The Royal Kensington and Chelsea: Health Needs, Inequalities and ICS Priorities

The Centre for Population Health January 2026

Introduction

This summary provides an integrated overview of The Royal Kensington and Chelsea's population, health needs, inequalities and systemwide priorities. It brings together demographic analysis, deprivation patterns, health outcomes, and strategic priorities aligned with the Integrated Care System to support evidence based planning across health, social care and community partners.

The pack has been created by the Centre for Population Health using the best possible publicly available resources to provide a borough-by-borough outline for participants and supporters of the NWL and NCL Population Health Management Leadership Programme (see References Section at the end of this pack). The aim of this pack is to help create a shared understanding about the local area, population needs and to highlight some good examples to help inform discussions about improving population health and equity across West and North London. Information provided in this pack should be supplemented with local insights through conversations with communities and partners, and latest non-public datasets to ensure the best possible information is being used to inform decision making for this.

Borough Geography and Context

Kensington and Chelsea is a small, densely populated borough with significant internal contrasts.

Northern neighbourhoods experience higher deprivation, overcrowding and poorer health outcomes.

Southern areas are more affluent with better housing conditions and longer life expectancy.

The borough contains diverse communities with varied cultural and socioeconomic backgrounds.

Population mobility is high, affecting continuity of care and service engagement.

Geography influences access to green space, healthy environments and community resources.

Population Characteristics

RBKC has 143,659 residents making it the least populous borough in London

Population density is 15,000 people per square kilometre which is double the London average

The borough experienced a 10 percent population decline between 2011 and 2021

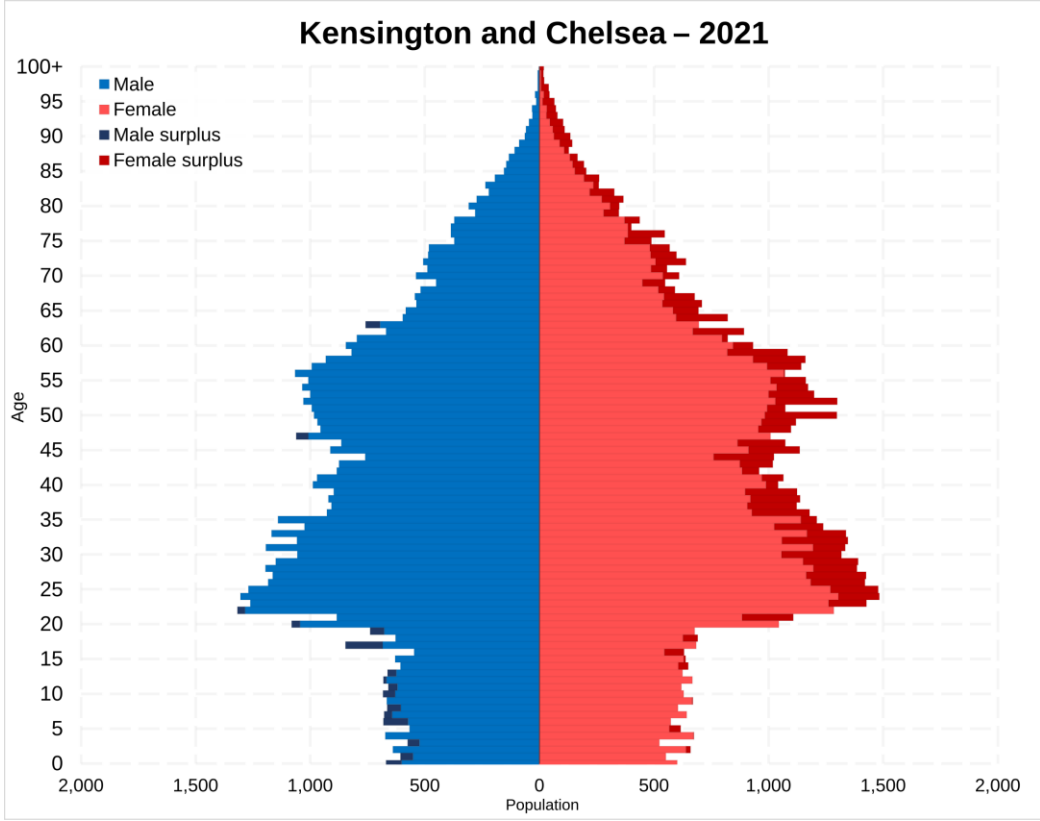
2023 estimates suggest a rebound to approximately 147,500 residents

High mobility with 18 to 20 percent of residents moving in or out each year

Population concentrated in northern estates and around Earl's Court

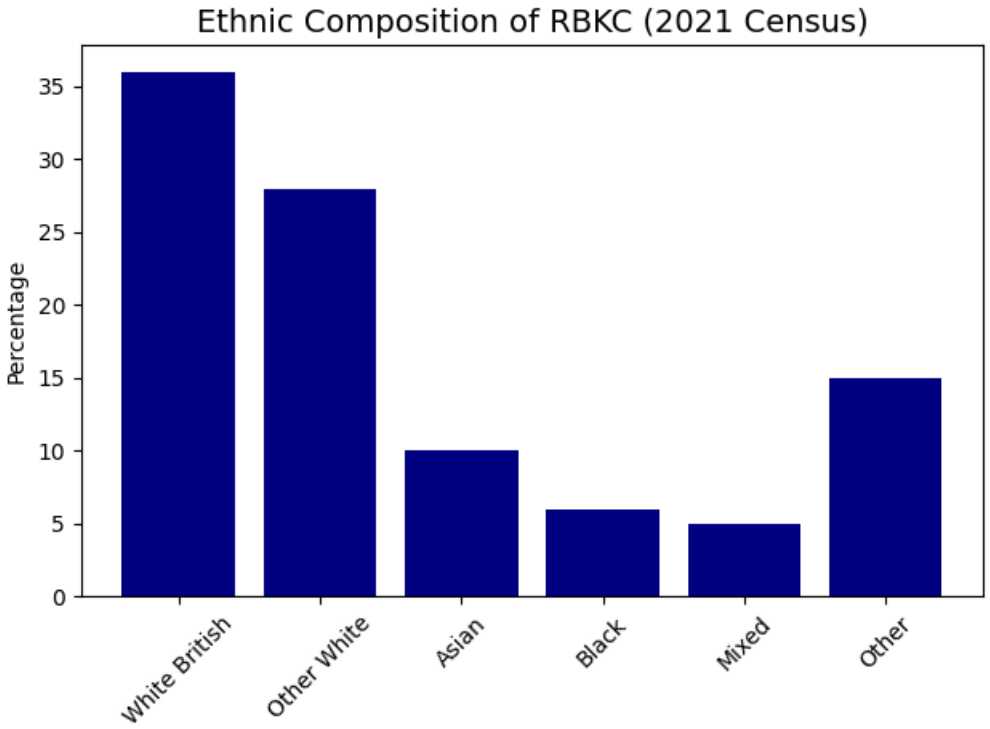
Population Characteristics

- Age profile is younger than national average but older than some Inner London boroughs
- 14 percent are children 71 percent working age and 15 percent are aged 65 and over
- RBKC has 7 percent of residents aged 75 and over which is above the London average
- About 2,300 residents are aged 85 and over with higher health and care needs
- Children numbers are stable or declining while over 65s are projected to rise by 39 percent
- High turnover challenges continuity of care and public health communication



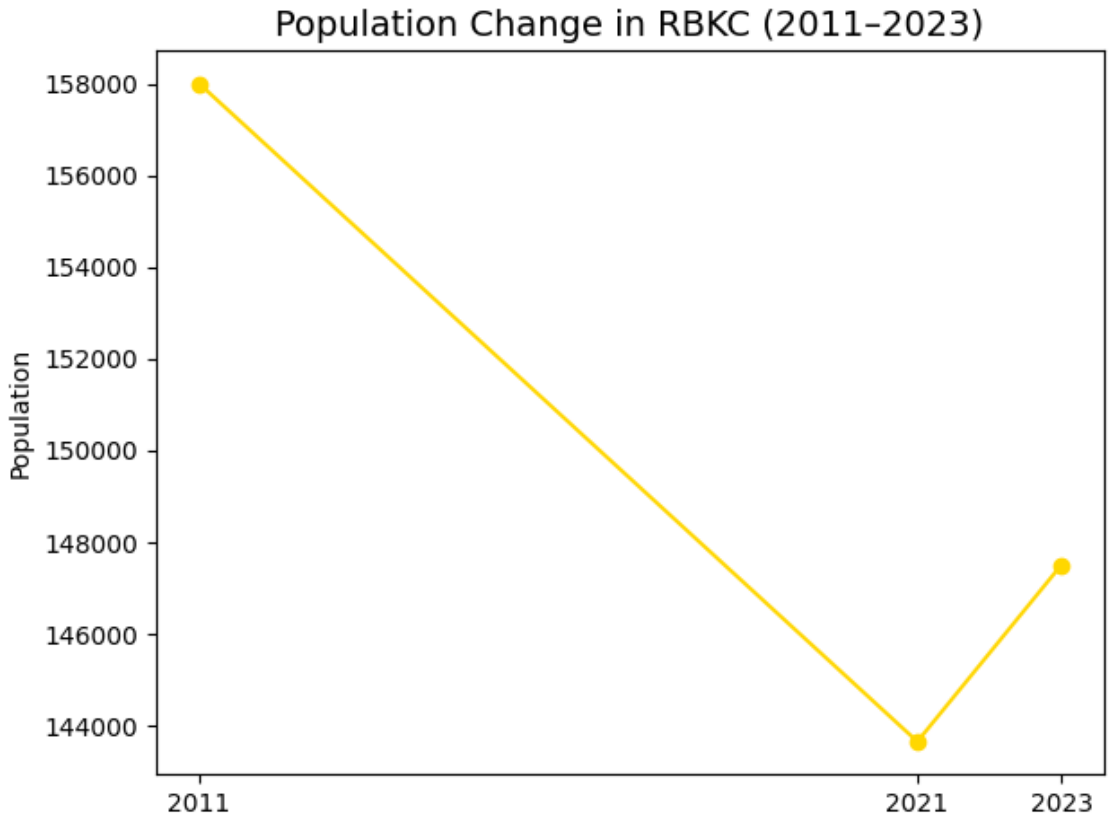
Population Characteristics

- RBKC is highly diverse with 36 percent of residents from minority ethnic backgrounds
- Largest minority group is Other White including French Italian Spanish and American residents
- Asian residents make up 10 percent mainly South Asian and Arab communities
- Black residents comprise 6 percent mostly African and Caribbean origin
- Mixed and other ethnic groups account for 20 percent of the population
- Over 100 nationalities are represented with strong cultural neighbourhood identities



Population Characteristics

- Population declined by 10 percent between 2011 and 2021 due to Brexit and COVID impacts
- 2023 estimates show population rebounding to 147,500 due to resumed international migration
- High proportion of short-term residents including students and international professionals
- Population turnover affects GP registration and continuity of care
- Public health messaging must adapt to changing and mobile population
- High density and housing costs influence family size and age structure



Key Health Inequalities

- Health outcomes vary sharply between northern and southern wards across multiple indicators.
- Deprivation strongly influences obesity, long term conditions and mental health outcomes.
- Preventive service uptake is lowest in deprived and minority communities.
- Housing quality and overcrowding significantly influence health and wellbeing.
- Environmental exposures disproportionately affect residents in the north.
- Addressing inequalities requires coordinated action across health, housing and community sectors.

Golborne & Notting Dale (North K&C) – IMD Bottom 10%

- Among London's most deprived wards
- High child poverty, overcrowding, unemployment
- Lower life expectancy and higher illness rates

Queen's Gate & Chelsea (South K&C) – IMD Top 10%

- Among least deprived areas nationally
- High incomes, good housing, low poverty
- Residents enjoy excellent health outcomes

Key Health Needs Across the Life Course

Children in deprived wards experience higher obesity, poorer early development and reduced school readiness outcomes.

Young people face rising mental health needs, long waits for support and limited early intervention access.

Adults in northern neighbourhoods have higher burdens of long term conditions and lifestyle risk factors.

Preventive care uptake is consistently lower in deprived communities, widening long term health inequalities.

Older adults experience loneliness, frailty and increased risk of falls, particularly in isolated households.

Trauma related needs remain significant in communities affected by the Grenfell tragedy and ongoing instability.

Inequalities Driven by Housing, Environment and Access

Overcrowding affects one in five northern households, contributing to respiratory illness and chronic stress.

Poor housing conditions increase risks of damp, cold exposure and preventable health complications.

Temporary accommodation disrupts continuity of care and reduces engagement with essential health services.

Environmental exposures such as pollution and limited green space disproportionately affect deprived neighbourhoods.

Digital exclusion and language barriers reduce access to primary care and preventive health information.

Service engagement is lower among residents experiencing housing insecurity, instability or limited trust in institutions.

Mental Health, Safety, and Community Connectedness

Mental health needs are elevated across all ages, particularly in North Kensington and trauma affected groups.

Minority communities underuse talking therapies due to stigma, cultural barriers and limited tailored support.

Older adults experience persistent loneliness and isolation, increasing risks of depression and poor wellbeing.

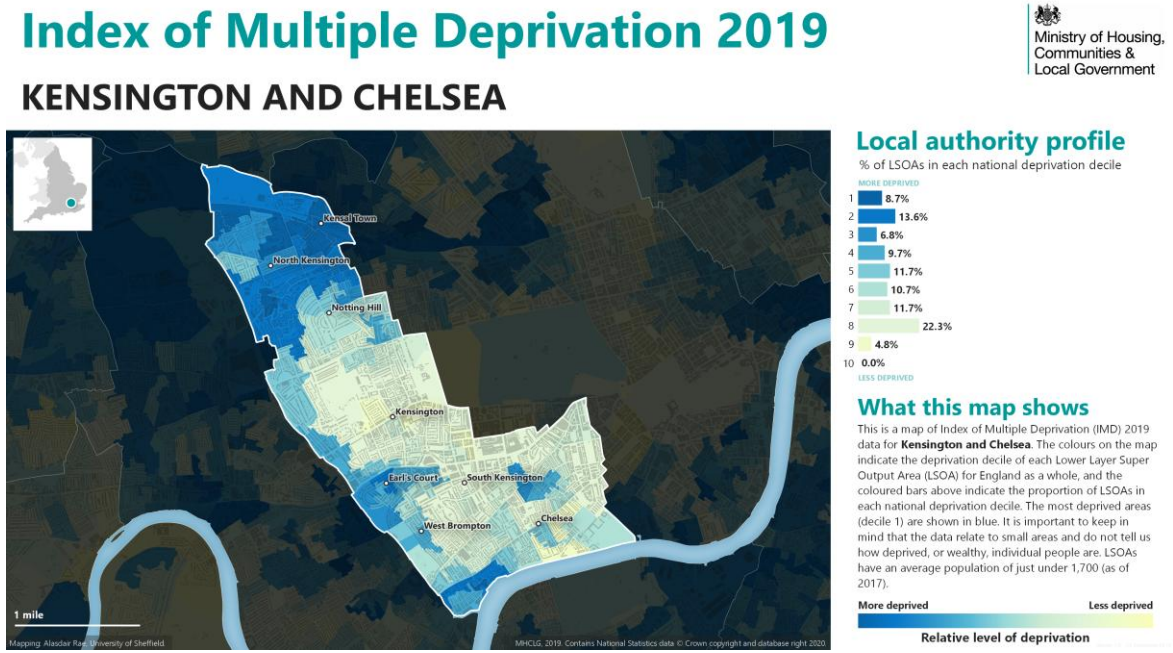
Youth violence and antisocial behaviour remain concerns in deprived areas, affecting safety and community cohesion.

Women and girls report harassment and safety concerns in public spaces, influencing mobility and wellbeing.

Community organisations provide essential support but require sustainable funding to maintain trusted local services.

Index of Multiple Deprivation

- Deprivation is concentrated in Golborne, Notting Dale and Dalgarno, forming a clear north south divide.
- The borough contains some of England's most deprived neighbourhoods despite overall affluence.
- Income, housing and living environment domains drive the most significant inequalities.
- Deprived areas experience higher unemployment, lower income and greater financial insecurity.
- Poor housing quality and overcrowding are major contributors to health risks in the north.
- Deprivation patterns closely align with poorer health outcomes and reduced service engagement.



Extreme Internal Inequality

Kensington & Chelsea has some of England's richest and poorest neighbourhoods side by side. Golborne (North Kensington) is in the most deprived 1% nationally, while parts of South Kensington are in the least deprived 1%.

North vs South Divide

The north of the borough (Notting Dale, Golborne wards) contains all of RBKC's areas that fall into the bottom 10% on IMD. These areas suffer entrenched poverty, whereas southern wards like Hans Town rank among the top 10% (very affluent).

Housing & Cost of Living

The entire borough scores poorly on housing affordability. RBKC is in the worst 5% in England for housing "barriers" domain – reflecting sky-high house prices/rents and prevalent overcrowding even in otherwise affluent areas.

Neighbouring H&F's Profile

Hammersmith & Fulham is somewhat less polarised. It has deprived pockets (e.g. White City) but no longer any area in England's bottom 10%. Its overall deprivation ranking improved from 2015 to 2019 (now around mid-range nationally).

IMD: Eight Key Takeaways

Deprivation is highly localised, requiring targeted neighbourhood based interventions rather than borough wide approaches.

Health outcomes worsen significantly in areas with overcrowding, low income and poor housing conditions.

Deprived communities experience higher levels of chronic disease, obesity and mental health challenges.

Preventive service uptake is lowest in the most deprived wards, widening long term inequalities.

Environmental exposures such as pollution and limited green space disproportionately affect northern estates.

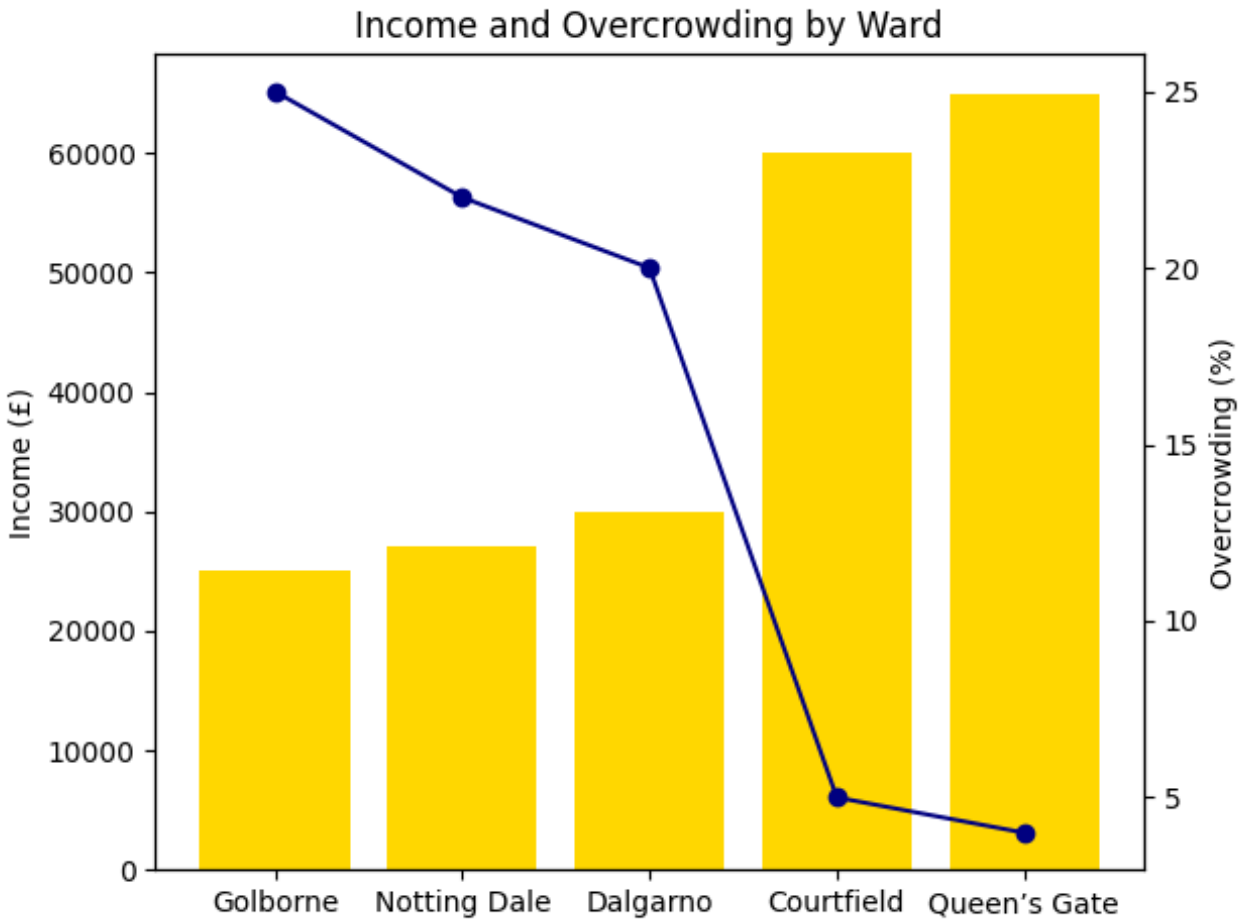
Housing insecurity and temporary accommodation contribute to instability and poorer health outcomes.

Deprivation affects access to services, trust in institutions and engagement with preventive care.

Addressing deprivation is essential for improving population health and reducing inequalities.

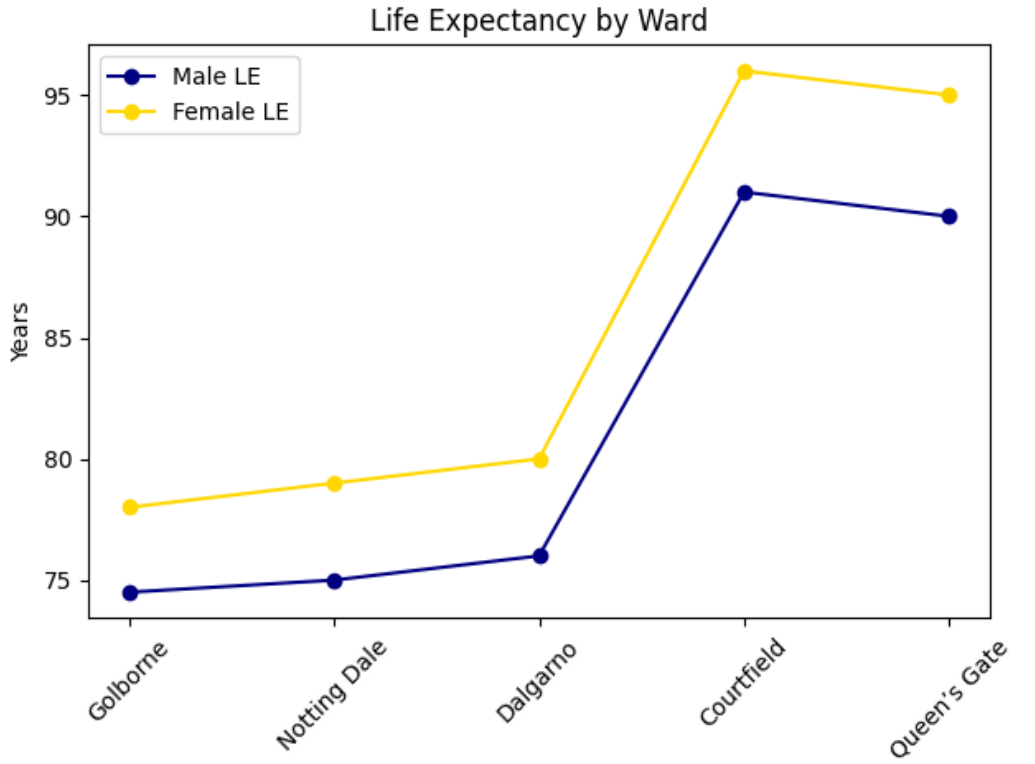
IMD Indicators: Income and Overcrowding

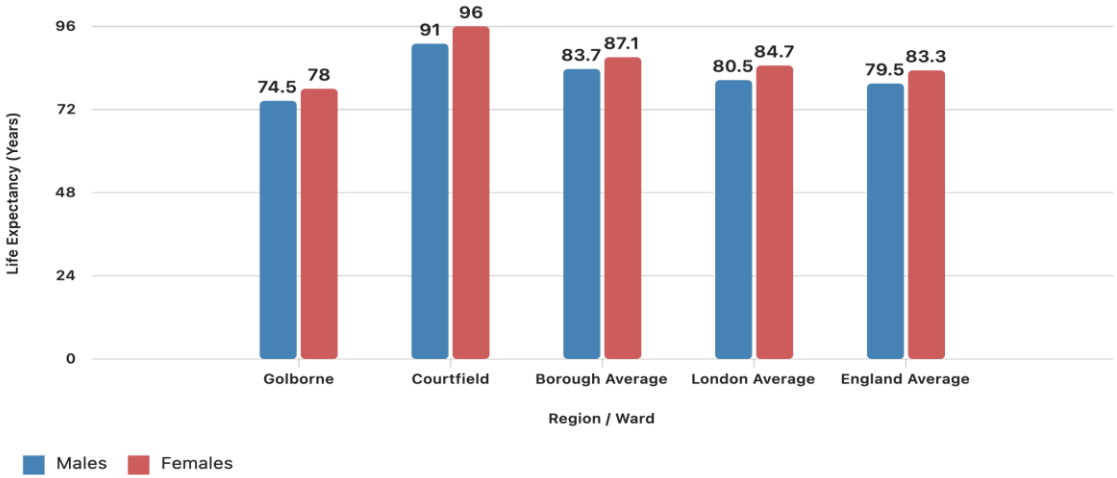
- Golborne has lowest income and highest overcrowding among RBKC wards
- Courtfield and Queen's Gate have highest incomes and lowest overcrowding
- Overcrowding exceeds 20 percent in deprived wards compared to under 5 percent in affluent areas
- Income disparity exceeds £35,000 between richest and poorest wards
- Housing stress is a key driver of health inequalities in North Kensington
- Targeted housing and income support needed to reduce deprivation



IMD Indicators: Life Expectancy Gap

- Life expectancy varies by over 16 years between poorest and richest wards
- Golborne has lowest male LE at 74.5 years and female LE at 78 years
- Courtfield has highest male LE at 91 years and female LE at 96 years
- North South divide in health outcomes is stark and persistent
- Deprivation strongly correlates with earlier onset of chronic illness
- Reducing LE gap is a key goal of the health and wellbeing strategy





Best start in life for children

- Childhood obesity rates are three times higher in poorest areas than wealthiest wards
- Only 64 percent of children receive both MMR doses by age five in RBKC
- Low birth weight more common in deprived wards linked to maternal health and smoking
- High child poverty in Golborne with 37 percent affected after housing costs
- Declining school enrolment in some areas reflects fewer children and high housing costs
- Educational attainment gaps persist for some ethnic minority groups like Somali children

Best start in life for children – Actions

Expand	Expand early years nutrition and parenting support in deprived neighbourhoods
Improve	Improve MMR and childhood immunisation uptake through targeted outreach and reminders
Enhance	Enhance access to health visitors and early intervention for vulnerable families
Support	Support healthy school meals and physical activity in primary schools
Partner	Partner with schools to address educational inequalities and health literacy
Invest in	Invest in culturally appropriate maternal health and perinatal services

Healthy lifestyles and prevention

- 42 percent of adults are overweight or obese in RBKC
- 20 percent of adults are physically inactive increasing risk of chronic disease
- Low cervical screening uptake at 55 to 60 percent below national average
- Smoking rates higher in deprived areas contributing to lung cancer disparities
- High alcohol-related health issues among White British and European residents
- Preventive service uptake is low in deprived communities increasing avoidable illness

Healthy lifestyles and prevention – Actions

- Promote physical activity through community walking groups and active travel infrastructure
- Increase cervical screening uptake through reminders and culturally sensitive outreach
- Expand smoking cessation services in North Kensington and deprived estates
- Deliver healthy eating campaigns in schools and community centres
- Use social prescribing to connect residents with lifestyle support services
- Target alcohol harm reduction in high-risk groups with tailored messaging

Mental health and wellbeing

- Eight percent of residents diagnosed with depression likely an underestimation
- Up to 20 percent of residents report high levels of anxiety
- Grenfell tragedy continues to impact mental health and community trust
- Loneliness affects older adults especially those in private renting or living alone
- Youth mental health concerns linked to housing stress and unemployment
- Access to culturally appropriate mental health services remains inconsistent

Mental health and wellbeing – Actions

Expand	Expand trauma-informed mental health services in North Kensington
Support	Support community-based mental health hubs and peer support networks
Increase	Increase access to talking therapies for underrepresented groups
Train	Train frontline staff in mental health first aid and cultural competence
Promote	Promote mental wellbeing through arts, culture and volunteering programmes
Address	Address youth mental health through schools and youth clubs

Good quality housing

RBKC ranks in bottom 5 percent nationally for housing affordability and overcrowding

Overcrowding affects 20 to 25 percent of homes in Golborne and Notting Dale

Average flat price is £1.2 million creating barriers for families and key workers

Poor housing linked to respiratory illness, TB and poor mental health

300 households in temporary accommodation mainly in North Kensington

Post-Grenfell housing regeneration is a key priority for the Council

Good quality housing - Actions

- Invest in housing upgrades to reduce damp, cold and overcrowding
- Accelerate post-Grenfell estate regeneration with resident involvement
- Expand affordable housing options for low-income families and key workers
- Improve temporary accommodation standards and support pathways to permanent housing
- Use housing officers to identify and refer residents with health risks
- Integrate housing and health data to target interventions

Safe and connected communities

Only 60 percent of Golborne residents feel safe at night versus 85 percent in Chelsea

Fear of crime reduces outdoor activity and community participation

Grenfell tragedy reduced trust in authorities and increased trauma

Youth safety concerns include knife crime and gang activity spillover

Social isolation affects older adults and young professionals in single households

Community assets like faith groups and resident associations are vital for cohesion

Safe and connected communities - Actions

- Support community safety partnerships to reduce crime and build trust
- Expand youth clubs and mentoring to prevent violence and promote wellbeing
- Invest in community connectors and social prescribing to reduce isolation
- Use community champions to promote health and safety messages
- Strengthen resident associations and local leadership in deprived areas
- Deliver trauma-informed services and co-design with affected communities

Healthy environment

North Kensington has higher air pollution due to Westway flyover and traffic

Buildings in deprived areas often lack central heating and suffer from damp

Access to green space is lower in North Kensington than in the south

Environmental deprivation affects respiratory health and mental wellbeing

RBKC ranks 10th worst nationally in the IMD Living Environment domain

Climate resilience is a growing concern for vulnerable residents

Healthy environment – Actions

Improve	Improve air quality through traffic reduction and green infrastructure
Retrofit	Retrofit homes to improve insulation and reduce damp and cold
Expand	Expand access to green spaces in deprived neighbourhoods
Promote	Promote active travel and cycling infrastructure borough-wide
Engage	Engage communities in climate resilience and sustainability initiatives
Monitor and address	Monitor and address environmental health risks in high-risk areas

Accessible integrated services

Service fragmentation affects continuity of care especially for older adults

High population turnover challenges GP registration and follow-up

Language barriers affect access for non-English speaking residents

Digital exclusion affects 8 to 10 percent of residents mainly older adults

Complex needs require coordination across health, social care and housing

Residents value personalised and culturally competent care

Accessible integrated services – Actions

Join up health and social care records for seamless patient experience

Expand interpreter services and multilingual health materials

Support digital inclusion through device lending and training

Use care navigators to support residents with complex needs

Co-locate services in community hubs for easier access

Engage communities in service design and feedback

Tackling health inequalities

Life expectancy gap exceeds 16 years between richest and poorest wards

Childhood obesity and dental decay higher in deprived areas

Black residents have higher rates of diabetes, hypertension and stroke

Preventive service uptake lower in deprived and minority communities

Housing, income and education disparities drive health outcomes

One-size-fits-all services fail to meet diverse community needs

Tackling health inequalities – Actions

- Target services to high-need neighbourhoods using local data
- Deliver culturally competent care and outreach
- Use community champions to reach underrepresented groups
- Address social determinants through cross-sector collaboration
- Monitor and publish equity metrics for accountability
- Invest in workforce diversity and inclusion training

Financial wellbeing

Cost-of-living pressures affect low-income families and older adults

Golborne has median income under £25k compared to £60k in Knightsbridge

24 percent of children in RBKC live in poverty after housing costs

Many residents in social housing rely on benefits or low-wage jobs

Pandemic increased unemployment especially in hospitality and retail sectors

Financial stress linked to poor mental and physical health outcomes

Financial wellbeing – Actions

Expand	Expand access to welfare advice and income maximisation services
Support	Support employment and skills programmes in deprived areas
Partner	Partner with voluntary sector to deliver financial resilience workshops
Provide	Provide targeted cost-of-living support for vulnerable households
Promote	Promote uptake of Healthy Start and other entitlements
Integrate	Integrate financial wellbeing into health and care planning

Healthy ageing and independence

RBKC has high proportion of residents aged 75 and over

Older adults more likely to live alone and experience loneliness

Dementia prevalence is 0.75 percent with 830 patients on GP registers

Falls, frailty and long-term conditions increase with age

Older adults in social housing face barriers to accessing services

Healthy life expectancy is 68 for women and 70 for men

Healthy ageing and independence - Actions

- Expand falls prevention and strength training programmes
- Support ageing in place through home adaptations and care packages
- Increase dementia support and carer respite services
- Use social prescribing to reduce loneliness and isolation
- Train staff in frailty identification and proactive care
- Promote age-friendly communities and intergenerational activities

Best Practice Examples in Kensington and Chelsea

Community Health and Wellbeing Workers in North Kensington

Go Golborne – A Community Campaign to Tackle Childhood Obesity

My Care, My Way – Integrated Care for Older Adults

Community Champions – Empowering Residents as Health Champions

Changing Futures – Supporting Residents with Multiple Disadvantages

Community Health and Wellbeing Workers in North Kensington

- Launched after Grenfell to rebuild trust and reach underserved North Kensington communities.
- Recruited bilingual residents with lived experience to serve as trusted community health workers.
- Provided training in public health, outreach, coaching, and local service navigation techniques.
- Conducted door-to-door visits and listening tours to understand residents' needs and concerns.
- Supported GP registration, appointment booking, and access to housing and benefits advice.
- Delivered health education on diabetes, mental wellbeing, immunisations, and healthy eating.
- Worked from community venues like The Curve to increase accessibility and visibility.
- Adapted roles during COVID-19 to support vaccine rollout and counter misinformation effectively.

Why This Is a Best Practice

- Built trust with residents who previously distrusted or disengaged from statutory health services.
- Reached marginalised groups through culturally competent, language-matched community engagement.
- Improved uptake of services like GP registration, mental health support, and immunisations.
- Freed up clinical staff by handling preventive and supportive non-clinical health tasks.
- Empowered residents to manage their health through coaching and personalised support.
- Demonstrated scalable model for integrating community members into the health workforce.

Lessons for Intervention Planning

- Recruit empathetic, trusted locals rather than relying solely on formal qualifications or clinicians.
- Provide strong supervision and mental health support to prevent burnout among outreach workers.
- Clearly define roles to avoid duplication with Champions or Social Prescribers in the ecosystem.
- Embed flexibility to adapt to emerging needs like pandemic response or new health priorities.
- Use co-location in community venues to increase accessibility and reduce institutional barriers.
- Secure long-term funding and career pathways to retain talent and sustain programme impact.

Evaluation Results

- Over 5,000 meaningful contacts and 1,200 unique individuals reached in the first 18 months.
- More than 300 residents supported to register with a GP for the first time.
- 250+ referrals made to smoking cessation, dietitian, and other preventive services.
- Immunisation uptake increased in communities with historically low engagement.
- Patient activation scores improved by 10 points after three or more CHWW contacts.
- Over 95 percent of residents surveyed reported trust and satisfaction with CHWW support.

Go Golborne – A Community Campaign to Tackle Childhood Obesity

- Launched in 2015 to address high childhood obesity rates in Golborne ward of North Kensington.
- Used themed campaigns like Snack Smart and Unplug & Play to promote healthy behaviours.
- Partnered with all local primary schools to implement healthier menus and daily physical activity.
- Installed water fountains and promoted water-only policies in schools and community venues.
- Engaged over 70 local businesses in a healthier catering scheme with smaller portion pledges.
- Provided mini-grants to community groups for cooking clubs, play sessions, and fitness events.
- Used creative methods like murals, parades, and films to engage children and families.
- Applied a whole-systems approach addressing environment, behaviour, and community empowerment.

Why This Is a Best Practice

- Halted and reversed rising obesity trends in a high-risk, deprived London ward.
- Engaged entire community including schools, families, businesses, and local organisations.
- Used positive, non-stigmatising messaging to promote healthy lifestyles for all children.
- Empowered residents through co-design and peer-led delivery of campaign activities.
- Demonstrated measurable improvements in healthy behaviours and school food environments.
- Served as a national pilot for whole-systems approaches to childhood obesity prevention.

Lessons for Intervention Planning

- Sustained, multi-year engagement is essential to shift behaviours and community norms.
- Positive framing avoids stigma and encourages inclusive participation across all weight groups.
- Mini-grants empower local groups to tailor interventions to cultural and community needs.
- Creative engagement methods like arts and games increase participation and message retention.
- Partnerships with schools and trusted community centres are critical for reach and legitimacy.
- Use data and feedback loops to refine campaigns and demonstrate impact to funders.

Evaluation Results

- Obesity in Year 6 children declined from 28 percent to 26 percent over three years.
- Water-only policies adopted in all Golborne primary schools and several community venues.
- Surveys showed increased fruit and vegetable intake and reduced sugary drink consumption.
- Over 3,300 children participated in at least one Go Golborne activity or event.
- More than 100 community-led events supported by 52 mini-grants across three years.
- All Golborne primary schools achieved Healthy Schools London awards by project end.

My Care, My Way – Integrated Care for Older Adults

- Launched in 2015 to support older adults with long-term conditions in Kensington and Chelsea.
- Each GP practice formed a multidisciplinary team including nurses, coordinators, and specialists.
- Patients aged 65+ received holistic assessments covering health, wellbeing, and personal goals.
- Personalised care plans were co-developed and shared across health and social care providers.
- Care coordinators provided regular follow-up, appointment support, and hospital discharge planning.
- Age UK staff embedded in practices addressed social needs like isolation and housing support.
- Extended GP appointments allowed time to address complex medical and psychosocial issues.
- Programme continuously improved based on feedback, adding mental health and geriatrician input.

Why This Is a Best Practice

- Improved patient experience through coordinated, personalised care and single point of contact.
- Reduced emergency admissions and A&E visits among enrolled older patients over one year.
- Enhanced chronic disease management and functional outcomes through proactive care planning.
- Integrated voluntary sector support addressed social determinants like isolation and housing.
- Freed GP time by delegating follow-up and coordination to trained care managers and staff.
- Recognised nationally as a scalable model for integrated care aligned with NHS priorities.

Lessons for Intervention Planning

- Co-design with GPs and patients ensures relevance, buy-in, and practical implementation success.
- Embedding voluntary sector partners like Age UK enhances social support and community links.
- Clear role definitions and joint training prevent duplication and improve team collaboration.
- Integrated IT systems and shared records are essential for seamless care coordination.
- Stratify patients by risk to prioritise resources for those with highest complexity and need.
- Sustainability requires demonstrating value early to secure long-term funding and workforce integration.

Evaluation Results

- Emergency admissions reduced by 20 percent among enrolled patients after one year.
- A&E attendances dropped by 18 percent compared to similar patients in neighbouring boroughs.
- GPs saved 15–20 percent of time on admin tasks due to care coordinator support.
- Diabetes control improved with 8 percent more patients achieving target HbA1c levels.
- Falls among high-risk patients decreased by 25 percent after targeted interventions.
- 92 percent of patients rated care as excellent or good, citing improved confidence and support.

Community Champions – Empowering Residents as Health Champions

- Volunteer-based programme launched in early 2010s across Kensington and Chelsea neighbourhoods.
- Champions recruited locally to reflect community diversity and build trust with residents.
- Trained in health messaging, communication, and event delivery to promote healthy lifestyles.
- Organised activities like cooking classes, exercise groups, and mental health tea sessions.
- Champions tailored outreach to local needs, such as women-only fitness or language-specific events.
- Worked with GPs, schools, and public health teams to promote screenings and vaccinations.
- Champions relayed community concerns to services, acting as trusted local intermediaries.
- Played key roles during Grenfell and COVID-19, supporting residents and sharing accurate information.

Why This Is a Best Practice

- Improved health behaviours and service uptake in deprived and underrepresented communities.
- Built social capital and trust through peer-led, culturally relevant health promotion.
- Cost-effective model with high social return on investment through volunteer engagement.
- Flexible and responsive to local needs, increasing relevance and community participation.
- Developed local leadership and skills, with many Champions progressing to paid roles.
- Strengthened community resilience during crises through trusted networks and rapid mobilisation.

Lessons for Intervention Planning

- Community ownership and co-design ensure relevance and sustained engagement in interventions.
- Support structures like coordinators and training maintain volunteer motivation and quality.
- Partnerships with local services and venues expand reach and resource availability.
- Use local data to target efforts and measure impact, creating feedback loops with services.
- Flexibility enables creative, culturally tailored approaches that resonate with diverse communities.
- Recognition and progression pathways help retain volunteers and build long-term community capacity.

Evaluation Results

- Increased uptake of flu vaccines and cancer screenings in targeted estates with Champion outreach.
- Residents reported improved health knowledge and behaviours after participating in activities.
- High satisfaction with Champions' support and trust in peer-delivered health information.
- Champions engaged hard-to-reach groups including migrants, older adults, and isolated residents.
- SROI analysis showed £5–£6 social value generated for every £1 invested in the programme.
- Champions sustained health promotion activities beyond funding through community ownership.

Changing Futures – Supporting Residents with Multiple Disadvantages

- Launched in 2021 to support adults facing homelessness, trauma, addiction, and complex needs.
- Formed multidisciplinary teams with housing, mental health, substance misuse, and peer mentors.
- Each participant assigned a navigator for intensive, personalised case management and advocacy.
- Support tailored to individual priorities, including housing, health, family, or legal issues.
- Flexible funds used to meet urgent needs like phones, transport, or training opportunities.
- No wrong door approach ensured continuity even during relapse or disengagement from services.
- Peer mentors with lived experience built trust and improved engagement with hard-to-reach clients.
- Programme also worked to reform local systems and improve cross-agency collaboration and data sharing.

Why This Is a Best Practice

- Reached individuals excluded from traditional services due to complex, overlapping disadvantages.
- Reduced crisis service use by addressing root causes like housing, trauma, and social exclusion.
- Built trust through persistent, trauma-informed, and person-centred engagement strategies.
- Peer mentors provided relatable support and improved service uptake among marginalised groups.
- Flexible funding enabled rapid, personalised responses to individual needs and goals.
- Generated insights to inform systemic reforms and improve integrated care for complex populations.

Lessons for Intervention Planning

- Integrated teams with shared plans reduce duplication and improve outcomes for complex cases.
- Single navigator model simplifies access and builds trust through consistent, personalised support.
- Trauma-informed care and flexibility improve engagement and reduce service drop-out rates.
- Peer involvement enhances credibility, trust, and relevance of services for marginalised populations.
- Long-term funding is essential to sustain impact and avoid disruption to vulnerable clients.
- Broader outcome measures like wellbeing and stability better reflect progress than clinical metrics.

Evaluation Results

- Participants secured stable housing and reduced reliance on emergency and crisis services.
- Improved mental wellbeing and social inclusion reported by clients and peer mentors.
- Over 250 individuals supported with intensive case management and personalised care plans.
- Flexible funds enabled over 100 rapid interventions addressing urgent personal needs.
- System learning informed new protocols for data sharing and cross-agency collaboration.
- Programme cited as national model for integrated support for multiply disadvantaged adults.

Cross Case Insights

- Community based workforces consistently build trust and reach residents who disengage from statutory services.
- Trauma informed practice improves engagement and outcomes across all high need population groups.
- Integrated multi agency teams reduce duplication and improve outcomes for complex individuals.
- Community intelligence combined with formal data strengthens targeting and intervention design.
- Long term funding enables stability and sustained impact across successful programmes.
- Prevention is most effective when delivered through whole systems approaches and community empowerment.

System Recommendations

- Invest in trusted community based roles across PCNs housing estates and high need neighbourhoods.
- Embed trauma informed practice across all frontline services including housing and voluntary sector partners.
- Expand integrated team around the person models for older adults and complex households.
- Build shared dashboards combining clinical data community insights and voluntary sector intelligence.
- Move proven programmes into core ICS budgets to reduce reliance on short term grants.
- Increase social prescribing capacity and embed voluntary sector partners within primary care networks.

What This Means for the ICS

- ICS partners should prioritise prevention and early intervention through community embedded models.
- Borough and ICS teams must strengthen collaboration with voluntary and community sector organisations.
- Integrated care pathways should reflect lessons from successful local programmes and case studies.
- Workforce planning should include community based roles with clear progression pathways.
- Data sharing agreements must support multi agency working and reduce fragmentation.
- ICS governance should champion co production and lived experience involvement in all programmes.

Next Steps for RBKC and NW London ICS

- Review current programmes and identify opportunities to scale successful models borough wide.
- Develop a joint commissioning plan to sustain community based and integrated care roles.
- Establish a cross borough learning network to share insights from case studies and evaluations.
- Strengthen partnerships with community organisations to co design future interventions.
- Align JSNA findings with ICS strategic priorities and neighbourhood level delivery plans.
- Monitor progress using shared indicators focused on prevention wellbeing and reduced inequalities.

Summary of Recommendations

Strengthen	Strengthen community based workforces with stable funding supervision and progression pathways.
Embed	Embed trauma informed practice across health housing and voluntary sector services.
Scale	Scale integrated multi agency teams for older adults families and complex households.
Combine	Combine clinical data with community intelligence to target interventions more effectively.
Secure	Secure long term funding for proven programmes and reduce reliance on short term grants.
Expand	Expand social prescribing and co produced prevention programmes across neighbourhoods.

Closing Reflections

- Kensington and Chelsea has strong foundations and proven models that improve lives.
- Community embedded integrated and trauma informed approaches consistently deliver better outcomes.
- Scaling what works requires long term investment shared data and cross sector collaboration.
- The ICS has an opportunity to reduce inequalities through prevention and partnership.
- Together we can build a healthier more connected borough for all residents.
- Thank you. We look forward to working together on the next phase.