

DRAFT

Shadow Shadow

Kent Health and Wellbeing Strategy

Version one for January Kent Health and Wellbeing Board

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

Executive summary

Health Inequalities

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

2.4	<p>Lastly reducing health gradients provides a comprehensive policy goal: one that subsumes remedying disadvantages and narrowing health gaps between the broader goal of equalizing health chances across socio-economic groups. To improve the health of poorer groups are necessary elements in a strategy to reduce the socio-economic gradient. But this is insufficient. To reduce the socio-economic gradient, health in other socio-economic groups also needs to improve at a faster rate than in the highest socio-economic group.</p>
2.5	<p>The tables and figures below show that poverty exists all over Kent and Medway and is not confined to specific areas. Nevertheless there are major concentrations of deprivation in the Thames-side boroughs of Dartford and Gravesham, in the Medway towns and throughout the coastal east of the county, interspersed with some localised areas of high affluence. The more consistently affluent parts of the county are to be found in Maidstone and the south west quarter of Kent.</p>
2.6	<div data-bbox="379 745 1337 1406" data-label="Figure"> <p style="text-align: center;">Index of Multiple Deprivation 2010: Kent and Medway (local quintiles)</p> <p style="text-align: right; font-size: small;"> Kent & Medway IMD 2010 (local quintiles) ■ Least Deprived ■ ■ ■ ■ ■ ■ Most Deprived </p> <p style="text-align: right; font-size: x-small;"> Source: Department of Communities and Local Government Produced by (Malsha Roberts), Kent & Medway Public Health Observatory, (21/06/2011) </p> </div> <p>Map 1 - Deprivation status of areas in Kent and Medway</p>
3.0	<i>Life expectancy</i>
3.1	<p>Life expectancy tells us how long a child born today would be expected to live if they experienced the current mortality rates of the area they were born in throughout their lifetime.</p> <p>Using the data from IMD 2007 for all the electoral wards in Kent, it is possible to demonstrate a highly significant correlation between relative deprivation and life expectancy across the county as a whole, also for Medway and for many of the district council areas.</p>

3.2

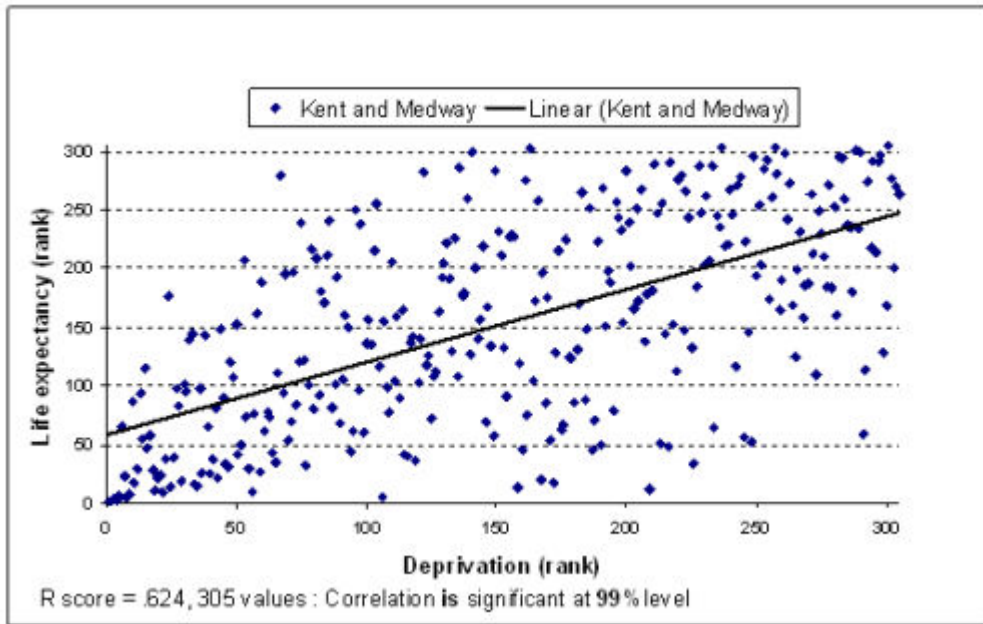


Figure 2 - Rank correlation of deprivation with life expectancy - Kent and Medway

3.3

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

3.4

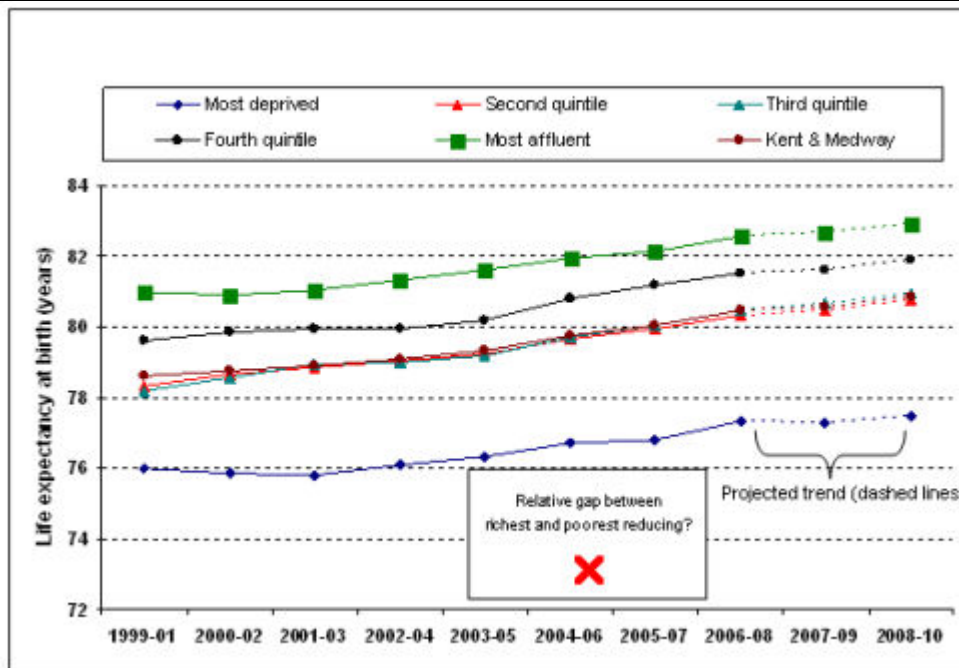


Figure 3 – Life expectancy trends by deprivation status, 3-year averages, Kent & Medway

4.0

All age all cause mortality

4.1

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

The overall mortality gap between the richest and poorest in Kent and Medway is increasing over time with quintiles two to five converging upon each other but the most deprived quintile becoming increasingly further away, i.e. the gap is widening.

4.2

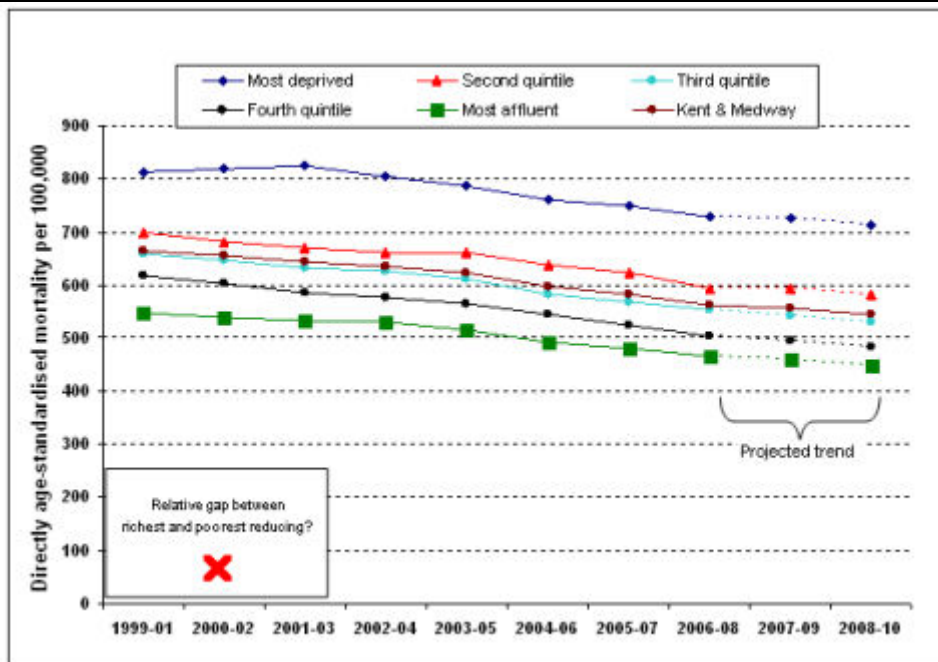


Figure 4 - All age, all cause mortality rates, 3-year averages, Kent and Medway

5.0

Fair Society, Healthy Lives: The Marmot Report

5.1

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

5.2

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

5.3

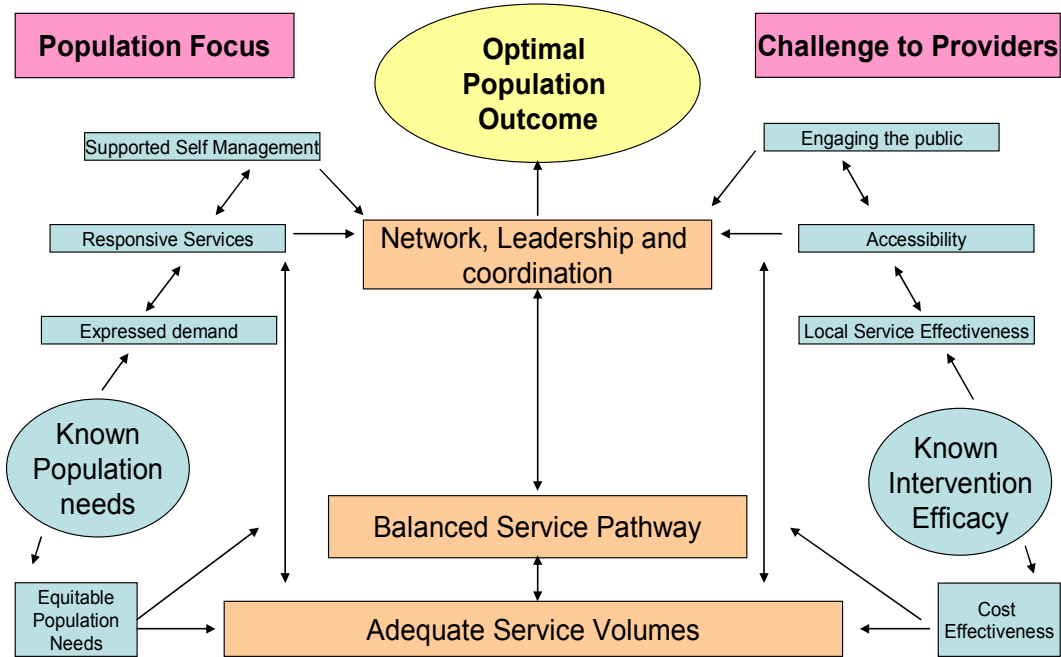
Reducing health inequalities will require action on six policy objectives:

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

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

6.2

“Christmas Tree”: Planning for Best Population Level Outcomes



6.3

What contributes most to health inequalities

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

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

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

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

7.0

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

7.1

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

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

Dementia

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

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

Children and Young People's Mental Health

[Assessment 2011.](#)

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

proportion of children according to need in T2

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

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

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

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

Table 3 - Gap according to need for targeted groups

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