From: Clair Bell, Cabinet Member for Adult Social Care and Public Health

Anjan Ghosh, Director of Public Health

To: Kent Health and Wellbeing Board, 23 September 2022

Subject: 2022 Kent Joint Strategic Needs Assessment (JSNA) Summary Report

Classification: Unrestricted

Summary:

This report describes the latest changes made to the Kent Joint Strategic Needs Assessment (JSNA) development process and provides a summary of new priorities emerging from key population highlights from various reports, needs assessments and population profiles done over the last 2 years. Latest intelligence, based on available data, shows most if not all HCP (Health and Care Partnership) footprints are experiencing similar patterns of ill health around falls, obesity, and mental health including suicide.

Recommendation(s):

The Kent Health and Wellbeing Board is asked to **COMMENT** and **ENDORSE** the following recommendations:

- The new NHS ICB (Integrated Care Board) and HCPs need to adopt a broader consistent structure for outlining priorities for population health improvement, encompassing primary prevention, (behaviour change), secondary prevention (early diagnosis and treatment including health checks) for those at risk of LTCs (Long Term Conditions) e.g. Cancer and Mental Health; and tertiary prevention (recovery, rehabilitation and reablement of patient with complex needs), ensuring better quality of care.
- As part of the Whole System Approach to Healthy Weight programme, a long-term obesity plan needs to be developed and aligned with the Kent Public Health and ICB strategies, optimising existing pathways with better referral criteria, emphasising more on population level focus, and ensuring impact on wider determinants of health.
- Greater emphasis from the ICB board and KCC is required on smoking prevention as well as cessation, integrating directly into local care and acute care models. Better emphasis on workforce planning to enhance Making Every Contact Count (MECC) particularly on frontline services (e.g. NHS Trusts) that have yet to implement as such, and increase referrals into existing One You and other relevant social prescribing services.
- Local senior leadership (county and district) to go further and faster in better data sharing with the NHS and instruct their data infrastructure teams to work with their respective NHS counterparts in moving towards a common solution for data sharing and linkage, linking into the NHS led Population Health Management programme.

1. Background

1.1. The JSNA summary / exception report is a routine annual report presented to the Kent Health & Wellbeing Board. This report is broadly divided into two sections:

- A high-level description of key population highlights taken from various reports and latest population profiling tools and latest updates to the Kent JSNA currently available on the Kent Public Health Observatory (KPHO) website. COVID impacts on Kent population are discussed separately in the COVID Impact Assessment report so are not included here.
- Recent changes and updates made to the Kent JSNA development process.

1.2. The last JSNA exception report was published in 2019. In 2020, the exception report was replaced by the Kent & Medway Health Needs Assessment which was submitted to the Joint Kent & Medway Health & Wellbeing Board as part of the Kent & Medway ICS (Integrated Care System) submission for their 5 Year Long Term Plan to NHS England. Exception reporting was again stood down in 2021 while the Kent Public Health department focused their attention and resources towards the COVID pandemic.

1.3. In 2022, new developments have taken place such as the creation of the Kent & Medway Integrated Care Board and the rollout of the Population Health Management programme. These and other developments will have a significant impact on the JSNA development process and so it is expected the data sources, tools and reports are likely to change.

1.4 The Kent Public Health Strategy will describe, among other things, the development of the Research, Innovation and Improvement Function for the Public Health department. Over time, this will allow us to develop a more robust evidence base for effectiveness of intervention activities for prevention which will feed into the prioritisation process for strategy and action planning going forward.

2. Key Population Highlights

2.1 Demographic Changes

2.1.1 The Office for National Statistics (ONS) has released the first results from Census 2021 in June 2022. Further insights will be released over the next 2 years, and we expect future JSNA exception reports to cover some of these. Some of the key demographic features include:

- Kent remains the most populous county within the Southeast at 1,576,100. The population in Kent grew by 112,400 people between 2011 and 2021 which is equal to a 7.7% increase.
- In 2021, Maidstone was the most populous local authority within Kent at 175,800. Maidstone's population accounts for 11.2% of the total population of Kent. Maidstone also experienced the

highest increase in absolute terms in total population where the population rose by 20,600 between 2011 and 2021. This is the largest increase of all twelve local authorities in Kent and equates to a 13.3% increase.

2.1.2 However, Dartford saw the highest percentage total population increase with 19.9% or 19,400 people. Tunbridge Wells experienced the smallest increase in population between the 2011 and 2021 Census, rising by 300 people or a 0.3% increase.

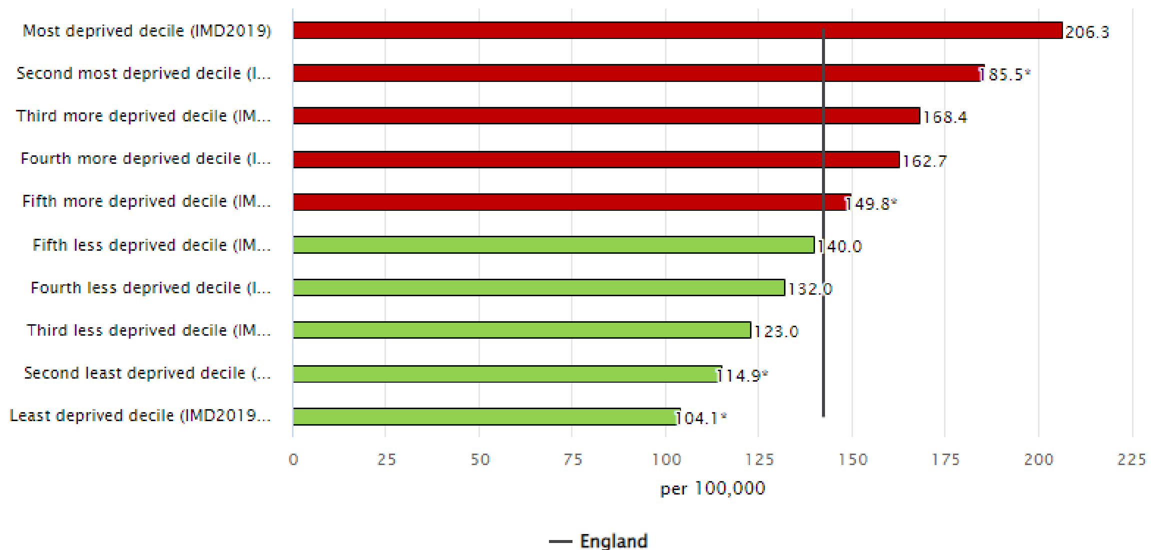
2.1.3 The latest KCC housing led forecasts suggests the Kent population is due to grow by 91,000 (5.7%) from 2020 to 2025. Dartford, Ashford, and Dover are predicted to see the highest percentage population growth increases. Older people are the fastest growing group of people in Kent. Latest projections estimate that the population aged 65 and over will grow by 9.8% over the same period, compared to 4.7% for those under 65.

2.1.4 In 2020 the leading causes of premature (preventable) death in the Kent population for the under 75 age group were:

- Cancer - 48.9 per 100,000 population
- Cardiovascular diseases - 25.4 per 100,000 population
- Respiratory disease - 16.0 per 100,000 population
- Liver disease - 16.0 per 100,000 population

2.1.5 The above death rates showed no significant change from the previous time period but the overall difference in rates by deprivation still continue to be wide, with 5 worst deciles higher than the England average (see Figure 1).

Figure 1 Under 75 all cause premature mortality rate by deprivation decile (3 year range for 2017-19)



Source: Fingertips

2.2 Health Care Partnership (HCP) & Primary Care Network (PCN) Profiles

2.2.1 Following the submission of the Kent & Medway 5 Year Long Term Plan in late 2019, the Public Health Observatory and Medway Council Public Health Intelligence team have created annually updated population profiles for each Health Care Partnership (HCPs) and Primary Care Network (PCNs), which are currently available on the KPHO website.

2.2.2 The overall aim of the work is to highlight the health and social care needs of each area and to identify priority areas to explore further. Excerpts of the latest profiles, updated in May 2022, are shown in Appendix 1 for the 4 HCPs describing performance across 41 indicators against England average. A key summary for each HCP is shown below.

2.2.3 East Kent performs relatively worse in 8 indicators which are smoking status at time of delivery, teenage conceptions, A&E attendances, hospital admissions for self-harm, falls in the elderly, suicide and cancer mortality.

2.2.4 West Kent performs relatively worse in 4 indicators which are smoking status, A&E attendances, hospital admissions for self-harm and falls in the elderly.

2.2.5 Dartford Gravesham & Swanley performs worse in 13 indicators which are smoking prevalence, adult and childhood obesity, physical inactivity, breast cancer screening coverage, smoking status at time of delivery, A&E attendances, hospital admissions for diabetes, Ambulatory Care Sensitive Conditions, falls and hip fracture, and suicides.

2.2.6 Sheppey and Sittngbourne PCNs form the Kent footprint of the Medway & Swale HCP. Sheppey PCN performs worse in 7 indicators which include Life expectancy, premature mortality, obesity, A&E attendances, and hospital admissions for asthma. Sittingbourne PCN performs worse in one indicator which is A&E attendances.

2.3 Smoking

2.3.1 Prevalence of smoking in Kent is 13.4%, 1.3% above the national average (12.1%), based 2020 data. (see table 1)

2.3.2 Although smoking rates have declined nationally and in Kent, smoking still remains the main cause of preventable disease as mentioned above.

2.3.3 Mortality rates due to smoking are 3 times higher in the most deprived areas than the affluent areas demonstrating that smoking is intrinsically linked to inequalities.

2.3.4 The recent Khan review recommends further measures, particularly to prevent the take up of smoking among young people, which is intended to inform a new national tobacco control strategy later in 2022.

Table 1 Overall prevalence of smoking by district

District	Estimated Prevalence
Ashford	12.7%
Canterbury	9%
Dartford	16.8%
Dover	13.6%
Folkestone & Hythe	11.9%
Gravesham	17.6%
Maidstone	14.1%
Sevenoaks	11.3%
Swale	17.7%
Thanet	16.1%
Tonbridge and Malling	10.3%
Tunbridge Wells	11.3%

2.3.5 Table 2 shows the highest smoking rates in Dartford, Gravesham, Thanet and Swale districts.

2.3.6 Smoking rates are typically higher among routine and manual workers and other deprived groups (see table 2). Relatively affluent districts may have high concentration of smokers in pockets of deprivation. Smoking estimates among routine and manual workers in West Kent range from 15.1% to 38.7% (2019 data).

Table 2 Smoking prevalence among Routine and Manual workers

District	Estimated Prevalence (R&M workers)
Ashford	16.5%
Canterbury	10.9%
Dartford	48.2%
Dover	26%
Folkestone & Hythe	31.2%
Gravesham	12.4%
Maidstone	22.8%
Sevenoaks	15.1%
Swale	24.6%
Thanet	43.4%
Tonbridge and Malling	15.2%
Tunbridge Wells	38.7%

2.4 Health Checks

2.4.1 Following reduced rates during the COVID period, Health Checks uptake have increased over the past year and likely to continue the upward trend, helping towards meeting our constitutional coverage targets for this year.

2.4.2 However, some practices have opted out of the Health Checks programme and this has increased the need for Kent Community Health Foundation NHS

Trust to step in and pick up this unmet need and offer checks for these practice populations and minimise risk of further health inequalities caused by inequitable health checks provision.

2.5 Coastal Excess

2.5.1 Further to the Chief Medical Officer's Annual Report in 2021, last year's Annual Public Health Report for Kent focused on the health of coastal communities and a description of 'coastal excess' in terms of health inequalities. There are 12 coastal towns in the county with a population between 5,000 to 225,000, which were included in the analyses.

2.5.2 The key findings are:

- There is a higher burden of disease in coastal towns compared to non-coastal towns in Kent. This is the case for all health conditions investigated and is most evident for chronic pulmonary obstructive disease and coronary heart disease. Risk factors such as obesity and smoking also show a coastal excess when compared to non-coastal towns, Kent and England.
- Disease burden varies across coastal towns, with Dover, Folkestone, Margate and Ramsgate containing some of the wards with the highest coastal excess. This coastal effect remains even after adjusting for differences in demographics and deprivation.
- Premature mortality from all causes and cancer are also significantly higher in these areas, as well as higher rates of hospital admissions related to alcohol and self-harm.
- Six out of the seven domains of deprivation are worse in coastal areas. This means that economic growth needs to be linked with health in local plans in these areas.
- Lack of local data continues to hinder efforts for more detailed analysis of the health of local communities, both on and beyond the coastal fringe.

2.5.3 The stark nature of health inequalities implies the need to work with local providers to further improve provision of health and social care services, particularly around prevention of long-term conditions which contribute the most towards premature mortality.

2.6 Children And Young People

2.6.1 The children under 5 years Health Needs Assessment was completed earlier this year. Key findings include:

- The social gradient in health is being accentuated in Kent. There is a changing picture of need and indicative measures of poor future health status are being observed.
- Children aged 0-4 years are mostly seen in isolation, by a range of individuals and services, without their peers, but when their family is present.

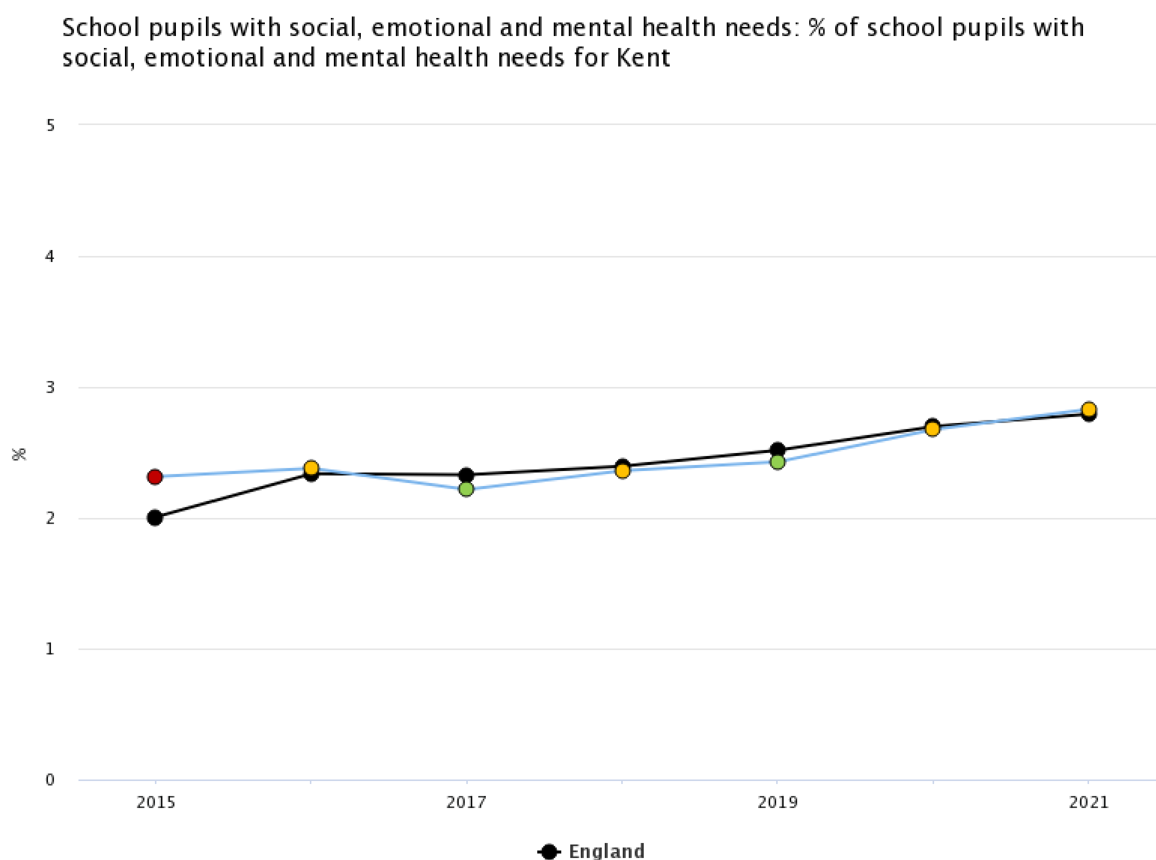
- The approach to prevention of poor health outcomes is inconsistent and not helped by reduced workforce capacities.
- Changes to the support infrastructures have impacted most negatively in areas where there was greater dependency upon them.
- Infant mental health is not prioritised and understanding of the impacts misplaced.
- The provision and levels of support is variable and children with more complex needs are needing to be managed.

2.6.2 Increasing demand for education health care plans (EHCP)s from years 5 – 11 is of concern, where social, emotional & mental health are identified as the primary needs. Reasons for these are multi factorial. Children and young people will have experienced the Covid-19 pandemic and the environments for education at home and schooling challenging (see Figure 2). Prevention, early identification, and support of emotional and mental health needs thus remains a priority.

2.6.3 Assessment of the health needs of looked after children including unaccompanied asylum-seeking children have highlighted again another example of little or no local data availability and data integration, which essential for further deep dive analyses. Better understanding of differentiation of needs by deprivation and ethnicity in key services areas such as hearing screening, SEND and child weight.

2.6.4 In Kent, over 1 in 4 children in reception year (26.6%) were classified as having excess weight (England 27.7%) in 2020/21. Tonbridge and Malling had the highest (23.4%) prevalence of excess weight in Year R in West Kent in 2020/21. For obesity, in West Kent, obesity and severe obesity have increased in Tonbridge and Malling and Sevenoaks since the previous year.

Figure 2



Source: Fingertips

2.7 Adult Obesity

2.7.1 The estimated proportion of adults aged 18 and over in Kent classified as overweight and obese in 2020/21 was 63.2% (England,63.5%). The prevalence of overweight and obesity remains high across most Kent districts, with Dartford and Swale (70.6 %, 70.4%) being the highest and Sevenoaks the lowest (55.3%) in 2020-21.

2.7.2 The proportion of people classified as obese has steadily increased from 23.1% in 2015/16 to 26.0% in 2020/21. Among the Kent districts, Ashford, Swale and Thanet, had the higher (>30%) adult obesity prevalence while Maidstone had the least (20.4%).

2.7.3 The whole system approach programme to healthy weight in Kent began in 2020 by engaging the stakeholders from across the 'system'. Programme roll out across each HCP was carried on different timescales. Stakeholders in each area were involved in system mapping, action mapping, and drafting of visions, planning, and delivering of actions to promote healthy weight among the Kent population.

2.7.4 Local engagement work across each of the areas revealed similar themes concerning socio economic determinants were considered major causes of

obesity while current prevention activities are more focused on individual life factors.

2.8 Mental Health

2.8.1 Self-harm in adults has increased (Emergency Hospital Admissions for self-harm per 100,000 patients) in Kent and is above the national average of 181 per 100,000. The rate in Thanet is 339 per 100,000, followed closely by Dover (294 per 100,000). Only Dartford and Gravesham are below the national average.

2.8.2 Thanet is the only district in Kent where the admissions due to alcohol are approaching the national average. Overall, in Kent the trend is down.

2.8.3 Recorded Quality Outcomes Framework (QOF) prevalence of depression has increased. The last needs assessment in 2019 reported a real increase in prevalence of depression, through National Psychiatric Morbidity Survey Data, by 7% from 2007 to 2014.

2.8.4 Modelled estimates of depression, anxiety and all common mental illness to people over 16 years old in Kent and Medway is 16% (9% for over 65s). Seven of the Kent districts have higher and increasing prevalence of common mental illness. The areas of highest prevalence are Dover, Folkstone and Hythe, Swale (17%) and Thanet at 18.2% is the highest in Kent.

2.8.5 Recent QOF data triangulates with this and shows an increase of 14.6% compared to 12.3% nationally. Kent has the 4th highest depression QOF prevalence in England and the highest incidence of depression of 1.7%.

2.8.6 QOF prevalence for all mental illness has increased, 0.84% or 16,227 people, but this is below the national average.

2.8.7 Thanet and Folkestone and Hythe continue to have the highest prevalence of severe mental illness (32 and 33 per 1000 working population) based on 2018 data on ESA claimant rates, compared to 27.3 nationally and 16.1 in Sevenoaks.

2.8.8 ONS data published in 2020 showed that the three-year rolling aggregate rate for suicide per 100,000 in Kent is 10.3 per 100,000 for the period 2017-19 compared to a national average of 10.1 per 100,000, but not statistically significantly different. District variation exists, with Canterbury and Thanet continue to have year on year rates above the national average. Male rates of suicide continue to be higher than female rates, which is similar the national and historic picture.

2.8.9 It has been noted nationally and locally that ethnicity data for understanding impact of ethnicity in suicide is poor. National research shows that Black men

are also at risk (alongside white men) of higher rates of suicide but again data is poor quality. Emerging national research also points to increasing risk of suicide for BAME women compared to white women (again local and national data is often not collected or poor. Therefore, it is a local recommendation to investigate this further.

3. Engagement And Insight

3.1 ‘Kent and Medway Listens’ is an engagement project set up over the last year by KCC, Medway Council and Kent & Medway Partnership NHS Trust to understand the pressures impacting mental wellbeing of the local population, particularly seldom heard communities.

3.2 Voluntary organisations across the 4 HCPs held listening events with approximately 1,400 individuals who were selected based on their background i.e., deprivation, ethnic and religious minorities, refugee status, coastal communities. An additional 3,300 individuals shared their thoughts through the ‘Kent and Medway Listens’ digital platform.

3.3 Fifty community-initiated projects were funded to immediately address the pressures impacting mental wellbeing that were being raised through the listening events for e.g., Befriending services, support through accredited courses for gainful employment and local community walking groups.

3.4 Key themes that emerged include:

- Wider determinants of health such as growing financial concerns, poor housing and the inability to access health services were impacting mental wellbeing.
- Local communities expressed distrust with the system borne out of lack of change, the frustration around siloed working and wider societal issues such as racism.
- VCS partner organisations expressed difficulty in providing much needed services due to the short-term funding opportunities from commissioners.

3.5 These themes indicate a need for a system wide approach to tackle health inequalities on an individual and population level. Collaborating with voluntary organisations highlighted the need for an integrated and sustainable approach to address the wider determinants of health.

3.6 Over 100 different suggestions for actions were generated by four HCP level workshops and were presented to system leaders at an event in July 2022. System leaders committed to driving progress on a range of issues through such projects as the ICB Health Inequalities Strategy and the Kent Public Health Strategy.

4. JSNA Development Process

4.1 Key Principles

4.1.1 A brief internal consultant led review was undertaken earlier this year on the development process. The following key principles were discussed that would help shape future development:

- Granularity – analytical outputs to be localised as far as possible at sub-Kent geographical level, linked to local priorities at a granular level and acknowledge relevant themes such as 'coastal excess'.
- Complementary - Minimise duplication against national Public Health intelligence resources such as Fingertips.
- Automation - Advanced use of information systems such as Microsoft Power BI where automated data processing can be designed to flag outliers or metrics with significant increases/decreases to identify key areas of concern.
- Customization - Ability to quickly generate custom profiles for an area
- Deep dive analytics - Ability to undertake service evaluation, exploratory regression analysis, depending linked dataset availability.
- Forward planning – Ability to undertake capacity planning / demand modelling as a regular feature in health needs assessments.
- Peer review - Undertake peer review publication of JSNA products where feasible and appropriate

4.2 Completed Health Needs Assessments

4.2.1 The following reports were completed by the Public Health team in the last 2 years, most of them available on the Kent Public Health Observatory (KPHO) website:

- 0-5 years Health Needs Assessment (2022 – to be published)
- Unaccompanied Asylum Seekers Needs Assessment (2022 – to be published)
- Kent Annual Public Health Report (2021)
- Rough Sleepers Needs Assessment (2021)
- Alcohol Needs Assessment for Kent (2021)
- Domestic Abuse Needs Assessment (2021)
- NCMP_analytical_reports (2021)
- NCMP_analytical_reports (2020)
- Kent Childhood Weight Health Needs Assessment (2020)
- Domestic Abuse Needs Assessment (2020)
- SEND Health Needs Assessment(2020)
- Maternal Weight Needs Assessment (2019)
- East Kent Needs Assessment (2019)

4.3 Other JSNA products

4.3.1 JSNA Infographics – the latest set of infographics have been published for this year and available on the website. Format and design may change in the future and move towards automated update processes and pull together various analytical outputs from Fingertips in an improved user-friendly version.

4.3.2 JSNA Health & Social Care Maps – Current maps are available both as an instant atlas and static PDF formats, using similar national data sources as like the ICP and PCN profiles mentioned above. A new format and design will be agreed later this year which will apply some of the key principles outlined above eg. use of Power BI platform for interactive dashboard reporting

4.3.3 JSNA population cohort model – this is a forward planning tool that was commissioned by the Kent Health & Wellbeing Board in 2017 to generate and quantify a more explicit understanding of the impact of prevention interventions on the Kent population. The tool uses specialist simulation modelling software known as systems dynamics, increasingly used methodology for health care system planning elsewhere in the NHS. The model has been used extensively in many needs assessments and reports, most notably, 5-year Long Term Plan submission by Kent & Medway ICS. More recently an adapted version was used regularly for local COVID response work and the whole systems obesity programme in Kent. The model is now undergoing refresh and updates and is likely to be used for scenario testing to contribute towards the Kent Public Health Strategy development.

4.3.4 Stakeholder Insight – this has been generally a qualitative exercise where proactive engagement work is carried out with the wider public around the views and attitudes of health and wellbeing. The Kent & Medway Listens project is the latest example of this. Broader engagement work will be commenced later in the year by the Public Health Communication teams in support of the Kent Public Health Strategy development. The final report once completed will be published on the KPHO website.

4.4 Other important activities relevant to the JSNA development process

4.4.1 Linked dataset development

4.4.1.1 Kent has had a long track record in linked dataset development, based on the success of the Kent Integrated Dataset. Over the last few years, a number of linked datasets have been developed out of different IT initiatives such as the Mede analytics commissioner tool and Kent & Medway Care Record but all have had varying levels of success and usefulness in their use for population health analytics.

4.4.1.2 Going forward, a new linked dataset is being developed by the NHS called the KERNEL which will feature in the new Data and Digital strategy currently being developed by the Kent & Medway ICB. KERNEL development has

already started, and a detailed business case is being worked to estimate the costs and resources for data integration between NHS and local government. Alongside this, a new model for data access has been set up by the county wide analytics oversight group known as the Shared Health & Care Analytics Board of which Public Health has core membership of.

4.4.1.3 Two other council led projects also involve linked dataset (district and county council) development for case finding and population segmentation, by consultancy partners Xantura and Policy in Practice. Early results of both pilots have been positive and further discussions have taken place to explore the feasibility integrating NHS data in these projects, particularly around information governance arrangements.

4.4.2 'Bridges to Health' Population Segmentation

4.4.2.1 This is the local rollout of an NHS England programme which involves a data driven approach using advanced population segmentation analyses for broader Population Health Management to improve population health and care outcomes. See Appendix 2 which lists the segments and detailed breakdown.

4.4.2.2 The Kent & Medway CCG / ICB has commissioned Outcome Based Healthcare, consultancy partner to NHS England, to utilise locally linked data to generate detailed population profiles that can be used for viewing system transformation programmes through a person-centred (and segment-specific) lens by baselining, tracking and monitoring changes following interventions or service redesign for specific cohorts. The approach in the long term can also help target specific cohorts/populations, with different needs, in different ways depending on the care they need, and improve coordination of care by focusing on different population segments/subsegments at local level. It can also help Improve resource utilisation efficiency, understand drivers of demand more accurately, and forecast and plan for changes in demand.

4.4.2.3 The project is due to start in August 2022 in West Kent and Medway & Swale HCPs, and will continue for a year, generating monthly data extracts for analysis and reporting. The work is closely being monitored by the Public Health team who intend to apply the results of the work to the JSNA Cohort Model development and well as other health needs assessment work.

4.4.3 Research Innovation and Improvement

4.4.3.1 Over the last 2 years, the National Institute for Health Research (NIHR) have been advocating the need to build up Public Health research expertise and capability, based in local government. A new research programme called Health Determinants Research Collaboration is actively inviting

4.4.3.2 A research study was undertaken in late 2020 by Centre for Health Science Studies (CHSS) based at University of Kent indicated significant interest amongst KCC senior officers and members to become more 'research active' and building a sustainable function. Over the last year, academics from local

and regional organisations have contacted the Public Health team to collaborate on variety of research activities.

4.4.3.3 Future research collaboration will pave the way strengthening local evidence base for prevention activities that we as a system commission and the JSNA development process will be the medium where we can showcase that strong local evidence base and provide rigour in our decision-making processes in planning, investing and commissioning prevention intervention activities.

5. Conclusion

5.1 Latest exceptions and population highlights show cross cutting themes affecting several HCP footprints such as falls prevention, obesity, mental health including suicide.

6. Recommendations

The Kent Health and Wellbeing Board is asked to **COMMENT** and **ENDORSE** the following recommendations:

- The new NHS ICB (Integrated Care Board) and HCPs need to adopt a broader consistent structure for outlining priorities for population health improvement, encompassing primary prevention, (behaviour change), secondary prevention (early diagnosis and treatment including health checks) for those at risk of LTCs (Long Term Conditions) e.g. Cancer and Mental Health; and tertiary prevention (recovery, rehabilitation and reablement of patient with complex needs), ensuring better quality of care.
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- Greater emphasis from the ICB board and KCC is required on smoking prevention as well as cessation, integrating directly into local care and acute care models. Better emphasis on workforce planning to enhance Making Every Contact Count (MECC) particularly on frontline services (e.g NHS Trusts) that have yet to implement as such, and increase referrals into existing One You and other relevant social prescribing services.
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