To:	Cabinet
On:	Monday 16 May 2011
By:	Graham Gibbens (Cabinet Member for Adult Social Care and Public Health) Meradin Peachey (Director of Public Health)
Subject:	Annual Public Health Report
Classification:	Unrestricted

1 Summary:

1.1 The Annual Public Health Report of the Director of Public Health 2009/10 focussed on two issues, Dementia and Excess Winter Deaths. This shows where significant changes need be made to improve health and the quality of health services. This report summarises the main points and recommendations.

2 Introduction:

2.1 The Annual Public Health is an opportunity for the Director of Public Health to report on the health of the Kent population. This is in addition to the vast amount of needs assessment that is already available on the Kent and Medway Public Health Observatory website. www.kmpho.nhs.uk

The Joint Strategic Needs Assessment (JSNA) for adults and children is the main way of reporting on the health trends of care groups, age groups, and localities of the Kent population. The Annual Public Health Report itself can be found at www.kmpho.nhs.uk/reports-and-strategies/annual-public-health-report/?locale=en

2.2 This is some of the progress since last year's annual report.

2.2.1 Child and Adolescent Mental Health Service (CAMHS)

There is a significant increase in investment from West Kent for the provision of services for 16-18 year olds, achieving the "your welcome" standard is in progress which means more young people are involved in service design. There has been a decrease in waiting times for services in East Kent (although not good enough yet) and there has been a change in emphasis of services so Looked After Children are prioritised. There is still more to go but the right people seem to be around the table.

£750 000 has been secured through NHS West Kent to address gaps identified through the CQC and Ofsted inspections of Children's Services at the end of 2010.

£500,000 of this will deliver a CAMHS service for young people up to their 18th birthday and address the gap identified in West Kent for services for 17 year olds.

There will be more support and treatment for 16 and 17-year-olds across West Kent, including a specific package of care for young people newly diagnosed with mental health problems. The transition from CAMHS to adult services will also be improved

£78,000 will provide support to young people with ADHD in Dartford, Gravesham and Swanley, where there are particular pressures on the CAMHS service due to high numbers of this group. This extends the provision which already is in place in other parts of Kent ensuring that children and young people benefit from clinics to offer advice and support, home visits in times of crisis and workshops for them and their families.

£170,000 will support CAMHS out of hour's provision in West Kent. More specialist nurses and medical staff will be employed as part of the investment. Specialist nurses will be available from 5.00 p.m.-midnight 365 days a year, to provide assessments for under-18s in the emergency departments, medical wards and paediatric wards at Darent Valley, Maidstone and Pembury hospitals.

Waiting Times

Historically waiting times for assessment for Tier 3 services have been a concern across Kent and in particular in East Kent. Significant work has taken place between commissioners and providers across Kent and we are beginning to see the impact of this.

In East Kent waiting times in Shepway and Canterbury were of particular concern. In September 2010 wait times were 60 weeks and 48 weeks. By April 2010 these had reduced considerably to 26 weeks and 15 weeks. Across the rest of East Kent wait times are under 18 weeks. Staff have been undertaking waiting list initiatives targeting those who have waited the longest and by running extra clinics on a Saturday to tackle the backlog. In West Kent in the same period 70% of wait times were under 18 weeks. Contract negotiations this financial year require that average waiting times for assessments will be under 18 weeks across east Kent by 6 months into contract.

There is clearly more work to do although this is moving in the right direction. In July 2011 commissioners will be seeking approval from NHS Boards and KCC to

decommission the current service provision and re-commission services in line with a model which is already in place in many parts of the country and evidence shows provide high quality services with much reduced waiting times. (South East colleagues report between 2 and 8 weeks).

Community CAMHS model.

In addition to the Annual Public Health Report National Support Team (NST) visited Kent in October 2010 and identified the need for whole system redesign. In particular the visit identified that the early intervention resource in Kent was much too dispersed and was not effectively reducing demand on specialist services. One result is children sitting on long waiting times for specialist services and conditions becoming significantly worse by the time they receive a service. Another is that specialist services hold on to children for too long, when those children could be seen by less expensive more appropriate, more responsive services if in place.

The NST set the challenge for Kent to develop a strategic 'whole system' model and provide a framework for much better integration of commissioning and planning of all services. There has been good progress made in the last 6 months. This includes significant consultation with children young people and families, professional workshops and provider service consultation, review of national models and services, unpicking of current contract values and the outcomes delivered and a focussed needs assessment for child and adolescent mental health identifying how current service doesn't match need. In July 2011, commissioners within the NHS and in KCC will be seeking approval to re-procure the redesigned model.

2.2.2 **Cancer**

Smoking is still the biggest avoidable cause of cancer. The new tobacco strategy for Kent focuses on specific action for young people and we have started to see a positive turn in the rise in young girls starting to smoke. There is a 2.6mill investment in our community services to help people quit smoking and this led to over 7,000 quitters last year.

2.3 This years topics were chosen as they either showed poor quality services or unexpected patterns of poor health that are avoidable.

This year's report details:

- The size of problem in terms of the numbers of the Kent population who are currently undiagnosed with Dementia and the implications for service provision for both the individuals and their families

- The immediacy of the problem in that we need to make changes in service delivery now to keep pace with the growth in the elderly population

- The need to make our services as integrated as possible in that only together will we succeed

- Excess winter deaths can be prevented if people at risk keep warm indoors and minimise their exposure to cold temperatures outdoors.

- The population at the greatest risk of dying in winter due to the cold weather are people over 75 years old with underlying heart and lung conditions.

- There is considerable variation across the districts in Kent regarding excess winter mortality.

- Some of the highest excess winter death ratios in Kent are in areas of relative affluence, thus in this specific instance the association between relative deprivation and a high excess winter death ratio is unclear.

- Recommendations include looking at establishing a GP winter warmth referral project and establishing a local partnership to address the issue in Canterbury.

- The progress we are making to date.

3 Dementia

3.1 Dementia has a devastating impact on those affected and their family carers, because of the human impact, the growing numbers and increasing costs, dementia presents a significant and urgent challenge for both health and social care.

3.2 Dementia is one of the main causes of disability in later life it has a huge impact on capacity for independent living. As a result of the predicted doubling of the number of people who have dementia in the next 30 years, it is thought that the cost of dementia in the UK will rise rapidly and significantly, possibly trebling within this period. Dementia costs the health and social care economy more than cancer, heart disease and stroke combined.

3.3 It has been estimated that in Kent 17,400 people (2006 figures) are living with dementia of which 400 have early onset (i.e. development of dementia before the age of 65). The total number of people with dementia is predicted to rise to over 30,000 by 2026. Modelling predicts that some areas will see more growth than other areas due to the differences in the demographics and the greatest increase in numbers will be the over 85 age group.

3.4 Two thirds of people with Dementia live in the community and the other third live in care homes.

Figure 1: Estimated number of patients* with Dementia in Kent (excl. Medway) Dementia UK prevalence estimates applied to Mid-2009 resident population estimates from ONS

	2006		2026		Difference	
	Est. number	Est. prev	Est. number	Est. prev	Number	Percentage
Kent	**17,400**	**1.3%**	**30,100**	**1.9%**	**12,600**	**0.6%**
Ashford	1,300	1.2%	2,500	1.6%	1,300	0.4%
Canterbury	2,100	1.4%	2,900	1.9%	900	0.5%
Dover	900	1.0%	1,700	1.3%	800	0.3%
Shepway	1,500	1.5%	2,600	2.5%	1,100	1.0%
Swale	1,400	1.1%	2,600	1.8%	1,200	0.8%
Thanet	2,100	1.6%	3,000	2.2%	900	0.5%
NHS Eastern & Coastal Kent	**9,200**	**1.3%**	**15,300**	**1.9%**	**6,100**	**0.5%**
Dartford	1,500	1.4%	2,500	2.1%	1,000	0.7%
Gravesham	1,100	1.1%	1,900	1.7%	900	0.6%
Maidstone	1,600	1.1%	3,100	1.8%	1,500	0.7%
Sevenoaks	1,500	1.3%	2,500	2.2%	1,100	0.9%
Tonbridge & Malling	1,200	1.1%	2,400	1.9%	1,200	0.8%
Tunbridge Wells	1,300	1.3%	2,300	2.1%	1,000	0.8%
NHS West Kent	**8,200**	**1.2%**	**14,800**	**2.0%**	**6,600**	**0.7%**

Figures may not sum due to rounding

3.5 The National Dementia Strategy (2010) sets out a vision for dementia services which highlighted the importance of the following areas:

- Improved awareness - encouraging individuals to ask for help and professionals to offer it
- Make early diagnosis and treatment the rule
- High quality care that enables people to *live well* with dementia at all stages of the illness and in whatever setting

3.6 With the work that has already been undertaken we know that local people want improved advice information and guidance, better support from GPs, more support at the early stages, more respite and short breaks and more support for their family and careers.

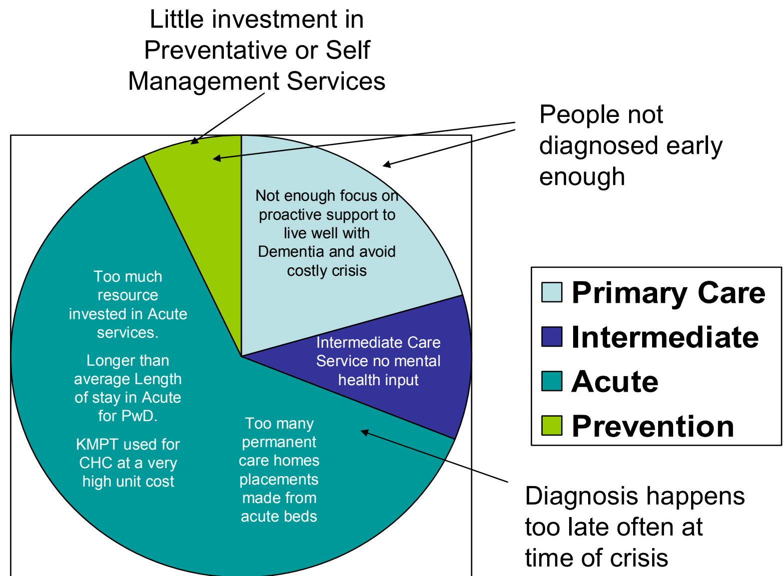
4 A case for change and the need for large scale service redesign

4.1 We have a rapidly increasing population living with Dementia with most of the growth in our very elderly populations. We need to redesigned services so that they provide early diagnosis and advice for patients.

4.2 We know that there is a lack of integration in our services which means people fall between services and default to expensive inappropriate acute hospital services. The majority of health funding is currently invested in secondary care services and is reactive not proactive.

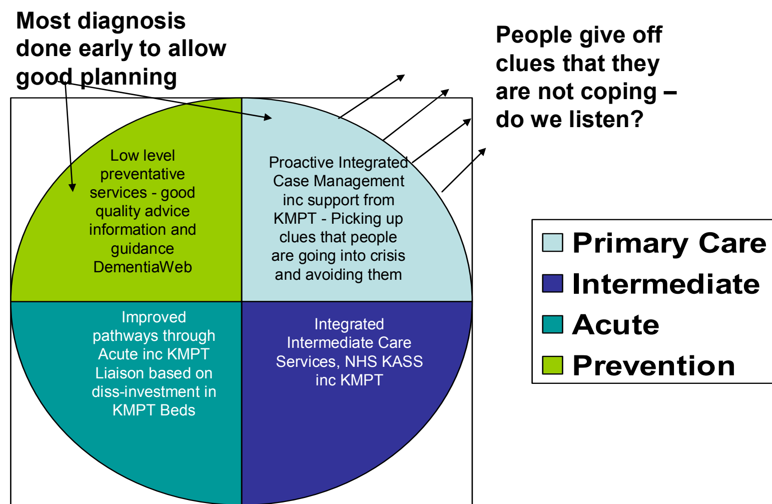
4.3 Figure 2 shows the current service model where we know there is not enough investment in preventative or self management services which leads to people being diagnosed too late and then require acute care and crisis intervention.

Figure 2: Current Service Model



4.4 Figure 3 represents an integrated model for health and social care which will deliver much better outcomes for our population.

Figure 3: Redesigned Service Model



4.5 The outcomes expected from the large scale change in service delivery should be:

- Increased carer and patient satisfaction
- Increase in self care supported by better access to information and support
- More people treated earlier in their own homes
- Personalised care planning and tailored personal care
- Proactive disease management avoiding unnecessary crisis situations and admissions
- Better clinical coding giving secondary diagnoses including Dementia
- Reduced number of admissions to and length of stay in acute hospitals

4.6 To deliver this change four main work streams are in the process of being set up:

- Primary Care, improved diagnosis, increased co-ordination of care and sign posting
- Acute Services, admission avoidance/crisis response, acute psychiatric liaison, intermediate care, Carer's support workers and enablement
- Care Home Services, In reach support, person centred care, housing options and assistive technology
- The Big Society, improve range and availability of community and voluntary sector services, implementing integrated contract management

5 Diagnosis gap

5.1 In the 2009 Public Health Annual Report (2010), reference was made to a diagnosis gap in that levels for the diagnosis of dementia varied significantly between individual GP practices, with some GPs having a much better diagnosis rate than others.

5.2 In order to address this issue the QIPP programme will radically overhaul the dementia pathway to ensure that services are more responsive and proactive and are based around primary care. A key objective of the Dementia service redesign is to increase diagnosis rates, identify people early and ensure that they get access into services to prevent crisis situations further down the line.

5.3 However, patient choice will always have its part to play in the numbers of people choosing to take up a formal diagnosis and work we have undertaken with patients has shown that many people do not want a diagnosis and even though those involved in their care and support believe the evidence points strongly towards dementia they refuse a diagnosis. Also many people develop symptoms but without any behavioural or care complications. Families and individuals see this as a natural part of ageing and never think that there could be a need for a diagnosis, therefore public and professional awareness has a huge part to play in increasing diagnosis rates.

5.4 This being said the best performing PCT in the country has only 52% diagnosis, Kent's performance must been seen in this context.

5.5 Through the redesign of services we will strive to ensure we meet the needs of people with dementia and their carers.

6 What we have already achieved

6.1 In addition to an additional £1mill spent on acute and community services we have had some success in jointly commissioning some services between the NHS and Local Authorities, eg

- Kent & Medway website and helpline
    - Funded by KCC, Medway Council and three PCTs
    - 24*7 with 3,000+ visitors to the website/month

6.2 The following are a range of other services which have been established over recent years, but are not currently Kent and Medway wide.

- West Kent Dementia Crisis Service
- East Kent Psychiatric Liaison Service
- East Kent Home Treatment Service

- Broad Meadow Centre of Excellence opening June 2011 with a further three PFIs coming further up stream
- New model for day care services: Private sector and voluntary sector services in-reaching (KCC and Alzheimer's Society)
- Independent Dementia Advocacy

7 In summary

7.1 By redesigning our service model we will be able to ensure care is proactive and integrated in order to identify people earlier, encourage diagnosis and provide the personalised support necessary to prevent people reaching crisis point. There will be a greater emphasis on the provision of community services and a greater role for primary care. Only by doing this will we break our reliance on expensive and inappropriate acute inpatient care and long term care home provision.

7.2 The mechanism for achieving this will be via the recently established Kent and Medway health and social care QIPP Board for dementia. This will help to ensure equitable service delivery with agreed outcomes. A commissioning plan is being established, an investment plan through the health and social care funding agreed and service specifications will be drawn up to make the shift from secondary to primary , community and integrated services.

8 Excess winter deaths

8.1 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. The excess winter deaths ratio shows the percentage of deaths above the mortality rate if it was stable throughout the year.

8.2 There were an estimated 36,700 excess winter deaths in England and Wales in 2008/09. This was an increase of 49 per cent compared with figures for 2007/08 and was the highest number in a year since 1999/2000.

8.3 It is estimated that half of the excess winter deaths are from cardiovascular and circulatory diseases and a third from respiratory disease. In non-epidemic years, influenza was found to account for a tenth of deaths and hypothermia for less than 500 deaths (just over 1%).

8.4 Environmental exposure to excess cold can have a number of health impacts including an increase in blood pressure and clotting which can increase the risk of a heart attack and stroke and exacerbate existing cardio-vascular conditions. Cold temperatures can also impair lung function and can trigger broncho-constriction in asthma and COPD. It can also impair the body's resistance to respiratory infections.

8.5 The key public health issue is that a considerable proportion of excess winter deaths are preventable. Excess winter deaths can be minimised if people are able to keep warm indoors (a combination of adequate heating, insulation and ventilation; keep warm outdoors (sufficient warm clothing and physical activity, such as walking) and ensure uptake of other preventive measures such as flu and pneumococcal vaccination where appropriate.

8.6 The table below shows the variation between the different districts in Kent. Data at local authority level shows that Canterbury has the highest excess winter death ratio, followed by Maidstone, with Dover having the lowest ratio. Most of the local authority districts have ratios that are relatively close to the Kent average.

Table 1: Excess winter deaths ratios for local authority areas in Kent and comparison to national average, August 2006 – July 2008

Area	Excess Winter Death Ratio
Ashford	13.3
Canterbury	25.3
Dartford	9.3
Dover	7.0
Gravesham	16.5
Maidstone	13.1
Sevenoaks	11.3
Shepway	15.1
Swale	15.4
Thanet	12.3
Tonbridge & Malling	13.1
Tunbridge Wells	14.8
Kent	14.2
England	15.6

Table 2: Wards in Kent with relatively high excess winter mortality for the period 2002 – 2010

Ward	Excess Winter Mortality Ratio	Number of deaths
North Willesborough	38.2	558
Beaver	37.1	423
Canterbury		

Chestfield and Swalecliffe	39.2	853
Heron	31.2	1,270
North Nailbourne	27.5	447
Greenhill and Eddington	26.9	425
West Bay	26.5	653
Harbour	25.2	465
Lydden and Temple Ewell	25.9	440
Staplehurst	45.2	454
Fant	40.8	564
Bridge	32.9	749
East	29.9	579
Allington	27.0	515
Shepway South	25.2	639
New Romney Coast	29.5	626
Folkestone Harvey Central	27.8	777
Eastcliff	31.1	735
Bradstowe	29.1	436
Southborough North	26.8	415
Speldhurst and Bidborough	25.2	613

8.7 Wards were identified as having a relatively high excess winter mortality ratio between 2002 and 2010 if there were at least 400 deaths and there was a ratio of at least 25.0.

9 What is being done to address the issue?

9.1 A pilot GP practice winter warmth referral scheme will start in the summer of 2011. This is an ideal time because if home improvements are needed, they can be made without impacting in the indoor temperature. The pilot will take place at two practices (Whitstable Medical Practice and St Peters Surgery Broadstairs). The aim of the scheme is for practitioners to identify people during routine appointments, who have the highest risk of morbidity and mortality due to cold temperatures and refer them for further support to Creative Environmental Networks (CEN). CEN is a social enterprise that has particular expertise in stimulating carbon reduction, alleviating fuel poverty and facilitating environmental improvement. A CRB checked representative from CEN will undertake a home visit and offer a range of potential interventions to referred patients. These include:

- Inspection of the home including the loft, walls and individual rooms
- Demonstration of heating controls and how to use them most efficiently without compromising thermal comfort
- Reading meters and providing readings
- Verbal advice on heating, lighting, insulation, combating draughts and condensation, winter fuel payment, changing fuel supplier, tariff and

payment options, understanding their utility bills and fuel debt advice as appropriate

- Grant and discount scheme referrals
- Fact sheets and leaflets
- Referral to a benefits health check service where appropriate
- Other services (HIA, handy person, security measures, Priority Service Register, fire safety checks and smoke alarms) as appropriate.

9.2 It is vital to ensure that the pilot is monitored and evaluated effectively to ascertain the merit of extending it to other areas. Colin Thompson, Public Health Specialist is managing this project.

9.3 A steering group has also been set up in the Canterbury district to look at how different agencies can work together to address the local issues that may influence excess winter deaths. Attendees include representatives from housing at Canterbury City Council, NHS Eastern and Coastal Kent, Kent County Council (Families and Social Care), Canterbury Agewise, Age UK and local voluntary sector organisations. The aim of the group is to develop long-term effective partnerships at a local level that have a shared understanding of the seasonal excess deaths agenda, can raise awareness of the issue within the local community, develop a local action plan incorporating the published interventions recommended by the former National Support Team for Health Inequalities and explore how vaccine take-up in susceptible groups can be increased. This steering group which is also chaired by Colin Thompson, Public Health Specialist, will report to and be monitored by the Canterbury Health and Wellbeing group.

9.4 It is important to review data each year relating to excess winter deaths at a local level to assess if changes to practice are necessary. This analysis will be undertaken by the Kent and Medway Public Health Observatory. The data should be available in August 2011. Results of the review will then be considered by the Kent Joint Policy and Planning Board (Housing) and other health improvement fora.

9.5 The Kent Health and Affordable Warmth group is currently developing a strategy of which excess winter deaths will be a key component and note will be taken of the findings highlighted in the annual report. The strategy should be published later in 2011.

10 Conclusion/Recommendations:

Cabinet Members are asked to note the report and the actions that need to be taken.

Meradin Peachey
Director of Public Health