's priorities, and safeguard adults at risk of abuse and neglect.

The North West London Collaboration of Clinical Commissioning Groups (NWL CCGs)



are committed to safeguarding the wellbeing of vulnerable adults who access services that are commissioned by the NWL CCGs. As a member of the Safeguarding Adults Executive Board and in line with multi-agency Pan London Adult Safeguarding policies and procedures, NWL CCGs ensure that staff have appropriate policies, procedures, training and access to expert advice to ensure that adults at risk are identified and where appropriate a referral is made to adult social care. Safeguarding is about making sure everyone is treated with dignity and respect and does not suffer abuse. This is particularly important for those who are unable to protect themselves from harm or abuse, possibly because of their age, a disability or because they are unwell. To ensure this, care has to be of a high quality in order to prevent abuse happening. It also means there is an effective response if there is evidence or suspicion of abuse.

*Deputy Director Quality, Nursing and Safeguarding,
North West London Collaboration of Clinical
Commissioning Groups*

WHAT IS THE SAFEGUARDING ADULTS EXECUTIVE BOARD?



*** Section 43:**

Requires the Local Authority to establish a Safeguarding Adults Board (SAB) whose main objective is to protect adults from experiencing, or being at risk of abuse and neglect. The three main duties of the SAB are to produce an annual strategic plan, publish an annual report and undertake a safeguarding adults review under certain circumstances.

*** Section 44:**

Requires the SAB to arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

ADULT SAFEGUARDING STRATEGY 2015-19

The Care Act says the Board must publish its strategic plan and what members of the Board are doing to implement that plan.

The Board's Strategy framework came out of a series of consultation events in 2015 and 2016. We consulted with people living in the three boroughs, and with organisations working with people who have care and support needs, to develop the Board's four-year plan.

From what people told us was important to them, we created the Adult Safeguarding Strategy 2015-2019 'house' below which is built upon the well-being principle.

People said they do not want to be seen as victims, and said how important it is to be in control of the decisions they

make about their life, even when they have experienced abuse or neglect.

Residents said they want to be healthy and safe. They want to know what to do when they themselves, or someone they know, is being neglected or abused, and they want to be listened to.

We said that we want to be leaders who listen and learn from what people are telling us.

"This strategy has supported the Board to ensure that all its safeguarding adults work is focused on making safeguarding better by being Person led, Outcome-focused, Improving quality of life, wellbeing and safety "

Making Safeguarding Personal

I am able to make choices about my own well-being

Creating a Safe and Healthy Community

I am aware of what abuse looks like
and feel listened to when it is reported

I am kept up-to-date and
know what is happening

My choices are important

My recovery is important

You are willing to work with me

Leading, Listening and Learning

We are open to new ideas

We are a partnership of listeners

We give people a voice

We hold each other to account

We want to learn from you

WHAT HAS THE BOARD BEEN DOING?

MAKING SAFEGUARDING PERSONAL

YOU SAID:

I am able to make choices about my own wellbeing.

WE DID:

The Better Outcomes for People subgroup was asked by the Board to explore the extent to which Making Safeguarding personal was being applied across board member organisations.

The group analysed safeguarding data to identify to whether:

- The person or person's representative was asked about their desired outcomes
- If desired outcomes had been expressed, whether these were met

The report highlighted:

"Over 90% of peoples wishes and desires about the safeguarding incident are recorded as being achieved"

- That engagement of advocacy had a positive impact on ensuring that the person's voice was heard throughout the safeguarding enquiry
- When the adult at risk is supported by agencies to find the right solutions to keep them safe informed decisions are made leading to longer lasting outcomes

Safeguarding Principles- Care Act Statutory Guidance 2014

Empowerment

I am best placed to judge my well-being. Don't make assumptions about what is important to me and how I view risk and safety.

Protection of the person and others from further harm
Proportionate most effective, least intrusive response
Partnership working together and sharing information to understand what happened
Accountable duty of candour and transparency
Prevention learning lessons and making changes

WHAT HAS THE BOARD BEEN DOING?

MAKING SAFEGUARDING PERSONAL

Here are three case examples of how the work of the Safeguarding Adults Executive Board is making a difference to residents using the safeguarding principles

How we supported Mr Cheng* to maintain his independence

I have one close friend that visits me as I have no family. I have a good relationship with the Manager of my sheltered accommodation and I rely on him for help. I have carers who come to help me about four times a day as I have memory problems and Parkinson's. I find it difficult to get out of bed, to wash, brush my teeth and shave. I use a wheel chair to get round and about and have a carer who helps me get to the bank to pay my bills. I feel indebted to the carers who help me. I like to give them a little something extra when I can.

I told my friend about this last week and he seemed concerned. Last week the Manager came to me and said he had been aware that over the past 11-months about £1000 was taken out of my bank account each month and wanted to know what I was spending it on.

I was very irritated by this. I may be in a wheel chair but I am not stupid. I told him no one is stealing my money.

Over the next few weeks I had many visitors who were worried about me and talked of me being under safeguarding. I then had a visit from the Police who made me think about one of the carers who sometimes comes to the bank with me.

I think that this carer was taking my money and I told her I did not want her to visit me again. I dealt with it my way.

Outcome

A Mental Capacity Assessment was completed to determine Mr Cheng's ability to manage his finances. The outcome of this assessment found that although he is able to understand and retain relevant information and relay his decisions, he was unable to weigh up that information. Therefore, it was decided he was unable to manage his finances effectively but it was clear he was a proud man and wanted to retain as much control over his financial decisions as possible.

Professionals involved considered safe options in his best interest, his friend helped Mr Cheng to communicate what he wanted to happen and as an outcome the least restrictive option was chosen. This was a plan which allowed Mr Cheng to continue to manage his own finances with monitoring and oversight from the local authority and the Manager of the Sheltered Housing Scheme and his friend.

Unfortunately, the whereabouts of the money already removed remain unknown and the Police investigation is on-going.

* Not his real name.

WHAT HAS THE BOARD BEEN DOING?

MAKING SAFEGUARDING PERSONAL

How we supported Mrs Khan* to be looked after by her daughter who was preventing carers entering into their flat

My daughter looks after me which must be very difficult for her as she has her own life. I don't like to make a fuss but I don't go out much anymore, not like I used to. I have carers who help my daughter to look after me but I don't think they come any more. My daughter has very high standards.

A social worker came round the other day to see how I was. My daughter seemed angry when she left.

Outcome

A traditional, heavily interventionist response to ensure Mrs Khan received the services needed, regardless of the daughter's wishes, could have damaged an important relationship and not achieved a positive outcome. Instead, social workers worked with Mrs Khan and her daughter to find a solution that achieved the best care outcomes for everyone involved. They addressed the daughter's concerns by finding ways to support her in her caring role and showing real commitment to tailoring the intervention to the particular needs of the family. Working together and addressing both the needs of Mrs Khan, who wanted to go out more, and her daughters concerns around the standard of care being delivered by the care agency ensured that Mrs Khan was receiving all the support needed. Social Services arranged for services to escort Mrs Khan to social clubs and events. Mrs Khan's physical and emotional health and wellbeing has improved and she says,

"I now have something to look forward to each week."

'No decision about me, without me'

The Trust has continued to make safeguarding personal with the approach of "No Decision About Me Without Me". This ensures that patient's wishes and views are central to discussions with other agencies to support them to make

informed choices and to keep them safe and is a key part of discussion when discussing safeguarding adult's referrals with patients.



The Royal Marsden NHS Foundation Trust

* Not her real name.

WHAT HAS THE BOARD BEEN DOING?

MAKING SAFEGUARDING PERSONAL

How the Deprivation of Liberty Safeguards have made a real difference for Mrs O'Reilly*

When Bill and I married we came to London. It was 1963 and we have never spent a single day apart, not one. We are both getting older now and want to look after each other in our own house as we get older.

My memory is not so good these days and Bill looks after me. Bill says that the ambulance found me walking down the High Street the other day at 10 o'clock at night. I don't know how I got there! I don't remember.

Emergency services have been called out several times in the last six months for Mrs O'Reilly who has been found wandering the streets late at night. Family members raised concerns that the home environment was no longer safe for Mrs O'Reilly.

Mr O'Reilly very reluctantly agreed with his family and social services to arrange for his wife to go into a care home to keep her safe at night.

Following her admission, the care home raised concerns that Mr O'Reilly was visiting all day, every day and when visiting time was over, he would sleep in his car until the following morning. Mrs O'Reilly was very unhappy in the care home and desperately unhappy without him always calling out his name and asking staff where he was.

The care home made a referral to the Deprivation of Liberty Safeguards Team who arranged for an Assessment to be undertaken. This determined that Mrs O'Reilly lacked capacity to consent to care or treatment but under European Convention of Human Rights (ECHR) Article 8 had a right to family and private life.

Mrs O'Reilly is now back at home with her husband and her care is being managed in a less restrictive manner with telecare monitoring and support.

Simple Adjustments make a big difference

Chelsea and Westminster NHS Trust have embraced Mencaps 'Treat me well' campaign which is transforming how the NHS treats people with a learning disability in hospital. The Trust puts the patient at

the heart of discussions and works closely with families to support decisions in the best interests of the patient.

Chelsea Westminster Hospital NHS Trust



* Not her real name.

WHAT HAS THE BOARD BEEN DOING?

MAKING SAFEGUARDING PERSONAL

'This is Me'



Central London Community Healthcare NHS Trust is committed to supporting people with dementia and have a competent workforce who advocate for both patients and carers. In order to support the effective co-ordination of care and communication for dementia sufferers, the Trust is implementing the use of the 'This is Me' document to enable person-centred care so as to reduce distress for the person with dementia and their carer. In addition, a 'This is what I would like you to know about me...' information sheet, has been developed to promote sharing of important information about the patient's preferences, dislikes, routines and specific requests to personalise care and support choice and independence.

*Head of Safeguarding,
Central London Community Healthcare NHS Trust*

John's Campaign



Chelsea and Westminster and West Middlesex Hospital have launched John's Campaign across the Trust as part of plans to improve patient experience and make the Trust more dementia friendly. We have introduced activities to our elderly care wards, as well as improving the environment on our key ward. The next steps include providing a more suitable environment in emergency departments, along with activities to distract patients with dementia. We are considering a fast track system within our emergency and outpatient's departments for patients with dementia.

*Director of Nursing,
West Middlesex & Chelsea and Westminster Hospital Trust*

Patient Involvement



Working in partnership with patients is fundamental to delivering high quality care. That's why CNWL involves patients in many of the practical aspects of providing services. The Mental Capacity Act 2005 (MCA) provides a framework to assess whether a patient has capacity to take decisions, for example, whether to consent to medical treatment, or whether to agree to a proposed home care package. The Act makes clear who can take decisions in which situations, and how they should go about this. Anyone who works with or cares for an adult who lacks capacity must comply with the MCA when making decisions or acting for that person. This applies whether decisions are life changing events or more every day matters and is relevant to adults of any age, regardless of when they lost capacity. The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests. In 2017/18 CNWL developed a Mental Capacity Toolkit to equip staff to make assessments and ensure documentation is consistent and legally compliant.

*Associate Director of Quality - Safeguarding and Safety,
Central North West London NHS Foundation Trust*

WHAT HAS THE BOARD BEEN DOING?

LEADING, LISTENING AND LEARNING

The Care Act 2014 states that the Board must conduct a Safeguarding Adults Review in accordance with Section 44 of the Act.

“The Group considers the recommendations and lessons learned from enquiries and Safeguarding Adults Review and where relevant, from Children’s Serious Case Reviews; Domestic Homicide Reviews; and reviews of Fatal Fires”

YOU SAID:

We want you to listen and hold each other to account.

WE DID:

This year we have been working on what safeguarding enquiries and safeguarding adult reviews, SARs, are telling us needs to change and improve.

Local cases are received and reviewed by the Group involving the death of an adult at risk, or a near miss to determine whether or not to recommend that a SAR be conducted.

In 2017-18 six cases were accepted for discussion by the Group as possibly meeting the Section 44 Safeguarding Adults Review criteria.

A list of the emerging themes from the Reviews is found at the back of this report in APPENDIX 1.

What the Board worked on in 2017-18:

Emerging Themes and Board Priorities

Hoarding and Self Neglect:

Working together to win the trust of people who are reluctant to accept care from statutory services, with the result that their health and care needs are not being met. The Board held a very successful Hoarding Conference in May 2018.

Mental Capacity Act (MCA) 2005:

Increasing staff confidence with application of the Mental Capacity Act 2005; with the result that the MCA Champions network is growing in strength to support advice giving right down to front line staff.

Physical Health:

Improving the physical health of people with mental health needs and learning disabilities. Work undertaken by the Group has supported change within agencies so that individuals with mental health needs or a learning disability have access to the same treatment options as the general population.

Safe Transfers Between Care Settings:

Improving people’s experiences of transferring between care settings.

No Replies / No Access:

Improving compliance and escalation across organisations and agencies when staff cannot gain access was a focused piece of work completed by Central London Community Health Care Trust.

WHAT HAS THE BOARD BEEN DOING?

LEADING, LISTENING AND LEARNING

Why asking about outcomes matters?

Winifred's* Story

'I have spent my whole life looking after others and now I would like a little help'

Winifred told her story in person to the Safeguarding Adults Review Group. This was a powerful experience for the group members.

"I was born in Freetown, Sierra Leone in 1950 the youngest of 4. I came to Britain looking for work as there was nothing for me in Sierra Leone. I left behind my family but I was excited about my new life. I lived in privately rented property in London and have always paid my bills. I never did get married. Some people don't.

I worked as a secretary for most of my life looking after directors of large organisations like yours. I took retirement at 62. I have paid my taxes and don't ask for anything from the State. I have found the last few years a bit of a struggle. I feel that I lost my way a bit but not sure why. I don't want to bother my neighbours. The Post Office on my street has recently closed down and this makes me anxious, life has become more complicated.

I think I was in a bit of a muddle just before Christmas. I liked to light candles around my flat at Christmas and

one day a small fire broke out. My neighbours called the fire brigade and an ambulance. I was taken to hospital. I was a bit confused. So many people were asking me questions my head wasn't working right. My neighbour came to visit me and I asked to go home. A social worker came to see me. He asked me lots of questions about where I wanted to live which I thought was a bit strange. I told him I wanted to live at home. I had no one to talk to and was feeling very scared.

I was told I was going to a new home where I would be cared for. I remember arriving at the care home in a nightdress and coat which did not belong to me. I was asked if I wanted to see my bedroom when I arrived and I said **'I did not and I shouldn't be here'**. All I could think of was trying to leave this place as soon as possible and go home and that is what I did. I managed to find my way back to my flat and as I walked up to the front door a police officer and a woman were there waiting for me. She asked me if I had any family or friends and I spoke of my neighbours. I said that I had not been very well but was feeling much better. We sat down and had a cup of tea she asked me what had been going on for me and what I wanted to do next. I wanted to go home. She was the first person who actually spent time talking with me, finding out a little about who I was. I now live in a sheltered home with a warden my neighbours come and visit me.

The group identified three key messages after hearing Winifred's story:

- 1. We need to continue to help staff to deliver a more personalised response to all our interventions and to not assume that we or clients know what a person centred response looks like.**
- 2. Winifred's story demonstrates the amount of resources which are wasted when we do not put the person at the centre of the process.**
- 3. We are continuing to be challenged by pressures in the systems which impacts upon our decision making. E.g. winter pressures in hospitals to discharge people puts pressure on systems and allows for practitioners to not follow process. In Winifred's case failing to follow the principles of the Mental Capacity Act ensured her voice was not heard.**

* Not her real name.

WHAT HAS THE BOARD BEEN DOING?

LEADING, LISTENING AND LEARNING

No Replies / No Access: Following a number of cases where staff cannot gain access this emerging theme was explored.

Initial actions are as follows:

Adult Safeguarding learning in action

ISSUES

- Staff did not follow the 'No Reply' procedure
- Family members prevented staff accessing the adult at risk
- Challenges were presented by clients who allowed access on an intermittent basis

PROCEDURE EXPLAINED

- **No Access/No Reply:** Where there is no access or contact with the service user at a planned or agreed visit.
- **Failed Visit:** Where the purpose of the visit is not achieved because although the service user is there, they refuse access or where access arrangements in place allow the visiting agency to enter the property and find the service user not present and their whereabouts need to be determined to ensure that they are safe.
- **Cancelled Visit: These should be considered when the service user has cancelled a visit.** In such instances, it is important to check that the service user has capacity to make such a decision. If they do not, then the visit must still take place which will potentially result in a failed visit or no reply.

- **Was not brought:** this is where someone with care and support is dependent on others accompanying to appointments and they are not supported to do so.

LEARNING IN ACTION

Two workshops have been held across the local health provider partnership. An agreement was made to develop a standard response with clear escalation processes and in collaboration with other agencies.

REFLECTIONS

We need to improve our working relationship with people who use services. We need get better at having conversations with people about why we need to be informed if they are not going to be at home. We need to understand with people why they may wish to refuse care and not let services in.

"Maintaining good communication and relationships with people who use services means that we are more likely to know what is going on and will appear less intrusive in people's lives."

Central London Community Healthcare NHS Trust

WHAT HAS THE BOARD BEEN DOING?

LEADING, LISTENING AND LEARNING

In December 2017 the Chairs of the Safeguarding Adults Case Review Group made a recommendation to the Independent Chair of the Safeguarding Adults Executive Board to commission a statutory Safeguarding Adults Review (SAR) to learn from the case of a person where staff could not gain access leading to a near miss.

As an outcome to the subsequent Police investigation the Local Safeguarding Children Board has agreed to make a contribution to the Safeguarding Adults Review.



This review is being carried out using the SCIE Learning Together model, which is based on a systems approach, and will be led by an Independent Reviewer.

“The focus of a SAR is not about blame but instead it intends to gain learning to support improvements to the local safeguarding system”



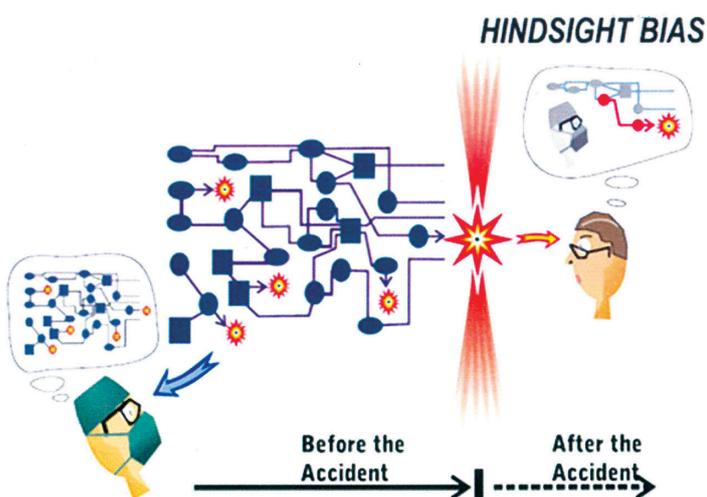
A systems approach

SCIE has adapted the systems approach specifically for use in reviews of multi-agency adult safeguarding and child protection work. While historically reviews of practice have often ended up tending to blame individuals for mistakes and failures, the SCIE systems approach takes account of the context people work in, the tasks they perform, and the tools they use. Using the concept of “Hindsight Bias”. It addresses what happened but focuses on understanding the reasons behind the approaches and decisions taken – i.e. why someone acted (or did not act) in a certain way. It highlights what factors in the wider system contributed to people’s actions and decisions. The SCIE process also highlights what is working well locally and patterns of good practice.

WHAT HAS THE BOARD BEEN DOING?

LEADING, LISTENING AND LEARNING

Hindsight Bias: also known as the knew-it-all-along effect, is the inclination, after an event has occurred, to see the event as having been predictable, despite there having been little or no objective basis for predicting it.



Holding each other to account

This is a summary of findings and outcomes of a Safeguarding Adults Review commissioned from SCIE by the Board in August 2015

What can we learn about how placements for people with dementia are commissioned, made and monitored across the three boroughs?

The decision was made not to focus the SAR on the person who had died but instead on the person who caused the harm, who himself had care and support needs. He is referred to in this document as Andrew by the request of his family. It is acknowledged that not to focus on the adult who died is unusual so attention was paid to ensure that the family members of both service users were kept informed of the SAR process and outcomes.

Case history

Andrew* stayed at the care home in question for two and a half months. Andrew was removed after he pushed over a fellow patient in the home, who broke her hip and suffered a bleed on the brain as a result. She subsequently died. The coroner at the inquest determined:

“the placement was not the right place .. but the decision to place...at the time was based on information available so was not 'unreasonable'. The Coroner said it was a 'pity there was no understanding what was being commissioned.”

The final report posed questions to Board members about the provision of dementia care. Evidence in the full SAR report demonstrated that these are systemic issues and not a one-off event.

1. How current workplace pressures are perceived to be making it more difficult to make shared values a reality for individual patients and service users. The update to this finding is themed in two areas of current Adult Social Care activity: Delayed Transfer of Care and delivery of Section 42 enquiries
2. That there is a minimal range of care options available for people with dementia creating a mismatch between needs and services.
3. Professionals despite policies and practices, fail to recognise or accommodate situations where the person causing the harm also has care and support needs
4. Decision-making about the kind of placement for someone with dementia needs and market provision is not straightforward. Having the right people, with the right knowledge, skills and experience making those decisions is therefore critical.

* Not his real name.

WHAT HAS THE BOARD BEEN DOING?

LEADING, LISTENING AND LEARNING

WE DID:

A re-design of the whole systems approach to commissioning residential and nursing care for dementia. The following changes have been put in place.

- The discharge to assess scheme designed to speed up the transfer of patients to an appropriate care setting has been improved.
- Integration of IT systems between Adult Social Care and health providers is being reviewed.
- The Better Outcomes Panel oversees all placement decisions.

“The case for change is a recognition that the Health and Social Care system is confronted by clients with challenging behaviours but this client group only makes up 10% of residents aged 65+ living in care homes. However, it is encouraging to see how agencies have responded in such a positive way to the need to change their approaches to dementia care for the residents of the three boroughs. This momentum needs to be maintained as decision making about the kind of placement for someone with dementia needs, and where exactly to place them, is not straightforward. Having the right people, with the right knowledge, skills and experience making those decisions is therefore critical”

Board Chair

Dementia Care Champions

Central London Community Healthcare NHS Trust has a dementia charter and strategy in place, and is a partner in the Dementia Alliance Action Plan which has actively increased the number of Dementia Friends across our organisation. Our dementia engagement project has been listening to and working alongside people with dementia and their carers since January 2016. The Dementia Care Champion programme has been in place since 2015 and this enhanced training is aimed at practitioners and compliments mandatory organisational dementia training requirements for clinical staff. The programme includes input from dementia patients and their carers, who review staff projects and give feedback and advice to enhance the learning experience and services to people with dementia. It is the only programme of its kind in London. Community dementia champions can support and advise people with dementia and their families to maintain independence, especially in their choice of living accommodation. Champions also support residential care staff with nursing or therapy assessments to ensure an individual's needs or increasing risk is explored and escalated as needed. The electronic clinical record systems used in the Trust have had electronic alerts to flag patients with a diagnosis of Dementia and help ensure they are identified by staff and any appropriate care and support is provided.

*Director of Nursing and Therapies (Patient Experience),
Central London Community Healthcare NHS Trust*

Dementia Care Champions

The Trust, Dementia Champions Network, has been key to continue to improve the health care provision and experience of patients coming into the Trust with different types of dementia. During this year, we have also improved

our hospital environments to make them more dementia friendly through improved signage and facilities, especially in bathrooms. We have also installed dementia friendly clocks across the Trust.

*Head of Adult Safeguarding,
The Royal Marsden NHS Foundation Trust*

WHAT HAS THE BOARD BEEN DOING?

CREATING A SAFE AND HEALTHY COMMUNITY



YOU SAID:

My choices are important

WE DID:

Prompted by themes emerging from safeguarding enquiries and reviews, the Board held a Hoarding and Self Neglect Conference on National Hoarding awareness week.

The Conference was attended by key partners, including:

- The person who is hoarding
- Adult Social Care
- Mental Health
- The London Fire Brigade
- Environmental Health
- Housing

A partner who is increasingly valued is EASL (Enabling Assessment Service London) who work sensitively with the person to understand why they feel the need to collect things. This is a personalised empathetic approach to tackling Hoarding and Self-Neglect which has been shown to result in longer-term reductions in clutter, and happier outcomes for the person.

Easl's Message

- Don't give up, hold hope
- Be curious and aware of your own judgements
- Allow a lot of time and be consistent
- Recognise small changes and celebrate them
- Be dynamic and creative, keep trying new things
- Three most important things...
Relationship, relationship and relationship!

WHAT HAS THE BOARD BEEN DOING?

CREATING A SAFE AND HEALTHY COMMUNITY

How we supported Mr. Johnson not to sweep his clutter under the carpet

Case study - Mr Johnson*

Mr. Johnson loves reading and has hundreds of newspapers and gardening magazines cluttering the hallway and living room preventing access to the bathroom and making it very difficult to get through the front door. He and his late wife used to have an allotment and he says

“I like to keep up with all the gardening news you just never know when you may need it.”

Mr Johnson is also keen on recycling and is proud of his contribution to the ‘**In It to Win It**’ scheme, which provides monetary rewards to local schools for increasing their recycling. However the build-up of plastic cartons in his kitchen prevented him from moving safely round his home. These items were rarely washed, creating a contaminated and unhealthy environment. Following numerous complaints from neighbours about the smell of rubbish and flies populating the communal corridors of his building, two public health notices were served to clear his home.

In early 2017 Mr Johnson fell over his clutter and was admitted to hospital. He was no longer able to move around independently and was struggling with his care needs. This crisis situation led him to agreeing to accept more support from services which he had in the past

refused. This support included him attending network meetings with The London Fire Brigade, Environmental Health, Clouds End and Adult Social Care. Using a collaborative approach Mr Johnson felt valued



and slowly trust developed. This led to all his newspapers and magazines being moved into a nearby storage unit which he visits regularly to check they are safe. He now receives two visits a week from cleaning services who work sensitively with him to organise his belongings.

A Good Outcome

At a recent network meeting Mr. Johnson acknowledged that

“I know I haven’t made things easy for you lot but since my wife died I have felt very lonely. I want to thank you for all the support you have given me and for doing it my way.”

The Hoarding and Self Neglect protocol

Housing, Supported Housing providers, City West Homes, Environmental Health, Registered Providers, Floating support, Mental Health Teams, Adult Social Care, The Metropolitan Police and the London Fire Brigade work together to reduce the risk to the person who is hoarding or self-neglecting, and to reduce the risk to other people. The protocols emphasis is on multi-disciplinary working

and a person centred approach to the support being offered to all residents. “Organisations raise awareness and contribute to prevention by working collaboratively and sensitively with each other and with people who hoard”

*Head of Prevention, Housing Department,
City of Westminster Council*

* Not his real name.

WHAT HAS THE BOARD BEEN DOING?

CREATING A SAFE AND HEALTHY COMMUNITY

YOU SAID:

I am kept up to date and know what is happening.



Taking a 'Stand against Scams' Work with Trading Standards and Community Champions 'SCAMchampions'



Zara Ghods, Kensington and Chelsea Forum for Older Residents

WE DID:

National Friends Against Scams Campaign

This year Trading Standards have continued to support the National Friends Against Scams Campaign to raise awareness about scams, by delivering free training within the community in partnership with Kensington and Chelsea Forum for Older Residents, Age UK Kensington and Chelsea, Community Safety, Hammersmith United Charities, Age UK Hammersmith & Fulham, Caring for Carers Association, Carer's Rights Network, Community Champions and Barclays Bank

Trading Standards delivered Friends Against Scams Training to 100 Royal Mail postal workers. The training focussed on how to spot scam mail and to identify and report details of residents, who may be receiving large volumes, being targeted by scammers. The training was well received.

"I have seen this type of mail all the time but didn't know it was scam mail or how to report it"

Royal Mail Worker

We participated in London Trading Standards Week in September. This included holding scams awareness events at Kensington Town Hall, delivering Friends Against Scams Training to residents and carrying out home visits to local residents who had responded to fraudulent prize draws, to provide advice and support for the future. At Hammersmith Town Hall. in partnership with Barclays Bank, we delivered training to 50 local residents and businesses.

In March, officers delivered Friends Against Scams training to 180 residents in partnership with the Community Safety Team, the National Trading Standards Scams Team and Zara Ghods, Chief Executive, Kensington and Chelsea Forum for Older Residents, who has signed up as a SCAMBassador.

WHAT HAS THE BOARD BEEN DOING?

CREATING A SAFE AND HEALTHY COMMUNITY

How we know we are making a difference to people who are a victim of scamming

Case Study - Jim*

In April 2014 the National Trading Standards Team notified the local Trading Standards Teams that Jim had been a victim of scam mail. When an officer visited his home they found scam mail from around the world. He confirmed he would return requests for small amounts of money as he

“did not want to miss his opportunity to win the lottery.”

The officer removed several shopping trollies full of mail and under data protection enforcement arranged to have his details removed from hundreds of lists. In December 2014 the work undertaken had proved to be successful. Post had stopped coming in and Jim was able to successfully manage any ‘nuisance’ calls received.

However, in January 2018 Adult Social Care raised a concern that Jim had received calls from his banks fraud department informing him that he needed to transfer £10,000.00 as part of an undercover operation to identify corrupt bank staff.

This sounded suspicious but Jim’s law-abiding fear of financial authorities and the importance he placed on helping them led him to complete the transfer. When

he got home he began to question his actions. He called his bank, who immediately alerted the Police who made a full investigation and £5,000 of the funds were recovered. The bank staff were questioned about whether they had followed the Banking Protocol for large and unusual transactions. Jim had been confused about the conversation that had taken place within the branch and had not co-operated about the transfer request, believing that he was part of an undercover operation.

“He had been effectively ‘groomed’ by the fraudster.”

Trading Standards have now installed a Nuisance call blocking device into his home and continue to provide ongoing support to Jim.

“The national average of nuisance calls received is 18 per month. Monitoring Jim’s nuisance phone-calls, confirms he receives approximately 117 a month.”

* Not his real name.

WHAT HAS THE BOARD BEEN DOING?

HOW WE KNOW WE ARE MAKING A DIFFERENCE

YOU SAID:

You are willing to work with me.

WE DID:

In 2017/18 520 referrals were made from the three boroughs to the London Fire Brigade to carry out Home Fire Safety visits. The visits included installation of a range of products such as sprinklers, smoke alarms, and fire retardant furnishings.

The London Fire Brigade

Protecting the lives of people at risk

In 2018 the London Fire Brigade introduced the person centred risk assessment.

This form has been designed for carers, support workers, housing officers and social workers, but can be also used by family members to assess the risk of fire to individuals.

A new training programme supported by the Community Engagement Group will be provided to all multi-agency membership organisations, Community Champions and the wider voluntary sector across the three boroughs. The training will enable the workforce in all agencies to confidently carry out initial **Person-centred Risk Assessments**, support people to make fire safety decisions in their own homes and make necessary onward referrals to the London Fire Brigade to carry out home safety visits.



Community Champions

Connecting communities and residents with local services

YOU SAID:

I am aware of what abuse looks like and feel listened to when it is reported.

WE DID:

Adult Safeguarding have linked up with Public Health Behaviour Change Services and have developed a bespoke Adult Safeguarding 'Train the Trainers' model and 'Keeping Safe' tool-kit to support building capacity and expertise in the Community Champions programme.

We know from national and local evidence that using a community engagement approach is both cost effective and leads to improved health and well-being. We have replicated this by raising awareness of adult safeguarding and supporting a strong prevention agenda which:

- Empowers people by giving them confidence to raise concerns
- Increases confidence, self-esteem and self-efficacy and gives people an increased sense of control over decisions affecting their lives particularly in areas of safety decisions
- Contributes to developing and sustaining areas of need
- Working with community safety teams

"I joined the team of Community Champions. It was a great opportunity to gain knowledge about Public Health Campaigns and Community Research and also to know better the local community and the local services. Exactly what I was looking for! The Community Champions project manager and the Volunteer Centre staff made me feel very welcome from the start and helped me feel a valuable team member."



WHAT HAS THE BOARD BEEN DOING?

HOW WE KNOW WE ARE MAKING A DIFFERENCE

YOU SAID:

My recovery is important.

WE DID:

Board member organisations tackle domestic abuse and provide support services

Joint working protocols were established between the Violence Against Women and Girls Group; The Local Safeguarding Children's Board; and the Safeguarding Adult Executive Board. The Partnership is driven by seven strategic priorities which include ongoing communication, prevention and awareness-raising activities, creating a menu of options for survivors and their children and continuing to strengthen the coordinated community response. The success of the Partnership's work is evident through the range of referrals to the Angelou Partnership and to the Multi-Agency-Risk Assessment Conferences. The partnership is focused on ensuring there is preventative, immediate and long term support for survivors and their children. They have recently launched a new service, 'Meeting Survivors Where They Are,' which provides support for survivors with the most complex needs or experiencing multiple disadvantages.

"The Angelou Partnership saved my life as I wouldn't have been able to go on without the support I received."

Survivor

Case Study - Pam

Pam* disclosed to hospital staff that she had been in an abusive relationship with a much older man since she was 15 years old. A safeguarding meeting was held and attended by Pam who was supported by a family friend. She was able to report the sexual assault to the police and was allocated a specialist officer who helped her to give a video interview. Over the course of a year, intensive support was provided by the team as Pam found it very difficult to leave this abusive relationship, and remained at risk of sexual, physical and psychological abuse.

Due to the extensive support from services Pam has been able to leave her long term relationship with the abusive ex-partner, is living alone, has stable mental health and has returned to work. She continues to access counselling at the Haven and is also considering re-training for a change of career.

Championing Responses to Domestic Abuse

Chelsea and Westminster and West Middlesex NHS Trust have 100 trained Domestic Abuse Links who work across the Trust in a variety of roles and who champion responses to domestic abuse. The Trust charity is funding a Domestic Abuse coordinator who will provide training, development and support across all sites.

Board Member Organisations Working Together

The West London Mental Health Trust is working closely with Standing Together to develop a network of Domestic Abuse Leads across the organisation. Standing Together supports organisations, including the Police, criminal justice partners, social services, healthcare workers and charities to identify and respond effectively together to domestic abuse.

Standing Together and West London Mental Health NHS Trust

* Not his real name.

WHAT HAS THE BOARD BEEN DOING?

SAFEGUARDING IN ACTION

A Learning Culture

The West London Mental Health Trust have developed a 'Think Incident Think Safeguarding' bespoke training for all teams, supporting staff awareness of Safeguarding Adult Practice.

West London Mental Health NHS Trust

Assisting residents to stay 'Safe at Home'

Age UK Kensington & Chelsea assists residents who are aged 55 and over to maintain their independence, making the tasks of daily living a bit easier. The aim of the 'Safe at Home' service is to reduce the risk of falls in the home, reduce the risk of harm from other hazards in the home, improve health, wellbeing and peace of mind by ensuring that the home environment is safe for the resident.

*Community Engagement Manager,
Age UK Kensington & Chelsea*

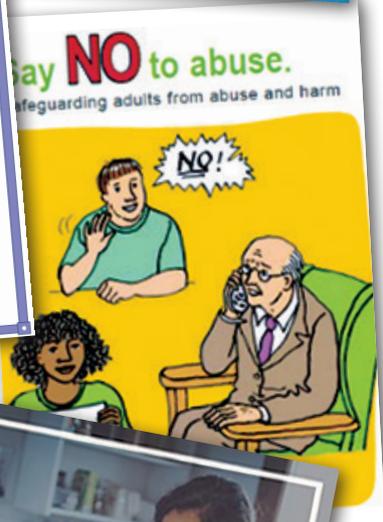
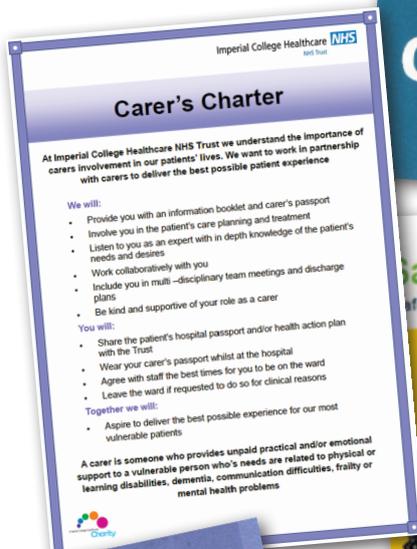
Respecting the right to make unwise or risky decisions

In 2017 we have had a number of cases where we have worked with customers to reduce hoarding and improve their living conditions. This work has meant we have not had to seek possession of their property and instead we support them to maintain their home. We have also embedded learning and awareness amongst staff using case studies provided by the Safeguarding Adults Executive Board to explore the complex issues surrounding self-neglect, capacity and the right to make unwise or risky decisions.

*Head of Safeguarding
Notting Hill Genesis*



WHAT HAS THE BOARD BEEN DOING?



The Carer's Charter



Imperial College Healthcare NHS Trust understand the importance of carers involvement in our patients lives and we work in partnership with carers. In 2017 we revised our approach and guidance in relation to supporting carers of people with dementia and other vulnerabilities. We recognise the benefits of having carers actively involved in the care and of people with complex needs as they usually know the patient better than hospital staff. Their input can make the experience less distressing for the patient and help to facilitate care and treatment. The Trust introduced a carer's charter that outlines how we will work with carers to support vulnerable patients. Carers are also issued with special "carers passports" which enable them to get access out of normal visiting hours.

*Deputy Director, Patient Experience,
Imperial College Healthcare NHS Trust*

The Metropolitan Police are making safeguarding their highest priority within the new Basic Command Unit structure

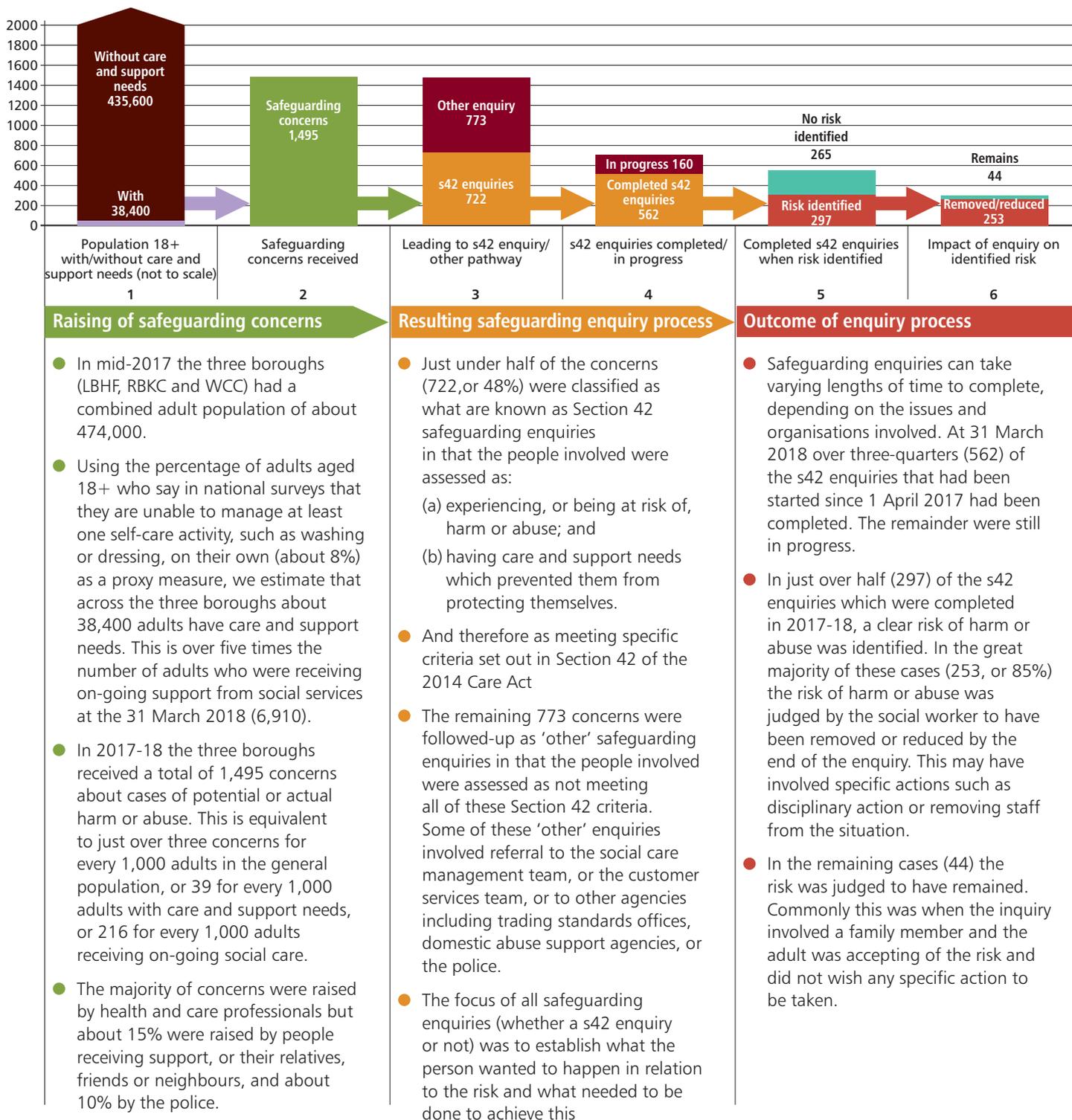


The Metropolitan Police Service are changing the way they help safeguard vulnerable people by investing more resources in preventing and investigating domestic abuse, sexual offences and all other types of abuse within the new Basic Command Unit Structure. Locally this will result in the policing units of Hammersmith and Fulham, Kensington and Chelsea and Westminster boroughs amalgamating to form 'Central West Basic Command Units' led by BCU Commander Rob Jones. Having an all-encompassing safeguarding function locally will mean the Police can work in a more holistic approach putting vulnerable people at the centre of our policing response in conjunction with our partners. Safeguarding is Everyone's Business!

*Safeguarding Lead,
Tri-Borough Metropolitan Police Service*

WHAT ARE THE NUMBERS TELLING US?

Chart 1
The safeguarding journey, from raising of safeguarding concern to outcome of safeguarding enquiry

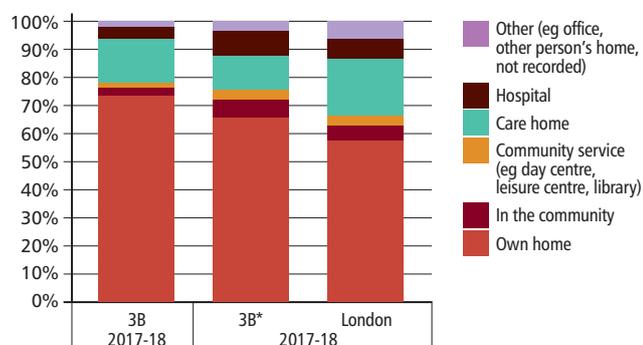


WHAT ARE THE NUMBERS TELLING US?

A COMPARISON WITH 2016-17- FOR s42 ENQUIRIES COMPLETED IN THE YEAR

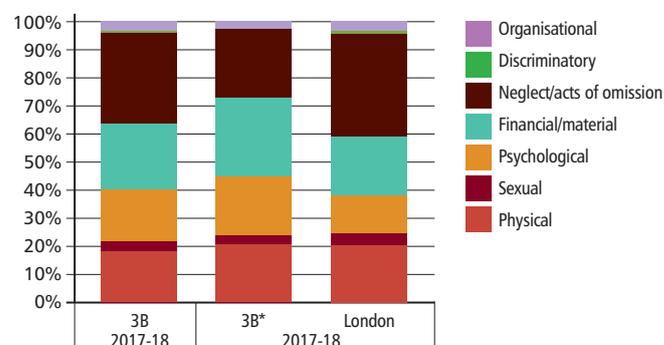
* Care needs to be taken when drawing comparisons with 3B data for 2016-17 as a new safeguarding pathway was introduced part way through this year.

Chart 2
Where the alleged harm or abuse occurred



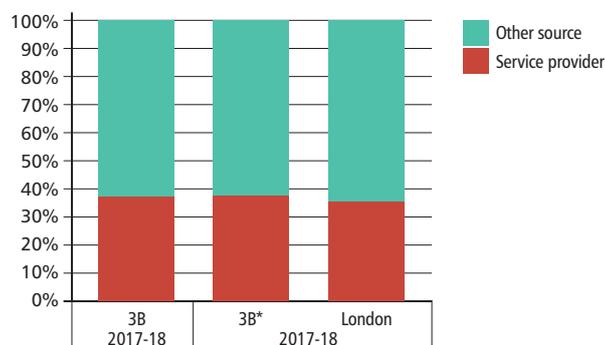
Compared with London as a whole, a higher percentage of s42 enquires in 3B related to abuse in people's own homes, while a lower percentage related to care homes.

Chart 3
Types of harm or abuse alleged



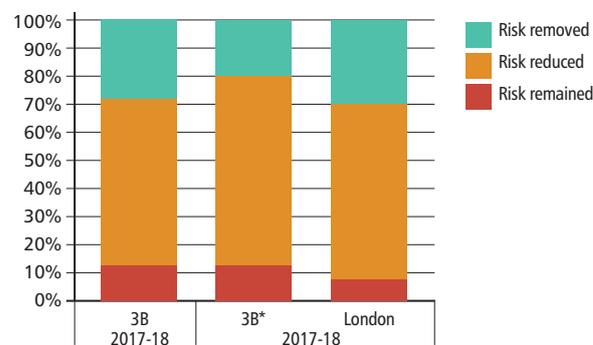
The frequency with which different types of abuse were reported in 3B in 2017-18 was similar to London in 2016-17 but proportionately fewer s42 enquiries involved instances of neglect. These nearly always involved care providers.

Chart 4
Source of risk or harm or abuse



In about four out ten s42 enquiries the source of risk was a service provider, consistent with the pattern for London as a whole in 2016-17. Where the source of risk was not a service provider, in the majority of cases the person causing harm or abuse was known to the adult at risk.

Chart 5
Whether, where a risk of abuse was identified, the risk had been reduced or removed at the end of the enquiry



The frequency with which different types of abuse were reported in 3B in 2017-18 was similar to London in 2016-17 but proportionately fewer s42 enquiries involved instances of neglect. These nearly always involved care providers.

WHAT THE BOARD WILL BE WORKING ON IN 2018/19

Making Safeguarding Personal

I am able to make choices about my own well-being

Creating a Safe and Healthy Community

I am aware of what abuse looks like and feel listened to when it is reported

I am kept up-to-date and know what is happening

My choices are important

My recovery is important

You are willing to work with me

Leading, Listening and Learning

We are open to new ideas

We are a partnership of listeners

We give people a voice

We hold each other to account

We want to learn from you

Establishing and developing 'Making Safeguarding Personal' as a core objective of both Safeguarding Adults Boards will continue.

Mike Howard
Independent Chair

JARGON BUSTER

There is a lot of safeguarding jargon in health and social care and we are committed to busting it. This is Our Safeguarding Jargon Buster using plain English definitions of the most commonly used words and phrases in this annual report.

Abuse

Harm that is caused by anyone who has power over another person, which may include family members, friends, unpaid carers and health or social care workers. It can take various forms, including physical harm or neglect, and verbal, emotional or sexual abuse. Adults at risk can also be the victim of financial abuse from people they trust. Abuse may be carried out by individuals or by the organisation that employs them.

Accountability

When a person or organisation is responsible for ensuring that things happen, and is expected to explain what happened and why.

Adult at risk

An adult who is in need of extra support because of their age, disability, or physical or mental ill-health, and who may be unable to protect themselves from harm, neglect or exploitation.

Advocacy

Help to enable you to get the care and support you need that is independent of your local council. An advocate can help you express your needs and wishes, and weigh up and take decisions about the options available to you. They can help you find services, make sure correct procedures are followed and challenge decisions made by councils or other organisations.

Autonomy

Having control and choice over your life and the freedom to decide what happens to you. Even when you need a lot of care and support, you should still be able to make your own choices and should be treated with dignity.

Best interests decision

Other people should act in your 'best interests' if you are unable to make a particular decision for yourself (for example, about your health or your finances). The law does not define what 'best interests' might be, but gives a list of things that the people around you must consider when they are deciding what is best for you. These include your wishes, feelings and beliefs, the views of your close family and friends on what you would want, and all your personal circumstances.

Carer

A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or disabled and could not manage without this help. This is distinct from a care worker, who is paid to support people.

Challenging behaviour

Challenging behaviour may cause harm to the person or to those around them, and may make it difficult for them to go out and about. It may include aggression, self-injury or disruptive or destructive behaviour. It is often caused by a person's difficulty in communicating what they need - perhaps because of a learning disability, autism, dementia or a mental health problem. People whose behaviour is a threat to their own wellbeing or to others need the right support. They may be referred by their GP to a specialist behavioural team. The specialist team will work on understanding the causes of the behaviour and finding solutions. This is sometimes known as positive behaviour support.

Deprivation of liberty safeguards

Legal protection for people in hospitals or care homes who are unable to make decisions about their own care and support, property or finances. People with mental health conditions, including dementia, may not be allowed to make decisions for themselves, if this is deemed to be in their best interests. The safeguards exist to make sure that people do not lose the right to make their own decisions for the wrong reasons.

JARGON BUSTER

Dignity

Being worthy of respect as a human being and being treated as if you matter. You should be treated with dignity by everyone involved in your care and support. If dignity is not part of the care and support you receive, you may feel uncomfortable, embarrassed and unable to make decisions for yourself. Dignity applies equally to everyone, regardless of whether they have capacity.

European Convention on Human Rights (ECHR)

Formally the Convention for the Protection of Human Rights and Fundamental Freedoms, the ECHR is an international treaty to protect human rights and political freedoms in Europe.

Human trafficking

When someone is dishonest to you about the job you are interested in and you travel to a place and find out that you have been lied to. But you have paid money to get there and find out you now need to pay this money back before you are allowed to leave.

Making Safeguarding Personal (MSP)

It means that you are asked what you want to do about the incident of abuse and how you may be supported in making yourself safe. It helps you to take control and it gives you choice.

Mental Capacity Act 2005

A law that is designed to protect people who are unable to make decisions about their own care and support, property or finances, because of a mental health condition, learning disability, brain injury or illness. 'Mental capacity' is the ability to make decisions for yourself. The law says that people may lose the right to make decisions if this is in their best interests.

Near miss

Something that is not supposed to happen and is prevented before harm is caused.

Outcomes

In social care, an 'outcome' refers to an aim or objective you would like to achieve or need to happen - for example, continuing to live in your own home, or being able to go out and about. You should be able to say which outcomes are the most important to you, and receive support to achieve them.

Pressure ulcer

Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localized damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.

Prevention

Any action that prevents or delays the need for you to receive care and support, by keeping you well and enabling you to remain independent

Proportionality

Doing what is needed, without intruding into people's lives any further than is necessary to meet their needs or keep them safe. It is an important principle in the Care Act 2014.

Root cause analysis

Root cause analysis is a method of problem solving used for identifying the root causes of faults or problems. A factor is considered a root cause if removal thereof from the problem-fault-sequence prevents the final undesirable outcome from recurring; whereas a causal factor is one that affects an event's outcome, but is not a root cause. Though removing a causal factor can benefit an outcome, it does not prevent its recurrence with certainty.

APPENDIX

Cases Accepted for discussion by the Safeguarding Adults Review Group in 2017-18: Emerging Themes and Changes Made

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
1	11 April 2017	<p>This is a 'near miss' case involving a person who was discharged from hospital. Using information gathered from the safeguarding enquiry, the review highlighted:</p> <ul style="list-style-type: none"> ● staff lacked confidence and knowledge on how to refer to the Deprivation of Liberty Team ● staff had not properly assessed the risk of domestic abuse/violence. ● a lack of domestic abuse awareness and support available. <p>The case was discussed with all staff to raise awareness of these issues and to instil future confidence in making necessary referrals. A full report was distributed to Group members who noted the learning undertaken by the relevant agencies..</p>
2	13 June 2017	<p>A case concerning a woman who was admitted to an appropriate care setting under a Mental Health Act order due to her violent behaviour. She was physically fit and refused all support offered by staff so was discharged the next day. Four days later she was admitted to hospital after reporting hallucinations, saying that she felt unsafe and lonely. A few days later she died from a heart attack. The death of this woman was investigated using a Root Cause Analysis (RCA) as this case did not meet the criteria for a full safeguarding adult review. The analysis revealed the need for crisis and contingency planning for all discharges from inpatient and recovery wards. This is now in place together with a new female Psychiatric Intensive Care Unit pathway which opened earlier this year.</p>
3	13 September 2017	<p>A case concerning a woman with care and support needs who was at risk of harm, consistently refused any offers of medical help over a long period. She refused to admit nurses and care staff to her home. Her primary carer also had care and support but also refused to allow any engagement, despite the individual concerned being unable at times to make decisions for themselves.</p> <p>This case highlighted the consequences of unwise decision making over time. The Group shared this learning with Mental Capacity Act Training Leads to seek assurances that training and 'toolkits' are in place to equip staff with the necessary skills to cope with such situations and to ensure that escalation pathways are embedded within all policy and procedures across Board member organisations.</p>

APPENDIX

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
4	25 January 2018	<p>A case concerning a woman with learning disabilities who, over a number of years, had suffered from family violence and coercive, controlling behaviour. Family members made it very difficult to speak for herself. Whilst the case had been reported, there was a lack of consistent engagement from safeguarding agencies. Ultimately, she went missing on numerous occasions in 2017 due to her unhappiness at home.</p> <p>This case highlighted that someone with learning difficulties who is experiencing domestic abuse may find it harder to protect themselves, access sources of help, or remove themselves from the abusive situation. This person was socially isolated because of their learning difficulties and had no opportunity to see health or social care professionals without their abusers being present. This prevented professionals from understanding and assessing the risk to the person. This person now lives on her own in a supported environment with regular visits from her mother.</p>
5	25 January 2018	<p>This case concerns a person with a learning disability who was discharged from hospital after initial treatment for a broken arm with sheltered housing staff being given the responsibility for further ongoing treatment. However, the arm did not properly heal and the person is now on the waiting list for an operation. Hospital staff over-estimated the ability of residential staff to care for a serious injury and the review raised concerns regarding communication with Learning Disability patients. This prompted training across the Hospital Trust and the Learning Disability and Autism policy was ratified which includes the 'Purple Pathway' for Learning Disability inpatients, outpatients and A&E attenders.</p>
6	12 March 2018	<p>In this case relatives felt that internal systems and service provision may have contributed to the death of a family member who was admitted to hospital from a care home with six pressure ulcers. This person was transferred a number of times between interim beds in a residential care home and hospital in a deteriorating condition. Various safeguarding enquiries were open at different stages of this person's journey. This review illustrated the value of working with the family to identify further themes. A Root Cause Analysis (RCA) identified a lack of multi-disciplinary information sharing which contributed to a poor care plan with the family not being aware of the condition of the pressure areas. However, the safeguarding enquiry concluded that the person was not a victim of neglect and that good practice was being applied within care homes who were adhering to the Pressure Ulcer Protocol.</p>

mistreated?
bullied?
hit?
neglected?
hurt?
exploited?
silenced?

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