From:	Graham Gibbens Cabinet Member for Adult Social Care and Public Health
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To:	Kent Health and Wellbeing Board
Date:	22nd March 2017
Subject:	Kent Joint Strategic Needs Assessment Exception Report 2016/17
Classification:	Unrestricted

Summary:

This paper provides a very brief list of key population highlights arising from the 2016/17 refresh of the Kent JSNA. The list enables the Kent Health and Wellbeing Board to be aware of relevant issues and trends which need to be addressed and reflect the key priorities and outcomes of the emerging Kent Joint Health and Wellbeing Strategy, due to be completed later this year.

Recommendations:

The Kent Health and Wellbeing Board is asked to **COMMENT** and **ENDORSE** the following recommendations:

- Ensure a system wide focus on prevention for the Kent & Medway STP.
- Continue the focus on the local populations that have the highest health inequalities.
- Support the ongoing development of the KID programme.

1 Introduction

1.1 The current JSNA 2016/17 refresh process is well underway and nearing completion and it has been taking place in parallel with the refresh of the Joint Health & Wellbeing Strategy (JHWS) as well as the Sustainability and Transformation Plan (STP) which has been developed jointly with NHS, Social Care and Public Health leaders across Kent and Medway.

1.2 The following needs assessments have been completed by the Public Health team in the last one year:

1.2.1 Oral Health
1.2.2 Perinatal Mental Health
1.2.3 Personality Disorders
1.2.4 All Age Autism Spectrum Disorders

1.2.5 Health Inequalities Action Plan
1.2.6 Sexual Health needs of prisoners
1.2.7 Evidence review of hyper-acute stroke units

2 Emerging Issues

2.1 The Joint Strategic Needs Assessment (JSNA) overview report for 2016 and the ensuing refresh of JSNA chapter summaries in late 2016 and early 2017 indicate key issues worthy of mention, including increased migration into Kent, an older population and inequities in heath and care service access, leading to health inequalities. Some of these exceptions have already been outlined in the 'case for change' section of the Kent & Medway STP discussed at the November 2016 Kent Health & Wellbeing Board meeting. As such they also act as a foundation for the short-term priorities for the Kent JHWS 2018 - 2023.

2.2 The following highlights have been summarised from latest health and demographic information for Kent:-

2.2.1 Latest local estimates suggest that in the next five years (2017 to 2022) the KCC area population is forecast to grow by 95,300, a 6.1% increase. Of this number, up to 12,000 will potentially be in the new town in Ebbsfleet, if development proceeds there as expected.

2.2.2 The number of people aged 65 and over is growing much faster (at 11.1%) than the population aged under 65 (at 4.9%).

2.2.3 Local analyses using the Kent Integrated Dataset (KID) indicate more than a third of the Kent population have at least one long term condition. However the majority of these people have multiple long term conditions, often both physical and mental health.

2.2.4 Most deaths in Kent were caused by chronic long term conditions including cardiovascular (including coronary heart disease and stroke) diseases (29%), cancer (28%) & respiratory disease (16%).

2.2.5 Poorer health behaviours and outcomes correlate strongly with those living in deprived areas and vulnerable risk groups such as children in care: obesity prevalence, smoking prevalence, teenage pregnancy rates, alcohol related disease, registered disease prevalence, to name a few.

2.2.6 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, the gap between the most affluent and the most deprived has not changed over the last 10 years, suggesting that efforts to tackle health inequalities are not yet having an impact on relative mortality rates. This is particularly true in terms of cancer across Kent. (See Figure 1 below).

2.2.7 Much of the inequalities gap (for cancer deaths) is mostly down to lung cancer with the number of deaths from lung cancer in the most deprived rising by 24% with the majority of these extra deaths being female (a 55% increase compared to 5% in males). There is also a similar widening in digestive cancers with the most deprived up 36% and the least deprived up 21%. This overall rise is driven by Oesophagus and pancreas cancers.

2.2.8 Lifestyle choices such as smoking, drinking, exercise and diet have an impact on our likelihood to develop these conditions so early prevention is becoming increasingly important to reduce demand in a health and social care system that is already stretched and facing significant financial challenges.

2.2.9 Population segmentation analyses carried out for the STP has helped identify the target risk populations, their per capita spend and the impact of interventions delivered at pace and scale (see Figure 2)

Figure 1: Summary for progress in mortality rates, 2009-11 – 2014-16, comparing most deprived decile with least deprived, by clinical commissioning group (CCG), various disease categories

	Cancer		Circulatory		Respiratory		Other Causes		All Causes	
CCG	Under 75s	All Ages	Under 75s	All Ages	Under 75s	All Ages	Under 75s	All Ages	Under 75s	All Ages
Ashford	↓	↓	↓	↑	↑	↑	↓	↓	↓	↓
Canterbury & Coastal	↑	↑	↓	↓	↑	↓	↑	↓	↑	↔
Dartford, Gravesham & Swanley	↑	↑	↓	↓	↓	↓	↓	↓	↓	↓
South Kent Coast	↑	↑	↑	↓	↓	↓	↓	↓	↔	↓
Swale	↑	↑	↑	↓	↓	↓	↑	↑	↑	↑
Thanet	↑	↑	↓	↓	↓	↓	↔	↑	↔	↔
West Kent	↓	↓	↓	↑	↓	↓	↓	↓	↓	↓
Kent	↑	↑	↓	↔	↓	↓	↔	↓	↔	↔

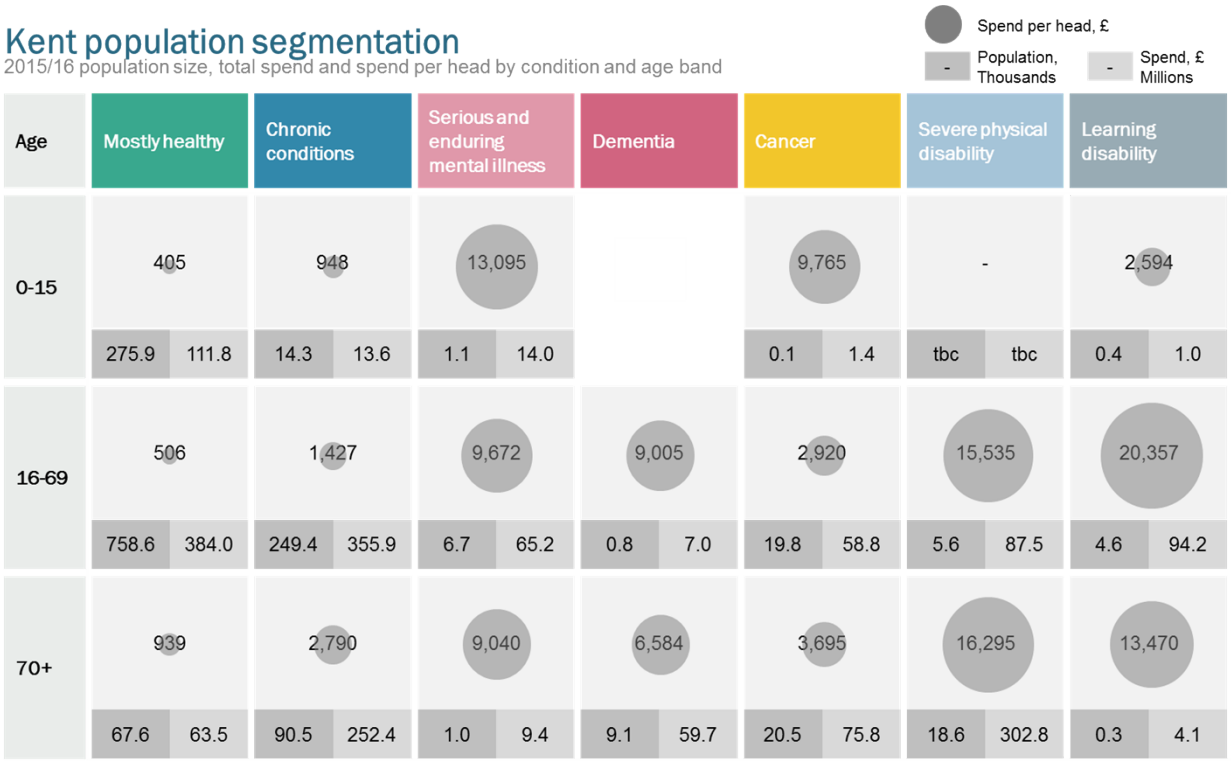
Source: PCMD, ONS, IMD, KPHO

↓ Gap between most and least deprived deciles is decreasing

↑ Gap between most and least deprived deciles is increasing

↔ Gap between most and least deprived deciles has remained unchanged (within a 5% tolerance)

Figure 2 Population Segmentation analysis showing per capita spend across different risk groups



Notes: People registered to GP surgeries which flow into KID but had no activity in 2015/16 have been added to "mostly healthy" segments. Populations have been scaled to account for population registered to practices not flowing data into the KID. Spend has been scaled to match CCG data returns to account for data not included in the KID (e.g. CAMHS, non-PbR acute activity). Children's social care, prescribing costs and continuing care costs are not included.
Source: Kent Integrated Dataset; Carnall Farrar analysis; latest version as of 30/11/2016

3. Conclusions

3.1 Whilst health outcomes have been improving for Kent as a whole, important differences in the outcomes between affluent and deprived populations persist, requiring a whole-systems approach to implementing preventative measures at population level.

3.2 Unless there is Wanless - type 'full engagement' of health and social care commissioners, providers, voluntary sector and communities themselves in preventing avoidable disease and disability and in delaying the onset of age-related disability, both the health and social care system in Kent and Medway will continue to be under pressure.

3.3 Previous discussions at Kent Health & Wellbeing Board raised the importance of targeting the populations residing in the 88 areas in Kent with the highest rates of all-age all-cause mortality. This continues to be a priority for Kent's health and care system.

3.4 A suite of preventative measures during and beyond the five year STP period is likely to yield a substantial financial and societal benefit to the Kent system if delivered at pace and scale with the participation of the wider health, social care and wider public sector workforce under the auspices of *Making Every Contact Count.*

3.5 A detailed economic case for prevention is being made through the use of local data and modelling techniques, results of which will be described in a future STP submission and the next iteration of the Joint Health & Wellbeing Strategy.

3.6 Much of the STP is already focused on the design and implementation of local care models, moving services out of hospital with health and social care staff working together (integration) to support an individual with their health and care needs. Emphasis is also given to parity of esteem, integrating physical and mental health services.

4 Moving the JSNA Forward

4.1 The development of the Kent Integrated Dataset (KID) is an exceedingly valuable resource which offers new opportunities to better understand historic integrated data and move the assessment of future need to new quality standards.

4.2 The JSNA development process is expected to change significantly in light of changes in staffing and the shift towards the use of better analytics for improved service planning and help inform STP and the Joint Health & Wellbeing Strategy going forward.

5 Recommendations

5.1 The Kent Health and Wellbeing Board is asked to **comment and endorse** the following recommendations:

- Ensure a system wide focus on prevention for the Kent & Medway STP.
- Continue the focus on the local populations that have the highest health inequalities.
- Support the ongoing development of the KID programme.

6 Contact Details

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