From:	Roger Gough, Chairman and Cabinet Member for Education and Health Reform Andrew Scott-Clark, Director of Public Health
To:	Health and Wellbeing Board 25th May 2016
Subject:	Refreshed Kent Joint Strategic Needs Assessment (JSNA) Overview Report 2016
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None
Electoral Division:	All

Summary: This abridged version of the refreshed Kent JSNA Overview Report 2016 focuses attention upon the key locality and Kent wide priorities that have emerged from the refresh of the current JSNA.

Detailed commentary and recommendations upon the many conditions and other health and wellbeing influences are contained within a separate detailed document which is to be found on the Kent Public Health Observatory (KPHO) website at www.kpho.org.uk. The site also holds further supporting resources such as the locality Health and Social Care Maps.

Eight priorities, comprising six clinical areas and health improvement/prevention, and two influencing priorities namely demographics and growth emerge as those that necessitate commissioning action either at county level or at specified Clinical Commissioning Group (CCG)/district localities.

Recommendation: The Health and Wellbeing Board is asked to comment on the key strategic findings of the refreshed JSNA Overview Report 2016 and endorse the priorities.

Abridged Kent JSNA Overview Report 2016

1. Background

1.1 The purpose of the Joint Strategic Needs Assessment is to analyse the current and future health and wellbeing needs of the local population to inform the commissioning and provision of health, wellbeing and care services.

1.2 The current Kent JSNA has recently been refreshed with the most up to date data available. The Health and Wellbeing Board previously considered in September 2015 six key priorities for Kent from the JSNA for the 2016/2017 commissioning/contracting round

1.3 This abridged version of the refreshed Kent JSNA Overview Report is intended to focus attention upon the key locality and Kent wide priorities that have emerged from the refresh in order to support development of the Sustainability, Transformation Plans (STP) and future commissioning and provision of health and care services.

1.4 The report identifies eight priorities, comprising six clinical/health improvement areas:

- Diabetes,
- Cancer,
- Stroke,
- Mental Health,
- Healthy weight and
- Health inequalities

Included are two influencing priorities namely:

- Demographic pressures and
- Population growth

These strategic priorities will require commissioning action either at county level or at specified Clinical Commissioning Group (CCG)/district localities.

1.5 This report is structured to highlight those priorities that have a locus at County and sub County level. Priorities centred on the CCG(s) are grouped according to East Kent, North Kent and West Kent. Detailed commentary and recommendations on the many conditions and other health and wellbeing influences are contained within the detailed Kent JSNA which can be viewed on the Kent Public Health Observatory (KPHO) website at www.kpho.org.uk.

2. Kent Emerging Priorities

2.1 Diabetes

2.1.1 Across Kent, the recorded diabetes prevalence has risen from 4.5% in 2006/07 to 6.2% in 2014/15, an average annual increase of 0.2%. This rate of increase is similar across all CCGs, with none of the CCGs increasing at a significantly different rate to Kent.

2.1.2 West Kent CCG consistently has had the lowest prevalence (5.48%). Whilst Thanet (7.12%) and Swale (7.07%) CCGs tend to have fairly high prevalence. In 2014/15, West Kent and Canterbury and Coastal CCGs had significantly lower recorded diabetes prevalence than Kent, whilst East Kent, South Kent

Coast (SKC) and Thanet CCGs have significantly higher prevalence. In North Kent Swale CCG has significantly higher prevalence.

2.1.3 From 2006/07, the emergency diabetes admission rate increased steadily across Kent from 76.0 admissions per 10,000 population to 131.4 in 2014/15. All CCGs have had a similar increasing trend, with Thanet CCG consistently having the highest rate. West Kent CCG has had the lowest emergency admission rate since 2010/11. In East Kent, Canterbury and Coastal (156.8), South Kent Coast (154.4) and Thanet (160.0) all have significantly higher emergency admission rates per 10,000 population than Kent (131.4), whilst West Kent CCG had a significantly lower rate (105.7) in 2014/15.

2.1.4 Amputation rates show a steady rise in hospital admission rates across Kent over these time periods, from 0.24 to 0.65 admissions per 10,000 population. In North Kent the Swale CCG rate has increased notably since 2009/10 to 2011/12 (pooled), to 1.19 admissions per 10,000 population in 2012/13 to 2014/15 (pooled).

2.1.5 Diabetes related blindness is low. Between 2006/07 to 2014/15, the admission rate in Kent has increased steadily from 0.96 admissions per 10,000 population to 1.93 admissions. In East Kent Thanet CCG has consistently had the highest rate, although the rate in North Kent Dartford, Gravesham and Swanley (DGS) CCG increased to a level similar to that of Thanet CCG in the last time period.

2.1.6 Obesity accounts for 80–85% of the overall risk of developing Type 2 diabetes. Deprivation is strongly associated with higher levels of obesity. Physical inactivity, unhealthy diet, smoking and poor blood pressure control also increase the risk of diabetes or the risk of serious complications for those already diagnosed.

2.1.7 All CCGs in Kent have priorities that recognise that this clinical area requires commissioned action but specifically mentioned by Canterbury and Coastal and South Kent Coast CCGs.

2.1.8 Recommendations:

- That the population is advised about how to change behaviour to achieve a healthier diet and take more physical activity.
- Primary care should keep updated records of people's level of risk and create a recall system which will allow patients to be contacted and invited for regular reviews. In Kent this will be expected to be implemented through the National Diabetes Prevention Programme from 2016.
- Effective systems should be in place to ensure that people know what services and treatment is available, especially those aimed at people who are disadvantaged.

- Increase the number of people with diabetes who are achieving NICE targets for care management and the numbers of people who are receiving all of the nine NICE key processes of diabetes care reported in the National Diabetes Audit.

2.2 Cancer

2.2.1 Cancer is one of the largest causes of mortality in Kent. Cancer was recorded as the underlying cause of death in 29% of mortalities in 2014. This figure is even more pronounced in younger adults with cancer, accounting for 43% of premature mortalities (death under 75 years) in Kent in 2014.

2.2.2 The prevalence of cancer has increased due to a combination of an increasing average life expectancy of the population and an increased occurrence of risk factors for cancer (e.g. obesity). Survival rates have been improved due to better diagnosis and treatment.

2.2.3 There are marked inequalities in health outcomes of cancer between men and women, with the former group experiencing a significantly higher incidence of cancer mortality and years of life lost due to the disease. Similarly, there is inequality in the distribution of cancer diagnosis and outcomes associated with socioeconomic status.

2.2.4 In Kent the most common cancers in men are: prostate, colorectal and lung cancers: in women, breast, colorectal and lung cancer. The highest incidence of cancer in Kent is seen in East Kent in the Dover and Thanet districts. Analysis of CCG Quality and Outcomes Framework (QOF) 2014/15 data also suggests that the incidence of cancer is higher in East Kent than in North and West Kent.

2.2.5 The trend in one year survival after cancer diagnosis is upward, and is 69% in Kent overall, which is consistent with the England average. However, lower one year survival is noted in both East and North Kent namely Thanet and Swale CCGs (2009-2011).

2.2.6 Early diagnosis of cancer e.g.at stage 1 or 2, improves prognosis. The proportion of cancers in Kent which are diagnosed early is slightly lower than the England average. This will have a negative impact on morbidity and mortality, and may limit treatment options available to patients.

2.2.7 Nationally it has been demonstrated that the route of diagnosis is associated with survival, with emergency presentations having low survival outcomes compared to other routes. For example between 2006-13 one year survival was 97% for colorectal cancer patients diagnosed through screening,

compared to 82% for patients diagnosed via urgent GP referral, and 49% for emergency presentations. For cervical cancer the figures are 99%, 83% and 45% respectively and for female breast cancer the figures are 100%, 97% and 53% respectively.

2.2.8 There is variation in the rate of urgent GP referrals across Kent, with significantly higher rates of urgent referral noted in East Kent compared to North and West Kent.

2.2.9 Public Health England report lower uptake of bowel screening in East Kent (Thanet) and North Kent (DGS and Swale) and gradually reducing engagement for cervical screening (77.1%) across all Kent CCGs. They reinforce the need to increase breast screening rates across the County currently at 77.6%.

2.2.10 Both Thanet and Swale CCGs specifically mention cancer in their priorities. A cancer strategy and action plan has been developed by Thanet CCG and KCC Public Health.

2.2.11 Recommendations:

- Prevention of cancer and subsequent death involves both reduction in risk factors for cancer, such as smoking and obesity and early detection of pre-cancerous changes through screening programmes.
- Risk factors for cancer include the male sex and lower socioeconomic status. These risk groups should be targeted to reduce cancer incidence.
- More work is needed to understand the significance of the high rate of urgent GP referrals to cancer services in East Kent.
- Improving uptake of screening programmes with a particular emphasis in more deprived communities that have the lowest uptake rates

2.3 Stroke

2.3.1 The prevalence of stroke in Kent is increasing. Between 2006-07 and 2013-14, the prevalence of stroke increased by 1.34% across Kent and Medway compared to 0.94% for England.

2.3.2 The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence based standards and national and local benchmarks. Kent's stroke providers score quite well relative to the rest of the South East Coast Strategic Clinical Network (SCN), with high organisational scores in East Kent - Ashford, Canterbury and Margate. There are low scores in West and North Kent - Maidstone and Dartford.

2.3.3 Atrial Fibrillation is a known risk factor for stroke and its identification along with treatment is important for prevention. Across Kent there is a variation in assessing this risk of having a stroke amongst individuals with known Atrial Fibrillation and providing appropriate intervention. Overall the Kent & Medway prevalence of atrial fibrillation (1.80%) was higher than England (1.57%) in 2013/14; however, the rate of change between 2006/07 and 2013/14 was not increasing at a greater pace than England.

2.3.4 As more people are surviving stroke, an important role is placed upon post stroke care. This includes services such as early supported discharge (within 10 days) and multidisciplinary community rehabilitation services. The South East Coast SCN recently published guidance for commissioners on post stroke care "Life after Stroke" to better support those who have had a stroke to get back to living a full and active life and reintegrating within society.

2.3.5 Thanet CCG specifically highlights stroke in its priorities.

2.3.6 Recommendations:

- Public health commissioners should continue to commission services that promote healthier lifestyles, smoking cessation, and cholesterol and hypertension management as well as NHS Health Checks to reduce stroke risk factors.
- Service Commissioners should commission acute stroke care services to meet core performance and quality standards to achieve best possible outcomes for individuals who are affected by stroke.
- Service commissioners should commission post stroke care to ensure that stroke patients can recover as best as possible and minimise the impact of disability on their life and wider society.

2.4 Mental Health

2.4.1 The number of people with mental health problems can be calculated by using The Adult Psychiatric Morbidity Survey (2007) and applying it to the Kent population.

- estimated number of people with common mental illness: 85,000
- estimated number of people with only one common mental illness: 25,000
- estimated number of people with severe mental illness: 58,000
- estimated number of people with more than one mental health problem: 58,000.
- estimated number of people with depression over 65: 20,000

2.4.2 The majority of people with the worst mental health in Kent are aged 35-65 years old. The over 65s also face non dementia related depression and anxiety. There is a strong link between the severity and duration of common mental illness and socioeconomic conditions. The risk groups include perinatal women, offenders and substance misusers.

2.4.3 Mental health including suicides is mentioned in priorities by three East Kent CCGs – Canterbury and Coastal, South Kent Coastal and Thanet CCGs

2.4.4 There are a significant number of recommendations from the Needs Assessment including dual diagnosis and these include:

- Commission in a way that enhances local community asset mapping and development, and engagement, thereby enabling people to feel connected and in control.
- Commissioners must ensure there is equity in the delivery of psychological therapy.
- Ensure all front line professionals feel equipped to tackle emotional wellbeing and sign post to early help for community wellbeing. e.g. training and support and suicide prevention
- Improve social and community support via integrated work from troubled families, drug and alcohol services, mental health services and criminal justice systems.
- Commissioners to prioritise the health improvement of people who have mental health diagnosis – and the mental health of people with physical health problems.
- CCG and KCC commissioners to work together strategically on a joint approach to commissioning children's mental health, particularly following guidance and recommendations the in JSNA for Children and Adolescent Mental Health Services (CAMHS) and prioritising supporting parents and Early Help.

2.5 Healthy Weight

2.5.1 The prevalence of obesity varies across Kent, with the highest prevalence rates of adult obesity to be found in North and East Kent. The percentage of adults classified as overweight or obese (2012) in the County had risen from 63.8% to 64.6% whilst that for children aged 10-11 has dropped from 33.5% to 32.7%. Children aged 4-5 has also dropped from 22.5% to 20.8%.

2.5.2 The prevalence of obesity varies across Kent, with the highest prevalence rates of adult obesity to be found in North Kent in Dartford and Swale CCGs and in East Kent Shepway CCG. The highest rates in four to five year olds

are also found in these CCGs. The highest rates in 10 to 11 year olds are found in North Kent DGS CCG, and in East Kent in SKC CCG (Thanet and Dover). The Kent trend has not significantly changed in year R and year 6 for overweight, obesity and excess weight 2010-11 to 2014-15.

2.5.3 People who are obese are at far higher risk than the general population of serious illness including diabetes, heart disease and stroke. Approximately nine years of life is prematurely lost to obesity related conditions.

2.5.4 Healthy weight including obesity and physical activity is cited as a priority by both North Kent CCGs (DGS and Swale) and three East Kent CCGs – Canterbury and Coastal, South Kent Coastal and Thanet. Local health and wellbeing boards have prioritised healthy weight and have been involved with reviewing local action plans for addressing obesity and improving population outcomes for children and adults.

2.5.5 Recommendations:

- Commissioners should develop an integrated model for obesity that includes other related health improvement strands such as emotional health and wellbeing, smoking and alcohol.
- Facilitate workforce development to enable the combined workforces of the health economy to feel confident in raising the issue of weight and providing consistent advice about the benefits of behaviour change.
- Commissioners should adopt a more targeted approach to ensure that the needs of those most at risk are met.
- Commissioners should facilitate better data sharing across the system to enable a more robust measurement of outcomes and inform commissioning of effective interventions based on more accurate calculations of return on investment.
- There is a need for better evaluation of what works, and links to academic partners would provide more robust methodologies.

2.6 Demographics

2.6.1 The projected growth in Kent's population to 2020 highlights the growth particularly in the two age bands of 65–84 (9.6%) and over 85 (13%). This has implications for both health and social care as these two age cohorts place increasing pressures on services through increasing numbers of patients with long term conditions needing complex care and treatment from different organisations.

2.6.2 It brings into focus the need for strategies and interventions to support Living Well and Ageing Well to help modify the impact that these individuals will present and to ensure that efforts to maximise life expectancy are achieved. This issue reinforces the need to have robust prevention programmes in place to support investment in behaviour change. It takes time, effort and new approaches to keep people with these conditions well and out of hospital.

2.6.3 The KCC produced strategy forecasts for population show the larger increases in general population occurring in both North Kent DGS CCG and East Kent SKC CCG areas (10% for DGS, mainly focused on Dartford area and 7% for SKC, mainly focused on Dover area). Ashford shows a 5% rise. The remaining areas are between 1% and 4%

2.7 Health Inequalities

2.7.1 Whilst health outcomes have been improving for Kent as a whole, the differences in these outcomes between affluent and deprived populations persist. Current data highlights this - whilst mortality rates are coming down across all deprivation deciles, the gap between the most affluent (the bottom line) and the most deprived (the top line) has not changed over the last 10 years, suggesting that efforts to tackle health inequalities are not yet having an impact on mortality rates.

2.7.2 Whilst Kent scores above the England average on a range of indicators, this countywide analysis hides the great diversity and disparities which exist within and between Kent's communities. Local Kent data demonstrates that poorer health behaviours and outcomes correlate strongly with these deprived areas: obesity prevalence, smoking prevalence, teenage pregnancy rates, alcohol related disease, registered disease prevalence, to name a few.

2.7.3 What is noticeable in the latest mortality and life expectancy data is that the tenth decile (most deprived), suffer disproportionately poorer health outcomes than other deciles. Analysis indicates that excess premature mortality in these areas is primarily caused by preventable chronic diseases which are the result of behavioural risk factors such as smoking, physical inactivity and poor diets.

2.7.4 A new action plan is being developed that aims to focus more systematic efforts towards the most deprived geographic areas in Kent. This will have the greatest impact on reducing health inequalities and the life expectancy gap.

2.7.5 Both South Kent Coast CCG and West Kent CCG specifically have health inequalities as a priority. Thanet Health and Wellbeing Board have prioritised health inequalities and a multi-agency sub-group focusing on inequalities has recently been established.

2.8 Growth

2.8.1 The Kent and Medway Growth and Infrastructure Framework (GIF) has been developed to provide a clear picture of housing and economic growth to 2031 and the infrastructure needed to support this growth.

2.8.2 Primary healthcare required to support population growth to 2031 was mapped, and the analysis of the provision of GP numbers identified that there is a lack of capacity in proposed growth areas. One hundred and forty-six additional GPs and associated premises of 24,100 sq.m and 121 additional dentists and associated premises of 6,000 sq.m will be required.

2.8.3 The number of additional beds required to support population growth, including both hospital beds and mental health beds was also examined and the following was highlighted. Dartford, Gravesham, Medway and Canterbury are all near capacity in bed provision, despite facing significant housing growth. The forecast population growth could equate to 515 additional hospital beds across Kent and Medway, with a further 106 additional mental health beds.

2.8.4 In North Kent DGS CCG will be under significant pressure in the next 15 years with Ebbsfleet Garden City comprising just 50% of the growth across the CCG area. Young professionals and young families are expected to move into the area but the older generation will also be invited to support community cohesion and avoid the creation of a dormitory town. The CCG state that existing healthcare services are already under significant strain and new models of care and a focus on prevention are going to be a priority to manage the current population healthcare demands and new growth.

2.8.5 There are limitations on the data used for the GIF, but there is a clear need to refine the picture of health and care infrastructure to meet future growth in the next and future iterations of the GIF. The GIF authors cite whilst the findings of the GIF should be read with caution; they highlight a critical challenge in

funding health and social care provision to meet future demand. In particular, the GIF has highlighted challenges in such provision in growth areas where the viability is more marginal.

3. Recommendation

3.1 Recommendation: The Health and Wellbeing Board is asked to **comment** on the key strategic findings of the refreshed JSNA Overview Report 2016 and **endorse** the priorities.

4. Contact details

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