AGENDA

HEALTH AND WELLBEING BOARD (SHADOW)

Wednesday, 23rd November, 2011, at 6.30 pm
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Peter Sass**
Telephone: **(01622) 694002**

Tea/Coffee will be available 15 minutes before the meeting.

UNRESTRICTED ITEMS
(During these items the meeting is likely to be open to the public)

1. Welcome

2. Substitutes

3. Declaration of Interests by Members in Items on the Agenda for this meeting

4. Previous minutes/action points (Pages 1 - 6)

5. Health Needs for Kent - Health & Social Care maps - the JSNA for Kent - getting the right product (Pages 7 - 118)

6. Towards a Health & Wellbeing Strategy (Pages 119 - 122)

7. Developing provider relationships, what does the Health and Well-Being Board need? (Pages 123 - 126)

8. Future dates to April 2013

Bi monthly meetings – future dates are:

- 18th January 2012
- 21st March 2012
- 30th May 2012
- 18th July 2012
- 19th September 2012
- 21 November 2012
- 30th January 2013
- 27th March 2013

Peter Sass
Head of Democratic Services
Tuesday, 15 November 2011

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

Delegates:

Dr John Allingham	-	Clinical Lead, Shepway Locality, South Kent CCG
Dr Bob Bowes	-	Chair West Kent & Weald CCG Group
Cllr Andrew Bowles Represented by		
Cllr Lesley Ingham	-	Member, Housing, Health and Wellbeing, Swale BCl
Cllr Paul Carter	-	Leader of Kent County Council
Dr Fiona Armstrong	-	Joint Clinical Lead, Swale CCG
Dr Sourja Chaudhuri	-	Clinical Lead, Dover Locality, South Kent CCG
Cllr John Cunningham	-	Tunbridge Wells Borough Council
Cllr Graham Gibbens	-	Cabinet Member for Adult Social Care and Public Health – KCC
Cllr Roger Gough	-	Cabinet Member for Business Strategy, Performance & Health Reform, KCC
Dr Mark Jones	-	Chair & Clinical Lead C4 Canterbury CCG
Roger Kendall	-	Kent LINk
Dr Roger Pinnock	-	Chair, Ashford CCG
Dr Chee Mah	-	Clinical Lead, Deal Locality, South Kent CCG
Dr Tony Martin	-	Chair & Clinical Lead, Thanet CCG
Dr John Neden	-	Chair & Clinical Lead, East Cliff Commissioning Practice
Andrew Ireland	-	Corporate Director Families and Social Care
Meradin Peachey	-	Director of Public Health
Dr Roger Pinnock	-	Chair, Ashford CCG
Dr John Ribchester	-	Chair & Clinical Lead, Whitstable CCG
Dr Garry Singh	-	Clinical Lead, Maidstone & Malling CCG
Ann Sutton	-	Chief Executive, Kent & Medway Cluster
Cllr Jenny Whittle	-	Cabinet Member for Specialist Children's Services, KCC
Cllr Mark Worrall	-	Leader, Tonbridge & Malling Borough Council

Invited Observer

Katherine Kerswell	-	Managing Director, KCC
Colin Tomson	-	Chair, Kent & Medway Cluster

KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD (SHADOW)

MINUTES of a meeting of the Health and Wellbeing Board (Shadow) held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 28 September 2011.

PRESENT: Dr Fiona Armstrong, Dr B Bowes, Mr P B Carter, Dr S Chaudhuri, Cllr J Cunningham, Mr G K Gibbens, Mr R W Gough, Cllr L Ingham (Substitute for Mr A Bowles), Mr R Kendall, Dr S Lundy (Substitute for Dr M Jones), Mr M Newsam, Ms M Peachey, Dr R Pinnock, Dr G Singh, Mr A Stibbs (Substitute for Dr T Martin), Ms A Sutton, Mrs J Whittle and Cllr M Worrall

ALSO PRESENT: Cllr R Davison, Ms K Kerswell, Dr D O'Neill, Ms D Stock, Dr J Thallon, Mr R Tolputt and Mr C Tomson

IN ATTENDANCE: Ms D Benton (Staff Officer to the Cabinet Member for Business, Strategy, Performance and Health Reform), Ms S Brown (Business Manager - Public Health Unit), Mr P Sass (Head of Democratic Services) and Mr D Whittle (Policy Manager)

UNRESTRICTED ITEMS

1. Welcome

(Item 1)

Peter Sass, Head of Democratic Services (Kent County Council) welcomed all to this first formal meeting of the Shadow Health and Wellbeing Board.

2. Election of Chairman

(Item 4)

It was proposed by Ann Sutton, seconded by Graham Gibbens that Roger Gough be elected as Chairman. There being no other nominations, it was:

Resolved: that Mr Roger Gough be elected Chairman of the Shadow Health and Wellbeing Board.

(Roger Gough took the Chair)

3. Terms of Reference and Standing Orders

(Item 5)

The Chairman proposed the adoption of the draft Terms of Reference and Standing Orders, which had been approved by Kent County Council.

Resolved: that the Terms of Reference and Standing Orders for the Shadow Health and Wellbeing Board be adopted as set out in the Board papers.

4. Code of Conduct
(Item 6)

The Chairman proposed the adoption of the Cabinet Office 'Code of Conduct for Board Members of Public Bodies.'

Resolved: that the Cabinet Office 'Code of Conduct for Board Members of Public Bodies' be adopted as being applicable to all Members of the Shadow Health and Wellbeing Board.

5. Declaration of Interests by Members in Items on the Agenda for this meeting
(Item 3)

The following interests were declared by Shadow Board Members:

Dr Sourja Chaudhari, Clinical Lead, Dover Locality, South Kent Clinical Commissioning Group (CCG), declared an interest in item 10 (Dover District Council (DDC) – Early Implementer – Health and Wellbeing Board)

Dr Roger Pinnock – Chair of Ashford CCG sought clarification that the fact GPs held an NHS PMS or GMS contract did not constitute a declarable interest. This was confirmed.

Jenny Whittle, Cabinet Member for Specialist Children's Services, KCC, declared an interest as her husband, who worked for KCC as a Policy Manager, had authored a number of the reports for the Health and Wellbeing Board.

Mark Worrall, Leader of Tonbridge and Malling Borough Council, declared in interest in view of him being a Non Executive Director of the Maidstone and Tunbridge Wells NHS Trust as well as the Chairman for Age Concern Malling.

Dr Garry Singh, Clinical Lead, Maidstone and Malling CCG, as his surgery provided services to prisoners in West Kent.

Peter Sass undertook to compile a register of Members' interests for retention centrally.

6. Needs of the Population driving change in Commissioning - Presentation of Case Studies
(Item 7)

Declan O'Neill, Director of Kent Public Health, gave a presentation of a number of case studies relating to the needs of the population driving change in commissioning.

It was noted that the Health and Wellbeing (HWB) Strategy would be informed by the Joint Strategic Needs Assessment (JSNA) and would provide direction and assist commissioners in making decisions. There was a detailed discussion about the

drafting, consultation and finalisation of the JSNA and a number of clear messages came through:

- Through the Shadow Health and Wellbeing Board, there was an opportunity to ensure that the JSNA was more inclusive and used more to influence policy decisions than previously and that public health colleagues needed to work more closely with primary care and social care.

- Opportunities also existed for better engagement with the CCGs in the development of the JSNA and that connections needed to be made with the wider determinants of health and wellbeing, e.g. housing conditions, regeneration and environment

- In relation to the overall spend on health, Paul Carter stated that the Board needed to better understand the reasons for commissioning decisions, where the money goes and the extent to which CCGs and GPs are involved in the future and how things could be done differently for collective gain.

- In view of the responsibility that the Health and Wellbeing Board would have in holding CCGs to account, the ideal way forward would be to seek to establish the Health and Wellbeing Strategy by April 2012, so that there would be a period of 12 months in shadow form.

- Mark Worrall suggested that the outline template for the JSNA should be shared as widely as possible, including organisations in the third sector, church charities, Age UK etc, to ensure that the JSNA was as robust and accurate as possible

The Group agreed a way forward as follows:

1. Meradin Peachey to report to the next meeting of the Shadow Health and Wellbeing Board on the process and progress of developing the JSNA, including the arrangements for engaging the CCGs.

2. The Shadow Board would be asked via the Evaluation forms whether they wanted a separate workshop for the JSNA and, in particular, how it contributed to the Health and Wellbeing Strategy.

7. Our Vision for the Role of Kent Health and Wellbeing Board
(Item 8)

The Board was asked to discuss its vision for the role of the Kent Health and Wellbeing Board. In particular, the Board was invited to consider a number of issues, as follows:

- What the H&WBB can do?

- How does the Board lead on population health and health economy?

- What decisions does the Board need to make on ensuring Health Improvement?

- How does the Board assist with the joining up of Health, Social Care and Public Health?
- How does the Board do things differently and allow others to do the same?
- How does the Board ensure that it addresses the health and wellbeing of children?
- What factors does the Board need to take into account in the development of its work programme?
- What strategic direction does the Board want to give?

Referring to the proposed timetable for the formal establishment of Health and Wellbeing Boards and Healthwatch on page 49 of the agenda, the consensus of the meeting was that there was a lot of work to do very quickly, particularly if the refreshed JSNA was to lead to the compilation of a successful Joint Health and Wellbeing Strategy.

Jenny Whittle requested implementation of integrated provision of occupational therapy waiting times for children and young people and that the lessons learned from integration needed to be reflected in the work of the Board.

Board Members commented on the need to manage the relationship with the acute providers in a different way; the acute providers were too influential and powerful and there were a number of examples where services would be better being led in the community and away from acute providers, e.g. dermatology. The Board agreed that a paper on relationships with providers should be brought to the next meeting, to include examination of the concept of Pathway Advisory Groups (PAGs) put forward by KCC in its submission to the NHS Futures Forum and other possible mechanisms by which providers could be engaged.

The Chairman also endorsed the comments made by Meradin Peachey that all Board Members should join one of the national learning sets and reminded colleagues to respond to the e-mail that had recently gone out.

8. Clinical Commissioning Group Authorisation Process - Presentation

(Item 9)

The Board received a presentation from Dr James Thallon, Medical Director, Kent and Medway PCT in relation to the Clinical Commissioning Group (CCG) authorisation process. The key points arising from the presentation and ensuing discussion were as follows:

- The NHS Commissioning Board would be the authorising body but the Board had not yet been established.
- There was no “right size” for CCGs; however it was felt that in order to be effective, they should be small enough to work closely with their stakeholders

yet large enough to avoid the problems associated with Primary Care Groups, i.e. capacity and affordability.

- The role of the County Council Chief Executive (Managing Director) needed to be clarified with the SHA

- The CCG toolkit was an iterative process and it was accepted that some of the guidance doesn't yet exist; therefore there were opportunities to shape the authorisation process and promote individuality

- CCG commissioning plans needed to relate to the JSNA

The Chairman stated that the Board should re-examine the authorisation process again early in the New Year, which was supported by the Board.

9. Dover District Council (DDC) early implementer Health and Wellbeing Board
(Item 10)

The Board noted that Dover District Council had been awarded early implementer status by the Department of Health, as it seeks to identify best practice for HWBs operating in two tier local government areas. The Board noted that the scale of activity already undertaken in Dover was distinctive and the report discussed how the Dover HWB might best be established to complement and support the relative roles that District and County level HWBs might play whilst in shadow form. The Board noted that the proposal for the creation of a Sub Committee for the Dover HWB was the most appropriate way forward in this instance as a testing ground for local, sub-County and the issues that this raised, although this would not necessarily be a precedent for the future.

Resolved: that

(1) Dover DC be invited to agree that its early implementer HWB should be a sub-committee of the county-wide HWB for the duration of the period that the County HWB is operating in shadow form (i.e. until April 2013); and

(2) the Director of Public Health (as the lead officer for health reform), be authorised to liaise with Dover DC and agree terms of reference, membership and a Memorandum of Understanding (MOU) over the practical operation of the Dover HWB, in consultation with the Director of Governance and Law (KCC).

10. Developing a Communication Strategy for the Health and Wellbeing Board
(Item 11)

The Chairman suggested that, in view of the time of the evening, Board Members should give their views on the proposed Communication Strategy for the HWB on the evaluation form or via e-mail to Meradin Peachey.

11. Future dates to April 2013 (Oral report)
(Item 12)

The Chairman stated that KCC officers would suggest a number of future meeting dates and times and circulate these to Board Members.

Joint Strategic Needs Assessment 2011

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Background

JSNA is an ongoing process through the range of data, information and analysis about the health and wellbeing of Kent is collated, assessed and compared in order to present an understanding of the all the issues impacting on the population of Kent. Through this process we can gain a high level understanding of the inequalities and needs that exist within.

The JSNA is not a strategy and does not in itself offer any answers to the issues it presents. It provides some key priorities and makes recommendations on how action to address these should be taken forward.

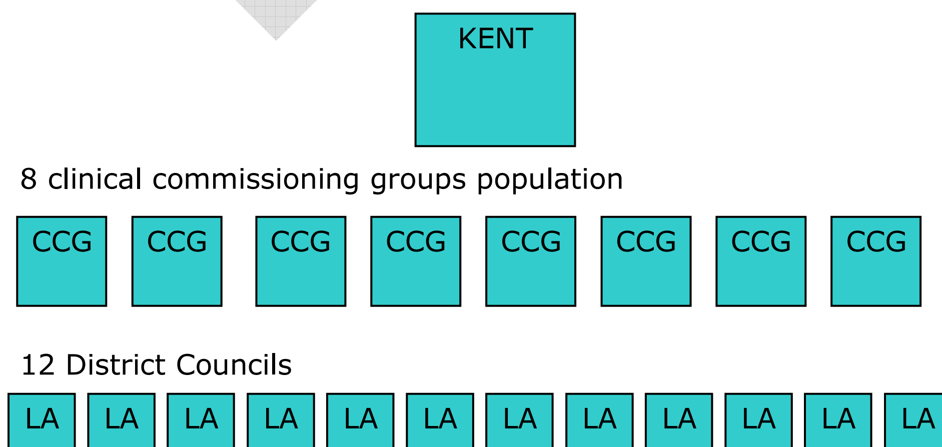
It has the following purpose

- To coordinate strategic direction, effort and resource commitment of the range of public, private and voluntary/community sector organisations that work to the common goals of improving health and well being for the population of Kent.
- To ensure that resources are focused on achieving maximum impact on improving the health and wellbeing of the people of Kent specifically targeting those who are in greatest need.
- To maintain a focus on health improvement and prevention and ensuring efficient use of available resources.
- To provide evidence of cost effectiveness and value for money

The Health and Wellbeing Strategy will provide the strategic direction for Kent.

Kent Approach
Kent is a two Tier County Authority, with 12 District Councils and 8 emerging Clinical Commissioning groups.

The JSNA needs to be relevant to a number of difference audiences to ensure a joined up approach to reducing health inequalities and address the Health and Social Care Needs of the population of Kent. Priorities and recommendations made at a Kent level should be relevant to both District Councils and Clinical Commissioning Groups.



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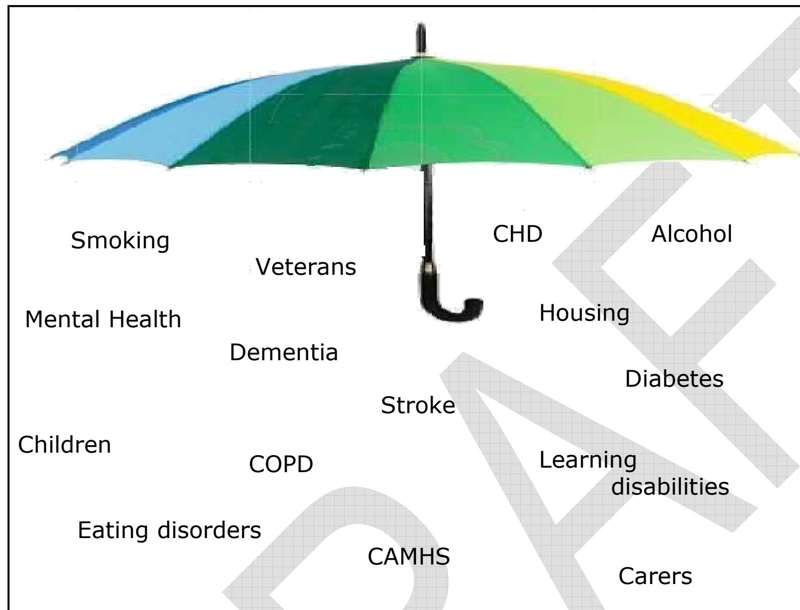
Phase 1
Kent has traditionally produced two JSNA documents, one for Adults and one for Children. The Adults JSNA was refreshed in July 2011 and the Children's update will be published in December 2011. These provide high level recommendations for improving the Health and Wellbeing of Kent. Executive summaries of a number of needs assessments were produced on a number of different topics. An executive summary contains the high level priorities for Kent, available at www.kmpho.nhs.uk/jsna.

Umbrella of Needs Assessments



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The JSNA refresh had a focus on **Quality Innovation Productivity and Prevention** (QIPP). The current economic situation requires NHS in Kent and Medway to deliver improved quality of care and productivity as per the Next Stage Review (NSR) Vision over the next five years. The total projected funding gap is £686m across K&M over the next five years (£270m in West Kent, £303m in East Kent) and with expected increases in both cost base and demand from our population.

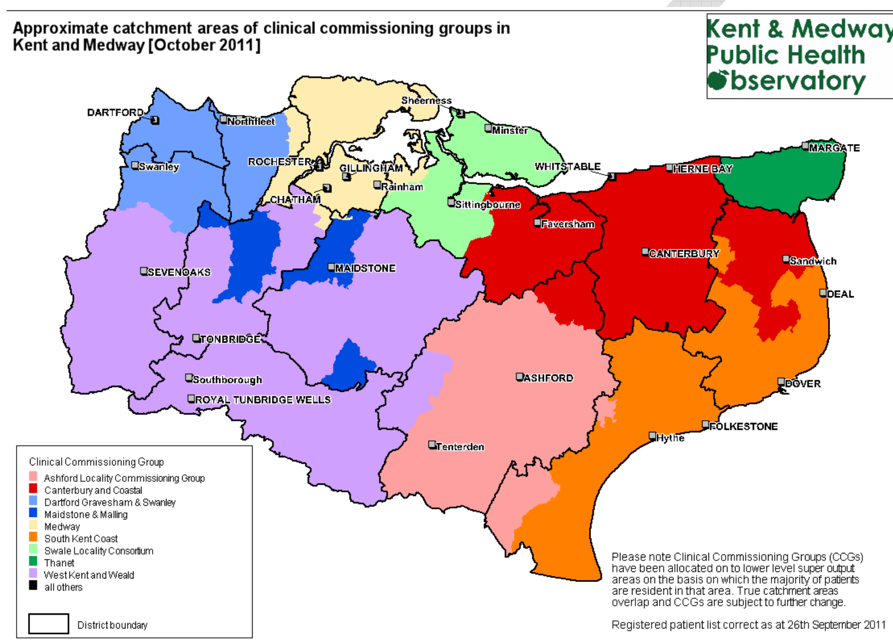
- Three areas of savings have been identified:
    - Service improvement initiatives. e.g. pathway optimisation, to drive efficiency through commissioning expenditure
    - Commissioning lever initiatives to drive up quality and productivity gains e.g. through utilising to full effect contract levers and system management opportunities, PbR tariffs and primary care contracting
    - Transformational change initiatives at the whole system level e.g. prevention, self care, care closer to home, to deliver more effective and efficient services

Phase 2
To develop a series of products that present the JSNA to a number of audiences at a level of granularity that is relevant to them. To ensure that we have the right products for our customers' consultation with Key stakeholders will need to take place, Appendix B is an example of a profile for Ashford.

Kent

As a County Kent generally has better health and social care outcomes than England. However the is significant variation across the districts. Thanet and Swale consistently have poor outcomes.

Kent expands from the coast to the boundary of London and shares its borders with Surrey and Sussex. There are 12 districts within Kent and 8 emerging Clinical Commissioning groups, whose boundaries, as the following map shows are not co-terminus with districts. Kent CC is responsible for approximately 1.5 million people.



Executive Summary

Important demographic issues

- The biggest population growth will be in the 65+ age group which is predicted to increase by 9.7% between 2012 and 2016 in Kent. There is significant variation across the districts ranging from a predicted population growth in the 65+ age group of 7.4% in Gravesham to 11.8% in Swale. However, there is the 0-4 age group is projected to grow very little in Kent ie. 0.1%. A predicted decrease in this group is predicted in Tunbridge Wells by 4.5% whereas growth in Dartford and Gravesham by 4.3% & 2.9% respectively.
- Parts of Kent are more ethnically diverse than others. The population of Kent was 94% white British in 2001 at the time of the last census. The Office of National Statistics estimates that in 2009 the population was 90.5% white British, with a relatively even growth across the other ethnic groups, including whites of non-British/non-Irish background. Local knowledge suggests that there has been an increase in populations from Eastern European countries such as Poland, data from the 2011 census will enable more discreet profiling of these communities. Gravesham district has the largest communities of BME groups approximately 13%, 7.1% from Asian communities.

- Latest QOF data indicates Swale, Shepway, Thanet and Dover districts having some of the highest prevalence for long term conditions.
- Kent County has better health outcomes when compared to England. However there is variation at district level with Dartford, Dover, Swale and Thanet consistently have higher all age all cause mortality rates than the other Kent Districts.
- The districts mentioned above experience some of the highest levels of deprivation and unemployment, within Kent. The greatest levels of unemployment are in the Thanet District with a rate of 5.6 compared to a rate of 3.7 for England.

Health Inequalities

- The Strategic Review of health Inequalities in England post 2010 (Marmot - Home page) starts with the wider determinants of health, stating that health is an interaction of what we are born with (our genetics), our lifestyle choices, the social and physical environments in which we live and health care services.
- Poverty exists all over Kent and Medway and is not confined to specific areas. Nevertheless there are major concentrations of deprivation in the boroughs of Dartford and Gravesham and throughout the coastal east of the county, interspersed with some localised areas of high affluence. The more consistently affluent parts of the county are to be found in Maidstone and the south west quarter of Kent.
- There has been an improvement in life expectancy for the intermediate quintiles of deprivation from 2000 – 2007. However for the most deprived, a pattern of divergence (a widening health gap) has continued throughout this period.
- Analysis indicates that circulatory diseases contributes more towards life expectancy gaps across all district authorities compared to other long term conditions and diseases.
- The overall mortality gap between the richest and poorest in Kent and Medway is increasing over time with quintiles two to five converging upon each other but the most deprived quintile becoming increasingly orphaned.
- The framework also proposes that these influences accumulate across our lives. Some influences are protective and others present risks. Where risk outweighs protective factors, chronic disease, disability and mortality begin manifesting from around age 50.
- Latest results published in 2011 indicate that for 5 out of 10 social determinant and health outcome indicators, Kent County performed significantly better than the England average such as, male and female life expectancy, child development at age 5, young people in education, employment or training and households in receipt of benefits. The remaining 5 indicators were not significantly different from the England average.

Lifestyles

Smoking

- In Kent, approximately 10,000 admissions each year are attributed to smoking £10 million and £12 million in West and East Kent respectively. A further £860,000 and £1.3 million are also attributed to annual outpatient costs.
- The national prevalence of smoking among adults dropped from 24% in 2005 to 21% in 2008. Smoking prevalence in Kent was higher than the national figure at 24.9% (or 281,300 in 2009), varying from 16% in Sevenoaks and 26.3% in Dartford. However this is expected to reduce in future in line with the downward trend nationally.

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- However, the above are based on national synthetic estimates, so there is a need for more local data either through surveys or through an augmentation of the Annual Health Survey for England.
- The Stop Smoking service currently treats 2.2% of the local smoking population. This needs to increase to 5% or 14,000 smokers.
- Further emphasis is required to concentrate on vulnerable / at risk groups such young people (especially 20-24 yrs old where prevalence is as high as 32%), pregnancy, mental health, prisoners, etc.

Physical Activity, Diet and Obesity

- The annual estimated cost of treating diseases related to obesity across Kent was £187.7 million in 2007 and £203.3 million in 2010. This will rise to £233.5 million in 2015 if unchecked.
- There is an obvious strong correlation of social factors such as deprivation with lack of physical activity and poor diets leading to overweight and obesity.
- Recent data suggests areas with higher levels of deprivation such as Swale, Thanet, Dover and Dartford appear to have less physical activity levels than those in more affluent areas. Overall, Kent appears to have slightly lower physical activity levels than the rest of England (10% vs 11%) *(hyperlink to behaviour chapter)*
- Similar trends are seen for obesity levels, where 25-30% of adult population in the same areas mentioned above, are obese compared to 20-25% in more affluent areas such as Tunbridge Wells. If those who are overweight are included, this makes up approximately 50% of the total adult population in Kent.
- The effects of obesity are considerable ranging from heart disease, diabetes, osteoarthritis and cancer, *hyperlink to relevant chapters*, where high levels of unmet need pose a considerable burden on health care services.
- A life course approach (as suggested by Marmot) incorporated within an integrated service model to healthy weight achievement and maintenance is imperative for success, spanning from antenatal programmes, breastfeeding, early years, healthy schools, to Change 4 Life, adult weight management and Tier 3 to 4 specialist services.
- In this regard, Kent is developing the service model offering four tiers of service which range from a population approach to maintaining and achieving a Health Weight to surgical procedures to achieve dramatic weight loss for those patients with higher BMI's.

Alcohol & Substance misuse

- It is estimated that excessive drinking accounts for 9.2% of disability-adjusted life years worldwide with only smoking and high blood pressure as higher risk factors. Alcohol related liver disease is now the 5th largest cause of death in the UK.
- The rates of all alcohol-related age standardised admissions is predicted rise further in Kent in line with national trends.
- There were 12,082 admissions to hospital through A&E for alcohol-related conditions in 2007-08 compared with 5,713 in 2002-03.
- The rates of drug misuse related admissions have fluctuated over the last 5 years roughly equating to 210 admissions per year in Kent.
- National guidance estimates that for every £6 spent on implementing identification and brief advice on alcohol harm reduction, could return savings to the NHS of £10 over four years.

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- Recent analysis suggests that despite the large increase in numbers in treatment, there are an estimated 1,786 treatment Problem Drug Users who have not been in contact with structured treatment in the past two years.
- Alcohol is also the most commonly used substance among dual diagnosis clients with a substance misuse problems. Half of substance misuse service users are estimated to have mental health needs; this would equate to 982 people in 2010-2011 in alcohol structured treatment (dependent drinkers alone).
- A recent survey on young people's attitudes and behaviours indicated that a small proportion of underage drinking, smoking and substance misuse still exists in Kent stressing the need for further action is still needed such as strict enforcement of banning the sale of tobacco products to under 18s.
- Good, responsive services on referral will encourage more clinicians in all settings to use Alcohol Identification and Brief Advice intervention, which in itself acts as a successful treatment for increasing risk and higher risk drinkers.
- Service redesign to a combined drug and alcohol treatment service should reflect the relative prevalence of need for drug and alcohol treatment. The need for alcohol services for dependent drinkers far outweighs the need for drug treatment services in Kent.

Dental Health

Adults

- Twenty percent of adults in South East Coast have active tooth decay and 25% of older adults have severe gum disease, with 7% reporting pain.
- There is geographical inequality in uptake of primary care dental services and commissioned activity per population. Across Kent and Medway the dental activity commissioned ranged from 1.2 Units of Dental Activity per West Kent resident to 1.9 UDA per Medway resident. In the 24 months previous to 31 Mar 2011, the number of patients treated in West Kent represented 45% of the West Kent adult population compared to nearly 70% for Medway.
- Current population projections indicate high service need in future particularly for the elderly.
- National surveys provide data at the SHA level but there is a lack of local data.
- A review of specialist dental services is required. For example, there are no sedation services in West Kent and domiciliary services need to expand their provision.
- A targeted approach to health promotion initiatives is required particularly in the elderly.

Children

- Surveys carried out in 2007/08 and 2008/09 some 23.5% of 5-year-olds and 23.6% of 12-year-olds in Kent and Medway were estimated to have experience of tooth decay. Of those with experience of tooth decay, an average 2.8 decayed, missing and filled deciduous teeth (dmft) was reported for 5-year-olds and an average 2.0 decayed, missing and filled permanent teeth (DMFT) for 12-year-olds (Figure 2). Although lower in prevalence and severity when compared to the regional (South East Coast SHA) and national average, geographical variations in the experience of tooth decay within Kent and Medway are clearly evident.
- Further information required such as survey of dental health of under 5 year old, as well as a coordinated approach involving primary care dental services to focus on prevention in line with *Delivering Better Oral Health – a toolkit for prevention* by Department of Health.

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Children

Breastfeeding

- Breast feeding is not being sustained into the early months of infancy for a large number of children. However there has been a welcome increase in rates of breast feeding in east Kent over the last three years, the position in west Kent being unchanged.
- Nine out of 10 women who stop before week six are reported as saying that they wished to have breast fed for longer. The fastest drop-off in breast feeding rates happens within the first four days of birth (12%). A third of women have stopped breast feeding by week six so that only 50% of babies get any breast milk at this stage. By six months only 26% of babies continue to be breast fed.
- Support to mothers breast feeding should be commissioned according to the stated evidence base and the number of mothers breast feeding needs to be substantially increased in all parts of Kent.

Immunisation and Vaccination

- The percentage of children being immunised in accordance with the national vaccination and immunisation schedule by the age of one, is broadly lower than the national and indeed SHA figure in East Kent.
- To improve the east Kent performance a National Support Team (NST) has reviewed local practice and made 29 detailed recommendations as part of a strategy to improve vaccination and immunisation, which inevitably focuses upon children and young people.
- By the second birthday, the overall percentage of children immunised in Kent is better than the England average and the SHA average with the exception of Men C.
- The MMR rate in Kent whilst recovering is not at the 95% level recorded by the WHO as being necessary to prevent an outbreak requiring further public campaigns to bolster the uptake rates.
- HPV vaccination uptake has recorded varying levels (for each of the three scheduled doses) across Kent and Medway in comparison regionally and nationally.

Parenting

- The relationship between infants and parents or primary caregivers is critical to the child's emotional, psychological and cognitive development. Developmental and behavioural problems – often continuing into later life – most commonly arise from disturbances in that relationship.
- Historical impact of Sure Start programmes have yielded mixed results in terms of developmental trajectories of young children. Recent results of Sure Start Local Programmes showed children displaying more positive social behaviour and greater independence and their parents less negative parenting and a better home environment.
- However there are concerns have arisen relating to the extent of local boards running these services, their provision of child care services and most importantly, the long term funding.
- Agencies in Kent should maintain their commitment of differential funding to first wave Sure Start Children's Centres on the basis that these have been set up as targeted resources in areas of the county identified as being in greatest need. This is a proper application of the principles of equity.

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Childhood obesity

- The National Child Measurement Programme indicates fluctuating levels of obesity in Year R but a steady increase in prevalence in Year 6 from 2007 – 2010, in Kent.
- In 2009/10 the percentage of children in year 6 who were classed as overweight or obese in Kent was 32.9%, ranging from 29.5% in Sevenoaks to 37.9% in Dartford.
- Obesity services and healthy eating interventions children should be commissioned based on national and international evidence such as treatment programmes to assist changes in child and family behaviour, social marketing techniques promoting healthy lifestyles, systematic collection of local data, etc.

Avoidable injury

- Road accidents involving children are more scattered than those involving adults with an obvious relationship to the roads near home.
- While the numbers of road casualties have decreased across all District Authorities over the last 15 years, Thanet and Maidstone still appear to have relatively higher number of casualties than the rest.
- Multi-agency initiatives in Kent to reduce accidents whether on the road or a home and in leisure facilities should continue. Transport planners, road safety experts as well as other local authority officials need to have greater ownership of this agenda.

Children in care

- Kent continues to have a higher proportion of looked after children who are aged 16 and over than the national figure but a smaller proportion of looked after children aged under 10 years old.
- There is an increased proportion of white looked after children from 2009 to 2010 with the proportion of Asian or Asian British looked after children falling, but this does not match the national picture which has stayed static since 2009.
- The 2010 OFSTED review highlighted the inadequate child safeguards and protection arrangements as well as lack of robust quality assurance and performance management systems, and has suggested a number of recommendations including a review of the current caseload, workforce capacity, and improving the quality and timeliness of assessment process.

Domestic Abuse

- In Kent there are very few services specifically for children affected by Domestic abuse. Services which raise awareness, change attitudes, allow an environment where people are comfortable making disclosures, and provide early interventions which prevent problems from escalating can all be described as Preventative. The majority of prevention services are universal and provided by statutory services, such as health and education.

Teenage Pregnancy

- National guidance estimates that for every £1 invested in contraception saves the NHS £11 plus additional welfare costs, which is a powerful economic argument for maintaining contraceptive services.
- In Kent the teenage pregnancy rate is 34.7 per 1000 females 15-17 years (2009) which compares favorably to an England rate of 38.
- Thanet has the highest level of teenage conceptions within Kent (53.6 per 1,000 females aged 13-17).

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- Rates have reduced by 18% from a baseline of 1998 similar to the national trend.
- However there is still significant variation in progress to rate reduction such as in Maidstone where there has been a 10% rise with a strong association to deprivation.
- There is a significant lack of information concerning particular at risk groups such as BME, young fathers, looked after children, young offenders where more detailed needs assessments should be carried out.
- Dartford, Maidstone and Sevenoaks are the districts with the highest rates of termination of pregnancy in this age group. However, there is only service provider operating from Maidstone for the whole county and so there is a need to offer termination services elsewhere.
- There is also disparity in the number of sites offering LARC (long acting reversible contraception) as mentioned in the recommendations for Sexual Health improvement.
- Apart from the above, the teenage Pregnancy Action plan also links in with other partners, services and strategies such as Children Centres, Relationship and Sex Education in schools, etc.

Adults

Long term conditions

- COPD - QOF recorded prevalence is approximately 2% with another 1% undiagnosed totalling to over 35,000 patients in Kent. Generally there are more undiagnosed cases in the west of Kent, taking into account the undiagnosed patients east Kent still has a higher prevalence, linked to deprivation, but mortality rates are slightly higher in East Kent, at around 27% and more than the England average.
- CVD – Prevalence is expected to increase by at least 0.6% over the next ten years to 2020, with East Kent having a consistent prevalence of 1% higher than West Kent. Swale, Thanet, Shepway and Dover appear to have relatively higher mortality rates compared to the other districts in Kent. This will have profound effects on access and demand for cardiac services for surgical treatment, revascularisation and rehabilitation.
- Diabetes – the age adjusted prevalence of Diabetes has increased slightly from 5.4% to 5.7% in Kent. Eight six percent of the diabetics are Type 2 while the rest are either Type 1 or other rare forms. Greater emphasis on obesity prevention is essential for prevention of Type 2 diabetes. Therefore greater service integration is required with the Kent Healthy Weight Care Pathway for Adults and Children right through to specialist diabetes services.
- Cancer – While there has been increase in incidence of some cancers such as breast, skin and prostate, lung cancer continues to have the lowest survival rates because of high proportion of late stage presentations, emphasising the important of increasing public awareness of signs and symptoms encouraging early presentation in primary care, as mentioned in the national Cancer reform strategy. Innovation in delivery of appropriate care is also of emerging importance with examples such provision of laparoscopic surgery, Enhanced Recovery after Surgery and systematic approach to chemotherapy pricing.

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Screening

- Current screening programmes in Kent are for the prevention of most prevalent cancers, abdominal aortic aneurysm, Chlamydia, diabetic retinopathy, neonatal and antenatal screening programmes and more recently, vascular health checks.
- Kent and Medway is achieving the national standard for cervical and breast cancer screening but there is still variation between the different regions.
- There has been more than a 50% uptake in Bowel Cancer screening in 2010 with plans to extend the screening age up to 75 years.
- Programme boards are being set up in Kent and Medway for Abdominal Aortic Aneurysm and Diabetic Retinopathy screening to monitor performance and analyse variation in uptake.
- All Trusts are now carrying out 1st trimester combined testing as part of the fetal anomaly screening programme.
- Two Acute Trusts – Darent Valley Hospital and Medway Foundation Trust were recently recommended to move to High Prevalence status for Sickle Cell Screening.
- Vascular health checks are to be provided to people between 40 and 74 years across Kent. With full roll out, approximately 19,000 checks are to be delivered across Kent on an annual basis.

Dementia

- The current prevalence (based on national estimates) is approximately 1.36% and 1.18% for Eastern & Coastal Kent and West Kent respectively equating to a combined prevalence of 1.28%, far higher than the General Practice recorded prevalence of 0.49%. This equates to approximately 17,400 people in 2006 rising to 30,100 in 2026.
- Shepway, Sevenoaks, Tunbridge Wells, Tonbridge and Swale are district authorities with greater growth of dementia patients.
- One third of patients live in care homes as well as high risk groups such as learning disabilities and ethnic minorities.
- The QIPP work plan has outlined a number of initiatives which allow better partnership working and service integration such as crisis resolution, domiciliary care, advocacy, awareness raising, specialist memory assessment, integrated case management, etc.

Falls and Fractures

- There has been a 53% increase in falls related hospital admissions in West Kent compared to 30% in East Kent over the last 5 years. Almost 65% of these admissions resulted in no fracture and / or injury. The cause of the fall is more often related to medical and social reasons such as UTIs, dementia, pneumonia.
- The 2010 national falls and bone health audit showed considerable variation in access and availability of minimum standards of care across the community and acute Trusts in Kent, particularly secondary falls prevention and bone health assessment including home hazard assessment. However it may be noted that ECKHT performs relatively better than MTW and DVH on some of the indicators including the above mentioned.
- Discussions have already under way in West Kent to implement, step by step, a five point integrated action plan consisting of hospital and primary care based fracture liaison services, integrated elderly care rapid access clinics including specialist assessment for falls and osteoporosis, community based therapeutic exercises and falls call out response services.

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Mental Health

- Mental health illness is broadly divided into common mental health illness and severe enduring mental health illness.
- Recent estimates suggest that mental health problems contribute a higher percentage of total disability adjusted life years in the UK than any other chronic illness (26.6%, compared to CVD 16.2%, cancer 15.6% and respiratory illnesses 8.3%).
- There is currently an incomplete picture of the level of mental health problems in Kent. Data currently available suggest that people in Kent have around the same degree of mental health problems as the England average, but there is significant local variation associated with deprivation, variations in local well-being resources and access to timely services.
- Overall, it is estimated that approximately 190,000 people in Kent and Medway are expected to suffer a Mental Health problem at any given time which an estimated 37,400 people will access services for treatment.
- A number of vulnerable groups such as the unemployed, homeless, children that are abused, minority ethnic groups have a higher risk of suffering mental health illness, particularly those with a dual diagnosis of drug/alcohol problems as well.
- A refresh of the previous needs assessment needs to be carried out to analyse performance of existing services.
- Ensure services are commissioned that are accessible to all, including those at highest risk, have an emphasis on promoting recovery, and consider an individual's physical health needs as well as their mental health needs.

Learning Disabilities

- People with learning disabilities (LD) have a wide range of social and health care needs depending on the severity of their condition.
- The latest estimated prevalence for LD in Kent by reference to QOF data is approximately 0.3%, with higher rates recorded in Dover, Thanet and Shepway.
- However, this appears to underestimate the prevalence estimates from the national epidemiological literature considerably, by up to 3% of the population. This implies a important training need particularly around specialist assessment, diagnosis and chronic disease management to improve recording of prevalence.
- As of January 2009 an estimated 29,000 primary and secondary school children in Kent have been identified with a disability requiring Special Educational Needs. The Aiming High for Disabled Children programme aims to improve services by local focus on improved access, parent / carer support, social networks and information.
- The majority of learning disability cases are due to genetic factors.
- Over the last few years, there has been a change in need and people with learning disabilities are choosing to live more independently, seeing a shift away from residential care, to more community based, flexible services to meet individual person centred plans.

Sexually Transmitted Infections

- The England average rate is approximately 775 diagnoses per 100,000 population whereas NHS Eastern and Coastal Kent and NHS West Kent are much lower at 573 and 519 per 100,000 respectively. Genital Warts, Chlamydia and non specific genital infections make up the majority proportion of STIs diagnosed.
- For Chlamydia, the female age group 16-19 yrs appears to be at the highest risk across Kent among the other age groups, in line with national trends.
- However late of HIV appears to be a problem particularly for West Kent with 55%,

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compared to approximately 20% in East Kent.

- Projections estimate a 23% and 28% increase in first attendances for GUM clinics for East and West Kent respectively.
- More work is still required to map, integrate and improve uptake of sexual health services like Chlamydia testing and long acting reversible contraception.

Offender Health

- There is a high rate of non-attendance at appointments offered within healthcare at some prisons in Kent such as refusal of psychological interventions associated with the Integrated Drug Treatment System (IDTS) and low uptake of Hepatitis B vaccination, coupled with high rates of smoking. and hazardous drinking.
- Development of clear pathways and referral processes that enable offenders currently in as well as leaving custody to access community drug and alcohol services and other health care services including health checks.

Excess Winter Deaths

- There is considerable variation between the different districts in Kent, with Canterbury has the highest excess winter death ratio (ie. Winter vs summer), followed by Maidstone and Dover having the lowest ratio. Most of the local authority districts have ratios that are relatively close to the Kent average.
- There is a service gap in terms of the link between primary care and those able to offer support to the people most vulnerable from poor health outcomes due to cold temperatures.
- A number of pilots have been suggested or implemented such as GP practice winter warmth referral, which, if successful, should be rolled out to other areas.

Other important QIPP work streams

Urgent care - National evidence shows almost a 12% rise in unscheduled care activity from 2004 to 2009 attributed to a number of factors such as population age distribution changes (towards more elderly), central policy initiatives like 4 hour A&E waiting targets and advances in clinical practice leading lower threshold for decision to admit. In Kent, due to a variation in quality and practice of submission of non elective data across different local provider trust organisations, non elective activity cannot be accurately described. However, there is clear evidence indicating conversion rates from attendance to admissions are increasing steadily with age. Non-elective admission rates for ACS conditions such as COPD are also consistently higher in East Kent than West Kent.

End of Life Care – Both NHS West Kent and Eastern and Coastal Kent have signed up to the national Dying Matters Coalition, which seeks to raise awareness of death, dying and bereavement, and to encourage early discussion and planning. Development work must be underpinned by analysis and evidence of local need, both now and in the future. Currently there are no precise indicators or measures that can accurately measure the end of life care need and activity. Some proxy measures that have been used such as proportion of patients dying at home which is approximately around 35 to 40%, implying the need for further research and development around this.

Maternity and Babies - The population of women of a childbearing age is projected to increase in the Dartford and Gravesham Local Authority areas (~9% over ten years), and to a lesser extent in the Ashford, Canterbury and Sevenoaks areas (~1-2%), although overall the population of women of a childbearing age in Kent is

projected to decrease slightly. East Kent has consistently higher infant mortality rate compared to West Kent but not significantly different from the England average. Focus on new tests such as fetal fibronectin to predict preterm labour and development of robust indicators to monitor variation in caesarean section activity across provider organisation has been recommended.

Planned Care – First appointment follow up ratios for outpatient activity are consistently higher in cancer specialties like oncology and haematology. Total elective care activity in consistently higher for East Kent compared to West Kent till 2009/10. For example, skin lesion procedures have increased by 82% in East Kent over the last five years compared to just 6% in West Kent. It is unclear to what extent this difference in activity reflects unmet need, variation in clinical practice or other factors. A number of demand management initiatives have already been suggested such as Enhanced Quality Programme for hip and knee replacements, review of high risk low gain procedures, cataract pathway redesign, teledermatology triage for skin conditions, etc.

Social factors

Housing and homelessness

- The estimated shortfall in affordable housing far exceeds what will be delivered through new supply. Collectively, the housing need assessments that have been undertaken across the County would suggest that there is an annual need for almost 12,000 additional affordable homes.
- Shortfall in housing varied in Kent partly due to percentage and absolute growth in population in each of different areas.

Carers

- Current estimations show that one in ten people in the UK is a carer; the percentage in Kent is even higher, on average 12.58 per cent, rising to 14 per cent in Thanet. Based on the 2008 Mid Year Population Estimates, which is the latest government dataset, there is now an estimated 139,500 carers in Kent.
- A number of wider determinants and factors influence the background of the carers as well as intensity of care, in a community such as area deprivation, age, whether from ethnic minorities, as well as the physical or mental health problems of the persons receiving care, particularly dementia.
- The 2001 census indicates higher proportion of older age carers, starting from children aged 10 years and peaking between 50 to 60 years of age for both males and females.
- A recent survey describes a correlation between age of carers, hours spent on caring and decline in carer health.
- Due to the lack of more recent data, there is a need to update the full extent of carers in Kent particularly unknown carers who have yet to self declare their role, possibly through the use of MOSAIC analysis.

Community Pharmacies

- All PCTs in England are required to publish a Pharmaceutical Needs Assessment. These will be used to determine future applications to provide access to new pharmaceutical and dispensing services will be approved.
- In West Kent dispensing services are provided by 113 pharmacies and 32 dispensing practices of which six were '100 hours' pharmacies situated relatively evenly across the six localities. Consultation showed that this level of access to

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extended hours is the minimum needed; any reduction in the opening hours of those pharmacies would create a gap in service provision.

- In East Kent, consultation indicated access to pharmaceutical services beyond the normal pharmacy contractual hours of 40 hours per week. Thus '100 hour' pharmacies are not allowed and those pharmacies with 100 hour contracts are to reduced to a 40 hour contract. Consultation shows the need for 100 hour contract provision on the Isle of Sheppey and in the town of Dover. East Kent consultation showed that there was a need for better understanding of the access to enhanced services such as emergency contraception provided by pharmacies and other contractors.
- Training of pharmacists and their staff in preventive health is required in order to work towards the development of pharmacies delivering 'Healthy Living Centre' functions in conjunction with other providers.

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Ashford Locality Group (Ashford District)

Demographics
Ashford locality commissioning group is made up of 16 practices. 15 of the practices are located within the district boundary of Ashford and 1 is located within the district boundary of Swale.

Population
Understanding the population age structure is important for further and currently planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 122,599[1] people are registered to practices within ALG this is 8% of the total registered practice population for Kent.
- The population age and sex structure is similar to that for the total Kent and Medway registered population.
- There are slightly more people registered between the ages 40 and 49 and slightly fewer aged between 20 and 39.
- Using data for Ashford District, the population is projected to increase by 6% over the next 5 years[2] and 13% over the next 10 years. The greatest population growth is in the 65+ (18%) and 85+ (17%) age groups.
- Kent as a county has a predominately white population estimated at 92% in 2009. The proportion of the population from Ashford from a BME community is estimated to be 6%.
- Life expectancy for ALG is 82 years compared to 80.9 for Kent and Medway. The difference in life expectancy for wards is 13.1 years the lowest life expectancy is within St Michaels ward.

As the population ages more people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes. Dementia is predicted to be a significant issue.

Deprivation
Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates most deprived.

- Ashford is ranked 198 out of 326 local authorities, and 8 of the 12 Kent districts.
- 5.7% of Ashford lower level super out put areas are in the 20% most deprived for England.
- The highest levels of deprivation are found within Stanhope, Aylesford Green and Victoria, in an around Ashford town centre.

[1] PCIS registered practices populations September 2011
[2] ONS 2008-Based population projections 2011-2016, 2011-2021

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Housing, Education and Employment
Health and social care outcomes are very much influenced by the environment in which the population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been seen to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The rate of unemployment within Ashford district is 2.6% [September 2011] lower than Kent (3.2%) and well below the level for the UK (3.9%).
- Unemployment in Ashford has increased by 10% since the September period 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed 30.5%. The rate for Kent 31.5%.
- 53.1% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 3.96% of households within Ashford are classified as statutory homeless; this is significantly higher than England (1.86%)

Risk Factors
Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults
- Prevalence of obese adults in Ashford (27%) is significantly higher than England (24.2%)
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males. There was a slight reduction in admissions to hospital for females between 2009/10 and 2010/11.

Children
- There are significantly fewer physically active children in Ashford (52.3%) compared to England (55.1%)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)

Health Issues
Prevalence
- The 2010/11 disease registers show that the population of ALG have a higher prevalence for

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- hypertension, depression, obesity and Atrial Fibrillation, than England. Assessing variation at a practice level will enable the CCG to target resources.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care.

- ALG has higher emergency admissions rates for Diabetes and Stroke, than Kent and Medway
- COPD emergency admission rates are lower than Kent and Medway, however the trend shows that admissions are increasing.
- Emergency admission rates for Dementia are the lowest of all the CCGs. The trend shows an increase in Dementia emergency admissions but at a slower rate than Kent and Medway.

Mortality

- 77% of all deaths are from three main diseases: Circulatory disease (34.1% of all deaths), Cancer (29.4% of all deaths) and respiratory disease (13.5% of all deaths).
    - Mortality rate from Circulatory disease (Coronary Heart disease and Stroke) have been steadily declining since 1995, and the rate of premature mortality is lower than that of England. The same can be said for Cancer.

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Canterbury and Coastal (Canterbury District)

Demographics
Canterbury and Coastal CCG consists of 23 practices, the majority of which (20) are located within the district boundary of Canterbury and the remaining three are located within Dover district.

Population
Understanding the population age structure is important for further and currently planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 211,651 people are registered with practices within C&C this is 14% of the total registered practice population for Kent.
- The population age and sex structure differs from that for Kent and Medway. Canterbury is a university town and have a larger number of people aged between 15 and 29.
- Using data for Canterbury District, the population is projected to increase by 4% over the next 5 years[3] and 8% over the next 10 years. The greatest population growth is in the 65+ (14%) and 85+ (11%) age groups.

More people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes. Prevalence of conditions

This population group are less likely to require social care services. Health promotion and lifestyle issues are key for these group as they are likely to smoke, go out drinking and experiment with drugs. Sexual health services may also be a priority for this group.

Deprivation
Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates most deprived.

- Canterbury is ranked 166 out of 326 local authorities, and is ranked 6 of the 12 Kent districts.
- 8.9% of Canterbury's lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Gorrell, Heron and Wincheap.

Housing, Education and Employment
Health and social care outcomes are very much influenced by the environment in which population live and the opportunities available to them.

[3] ONS 2008-Based population projections 2011-2016, 2011-2021

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Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Canterbury district is 2.3%, lower than Kent (3.2%) and considerably lower than the level for the UK (3.9%)
- Unemployment in Canterbury has increased by 12.3% since the same period 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed 33.4%. The rate for Kent 31.5%.
- 53.7% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 0.77% of households within Ashford are classified as statutory homeless; this is significantly lower than England (1.86%)

Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of smoking, obesity, physical activity and healthy eating are all similar to the rates for England.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males.

Children

- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)

Health Issues

Prevalence

- The 2010/11 disease registers show that the population of Canterbury and Coastal populations have a similar prevalence of diseases to that for England. With slightly greater proportion on the stroke register.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care.

- Canterbury and Costal have higher emergency admission rates for Dementia, CHD and COPD. The trend for each of this conditions is increasing.
- Cancer emergency admissions rates are lower than Kent and Medway and continue to decline.

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- Significantly higher hospital admission rate due to self harm than England.

Mortality

- 77.2% of all deaths are from three main diseases: Circulatory disease (37.2% of all deaths), Cancer (27.1% of all deaths) and respiratory disease (12.9% of all deaths).
    - Mortality rate from Circulatory disease (Coronary Heart disease and Stroke) have been steadily declining since 1995, and the rate of premature mortality is lower than that of England. The same can be said for Cancer

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Dartford, Gravesham and Swanley (Dartford and Gravesham Districts)

Demographics
There are 39 practices within the Dartford, Gravesham and Swanley CCG. These are located within the three districts of Dartford (16), Gravesham (16) and Sevenoaks (7).

Population
Understanding the population age structure is important for further and currently planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 249,935 people are registered with a practice in DGS CCGs. This is 17% of the total registered practice population for Kent.
- DGS is the second largest of the CCG, West Kent and Weald is bigger with 53 practices and 25% of the total registered Kent population.
- Combining population project for Dartford and Gravesham, the population is projected to increase by 5% over the next 5 years and 11% over the next 10 years. The biggest population growth is In the 65+ (13%) and the 85+ (26%) age groups.
- Dartford and Gravesham account for just over 23% of the Kent County's BME population.

Deprivation
Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Dartford is ranked 175 and Gravesham is ranked 142 out of 326 local authorities. Dartford is ranked 7 and Gravesham 5 of the 12 Kent districts.
- 5.2% of Dartford's and 12.7% of Gravesham's lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within, Littlebrook Joyce Green and Princes (Dartford), Singlewell, Northfleet North and Central (Gravesham).

Housing, Education and Employment
Health and social care outcomes are very much influenced by the environment in which population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

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Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Dartford is 3.2% and Gravesham 4.2%. The rate for Kent is 3.2%.
- Unemployment in Dartford has increased by 8.1% and for Gravesham 20.2% since September 2010. The increase for Kent 13.6%.
- 18-24s make up the biggest proportion of unemployed (Dartford 31.9%, Gravesham 32.1%). The rate for Kent 31.5%.
- 63.1% of children in Dartford (Significantly better) and 54.2% of Children in Gravesham achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 2.63% of households within Dartford (Significantly worse) and 1.83% of households in Gravesham are classified as statutory homeless; this is significantly lower than England (1.86%)

Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Dartford (28.2%) and Gravesham (28.5%) is significantly higher than England (24.2%)
- There are significantly fewer physically active adults in Dartford (8.6%) compared to England (11.5%).
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males.

Children

- There are significantly fewer physically active children in Gravesham (47.1%) compared to England (55.1%)
- In Dartford (22.7%) the proportion of Year 6 children who are obese is significantly greater than that for England (18.7%)

Health Issues

Prevalence

- The 2010/11 registers show that the population of DGS have a higher prevalence of hypertension, hyperthyroidism, Chronic Kidney disease and obesity, than England. T
- he population of DGS in more ethnically diverse that the rest of Kent with a larger Asian population which may go part way to explain the increased prevalence's.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- DGS has a higher emergency admission rate than Kent and Medway for Diabetes, dementia and CHD.

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- The trend for CHD shows a decline in emergency admissions. Emergency admissions for the other conditions mentioned are increasing.

Mortality

73.4% of all deaths are from three main diseases: Circulatory disease (31.3% of all deaths), Cancer (28.9% of all deaths) and respiratory disease (13.1% of all deaths, within Dartford and Gravesham districts.

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Maidstone and Malling (Maidstone Districts)

Demographics
There are 11 practices within the Maidstone and Malling CCG. All but one of these practices are located within the district boundary of Maidstone, one practice is within the district boundary of Tonbridge and Malling.

Population
Understanding the population age structure is important for further and currently planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 99,067 people are registered with practice in M&M CCGs. This is 7% of the total registered practice population for Kent.
- M&M is one of the smallest CCGs, and has the most dispersed population, with 3 distinct communities.
- The percentage of the population within the age groups 25 to 49 is greater than that for Kent and Medway. There is a greater proportion within the 0 to 4 age group.
- Using data for Maidstone District, the population is projected to increase by 4% over the next 5 years[4] and 9% over the next 10 years. The greatest population growth is in the 65+ (18%) and 85+ (19%) age groups.
- 6.7% of the Maidstone population are from a BME group this compares to 7.6% for Kent County.
- Life expectancy from birth for Maidstone and Malling is 81 years this compares to 80.9 for Kent and Medway. There is 7.9 years difference between the ward with the lowest life expectancy [Bridge, 76.1 years] and the ward with the highest life expectancy [Downswood and Otham 84.2 years]

Deprivation
Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Maidstone is ranked 217 out of 326 local authorities and is the 9 most deprived district in Kent.
- 6.5% of Maidstone's lower layer supper output areas are in the 20% most deprived for England,

Housing, Education and Employment
Health and social care outcomes are very much influenced by the environment in which population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of

[4] ONS 2008-Based population projections 2011-2016, 2011-2021

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people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Maidstone is 2.5%, lower than the rate for Kent 3.9%.
- Unemployment in Maidstone has increased by 13% since September 2010. The increase for Kent is 13.6%.
- 18-24s make up the biggest proportion of unemployed (31.1%). The rate for Kent 31.5%.
- 65.1% of children achieve 5 A*-C grade GCSEs (including Maths and English) significantly higher than the rate for England 55.3%.
- 0.12% of households within Ashford are classified as statutory homeless; this is significantly lower than England (1.86%)

Risk Factors
Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Maidstone (26.3%) is significantly higher than England (24.2%)
- The number of admissions to hospital due to alcohol specific conditions reduced between 2009/10 and 2010/11.

Children

- There are significantly fewer physically active children in Ashford (46.2%) compared to England (55.1%)

Health Issues
Prevalence

- The 2010/11 registers show that the population of Maidstone and Malling have a higher prevalence of hyperthyroidism, than England.

Morbidity
Emergency admissions can be an indicator of how well patients are being managed within primary care

- Maidstone and Malling population have a higher emergency admission rate than Kent and Medway for COPD, Dementia, Cancer and CHD.
- The trends for COPD and Dementia shows emergency admissions for these conditions increasing.

Mortality

- 75.7% of all deaths are from three main diseases: Circulatory disease (33.3% of all deaths), Cancer (27.8% of all deaths) and respiratory disease (14.5% of all deaths).

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Swale Locality Consortium (Swale District)

Demographics
There are 21 practices within the Swale locality consortium CCG. All of these practices are located with in the district boundary of Swale.

Population
Understanding the population age structure is important for further and currently planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 106,215 people are registered with a practice in Swale locality consortium. This is 7% of the total registered practice population for Kent.
- Swale locality group is one of the smallest CCGs.
- The population of Swale locality group is similar to that for Kent as a whole. The largest proportion of the population in the 40-49 age group.
- Using data for Swale District, the population is projected to increase by 4% over the next 5 years[5] and 9% over the next 10 years.
- The greatest population growth is in the 65+ (20%) and 85+ (32%) age groups
- 5.5% of the Swale population is from a BME group
- Life expectancy from birth is the lowest of all CCGs at 79.3 years. The life expectancy for Kent and Medway is 80.9 years.

More people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes. Prevalence of conditions

Deprivation
Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Swale is ranked 99 out of 326 local authorities and is the 3 most deprived district in Kent.
- 20.7% of Swales lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Sheerness East, Murston and Leysdown and Warden.

Housing, Education and Employment
Health and social care outcomes are very much influenced by the environment in which population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of

[5] ONS 2008-Based population projections 2011-2016, 2011-2021

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people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The rate of unemployment within Swale is 3.9%, higher than the rate for Kent 3.2% and equivalent to the rate for Great Britain (3.9%)
- Unemployment in Swale has increased by 13.4% since September 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed (36.3%). The rate for Kent 31.5%.
- 53.7% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 1.11% of households within Ashford are classified as statutory homeless; this is significantly lower than England (1.86%)

Risk Factors
Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Swale (30.2%) is significantly higher than England (24.2%)
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males. There was a slight reduction in admissions to hospital for females between 2009/10 and 2010/11.

Children

- There are significantly fewer physically active children in Swale (38.9%) compared to England (55.1%)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)
- Teenage conception rate for Swale (46.7) is significantly higher than England (40.2)

Health Issues
Prevalence

- The 2010/11 registers show that the population of Swale locality consortium have a higher prevalence of hypertension, Diabetes, COPD, and obesity, than England.

Morbidity
Emergency admissions can be an indicator of how well patients are being managed within primary care

- Swale locality consortium have a higher emergency admission rate than Kent and Medway for all long term conditions (COPD, Stroke, CHD, Dementia, Diabetes and Cancer).

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- For all conditions except Stroke the trend shows and increase in the rate of emergency admissions.

Mortality

- Around 75.5% of all deaths are from three main diseases: Circulatory disease (31.9% of all deaths), Cancer (28.4% of all deaths) and respiratory disease (15.2% of all deaths).

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South Kent Coast (Dover and Shepway District)

Demographics
There are 33 practices within South Kent Coast, 15 of these practices are located within Dover district and 18 within Shepway district.

Population

- 199,876 people are registered with a practice in South Kent Coast CCGs. This is 13% of the total registered practice population for Kent.
- The population is older than that for Kent, with fewer people under the age of 40. The largest proportion of the population is aged between 40 and 69.
- Combining the data for Dover and Shepway Districts, the population is projected to increase by 3% over the next 5 years[6] and 7% over the next 10 years.
- The greatest population growth is in the 65+ (16%) and 85+ (12%) age groups. The age group of 0 to 4 is not projected to grow.

More people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes. Prevalence of conditions

Deprivation
Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Dover is ranked 127 and Shepway is 97 ranked out of 326 local authorities and is the 3 most deprived district in Kent.
- 16.4% of Dover and 16.9% of Shepway's lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within St.Radigunds, Buckland and Tower Hamlets (Dover), Folkestone Harvey Central, Folkestone Harbour and Folkestone East (Shepway)

Housing, Education and Employment
Health and social care outcomes are very much influenced by the environment in which population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Dover is 3.7% and Shepway 4.2%. The rate for Kent is 3.2%.

[6] ONS 2008-Based population projections 2011-2016, 2011-2021

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- Unemployment in Dover has increased by 25.2%, the greatest increase of the 12 Kent districts, the contrasts with an 11.5% increase in Shepway since September 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed (Dover 32.1%, Shepway 28.3%). The rate for Kent 31.5%.
- 50.3% of children in Dover and 52.3% of children in Shepway achieve 5 A*-C grade GCSEs (including Maths and English) significantly lower than the rate for England 55.3%.
- 1.35% of households within Dover (significantly lower) and 1.82% of Households in Shepway are classified as statutory homeless; both are lower than England (1.86%)

Risk Factors
Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults
- Prevalence of obese adults in Dover (26.8%) is significantly higher than England (24.2%)
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year.

Children
- There are significantly fewer physically active children in Shepway (48.3%) compared to England (55.1%)
- Teenage conception rate for Shepway (46.6) is significantly higher than the rate for England (40.2).
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)

Health Issues
Prevalence
- The 2010/11 registers show that the population of SKC have a higher prevalence of CHD, stroke, Hypertension, Diabetes, Epilepsy, Hypothyroidism, Cancer, Artrial Fibrillation and learning disabilities when compared to England.

Morbidity
Emergency admissions can be an indicator of how well patients are being managed within primary care
- South Kent Coast have a higher emergency admission rate than Kent and Medway for all long term conditions (COPD, Stroke, CHD, Dementia and Diabetes), except Cancer..
- For all conditions except Cancer the trend shows an increase in the rate of emergency admissions.

Mortality

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76.3% of all deaths are from three main diseases: Circulatory disease (34.2% of all deaths), Cancer (27% of all deaths) and respiratory disease (15% of all deaths).

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Thanet (Thanet District)

Demographics
There are 23 practices within Thanet CCG all of these practices are located within the district of Thanet.

Population
Understanding the population age structure is important for further and currently planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 140,563 people are registered with a practice in Thanet CCG. This is 9.4% of the total registered practice population for Kent.
- There are two main peaks in the population of Thanet.
- Using data for Thanet District, the population is projected to increase by 3% over the next 5 years[7] and 7.6% over the next 10 years.
- The greatest population growth is in the 65+ (13%) and 85+ (9%) age groups
- 7% of the Thanet population are from a BME group, this compares to 7.6% for Kent County.
- Life expectancy from birth is 79.6 years this is the second lowest of all the CCGs. There is 12.1 years between the ward with the lowest life expectancy [Cliftonville West 72.3 years] and the ward with the greatest life expectancy. [Kingsgate 84.4 years]

Deprivation
Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Thanet is ranked 49 out of 326 local authorities and is the 1 most deprived district in Kent.
- 29.8% of Thanet's lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Margate Central, Clifftonville West and East Cliffe.

Housing, Education and Employment
Health and social care outcomes are very much influenced by the environment in which population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

[7] ONS 2008-Based population projections 2011-2016, 2011-2021

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Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The rate of unemployment with Thanet (5.8%) is the greatest of all the 12 districts in Kent
- Unemployment in Thanet has increased by 16.8% since September 2010. The increase for Kent is 13.6%
- 18-24s make up the biggest proportion of unemployed (32.5%). The rate for Kent 31.5%.
- 49.7% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 1.11% of households within Thanet are classified as statutory homeless; this is lower than England (1.86%)

Risk Factors
Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults
- Prevalence of obese adults, physical activity, and smoking are significantly higher for Thanet compared to England.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year.

Children
- There are significantly fewer physically active children in Thanet (51%) compared to England (55.1%)
- Teenage conception rate for Thanet (51) is significantly higher than that for England (40.2)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)

Health Issues
Prevalence
- The 2010/11 registers show that the population of Thanet have a higher prevalence for most conditions recorded on primary care disease registers, with the exception of Asthma, Heart failure and Depression.

Morbidity
Emergency admissions can be an indicator of how well patients are being managed within primary care
- Thanet CCG have a higher emergency admission rate than Kent and Medway for Diabetes, COPD, CHD and Stroke.
- The emergency admission rate for Dementia is lower the trend shows an increase.
- The trend for Cancer emergency admissions shows a decline in the rate.

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Mortality

- Around 75.3% of all deaths are from three main diseases: Circulatory disease (33.6% of all deaths), Cancer (26.5% of all deaths) and respiratory disease (15.1% of all deaths)

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West Kent and Weald (Maidstone, Sevenoaks, Tonbridge and Malling and Tunbridge Wells Districts)

Demographics
There are 53 practices within the West Kent and Weald CCG. These are located within the three districts of Dartford (16), Gravesham (16) and Sevenoaks (7).

Population
Understanding the population age structure is important for further and currently planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- WKW is the largest off the 8 Kent CCGs, with a registered practice population of 366,974, which is 25% of the total registered population for Kent.
- The proportion of the population aged between is 20 to 35, there is a peak in the 0 to 20 years olds, which may have implications for deliver of services to the young population.
- Combining data for the 4 districts the population of WKW is projected to increase by 4% over the next 5 years and by 9% over the next 10 years
- The greatest population growth is in the 65+ (18%) and 85+ (19%) age groups
- 6.8% of the population are from a BME group, compared to 7.6% for Kent County
- Life expectancy is 82.3 years compared to 80.9 for Kent and Medway, the population of WKW is highest of all the CCGs. The difference is life expectancy between wards within the four districts is 16.9 years. Both the highest life expectancy and the lowest life expectancy are for wards within Tonbridge and Malling District. [Kings Hill 92 years, Bumham, Eccles and Wouldham 75,1 years]

Deprivation
Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- The CCG of West Kent and Weald span 4 districts. These 4 districts have the lowest levels of deprivation for Kent ranked between 9 and 12. Sevenoaks has the lowest levels of deprivation across Kent and and with Tonbridge and Malling fall within the 20% least deprived districts in England.
- Two districts (Tonbridge & Malling and Tunbridge Wells) have no lower layer supper output areas are in the 20% most deprived for England, 1.4% of Sevenoaks and 6.5% of Maidstone lower layer super output areas are in the 20% most deprived for England.

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Housing, Education and Employment
Health and social care outcomes are very much influenced by the environment in which population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment for each of the 4 districts, Maidstone (2.5%), Sevenoaks (1.8%), Tonbridge and Malling (2.0%) and Tunbridge Wells (1.8%), have lower levels of unemployment of Kent (3.2%)
- Unemployment has increased by 13% (Maidstone), 7.3% (Sevenoaks), 11% (Tonbridge and Malling) and 2.4% (Tunbridge Wells) since September 2010. The increase for Kent 13.6%.
- 18-24s make up the biggest proportion of unemployed (Maidstone 31.1%, Sevenoaks 27.8%, Tonbridge and Malling 30.2% and Tunbridge Wells 23.7%). The rate for Kent 31.5%.
- For three of the districts children achieving 5 A*-C grade GCSEs (including Maths and English) ranging from 61.2% to 71% have rates that a significantly higher when compared to 55.3% for England. Sevenoaks however at 38.7% is significantly worse than the rate for England
- All four districts have significantly lower rate of households classified as statutory homeless ranging from 0.12% to 1.06%/ The rate for England is 1.86%

Risk Factors
Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults
- Prevalence of obese adults in Maidstone (26.3%) is significantly higher than England (24.2%) the prevalence of adult obesity in the other districts is generally not significantly different or is significantly lower.
- The number of admissions to hospital due to alcohol specific conditions declined between 2009/10 and 2010/1

Children
- There are significantly fewer physically active children in Maidstone (46.2%) compared to England (55.1%)

Health Issues
Prevalence

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- The 2010/11 registers show that the population of WKW have a higher prevalence of Stroke, hyperthyroidism, and Cancer than England.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- WKW has an emergency admission rate higher than Kent and Medway for Cancer, and the trend continues to decline.
- Emergency admission rates are increasing for Dementia, COPD and CHD.
- Stroke and Diabetes emergency admission rates are reducing.

Mortality

- Around 76.5% of all deaths are from three main diseases: Circulatory disease (34.3% of all deaths), Cancer (28.6% of all deaths) and respiratory disease (13.6% of all deaths).

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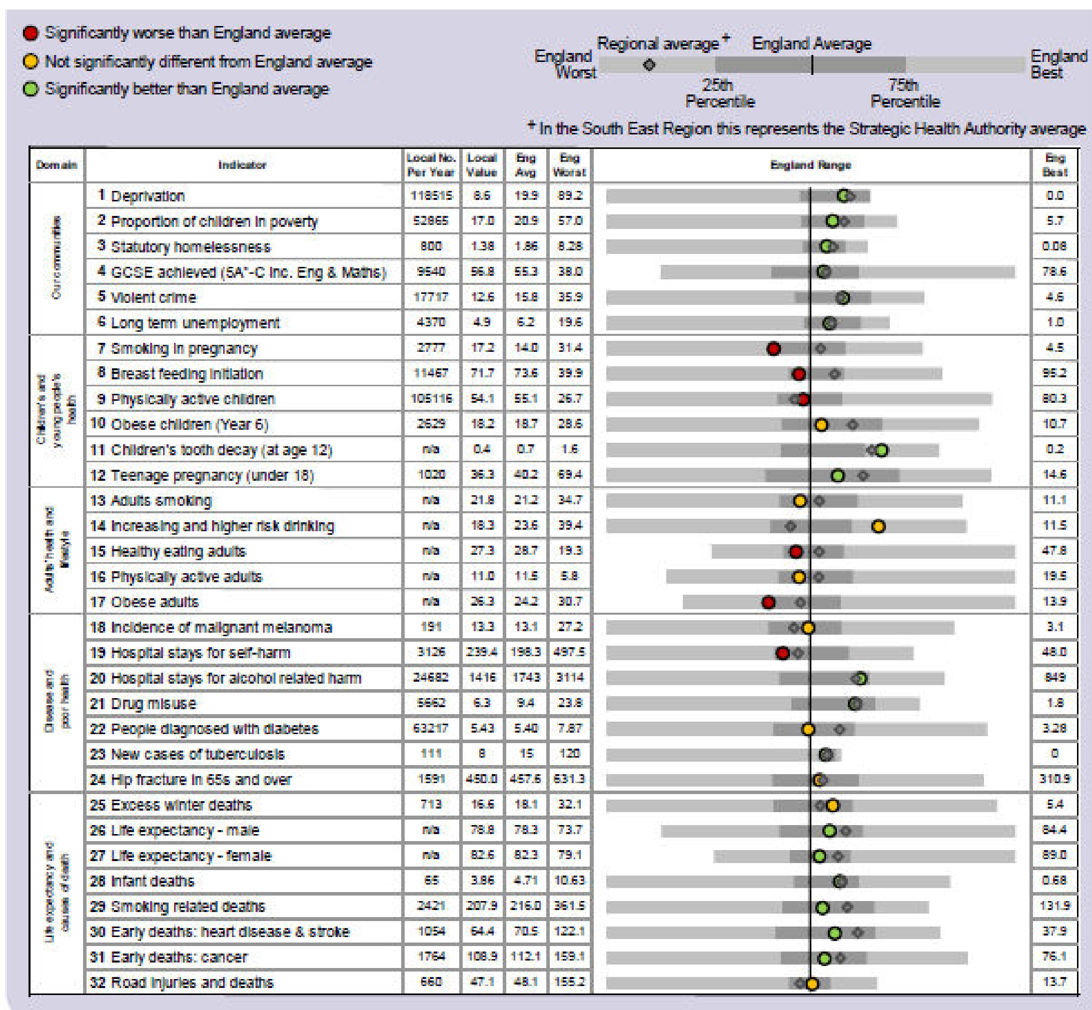
Appendix B – Health Profiles 2011

Kent County Council



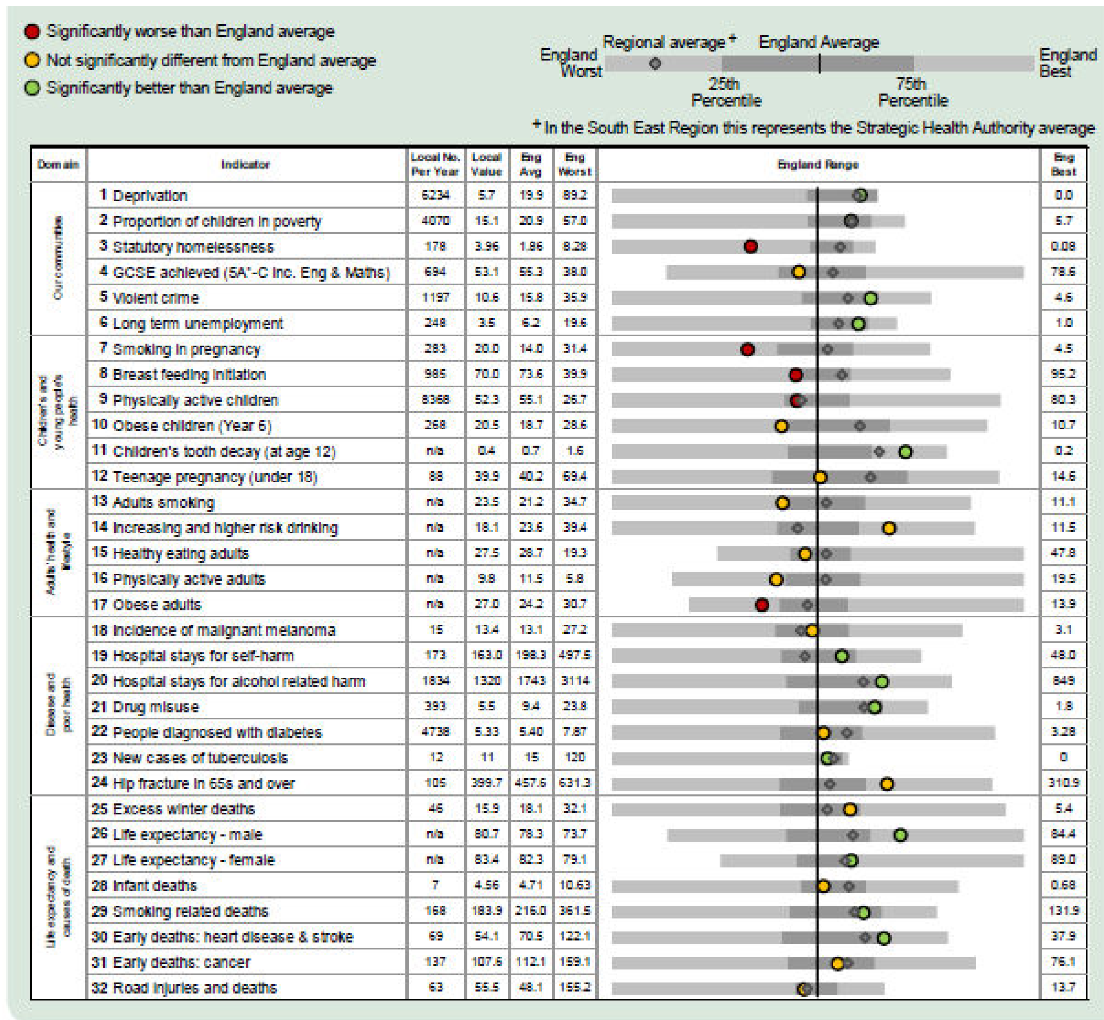
Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	118515	8.6	19.9	89.2		0.0
	2 Proportion of children in poverty	52865	17.0	20.9	57.0		5.7
	3 Statutory homelessness	800	1.38	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	9540	56.8	55.3	38.0		78.6
	5 Violent crime	17717	12.6	15.8	35.9		4.6
	6 Long term unemployment	4370	4.9	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	2777	17.2	14.0	31.4		4.5
	8 Breast feeding initiation	11467	71.7	73.6	39.9		95.2
	9 Physically active children	105116	54.1	55.1	26.7		80.3
	10 Obese children (Year 6)	2629	18.2	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	1020	36.3	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	21.8	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	18.3	23.6	39.4		11.5
	15 Healthy eating adults	n/a	27.3	28.7	19.3		47.8
	16 Physically active adults	n/a	11.0	11.5	5.8		19.5
	17 Obese adults	n/a	26.3	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	191	13.3	13.1	27.2		3.1
	19 Hospital stays for self-harm	3126	239.4	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	24682	1416	1743	3114		849
	21 Drug misuse	5662	6.3	9.4	23.8		1.8
	22 People diagnosed with diabetes	63217	5.43	5.40	7.87		3.28
	23 New cases of tuberculosis	111	8	15	120		0
	24 Hip fracture in 65s and over	1591	450.0	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	713	16.6	18.1	32.1		5.4
	26 Life expectancy - male	n/a	78.8	78.3	73.7		84.4
	27 Life expectancy - female	n/a	82.6	82.3	79.1		89.0
	28 Infant deaths	65	3.86	4.71	10.63		0.68
	29 Smoking related deaths	2421	207.9	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	1054	64.4	70.5	122.1		37.9
	31 Early deaths: cancer	1764	108.9	112.1	159.1		76.1
	32 Road injuries and deaths	660	47.1	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

Ashford



Significantly worse than England average
Not significantly different from England average
Significantly better than England average

England Worst | Regional average + | England Average | 25th Percentile | 75th Percentile | England Best

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	6234	5.7	19.9	89.2		0.0
	2 Proportion of children in poverty	4070	15.1	20.9	57.0		5.7
	3 Statutory homelessness	178	3.96	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	694	53.1	55.3	38.0		78.6
	5 Violent crime	1197	10.6	15.8	35.9		4.6
	6 Long term unemployment	248	3.5	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	283	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	985	70.0	73.6	39.9		95.2
	9 Physically active children	8368	52.3	55.1	26.7		80.3
	10 Obese children (Year 6)	268	20.5	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	88	39.9	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	23.5	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	18.1	23.6	39.4		11.5
	15 Healthy eating adults	n/a	27.5	28.7	19.3		47.8
	16 Physically active adults	n/a	9.8	11.5	5.8		19.5
	17 Obese adults	n/a	27.0	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	15	13.4	13.1	27.2		3.1
	19 Hospital stays for self-harm	173	163.0	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1834	1320	1743	3114		849
	21 Drug misuse	393	5.5	9.4	23.8		1.8
	22 People diagnosed with diabetes	4738	5.33	5.40	7.87		3.28
	23 New cases of tuberculosis	12	11	15	120		0
	24 Hip fracture in 65s and over	105	399.7	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	46	15.9	18.1	32.1		5.4
	26 Life expectancy - male	n/a	80.7	78.3	73.7		84.4
	27 Life expectancy - female	n/a	83.4	82.3	79.1		89.0
	28 Infant deaths	7	4.56	4.71	10.63		0.68
	29 Smoking related deaths	168	183.9	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	69	54.1	70.5	122.1		37.9
	31 Early deaths: cancer	137	107.6	112.1	159.1		76.1
	32 Road injuries and deaths	63	55.5	48.1	155.2		13.7

Indicator Notes
1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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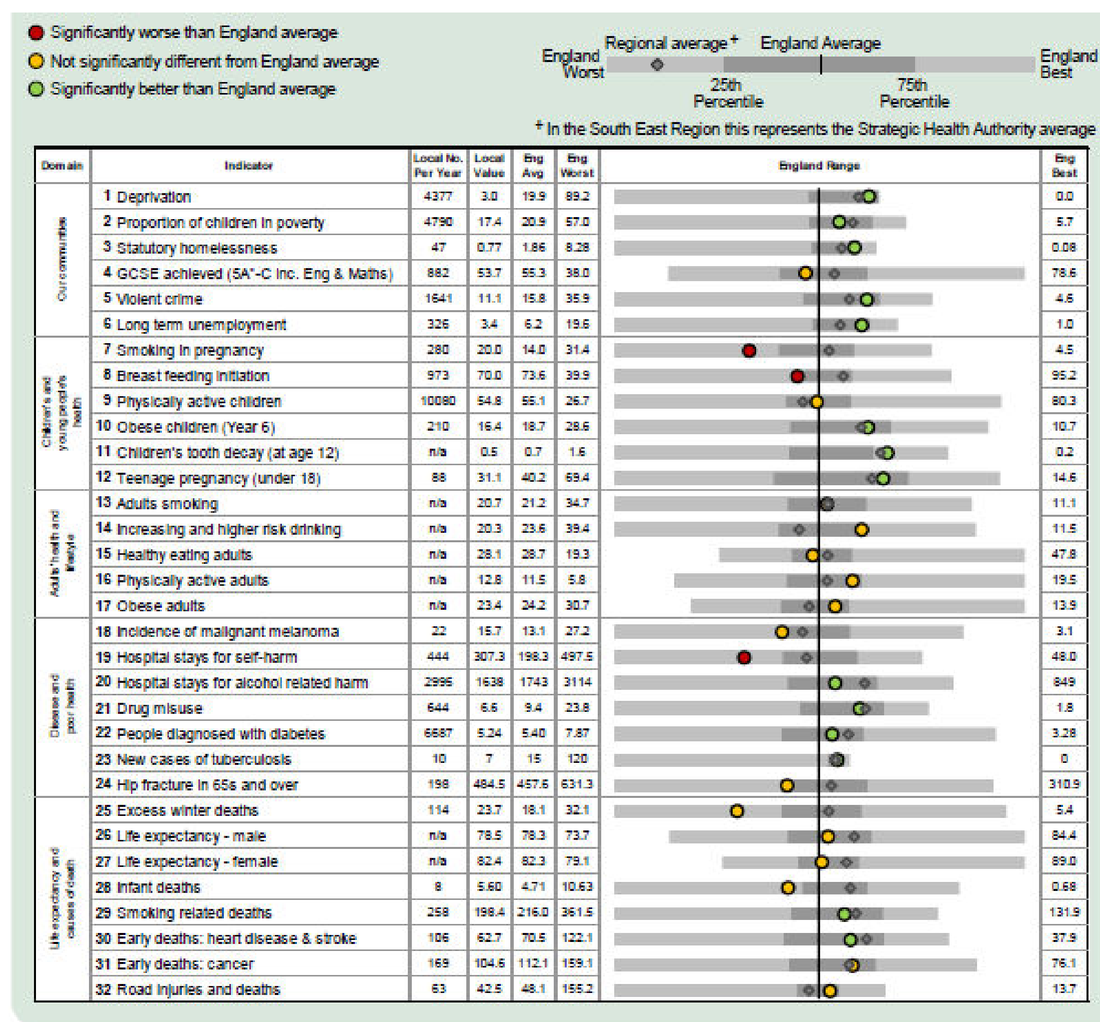
Canterbury



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	4377	3.0	19.9	89.2		0.0
	2 Proportion of children in poverty	4790	17.4	20.9	57.0		5.7
	3 Statutory homelessness	47	0.77	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	882	53.7	55.3	38.0		78.6
	5 Violent crime	1641	11.1	15.8	35.9		4.6
	6 Long term unemployment	326	3.4	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	280	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	973	70.0	73.6	39.9		95.2
	9 Physically active children	10080	54.8	55.1	26.7		80.3
	10 Obese children (Year 6)	210	16.4	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	88	31.1	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	20.7	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	20.3	23.6	39.4		11.5
	15 Healthy eating adults	n/a	28.1	28.7	19.3		47.8
	16 Physically active adults	n/a	12.8	11.5	5.8		19.5
	17 Obese adults	n/a	23.4	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	22	15.7	13.1	27.2		3.1
	19 Hospital stays for self-harm	444	307.3	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	2996	1638	1743	3114		849
	21 Drug misuse	644	6.6	9.4	23.8		1.8
	22 People diagnosed with diabetes	6687	5.24	5.40	7.87		3.28
	23 New cases of tuberculosis	10	7	15	120		0
	24 Hip fracture in 65s and over	198	484.5	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	114	23.7	18.1	32.1		5.4
	26 Life expectancy - male	n/a	78.5	78.3	73.7		84.4
	27 Life expectancy - female	n/a	82.4	82.3	79.1		89.0
	28 Infant deaths	8	5.60	4.71	10.63		0.68
	29 Smoking related deaths	258	198.4	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	106	62.7	70.5	122.1		37.9
	31 Early deaths: cancer	169	104.6	112.1	159.1		76.1
	32 Road injuries and deaths	63	42.5	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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Dartford

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	4608	5.2	19.9	89.2		0.0
	2 Proportion of children in poverty	3440	16.1	20.9	57.0		5.7
	3 Statutory homelessness	100	2.63	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	855	63.1	55.3	38.0		78.6
	5 Violent crime	1407	15.2	15.8	35.9		4.6
	6 Long term unemployment	388	6.3	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	180	14.2	14.0	31.4		4.5
	8 Breast feeding initiation	919	73.6	73.6	39.9		95.2
	9 Physically active children	9463	62.0	55.1	26.7		80.3
	10 Obese children (Year 6)	238	22.7	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.6	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	65	36.1	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	24.4	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	18.1	23.6	39.4		11.5
	15 Healthy eating adults	n/a	25.0	28.7	19.3		47.8
	16 Physically active adults	n/a	8.6	11.5	5.8		19.5
	17 Obese adults	n/a	28.2	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	9	10.7	13.1	27.2		3.1
	19 Hospital stays for self-harm	197	213.4	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1380	1325	1743	3114		849
	21 Drug misuse	299	4.8	9.4	23.8		1.8
	22 People diagnosed with diabetes	4342	5.03	5.40	7.87		3.28
	23 New cases of tuberculosis	10	10	15	120		0
	24 Hip fracture in 65s and over	91	451.3	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	33	13.0	18.1	32.1		5.4
	26 Life expectancy - male	n/a	78.9	78.3	73.7		84.4
	27 Life expectancy - female	n/a	81.1	82.3	79.1		89.0
	28 Infant deaths	4	2.99	4.71	10.63		0.68
	29 Smoking related deaths	138	220.9	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	70	75.0	70.5	122.1		37.9
	31 Early deaths: cancer	101	111.6	112.1	159.1		76.1
	32 Road injuries and deaths	48	51.4	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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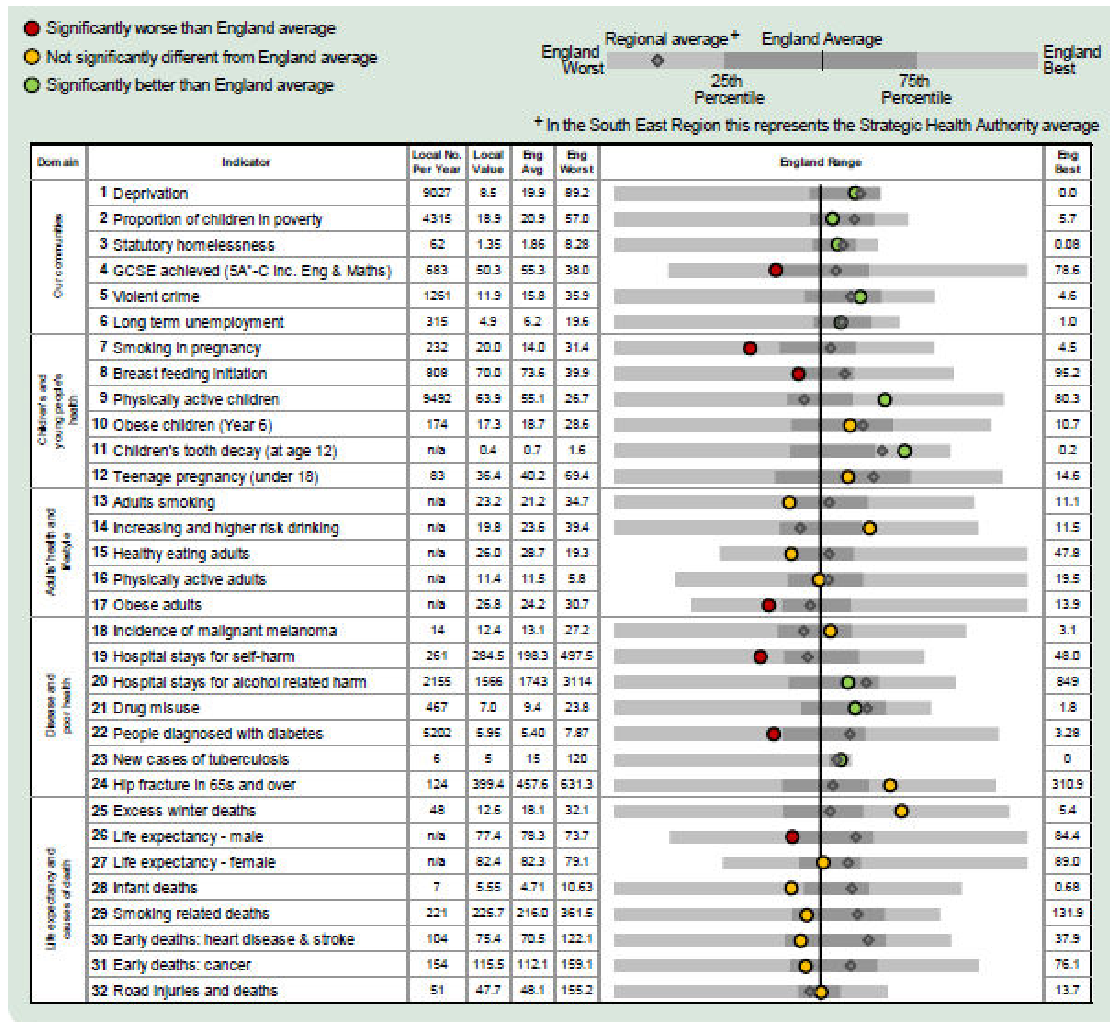
Dover



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	Eng Best
Our communities	1 Deprivation	9027	8.5	19.9	89.2	0.0
	2 Proportion of children in poverty	4315	18.9	20.9	57.0	5.7
	3 Statutory homelessness	62	1.35	1.86	8.28	0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	683	50.3	55.3	38.0	78.6
	5 Violent crime	1261	11.9	15.8	35.9	4.6
	6 Long term unemployment	315	4.9	6.2	19.6	1.0
Children's and young people's health	7 Smoking in pregnancy	232	20.0	14.0	31.4	4.5
	8 Breast feeding initiation	808	70.0	73.6	39.9	95.2
	9 Physically active children	9492	63.9	55.1	26.7	80.3
	10 Obese children (Year 6)	174	17.3	18.7	28.6	10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6	0.2
	12 Teenage pregnancy (under 18)	83	36.4	40.2	69.4	14.6
Adults' health and lifestyle	13 Adults smoking	n/a	23.2	21.2	34.7	11.1
	14 Increasing and higher risk drinking	n/a	19.8	23.6	39.4	11.5
	15 Healthy eating adults	n/a	26.0	28.7	19.3	47.8
	16 Physically active adults	n/a	11.4	11.5	5.8	19.5
	17 Obese adults	n/a	26.8	24.2	30.7	13.9
Disease and poor health	18 Incidence of malignant melanoma	14	12.4	13.1	27.2	3.1
	19 Hospital stays for self-harm	261	284.5	198.3	497.5	48.0
	20 Hospital stays for alcohol related harm	2155	1566	1743	3114	849
	21 Drug misuse	467	7.0	9.4	23.8	1.8
	22 People diagnosed with diabetes	5202	5.96	5.40	7.87	3.28
	23 New cases of tuberculosis	6	5	15	120	0
	24 Hip fracture in 65s and over	124	399.4	457.6	631.3	310.9
Life expectancy and causes of death	25 Excess winter deaths	48	12.6	18.1	32.1	5.4
	26 Life expectancy - male	n/a	77.4	78.3	73.7	84.4
	27 Life expectancy - female	n/a	82.4	82.3	79.1	89.0
	28 Infant deaths	7	5.55	4.71	10.63	0.68
	29 Smoking related deaths	221	225.7	216.0	361.5	131.9
	30 Early deaths: heart disease & stroke	104	75.4	70.5	122.1	37.9
	31 Early deaths: cancer	154	115.5	112.1	159.1	76.1
	32 Road injuries and deaths	51	47.7	48.1	155.2	13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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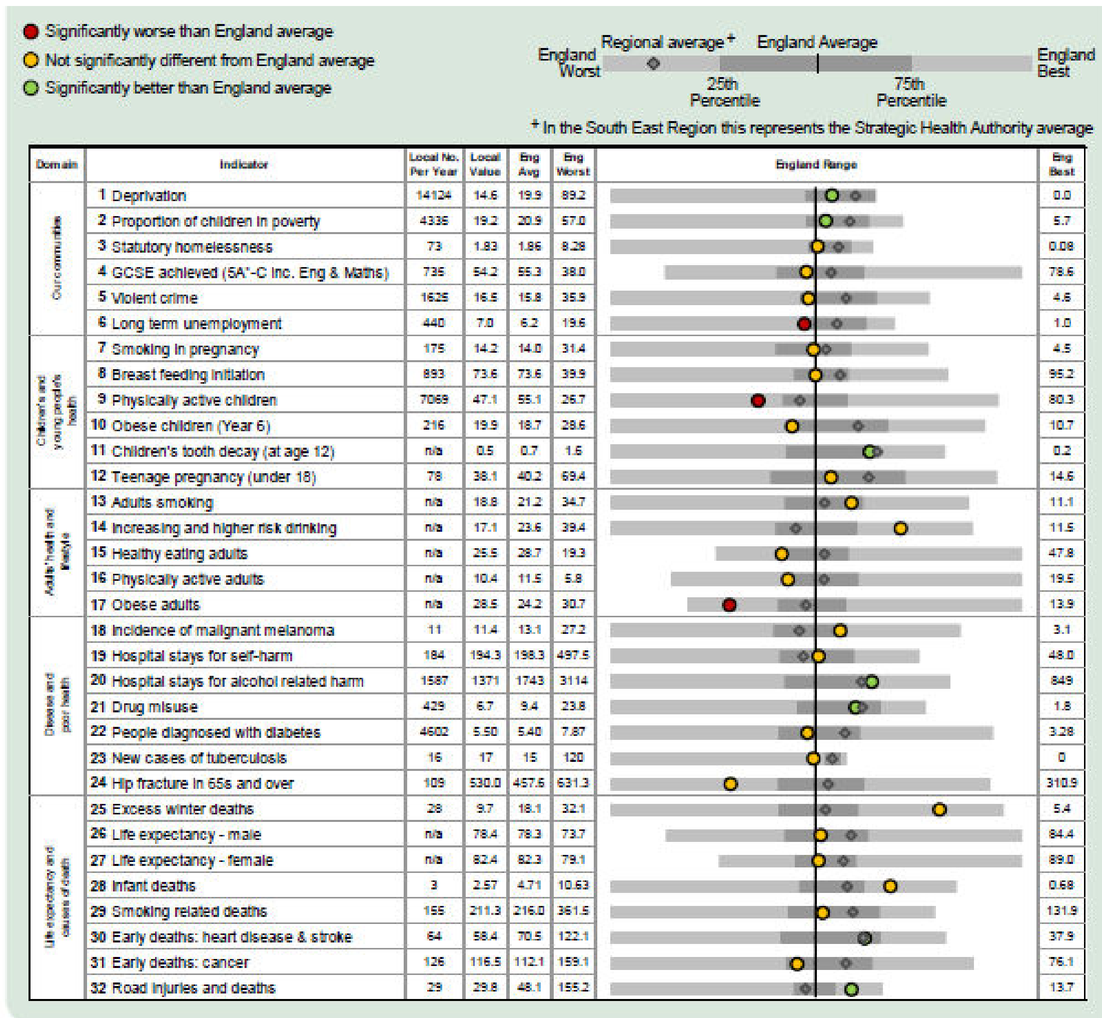
Gravesham



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	14124	14.6	19.9	89.2		0.0
	2 Proportion of children in poverty	4335	19.2	20.9	57.0		5.7
	3 Statutory homelessness	73	1.83	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	735	54.2	55.3	38.0		78.6
	5 Violent crime	1625	16.5	15.8	35.9		4.6
	6 Long term unemployment	440	7.0	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	175	14.2	14.0	31.4		4.5
	8 Breast feeding initiation	893	73.6	73.6	39.9		95.2
	9 Physically active children	7069	47.1	55.1	26.7		80.3
	10 Obese children (Year 6)	216	19.9	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	78	38.1	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	18.8	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	17.1	23.6	39.4		11.5
	15 Healthy eating adults	n/a	25.5	28.7	19.3		47.8
	16 Physically active adults	n/a	10.4	11.5	5.8		19.5
	17 Obese adults	n/a	28.5	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	11	11.4	13.1	27.2		3.1
	19 Hospital stays for self-harm	184	194.3	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1587	1371	1743	3114		849
	21 Drug misuse	429	6.7	9.4	23.8		1.8
	22 People diagnosed with diabetes	4602	5.50	5.40	7.87		3.28
	23 New cases of tuberculosis	16	17	15	120		0
	24 Hip fracture in 65s and over	109	530.0	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	28	9.7	18.1	32.1		5.4
	26 Life expectancy - male	n/a	78.4	78.3	73.7		84.4
	27 Life expectancy - female	n/a	82.4	82.3	79.1		89.0
	28 Infant deaths	3	2.57	4.71	10.63		0.68
	29 Smoking related deaths	155	211.3	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	64	58.4	70.5	122.1		37.9
	31 Early deaths: cancer	126	116.5	112.1	159.1		76.1
	32 Road injuries and deaths	29	29.8	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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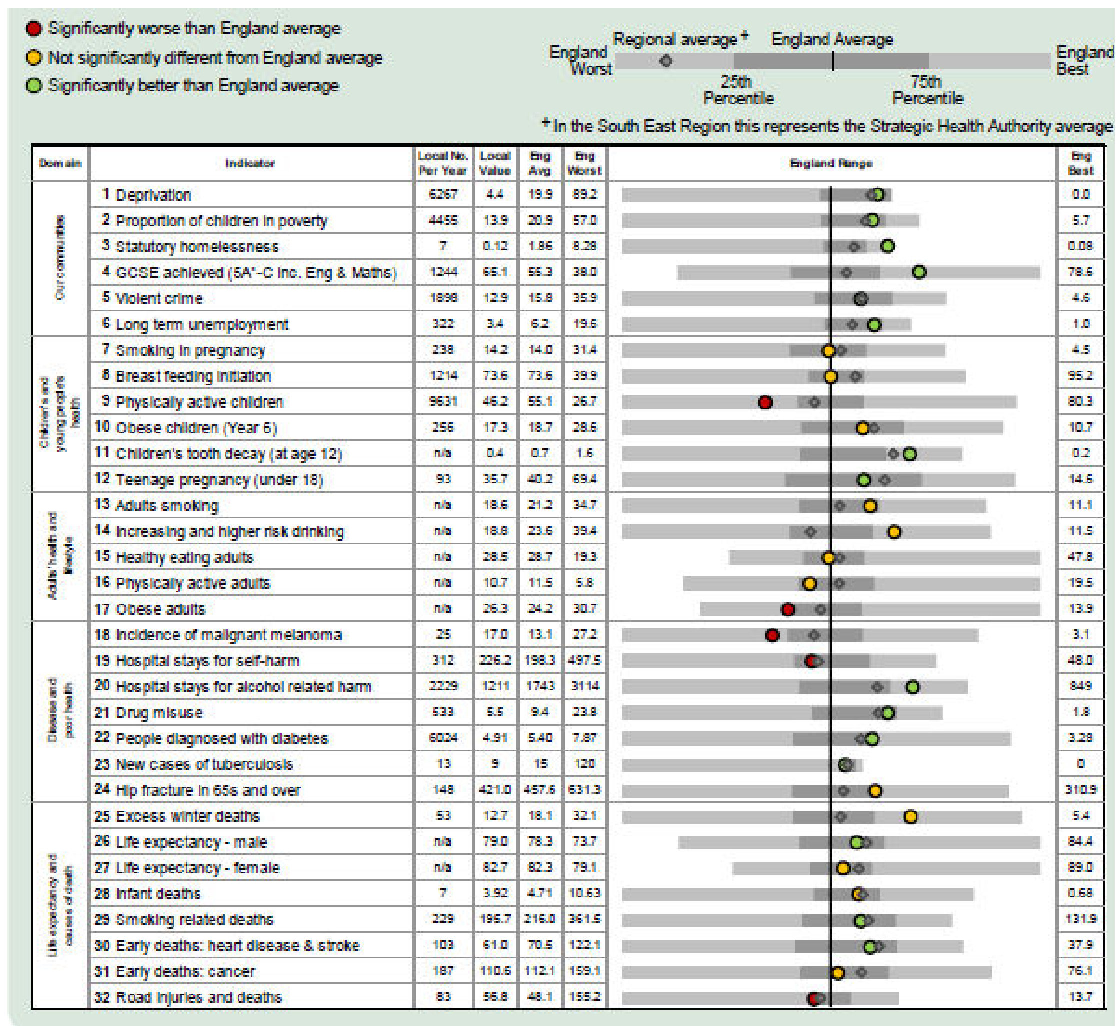
Maidstone



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	6267	4.4	19.9	89.2		0.0
	2 Proportion of children in poverty	4455	13.9	20.9	57.0		5.7
	3 Statutory homelessness	7	0.12	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1244	65.1	55.3	38.0		78.6
	5 Violent crime	1898	12.9	15.8	35.9		4.6
	6 Long term unemployment	322	3.4	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	238	14.2	14.0	31.4		4.5
	8 Breast feeding initiation	1214	73.6	73.6	39.9		95.2
	9 Physically active children	9631	46.2	55.1	26.7		80.3
	10 Obese children (Year 6)	256	17.3	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	93	35.7	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	18.6	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	18.8	23.6	39.4		11.5
	15 Healthy eating adults	n/a	28.5	28.7	19.3		47.8
	16 Physically active adults	n/a	10.7	11.5	5.8		19.5
	17 Obese adults	n/a	26.3	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	25	17.0	13.1	27.2		3.1
	19 Hospital stays for self-harm	312	226.2	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	2229	1211	1743	3114		849
	21 Drug misuse	533	5.5	9.4	23.8		1.8
	22 People diagnosed with diabetes	6024	4.91	5.40	7.87		3.28
	23 New cases of tuberculosis	13	9	15	120		0
	24 Hip fracture in 65s and over	148	421.0	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	53	12.7	18.1	32.1		5.4
	26 Life expectancy - male	n/a	79.0	78.3	73.7		84.4
	27 Life expectancy - female	n/a	82.7	82.3	79.1		89.0
	28 Infant deaths	7	3.92	4.71	10.63		0.68
	29 Smoking related deaths	229	195.7	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	103	61.0	70.5	122.1		37.9
	31 Early deaths: cancer	187	110.6	112.1	159.1		76.1
	32 Road injuries and deaths	83	56.8	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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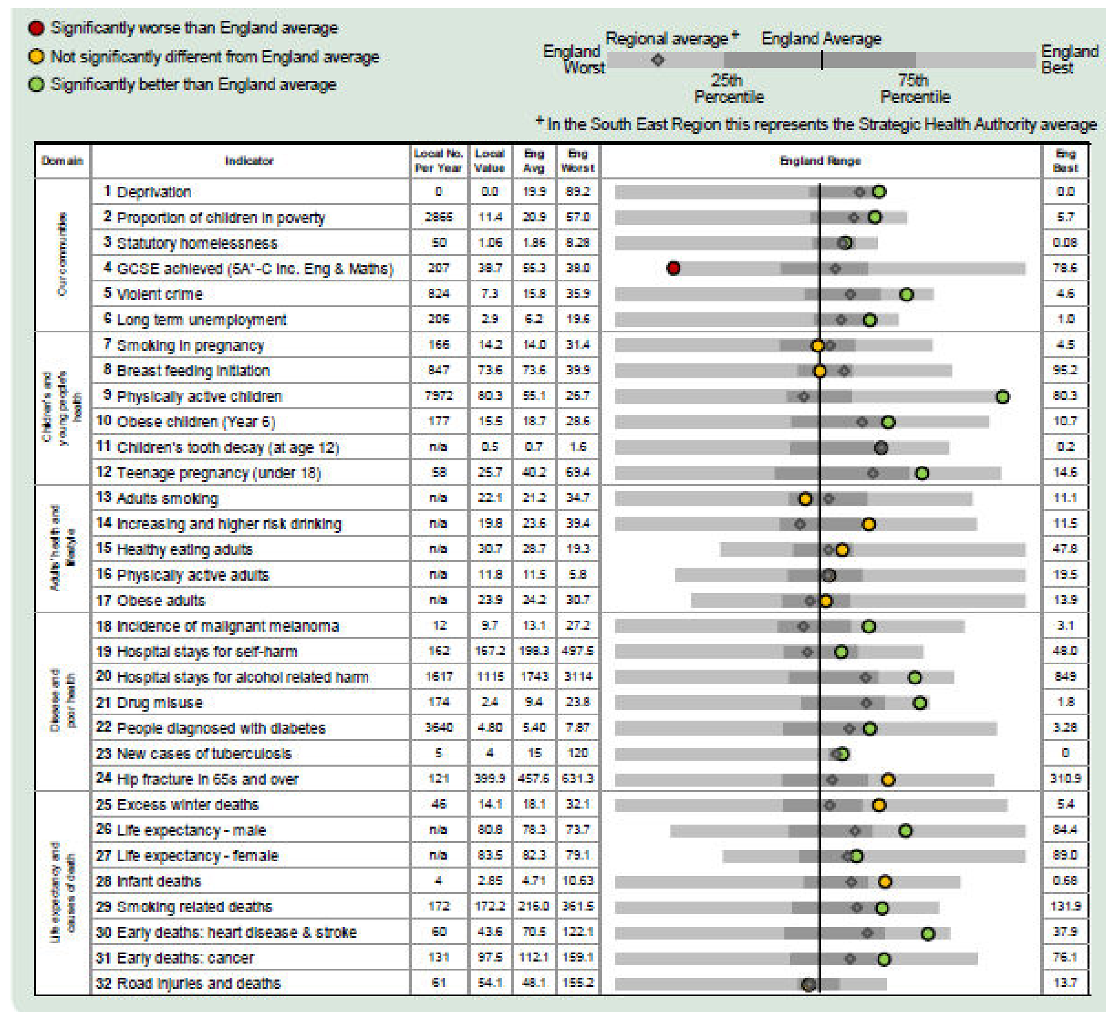
Sevenoaks



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Proportion of children in poverty	2865	11.4	20.9	57.0		5.7
	3 Statutory homelessness	50	1.06	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	207	38.7	55.3	38.0		78.6
	5 Violent crime	824	7.3	15.8	35.9		4.6
	6 Long term unemployment	206	2.9	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	166	14.2	14.0	31.4		4.5
	8 Breast feeding initiation	847	73.6	73.6	39.9		95.2
	9 Physically active children	7972	80.3	55.1	26.7		80.3
	10 Obese children (Year 6)	177	15.5	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	58	25.7	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	22.1	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	19.8	23.6	39.4		11.5
	15 Healthy eating adults	n/a	30.7	28.7	19.3		47.8
	16 Physically active adults	n/a	11.8	11.5	5.8		19.5
	17 Obese adults	n/a	23.9	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	12	9.7	13.1	27.2		3.1
	19 Hospital stays for self-harm	162	167.2	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1617	1115	1743	3114		849
	21 Drug misuse	174	2.4	9.4	23.8		1.8
	22 People diagnosed with diabetes	3640	4.80	5.40	7.87		3.28
	23 New cases of tuberculosis	5	4	15	120		0
	24 Hip fracture in 65s and over	121	399.9	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	46	14.1	18.1	32.1		5.4
	26 Life expectancy - male	n/a	80.8	78.3	73.7		84.4
	27 Life expectancy - female	n/a	83.5	82.3	79.1		89.0
	28 Infant deaths	4	2.85	4.71	10.63		0.68
	29 Smoking related deaths	172	172.2	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	60	43.6	70.5	122.1		37.9
	31 Early deaths: cancer	131	97.5	112.1	159.1		76.1
	32 Road injuries and deaths	61	54.1	48.1	155.2		13.7

Indicator Notes
1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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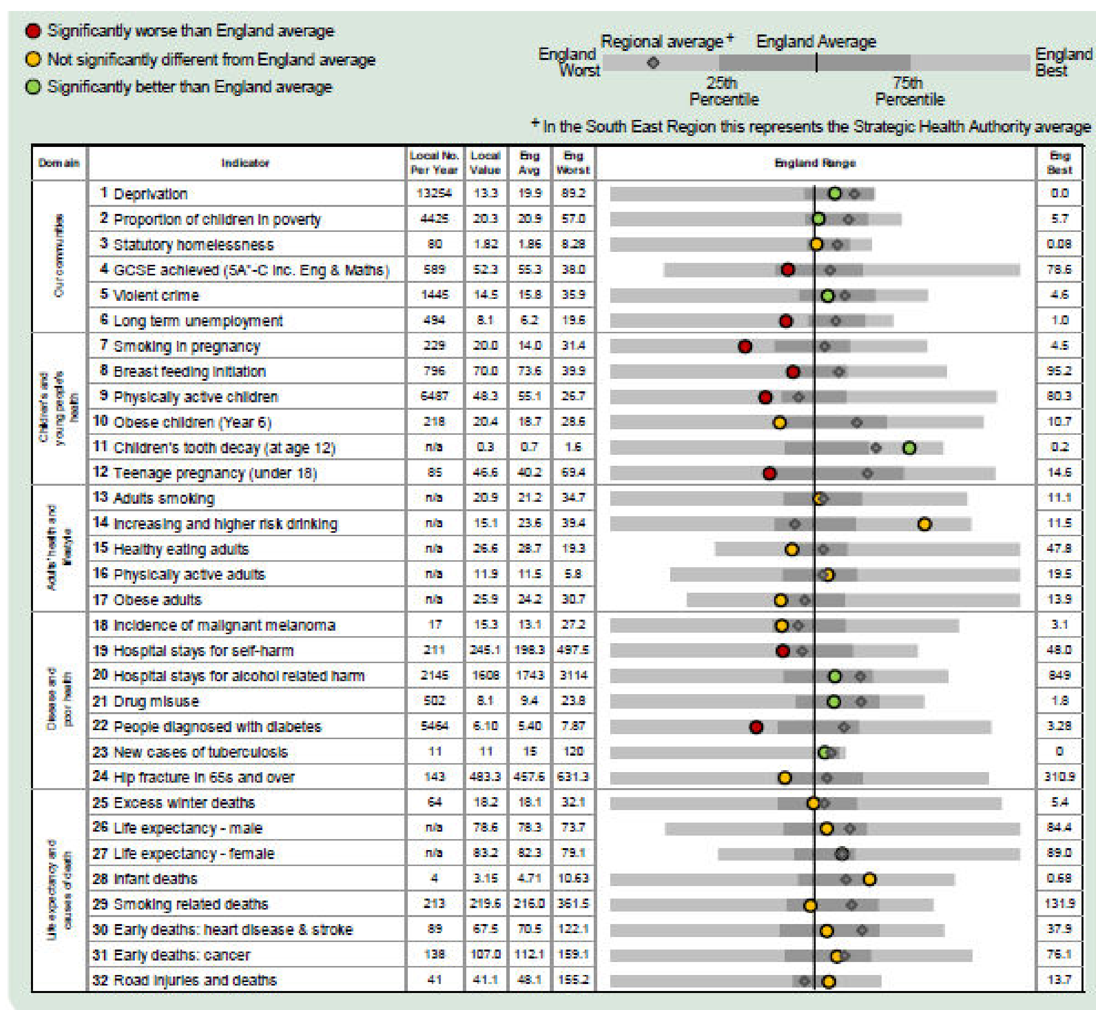
Shepway



Significantly worse than England average
Not significantly different from England average
Significantly better than England average

England Worst | Regional average + | England Average | 25th Percentile | 75th Percentile | England Best

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	13254	13.3	19.9	89.2		0.0
	2 Proportion of children in poverty	4425	20.3	20.9	57.0		5.7
	3 Statutory homelessness	80	1.82	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	589	52.3	55.3	38.0		78.6
	5 Violent crime	1445	14.5	15.8	35.9		4.6
	6 Long term unemployment	494	8.1	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	229	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	796	70.0	73.6	39.9		95.2
	9 Physically active children	6487	48.3	55.1	26.7		80.3
	10 Obese children (Year 6)	218	20.4	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.3	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	85	46.6	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	20.9	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	15.1	23.6	39.4		11.5
	15 Healthy eating adults	n/a	26.6	28.7	19.3		47.8
	16 Physically active adults	n/a	11.9	11.5	5.8		19.5
	17 Obese adults	n/a	25.9	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	17	15.3	13.1	27.2		3.1
	19 Hospital stays for self-harm	211	245.1	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	2145	1608	1743	3114		849
	21 Drug misuse	502	8.1	9.4	23.8		1.8
	22 People diagnosed with diabetes	5464	6.10	5.40	7.87		3.28
	23 New cases of tuberculosis	11	11	15	120		0
	24 Hip fracture in 65s and over	143	483.3	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	64	18.2	18.1	32.1		5.4
	26 Life expectancy - male	n/a	78.6	78.3	73.7		84.4
	27 Life expectancy - female	n/a	83.2	82.3	79.1		89.0
	28 Infant deaths	4	3.15	4.71	10.63		0.68
	29 Smoking related deaths	213	219.6	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	89	67.5	70.5	122.1		37.9
	31 Early deaths: cancer	138	107.0	112.1	159.1		76.1
	32 Road injuries and deaths	41	41.1	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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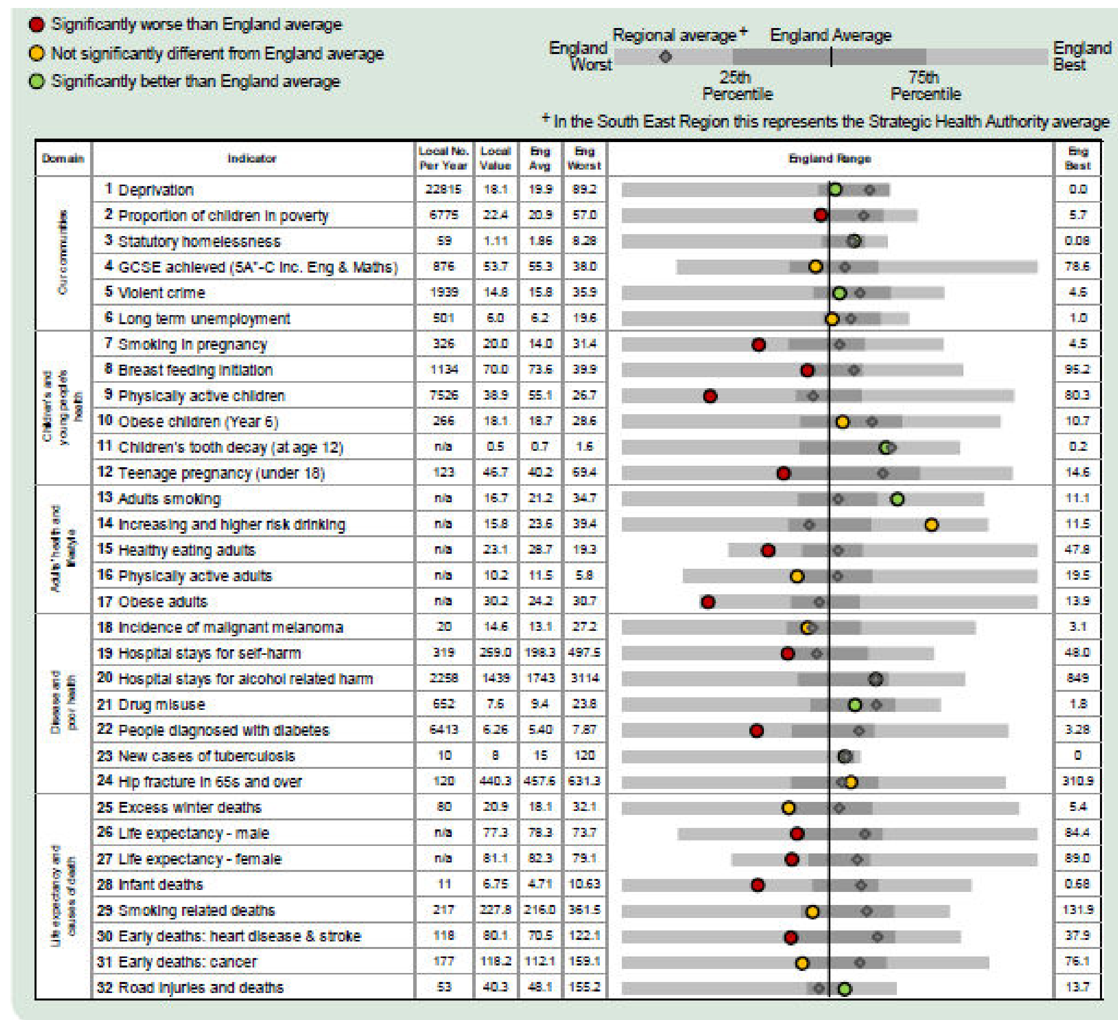
Swale



Significantly worse than England average
Not significantly different from England average
Significantly better than England average

England Worst | Regional average+ | 25th Percentile | England Average | 75th Percentile | England Best

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	Eng Best
Our communities	1 Deprivation	22815	18.1	19.9	89.2	0.0
	2 Proportion of children in poverty	6775	22.4	20.9	57.0	5.7
	3 Statutory homelessness	59	1.11	1.86	8.28	0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	876	53.7	55.3	38.0	78.6
	5 Violent crime	1939	14.8	15.8	35.9	4.6
	6 Long term unemployment	501	6.0	6.2	19.6	1.0
Children's and young people's health	7 Smoking in pregnancy	326	20.0	14.0	31.4	4.5
	8 Breast feeding initiation	1134	70.0	73.6	39.9	95.2
	9 Physically active children	7526	38.9	55.1	26.7	80.3
	10 Obese children (Year 6)	266	18.1	18.7	28.6	10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6	0.2
	12 Teenage pregnancy (under 18)	123	46.7	40.2	69.4	14.6
Adults' health and lifestyle	13 Adults smoking	n/a	16.7	21.2	34.7	11.1
	14 Increasing and higher risk drinking	n/a	15.8	23.6	39.4	11.5
	15 Healthy eating adults	n/a	23.1	28.7	19.3	47.8
	16 Physically active adults	n/a	10.2	11.5	5.8	19.5
	17 Obese adults	n/a	30.2	24.2	30.7	13.9
Disease and poor health	18 Incidence of malignant melanoma	20	14.6	13.1	27.2	3.1
	19 Hospital stays for self-harm	319	259.0	198.3	497.5	48.0
	20 Hospital stays for alcohol related harm	2258	1439	1743	3114	849
	21 Drug misuse	652	7.6	9.4	23.8	1.8
	22 People diagnosed with diabetes	6413	6.26	5.40	7.87	3.28
	23 New cases of tuberculosis	10	8	15	120	0
	24 Hip fracture in 65s and over	120	440.3	457.6	631.3	310.9
Life expectancy and causes of death	25 Excess winter deaths	80	20.9	18.1	32.1	5.4
	26 Life expectancy - male	n/a	77.3	78.3	73.7	84.4
	27 Life expectancy - female	n/a	81.1	82.3	79.1	89.0
	28 Infant deaths	11	6.75	4.71	10.63	0.68
	29 Smoking related deaths	217	227.8	216.0	361.5	131.9
	30 Early deaths: heart disease & stroke	118	80.1	70.5	122.1	37.9
	31 Early deaths: cancer	177	118.2	112.1	159.1	76.1
	32 Road injuries and deaths	53	40.3	48.1	155.2	13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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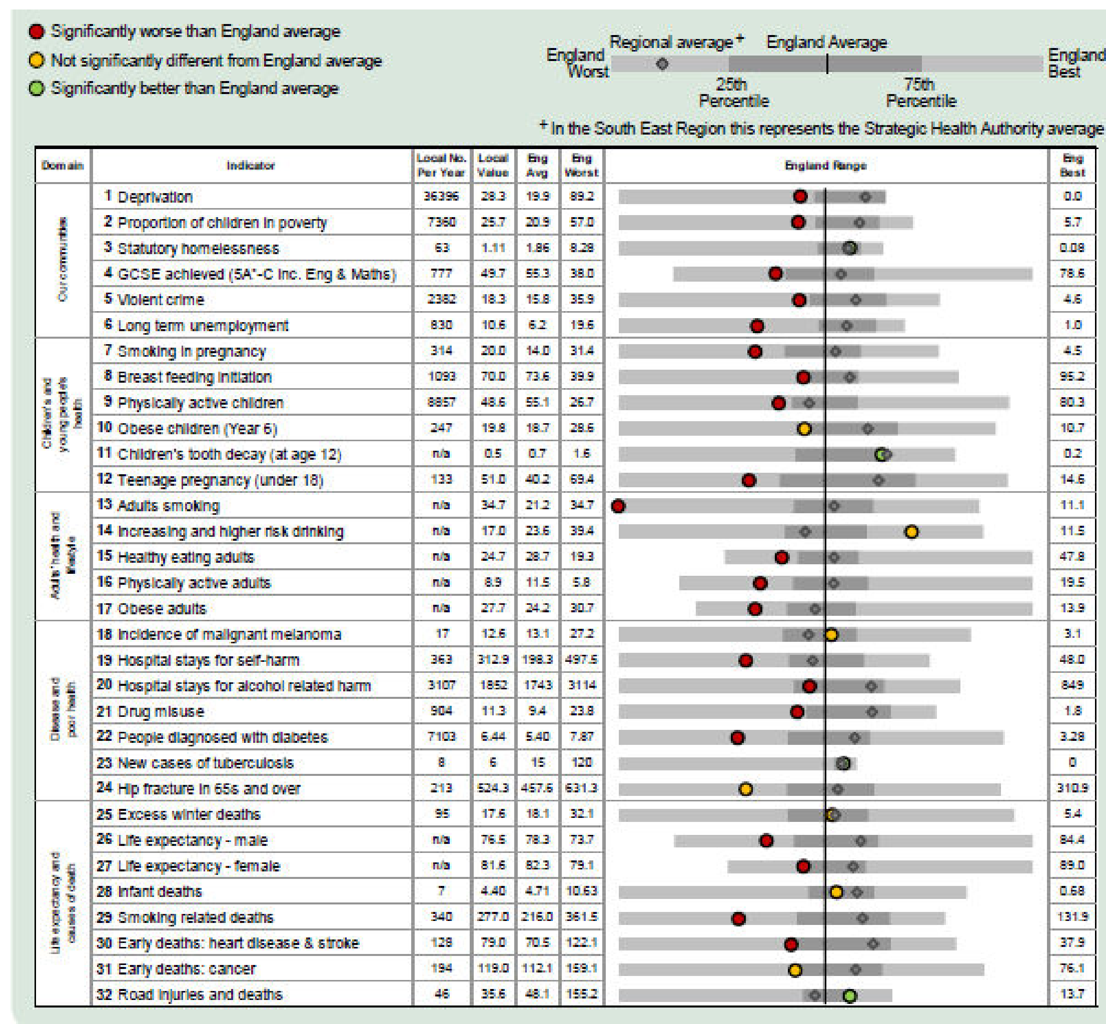
Thanet



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	36396	28.3	19.9	89.2		0.0
	2 Proportion of children in poverty	7360	25.7	20.9	57.0		5.7
	3 Statutory homelessness	63	1.11	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	777	49.7	55.3	38.0		78.6
	5 Violent crime	2382	18.3	15.8	35.9		4.6
	6 Long term unemployment	830	10.6	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	314	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	1093	70.0	73.6	39.9		95.2
	9 Physically active children	8857	48.6	55.1	26.7		80.3
	10 Obese children (Year 6)	247	19.8	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	133	51.0	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	34.7	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	17.0	23.6	39.4		11.5
	15 Healthy eating adults	n/a	24.7	28.7	19.3		47.8
	16 Physically active adults	n/a	8.9	11.5	5.8		19.5
	17 Obese adults	n/a	27.7	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	17	12.6	13.1	27.2		3.1
	19 Hospital stays for self-harm	363	312.9	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	3107	1852	1743	3114		849
	21 Drug misuse	904	11.3	9.4	23.8		1.8
	22 People diagnosed with diabetes	7103	6.44	5.40	7.87		3.28
	23 New cases of tuberculosis	8	6	15	120		0
	24 Hip fracture in 65s and over	213	524.3	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	95	17.6	18.1	32.1		5.4
	26 Life expectancy - male	n/a	76.5	78.3	73.7		84.4
	27 Life expectancy - female	n/a	81.6	82.3	79.1		89.0
	28 Infant deaths	7	4.40	4.71	10.63		0.68
	29 Smoking related deaths	340	277.0	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	128	79.0	70.5	122.1		37.9
	31 Early deaths: cancer	194	119.0	112.1	159.1		76.1
	32 Road injuries and deaths	46	35.6	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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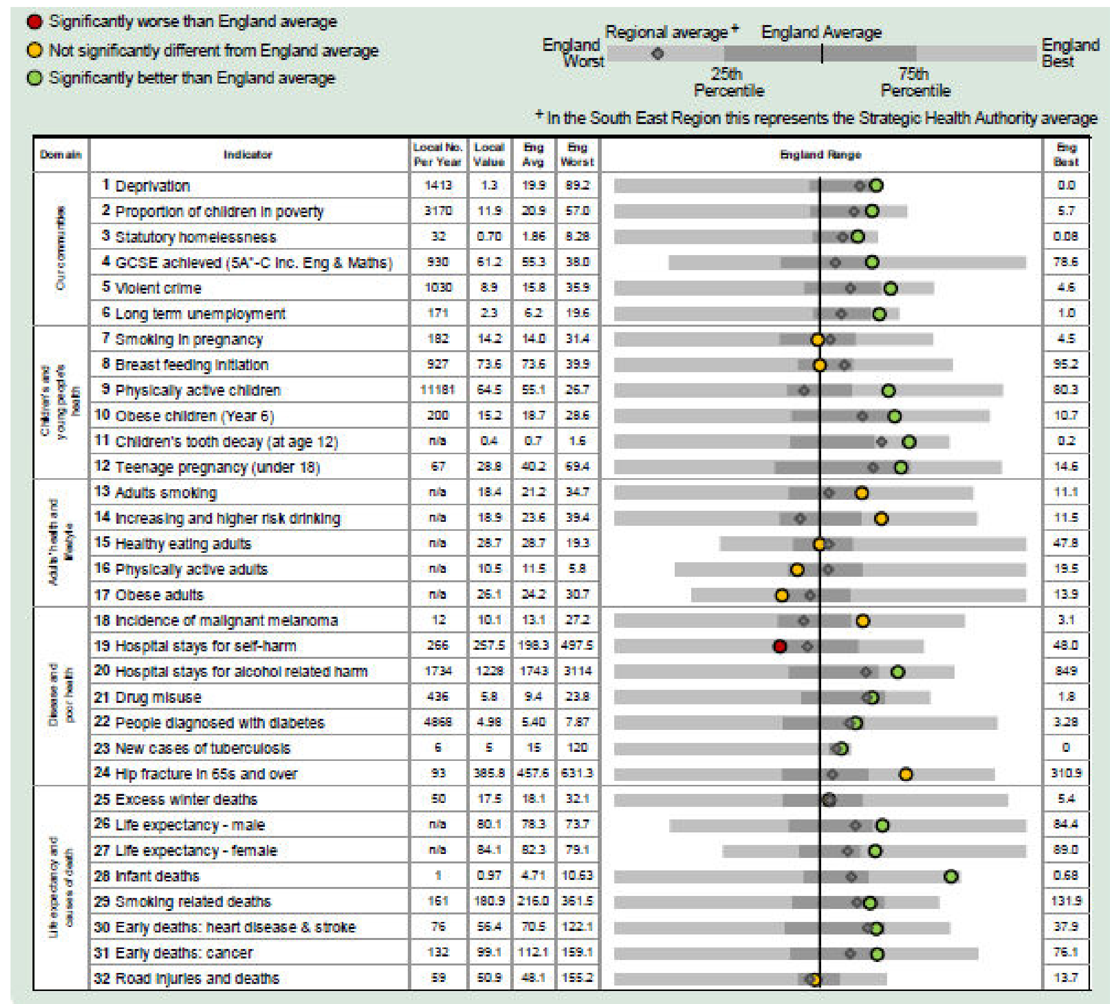
Tonbridge and Malling



Significantly worse than England average
Not significantly different from England average
Significantly better than England average

England Worst | Regional average + | England Average | England Best | 25th Percentile | 75th Percentile

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	1413	1.3	19.9	89.2		0.0
	2 Proportion of children in poverty	3170	11.9	20.9	57.0		5.7
	3 Statutory homelessness	32	0.70	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	930	61.2	55.3	38.0		78.6
	5 Violent crime	1030	8.9	15.8	35.9		4.6
	6 Long term unemployment	171	2.3	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	182	14.2	14.0	31.4		4.5
	8 Breast feeding initiation	927	73.6	73.6	39.9		95.2
	9 Physically active children	11181	64.5	55.1	26.7		80.3
	10 Obese children (Year 6)	200	15.2	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	67	28.8	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	18.4	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	18.9	23.6	39.4		11.5
	15 Healthy eating adults	n/a	28.7	28.7	19.3		47.8
	16 Physically active adults	n/a	10.5	11.5	5.8		19.5
	17 Obese adults	n/a	26.1	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	12	10.1	13.1	27.2		3.1
	19 Hospital stays for self-harm	266	257.5	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1734	1228	1743	3114		849
	21 Drug misuse	436	5.8	9.4	23.8		1.8
	22 People diagnosed with diabetes	4868	4.98	5.40	7.87		3.28
	23 New cases of tuberculosis	6	5	15	120		0
	24 Hip fracture in 65s and over	93	385.8	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	50	17.5	18.1	32.1		5.4
	26 Life expectancy - male	n/a	80.1	78.3	73.7		84.4
	27 Life expectancy - female	n/a	84.1	82.3	79.1		89.0
	28 Infant deaths	1	0.97	4.71	10.63		0.68
	29 Smoking related deaths	161	180.9	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	76	56.4	70.5	122.1		37.9
	31 Early deaths: cancer	132	99.1	112.1	159.1		76.1
	32 Road injuries and deaths	59	50.9	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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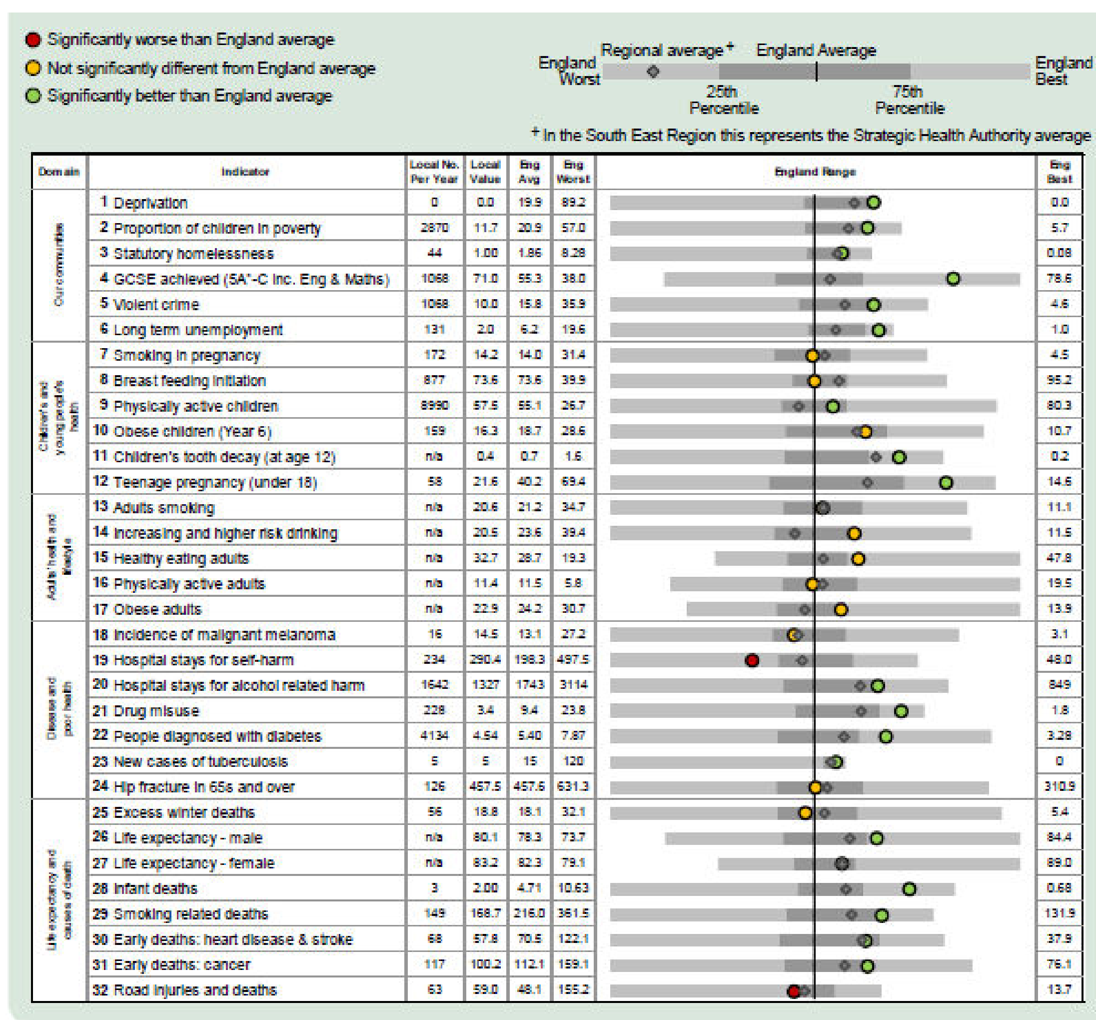
Tunbridge Wells



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Proportion of children in poverty	2870	11.7	20.9	57.0		5.7
	3 Statutory homelessness	44	1.00	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1068	71.0	55.3	38.0		78.6
	5 Violent crime	1068	10.0	15.8	35.9		4.6
	6 Long term unemployment	131	2.0	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	172	14.2	14.0	31.4		4.5
	8 Breast feeding initiation	877	73.6	73.6	39.9		95.2
	9 Physically active children	8990	57.5	55.1	26.7		80.3
	10 Obese children (Year 6)	159	16.3	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	58	21.6	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	20.6	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	20.5	23.6	39.4		11.5
	15 Healthy eating adults	n/a	32.7	28.7	19.3		47.8
	16 Physically active adults	n/a	11.4	11.5	5.8		19.5
	17 Obese adults	n/a	22.9	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	16	14.5	13.1	27.2		3.1
	19 Hospital stays for self-harm	234	290.4	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1642	1327	1743	3114		849
	21 Drug misuse	228	3.4	9.4	23.8		1.8
	22 People diagnosed with diabetes	4134	4.54	5.40	7.87		3.28
	23 New cases of tuberculosis	5	5	15	120		0
	24 Hip fracture in 65s and over	126	457.5	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	56	18.8	18.1	32.1		5.4
	26 Life expectancy - male	n/a	80.1	78.3	73.7		84.4
	27 Life expectancy - female	n/a	83.2	82.3	79.1		89.0
	28 Infant deaths	3	2.00	4.71	10.63		0.68
	29 Smoking related deaths	149	168.7	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	68	57.8	70.5	122.1		37.9
	31 Early deaths: cancer	117	100.2	112.1	159.1		76.1
	32 Road injuries and deaths	63	59.0	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

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Joint Strategic Needs Assessment 2011

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1. Background

JSNA is an ongoing process through the range of data, information and analysis about the health and wellbeing of Kent is collated, assessed and compared in order to present an understanding of the all the issues impacting on the population of Kent. Through this process we can gain a high level understanding of the inequalities and needs that exist within.

The JSNA is not a strategy and does not in itself offer any answers to the issues it presents. It provides some key priorities and makes recommendations on how action to address these should be taken forward.

It has the following purpose

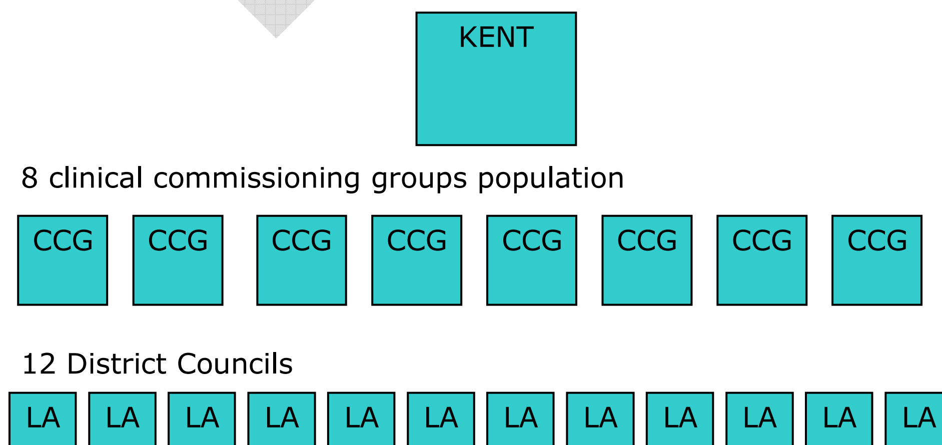
- To coordinate strategic direction, effort and resource commitment of the range of public, private and voluntary/community sector organisations that work to the common goals of improving health and well being for the population of Kent.
- To ensure that resources are focused on achieving maximum impact on improving the health and wellbeing of the people of Kent specifically targeting those who are in greatest need.
- To maintain a focus on health improvement and prevention and ensuring efficient use of available resources.
- To provide evidence of cost effectiveness and value for money

The Health and Wellbeing Strategy will provide the strategic direction for Kent.

1.1 Kent Approach

Kent is a two Tier County Authority, with 12 District Councils and 8 emerging Clinical Commissioning groups.

The JSNA needs to be relevant to a number of difference audiences to ensure a joined up approach to reducing health inequalities and address the Health and Social Care Needs of the population of Kent. Priorities and recommendations made at a Kent level should be relevant to both District Councils and Clinical Commissioning Groups.



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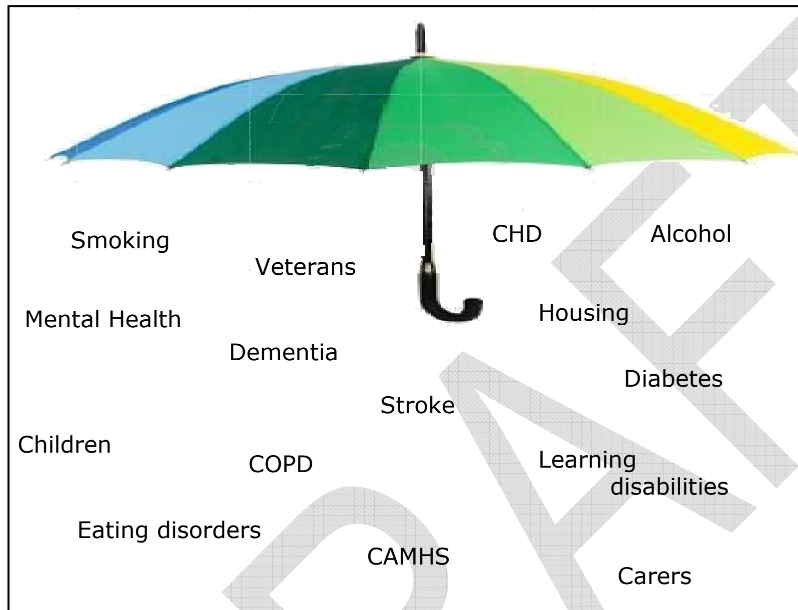
1.2 Phase 1

Kent has traditionally produced two JSNA documents, one for Adults and one for Children. The Adults JSNA was refreshed in July 2011 and the Children's update will be published in December 2011. These provide high level recommendations for improving the Health and Wellbeing of Kent. Executive summaries of a number of needs assessments were produced on a number of different topics. An executive summary contains the high level priorities for Kent, available at www.kmpho.nhs.uk/jsna.

The JSNA is an Umbrella of Needs Assessments



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The JSNA refresh focussed on **Quality Innovation Productivity and Prevention** (QIPP). The current economic situation requires NHS in Kent and Medway to deliver improved quality of care and productivity as per the Next Stage Review (NSR) Vision over the next five years. The total projected funding gap is £686m across K&M over the next five years (£270m in West Kent, £303m in East Kent) and with expected increases in both cost base and demand from our population.

- Three areas of savings have been identified:
  - Service improvement initiatives. e.g. pathway optimisation, to drive efficiency through commissioning expenditure
  - Commissioning lever initiatives to drive up quality and productivity gains e.g. through utilising to full effect contract levers and system management opportunities, PbR tariffs and primary care contracting
  - Transformational change initiatives at the whole system level e.g. prevention, self care, care closer to home, to deliver more effective and efficient services

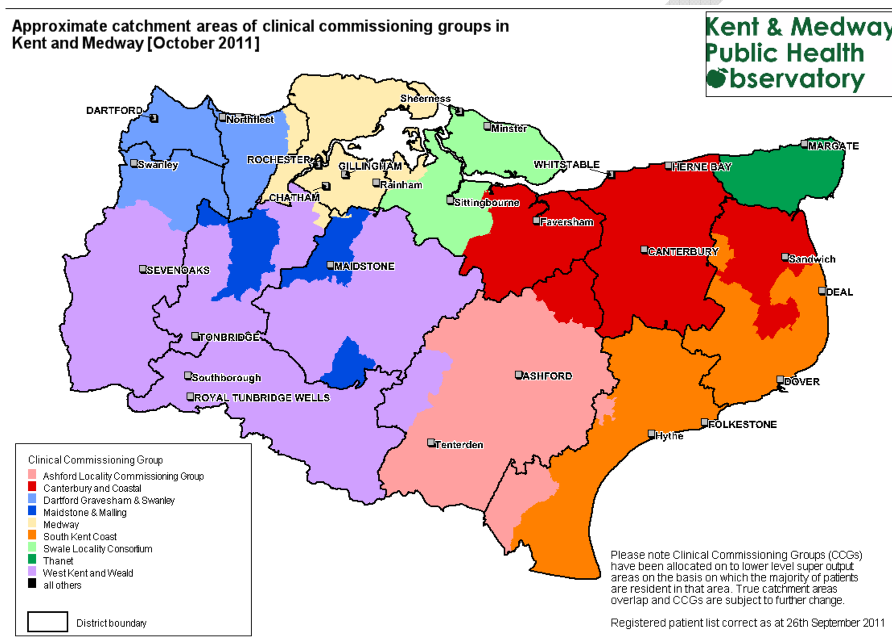
1.3 Phase 2

To develop a series of products that present the JSNA to a number of audiences at a level of granularity that is relevant to them. To ensure that we have the right products for our customers' consultation with Key stakeholders will need to take place, Appendix B is an example of a profile for Ashford.

1.4 Kent

As a County Kent generally has better health and social care outcomes than England. However the is significant variation across the districts. Thanet and Swale consistently have poor outcomes similar to other coastal towns.

Kent expands from the coast to the boundary of London and shares its borders with Surrey and Sussex. There are 12 districts within Kent and 8 emerging Clinical Commissioning groups, whose boundaries, as the following map shows are not co-terminus with districts. Kent CC is responsible for approximately 1.5 million people.



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2 Executive Summary

2.1 Important demographic issues

- The biggest population growth will be in the 65+ age group which is predicted to increase by 9.7% between 2012 and 2016 in Kent. There is significant variation across the districts ranging from a predicted population growth in the 65+ age group of 7.4% in Gravesham to 11.8% in Swale. However, there is the 0-4 age group is projected to grow very little in Kent ie. 0.1%. A predicted decrease in this group is predicted in Tunbridge Wells by 4.5% whereas growth in Dartford and Gravesham by 4.3% & 2.9% respectively.
- Parts of Kent are more ethnically diverse than others. The population of Kent was 94% white British in 2001 at the time of the last census. The Office of National Statistics estimates that in 2009 the population was 90.5% white British, with a relatively even growth across the other ethnic groups, including whites of non-British/non-Irish background. Local knowledge suggests that there has been an increase in populations from Eastern European countries such as Poland, data from the 2011 census will enable more discreet profiling of these communities. Gravesham district has the largest communities of BME groups approximately 13%, 7.1% from Asian communities.
- Latest QOF data indicates Swale, Shepway, Thanet and Dover districts having some of the highest prevalence for long term conditions.
- Kent County has better health outcomes when compared to England. However there is variation at district level with Dartford, Dover, Swale and Thanet consistently have higher all age all cause mortality rates than the other Kent Districts.
- The districts mentioned above experience some of the highest levels of deprivation and unemployment, within Kent. The greatest levels of unemployment are in the Thanet District with a rate of 5.8 compared to a rate of 3.9 for Great Britain.

2.2 Health Inequalities

- The Strategic Review of health Inequalities in England post 2010 (Marmot - Home page) starts with the wider determinants of health, stating that health is an interaction of what we are born with (our genetics), our lifestyle choices, the social and physical environments in which we live and health care services.
- Poverty exists all over Kent and Medway and is not confined to specific areas. Nevertheless there are major concentrations of deprivation in the boroughs of Dartford and Gravesham and throughout the coastal east of the county, interspersed with some localised areas of high affluence. The more consistently affluent parts of the county are to be found in Maidstone and the south west quarter of Kent.
- There has been an improvement in life expectancy for the intermediate quintiles of deprivation from 2000 – 2007. However for the most deprived, a pattern of divergence (a widening health gap) has continued throughout this period.

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- Analysis indicates that circulatory diseases contributes more towards life expectancy gaps across all district authorities compared to other long term conditions and diseases.
- The overall mortality gap between the richest and poorest in Kent and Medway is increasing over time with quintiles two to five converging upon each other but the most deprived quintile becoming increasingly orphaned.
- The framework also proposes that these influences accumulate across our lives. Some influences are protective and others present risks. Where risk outweighs protective factors, chronic disease, disability and mortality begin manifesting from around age 50.
- Latest results published in 2011 indicate that for 5 out of 10 social determinant and health outcome indicators, Kent County performed significantly better than the England average such as, male and female life expectancy, child development at age 5, young people in education, employment or training and households in receipt of benefits. The remaining 5 indicators were not significantly different from the England average.
- That cancer survival rates have improved and that survival rate has improved more for the lowest socio-economic groups. This is a product of the National Cancer Plan and the improvements to cancer services in Kent.
- Heart disease, respiratory disease and all age all cause mortality has improved for all socio-economic groups across Kent. However the rates of improvement are differential and the greatest improvements are in the most prosperous and middle range quintiles of the Kent population. Whilst there have been notable improvements in rates for the poorest, these have not been as notable as for the majority of Kent's population. Accordingly for these conditions, the health inequalities gap has continued to widen over the period 1999-2001 to 2008-10.

Recommendation

- To map where inequalities has improved in Kent and the possible contributing factors
- To map where inequalities has not improved and the contributing factors and action needed
- To map performance in Kent against the Marmot lifecourse approach
- A paper is being prepared for discussion at the Kent County Council January 2012

2.3 Lifestyles

2.3.1 Smoking

- In Kent, approximately 10,000 admissions each year are attributed to smoking £10 million and £12 million in West and East Kent respectively. A further £860,000 and £1.3 million are also attributed to annual outpatient costs.
- The national prevalence of smoking among adults dropped from 24% in 2005 to 21% in 2008. Smoking prevalence in Kent was higher than the

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national figure at 24.9% (or 281,300 in 2009), varying from 16% in Sevenoaks and 26.3% in Dartford. However this is expected to reduce in future in line with the downward trend nationally.
- However, the above are based on national synthetic estimates, so there is a need for more local data either through surveys or through an augmentation of the Annual Health Survey for England.
- The Stop Smoking service currently treats 2.2% of the local smoking population. This needs to increase to 5% or 14,000 smokers.

Recommendation

Further emphasis is required to concentrate on vulnerable / at risk groups such young people (especially 20-24 yrs old where prevalence is as high as 32%), pregnancy, mental health and prisoners. This will reduce NHS acute sector costs and long term conditions costs to health and social care.

2.3.2 Physical Activity, Diet and Obesity

- The annual estimated cost of treating diseases related to obesity across Kent was £187.7 million in 2007 and £203.3 million in 2010. This will rise to £233.5 million in 2015 if unchecked.
- There is an obvious strong correlation of social factors such as deprivation with lack of physical activity and poor diets leading to overweight and obesity.
- Recent data suggests areas with higher levels of deprivation such as Swale, Thanet, Dover and Dartford appear to have less physical activity levels than those in more affluent areas. Overall, Kent appears to have slightly lower physical activity levels than the rest of England (10% vs 11%)
- Similar trends are seen for obesity levels, where 25-30% of adult population in the same areas mentioned above, are obese compared to 20-25% in more affluent areas such as Tunbridge Wells. If those who are overweight are included, this makes up approximately 50% of the total adult population in Kent.
- The effects of obesity are considerable ranging from heart disease, diabetes, osteoarthritis and cancer, where high levels of unmet need pose a considerable burden on health care services.

Recommendation

A life course approach (as suggested by Marmot) incorporated within an integrated service model to healthy weight achievement and maintenance is imperative for success, spanning from antenatal programmes, breastfeeding, early years, healthy schools, to Change 4 Life, adult weight management and Tier 3 to 4 specialist services.

In this regard, Kent is developing the service model offering four tiers of service which range from a population approach to maintaining and achieving

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a Health Weight to surgical procedures to achieve dramatic weight loss for those patients with higher BMI's.

Consider the behavioural model on the healthy weight pathway.

2.3.4 Alcohol & Substance misuse

- It is estimated that excessive drinking accounts for 9.2% of disability-adjusted life years worldwide with only smoking and high blood pressure as higher risk factors. Alcohol related liver disease is now the 5th largest cause of death in the UK.
- The rates of all alcohol-related age standardised admissions is predicted rise further in Kent in line with national trends.
- There were 12,082 admissions to hospital through A&E for alcohol-related conditions in 2007-08 compared with 5,713 in 2002-03.
- The rates of drug misuse related admissions have fluctuated over the last 5 years roughly equating to 210 admissions per year in Kent.
- National guidance estimates that for every £6 spent on implementing identification and brief advice on alcohol harm reduction, could return savings to the NHS of £10 over four years.
- Recent analysis suggests that despite the large increase in numbers in treatment, there are an estimated 1,786 treatment Problem Drug Users who have not been in contact with structured treatment in the past two years.
- Alcohol is also the most commonly used substance among dual diagnosis clients with a substance misuse problems. Half of substance misuse service users are estimated to have mental health needs; this would equate to 982 people in 2010-2011 in alcohol structured treatment (dependent drinkers alone).
- A recent survey on young people's attitudes and behaviours indicated that a small proportion of underage drinking, smoking and substance misuse still exists in Kent stressing the need for further action is still needed such as strict enforcement of banning the sale of tobacco products to under 18s.
- Good, responsive services on referral will encourage more clinicians in all settings to use Alcohol Identification and Brief Advice intervention, which in itself acts as a successful treatment for increasing risk and higher risk drinkers.

Recommendation

Service redesign to a combined drug and alcohol treatment service should reflect the relative prevalence of need for drug and alcohol treatment. The need for alcohol services for dependent drinkers far outweighs the need for drug treatment services in Kent.

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2.3.5 Dental Health

Adults

- Twenty percent of adults in South East Coast have active tooth decay and 25% of older adults have severe gum disease, with 7% reporting pain.
- There is geographical inequality in uptake of primary care dental services and commissioned activity per population. Across Kent and Medway the dental activity commissioned ranged from 1.2 Units of Dental Activity per West Kent resident to 1.9 UDA per Medway resident. In the 24 months previous to 31 March 2011, the number of patients treated in West Kent represented 45% of the West Kent adult population compared to nearly 70% for Medway.
- Current population projections indicate high service need in future particularly for the elderly.
- National surveys provide data at the SHA level but there is a lack of local data.

Children

- Surveys carried out in 2007/08 and 2008/09 some 23.5% of 5-year-olds and 23.6% of 12-year-olds in Kent and Medway were estimated to have experience of tooth decay. Of those with experience of tooth decay, an average 2.8 decayed, missing and filled deciduous teeth (dmft) was reported for 5-year-olds and an average 2.0 decayed, missing and filled permanent teeth (DMFT) for 12-year-olds (Figure 2). Although lower in prevalence and severity when compared to the regional (South East Coast SHA) and national average, geographical variations in the experience of tooth decay within Kent and Medway are clearly evident..

<u>Recommendation</u>

Adults
A review of specialist dental services is required. For example, there are no sedation services in West Kent and domiciliary services need to expand their provision.

A targeted approach to health promotion initiatives is required particularly in the elderly.

Children
Further information required such as survey of dental health of under 5 year old, as well as a coordinated approach involving primary care dental services to focus on prevention in line with *Delivering Better Oral Health – a toolkit for prevention* by Department of Health

2.4 Children

2.4.1 Early Years

- What happens in the early years of a child's life is crucial for later life development. Research on brain development shows that its structure is formed by experience in the first few years of life (and more

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particularly the first few months). Early interaction between babies and their carers have implications for brain development. The quality of these relationships has profound implications for a child's emotional and cognitive development as well as for future mental health.
- The secure child is more likely to do well at school, form satisfying relationships, develop a capacity for compassion and empathy and have inherent resilience in the face of misfortune. Children who experience poor relationships in their early years with adults who care for them, have a greater likelihood of developing significant mental health problems, conduct disorder and educational difficulties.

Recommendation

Universal programmes (e.g. baby massage, the Solihull approach, the neo-natal behavioural assessment scale [NBAS], the Family Partnership model) are primarily concerned with the promotion of infant mental health. Targeted programmes, e.g. Family Nurse Partnership and health visiting practise must be provided to families at risk of poor outcomes due to a range of social dysfunction or psychological pressures.

2.4.2 Breastfeeding

- Breast feeding is not being sustained into the early months of infancy for a large number of children. However there has been a welcome increase in rates of breast feeding in east Kent over the last three years, the position in west Kent being unchanged.
- Nine out of 10 women who stop before week six are reported as saying that they wished to have breast fed for longer. The fastest drop-off in breast feeding rates happens within the first four days of birth (12%). A third of women have stopped breast feeding by week six so that only 50% of babies get any breast milk at this stage. By six months only 26% of babies continue to be breast fed.
- Support to mothers breast feeding should be commissioned according to the stated evidence base and the number of mothers breast feeding needs to be substantially increased in all parts of Kent.

2.4.3 Immunisation and Vaccination

- The percentage of children being immunised in accordance with the national vaccination and immunisation schedule by the age of one, is broadly lower than the national and indeed SHA figure in East Kent.
- To improve the east Kent performance a National Support Team (NST) has reviewed local practice and made 29 detailed recommendations as part of a strategy to improve vaccination and immunisation, which inevitably focuses upon children and young people.
- By the second birthday, the overall percentage of children immunised in Kent is better than the England average and the SHA average with the exception of Men C.
- The MMR rate in Kent whilst recovering is not at the 95% level recorded by the WHO as being necessary to prevent an outbreak requiring further public campaigns to bolster the uptake rates.

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- HPV vaccination uptake has recorded varying levels (for each of the three scheduled doses) across Kent and Medway in comparison regionally and nationally.

Recommendation

Immunisation performance to be improved through the sustained implementation in primary care of the National Support Team recommendations.

MMR targeted initiatives to ensure a pattern of optimised take-up of MMR vaccination across Kent.

HPV targeted initiatives to ensure a pattern of optimised take-up of HPV vaccination across Kent.

2.4.4 Children's Centres

- The results from the later evaluations of the National Sure Start Programme (NESS) have shown that this programme produces positive results. However the programme needs to be sustained for a number of years more to demonstrate robust results which are statistically reliable.
- Children's centres need to bring the benefits of joined-up play groups, healthcare and parenting support to the local population that they serve. They should be a hub for the local communities that they serve.
- Universal services (health, social care and third sector provided) need to be maintained in children's centres. The services provided by children's centres should be evidence based, practitioners should be highly skilled and there should be a continued commitment to support families' economic wellbeing and financial independence.
- Health visitors should work from children's centres, thereby focusing on early intervention, prevention and health promotion in a setting where they can have the greatest impact. In this regard health visitor practise should reflect a detailed knowledge of the communities in which they work and with other professionals and agencies both statutory and voluntary. Health visitors should use the capacity of children's centres to deliver intensive programmes for the most vulnerable children and families.

Recommendation

A balanced range of services from health, social care and the third sector should be provided from children's centres. The current focus from social care excessively focuses on families in need. Health services are universal and offered to children and families as of right. To enable the health service offer within children's centres attractive, the role of children's centres should be broadly based and all services (regardless of commissioner) should not just be targeted on the needs of vulnerable families.

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2.4.5 Parenting

- The relationship between infants and parents or primary caregivers is critical to the child's emotional, psychological and cognitive development. Developmental and behavioural problems – often continuing into later life – most commonly arise from disturbances in that relationship.
- Historical impact of Sure Start programmes have yielded mixed results in terms of developmental trajectories of young children. Recent results of Sure Start Local Programmes showed children displaying more positive social behaviour and greater independence and their parents less negative parenting and a better home environment.
- However there are concerns have arisen relating to the extent of local boards running these services, their provision of child care services and most importantly, the long term funding.

Recommendation

Agencies in Kent should maintain their commitment of differential funding to first wave Sure Start Children's Centres on the basis that these have been set up as targeted resources in areas of the county identified as being in greatest need. This is a proper application of the principles of equity.

2.4.6 Childhood obesity

- The National Child Measurement Programme indicates fluctuating levels of obesity in Year R but a steady increase in prevalence in Year 6 from 2007 – 2010, in Kent.
- In 2009/10 the percentage of children in year 6 who were classed as overweight or obese in Kent was 32.9%, ranging from 29.5% in Sevenoaks to 37.9% in Dartford.

Recommendation

Obesity services and healthy eating interventions children should be commissioned based on national and international evidence such as treatment programmes to assist changes in child and family behaviour, social marketing techniques promoting healthy lifestyles, systematic collection of local data, etc.

Substantial investment in programmes to address obesity in children and young people in Kent should be made covering:

- A focus in early years and school settings that fosters a healthy environment, including the provision of active help for children at risk of becoming overweight;
- Support treatment programmes to assist changes in child and family behaviour towards maintaining a healthy weight;
- The appraisal of the potential of social marketing techniques to communicate simple and positive messages about healthy lifestyles;

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- The provision of appropriate workforce training and the development of a targeted evidence of what works specifically as regards children and young people;
- The systematic collection of local data;
- An action-learning approach to treatment interventions.

2.4.7 Avoidable injury

- Road accidents involving children are more scattered than those involving adults with an obvious relationship to the roads near home.
- While the numbers of road casualties have decreased across all District Authorities over the last 15 years, Thanet and Maidstone still appear to have relatively higher number of casualties than the rest.

Recommendation

Multi-agency initiatives in Kent to reduce accidents whether on the road or at home and in leisure facilities should continue. Transport planners, road safety experts as well as other local authority officials need to have greater ownership of this agenda.

2.4.8 Children in care

- Kent continues to have a higher proportion of looked after children who are aged 16 and over than the national figure but a smaller proportion of looked after children aged under 10 years old.
- There is an increased proportion of white looked after children from 2009 to 2010 with the proportion of Asian or Asian British looked after children falling, but this does not match the national picture which has stayed static since 2009.

Recommendation

The 2010 OFSTED review highlighted the inadequate child safeguards and protection arrangements as well as lack of robust quality assurance and performance management systems, and has suggested a number of recommendations including a review of the current caseload, workforce capacity, and improving the quality and timeliness of assessment process.

All agencies need to be mindful of the continuing need to support young carers and young carers projects. KCC's strategy 'Invisible People: A multi-agency strategy for young carers in Kent' should continue to be implemented.

All agencies but in particular KDAAT, need to focus on the specific needs of children whose health and development are frequently compromised through alcohol and substance misuse by parents.

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2.4.9 Domestic Abuse

- In Kent there are very few services specifically for children affected by Domestic abuse. Services which raise awareness, change attitudes, allow an environment where people are comfortable making disclosures, and provide early interventions which prevent problems from escalating can all be described as Preventative. The majority of prevention services are universal and provided by statutory services, such as health and education.

Recommendation

The framework of domestic abuse services across the County has been grown and largely sustained through the third sector. In consequence accessibility to services varies across the County. The Kent Ambition Board Two Tackling Disadvantage should promote a County-wide framework for these services and promote sustained funding solutions to enable the voluntary sector to continue to provide appropriate interventions for people who suffer domestic abuse. In this regard it is important to recognise that the true level of need is grossly under-estimated and will take some years to establish.

2.4.10 Teenage Pregnancy

- National guidance estimates that for every £1 invested in contraception saves the NHS £11 plus additional welfare costs, which is a powerful economic argument for maintaining contraceptive services.
- In Kent the teenage pregnancy rate is 34.7 per 1000 females 15-17 years (2009) which compares favorably to an England rate of 38.
- Thanet has the highest level of teenage conceptions within Kent (53.6 per 1,000 females aged 13-17).
- Rates have reduced by 18% from a baseline of 1998 similar to the national trend.
- However there is still significant variation in progress to rate reduction such as in Maidstone where there has been a 10% rise with a strong association to deprivation.
- There is a significant lack of information concerning particular at risk groups such as BME, young fathers, looked after children, young offenders where more detailed needs assessments should be carried out.
- Dartford, Maidstone and Sevenoaks are the districts with the highest rates of termination of pregnancy in this age group. However, there is only service provider operating from Maidstone for the whole county and so there is a need to offer termination services elsewhere.
- There is also disparity in the number of sites offering LARC (long acting reversible contraception) as mentioned in the recommendations for Sexual Health improvement.
- Apart from the above, the teenage Pregnancy Action plan also links in with other partners, services and strategies such as Children Centres, Relationship and Sex Education in schools, etc.

Recommendation

Unlike some other counties, Kent has retained a Teenage Pregnancy Co-ordinator and a County-wide framework of district-based Teenage Pregnancy Groups. This framework must continue to be sustained as must the programme of planned reductions in rates. Teenage pregnancy whilst complex, is significantly a product of lack of aspiration. The risks to the programme of planned reduction through the lack of prospects for many young people at present places the success of this programme at particular risk.

Termination services should be re-tendered for to allow for ease of access across the County. The current base of Maidstone disadvantages young people faced with this dilemma living in east Kent. A model that has two bases that serve respectively east and west Kent needs would improve access and raise termination rates.

2.5 Adults

2.5.1 Long term conditions

- COPD - QOF recorded prevalence is approximately 2% with another 1% undiagnosed totalling to over 35,000 patients in Kent. Generally there are more undiagnosed cases in the west of Kent, taking into account the undiagnosed patients east Kent still has a higher prevalence, linked to deprivation, but mortality rates are slightly higher in East Kent, at around 27% and more than the England average.
- CVD – Prevalence is expected to increase by at least 0.6% over the next ten years to 2020, with East Kent having a consistent prevalence of 1% higher than West Kent. Swale, Thanet, Shepway and Dover appear to have relatively higher mortality rates compared to the other districts in Kent. This will have profound effects on access and demand for cardiac services for surgical treatment, revascularisation and rehabilitation.
- Diabetes – the age adjusted prevalence of Diabetes has increased slightly from 5.4% to 5.7% in Kent. Eighty six percent of the diabetics are Type 2 while the rest are either Type 1 or other rare forms. Greater emphasis on obesity prevention is essential for prevention of Type 2 diabetes. Therefore greater service integration is required with the Kent Healthy Weight Care Pathway for Adults and Children right through to specialist diabetes services.
- Cancer – While there has been increase in incidence of some cancers such as breast, skin and prostate, lung cancer continues to have the lowest survival rates because of high proportion of late stage presentations, emphasising the important of increasing public awareness of signs and symptoms encouraging early presentation in primary care, as mentioned in the national Cancer reform strategy. Innovation in delivery of appropriate care is also of emerging importance with examples such provision of laparoscopic surgery, Enhanced Recovery after Surgery and systematic approach to chemotherapy pricing.

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Recommendation

Greater emphasis on obesity prevention is essential for prevention of Type 2 diabetes. Therefore greater service integration is required with the Kent Healthy Weight Care Pathway for Adults and Children right through to specialist diabetes services.

Earlier diagnosis of diabetes using NHS health checks.

2.5.2 Screening

- Current screening programmes in Kent are for the prevention of most prevalent cancers, abdominal aortic aneurysm, Chlamydia, diabetic retinopathy, neonatal and antenatal screening programmes and more recently, vascular health checks.
- Kent and Medway is achieving the national standard for cervical and breast cancer screening but there is still variation between the different regions.
- There has been more than a 50% uptake in Bowel Cancer screening in 2010 with plans to extend the screening age up to 75 years.
- Programme boards are being set up in Kent and Medway for Abdominal Aortic Aneurysm and Diabetic Retinopathy screening to monitor performance and analyse variation in uptake.
- All Trusts are now carrying out 1st trimester combined testing as part of the fetal anomaly screening programme.
- Two Acute Trusts – Darent Valley Hospital and Medway Foundation Trust were recently recommended to move to High Prevalence status for Sickle Cell Screening.
- Vascular health checks are to be provided to people between 40 and 74 years across Kent. With full roll out, approximately 19,000 checks are to be delivered across Kent on an annual basis.

2.5.3 Dementia

- The current prevalence (based on national estimates) is approximately 1.36% and 1.18% for Eastern & Coastal Kent and West Kent respectively equating to a combined prevalence of 1.28%, far higher than the General Practice recorded prevalence of 0.49%. This equates to approximately 17,400 people in 2006 rising to 30,100 in 2026.
- Shepway, Sevenoaks, Tunbridge Wells, Tonbridge and Swale are district authorities with greater growth of dementia patients.
- One third of patients live in care homes as well as high risk groups such as learning disabilities and ethnic minorities.
- The QIPP work plan has outlined a number of initiatives which allow better partnership working and service integration such as crisis resolution, domiciliary care, advocacy, awareness raising, specialist memory assessment, integrated case management, etc.

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Recommendation

Move to a social model of care for people with Dementia and map the cost of the current system and map the change in costs as care moves to the community.

Significant shift in hospital to community care and costs can be made.

Agree a dementia pathway with all clinicians on the pathway and monitor its implementation

Earlier diagnosis of Dementia by GPs to a prevalence that is expected in Kent so services can be offered earlier and not in a crisis situation.

2.5.4 Falls and Fractures

- There has been a 53% increase in falls related hospital admissions in West Kent compared to 30% in East Kent over the last 5 years. Almost 65% of these admissions resulted in no fracture and / or injury. The cause of the fall is more often related to medical and social reasons such as UTIs, dementia, pneumonia.
- The 2010 national falls and bone health audit showed considerable variation in access and availability of minimum standards of care across the community and acute Trusts in Kent, particularly secondary falls prevention and bone health assessment including home hazard assessment. However it may be noted that ECKHT performs relatively better than MTW and DVH on some of the indicators including the above mentioned.
- Discussions have already under way in West Kent to implement, step by step, a five point integrated action plan consisting of hospital and primary care based fracture liaison services, integrated elderly care rapid access clinics including specialist assessment for falls and osteoporosis, community based therapeutic exercises and falls call out response services.

2.5.5 Mental Health

- The data that is currently available, together with national models of need suggest that people in Kent have a little less degree of mental health 'need' compared to the England average. However Kent is a large County with significant local variation and the mental health needs vary according to socio economic status, variations in local well-being resources and access to timely services making equity audit essential.
- People with poor mental health also experience poor physical health and reduced life expectancy. There is a need to improve physical healthcare provision for those individuals with chronic mental illness, offering health checks to people with mental health problems is important.
- Equity Audits in the provision and access to community mental health teams and psychological therapies is a priority in Kent.
- Promoting positive mental wellbeing will require a partnership approach that cuts across a number of agendas, to effectively tackle the factors that

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can impact on an individual's mental wellbeing e.g improving community cohesion and 'social capital'.

- There are currently gaps in service provision to need in dual diagnosis (alcohol and mental health), transition services between child and adult mental health services, services tackling maternal depression and maternal mental illness, older people's mental health (excluding dementia) and eating disorders, personality disorders, offenders in the community and veterans. Many of these issues are being tackled in the current commissioning intentions for 2011 and 2012.
- The mental health needs of Black and minority ethnic communities and high-risk groups, such as offenders and asylum seekers/refugees need to be better understood to ensure appropriate service provision in Kent.
- Further needs analysis, assessment and targeting of older people (excluding dementia) are needed.
- Of Kent's population of adults with severe and enduring mental health problems, only 8% are in employment, improving the employment prospects of people with mental health problems is important.

What is Currently Happening in Kent to Improve Mental Well Being and Mental Health of Adults in Kent.

- There is a comprehensive strategy and commitment to tackle Mental Well Being in partnership between the Council, Voluntary Sector and NHS. This is called "Live it Well" http://www.liveitwell.org.uk/
- There is an accessible website of information which is being updated regularly to provide help and information to the public. There is a plan to provide information in other accessible formats too in 2012.
- There is an East Kent and West Kent Mental Well Being Strategy. These are plans and commitments of many agencies working together to raise the awareness of mental well being. In 2012 these will be united and updated.
- The NHS and the Council will work together with the voluntary sector to publicise campaigns to reduce stigma and improve awareness of well being.
- The Kent Public Health team are working with NHS and Council commissioners to provide better analysis and information to improve equity of service use e.g. liaison psychiatry, community mental health and primary care mental health services.
- The Kent Public health team with its partners are implanting a series of well being initiatives such as Change 4 Life, Health Trainers, Healthy Living Pharmacies, Active Mobs and Well Being Impact Assessment – all of which have an impact on well being.
- There is a systematic approach led by Kent council and Kent Police - to improving awareness and service access for people suffering domestic violence.
- There is a comprehensive commissioning plan set out in the 'Live it Well' commitments and is described below.
- There are community development workers working alongside a voluntary organisation in Kent and Medway to improve equity and access for people in vulnerable and minority groups.

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- There is a focus on the mental health of ex military service people (Veterans) and an initiative to improve mental health services for them is underway.

Recommendation

- Refresh the data collected in the 2009 Mental Health Needs Assessment and evaluate performance using service outcome measures.
- Ensure services are commissioned that are accessible to all, including those at highest risk, have an emphasis on promoting recovery, and consider an individual's physical health needs as well as their mental health needs.
- Promote equity at the heart of the "Live it Well" strategy.
- Commission initiatives that address the employment and accommodation needs of adults with mental health problems and evaluate their success.
- Develop a strategic approach to improve the mental well-being of Kent County that also addresses the broader determinants of mental health and can measure the impact of changes to well being.
- Scrutinise and assess the needs and care of the elderly people in mental health services.
- Implement actions from the **Strategy for the reduction and prevention of suicide in Kent 2010-2015**
- Improve the mental health outcomes of veterans and ex-offenders in the community.

Older People's Mental Health

- Work with all Commissioners to redesign the OPMHN/Dementia Care Pathways, ensuring services are more community/primary care focussed, integrated with community health services and collaborating to support the private and voluntary sectors
- Review the role of day treatment services in east Kent
- Decrease acute in-patient mental health capacity by 15 beds in east Kent
- Review all KMPT OPMHN inpatient units, including continuing healthcare, to assure best value for money; and undertake benchmarking market development exercise with independent sector
- Explore and develop models of integration in acute (non mental health) care or primary care; for case management, and joint working between intermediate care, acute and community services – resulting in fewer general hospital admissions for people with dementia.

Learning Disabled Mental Health

- Analyse data to inform a needs assessment that in turn allows design of an options appraisal for the future commissioning of in-patient services for people with learning disability and mental health needs
- Analysis of demand, activity and costs of the service to consider whether contracted bed numbers should be reduced to allow investment in learning disability community forensic services
- Commission additional nursing posts in support of the community mental health of learning disability service.

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2.5.6 Learning Disabilities

- People with learning disabilities (LD) have a wide range of social and health care needs depending on the severity of their condition.
- The latest estimated prevalence for LD in Kent by reference to QOF data is approximately 0.3%, with higher rates recorded in Dover, Thanet and Shepway.
- However, this appears to underestimate the prevalence estimates from the national epidemiological literature considerably, by up to 3% of the population. This implies a important training need particularly around specialist assessment, diagnosis and chronic disease management to improve recording of prevalence.
- As of January 2009 an estimated 29,000 primary and secondary school children in Kent have been identified with a disability requiring Special Educational Needs. The Aiming High for Disabled Children programme aims to improve services by local focus on improved access, parent / carer support, social networks and information.
- The majority of learning disability cases are due to genetic factors.
- Over the last few years, there has been a change in need and people with learning disabilities are choosing to live more independently, seeing a shift away from residential care, to more community based, flexible services to meet individual person centred plans.

<u>Recommendation</u>

Continue to support the Aiming High for Disabled Children programme which aims to improve services by local focus on improved access, parent / carer support, social networks and information.

2.5.7 Sexually Transmitted Infections

- The England average rate is approximately 775 diagnoses per 100,000 population whereas NHS Eastern and Coastal Kent and NHS West Kent are much lower at 573 and 519 per 100,000 respectively. Genital Warts, Chlamydia and non specific genital infections make up the majority proportion of STIs diagnosed.
- For Chlamydia, the female age group 16-19 yrs appears to be at the highest risk across Kent among the other age groups, in line with national trends.
- However late of HIV appears to be a problem particularly for West Kent with 55%, compared to approximately 20% in East Kent.
- Projections estimate a 23% and 28% increase in first attendances for GUM clinics for East and West Kent respectively.

<u>Recommendation</u>

More work is still required to map, integrate and improve uptake of sexual health services like Chlamydia testing and long acting reversible contraception.

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2.5.8 Offender Health

- There is a high rate of non-attendance at appointments offered within healthcare at some prisons in Kent such as refusal of psychological interventions associated with the Integrated Drug Treatment System (IDTS) and low uptake of Hepatitis B vaccination, coupled with high rates of smoking and hazardous drinking.

Recommendation

- Development of clear pathways and referral processes that enable offenders currently in as well as leaving custody to access community drug and alcohol services and other health care services including health checks.

2.5.9 Excess Winter Deaths

- There is considerable variation between the different districts in Kent; with Canterbury has the highest excess winter death ratio (ie. Winter vs summer), followed by Maidstone and Dover having the lowest ratio. Most of the local authority districts have ratios that are relatively close to the Kent average.
- There is a service gap in terms of the link between primary care and those able to offer support to the people most vulnerable from poor health outcomes due to cold temperatures.
- A number of pilots have been suggested or implemented such as GP practice winter warmth referral, which, if successful, should be rolled out to other areas.

2.6 Other important QIPP work streams

2.6.1 Urgent care

National evidence shows almost a 12% rise in unscheduled care activity from 2004 to 2009 attributed to a number of factors such as population age distribution changes (towards more elderly), central policy initiatives like 4 hour A&E waiting targets and advances in clinical practice leading lower threshold for decision to admit. In Kent, due to a variation in quality and practice of submission of non elective data across different local provider trust organisations, non elective activity cannot be accurately described. However, there is clear evidence indicating conversion rates from attendance to admissions are increasing steadily with age. Non-elective admission rates for ACS conditions such as COPD are also consistently higher in East Kent than West Kent.

2.6.2 End of Life Care

Both NHS West Kent and Eastern and Coastal Kent have signed up to the national Dying Matters Coalition, which seeks to raise awareness of death, dying and bereavement, and to encourage early discussion and planning. Development work must be underpinned by analysis and evidence of local need, both now and in the future. Currently there are no precise indicators or measures that can accurately measure the end of life care need and activity.

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Some proxy measures that have been used such as proportion of patients dying at home which is approximately around 35 to 40%, implying the need for further research and development around this.

2.6.3 Maternity and Babies

The population of women of a childbearing age is projected to increase in the Dartford and Gravesham Local Authority areas (~9% over ten years), and to a lesser extent in the Ashford, Canterbury and Sevenoaks areas (~1-2%), although overall the population of women of a childbearing age in Kent is projected to decrease slightly. East Kent has consistently higher infant mortality rate compared to West Kent but not significantly different from the England average. Focus on new tests such as fetal fibronectin to predict preterm labour and development of robust indicators to monitor variation in caesarean section activity across provider organisation has been recommended.

2.6.4 Planned Care

First appointment follow up ratios for outpatient activity are consistently higher in cancer specialties like oncology and haematology. Total elective care activity in consistently higher for East Kent compared to West Kent till 2009/10. For example, skin lesion procedures have increased by 82% in East Kent over the last five years compared to just 6% in West Kent. It is unclear to what extent this difference in activity reflects unmet need, variation in clinical practice or other factors. A number of demand management initiatives have already been suggested such as Enhanced Quality Programme for hip and knee replacements, review of high risk low gain procedures, cataract pathway redesign, teledermatology triage for skin conditions, etc.

2.7 Social factors

2.7.1 Housing and homelessness

- The estimated shortfall in affordable housing far exceeds what will be delivered through new supply. Collectively, the housing need assessments that have been undertaken across the County would suggest that there is an annual need for almost 12,000 additional affordable homes.
- Shortfall in housing varied in Kent partly due to percentage and absolute growth in population in each of different areas.

2.7.2 Carers

- Current estimations show that one in ten people in the UK is a carer; the percentage in Kent is even higher, on average 12.58 per cent, rising to 14 per cent in Thanet. Based on the 2008 Mid Year Population Estimates, which is the latest government dataset, there is now an estimated 139,500 carers in Kent.
- A number of wider determinants and factors influence the background of the carers as well as intensity of care, in a community such as area deprivation, age, whether from ethnic minorities, as well as the physical or

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mental health problems of the persons receiving care, particularly dementia.

- The 2001 census indicates higher proportion of older age carers, starting from children aged 10 years and peaking between 50 to 60 years of age for both males and females.
- A recent survey describes a correlation between age of carers, hours spent on caring and decline in carer health.
- Due to the lack of more recent data, there is a need to update the full extent of carers in Kent particularly unknown carers who have yet to self declare their role, possibly through the use of MOSAIC analysis.

2.7.3 Community Pharmacies

- All PCTs in England are required to publish a Pharmaceutical Needs Assessment. These will be used to determine future applications to provide access to new pharmaceutical and dispensing services will be approved.
- In West Kent dispensing services are provided by 113 pharmacies and 32 dispensing practices of which six were '100 hours' pharmacies situated relatively evenly across the six localities. Consultation showed that this level of access to extended hours is the minimum needed; any reduction in the opening hours of those pharmacies would create a gap in service provision.
- In East Kent, consultation indicated access to pharmaceutical services beyond the normal pharmacy contractual hours of 40 hours per week. Thus '100 hour' pharmacies are not allowed and those pharmacies with 100 hour contracts are to reduced to a 40 hour contract. Consultation shows the need for 100 hour contract provision on the Isle of Sheppey and in the town of Dover. East Kent consultation showed that there was a need for better understanding of the access to enhanced services such as emergency contraception provided by pharmacies and other contractors.
- Training of pharmacists and their staff in preventive health is required in order to work towards the development of pharmacies delivering 'Healthy Living Centre' functions in conjunction with other providers.

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3 Ashford Locality Group

3.1 Demographics

Ashford locality commissioning group is made up of 16 practices. 15 of the practices are located within the district boundary of Ashford and 1 is located within the district boundary of Shepway.

3.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 122,599[1] people are registered to practices within ALG this is 8% of the total registered practice population for Kent.
- The population age and sex structure is similar to that for the total Kent and Medway registered population.
- There are slightly more people registered between the ages 40 and 49 and slightly fewer aged between 20 and 39.
- Using data for Ashford District, the population is projected to increase by 6% over the next 5 years[2] and 13% over the next 10 years. The greatest population growth is in the 65+ (18%) and 85+ (17%) age groups.
- Kent as a county has a predominately white population estimated at 92% in 2009. The proportion of the population from Ashford from a BME community is estimated to be 6.7%, .
- Life expectancy for ALG is 82 years compared to 80.9 for Kent and Medway. The difference in life expectancy for wards is 13.1 years the lowest life expectancy is within St Michaels ward.

As the population ages more people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes. Dementia is predicted to be a significant issue.

3.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates most deprived.

- Ashford is ranked 198 out of 326 local authorities, and 8 of the 12 Kent districts.
- 5.7% of Ashford lower level super out put areas are in the 20% most deprived for England.
- The highest levels of deprivation are found within Stanhope, Aylesford Green and Victoria, in an around Ashford town centre.

[1] PCIS registered practices populations September 2011
[2] ONS 2008-Based population projections 2011-2016, 2011-2021

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3.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the environment in which the population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been seen to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The rate of unemployment within Ashford district is 2.6% [September 2011] lower than Kent (3.2%) and well below the level for the UK (3.9%).
- Unemployment in Ashford has increased by 10% since the September period 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed 30.5%. The rate for Kent 31.5%.
- 53.1% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 3.96% of households within Ashford are classified as statutory homeless; this is significantly higher than England (1.86%)

3.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Ashford (27%) is significantly higher than England (24.2%)
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males. There was a slight reduction in admissions to hospital for females between 2009/10 and 2010/11.

Children

- There are significantly fewer physically active children in Ashford (52.3%) compared to England (55.1%)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)

3.6 Health Issues

Prevalence

- The 2010/11 disease registers show that the population of ALG have a higher prevalence for hypertension, depression, obesity and Atrial Fibrillation, than England. Assessing variation at a practice level will enable the CCG to target resources.

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Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care.

- ALG has higher emergency admissions rates for Diabetes and Stroke, than Kent and Medway
- COPD emergency admission rates are lower than Kent and Medway, however the trend shows that admissions are increasing.
- Emergency admission rates for Dementia are the lowest of all the CCGs. The trend shows an increase in Dementia emergency admissions but at a slower rate than Kent and Medway.

Mortality

- 77% of all deaths are from three main diseases: Circulatory disease (34.1% of all deaths), Cancer (29.4% of all deaths) and respiratory disease (13.5% of all deaths).
    - Mortality rate from Circulatory disease (Coronary Heart disease and Stroke) have been steadily declining since 1995, and the rate of premature mortality is lower than that of England. The same can be said for Cancer.

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4 Canterbury and Coastal

4.1 Demographics

Canterbury and Coastal CCG consists of 23 practices, the majority of which (16) are located within the district boundary of Canterbury, four practices are located in Faversham within Swale District and the remaining three are located within Dover district.

4.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 211,651 people are registered with practices within C&C this is 14% of the total registered practice population for Kent.
- The population age and sex structure differs from that for Kent and Medway. Canterbury is a university town and has a larger number of people aged between 15 and 29.
- Using data for Canterbury District, the population is projected to increase by 4% over the next 5 years[3] and 8% over the next 10 years. The greatest population growth is in the 65+ (14%) and 85+ (11%) age groups.

The population group aged 15 to 29 is less likely to require social care services. Health promotion and lifestyle issues are key for this age group as they are likely to smoke, go out drinking and experiment with drugs. Sexual health services will also be a priority for this group.

4.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates most deprived.

- Canterbury is ranked 166 out of 326 local authorities, and is ranked 6 of the 12 Kent districts.
- 8.9% of Canterbury's lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Gorrell, Heron and Wincheap.

4.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the environment in which populations live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of

[3] ONS 2008-Based population projections 2011-2016, 2011-2021

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people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Canterbury district is 2.3%, lower than Kent (3.2%) and considerably lower than the level for the UK (3.9%)
- Unemployment in Canterbury has increased by 12.3% since the same period 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed 33.4%. The rate for Kent 31.5%.
- 53.7% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 0.77% of households within Canterbury are classified as statutory homeless; this is significantly lower than England (1.86%)

4.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of smoking, obesity, physical activity and healthy eating are all similar to the rates for England.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males.

Children

- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)

4.6 Health Issues

Prevalence

- The 2010/11 disease registers show that the population of Canterbury and Coastal populations have a similar prevalence of diseases to that for England. With slightly greater proportion on the stroke register.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care.

- Canterbury and Costal have higher emergency admission rates for Dementia, CHD and COPD. The trend for each of these conditions is increasing.
- Cancer emergency admissions rates are lower than Kent and Medway and continue to decline.
- Significantly higher hospital admission rate due to self harm than England.

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Mortality

- 77.2% of all deaths are from three main diseases: Circulatory disease (37.2% of all deaths), Cancer (27.1% of all deaths) and respiratory disease (12.9% of all deaths).
    - Mortality rate from Circulatory disease (Coronary Heart disease and Stroke) have been steadily declining since 1995, and the rate of premature mortality is lower than that of England. The same can be said for Cancer

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5 Dartford, Gravesham and Swanley

5.1 Demographics

There are 39 practices within the Dartford, Gravesham and Swanley CCG. These are located within the three districts of Dartford (16), Gravesham (16) and Sevenoaks (7).

5.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 249,935 people are registered with a practice in DGS CCGs. This is 17% of the total registered practice population for Kent.
- DGS is the second largest of the CCG, West Kent and Weald is bigger with 53 practices and 25% of the total registered Kent population.
- Combining data for Dartford and Gravesham, the population is projected to increase by 5% over the next 5 years and 11% over the next 10 years. The biggest population growth is In the 65+ (13%) and the 85+ (26%) age groups.
- Dartford and Gravesham account for just over 23% (24,900) of the total Kent County's BME population (108,000).

5.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Dartford is ranked 175 and Gravesham is ranked 142 out of 326 local authorities. Dartford is ranked 7 and Gravesham 5 of the 12 Kent districts.
- 5.2% of Dartford's and 12.7% of Gravesham's lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within, Littlebrook Joyce Green and Princes (Dartford), Singlewell, Northfleet North and Central (Gravesham).

5.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the environment in which populations live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

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- The level of unemployment within Dartford is 3.2% and Gravesham 4.2%. The rate for Kent is 3.2%.
- Unemployment in Dartford has increased by 8.1% and for Gravesham 20.2% since September 2010. The increase for Kent 13.6%.
- 18-24s make up the biggest proportion of unemployed (Dartford 31.9%, Gravesham 32.1%). The rate for Kent is 31.5%.
- 63.1% of children in Dartford (Significantly better) and 54.2% of Children in Gravesham achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 2.63% of households within Dartford (Significantly worse) and 1.83% of households in Gravesham are classified as statutory homeless; this is significantly lower than England (1.86%)

5.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Dartford (28.2%) and Gravesham (28.5%) is significantly higher than England (24.2%)
- There are significantly fewer physically active adults in Dartford (8.6%) compared to England (11.5%). The rate for Gravesham is 10.4%.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males.

Children

- There are significantly fewer physically active children in Gravesham (47.1%) compared to England (55.1%). The rate for Dartford is significantly higher at (62.0%).
- In Dartford (22.7%) the proportion of Year 6 children who are obese is significantly greater than that for England (18.7%). The rate for Gravesham is 19.9%.

5.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of DGS have a higher prevalence of hypertension, hyperthyroidism, Chronic Kidney disease and obesity, than England. T
- the population of DGS in more ethnically diverse that the rest of Kent with a larger Asian population which may go part way to explain the increased prevalence's.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- DGS has a higher emergency admission rate than Kent and Medway for Diabetes, dementia and CHD.

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- The trend for CHD shows a decline in emergency admissions. Emergency admissions for the other conditions mentioned are increasing.

Mortality

73.4% of all deaths are from three main diseases: Circulatory disease (31.3% of all deaths), Cancer (28.9% of all deaths) and respiratory disease (13.1% of all deaths, within Dartford and Gravesham districts.

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6 Maidstone and Malling

6.1 Demographics

There are 11 practices within the Maidstone and Malling CCG. All but one of these practices are located within the district boundary of Maidstone, one practice is within the district boundary of Tonbridge and Malling.

6.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 99,067 people are registered with practice in M&M CCGs. This is 7% of the total registered practice population for Kent.
- M&M is one of the smallest CCGs, and has the most dispersed population, with 3 distinct communities.
- The percentage of the population within the age groups 25 to 49 is greater than that for Kent and Medway. There is a greater proportion within the 0 to 4 age group.
- Using data for Maidstone District, the population is projected to increase by 4% over the next 5 years[4] and 9% over the next 10 years. The greatest population growth is in the 65+ (18%) and 85+ (19%) age groups.
- 6.7% of the Maidstone population are from a BME group this compares to 7.6% for Kent County.
- Life expectancy from birth for Maidstone and Malling is 81 years this compares to 80.9 for Kent and Medway. There is 7.9 years difference between the ward with the lowest life expectancy [Bridge, 76.1 years] and the ward with the highest life expectancy [Downswood and Otham 84.2 years]

6.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Maidstone is ranked 217 out of 326 local authorities and is the 9 most deprived district in Kent.
- 6.5% of Maidstone's lower layer supper output areas are in the 20% most deprived for England,

6.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the environment in which population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of

[4] ONS 2008-Based population projections 2011-2016, 2011-2021

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people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Maidstone is 2.5%, lower than the rate for Kent 3.9%.
- Unemployment in Maidstone has increased by 13% since September 2010. The increase for Kent is 13.6%.
- 18-24s make up the biggest proportion of unemployed (31.1%). The rate for Kent 31.5%.
- 65.1% of children achieve 5 A*-C grade GCSEs (including Maths and English) significantly higher than the rate for England 55.3%.
- 0.12% of households within Ashford are classified as statutory homeless; this is significantly lower than England (1.86%)

6.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Maidstone (26.3%) is significantly higher than England (24.2%). The rate for Tonbridge and Malling is 26.1%.
- The number of admissions to hospital due to alcohol specific conditions for Maidstone and Malling CCG reduced between 2009/10 and 2010/11.

Children

- There are significantly fewer physically active children in Maidstone
- (46.2%) compared to England (55.1%). The rate for Tonbridge and Malling is 64.5%, significantly better than England.

6.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of Maidstone and Malling CCG have a higher prevalence of hyperthyroidism, than England.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- Maidstone and Malling population have a higher emergency admission rate than Kent and Medway for COPD, Dementia, Cancer and CHD.
- The trends for COPD and Dementia shows that emergency admissions for these conditions are increasing.

Mortality

- 75.7% of all deaths are from three main diseases: Circulatory disease (33.3% of all deaths), Cancer (27.8% of all deaths) and respiratory disease (14.5% of all deaths).

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7 Swale Locality Consortium

7.1 Demographics
There are 20 practices within the Swale locality consortium CCG. All of these practices are located with in the district boundary of Swale.

7.2 Population
Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 106,215 people are registered with a practice in Swale locality consortium. This is 7% of the total registered practice population for Kent.
- Swale locality group is one of the smallest CCGs.
- The population of Swale locality group is similar to that for Kent as a whole. The largest proportion of the population in the 40-49 age group.
- Using data for Swale District, the population is projected to increase by 4% over the next 5 years[5] and 9% over the next 10 years.
- The greatest population growth is in the 65+ (20%) and 85+ (32%) age groups
- 5.5% of the Swale population is from a BME group
- Life expectancy from birth is the lowest of all CCGs at 79.3 years. The life expectancy for Kent and Medway is 80.9 years.

More people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes.

7.3 Deprivation
Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Swale is ranked 99 out of 326 local authorities and is the 3 most deprived district in Kent.
- 20.7% of Swales lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Sheerness East, Murston and Leysdown and Warden.

7.4 Housing, Education and Employment
Health and social care outcomes are very much influenced by the environment in which population live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

[5] ONS 2008-Based population projections 2011-2016, 2011-2021

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Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The rate of unemployment within Swale is 3.9%, higher than the rate for Kent 3.2% and equivalent to the rate for Great Britain (3.9%)
- Unemployment in Swale has increased by 13.4% since September 2010. The increase for Kent 13.6%
- 18-24s make up the biggest proportion of unemployed (36.3%). The rate for Kent 31.5%.
- 53.7% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 1.11% of households within Ashford are classified as statutory homeless; this is significantly lower than England (1.86%)

7.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Swale (30.2%) is significantly higher than England (24.2%)
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year this is specifically true for males. There was a slight reduction in admissions to hospital for females between 2009/10 and 2010/11.

Children

- There are significantly fewer physically active children in Swale (38.9%) compared to England (55.1%)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)
- Teenage conception rate for Swale (46.7) is significantly higher than England (40.2)

7.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of Swale locality consortium have a higher prevalence of hypertension, Diabetes, COPD, and obesity, than England.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- Swale locality consortium have a higher emergency admission rate than Kent and Medway for all long term conditions (COPD, Stroke, CHD, Dementia, Diabetes and Cancer).
- For all conditions except Stroke the trend shows an increase in the rate of emergency admissions.

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Mortality

- Around 75.5% of all deaths are from three main diseases: Circulatory disease (31.9% of all deaths), Cancer (28.4% of all deaths) and respiratory disease (15.2% of all deaths).

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8 South Kent Coast

8.1 Demographics

There are 33 practices within South Kent Coast, 15 of these practices are located within Dover district and 18 within Shepway district.

8.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 199,876 people are registered with a practice in South Kent Coast CCGs. This is 13% of the total registered practice population for Kent.
- The population is older than that for Kent, with fewer people under the age of 40. The largest proportion of the population is aged between 40 and 69.
- Combining the data for Dover and Shepway Districts, the population is projected to increase by 3% over the next 5 years[6] and 7% over the next 10 years.
- The greatest population growth is in the 65+ (16%) and 85+ (12%) age groups. The age group of 0 to 4 is not projected to grow.

More people are living longer managing long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes.

8.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Dover is ranked 127 and Shepway is 97 ranked out of 326 local authorities and is the third most deprived district in Kent.
- 16.4% of Dover and 16.9% of Shepway's lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within St.Radigunds, Buckland and Tower Hamlets (Dover), Folkestone Harvey Central, Folkestone Harbour and Folkestone East (Shepway)

8.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the environment in which populations live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

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[6] ONS 2008-Based population projections 2011-2016, 2011-2021

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Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment within Dover is 3.7% and Shepway 4.2%. The rate for Kent is 3.2%.
- Unemployment in Dover has increased by 25.2%, the greatest increase of the 12 Kent districts, this contrasts with an 11.5% increase in Shepway since September 2010. The increase for Kent is 13.6%
- 18-24s make up the biggest proportion of unemployed (Dover 32.1%, Shepway 28.3%). The rate for Kent is 31.5%.
- 50.3% of children in Dover and 52.3% of children in Shepway achieve 5 A*-C grade GCSEs (including Maths and English) significantly lower than the rate for England 55.3%.
- 1.35% of households within Dover (significantly lower) and 1.82% of Households in Shepway are classified as statutory homeless; both are lower than England (1.86%)

8.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Dover (26.8%) is significantly higher than England (24.2%). The rate for Shepway 25.9%.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year for South Kent CCG.

Children

- There are significantly fewer physically active children in Shepway (48.3%) compared to England (55.1%). The rate for Dover is (63.9%) which is significantly more than England.
- Teenage conception rate for Shepway (46.6) is significantly higher than the rate for England (40.2). The rate for Dover is (36.4)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)

8.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of SKC have a higher prevalence of CHD, stroke, Hypertension, Diabetes, Epilepsy, Hypothyroidism, Cancer, Artrial Fibrillation and learning disabilities when compared to England.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

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- South Kent Coast have a higher emergency admission rate than Kent and Medway for all long term conditions (COPD, Stroke, CHD, Dementia and Diabetes), except Cancer..
- For all conditions except Cancer the trend shows an increase in the rate of emergency admissions.

Mortality

76.3% of all deaths are from three main diseases: Circulatory disease (34.2% of all deaths), Cancer (27% of all deaths) and respiratory disease (15% of all deaths).

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9 Thanet

9.1 Demographics

There are 21 practices within Thanet CCG all of these practices are located within the district of Thanet.

9.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- 140,563 people are registered with a practice in Thanet CCG. This is 9.4% of the total registered practice population for Kent.
- Thanet has fewer people aged between 20 and 49 compared to Kent and Medway.
- Using data for Thanet District, the population is projected to increase by 3% over the next 5 years[7] and 7.6% over the next 10 years.
- The greatest population growth is in the 65+ (13%) and 85+ (9%) age groups
- 7% of the Thanet population are from a BME group, this compares to 7.6% for Kent County.
- Life expectancy from birth is 79.6 years this is the second lowest of all the CCGs. There is 12.1 years between the ward with the lowest life expectancy [Cliftonville West 72.3 years] and the ward with the greatest life expectancy. [Kingsgate 84.4 years]

9.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- Thanet is ranked 49 out of 326 local authorities and is the 1 most deprived district in Kent.
- 29.8% of Thanet's lower layer supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Margate Central, Clifftonville West and East Cliffe.

9.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the environment in which populations live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

[7] ONS 2008-Based population projections 2011-2016, 2011-2021

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Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The rate of unemployment with Thanet (5.8%) is the greatest of all the 12 districts in Kent. The rate for Kent is 3.2%.
- Unemployment in Thanet has increased by 16.8% since September 2010. The increase for Kent is 13.6%
- 18-24s make up the biggest proportion of unemployed (32.5%). The rate for Kent 31.5%.
- 49.7% of children achieve 5 A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 1.11% of households within Thanet are classified as statutory homeless; this is lower than England (1.86%)

9.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults, physical activity, and smoking are significantly higher for Thanet compared to England.
- The number of admissions to hospital due to alcohol specific conditions has been rising year on year.

Children

- There are significantly fewer physically active children in Thanet (51%) compared to England (55.1%)
- Teenage conception rate for Thanet (51) is significantly higher than that for England (40.2)
- Smoking during pregnancy (20%) and Breast feeding initiation rates (70%) are significantly worse that England (smoking 14% Breastfeeding 73.6%)

9.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of Thanet have a higher prevalence for most conditions recorded on primary care disease registers, with the exception of Asthma, Heart failure and Depression.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- Thanet CCG has a higher emergency admission rate than Kent and Medway for Diabetes, COPD, CHD and Stroke.
- The emergency admission rate for Dementia is lower. The trend shows an increase.
- The trend for Cancer emergency admissions shows a decline.

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Mortality

- Around 75.3% of all deaths are from three main diseases: Circulatory disease (33.6% of all deaths), Cancer (26.5% of all deaths) and respiratory disease (15.1% of all deaths)

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10 West Kent and Weald

10.1 Demographics

There are 53 practices within the West Kent and Weald CCG. These are located within the four districts of Maidstone (14), Sevenoaks (7), Tonbridge and Malling (11) and Tunbridge Wells(21).

10.2 Population

Understanding the population age structure is important for future and current planning of services. Younger populations will have an impact on the level of services required, including provision of educational services, number of health visitors and target programmes towards children such as immunisation and vaccinations.

- WKW is the largest off the 8 Kent CCGs, with a registered practice population of 366,974, which is 25% of the total registered population for Kent.
- The proportion of the population aged between is 20 to 35, there is a peak in the 0 to 20 years olds, which may have implications for deliver of services to the young population.
- Combining data for the 4 districts the population of WKW is projected to increase by 4% over the next 5 years and by 9% over the next 10 years
- The greatest population growth is in the 65+ (18%) and 85+ (19%) age groups
- 6.8% of the population are from a BME group, compared to 7.6% for Kent County
- Life expectancy is 82.3 years compared to 80.9 for Kent and Medway, the population of WKW is highest of all the CCGs. The difference is life expectancy between wards within the four districts is 16.9 years. Both the highest life expectancy and the lowest life expectancy are for wards within Tonbridge and Malling District. [Kings Hill 92 years, Bumham, Eccles and Wouldham 75,1 years]

10.3 Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas. A rank of 1 indicates the most deprived.

- The CCG of West Kent and Weald spans 4 districts. These 4 districts have the lowest levels of deprivation for Kent ranked between 9 and 12. Sevenoaks has the lowest levels of deprivation across Kent and with Tonbridge and Malling falling within the 20% least deprived districts in England.
- Two districts (Tonbridge & Malling and Tunbridge Wells) have no lower layer supper output areas are in the 20% most deprived for England, 1.4% of Sevenoaks and 6.5% of Maidstone lower layer super output areas are in the 20% most deprived for England.

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10.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the environment in which populations live and the opportunities available to them. Economic downturn will have an impact in the short term and potential longer term on mental and physical health. In previous recessions the number of people suffering depression and anxiety has been shown to increase, as has the rate of suicides.

Access to good Education, enables individuals to progress further in life opening up opportunities to better paid jobs.

- The level of unemployment for each of the 4 districts, Maidstone (2.5%), Sevenoaks (1.8%), Tonbridge and Malling (2.0%) and Tunbridge Wells (1.8%), have lower levels of unemployment of Kent (3.2%)
- Unemployment has increased by 13% (Maidstone), 7.3% (Sevenoaks), 11% (Tonbridge and Malling) and 2.4% (Tunbridge Wells) since September 2010. The increase for Kent is 13.6%.
- 18-24s make up the biggest proportion of unemployed (Maidstone 31.1%, Sevenoaks 27.8%, Tonbridge and Malling 30.2% and Tunbridge Wells 23.7%). The rate for Kent 31.5%.
- For three of the districts children achieving 5 A*-C grade GCSEs (including Maths and English) ranging from 61.2% to 71% have rates that a significantly higher when compared to 55.3% for England. Sevenoaks however at 38.7% is significantly worse than the rate for England
- All four districts have significantly lower rate of households classified as statutory homeless ranging from 0.12% to 1.06%. The rate for England is 1.86%

10.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact of health and social care outcomes. Smoking is the single biggest contributor to health inequalities.

Adults

- Prevalence of obese adults in Maidstone (26.3%) is significantly higher than England (24.2%) the prevalence of adult obesity in the other districts are generally not significantly different or are significantly lower.
- The number of admissions to hospital due to alcohol specific conditions declined between 2009/10 and 2010/1

Children

- There are significantly fewer physically active children in Maidstone (46.2%) compared to England (55.1%)

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10.6 Health Issues

Prevalence

- The 2010/11 registers show that the population of WKW have a higher prevalence of Stroke, hyperthyroidism, and Cancer than England.

Morbidity

Emergency admissions can be an indicator of how well patients are being managed within primary care

- WKW has an emergency admission rate higher than Kent and Medway for Cancer, and the trend continues to decline.
- Emergency admission rates are increasing for Dementia, COPD and CHD.
- Stroke and Diabetes emergency admission rates are reducing.

Mortality

- Around 76.5% of all deaths are from three main diseases: Circulatory disease (34.3% of all deaths), Cancer (28.6% of all deaths) and respiratory disease (13.6% of all deaths).

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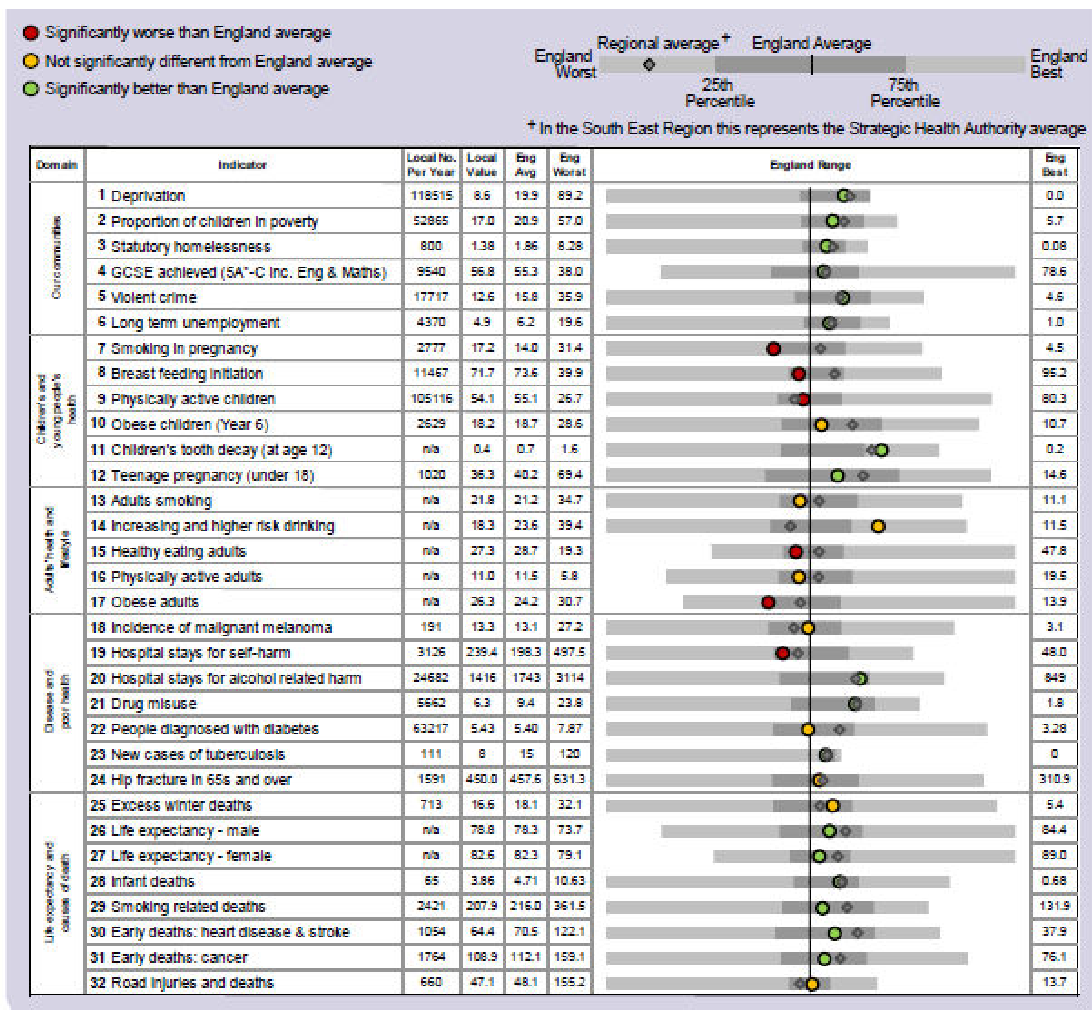
Appendix B – Health Profiles 2011

Kent County Council



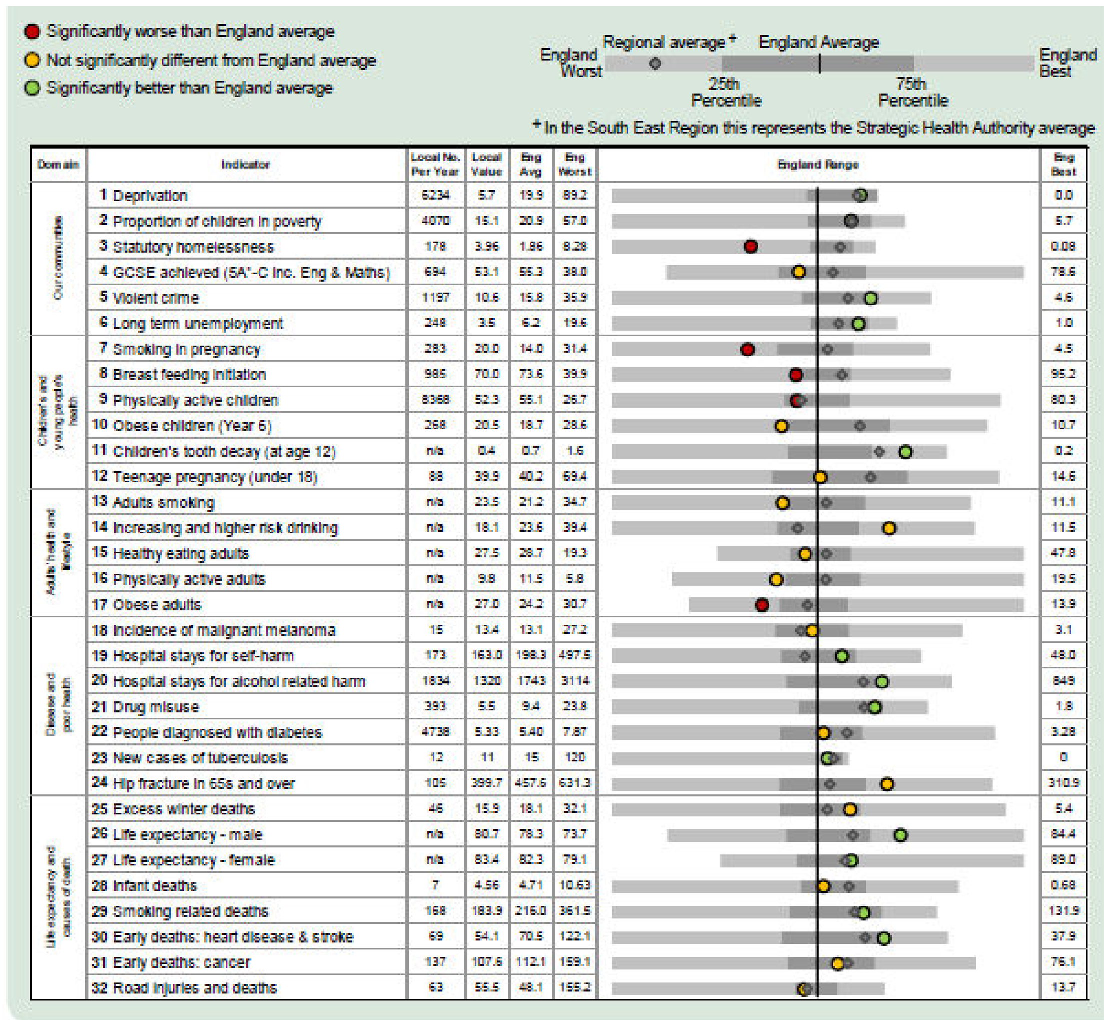
Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	118515	8.6	19.9	89.2		0.0
	2 Proportion of children in poverty	52865	17.0	20.9	57.0		5.7
	3 Statutory homelessness	800	1.38	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	9540	56.8	55.3	38.0		78.6
	5 Violent crime	17717	12.6	15.8	35.9		4.6
	6 Long term unemployment	4370	4.9	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	2777	17.2	14.0	31.4		4.5
	8 Breast feeding initiation	11467	71.7	73.6	39.9		95.2
	9 Physically active children	105116	54.1	55.1	26.7		80.3
	10 Obese children (Year 6)	2629	18.2	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	1020	36.3	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	21.8	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	18.3	23.6	39.4		11.5
	15 Healthy eating adults	n/a	27.3	28.7	19.3		47.8
	16 Physically active adults	n/a	11.0	11.5	5.8		19.5
	17 Obese adults	n/a	26.3	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	191	13.3	13.1	27.2		3.1
	19 Hospital stays for self-harm	3126	239.4	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	24682	1416	1743	3114		849
	21 Drug misuse	5662	6.3	9.4	23.8		1.8
	22 People diagnosed with diabetes	63217	5.43	5.40	7.87		3.28
	23 New cases of tuberculosis	111	8	15	120		0
	24 Hip fracture in 65s and over	1591	450.0	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	713	16.6	18.1	32.1		5.4
	26 Life expectancy - male	n/a	78.8	78.3	73.7		84.4
	27 Life expectancy - female	n/a	82.6	82.3	79.1		89.0
	28 Infant deaths	65	3.86	4.71	10.63		0.68
	29 Smoking related deaths	2421	207.9	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	1054	64.4	70.5	122.1		37.9
	31 Early deaths: cancer	1764	108.9	112.1	159.1		76.1
	32 Road injuries and deaths	660	47.1	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

Ashford



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	6234	5.7	19.9	89.2		0.0
	2 Proportion of children in poverty	4070	15.1	20.9	57.0		5.7
	3 Statutory homelessness	178	3.96	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	694	53.1	55.3	38.0		78.6
	5 Violent crime	1197	10.6	15.8	35.9		4.6
	6 Long term unemployment	248	3.5	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	283	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	985	70.0	73.6	39.9		95.2
	9 Physically active children	8368	52.3	55.1	26.7		80.3
	10 Obese children (Year 6)	268	20.5	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	88	39.9	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	23.5	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	18.1	23.6	39.4		11.5
	15 Healthy eating adults	n/a	27.5	28.7	19.3		47.8
	16 Physically active adults	n/a	9.8	11.5	5.8		19.5
	17 Obese adults	n/a	27.0	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	15	13.4	13.1	27.2		3.1
	19 Hospital stays for self-harm	173	163.0	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1834	1320	1743	3114		849
	21 Drug misuse	393	5.5	9.4	23.8		1.8
	22 People diagnosed with diabetes	4738	5.33	5.40	7.87		3.28
	23 New cases of tuberculosis	12	11	15	120		0
	24 Hip fracture in 65s and over	105	399.7	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	46	15.9	18.1	32.1		5.4
	26 Life expectancy - male	n/a	80.7	78.3	73.7		84.4
	27 Life expectancy - female	n/a	83.4	82.3	79.1		89.0
	28 Infant deaths	7	4.56	4.71	10.63		0.68
	29 Smoking related deaths	168	183.9	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	69	54.1	70.5	122.1		37.9
	31 Early deaths: cancer	137	107.6	112.1	159.1		76.1
	32 Road injuries and deaths	63	55.5	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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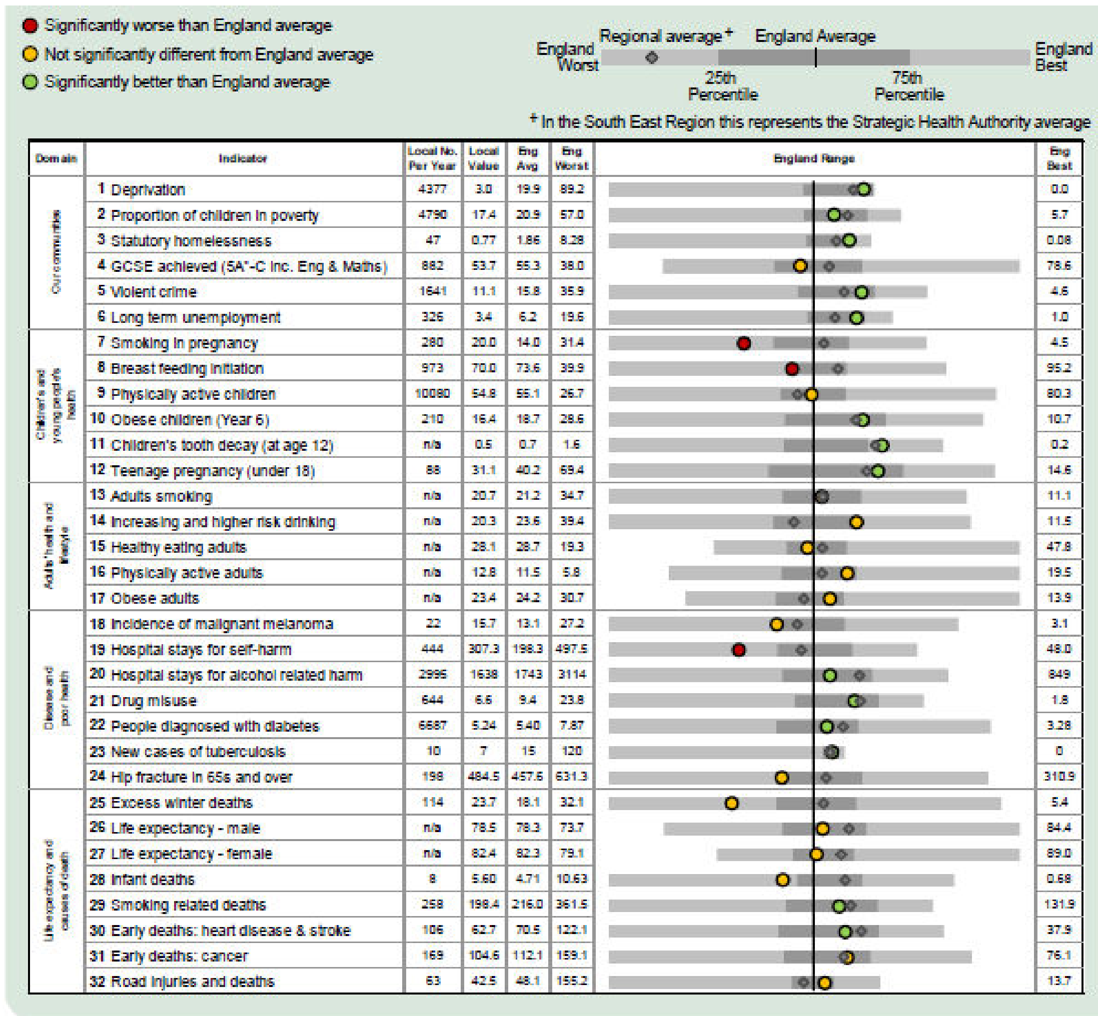
Canterbury



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	4377	3.0	19.9	89.2		0.0
	2 Proportion of children in poverty	4790	17.4	20.9	57.0		5.7
	3 Statutory homelessness	47	0.77	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	882	53.7	55.3	38.0		78.6
	5 Violent crime	1641	11.1	15.8	35.9		4.6
	6 Long term unemployment	326	3.4	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	280	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	973	70.0	73.6	39.9		95.2
	9 Physically active children	10080	54.8	55.1	26.7		80.3
	10 Obese children (Year 6)	210	16.4	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	88	31.1	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	20.7	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	20.3	23.6	39.4		11.5
	15 Healthy eating adults	n/a	28.1	28.7	19.3		47.8
	16 Physically active adults	n/a	12.8	11.5	5.8		19.5
	17 Obese adults	n/a	23.4	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	22	15.7	13.1	27.2		3.1
	19 Hospital stays for self-harm	444	307.3	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	2996	1638	1743	3114		849
	21 Drug misuse	644	6.6	9.4	23.8		1.8
	22 People diagnosed with diabetes	6687	5.24	5.40	7.87		3.28
	23 New cases of tuberculosis	10	7	15	120		0
	24 Hip fracture in 65s and over	198	484.5	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	114	23.7	18.1	32.1		5.4
	26 Life expectancy - male	n/a	78.5	78.3	73.7		84.4
	27 Life expectancy - female	n/a	82.4	82.3	79.1		89.0
	28 Infant deaths	8	5.60	4.71	10.63		0.68
	29 Smoking related deaths	258	198.4	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	106	62.7	70.5	122.1		37.9
	31 Early deaths: cancer	169	104.6	112.1	159.1		76.1
	32 Road injuries and deaths	63	42.5	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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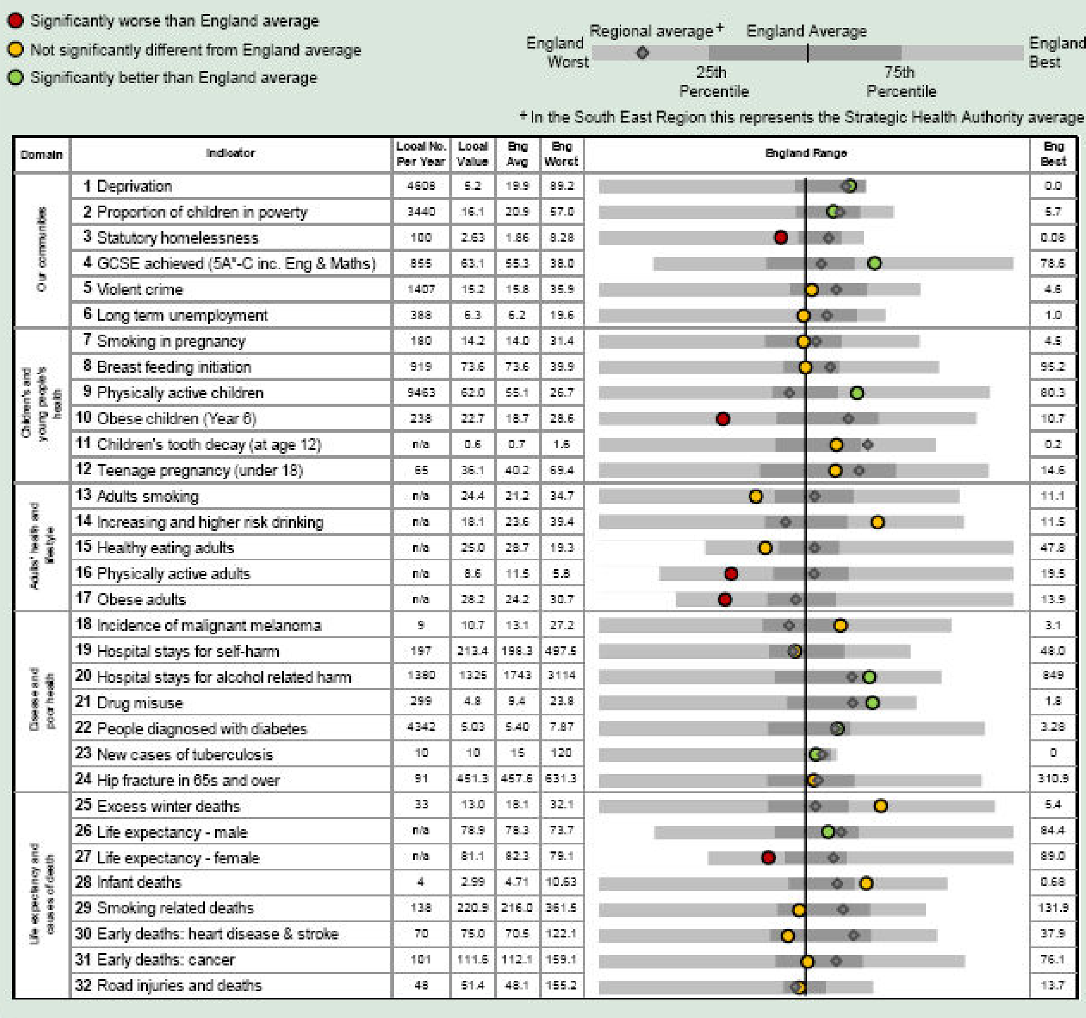
Dartford



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	Eng Best
Our communities	1 Deprivation	4608	5.2	19.9	89.2	0.0
	2 Proportion of children in poverty	3440	16.1	20.9	57.0	5.7
	3 Statutory homelessness	100	2.63	1.86	8.28	0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	855	63.1	55.3	38.0	78.6
	5 Violent crime	1407	15.2	15.8	35.9	4.6
	6 Long term unemployment	388	6.3	6.2	19.6	1.0
Children's and young people's health	7 Smoking in pregnancy	180	14.2	14.0	31.4	4.5
	8 Breast feeding initiation	919	73.6	73.6	39.9	95.2
	9 Physically active children	9463	62.0	55.1	26.7	80.3
	10 Obese children (Year 6)	238	22.7	18.7	28.6	10.7
	11 Children's tooth decay (at age 12)	n/a	0.6	0.7	1.6	0.2
	12 Teenage pregnancy (under 18)	65	36.1	40.2	69.4	14.6
Adults' health and lifestyle	13 Adults smoking	n/a	24.4	21.2	34.7	11.1
	14 Increasing and higher risk drinking	n/a	18.1	23.6	39.4	11.5
	15 Healthy eating adults	n/a	25.0	28.7	19.3	47.8
	16 Physically active adults	n/a	8.6	11.5	5.8	19.5
	17 Obese adults	n/a	28.2	24.2	30.7	13.9
Disease and poor health	18 Incidence of malignant melanoma	9	10.7	13.1	27.2	3.1
	19 Hospital stays for self-harm	197	213.4	198.3	497.5	48.0
	20 Hospital stays for alcohol related harm	1380	1325	1743	3114	849
	21 Drug misuse	299	4.8	9.4	23.8	1.8
	22 People diagnosed with diabetes	4342	5.03	5.40	7.87	3.28
	23 New cases of tuberculosis	10	10	15	120	0
	24 Hip fracture in 65s and over	91	451.3	457.6	631.3	310.9
Life expectancy and causes of death	25 Excess winter deaths	33	13.0	18.1	32.1	5.4
	26 Life expectancy - male	n/a	78.9	78.3	73.7	84.4
	27 Life expectancy - female	n/a	81.1	82.3	79.1	89.0
	28 Infant deaths	4	2.99	4.71	10.63	0.68
	29 Smoking related deaths	138	220.9	216.0	361.5	131.9
	30 Early deaths: heart disease & stroke	70	75.0	70.5	122.1	37.9
	31 Early deaths: cancer	101	111.6	112.1	159.1	76.1
	32 Road injuries and deaths	48	51.4	48.1	155.2	13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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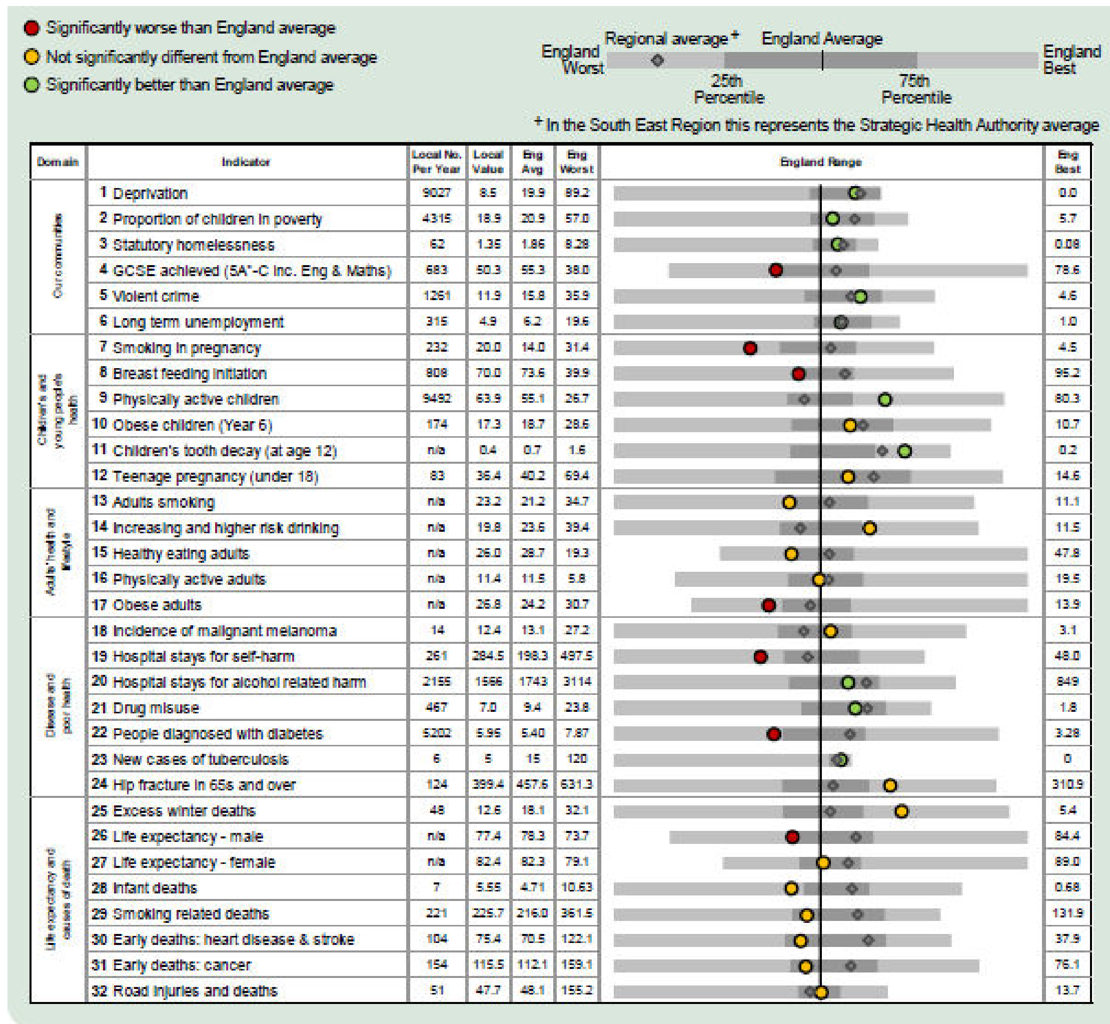
Dover



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	9027	8.5	19.9	89.2		0.0
	2 Proportion of children in poverty	4315	18.9	20.9	57.0		5.7
	3 Statutory homelessness	62	1.35	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	683	50.3	55.3	38.0		78.6
	5 Violent crime	1261	11.9	15.8	35.9		4.6
	6 Long term unemployment	315	4.9	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	232	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	808	70.0	73.6	39.9		95.2
	9 Physically active children	9492	63.9	55.1	26.7		80.3
	10 Obese children (Year 6)	174	17.3	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	83	36.4	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	23.2	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	19.8	23.6	39.4		11.5
	15 Healthy eating adults	n/a	26.0	28.7	19.3		47.8
	16 Physically active adults	n/a	11.4	11.5	5.8		19.5
	17 Obese adults	n/a	26.8	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	14	12.4	13.1	27.2		3.1
	19 Hospital stays for self-harm	261	284.5	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	2155	1566	1743	3114		849
	21 Drug misuse	467	7.0	9.4	23.8		1.8
	22 People diagnosed with diabetes	5202	5.96	5.40	7.87		3.28
	23 New cases of tuberculosis	6	5	15	120		0
	24 Hip fracture in 65s and over	124	399.4	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	48	12.6	18.1	32.1		5.4
	26 Life expectancy - male	n/a	77.4	78.3	73.7		84.4
	27 Life expectancy - female	n/a	82.4	82.3	79.1		89.0
	28 Infant deaths	7	5.55	4.71	10.63		0.68
	29 Smoking related deaths	221	225.7	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	104	75.4	70.5	122.1		37.9
	31 Early deaths: cancer	154	115.5	112.1	159.1		76.1
	32 Road injuries and deaths	51	47.7	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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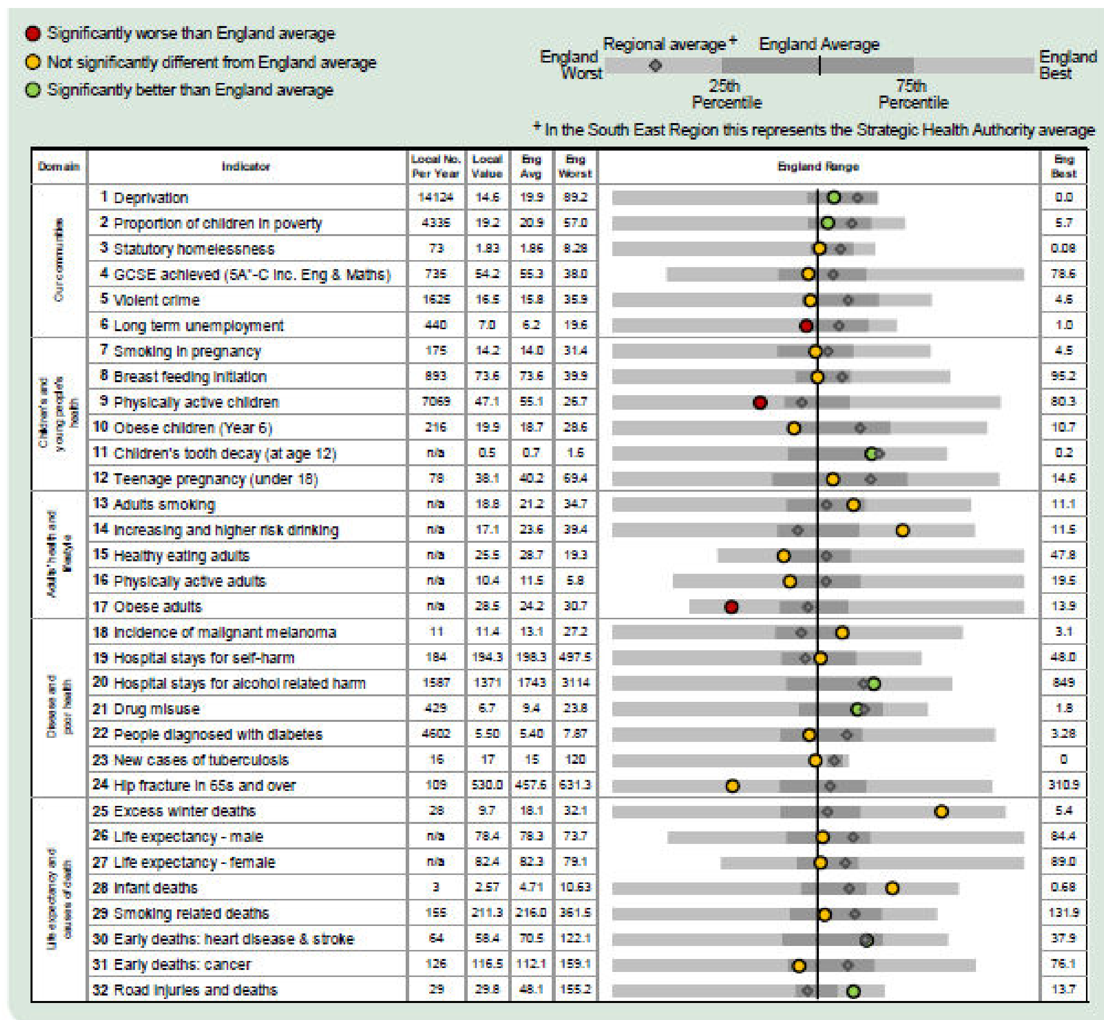
Gravesham



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	Eng Best
Our communities	1 Deprivation	14124	14.6	19.9	89.2	0.0
	2 Proportion of children in poverty	4335	19.2	20.9	57.0	5.7
	3 Statutory homelessness	73	1.83	1.86	8.28	0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	735	54.2	55.3	38.0	78.6
	5 Violent crime	1625	16.5	15.8	35.9	4.6
	6 Long term unemployment	440	7.0	6.2	19.6	1.0
Children's and young people's health	7 Smoking in pregnancy	175	14.2	14.0	31.4	4.5
	8 Breast feeding initiation	893	73.6	73.6	39.9	95.2
	9 Physically active children	7069	47.1	55.1	26.7	80.3
	10 Obese children (Year 6)	216	19.9	18.7	28.6	10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6	0.2
	12 Teenage pregnancy (under 18)	78	38.1	40.2	69.4	14.6
Adults' health and lifestyle	13 Adults smoking	n/a	18.8	21.2	34.7	11.1
	14 Increasing and higher risk drinking	n/a	17.1	23.6	39.4	11.5
	15 Healthy eating adults	n/a	25.5	28.7	19.3	47.8
	16 Physically active adults	n/a	10.4	11.5	5.8	19.5
	17 Obese adults	n/a	28.5	24.2	30.7	13.9
Disease and poor health	18 Incidence of malignant melanoma	11	11.4	13.1	27.2	3.1
	19 Hospital stays for self-harm	184	194.3	198.3	497.5	48.0
	20 Hospital stays for alcohol related harm	1587	1371	1743	3114	849
	21 Drug misuse	429	6.7	9.4	23.8	1.8
	22 People diagnosed with diabetes	4602	5.50	5.40	7.87	3.28
	23 New cases of tuberculosis	16	17	15	120	0
	24 Hip fracture in 65s and over	109	530.0	457.6	631.3	310.9
Life expectancy and causes of death	25 Excess winter deaths	28	9.7	18.1	32.1	5.4
	26 Life expectancy - male	n/a	78.4	78.3	73.7	84.4
	27 Life expectancy - female	n/a	82.4	82.3	79.1	89.0
	28 Infant deaths	3	2.57	4.71	10.63	0.68
	29 Smoking related deaths	155	211.3	216.0	361.5	131.9
	30 Early deaths: heart disease & stroke	64	58.4	70.5	122.1	37.9
	31 Early deaths: cancer	126	116.5	112.1	159.1	76.1
	32 Road injuries and deaths	29	29.8	48.1	155.2	13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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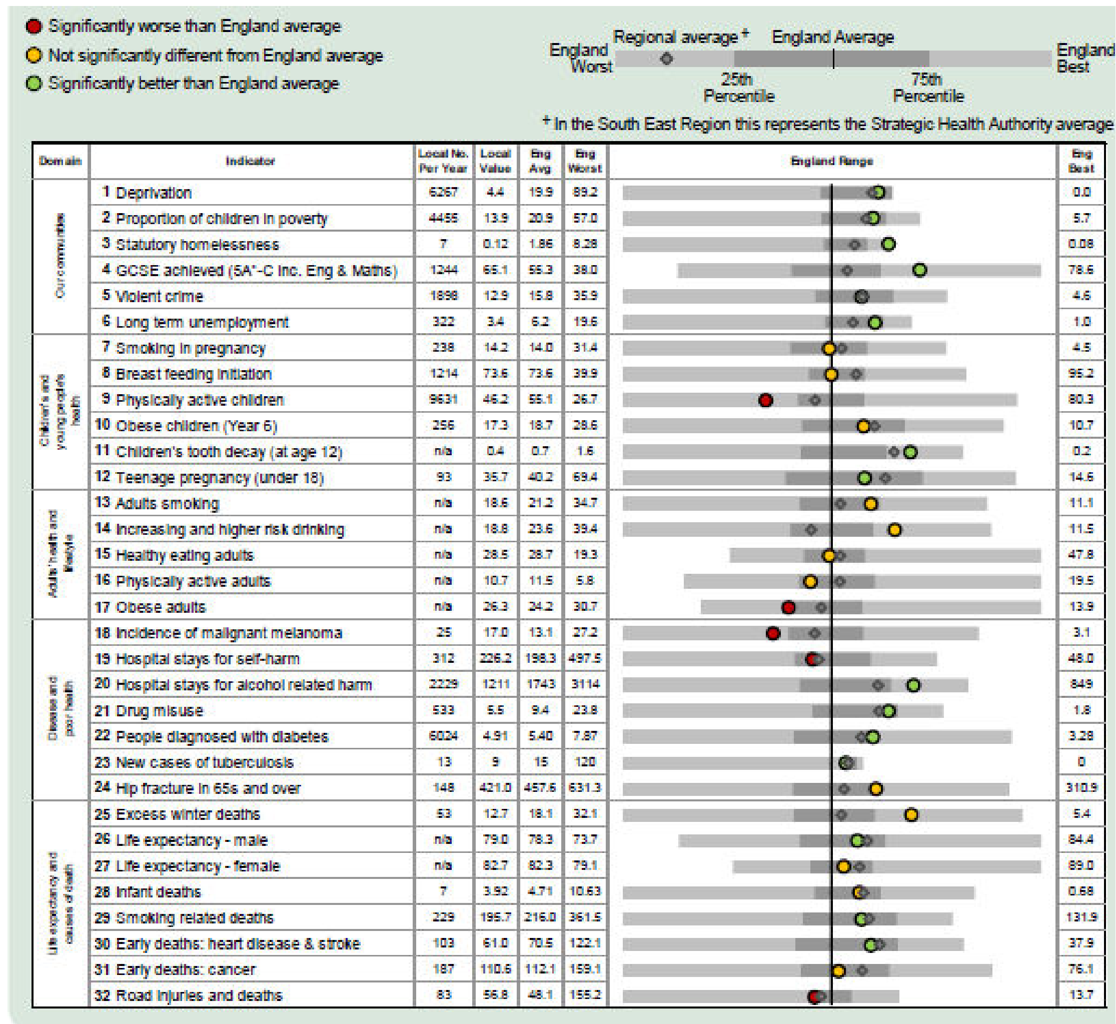
Maidstone



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	Eng Best
Our communities	1 Deprivation	6267	4.4	19.9	89.2	0.0
	2 Proportion of children in poverty	4455	13.9	20.9	57.0	5.7
	3 Statutory homelessness	7	0.12	1.86	8.28	0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1244	65.1	55.3	38.0	78.6
	5 Violent crime	1898	12.9	15.8	35.9	4.6
	6 Long term unemployment	322	3.4	6.2	19.6	1.0
Children's and young people's health	7 Smoking in pregnancy	238	14.2	14.0	31.4	4.5
	8 Breast feeding initiation	1214	73.6	73.6	39.9	95.2
	9 Physically active children	9631	46.2	55.1	26.7	80.3
	10 Obese children (Year 6)	256	17.3	18.7	28.6	10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6	0.2
	12 Teenage pregnancy (under 18)	93	35.7	40.2	69.4	14.6
Adults' health and lifestyle	13 Adults smoking	n/a	18.6	21.2	34.7	11.1
	14 Increasing and higher risk drinking	n/a	18.8	23.6	39.4	11.5
	15 Healthy eating adults	n/a	28.5	28.7	19.3	47.8
	16 Physically active adults	n/a	10.7	11.5	5.8	19.5
	17 Obese adults	n/a	26.3	24.2	30.7	13.9
Disease and poor health	18 Incidence of malignant melanoma	25	17.0	13.1	27.2	3.1
	19 Hospital stays for self-harm	312	226.2	198.3	497.5	48.0
	20 Hospital stays for alcohol related harm	2229	1211	1743	3114	849
	21 Drug misuse	533	5.5	9.4	23.8	1.8
	22 People diagnosed with diabetes	6024	4.91	5.40	7.87	3.28
	23 New cases of tuberculosis	13	9	15	120	0
	24 Hip fracture in 65s and over	148	421.0	457.6	631.3	310.9
Life expectancy and causes of death	25 Excess winter deaths	53	12.7	18.1	32.1	5.4
	26 Life expectancy - male	n/a	79.0	78.3	73.7	84.4
	27 Life expectancy - female	n/a	82.7	82.3	79.1	89.0
	28 Infant deaths	7	3.92	4.71	10.63	0.68
	29 Smoking related deaths	229	195.7	216.0	361.5	131.9
	30 Early deaths: heart disease & stroke	103	61.0	70.5	122.1	37.9
	31 Early deaths: cancer	187	110.6	112.1	159.1	76.1
	32 Road injuries and deaths	83	56.8	48.1	155.2	13.7

Indicator Notes
1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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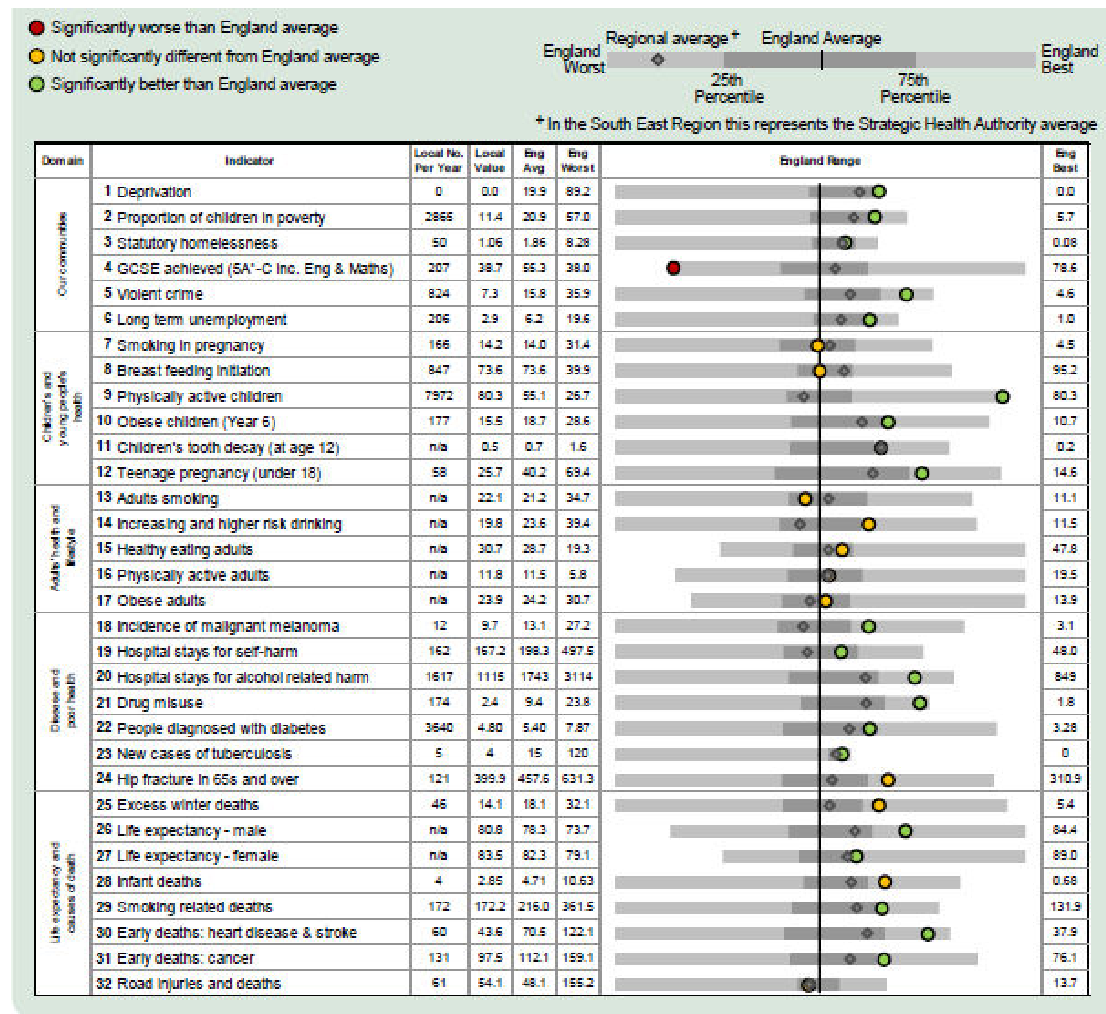
Sevenoaks



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2	0.0
	2 Proportion of children in poverty	2865	11.4	20.9	57.0	5.7
	3 Statutory homelessness	50	1.06	1.86	8.28	0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	207	38.7	55.3	38.0	78.6
	5 Violent crime	824	7.3	15.8	35.9	4.6
	6 Long term unemployment	206	2.9	6.2	19.6	1.0
Children's and young people's health	7 Smoking in pregnancy	166	14.2	14.0	31.4	4.5
	8 Breast feeding initiation	847	73.6	73.6	39.9	95.2
	9 Physically active children	7972	80.3	55.1	26.7	80.3
	10 Obese children (Year 6)	177	15.5	18.7	28.6	10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6	0.2
	12 Teenage pregnancy (under 18)	58	25.7	40.2	69.4	14.6
Adults' health and lifestyle	13 Adults smoking	n/a	22.1	21.2	34.7	11.1
	14 Increasing and higher risk drinking	n/a	19.8	23.6	39.4	11.5
	15 Healthy eating adults	n/a	30.7	28.7	19.3	47.8
	16 Physically active adults	n/a	11.8	11.5	5.8	19.5
	17 Obese adults	n/a	23.9	24.2	30.7	13.9
Disease and poor health	18 Incidence of malignant melanoma	12	9.7	13.1	27.2	3.1
	19 Hospital stays for self-harm	162	167.2	198.3	497.5	48.0
	20 Hospital stays for alcohol related harm	1617	1115	1743	3114	849
	21 Drug misuse	174	2.4	9.4	23.8	1.8
	22 People diagnosed with diabetes	3640	4.80	5.40	7.87	3.28
	23 New cases of tuberculosis	5	4	15	120	0
	24 Hip fracture in 65s and over	121	399.9	457.6	631.3	310.9
Life expectancy and causes of death	25 Excess winter deaths	46	14.1	18.1	32.1	5.4
	26 Life expectancy - male	n/a	80.8	78.3	73.7	84.4
	27 Life expectancy - female	n/a	83.5	82.3	79.1	89.0
	28 Infant deaths	4	2.85	4.71	10.63	0.68
	29 Smoking related deaths	172	172.2	216.0	361.5	131.9
	30 Early deaths: heart disease & stroke	60	43.6	70.5	122.1	37.9
	31 Early deaths: cancer	131	97.5	112.1	159.1	76.1
	32 Road injuries and deaths	61	54.1	48.1	155.2	13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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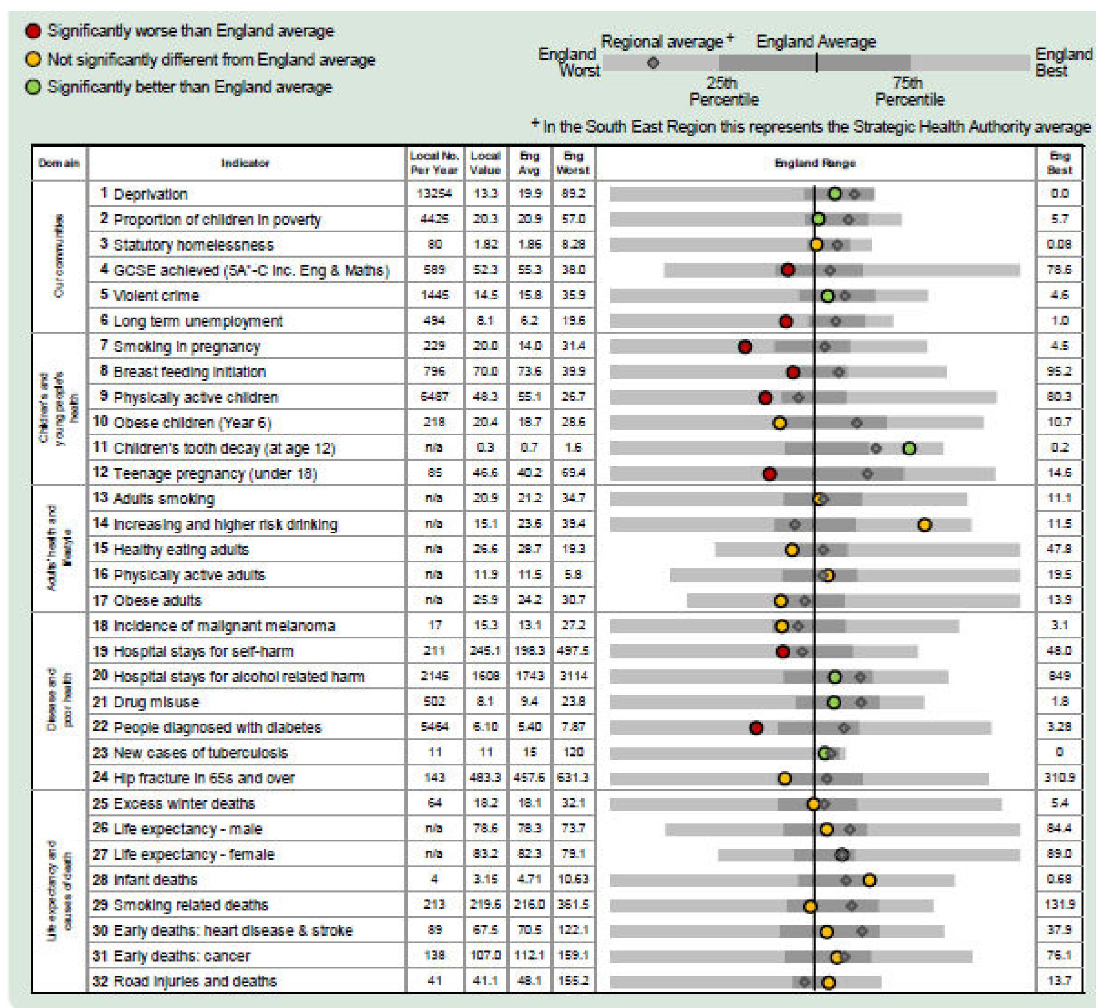
Shepway



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	13254	13.3	19.9	89.2		0.0
	2 Proportion of children in poverty	4425	20.3	20.9	57.0		5.7
	3 Statutory homelessness	80	1.82	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	589	52.3	55.3	38.0		78.6
	5 Violent crime	1445	14.5	15.8	35.9		4.6
	6 Long term unemployment	494	8.1	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	229	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	796	70.0	73.6	39.9		95.2
	9 Physically active children	6487	48.3	55.1	26.7		80.3
	10 Obese children (Year 6)	218	20.4	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.3	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	85	46.6	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	20.9	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	15.1	23.6	39.4		11.5
	15 Healthy eating adults	n/a	26.6	28.7	19.3		47.8
	16 Physically active adults	n/a	11.9	11.5	5.8		19.5
	17 Obese adults	n/a	25.9	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	17	15.3	13.1	27.2		3.1
	19 Hospital stays for self-harm	211	245.1	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	2145	1608	1743	3114		849
	21 Drug misuse	502	8.1	9.4	23.8		1.8
	22 People diagnosed with diabetes	5464	6.10	5.40	7.87		3.28
	23 New cases of tuberculosis	11	11	15	120		0
	24 Hip fracture in 65s and over	143	483.3	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	64	18.2	18.1	32.1		5.4
	26 Life expectancy - male	n/a	78.6	78.3	73.7		84.4
	27 Life expectancy - female	n/a	83.2	82.3	79.1		89.0
	28 Infant deaths	4	3.15	4.71	10.63		0.68
	29 Smoking related deaths	213	219.6	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	89	67.5	70.5	122.1		37.9
	31 Early deaths: cancer	138	107.0	112.1	159.1		76.1
	32 Road injuries and deaths	41	41.1	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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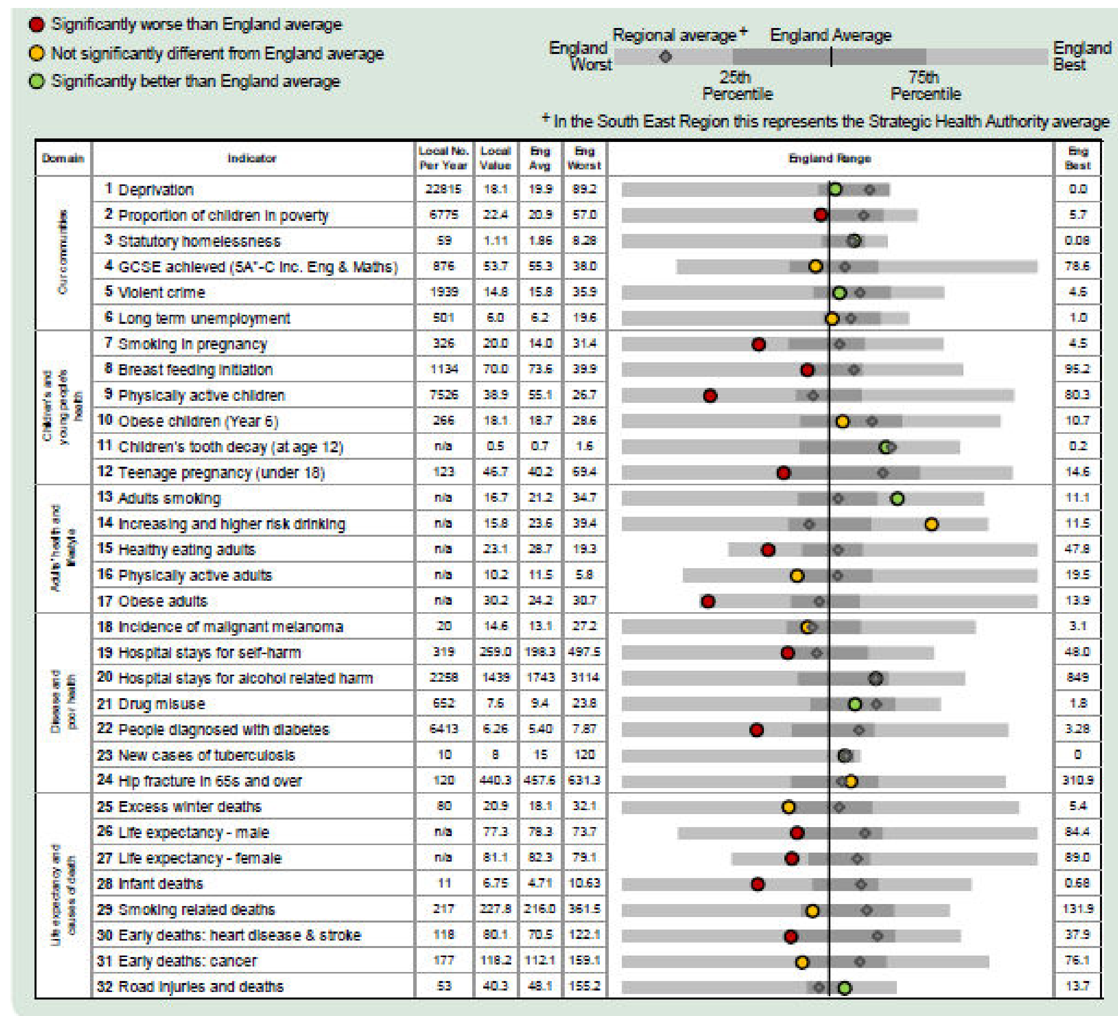
Swale



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	22815	18.1	19.9	89.2		0.0
	2 Proportion of children in poverty	6775	22.4	20.9	57.0		5.7
	3 Statutory homelessness	59	1.11	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	876	53.7	55.3	38.0		78.6
	5 Violent crime	1939	14.8	15.8	35.9		4.6
	6 Long term unemployment	501	6.0	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	326	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	1134	70.0	73.6	39.9		95.2
	9 Physically active children	7526	38.9	55.1	26.7		80.3
	10 Obese children (Year 6)	266	18.1	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	123	46.7	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	16.7	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	15.8	23.6	39.4		11.5
	15 Healthy eating adults	n/a	23.1	28.7	19.3		47.8
	16 Physically active adults	n/a	10.2	11.5	5.8		19.5
	17 Obese adults	n/a	30.2	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	20	14.6	13.1	27.2		3.1
	19 Hospital stays for self-harm	319	259.0	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	2258	1439	1743	3114		849
	21 Drug misuse	652	7.6	9.4	23.8		1.8
	22 People diagnosed with diabetes	6413	6.26	5.40	7.87		3.28
	23 New cases of tuberculosis	10	8	15	120		0
	24 Hip fracture in 65s and over	120	440.3	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	80	20.9	18.1	32.1		5.4
	26 Life expectancy - male	n/a	77.3	78.3	73.7		84.4
	27 Life expectancy - female	n/a	81.1	82.3	79.1		89.0
	28 Infant deaths	11	6.75	4.71	10.63		0.68
	29 Smoking related deaths	217	227.8	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	118	80.1	70.5	122.1		37.9
	31 Early deaths: cancer	177	118.2	112.1	159.1		76.1
	32 Road injuries and deaths	53	40.3	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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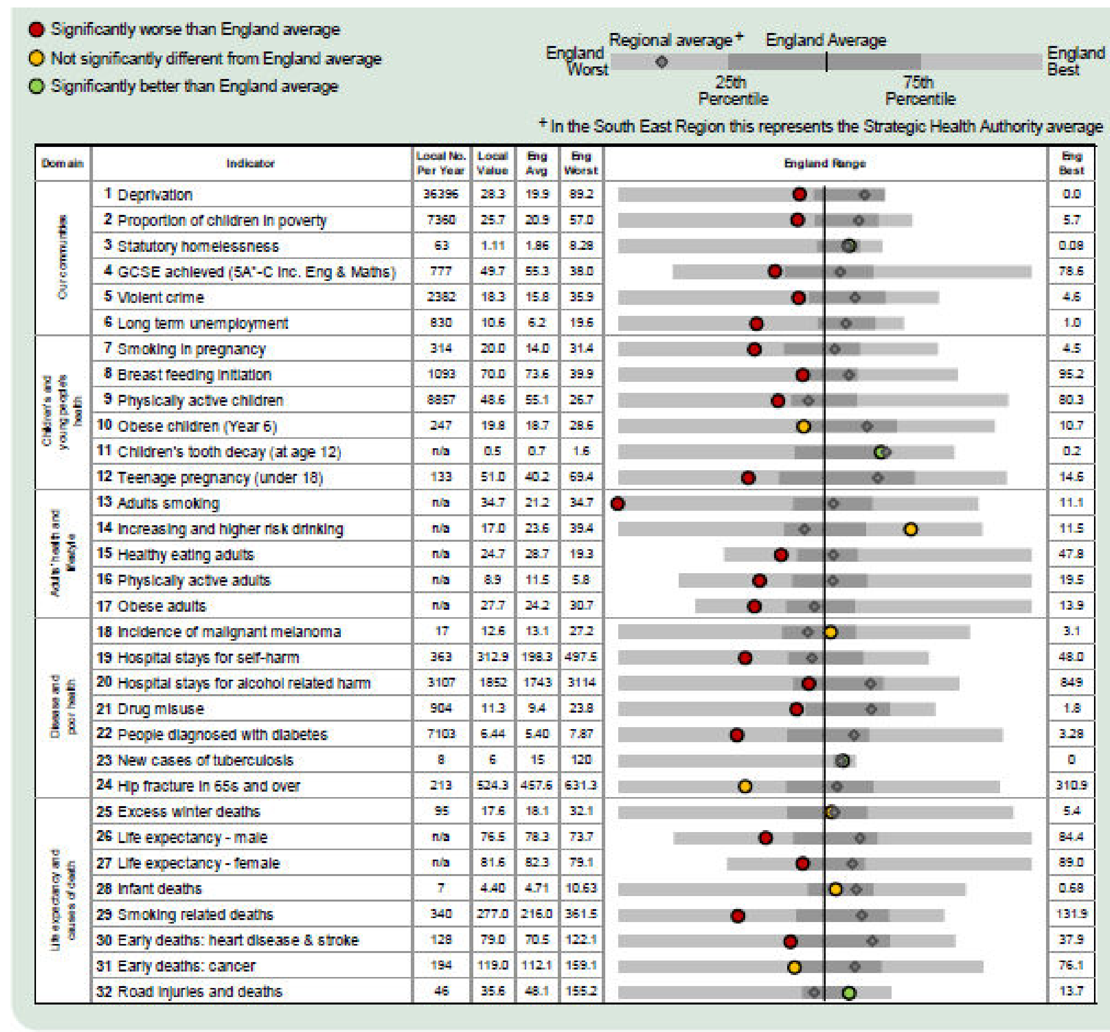
Thanet



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	36396	28.3	19.9	89.2		0.0
	2 Proportion of children in poverty	7360	25.7	20.9	57.0		5.7
	3 Statutory homelessness	63	1.11	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	777	49.7	55.3	38.0		78.6
	5 Violent crime	2382	18.3	15.8	35.9		4.6
	6 Long term unemployment	830	10.6	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	314	20.0	14.0	31.4		4.5
	8 Breast feeding initiation	1093	70.0	73.6	39.9		95.2
	9 Physically active children	8857	48.6	55.1	26.7		80.3
	10 Obese children (Year 6)	247	19.8	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	133	51.0	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	34.7	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	17.0	23.6	39.4		11.5
	15 Healthy eating adults	n/a	24.7	28.7	19.3		47.8
	16 Physically active adults	n/a	8.9	11.5	5.8		19.5
	17 Obese adults	n/a	27.7	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	17	12.6	13.1	27.2		3.1
	19 Hospital stays for self-harm	363	312.9	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	3107	1852	1743	3114		849
	21 Drug misuse	904	11.3	9.4	23.8		1.8
	22 People diagnosed with diabetes	7103	6.44	5.40	7.87		3.28
	23 New cases of tuberculosis	8	6	15	120		0
	24 Hip fracture in 65s and over	213	524.3	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	95	17.6	18.1	32.1		5.4
	26 Life expectancy - male	n/a	76.5	78.3	73.7		84.4
	27 Life expectancy - female	n/a	81.6	82.3	79.1		89.0
	28 Infant deaths	7	4.40	4.71	10.63		0.68
	29 Smoking related deaths	340	277.0	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	128	79.0	70.5	122.1		37.9
	31 Early deaths: cancer	194	119.0	112.1	159.1		76.1
	32 Road injuries and deaths	46	35.6	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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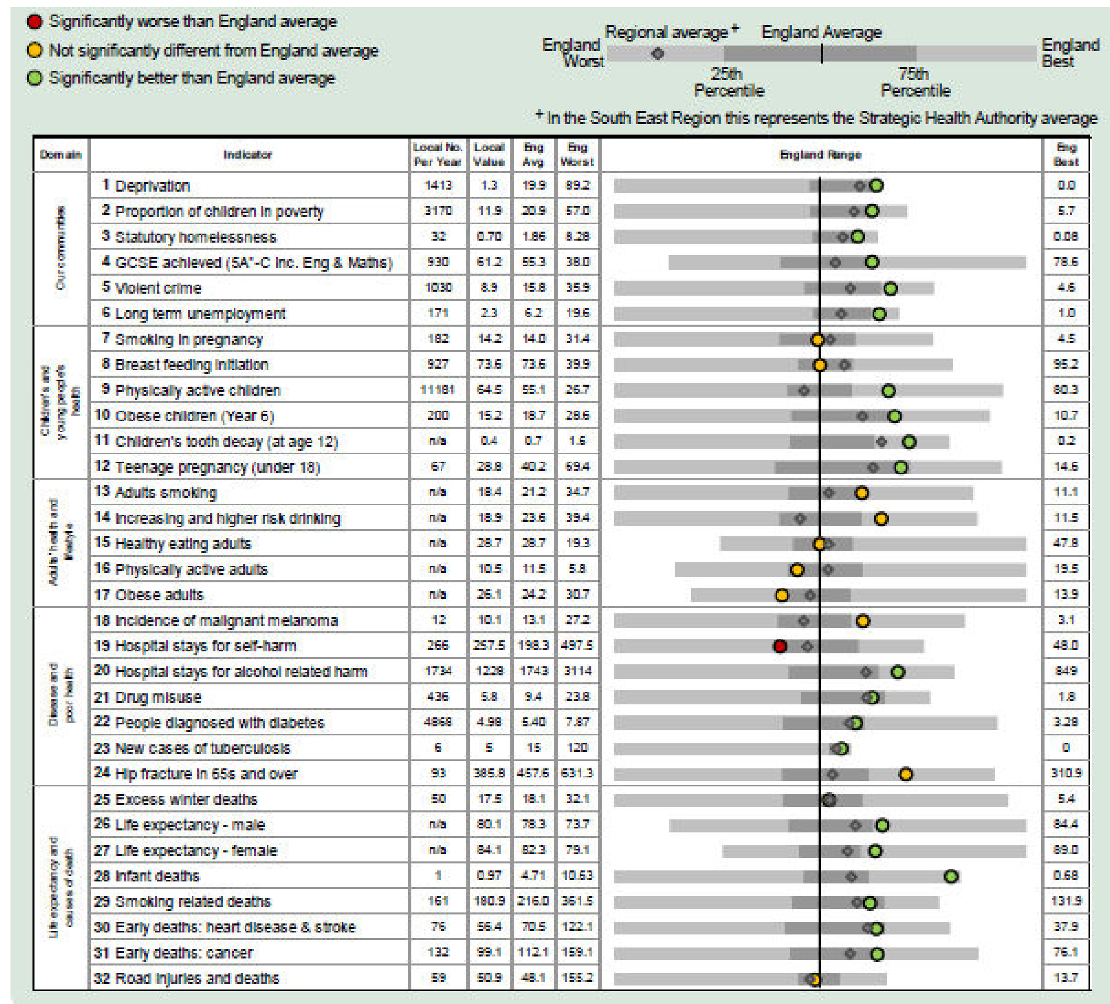
Tonbridge and Malling



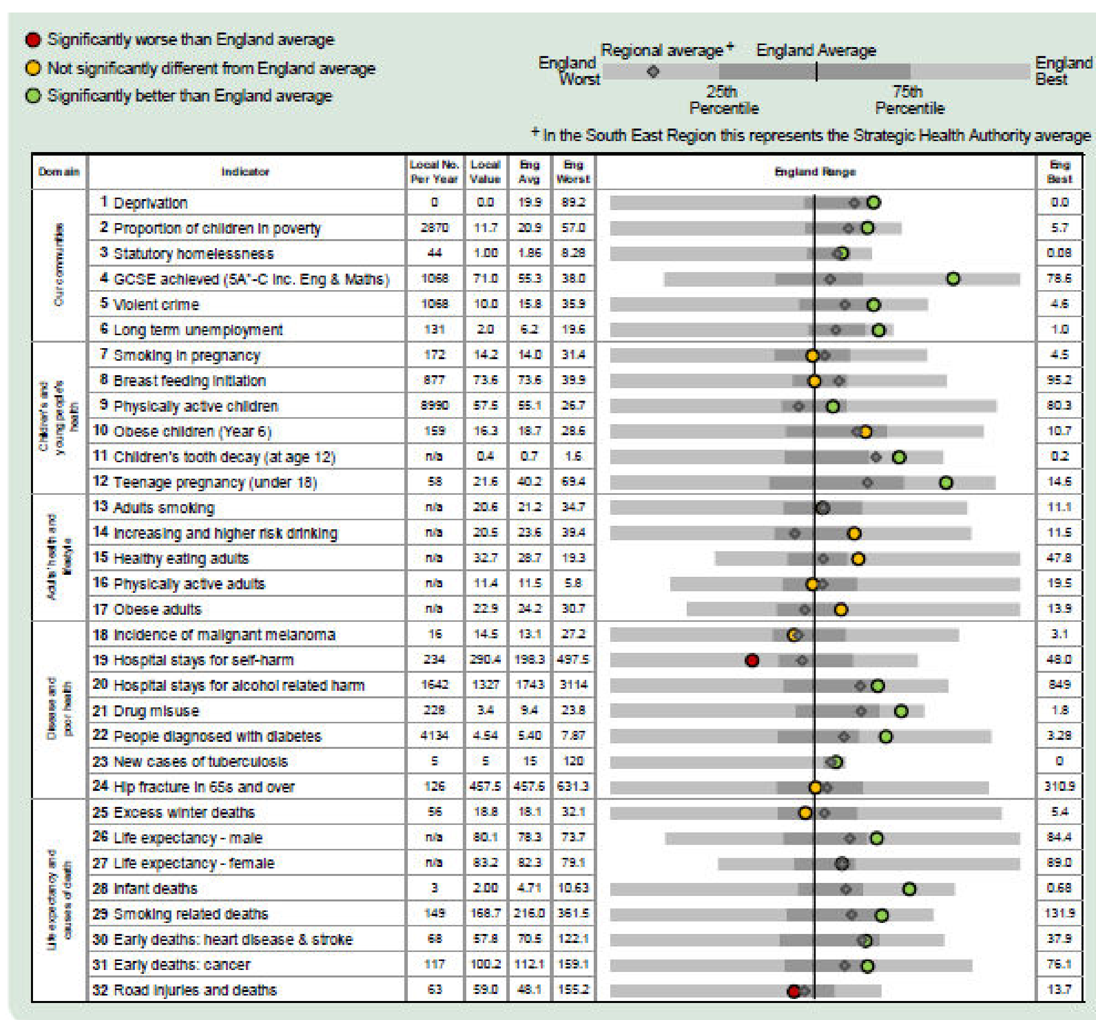
Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	1413	1.3	19.9	89.2		0.0
	2 Proportion of children in poverty	3170	11.9	20.9	57.0		5.7
	3 Statutory homelessness	32	0.70	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	930	61.2	55.3	38.0		78.6
	5 Violent crime	1030	8.9	15.8	35.9		4.6
	6 Long term unemployment	171	2.3	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	182	14.2	14.0	31.4		4.5
	8 Breast feeding initiation	927	73.6	73.6	39.9		95.2
	9 Physically active children	11181	64.5	55.1	26.7		80.3
	10 Obese children (Year 6)	200	15.2	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	67	28.8	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	18.4	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	18.9	23.6	39.4		11.5
	15 Healthy eating adults	n/a	28.7	28.7	19.3		47.8
	16 Physically active adults	n/a	10.5	11.5	5.8		19.5
	17 Obese adults	n/a	26.1	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	12	10.1	13.1	27.2		3.1
	19 Hospital stays for self-harm	266	257.5	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1734	1228	1743	3114		849
	21 Drug misuse	436	5.8	9.4	23.8		1.8
	22 People diagnosed with diabetes	4868	4.98	5.40	7.87		3.28
	23 New cases of tuberculosis	6	5	15	120		0
	24 Hip fracture in 65s and over	93	385.8	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	50	17.5	18.1	32.1		5.4
	26 Life expectancy - male	n/a	80.1	78.3	73.7		84.4
	27 Life expectancy - female	n/a	84.1	82.3	79.1		89.0
	28 Infant deaths	1	0.97	4.71	10.63		0.68
	29 Smoking related deaths	161	180.9	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	76	56.4	70.5	122.1		37.9
	31 Early deaths: cancer	132	99.1	112.1	159.1		76.1
	32 Road injuries and deaths	59	50.9	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

Tunbridge Well



Significantly worse than England average
Not significantly different from England average
Significantly better than England average

England Worst | Regional average+ | England Average | England Best | 25th Percentile | 75th Percentile

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Proportion of children in poverty	2870	11.7	20.9	57.0		5.7
	3 Statutory homelessness	44	1.00	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1068	71.0	55.3	38.0		78.6
	5 Violent crime	1068	10.0	15.8	35.9		4.6
	6 Long term unemployment	131	2.0	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	172	14.2	14.0	31.4		4.5
	8 Breast feeding initiation	877	73.6	73.6	39.9		95.2
	9 Physically active children	8990	57.5	55.1	26.7		80.3
	10 Obese children (Year 6)	159	16.3	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	58	21.6	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	20.6	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	20.5	23.6	39.4		11.5
	15 Healthy eating adults	n/a	32.7	28.7	19.3		47.8
	16 Physically active adults	n/a	11.4	11.5	5.8		19.5
	17 Obese adults	n/a	22.9	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	16	14.5	13.1	27.2		3.1
	19 Hospital stays for self-harm	234	290.4	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1642	1327	1743	3114		849
	21 Drug misuse	228	3.4	9.4	23.8		1.8
	22 People diagnosed with diabetes	4134	4.54	5.40	7.87		3.28
	23 New cases of tuberculosis	5	5	15	120		0
	24 Hip fracture in 65s and over	126	457.5	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	56	18.8	18.1	32.1		5.4
	26 Life expectancy - male	n/a	80.1	78.3	73.7		84.4
	27 Life expectancy - female	n/a	83.2	82.3	79.1		89.0
	28 Infant deaths	3	2.00	4.71	10.63		0.68
	29 Smoking related deaths	149	168.7	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	68	57.8	70.5	122.1		37.9
	31 Early deaths: cancer	117	100.2	112.1	159.1		76.1
	32 Road injuries and deaths	63	59.0	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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By: Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform

Meradin Peachey, Director of Public Health

To: Shadow Health & Wellbeing Board – 27 November 2011

Subject: Towards a Health and Wellbeing Strategy

1 Introduction

Healthy Lives, Healthy People: Update and way forward[1] outlined the following in relation to Health and Wellbeing Boards (H&WBB), Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy:

"Bringing the whole system together at the local level will be health and wellbeing boards. They will maximise opportunities for integration between the NHS, public health and social care, promoting joint commissioning, and driving improvements in the health and wellbeing of the local population. Health and wellbeing boards will provide the vehicle for local government to work in partnership with commissioning groups to develop comprehensive Joint Strategic Needs Assessments and robust joint health and wellbeing strategies, which will in turn set the local framework for commissioning of health care, social care and public health services, and taking into account wider ranging local interventions to support health and wellbeing across the life course (e.g. local planning and leisure policies and working with community safety partnerships and police and crime commissioners)."

Thus, the role of the H&WBB can be summarised as:

- Developing a joint strategic needs assessment for the locality
- Drawing on the JSNA, to agree a Joint Health and Wellbeing Strategy
- Ensuring individual commissioning plans (health, public health and social care) and wider interventions (e.g. local planning, leisure services etc) relating to the wider determinants of health align with the Joint Health and Wellbeing Strategy.

This paper outlines some of the key elements that need to be considered now in advance of national guidance being available. We envisage the first Kent Health and Wellbeing Strategy will be required to be published before the end of the current financial year.

2. Elements that need consideration

2.1 Context

The context in which the strategy is developed is important, both from

[1] Healthy Lives, Healthy People: Update and way forward. Department of Health July 2011.

a health, public health and social care view point. Clearly the Strategy will need to contribute to the delivery of “Bold Steps for Kent” and will also need to reflect Social Care plans and National Health Service operating plan. Importantly, the NHS, Public Health and Social Care are moving rapidly towards an outcomes based approach. At the time of writing the NHS are already working towards delivery of the NHS Outcome Framework, with publication of the Public Health outcomes framework imminent.

Additionally, the work of the emerging Health and Wellbeing Board has already flagged a number of priorities going forward e.g. Dementia.

Thus the strategy will need to cover:
- ✓ Health Services
- ✓ Social Care Services
- ✓ Improving Health and
- ✓ Reducing Health Inequalities

2.2 Kent JSNA and relevance to Clinical Commissioning Groups and Districts in Kent

Production of the Kent JSNA is currently being undertaken by the Public Health Directorate. Further work is required to translate this into a more meaningful story at both District and Clinical Commissioning Group level given the size and variation of need across Kent’s geography. The Health and Wellbeing Strategy will need to be strategic enough to support differing locality needs and priorities.

2.3 Stakeholders and working with partners

There are many stakeholders we will need to consider in the production of the Health and Wellbeing Strategy. This includes Statutory members of the H&WBB together with Directorates of KCC, District Authorities within Kent, Health and Social Care providers, Kent and Medway Cluster, and finally, but not least the population of Kent.

2.4 Inequalities and Marmot

Given the Health Inequalities in Kent, the strategy will also need to align where possible with the objectives set out in Sir Michael Marmot’s report “Fair Society Healthy Lives”[2]

2.5 Production and Process

We will also need to consider, given the multiplicity of stakeholders who leads this process, how we get the physical document written,

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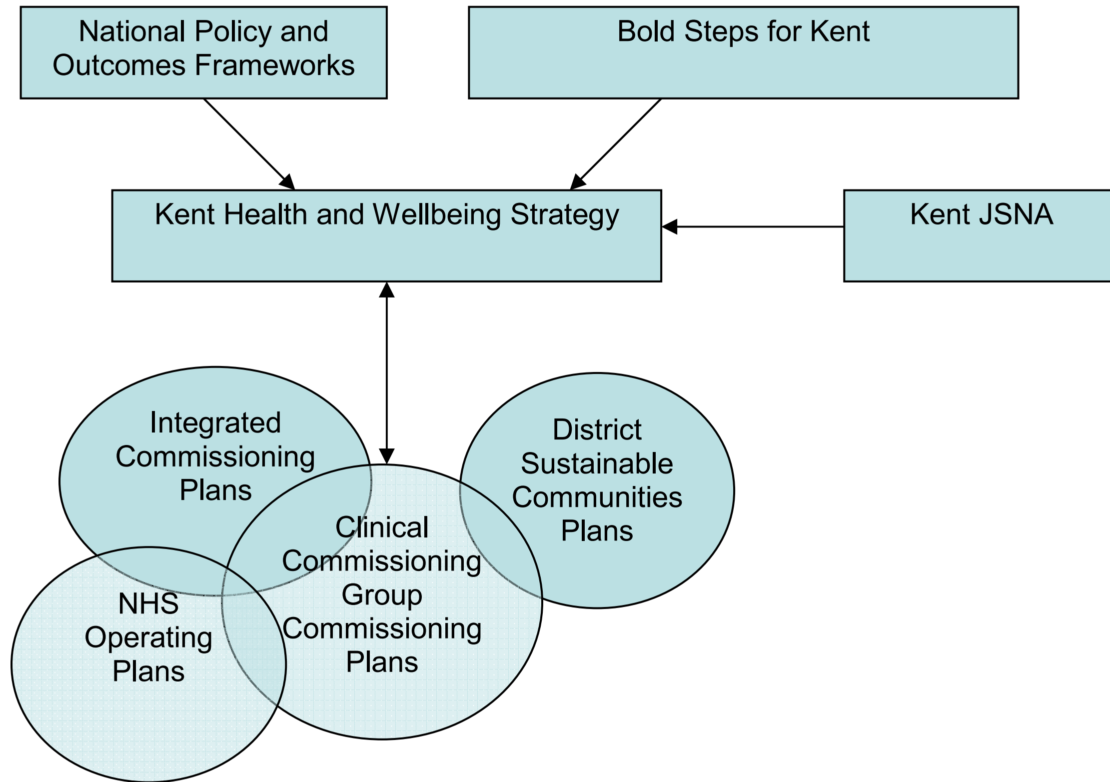
[2] Fair Society Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post-2010. February 2010

what the document will look like and how it is published, distributed and communicated and to what timeline.

3.0 Envisaged Relationship of the Strategy to Existing Commissioning Strategies



4.0 Suggested Outline of the Strategy

4.1 Executive Summary

4.2. Summary of the Context within which the Strategy exists

- National
- Local
  - Bold Steps for Kent
  - Direction of local and national policy.

4.3 Summary and priorities of the Joint Strategic Needs Assessment is highlighting Kent wide priorities, however, will need to take account of local priorities where they are important but differ from Kent.

4.4 High level mapping of existing resources i.e. where the money is currently spent across health and social care; this would then help us consider how it needs to move.

4.5 Vision for what the health of the population of Kent will look like in future years

4.6. Strategy setting out key directions for major initiative for the year e.g. change in pathways

4.7 Implementation plan together with targets that relate to delivering the vision with the Strategy.

Development and production of the strategy could become all encompassing and there is the potential to create a document which adds little and potentially disengages the very people we want engaged. Thus, I envisage the strategy to be short and succinct, to point to, and to reference, existing commissioning strategies without replicating and duplicating these.

Andrew Scott-Clark
Director Health Improvement (KCC)
November 2011

By: Roger Gough, Cabinet Member for Business Strategy, Performance & Health Reform

Meradin Peachey, Director of Public Health

To: Shadow Health & Wellbeing Board – 23 November 2011

Subject: Developing provider relationships - what does the Health and Well-Being Board need?

Summary: At the first meeting of the Health and Wellbeing Board (HWB) members identified the need for means to support the Board in engaging with Healthcare Providers. This paper considers the potential to utilise Clinical Leadership Groups as such a mechanism.

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1. Background:

1.1 During the development of the terms of reference (ToR) for the shadow HWB, consideration had been given to explicitly provide for Pathway Advisory Groups (PAG) as a mechanism to support Clinical Commissioning Group (CCG) and HWB engagement with healthcare providers in order to facilitate pathway redesign, improve the patient journey and healthcare outcomes. This would also have enabled the formal commissioner/provider split inherent in the Health and Social Care Bill to be maintained.

1.2 Reference to PAG (but not the role to support pathway redesign) was removed from the HWB ToR on the basis that the Clinical Senates, announced as part of the NHS Futures Forum, might take on that function instead. However, given the spatial scale that Clinical Senates will seemingly operate at (national and regional tier) they will likely focus on supporting pre-existing clinical Pathway Development Groups for nationally and specialised services, and may not cover the range of services currently commissioned by PCTs or those services which will be commissioned by CCGs post April 2013.

1.3 This paper explores the current configuration of clinical leadership for pathway development within Kent and the issues the Board might wish to consider in developing a PAG or other mechanism.

2. Clinical Care Pathway Development Groups

2.1 Clinical services are planned and commissioned based on different population sizes. Some diseases or conditions are rare and therefore affect small number of patients. These services are provided in a small number of Trusts by highly specialised teams, and are commissioned by the National Specialised Commissioning Group. Some of the services that fall in this category are: heart transplantation, high secure mental

health services and certain children's cancers. The Clinical Care Pathways for these diseases are developed at the national level.

2.2 Regional Specialist Services are commissioned by regional Specialised Commissioning Groups on behalf of the Primary Care Trusts. Locally, there is a South East Coast Specialist Commissioning Team which supports the three PCT Clusters and CCGs in Kent & Medway, Surrey and Sussex. There are 38 services that are defined as regional specialised services. The planning and commissioning of these services requires populations in excess of 1 million. Some of the examples of these services are: haemophilia services, bone marrow transplantation services, paediatric cardiac services and paediatric neurosurgery services. The developments of Clinical Care Pathways for these services usually involve Specialised Commissioning Groups, local commissioners and providers of these services.

2.3 The majority of the NHS services are currently commissioned by the PCTs. Clinical Networks and other clinical groups support the commissioning of services by the PCT. The most prominent examples of Clinical Networks are: Cancer Network, Cardiac and Stroke and Vascular Services Network. These networks in Kent and Medway have supported the development of Clinical Care Pathways relevant to their services. In the future, this type of clinical network is likely to be hosted by the National Commissioning Board but will continue to operate at local level.

2.4 The leadership arrangements for pathway redesign for other services have evolved differently in different PCTs. NHS West Kent and NHS Eastern & Coastal Kent each had structures in place which involved clinical leaders from providers and commissioners together in reviewing pathways, and a range of groups have been established, generally feeding into local whole system planning arrangements – for example the Whole System Delivery Boards in West Kent and the Integrated Care Board in Eastern & Coastal Kent – as well as into the governance structures of individual organisations. Even if one was to hold a census of these groups, this would only provide a snapshot. It is worth noting that the number of groups reviewing pathways at any one time reflect the number of clinical care pathways that need developing or revising and that will change over time.

3. Issues:

3.1 Clearly provider engagement is important. However, in developing a mechanism for engaging with providers there are a number of issues/questions that the shadow HWB must consider:

a) Presuming that the NHS Commissioning Board and Clinical Senates become the locus for supporting Clinical Care Pathway Development Groups for specialist and nationally commissioned services, how will the HWB and local commissioners receive clinical advice on pathway development for locally commissioned services?

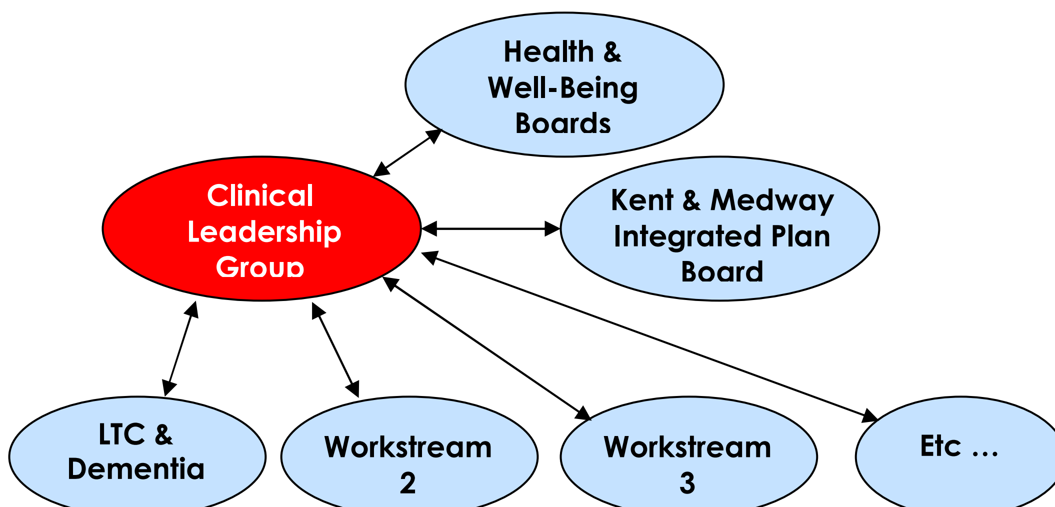
b) Is there a clear scope for the role of any proposed PAG under the HWB? It should be noted that existing groups are focussed on the improvement of clinical outcomes and patient experience, and the need to deliver best value for money. Increasingly, this will require a shift in spending from the acute sector and into the community sector.

c) Although the number of groups reviewing pathways in existence at any point in time will vary, the Board, at least whilst operating in shadow form, needs to be careful that it doesn't further confuse the landscape before details of how they might operate post April 2013 becomes clearer. Moreover, it should also be noted that neither KCC nor the HWB has a budget to support an extensive number of PAG.

3.2 On Wednesday 9th November clinical leads from commissioners and providers across Kent and Medway, including representatives of public health and social care, met to consider proposals for establishing a local clinical leadership group. There was strong support for such a group to be established, and to provide the leadership drive for service redesign, focusing in particular on those issues which are bigger than any one local system – for example major trauma, pathology and paediatric surgery – and on a significant shift in emphasis for services for people with long term conditions and dementia, such that the expectation for these large and growing groups of individuals is that their care is co-ordinated by the primary care team with specialist input, rather than the reverse, and a significant proportion of the 'care episode' shifts to the community.

3.3 The group felt strongly that membership of the clinical leadership group and any specific pathway review groups meeting under its aegis should be representative of the 'whole system' – health and social care commissioners and the full range of providers – and be multi-professional, involving nurses, allied health professionals and social care professionals in addition to doctors.

3.4 A diagram showing the potential relationship of this clinical leadership group, and the pathway review groups which it may set up, to the HWBs in both Kent and Medway is shown below:



4. Next Steps:

4.1 The HWB needs to be careful about how it progresses further on this agenda as it is likely to develop further as CCGs take over commissioning responsibilities from the PCT in April 2013 and the HWB moves out of shadow form. However, it would be unfortunate to miss the opportunity whilst in shadow form to shape how Kent HWB and CCG may engage with healthcare providers in Kent and feed this back through the national learning sets into the guidance likely to emerge from the Department for Health.

4.2 It is therefore suggested that the Board support the model proposed by local clinical leaders, and request feedback on progress throughout the period that the HWB is in shadow form. Given the pre-existing work that has been undertaken on dementia, and a clear appetite to improve outcomes for patients in this area, it is further suggested that a report on specific actions agreed to improve the pathways of care for people with dementia be requested from this group at the next HWB meeting.

5. Recommendations:

5.1 The Board is asked to:

a) Note the report.
b) Agree to the establishment of the Clinical Leadership Group to test the model of HWB/CCG engagement with providers to run alongside the shadow HWB.
c) Agree that an early focus of this group should be on Dementia or suggest suitable alternatives.

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