



AGENDA

HEALTH AND WELLBEING BOARD (SHADOW)

Wednesday, 18th January, 2012, 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 - 23 November 2011 (Pages 1 - 6)
5. Structure of the Health and Wellbeing Board (Pages 7 - 14)
6. DH Guidance on JSNA & Health & Well Being Strategy (Pages 15 - 42)
7. Kent Health and Wellbeing Strategy (Pages 43 - 108)
8. Joint Strategic Needs Assessment (JSNA) (Pages 109 - 226)
9. Pathway for Adult Obesity Services (Pages 227 - 236)

Peter Sass
Head of Democratic Services
Tuesday, 10 January 2012

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 BCI
Cllr Paul Carter - Leader of Kent County Council
Dr Fiona Armstrong - Joint Clinical Lead, Swale CCG
Cllr Paul Watkins - Leader Dover DC
Michelle Farrow - Leadership Support Manager, Dover DC
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
Caroline Davis - Strategic Policy Advisor (Health & Wellbeing) KCC
Invited Observer

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 Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 23 November 2011.

PRESENT: Dr J Allingham, Ms J Bostock (Substitute for Dr M Jones), Dr B Bowes, Ms H Buckingham (Substitute for Ms A Sutton), Dr M Cantor (Substitute for Dr Fiona Armstrong), Mr P B Carter, Dr S Chaudhuri, Cllr M A Coffin (Substitute for Cllr M Worrall), Cllr J Cunningham, Mr G K Gibbens, Mr R W Gough, Cllr L Ingham (Substitute for Mr A Bowles), Mr A Ireland, Mr R Kendall, Ms M Peachey, Dr R Pinnock, Dr G Singh, Mr C Tomson, Mrs J Whittle and Dr D Woodhead

ALSO PRESENT: Cllr R Davison

IN ATTENDANCE: Ms S Brown (Business Manager - Public Health Unit) and Mr P Sass (Head of Democratic Services)

UNRESTRICTED ITEMS**12. Welcome**

(Item 1)

The Chairman, Roger Gough, Cabinet Member for Business Strategy, Performance and Health Reform (KCC), welcomed everyone to this second meeting of the Shadow Health and Wellbeing Board.

13. Substitutes

(Item 2)

The following apologies and substitutes were received and noted:

Katherine Kerswell

Ann Sutton (represented by Helen Buckingham)

Dr Mark Jones (represented by Jenny Bostock)

Cllr Mark Worrall (represented by Cllr Martin Coffin)

Dr Fiona Armstrong (represented by Mr Mick Cantor)

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

(Item 3)

Roger Gough explained that a template for the formal registration of interests by members of the Shadow Health and Wellbeing Board had been prepared and that it would be sent out to Board members for their views on the format and requested interest categories. Once agreed, Board members would be asked to complete the register with their own interests under each relevant category and return it to Peter Sass who would maintain a central register of interests. Even after completion, Board members would be required to declare any relevant interests at meetings of the

Shadow Health and Wellbeing Board if there was an item on the agenda that related to one of their registered interests. Any declared interests would be recorded in the minutes of Board meetings.

No members of the Shadow Health and Wellbeing Board declared any interests in relation to items on the agenda for this meeting.

15. Previous minutes/action points

(Item 4)

Referring to the minute of the discussion under item 7 (Our Vision for the role of the Health and Wellbeing Board), Jenny Whittle asked for the minutes to be amended to make reference to the need for a review of integrated provision for occupational therapy waiting times for children and young people, rather than the reference in the minutes to there having already been a successful pilot.

Subject to the above amendment, the Board agreed that the Minutes of the meeting held on 28 September 2011 were a correct record and authorised the Chairman to sign them as such.

Paul Carter updated the Board on the excellent progress being made on the Kent Health Commission in the Dover District area with Localis. The Commission was a forward-thinking project that sought to effect real change by re-shaping services delivered by acute hospital trusts, GPs and social care, with a view to achieving improved outcomes for community health by improving pathways for patients and managing budgets more efficiently. The Commission had its first meeting recently, which had been attended by Charlie Elphicke MP and he added that the Secretary of State for Health, Andrew Lansley, was very keen on the proposal and had asked for an interim report on progress by mid-December. Paul Carter stated that this was an exciting development and exactly the sort of thing that the Health and Wellbeing Board should be encouraging and supporting, adding that even a 5% saving on acute health budgets would produce £6 to £7m every year for community health spend.

Dr Chaudhuri declared a personal interest in the discussion on the Kent Health Commission as the clinical lead for the Dover Locality, South Kent CCG.

16. Health Needs for Kent - Health & Social Care maps - the JSNA for Kent - getting the right product

(Item 5)

Roger Gough explained that the agenda for this meeting had three main and connected strands: the Joint Strategic Needs Assessment (JSNA); the Health and Wellbeing Strategy; and developing provider relationships. With regard to the JSNA, he stated that it would come back to the Board in January for endorsement.

Graham Gibbens, Cabinet Member for Adult Social Care and Public Health, introduced Andrew Ireland, the recently appointed Corporate Director of Families and Social Care, to the Board.

Graham Gibbens introduced the draft JSNA, stating that it was currently out for consultation and being amended and improved all of the time prior to being adopted formally in March 2012 and that he welcomed any comments or suggestions as to

how the document could be shaped and further improved by the Board. He stated that the key to producing a good JSNA was about bringing together intelligence about the health and social care needs for the good of the people of Kent.

It was noted that one area of the document that would change was in relation to services for mental health and Mr Gibbens stated that CAMHS were currently reviewing the document with a view to providing much more information for the next iteration. Mr Gibbens referred to a number of examples in the current version of the document where there was excellent statistical information that would undoubtedly lead to intelligent and appropriate commissioning of relevant services.

A number of specific comments were made about where the document could provide more detail, such as in relation to local demographic information and population trends; determinants of health inequalities in different District areas; and where preventative services could have a wider role in reducing the need for other services.

CCG representatives welcomed the document and expressed the desire for it to be finalised as quickly as possible so that it could inform their commissioning plans, procurement activity, the relative priority attached to each service provided and the targeting and marketing of those services.

17. Towards a Health & Wellbeing Strategy *(Item 6)*

Andrew Scott-Clark, Director of Health Improvement (KCC) gave a presentation on the development of a Health and Wellbeing Strategy. The presentation discussed the context for the development of the Strategy and the strategy timescales for the purposes of guiding commissioning intentions. Of particular significance were the proposed priorities, which came out of the workshops earlier in the year. These were:

- Dementia
 - Early diagnosis
 - Integrated model
 - Accessible care pathways
- CAMHS
- Addressing Health Inequalities
- Equity of Health provision
- Integrated commissioning
- Push for 5% more investment in primary and community through shift in funding

It was suggested that these priorities were used to develop a shadow shadow Health and Wellbeing Strategy between now and the end of the financial year and that the period between April and October 2012 be used to iteratively develop the full Kent Health and Wellbeing Strategy, which would feed into the development of CCG and other Commissioners' Plans between October 2012 and March 2013.

Roger Gough asked the Board to discuss whether they thought the proposed priorities were the correct ones, adding that he thought it was better to start "lean and focused" at the beginning.

Paul Carter stated that the proposed priorities for the Health and Wellbeing Strategy were not dissimilar to those being examined by the Kent Health Commission in the Dover area, which he referred to earlier in the meeting.

A number of comments and suggestions were made by Board members, as follows:

- It was right to have Dementia as a priority, but the number of falls by elderly people had increased a great deal.
- Services for children were crucial, particularly healthy eating
- Increased joint-working was key to the future successful implementation of the Strategy, such as in relation to bed-blocking and improved pathways
- It was important to ensure that the Board was measuring the right things
- A suggestion was made that the Strategy should include Kent-level information, from which individual CCGs could tailor their priorities
- It was important to be realistic about what could be achieved in the Strategy and not seek to raise expectations too highly
- Health Inequalities was too broad and that it should be broken down to its individual determinants in different areas, e.g. obesity and smoking, so that individual CCGs could decide how best to tackle Health Inequalities in their own areas

Roger Gough thanked the Board for their helpful suggestions and comments, adding that the strategy was iterative and would come back to the Board again in January for further discussion.

18. Developing provider relationships, what does the Health and Well-Being Board need?

(Item 7)

Helen Buckingham introduced the item on developing provider relationships and what the Health and Wellbeing Board would need from these relationships. In particular, the Board was reminded that it had agreed there was a need for means to support the Board in engaging with Healthcare providers and a proposal was made to utilise Clinical Leadership Groups as such a mechanism.

The Board was in broad agreement to the role that the Clinical Leadership Group could have, as long as there was no “mission creep” and the Health and Wellbeing Board needed to be focused on commissioning. It was agreed that there was more work to do in relation to the specific roles and practical objectives for the CLG and that it would come back to the next meeting for a discussion.

19. Future dates to April 2013

(Item 8)

The following dates for future meetings were noted:

18 January 2012
21 March 2012
30 May 2012
18 July 2012

19 September 2012
21 November 2012
30 January 2013
27 March 2013

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

To: Health and Wellbeing Board

Subject: Structure of the Health and Wellbeing Board

Classification: Unrestricted

Purpose

The actual designated responsibilities of the Health and Wellbeing Board (H&WB Board) are relatively few:

- Ensuring that a Joint Strategic Needs Assessment (JSNA), a Pharmaceutical Needs Assessment and a Joint Health and Wellbeing Strategy (JHWS) are produced
- Ensuring that the commissioning decisions of the Clinical Commissioning Groups and the local authority, for public health, meet the needs and priorities identified in the JSNA and the JHWS
- Promoting the integration of commissioning of health and social care services

Whilst few in number if the H&WB Board is to discharge these responsibilities properly it will require support to enable it to influence complex processes and make informed decisions. There are also limitations on how frequently and for how long the Board can meet. It is therefore essential that a robust infrastructure is created for the Board to operate effectively.

This infrastructure needs to be able to inform the Board on technical matters such as commissioning and integration of service delivery as well as ensuring that appropriate relationships are fostered with key partners, especially the CCGs and District Councils.

In addition to ensuring good relationships with key partner organisations the Board also needs to ensure it is communicating effectively with patients in Kent and the wider population.

Commissioning will be a key area of activity for the Board to understand and influence. This report focuses on proposals for an Integrated Commissioning Executive and a Health Improvement Commissioning Board that have been developed to ensure that the Board is advised appropriately and is able to ensure that the commissioning decisions made for health, social care and public health in Kent meet the needs of the people of Kent and are commensurate with the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy.

Integrated Commissioning

Whilst current arrangements often work well at a local level to promote co-operation and joint working there is no formal framework to develop properly integrated commissioning between agencies. We need to establish an integrated commissioning framework which will then be able to consider best possible arrangements for integrated services and commissioning support.

Commissioning services and moving towards integrated commissioning

The issue for service commissioning is what degree of integration is necessary to achieve the greatest added value.

The proposal divides service areas where health and social care need to work together into 3 broad categories in order to break down the work to make it manageable and group service areas together where it makes sense to take an overview. It is accepted that this not always a perfect fit and there must be a read across and we must avoid creating silos. The service areas proposed are:

- Children and Young People
- Older People and People with a Disability
- Mental Health

It is proposed that groups are established for each of these consisting of the appropriate Directors and other senior managers from the PCT cluster and KCC as well as lead GPs representing Clinical Commissioning Groups and Members as appropriate.

Each group will review existing arrangements within their respective area and agree outcomes to be achieved (referenced to the 3 DH outcome frameworks). Priorities will be identified and potential degrees of integration evaluated. Each group will produce a report for the Strategic Oversight Board and Clinical Commissioning Groups. The report will also address how principles of prevention, personalisation, incentivisation and localism will be achieved.

Possible models of engagement with districts and CCGs at a more local level are being considered as part of the current Kent Health Commission work.

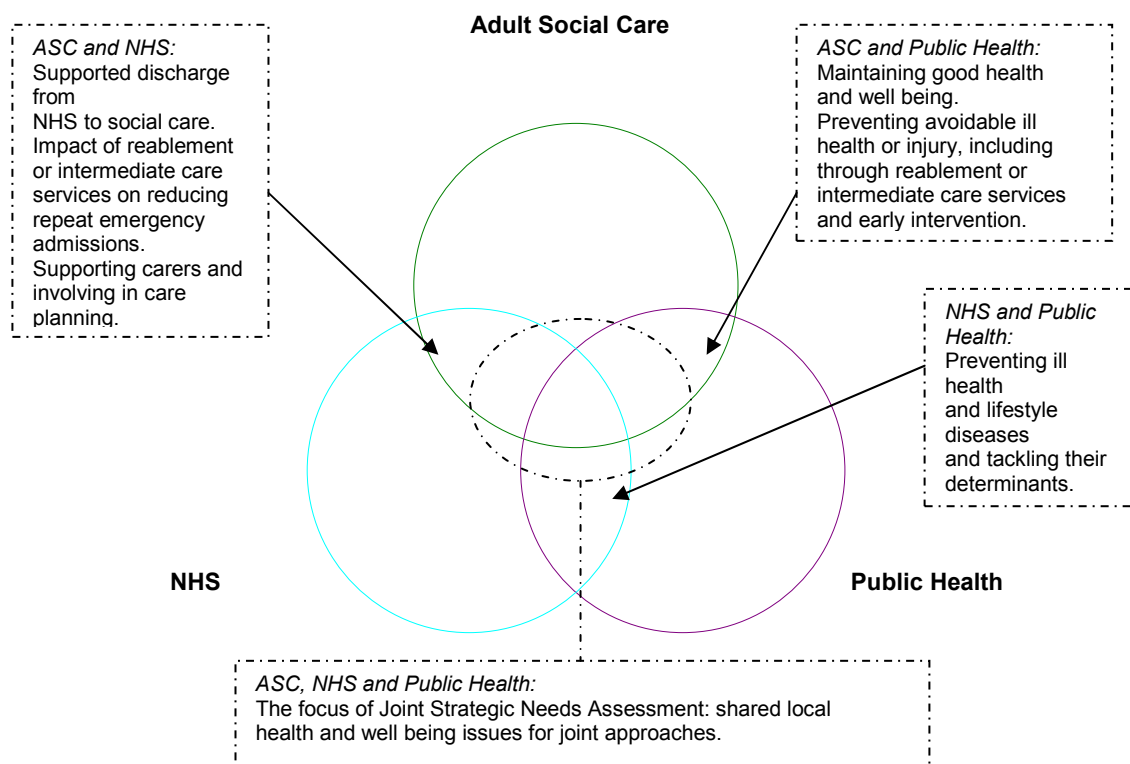
Once plans have been agreed the groups could move to an Executive function with an appropriate sub structure put in place. The NHS Kent and Medway Director of Whole System Commissioning and KCC Director of Strategic Commissioning will ensure that the groups work seamlessly together and that cross cutting areas such as prevention and support to carers are co-ordinated.

It is proposed that a quarterly meeting of an Integrated Commissioning Executive is established to oversee the work of the groups. The Executive will comprise of PCT Cluster Chief Executive and the Corporate Director of FSC, KCC and their Directors as well as lead GP's representing the CCGs.

The combined priorities contained within the plans will form the basis of the Joint Health and Wellbeing Strategy. The integrated Commissioning Executive will decide where decisions need to be sought, CCG Board, KCC Cabinet or Health and Wellbeing Board.

It is suggested the work to align outcomes of health, public health and social care should shape the basic framework within which the integrated commissioning strategy should operate. Identifying the overlapping areas between the respective agencies strongly encourages integrated working and commissioning and supports a “whole systems” approach. This is illustrated in the diagram below.

Figure 2. Aligning NHS and Adult Social Care Outcomes



Commissioning support

Dependent upon the degree of integration of services consideration can then be given to the best possible arrangements for commissioning support.

Health Improvement Commissioning Board

Changes to the NHS and transition of public health to KCC from April 2013 offer opportunities to redesign the commissioning landscape and enable much better integration across functions. It is important that commissioning services for health improvement is properly aligned with the other elements of commissioning for health and social care and the Health and Wellbeing Board, the Clinical Commissioning Groups and KCC. The Kent Forum and associated Locality Boards, or other local arrangements, will also be important elements of the structure. The arrangements to support the Board to discharge its functions towards the commissioning of public health may therefore be more complicated than those for integrating the commissioning of health and social care services.

Current commissioning arrangements

The total public health budget that will be allocated to KCC is expected to be in the region of £30-£40 million but this is subject to revision when the indicative budgets are published by the Department of Health. A large proportion of this is tied into block contracts for screening and other preventative measures commissioned from the acute hospital trusts leaving c. £17.2 million that has been identified as commissioning services for healthy lifestyles.

The majority of this budget (c £15 million) is within contracts with the Community Health Trust for services such as smoking cessation, sexual health and healthy weight. Most of these contracts are renewed annually and would require a 6 month notice of variation. Contract performance review and monitoring is currently the responsibility of a group established by the PCT Cluster following the establishment of the Community Health Trust.

c £1 million is currently placed with district councils, mainly in the West of Kent for healthy lifestyle interventions. District Councils are concerned about whether this funding will be maintained and what arrangements for commissioning services will be in the future.

The formal accountability for commissioning public health services still rests with the PCT Cluster Board but the responsibility for commissioning has been delegated to KCC under a Memorandum of Understanding. Current arrangements are that commissioning decisions are taken at the Public Health Directorate Management Team in consultation with the Cabinet Member. Performance management of commissioned services within the Community Health Trust is carried out jointly with the PCT Cluster.

The necessary arrangements for effective joint working with District Councils and others at a local level are still subject to discussion but will need to be incorporated into the new structures.

It is intended that the Health Improvement Commissioning Board/Committee would replace the commissioning functions of the Public Health Directorate Management Team and other groups such as the West Kent Health Policy Board.

Functions of a Health Improvement Commissioning Board

A Health Improvement Commissioning Board should:

- Provide robust and comprehensive commissioning, and de-commissioning, arrangements to meet the needs identified through the JSNA and aligned with the Health and Wellbeing strategy
- Ensure the outcome frameworks for public health, NHS and social care are embedded in commissioning for health improvement
- Support integrated commissioning of services across health and social care and link with other community services
- Complement the other commissioning groups in new integrated structure
- Ensure effective relationships with the Health and Wellbeing Board, Kent Forum, CCGs, Districts and KCC.
- Review and evaluate the performance of commissioned services
- Deliver measurable improvements to health and wellbeing and reduce health inequalities in Kent

Membership

The proposed membership of the Health Improvement Commissioning Board would include: the Director of Public Health; Director of Health Improvement; KCC directors; Senior district officers, PCT Cluster and CCG representatives and Members as appropriate. It would be helpful if some membership was shared with the Integrated Commissioning Executive.

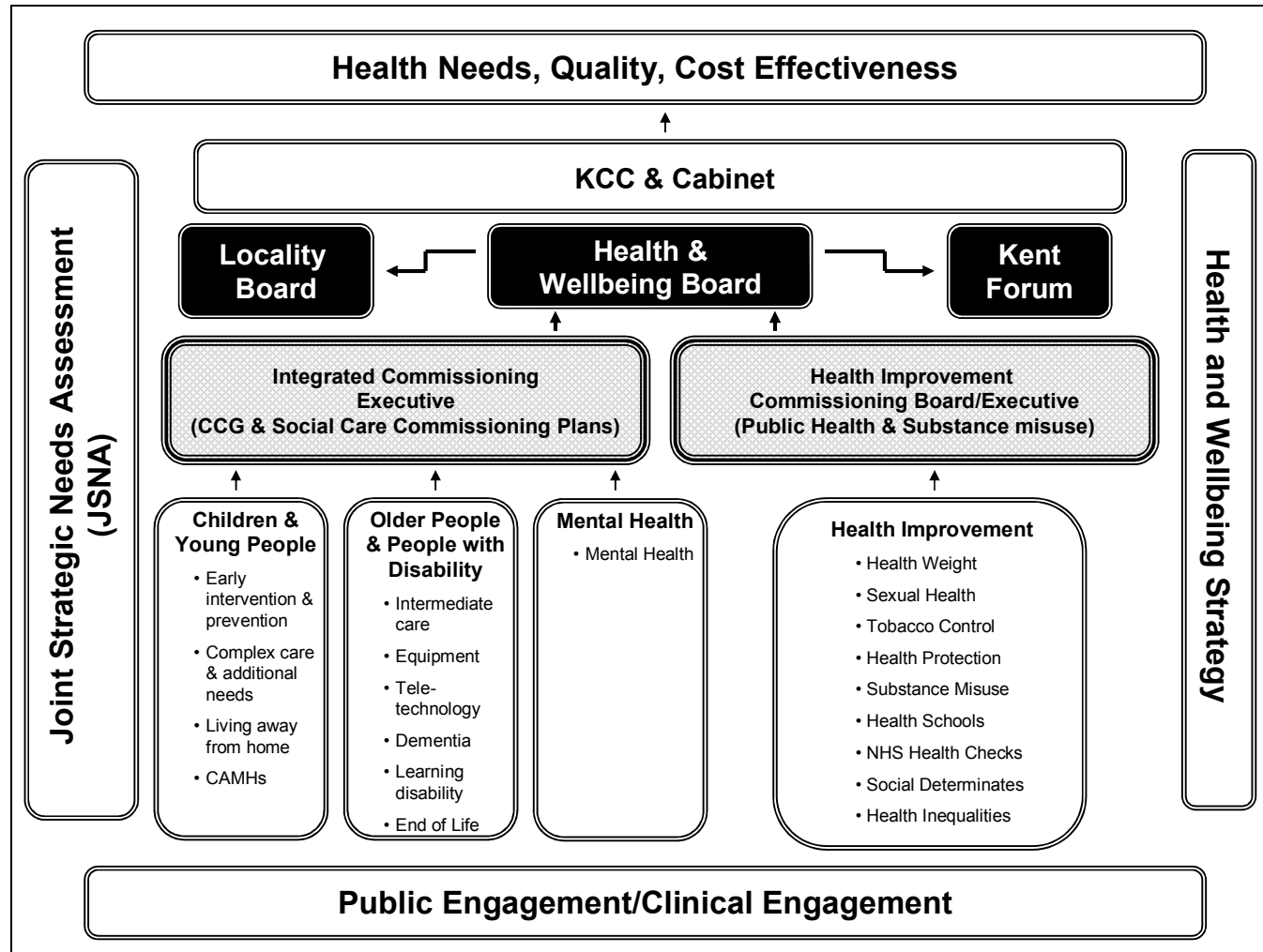
Linkages and Reporting

The relationship between the Board and the Districts will be particularly important in order to deliver health improvements and Locality Boards, where they exist, potentially offer the best mechanism to achieve this. The detail of this will need to be resolved as Locality Boards mature. In other areas existing bodies that consider local public health matters, such as local Health and Wellbeing Groups, could be appropriate. An important issue that remains outstanding is how the links with Districts and CCG's will operate at a local level. Both will have a crucial role to play in delivery of public health but more consideration of how the linkages will be made is still required.

Regular reports from the Health Improvement Commissioning Board would be provided to the H&WB Board, Strategic Oversight Board, KCC, CCG's, Integrated Commissioning Executive, and for the Kent Forum. Reports should also be available to Locality Boards and other local bodies as appropriate.

Structure Chart

The following chart shows the proposed structure to support the Health and Wellbeing Board to discharge its commissioning related responsibilities:



Conclusion and recommendations

The Health and Wellbeing Board is asked to consider what advice, analysis and support it requires to discharge its responsibilities concerning the commissioning of health, social care and public health services and whether the outline proposals contained in this report form a basis for further development.

The Board may also want to consider the administrative support that will be necessary which could include a Steering Group to assist the work of the Commissioning Boards which would replace the existing Strategic Oversight Board.

By: Andrew Scott-Clark, Director of Health Improvement (Public Health) KCC.

To: Health and Wellbeing Board

Subject: Department of Health

Classification: Unrestricted

Recommendations

Health and Wellbeing Board is asked to receive this paper for INFORMATION to help inform ongoing development of our local JSNA and Health and Wellbeing Strategy

1. Introduction

- 1.1 On the 5th December 2011 the Department of Health published the document 'Joint Strategic Needs Assessment and joint health and wellbeing strategies explained'
- 1.2 This short paper summarises the content; the full document is attached.
- 1.3 The paper also sets out the national recommended timeline for the refresh of the Joint Strategic Needs Assessment and development of local Health and wellbeing strategies.

2. Joint Strategic Needs Assessments and H&WB Strategies

- 2.1 It is expected that emerging Health and Wellbeing Boards will now be jointly beginning to refresh the JSNAs and beginning to develop H&WB Strategies.
- 2.2 The Department of Health plan to further support this process through:
 - Development of statutory guidance on JSNA and H&WB Strategies and
 - Work with partners to develop resources to support the development and effective use of JSNAs and joint H&WB Strategies.
- 2.3 This statutory guidance is due to be published in January 2012 in draft form but will not be formally published until following the Health and Social Care Bill receiving Royal Assent.
- 2.4 The DoH have also set up a National Learning Network for health and wellbeing boards to develop knowledge and behaviours that enable them to work more effectively to deliver their shared purpose

- 2.5 The paper also sets out the context from the vision set out in Equity and Excellence: Liberating the NHS¹
- 2.6 The three key messages are as follows:
1. Health and Wellbeing Boards
‘The health and well being board provides an opportunity to build upon good practice (the best JSNAs have been those undertaken collaboratively through strong and collaborative partnerships at all levels) in taking existing JSNAs further so enabling the transformation of services through collaborative leadership and the development of a joint health and wellbeing strategy’.
 2. ‘The H&WB Strategy supports the Health and Wellbeing Board to take the step from assessing needs and available assets to planning and delivery of integrated services and collectively addressing the underlying determinants of health and wellbeing. In this way the JSNA and joint Health and Wellbeing Strategy combined form the basis for local decisions that drive service change such as investment and disinvestment in services according to local needs and engagement in the local community’.
 3. ‘The joint health and wellbeing strategy is a unique opportunity for the health and wellbeing board members to explore together the local issues they have not managed to tackle on their own’
- 2.7 In assessing needs and priorities the H&WB Board should adopt an ‘outcomes based approach’ and could be the place where the three national outcomes frameworks come together
- 2.8 The paper also describes commissioning and service provision as a priority
- 2.9 Finally, but not least the paper describes the duty to involve users and the public in the development of both the JSNA and the joint health and wellbeing strategy and pay due regard to the Public Sector Equality Duty.

3. Timeline

- 3.1 The document also sets out indicative timings for Health and Wellbeing boards which suggests completion of JSNAs by April to inform Health and Wellbeing strategies by May; in time for Clinical Commissioning Groups and Local Authorities to begin planning for the financial year 2013 to 2014.

1

[Http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)

4. Conclusion

- 4.1 Given the above points the H&WB Board will need to consider the local development of both the JSNA and H&WB Strategy

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Joint Strategic Needs Assessment and joint health and wellbeing strategies explained

Commissioning for populations

Joint Strategic Needs Assessment and joint health and wellbeing strategies explained – commissioning for populations

DH INFORMATION READER BOX	
Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working
Document Purpose	For Information
Gateway Reference	16731
Title	Joint Strategic Needs Assessments and joint health and wellbeing strategies explained
Author	Department of Health
Publication Date	05 Dec 2011
Target Audience	PCT CEs, NHS Trust CEs, Directors of PH, Local Authority CEs, Directors of Adult SSs, GPs, Directors of Children's SSs, HealthWatch England and Local pathfinders, CCG pathfinders, early implementer HWBs
Circulation List	
Description	This publication is intended to support the NHS, local government and emerging health and wellbeing boards to develop their understanding of the purpose of Joint Strategic Needs Assessments (JSNA) and joint health and wellbeing strategies, and to set out the resources which can be expected from DH and its partners.
Cross Ref	Equity and Excellence: Liberating the NHS
Superseded Docs	N/A
Action Required	N/A
Timing	N/A
Contact Details	Freya Lock Social Care Leadership and Performance 114 Wellington House 133 - 155 Waterloo Road SE1 8UG 2079724237
For Recipient's Use	

Joint Strategic Needs Assessments and joint health and wellbeing strategies explained

Commissioning for populations

Prepared by Social Care, Local Government and Care Partnerships Directorate

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Foreword

Health and wellbeing boards are at the heart of our plans to transform health and care and achieve better population health and wellbeing.

Leaders from across the local community will come together in health and wellbeing boards. They will have a collective focus – to improve services for the whole community so individuals and communities are able to live healthier lives, and have a better experience of the health and care system.



This publication is an important call to action to emerging health and wellbeing boards. It makes the case for starting work now on two core responsibilities for future health and wellbeing boards – preparing joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies.

While statutory guidance is being developed, and will follow in 2012, taking action now means health and wellbeing boards will grasp an important opportunity. The JSNA and joint health and wellbeing strategy are the key to putting localism into action.

Refreshing the JSNA and developing the joint health and wellbeing strategy over the coming months will provide local partners including clinical commissioning groups (CCGs) with a jointly-agreed and locally determined set of priorities on which to base their commissioning plans within the reformed health and care system going forward. Demonstrating the partnership work necessary to make this happen will play an important role in authorising CCGs to take on their crucial role.

The strengthened role of JSNAs and joint health and wellbeing strategies will enable the local health and care system to go further than ever before. For the first time, decisions about health and care will be made on the basis of clinical expertise, evidence from the JSNA, and the valuable input of locally elected councillors and the public, via local HealthWatch and wider engagement with the community. This means decisions about action, investment and disinvestment can be genuinely local, rather than a reflection of national priorities.

But, I am clear that JSNAs won't have such a galvanising effect on their own. It is only the combination of the JSNA, joint health and wellbeing strategy and aligned commissioning plans that have that potential to be transformational in improving health, care and wider services for people in our communities.

Joint Strategic Needs Assessment and joint health and wellbeing strategies explained – commissioning for populations

This document aims to help health and wellbeing boards take positive action now, so individuals and communities feel the difference sooner rather than later. By agreeing a set of local priorities now, health and wellbeing boards can influence local commissioning plans for the future and grasp the opportunity to create local services shaped around the individuals who use them.

A handwritten signature in black ink that reads "Paul Burstow". The signature is written in a cursive, flowing style.

Paul Burstow, Minister for care Services, Department of Health

Introduction

*Liberating the NHS – Legislative Framework and Next Steps*¹; *Healthy Lives, Healthy People*² and *Capable Communities and Active Citizens*³ set out the government’s ambition for an enhanced role for joint strategic needs assessments (JSNAs). This strengthened role of JSNAs and joint health and wellbeing strategies will enable Local Councillors, GPs and Directors of Public Health, Adult and Children’s services to work with their communities in leading a more effective and responsive local health and care system. They will sit at the heart of local commissioning decisions, underpinning improved health, social care and public health outcomes for the whole community. As such, they are a key to the success of health and wellbeing boards and individual commissioners in the future local health and care system.

JSNAs will be the means by which local leaders work together to understand and agree the needs of all local people, with the joint health and wellbeing strategy setting the priorities for collective action. Taken together they will be the pillars of local decision-making, focussing leaders on the priorities for action and providing the evidence base for decisions about local services. The Government’s ambitions for health and wellbeing clearly envisage clinical commissioning groups (CCGs) and local authorities jointly leading the local health and care system, through health and wellbeing boards and in collaboration with their communities. New relationships between councillors, directors of public health and clinicians will therefore be key to rejuvenating the local approaches to improving the health and wellbeing of their populations.

The JSNA and joint health and wellbeing strategy can be the foundations upon which health and wellbeing boards exercise their shared leadership across the wider determinants that influence improved health and wellbeing, such as housing and education. JSNAs and joint health and wellbeing strategies will enable commissioners to plan and commission integrated services that meet the needs of their whole local community, in particular for the most vulnerable individuals and the groups with the worst health outcomes. Health and wellbeing boards will have the opportunity to better engage their communities in their development, thereby empowering local people have a say in shaping the services they use. Service providers, commissioners, district and borough councils and local voluntary and community organisations will all have an important role to play in identifying and acting upon local priorities.

As the transition to the new health and care system takes shape, emerging health and wellbeing boards will want to drive the refreshing of JSNAs and preparation of joint health and

¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661

² <http://www.dh.gov.uk/en/PublicHealth/Healthyliveshealthypeople/index.htm>

³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

wellbeing strategies, not only to help the authorisation of their CCG members, and to underpin commissioning plans for 2013-14; but also to give all local partners a set of jointly agreed priorities to work on together in the new health and care system. Through the National Learning Network for health and wellbeing boards (described further on p.14) and the development of resources, we want to support health and wellbeing boards through this transition.

Summary

The purpose of this document is to support emerging health and wellbeing boards as they engage with the refresh of Joint Strategic Needs Assessments and develop their preparatory joint health and wellbeing strategy. It also describes what support the Department of Health will provide, including what resources will be available and when, and how we will build in learning from early implementer health and wellbeing boards in this.

This document should be read as part of the wider approach to supporting the development and implementation of health and wellbeing boards led by early implementer health and wellbeing boards and the National Learning Network for health and wellbeing boards.

The statements in this document are subject to the successful passage of the Health and Social Care Bill through Parliament and reflect the current intentions of the Department of Health in relation to the JSNA and joint health and wellbeing strategy following Royal Assent.

During transition

Although new statutory duties will not take effect until April 2013, activity in the next year of transition will be crucial for the development of the reformed health and care system. It is an opportunity to develop strong relationships, embed new ways of working, build on good practice, and agree priorities for the future before taking full responsibility for the day-to-day running of the system.

Many emerging health and wellbeing boards have already begun to build new relationships in their local areas. We know that many are looking to the future, and capitalising on these new opportunities by involving elected councillors, officers and emerging CCGs supported by their PCTs, and community representatives in reviewing the JSNA and setting a timetable for developing the preparatory joint health and wellbeing strategy. This will have the benefit of providing a local context and collective priorities for the key players in the new system, including CCGs, to develop their commissioning plans from April 2013 when the statutory responsibility passes from the PCT.

Although undertaking these processes will build on existing ways of working, it also signals a break from the past and as health and wellbeing boards emerge, they will be able to develop relationships between those who will be responsible in the future including CCGs, supported by those who currently have responsibility in PCTs.

During the transition period, each emerging clinical commissioning group will seek authorisation through the NHS Commissioning Board. *Towards Authorisation* states that a commissioning plan should be a key source of evidence in authorising CCGs, and the intention is that these will be in line with the relevant preparatory joint health and wellbeing strategies. Of course, collaboration between CCGs and emerging health and wellbeing boards will help CCGs achieve authorisation, but what is crucial is that they develop the JSNA and joint health and wellbeing strategy together, enabling them to commission on the basis of mutual priorities across the broader health and care landscape, not simply from a health perspective.

Beginning the work now, during transition, will give the best possible chance of this.

To ensure a successful approach, emerging health and wellbeing boards will want to develop their local plans with the engagement of the relevant emerging CCGs during 2012. Working under delegated authority from PCT cluster boards, CCGs will want to contribute to a refresh of existing JSNAs that existing partnerships have previously produced and these will inform the first joint health and wellbeing strategies and CCG commissioning plans for their first year of operation. PCT clusters will play an active role in facilitating this transition as well as continuing to provide input on those areas of commissioning which will pass from PCTs to the NHS Commissioning Board in April 2013.

Emerging health and wellbeing boards tell us that during this period they also want to be engaging with their local stakeholders and communities in developing the JSNA and joint health and wellbeing strategy. Many want to develop the relationships and model the collaborative approach that the new system is designed to deliver before it comes into statutory form, thereby hard-wiring it into the way they operate. Identifying key stakeholders now and beginning to build enduring relationships will be critical as will remaining flexible in relation to new changes to the local landscape. Getting the right relationships will be key to unlocking the wider determinants of health such as education, housing, employment and community safety.

Case study - Wigan

Wigan see a real opportunity to transform their approach to achieve better population health, at reduced cost to the public purse, through the development of its Health and Wellbeing Board.

They are trying to address challenging issues: reducing health inequalities, building self-reliance in communities, delivering care closer to home, transforming services to improve outcomes. While significant effort has been put into tackling these issues in the past, the Board has concluded it cannot solve problems by using the same kind of thinking.

For example, previous joint strategic needs assessments (JSNAs) presented a strategic picture of health and disease in Wigan. In 2011, as the shadow Health and Wellbeing Board progressed locally, the JSNA was reshaped to develop an 'asset led' approach. The move from focusing on population problems and 'needs' to assets meant Wigan were able to ask different sorts of questions, such as 'here's what we've got, how can we grow it?'

Wigan also reviewed their activity to address inequalities, and brought in intelligence from a broad range of health indicators, including the social determinants. Wigan put this approach into action in a recent needs and asset assessment on domestic abuse. To ensure that a true picture of need, current delivery, gaps and assets was achieved Wigan engaged with a range of individuals including lead officers, service users, victims, perpetrators, staff and volunteers. This process gathered qualitative intelligence to complement the quantitative data and, amongst other positive outcomes, it identified inequalities in the overall offer that would not have been picked up elsewhere.

In developing its JSNA, Wigan's shadow Health and Wellbeing Board is particularly keen to prioritise the development of intelligence about patients' and the public's experience of services, as well as population health. They are also keen to ensure their JSNA develops in a way that continuously improves the evidence base about what works. This will allow the Board to ensure that commissioning and improvement priorities are implemented in innovative and cost-effective ways.

Once health and wellbeing boards are established on a statutory footing in April 2013, they will take over the statutory responsibility for undertaking the JSNA and joint health and wellbeing strategy. From this point, health and wellbeing boards will want to continue the ongoing process of refreshing the JSNA and developing the joint health and wellbeing strategy ready to feed into the commissioning cycle for 2014-15 and beyond.

The Government sees discussion with local areas as critical during this transition and they will inform this process. Figure 2 below illustrates indicative timings health and wellbeing boards will want to consider as part of their thinking on JSNAs and joint health and wellbeing strategies as they prepare for the new health and care system and to support CCG members in becoming authorised.

	Dec 11	Jan 12	April 12	May 12	July 12	Oct 12	Feb 13	Mar 13	April 13
Health and wellbeing board		Continuous engagement with stakeholders, users and the public	Non-statutory operation						Full statutory responsibility
JSNA	Draft guidance available	JSNA refresh begins or already underway							↑
Joint health and wellbeing strategy	Draft guidance available		Priorities from JSNA needed to inform strategy	Strategy to be developed to feed into commissioning plans					
Clinical commissioning group			Non-statutory operation		Start of authorisation submissions	Authorisation process begins	Commissioning plans to be agreed		Full statutory responsibility Implement agreed commissioning plans
Local Authority planning cycle			Data collection and analysis		Reviewing priorities	Financial planning		Business plan finalised and published	
NHS Commissioning Board	Operating as an SphA focused on business preparation (from October 2011)		Established as an Executive Non-Departmental Public Body with limited statutory responsibility			Partial running as Executive Non-Departmental Public Body			Fully operational with full statutory responsibility

How we will support you

The Government is taking a new approach to implementing change in public services, with innovation and change driven locally to shape services around communities, with the space created by national partners to enable the sharing of work works. You have told us that sharing learning across sectors and between partnerships is vital during this transition, and we will be supporting this nationally and locally.

Statutory guidance and resources

To support the new policy on JSNAs and joint health and wellbeing strategies the Government has committed to producing new guidance on JSNAs and joint health and wellbeing strategies. We have worked with Local Government Association, the NHS Confederation and early implementer health and wellbeing boards to agree how we will take this forward through the National Learning Network for healthy and wellbeing boards (described further on p.14) and plan to:

- develop statutory guidance on JSNAs and joint health and wellbeing strategies, and
- work with partners to develop wider resources to support the development and effective use of JSNAs and joint health and wellbeing strategies.

The statutory guidance, developed with early implementers will build on existing guidance on JSNAs and will cover the joint health and wellbeing strategy, as committed to in the Government response to the NHS Future Forum's recommendations. It will describe the principles of the JSNA and joint health and wellbeing strategy; not specifying form or detailed content, as health and wellbeing boards will determine this locally.

The statutory guidance will be available in draft form in January 2012, but will not be formally published until after the Health and Social Care Bill has gained Royal Assent. However, we recognise that this will not enable health and wellbeing board members, including emerging CCGs to incorporate jointly agreed priorities for action based on identified needs into their planning for April 2013. Hence, the intention that draft guidance will be issued in January 2012.

This draft guidance will be then be further developed with health and wellbeing board early implementers and other voluntary and community stakeholders ahead of publication. From January 2012 we will be engaging with stakeholders on this draft guidance, developed with health and wellbeing board early implementers, and that engagement will then be followed by a short public consultation ahead of the final publication of the final, statutory guidance after Royal Assent. The aim is both to support health and wellbeing boards as they start refreshing the JSNA and developing a preparatory joint health and wellbeing strategy; and also to ensure the final product has taken full account of local circumstances and views, and is fit for purpose.

Our approach to the development and sharing of this guidance aims to be supportive to emerging health and wellbeing boards as they develop their own understanding and discussions on JSNAs and joint health and wellbeing strategies. We also want this process to be an open dialogue with emerging health and wellbeing boards to ensure that the final statutory guidance is fit for purpose and meets their needs by the time they become statutory bodies.

To further support health and wellbeing boards to undertake JSNAs and joint health and wellbeing strategies, and to support stakeholders to engage in the process locally we will work in partnership with sector leaders and interested partners to produce complementary resources. These will build on the statutory guidance and will feature products to explore issues faced by emerging health and wellbeing boards, alongside themes and best practice. These resources are just as important as the statutory guidance – we are taking this different approach to paint a picture of how the JSNA and joint health and wellbeing strategy can work on the ground, informed by those who are actually engaged in them locally.

These products will be shaped and informed by what health and wellbeing board early implementers and wider stakeholders tell us they would find supportive and useful to meet their own needs and interests. These will be available in early 2012, and again emerging health and wellbeing boards will be able to feed into this process through the National Learning Network and through work underway at a sub-national level.

Support for health and wellbeing board implementation

Support for the implementation of health and wellbeing boards has been developed with the Government's new approach in mind. Health and wellbeing boards with truly collaborative leadership and partnership across local services will be key within the new health and care system; therefore, we have taken a lot of care in their development and implementation. Early implementers and stakeholders have been united in a desire for health and wellbeing boards to make a real difference and not just be 'talking shops'. In some places this means using the creation of the health and wellbeing board to drive existing partnership work further. In others, it is an opportunity to do things differently, recognising that existing partnerships are not 'delivering the goods'. The National Learning Network provides an opportunity for health and wellbeing boards to debate and stimulate fresh thinking with their peers, as well as supporting the development of highly effective health and wellbeing boards in each locality.

Work with partners has focused on supporting local authorities, CCGs and other partners to bring their own innovation and expertise to the process of identifying and promoting best practice, to ensure health and wellbeing boards are effective. We have also sought to further stimulate and support this localist approach through sub-national activity led by Deputy Regional Directors for social care, SHAs and sub-national local government networks, where it adds value.

The National Learning Network for health and wellbeing boards

We have set up the National Learning Network for health and wellbeing boards to develop knowledge and behaviours that will enable them to work effectively to deliver their shared purpose. The National Learning Network will support all health and wellbeing boards to develop a clear sense of purpose and shared local priorities, collaborative behaviours and strong relationships; and a focus on outcomes and sustainable improvement for local people; so that the health and wellbeing board is greater than the sum of its parts. With this in mind it has been developed in partnership with and driven by the needs of those who are actually developing their health and wellbeing boards, and to complement wider activities at national, sub-national and local levels.

The National Learning Network is made up of:

- a virtual learning hub, hosted through the Local Government Association Communities of Practice⁴, to enable information sharing, collaboration and networking across all sectors engaged in developing health and wellbeing boards
- national learning sets which will enable health and wellbeing board members to work with their peers across the country on key themes of common interest
- leadership development for elected members, alongside clinical leaders and other local partners, delivered by the Local Government Association building on previous development work with elected councillors
- ensuring that the Learning Network for health and wellbeing boards aligns with development and transition support for CCGs, public health and HealthWatch.

We have already developed some parts of the network, and we are working together to complete the other elements. We intend to be flexible in our approach, responding to the network's feedback and ideas. Government will not be issuing guidance across the board, but only on those areas where health and wellbeing boards early implementers tell us they would like additional support – any such resources will be developed with and shaped by the National Learning Network to ensure that they deliver the support where it is needed.

The National Learning Network builds upon the work of the Local Government Association's Healthy Communities Programme, and they have been a key partner in informing and developing this approach as well as showcasing developments already underway at a local level in *New Partnerships, New Opportunities: a resource to assist setting up and running health and wellbeing boards*⁵.

⁴ <http://www.communities.idea.gov.uk/comm/landing-home.do?id=10113659>

⁵ <http://www.idea.gov.uk/idk/core/page.do?pagelId=31196365>

The context

*Equity and Excellence: Liberating the NHS*⁶ set out a vision of a health and care system that achieves the best outcomes in the world. It outlined a move to a new system, which shifts away from centrally driven targets, and instead focuses on putting patients and the public first, delivering the outcomes that matter most to people, and strengthening accountability and local democratic legitimacy.

The joint local leadership of CCGs and local authorities through the health and wellbeing board will be at the heart of this new health and social care system. Through this forum elected councillors, clinicians, and directors of public health, adults and children's services will have a key role to play in using their expertise to achieve a collective focus on improving outcomes and reducing inequalities. They will enable greater local democratic legitimacy of commissioning decisions, and provide an opportunity for challenge, discussion, and the involvement of local representatives.

The *Health and Social Care Bill*⁷ will require the establishment of health and wellbeing boards on a statutory basis in every upper-tier local authority in England. They will operate in shadow form from April 2012, and take on their statutory functions from April 2013. The process of transition from the current health system to the new arrangements is underway, and many health and wellbeing boards are beginning to operate in shadow form.

To support the development and implementation of health and wellbeing boards at a local level, the NHS Confederation has worked with partners to develop *Operating principles for health and wellbeing boards*⁸. This document intends to help health and wellbeing board members consider how to create effective partnerships across local government and the NHS as they set up and establish their health and wellbeing boards.

Health and wellbeing boards will be the forum for councillors, commissioners and communities work with wider partners to address the determinants of health and reduce health inequalities. This is not just about statutory members of the health and wellbeing board – other partners can help to achieve these aims. For instance, the voluntary and community sector can help access chronically excluded groups, and many emerging health and wellbeing boards are finding innovative ways of engaging the sector.

⁶ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

⁷ <http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm>

⁸ <http://www.nhsconfed.org/Publications/reports/Pages/Operating-principles.aspx>

One of the key benefits of establishing health and wellbeing boards will be to increase the influence of local people in shaping services by involving democratically elected councillors and through local HealthWatch, so that services can better meet local need, improve the experience of service users, and improve the outcomes for individuals and communities.

Case study - Harrow

One of the key principles for the development of the shadow Health and Wellbeing Board in Harrow is a focus on user outcomes and engagement.

Over 100 stakeholders and patients joined in an engagement event to begin a discussion on issues and themes Harrow's refreshed joint strategic needs assessment (JSNA). The event gave the emerging health and wellbeing board clear feedback on what the community saw as priorities for a renewed JSNA and highlighted the perspectives of the wide variety of stakeholders in the local health and care system.

In holding the event, Harrow was also able to gain insight into how best to engage with the public and local stakeholder groups. Using the feedback they gathered Harrow are now producing a pan-Harrow engagement plan. The plan will help the Board to have a genuine dialogue with local citizens and groups, hear the issues they raise and respond. As a result of what they heard at the event, they are also developing a new webpage and newsletter to keep people informed,

Over the coming months Harrow plan to:

- make an impact on the 3 priorities of older people, most excluded families; and health and worklessness
- continue to develop the Board
- refresh the JSNA by March 2012
- develop their Joint health and wellbeing strategy for September 2012.

These changes are happening against a backdrop of whole system change, as clinical commissioning groups, the NHS Commissioning Board, HealthWatch and the transition of public health to local government take shape. Where successful JSNAs exist, the successful relationships underpinning them will offer continuity and focus through this transition. In areas where new arrangements need to emerge, a focus on the JSNA and joint health and wellbeing strategy through the health and wellbeing board will provide a focus that can help to identify common goals and ambitions.

Case study - Buckinghamshire

Buckinghamshire are in the process of developing their joint health and wellbeing strategy. The emerging health and wellbeing board is clear that it has responsibility for improving the health and wellbeing of all residents, from the 'cradle to the grave'; and has agreed four overarching outcomes:

- every child has the best start in life
- everyone takes greater responsibility for their health and wellbeing
- everyone is treated fairly and has the opportunity to fulfil their potential
- keeping people healthier for longer - add years to life and life to years.

Buckinghamshire took a number of factors into account in to arrive at these outcomes, including:

- information on existing priorities from other strategies in Buckinghamshire; including the existing joint strategic needs assessment
- professional and personal experiences from board members
- taking a positive approach to outcomes, but building in an emphasis that residents must take some responsibility for their own health
- using plain English and being recognisable to residents
- good practice examples of other joint health and wellbeing strategies were also used to inform the discussions.

Over the next few months, the board will begin to refine the priorities within each outcome, prior to a public consultation on the strategy. They are keen that the priorities to be included in the consultation should not duplicate areas of work being carried out by others. In future meetings the board will consider where it can add value, where a different or innovative approach may be required and where the inequalities 'gap' can be reduced most effectively

The development of a new JSNA will be discussed in early 2012 and will be used to inform the joint health and wellbeing strategy in 2013 when the board becomes a statutory body.

The JSNA and joint health and wellbeing strategy are crucial enablers of the new system, important for commissioners, providers, service users and the wider community.

The Joint Strategic Needs Assessment and joint health and wellbeing strategy

Building on existing foundations

The JSNA was introduced to create stronger partnerships between communities, local government and the NHS, providing a firm foundation for commissioning that improves health and social care provision and reduces health inequalities. It was intended to help commissioners shape services to address local needs, and a number of supportive resources have been produced to help local areas undertake their JSNAs.

Local areas have told us that since they were introduced in 2008, the best JSNAs have been those undertaken through strong and collaborative partnerships at all levels, who recognise the opportunity and share the responsibility to improve health and wellbeing across all local services; using this to drive innovation and new ways of working. **The health and wellbeing board provides an opportunity to build upon this good practice in taking existing JSNAs further so enabling the transformation of services through collaborative leadership and the development of a joint health and wellbeing strategy.**

In the new system, responsibility for undertaking the JSNA and joint health and wellbeing strategy will come through the health and wellbeing board, and elected councillors, directors of public health and clinicians will have critical roles to play. They will be a vital tool to support health and wellbeing boards to understand the needs of their whole community, and agree collective action to address those needs. By bringing together insights from communities with a range of high quality evidence and information, which could include other local assessments and non-health data, the health and wellbeing board can make collaborative decisions on how best to meet those needs, through joined up, integrated and appropriate services and by tackling the wider determinants of health. They will, enable users and the public to understand the factors that influence services in their area and have input into shaping those services.

Health and wellbeing boards will provide local strategic and collaborative leadership in the reformed health system. As such they are the natural home for the JSNA as a tool to support the local service leaders to take a strategic view of the needs and assets in their areas and use this knowledge to inform service planning. CCGs will commission the majority of services, with the NHS Commissioning Board directly commissioning the remainder of services, which will also be supported by the evidence in the JSNA.

From April 2013, the local authority and the clinical commissioning groups, together with local HealthWatch, will be required to prepare the JSNA through the health and wellbeing board, undertaking a comprehensive analysis of the current and future needs and assets of their area. In the context of the JSNA an asset could be anything that can be used to improve outcomes and impact on the wider determinants of health. This could be facilities such as a One Stop Shop, or green spaces; but also local businesses, local providers with a specific expertise, or capacity within the local community, such as lunch clubs for isolated older people. This includes needs and assets relevant to health, social care and public health across the full lifecourse, covering children, young people and adults; and involves an analysis of the wider determinants of health.

By looking at these assets health and wellbeing boards can explore what other resources are available to them by working with partners to meet local needs and achieve shared priorities. This could create innovative solutions to issues or create opportunities for wider community involvement. For instance, links to a Local Enterprise Partnership could be used to encourage and support people back into work as a way improving their health and wellbeing as well as supporting the local economy.

Based on the JSNA, the members of the health and wellbeing board will then develop a joint health and wellbeing strategy for their area. This joint strategy should support health and wellbeing board members to take the important step from assessing needs and available assets to planning the delivery of integrated local services based upon those needs and assets, and collectively addressing the underlying determinants of health and wellbeing. **In this way the JSNA and joint health and wellbeing strategy combined form the basis for local decisions that drive service change such as investment and disinvestment in services according to local needs and engagement with the local community.**

The joint health and wellbeing strategy is intended to inform commissioning decisions across local services such that they are focussed on the needs of service users and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. Likewise, the joint health and wellbeing strategy will also need to take account of the NHS Commissioning Board's Mandate from the Secretary of State for Health. Coherence and understanding of local commissioning arrangements across partners will ensure that vulnerable groups are not overlooked. The joint health and wellbeing strategy can also be used to influence the commissioning of local services beyond health and care to make a real impact upon the wider determinants of health.

The joint health and wellbeing strategy drives the collective actions of the NHS and local government, both commissioners and providers, and engages communities in the improvement of their own health and wellbeing. Local authorities, CCGs and the NHS Commissioning Board will need to have regard to local JSNAs and joint health and wellbeing strategies as they draw up their commissioning plans so that their plans are fully aligned with their jointly agreed priorities.

The joint health and wellbeing strategy is a unique opportunity for the health and wellbeing board members to explore together the local issues that they have not managed to tackle on their own. The JSNA and joint health and wellbeing strategy allow the health and wellbeing board to analyse the wider perspective of wellbeing, helping local partners on the health and wellbeing board reach a consensus on the priorities to be addressed across the system, and how to make best use of collective resources to achieve them. No single organisation can do this alone, but a shared sense of priorities, built on confidence and trust and supported by a robust evidence base, can help partners work together and focus in on key issues that really matter locally.

A focus on outcomes

In assessing needs and priorities, the health and wellbeing board should adopt an ‘outcomes-based approach’, considering how their work can focus on improving the outcomes that matter most to their populations. Through the joint health and wellbeing strategy they will set the local priorities for joint action. They will be able to use information and indicators from the national outcomes frameworks for the NHS, Adult Social Care, Public Health (and at clinical commissioning group level, the Commissioning Outcomes Framework) to assess current outcomes to inform their JSNA, and identify desired outcomes to drive their joint health and wellbeing strategy. The health and wellbeing board could be the place where the national outcomes frameworks come together, supporting a primary focus on local priorities.

The collaborative nature of health and wellbeing boards will go beyond a joint assessment of needs and priorities as these are not ends in themselves. The health and wellbeing board will also be involved in the development of commissioning plans of constituent health and wellbeing board members. This opens up opportunities for the collaborative design and evaluation of commissioning intentions between health and wellbeing board members to look together at the congruence of commissioning priorities with objective information from the JSNA.

Commissioners will be required to consider the Health Act flexibilitiesⁱ for joint working, such as pooled budgets; which has the potential to further enhance the partnership aspect of health and wellbeing boards based on evidence from the JSNA and priorities from the joint health and wellbeing strategy. The membership of the health and wellbeing board also provides an opportunity to look across the NHS, Adult Social Care, and Public Health Outcomes Frameworks as a piece, to agree and express their priorities and outcomes as a locality, across all these areas.

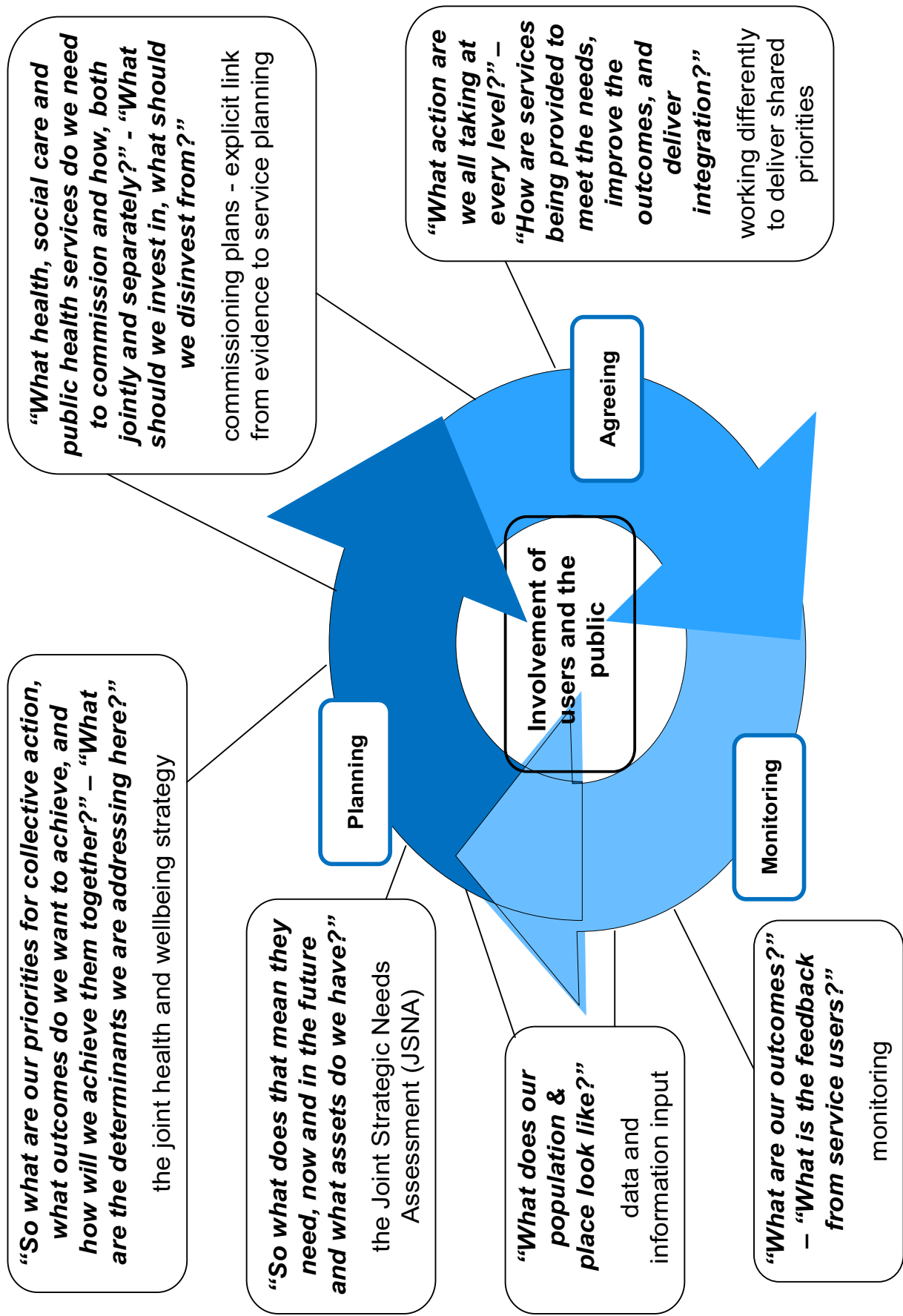


Figure 1: How the commissioning cycle and JSNA and joint health and wellbeing strategy fit together

Promoting integration

There are increasing numbers of people living with multiple long-term conditions, and as such improved integration across services is now a priority. There are many aspects of the health and care modernisation programme which promote integration, and health and wellbeing boards will be key to this agenda locally.

The NHS Future Forum and the Social Care engagement exercise, *Caring for our future*⁹, are both exploring how to integrate the delivery of services; what the barriers and potential incentives are on the ground; which services should be more integrated around users; and how integration can achieve better value for money. Collectively this work will not only inform Government and the modernised health and care system; but will also provide potential solutions and best practice from across the NHS and local government.

Health and wellbeing boards and CCGs will have a duty to encourage integrated working of commissioners and providers in order to improve the health and wellbeing of the local population, reduce inequalities, and improve the quality and experience of services for the local population. They have the opportunity to do this not only at a strategic level, but also to establish this approach with wider partners at a local level.

These benefits are not merely for the local system and organisations however; they will improve the quality of services, and experiences and outcomes for service users, their families and carers in accessing services centred around them. In a period of both economic and demographic pressure, this alignment of service planning and provision could also be of great benefit to the taxpayer, with the opportunity for more efficient use of shared resources.

In the transition of public health functions to local government the director of public health will be able to use their membership of the health and wellbeing board to act as a lynchpin between local health and local authority services. This will ensure better integration between public health and services such as housing and education that have considerable impact on the wider determinants of health.

Providing support to directors of public health and teams across local authorities will be a new national organisation, Public Health England (PHE). PHE will be responsible for the provision of integrated advice and services to protect the health of the people of England from new and existing health threats, and to promote their health and wellbeing. The organisations that will make up PHE - including the Health Protection Agency, the public health observatories and the cancer registries, among others - will continue to provide information and intelligence support to the development of JSNAs. This will be both at a national level, by ensuring that public health data is readily available, and at a local level through the provision of expert localised advice and support to understanding and interpreting this information.

⁹ <http://caringforourfuture.dh.gov.uk/>

In undertaking the JSNA and joint health and wellbeing strategy, boards will also have the opportunity to align with other parts of the local system that impact upon health, care and the wider determinants of health. As part of this, health and wellbeing boards can consider joint commissioning opportunities with other local bodies, thereby enabling joined-up interventions and alignment of resources in tackling issues that will benefit from multi-agency working, for example, tackling worklessness, reducing crime and re-offending, improving housing quality, or child and adult safeguarding. Such local alignments will help the health and wellbeing board to take an overview over how the determinants of health affect their local populations and how they could be better addressed across the spectrum of local services. Some of these relationships and partnerships may already exist in some areas, but some health and wellbeing boards will wish to build upon these or establish improved ways of working. These relationships can be mutually beneficial for local services, and the health and wellbeing board may help local partners to achieve their own aims through joint working. For instance, initiatives to support ex-offenders into the workplace will have a positive impact on their health and wellbeing (and possibly wider determinants of health, such as housing status), whilst stimulating the local economy and reducing their chances of re-offending.

Engaging the public

The health and wellbeing board will have a duty to involve users and the public in the development of both the JSNA and the joint health and wellbeing strategy, and pay due regard to the Public Sector Equality Duty. This will strengthen local accountability, enabling health and wellbeing boards to work with the local community and partners to identify needs and assets, and to jointly decide and agree actions to address them and utilise their potential. Through this involvement, the local community will have the ability to influence local services and have an understanding of what other factors have influenced service provision in their area. There is an opportunity here for greater partnership with local stakeholders and the community, through which local assets and resources can be offered and used as a way to work together to address local needs and tackle the wider determinants of health in a different way.

This will not be the only opportunity for the public to shape their services, as CCGs and the NHS Commissioning Board will also be required to involve the public and service users in the planning of services or service change, as local authorities already do. Health and wellbeing boards might consider how other local partners engage with the public and identify opportunities for alignment and rationalisation.

The JSNA and joint health and wellbeing strategy will therefore be of interest not just to health and wellbeing boards, the local health and care system commissioners and providers; but also to the users of services, their families and carers; and the wider community. JSNAs and joint health and wellbeing strategies which are open and accessible to all will be able to facilitate and assist the engagement of a variety of audiences with differing needs, and will be of use to them all to drive the direction of the local system as intended by the wider health and care reforms, **bringing decision making about services closer to users and the public.**

Joint Strategic Needs Assessment and join health and wellbeing strategies explained – commissioning for populations

For further information please email JSNAandJHWS@dh.gsi.gov.uk

ⁱ NHS Act 2006, section 75.

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

To: Health and Wellbeing Board

Subject: Kent Health and Wellbeing Strategy

Classification: Unrestricted

Recommendations

Health and Wellbeing Board is asked to receive the draft H&WB Strategy and consider the questions laid out in this coversheet

1. Introduction

- 1.1 At the last H&WB Board it was agreed to begin work on the Kent Health and Wellbeing strategy with the aim to have an early draft in advance of an agreed Shadow Health and Wellbeing strategy for the financial year 2012 to 2013 by March 2012.
- 1.2 The Board agreed a fuller strategy would then be developed in time for the next commissioning round which, at the time, we envisaged to be around October 2012.

2. Progress

- 2.1 Attached is progress that has been made since the last meeting with a substantial amount of work done on the health inequalities in the Kent population element; including both the strategy and an implementation or delivery plan. The document builds upon some of the Kent County Council work provided by Prof Chris Bentley who led the National Health Inequalities Service team (HINST) which worked with 'spearhead' PCTs to reduce health inequalities. Whilst within the national timeframe, spearheads were not able to show appreciable reduction; the view is that these reductions will be there by this year. Hence the 'Christmas Tree Model' being promoted as a tool the all commissioners and providers should be using to test how balanced their services are. The county has further engaged the expertise of Chris Bentley in helping to develop the implementation plan.
- 2.2 Less information has been populated for the two disease areas the H&WB Board previously articulated; however further work on both areas is being undertaken by the relevant commissioners on teams with sessions arranged to populate the document.

3. Questions for the Health and Wellbeing Board

- 3.1 Is the strategy, albeit in this stage of draft development, along the lines members of the Board envisage?
- 3.2 Given the Department of Health publication on JSNA and Health and Wellbeing strategies is it appropriate to produce a shadow draft Kent Health and Wellbeing strategy by March when guidance suggests the full strategy needs to be developed by May 2012? (Following the January meeting of the H&WB Board; there are only two more Board meetings before May 2012).

There is also an expectation is that public (and partner) consultation on the JSNA and H&WB Strategy will need to be held before they can be finally agreed.

- 3.3 The Board will need to consider the style the Health and Wellbeing strategy should take; the document currently lifts some information directly from the JSNA which in itself contains language that is not public facing or user friendly. Do members of the Board agree?
- 3.4 The substantial element of the strategy, in my opinion includes both prevention and reduction in health inequalities and, at this stage is more or less encapsulated in the Health inequalities action plan; should the strategy separately cover prevention?
- 3.5 Integrated Commissioning has also been discussed as a priority, however this is a process or means to an end rather than an area that needs to be addressed directly in the Health and Wellbeing strategy. Is this agreed?

DRAFT

Shadow Shadow

Kent Health and Wellbeing Strategy

Version one for January Kent Health and Wellbeing Board

Foreword: from DPH and Chair of the H&WB Board

Executive summary

Health Inequalities

1.0	Introduction
1.1	Inequalities in health describe the systematic differences in health associated with people's different and unequal positions in society. This concept links the health of individuals to the structures of social inequality which shape their lives. Outside of the UK, health inequalities are more accurately described as social inequity. Health inequalities are often referred to as the social determinants of health or the causes of the causes.
1.2	Whilst factors such as biological or genetic disposition are important, social inequalities are the key driver of ill health. Factors such as employment, education, housing, transport, leisure, neighbourhood renewal, child poverty, fuel poverty, food poverty and crime and disorder all make a significant contribution to health and wellbeing. The NHS therefore largely addresses the consequences of inequalities in dealing with the health manifestations of these.
1.3	This is why partnership working particularly through the leadership of local government, tackling the social determinants of health is vital to reducing health inequality.
1.4	However the NHS can significantly contribute to reducing health inequalities through interventions that are made at a population level, rather than through patchy interventions provided unevenly across populations.
2.0	The Size of the Problem
2.1	Health inequalities are not solely about differences between poorer and better off groups. They describe the systematic relationship between socio-economic position and health. Health inequalities follow a social gradient. Health inequalities show a stepwise relation to social position in a gradient which correlates higher social class with increased health throughout the different social groups health is related to an individual's position in society at every level.
2.2	A focus on socio-economic differentials rather than social disadvantage widens the frame of health inequality policy in three major ways. Firstly it searches for the causes of health inequality not in the disadvantaged circumstance and health damaging behaviours of the poorest groups but in the systematic differences in life changes, living standards and lifestyles associated with people's unequal positions in the socio-economic hierarchy.
2.3	Secondly and in consequence, tackling health inequalities is a population-wide goal. It includes everyone. Framed in inclusive terms, the health gradient approach attracts attention to the composition of a population and the distribution of economic advantage and disadvantage. The size of socio-economic groups as well as their levels of health, matter for reducing the socio-economic gradient of health. Thus the intermediate socio-economic groups lying between the top (professional) and the bottom (unskilled manual) make up the majority of the population. Mortality rates are lower than in the poorest group but the compromised health makes a larger contribution to the toll that socio-economic inequality takes on the health of a population. In consequence focusing on the poorest alone will not reduce the size of gain in life expectancy needed to close the gap.

2.4	<p>Lastly reducing health gradients provides a comprehensive policy goal: one that subsumes remedying disadvantages and narrowing health gaps between the broader goal of equalizing health chances across socio-economic groups. To improve the health of poorer groups are necessary elements in a strategy to reduce the socio-economic gradient. But this is insufficient. To reduce the socio-economic gradient, health in other socio-economic groups also needs to improve at a faster rate than in the highest socio-economic group.</p>
2.5	<p>The tables and figures below show that poverty exists all over Kent and Medway and is not confined to specific areas. Nevertheless there are major concentrations of deprivation in the Thames-side boroughs of Dartford and Gravesham, in the Medway towns 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.</p>
2.6	<div data-bbox="379 741 1337 1406" data-label="Figure"> </div> <p>Map 1 - Deprivation status of areas in Kent and Medway</p>
3.0	<p><i>Life expectancy</i></p>
3.1	<p>Life expectancy tells us how long a child born today would be expected to live if they experienced the current mortality rates of the area they were born in throughout their lifetime.</p> <p>Using the data from IMD 2007 for all the electoral wards in Kent, it is possible to demonstrate a highly significant correlation between relative deprivation and life expectancy across the county as a whole, also for Medway and for many of the district council areas.</p>

3.2

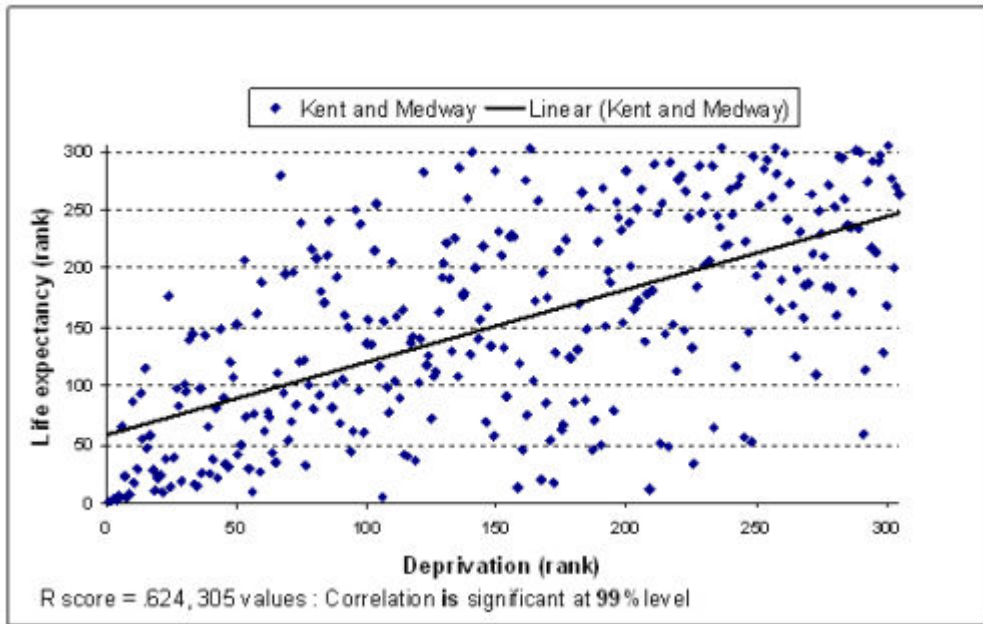


Figure 2 - Rank correlation of deprivation with life expectancy - Kent and Medway

3.3

Comparing 2000 with 2007 it is evident that at the beginning of the period there is a pattern of poorer health as defined by life expectancy for all quintiles relative to the most affluent, but in the later period (2006-08), there has been relative improvement in the intermediate quintiles relative to the most affluent. However for the most deprived, a pattern of divergence (a widening health gap) has continued throughout this period. This pattern is projected to continue to 2010. [Table 4]

3.4

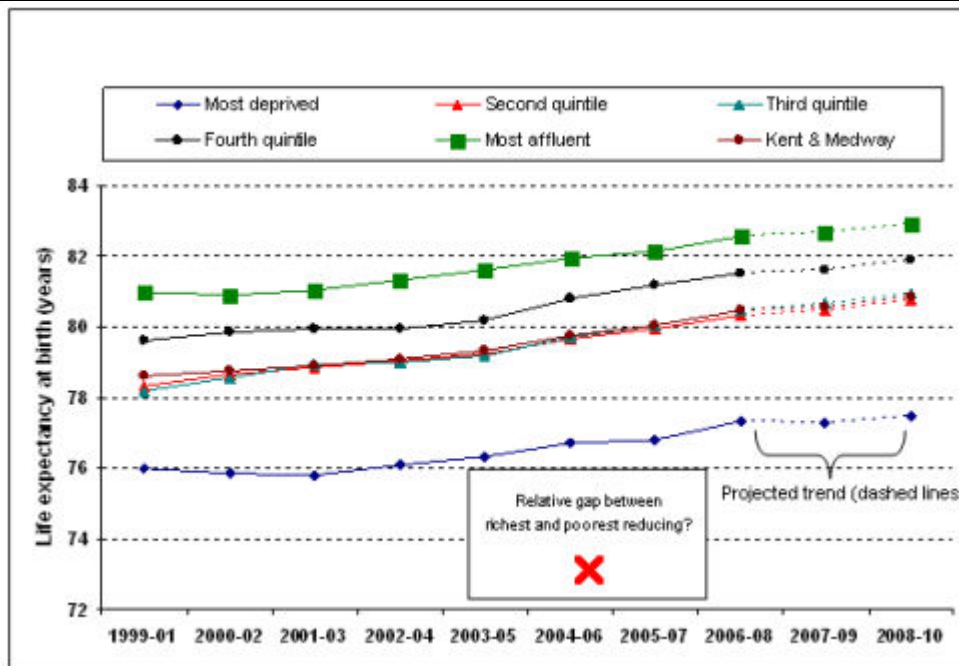


Figure 3 – Life expectancy trends by deprivation status, 3-year averages, Kent & Medway

4.0

All age all cause mortality

4.1

All age all cause mortality is the accepted convention for measuring overall health status of communities[

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 further away, i.e. the gap is widening.

4.2

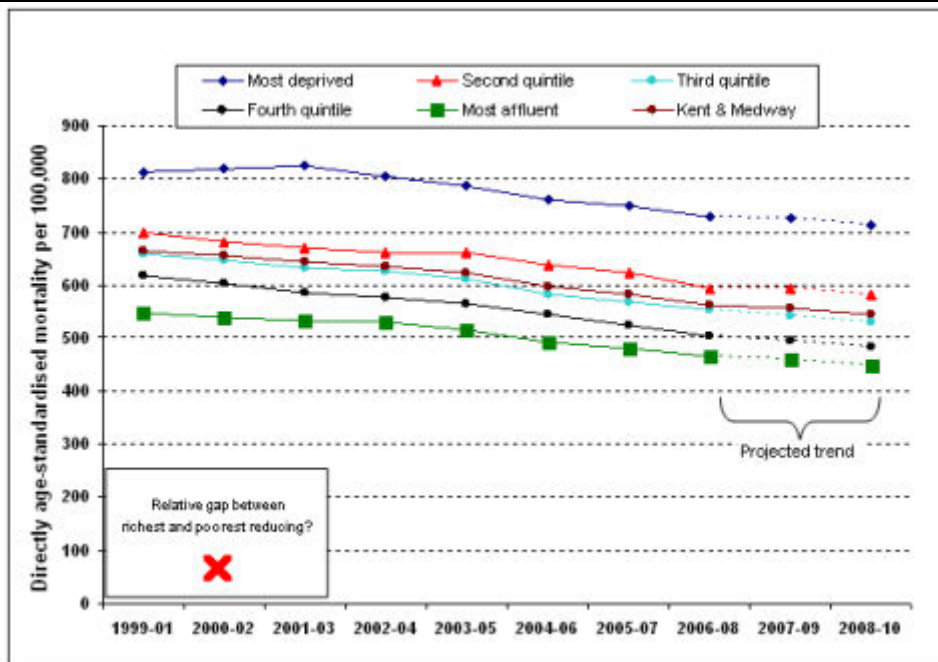


Figure 4 - All age, all cause mortality rates, 3-year averages, Kent and Medway

5.0

Fair Society, Healthy Lives: The Marmot Report

5.1

In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The final report, 'Fair Society Healthy Lives', was published in February 2010,

5.2

The report concluded that here is a social gradient in health – the lower a person’s social position, the worse his or her health is likely to be. Action should focus on reducing the gradient in health. Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.⁴ Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

5.3

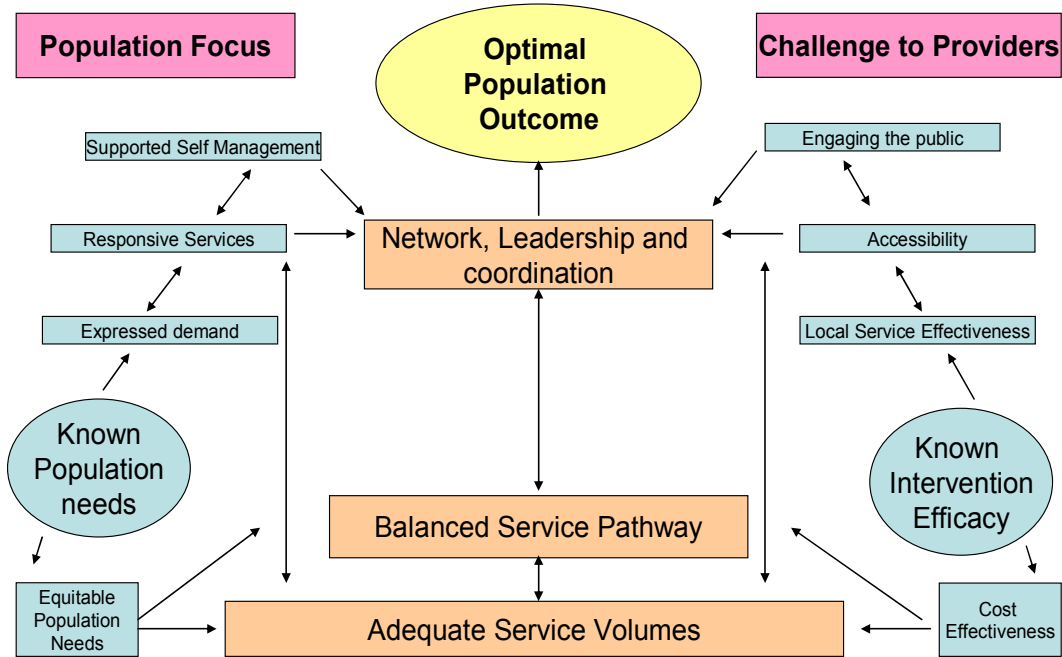
Reducing health inequalities will require action on six policy objectives:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

<p>6.0</p>	<p><i>What the Health Service and other services can do?</i></p>
<p>6.1</p>	<p>The challenge faced is to ensure population level outcomes are achieved based on good evidence-based interventions. This is not only the case for health services but also for those influencing all the wider social determinants in health. Best population health outcomes can be defined as:</p> <p>“Greatest improvement in health and wellbeing, with minimal health inequalities”</p> <p>The Health Inequalities National Service Team (HINST) has promoted the “Christmas Tree diagnostic model which provides a checklist of the most important issues in determining how we can get the most out of our services.</p> <p>Two important features of the model are:</p> <ul style="list-style-type: none"> • Symmetry of the model giving equal weight to how the population uses services as well as service quality • There is a strong organizing trunk which holds together and supports both sides of the programme. <p>The success test will be to achieve a percentage change in our selected outcome at population level in a given time period and fairly shared across our defined equity groups.</p> <p>Success can not be achieved through small projects on their own, however good the quality and effectiveness. Success requires considered programmes which are systematic, scaled up and sustainable in the long term.</p>

6.2

“Christmas Tree”: Planning for Best Population Level Outcomes



6.3

What contributes most to health inequalities

There is a strong link between cigarette smoking and socio-economic group. Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. Smoking accounts for over half of the difference in risk of premature death between social classes.

Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off.

Long-term smokers bear the heaviest burden of death and disease related to their smoking. Long term smokers are disproportionately drawn from lower socio-economic groups. People in poorer social groups who smoke, start smoking at an earlier age: of those in managerial and professional households about one third start smoking before age 16 compared with almost half of those in routine and manual households

Thus any health inequality strategy should address the overall prevalence of smokers within the population as well as the differences across geographical/socio economic areas.

7.0

What is our Strategy to reduce Health Inequalities in the Kent population?

7.1

1. Ensure we have a comprehensive plan that addresses the six objectives described by Marmot
 - a. Give every child the best start in life

	<ul style="list-style-type: none"> b. Enable all children young people and adults to maximise their capabilities and have control over their lives c. Create fair employment and good work for all d. Ensure healthy standard of living for all e. Create and develop healthy and sustainable places and communities f. Strengthen the role and impact of ill health prevention <ol style="list-style-type: none"> 2. Systematically apply the Christmas tree model described by the National Health Inequalities service team to all local health services and reduce variation in service access and outcomes as much as possible across the Kent geography 3. Develop in tandem with the Health and Wellbeing strategy a comprehensive and agreed Health Inequalities Implementation plan that reflects both the Marmot objectives and reflects the wider determinants of health. 4. Ensure a systematic approach to reducing the prevalence of smoking in the Kent population through the systematic delivery of the Kent Tobacco Control Strategy including the commissioning of high quality and accessible stop smoking services. 5. Ensure systematic and population based approach to the provision of health checks.
8.0	<i>Kent Health Inequalities Action Plan</i>
8.1	<p>Attached to this document is a draft of Kent’s Health Inequality Action plan which supports delivery of this strategy.</p> <p>The Plan:</p> <ul style="list-style-type: none"> • is based on the six Marmot objectives • covers the wider determinants of health • sets out our aspiration for improvement • covers the outcomes we expect to be published in the Public Health Outcomes framework • uses a screening tool to demonstrate the right people are accessing treatment <p>The implementation plan is in draft for consultation at the moment and more work is required to:</p> <ul style="list-style-type: none"> • Check and develop our aspiration • Ensure patient and public support for the plan • Gain ownership through continued multi-agency input to the plan • Delineate what is expected of our partners, whether that be Clinical Commissioning consortia, GPs as providers, or other partners including district councils, Kent County Council itself.

Dementia

	<p>Background</p>
	<p>The term 'dementia' is used to describe a syndrome, which may be caused by a number of illnesses, in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, causing problems in themselves, complicating care, and occurring at any stage of the illness.</p>
	<p>It is thought that many factors, including age, genetic background, medical history and lifestyle can combine to lead to the onset of dementia. However, the main risk factor for most forms of dementia is advanced age, with prevalence roughly doubling every five years over the age of 65. Onset before this age is known as young or early onset dementia. It is very unusual and, in the case of Alzheimer's disease, often suggests a genetic cause.</p>
	<p>The case</p>
	<p>Dementia is a priority in Kent as according to estimates the numbers of people in the population diagnosed with dementia is set to rise with the rising numbers of older people. Diagnosed populations will not be evenly spread across Kent with some districts; likely to have greater prevalence than others.</p>
	<p>Moreover, in the work currently being undertaken around dementia it is acknowledged that current services are not meeting the needs of this group of patients.</p>
	<p>The NHS Operating Plan 2012/13 makes specific mention of older people and dementia; particularly in relation to joint plans with local authorities</p> <p>“For the first time to support local accountability in 2011/12, PCTs were asked to work with their local authorities and publish dementia plans which set out locally the progress they were making on the National Dementia Strategy⁴. That requirement will also apply for 2012/13 with the additional expectation that any local or national CQUIN goals should be included”</p>
	<p>What does a good Dementia Service look like?</p>
	<p>The National Institute for Health and Clinical Excellence (NICE) has published guidance for dementia including:</p> <ul style="list-style-type: none"> • Clinical guidance (CG42 Dementia) • NICE Dementia Pathway • A number of audit tools and commissioning guides

	<ul style="list-style-type: none"> • Quality Standards for dementia
	<p>High quality dementia pathways should reflect the following</p> <ul style="list-style-type: none"> • Principles of care • Risk factors and prevention • Early identification • Diagnosis and assessment • Integrated and Co-ordinated care • Promoting independence and maintaining function • Interventions • Accommodation and hospital care • Palliative and end of life care <p>Supported by staff training and awareness and carers support.</p>

Children and Young People's Mental Health

[Assessment 2011.](#)

Introduction																					
<p>Teenage brains are a work in progress. They may look like adults, they may behave like adults, they may even come to the same conclusions as adults but what is going on in their brain is different. Adolescence and young adulthood is a time of great potential for change and development. The brain of young people particularly in infancy and in adolescence is very malleable. Experience both positive and negative plays a crucial role. Neural systems that are chronically activated by threat can change in permanent ways. Experience plays an important role in determining connections made. The types of brain activities engaged in during adolescence probably have a significant impact on what cognitive abilities people will have for the rest of their lives. The Prefrontal cortex is still underdeveloped. Executive functioning, controlling and co-ordinating through and behaviour, directing attention and thinking about future consequences, are limited.</p> <p>There are a range of diagnosable mental health conditions that children and young people (aged 5 to 16) can have (see Table xxx):</p> <p style="text-align: center;">Table xxx - A classification of mental disorders</p> <table border="1"> <thead> <tr> <th>Mental disorder</th> <th>Examples</th> </tr> </thead> <tbody> <tr> <td>Emotional disorders</td> <td>Phobias, anxiety states and depression. These may be made manifest in physical symptoms such as chronic headache or abdominal pain.</td> </tr> <tr> <td>Conduct disorders</td> <td>Stealing, defiance, fire-setting, aggression and antisocial behaviour.</td> </tr> <tr> <td>Hyper-kinetic disorders</td> <td>Disturbance of activity and attention.</td> </tr> <tr> <td>Development disorders</td> <td>Delay in acquiring certain skills such as speech, bladder control and social ability. These disorders may affect one area of development, or pervade a number of areas, as in children with autism.</td> </tr> <tr> <td>Eating disorders</td> <td>Pre-school eating problems, anorexia nervosa and bulimia nervosa</td> </tr> <tr> <td>Habit disorders</td> <td>Tics, sleeping problems and soiling.</td> </tr> <tr> <td>Post-traumatic syndromes</td> <td>Post-traumatic stress disorder</td> </tr> <tr> <td>Somatic disorders</td> <td>Chronic fatigue syndrome.</td> </tr> <tr> <td>Psychotic disorders</td> <td>Schizophrenia, manic depressive disorder or drug-induced psychoses</td> </tr> </tbody> </table>		Mental disorder	Examples	Emotional disorders	Phobias, anxiety states and depression. These may be made manifest in physical symptoms such as chronic headache or abdominal pain.	Conduct disorders	Stealing, defiance, fire-setting, aggression and antisocial behaviour.	Hyper-kinetic disorders	Disturbance of activity and attention.	Development disorders	Delay in acquiring certain skills such as speech, bladder control and social ability. These disorders may affect one area of development, or pervade a number of areas, as in children with autism.	Eating disorders	Pre-school eating problems, anorexia nervosa and bulimia nervosa	Habit disorders	Tics, sleeping problems and soiling.	Post-traumatic syndromes	Post-traumatic stress disorder	Somatic disorders	Chronic fatigue syndrome.	Psychotic disorders	Schizophrenia, manic depressive disorder or drug-induced psychoses
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<ul style="list-style-type: none"> ▪ Kent CAMHS services in 2009/10 were seeing fewer than expected 																					

proportion of children according to need in T2

- There is considerable % of self harm and psychosis seen in T2-3
- In Kent slightly fewer males and slightly more females access services than would be expected nationally
- There is an under representation of conduct disorder and hyperkinetic disorders and fewer younger boys are being seen than expected nationally
- Although smaller numbers of BME are expected in Kent CAMHS services than nationally, Kent CAMHS have an underrepresentation of African and Caribbean children and an over representation of Asian and mixed race children than is expected.
- Kent CAMHS are seeing more children with learning disability than expected nationally but children looked after and young offenders are under represented both according to local need and to national comparison.
- CAMHS services are being accessed by more children and young people aged 10-14 than at 15-18
- There is a gap in transition services from CAMHS to Adult services.
- There is under representation from BME groups from a number of providers notably NHS West Kent where there is a large Asian population. KMPT is seeing expected numbers of mixed race children and Asian children. KCC reports large numbers of White Irish, White Other and mixed race young people.

When comparing the vulnerable children in Kent in three categories, (children looked after, young offenders and children with learning disability), in need of a CAMHS service compared to the children accessing services there is a very large gap in provision (Table 3). However, nationally all CAMHS services struggle to meet 'actual' need and this is recognised as a major resourcing issue. Therefore when compared to national average performance, Kent appears to be performing well regarding the treatment of vulnerable children with learning disabilities compared to national. However Kent performance for Children looked after and young offenders is comparatively poor. This is in stark contrast to the number of children who are recorded on CAMHS mapping data as having 'emotional disorders', many who would be expected to be seen in more universal services e.g IAPT or primary care.

Table 2 - Percentages of vulnerable young people on CAMHS caseloads in Kent

CAMHS Provider	Looked after children	Learning disability	Young offenders
EKHT	9	9.7	2.3
KMPT	4.9	8.6	1.5
ECK PCT	2.9	2	1.2
WKPCT	7.6	1.7	0.8
National	9.5	7.8	3.8

Table 3 - Gap according to need for targeted groups

	Vulnerable group	Number with need of CAMHS in Kent	Estimated number on Kent CAMHS caseload	Kent % GAP to need	National standard	Kent % Gap to national standard
	Looked after children	1192	259	78	372	-31%
	Learning disability	2425	326	87	305	+6%
	Young offenders	5538	70	99	148	-53%
<p>The children and young people’s emotional well-being and mental health national support team (NST) from the Department of Health visited Kent in September 2010, and interviewed a wide range of clinicians and professionals across mental health and wider emotional wellbeing services in Kent.</p> <p>Following this visit the team made a series of recommendations. This captured the strengths that they found in Kent, including strong dedication and commitment across services, but also significant systemic errors. The overarching recommendation of the visit was a complete system redesign and the development of a Community CAMHS model.</p> <p>One of the key issues identified was the large number of young people referred to a specialist CAMHS service at tier 3, who could have been seen earlier and more effectively in tier 2 services. Part of this is due to a lack of clarity for the current system of referral.</p>						

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Working Draft

Healthy Lives: Healthy Kent

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Kent's Health Inequality Action Plan

2012 - 2015

The Six Stages of the Life Course



INTRODUCTION

Foreword– Meradin Peachey, Director for Public Health-to be added

Foreword – Graham Gibbens, Cabinet Member for Adult Social Care and Public Health- to be added

We are pleased to be working towards Marmot’s life-course approach adopted by KCC Cabinet to reach the touch points of people’s lives when, where and in a way they most need them.

Background

The Kent County Council Health Inequalities Strategy (2008) sets out the direction and approach to reducing health inequalities in Kent. Since its publication, the Marmot Policy Objectives recommended to significantly reduce health inequalities have been endorsed by the County Council and the release of the Public Health White Paper in 2011 has meant that by 2013, responsibility for many areas of Public Health will be transferred from Primary Care Trusts to the Local Authority. In Kent, an early shadow arrangement has already commenced, enabling a stronger partnership and collaborative commitment to reducing inequalities and greater opportunities for addressing the wider determinants of health and individual lifestyles that determine fundamental outcomes for people.

The Kent Health Inequalities Action Plan refreshes the commitment and strengthens the contributions made by all key stakeholders. It has a wider and more collective ownership and commitment to health inequalities, so that we can all work together to really make a difference. This will require a focused, targeted approach to inequalities and strong partnerships with the Kent Community to gain insight into attitudes and behaviours raise aspirations and increase opportunities for people and communities to maximise the potential for healthier, stronger lives. We want all residents in Kent to live longer, healthier lives and we want to improve the lives of the poorest fastest.

Over £21bn of the UK’s annual health budget has been spent on reducing health inequalities and yet the gap between the richest and poorest in society has increased rather than reduced. Under the new Local Authority responsibilities there is an opportunity to ensure that an appropriate proportion of health inequalities funding can now be committed to reducing the cause and not just tackling the consequences of inequalities.

This Action Plan, driven by the Joint Strategic Needs Assessment and Marmot’s Life-course objectives provides a clear, focused commitment to how and by when we will see outcomes to reduce to the inequalities gap.

Main causes of deaths in England –Wales 2001 (ONS)
The greatest (and broadest) measure of health inequalities is ‘life expectancy at birth’. Against this

measure, the UK is currently positioned 28th in the world with main causes of premature death:

1. Circulatory Disease 219,087
2. Cancers 136,234
3. All other causes 105,201
4. Respiratory 67,468

Access to early diagnosis and treatment pathways are essential to effectively treat people with these conditions, but it is more efficient and beneficial to prevent the conditions in the first place. This requires targeting health promotion and interventions, in ways that best reach those more at risk of conditions, most of which are prevalent in areas of deprivation and low socio-economic groups. By developing the Mental Health and Wellbeing Impact Assessment, we will produce a screening tool that can demonstrate that the right people are accessing interventions. Together, Public, Private, Voluntary sectors can contribute to reducing the risk and prevalence of these health conditions that result in premature mortality disproportionately among the more deprived groups.

Developing the Action Plan

This Action Plan is centred around needs and priorities identified in Kent's Joint Strategic Needs Assessment and which in turn, informs the Strategies, Business Plans and Local Delivery Frameworks across the Local Authority. As the responsibility for Public Health transfers into Local Authorities by 2013 it is a timely opportunity for Public, Private, Voluntary sectors and social enterprises to work collaboratively and join forces to reach a variety of aspects of people's lives in order to make a difference.

Together, we can be smarter in the effective targeting of inequalities; intelligence held by the Kent Public Health Observatory and Mosaic; re-modeling existing screening tools such as the Mental Wellbeing Impact Assessment and listening to the public voice should be routinely applied and mainstreamed throughout the Public Sector. These will be essential tasks to supporting the Action Plan.

The Health Inequalities Action Plan has been composed under the 6 Marmot Policy themes endorsed by Kent County Council. This promotes the 'life-course' approach and encourages the inclusion of wider social determinants such as Housing, Transport, Education and Employment.

Under each Life-course theme, a set of priorities have been identified from the JSNA and partners have agreed actions that support them. Only actions that demonstrate the effective targeting of reducing inequalities for most vulnerable groups have been included. Health promotion issues that are widespread in all social and local groups and not endemic in health inequalities (such as dementia) have not been included. Each chapter also highlights the significance to Districts who have a role in prioritising health inequalities in their locality.

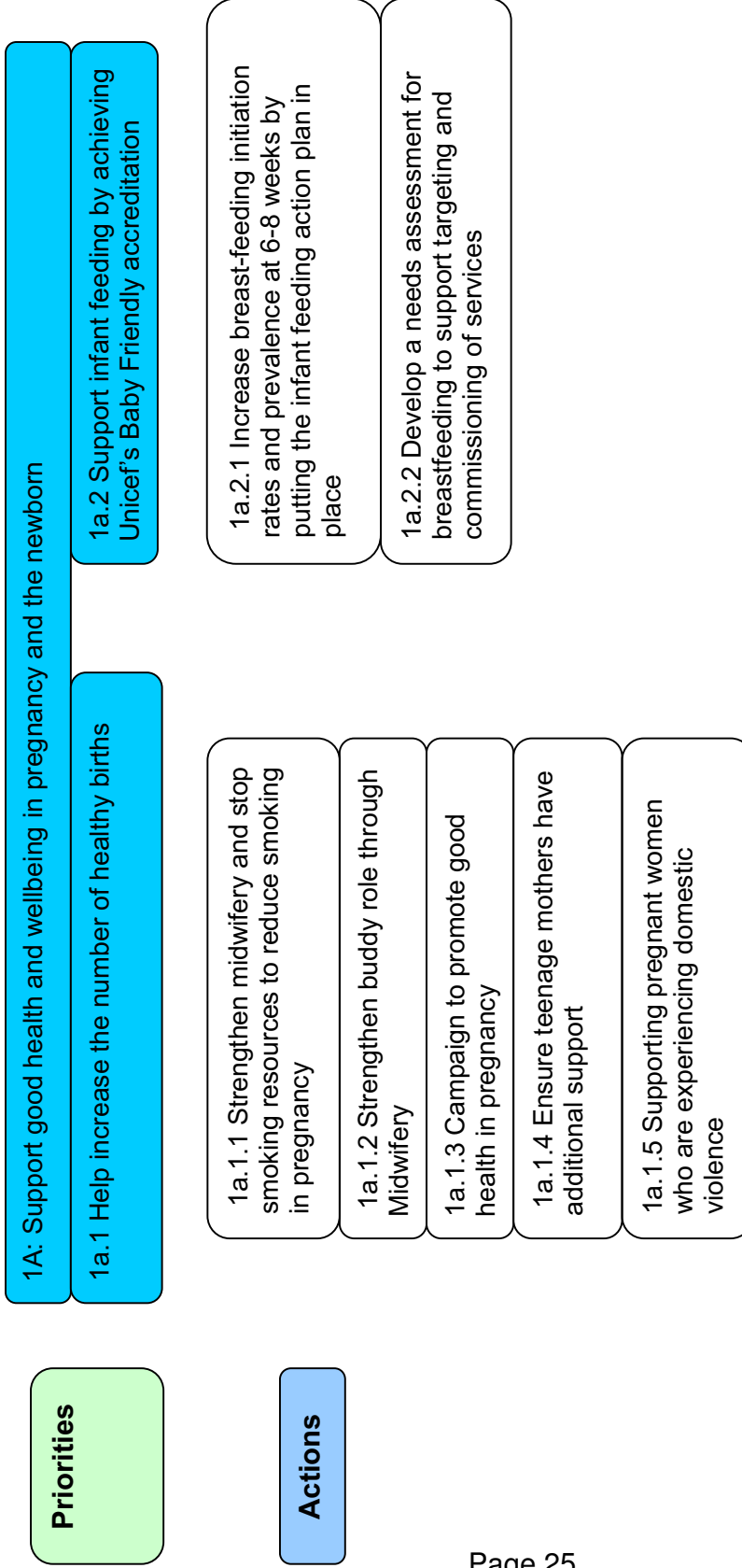
Lastly but importantly, all actions include measurable indicators to ensure that progress can be monitored against health inequalities. All stakeholders are committed to aspiring to achieve a measure of good practice under the 'What Good Will Look Like in 2015' section. This is where the scaling up and systematic delivery of effective programmes with robust outcomes will come into effect and where challenges, risks and innovation will need to be applied.

1: Give every child the best start in life

Improving health in the early years of life contributes considerably to better health outcomes in later life, with reduced levels of diabetes, coronary heart disease and hypertension, all of which have a significant impact on the NHS as well as wider society, children and their families.

The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. (Marmot Review 2010)

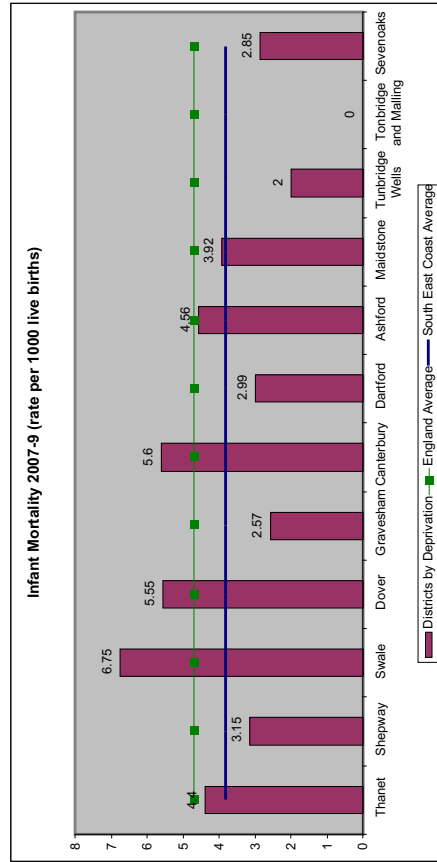
Objective 1A: Give every child the best start in life (Conception-9 months)



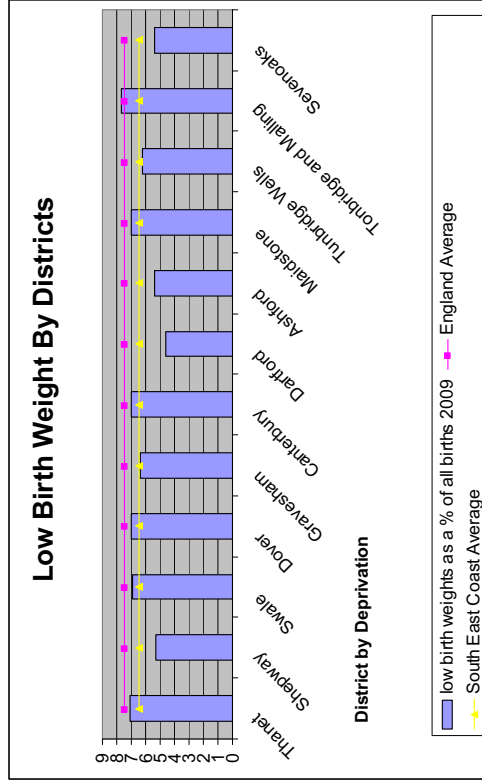
1A. Give every child the best start in life

Priority 1a.1 Help increase number of healthy births

- The overall rate for infant mortality for Kent has been consistently lower than the England and Wales rate. However there are differences in infant mortality rates which could point to a health inequality based on socio-economic circumstances. There are a higher number of infant deaths in East Kent and latest data indicates that Swale far exceeds the England average with Canterbury and Dover above the England average. There were NO infant deaths reported in Tonbridge and Malling. It should be noted that the incidence is low and the overall trend can be distorted by specific cases.



Chimat 2011



- Low birth weight has serious consequences for health in later life. Increased viability and survival of very pre-term infants due to advances in medical technology will account for some of the very low birth rate weights.
- Smoking in pregnancy is known to affect both birth weight and incidence of infant mortality and continues to impact on the health of a child.
- Domestic violence is more likely to occur to women in their reproductive years, from lower socio-economic areas and often increases during pregnancy.
- A particularly vulnerable group is teenage mothers who are much more likely to be smoking both at booking and at delivery posing considerable risk to both themselves and their babies. They are also highly likely to access services late, potentially further compromising their care. Teenage mothers had a statistically significant higher rate of stillbirths. Postnatally they had much lower rates of breastfeeding at both birth at 6-8 weeks.

1a.2 Support infant feeding by achieving Unicef's Baby Friendly accreditation

Breastfeeding makes an important contribution to the health of mothers and infants. The Government has committed to increase support for breastfeeding as part of its strategy to reduce health inequalities and has set a target to increase breastfeeding initiation rates by 2% per year, focusing particularly on women from disadvantaged groups. In Kent averages in breastfeeding at birth mask significant disparity between Hospital Trusts. For example from April- June 2011 65% of new mothers breastfed at the Darent Valley Hospital, 78% did so at Maidstone and Tunbridge Wells.

Local Profile

District comparison to the Strategic Health Authority average. All districts are performing poorly against SHA average for breastfeeding initiation but data has been aggregated across the 12 Districts so there is some masking of performance. A needs assessment exploring breastfeeding should address this issue.

	Breast Feeding Initiation	Low Birth weight	Infant Mortality	Smoking in pregnancy
Ashford	x	-	-	x
Canterbury	x	x	-	x
Dartford	x	x	-	-
Dover	x	-	-	x
Gravesham	x	-	-	-
Maidstone	x	x	-	-
Sevenoaks	x	-	-	-
Shepway	x	-	-	x
Swale	x	x	x	x
Thanet	x	x	-	x
Tonbridge & Malling	x	x	-	-
Tunbridge Wells	x	√	√	-

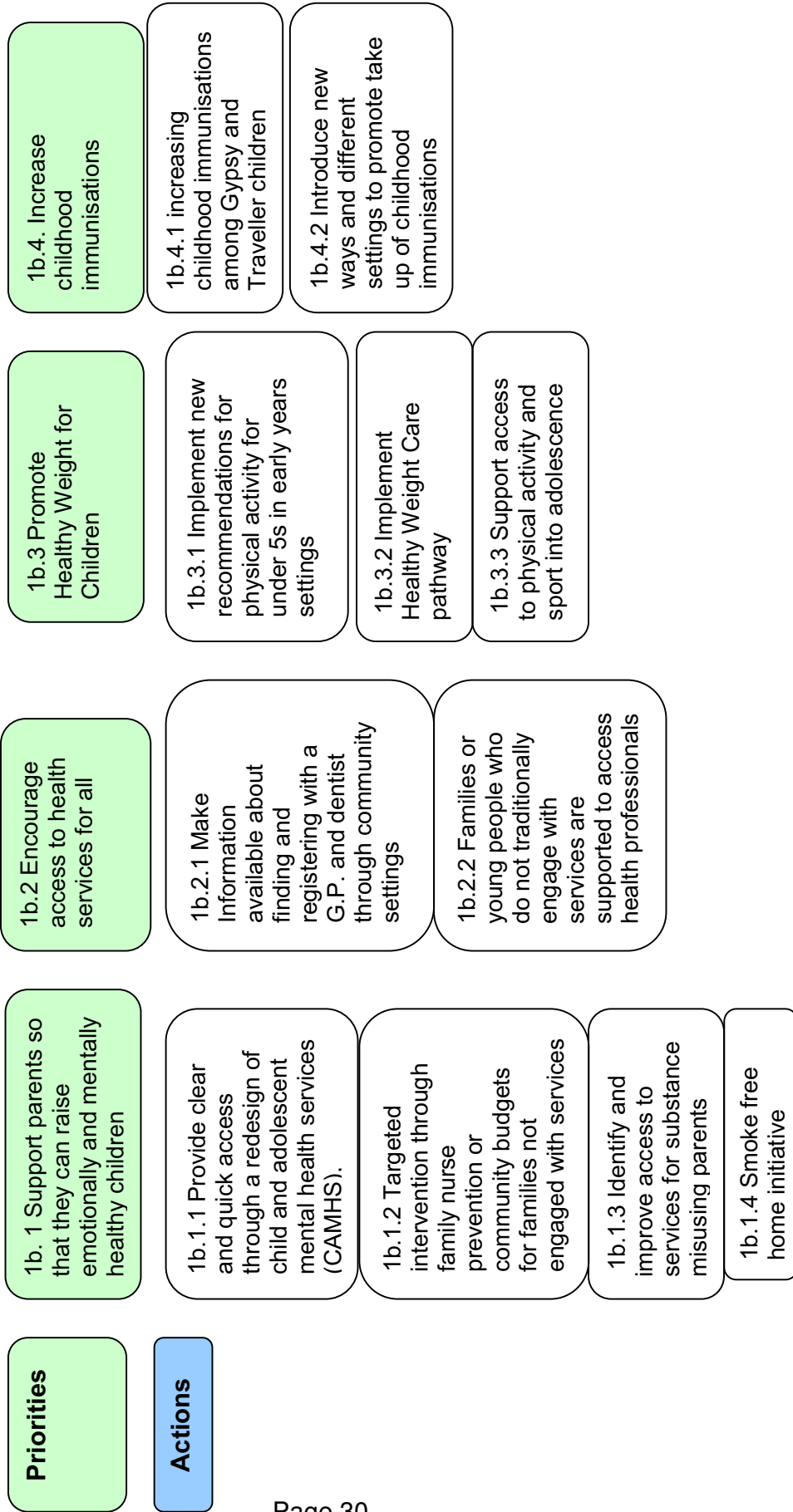
X	Significantly worse than SHA average
-	Not significantly different from SHA average
√	Significantly better than SHA average

The Aspirations

Action	What good will look like in 2015	Aspirational Targets
1a.1 Increase Numbers of Healthy Births		
All women are supported throughout their pregnancy, know how and when to access services and can easily find support in their community. They have access to help and information about avoidable risks and lifestyle choices to keep their baby healthy. Women in deprived areas or in at risk groups receive additional targeted support in ways that suit them and they access services in good time.		
1.1.1 Strengthen midwifery and stop smoking resources to reduce smoking in pregnancy	Linking pathways between acute and primary interventions and provide motivational interview training skills for Midwives	<ul style="list-style-type: none"> • Reduction in Infant mortality • 1% reduction in smoking in pregnancy per annum • 1% reduction in low birth weight
1.1.2 Strengthen midwifery resources to provide health buddy support through pregnancy	Giving priority to pre and post natal interventions including intensive home visiting with outreach to increase take-up from the most disadvantaged families Health buddy support -repeated broad based contacts with either a professional or peer educator both before and after birth to assist in take up of breast feeding and smoking cessation	
1.1.3 Deliver effective campaign to promote good health and wellbeing in pregnancy	All women have access to good information and signposting to support lifestyle choices and wellbeing	
1.1.4 Ensure teenage mothers have additional support	New ways of working: Children's Centres taking on the main role for providing tailored support to teenage parents including the facilitation of provision of specific education programmes within the young parent support groups. Reduction in greater prevalence of smoking among teenage mums in areas of deprivation. Smoking cessation support is available in new non medical places targeted to where mums will go- soft play centres, libraries, children centres.	For teenage mums- <ul style="list-style-type: none"> • 1% reduction in low birth weight • 2% Increase breast feeding initiation rates • 2% Increase in breast feeding prevalence 6-8 weeks after birth • Reduce greater prevalence of smoking amongst teenage Mums in areas of deprivation
1a.1.5 Support pregnant women who are	Front line staff are given training and awareness raising about domestic violence, how to recognize it and what support is	

experiencing domestic violence	available NICE Guidelines for women with complex social circumstances implemented	
1a.2 Support infant feeding by achieving Unicef's Baby Friendly accreditation		
The Baby Friendly Initiative works with the health-care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies. In whatever way a woman chooses to feed her baby health care professionals will make sure mums are supported and confident The Kent and Medway Infant feeding strategy will be fully implemented.		<ul style="list-style-type: none"> • 2% Increase breast feeding initiation rates • 2% Increase in breast feeding prevalence 6-8 weeks after birth particularly in the most disadvantaged groups • Healthy Start Scheme
1a.2.1 Increase breast-feeding initiation rates and prevalence at 6-8 weeks	Working through maternity units, hospitals, children centres, midwives and Health Visitors to achieve Unicef's baby friendly accreditation. Best practice is in place in a range of medical and community settings and Unicef's assessment and accreditation process is in progress recognising those that have achieved the required standard There will be a quarter on quarter increase in the uptake of the Healthy Start scheme-a statutory scheme providing a nutritional safety net and encouragement for breastfeeding and healthy eating for pregnant women and children under 4 in low income and disadvantaged families across the UK.	
1a.2.2 Develop a needs assessment for breastfeeding to support targeting and commissioning of services	The needs assessment is being used to identify groups or areas where targeted support will increase breastfeeding	2% increase in breastfeeding rates in the most disadvantaged groups

Objective 1B: Give every child the best start in life (9 months+)



Priorities

Actions

Objective 1B: Give every child the best start in life (9 months+)

Priority 1b. 1 Support parents so that they can raise emotionally and mentally healthy children

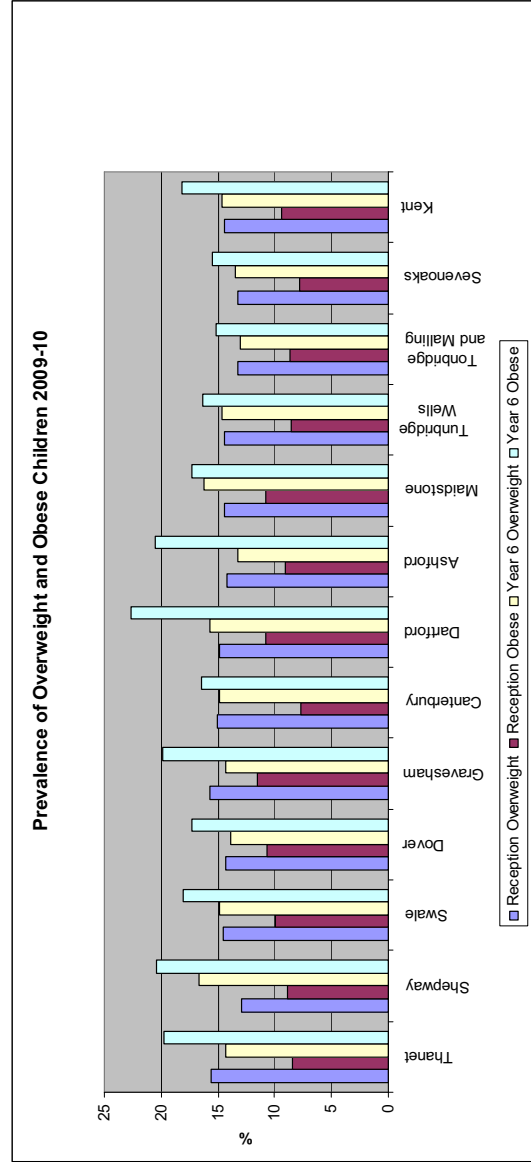
The role parents play in the health and wellbeing of their children cannot be overstated. Assisting parents to make the right choices to support healthy outcomes is a key part of tackling health inequalities for young people. The county council and districts are uniquely placed to communicate and support parents through children centres, schools, council services, libraries and Gateways and have a specialist family commissioning team to develop new services to support the most disadvantaged families in our communities

Priority 1b.2 Encourage access to health services for all

GP and Dentist registrations- access to health professionals is vital to support good health outcomes and finding and visiting a GP can be more difficult for those experiencing disruption in their lives- including looked after children and the homeless.

Priority 1b.3 Promote Healthy Weight for Children

Mounting evidence suggests that a critical period during which to prevent childhood obesity and its related consequences is before the age of five. The best thing we can do for children from 0-5 is create ways of life which continue to make obesity unlikely. Children who live in more deprived areas are more likely to be overweight and obese than those from the most affluent areas. Making what may seem like simple changes to daily habits (physical and nutritional) is sometimes simply too difficult given all



the other difficulties many families have to confront.

Source: The Health and Social Care Information Centre 2011

Priority 1b.4 Increase childhood immunisations

The national immunisation programme is an essential part of protecting children's health. Low vaccine uptake puts children at risk. Measles has made resurgence in the UK and the rate of take up of the MMR vaccine in Kent whilst improving, is not at the 95% level recorded by the World Health Organisation as being necessary to prevent an outbreak.

Percentage of children immunised by their 5th birthday 2010-11

	DTP		Hib		DTPP		MMR	
	Primary %	93.7	Primary %	94.9	Booster %	91.4	First dose %	87.4
West Kent PCT								
Eastern & Coastal Kent PCT	96.3		96.7		90.1		93.5	87.0
South East Coast	92.5		92.6		84.4		89.0	80.9
England	94.7		94.2		85.9		91.9	84.2

Diphtheria Tetanus, Polio (DTP) Diphtheria Tetanus, Polio, Pertussis (DTPP) Information Centre 2011

Local Profile

District comparison to the Health Authority average

X	Significantly worse than SHA average
-	Not significantly different from SHA average
√	Significantly better than SHA average

	Tooth Decay (at age 12)	Physically active children	Obese children yr 6
Ashford	-	-	X
Canterbury	-	√	-
Dartford	-	√	X
Dover	-	√	-
Gravesham	-	X	X
Maidstone	-	X	-
Sevenoaks	-	√	-
Shepway	√	X	X
Swale	-	X	-
Thanet	-	X	X
Tonbridge & Malling	-	√	-
Tunbridge Wells	-	√	-

Strategic

The Aspirations

Action	What good will look like in 2015	Targets and achievements
1b. 1 Support parents so that they can raise emotionally and mentally healthy children		
All our children have a right to a good childhood and a positive future. Parents and carers will feel supported to bring up their children to be physically, mentally and emotionally healthy, to help them fulfill their potential and equip them to contribute to society. Services will offer targeted support to those families that are finding it hard to cope or face challenging situations.		
1b.1.1 Provide clear and quick access through a redesign of child and adolescent mental health services (CAMHS)	CAMHS are easily accessible with short waiting times and improved access to psychological therapies Routine support to meet social need via outreach to families is available through schools, parenting programmes, children's centres and key workers	Access to and effective treatment from Camhs outcomes indicator
1b.1.2 Target family support to the most vulnerable families	Family nurse prevention and the community budgets model are used to engage families in deprived areas or those facing additional challenges There is access to effective parenting programmes. Children are ready for school and families are supported through the transition to school	Crude rate of hospital admissions caused by unintentional and deliberate injuries in age 0-17 per 100,00 resident population Childhood development at 2-2.5 years
1b.1.3 Identify and improve access to services for substance misusing parents		
1b.1.4 Smoke free home initiative	Reduce amount of second hand smoke children are exposed to by making smoking outside the house the acceptable social norm	
1b.2 Encouraging access to health services for all		

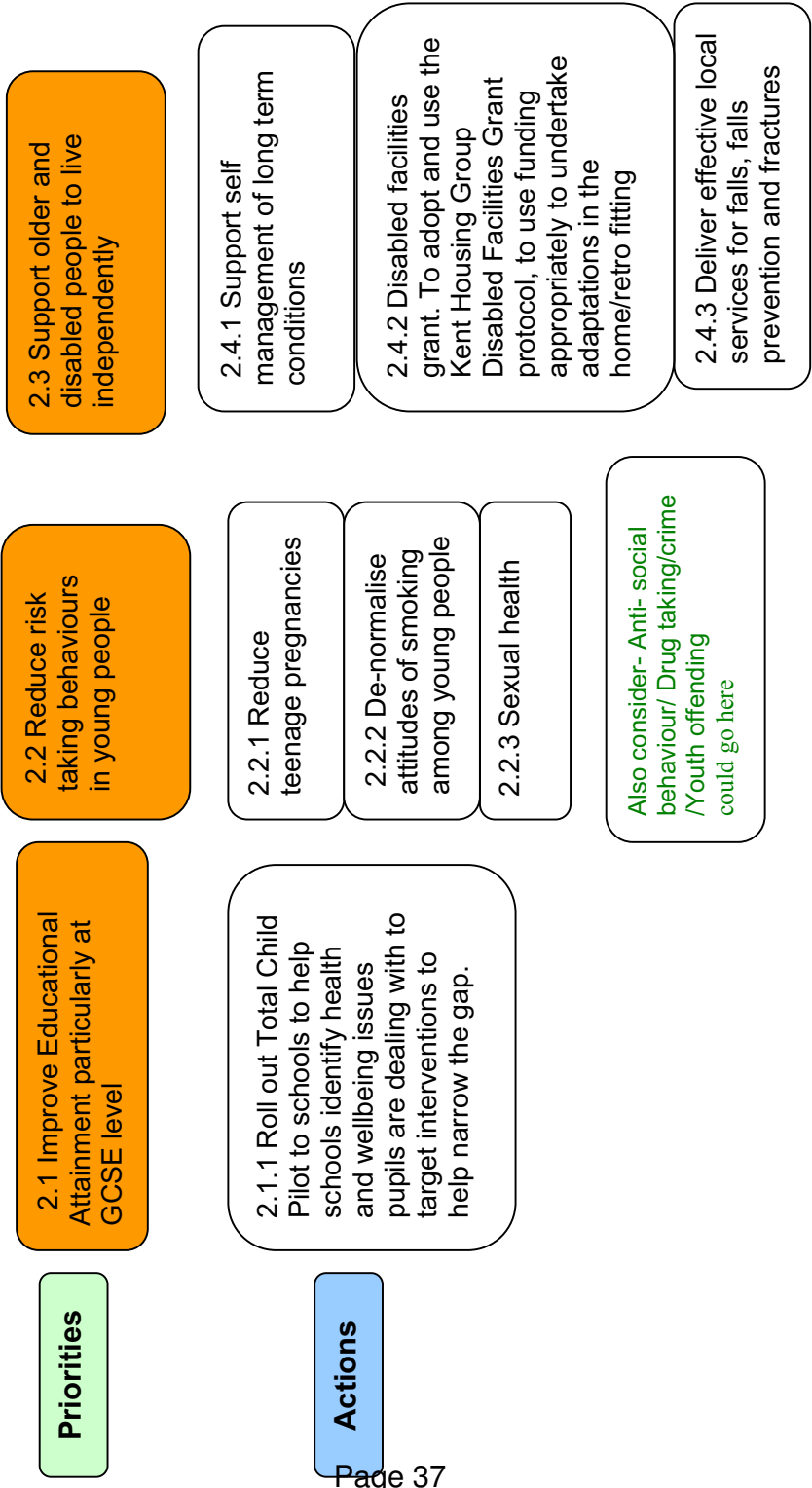
<p>1b.2.1 Information is available about finding a G.P. and dentist through community settings</p>	<p>Health Trainers making Information about finding a G.P. and dentist and how to register available at Gateways, Children's centres, schools and libraries. Health Trainers engaging with Gypsy and Travellers to increase numbers registered with GP & Dentist</p>	<ul style="list-style-type: none"> • LAC having a health check • Rate of tooth decay in children aged 5 years • Increasing immunisation
<p>1b.2.2 Families or young people who do not traditionally engage with services are supported to access health professionals</p>	<p>Children and Young People from the following groups are able to get access to health services:</p> <ul style="list-style-type: none"> • People with a learning disability • Looked after children • Homeless or in temporary accommodation • Gypsies and travellers 	
<p>1b.3 Promote Healthy Weight for Children</p>		
	<p>Measures for early intervention are targeted to areas of deprivation. Parents and carers are supported and informed in the early years about adopting good habits - how breast feeding and the introduction of good eating habits, physical activity and sleeping routines are likely to prevent the development of obesity. Children and young people have access to physical activity, sport at school, healthy food at school, affordable leisure activities and places to play</p>	<ul style="list-style-type: none"> • From the 11/12 trend baseline we will aim to reduce the percentage increase from yr R to yr 6 by 1% per annum
<p>1b.3.1 Implement new recommendations for physical activity for under 5s in early years settings</p>	<p>Healthy schools Team working in new ways with early years settings and rolling out the effective early years pilot to areas of deprivation Early years (under 5s) should be physically active daily for at least 180 minutes (three hours), spread throughout the day (once a child is able to walk.) Improved referral rates to programmes from health care professionals to family healthy weight programmes such as MEND</p>	
<p>1b.3.2 Implement Healthy Weight Care pathway</p>		
<p>1b.3.3 Provide access to physical activity and sport into adolescence for all</p>	<p>Continue to develop opportunities and programmes with partners and the 3rd Sector for young people to take part in sport – such as Sportivate and use the legacy of the 2012 Olympics and Para Olympics to promote the benefits of sport i.e. through the Kent school games Revise and promote the Active Kent website to provide</p>	<p>http://www.kentsport.org/ http://www.activekent.co.uk/</p>

	information on local activities & services	
1b.4 Increase childhood immunisations among most vulnerable groups		
New, non medical places will be promoting and offering immunisations with specialist targeting to groups with low take up rates		<ul style="list-style-type: none"> • 1% Increase in immunisations take up by age 5 in groups with low take up rates
1b.4.1 Increasing childhood immunisations among Gypsy and Traveller children		
1b.4.2 Introduce new ways and different settings to promote take up of childhood immunizations	<ul style="list-style-type: none"> • Promoting take-up in children's centres • Start in school programme as part of primary school registration in most deprived areas • Targeted Opportunistic Vaccinations for children presenting at A& E 	

**2. Enable All
Children, Young
People And Adults
To Maximise Their
Capabilities And
Have Control Over
Their Lives**

*Central to our vision is the full development of people’s capabilities across the social gradient.
Without life skills and readiness for work, as well as educational achievement, young people will not be able to fulfil their full potential, to flourish and take control over their lives
(Marmot review 2010)*

Objective 2: Enable all children, Young People and adults to maximise their capabilities & have control over their lives

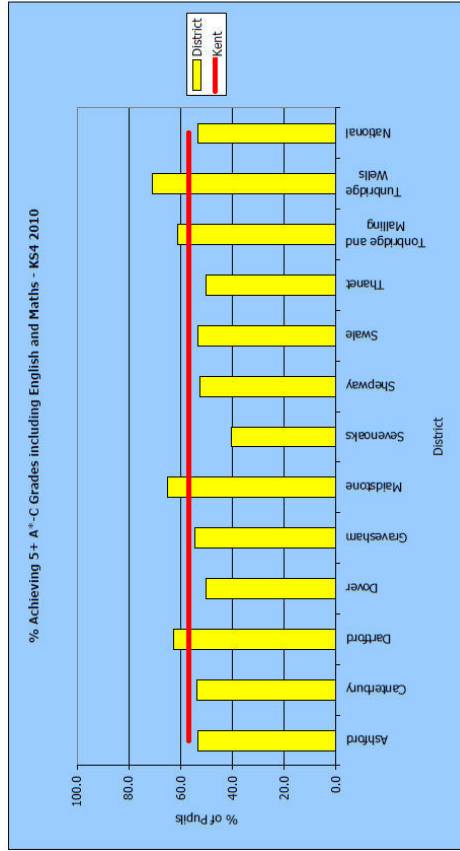


Objective 2: Enable all children, Young People and adults to maximise their capabilities & have control over their lives

Priority 2.1 Improve Educational Attainment particularly at GCSE level

There is a clear relationship between low educational attainment and poor health over a lifecourse. For young people educational attainment supports economic wellbeing- the ability to get and keep a job which indicates better mental wellbeing and health outcomes for the rest of their lives.

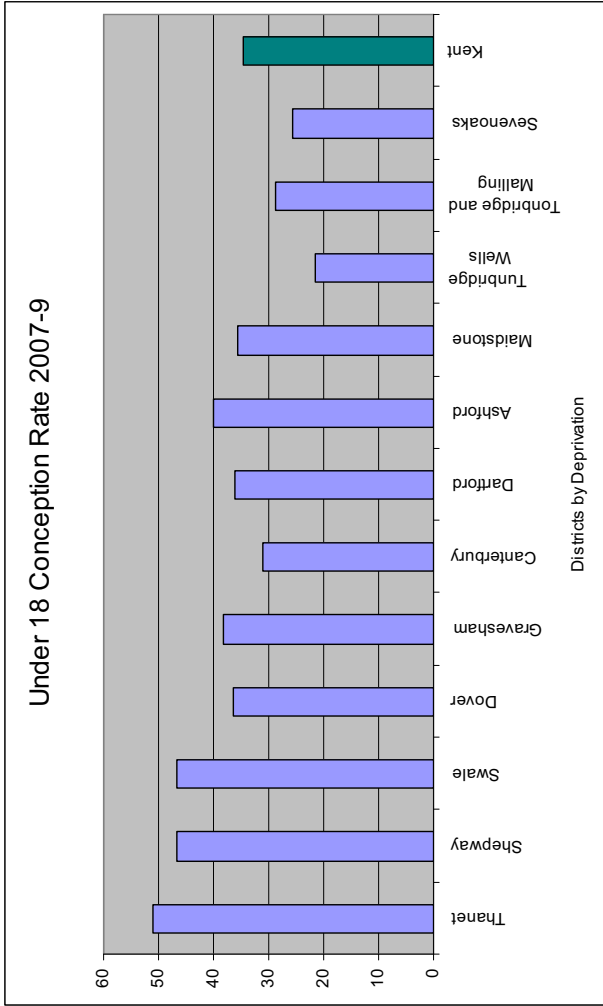
In 2009-10 GCSE statistics showed that around a third of pupils who had been on Free School Meals in the previous six years achieved five or more A*- C grades, compared to more than two thirds of their fellow pupils. In Kent, children who take free school meals experience marked inequality in comparison to the achievement of their peers- including significantly lower outcomes at GCSE. Those children achieving 5+ A*-C GCSEs are more likely to experience longer term employment and have the capability to retrain at least twice during a working life.



Whilst schools serving areas with significant concentrations of relative deprivation mainly do well against the England average they struggle to match the outcomes of the most affluent areas.

2.2 Reduce risk taking behaviours in young people

Teenage mothers and their children face particular inequalities: The link with a lack of aspiration is significant, young people need the motivation as well as the means to prevent pregnancy and engagement in education through the teenage years is a strong protective factor



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.

There is however significant difference in progress to reduce rates across the districts of Kent, with Canterbury having achieved the best reduction of 19% while Maidstone has demonstrated an increase of 10%.

(To avoid annual fluctuations rates are calculated on three year rolling averages.)

Sexual health: Sexually transmitted infections particularly affect young people and 15 to 24 year olds, particularly young women, continue to be the group most affected by sexually transmitted infections (STIs) in the UK or the group that most present for treatment. Untreated infection can lead to serious health problems, including infertility. Acute STIs diagnosed between 1998 and 2009, increased by 100% in the east Kent and west Kent clinics. Late diagnosis of HIV is a problem in some areas of Kent, for example almost 55% of HIV diagnoses in West Kent are classified as late diagnosis.

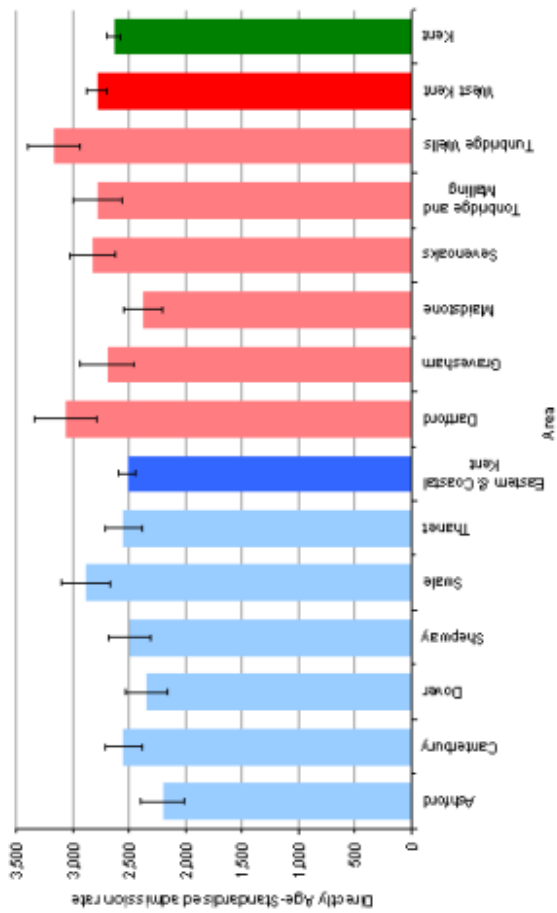
Priority 2.3 Support older and disabled people to live independently

Services that promote the health, well being and independence of older people and, in so doing, prevent or delay the need for more intensive or institutional care, make a significant contribution to ameliorating health inequalities. (Marmot Review 2010)

For adults and older people having choice and control over their own situation not only reduces pressure on health and social care services it also supports people to live more fulfilled and independent lives.

Assistive technologies enable people with health and care needs, such as the frail elderly and those with Long Term Conditions (LTCs), to gain independence in their own homes. Evaluation of a recent pilot in Kent reported that people who use telehealth have fewer hospital admissions and shorter stays when they do, reduced GP contacts and in some cases fewer visits from community nursing teams. There was also an estimated saving of £7.5m to the health and social care economy.

Directly age-standardised rates for falls related hospital admissions per 100,000 population aged 65+ by Primary Care Trust and Local Authority district



Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK, with large implications for the quality of life of older people who survive a fall. There are also considerable inequalities, both in terms of risk and longer term implications. For many older people a hip fracture is the event that forces them to leave their homes and move into residential care. Mortality after hip fracture is high: around 30% for one year. Tunbridge Wells, Dartford and Swale have the highest falls related admissions by District.

Local Profile

Districts compared to the Strategic Health Authority average

	Teenage pregnancy U18	Hospital stays for self harm	Hip fractures in Over 65s	GCSE achieved (5A*-c inc Eng & Maths)
Ashford	X	√	-	X
Canterbury	-	X	-	X
Dartford	-	-	-	√
Dover	-	X	-	X
Gravesham	X	-	-	X
Maidstone	-	-	-	√
Sevenoaks	-	√	-	X
Shepway	X	-	-	X
Swale	X	X	-	X

Thanet	x	x	x	x
Tonbridge & Malling	-	x	-	√
Tunbridge Wells	√	x	-	√

The Aspirations

Action	What Good	Will Look like in 2015	Targets and achievements
2.1 Improve Educational Attainment particularly at GCSE level			
2.1.1 Roll out Total Child Pilot to schools to help schools identify health and wellbeing issues pupils are dealing with to target interventions to help narrow the gap.	<ul style="list-style-type: none"> Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education Consistently implementing the full range of extended services in and around schools Developing the school-based workforce to build their skills in working across school– home boundaries and addressing social and emotional development, physical and mental health and well-being. 		<ul style="list-style-type: none"> Narrowing the gap between pupils on free school meals and their peers achieving 5* A-C Narrowing the gap between achievement across Districts
2.2 Reduce Risk taking Behaviours in young people			
2.2.1 Continue to implement Kent's teenage pregnancy strategy to reduce teenage pregnancies			<ul style="list-style-type: none"> Reduction in teenage pregnancy
2.2.2 De-normalise attitudes of smoking among young people			<ul style="list-style-type: none"> Reduce smoking prevalence rates among under 15 year olds Reduce illicit tobacco and supply of tobacco to under 18s
2.2.3 Improve sexual health by reducing late diagnosis of HIV in Kent and increase Chlamydia screening	<p>A range of targeted work will increase HIV testing</p> <ul style="list-style-type: none"> For Black African women Through MSM to increase early testing in high prevalence areas in Kent <p>Health care professionals will receive training to broach the topic of risk factors for STIs and work to increase Chlamydia screening in poor performing areas</p>		<ul style="list-style-type: none"> Reduction in late diagnosis of HIV by 1% Increase in take up of Chlamydia screening in Primary care In partners In young males
2.4 Support older or disabled people to live independently			

<p>2.4.1 Support self management of long term conditions</p>	<p>Mainstream use of assistive technology- telehealth & Telecare</p> <p>Recognising and making the most of opportunities presented to Public Health from the Integration of health and social care</p> <p>People with long term conditions will</p> <ul style="list-style-type: none"> • experience integrated, co-ordinated care in the community and will benefit from personalised interventions which enable them to become experts in their own condition. • have better outcomes in relation to physical and mental health, ability to carry out day to day activities and a reduced risk of acute hospital admission. • Their Carers will have an enhanced quality of life. <p>Community health and social care services will use risk stratification tools to target support to the right individuals at the right time.</p>	<ul style="list-style-type: none"> • People living independently in their own homes • Number of people accessing enablement and intermediate care services will meet "expected" targets • All people with LTC will benefit from social care personal budgets, personal health budgets or integrated personal budgets • Reduction in admissions to residential / nursing care • Reduction in emergency admissions • Reduction in emergency bed days • Reduction in admissions to residential and nursing care direct from hospital
<p>2.4.2 Disabled facilities grant. To adopt and use the Kent Housing Group Disabled Facilities Grant protocol, to use funding appropriately to undertake adaptations</p>		
<p>2.4.3 Deliver effective local services for falls, falls prevention and fractures</p>	<p>Services are reconfigured and commissioned to prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards</p> <ul style="list-style-type: none"> • acute and primary care-based fracture liaison service • community-based falls clinics • local authority-based postural stability community therapeutic exercise programmes 	

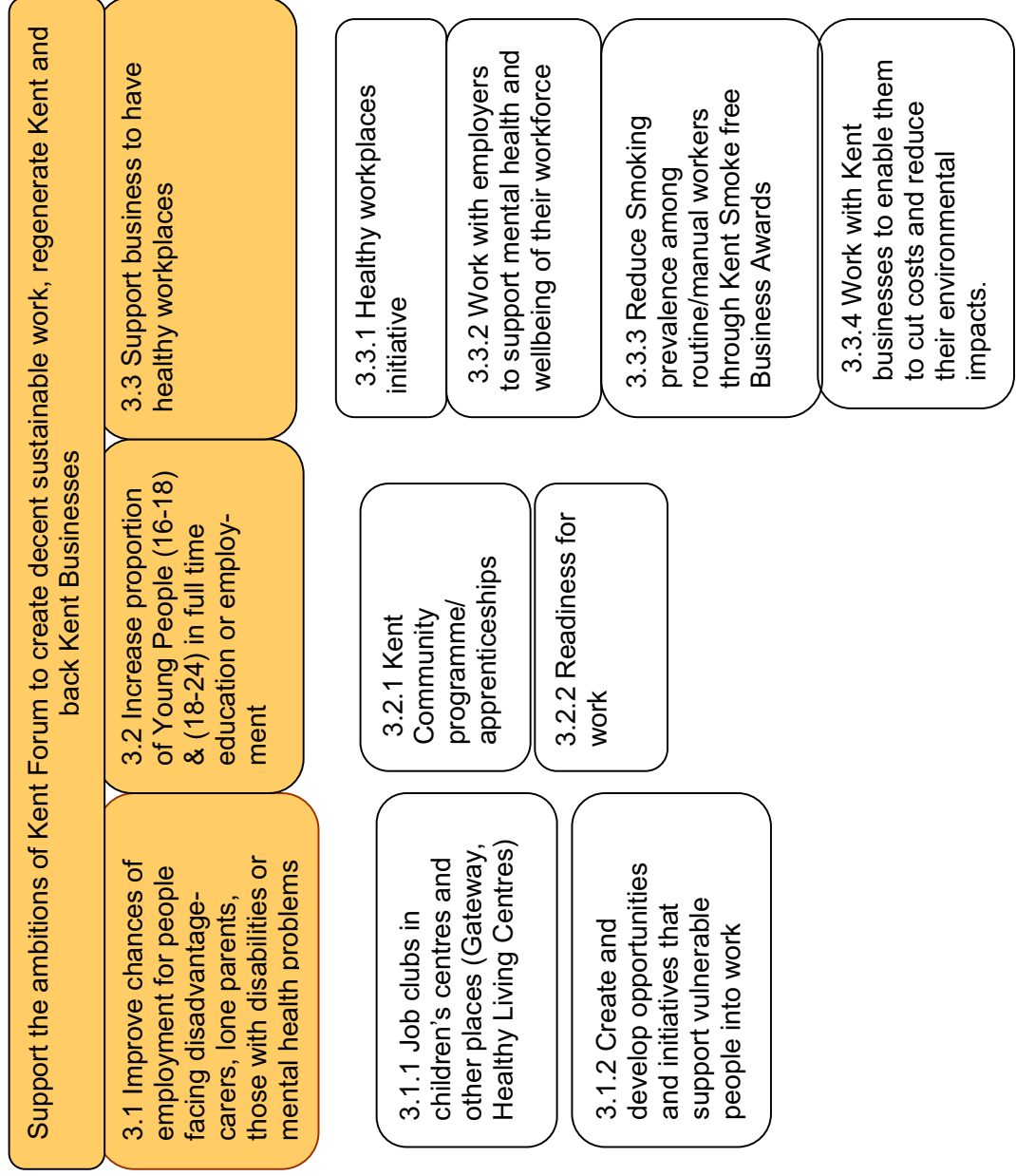
	<ul style="list-style-type: none"> • community/local authority-based falls call-out service(s), • Older and disabled people have access to home safety improvements 	
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3. Create fair employment & good work for all

The recession is leading to increasing unemployment across Kent. Marmot says that work is good – and unemployment bad – for physical and mental health.

However the quality of work is also important with underlying low levels of stress connected to low paid and insecure work in poor conditions contributing to poorer health outcomes. Work cannot provide a sustainable route out of poverty if job security, low pay and lack of progression are not also addressed

Objective 3 Create fair employment & good work for all



Objective 3 Create fair employment & good work for all

Priority 3.1 Improve chances of employment for people facing disadvantage- carers, lone parents, those with disabilities or mental health problems

Disabled workers, those with low or no qualifications and lone parents are among the groups of people most likely to find themselves long-term unemployed. (Begum 2004) With fewer jobs available it is likely that unemployment rates for all vulnerable groups will increase- causing an increase in demand for support from Health, Welfare and Social Care services

	Eastern and Coastal Kent	West Kent PCT	England Average
% of adults with mental health problems aged 18-69 in contact with secondary mental health services who were known to be in paid employment at the time of their assessment or latest review. 2009	5.2%	5.8%	7.9%

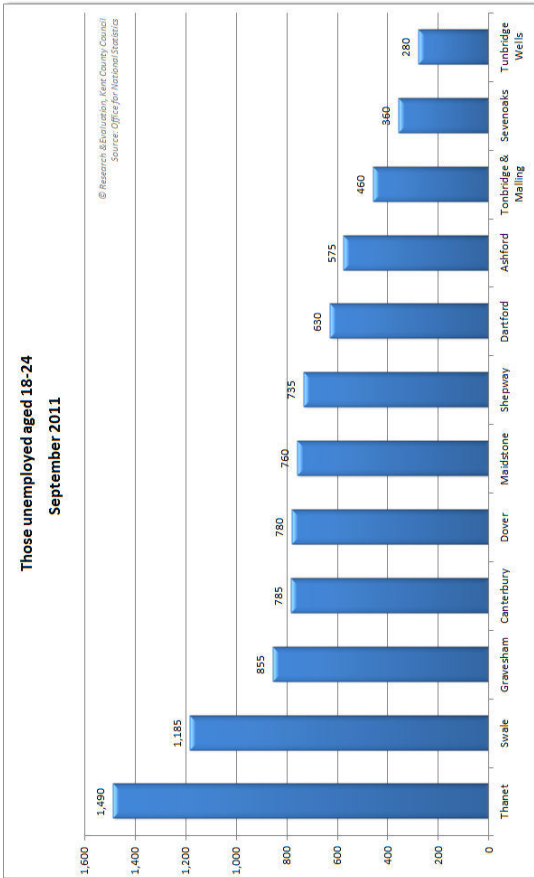
The employment rate for people who are disabled in the KCC area is 51.9%, this is lower than the employment rate for people without a disability which is 78.4% in the KCC area. This is below the South East average rate of 55.7% but above the national average rate of 48.8%.

The difference in employment rates also varies across the KCC area. In Ashford the employment rate for people with a disability is 69.0% and for those without the rate is 79.3%, however in Thanet it only 42.2% of disabled people are in employment as opposed to 80.0% of people without a disability.

As of May 2011 nearly 34,000 lone parents were claiming income support. (11,000 men, 22,000 women) Benefit reforms are expected to have the most impact on unemployed, lone, female parents causing them to be worse off financially.

Priority 3.2 Increase proportion of Young People (16-18) & (18-24) in full time education or employment

Young people continue to be disproportionately affected by the economic downturn with those aged 18-24 making up the biggest proportion of unemployed in the KCC area. Again areas of deprivation are experiencing the biggest impact and the social gradient can be clearly demonstrated



Research has shown that being NEET between the ages of 16 and 18 is a major predictor of future unemployment, low income, teenage parenting and poor health. Young people who are NEET are also 5 times more likely to enter the criminal justice system, with the life-time cost to the state of each young person who is NEET standing at £97,000.

Kent continues to perform well in decreasing the numbers of young people who are NEET and is below the National and South East average. However performance varies across Districts, with Thanet, Maidstone, Swale and Shepway historically having higher numbers of NEET (16-18). Young people with special educational needs (SEN), offending behaviour, health issues and looked after children (LAC) all perform poorly in comparison with their peers.

Local Profile

Districts comparison to the Strategic Health Authority average

	Long term unemployment
Ashford	✓
Canterbury	✓
Dartford	x
Dover	-
Gravesham	x
Maidstone	✓
Sevenoaks	✓
Shepway	x
Swale	x
Thanet	x
Tonbridge & Malling	✓
Tunbridge Wells	✓

The Aspirations

Action	What Good will look like in 2015	Targets and achievements
3.1 Improve chances of employment for people facing disadvantage- carers, lone parents, those with disabilities or mental health problems		
3.1.1 Job clubs in children's centres and other places (gateway, Healthy Living Centres)	Employers have been encouraged/ incentivized to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems	Employment of people with long term conditions
3.1.2 Create and develop opportunities and initiatives that support vulnerable people into work	<ul style="list-style-type: none"> • Maximise opportunities to support people into work through initiatives such as <ul style="list-style-type: none"> ○ Kent Supporting People ○ Kent Supported Employment • Support development of Social enterprises with the voluntary sector • Work with employers and service users to support sustainable employment for people with mental health problems 	Employment of people with mental health problems
3.2 Increase proportion of Young People (16-18) & (18-24) in full time education or employment		
3.2.1 Kent Community programme/ apprenticeships		
3.2.2 Readiness for work	Partners have worked with employers to gain an understanding of what skills the employers of Kent want and educational settings have come together to ensure training, work opportunities or further education is targeted to these skills Providing support and advice for 16–25 year olds on life skills, training and employment opportunities, delivered through centres that are easily accessible to young people Kent's number of NEETS remains low	Rate of young people who are NEETS
3.3 Support business to have healthy workplaces		
3.3.1 Healthy workplaces initiative		

<p>3.3.2 Work with employers to support mental health and wellbeing of their workforce</p>	<p>Wellbeing of staff is a priority, especially in the context where many are being made redundant and workloads are increasing.</p>	
<p>3.3.3 Reduce Smoking prevalence among routine/manual workers through Kent Smoke free Business Awards</p>		<ul style="list-style-type: none"> • Smoking prevalence in routine and manual workers
<p>3.3.4 Work with Kent businesses to enable them to cut costs and reduce their environmental impacts</p>		

**4 Ensure
healthy
standard of
living for all**

Having insufficient money to lead a healthy life is a highly significant cause of health inequalities

(Marmot Review 2010)

Objective 4: Ensure healthy standard of living for all

Priorities

4.1 Support financial capacity and inclusion

4.2 Promote opportunities to support families in poverty (support implementation of Kent's family poverty strategy)

Actions

4.1.1 Continue to promote Kent Credit Savers Union to enable people to smooth their incomes and have access to affordable credit

4.1.2 Provide financial advice as to how best to manage debts and household budgets in general.

4.1.3 Campaigns to highlight the pitfalls of doorstep lending and loan sharks

4.2.1 Access to free or affordable childcare places to help people work

4.2.2 Enable Kent Population to access information and advice about benefits and available financial support in places where they go

4.2.3 Provide information and signposting for older people who may be struggling to heat their homes

Objective 4: Ensure healthy standard of living for all

Financial security is recognised within the Marmot Review as a social determinant of health, specifically through the concept of the 'social safety net'.

Deprivation is associated with a cluster of health problems including higher levels of unhealthy weight and obesity, physical inactivity, smoking, poor blood pressure control, and other factors that effect physical health. It is also integral to lower educational attainment, lack of employment opportunities, poor housing status, poor access to services, referral differences of practitioners and poor compliance with disease management

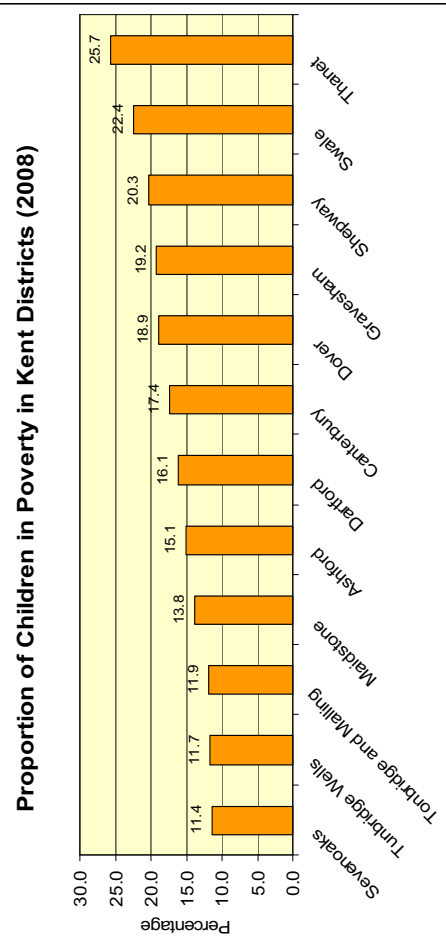
Priority 4.1 Support financial capacity and inclusion

This is particularly relevant now when greater financial responsibility and engagement is being asked of people, whether that is managing care needs in retirement or managing personalised health and social care budgets. A credit union provides access to fair and affordable credit that allows people to smooth peaks and troughs of income. Conversely, overindebtedness is causing real misery for households and communities. 8 in 10 financially excluded individuals live in social housing.

Poor financial skills can result in debt:

"It is due to negligence on my part and not having enough experience of handling money when I moved out of my parents' home."
from A Life in Debt- The profile of CAB debt clients in 2008

Priority 4.2 Promote opportunities to support families in poverty (support implementation of Kent's family poverty strategy)



The most recent data available at a local level is for child poverty in 2008. This shows 17% of children living in Kent as living in poverty, compared to a national figure of 21%, and equates to over 53,000 children. Within Kent there is considerable variation across districts ranging from 11% in Sevenoaks to 26% in Thanet.

Childcare availability, cost and quality, can be an issue for parents, particularly those of young children. Cost can make low-paid work financially unviable; care is also sometimes not flexible enough, with parents unable to find care for evenings, weekends, at short notice, and in school holidays. In Kent it is estimated that a total of 4,409 additional childcare places are required across Kent and the most significant need for additional places occur within the most deprived areas of Kent.

Local Profile

Districts that are performing significantly worse than the Strategic Health Authority average

	Deprivation	Proportion of Children in Poverty	Life expectancy - female	Life expectancy - male
Ashford	√	-	-	√
Canterbury	√	X	X	X
Dartford	√	X	X	-
Dover	X	X	X	X
Gravesham	X	X	X	X
Maidstone	√	√	-	-
Sevenoaks	√	√	-	√
Shepway	X	X	-	X
Swale	X	X	X	X
Thanet	X	X	X	X
Tonbridge & Malling	√	√	√	√
Tunbridge Wells	√	√	√	√

The Aspirations

Action	What Good will look like in 2015	Targets and achievements
4.1 Support financial capacity and inclusion		
4.1.1 Continue to promote Kent Credit Savers Union - Kent's credit Union, to enable people to smooth their incomes and have access to affordable credit	Kent credit union is being used by local people with regular promotions to local authority staff and local communities.	
4.1.2 Provide financial advice as to how best to manage debts and household budgets in general	Money management for Vulnerable Young people extended from schools to HOUSE & Youth Hubs – possibly delivered by Healthy Schools Team.	
	Continue to provide free hosting for CAB at	

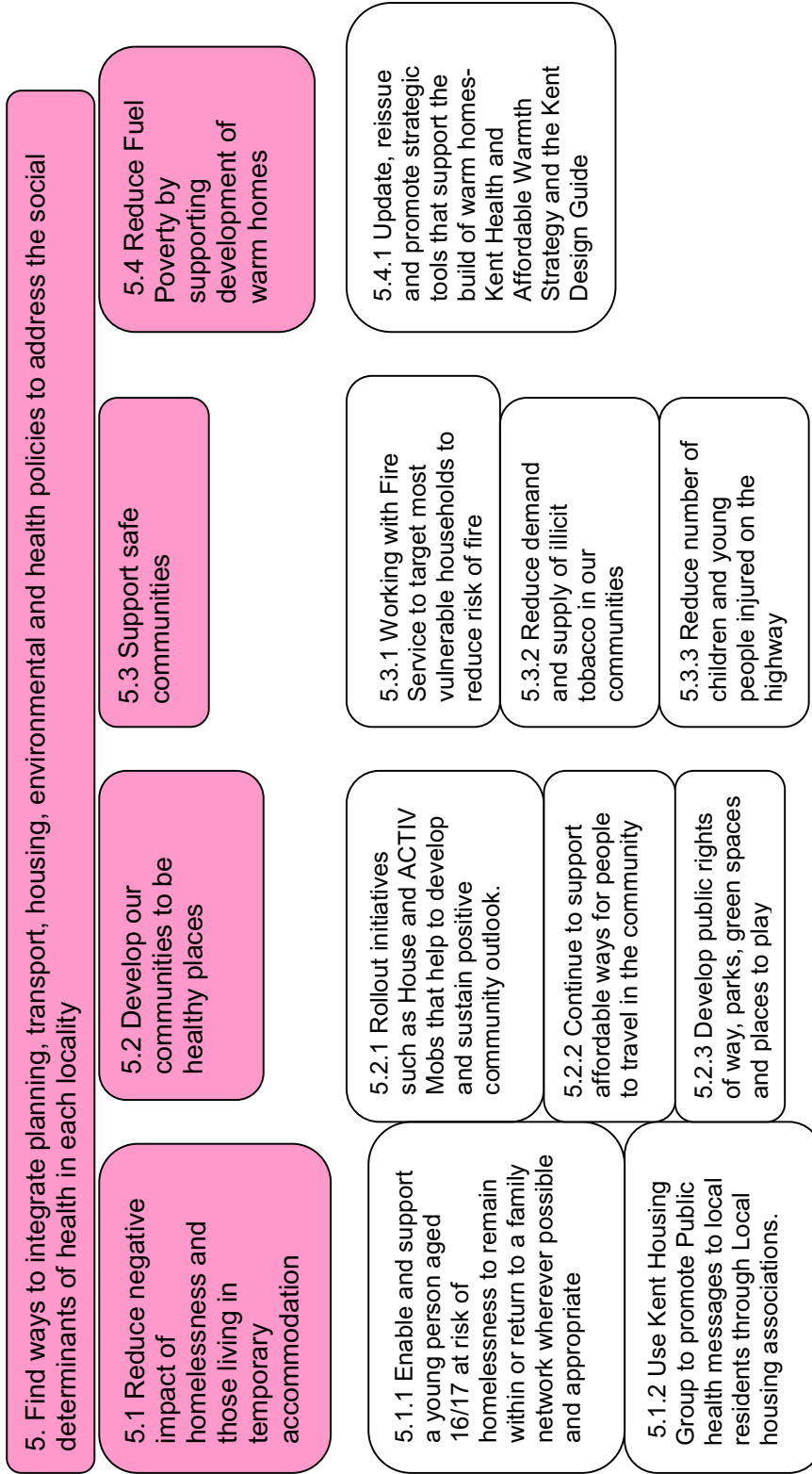
	Gateways	
4.1.3 Campaigns to highlight the pitfalls of doorstep lending and loan sharks	Signposting, advice and guidance available from kent.gov.uk and partners sites.	
4.2 Promote opportunities to support families in poverty (support implementation of Kent's family poverty strategy)		
4.2.1 Access to free or affordable childcare places to help people work	Increase in affordable child care places	Reduction of number of children in poverty
4.2.2 Enable Kent Population to access information and advice about benefits and available financial support in places where they go		
4.2.3 Provide information and signposting for older people who may be struggling to heat their homes	Keep Warm in Winter campaign signposting to benefits and energy saving measures	

**5. Create and
Develop Healthy
and Sustainable
Places &
Communities**

*Dream with me of a fairer world, but let us take
the pragmatic steps necessary to achieve it*

Sir Michael Marmot October 2011

Objective 5: Create and Develop Healthy and Sustainable Places & Communities



Priorities

Actions

Objective 5: Create and Develop Healthy and Sustainable Places & Communities

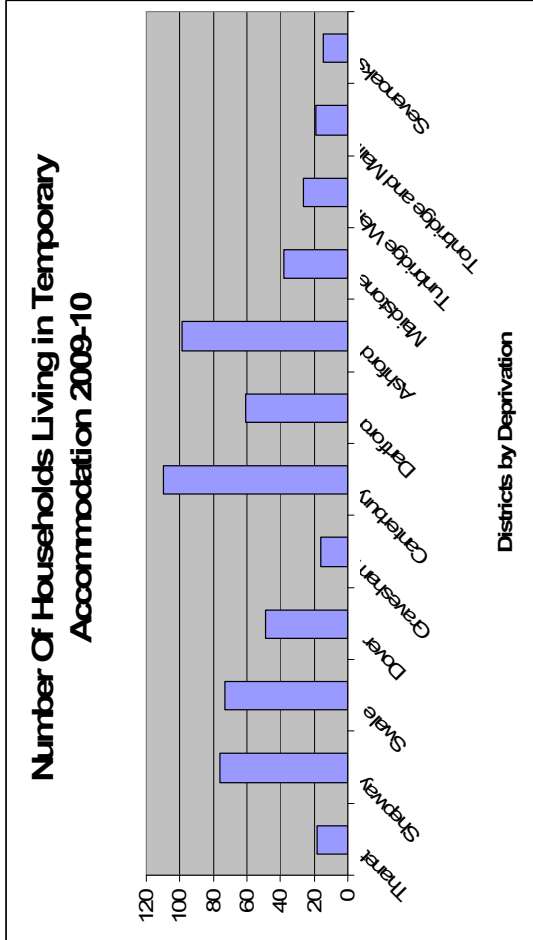
Promoting wellbeing is at the heart of what local government is about: supporting a better life for its citizens and helping to build resilient communities, now and over the longer term

5.1 Reduce negative impact of homelessness and those living in temporary accommodation

- The number of households being made homeless is increasing in Kent due to the recession, rising unemployment and cost of living so that families are finding themselves unable to meet the cost of mortgages and rent. From April to June 2011 Kent local authorities made 588 decisions on applications for housing assistance. This is 43% higher than the same quarter in 2010. Of the 588 decisions 229 households were accepted as homeless, an increase of 13% compared to one year ago.
- Districts have made significant improvements from more than 1,800 households living in temporary accommodation in 2004/05 to 583 in 2009/10
- Many homeless young people are placed in temporary accommodation, including Bed & Breakfast. Homeless young people are often very vulnerable, have multiple needs and are in need of support as well as accommodation. Most recent data shows that young people leaving care in Kent (2009-10 data) and young offenders (2008-9) are less likely to find suitable accommodation than is the case nationally and across our statistical neighbours

Shelter Living in limbo: Survey of homeless households living in temporary accommodation 2004

- Over half of people said that their health or their family's health had suffered due to living in temporary accommodation
- Children had missed an average of 55 school days due to the disruption of moves into and between temporary accommodation
- Two thirds of respondents said their children had problems at school; and nearly half described their children as 'often unhappy or depressed'
- Over three quarters of households (77 per cent) had no family member working. The reasons for this included health or mobility problems, the insecurity of their accommodation, high rents and worries about changes to benefits



Priority 5.2 Develop our communities to be healthy places

Within our county there are health inequalities that are differentiated geographically. Local authorities are the planning authorities for their areas and, as such, have huge opportunities to influence both the infrastructure and the services provided in an area.

In general 20% of households cannot afford a car. Data for Kent shows that 20.5% of lower super output areas in Kent (181 small areas) are within England's most deprived 20% of areas experiencing barriers to housing and services (home ownership and road distance to key services such as GP, primary school, post office, supermarket). Deprivation related to barriers to housing and services is concentrated in rural areas. This is partially related to the distance people live from services in rural areas but also because of difficulty people in rural areas have entering owner-occupation.

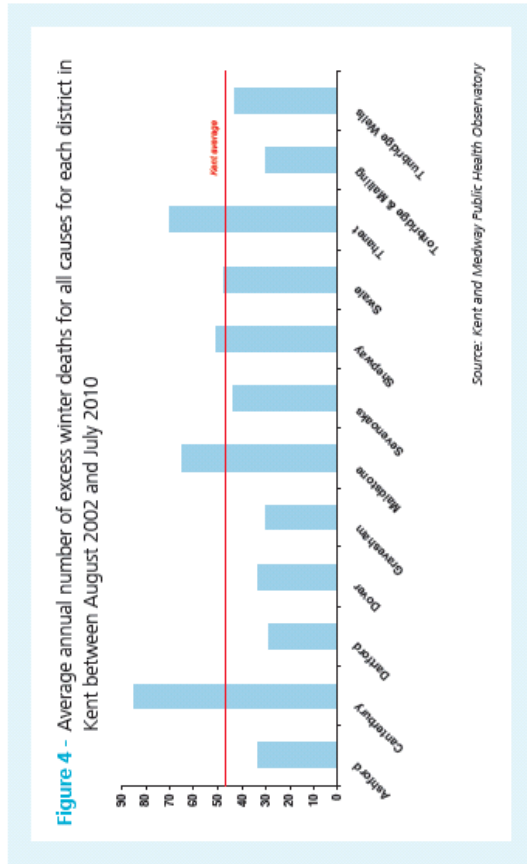
Priority 5.3 Support safe communities

- Road Safety: Injury is not only most often the cause of child death in the UK, but also has a steeper social class gradient than any other cause of child death. Casualty rates for child pedestrians are estimated to be five times higher in the most affluent than least affluent wards (Social Exclusion Unit 2003). Traffic calming, design which encourages cycling and discourages car use and parking in the least affluent areas are all part of the contribution local government can make to improving health and reducing health inequalities.

- **Fire Safety:** In 2010-11 Kent Fire and rescue services attended 677 accidental dwelling fires. 2 people died and 77 people were injured as a result of accidental fires. In Kent there are on average 46 fires per year in households and household dwellings caused by smoking. This results in a total cost of £1,150,000 pa in Kent. A child from the lowest social class is nine times more likely to die in a house fire than a child from a well off home.

Priority 5.4 Reduce Fuel Poverty by supporting development of warm homes

Fuel poverty, is said to occur when people in a household need to spend more than 10 percent of their income total in order to heat their home. 6% of households in the KCC area are estimated to be living in fuel poverty. This is approximately 33,000 households. This proportion is higher than the South East average (5.7%) but slightly lower than the national average (6.1%). Of all Kent districts, Thanet has the highest number and proportion of households estimated to be living in fuel poverty, (3,654 Thanet households, which is equivalent to 6.6% of all Thanet households). Dover (6.5%), Swale (6.3%) and Shepway (6.2%) also have a higher estimated proportion of households in fuel poverty compared to the national average.



The people most likely to die or become ill during the cold weather are those least able to afford to heat their homes. For every one degree Celsius that the outdoor temperature falls below the winter average, there are an 8,000 extra winter deaths in England. This would equate to an estimated 240 deaths across Kent. Living in a cold home can lead to or worsen a large number of health problems including heart disease, stroke, respiratory illness, falls, asthma and mental health problems.

**Local Profile
Districts comparison to the Strategic Health Authority average**

	Excess Winter Deaths	Road Injuries and deaths- all ages	Violent Crime	Statutory Homelessness
Ashford	-	-	√	x
Canterbury	-	√	√	√
Dartford	-	-	x	x
Dover	-	-	-	-
Gravesham	-	-	x	x
Maidstone	-	-	-	-
Sevenoaks	-	-	-	-
Shepway	-	√	x	x
Swale	-	√	x	-
Thanet	-	√	x	-
Tonbridge & Malling	-	-	√	√
Tunbridge Wells	-	-	√	-

The Aspirations

Action	What Good will look like in 2015	Targets and achievements
5.1 Reduce negative impact of homelessness and those living in temporary accommodation		
5.1.1 Enable and support a young person aged 16/17 at risk of homelessness to remain within or return to a family network wherever possible and appropriate	JPPB to monitor and review Dartford pilot on joint preventative services between housing and FSC children's department re homeless 16/17 year olds and roll out across Kent	Reduction in numbers living in temporary accommodation
5.1.2 Use Kent Housing Group to promote Public health messages to local residents through Local housing associations	Fewer young people becoming looked after at age 16/17 Reduced dependency on the state at age 19 Strengthen positive relationships within family and social networks	
5.2 Develop our communities to be healthy places		
5.2.1 Rollout initiatives such	Relatively small scale interventions designed in partnership with local	House and House on

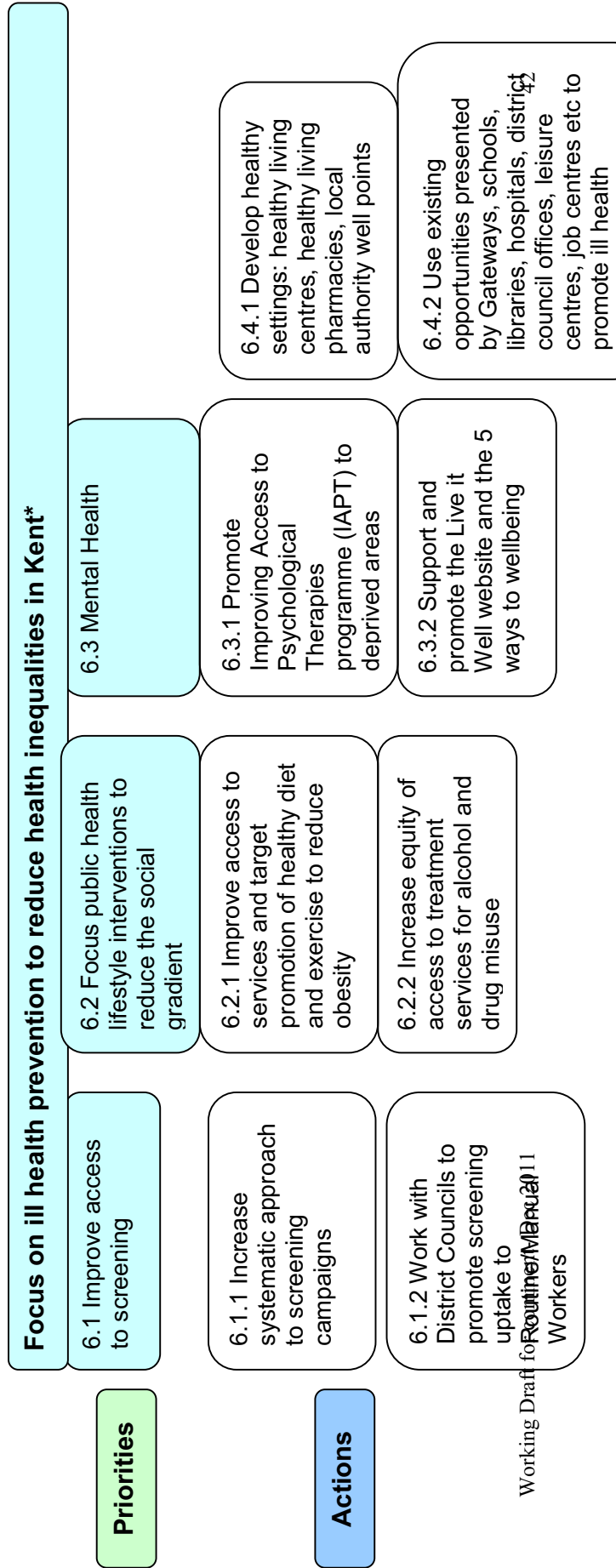
as House and ACTIV Mobs that help to develop and sustain positive community outlook.	residents, forming part of wider good quality and sustained neighbourhood working, (family poverty Report recommendation)	the Move available to young people in town centres
5.2.2 Continue to support affordable ways for people to travel in the community	<p>Increasing active travel across the social gradient and ensure health inequalities are being addressed by this initiative by</p> <ul style="list-style-type: none"> analysis of postcodes data for purchasing the Kent Freedom Pass and in the future concessionary bus passes. Evaluation and outcomes of Cycle Instruction and Walking Schemes targeted to schools in deprived areas, including bike loan/and or repair 	Take up of Freedom passes, concessionary bus passes.
5.2.3 Develop public rights of way, parks, green spaces and places to play	Improving access and quality of public rights of way, open and greenspaces available across the social gradient. Through the Explore Kent website people are signposted to accessible places to go and free events such as guided walking so everyone can get involved	
5.3 Develop our communities to be safe places		
5.3.1 Working with Fire Service to target most vulnerable households to reduce risk of fire	Increase the number of above and well above average risk home safety visit referrals from partner agencies	Reduction in accidental fires in dwellings
5.3.2 Reduce demand and supply of illicit tobacco in our communities	Increase No. of sprinkler installations in vulnerable homes Reduction in supply of illicit tobacco	1% Reduction In Smoking Prevalence rate per annum
5.3.3 Reduce number of children and young people injured on the highway	Walking and cycling initiatives, including walking and cycling to school projects and campaigns Continuing programme of targeted Road Safety projects that have been reviewed and evaluated as effective-e.g. Small Steps – pedestrian training Cycle Instruction B-Viz – campaign to improve visibility especially in winter months Schools continue to produce and promote travel plans	Reduction in road accidents to children
5.4 Reduce Fuel Poverty by supporting development of warm homes		

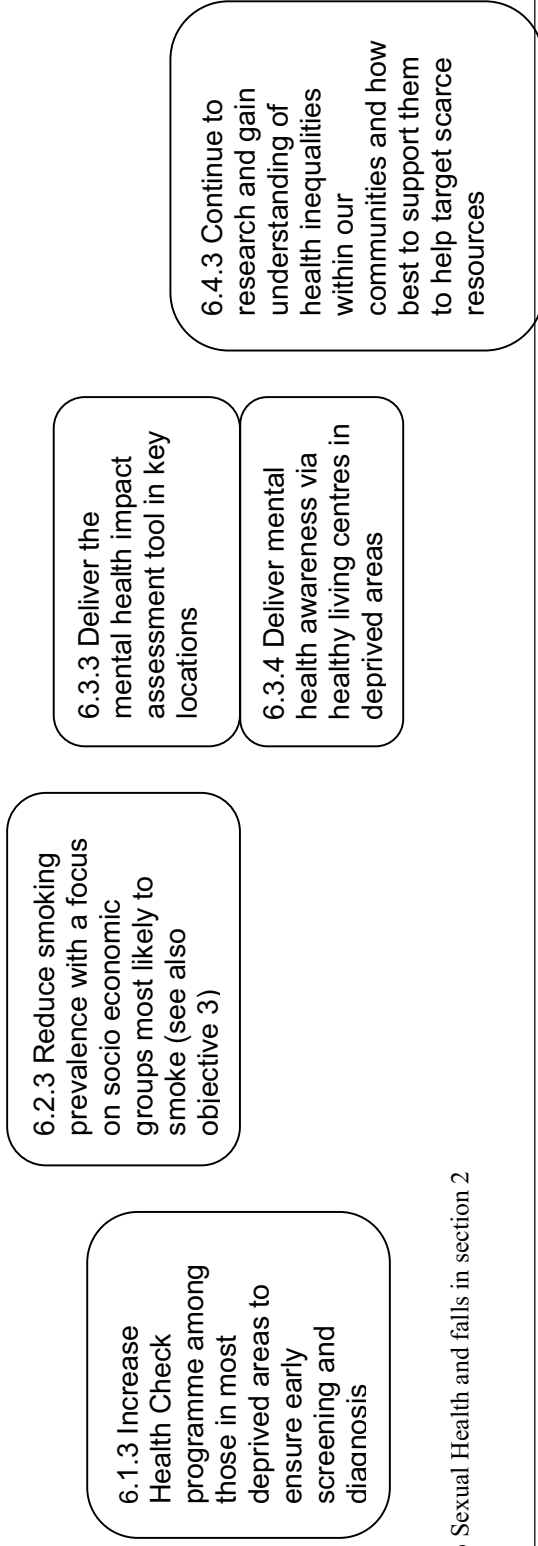
<p>5.4.1 Update, reissue and promote strategic tools that support the build of warm homes- Kent Health and Affordable Warmth Strategy and the Kent Design Guide</p>	<p>Better/improved joint working between housing and health partners to ensure that homes are warm and safe leading to prevention of falls/COPD/Heart problems, good mental health</p>	<p>Reduction in Excess winter deaths Proportion in fuel poverty</p>
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6. Strengthen the role and

Many of the key health behaviours significant to the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition.
(Marmot Review 2010)

Objective 6: Strengthen the role and impact of ill health prevention





*See also Sexual Health and falls in section 2

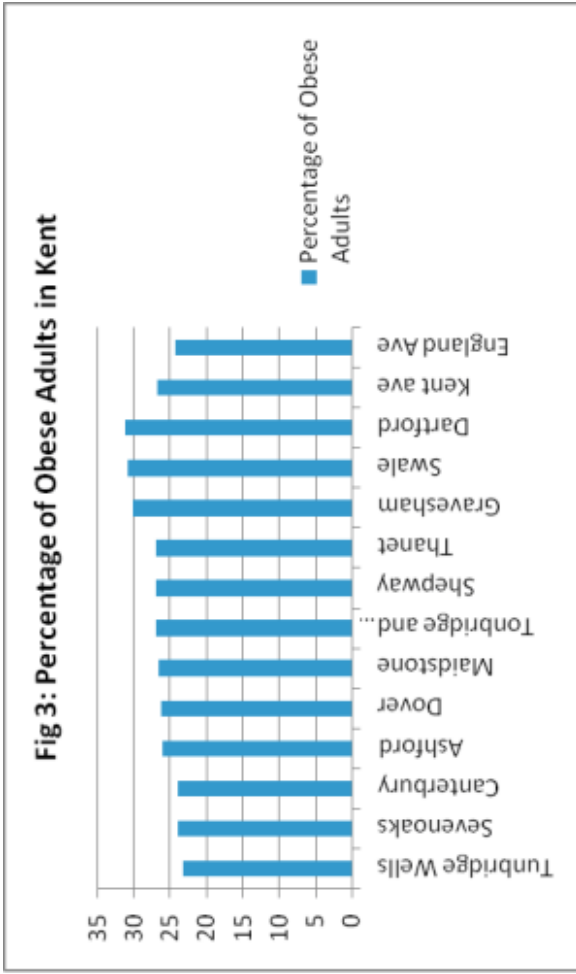
Objective 6: Strengthen Ill Health Prevention

Priority 6.1 Improve access to screening

The aim of national screening is to reduce the amount of disease in a population, or to detect disease at an early stage to improve patient outcome. The most deprived and ethnic minority groups are less likely to take up screening. The incidence and prevalence of vascular diseases reflect health inequalities in the UK and the widening gaps in life expectancy between the most and the least disadvantaged in society. Gaps in life expectancy across west Kent, for example, can be as high as 14 years. There are also inequalities in the uptake of cervical cancer screening through low uptake amongst younger women with only 69% coverage across Kent for those aged 25-29.

Priority 6.2 Focus public health lifestyle interventions to reduce the social gradient

Obesity: Adult obesity is far more prevalent in socially disadvantaged groups. It is estimated that approximately 28% of the Kent population is obese (354,022).



Source: Health Profiles 2010 APHO and Department of Health

Smoking: Smoking prevalence in Kent is 24.9%, however there is a significant amount of variation across Kent and it is a major reason for our health inequalities. Routine and manual smokers represent the single biggest group of smokers –half of all smokers belong to the routine and manual group

Of the 11,250 deaths of Kent residents aged 35 and over in 2008, approximately 2,250 (20%) can be attributed to smoking. Approximately 10,300 hospital admissions of Kent residents aged 35 and over in 2008 can be attributed to smoking (5% of the total 205,932 admissions). The majority of these are due to lung cancer, chronic airway obstruction and ischaemic (coronary) heart disease.

Table 7 Cost burden of obesity to SEC PCTs 2006

PCT	NHS Cost of principle diseases related to obesity (millions)
Eastern and Coastal Kent	279.2
West Kent	221.4

Alcohol Misuse: The impact of alcohol misuse is widespread; it encompasses alcohol related illness and injuries as well as significant social impacts including crime and violence, teenage pregnancy, loss of workplace productivity and homelessness. Health inequalities are clearly evident as a result of alcohol-related harm; national data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation. It is estimated that 259,103 adults in Kent are drinking at 'increasing risk' levels or 'high risk' levels. In 2009-10 the equivalent of 24,682 people in Kent were admitted to hospital for alcohol related harm, costing over £45 million.

Substance Misuse: There are strong links between levels of deprivation, prevalence of problem drug use, drug related hospital admissions and mortality. Estimates indicate that there are between 3640 and 7591 problem drug users in Kent and that a further 2500 problem drug users are not engaged with services. Hospital admissions continue on an upward trend.

Priority 6.3 Mental Health

People with mental health problems are more prone to factors that lead to worse health outcomes, such as poor diet, smoking, drug and alcohol misuse and low rates of physical activity. Higher rates of heart disease, stroke, high blood pressure, breast and bowel cancer and diabetes are experienced by people with a serious mental illness. The Mental Health Joint Strategic Needs Assessment for Kent and Medway estimates that there are more than 60,000 people estimated to have severe mental illness, and around 12,000 people are estimated to have severe and enduring mental illness.

Drug-specific admissions (primary diagnosis) per 100,000	2006/7	2007/8	2008/9	2009/10	2010/11
All Kent	14.21	16.72	10.14	15.81	16.77
East Kent	14.84	17.75	11.36	16.67	18.20
West Kent	12.86	15.26	9.36	14.53	15.79

Priority 6.4 Grow partnerships and find new ways to deliver services in places where people go

Reducing barriers so that everyone, but especially those dealing with stigmatization or discrimination is able to access health services as locally as possible.

Local Profile

Districts comparison to the Strategic Health Authority average

	Heart disease & stroke	Early death-cancer	Obese adults	physically active adults	Healthy eating adults	People diagnosed with diabetes	Smoking related deaths	Drug Misuse	Hospital Stays for alcohol related harm	Adults smoking
Ashford	-	-	x	-	-	x	x	x	x	x
Canterbury	-	-	-	-	-	x	x	x	x	x
Dartford	x	-	x	x	x	-	-	-	-	-
Dover	x	-	x	-	-	x	x	x	x	x
Gravesham	-	-	x	-	-	-	-	-	-	-
Maidstone	-	-	-	-	-	√	√	√	√	√
Sevenoaks	√	-	-	-	-	√	√	√	√	√
Shepway	x	-	-	-	-	x	x	x	x	x
Swale	x	x	x	-	x	x	x	x	x	x
Thanet	x	x	x	x	x	x	x	x	x	x
Tonbridge & Malling	-	-	-	-	-	-	-	-	-	-
Tunbridge Wells	-	-	-	-	-	√	√	√	√	√

The Aspirations

Action	What Good Will Look Like in 2015	Targets and achievements
6.1 Improve access to screening 6.1.1 Increase systematic approach to screening campaigns	There will increasing take up from groups who traditionally do not attend screening. Work will have been undertaken to: <ul style="list-style-type: none"> review variations in the uptake and coverage of all cancer screening programmes and commission programmes to maintain national standards and to reduce local health inequalities. develop commissioning framework for the local implementation of the HPV triage for cervical cancer screening. support and monitor the implementation of age extension for Breast Cancer Screening Programme. develop commissioning framework for the local implementation of age extension for Bowel Cancer Screening Programme 	Proportion of aged 53-64 women who have been successfully screened for breast cancer (+ %) Mortality from all cancer, direct age standardised rate for persons <75yrs Increase in numbers of young women taking up cervical screening.....
6.1.2 Work with District Councils to promote screening uptake to		

Routine/Manual Workers			
6.1.3 Increase Health Check programme among those in most deprived areas to ensure early screening and diagnosis	NHS Health Check programme employing more targeted delivery via alternative providers, from non-clinical, non-NHS sites, so that those with the greatest health needs are effectively reached by the programme JSNA	Health checks' are to be provided to people between 40 and 74 years across Kent. With full roll out 880,211 checks are to be delivered across Kent on an annual basis from 2013	
6.2 Focus public health lifestyle interventions to reduce the social gradient			
6.2.1 Improve access to services and target promotion of healthy diet and exercise to reduce obesity	The Health Trainer service had been developed to target those in areas of high deprivation. Pathways from services into lifestyle behaviour programmes are clear and easily accessible so that people at risk following a health check or coping with chronic conditions where diet and physical activity would make a difference have improved outcomes. Services have been reviewed, are fit for purpose and provide quality interventions.	Slow the increase in obesity in adults by 1% per annum	
6.2.2 Increase equity of access to treatment services for alcohol and drug misuse	<ul style="list-style-type: none"> Industrialising opportunistic Identification and Brief Advice (IBA) for those at risk through alcohol misuse as part of Healthy Lifestyles services through local authority commissioning for prevention. Increased awareness and support to veterans regarding substance and alcohol misuse and mental health (also ex offenders have been mentioned) For problem drug users structured counselling, intensive family based interventions, practical group work activities and better links with mental health services will be used to develop relevant social skills that increase service users capacity to sustain long term improvements in terms of substance use and their health and social functioning. Recovery focused intensive keyworking will also provide a specific focus throughout the treatment journey (JSNA) 	<p>1% reduction in hospital stays for alcohol related harm per annum</p> <p>1% reduction in drug misuse</p> <p>Commission IBA in a variety of clinical settings for at least 10% of dependent drinkers in Kent, increasing to 20% over the next two years using referral tools and pathways already agreed by commissioners and providers</p>	
6.2.3 Reduce smoking prevalence with a focus on socio economic groups most likely to smoke (see also objective 3)	<p>Assessment of risk factors for early identification of people with COPD and Lung cancer has led to more effective targeting of services leading to evidence of smoking prevalence reduced in cohorts:</p> <ul style="list-style-type: none"> - Routine/Manual workers in Kent - Prison population in Kent 	<p>1% reduction per annum smoking prevalence rates</p> <p>Rate of deaths attributable to smoking in all persons aged 35+</p> <p>Mortality from lung cancer directly</p>	

	<p>- Pregnant women</p> <p>- Families who smoke in areas of deprivation</p> <p>Stop smoking services should aim to treat at least 5% of the local smoking population each year. In Kent, this equates to at least 14,000 smokers</p>	ASR for persons <75*+slope index
6.3 Mental Health		
<p>There is an embedded approach across partners to improve mental well-being that also addresses the broader determinants of mental health and can measure the impact of changes to well being. There can be no health without mental health and those experiencing stigma or discrimination will be supported.</p>		
6.3.1 Promote Improving Access to Psychological Therapies programme (IAPT) to deprived areas	<p>Training for staff and access to new or improved services to help children, young people and adults with depression or anxiety within their own communities.</p>	
6.3.2 Support and promote the Live it Well website and the 5 ways to wellbeing		http://www.liveitwell.org.uk/
6.3.3 Deliver the mental health impact assessment tool in key locations	<p>Mental Wellbeing Impact Assessment (MWIA) enables local service commissioners and community organisations to assess and measure the impact of their interventions on their population's mental health and wellbeing.</p> <p>It will provide an effective approach to creating policy and services that have the best possible impact on mental well-being</p>	
6.3.4 Deliver mental health awareness via healthy living centres in deprived areas		
6.4 Grow partnerships and find new ways to target and deliver services in places where people go (Asset based community development)		
6.4.1 Develop healthy settings: healthy living centres, healthy living pharmacies, local authority well points	<p>Partner organizations including the 3rd sector come together to tackle broad health issues within a community. Such Hubs promote good health and well being by encouraging healthy lifestyle choices and provide tailored support, advice and guidance to tackle local issues, such as debt, family relationships etc</p>	

<p>6.4.2 Use existing opportunities presented by Gateways, schools, libraries, hospitals, district council offices, the 3rd Sector, leisure centres, job centres etc to promote ill health prevention</p>	<p>Partnerships and links are working between different organisations across the public and voluntary sectors, and different departments to deliver access to health services and information in places where people feel comfortable and experience positive interactions with services</p>	
<p>6.4.3 Continue to research and gain understanding of our communities and how best to support them to help target scarce resources</p>	<p>More accurate understanding of prevalence by district has influenced commissioning of targeted services leading a reduction in the social gradient (the gap has narrowed between the health of the richest and the poorest)</p>	

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By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
To: Health and Wellbeing Board
Subject: Joint Strategic Needs Assessment (JSNA)
Classification: Unrestricted

Recommendations

The Joint Strategic Needs Assessment has been significantly developed and updated to be relevant for KCC, emerging CCGs and Districts. It is proposed that this draft goes for consultation until March 2012.

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Joint Strategic Needs Assessment

Executive Summary 2011

Version 10

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1. Why have a JSNA?

The JSNA is our diagnostic on the health of people in Kent to show us where we need to commission or provide better services.

We don't have to follow any format; this is designed specifically for Kent.

It uses data, analysis, quality of services, costs and cost benefits and what the public tell us. It will tell us where services are going wrong as well as where health patterns are improving.

It will show where priorities need to be changed and will give a series of recommendations.

The purpose of producing a JSNA is:

- 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 for Kent will be based on the JSNA and will provide the future strategic direction for commissioning.

2. Who should use the JSNA?

Kent is a two tier County Authority, with 12 District Councils and eight emerging Clinical Commissioning groups. These organisations must work in partnership to commission local services in order to meet the changing demands of our local residents.

The JSNA will be a valuable tool for:

- Clinical Commissioning Groups
- Kent County Council commissioning and members
- Local authorities
- Private and/ or voluntary organisations

Why is it relevant for CCGs?

General Practitioners are the first point of contact for patients.

Reduction in practice variation will result in better health outcomes and will contribute to reducing the gap in health inequalities for the population of Kent.

Case finding through NHS Health Checks will result in people being identified earlier and in treatment sooner reducing complications associated with late diagnosis.

Prevention and brief intervention for smoking, alcohol and healthy weight will reduce the number of people with long term conditions

Why is it relevant for local authorities?

District councils have a key primary prevention role in minimising the effect of poor housing, lower educational attainment, poor environment, [e.g. noise, air and water pollution] and transport all of which have an impact on health and social care outcomes.

District councils provide health and wellbeing services in particular for, smoking, alcohol, physical activity, healthy weight. They therefore need to adopt a high risk approach and work more closely with primary care and acute care organisations to ensure that services are targeted towards the most vulnerable and at risk groups to achieve optimum effectiveness. This can be done by ensuring NHS based care pathways for Long Term Conditions are integrated and include such services – for example prescribed exercise programmes for the elderly (frequent fallers) to reduce falls and fractures, Health Weight Care Pathway for adults and children who are clinically obese or overweight for the prevention of Diabetes.

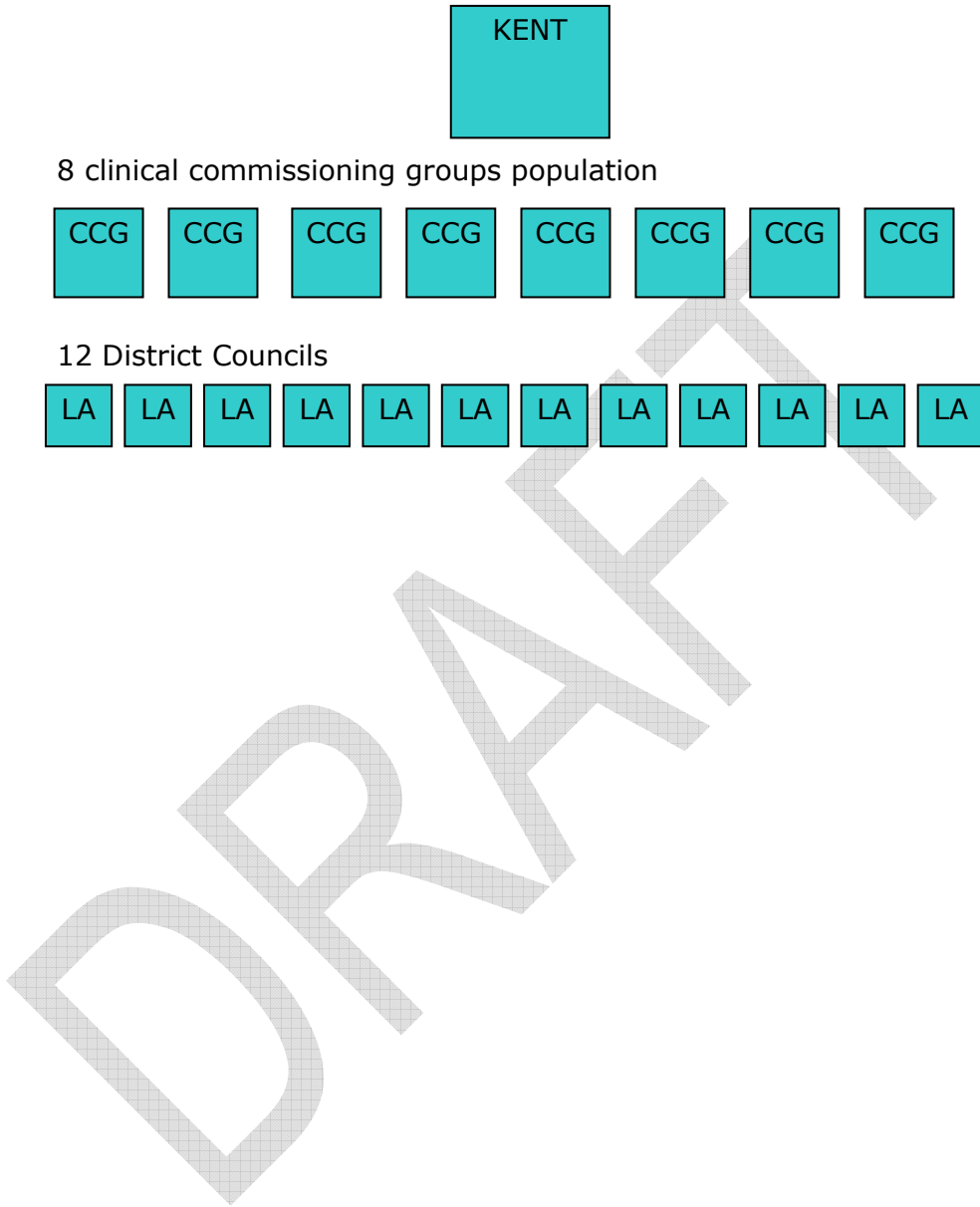
Why is it relevant to providers of health and social care?

Health systems that employ models of chronic care management in which care co-ordination is a central component – tend to be associated with lower costs, as well as better outcomes and higher patient satisfaction.

The latest results of the Utilization Review of hospital admissions across Kent and Medway indicate up to 9% of admissions were found to be inappropriate. A further 52% of admissions whose day of care was found to be inappropriate.

This emphasises the importance of multi professional teams, including generalists working along side specialists, a focus on care management and support to home-based care, joint planning and co-ordinated assessment of care needs, personalised health care programmes and clinical records that are shared across the multi-professional team are some of the key components for an integrated health care model.

Why is it relevant for Kent County Council commissioning and members?



3. Phase 1 – Reviewing where we are.

A JSNA has been produced in Kent since 2006.

Kent has traditionally produced two JSNA documents, one for adults and one for children. The Adult's JSNA was refreshed in July 2011 and the Children's in December 2011.

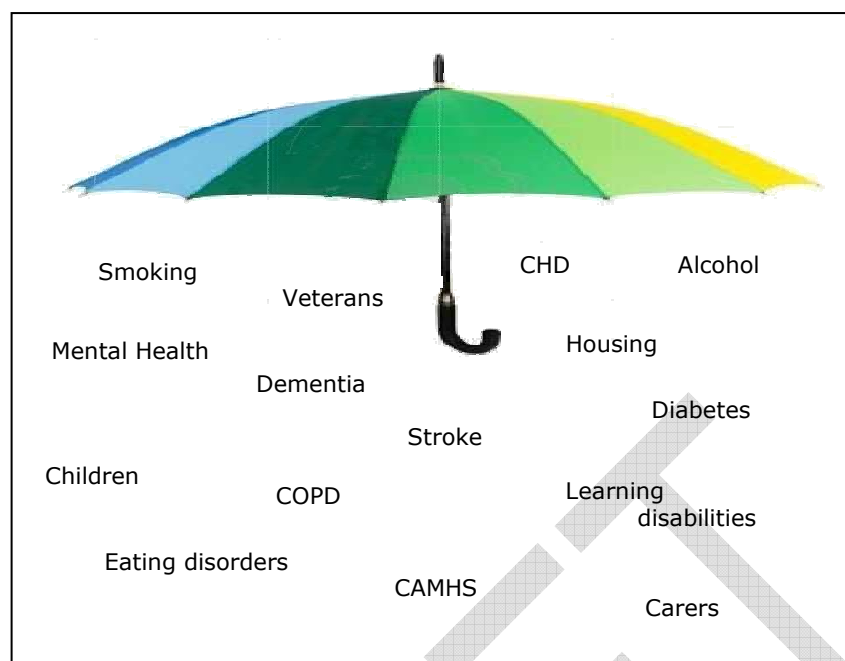
The JSNA includes many health needs assessments which are every year on specific topics such as mental health, children in care, housing, and carers. More than 40 needs assessment have been carried out in Kent since 2008 exploring in-depth the health and social care needs, gaps in service provision and levels of un-met need.

An executive summary is available for each of these needs assessments. These are available from the Kent and Medway Public Health Observatory Website www.kmpho.nhs.uk/jsna.

These summaries - along with key population indicators presented in the Health and Social Care Maps and locally developed Clinical Commissioning Group profiles - provide the basis for the Kent JSNA.

Figure 1 details some of the needs assessments that have been recently undertaken.

Figure 1: Umbrella of Needs Assessments



Commissioners are often involved in the development of needs assessments and we also try to include the views of patients, users, voluntary sector and carers where appropriate – for example this has been done significantly in the carers and mental health needs assessments.

Quality Innovation Productivity and Prevention (QIPP)

The refresh includes a bigger section on the QIPP priorities.

The current economic situation requires the NHS in Kent and Medway to deliver improved quality of care and productivity over the next five years.

The total projected funding gap is £686m across Kent and Medway over the next five years (£270m in West Kent, £303m in East Kent) although this estimate is subject to change. With expected increases in both cost base and demand from our population.

- Three areas of savings have been identified:
 - Service improvement initiatives to improve efficiency – for example. care pathway optimisation

- Commissioning 'lever' initiatives to drive up quality and productivity gains - for example, utilising to full effect contract levers and system management opportunities, PbR (Performance by Results) tariffs and primary care contracting
- 'change initiatives' that have an impact on the whole system – for example prevention, self care, or provision of care closer to home.

The recent Utilization Review of hospital admissions into the four acute Trusts in Kent and Medway represents a unique opportunity to benchmark appropriate acute care in using a cohort of patient admissions. Initial results estimate up to 9% of admissions were found to be inappropriate and 52% of admissions did not require care in an acute care facility. The results are expected to aid the ongoing discussions between Kent and Medway Integrated Plan (QIPP) Board, Clinical Commissioning Groups and Acute Trusts around shifting resources into community and social services, raising standards of general practice, and promoting early intervention and self-care.

4. Phase 2 – Continued development of JSNA

See the profile for Ashford shown later in this document. This is how the locality profiles are being developed in liaison with GPs.

Public Health consultants are working closely with individual CCG leads to develop tools and resources which enable CCGs to identify commissioning needs for their local populations.

5. What are the big issues in Kent and how can we get the biggest health gains for Kent?

Early Years – The life course approach emphasised in the Marmot Review stresses the importance of continued investment in key areas:

- ***Improving the continuation (and recording) of breastfeeding rates beyond six weeks.***
- The rates of breastfeeding in Kent at six to eight weeks (36%) are almost half that of the breast feeding rates seen at birth, and significantly worse than the average for South East Coast.
- Health and social care organisations need to fully implement key recommendations from the Healthy Child and Baby Friendly Initiative Programmes, in order to improve the uptake and continuation of breastfeeding.
- ***Improving MMR uptake as well as general routine immunisation rates and reduce variation in general practice coverage to ensure herd immunity and prevent future epidemics.***
- This will be achieved through closer working between the immunisation and vaccination coordination service and GP practices, utilizing a targeted approach to those practices and vulnerable population groups where uptake is lowest. Social marketing campaigns and improved monitoring systems.
- Current MMR vaccination rates by Year 5 are 84% and 87% in East and West Kent respectively, well below the 95% coverage required for herd immunity (the level at which risk of spread of infection is reduced)
- Using health visitor expertise in Children Centres to deliver integrated services to vulnerable high risk families – including messages around health promotion and behaviour change such as reduction of second hand smoke, alcohol and substance abuse, domestic violence and healthy weight to ensure long-term benefits to the health and social sectors.

56,830 (18%) Kent children are living in poverty.

Preventing Long Term Conditions

Significant variation in the prevalence of unhealthy lifestyles exists across the 12 districts, often linked with deprivation.

A significant proportion of Long Term Conditions can be prevented if the people who are at future risk, are identified early enough, and lifestyle and behaviour are modified accordingly - through self management with support from integrated frontline services such as Stop Smoking, IBA (Alcohol), Healthy Weight etc.

The rollout of the national Health Checks programme across Kent needs to be accelerated in keys areas such as Thanet and Swale.

80% heart disease, stroke and type 2 diabetes, and 40% cancer could be avoided if common lifestyle risk factors were eliminated

Kings Fund 2011

The aging population –

The ageing population of Kent in the older age group (65+ and 85+) is predicted to increase significantly over the next 5 to 10 years.

This presents challenges – an increase in long term conditions, rising levels of dementia, falls and fractures. These conditions are likely to cause tremendous

pressure on health and social care services - particularly urgent care and a lack of funded placements further exacerbated by lack of carers and carer support. For example emergency admissions for falls and dementia in the elderly have increased by more than 50% and 85% respectively over the last 5 years.

Risk stratification of the Kent population is urgently required to pro-actively identify complex patients in need of a multi disciplinary integrated approach (across primary care, community, and acute care and social services) towards crisis response and support, and exacerbation management ultimately resulting in hospital admission avoidance.

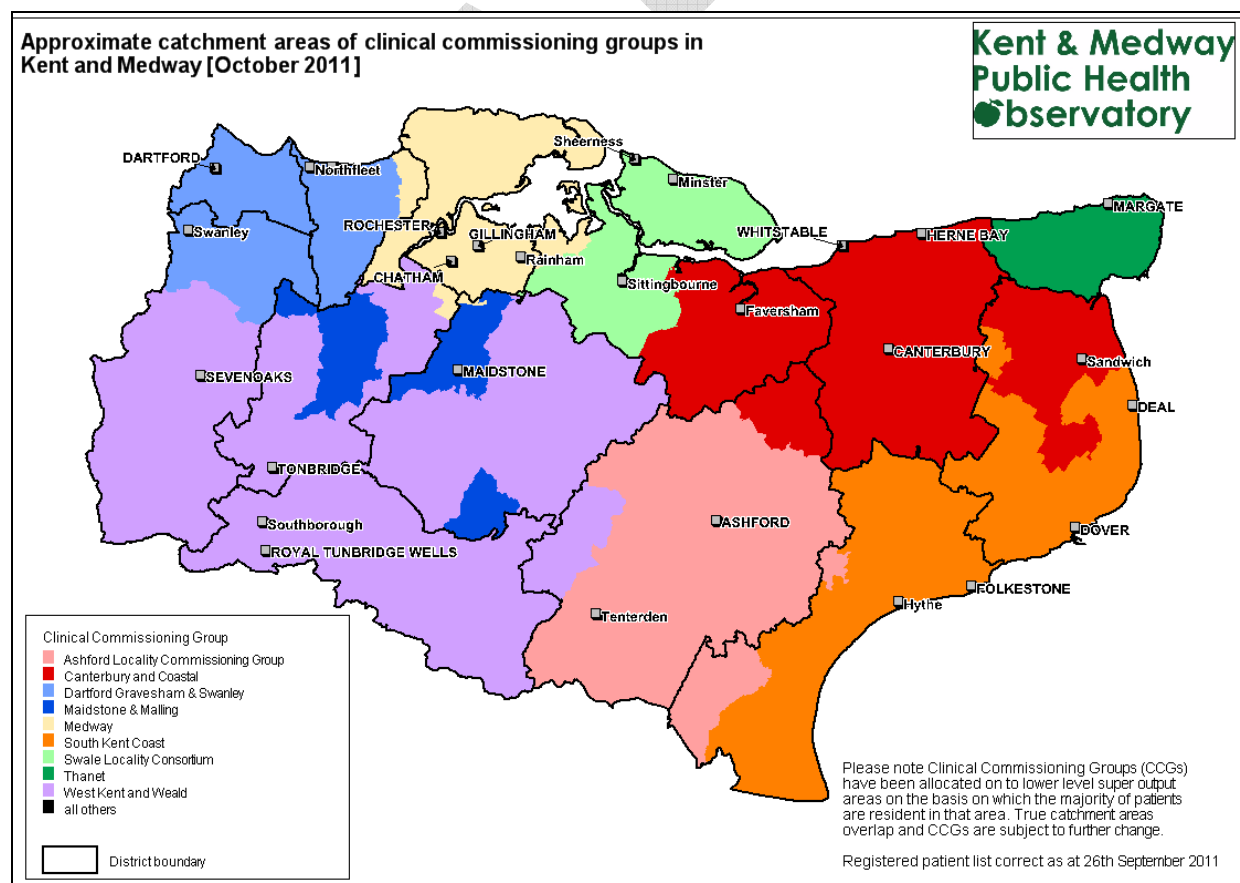
DRAFT

Kent - Population Demographics

As a County Kent generally has better health and social care outcomes than England. However there is significant variation across the districts. Thanet and Swale consistently have poorer 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 (CCG), whose boundaries, as the following map shows are not co-terminus with districts. Kent CC is responsible for approximately 1.5 million people.

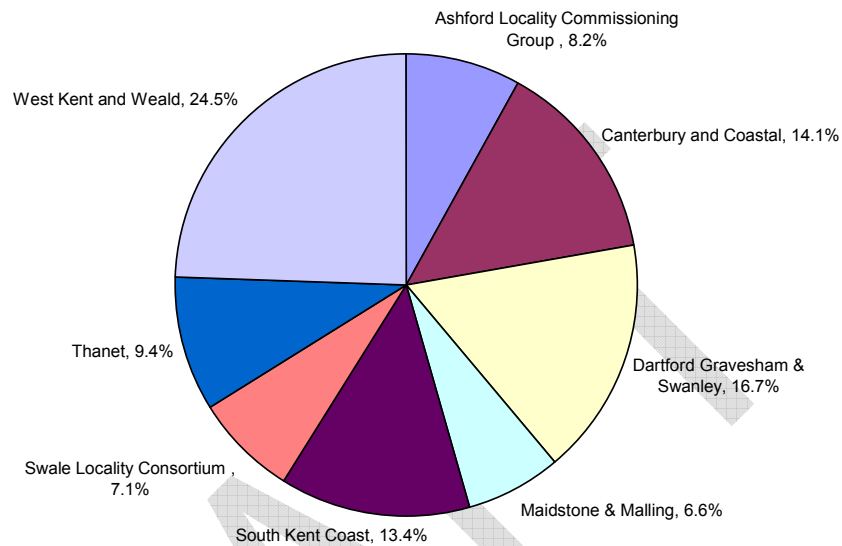
Figure 2: Approximate catchment areas of clinical commissioning groups in Kent.



West Kent and Malling is the largest of all the Kent CCGs responsible for a quarter of the total Kent registered practice population. The smallest is

Maidstone and Malling consisting of 11 general practices responsible for 6.6% of the Kent registered practice population.

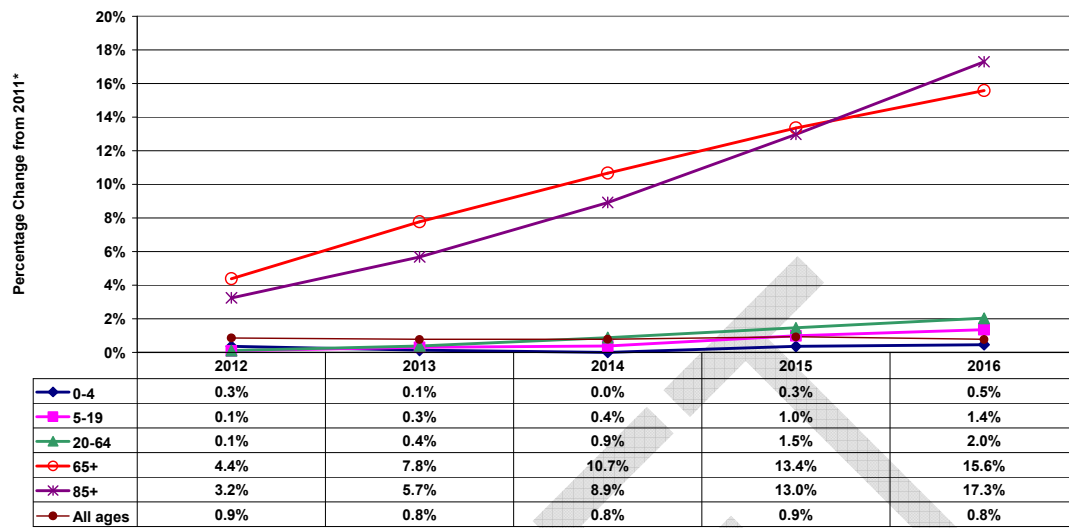
Figure 3: Percentage of Kent registered practice population by clinical commissioning group as at September 2011



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, in the 0-4 age group the proportion of the population is projected to grow very little in Kent just 0.1%. In Tunbridge Wells the proportion of 0 to 4 year olds is expected to decrease by 4.5% whereas it is predicted to increase in Dartford and Gravesham by 4.3% & 2.9% respectively.

Figure 4 Projected population change

Projected Population Change in 2012-2016 from 2011* for Ashford Local Authority by Broad Age Groups

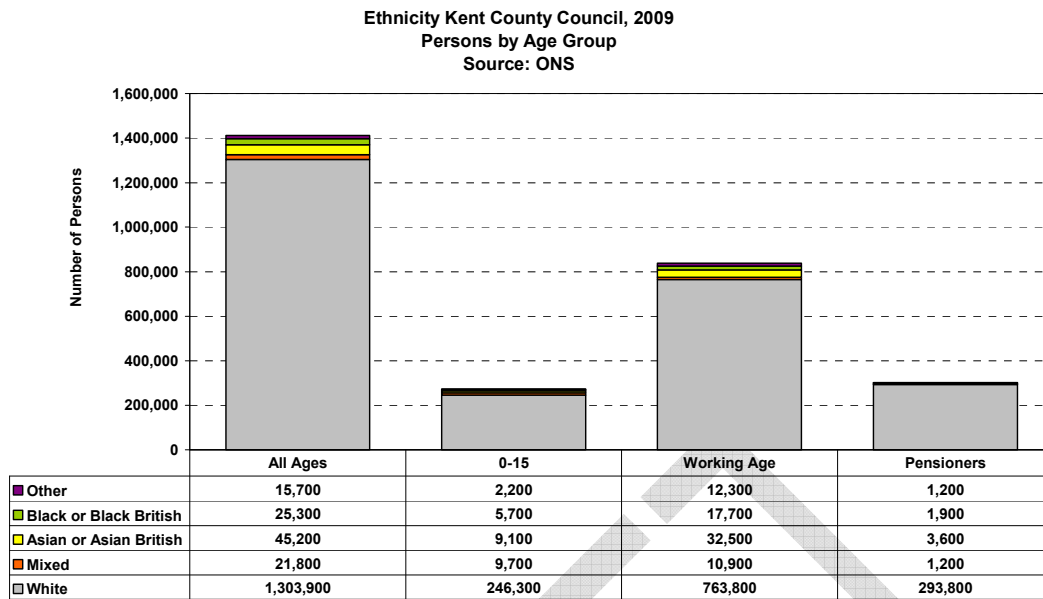


* derived from ONS 2008 based projections

6.1 Ethnicity

Parts of Kent are more ethnically diverse than others. The population of Kent is predominately white British, 94% at the time of the 2001 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% are from Asian communities.

Figure 5 Proportion of the Kent population by ethnic group



6.2 Unemployment

3.2% of the population of Kent were unemployed and claiming benefit in November 2011 this compares to a rate of 3.8% for England. The country has been in recession since 2008 and as a consequence levels of unemployment have been increasing. The highest levels of unemployment are seen in Thanet and Shepway [Figure 7].

Figure 6 Trends in unemployment rate KCC from 1992 to 2011

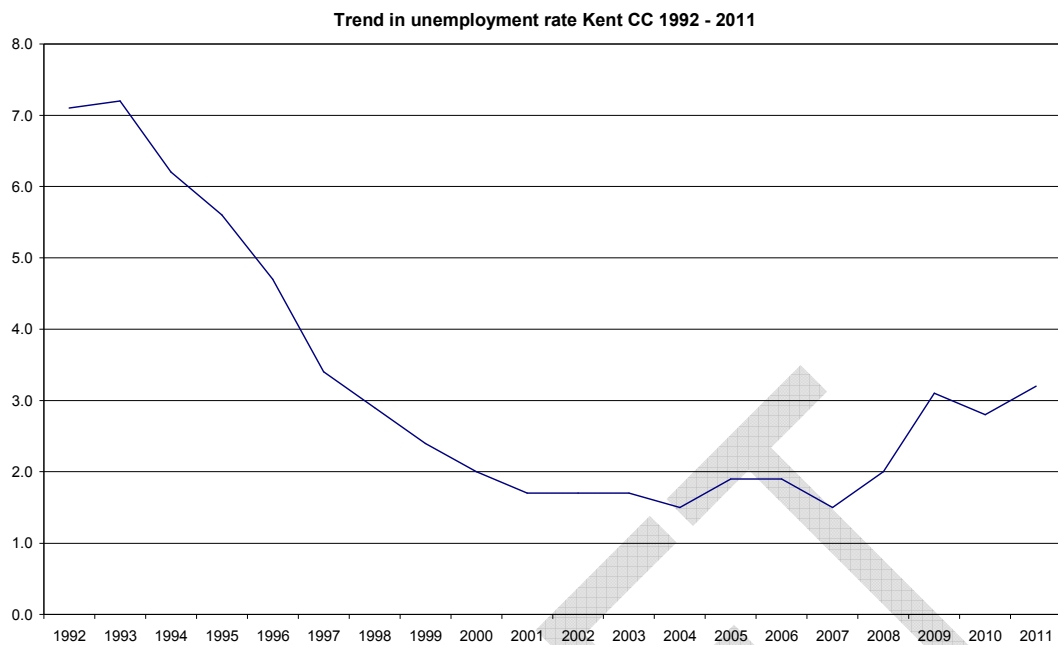
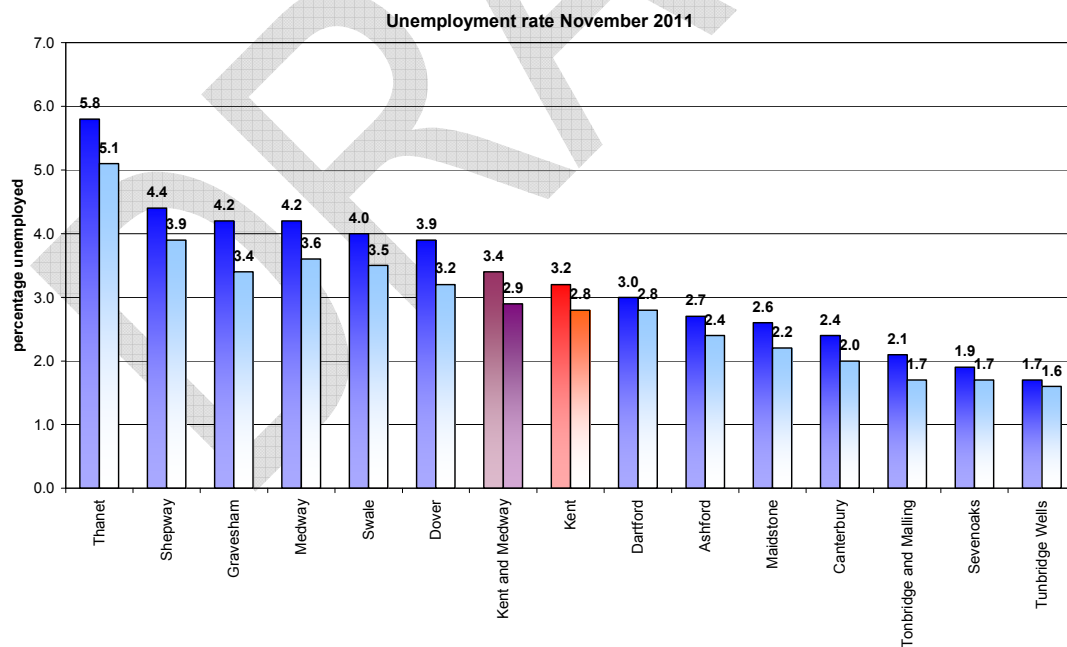


Figure 7 Comparison of unemployment rates November 2010 and November 2011 by districts

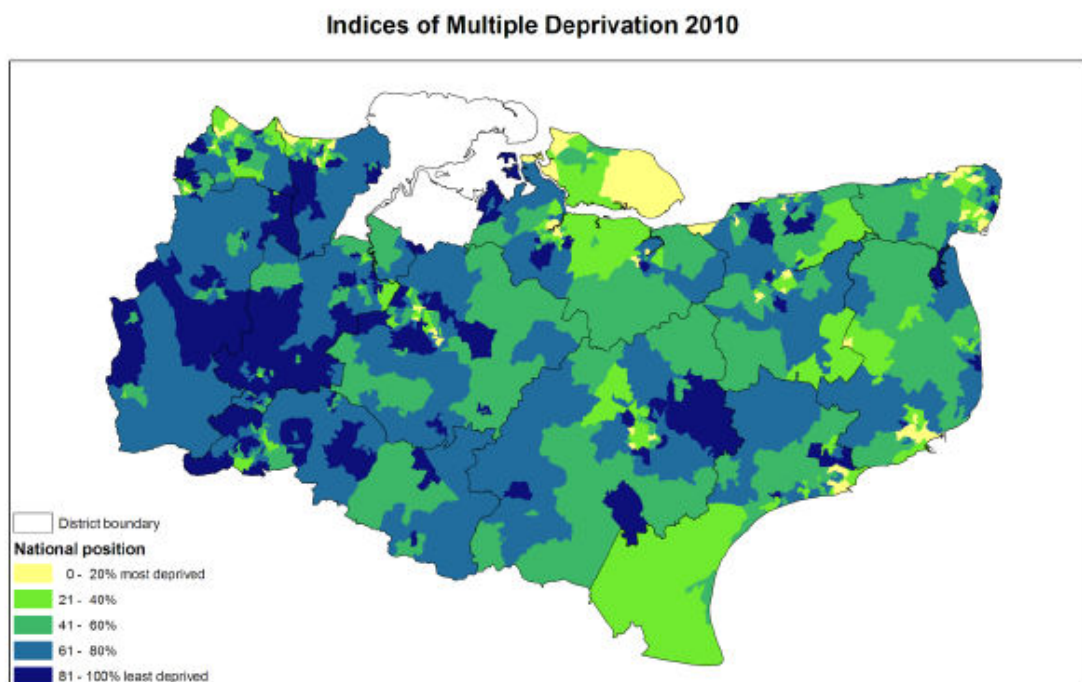


6.3 Deprivation

Figure 8 depicts deprivation across Kent, the areas of dark blue represent the least deprived. There is an obvious difference between the level so

deprivation in the east of the count and the west of the county. 94 of the 883 LOSA (11%) are in the 20% most deprived for England. Thanet is the most deprived of the 12 Kent districts and Sevenoaks is the least deprived.

Figure 8 Index of multiple deprivation LSOAs in Kent using National deprivation scale.



6.4 Coastal Towns

Seaside resorts are uniquely exposed to many interactive forces including:

- Human forces – bringing in both the elderly and transient whilst luring the indigenous young out of the area whilst keeping holiday makers away;
- Economic forces – maintaining seasonality, polarising housing markets;
- Social forces – contributing to transience, low pay and worklessness;
- Cultural forces – defining the ‘personality’ and meaning of resorts;
- Forces of inertia – that can maintain the status quo of decline.

Table 1 Key issues for public health and regeneration in coastal resorts

Key coastal issue	Relevance to public health and regeneration
Alcohol	Recent gains made by the NHS through clinical improvements in interventions for cancers and heart disease have been almost cancelled out by the continuing steep rise in alcohol related morbidity and mortality over the past five to 10 years. This reflects increases in alcohol consumption across the whole population and is driven by increased availability and reduced cost of alcohol relative to disposable income. Economic regeneration policies focused on alcohol and the night time economy are a major driver (Regeneris Consulting 2007).
In-migration of older people/demographic change	Can create additional pressures on social care and NHS services. Poor mental health, e.g. older people becoming isolated and requiring support following bereavement. Prevention agenda becomes key: this may require regeneration policies to provide relevant opportunities/services.
Houses in multiple occupation	HMOs may attract vulnerable groups or those already receiving benefits, requiring specific support and long term collaborative planning that reduces. HMOs numbers overall and supports homeless and vulnerably housed.
Opportunities for young people	Limited opportunities may lead to low self-esteem, poor mental health, harmful behaviours and difficulties in providing a stable workforce.

6.5 Health inequalities indicators

There are four main indicators used to assess health inequalities within Kent and Medway, these are

- life expectancy from birth
- all age all cause mortality
- cancer mortality under 75s

- circulatory disease under 75s

Table 2 presents a summary of how well each of the districts are doing in closing the gap between those populations within the most deprived 20% and the least deprived 20%. 6 of the 12 Kent districts have closed the gap in life expectancy, the biggest contributor to increasing health inequalities would appear to be deaths from circulatory conditions.

Table 2 Summary of health inequalities by Kent Districts

District	Health inequality indicators				Proportion of population	
	Life Expectancy	All age all cause mortality	Cancer under 75	Circulatory disease under 75	Most deprived	Least deprived
Ashford	No	Yes	Yes	No	13%	27%
Canterbury	No	No	No	No	13%	9%
Dartford	Yes	No	No	No	17%	24%
Dover	Yes	No	Yes	Yes	21%	7%
Gravesham	No	No	Yes	Yes	29%	17%
Maidstone	No	No	Yes	No	10%	37%
Sevenoaks	Yes	Yes	Yes	No	6%	42%
Shepway	No	No	No	Yes	29%	8%
Swale	Yes	Yes	Yes	No	31%	5%
Thanet	No	No	No	Yes	42%	2%
Tonbridge and Malling	Yes	No	y	Yes	4%	44%
Tunbridge wells	Yes	Yes	No	Yes	4%	32%
Kent and Medway	No	No	Yes	No		
Medway	Yes	Yes	Yes	Yes	28%	15%

Adapted from Trends in Health Inequalities 2010, Jonathan Sexton and Julian Barlow

Kent County general 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. These districts also experience some of the highest levels of deprivation and unemployment within Kent.

6.6 Quality Indicators

There are a number of measures that are used to assess quality of health care services. These are reported routinely to at the Cluster Executive Board. Indicators of particular interest include indicators on effectiveness, satisfaction and safety, such as the management of hospital acquired infections and the safe guarding of vulnerable children and adults.

Figures 9 and 8 demonstrate the MRSA and *Clostridium difficile* April 2011 to September 2011 cumulative rates for Dartford and Gravesham NHS Trust (D&G), East Kent Hospitals University Foundation Trust (EKHUFT), Maidstone and Tonbridge Wells NHS Trust (MTW) and Medway Foundation Trust (MFT).

The rates for both MRSA and *Clostridium difficile* at EKHUFT are below the south east coast average. D&G and MFT are above the South East Coast average for MRSA but are within their Trust trajectory limit. MTW are above the South East Coast average for *Clostridium difficile*, an internal evaluation is underway to determine any changes in infection rates resulting from the move to the new Tunbridge Wells Hospital site. The outcome of the evaluation will be reported to the Kent and Medway Cluster Infection, Prevention and Control Committee in November 2011.

Figure 9

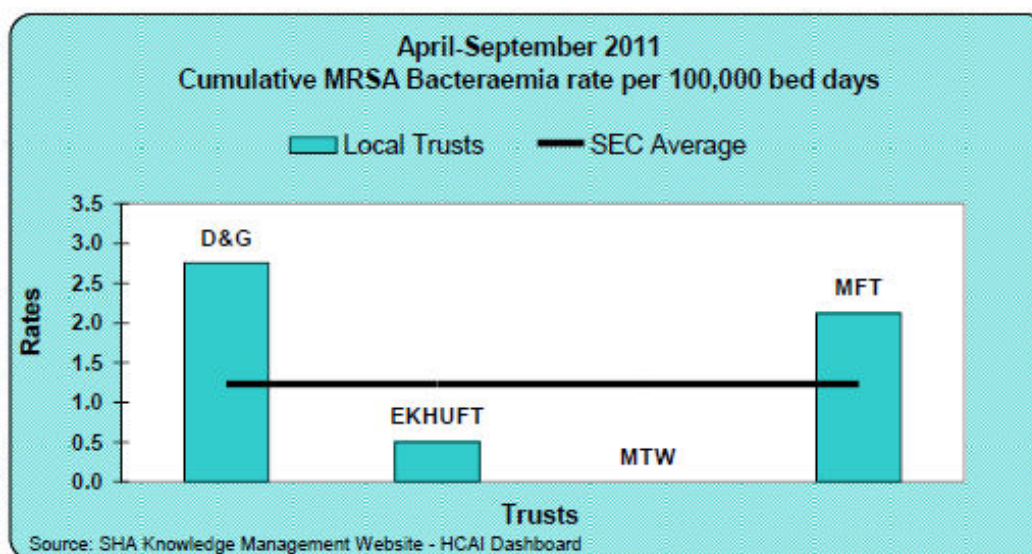
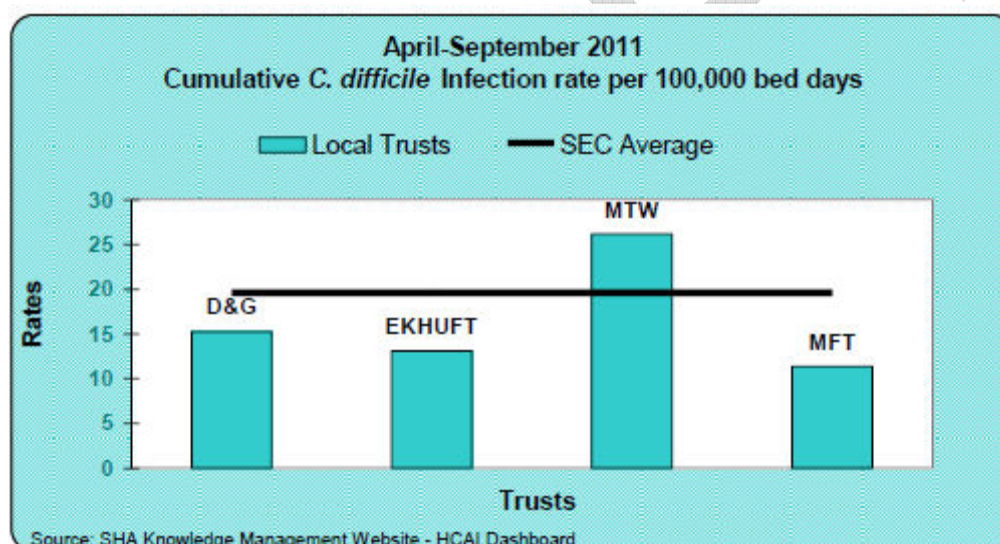


Figure 10



The key focus of children's safeguarding activity has been to take forward the Kent Safeguarding and Looked After Children's Improvement Board Plan arising from the Ofsted/CQC Inspection in Kent. The joint presentation made by NHS K&M and KCC directors to the November 2011 meeting of the Kent Safeguarding Children Board that highlights key achievements for safeguarding children and improving outcomes for LAC to date and sets out the seven steps for further improvement is included here. The seven steps are:

- Keeping on top of the basics – for health partners continuing to focus on use of the common assessment framework (CAF) and engaging in the development and delivery of child protection plans
- Improving the quality of case work

- Strengthening prevention – for health partners delivering the health visiting programme
- Further improving outcomes for LAC
- Reducing the number of LAC
- Reducing the number of children with a protection plan
- Strengthening locality management

6.7 Additional Indicators

Indicators and data to support the JSNA are produced for each of the 12 districts in Kent is presented in the Health and Social Care Maps accessible from the [Kent and Medway Public Health Observatory Website](#). The maps area focussed around a number of key themes

- Overview and Demographics
- Health Inequalities
- Disadvantaged Children
- Mental Health and Wellbeing
- Older People
- Key Killers
- Service provision
- Activity and Prevalence

6. Executive Summary

The following section provides highlights and recommendations from the needs assessments that have been undertaken across Kent. From these needs assessments underlying themes and issues have been identified as factors most important to Kent to reduce health inequalities, improve health and wellbeing and to deliver improved health and social care outcomes.

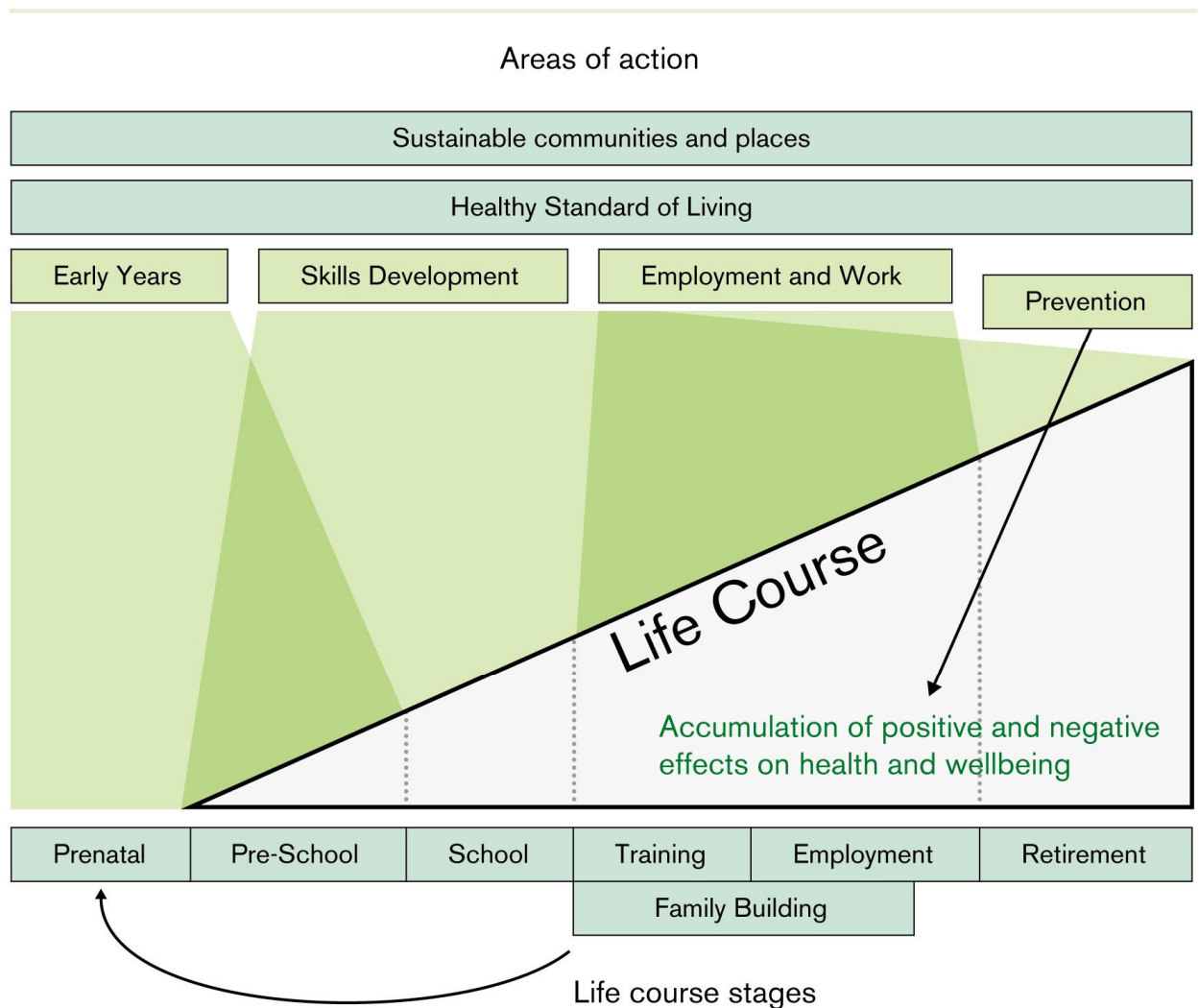
7.1 Health Inequalities

The Strategic Review of health Inequalities in England post 2010 ([Marmot - Fairer Lives Healthy Society](#)) 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.

The diagram below describes health inequalities across a person's life course from cradle to grave. Marmot specifies 6 key areas where work needs to be undertaken to reduce health inequalities

1. Give every child the best start in life
2. Enable all children and young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop health and sustainable place and communities
6. Strengthen the role and impact of ill health prevention

Figure 8 Life course diagram



- Poverty exists all over Kent and Medway. 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 to 2007. However for the most deprived, 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. Life expectancy in the most deprived 20 per cent of the population is 5 years less than the population in the most affluent 20 per cent. The difference in life expectancy between the poorest quintile and the second poorest quintile is 3 years.
- The Marmot 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 however this masks major disparities across the County. 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 life course approach
- A paper is being prepared for discussion at the Kent County Council January 2012

7.2 Lifestyles

7.2.1 Smoking

- In Kent, approximately 10,000 admissions each year are attributed to smoking costing £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% (281,300 people) in 2009, varying from 16% in Sevenoaks to 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 and 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.

7.2.2 Physical Activity, Diet and Obesity

Obesity costs Kent £187.7 million in 2007, rising to £203.3 million in 2009 and is expected to rise to £233.5 million if left unchecked.

- There is a 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% (557,000 people) 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 a Healthy Weight to surgical procedures to achieve dramatic weight loss for those patients with higher BMI's.

People need to be motivated to change before weight loss ensues. There is a need to consider how to incorporate the behavioural model into the healthy weight pathway

Potential impact of primary care on health improvement

Five minutes of advice in general practice to middle-age smokers to quit smoking can increase quit rates and save £30 per person for a cost of £11 per person

Brief interventions in general practice to reduce problem drinking can reduce alcohol consumption by 40% over 12 months with overall cost savings outweighing intervention costs

Brief interventions in general practice to improve exercise uptake can increase the chances of adults undertaking moderate activity by over 20% and vigorous activity by 6% with cost savings of £3,300 per person.

Kings Fund 2011

7.2.3 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 to rise further in Kent this is 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. Further action is still needed such as strict enforcement of the ban on sales of alcohol and tobacco products to under 18s. This will need to encompass work on preventing proxy sales.
- 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.

Recommendations

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. As with smoking cessation, a broad approach encompassing primary, secondary and tertiary prevention work across clinical and non-clinical settings is needed.

Alcohol Treatment commissioners

Aim to commission additional mainstream capacity for treatment of at least 10% of dependent drinkers in Kent, increasing to 20% over the next two years, including expansion of specialist services to include in reach into acute wards and Accident and Emergency (Tier 3 services). Research shows that this is a cost effective exercise (UKAAT, 2003, 2005), and it is one of the high impact actions identified by the Department of Health.

Aim to expand tier 2 services to meet the need for at least 10% of higher risk drinkers in west Kent, increasing to 20% over the following two years for those requiring specialist treatment identified by Identification and Brief Advice (IBA – AUDIT-C is recommended).

Dual diagnosis, co-morbidity, mental health disorders and social problems are common in people who misuse alcohol. Wraparound drug and alcohol services as envisaged in the new treatment specifications will need to link into mental health services at all levels, including signposting and referral to primary care psychological services.

Commissioned services need to be responsive in meeting the needs of changing ethnic minority profiles across Kent, including new communities. The 2011 Census report will inform this.

NHS Acute, Primary, Community Care and Mental Health commissioners

Good, responsive services on referral will encourage more clinicians in all settings to use Alcohol IBA, which in itself acts as a successful treatment for over 12% of increasing risk and higher risk drinkers.

Commission IBA in a variety of clinical settings for at least 10% of dependent drinkers in Kent, increasing to 20% over the next two years using referral tools and pathways already agreed by commissioners and providers.

Use AUDIT-C within the NHS Health checks programme.

Commissioners of Cancer, Gastro and CVD acute services should ensure that alcohol IBA and referral mechanisms are explicit within their commissioned treatment pathways, using referral tools and pathways already agreed by commissioners and providers, and give consideration to the financial benefit of contributing to additional treatment service provision which will be needed as a result.

Industrialise routine delivery of IBA in Accident and Emergency and acute services generally for patients experiencing falls/accident/assault/head injury: gastro-intestinal, cardiac, mental and behavioural problems: collapse or feeling unwell. Use referral tools and pathways already agreed by commissioners and providers.

NHS Acute contracting team need to ensure that Hospital Trusts provide accurate data recording and data extraction, to monitor progress of initiatives, by building specifications on this into contracts and service level agreements. This will ensure that relevant data are available for performance management and to inform further JSNA refresh.

Industrialise routine delivery of IBA in Primary Care through inclusion in NHS Health Checks wherever and however commissioned and delivered, to mitigate risk of development of chronic conditions and identify patients requiring specialist treatment for alcohol harm reduction. Seek to Industrialise routine delivery of IBA in Primary Care generally for patients experiencing gastro-intestinal, cardiac, mental & behavioural problems or feeling unwell. Use referral tools and pathways already agreed by commissioners and providers.

Industrialise routine delivery of IBA in Community Nursing, for the same groupings of patients and others who demonstrate health risk behaviour (e.g. in sexual health services). Use referral tools and pathways already agreed by commissioners and providers. Community commissioners to require accurate data recording and effective data extraction processes, by building specifications on data collection and data sharing into contracts / SLAs to monitor progress of initiatives.

Work for further development of generic young people's risk reduction services to include brief advice for alcohol identification and referral to specialist services (pathway development). This would be the responsibility of Child Health Commissioners, through and with KDAAT, alongside KCC Education.

Develop a joint working policy, procedure and care pathway for clients with mental health and alcohol misuse problems (significant co-morbidity with mental illness requires pathway development into alcohol / mental health dual diagnosis services). Use referral tools and pathways already agreed by commissioners and providers.

Develop links with the IAPT programme once that service is well-established.

Public Health Commissioners

Industrialise opportunistic IBA as part of Healthy Lifestyles services through local authority commissioning for prevention, and by Community Wardens, housing staff, anti-social behaviour officers.

Through co-commissioning and local partnerships, explore opportunistic delivery by non-specialist police and probation service staff including PCSOs; and routine use of IBA with arrestees in custody suites (Alcohol Arrest Referral).

Raise awareness through campaigns in the press, radio and through partner newsletters including workforce initiatives about the risks of drinking at

increasing and higher risk levels and binge drinking. Give consideration to wider distribution of culturally appropriate resources for new communities.

7.2.4 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.

Recommendation

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

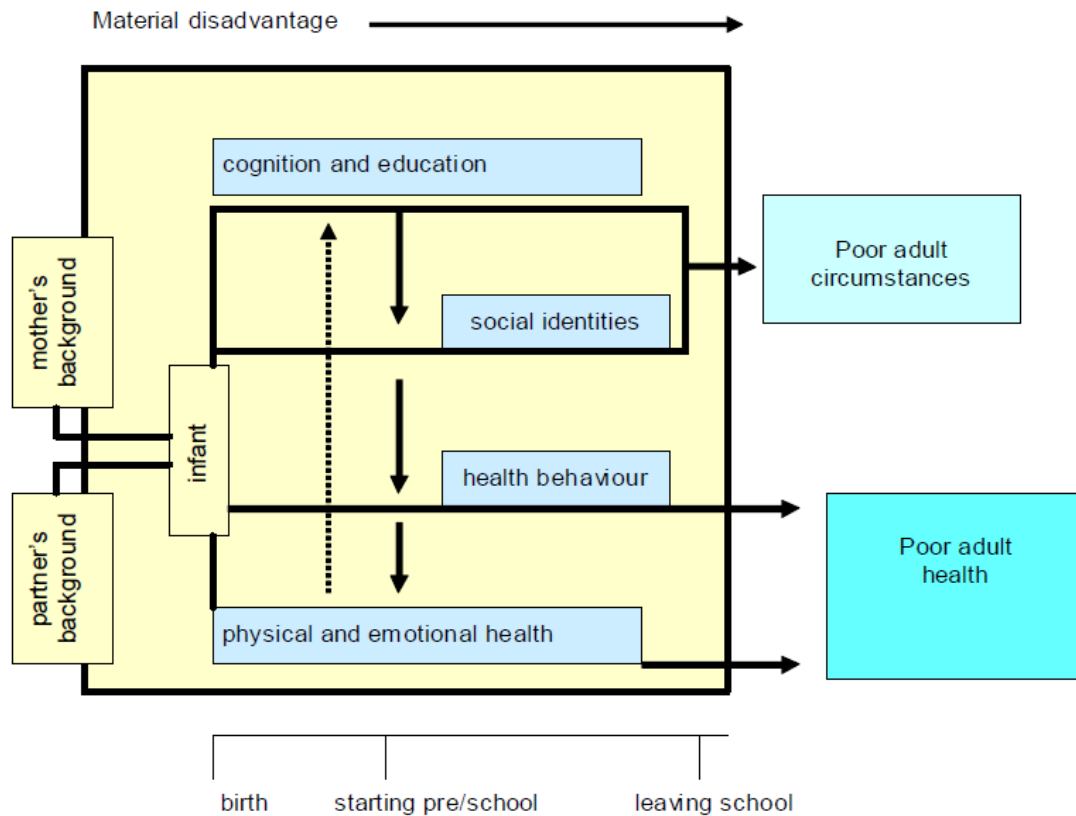
Further information required such as survey of dental health of under 5 year old, as well as a coordinated approach involving primary care dental services to focus on prevention in line with *Delivering Better Oral Health – a toolkit for prevention* by Department of Health

7.3 Children

7.3.1 Early Years

- The life course framework mentioned earlier puts the focus on childhood disadvantage, from before birth and throughout childhood (Figure 8). The pathways running from childhood circumstances to adult circumstances and adult health are set in this context. Four pathways are highlighted. They include the development of physical and emotional health and the development of health behaviours. But they also range across cognitive development and educational progress and investment in social identities such as becoming a parent in adolescence /early adulthood. The framework identifies these four dimensions as central to the link between childhood disadvantage and poor adult health.

Figure 9 Childhood disadvantage and adult health: a life course approach



Source: Childhood disadvantage and adult health: a life course framework

Recommendation

- Therefore, a mixture of universal and targeted programmes such as baby massage, the Solihull approach, the neo-natal behavioural assessment scale [NBAS] and the Family Partnership model) are primarily concerned with the promotion of infant mental health concentrating on the above four dimensions. Targeted programmes should be provided to families at risk of poor outcomes due to a range of social dysfunction or psychological pressures.
- Children centres have a key role to provide a location around which the Health Child Programme can be managed and delivered on a multi-disciplinary and multi-agency basis. This means that children's centres must accommodate universal programmes as defined by health as well as more discretionary family support-based services that are a concern of children's social services.

7.3.2 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 has remained stable.
- 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.

	NHS Eastern and Coastal Kent	NHS West Kent	Kent County
Number of maternities	8,546	8,231	16,777
Number known to be breast feeding	6,040	5,922	11,962
% breast feeding	70.7%	71.9%	71.3%
Number known to be not breast feeding	2,489	2,133	4,622
% not breast feeding	29.1%	25.9%	27.5%
Breast feeding status unknown	17	176	193
% unknown	0.2%	2.1%	1.2%

Health Area	Number of infants due for 6-8 week check	Children being breastfed at 6-8 weeks	Children not being breastfed at 6-8 weeks	Children receiving both breast milk and infant formula	Children whose breast feeding status is unknown	Prevalence: % of children being breastfed	Coverage: % of children with a breast feeding status recorded
NHS West Kent	8,489	2,429	3,885	1,194	981	42.7%	88.4%
NHS Eastern and Coastal Kent	9,261	2,108	3,899	778	2,476	31.2%	73.3%
Kent County	17,750	4,537	7,784	1,972	3,457	36.7%	80.5%

Recommendation

Implementation of the 'Baby Friendly Initiative' to which all key stakeholders are signed up to, this includes, health visitors, children's centres and maternity units, will improve the uptake of breastfeeding as women will feel more supported.

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.

7.3.3 Immunisation and Vaccination

- There are a number of vaccination programmes these include childhood immunisations, influenza, HPV and Hep B
- 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 SHA figure in east Kent. In the west of the county uptake is generally better.
- 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.
- The MMR rate in east Kent whilst improving is not at the 95% level recorded by the WHO (World Health Organisation) as being necessary to prevent an outbreak requiring further public campaigns to bolster the uptake rates.

2,255 children are unprotected from measles mumps or rubella¹. GP and Health Visitors in one to one meetings with families can encourage the uptake of MMR

- HPV vaccination uptake has recorded varying levels (for each of the three scheduled doses) across Kent and Medway in comparison regionally and nationally.
- A project in conjunction with colleagues from the Somme is being developed to assess the differences in uptake of the HPV vaccine, to share best practice and to ensure that uptake of all three doses of the vaccine is maintained.
-

¹ Based on the difference needed to achieve 95% Jan-Mar 2011 and MYE 2010 5 year olds

Uptake of MMR vaccination

		MMR (24 months)	MMR1 (by 5th birthday)	MMR2 (by 5th birthday)
April 2010 - June 2010	NHS Eastern and Coastal Kent	85.2	92.6	84.6
	NHS West Kent	88.3	89.5	81
	South East Coast	86.3	89.4	79.8
	England	88.3	91.4	83.3
July 2010 - September 2010	NHS Eastern and Coastal Kent	89.6	93.8	86.2
	NHS West Kent	91	90.7	81.9
	South East Coast	87.4	88.8	79.2
	England	88.3	91.6	83.7
October 2010 - December 2010	NHS Eastern and Coastal Kent	85.6	93.1	83.5
	NHS West Kent	94	92.4	87.8
	South East Coast	87.3	89	80
	England	88.9	92.2	84
January 2011 - March 2011	NHS Eastern and Coastal Kent	89.1	91.9	84.8
	NHS West Kent	95.1	91.9	87.7
	South East Coast	89	89.4	81
	England	89.5	92.2	84.5

Source: www.hpa.org.uk - COVER Data 2011

Key	
Zero	Less than 80
80 or more but less than 90	90 or more but less than 95
95 or more	

Recommendation

- An action plan to increase the uptake of the MMR vaccination across Kent is required. CCGs should improve access to the MMR vaccination for their patients. To reduce variation within practices and ensure that all areas have a level of vaccination which offers herd immunity i.e where enough people are vaccinated within the population to minimise the risk of spread of infection. This will require targeted initiatives to ensure a pattern of optimised take-up of MMR vaccination across Kent, starting with those most vulnerable populations.
- Increase the uptake of HPV vaccination for all three doses, through developing a targeted approach for those populations where uptake is lowest to reduce variation across Kent.

- Develop a local enhanced service [LES] to improve uptake of influenza vaccination including workforce within primary and community care and all professionals who come in direct contact with patients and clients.
- Increase uptake of influenza vaccination through the use of healthy living pharmacies.
- Ensure that Hepatitis B vaccination is offered to all at risk mothers

‘Don’t Hesitate, Vaccinate’ – was a successful social marketing campaign in West Kent which contributed to the increase in MMR uptake (by Year 2) from 77% in April-Jun 2010 to 95% in Jan-Mar 2011

7.3.4 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.
- The Healthy Child Programme, especially the 0-5 years, are grounded on the Marmot principles of progressive universalisms. All agencies should target their approach focusing on the family as a whole rather than a child’s behaviour. Services should be commissioned to recognise home visiting as a key intervention to address inter-generational improvements in parenting, child behaviour and cognitive development. The use of the third sector and specifically the commissioning of HomeStart programmes should be maintained throughout Kent.
- Agencies in Kent should maintain their commitment to children’s centres and the differential funding to first wave Sure Start children’s centres on the basis that these have been set up as targeted resources

in areas across the County identified as being in greatest need. This is the proper application of the principles of equity.

- The role of the health visitor is central to the delivery of the Healthy Child
- Programme. Health visitors have a critical role in leading the practise of the Healthy Child Programme. Accordingly they should be based in children's centres whilst maintaining clear and unambiguous links to local primary care services. Health visitor practise should therefore give equal commitment to prevention and promotion of population health for children and their families, as well as to safeguarding.
- There is a national programme to increase substantially the number of practising health visitors and a Kent and Medway working party is co-ordinating the local implementation of this, ensuring that full quotas of newly recruited and trained health visitors meet specified staffing level targets by 2015.

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 This contradicts the bullet point above .

7.3.5 Parenting

- The relationship between infants and parents or primary care givers 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 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.

7.3.6 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 for children should be commissioned based on national and international evidence such as programmes to assist changes in child and family behaviour and social marketing techniques promoting healthy lifestyles. There also needs to be systematic collection of local data.

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 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;
- 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.

7.3.7 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.

7.3.8 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. 'An unannounced follow-up visit by OFSTED in late 2011 reported significant improvement notwithstanding that the fundamental challenges outlined in their original inspection remain'.

All agencies need to be mindful of the continuing need to support young carers and young carer's 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.

7.3.9 Domestic Abuse

- On average, two women a week are killed by a male partner or former partner in the UK (Povey, 2005); this constitutes around one-third of all

female homicide victims. On average there are five domestic homicides a year in Kent & Medway.

- The Violence against Women and Girls 'Ready Reckoner' (Home Office) estimates that out of a population of 1,411,100 in Kent, numbers of women likely to have been affected in the past year are as follows:
 - 45,861 women and girls aged 16-59 have been a victim of domestic abuse
 - 23,283 women and girls aged 16-59 have been a victim of sexual assault
 - 56,867 women and girls aged 16-59 have been a victim of stalking
- There were 17,551 reported incidents of domestic abuse in Kent in 2009/10. Approximately 22% of these were repeat incidents.
- Overall, in Kent rates of repeat victimisation are increasing.
- Services commissioned across partner organisations include:
 1. Multi-Agency Risk Assessment Conferences (MARACs) for victims and families assessed at highest risk of future serious abuse / danger.
 2. Independent Domestic Violence Advisors (IDVAs). There are 16 IDVAs (w.t.e) currently working across Kent. They are employed by a number of organisations, and supported by many different sources of funding. There are no standard job descriptions or conditions of service, although most Kent Job Descriptions derive from the *Co-ordinated Action against Domestic Abuse (CAADA)* framework for IDVA services². There is no common agreed outcome framework currently applied across Kent. Two of these posts support the two Kent Specialist Domestic Violence courts. A third court opens in Medway in July 2011, and funding has been secured from the Home Office for an IDVA to support the work of this court.
 3. Community Perpetrator programmes Programmes are currently available across Kent for men who refer themselves and are assessed as suitable for the programme. These courses are funded from a variety of sources. There is also a Women's Safety Worker Service

²http://www.caada.org.uk/qualityassurance_accreditation/The%20Charter%20and%20Key%20Criteria%20for%20CAADA%20March%202011.pdf

and a Children's Safety Worker attached to the community programme service.

4. Other local support services and projects (often small scale) are delivered by non-governmental organisations, supported by funding sources too numerous to list. Some local services receive part of their funding from the local authorities or PCTs in Kent, but this is a very small proportion of the whole. Most of these projects are greatly valued by the local community: but the detail of outcomes is rarely comprehensively and independently evaluated.

5. Refuges are principally funded by *Supporting People*.

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.

Rates of reported domestic abuse (including domestic violence) continue to rise across Kent. Although some of this may be ascribed to improve reporting, it is likely that incidence is indeed increasing, and current services are inadequate. Evidence suggests that family violence increases in times of economic hardship, and it is likely that, over the next 3-5 years, more services will be needed to support victims. Even more concern relates to the rising rate of repeat victimisation. This suggests that victims require more pro-active support than is currently available.

Recommendations

- Commissioners should require NHS staff to be trained in Safe Enquiry (understanding of issues relating to domestic abuse and domestic violence). NHS staff should also know how to refer patients to the relevant local domestic abuse services)

- Co-commission one single Point of Contact service for Domestic Violence victims in Kent
- The sustainable maintenance of IDVA's across the county, located according to need
- Safe Enquiry should be part of an overall approach encompassing multi-agency training for all frontline staff to raise their awareness of domestic violence, possibly by expanding the screening role of alcohol and other specialist workers, to enable them to ask about domestic violence safely and link enquiry with a pathway for safe discharge. Ideally this should be underpinned by support for them from specialist domestic violence practitioners in the community.
- Further needs assessments are required:
 - Assessment of outcomes of DV support services in a consistent framework: and development of local measures of success
 - Exploration of volume of local needs in BME groups –travellers (in particular Roma) and new communities (principally Eastern European). In the longer-term (following release of 2011 census data) a general health needs assessment for these BME communities in Kent should be undertaken, in partnership with KCC.
- Undertake robust evaluation of perpetrator programmes run in Kent and Medway to establish effectiveness in reducing violent assaults over a number of years
- There is a need to protect access to front line domestic abuse services. 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 underestimated and will take some years to establish.

7.3.10 Child and Adolescent Mental Health (CAMHS)

- Kent CAMHS services in 2009/10 were seeing fewer than expected proportion of children according to need in Tier 2
- There is a considerable percentage of self harm and psychosis seen in Tier2 and Tier 3 services.
- In Kent slightly fewer males and slightly more females access services than would be expected nationally
- There is an under representation of conduct disorder and hyperkinetic disorders and fewer younger boys are being seen than expected nationally
- Although smaller numbers of Black and Minority Ethnic (BME) groups are expected in Kent CAMHS services than nationally, Kent CAMHS have an underrepresentation of African and Caribbean children and an over representation of Asian and mixed race children than is expected.
- Kent CAMHS are seeing more children with learning disability than expected nationally but children looked after and young offenders are under represented both according to local need and to national comparison.
- CAMHS services are being accessed by more children and young people aged 10-14 than at 15-18
- There is a gap in transition services from CAMHS to Adult services.
- There is under representation from BME groups from a number of providers notably NHS West Kent where there is a large Asian population. Kent and Medway Partnership Trust (KMPT) is seeing expected numbers of mixed race children and Asian children. KCC reports large numbers of White Irish, White Other and mixed race young people.

Recommendation

- Focusing work on vulnerable groups : particularly CAMHS Tier 2 and Tier 3 support for young offenders and Children looked after
- Children with mothers with mental health problems and children with alcohol dependant children is a high impact area that needs addressing.

This would be achieved through working more closely with adult services to identify, risk assess and intervene in family support and provide good Tier 2 type support for those children at risk.

- Improve equity : e.g. BME engagement
- Emotional well being services and support need to be targeted to areas of key deprivation (Thanet / Shepway/ Swale/ Gravesham)
- Better Data quality and on going needs assessment using real time data to test for equity and outcomes

7.3.11 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 in Kent 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 one 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.
- To reduce the number of girls who have repeat abortions three outreach workers have been employed to identify girls at risk and to provide support and information to improve their awareness of good sexual health.

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.

Whilst prevention of pregnancy is preferable, 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.

7.4 Adults

7.4.1 Long term conditions

- Chronic obstructive pulmonary disease (COPD) – Quality Outcomes Framework (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.
- Cardiovascular Disease (CVD) – Prevalence is expected to increase by at least 0.6% over the next ten years to 2020. East Kent has a prevalence rate which is consistently 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. Some of the key recommendations include:
 - Ensure monitoring of CVD prevalence at practice level such as validation of Atrial Fibrillation registers
 - Prioritise health improvement programmes including rollout of health checks as well as evidence based social marketing techniques.
 - Service and care pathway development focusing on latest NICE Guidance on Personalised Care Plans, developing Heart Failure registers, integrated community teams, identify patients in acute trusts, tele-technology and improved access to End of life care.
- Stroke - In Kent & Medway 25,889 people were recorded as having a Stroke or TIA. This is a prevalence of 1.7% across Kent and Medway. The lowest prevalence of stroke was seen in Medway with just 1.3% of the population appearing on a stroke register. West Kent has a prevalence of 1.7% and East Kent 1.8%, in 2009/10. The national prevalence from the

quality and outcomes framework (QOF) is 1.7%. The following actions are required to improve the care of people following a stroke:

- Early Supported Discharge Teams to cover the whole of Kent.
 - Educate GPs as to the importance of correct anti-coagulation in patients with AF.
 - Encourage Stroke Champions / Peer support schemes for people who have had a stroke.
 - Translation of FAST materials to culturally appropriate formats.
 - Increase awareness of stroke and the services available with Black and Minority Ethnic groups, in particular South Asian and African-Caribbean groups.
- 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. This entails improving service integration of the Kent Healthy Weight Care Pathway for Adults and Children right through to specialist diabetes services. This should be a priority for CCGs and District Authorities as prevention targeting those at highest risk will enable savings on treatment which can be invested elsewhere.
 - Cancer – While there has been an increase in incidence and the survival rates of some cancers such as breast, skin and prostate, lung cancer continues to have the lowest survival rate this is due to a high proportion of people having the disease diagnosed at a late stage, when the cancer is more advanced., 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.

Feedback from the Strategic Health Authority and the Department of Health Long Term Condition review team recognised improvement in the Kent and Medway QIPP programme, recommending additional improvements:

- greater combination and adoption of existing risk stratification models
- greater unification of local approaches and adoption of integrated working practices
- urgent development processes to evaluate the success levels of projects, to enable the rapid spread and take up of the most successful initiatives
- adoption of the findings from the SEC Personalised Care Planning pilot, combined with the Personal Health Budget programme
- capitalising on the supported self management progress and learning gained from implementing telehealth/telecare as a part the large scale national trial (Whole Systems Demonstrator)
- working with the SEC wide LTC commissioning development programme, co- designed by clinicians and linked with SEC Enhancing Quality principles.

Risk stratification – key points

Predictive risk models are used for predicting events such as unplanned hospital admissions, which are undesirable, costly and potentially preventable.

Such models have been shown to be superior to other ‘case finding’ approaches, including threshold models and clinical opinion. Although the Department of Health has previously funded two predictive models for the NHS in England, the current policy is to promote an open market in terms of suppliers of risk tools.

Commissioners should consider a range of factors when choosing whether to ‘make or buy’ a predictive model, including the outcome to be predicted, the accuracy of the predictions made, the cost of the model and its software, and the availability of the data on which the model is run.

Predictive models should be seen as one component of a wider strategy for managing patients with chronic illness.

Although there are opportunities here for improving the health status of patients with complex needs while making net savings for the NHS, the evidence for hospital-avoidance interventions is patchy and therefore robust evaluations should be built into any proposed local strategies. In the future, it is unclear whether predictive risk models in England should best be procured or built at a local, regional or national level.

Nuffield Trust

7.4.2 Screening

- Screening aims to reduce illness and deaths from certain preventable diseases. NHS national screening programmes exist for:
 - Antenatal and Newborn Screening (infectious diseases, sickle cell and Thalassaemia. fetal anomaly (includes Down's), Newborn (bloodspot, hearing and Infant physical examination)
 - Diabetic Retinopathy
 - Abdominal Aortic Aneurysm
 - Cancer (cervical, breast and bowel)
- The level of uptake in Kent and Medway for all screening programmes is good.
- 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.
- The diabetic retinopathy screening programme is meeting key national standards however further work is needed to improve the accuracy of the database used for invitations and also to improve attendance for screening
- The abdominal aortic aneurysm screening programme started in 2011 and is running successfully.
- In March 2012, the cervical screening programme will incorporate testing of cervical screening samples (depending upon the cytology result) for the virus that caused almost all cervical cancer, Human Papilloma Virus (HPV). This will improve further the accuracy and efficiency of the screening programme.

Recommendation

Reorganisation and safety

- It has been shown repeatedly that service reorganisation can easily lead to unsafe and ungoverned screening programmes. It is essential that those responsible for leading, commissioning and quality assuring screening programmes at PCT, SHA and Quality Assurance level are able to continue to focus of safe deliver on screening programmes

Programme development, higher national standards increased expectations.

- All programmes are developing and revised standards appear for programmes on a frequent basis. There is also an expectation to provide more thorough governance and assurance following recent serious incidents (elsewhere). Coordination and leadership of these require appropriate resourcing.

7.4.3 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.
- Dementia related emergency admissions have increased by almost 85% from 3497 to 6466 admissions over the last 5 years.
- 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.

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.

7.4.3 Falls and Fractures in the elderly

- The Department of Health states 'Preventing older people from falling is a key challenge for the NHS and local authorities. It is not the preserve of one agency as the consequences of a fall and resultant fragility fracture cut across all local agencies working with older people. All local organisations working with older people, including statutory and voluntary service providers, are a part of the solution and must be supported to understand their contribution to reducing the number of falls locally.'
- In Kent, 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 an interaction of a variety of medical and social reasons such as UTIs, dementia, pneumonia as well as poor housing conditions and lack of equipment and adaptations or carer support.
- The number of falls admissions is listed as one of the highest (if not the highest) ACS (Ambulatory Care Sensitive) conditions within urgent care.
- 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.

Recommendations

Taking into account of the local context, the Department of Health guidance suggests an integrated approach largely towards secondary prevention of falls and fractures involving:

- **Acute care fracture liaison services** based in Acute Care trusts, identifying and assessing elderly patients admitted for hip or fragility fractures for future risk of repeat fractures, followed by regular osteoporosis treatment.
- **Primary care-based fracture liaison service** - mainly concerns proactive case finding by General Practice for patients with past history of falls and fractures who have not yet been properly assessed.
- **Reconfiguring community-based falls clinics** to be jointly carried out by ortho geriatricians and community health teams. Services both in community and acute trusts are inadequate and poorly integrated to meet the growing number of elderly falling and being treated in hospital, so more efficient methods as well as expansion of current nursing and therapy capacity is urgently needed.
- **Non NHS based prescribed community therapeutic / postural stability exercise programmes.** Additional funding is required to build on existing programmes run by district authorities and / or voluntary organisations and concentrate on substantive referrals from health and social care professionals, particularly community health teams.
- **Targeting non conveyed fallers.** Taking into account best practice from other counties, South East Coast Ambulance Service (SECAMB) should work more closely with other health and social care professionals (either through existing integrated pathways or joined up services) in ensuring that elderly fallers who are not conveyed to hospital are properly screened

for risk of falls and referred onward for specialist assessment and management.

7.4.5 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 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.
- 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.

7.4.6 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.

Recommendation

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.

7.4.7 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 years appears to be at the highest risk across Kent among the other age groups, in line with national trends.
- implementation of a community sexual health model will be reviewed in 2013
- Late diagnosis of HIV appears to be a problem particularly for West Kent with 55%, compared to approximately 20% in East Kent.
- A research project looking into reasons for late diagnosis of HIV is being

developed in conjunction with the Health and Europe Centre.

- Projections estimate a 23% and 28% increase in first attendances for GUM clinics for East and West Kent respectively.

Recommendation

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

To ensure earlier diagnosis of HIV work needs to be undertaken to increase the up-take of point of contact testing for all patients in contact with services. An HIV test should be offered routinely through General Practices and Community Services in high incidence areas in Kent.

Ensure that as part of the Healthy living pharmacies programme, there is a requirement to promote good sexual health and to deliver Chlamydia screening, Emergency Hormone Contraception (EHC) and the prescribing of oral contraception.

Continued investment and development of a Kent and Medway Sexual Assault referral centre (SARC)

7.4.8 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.

There is a need for a Medicines Management Performance Framework to be in place to harmonise prescribing and medicine management financial practice across the Sheppey prison estate

There is a need to ensure that timely and appropriate screening has taken place including screening for Bowel Cancer and AAA.

Bedwatch and escort events should be subject to a special review to ensure that as many clinical services as possible are offered in the Prison.

There should be a specific review of In Patient facilities in HMPs Elmley and Swaleside

7.4.9 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.

Recommendation

- Consider the results of the pilot evaluation when complete to assess if the scheme is feasible to roll out to other areas.

- Commissioners should support local initiatives within local districts such as community wardens giving out portable thermometers to people over 65 in specific geographical areas
- Identify way in how agencies can work together to identify those at greatest risk of morbidity and mortality due to cold weather.
- Work with voluntary and community sector to explore how they can deliver interventions to those at risk.

7.5 Other important QIPP work streams

7.5.1 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.

7.5.2 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. 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.

The development of EOLC registers, and supporting GPs in identification of their “1%”, i.e. the 1% of patients who are likely to die in the next 12 months

7.5.3 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.

7.5.4 Planned Care

First appointment follow up ratios for outpatient activity are consistently higher in cancer specialties like oncology and haematology. Total elective care activity is 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.

7.6 Social factors and population groups

7.6.1 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.

7.6.2 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 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.

7.6.3 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.

7.6.4 Veterans

- Local modelling suggests there are approximately **130,000 veterans** in Kent and Medway, with the highest density in Thanet, Dover, Shepway, Swale and Medway.
- The armed forces recruit heavily from deprived communities, veterans are known to have lower than average household incomes, and in Kent and Medway the areas with the highest prevalence of veterans are also some of the most deprived

- The focus for Kent and Medway is recent veterans, particularly those deployed to Iraq and Afghanistan. This is the group with the most *distinctive needs*, and where interventions and alterations to services are most likely to have a beneficial impact on long-term health outcomes
- A typical UK recruit is a relatively poor, white teenager with limited education and work prospects, recruited from a difficult home environment into the Army infantry. An estimated 86% of UK veterans are male, 94% are white, and only 9% of recruits have a GCSE grade A* to C in English (compared with a 61% national average). For these young men, military service can be a very positive intervention.
- Although the rate common mental illness (depression and anxiety) are not higher than that observed in the population at large, military personnel and veterans were found to be misusing alcohol, more than twice the rate observed in the general population, 13% for military and 6% in the general population.

Recommendation

Recommendations are made in 4 key areas; the transition from The Defence Medical Services (DMS) to the NHS; physical health services for veterans; mental health services for veterans; and raising awareness of veterans' issues:

- **Transition from DMS to the NHS**
 - Facilitate GP registration prior to discharge
 - Improve awareness of DMS record transfer
- **Physical Health Services for Veterans**

- Review Kent and Medway’s prosthetic limb service to allow implementation of Murrison Review
- Raise awareness of the principle of prioritisation
- Support extension of the SSAFA referral project from custodies to A&Es

- **Mental Health Services for Veterans**
 - Local implementation of the Murrison Report on veteran mental health based on the findings of this health needs assessment
 - Targeted support for veterans known to be at high risk of mental health problems
 - Regional qualitative research to allow the veteran voice to influence mental health services
 - Fully map and integrate mental health provision for veterans
 - Continued local representation on the South East Coast Armed Forces Forum Mental Health Working Group
 - Exploratory work with KDAAT/Medway Alcohol Services about service accessibility for veterans

- **Raising Awareness of Veterans Issues**
 - Maintain and expand the Kent Military Health Working Group
 - Raise the profile of the Welfare Pathway
 - Armed forces/veteran representation or close link to/on Health and Wellbeing Boards

7.6.5 Health, Wellbeing and Sustainability

- Sustainability³ is defined as “meeting the needs of today without compromising the ability of others to meet their needs tomorrow”. In Kent sustainability is not just an environmental issue but Health and Social care

³ [http://www.sdu.nhs.uk/documents/publications/APHO_TB9\(4211\)](http://www.sdu.nhs.uk/documents/publications/APHO_TB9(4211))

services acknowledge links with pressure on resources which in turn is linked with poverty, unemployment and social exclusion. These pressures on resources directly impact on the health and well being of local communities leading.

Recommendation

- To further enhance local cross sector partnerships and develop joint action plans for strategies such as Health Inequalities, Housing for Vulnerable population etc.
- To embed sustainability in everyday business by developing sustainability impact assessments for all policies.
- To make sustainability assessments as an integral theme for all commissioning intentions.
- To link sustainability plans to the delivery of QIPP agenda.
- To adopt Health Impact Assessments an integral part of the planning process using sustainability as the guiding principle.
- To embed a sustainable approach into all aspects of care pathway development and procurement of new services.

7. Ashford Clinical Commissioning Group (ACCG)

8.1 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.

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.

- 122,599⁴ 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 years⁵ 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.

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 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 output areas are in the 20% most deprived for England.

⁴ PCIS registered practices populations September 2011

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

- The highest levels of deprivation are found within Stanhope, Aylesford Green and Victoria, in an around Ashford town centre.

8.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially 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 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%)

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 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 than 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.

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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8. C4 Canterbury and Whitstable CCG

9.1 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. Dr Kinnersley has a branch practice located in Chilham which is in the district boundary of Ashford.

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.

- 211,651 people are registered with practices within C4 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 years⁶ 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.

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

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 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 super output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Gorrell, Heron and Wincheap.

9.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially 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 Canterbury are classified as statutory homeless; this is significantly 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 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 than England (smoking 14% Breastfeeding 73.6%)

9.6 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 Coastal 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.

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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9. Dartford, Gravesham and Swanley CCG

10.1 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).

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.

- 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).

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.

- 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 super 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).

10.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially 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 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%)

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 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%.

10.6 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 is more ethnically diverse than 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.

- 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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10. Maidstone and Malling CCG

11.1 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.

11.2 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 years⁷ 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]

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

and the ward with the highest life expectancy [Downswood and Otham 84.2 years]

11.3 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 super output areas are in the 20% most deprived for England,

11.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially 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 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%)

11.5 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.

11.6 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).

DRAFT

11. Swale CCG

12.1 Demographics

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

12.2 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 is in the 40-49 age group.
- Using data for Swale District, the population is projected to increase by 4% over the next 5 years⁸ 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.

12.3 Deprivation

⁸ ONS 2008-Based population projections 2011-2016, 2011-2021

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 super 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.

12.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially 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 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%)

12.5 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 than England (smoking 14% Breastfeeding 73.6%)
- Teenage conception rate for Swale (46.7) is significantly higher than England (40.2)

12.6 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.

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).

DRAFT

12. South Kent Coast CCG

13.1 Demographics

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

13.2 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 years⁹ 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.

13.3 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.

⁹ ONS 2008-Based population projections 2011-2016, 2011-2021

- 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 super 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)

13.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially 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%.
- 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%)

13.5 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 than England (smoking 14% Breastfeeding 73.6%)

13.6 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

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).

DRAFT

13. Thanet and East Cliff CCG

14.1 Demographics

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

14.2 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 years¹⁰ 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]

14.3 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.

¹⁰ ONS 2008-Based population projections 2011-2016, 2011-2021

- 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 super output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Margate Central, Cliftonville West and East Cliffe.

14.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially 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 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 than England (smoking 14% Breastfeeding 73.6%)

14.6 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.

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)

DRAFT

14. West Kent and Weald CCG

15.1 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). Dr Winch has branch surgery located in Biddenden within the district of Ashford.

15.2 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 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]

15.3 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 super output areas 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.

15.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. Economic downturn will have an impact in the short term and potentially 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%

15.5 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%)

15.6 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.

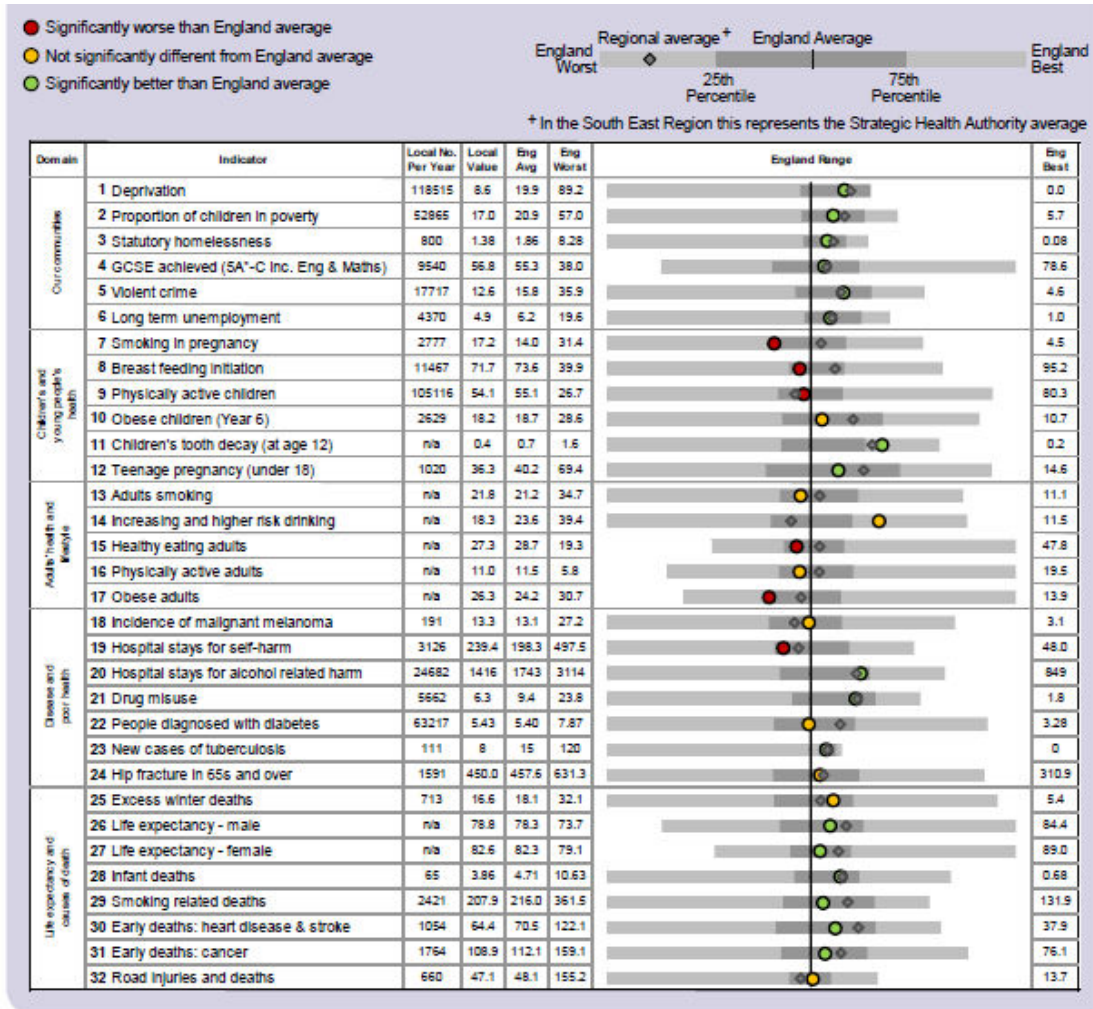
Mortality

- 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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16 Appendix B – Health Profiles 2011

Kent County Council

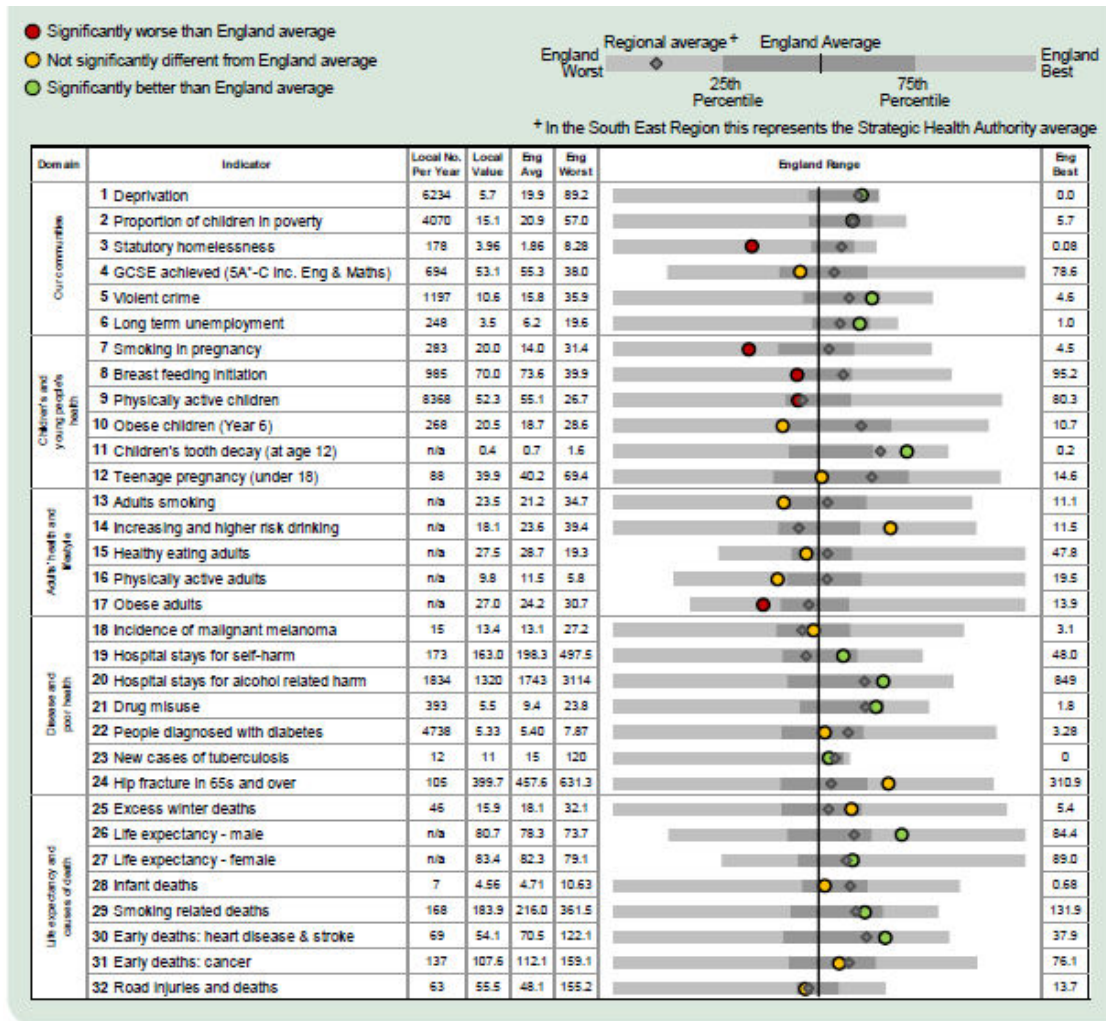


Indicator Notes

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 aged 16-64, 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

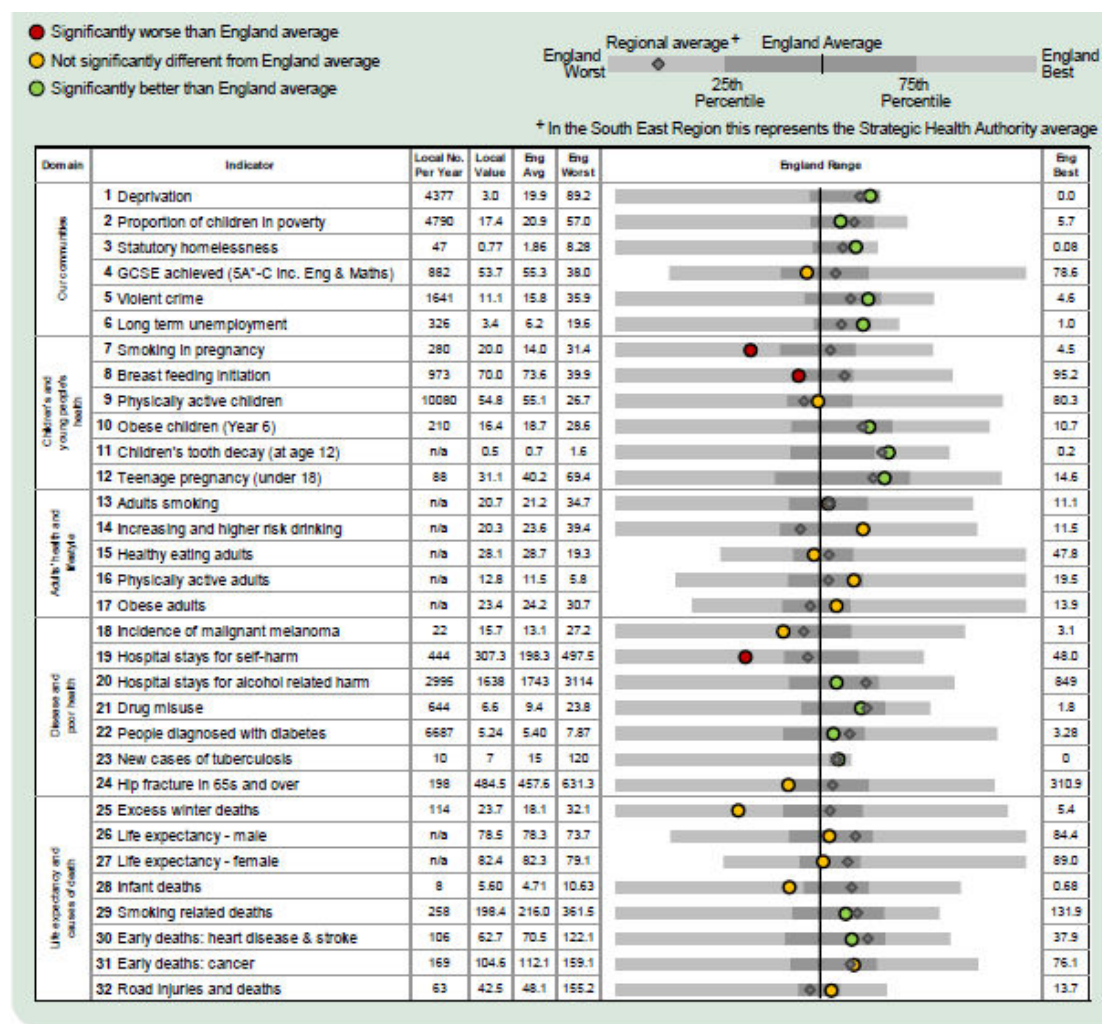


Indicator Notes

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 2006 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 aged 16-64, 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 16+, 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.

Canterbury



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 aged 16-64, 2010 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 aged 16-64, 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.

Dartford

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



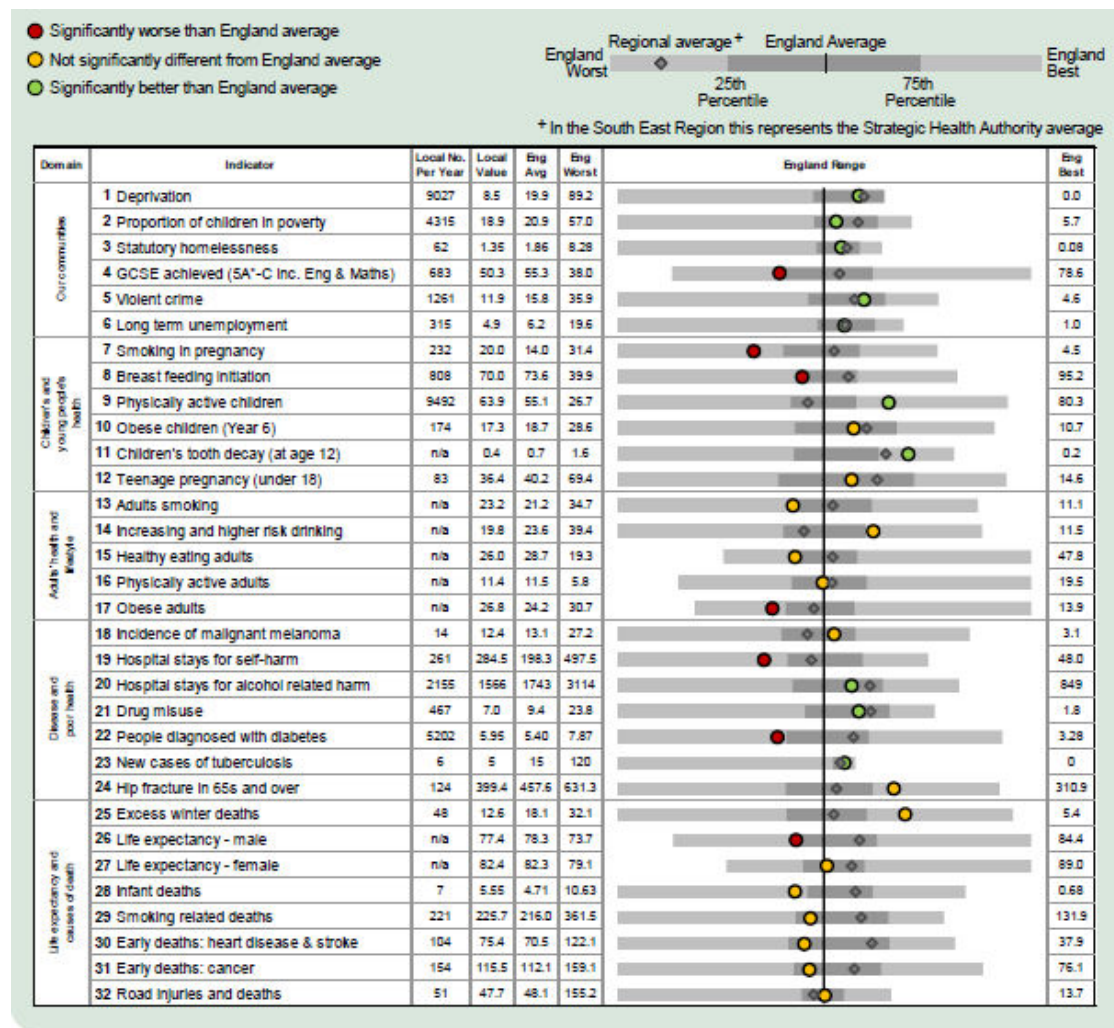
Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	4608	5.2	19.9	89.2	[Bar chart showing Dartford at 5.2, significantly better than England average]	0.0
	2 Proportion of children in poverty	3440	16.1	20.9	57.0	[Bar chart showing Dartford at 16.1, significantly better than England average]	5.7
	3 Statutory homelessness	100	2.63	1.86	8.28	[Bar chart showing Dartford at 2.63, significantly worse than England average]	0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	855	63.1	55.3	38.0	[Bar chart showing Dartford at 63.1, significantly better than England average]	78.6
	5 Violent crime	1407	15.2	15.8	35.9	[Bar chart showing Dartford at 15.2, not significantly different from England average]	4.6
	6 Long term unemployment	388	6.2	6.2	19.6	[Bar chart showing Dartford at 6.2, not significantly different from England average]	1.0
Children's and young people's health	7 Smoking in pregnancy	180	14.2	14.0	31.4	[Bar chart showing Dartford at 14.2, not significantly different from England average]	4.5
	8 Breast feeding initiation	919	73.6	73.6	39.9	[Bar chart showing Dartford at 73.6, significantly better than England average]	95.2
	9 Physically active children	9463	62.0	55.1	26.7	[Bar chart showing Dartford at 62.0, significantly better than England average]	80.3
	10 Obese children (Year 6)	238	22.7	18.7	28.6	[Bar chart showing Dartford at 22.7, significantly worse than England average]	10.7
	11 Children's tooth decay (at age 12)	n/a	0.6	0.7	1.6	[Bar chart showing Dartford at 0.6, significantly better than England average]	0.2
	12 Teenage pregnancy (under 18)	65	36.1	40.2	69.4	[Bar chart showing Dartford at 36.1, significantly better than England average]	14.6
Adults' health and lifestyle	13 Adults smoking	n/a	24.4	21.2	34.7	[Bar chart showing Dartford at 24.4, significantly worse than England average]	11.1
	14 Increasing and higher risk drinking	n/a	18.1	23.6	39.4	[Bar chart showing Dartford at 18.1, significantly better than England average]	11.5
	15 Healthy eating adults	n/a	25.0	28.7	19.3	[Bar chart showing Dartford at 25.0, not significantly different from England average]	47.8
	16 Physically active adults	n/a	8.6	11.5	5.8	[Bar chart showing Dartford at 8.6, significantly worse than England average]	19.5
	17 Obese adults	n/a	28.2	24.2	30.7	[Bar chart showing Dartford at 28.2, significantly worse than England average]	13.5
Disease and poor health	18 Incidence of malignant melanoma	9	10.7	13.1	27.2	[Bar chart showing Dartford at 10.7, significantly better than England average]	3.1
	19 Hospital stays for self-harm	197	213.4	198.3	497.5	[Bar chart showing Dartford at 213.4, significantly better than England average]	48.0
	20 Hospital stays for alcohol related harm	1380	1325	1743	3114	[Bar chart showing Dartford at 1325, significantly better than England average]	849
	21 Drug misuse	299	4.8	9.4	23.8	[Bar chart showing Dartford at 4.8, significantly better than England average]	1.8
	22 People diagnosed with diabetes	4342	5.03	5.40	7.87	[Bar chart showing Dartford at 5.03, significantly better than England average]	3.28
	23 New cases of tuberculosis	10	10	15	120	[Bar chart showing Dartford at 10, significantly better than England average]	0
	24 Hip fracture in 65s and over	91	451.3	457.6	631.3	[Bar chart showing Dartford at 451.3, significantly better than England average]	210.9
	25 Excess winter deaths	33	13.0	18.1	32.1	[Bar chart showing Dartford at 13.0, significantly better than England average]	5.4
Life expectancy and causes of death	26 Life expectancy - male	n/a	78.9	78.3	73.7	[Bar chart showing Dartford at 78.9, significantly better than England average]	84.4
	27 Life expectancy - female	n/a	81.1	82.3	79.1	[Bar chart showing Dartford at 81.1, significantly better than England average]	89.0
	28 Infant deaths	4	2.89	4.71	10.63	[Bar chart showing Dartford at 2.89, significantly better than England average]	0.68
	29 Smoking related deaths	138	220.9	216.0	361.5	[Bar chart showing Dartford at 220.9, significantly better than England average]	131.9
	30 Early deaths: heart disease & stroke	70	75.0	70.5	122.1	[Bar chart showing Dartford at 75.0, significantly better than England average]	37.5
	31 Early deaths: cancer	101	111.6	112.1	159.1	[Bar chart showing Dartford at 111.6, significantly better than England average]	76.1
	32 Road injuries and deaths	48	51.4	48.1	155.2	[Bar chart showing Dartford at 51.4, significantly better than England average]	13.7

Indicator Notes

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Dover

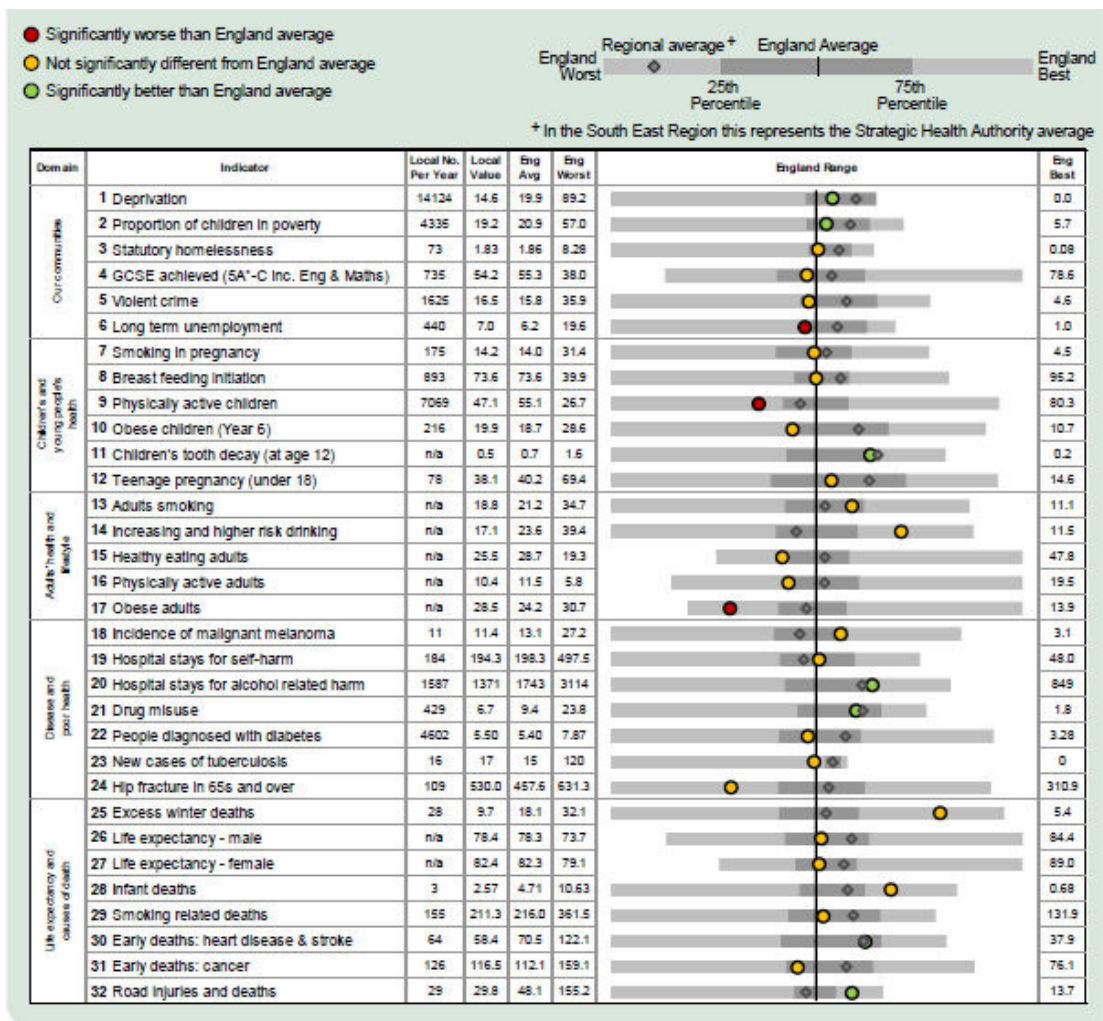


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Gravesham

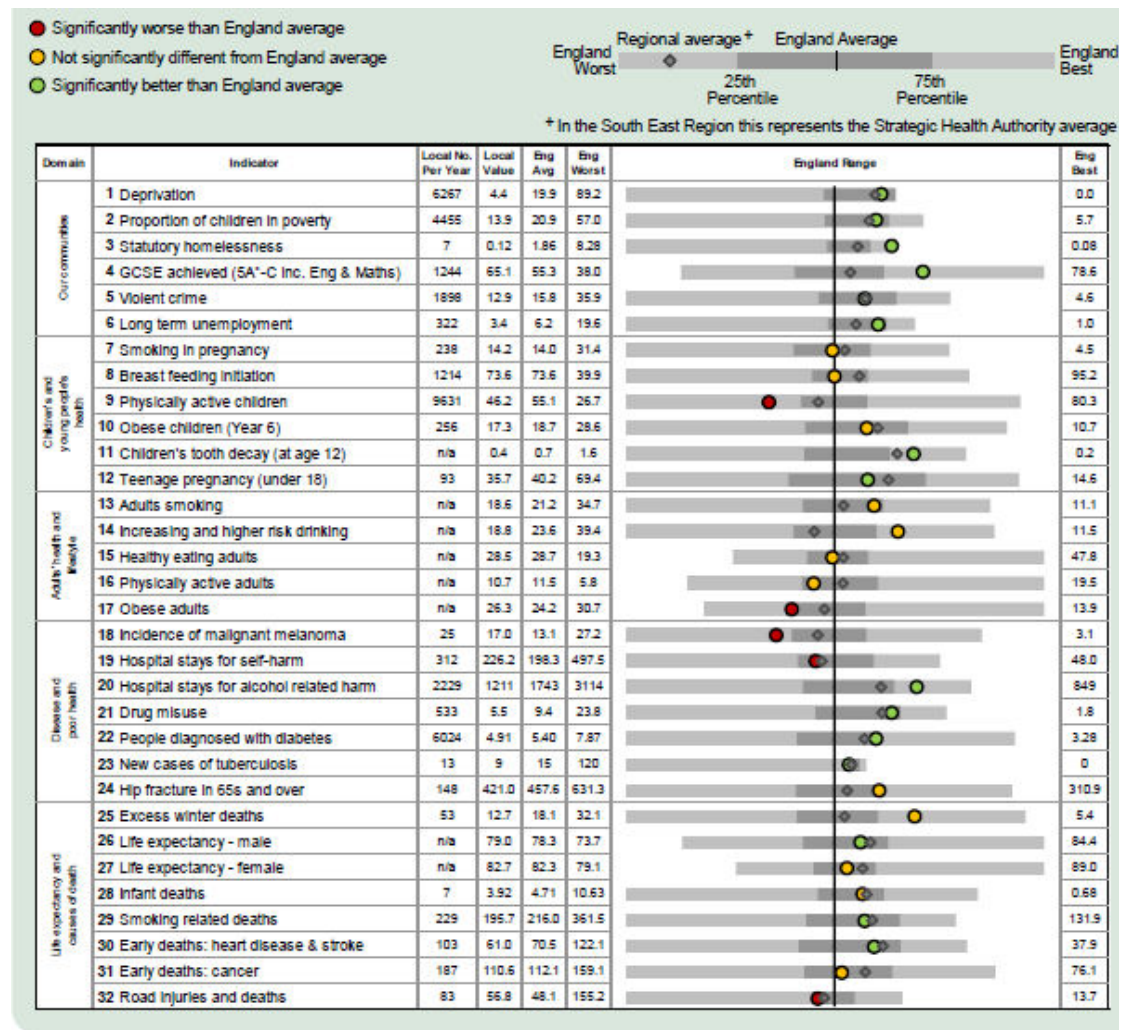


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Maidstone

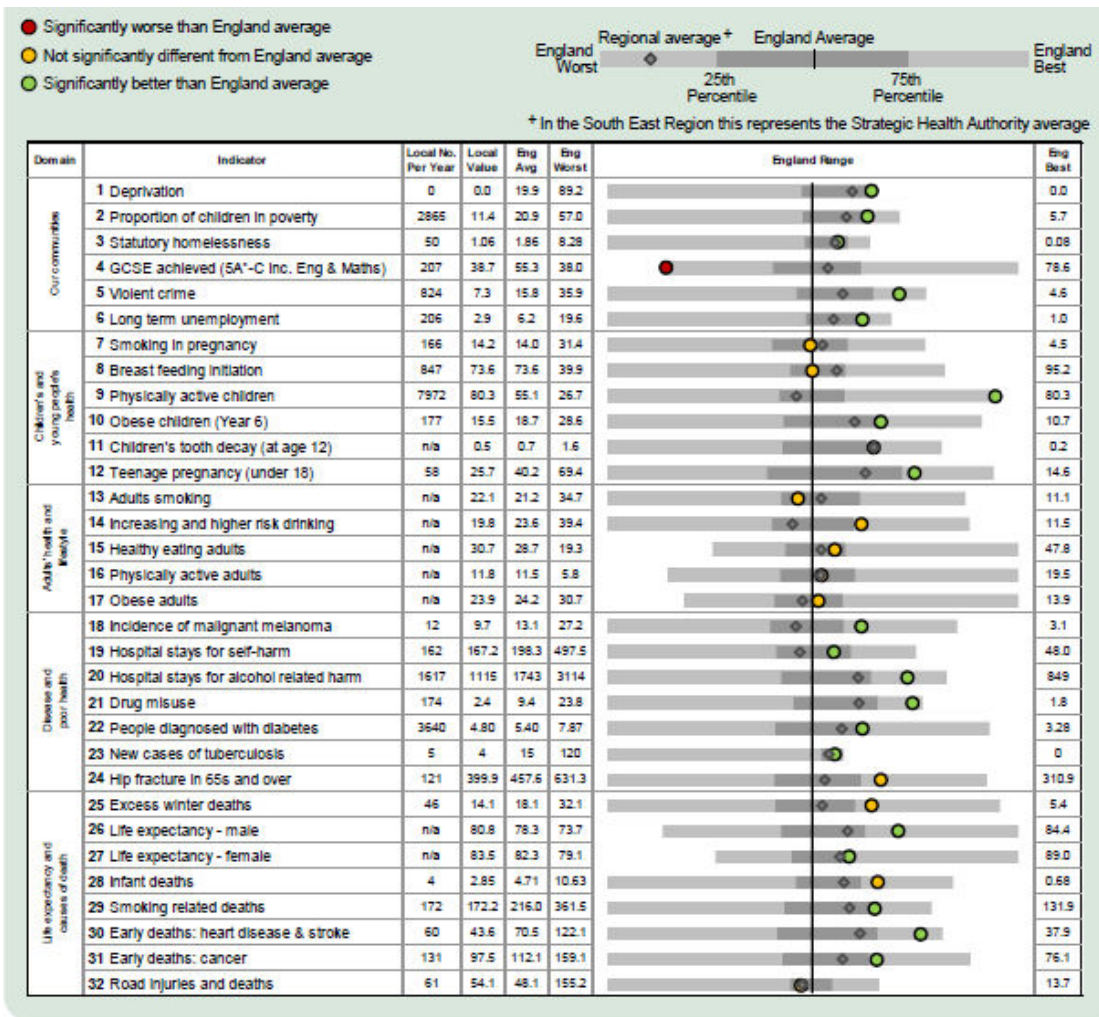


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Maidstone

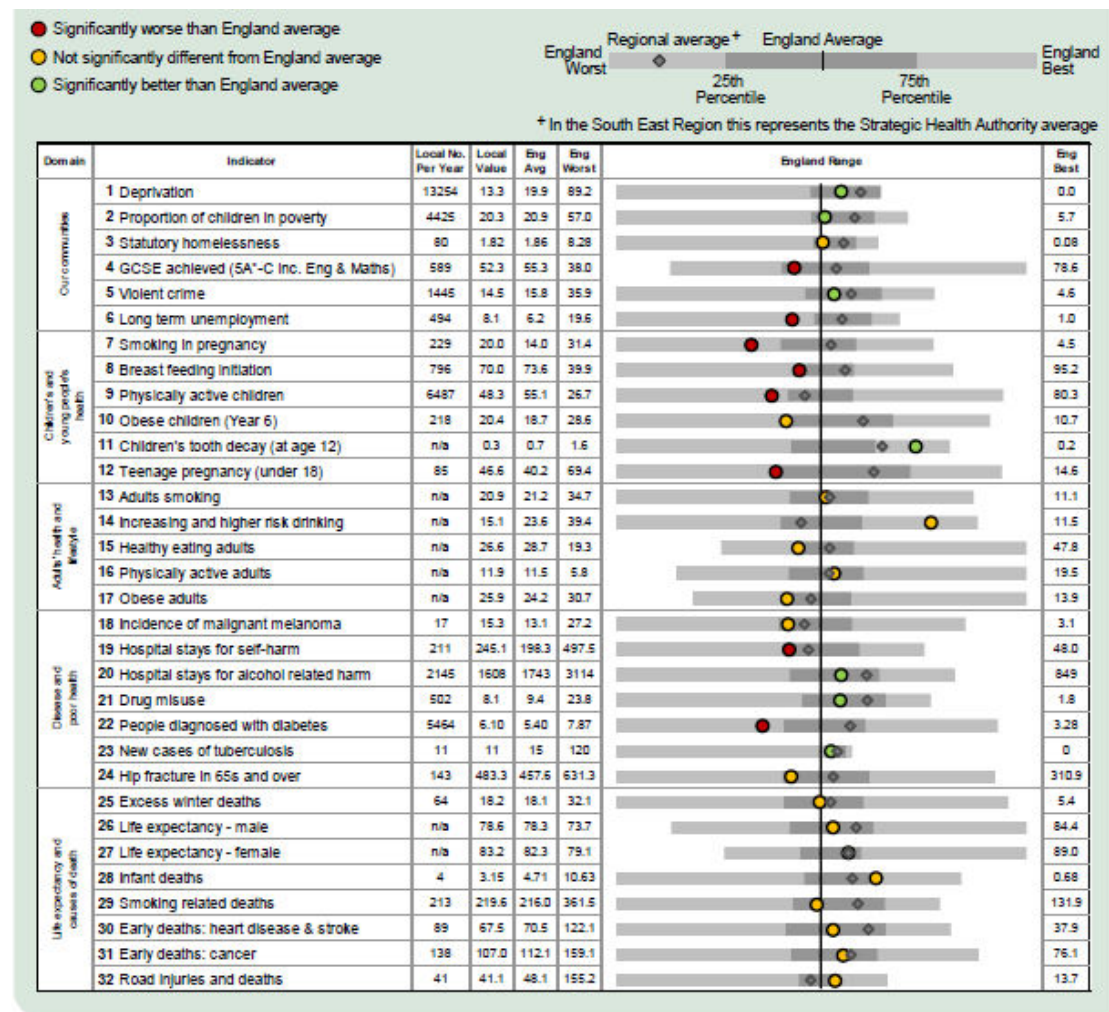


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Shepway

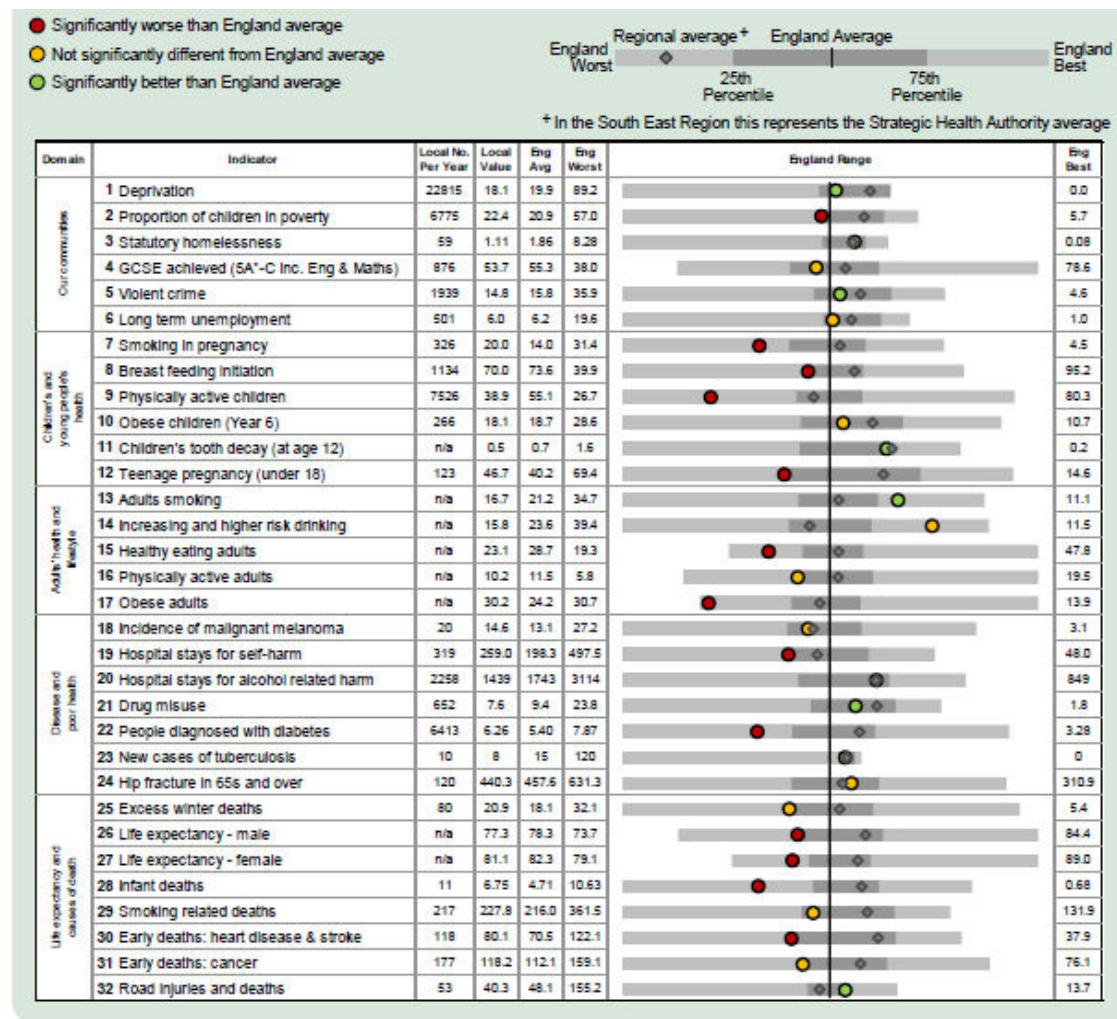


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Swale

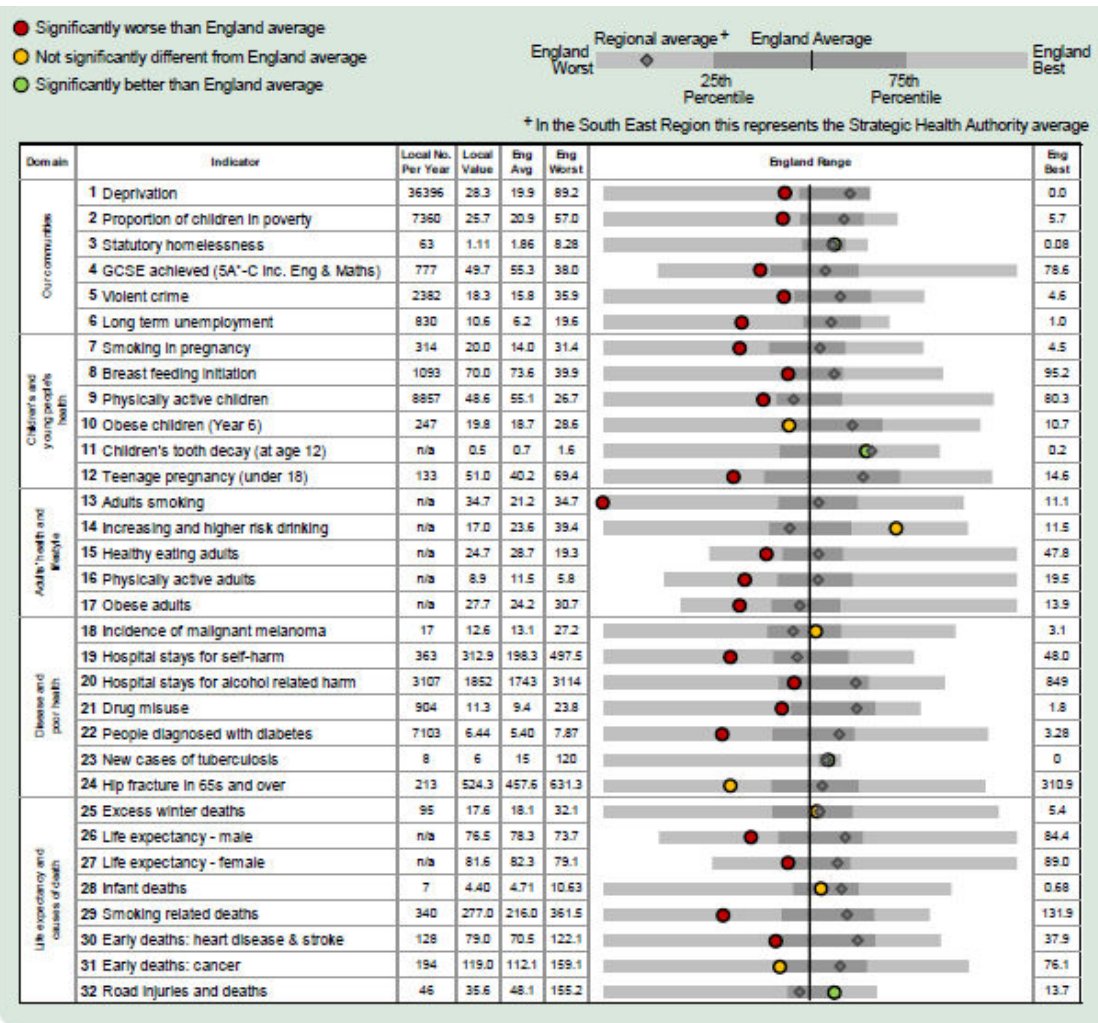


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Thanet

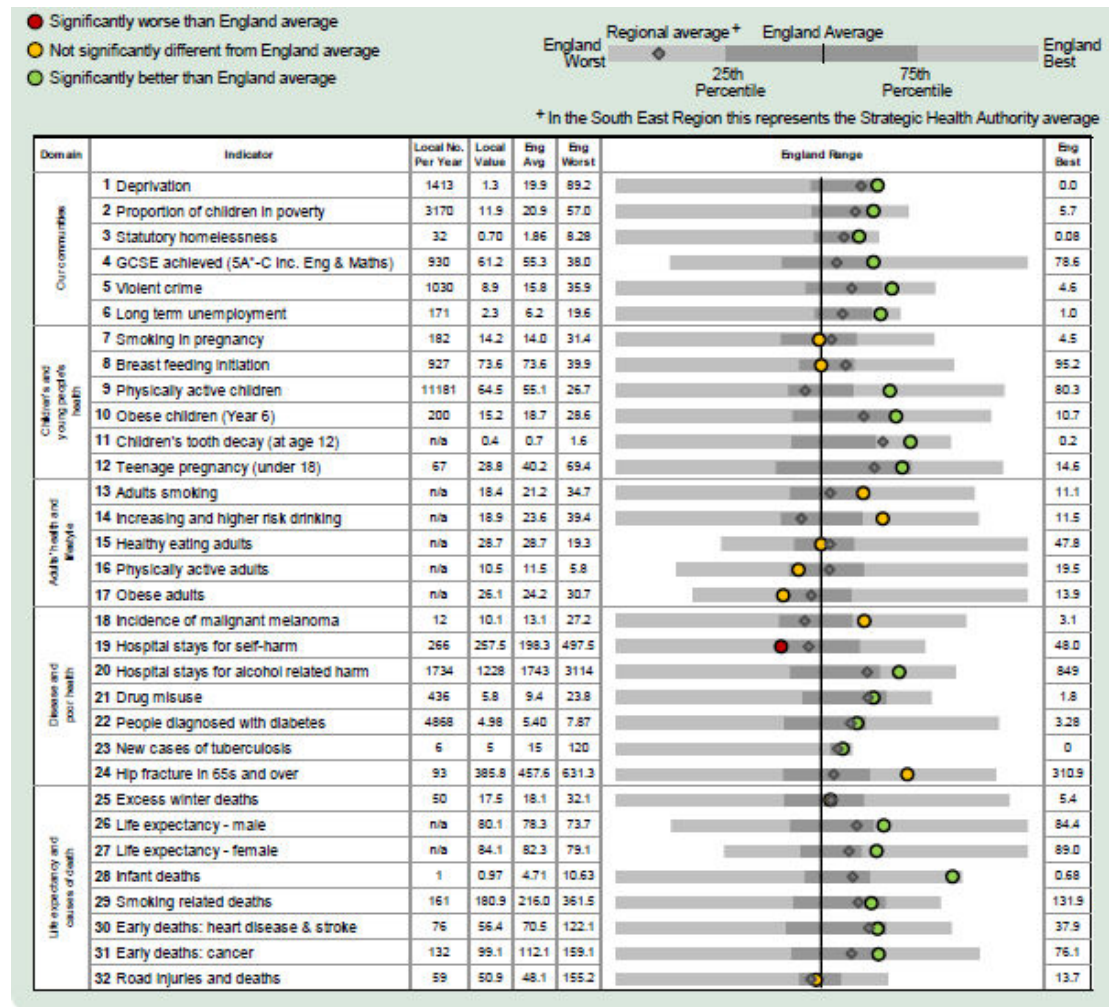


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Tonbridge and Malling

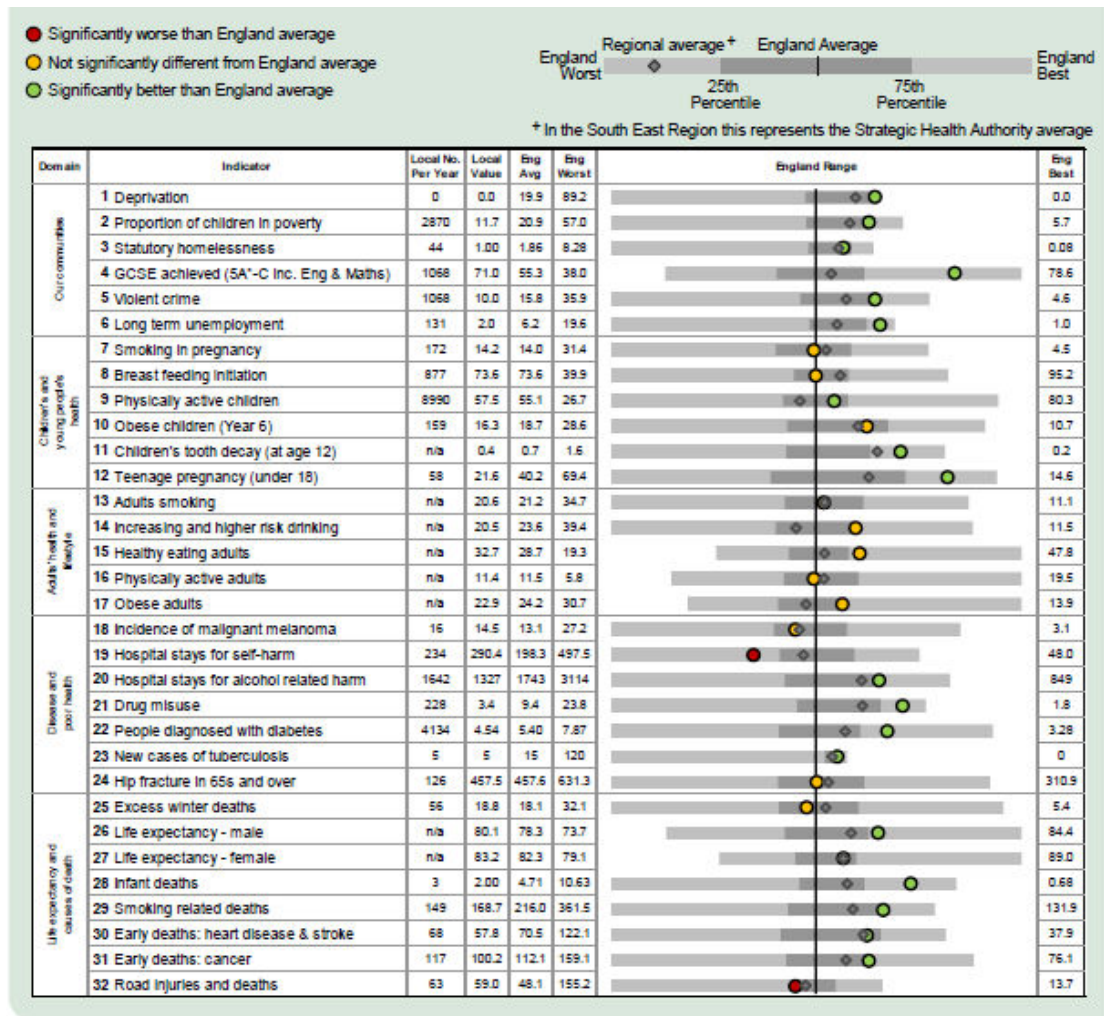


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Tunbridge Wells



Indicator Notes

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By: Meradin Peachey, Kent Director of Public Health
To: Health and Wellbeing Board – 18 January 2012
Subject: Pathway for Adult Obesity Services
Classification: Unrestricted

Recommendations

Health and Wellbeing Board is asked to receive this paper for INFORMATION.

1. Introduction

- 1.1 This paper sets out a case for pro actively making radical changes for the investment in prevention with respect addressing the levels of obesity in Kent. Kent cannot afford **not** to invest in prevention and we cannot afford to do nothing.

2. Relevant priority outcomes

- 2.1 To improve the health of the Kent population

3. Financial Implications

- 3.1 Obesity is currently costing the Kent economy £500 million per annum and currently approximately 7,000 people are estimated to be eligible for bariatric surgery at a cost of £10,000 per operation. Kent faces a bill of £70 million if we do nothing to address this situation¹. This bill is set to rise as the population of Kent steadily increases their BMI's in the absence of an industrial approach to prevention programmes.

4. Legal Implications

- 4.1 N/A

5. Main body and purpose of report

- 5.1 In December 2011 the 20th annual Health Survey for England has been published by the NHS Information Centre for health and social care. The report stated that,

'Between 1993 and 2010, there has been a marked increase in the proportion of the population that was obese. This proportion increased from 13% of men in 1993 to 26% in 2010 and from 16% of women in 1993 to 26% in 2010. The rate of increase in obesity prevalence has been slower in the second half of the period than the first half, and there are indications that the trend may be flattening out, at least temporarily. However, obesity in men and women in 2010 was at its highest level since 1993, and in men the 2010 level was also significantly higher than in the period between 2000 and 2005'.

¹ South East Coast Primary Care Trusts' Policy Review and Recommendation Process Bariatric surgery for obesity and related co morbidities Final Report April 2011
Page 227

5.2 Background

5.2.1 Overweight and obesity presents a major challenge to the current and future health of the population of Kent. Higher body mass index (BMI) is associated with an increased risk of morbidity and mortality from a range of conditions including hypertension, heart disease, stroke, diabetes and several cancers.

5.3 Definition

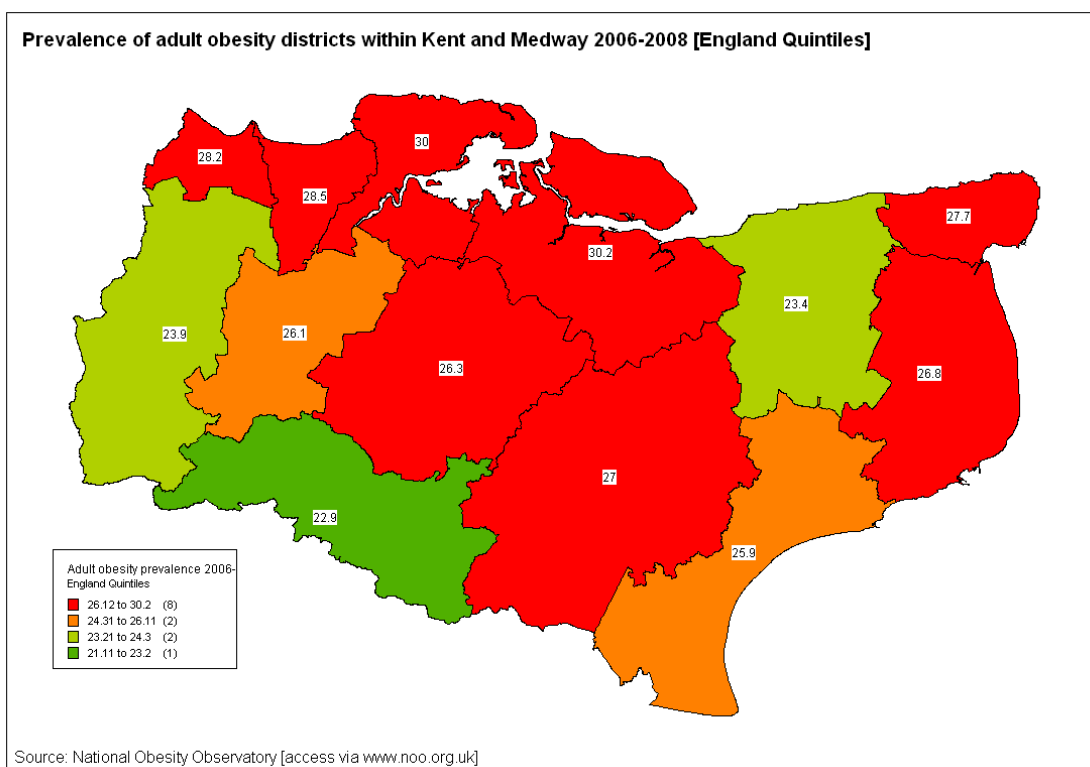
5.3.1 BMI is defined as weight in kilograms divided by the square of the height in metres (kg/m²)

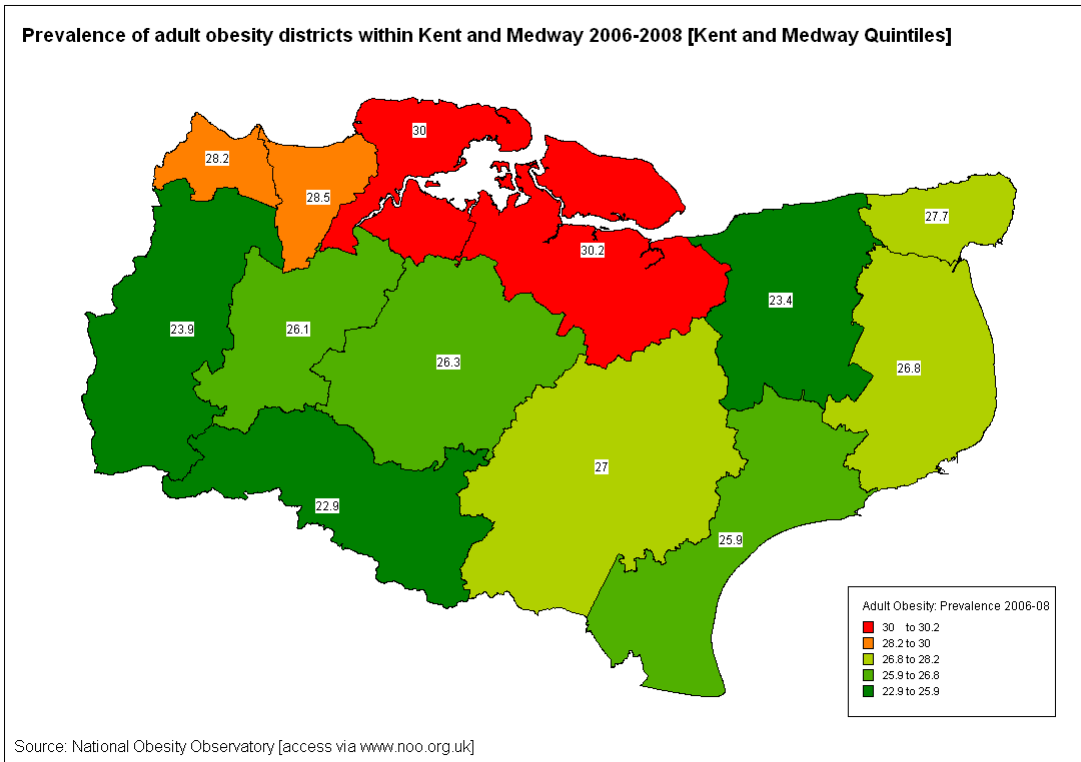
Table 1

Definition	BMI range (kg/m ²)
Underweight	Under 18.5
Normal	18.5 to less than 25
Overweight	25 to less than 30
Obese	30 to less than 40
Obese I	30 to less than 35
Obese II	35 to less than 40
Morbidly obese	40 and over
Overweight including obese	25 and over
Obese including morbidly obese	30 and over

5.4 Prevalence in Kent

5.4.1 **Fig 1** compares prevalence rates for obesity with the rest of England and shows that we have many areas that are showing prevalence rates between 26-30%. **Fig 2** shows the variability with Kent and Medway comparing the districts and showing Swale and Sheppey recording the highest prevalence rates of obesity.

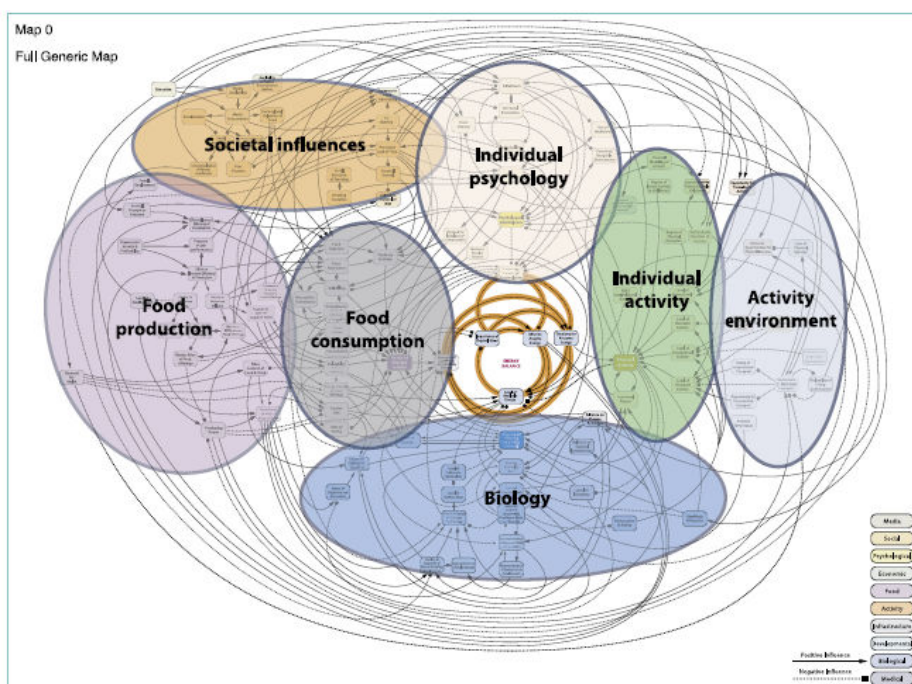




5.5 Obesity: a complex system

5.5.1 The Foresight Report (2009) set out a comprehensive ‘whole systems’ view of the determinants of energy balance that impacts on obesity. The system map, together with scientific and other evidence, confirms that energy balance (or imbalance) is determined by a complex multifaceted system of determinants (causes) where no single influence dominates. Tackling obesity is far from straightforward as Figure 3 illustrates.

5.6 Fig 3: The full obesity system map with thematic clusters



5.7 Cost Burden of Obesity

5.7.1 In Kent the cost of principle diseases relating to obesity is estimated to be in the region of 500 million. If Kent starts to invest in preventing obesity then there will be savings on the impact of this work as obesity plays a major role in the pathologies of so many other diseases.

Area	NHS costs of principle diseases related to obesity (million)
Kent	500.6
Medway	96.4

Source: Foresight, Tackling Obesities Future Choices- Modelling Future Trends in Obesity and the impact on Health 2006. Analysed by DH to local level using national resource allocation formula

5.7.2 Interventions in Kent have to incorporate a population approach to helping people achieve and then maintain a healthy weight but we also need to provide services for those patients that are already morbidly obese and fit NICE criteria for specialist weight management services and surgical procedures.

5.7.3 The Specialised Services National Definition Set (SSNDS) for Morbid Obesity (3rd edition) estimates that the group of patients requiring access to a Specialised Weight Management Service amounts to approximately 120,000 adults nationally. This grouping is derived from a tighter set of criteria than used by NICE and includes all patients with a BMI over 50kg/m² and patients with a BMI over 40kg/m² who have the following co-morbidity (note: this is not an exhaustive list):

- endocrine conditions
- genetic conditions (rare causes of severe obesity)
- organ failure and are being considered for transplantation, e.g. renal, heart awaiting major surgery (with the attendant anaesthetic risk)
- women seeking infertility treatment
- failure with other methods of weight-loss management

5.7.4 For SEC PCTs (assuming an equal distribution to that seen nationally) this represents approximately 10,000 adults and is represented in Table 1.

Table 1: SSNDS 35 population estimates of surgical demand, compared to NICE benchmark prediction of annual presentation at surgical centres

Area	Population(1)	Estimated population derived from thresholds in SSNDS 35	Estimated population derived from NICE criteria (NICE) (2)	Estimated population eligibility and willing (NICE) (3)	Estimated surgical benchmark (NICE 0.01%) (4)
Kent	819,800	3,264	18,200	4,368	82
Medway	552,100	577	12,257	2,942	55
Total				7,310	

Sources:

1. 2009 Population estimates; 2006-based sub national population projections to 2013-Adults
2. 2011 estimated prevalence using NICE 2.22% population
3. NICE CG43 algorithm to determine potential demand, with no assumptions for annual access rates
4. NICE CG43 estimated appropriate annual provision benchmark

5.7.5 We need to understand the complexities associated with behaviour change and weight loss so we can commission a range of comprehensive services that meet the needs of the people that would benefit from maintaining and achieving a healthy weight.

5.7.6 For these reason we need commissioned services using a tiered strategy approach. The tiers are set out below:

Tier 1 is population level interventions whereby people are well motivated and able to access local services with minimal support.

Tier 2 services are a bit more targeted and have a higher level of support and are more prescriptive.

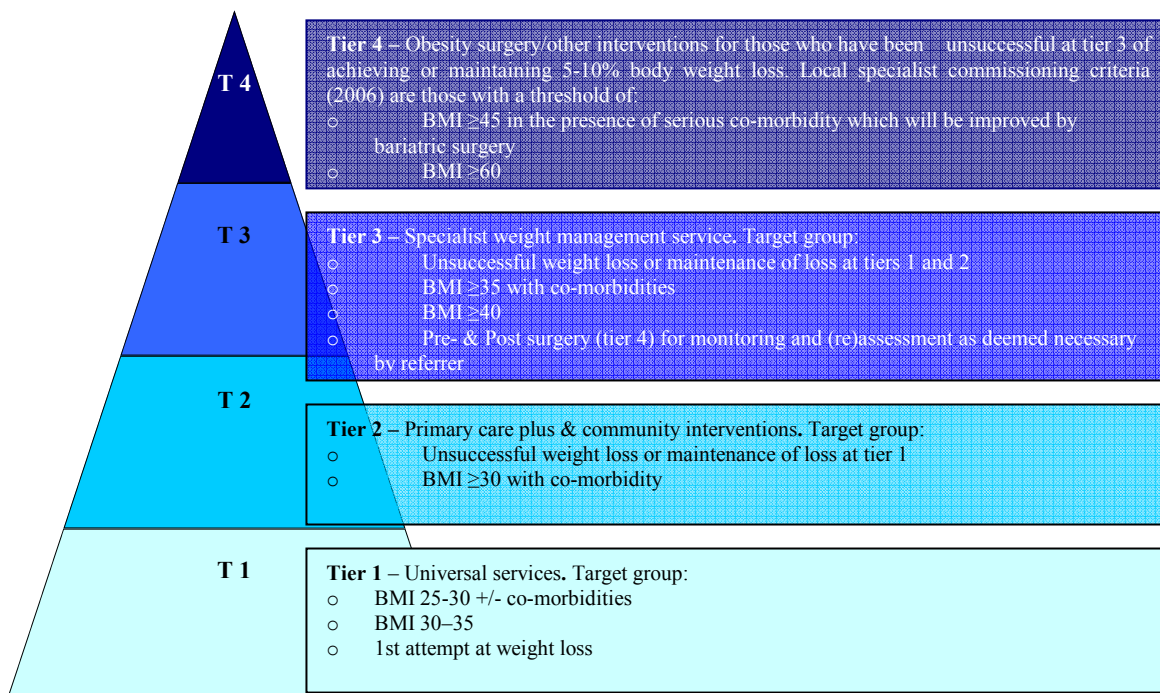
Tier 3 services require specialist practitioners to deliver a multi-disciplinary approach which includes psychological support

Tier 4 are those services that treat patients with surgical intervention

5.7.7 Each Tier requires more comprehensive and intensive strategies to help people adopt changes to their lifestyles and the greater the severity of the problem the longer the support has to be provided at greater cost to the NHS.

5.7.8 Behaviour change and tackling obesity needs interventions that change individual behaviour but we also need to facilitate macro changes which change our living environment to facilitate the behaviour change. Fig 4 sets out the four tiers of intervention that are being developed in Kent.

Figure 4:- Weight management care pathway for adults



5.8 Tier 1 Services

5.8.1 These are universal services that target the population as a whole and assume moderate motivation levels in order to access local service provision. The **ActiveKent** website is designed as a portal to bring a wealth of information together about local opportunities to become more active to enable and encourage the public in general to engage with their environment in a number of ways and is not focused on 'exercise' per se.

5.9 Activekent.co.uk



5.9.1 Behind the ActiveKent website is a plethora of links that drill down to local activities that are updated and maintained on a locality basis.

5.9.2 There are plans to roll out the Healthy Passport Club that was piloted in west Kent and which supports the national Change for Life programme. This offers a range of activities and classes for those who want to make small changes to keep flexible, maintain their mobility, improve their diet or lose weight.

5.10 Tier 2 Services

5.10.1 These services are more targeted and include Primary Care engagement and community interventions. Target groups would include unsuccessful weight loss or maintenance of loss at Tier 1. All of these services are set out within the **ActiveKent** website and are actively promoted through Primary Care. The service also has a free phone help line so that people can be signposted to other services. The Healthy Passport scheme also acts as an entry point to interventions that promote more healthy behaviour. In west Kent adults with a BMI of 30 (or less if they meet certain criteria) can be referred to 12 week weight management programmes commissioned from local authority providers.

Overview of the Healthy Passport Club

- The Healthy Passport Club is a free, virtual club, open to everyone living in West Kent
- Members fill out an application form to join (also available online www.healthyclub.nhs.uk)
- Members receive access to the Healthy Club website and a hard copy 'Travel Pack' – both enable members to set goals, get involved in local activities and monitor their healthy steps with fun tools to capture healthy efforts, such as:
 - Passport (to log healthy eating and exercise activities as steps around the world)
 - Wall charts (to monitor progress against dates)
- Members receive regular information via newsletters, emails and website updates, including:
 - New events/activities in their area
 - Health messages
 - Challenges
 - Discussions and polls



www.activekent.co.uk
Free phone number: 0800 849 4000

NHS
Eastern and Coastal Kent

East Kent Healthy Lifestyle Programmes

Information

<p>Exercise Referral Scheme</p> <ul style="list-style-type: none"> The aim of the referral scheme is to improve the health and well being of inactive clients by encouraging a long term lifestyle change through increasing physical activity levels. We work with local exercise providers to provide an appropriate range of physical activity options, that are safe, effective and of a high quality. 	<ul style="list-style-type: none"> Continues monitoring, evaluation and development of the scheme. <p><small>NB referral must be made through GPH/Health professional</small></p>
<p>Weight Management Scheme</p> <ul style="list-style-type: none"> 1:1 support for people with BMI over 25, aged over 18 Delivered by trained pharmacy assistants 12 sessions over 6 months Optional follow up at 9 and 12 months 	<ul style="list-style-type: none"> Includes a 1:1 appointment with a Dietitian Focuses on healthy eating and physical activity Direct referrals available into Exercise Referral Scheme Programme, available in some GP surgeries, including counselling support
<p>Food and Health</p> <ul style="list-style-type: none"> Health Promotion Practitioner Specialists working across the locality deliver training that supports the implementation of a range of healthy eating projects. This work includes the delivery of Food Facilitator training, a practical course to support facilitators to run cookery clubs and/or food activities in the community. 	<ul style="list-style-type: none"> Cook 4 Life sessions take place in local venues in the community to encourage people to learn practical cooking skills and healthier methods of preparing dishes for family or friends. <p><small>www.rhul.co.uk/hangoff</small></p>
<p>SMOKEFREE</p> <ul style="list-style-type: none"> Did you know that if a patient decides to stop smoking they are 4 times more likely to quit and stay quit using the Eastern and Coastal Stop Smoking Service. Patients can choose a number of ways to help find the best approach for them and we offer advice and support on how to stop and stay stopped. What we can offer... 	<ul style="list-style-type: none"> 7 week support courses Telephone support Drop in clinics Nicotine Replacement therapy One-to-one support Expert advice and coping strategies to help you quit and stay quit. Contact www.eastkenths.uk or text 0300 10 01021
<p>Health Trainers</p> <ul style="list-style-type: none"> Based in community settings in deprived wards, Health Trainers work with people on a 1:1 basis to help them improve their health and wellbeing. Health Trainers are not medically trained but offer motivational support, advice and guidance. This is a FREE and confidential service where people can be seen for up to six sessions and are actively signposted to appropriate professional services. 	<ul style="list-style-type: none"> No need to book, just turn up for a free HealthWalk. Most of the HealthWalks finish with refreshments and a chat. <p><small>www.well.org.uk/about</small></p>
<p>walking with health east kent</p> <ul style="list-style-type: none"> HealthWalks are free, short, volunteer led, local walks aimed at those who wish to be more active. Walks are generally between 45-90 minutes and leave from accessible venues such as libraries and leisure centres. 	<ul style="list-style-type: none"> Includes healthy eating, physical activity and behaviour change techniques. <p><small>www.mendprogramme.org</small></p>
<p>mend</p> <ul style="list-style-type: none"> For overweight/obese children aged between 7 and 13 years old 10 week community, family based initiative. Search for Mend, Gaverus, Nurseries, Do It! 	<ul style="list-style-type: none"> Helping to promote healthy weight Promoting mental health and well being Accident and injury prevention <p><small>For your local Children's Centre, please call the Children and Families Information Service on 08000 32 32 30 or email child@nhs.uk</small></p> <p><small>www.kent.gov.uk/childrenservices</small></p>
<p>Sure Start Children's Centres Kent</p> <ul style="list-style-type: none"> Children's Centres are places that provide information and offer advice and access to services for families with young children aged 0-5 in the local community. Promoting health is one of the core activities in a Children's Centre and may include: <ul style="list-style-type: none"> • Delivering activities that encourage an understanding of the importance of diet and nutrition. • Helping parents to stop smoking 	

Living in West Kent and worried about your own or your child's weight?

Help is at hand!

In partnership with NHS West Kent, your local Council runs a range of healthy weight programmes for adults, young people and families.

If you live in or around any of the following areas, contact your local Council **NOW** to find out more!

Dartford Healthy Living Centre
Healthy Living Team -
t: 01322 311265 e: info@hlc.dartford.co.uk

Gravesham Borough Council
The Gr@nd Healthy Living Centre -
t: 01474 320123
e: healthyweight@gravesham.gov.uk

Maldstone Borough Council
Community Development Team -
t: 01622 602512
e: healthy.living@maidstone.gov.uk

Sevenoaks District Council
Healthy Living Team -
t: 01732 227000
e: healthy.living@sevenoaks.gov.uk

Tonbridge & Malling Borough Council
Healthy Living Co-ordinator -
t: 01732 876155
e: healthy.living@tmbc.gov.uk

Tunbridge Wells Borough Council
Communities & Health Team -
t: 01892 554411
e: health@tunbridgewells.gov.uk

Make the change today to become fitter, healthier and happier!

Making healthier choices easier across West Kent

NHS West Kent

5.11 Tier 3 services

5.11.1 Tier 3 services are specialist services and the target group is:

- Unsuccessful weight loss or maintenance of loss at tiers 1 and 2
- BMI ≥ 35 with co-morbidities
- BMI ≥ 40
- Pre- & Post surgery (tier 4) for monitoring and (re)assessment as deemed necessary by referrer

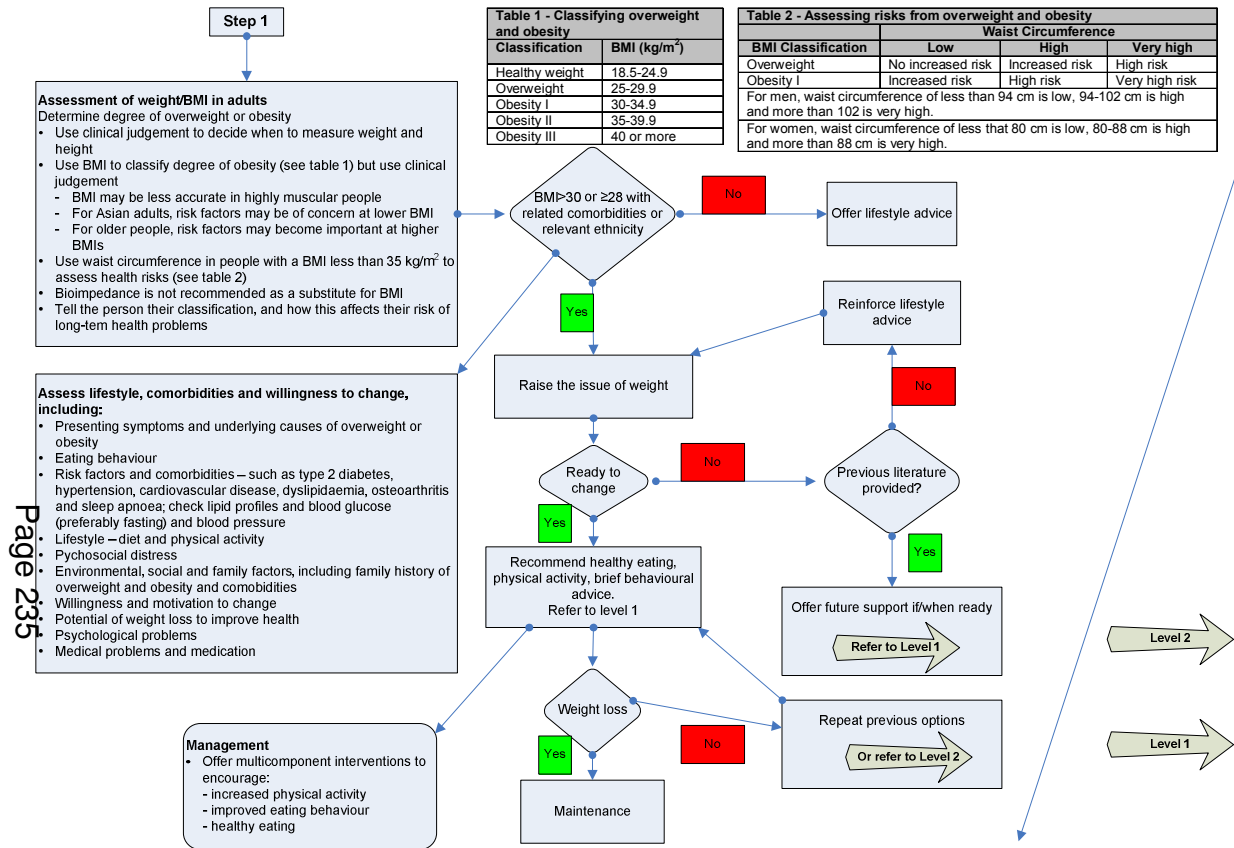
5.11.2 An important component to these specialist services is the psychological support for adults presenting with severe and complex morbid obesity. The service also provides a prevention step for patients to reconsider their decision about proceeding onto a Tier 4 pathway for surgical procedure.

5.12 Tier 4 services

5.12.1 Tier 4 services are obesity surgery/other interventions for those who have been unsuccessful at Tier 3 of achieving or maintaining 5-10% body weight loss. Local specialist commissioning criteria (2006) are those with a threshold of:

- BMI ≥ 45 in the presence of serious co-morbidity which will be improved by bariatric surgery
- BMI ≥ 60

Fig 5 shows the pathway as to how patients are referred through to the different tiers as set out above.



6. Consultation and Communication

6.1 Ongoing process with the Kent population.

7. Risk and Business Continuity Management

7.1 N/A

8. Sustainability Implications

8.1 N/A

9. Conclusion

9.1 If Kent is going to impact on reducing the numbers of people who are overweight/obese, then it is necessary for an industrialised approach to be taken to this issue. This paper outlines the gravity of the situation and the implications it will have on the Kent economy if no action is taken. Recommendations therefore are:

- That the pathway outlined in this paper should be endorsed by the Kent Health and Wellbeing Board;
- That the four tiered approach should be included in Clinical Commissioning Group (CCG) commissioning intentions;
- That the Health and Wellbeing Board should support long term investment in preventative services by all partners in order to reduce obesity related morbidity and therefore secure long term savings for the local economy.

10. Background Documents

10.1 It is a legal requirement to include a reference to all background documents that have been taken into account in preparing the report. Anything that can be classified as 'exempt' or 'confidential' (as defined in Schedule 12A of the Local Government Act 1972) does not have to be listed. For further advice see the attached Appendix Section 1.