

# **Joint Strategic Needs Assessment**

## **Executive Summary 2011**

**Version 5a**

## Background

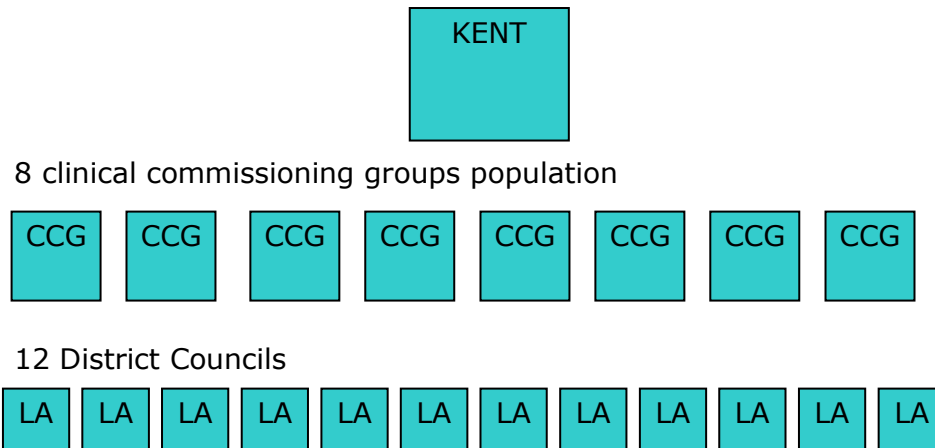
1. JSNA is an ongoing process a range of data, information and analysis about the health and wellbeing of Kent is collated, assessed and compared in order to present an understanding of the all the issues impacting on the population of Kent. Through this process we can gain a high level understanding of the inequalities and needs that exist within.
2. The JSNA is not a strategy and does not in itself offer any answers to the issues it presents. It provides some key priorities and makes recommendations on how action to address these should be taken forward.
3. It has the following purpose
  - To coordinate strategic direction, effort and resource commitment of the range of public, private and voluntary/community sector organisations that work to the common goals of improving health and well being for the population of Kent.
  - To ensure that resources are focused on achieving maximum impact on improving the health and wellbeing of the people of Kent specifically targeting those who are in greatest need.
  - To maintain a focus on health improvement and prevention and ensuring efficient use of available resources.
  - To provide evidence of cost effectiveness and value for money

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

### **Kent Approach**

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

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



## 1.2 Phase 1 – Reviewing where we are.

Kent has traditionally produced two JSNA documents, one for Adults and one for Children. The Adults JSNA was refreshed in July 2011 and the Children’s update will be published in December 2011. These provide high level recommendations for improving the Health and Wellbeing of Kent.

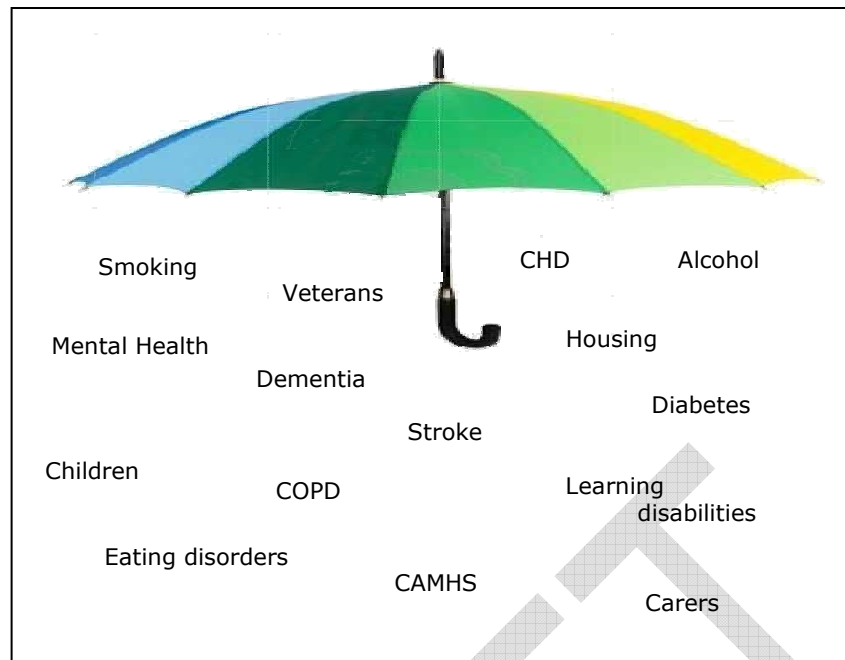
The JSNA can be seen as an umbrella under which other health needs assessment are produced to answer gaps in knowledge and understanding.

The approach during 2011 has been different to previous years. Within Kent Health Needs Analysis are undertaken for specific conditions or for specific population groups. These contain a wealth of information and recommendations for action to reduce inequity in provision of services and to reduce inequalities within the Kent population.

In excess of 40 needs assessments have been undertaken across Kent, exploring in-depth the health needs of the population of Kent, gaps in service provision and levels of un-met need. For each of these needs assessments an executive summary has been produced detailing the key issues in a structured format. These are available from the Kent and Medway Public Health Observatory Website [www.kmpho.nhs.uk/jsna](http://www.kmpho.nhs.uk/jsna), these summaries along with key population indicators presented in the Health and Social Care Maps and locally developed Clinical Commissioning Group profiles provide the basis for the Kent JSNA.

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

Figure X: **The JSNA is an Umbrella of Needs Assessments**



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

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

### 1.3 Phase 2

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

## Biggest issues for Kent

Through consolidating and reviewing the needs assessment and assessing the indicators there are a number of key themes that are relevant to Kent.

1. The aging population

It is well understood that the population of Kent in the older age groups 64+ and 85+ are predicted to increase over the next 5 and 10 years. The biggest challenges include a larger proportion of the population living with long term conditions, increase levels of dementia and the pressure on health and social care services this increase need will bring.

2. Sustainability

3. Prevention

Reducing modifiable risk factors – smoking, levels of obesity, alcohol consumption, increasing level of physical activity

4. Economic climate

Access to good quality employment,  
more people are likely to become unemployed over the next two years  
impact of unemployment on mental health

Recovery

Impact on 18-24s out of work on future health outcomes

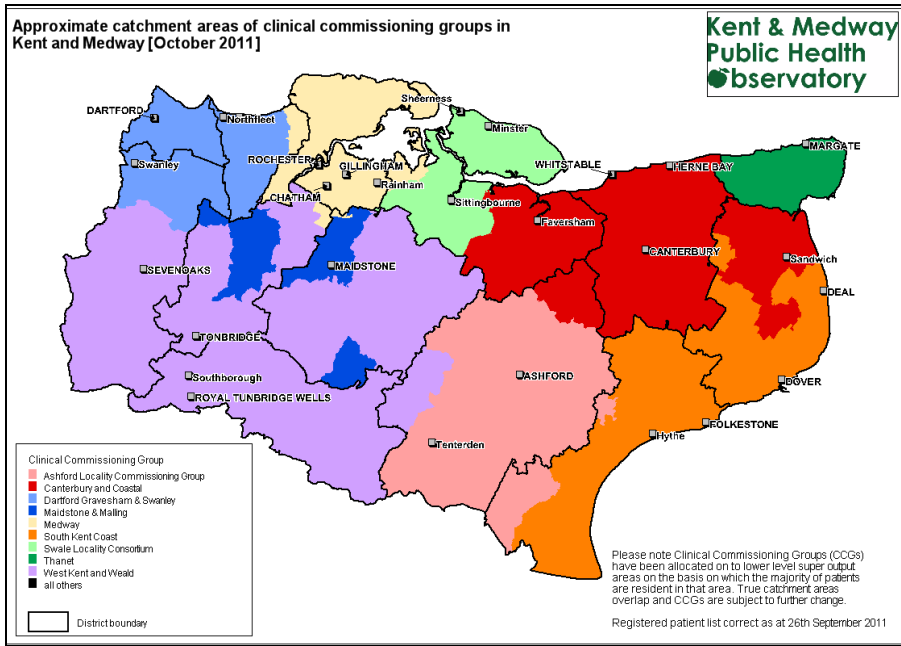
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## 1.4 Kent

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

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

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

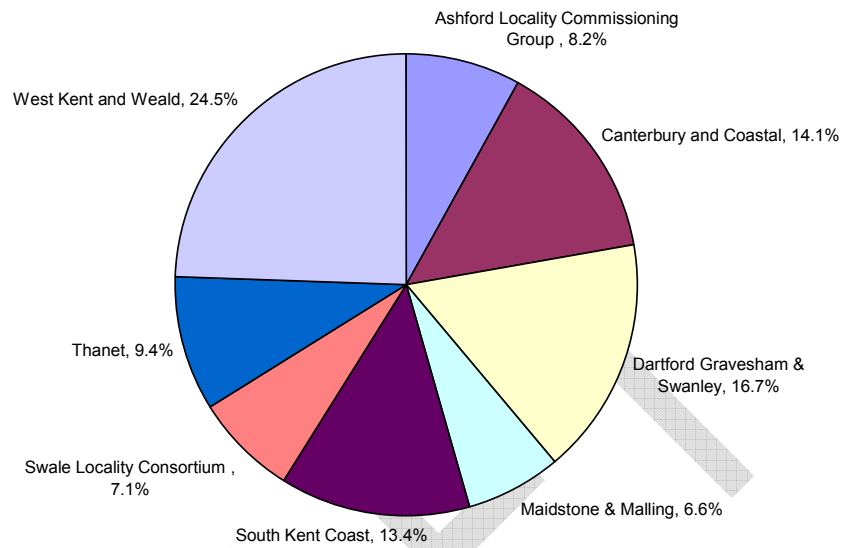


West Kent and Weald is the largest of all the Kent CCGs responsible for a quarter of the total Kent registered practice population. The smallest is Maidstone and Malling consisting of 11 general practices responsible for 6.6% of the Kent registered practice population.

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

Percentage of Kent registered practice population within each CCG as at September 2011



The population is projected to increase by XX% over the next five years and by XX% in 2021. The biggest increase will be in the population aged 65 or older

Insert populations projection chart

### Coastal Towns

Seaside resorts are uniquely exposed to many interactive forces including:

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

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

Key coastal issue	Relevance to public health and regeneration
Alcohol	Recent gains made by the NHS through clinical improvements in interventions for cancers and heart disease have been almost cancelled out by the continuing steep rise in alcohol related morbidity

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

### Health inequalities indicators

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

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

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

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*

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## 2 Executive Summary

### 2.1 Important demographic issues

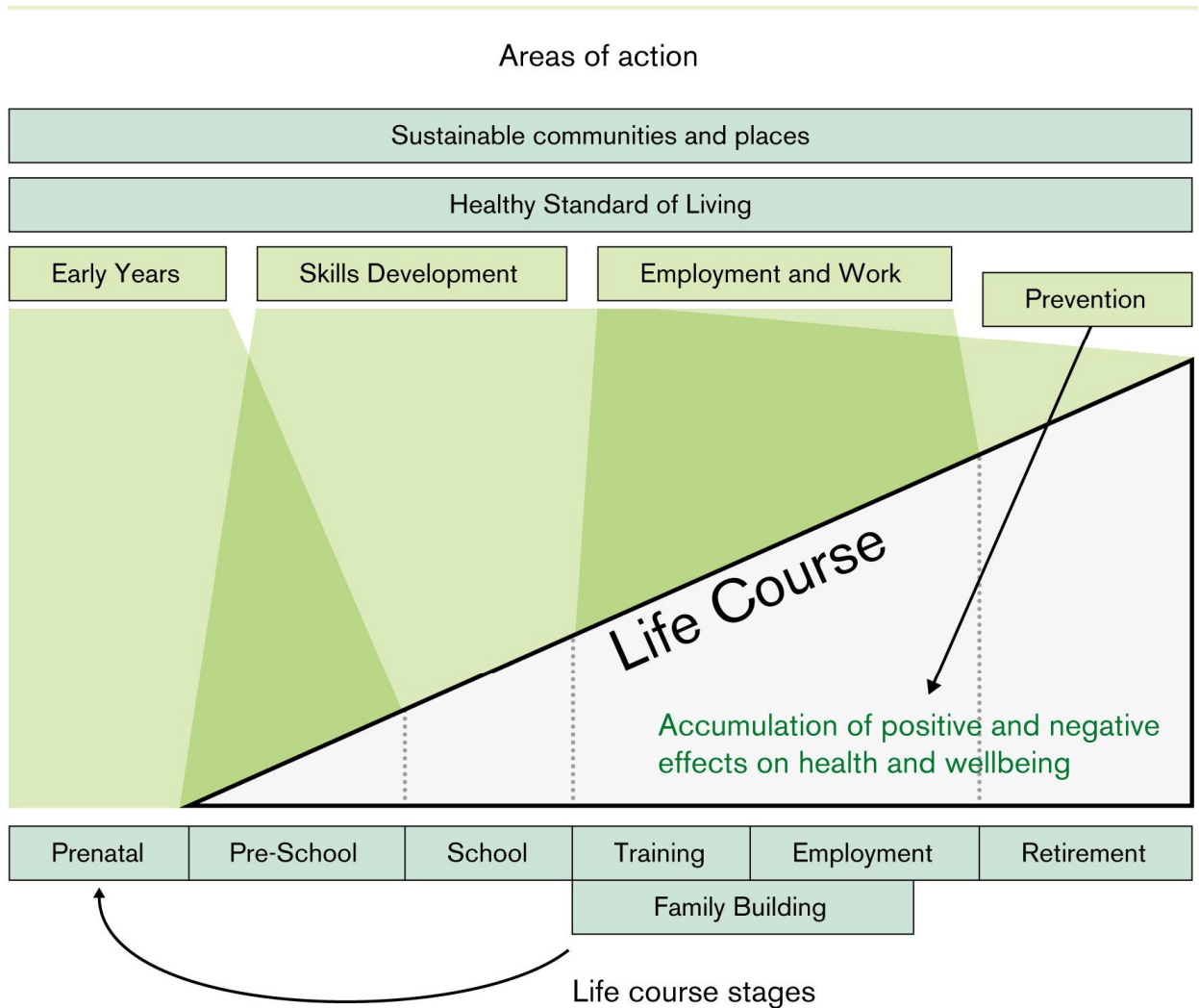
- The biggest population growth will be in the 65+ age group which is predicted to increase by 9.7% between 2012 and 2016 in Kent. There is significant variation across the districts ranging from a predicted population growth in the 65+ age group of 7.4% in Gravesham to 11.8% in Swale. However, there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

### 2.2 Health Inequalities

The Strategic Review of health Inequalities in England post 2010 ([Marmot - Fairer Lives Healthy Society](#)) starts with the wider determinants of health, stating that health is an interaction of what we are born with (our genetics), our lifestyle choices, the social and physical environments in which we live and health care services.

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

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



- Poverty exists all over Kent and Medway and is not confined to specific areas. Nevertheless there are major concentrations of deprivation in the boroughs of Dartford and Gravesham and throughout the coastal east of the county, interspersed with some localised areas of high affluence. The more consistently affluent parts of the county are to be found in Maidstone and the south west quarter of Kent.
- There has been an improvement in life expectancy for the intermediate quintiles of deprivation from 2000 – 2007. However for the most deprived, a pattern of divergence (a widening health gap) has continued throughout this period.

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

### Recommendation

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

## 2.3 Lifestyles

### 2.3.1 Smoking

- In Kent, approximately 10,000 admissions each year are attributed to smoking £10 million and £12 million in West and East Kent respectively. A further £860,000 and £1.3 million are also attributed to annual outpatient costs.
- The national prevalence of smoking among adults dropped from 24% in 2005 to 21% in 2008. Smoking prevalence in Kent was higher than the national figure at 24.9% (or 281,300 in 2009), varying from 16% in Sevenoaks and 26.3% in Dartford. However this is expected to reduce in future in line with the downward trend nationally.
- However, the above are based on national synthetic estimates, so there is a need for more local data either through surveys or through an augmentation of the Annual Health Survey for England.
- The Stop Smoking service currently treats 2.2% of the local smoking population. This needs to increase to 5% or 14,000 smokers.

#### Recommendation

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

### 2.3.2 Physical Activity, Diet and Obesity

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

#### Recommendation

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

In this regard, Kent is developing the service model offering four tiers of service which range from a population approach to maintaining and achieving a Health Weight to surgical procedures to achieve dramatic weight loss for those patients with higher BMI's.

Consider the behavioural model on the healthy weight pathway.

### **2.3.4 Alcohol & Substance misuse**

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

### **Recommendation**

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

### **Alcohol Treatment commissioners**

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

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

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

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

### **NHS Acute, Primary, Community Care and Mental Health commissioners**

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

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

Use AUDIT-C within the NHS Health checks programme.

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

Industrialise routine delivery of IBA in Accident and Emergency and acute services generally for patients experiencing falls/accident/assault/head injury:

gastro-intestinal, cardiac, mental and behavioural problems: collapse or feeling unwell. Use referral tools and pathways already agreed by commissioners and providers.

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

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

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

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

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

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

### **Public Health Commissioners**

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

Through co-commissioning and local partnerships, explore opportunistic delivery by non-specialist police and probation service staff including PCSOs;

and routine use of IBA with arrestees in custody suites (Alcohol Arrest Referral).

Raise awareness through campaigns in the press, radio and through partner newsletters including workforce initiatives about the risks of drinking at increasing and higher risk levels and binge drinking. Give consideration to wider distribution of culturally appropriate resources for new communities.

### **2.3.5 Dental Health**

#### **Adults**

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

#### **Children**

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

#### Recommendation

##### *Adults*

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

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

##### *Children*

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

## 2.4 Children

### 2.4.1 Early Years

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

#### Recommendation

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

### 2.4.2 Breastfeeding

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

#### Recommendation

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

- Support to mothers breast feeding should be commissioned according to the stated evidence base and the number of mothers breast feeding needs to be substantially increased in all parts of Kent.

### **2.4.3 Immunisation and Vaccination**

- There are a number of vaccination programmes these include childhood immunisations, influenza, HPV and Hep B
- The percentage of children being immunised in accordance with the national vaccination and immunisation schedule by the age of one, is broadly lower than the national and SHA figure in East Kent. In the west of the county uptake is generally better.
- To improve the east Kent performance a National Support Team (NST) has reviewed local practice and made 29 detailed recommendations as part of a strategy to improve vaccination and immunisation, which inevitably focuses upon children and young people.
- By the second birthday, the overall percentage of children immunised in Kent is better than the England average and the SHA.
- The MMR rate in east Kent whilst improving is not at the 95% level recorded by the WHO as being necessary to prevent an outbreak requiring further public campaigns to bolster the uptake rates.
- HPV vaccination uptake has recorded varying levels (for each of the three scheduled doses) across Kent and Medway in comparison regionally and nationally.
- A project in conjunction with colleagues from the Somme is being developed to assess the differences in uptake of the HPV vaccine, to share best practice and to ensure that uptake of all three doses of the vaccine is maintained.

#### Recommendation

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

Increase the uptake of HPV vaccination for all three doses, through the 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

### **2.4.4 Children's Centres**

- The results from the later evaluations of the National Sure Start Programme (NESS) have shown that this programme produces positive results. However the programme needs to be sustained for a number of years more to demonstrate robust results which are statistically reliable.
- Children's centres need to bring the benefits of joined-up play groups, healthcare and parenting support to the local population that they serve. They should be a hub for the local communities that they serve.
- Universal services (health, social care and third sector provided) need to be maintained in children's centres. The services provided by children's centres should be evidence based, practitioners should be highly skilled and there should be a continued commitment to support families' economic wellbeing and financial independence.
- Health visitors should work from children's centres, thereby focusing on early intervention, prevention and health promotion in a setting where they can have the greatest impact. In this regard health visitor practise should reflect a detailed knowledge of the communities in which they work and with other professionals and agencies both statutory and voluntary. Health visitors should use the capacity of children's centres to deliver intensive programmes for the most vulnerable children and families.
- There is a national programme to increase substantially the number of practising health visitors and a Kent and Medway working party will co-ordinate the development of this programme to ensure that full quotas of newly recruited and trained health visitors meet required targets by 2015.

### Recommendation

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

#### **2.4.5 Parenting**

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

- However there are concerns have arisen relating to the extent of local boards running these services, their provision of child care services and most importantly, the long term funding.

### Recommendation

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

#### **2.4.6 Childhood obesity**

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

### Recommendation

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

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

- A focus in early years and school settings that fosters a healthy environment, including the provision of active help for children at risk of becoming overweight;
- Support treatment programmes to assist changes in child and family behaviour towards maintaining a healthy weight;
- The appraisal of the potential of social marketing techniques to communicate simple and positive messages about healthy lifestyles;
- The provision of appropriate workforce training and the development of a targeted evidence of what works specifically as regards children and young people;
- The systematic collection of local data;
- An action-learning approach to treatment interventions.

#### **2.4.7 Avoidable injury**

- Road accidents involving children are more scattered than those involving adults with an obvious relationship to the roads near home.

- While the numbers of road casualties have decreased across all District Authorities over the last 15 years, Thanet and Maidstone still appear to have relatively higher number of casualties than the rest.

#### Recommendation

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

#### **2.4.8 Children in care**

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

#### Recommendation

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

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

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

#### **2.4.9 Domestic Abuse**

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

#### Recommendation

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

Increase training and raise awareness among professionals in spotting signs of domestic violence

Ensure that there are sufficient referral centres for victims of domestic violence to receive help.

Undertake robust evaluation of perpetrator programmes run in Kent and Medway to establish effectiveness in reducing violent assaults over a number of years

### **Child and Adolescent Mental Health (CAMHS)**

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

### **Recommendation**

- Focusing work on vulnerable groups : particularly CAMHS Tier 2 and Tier 3 support for young offenders and Children looked after
- Children with mothers with mental health problems and children with alcohol dependant children is a high impact area that needs addressing. This would be achieved through working more closely with adult services to identify, risk assess and intervene in family support and provide good Tier 2 type support for those children at risk.
- Improve equity : e.g BME engagement
- Emotional well being services and support need to be targeted to areas of key deprivation (Thanet / Shepway/ Swale/ Gravesham)
- Better Data quality and on going needs assessment using real time data to test for equity and outcomes

#### **2.4.10 Teenage Pregnancy**

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

#### **Recommendation**

Unlike some other counties, Kent has retained a Teenage Pregnancy Co-ordinator and a County-wide framework of district-based Teenage Pregnancy Groups. This framework must continue to be sustained as must the

programme of planned reductions in rates. Teenage pregnancy whilst complex, is significantly a product of lack of aspiration. The risks to the programme of planned reduction through the lack of prospects for many young people at present places the success of this programme at particular risk.

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

## **2.5 Adults**

### **2.5.1 Long term conditions**

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

### Recommendation

#### *Diabetes*

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

specialist diabetes services. This should be a priority for CCGs as early prevention will enable savings on treatment which can be invested elsewhere.

### *Cardiovascular disease*

The continued implementation of health checks ensure risk factors for cardiovascular disease are identified at an earlier stage to delay onset of long term conditions.

### Review of cardiac rehabilitation services

Primary event ranging from acute heart failure to primary PCI

Assess the gap in service provision for cardiac rehabilitation services

Review of defibrillation

## **2.5.2 Screening**

- Screening aims to reduce illness and deaths from certain preventable diseases. NHS national screening programmes exist for:
  - Antenatal and Newborn Screening (infectious diseases, sickle cell and Thalassaemia. fetal anomaly (includes Down's), Newborn (bloodspot, hearing and Infant physical examination)
  - Diabetic Retinopathy
  - Abdominal Aortic Aneurysm
  - Cancer (cervical, breast and bowel)
- The level of uptake in Kent and Medway for all screening programmes is good.
- There has been more than a 50% uptake in Bowel Cancer screening in 2010 with plans to extend the screening age up to 75 years.
- The diabetic retinopathy screening programme is meeting key national standards however further work is needed to improve the accuracy of the database used for invitations and also to improve attendance for screening
- The abdominal aortic aneurysm screening programme started in 2011 and is running successfully.
- In March 2012, the cervical screening programme will incorporate testing of cervical screening implies samples for the virus that caused almost all cervical cancer, Human Papilloma Virus (HPV). This will improve further the accuracy and efficiency of the screening programme.

### Recommendation

#### *Reorganisation and safety*

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

### **2.5.3 Dementia**

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

#### Recommendation

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

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

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

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

### **2.5.4 Falls and Fractures**

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

community based therapeutic exercises and falls call out response services.

### **Recommendation**

The results of the National Falls and Bone Health Audit 2010 give the local picture on how well we are achieving the required standards

In the light of recent admission and ambulance activity trends explained earlier, it has been suggested to reconfigure falls and bone health services in West Kent by:

**Commissioning acute care fracture liaison service\*** based at Acute Care trusts (as recommended in Objective 2 of the DH paper (2009) above).

**Commissioning primary care-based fracture liaison service\*** - mainly concerns pro-active case finding through GP databases for patients at high risk of osteoporosis and falls (as recommended in Objective 2 of the DH paper (2009) above) as well as providing adequate capacity for onward referral for DXA scanning.

**Reconfiguring community-based falls clinics** to be jointly carried out by ortho geriatricians and community health teams, possibly as rapid access clinics (in line with having a Falls Service as per Objective 3 of the DH paper (2009)). In the north of west Kent, discussions have been initiated by the GPCC with the DVH and local intermediate care and rapid response teams for an integrated rapid access clinic which will be geriatrician led, carrying out holistic assessment of patients, focusing on falls assessment. ECK have also outlined this as one of their commissioning intentions as well.

**Commissioning local authority-based postural stability community therapeutic exercise programmes** across west Kent clinics (in line with Objective 3 of the DH paper (2009)). A six month pilot funded by the SHA to refocus and build on the existing programmes to encourage formal referrals from GPs and other health professionals rather self referrals. The pilot is to be carried out both in Dartford Gravesham and Swanley and west Kent and Weald (Salveo)

**Commissioning community/local authority-based falls call-out service(s)**, possibly in the form of community call-out vehicle/community mobile warden/community alarm/community volunteer service as diversion from South East Coast Ambulance Service (SECAMB) (taking non-conveyed by ambulance patients to other services as suggested in Objective 4 of the DH paper (2009)). A number of pilots are currently operating elsewhere in the country. Most notably the integrated service between East of England Ambulance and Hertfordshire Council Adult Social Services.

### 2.5.5 Mental Health

- The data that is currently available, together with national models of need suggest that people in Kent have a little less degree of mental health 'need' compared to the England average. However Kent is a large County with significant local variation and the mental health needs vary according to socio economic status, variations in local well-being resources and access to timely services making equity audit essential.
- People with poor mental health also experience poor physical health and reduced life expectancy. There is a need to improve physical healthcare provision for those individuals with chronic mental illness, offering health checks to people with mental health problems is important.
- Equity Audits in the provision and access to community mental health teams and psychological therapies is a priority in Kent.
- Promoting positive mental wellbeing will require a partnership approach that cuts across a number of agendas, to effectively tackle the factors that can impact on an individual's mental wellbeing e.g improving community cohesion and 'social capital'.
- There are currently gaps in service provision to need in dual diagnosis (alcohol and mental health), transition services between child and adult mental health services, services tackling maternal depression and maternal mental illness, older people's mental health (excluding dementia) and eating disorders, personality disorders, offenders in the community and veterans. Many of these issues are being tackled in the current commissioning intentions for 2011 and 2012.
- The mental health needs of Black and minority ethnic communities and high-risk groups, such as offenders and asylum seekers/refugees need to be better understood to ensure appropriate service provision in Kent.
- Further needs analysis, assessment and targeting of older people (excluding dementia) are needed.
- Of Kent's population of adults with severe and enduring mental health problems, only 8% are in employment, improving the employment prospects of people with mental health problems is important.

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

- There is a comprehensive strategy and commitment to tackle Mental Well Being in partnership between the Council, Voluntary Sector and NHS. This is called "Live it Well" <http://www.liveitwell.org.uk/>
- There is an accessible website of information which is being updated regularly to provide help and information to the public. There is a plan to provide information in other accessible formats too in 2012.
- There is an East Kent and West Kent Mental Well Being Strategy. These are plans and commitments of many agencies working together to raise the awareness of mental well being. In 2012 these will be united and updated.
- The NHS and the Council will work together with the voluntary sector to publicise campaigns to reduce stigma and improve awareness of well being.

- The Kent Public Health team are working with NHS and Council commissioners to provide better analysis and information to improve equity of service use e.g liaison psychiatry, community mental health and primary care mental health services.
- The Kent Public health team with its partners are implanting a series of well being initiatives such as Change 4 Life, Health Trainers, Healthy Living Pharmacies, Active Mobs and Well Being Impact Assessment – all of which have an impact on well being.
- There is a systematic approach led by Kent council and Kent Police - to improving awareness and service access for people suffering domestic violence.
- There is a comprehensive commissioning plan set out in the ‘Live it Well’ commitments and is described below.
- There are community development workers working alongside a voluntary organisation in Kent and Medway to improve equity and access for people in vulnerable and minority groups.
- There is a focus on the mental health of ex military service people (Veterans) and an initiative to improve mental health services for them is underway.

#### Recommendation

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

#### Older People’s Mental Health

- Work with all Commissioners to redesign the OPMHN/Dementia Care Pathways, ensuring services are more community/primary care focussed, integrated with community health services and collaborating to support the private and voluntary sectors
- Review the role of day treatment services in east Kent
- Decrease acute in-patient mental health capacity by 15 beds in east Kent

- Review all KMPT OPMHN inpatient units, including continuing healthcare, to assure best value for money; and undertake benchmarking market development exercise with independent sector
- Explore and develop models of integration in acute (non mental health) care or primary care; for case management, and joint working between intermediate care, acute and community services – resulting in fewer general hospital admissions for people with dementia.

#### Learning Disabled Mental Health

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

#### **2.5.6 Learning Disabilities**

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

#### Recommendation

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

#### **2.5.7 Sexually Transmitted Infections**

- The England average rate is approximately 775 diagnoses per 100,000

population whereas NHS Eastern and Coastal Kent and NHS West Kent are much lower at 573 and 519 per 100,000 respectively. Genital Warts, Chlamydia and non specific genital infections make up the majority proportion of STIs diagnosed.

- For Chlamydia, the female age group 16-19 years appears to be at the highest risk across Kent among the other age groups, in line with national trends.
- A community sexual health model for Kent will be implemented from April 2013.
- Late diagnosis of HIV appears to be a problem particularly for West Kent with 55%, compared to approximately 20% in East Kent.
- A research project looking into reasons for late diagnosis of HIV is being developed in conjunction with the Health and Europe Centre.
- Projections estimate a 23% and 28% increase in first attendances for GUM clinics for East and West Kent respectively.

### Recommendation

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

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

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)

### **2.5.8 Offender Health**

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

### Recommendation

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

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

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

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

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

### **2.5.9 Excess Winter Deaths**

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

#### Recommendation

- Consider the results of the pilot evaluation when complete to assess if the scheme is feasible to roll out to other areas.
- Commissioners should support local initiatives within local districts such as community wardens giving out portable thermometers to people over 65 in specific geographical areas
- Identify way in how agencies can work together to identify those at greatest risk of morbidity and mortality due to cold weather.
- Work with voluntary and community sector to explore how they can deliver interventions to those at risk.

## **2.6 Other important QIPP work streams**

### **2.6.1 Urgent care**

National evidence shows almost a 12% rise in unscheduled care activity from 2004 to 2009 attributed to a number of factors such as population age distribution changes (towards more elderly), central policy initiatives like 4 hour A&E waiting targets and advances in clinical practice leading lower threshold for decision to admit. In Kent, due to a variation in quality and practice of submission of non elective data across different local provider trust organisations, non elective activity cannot be accurately described. However,

there is clear evidence indicating conversion rates from attendance to admissions are increasing steadily with age. Non-elective admission rates for ACS conditions such as COPD are also consistently higher in East Kent than West Kent.

### **2.6.2 End of Life Care**

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

### **2.6.3 Maternity and Babies**

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

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

### **2.6.4 Planned Care**

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

## **2.7 Social factors**

### **2.7.1 Housing and homelessness**

- The estimated shortfall in affordable housing far exceeds what will be delivered through new supply. Collectively, the housing need assessments that have been undertaken across the County would suggest that there is an annual need for almost 12,000 additional affordable homes.

- Shortfall in housing varied in Kent partly due to percentage and absolute growth in population in each of different areas.

### **2.7.2 Carers**

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

### **2.7.3 Community Pharmacies**

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

### **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.
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### Recommendation

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

- **Transition from DMS to the NHS**
  - Facilitate GP registration prior to discharge
  - Improve awareness of DMS record transfer
- **Physical Health Services for Veterans**
  - Review Kent and Medway's prosthetic limb service to allow implementation of Murrison Review
  - Raise awareness of the principle of prioritisation
  - Support extension of the SSAFA referral project from custodies to A&Es
- **Mental Health Services for Veterans**
  - Local implementation of the Murrison Report on veteran mental health based on the findings of this health needs assessment

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

▪ **Raising Awareness of Veterans Issues**

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

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## **3 Ashford Clinical Commissioning Group (ACCG)**

### **3.1 Demographics**

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

### **3.2 Population**

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

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

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

### **3.3 Deprivation**

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

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

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<sup>1</sup> PCIS registered practices populations September 2011

<sup>2</sup> ONS 2008-Based population projections 2011-2016, 2011-2021

### **3.4 Housing, Education and Employment**

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

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

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

### **3.5 Risk Factors**

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

#### Adults

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

#### Children

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

### **3.6 Health Issues**

#### Prevalence

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

## Morbidity

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

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

## Mortality

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

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## **4 C4 Canterbury and Whitstable CCG**

### **4.1 Demographics**

Canterbury and Coastal CCG consists of 23 practices, the majority of which (16) are located within the district boundary of Canterbury, four practices are located in Faversham within Swale District and the remaining three are located within Dover district. Dr Kinnersley has a branch practice located in Chilham which is in the district boundary of Ashford.

### **4.2 Population**

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

- 211,651 people are registered with practices within C4 this is 14% of the total registered practice population for Kent.
- The population age and sex structure differs from that for Kent and Medway. Canterbury is a university town and has a larger number of people aged between 15 and 29.
- Using data for Canterbury District, the population is projected to increase by 4% over the next 5 years<sup>3</sup> and 8% over the next 10 years. The greatest population growth is in the 65+ (14%) and 85+ (11%) age groups.

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

### **4.3 Deprivation**

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

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

### **4.4 Housing, Education and Employment**

Health and social care outcomes are very much influenced by the 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

<sup>3</sup> ONS 2008-Based population projections 2011-2016, 2011-2021

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

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

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

#### **4.5 Risk Factors**

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

Adults

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

Children

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

#### **4.6 Health Issues**

Prevalence

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

Morbidity

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

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

Mortality

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

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## **5 Dartford, Gravesham and Swanley CCG**

### **5.1 Demographics**

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

### **5.2 Population**

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

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

### **5.3 Deprivation**

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

- Dartford is ranked 175 and Gravesham is ranked 142 out of 326 local authorities. Dartford is ranked 7 and Gravesham 5 of the 12 Kent districts.
- 5.2% of Dartford's and 12.7% of Gravesham's lower layer 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).

### **5.4 Housing, Education and Employment**

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

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

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

## 5.5 Risk Factors

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

### Adults

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

### Children

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

## 5.6 Health Issues

### Prevalence

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

### Morbidity

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

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

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

#### Mortality

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

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## 6 Maidstone and Malling CCG

### 6.1 Demographics

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

### 6.2 Population

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

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

### 6.3 Deprivation

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

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

### 6.4 Housing, Education and Employment

Health and social care outcomes are very much influenced by the 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

<sup>4</sup> ONS 2008-Based population projections 2011-2016, 2011-2021

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

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

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

## **6.5 Risk Factors**

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

### Adults

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

### Children

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

## **6.6 Health Issues**

### Prevalence

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

### Morbidity

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

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

### Mortality

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

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## **7 Swale CCG**

### **7.1 Demographics**

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

### **7.2 Population**

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

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

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

### **7.3 Deprivation**

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

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

### **7.4 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

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<sup>5</sup> ONS 2008-Based population projections 2011-2016, 2011-2021

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

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

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

## **7.5 Risk Factors**

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

### **Adults**

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

### **Children**

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

## **7.6 Health Issues**

### **Prevalence**

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

### **Morbidity**

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

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

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

#### Mortality

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

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## 8 South Kent Coast CCG

### 8.1 Demographics

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

### 8.2 Population

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

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

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

### 8.3 Deprivation

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

- Dover is ranked 127 and Shepway is 97 ranked out of 326 local authorities and is the third most deprived district in Kent.
- 16.4% of Dover and 16.9% of Shepway's lower layer 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)

### 8.4 Housing, Education and Employment

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

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<sup>6</sup> ONS 2008-Based population projections 2011-2016, 2011-2021

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

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

## 8.5 Risk Factors

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

### Adults

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

### Children

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

## 8.6 Health Issues

### Prevalence

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

### Morbidity

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

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

#### Mortality

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

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## 9 Thanet and East Cliff CCG

### 9.1 Demographics

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

### 9.2 Population

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

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

### 9.3 Deprivation

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

- Thanet is ranked 49 out of 326 local authorities and is the 1 most deprived district in Kent.
- 29.8% of Thanet's lower layer 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.

### 9.4 Housing, Education and Employment

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

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<sup>7</sup> ONS 2008-Based population projections 2011-2016, 2011-2021

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

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

## 9.5 Risk Factors

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

### Adults

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

### Children

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

## 9.6 Health Issues

### Prevalence

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

### Morbidity

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

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

### Mortality

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

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## 10 West Kent and Weald CCG

### 10.1 Demographics

There are 53 practices within the West Kent and Weald CCG. These are located within the four districts of Maidstone (14), Sevenoaks (7), Tonbridge and Malling (11) and Tunbridge Wells(21). Dr Winch has branch surgery located in Biddenden within the district of Ashford.

### 10.2 Population

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

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

### 10.3 Deprivation

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

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

## 10.4 Housing, Education and Employment

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

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

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

## 10.5 Risk Factors

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

### Adults

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

### Children

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

## 10.6 Health Issues

### Prevalence

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

#### Morbidity

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

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

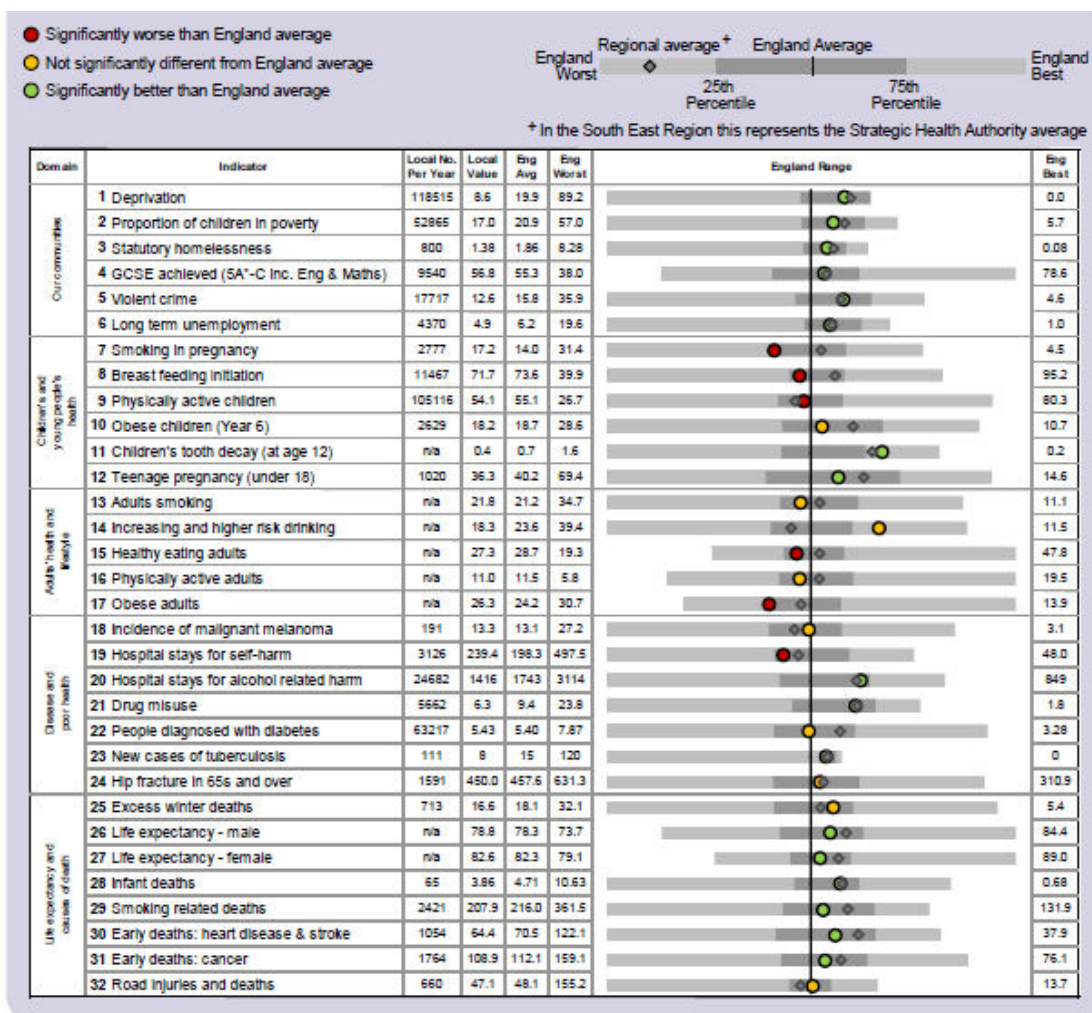
#### Mortality

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

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# Appendix B – Health Profiles 2011

## Kent County Council

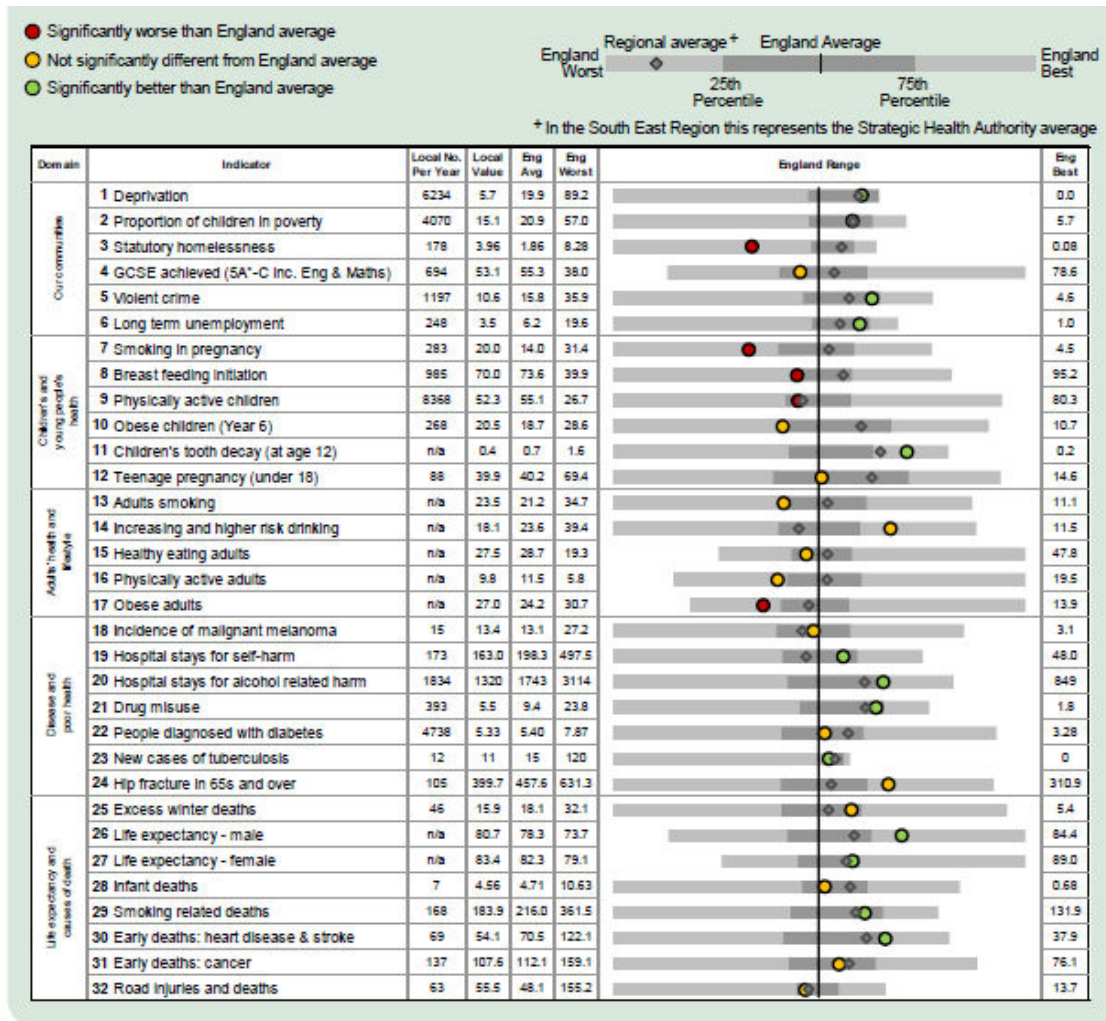


### Indicator Notes

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# Ashford

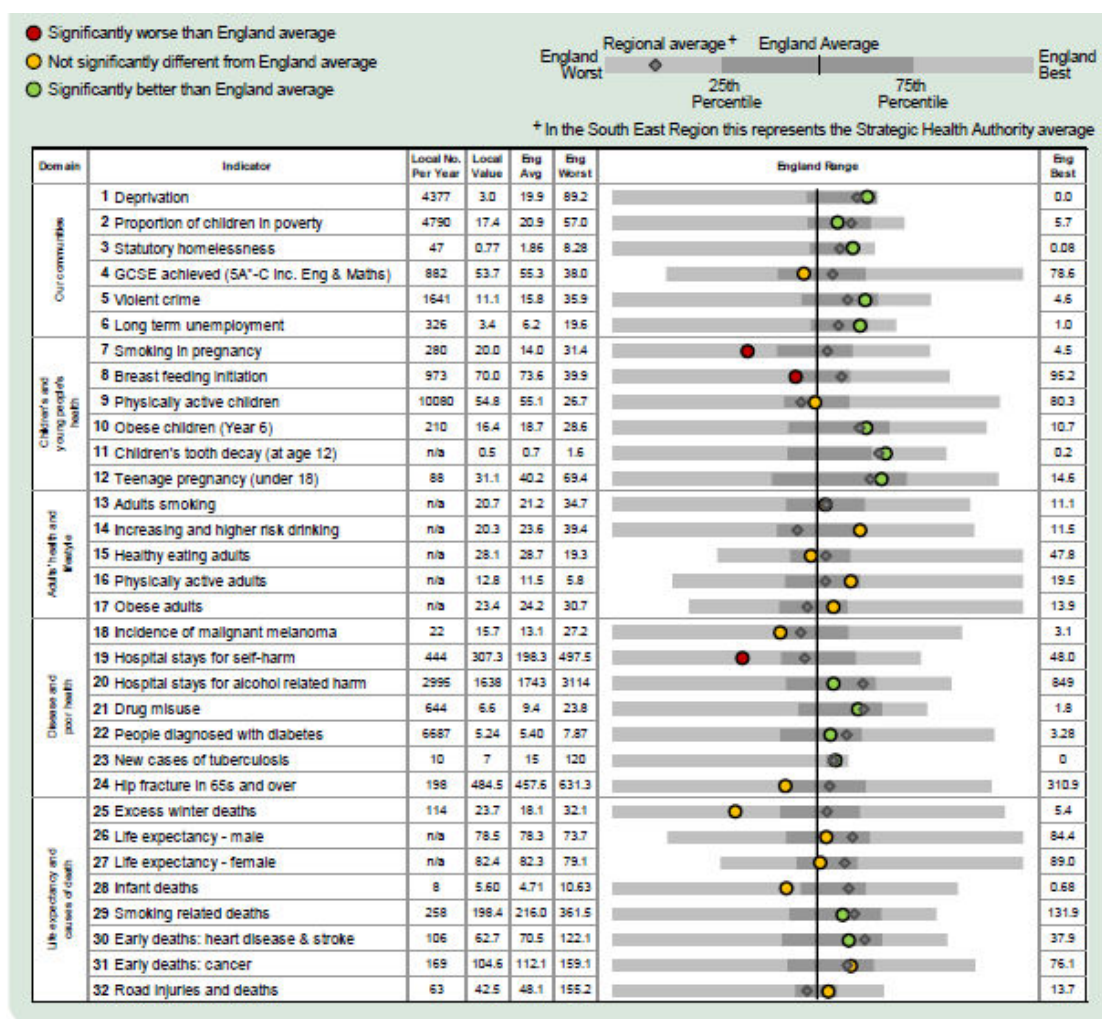


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# Canterbury

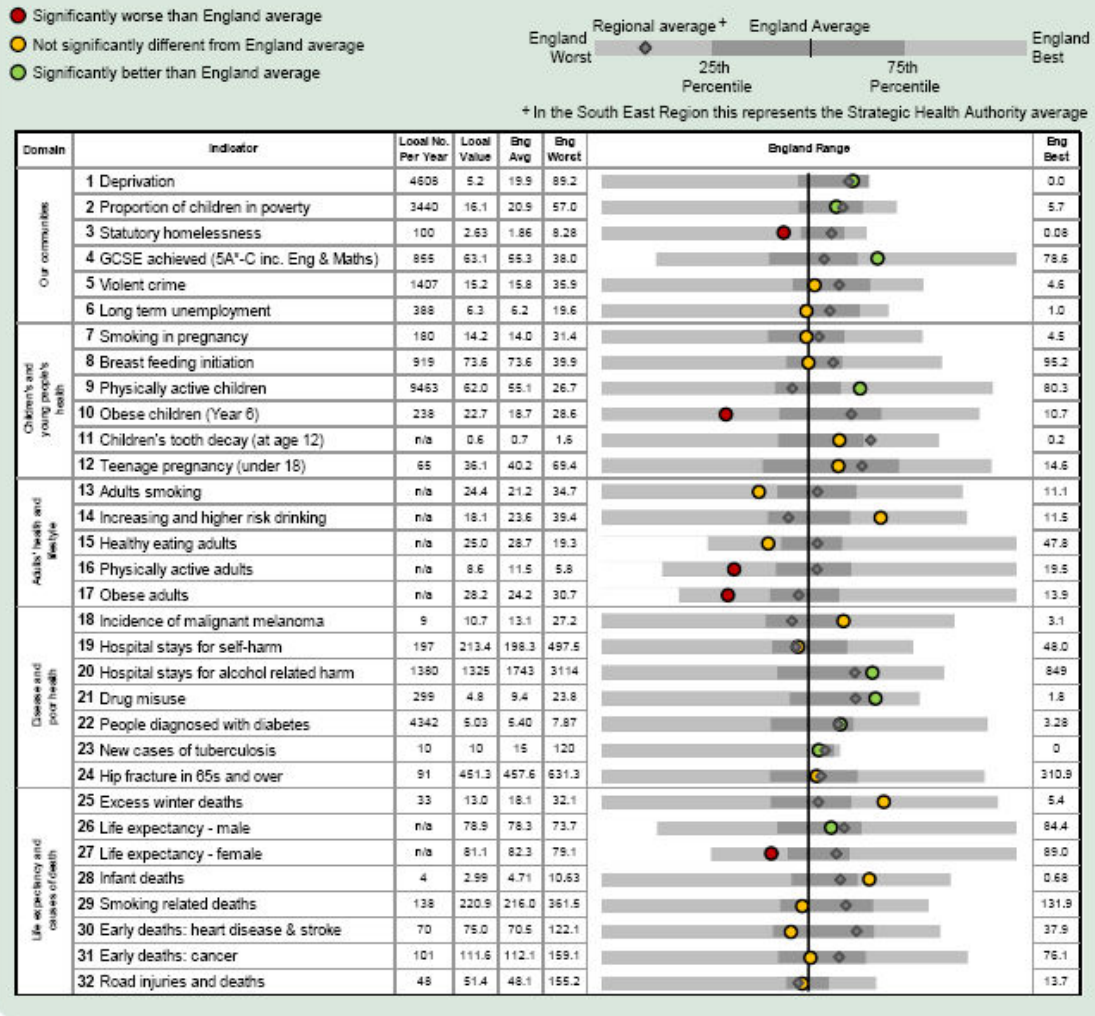


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# Dartford

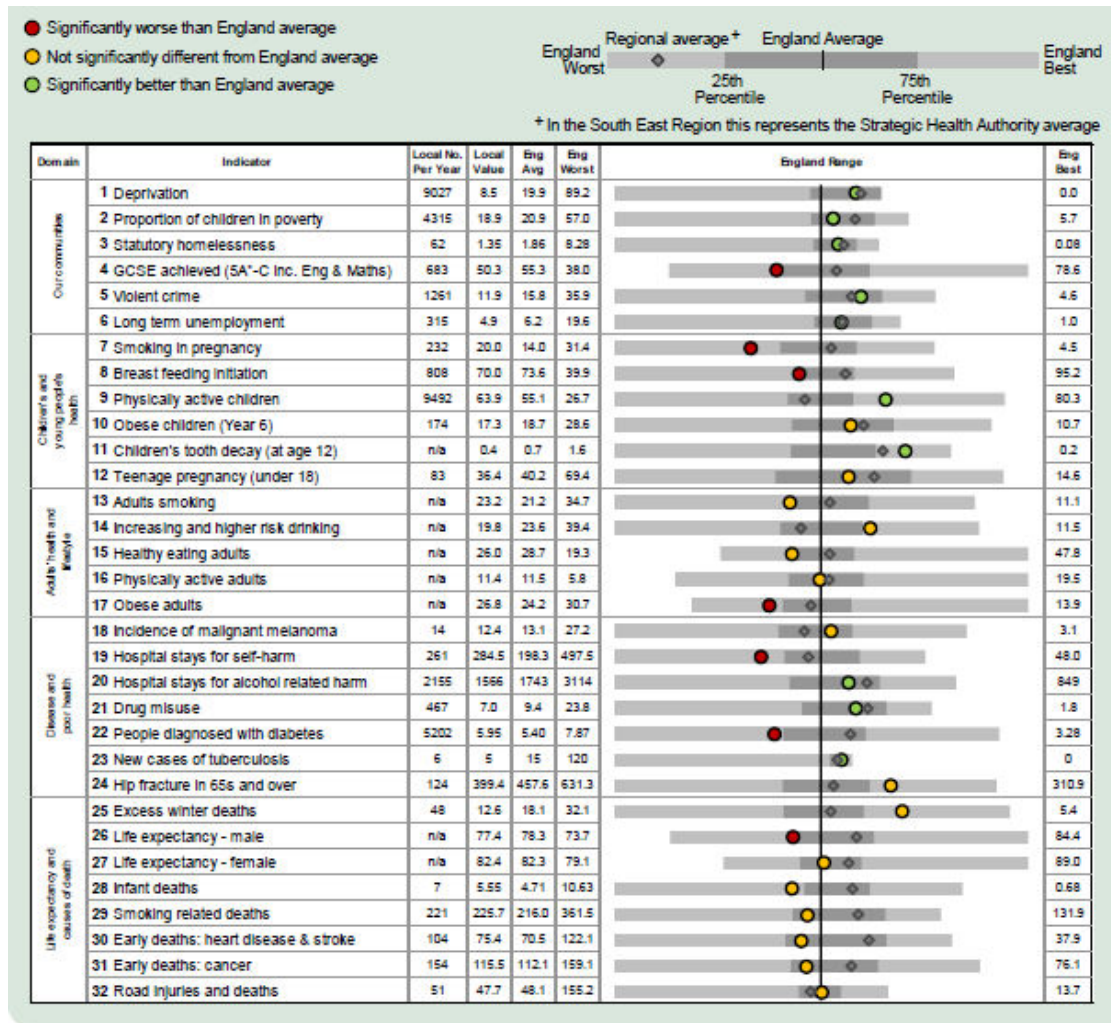


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# Dover

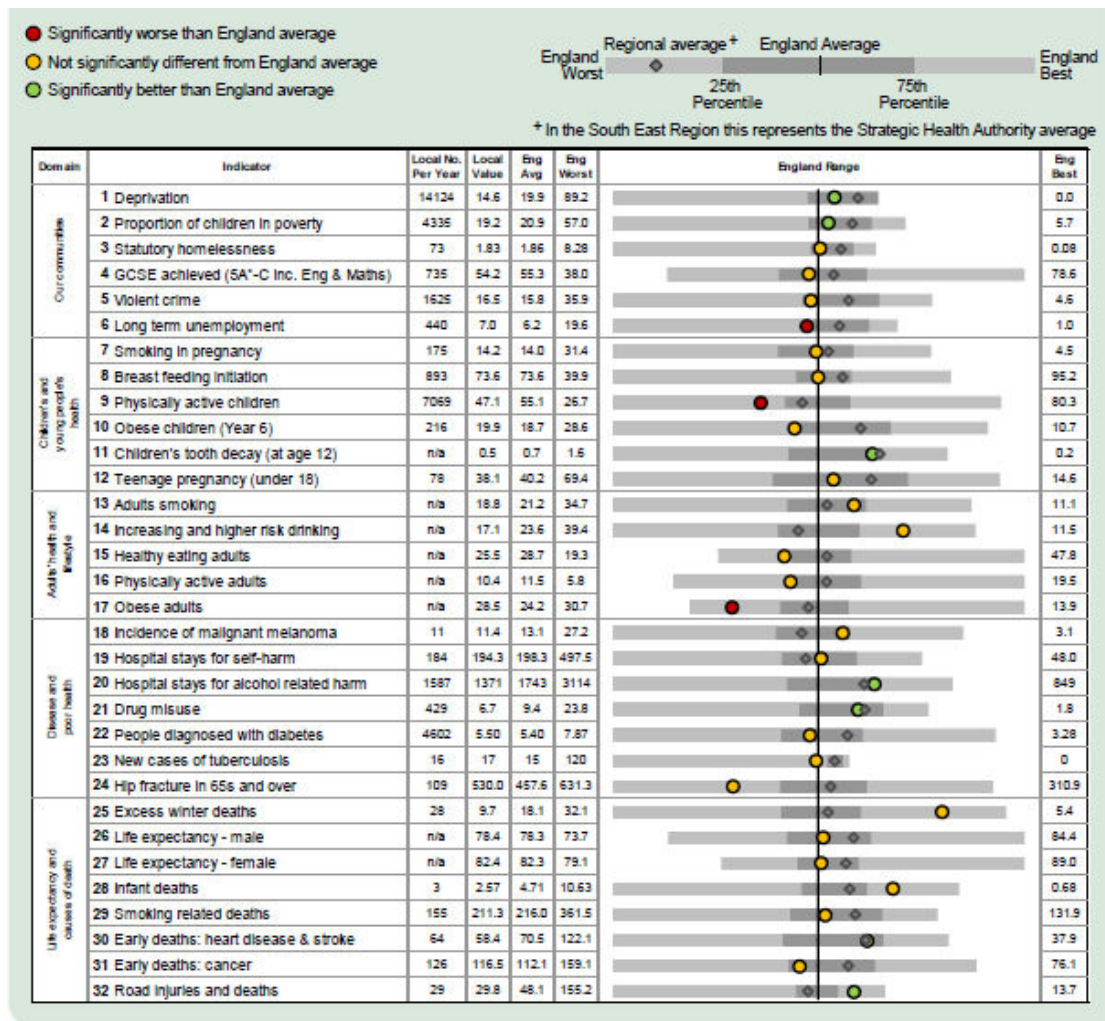


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# Gravesham

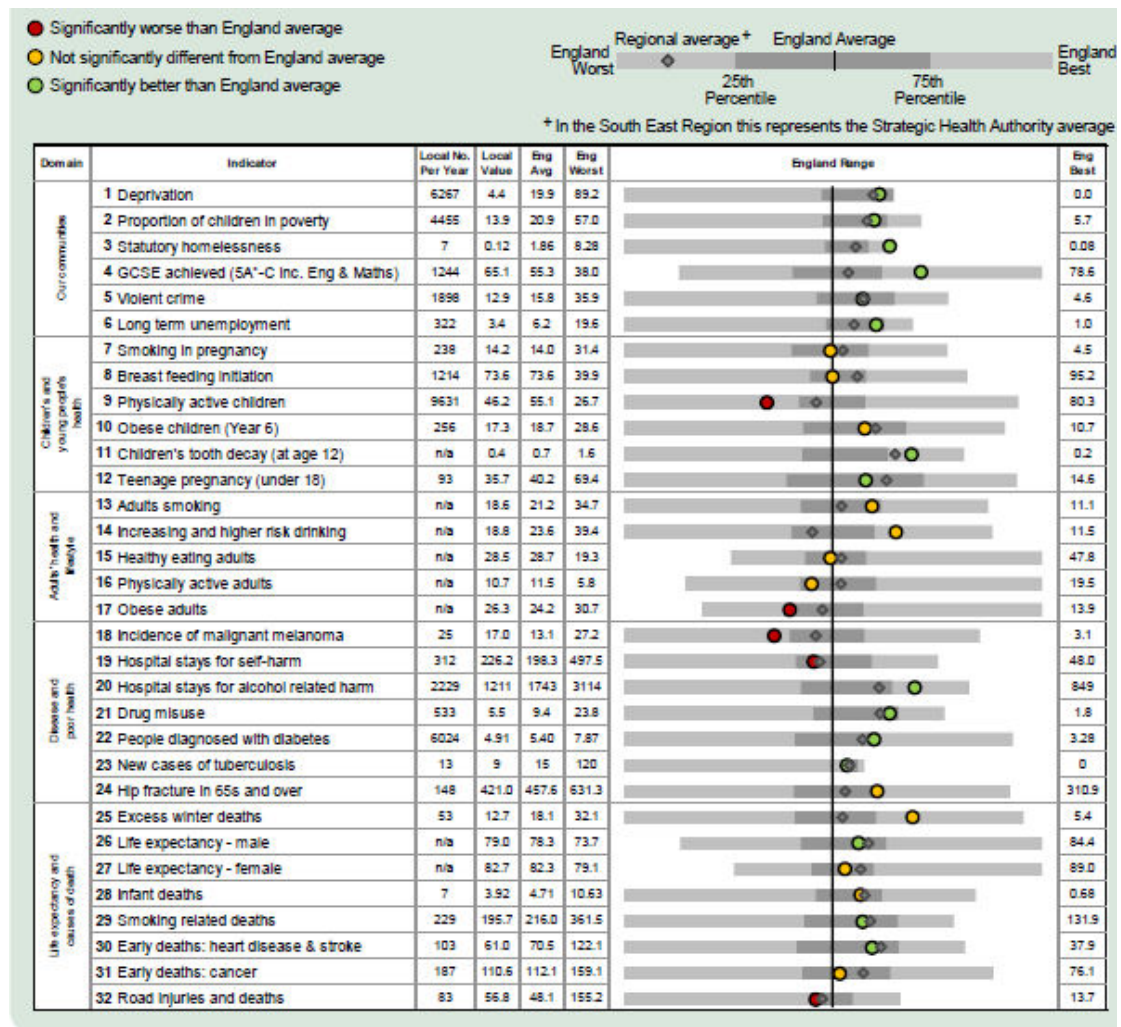


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# Maidstone

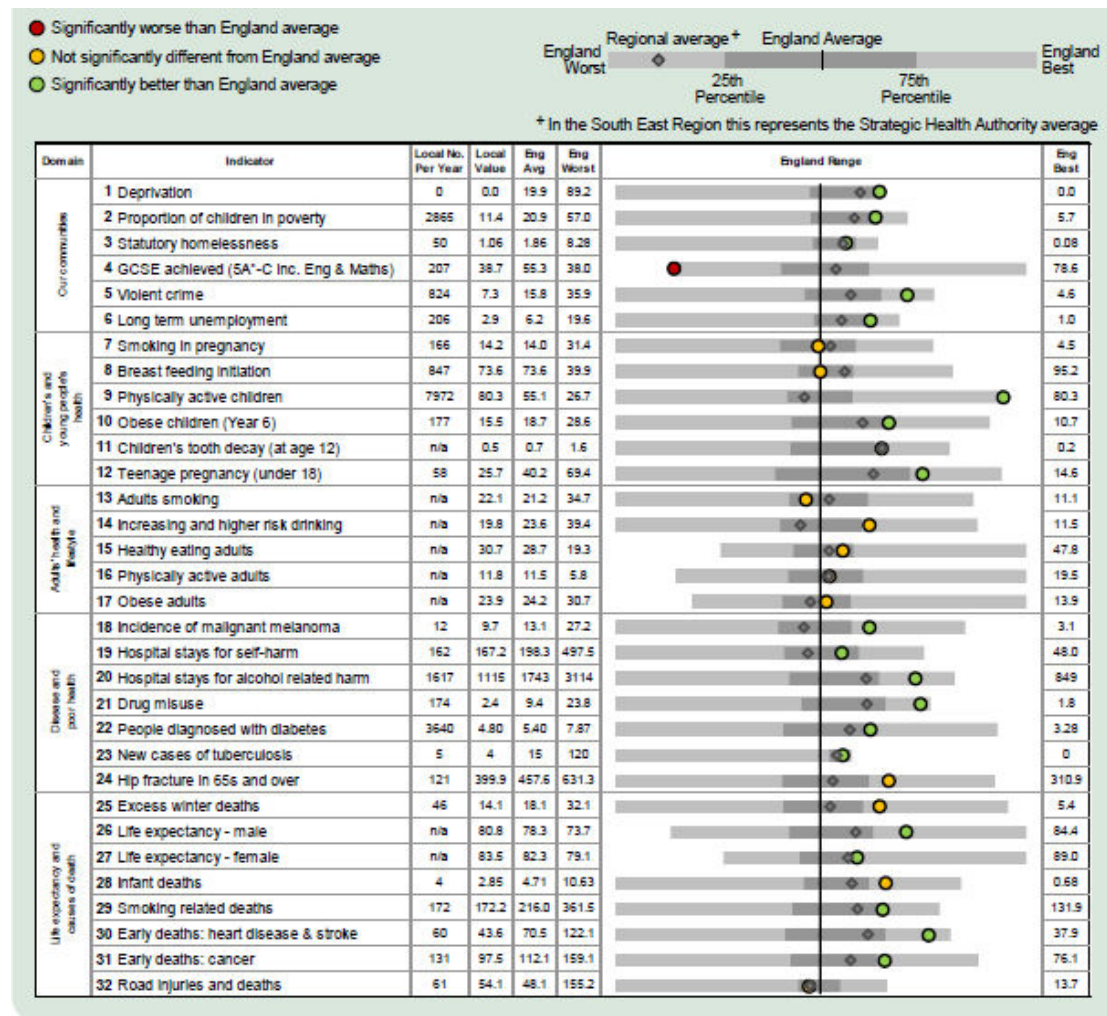


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# Sevenoaks

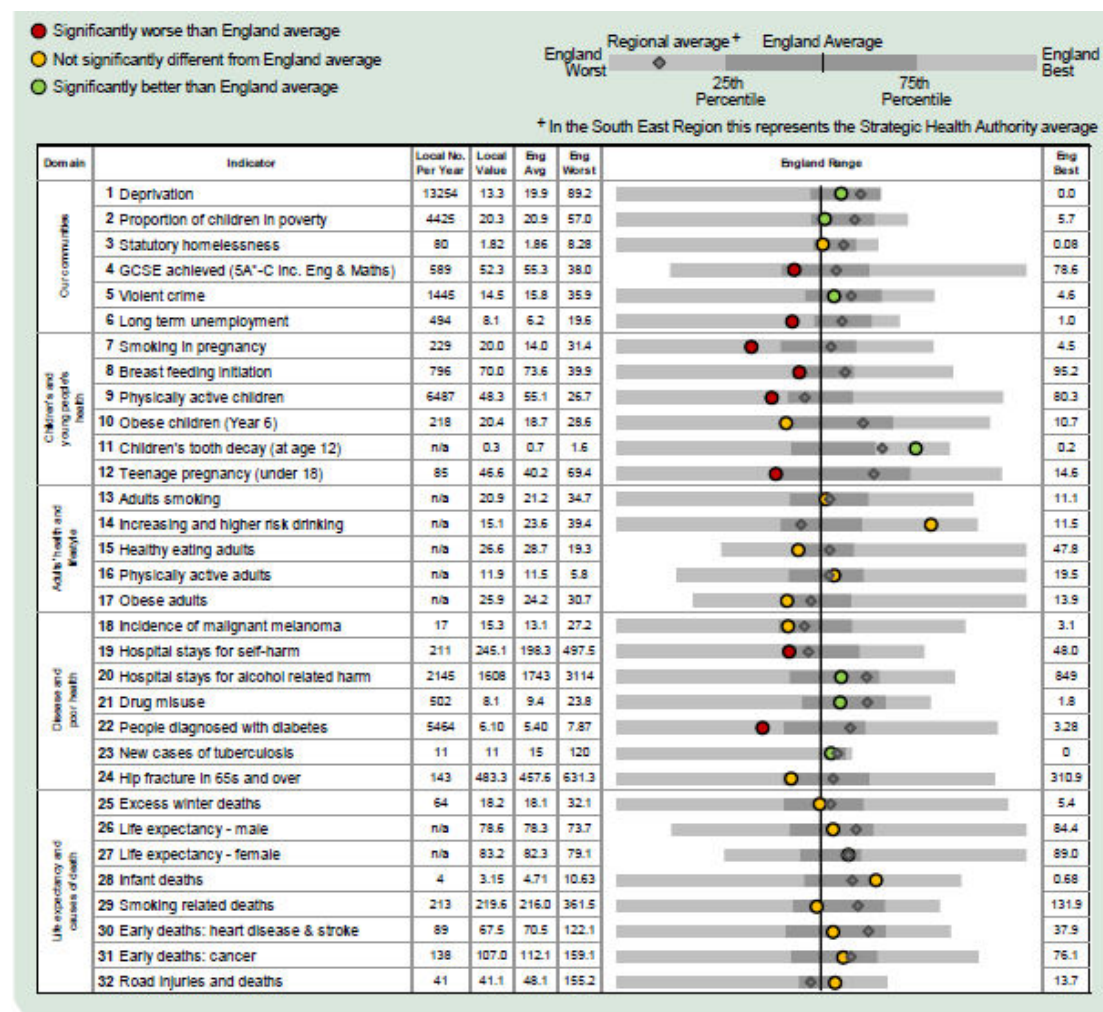


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# Shepway

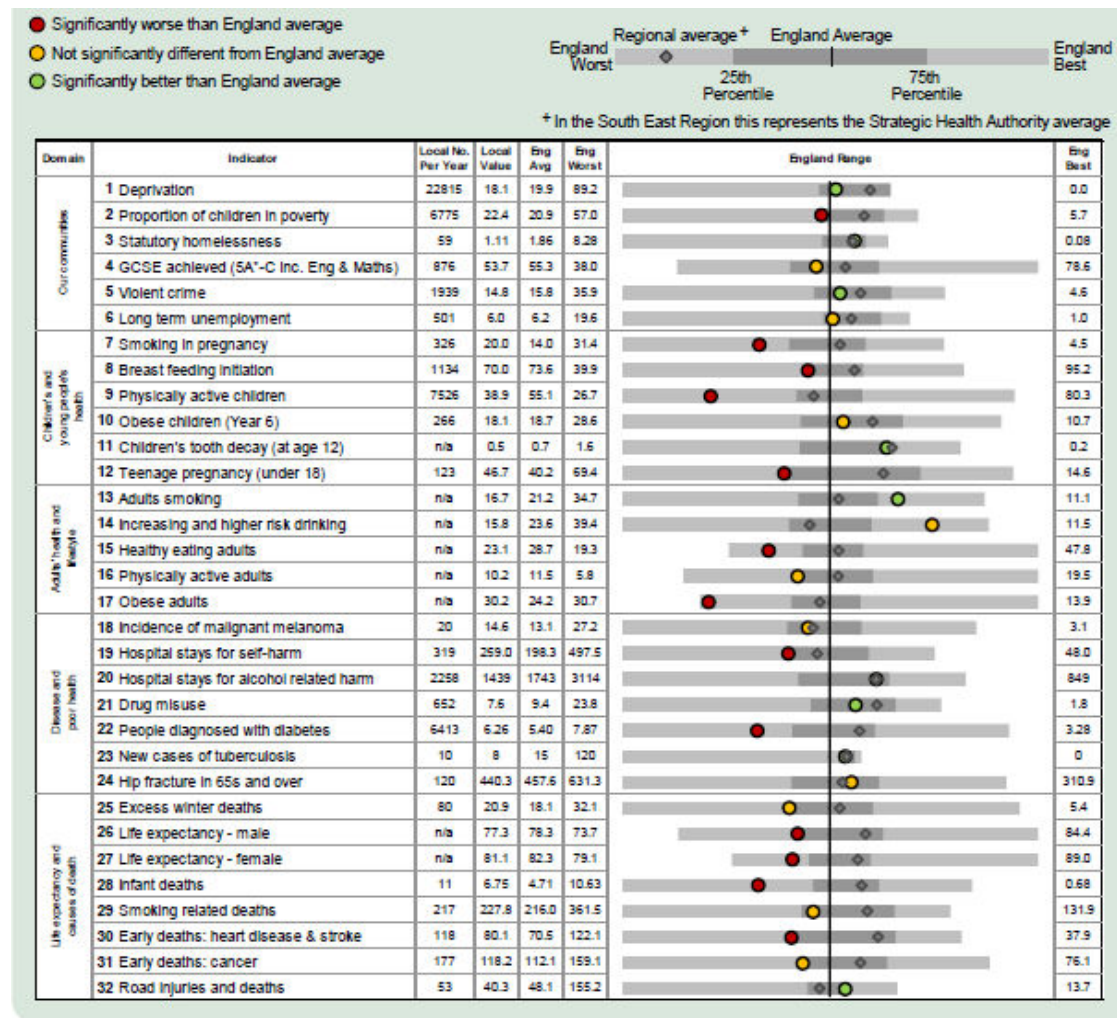


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# Swale

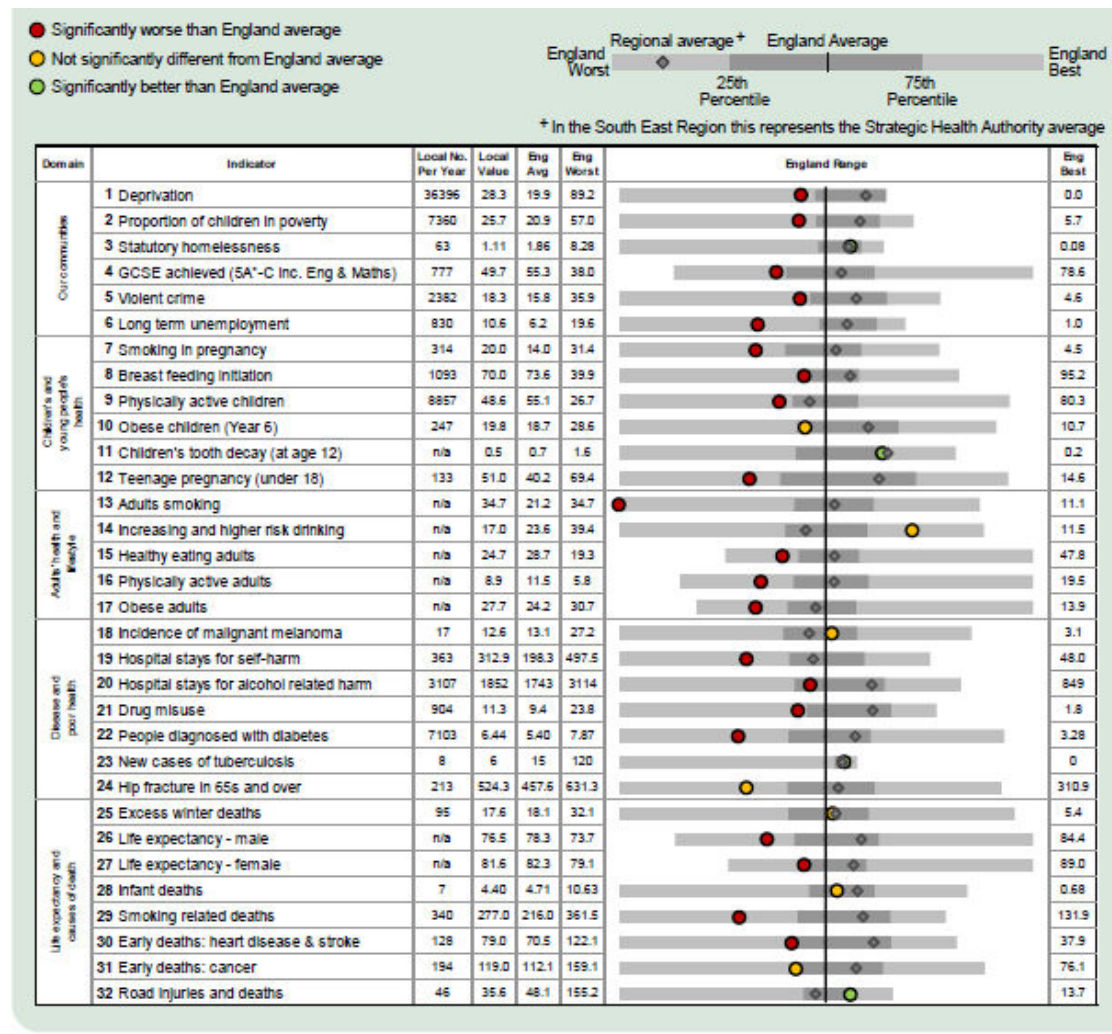


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# Thanet

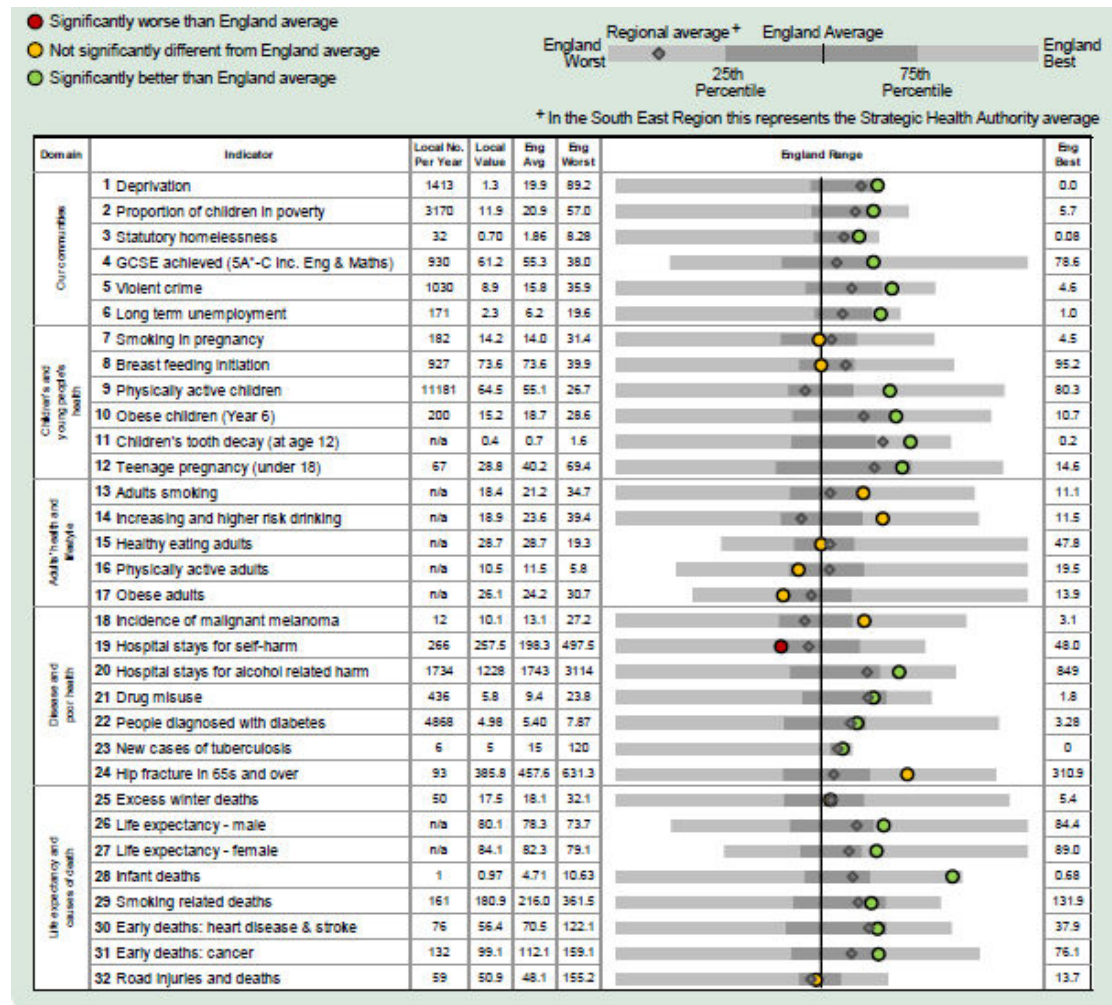


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# Tonbridge and Malling

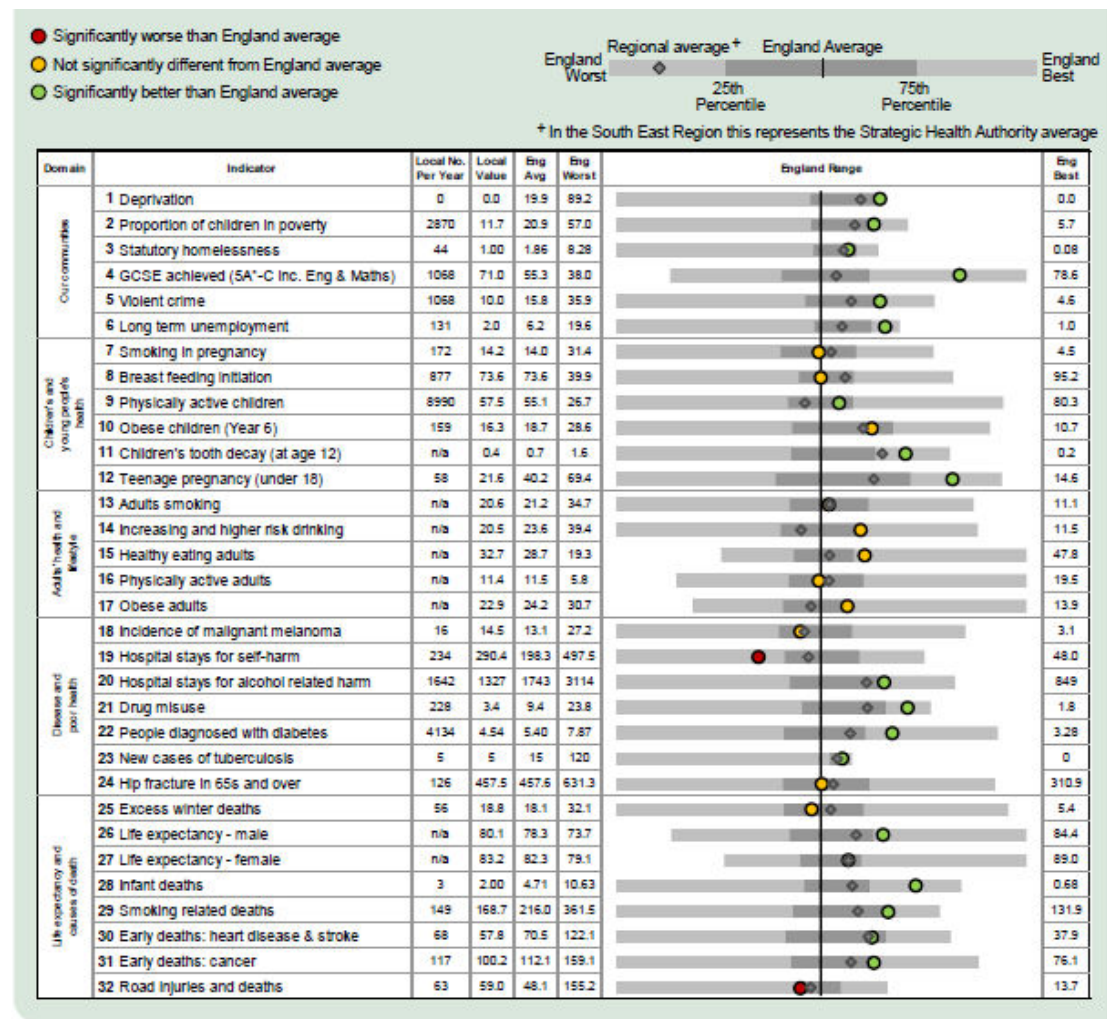


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# Tunbridge Well



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