



AGENDA

HEALTH AND WELLBEING BOARD (SHADOW)

Wednesday, 21st March, 2012, at 6.30 pm Ask for: **Peter Sass**
Darent Room, Sessions House, County Telephone: **(01622) 694002**
Hall, Maidstone

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 - 18 January 2012 (Pages 1 - 10)
5. Chairman's remarks - the Board's work programme (Oral report)
6. Joint Strategic Needs Assessment (JSNA) (Pages 11 - 156)
 - (a) Update on Progress (Oral report)
 - (b) Community/citizen's engagement plan (Oral report)
7. Health and Wellbeing Strategy: Progress to date and the way forward (Presentation) (Pages 157 - 176)
8. Strategic Overview of NHS and Social Care finance (Presentation)
9. The Principles and Health & Wellbeing Outcomes of Children's Centres (Pages 177 - 204)
10. Dover Health and Wellbeing Board: Progress Report (To follow)
11. Any other business
12. Date of next meeting - Wednesday, 30 May 2012

Peter Sass
Head of Democratic Services
Tuesday, 13 March 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
 - 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
 - David Woodhead - Clinical Lead, Gravesham & Swanley CCG
- 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, 18 January 2012.

PRESENT: Dr B Bowes, Dr M Cantor, Dr S Chaudhuri, Cllr J Cunningham, Mr G K Gibbens, Mr R W Gough, Mr A Ireland, Mr R Kendall, Dr S Lundy, Cllr M Lyons, Ms M Peachey, Dr R Pinnock, Ms A Sutton and Mr C Tomson

IN ATTENDANCE: Mr P D Wickenden (Democratic Services Transition Manager)

UNRESTRICTED ITEMS

20. Welcome

(Item 1)

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

21. Substitutes

(Item 2)

The following apologies were received and noted:

John Allingham
Fiona Armstrong
Andrew Bowles
Paul Carter
Lesley Ingham
Robert Stewart
Jenny Whittle
Mark Worrall

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

(Item 3)

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

23. Previous Minutes/action points - 23 November 2011

(Item 4)

(1) The Board agreed that the Minutes of the meeting held on 23 November 2011 were a correct record and that they be signed by the Chairman subject to minute 13 reflecting that Jenny Bostock was substituting for Dr S Lundy.

Matters arising/ Action Points

Developing Provider Relationships, what does the Health and Wellbeing Board Need?

(2) The Chairman informed the Board of the progress on this issue and the relationship with the Clinical Commissioning Groups (CCGs). Ann Sutton reported on a recent meeting of the Clinical Leadership Group, chaired by Robert Stewart. The Group discussed Long Term Conditions with primary care being the main choice.

(3) It was agreed that Robert Stewart be invited to make this report to the Shadow Health and Wellbeing Board at its next meeting.

24. Structure of the Health and Wellbeing Board

(Item 5)

(1) The Chairman submitted a report inviting the Shadow Health and Wellbeing Board to comment on the development of a robust infrastructure which enables the Board to operate effectively to deliver its designated responsibilities of:

- 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 (CCGs) and the local authority, for public health, meet the priorities identified in the JSNA and the JHWS; and
- Promoting the integration of commissioning of health and social care services.

(2) The 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.

(3) Communicating effectively with patients in Kent and the wider population will be key.

(4) Commissioning will be a key area of activity for the Board to understand and influence. The issue for service commissioning is what degree of integration is necessary to achieve the greatest added value. The report proposed that groups are established for Children and Young People, Older People with a Disability and Mental Health with appropriate Directors and other senior managers from the Primary Care Trust cluster and Kent County Council as well as lead GPs representing CCGs and members as appropriate. Each group will review existing arrangements within their respective area and agree outcomes to be achieved. Each Group will produce a report for the Strategic Oversight Board and CCGs setting out the priorities and how integration can be evaluated. The combined priorities will form the basis of the Joint Health and Wellbeing Strategy.

(5) 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.

(6) The report proposed that an Integrated Commissioning Executive comprising the PCT Cluster Chief Executive, the Corporate Director of Families and Social Care, Kent County Council and their Directors as well as the GPs representing the CCGs is established to oversee the work of the three groups. The Integrated Commissioning Executive will decide where decisions need to be brought; to the CCG Board, KCC Cabinet or the Health and Wellbeing Board.

(7) The report also proposed the establishment of a Health and Commissioning Board to:

- 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 of the framework 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 one integrated structure;
- Ensure effective relationships with the Health and Wellbeing Board, Kent Forum, CCGs, Districts and Kent County Council;
- Review and evaluate the performance of commissioned services; and
- Deliver measurable improvements to health and wellbeing and reduce health inequalities in Kent.

(8) Regular reports from the Health Improvement Commissioning Board will be provided to the Health and Wellbeing Board, Strategic Oversight Board, Kent County Council Clinical Commissioning Groups, Integrated Commissioning, the Kent Forum and the emerging Locality Boards.

(9) Attached as an appendix to these minutes is a proposed structure to support the Health and Wellbeing Board to discharge its commissioning related responsibilities. Meradin Peachey informed the Board that if this infrastructure had the support of the Shadow Health and Wellbeing Board it would streamline some of the infrastructure.

(10) An important issue which remained outstanding that the Board were asked to consider is how the links with the Districts and CCGs would operate at a local level.

(11) During the debate which followed the following themes emerged:-

- The infrastructure should reflect where accountability is best executed
- Guidance is required for all partners around the future direction of Public Health
- Acknowledged that every iteration of the Coalition Government on the creation of the Health and Wellbeing Boards had strengthened the role of the Board

- The Shadow Board acknowledged that the role of the Board was strategic leadership and strategic oversight
- There was an inevitable focus on integrated commissioning and provision
- There was an inherent tension between the County Council, District Councils and partners which needed to be overcome. One of the pre-requisites had to be avoiding duplication.
- The emphasis being placed on Locality Boards would be disruptive for some of the CCGs where there was not co-terminosity with District Council boundaries
- The CCG for the Dover area, Dover District Council and Kent County Council were working well on how they would integrate commissioning – a second facilitated session with representatives of the Department of Health was due to take place shortly
- Concerns were expressed about CCGs capacity to serve the infrastructure in the appendix to these Minutes effectively.
- There had always been tensions around accountability – it should be about local mobilisation to solve problems
- The infrastructure suggested adds to the complexity. Should build on the existing infrastructure. It was about the coming together of willing partners
- There was an opportunity to look at the structure in a more thematic way

(12) The Board resolved that it should think again on the appropriate way forward. The Chairman indicated that that he would welcome Members sharing their views with him on an informal basis.

25. Department of Health Guidance on JSNA & Health & Well Being Strategy (Item 6)

(1) The Shadow Health and Wellbeing Board noted that the Department of Health had published a document explaining the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategies. A copy of the document was attached to the report for the Shadow Boards reference.

(2) The statutory guidance on the development of the Joint Strategic Needs Assessment and the Health and Wellbeing Strategies is due to be published this month following the enactment of the Health and Social Care Bill.

(3) The Department of Health has 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.

(4) The three key messages for Health and Wellbeing Boards were:

- The Board provides an opportunity to build upon 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;
- The Health and Wellbeing 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; and
- 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.

(5) The JSNAs were due for completion by April 2012 which would inform the 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. There was widespread agreement that this timetable should be achieved.

(6) The Chairman drew the Shadow Board's attention to the government's timetable on page 29 of the guidance as well as the important paragraphs on page 41 relating to "Engaging the Public"

"This will not only be the 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".

(7) The Board acknowledged that it was ahead in the preparation of the JSNA. Much more work was needed to get the JSNA as final as possible and acceptable to all the partners. It was important that Meradin Peachey worked with colleagues in the District Councils CCGs PCT and with the Community Engagement Team of the County Council to develop a comprehensive Engagement Strategy

(8) The role of the Patient Participation Groups was emphasised as well as the LINK.

(9) Some of the work which had been used in the successful bid for Healthwatch Pathfinder status would be useful resource.

(10) **The Board resolved** that the resources with expertise within the PCT, County Council and District Councils should ensure that they are working together on a shared engagement strategy which is welcomed support for the Clinical Commissioning Groups.

26. Kent Health and Wellbeing Strategy

(Item 7)

(1) Further to Minute 17 of 2011 the Shadow Board received a draft of the Shadow Health and Wellbeing Strategy. The Shadow Board were enthusiastic in developing the Strategy as soon as possible to adhere to the Governments timetable.

(2) The Board noted that the Public Health Outcomes Framework was expected to be published shortly which would help to inform the Strategy.

(3) It was acknowledged that the Health and Wellbeing Strategy needed to be more readable and “punchy”. It should be a document which the public wanted to read. It needed to be called something else if it was to be picked up and read. The Chairman welcomed suggestions for a new title being sent to him on an informal basis.

(4) **The Board resolved** that the Strategy should continue to be developed through an iterative process to meet the deadline of May 2012.

27. Joint Strategic Needs Assessment (JSNA)

(Item 8)

(1) The Shadow Health and Wellbeing Board discussed the draft Joint Strategic Needs Assessment which would now be the subject of a consultation until the end of March 2012.

(2) In addition to the suggestions already made on the JSNA during the discussion of other items on the agenda Mr Gibbens stressed the importance of the big issues in Kent and how the biggest health gains can be achieved for Kent residents. These were:

- Early Years
- Preventing Long Term Conditions
- The aging population

(3) Several areas of the JSNA needed strengthening including the paragraphs on Dementia and long term conditions. Mr Gibbens also invited the Boards views on how children were addressed in the document especially Children’s Mental Health Services (CAMHS). He said that this was an area of concern for many local authorities across the country.

(4) The view was expressed that there should be more of a focus on assets as opposed to needs and he cited the excellent examples in Kent of telehealth and telecare.

(5) Another view was whilst there had been an improvement in CAMHS over the years the service needs further development. A huge cause for concern was the disintegration of the Health Visiting Service.

(6) The JSNA and Health and Wellbeing Strategy should support the agenda of early intervention and prevention.

(7) **The Board resolved** that the JSNA be brought back to the Board on 21 March following the consultation with partners which would now commence.

28. Pathway for Adult Obesity Services

(Item 9)

(1) The Shadow Health and Wellbeing Board considered a report which set 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) The Shadow Board noted that in Kent the cost of principle diseases related to obesity was estimated to be in the region of £500m.

(3) The recommended a four tiered pathway for obesity services:

- **Tier 1** is population level interventions whereby people are well motivated and able to access local services with minimum support;
- **Tier 2** services are a bit more targeted and have a higher level of support are more prescriptive;
- **Tier 3** services require specialist practitioners to deliver a multi-disciplinary approach which includes psychological support; and
- **Tier 4** are those services that treat patients with surgical intervention.

(4) **The Board resolved** – that the Shadow Health and Wellbeing Board:

- (a) endorse the Pathway set out in sub paragraph 3 above;
- (b) that the four tiered approach be included in the Clinical Commissioning Group (CCG) commissioning intentions; and
- (c) should support long term investment in preventative services by all partners from all in order to reduce obesity related morbidity and therefore secure long term savings for the local economy.

(Footnote: Any organisation who has assets which impact on the public health issue of obesity would be asked to participate).

29. Next Meeting and Proposed Items for Discussion

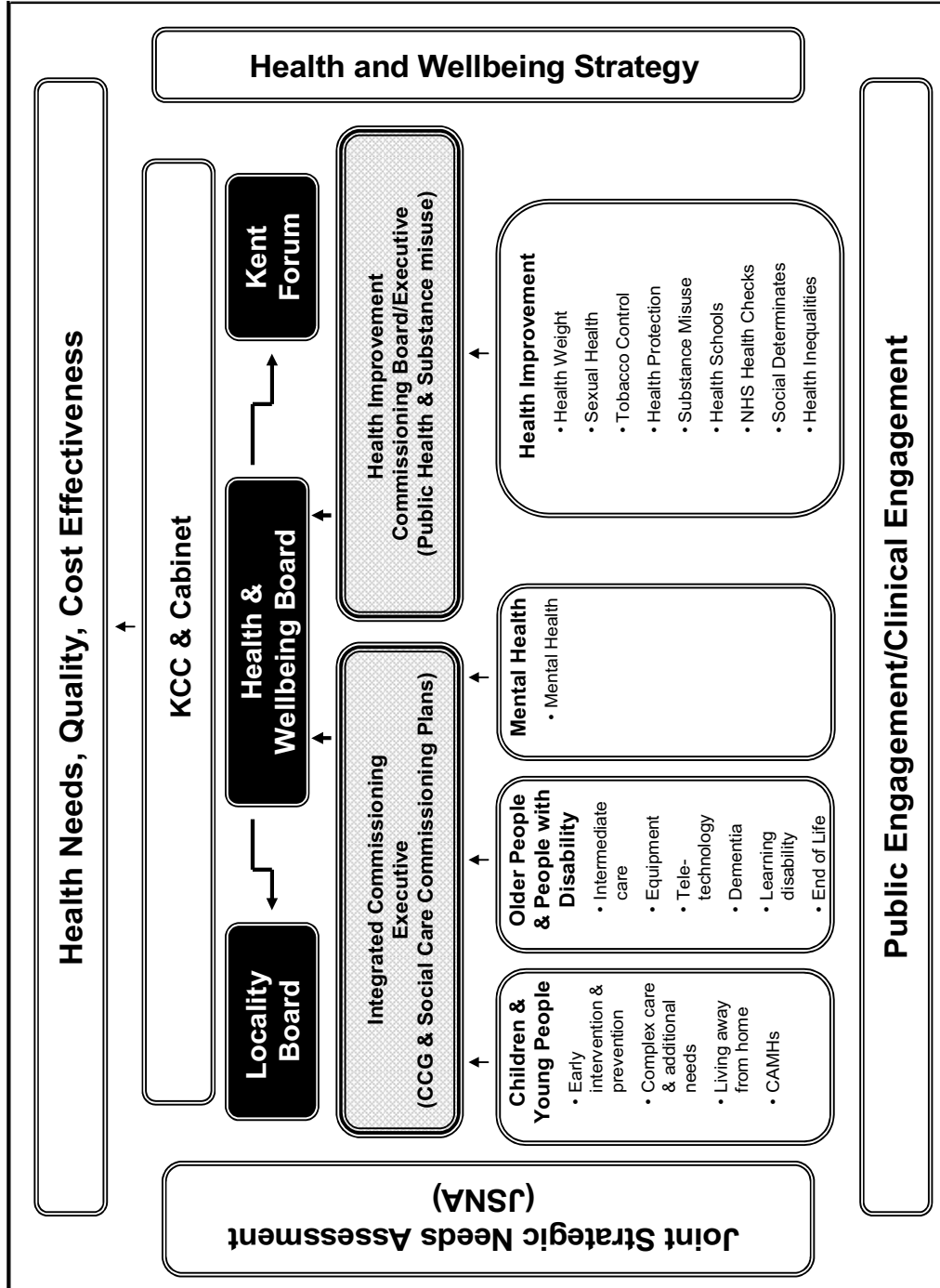
The next meeting of the Shadow Health and Wellbeing Board is scheduled for 21 March 2012. Proposed items for the agenda included:

- Dementia – to be debated in detail
- Children's Centres
- Quality
- Presentation by Robert Stewart on Developing Provider Relationships – using Long Term conditions as an example.

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Structure Chart

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



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Joint Strategic Needs Assessment

2012

Version 12

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1. What is a JSNA and why do we need it?

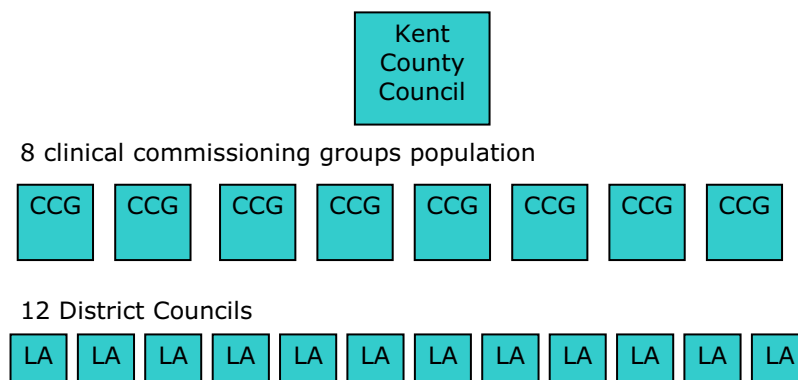
Joint Strategic Needs Assessment (JSNA) is an on-going process by which a range of data, information and analysis about the health and wellbeing of Kent is collated, assessed and compared in order to present an understanding of the issues impacting on the population of Kent.

The Department of Health white paper (2010) entitled 'Healthy lives, Healthy People: Our Strategy for Public Health in England' states that Clinical Commissioning Groups (CCG) and local authorities, including Directors of Public Health, will each have an equal and explicit obligation to prepare the JSNA, and to do so through the arrangements made by the Health and Wellbeing Board. The board will then develop the Joint Health and Wellbeing Strategy (JHWS), based on the assessment of need and recommendations outlined in their JSNA.

The Kent Approach to the JSNA involves the development of a number of products which describe the needs of the population at different levels:

- Kent County Council (of which this document represents)
- 8 Clinical Commissioning Groups (CCGs)
- 12 District Authorities

Figure 1: JSNA 1 plus 8 plus 12



This document summarise the needs at the Kent County level, with brief descriptions at CCG and District Authority level.

The key objectives for producing a JSNA are:

- 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

2. Who should use the JSNA?

The JSNA will be a valuable tool for:

- Kent County Council
- District Authorities
- Clinical Commissioning Groups
- Providers of health and social care

Why is it relevant for Kent County Council

The JSNA supports and underpins implementation of Kent County Council's overarching plan, Bold Steps for Kent.

- To help the Kent economy grow
- To put the citizen in control
- To tackle disadvantage

It also supports development of a more effective and responsive local health and care system, shared understanding and shared ownership leading to agreement of priorities and collective action. Some examples of the economic

development in Kent involves programmes such as the building of the ‘Turner Contemporary’ in Margate, minimising the impact of Pfizer moving away from its Sandwich site, stimulating employment and influencing the local people’s health and wellbeing.

Why is it relevant for district authorities?

District Authorities have a key primary prevention role in minimising the effect of poor housing, poor environment, [e.g. noise, air and water pollution] and transport (for example road safety measures to reduce accidents) all of which have an impact on health and social care outcomes.

District authorities also 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 for Clinical Commissioning Groups?

CCGs as commissioners can transform quality, clinical and cost effectiveness of health services, and make the shift to out of hospital care.

General Practitioners are the first and critical 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. For example, case finding (of people at risk of heart disease, stroke, diabetes and chronic kidney disease) through NHS Health Checks will result in people being identified earlier and treated sooner, reducing the risk of ill health and death associated with late diagnosis. Brief interventions for smoking, alcohol

and healthy weight will reduce the number of people with long term conditions.

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 into the four acute trusts across Kent and Medway indicate up to 9% of admissions could have been prevented had they accessed the appropriate existing services in the community. In 52% of admissions, no acute care (for which a hospital bed is required) was provided on the day of care that was reviewed for each admission.

This emphasises the importance of various health and social care providers to collaborate and function as integrated teams to deliver more proactive approach to patient care, utilising hospital services more economically. For example, The Kings Fund (2011) suggests GPs working along side specialists focusing 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.

3. History of Kent County JSNA

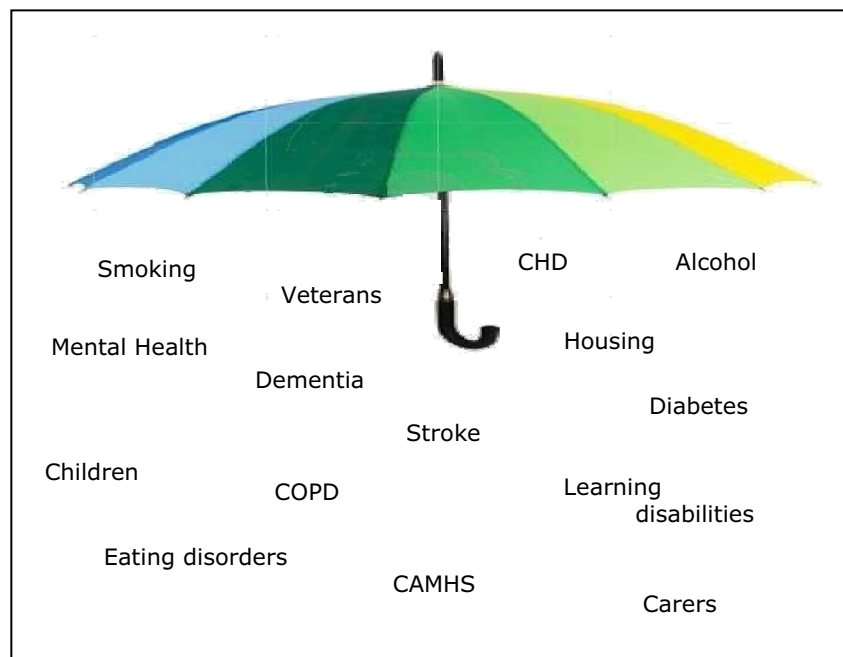
A JSNA has been produced in Kent since 2006, broadly divided into two documents, adults and children, both updated in July and December 2011 respectively.

The JSNA includes many health needs assessments which are undertaken each 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. These have been developed and summarised in a standardised format available on the Kent and Medway Public Health Observatory Website www.kmpho.nhs.uk/jsna. In addition, key population indicators are also presented in (District Authority based) Health and Social Care Maps across 8 themes (www.kmpho.nhs.uk/homepage/health-and-social-care-maps)

Figure 2 details some of the needs assessments that have been recently undertaken.

Figure 2: JSNA as an umbrella of Needs Assessments



Engaging the public in the JSNA

Users, voluntary sector and carers views are sought as part of the gathering of data in all needs assessments. There has been considerable input from carers in the carers needs assessment and mental health users in the mental health needs assessment.

The commissioning document that followed the JSNA process for mental health is the 'Live it Well' strategy for Kent and Medway <http://www.liveitwell.org.uk/>. This was developed with extensive involvement of local people and service users in particular. A number of methods of involvement were used from engaging with service users via the local planning meetings and in invited workshops. All the key issues the service users highlighted are reflected in this strategy, notably better outcomes for people needing dual diagnosis services and better mental health treatment for offenders.

Quality Innovation Productivity and Prevention (QIPP)

QIPP is a large scale transformational programme for the NHS and other provider organisations to improve the quality of care the NHS delivers whilst making up to £20 billion of efficiency savings by 2014-15 to be reinvested in frontline care. The Kent and Medway Integrated Plan Board has developed plans to address the quality and productivity challenge across a number workstreams for example urgent care, end of life and dementia. As of February 2011, 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 over time. 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 above mentioned Utilization Review of hospital admissions represents a unique opportunity to benchmark appropriate acute care. The results suggests further efficiencies to our health and social care system can be made, and is expected to contribute towards the ongoing discussions between the Integrated Plan Board, CCGs and Health and Social Care Providers around shifting resources into community and social services, raising standards of general practice promoting early intervention and self-care.

4. JSNA for CCGs

Individual demographic and health profiles for CCGs are currently under development to support development of commissioning intentions. 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. A recently completed health profile for Ashford CCG can be accessed from www.kmpho.nhs.uk. Appendix A summarises key health and demographic indicators for all 8 CCGs.

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

National policy emphasises a life course approach towards improving health inequalities and health and wellbeing, where a combination of health, social and economic factors affect people's health outcomes at different periods in their lives. In Kent, a number of priorities have been suggested orientated around three main areas:

1. Early Years

Improving the continuation (and recording) of breastfeeding rates beyond six weeks.

- There is no doubt over the benefits of breastfeeding towards health and wellbeing of children. However breastfeeding is not being sustained into the early months of infancy for a large number of children. The rates of breastfeeding in Kent drop from around 70% at birth to 25% at six months of age.
- 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.

- The 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)
- 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.

Using Children Centres more effectively to deliver integrated services to vulnerable high risk families

This includes services such as health visitors delivering messages around health promotion and behaviour change such as reduction of second hand smoke, alcohol and substance abuse, domestic violence and improving healthy weight and mental wellbeing.

2. Young People and Lifestyle choices

The numbers of young people drinking responsibly has increased in Kent as it has nationally, and fewer children drink. However the small number of young people who do drink at increasing risk or higher risk levels and those who regularly binge drink are likely to be drinking more hazardously. 11% of 11-16s in the Kent Children's *Smoking Drinking and Drugs* survey (2008) indicated that they did drink alcohol most days or once or twice a week. They are also likely to be from a more vulnerable group of young people. In the same way, although most children will not misuse drugs, and most of those young people who do experiment will not continue to do so, these more vulnerable young people are more likely to continue in dangerous drug use.

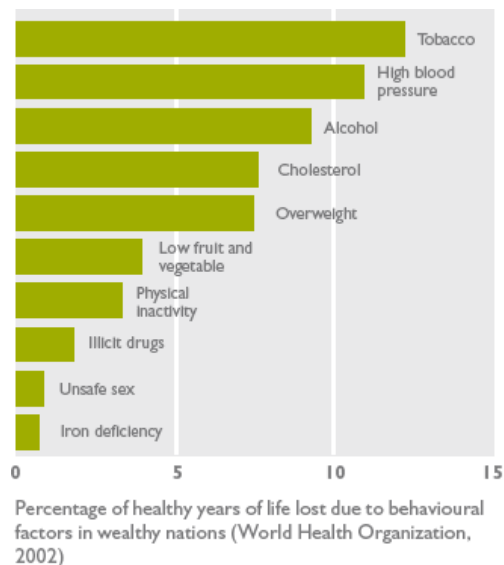
This small group of young people in Kent are likely to have multiple risk factors such as parental substance misuse, family breakdown, domestic violence, poverty, truancy or school exclusion. They show significant levels of poor physical and mental health as well as poor sexual health and substance misuse issues. They are often disengaged from school as a result of behavioural issues, and are more likely to be 'Looked after Children' or known to the Youth Offending Service. The more vulnerable the young person is, i.e. the more risk factors they have: the more likely it is that the child will misuse drugs, alcohol and tobacco.

Young people benefit from life skills approaches to early intervention. They need to be engaged in learning and in school: and positively engaged in

activity to build resilience over time through developing friendships, life skills and positive social peer networks. Positive relationships with adults in specialist services who understand the needs of young people and adolescent behaviours like substance misuse and risking sexual health are also needed. Currently, there are specialist services commissioned to tackle young people’s substance misuse needs, and this includes understanding the dangers and consequences of a range of risk-taking behaviours. The DUST screening tool is promoted to identify those who need help, and further work is being developed in 2012 to support those families and young people in greatest need in Kent and help them to tackle their problems.

3. Prevention

Figure 3: Percentage of health years of life lost due to behavioural factors in wealthy nations.



Cabinet Office (2010) Applying behavioural insight to health

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

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

pressure and alcohol contribute to the largest proportion of healthy years life lost [Figure 3]. Therefore, people, who are at future risk, need to be identified early enough and their lifestyle and behaviour should be modified accordingly through self management, supported by social marketing campaigns such as Change 4 Life and integrated frontline services such as Stop Smoking, IBA (Alcohol), and Healthy Weight. Therefore, the rollout of the national Health Checks programme across Kent needs to be accelerated across the county and a specific focus on keys areas such as Thanet and Swale.

Change4Life three year social marketing strategy

In just three years, Change4Life has become one of the most instantly recognisable brands in health improvement, enjoying high levels of trust and involvement, not only from the public, but from healthcare professionals, staff in schools and early years' settings, local authorities, community leaders, charities and businesses.

The first year of Change4Life in 2009 was successful, awareness of the brand built rapidly and attitudes towards it were (and remain) very positive. Over 400,000 families joined Change4Life in its first year and over 1 million mothers claimed to have made changes to their children's behaviours as a direct result of Change4Life

Tesco club card research analysing the purchases of 10,000 Change4Life families has shown early signs of positive behaviour change in food purchasing patterns and that the campaign is resonating with and attracting the intended target audience (DH 2010)

Locally NHS West Kent developed – the **Change 4 Life (C4L) – Healthy Passport Club**, a locally designed social marketing campaign to promote the Department of Health 'Change4life' programme since April 2011. The aim of the club is to promote the national C4L messages of healthy living, diet and exercise. The campaign has set out to build a supportive environment, provide tools for people to set goals, record achievements and provide motivational support in a fun way.

To date more than 14,000 people from all walks of life have joined the club, a significant proportion encouraged by GPs. All the activities undertaken by those involved are recorded as steps around the world; currently this stands at 10,562,491 steps or 5,300 miles.

As this campaign has been so successful in west Kent it has been agreed that it should be rolled out across Kent.

4. The Shift to Out of Hospital Care

The population of Kent in the older age group (65+ and 85+) is predicted to increase significantly over the next 5 to 10 years. This is a demographic bubble leading to disproportionate numbers of older folk in our population. It is just emerging now and expected to persist for the next 25 years or so. This bubble along with the changing nature of longevity and health deterioration, has led us to consider major changes to the way the health and social care system work.

The system we operate comprises myriad silos of care, with inherently high levels of referral out of one and back to another. There is limited coordination and integration between them. The environment is such that, these transfers from one isolated part of the system to another, almost occur by default for reasons of infrastructure and culture. For example after hours care providers do not usually have access to information from the patient record, other providers who may need to make decisions in isolation e.g. community matrons, may be similarly disconnected from the central primary care information store. As a result, emergency admissions in the elderly for falls and dementia 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 elderly 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.

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.

In NHS Blackpool, risk profiling was used to target resources more effectively to reduce unplanned care activity, using the combined predictive model. Approximate annual spend is around £26 million per year and makes up 65% of occupied bed days. The model used primary care and hospital data, (inpatient, outpatient and A&E data). The initial results showed that out of the 150,000 population in Blackpool approximately 765 patients were identified as very high risk generating more than 2,639 unplanned admissions in the previous year and the admissions avoided (323) if the necessary clinical intervention was delivered, generating £586,000 in gross savings. Apart from the benefits of identifying very high risk patients the tool enables access to real-time clinical patient data and prioritisation of community matron workload.

Nuffield Trust (2011)

Information sharing

The successful delivery and evaluation of programmes will depend on developing more robust arrangements for sharing information between health and social care organisations. For example use of an identifier such as NHS number will help to understand how patients access services across the continuum of care.

Care for older people in Torbay

Care for older people in Torbay is delivered through integrated teams of health and social care staff, first established on a pilot basis in 2004 and since extended throughout the area. Each team serves a locality of between 25,000 and 40,000 people and is aligned with the general practices in the locality. Budgets are pooled and used flexibly by teams who are able to arrange and fund services to meet the specific needs of older people. A major priority has been to increase spending on intermediate care services that enable older people to be supported at home and help avoid inappropriate hospital admissions. The work of integrated teams has been taken forward through the work of the Torbay Care Trust, created in 2005. Results include a reduction in the daily average number of occupied beds from 750 in 1998/9 to 502 in 2009/10, emergency bed day use in the population aged 65 and over that is the lowest in the region, and negligible delayed transfers of care. Since 2007/8, Torbay Care Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes, with a corresponding increase in home care services targeted at prevention and low-level support.

Chronic care management in Wales

In Wales, three Chronic Care Management Demonstrators in Carmarthenshire, Cardiff and Gwynedd Local Health Boards pioneered strategies to co-ordinate care for people with multiple chronic illness. By employing a 'shared care' model of working between primary, secondary and social care – and investing in multidisciplinary teams – the three demonstrators report a reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent respectively between 2007 and 2009. This represented an overall cost reduction of £2,224,201.

Nuffield Trust (2012)

6 Key Highlights and Recommendations

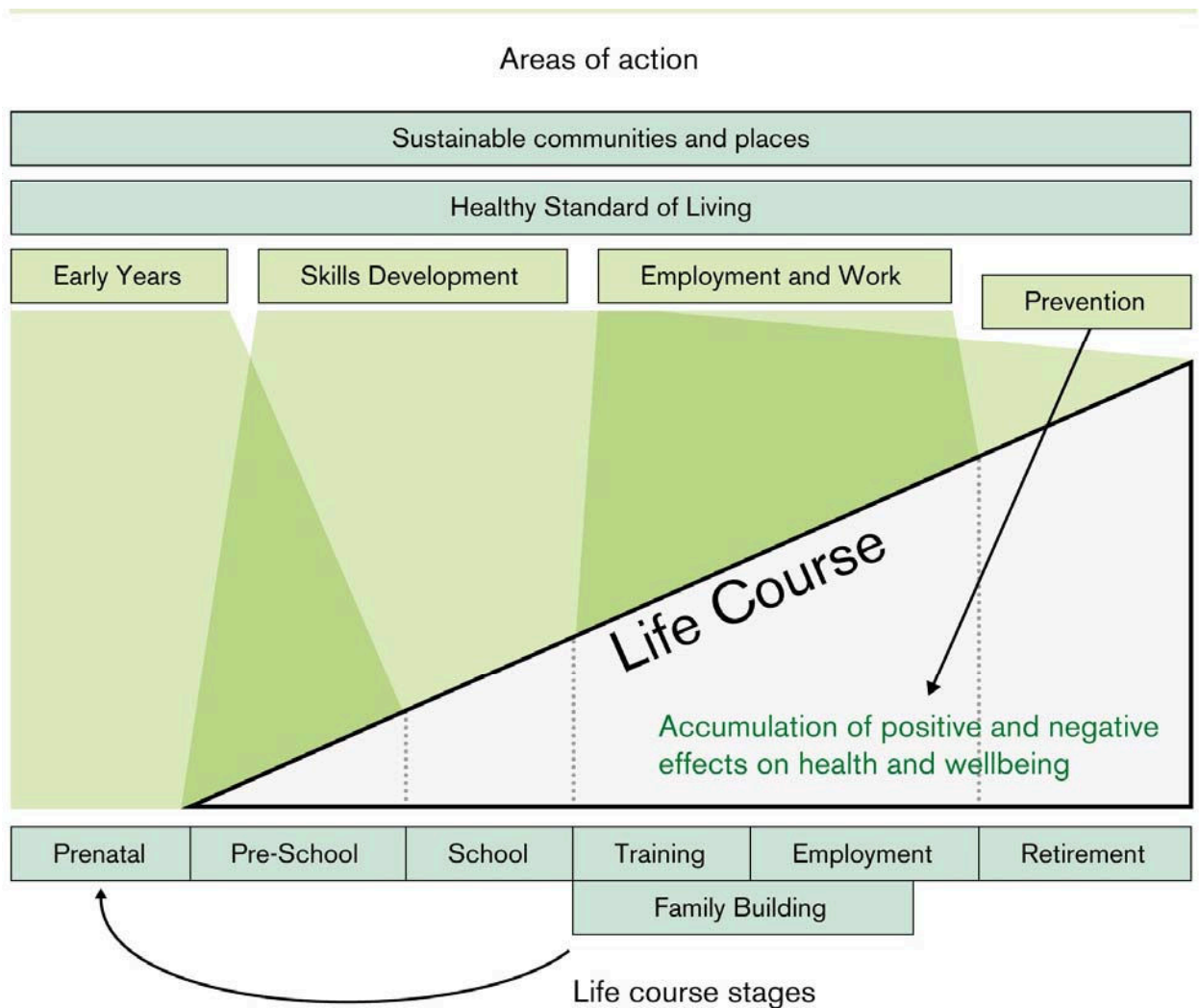
The following section provides highlights and recommendations from the needs assessments that have been undertaken across Kent. From these needs assessments underlying themes and issues have been identified as factors most important to Kent to reduce health inequalities, improve health and wellbeing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

6.1 Health Inequalities

The Strategic Review of Health Inequalities in England post 2010 ([Marmot - Fair Society Healthy Lives](#)) states “that people with higher socio-economic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the ‘real’ concerns with health – health care and unhealthy behaviours – it should become the main focus”.

Figure 4 describes a person’s life course from cradle to grave implying a variety of factors which may influence a person’s health and wellbeing at various life stages which ultimately lead to health inequalities at a population level. The Marmot framework also proposes that these influences accumulate across our lives. Some influences are protective and others prevent risks. Where risk outweighs protective factors, chronic disease, disability and mortality begin manifesting from around age 50. This highlights the importance that no one solution at a particular stage can have a definitive impact of health inequalities and therefore a multi agency approach across all stages is required.

Figure 4: Life course diagram



The Marmot Review also emphasises creating the necessary conditions for people to take control over their lives that will influence their health and wellbeing. The following six key policy areas where work needs to be undertaken to reduce health inequalities:

- 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 a healthy standard of living for all
- Create and develop health and sustainable place and communities
- Strengthen the role and impact of ill health prevention

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 (Appendix B), interspersed with some localised areas of high affluence. The more consistently affluent parts of the county are to be found in the south west quarter of Kent.

There has been an improvement in life expectancy for the intermediate quintiles¹ 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 contribute 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 five 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 three years.

¹ Quintile – divides the population into 5 equal parts – 20%

Table 1: 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

Latest results published in 2011 indicate that for five out of 10 social determinant and health outcome indicators, Kent County performed significantly better than the England average (shown as green in table 1) such as, male and female life expectancy, child development at age five, young people in education, employment or training and households in receipt of benefits however this masks major disparities across the County. The remaining five indicators were not significantly different from the England average (Department of Health and Association of Public Health Observatories (APHO 2011)). The APHO Health Profile for Kent (Appendix F) highlights six areas where improvements are required:

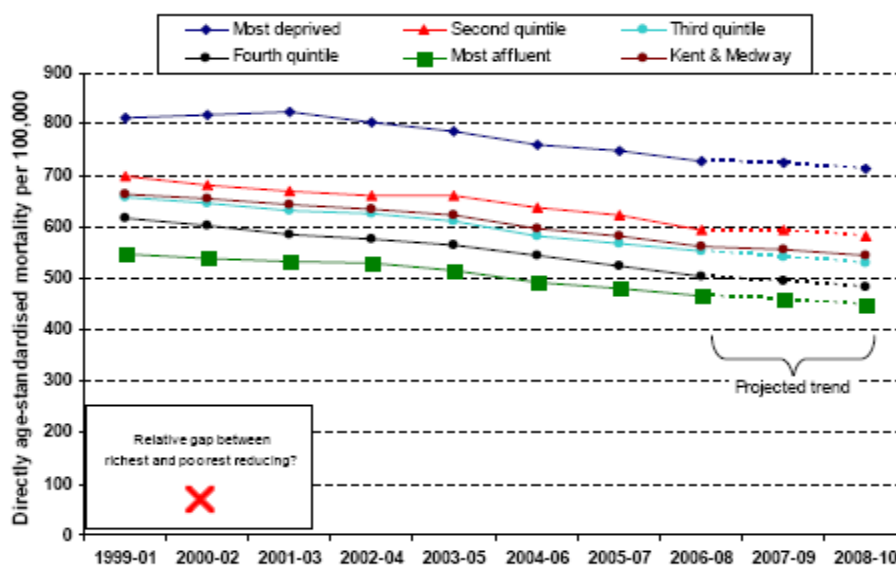
- Smoking in pregnancy

- Breastfeeding initiation
- Physically active children,
- Healthy eating in adults
- Adult obesity
- Hospital stays for self harm

Cancer survival rates have improved, particularly 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 have improved for all socio-economic groups across Kent (Figure 5). 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.

Figure 5: Trend in all age all cause mortality rate 3 year rolling averages Kent and Medway



Source: Trends in Health Inequalities in Kent and Medway 2010

Recommendations

- To map where inequalities have improved in Kent and the possible contributing factors
- To map where inequalities have not improved and the contributing factors and action needed
- To map performance in Kent against the Marmot life course approach

6.2 Lifestyles

6.2.1 Smoking

- In Kent, approximately 10,000 hospital 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. This is expected to reduce in future in line with the downward trend nationally. These are 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 supports 2.2% of the local smoking population. A target has been set to increase this to 5% or approximately 14,000 smokers.

Recommendations

- Further emphasis is required to concentrate on vulnerable and at risk groups such as young people (especially 20-24 yrs old where prevalence is as high as 32%), pregnant women (as identified in the latest APHO Health Profile for Kent), those with chronic mental illness and prisoners.

6.2.2 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.

National Obesity Toolkit

- 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.

Recommendations

- A life course approach (as suggested by Marmot) incorporated within an integrated service model for healthy weight achievement and maintenance is imperative for success. This ranges from antenatal programmes, breastfeeding, healthy schools, to Change 4 Life, adult weight management, and specialist services. 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.
- Consequently, Kent is developing the service model offering four levels of service which range from a population approach to maintaining and

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

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

6.2.3 Health Checks

- NHS Health Check Is a national primary prevention programme to assess an individual's risk of heart disease, Stroke, Diabetes and Chronic Kidney Disease.
- It is a check that is offered every five years for people age 40 to 74 years which consists of face to face individual risk assessment followed by advice and appropriate management.
- The South East Coast Strategic Health Authority has agreed a target of 20% (> 90,000) of the Kent population are to be offered a NHS Health check for 2012/13.
- **Commissioners** need to monitor the uptake of health checks across the county to ensure provision is equitable. **Clinical commissioning groups** need to develop models of health check provision that are appropriate for the populations that they are responsible for. This will involve working with a wide variety of providers such as Public Health, Kent Community Health Trust, GP practices local authority providers and voluntary sector providers to ensure services are accessible for all. Once the programme is fully operational it will be necessary for **Public Health** to determine whether

there are sufficient lifestyle services across Kent to support those identified as requiring intervention due to their risk.

Benefits of Health Checks

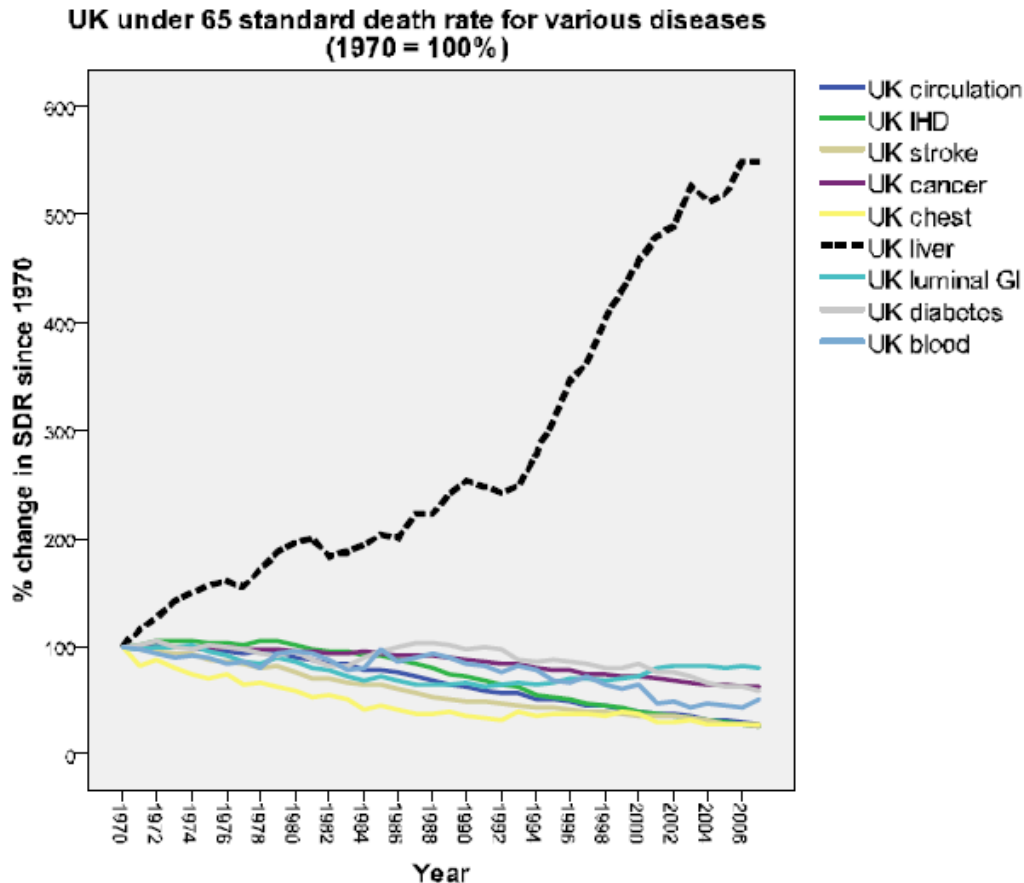
In Kent, for every 100 people between 40-74 years offered a NHS health check, 42 people will be expected to take up the offer². Just under half (48%) will be diagnosed with a disease and require anti-hypertensives and statins. This programme will save 1,870 quality adjusted life years (QALYs), resulting in averting 29 strokes, 22 heart attacks, prevent between 303 and 382 from getting diabetes and chronic kidney disease per year over the first 4 years³.

6.2.4 Alcohol & Substance misuse

- The rates of drug misuse related admissions have fluctuated over the last 5 years roughly equating to 210 admissions per year in Kent.
- Recent analysis suggests that despite the large increase in numbers in treatment, there are an estimated 1,786 Problem Drug Users who have not been in contact with structured treatment in the past two years.
- There are also well-recognised and serious consequences for the children of problem drug users, including the risk of abuse or neglect and the disruption of family life. Across communities and society as a whole, the negative impact of drug use includes increased levels of crime, prostitution and sexually transmitted infections the health risks posed by used needles discarded in public places; and the costs associated with healthcare, police time and the prison service (SEPHO, 2006)
- 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 [Figure 3 pg 12].

² Based on data from Medway where the programme has been in operation for longer than Kent

³ Based on DH modelling [Economic modelling for vascular checks \(PDF, 1023K\)](#) - April 2008



- In Kent, there were 12,082 admissions to hospital through A&E for alcohol-related⁴ conditions in 2007-08, up from 5,713 in 2002-03, and these are predicted to rise even further, similar to national trends.
- In West Kent alone, there were 258 admissions to hospital for alcohol-specific conditions in 2010-2011, at an average cost of £2,643.50 per spell totalling £682,025.
- 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).

⁴ Alcohol related conditions include accidental falls and conditions such as heart disease and stroke, where alcohol isn't directly attributable to the condition but is associated with it. Alcohol specific there are 13 conditions a list if these is available from http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf

- 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.
- The evidence is clear that investing in alcohol services for all problem drinkers saves money and improves health outcomes. Indeed, for every £1 invested in specialist alcohol treatment, £5 is saved on health, welfare and crime costs. (National Treatment agency 2006)
- Good, responsive treatment 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

Drug treatment is cost-effective and has been shown to deliver significant benefits for society in terms of reduced crime and associated healthcare costs as dual diagnosis, co-morbidity, mental health disorders and social problems are common in people who misuse drugs. There is a continuing need for investment in drug treatment services in Kent to ensure ongoing delivery of these benefits. Service re-design to improve post-treatment support and wraparound provision in a full recovery model is central to the re-tender process for drug and alcohol services that is currently taking place.

In Kent, a target to identify and treat at least 10% of dependent drinkers, increasing to 20% over the next two years is needed. This reflects guidance given in *Signs for Improvement – commissioning intentions to reduce Alcohol-related Harm* (Department of Health, 2009). It is reiterated in NICE guidance: [Alcohol-use disorders: preventing the development of hazardous and harmful drinking](#) which recommends commissioners should ensure at least one in seven dependent drinkers can get treatment locally. A reduction of 10% in alcohol-specific admissions would realise a saving of £68,203 in west Kent alone, and this should be matched by similar savings in east Kent.

There are an estimated 259,100 increasing and higher risk drinkers in Kent, with an 8.5% likelihood of alcohol-related admission at an average cost of £1,824⁵. To treat 10% (25,910) of the treatable population through Identification and Brief Advice (IBA), 103,640 IBAs need to be delivered. One in eight interventions will be immediately successful, reducing the risk of alcohol-related admission of 3,329 patients to zero, i.e. a saving of 275.3 admissions. This would generate a full-year cost saving of £502,147 across Kent. There is an additional duration of IBA effect which adds to this saving by a further 50% in the following year⁶

Large numbers of IBA can be delivered through the industrialisation and expansion of standardised IBA services using the AUDIT-C tool across all settings, from primary care to tertiary care, for example in-reach into acute wards and Accident and Emergency. Links should be made into mental health services (including for complex and dual diagnosis patients) at all levels including primary care psychological services. Expansion of IBA services should strategically fit within other existing frontline services in GP Practices, Community Nursing and Community Pharmacy, for example routine use of the AUDIT-C questionnaire in Health Checks: sexual health services and embedded in other relevant care pathways e.g. Liver disease, cancer.

Non-NHS services such as Community Wardens, police and probation staff can also play an important role in IBA service provision, with adequate training and help through social marketing campaigns in the media. In addition, strict enforcement of the ban on sales of alcohol and tobacco products to under-18s is still needed. This will need to include work on preventing proxy sales.

⁵ Moriarty *et al.* 2010. *Alcohol-related Disease – Meeting the challenge of improved quality of care and better use of resources*

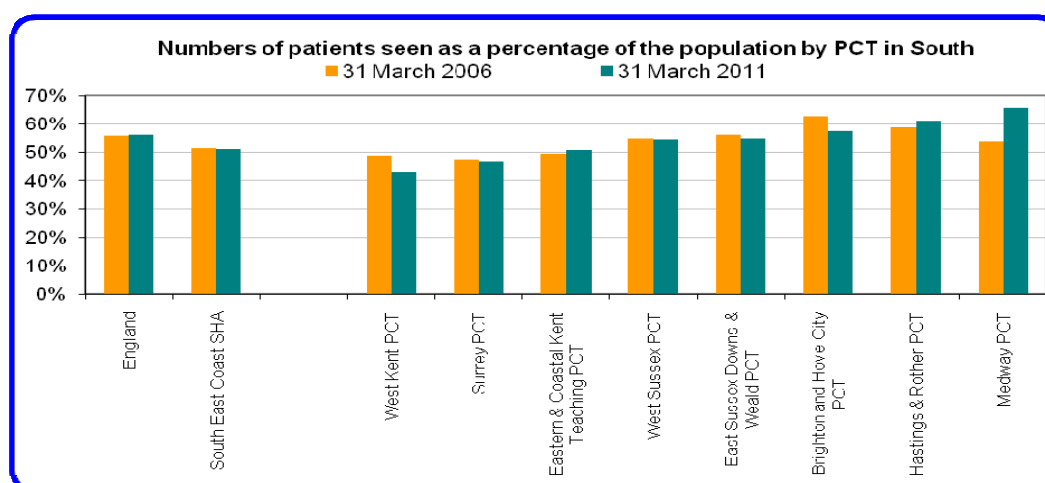
⁶ Additional duration of IBA effect decays linearly to zero over three years, see Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L. B., Stauffacher, E. A., Barry, K. L. 2002. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcoholism: Clinical & Experimental Research*, vol. 26, no. 1, pp. 36-43.

6.2.5 Dental Health

Adults

- Twenty percent of adults in South East Coast have active tooth decay and 25% of older adults have severe gum disease.
- A significant 7%, compared to 10% for England, reported experiencing pain from their teeth or gums at the time of the 2009/10 survey. Extrapolating this to the Kent adult population suggests that some 79,400⁷ adults are experiencing current dental 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 (UDA) per west Kent resident to 1.9 UDA per Medway resident. Figure 6 shows a decline in patients accessing dental services in west Kent compared to an marginal increase in east Kent over the last five years (45% and 50% in 2011 respectively)

Figure 6: Number of patients seen as a percentage of the population by PCT



- 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.

⁷ Based on ONS 2010 Mid Year Population Estimate 18 years and over for Kent

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 and level of DMFT across Kent are clearly evident, particularly in Thanet and Shepway.

Recommendations

Adults

- Promote orientation of primary care dental services to focus on prevention in line with **Delivering Better Oral Health – a toolkit for prevention**(Department of Health, 2009)
- Improving uptake of services by local residents through ensuring availability of accessible services and provision of information to support uptake
- Improving access to specialist services
- Promote development of an appropriate skills-mix workforce in order to meet the dental needs of the population effectively and efficiently
- Commission specialist sedation and domiciliary services according to local need
- Develop oral health promotion initiatives for the elderly and other vulnerable adult groups
- Robust, annual monitoring and evaluation of dental practices

Children

- Undertake a census survey of dental health of 5-year-olds
- Undertake a census survey of dental health of 3-year-olds

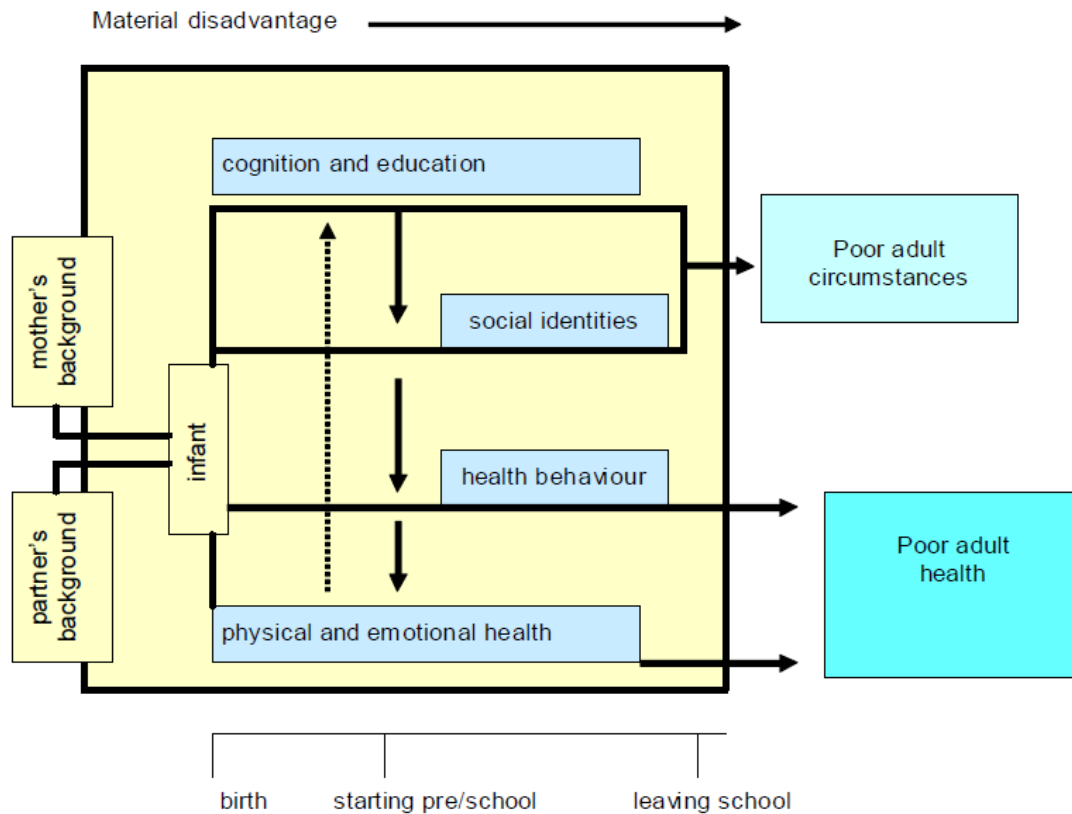
- Promote a coordinated approach to the control of tooth decay through evidence-based oral health promotion interventions
- Promote orientation of primary care dental services to focus on prevention in line with **Delivering Better Oral Health – a toolkit for prevention**(Department of Health, 2009)
- Promote regular dental visits for prevention
- Promote development of an appropriate skills-mix workforce in order to meet the dental needs of the population effectively and efficiently

6.3 Children

6.3.1 Early years

- The life course framework [Figure 7] puts the focus on childhood disadvantage, from before birth and throughout childhood (large box). 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. Whilst not providing a complete explanation of health inequalities in later life, the life course model highlights the crucial effects of early years, childhood and adolescence on good health. It also demonstrates that specialist services focusing on the risks to health during childhood need to be safeguarded.

Figure 7: Childhood disadvantage and adult health: a life course approach



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

The economic costs of not acting effectively in childhood are unsustainable. Whilst currently the sum of £40 per child is spent annually on universal health services in the UK, the cost of maintaining a child in the criminal justice system is £300,000 per annum. The required inter-agency effort and work need advocacy, leadership and participation of a multi-disciplinary force for child public health so as to ensure educational achievement, income security, employment opportunities, access to material resources and the chance to develop resilience and capabilities for individual and societal sustainability.

Heckman (2006)

Recommendations

- The Healthy Child Programme is fully evidence based and is structured according to the principles of progressive universalism. It must be led by health visitors and delivered by a range of practitioners across the health

service and wider children's workforce. The use of children's centres in this regard is important as demonstrated in the following examples.

- Targeted programmes such as the needs-led more intensive focus of health visitor practise and also the Family Nurse Partnership programme, must be provided to children and families at risk of poorer health outcomes. Programmes to improve parent/child attachment such as the Solihull approach, should also be employed where professionally judged to be appropriate within the overall Healthy Child Programme
- Children's centres have a key role to provide a location around which the Healthy 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

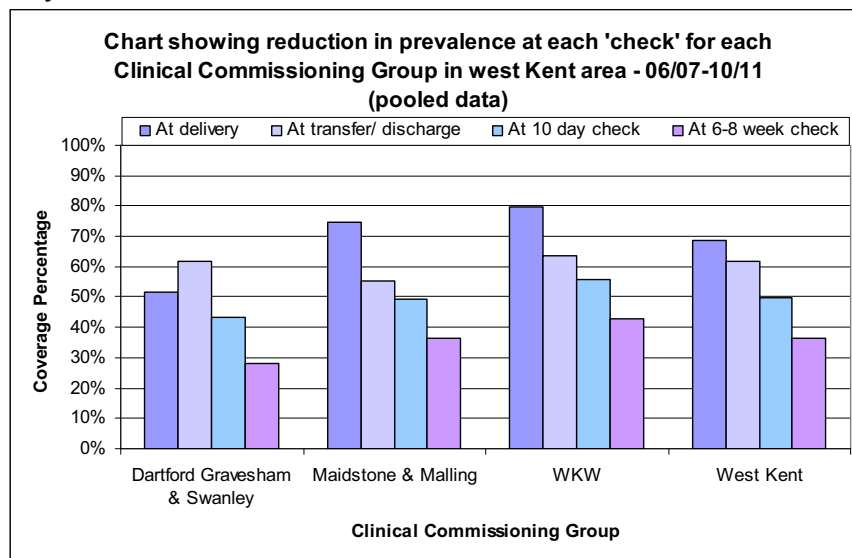
6.3.2 Breastfeeding

- The World Health Organisation (WHO) recommends that babies should be exclusively breast fed for six months. This recommendation was taken up by the Department of Health in 2003 (See Appendix C).
- Breastfeeding 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 breastfeeding 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 breastfeeding rates happens within the first four days of birth (12%). A third of women have stopped breastfeeding 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 [Table 2].

Profile of breastfeeding in west Kent

This study is currently being undertaken to gain a greater understanding locally of when best to intervene to increase breastfeeding rates. Approximately 34,000 records were analysed to determine factors influencing the rates of breastfeeding as well as the estimated impact on childhood hospital admissions. Some initial results are shown below.

The first chart shows differences in prevalence by Clinical Commissioning Groups. The prevalence of Dartford Gravesham and Swanley CCG is lower than the other groups at delivery but all CCGs show the same pattern of reduction by 6-8 weeks.



The second chart displays differences in hospital admission rates between children who have been breastfed for up to 6 months and children who have not been breastfed at all. This shows that breastfeeding may have a protective effect for all admissions, which includes those for, respiratory illnesses, but not for gastro enteritis.

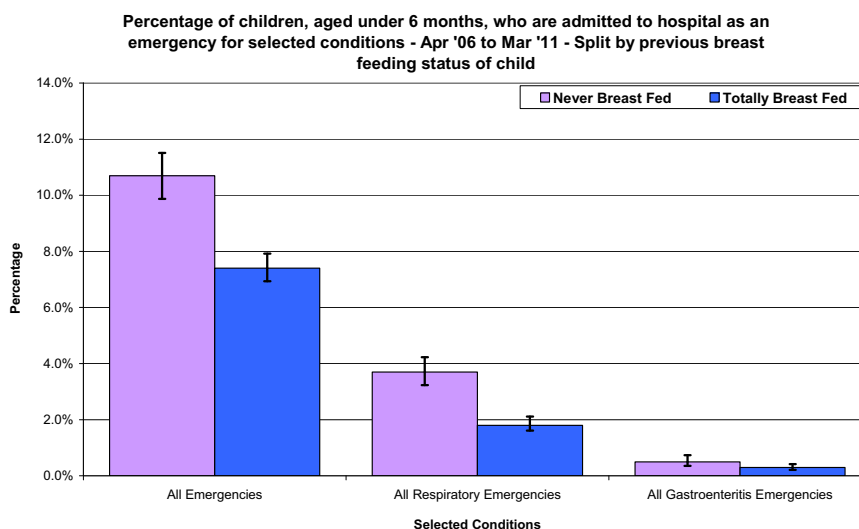


Table 2: Breastfeeding summary data 2010/11

	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%

Recommendations

Support to mothers breastfeeding should be commissioned according to the stated evidence base and national policies such as

- ‘Baby Friendly Initiative’ which all key stakeholders are signed up to (for e.g. health visitors, children’s centres and maternity units)
- Healthy Start Programme to provide of range of benefits to pregnant women from low income families
- The universally based Healthy Child Programme

6.3.3 Immunisation and vaccination

- National vaccination programmes including the childhood immunisation programme are an essential part of protecting adult and children’s health. Low vaccine uptake puts them at risk, particularly in view of high rates of migration from countries that are experiencing a resurgence of certain diseases. Polio has started to re-emerge in Nigeria and diphtheria is increasing in Eastern Europe.

- 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 [Table 3].
- 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 across the county is better than the England and SHA averages.
- 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 rubella⁸.
GPs and Health Visitors in one to one consultations with families
can encourage the uptake of MMR*

According to one study⁹ carried out in the USA the total net direct saving resulting from the two dose MMR vaccination programme was \$3,513,222,853 and the total net societal saving was \$7,575,299,505

The findings from another study¹⁰ suggest that from the societal perspective the estimated average cost per measles case is \$307 in UK and the average cost of adverse events following immunisation per vaccine is \$1.93 in UK. The benefits of MMR vaccination hugely outweigh the adverse effects.

⁸ Based on the difference needed to achieve 95% Jan-Mar 2011 and MYE 2010 5 year olds

⁹ An economic analysis of the current universal 2 dose measles-mumps-rubella vaccination programme in United States, Zhou FJ, Reef S, Massoudi M, Papania MJ, Yusuf HR, Bardenhuir B, Zimmerman L, McCauley MM.

¹⁰ The average cost of measles cases and adverse events following vaccination in industrialised countries, Helene Carabin, W John Edmunds, Ulla Kou, Susan van Der Hof, Van Hung Nguyen.

Table 3: 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				

The uptake of the Human Papilloma Virus (HPV) vaccination has a mixed pattern across Kent when compared both regionally and nationally.

Recommendations

- An action plan to increase the uptake of the MMR vaccination across Kent is required. Primary care services 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
- 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 two years of age) from 77% in April-Jun 2010 to 95% in Jan-Mar 2011

6.3.4 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 few more years more to demonstrate statistically reliable results.
- Children’s centres should act as a hub, bringing the benefits of joined-up play groups, healthcare and parenting support to the local communities that they serve.

Home-Start offers one to one, personalised support for parents with children under five; reaching out to families at risk of social exclusion, including those who do not engage with other services.

Home-Start places trained volunteers alongside parents. Support is tailored to the individual needs of each family and is provided for as long as the family needs it.

Volunteers are managed and supervised by their local Home-Start scheme which is in turn supported by Home-Start UK; a community resource with all the benefits of a strong national organisation.

www.home-start.org.uk

- The Healthy Child Programme, especially the 0-5 years, are grounded on the Marmot principles of progressive universalism. All agencies should focus their approach focusing on the family as a whole rather than primarily upon 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 Home-Start 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. This is consistent with the Graham Allen (2011) review, reflected also in a draft national service specification on health visitor practise: as leaders of the Healthy Child Programme working out of children centres in conjunction with other services provided either within children centres or into them. Health visitor practise should therefore give equal commitment to the promotion of population health, 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.

6.3.5 Parenting

- The life course approach highlights the relationship between infants and parents as being 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.
- Evaluations of Sure Start programmes have yielded mixed results in terms of developmental trajectories of young children. Later results of Sure Start Local Programmes showed children displaying more positive social behaviour and greater independence.

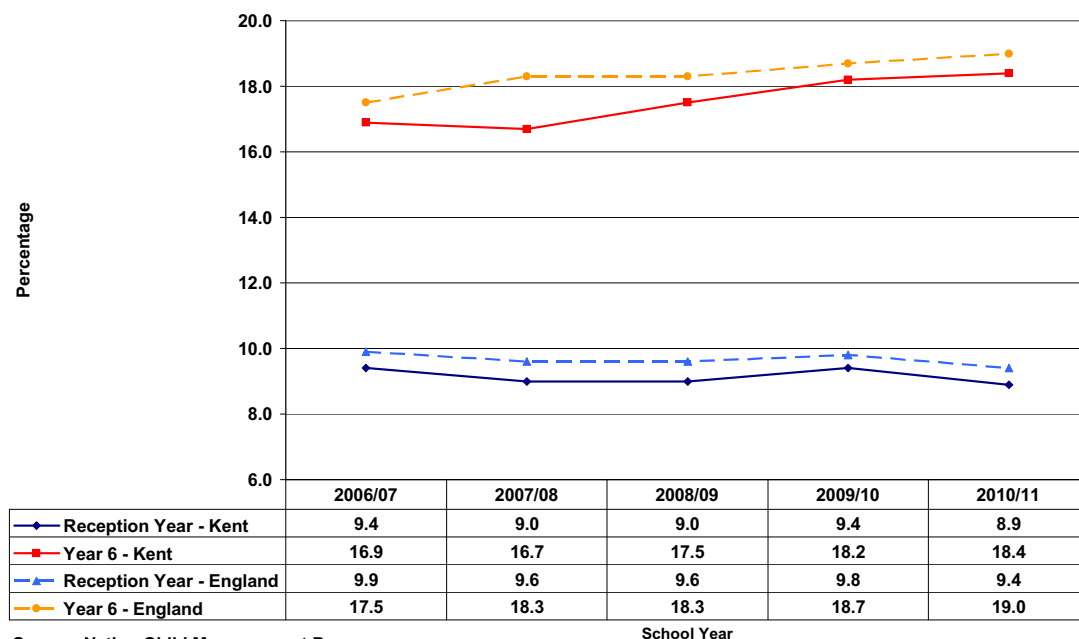
Recommendation

- 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.

6.3.6 Childhood obesity

- The National Child Measurement Programme (NCMP) indicates fluctuating levels of obesity in Year R but a steady increase in prevalence in Year 6 from 2007 – 2011, in Kent. [Figure 8]
- The latest NCMP results for 2010/11 indicate:
 - Of the 15,115 children in Year R, 2,131 (14.1%) were overweight and 345 (8.9%) were obese.
 - Of the 14,132 children Year 6, 2,120 (15.0%) were overweight and 2,600 (18.4%) were obese.
 - Locally prevalence of overweight and obesity in Year 6 ranged from 28.2% in Canterbury to 37.3% in Dover.

Figure 8: Trends in the rate of childhood obesity in reception year and year 6 in Kent – 2006/07 to 2010/11.



Source: Nation Child Measurement Programme

Recommendations

- The above findings suggest that for every 1% reduction in the combined prevalence of overweight and obesity in childhood, a minimum of 84 children would need to be targeted to achieve a healthy weight in Kent.
- 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 such as Healthy Passport Change 4 Life programme targeting nearly 48,000 primary school children in west Kent.
- 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.

6.3.7 Avoidable injury

- 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 other districts of Kent.

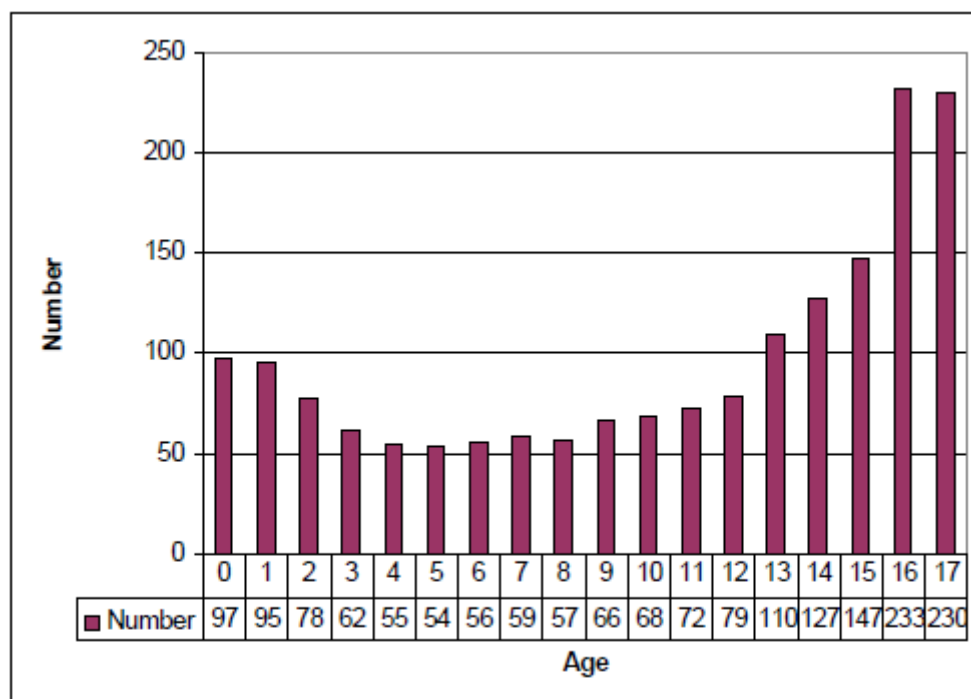
Recommendation

- 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.

6.3.8 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 [Figure 9].
- 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.

Figure 9: Number of Kent ‘Looked After’ children by age as of end of June 2011



Source: Joint Strategic Needs Assessment for Children in Kent, Sexton 2011

Recommendations

- 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 the 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 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.

6.3.9 Domestic abuse

- 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 may have been a victim of domestic abuse
 - 23,283 women and girls aged 16-59 may have been a victim of sexual assault
 - 56,867 women and girls aged 16-59 may 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.
- Some of the key 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 advisors currently working across Kent, but employed by a number of organisations, funded by different sources, and varying roles and responsibilities, although most are derive from the *Co-ordinated Action against Domestic Abuse (CAADA)* framework for IDVA services¹¹.
 3. Community Perpetrator programmes are currently available across Kent for men who refer themselves and are assessed as suitable for the programme.
 4. Very few services specifically cater for children affected by Domestic abuse.
- 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

¹¹http://www.caada.org.uk/qualityassurance_accreditation/The%20Charter%20and%20Key%20Criteria%20for%20CAADA%20March%202011.pdf

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

- 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. This 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.
- Co-commission one single Point of Contact service for Domestic Violence victims in Kent
- The Kent Ambition Board Two Tackling Disadvantage should promote a County-wide framework for these services and promote sustained funding solutions to maintain existing services to continue to provide appropriate interventions for people who suffer domestic abuse.
- In this regard it is important to recognise that the true level of need is grossly under-estimated and will take some years to establish.

6.3.10 Child and Adolescent Mental Health Services (CAMHS)

- Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system.
- The National Service Framework for Children, Young People and Maternity Services set out the standards and milestones for improvement of CAMHS stratified into 4 tiers or levels of provision, from universal services like GPs and social workers to highly specialised tertiary level inpatient and outpatient units.

- Estimates from Health and Social Care Advisory Service and ONS indicate that 15% (34,293) of all children and young people in Kent (5-18 years) will need a CAMHS service. More than half of them (19,910) will have a diagnosable mental health disorder (see Appendix D), of which the most common ones are conduct disorders, emotional disorders as well as particularly high number of children with Autistic Spectrum Disorder (ASD).
- Current quality of data concerning access to CAMHS in Kent is limited. However some observed differences (than what would be expected) have been identified such as:
 - Fewer numbers of children were being seen in Tier 2 services.
 - Higher levels of self harm and psychosis seen in Tier 2 and Tier 3 services.
 - Slightly fewer males and slightly more females access services than would be expected nationally.
 - An under representation of conduct disorder and hyperkinetic disorders and fewer younger boys are being seen than expected nationally
 - An under representation of African and Caribbean children and an over representation of Asian and mixed race children. This varies across different providers i.e. NHS West Kent and Kent and Medway Partnership Trust (KMPT).
 - More children with learning disabilities accessing services
 - Looked after and young offenders are under represented both according to local need and to national comparison.
 - Children and young people aged 10-14 years accessing services more than at 15-18.
 - A gap in transition services from CAMHS to Adult services.
- Community CAMHS model – CAMHS is everybody's business not only the actions of the Specialised CAMHS services. A community model has been developed for Kent that recognises that although vulnerable children may need CAMHS services at some point, all partner services need to be responsive and able to cope with a child's emotional needs. For example if a child is bullied severely at school and in distress rather than referring to

CAMHS, the school with support from CAMHS services should be able to help the child. For the community model to be effective all agencies need to agree and sign-up to a common way of working – through the Common Assessment Framework (CAF). This will ensure that a child gets the appropriate level of service and intervention when they require it.

Recommendations

- 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 parents 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

6.3.11 Teenage pregnancy

- National guidance estimates that for every £1 invested in contraception saves the NHS £11 plus additional welfare costs.
- In Kent the teenage pregnancy rate is 34.7 per 1,000 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 the 1998 baseline, in line with 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 and travelers, 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 that are acceptable, particularly for the east of the County.
- There is also disparity in the availability of LARC (long acting reversible contraception) across the County as mentioned in the recommendations for Sexual Health improvement.

Recommendations

- Kent has retained a specialist commissioner for Teenage Pregnancy and a County-wide framework of district-based Teenage Pregnancy Groups action 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 and it is therefore recommended that KCC's Education, Learning and Skills consider how it can support low-achieving girls and young women in deprived parts of Kent to have realistically higher aspirations for their careers and lives.
- Prevention of pregnancy services should be re-commissioned across the County. The current base of Maidstone disadvantages young people faced with this dilemma living in east Kent. A model that has more access points that serve respectively east and west Kent needs, would improve access to all contraception and pregnancy services.

6.4 Adults

Table 4: Recorded and estimated prevalence of specific long term conditions in Kent 2010/11

Disease/Condition	QOF Registered	Prevalence (estimated no.)
Stroke & TIA	26,411	31,536
CHD	47,958	70,439
COPD	24,127	36,940
Diabetes	66,098	85,613

Source: QOF 2011 and APHO

6.4.1 Long term conditions (LTC)

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 such as Whole Systems Demonstrator (WSD) project for tele-care, tele-health and tele-technology to improve self management, as well as innovations in other areas like crisis response services for dementia and end of life care
- adoption of the findings from the SEC Personalised Care Planning pilot, combined with the Personal Health Budget programme
- working with the SEC wide LTC commissioning development programme, co- designed by clinicians and linked with SEC Enhancing Quality principles.

Tele-health and Tele-care

Assistive technologies enable people with health and social care needs, such as the frail elderly and those with Long Term Conditions (LTCs), to gain independence in their own homes and improve the quality of life for them and their carers.

Tele-Health

Tele-health is the remote exchange of physiological data between a patients' home and their clinician to assist in monitoring and diagnosis. This includes a home hub with peripherals to monitor vital signs the data is transferred down the telephone system.

In 2005 a pilot was setup in Kent, to test the effectiveness of tele-health technology, rolled out to 250 people with a LTC over a 2 year period, developing different clinical models of care and different frequencies of monitoring. It brought about significant changes in how health and social care services work together and allowed to support more people longer at home and in some cases facilitated some users dying at home, better for the patient and their carers.

The results of the pilot indicated an overall reduction of 88 A&E visits and 536 bed days of care along with significant improvement in quality of life scores. The pilot also demonstrated an average half yearly saving of £1,878 per patient or a total of £7.5 million per year for the three main LTC (COPD, CHD and Diabetes).

Tele-Care

Telecare is a 24/7 remote monitoring system for vulnerable adults to enable them to live safely and independently at home.

In an emergency, remote sensors (personal triggers or environmental sensors will send messages to a central monitoring centre. followed by necessary action to deal with the emergency.

More than 700 users were engaged in the tele-care pilot in 2006. Like tele-health there were also positive responses from them and their carers around increased independence and helping them to stay in their own homes.

The whole systems demonstrator (WSD), recommended in the Government's White Paper "**Our Health, Our Care, Our Say**", was set up to prove the benefits of assistive technologies following on from the results of the two pilots. The final report is expected in 2012.

www.kent.gov.uk

6.4.2 Chronic obstructive pulmonary disease (COPD)

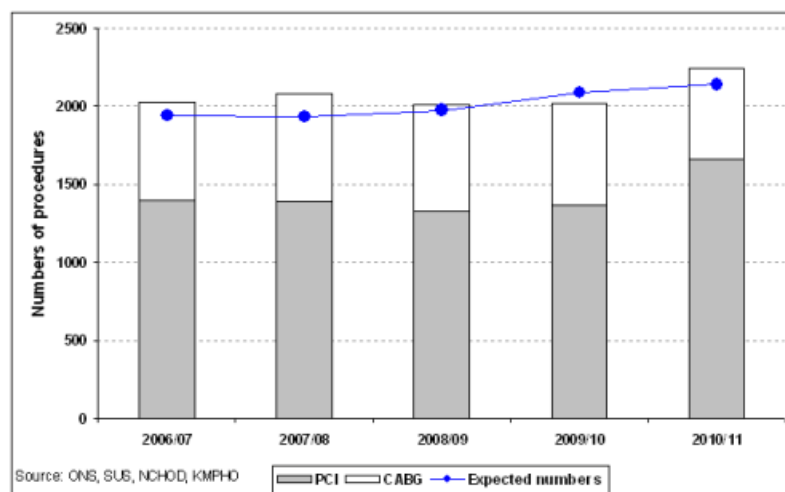
- COPD develops over time and most patients are not diagnosed until later in life. QOF recorded prevalence of COPD is 2% in Kent with a 1% estimated to be undiagnosed, an estimated 12,000 people. Prevalence is higher in the east, 2.2% of adult population compared to 1.7% in the west. The areas of Thanet and Dover have the highest prevalence. Dartford and Gravesham have a much higher number of undiagnosed patients than other areas; these are areas of higher deprivation in the west. West Kent has a higher prevalence of undiagnosed COPD cases compared to east Kent. [Table 4].
- Emergency admissions in Kent for COPD have increased from 2,535 in 2007 to 2,930 in 2010 an increase of 16%. The majority of admissions had a length of stay between 1 and 3 days.
- East Kent spends £11.51 per head on obstructive airways disease (ranked 101 out of 152 PCTs) and west Kent £11.23 (ranked 106). Mortality from bronchitis, emphysema and COPD, east Kent ranks 81st whilst west Kent ranks 48th. 16+ smoking quitters per 100,000 83rd and 113th respectively. Yorkshire and Humber public health observatory (2009/10)
- Recommendations for prevention and chronic disease management include:
 - Higher priority for targeted prevention, particularly Smoke Free and Smoking Cessation initiatives
 - Public and patient engagement aimed at 'finding the missing thousands' and better informed patients to reduce emergency hospital admissions.
- Using data to inform targeting and prioritisation for service improvement particularly to areas of deprivation and in addressing disparity of outcomes between east and west Kent.
- COPD ranks one of the highest Ambulatory Care Sensitive Conditions in terms of readmissions and opportunity for admission avoidance. It is one of the key LTCs where an integrated health and social care team approach towards case management is most needed.

6.4.3 Coronary heart disease (CHD)

The following section has been adapted from The Kent Cardiac Network Strategy 2011-2016

- CHD modelled prevalence is expected to increase by at least 0.6% by the year 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. From the data in table 4 it is important to note that there is a 47% difference between the recorded prevalence of CHD on QOF and the modelled expected prevalence.
- Activity related to CHD diagnosis and treatment has changed over the last five years according to previous plans to repatriate procedures from specialist units in London to Kent. The number of Coronary Artery By-pass Graft procedures (CABG) has decreased at a lower than expected rate whereas the number of Percutaneous Coronary Interventions (PCIs) has increased, except in 2008-09 where the rates were lower than expected. [Figure 10]

Figure 10: Number of revascularisations 2006/07 to 2010/11



- The 2010/11 QOF prevalence for heart failure (HF) was 0.6% (9,000 patients). Admissions for heart failure for Kent have increased from 1,381 2006/07 to 1,632 in 2010/11 an increase of 18%. This may be due to the variation in care pathways and services available for HF patients across Kent. By shifting the care of HF patient to a community service admissions and readmissions can be avoided. The newly formed Kent Community Health is expected to tackle the historically differing models of care across west and east Kent in terms of number of specialist nurses, nurse:patient ratios, multi disciplinary teams providing the best package of care.
- Cardiac rehabilitation programmes are divided into 4 phases:
 - After hospital admission with CHD
 - Early discharge period
 - Formal rehabilitation programme
 - Long-term maintenance

It is important that it is integrated across traditional sector boundaries, including secondary care, primary care, public health, local authorities and community and voluntary organisations and be appropriate to local need and preference.

Recommendations

- Prevention and detection
 - Ensure monitoring of CHD prevalence at practice level such as validation of Atrial Fibrillation registers
 - Prioritise health improvement programmes including rollout of health checks, smoking cessation, lipid modification and hypertension management.
- Cardiac imaging and diagnostics
 - As per NICE Guidance, support the introduction and increase the use of specialist equipment such as CT, Stress Echo and cardiac resonance imaging to reduce the need for referral into specialist services in London.

- Arrhythmias
 - GP practice need to improve quality of Atrial Fibrillation (AF registers) working with medicines management to carry out medication reviews and introduce opportunistic screening for AF (pulse check)
- Devices
 - Further analysis is required exploring variation in methods of device implantation.
- Revascularisation and cardiac surgery
 - Review current diagnostic and surgical intervention capacity, such as whether primary angioplasty 150 minute call-to-balloon targets can be consistently met, High Sensitive Troponin Test for chest pain patients seen in A&E.
- Cardiac Rehabilitation
 - Further needs assessment is required to estimate potential number of patients who would be eligible for this service.
- Heart failure and end of life care (EOLC)
 - Key recommendations include - development of high quality care pathways with clear entry and exit points (with particular links to EOLC), introducing personalised care plans and self management programmes improving quality of GP registers

6.4.4 Stroke and Transient Ischemic Attack (TIA)

- In Kent 26,411 people were recorded as having a Stroke or TIA. This is a prevalence of 1.7% across Kent similar to the national QOF prevalence.
- The national FAST campaign was launched in spring 2009. 'FAST' is a simple way to remember 3 specific symptoms of stroke: **F**acial weakness; **A**rm weakness; **S**peech problems; **T**ime to call 999. A number of events were organised across Kent and are ongoing, to help project the FAST message. The campaign was successful in raising national awareness of stroke and TIA, and was repeated in November 2009.
- All areas of Kent now have rapid response TIA clinics where high risk patients are seen within 24 hours and all patients are seen within a week.

All stroke patients require high-dependency care on an acute stroke unit for the first 24 hours of the illness. Every district general hospital in Kent offers thrombolysis (early clot bursting drugs) and dedicated acute stroke care. All areas have access to dedicated Stroke Rehabilitation Units (SRU) when in-patient stroke rehabilitation is needed.

- These services offer early supported discharge or ESD (typically within 10 days) and rehabilitation in the patient's own home; about 30% of patients are suitable for this model of care. ESD teams operate in west Kent. This multi-disciplinary team (Physiotherapists, Occupational therapists, Mental Health Nurse, Speech and language Therapist and support workers) provides longer-term community rehabilitation services for stroke survivors.
- The latest results of the National Sentinel Audit of Stroke Care (2011) across the six hospital sites across in Kent indicate consistent performance in the upper quartile, although variation does exist between sites for some of the standards such as timely access to diagnostics and planning for rehabilitation. It may be noted that the recent results of the utilization review shows a significant proportion of patients (including stroke) whose day of care was inappropriate, experienced delayed discharge for a number of reasons such as lack of suitable community or social care placements.

Recommendations

- 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 BME groups, in particular South Asian and African-Caribbean groups.

6.4.5 Diabetes

- The age adjusted prevalence of Diabetes has increased slightly from 5.4% to 5.7% in Kent over the last two years. 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.
- The majority of cases of type 2 diabetes are preventable as diabetes is strongly associated with both child and adult obesity. There are services and activities provided for children, families and adults in Kent. A lack of confidence often prevents professionals' signposting and making referrals to appropriate services.
- Glycaemic control is critical and both eastern coastal Kent and west Kent have higher levels of HbA1c of 7% or less, compared with the national average.
- Secondary prevention of complications for people who have diabetes is shown to be particularly poor in west Kent, compared to similar PCTs. The rate per 1,000 for emergency admissions for ketoacidosis and coma between 2007/8-2009/10 was 8% in west Kent, compared to 4.6% in eastern coastal Kent and 4.7% for PCTs elsewhere of similar characteristics (peer group) (5.1% nationally). West Kent has higher rates of minor lower limb amputations 1.9% compared to 1.7% in eastern coastal Kent (peer group rate is 1.7% and national rate is 1.5%). Rates for major lower limb amputation in Kent are comparable with the peer group and the national average.
- In England people with diabetes are twice as likely as people without the condition to die between the ages of 20 and 79 years. It is estimated that

these extra deaths accounted for 392 patients in eastern coastal Kent and 282 deaths in west Kent in 2005.

- There is a real variation in the uptake of primary prevention and in the quality of care for diabetes across Kent shown in the results of the National Diabetes Audit. Comprehensive tailored education programmes are required for professionals, patient and the general public who are at risk.
- Social deprivation and ethnicity is very strongly linked to both the risk of diabetes and the complexity of the outcomes of having diabetes, the management of co-morbidities is challenging, particularly for those with fewer resources.
- The commissioning spend on diabetes is unsustainable as the prevalence of obesity and diabetes are rising, there is a need for more cost effective interventions locally.
- The requirement of health services to provide more patient choice and control in line with the principle of 'no decisions about me without me.'

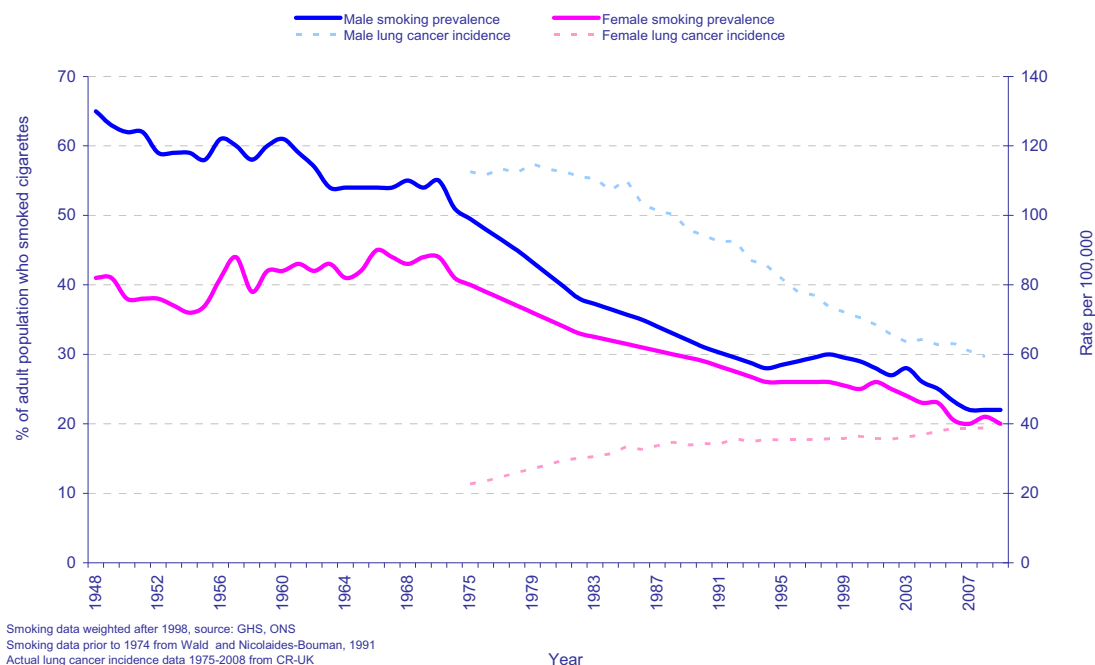
Recommendations

- The roll out of Health Checks will have a significant impact of primary prevention for diabetes. Through the appropriate referral of at risk patients to the key lifestyle and behavioural change interventions. For example greater integration with the Healthy Weight care pathway for adults and children will ensure appropriate referrals to the right services such as weight management programmes provided by district authorities.
- There is a need to substantially improve the detection of undiagnosed diabetics currently there is a gap of 30% between recorded and estimated prevalence.
- Ensure equitable distribution of tertiary level specialist services such as podiatry, dietetics and psychology services. More specifically diabetes care in children and adolescents, and pregnant women needs further review to ensure that the appropriate care processes are agreed upon and carried out across Kent and that specialist paediatric and ante-natal services are readily accessible.

6.4.6 Cancer

- Over the last ten years, the incidence rate for all cancers in Kent and Medway has remained steady for males, with a slight increase for females. There is a downward trend in mortality for all cancers in both males and females in Kent and Medway from 1994-96 to 2005-07 Kent and Medway Cancer Network (2009-10) 1.7% of the Kent population are recorded on the QOF cancer register. [Appendix E]
- Currently 3.3% of UK population or 2 million are cancer survivors, and rising at an estimated 3.2% per year, with breast cancer contributing the most. In the elderly population aged 65 and over the proportion of cancer survival rises to 10%.
- These latest estimates are much higher than previous forecasts of cancer prevalence, mainly because, although incidence has been rising, death rates have continued to fall, leading to better survival. This trend is expected to continue over the coming years as a result of a number of factors, including an ageing population, anticipated effects of population growth, earlier detection of cancer and continued improvements in treatment.
- Cancer of the breast, lung, colorectal and prostate together remains the four most common cancers in Kent and Medway and account for about 50% of all cancer diagnosed and causes of death from cancer. Lung cancer remains the main cause of death from cancer, although national incidence rates have been falling over the last 50 years particularly in males and also in line with similar reductions in national smoking prevalence. [Figure 11]
- One year survival rates from lung cancer are generally poor for all areas when compared to other cancers. [Appendix D] These are a proxy measure of the proportion of patients presenting with late stage disease, as most patients who die within a year of diagnosis have advanced disease at the time of diagnosis, suggesting that delay (patient, primary care or hospital) in diagnosis and treatment may be an issue. This emphasises the need to increase the public's knowledge of signs and symptoms of these cancers and to promote earlier presentation.

Figure 11: Lung cancer incidence and smoking trends, Great Britain, by sex, 1948-2009



Recommendations

Preventing cancer

- It is estimated that over half of all cancers are preventable. Details of lifestyle and behaviour change interventions are mentioned previous sections.
- Ensuring access to eligible people to high quality screening programmes which is explained in detail within the Screening section.

Awareness and early diagnosis

- The National Awareness and Early Diagnosis Initiative was first announced in the Cancer Reform Strategy in December 2007. It seeks to achieve a balance between action and research, as reflected by the seven work streams that form its core:
 - Awareness measurement
 - Promoting earlier presentation
 - Reducing primary care delay

- Key messages
- Review evidence base
- International comparisons
- New research

It is imperative that CCGs implement appropriate initiatives to detect cancers of specific sites where no screening programme to detect them currently exists. For example patients with Lung cancer have the poorest survival rates (20% to 30% after one year) because of the higher proportion of late stage presentations.

Initiatives around raising awareness and early diagnosis of lung cancer can improve overall one year survival rates by more than 5%, resulting in an average cost per life saved of £2,376 as opposed to the cost of anti cancer drugs for advanced lung cancers which would be approximately £30,000 per year per patient.

Department of Health (2011)

Ensuring better treatment and delivering care in the most appropriate setting

- The process of Enhanced Recovery after Surgery is a prime example of an integrated care pathway, involving a multi modal and multi-disciplinary approach to patient care following major surgery, in order to reduce the length of hospital stay and the physiological impact. Since inception, majority of colorectal cancer patients who have passed through this pathway have so far reported positive outcomes. The pathway has also been introduced Gynaecological Oncology and Upper Gastrointestinal cancer patients.
- Different innovations for different cancer sites are required to improve the quality of care management, such as advanced diagnostics for blood cancers, laparoscopic surgery for bowel cancer, multi disciplinary teams for skin cancer, and use of information technology tools to planning chemotherapy.

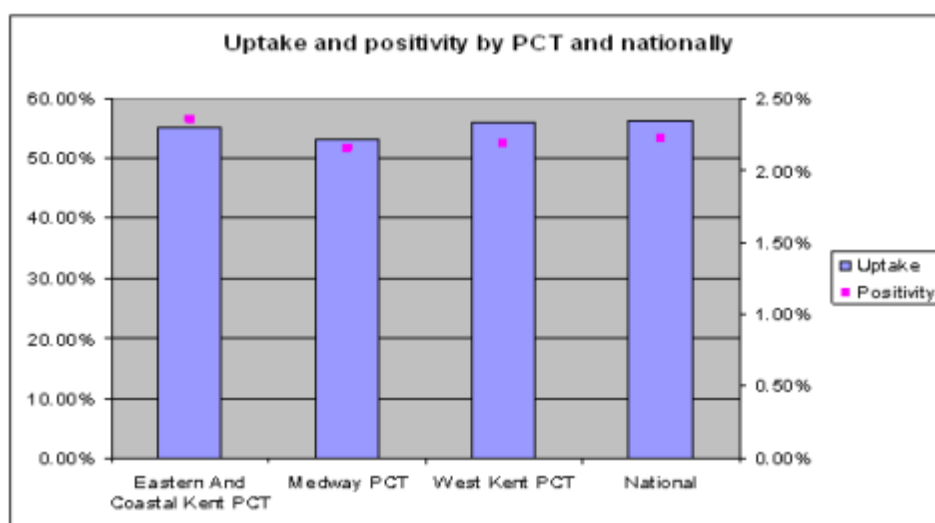
Living with and beyond cancer

- Redesigning existing high quality rehabilitation services into four levels (based on the national model) have been suggested, ranging from therapy services, dietetics to psychological support and counselling linking into palliative care.

6.4.7 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 [Figure 12].
- 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.

Figure 12: Uptake and positivity rates of bowel screening programme by PCTs in Kent February 2010 to January 2011



Recommendations

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.

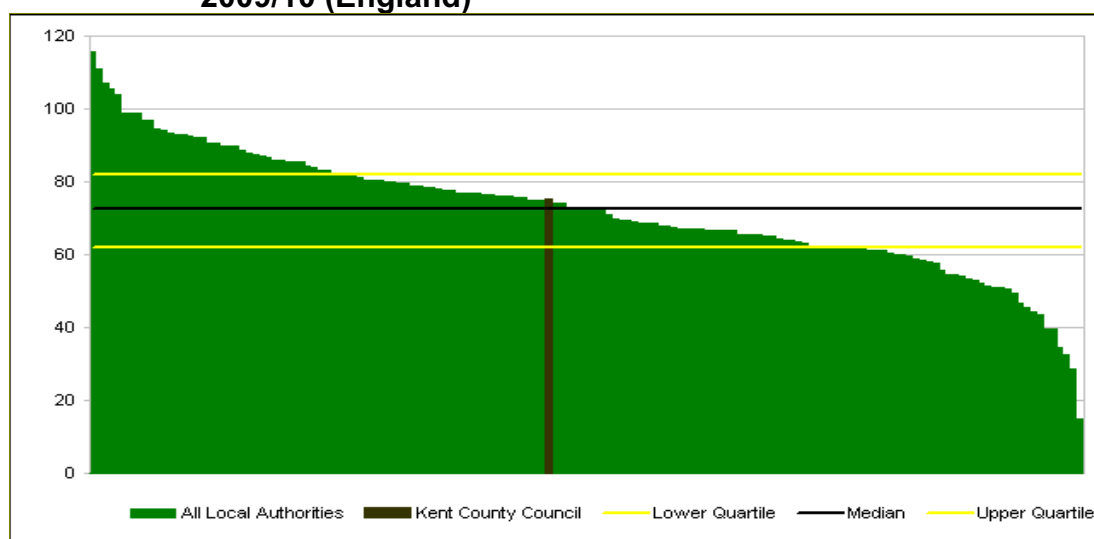
6.4.8 Dementia

- 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.
- The value of early interventions such as support at home from specialist teams, support for carers and counselling and diagnosis can reduce demand for care home placements by up to 28% and reduce hospital admissions even further.
- In 2009/10 KCC had a care homes admission rate of 75 per 10000 65 years and over population which just above the England median rate of 71. [Figure 13]

Figure 13 Variation in the number of 65+ permanent admissions to residential care and nursing care per 10,000 population, 2009/10 (England)



Source: Health and social care interface tool, Audit Commission 2011

- However a recent small scale audit carried out in DVH (Darent Valley Hospital) indicated a growing concern that a number of patients are discharged directly from an acute hospital bed into nursing homes despite many of them previously living in their own homes. It should be pointed out that the patients who were undiagnosed prior to admission could have been struggling to cope or coping with a high input of support from family or friends for a long time.

Importance of early intervention

- Early provision of support at home can decrease institutionalisation by 22%;
- Even in complex cases, and where the control group is served by a highly skilled mental health team, case management can reduce admission to care homes by 6%;
- Older people's mental health services can help with behavioural disturbance, hallucinations and depression in dementia, reducing the need for institutional care;
- Carer support and counselling at diagnosis can reduce care home placement by 28%;
- Early diagnosis and intervention improves quality of life of people with dementia; and early intervention has positive effects on the quality of life of family carers.

National Dementia Strategy 2009

Recommendations

- Move to a social model of care for people with Dementia and map the cost of the current system and change in costs, as care moves to the community. Significant shift in hospital to community care and costs can be made as highlighted in the recent utilization review results.
- Agree a dementia pathway with all clinicians 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.
- Dementia patients often need a longer period of assessment and rehabilitation to return home. Facilities in the community should

therefore provide assessment and intermediate care to accommodate these patient needs rather than placement in nursing homes.

6.4.9 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. ([National audit falls and bone health older people](#))

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:

- **Reconfiguring community-based falls clinics** to be jointly carried out by orthogeriatricians 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. Participation in such programmes by at risk patients for up to a year can reduce the incidence of falls by approximately 40%.
- **Case finding of patient with previous history of fragility fractures in primary care** - mainly concerns pro-active case finding by GPs for patients with past history of falls and fractures who have not yet been properly assessed.
- **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. This function could be supported by community pharmacists via the Medicine Use Review (MUR) service in order to improve compliance rate of osteoporosis medication.
- **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.

6.4.10 Mental Health

- Nearly one third of GP consultations are related to mental health problems. Approximately one in four people will have a common mental illness during their lifetime and one in six people in England have a mental health problem at any given time (point prevalence). One in seven people will have 2 or more mental health problems at any point in time.
- The majority experience a common mental health condition such as anxiety or depression (these terms cover a technical classification of six neurotic disorders).
 - Mixed anxiety and depression
 - Generalised anxiety disorder
 - Depression
 - Phobias
 - Obsessive compulsive disorder
 - Panic disorder

The estimate of people with neurotic disorders in Kent and Medway is approximately 160,000. Some key factors influence variation in prevalence of mental disorders for example

- Common mental illness is higher in deprived areas
- Anxiety and Depression is higher in older people
- Common mental illness is higher in unemployed people
- Depression is high in people with long term physical health conditions.
- Three quarters of these people will either self help or get better in time, so not all will require NHS services. The latest ONS figures estimate around one quarter or 40,000 people will need treatment with drugs and/or psychological therapies. Revised estimates put this figure at 34,700 for Kent and Medway.
- 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.

- 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 (BME) communities and high-risk groups, such as offenders and asylum seekers/refugees need to be better understood to ensure appropriate service provision in Kent.
- Of Kent's population of adults with severe and enduring mental health problems, only 8% are in employment, therefore improving the employment prospects of people with mental health problems is important.
- 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/>
- The Kent Public health team with its partners are embedding a series of mental well being initiatives into main stream services such as Change 4 Life, Health Trainers, Healthy Living Pharmacies, Active Mobs and Well Being Impact Assessment.
- In view of the limited quality of data available from KMPT improvements need to be made to inform the on going needs assessments using real time data to test for equity and outcomes.

Recommendations

Adult mental health

Community mental health teams: Redesign underway to:

- Define and quantify those multi-disciplinary care pathways which should be delivered in access and recovery services
- Cost each care pathway in line with payment by results implementation
- Review workforce skill mix to ensure pathway delivery.

Inpatient rehabilitation services: Review existing inpatient rehabilitation services to:

- Improve pathway efficiency and movement through the service
- Better meet the needs of the local population to prevent costly Out of Area Treatments.

Acute In-patient Services: Support the redesign of acute inpatient mental health services for east Kent in line with the provisions of the full business case.

Eating Disorder Service: Undertake a multi key stakeholder review of the Eating Disorders Care Pathway through health promotion, primary care, secondary care and tertiary care provision. Particular attention will be paid to the current KMPT Red House Inpatient Eating Disorders Service

Mother and Infant Mental Health Services: Review the existing services in order to ensure maximum use of resources across the care pathway

Personality Disorders Service - Intensive Day Treatment: Secure provision of comprehensive staff training programme to support secondary mental health services, personality disorder and other professionals across west Kent and Medway in line with NICE recommendations, and roll out training across eastern and coastal Kent.

Adult Attention Deficit Hyperactivity Disorder Service: Secure a local Adult ADHD service

Asperger's syndrome – Social Communication Assessment Service (SCAS): Commission a small, bespoke Asperger's SCAS, attached to a community mental health service

Transition services: In 2011/12, services for 17 year olds (up to the age of 18) will be provided by a team of experienced CAMHS staff, including medical input, to work alongside Adult Mental Health Services (AMHS) to provide assessments, signposting to appropriate services, short-term treatment and to assist with transitional arrangements for those young people who will require a longer-term mental health service from AMHS

Older People's Mental Health

- Work with all Commissioners to redesign the Older People Mental Health Needs (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.

6.4.11 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 an 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.

Recommendations

- 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.
- The provision of healthy diet and adequate opportunity for physical activity within residential accommodation for persons with learning disability should be appraised and the SLAs adjusted to maximise such healthy living opportunities – led by Adult Social Services.
- All agencies should be rigorous in assuring good dental health for persons with learning disability.

- All agencies should be rigorous in assuring that persons with learning disability receive appropriate services with regard to sight and hearing, in recognition that their population needs are predicted as being greater than the general population.
- All agencies need to develop a targeted response strategy to the sexual health needs of persons with learning disability.
- All agencies should map the provision of activities for daily living, particularly with regard to individuals with severe learning disability.
- The restriction of social participation and its consequences should form the core agenda for future policy analysis if it is corporately agreed to expand this needs assessment into a joint strategic needs assessment for learning disability.
- To explore the potential for improvements in coding for secondary care services in order to better determine the treatments provided to persons with learning disability.
- To review the Kent Good Health Action Plan in the light of this needs assessment.
- Service planning and commissioning must include the needs of carers. This is of particular importance given the increased life expectancy of many people with learning disabilities and the inevitable ageing of their carers.

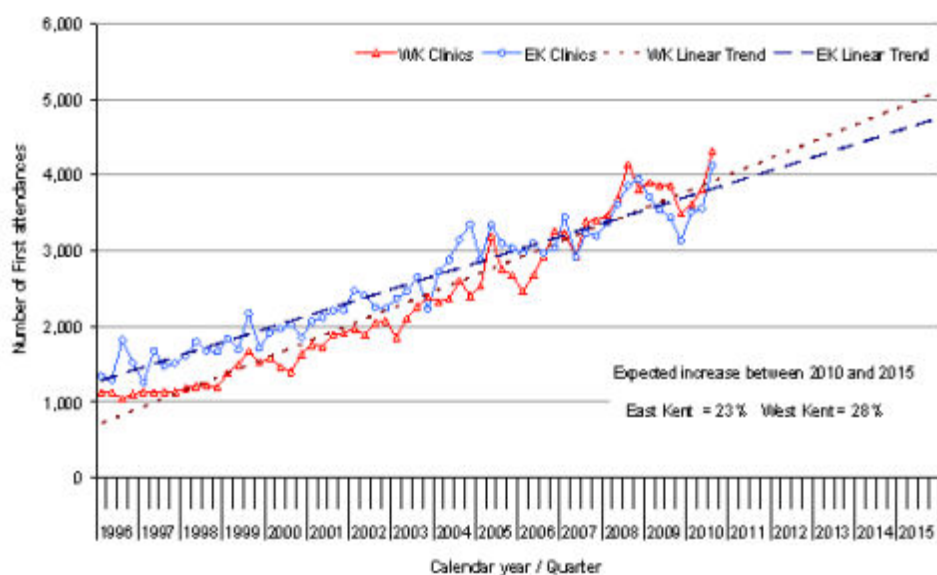
6.4.12 Sexually Transmitted Infections

- 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 to 2015 [Figure 14].

Figure 14: Projected Trends in first attendances at GUM Clinics in east Kent and west Kent areas



Recommendations

- 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 or oral contraception.

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

6.4.13 Offender Health

- The term 'offender' refers to an individual who is convicted in a court of law as having committed a crime, violated a law or transgressed a code of conduct. There is a distinction made between **community offenders** and those **accommodated in prison**. The term 'youth offender' is used to refer to those under the age of 18 who offend in preference to 'young offender' as this may be confused with the prison Youth Offending Institution (YOI) estate that manages prisoners between the ages of 18 and 21.
- Based on surveys carried out between 2008 and 2011 there were approximately 3,741 offenders accommodated in prison. Higher proportion offenders are in the age group 20 to 49 years. Apart from Dover Immigration Removal Centre the highest proportion of offenders from BME groups was found in Canterbury prison.
- The number of community offenders in the Kent probation workload remains largely unchanged, 6,591 in 2008/09 and 6,544 in 2009/10.
- Previous studies indicate that of the offenders screened:
 - 13% reported not being registered with a GP
 - 37% reported not being registered with a dentist
 - 26% rated physical health as being fair / bad / very bad
 - 25% reported low mood
 - 22% reported feeling anxious
 - 33% reported feeling stressed
 - 29% reported having problems sleeping
 - Only 39% reported eating fruit and vegetables daily

- 63% were smokers.
- 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.

Recommendations

- 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.
- A Medicines Management Performance Framework should be in place to harmonise prescribing and medicine management financial practice across the Sheppey prison estate
- Improve uptake rates screening such as 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

6.4.14 Excess Winter Deaths

- In Kent there is considerable variation between the mortality data of the different districts from 2002-2010. Canterbury had the highest excess winter death ratio (22.7) and Dover the lowest (11.3)¹². Most other local authority districts had ratios relatively close to the Kent average of 17.0.

¹² Excess winter deaths are defined by the Office for National Statistics (ONS) as the difference between the number of deaths during the four winter months (December–March) and the average number of deaths during the preceding four months (August–November) and the following four months (April–July). The excess winter deaths ratio is not a reflection of the overall mortality rate. It shows the percentage of deaths above the mortality rate if it was stable throughout the year.

- 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 implemented such as GP practice winter warmth referral, which, if successful, could be rolled out to other areas of the County

Warm Homes Healthy People Fund

The Kent Public Health Directorate has recently obtained funding from the Department of Health's Warm Homes Healthy People Fund to target those at greatest risk of poor health due to cold temperatures. The local Age UKs and Home Improvement Agencies in Kent will offer support via home visits by improving awareness of the risks, providing advice on energy efficiency, benefit checks, arranging delivery of hot meals and provision of warm clothing. There will also be work to minimise the need for people to go outside during particularly cold weather, ie collection of prescriptions and shopping for essential items.

Recommendations

- Evaluation of the above pilot schemes upon completion, 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 ways in which agencies can work together to target those at greatest risk of morbidity and mortality due to cold weather.
- Work with the voluntary and community sector to explore how they can deliver interventions to those at risk.

6.5 Delivering QIPP (Quality, Innovation, Productivity prevention)

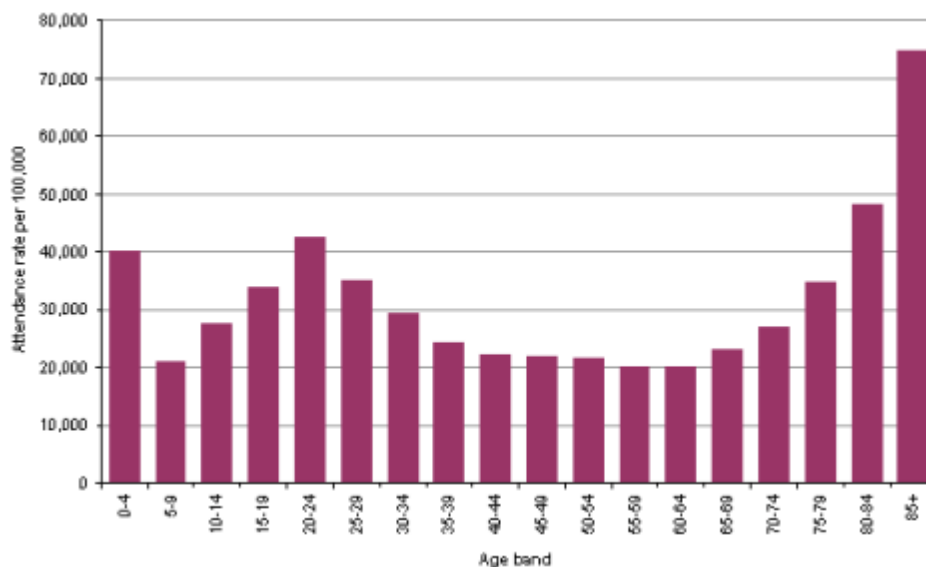
6.5.1 Urgent Care

- 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.

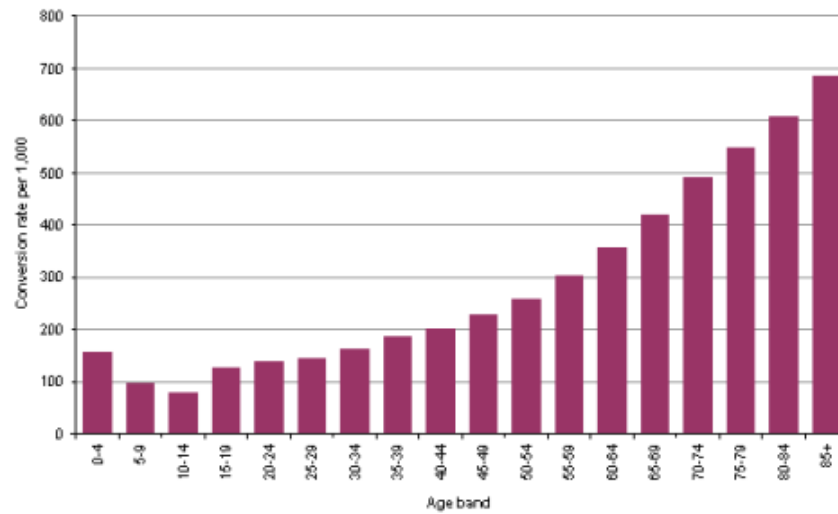
- In Kent, due to a variation in quality and practice of submission of non elective data across different local provider trust organisations, non elective activity cannot be accurately described year by year. However NHS comparators estimates that there has been a rise in cost of emergency admissions between 2005/06 and 2009/10 of approximately 6% from £201m to £213m.
- Figure 15 shows the age distribution of A&E attendance rates for the Kent population for 2010/11. Three groups which appear to attend A&E more frequently: the under 5s, 20-24 yrs and >80yrs.
- Development an integrated urgent care model – bringing together all key providers, including ambulance, walk in centre, minor injuries, community, primary and acute services; in line with the national single point of access programme.

Figure 15: Accident & Emergency / Minor Injury Unit age-specific attendance rate in Kent April 2010 to March 2011



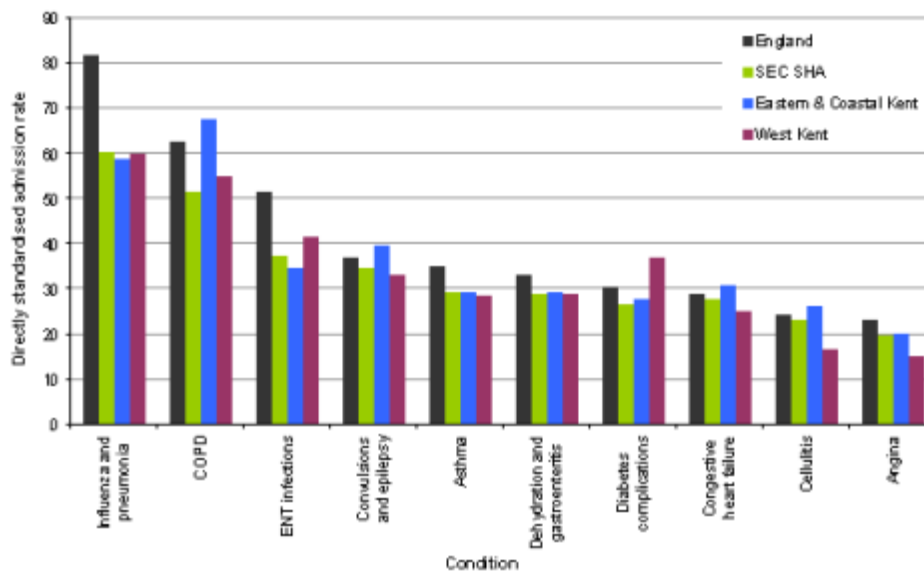
- Figure 16 shows that, apart from a small increase for under 5s, conversion rates from A&E attendance to admission appears to gradually increase with increasing age with the above 85 year age group 70% likely to be admitted.

Figure 16: Age-specific A&E/MIU conversion rate in Kent April 2010 to March 2011



- Figure 17 shows that patients are more likely to be admitted with a respiratory related illnesses such as, influenza and pneumonia and COPD.

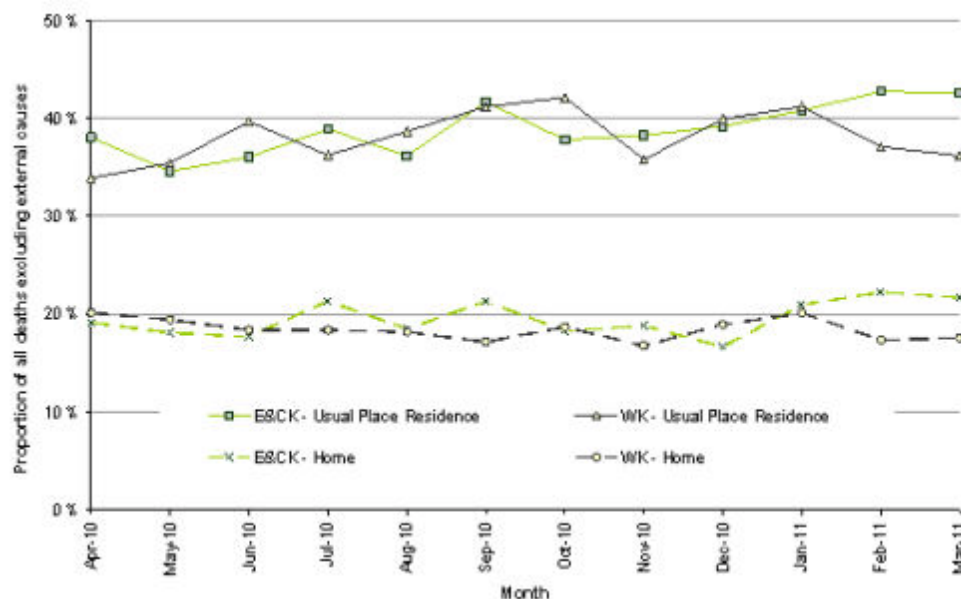
Figure 17: Top 10 Ambulatory Care Sensitive Conditions Emergency Admission rate October 2010 to December 2010



6.5.2 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.
- Figure 18 shows that the percentage of deaths at home is similar in both east and west as are the deaths within usual place of residence. Over the three month period January to March 2011 there was a slight increase in the number of people who died at home or in their usual place of residence within east Kent, however a decline was seen during the same period for west Kent.

Figure 18: Proportion of all deaths occurring at home or in usual place of residence

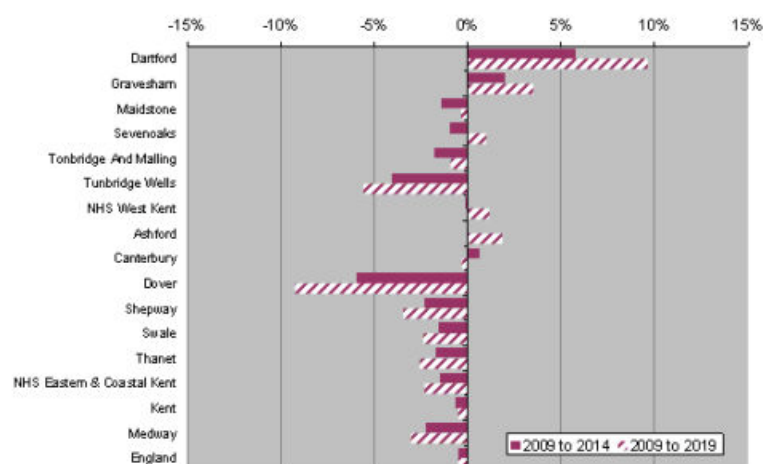


- While the national priority is to increase the proportion of identified EOLC patients to die at home, there is also an important need to increase the proportion of non-cancer patients in this regard and extend and offer generalist and specialist palliative care services to them wherever applicable. This links to the issues discussed in earlier sections around identifying non-cancer patients (through risk stratification) with chronic conditions (for example heart failure and COPD) who are at high risk of re-hospitalisation and using a multi disciplinary approach to determine if they are in an end of life situation and pro-actively embed advanced care plans to enable crisis management, obviating the need for future hospital admissions.

6.5.3 Maternity and Babies

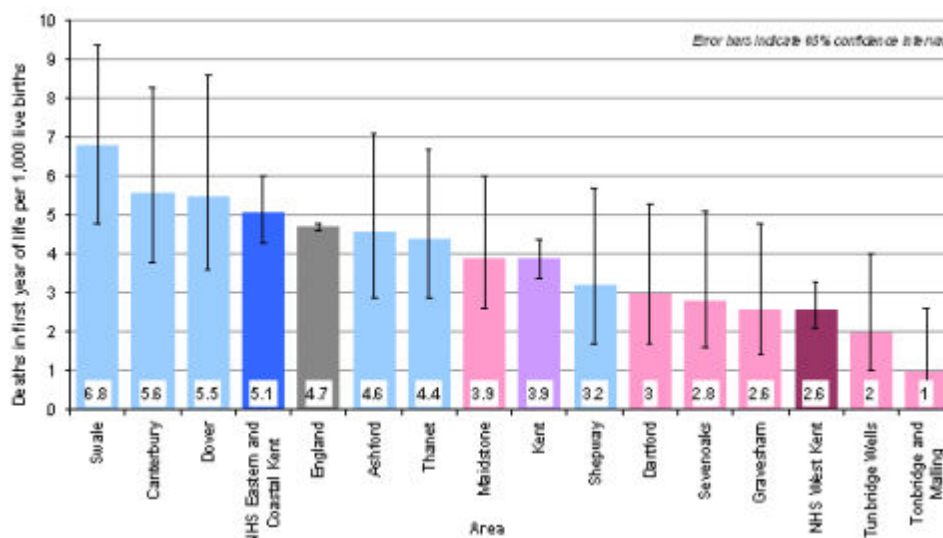
- The population of women of a childbearing age is projected to increase in the Dartford and Gravesham Local Authority areas (approximately 9% over ten years), and to a lesser extent in the Ashford, Canterbury and Sevenoaks areas (approximately 1-2%), although overall the population of women of a childbearing age in Kent is projected to decrease slightly [Figure 19].

Figure 19: Population trends for women of child bearing age by District Authority



- Swale, Canterbury and Dover have significantly higher rates of infant mortality compared to Tonbridge and Malling [Figure 20] a good example of where health inequalities exist requiring a targeted approach.

Figure 20: Infant Mortality rate by area of residence – 2007 to 2009 pooled



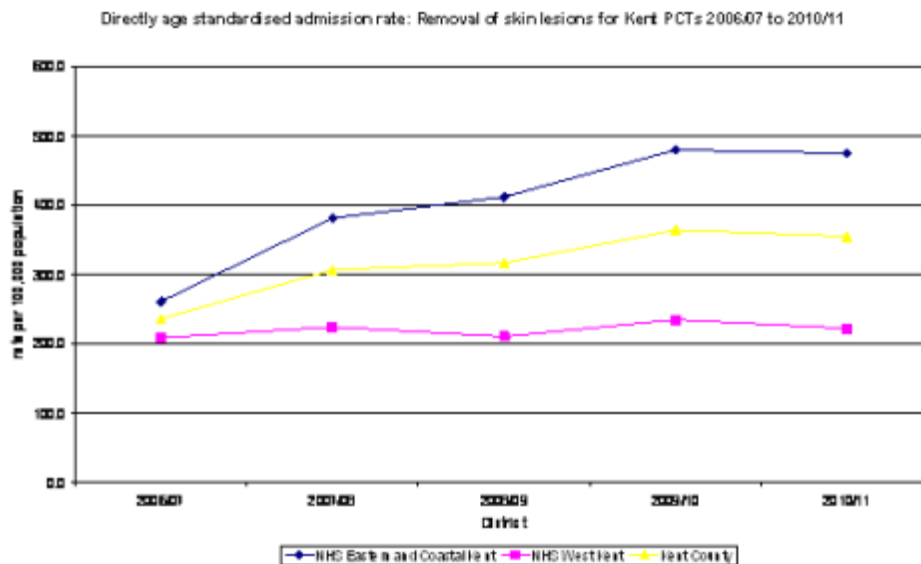
- Focus on new tests such as fetal fibronectin to predict preterm labour and development of robust indicators to monitor variation in caesarean section activity across provider organisation has been recommended.

6.5.4 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 [Figure 21]. 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, and teledermatology triage for skin conditions.

Figure 21: Directly age standardised rate: Removal of skin lesions; Kent PCTs 2006/07 to 2010/11



The results of the recent utilization review highlights the urgent need to initiate systematic transformation change across the health and social care economy to enable admission avoidance and cost effective use of scarce resources. The Kings Fund (2011) suggests 10 priorities for commissioners of which the following have been recommended to achieve the most potential economic impact for Kent and Medway.

- Operationalising integrated health and social care teams.
- Integrated investment across primary prevention
- Improving end of life care systems of care
- Admission avoidance initiatives to manage the top 19 ACS conditions

6.5.5 Selected indicators describing provider performance and quality of care

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

Figures 22 and 23 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 SEC 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 22

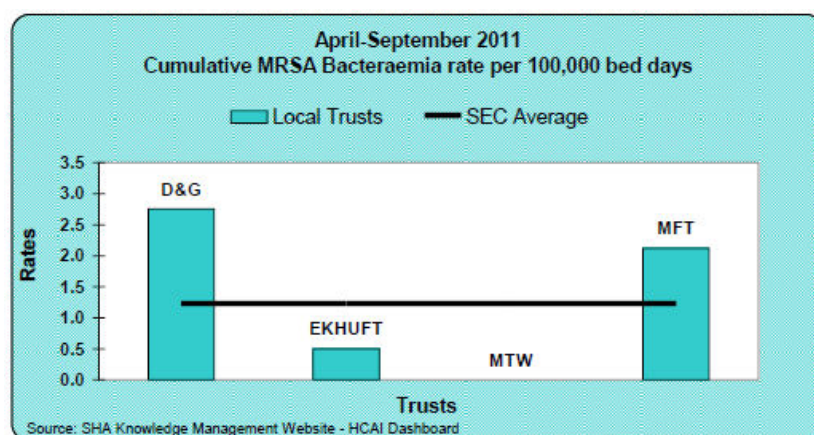
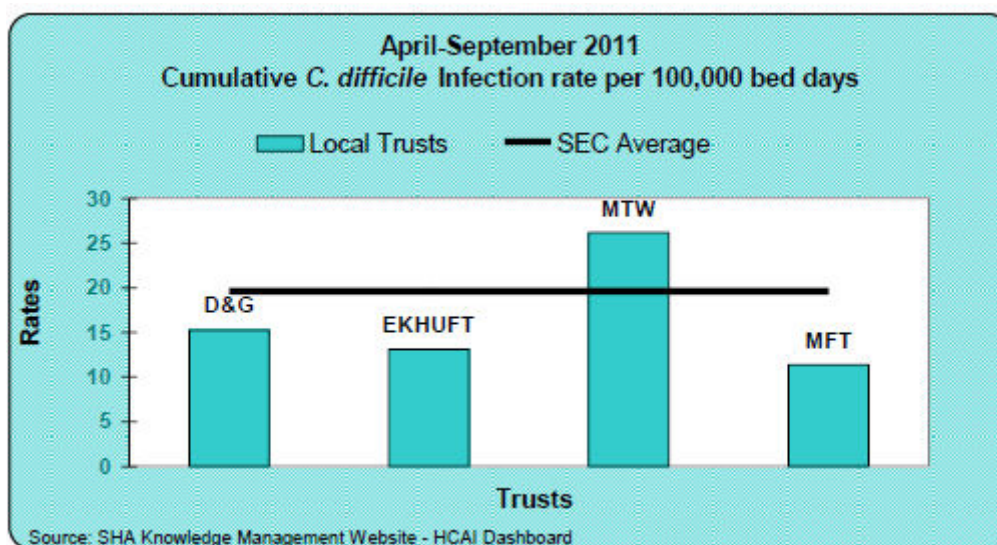


Figure 23



East Kent University Hospital Trust (EKUHT) has the largest number of beds and the lowest rate of complaints for the three acute provider trusts within Kent. [Table 5]

Table 5 Number of complaints from patients as a ratio of total beds

Complaints within Acute Trusts	BEDS	COMPLAINTS	RATE
East Sussex	944	532	0.56
East Kent	1106	722	0.65
Sussex and Surrey	527	484	0.92
Maldstone and Tonbridge Wells	687	708	1.03
South London	1036	1090	1.05
Dartford and Gravesham	425	463	1.09
Medway	499	552	1.11
Brighton and Sussex	944	1312	1.39

The following key themes are emerging from early analysis of all Acute Trusts complaints data within Kent and Medway:

- Staff attitude (nursing, and medical staff)
- Poor Communication between Medical/Nursing staff
- Poor Patient Communications
- Nursing/medical care not meeting patient expectation
- Clinical Treatment (Operative)
- Waiting Times

Mortality

The latest HSMR¹³ figures from Dr Foster [Table 6] indicate that Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust have significantly higher rates compared to the England average, East Kent Hospitals University NHS Foundation Trust has a low score, however this maybe a coding issues.

Table 6: Hospital Standardised Mortality Rate, Acute Trusts in Kent and Medway. April 2010 to August 2011

Trust	Observed deaths	Expected deaths	HSMR
ALL	8209	8619.2	95.2
East Kent Hospitals University NHS Foundation Trust	3313	4003.8	82.7
Maidstone and Tunbridge Wells NHS Trust	1929	1915	100.7
Medway NHS Foundation Trust	1614	1474.9	109.4
Dartford and Gravesham NHS Trust	1353	1225.4	110.4

A detailed list of integrated performance measures are in appendix G. The Kent and Medway cluster continues to achieve a standard of 95% delivery of the 4 hour wait. However there have been several occasions where pressures at occurred various hospitals, for example Darent Valley Hospital in September 2011. This was caused by a peak in activity and report increase in acuity of patients.

6.6 Social factors and population groups

6.6.1 Housing and homelessness

- The estimated shortfall in affordable housing far exceeds what will be delivered through new supply. Collectively, the housing need assessments

¹³ Hospital Standardised Mortality Rate

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.

6.6.2 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.

6.6.3 Community pharmacies

- All PCTs in England are required to publish a Pharmaceutical Needs Assessment. These will be used to determine future approval of applications for new pharmaceutical and dispensing services.
- 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.

- 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.
- Use of the Medicines Use Review (MUR) service linking in with primary care, community care and hospitals can optimise compliance of drugs for example osteoporosis treatment toward prevention of fragility fractures.

6.6.4 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.

Recommendations

- Recommendations are made in 4 key areas; the transition from The Defense 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

- Implementation of the Murrison Review to evaluate Kent and Medway prosthetic limb service.
- Support extension of the Soldiers, Sailors, Airmen and Families Association (SSAFA) referral project from custodies to A&Es.

Mental Health Services for Veterans

- 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.
- Encourage Armed forces/veteran representation or close links with Health and Wellbeing Boards.

6.6.5 Health, wellbeing and sustainability

- Sustainability¹⁴ 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 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.

Recommendations

- 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.

¹⁴ [http://www.sdu.nhs.uk/documents/publications/APHO_TB9\(4211\)](http://www.sdu.nhs.uk/documents/publications/APHO_TB9(4211))

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APPENDIX A – CCG PROFILES

Please note that data within the health issues section are calculated for registered practice populations, which are not confined by a distinct geographical boundary as opposed to resident populations within a district authority boundary.

Ashford Clinical Commissioning Group (CCG)

1.1 Demographics

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

1.2 Population

Understanding the population age structure is important for future and current planning of services.

- 122,599¹⁵ 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 years¹⁶ 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.

¹⁵ PCIS registered practices populations September 2011

¹⁶ ONS 2008-Based population projections 2011-2016, 2011-2021

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

1.3 Relative Deprivation

Poor health outcomes are associated with relative deprivation; poorer health outcomes are generally seen in populations that live in more deprived areas. Relative deprivation is the single biggest contributor to health inequalities.

Using a rank of one to indicate the most deprived district council area in England Ashford is ranked 198 out of 326 local authorities, and eighth of the 12 Kent districts.

- 5.7% of Ashford lower level super output areas are in the 20% most deprived for England.
- The highest levels of deprivation are found within Stanhope, Aylesford Green and Victoria, in an around Ashford town centre.

1.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. The 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 with depression and anxiety problems has been shown to increase, as has the rate of suicides.

Good educational attainment increases the likelihood of sustained employability including the capacity to re-train throughout different stages of life (the life course)

- 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 was 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%)

1.5 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.

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 Breastfeeding initiation rates (70%) are significantly worse than England (smoking 14% Breastfeeding 73.6%)

1.6 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 hospital 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 attributable to three main diseases: Circulatory disease (34.1%), Cancer (29.4%) and respiratory disease (13.5%).
- 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.

Canterbury and Coastal Clinical Commissioning Groups (C4G)

1.1 Demographics

C4G comprises 23 practices, the majority (16) are located within Canterbury City Council area. Four practices are located in Faversham within Swale Borough Council area and the remaining three serve people living in part of Dover District Council area. There is also a branch practice located in Chilham which is in the Ashford Borough Council area.

1.2 Population

Understanding the population age structure is important for future and current planning of services.

- 211,651 people are registered with practices within C4G 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 city and has a larger proportion of people aged between 15 and 29 because of its student population.
- Based on data for Canterbury City Council area, the population is projected to increase by 4% over the next five years¹⁷ 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 least likely to require social care services. Lifestyle risks are key for this age group as they are more likely to smoke, abuse alcohol and experiment with drugs. Sexual health services will also be a priority for this group.

1.3 Relative Deprivation

Poor health outcomes are associated with relative deprivation; poorer health outcomes are generally seen in populations that live in more deprived areas. Relative deprivation is the single biggest contributor to health inequalities.

¹⁷ ONS 2008-Based population projections 2011-2016, 2011-2021

Using a rank of one to indicate the most deprived district council area in England Canterbury is ranked 166 out of 326 local authorities, and is ranked sixth 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 concentrations of relative deprivation are to be found within the Gorrell, Heron and Wincheap.

1.4 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 with depression and anxiety problems has been shown to increase, as has the rate of suicides.

Good educational attainment increases the likelihood of sustained employability including the capacity to re-train throughout different stages of life (the life course).

- The level of unemployment within Canterbury City Council area 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 five 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%)

1.5 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

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 breastfeeding initiation rates (70%) are significantly worse than England (smoking 14% breastfeeding 73.6%)

1.6 Health Issues

Prevalence

- The 2010/11 QOF disease registers show that the population of C4G populations has a prevalence pattern similar to that of England, but with slightly greater numbers on the stroke register.

Morbidity

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

- C4G 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.
- There are significantly higher hospital admission rates due to self harm than England.

Mortality

- 77.2% of all deaths are attributable to three main diseases: Circulatory disease (37.2%), Cancer (27.1%) and respiratory disease (12.9%).

- Mortality rates from Circulatory disease (Coronary Heart disease and Stroke) and Cancer have been steadily declining since 1995, and the rate of premature mortality is lower than that of England.

Dartford, Gravesham and Swanley CCG

1.1 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).

1.2 Population

Understanding the population age structure is important for future and current planning of services.

- 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).

1.3 Relative Deprivation

Poor health outcomes are associated with relative deprivation; poorer health outcomes are generally seen in populations that live in more deprived areas. Relative deprivation is the single biggest contributor to health inequalities.

Using a rank of one to indicate the most deprived district council area in England Dartford is ranked 175 and Gravesham is ranked 142 out of 326 local authorities. Dartford is ranked seventh and Gravesham fifth 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).

1.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. The 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 with depression and anxiety problems has been shown to increase, as has the rate of suicides.

Good educational attainment increases the likelihood of sustained employability including the capacity to re-train throughout different stages of life (the life course)

- 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%)

1.5 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.

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%.

1.6 Health Issues

Prevalence

- The 2010/11 QOF registers show that the population of DGS have a higher prevalence of hypertension, hyperthyroidism, Chronic Kidney disease and obesity, than England.
- 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 hospital 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 attributable to three main diseases: Circulatory disease (31.3%), Cancer (28.9%) and respiratory disease (13.1%), within Dartford and Gravesham districts.

Maidstone and Malling CCG

1.1 Demographics

There are 11 practices within the Maidstone and Malling CCG, all but one of these practices are located within the Maidstone Borough Council area, one practice is located within the Tonbridge and Malling Borough Council area.

1.2 Population

Understanding the population age structure is important for future and current planning of services.

- 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 years¹⁸ 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 at birth for Maidstone and Malling is 81 years this compares to 80.9 for Kent and Medway. There is 7.9 years difference between the ward with the lowest life expectancy [Bridge, 76.1 years] and the ward with the highest life expectancy [Downswood and Otham 84.2 years]

1.3 Relative Deprivation

Poor health outcomes are associated with relative deprivation; poorer health outcomes are generally seen in populations that live in more deprived areas.

¹⁸ ONS 2008-Based population projections 2011-2016, 2011-2021

Relative deprivation is the single biggest contributor to health inequalities.

Using a rank of one to indicate the most deprived district council area in England Maidstone is ranked 217 out of 326 local authorities and is the ninth most deprived district in Kent.

- 6.5% of Maidstone's lower layer super output areas are in the 20% most deprived for England,

1.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. The 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 with depression and anxiety problems has been shown to increase, as has the rate of suicides.

Good educational attainment increases the likelihood of sustained employability including the capacity to re-train throughout different stages of life (the life course)

- 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 Maidstone are classified as statutory homeless; this is significantly lower than England (1.86%)

1.5 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.

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.

1.6 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 hospital 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 show that emergency admissions for these conditions are increasing.

Mortality

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

Swale Clinical Commissioning Group

1.1 Demographics

There are 20 practices within the Swale CCG, all which located within the Swale Borough Council area.

1.2 Population

Understanding the population structure is important for future and current planning of services

- 106,215 people are registered with practices in Swale locality consortium. This is 7% of the total registered practice population for Kent.
- Swale is one of the smallest CCGs.
- The population structure of Swale CCG locality group is similar to that for Kent as a whole. The largest proportion of the population is in the 40-49 age groups.
- Using data for Swale District, the population is projected to increase by 4% over the next 5 years¹⁹ 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 has a Black or Minority Ethnic (BME) background
- Life expectancy at 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 with long term conditions such as, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and Diabetes.

1.3 Relative Deprivation

Poor health outcomes are associated with relative deprivation; poorer health outcomes are generally seen in populations that live in more deprived areas. Relative deprivation is the single biggest contributor to health inequalities.

¹⁹ ONS 2008-Based population projections 2011-2016, 2011-2021

Using a rank of one to indicate the most deprived district council area in England Swale is ranked 99 out of 326 local authorities and is the third most deprived district in Kent.

- 20.7% of Swale's lower layer super output areas are in the 20% most deprived for England,
- The highest number of people living in relative deprivation are to be found within the Sheerness East, Murston and Leysdown and Warden wards.

1.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. The 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 with depression and anxiety problems has been shown to increase, as has the rate of suicides.

Good educational attainment increases the likelihood of sustained employability including the capacity to re-train throughout different stages of life (the life course)

- 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 five A*-C grade GCSEs (including Maths and English) compared to 55.3% for England
- 1.11% of households within Swale are classified as statutory homeless; this is significantly lower than England (1.86%)

1.5 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.

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 breastfeeding initiation rates (70%) are significantly worse than England (smoking 14% breastfeeding 73.6%)
- The teenage conception rate for Swale (46.7) is significantly higher than England (40.2) but has progressively reduced since 2009

1.6 Health Issues

Prevalence

- The 2010/11 QOF registers show that the registered population of Swale CCG has a higher prevalence of hypertension, Diabetes, COPD, and obesity, than England.

Morbidity

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

- Swale CCG has 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

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

South Kent Coast CCG

1.1 Demographics

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

1.2 Population

Understanding the population age structure is important for future and current planning of services.

- 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 years²⁰ 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.

1.3 Relative Deprivation

Poor health outcomes are associated with relative deprivation; poorer health outcomes are generally seen in populations that live in more deprived areas.

Relative deprivation is the single biggest contributor to health inequalities.

Using a rank of one to indicate the most deprived district council area in England Dover is ranked 127 and Shepway is 97 ranked out of 326 local authorities. Shepway is the third most deprived district in Kent.

²⁰ ONS 2008-Based population projections 2011-2016, 2011-2021

- 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)

1.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. The 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 with depression and anxiety problems has been shown to increase, as has the rate of suicides.

Good educational attainment increases the likelihood of sustained employability including the capacity to re-train throughout different stages of life (the life course).

- 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%)

1.5 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.

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 breastfeeding initiation rates (70%) are significantly worse than England (smoking 14% breastfeeding 73.6%)

1.6 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 hospital 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 attributable to three main diseases: Circulatory disease (34.2%), Cancer (27%) and respiratory disease (15%).

Thanet and East Cliff CCG

1.1 Demographics

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

1.2 Population

Understanding the population age structure is important for future and current planning of services.

- 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 years²¹ 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]

1.3 Relative Deprivation

Poor health outcomes are associated with relative deprivation; poorer health outcomes are generally seen in populations that live in more deprived areas. Relative deprivation is the single biggest contributor to health inequalities.

Using a rank of one to indicate the most deprived district council area in England Thanet is ranked 49 out of 326 local authorities and is the most deprived district in Kent.

²¹ ONS 2008-Based population projections 2011-2016, 2011-2021

- 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.

1.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. The 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 with depression and anxiety problems has been shown to increase, as has the rate of suicides.

Good educational attainment increases the likelihood of sustained employability including the capacity to re-train throughout different stages of life (the life course)

- 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%)

1.5 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.

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 breastfeeding initiation rates (70%) are significantly worse than England (smoking 14% breastfeeding 73.6%)

1.6 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 hospital 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

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

West Kent and Weald CCG

1.1 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.

1.2 Population

Understanding the population age structure is important for future and current planning of services.

- 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 population of WKW is broadly similar to that for Kent and Medway. WKW has a slightly larger population of 40 to 54 year olds and slightly fewer 24 to 34 year olds
- 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 in 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]

1.3 Relative Deprivation

Poor social care and health outcomes are associated with deprivation poor outcomes are generally seen in populations who live in more deprived areas.

Relative deprivation is the single biggest contributor to health inequalities.

- The CCG of West Kent and Weald spans 4 districts. These 4 districts have the lowest levels of deprivation for Kent using a rank of one to indicate the most deprived district council area in England. The four districts in WKW are 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 are in the 20% most deprived for England, 1.4% of Sevenoaks and 6.5% of Maidstone lower layer super output areas are in the 20% most deprived for England.

1.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the socio-economic factors and the opportunities available to populations. The 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 with depression and anxiety problems has been shown to increase, as has the rate of suicides.

Good educational attainment increases the likelihood of sustained employability including the capacity to re-train throughout different stages of life (the life course)

- 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 are 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%

1.5 Risk Factors

Modifiable lifestyle factors such as smoking, maintaining a healthy diet and limiting alcohol consumption can have a significant impact on health and social care outcomes.

Adults

- Prevalence of obese adults in Maidstone (26.3%) is significantly higher than England (24.2%) the prevalence of adult obesity in the other districts is generally not significantly different or are significantly lower.
- The number of admissions to hospital due to alcohol specific conditions declined between 2009/10 and 2010/11

Children

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

1.6 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 hospital 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

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

APPENDIX B – Coastal Deprivation

If the 1930s to the 1950s were the heyday of the coastal resort then the 1970s and 1980s witnessed the social and economic changes that impacted upon established resort structures as staying visitors declined, holiday accommodation became cheap housing and urban-bred social problems came to the seaside.

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.

What is troubling for coastal towns is not unique to them, other than it reflects a particular focus of economic paradigm change (Fordist to Post Fordist) through loss of security and predictability juxtaposed with the currently converse ideologies of choice, competition, consumerism. Until the 1970s there was a regular rhythm to play (fixed holiday periods) as well as work. These patterns fragmented with the collapse of the old industries and their

holiday schedules, coinciding with the opening out of private transport and new holiday destinations. Generational differences in leisure preferences have come to the fore, in step with the invention of the teenager (USA 1944) and rapid expansion of seaside retirement.

Many of the problems of coastal towns are not new. Low wages, precarious small businesses, extended working hours, unemployment, part time work and seasonal economies, have been staple problems of such towns since their beginning. Women's work has been particularly exploited, especially by small employers. Schooling has often been problematic.

The obvious countervailing force for change – money – is no longer as readily available as hitherto and will become even scarcer in coming years as what remains of public resources is diverted to reducing the national debt. Asking regeneration practitioners to deliver more with less notwithstanding that many coastal resorts were passed by during the economically good times, raises questions as to whether coastal issues have become too large and complex for the resources and structures available.

Much of the attraction of seaside towns is ephemeral and thus difficult to define. In order to survive, revive and prosper, seaside towns need to retain the loyalty of their remaining established customers while recruiting the next generation and reaching out to new or lost constituencies. They cannot afford to change too completely. Regeneration of the built environment, of places of pleasure and relaxation, residential as well as recreational, need to be handled sensitively. The more successful have settled comfortably and successfully as small to middling places with renewable niche markets, loyal regular visitors, retired residents and attractive natural and built environments. Regeneration needs to be carefully considered, sensitive and interdisciplinary.

Reference

Regeneris Consulting (2007) LEGI: *National Baseline and Evaluation Feasibility – Scoping Report*. Regeneris Consulting, London and Manchester

APPENDIX C - Benefits of breastfeeding (World Health Organisation)

10 facts on breastfeeding

Breastfeeding is one of the most effective ways to ensure child health and survival. A lack of exclusive breastfeeding during the first six months of life contributes to over a million avoidable child deaths each year. Globally less than 40% of infants under six months of age are exclusively breastfed. Adequate breastfeeding support for mothers and families could save many young lives. WHO actively promotes breastfeeding as the best source of nourishment for infants and young children. This fact file explores the many benefits of the practice, and how robust help for mothers can increase breastfeeding worldwide.

WHO recommends

WHO strongly recommends exclusive breastfeeding for the first six months of life. At six months, other foods should complement breastfeeding for up to two years or more. In addition:

- breastfeeding should begin within an hour of birth;
- breastfeeding should be "on demand", as often as the child wants day and night; and
- bottles or pacifiers should be avoided.

Health benefits for infants

Breast milk is the ideal food for newborns and infants. It gives infants all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses - such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide. Breast milk is readily available and affordable, which helps to ensure that infants get adequate sustenance.

Benefits for mothers

Breastfeeding also benefits mothers. The practice when done exclusively often induces a lack of menstruation, which is a natural (though not fail-safe) method of birth control. It reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity.

Long-term benefits for children

Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adults who were breastfed as babies often have lower blood pressure and lower cholesterol, as well as lower rates of overweight, obesity and type-2 diabetes. There is evidence that people who were breastfed perform better in intelligence tests.

Why not infant formula?

Infant formula does not contain the antibodies found in breast milk and is linked to some risks, such as water-borne diseases that arise from mixing powdered formula with unsafe water (many families lack access to clean water). Malnutrition can result from over-diluting formula to "stretch" supplies. Further, frequent feedings maintain the breast milk supply. If formula is used but becomes unavailable, a return to breastfeeding may not be an option due to diminished breast milk production.

HIV and breastfeeding

For HIV-positive mothers, WHO recommends exclusive breastfeeding for the first six months unless replacement feeding is:

- acceptable (socially welcome)
- feasible (facilities and help are available to prepare formula)
- affordable (formula can be purchased for six months)
- sustainable (feeding can be sustained for six months)
- safe (formula is prepared with safe water and in hygienic conditions).

Regulating breast-milk substitutes

An international code to regulate the marketing of breast-milk substitutes was adopted in 1981. It calls for:

- all formula labels and information to state the benefits of breastfeeding and the health risks of substitutes;
- no promotion of breast-milk substitutes;
- no free samples of substitutes to be given to pregnant women, mothers or their families; and
- no distribution of free or subsidized substitutes to health workers or facilities.

Support for mothers is essential

Breastfeeding has to be learned and many women encounter difficulties at the beginning. Nipple pain, and fear that there is not enough milk to sustain the baby are common. Health facilities that support breastfeeding - by making trained breastfeeding counsellors available to new mothers - encourage higher rates of the practice. To provide this support and improve care for mothers and newborns, there are now more than 20 000 "baby-friendly" facilities in 152 countries thanks to a WHO-UNICEF initiative.

Work and breastfeeding

WHO recommends that a new mother should have at least 16 weeks of absence from work after delivery, to be able to rest and breastfeed her child. Many mothers who go back to work abandon exclusive breastfeeding before the recommended six months because they do not have sufficient time, or an adequate place to breastfeed or express and store their milk at work. Mothers need access to a safe, clean and private place in or near their workplaces to continue the practice.

The next step: phasing in new foods

To meet the growing needs of babies at six months of age, complementary foods should be introduced as they continue to breastfeed. Foods for the baby can be specially prepared or modified from family meals. WHO notes that:

- breastfeeding should not be decreased when starting complementary feeding;
- complementary foods should be given with a spoon or cup, not in a bottle;
- foods should be clean, safe and locally available; and
- ample time is needed for young children to learn to eat solid foods.

APPENDIX D – Estimated number of children with mental health conditions in Kent

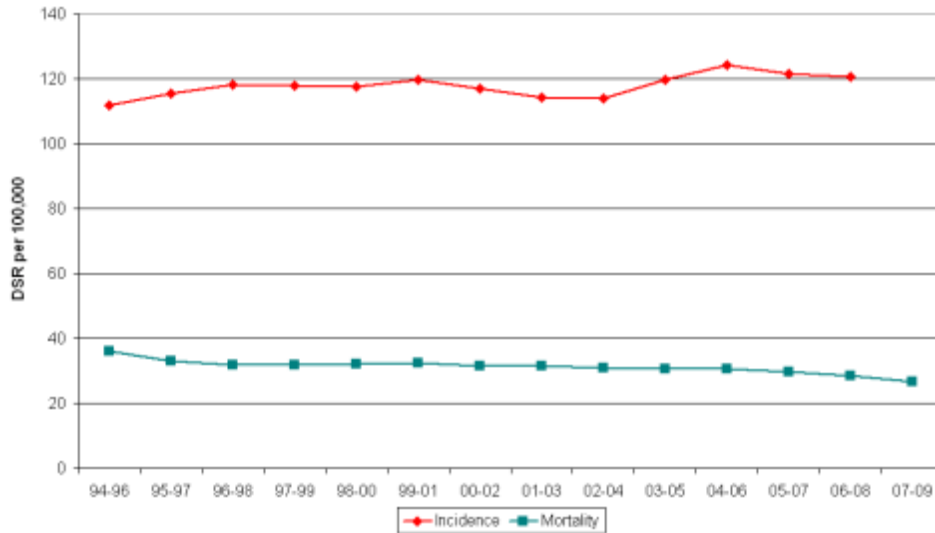
		5-10 year olds			11-16year olds			5-16 yrs
		Boys	Girls	All	Boys	Girls	All	All
		50,098	47,342	97,440	56,174	53,778	109,952	207,392
Emotional disorders		1,102	1,184	2,339	2,247	3,280	5,498	7,674
Anxiety disorders		1,052	1,136	2,144	2,022	2,796	4,838	6,844
	Separation anxiety	200	331	585	169	215	330	830
	Specific phobia	401	331	682	449	484	990	1,659
	Social phobia	50	47	97	281	323	550	622
	Panic	0	0	0	112	269	440	415
	Agoraphobia	0	0	0	112	215	330	207
	PTSD	0	47	0	56	269	330	415
	OCD	50	95	195	169	108	220	415
	GAD	100	142	292	506	860	1,319	1,659
	Other anxiety	301	331	682	506	807	1,319	1,867
Depression		100	142	195	562	1,022	1,539	1,867
	Depression episode	50	95	195	449	753	1,209	1,244
	Other depressive episode	0	47	97	169	269	440	415
Conduct disorders		3,457	1,326	4,775	4,550	2,743	7,257	12,029
	Oppositional defiant disorder	2,254	1,136	3,410	1,966	914	2,859	6,222
	Unsocialised conduct disorder	451	142	585	674	430	1,100	1,659
	Socialised conduct disorder	301	0	292	1,461	1,022	2,419	2,696
	Other conduct disorder	451	47	487	393	430	880	1,244
Hyperkinetic disorders		1,353	189	1,559	1,348	215	1,539	3,111
Less common disorders		1,102	189	1,267	899	592	1,539	2,696
	Autistic Spectrum disorder	952	47	974	562	269	880	1,867
	Tic disorder	0	47	97	0	0	0	0
	Eating disorder	250	95	292	337	54	440	622
	Mutism	0	47	0	56	215	330	207
Any disorder		5,110	2,414	7,503	7,078	5,539	12,644	19,910

Source: Kent CAHMS needs assessment, June 2011

APPENDIX E – Cancer incidence and mortality charts

Breast Cancer

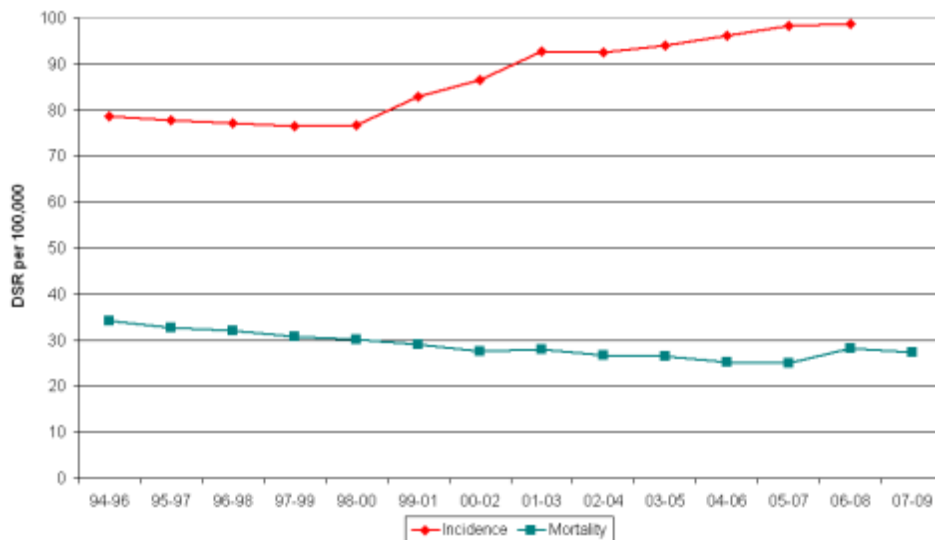
Trends in breast cancer incidence and mortality in KMCN three year rolling averages 1994-1996 to 2007-2009 (2006-2008 - incidence)



Source: NCINAPHOUKACR From Cancer e-Atlas 2010 (www.ncin.org.uk/eatlas)

Prostate Cancer

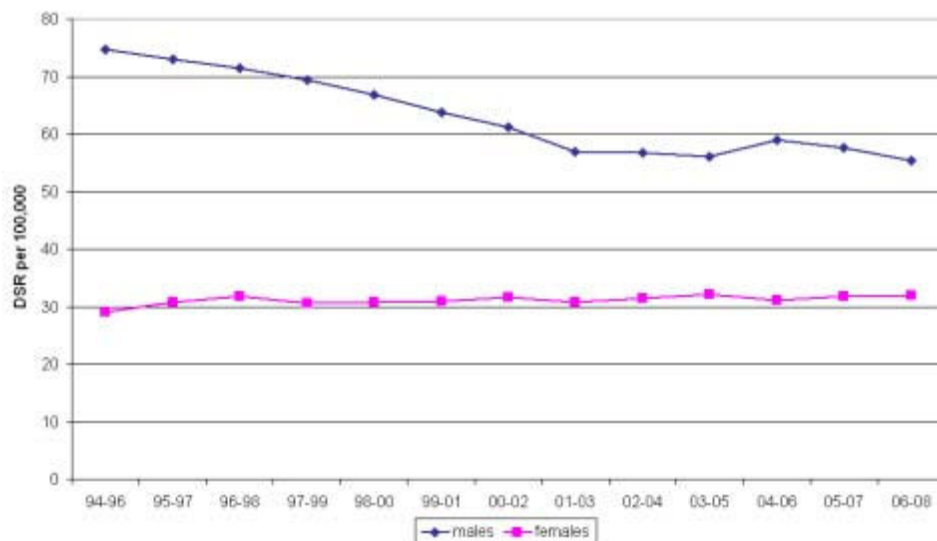
Trends in prostate cancer incidence and mortality in KMCN three year rolling averages 1994-1996 to 2007-2009 (2006-2008 - incidence)



Source: NCINAPHOUKACR From Cancer e-Atlas 2010 (www.ncin.org.uk/eatlas)

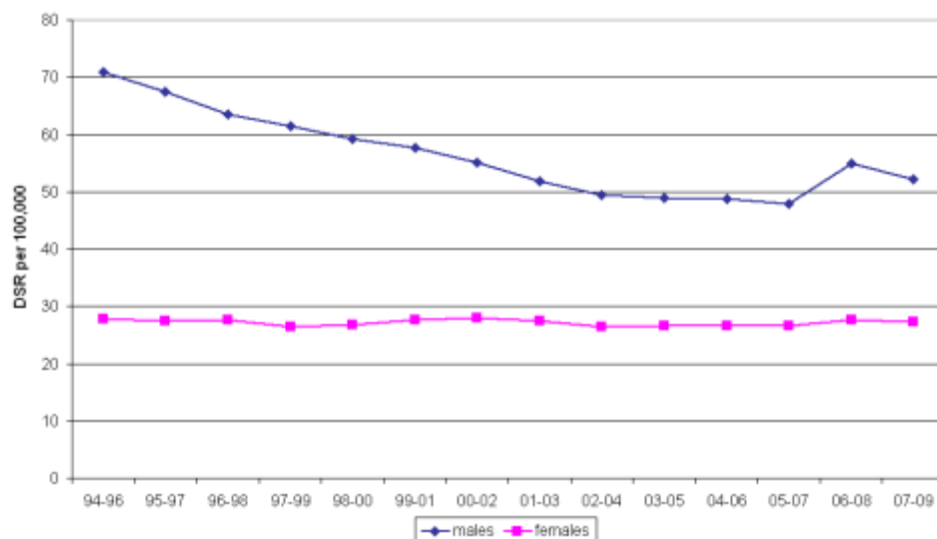
Lung Cancer

Trend in lung cancer incidence in KMCN by gender three year rolling averages 1994-1996 to 2006-2008



Source: NCINAPHOUKACR From Cancer e-Atlas 2010 (www.ncin.org.uk/eatlas)

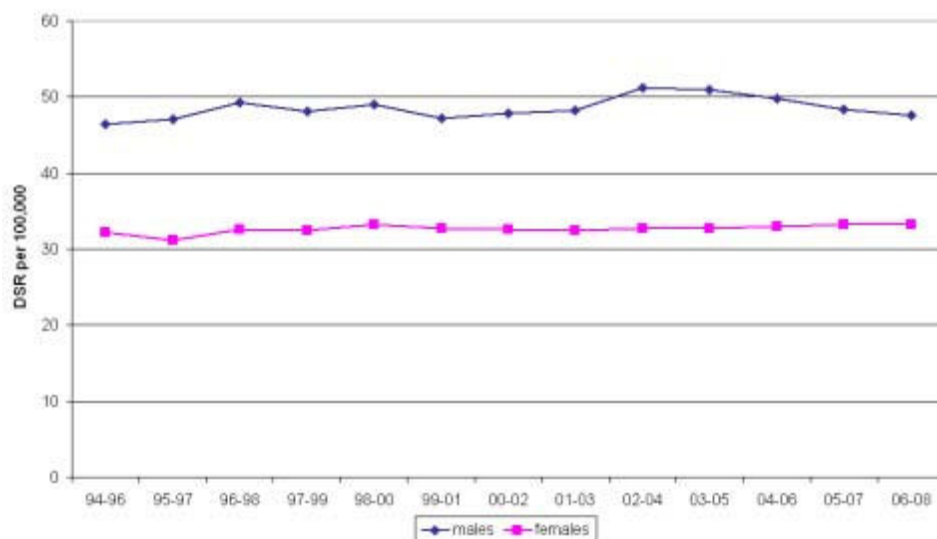
Trend in lung cancer mortality in KMCN by gender three year rolling averages 1994-1996 to 2007-2009



Source: NCINAPHOUKACR From Cancer e-Atlas 2010 (www.ncin.org.uk/eatlas)

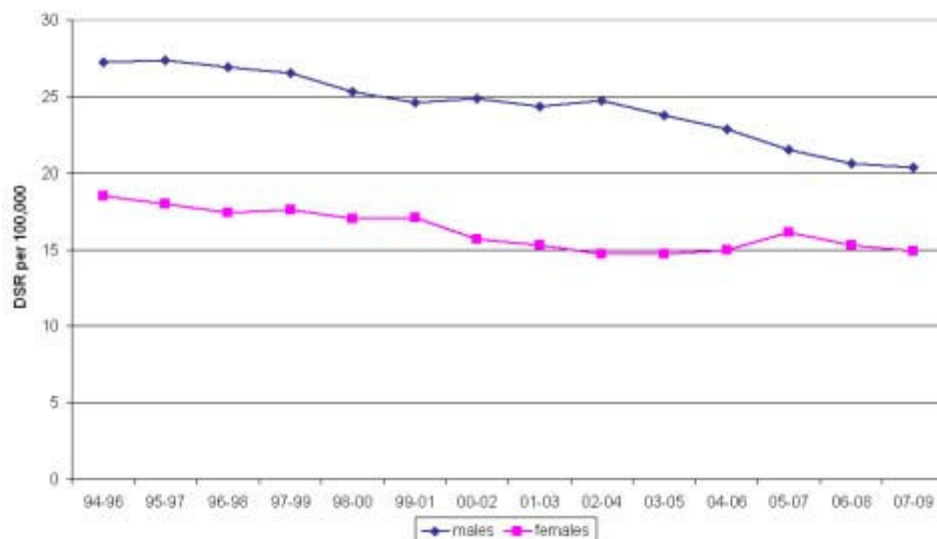
Colorectal Cancer

Trend in colorectal cancer incidence in KMCN by gender three year rolling averages 1994-1996 to 2006-2008



Source: NCIN/APHO/UKACR From Cancer e-Atlas 2010 (www.ncin.org.uk/eatlas)

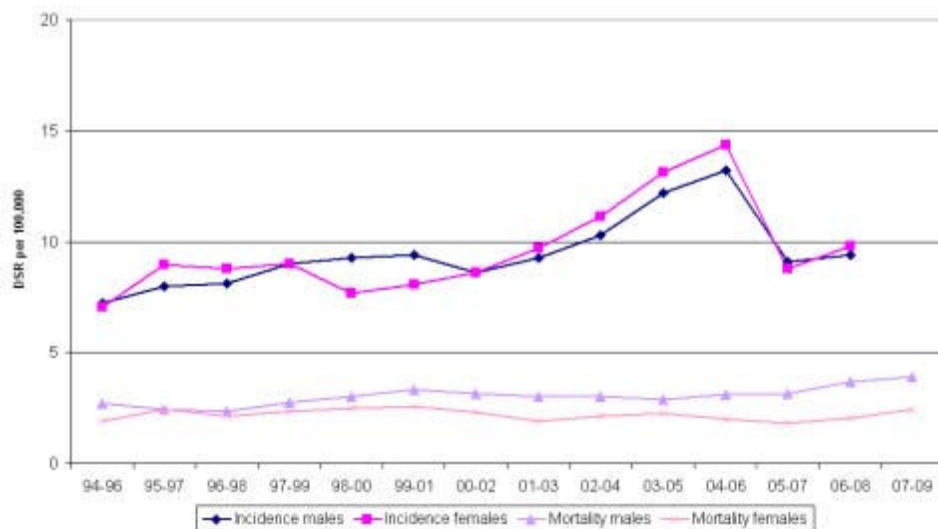
Trend in colorectal cancer mortality in KMCN by gender three year rolling averages 1994-1996 to 2007-2009



Source: NCIN/APHO/UKACR From Cancer e-Atlas 2010 (www.ncin.org.uk/eatlas)

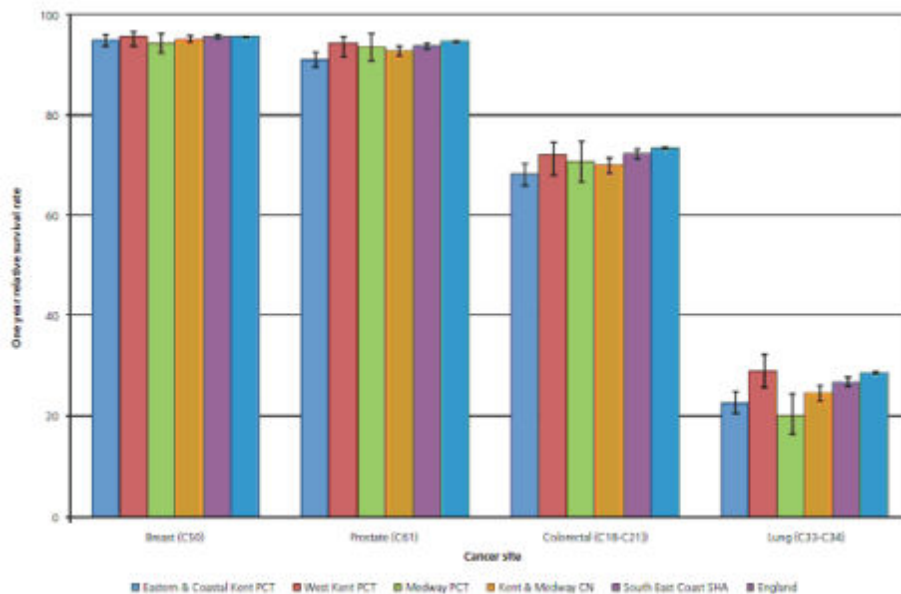
Skin Cancer

Skin cancer incidence and mortality: males and females 1994-1996 to 2007-2009 (2006-08 - incidence)



Source: NCINAPHO/KACR From Cancer e-Atlas 2010 (www.ncin.org.uk/eatlas)

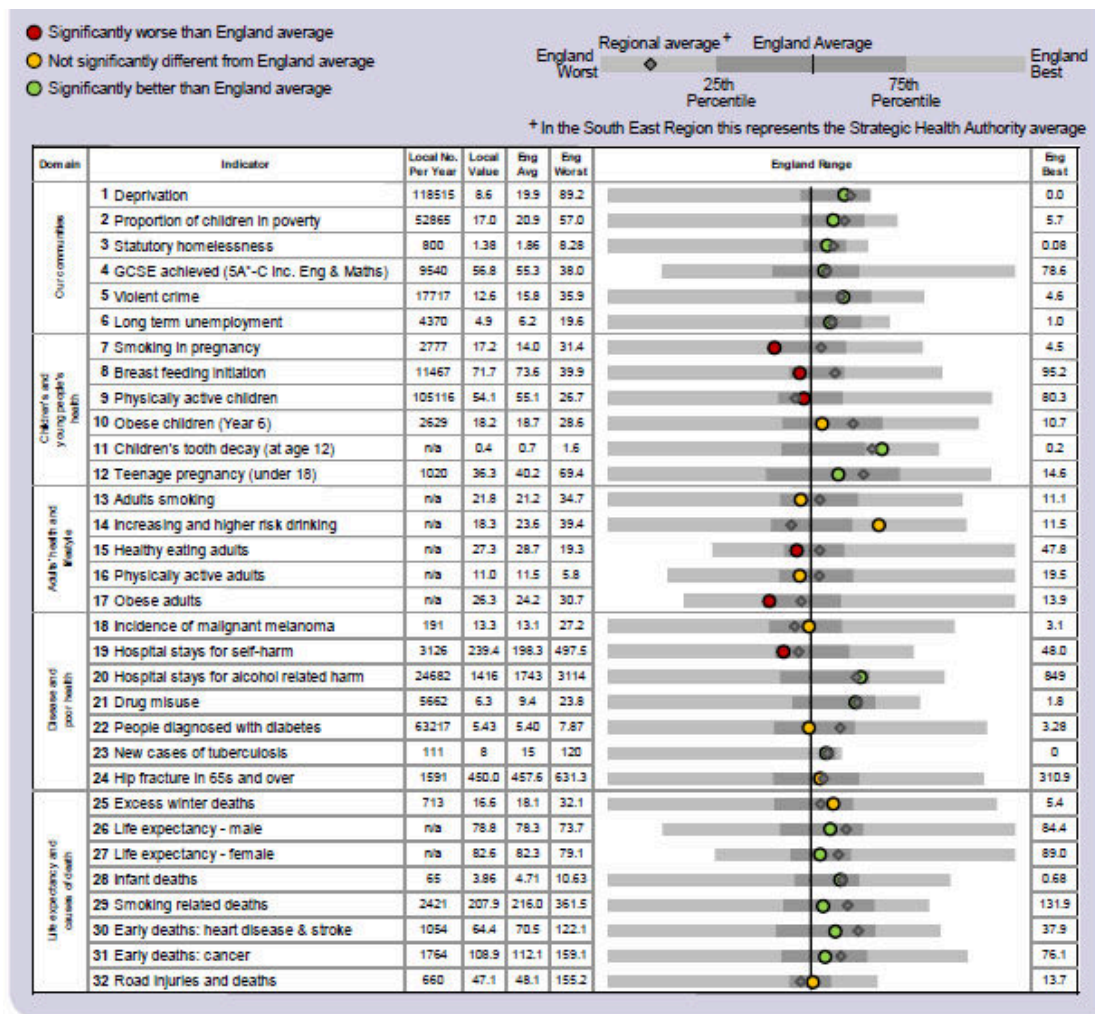
One year survival rate by area of resident and cancer site. Period of diagnosis: 2003-2007 (with follow up 2008)



APPENDIX F – Health Profiles 2011

Please note that all data for indicators are calculated for resident populations within a district authority boundary.

Kent County Council

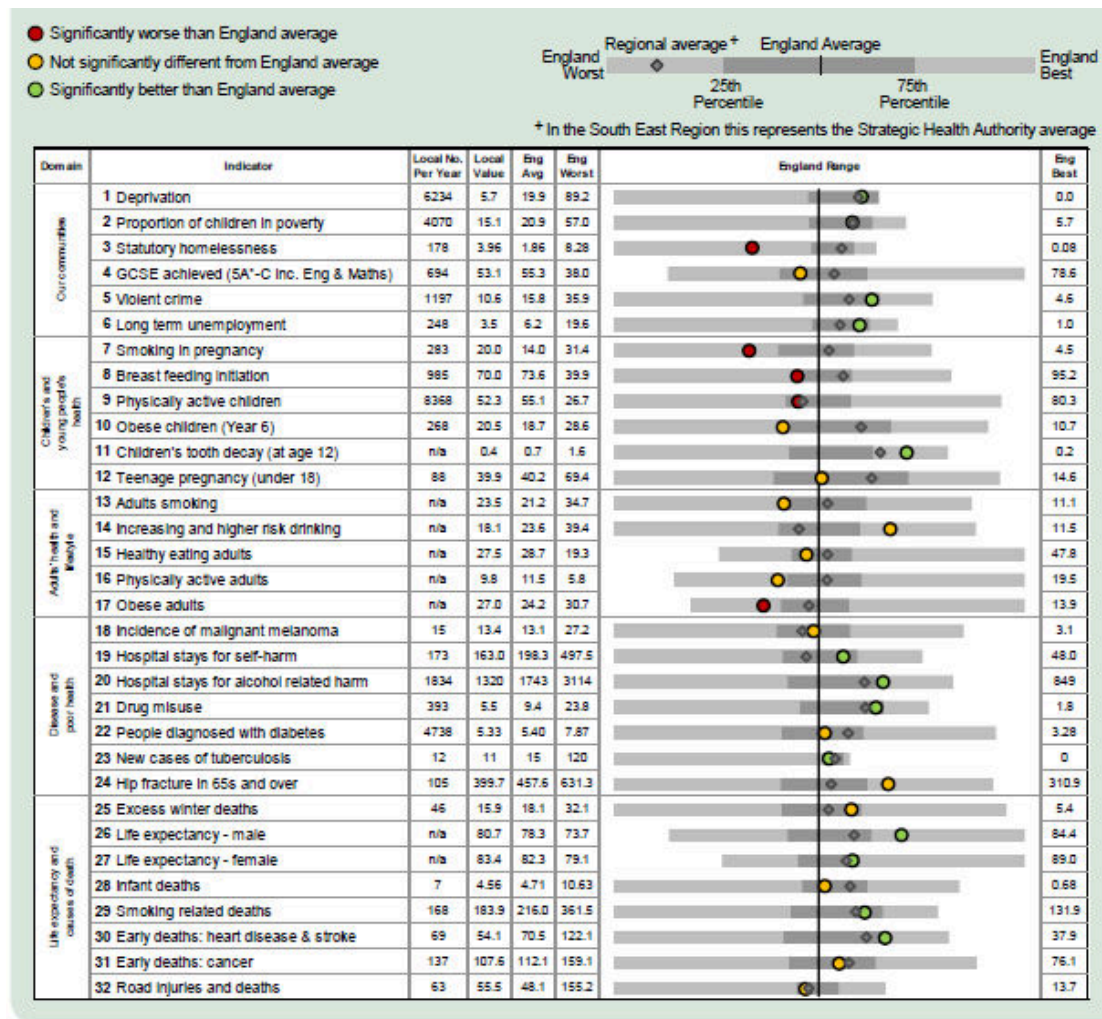


Indicator Notes

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



Other important issues

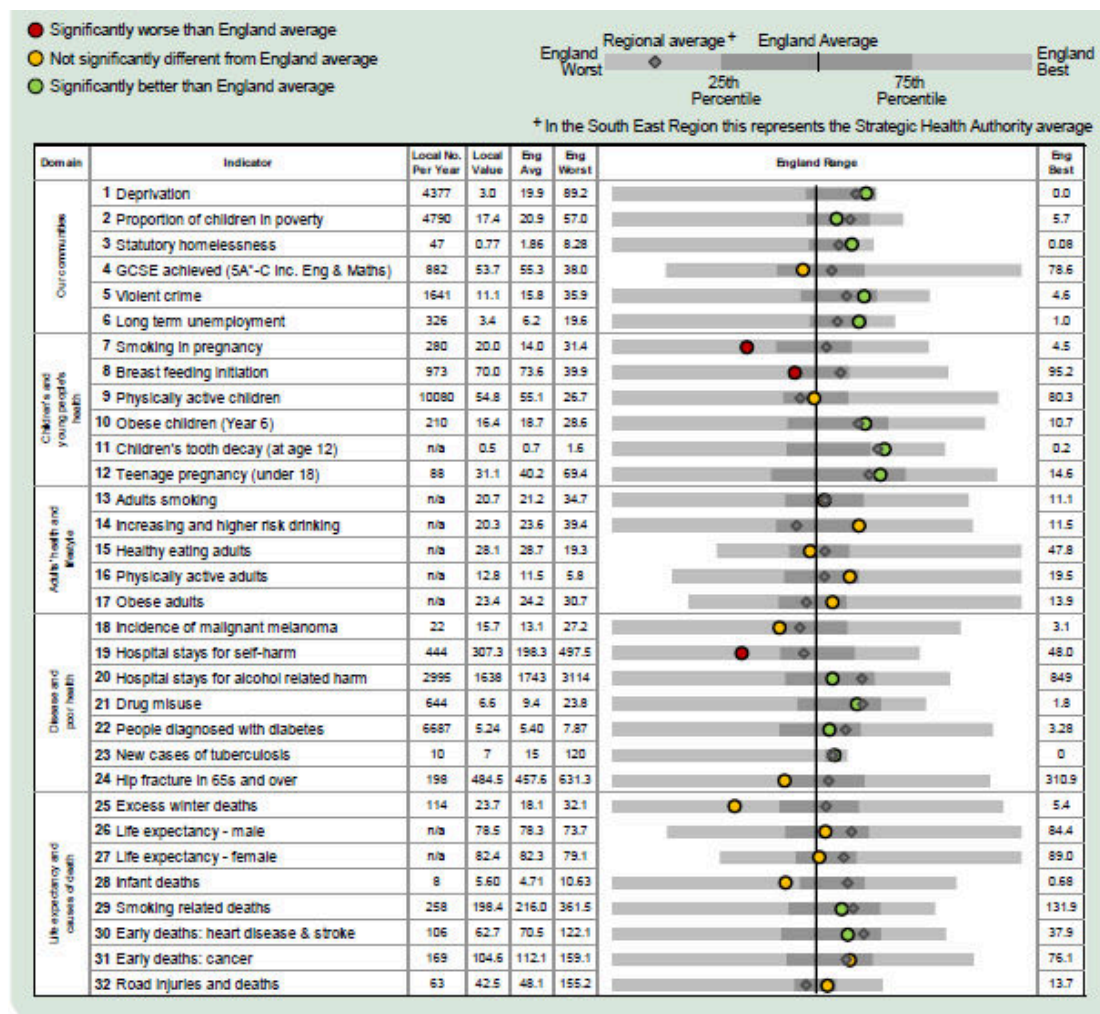
Ashford has the highest age standardised rate of emergency admissions (278 per 1,000) for people aged over 65 of all 12 Kent districts. The rate for Kent is 204 per 1,000 population aged 65 or over.

The rate of diabetes related emergency admissions for Ashford are high 78.5 per 100,000 total population, the second highest district within Kent, which has an overall rates of 69 per 100,000 total population.

The birth rate in Ashford of 68.5 per female population aged 15 to 44 years is the second highest for all districts in Kent. The rate for Kent is 66.7.

Deaths from respiratory conditions are higher in Ashford (30.2 per 100,000 total population) than for Kent (20.8); however rates for deaths in those aged less than 75 years for cancers and circulatory conditions are some of the lowest in the county.

Canterbury



Other important issues

Emergency hospital admission rates due to Myocardial Infarction (MI) in Canterbury is the highest of all the Kent districts at 87.7 per 100,000 total population, this compares to a rate for Kent of 67.0.

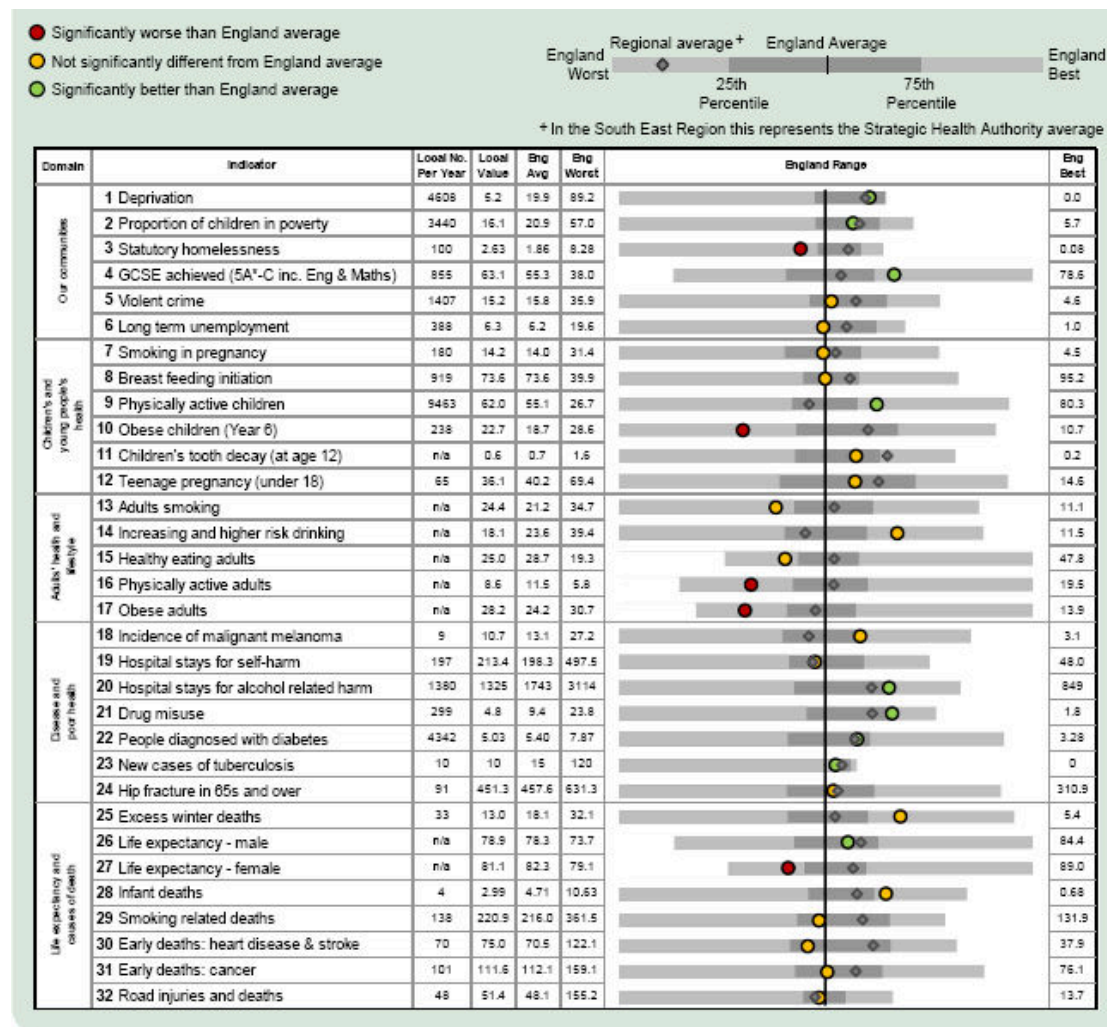
Emergency hospital admission rates due to a stroke are also high, Canterbury has the second highest rate in Kent (114 per 100,000 total population) compared to a rate of 101 per 100,000 population for Kent. However rates of deaths in those aged 75 or younger, from circulatory disease are about average for the county.

Emergency hospital admission rates for asthma by district are highest in Canterbury at 131.7 per 100,000 compared to just 96 per 100,000 for Kent.

Canterbury has the second highest rate of people (57.7 per 100,000) with of Elderly Mental Health (65+) of all districts in Kent (46.9).

Alcohol related admission rates for residents of Canterbury (1814 per 100,000) are the second highest in the county (1543 per 100,000).

Dartford



Other important issues

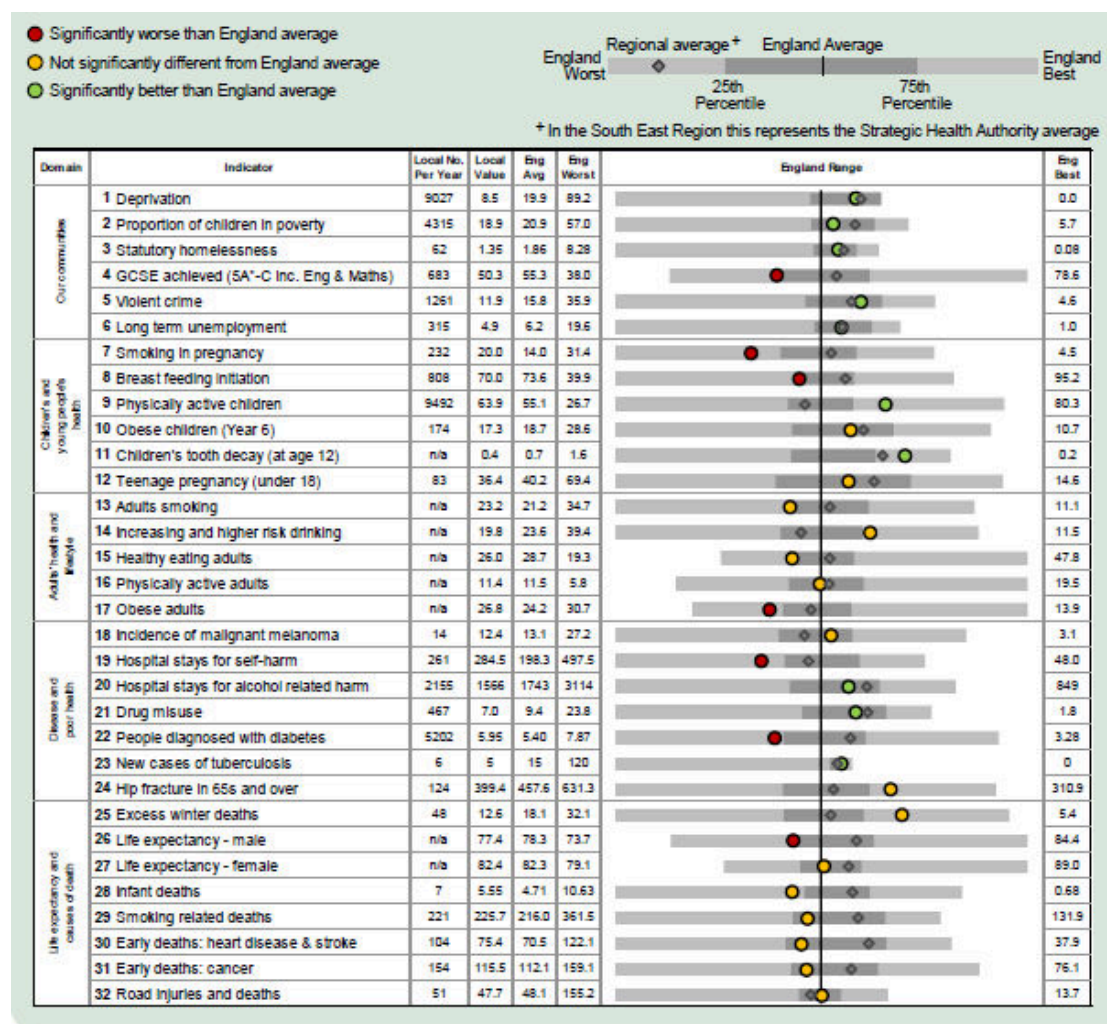
Dartford has the highest smoking prevalence of all districts in Kent, at 26.3% compared to just 20.8% for Kent.

20% of children aged 10/11 years are classified as obese the second highest of all districts, the value for Kent is 17.8%).

The standardised rate of deaths from all causes and in those aged 75 or younger (premature) deaths from circulatory disease are the second highest, of all Kent districts, in Dartford. The all age all cause rate death rate in Dartford is 608 per 100,000 compared to 543 in Kent. For circulatory deaths in the under 75s it is 82 per 100,000 in Dartford and 64 per 100,000 in Kent. Dartford also has the third lowest life expectancy for Kent districts at 80 years compared to 82 years in Tonbridge and Malling.

Alcohol related admission rates for residents of Dartford (1,814 per 100,000) are the second highest in west Kent, and higher than those for Kent (1,543 per 100,000).

Dover



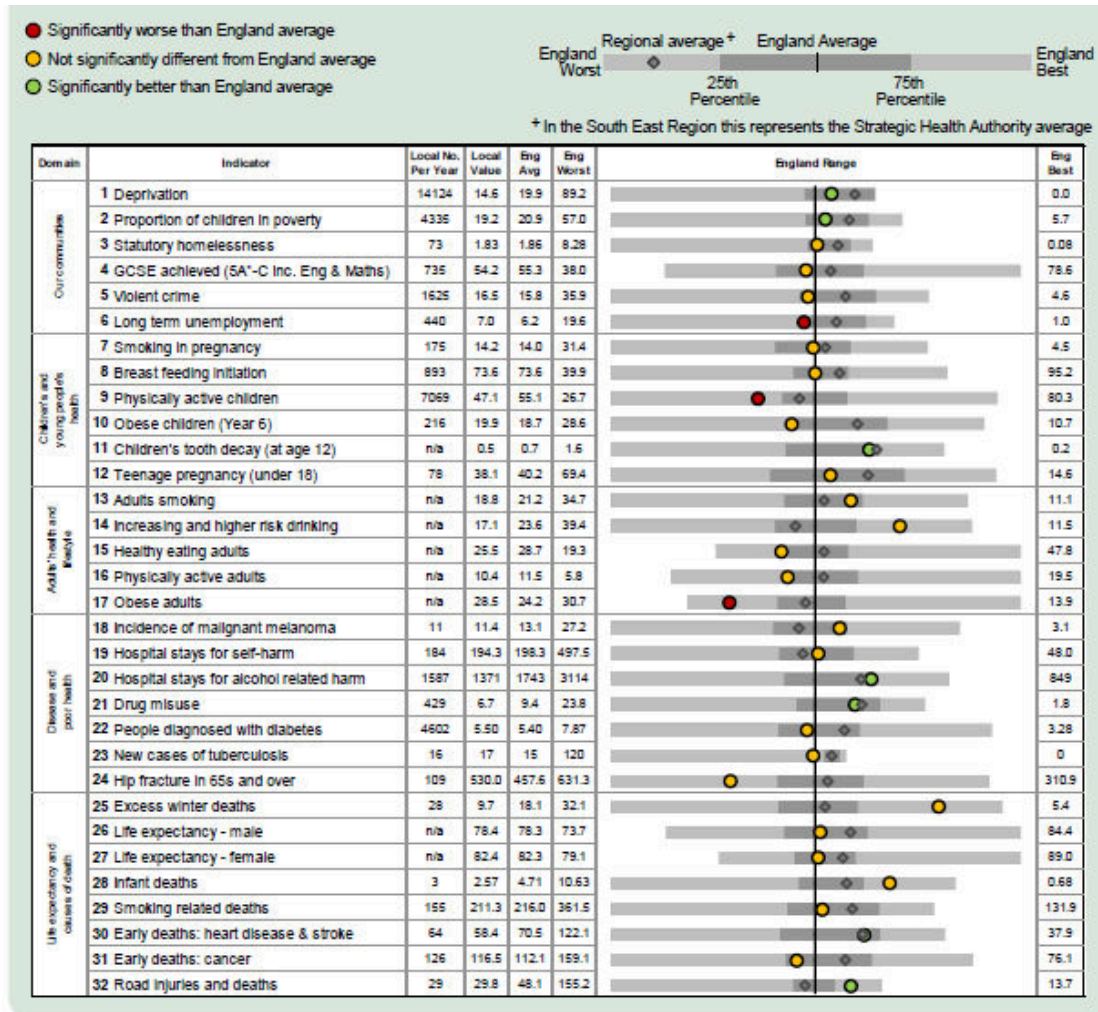
Other important issues

Dover has the second highest standardised rate of death from respiratory disease (34 per 100,000) of all districts in Kent. The rate for Kent is 20.7 per 100,000. Dover also has higher rates than Kent for deaths in those aged 75 or younger due to circulatory disease, 78.7 per 100,000 compared to 63.5 for Kent, but lower than expected rates for cancer.

Adult Mental Health rates in Dover are the second highest of all districts in Kent, 27.4 per 100,000 (adults aged 16-64) compared to 23.6 for Kent.

Standardised emergency hospital admissions for Stroke are relatively high in Dover at 113.3 per 100,000, third highest of all districts in Kent (101 per 100,000).

Gravesham



Other important issues

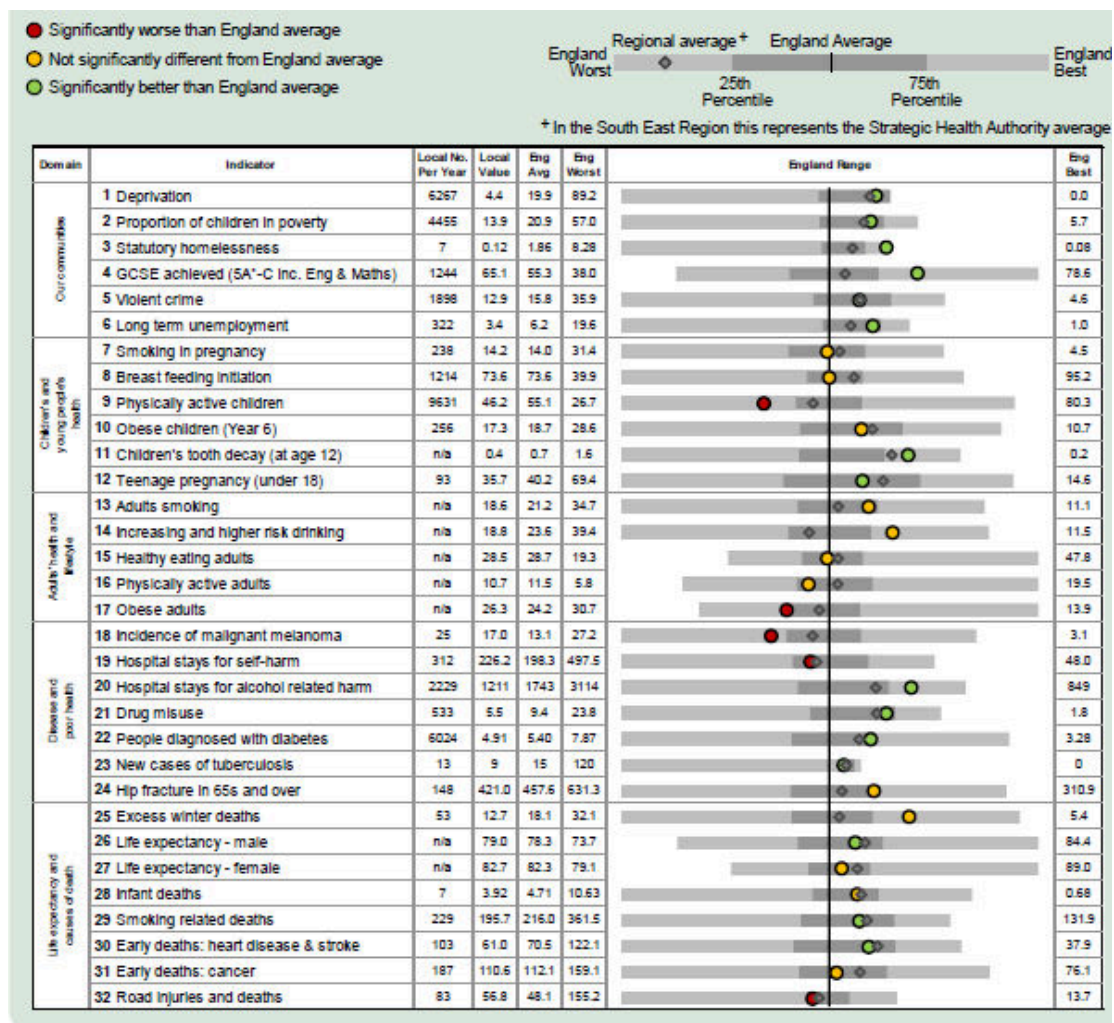
21.6% of children aged 10/11 in Gravesham are classified as obese this is the highest of the 12 Kent districts. The rate for Kent is 17.8%. Gravesham also has the second highest percentage of obese children in year R at 10.4% compared to 9.1% for Kent. This is also reflected in the adult obesity rate which is also the second highest (28.5%) of all districts in Kent (26.4%).

Gravesham has the second highest age standardised rate of emergency hospital admissions (80.6 per 100,000) for Myocardial Infarction (MI) for all districts in Kent (67.0 per 100,000).

Smoking prevalence (21.8%), Adult Mental Health rates (25.6 per 100,000) and admissions for injury in the under 17s (120 per 10,000) are also relatively high in Gravesend compared to Kent whose rates are 20.8%, 23.5 per 100,000 and 107 per 10,000 respectively.

Alcohol related admission rates for residents of Gravesham (1,694 per 100,000) are the highest in west Kent, and higher than those for Kent (1,543 per 100,000).

Maidstone



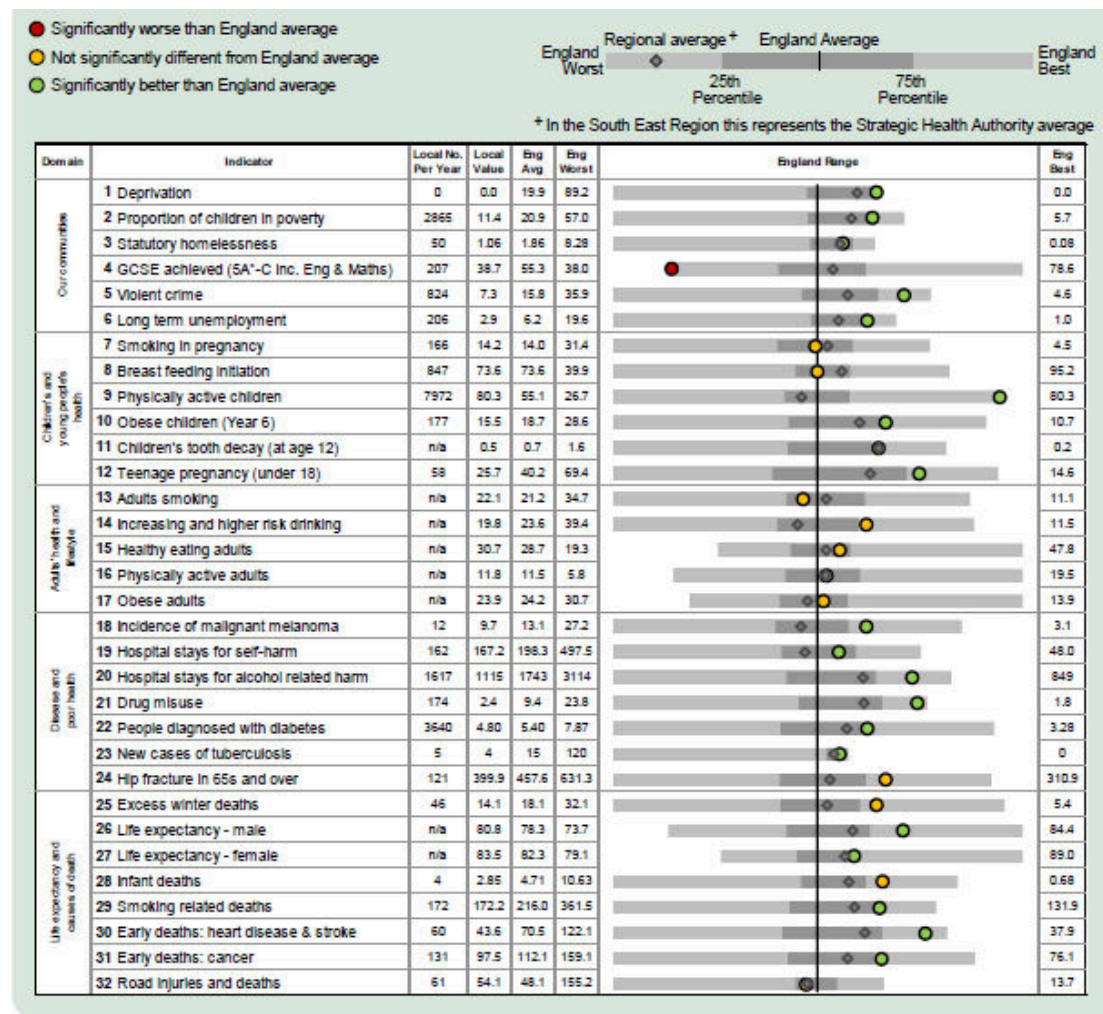
Other important issues

There is a relatively high rate of premature death (under the age of 75) from cancer in Maidstone, 114.5 per 100,000 compared to 106.4 per 100,000 for Kent.

10.3% of children aged 4/5 are classified as obese in Maidstone this is the third highest of the 12 Kent districts. Conversely the rate of obesity in the 10/11 age group, Maidstone has one of the lowest rates with just 16% compared to the highest in Gravesham at 21.6%.

The birth rate in Maidstone is the highest for all districts in west Kent (fourth for all Kent) at 67.6 per 1,000 women aged 15-44, the Kent rate is 66.7.

Sevenoaks

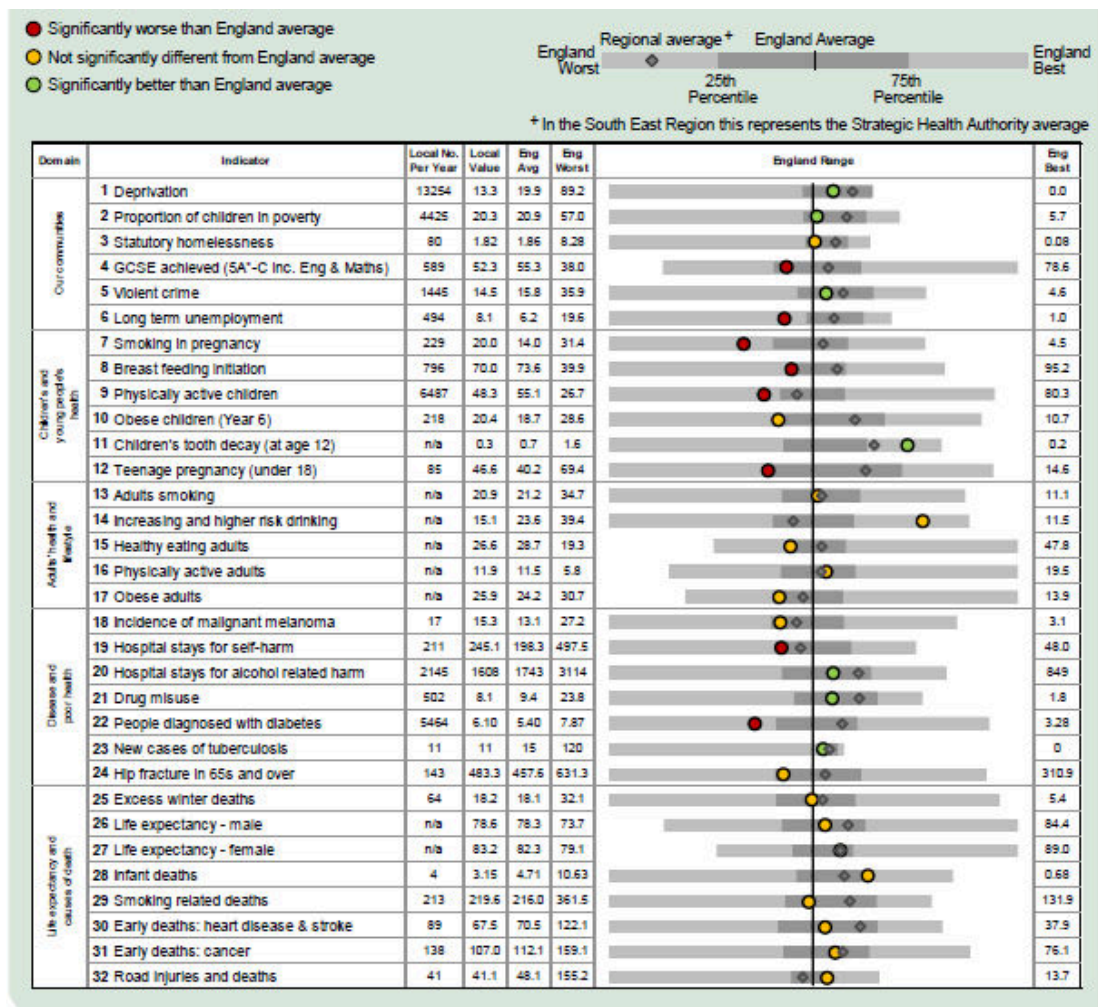


Other important issues

Whilst Sevenoaks compares favourably with other districts in Kent across most health outcomes there are high rates of emergency admissions for asthma (102.4 per 100,000), the third highest district in Kent (96 per 100,00).

Mortality rates from respiratory disease are higher in Sevenoaks (28.3 per 100,000) than in Kent overall (20.7).

Shepway



Other important issues

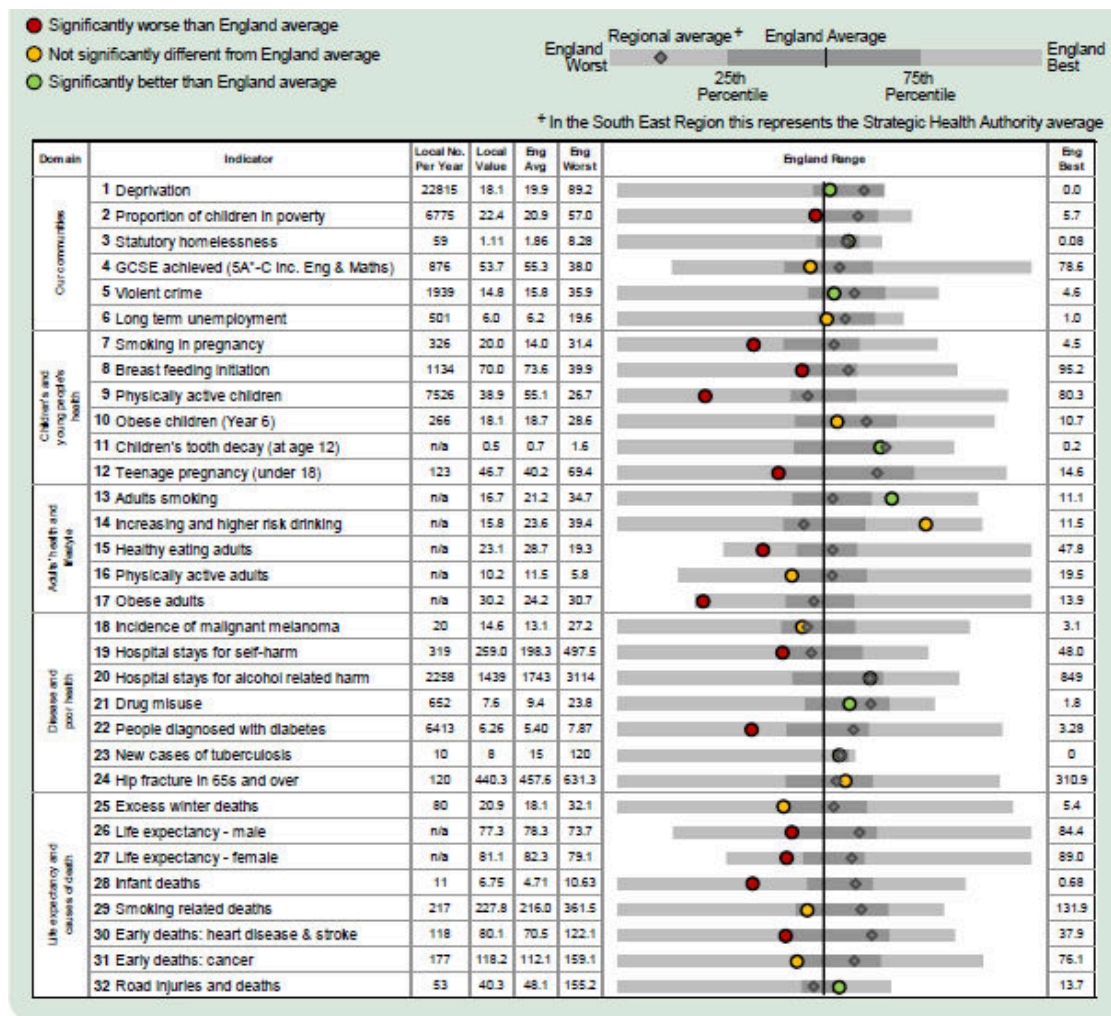
Shepway has the highest rate of emergency hospital admissions for Stroke of all districts in Kent at 129 per 100,000 compared to 101 per 100,000 for Kent. The rate of emergency admissions for diabetes (85.9 per 100,000) is also the highest in the county (69 per 100,000).

The birth rate in Shepway is the third highest for all districts in Kent at 68.5 per 1,000 women aged 15-44, the Kent rate is 66.7. Shepway also has the third highest teenage conception rate at 46.7 for districts in Kent (36.2).

Adult Mental Health rates in Shepway are the third highest of all districts in Kent, 27.4 per 100,000 (adults aged 16-64) compared to 23.6 for Kent.

Alcohol related admission rates for residents of Shepway (1,747 per 100,000) are the second highest of all districts in the county (1,543 per 100,000).

Swale



Other important issues

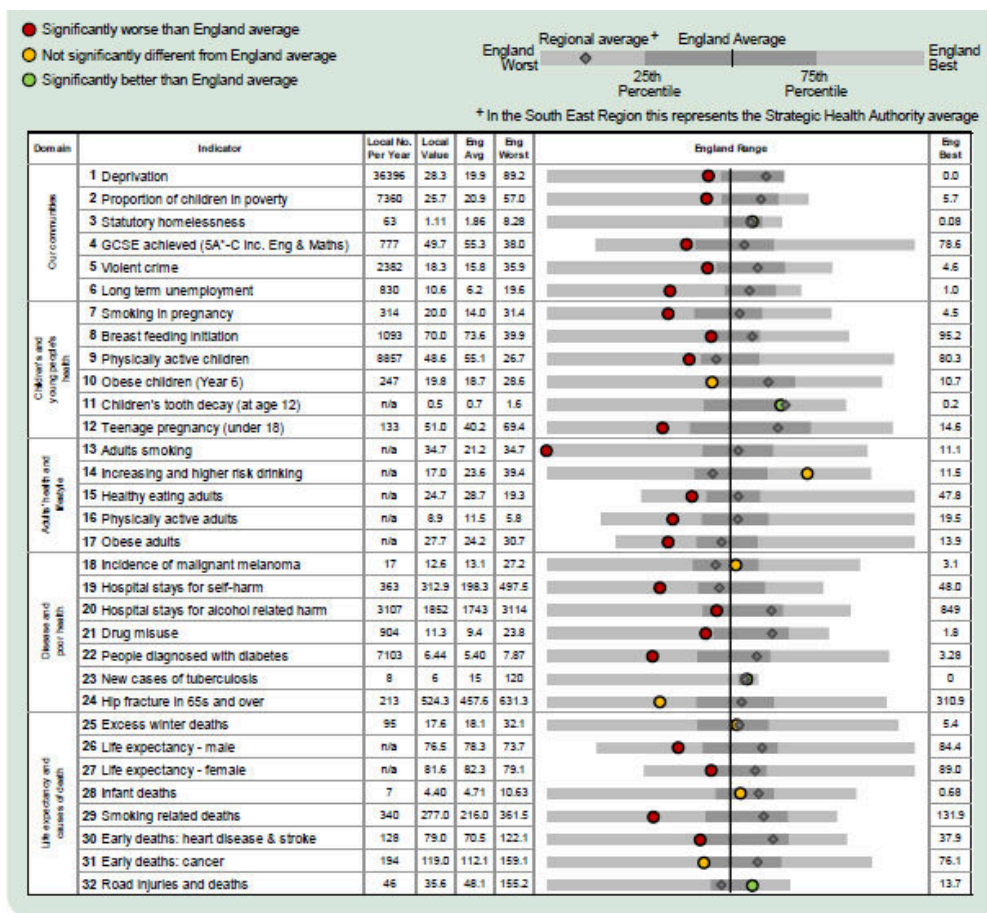
Adult obesity in Swale at 30.2% is the highest of all districts in Kent (26.4).

Swale has relatively high emergency hospital admissions due to Myocardial Infarction (78 per 100,000) and Diabetes (78.3 per 100,000) compared to Kent rates of 67 and 69 per 100,000 respectively.

Swale has the second highest district prevalence for smoking in Kent. A prevalence of 26.4% compared to 20.8% for Kent.

Mortality for all ages and all causes is relatively high in Swale, 607 per 100,000, placing it as the third worst district in Kent (543 per 100,000). Swale is also the third highest for premature deaths (aged under 75) for circulatory disease (80.3 per 100,000) and cancer (113.5 per 100,000) compared to Kent rates of 63.5 for circulatory disease and 106 for cancer. Life expectancy is also one of the lowest in the county at 79.4 compared to 80.8 for Kent.

Thanet



Other important issues

The birth rate in Thanet is the highest for all districts in Kent at 70.4 per 1,000 women aged 15-44, the Kent rate is 66.7.

In general the health outcomes in Thanet are poorer than most of the Kent districts. Thanet has the highest levels of teenage conceptions 51 per 1,000 female population aged 15 to 44.

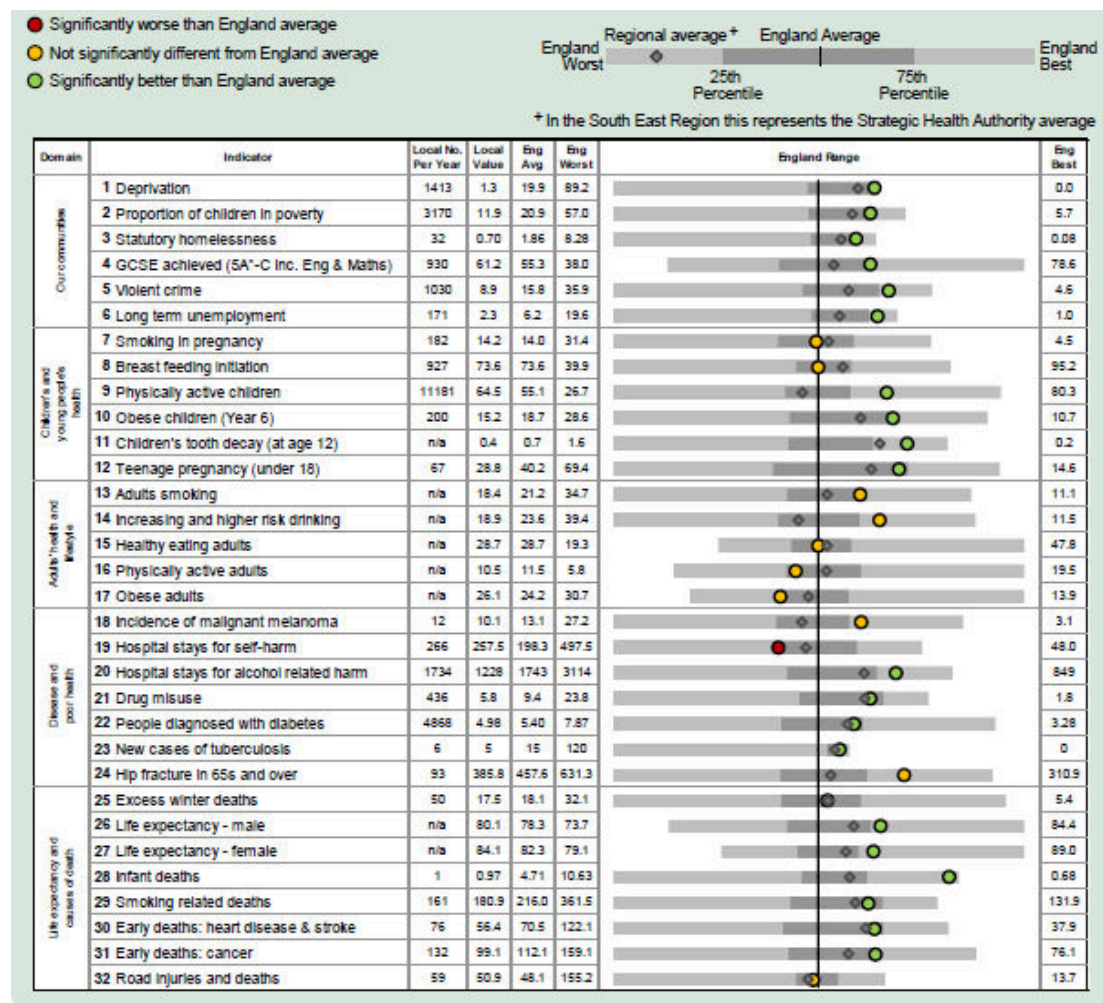
The mortality rate for all ages and all causes, at 664 per 100,000 population is the highest in Kent as are the rates of premature mortality (deaths in those aged 75 or younger) from circulatory disease (91 per 100,000) and Cancer (122 per 100,000). These rates are significantly worse than those for Kent.

The rate of Elderly Mental Health (65+) is the highest for districts in the County, the 59.7 per 100,000 compared to 46.9 for Kent.

Alcohol related admission rate for residents of Thanet (1986 per 100,000) is the highest of all districts in the county (1543 per 100,000).

Thanet has relatively high rates of emergency admissions for COPD (146.5 per 100,000) and falls (472 per 100,000) compared Kent whose rates are 125 and 425 per 100,000 respectively.

Tonbridge and Malling



Other important issues

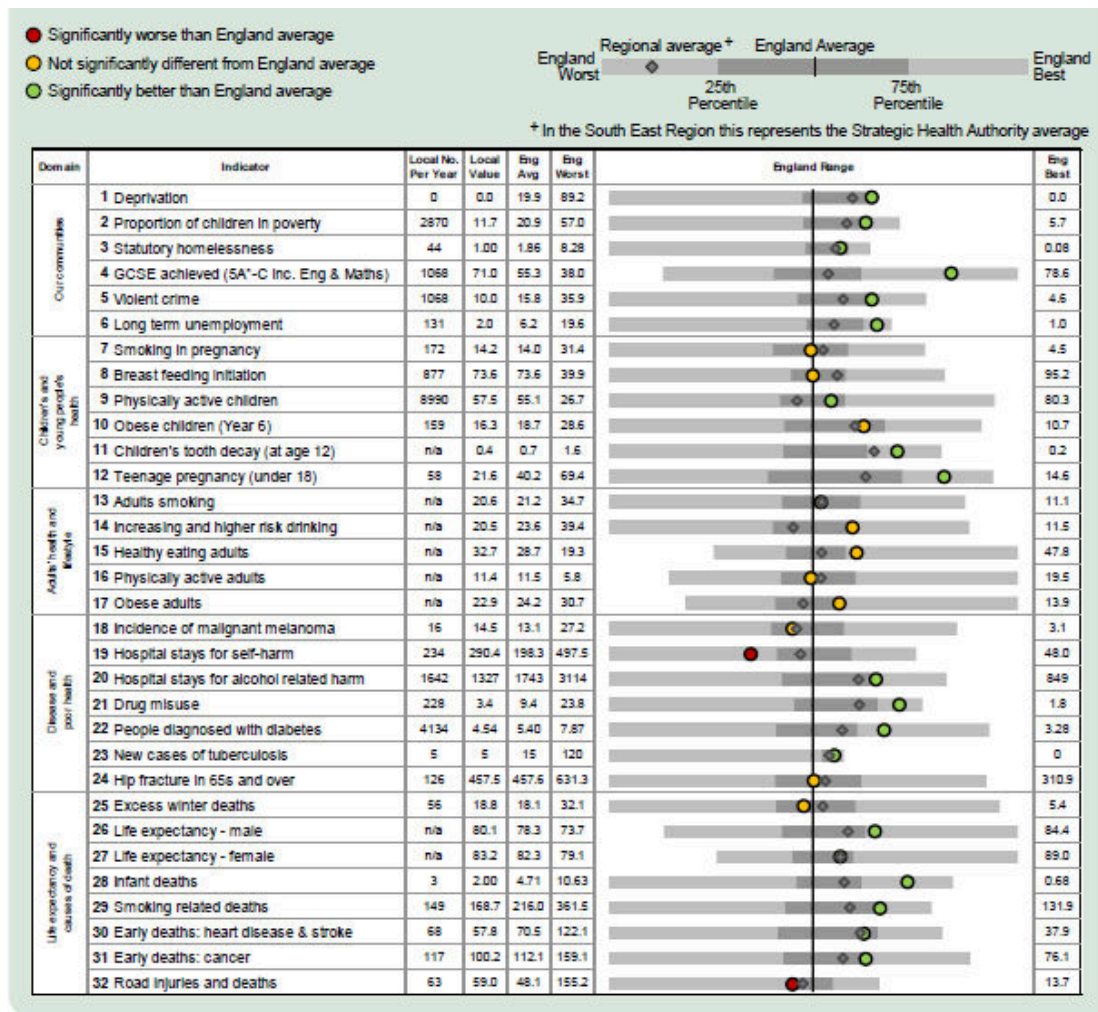
Tonbridge and Malling has a higher rate of admissions for injury in under 18s (109 per 10,000) than that for Kent (107 per 10,000).

Emergency hospital admissions rates for COPD (129 per 100,000) in Tonbridge and Malling are higher than those for Tunbridge Wells and Sevenoaks who have rates of just 96 and 89 per 100,000 respectively. The rate for Kent is 125 per 100,000.

Tonbridge and Malling has relatively high rates of emergency hospital admissions as a result of a fall (426 per 100,000) than the rate for Sevenoaks (396) and Canterbury (371). The Kent rate is slightly lower than Tonbridge and Malling at 425 per 100,000).

Tonbridge and Malling has the highest mortality rate for respiratory disease (39.2 per 100,000) of any district in Kent (20.7).

Tunbridge Wells



Other important issues

Tunbridge Wells has the highest emergency hospital admissions rate as a result of a fall, 531 531 per 100,000 compared to just 425 per 100,000 across Kent.

The rate of admissions to hospital following an injury to a child is highest in Tunbridge (aged 0-17 years) of all the districts in Kent. The rate of 139 per 10,000 is far higher than that for Kent at just 107 per 10,000.

Child obesity in children aged 4/5 year olds in Tunbridge Wells is the highest of all districts in Kent at 11%, this compares to a county percentage of 9.1%.

There are relatively high levels of Elderly Mental Health in Tunbridge Wells (48.6 per 100,000) compared to Kent (46.9) and Sevenoaks (41.7).

APPENDIX G – Quality and performance indicators

Taken from the Kent and Medway Cluster performance report

NHS Kent and Medway
Integrated Performance Measures Reporting by Cluster
NHS Operating Framework for 2011/12
Updated with latest performance information available as at: 11th November 2011

Indicator ID	Indicator Description	2011/12 Performance Measure / Ambition	Monitoring Frequency	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
COMMISSIONER INDICATORS															
HQU01Comm	MRSA bacteraemia - Commissioner	Cluster limit is 41	M	April 6 YTD 6 YTD Limit 5	May 2 YTD 8 YTD Limit 8	June 5 YTD 13 YTD Limit 11	July 4 YTD 17 YTD Limit 14	Aug 3 YTD 20 YTD Limit 17	Sep 4 YTD 24 YTD Limit 20						
HQU02Comm	Incidence of C. Difficile - Commissioner	Cluster limit is 455	M	April 36 YTD 36 YTD Limit 37	May 39 YTD 75 YTD Limit 74	June 31 YTD 106 YTD Limit 110	July 45 YTD 151 YTD Limit 146	Aug 41 YTD 192 YTD Limit 182	Sep 43 YTD 235 YTD Limit 218						
HQU05	Referral to Treatment waits for Admitted patients (95th percentile measures)	23 Weeks	M	23.14 Weeks	24.23 Weeks	21.15 Weeks	22.64 Weeks	22.45 Weeks	22.62 Weeks						
HQU06	Referral to Treatment waits for Non-Admitted patients (95th percentile measures)	18.3 Weeks	M	13.40 Weeks	13.09 Weeks	15.76 Weeks	15.72 Weeks	15.38 Weeks	15.73 Weeks						
HQU07	Referral to Treatment waits for patients on Incomplete pathways (95th percentile measures)	28 Weeks	M	18.00 Weeks	17.79 Weeks	23.12 Weeks	23.86 Weeks	22.52 Weeks	22.78 Weeks						
HQU14 - Part A	Cancer 2 Week Wait - Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	Operating Standard 93%	M	95.70%	May 94.8% YTD 95.3% YTD 95.9%	June 94.4% YTD 95.0%	July 95.9% YTD 95.2%	Aug 95.7% YTD 95.3%	Sep 95.3% YTD 95.7%						
HQU14 - Part B	Cancer 2 Week Wait - Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Operating Standard 93%	M	94.10%	May 93.6% YTD 93.8%	June 94.2% YTD 93.9%	July 94.8% YTD 94.2%	Aug 95.1% YTD 94.6%	Sep 94.3% YTD 94.3%						
HQU15 - Part A	Cancer 62 Day Wait - Percentage of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	Operating Standard 90%	M	100.00%	May 97.1% YTD 98.5%	June 95.6% YTD 97.8%	July 98.6% YTD 95.2%	Aug 96.7% YTD 95.2%	Sep 97.8% YTD 95.0%						
HQU15 - Part B	Cancer 62 Day Wait - Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Operating Standard 85%	M	80.20%	May 86.3% YTD 88.3%	June 88.9% YTD 88.5%	July 88.9% YTD 88.6%	Aug 89.8% YTD 88.8%	Sep 88.3% YTD 88.7%						
SQU02	% Deaths at Home (inc Care Homes)		Q												
SQU05 - Part A	Cancer 31 Day Wait - Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	Operating Standard 96%	M	98.80%	May 97.5% YTD 98.1%	June 99.2% YTD 98.5%	July 98.7% YTD 98.4%	Aug 98.7% YTD 98.6%	Sep 98.5% YTD 98.6%						
SQU05 - Part B	Cancer 31 Day Wait - Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Surgery	Operating Standard 94%	M	95.90%	May 97.6% YTD 96.8%	June 94.5% YTD 96.0%	July 100% YTD 97.0%	Aug 97.0% YTD 97.2%	Sep 98.6% YTD 97.3%						

NHS Kent and Medway
Integrated Performance Measures Reporting by Cluster
NHS Operating Framework for 2011/12
Updated with latest performance information available as at: 11th November 2011

Indicator ID	Indicator Description	2011/12 Performance Measure / Ambition	Monitoring Frequency	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
SQU05 - Part C	Cancer 31 Day Wait - Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is an Anti-Cancer Drug Regimen	Operating Standard 90%	M	98.80%	May 100% YTD 99.1%	June 97.9% YTD 98.8%	July 99.3% YTD 98.9%	Aug 100% YTD 99.2%	Sep 99.3% YTD 99.2%						
SQU05 - Part D	Cancer 31 Day Wait - Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Radiotherapy Treatment Course	Operating Standard 94%	M	98.20%	May 99.3% YTD 98.8%	June 99.7% YTD 99.2%	July 100% YTD 99.4%	Aug 99.7% YTD 99.4%	Sep 100% YTD 99.5%						
SQU06 - Part C	Stroke Indicator - People who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	90%	Q			Qtr 1 90.22%			Qtr 2 83.00% YTD 81.27%						
SQU06 - Part D	Stroke Indicator - People at high risk of stroke who experience a TIA are assessed and treated within 24 hours	90%	Q			Qtr 1 85.87%			Qtr 2 86.79% YTD 82.83%						
SQU07	Community Services	Indicator to be developed in 2011/12													
SQU09	Access to NHS Dentistry - Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period		M	Patients 828,294 (47,496 per 100,000)	Patients 829,285 (47,253 per 100,000)	Patients 829,853 (47,386 per 100,000)	Patients 832,250 (47,723 per 100,000)	Patients 832,780 (47,754 per 100,000)							
SQU12	Early access to Maternity services - Percentage of women who have seen a midwife or a maternity healthcare professional for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy	90%	Q			Qtr 1 83.34% (4369 of 5294)			Qtr 2 84.13% (4583 of 5422)						
SQU13	Mental Health Measure - Number of new cases for Early Intervention in Psychosis Commissioner view - All Providers		Q			57			Qtr 2 51 YTD 108						
SQU14	Mental Health Measure - Number of Crisis Resolution Home Treatment Episodes Commissioner view - All Providers		Q			999			Qtr 2 500 YTD 1499						
SQU15	Mental Health Measure - Proportion of patients on Care Programme Approach (CPA) discharged from hospital care who are followed up within 7 days Commissioner view - All Providers		Q			94.7% (288 of 304)			Qtr 2 97.85% YTD 96.15%						

PROVIDER REGULATIONS

HQ000 and SQU00	Ambulance Quality Indicators	2011/12 Performance Measure / Ambition	Monitoring Frequency	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
HQ003_01	Call A 8 Minute Response Time	75%	M	April 73.8% YTD 73.8%	May 75.6% YTD 75.7%	June 75.0% YTD 75.4%	July 76.7% YTD 75.8%	August 77.0% YTD 76.1%	Sept 76.0% YTD 76.1%						
HQ003_02	Call A 19 Minute Transportation Time	90%	M	April 98.1% YTD 98.1%	May 98.2% YTD 98.2%	June 97.8% YTD 98.1%	July 98.2% YTD 98.1%	August 98.3% YTD 98.1%	Sept 98.2% YTD 98.1%						
SQU03_01	Ambulance Clinical Quality - Call Abandonment Rate	Lower rates are a marker of better patient care & experience	M	0.6% [England 1.0%]	0.7% [England 0.6%]	1.1% [England 1.4%]	1.0% [England 1.1%]	0.7% [England 1.1%]	0.9% [England 1.1%]						

By: Meradin Peachy, Director of Public Health, KCC.

To: Health and Wellbeing Board

Subject: Health and Wellbeing Strategy...progress to date

Classification: Unrestricted

Recommendations

Health and Wellbeing Board is asked to receive this paper and comment on content, specifically the aspiration to help inform ongoing development of our final Kent Health and Wellbeing Strategy

1. Introduction

- 1.1 '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'

2. Progress

- 2.1 The strategy attached conforms to the outline submitted to the Health and Wellbeing Board last November

The detailed sections of:

- Context
 - National
 - Local
- The big issues in Kent extracted from the latest draft of the Kent JSNA
- High level resource mapping
 - To be completed
- Our aspiration for the health and wellbeing outcomes for the population of Kent
- Implementation plans
 - are partially completed and these will require populating as CCG and Networks confirm commissioning intentions and plans as

3. Discussion

3.1 Is the strategy on the right track?

Are the aspirations highlighted in the plan 'aspirational'?

Are they the right ones to focus upon?

More detail and a broader approach are to be found in the Kent Health Inequalities Plan.

Do we cover enough of the priorities set out in the JSNA (bearing in mind the JSNA still requires consultation and thus could change)?

Does the context encapsulate both the national and local well enough to be meaningful?

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DRAFT

Kent Health and Wellbeing Strategy

Version Two for March Kent Health and Wellbeing Board

Foreword: Chair of the H&WB Board and DPH for Kent for inside page....

Executive summary

To be completed on completion of strategy

Context within which this strategy is produced

1. *National Context*

We are in a new national context, a context in which there are ongoing wholesale changes to the way health and health services are structured, commissioned and provided. As part of these changes we will have Public Health professionals working for us and directly advising us, we will commission directly some health improvement services and will have a much greater role in the delivery of health improvement, health protection and health services. We are evolving into a Public Health organisation concerned with improving the health and wellbeing and reducing differences in health outcomes for the people of Kent

It is within this context that this strategy is being produced for the first time.

At the time of writing, the Health and Social Care bill continues to progress through the various stages of parliament in order to be agreed and enacted.

The current national context of the Health and Wellbeing strategy is as follows:

'The ambition is for health and wellbeing boards to go further than analysis of common problems and to develop deep and productive partnerships that develop solutions to those commissioning challenges, rather than just commenting on what those problems and challenges are. Building on enhanced JSNAs, the Bill places an additional duty on the local authority and CCGs to develop a joint health and wellbeing strategy for meeting the needs identified in the relevant local JSNA are to be met. This could potentially consider how commissioning of services related to wider health determinants such as housing, education or lifestyle behaviours can be more closely integrated with commissioning of health and social care services. Once again, this function is to be undertaken through the health and wellbeing board. In line with other local authority committees, the health and wellbeing board is able to request information for the purposes of enabling or assisting its performance of functions from the local authority and certain members and persons who are represented on the health and wellbeing board. In preparing JSNAs and joint health and wellbeing strategies, local authorities and CCGs must have regard to any guidance issued by the Secretary of State and to the Secretary of State's mandate to the NHS Commissioning Board. The NHS Commissioning Board must appoint a representative to participate in preparation of JSNAs and joint health and wellbeing strategies. The joint health and wellbeing strategy may consider services beyond health and social care – how the commissioning of health and social care services, and wider health-related services, could be more closely integrated – enabling the board to look more broadly at factors affecting the health and wellbeing of

their populations. Both JSNAs and joint health and wellbeing strategies must be published.'

A key element of the health reforms is the move towards commissioning for **outcomes**; rather than the current situation which is commissioning to achieve targets, that often relate to process, not outcomes.

The national ambition is to deliver outcomes that are amongst the best in the world, supported by three outcomes frameworks:

- The NHS Outcomes Framework,
- The Public Health Outcomes Framework and
- The Adult Social Care Outcomes framework

The three outcomes frameworks will drive future commissioning and thus are critical to the context of our health and Wellbeing strategy for Kent.

NHS Outcomes Framework

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on:

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
Domain 4	Ensuring that people have a positive experience of care; and
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Overall the NHS Outcomes aspiration is to:

- Reduce years of life lost from conditions amenable to health care intervention and improve under 75yrs of age life expectancy.
- Improve health related quality of life for people with long term conditions.
- Improve experience of people of the care they receive.

- Reduce emergency admissions (for acute conditions that should not usually require hospital admission) and readmissions within 30 days of discharge
- Reduce the number of patient safety incidents including those that result from severe harm or death.

Public Health Outcomes Framework

In January 2012 the Department of Health published 'Improving Outcomes and Supporting Transparency. Part 1 A public health outcomes framework for England, 2012 to 2016'. The framework is geared to refocus around achieving positive health outcomes for the population and reducing health inequalities.

The framework is focused on two high-level outcomes which are:

1. **increased healthy life expectancy**
2. **reduced differences in life expectancy and healthy life expectancy within and between communities**

It is acknowledged that improvements in these outcomes make take years – sometimes even decades- to see marked change. Thus a set of supporting public health indicators have been developed to show how well we are doing year on year. These are as follows:

Domain 1	improving the wider determinants of health
Domain 2	health improvement
Domain 3	health protection
Domain 4	healthcare public health and preventing premature mortality.

Social Care Outcomes Framework (ASCOF)

The ASCOF is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care. They are not a performance measurement tool but have been devised nationally to guide local commissioning and provision of service.. The framework will allow benchmarking and comparison with other areas which is critical to local accountability of councils and reporting to their citizens on a consistent basis

Again, the ASCOF is structured into four domains as follows:

Domain 1	Enhancing quality of life for people with care and support needs
Domain 2	Delaying and reducing the need for care and support
Domain 3	Ensuring that people have a positive experience of care and support
Domain 4	Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm

Delivery of these outcomes will require collective effort over all parts of the Kent system and Kent population and provides the opportunity for systematic coherence in order to protect and improve the health of the people of Kent.

2. Local Context

Bold Steps for Kent

Bold Steps for Kent sets out how Kent County Council needs to change the way it works to reflect the changing shape of public services, as the Government has set out plans to fundamentally reform how key public services, such as education and health, will be provided in the future, underpinned by the clear message that residents should have more influence on how services are provided locally.

There are three clear aims that run throughout Bold Steps for Kent:

- To help the Kent economy grow - We must support and facilitate the new growth in the Kent economy by delivering the priorities in our regeneration framework Unlocking Kent's Potential, by delivering new housing and new infrastructure and by working with key business sectors.
- To put the citizen in control – power and influence must be in the hands of local people so they are able to take responsibility for their own community and service needs.
- To tackle disadvantage – We will make Kent a county of opportunity where aspiration rather than dependency is supported, particularly for those who are disadvantaged or who struggle to help themselves and their family.

More specifically the County set out the following in relation to Health:

Bold Steps for Health

The health reforms proposed by the Government will give greater power to GPs to choose the best services for their patients, with local government having strategic responsibility to ensure the County's health needs are met. We must use this opportunity to improve the quality of the health service in Kent.

- We will help ensure that GP commissioning plans meet the health needs of all residents and communities in Kent. Working at County and District level we want Locality Boards to play a key role in this commissioning process, better connecting KCC and wider public services with health provision at the local level.
- We will work with GP consortia to encourage new healthcare providers to enter the market for health services in Kent. This will drive up standards, provide competition, increase choice and drive greater value for money for GPs and patients.
- We will work to join up and integrate health and social care service provision to reduce costs and demand that could be avoided - for example, by joining up our assessment processes.
- We will focus on a preventative approach to public health, supporting people to make better lifestyle choices and consider their own future health needs – so expensive health services aren't required as frequently as now.

3 Summary

The context within which this Health and Wellbeing Strategy is produced reflects not only the national changes happening in a reorganising NHS and Local Authority environment, but also in a context of national and local aspiration to improve health outcomes, reduce health inequalities and integrate care in order to improve the health of the population of Kent.

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

National policy emphasises a life course approach towards improving health inequalities and health and wellbeing, where a combination of health, social and economic factors affect people's health outcomes at different periods in their lives. In Kent, a number of priorities have been suggested orientated around five main areas:

1. Early Years

Improving the continuation (and recording) of breastfeeding rates beyond six weeks.

There is no doubt over the benefits of breastfeeding towards health and wellbeing of children. However breastfeeding is not being sustained into the early months of infancy for a large number of children. The rates of breastfeeding in Kent drop from around 70% at birth to 25% at six months of age.

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.

The 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)

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.

Using Children Centres more effectively to deliver integrated services to vulnerable high risk families

This includes services such as health visitors delivering messages around health promotion and behaviour change such as reduction of second hand smoke, alcohol and substance abuse, domestic violence and improving healthy weight and emotional wellbeing.

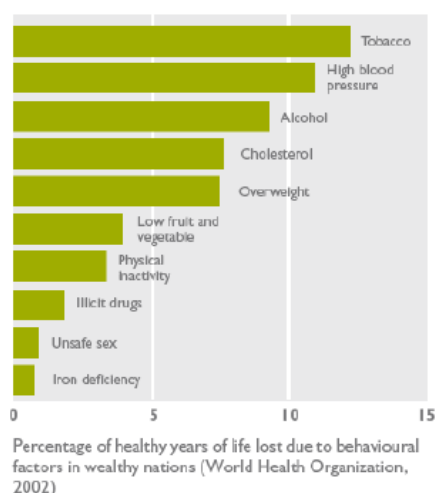
2. Young People and Lifestyle choices

The numbers of young people drinking responsibly has increased in Kent as it has nationally, and fewer children drink. However the small number of young people who do drink at increasing risk or higher risk levels and those who regularly binge drink are likely to be drinking more hazardously. 11% of 11-16s in the Kent Children's *Smoking Drinking and Drugs* survey (2008) indicated that they did drink alcohol most days or once or twice a week. They are also likely to be from a more vulnerable group of young people. In the same way, although most children will not misuse drugs, and most of those young people who do experiment will not continue to do so, these more vulnerable young people are more likely to continue in dangerous drug use. This small group of young people in Kent are likely to have multiple risk factors such as parental substance misuse, family breakdown, domestic violence, poverty, truancy or school exclusion. They show significant levels of poor physical and mental health as well as poor sexual health and substance misuse issues. They are often disengaged from school as a result of behavioural issues, and are more likely to be 'Looked after Children' or known to the Youth Offending Service. The more vulnerable the young person is, i.e. the more risk factors they have: the more likely it is that the child will misuse drugs, alcohol and tobacco.

Young people benefit from life skills approaches to early intervention. They need to be engaged in learning and in school: and positively engaged in activity to build resilience over time through developing friendships, life skills and positive social peer networks. Positive relationships with adults in specialist services who understand the needs of young people and adolescent behaviours like substance misuse and risking sexual health are also needed. Currently, there are specialist services commissioned to tackle young people's substance misuse needs, and this includes understanding the dangers and consequences of a range of risk-taking behaviours. The DUST screening tool is promoted to identify those who need help, and further work is being developed in 2012 to support those families and young people in greatest need in Kent and help them to tackle their problems.

3. Prevention

Percentage of health years of life lost due to behavioural factors in wealthy nations.



Percentage of health years of life lost due to behavioural factors in wealthy nations.

Cabinet Office (2010) *Applying behavioural insight to health*

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

80% heart disease, stroke and type 2 diabetes, and 40% cancer could be avoided if common lifestyle risk factors were eliminated. Smoking, high blood pressure and alcohol contribute to the largest proportion of healthy years life lost [Figure 3]. Therefore, people, who are at future risk, need to be identified early enough and their lifestyle and behaviour should be modified accordingly through self management, supported by social marketing campaigns such as Change 4 Life and integrated frontline services such as Stop Smoking, IBA (Alcohol), and Healthy Weight. Therefore, the rollout of the national Health Checks programme across Kent needs to be accelerated across the county and a specific focus on keys areas such as Thanet and Swale.

Change4Life three year social marketing strategy

In just three years, Change4Life has become one of the most instantly recognisable brands in health improvement, enjoying high levels of trust and involvement, not only from the public, but from healthcare professionals, staff in schools and early years' settings, local authorities, community leaders, charities and businesses. The first year of Change4Life in 2009 was successful, awareness of the brand built rapidly and attitudes towards it were (and remain) very positive.

Over 400,000 families joined Change4Life in its first year and over 1 million mothers claimed to have made changes to their children's behaviours as a direct result of Change4Life Tesco club card research analysing the purchases of 10,000 Change4Life families has shown early signs of positive behaviour change in food

purchasing patterns and that the campaign is resonating with and attracting the intended target audience (DH 2010)

Locally NHS West Kent developed – the **Change 4 Life (C4L) – Healthy Passport Club**, a locally designed social marketing campaign to promote the Department of Health ‘Change4life’ programme since April 2011. The aim of the club is to promote the national C4L messages of healthy living, diet and exercise. The campaign has set out to build a supportive environment, provide tools for people to set goals, record achievements and provide motivational support in a fun way.

To date more than 14,000 people from all walks of life have joined the club, a significant proportion encouraged by GPs. All the activities undertaken by those involved are recorded as steps around the world; currently this stands at 10,562,491 steps or 5,300 miles. As this campaign has been so successful in west Kent it has been agreed that it should be rolled out across Kent.

4. The Shift to Out of Hospital Care

The population of Kent in the older age group (65+ and 85+) is predicted to increase significantly over the next 5 to 10 years. This is a demographic bubble leading to disproportionate numbers of older folk in our population. It is just emerging now and expected to persist for the next 25 years or so. This bubble along with the changing nature of longevity and health deterioration, has led us to consider major changes to the way the health and social care system work.

The system we operate comprises myriad silos of care, with inherently high levels of referral out of one and back to another. There is limited coordination and integration between them. The environment is such that, these transfers from one isolated part of the system to another, almost occur by default for reasons of infrastructure and culture. For example after hours care providers do not usually have access to information from the patient record, other providers who may need to make decisions in isolation e.g. community matrons, may be similarly disconnected from the central primary care information store. As a result, emergency admissions in the elderly for falls and dementia 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 elderly 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.

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.

In NHS Blackpool, risk profiling was used to target resources more effectively to reduce unplanned care activity, using the combined predictive model.

Approximate annual spend is around £26 million per year and makes up 65% of occupied bed days. The model used primary care and hospital data, (inpatient, outpatient and A&E data). The initial results showed that out of the 150,000 population in Blackpool approximately 765 patients were identified as very high risk generating more than 2,639 unplanned admissions in the previous year and the admissions avoided (323) if the necessary clinical intervention was delivered, generating £586,000 in gross savings. Apart from the benefits of identifying very high risk patients the tool enables access to real-time clinical patient data and prioritisation of community matron workload. *Nuffield Trust (2011)*

5. Information sharing

The successful delivery and evaluation of programmes will depend on developing more robust arrangements for sharing information between health and social care organisations. For example use of an identifier such as NHS number will help to understand how patients access services across the continuum of care.

Care for older people in Torbay

Care for older people in Torbay is delivered through integrated teams of health and social care staff, first established on a pilot basis in 2004 and since extended throughout the area. Each team serves a locality of between 25,000 and 40,000 people and is aligned with the general practices in the locality. Budgets are pooled and used flexibly by teams who are able to arrange and fund services to meet the specific needs of older people. A major priority has been to increase spending on intermediate care services that enable older people to be supported at home and help avoid inappropriate hospital admissions. The work of integrated teams has been taken forward through the work of the Torbay Care Trust, created in 2005. Results include a reduction in the daily average number of occupied beds from 750 in 1998/9 to 502 in 2009/10, emergency bed day use in the population aged 65 and over that is the lowest in the region, and negligible delayed transfers of care. Since 2007/8, Torbay Care Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes, with a corresponding increase in home care services targeted at prevention and low-level support.

Chronic care management in Wales

In Wales, three Chronic Care Management Demonstrators in Carmarthenshire, Cardiff and Gwynedd Local Health Boards pioneered strategies to co-ordinate care for people with multiple chronic illness. By employing a 'shared care' model of working between primary, secondary and social care – and investing in multidisciplinary teams – the three demonstrators report a reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent respectively between 2007 and 2009. This represented an overall cost reduction of £2,224,201. Nuffield Trust (2012).

In summary the Kent JSNA in totality has pointed to a large number of priorities.

Specifically it highlights the following as priorities for Kent:

- Early Years
 - Improving breast feeding rates
 - Improving coverage of immunisations
 - Improving the use of children and families centres

 - Young people and lifestyle choices

 - Prevention
 - Reduction in risk from life style behaviours
 - Roll out of Health Checks

 - Shifting care to outside hospitals
 - Risk profiling
 - Provision of integrated care teams
 - Move to self management

 - Information sharing between organisations
-

High level resource mapping where the money is currently spent

This section is to be completed

What is our aspiration for the health and wellbeing outcomes for the population of Kent?

Our overarching aspirations are to:

Halt the widening of health inequalities gap both within and between communities and improve healthy life expectancy.

Through this work we should achieve by 2015

- Increase breast-feeding initiation rates and prevalence at 6-8 weeks in all parts of Kent
- Roll out Total Child Pilot to schools to help schools identify health and wellbeing issues for pupils
- Increase proportion of Young People (16-18) & (18-24) in full time education or employment
- Reduction in the levels of inequalities for Life Expectancy for Males and Females
- Reduce homelessness and its negative impact for those living in temporary accommodation
- Reduce the rate of deaths attributable to smoking in all persons

This means we will do the following:

1. Ensure we have a comprehensive plan that addresses both the six objectives described by Marmot and the wider determinants of health:
 - a. Give every child the best start in life
 - 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
2. Systematically apply the Christmas tree model described by the National Health Inequalities Service Team to all local health and other services in order to ensure effective interventions are delivered at population level in order to reduce variation in service access and outcomes as much as possible across the Kent geography.
3. Ensure the plan picks up the key priorities as described in the JSNA and summarised previously within the document
4. Assess impact on health inequalities by applying the wellbeing screening tool and by listening to local communities
5. 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.

Reduce premature death caused by the key killers including:

- **Vascular disease (heart disease and stroke).**
- **Cancers.**
- **Respiratory illness.**

This means we will do the following:

1. Ensure primary preventative strategies are systematically in place locally to address the lifestyle contributory causes of the big killers, e.g. smoking, obesity
2. Ensure secondary prevention interventions are systematically in place locally and delivered at scale in order to have an impact on life expectancy.
3. Ensure the critical care pathways are in place across the Kent population to manage acute events according to nationally advised guidance (i.e. NICE) e.g. acute myocardial infarction and stroke
4. Ensure rehabilitation pathways and screening services are in place and systematically applied so all people eligible are offered service.
5. Ensure people are aware of symptoms, particularly cancer and encouraged to access services early.
6. Ensure systematic and population based approach to the provision of health checks.

Halt the rise of people with long term conditions being unnecessarily hospitalised from acute episodes.

- **Risk profiling**
- **Provide integrated health and social care teams**
- **Support self management of individuals**

Through this work we should be able to achieve:

- 15% reduction in A&E visits;
- A 20% reduction in emergency admissions,
- A 14% reduction in elective admissions
- A striking 45% reduction in mortality rates.

This means we will do the following:

1. Ensure risk profiling is done consistently across the population of Kent using the same tool and done at scale, using both GP and social care data

2. Ensure integrated care teams mirror evidenced based characteristics:
 - Multi-professional teams including generalists working alongside specialists
 - A focus on case management and support to home based care
 - Joint care planning and co-ordinated assessments of care needs
 - General practitioners acting as navigators, rather than gatekeepers, retaining responsibility for patient care and experiences throughout the patient journey
 - Clinical records that are shared across the multi-professional team.

3. Ensure a range of self management approaches are in place including:
 - patient and carer education programmes
 - medicines management advice and support
 - the provision of telecare and telehealth,
 - psychological interventions (e.g. health trainers)
 - telephone based health coaching
 - pain management
 - patient access to own records
 - systematic training for health providers in consultation skills that help engage patients

Develop County wide Dementia services that conform to the requirements of the National Dementia Strategy

This means we will do the following:

1. Work on developing an integrated model of care which reflects the following:
 - 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

Implementation plans together with targets that relate to delivering the aspiration

1. Health Inequalities

The Kent Health Inequalities action plan entitled 'Mind the Gap; Building bridges to better health for all' is being consulted upon in parallel to development of this strategy and is expected to be debated at the full Kent County Council meeting in March

2. Key Killers

Plans by the Cardiac, Stroke and Cancer networks are required
GP Commissioning groups will need to develop local commissioning plans that deliver reduction in premature mortality rates in CCG populations

3. Integrated Care

Integrated care boards, KASS, NHS Kent and Medway and PH are currently working through to develop implementation plans on risk profiling and integrated care models

4. Dementia

Care pathway work across Kent again is in development....more detailed required for next iteration.

By: Lorraine Goodsell – Associate Director, Children’s Health and Maternity Commissioning, NHS Kent and Medway
Andrew Ireland, Corporate Director, Families and Social Care

To: The Health and Wellbeing Board

Subject: The Principles and Health and Wellbeing Outcomes of Children’s Centres

Classification: Unrestricted

Recommendations

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

1. Introduction

1.1 Children’s Centres in Kent were developed over three rounds of delivery between 2004 and 2010. In the first phase Children’s Centres were developed from Sure Start Local Programmes, Neighbourhood Nurseries and Early Excellence Centres. The majority of areas of disadvantage in Kent received Children’s Centre services within the first phase.

1.2 The second phase captured the small number of targeted areas remaining, whilst phase three mainly supported those areas within the 40 to 50 per cent most deprived wards. All phase three centres in Kent were situated outside of the most disadvantaged areas and therefore offered a less intensive level of support than those in phases one and two.

1.3 In 2011 Kent’s programme of 97 Children’s Centres was in its final phase of delivering the universal offer to all Kent communities and serving 84,665 children across the county. Kent was allocated total capital funding of £8.1m across all three phases between April 2008 and March 2011 which supported the development of fully operational services in all of its Children’s Centres.

1.4 A broad range of services have been provided to families, ranging from ante-natal care to supporting children’s transition to school. Kent’s families have received seamless services from partners delivering through Children’s Centres. Services have been well-regarded by families and helped build confidence to access the support needed to ensure families and children flourish from the start.

2 Health Services Currently Being Delivered in Kent Children’s Centres:

2.1 Health services have been critical to some Children’s Centres in giving access to a wide range of multi-agency services; however, the delivery of health services in Children’s Centres has been piecemeal predominantly due to the

lack of a clear strategic multi-agency approach. In some areas there are only core services delivered such as child health clinics offered by health visiting teams and ante natal and postnatal care offered by midwives/health visiting teams whereas in others there are also speech and language therapy services, breastfeeding drop in sessions, active movement sessions and other activities centred on disabled children.

2.2 There is a huge variance in additional health services that Children's Centres have commissioned. There is also a wide diversity in the health services being offered from Children's Centres even within the same town or locality and the aim should, therefore, be to standardise this through a health framework so there is equity of provision and access across Kent.

2.3 There is also variance in current links between Children's Centres and health professionals across Kent. There is a particular gap in the links between General Practice and Children's Centres. The success of true integration and partnership working is often dependant on individual relationships and/or co-location of staff and this should not be the case. This is resulting in missed opportunities for Health professionals and Children's Centre staff to utilise resource for children and families and a gap in both access to and integration of services that families receive.

2.4 There are also significant concerns about the lack of live birth data sharing. A recently published report of the Cross Parliamentary Group for Sure Start states **'we recommend that it (new guidance about information sharing) contain a clear statement that new births data in particular must be shared with Children's Centres'**¹.

3. Other Services Delivered in Children's Centres

3.1 Children's Centres provide multi-agency services that are flexible and meet the locally identified needs of young children aged 0-5 years and their families. The Government intends that the provision of good quality integrated services should have a broad and lasting impact on children, their parents/carers and the wider community. The types of services available in Kent's Children's Centres will include some or all of the following, dependant on local requirements:

- Early education integrated with childcare
- Family support and outreach to parents
- Drop-in sessions for parents/carers and children
- Information and advice about parenting and speech and language
- Services for children with special needs and disabilities
- Childcare provision
- Encouragement and support for parents/carers thinking about training or finding a new job
- Links with voluntary agencies
- Links with local schools

¹ Sure Start Delivery in 2011/12: An Inquiry, Interim Report

- Information and advice about breastfeeding
- Ante-natal classes and baby clinics

4. Children's Centre Outcomes

4.1 The Kent Children's Centres Outcomes Framework for commissioned services provides an overview of strategic outcomes to guide and support commissioners in developing services within Children's Centres in Kent (See Appendix 1).

4.2 The Outcomes Framework aims to deliver the revised core purpose for Children's Centres which enables and guides services to be targeted at those most in need whilst maintaining availability to all.

4.3 In order to commission high quality, evidence based, user led services, that deliver the key outcomes for young children and their families the Children's Centre Outcomes Framework is used in conjunction with needs assessment and other supporting information including Equality Impact Assessments, detailed service specifications, The Early Intervention and Prevention Strategy, Joint Strategic Needs Assessment and Kent's Principles for Commissioning Quality Children's Centre Services.

4.4 Children's Centres contribute significantly to the Public Health Outcomes Framework:

Improving the wider determinants of health

- Children in poverty
- School readiness
- Domestic abuse

Health improvement

- Low birth weight of term babies
- Breastfeeding
- Under 18 conceptions
- Child development at two
- Excess weight in 4-5 year olds
- Smoking prevalence 15 year olds
- Diet
- Excess weight in adults
- Smoking prevalence – adult over 18
- Self reported wellbeing

Health protection

- Population vaccination coverage

Healthcare, public health and preventing premature mortality

- Infant mortality
- Tooth decay in children aged five

5 Health Visitor Implementation Plan

5.1 The *Health Visitor Implementation Plan 2011-2015 – A Call to Action*² was published in February 2011. This sets out the framework for the development of the Coalition Government's vision to increase the number of Health Visitors (HVs) by 4,200 nationally and describes the new Health Visiting model (see Appendix 2). Kent and Medway have the highest target increase in Health Visiting numbers to achieve.

5.2 The commitment is based on the significant evidence of the importance of intervention in the early years³ as outlined in the recent document *Supporting Families in the Foundation Years*⁴ and previous reviews by Sir Michael Marmot, Frank Field, Graham Allen, Dame Clare Tickell and Professor Eileen Munro which have all reinforced the importance of early intervention in the foundation years.

5.3 Over the period 2011 -15, the Cluster led Health Visiting Programme will, in partnership with Kent County Council, provider organisations and other stakeholders, oversee the commissioning and delivery of improved Health Visiting services that will result in the following key outcomes for the population of Kent:

- Delivery of a public health and Healthy Child Programme aligned service for children aged 0-5 years and their families predominantly through Children's Centres;
- All children aged 0-5 years will receive early intervention, prevention and health promotion services which will help them achieve their optimum health and well-being;
- Traditionally 'hard to reach' groups of children who are vulnerable due to ill health, disability and/or disadvantage are reached in a timely manner to and receive the health input required;
- Outcomes for children as identified in national strategies (Action on Health Visiting) are achieved.

5.4 The HV programme provides exciting opportunities to further align health and Children's Centre services to improve outcomes for children and their families. The Cross Parliamentary Group for Sure Start report states:

“Health visitors have an immensely valuable role to play in co-ordinating health provision at Children's Centres and in maintaining links to other health professionals, especially GPs. It is vital that health visitors in all parts of the country are fully bound in to Children's Centres to allow Centres to reach their full potential as hubs for all services for children under five”.

NHS Kent & Medway will be leading on engagement strategy around the HV implementation process with CCGs and other key health stakeholders.

² The Health Visitor Implementation Plan 2011-2015 – A Call to Action DH Feb 2011

³ Health Visitor Implementation Plan – A Call To Action DH Feb 2011

⁴ Supporting Families in the Foundation Years DFE DH 2011

5.5 The Healthy Child Programme (HCP) is 'the early intervention and prevention public health programme that lies at the heart of universal services for children and families'⁵. It is based on a model of 'progressive universalism' and has two key programmes of work, one for pregnancy to five year olds and one for five to nineteen year olds. For the purpose of this paper the former is the section referred to throughout in line with the age group Children's Centres currently serve.

5.6 The HCP incorporates many public health programmes including:

- Immunisation according to the national schedule
- Antenatal and newborn screening according to the criteria laid down by the National Screening Committee to include:
 - Newborn bloodspot screening
 - NIPE (Newborn Infant Physical Examination)
 - NHSP (Newborn Hearing Screening Programme)
 - Child health reviews
 - Universal hearing screening at 4-5 yrs
 - Universal screening at 4-5 yrs
- Breastfeeding
- National Child Measurement Programme (Healthy Weight)

5.7 The HCP also provides a comprehensive and detailed schedule of what universal and progressive aspects need to be included at given ages whilst providing guidance on which health promotion and parenting guidance e.g. infant feeding, smoking cessation, substance misuse, SIDS (Sudden Infant Death Syndrome) maternal mental health and relationship issues should be delivered at each stage of the child's life in order to achieve best outcomes for both the child and their family.

5.8 The programme incorporates many previously individualised areas such as ante natal care, immunisation programmes, breastfeeding and healthy eating, healthy weight, emotional health and well being, support for parenting and ultimately and most importantly safeguarding. The key outcomes and priorities are attached as Appendix 3.

6 Health Services that could be delivered in Children's Centres

6.1 Close working between Children's Centres and Health Professionals could result in more joined up services being delivered. The health services to be delivered through a Children's Centre might include some of the following:

- ante-natal education
- appropriate maternity services (including early ante-natal engagement to include screening and post natal clinics/support to include screening)
- breastfeeding promotion and support/drop in clinics
- parenting advice including behavioural management

⁵ The Healthy Child Programme, Pregnancy and the First Five years of Life DH/DCSF 2009

- working with families and disabled children
- healthy lifestyles advice e.g. healthy weight/obesity including screening such as the National Child Measurement Programme, diet and nutrition advice including healthy weaning and dental advice, physical exercise, smoking, sexual health
- promotion of active play
- emotional health and well being support and mental health promotion
- speech and communication and language development
- immunisation promotion
- advice on accident and injury prevention including prevention of Sudden Infant death Syndrome (cot deaths)

6.2 Some of these areas can be delivered by non clinical staff, however, the following will need to be delivered specifically by clinical staff albeit with multi-agency contribution:

- health and development reviews
- screening
- immunisations
- assessment of mental health needs
- extra support with breastfeeding
- support with behaviour change (smoking, diet, keeping safe, SIDS, dental health)
- additional support & monitoring for infants with health or developmental problems

6.3 Whatever health services are delivered from Children's Centres they need to be linked to the domains cited in the Public Health Outcomes Framework⁶ (along with the indicators) as follows:

DOMAIN 1: Improving the wider determinants of health

DOMAIN 2: Health improvement

DOMAIN 3: Health protection

DOMAIN 4: Healthcare public health and preventing premature mortality

6.4 Services also need to utilise needs analysis as set out in the Joint Strategic Needs Assessment. Consideration also needs to be given to the most relevant sections of Kent's Health Inequalities Action Plan⁷: specifically 'Give every child the best start in life' and 'Enable all children, young people and adults to maximise their capabilities and have control over their lives'.

7 Future Service Options Review

7.1 Children's Centres have been selected as one of the initial pilots of the Future Service Options programme. This programme is designed to help KCC and its partners think through the options that might be available to a particular

⁶ Public Health Outcomes Framework DH 2012

⁷ Mind the Gap Building Bridges to Better Health for all 2012 -15 KCC

service to meet its future vision. This programme requires that each pilot goes through a number of stages of development which include:

- undergoing a review which identifies certain options and leads to a recommendation
- a 'decision in principle' which identifies which options KCC is interested in exploring further with its partners
- scoping identified options
- a final direction is decided on
- the project is implemented

7.2 An options appraisal is expected to be completed by the middle of April 2012. The review provides an opportunity to further explore joint service delivery and how health outcomes can be more effectively delivered across the county.

7.3 The Health & Wellbeing Board may wish to discuss how the review of the delivery of Children's Centres may further develop joint working and improve outcomes including:

- should the age range be extended to have a more family focus whilst not diluting the core purpose for 0-5 year olds?
- could some Children's Centres have specialisms?
- could more targeted and specialist services be delivered in those areas with the most vulnerable families?

8. Financial Implications

8.1 The 2012-13 budget for Children's Centres is £17,596,375. NHS Kent & Medway expect to invest approximately £2.3 million in order to retain the required trajectory of Health Visitors in Kent by 2013. Year on year investment up to April 2015 will be required to deliver the overall increase in Health Visitor numbers.

8.2 There is a challenge in how the additional investment is managed and the related outcomes delivered whilst there are significant efficiency savings for Children's Centres.

8.3 The County Council has made a commitment that in the short-term the 97 Sure Start Children's Centres will be retained, serving families and communities across the county. Consideration, however, does need to be given longer term whether maintaining 97 buildings is the most appropriate and effective strategy to deliver Children's Centre services against significant budget pressures. Every effort is being made to minimise disruption to services, however some changes are required in order that the Council, Districts, health and key partners can continue reaching and supporting families within the budget that will be available for 2012/13. This means that centre managers and delivery partners are working hard to make choices about what they are providing to ensure that the right staff and services are in place to maintain the high standards to which Children's Centres work.

9. Conclusion

9.1 The following example recommendations are within in the HCP (Healthy Child Programme) and are suggested as key to the successful implementation of the programme across Kent:

- Continued development of the provision of health services in Children's Centres
- The need to ensure that there is a named Health Visitor for each Children's Centre
- The requirement to maximise the available resources from all agencies in order to deliver the Healthy Child Programme
- The need to deliver equitable health services, dependent on local need, in Children's Centres across Kent
- The need to bring together the various strands of work that relate to the Healthy Child Programme such as Think Family, Maternal and Infant Mental Health Service (MIMHS) and work that is taking place around breastfeeding
- The need to ensure that 'clinical governance arrangements and professional leadership is in place to ensure protection of the public and safe practice'. This includes processes for confidentiality and information sharing, assessment of competence of the workforce, clinical supervision and safeguarding.⁸

9.2 With 'Action on Health Visiting' 2011 and the increased capacity of registered HVs it seems timely whilst implementing the new national HV model to consider a new integrated approach/model to develop 'Children's Centre teams' with co-location of HVs in Children's Centres to improve outcomes for children and their families. It is suggested therefore:

- A core health specification is produced to outline the standard health services that can be delivered within a Children's Centre setting
- 'Children's Centre teams' be led in an integrated manner by HV and Children's Centre manager working closely together to lead their staff thus normalising the relationship between Health and Children's Centre staff. This relationship at a senior level to be mirrored by Health and Children's Centre staff who are the 'Children's Centre team' with HCP being led by HVs
- Data/information sharing protocol with a clear flowchart is utilised
- Clarity with regards to training (especially safeguarding and preferably joint – Health, Social Care and other agencies) for 'Children's Centre team' to include confidentiality, boundaries and roles and responsibilities with a period of induction which incorporates 'shadowing'
- Clarity with regards to the competencies of Children's Centre staff and the ability for health staff, namely HVs, to be able to see demonstrable

⁸ The Healthy Child Programme, Pregnancy and the First Five years of Life DH/DCSF 2009. pg 57

evidence of these in order that they can safely delegate work as appropriate as highlighted in 'Getting it Right for Children and Families'⁹

- A uniform approach to the governance arrangements to include recording of meetings, attendance and clear auditable pathways for actions with regards to allocation meetings and caseload discussions both of which are to be led by the Health Visitor
- Integrated links with the local GP surgery.

9.3 However the following needs to be noted that:

- The development of equitable health services within Children's Centres will need to be on an incremental / 'phased in' basis and will commence with universal provision
- As appropriate targeted health services will be added also on an incremental / 'phased in' basis
- Provision of health services from Children's Centres will need to be negotiated according to local capacity particularly with regards to midwifery services
- Consideration of the extent of health services in any one Children's Centre to be influenced by the size and capacity of that centre

10. Recommendations

This paper is for discussion. In addition to Section 7.3 the Health & Wellbeing Board may also wish to consider:

- The main principles for joint commissioning / provision of the Children's Centre programme
- How Children's Centres can help achieve public health outcomes
- How public health and health services can help deliver the core purpose of Children's Centres
- The proposed model for HV and engagement of CCGS and key health stakeholders in its development

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⁹ Getting it Right for Children and Families DH October 2009

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Kent's Children's Centres

Outcomes Framework for Commissioned Services

1.0 Introduction

The DfES has reviewed and redefined the Core Purpose for Children's Centres (Appendix 1.) Running along side this, KCC, at a time of considerable pressure on our specialist services, has reprioritised targeted early interventions as described in our draft Early Intervention and Prevention Strategy. *(Link to be inserted when available.)*

Integrated support in the early years plays a vital role in ensuring that children's needs are met at the earliest opportunity and families get the support they need quickly. Children's Centre services across Kent will be refocused to ensure that the most vulnerable families are targeted and efficiency savings are met. Services will be flexible and responsive to emerging needs in order to further integrate children centres into the continuum of family support.

2.0 Purpose of Framework

The Outcomes Framework for Commissioned Services provides an overview of strategic outcomes **to guide and support commissioners in developing services** within Children's Centres in Kent. These strategic outcomes will not be achieved solely by Children's Centre services.

In order to commission high quality, evidence based, user led services, that deliver the key outcomes for young children and their families the Children's Centre Commissioned Services Outcomes Framework should be used in conjunction with;

- A robust needs assessment that draws on a number of sources including local intelligence, joint strategic needs assessments, consultation and equalities impact
- A detailed service specification that includes service outcomes and service performance measures. (A template and guidance is available from the commissioning unit at commissioning@kent.gov.uk)
- Kent's Principles for Commissioning Quality Children's Centre Services (Appendix 2)
- The Early Intervention and Prevention Multiple Supplier Framework
- Spending the Council's Money
- The Kent Compact

To support access to and delivery of services Children's Centres will continue to embed multi-agency implementation of the Common Assessment Framework and Team around the Child/Family including the Lead Professional role.

The framework does not include the holistic outcomes, judged by Ofsted, which Children's Centre provision should achieve. (<http://www.ofsted.gov.uk/resources/childrens-centres-evaluation-schedule-and-grade-descriptors>)

2.0 Children's Centre Commissioned Services Outcomes Framework

2.1 Universal Services (Core Purpose Universal Theme 1, 2, 3 and 4)

Children's Centres provide (directly or indirectly) early childhood services in an integrated manner within their catchment area. In Kent, the establishment of children centres throughout the county has enabled services to be targeted at those most in need whilst maintaining availability to all.

As recognised by Ofsted, groups most in need include;

- Teenage mothers and pregnant teenagers
- Lone parents
- Children in workless households
- Children in Black and Minority Ethnic groups
- Disabled children and children of disabled parents
- Other groups which are priority vulnerable groups in children's centre area.

Outreach is provided to those families who are disengaged from services because of isolation, language or multiple problems.

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UNIVERSAL SERVICES CORE PURPOSE THEME 1 - High quality, inclusive, early learning and childcare

Link to Kent Strategic Outcome¹	Intended Outcomes from Commissioned Services	Examples of Performance Measures <small>(Service performance measures to be agreed locally)</small>	Examples of types of services
<p>Children entering school are ready to learn and have sufficiently developed social and emotional skills for their age group.</p> <p>Children are able to achieve their full potential. Achievement in the early years contributes to children's outcomes throughout primary learning.</p> <p>Children and families feel positive about learning and actively seek ways to learn together.</p>	<p>Parents are provided with information and advice on childcare, early years provision and education services.</p> <p>All children have access to and experience the highest possible quality of childcare and early years education.</p> <p>Children engage in a variety of early learning activities that develop good learning skills, improve their interpersonal skills, sense of wellbeing, levels of resilience.</p> <p>Parents value early years education and are engaged in their child's personal and social development to ensure they develop skills for the future.</p> <p>Language for life is promoted in all early years settings.</p>	<p>Outcome Indicators: NI72: Achievement of at least 78 points across EYFS including at least 6 points in both PSED and CLL.</p> <p>NI92: Narrowing the gap between the lowest achieving 20% in the Early Years Foundation Stage Profile.</p> <p>Performance Indicators: Early Years Settings Ofsted inspections</p> <p>Take up of free 2 year old places for vulnerable children.</p> <p>Demand and supply of high quality early years provision.</p> <p>Take up of early years education</p>	<p>Part of the Multiple Supplier Framework: Early learning activities Play interventions</p> <p>Not part of the Multiple Supplier Framework: Early Years Provision including targeted free learning for two year olds. Childcare Childminders and childminder networks Childcare information service</p>

¹ Sources: Bold Steps for Kent, Children's Services Improvement Plan 'Putting Children First', Kent's Early Intervention and Prevention Strategy, Kent Strategic Planning Framework to Support Positive Outcomes for Children and Young People.
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UNIVERSAL SERVICES CORE OFFER THEME 2 - Information and activities for families

<p>Link to Kent Strategic Outcome</p>	<p>Intended Outcomes from Commissioned Services</p>	<p>Examples of Performance Measures <i>(Service performance measures to be agreed locally)</i></p>	<p>Examples of types of services</p>
<p>Parents are able to make informed decisions and recognise the impact of those decisions.</p> <p>Children and families feel positive about learning, develop good learning skills and actively seek ways to learn together (also linked to 1).</p> <p>Parents actively participate, lead and/ or deliver local community service.</p> <p>Parents feel empowered and supported to seek guidance and advice to represent their needs and the needs of the child.</p>	<p>Parents are aware of the help available to them and are able to keep their children safe and protected.</p> <p>Local families interact with each other to improve interpersonal skills, sense of wellbeing and build resilience.</p> <p>Child development needs are diagnosed early.</p> <p>Parents are empowered and understand their influence in their child's development.</p> <p>Parents are confident in supporting their children to achieve their full potential.</p>	<p>Performance Indicators: Participation rates by the target groups of families (including outreach)</p> <p>The percentage of families that say and/or show that they feel safe and are confident to share concerns with staff. (Ofsted Assessed)</p> <p>Number of appropriate referrals e.g. speech and language, CAF</p> <p>The percentage of families using the centre that are involved in additional community-based development activities and projects.</p>	<p>Part of the Multiple Supplier Framework: Play interventions Parent and toddler groups Early learning activities Parent – child home programmes Recreational activities Support groups Good quality guidance and advice e.g. benefits, housing, child development</p>

UNIVERSAL SERVICES CORE PURPOSE THEME 3 - Adult learning and employment support

Link to Kent Strategic Outcome	Intended Outcomes from Commissioned Services	Examples of Performance Measures <small>(Service performance measures to be agreed locally)</small>	Examples of types of services
<p>All children achieve their full potential.</p> <p>Reduced levels of children and young people living in poverty.</p>	<p>Parents are inspired to achieve their full potential.</p> <p>Parents have improved levels of literacy and numeracy.</p> <p>Families (including teenage parents) are engaged in training, adult learning or relevant activities that lead to suitable employment.</p> <p>Local families have improved economic stability and independence and parents are aware of the options and help available to them.</p>	<p>Outcome Indicators:</p> <p>The percentage of parents from the target group engaging in activities that progress to employment or further learning opportunities.</p> <p>The percentage of teenage mothers aged 16-19 in education, employment or training.</p> <p>The percentage of children aged 0-4 living in households dependent on workless benefits (NI 116).</p> <p>Performance Indicators:</p> <p>The number of accredited courses run, attended and completed by target families.</p> <p>Average length of time targeted parents waited to access an accredited course following identification of need.</p> <p>The assessment of learners' performance, standards and progress based on initially identified needs.</p>	<p>Part of the Multiple Supplier Framework:</p> <p>Return to work activities</p> <p>Family literacy and numeracy</p> <p>Family learning activities</p> <p>Basic skills</p> <p>Signposting to opportunities e.g. Job Centre Plus, CAB</p> <p>Advice and guidance e.g. debt</p> <p>Creches</p>

UNIVERSAL SERVICES CORE PURPOSE THEME 4 - Integrated child and family health services

Link to Kent Strategic Outcome	Intended Outcomes from Commissioned Services	Examples of Performance Measures <i>(Service performance measures to be agreed locally)</i>	Examples of types of services
<p>Infants are born healthy and receive the best start in life during their early years.</p> <p>Reduced health inequalities.</p> <p>Children and young people are a healthy weight and lead active lifestyles.</p>	<p>Antenatal support results in low infant mortality rates and healthy weight babies.</p> <p>Post natal support, information and guidance improves the health and wellbeing of babies and young children aged 0-5.</p> <p>Children and families are able to make healthy lifestyle choices and lead healthy lifestyles.</p> <p>Mothers are emotionally, mentally and physically healthy, and are able to form strong attachments with their infant and meet their needs.</p>	<p>Outcome Indicators:</p> <p>CT3: The percentage of mothers smoking during pregnancy</p> <p>CT11 Infant mortality rates</p> <p>CT13: Low birth weights</p> <p>NI70: Hospital admissions caused by unintentional/deliberate injuries (0-5 year olds.)</p> <p>The percentage of mothers initiating breastfeeding</p> <p>The percentage of mother's sustaining breastfeeding post 8 weeks from birth</p> <p>NI53: Prevalence of mothers breastfeeding at 6 – 8 weeks from birth</p> <p>CT4: Proportion having MMR immunisations by 2nd birthday</p> <p>National Child Measurement Programme (Healthy Weight)</p> <p>NI55: Obesity among primary school children in reception year</p> <p>Performance Indicators:</p> <p>Ability to meet different levels of need and risk (HCP progressive universalism.)</p>	<p>Part of the Multiple Supplier Framework:</p> <p>Universal family and parenting support e.g. smoking cessation, health eating, exercise, safer choices</p> <p>Peer support schemes e.g. breast feeding</p> <p>Not part of the Multiple Supplier Framework:</p> <p>Healthy Child Programme including:</p> <ul style="list-style-type: none"> • Immunisation, • Antenatal and newborn screening, • Breastfeeding, • National Child Measurement Programme (Healthy Weight), • Emotional health and well being • Sexual health.

2.2 Targeted Services (Core Purpose Targeted Theme 1 and 2)

Targeted services are short term interventions that are reviewed on a regular basis to enable the child and family to move back to universal services support. A child and family may need a number of these short term supports as their needs change.

Initially targeted children's centre services will be accessed through escalation from universal services and via specialist services.

Service users are likely to be children needing some additional support without which they would be at risk of not meeting their full potential. Their identified needs may relate to their health, educational or social development. In Kent, service users are likely to be families who experience²:

- Poverty;
- Domestic violence;
- Housing difficulties including homelessness
- Teenage pregnancy
- Child or parental disability, illness or mental health problems; and
- Parental substance misuse.

As Kent children's centre services move towards aligning with the Early Intervention and Prevention Strategy, targeted service will prioritise at **Tier 2.5 and above**. Targeted services will be increasingly accessed through the Common Assessment Framework and Team around the Child/Family.

² CYPP Root Cause Analysis 2010

TARGETED SERVICES CORE PURPOSE THEME 1 - Parenting and family support

Link to Kent Strategic Outcome	Intended Outcomes from Commissioned Services	Examples of Performance Measures (Service performance measures to be agreed locally)	Examples of types of services
<p>Effective early intervention prevents escalation of need and reduces the number of children in need.</p> <p>Effective interventions enable children and families in need to move back to universal support services.</p> <p>Coordinated support for families in greatest need is provided at the earliest point in order to prevent crisis situations.</p> <p>The developmental needs of babies and children are met.</p> <p>Children are safe and protected from harm and are better able to form and manage healthy relationships.</p> <p>Parents, carers, and children are less likely to engage in an abusive relationship.</p> <p>Fewer infants are born to teenage parents.</p>	<p>Parents are supported to provide basic care, safety and protection for their children.</p> <p>Targeted family support meets the needs of individual families.</p> <p>Fathers are engaged in their children's lives.</p> <p>Vulnerable families are increasingly engaged with children's centres.</p> <p>Negative effects of childhood adverse experiences are reduced.</p> <p>Parents establish and retain clear boundaries with their children.</p> <p>Parents are enabled to build resilience.</p> <p>Improved levels of attachment between parent and child.</p> <p>Parents have improved self esteem and levels of confidence.</p> <p>Teenage parents are supported to raise physically, mentally and emotionally healthy children</p> <p>Fewer teenage mothers have subsequent pregnancies.</p>	<p>Outcome Indicators: Hospital admissions caused by unintentional/ deliberate injuries</p> <p>Number of children and families in need of targeted support that are enabled to move back to universal support services.</p> <p>Under 18 conception rate</p> <p>Repeat incidents of domestic abuse</p> <p>Performance Indicators: Number and percentage of children using the service who have a family CAF initiated.</p> <p>Number of vulnerable families accessing services/ reach of service.</p>	<p>Part of the Multiple Supplier Framework: Family support service Emotional support services Outreach services Relationship counselling/ mediation Support services for young parents Support groups</p> <p>Targeted support services where there is:</p> <ul style="list-style-type: none"> • A parental physical disability/ parental illness • Housing issues • Parental Substance misuse • Parental mental health issues • Domestic abuse

TARGETED SERVICES CORE PURPOSE THEME 2 - Targeted evidence-based early intervention programmes

<p align="center">Link to Kent Strategic Outcome</p>	<p align="center">Intended Outcomes from Commissioned Services</p>	<p align="center">Examples of Performance Measures <small>(Service performance measures to be agreed locally)</small></p>	<p align="center">Examples of types of services</p>
<p>Parents and carers are able to provide good parenting.</p> <p>Reduce negative intergenerational parenting practices.</p> <p>Health and attainment inequalities are reduced.</p>	<p>Parents have good relationships with their children and family</p> <p>Parents promote their child’s learning and involvement in education.</p> <p>Parents promote resilience in their children and young people</p> <p>Parents empathise with their child and communicate respectfully and effectively</p> <p>Parents feel in control and remain calm when facing difficulties and find ways to avoid conflict</p> <p>Parents establish and retain clear boundaries and successfully manage behaviour issues.</p> <p>Parents effectively manage the pressures of parenting</p> <p>Parents make informed choices and decisions to support positive outcomes for their child</p> <p>Parents provide stimulation and support their child to develop.</p> <p>Parents provide emotional warmth and stability for their children.</p> <p>Parents have improved self esteem and levels of confidence.</p>	<p>Performance Indicators:</p> <p>Within the target group: Number and percentage of parents / carers who have completed validated parenting programmes</p> <p>Average length of time parents have waited to access a programme following identification of need.</p> <p>Percentage of parents reporting programme has met their needs.</p> <p>Percentage of parents reporting an improvement in their parenting ability/ skills.</p> <p>Improvements in the quality of a parent-child relationship during the course of a programme, as measured by the Parent Child Relationship Inventory (PCRI).</p>	<p>Part of the Multiple Supplier Framework:</p> <p>e.g. Strengthening Families, Strengthening Communities, Incredible Years Mellow Parenting Incredible Babies Mellow Babies Direct instruction Early Literacy and Learning Model Even Start</p>

2.3 Links with Specialist Services (Core Purpose Targeted Theme 3)

Some service users will require longer term interventions and specialist support. In these instances Children's Centres will continue to provide appropriate links with specialist services.

These children will be those who are highly vulnerable or experiencing the greatest level of adversity. This will include Children in Need. Only a small fraction of children will fall in this band.

Further information on threshold criteria and/ or the common assessment framework is available at:

http://www.kenttrustweb.org.uk/UserFiles/CW/File/Childrens_Services/Kent_Childrens_Trust/CAF/KM_Eligibility_and_Access_FINAL_Electronic_March_2011.pdf and
http://www.kenttrustweb.org.uk/Children/kct_CAF.cfm

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TARGETED SERVICES CORE PURPOSE THEME 3 - Links with specialist services

Link to Kent Strategic Outcome	Intended Outcomes from Commissioned Services	Examples of Performance Measures <small>(Service performance measures to be agreed locally)</small>	Examples of types of services
<p>Children are appropriately referred to children’s social care (reducing re-referrals and increasing the number of initial assessments.)</p> <p>All children in need of safeguarding and protection receive appropriate services as and when they most require them.</p> <p>Parents are supported to raise emotionally and mentally healthy children, reducing adverse childhood experiences (e.g. parental substance misuse.)</p> <p>Children and young people can access emotional health and wellbeing support at the earliest possible stage.</p> <p>All children and young people have adequate communication and interaction skills to enable them to learn and develop social relationships.</p>	<p>In times of crisis and transition, families feel confident in turning to the Children’s Centre.</p> <p>Parents are supported to build and maintain positive relationships with responsive personalised services that meet individual needs.</p> <p>Families are continually supported through and after their engagement with specialist services.</p> <p>Parents are empowered and supported to seek guidance and advice to represent their individual needs and the needs of their child.</p> <p>Children’s disabilities or learning difficulties are diagnosed early and services are provided to prevent escalation of need.</p>	<p>Outcome Indicators: Numbers of children with a CP Plan per 10,000 population</p> <p>Performance Indicators: Number of referrals from children centres to CSS that go on to initial assessment.</p> <p>Percentage of families with CP plan or CHIN plan that are being supported by Children’s Centres</p> <p>Number of family CAFs initiated or supported</p> <p>Number of practitioners that are involved regularly in TAC</p> <p>Number and percentage of children who receive timely access to specialist services where required (e.g. children’s social care, tier 3 health services)</p> <p>Number and percentage of children supported who are referred to the service by specialist services</p> <p>Levels of practitioner confidence in their skills and abilities (e.g. safeguarding, disability awareness, Common Assessment Framework)</p> <p>Parental satisfaction</p>	<p>Part of the Multiple Supplier Framework: Family Support Service Other support services EWMH services e.g. normative behaviour activities Speech and language support services Parent Advocacy Counselling Mediation</p> <p>Not part of the Multiple Supplier Framework: Family contact services Portage Educational Psychology Workforce development/ training services Referral service e.g. to CSS, community CAMHS/ EWMH, services not deliver by Children’s Centre e.g. bereavement and loss, specialist support, DCS, KDDAT, adult MHS</p>

3.0 Performance Management

3.1 Performance Management of Commissioned Services

Services will be specified, contracted and performance managed as appropriate.

All service specifications will outline the purpose of a service, what it aims to achieve and how we will measure progress towards meeting the outcomes of the individual service. This will include a range of Outcomes Based Accountability Measures:

- How much did we do? e.g. levels of activity
- How well did we do it? e.g. parental satisfaction
- Is anyone better off?
- Was this the best use of our resources?
- Could we have used the resource more effectively?

The commissioning outcomes framework outlines ways in which performance against strategic outcomes could be measured, and provides context to the core areas for consideration when a service's outcomes measures are established. Where appropriate, measures will be specific, measurable, achievable and time specific.

3.2 Performance Management of Children's Centres

Inspectors will continue to judge children's centre provision through Ofsted Inspections. Performance of services will contribute in part to this assessment.

<http://www.ofsted.gov.uk/resources/childrens-centres-evaluation-schedule-and-grade-descriptors>

Performance management in children's centres will adhere to KCC's Standard of Required Practice (SORP) for performance management. <http://knet/Change/Documents/sorp-1-final.pdf>

Appendix 1 - The Department for Education Children's Centre Core Purpose

In July 2011, the Department for Education published a Children's Centre Core Purpose, and this was defined as:

Improving outcomes for young children and their families, with a particular focus on the most disadvantaged families, in order to reduce inequalities in child development and school readiness.

The Core Purpose maintains a focus on Children's Centres providing both Universal and Targeted services, whilst providing the guidance that Children's Centres should also be:

- 1) Acting as a hub for the local community, building social capital and cohesion.
- 2) Sharing expertise with other early years settings to improve quality.
- 3) Respecting and engaging parents
- 4) Partnership working

The Core Purpose for Children's Centres outlines 7 key areas for focus, 4 of which are described as 'universal' and three of which are described as 'targeted'. Children's Centres must ensure that they provide services from all seven strands of the Core Purpose to ensure a high standard of provision, and to ensure that they are able to reduce inequalities in child development and to ensure that when children start school, they are ready to achieve. When Ofsted Inspect Children's Centres, they will be assessing how well the Centre delivers the core purpose, as this will give a clear indication as to the success of centres in improving outcomes for children and their families.

Universal Services

1. High quality, inclusive, early learning and childcare
2. Information and activities for families
3. Adult learning and employment support
4. Integrated child and family health services

Targeted Services

1. Parenting and Family Support
2. Targeted evidence-based early intervention programmes
3. Links with Specialist Services

Appendix 2 - Kent Principles for Commissioning Quality Children's Centre Services

Within Kent, we are committed to delivering quality Children's Centre Services. Kent's principles for commissioning quality children's centre services have been drafted in line with Bold Steps for Kent, Spending the Council's Money and the Kent Partners Compact.

<https://shareweb.kent.gov.uk/Documents/priorities-policies-plans/Bold%20Steps%20for%20Kent/Bold%20Steps%20for%20Kent%20Dec%202010.pdf>

<http://knet2/policies-and-procedures/finance-and-procurement/procurement/spending-the-councils-money>

<https://shareweb.kent.gov.uk/Documents/community-and-living/volunteering/kent-partners-compact-2009.pdf>

We will:

1. Safeguard children.
2. Target the most vulnerable families, aiming to reduce inequalities in outcomes for parents and children.
3. Commission services based on a robust needs assessment.
4. Commission outcome and evidence based services.
5. Engage service users and key stakeholders in commissioning arrangements.
6. Provide clear access routes to all services. We will actively seek to mitigate against access inequality.
7. Seek to ensure a continuum of support services to the whole family.
8. Sustain and develop effective partnerships with all stakeholders.
9. Develop and support the market to ensure that we have a range of high quality providers.
10. Deliver services that are cost effective, demonstrating efficiency through robust performance monitoring and contract review.
11. Secure a high quality work force and ensure that there is continuous workforce development, support and supervision.

New Health Visiting Model

The health visiting service will be offered to every family with a child/children under the age of 5 years ensuring access to the health visiting service as described in the Health Visitor Implementation Plan 2011-2015 – A Call to Action. The provider will work closely with commissioners to implement the new health visiting model as described below by 2015:

- **Community** – Based on the Joint Strategic Needs Assessment the service will understand the needs of local communities contributing to a directory of services to meet those needs. Health visiting professionals in the local area are to be supported in community development work undertaking the new 'building community capacity' training module.
- **Universal** – All elements of the Healthy Child Programme (HCP) 'Pregnancy and the First Five Years of Life' are to be delivered using evidence – based universal prevention (including routine childhood immunisations and non-routine immunisations for at-risk babies e.g. Hepatitis B and BCG, health and development checks).
- Health visitors will lead the delivery of the core universal contacts through integrated children's services whilst directly delivering those areas specific to health visiting prioritising first time parents and working in partnership with Family Nurse Partnership (FNP) once implemented in Kent.
- **Universal plus** – The health visiting service will undertake specific areas of each progressive part of the programme where clearly it is the role of the health visiting service to do so using clearly defined evidence based care packages. Where the progressive elements of the programme relate to other disciplines or agencies the health visiting service will make timely referrals to or sign post on to other disciplines/agencies providing a flexible and seamless approach.
- **Universal partnership plus** – as a minimum the HV service will ensure that there is a health visiting representative on the Steering Group of each Children's Centre and that there is a health visiting representative on each of the Children Centre Advisory Boards across the districts in Kent. The HV service will ensure there are services/drop-in sessions provided by health visitors through Children's Centres. The health visiting service will actively participate in the Common Assessment Framework (CAF) process.
- The health visiting service will actively contribute to the safeguarding of pre - school aged children and ensure the most current Child Protection processes are adhered to, working closely with other services particularly Social Services to support the Child Protection processes for children aged 0-5 years
- The health visiting service will work with the virtual school to ensure that all looked after children (LAC) are identified as being vulnerable and that

they have appropriate and timely access to HV advice and support in relation to the HCP.

- The health visiting service will contribute to the narrowing of the gap in inequalities agenda using the Joint Strategic Needs Assessment whilst contributing to the Public Health Outcomes

Appendix 3

Key Outcomes and Priorities

In the Healthy Child Programme (HCP) it is stated that the implementation should lead to:

- strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children;
- care that helps to keep children healthy and safe;
- healthy eating and increased activity, leading to a reduction in obesity;
- prevention of some serious and communicable diseases;
- increased rates of initiation and continuation of breastfeeding;
- readiness for school and improved learning;
- early recognition of growth disorders and risk factors for obesity;
- early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety;
- identification of factors that could influence health and wellbeing in families
- improved short- and long-term outcomes for children who are at risk of social exclusion.

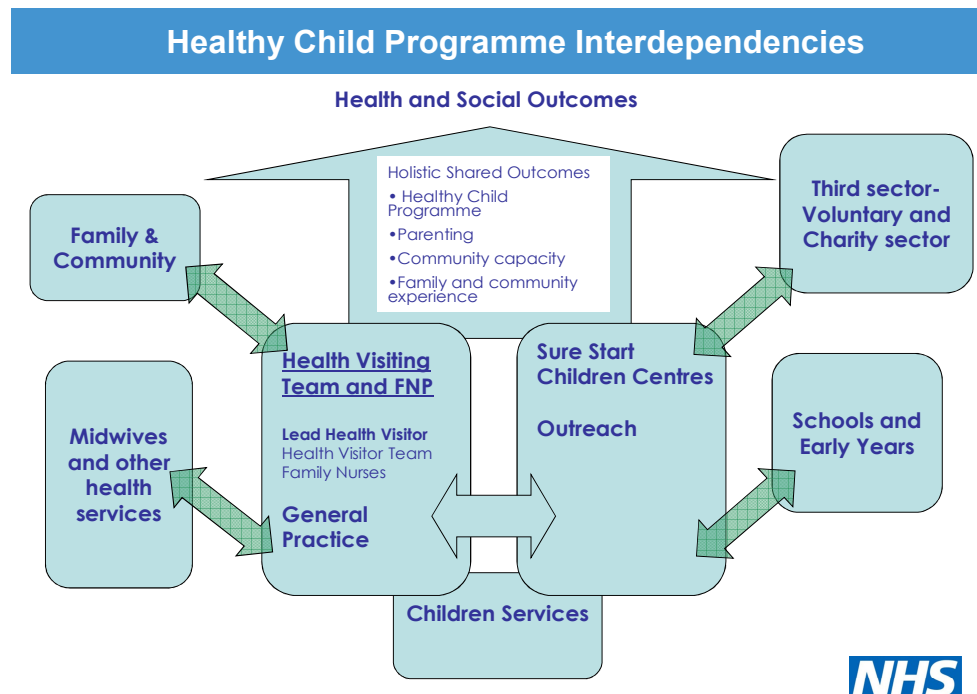


Fig 1: Diagram illustrating the interdependencies related to the HCP

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