Joint Strategic Needs Assessment

Executive Summary 2011

Version 10

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1. Why have a JSNA?

The JSNA is our diagnostic on the health of people in Kent to show us where we need to commission or provide better services.

We don't have to follow any format; this is designed specifically for Kent.

It uses data, analysis, quality of services, costs and cost benefits and what the public tell us. It will tell us where services are going wrong as well as where health patterns are improving.

It will show where priorities need to be changed and will give a series of recommendations.

The purpose of producing a JSNA is:

- 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 for Kent will be based on the JSNA and will provide the future strategic direction for commissioning.

2. Who should use the JSNA?

Kent is a two tier County Authority, with 12 District Councils and eight emerging Clinical Commissioning groups. These organisations must work in partnership to commission local services in order to meet the changing demands of our local residents.

The JSNA will be a valuable tool for:

- Clinical Commissioning Groups
- Kent County Council commissioning and members
- Local authorities
- Private and/ or voluntary organisations

Why is it relevant for CCGs?
General Practitioners are the first point of contact for patients.

Reduction in practice variation will result in better health outcomes and will contribute to reducing the gap in health inequalities for the population of Kent.

Case finding through NHS Health Checks will result in people being identified earlier and in treatment sooner reducing complications associated with late diagnosis.

Prevention and brief intervention for smoking, alcohol and healthy weight will reduce the number of people with long term conditions

Why is it relevant for local authorities?
District councils have a key primary prevention role in minimising the effect of poor housing, lower educational attainment, poor environment, [e.g. noise, air and water pollution] and transport all of which have an impact on health and social care outcomes.

District councils provide health and wellbeing services in particular for, smoking, alcohol, physical activity, healthy weight. They therefore need to adopt a high risk approach and work more closely with primary care and acute care organisations to ensure that services are targeted towards the most vulnerable and at risk groups to achieve optimum effectiveness. This can be done by ensuring NHS based care pathways for Long Term Conditions are integrated and include such services – for example prescribed exercise programmes for the elderly (frequent fallers) to reduce falls and fractures, Health Weight Care Pathway for adults and children who are clinically obese or overweight for the prevention of Diabetes.

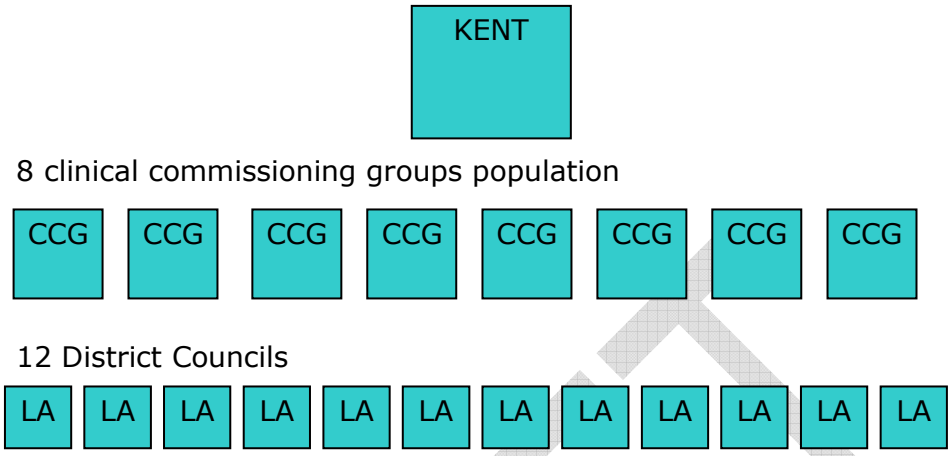
Why is it relevant to providers of health and social care?

Health systems that employ models of chronic care management in which care co-ordination is a central component – tend to be associated with lower costs, as well as better outcomes and higher patient satisfaction.

The latest results of the Utilization Review of hospital admissions across Kent and Medway indicate up to 9% of admissions were found to be inappropriate. A further 52% of admissions whos of day of care was found to be inappropriate.

This emphasises the importance of multi professional teams, including generalists working along side specialists, a focus on care management and support to home-based care, joint planning and co-ordinated assessment of care needs, personalised health care programmes and clinical records that are shared across the multi-professional team are some of the key components for an integrated health care model.

Why is it relevant for Kent County Council commissioning and members?



3. Phase 1 – Reviewing where we are.

A JSNA has been produced in Kent since 2006.

Kent has traditionally produced two JSNA documents, one for adults and one for children. The Adult's JSNA was refreshed in July 2011 and the Children's in December 2011.

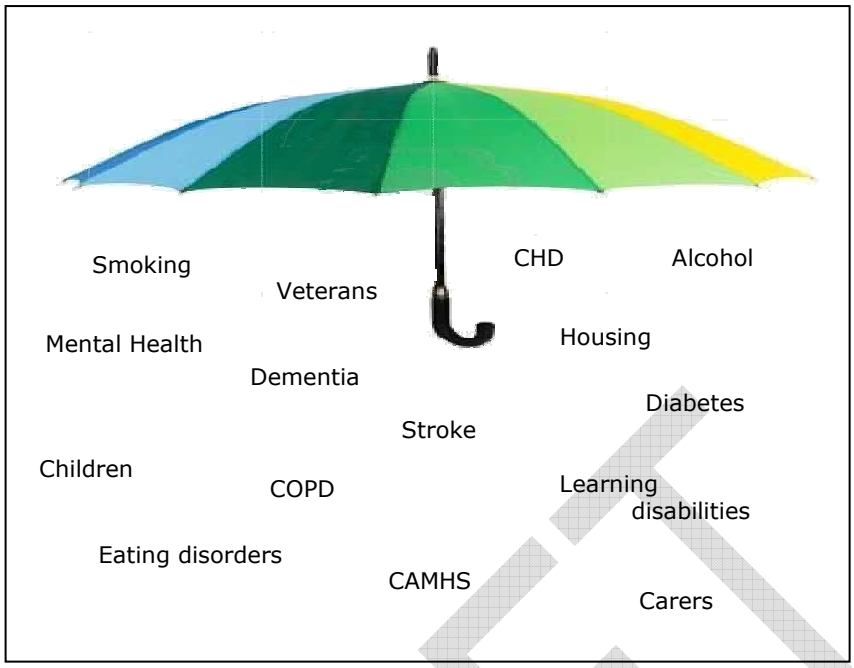
The JSNA includes many health needs assessments which are every year on specific topics such as mental health, children in care, housing, and carers. More than 40 needs assessment have been carried out in Kent since 2008 exploring in-depth the health and social care needs, gaps in service provision and levels of un-met need.

An executive summary is available for each of these needs assessments. These are available form the Kent and Medway Public Health Observatory Website 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 1 details some of the needs assessments that have been recently undertaken.

Figure 1: Umbrella of Needs Assessments



Commissioners are often involved in the development of needs assessments and we also try to include the views of patients, users, voluntary sector and carers where appropriate – for example this has been done significantly in the carers and mental health needs assessments.

Quality Innovation Productivity and Prevention (QIPP)

The refresh includes a bigger section on the QIPP priorities.

The current economic situation requires the NHS in Kent and Medway to deliver improved quality of care and productivity over the next five years.

The total projected funding gap is £686m across Kent and Medway over the next five years (£270m in West Kent, £303m in East Kent) although this estimate is subject to change. With expected increases in both cost base and demand from our population.

- Three areas of savings have been identified:
  - Service improvement initiatives to improve efficiency – for example. care pathway optimisation

- Commissioning 'lever' initiatives to drive up quality and productivity gains - for example, utilising to full effect contract levers and system management opportunities, PbR (Performance by Results) tariffs and primary care contracting
- 'change initiatives' that have an impact on the whole system – for example prevention, self care, or provision of care closer to home.

The recent Utilization Review of hospital admissions into the four acute Trusts in Kent and Medway represents a unique opportunity to benchmark appropriate acute care in using a cohort of patient admissions. Initial results estimate up to 9% of admissions were found to be inappropriate and 52% of admissions did not require care in an acute care facility. The results are expected to aid the ongoing discussions between Kent and Medway. Integrated Plan (QIPP) Board, Clinical Commissioning Groups and Acute Trusts around shifting resources into community and social services, raising standards of general practice, and promoting early intervention and self-care.

4. Phase 2 – Continued development of JSNA

See the profile for Ashford shown later in this document. This is how the locality profiles are being developed in liaison with GPs.

Public Health consultants are working closely with individual CCG leads to develop tools and resources which enable CCGs to identify commissioning needs for their local populations.

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

Early Years – The life course approach emphasised in the Marmot Review stresses the importance of continued investment in key areas:

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

- The rates of breastfeeding in Kent at six to eight weeks (36%) are almost half that of the breast feeding rates seen at birth, and significantly worse than the average for South East Coast.

- Health and social care organisations need to fully implement key recommendations from the Healthy Child and Baby Friendly Initiative Programmes, in order to improve the uptake and continuation of breastfeeding.

- ***Improving MMR uptake as well as general routine immunisation rates and reduce variation in general practice coverage to ensure herd immunity and prevent future epidemics.***

- This will be achieved through closer working between the immunisation and vaccination coordination service and GP practices, utilizing a targeted approach to those practices and vulnerable population groups where uptake is lowest. Social marketing campaigns and improved monitoring systems.

- Current MMR vaccination rates by Year 5 are 84% and 87% in East and West Kent respectively, well below the 95% coverage required for herd immunity (the level at which risk of spread of infection is reduced)

- Using health visitor expertise in Children Centres to deliver integrated services to vulnerable high risk families – including messages around health promotion and behaviour change such as reduction of second hand smoke, alcohol and substance abuse, domestic violence and healthy weight to ensure long-term benefits to the health and social sectors.

56,830 (18%) Kent children are living in poverty.

Preventing Long Term Conditions

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

A significant proportion of Long Term Conditions can be prevented if the people who are at future risk, are identified early enough, and lifestyle and behaviour are modified accordingly - through self management with support from integrated frontline services such as Stop Smoking, IBA (Alcohol), Healthy Weight etc.

The rollout of the national Health Checks programme across Kent needs to be accelerated in keys areas such as Thanet and Swale.

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

Kings Fund 2011

The aging population –

The ageing population of Kent in the older age group (65+ and 85+) is predicted to increase significantly over the next 5 to 10 years.

This presents challenges – an increase in long term conditions, rising levels of dementia, falls and fractures. These conditions are likely to cause tremendous

pressure on health and social care services - particularly urgent care and a lack of funded placements further exacerbated by lack of carers and carer support. For example emergency admissions for falls and dementia in the elderly have increased by more than 50% and 85% respectively over the last 5 years.

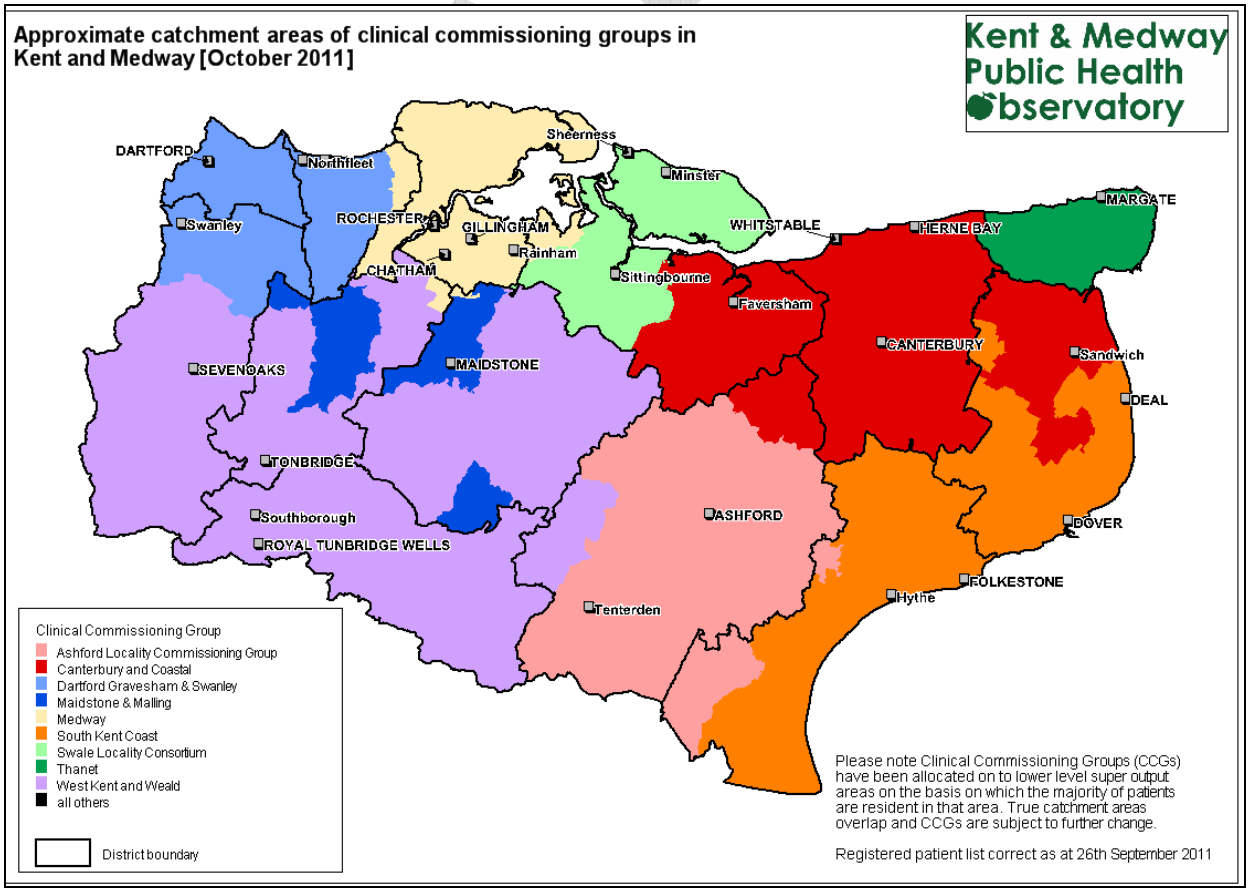
Risk stratification of the Kent population is urgently required to pro-actively identify complex patients in need of a multi disciplinary integrated approach (across primary care, community, and acute care and social services) towards crisis response and support, and exacerbation management ultimately resulting in hospital admission avoidance.

Kent - Population Demographics

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.

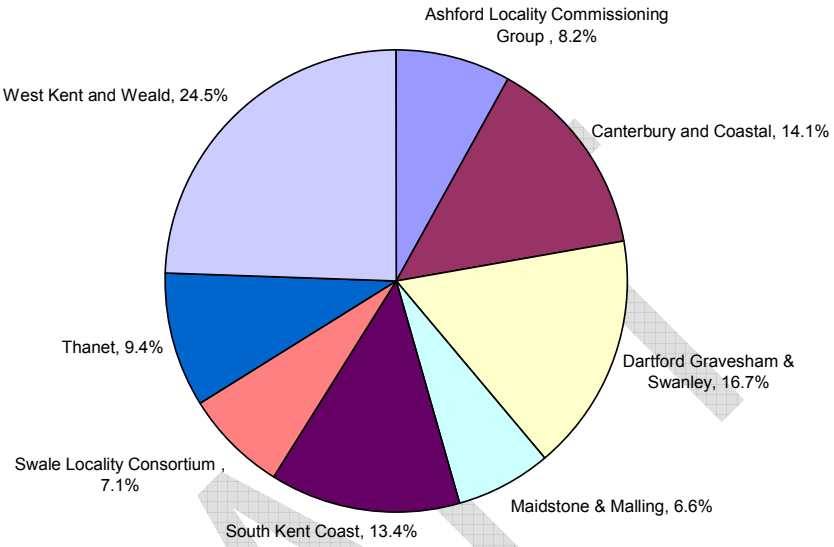
Figure 2: Approximate catchment areas of clinical commissioning groups in Kent.



West Kent and Malling 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.

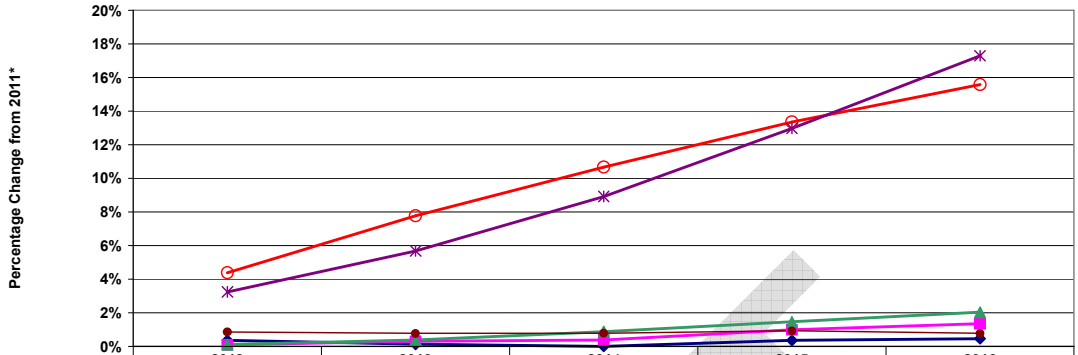
Figure 3: Percentage of Kent registered practice population by clinical commissioning group as at September 2011



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, in the 0-4 age group the proportion of the population is projected to grow very little in Kent just 0.1%. In Tunbridge Wells the proportion of 0 to 4 year olds is expected to decrease by 4.5% whereas it is predicted to increase in Dartford and Gravesham by 4.3% & 2.9% respectively.

Figure 4 Projected population change

Projected Population Change in 2012-2016 from 2011* for Ashford Local Authority by Broad Age Groups



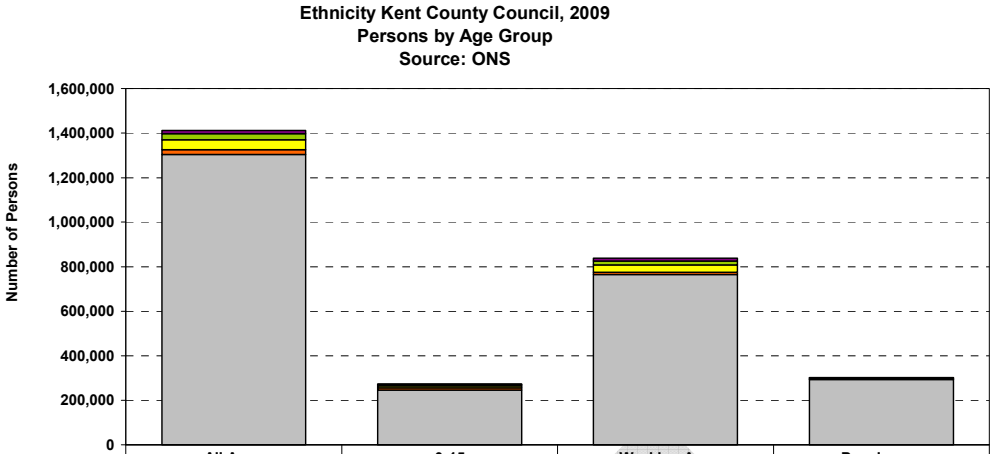
	2012	2013	2014	2015	2016
0-4	0.3%	0.1%	0.0%	0.3%	0.5%
5-19	0.1%	0.3%	0.4%	1.0%	1.4%
20-64	0.1%	0.4%	0.9%	1.5%	2.0%
65+	4.4%	7.8%	10.7%	13.4%	15.6%
85+	3.2%	5.7%	8.9%	13.0%	17.3%
All ages	0.9%	0.8%	0.8%	0.9%	0.8%

* derived from ONS 2008 based projections

6.1 Ethnicity

Parts of Kent are more ethnically diverse than others. The population of Kent is predominately white British, 94% at the time of the 2001 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% are from Asian communities.

Figure 5 Proportion of the Kent population by ethnic group



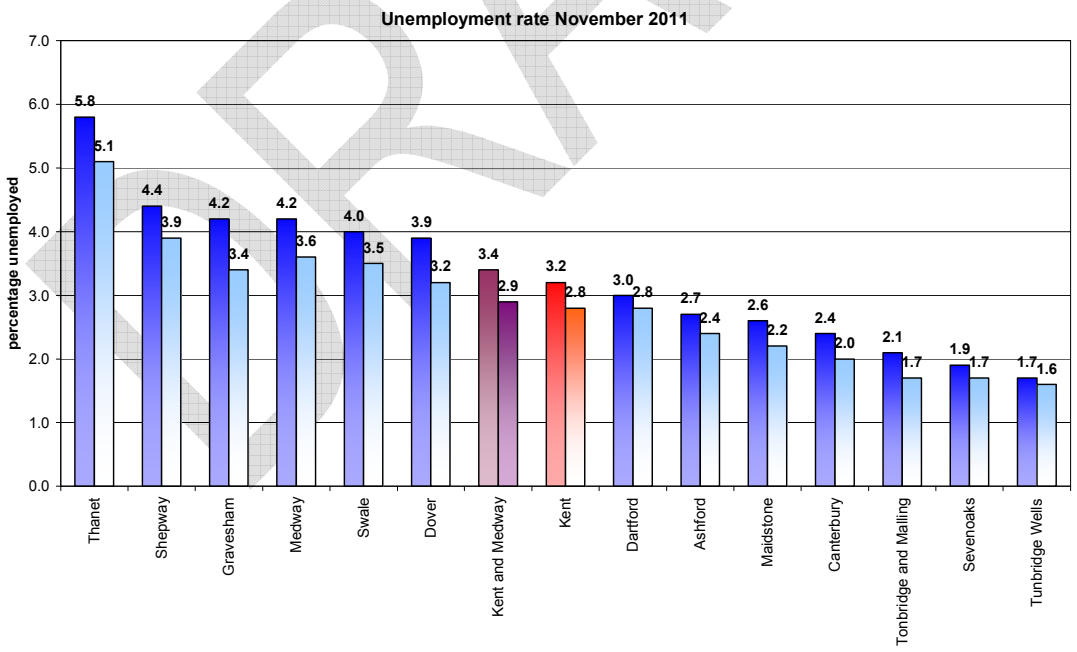
	All Ages	0-15	Working Age	Pensioners
Other	15,700	2,200	12,300	1,200
Black or Black British	25,300	5,700	17,700	1,900
Asian or Asian British	45,200	9,100	32,500	3,600
Mixed	21,800	9,700	10,900	1,200
White	1,303,900	246,300	763,800	293,800

6.2 Unemployment

3.2% of the population of Kent were unemployed and claiming benefit in November 2011 this compares to a rate of 3.8% for England. The country has been in recession since 2008 and as a consequence levels of unemployment have been increasing. The highest levels of unemployment are seen in Thanet and Shepway [Figure 7].

Figure 6 Trends in unemployment rate KCC from 1992 to 2011

Figure 7 Comparison of unemployment rates November 2010 and November 2011 by districts

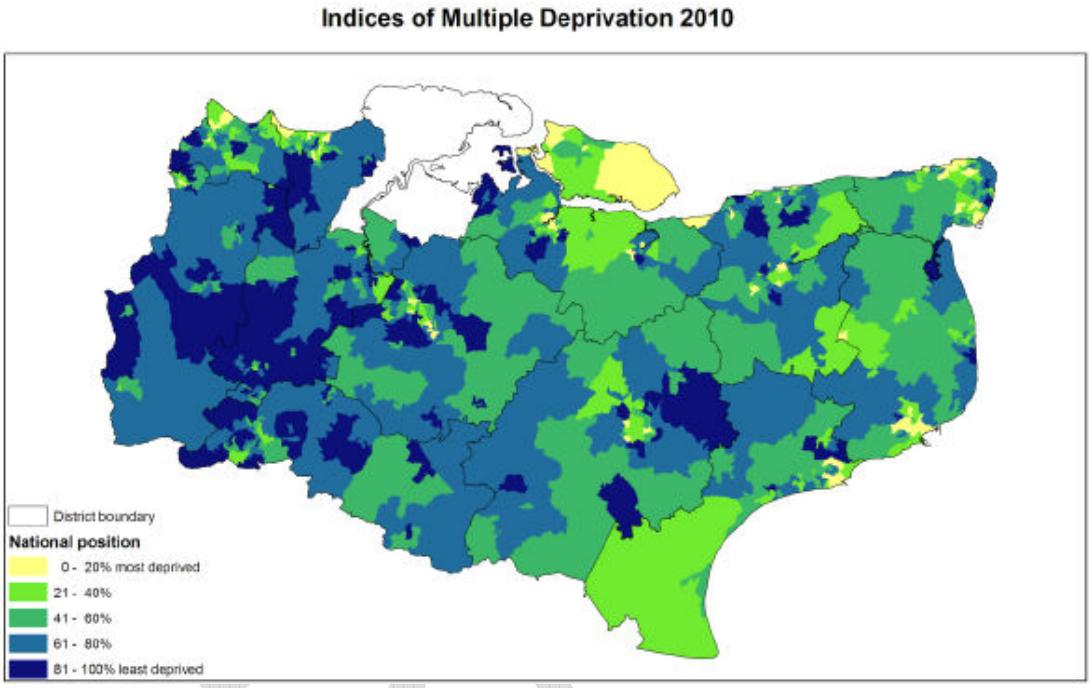


6.3 Deprivation

Figure 8 depicts deprivation across Kent, the areas of dark blue represent the least deprived. There is an obvious difference between the level so

deprivation in the east of the count and the west of the county. 94 of the 883 LOSA (11%) are in the 20% most deprived for England. Thanet is the most deprived of the 12 Kent districts and Sevenoaks is the least deprived.

Figure 8 Index of multiple deprivation LSOAs in Kent using National deprivation scale.



6.4 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.

6.5 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 2 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.

Table 2 Summary of health inequalities by Kent Districts

	Health inequality indicators				Proportion of population	
District	**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

Kent County general 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. These districts also experience some of the highest levels of deprivation and unemployment within Kent.

6.6 Quality Indicators

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

Figures 9 and 8 demonstrate the MRSA and *Clostridium difficile* April 2011 to September 2011 cumulative rates for Dartford and Gravesham NHS Trust (D&G), East Kent Hospitals University Foundation Trust (EKHUFT), Maidstone and Tonbridge Wells NHS Trust (MTW) and Medway Foundation Trust (MFT).

The rates for both MRSA and *Clostridium difficile* at EKHUFT are below the south east coast average. D&G and MFT are above the South East Coast average for MRSA but are within their Trust trajectory limit. MTW are above the South East Coast average for *Clostridium difficile,* an internal evaluation is underway to determine any changes in infection rates resulting from the move to the new Tunbridge Wells Hospital site. The outcome of the evaluation will be reported to the Kent and Medway Cluster Infection, Prevention and Control Committee in November 2011.

Figure 9

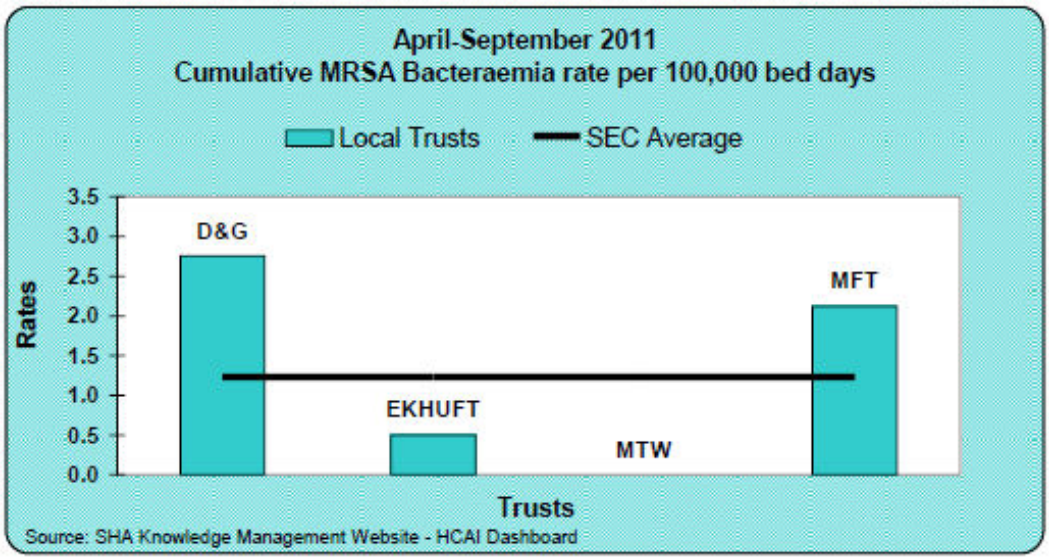
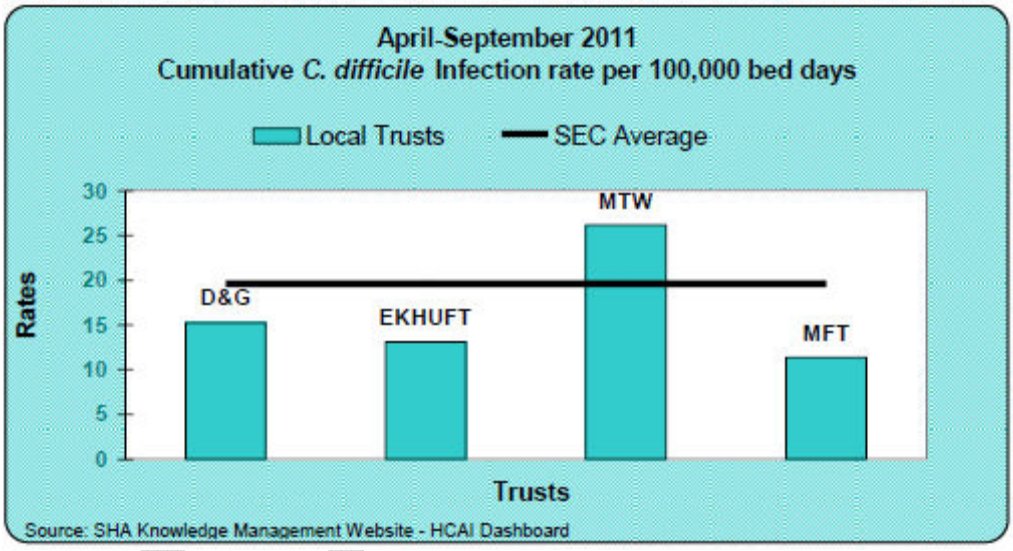


Figure 10



The key focus of children's safeguarding activity has been to take forward the Kent Safeguarding and Looked After Children's Improvement Board Plan arising form the Ofsted/CQC Inspection in Kent. The joint presentation made by NHS K&M and KCC directors to the November 2011 meeting of the Kent Safeguarding Children Board that highlights key achievements for safeguarding children and improving outcomes for LAC to date and sets out the seven steps for further improvement is included here. The seven steps are:

- Keeping on top of the basics – for health partners continuing to focus on use of the common assessment framework (CAF) and engaging in the development and delivery of child protection plans
- Improving the quality of case work

- Strengthening prevention – for health partners delivering the health visiting programme
- Further improving outcomes for LAC
- Reducing the number of LAC
- Reducing the number of children with a protection plan
- Strengthening locality management

6.7 Additional Indicators

Indictors and data to support the JSNA are produced for each of the 12 districts in Kent is presented in the Health and Social Care Maps accessible from the Kent and Medway Public Health Observatory Website. The maps area focussed around a number of key themes

- Overview and Demographics
- Health Inequalities
- Disadvantaged Children
- Mental Health and Wellbeing
- Older People
- Key Killers
- Service provision
- Activity and Prevalence

6. Executive Summary

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

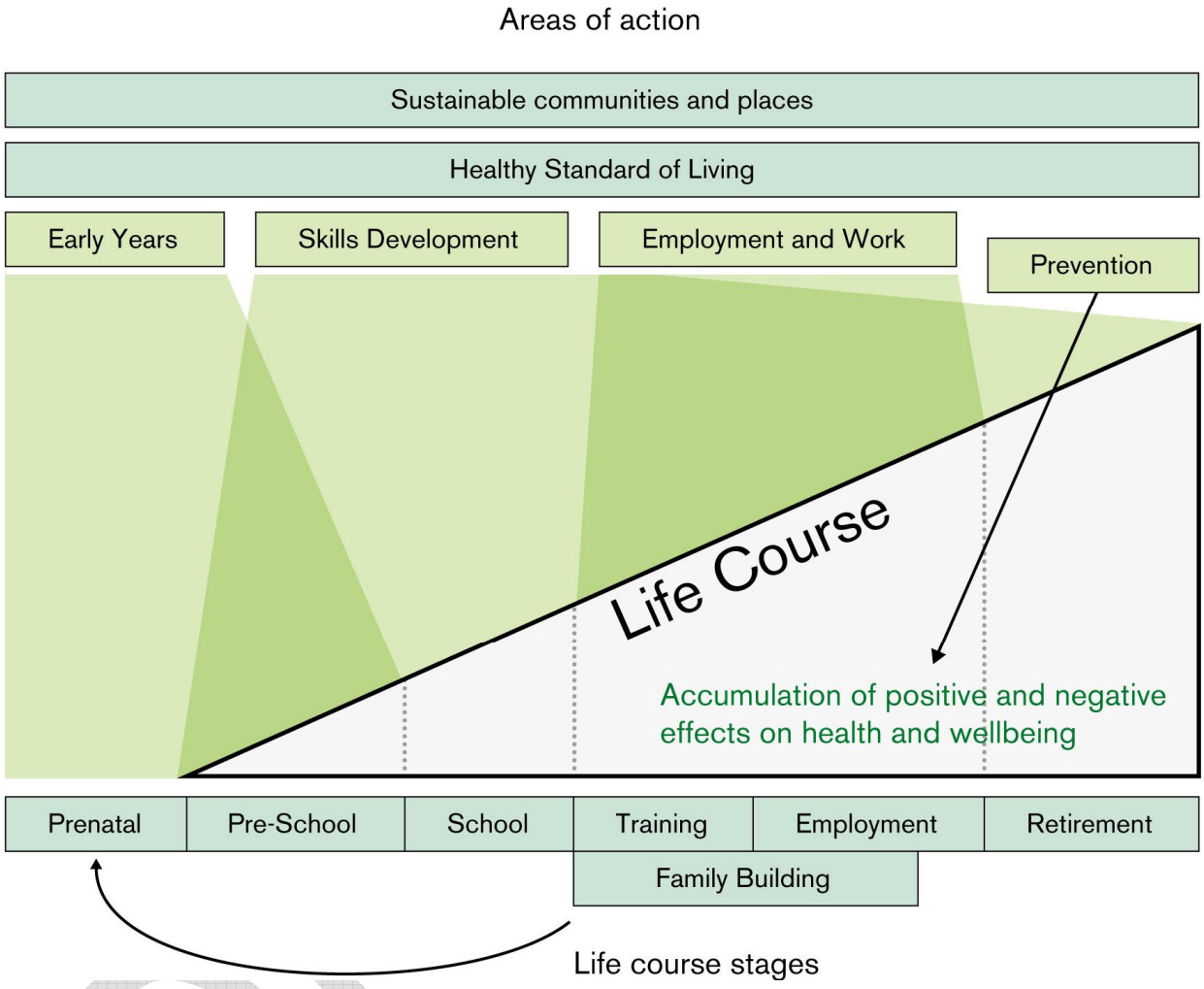
7.1 Health Inequalities

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

Figure 8 Life course diagram



- Poverty exists all over Kent and Medway. There are major concentrations of deprivation in the boroughs of Dartford and Gravesham and throughout the coastal east of the county, 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 to 2007. However for the most deprived, 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. Life expectancy in the most deprived 20 per cent of the population is 5 years less than the population in the most affluent 20 per cent. The difference in life expectancy between the poorest quintile and the second poorest quintile is 3 years.

- The Marmot 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

7.2 Lifestyles

7.2.1 Smoking

- In Kent, approximately 10,000 admissions each year are attributed to smoking costing £10 million and £12 million in West and East Kent respectively. A further £860,000 and £1.3 million are also attributed to annual outpatient costs.
- The national prevalence of smoking among adults dropped from 24% in 2005 to 21% in 2008. Smoking prevalence in Kent was higher than the national figure at 24.9% (281,300 people) in 2009, varying from 16% in Sevenoaks to 26.3% in Dartford. 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.

7.2.2 Physical Activity, Diet and Obesity

Obesity costs Kent £187.7 million in 2007, rising to £203.3 million in 2009 and is expected to rise to £233.5 million if left unchecked.

- There is a strong correlation of social factors such as deprivation with lack of physical activity and poor diets leading to overweight and obesity.
- Recent data suggests areas with higher levels of deprivation such as Swale, Thanet, Dover and Dartford appear to have less physical activity levels than those in more affluent areas. Overall, Kent appears to have slightly lower physical activity levels than the rest of England (10% vs 11%)
- Similar trends are seen for obesity levels, where 25-30% of adult population in the same areas mentioned above, are obese compared to 20-25% in more affluent areas such as Tunbridge Wells. If those who are overweight are included, this makes up approximately 50% (557,000 people) of the total adult population in Kent.
- The effects of obesity are considerable ranging from heart disease, diabetes, osteoarthritis and cancer, where high levels of unmet need pose a considerable burden on health care services.

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

People need to be motivated to change before weight loss ensues. There is a need to consider how to incorporate the behavioural model into the healthy weight pathway

Potential impact of primary care on health improvement

Five minutes of advice in general practice to middle-age smokers to quit smoking can increase quit rates and save £30 per person for a cost of £11 per person

Brief interventions in general practice to reduce problem drinking can reduce alcohol consumption by 40% over 12 months with overall cost savings outweighing intervention costs

Brief interventions in general practice to improve exercise uptake can increase the chances of adults undertaking moderate activity by over 20% and vigorous activity by 6% with cost savings of £3,300 per person.

Kings Fund 2011

7.2.3 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 5th 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. Further action is still needed such as strict enforcement of the ban on sales of alcohol and tobacco products to under 18s. This will need to encompass work on preventing proxy sales.
- 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.

Recommendations

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. As with smoking cessation, a broad approach encompassing primary, secondary and tertiary prevention work across clinical and non-clinical settings is needed.

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 in reach 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 – AUDIT-C is recommended).

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.

7.2.4 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.

<u>Recommendation</u>

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

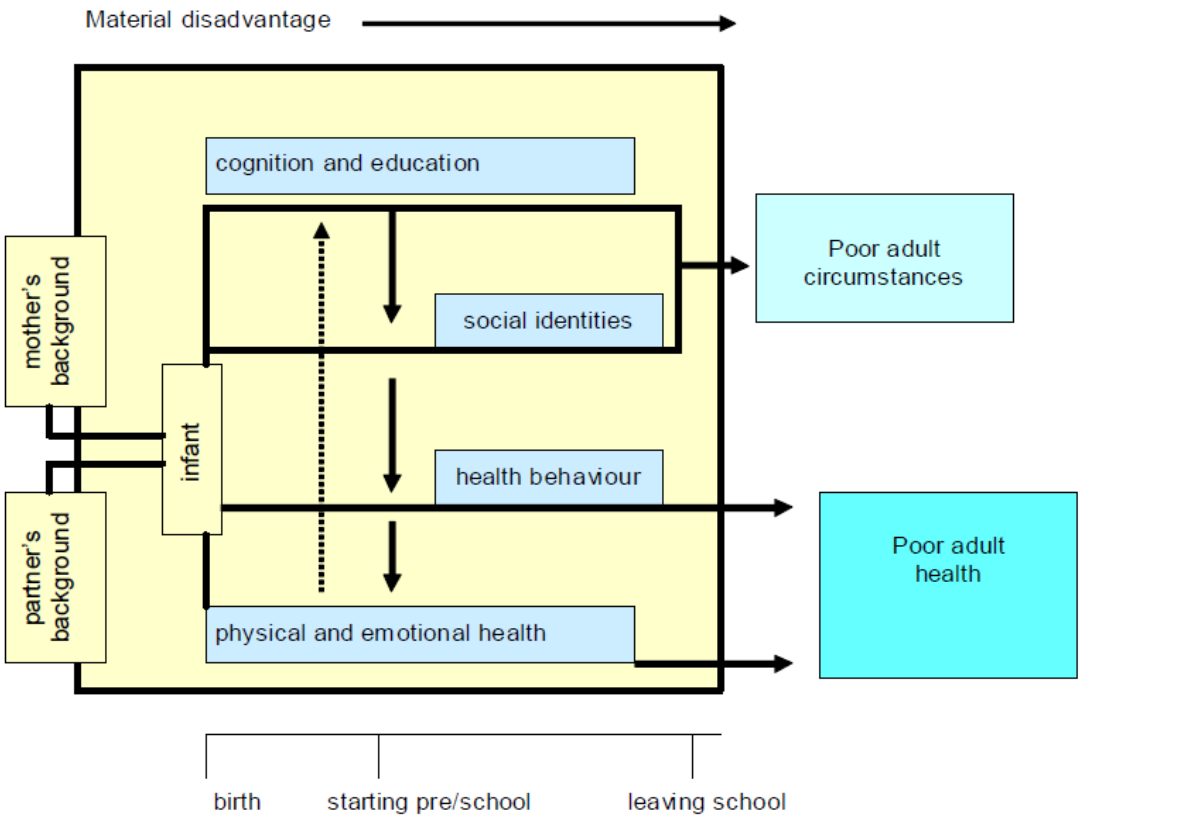
Further information required such as survey of dental health of under 5 year old, as well as a coordinated approach involving primary care dental services to focus on prevention in line with *Delivering Better Oral Health – a toolkit for prevention* by Department of Health

7.3 Children

7.3.1 Early Years

- The life course framework mentioned earlier puts the focus on childhood disadvantage, from before birth and throughout childhood (Figure 8). The pathways running from childhood circumstances to adult circumstances and adult health are set in this context. Four pathways are highlighted. They include the development of physical and emotional health and the development of health behaviours. But they also range across cognitive development and educational progress and investment in social identities such as becoming a parent in adolescence /early adulthood. The framework identifies these four dimensions as central to the link between childhood disadvantage and poor adult health.

  Figure 9 Childhood disadvantage and adult health: a life course approach



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

Recommendation

- Therefore, a mixture of universal and targeted programmes such as baby massage, the Solihull approach, the neo-natal behavioural assessment scale [NBAS] and the Family Partnership model) are primarily concerned with the promotion of infant mental health concentrating on the above four dimensions. Targeted programmes should be provided to families at risk of poor outcomes due to a range of social dysfunction or psychological pressures.
- Children centres have a key role to provide a location around which the Health Child Programme can be managed and delivered on a multi-disciplinary and multi-agency basis. This means that children's centres must accommodate universal programmes as defined by health as well as more discretionary family support-based services that are a concern of children's social services.

7.3.2 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 has remained stable.
- Nine out of 10 women who stop before week six are reported as saying that they wished to have breast fed for longer. The fastest drop-off in 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.

	NHS Eastern and Coastal Kent	NHS West Kent	Kent County
Number of maternities	8,546	8,231	16,777
Number known to be breast feeding	6,040	5,922	11,962
% breast feeding	70.7%	71.9%	71.3%
Number known to be not breast feeding	2,489	2,133	4,622
% not breast feeding	29.1%	25.9%	27.5%
Breast feeding status unknown	17	176	193
% unknown	0.2%	2.1%	1.2%

Health Area	Number of infants due for 6-8 week check	Children being breastfed at 6-8 weeks	Children not being breastfed at 6-8 weeks	Children receiving both breast milk and infant formula	Children whose breast feeding status is unknown	Prevalence: % of children being breastfed	Coverage: % of children with a breast feeding status recorded
NHS West Kent	8,489	2,429	3,885	1,194	981	42.7%	88.4%
NHS Eastern and Coastal Kent	9,261	2,108	3,899	778	2,476	31.2%	73.3%
Kent County	**17,750**	**4,537**	**7,784**	**1,972**	**3,457**	**36.7%**	**80.5%**

<u>Recommendation</u>

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.

7.3.3 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 (World Health Organisation) as being necessary to prevent an outbreak requiring further public campaigns to bolster the uptake rates.

2,255 children are unprotected from measles mumps or rubella[1]. GP and Health Visitors in one to one meetings with families can encourage the uptake of MMR

- 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.
-

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

Uptake of MMR vaccination

		MMR (24 months)	MMR1 (by 5th birthday)	MMR2 (by 5th birthday)
April 2010 - June 2010	NHS Eastern and Coastal Kent	85.2	92.6	84.6
	NHS West Kent	88.3	89.5	81
	South East Coast	86.3	89.4	79.8
	England	88.3	91.4	83.3
July 2010 - September 2010	NHS Eastern and Coastal Kent	89.6	93.8	86.2
	NHS West Kent	91	90.7	81.9
	South East Coast	87.4	88.8	79.2
	England	88.3	91.6	83.7
October 2010 - December 2010	NHS Eastern and Coastal Kent	85.6	93.1	83.5
	NHS West Kent	94	92.4	87.8
	South East Coast	87.3	89	80
	England	88.9	92.2	84
January 2011 - March 2011	NHS Eastern and Coastal Kent	89.1	91.9	84.8
	NHS West Kent	95.1	91.9	87.7
	South East Coast	89	89.4	81
	England	89.5	92.2	84.5

Source: www.hpa.org.uk - COVER Data 2011

Key	
Zero	Less than 80
80 or more but less than 90	90 or more but less than 95
95 or more	

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, starting with those most vulnerable populations.
- Increase the uptake of HPV vaccination for all three doses, through developing a targeted approach for those populations where uptake is lowest to reduce variation across Kent.

- Develop a local enhanced service [LES] to improve uptake of influenza vaccination including workforce within primary and community care and all professionals who come in direct contact with patients and clients.
- Increase uptake of influenza vaccination through the use of healthy living pharmacies.
- Ensure that Hepatitis B vaccination is offered to all at risk mothers

'Don't Hesitate, Vaccinate' – was a successful social marketing campaign in West Kent which contributed to the increase in MMR uptake (by Year 2) from 77% in April-Jun 2010 to 95% in Jan-Mar 2011

7.3.4 Children's Centres

- The results from the later evaluations of the National Sure Start Programme (NESS) have shown that this programme produces positive results. However the programme needs to be sustained for a 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.
- The Healthy Child Programme, especially the 0-5 years, are grounded on the Marmot principles of progressive universalisms. All agencies should target their approach focusing on the family as a whole rather than a child's behaviour. Services should be commissioned to recognise home visiting as a key intervention to address inter-generational improvements in parenting, child behaviour and cognitive development. The use of the third sector and specifically the commissioning of HomeStart programmes should be maintained throughout Kent.
- Agencies in Kent should maintain their commitment to children's centres and the differential funding to first wave Sure Start children's centres on the basis that these have been set up as targeted resources

in areas across the County identified as being in greatest need. This is the proper application of the principles of equity.

- The role of the health visitor is central to the delivery of the Healthy Child
- Programme. Health visitors have a critical role in leading the practise of the Healthy Child Programme. Accordingly they should be based in children's centres whilst maintaining clear and unambiguous links to local primary care services. Health visitor practise should therefore give equal commitment to prevention and promotion of population health for children and their families, as well as to safeguarding.
- There is a national programme to increase substantially the number of practising health visitors and a Kent and Medway working party is co-ordinating the local implementation of this, ensuring that full quotas of newly recruited and trained health visitors meet specified staffing level targets by 2015.

<u>Recommendation</u>

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 This contradicts the bullet point above .

7.3.5 Parenting

- The relationship between infants and parents or primary care givers 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 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.

7.3.6 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 for children should be commissioned based on national and international evidence such as programmes to assist changes in child and family behaviour and social marketing techniques promoting healthy lifestyles. There also needs to be systematic collection of local data.

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

- A focus in early years and school settings that fosters a healthy environment, including the provision of active help for children at risk of becoming overweight;
- Support programmes to assist changes in child and family behaviour towards maintaining a healthy weight;
- The appraisal of the potential of social marketing techniques to communicate simple and positive messages about healthy lifestyles;
- 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.

7.3.7 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.

7.3.8 Children in care

- Kent continues to have a higher proportion of looked after children who are aged 16 and over than the national figure but a smaller proportion of looked after children aged under 10 years old.
- 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. 'An unannounced follow-up visit by OFSTED in late 2011 reported significant improvement notwithstanding that the fundamental challenges outlined in their original inspection remain'.

All agencies 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.

7.3.9 Domestic Abuse

- On average, two women a week are killed by a male partner or former partner in the UK (Povey, 2005); this constitutes around one-third of all

female homicide victims. On average there are five domestic homicides a year in Kent & Medway.

- The Violence against Women and Girls 'Ready Reckoner' (Home Office) estimates that out of a population of 1,411,100 in Kent, numbers of women likely to have been affected in the past year are as follows:
    - 45,861 women and girls aged 16-59 have been a victim of domestic abuse
    - 23,283 women and girls aged 16-59 have been a victim of sexual assault
    - 56,867 women and girls aged 16-59 have been a victim of stalking
- There were 17,551 reported incidents of domestic abuse in Kent in 2009/10. Approximately 22% of these were repeat incidents.
- Overall, in Kent rates of repeat victimisation are increasing.
- Services commissioned across partner organisations include:

    1. Multi-Agency Risk Assessment Conferences (MARACs) for victims and families assessed at highest risk of future serious abuse / danger.

    2. Independent Domestic Violence Advisors (IDVAs). There are 16 IDVAs (w.t.e) currently working across Kent. They are employed by a number of organisations, and supported by many different sources of funding. There are no standard job descriptions or conditions of service, although most Kent Job Descriptions derive from the *Co-ordinated Action against Domestic Abuse* (CAADA) framework for IDVA services[2]. There is no common agreed outcome framework currently applied across Kent. Two of these posts support the two Kent Specialist Domestic Violence courts. A third court opens in Medway in July 2011, and funding has been secured from the Home Office for an IDVA to support the work of this court.

    3. Community Perpetrator programmes Programmes are currently available across Kent for men who refer themselves and are assessed as suitable for the programme. These courses are funded from a variety of sources. There is also a Women's Safety Worker Service

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

and a Children's Safety Worker attached to the community programme service.

4. Other local support services and projects (often small scale) are delivered by non-governmental organisations, supported by funding sources too numerous to list. Some local services receive part of their funding from the local authorities or PCTs in Kent, but this is a very small proportion of the whole. Most of these projects are greatly valued by the local community: but the detail of outcomes is rarely comprehensively and independently evaluated.

5. Refuges are principally funded by *Supporting People*.

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.

Rates of reported domestic abuse (including domestic violence) continue to rise across Kent. Although some of this may be ascribed to improve reporting, it is likely that incidence is indeed increasing, and current services are inadequate. Evidence suggests that family violence increases in times of economic hardship, and it is likely that, over the next 3-5 years, more services will be needed to support victims. Even more concern relates to the rising rate of repeat victimisation. This suggests that victims require more pro-active support than is currently available.

<u>Recommendations</u>

- Commissioners should require NHS staff to be trained in Safe Enquiry (understanding of issues relating to domestic abuse and domestic violence). NHS staff should also know how to refer patients to the relevant local domestic abuse services)

- Co-commission one single Point of Contact service for Domestic Violence victims in Kent
- The sustainable maintenance of IDVA's across the county, located according to need
- Safe Enquiry should be part of an overall approach encompassing multi-agency training for all frontline staff to raise their awareness of domestic violence, possibly by expanding the screening role of alcohol and other specialist workers, to enable them to ask about domestic violence safely and link enquiry with a pathway for safe discharge. Ideally this should be underpinned by support for them from specialist domestic violence practitioners in the community.
- Further needs assessments are required:
    - Assessment of outcomes of DV support services in a consistent framework: and development of local measures of success
    - Exploration of volume of local needs in BME groups –travellers (in particular Roma) and new communities (principally Eastern European). In the longer-term (following release of 2011 census data) a general health needs assessment for these BME communities in Kent should be undertaken, in partnership with KCC.
- Undertake robust evaluation of perpetrator programmes run in Kent and Medway to establish effectiveness in reducing violent assaults over a number of years
- There is a need to protect access to front line domestic abuse services. 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.

7.3.10 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 then 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.

<u>Recommendation</u>

- 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

7.3.11 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 one 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.

Whiles 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.

7.4 Adults

7.4.1 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. East Kent has a prevalence rate which is consistently 1% higher than West Kent. Swale, Thanet, Shepway and Dover appear to have relatively higher mortality rates compared to the other districts in Kent. This will have profound effects on access and demand for cardiac services for surgical treatment, revascularisation and rehabilitation. Some of the key recommendations include:
    - Ensure monitoring of CVD prevalence at practice level such as validation of Atrial Fibrillation registers
    - Prioritise health improvement programmes including rollout of health checks as well as evidence based social marketing techniques.
    - Service and care pathway development focusing on latest NICE Guidance on Personalised Care Plans, developing Heart Failure registers, integrated community teams, identify patients in acute trusts, tele-technology and improved access to End of life care.
- Stroke - In Kent & Medway 25,889 people were recorded as having a Stroke or TIA. This is a prevalence of 1.7% across Kent and Medway. The lowest prevalence of stroke was seen in Medway with just 1.3% of the population appearing on a stroke register. West Kent has a prevalence of 1.7% and East Kent 1.8%, in 2009/10. The national prevalence from the

quality and outcomes framework (QOF) is 1.7%. The following actions are required to improve the care of people following a stroke:

  - Early Supported Discharge Teams to cover the whole of Kent.
  - Educate GPs as to the importance of correct anti-coagulation in patients with AF.
  - Encourage Stroke Champions / Peer support schemes for people who have had a stroke.
  - Translation of FAST materials to culturally appropriate formats.
  - Increase awareness of stroke and the services available with Black and Minority Ethnic groups, in particular South Asian and African-Caribbean groups.

- 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. Greater emphasis on obesity prevention is essential for prevention of Type 2 diabetes. This entails improving service integration of the Kent Healthy Weight Care Pathway for Adults and Children right through to specialist diabetes services. This should be a priority for CCGs and District Authorities as prevention targeting those at highest risk will enable savings on treatment which can be invested elsewhere.
- 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.

Feedback from the Strategic Health Authority and the Department of Health Long Term Condition review team recognised improvement in the Kent and Medway QIPP programme, recommending additional improvements:

- greater combination and adoption of existing risk stratification models
- greater unification of local approaches and adoption of integrated working practices
- urgent development processes to evaluate the success levels of projects, to enable the rapid spread and take up of the most successful initiatives
- adoption of the findings from the SEC Personalised Care Planning pilot, combined with the Personal Health Budget programme
- capitalising on the supported self management progress and learning gained from implementing telehealth/telecare as a part the large scale national trial (Whole Systems Demonstrator)
- working with the SEC wide LTC commissioning development programme, co- designed by clinicians and linked with SEC Enhancing Quality principles.

Risk stratification – key points

Predictive risk models are used for predicting events such as unplanned hospital admissions, which are undesirable, costly and potentially preventable.

Such models have been shown to be superior to other 'case finding' approaches, including threshold models and clinical opinion. Although the Department of Health has previously funded two predictive models for the NHS in England, the current policy is to promote an open market in terms of suppliers of risk tools.

Commissioners should consider a range of factors when choosing whether to 'make or buy' a predictive model, including the outcome to be predicted, the accuracy of the predictions made, the cost of the model and its software, and the availability of the data on which the model is run.

Predictive models should be seen as one component of a wider strategy for managing patients with chronic illness.

Although there are opportunities here for improving the health status of patients with complex needs while making net savings for the NHS, the evidence for hospital-avoidance interventions is patchy and therefore robust evaluations should be built into any proposed local strategies.
In the future, it is unclear whether predictive risk models in England should best be procured or built at a local, regional or national level.

Nuffiield Trust

7.4.2 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 samples (depending upon the cytology result) for the virus that caused almost all cervical cancer, Human Papilloma Virus (HPV). This will improve further the accuracy and efficiency of the screening programme.

<u>Recommendation</u>

Reorganisation and safety

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

Programme development, higher national standards increased expectations.

- All programmes are developing and revised standards appear for programmes on a frequent basis. There is also an expectation to provide more thorough governance and assurance following recent serious incidents (elsewhere). Coordination and leadership of these require appropriate resourcing.

7.4.3 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.
- Dementia related emergency admissions have increased by almost 85% from 3497 to 6466 admissions over the last 5 years.
- Shepway, Sevenoaks, Tunbridge Wells, Tonbridge and Swale are district authorities with greater growth of dementia patients.
- One third of patients live in care homes as well as high risk groups such as learning disabilities and ethnic minorities.
- The QIPP work plan has outlined a number of initiatives which allow better partnership working and service integration such as crisis resolution, domiciliary care, advocacy, awareness raising, specialist memory assessment, integrated case management, etc.

<u>Recommendation</u>

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.

7.4.3 Falls and Fractures in the elderly

- The Department of Health states 'Preventing older people from falling is a key challenge for the NHS and local authorities. It is not the preserve of one agency as the consequences of a fall and resultant fragility fracture cut across all local agencies working with older people. All local organisations working with older people, including statutory and voluntary service providers, are a part of the solution and must be supported to understand their contribution to reducing the number of falls locally.'
- In Kent, there has been a 53% increase in falls related hospital admissions in West Kent compared to 30% in East Kent over the last 5 years. Almost 65% of these admissions resulted in no fracture and or injury. The cause of the fall is more often an interaction of a variety of medical and social reasons such as UTIs, dementia, pneumonia as well as poor housing conditions and lack of equipment and adaptations or carer support.
- The number of falls admissions is listed as one of the highest (if not the highest) ACS (Ambulatory Care Sensitive) conditions within urgent care.
- The 2010 national falls and bone health audit showed considerable variation in access and availability of minimum standards of care across the community and acute Trusts in Kent, particularly secondary falls prevention and bone health assessment including home hazard

assessment. However it may be noted that ECKHT performs relatively better than MTW and DVH on some of the indicators including the above mentioned.

Recommendations

Taking into account of the local context, the Department of Health guidance suggests an integrated approach largely towards secondary prevention of falls and fractures involving:

- **Acute care fracture liaison service**s based in Acute Care trusts, identifying and assessing elderly patients admitted for hip or fragility fractures for future risk of repeat fractures, followed by regular osteoporosis treatment.
- **Primary care-based fracture liaison service** - mainly concerns pro-active case finding by General Practice for patients with past history of falls and fractures who have not yet been properly assessed.
- **Reconfiguring community-based falls clinics** to be jointly carried out by ortho geriatricians and community health teams. Services both in community and acute trusts are inadequate and poorly integrated to meet the growing number of elderly falling and being treated in hospital, so more efficient methods as well as expansion of current nursing and therapy capacity is urgently needed.
- **Non NHS based prescribed community therapeutic / postural stability exercise programmes**. Additional funding is required to build on existing programmes run by district authorities and / or voluntary organisations and concentrate on substantive referrals from health and social care professionals, particularly community health teams.
- **Targeting non conveyed fallers.** Taking into account best practice from other counties, South East Coast Ambulance Service (SECAMB) should work more closely with other health and social care professionals (either through existing integrated pathways or joined up services) in ensuring that elderly fallers who are not conveyed to hospital are properly screened

for risk of falls and referred onward for specialist assessment and management.

7.4.5 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.

<u>Recommendation</u>

- 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.

7.4.6 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.

7.4.7 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.
- implementation of .a community sexual health model will be reviewed in 2013
- Late diagnosis of HIV appears to be a problem particularly for West Kent with 55%, compared to approximately 20% in East Kent.
- A research project looking into reasons for late diagnosis of HIV is being

developed in conjunction with the Health and Europe Centre.

- Projections estimate a 23% and 28% increase in first attendances for GUM clinics for East and West Kent respectively.

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 in high incidence areas in Kent.

Ensure that as part of the Healthy living pharmacies programme, there is a requirement to promote good sexual health and to deliver Chlamydia screening, Emergency Hormone Contraception (EHC) and the prescribing or oral contraception.

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

7.4.8 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

7.4.9 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.

<u>Recommendation</u>

- 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.

7.5 Other important QIPP work streams

7.5.1 Urgent care

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

7.5.2 End of Life Care

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

The development of EOLC registers, and supporting GPs in identification of their “1%”, i.e. the 1% of patients who are likely to die in the next 12 months

7.5.3 Maternity and Babies

The population of women of a childbearing age is projected to increase in the Dartford and Gravesham Local Authority areas (~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.

7.5.4 Planned Care

First appointment follow up ratios for outpatient activity are consistently higher in cancer specialties like oncology and haematology. Total elective care activity in 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.

7.6 Social factors and population groups

7.6.1 Housing and homelessness

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

7.6.2 Carers

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

7.6.3 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.

7.6.4 Veterans

- Local modelling suggests there are approximately **130,000 veterans** in Kent and Medway, with the highest density in Thanet, Dover, Shepway, Swale and Medway.
- The armed forces recruit heavily from deprived communities, veterans are known to have lower than average household incomes, and in Kent and Medway the areas with the highest prevalence of veterans are also some of the most deprived

- The focus for Kent and Medway is recent veterans, particularly those deployed to Iraq and Afghanistan. This is the group with the most *distinctive needs*, and where interventions and alterations to services are most likely to have a beneficial impact on long-term health outcomes
- A typical UK recruit is a relatively poor, white teenager with limited education and work prospects, recruited from a difficult home environment into the Army infantry. An estimated 86% of UK veterans are male, 94% are white, and only 9% of recruits have a GCSE grade A* to C in English (compared with a 61% national average). For these young men, military service can be a very positive intervention.
- Although the rate common mental illness (depression and anxiety) are not higher then 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.

<u>Recommendation</u>

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

7.6.5 Heath, Wellbeing and Sustainability

- Sustainability[3] is defined as "meeting the needs of today without compromising the ability of others to meet their needs tomorrow". In Kent sustainability is not just an environmental issue but Health and Social care

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

services acknowledge links with pressure on resources which in turn is linked with poverty, unemployment and social exclusion. These pressures on resources directly impact on the health and well being of local communities leading.

Recommendation

- To further enhance local cross sector partnerships and develop joint action plans for strategies such as Health Inequalities, Housing for Vulnerable population etc.
- To embed sustainability in everyday business by developing sustainability impact assessments for all policies.
- To make sustainability assessments as an integral theme for all commissioning intentions.
- To link sustainability plans to the delivery of QIPP agenda.
- To adopt Health Impact Assessments an integral part of the planning process using sustainability as the guiding principle.
- To embed a sustainable approach into all aspects of care pathway development and procurement of new services.

7. Ashford Clinical Commissioning Group (ACCG)

8.1 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.

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.

- 122,599[4] 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[5] 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.

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 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.

[4] PCIS registered practices populations September 2011
[5] ONS 2008-Based population projections 2011-2016, 2011-2021

- The highest levels of deprivation are found within Stanhope, Aylesford Green and Victoria, in an around Ashford town centre.

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.

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%)

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 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 that 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.

8. C4 Canterbury and Whitstable CCG

9.1 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.

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.

- 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[6] 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.

[6] ONS 2008-Based population projections 2011-2016, 2011-2021

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 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 supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Gorrell, Heron and Wincheap.

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.

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%)

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 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 that England (smoking 14% Breastfeeding 73.6%)

9.6 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 Costal 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

9. Dartford, Gravesham and Swanley CCG

10.1 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).

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.

- 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).

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.

- 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 supper 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).

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 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%)

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 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%.

10.6 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 in more ethnically diverse that 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.

10. Maidstone and Malling CCG

11.1 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.

11.2 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[7] 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]

[7] ONS 2008-Based population projections 2011-2016, 2011-2021

and the ward with the highest life expectancy [Downswood and Otham 84.2 years]

11.3 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 supper output areas are in the 20% most deprived for England,

11.4 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 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%)

11.5 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.

11.6 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).

11. Swale CCG

12.1 Demographics

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

12.2 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 in the 40-49 age group.
- Using data for Swale District, the population is projected to increase by 4% over the next 5 years[8] 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.

12.3 Deprivation

[8] ONS 2008-Based population projections 2011-2016, 2011-2021

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 supper 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.

12.4 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 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%)

12.5 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 that England (smoking 14% Breastfeeding 73.6%)
- Teenage conception rate for Swale (46.7) is significantly higher than England (40.2)

12.6 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).

12. South Kent Coast CCG

13.1 Demographics

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

13.2 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[9] 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.

13.3 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.

[9] ONS 2008-Based population projections 2011-2016, 2011-2021

- 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 supper 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)

13.4 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 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%)

13.5 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 that England (smoking 14% Breastfeeding 73.6%)

13.6 Health Issues

Prevalence

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

Morbidity

Emergency 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).

13. Thanet and East Cliff CCG

14.1 Demographics

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

14.2 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[10] 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]

14.3 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.

[10] ONS 2008-Based population projections 2011-2016, 2011-2021

- 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 supper output areas are in the 20% most deprived for England,
- The highest levels of deprivation are found within Margate Central, Clifftonville West and East Cliffe.

14.4 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 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 that England (smoking 14% Breastfeeding 73.6%)

14.6 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)

14. West Kent and Weald CCG

15.1 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.

15.2 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 is 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]

15.3 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 supper output areas are in the 20% most deprived for England, 1.4% of Sevenoaks and 6.5% of Maidstone lower layer super output areas are in the 20% most deprived for England.

15.4 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%

15.5 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%)

15.6 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

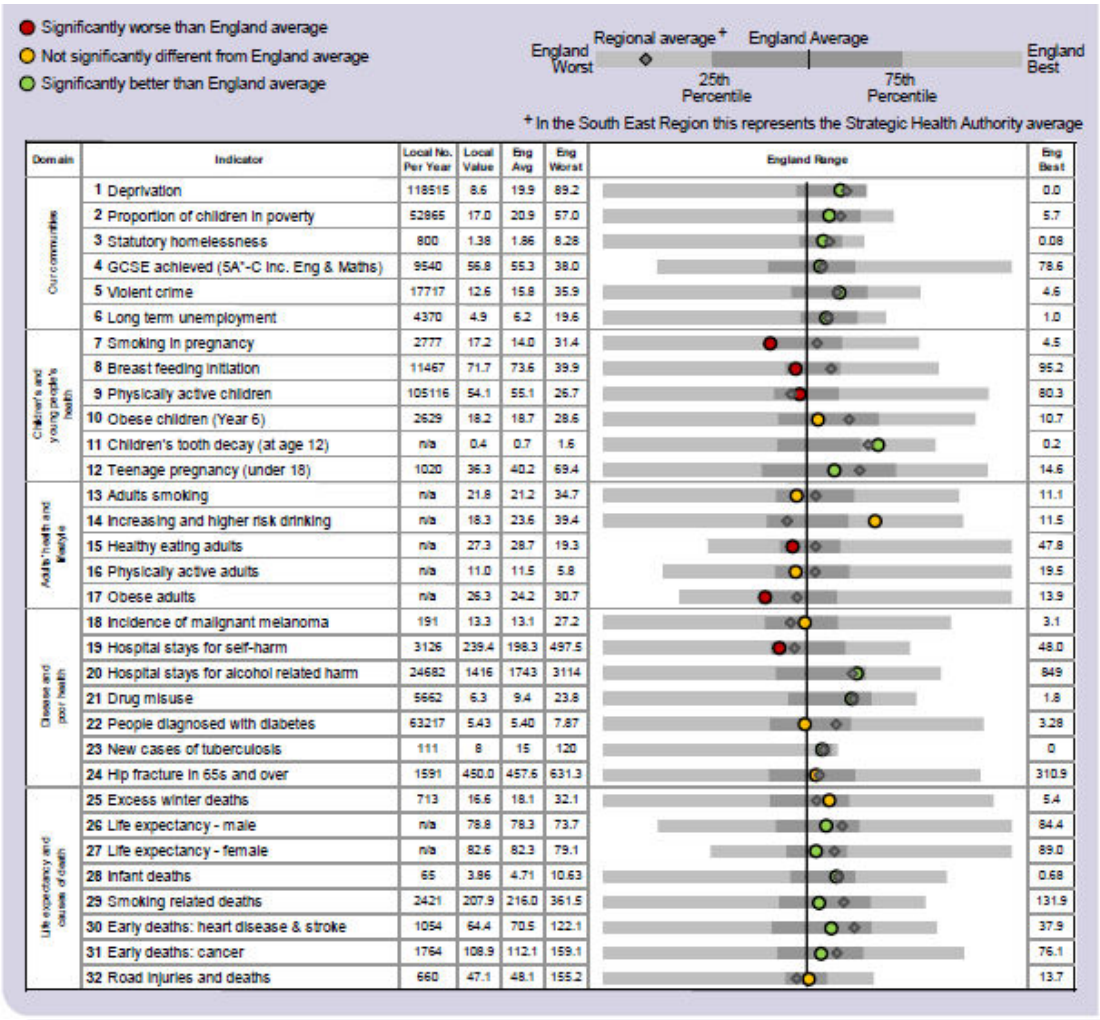
- WKW has an emergency admission rate higher than Kent and Medway for Cancer, and the trend continues to decline.
- Emergency admission rates are increasing for Dementia, COPD and CHD.
- Stroke and Diabetes emergency admission rates are reducing.

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).

16 Appendix B – Health Profiles 2011

Kent County Council



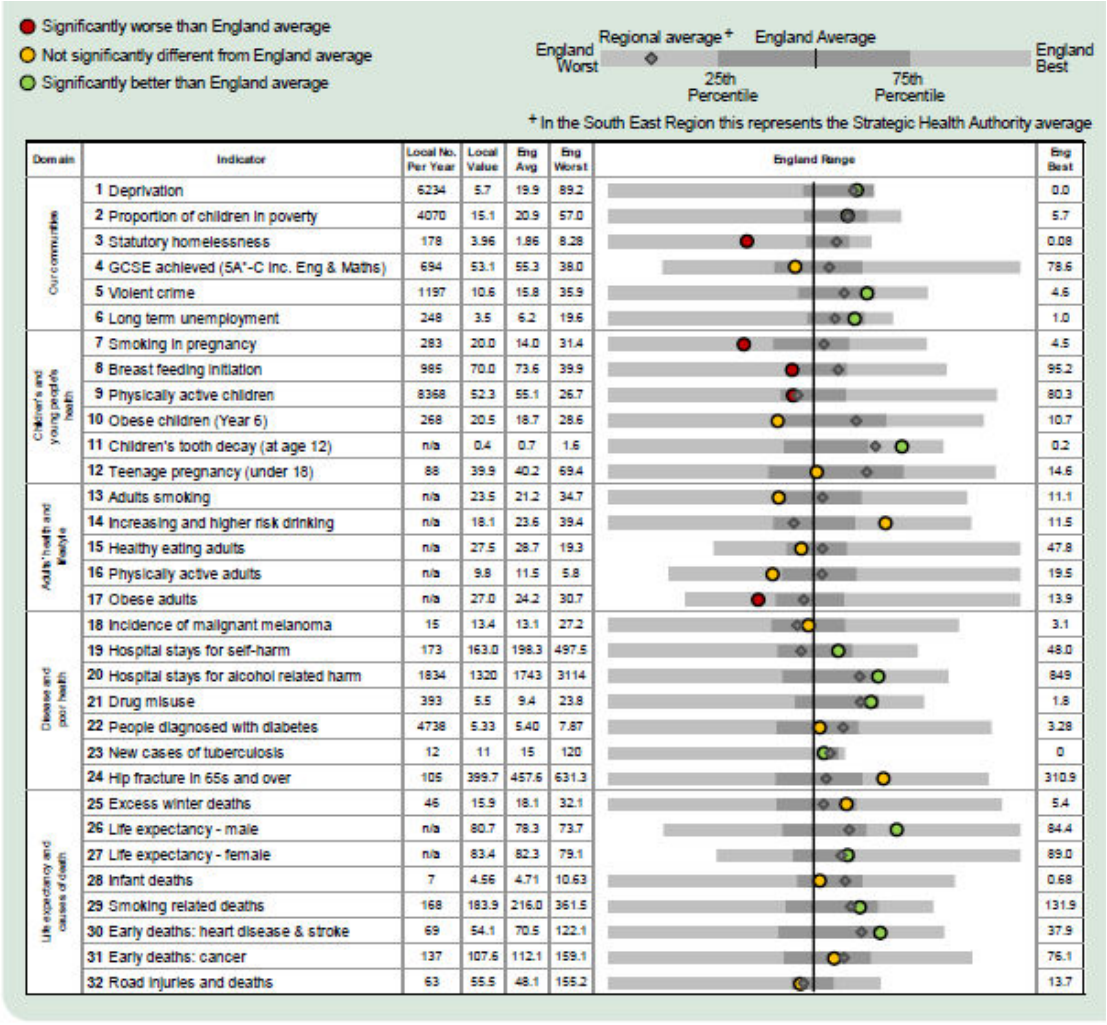
Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	118515	8.6	19.9	89.2		0.0
	2	Proportion of children in poverty	52865	17.0	20.9	57.0		5.7
	3	Statutory homelessness	800	1.38	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	9540	56.8	55.3	38.0		78.6
	5	Violent crime	17717	12.6	15.8	35.9		4.6
	6	Long term unemployment	4370	4.9	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	2777	17.2	14.0	31.4		4.5
	8	Breast feeding initiation	11467	71.7	73.6	39.9		95.2
	9	Physically active children	105116	54.1	55.1	26.7		80.3
	10	Obese children (Year 6)	2629	18.2	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	1020	36.3	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	21.8	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	18.3	23.6	39.4		11.5
	15	Healthy eating adults	n/a	27.3	28.7	19.3		47.8
	16	Physically active adults	n/a	11.0	11.5	5.8		19.5
	17	Obese adults	n/a	26.3	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	191	13.3	13.1	27.2		3.1
	19	Hospital stays for self-harm	3126	239.4	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	24682	1416	1743	3114		849
	21	Drug misuse	5662	6.3	9.4	23.8		1.8
	22	People diagnosed with diabetes	63217	5.43	5.40	7.87		3.28
	23	New cases of tuberculosis	111	8	15	120		0
	24	Hip fracture in 65s and over	1591	450.0	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	713	16.6	18.1	32.1		5.4
	26	Life expectancy - male	n/a	78.8	78.3	73.7		84.4
	27	Life expectancy - female	n/a	82.6	82.3	79.1		89.0
	28	Infant deaths	65	3.86	4.71	10.63		0.68
	29	Smoking related deaths	2421	207.9	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	1054	64.4	70.5	122.1		37.9
	31	Early deaths: cancer	1764	108.9	112.1	159.1		76.1
	32	Road injuries and deaths	660	47.1	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

Ashford



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	6234	5.7	19.9	89.2		0.0
	2	Proportion of children in poverty	4070	15.1	20.9	57.0		5.7
	3	Statutory homelessness	178	3.96	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	694	53.1	55.3	38.0		78.6
	5	Violent crime	1197	10.6	15.8	35.9		4.6
	6	Long term unemployment	248	3.5	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	283	20.0	14.0	31.4		4.5
	8	Breast feeding initiation	985	70.0	73.6	39.9		95.2
	9	Physically active children	8368	52.3	55.1	26.7		80.3
	10	Obese children (Year 6)	268	20.5	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	88	39.9	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	23.5	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	18.1	23.6	39.4		11.5
	15	Healthy eating adults	n/a	27.5	28.7	19.3		47.8
	16	Physically active adults	n/a	9.8	11.5	5.8		19.5
	17	Obese adults	n/a	27.0	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	15	13.4	13.1	27.2		3.1
	19	Hospital stays for self-harm	173	163.0	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	1834	1320	1743	3114		849
	21	Drug misuse	393	5.5	9.4	23.8		1.8
	22	People diagnosed with diabetes	4738	5.33	5.40	7.87		3.28
	23	New cases of tuberculosis	12	11	15	120		0
	24	Hip fracture in 65s and over	105	399.7	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	46	15.9	18.1	32.1		5.4
	26	Life expectancy - male	n/a	80.7	78.3	73.7		84.4
	27	Life expectancy - female	n/a	83.4	82.3	79.1		89.0
	28	Infant deaths	7	4.56	4.71	10.63		0.68
	29	Smoking related deaths	168	183.9	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	69	54.1	70.5	122.1		37.9
	31	Early deaths: cancer	137	107.6	112.1	159.1		76.1
	32	Road injuries and deaths	63	55.5	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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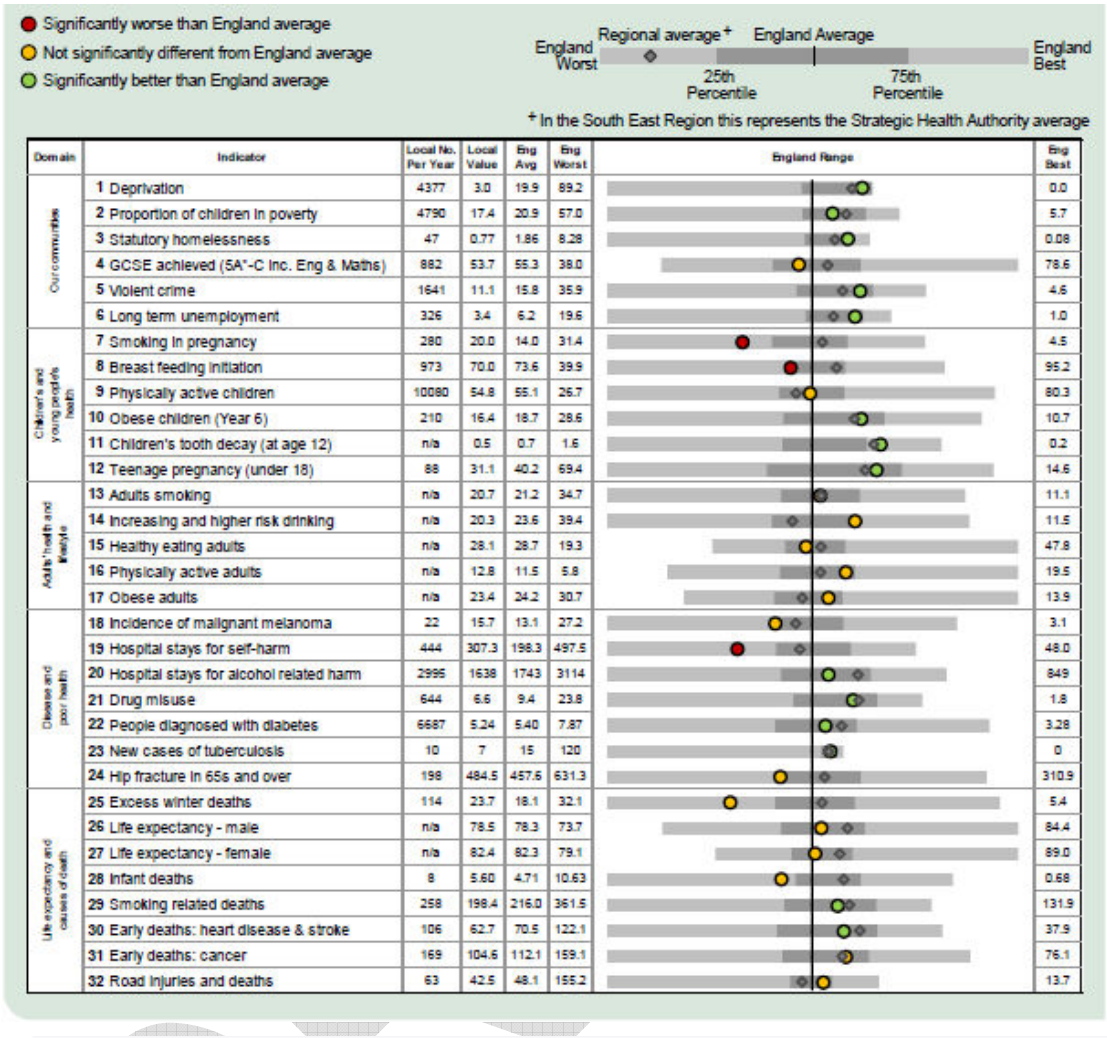
Canterbury



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	4377	3.0	19.9	89.2		0.0
	2	Proportion of children in poverty	4790	17.4	20.9	57.0		5.7
	3	Statutory homelessness	47	0.77	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	882	53.7	55.3	38.0		78.6
	5	Violent crime	1641	11.1	15.8	35.9		4.6
	6	Long term unemployment	326	3.4	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	280	20.0	14.0	31.4		4.5
	8	Breast feeding initiation	973	70.0	73.6	39.9		95.2
	9	Physically active children	10080	54.8	55.1	26.7		80.3
	10	Obese children (Year 6)	210	16.4	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	88	31.1	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	20.7	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	20.3	23.6	39.4		11.5
	15	Healthy eating adults	n/a	28.1	28.7	19.3		47.8
	16	Physically active adults	n/a	12.8	11.5	5.8		19.5
	17	Obese adults	n/a	23.4	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	22	15.7	13.1	27.2		3.1
	19	Hospital stays for self-harm	444	307.3	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	2995	1638	1743	3114		849
	21	Drug misuse	644	6.6	9.4	23.8		1.8
	22	People diagnosed with diabetes	6687	5.24	5.40	7.87		3.28
	23	New cases of tuberculosis	10	7	15	120		0
	24	Hip fracture in 65s and over	198	484.5	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	114	23.7	18.1	32.1		5.4
	26	Life expectancy - male	n/a	78.5	78.3	73.7		84.4
	27	Life expectancy - female	n/a	82.4	82.3	79.1		89.0
	28	Infant deaths	8	5.60	4.71	10.63		0.68
	29	Smoking related deaths	258	198.4	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	106	62.7	70.5	122.1		37.9
	31	Early deaths: cancer	169	104.6	112.1	159.1		76.1
	32	Road injuries and deaths	63	42.5	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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Dartford

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

England Worst — Regional average + — England Average — England Best

25th Percentile — 75th Percentile

+ In the South East Region this represents the Strategic Health Authority average

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	4608	5.2	19.9	89.2		0.0
	2	Proportion of children in poverty	3440	16.1	20.9	57.0		5.7
	3	Statutory homelessness	100	2.63	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	855	63.1	55.3	38.0		78.6
	5	Violent crime	1407	15.2	15.8	35.9		4.6
	6	Long term unemployment	388	6.3	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	180	14.2	14.0	31.4		4.5
	8	Breast feeding initiation	919	73.6	73.6	39.9		95.2
	9	Physically active children	9463	62.0	55.1	26.7		80.3
	10	Obese children (Year 6)	238	22.7	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.6	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	65	36.1	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	24.4	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	18.1	23.6	39.4		11.5
	15	Healthy eating adults	n/a	25.0	28.7	19.3		47.8
	16	Physically active adults	n/a	8.6	11.5	5.8		19.5
	17	Obese adults	n/a	28.2	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	9	10.7	13.1	27.2		3.1
	19	Hospital stays for self-harm	197	213.4	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	1380	1325	1743	3114		849
	21	Drug misuse	299	4.8	9.4	23.8		1.8
	22	People diagnosed with diabetes	4342	5.03	5.40	7.87		3.28
	23	New cases of tuberculosis	10	10	15	120		0
	24	Hip fracture in 65s and over	91	451.3	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	33	13.0	18.1	32.1		5.4
	26	Life expectancy - male	n/a	78.9	78.3	73.7		84.4
	27	Life expectancy - female	n/a	81.1	82.3	79.1		89.0
	28	Infant deaths	4	2.99	4.71	10.63		0.68
	29	Smoking related deaths	138	220.9	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	70	75.0	70.5	122.1		37.9
	31	Early deaths: cancer	101	111.6	112.1	159.1		76.1
	32	Road injuries and deaths	48	51.4	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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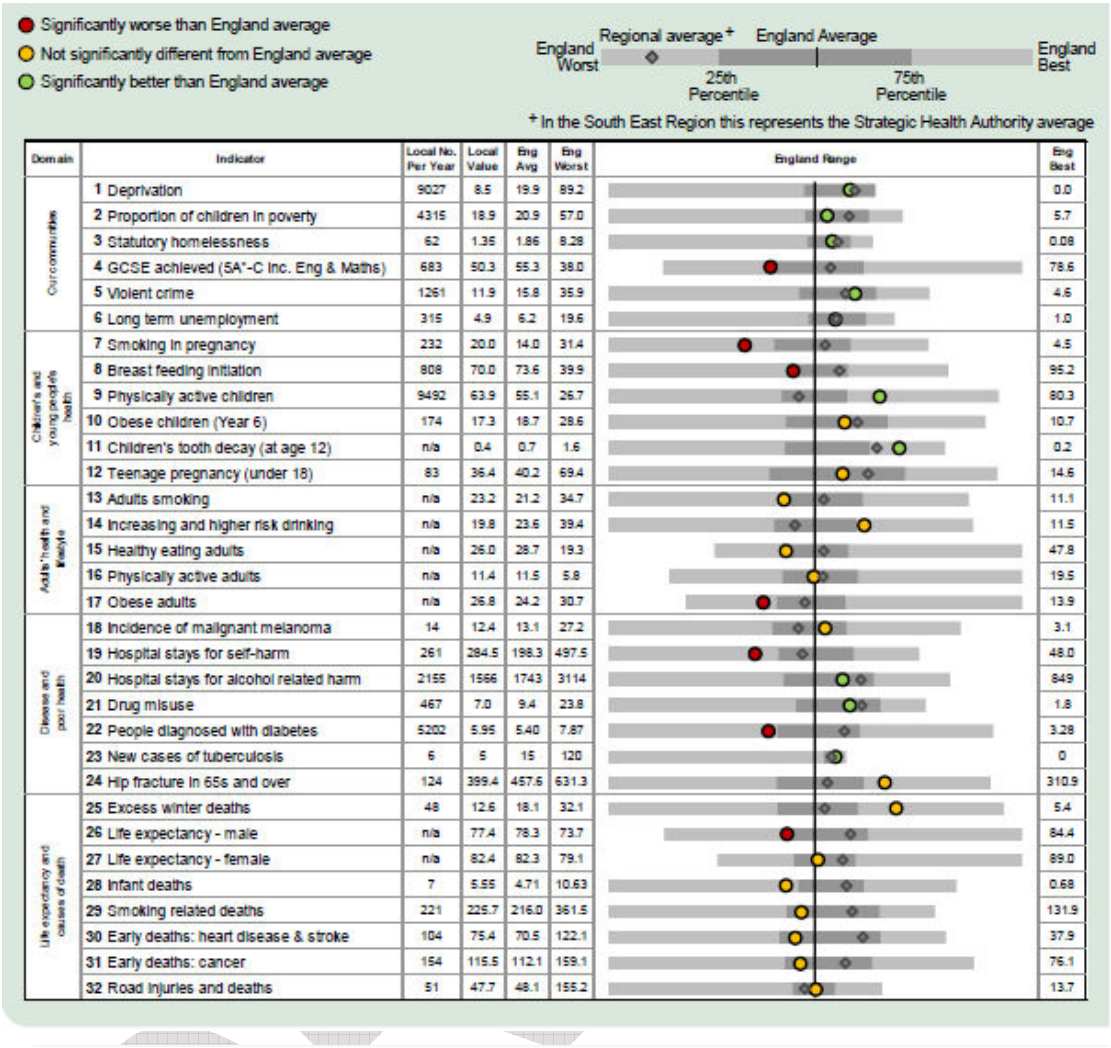
Dover



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	9027	8.5	19.9	89.2		0.0
	2	Proportion of children in poverty	4315	18.9	20.9	57.0		5.7
	3	Statutory homelessness	62	1.35	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	683	50.3	55.3	38.0		78.6
	5	Violent crime	1261	11.9	15.8	35.9		4.6
	6	Long term unemployment	315	4.9	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	232	20.0	14.0	31.4		4.5
	8	Breast feeding initiation	808	70.0	73.6	39.9		95.2
	9	Physically active children	9492	63.9	55.1	26.7		80.3
	10	Obese children (Year 6)	174	17.3	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	83	36.4	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	23.2	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	19.8	23.6	39.4		11.5
	15	Healthy eating adults	n/a	26.0	28.7	19.3		47.8
	16	Physically active adults	n/a	11.4	11.5	5.8		19.5
	17	Obese adults	n/a	26.8	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	14	12.4	13.1	27.2		3.1
	19	Hospital stays for self-harm	261	284.5	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	2155	1566	1743	3114		849
	21	Drug misuse	467	7.0	9.4	23.8		1.8
	22	People diagnosed with diabetes	5202	5.95	5.40	7.87		3.28
	23	New cases of tuberculosis	6	5	15	120		0
	24	Hip fracture in 65s and over	124	399.4	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	48	12.6	18.1	32.1		5.4
	26	Life expectancy - male	n/a	77.4	78.3	73.7		84.4
	27	Life expectancy - female	n/a	82.4	82.3	79.1		89.0
	28	Infant deaths	7	5.55	4.71	10.63		0.68
	29	Smoking related deaths	221	225.7	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	104	75.4	70.5	122.1		37.9
	31	Early deaths: cancer	154	115.5	112.1	159.1		76.1
	32	Road injuries and deaths	51	47.7	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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Gravesham

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

England Worst — Regional average + — England Average — England Best

25th Percentile — 75th Percentile

+ In the South East Region this represents the Strategic Health Authority average

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	14124	14.6	19.9	89.2		0.0
	2	Proportion of children in poverty	4335	19.2	20.9	57.0		5.7
	3	Statutory homelessness	73	1.83	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	735	54.2	55.3	38.0		78.6
	5	Violent crime	1625	16.5	15.8	35.9		4.6
	6	Long term unemployment	440	7.0	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	175	14.2	14.0	31.4		4.5
	8	Breast feeding initiation	893	73.6	73.6	39.9		95.2
	9	Physically active children	7069	47.1	55.1	26.7		80.3
	10	Obese children (Year 6)	216	19.9	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	78	38.1	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	18.8	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	17.1	23.6	39.4		11.5
	15	Healthy eating adults	n/a	25.5	28.7	19.3		47.8
	16	Physically active adults	n/a	10.4	11.5	5.8		19.5
	17	Obese adults	n/a	28.5	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	11	11.4	13.1	27.2		3.1
	19	Hospital stays for self-harm	184	194.3	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	1587	1371	1743	3114		849
	21	Drug misuse	429	6.7	9.4	23.8		1.8
	22	People diagnosed with diabetes	4602	5.50	5.40	7.87		3.28
	23	New cases of tuberculosis	16	17	15	120		0
	24	Hip fracture in 65s and over	109	530.0	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	28	9.7	18.1	32.1		5.4
	26	Life expectancy - male	n/a	78.4	78.3	73.7		84.4
	27	Life expectancy - female	n/a	82.4	82.3	79.1		89.0
	28	Infant deaths	3	2.57	4.71	10.63		0.68
	29	Smoking related deaths	155	211.3	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	64	58.4	70.5	122.1		37.9
	31	Early deaths: cancer	126	116.5	112.1	159.1		76.1
	32	Road injuries and deaths	29	29.8	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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Maidstone

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

England Worst | Regional average + | England Average | England Best

25th Percentile | 75th Percentile

+ In the South East Region this represents the Strategic Health Authority average

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	6267	4.4	19.9	89.2		0.0
	2	Proportion of children in poverty	4455	13.9	20.9	57.0		5.7
	3	Statutory homelessness	7	0.12	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1244	65.1	55.3	38.0		78.6
	5	Violent crime	1898	12.9	15.8	35.9		4.6
	6	Long term unemployment	322	3.4	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	238	14.2	14.0	31.4		4.5
	8	Breast feeding initiation	1214	73.6	73.6	39.9		95.2
	9	Physically active children	9631	46.2	55.1	26.7		80.3
	10	Obese children (Year 6)	256	17.3	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	93	35.7	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	18.6	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	18.8	23.6	39.4		11.5
	15	Healthy eating adults	n/a	28.5	28.7	19.3		47.8
	16	Physically active adults	n/a	10.7	11.5	5.8		19.5
	17	Obese adults	n/a	26.3	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	25	17.0	13.1	27.2		3.1
	19	Hospital stays for self-harm	312	226.2	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	2229	1211	1743	3114		849
	21	Drug misuse	533	5.5	9.4	23.8		1.8
	22	People diagnosed with diabetes	6024	4.91	5.40	7.87		3.28
	23	New cases of tuberculosis	13	9	15	120		0
	24	Hip fracture in 65s and over	148	421.0	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	53	12.7	18.1	32.1		5.4
	26	Life expectancy - male	n/a	79.0	78.3	73.7		84.4
	27	Life expectancy - female	n/a	82.7	82.3	79.1		89.0
	28	Infant deaths	7	3.92	4.71	10.63		0.68
	29	Smoking related deaths	229	195.7	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	103	61.0	70.5	122.1		37.9
	31	Early deaths: cancer	187	110.6	112.1	159.1		76.1
	32	Road injuries and deaths	83	56.8	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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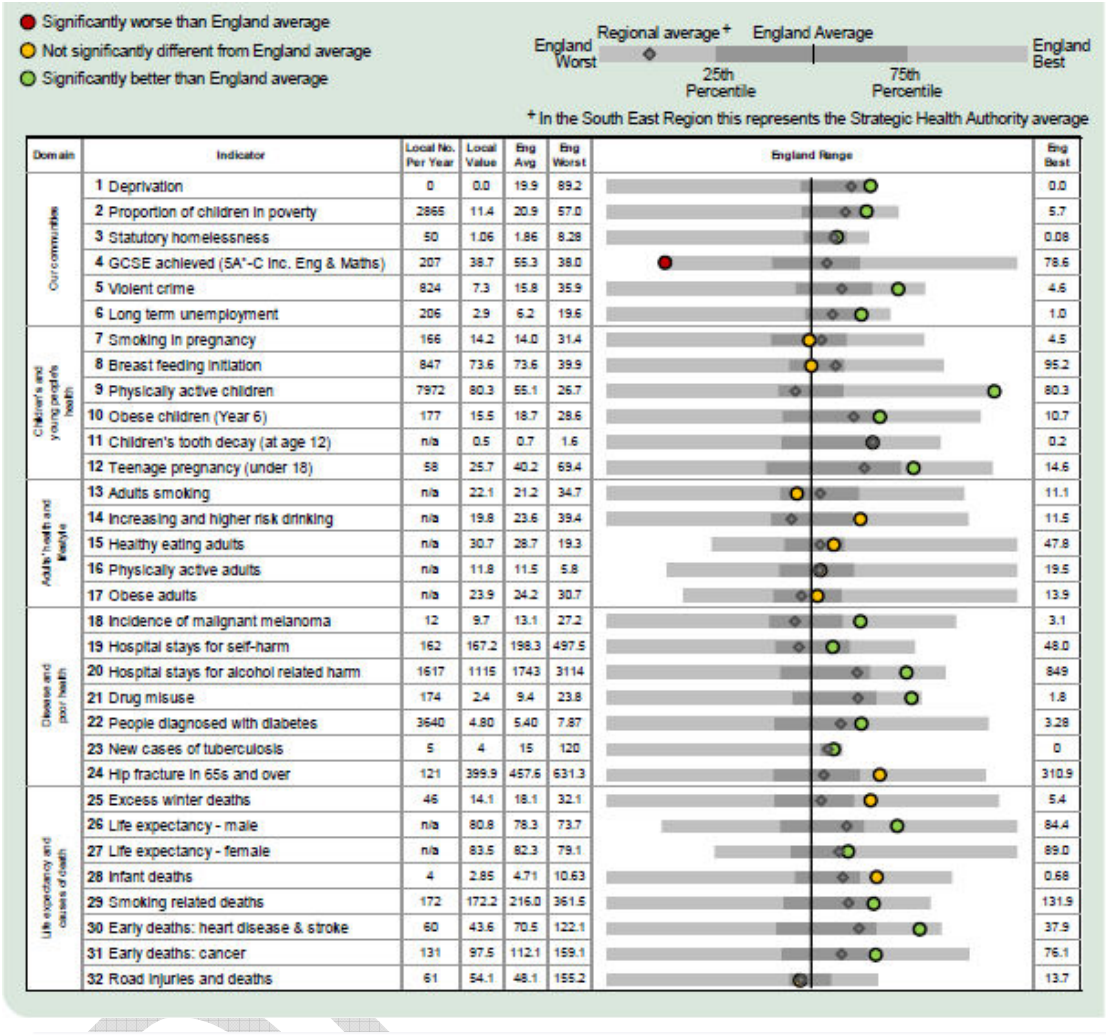
Maidstone



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Proportion of children in poverty	2865	11.4	20.9	57.0		5.7
	3 Statutory homelessness	50	1.06	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	207	38.7	55.3	38.0		78.6
	5 Violent crime	824	7.3	15.8	35.9		4.6
	6 Long term unemployment	206	2.9	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	166	14.2	14.0	31.4		4.5
	8 Breast feeding initiation	847	73.6	73.6	39.9		95.2
	9 Physically active children	7972	80.3	55.1	26.7		80.3
	10 Obese children (Year 6)	177	15.5	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	58	25.7	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	22.1	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	19.8	23.6	39.4		11.5
	15 Healthy eating adults	n/a	30.7	28.7	19.3		47.8
	16 Physically active adults	n/a	11.8	11.5	5.8		19.5
	17 Obese adults	n/a	23.9	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	12	9.7	13.1	27.2		3.1
	19 Hospital stays for self-harm	162	167.2	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	1617	1115	1743	3114		849
	21 Drug misuse	174	2.4	9.4	23.8		1.8
	22 People diagnosed with diabetes	3640	4.80	5.40	7.87		3.28
	23 New cases of tuberculosis	5	4	15	120		0
	24 Hip fracture in 65s and over	121	399.9	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	46	14.1	18.1	32.1		5.4
	26 Life expectancy - male	n/a	80.8	78.3	73.7		84.4
	27 Life expectancy - female	n/a	83.5	82.3	79.1		89.0
	28 Infant deaths	4	2.85	4.71	10.63		0.68
	29 Smoking related deaths	172	172.2	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	60	43.6	70.5	122.1		37.9
	31 Early deaths: cancer	131	97.5	112.1	159.1		76.1
	32 Road injuries and deaths	61	54.1	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2006 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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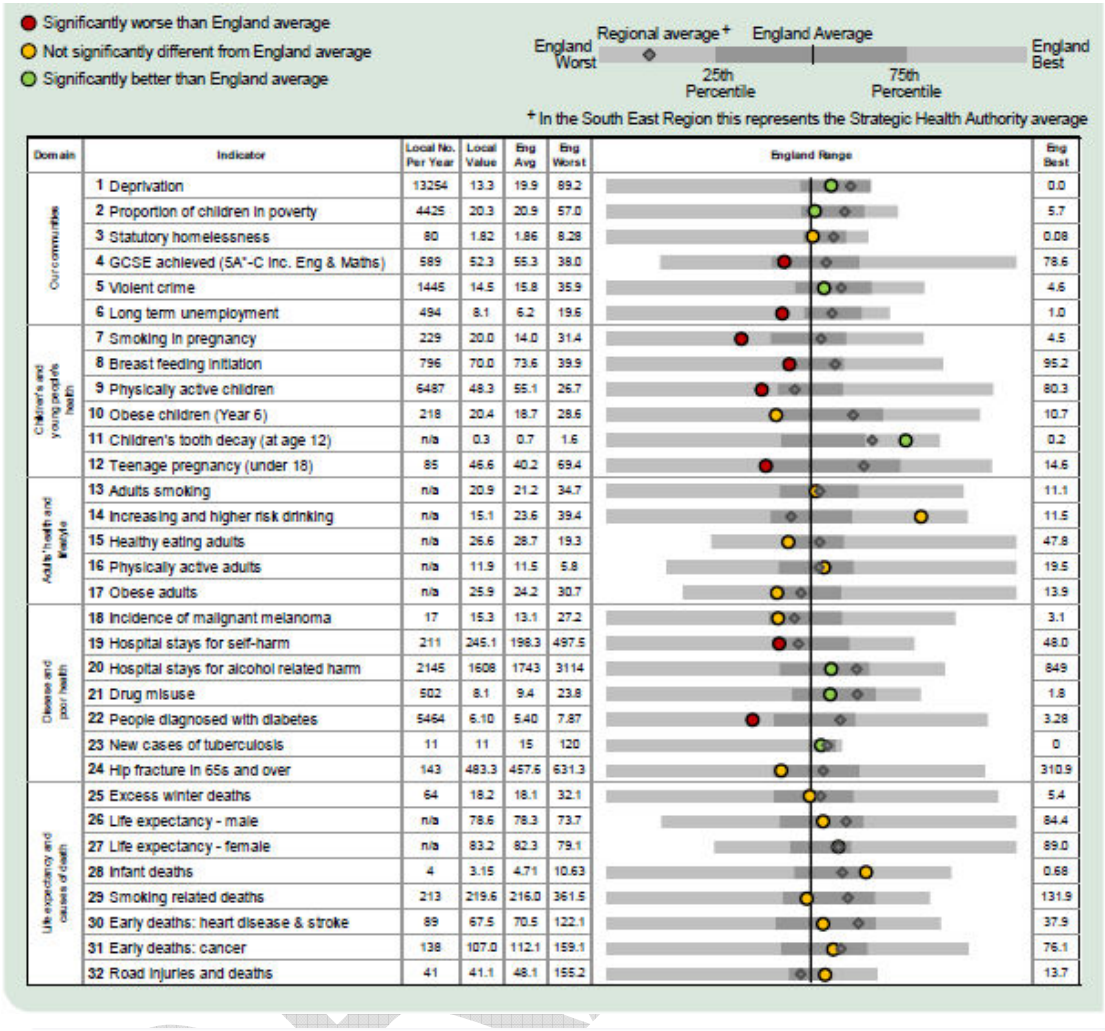
Shepway



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	13254	13.3	19.9	89.2		0.0
	2	Proportion of children in poverty	4425	20.3	20.9	57.0		5.7
	3	Statutory homelessness	80	1.82	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	589	52.3	55.3	38.0		78.6
	5	Violent crime	1445	14.5	15.8	35.9		4.6
	6	Long term unemployment	494	8.1	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	229	20.0	14.0	31.4		4.5
	8	Breast feeding initiation	796	70.0	73.6	39.9		95.2
	9	Physically active children	6487	48.3	55.1	26.7		80.3
	10	Obese children (Year 6)	218	20.4	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.3	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	85	46.6	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	20.9	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	15.1	23.6	39.4		11.5
	15	Healthy eating adults	n/a	26.6	28.7	19.3		47.8
	16	Physically active adults	n/a	11.9	11.5	5.8		19.5
	17	Obese adults	n/a	25.9	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	17	15.3	13.1	27.2		3.1
	19	Hospital stays for self-harm	211	245.1	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	2145	1608	1743	3114		849
	21	Drug misuse	502	8.1	9.4	23.8		1.8
	22	People diagnosed with diabetes	5464	6.10	5.40	7.87		3.28
	23	New cases of tuberculosis	11	11	15	120		0
	24	Hip fracture in 65s and over	143	483.3	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	64	18.2	18.1	32.1		5.4
	26	Life expectancy - male	n/a	78.6	78.3	73.7		84.4
	27	Life expectancy - female	n/a	83.2	82.3	79.1		89.0
	28	Infant deaths	4	3.15	4.71	10.63		0.68
	29	Smoking related deaths	213	219.6	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	89	67.5	70.5	122.1		37.9
	31	Early deaths: cancer	138	107.0	112.1	159.1		76.1
	32	Road injuries and deaths	41	41.1	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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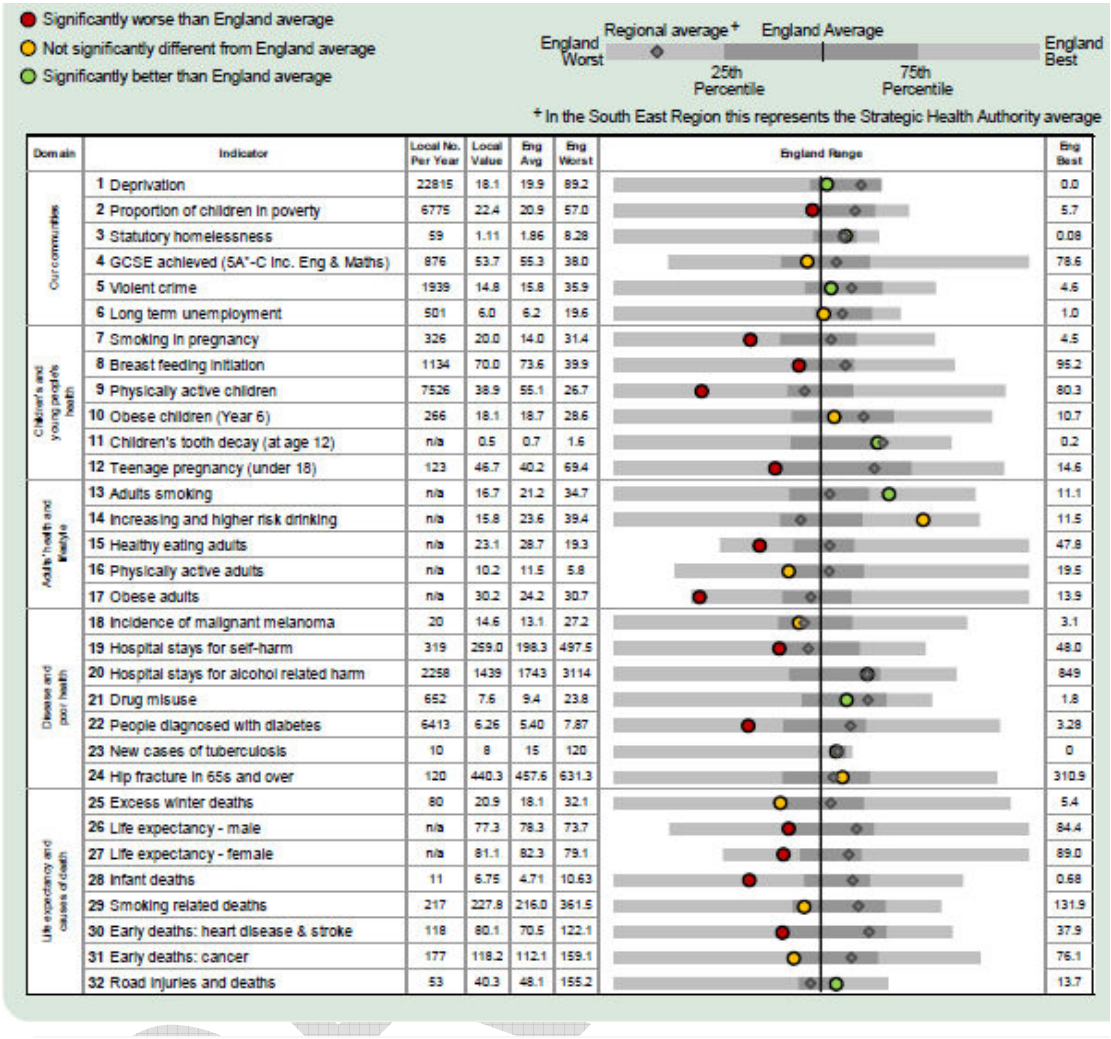
Swale



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	22815	18.1	19.9	89.2		0.0
	2	Proportion of children in poverty	6775	22.4	20.9	57.0		5.7
	3	Statutory homelessness	59	1.11	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	876	53.7	55.3	38.0		78.6
	5	Violent crime	1939	14.8	15.8	35.9		4.6
	6	Long term unemployment	501	6.0	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	326	20.0	14.0	31.4		4.5
	8	Breast feeding initiation	1134	70.0	73.6	39.9		95.2
	9	Physically active children	7526	38.9	55.1	26.7		80.3
	10	Obese children (Year 6)	266	18.1	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	123	46.7	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	16.7	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	15.8	23.6	39.4		11.5
	15	Healthy eating adults	n/a	23.1	28.7	19.3		47.8
	16	Physically active adults	n/a	10.2	11.5	5.8		19.5
	17	Obese adults	n/a	30.2	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	20	14.6	13.1	27.2		3.1
	19	Hospital stays for self-harm	319	259.0	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	2258	1439	1743	3114		849
	21	Drug misuse	652	7.6	9.4	23.8		1.8
	22	People diagnosed with diabetes	6413	6.26	5.40	7.87		3.28
	23	New cases of tuberculosis	10	8	15	120		0
	24	Hip fracture in 65s and over	120	440.3	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	80	20.9	18.1	32.1		5.4
	26	Life expectancy - male	n/a	77.3	78.3	73.7		84.4
	27	Life expectancy - female	n/a	81.1	82.3	79.1		89.0
	28	Infant deaths	11	6.75	4.71	10.63		0.68
	29	Smoking related deaths	217	227.8	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	118	80.1	70.5	122.1		37.9
	31	Early deaths: cancer	177	118.2	112.1	159.1		76.1
	32	Road injuries and deaths	53	40.3	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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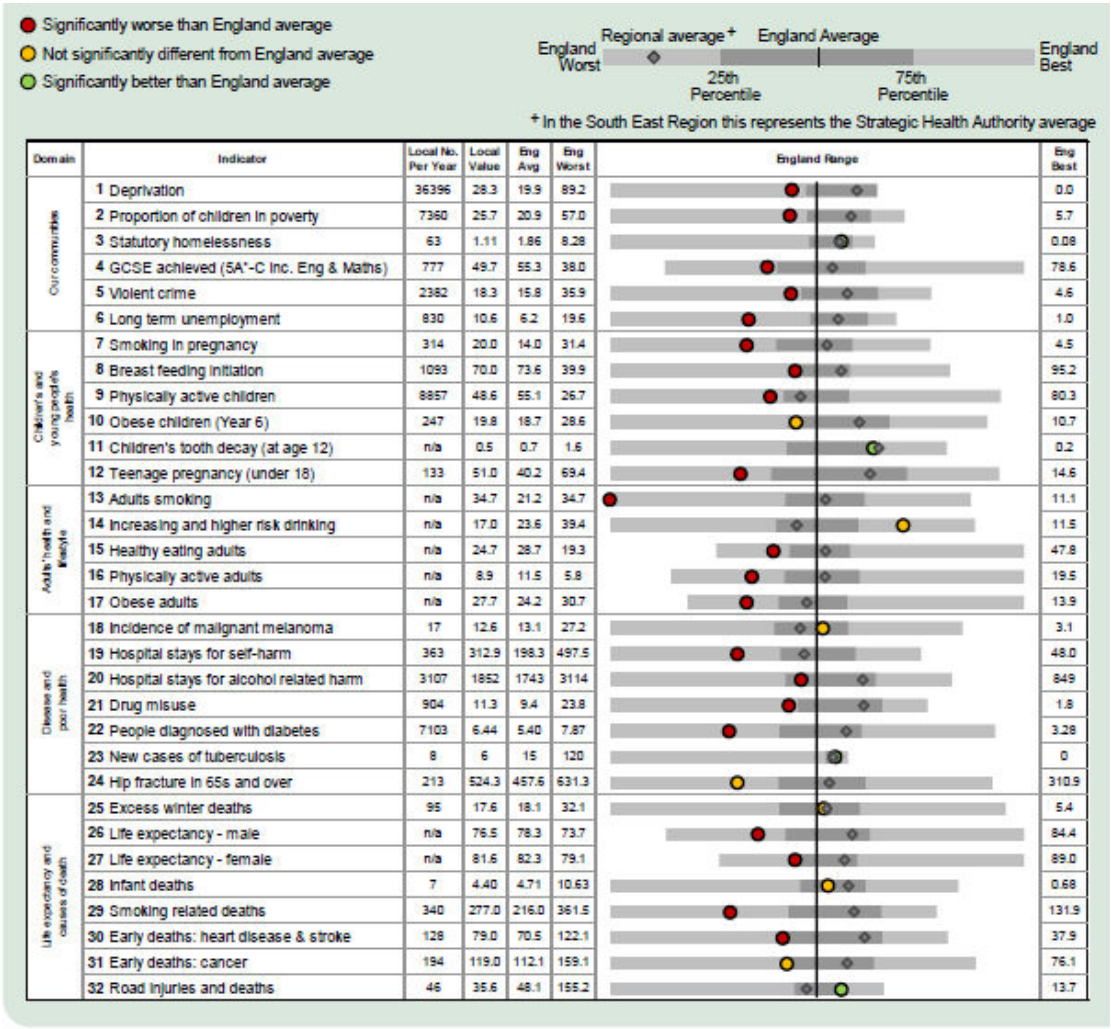

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	36396	28.3	19.9	89.2		0.0
	2	Proportion of children in poverty	7360	25.7	20.9	57.0		5.7
	3	Statutory homelessness	63	1.11	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	777	49.7	55.3	38.0		78.6
	5	Violent crime	2382	18.3	15.8	35.9		4.6
	6	Long term unemployment	830	10.6	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	314	20.0	14.0	31.4		4.5
	8	Breast feeding initiation	1093	70.0	73.6	39.9		95.2
	9	Physically active children	8857	48.6	55.1	26.7		80.3
	10	Obese children (Year 6)	247	19.8	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.5	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	133	51.0	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	34.7	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	17.0	23.6	39.4		11.5
	15	Healthy eating adults	n/a	24.7	28.7	19.3		47.8
	16	Physically active adults	n/a	8.9	11.5	5.8		19.5
	17	Obese adults	n/a	27.7	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	17	12.6	13.1	27.2		3.1
	19	Hospital stays for self-harm	363	312.9	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	3107	1852	1743	3114		849
	21	Drug misuse	904	11.3	9.4	23.8		1.8
	22	People diagnosed with diabetes	7103	6.44	5.40	7.87		3.28
	23	New cases of tuberculosis	8	6	15	120		0
	24	Hip fracture in 65s and over	213	524.3	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	95	17.6	18.1	32.1		5.4
	26	Life expectancy - male	n/a	76.5	78.3	73.7		84.4
	27	Life expectancy - female	n/a	81.6	82.3	79.1		89.0
	28	Infant deaths	7	4.40	4.71	10.63		0.68
	29	Smoking related deaths	340	277.0	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	128	79.0	70.5	122.1		37.9
	31	Early deaths: cancer	194	119.0	112.1	159.1		76.1
	32	Road injuries and deaths	46	35.6	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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Tonbridge and Malling

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

England Worst — Regional average + — England Average — England Best
25th Percentile — 75th Percentile

+ In the South East Region this represents the Strategic Health Authority average

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	1413	1.3	19.9	89.2		0.0
	2	Proportion of children in poverty	3170	11.9	20.9	57.0		5.7
	3	Statutory homelessness	32	0.70	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	930	61.2	55.3	38.0		78.6
	5	Violent crime	1030	8.9	15.8	35.9		4.6
	6	Long term unemployment	171	2.3	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	182	14.2	14.0	31.4		4.5
	8	Breast feeding initiation	927	73.6	73.6	39.9		95.2
	9	Physically active children	11181	64.5	55.1	26.7		80.3
	10	Obese children (Year 6)	200	15.2	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	67	28.8	40.2	69.4		14.6
Adults health and lifestyle	13	Adults smoking	n/a	18.4	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	18.9	23.6	39.4		11.5
	15	Healthy eating adults	n/a	28.7	28.7	19.3		47.8
	16	Physically active adults	n/a	10.5	11.5	5.8		19.5
	17	Obese adults	n/a	26.1	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	12	10.1	13.1	27.2		3.1
	19	Hospital stays for self-harm	266	257.5	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	1734	1228	1743	3114		849
	21	Drug misuse	436	5.8	9.4	23.8		1.8
	22	People diagnosed with diabetes	4868	4.98	5.40	7.87		3.28
	23	New cases of tuberculosis	6	5	15	120		0
	24	Hip fracture in 65s and over	93	385.8	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	50	17.5	18.1	32.1		5.4
	26	Life expectancy - male	n/a	80.1	78.3	73.7		84.4
	27	Life expectancy - female	n/a	84.1	82.3	79.1		89.0
	28	Infant deaths	1	0.97	4.71	10.63		0.68
	29	Smoking related deaths	161	180.9	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	76	56.4	70.5	122.1		37.9
	31	Early deaths: cancer	132	99.1	112.1	159.1		76.1
	32	Road injuries and deaths	59	50.9	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

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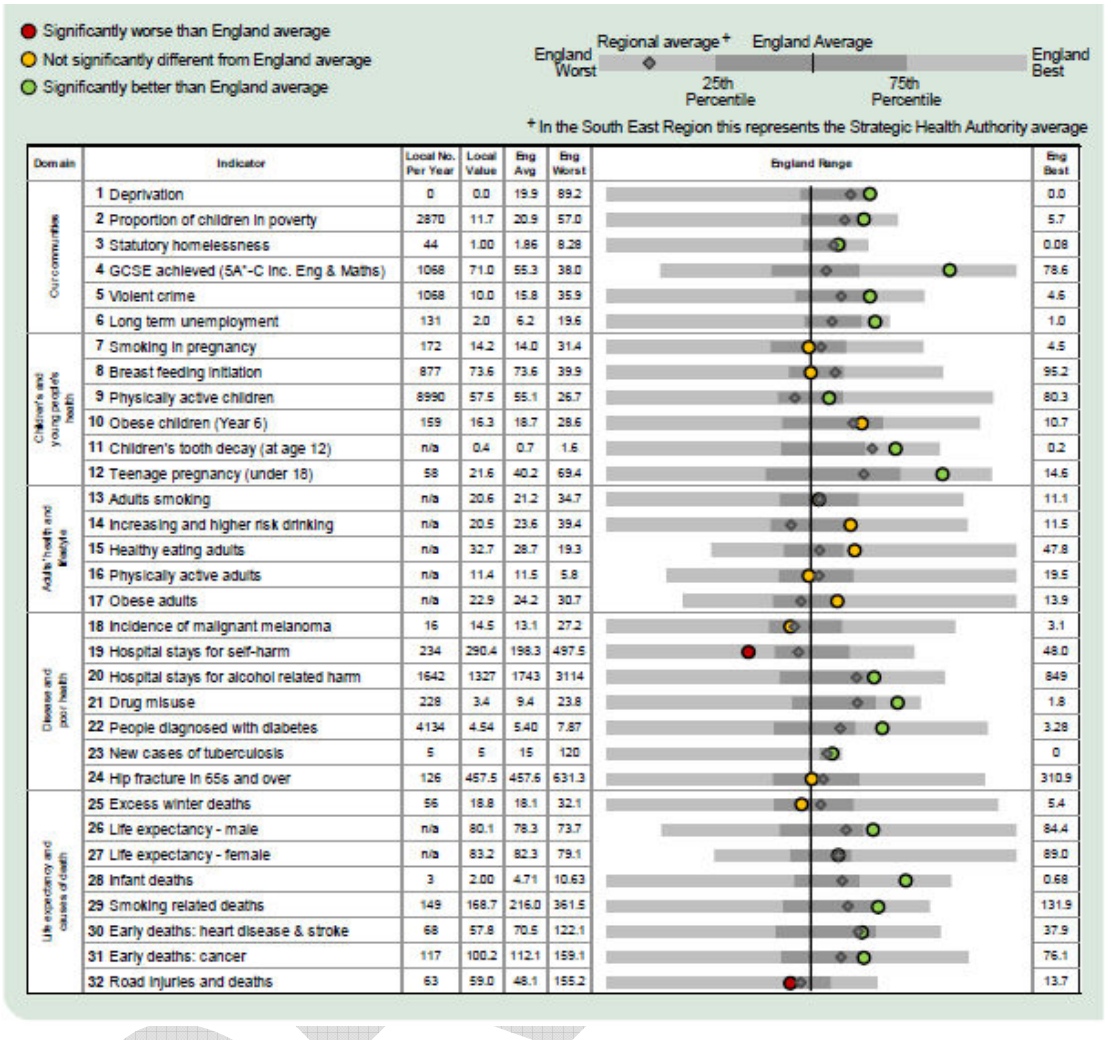
Tunbridge Wells



Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	0	0.0	19.9	89.2		0.0
	2	Proportion of children in poverty	2870	11.7	20.9	57.0		5.7
	3	Statutory homelessness	44	1.00	1.86	8.28		0.08
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1068	71.0	55.3	38.0		78.6
	5	Violent crime	1068	10.0	15.8	35.9		4.6
	6	Long term unemployment	131	2.0	6.2	19.6		1.0
Children's and young people's health	7	Smoking in pregnancy	172	14.2	14.0	31.4		4.5
	8	Breast feeding initiation	877	73.6	73.6	39.9		95.2
	9	Physically active children	8990	57.5	55.1	26.7		80.3
	10	Obese children (Year 6)	159	16.3	18.7	28.6		10.7
	11	Children's tooth decay (at age 12)	n/a	0.4	0.7	1.6		0.2
	12	Teenage pregnancy (under 18)	58	21.6	40.2	69.4		14.6
Adults' health and lifestyle	13	Adults smoking	n/a	20.6	21.2	34.7		11.1
	14	Increasing and higher risk drinking	n/a	20.5	23.6	39.4		11.5
	15	Healthy eating adults	n/a	32.7	28.7	19.3		47.8
	16	Physically active adults	n/a	11.4	11.5	5.8		19.5
	17	Obese adults	n/a	22.9	24.2	30.7		13.9
Disease and poor health	18	Incidence of malignant melanoma	16	14.5	13.1	27.2		3.1
	19	Hospital stays for self-harm	234	290.4	198.3	497.5		48.0
	20	Hospital stays for alcohol related harm	1642	1327	1743	3114		849
	21	Drug misuse	228	3.4	9.4	23.8		1.8
	22	People diagnosed with diabetes	4134	4.54	5.40	7.87		3.28
	23	New cases of tuberculosis	5	5	15	120		0
	24	Hip fracture in 65s and over	126	457.5	457.6	631.3		310.9
Life expectancy and causes of death	25	Excess winter deaths	56	18.8	18.1	32.1		5.4
	26	Life expectancy - male	n/a	80.1	78.3	73.7		84.4
	27	Life expectancy - female	n/a	83.2	82.3	79.1		89.0
	28	Infant deaths	3	2.00	4.71	10.63		0.68
	29	Smoking related deaths	149	168.7	216.0	361.5		131.9
	30	Early deaths: heart disease & stroke	68	57.8	70.5	122.1		37.9
	31	Early deaths: cancer	117	100.2	112.1	159.1		76.1
	32	Road injuries and deaths	63	59.0	48.1	155.2		13.7

Indicator Notes

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